

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. ELECTRONICALLY FILED COST REPORT DATE: 02-14-2013 TIME: 16:44
 2. MANUALLY SUBMITTED COST REPORT
 3. IF THIS IS AN AMENDED REPORT ENTER THE NUMBER OF TIMES THE PROVIDER RESUBMITTED THIS COST REPORT
 4. MEDICARE UTILIZATION. ENTER "F" FOR FULL OR "L" FOR LOW.

CONTRACTOR USE ONLY 5. COST REPORT STATUS 6. DATE RECEIVED: _____ 10. NPR DATE: _____
 1 - AS SUBMITTED 7. CONTRACTOR NO: _____ 11. CONTRACTOR'S VENDOR CODE: _____
 2 - SETTLED WITHOUT AUDIT 8. INITIAL REPORT FOR THIS PROVIDER CCN 12. IF LINE 5, COLUMN 1 IS 4: ENTER
 3 - SETTLED WITH AUDIT 9. FINAL REPORT FOR THIS PROVIDER CCN NUMBER OF TIMES REOPENED - 0-9.
 4 - REOPENED
 5 - AMENDED

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 WHERE OTHERWISE ILLEGAL, CRIMINAL, CIVIL AND ADMINISTRATIVE ACTION, FINES AND/OR IMPRISONMENT MAY RESULT.

CERTIFICATION BY OFFICER OR ADMINISTRATOR OF PROVIDER(S)

I HEREBY CERTIFY THAT I HAVE READ THE ABOVE 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 10/01/2011 AND ENDING 09/30/2012, AND TO THE BEST OF MY KNOWLEDGE AND BELIEF, IT IS A TRUE, CORRECT AND COMPLETE STATEMENT PREPARED FROM THE BOOKS AND RECORDS OF THE PROVIDER IN ACCORDANCE WITH APPLICABLE INSTRUCTIONS, EXCEPT AS NOTED. I FURTHER CERTIFY THAT I AM FAMILIAR WITH THE LAWS AND REGULATIONS REGARDING THE PROVISION OF HEALTH CARE SERVICES, AND THAT THE SERVICES IDENTIFIED IN THIS COST REPORT WERE PROVIDED IN COMPLIANCE WITH SUCH LAWS AND REGULATIONS.

(SIGNED) _____
 OFFICER OR ADMINISTRATOR OF PROVIDER(S)

 TITLE

 DATE

PART III - SETTLEMENT SUMMARY

	TITLE V 1	TITLE XVIII PART A 2	PART B 3	HIT 4	TITLE XIX 5
1 HOSPITAL		104,596	43,605	-88,613	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			15,649		10
10.01 HEALTH CLINIC - RHC II			19		10.01
10.02 HEALTH CLINIC - RHC III			26,190		10.02
11 HEALTH CLINIC - FQHC					11
12 OUTPATIENT REHABILITATION PROVIDER					12
200 TOTAL		104,596	85,463	-88,613	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 RESPOND TO A COLLECTION OF INFORMATION UNLESS IT DISPLAYS A VALID OMB CONTROL NUMBER. THE VALID OMB CONTROL NUMBER FOR THIS INFORMATION COLLECTION IS 0938-0050. THE TIME REQUIRED TO COMPLETE 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.

HOSPITAL AND HEALTH CARE COMPLEX IDENTIFICATION DATA

WORKSHEET S-2
 PART I

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX ADDRESS:

1 STREET: 200 FAIRMAN AVENUE
 2 CITY: WATSEKA

STATE: IL

P.O.BOX:
 ZIP CODE: 60970

COUNTY: IROQUOIS

1
 2

HOSPITAL AND HOSPITAL-BASED COMPONENT IDENTIFICATION:

COMPONENT 0	COMPONENT NAME 1	CCN NUMBER 2	CBSA NUMBER 3	PROV TYPE 4	DATE CERTIFIED 5	PAYMENT SYSTEM (P, T, O, OR N)			
						V 6	XVIII 7	XIX 8	
3	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	14-U167	99914		12/31/2006	N	P	N	7
8	SWING BEDS - NF								8
9	HOSPITAL-BASED SNF	14-6049	99914		08/18/2003	N	P	N	9
10	HOSPITAL-BASED NF								10
11	HOSPITAL-BASED OLTC								11
12	HOSPITAL-BASED HHA	14-7586	99914		09/30/1994	N	P	N	12
13	SEPARATELY CERTIFIED ASC								13
14	HOSPITAL-BASED HOSPICE	14-1616	99914		11/04/2004				14
15	HOSPITAL-BASED HEALTH CLINIC - RHC	14-3424	99914		09/04/1996	N	O	N	15
15.01	HOSPITAL-BASED HEALTH CLINIC - RHC II	14-3425	99914		10/09/1996	N	O	N	15.01
15.02	HOSPITAL-BASED HEALTH CLINIC - RHC III	15-3979	99915		10/29/1996	N	O	N	15.02
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: 10/01/2011			TO: 09/30/2012				20
21	TYPE OF CONTROL								21

INPATIENT PPS INFORMATION

22	DOES THIS FACILITY QUALIFY FOR AND RECEIVE DISPROPORTIONATE SHARE HOSPITAL PAYMENT IN ACCORDANCE WITH 42 CFR §412.106 IN COLUMN 1, ENTER 'Y' FOR YES AND '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.							1	2
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		OUT-OF-STATE		OTHER		
		MEDICAID PAID DAYS	MEDICAID ELIGIBLE UNPAID DAYS	MEDICAID PAID DAYS	MEDICAID ELIGIBLE UNPAID DAYS	MEDICAID HMO PAID DAYS	MEDICAID OTHER MEDICAID DAYS	
		1	2	3	4	5	6	
24	IF THIS PROVIDER IS AN IPHS HOSPITAL, ENTER THE IN-STATE MEDICAID PAID DAYS IN COL. 1, IN-STATE MEDICAID ELIGIBLE UNPAID DAYS IN COL. 2, OUT-OF-STATE MEDICAID PAID DAYS IN COL. 3, OUT-OF-STATE MEDICAID ELIGIBLE UNPAID DAYS IN COL. 4, MEDICAID HMO PAID AND ELIGIBLE BUT UNPAID DAYS IN COL. 5, AND OTHER MEDICAID DAYS IN COL. 6.	525		9				24
25	IF THIS PROVIDER IS AN IRF, ENTER THE IN-STATE MEDICAID PAID DAYS IN COL. 1, IN-STATE MEDICAID ELIGIBLE UNPAID DAYS IN COL. 2, OUT-OF STATE MEDICAID DAYS IN COL. 3, OUT-OF STATE MEDICAID ELIGIBLE UNPAID DAYS IN COL. 4, MEDICAID HMO PAID AND ELIGIBLE BUT UNPAID DAYS IN COL. 5, AND OTHER MEDICAID DAYS IN COL. 6.							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: 10/01/2011	ENDING: 09/30/2012	36
37	IF THIS IS A MEDICARE DEPENDENT HOSPITAL (MDH), ENTER THE NUMBER OF PERIODS MDH STATUS IN EFFECT IN THE COST REPORTING PERIOD.							37
38	ENTER APPLICABLE BEGINNING AND ENDING DATES OF MDH STATUS. SUBSCRIPT LINE 38 FOR NUMBER PERIODS IN EXCESS OF ONE AND ENTER SUBSEQUENT DATES.					BEGINNING:	ENDING:	38

PROSPECTIVE PAYMENT SYSTEM(PPS)-CAPITAL

		V	XVIII	XIX
		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
46	IS THIS FACILITY ELIGIBLE FOR ADDITIONAL PAYMENT EXCEPTION FOR EXTRAORDINARY CIRCUMSTANCES PURSUANT TO 42 CFR §412.348(f)? IF YES, COMPLETE WORKSHEET L, PART III AND L-1, PARTS I THROUGH III.	N	N	N
47	IS THIS A NEW HOSPITAL UNDER 42 CFR §412.300 PPS CAPITAL? ENTER 'Y' FOR YES OR 'N' FOR NO.	N	N	N
48	IS THE FACILITY ELECTING FULL FEDERAL CAPITAL PAYMENT? ENTER 'Y' FOR YES OR 'N' FOR NO.	N	N	N

HOSPITAL AND HEALTH CARE COMPLEX IDENTIFICATION DATA

WORKSHEET S-2
 PART I (CONT)

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 WORKSHEET E-4. IF COLUMN 2 IS 'N', COMPLETE WORKSHEET D, PART III & IV AND D-2, PART II, IF APPLICABLE.	N	N	57
58	IF LINE 56 IS YES, DID THIS FACILITY ELECT COST REIMBURSEMENT FOR PHYSICIANS' SERVICES AS DEFINED IN CMS PUB 15-1, SECTION 2148? IF YES, COMPLETE WORKSHEET D-5.	N		58
59	ARE COSTS CLAIMED ON LINE 100 OF WORKSHEET A? IF YES, COMPLETE WORKSHEET D-2, PART I.	N		59
60	ARE YOU CLAIMING NURSING SCHOOL AND/OR ALLIED HEALTH COSTS FOR A PROGRAM THAT MEETS THE PROVIDER-OPERATED CRITERIA UNDER §413.85? ENTER 'Y' FOR YES OR 'N' FOR NO. (SEE INSTRUCTIONS)	N		60

	Y/N	IME AVERAGE	DIRECT GME AVERAGE	
61	DID YOUR FACILITY RECEIVE ADDITIONAL FTE SLOTS UNDER ACA SECTION 5503? ENTER 'Y' FOR YES OR 'N' FOR NO IN COLUMN 1. IF 'Y', EFFECTIVE FOR PORTIONS OF COST REPORTING PERIODS BEGINNING ON OR AFTER JULY 1, 2011 ENTER THE AVERAGE NUMBER OF PRIMARY CARE FTE RESIDENTS FOR IME IN COLUMN 2 AND DIRECT GME IN COLUMN 3 FROM THE HOSPITAL'S THREE MOST RECENT COST REPORTS ENDING AND SUBMITTED BEFORE MARCH 23, 2010. (SEE INSTRUCTIONS)	N		61

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 RECEIVED 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 NON-PROVIDER SETTINGS

63	HAS YOUR FACILITY TRAINED RESIDENTS IN NON-PROVIDER SETTINGS DURING THIS COST REPORTING PERIOD? ENTER 'Y' FOR YES OR 'N' FOR NO. IF YES, COMPLETE LINES 64-67. (SEE INSTRUCTIONS)	N		63
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SECTION 5504 OF THE ACA BASE YEAR FTE RESIDENTS IN NON-PROVIDER SETTINGS

	UNWEIGHTED FTES NONPROVIDER SITE	UNWEIGHTED FTES IN HOSPITAL	RATIO (COL.1/ (COL.1+COL.2))	
64	THIS BASE YEAR IS YOUR COST REPORTING PERIOD THAT BEGINS ON OR AFTER JULY 1, 2009 AND BEFORE JUNE 30, 2010. ENTER IN COLUMN 1, IF LINE 63 IS YES, OR YOUR FACILITY TRAINED RESIDENTS IN THE BASE YEAR PERIOD, THE NUMBER OF UNWEIGHTED NON-PRIMARY CARE RESIDENT FTES ATTRIBUTABLE TO ROTATIONS OCCURRING IN ALL NON-PROVIDER SETTINGS. ENTER IN COLUMN 2 THE NUMBER OF UNWEIGHTED NON-PRIMARY CARE RESIDENT FTES THAT TRAINED IN YOUR HOSPITAL. ENTER IN COLUMN 3 THE RATIO OF (COLUMN 1 DIVIDED BY (COLUMN 1 + COLUMN 2)). (SEE INSTRUCTIONS)			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.1/ (COL.3+COL.4))
1	2	3	4	5

SECTION 5504 OF THE ACA CURRENT YEAR FTE RESIDENTS IN NON-PROVIDER SETTINGS

	UNWEIGHTED FTES NONPROVIDER SITE	UNWEIGHTED FTES IN HOSPITAL	RATIO (COL.1/ (COL.1+COL.2))	
66	EFFECTIVE FOR COST REPORTING PERIODS BEGINNING ON OR AFTER JULY 1, 2010 ENTER IN COLUMN 1, THE NUMBER OF UNWEIGHTED NON-PRIMARY CARE RESIDENT FTES ATTRIBUTABLE TO ROTATIONS OCCURRING IN ALL NON-PROVIDER SETTINGS. ENTER IN COLUMN 2 THE NUMBER OF UNWEIGHTED NON-PRIMARY CARE RESIDENT FTES THAT TRAINED IN YOUR HOSPITAL. ENTER IN COLUMN 3 THE RATIO OF (COLUMN 1 DIVIDED BY (COLUMN 1 + COLUMN 2)). (SEE INSTRUCTIONS)			66

HOSPITAL AND HEALTH CARE COMPLEX IDENTIFICATION DATA

WORKSHEET S-2
 PART I (CONT)

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 FTE NONPROVIDER SITE	UNWEIGHTED FTE IN HOSPITAL	RATIO (COL.1 / (COL.3+COL.4))
1	2	3	4	5
INPATIENT PSYCHIATRIC FACILITY PPS				
70	IS THIS FACILITY AN INPATIENT PSYCHIATRIC FACILITY (IPF), OR DOES IT CONTAIN AN IPF SUBPROVIDER?			N 70
71	IF LINE 70 YES: COLUMN 1: DID THE FACILITY HAVE A TEACHING PROGRAM IN THE MOST RECENT COST REPORT FILED ON OR BEFORE NOVEMBER 15, 2004? ENTER 'Y' FOR YES OR 'N' FOR NO. COLUMN 2: DID THIS FACILITY TRAIN RESIDENTS IN A NEW TEACHING PROGRAM IN ACCORDANCE WITH 42 CFR §412.424(d)(1)(iii)(D)? ENTER 'Y' FOR YES AND 'N' FOR NO. COLUMN 3: IF COLUMN 2 IS Y, ENTER 1, 2, OR 3 RESPECTIVELY IN COLUMN 3. IF THIS COST REPORTING PERIOD COVERS THE BEGINNING OF THE FOURTH YEAR, ENTER 4 IN COLUMN 3, OR IF THE SUBSEQUENT ACADEMIC YEARS OF THE NEW TEACHING PROGRAM IN EXISTENCE, ENTER 5.			71
INPATIENT REHABILITATION FACILITY PPS				
75	IS THIS FACILITY AN INPATIENT REHABILITATION FACILITY (IRF), OR DOES IT CONTAIN AN IRF SUBPROVIDER?			N 75
76	IF LINE 75 YES: COLUMN 1: DID THE FACILITY HAVE A TEACHING PROGRAM IN THE MOST RECENT COST REPORTING PERIOD ENDING ON OR BEFORE NOVEMBER 15, 2004? ENTER 'Y' FOR YES OR 'N' FOR NO. COLUMN 2: DID THIS FACILITY TRAIN RESIDENTS IN A NEW TEACHING PROGRAM IN ACCORDANCE WITH 42 CFR §412.424(d)(1)(iii)(D)? ENTER 'Y' FOR YES AND 'N' FOR NO. COLUMN 3: IF COLUMN 2 IS Y, ENTER 1, 2, OR 3 RESPECTIVELY IN COLUMN 3. IF THIS COST REPORTING PERIOD COVERS THE BEGINNING OF THE FOURTH YEAR, ENTER 4 IN COLUMN 3, OR IF THE SUBSEQUENT ACADEMIC YEARS OF THE NEW TEACHING PROGRAM IN EXISTENCE, ENTER 5.			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
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.			N 86
TITLE V AND XIX INPATIENT SERVICES				
90	DOES THIS FACILITY HAVE TITLE V AND/OR XIX INPATIENT HOSPITAL SERVICES? ENTER 'Y' FOR YES, OR 'N' FOR NO IN APPLICABLE COLUMN.			V 1 2 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/MR 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
RURAL PROVIDERS				
105	DOES THIS HOSPITAL QUALIFY AS A CRITICAL ACCESS HOSPITAL (CAH)?			1 2 N 105
106	IF THIS FACILITY QUALIFIES AS A CAH, HAS IT ELECTED THE ALL-INCLUSIVE METHOD OF PAYMENT FOR OUTPATIENT SERVICES.			106
107	COLUMN 1: 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. IF YES, THE GME ELIMINATION WOULD NOT BE ON WORKSHEET B, PART I, COLUMN 26 AND THE PROGRAM WOULD BE COST REIMBURSED. IF YES, COMPLETE WORKSHEET D-2, PART II, COLUMN 2: IF THIS FACILITY IS A CAH, DO I&RS IN AN APPROVED MEDICAL EDUCATION PROGRAM TRAIN IN THE CAH'S EXCLUDED IPF AND/OR IRF UNIT? ENTER 'Y' FOR YES OR 'N' FOR NO IN COLUMN 2.			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
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.		PHY- OCCUP- RESPI- SICAL ATIONAL SPEECH RATORY	N N N N 109

HOSPITAL AND HEALTH CARE COMPLEX IDENTIFICATION DATA

WORKSHEET S-2
 PART I (CONT)

MISCELLANEOUS COST REPORTING INFORMATION

115	IS THIS AN ALL-INCLUSIVE RATE PROVIDER? ENTER 'Y' FOR YES OR 'N' FOR NO IN COLUMN 1. IF YES, ENTER THE METHOD USED (A, B, OR E ONLY) IN COLUMN 2. IF COLUMN 2 IS 'E', ENTER IN COLUMN 3 EITHER '93' PERCENT FOR SHORT TERM HOSPITAL OR '98' PERCENT FOR LONG TERM CARE (INCLUDES PSYCHIATRIC, REHABILITATION AND LONG TERM HOSPITALS PROVIDERS) BASED ON THE DEFINITION IN CMS 15-1§ 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
118.01	LIST AMOUNTS OF MALPRACTICE PREMIUMS AND PAID LOSSES: PREMIUMS: 87,615 PAID LOSSES: SELF INSURANCE:			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 IMPLANTABLE DEVICES CHARGED TO PATIENTS? ENTER 'Y' FOR YES OR 'N' FOR NO.	Y		121

TRANSPLANT CENTER INFORMATION

125	DOES THIS FACILITY OPERATE A TRANSPLANT CENTER? ENTER 'Y' FOR YES OR 'N' FOR NO. IF YES, ENTER CERTIFICATION DATE(S) (MM/DD/YYYY) BELOW.	N		125
126	IF THIS IS A MEDICARE CERTIFIED KIDNEY TRANSPLANT CENTER, ENTER THE CERTIFICATION DATE IN COLUMN 1 AND TERMINATION DATE, IF APPLICABLE, IN COLUMN 2.			126
127	IF THIS IS A MEDICARE CERTIFIED HEART TRANSPLANT CENTER, ENTER THE CERTIFICATION DATE IN COLUMN 1 AND TERMINATION DATE, IF APPLICABLE, IN COLUMN 2.			127
128	IF THIS IS A MEDICARE CERTIFIED LIVER TRANSPLANT CENTER, ENTER THE CERTIFICATION DATE IN COLUMN 1 AND TERMINATION DATE, IF APPLICABLE, IN COLUMN 2.			128
129	IF THIS IS A MEDICARE CERTIFIED LUNG TRANSPLANT CENTER, ENTER THE CERTIFICATION DATE IN COLUMN 1 AND TERMINATION DATE, IF APPLICABLE, IN COLUMN 2.			129
130	IF THIS IS A MEDICARE CERTIFIED PANCREAS TRANSPLANT CENTER, ENTER THE CERTIFICATION DATE IN COLUMN 1 AND TERMINATION DATE, IF APPLICABLE, IN COLUMN 2.			130
131	IF THIS IS A MEDICARE CERTIFIED INTESTINAL TRANSPLANT CENTER, ENTER THE CERTIFICATION DATE IN COLUMN 1 AND TERMINATION DATE, IF APPLICABLE, IN COLUMN 2.			131
132	IF THIS IS A MEDICARE CERTIFIED ISLET TRANSPLANT CENTER, ENTER THE CERTIFICATION DATE IN COLUMN 1 AND TERMINATION DATE, IF APPLICABLE, IN COLUMN 2.			132
133	IF THIS IS A MEDICARE CERTIFIED OTHER TRANSPLANT CENTER, ENTER THE CERTIFICATION DATE IN COLUMN 1 AND TERMINATION DATE, IF APPLICABLE, IN COLUMN 2.			133
134	IF THIS IS AN ORGAN PROCUREMENT ORGANIZATION (OPO), ENTER THE OPO NUMBER IN COLUMN 1 AND TERMINATION DATE, IF APPLICABLE, IN COLUMN 2.			134

ALL PROVIDERS

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.	1 N	2	140
-----	--	--------	---	-----

IF THIS FACILITY IS PART OF A CHAIN ORGANIZATION, ENTER ON LINES 141 THROUGH 143 THE NAME AND ADDRESS OF THE HOME OFFICE AND ENTER THE HOME OFFICE CONTRACTOR NAME AND CONTRACTOR NUMBER.

141	NAME:	CONTRACTOR'S NAME:	CONTRACTOR'S NUMBER:	141
142	STREET:	P.O. BOX:		142
143	CITY:	STATE:	ZIP CODE:	143
144	ARE PROVIDER BASED PHYSICIANS' COSTS INCLUDED IN WORKSHEET A?		Y	144
145	IF COSTS FOR RENAL SERVICES ARE CLAIMED ON WORKSHEET A, LINE 74 ARE THEY COSTS FOR INPATIENT SERVICES ONLY? ENTER 'Y' FOR YES, OR 'N' FOR NO.		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, SECTION 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		TITLE V	TITLE XIX
	PART A	PART B	V	XIX
	1	2	3	4
155	HOSPITAL	N	N	N
156	SUBPROVIDER - IPF	N	N	156
157	SUBPROVIDER - IRF	N	N	157
158	SUBPROVIDER - (OTHER)	N	N	158
159	SNF	N	N	159
160	HHA	N	N	160
161	CMHC		N	161

PROVIDER CCN: 14-0167 IROQUOIS MEMORIAL HOSPITAL
PERIOD FROM 10/01/2011 TO 09/30/2012

OPTIMIZER SYSTEMS, INC. WIN-LASH MICRO SYSTEM
IN LIEU OF FORM CMS-2552-10 (08/2011)

VERSION: 2012.11
02/14/2013 16:44

HOSPITAL AND HEALTH CARE COMPLEX IDENTIFICATION DATA

WORKSHEET S-2
PART I (CONT)

MULTICAMPUS

165 IS THIS HOSPITAL PART OF A MULTICAMPUS HOSPITAL THAT HAS ONE OR MORE CAMPUSES IN DIFFERENT CBSAs? N 165
ENTER 'Y' FOR YES OR 'N' FOR NO.

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.

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 A MEANINGFUL USER (LINE 167 IS 'Y'),
ENTER THE REASONABLE COST INCURRED FOR THE HIT ASSETS. 168

169 IF THIS PROVIDER IS A MEANINGFUL USER (LINE 167 IS 'Y') AND IS NOT A CAH
(LINE 105 IS 'N'), ENTER THE TRANSITIONAL FACTOR. 1.00 169

HOSPITAL AND 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	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)	1 N	2	1
		Y/N	DATE	V/I
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.	1 N	2	3 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
FINANCIAL DATA AND REPORTS				
		Y/N	TYPE	DATE
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.	1 Y	2 A	3 4
5	ARE THE COST REPORT TOTAL EXPENSES AND TOTAL REVENUES DIFFERENT FROM THOSE ON THE FILED FINANCIAL STATEMENTS? IF YES, SUBMIT RECONCILIATION.	N		5
APPROVED EDUCATIONAL ACTIVITIES				
		Y/N		Y/N
6	COLUMN 1: ARE COSTS CLAIMED FOR NURSING SCHOOL? COLUMN 2: IF YES, IS THE PROVIDER THE LEGAL OPERATOR OF THE PROGRAM?	1 N		2 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 INTERN-RESIDENT PROGRAMS CLAIMED ON THE CURRENT COST REPORT? IF YES, SEE INSTRUCTIONS.	N		9
10	WAS AN INTERN-RESIDENT PROGRAM INITIATED OR RENEWED IN THE CURRENT COST REPORTING PERIOD? IF YES, SEE INSTRUCTIONS.	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
				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				
		Y/N	DATE	
PS&R REPORT DATA				
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)	1 Y	2 12/11/2012	3 4 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		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		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		19
20	IF LINE 16 OR 17 IS YES, WERE ADJUSTMENTS MADE TO PS&R REPORT DATA FOR OTHER? DESCRIBE THE OTHER ADJUSTMENTS:	N		20
21	WAS THE COST REPORT PREPARED ONLY USING THE PROVIDER'S RECORDS? IF YES, SEE INSTRUCTIONS.	N		21

HOSPITAL AND 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 RELIEFED 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 CAPITALIZED 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

HOME OFFICE COSTS

	Y/N	DATE	
	1	2	
36			WERE 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	N		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: DAVID	LAST NAME: SCHNAKE	TITLE: PARTNER	41
42	EMPLOYER: KERBER, ECK & BRAECKEL LLP			42
43	PHONE NUMBER: 618-529-1040	E-MAIL ADDRESS: DAVIDS@KEBCPA.COM		43

HOSPITAL WAGE INDEX INFORMATION

WORKSHEET S-3
 PART II & III

PART II - WAGE DATA

	WKST A LINE NUMBER	AMOUNT REPORTED	RECLASS OF SALARIES (FROM WKST A-6)	ADJUSTED SALARIES (COL. 2 + COL. 3)	PAID HOURS RELATED TO SALARIES IN COL. 4	AVERAGE HOURLY WAGE (COL. 4 + COL. 5)	
	1	2	3	4	5	6	
SALARIES							
1	TOTAL SALARIES (SEE INSTRUCTIONS)	200	15,354,024	15,354,024	689,725.00	22.26	1
2	NON-PHYSICIAN ANESTHETIST PART A						2
3	NON-PHYSICIAN ANESTHETIST PART B						3
4	PHYSICIAN-PART A ADMINISTRATIVE						4
4.01	PHYSICIAN-PART A - TEACHING						4.01
5	PHYSICIAN-PART B	528,434		528,434	3,644.00	145.01	5
6	NON-PHYSICIAN-PART B	851,361		851,361	39,084.00	21.78	6
7	INTERNS & RESIDENTS (IN AN APPROVED PROGRAM)						7
7.01	CONTRACTED INTERNS & RESIDENTS (IN AN APPROVED PGM)						7.01
8	HOME OFFICE PERSONNEL						8
9	SNF	44	924,815	924,815	54,429.00	16.99	9
10	EXCLUDED AREA SALARIES (SEE INSTRUCTIONS)		3,148,605	3,148,605	128,740.00	24.46	10
	OTHER WAGES & RELATED COSTS						
11	CONTRACT LABOR (SEE INSTRUCTIONS)		1,219,525	1,219,525	13,992.00	87.16	11
12	CONTRACT MANAGEMENT AND ADMINISTRATIVE SERVICES						12
13	CONTRACT LABOR: PHYSICIAN-PART A - ADMINISTRATIVE						13
14	HOME OFFICE SALARIES & WAGE-RELATED COSTS						14
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)		1,825,804	1,825,804			17
18	WAGE-RELATED COSTS (OTHER)						18
19	EXCLUDED AREAS		732,362	732,362			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		45,057	45,057			23
24	WAGE-RELATED COSTS (RHC/FQHC)		155,055	155,055			24
25	INTERNS & RESIDENTS (IN AN APPROVED PROGRAM)						25
	OVERHEAD COSTS - DIRECT SALARIES						
26	EMPLOYEE BENEFITS		143,404	143,404	7,947.00	18.05	26
27	ADMINISTRATIVE & GENERAL		1,227,054	1,227,054	65,053.00	18.86	27
28	ADMINISTRATIVE & GENERAL UNDER CONTACT (SEE INST.)		463,679	463,679	2,473.00	187.50	28
29	MAINTENANCE & REPAIRS						29
30	OPERATION OF PLANT		240,731	240,731	14,799.00	16.27	30
31	LAUNDRY & LINEN SERVICE		38,057	38,057	3,561.00	10.69	31
32	HOUSEKEEPING		274,946	274,946	26,986.00	10.19	32
33	HOUSEKEEPING UNDER CONTRACT (SEE INSTRUCTIONS)						33
34	DIETARY		310,240	145,460	13,758.00	10.57	34
35	DIETARY UNDER CONTRACT (SEE INSTRUCTIONS)		28,157	28,157	431.00	65.33	35
36	CAFETERIA			164,780	15,583.00	10.57	36
37	MAINTENANCE OF PERSONNEL						37
38	NURSING ADMINISTRATION		526,899	526,899	17,740.00	29.70	38
39	CENTRAL SERVICES AND SUPPLY						39
40	PHARMACY						40
41	MEDICAL RECORDS & MEDICAL RECORDS LIBRARY		420,726	420,726	25,945.00	16.22	41
42	SOCIAL SERVICE						42
43	OTHER GENERAL SERVICE						43

PART III - HOSPITAL WAGE INDEX SUMMARY

1	NET SALARIES (SEE INSTRUCTIONS)	14,466,065		14,466,065	649,901.00	22.26	1
2	EXCLUDED AREA SALARIES (SEE INSTRUCTIONS)	4,073,420		4,073,420	183,169.00	22.24	2
3	SUBTOTAL SALARIES (LINE 1 MINUS LINE 2)	10,392,645		10,392,645	466,732.00	22.27	3
4	SUBTOTAL OTHER WAGES & RELATED COSTS (SEE INST.)	1,219,525		1,219,525	13,992.00	87.16	4
5	SUBTOTAL WAGE-RELATED COSTS (SEE INST.)	1,825,804		1,825,804		17.57%	5
6	TOTAL (SUM OF LINES 3 THRU 5)	13,437,974		13,437,974	480,724.00	27.95	6
7	TOTAL OVERHEAD COST (SEE INSTRUCTIONS)	3,673,893		3,673,893	194,276.00	18.91	7

HOSPITAL WAGE RELATED COSTS

WORKSHEET S-3
PART IV

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)	1,306,494 8
9 PRESCRIPTION DRUG PLAN	9
10 DENTAL, HEARING AND VISION PLAN	10
11 LIFE INSURANCE (IF EMPLOYER IS OWNER OR BENEFICIARY)	11
12 ACCIDENTAL 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	365,292 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	1,045,792 17
18 MEDICARE TAXES - EMPLOYERS PORTION ONLY	18
19 UNEMPLOYMENT INSURANCE	33,152 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	7,549 23
24 TOTAL WAGE RELATED COST (SUM OF LINES 1-23)	2,758,279 24
PART B - OTHER THAN CORE RELATED COST	
25 OTHER WAGE RELATED (OTHER WAGE RELATED COST)	25

PROVIDER CCN: 14-0167 IROQUOIS MEMORIAL HOSPITAL
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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	BENEFIT
0		LABOR	COST
		1	2
1	TOTAL FACILITY CONTRACT LABOR AND BENEFIT COST		1
2	HOSPITAL	1,247,682	2
3	SUBPROVIDER - IPF	1,247,682	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
15	HOSPITAL-BASED HEALTH CLINIC - FQHC		15
16	HOSPITAL-BASED (CMHC)		16
17	RENAL DIALYSIS		17
18	OTHER		18

HOSPITAL-BASED HOME HEALTH AGENCY STATISTICAL DATA

HHA NO.: 14-7586

WORKSHEET S-4

HOME HEALTH AGENCY STATISTICAL DATA

COUNTY:

DESCRIPTION	TITLE V 1	TITLE XVIII 2	TITLE XIX 3	OTHER 4	TOTAL 5	
1 HOME HEALTH AIDE HOURS		2,169		535	2,704	1
2 UNDUPLICATED CENSUS COUNT (SEE INSTRUCTION)		107.00	4.00	22.00	133.00	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 1	CONTRACT 2	TOTAL 3	
3 ADMINISTRATOR AND ASSISTANT ADMINISTRATOR(S)	0.60		0.60	3
4 DIRECTOR(S) AND ASSISTANT DIRECTOR(S)				4
5 OTHER ADMINISTRATIVE PERSONNEL	0.90		0.90	5
6 DIRECT NURSING SERVICE	2.75		2.75	6
7 NURSING SUPERVISOR				7
8 PHYSICAL THERAPY SERVICE	0.75		0.75	8
9 PHYSICAL THERAPY SUPERVISOR				9
10 OCCUPATIONAL THERAPY SERVICE	0.15		0.15	10
11 OCCUPATIONAL THERAPY SUPERVISOR				11
12 SPEECH PATHOLOGY SERVICE	0.05		0.05	12
13 SPEECH PATHOLOGY SUPERVISOR				13
14 MEDICAL SOCIAL SERVICE	0.05		0.05	14
15 MEDICAL SOCIAL SERVICE SUPERVISOR				15
16 HOME HEALTH AIDE	1.30		1.30	16
17 HOME HEALTH AIDE SUPERVISOR				17
18 OTHER (SPECIFY)				18

HOME HEALTH AGENCY CBSA CODES

19 ENTER IN COLUMN 1 THE NUMBER OF CBSAs WHERE YOU PROVIDED SERVICES DURING THE COST REPORTING PERIOD.	3	19
20 LIST THOSE CBSA CODE(S) IN COLUMN 1 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				TOTAL (COLS. 1-4)	
	WITHOUT OUTLIERS 1	WITH OUTLIERS 2	LUPA EPISODES 3	PEP ONLY EPISODES 4		
21 SKILLED NURSING VISITS	950	23	41	25	1,039	21
22 SKILLED NURSING VISIT CHARGES	144,638	3,502	6,242	3,806	158,188	22
23 PHYSICAL THERAPY VISITS	602	5	8	14	629	23
24 PHYSICAL THERAPY VISIT CHARGES	91,655	761	1,218	2,132	95,766	24
25 OCCUPATIONAL THERAPY VISITS	147			3	150	25
26 OCCUPATIONAL THERAPY VISIT CHARGES	22,381			457	22,838	26
27 SPEECH PATHOLOGY VISITS	8				8	27
28 SPEECH PATHOLOGY VISIT CHARGES	1,218				1,218	28
29 MEDICAL SOCIAL SERVICE VISITS	3	1			4	29
30 MEDICAL SOCIAL SERVICE VISIT CHARGES	567	189			756	30
31 HOME HEALTH AIDE VISITS	793	15	4	7	819	31
32 HOME HEALTH AIDE VISIT CHARGES	74,939	1,418	378	662	77,397	32
33 TOTAL VISITS (SUM OF LINES 21, 23, 25, 27, 29, AND 31)	2,503	44	53	49	2,649	33
34 OTHER CHARGES						34
35 TOTAL CHARGES (SUM OF LINES 22, 24, 26, 28, 30, 32 AND 34)	335,398	5,870	7,838	7,057	356,163	35
36 TOTAL NUMBER OF EPISODES (STANDARD/ NON-OUTLIER)	179		21	5	205	36
37 TOTAL NUMBER OF OUTLIER EPISODES		1			1	37
38 TOTAL NON-ROUTINE MEDICAL SUPPLY CHARGES	2,897		311	3	3,211	38

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 IN COLUMN 1 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.	N	2			
						TOTAL (COLS. 2 + 3)
	GROUP			SNF DAYS	SWING BED SNF DAYS	
	1			2	3	4
3	RUX					3
4	RUL					4
5	RVX					5
6	RVL					6
7	RHX					7
8	RHL					8
9	RMX					9
10	RML					10
11	RLX					11
12	RUC					12
13	RUB					13
14	RUA					14
15	RVC			59		59
16	RVB					16
17	RVA			210		210
18	RHC			245		245
19	RHB			234		234
20	RHA			712		712
21	RMC			36		36
22	RMB			10		10
23	RMA			99		99
24	RLB					24
25	RLA					25
26	ES3					26
27	ES2					27
28	ES1					28
29	HE2					29
30	HE1					30
31	HD2			14		14
32	HD1					32
33	HC2					33
34	HC1					34
35	HB2			14		14
36	HB1			21		21
37	LE2					37
38	LE1			3		3
39	LD2			2		2
40	LD1			8		8
41	LC2					41
42	LC1					42
43	LB2					43
44	LB1					44
45	CE2					45
46	CE1					46
47	CD2					47
48	CD1			9		9
49	CC2					49
50	CC1					50
51	CB2			13		13
52	CB1			8		8
53	CA2					53
54	CA1			37		37
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					66
67	BA2					67
68	BA1					68

PROSPECTIVE PAYMENT FOR SNF
 STATISTICAL DATA

WORKSHEET S-7

		SNF	SWING BED	TOTAL
		DAYS	SNF DAYS	(COLS.
		2	3	2 + 3)
GROUP				4
1				
69	PE2			69
70	PE1			70
71	PD2			71
72	PD1			72
73	PC2			73
74	PC1			74
75	PB2			75
76	PB1	1		1 76
77	PA2			77
78	PA1	2		2 78
199	AAA			199
200	TOTAL	1,737		1,737 200

		CBSA AT	CBSA ON/AFTER	
		BEGINNING	OCT 1 OF THE	
		OF COST	COST REPORTING	
		REPORTING	PERIOD (IF	
		PERIOD	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 CATEGORY. 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	
		1	2	WITH	
				DIRECT	
				PATIENT	
				CARE AND	
				RELATED	
				EXPENSES?	
				3	
202	STAFFING	924,815	54.30%	Y	202
203	RECRUITMENT				203
204	RETENTION OF EMPLOYEES				204
205	TRAINING				205
206	OTHER (SPECIFY)				206
207	TOTAL SNF REVENUE (WORKSHEET G-2, PART I, LINE 7, COLUMN 3)	1,703,049			207

HOSPICE IDENTIFICATION DATA

HOSPICE NO.: 14-1616

WORKSHEET S-9
 PARTS I & II

PART I - ENROLLMENT DAYS

----- UNDUPLICATED DAYS -----						
	TITLE XVIII 1	TITLE XIX 2	TITLE XVIII SKILLED NURSING FACILITY 3	TITLE XIX NURSING FACILITY 4	ALL OTHER 5	TOTAL (SUM OF COLS. 1, 2 & 5) 6
1	CONTINUOUS HOME CARE					1
2	ROUTINE HOME CARE	4,735	23	4,605	331	5,089
3	INPATIENT RESPITE CARE	100				100
4	GENERAL INPATIENT CARE	11				11
5	TOTAL HOSPICE DAYS	4,846	23	4,605	331	5,200

PART II - CENSUS DATA

	TITLE XVIII 1	TITLE XIX 2	TITLE XVIII SKILLED NURSING FACILITY 3	TITLE XIX NURSING FACILITY 4	ALL OTHER 5	TOTAL (SUM OF COLS. 1, 2 & 5) 6
6	NUMBER OF PATIENTS RECEIVING HOSPICE CARE	70	2	133	6	78
7	TOTAL NUMBER OF UNDUPLICATED CONTINUOUS CARE HOURS BILLABLE TO MEDICARE					7
8	AVERAGE LENGTH OF STAY (LINE 5/LINE 6)	69.23	11.50	34.62	55.17	66.67
9	UNDUPLICATED CENSUS COUNT	128	2	74	7	137

NOTE: PARTS I & II, COLUMNS 1 AND 2 ALSO INCLUDE THE DAYS REPORTED IN COLUMN 3 AND 4.

HOSPITAL UNCOMPENSATED CARE AND INDIGENT CARE DATA

WORKSHEET S-10

UNCOMPENSATED AND INDIGENT CARE COST COMPUTATION

1	COST TO CHARGE RATIO (WKST C, PART I, LINE 202, COL. 3 DIVIDED BY LINE 202, COL. 8)				0.418215	1
MEDICAID (SEE INSTRUCTIONS FOR EACH LINE)						
2	NET REVENUE FROM MEDICAID				2,293,835	2
3	DID YOU RECEIVE DSH OR SUPPLEMENTAL PAYMENTS FROM MEDICAID?				Y	3
4	IF LINE 3 IS YES, DOES LINE 2 INCLUDE ALL DSH OR SUPPLEMENTAL PAYMENTS FROM MEDICAID?				Y	4
5	IF LINE 4 IS NO, ENTER DSH OR SUPPLEMENTAL PAYMENTS FROM MEDICAID					5
6	MEDICAID CHARGES				8,263,918	6
7	MEDICAID COST (LINE 1 TIMES LINE 6)				3,456,094	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.				1,162,259	8
STATE CHILDREN'S HEALTH INSURANCE PROGRAM (SCHIP)(SEE INSTRUCTIONS FOR EACH LINE)						
9	NET REVENUE FROM STAND-ALONE SCHIP					9
10	STAND-ALONE SCHIP CHARGES					10
11	STAND-ALONE SCHIP COST (LINE 1 TIMES LINE 10)					11
12	DIFFERENCE BETWEEN NET REVENUE AND COSTS FOR STAND-ALONE SCHIP (LINE 11 MINUS LINE 9) IF LINE 11 IS LESS THAN LINE 9, THEN ENTER ZERO.					12
OTHER STATE OR LOCAL GOVERNMENT INDIGENT CARE PROGRAM (SEE INSTRUCTIONS FOR EACH LINE)						
13	NET REVENUE FROM STATE OR LOCAL INDIGENT CARE PROGRAM (NOT INCLUDED ON LINES 2, 5, OR 9)					13
14	CHARGES FOR PATIENTS COVERED UNDER STATE OR LOCAL INDIGENT CARE PROGRAM (NOT INCLUDED IN LINES 6 OR 10)					14
15	STATE OR LOCAL INDIGENT CARE PROGRAM COST (LINE 1 TIMES LINE 14)					15
16	DIFFERENCE BETWEEN NET REVENUE AND COSTS FOR STATE OR LOCAL INDIGENT CARE PROGRAM (LINE 15 MINUS LINE 13) IF LINE 15 IS LESS THAN LINE 13, THEN ENTER ZERO.					16
UNCOMPENSATED CARE (SEE INSTRUCTIONS FOR EACH LINE)						
17	PRIVATE GRANTS, DONATIONS, OR ENDOWMENT INCOME RESTRICTED TO FUNDING 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)				1,162,259	19
		UNINSURED PATIENTS	INSURED PATIENTS	TOTAL		
		1	2	3		
20	TOTAL INITIAL OBLIGATION OF PATIENTS APPROVED FOR CHARITY CARE (AT FULL CHARGES EXCLUDING NON-REIMBURSABLE COST CENTERS) FOR THE ENTIRE FACILITY	1,137,636	138,665	1,276,301		20
21	COST OF INITIAL OBLIGATION OF PATIENTS APPROVED FOR CHARITY CARE (LINE 1 TIMES LINE 20)	475,776	57,992	533,768		21
22	PARTIAL PAYMENT BY PATIENTS APPROVED FOR CHARITY CARE			0		22
23	COST OF CHARITY CARE	475,776	57,992	533,768		23
24	DOES THE AMOUNT IN LINE 20, COLUMN 2 INCLUDE CHARGES FOR PATIENT DAYS BEYOND A LENGTH OF STAY LIMIT IMPOSED ON PATIENTS COVERED BY MEDICAID OR OTHER INDIGENT CARE PROGRAM					N 24
25	IF LINE 24 IS YES, ENTER CHARGES FOR PATIENT DAYS BEYOND AN INDIGENT CARE PROGRAM'S LENGTH OF STAY LIMIT (SEE INSTRUCTIONS)					25
26	TOTAL BAD DEBT EXPENSE FOR THE ENTIRE HOSPITAL COMPLEX (SEE INSTRUCTIONS)			1,384,858		26
27	MEDICARE BAD DEBTS FOR THE ENTIRE HOSPITAL COMPLEX (SEE INSTRUCTIONS) WORKSHEET E-3, PART V			261,759		27
28	NON-MEDICARE AND NON-REIMBURSABLE BAD DEBT EXPENSE (LINE 26 MINUS LINE 27)			1,123,099		28
29	COST OF NON-MEDICARE BAD DEBT EXPENSE (LINE 1 TIMES LINE 28)			469,697		29
30	COST OF NON-MEDICARE UNCOMPENSATED CARE (LINE 23, COL. 3 PLUS LINE 29)			1,003,465		30
31	TOTAL UNREIMBURSED AND UNCOMPENSATED CARE COST (LINE 19 PLUS LINE 30)			2,165,724		31

RECLASSIFICATION AND ADJUSTMENT OF TRIAL BALANCE OF EXPENSES

WORKSHEET A

COST CENTER		SALARIES	OTHER	TOTAL (COL. 1 + COL. 2)	RECLASSIFI- CATIONS	
		1	2	3	4	
GENERAL SERVICE COST CENTERS						
1	00100		1,733,654	1,733,654	-584,066	1
2	00200				900,281	2
3	00300					3
4	00400	143,404	1,613,653	1,757,057	217,176	4
5.01	00540	329,715	227,556	557,271	-652	5.01
5.02	00550	113,953	58,258	172,211	-55,025	5.02
5.03	00560	244,724	296,151	540,875	26,774	5.03
5.04	00570		152,125	152,125	21,333	5.04
5.05	00580	148,201	109,285	257,486	-644	5.05
5.06	00590	390,461	2,632,714	3,023,175	121,297	5.06
6	00600					6
7	00700	240,731	676,076	916,807	42,696	7
8	00800	38,057	6,324	44,381		8
9	00900	274,946	74,699	349,645		9
10	01000	310,240	311,798	622,038	-331,110	10
11	01100				330,387	11
12	01200					12
13	01300	526,899	68,624	595,523	-936	13
14	01400		10,364	10,364		14
15	01500					15
16	01600	420,726	382,074	802,800	-2,269	16
17	01700					17
19	01900					19
20	02000					20
21	02100					21
22	02200					22
23	02300					23
INPATIENT ROUTINE SERV COST CENTERS						
30	03000	1,840,906	826,746	2,667,652	-522,992	30
43	04300		66	66	314,039	43
44	04400	924,815	224,678	1,149,493	-28,092	44
ANCILLARY SERVICE COST CENTERS						
50	05000	716,299	1,956,396	2,672,695	-1,245,406	50
52	05200				161,730	52
53	05300		335,568	335,568	-10,734	53
54	05400	797,509	1,529,578	2,327,087	-590,679	54
60	06000	606,704	995,037	1,601,741	-4,047	60
62.30	06250					62.30
65	06500	331,504	146,626	478,130	-49,234	65
66	06600	591,198	404,768	995,966	-13,824	66
69	06900	115,421	56,386	171,807	-674	69
71	07100				657,556	71
72	07200				1,413,368	72
73	07300	470,968	963,925	1,434,893	101,339	73
76.97	07697					76.97
76.98	07698					76.98
76.99	07699					76.99
OUTPATIENT SERVICE COST CENTERS						
88	08800	323,829	126,710	450,539	-26,910	88
88.01	08801	249,598	143,586	393,184	-41,589	88.01
88.02	08802	783,852	301,469	1,085,321	-70,875	88.02
90	09000	486,926	-101,972	384,954	-51,162	90
91	09100	783,833	665,349	1,449,182	-24,473	91
92	09200					92
OTHER REIMBURSABLE COST CENTERS						
95	09500	706,820	206,296	913,116	-36,940	95
101	10100	354,603	103,158	457,761	-8,872	101
SPECIAL PURPOSE COST CENTERS						
113	11300		290,612	290,612	-290,612	113
116	11600	611,128	416,938	1,028,066	-105,237	116
118		13,877,970	17,945,275	31,823,245	210,922	118
NONREIMBURSABLE COST CENTERS						
190	19000		2,738	2,738	14,531	190
192	19200					192
194	07950	1,085,781	970,921	2,056,702	-51,711	194
194.01	07951	154,965	255,738	410,703	-144,011	194.01
194.02	07952	235,308	462,957	698,265	-29,731	194.02
194.03	07953					194.03
194.04	07954					194.04
200		15,354,024	19,637,629	34,991,653		200

RECLASSIFICATION AND ADJUSTMENT OF TRIAL BALANCE OF EXPENSES

WORKSHEET A

COST CENTER		RECLASSIFIED TRIAL BALANCE (COL. 3 ± COL. 4) 5	ADJUST- MENTS 6	NET EXPENSES FOR ALLOCATION (COL. 5 ± COL. 6) 7	
1	00100 GENERAL SERVICE COST CENTERS				
2	00200 CAP REL COSTS-BLDG & FIXT	1,149,588	-27,911	1,121,677	1
3	00300 CAP REL COSTS-MVBLE EQUIP	900,281	-4,187	896,094	2
4	00400 OTHER CAPITAL RELATED COSTS				3
5	00500 EMPLOYEE BENEFITS	1,974,233	-8,852	1,965,381	4
5.01	00540 ADMISSIONS	556,619	-30,007	526,612	5.01
5.02	00550 PURCHASING, RECEIVING, AND STORES	117,186		117,186	5.02
5.03	00560 DATA PROCESSING	567,649		567,649	5.03
5.04	00570 COMMUNICATIONS	173,458		173,458	5.04
5.05	00580 BUSINESS OFFICE	256,842		256,842	5.05
5.06	00590 OTHER ADMINISTRATIVE AND GENERAL	3,144,472	-1,003,633	2,140,839	5.06
6	00600 MAINTENANCE & REPAIRS				6
7	00700 OPERATION OF PLANT	959,503	-12,785	946,718	7
8	00800 LAUNDRY & LINEN SERVICE	44,381	-117	44,264	8
9	00900 HOUSEKEEPING	349,645	-1,384	348,261	9
10	01000 DIETARY	290,928		290,928	10
11	01100 CAFETERIA	330,387	-127,915	202,472	11
12	01200 MAINTENANCE OF PERSONNEL				12
13	01300 NURSING ADMINISTRATION	594,587	-928	593,659	13
14	01400 CENTRAL SERVICES & SUPPLY	10,364		10,364	14
15	01500 PHARMACY				15
16	01600 MEDICAL RECORDS & LIBRARY	800,531	-3,072	797,459	16
17	01700 SOCIAL SERVICE				17
19	01900 NONPHYSICIAN ANESTHETISTS				19
20	02000 NURSING SCHOOL				20
21	02100 I&R SRVCES-SALARY & FRINGES APPRVD				21
22	02200 I&R SRVCES-OTHER PRGM COSTS APPRVD				22
23	02300 PARAMED ED PRGM-(SPECIFY)				23
	INPATIENT ROUTINE SERV COST CENTERS				
30	03000 ADULTS & PEDIATRICS	2,144,660	-10,423	2,134,237	30
43	04300 NURSERY	314,105		314,105	43
44	04400 SKILLED NURSING FACILITY	1,121,401	-801	1,120,600	44
	ANCILLARY SERVICE COST CENTERS				
50	05000 OPERATING ROOM	1,427,289	-350,857	1,076,432	50
52	05200 DELIVERY ROOM & LABOR ROOM	161,730		161,730	52
53	05300 ANESTHESIOLOGY	324,834	-322,169	2,665	53
54	05400 RADIOLOGY-DIAGNOSTIC	1,736,408	-62,024	1,674,384	54
60	06000 LABORATORY	1,597,694		1,597,694	60
62.30	06250 BLOOD CLOTTING FOR HEMOPHILIACS				62.30
65	06500 RESPIRATORY THERAPY	428,896	-25,125	403,771	65
66	06600 PHYSICAL THERAPY	982,142	-10,909	971,233	66
69	06900 ELECTROCARDIOLOGY	171,133	-36,890	134,243	69
71	07100 MEDICAL SUPPLIES CHRGD TO PATIENTS	657,556	-482	657,074	71
72	07200 IMPL. DEV. CHARGED TO PATIENT	1,413,368		1,413,368	72
73	07300 DRUGS CHARGED TO PATIENTS	1,536,232		1,536,232	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 (RHC)	423,629		423,629	88
88.01	08801 RHC II	351,595		351,595	88.01
88.02	08802 RHC III	1,014,446		1,014,446	88.02
90	09000 CLINIC	333,792	-139,029	194,763	90
91	09100 EMERGENCY	1,424,709	-533,219	891,490	91
92	09200 OBSERVATION BEDS				92
	OTHER REIMBURSABLE COST CENTERS				
95	09500 AMBULANCE SERVICES	876,176	-62,987	813,189	95
101	10100 HOME HEALTH AGENCY	448,889		448,889	101
	SPECIAL PURPOSE COST CENTERS				
113	11300 INTEREST EXPENSE				113
116	11600 HOSPICE	922,829	-26,758	896,071	116
118	SUBTOTALS (SUM OF LINES 1-117)	32,034,167	-2,802,464	29,231,703	118
	NONREIMBURSABLE COST CENTERS				
190	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	17,269		17,269	190
192	19200 PHYSICIANS' PRIVATE OFFICES				192
194	07950 IROQUOIS WOMEN'S HEALTH	2,004,991		2,004,991	194
194.01	07951 OTHER NON-REIMBURSABLE COSTS	266,692		266,692	194.01
194.02	07952 DURABLE MEDICAL EQUIPMENT SALES/RENT	668,534		668,534	194.02
194.03	07953 WELLNESS				194.03
194.04	07954 RENTED SPACE				194.04
200	TOTAL (SUM OF LINES 118-199)	34,991,653	-2,802,464	32,189,189	200

RECLASSIFICATIONS

WORKSHEET A-6

EXPLANATION OF RECLASSIFICATION ENTRY	CODE	COST CENTER	INCREASE	SALARY	OTHER
	1	2	LINE #	4	5
1 RECLASS MOVEABLE EQUIP DEPR	A	CAP REL COSTS-MVBLE EQUIP	2		850,303 1
500 TOTAL RECLASSIFICATIONS					850,303 500
CODE LETTER - A					
1 RECLASS ADVERTISING	B	OTHER ADMINISTRATIVE AND GENE	5.06		163,827 1
2					2
3					3
4					4
5					5
6					6
7					7
500 TOTAL RECLASSIFICATIONS					163,827 500
CODE LETTER - B					
1 RECLASS MEDICAL SUPPLIES	C	MEDICAL SUPPLIES CHRGED TO PA	71		657,556 1
2					2
3					3
4					4
5					5
6					6
7					7
8					8
9					9
10					10
11					11
12					12
13					13
14					14
15					15
500 TOTAL RECLASSIFICATIONS					657,556 500
CODE LETTER - C					
1 RECLASS DRUGS CHARGED TO PATIENTS	D	DRUGS CHARGED TO PATIENTS	73		101,382 1
2					2
3					3
4					4
5					5
6					6
7					7
8					8
9					9
10					10
500 TOTAL RECLASSIFICATIONS					101,382 500
CODE LETTER - D					
1 RECLASS TELEPHONE EXPENSE	E	COMMUNICATIONS	5.04		21,333 1
2					2
3					3
4					4
5					5
6					6
7					7
8					8
9					9
10					10
11					11
500 TOTAL RECLASSIFICATIONS					21,333 500
CODE LETTER - E					
1 RECLASS INTEREST EXPENSE	F	CAP REL COSTS-BLDG & FIXT	1		252,698 1
2		CAP REL COSTS-MVBLE EQUIP	2		37,908 2
3		OTHER ADMINISTRATIVE AND GENE	5.06		6 3
500 TOTAL RECLASSIFICATIONS					290,612 500
CODE LETTER - F					
1 RECLASS CAFETERIA	G	CAFETERIA	11	164,780	165,607 1
500 TOTAL RECLASSIFICATIONS				164,780	165,607 500
CODE LETTER - G					

RECLASSIFICATIONS

WORKSHEET A-6

EXPLANATION OF RECLASSIFICATION ENTRY	CODE	----- INCREASE -----		SALARY	OTHER	
		COST CENTER	LINE #			
	1	2	3	4	5	
1 RECLASS NURSERY COST	H	NURSERY	43	198,592	115,447	1
2		DELIVERY ROOM & LABOR ROOM	52	102,275	59,455	2
500 TOTAL RECLASSIFICATIONS				300,867	174,902	500
CODE LETTER - H						
1 RECLASS OPERATION OF PLANT COST	I	OPERATION OF PLANT	7		42,696	1
2						2
3						3
4						4
5						5
6						6
7						7
8						8
9						9
500 TOTAL RECLASSIFICATIONS					42,696	500
CODE LETTER - I						
1 RECLASS TRANSPORTATION	J	OTHER ADMINISTRATIVE AND GENE	5.06		19,182	1
2						2
500 TOTAL RECLASSIFICATIONS					19,182	500
CODE LETTER - J						
1 RECLASS IT COST	K	DATA PROCESSING	5.03		27,004	1
2						2
3						3
4						4
5						5
6						6
7						7
8						8
9						9
10		RESPIRATORY THERAPY	65		1,809	10
11						11
12						12
13						13
14						14
15						15
16						16
17						17
18						18
500 TOTAL RECLASSIFICATIONS					28,813	500
CODE LETTER - K						
1 RECLASS GIFT SHOP	L	GIFT, FLOWER, COFFEE SHOP & C	190		14,531	1
500 TOTAL RECLASSIFICATIONS					14,531	500
CODE LETTER - L						
1 RECLASS SHELDON CLINIC	M	OTHER NON-REIMBURSABLE COSTS	194.01		12,062	1
2						2
500 TOTAL RECLASSIFICATIONS					12,062	500
CODE LETTER - M						
1 RECLASS OTHER CAP RELATED COST	N	OTHER CAPITAL RELATED COSTS	3		33,312	1
500 TOTAL RECLASSIFICATIONS					33,312	500
CODE LETTER - N						
1 RECLASS EMPLOYEE BENEFITS	O	EMPLOYEE BENEFITS	4		217,176	1
2						2
3						3
4						4
5						5
6						6
500 TOTAL RECLASSIFICATIONS					217,176	500
CODE LETTER - O						

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OPTIMIZER SYSTEMS, INC. WIN-LASH MICRO SYSTEM
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RECLASSIFICATIONS

WORKSHEET A-6

EXPLANATION OF RECLASSIFICATION ENTRY	CODE	INCREASE					
		COST CENTER	LINE #	SALARY			
	1	2	3	4	OTHER	5	
1 RECLASS IMPL MED SUPPLIES	P	IMPL. DEV. CHARGED TO PATIENT	72			1,413,368	1
2							2
500 TOTAL RECLASSIFICATIONS						1,413,368	500
CODE LETTER - P							
GRAND TOTAL (INCREASES)					465,647	4,206,662	

RECLASSIFICATIONS

WORKSHEET A-6

EXPLANATION OF RECLASSIFICATION ENTRY	CODE	COST CENTER	DECREASE 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		850,303	9 1
500 TOTAL RECLASSIFICATIONS					850,303	500
CODE LETTER - A						
1 RECLASS ADVERTISING	B	RURAL HEALTH CLINIC (RHC)	88		2,699	1
2		RHC II	88.01		1,770	2
3		RHC III	88.02		358	3
4		HOME HEALTH AGENCY	101		349	4
5		HOSPICE	116		2,010	5
6		IROQUOIS WOMEN'S HEALTH	194		5,509	6
7		OTHER NON-REIMBURSABLE COSTS	194.01		151,132	7
500 TOTAL RECLASSIFICATIONS					163,827	500
CODE LETTER - B						
1 RECLASS MEDICAL SUPPLIES	C	PURCHASING, RECEIVING, AND ST	5.02		54,595	1
2		ADULTS & PEDIATRICS	30		46,099	2
3		SKILLED NURSING FACILITY	44		21,236	3
4		OPERATING ROOM	50		356,275	4
5		ANESTHESIOLOGY	53		10,734	5
6		RADIOLOGY-DIAGNOSTIC	54		57,399	6
7		RESPIRATORY THERAPY	65		51,038	7
8		PHYSICAL THERAPY	66		3,577	8
9		ELECTROCARDIOLOGY	69		674	9
10		CLINIC	90		450	10
11		EMERGENCY	91		24,411	11
12		AMBULANCE SERVICES	95		10,926	12
13		HOME HEALTH AGENCY	101		3,039	13
14		HOSPICE	116		10,871	14
15		IROQUOIS WOMEN'S HEALTH	194		6,232	15
500 TOTAL RECLASSIFICATIONS					657,556	500
CODE LETTER - C						
1 RECLASS DRUGS CHARGED TO PATIENTS	D	ADULTS & PEDIATRICS	30		412	1
2		SKILLED NURSING FACILITY	44		1,576	2
3		OPERATING ROOM	50		96	3
4		RADIOLOGY-DIAGNOSTIC	54		7,547	4
5		LABORATORY	60		3,544	5
6		RESPIRATORY THERAPY	65		5	6
7		PHYSICAL THERAPY	66		435	7
8		EMERGENCY	91		27	8
9		AMBULANCE SERVICES	95		977	9
10		HOSPICE	116		86,763	10
500 TOTAL RECLASSIFICATIONS					101,382	500
CODE LETTER - D						
1 RECLASS TELEPHONE EXPENSE	E	PURCHASING, RECEIVING, AND ST	5.02		430	1
2		DATA PROCESSING	5.03		230	2
3		OTHER ADMINISTRATIVE AND GENE	5.06		5,727	3
4		NURSING ADMINISTRATION	13		936	4
5		MEDICAL RECORDS & LIBRARY	16		5	5
6		OPERATING ROOM	50		161	6
7		RADIOLOGY-DIAGNOSTIC	54		432	7
8		LABORATORY	60		195	8
9		CLINIC	90		7,461	9
10		EMERGENCY	91		35	10
11		AMBULANCE SERVICES	95		5,721	11
500 TOTAL RECLASSIFICATIONS					21,333	500
CODE LETTER - E						
1 RECLASS INTEREST EXPENSE	F	INTEREST EXPENSE	113		290,612	11 1
2						11 2
3						3
500 TOTAL RECLASSIFICATIONS					290,612	500
CODE LETTER - F						
1 RECLASS CAFETERIA	G	DIETARY	10	164,780	165,607	1
500 TOTAL RECLASSIFICATIONS				164,780	165,607	500
CODE LETTER - G						

RECLASSIFICATIONS

WORKSHEET A-6

EXPLANATION OF RECLASSIFICATION ENTRY	CODE	COST CENTER	DECREASE LINE #	SALARY	OTHER	WKST A-7 REF.
	1	6	7	8	9	10
1 RECLASS NURSERY COST	H	ADULTS & PEDIATRICS	30	300,867	174,902	1
2						2
500 TOTAL RECLASSIFICATIONS				300,867	174,902	500
CODE LETTER - H						
1 RECLASS OPERATION OF PLANT COST	I	OTHER ADMINISTRATIVE AND GENE	5.06		557	1
2		PHYSICAL THERAPY	66		9,812	2
3		RURAL HEALTH CLINIC (RHC)	88		5,449	3
4		RHC II	88.01		6,022	4
5		RHC III	88.02		2,037	5
6		AMBULANCE SERVICES	95		5,075	6
7		HOME HEALTH AGENCY	101		2,072	7
8		HOSPICE	116		2,181	8
9		IROQUOIS WOMEN'S HEALTH	194		9,491	9
500 TOTAL RECLASSIFICATIONS					42,696	500
CODE LETTER - I						
1 RECLASS TRANSPORTATION	J	AMBULANCE SERVICES	95		14,241	1
2		OTHER NON-REIMBURSABLE COSTS	194.01		4,941	2
500 TOTAL RECLASSIFICATIONS					19,182	500
CODE LETTER - J						
1 RECLASS IT COST	K	ADMISSIONS	5.01		652	1
2		BUSINESS OFFICE	5.05		644	2
3		OTHER ADMINISTRATIVE AND GENE	5.06		3,232	3
4		DIETARY	10		723	4
5		MEDICAL RECORDS & LIBRARY	16		2,264	5
6		ADULTS & PEDIATRICS	30		712	6
7		SKILLED NURSING FACILITY	44		5,280	7
8		RADIOLOGY-DIAGNOSTIC	54		807	8
9		LABORATORY	60		308	9
10						10
11		DRUGS CHARGED TO PATIENTS	73		43	11
12		RURAL HEALTH CLINIC (RHC)	88		634	12
13		RHC II	88.01		319	13
14		RHC III	88.02		70	14
15		CLINIC	90		1,239	15
16		HOME HEALTH AGENCY	101		3,412	16
17		HOSPICE	116		3,412	17
18		IROQUOIS WOMEN'S HEALTH	194		5,062	18
500 TOTAL RECLASSIFICATIONS					28,813	500
CODE LETTER - K						
1 RECLASS GIFT SHOP	L	OTHER ADMINISTRATIVE AND GENE	5.06		14,531	1
500 TOTAL RECLASSIFICATIONS					14,531	500
CODE LETTER - L						
1 RECLASS SHELDON CLINIC	M	CAP REL COSTS-BLDG & FIXT	1		7,703	9 1
2		OTHER ADMINISTRATIVE AND GENE	5.06		4,359	2
500 TOTAL RECLASSIFICATIONS					12,062	500
CODE LETTER - M						
1 RECLASS OTHER CAP RELATED COST	N	OTHER ADMINISTRATIVE AND GENE	5.06		33,312	14 1
500 TOTAL RECLASSIFICATIONS					33,312	500
CODE LETTER - N						
1 RECLASS EMPLOYEE BENEFITS	O	RURAL HEALTH CLINIC (RHC)	88		18,128	1
2		RHC II	88.01		33,478	2
3		RHC III	88.02		68,410	3
4		CLINIC	90		42,012	4
5		IROQUOIS WOMEN'S HEALTH	194		25,417	5
6		DURABLE MEDICAL EQUIPMENT SAL	194.02		29,731	6
500 TOTAL RECLASSIFICATIONS					217,176	500
CODE LETTER - O						

RECLASSIFICATIONS

WORKSHEET A-6

EXPLANATION OF RECLASSIFICATION ENTRY	CODE	----- COST CENTER	DECREASE LINE #	SALARY	OTHER	WKST A-7 REF. 10
	1	6	7	8	9	
1 RECLASS IMPL MED SUPPLIES	P	OPERATING ROOM	50		888,874	1
2		RADIOLOGY-DIAGNOSTIC	54		524,494	2
500 TOTAL RECLASSIFICATIONS					1,413,368	500
CODE LETTER - P						
GRAND TOTAL (DECREASES)				465,647	4,206,662	

RECONCILIATION OF CAPITAL COST CENTERS

WORKSHEET A-7
 PARTS I, II & III

PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES

DESCRIPTION	BEGINNING BALANCES 1	----- ACQUISITIONS -----			DISPOSALS AND RETIREMENTS 5	ENDING BALANCE 6	FULLY DEPRECIATED ASSETS 7
		PURCHASE 2	DONATION 3	TOTAL 4			
1 LAND	267,535					267,535	1
2 LAND IMPROVEMENTS							2
3 BUILDINGS AND FIXTURES	23,296,839	794,294		794,294	86,564	24,004,569	3
4 BUILDING IMPROVEMENTS	477,850					477,850	4
5 FIXED EQUIPMENT							5
6 MOVABLE EQUIPMENT	13,499,643	1,620,373		1,620,373	1,209,434	13,910,582	6
7 HIT DESIGNATED ASSETS							7
8 SUBTOTAL (SUM OF LINES 1-7)	37,541,867	2,414,667		2,414,667	1,295,998	38,660,536	8
9 RECONCILING ITEMS							9
10 TOTAL (LINE 7 MINUS LINE 9)	37,541,867	2,414,667		2,414,667	1,295,998	38,660,536	10

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

----- SUMMARY OF CAPITAL -----

DESCRIPTION	DEPREC- IATION 9	LEASE 10	INTEREST 11	INSURANCE (SEE INSTR.) 12	TAXES (SEE INSTR.) 13	OTHER CAPITAL- RELATED COSTS (SEE INSTR.) 14	TOTAL(1)
							(SUM OF COLS. 9-14) 15
1 CAP REL COSTS-BLDG & FIXT	1,733,654						1,733,654 1
2 CAP REL COSTS-MVBLE EQUIP							2
3 TOTAL (SUM OF LINES 1-2)	1,733,654						1,733,654 3

PART III - RECONCILIATION OF CAPITAL COST CENTERS

----- COMPUTATION OF RATIOS ----- ALLOCATION OF OTHER CAPITAL -----

DESCRIPTION	GROSS ASSETS 1	CAPITALIZED LEASES 2	GROSS ASSETS FOR RATIO (COL. 1 - COL. 2) 3		RATIO (SEE INSTR.) 4	INSURANCE 5	TAXES 6	OTHER CAPITAL- RELATED COSTS 7	TOTAL (SUM OF COLS. 5-7) 8
			1 CAP REL COSTS-BLDG & FIXT	24,482,419					
2 CAP REL COSTS-MVBLE EQUIP	13,910,582		13,910,582	0.362321			12,070	12,070 2	
3 TOTAL (SUM OF LINES 1-2)	38,393,001		38,393,001	1.000000			33,312	33,312 3	

----- SUMMARY OF CAPITAL -----

DESCRIPTION	DEPREC- IATION 9	LEASE 10	INTEREST 11	INSURANCE (SEE INSTR.) 12	TAXES (SEE INSTR.) 13	OTHER CAPITAL- RELATED COSTS (SEE INSTR.) 14	TOTAL(2)
							(SUM OF COLS. 9-14) 15
1 CAP REL COSTS-BLDG & FIXT	875,648			224,787		21,242	1,121,677 1
2 CAP REL COSTS-MVBLE EQUIP	850,303			33,721		12,070	896,094 2
3 TOTAL	1,725,951			258,508		33,312	2,017,771 3

ADJUSTMENTS TO EXPENSES

WORKSHEET A-8

DESCRIPTION	BASIS	AMOUNT	EXPENSE CLASSIFICATION ON WORKSHEET A TO/ FROM WHICH THE AMOUNT IS TO BE ADJUSTED			WKST A-7 REF
			COST CENTER	LINE NO.	5	
	1	2	3	4		
1 INVESTMENT INCOME-BUILDINGS & FIXTURES (CHAPTER 2)	B	-27,911	CAP REL COSTS-BLDG & FIXT	1	11	1
2 INVESTMENT INCOME-MOVABLE EQUIPMENT (CHAPTER 2)	B	-4,187	CAP REL COSTS-MVBLE EQUIP	2	11	2
3 INVESTMENT INCOME-OTHER (CHAPTER 2)	B	-1	OTHER ADMINISTRATIVE AND GENERA	5.06		3
4 TRADE, QUANTITY, AND TIME DISCOUNTS (CHAPTER 8)	B	-502	OTHER ADMINISTRATIVE AND GENERA	5.06		4
5 REFUNDS AND REBATES OF EXPENSES (CHAPTER 8)						5
6 RENTAL OF PROVIDER SPACE BY SUPPLIERS (CHAPTER 8)						6
7 TELEPHONE SERVICES (PAY STATIONS EXCL) (CHAPTER 21)						7
8 TELEVISION AND RADIO SERVICE (CHAPTER 21)	A	-12,785	OPERATION OF PLANT	7		8
9 PARKING LOT (CHAPTER 21)						9
10 PROVIDER-BASED PHYSICIAN ADJUSTMENT	WKST A-8-2	-1,417,623				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	B	-117	LAUNDRY & LINEN SERVICE	8		13
14 CAFETERIA - EMPLOYEES AND GUESTS	B	-127,915	CAFETERIA	11		14
15 RENTAL OF QUARTERS TO EMPLOYEES & OTHERS						15
16 SALE OF MEDICAL AND SURGICAL SUPPLIES TO OTHER THAN PATIENTS	B	-482	MEDICAL SUPPLIES CHRGED TO PATI	71		16
17 SALE OF DRUGS TO OTHER THAN PATIENTS						17
18 SALE OF MEDICAL RECORDS AND ABSTRACTS	B	-3,072	MEDICAL RECORDS & LIBRARY	16		18
19 NURSING SCHOOL (TUITION,FEES,BOOKS,ETC.)						19
20 VENDING MACHINES						20
21 INCOME FROM IMPOSITION OF INTEREST, FINANCE OR PENALTY CHARGES (CHAPTER 21)						21
22 INTEREST EXP ON MEDICARE OVERPAYMENTS & BORROWINGS TO REPAY MEDICARE OVERPAYMENT						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)				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 AND						32
33 CNA CLASS REVENUE	B	-928	NURSING ADMINISTRATION	13		33
34 OTHER REVENUE SPORTS MEDICINE	B	-2,694	PHYSICAL THERAPY	66		34
35 OTHER REVENUE WELLNESS	B	-3,195	PHYSICAL THERAPY	66		35
36 AMBULANCE TOWNSHIP INCOME	B	-62,384	AMBULANCE SERVICES	95		36
37 RENTAL INCOME	B	-1,300	OPERATING ROOM	50		37
38 RENTAL INCOME	B	-60,813	CLINIC	90		38
39 RENTAL INCOME	B	-4,950	PHYSICAL THERAPY	66		39
40 COLLECTION FEES REVENUE	B	-30,007	ADMISSIONS	5.01		40
41 OTHER REVENUE HSKP	B	-1,384	HOUSEKEEPING	9		41
42						42
43 OTHER REVENUE REHAB	B	-70	PHYSICAL THERAPY	66		43
44						44
45 MISC INCOME A&G	B	-1,693	OTHER ADMINISTRATIVE AND GENERA	5.06		45
46 MISC INCOME AUXILLIARY	B	-29,108	OTHER ADMINISTRATIVE AND GENERA	5.06		46
47 MISC INCOME MED STAFF	B	-10,050	OTHER ADMINISTRATIVE AND GENERA	5.06		47
48 MISC INCOME EMPL COMMITTEE	B	-9,778	OTHER ADMINISTRATIVE AND GENERA	5.06		48
49 PHYSICIAN BENEFIT OFFSET	A	-3,696	EMPLOYEE BENEFITS	4		49
49.01 PHYSICIAN BENEFIT OFFSET	A	-2,578	EMPLOYEE BENEFITS	4		49.01
49.02 PHYSICIAN BENEFIT OFFSET	A	-2,578	EMPLOYEE BENEFITS	4		49.02
49.03 DONATION EXPENSE	A	-750	OTHER ADMINISTRATIVE AND GENERA	5.06		49.03
49.04 ALCOHOL EXPENSE	A	-2,484	OTHER ADMINISTRATIVE AND GENERA	5.06		49.04
49.08 ADVERTISING EXPENSE	A	-132,001	OTHER ADMINISTRATIVE AND GENERA	5.06		49.08
49.09 PHYSICIAN RECRUITMENT	A	-36,346	OTHER ADMINISTRATIVE AND GENERA	5.06		49.09
49.10 LOBBYING EXPENSE	A	-13,400	OTHER ADMINISTRATIVE AND GENERA	5.06		49.10
49.11 LOBBYING EXPENSE	A	-801	SKILLED NURSING FACILITY	44		49.11
49.12 PROVIDER TAX EXPENSE	A	-754,463	OTHER ADMINISTRATIVE AND GENERA	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 GENERA	5.06		49.14
49.15 HOSPICE PRO FEE	A	-26,758	HOSPICE	116		49.15

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ADJUSTMENTS TO EXPENSES

WORKSHEET A-8

DESCRIPTION	BASIS 1	AMOUNT 2	EXPENSE CLASSIFICATION ON WORKSHEET A TO/ FROM WHICH THE AMOUNT IS TO BE ADJUSTED		WKST A-7 REF 5
			COST CENTER 3	LINE NO. 4	
49.16 FOUNDATION PURCHASED SERVICE	A	-12,368	OTHER ADMINISTRATIVE AND GENERA	5.06	49.16
50 TOTAL (SUM OF LINES 1 THRU 49) TRANSFER TO WKST A, COL. 6, LINE 200)		-2,802,464			50

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 THE CLAIMING OF HOME OFFICE COSTS:

LINE NO.	COST CENTER	EXPENSE ITEMS	AMOUNT OF ALLOWABLE COST	AMOUNT (INCL IN WKST A, COL. 5)	NET ADJ- USTMENTS (COL. 4-5)	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)					5
	TRANSFER COL. 6, LINE 5 TO WKST A-8, COL. 2, LINE 12.					

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

THE SECRETARY, BY VIRTUE OF 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.

THE INFORMATION IS USED BY THE HEALTH CARE FINANCING ADMINISTRATION AND ITS INTERMEDIARIES 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.

SYMBOL (1)	NAME	----- RELATED ORGANIZATION(S) AND/OR HOME OFFICE -----				
		PERCENT OF OWNERSHIP	NAME	PERCENT 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:

PROVIDER-BASED PHYSICIAN ADJUSTMENTS

WORKSHEET A-8-2

WKST A	COST CENTER/ PHYSICIAN IDENTIFIER		TOTAL REMUNERA- TION INCL FRINGES	PROFES- SIONAL COMPONENT	PROVIDER COMPONENT	RCE AMOUNT	PHYSICIAN/ PROVIDER COMPONENT HOURS	UNAD- JUSTED RCE LIMIT	5 PERCENT OF UNAD- JUSTED RCE LIMIT
LINE NO.	1	2	3	4	5	6	7	8	9
1	30	ADULTS & PEDIATRICS	AGGREGATE	10,423	10,423				1
2	50	OPERATING ROOM	AGGREGATE	349,557	349,557				2
3	53	ANESTHESIOLOGY	AGGREGATE	322,169	322,169				3
4	54	RADIOLOGY-DIAGNOSTIC	AGGREGATE	62,024	62,024				4
5	65	RESPIRATORY THERAPY	AGGREGATE	25,125	25,125				5
6	69	ELECTROCARDIOLOGY	AGGREGATE	36,890	36,890				6
7	90	CLINIC	AGGREGATE	78,216	78,216				7
8	91	EMERGENCY	AGGREGATE	533,219	533,219				8
200		TOTAL		1,417,623	1,417,623				200

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PROVIDER-BASED PHYSICIAN ADJUSTMENTS

WORKSHEET A-8-2

WKST A	COST CENTER/ PHYSICIAN IDENTIFIER		COST OF MEMBERSHIP & CONTIN. EDUCATION	PROVIDER COMPONENT SHARE OF COLUMN 12	PHYSICIAN COST OF MALPRACTICE INSURANCE	PROVIDER COMPONENT SHARE OF COLUMN 14	ADJUSTED RCE LIMIT	RCE DIS- ALLOWANCE	ADJUST- MENT	
LINE NO.	11		12	13	14	15	16	17	18	
1	30	ADULTS & PEDIATRICS	AGGREGATE						10,423	1
2	50	OPERATING ROOM	AGGREGATE						349,557	2
3	53	ANESTHESIOLOGY	AGGREGATE						322,169	3
4	54	RADIOLOGY-DIAGNOSTIC	AGGREGATE						62,024	4
5	65	RESPIRATORY THERAPY	AGGREGATE		12,883				25,125	5
6	69	ELECTROCARDIOLOGY	AGGREGATE						36,890	6
7	90	CLINIC	AGGREGATE						78,216	7
8	91	EMERGENCY	AGGREGATE						533,219	8
200		TOTAL			12,883				1,417,623	200

COST ALLOCATION - GENERAL SERVICE COSTS

WORKSHEET B
 PART I

COST CENTER DESCRIPTION	ALLOCATION (FROM WKST A, COL.7) 0	CAP BLDGS & FIXTURES 1	CAP MOVABLE EQUIPMENT 2	EMPLOYEE BENEFITS 4	ADMITTING 5.01	
GENERAL SERVICE COST CENTERS						
1 CAP REL COSTS-BLDG & FIXT	1,121,677	1,121,677				1
2 CAP REL COSTS-MVBLE EQUIP	896,094		896,094			2
4 EMPLOYEE BENEFITS	1,965,381	4,620		1,970,001		4
5.01 ADMISSIONS	526,612	9,667		42,855	579,134	5.01
5.02 PURCHASING, RECEIVING, AND STORES	117,186	12,568		14,811		5.02
5.03 DATA PROCESSING	567,649	4,158	129,288	31,808		5.03
5.04 COMMUNICATIONS	173,458	2,716	3,396			5.04
5.05 BUSINESS OFFICE	256,842	10,748	1,442	19,263		5.05
5.06 OTHER ADMINISTRATIVE AND GENERAL	2,140,839	45,181	3,453	50,751		5.06
6 MAINTENANCE & REPAIRS						6
7 OPERATION OF PLANT	946,718	111,992	14,655	31,289		7
8 LAUNDRY & LINEN SERVICE	44,264	19,367		4,946		8
9 HOUSEKEEPING	348,261	5,609	22	35,736		9
10 DIETARY	290,928	26,275	2,408	18,906		10
11 CAFETERIA	202,472	8,719		21,417		11
12 MAINTENANCE OF PERSONNEL						12
13 NURSING ADMINISTRATION	593,659	13,850	179	68,484		13
14 CENTRAL SERVICES & SUPPLY	10,364	12,618	12,948			14
15 PHARMACY						15
16 MEDICAL RECORDS & LIBRARY	797,459	12,509	2,508	54,684		16
17 SOCIAL SERVICE						17
19 NONPHYSICIAN ANESTHETISTS						19
20 NURSING SCHOOL						20
21 I&R SRVCES-SALARY & FRINGES APPRVD						21
22 I&R SRVCES-OTHER PRGM COSTS APPRVD						22
23 PARAMED ED PRGM-(SPECIFY)						23
INPATIENT ROUTINE SERV COST CENTERS						
30 ADULTS & PEDIATRICS	2,134,237	149,076	50,715	200,165	39,408	30
43 NURSERY	314,105	4,703	5,919	25,812	2,397	43
44 SKILLED NURSING FACILITY	1,120,600	81,358	10,878	120,204	15,470	44
ANCILLARY SERVICE COST CENTERS						
50 OPERATING ROOM	1,076,432	137,136	165,573	91,060	73,037	50
52 DELIVERY ROOM & LABOR ROOM	161,730	1,878		13,293	1,280	52
53 ANESTHESIOLOGY	2,665	922	27,865		3,131	53
54 RADIOLOGY-DIAGNOSTIC	1,674,384	46,061	260,839	101,615	133,088	54
60 LABORATORY	1,597,694	30,325	53,182	78,857	89,786	60
62.30 BLOOD CLOTTING FOR HEMOPHILIACS						62.30
65 RESPIRATORY THERAPY	403,771	17,447	17,985	43,088	8,465	65
66 PHYSICAL THERAPY	971,233	103,650	18,308	76,842	29,427	66
69 ELECTROCARDIOLOGY	134,243	5,030		15,002	12,104	69
71 MEDICAL SUPPLIES CHRGD TO PATIENTS	657,074				11,370	71
72 IMPL. DEV. CHARGED TO PATIENT	1,413,368				25,074	72
73 DRUGS CHARGED TO PATIENTS	1,536,232	15,695	12,567	61,215	64,496	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 (RHC)	423,629	21,798	1,216	42,090		88
88.01 RHC II	351,595	7,546	682	32,442		88.01
88.02 RHC III	1,014,446	35,313	12,483	101,882		88.02
90 CLINIC	194,763	22,746	2,958	60,362	505	90
91 EMERGENCY	891,490	25,336	22,090	101,879	41,060	91
92 OBSERVATION BEDS						92
OTHER REIMBURSABLE COST CENTERS						
95 AMBULANCE SERVICES	813,189	1,735	57,210	91,870	29,036	95
101 HOME HEALTH AGENCY	448,889	10,681	553	46,090		101
SPECIAL PURPOSE COST CENTERS						
113 INTEREST EXPENSE						113
116 HOSPICE	896,071	10,748	804	79,432		116
118 SUBTOTALS (SUM OF LINES 1-117)	29,231,703	1,029,781	892,126	1,778,150	579,134	118
NONREIMBURSABLE COST CENTERS						
190 GIFT, FLOWER, COFFEE SHOP & CANTEEN	17,269	7,696				190
192 PHYSICIANS' PRIVATE OFFICES						192
194 IROQUOIS WOMEN'S HEALTH	2,004,991	39,480	3,173	141,125		194
194.01 OTHER NON-REIMBURSABLE COSTS	266,692	44,720	795	20,142		194.01
194.02 DURABLE MEDICAL EQUIPMENT SALES/RENT	668,534			30,584		194.02
194.03 WELLNESS						194.03
194.04 RENTED SPACE						194.04
200 CROSS FOOT ADJUSTMENTS						200
201 NEGATIVE COST CENTER						201
202 TOTAL (SUM OF LINES 118-201)	32,189,189	1,121,677	896,094	1,970,001	579,134	202

COST ALLOCATION - GENERAL SERVICE COSTS

WORKSHEET B
 PART I

COST CENTER DESCRIPTION	PURCHASING	DATA	COMMUNICAT	BUSINESS	SUBTOTAL (COLS.0-4) 4A	
	RECEIVING AND STORES 5.02	PROCESSING 5.03	IONS 5.04	OFFICE 5.05		
GENERAL SERVICE COST CENTERS						
1 CAP REL COSTS-BLDG & FIXT						1
2 CAP REL COSTS-MVBLE EQUIP						2
4 EMPLOYEE BENEFITS						4
5.01 ADMISSIONS						5.01
5.02 PURCHASING, RECEIVING, AND STORES	144,565					5.02
5.03 DATA PROCESSING	95	732,998				5.03
5.04 COMMUNICATIONS			179,570			5.04
5.05 BUSINESS OFFICE	227	10,961		299,483		5.05
5.06 OTHER ADMINISTRATIVE AND GENERAL	295	13,226	8,702		2,262,447	5.06
6 MAINTENANCE & REPAIRS						6
7 OPERATION OF PLANT	2,644	17,010	2,373		1,126,681	7
8 LAUNDRY & LINEN SERVICE	211	4,093	791		73,672	8
9 HOUSEKEEPING	1,267	31,018	1,582		423,495	9
10 DIETARY	1,016	15,814	3,955		359,302	10
11 CAFETERIA	1,150	17,911	1,582		253,251	11
12 MAINTENANCE OF PERSONNEL						12
13 NURSING ADMINISTRATION	152	17,466	8,702		702,492	13
14 CENTRAL SERVICES & SUPPLY	901		791		37,622	14
15 PHARMACY						15
16 MEDICAL RECORDS & LIBRARY	308	29,821	11,075		908,364	16
17 SOCIAL SERVICE						17
19 NONPHYSICIAN ANESTHETISTS						19
20 NURSING SCHOOL						20
21 I&R SRVCES-SALARY & FRINGES APPRVD						21
22 I&R SRVCES-OTHER PRGM COSTS APPRVD						22
23 PARAMED ED PRGM-(SPECIFY)						23
INPATIENT ROUTINE SERV COST CENTERS						
30 ADULTS & PEDIATRICS	3,698	75,279	18,985	20,376	2,691,939	30
43 NURSERY		9,178	791	1,239	364,144	43
44 SKILLED NURSING FACILITY	2,152	62,561	7,120	7,999	1,428,342	44
ANCILLARY SERVICE COST CENTERS						
50 OPERATING ROOM	1,145	30,994	9,493	37,765	1,622,635	50
52 DELIVERY ROOM & LABOR ROOM		4,728	791	662	184,362	52
53 ANESTHESIOLOGY	536		791	1,619	37,529	53
54 RADIOLOGY-DIAGNOSTIC	5,866	39,694	11,866	68,849	2,342,262	54
60 LABORATORY	20,377	36,602	9,493	46,425	1,962,741	60
62.30 BLOOD CLOTTING FOR HEMOPHILIACS						62.30
65 RESPIRATORY THERAPY	2,771	17,662	3,955	4,377	519,521	65
66 PHYSICAL THERAPY	415	33,317	11,075	15,216	1,259,483	66
69 ELECTROCARDIOLOGY		4,318		6,259	176,956	69
71 MEDICAL SUPPLIES CHRGD TO PATIENTS	20,407		791	5,879	695,521	71
72 IMPL. DEV. CHARGED TO PATIENT	70,197			12,965	1,521,604	72
73 DRUGS CHARGED TO PATIENTS	275	19,238	3,164	33,349	1,746,231	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 (RHC)	299	11,488	1,582		502,102	88
88.01 RHC II	260	9,129	2,373		404,027	88.01
88.02 RHC III	602	28,371	1,582		1,194,679	88.02
90 CLINIC	238	27,815	2,373	261	312,021	90
91 EMERGENCY	1,889	35,881	7,120	21,230	1,147,975	91
92 OBSERVATION BEDS						92
OTHER REIMBURSABLE COST CENTERS						
95 AMBULANCE SERVICES	889	53,560	3,955	15,013	1,066,457	95
101 HOME HEALTH AGENCY	252	15,650	3,955		526,070	101
SPECIAL PURPOSE COST CENTERS						
113 INTEREST EXPENSE						113
116 HOSPICE	2,826	29,007	5,537		1,024,425	116
118 SUBTOTALS (SUM OF LINES 1-117)	143,360	701,792	146,345	299,483	28,878,352	118
NONREIMBURSABLE COST CENTERS						
190 GIFT, FLOWER, COFFEE SHOP & CANTEEN	15		1,582		26,562	190
192 PHYSICIANS' PRIVATE OFFICES						192
194 IROQUOIS WOMEN'S HEALTH	630	21,554	31,643		2,242,596	194
194.01 OTHER NON-REIMBURSABLE COSTS	560	9,652			342,561	194.01
194.02 DURABLE MEDICAL EQUIPMENT SALES/RENT					699,118	194.02
194.03 WELLNESS						194.03
194.04 RENTED SPACE						194.04
200 CROSS FOOT ADJUSTMENTS						200
201 NEGATIVE COST CENTER						201
202 TOTAL (SUM OF LINES 118-201)	144,565	732,998	179,570	299,483	32,189,189	202

COST ALLOCATION - GENERAL SERVICE COSTS

WORKSHEET B
 PART I

COST CENTER DESCRIPTION	OTHER ADMIN NISTRATIVE AND GENERAL 5.06	OPERATION OF PLANT 7	LAUNDRY & LINEN SERVICE 8	HOUSE- KEEPING 9	DIETARY 10	
GENERAL SERVICE COST CENTERS						
1 CAP REL COSTS-BLDG & FIXT						1
2 CAP REL COSTS-MVBLE EQUIP						2
4 EMPLOYEE BENEFITS						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	2,262,447					5.06
6 MAINTENANCE & REPAIRS						6
7 OPERATION OF PLANT	85,177	1,211,858				7
8 LAUNDRY & LINEN SERVICE	5,570	25,510	104,752			8
9 HOUSEKEEPING	32,016	7,388	4,183	467,082		9
10 DIETARY	27,163	34,610	851	13,712	435,638	10
11 CAFETERIA	19,146	11,485		4,550		11
12 MAINTENANCE OF PERSONNEL						12
13 NURSING ADMINISTRATION	53,108	18,244		7,228		13
14 CENTRAL SERVICES & SUPPLY	2,844	16,620	73	6,585		14
15 PHARMACY						15
16 MEDICAL RECORDS & LIBRARY	68,672	16,477		6,528		16
17 SOCIAL SERVICE						17
19 NONPHYSICIAN ANESTHETISTS						19
20 NURSING SCHOOL						20
21 I&R SRVCES-SALARY & FRINGES APPRVD						21
22 I&R SRVCES-OTHER PRGM COSTS APPRVD						22
23 PARAMED ED PRGM-(SPECIFY)						23
INPATIENT ROUTINE SERV COST CENTERS						
30 ADULTS & PEDIATRICS	203,497	196,359	24,723	77,794	111,088	30
43 NURSERY	27,529	6,195	329	2,454		43
44 SKILLED NURSING FACILITY	107,983	107,164	40,893	42,456	264,441	44
ANCILLARY SERVICE COST CENTERS						
50 OPERATING ROOM	122,671	180,635	13,702	71,564	535	50
52 DELIVERY ROOM & LABOR ROOM	13,938	2,474		980		52
53 ANESTHESIOLOGY	2,837	1,215		481		53
54 RADIOLOGY-DIAGNOSTIC	177,075	60,672	4,910	24,037		54
60 LABORATORY	148,383	39,944	239	15,825		60
62.30 BLOOD CLOTTING FOR HEMOPHILIACS						62.30
65 RESPIRATORY THERAPY	39,276	22,981		9,105		65
66 PHYSICAL THERAPY	95,217	136,528	4,306	54,090		66
69 ELECTROCARDIOLOGY	13,378	6,626		2,625		69
71 MEDICAL SUPPLIES CHRGD TO PATIENTS	52,581					71
72 IMPL. DEV. CHARGED TO PATIENT	115,033					72
73 DRUGS CHARGED TO PATIENTS	132,015	20,673		8,190		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 (RHC)	37,959	28,713		11,375		88
88.01 RHC II	30,544	9,939		3,938		88.01
88.02 RHC III	90,318	46,514		18,428		88.02
90 CLINIC	23,589	29,960	770	11,870	902	90
91 EMERGENCY	86,787	33,373	9,216	13,222	2,369	91
92 OBSERVATION BEDS						92
OTHER REIMBURSABLE COST CENTERS						
95 AMBULANCE SERVICES	80,624	2,286	555	906		95
101 HOME HEALTH AGENCY	39,771	14,069		5,574		101
SPECIAL PURPOSE COST CENTERS						
113 INTEREST EXPENSE						113
116 HOSPICE	77,447	14,158		5,609		116
118 SUBTOTALS (SUM OF LINES 1-117)	2,012,148	1,090,812	104,750	419,126	379,335	118
NONREIMBURSABLE COST CENTERS						
190 GIFT, FLOWER, COFFEE SHOP & CANTEEN	2,008	10,138		4,016		190
192 PHYSICIANS' PRIVATE OFFICES			2			192
194 IROQUOIS WOMEN'S HEALTH	169,540	52,003		20,603		194
194.01 OTHER NON-REIMBURSABLE COSTS	25,898	58,905		23,337	56,303	194.01
194.02 DURABLE MEDICAL EQUIPMENT SALES/RENT	52,853					194.02
194.03 WELLNESS						194.03
194.04 RENTED SPACE						194.04
200 CROSS FOOT ADJUSTMENTS						200
201 NEGATIVE COST CENTER						201
202 TOTAL (SUM OF LINES 118-201)	2,262,447	1,211,858	104,752	467,082	435,638	202

COST ALLOCATION - GENERAL SERVICE COSTS

WORKSHEET B
 PART I

COST CENTER DESCRIPTION	CAFETERIA 11	NURSING ADMINIS- TRATION 13	CENTRAL SERVICES & SUPPLY 14	MEDICAL RECORDS & LIBRARY 16	SUBTOTAL 24	
GENERAL SERVICE COST CENTERS						
1 CAP REL COSTS-BLDG & FIXT						1
2 CAP REL COSTS-MVBLE EQUIP						2
4 EMPLOYEE BENEFITS						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	288,432					11
12 MAINTENANCE OF PERSONNEL						12
13 NURSING ADMINISTRATION	8,091	789,163				13
14 CENTRAL SERVICES & SUPPLY			63,744			14
15 PHARMACY						15
16 MEDICAL RECORDS & LIBRARY	13,802			1,013,843		16
17 SOCIAL SERVICE						17
19 NONPHYSICIAN ANESTHETISTS						19
20 NURSING SCHOOL						20
21 I&R SRVCES-SALARY & FRINGES APPRVD						21
22 I&R SRVCES-OTHER PRGM COSTS APPRVD						22
23 PARAMED ED PRGM-(SPECIFY)						23
INPATIENT ROUTINE SERV COST CENTERS						
30 ADULTS & PEDIATRICS	34,854	232,884	4,951	63,290	3,641,379	30
43 NURSERY	4,250	28,393		3,849	437,143	43
44 SKILLED NURSING FACILITY	28,965			24,846	2,045,090	44
ANCILLARY SERVICE COST CENTERS						
50 OPERATING ROOM	14,344	95,882	39,318	117,298	2,278,584	50
52 DELIVERY ROOM & LABOR ROOM	2,191	14,625		2,056	220,626	52
53 ANESTHESIOLOGY				5,028	47,090	53
54 RADIOLOGY-DIAGNOSTIC	18,373		1,536	213,784	2,842,649	54
60 LABORATORY	16,945			144,198	2,328,275	60
62.30 BLOOD CLOTTING FOR HEMOPHILIACS						62.30
65 RESPIRATORY THERAPY	8,179	54,638	248	13,595	667,543	65
66 PHYSICAL THERAPY	15,429			47,261	1,612,314	66
69 ELECTROCARDIOLOGY	2,003			19,439	221,027	69
71 MEDICAL SUPPLIES CHRGD TO PATIENTS				18,260	766,362	71
72 IMPL. DEV. CHARGED TO PATIENT				40,270	1,676,907	72
73 DRUGS CHARGED TO PATIENTS	8,910			103,582	2,019,601	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 (RHC)	5,324		579	6,308	592,360	88
88.01 RHC II	4,228		221	6,920	459,817	88.01
88.02 RHC III	13,138		1,890	16,376	1,381,343	88.02
90 CLINIC	12,872	86,047	1,168	812	480,011	90
91 EMERGENCY	16,613	111,001	1,080	65,942	1,487,578	91
92 OBSERVATION BEDS						92
OTHER REIMBURSABLE COST CENTERS						
95 AMBULANCE SERVICES	24,792	165,693	294	46,632	1,388,239	95
101 HOME HEALTH AGENCY	7,250			6,583	599,317	101
SPECIAL PURPOSE COST CENTERS						
113 INTEREST EXPENSE						113
116 HOSPICE	13,425			22,668	1,157,732	116
118 SUBTOTALS (SUM OF LINES 1-117)	273,978	789,163	51,285	988,997	28,350,987	118
NONREIMBURSABLE COST CENTERS						
190 GIFT, FLOWER, COFFEE SHOP & CANTEEN					42,724	190
192 PHYSICIANS' PRIVATE OFFICES					2	192
194 IROQUOIS WOMEN'S HEALTH	9,983		12,459	24,846	2,532,030	194
194.01 OTHER NON-REIMBURSABLE COSTS	4,471				511,475	194.01
194.02 DURABLE MEDICAL EQUIPMENT SALES/RENT					751,971	194.02
194.03 WELLNESS						194.03
194.04 RENTED SPACE						194.04
200 CROSS FOOT ADJUSTMENTS						200
201 NEGATIVE COST CENTER						201
202 TOTAL (SUM OF LINES 118-201)	288,432	789,163	63,744	1,013,843	32,189,189	202

COST ALLOCATION - GENERAL SERVICE COSTS

WORKSHEET B
 PART I

COST CENTER DESCRIPTION	I&R COST & POST STEP-		TOTAL
	25	26	
GENERAL SERVICE COST CENTERS			
1 CAP REL COSTS-BLDG & FIXT			1
2 CAP REL COSTS-MVBLE EQUIP			2
4 EMPLOYEE BENEFITS			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 SRVCES-SALARY & FRINGES APPRVD			21
22 I&R SRVCES-OTHER PRGM COSTS APPRVD			22
23 PARAMED ED PRGM-(SPECIFY)			23
INPATIENT ROUTINE SERV COST CENTERS			
30 ADULTS & PEDIATRICS	3,641,379		30
43 NURSERY	437,143		43
44 SKILLED NURSING FACILITY	2,045,090		44
ANCILLARY SERVICE COST CENTERS			
50 OPERATING ROOM	2,278,584		50
52 DELIVERY ROOM & LABOR ROOM	220,626		52
53 ANESTHESIOLOGY	47,090		53
54 RADIOLOGY-DIAGNOSTIC	2,842,649		54
60 LABORATORY	2,328,275		60
62.30 BLOOD CLOTTING FOR HEMOPHILIACS			62.30
65 RESPIRATORY THERAPY	667,543		65
66 PHYSICAL THERAPY	1,612,314		66
69 ELECTROCARDIOLOGY	221,027		69
71 MEDICAL SUPPLIES CHRGD TO PATIENTS	766,362		71
72 IMPL. DEV. CHARGED TO PATIENT	1,676,907		72
73 DRUGS CHARGED TO PATIENTS	2,019,601		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 (RHC)	592,360		88
88.01 RHC II	459,817		88.01
88.02 RHC III	1,381,343		88.02
90 CLINIC	480,011		90
91 EMERGENCY	1,487,578		91
92 OBSERVATION BEDS			92
OTHER REIMBURSABLE COST CENTERS			
95 AMBULANCE SERVICES	1,388,239		95
101 HOME HEALTH AGENCY	599,317		101
SPECIAL PURPOSE COST CENTERS			
113 INTEREST EXPENSE			113
116 HOSPICE	1,157,732		116
118 SUBTOTALS (SUM OF LINES 1-117)	28,350,987		118
NONREIMBURSABLE COST CENTERS			
190 GIFT, FLOWER, COFFEE SHOP & CANTEEN	42,724		190
192 PHYSICIANS' PRIVATE OFFICES	2		192
194 IROQUOIS WOMEN'S HEALTH	2,532,030		194
194.01 OTHER NON-REIMBURSABLE COSTS	511,475		194.01
194.02 DURABLE MEDICAL EQUIPMENT SALES/RENT	751,971		194.02
194.03 WELLNESS			194.03
194.04 RENTED SPACE			194.04
200 CROSS FOOT ADJUSTMENTS			200
201 NEGATIVE COST CENTER			201
202 TOTAL (SUM OF LINES 118-201)	32,189,189		202

ALLOCATION OF CAPITAL-RELATED COSTS

WORKSHEET B
 PART II

COST CENTER DESCRIPTION	DIR ASSGND	CAP	CAP	SUBTOTAL	EMPLOYEE	
	CAP-REL COSTS	BLDGS & FIXTURES	MOVABLE EQUIPMENT		BENEFITS	
	0	1	2	2A	4	
GENERAL SERVICE COST CENTERS						
1 CAP REL COSTS-BLDG & FIXT						1
2 CAP REL COSTS-MVBLE EQUIP						2
4 EMPLOYEE BENEFITS	322	4,620		4,942	4,942	4
5.01 ADMISSIONS	1,989	9,667		11,656	107	5.01
5.02 PURCHASING, RECEIVING, AND STORES	360	12,568		12,928	37	5.02
5.03 DATA PROCESSING	795	4,158	129,288	134,241	80	5.03
5.04 COMMUNICATIONS		2,716	3,396	6,112		5.04
5.05 BUSINESS OFFICE	12,628	10,748	1,442	24,818	48	5.05
5.06 OTHER ADMINISTRATIVE AND GENERAL	8,842	45,181	3,453	57,476	127	5.06
6 MAINTENANCE & REPAIRS						6
7 OPERATION OF PLANT	72	111,992	14,655	126,719	78	7
8 LAUNDRY & LINEN SERVICE		19,367		19,367	12	8
9 HOUSEKEEPING		5,609	22	5,631	90	9
10 DIETARY	1,275	26,275	2,408	29,958	47	10
11 CAFETERIA	1,444	8,719		10,163	54	11
12 MAINTENANCE OF PERSONNEL						12
13 NURSING ADMINISTRATION	2,471	13,850	179	16,500	172	13
14 CENTRAL SERVICES & SUPPLY		12,618	12,948	25,566		14
15 PHARMACY						15
16 MEDICAL RECORDS & LIBRARY	2,729	12,509	2,508	17,746	137	16
17 SOCIAL SERVICE						17
19 NONPHYSICIAN ANESTHETISTS						19
20 NURSING SCHOOL						20
21 I&R SRVCES-SALARY & FRINGES APPRVD						21
22 I&R SRVCES-OTHER PRGM COSTS APPRVD						22
23 PARAMED ED PRGM-(SPECIFY)						23
INPATIENT ROUTINE SERV COST CENTERS						
30 ADULTS & PEDIATRICS	21,031	149,076	50,715	220,822	503	30
43 NURSERY	15,471	4,703	5,919	26,093	65	43
44 SKILLED NURSING FACILITY	1,407	81,358	10,878	93,643	301	44
ANCILLARY SERVICE COST CENTERS						
50 OPERATING ROOM	13,672	137,136	165,573	316,381	228	50
52 DELIVERY ROOM & LABOR ROOM	7,969	1,878		9,847	33	52
53 ANESTHESIOLOGY		922	27,865	28,787		53
54 RADIOLOGY-DIAGNOSTIC	235,405	46,061	260,839	542,305	255	54
60 LABORATORY	36,576	30,325	53,182	120,083	198	60
62.30 BLOOD CLOTTING FOR HEMOPHILIACS						62.30
65 RESPIRATORY THERAPY	25,606	17,447	17,985	61,038	108	65
66 PHYSICAL THERAPY	3,549	103,650	18,308	125,507	193	66
69 ELECTROCARDIOLOGY	836	5,030		5,866	38	69
71 MEDICAL SUPPLIES CHRGD TO PATIENTS						71
72 IMPL. DEV. CHARGED TO PATIENT						72
73 DRUGS CHARGED TO PATIENTS	711	15,695	12,567	28,973	154	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 (RHC)	843	21,798	1,216	23,857	106	88
88.01 RHC II	684	7,546	682	8,912	81	88.01
88.02 RHC III	2,143	35,313	12,483	49,939	256	88.02
90 CLINIC	6,743	22,746	2,958	32,447	151	90
91 EMERGENCY	11,443	25,336	22,090	58,869	256	91
92 OBSERVATION BEDS						92
OTHER REIMBURSABLE COST CENTERS						
95 AMBULANCE SERVICES	25,574	1,735	57,210	84,519	230	95
101 HOME HEALTH AGENCY	3,190	10,681	553	14,424	116	101
SPECIAL PURPOSE COST CENTERS						
113 INTEREST EXPENSE						113
116 HOSPICE	85,379	10,748	804	96,931	199	116
118 SUBTOTALS (SUM OF LINES 1-117)	531,159	1,029,781	892,126	2,453,066	4,460	118
NONREIMBURSABLE COST CENTERS						
190 GIFT, FLOWER, COFFEE SHOP & CANTEEN		7,696		7,696		190
192 PHYSICIANS' PRIVATE OFFICES						192
194 IROQUOIS WOMEN'S HEALTH	11,811	39,480	3,173	54,464	354	194
194.01 OTHER NON-REIMBURSABLE COSTS		44,720	795	45,515	51	194.01
194.02 DURABLE MEDICAL EQUIPMENT SALES/RENT					77	194.02
194.03 WELLNESS						194.03
194.04 RENTED SPACE						194.04
200 CROSS FOOT ADJUSTMENTS						200
201 NEGATIVE COST CENTER						201
202 TOTAL (SUM OF LINES 118-201)	542,970	1,121,677	896,094	2,560,741	4,942	202

ALLOCATION OF CAPITAL-RELATED COSTS

WORKSHEET B
 PART II

COST CENTER DESCRIPTION	ADMITTING 5.01	PURCHASING RECEIVING AND STORES 5.02	DATA PROCESSING 5.03	COMMUNICAT IONS 5.04	BUSINESS OFFICE 5.05	
GENERAL SERVICE COST CENTERS						
1 CAP REL COSTS-BLDG & FIXT						1
2 CAP REL COSTS-MVBLE EQUIP						2
4 EMPLOYEE BENEFITS						4
5.01 ADMISSIONS	11,763					5.01
5.02 PURCHASING, RECEIVING, AND STORES		12,965				5.02
5.03 DATA PROCESSING		8	134,329			5.03
5.04 COMMUNICATIONS				6,112		5.04
5.05 BUSINESS OFFICE		20	2,009		26,895	5.05
5.06 OTHER ADMINISTRATIVE AND GENERAL		26	2,424	296		5.06
6 MAINTENANCE & REPAIRS						6
7 OPERATION OF PLANT		237	3,117	81		7
8 LAUNDRY & LINEN SERVICE		19	750	27		8
9 HOUSEKEEPING		114	5,684	54		9
10 DIETARY		91	2,898	135		10
11 CAFETERIA		103	3,282	54		11
12 MAINTENANCE OF PERSONNEL						12
13 NURSING ADMINISTRATION		14	3,201	296		13
14 CENTRAL SERVICES & SUPPLY		81		27		14
15 PHARMACY						15
16 MEDICAL RECORDS & LIBRARY		28	5,465	377		16
17 SOCIAL SERVICE						17
19 NONPHYSICIAN ANESTHETISTS						19
20 NURSING SCHOOL						20
21 I&R SRVCES-SALARY & FRINGES APPRVD						21
22 I&R SRVCES-OTHER PRGM COSTS APPRVD						22
23 PARAMED ED PRGM-(SPECIFY)						23
INPATIENT ROUTINE SERV COST CENTERS						
30 ADULTS & PEDIATRICS	798	332	13,797	646	1,831	30
43 NURSERY	49		1,682	27	111	43
44 SKILLED NURSING FACILITY	313	193	11,465	242	719	44
ANCILLARY SERVICE COST CENTERS						
50 OPERATING ROOM	1,479	103	5,680	323	3,393	50
52 DELIVERY ROOM & LABOR ROOM	26		866	27	59	52
53 ANESTHESIOLOGY	63	48		27	145	53
54 RADIOLOGY-DIAGNOSTIC	2,730	526	7,274	404	6,176	54
60 LABORATORY	1,819	1,827	6,708	323	4,171	60
62.30 BLOOD CLOTTING FOR HEMOPHILIACS						62.30
65 RESPIRATORY THERAPY	171	249	3,237	135	393	65
66 PHYSICAL THERAPY	596	37	6,106	377	1,367	66
69 ELECTROCARDIOLOGY	245		791		562	69
71 MEDICAL SUPPLIES CHRGD TO PATIENTS	230	1,830		27	528	71
72 IMPL. DEV. CHARGED TO PATIENT	508	6,297			1,165	72
73 DRUGS CHARGED TO PATIENTS	1,306	25	3,525	108	2,996	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 (RHC)		27	2,105	54		88
88.01 RHC II		23	1,673	81		88.01
88.02 RHC III		54	5,199	54		88.02
90 CLINIC	10	21	5,097	81	23	90
91 EMERGENCY	832	169	6,576	242	1,907	91
92 OBSERVATION BEDS						92
OTHER REIMBURSABLE COST CENTERS						
95 AMBULANCE SERVICES	588	80	9,815	135	1,349	95
101 HOME HEALTH AGENCY		23	2,868	135		101
SPECIAL PURPOSE COST CENTERS						
113 INTEREST EXPENSE						113
116 HOSPICE		253	5,316	188		116
118 SUBTOTALS (SUM OF LINES 1-117)	11,763	12,858	128,610	4,983	26,895	118
NONREIMBURSABLE COST CENTERS						
190 GIFT, FLOWER, COFFEE SHOP & CANTEEN		1		54		190
192 PHYSICIANS' PRIVATE OFFICES						192
194 IROQUOIS WOMEN'S HEALTH		56	3,950	1,075		194
194.01 OTHER NON-REIMBURSABLE COSTS		50	1,769			194.01
194.02 DURABLE MEDICAL EQUIPMENT SALES/RENT						194.02
194.03 WELLNESS						194.03
194.04 RENTED SPACE						194.04
200 CROSS FOOT ADJUSTMENTS						200
201 NEGATIVE COST CENTER						201
202 TOTAL (SUM OF LINES 118-201)	11,763	12,965	134,329	6,112	26,895	202

ALLOCATION OF CAPITAL-RELATED COSTS

WORKSHEET B
 PART II

COST CENTER DESCRIPTION	OTHER ADMI NISTRATIVE AND GENER 5.06	OPERATION OF PLANT 7	LAUNDRY & LINEN SERVICE 8	HOUSE- KEEPING 9	DIETARY 10	
GENERAL SERVICE COST CENTERS						
1 CAP REL COSTS-BLDG & FIXT						1
2 CAP REL COSTS-MVBLE EQUIP						2
4 EMPLOYEE BENEFITS						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	60,349					5.06
6 MAINTENANCE & REPAIRS						6
7 OPERATION OF PLANT	2,273	132,505				7
8 LAUNDRY & LINEN SERVICE	149	2,789	23,113			8
9 HOUSEKEEPING	854	808	923	14,158		9
10 DIETARY	725	3,784	188	416	38,242	10
11 CAFETERIA	511	1,256		138		11
12 MAINTENANCE OF PERSONNEL						12
13 NURSING ADMINISTRATION	1,417	1,995		219		13
14 CENTRAL SERVICES & SUPPLY	76	1,817	16	200		14
15 PHARMACY						15
16 MEDICAL RECORDS & LIBRARY	1,832	1,802		198		16
17 SOCIAL SERVICE						17
19 NONPHYSICIAN ANESTHETISTS						19
20 NURSING SCHOOL						20
21 I&R SRVCES-SALARY & FRINGES APPRVD						21
22 I&R SRVCES-OTHER PRGM COSTS APPRVD						22
23 PARAMED ED PRGM-(SPECIFY)						23
INPATIENT ROUTINE SERV COST CENTERS						
30 ADULTS & PEDIATRICS	5,416	21,472	5,455	2,356	9,752	30
43 NURSEY	734	677	73	74		43
44 SKILLED NURSING FACILITY	2,881	11,717	9,024	1,287	23,214	44
ANCILLARY SERVICE COST CENTERS						
50 OPERATING ROOM	3,273	19,751	3,023	2,169	47	50
52 DELIVERY ROOM & LABOR ROOM	372	270		30		52
53 ANESTHESIOLOGY	76	133		15		53
54 RADIOLOGY-DIAGNOSTIC	4,724	6,634	1,083	729		54
60 LABORATORY	3,959	4,367	53	480		60
62.30 BLOOD CLOTTING FOR HEMOPHILIACS						62.30
65 RESPIRATORY THERAPY	1,048	2,513		276		65
66 PHYSICAL THERAPY	2,540	14,928	950	1,640		66
69 ELECTROCARDIOLOGY	357	724		80		69
71 MEDICAL SUPPLIES CHRGD TO PATIENTS	1,403					71
72 IMPL. DEV. CHARGED TO PATIENT	3,069					72
73 DRUGS CHARGED TO PATIENTS	3,522	2,260		248		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 (RHC)	1,013	3,139		345		88
88.01 RHC II	815	1,087		119		88.01
88.02 RHC III	2,410	5,086		559		88.02
90 CLINIC	629	3,276	170	360	79	90
91 EMERGENCY	2,315	3,649	2,033	401	208	91
92 OBSERVATION BEDS						92
OTHER REIMBURSABLE COST CENTERS						
95 AMBULANCE SERVICES	2,151	250	122	27		95
101 HOME HEALTH AGENCY	1,061	1,538		169		101
SPECIAL PURPOSE COST CENTERS						
113 INTEREST EXPENSE						113
116 HOSPICE	2,066	1,548		170		116
118 SUBTOTALS (SUM OF LINES 1-117)	53,671	119,270	23,113	12,705	33,300	118
NONREIMBURSABLE COST CENTERS						
190 GIFT, FLOWER, COFFEE SHOP & CANTEEN	54	1,108		122		190
192 PHYSICIANS' PRIVATE OFFICES						192
194 IROQUOIS WOMEN'S HEALTH	4,523	5,686		624		194
194.01 OTHER NON-REIMBURSABLE COSTS	691	6,441		707	4,942	194.01
194.02 DURABLE MEDICAL EQUIPMENT SALES/RENT	1,410					194.02
194.03 WELLNESS						194.03
194.04 RENTED SPACE						194.04
200 CROSS FOOT ADJUSTMENTS						200
201 NEGATIVE COST CENTER						201
202 TOTAL (SUM OF LINES 118-201)	60,349	132,505	23,113	14,158	38,242	202

ALLOCATION OF CAPITAL-RELATED COSTS

WORKSHEET B
 PART II

COST CENTER DESCRIPTION	CAFETERIA 11	NURSING ADMINIS- TRATION 13	CENTRAL SERVICES & SUPPLY 14	MEDICAL RECORDS & LIBRARY 16	SUBTOTAL 24	
GENERAL SERVICE COST CENTERS						
1 CAP REL COSTS-BLDG & FIXT						1
2 CAP REL COSTS-MVBLE EQUIP						2
4 EMPLOYEE BENEFITS						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	15,561					11
12 MAINTENANCE OF PERSONNEL						12
13 NURSING ADMINISTRATION	436	24,250				13
14 CENTRAL SERVICES & SUPPLY			27,783			14
15 PHARMACY						15
16 MEDICAL RECORDS & LIBRARY	745			28,330		16
17 SOCIAL SERVICE						17
19 NONPHYSICIAN ANESTHETISTS						19
20 NURSING SCHOOL						20
21 I&R SRVCES-SALARY & FRINGES APPRVD						21
22 I&R SRVCES-OTHER PRGM COSTS APPRVD						22
23 PARAMED ED PRGM-(SPECIFY)						23
INPATIENT ROUTINE SERV COST CENTERS						
30 ADULTS & PEDIATRICS	1,882	7,157	2,158	1,770	296,147	30
43 NURSERY	229	872		108	30,794	43
44 SKILLED NURSING FACILITY	1,563			695	157,257	44
ANCILLARY SERVICE COST CENTERS						
50 OPERATING ROOM	774	2,946	17,138	3,280	379,988	50
52 DELIVERY ROOM & LABOR ROOM	118	449		58	12,155	52
53 ANESTHESIOLOGY				141	29,435	53
54 RADIOLOGY-DIAGNOSTIC	991		669	5,953	580,453	54
60 LABORATORY	914			4,033	148,935	60
62.30 BLOOD CLOTTING FOR HEMOPHILIACS						62.30
65 RESPIRATORY THERAPY	441	1,679	108	380	71,776	65
66 PHYSICAL THERAPY	832			1,322	156,395	66
69 ELECTROCARDIOLOGY	108			544	9,315	69
71 MEDICAL SUPPLIES CHRGD TO PATIENTS				511	4,529	71
72 IMPL. DEV. CHARGED TO PATIENT				1,126	12,165	72
73 DRUGS CHARGED TO PATIENTS	481			2,897	46,495	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 (RHC)	287		252	176	31,361	88
88.01 RHC II	228		96	194	13,309	88.01
88.02 RHC III	709		824	458	65,548	88.02
90 CLINIC	694	2,644	509	23	46,214	90
91 EMERGENCY	896	3,411	471	1,844	84,079	91
92 OBSERVATION BEDS						92
OTHER REIMBURSABLE COST CENTERS						
95 AMBULANCE SERVICES	1,338	5,092	128	1,304	107,128	95
101 HOME HEALTH AGENCY	391			184	20,909	101
SPECIAL PURPOSE COST CENTERS						
113 INTEREST EXPENSE						113
116 HOSPICE	724			634	108,029	116
118 SUBTOTALS (SUM OF LINES 1-117)	14,781	24,250	22,353	27,635	2,412,416	118
NONREIMBURSABLE COST CENTERS						
190 GIFT, FLOWER, COFFEE SHOP & CANTEEN					9,035	190
192 PHYSICIANS' PRIVATE OFFICES						192
194 IROQUOIS WOMEN'S HEALTH	539		5,430	695	77,396	194
194.01 OTHER NON-REIMBURSABLE COSTS	241				60,407	194.01
194.02 DURABLE MEDICAL EQUIPMENT SALES/RENT					1,487	194.02
194.03 WELLNESS						194.03
194.04 RENTED SPACE						194.04
200 CROSS FOOT ADJUSTMENTS						200
201 NEGATIVE COST CENTER						201
202 TOTAL (SUM OF LINES 118-201)	15,561	24,250	27,783	28,330	2,560,741	202

ALLOCATION OF CAPITAL-RELATED COSTS

WORKSHEET B
 PART II

COST CENTER DESCRIPTION	I&R COST & POST STEP-		TOTAL
	DOWN ADJS	25	
GENERAL SERVICE COST CENTERS			
1 CAP REL COSTS-BLDG & FIXT			1
2 CAP REL COSTS-MVBLE EQUIP			2
4 EMPLOYEE BENEFITS			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 SRVCES-SALARY & FRINGES APPRVD			21
22 I&R SRVCES-OTHER PRGM COSTS APPRVD			22
23 PARAMED ED PRGM-(SPECIFY)			23
INPATIENT ROUTINE SERV COST CENTERS			
30 ADULTS & PEDIATRICS		296,147	30
43 NURSERY		30,794	43
44 SKILLED NURSING FACILITY		157,257	44
ANCILLARY SERVICE COST CENTERS			
50 OPERATING ROOM		379,988	50
52 DELIVERY ROOM & LABOR ROOM		12,155	52
53 ANESTHESIOLOGY		29,435	53
54 RADIOLOGY-DIAGNOSTIC		580,453	54
60 LABORATORY		148,935	60
62.30 BLOOD CLOTTING FOR HEMOPHILIACS			62.30
65 RESPIRATORY THERAPY		71,776	65
66 PHYSICAL THERAPY		156,395	66
69 ELECTROCARDIOLOGY		9,315	69
71 MEDICAL SUPPLIES CHRGD TO PATIENTS		4,529	71
72 IMPL. DEV. CHARGED TO PATIENT		12,165	72
73 DRUGS CHARGED TO PATIENTS		46,495	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 (RHC)		31,361	88
88.01 RHC II		13,309	88.01
88.02 RHC III		65,548	88.02
90 CLINIC		46,214	90
91 EMERGENCY		84,079	91
92 OBSERVATION BEDS			92
OTHER REIMBURSABLE COST CENTERS			
95 AMBULANCE SERVICES		107,128	95
101 HOME HEALTH AGENCY		20,909	101
SPECIAL PURPOSE COST CENTERS			
113 INTEREST EXPENSE			113
116 HOSPICE		108,029	116
118 SUBTOTALS (SUM OF LINES 1-117)		2,412,416	118
NONREIMBURSABLE COST CENTERS			
190 GIFT, FLOWER, COFFEE SHOP & CANTEEN		9,035	190
192 PHYSICIANS' PRIVATE OFFICES			192
194 IROQUOIS WOMEN'S HEALTH		77,396	194
194.01 OTHER NON-REIMBURSABLE COSTS		60,407	194.01
194.02 DURABLE MEDICAL EQUIPMENT SALES/RENT		1,487	194.02
194.03 WELLNESS			194.03
194.04 RENTED SPACE			194.04
200 CROSS FOOT ADJUSTMENTS			200
201 NEGATIVE COST CENTER			201
202 TOTAL (SUM OF LINES 118-201)		2,560,741	202

COST ALLOCATION - STATISTICAL BASIS

WORKSHEET B-1

COST CENTER DESCRIPTION	CAP	CAP	EMPLOYEE	ADMITTING	PURCHASING	
	BLDGS & FIXTURES SQUARE FEET	MOVABLE EQUIPMENT DOLLAR VALUE NEW	BENEFITS GROSS SAL	GROSS CHARGES	RECEIVING AND STORES COST REQ'S	
	1	2	4	5.01	5.02	
GENERAL SERVICE COST CENTERS						
1 CAP REL COSTS-BLDG & FIXT	133,789					1
2 CAP REL COSTS-MVBLE EQUIP		700,349				2
4 EMPLOYEE BENEFITS	551		15,156,689			4
5.01 ADMISSIONS	1,153		329,715	63,756,270		5.01
5.02 PURCHASING, RECEIVING, AND STORES	1,499		113,953		2,910,621	5.02
5.03 DATA PROCESSING	496	101,046	244,724		1,908	5.03
5.04 COMMUNICATIONS	324	2,654				5.04
5.05 BUSINESS OFFICE	1,282	1,127	148,201		4,578	5.05
5.06 OTHER ADMINISTRATIVE AND GENERAL	5,389	2,699	390,461		5,933	5.06
6 MAINTENANCE & REPAIRS						6
7 OPERATION OF PLANT	13,358	11,454	240,731		53,231	7
8 LAUNDRY & LINEN SERVICE	2,310		38,057		4,241	8
9 HOUSEKEEPING	669	17	274,946		25,501	9
10 DIETARY	3,134	1,882	145,460		20,450	10
11 CAFETERIA	1,040		164,780		23,162	11
12 MAINTENANCE OF PERSONNEL						12
13 NURSING ADMINISTRATION	1,652	140	526,899		3,064	13
14 CENTRAL SERVICES & SUPPLY	1,505	10,120			18,133	14
15 PHARMACY						15
16 MEDICAL RECORDS & LIBRARY	1,492	1,960	420,726		6,193	16
17 SOCIAL SERVICE						17
19 NONPHYSICIAN ANESTHETISTS						19
20 NURSING SCHOOL						20
21 I&R SRVCES-SALARY & FRINGES APPRVD						21
22 I&R SRVCES-OTHER PRGM COSTS APPRVD						22
23 PARAMED ED PRGM-(SPECIFY)						23
INPATIENT ROUTINE SERV COST CENTERS						
30 ADULTS & PEDIATRICS	17,781	39,637	1,540,039	4,338,183	74,456	30
43 NURSERY	561	4,626	198,592	263,834		43
44 SKILLED NURSING FACILITY	9,704	8,502	924,815	1,703,049	43,323	44
ANCILLARY SERVICE COST CENTERS						
50 OPERATING ROOM	16,357	129,405	700,592	8,040,176	23,046	50
52 DELIVERY ROOM & LABOR ROOM	224		102,275	140,948		52
53 ANESTHESIOLOGY	110	21,778		344,666	10,799	53
54 RADIOLOGY-DIAGNOSTIC	5,494	203,860	781,802	14,653,717	118,108	54
60 LABORATORY	3,617	41,565	606,704	9,883,995	410,269	60
62.30 BLOOD CLOTTING FOR HEMOPHILIACS						62.30
65 RESPIRATORY THERAPY	2,081	14,056	331,504	931,838	55,797	65
66 PHYSICAL THERAPY	12,363	14,309	591,198	3,239,477	8,349	66
69 ELECTROCARDIOLOGY	600		115,421	1,332,468		69
71 MEDICAL SUPPLIES CHRGD TO PATIENTS				1,251,643	410,870	71
72 IMPL. DEV. CHARGED TO PATIENT				2,760,286	1,413,368	72
73 DRUGS CHARGED TO PATIENTS	1,872	9,822	470,968	7,099,986	5,528	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 (RHC)	2,600	950	323,829		6,025	88
88.01 RHC II	900	533	249,598		5,233	88.01
88.02 RHC III	4,212	9,756	783,852		12,117	88.02
90 CLINIC	2,713	2,312	464,409	55,639	4,786	90
91 EMERGENCY	3,022	17,265	783,833	4,519,995	38,023	91
92 OBSERVATION BEDS						92
OTHER REIMBURSABLE COST CENTERS						
95 AMBULANCE SERVICES	207	44,713	706,820	3,196,370	17,897	95
101 HOME HEALTH AGENCY	1,274	432	354,603		5,082	101
SPECIAL PURPOSE COST CENTERS						
116 HOSPICE	1,282	628	611,128		56,898	116
118 SUBTOTALS (SUM OF LINES 1-117)	122,828	697,248	13,680,635	63,756,270	2,886,368	118
NONREIMBURSABLE COST CENTERS						
190 GIFT, FLOWER, COFFEE SHOP & CANTEEN	918				302	190
192 PHYSICIANS' PRIVATE OFFICES						192
194 IROQUOIS WOMEN'S HEALTH	4,709	2,480	1,085,781		12,681	194
194.01 OTHER NON-REIMBURSABLE COSTS	5,334	621	154,965		11,270	194.01
194.02 DURABLE MEDICAL EQUIPMENT SALES/RENT			235,308			194.02
194.03 WELLNESS						194.03
194.04 RENTED SPACE						194.04

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COST ALLOCATION - STATISTICAL BASIS

WORKSHEET B-1

COST CENTER DESCRIPTION		CAP BLDGS & FIXTURES SQUARE FEET 1	CAP MOVABLE EQUIPMENT DOLLAR VALUE NEW 2	EMPLOYEE BENEFITS GROSS SAL 4	ADMITTING GROSS CHARGES 5.01	PURCHASING RECEIVING AND STORES COST REQ'S 5.02	
200	CROSS FOOT ADJUSTMENTS						200
201	NEGATIVE COST CENTER						201
202	COST TO BE ALLOC PER B PT I	1,121,677	896,094	1,970,001	579,134	144,565	202
203	UNIT COST MULT-WS B PT I	8.383925	1.279496	0.129976	0.009084	0.049668	203
204	COST TO BE ALLOC PER B PT II			4,942	11,763	12,965	204
205	UNIT COST MULT-WS B PT II			0.000326	0.000184	0.004454	205

COST ALLOCATION - STATISTICAL BASIS

WORKSHEET B-1

COST CENTER DESCRIPTION	DATA	COMMUNICAT	BUSINESS	RECON- CILIATION	OTHER ADMI
	PROCESSING	IONS	OFFICE		NISTRATIVE
	TIME	# OF	GROSS		AND GENER
	SPENT	PHONES	CHARGES		ACCUM
	5.03	5.04	5.05	5A.06	COST
					5.06
GENERAL SERVICE COST CENTERS					
1 CAP REL COSTS-BLDG & FIXT					1
2 CAP REL COSTS-MVBLE EQUIP					2
4 EMPLOYEE BENEFITS					4
5.01 ADMISSIONS					5.01
5.02 PURCHASING, RECEIVING, AND STORES					5.02
5.03 DATA PROCESSING	637,716				5.03
5.04 COMMUNICATIONS		227			5.04
5.05 BUSINESS OFFICE	9,536		63,756,270		5.05
5.06 OTHER ADMINISTRATIVE AND GENERAL	11,507	11		-2,262,447	29,926,742 5.06
6 MAINTENANCE & REPAIRS					6
7 OPERATION OF PLANT	14,799	3			1,126,681 7
8 LAUNDRY & LINEN SERVICE	3,561	1			73,672 8
9 HOUSEKEEPING	26,986	2			423,495 9
10 DIETARY	13,758	5			359,302 10
11 CAFETERIA	15,583	2			253,251 11
12 MAINTENANCE OF PERSONNEL					
13 NURSING ADMINISTRATION	15,196	11			702,492 13
14 CENTRAL SERVICES & SUPPLY		1			37,622 14
15 PHARMACY					
16 MEDICAL RECORDS & LIBRARY	25,945	14			908,364 16
17 SOCIAL SERVICE					
19 NONPHYSICIAN ANESTHETISTS					
20 NURSING SCHOOL					
21 I&R SRVCES-SALARY & FRINGES APPRVD					
22 I&R SRVCES-OTHER PRGM COSTS APPRVD					
23 PARAMED ED PRGM-(SPECIFY)					
INPATIENT ROUTINE SERV COST CENTERS					
30 ADULTS & PEDIATRICS	65,494	24	4,338,183		2,691,939 30
43 NURSERY	7,985	1	263,834		364,144 43
44 SKILLED NURSING FACILITY	54,429	9	1,703,049		1,428,342 44
ANCILLARY SERVICE COST CENTERS					
50 OPERATING ROOM	26,965	12	8,040,176		1,622,635 50
52 DELIVERY ROOM & LABOR ROOM	4,113	1	140,948		184,362 52
53 ANESTHESIOLOGY		1	344,666		37,529 53
54 RADIOLOGY-DIAGNOSTIC	34,534	15	14,653,717		2,342,262 54
60 LABORATORY	31,844	12	9,883,995		1,962,741 60
62.30 BLOOD CLOTTING FOR HEMOPHILIACS					
65 RESPIRATORY THERAPY	15,366	5	931,838		519,521 65
66 PHYSICAL THERAPY	28,986	14	3,239,477		1,259,483 66
69 ELECTROCARDIOLOGY	3,757		1,332,468		176,956 69
71 MEDICAL SUPPLIES CHRGD TO PATIENTS		1	1,251,643		695,521 71
72 IMPL. DEV. CHARGED TO PATIENT			2,760,286		1,521,604 72
73 DRUGS CHARGED TO PATIENTS	16,737	4	7,099,986		1,746,231 73
76.97 CARDIAC REHABILITATION					
76.98 HYPERBARIC OXYGEN THERAPY					
76.99 LITHOTRIPSY					
OUTPATIENT SERVICE COST CENTERS					
88 RURAL HEALTH CLINIC (RHC)	9,995	2			502,102 88
88.01 RHC II	7,942	3			404,027 88.01
88.02 RHC III	24,683	2			1,194,679 88.02
90 CLINIC	24,199	3	55,639		312,021 90
91 EMERGENCY	31,217	9	4,519,995		1,147,975 91
92 OBSERVATION BEDS					
OTHER REIMBURSABLE COST CENTERS					
95 AMBULANCE SERVICES	46,598	5	3,196,370		1,066,457 95
101 HOME HEALTH AGENCY	13,616	5			526,070 101
SPECIAL PURPOSE COST CENTERS					
116 HOSPICE	25,236	7			1,024,425 116
118 SUBTOTALS (SUM OF LINES 1-117)	610,567	185	63,756,270	-2,262,447	26,615,905 118
NONREIMBURSABLE COST CENTERS					
190 GIFT, FLOWER, COFFEE SHOP & CANTEEN		2			26,562 190
192 PHYSICIANS' PRIVATE OFFICES					
194 IROQUOIS WOMEN'S HEALTH	18,752	40			2,242,596 194
194.01 OTHER NON-REIMBURSABLE COSTS	8,397				342,561 194.01
194.02 DURABLE MEDICAL EQUIPMENT SALES/RENT					699,118 194.02
194.03 WELLNESS					
194.04 RENTED SPACE					

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COST ALLOCATION - STATISTICAL BASIS

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COST CENTER DESCRIPTION		DATA PROCESSING	COMMUNICAT IONS	BUSINESS OFFICE	RECON- CILIATION	OTHER ADMI NISTRATIVE AND GENER ACCUM COST	
		TIME SPENT	# OF PHONES	GROSS CHARGES			
		5.03	5.04	5.05	5A.06	5.06	
200	CROSS FOOT ADJUSTMENTS						200
201	NEGATIVE COST CENTER						201
202	COST TO BE ALLOC PER B PT I	732,998	179,570	299,483		2,262,447	202
203	UNIT COST MULT-WS B PT I	1.149411	791.057269	0.004697		0.075600	203
204	COST TO BE ALLOC PER B PT II	134,329	6,112	26,895		60,349	204
205	UNIT COST MULT-WS B PT II	0.210641	26.925110	0.000422		0.002017	205

COST ALLOCATION - STATISTICAL BASIS

WORKSHEET B-1

COST CENTER DESCRIPTION	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSE-KEEPING	DIETARY	CAFETERIA	
	SQUARE FEET	POUNDS	SQUARE FEET	MEALS	FTE'S	
	7	8	9	10	11	
GENERAL SERVICE COST CENTERS						
1 CAP REL COSTS-BLDG & FIXT						1
2 CAP REL COSTS-MVBLE EQUIP						2
4 EMPLOYEE BENEFITS						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	109,737					7
8 LAUNDRY & LINEN SERVICE	2,310	337,180				8
9 HOUSEKEEPING	669	13,465	106,758			9
10 DIETARY	3,134	2,740	3,134	43,941		10
11 CAFETERIA	1,040		1,040		26,060	11
12 MAINTENANCE OF PERSONNEL						12
13 NURSING ADMINISTRATION	1,652		1,652		731	13
14 CENTRAL SERVICES & SUPPLY	1,505	235	1,505			14
15 PHARMACY						15
16 MEDICAL RECORDS & LIBRARY	1,492		1,492		1,247	16
17 SOCIAL SERVICE						17
19 NONPHYSICIAN ANESTHETISTS						19
20 NURSING SCHOOL						20
21 I&R SRVCES-SALARY & FRINGES APPRVD						21
22 I&R SRVCES-OTHER PRGM COSTS APPRVD						22
23 PARAMED ED PRGM-(SPECIFY)						23
INPATIENT ROUTINE SERV COST CENTERS						
30 ADULTS & PEDIATRICS	17,781	79,580	17,781	11,205	3,149	30
43 NURSERY	561	1,060	561		384	43
44 SKILLED NURSING FACILITY	9,704	131,625	9,704	26,673	2,617	44
ANCILLARY SERVICE COST CENTERS						
50 OPERATING ROOM	16,357	44,105	16,357	54	1,296	50
52 DELIVERY ROOM & LABOR ROOM	224		224		198	52
53 ANESTHESIOLOGY	110		110			53
54 RADIOLOGY-DIAGNOSTIC	5,494	15,805	5,494		1,660	54
60 LABORATORY	3,617	770	3,617		1,531	60
62.30 BLOOD CLOTTING FOR HEMOPHILIACS						62.30
65 RESPIRATORY THERAPY	2,081		2,081		739	65
66 PHYSICAL THERAPY	12,363	13,860	12,363		1,394	66
69 ELECTROCARDIOLOGY	600		600		181	69
71 MEDICAL SUPPLIES CHRGD TO PATIENTS						71
72 IMPL. DEV. CHARGED TO PATIENT						72
73 DRUGS CHARGED TO PATIENTS	1,872		1,872		805	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 (RHC)	2,600		2,600		481	88
88.01 RHC II	900		900		382	88.01
88.02 RHC III	4,212		4,212		1,187	88.02
90 CLINIC	2,713	2,480	2,713	91	1,163	90
91 EMERGENCY	3,022	29,665	3,022	239	1,501	91
92 OBSERVATION BEDS						92
OTHER REIMBURSABLE COST CENTERS						
95 AMBULANCE SERVICES	207	1,785	207		2,240	95
101 HOME HEALTH AGENCY	1,274		1,274		655	101
SPECIAL PURPOSE COST CENTERS						
116 HOSPICE	1,282		1,282		1,213	116
118 SUBTOTALS (SUM OF LINES 1-117)	98,776	337,175	95,797	38,262	24,754	118
NONREIMBURSABLE COST CENTERS						
190 GIFT, FLOWER, COFFEE SHOP & CANTEEN	918		918			190
192 PHYSICIANS' PRIVATE OFFICES		5				192
194 IROQUOIS WOMEN'S HEALTH	4,709		4,709		902	194
194.01 OTHER NON-REIMBURSABLE COSTS	5,334		5,334	5,679	404	194.01
194.02 DURABLE MEDICAL EQUIPMENT SALES/RENT						194.02
194.03 WELLNESS						194.03
194.04 RENTED SPACE						194.04

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COST ALLOCATION - STATISTICAL BASIS

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COST CENTER DESCRIPTION		OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSE- KEEPING	DIETARY	CAFETERIA	
		SQUARE FEET	POUNDS	SQUARE FEET	MEALS	FTE'S	
		7	8	9	10	11	
200	CROSS FOOT ADJUSTMENTS						200
201	NEGATIVE COST CENTER						201
202	COST TO BE ALLOC PER B PT I	1,211,858	104,752	467,082	435,638	288,432	202
203	UNIT COST MULT-WS B PT I	11.043294	0.310671	4.375148	9.914158	11.067997	203
204	COST TO BE ALLOC PER B PT II	132,505	23,113	14,158	38,242	15,561	204
205	UNIT COST MULT-WS B PT II	1.207478	0.068548	0.132618	0.870303	0.597122	205

COST ALLOCATION - STATISTICAL BASIS

WORKSHEET B-1

COST CENTER DESCRIPTION	NURSING ADMINIS- TRATION NURSING HOURS	CENTRAL SERVICES & SUPPLY CSS CSTED REQ'	MEDICAL RECORDS & LIBRARY GROSS REVENUE	
	13	14	16	
GENERAL SERVICE COST CENTERS				
1 CAP REL COSTS-BLDG & FIXT				1
2 CAP REL COSTS-MVBLE EQUIP				2
4 EMPLOYEE BENEFITS				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	221,937			13
14 CENTRAL SERVICES & SUPPLY		13,865		14
15 PHARMACY				15
16 MEDICAL RECORDS & LIBRARY			69,493,501	16
17 SOCIAL SERVICE				17
19 NONPHYSICIAN ANESTHETISTS				19
20 NURSING SCHOOL				20
21 I&R SRVCES-SALARY & FRINGES APPRVD				21
22 I&R SRVCES-OTHER PRGM COSTS APPRVD				22
23 PARAMED ED PRGM-(SPECIFY)				23
INPATIENT ROUTINE SERV COST CENTERS				
30 ADULTS & PEDIATRICS	65,494	1,077	4,338,183	30
43 NURSERY	7,985		263,834	43
44 SKILLED NURSING FACILITY			1,703,049	44
ANCILLARY SERVICE COST CENTERS				
50 OPERATING ROOM	26,965	8,552	8,040,176	50
52 DELIVERY ROOM & LABOR ROOM	4,113		140,948	52
53 ANESTHESIOLOGY			344,666	53
54 RADIOLOGY-DIAGNOSTIC		334	14,653,717	54
60 LABORATORY			9,883,995	60
62.30 BLOOD CLOTTING FOR HEMOPHILIACS				62.30
65 RESPIRATORY THERAPY	15,366	54	931,838	65
66 PHYSICAL THERAPY			3,239,477	66
69 ELECTROCARDIOLOGY			1,332,468	69
71 MEDICAL SUPPLIES CHRGD TO PATIENTS			1,251,643	71
72 IMPL. DEV. CHARGED TO PATIENT			2,760,286	72
73 DRUGS CHARGED TO PATIENTS			7,099,986	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 (RHC)		126	432,394	88
88.01 RHC II		48	474,331	88.01
88.02 RHC III		411	1,122,475	88.02
90 CLINIC	24,199	254	55,639	90
91 EMERGENCY	31,217	235	4,519,995	91
92 OBSERVATION BEDS				92
OTHER REIMBURSABLE COST CENTERS				
95 AMBULANCE SERVICES	46,598	64	3,196,370	95
101 HOME HEALTH AGENCY			451,207	101
SPECIAL PURPOSE COST CENTERS				
116 HOSPICE			1,553,744	116
118 SUBTOTALS (SUM OF LINES 1-117)	221,937	11,155	67,790,421	118
NONREIMBURSABLE COST CENTERS				
190 GIFT, FLOWER, COFFEE SHOP & CANTEEN				190
192 PHYSICIANS' PRIVATE OFFICES				192
194 IROQUOIS WOMEN'S HEALTH		2,710	1,703,080	194
194.01 OTHER NON-REIMBURSABLE COSTS				194.01
194.02 DURABLE MEDICAL EQUIPMENT SALES/RENT				194.02
194.03 WELLNESS				194.03
194.04 RENTED SPACE				194.04

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COST ALLOCATION - STATISTICAL BASIS

WORKSHEET B-1

COST CENTER DESCRIPTION	NURSING ADMINIS- TRATION NURSING HOURS	CENTRAL SERVICES & SUPPLY CSS CSTED REQ'	MEDICAL RECORDS & LIBRARY GROSS REVENUE	
200 CROSS FOOT ADJUSTMENTS	13	14	16	200
201 NEGATIVE COST CENTER				201
202 COST TO BE ALLOC PER B PT I	789,163	63,744	1,013,843	202
203 UNIT COST MULT-WS B PT I	3.555797	4.597476	0.014589	203
204 COST TO BE ALLOC PER B PT II	24,250	27,783	28,330	204
205 UNIT COST MULT-WS B PT II	0.109265	2.003823	0.000408	205

COMPUTATION OF RATIO OF COST TO CHARGES

WORKSHEET C
 PART I

COST CENTER DESCRIPTION	TOTAL COST	THERAPY	TOTAL	RCE	TOTAL	
	(FROM WKST B, PART I, COL 26)	LIMIT ADJUSTMENT	COSTS	DISALLOWANCE	COSTS	
	1	2	3	4	5	
INPATIENT ROUTINE SERV COST CENTERS						
30 ADULTS & PEDIATRICS	3,641,379		3,641,379		3,641,379	30
43 NURSERY	437,143		437,143		437,143	43
44 SKILLED NURSING FACILITY	2,045,090		2,045,090		2,045,090	44
ANCILLARY SERVICE COST CENTERS						
50 OPERATING ROOM	2,278,584		2,278,584		2,278,584	50
52 DELIVERY ROOM & LABOR ROOM	220,626		220,626		220,626	52
53 ANESTHESIOLOGY	47,090		47,090		47,090	53
54 RADIOLOGY-DIAGNOSTIC	2,842,649		2,842,649		2,842,649	54
60 LABORATORY	2,328,275		2,328,275		2,328,275	60
62.30 BLOOD CLOTTING FOR HEMOPHIL						62.30
65 RESPIRATORY THERAPY	667,543		667,543		667,543	65
66 PHYSICAL THERAPY	1,612,314		1,612,314		1,612,314	66
69 ELECTROCARDIOLOGY	221,027		221,027		221,027	69
71 MEDICAL SUPPLIES CHRGED TO	766,362		766,362		766,362	71
72 IMPL. DEV. CHARGED TO PATIE	1,676,907		1,676,907		1,676,907	72
73 DRUGS CHARGED TO PATIENTS	2,019,601		2,019,601		2,019,601	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 (RHC)	592,360		592,360		592,360	88
88.01 RHC II	459,817		459,817		459,817	88.01
88.02 RHC III	1,381,343		1,381,343		1,381,343	88.02
90 CLINIC	480,011		480,011		480,011	90
91 EMERGENCY	1,487,578		1,487,578		1,487,578	91
92 OBSERVATION BEDS	1,026,006		1,026,006		1,026,006	92
OTHER REIMBURSABLE COST CENTERS						
95 AMBULANCE SERVICES	1,388,239		1,388,239		1,388,239	95
101 HOME HEALTH AGENCY	599,317		599,317		599,317	101
113 INTEREST EXPENSE						113
116 HOSPICE	1,157,732		1,157,732		1,157,732	116
200 SUBTOTAL (SEE INSTRUCTIONS)	29,376,993		29,376,993		29,376,993	200
201 LESS OBSERVATION BEDS	1,026,006		1,026,006		1,026,006	201
202 TOTAL (SEE INSTRUCTIONS)	28,350,987		28,350,987		28,350,987	202

COMPUTATION OF RATIO OF COST TO CHARGES

WORKSHEET C
 PART I (CONT)

COST CENTER DESCRIPTION	----- CHARGES -----			COST OR OTHER RATIO 9	TEFRA INPATIENT RATIO 10	PPS INPATIENT RATIO 11
	INPATIENT 6	OUTPATIENT 7	TOTAL (COLS. 6 + 7) 8			
INPATIENT ROUTINE SERV COST CENTERS						
30 ADULTS & PEDIATRICS	2,613,007		2,613,007			30
43 NURSERY	263,834		263,834			43
44 SKILLED NURSING FACILITY	1,703,049		1,703,049			44
ANCILLARY SERVICE COST CENTERS						
50 OPERATING ROOM	1,971,089	6,069,087	8,040,176	0.283400	0.283400	0.283400 50
52 DELIVERY ROOM & LABOR ROOM	126,580	14,368	140,948	1.565301	1.565301	1.565301 52
53 ANESTHESIOLOGY	114,884	229,782	344,666	0.136625	0.136625	0.136625 53
54 RADIOLOGY-DIAGNOSTIC	1,793,222	12,860,495	14,653,717	0.193988	0.193988	0.193988 54
60 LABORATORY	1,243,442	8,640,553	9,883,995	0.235560	0.235560	0.235560 60
62.30 BLOOD CLOTTING FOR HEMOPHIL						62.30
65 RESPIRATORY THERAPY	272,650	659,188	931,838	0.716372	0.716372	0.716372 65
66 PHYSICAL THERAPY	626,763	2,612,714	3,239,477	0.497708	0.497708	0.497708 66
69 ELECTROCARDIOLOGY	370,092	962,376	1,332,468	0.165878	0.165878	0.165878 69
71 MEDICAL SUPPLIES CHRGD TO	524,918	726,725	1,251,643	0.612285	0.612285	0.612285 71
72 IMPL. DEV. CHARGED TO PATIE	1,049,668	1,710,618	2,760,286	0.607512	0.607512	0.607512 72
73 DRUGS CHARGED TO PATIENTS	2,527,456	4,572,530	7,099,986	0.284451	0.284451	0.284451 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 (RHC)		432,394	432,394			88
88.01 RHC II		474,331	474,331			88.01
88.02 RHC III		1,122,475	1,122,475			88.02
90 CLINIC	449	55,190	55,639	8.627240	8.627240	8.627240 90
91 EMERGENCY	456,357	4,063,638	4,519,995	0.329111	0.329111	0.329111 91
92 OBSERVATION BEDS	259,817	1,465,359	1,725,176	0.594725	0.594725	0.594725 92
OTHER REIMBURSABLE COST CENTERS						
95 AMBULANCE SERVICES	1,064	3,195,306	3,196,370	0.434317	0.434317	0.434317 95
101 HOME HEALTH AGENCY		451,207	451,207			101
113 INTEREST EXPENSE						113
116 HOSPICE		1,553,744	1,553,744			116
200 SUBTOTAL (SEE INSTRUCTIONS)	15,918,341	51,872,080	67,790,421			200
201 LESS OBSERVATION BEDS						201
202 TOTAL (SEE INSTRUCTIONS)	15,918,341	51,872,080	67,790,421			202

APPORTIONMENT OF INPATIENT ROUTINE SERVICE CAPITAL COSTS

WORKSHEET D
 PART I

CHECK [] TITLE V
 APPLICABLE [XX] TITLE XVIII-PT A
 BOXES [] TITLE XIX

COST CENTER DESCRIPTION	CAP-REL	SWING-BED	REDUCED	TOTAL	PER	INPAT	INPAT PGM
	COST (FROM WKST B, PT. II, COL. 26)	ADJUSTMENT	CAP-REL COST (COL.1 MINUS COL.2)	PATIENT DAYS	DIEM (COL.3 ÷ COL.4)	PGM DAYS	CAP COST (COL.5 x COL.6)
	1	2	3	4	5	6	7
INPAT ROUTINE SERV COST CTRS							
30 ADULTS & PEDIATRICS	296,147		296,147	3,723	79.55	1,768	140,644
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	30,794		30,794	224	137.47		43
44 SKILLED NURSING FACILITY	157,257		157,257	9,252	17.00	1,737	29,529
45 NURSING FACILITY							45
200 TOTAL (LINES 30-199)	484,198		484,198	13,199		3,505	170,173

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS

WORKSHEET D
 PART II

CHECK [] TITLE V [XX] HOSPITAL (14-0167) [] SUB (OTHER)
 APPLICABLE [XX] TITLE XVIII-PT A [] IPF
 BOXES [] TITLE XIX [] IRF

[XX] PPS
 [] TEFRA

COST CENTER DESCRIPTION	CAP-REL COST (FROM WKST B, PT. II, COL. 26) 1	TOTAL CHARGES (FROM WKST C, PT. I, COL. 8) 2	RATIO OF COST TO CHARGES (COL.1 ÷ COL.2) 3	INPATIENT PROGRAM CHARGES 4	CAPITAL (COL.3 x COL.4) 5	
ANCILLARY SERVICE COST CENTERS						
50 OPERATING ROOM	379,988	8,040,176	0.047261	870,007	41,117	50
52 DELIVERY ROOM & LABOR ROOM	12,155	140,948	0.086237			52
53 ANESTHESIOLOGY	29,435	344,666	0.085402	49,030	4,187	53
54 RADIOLOGY-DIAGNOSTIC	580,453	14,653,717	0.039611	1,068,312	42,317	54
60 LABORATORY	148,935	9,883,995	0.015068	1,005,368	15,149	60
62.30 BLOOD CLOTTING FOR HEMOPHILIA						62.30
65 RESPIRATORY THERAPY	71,776	931,838	0.077026	221,050	17,027	65
66 PHYSICAL THERAPY	156,395	3,239,477	0.048278	111,518	5,384	66
69 ELECTROCARDIOLOGY	9,315	1,332,468	0.006991	297,605	2,081	69
71 MEDICAL SUPPLIES CHRGD TO PA	4,529	1,251,643	0.003618	372,900	1,349	71
72 IMPL. DEV. CHARGED TO PATIENT	12,165	2,760,286	0.004407	784,760	3,458	72
73 DRUGS CHARGED TO PATIENTS	46,495	7,099,986	0.006549	1,527,169	10,001	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 (RHC)	31,361	432,394	0.072529			88
88.01 RHC II	13,309	474,331	0.028058			88.01
88.02 RHC III	65,548	1,122,475	0.058396			88.02
90 CLINIC	46,214	55,639	0.830604			90
91 EMERGENCY	84,079	4,519,995	0.018602	371,151	6,904	91
92 OBSERVATION BEDS	83,443	1,725,176	0.048368	173,731	8,403	92
OTHER REIMBURSABLE COST CENTERS						
95 AMBULANCE SERVICES						95
200 TOTAL (SUM OF LINES 50-199)	1,775,595	58,009,210		6,852,601	157,377	200

PROVIDER CCN: 14-0167 IROQUOIS MEMORIAL HOSPITAL
 PERIOD FROM 10/01/2011 TO 09/30/2012

OPTIMIZER SYSTEMS, INC. WIN-LASH MICRO SYSTEM
 IN LIEU OF FORM CMS-2552-10 (08/2011)

VERSION: 2012.11
 02/14/2013 16:44

APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PASS THROUGH COSTS

WORKSHEET D
 PART III

CHECK [] TITLE V
 APPLICABLE [XX] TITLE XVIII-PT A
 BOXES [] TITLE XIX

COST CENTER DESCRIPTION	NURSING SCHOOL 1	ALLIED HEALTH COST 2	ALL OTHER MEDICAL EDUCATION COST 3	SWING-BED ADJUSTMENT AMOUNT (SEE INSTR.) 4	TOTAL COSTS (SUM OF COLS. 1-3 MINUS COL. 4) 5
INPAT ROUTINE SERV COST CTRS					30
30 ADULTS & PEDIATRICS					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 (SUM OF LINES 30-199)					200

PROVIDER CCN: 14-0167 IROQUOIS MEMORIAL HOSPITAL
 PERIOD FROM 10/01/2011 TO 09/30/2012

OPTIMIZER SYSTEMS, INC. WIN-LASH MICRO SYSTEM
 IN LIEU OF FORM CMS-2552-10 (08/2011)

VERSION: 2012.11
 02/14/2013 16:44

APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PASS THROUGH COSTS

WORKSHEET D
 PART III

CHECK [] TITLE V
 APPLICABLE [XX] TITLE XVIII-PT A
 BOXES [] TITLE XIX

COST CENTER DESCRIPTION	TOTAL PATIENT DAYS 6	PER DIEM COL.5 ÷ COL.6) 7	INPATIENT PROGRAM DAYS 8	INPAT PGM PASS THRU COSTS (COL.7 x COL.8) 9	
INPAT ROUTINE SERV COST CTRS					
30 ADULTS & PEDIATRICS	3,723		1,768		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	224				43
44 SKILLED NURSING FACILITY	9,252		1,737		44
45 NURSING FACILITY					45
200 TOTAL (SUM OF LINES 30-199)	13,199		3,505		200

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

WORKSHEET D
 PART IV

CHECK [] TITLE V [XX] HOSPITAL (14-0167) [] SUB (OTHER) [] ICF/MR [XX] PPS
 APPLICABLE [XX] TITLE XVIII-PT A [] IPF [] SNF [] TEFRA
 BOXES [] TITLE XIX [] IRF [] NF

COST CENTER DESCRIPTION	NON	NURSING	ALLIED	ALL OTHER	TOTAL	TOTAL O/P
	PHYSICIAN			HEALTH	MEDICAL	COST
	ANESTHETIST	SCHOOL	HEALTH	EDUCATION	(SUM OF	(SUM OF
	COST			COST	COLS.1-4)	COLS.2-4)
	1	2	3	4	5	6
ANCILLARY SERVICE COST CENTERS						
50 OPERATING ROOM						50
52 DELIVERY ROOM & LABOR ROOM						52
53 ANESTHESIOLOGY						53
54 RADIOLOGY-DIAGNOSTIC						54
60 LABORATORY						60
62.30 BLOOD CLOTTING FOR HEMOPHILIA						62.30
65 RESPIRATORY THERAPY						65
66 PHYSICAL THERAPY						66
69 ELECTROCARDIOLOGY						69
71 MEDICAL SUPPLIES CHRGED TO PA						71
72 IMPL. DEV. CHARGED TO PATIENT						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 (RHC)						88
88.01 RHC II						88.01
88.02 RHC III						88.02
90 CLINIC						90
91 EMERGENCY						91
92 OBSERVATION BEDS						92
OTHER REIMBURSABLE COST CENTERS						
95 AMBULANCE SERVICES						95
200 TOTAL (SUM OF LINES 50-199)						200

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

WORKSHEET D
 PART IV

CHECK [] TITLE V [XX] HOSPITAL (14-0167) [] SUB (OTHER) [] ICF/MR [XX] PPS
 APPLICABLE [XX] TITLE XVIII-PT A [] IPF [] SNF [] TEFRA
 BOXES [] TITLE XIX [] IRF [] NF

COST CENTER DESCRIPTION	TOTAL CHARGES (FROM WKST C, PT. I, COL. 8) 7	RATIO OF COST TO CHARGES (COL. 5 ÷ COL. 7) 8	O/P RATIO OF COST TO CHARGES (COL. 6 ÷ COL. 7) 9	INPAT PGM CHARGES 10	INPAT PGM PASS-THRU COSTS (COL. 8 x COL. 10) 11	O/P PGM CHARGES 12	O/P PGM PASS-THRU COSTS (COL. 9 x COL. 12) 13
ANCILLARY SERVICE COST CENTERS							
50 OPERATING ROOM	8,040,176			870,007		2,573,353	50
52 DELIVERY ROOM & LABOR ROOM	140,948						52
53 ANESTHESIOLOGY	344,666			49,030		91,181	53
54 RADIOLOGY-DIAGNOSTIC	14,653,717			1,068,312		5,907,013	54
60 LABORATORY	9,883,995			1,005,368		258,111	60
62.30 BLOOD CLOTTING FOR HEMOPHILI							62.30
65 RESPIRATORY THERAPY	931,838			221,050		285,912	65
66 PHYSICAL THERAPY	3,239,477			111,518			66
69 ELECTROCARDIOLOGY	1,332,468			297,605		509,969	69
71 MEDICAL SUPPLIES CHRGED TO P	1,251,643			372,900		355,216	71
72 IMPL. DEV. CHARGED TO PATIEN	2,760,286			784,760		1,269,781	72
73 DRUGS CHARGED TO PATIENTS	7,099,986			1,527,169		2,082,023	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 (RHC)	432,394						88
88.01 RHC II	474,331						88.01
88.02 RHC III	1,122,475						88.02
90 CLINIC	55,639					12,435	90
91 EMERGENCY	4,519,995			371,151		1,194,678	91
92 OBSERVATION BEDS	1,725,176			173,731		943,635	92
OTHER REIMBURSABLE COST CENTERS							
95 AMBULANCE SERVICES							95
200 TOTAL (SUM OF LINES 50-199)	58,009,210			6,852,601		15,483,307	200

APPORTIONMENT OF MEDICAL AND OTHER HEALTH SERVICES COSTS

WORKSHEET D
 PART V

CHECK [] TITLE V - O/P [XX] HOSPITAL (14-0167) [] SUB (OTHER) [] S/B-SNF
 APPLICABLE [XX] TITLE XVIII-PT B [] IPF [] SNF [] S/B-NF
 BOXES [] TITLE XIX - O/P [] IRF [] NF [] ICF/MR

COST CENTER DESCRIPTION	PROGRAM CHARGES				PROGRAM COSTS		
	COST TO CHARGE RATIO FROM WKST C, PT I, COL. 9 1	PPS REIMBURSED SERVICES 2	COST REIMB. SERVICES SUBJECT TO DED & COINS 3	COST REIMB. SVCES NOT SUBJECT TO DED & COINS 4	PPS SERVICES 5	COST SERVICES SUBJECT TO DED & COINS 6	COST SVCES NOT SUBJECT TO DED & COINS 7
ANCILLARY SERVICE COST CENTERS							
50 OPERATING ROOM	0.283400	2,573,353			729,288		50
52 DELIVERY ROOM & LABOR ROOM	1.565301						52
53 ANESTHESIOLOGY	0.136625	91,181			12,458		53
54 RADIOLOGY-DIAGNOSTIC	0.193988	5,907,013			1,145,890		54
60 LABORATORY	0.235560	258,111			60,801		60
62.30 BLOOD CLOTTING FOR HEMOPHILIACS							62.30
65 RESPIRATORY THERAPY	0.716372	285,912			204,819		65
66 PHYSICAL THERAPY	0.497708						66
69 ELECTROCARDIOLOGY	0.165878	509,969			84,593		69
71 MEDICAL SUPPLIES CHRGED TO PATI	0.612285	355,216			217,493		71
72 IMPL. DEV. CHARGED TO PATIENT	0.607512	1,269,781			771,407		72
73 DRUGS CHARGED TO PATIENTS	0.284451	2,082,023	4,109		592,234	1,169	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 (RHC)							88
88.01 RHC II							88.01
88.02 RHC III							88.02
90 CLINIC	8.627240	12,435			107,280		90
91 EMERGENCY	0.329111	1,194,678			393,182		91
92 OBSERVATION BEDS	0.594725	943,635			561,203		92
OTHER REIMBURSABLE COST CENTERS							
95 AMBULANCE SERVICES	0.434317						95
200 SUBTOTAL (SEE INSTRUCTIONS)		15,483,307	4,109		4,880,648	1,169	200
201 LESS PBP CLINIC LAB SERVICES							201
202 NET CHARGES (LINE 200 - LINE 201)		15,483,307	4,109		4,880,648	1,169	202

APPORTIONMENT OF MEDICAL AND OTHER HEALTH SERVICES COSTS

WORKSHEET D
 PART V

CHECK [] TITLE V - O/P [] HOSPITAL [] SUB (OTHER) [XX] S/B-SNF (14-U167)
 APPLICABLE [XX] TITLE XVIII-PT B [] IPF [] SNF [] S/B-NF
 BOXES [] TITLE XIX - O/P [] IRF [] NF [] ICF/MR

COST CENTER DESCRIPTION	PROGRAM CHARGES				PROGRAM COSTS		
	COST TO	PPS	COST REIMB. SERVICES	COST REIMB. SVCES NOT SUBJECT TO	COST SERVICES SUBJECT TO	COST SVCES NOT SUBJECT TO	
	FROM WKST C, PT I, COL. 9	REIMBURSED SERVICES	SUBJECT TO DED & COINS	SUBJECT TO DED & COINS	PPS SERVICES	SUBJECT TO DED & COINS	SUBJECT TO DED & COINS
	1	2	3	4	5	6	7
ANCILLARY SERVICE COST CENTERS							
50 OPERATING ROOM	0.283400						50
52 DELIVERY ROOM & LABOR ROOM	1.565301						52
53 ANESTHESIOLOGY	0.136625						53
54 RADIOLOGY-DIAGNOSTIC	0.193988						54
60 LABORATORY	0.235560						60
62.30 BLOOD CLOTTING FOR HEMOPHILIACS							62.30
65 RESPIRATORY THERAPY	0.716372						65
66 PHYSICAL THERAPY	0.497708						66
69 ELECTROCARDIOLOGY	0.165878						69
71 MEDICAL SUPPLIES CHRGD TO PATI	0.612285						71
72 IMPL. DEV. CHARGED TO PATIENT	0.607512						72
73 DRUGS CHARGED TO PATIENTS	0.284451						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 (RHC)							88
88.01 RHC II							88.01
88.02 RHC III							88.02
90 CLINIC	8.627240						90
91 EMERGENCY	0.329111						91
92 OBSERVATION BEDS	0.594725						92
OTHER REIMBURSABLE COST CENTERS							
95 AMBULANCE SERVICES	0.434317						95
200 SUBTOTAL (SEE INSTRUCTIONS)							200
201 LESS PBP CLINIC LAB SERVICES							201
202 NET CHARGES (LINE 200 - LINE 201)							202

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

WORKSHEET D
 PART IV

CHECK [] TITLE V [] HOSPITAL [] SUB (OTHER) [] ICF/MR [XX] PPS
 APPLICABLE [XX] TITLE XVIII-PT A [] IPF [XX] SNF (14-6049) [] TEFRA
 BOXES [] TITLE XIX [] IRF [] NF

COST CENTER DESCRIPTION	NON PHYSICIAN ANESTHETIST COST 1	NURSING SCHOOL 2	ALLIED HEALTH 3	ALL OTHER MEDICAL EDUCATION COST 4	TOTAL COST (SUM OF COLS.1-4) 5	TOTAL O/P COST (SUM OF COLS.2-4) 6
ANCILLARY SERVICE COST CENTERS						
50 OPERATING ROOM						50
52 DELIVERY ROOM & LABOR ROOM						52
53 ANESTHESIOLOGY						53
54 RADIOLOGY-DIAGNOSTIC						54
60 LABORATORY						60
62.30 BLOOD CLOTTING FOR HEMOPHILIA						62.30
65 RESPIRATORY THERAPY						65
66 PHYSICAL THERAPY						66
69 ELECTROCARDIOLOGY						69
71 MEDICAL SUPPLIES CHRGED TO PA						71
72 IMPL. DEV. CHARGED TO PATIENT						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 (RHC)						88
88.01 RHC II						88.01
88.02 RHC III						88.02
90 CLINIC						90
91 EMERGENCY						91
92 OBSERVATION BEDS						92
OTHER REIMBURSABLE COST CENTERS						
95 AMBULANCE SERVICES						95
200 TOTAL (SUM OF LINES 50-199)						200

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

WORKSHEET D
 PART IV

CHECK [] TITLE V [] HOSPITAL [] SUB (OTHER) [] ICF/MR [XX] PPS
 APPLICABLE [XX] TITLE XVIII-PT A [] IPF [XX] SNF (14-6049) [] TEFRA
 BOXES [] TITLE XIX [] IRF [] NF

COST CENTER DESCRIPTION	TOTAL CHARGES	RATIO OF COST TO CHARGES	O/P RATIO OF COST TO CHARGES	INPAT PGM CHARGES	INPAT PGM PASS-THRU COSTS	O/P PGM CHARGES	O/P PGM PASS-THRU COSTS
	(FROM WKST C, PT. I, COL. 8) 7	(COL. 5 ÷ COL. 7) 8	(COL. 6 ÷ COL. 7) 9	10	(COL. 8 x COL. 10) 11	12	(COL. 9 x COL. 12) 13
ANCILLARY SERVICE COST CENTERS							
50 OPERATING ROOM	8,040,176						50
52 DELIVERY ROOM & LABOR ROOM	140,948						52
53 ANESTHESIOLOGY	344,666						53
54 RADIOLOGY-DIAGNOSTIC	14,653,717			18,193			54
60 LABORATORY	9,883,995			38,216			60
62.30 BLOOD CLOTTING FOR HEMOPHILI							62.30
65 RESPIRATORY THERAPY	931,838			150			65
66 PHYSICAL THERAPY	3,239,477			436,014			66
69 ELECTROCARDIOLOGY	1,332,468			150			69
71 MEDICAL SUPPLIES CHRGD TO P	1,251,643			11,583			71
72 IMPL. DEV. CHARGED TO PATIEN	2,760,286						72
73 DRUGS CHARGED TO PATIENTS	7,099,986			73,408			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 (RHC)	432,394						88
88.01 RHC II	474,331						88.01
88.02 RHC III	1,122,475						88.02
90 CLINIC	55,639						90
91 EMERGENCY	4,519,995						91
92 OBSERVATION BEDS	1,725,176			87			92
OTHER REIMBURSABLE COST CENTERS							
95 AMBULANCE SERVICES							95
200 TOTAL (SUM OF LINES 50-199)	58,009,210			577,801			200

APPORTIONMENT OF MEDICAL AND OTHER HEALTH SERVICES COSTS

WORKSHEET D
 PART V

CHECK [] TITLE V - O/P [] HOSPITAL [] SUB (OTHER) [] S/B-SNF
 APPLICABLE [XX] TITLE XVIII-PT B [] IPF [XX] SNF (14-6049) [] S/B-NF
 BOXES [] TITLE XIX - O/P [] IRF [] NF [] ICF/MR

COST CENTER DESCRIPTION	PROGRAM CHARGES				PROGRAM COSTS		
	COST TO	PPS	COST REIMB. SERVICES	COST REIMB. SVCES NOT SUBJECT TO	COST SERVICES SUBJECT TO	COST SVCES NOT SUBJECT TO	
	FROM WKST C, PT I, COL. 9	REIMBURSED SERVICES	SUBJECT TO DED & COINS	SUBJECT TO DED & COINS	PPS SERVICES	SUBJECT TO DED & COINS	SUBJECT TO DED & COINS
	1	2	3	4	5	6	7
ANCILLARY SERVICE COST CENTERS							
50 OPERATING ROOM	0.283400						50
52 DELIVERY ROOM & LABOR ROOM	1.565301						52
53 ANESTHESIOLOGY	0.136625						53
54 RADIOLOGY-DIAGNOSTIC	0.193988						54
60 LABORATORY	0.235560						60
62.30 BLOOD CLOTTING FOR HEMOPHILIACS							62.30
65 RESPIRATORY THERAPY	0.716372						65
66 PHYSICAL THERAPY	0.497708						66
69 ELECTROCARDIOLOGY	0.165878						69
71 MEDICAL SUPPLIES CHRGD TO PATI	0.612285						71
72 IMPL. DEV. CHARGED TO PATIENT	0.607512						72
73 DRUGS CHARGED TO PATIENTS	0.284451						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 (RHC)							88
88.01 RHC II							88.01
88.02 RHC III							88.02
90 CLINIC	8.627240						90
91 EMERGENCY	0.329111						91
92 OBSERVATION BEDS	0.594725						92
OTHER REIMBURSABLE COST CENTERS							
95 AMBULANCE SERVICES	0.434317						95
200 SUBTOTAL (SEE INSTRUCTIONS)							200
201 LESS PBP CLINIC LAB SERVICES							201
202 NET CHARGES (LINE 200 - LINE 201)							202

APPORTIONMENT OF INPATIENT ROUTINE SERVICE CAPITAL COSTS

WORKSHEET D
 PART I

CHECK [] TITLE V
 APPLICABLE [] TITLE XVIII-PT A
 BOXES [XX] TITLE XIX

COST CENTER DESCRIPTION	CAP-REL COST	SWING-BED	REDUCED CAP-REL COST	TOTAL PATIENT	PER DIEM	INPAT PGM	INPAT PGM	
	(FROM WKST B, PT. II, COL. 26)	ADJUSTMENT	(COL.1 MINUS COL.2)	DAYS	(COL.3 ÷ COL.4)	DAYS	CAP COST (COL.5 x COL.6)	
	1	2	3	4	5	6	7	
INPAT ROUTINE SERV COST CTRS								
30 ADULTS & PEDIATRICS	296,147		296,147	3,723	79.55	366	29,115	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	30,794		30,794	224	137.47	168	23,095	43
44 SKILLED NURSING FACILITY	157,257		157,257	9,252	17.00			44
45 NURSING FACILITY								45
200 TOTAL (LINES 30-199)	484,198		484,198	13,199		534	52,210	200

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS

WORKSHEET D
 PART II

CHECK [] TITLE V [XX] HOSPITAL (14-0167) [] SUB (OTHER) [XX] PPS
 APPLICABLE [] TITLE XVIII-PT A [] IPF [] TEFRA
 BOXES [XX] TITLE XIX [] IRF [] OTHER

COST CENTER DESCRIPTION	CAP-REL COST (FROM WKST B, PT. II, COL. 26) 1	TOTAL CHARGES (FROM WKST C, PT. I, COL. 8) 2	RATIO OF COST TO CHARGES (COL.1 ÷ COL.2) 3	INPATIENT PROGRAM CHARGES 4	CAPITAL (COL.3 x COL.4) 5
ANCILLARY SERVICE COST CENTERS					
50 OPERATING ROOM	379,988	8,040,176	0.047261		50
52 DELIVERY ROOM & LABOR ROOM	12,155	140,948	0.086237		52
53 ANESTHESIOLOGY	29,435	344,666	0.085402		53
54 RADIOLOGY-DIAGNOSTIC	580,453	14,653,717	0.039611		54
60 LABORATORY	148,935	9,883,995	0.015068		60
62.30 BLOOD CLOTTING FOR HEMOPHILIA					62.30
65 RESPIRATORY THERAPY	71,776	931,838	0.077026		65
66 PHYSICAL THERAPY	156,395	3,239,477	0.048278		66
69 ELECTROCARDIOLOGY	9,315	1,332,468	0.006991		69
71 MEDICAL SUPPLIES CHRGD TO PA	4,529	1,251,643	0.003618		71
72 IMPL. DEV. CHARGED TO PATIENT	12,165	2,760,286	0.004407		72
73 DRUGS CHARGED TO PATIENTS	46,495	7,099,986	0.006549		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 (RHC)	31,361	432,394	0.072529		88
88.01 RHC II	13,309	474,331	0.028058		88.01
88.02 RHC III	65,548	1,122,475	0.058396		88.02
90 CLINIC	46,214	55,639	0.830604		90
91 EMERGENCY	84,079	4,519,995	0.018602		91
92 OBSERVATION BEDS	83,443	1,725,176	0.048368		92
OTHER REIMBURSABLE COST CENTERS					
95 AMBULANCE SERVICES					95
200 TOTAL (SUM OF LINES 50-199)	1,775,595	58,009,210			200

PROVIDER CCN: 14-0167 IROQUOIS MEMORIAL HOSPITAL
 PERIOD FROM 10/01/2011 TO 09/30/2012

OPTIMIZER SYSTEMS, INC. WIN-LASH MICRO SYSTEM
 IN LIEU OF FORM CMS-2552-10 (08/2011)

VERSION: 2012.11
 02/14/2013 16:44

APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PASS THROUGH COSTS

WORKSHEET D
 PART III

CHECK [] TITLE V
 APPLICABLE [] TITLE XVIII-PT A
 BOXES [XX] TITLE XIX

COST CENTER DESCRIPTION	NURSING SCHOOL 1	ALLIED HEALTH COST 2	ALL OTHER MEDICAL EDUCATION COST 3	SWING-BED ADJUSTMENT AMOUNT (SEE INSTR.) 4	TOTAL COSTS (SUM OF COLS. 1-3 MINUS COL. 4) 5
INPAT ROUTINE SERV COST CTRS					30
30 ADULTS & PEDIATRICS					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 (SUM OF LINES 30-199)					200

PROVIDER CCN: 14-0167 IROQUOIS MEMORIAL HOSPITAL
 PERIOD FROM 10/01/2011 TO 09/30/2012

OPTIMIZER SYSTEMS, INC. WIN-LASH MICRO SYSTEM
 IN LIEU OF FORM CMS-2552-10 (08/2011)

VERSION: 2012.11
 02/14/2013 16:44

APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PASS THROUGH COSTS

WORKSHEET D
 PART III

CHECK [] TITLE V
 APPLICABLE [] TITLE XVIII-PT A
 BOXES [XX] TITLE XIX

COST CENTER DESCRIPTION	TOTAL PATIENT DAYS 6	PER DIEM COL.5 ÷ COL.6) 7	INPATIENT PROGRAM DAYS 8	INPAT PGM PASS THRU COSTS (COL.7 x COL.8) 9	
INPAT ROUTINE SERV COST CTRS					
30 ADULTS & PEDIATRICS	3,723		366		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	224		168		43
44 SKILLED NURSING FACILITY	9,252				44
45 NURSING FACILITY					45
200 TOTAL (SUM OF LINES 30-199)	13,199		534		200

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

WORKSHEET D
 PART IV

CHECK [] TITLE V [XX] HOSPITAL (14-0167) [] SUB (OTHER) [] ICF/MR [XX] PPS
 APPLICABLE [] TITLE XVIII-PT A [] IPF [] SNF [] TEFRA
 BOXES [XX] TITLE XIX [] IRF [] NF [] OTHER

COST CENTER DESCRIPTION	NON PHYSICIAN ANESTHETIST COST 1	NURSING SCHOOL 2	ALLIED HEALTH 3	ALL OTHER MEDICAL EDUCATION COST 4	TOTAL COST (SUM OF COLS.1-4) 5	TOTAL O/P COST (SUM OF COLS.2-4) 6
ANCILLARY SERVICE COST CENTERS						
50 OPERATING ROOM						50
52 DELIVERY ROOM & LABOR ROOM						52
53 ANESTHESIOLOGY						53
54 RADIOLOGY-DIAGNOSTIC						54
60 LABORATORY						60
62.30 BLOOD CLOTTING FOR HEMOPHILIA						62.30
65 RESPIRATORY THERAPY						65
66 PHYSICAL THERAPY						66
69 ELECTROCARDIOLOGY						69
71 MEDICAL SUPPLIES CHRGED TO PA						71
72 IMPL. DEV. CHARGED TO PATIENT						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 (RHC)						88
88.01 RHC II						88.01
88.02 RHC III						88.02
90 CLINIC						90
91 EMERGENCY						91
92 OBSERVATION BEDS						92
OTHER REIMBURSABLE COST CENTERS						
95 AMBULANCE SERVICES						95
200 TOTAL (SUM OF LINES 50-199)						200

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

WORKSHEET D
 PART IV

CHECK [] TITLE V [XX] HOSPITAL (14-0167) [] SUB (OTHER) [] ICF/MR [XX] PPS
 APPLICABLE [] TITLE XVIII-PT A [] IPF [] SNF [] TEFRA
 BOXES [XX] TITLE XIX [] IRF [] NF [] OTHER

COST CENTER DESCRIPTION	TOTAL CHARGES (FROM WKST C, PT. I, COL. 8) 7	RATIO OF COST TO CHARGES (COL. 5 ÷ COL. 7) 8	O/P RATIO OF COST TO CHARGES (COL. 6 ÷ COL. 7) 9	INPAT PGM CHARGES 10	INPAT PGM PASS-THRU COSTS (COL. 8 x COL. 10) 11	O/P PGM CHARGES 12	O/P PGM PASS-THRU COSTS (COL. 9 x COL. 12) 13
ANCILLARY SERVICE COST CENTERS							
50 OPERATING ROOM	8,040,176						50
52 DELIVERY ROOM & LABOR ROOM	140,948						52
53 ANESTHESIOLOGY	344,666						53
54 RADIOLOGY-DIAGNOSTIC	14,653,717						54
60 LABORATORY	9,883,995						60
62.30 BLOOD CLOTTING FOR HEMOPHILI							62.30
65 RESPIRATORY THERAPY	931,838						65
66 PHYSICAL THERAPY	3,239,477						66
69 ELECTROCARDIOLOGY	1,332,468						69
71 MEDICAL SUPPLIES CHRGED TO P	1,251,643						71
72 IMPL. DEV. CHARGED TO PATIEN	2,760,286						72
73 DRUGS CHARGED TO PATIENTS	7,099,986						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 (RHC)	432,394						88
88.01 RHC II	474,331						88.01
88.02 RHC III	1,122,475						88.02
90 CLINIC	55,639						90
91 EMERGENCY	4,519,995						91
92 OBSERVATION BEDS	1,725,176						92
OTHER REIMBURSABLE COST CENTERS							
95 AMBULANCE SERVICES	3,196,370						95
200 TOTAL (SUM OF LINES 50-199)	58,009,210						200

APPORTIONMENT OF MEDICAL AND OTHER HEALTH SERVICES COSTS

WORKSHEET D
 PART V

CHECK [] TITLE V - O/P [XX] HOSPITAL (14-0167) [] SUB (OTHER) [] S/B-SNF
 APPLICABLE [] TITLE XVIII-PT B [] IPF [] SNF [] S/B-NF
 BOXES [XX] TITLE XIX - O/P [] IRF [] NF [] ICF/MR

COST CENTER DESCRIPTION	PROGRAM CHARGES				PROGRAM COSTS		
	COST TO	PPS	COST REIMB. SERVICES	COST REIMB. SVCES NOT SUBJECT TO	COST SERVICES SUBJECT TO	COST SVCES NOT SUBJECT TO	
	FROM WKST C, PT I, COL. 9	REIMBURSED SERVICES	SUBJECT TO DED & COINS	SUBJECT TO DED & COINS	PPS SERVICES	SUBJECT TO DED & COINS	SUBJECT TO DED & COINS
	1	2	3	4	5	6	7
ANCILLARY SERVICE COST CENTERS							
50 OPERATING ROOM	0.283400						50
52 DELIVERY ROOM & LABOR ROOM	1.565301						52
53 ANESTHESIOLOGY	0.136625						53
54 RADIOLOGY-DIAGNOSTIC	0.193988						54
60 LABORATORY	0.235560						60
62.30 BLOOD CLOTTING FOR HEMOPHILIACS							62.30
65 RESPIRATORY THERAPY	0.716372						65
66 PHYSICAL THERAPY	0.497708						66
69 ELECTROCARDIOLOGY	0.165878						69
71 MEDICAL SUPPLIES CHRGD TO PATI	0.612285						71
72 IMPL. DEV. CHARGED TO PATIENT	0.607512						72
73 DRUGS CHARGED TO PATIENTS	0.284451						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 (RHC)							88
88.01 RHC II							88.01
88.02 RHC III							88.02
90 CLINIC	8.627240						90
91 EMERGENCY	0.329111						91
92 OBSERVATION BEDS	0.594725						92
OTHER REIMBURSABLE COST CENTERS							
95 AMBULANCE SERVICES	0.434317						95
200 SUBTOTAL (SEE INSTRUCTIONS)							200
201 LESS PBP CLINIC LAB SERVICES							201
202 NET CHARGES (LINE 200 - LINE 201)							202

COMPUTATION OF INPATIENT OPERATING COST

CHECK [] TITLE V-INPT [XX] HOSPITAL (14-0167) [] SUB (OTHER) [] ICF/MR [XX] PPS
 APPLICABLE [XX] TITLE XVIII-PT A [] IPF [] SNF [] TEFRA
 BOXES [] TITLE XIX-INPT [] IRF [] NF [] OTHER

PART I - ALL PROVIDER COMPONENTS

INPATIENT DAYS			
1	INPATIENT DAYS (INCLUDING PRIVATE ROOM DAYS AND SWING-BED DAYS, EXCLUDING NEWBORN)	3,723	1
2	INPATIENT DAYS (INCLUDING PRIVATE ROOM DAYS, EXCLUDING SWING-BED AND NEWBORN DAYS)	3,723	2
3	PRIVATE ROOM DAYS (EXCLUDING SWING-BED PRIVATE ROOM DAYS)		3
4	SEMI-PRIVATE ROOM DAYS (EXCLUDING SWING-BED PRIVATE ROOM DAYS)	2,674	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 (INCL PRIVATE ROOM DAYS) THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD		7
8	TOTAL SWING-BED NF-TYPE INPATIENT DAYS (INCL PRIVATE ROOM DAYS) AFTER DECEMBER 31 OF THE COST REPORTING PERIOD (IF CALENDAR YEAR, ENTER 0 ON THIS LINE)		8
9	INPATIENT DAYS INCLUDING PRIVATE ROOM DAYS APPLICABLE TO THE PROGRAM (EXCLUDING SWING-BED AND NEWBORN DAYS)	1,768	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 TITLE XIX ONLY)		15
16	TITLE V OR XIX NURSERY DAYS (TITLE V OR TITLE 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	188.27	17
18	MEDICARE RATE FOR SWING-BED SNF SERVICES APPLICABLE TO SERVICES AFTER DECEMBER 31 OF THE COST REPORTING PERIOD	192.90	18
19	MEDICAID RATE FOR SWING-BED NF SERVICES APPLICABLE TO SERVICES THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD		19
20	MEDICAID RATE FOR SWING-BED NF SERVICES APPLICABLE TO SERVICES AFTER DECEMBER 31 OF THE COST REPORTING PERIOD		20
21	TOTAL GENERAL INPATIENT ROUTINE SERVICE COST (SEE INSTRUCTIONS)	3,641,379	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	3,641,379	27
PRIVATE ROOM DIFFERENTIAL ADJUSTMENT			
28	GENERAL INPATIENT ROUTINE SERVICE CHARGES (EXCLUDING SWING-BED CHARGES)	2,613,007	28
29	PRIVATE ROOM CHARGES (EXCLUDING SWING-BED CHARGES)		29
30	SEMI-PRIVATE ROOM CHARGES (EXCLUDING SWING-BED CHARGES)	2,613,007	30
31	GENERAL INPATIENT ROUTINE SERVICE COST/CHARGE RATIO (LINE 27 ÷ LINE 28)	1.393559	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)	977.19	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 - LINE 36)	3,641,379	37

WORKSHEET D-1
 PART II

COMPUTATION OF INPATIENT OPERATING COST

CHECK [] TITLE V-INPT [XX] HOSPITAL (14-0167) [] SUB (OTHER) [XX] PPS
 APPLICABLE [XX] TITLE XVIII-PT A [] IPF [] TEFRA
 BOXES [] TITLE XIX-INPT [] IRF [] OTHER

PART II - HOSPITAL AND SUBPROVIDERS ONLY

PROGRAM INPATIENT OPERATING COST BEFORE PASS-THROUGH COST ADJUSTMENTS
 38 ADJUSTED GENERAL INPATIENT ROUTINE SERVICE COST PER DIEM (SEE INSTRUCTIONS) 978.08 38
 39 PROGRAM GENERAL INPATIENT ROUTINE SERVICE COST (LINE 9 x LINE 38) 1,729,245 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) 1,729,245 41

	TOTAL INPATIENT COST 1	TOTAL INPATIENT DAYS 2	AVERAGE PER DIEM (COL. 1 ÷ COL. 2) 3	PROGRAM DAYS 4	PROGRAM COST (COL. 3 x COL. 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
48 PROGRAM INPATIENT ANCILLARY SERVICE COST (WKST D-3, COL. 3, LINE 200)					2,325,495	48
49 TOTAL PROGRAM INPATIENT COSTS (SEE INSTRUCTIONS)					4,054,740	49

PASS-THROUGH COST ADJUSTMENTS
 50 PASS THROUGH COSTS APPLICABLE TO PROGRAM INPATIENT ROUTINE SERVICES (FROM WKST D, SUM OF PARTS I AND III) 140,644 50
 51 PASS THROUGH COSTS APPLICABLE TO PROGRAM INPATIENT ANCILLARY SERVICES (FROM WKST D, SUM OF PARTS II AND IV) 157,377 51
 52 TOTAL PROGRAM EXCLUDABLE COST 298,021 52
 53 TOTAL PROGRAM INPATIENT OPERATING COST EXCLUDING CAPITAL RELATED, NONPHYSICIAN ANESTHETIST AND MEDICAL EDUCATION COSTS (LINE 49 MINUS LINE 52) 3,756,719 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 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 (LINES 54 x 60), OR 1% OF THE TARGET AMOUNT (LINE 56), OTHERWISE ENTER 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

PART IV - COMPUTATION OF OBSERVATION BED PASS-THROUGH COST

87 TOTAL OBSERVATION BED DAYS (SEE INSTRUCTIONS) 1,049 87
 88 ADJUSTED GENERAL INPATIENT ROUTINE COST PER DIEM (LINE 27 ÷ LINE 2) 978.08 88
 89 OBSERVATION BED COST (LINE 87 x LINE 88) (SEE INSTRUCTIONS) 1,026,006 89

	COST 1	ROUTINE COST (FROM LINE 27) 2	COL. 1 ÷ COL. 2 3	TOTAL OBS. BED COST (FROM LINE 89) 4	OBS. BED PASS-THRU COST (COL. 3 x COL. 4) (SEE INSTR.) 5	
COMPUTATION OF OBSERVATION BED PASS-THROUGH COST						
90 CAPITAL-RELATED COST	296,147	3,641,379	0.081328	1,026,006	83,443	90
91 NURSING SCHOOL COST						91
92 ALLIED HEALTH COST						92
93 ALL OTHER MEDICAL EDUCATION						93

COMPUTATION OF INPATIENT OPERATING COST

CHECK [] TITLE V-INPT [] HOSPITAL [] SUB (OTHER) [] ICF/MR [XX] PPS
 APPLICABLE [XX] TITLE XVIII-PT A [] IPF [XX] SNF (14-6049) [] TEFRA
 BOXES [] TITLE XIX-INPT [] IRF [] NF [] OTHER

PART I - ALL PROVIDER COMPONENTS

INPATIENT DAYS			
1	INPATIENT DAYS (INCLUDING PRIVATE ROOM DAYS AND SWING-BED DAYS, EXCLUDING NEWBORN)	9,252	1
2	INPATIENT DAYS (INCLUDING PRIVATE ROOM DAYS, EXCLUDING SWING-BED AND NEWBORN DAYS)	9,252	2
3	PRIVATE ROOM DAYS (EXCLUDING SWING-BED PRIVATE ROOM DAYS)		3
4	SEMI-PRIVATE ROOM DAYS (EXCLUDING SWING-BED PRIVATE ROOM DAYS)	9,252	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 (INCL PRIVATE ROOM DAYS) THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD		7
8	TOTAL SWING-BED NF-TYPE INPATIENT DAYS (INCL PRIVATE ROOM DAYS) AFTER DECEMBER 31 OF THE COST REPORTING PERIOD (IF CALENDAR YEAR, ENTER 0 ON THIS LINE)		8
9	INPATIENT DAYS INCLUDING PRIVATE ROOM DAYS APPLICABLE TO THE PROGRAM (EXCLUDING SWING-BED AND NEWBORN DAYS)	1,737	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 TITLE XIX ONLY)		15
16	TITLE V OR XIX NURSERY DAYS (TITLE V OR TITLE 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)	2,045,090	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	2,045,090	27
PRIVATE ROOM DIFFERENTIAL ADJUSTMENT			
28	GENERAL INPATIENT ROUTINE SERVICE CHARGES (EXCLUDING SWING-BED CHARGES)	1,703,049	28
29	PRIVATE ROOM CHARGES (EXCLUDING SWING-BED CHARGES)		29
30	SEMI-PRIVATE ROOM CHARGES (EXCLUDING SWING-BED CHARGES)	1,703,049	30
31	GENERAL INPATIENT ROUTINE SERVICE COST/CHARGE RATIO (LINE 27 ÷ LINE 28)	1.200840	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)	184.07	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 - LINE 36)	2,045,090	37

PROVIDER CCN: 14-0167 IROQUOIS MEMORIAL HOSPITAL
PERIOD FROM 10/01/2011 TO 09/30/2012

OPTIMIZER SYSTEMS, INC. WIN-LASH MICRO SYSTEM
IN LIEU OF FORM CMS-2552-10 (08/2011)

VERSION: 2012.11
02/14/2013 16:44

WORKSHEET D-1
PARTS III & IV

COMPUTATION OF INPATIENT OPERATING COST

CHECK [] TITLE V-INPT [] HOSPITAL [] SUB (OTHER) [] ICF/MR [XX] PPS
APPLICABLE [XX] TITLE XVIII-PT A [] IPF [XX] SNF (14-6049) [] TEFRA
BOXES [] TITLE XIX-INPT [] IRF [] NF [] OTHER

PART III - SKILLED NURSING FACILITY, NURSING FACILITY AND ICF/MR ONLY

70	SKILLED NURSING FACILITY/OTHER NURSING FACILITY/ICF/MR ROUTINE SERVICE COSTS (LINE 37)	2,045,090	70
71	ADJUSTED GENERAL INPATIENT ROUTINE SERVICE COST PER DIEM (LINE 70 ÷ LINE 2)	221.04	71
72	PROGRAM ROUTINE SERVICE COST (LINE 9 x LINE 71)	383,946	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)	383,946	74
75	CAPITAL-RELATED COST ALLOCATED TO INPATIENT ROUTINE SERVICE COSTS (FROM WKST B, PART II, COL. 26, LINE 45)		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)	383,946	83
84	PROGRAM INPATIENT ANCILLARY SERVICES (SEE INSTRUCTIONS)	257,696	84
85	UTILIZATION REVIEW--PHYSICIAN COMPENSATION (SEE INSTRUCTIONS)		85
86	TOTAL PROGRAM INPATIENT OPERATING COSTS (SUM OF LINES 83 THROUGH 85)	641,642	86

COMPUTATION OF INPATIENT OPERATING COST

CHECK [] TITLE V-INPT [XX] HOSPITAL (14-0167) [] SUB (OTHER) [] ICF/MR [XX] PPS
 APPLICABLE [] TITLE XVIII-PT A [] IPF [] SNF [] TEFRA
 BOXES [XX] TITLE XIX-INPT [] IRF [] NF [] OTHER

PART I - ALL PROVIDER COMPONENTS

INPATIENT DAYS			
1	INPATIENT DAYS (INCLUDING PRIVATE ROOM DAYS AND SWING-BED DAYS, EXCLUDING NEWBORN)	3,723	1
2	INPATIENT DAYS (INCLUDING PRIVATE ROOM DAYS, EXCLUDING SWING-BED AND NEWBORN DAYS)	3,723	2
3	PRIVATE ROOM DAYS (EXCLUDING SWING-BED PRIVATE ROOM DAYS)		3
4	SEMI-PRIVATE ROOM DAYS (EXCLUDING SWING-BED PRIVATE ROOM DAYS)	2,674	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 (INCL PRIVATE ROOM DAYS) THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD		7
8	TOTAL SWING-BED NF-TYPE INPATIENT DAYS (INCL PRIVATE ROOM DAYS) AFTER DECEMBER 31 OF THE COST REPORTING PERIOD (IF CALENDAR YEAR, ENTER 0 ON THIS LINE)		8
9	INPATIENT DAYS INCLUDING PRIVATE ROOM DAYS APPLICABLE TO THE PROGRAM (EXCLUDING SWING-BED AND NEWBORN DAYS)	366	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 TITLE XIX ONLY)	224	15
16	TITLE V OR XIX NURSERY DAYS (TITLE V OR TITLE XIX ONLY)	168	16
SWING-BED ADJUSTMENT			
17	MEDICARE RATE FOR SWING-BED SNF SERVICES APPLICABLE TO SERVICES THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD	188.27	17
18	MEDICARE RATE FOR SWING-BED SNF SERVICES APPLICABLE TO SERVICES AFTER DECEMBER 31 OF THE COST REPORTING PERIOD	192.90	18
19	MEDICAID RATE FOR SWING-BED NF SERVICES APPLICABLE TO SERVICES THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD		19
20	MEDICAID RATE FOR SWING-BED NF SERVICES APPLICABLE TO SERVICES AFTER DECEMBER 31 OF THE COST REPORTING PERIOD		20
21	TOTAL GENERAL INPATIENT ROUTINE SERVICE COST (SEE INSTRUCTIONS)	3,641,379	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	3,641,379	27
PRIVATE ROOM DIFFERENTIAL ADJUSTMENT			
28	GENERAL INPATIENT ROUTINE SERVICE CHARGES (EXCLUDING SWING-BED CHARGES)	2,613,007	28
29	PRIVATE ROOM CHARGES (EXCLUDING SWING-BED CHARGES)		29
30	SEMI-PRIVATE ROOM CHARGES (EXCLUDING SWING-BED CHARGES)	2,613,007	30
31	GENERAL INPATIENT ROUTINE SERVICE COST/CHARGE RATIO (LINE 27 ÷ LINE 28)	1.393559	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)	977.19	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 - LINE 36)	3,641,379	37

WORKSHEET D-1
 PART II

COMPUTATION OF INPATIENT OPERATING COST

CHECK [] TITLE V-INPT [XX] HOSPITAL (14-0167) [] SUB (OTHER) [XX] PPS
 APPLICABLE [] TITLE XVIII-PT A [] IPF [] TEFRA
 BOXES [XX] TITLE XIX-INPT [] IRF [] OTHER

PART II - HOSPITAL AND SUBPROVIDERS ONLY

PROGRAM INPATIENT OPERATING COST BEFORE PASS-THROUGH COST ADJUSTMENTS
 38 ADJUSTED GENERAL INPATIENT ROUTINE SERVICE COST PER DIEM (SEE INSTRUCTIONS) 978.08 38
 39 PROGRAM GENERAL INPATIENT ROUTINE SERVICE COST (LINE 9 x LINE 38) 357,977 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) 357,977 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)	437,143	224	1,951.53	168	327,857 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
 48 PROGRAM INPATIENT ANCILLARY SERVICE COST (WKST D-3, COL. 3, LINE 200) 48
 49 TOTAL PROGRAM INPATIENT COSTS (SEE INSTRUCTIONS) 685,834 49

PASS-THROUGH COST ADJUSTMENTS
 50 PASS THROUGH COSTS APPLICABLE TO PROGRAM INPATIENT ROUTINE SERVICES (FROM WKST D, SUM OF PARTS I AND III) 52,210 50
 51 PASS THROUGH COSTS APPLICABLE TO PROGRAM INPATIENT ANCILLARY SERVICES (FROM WKST D, SUM OF PARTS II AND IV) 51
 52 TOTAL PROGRAM EXCLUDABLE COST 52,210 52
 53 TOTAL PROGRAM INPATIENT OPERATING COST EXCLUDING CAPITAL RELATED, NONPHYSICIAN ANESTHETIST AND MEDICAL EDUCATION COSTS (LINE 49 MINUS LINE 52) 633,624 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 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 (LINES 54 x 60), OR 1% OF THE TARGET AMOUNT (LINE 56), OTHERWISE ENTER 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

PART IV - COMPUTATION OF OBSERVATION BED PASS-THROUGH COST

87 TOTAL OBSERVATION BED DAYS (SEE INSTRUCTIONS) 1,049 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

	ROUTINE COST (FROM LINE 27)	COL. 1 ÷ COL. 2	TOTAL OBS. BED COST (FROM LINE 89)	OBS. BED PASS-THRU COST (COL. 3 x COL. 4) (SEE INSTR.)
	1	2	3	4
COMPUTATION OF OBSERVATION BED PASS-THROUGH COST				
90 CAPITAL-RELATED COST				90
91 NURSING SCHOOL COST				91
92 ALLIED HEALTH COST				92
93 ALL OTHER MEDICAL EDUCATION				93

INPATIENT ANCILLARY COST APPORTIONMENT

WORKSHEET D-3

CHECK [] TITLE V [XX] HOSPITAL (14-0167) [] SUB (OTHER) [] S/B SNF [XX] PPS
 APPLICABLE [XX] TITLE XVIII-PT A [] IPF [] SNF [] S/B NF [] TEFRA
 BOXES [] TITLE XIX [] IRF [] NF [] ICF/MR [] OTHER

COST CENTER DESCRIPTION	RATIO OF COST TO CHARGES 1	INPATIENT PROGRAM CHARGES 2	INPATIENT PROGRAM COSTS (COL.1 x COL.2)		
			3	3	
INPATIENT ROUTINE SERVICE COST CENTERS					
30 ADULTS & PEDIATRICS		1,629,776			30
ANCILLARY SERVICE COST CENTERS					
50 OPERATING ROOM	0.283400	870,007	246,560		50
52 DELIVERY ROOM & LABOR ROOM	1.565301				52
53 ANESTHESIOLOGY	0.136625	49,030	6,699		53
54 RADIOLOGY-DIAGNOSTIC	0.193988	1,068,312	207,240		54
60 LABORATORY	0.235560	1,005,368	236,824		60
62.30 BLOOD CLOTTING FOR HEMOPHILIACS					62.30
65 RESPIRATORY THERAPY	0.716372	221,050	158,354		65
66 PHYSICAL THERAPY	0.497708	111,518	55,503		66
69 ELECTROCARDIOLOGY	0.165878	297,605	49,366		69
71 MEDICAL SUPPLIES CHRGD TO PATI	0.612285	372,900	228,321		71
72 IMPL. DEV. CHARGED TO PATIENT	0.607512	784,760	476,751		72
73 DRUGS CHARGED TO PATIENTS	0.284451	1,527,169	434,405		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 (RHC)					88
88.01 RHC II					88.01
88.02 RHC III					88.02
90 CLINIC	8.627240				90
91 EMERGENCY	0.329111	371,151	122,150		91
92 OBSERVATION BEDS	0.594725	173,731	103,322		92
OTHER REIMBURSABLE COST CENTERS					
95 AMBULANCE SERVICES					95
200 TOTAL (SUM OF LINES 50-94 AND 96-98)		6,852,601	2,325,495		200
201 LESS PBP CLINIC LAB SVCS-PGM ONLY CHARGES					201
202 NET CHARGES (LINE 200 MINUS LINE 201)		6,852,601			202

INPATIENT ANCILLARY COST APPORTIONMENT

WORKSHEET D-3

CHECK [] TITLE V [] HOSPITAL [] SUB (OTHER) [XX] S/B SNF (14-U167) [XX] PPS
 APPLICABLE [XX] TITLE XVIII-PT A [] IPF [] SNF [] S/B NF [] TEFRA
 BOXES [] TITLE XIX [] IRF [] NF [] ICF/MR [] OTHER

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	0.283400			50
52 DELIVERY ROOM & LABOR ROOM	1.565301			52
53 ANESTHESIOLOGY	0.136625			53
54 RADIOLOGY-DIAGNOSTIC	0.193988			54
60 LABORATORY	0.235560			60
62.30 BLOOD CLOTTING FOR HEMOPHILIACS				62.30
65 RESPIRATORY THERAPY	0.716372			65
66 PHYSICAL THERAPY	0.497708			66
69 ELECTROCARDIOLOGY	0.165878			69
71 MEDICAL SUPPLIES CHRGD TO PATI	0.612285			71
72 IMPL. DEV. CHARGED TO PATIENT	0.607512			72
73 DRUGS CHARGED TO PATIENTS	0.284451			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 (RHC)				88
88.01 RHC II				88.01
88.02 RHC III				88.02
90 CLINIC	8.627240			90
91 EMERGENCY	0.329111			91
92 OBSERVATION BEDS	0.594725			92
OTHER REIMBURSABLE COST CENTERS				
95 AMBULANCE SERVICES				95
200 TOTAL (SUM OF LINES 50-94 AND 96-98)				200
201 LESS PBP CLINIC LAB SVCS-PGM ONLY CHARGES				201
202 NET CHARGES (LINE 200 MINUS LINE 201)				202

INPATIENT ANCILLARY COST APPORTIONMENT

WORKSHEET D-3

CHECK [] TITLE V [] HOSPITAL [] SUB (OTHER) [] S/B SNF [XX] PPS
 APPLICABLE [XX] TITLE XVIII-PT A [] IPF [XX] SNF (14-6049) [] S/B NF [] TEFRA
 BOXES [] TITLE XIX [] IRF [] NF [] ICF/MR [] OTHER

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	0.283400				50
52 DELIVERY ROOM & LABOR ROOM	1.565301				52
53 ANESTHESIOLOGY	0.136625				53
54 RADIOLOGY-DIAGNOSTIC	0.193988	18,193	3,529		54
60 LABORATORY	0.235560	38,216	9,002		60
62.30 BLOOD CLOTTING FOR HEMOPHILIACS					62.30
65 RESPIRATORY THERAPY	0.716372	150	107		65
66 PHYSICAL THERAPY	0.497708	436,014	217,008		66
69 ELECTROCARDIOLOGY	0.165878	150	25		69
71 MEDICAL SUPPLIES CHRGD TO PATI	0.612285	11,583	7,092		71
72 IMPL. DEV. CHARGED TO PATIENT	0.607512				72
73 DRUGS CHARGED TO PATIENTS	0.284451	73,408	20,881		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 (RHC)					88
88.01 RHC II					88.01
88.02 RHC III					88.02
90 CLINIC	8.627240				90
91 EMERGENCY	0.329111				91
92 OBSERVATION BEDS	0.594725	87	52		92
OTHER REIMBURSABLE COST CENTERS					
95 AMBULANCE SERVICES					95
200 TOTAL (SUM OF LINES 50-94 AND 96-98)		577,801	257,696		200
201 LESS PBP CLINIC LAB SVCS-PGM ONLY CHARGES					201
202 NET CHARGES (LINE 200 MINUS LINE 201)		577,801			202

INPATIENT ANCILLARY COST APPORTIONMENT

WORKSHEET D-3

CHECK [] TITLE V [XX] HOSPITAL (14-0167) [] SUB (OTHER) [] S/B SNF [XX] PPS
 APPLICABLE [] TITLE XVIII-PT A [] IPF [] SNF [] S/B NF [] TEFRA
 BOXES [XX] TITLE XIX [] IRF [] NF [] ICF/MR [] OTHER

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
43 NURSERY				43
ANCILLARY SERVICE COST CENTERS				
50 OPERATING ROOM	0.283400			50
52 DELIVERY ROOM & LABOR ROOM	1.565301			52
53 ANESTHESIOLOGY	0.136625			53
54 RADIOLOGY-DIAGNOSTIC	0.193988			54
60 LABORATORY	0.235560			60
62.30 BLOOD CLOTTING FOR HEMOPHILIACS				62.30
65 RESPIRATORY THERAPY	0.716372			65
66 PHYSICAL THERAPY	0.497708			66
69 ELECTROCARDIOLOGY	0.165878			69
71 MEDICAL SUPPLIES CHRGD TO PATI	0.612285			71
72 IMPL. DEV. CHARGED TO PATIENT	0.607512			72
73 DRUGS CHARGED TO PATIENTS	0.284451			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 (RHC)				88
88.01 RHC II				88.01
88.02 RHC III				88.02
90 CLINIC	8.627240			90
91 EMERGENCY	0.329111			91
92 OBSERVATION BEDS	0.594725			92
OTHER REIMBURSABLE COST CENTERS				
95 AMBULANCE SERVICES				95
200 TOTAL (SUM OF LINES 50-94 AND 96-98)				200
201 LESS PBP CLINIC LAB SVCS-PGM ONLY CHARGES				201
202 NET CHARGES (LINE 200 MINUS LINE 201)				202

CALCULATION OF REIMBURSEMENT SETTLEMENT

WORKSHEET E
 PART A

CHECK [XX] HOSPITAL (14-0167)
 APPLICABLE BOX: [] SUB (OTHER)

PART A - INPATIENT HOSPITAL SERVICES UNDER PPS

1	DRG AMOUNTS OTHER THAN OUTLIER PAYMENTS	3,846,638	1
2	OUTLIER PAYMENTS FOR DISCHARGES (SEE INSTRUCTIONS)	10,828	2
2.01	OUTLIER RECONCILIATION AMOUNT		2.01
3	MANAGED CARE SIMULATED PAYMENTS		3
4	BED DAYS AVAILABLE DIVIDED BY NUMBER OF DAYS IN THE COST REPORTING PERIOD (SEE INSTRUCTIONS)	46.13	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) AND VOL. 64 FEDERAL REGISTER, MAY 12, 1998, PAGE 26340 AND VOL. 67 FEDERAL REGISTER, PAGE 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 LINES (8, 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 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
INDIRECT MEDICAL EDUCATION ADJUSTMENT FOR THE ADD-ON			
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 (SEE INSTRUCTIONS)		27
28	IME ADJUSTMENT (SEE INSTRUCTIONS)		28
29	TOTAL IME PAYMENT (SUM OF LINES 22 AND 28)		29
DISPROPORTIONATE SHARE ADJUSTMENT			
30	PERCENTAGE OF SSI RECIPIENT PATIENT DAYS TO MEDICARE PART A PATIENT DAYS (SEE INSTRUCTIONS)	0.0236	30
31	PERCENTAGE OF MEDICAID PATIENT DAYS TO TOTAL DAYS REPORTED ON WORKSHEET S-2, PART I, LINE 24 (SEE INSTRUCTIONS)	0.1843	31
32	SUM OF LINES 30 AND 31	0.2079	32
33	ALLOWABLE DISPROPORTIONATE SHARE PERCENTAGE (SEE INSTRUCTIONS)	0.0637	33
34	DISPROPORTIONATE SHARE ADJUSTMENT (SEE INSTRUCTIONS)	245,031	34
ADDITIONAL PAYMENT FOR HIGH PERCENTAGE OF ESRD BENEFICIARY DISCHARGES			
40	TOTAL MEDICARE DISCHARGES ON WORKSHEET S-3, PART I 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
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 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)		46
47	SUBTOTAL (SEE INSTRUCTIONS)	4,102,497	47
48	HOSPITAL SPECIFIC PAYMENTS (TO BE COMPLETED BY SCH AND MDH, SMALL RURAL HOSPITALS ONLY (SEE INSTRUCTIONS)	4,675,249	48
49	TOTAL PAYMENT FOR INPATIENT OPERATING COSTS SCH AND MDH ONLY (SEE INSTRUCTIONS)	4,675,249	49
50	PAYMENT FOR INPATIENT PROGRAM CAPITAL (FROM WKST L, PARTS I, II, AS APPLICABLE)	309,963	50

CALCULATION OF REIMBURSEMENT SETTLEMENT

WORKSHEET E
 PART A

CHECK [XX] HOSPITAL (14-0167)
 APPLICABLE BOX: [] SUB (OTHER)

PART A - INPATIENT HOSPITAL SERVICES UNDER PPS

51	EXCEPTION PAYMENT FOR INPATIENT PROGRAM CAPITAL (WKST L, PART 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, PART III, COL. 1, LINE 69)		55
56	COST OF TEACHING PHYSICIANS (WKST D-5, PART II, COL. 3, LINE 20)		56
57	ROUTINE SERVICE OTHER PASS THROUGH COSTS		57
58	ANCILLARY SERVICE OTHER PASS THROUGH COSTS (WKST D, PART IV, COL. 11, LINE 200)		58
59	TOTAL (SUM OF AMOUNTS ON LINES 49 THROUGH 58)	4,985,212	59
60	PRIMARY PAYER PAYMENTS		60
61	TOTAL AMOUNT PAYABLE FOR PROGRAM BENEFICIARIES (LINE 59 MINUS LINE 60)	4,985,212	61
62	DEDUCTIBLES BILLED TO PROGRAM BENEFICIARIES	499,208	62
63	COINSURANCE BILLED TO PROGRAM BENEFICIARIES		63
64	ALLOWABLE BAD DEBTS (SEE INSTRUCTIONS)	106,964	64
65	ADJUSTED REIMBURSABLE BAD DEBTS (SEE INSTRUCTIONS)	74,875	65
66	ALLOWABLE BAD DEBTS FOR DUAL ELIGIBLE BENEFICIARIES (SEE INSTRUCTIONS)	102,963	66
67	SUBTOTAL (LINE 61 PLUS LINE 65 MINUS LINES 62 AND 63)	4,560,879	67
68	CREDITS RECEIVED FROM MANUFACTURERS FOR REPLACED DEVICES APPLICABLE TO MS-DRG (SEE INSTRUCTIONS)		68
69	OUTLIER PAYMENTS RECONCILIATION		69
70	OTHER ADJUSTMENTS (SPECIFY) (SEE INSTRUCTIONS)		70
70.97	LOW VOLUME PAYMENT ADJUSTMENT - 2	390,806	70.97
71	AMOUNT DUE PROVIDER (LINE 67 MINUS LINE 68 PLUS/MINUS LINES 69 AND 70)	4,951,685	71
72	INTERIM PAYMENTS	4,847,089	72
73	TENTATIVE SETTLEMENT (FOR CONTRACTOR USE ONLY)		73
74	BALANCE DUE PROVIDER/PROGRAM (LINE 71 MINUS THE SUM OF LINES 72 AND 73)	104,596	74
75	PROTESTED AMOUNTS (NONALLOWABLE COST REPORT ITEMS) IN ACCORDANCE WITH CMS PUB. 15-II, SECTION 115.2		75
TO BE COMPLETED BY CONTRACTOR			
90	OPERATING OUTLIER AMOUNT FROM WORKSHEET E, PART A, LINE 2		90
91	CAPITAL OUTLIER FROM WORKSHEET L, PART 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

CALCULATION OF REIMBURSEMENT SETTLEMENT

WORKSHEET E
PART B

CHECK APPLICABLE BOX: HOSPITAL IPF IRF
 SUB (OTHER) SNF (14-6049)

PART B - MEDICAL AND OTHER HEALTH SERVICES

1	MEDICAL AND OTHER SERVICES (SEE INSTRUCTIONS)		1
2	MEDICAL AND OTHER SERVICES REIMBURSED UNDER OPPTS (SEE INSTRUCTIONS)		2
3	PPS PAYMENTS		3
4	OUTLIER PAYMENT (SEE INSTRUCTIONS)		4
5	ENTER THE HOSPITAL SPECIFIC PAYMENT TO COST RATIO (SEE INSTRUCTIONS)		5
6	LINE 2 TIMES LINE 5		6
7	SUM OF LINE 3 PLUS LINE 4 DIVIDED BY LINE 6		7
8	TRANSITIONAL CORRIDOR PAYMENT (SEE INSTRUCTIONS)		8
9	ANCILLARY SERVICE OTHER PASS THROUGH COSTS FROM WKST D, PART 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, LINE 69, COL. 4)		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 REASONABLE COST (COMPLETE ONLY IF LINE 18 EXCEEDS LINE 11 (SEE INSTRUCTIONS))		19
20	EXCESS OF REASONABLE COST OVER CUSTOMARY CHARGES (COMPLETE ONLY IF LINE 11 EXCEEDS LINE 18 (SEE INSTRUCTIONS))		20
21	LESSER OF COST OR CHARGES (LINE 11 MINUS LINE 20) (FOR CAH, SEE INSTRUCTIONS)		21
22	INTERNS AND RESIDENTS (SEE INSTRUCTIONS)		22
23	COST OF TEACHING PHYSICIANS (SEE INSTR., 42 CFR 415.160 AND CMS PUB. 15-1 §2148)		23
24	TOTAL PROSPECTIVE PAYMENT (SUM OF LINES 3, 4, 8 AND 9)		24
	COMPUTATION OF REIMBURSEMENT SETTLEMENT		
25	DEDUCTIBLES AND COINSURANCE (SEE INSTRUCTIONS)		25
26	DEDUCTIBLES AND COINSURANCE RELATING TO AMOUNT ON LINE 24 (SEE INSTRUCTIONS)		26
27	SUBTOTAL {(LINES 21 AND 24 - 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 (SUM OF LINES 32, 33 AND 34 OR 35) (LINE 35 HOSPITAL AND SUBPROVIDERS ONLY)		37
38	MSP-LCC RECONCILIATION AMOUNT FROM PS&R		38
39	OTHER ADJUSTMENTS (SPECIFY) (SEE INSTRUCTIONS)		39
40	SUBTOTAL (LINE 37 PLUS OR MINUS LINES 39 MINUS 38)		40
41	INTERIM PAYMENTS		41
42	TENTATIVE SETTLEMENT (FOR CONTRACTOR USE ONLY)		42
43	BALANCE DUE PROVIDER/PROGRAM (LINE 40 MINUS THE SUM OF LINES 41 AND 42)		43
44	PROTESTED AMOUNTS (NONALLOWABLE COST REPORT ITEMS) IN ACCORDANCE WITH CMS PUB. 15-II, SECTION 115.2		44
	TO BE COMPLETED BY CONTRACTOR		
90	ORIGINAL OUTLIER AMOUNT (SEE INSTRUCTIONS)		90
91	OUTLIER RECONCILIATION ADJUSTMENT AMOUNT (SEE 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

ANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED

WORKSHEET E-1
 PART I

CHECK [XX] HOSPITAL (14-0167) [] SUB (OTHER)
 APPLICABLE [] IPF [] SNF
 BOX: [] IRF [] SWING BED SNF

INPATIENT
 PART A PART B

DESCRIPTION	MM/DD/YYYY		AMOUNT	
	1	2	3	4
1 TOTAL INTERIM PAYMENTS PAID TO PROVIDER		4,812,341		3,758,435
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.		NONE		NONE
3 LIST SEPARATELY EACH RETROACTIVE LUMP SUM ADJUSTMENT AMOUNT BASED ON SUBSEQUENT REVISION OF THE INTERIM RATE FOR THE COST REPORTING PERIOD. ALSO SHOW DATE OF EACH PAYMENT. IF NONE, WRITE 'NONE' OR ENTER A ZERO.	.01 05/18/2012	34,748		NONE
PROGRAM .02				3.01
TO .03				3.02
PROVIDER .04				3.03
.05				3.04
.06				3.05
.07				3.06
.08				3.07
.09				3.08
.50		NONE		3.09
.51			05/18/2012	3.50
PROVIDER .52				3.51
TO .53				3.52
PROGRAM .54				3.53
.55				3.54
.56				3.55
.57				3.56
.58				3.57
.59				3.58
.99				3.59
SUBTOTAL (SUM OF LINES 3.01-3.49 MINUS SUM OF LINES 3.50-3.98)		34,748		-2,385
4 TOTAL INTERIM PAYMENTS (SUM OF LINES 1, 2 AND 3.99) (TRANSFER TO WKST E OR E-3, LINE AND COLUMN AS APPROPRIATE)		4,847,089		3,756,050
TO BE COMPLETED BY CONTRACTOR				
5 LIST SEPARATELY EACH TENTATIVE SETTLEMENT PAYMENT AFTER DESK REVIEW. ALSO SHOW DATE OF EACH PAYMENT. IF NONE, WRITE 'NONE' OR ENTER A ZERO.	PROGRAM .01		NONE	NONE
TO .02				5.01
PROVIDER .03				5.02
.04				5.03
.05				5.04
.06				5.05
.07				5.06
.08				5.07
.09				5.08
PROVIDER .50			NONE	5.09
TO .51				5.50
PROGRAM .52				5.51
.53				5.52
.54				5.53
.55				5.54
.56				5.55
.57				5.56
.58				5.57
.59				5.58
.99				5.59
SUBTOTAL (SUM OF LINES 5.01-5.49 MINUS SUM OF LINES 5.50-5.98)				5.99
6 DETERMINE NET SETTLEMENT AMOUNT (BALANCE DUE) BASED ON THE COST REPORT	PROGRAM .01			
TO .02		104,596		43,605
PROVIDER .03				6.01
PROVIDER .04				6.02
TO .05				6.03
PROGRAM .06				6.04
7 TOTAL MEDICARE PROGRAM LIABILITY (SEE INSTR.)		4,951,685		3,799,655
8 NAME OF CONTRACTOR:		CONTRACTOR NUMBER:	NPR DATE:	8

ANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED

WORKSHEET E-1
 PART I

CHECK [] HOSPITAL [] SUB (OTHER)
 APPLICABLE [] IPF [XX] SNF (14-6049)
 BOX: [] IRF [] SWING BED SNF

INPATIENT
 PART A PART B

DESCRIPTION	MM/DD/YYYY	AMOUNT	MM/DD/YYYY	AMOUNT
	1	2	3	4
1 TOTAL INTERIM PAYMENTS PAID TO PROVIDER		491,846		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.		NONE		2
3 LIST SEPARATELY EACH RETROACTIVE LUMP SUM ADJUSTMENT AMOUNT BASED ON SUBSEQUENT REVISION OF THE INTERIM RATE FOR THE COST REPORTING PERIOD. ALSO SHOW DATE OF EACH PAYMENT. IF NONE, WRITE 'NONE' OR ENTER A ZERO.	.01 .02 PROGRAM .03 TO .04 PROVIDER .05 .06 .07 .08 .09 .50 .51 PROVIDER .52 TO .53 PROGRAM .54 .55 .56 .57 .58 .59 .99	NONE		3.01 3.02 3.03 3.04 3.05 3.06 3.07 3.08 3.09 3.50 3.51 3.52 3.53 3.54 3.55 3.56 3.57 3.58 3.59 3.99
SUBTOTAL (SUM OF LINES 3.01-3.49 MINUS SUM OF LINES 3.50-3.98)				
4 TOTAL INTERIM PAYMENTS (SUM OF LINES 1, 2 AND 3.99) (TRANSFER TO WKST E OR E-3, LINE AND COLUMN AS APPROPRIATE)		491,846		4
TO BE COMPLETED BY CONTRACTOR				
5 LIST SEPARATELY EACH TENTATIVE SETTLEMENT PAYMENT AFTER DESK REVIEW. ALSO SHOW DATE OF EACH PAYMENT. IF NONE, WRITE 'NONE' OR ENTER A ZERO.	.01 .02 PROGRAM .03 TO .04 PROVIDER .05 .06 .07 .08 .09 PROVIDER .50 TO .51 PROGRAM .52 .53 .54 .55 .56 .57 .58 .59 .99	NONE		5.01 5.02 5.03 5.04 5.05 5.06 5.07 5.08 5.09 5.50 5.51 5.52 5.53 5.54 5.55 5.56 5.57 5.58 5.59 5.99
SUBTOTAL (SUM OF LINES 5.01-5.49 MINUS SUM OF LINES 5.50-5.98)				
6 DETERMINE NET SETTLEMENT AMOUNT (BALANCE DUE) BASED ON THE COST REPORT	PROGRAM TO .01 PROVIDER PROVIDER TO .02 PROGRAM			6.01 6.02
7 TOTAL MEDICARE PROGRAM LIABILITY (SEE INSTR.)		491,846		7
8 NAME OF CONTRACTOR:		CONTRACTOR NUMBER:	NPR DATE:	8

PROVIDER CCN: 14-0167 IROQUOIS MEMORIAL HOSPITAL
PERIOD FROM 10/01/2011 TO 09/30/2012

OPTIMIZER SYSTEMS, INC. WIN-LASH MICRO SYSTEM
IN LIEU OF FORM CMS-2552-10 (08/2011)

VERSION: 2012.11
02/14/2013 16:44

CALCULATION OF REIMBURSEMENT SETTLEMENT FOR HIT

WORKSHEET E-1
PART II

CHECK [XX] HOSPITAL (14-0167) [] CAH
APPLICABLE BOX

TO BE COMPLETED BY CONTRACTOR FOR NONSTANDARD COST REPORTS

HEALTH INFORMATION TECHNOLOGY DATA COLLECTION AND CALCULATION

1	TOTAL HOSPITAL DISCHARGES AS DEFINED IN AARA §4102 FROM WKST S-3, PART I, COLUMN 15, LINE 14	973	1
2	MEDICARE DAYS FROM WKST S-3, PART I, COLUMN 6, SUM OF LINES 1, 8-12	1,768	2
3	MEDICARE HMO DAYS FROM WKST S-3, PART I, COLUMN 6, LINE 2	11	3
4	TOTAL INPATIENT DAYS FROM S-3, PART I, COLUMN 8, SUM OF LINES 1, 8-12	2,674	4
5	TOTAL HOSPITAL CHARGES FROM WKST C, PART I, COLUMN 8, LINE 200	67,790,421	5
6	TOTAL HOSPITAL CHARITY CARE CHARGES FROM WKST S-10, COLUMN 3, LINE 20	1,276,301	6
7	CAH ONLY - THE REASONABLE COST INCURRED FOR THE PURCHASE OF CERTIFIED HIT TECHNOLOGY FROM WORKSHEET S-2, PART I, LINE 168		7
8	CALCULATION OF THE HIT INCENTIVE PAYMENT (SEE INSTRUCTIONS)	1,355,946	8
INPATIENT HOSPITAL SERVICES UNDER PPS & CAH			
30	INITIAL/INTERIM HIT PAYMENT(S)	1,444,559	30
31	OTHER ADJUSTMENTS (SPECIFY)		31
32	BALANCE DUE PROVIDER (LINE 8 MINUS LINE 30 ± LINE 31)	-88,613	32

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		
1	RESOURCE UTILIZATION GROUP (RUGS) PAYMENT	572,523 1
2	ROUTINE SERVICE OTHER PASS THROUGH COSTS	2
3	ANCILLARY SERVICE OTHER PASS THROUGH COSTS	3
4	SUBTOTAL (SUM OF LINES 1-3)	572,523 4
COMPUTATION OF NET COST OF COVERED SERVICES		
5	MEDICAL AND OTHER SERVICES	5
6	DEDUCTIBLES	6
7	COINSURANCE	80,677 7
8	ALLOWABLE BAD DEBTS (SEE INSTRUCTIONS)	8
9	REIMBURSABLE BAD DEBTS FOR DUAL ELIGIBLE BENEFICIARIES (SEE INSTRUCTIONS)	9
10	ALLOWABLE REIMBURSABLE BAD DEBTS (SEE INSTRUCTIONS)	10
11	UTILIZATION REVIEW	11
12	SUBTOTAL (SUM OF LINES 4, 5 MINUS 6 & 7 PLUS 10 AND 11) (SEE INSTRUCTIONS)	491,846 12
13	INPATIENT PRIMARY PAYER PAYMENTS	13
14	OTHER ADJUSTMENTS (SPECIFY) (SEE INSTRUCTIONS)	14
15	SUBTOTAL (LINE 12 MINUS 13 ± LINE 14)	491,846 15
16	INTERIM PAYMENTS	491,846 16
17	TENTATIVE SETTLEMENT (FOR CONTRACTOR USE ONLY)	17
18	BALANCE DUE PROVIDER/PROGRAM (LINE 15 MINUS THE SUM OF LINES 16 AND 17)	18
19	PROTESTED AMOUNTS (NONALLOWABLE COST REPORT ITEMS) IN ACCORDANCE WITH CMS PUB 15-2, SECTION 115.2	19

CALCULATION OF REIMBURSEMENT SETTLEMENT

WORKSHEET E-3
 PART VII

CHECK [] TITLE V [XX] HOSPITAL (14-0167) [] SNF [XX] PPS
 APPLICABLE [XX] TITLE XIX [] IPF [] NF [] TEFRA
 BOXES: [] IRF [] ICF/MR [] OTHER
 [] SUB (OTHER)

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

	INPATIENT	OUTPATIENT
	TITLE V OR	TITLE V OR
	TITLE XIX	TITLE XIX
COMPUTATION OF NET COST OF COVERED SERVICES		
1 INPATIENT HOSPITAL SNF/NF SERVICES		1
2 MEDICAL AND OTHER SERVICES		2
3 ORGAN ACQUISITION (CERTIFIED TRANSPLANT CENTERS ONLY)		3
4 SUBTOTAL (SUM OF LINES 1, 2 AND 3)		4
5 INPATIENT PRIMARY PAYER PAYMENTS		5
6 OUTPATIENT PRIMARY PAYER PAYMENTS		6
7 SUBTOTAL (LINE 4 LESS SUM OF LINES 5 AND 6)		7
COMPUTATION OF LESSER OF COST OR CHARGES		
REASONABLE CHARGES		
8 ROUTINE SERVICE CHARGES		8
9 ANCILLARY SERVICE CHARGES		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)		12
CUSTOMARY CHARGES		
13 AMOUNT ACTUALLY COLLECTED FROM PATIENTS LIABLE FOR PAYMENT FOR SERVICES ON A CHARGE 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)		16
17 EXCESS OF CUSTOMARY CHARGES OVER REASONABLE COST (COMPLETE ONLY IF LINE 16 EXCEEDS LINE 4 (SEE INSTRUCTIONS))		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 TEACHING PHYSICIANS (SEE INSTRUCTIONS)		20
21 COST OF COVERED SERVICES (LESSER OF LINE 4 OR LINE 16) (FOR CAH, SEE INSTRUCTIONS)		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 SUM OF LINES 27 AND 21		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)		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)		36
37 OTHER ADJUSTMENTS (SPECIFY) (SEE INSTRUCTIONS)		37
38 SUBTOTAL (LINE 36 ± LINE 37)		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)		40
41 INTERIM PAYMENTS		41
42 BALANCE DUE PROVIDER/PROGRAM (LINE 40 MINUS 41)		42
43 PROTESTED AMOUNTS (NONALLOWABLE COST REPORT ITEMS) IN ACCORDANCE WITH CMS PUB 15-2, SECTION 115.2		43

BALANCE SHEET

WORKSHEET G

ASSETS		GENERAL FUND	SPECIFIC PURPOSE FUND	ENDOWMENT FUND	PLANT FUND
		1	2	3	4
CURRENT ASSETS					
1	CASH ON HAND AND IN BANKS	1,366,603			1
2	TEMPORARY INVESTMENTS	378,147			2
3	NOTES RECEIVABLE				3
4	ACCOUNTS RECEIVABLE	5,804,241			4
5	OTHER RECEIVABLES				5
6	ALLOWANCE FOR UNCOLLECTIBLE NOTES & ACCOUNTS RECEIVABLE	-1,190,000			6
7	INVENTORY	1,413,223			7
8	PREPAID EXPENSES	1,025,586			8
9	OTHER CURRENT ASSETS	107,000			9
10	DUE FROM OTHER FUNDS				10
11	TOTAL CURRENT ASSETS (SUM OF LINES 1-10)	8,904,800			11
FIXED ASSETS					
12	LAND	267,535			12
13	LAND IMPROVEMENTS				13
14	ACCUMULATED DEPRECIATION				14
15	BUILDINGS	24,004,569			15
16	ACCUMULATED DEPRECIATION	-13,425,123			16
17	LEASEHOLD IMPROVEMENTS	477,850			17
18	ACCUMULATED AMORTIZATION	-420,707			18
19	FIXED EQUIPMENT				19
20	ACCUMULATED DEPRECIATION				20
21	AUTOMOBILES AND TRUCKS				21
22	ACCUMULATED DEPRECIATION				22
23	MAJOR MOVABLE EQUIPMENT	13,910,581			23
24	ACCUMULATED DEPRECIATION	-10,648,988			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)	14,165,717			30
OTHER ASSETS					
31	INVESTMENTS	1,980,932			31
32	DEPOSITS ON LEASES				32
33	DUE FROM OWNERS/OFFICERS				33
34	OTHER ASSETS	8,020,106			34
35	TOTAL OTHER ASSETS (SUM OF LINES 31-34)	10,001,038			35
36	TOTAL ASSETS (SUM OF LINES 11, 30 AND 35)	33,071,555			36
LIABILITIES AND FUND BALANCES					
		GENERAL FUND	SPECIFIC PURPOSE FUND	ENDOWMENT FUND	PLANT FUND
		1	2	3	4
CURRENT LIABILITIES					
37	ACCOUNTS PAYABLE	1,285,466			37
38	SALARIES, WAGES & FEES PAYABLE	2,140,585			38
39	PAYROLL TAXES PAYABLE				39
40	NOTES & LOANS PAYABLE (SHORT TERM)	1,065,097			40
41	DEFERRED INCOME				41
42	ACCELERATED PAYMENTS				42
43	DUE TO OTHER FUNDS				43
44	OTHER CURRENT LIABILITIES	439,000			44
45	TOTAL CURRENT LIABILITIES (SUM OF LINES 37-44)	4,930,148			45
LONG-TERM LIABILITIES					
46	MORTGAGE PAYABLE				46
47	NOTES PAYABLE	5,686,007			47
48	UNSECURED LOANS				48
49	OTHER LONG TERM LIABILITIES				49
50	TOTAL LONG TERM LIABILITIES (SUM OF LINES 46-49)	5,686,007			50
51	TOTAL LIABILITIES (SUM OF LINES 45 AND 50)	10,616,155			51
CAPITAL ACCOUNTS					
52	GENERAL FUND BALANCE	22,455,400			52
53	SPECIFIC PURPOSE FUND BALANCE				53
54	DONOR CREATED-ENDOWMENT FUND BAL-RESTRICTED				54
55	DONOR CREATED-ENDOWMENT FUND BAL-UNRESTRICTED				55
56	GOVERNING BODY CREATED - ENDOWMENT FUND BAL				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 52-58)	22,455,400			59
60	TOTAL LIABILITIES AND FUND BALANCES (SUM OF LINES 51 AND 59)	33,071,555			60

STATEMENT OF CHANGES IN FUND BALANCES

WORKSHEET G-1

	GENERAL FUND	SPECIFIC PURPOSE FUND	ENDOWMENT FUND	PLANT FUND	
	1	3	5	7	
	2	4	6	8	
1 FUND BALANCES AT BEGINNING OF PERIOD	19,718,864				1
2 NET INCOME (LOSS) (FROM WKST G-3, LINE 29)	673,882				2
3 TOTAL (SUM OF LINE 1 AND LINE 2)	20,392,746				3
4 ADDITIONS (CREDIT ADJUSTMENTS)					4
5 INCREASE IN PERPETUAL TRUST	2,062,654				5
6					6
7					7
8					8
9					9
10 TOTAL ADDITIONS (SUM OF LINES 4-9)	2,062,654				10
11 SUBTOTAL (LINE 3 PLUS LINE 10)	22,455,400				11
12 DEDUCTIONS (DEBIT ADJUSTMENTS)					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)	22,455,400				19

STATEMENT OF PATIENT REVENUES AND OPERATING EXPENSES

WORKSHEET G-2
 PARTS I & II

PART I - PATIENT REVENUES

REVENUE CENTER	INPATIENT 1	OUTPATIENT 2	TOTAL 3	
1 GENERAL INPATIENT ROUTINE CARE SERVICES				1
2 HOSPITAL	2,900,715		2,900,715	2
3 SUBPROVIDER IPF				3
5 SUBPROVIDER IRF				5
6 SWING BED - SNF				6
7 SKILLED NURSING FACILITY	1,703,049		1,703,049	7
8 NURSING FACILITY				8
9 OTHER LONG TERM CARE				9
10 TOTAL GENERAL INPATIENT CARE SERVICES (SUM OF LINES 1-9)	4,603,764		4,603,764	10
11 INTENSIVE CARE TYPE INPATIENT HOSPITAL SERVICES				11
12 INTENSIVE CARE UNIT				12
13 CORONARY CARE UNIT				13
14 BURN INTENSIVE CARE UNIT				14
15 SURGICAL INTENSIVE CARE UNIT				15
16 OTHER SPECIAL CARE (SPECIFY)				16
17 TOTAL INTENSIVE CARE TYPE INPATIENT HOSPITAL SERVICES (SUM OF LINES 11-15)				17
18 TOTAL INPATIENT ROUTINE CARE SERVICES (SUM OF LINES 10 AND 16)	4,603,764		4,603,764	18
19 ANCILLARY SERVICES	9,587,387	43,408,549	52,995,936	19
20 OUTPATIENT SERVICES	449	2,686,065	2,686,514	20
20 RHC		432,394	432,394	20
20.01 RHC II		474,331	474,331	20.01
20.02 RHC III		1,122,475	1,122,475	20.02
21 FQHC				21
22 HOME HEALTH AGENCY		451,207	451,207	22
23 AMBULANCE	1,064	3,195,306	3,196,370	23
25 ASC				25
26 HOSPICE		1,553,744	1,553,744	26
27 IROQUOIS WOMENS HEALTH		1,703,080	1,703,080	27
27.01 NURSERY	273,686		273,686	27.01
27.02 DME		818,255	818,255	27.02
27.03 PROFESSIONAL FEES	144,056	156,599	300,655	27.03
28 TOTAL PATIENT REVENUES (SUM OF LINES 17-27) (TRANSFER COL. 3 TO WKST G-3, LINE 1)	14,610,406	56,002,005	70,612,411	28

PART II - OPERATING EXPENSES

	1	2	
29 OPERATING EXPENSES (PER WKST A, COL. 3, LINE 200)		34,991,653	29
30 ADD (SPECIFY)			30
31 PROVISION FOR BAD DEBTS	1,486,252		31
32			32
33			33
34			34
35			35
36 TOTAL ADDITIONS (SUM OF LINES 30-35)		1,486,252	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 WKST G-3, LINE 4)		36,477,905	43

STATEMENT OF REVENUES AND EXPENSES

WORKSHEET G-3

DESCRIPTION			
1	TOTAL PATIENT REVENUES (FROM WKST G-2, PART I, COL. 3, LINE 28)	70,612,411	1
2	LESS - CONTRACTUAL ALLOWANCES AND DISCOUNTS ON PATIENTS' ACCOUNTS	36,933,279	2
3	NET PATIENT REVENUES (LINE 1 MINUS LINE 2)	33,679,132	3
4	LESS - TOTAL OPERATING EXPENSES (FROM WKST G-2, PART II, LINE 43)	36,477,905	4
5	NET INCOME FROM SERVICE TO PATIENTS (LINE 3 MINUS LINE 4)	-2,798,773	5
OTHER INCOME			
6	CONTRIBUTIONS, DONATIONS, BEQUESTS, ETC.	1,273,027	6
7	INCOME FROM INVESTMENTS	32,240	7
8	REVENUE FROM TELEPHONE AND TELEGRAPH SERVICE		8
9	REVENUE FROM TELEVISION AND RADIO SERVICE		9
10	PURCHASE DISCOUNTS	502	10
11	REBATES AND REFUNDS OF EXPENSES		11
12	PARKING LOT RECEIPTS		12
13	REVENUE FROM LAUNDRY AND LINEN SERVICE	117	13
14	REVENUE FROM MEALS SOLD TO EMPLOYEES AND GUESTS	127,915	14
15	REVENUE FROM RENTAL OF LIVING QUARTERS		15
16	REVENUE FROM SALE OF MED & SURG SUPP TO OTHER THAN PATIENTS	482	16
17	REVENUE FROM SALE OF DRUGS TO OTHER THAN PATIENTS		17
18	REVENUE FROM SALE OF MEDICAL RECORDS AND ABSTRACTS	3,072	18
19	TUITION (FEES, SALE OF TEXTBOOKS, UNIFORMS, ETC.)		19
20	REVENUE FROM GIFTS, FLOWER, COFFEE SHOPS, CANTEEN		20
21	RENTAL OF VENDING MACHINES		21
22	RENTAL OF HOSPITAL SPACE		22
23	GOVERNMENTAL APPROPRIATIONS		23
24	OTHER (OTHER)	2,035,300	24
25	TOTAL OTHER INCOME (SUM OF LINES 6-24)	3,472,655	25
26	TOTAL (LINE 5 PLUS LINE 25)	673,882	26
27	OTHER EXPENSES (LOSS ON SALE OF ASSET)		27
28	TOTAL OTHER EXPENSES (SUM OF LINE 27 AND SUBSCRIPTS)		28
29	NET INCOME (OR LOSS) FOR THE PERIOD (LINE 26 MINUS LINE 28)	673,882	29

ANALYSIS OF PROVIDER-BASED HOME HEALTH AGENCY COSTS

HHA NO.: 14-7586

WORKSHEET H

	SALARIES	EMPLOYEE	TRANSPOR-	CONTRACTED/	OTHER	TOTAL
	1	BENEFITS	TATION	PURCHASED/	COSTS	(SUM OF
		2	(SEE INSTR.)	SERVICES		(COLS.1-5)
			3	4	5	6
1						1
2						2
3						3
4						4
5	36,718	2,938			54,263	93,919 5
6	211,187	17,249				228,436 6
7	62,720	4,595		14,606		81,921 7
8	11,484	919		2,767		15,170 8
9	1,528	156		108		1,792 9
10	828	106				934 10
11	30,138	2,412				32,550 11
12					3,039	3,039 12
13						13
14						14
15						15
16						16
17						17
18						18
19						19
20						20
21						21
22						22
23						23
24	354,603	28,375		17,481	57,302	457,761 24

ANALYSIS OF PROVIDER-BASED HOME HEALTH AGENCY COSTS

HHA NO.: 14-7586

WORKSHEET H
 (CONTINUED)

	RECLASS- IFICATIONS 7	RECLASSIFIED TRIAL BALANCE (COL.6 + COL.7) 8	ADJUSTMENTS 9	NET EXPENSES FOR ALLOCATION (COL.8 + COL.9) 10	
1					1
2					2
3					3
4					4
5	-5,833	88,086		88,086	5
6		228,436		228,436	6
7		81,921		81,921	7
8		15,170		15,170	8
9		1,792		1,792	9
10		934		934	10
11		32,550		32,550	11
12	-3,039				12
13					13
14					14
15					15
16					16
17					17
18					18
19					19
20					20
21					21
22					22
23					23
24	-8,872	448,889		448,889	24

COST ALLOCATION - HHA GENERAL SERVICE COST

HHA NO.: 14-7586

WORKSHEET H-1
 PART I

	NET EXPENSES FOR COST ALLOCATION	CAP REL COSTS BLDG & FIXTURES	CAP REL COSTS MVBL EQUIPMENT	PLANT OPERATN & MAINT	TRANSPORT- ATION	SUBTOTAL (COLS. 0-4) 4A	ADMIN & GENERAL 5	TOTAL (COLS. 4A+5) 6
1								1
2								2
3								3
4								4
5	88,086					88,086	88,086	5
	HHA REIMBURSABLE SERVICES							
6	228,436					228,436	55,095	6
7	81,921					81,921	19,757	7
8	15,170					15,170	3,659	8
9	1,792					1,792	432	9
10	934					934	225	10
11	32,550					32,550	7,850	11
12							1,068	12
13								13
14								14
	HHA NONREIMBURSABLE SERVICES							
15								15
16								16
17								17
18								18
19								19
20								20
21								21
22								22
23								23
24	448,889					448,889		24

COST ALLOCATION - HHA STATISTICAL BASIS

HHA NO.: 14-7586

WORKSHEET H-1
 PART II

	CAP REL COSTS BLDG & FIXTURES (SQUARE FEET)	CAP REL COSTS MVBL EQUIPMENT (DOLLAR VALUE)	PLANT OPERATN & MAINT (SQUARE FEET)	TRANSPORT- ATION (MILEAGE)	RECONCIL- IATION	ADMIN & GENERAL (ACCUM COST)	
	1	2	3	4	5A	5	
GENERAL SERVICE COST CENTER							
1 CAPITAL RELATED-BLDGS & FIXT							1
2 CAPITAL RELATED-MOVABLE EQUIP							2
3 PLANT OPERATION & MAINTENANCE							3
4 TRANSPORTATION (SEE INSTR.)							4
5 ADMINISTRATIVE AND GENERAL HHA REIMBURSABLE SERVICES					-88,086	365,234	5
6 SKILLED NURSING CARE						228,436	6
7 PHYSICAL THERAPY						81,921	7
8 OCCUPATIONAL THERAPY						15,170	8
9 SPEECH PATHOLOGY						1,792	9
10 MEDICAL SOCIAL SERVICES						934	10
11 HOME HEALTH AIDE						32,550	11
12 SUPPLIES (SEE INSTRUCTIONS)					4,429	4,429	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 MEALS PROGRAM							21
22 HOMEMAKER SERVICE							22
23 ALL OTHERS							23
23.50 TELEMEDICINE							23.50
24 TOTAL (SUM OF LINES 1-23)					-83,655	365,234	24
25 COST TO BE ALLOC (PER W/S H)						88,086	25
26 UNIT COST MULTIPLIER						0.241177	26

ALLOCATION OF GENERAL SERVICE COSTS TO HHA COST CENTERS

HHA NO.: 14-7586

WORKSHEET H-2
 PART I

HHA COST CENTER	ALLOCATED HHA A&G (SEE PT.2) 27	TOTAL HHA COSTS 28	
1			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
17			17
18			18
19			19
20			20
21			21
ADMINISTRATIVE AND GENERAL			
SKILLED NURSING CARE	45,707	380,198	
PHYSICAL THERAPY	16,143	134,276	
OCCUPATIONAL THERAPY	2,987	24,845	
SPEECH PATHOLOGY	356	2,962	
MEDICAL SOCIAL SERVICES	186	1,549	
HOME HEALTH AIDE	6,514	54,181	
SUPPLIES	157	1,306	
DRUGS			
DME			
HOME DIALYSIS AIDE SERVICES			
RESPIRATORY THERAPY			
PRIVATE DUTY NURSING			
CLINIC			
HEALTH PROMOTION ACTIVITIES			
DAY CARE PROGRAM			
HOME DELIVERED MEALS PROGRAM			
HOMEMAKER SERVICE			
ALL OTHERS			
TOTAL (SUM OF LINES 1-19)	72,050	599,317	
UNIT COST MULTIPLIER: COL. 26, LINE 1 DIVIDED BY THE SUM OF COL. 26, LINE 20 MINUS COL. 26, LINE 1, ROUNDED TO 6 DECIMAL PLACES.	0.136648		

ALLOCATION OF GENERAL SERVICE COSTS TO HHA COST CENTERS
 STATISTICAL BASIS

HHA NO.: 14-7586

WORKSHEET H-2
 PART II

HHA COST CENTER	CAP BLDGS & FIXTURES SQUARE FEET	CAP MOVABLE EQUIPMENT DOLLAR VALUE NEW	OTHER CAP REL COSTS NOT USED	EMPLOYEE BENEFITS GROSS SAL	ADMITTING GROSS CHARGES	PURCHASING RECEIVING AND STORES COST REQ'S	DATA PROCESSING TIME SPENT	COMMUNICAT IONS # OF PHONES
	1	2	3	4	5.01	5.02	5.03	5.04
1 ADMINISTRATIVE AND GENERAL	1,274	432		36,718		5,082	13,616	5
2 SKILLED NURSING CARE				211,187				2
3 PHYSICAL THERAPY				62,720				3
4 OCCUPATIONAL THERAPY				11,484				4
5 SPEECH PATHOLOGY				1,528				5
6 MEDICAL SOCIAL SERVICES				828				6
7 HOME HEALTH AIDE				30,138				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 TOTAL (SUM OF LINES 1-19)	1,274	432		354,603		5,082	13,616	5
21 TOTAL COST TO BE ALLOCATED	10,681	553		46,090		252	15,650	3,955
22 UNIT COST MULTIPLIER	8.383830						1.149383	
22 UNIT COST MULTIPLIER		1.280093		0.129976		0.049587		791.000000

ALLOCATION OF GENERAL SERVICE COSTS TO HHA COST CENTERS
 STATISTICAL BASIS

HHA NO.: 14-7586

WORKSHEET H-2
 PART II

HHA COST CENTER	CAFETERIA FTE'S 11	MAIN- TENANCE OF PERSONNEL NUMBER HOUSED 12	NURSING ADMINIS- TRATION NURSING HOURS 13	CENTRAL SERVICES & SUPPLY CSS CSTED REQ' 14	PHARMACY COSTED REQUIS. 15	MEDICAL RECORDS & LIBRARY GROSS REVENUE 16	SOCIAL SERVICE TIME SPENT 17	NONPHYSIC. ANESTHET. ASSIGNED TIME 19
1 ADMINISTRATIVE AND GENERAL	655					451,207		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 TOTAL (SUM OF LINES 1-19)	655					451,207		20
21 TOTAL COST TO BE ALLOCATED		7,250				6,583		21
22 UNIT COST MULTIPLIER	11.068702							22
22 UNIT COST MULTIPLIER						0.014590		22

ALLOCATION OF GENERAL SERVICE COSTS TO HHA COST CENTERS
 STATISTICAL BASIS

HHA NO.: 14-7586

WORKSHEET H-2
 PART II

HHA COST CENTER	NURSING SCHOOL	I&R SALARY & FRINGES	I&R PROGRAM COSTS	PARAMED EDUCATION	
	ASSIGNED TIME	ASSIGNED TIME	ASSIGNED TIME	ASSIGNED TIME	
	20	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 TOTAL (SUM OF LINES 1-19)					20
21 TOTAL COST TO BE ALLOCATED					21
22 UNIT COST MULTIPLIER					22
22 UNIT COST MULTIPLIER					22

APPORTIONMENT OF PATIENT SERVICE COSTS

HHA NO.: 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		FROM	FACILITY	SHARED	TOTAL HHA	TOTAL	AVERAGE	
PATIENT SERVICES		WKST H-2, PART I, COL 28, LINE	COSTS (FROM WKST H-2, PART I)	ANCILLARY COSTS (FROM PART II)	COSTS (COLS. 1+2)	VISITS	COST PER VISIT (COL.3 ÷ COL.4)	
			1	2	3	4	5	
1	SKILLED NURSING CARE	2	380,198		380,198	1,414	268.88	1
2	PHYSICAL THERAPY	3	134,276		134,276	793	169.33	2
3	OCCUPATIONAL THERAPY	4	24,845		24,845	184	135.03	3
4	SPEECH PATHOLOGY	5	2,962		2,962	13	227.85	4
5	MEDICAL SOCIAL SERVICES	6	1,549		1,549	4	387.25	5
6	HOME HEALTH AIDE	7	54,181		54,181	808	67.06	6
7	TOTAL (SUM OF LINES 1-6)		598,011		598,011	3,216		7

PATIENT SERVICES

8	SKILLED NURSING CARE							8
8.01	SKILLED NURSING CARE							8.01
8.02	SKILLED NURSING CARE							8.02
9	PHYSICAL THERAPY							9
9.01	PHYSICAL THERAPY							9.01
9.02	PHYSICAL THERAPY							9.02
10	OCCUPATIONAL THERAPY							10
10.01	OCCUPATIONAL THERAPY							10.01
10.02	OCCUPATIONAL THERAPY							10.02
11	SPEECH PATHOLOGY							11
11.01	SPEECH PATHOLOGY							11.01
11.02	SPEECH PATHOLOGY							11.02
12	MEDICAL SOCIAL SERVICES							12
12.01	MEDICAL SOCIAL SERVICES							12.01
12.02	MEDICAL SOCIAL SERVICES							12.02
13	HOME HEALTH AIDE							13
13.01	HOME HEALTH AIDE							13.01
13.02	HOME HEALTH AIDE							13.02
14	TOTAL (SUM OF LINES 8-13)							14

SUPPLIES AND DRUGS
 COST COMPUTATIONS

OTHER PATIENT SERVICES		FROM	FACILITY	SHARED	TOTAL HHA	TOTAL	RATIO	
		WKST H-2, PART I, COL 28, LINE	COSTS (FROM WKST H-2, PART I)	ANCILLARY COSTS (FROM PART II)	COSTS (COLS. 1+2)	CHARGES (FROM HHA RECORD)	(COL.3 ÷ COL.4)	
			1	2	3	4	5	
15	COST OF MEDICAL SUPPLIES	8	1,306	2,406	3,712	3,929	0.944770	15
16	COST OF DRUGS	9						16

APPORTIONMENT OF PATIENT SERVICE COSTS

HHA NO.: 14-7586

WORKSHEET H-3
 PARTS I & II
 (CONTINUED)

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			TOTAL PROGRAM COST (SUM OF COLS.9-10)
	PART A	NOT SUBJ TO DEDUCTIBLES & COINSUR	SUBJECT TO DEDUCTIBLES & COINSUR	PART A	NOT SUBJ TO DEDUCTIBLES & COINSUR	SUBJECT TO DEDUCTIBLES & COINSUR	
PATIENT SERVICES	6	7	8	9	10	11	12
1 SKILLED NURSING CARE	498	541		133,902	145,464		279,366
2 PHYSICAL THERAPY	384	245		65,023	41,486		106,509
3 OCCUPATIONAL THERAPY	67	83		9,047	11,207		20,254
4 SPEECH PATHOLOGY	7	1		1,595	228		1,823
5 MEDICAL SOCIAL SERVICES	3	1		1,162	387		1,549
6 HOME HEALTH AIDE	231	588		15,491	39,431		54,922
7 TOTAL (SUM OF LINES 1-6)	1,190	1,459		226,220	238,203		464,423

PATIENT SERVICES	CBSA NO.	PROGRAM VISITS		TOTAL
		PART A	NOT SUBJ TO DEDUCTIBLES & COINSUR	
8 SKILLED NURSING CARE	1	2	3	4
8 SKILLED NURSING CARE	99914	447	539	8
8.01 SKILLED NURSING CARE	16580	21		8.01
8.02 SKILLED NURSING CARE	19180	30	2	8.02
9 PHYSICAL THERAPY	99914	358	243	9
9.01 PHYSICAL THERAPY	16580	12		9.01
9.02 PHYSICAL THERAPY	19180	14	2	9.02
10 OCCUPATIONAL THERAPY	99914	67	83	10
10.01 OCCUPATIONAL THERAPY	16580			10.01
10.02 OCCUPATIONAL THERAPY	19180			10.02
11 SPEECH PATHOLOGY	99914	7	1	11
11.01 SPEECH PATHOLOGY	16580			11.01
11.02 SPEECH PATHOLOGY	19180			11.02
12 MEDICAL SOCIAL SERVICES	99914	3	1	12
12.01 MEDICAL SOCIAL SERVICES	16580			12.01
12.02 MEDICAL SOCIAL SERVICES	19180			12.02
13 HOME HEALTH AIDE	99914	231	587	13
13.01 HOME HEALTH AIDE	16580			13.01
13.02 HOME HEALTH AIDE	19180		1	13.02
14 TOTAL (SUM OF LINES 8-13)		1,190	1,459	14

SUPPLIES AND DRUGS COST COMPUTATIONS	PROGRAM COVERED CHARGES			COST OF SERVICES		
	PART A	NOT SUBJ TO DEDUCTIBLES & COINSUR	SUBJECT TO DEDUCTIBLES & COINSUR	PART A	NOT SUBJ TO DEDUCTIBLES & COINSUR	SUBJECT TO DEDUCTIBLES & COINSUR
OTHER PATIENT SERVICES	6	7	8	9	10	11
15 COST OF MEDICAL SUPPLIES						15
16 COST OF DRUGS						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 PHYSICAL THERAPY	66	0.497708		COL 2, LINE 2
2 OCCUPATIONAL THERAPY	67			COL 2, LINE 3
3 SPEECH PATHOLOGY	68			COL 2, LINE 4
4 MEDICAL SUPPLIES CHRGD TO PAT	71	0.612285	3,929	2,406
5 DRUGS CHARGED TO PATIENTS	73	0.284451		

CALCULATION OF HHA REMBURSEMENT SETTLEMENT

HHA NO.: 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

DESCRIPTION	PART A 1	----- PART B -----		
		NOT SUBJECT TO DEDUCTIBLES & COINSURANCE 2	SUBJECT TO DEDUCTIBLES & COINSURANCE 3	
1 REASONABLE COST OF PART A & PART B SERVICES				1
2 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 EXCEED 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 PAYMENTS				9

PART II - COMPUTATION OF HHA REIMBURSEMENT SETTLEMENT

DESCRIPTION	PART A SERVICES 1	PART B SERVICES 2	
10 TOTAL REASONABLE COST (SEE INSTRUCTIONS)			10
11 TOTAL PPS REIMBURSEMENT - FULL EPISODES WITHOUT OUTLIERS	179,324	219,536	11
12 TOTAL PPS REIMBURSEMENT - FULL EPISODES WITH OUTLIERS		2,466	12
13 TOTAL PPS REIMBURSEMENT - LUPA EPISODES	2,699	3,684	13
14 TOTAL PPS REIMBURSEMENT - PEP EPISODES	3,411	111	14
15 TOTAL PPS OUTLIER REIMBURSEMENT - FULL EPISODES WITH OUTLIERS		3	15
16 TOTAL PPS OUTLIER REIMBURSEMENT - PEP 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 10-20 MINUS LINE 21)	185,434	225,800	22
23 EXCESS REASONABLE COST (FROM LINE 8)			23
24 SUBTOTAL (LINE 22 MINUS LINE 23)	185,434	225,800	24
25 COINSURANCE BILLED TO PROGRAM PATIENTS (FROM YOUR RECORDS)			25
26 NET COST (LINE 24 MINUS LINE 25)	185,434	225,800	26
27 REIMBURSABLE BAD DEBTS (FROM YOUR RECORDS)			27
28 REIMBURSABLE BAD DEBTS FOR DUAL ELIGIBLE BENEFICIARIES (SEE INSTRUCTIONS)			28
29 TOTAL COSTS - CURRENT COST REPORTING PERIOD (LINE 26 PLUS LINE 27)	185,434	225,800	29
30 OTHER ADJUSTMENTS (SPECIFY) (SEE INSTRUCTIONS)			30
31 SUBTOTAL (LINE 29 PLUS/MINUS LINE 30)	185,434	225,800	31
32 INTERIM PAYMENTS (SEE INSTRUCTIONS)	185,434	225,800	32
33 TENTATIVE SETTLEMENT (FOR CONTRACTOR USE ONLY)			33
34 BALANCE DUE PROVIDER/PROGRAM (LINE 31 MINUS LINES 32 AND 33)			34
35 PROTESTED AMOUNTS (NONALLOWABLE COST REPORT ITEMS) IN ACCORDANCE WITH CMS PUB. 15-II, SECTION 115.2			35

ANALYSIS OF PAYMENTS TO PROVIDER-BASED HHA'S
 FOR SERVICES RENDERED TO PROGRAM BENEFICIARIES

HHA NO.: 14-7586

WORKSHEET H-5

DESCRIPTION	PART A		PART B		
	MO/DAY/YR 1	AMOUNT 2	MO/DAY/YR 3	AMOUNT 4	
1 TOTAL INTERIM PAYMENTS PAID TO PROVIDER		185,434		225,800	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.		NONE		NONE	2
3 LIST SEPARATELY EACH RETROACTIVE LUMP SUM ADJUSTMENT AMOUNT BASED ON SUBSEQUENT REVISION OF THE INTERIM RATE FOR THE COST REPORTING PERIOD. ALSO SHOW DATE OF EACH PAYMENT. IF NONE, WRITE 'NONE' OR ENTER A ZERO.	.01 .02 PROGRAM .03 TO .04 PROVIDER .05 .06 .07 .08 .09 .50 .51 PROVIDER .52 TO .53 PROGRAM .54 .55 .56 .57 .58 .59 .99	NONE		NONE	3.01 3.02 3.03 3.04 3.05 3.06 3.07 3.08 3.09 3.50 3.51 3.52 3.53 3.54 3.55 3.56 3.57 3.58 3.59 3.99
SUBTOTAL (SUM OF LINES 3.01-3.49 MINUS SUM OF LINES 3.50-3.98)					
4 TOTAL INTERIM PAYMENTS (SUM OF LINES 1, 2 AND 3.99) (TRANSFER TO WKST H-4, PART II, COLUMN AS APPROPRIATE, LINE 32)		185,434		225,800	4
TO BE COMPLETED BY INTERMEDIARY					
5 LIST SEPARATELY EACH TENTATIVE SETTLEMENT PAYMENT AFTER DESK REVIEW. ALSO SHOW DATE OF EACH PAYMENT. IF NONE, WRITE 'NONE' OR ENTER A ZERO.	PROGRAM .01 TO .02 PROVIDER .03 .04 .05 .06 .07 .08 .09 PROVIDER .50 TO .51 PROGRAM .52 .53 .54 .55 .56 .57 .58 .59 .99	NONE		NONE	5.01 5.02 5.03 5.04 5.05 5.06 5.07 5.08 5.09 5.50 5.51 5.52 5.53 5.54 5.55 5.56 5.57 5.58 5.59 5.99
SUBTOTAL (SUM OF LINES 5.01-5.49 MINUS SUM OF LINES 5.50-5.98)					
6 DETERMINE NET SETTLEMENT AMOUNT (BALANCE DUE) BASED ON THE COST REPORT (SEE INSTR.)	PROGRAM TO .01 PROVIDER PROVIDER TO .02 PROGRAM				6.01 6.02
7 TOTAL MEDICARE PROGRAM LIABILITY (SEE INSTR.)		185,434		225,800	7
8 NAME OF CONTRACTOR:		CONTRACTOR NUMBER:	NPR DATE:		8

ANALYSIS OF PROVIDER-BASED HOSPICE COSTS

HOSPICE NO.: 14-1616

WORKSHEET K

	SALARIES (FROM WKST K-1) 1	EMPLOYEE BENEFITS (FROM WKST K-2) 2	TRANS- PORTATION (SEE INSTR.) 3	CONTRACTED SERVICES (FROM WKST K-3) 4	OTHER 5	TOTAL (COLS. 1-5) 6
1 GENERAL SERVICE COST CENTER						1
2 CAPITAL RELATED COSTS-BLDG AND FIXT.						2
3 CAPITAL RELATED COSTS-MOVABLE EQUIP.						3
4 PLANT OPERATION AND MAINTENANCE					2,181	2,181
5 TRANSPORTATION - STAFF						4
6 VOLUNTEER SERVICE COORDINATION						5
7 ADMINISTRATIVE AND GENERAL	105,791	6,957		25,414	198,906	337,068
8 INPATIENT CARE SERVICE						6
9 INPATIENT - GENERAL CARE						7
10 INPATIENT - RESPITE CARE						8
11 VISITING SERVICES						9
12 PHYSICIAN SERVICES						10
13 NURSING CARE	436,486	28,712		24,337	125,887	615,422
14 NURSING CARE-CONTINUOUS HOME CARE						11
15 PHYSICAL THERAPY						12
16 OCCUPATIONAL THERAPY						13
17 SPEECH/LANGUAGE PATHOLOGY						14
18 MEDICAL SOCIAL SERVICES						15
19 SPIRITUAL COUNSELING						16
20 DIETARY COUNSELING						17
21 COUNSELING - OTHER						18
22 HOME HEALTH AIDE AND HOMEMAKER						19
23 HH AIDE & HOMEMAKER-CONT. HOME CARE						20
24 OTHER	68,851	4,544				73,395
25 OTHER HOSPICE SERVICE COSTS						21
26 DRUGS, BIOLOGICAL & INFUSION THERAPY						22
27 ANALGESICS						23
28 SEDATIVES/HYPNOTICS						24
29 OTHER - SPECIFY						25
30 DURABLE MEDICAL EQUIPMENT/OXYGEN						26
31 PATIENT TRANSPORTATION						27
32 IMAGING SERVICES						28
33 LABS AND DIAGNOSTICS						29
34 MEDICAL SUPPLIES						30
35 OUTPATIENT SERVICES (INCLUDING E/R DEPT.)						31
36 RADIATION THERAPY						32
37 CHEMOTHERAPY						33
38 OTHER						34
39 HOSPICE NONREIMBURSABLE SERVICE						35
40 BEREAVEMENT PROGRAM COSTS						36
41 VOLUNTEER PROGRAM COSTS						37
42 FUNDRAISING						38
43 OTHER PROGRAM COSTS						39
44 TOTAL (SUM OF LINES 1-38)	611,128	40,213		49,751	326,974	1,028,066

ANALYSIS OF PROVIDER-BASED HOSPICE COSTS

HOSPICE NO.: 14-1616

WORKSHEET K
 (CONTINUED)

	RECLASSIFI- CATION 7	SUBTOTAL (COL.6 ± COL.7) 8	ADJUST- MENTS 9	TOTAL (COL.8 ± COL.9) 10	
1					1
2					2
3					3
4					4
5					5
6					6
7					7
8					8
9					9
10					10
11					11
12					12
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15					15
16					16
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31					31
32					32
33					33
34					34
35					35
36					36
37					37
38					38
39					39
GENERAL SERVICE COST CENTER					
CAPITAL RELATED COSTS-BLDG AND FIXT.					
CAPITAL RELATED COSTS-MOVABLE EQUIP.					
PLANT OPERATION AND MAINTENANCE	-2,181				
TRANSPORTATION - STAFF					
VOLUNTEER SERVICE COORDINATION					
ADMINISTRATIVE AND GENERAL	-5,422	331,646	-26,758	304,888	
INPATIENT CARE SERVICE					
INPATIENT - GENERAL CARE					
INPATIENT - RESPITE CARE					
VISITING SERVICES					
PHYSICIAN SERVICES					
NURSING CARE	-97,634	517,788		517,788	
NURSING CARE-CONTINUOUS HOME CARE					
PHYSICAL THERAPY					
OCCUPATIONAL THERAPY					
SPEECH/LANGUAGE PATHOLOGY					
MEDICAL SOCIAL SERVICES					
SPIRITUAL COUNSELING					
DIETARY COUNSELING					
COUNSELING - OTHER					
HOME HEALTH AIDE AND HOME MAKER					
HH AIDE & HOME MAKER-CONT. HOME CARE					
OTHER		73,395		73,395	
OTHER HOSPICE SERVICE COSTS					
DRUGS, BIOLOGICAL & INFUSION THERAPY					
ANALGESICS					
SEDATIVES/HYPNOTICS					
OTHER - SPECIFY					
DURABLE MEDICAL EQUIPMENT/OXYGEN					
PATIENT TRANSPORTATION					
IMAGING SERVICES					
LABS AND DIAGNOSTICS					
MEDICAL SUPPLIES					
OUTPATIENT SERVICES (INCLUDING E/R DEPT.)					
RADIATION THERAPY					
CHEMOTHERAPY					
OTHER					
HOSPICE NONREIMBURSABLE SERVICE					
BEREAVEMENT PROGRAM COSTS					
VOLUNTEER PROGRAM COSTS					
FUNDRAISING					
OTHER PROGRAM COSTS					
TOTAL (SUM OF LINES 1-38)	-210,474	922,829	-53,516	896,071	

HOSPICE COMPENSATION ANALYSIS - EMPLOYEE BENEFITS (PAYROLL RELATED)

HOSPICE NO.: 14-1616

WORKSHEET K-2

	ADMINI- STRATOR 1	DIRECTOR 2	SOCIAL SERVICES 3	SUPER- VISORS 4	NURSES 5	TOTAL THERAPISTS 6	AIDES 7	ALL OTHER 8	TOTAL 9
1									1
2									2
3									3
4									4
5									5
6	6,957								6,957 6
7									7
8									8
9									9
10					28,712				28,712 10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21								4,544	4,544 21
22									22
23									23
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25									25
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29									29
30									30
31									31
32									32
33									33
34									34
35									35
36									36
37									37
38									38
39	6,957				28,712			4,544	40,213 39

HOSPICE COMPENSATION ANALYSIS - CONTRACTED SERVICES/PURCHASED SERVICES HOSPICE NO.: 14-1616 WORKSHEET K-3

	ADMINI- STRATOR 1	DIRECTOR 2	SOCIAL SERVICES 3	SUPER- VISORS 4	NURSES 5	TOTAL THERAPISTS 6	AIDES 7	ALL OTHER 8	TOTAL 9
1	GENERAL SERVICE COST CENTER								
2	CAP REL COSTS-BLDG AND FIXT.								
3	CAP REL COSTS-MOVABLE EQUIP.								
4	PLANT OPERATION & MAINT.								
5	TRANSPORTATION - STAFF								
6	VOLUNTEER SERVICE COORD.								
7	ADMINISTRATIVE AND GENERAL								
8	INPATIENT CARE SERVICE								
9	INPATIENT - GENERAL CARE								
10	INPATIENT - RESPITE CARE								
11	VISITING SERVICES								
12	PHYSICIAN SERVICES								
13	NURSING CARE								
14	NURSING CARE-CONT.HOME CARE								
15	PHYSICAL THERAPY								
16	OCCUPATIONAL THERAPY								
17	SPEECH/LANGUAGE PATHOLOGY								
18	MEDICAL SOCIAL SERVICES								
19	SPIRITUAL COUNSELING								
20	DIETARY COUNSELING								
21	COUNSELING - OTHER								
22	HH AIDE AND HOME MAKER								
23	HH AIDE & HMKR-CONT.HME CARE								
24	OTHER								
25	OTHER HOSPICE SERVICE COSTS								
26	DRUGS, BIOL. & INFUS. THER.								
27	ANALGESICS								
28	SEDATIVES / HYPNOTICS								
29	OTHER - SPECIFY								
30	DURABLE MED. EQUIP./OXYGEN								
31	PATIENT TRANSPORTATION								
32	IMAGING SERVICES								
33	LABS AND DIAGNOSTICS								
34	MEDICAL SUPPLIES								
35	OUTPAT.SERV.(INCL.E/R DEPT.)								
36	RADIATION THERAPY								
37	CHEMOTHERAPY								
38	OTHER								
39	HOSPICE NONREIMBURSABLE SERVICE								
40	BEREAVEMENT PROGRAM COSTS								
41	VOLUNTEER PROGRAM COSTS								
42	FUNDRAISING								
43	OTHER PROGRAM COSTS								
44	TOTAL (SUM OF LINES 1-38)								

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25,414

24,337

25,414

25,414
24,337
24,337
49,751

COST ALLOCATION - HOSPICE GENERAL SERVICE COST

HOSPICE NO.: 14-1616

WORKSHEET K-4
 PART I

	NET EXPENSES FOR COST ALLOCATION	CAP REL COSTS	CAP REL BLDG COSTS	CAP REL MVBL EQUIPMENT	PLANT OPERATN & MAINT	TRANSPOR- TATION	VOLUNTEER SERV. CO- ORDINATOR	SUBTOTAL (COLS.0-5) 5A	ADMIN & GENERAL 6	TOTAL (COL.5 ± COL.6) 7
1	GENERAL SERVICE COST CENTER									1
2	CAP REL COSTS-BLDG AND FIXT.									2
3	CAP REL COSTS-MOVABLE EQUIP.									3
4	PLANT OPERATION & MAINT.									4
5	TRANSPORTATION - STAFF									5
6	VOLUNTEER SERVICE COORD.									6
7	ADMINISTRATIVE AND GENERAL	304,888						304,888	304,888	7
8	INPATIENT CARE SERVICE									8
9	INPATIENT - GENERAL CARE									9
10	INPATIENT - RESPITE CARE									10
11	VISITING SERVICES									11
12	PHYSICIAN SERVICES									12
13	NURSING CARE	517,788						517,788	267,036	13
14	NURSING CARE-CONTINUOUS HOME									14
15	PHYSICAL THERAPY									15
16	OCCUPATIONAL THERAPY									16
17	SPEECH/LANGUAGE PATHOLOGY									17
18	MEDICAL SOCIAL SERVICES									18
19	SPIRITUAL COUNSELING									19
20	DIETARY COUNSELING									20
21	COUNSELING - OTHER									21
22	HH AIDE AND HOMEMAKER									22
23	HH AIDE & HMKR-CONT. HOME CA									23
24	OTHER	73,395						73,395	37,852	24
25	OTHER HOSPICE SERVICE COSTS									25
26	DRUGS, BIOL. & INFUS. THER.									26
27	ANALGESICS									27
28	SEDATIVES / HYPNOTICS									28
29	OTHER - SPECIFY									29
30	DURABLE MED. EQUIP./OXYGEN									30
31	PATIENT TRANSPORTATION									31
32	IMAGING SERVICES									32
33	LABS AND DIAGNOSTICS									33
34	MEDICAL SUPPLIES									34
35	OUTPAT.SERV.(INCL.E/R DEPT.)									35
36	RADIATION THERAPY									36
37	CHEMOTHERAPY									37
38	OTHER									38
39	HOSPICE NONREIMBURSABLE SERV.									39
40	BEREAVEMENT PROGRAM COSTS									40
41	VOLUNTEER PROGRAM COSTS									41
42	FUNDRAISING									42
43	OTHER PROGRAM COSTS									43
44	TOTAL (SUM OF LINES 1-38)	896,071						896,071		896,071 39

ALLOCATION OF GENERAL SERVICE COSTS TO HOSPICE COST CENTERS HOSPICE NO.: 14-1616

WORKSHEET K-5
 PART I

HOSPICE COST CENTER	ALLOC HOSP TOTAL HOSP		
	A&G (SEE PART II)	COSTS (COL 26 ± 27)	
	27	28	
1 ADMINISTRATIVE AND GENERAL			1
2 INPATIENT - GENERAL CARE			2
3 INPATIENT - RESPITE CARE			3
4 PHYSICIAN SERVICES			4
5 NURSING CARE	107,864	1,013,043	5
6 NURSING CARE-CONTINUOUS HOM			6
7 PHYSICAL THERAPY			7
8 OCCUPATIONAL THERAPY			8
9 SPEECH/LANGUAGE PATHOLOGY			9
10 MEDICAL SOCIAL SERV. - DIRE			10
11 SPIRITUAL COUNSELING			11
12 DIETARY COUNSELING			12
13 COUNSELING - OTHER			13
14 HOME HLTH AIDE & HOMEMAKERS			14
15 HH AIDE & HMKR-CONT. HOME C			15
16 OTHER	15,406	144,689	16
17 DRUGS,BIOLOGICALS & INFUSIO			17
18 ANALGESICS			18
19 SEDATIVES / HYPNOTICS			19
20 OTHER - SPECIFY			20
21 DURABLE MED. EQUIP./OXYGEN			21
22 PATIENT TRANSPORTATION			22
23 IMAGING SERVICES			23
24 LABS AND DIAGNOSTICS			24
25 MEDICAL SUPPLIES			25
26 OUTPAT. SERV.(INCL.E/R DEPT			26
27 RADIATION THERAPY			27
28 CHEMOTHERAPY			28
29 OTHER			29
30 BEREAVEMENT PROGRAM COSTS			30
31 VOLUNTEER PROGRAM COSTS			31
32 FUNDRAISING			32
33 OTHER PROGRAM COSTS			33
34 TOTALS (SUM OF LINES 1-33)		1,157,732	34
35 UNIT COST MULTIPLIER	0.119163		35

ALLOCATION OF GENERAL SERVICE COSTS TO HOSPICE COST CENTERS
 STATISTICAL BASIS

HOSPICE NO.: 14-1616

WORKSHEET K-5
 PART II

HOSPICE COST CENTER	CAP BLDGS & FIXTURES SQUARE FEET	CAP MOVABLE EQUIPMENT DOLLAR VALUE NEW	OTHER CAP REL COSTS NOT USED	EMPLOYEE BENEFITS GROSS SAL	ADMITTING GROSS CHARGES	PURCHASING RECEIVING AND STORES COST REQ'S	DATA PROCESSING TIME SPENT	COMMUNICAT IONS # OF PHONES
	1	2	3	4	5.01	5.02	5.03	5.04
1 ADMINISTRATIVE AND GENERAL	1,282	628		105,791		56,898	25,236	7
2 INPATIENT - GENERAL CARE								1
3 INPATIENT - RESPITE CARE								2
4 PHYSICIAN SERVICES								3
5 NURSING CARE				436,486				4
6 NURSING CARE-CONTINUOUS HOM								5
7 PHYSICAL THERAPY								6
8 OCCUPATIONAL THERAPY								7
9 SPEECH/LANGUAGE PATHOLOGY								8
10 MEDICAL SOCIAL SERV. - DIRE								9
11 SPIRITUAL COUNSELING								10
12 DIETARY COUNSELING								11
13 COUNSELING - OTHER								12
14 HOME HLTH AIDE & HOMEMAKERS								13
15 HH AIDE & HMKR-CONT. HOME C								14
16 OTHER				68,851				15
17 DRUGS,BIOLOGICALS & INFUSIO								16
18 ANALGESICS								17
19 SEDATIVES / HYPNOTICS								18
20 OTHER - SPECIFY								19
21 DURABLE MED. EQUIP./OXYGEN								20
22 PATIENT TRANSPORTATION								21
23 IMAGING SERVICES								22
24 LABS AND DIAGNOSTICS								23
25 MEDICAL SUPPLIES								24
26 OUTPAT. SERV.(INCL.E/R DEPT								25
27 RADIATION THERAPY								26
28 CHEMOTHERAPY								27
29 OTHER								28
30 BEREAVEMENT PROGRAM COSTS								29
31 VOLUNTEER PROGRAM COSTS								30
32 FUNDRAISING								31
33 OTHER PROGRAM COSTS								32
34 TOTALS (SUM OF LINES 1-33)	1,282	628		611,128		56,898	25,236	7
35 TOTAL COST TO BE ALLOCATED	10,748	804		79,432		2,826	29,007	5,537
36 UNIT COST MULTIPLIER	8.383775	1.280255		0.129976		0.049668	1.149429	791.000000

ALLOCATION OF GENERAL SERVICE COSTS TO HOSPICE COST CENTERS
 STATISTICAL BASIS

HOSPICE NO.: 14-1616

WORKSHEET K-5
 PART II

HOSPICE COST CENTER	BUSINESS OFFICE	RECON-CILIATION	OTHER ADMI NISTRATIVE AND GENER ACCUM COST	MAIN-TENANCE & REPAIRS SQUARE FEET	OPERATION OF PLANT SQUARE FEET	LAUNDRY & LINEN SERVICE POUNDS	HOUSE-KEEPING SQUARE FEET	DIETARY MEALS
	5.05	4A.06	5.06	6	7	8	9	10
1 ADMINISTRATIVE AND GENERAL			62,672		1,282		1,282	1
2 INPATIENT - GENERAL CARE								2
3 INPATIENT - RESPITE CARE								3
4 PHYSICIAN SERVICES								4
5 NURSING CARE			841,557					5
6 NURSING CARE-CONTINUOUS HOM								6
7 PHYSICAL THERAPY								7
8 OCCUPATIONAL THERAPY								8
9 SPEECH/LANGUAGE PATHOLOGY								9
10 MEDICAL SOCIAL SERV. - DIRE								10
11 SPIRITUAL COUNSELING								11
12 DIETARY COUNSELING								12
13 COUNSELING - OTHER								13
14 HOME HLTH AIDE & HOMEMAKERS								14
15 HH AIDE & HMKR-CONT. HOME C								15
16 OTHER			120,196					16
17 DRUGS,BIOLOGICALS & INFUSIO								17
18 ANALGESICS								18
19 SEDATIVES / HYPNOTICS								19
20 OTHER - SPECIFY								20
21 DURABLE MED. EQUIP./OXYGEN								21
22 PATIENT TRANSPORTATION								22
23 IMAGING SERVICES								23
24 LABS AND DIAGNOSTICS								24
25 MEDICAL SUPPLIES								25
26 OUTPAT. SERV.(INCL.E/R DEPT								26
27 RADIATION THERAPY								27
28 CHEMOTHERAPY								28
29 OTHER								29
30 BEREAVEMENT PROGRAM COSTS								30
31 VOLUNTEER PROGRAM COSTS								31
32 FUNDRAISING								32
33 OTHER PROGRAM COSTS								33
34 TOTALS (SUM OF LINES 1-33)			1,024,425		1,282		1,282	34
35 TOTAL COST TO BE ALLOCATED			77,447		14,158		5,609	35
36 UNIT COST MULTIPLIER			0.075600		11.043682		4.375195	36

ALLOCATION OF GENERAL SERVICE COSTS TO HOSPICE COST CENTERS
 STATISTICAL BASIS

HOSPICE NO.: 14-1616

WORKSHEET K-5
 PART II

HOSPICE COST CENTER	CAFETERIA FTE'S 11	MAIN- TENANCE OF PERSONNEL NUMBER HOUSED 12	NURSING ADMINIS- TRATION NURSING HOURS 13	CENTRAL SERVICES & SUPPLY CSS CSTED REQ' 14	PHARMACY COSTED REQUIS. 15	MEDICAL RECORDS & LIBRARY GROSS REVENUE 16	SOCIAL SERVICE TIME SPENT 17	NONPHYSIC. ANESTHET. ASSIGNED TIME 19
1 ADMINISTRATIVE AND GENERAL	1,213					1,553,744		1
2 INPATIENT - GENERAL CARE								2
3 INPATIENT - RESPITE CARE								3
4 PHYSICIAN SERVICES								4
5 NURSING CARE								5
6 NURSING CARE-CONTINUOUS HOM								6
7 PHYSICAL THERAPY								7
8 OCCUPATIONAL THERAPY								8
9 SPEECH/LANGUAGE PATHOLOGY								9
10 MEDICAL SOCIAL SERV. - DIRE								10
11 SPIRITUAL COUNSELING								11
12 DIETARY COUNSELING								12
13 COUNSELING - OTHER								13
14 HOME HLTH AIDE & HOMEMAKERS								14
15 HH AIDE & HMKR-CONT. HOME C								15
16 OTHER								16
17 DRUGS,BIOLOGICALS & INFUSIO								17
18 ANALGESICS								18
19 SEDATIVES / HYPNOTICS								19
20 OTHER - SPECIFY								20
21 DURABLE MED. EQUIP./OXYGEN								21
22 PATIENT TRANSPORTATION								22
23 IMAGING SERVICES								23
24 LABS AND DIAGNOSTICS								24
25 MEDICAL SUPPLIES								25
26 OUTPAT. SERV.(INCL.E/R DEPT								26
27 RADIATION THERAPY								27
28 CHEMOTHERAPY								28
29 OTHER								29
30 BEREAVEMENT PROGRAM COSTS								30
31 VOLUNTEER PROGRAM COSTS								31
32 FUNDRAISING								32
33 OTHER PROGRAM COSTS								33
34 TOTALS (SUM OF LINES 1-33)	1,213					1,553,744		34
35 TOTAL COST TO BE ALLOCATED	13,425					22,668		35
36 UNIT COST MULTIPLIER	11.067601					0.014589		36

ALLOCATION OF GENERAL SERVICE COSTS TO HOSPICE COST CENTERS HOSPICE NO.: 14-1616
 STATISTICAL BASIS

WORKSHEET K-5
 PART II

HOSPICE COST CENTER	NURSING	I&R	I&R	PARAMED	
	SCHOOL	SALARY & FRINGES	PROGRAM COSTS	EDUCATION	
	ASSIGNED TIME	ASSIGNED TIME	ASSIGNED TIME	ASSIGNED TIME	
	20	21	22	23	
1 ADMINISTRATIVE AND GENERAL					1
2 INPATIENT - GENERAL CARE					2
3 INPATIENT - RESPITE CARE					3
4 PHYSICIAN SERVICES					4
5 NURSING CARE					5
6 NURSING CARE-CONTINUOUS HOM					6
7 PHYSICAL THERAPY					7
8 OCCUPATIONAL THERAPY					8
9 SPEECH/LANGUAGE PATHOLOGY					9
10 MEDICAL SOCIAL SERV. - DIRE					10
11 SPIRITUAL COUNSELING					11
12 DIETARY COUNSELING					12
13 COUNSELING - OTHER					13
14 HOME HLTH AIDE & HOMEMAKERS					14
15 HH AIDE & HMKR-CONT. HOME C					15
16 OTHER					16
17 DRUGS,BIOLOGICALS & INFUSIO					17
18 ANALGESICS					18
19 SEDATIVES / HYPNOTICS					19
20 OTHER - SPECIFY					20
21 DURABLE MED. EQUIP./OXYGEN					21
22 PATIENT TRANSPORTATION					22
23 IMAGING SERVICES					23
24 LABS AND DIAGNOSTICS					24
25 MEDICAL SUPPLIES					25
26 OUTPAT. SERV.(INCL.E/R DEPT					26
27 RADIATION THERAPY					27
28 CHEMOTHERAPY					28
29 OTHER					29
30 BEREAVEMENT PROGRAM COSTS					30
31 VOLUNTEER PROGRAM COSTS					31
32 FUNDRAISING					32
33 OTHER PROGRAM COSTS					33
34 TOTALS (SUM OF LINES 1-33)					34
35 TOTAL COST TO BE ALLOCATED					35
36 UNIT COST MULTIPLIER					36

PROVIDER CCN: 14-0167 IROQUOIS MEMORIAL HOSPITAL
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APPORTIONMENT OF HOSPICE SHARED SERVICES

HOSPICE NO.: 14-1616

WORKSHEET K-5
 PART III

PART III - COMPUTATION OF TOTAL HOSPICE SHARED COSTS

	WKST C, PART I, COL. 9, LINE 0	COST TO CHARGE RATIO 1	TOTAL HOSPICE CHARGES (PROVIDER RECORDS) 2	HOSPICE SHARED ANCILLARY COSTS (COL.1 x 2) 3	
ANCILLARY SERVICE COST CENTERS					
1	PHYSICAL THERAPY	66	0.497708		1
2	OCCUPATIONAL THERAPY	67			2
3	SPEECH/LANGUAGE PATHOLOGY	68			3
4	DRUGS, BIOLOGICALS AND INFUSION	73	0.284451		4
5	DURABLE MEDICAL EQUIPMENT/OXYGEN	96			5
6	LABS AND DIAGNOSTICS	60	0.235560		6
7	MEDICAL SUPPLIES	71	0.612285		7
8	OUTPATIENT SERVICES (INCL. E/R DEPT)	93			8
9	RADIATION THERAPY	55			9
10	OTHER ANCILLARY (SPECIFY)	76			10
10.97	CARDIAC REHABILITATION	76.97			10.97
10.98	HYPERBARIC OXYGEN THERAPY	76.98			10.98
10.99	LITHOTRIPSY	76.99			10.99
11	TOTALS (SUM OF LINES 1-10)				11

CALCULATION OF HOSPICE PER DIEM COST

HOSPICE NO.: 14-1616

WORKSHEET K-6

COMPUTATION OF PER DIEM COST	TITLE XVIII 1	TITLE XIX 2	OTHER 3	TOTAL 4	
1 TOTAL COST (SEE INSTRUCTIONS)				1,157,732	1
2 TOTAL UNDUPLICATED DAYS (WKST S-9, COL. 6, LINE 5)				5,200	2
3 AVERAGE COST PER DIEM (LINE 1 DIVIDED BY LINE 2)				222.64	3
4 UNDUPLICATED MEDICARE DAYS (WKST S-9, COL. 1, LINE 5)	4,846				4
5 AGGREGATE MEDICARE COST (LINE 3 TIMES LINE 4)	1,078,913				5
6 UNDUPLICATED MEDICAID DAYS (WKST S-9, COL. 2, LINE 5)		23			6
7 AGGREGATE MEDICAID COST (LINE 3 TIMES LINE 6)		5,121			7
8 UNDUPLICATED SNF DAYS (WKST S-9, COL. 3, LINE 5)	4,605				8
9 AGGREGATE SNF COST (LINE 3 TIMES LINE 8)	1,025,257				9
10 UNDUPLICATED NF DAYS (WKST S-9, COL. 4, LINE 5)					10
11 AGGREGATE NF COST (LINE 3 TIMES LINE 10)					11
12 OTHER UNDUPLICATED DAYS (WKST S-9, COL. 5, LINE 5)			331		12
13 AGGREGATE COST FOR OTHER DAYS (LINE 3 TIMES LINE 12)			73,694		13

CALCULATION OF CAPITAL PAYMENT

WORKSHEET L

CHECK [] TITLE V [XX] HOSPITAL ((14-016)) [XX] PPS
 APPLICABLE [XX] TITLE XVIII-PT A [] SUB (OTHER) [] COST METHOD
 BOXES [] TITLE XIX

PART I - FULLY PROSPECTIVE METHOD

CAPITAL FEDERAL AMOUNT			
1	CAPITAL DRG OTHER THAN OUTLIER	309,051	1
2	CAPITAL DRG OUTLIER PAYMENTS	912	2
3	TOTAL INPATIENT DAYS DIVIDED BY NUMBER OF DAYS IN THE COST REPORTING PERIOD (SEE INSTRUCTIONS)	7.31	3
4	NUMBER OF INTERNS & RESIDENTS (SEE INSTRUCTIONS)		4
5	INDIRECT MEDICAL EDUCATION PERCENTAGE (SEE INSTRUCTIONS)		5
6	INDIRECT MEDICAL EDUCATION ADJUSTMENT (LINE 1 TIMES LINE 5)		6
7	PERCENTAGE OF SSI RECIPIENT PATIENT DAYS TO MEDICARE PART A PATIENT DAYS (WKST E, PART A, LINE 30) (SEE INSTRUCTIONS)		7
8	PERCENTAGE OF MEDICAID PATIENT DAYS TO TOTAL DAYS REPORTED ON WORKSHEET S-3, PART I (SEE INSTRUCTIONS)		8
9	SUM OF LINES 7 AND 8		9
10	ALLOWABLE DISPROPORTIONATE SHARE PERCENTAGE (SEE INSTRUCTIONS)		10
11	DISPROPORTIONATE SHARE ADJUSTMENT (LINE 10 TIMES LINE 1)		11
12	TOTAL PROSPECTIVE CAPITAL PAYMENTS (SUM OF LINES 1-2, 6 AND 11)	309,963	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 FOR EXTRAORDINARY CIRCUMSTANCES (LINE 1 MINUS LINE 2)		3
4	APPLICABLE EXCEPTION PERCENTAGE (SEE INSTRUCTIONS)		4
5	CAPITAL COST FOR COMPARISON TO PAYMENTS (LINE 3 TIMES LINE 4)		5
6	PERCENTAGE ADJUSTMENT FOR EXTRAORDINARY CIRCUMSTANCES (SEE INSTRUCTIONS)		6
7	ADJUSTMENT TO CAPITAL MINIMUM PAYMENT LEVEL FOR EXTRAORDINARY CIRCUMSTANCES (LINE 2 TIMES LINE 6)		7
8	CAPITAL MINIMUM PAYMENT LEVEL FOR EXTRAORDINARY CIRCUMSTANCES (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 FOR THE FOLLOWING PERIOD (FROM PRIOR YEAR WKST 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

CALCULATION OF CAPITAL PAYMENT

WORKSHEET L

CHECK [] TITLE V [XX] HOSPITAL ((14-016)) [XX] PPS
APPLICABLE [] TITLE XVIII-PT A [] SUB (OTHER) [] COST METHOD
BOXES [XX] TITLE XIX

PART I - FULLY PROSPECTIVE METHOD

1	CAPITAL FEDERAL AMOUNT	1
2	CAPITAL DRG OTHER THAN OUTLIER	2
3	CAPITAL DRG OUTLIER PAYMENTS	2
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 (LINE 1 TIMES LINE 5)	6
7	PERCENTAGE OF SSI RECIPIENT PATIENT DAYS TO MEDICARE PART A PATIENT DAYS (WKST E, PART A, LINE 30) (SEE INSTRUCTIONS)	7
8	PERCENTAGE OF MEDICAID PATIENT DAYS TO TOTAL DAYS REPORTED ON WORKSHEET S-3, PART I (SEE INSTRUCTIONS)	8
9	SUM OF LINES 7 AND 8	9
10	ALLOWABLE DISPROPORTIONATE SHARE PERCENTAGE (SEE INSTRUCTIONS)	10
11	DISPROPORTIONATE SHARE ADJUSTMENT (LINE 10 TIMES LINE 1)	11
12	TOTAL PROSPECTIVE CAPITAL PAYMENTS (SUM OF LINES 1-2, 6 AND 11)	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 FOR EXTRAORDINARY CIRCUMSTANCES (LINE 1 MINUS LINE 2)	3
4	APPLICABLE EXCEPTION PERCENTAGE (SEE INSTRUCTIONS)	4
5	CAPITAL COST FOR COMPARISON TO PAYMENTS (LINE 3 TIMES LINE 4)	5
6	PERCENTAGE ADJUSTMENT FOR EXTRAORDINARY CIRCUMSTANCES (SEE INSTRUCTIONS)	6
7	ADJUSTMENT TO CAPITAL MINIMUM PAYMENT LEVEL FOR EXTRAORDINARY CIRCUMSTANCES (LINE 2 TIMES LINE 6)	7
8	CAPITAL MINIMUM PAYMENT LEVEL FOR EXTRAORDINARY CIRCUMSTANCES (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 FOR THE FOLLOWING PERIOD (FROM PRIOR YEAR WKST L, PART III, LINE 14)	11
12	NET COMPARISON OF CAPITAL MINIMUM PAYMENT LEVEL TO CAPITAL PAYMENTS (LINE 10 PLUS LINE 11)	12
13	CURRENT YEAR EXCEPTION PAYMENT (IF LINE 12 IS POSITIVE, ENTER THE AMOUNT ON THIS LINE)	13
14	CARRYOVER OF ACCUMULATED CAPITAL MINIMUM PAYMENT LEVEL OVER CAPITAL PAYMENT FOR THE FOLLOWING PERIOD (IF LINE 12 IS NEGATIVE, ENTER THE AMOUNT ON THIS LINE)	14
15	CURRENT YEAR ALLOWABLE OPERATING AND CAPITAL PAYMENT (SEE INSTRUCTIONS)	15
16	CURRENT YEAR OPERATING AND CAPITAL COSTS (SEE INSTRUCTIONS)	16
17	CURRENT YEAR EXCEPTION OFFSET AMOUNT (SEE INSTRUCTIONS)	17

ALLOCATION OF ALLOWABLE CAPITAL COSTS FOR EXTRAORDINARY CIRCUMSTANCES

WORKSHEET L-1
 PART I

COST CENTER DESCRIPTION	EXTRAORDI- NARY CAP- REL COSTS 0	SUBTOTAL (COLS.0-4) 2A	SUBTOTAL 24	I&R COST & POST STEP- DOWN ADJS 25	TOTAL 26
GENERAL SERVICE COST CENTERS					
1 CAP REL COSTS-BLDG & FIXT					1
2 CAP REL COSTS-MVBLE EQUIP					2
4 EMPLOYEE BENEFITS					4
5.01 ADMISSIONS					5.01
5.02 PURCHASING, RECEIVING, AND STO					5.02
5.03 DATA PROCESSING					5.03
5.04 COMMUNICATIONS					5.04
5.05 BUSINESS OFFICE					5.05
5.06 OTHER ADMINISTRATIVE AND GENER					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 SRVCES-SALARY & FRINGES AP					21
22 I&R SRVCES-OTHER PRGM COSTS AP					22
23 PARAMED ED PRGM-(SPECIFY)					23
INPATIENT ROUTINE SERV COST CENTERS					
30 ADULTS & PEDIATRICS					30
43 NURSEY					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
60 LABORATORY					60
62.30 BLOOD CLOTTING FOR HEMOPHILIAC					62.30
65 RESPIRATORY THERAPY					65
66 PHYSICAL THERAPY					66
69 ELECTROCARDIOLOGY					69
71 MEDICAL SUPPLIES CHRGD TO PAT					71
72 IMPL. DEV. CHARGED TO PATIENT					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
88 RURAL HEALTH CLINIC (RHC)					88
88.01 RHC II					88.01
88.02 RHC III					88.02
OUTPATIENT SERVICE COST CENTERS					
90 CLINIC					90
91 EMERGENCY					91
92 OBSERVATION BEDS					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 & CA					190
192 PHYSICIANS' PRIVATE OFFICES					192
194 IROQUOIS WOMEN'S HEALTH					194
194.01 OTHER NON-REIMBURSABLE COSTS					194.01
194.02 DURABLE MEDICAL EQUIPMENT SALE					194.02
194.03 WELLNESS					194.03
194.04 RENTED SPACE					194.04

PROVIDER CCN: 14-0167 IROQUOIS MEMORIAL HOSPITAL
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ALLOCATION OF ALLOWABLE CAPITAL COSTS FOR EXTRAORDINARY CIRCUMSTANCES

WORKSHEET L-1
PART I

COST CENTER DESCRIPTION	EXTRAORDI- NARY CAP- REL COSTS	SUBTOTAL (COLS.0-4) 2A	SUBTOTAL 24	I&R COST & POST STEP- DOWN ADJS 25	TOTAL 26	
200	CROSS FOOT ADJUSTMENTS					200
201	NEGATIVE COST CENTER					201
202	TOTAL (SUM OF LINE 118 AND LINES 190-201)					202
203	TOTAL STATISTICAL BASIS					203
204	UNIT COST MULTIPLIER					204
204	UNIT COST MULTIPLIER					204

RHC I
 COMPONENT NO: 14-3424

WORKSHEET M-1

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

CHECK APPLICABLE BOX [XX] RHC [] FQHC

	COMPEN- SATION 1	OTHER COSTS 2	TOTAL (COL.1 + COL.2) 3	RECLASSIFI- CATIONS 4	RECLASSIFIED TRIAL BALANCE (COL.3+4) 5	ADJUST- MENTS 6	NET EXPENSES FOR ALLOCATION (COL.5+6) 7	
FACILITY HEALTH CARE STAFF COSTS								
1 PHYSICIAN	212,641		212,641		212,641		212,641	1
2 PHYSICIAN ASSISTANT	317		317		317		317	2
3 NURSE PRACTITIONER								3
4 VISITING NURSE								4
5 OTHER NURSE	78,601		78,601		78,601		78,601	5
6 CLINICAL PSYCHOLOGIST								6
7 CLINICAL SOCIAL WORKER								7
8 LABORATORY TECHNICIAN								8
9 OTHER FACILITY HEALTH CARE STAFF COSTS								9
10 SUBTOTAL (SUM OF LINES 1-9)	291,559		291,559		291,559		291,559	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 11-13)								14
OTHER HEALTH CARE COSTS								
15 MEDICAL SUPPLIES		3,905	3,905		3,905		3,905	15
16 TRANSPORTATION (HEALTH CARE STAFF)								16
17 DEPRECIATION-MEDICAL EQUIPMENT								17
18 PROFESSIONAL LIABILITY INSURANCE		9,007	9,007		9,007		9,007	18
19 OTHER HEALTH CARE COSTS		6,895	6,895		6,895		6,895	19
20 ALLOWABLE GME COSTS								20
21 SUBTOTAL (SUM OF LINES 15-20)		19,807	19,807		19,807		19,807	21
22 TOTAL COSTS OF HEALTH CARE SERVICES (SUM OF LINES 10, 14, AND 21)	291,559	19,807	311,366		311,366		311,366	22
COSTS OTHER THAN RHC/FQHC SERVICES								
23 PHARMACY								23
24 DENTAL								24
25 OPTOMETRY								25
26 ALL OTHER NONREIMBURSABLE COSTS								26
27 NONALLOWABLE GME COSTS								27
28 TOTAL NONREIMBURSABLE COSTS (SUM OF LINES 23-27)								28
FACILITY OVERHEAD								
29 FACILITY COSTS		6,777	6,777	-5,449	1,328		1,328	29
30 ADMINISTRATIVE COSTS	32,270	100,126	132,396	-21,461	110,935		110,935	30
31 TOTAL FACILITY OVERHEAD (SUM OF LINES 29 AND 30)	32,270	106,903	139,173	-26,910	112,263		112,263	31
32 TOTAL FACILITY COSTS (SUM OF LINES 22, 28 AND 31)	323,829	126,710	450,539	-26,910	423,629		423,629	32

RHC I
 COMPONENT NO: 14-3424

WORKSHEET M-2

ALLOCATION OF OVERHEAD TO RHC/FQHC SERVICES

CHECK APPLICABLE BOX [XX] RHC [] FQHC

VISITS AND PRODUCTIVITY

	NUMBER OF FTE PERSONNEL	TOTAL VISITS	PRODUCTIVITY STANDARD	MINIMUM VISITS (COL.1 x COL.3)	GREATER OF COL. 2 OR COL. 4	
	1	2	3	4	5	
1	PHYSICIANS	0.50	1,586	4,200	2,100	1
2	PHYSICIAN ASSISTANTS	0.95	2,693	2,100	1,995	2
3	NURSE PRACTITIONERS			2,100		3
4	SUBTOTAL (SUM OF LINES 1-3)	1.45	4,279		4,095	4
5	VISITING NURSE					5
6	CLINICAL PSYCHOLOGIST					6
7	CLINICAL SOCIAL WORKER					7
8	TOTAL FTEs AND VISITS (SUM OF LINES 4-7)	1.45	4,279			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)				311,366	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)				311,366	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)				112,263	14
15	PARENT PROVIDER OVERHEAD ALLOCATED TO FACILITY (SEE INSTRUCTIONS)				168,731	15
16	TOTAL OVERHEAD (SUM OF LINES 14 AND 15)				280,994	16
17	ALLOWABLE DIRECT GME OVERHEAD (SEE INSTRUCTIONS)					17
18	SUBTRACT LINE 17 FROM LINE 16				280,994	18
19	OVERHEAD APPLICABLE TO RHC/FQHC SERVICES (LINE 13 x LINE 18)				280,994	19
20	TOTAL ALLOWABLE COST OF RHC/FQHC SERVICES (SUM OF LINES 10 AND 19)				592,360	20

CALCULATION OF REIMBURSEMENT SETTLEMENT FOR RHC/FQHC SERVICES
 RHC I COMPONENT NO: 14-3424

WORKSHEET M-3

CHECK [XX] RHC [] TITLE V [] TITLE XIX
 APPLICABLE BOXES: [] FQHC [XX] TITLE XVIII

DETERMINATION OF RATE FOR RHC/FQHC SERVICES

1	TOTAL ALLOWABLE COST OF RHC/FQHC SERVICES (FROM WKST M-2, LINE 20)	592,360	1
2	COST OF VACCINES AND THEIR ADMINISTRATION (FROM WKST M-4, LINE 15)	2,967	2
3	TOTAL ALLOWABLE COST EXCLUDING VACCINE (LINE 1 MINUS LINE 2)	589,393	3
4	TOTAL VISITS (FROM WKST M-2, COL. 5, LINE 8)	4,279	4
5	PHYSICIANS VISITS UNDER AGREEMENT (FROM WKST M-2, COL. 5, LINE 9)		5
6	TOTAL ADJUSTED VISITS (LINE 4 PLUS LINE 5)	4,279	6
7	ADJUSTED COST PER VISIT (LINE 3 DIVIDED BY LINE 6)	137.74	7

CALCULATION OF LIMIT(1)
 PRIOR TO ON OR AFTER
 JANUARY 1 JANUARY 1 (SEE INSTR.)
 1 2 3

8	PER VISIT PAYMENT LIMIT (FROM CMS PUB 27, SEC. 505 OR YOUR CONTRACTOR)			8
9	RATE FOR PROGRAM COVERED VISITS (SEE INSTRUCTIONS)	137.74	137.74	137.74 9

CALCULATION OF SETTLEMENT

10	PROGRAM COVERED VISITS EXCLUDING MENTAL HEALTH SERVICES (FROM CONTRACTOR RECORDS)	270	808	10
11	PROGRAM COST EXCLUDING COSTS FOR MENTAL HEALTH SERVICES (LINE 9 x LINE 10)	37,190	111,294	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 (SUM OF LINES 11, 14, AND 15, COLS. 1, 2, AND 3)		148,484	16
16.01	TOTAL PROGRAM CHARGES (SEE INSTRUCTIONS)(FROM CONTRACTOR'S RECORDS)		95,820	16.01
16.02	TOTAL PROGRAM PREVENTIVE CHARGES (SEE INSTRUCTIONS)(FROM PROVIDER'S RECORDS)		318	16.02
16.03	TOTAL PROGRAM PREVENTIVE COSTS ((LINE 16.02/LINE 16.01) TIMES LINE 16)		493	16.03
16.04	TOTAL PROGRAM NON-PREVENTIVE COSTS ((LINE 16 MINUS LINE 16.03) TIMES 80%)		105,218	16.04
16.05	TOTAL PROGRAM COST (SEE INSTRUCTIONS)		105,711	16.05
17	PRIMARY PAYOR PAYMENTS			17
18	LESS: BENEFICIARY DEDUCTIBLE FOR RHC ONLY (SEE INSTRUCTIONS)(FROM CONTRACTOR RECORDS)		16,469	18
19	LESS: BENEFICIARY COINSURANCE FOR RHC/FQHC SERVICES (SEE INSTRUCTIONS) (FROM CONTRACTOR RECORDS)		15,870	19
20	NET MEDICARE COST EXCLUDING VACCINES (SEE INSTRUCTIONS)		105,711	20
21	PROGRAM COST OF VACCINES AND THEIR ADMINISTRATION (FROM WKST M-4, LINE 16)		2,150	21
22	TOTAL REIMBURSABLE PROGRAM COST (LINE 20 PLUS LINE 21)		107,861	22
23	REIMBURSABLE BAD DEBTS (SEE INSTRUCTIONS)		6,370	23
24	REIMBURSABLE BAD DEBTS FOR DUAL ELIGIBLE BENEFICIARIES (SEE INSTRUCTIONS)		6,370	24
25	OTHER ADJUSTMENTS (SPECIFY) (SEE INSTRUCTIONS)			25
26	NET REIMBURSABLE AMOUNT (LINES 22 PLUS 23 PLUS OR MINUS LINE 25)		114,231	26
27	INTERIM PAYMENTS		98,582	27
28	TENTATIVE SETTLEMENT (FOR CONTRACTOR USE ONLY)			28
29	BALANCE DUE COMPONENT/PROGRAM (LINE 26 MINUS LINES 27 AND 28)		15,649	29
30	PROTESTED AMOUNTS (NONALLOWABLE COST REPORT ITEMS) IN ACCORDANCE WITH CMS PUB 15-II, CHAPTER I, SECTION 115.2			30

(1) LINES 8 THROUGH 14: FISCAL YEAR PROVIDERS USE COLUMNS 1 & 2, CALENDAR YEAR PROVIDERS USE COLUMN 2 ONLY.

RHC I
 COMPONENT NO: 14-3424

WORKSHEET M-4

COMPUTATION OF PNEUMOCOCCAL AND INFLUENZA VACCINE COST

CHECK [XX] RHC [] TITLE V [] TITLE XIX
 APPLICABLE BOXES: [] FQHC [XX] TITLE XVIII

	PNEUMOCOCCAL 1	SEASONAL INFLUENZA 2	
1 HEALTH CARE STAFF COST (FROM WKST M-1, COL. 7, LINE 10)	291,559	291,559	1
2 RATIO OF PNEUMOCOCCAL AND INFLUNZA VACCINE STAFF TIME TO TOTAL HEALTH CARE STAFF TIME	0.000377	0.002221	2
3 PNEUMOCOCCAL AND INFUENZA VACCINE HEALTH CARE STAFF COST (LINE 1 x LINE 2)	110	648	3
4 MEDICAL SUPPLIES COST - PNEUMOCOCCAL AND INFUENZA VACCINE (FROM YOUR RECORDS)	141	661	4
5 DIRECT COST OF PNEUMOCOCCAL AND INFLUENZA VACCINE (LINE 3 PLUS LINE 4)	251	1,309	5
6 TOTAL DIRECT COST OF THE FACILITY (FROM WKST M-1, COL. 7, LINE 22)	311,366	311,366	6
7 TOTAL OVERHEAD (FROM WKST M-2, LINE 16)	280,994	280,994	7
8 RATIO OF PNEUMOCOCCAL AND INFUENZA VACCINE DIRECT COST TO TOTAL DIRECT COST (LINE 5 DIVIDED BY LINE 6)	0.000806	0.004204	8
9 OVERHEAD COST - PNEUMOCOCCAL AND INFLUENZA VACCINE (LINE 7 x LINE 8)	226	1,181	9
10 TOTAL PNEUMOCOCCAL AND INFLUENZA VACCINE COSTS AND THEIR ADMINISTRATION COSTS (SUM OF LINES 5 AND 9)	477	2,490	10
11 TOTAL NUMBER OF PNEUMOCOCCAL AND INFLUENZA VACCINE INJECTIONS (FROM YOUR RECORDS)	9	53	11
12 COST PER PNEUMOCOCCAL AND INFLUENZA VACCINE INJECTION (LINE 10/ LINE 11)	53.00	46.98	12
13 NUMBER OF PNEUMOCOCCAL AND INFLUENZA VACCINE INJECTIONS ADMINISTERED TO PROGRAM BENEFICIARIES	6	39	13
14 PROGRAM COST OF PNEUMOCOCCAL AND INFLUENZA VACCINES AND THEIR THEIR ADMINISTRATION COSTS (LINE 12 x LINE 13)	318	1,832	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)		2,967	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)		2,150	16

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

RHC I
 COMPONENT NO: 14-3424

WORKSHEET M-5

CHECK APPLICABLE BOX [XX] RHC [] FQHC

DESCRIPTION	PART B		
	1 MM/DD/YYYY	2 AMOUNT	
1 TOTAL INTERIM PAYMENTS PAID TO PROVIDER		105,744	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.		NONE	2
3 LIST SEPARATELY EACH RETROACTIVE LUMP SUM ADJUSTMENT AMOUNT BASED ON SUBSEQUENT REVISION OF THE INTERIM RATE FOR THE COST REPORTING PERIOD. ALSO SHOW DATE OF EACH PAYMENT. IF NONE, WRITE 'NONE' OR ENTER A ZERO.	.01 .02 PROGRAM .03 TO .04 PROVIDER .05 .06 .07 .08 .09 .50 .51 PROVIDER .52 TO .53 PROGRAM .54 .55 .56 .57 .58 .59 .99	NONE	3.01 3.02 3.03 3.04 3.05 3.06 3.07 3.08 3.09 3.50 3.51 3.52 3.53 3.54 3.55 3.56 3.57 3.58 3.59 3.99
SUBTOTAL (SUM OF LINES 3.01-3.49 MINUS SUM OF LINES 3.50-3.98)	05/18/2012	7,162	
4 TOTAL INTERIM PAYMENTS (SUM OF LINES 1, 2 AND 3.99) (TRANSFER TO WKST M-3, LINE 27)		98,582	4
TO BE COMPLETED BY INTERMEDIARY			
5 LIST SEPARATELY EACH TENTATIVE SETTLEMENT PAYMENT AFTER DESK REVIEW. ALSO SHOW DATE OF EACH PAYMENT. IF NONE, WRITE 'NONE' OR ENTER A ZERO.	PROGRAM .01 TO .02 PROVIDER .03 .04 .05 .06 .07 .08 .09 PROVIDER .50 TO .51 PROGRAM .52 .53 .54 .55 .56 .57 .58 .59 .99	NONE	5.01 5.02 5.03 5.04 5.05 5.06 5.07 5.08 5.09 5.50 5.51 5.52 5.53 5.54 5.55 5.56 5.57 5.58 5.59 5.99
6 DETERMINE NET SETTLEMENT AMOUNT (BALANCE DUE) BASED ON THE COST REPORT (SEE INSTR.	PROGRAM TO .01 PROVIDER PROVIDER TO .02 PROGRAM	15,649	6.01 6.02
7 TOTAL MEDICARE PROGRAM LIABILITY (SEE INSTR.)		114,231	7
8 NAME OF CONTRACTOR: _____	CONTRACTOR NUMBER: _____	NPR DATE: _____	8

RHC II
 COMPONENT NO: 14-3425

WORKSHEET M-1

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

CHECK APPLICABLE BOX [XX] RHC [] FQHC

	COMPEN- SATION 1	OTHER COSTS 2	TOTAL (COL.1 + COL.2) 3	RECLASSIFI- CATIONS 4	RECLASSIFIED TRIAL BALANCE (COL.3+4) 5	ADJUST- MENTS 6	NET EXPENSES FOR ALLOCATION (COL.5+6) 7	
FACILITY HEALTH CARE STAFF COSTS								
1 PHYSICIAN	142,646		142,646		142,646		142,646	1
2 PHYSICIAN ASSISTANT	912		912		912		912	2
3 NURSE PRACTITIONER								3
4 VISITING NURSE								4
5 OTHER NURSE	70,485		70,485		70,485		70,485	5
6 CLINICAL PSYCHOLOGIST								6
7 CLINICAL SOCIAL WORKER								7
8 LABORATORY TECHNICIAN								8
9 OTHER FACILITY HEALTH CARE STAFF COSTS								9
10 SUBTOTAL (SUM OF LINES 1-9)	214,043		214,043		214,043		214,043	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 11-13)								14
OTHER HEALTH CARE COSTS								
15 MEDICAL SUPPLIES		2,979	2,979		2,979		2,979	15
16 TRANSPORTATION (HEALTH CARE STAFF)								16
17 DEPRECIATION-MEDICAL EQUIPMENT								17
18 PROFESSIONAL LIABILITY INSURANCE		6,004	6,004		6,004		6,004	18
19 OTHER HEALTH CARE COSTS		5,553	5,553		5,553		5,553	19
20 ALLOWABLE GME COSTS								20
21 SUBTOTAL (SUM OF LINES 15-20)		14,536	14,536		14,536		14,536	21
22 TOTAL COSTS OF HEALTH CARE SERVICES (SUM OF LINES 10, 14, AND 21)	214,043	14,536	228,579		228,579		228,579	22
COSTS OTHER THAN RHC/FQHC SERVICES								
23 PHARMACY								23
24 DENTAL								24
25 OPTOMETRY								25
26 ALL OTHER NONREIMBURSABLE COSTS								26
27 NONALLOWABLE GME COSTS								27
28 TOTAL NONREIMBURSABLE COSTS (SUM OF LINES 23-27)								28
FACILITY OVERHEAD								
29 FACILITY COSTS								29
30 ADMINISTRATIVE COSTS	35,555	129,050	164,605	-41,589	123,016		123,016	30
31 TOTAL FACILITY OVERHEAD (SUM OF LINES 29 AND 30)	35,555	129,050	164,605	-41,589	123,016		123,016	31
32 TOTAL FACILITY COSTS (SUM OF LINES 22, 28 AND 31)	249,598	143,586	393,184	-41,589	351,595		351,595	32

RHC II
 COMPONENT NO: 14-3425

WORKSHEET M-2

ALLOCATION OF OVERHEAD TO RHC/FQHC SERVICES

CHECK APPLICABLE BOX [XX] RHC [] FQHC

VISITS AND PRODUCTIVITY

	NUMBER OF FTE PERSONNEL	TOTAL VISITS	PRODUCTIVITY STANDARD	MINIMUM VISITS (COL.1 x COL.3)	GREATER OF COL. 2 OR COL. 4	
	1	2	3	4	5	
1	PHYSICIANS	0.34	1,553	4,200	1,428	1
2	PHYSICIAN ASSISTANTS	0.71	2,390	2,100	1,491	2
3	NURSE PRACTITIONERS			2,100		3
4	SUBTOTAL (SUM OF LINES 1-3)	1.05	3,943		2,919	3,943
5	VISITING NURSE					5
6	CLINICAL PSYCHOLOGIST					6
7	CLINICAL SOCIAL WORKER					7
8	TOTAL FTEs AND VISITS (SUM OF LINES 4-7)	1.05	3,943			3,943
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)				228,579	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)				228,579	12
13	RATIO OF RHC/FQHC SERVICES (LINE 10 DIVIDED BY LINE 12)				1.000000	13
14	TOTAL FACILITY OVERHEAD (FROM WKST M-1, COL. 7, LINE 31)				123,016	14
15	PARENT PROVIDER OVERHEAD ALLOCATED TO FACILITY (SEE INSTRUCTIONS)				108,222	15
16	TOTAL OVERHEAD (SUM OF LINES 14 AND 15)				231,238	16
17	ALLOWABLE DIRECT GME OVERHEAD (SEE INSTRUCTIONS)					17
18	SUBTRACT LINE 17 FROM LINE 16				231,238	18
19	OVERHEAD APPLICABLE TO RHC/FQHC SERVICES (LINE 13 x LINE 18)				231,238	19
20	TOTAL ALLOWABLE COST OF RHC/FQHC SERVICES (SUM OF LINES 10 AND 19)				459,817	20

CALCULATION OF REIMBURSEMENT SETTLEMENT FOR RHC/FQHC SERVICES
 RHC II COMPONENT NO: 14-3425

WORKSHEET M-3

CHECK [XX] RHC [] TITLE V [] TITLE XIX
 APPLICABLE BOXES: [] FQHC [XX] TITLE XVIII

DETERMINATION OF RATE FOR RHC/FQHC SERVICES

1	TOTAL ALLOWABLE COST OF RHC/FQHC SERVICES (FROM WKST M-2, LINE 20)		459,817	1
2	COST OF VACCINES AND THEIR ADMINISTRATION (FROM WKST M-4, LINE 15)		5,697	2
3	TOTAL ALLOWABLE COST EXCLUDING VACCINE (LINE 1 MINUS LINE 2)		454,120	3
4	TOTAL VISITS (FROM WKST M-2, COL. 5, LINE 8)		3,943	4
5	PHYSICIANS VISITS UNDER AGREEMENT (FROM WKST M-2, COL. 5, LINE 9)			5
6	TOTAL ADJUSTED VISITS (LINE 4 PLUS LINE 5)		3,943	6
7	ADJUSTED COST PER VISIT (LINE 3 DIVIDED BY LINE 6)		115.17	7

CALCULATION OF LIMIT(1)
 PRIOR TO ON OR AFTER
 JANUARY 1 JANUARY 1 (SEE INSTR.)
 1 2 3

8	PER VISIT PAYMENT LIMIT (FROM CMS PUB 27, SEC. 505 OR YOUR CONTRACTOR)				8
9	RATE FOR PROGRAM COVERED VISITS (SEE INSTRUCTIONS)	115.17	115.17	115.17	9

CALCULATION OF SETTLEMENT

10	PROGRAM COVERED VISITS EXCLUDING MENTAL HEALTH SERVICES (FROM CONTRACTOR RECORDS)	321	962		10
11	PROGRAM COST EXCLUDING COSTS FOR MENTAL HEALTH SERVICES (LINE 9 x LINE 10)	36,970	110,794		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 (SUM OF LINES 11, 14, AND 15, COLS. 1, 2, AND 3)		147,764		16
16.01	TOTAL PROGRAM CHARGES (SEE INSTRUCTIONS)(FROM CONTRACTOR'S RECORDS)		116,933		16.01
16.02	TOTAL PROGRAM PREVENTIVE CHARGES (SEE INSTRUCTIONS)(FROM PROVIDER'S RECORDS)		230		16.02
16.03	TOTAL PROGRAM PREVENTIVE COSTS ((LINE 16.02/LINE 16.01) TIMES LINE 16)		291		16.03
16.04	TOTAL PROGRAM NON-PREVENTIVE COSTS ((LINE 16 MINUS LINE 16.03) TIMES 80%)		105,556		16.04
16.05	TOTAL PROGRAM COST (SEE INSTRUCTIONS)		105,847		16.05
17	PRIMARY PAYOR PAYMENTS				17
18	LESS: BENEFICIARY DEDUCTIBLE FOR RHC ONLY (SEE INSTRUCTIONS)(FROM CONTRACTOR RECORDS)		15,528		18
19	LESS: BENEFICIARY COINSURANCE FOR RHC/FQHC SERVICES (SEE INSTRUCTIONS) (FROM CONTRACTOR RECORDS)		20,281		19
20	NET MEDICARE COST EXCLUDING VACCINES (SEE INSTRUCTIONS)		105,847		20
21	PROGRAM COST OF VACCINES AND THEIR ADMINISTRATION (FROM WKST M-4, LINE 16)		4,662		21
22	TOTAL REIMBURSABLE PROGRAM COST (LINE 20 PLUS LINE 21)		110,509		22
23	REIMBURSABLE BAD DEBTS (SEE INSTRUCTIONS)		11,220		23
24	REIMBURSABLE BAD DEBTS FOR DUAL ELIGIBLE BENEFICIARIES (SEE INSTRUCTIONS)		11,220		24
25	OTHER ADJUSTMENTS (SPECIFY) (SEE INSTRUCTIONS)				25
26	NET REIMBURSABLE AMOUNT (LINES 22 PLUS 23 PLUS OR MINUS LINE 25)		121,729		26
27	INTERIM PAYMENTS		121,710		27
28	TENTATIVE SETTLEMENT (FOR CONTRACTOR USE ONLY)				28
29	BALANCE DUE COMPONENT/PROGRAM (LINE 26 MINUS LINES 27 AND 28)			19	29
30	PROTESTED AMOUNTS (NONALLOWABLE COST REPORT ITEMS) IN ACCORDANCE WITH CMS PUB 15-II, CHAPTER I, SECTION 115.2				30

(1) LINES 8 THROUGH 14: FISCAL YEAR PROVIDERS USE COLUMNS 1 & 2, CALENDAR YEAR PROVIDERS USE COLUMN 2 ONLY.

RHC II
 COMPONENT NO: 14-3425

WORKSHEET M-4

COMPUTATION OF PNEUMOCOCCAL AND INFLUENZA VACCINE COST

CHECK [XX] RHC [] TITLE V [] TITLE XIX
 APPLICABLE BOXES: [] FQHC [XX] TITLE XVIII

	PNEUMOCOCCAL 1	SEASONAL INFLUENZA 2	
1 HEALTH CARE STAFF COST (FROM WKST M-1, COL. 7, LINE 10)	214,043	214,043	1
2 RATIO OF PNEUMOCOCCAL AND INFLUNZA VACCINE STAFF TIME TO TOTAL HEALTH CARE STAFF TIME	0.000557	0.006188	2
3 PNEUMOCOCCAL AND INFUENZA VACCINE HEALTH CARE STAFF COST (LINE 1 x LINE 2)	119	1,324	3
4 MEDICAL SUPPLIES COST - PNEUMOCOCCAL AND INFUENZA VACCINE (FROM YOUR RECORDS)	141	1,248	4
5 DIRECT COST OF PNEUMOCOCCAL AND INFLUENZA VACCINE (LINE 3 PLUS LINE 4)	260	2,572	5
6 TOTAL DIRECT COST OF THE FACILITY (FROM WKST M-1, COL. 7, LINE 22)	228,579	228,579	6
7 TOTAL OVERHEAD (FROM WKST M-2, LINE 16)	231,238	231,238	7
8 RATIO OF PNEUMOCOCCAL AND INFUENZA VACCINE DIRECT COST TO TOTAL DIRECT COST (LINE 5 DIVIDED BY LINE 6)	0.001137	0.011252	8
9 OVERHEAD COST - PNEUMOCOCCAL AND INFLUENZA VACCINE (LINE 7 x LINE 8)	263	2,602	9
10 TOTAL PNEUMOCOCCAL AND INFLUENZA VACCINE COSTS AND THEIR ADMINISTRATION COSTS (SUM OF LINES 5 AND 9)	523	5,174	10
11 TOTAL NUMBER OF PNEUMOCOCCAL AND INFLUENZA VACCINE INJECTIONS (FROM YOUR RECORDS)	9	100	11
12 COST PER PNEUMOCOCCAL AND INFLUENZA VACCINE INJECTION (LINE 10 / LINE 11)	58.11	51.74	12
13 NUMBER OF PNEUMOCOCCAL AND INFLUENZA VACCINE INJECTIONS ADMINISTERED TO PROGRAM BENEFICIARIES	9	80	13
14 PROGRAM COST OF PNEUMOCOCCAL AND INFLUENZA VACCINES AND THEIR THEIR ADMINISTRATION COSTS (LINE 12 x LINE 13)	523	4,139	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)		5,697	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)		4,662	16

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

RHC II
 COMPONENT NO: 14-3425

WORKSHEET M-5

CHECK APPLICABLE BOX [XX] RHC [] FQHC

DESCRIPTION	PART B		
	1 MM/DD/YYYY	2 AMOUNT	
1 TOTAL INTERIM PAYMENTS PAID TO PROVIDER		127,597	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.		NONE	2
3 LIST SEPARATELY EACH RETROACTIVE LUMP SUM ADJUSTMENT AMOUNT BASED ON SUBSEQUENT REVISION OF THE INTERIM RATE FOR THE COST REPORTING PERIOD. ALSO SHOW DATE OF EACH PAYMENT. IF NONE, WRITE 'NONE' OR ENTER A ZERO.	.01 04/22/2011	NONE	3.01
	.02		3.02
	PROGRAM .03		3.03
	TO .04		3.04
	PROVIDER .05		3.05
	.06		3.06
	.07		3.07
	.08		3.08
	.09		3.09
	.50		3.50
	.51 05/18/2012	5,887	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	-5,887	3.99
4 TOTAL INTERIM PAYMENTS (SUM OF LINES 1, 2 AND 3.99) (TRANSFER TO WKST M-3, LINE 27)		121,710	4
TO BE COMPLETED BY INTERMEDIARY			
5 LIST SEPARATELY EACH TENTATIVE SETTLEMENT PAYMENT AFTER DESK REVIEW. ALSO SHOW DATE OF EACH PAYMENT. IF NONE, WRITE 'NONE' OR ENTER A ZERO.	PROGRAM .01	NONE	5.01
	TO .02		5.02
	PROVIDER .03		5.03
	.04		5.04
	.05		5.05
	.06		5.06
	.07		5.07
	.08		5.08
	.09		5.09
	PROVIDER .50	NONE	5.50
	TO .51		5.51
	PROGRAM .52		5.52
	.53		5.53
	.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) BASED ON THE COST REPORT (SEE INSTR.	PROGRAM TO .01	19	6.01
	PROVIDER PROVIDER TO .02		6.02
7 TOTAL MEDICARE PROGRAM LIABILITY (SEE INSTR.)		121,729	7
8 NAME OF CONTRACTOR: _____	CONTRACTOR NUMBER: _____	NPR DATE: _____	8

RHC III
 COMPONENT NO: 15-3979

WORKSHEET M-1

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

CHECK APPLICABLE BOX [XX] RHC [] FQHC

	COMPEN- SATION 1	OTHER COSTS 2	TOTAL (COL.1 + COL.2) 3	RECLASSIFI- CATIONS 4	RECLASSIFIED TRIAL BALANCE (COL.3+4) 5	ADJUST- MENTS 6	NET EXPENSES FOR ALLOCATION (COL.5+6) 7	
FACILITY HEALTH CARE STAFF COSTS								
1 PHYSICIAN	518,815		518,815		518,815		518,815	1
2 PHYSICIAN ASSISTANT								2
3 NURSE PRACTITIONER	46,314		46,314		46,314		46,314	3
4 VISITING NURSE								4
5 OTHER NURSE	156,472		156,472		156,472		156,472	5
6 CLINICAL PSYCHOLOGIST								6
7 CLINICAL SOCIAL WORKER								7
8 LABORATORY TECHNICIAN								8
9 OTHER FACILITY HEALTH CARE STAFF COSTS								9
10 SUBTOTAL (SUM OF LINES 1-9)	721,601		721,601		721,601		721,601	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 11-13)								14
OTHER HEALTH CARE COSTS								
15 MEDICAL SUPPLIES		7,433	7,433		7,433		7,433	15
16 TRANSPORTATION (HEALTH CARE STAFF)								16
17 DEPRECIATION-MEDICAL EQUIPMENT								17
18 PROFESSIONAL LIABILITY INSURANCE		17,848	17,848		17,848		17,848	18
19 OTHER HEALTH CARE COSTS		13,816	13,816		13,816		13,816	19
20 ALLOWABLE GME COSTS								20
21 SUBTOTAL (SUM OF LINES 15-20)		39,097	39,097		39,097		39,097	21
22 TOTAL COSTS OF HEALTH CARE SERVICES (SUM OF LINES 10, 14, AND 21)	721,601	39,097	760,698		760,698		760,698	22
COSTS OTHER THAN RHC/FQHC SERVICES								
23 PHARMACY								23
24 DENTAL								24
25 OPTOMETRY								25
26 ALL OTHER NONREIMBURSABLE COSTS								26
27 NONALLOWABLE GME COSTS								27
28 TOTAL NONREIMBURSABLE COSTS (SUM OF LINES 23-27)								28
FACILITY OVERHEAD								
29 FACILITY COSTS		11,844	11,844	-2,037	9,807		9,807	29
30 ADMINISTRATIVE COSTS	62,251	250,528	312,779	-68,838	243,941		243,941	30
31 TOTAL FACILITY OVERHEAD (SUM OF LINES 29 AND 30)	62,251	262,372	324,623	-70,875	253,748		253,748	31
32 TOTAL FACILITY COSTS (SUM OF LINES 22, 28 AND 31)	783,852	301,469	1,085,321	-70,875	1,014,446		1,014,446	32

RHC III
 COMPONENT NO: 15-3979

WORKSHEET M-2

ALLOCATION OF OVERHEAD TO RHC/FQHC SERVICES

CHECK APPLICABLE BOX [XX] RHC [] FQHC

VISITS AND PRODUCTIVITY

	NUMBER OF FTE PERSONNEL	TOTAL VISITS	PRODUCTIVITY STANDARD	MINIMUM VISITS (COL.1 x COL.3)	GREATER OF COL. 2 OR COL. 4	
	1	2	3	4	5	
1	PHYSICIANS	0.65	3,139	4,200	2,730	1
2	PHYSICIAN ASSISTANTS	1.27	3,572	2,100	2,667	2
3	NURSE PRACTITIONERS	0.94	2,885	2,100	1,974	3
4	SUBTOTAL (SUM OF LINES 1-3)	2.86	9,596		7,371	9,596
5	VISITING NURSE					5
6	CLINICAL PSYCHOLOGIST					6
7	CLINICAL SOCIAL WORKER					7
8	TOTAL FTEs AND VISITS (SUM OF LINES 4-7)	2.86	9,596			9,596
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)				760,698	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)				760,698	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)				253,748	14
15	PARENT PROVIDER OVERHEAD ALLOCATED TO FACILITY (SEE INSTRUCTIONS)				366,897	15
16	TOTAL OVERHEAD (SUM OF LINES 14 AND 15)				620,645	16
17	ALLOWABLE DIRECT GME OVERHEAD (SEE INSTRUCTIONS)					17
18	SUBTRACT LINE 17 FROM LINE 16				620,645	18
19	OVERHEAD APPLICABLE TO RHC/FQHC SERVICES (LINE 13 x LINE 18)				620,645	19
20	TOTAL ALLOWABLE COST OF RHC/FQHC SERVICES (SUM OF LINES 10 AND 19)				1,381,343	20

CALCULATION OF REIMBURSEMENT SETTLEMENT FOR RHC/FQHC SERVICES
 RHC III COMPONENT NO: 15-3979

WORKSHEET M-3

CHECK [XX] RHC [] TITLE V [] TITLE XIX
 APPLICABLE BOXES: [] FQHC [XX] TITLE XVIII

DETERMINATION OF RATE FOR RHC/FQHC SERVICES

1	TOTAL ALLOWABLE COST OF RHC/FQHC SERVICES (FROM WKST M-2, LINE 20)		1,381,343	1
2	COST OF VACCINES AND THEIR ADMINISTRATION (FROM WKST M-4, LINE 15)		6,392	2
3	TOTAL ALLOWABLE COST EXCLUDING VACCINE (LINE 1 MINUS LINE 2)		1,374,951	3
4	TOTAL VISITS (FROM WKST M-2, COL. 5, LINE 8)		9,596	4
5	PHYSICIANS VISITS UNDER AGREEMENT (FROM WKST M-2, COL. 5, LINE 9)			5
6	TOTAL ADJUSTED VISITS (LINE 4 PLUS LINE 5)		9,596	6
7	ADJUSTED COST PER VISIT (LINE 3 DIVIDED BY LINE 6)		143.28	7

CALCULATION OF LIMIT(1)
 PRIOR TO ON OR AFTER
 JANUARY 1 JANUARY 1 (SEE INSTR.)
 1 2 3

8	PER VISIT PAYMENT LIMIT (FROM CMS PUB 27, SEC. 505 OR YOUR CONTRACTOR)				8
9	RATE FOR PROGRAM COVERED VISITS (SEE INSTRUCTIONS)	143.28	143.28	143.28	9

CALCULATION OF SETTLEMENT

10	PROGRAM COVERED VISITS EXCLUDING MENTAL HEALTH SERVICES (FROM CONTRACTOR RECORDS)	845	2,534		10
11	PROGRAM COST EXCLUDING COSTS FOR MENTAL HEALTH SERVICES (LINE 9 x LINE 10)	121,072	363,072		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 (SUM OF LINES 11, 14, AND 15, COLS. 1, 2, AND 3)		484,144		16
16.01	TOTAL PROGRAM CHARGES (SEE INSTRUCTIONS)(FROM CONTRACTOR'S RECORDS)		352,491		16.01
16.02	TOTAL PROGRAM PREVENTIVE CHARGES (SEE INSTRUCTIONS)(FROM PROVIDER'S RECORDS)		1,260		16.02
16.03	TOTAL PROGRAM PREVENTIVE COSTS ((LINE 16.02/LINE 16.01) TIMES LINE 16)		1,731		16.03
16.04	TOTAL PROGRAM NON-PREVENTIVE COSTS ((LINE 16 MINUS LINE 16.03) TIMES 80%)		345,959		16.04
16.05	TOTAL PROGRAM COST (SEE INSTRUCTIONS)		347,690		16.05
17	PRIMARY PAYOR PAYMENTS		95		17
18	LESS: BENEFICIARY DEDUCTIBLE FOR RHC ONLY (SEE INSTRUCTIONS)(FROM CONTRACTOR RECORDS)		49,964		18
19	LESS: BENEFICIARY COINSURANCE FOR RHC/FQHC SERVICES (SEE INSTRUCTIONS) (FROM CONTRACTOR RECORDS)		60,489		19
20	NET MEDICARE COST EXCLUDING VACCINES (SEE INSTRUCTIONS)		347,595		20
21	PROGRAM COST OF VACCINES AND THEIR ADMINISTRATION (FROM WKST M-4, LINE 16)		4,660		21
22	TOTAL REIMBURSABLE PROGRAM COST (LINE 20 PLUS LINE 21)		352,255		22
23	REIMBURSABLE BAD DEBTS (SEE INSTRUCTIONS)		13,984		23
24	REIMBURSABLE BAD DEBTS FOR DUAL ELIGIBLE BENEFICIARIES (SEE INSTRUCTIONS)		13,984		24
25	OTHER ADJUSTMENTS (SPECIFY) (SEE INSTRUCTIONS)				25
26	NET REIMBURSABLE AMOUNT (LINES 22 PLUS 23 PLUS OR MINUS LINE 25)		366,239		26
27	INTERIM PAYMENTS		340,049		27
28	TENTATIVE SETTLEMENT (FOR CONTRACTOR USE ONLY)				28
29	BALANCE DUE COMPONENT/PROGRAM (LINE 26 MINUS LINES 27 AND 28)		26,190		29
30	PROTESTED AMOUNTS (NONALLOWABLE COST REPORT ITEMS) IN ACCORDANCE WITH CMS PUB 15-II, CHAPTER I, SECTION 115.2				30

(1) LINES 8 THROUGH 14: FISCAL YEAR PROVIDERS USE COLUMNS 1 & 2, CALENDAR YEAR PROVIDERS USE COLUMN 2 ONLY.

RHC III
 COMPONENT NO: 15-3979

WORKSHEET M-4

COMPUTATION OF PNEUMOCOCCAL AND INFLUENZA VACCINE COST

CHECK [XX] RHC [] TITLE V [] TITLE XIX
 APPLICABLE BOXES: [] FQHC [XX] TITLE XVIII

	PNEUMOCOCCAL 1	SEASONAL INFLUENZA 2	
1 HEALTH CARE STAFF COST (FROM WKST M-1, COL. 7, LINE 10)	721,601	721,601	1
2 RATIO OF PNEUMOCOCCAL AND INFLUNZA VACCINE STAFF TIME TO TOTAL HEALTH CARE STAFF TIME	0.000212	0.002335	2
3 PNEUMOCOCCAL AND INFUENZA VACCINE HEALTH CARE STAFF COST (LINE 1 x LINE 2)	153	1,685	3
4 MEDICAL SUPPLIES COST - PNEUMOCOCCAL AND INFUENZA VACCINE (FROM YOUR RECORDS)	172	1,510	4
5 DIRECT COST OF PNEUMOCOCCAL AND INFLUENZA VACCINE (LINE 3 PLUS LINE 4)	325	3,195	5
6 TOTAL DIRECT COST OF THE FACILITY (FROM WKST M-1, COL. 7, LINE 22)	760,698	760,698	6
7 TOTAL OVERHEAD (FROM WKST M-2, LINE 16)	620,645	620,645	7
8 RATIO OF PNEUMOCOCCAL AND INFUENZA VACCINE DIRECT COST TO TOTAL DIRECT COST (LINE 5 DIVIDED BY LINE 6)	0.000427	0.004200	8
9 OVERHEAD COST - PNEUMOCOCCAL AND INFLUENZA VACCINE (LINE 7 x LINE 8)	265	2,607	9
10 TOTAL PNEUMOCOCCAL AND INFLUENZA VACCINE COSTS AND THEIR ADMINISTRATION COSTS (SUM OF LINES 5 AND 9)	590	5,802	10
11 TOTAL NUMBER OF PNEUMOCOCCAL AND INFLUENZA VACCINE INJECTIONS (FROM YOUR RECORDS)	11	121	11
12 COST PER PNEUMOCOCCAL AND INFLUENZA VACCINE INJECTION (LINE 10/ LINE 11)	53.64	47.95	12
13 NUMBER OF PNEUMOCOCCAL AND INFLUENZA VACCINE INJECTIONS ADMINISTERED TO PROGRAM BENEFICIARIES	10	86	13
14 PROGRAM COST OF PNEUMOCOCCAL AND INFLUENZA VACCINES AND THEIR THEIR ADMINISTRATION COSTS (LINE 12 x LINE 13)	536	4,124	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)		6,392	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)		4,660	16

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

RHC III
 COMPONENT NO: 15-3979

WORKSHEET M-5

CHECK APPLICABLE BOX [XX] RHC [] FQHC

DESCRIPTION	PART B		
	1 MM/DD/YYYY	2 AMOUNT	
1 TOTAL INTERIM PAYMENTS PAID TO PROVIDER		341,894	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.		NONE	2
3 LIST SEPARATELY EACH RETROACTIVE LUMP SUM ADJUSTMENT AMOUNT BASED ON SUBSEQUENT REVISION OF THE INTERIM RATE FOR THE COST REPORTING PERIOD. ALSO SHOW DATE OF EACH PAYMENT. IF NONE, WRITE 'NONE' OR ENTER A ZERO.	.01 .02 PROGRAM .03 TO .04 PROVIDER .05 .06 .07 .08 .09 .50 .51 PROVIDER .52 TO .53 PROGRAM .54 .55 .56 .57 .58 .59 .99	NONE	3.01 3.02 3.03 3.04 3.05 3.06 3.07 3.08 3.09 3.50 3.51 3.52 3.53 3.54 3.55 3.56 3.57 3.58 3.59 3.99
SUBTOTAL (SUM OF LINES 3.01-3.49 MINUS SUM OF LINES 3.50-3.98)	05/18/2012	1,845	
4 TOTAL INTERIM PAYMENTS (SUM OF LINES 1, 2 AND 3.99) (TRANSFER TO WKST M-3, LINE 27)		-1,845	4
TO BE COMPLETED BY INTERMEDIARY			
5 LIST SEPARATELY EACH TENTATIVE SETTLEMENT PAYMENT AFTER DESK REVIEW. ALSO SHOW DATE OF EACH PAYMENT. IF NONE, WRITE 'NONE' OR ENTER A ZERO.	PROGRAM .01 TO .02 PROVIDER .03 .04 .05 .06 .07 .08 .09 PROVIDER .50 TO .51 PROGRAM .52 .53 .54 .55 .56 .57 .58 .59 .99	NONE	5.01 5.02 5.03 5.04 5.05 5.06 5.07 5.08 5.09 5.50 5.51 5.52 5.53 5.54 5.55 5.56 5.57 5.58 5.59 5.99
6 DETERMINE NET SETTLEMENT AMOUNT (BALANCE DUE) BASED ON THE COST REPORT (SEE INSTR.	PROGRAM TO .01 PROVIDER PROVIDER TO .02 PROGRAM	26,190	6.01 6.02
7 TOTAL MEDICARE PROGRAM LIABILITY (SEE INSTR.)		366,239	7
8 NAME OF CONTRACTOR:		CONTRACTOR NUMBER:	8
		NPR DATE:	