

IROQUOIS MEMORIAL HOSPITAL Provider CCN: 14-0167	In Lieu of Form <b>CMS-2552-10</b>	Period : From: 10/01/2014 To: 09/30/2015	Run Date: 02/24/2016 Run Time: 16:14 Version: 2015.10 (12/18/2015)
---	---------------------------------------	--	--

**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. <input checked="" type="checkbox"/> Electronically filed cost report 2. <input type="checkbox"/> Manually submitted cost report 3. <input type="checkbox"/> If this is an amended report enter the number of times the provider resubmitted the cost report 4. <input checked="" type="checkbox"/> Medicare Utilization. Enter 'F' for full or 'L' for low.	Date: 02/24/2016 Time: 16:14
Contractor use only	5. <input type="checkbox"/> Cost Report Status (1) As Submitted (2) Settled without audit (3) Settled with audit (4) Reopened (5) Amended	6. Date Received: _____ 7. Contractor No.: _____ 8. <input type="checkbox"/> Initial Report for this Provider CCN 9. <input type="checkbox"/> Final Report for this Provider CCN	10. NPR Date: _____ 11. Contractor's Vendor Code: ____ 12. <input type="checkbox"/> If line 5, column 1 is 4: Enter number of times reopened = 0-9.

**PART II - CERTIFICATION**

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

CERTIFICATION BY OFFICER OR ADMINISTRATOR OF PROVIDER(S)

I HEREBY CERTIFY that I have read the above certification statement and that I have examined the accompanying electronically filed or manually submitted cost report and the Balance Sheet and Statement of Revenue and Expenses prepared by

(Signed) \_\_\_\_\_  
Officer or Administrator of Provider(s)

N.  
Title

\_\_\_\_\_  
Date

**PART III - SETTLEMENT SUMMARY**

		TITLE V	TITLE XVIII		HIT	TITLE XIX	
			PART A	PART B			
		1	2	3	4	5	
1	HOSPITAL		9,945	69,375	-735		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			-11,948			9
10	HEALTH CLINIC - RHC			-18,694			10
10.01	HEALTH CLINIC - RHC II			29,076			10.01
10.02	HEALTH CLINIC - RHC III			12,727			10.02
11	HEALTH CLINIC - FQHC						11
12	OUTPATIENT REHABILITATION PROVIDER						12
200	TOTAL		9,945	80,536	-735		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. Please do not send applications, claims, payments, medical records or any documents containing sensitive information to the PRA Reports Clearance Office. Please note that any correspondence not pertaining to the information collection burden approved under the associated OMB control number listed on this form will not be reviewed, forwarded, or retained. If you have questions or concerns regarding where to submit your documents, please contact 1-800-MEDICARE.

IROQUOIS MEMORIAL HOSPITAL Provider CCN: 14-0167	In Lieu of Form CMS-2552-10	Period : From: 10/01/2014 To: 09/30/2015	Run Date: 02/24/2016 Run Time: 16:14 Version: 2015.10 (12/18/2015)
---	--------------------------------	--	--

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA

WORKSHEET S-2  
PART I

Hospital and Hospital Health Care Complex Address:

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

Hospital and Hospital-Based Component Identification:

Component	Component Name	CCN Number	CBSA Number	Provider Type	Date Certified	Payment System (P, T, O, or N)			
						V	XVIII	XIX	
0	1	2	3	4	5	6	7	8	
3	Hospital	IROQUOIS MEMORIAL HOSPITAL	14-0167	99914	1	07 / 01 / 1996	N	P	P
4	Subprovider - IPF								4
5	Subprovider - IRF								5
6	Subprovider - (OTHER)								6
7	Swing Beds - SNF	IROQUOIS MEMORIAL HOSPITAL	14-U167	99914		12 / 31 / 2006	N	P	N
8	Swing Beds - NF								8
9	Hospital-Based SNF	IROQUOIS RESIDENT HOME	14-6049	99914		08 / 18 / 2003	N	P	N
10	Hospital-Based NF								10
11	Hospital-Based OLTC								11
12	Hospital-Based HHA	IROQUOIS HOME HEALTH	14-7586	99914		09 / 30 / 1994	N	P	N
13	Separately Certified ASC								13
14	Hospital-Based Hospice	IROQUOIS MEMORIAL HOSPICE	14-1616	99914		11 / 04 / 2004			14
15	Hospital-Based Health Clinic - RHC	GILMAN CLINIC	14-3424	99914		09 / 04 / 1996	N	O	N
15.01	Hospital-Based Health Clinic - RHC II	MILFORD CLINIC	14-3425	99914		10 / 09 / 1996	N	O	N
15.02	Hospital-Based Health Clinic - RHC III	KENTLAND CLINIC	15-3979	99915		10 / 29 / 1996	N	O	N
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 / 2014	To: 09 / 30 / 2015	20
21	Type of control (see instructions)	2		21

Inpatient PPS Information

		1	2	3
22	Does this facility qualify for and receive disproportionate share hospital payments in accordance with 42 CFR §412.106? In column 1, enter 'Y' for yes or 'N' for no. Is this facility subject to 42 CFR §412.06(c)(2)(Pickle amendment hospital)? In column 2, enter 'Y' for yes or 'N' for no.	Y	N	22
22.01	Did this hospital receive interim uncompensated care payments for this cost reporting period? Enter in column 1, 'Y' for yes or 'N' for no for the portion of the cost reporting period occurring prior to October 1. Enter in column 2 'Y' for yes or 'N' for no for the portion of the cost reporting period occurring on or after October 1. (see instructions)	N	Y	22.01
22.02	Is this a newly merged hospital that requires final uncompensated care payments to be determined at cost report settlement? (see instructions) Enter in column 1, 'Y' for yes or 'N' for no, for the portion of the cost reporting period prior to October 1. Enter in column 2, 'Y' for yes or 'N' for no, for the portion of the cost reporting period on or after October 1.	N	N	22.02
22.03	Did this hospital receive a geographic reclassification from urban to rural as a result of the OMB standards for delineating statistical areas adopted by CMS in FY2015? Enter in column 1, 'Y' for yes or 'N' for no for the portion of the cost reporting period prior to October 1. Enter in column 2, 'Y' for yes or 'N' for no for the portion of the cost reporting period occurring on or after October 1. (see instructions) Does this hospital contain at least 100 but not more than 499 beds (as counted in accordance with 42 CFR 412.105)? Enter in column 3, 'Y' for yes or 'N' for no.	N	N	N
23	Which method is used to determine Medicaid days on lines 24 and/or 25 below? In column 1, enter 1 if date of admission, 2 if census days, or 3 if date of discharge. Is the method of identifying the days in this cost reporting period different from the method used in the prior cost reporting period? In column 2, enter 'Y' for yes or 'N' for no.	3	N	23

	In-State Medicaid paid days	In-State Medicaid eligible unpaid days	Out-of-State Medicaid paid days	Out-of-State Medicaid eligible unpaid days	Medicaid HMO days	Other Medicaid days	
	1	2	3	4	5	6	
24	If this provider is an IPPS hospital, enter the in-state Medicaid paid days in column 1, in-state Medicaid eligible unpaid days in column 2, out-of-state Medicaid paid days in column 3, out-of-state Medicaid eligible unpaid days in column 4, Medicaid HMO paid and eligible but unpaid days in column 5, and other Medicaid days in column 6.	362			29		43
25	If this provider is an IRF, enter the in-state Medicaid paid days in column 1, in-state Medicaid eligible unpaid days in column 2, out-of-state Medicaid days in column 3, out-of-state Medicaid eligible unpaid days in column 4, Medicaid HMO paid and eligible but unpaid days in column 5.						25

26	Enter your standard geographic classification (not wage) status at the beginning of the cost reporting period. Enter '1' for urban and '2' for rural.	2		26
27	Enter your standard geographic classification (not wage) status at the end of the cost reporting period. Enter in column 1, '1' for urban or '2' for rural. If applicable, enter the effective date of the geographic reclassification in column 2.	2		27
35	If this is a sole community hospital (SCH), enter the number of periods SCH status is 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 / 2014	Ending: 09 / 30 / 2015	36
37	If this is a Medicare dependent hospital (MDH), enter the number of periods MDH status is in effect in the cost reporting period.			37
38	If line 37 is 1, enter the beginning and ending dates of MDH status. If line 37 is greater than 1, subscript this line for the number of periods in excess of one and enter subsequent dates.	Beginning:	Ending:	38

IROQUOIS MEMORIAL HOSPITAL Provider CCN: 14-0167	In Lieu of Form CMS-2552-10	Period : From: 10/01/2014 To: 09/30/2015	Run Date: 02/24/2016 Run Time: 16:14 Version: 2015.10 (12/18/2015)
---	--------------------------------	--	--

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA

WORKSHEET S-2  
PART I

		V	XVIII	XIX	
39	Does this facility qualify for the inpatient hospital payment adjustment for low volume hospitals in accordance with 42 CFR §412.101(b)(2)(ii)? Enter in column 1 'Y' for yes or 'N' for no. Does the facility meet the mileage requirements in accordance with 42 CFR 412.101(b)(2)(ii)? Enter in column 2 'Y' for yes or 'N' for no. (see instructions)	Y	Y	39	
40	Is this hospital subject to the HAC program reduction adjustment? Enter 'Y' for yes or 'N' for no in column 1, for discharges prior to October 1. Enter 'Y' for yes or 'N' for no in column 2, for discharges on or after October 1. (see instructions)	N	N	40	
45	Does this facility qualify and receive capital payment for disproportionate share in accordance with 42 CFR §412.320?	N	N	45	
46	Is this facility eligible for additional payment exception for extraordinary circumstances pursuant to 42 CFR §412.348(f)? If yes, complete Wkst. L, Pt. III and Wkst. L-1, Pt. I through Pt. III.	N	N	46	
47	Is this a new hospital under 42 CFR §412.300 PPS capital? Enter 'Y' for yes or 'N' for no.	N	N	47	
48	Is the facility electing full federal capital payment? Enter 'Y' for yes or 'N' for no.	N	N	48	

Teaching Hospitals		1	2	3	
56	Is this a hospital involved in training residents in approved GME programs? Enter 'Y' for yes or 'N' for no.	N			56
57	If line 56 is yes, is this the first cost reporting period during which residents in approved GME programs trained at this facility? Enter 'Y' for yes or 'N' for no in column 1. If column 1 is 'Y' did residents start training in the first month of this cost reporting period? Enter 'Y' for yes or 'N' for no in column 2. If column 2 is 'Y', complete Wkst. E-4. If column 2 is 'N', complete Wkst. D, Part III & IV and D-2, Pt. II, if applicable.	N			57
58	If line 56 is yes, did this facility elect cost reimbursement for physicians' services as defined in CMS Pub 15-1, chapter 21, section 2148? If yes, complete Wkst. D-5.	N			58
59	Are costs claimed on line 100 of Worksheet A? If yes, complete Wkst. D-2, Pt. I.	N			59
60	Are you claiming nursing school and/or allied health costs for a program that meets the provider-operated criteria under §413.85? Enter 'Y' for yes or 'N' for no. (see instructions)	N			60
		Y/N	IME	Direct GME	
61	Did your hospital receive FTE slots under ACA section 5503? Enter 'Y' for yes or 'N' for no in column 1.(see instructions)	N			61
61.01	Enter the average number of unweighted primary care FTEs from the hospital's 3 most recent cost reports ending and submitted before March 23, 2010. (see instructions)				61.01
61.02	Enter the current year total unweighted primary care FTE count (excluding OB/GYN, general surgery FTEs, and primary care FTEs added under section 5503 of ACA). (see instructions)				61.02
61.03	Enter the baseline FTE count for primary care and/or general surgery residents, which is used for determining compliance with the 75% test. (see instructions)				61.03
61.04	Enter the number of unweighted primary care/or surgery allopathic and/or osteopathic FTEs in the current cost reporting period. (see instructions)				61.04
61.05	Enter the difference between the baseline primary and/or general surgery FTEs and the current year's primary care and/or general surgery FTE counts (line 61.04 minus line 61.03). (see instructions)				61.05
61.06	Enter the amount of ACA §5503 award that is being used for cap relief and/or FTEs that are nonprimary care or general surgery. (see instructions)				61.06

Of the FTEs in line 61.05, specify each new program specialty, if any, and the number of FTE residents for each new program (see instructions). Enter in column 1 the program name, enter in column 2 the program code, enter in column 3 the IME FTE unweighted count and enter in column 4 direct GME FTE unweighted count.

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

Of the FTEs in line 61.05, specify each expanded program specialty, if any, and the number of FTE residents for each expanded program (see instructions). Enter in column 1 the program name, enter in column 2 the program code, enter in column 3 the IME FTE unweighted count and enter in column 4 direct GME FTE unweighted count.

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

62	Enter the number of FTE residents that your hospital trained in this cost reporting period for which your hospital 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 Nonprovider Settings

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

IROQUOIS MEMORIAL HOSPITAL Provider CCN: 14-0167	In Lieu of Form CMS-2552-10	Period : From: 10/01/2014 To: 09/30/2015	Run Date: 02/24/2016 Run Time: 16:14 Version: 2015.10 (12/18/2015)
---	--------------------------------	--	--

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA

WORKSHEET S-2  
PART I

Section 5504 of the ACA Base Year FTE Residents in Nonprovider Settings--This base year is your cost reporting period that begins on or after July 1, 2009 and before June 30, 2010.				Unweighted FTEs Nonprovider Site	Unweighted FTEs in Hospital	Ratio (col. 1/ col. 1 + col. 2))	
64	Enter in column 1, if line 63 is yes, or your facility trained residents in the base year period, the number of unweighted non-primary care resident FTEs attributable to rotations occurring in all nonprovider settings. Enter in column 2 the number of unweighted non-primary care resident FTEs that trained in your hospital. Enter in 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. 3/ col. 3 + col. 4))	
	1	2		3	4	5	
65							65
Section 5504 of the ACA Current Year FTE Residents in Nonprovider Settings--Effective for cost reporting periods beginning on or after July 1, 2010				Unweighted FTEs Nonprovider Site	Unweighted FTEs in Hospital	Ratio (col. 1/ col. 1 + col. 2))	
66	Enter in column 1, the number of unweighted non-primary care resident FTEs attributable to rotations occurring in all nonprovider settings. Enter in column 2 the number of unweighted non-primary care resident FTEs that trained in your hospital. Enter in column 3 the ratio of (column 1 divided by (column 1 + column 2)). (see instructions)						66
Enter in lines 67-67.49, column 1 the program name. Enter in column 2 the program code. Enter in column 3 the number of unweighted primary care FTE residents attributable to rotations occurring in all non-provider settings. Enter in column 4 the number of unweighted primary care resident FTEs that trained in your hospital. Enter in column 5 the ratio of (column 3 divided by (column 3 ÷ column 4)). (see instructions)							
	Program Name	Program Code		Unweighted FTEs Nonprovider Site	Unweighted FTEs in Hospital	Ratio (col. 3/ col. 3 + col. 4))	
	1	2		3	4	5	
67							67
<b>Inpatient Psychiatric Facility PPS</b>				1	2	3	
70	Is this facility an Inpatient Psychiatric Facility (IPF), or does it contain an IPF subprovider? Enter 'Y' for yes or 'N' for no.			N			70
71	If line 70 yes: Column 1: Did the facility have a teaching program in the most recent cost report filed on or before November 15, 2004? Enter 'Y' for yes or 'N' for no. Column 2: Did this facility train residents in a new teaching program in accordance with 42 CFR §412.424(d)(1)(iii)(D)? Enter 'Y' for yes and 'N' for no. Column 3: If column 2 is Y, indicate which program year began during this cost reporting period. (see instructions)						71
<b>Inpatient Rehabilitation Facility PPS</b>				1	2	3	
75	Is this facility an Inpatient Rehabilitation Facility (IRF), or does it contain an IRF subprovider? Enter 'Y' for yes or 'N' for no.			N			75
76	If line 75 yes: Column 1: Did the facility have a teaching program in the most recent cost reporting period ending on or before November 15, 2004? Enter 'Y' for yes or 'N' for no. Column 2: Did this facility train residents in a new teaching program in accordance with 42 CFR §412.424(d)(1)(iii)(D)? Enter 'Y' for yes and 'N' for no. Column 3: If column 2 is Y, indicate which program year began during this cost reporting period. (see instructions)						76
<b>Long Term Care Hospital PPS</b>					N		80
80	Is this a Long Term Care Hospital (LTCH)? Enter 'Y' for yes or 'N' for no.				N		80
81	Is this a LTCH co-located within another hospital for part or all of the cost reporting period? Enter 'Y' for yes and 'N' for no.				N		81
<b>TEFRA Providers</b>					N		85
85	Is this a new hospital under 42 CFR §413.40(f)(1)(i) TEFRA?. Enter 'Y' for yes or 'N' for no.				N		85
86	Did this facility establish a new Other subprovider (excluded unit) under 42 CFR §413.40(f)(1)(ii)? Enter 'Y' for yes, or 'N' for no.						86
87	Is this hospital a 'subclause (II)' LTCH classified under section 1886(d)(1)(B)(iv)(II)? Enter 'Y' for yes and 'N' for no.				N		87

IROQUOIS MEMORIAL HOSPITAL Provider CCN: 14-0167	In Lieu of Form CMS-2552-10	Period : From: 10/01/2014 To: 09/30/2015	Run Date: 02/24/2016 Run Time: 16:14 Version: 2015.10 (12/18/2015)
---	--------------------------------	--	--

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA

WORKSHEET S-2  
PART I

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

Rural Providers

		1	2		
105	Does this hospital qualify as a critical access hospital (CAH)?	N		105	
106	If this facility qualifies as a CAH, has it elected the all-inclusive method of payment for outpatient services? (see instructions)			106	
107	If this facility qualifies as a CAH, is it eligible for cost reimbursement for I&R training programs? Enter 'Y' for yes and 'N' for no in column 1. (see instructions) If yes, the GME elimination is not made on Wkst. B, Pt. I, col. 25 and the program is cost reimbursed. If yes, complete Wkst. D-2, Pt. II.			107	
108	Is this a rural hospital qualifying for an exception to the CRNA fee schedule? See 42 CFR §412.113(c). Enter 'Y' for yes or 'N' for no.	N		108	
		Physical	Occupational	Speech	Respiratory
109	If this hospital qualifies as a CAH or a cost provider, are therapy services provided by outside supplier? Enter 'Y' for yes or 'N' for each therapy.		N	N	N
110	Did this hospital participate in the Rural Community Hospital Demonstration project (410A Demo) for the current cost reporting period? Enter 'Y' for yes or 'N' for no.			N	110

Miscellaneous Cost Reporting Information

115	Is this an all-inclusive rate provider? Enter 'Y' for yes or 'N' for no in column 1. If column 1 is yes, enter the method used (A, B, or E only) in column 2. If column 2 is 'E', enter in column 3 either '93' percent for short term hospital or '98' percent for long term care (includes psychiatric, rehabilitation and long term hospitals providers) based on the definition in CMS Pub. 15-I, chapter 22, section 2208.1.	N			115
116	Is this facility classified as a referral center? Enter 'Y' for yes or 'N' for no.	N			116
117	Is this facility legally required to carry malpractice insurance? Enter 'Y' for yes or 'N' for no.	N			117
118	Is the malpractice insurance a claims-made or occurrence policy? Enter 1 if the policy is claim-made. Enter 2 if the policy is occurrence.	1			118
		Premiums	Paid Losses	Self Insurance	
118.01	List amounts of malpractice premiums and paid losses:	476,722			118.01
118.02	Are malpractice premiums and paid losses reported in a cost center other than the Administrative and General cost center? If yes, submit supporting schedule listing cost centers and amounts contained therein.	N			118.02
120	Is this a SCH or EACH that qualifies for the Outpatient Hold Harmless provision in ACA §3121 and applicable amendments? (see instructions). Enter in column 1 'Y' for yes or 'N' for no. Is this a rural hospital with < 100 beds that qualifies for the Outpatient Hold Harmless provision in ACA §3121 and applicable amendments? (see instructions). Enter in column 2 'Y' for yes or 'N' for no.	Y		N	120
121	Did this facility incur and report costs for high cost implantable devices charged to patients? Enter 'Y' for yes or 'N' for no.	Y			121

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

IROQUOIS MEMORIAL HOSPITAL Provider CCN: 14-0167	In Lieu of Form CMS-2552-10	Period : From: 10/01/2014 To: 09/30/2015	Run Date: 02/24/2016 Run Time: 16:14 Version: 2015.10 (12/18/2015)
---	--------------------------------	--	--

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA

WORKSHEET S-2  
PART I

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 (see instructions)	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 Wkst. A, line 74 are the costs for inpatient services only? Enter 'Y' for yes, or 'N' for no in column 1. If column 1 is no, does the dialysis facility include Medicare utilization for this cost reporting period? Enter 'Y' for yes or 'N' for no in column 2.	N	N	145
146	Has the cost allocation methodology changed from the previously filed cost report? Enter 'Y' for yes and 'N' for no in column 1. (see CMS Pub. 15-2, chapter 40, §4020). If yes, enter the approval date (mm/dd/yyyy) in column 2.	N		146
147	Was there a change in the statistical basis? Enter 'Y' for yes or 'N' for no.	N		147
148	Was there a change in the order of allocation? Enter 'Y' for yes or 'N' for no.	N		148
149	Was there a change to the simplified cost finding method? Enter 'Y' for yes or 'N' for no.	N		149

Does this facility contain a provider that qualifies for an exemption from the application of the lower of costs or charges? Enter 'Y' for yes or 'N' for no for each component for Part A and Part B. See 42 CFR §413.13)

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

Multicampus

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

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

167	Is this provider a meaningful user under §1886(n)? Enter 'Y' for yes or 'N' for no.	Y		167
168	If this provider is a CAH (line 105 is 'Y') and is a meaningful user (line 167 is 'Y'), enter the reasonable cost incurred for the HIT assets. (see instructions)			168
168.01	If this provider is a CAH and is not a meaningful user, does this provider qualify for a hardship exception under §413.70(a)(6)(ii)? Enter 'Y' for yes or 'N' for no. (see instructions)			168.01
169	If this provider is a meaningful user (line 167 is 'Y') and is not a CAH (line 105 is 'N'), enter the transitional factor. (see instructions)	0.25		169
170	Enter in columns 1 and 2 the EHR beginning date and ending date for the reporting period respectively (mm/dd/yyyy)	10 / 01 / 2013	09 / 30 / 2015	170
171	If line 167 is 'Y', does this provider have any days for individuals enrolled in section 1876 Medicare cost plans reported on Wkst. S-3, Pt. I, line 2, col. 6? Enter 'Y' for yes and 'N' for no. (see instructions)		N	171

IROQUOIS MEMORIAL HOSPITAL Provider CCN: 14-0167	In Lieu of Form CMS-2552-10	Period : From: 10/01/2014 To: 09/30/2015	Run Date: 02/24/2016 Run Time: 16:14 Version: 2015.10 (12/18/2015)
---	--------------------------------	--	--

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX REIMBURSEMENT QUESTIONNAIRE

WORKSHEET S-2  
PART II

General Instruction: Enter Y for all YES responses. Enter N for all NO responses.  
Enter all dates in the mm/dd/yyyy format.

COMPLETED BY ALL HOSPITALS

Provider Organization and Operation		Y/N	Date		
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	2		1
		N			
		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	2	3	2
		N			
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)				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	2	3	4
		Y	A		
5	Are the cost report total expenses and total revenues different from those in the filed financial statements? If yes, submit reconciliation.				5
		N			

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	2	6
		N		
7	Are costs claimed for allied health programs? If yes, see instructions.			7
		N		
8	Were nursing school and/or allied health programs approved and/or renewed during the cost reporting period?			8
		N		
9	Are costs claimed for Interns and Residents in approved GME programs claimed on the current cost report? If yes, see instructions.			9
		N		
10	Was an approved Intern and Resident GME program initiated or renewed in the current cost reporting period? If yes, see instructions.			10
		N		
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.			11
		N		

Bad Debts		Y/N	
12	Is the provider seeking reimbursement for bad debts? If yes, see instructions.	1	2
		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.		13
		N	
14	If line 12 is yes, were patient deductibles and/or co-payments waived? If yes, see instructions.		14
		N	

Bed Complement		Y/N	
15	Did total beds available change from the prior cost reporting period? If yes, see instructions.	1	2
		N	15

		Part A		Part B	
PS&R Report Data		Y/N	Date	Y/N	Date
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	2	3	4
		Y	01/11/2016	Y	01/11/2016
17	Was the cost report prepared using the PS&R Report for totals and the provider's records for allocation? If either column 1 or 3 is yes, enter the paid-through date in columns 2 and 4. (see instructions)			N	
		N			17
18	If line 16 or 17 is yes, were adjustments made to PS&R Report data for additional claims that have been billed but are not included on the PS&R Report used to file the cost report? If yes, see instructions.			N	
		N			18
19	If line 16 or 17 is yes, were adjustments made to PS&R Report data for corrections of other PS&R Report information? If yes, see instructions.			N	
		N			19
20	If line 16 or 17 is yes, were adjustments made to PS&R Report data for Other? Describe the other adjustments:			N	
		N			20
21	Was the cost report prepared only using the provider's records? If yes, see instructions.			N	
		N			21

IROQUOIS MEMORIAL HOSPITAL Provider CCN: 14-0167	In Lieu of Form <b>CMS-2552-10</b>	Period : From: 10/01/2014 To: 09/30/2015	Run Date: 02/24/2016 Run Time: 16:14 Version: 2015.10 (12/18/2015)
---	---------------------------------------	--	--

**HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX REIMBURSEMENT QUESTIONNAIRE**

**WORKSHEET S-2  
PART II**

**General Instruction: Enter Y for all YES responses. Enter N for all NO responses.  
Enter all dates in the mm/dd/yyyy format.**

**COMPLETED BY COST REIMBURSED AND TEFRA HOSPITALS ONLY (EXCEPT CHILDRENS HOSPITALS)**

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

Interest Expense			
28	Were new loans, mortgage agreements or letters of credit entered into during the cost reporting period? If yes, see instructions.		28
29	Did the provider have a funded depreciation account and/or bond funds (Debt Service Reserve Fund) treated as a funded depreciation account? If yes, see instructions.		29
30	Has existing debt been replaced prior to its scheduled maturity with new debt? If yes, see instructions.		30
31	Has debt been recalled before scheduled maturity without issuance of new debt? If yes, see instructions.		31

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

Provider-Based Physicians			
34	Are services furnished at the provider facility under an arrangement with provider-based physicians? If yes, see instructions.		34
35	If line 34 is yes, were there new agreements or amended existing agreements with the provider-based physicians during the cost reporting period? If yes, see instructions.		35

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

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

IROQUOIS MEMORIAL HOSPITAL Provider CCN: 14-0167	In Lieu of Form CMS-2552-10	Period : From: 10/01/2014 To: 09/30/2015	Run Date: 02/24/2016 Run Time: 16:14 Version: 2015.10 (12/18/2015)
---	--------------------------------	--	--

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA

WORKSHEET S-3  
PART I

	Component	Wkst A Line No.	No. of Beds	Bed Days Available	CAH Hours	Inpatient Days / Outpatient Visits / Trips			Total All Patients	
						Title V	Title XVIII	Title XIX		
		1	2	3	4	5	6	7	8	
1	Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days) (see instructions for col. 2 for the portion of LDP room available beds)	30	25	9,125			1,387	342	2,154	1
2	HMO and other (see instructions)						50	72		2
3	HMO IPF Subprovider									3
4	HMO IRF Subprovider									4
5	Hospital Adults & Peds. Swing Bed SNF									5
6	Hospital Adults & Peds. Swing Bed NF									6
7	Total Adults & Peds. (exclude observation beds) (see instructions)		25	9,125			1,387	342	2,154	7
8	Intensive Care Unit	31								8
9	Coronary Care Unit	32								9
10	Burn Intensive Care Unit	33								10
11	Surgical Intensive Care Unit	34								11
12	Other Special Care (specify)	35								12
13	Nursery	43							125	13
14	Total (see instructions)		25	9,125			1,387	342	2,279	14
15	CAH Visits									15
16	Subprovider - IPF	40								16
17	Subprovider - IRF	41								17
18	Subprovider I	42								18
19	Skilled Nursing Facility	44	35	12,775			1,046		11,920	19
20	Nursing Facility	45								20
21	Other Long Term Care	46								21
22	Home Health Agency	101					3,766		5,438	22
23	ASC (Distinct Part)	115								23
24	Hospice (Distinct Part)	116	1	365					1	24
24.10	Hospice (non-distinct part)	30								24.10
25	CMHC	99								25
26	RHC	88					2,165		5,660	26
26.01	RHC II	88.01					1,453		3,202	26.01
26.02	RHC III	88.02					3,650		8,937	26.02
27	Total (sum of lines 14-26)		61							27
28	Observation Bed Days							104	923	28
29	Ambulance Trips						1,348			29
30	Employee discount days (see instructions)									30
31	Employee discount days-IRF									31
32	Labor & delivery (see instructions)							20	30	32
32.01	Total ancillary labor & delivery room outpatient days (see instructions)									32.01
33	LTCH non-covered days									33

IROQUOIS MEMORIAL HOSPITAL Provider CCN: 14-0167	In Lieu of Form CMS-2552-10	Period : From: 10/01/2014 To: 09/30/2015	Run Date: 02/24/2016 Run Time: 16:14 Version: 2015.10 (12/18/2015)
---	--------------------------------	--	--

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA

WORKSHEET S-3  
PART I

	Component	Full Time Equivalents			DISCHARGES				
		Total Interns & Residents	Employees On Payroll	Nonpaid Workers	Title V	Title XVIII	Title XIX	Total All Patients	
		9	10	11	12	13	14	15	
1	Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days) (see instructions for col. 2 for the portion of LDP room available beds)					454	126	798	1
2	HMO and other (see instructions)					17			2
3	HMO IPF Subprovider								3
4	HMO IRF Subprovider								4
5	Hospital Adults & Peds. Swing Bed SNF								5
6	Hospital Adults & Peds. Swing Bed NF								6
7	Total Adults & Peds. (exclude observation beds) (see instructions)								7
8	Intensive Care Unit								8
9	Coronary Care Unit								9
10	Burn Intensive Care Unit								10
11	Surgical Intensive Care Unit								11
12	Other Special Care (specify)								12
13	Nursery								13
14	Total (see instructions)		302.88			454	126	798	14
15	CAH Visits								15
16	Subprovider - IPF								16
17	Subprovider - IRF								17
18	Subprovider I								18
19	Skilled Nursing Facility		28.01						19
20	Nursing Facility								20
21	Other Long Term Care								21
22	Home Health Agency		9.39						22
23	ASC (Distinct Part)								23
24	Hospice (Distinct Part)		16.08						24
24.10	Hospice (non-distinct part)								24.10
25	CMHC								25
26	RHC		7.38						26
26.01	RHC II		4.46						26.01
26.02	RHC III		10.73						26.02
27	Total (sum of lines 14-26)		378.93						27
32.01	Total ancillary labor & delivery room outpatient days (see instructions)								32

IROQUOIS MEMORIAL HOSPITAL Provider CCN: 14-0167	In Lieu of Form CMS-2552-10	Period : From: 10/01/2014 To: 09/30/2015	Run Date: 02/24/2016 Run Time: 16:14 Version: 2015.10 (12/18/2015)
---	--------------------------------	--	--

HOSPITAL WAGE INDEX INFORMATION

WORKSHEET S-3  
PARTS II-III

Part II - Wage Data

	Wkst A Line No.	Amount Reported	Reclassif- ication of Salaries (from Worksheet A-6)	Adjusted Salaries (column 2 ± column 3)	Paid Hours Related to Salaries in Column 4	Average Hourly wage (column 4 ± column 5)	
	1	2	3	4	5	6	
<b>SALARIES</b>							
1	200	17,977,215		17,977,215	736,300.00	24.42	1
2							2
3							3
4							4
4.01							4.01
5		1,003,259		1,003,259	8,289.00	121.03	5
6		470,663		470,663	40,967.00	11.49	6
7	21						7
7.01							7.01
8							8
9	44	964,245		964,245	58,265.00	16.55	9
10		4,086,375		4,086,375	146,312.00	27.93	10
<b>OTHER WAGES &amp; RELATED COSTS</b>							
11		211,232		211,232	3,243.00	65.13	11
12							12
13							13
14							14
15							15
16							16
<b>WAGE-RELATED COSTS</b>							
17		2,525,402		2,525,402			17
18							18
19		1,084,400		1,084,400			19
20							20
21							21
22							22
22.01							22.01
23		99,691		99,691			23
24		179,403		179,403			24
25							25
<b>OVERHEAD COSTS - DIRECT SALARIES</b>							
26		121,118		121,118	5,046.00	24.00	26
27		1,917,249		1,917,249	88,602.00	21.64	27
28		108,337		108,337	918.00	118.01	28
29							29
30		251,569		251,569	14,979.00	16.79	30
31		41,450		41,450	3,649.00	11.36	31
32		296,208		296,208	28,340.00	10.45	32
33							33
34		354,757	-160,629	194,128	17,271.00	11.24	34
35		2,217		2,217	35.00	63.34	35
36			160,629	160,629	14,290.00	11.24	36
37							37
38		396,857		396,857	10,530.00	37.69	38
39							39
40							40
41		516,167		516,167	24,926.00	20.71	41
42							42
43							43

Part III - Hospital Wage Index Summary

1	Net salaries (see instructions)	16,613,847		16,613,847	687,997.00	24.15	1
2	Excluded area salaries (see instructions)	5,050,620		5,050,620	204,577.00	24.69	2
3	Subtotal salaries (line 1 minus line 2)	11,563,227		11,563,227	483,420.00	23.92	3
4	Subtotal other wages & related costs (see instructions)	211,232		211,232	3,243.00	65.13	4
5	Subtotal wage-related costs (see instructions)	2,525,402		2,525,402		21.84%	5
6	Total (sum of lines 3 through 5)	14,299,861		14,299,861	486,663.00	29.38	6
7	Total overhead cost (see instructions)	4,005,929		4,005,929	208,586.00	19.21	7

IROQUOIS MEMORIAL HOSPITAL Provider CCN: 14-0167	In Lieu of Form <b>CMS-2552-10</b>	Period : From: 10/01/2014 To: 09/30/2015	Run Date: 02/24/2016 Run Time: 16:14 Version: 2015.10 (12/18/2015)
---	---------------------------------------	--	--

**HOSPITAL WAGE RELATED COSTS**

**WORKSHEET S-3  
PART IV**

**Part IV - Wage Related Cost**

**Part A - Core List**

		Amount Reported	
	<b>RETIREMENT COST</b>		
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
	<b>PLAN ADMINISTRATIVE COSTS (Paid to External Organization):</b>		
5	401k/TSA Plan Administration Fees	13,598	5
6	Legal/Accounting/Management Fees-Pension Plan		6
7	Employee Managed Care Program Administration Fees		7
	<b>HEALTH AND INSURANCE COST</b>		
8	Health Insurance (Purchased or Self Funded)	2,512,481	8
9	Prescription Drug Plan		9
10	Dental, Hearing and Vision Plan		10
11	Life Insurance (If employee is owner or beneficiary)		11
12	Accident Insurance (If employee is owner or beneficiary)		12
13	Disability Insurance (If employee is owner or beneficiary)		13
14	Long-Term Care Insurance (If employee is owner or beneficiary)		14
15	Workers' Compensation Insurance	101,833	15
16	Retirement Health Care Cost (Only current year, not the extraordinary accrual required by FASB 106. Non cumulative portion)		16
	<b>TAXES</b>		
17	FICA-Employers Portion Only	1,006,136	17
18	Medicare Taxes - Employers Portion Only	235,306	18
19	Unemployment Insurance	8,022	19
20	State or Federal Unemployment Taxes		20
	<b>OTHER</b>		
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	11,520	23
24	Total Wage Related cost (Sum of lines 1-23)	3,888,896	24

**Part B - Other Than Core Related Cost**

25	OTHER WAGE RELATED COSTs (SPECIFY)		25
----	------------------------------------	--	----

IROQUOIS MEMORIAL HOSPITAL Provider CCN: 14-0167	Supporting Exhibit for Form <b>CMS-2552-10</b>	Period : From: 10/01/2014 To: 09/30/2015	Run Date: 02/24/2016 Run Time: 16:14 Version: 2015.10 (12/18/2015)
---	---	--	--

WAGE INDEX PENSION COST SCHEDULE (For Worksheet S-3, Part IV, Line 4)

EXHIBIT 3

<b>STEP 1: DETERMINE THE 3-YEAR AVERAGING PERIOD</b>			
1	Wage Index Fiscal Year Ending Date		1
2	Provider's Cost Reporting Period Used for Wage Index Year on Line 1 (FYB in Col. 1, FYE in Col. 2)		2
3	Midpoint of Provider's Cost Reporting Period Shown on Line 2, Adjusted to First of Month		3
4	Date Beginning the 3-Year Averaging Period (subtract 18 months from midpoint shown on Line 3)		4
5	Date Ending the 3-Year Averaging Period (add 18 months to midpoint shown on Line 3)		5
<b>STEP 2 (OPTIONAL): ADJUST AVERAGING PERIOD FOR A NEW PLAN (see instructions)</b>			
6	Effective Date of Pension Plan		6
7	First Day of the Provider Cost Reporting Period Containing the Pension Plan Effective Date		7
8	Starting Date of the Adjusted Averaging Period (date on Line 7, adjusted to first of month)		8

IF THIS DATE OCCURS AFTER THE PERIOD SHOWN ON LINE 2, STOP HERE AND SEE INSTRUCTIONS

<b>STEP 3: AVERAGE PENSION CONTRIBUTIONS DURING THE AVERAGING PERIOD</b>			
9	Beginning Date of Averaging Period from Line 4 or Line 8, as Applicable		9
10	Ending Date of Averaging Period from Line 5		10
11	Enter Provider Contributions Made During Averaging Period on Lines 9 & 10	<b>DEPOSIT DATE(S)</b>	<b>CONTRIBUTION(S)</b> 11
12	Total Calendar Months Included in Averaging Period (36 unless Step 2 completed)		12
13	Total Contributions Made During Averaging Period		13
14	Average Monthly Contribution (Line 13 divided by Line 12)		14
15	Number of MOonths in Provider Cost Reporting Period on Line 2		15
16	Average Pension Contributions (Line 14 times Line 15)		16
<b>STEP 4: TOTAL PENSION COST FOR WAGE INDEX</b>			
17	Annual Prefunding Installment (see instructions)		17
18	Reportable Prefunding Installment ((Line 17 times Line 15) divided by 12)		18
19	Total Pension Cost for Wage Index (Line 16 plus Line 18 - transfers to S-3 Part IV Line 4)		19

IROQUOIS MEMORIAL HOSPITAL Provider CCN: 14-0167	In Lieu of Form <b>CMS-2552-10</b>	Period : From: 10/01/2014 To: 09/30/2015	Run Date: 02/24/2016 Run Time: 16:14 Version: 2015.10 (12/18/2015)
---	---------------------------------------	--	--

**HOSPITAL CONTRACT LABOR AND BENEFIT COST**

**WORKSHEET S-3  
PART V**

**Part V - Contract Labor and Benefit Cost**

**Hospital and Hospital-Based Component Identification:**

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

IROQUOIS MEMORIAL HOSPITAL Provider CCN: 14-0167	In Lieu of Form CMS-2552-10	Period : From: 10/01/2014 To: 09/30/2015	Run Date: 02/24/2016 Run Time: 16:14 Version: 2015.10 (12/18/2015)
---	--------------------------------	--	--

HOSPITAL-BASED HOME HEALTH AGENCY STATISTICAL DATA

HHA CCN: 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		2,704			2,704	1
2	Unduplicated Census Count (see instructions)		205.00	11.00	36.00	252.00	2

HOME HEALTH AGENCY - NUMBER OF EMPLOYEES

	Enter the number of hours in your normal work week 40.00	Number of Employees (Full Time Equivalent)			
		Staff	Contract	Total	
		1	2	3	
3	Administrator and Assistant Administrator(s)	0.60		0.60	3
4	Director(s) and Assistant Director(s)				4
5	Other Administrative Personnel	0.90		0.90	5
6	Direct Nursing Service	4.40		4.40	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 the number of CBSAs where you provided services during the cost reporting period.		3	19
20	List those CBSA code(s) serviced during this cost reporting period (line 20 contains the first code).		99914	20
20.01			16580	20.01
20.02			19180	20.02

PPS ACTIVITY

		Full Episodes		LUPA Episodes	PEP only Episodes	Total (columns 1 through 4)	
		Without Outliers	With Outliers				
		1	2				
21	Skilled Nursing Visits	1,553	199	33	9	1,794	21
22	Skilled Nursing Visit Charges	240,918	30,970	5,161	1,393	278,442	22
23	Physical Therapy Visits	1,168	30	5	4	1,207	23
24	Physical Therapy Visit Charges	182,046	4,677	780	627	188,130	24
25	Occupational Therapy Visits	241	17	1		259	25
26	Occupational Therapy Visit Charges	37,282	2,643	157		40,082	26
27	Speech Pathology Visits	79	12			91	27
28	Speech Pathology Visit Charges	12,247	1,873			14,120	28
29	Medical Social Service Visits	8				8	29
30	Medical Social Service Visit Charges	1,540				1,540	30
31	Home Health Aide Visits	717		1	1	719	31
32	Home Health Aide Visit Charges	69,103		97	97	69,297	32
33	Total visits (sum of lines 21, 23, 25, 27, 29, and 31)	3,766	258	40	14	4,078	33
34	Other Charges						34
35	Total Charges (sum of lines 22, 24, 26, 28, 30, 32 and 34)	543,136	40,163	6,195	2,117	591,611	35
36	Total Number of Episodes (standard/non-outlier)	206		13	2	221	36
37	Total Number of Outlier Episodes						37
38	Total Non-Routine Medical Supply Charges	1,557			11	1,568	38

IROQUOIS MEMORIAL HOSPITAL Provider CCN: 14-0167	In Lieu of Form CMS-2552-10	Period : From: 10/01/2014 To: 09/30/2015	Run Date: 02/24/2016 Run Time: 16:14 Version: 2015.10 (12/18/2015)
---	--------------------------------	--	--

HOSPITAL RENAL DIALYSIS DEPARTMENT STATISTICAL DATA

WORKSHEET S-5

RENAL DIALYSIS STATISTICS

	DESCRIPTION	Outpatient		Training		Home		
		Regular	High Flux	Hemo-dialysis	CAPD CCPD	Hemo-dialysis	CAPD CCPD	
		1	2	3	4	5	6	
1	Number of patients in program at end of cost reporting period							1
2	Number of times per week patient receives dialysis							2
3	Average patient dialysis time including setup							3
4	CAPD exchanges per day							4
5	Number of days in year dialysis furnished							5
6	Number of stations							6
7	Treatment capacity per day per station							7
8	Utilization (see instructions)							8
9	Average times dialyzers re-used							9
10	Percentage of patients re-using dialyzers							10

ESRD PPS

		1	2	
10.01	Is the dialysis facility approved as a low-volume facility for this cost reporting period? Enter 'Y' for yes or 'N' for no. (see instructions)			10.01
10.02	Did your facility elect 100% PPS effective January 1, 2011? Enter 'Y' for yes or 'N' for no. (see instructions for 'new' providers)			10.02
10.03	If you responded 'N' to line 10.02, enter in column 1 the year of transition for periods prior to January 1 and enter in column 2 the year of transition for periods after December 31. (see instructions)		4	10.03

TRANSPLANT INFORMATION

11	Number of patients on transplant list		11
12	Number of patients transplanted during the cost reporting period		12

EPOETIN

13	Net costs of Epoetin furnished to all maintenance dialysis patients by the provider		13
14	Epoetin amount from Worksheet A for home dialysis program		14
15	Number of EPO units furnished relating to the renal dialysis department		15
16	Number of EPO units furnished relating to the home dialysis department		16

ARANESP

17	Net costs of ARANESP furnished to all maintenance dialysis patients by the provider		17
18	ARANESP amount from Worksheet A for home dialysis program		18
19	Number of ARANESP units furnished relating to the renal dialysis department		19
20	Number of ARANESP units furnished relating to the home dialysis department		20

PHYSICIAN PAYMENT METHOD (Enter 'X' for applicable method(s))

21	MCP	INITIAL METHOD	
----	-----	----------------	--

Erythropoiesis-Stimulating Agents (ESA) Statistics:		ESA Description	Net Cost of ESAs for Renal Patients	Net Cost of ESAs for Home Patients	Number of ESA Units - Renal Dialysis Dept.	Number of ESA Units - Home Dialysis Dept.	
		1	2	3	4	5	
22	Enter in column 1 the ESA description. Enter in column 2 the net costs of ESAs furnished to all renal dialysis patients. Enter in column 3 the net cost of ESAs furnished to all home dialysis program patients. Enter in column 4 the number of ESA units furnished to patients in the renal dialysis department. Enter in column 5 the number of units furnished to patients in the home dialysis program. (see instructions)						22

IROQUOIS MEMORIAL HOSPITAL Provider CCN: 14-0167	In Lieu of Form CMS-2552-10	Period : From: 10/01/2014 To: 09/30/2015	Run Date: 02/24/2016 Run Time: 16:14 Version: 2015.10 (12/18/2015)
---	--------------------------------	--	--

PROSPECTIVE PAYMENT FOR SNF STATISTICAL DATA

WORKSHEET S-7

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

	Group	SNF Days	Swing Bed SNF Days	Total (sum of col. 2 + 3)	
	1	2	3	4	
3	RUX				3
4	RUL				4
5	RVX	28		28	5
6	RVL				6
7	RHX	14		14	7
8	RHL				8
9	RMX	14		14	9
10	RML				10
11	RLX				11
12	RUC				12
13	RUB				13
14	RUA				14
15	RVC	40		40	15
16	RVB	22		22	16
17	RVA	63		63	17
18	RHC	172		172	18
19	RHB	166		166	19
20	RHA	290		290	20
21	RMC	119		119	21
22	RMB	28		28	22
23	RMA	15		15	23
24	RLB				24
25	RLA				25
26	ES3				26
27	ES2				27
28	ES1	3		3	28
29	HE2				29
30	HE1	2		2	30
31	HD2				31
32	HD1				32
33	HC2				33
34	HC1				34
35	HB2				35
36	HB1				36
37	LE2				37
38	LE1				38
39	LD2				39
40	LD1				40
41	LC2				41
42	LC1	3		3	42
43	LB2				43
44	LB1	42		42	44
45	CE2				45
46	CE1	14		14	46
47	CD2				47
48	CD1				48
49	CC2				49
50	CC1				50
51	CB2				51
52	CB1				52
53	CA2	7		7	53
54	CA1				54
55	SE3				55
56	SE2				56
57	SE1				57
58	SSC				58
59	SSB				59
60	SSA				60
61	IB2				61
62	IB1				62
63	IA1				63
64	IA2				64
65	BB2				65
66	BB1				66
67	BA2				67
68	BA1				68
69	PE2				69
70	PE1				70
71	PD2				71

IROQUOIS MEMORIAL HOSPITAL Provider CCN: 14-0167	In Lieu of Form <b>CMS-2552-10</b>	Period : From: 10/01/2014 To: 09/30/2015	Run Date: 02/24/2016 Run Time: 16:14 Version: 2015.10 (12/18/2015)
---	---------------------------------------	--	--

**PROSPECTIVE PAYMENT FOR SNF STATISTICAL DATA**

**WORKSHEET S-7**

	Group	SNF Days	Swing Bed SNF Days	Total (sum of col. 2 + 3)	
	1	2	3	4	
72	PD1				72
73	PC2				73
74	PC1	2		2	74
75	PB2				75
76	PB1				76
77	PA2				77
78	PA1				78
199	AAA	2		2	199
200	TOTAL	1,046		1,046	200

**SNF SERVICES**

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

A notice published in the Federal Register Volume 68, No. 149 August 4, 2003 provided for an increase in the RUG payments beginning 10/01/2003. Congress expected this increase to be used for direct patient care and related expenses. For lines 202 through 207: Enter in column 1 the amount of the expense for each 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 with Direct Patient Care and Related Expenses?	
		1	2	3	
202	Staffing	964,245	43.07%	Y	202
203	Recruitment				203
204	Retention of employees				204
205	Training	1,429	0.06%	Y	205
206	Other (specify)				206
207	Total SNF Revenue (Worksheet G-2, Part I, line 7, column 3)	2,238,875			207





IROQUOIS MEMORIAL HOSPITAL Provider CCN: 14-0167	In Lieu of Form CMS-2552-10	Period : From: 10/01/2014 To: 09/30/2015	Run Date: 02/24/2016 Run Time: 16:14 Version: 2015.10 (12/18/2015)
---	--------------------------------	--	--

HOSPITAL-BASED RURAL HEALTH CLINIC/FEDERALLY QUALIFIED HEALTH CENTER  
STATISTICAL DATA

COMPONENT CCN: 15-3979

WORKSHEET S-8

Check applicable box: [XX] RHC [ ] FQHC

Clinic Address and Identification:

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

Source of Federal Funds:

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

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

Facility hours of operations (1)

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

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

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

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

IROQUOIS MEMORIAL HOSPITAL Provider CCN: 14-0167	In Lieu of Form <b>CMS-2552-10</b>	Period : From: 10/01/2014 To: 09/30/2015	Run Date: 02/24/2016 Run Time: 16:14 Version: 2015.10 (12/18/2015)
---	---------------------------------------	--	--

**HOSPICE IDENTIFICATION DATA**

**HOSPICE CCN: 14-1616**

**WORKSHEET S-9  
PARTS I & II**

**PART I - ENROLLMENT DAYS**

		Unduplicated Days						
		Title XVIII	Title XIX	Title XVIII Skilled Nursing Facility	Title XIX Nursing Facility	All Other	Total (sum of cols. 1, 2, & 5)	
		1	2	3	4	5	6	
1	Continuous Home Care							1
2	Routine Home Care	4,627	62	6,239	71	332	5,021	2
3	Inpatient Respite Care	50					50	3
4	General Inpatient Care	57	20			6	83	4
5	Total Hospice Days	4,734	82	6,239	71	338	5,154	5

**PART II - CENSUS DATA**

		Title XVIII	Title XIX	Title XVIII Skilled Nursing Facility	Title XIX Nursing Facility	All Other	Total (sum of cols. 1, 2, & 5)	
		1	2	3	4	5	6	
6	Number of Patients Receiving Hospice Care	178	4	63	2	19	201	6
7	Total Number of Unduplicated Continuous Care Hours Billable to Medicare							7
8	Average Length of Stay (line 5/line 6)	26.60	20.50	99.03	35.50	17.79	25.64	8
9	Unduplicated Census Count	178	4	63	2	19	201	9

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

IROQUOIS MEMORIAL HOSPITAL Provider CCN: 14-0167	In Lieu of Form CMS-2552-10	Period : From: 10/01/2014 To: 09/30/2015	Run Date: 02/24/2016 Run Time: 16:14 Version: 2015.10 (12/18/2015)
---	--------------------------------	--	--

HOSPITAL UNCOMPENSATED AND INDIGENT CARE DATA

WORKSHEET S-10

Uncompensated and indigent care cost computation

1	Cost to charge ratio (Worksheet C, Part I, line 202, column 3 divided by line 202, column 8)		0.396949	1
---	--	--	----------	---

Medicaid (see instructions for each line)

2	Net revenue from Medicaid		3,120,906	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		11,609,802	6
7	Medicaid cost (line 1 times line 6)		4,608,499	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.		1,487,593	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 fundng 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)		1,487,593	19
		Uninsured patients	Insured patients	TOTAL (col. 1 + col. 2)
		1	2	3
20	Total initial obligation of patients approved for charity care (at full charges excluding non-reimbursable cost centers) for the entire facility	672,552	258,872	931,424
21	Cost of initial obligation of patients approved for charity care (line 1 times line 20)	266,969	102,759	369,728
22	Partial payment by patients approved for charity care			
23	Cost of charity care (line 21 minus line 22)	266,969	102,759	369,728

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)		1,585,923	26
27	Medicare bad debts for the entire hospital complex (see instructions)		203,425	27
28	Non-Medicare and non-reimbursable Medicare bad debt expense (line 26 minus line 27)		1,382,498	28
29	Cost of non-Medicare and non-reimbursable Medicare bad debt expense (line 1 times line 28)		548,781	29
30	Cost of uncompensated care (line 23, column 3 plus line 29)		918,509	30
31	Total unreimbursed and uncompensated care cost (line 19 plus line 30)		2,406,102	31

IROQUOIS MEMORIAL HOSPITAL Provider CCN: 14-0167	In Lieu of Form <b>CMS-2552-10</b>	Period : From: 10/01/2014 To: 09/30/2015	Run Date: 02/24/2016 Run Time: 16:14 Version: 2015.10 (12/18/2015)
---	---------------------------------------	--	--

RECLASSIFICATION AND ADJUSTMENT OF TRIAL BALANCE OF EXPENSES

WORKSHEET A

		COST CENTER DESCRIPTIONS	SALARIES	OTHER	TOTAL (col. 1 + col. 2)	RECLASSI- FICATIONS	RECLASSI- FIED TRIAL BALANCE (col. 3 ± col. 4)	ADJUST- MENTS	NET EXPENSES FOR ALLOC- ATION (col. 5 ± col. 6)	
			1	2	3	4	5	6	7	
		<b>GENERAL SERVICE COST CENTERS</b>								
1	00100	Cap Rel Costs-Bldg & Fixt		1,769,731	1,769,731	-622,876	1,146,855	-9,968	1,136,887	1
2	00200	Cap Rel Costs-Mvble Equip				937,350	937,350	-1,222	936,128	2
3	00300	Other Cap Rel Costs							-0-	3
4	00400	Employee Benefits Department	121,118	2,428,735	2,549,853	244,853	2,794,706	-48,247	2,746,459	4
5.01	00540	ADMISSIONS	343,185	243,230	586,415		586,415	-23,180	563,235	5.01
5.02	00550	PURCHASING, RECEIVING, AND STORES	110,549	116,122	226,671	-60,376	166,295		166,295	5.02
5.03	00560	DATA PROCESSING	324,991	335,426	660,417	4,206	664,623		664,623	5.03
5.04	00570	COMMUNICATIONS	34,589	202,391	236,980	11,354	248,334		248,334	5.04
5.05	00580	BUSINESS OFFICE	293,144	-147,148	145,996	240,390	386,386		386,386	5.05
5.06	00590	OTHER ADMINISTRATIVE AND GENERAL	810,791	2,215,403	3,026,194	22,735	3,048,929	-1,516,402	1,532,527	5.06
6	00600	Maintenance & Repairs								6
7	00700	Operation of Plant	251,569	924,768	1,176,337	58,020	1,234,357	-12,785	1,221,572	7
8	00800	Laundry & Linen Service	41,450	8,114	49,564		49,564		49,564	8
9	00900	Housekeeping	296,208	52,175	348,383		348,383	-1,488	346,895	9
10	01000	Dietary	354,757	321,706	676,463	-306,293	370,170		370,170	10
11	01100	Cafeteria				306,293	306,293	-156,832	149,461	11
12	01200	Maintenance of Personnel								12
13	01300	Nursing Administration	396,857	152,435	549,292	-90	549,202	-151	549,051	13
14	01400	Central Services & Supply		30,074	30,074		30,074	-1,040	29,034	14
15	01500	Pharmacy								15
16	01600	Medical Records & Library	516,167	131,320	647,487	-10	647,477	-820	646,657	16
17	01700	Social Service								17
19	01900	Nonphysician Anesthetists								19
20	02000	Nursing School								20
21	02100	I&R Services-Salary & Fringes Apprvd								21
22	02200	I&R Services-Other Prgm Costs Apprvd								22
23	02300	Paramed Ed Prgm-(specify)								23
		<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>								
30	03000	Adults & Pediatrics	2,094,626	339,207	2,433,833	-440,757	1,993,076	-40,554	1,952,522	30
43	04300	Nursery				243,915	243,915		243,915	43
44	04400	Skilled Nursing Facility	964,245	297,922	1,262,167	-38,135	1,224,032	-78	1,223,954	44
		<b>ANCILLARY SERVICE COST CENTERS</b>								
50	05000	Operating Room	701,994	1,693,399	2,395,393	-1,050,033	1,345,360	-363,688	981,672	50
52	05200	Delivery Room & Labor Room				172,451	172,451		172,451	52
53	05300	Anesthesiology		710,354	710,354	-8,787	701,567	-701,486	81	53
54	05400	Radiology-Diagnostic	712,123	881,899	1,594,022	-431,586	1,162,436	-47,386	1,115,050	54
57	05700	CT Scan	103,524	131,686	235,210		235,210		235,210	57
58	05800	MRI	47,271	206,194	253,465		253,465		253,465	58
60	06000	Laboratory	592,403	937,747	1,530,150	-1,343	1,528,807		1,528,807	60
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS								62.30
65	06500	Respiratory Therapy	405,390	150,211	555,601	-62,318	493,283	-33,460	459,823	65
66	06600	Physical Therapy	608,208	129,416	737,624	-18,862	718,762	-4,175	714,587	66
69	06900	Electrocardiology	52,250	78,432	130,682	-236	130,446	-39,140	91,306	69
71	07100	Medical Supplies Charged to Patients				664,975	664,975	-399	664,576	71
72	07200	Impl. Dev. Charged to Patients				1,082,758	1,082,758		1,082,758	72
73	07300	Drugs Charged to Patients	437,604	1,348,300	1,785,904	195,851	1,981,755		1,981,755	73
76.97	07697	CARDIAC REHABILITATION								76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY								76.98
76.99	07699	LITHOTRIPSY								76.99
		<b>OUTPATIENT SERVICE COST CENTERS</b>								
88	08800	Rural Health Clinic	750,771	210,195	960,966	-74,713	886,253		886,253	88
88.01	08801	RHC II	300,365	154,424	454,789	-69,185	385,604		385,604	88.01
88.02	08802	RHC III	827,388	301,297	1,128,685	-118,855	1,009,830		1,009,830	88.02
90	09000	Clinic	571,041	42,033	613,074	-70,528	542,546	-335,221	207,325	90
91	09100	Emergency	826,262	905,861	1,732,123	-40,022	1,692,101	-738,251	953,850	91
92	09200	Observation Beds (Non-Distinct Part)								92
		<b>OTHER REIMBURSABLE COST CENTERS</b>								
95	09500	Ambulance Services	712,541	244,360	956,901	-37,663	919,238	-59,879	859,359	95
101	10100	Home Health Agency	541,329	140,760	682,089	-9,183	672,906		672,906	101
		<b>SPECIAL PURPOSE COST CENTERS</b>								
113	11300	Interest Expense		231,843	231,843	-231,843				113
116	11600	Hospice	850,759	643,331	1,494,090	-202,345	1,291,745	-30,590	1,261,155	116
118		SUBTOTALS (sum of lines 1-117)	15,995,469	18,563,353	34,558,822	289,112	34,847,934	-4,166,442	30,681,492	118
		<b>NONREIMBURSABLE COST CENTERS</b>								
190	19000	Gift, Flower, Coffee Shop & Canteen		10,528	10,528	29,249	39,777		39,777	190
194	07950	IROQUOIS WOMEN'S HEALTH	1,650,984	769,961	2,420,945	-174,577	2,246,368		2,246,368	194
194.01	07951	OTHER NON-REIMBURSABLE COSTS	330,762	282,116	612,878	-143,784	469,094		469,094	194.01
200		TOTAL (sum of lines 118-199)	17,977,215	19,625,958	37,603,173		37,603,173	-4,166,442	33,436,731	200

IROQUOIS MEMORIAL HOSPITAL Provider CCN: 14-0167	In Lieu of Form <b>CMS-2552-10</b>	Period : From: 10/01/2014 To: 09/30/2015	Run Date: 02/24/2016 Run Time: 16:14 Version: 2015.10 (12/18/2015)
---	---------------------------------------	--	--

RECLASSIFICATIONS

WORKSHEET A-6

		INCREASES					
	EXPLANATION OF RECLASSIFICATION(S)	CODE (1)	COST CENTER	LINE #	SALARY	OTHER	
1	RECLASS MOVEABLE EQUIP DEPR	1		3			
		2					
		3					
		4					
		5					
		6					
		7					
		8					
500	Total reclassifications					881,189	1
	Code Letter - A					881,189	500
1	RECLASS ADVERTISING	B	OTHER ADMINISTRATIVE AND GENE	5.06		113,576	1
2							2
3							3
4							4
5							5
6							6
7							7
8							8
500	Total reclassifications					113,576	500
	Code Letter - B						
1	RECLASS MEDICAL SUPPLIES	C	Medical Supplies Charged to P	71		664,975	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					664,975	500
	Code Letter - C						
1	RECLASS DRUGS CHARGED TO PATIENTS	D	Drugs Charged to Patients	73		195,851	1
2							2
3							3
4							4
5							5
6							6
7							7
8							8
9							9
10							10
11							11
12							12
500	Total reclassifications					195,851	500
	Code Letter - D						
1	RECLASS TELEPHONE EXPENSE	E	COMMUNICATIONS	5.04		11,354	1
2							2
3							3
4							4
5							5
6							6
7							7
500	Total reclassifications					11,354	500
	Code Letter - E						
1	RECLASS INTEREST EXPENSE	F	Cap Rel Costs-Bldg & Fixt	1		206,356	1
2			Cap Rel Costs-Mvble Equip	2		25,294	2
3			OTHER ADMINISTRATIVE AND GENE	5.06		193	3
500	Total reclassifications					231,843	500
	Code Letter - F						
1	RECLASS CAFETERIA	G	Cafeteria	11	160,629	145,664	1
500	Total reclassifications				160,629	145,664	500
	Code Letter - G						
1	RECLASS NURSERY COST	H	Nursery	43	206,650	37,265	1
2			Delivery Room & Labor Room	52	146,104	26,347	2
500	Total reclassifications				352,754	63,612	500
	Code Letter - H						
1	RECLASS OPERATION OF PLANT COST	I	Operation of Plant	7		58,020	1
2							2
3							3

IROQUOIS MEMORIAL HOSPITAL Provider CCN: 14-0167	In Lieu of Form <b>CMS-2552-10</b>	Period : From: 10/01/2014 To: 09/30/2015	Run Date: 02/24/2016 Run Time: 16:14 Version: 2015.10 (12/18/2015)
---	---------------------------------------	--	--

**RECLASSIFICATIONS**

**WORKSHEET A-6**

		INCREASES					
	EXPLANATION OF RECLASSIFICATION(S)	CODE (1)	COST CENTER	LINE #	SALARY	OTHER	
		1	2	3	4	5	
4							4
5							5
6							6
7							7
8							8
9							9
10							10
500	Total reclassifications					58,020	500
	Code Letter - I						
1	RECLASS TRANSPORTATION	J	OTHER ADMINISTRATIVE AND GENE	5.06		25,164	1
2							2
500	Total reclassifications					25,164	500
	Code Letter - J						
1	RECLASS IT COST	K	DATA PROCESSING	5.03		5,255	1
2							2
3							3
4							4
500	Total reclassifications					5,255	500
	Code Letter - K						
1	RECLASS GIFT SHOP	L	Gift, Flower, Coffee Shop & C	190		29,249	1
500	Total reclassifications					29,249	500
	Code Letter - L						
1	RECLASS SHELDON CLINIC	M	OTHER ADMINISTRATIVE AND GENE	5.06		74	1
500	Total reclassifications					74	500
	Code Letter - M						
1	RECLASS OTHER CAP RELATED COST	N	Other Cap Rel Costs	3		82,824	1
500	Total reclassifications					82,824	500
	Code Letter - N						
1	RECLASS EMPLOYEE BENEFITS	O	Employee Benefits Department	4		244,853	1
2							2
3							3
4							4
5							5
6							6
500	Total reclassifications					244,853	500
	Code Letter - O						
1	RECLASS IMPL MED SUPPLIES	P	Impl. Dev. Charged to Patient	72		1,082,758	1
2							2
500	Total reclassifications					1,082,758	500
	Code Letter - P						
1	RECLASS BUSINESS OFFICE EXPENSE	Q	BUSINESS OFFICE	5.05		240,390	1
2							2
3							3
4							4
5							5
500	Total reclassifications					240,390	500
	Code Letter - Q						
	GRAND TOTAL (Increases)					513,383	4,076,651

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

IROQUOIS MEMORIAL HOSPITAL Provider CCN: 14-0167	In Lieu of Form CMS-2552-10	Period : From: 10/01/2014 To: 09/30/2015	Run Date: 02/24/2016 Run Time: 16:14 Version: 2015.10 (12/18/2015)
---	--------------------------------	--	--

RECLASSIFICATIONS

WORKSHEET A-6

		DECREASES						
	EXPLANATION OF RECLASSIFICATION(S)	CODE (1)	COST CENTER	LINE #	SALARY	OTHER	Wkst A-7 Ref.	
		1	6	7	8	9	10	
1	RECLASS MOVEABLE EQUIP DEPR	A	Cap Rel Costs-Bldg & Fixt	1		881,189	9	1
500	Total reclassifications					881,189		500
	Code letter - A							
1	RECLASS ADVERTISING	B	Rural Health Clinic	88		324		1
2			RHC II	88.01		452		2
3			RHC III	88.02		213		3
4			Home Health Agency	101		335		4
5			Hospice	116		3,190		5
6			IROQUOIS WOMEN'S HEALTH	194		51		6
7			OTHER NON-REIMBURSABLE COSTS	194.01		108,462		7
8			Clinic	90		549		8
500	Total reclassifications					113,576		500
	Code letter - B							
1	RECLASS MEDICAL SUPPLIES	C	PURCHASING, RECEIVING, AND ST	5.02		60,376		1
2			Adults & Pediatrics	30		24,084		2
3			Skilled Nursing Facility	44		36,747		3
4			Operating Room	50		295,840		4
5			Anesthesiology	53		8,787		5
6			Radiology-Diagnostic	54		94,404		6
7			Respiratory Therapy	65		62,299		7
8			Physical Therapy	66		1,674		8
9			Electrocardiology	69		236		9
10			Clinic	90		3,216		10
11			Emergency	91		40,011		11
12			Ambulance Services	95		12,489		12
13			Home Health Agency	101		5,762		13
14			Hospice	116		11,777		14
15			IROQUOIS WOMEN'S HEALTH	194		7,273		15
500	Total reclassifications					664,975		500
	Code letter - C							
1	RECLASS DRUGS CHARGED TO PATIENTS	D	Adults & Pediatrics	30		307		1
2			Skilled Nursing Facility	44		1,369		2
3			Operating Room	50		361		3
4			Radiology-Diagnostic	54		6,942		4
5			Laboratory	60		1,343		5
6			Respiratory Therapy	65		19		6
7								7
8			Clinic	90		224		8
9			Emergency	91		11		9
10			Ambulance Services	95		900		10
11			Home Health Agency	101		10		11
12			Hospice	116		184,365		12
500	Total reclassifications					195,851		500
	Code letter - D							
1	RECLASS TELEPHONE EXPENSE	E	DATA PROCESSING	5.03		1,049		1
2			OTHER ADMINISTRATIVE AND GENE	5.06		4,199		2
3			Nursing Administration	13		90		3
4			Medical Records & Library	16		10		4
5			Radiology-Diagnostic	54		1,028		5
6			Physical Therapy	66		2,658		6
7			OTHER NON-REIMBURSABLE COSTS	194.01		2,320		7
500	Total reclassifications					11,354		500
	Code letter - E							
1	RECLASS INTEREST EXPENSE	F	Interest Expense	113		231,843	11	1
2							11	2
3							11	3
500	Total reclassifications					231,843		500
	Code letter - F							
1	RECLASS CAFETERIA	G	Dietary	10	160,629	145,664		1
500	Total reclassifications				160,629	145,664		500
	Code letter - G							
1	RECLASS NURSERY COST	H	Adults & Pediatrics	30	352,754	63,612		1
2								2
500	Total reclassifications				352,754	63,612		500
	Code letter - H							
1	RECLASS OPERATION OF PLANT COST	I	Physical Therapy	66		14,530		1
2			Rural Health Clinic	88		5,227		2

IROQUOIS MEMORIAL HOSPITAL Provider CCN: 14-0167	In Lieu of Form <b>CMS-2552-10</b>	Period : From: 10/01/2014 To: 09/30/2015	Run Date: 02/24/2016 Run Time: 16:14 Version: 2015.10 (12/18/2015)
---	---------------------------------------	--	--

RECLASSIFICATIONS

WORKSHEET A-6

		DECREASES						
	EXPLANATION OF RECLASSIFICATION(S)	CODE (1)	COST CENTER	LINE #	SALARY	OTHER	Wkst A-7 Ref.	
		1	6	7	8	9	10	
3			RHC II	88.01		5,959	3	
4			RHC III	88.02		2,345	4	
5			Clinic	90		2,686	5	
6			Ambulance Services	95		4,678	6	
7			Home Health Agency	101		3,076	7	
8			Hospice	116		3,013	8	
9			IROQUOIS WOMEN'S HEALTH	194		14,655	9	
10			OTHER NON-REIMBURSABLE COSTS	194.01		1,851	10	
500	Total reclassifications					58,020	500	
	Code letter - I							
1	RECLASS TRANSPORTATION	J	Ambulance Services	95		19,596	1	
2			OTHER NON-REIMBURSABLE COSTS	194.01		5,568	2	
500	Total reclassifications					25,164	500	
	Code letter - J							
1	RECLASS IT COST	K					1	
2			Skilled Nursing Facility	44		19	2	
3			Radiology-Diagnostic	54		286	3	
4			Clinic	90		4,950	4	
500	Total reclassifications					5,255	500	
	Code letter - K							
1	RECLASS GIFT SHOP	L	OTHER ADMINISTRATIVE AND GENE	5.06		29,249	1	
500	Total reclassifications					29,249	500	
	Code letter - L							
1	RECLASS SHELDON CLINIC	M	OTHER NON-REIMBURSABLE COSTS	194.01		74	1	
500	Total reclassifications					74	500	
	Code letter - M							
1	RECLASS OTHER CAP RELATED COST	N	OTHER ADMINISTRATIVE AND GENE	5.06		82,824	14	
500	Total reclassifications					82,824	500	
	Code letter - N							
1	RECLASS EMPLOYEE BENEFITS	O	Rural Health Clinic	88		30,353	1	
2			RHC II	88.01		35,416	2	
3			RHC III	88.02		49,914	3	
4			Clinic	90		34,708	4	
5			IROQUOIS WOMEN'S HEALTH	194		68,953	5	
6			OTHER NON-REIMBURSABLE COSTS	194.01		25,509	6	
500	Total reclassifications					244,853	500	
	Code letter - O							
1	RECLASS IMPL MED SUPPLIES	P	Operating Room	50		753,832	1	
2			Radiology-Diagnostic	54		328,926	2	
500	Total reclassifications					1,082,758	500	
	Code letter - P							
1	RECLASS BUSINESS OFFICE EXPENSE	Q	Rural Health Clinic	88		38,809	1	
2			RHC II	88.01		27,358	2	
3			RHC III	88.02		66,383	3	
4			Clinic	90		24,195	4	
5			IROQUOIS WOMEN'S HEALTH	194		83,645	5	
500	Total reclassifications					240,390	500	
	Code letter - Q							
	GRAND TOTAL (Decreases)				513,383	4,076,651		

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

IROQUOIS MEMORIAL HOSPITAL Provider CCN: 14-0167	In Lieu of Form <b>CMS-2552-10</b>	Period : From: 10/01/2014 To: 09/30/2015	Run Date: 02/24/2016 Run Time: 16:14 Version: 2015.10 (12/18/2015)
---	---------------------------------------	--	--

**RECONCILIATION OF CAPITAL COST CENTERS**

**WORKSHEET A-7  
PARTS I, II & III**

**PART I - ANALYSIS OF CHANGES IN CAPITAL ASSETS BALANCES**

	Description	Beginning Balances	Acquisitions			Disposals and Retirements	Ending Balance	Fully Depreciated Assets	
			Purchases	Donation	Total				
		1	2	3	4	5	6	7	
1	Land	291,325					291,325		1
2	Land Improvements								2
3	Buildings and Fixtures	25,457,049	72,225		72,225	135,088	25,394,186		3
4	Building Improvements	483,750					483,750		4
5	Fixed Equipment								5
6	Movable Equipment	15,268,848	277,971		277,971		15,546,819		6
7	HIT-designated Assets								7
8	Subtotal (sum of lines 1-7)	41,500,972	350,196		350,196	135,088	41,716,080		8
9	Reconciling Items								9
10	Total (line 7 minus line 9)	41,500,972	350,196		350,196	135,088	41,716,080		10

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

	Description	SUMMARY OF CAPITAL							Total (1) (sum of cols. 9 through 14)	
		Depreciation	Lease	Interest	Insurance (see instructions)	Taxes (see instructions)	Other Capital-Related Costs (see instructions)			
*		9	10	11	12	13	14	15		
1	Cap Rel Costs-Bldg & Fixt	1,769,731						1,769,731	1	
2	Cap Rel Costs-Mvble Equip								2	
3	Total (sum of lines 1-2)	1,769,731						1,769,731	3	

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

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

**PART III - RECONCILIATION OF CAPITAL COST CENTERS**

	Description	COMPUTATION OF RATIOS				ALLOCATION OF OTHER CAPITAL				
		Gross Assets	Capitalized Leases	Gross Assets for Ratio (col. 1 - col. 2)	Ratio (see instructions)	Insurance	Taxes	Other Capital-Related Costs	Total (sum of cols. 5 through 7)	
*		1	2	3	4	5	6	7	8	
1	Cap Rel Costs-Bldg & Fi	26,169,261		26,169,261	0.627318			51,957	51,957	1
2	Cap Rel Costs-Mvble Equip	15,546,819		15,546,819	0.372682			30,867	30,867	2
3	Total (sum of lines 1-2)	41,716,080		41,716,080	1.000000			82,824	82,824	3

	Description	SUMMARY OF CAPITAL							Total (2) (sum of cols. 9 through 14)	
		Depreciation	Lease	Interest	Insurance (see instructions)	Taxes (see instructions)	Other Capital-Related Costs (see instructions)			
*		9	10	11	12	13	14	15		
1	Cap Rel Costs-Bldg & Fixt	888,542		196,388			51,957	1,136,887	1	
2	Cap Rel Costs-Mvble Equip	881,189		24,072			30,867	936,128	2	
3	Total (sum of lines 1-2)	1,769,731		220,460			82,824	2,073,015	3	

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

IROQUOIS MEMORIAL HOSPITAL Provider CCN: 14-0167	In Lieu of Form CMS-2552-10	Period : From: 10/01/2014 To: 09/30/2015	Run Date: 02/24/2016 Run Time: 16:14 Version: 2015.10 (12/18/2015)
---	--------------------------------	--	--

ADJUSTMENTS TO EXPENSES

WORKSHEET A-8

	DESCRIPTION(1)	BASIS/ CODE (2)	AMOUNT	EXPENSE CLASSIFICATION ON WORKSHEET A TO/FROM WHICH THE AMOUNT IS TO BE ADJUSTED			Wkst. A-7 Ref.
				COST CENTER		LINE#	
				1	2	3	
1	Investment income-buildings & fixtures (chapter 2)	B	-9,968	Cap Rel Costs-Bldg & Fixt	1	11	1
2	Investment income-movable equipment (chapter 2)	B	-1,222	Cap Rel Costs-Mvble Equip	2	11	2
3	Investment income-other (chapter 2)	B	-9	OTHER ADMINISTRATIVE AND GENERAL	5.06		3
4	Trade, quantity, and time discounts (chapter 8)	B	-404	OTHER ADMINISTRATIVE AND GENERAL	5.06		4
5	Refunds and rebates of expenses (chapter 8)						5
6	Rental of provider space by suppliers (chapter 8)						6
7	Telephone services (pay stations excl) (chapter 21)						7
8	Television and radio service (chapter 21)	A	-12,785	Operation of Plant	7		8
9	Parking lot (chapter 21)						9
10	Provider-based physician adjustment	Wkst A-8-2	-2,141,259				10
11	Sale of scrap, waste, etc. (chapter 23)						11
12	Related organization transactions (chapter 10)	Wkst A-8-1					12
13	Laundry and linen service						13
14	Cafeteria - employees and guests	B	-156,832	Cafeteria	11		14
15	Rental of quarters to employees & others						15
16	Sale of medical and surgical supplies to other than patients	B	-399	Medical Supplies Charged to Patients	71		16
17	Sale of drugs to other than patients						17
18	Sale of medical records and abstracts	B	-820	Medical Records & Library	16		18
19	Nursing school (tuition,fees,books,etc.)						19
20	Vending machines						20
21	Income from imposition of interest, finance or penalty charges (chapter 21)						21
22	Interest exp on Medicare overpayments & borrowings to repay Medicare overpayments						22
23	Adj for respiratory therapy costs in excess of limitation (chapter 14)	Wkst A-8-3		Respiratory Therapy	65		23
24	Adj for physical therapy costs in excess of limitation (chapter 14)	Wkst A-8-3		Physical Therapy	66		24
25	Util review-physicians' compensation (chapter 21)			Utilization Review-SNF	114		25
26	Depreciation--buildings & fixtures			Cap Rel Costs-Bldg & Fixt	1		26
27	Depreciation--movable equipment			Cap Rel Costs-Mvble Equip	2		27
28	Non-physician anesthetist			Nonphysician Anesthetists	19		28
29	Physicians' assistant						29
30	Adj for occupational therapy costs in excess of limitation (chapter 14)	Wkst A-8-3		Occupational Therapy	67		30
31	Adj for speech pathology costs in excess of limitation (chapter 14)	Wkst A-8-3		Speech Pathology	68		31
32	CAH HIT Adj for Depreciation						32
33	CNA CLASS REVENUE	B	-151	Nursing Administration	13		33
34							34
35	OTHER REVENUE WELLNESS	B	-575	Physical Therapy	66		35
36	AMBULANCE TOWNSHIP INCOME	B	-59,276	Ambulance Services	95		36
37							37
38	RENTAL INCOME	B	-110,967	Clinic	90		38
39	RENTAL INCOME	B	-3,600	Physical Therapy	66		39
40	COLLECTION FEES REVENUE	B	-23,180	ADMISSIONS	5.01		40
41	OTHER REVENUE HSKP	B	-1,488	Housekeeping	9		41
42	OTHER REVENUE-CENTRAL SUPPLY	B	-1,040	Central Services & Supply	14		42
43							43
44							44
45	MISC INCOME A&G	B	-294,847	OTHER ADMINISTRATIVE AND GENERAL	5.06		45
46	MISC INCOME AUXILLIARY	B	-21,697	OTHER ADMINISTRATIVE AND GENERAL	5.06		46
47	MISC INCOME MED STAFF	B	-8,650	OTHER ADMINISTRATIVE AND GENERAL	5.06		47
48	MISC INCOME EMPL COMMITTEE	B	-4,320	OTHER ADMINISTRATIVE AND GENERAL	5.06		48
49							49
49.01	PHYSICIAN BENEFIT OFFSET	A	-3,076	Employee Benefits Department	4		49.01
49.02	PHYSICIAN BENEFIT OFFSET	A	-3,076	Employee Benefits Department	4		49.02
49.03	DONATION EXPENSE	A	-1,555	OTHER ADMINISTRATIVE AND GENERAL	5.06		49.03
49.04	ALCOHOL EXPENSE	A	-3,731	OTHER ADMINISTRATIVE AND GENERAL	5.06		49.04
49.06	PHYSICIAN BENEFIT OFFSET	A	-42,095	Employee Benefits Department	4		49.06
49.08	ADVERTISING EXPENSE	A	-102,404	OTHER ADMINISTRATIVE AND GENERAL	5.06		49.08
49.09	PHYSICIAN RECRUITMENT	A	-58,252	OTHER ADMINISTRATIVE AND GENERAL	5.06		49.09
49.10	LOBBYING EXPENSE	A	-2,300	OTHER ADMINISTRATIVE AND GENERAL	5.06		49.10
49.11	LOBBYING EXPENSE	A	-78	Skilled Nursing Facility	44		49.11
49.12	PROVIDER TAX EXPENSE	A	-1,017,544	OTHER ADMINISTRATIVE AND GENERAL	5.06		49.12
49.13	AMB CABLE COST	A	-603	Ambulance Services	95		49.13
49.14	A&G CABLE TV COST	A	-689	OTHER ADMINISTRATIVE AND GENERAL	5.06		49.14
49.15	HOSPICE PRO FEE	A	-29,958	Hospice	116		49.15
49.16	ICU PRO FEE	A	-27,000	Adults & Pediatrics	30		49.16
49.17	SLEEP LAB PRO FEE	A	-19,960	Respiratory Therapy	65		49.17
49.20	LOBBYING EXPENSE	A	-632	Hospice	116		49.20

IROQUOIS MEMORIAL HOSPITAL Provider CCN: 14-0167	In Lieu of Form <b>CMS-2552-10</b>	Period : From: 10/01/2014 To: 09/30/2015	Run Date: 02/24/2016 Run Time: 16:14 Version: 2015.10 (12/18/2015)
---	---------------------------------------	--	--

ADJUSTMENTS TO EXPENSES

WORKSHEET A-8

				EXPENSE CLASSIFICATION ON WORKSHEET A TO/FROM WHICH THE AMOUNT IS TO BE ADJUSTED			
	DESCRIPTION(1)	BASIS/ CODE (2)	AMOUNT	COST CENTER	LINE#	Wkst. A-7 Ref.	
		1	2	3	4	5	
50	TOTAL (sum of lines 1 thru 49) (Transfer to worksheet A, column 6, line 200)		-4,166,442				50

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

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

IROQUOIS MEMORIAL HOSPITAL Provider CCN: 14-0167	In Lieu of Form CMS-2552-10	Period : From: 10/01/2014 To: 09/30/2015	Run Date: 02/24/2016 Run Time: 16:14 Version: 2015.10 (12/18/2015)
---	--------------------------------	--	--

STATEMENT OF COSTS OF SERVICES FROM RELATED ORGANIZATIONS AND HOME OFFICE COSTS

WORKSHEET A-8-1

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

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

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

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

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

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

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

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

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

IROQUOIS MEMORIAL HOSPITAL Provider CCN: 14-0167	In Lieu of Form <b>CMS-2552-10</b>	Period : From: 10/01/2014 To: 09/30/2015	Run Date: 02/24/2016 Run Time: 16:14 Version: 2015.10 (12/18/2015)
---	---------------------------------------	--	--

**PROVIDER-BASED PHYSICIANS ADJUSTMENTS**

**WORKSHEET A-8-2**

	Wkst A Line #	Cost Center/ Physician Identifier	Total Remun- eration	Professional Component	Provider Component	RCE Amount	Physician/ Provider Component Hours	Unadjusted RCE Limit	5 Percent of Unadjusted RCE Limit	
	1	2	3	4	5	6	7	8	9	
1	30	Adults & Pediatrics AGGREGATE	13,554	13,554						1
2	50	Operating Room AGGREGATE	363,688	363,688						2
3	53	Anesthesiology AGGREGATE	701,486	701,486						3
4	54	Radiology-Diagnostic AGGREGATE	47,386	47,386						4
5	65	Respiratory Therapy AGGREGATE	13,500	13,500						5
6	69	Electrocardiology AGGREGATE	39,140	39,140						6
7	90	Clinic AGGREGATE	224,254	224,254						7
8	91	Emergency AGGREGATE	738,251	738,251						8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
200		TOTAL	2,141,259	2,141,259						200

IROQUOIS MEMORIAL HOSPITAL Provider CCN: 14-0167	In Lieu of Form <b>CMS-2552-10</b>	Period : From: 10/01/2014 To: 09/30/2015	Run Date: 02/24/2016 Run Time: 16:14 Version: 2015.10 (12/18/2015)
---	---------------------------------------	--	--

**PROVIDER-BASED PHYSICIANS ADJUSTMENTS**

**WORKSHEET A-8-2**

	Wkst A Line #	Cost Center/ Physician Identifier	Cost of Memberships & Continuing Education	Provider Component Share of col. 12	Physician Cost of Malpractice Insurance	Provider Component Share of col. 14	Adjusted RCE Limit	RCE Disallowance	Adjustment	
	10	11	12	13	14	15	16	17	18	
1	30	Adults & Pediatrics AGGREGATE							13,554	1
2	50	Operating Room AGGREGATE							363,688	2
3	53	Anesthesiology AGGREGATE							701,486	3
4	54	Radiology-Diagnostic AGGREGATE							47,386	4
5	65	Respiratory Therapy AGGREGATE							13,500	5
6	69	Electrocardiology AGGREGATE							39,140	6
7	90	Clinic AGGREGATE							224,254	7
8	91	Emergency AGGREGATE							738,251	8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
200		TOTAL							2,141,259	200

IROQUOIS MEMORIAL HOSPITAL Provider CCN: 14-0167	In Lieu of Form CMS-2552-10	Period : From: 10/01/2014 To: 09/30/2015	Run Date: 02/24/2016 Run Time: 16:14 Version: 2015.10 (12/18/2015)
---	--------------------------------	--	--

COST ALLOCATION - GENERAL SERVICE COSTS

WORKSHEET B  
PART I

	COST CENTER DESCRIPTIONS	NET EXP FOR COST ALLOCATION (from Wkst A, col.7)	CAP BLDGS & FIXTURES	CAP MOVABLE EQUIPMENT	EMPLOYEE BENEFITS DEPARTMENT	ADMITTING	PURCHASING RECEIVING AND STORES	
		0	1	2	4	5.01	5.02	
	<b>GENERAL SERVICE COST CENTERS</b>							
1	Cap Rel Costs-Bldg & Fixt	1,136,887	1,136,887					1
2	Cap Rel Costs-Mvble Equip	936,128		936,128				2
4	Employee Benefits Department	2,746,459	4,893	91	2,751,443			4
5.01	ADMISSIONS	563,235	9,610		52,974	625,819		5.01
5.02	PURCHASING, RECEIVING, AND STORES	166,295	12,494		17,064		195,853	5.02
5.03	DATA PROCESSING	664,623	3,751	94,869	50,166		78	5.03
5.04	COMMUNICATIONS	248,334	2,501		5,339			5.04
5.05	BUSINESS OFFICE	386,386	10,685	573	45,250		263	5.05
5.06	OTHER ADMINISTRATIVE AND GENERAL	1,532,527	71,698	2,252	125,155		915	5.06
6	Maintenance & Repairs							6
7	Operation of Plant	1,221,572	111,214	17,513	38,832		3,081	7
8	Laundry & Linen Service	49,564	19,254		6,398		245	8
9	Housekeeping	346,895	5,576		45,723		2,182	9
10	Dietary	370,170	26,955	3,931	30,305		1,386	10
11	Cafeteria	149,461	8,668		24,456		1,147	11
12	Maintenance of Personnel							12
13	Nursing Administration	549,051	7,743		61,259		33	13
14	Central Services & Supply	29,034	12,544	9,199			2,057	14
15	Pharmacy							15
16	Medical Records & Library	646,657	14,295	1,285	79,676		327	16
17	Social Service							17
19	Nonphysician Anesthetists							19
20	Nursing School							20
21	I&R Services-Salary & Fringes Apprvd							21
22	I&R Services-Other Prgm Costs Apprvd							22
23	Paramed Ed Prgm-(specify)							23
	<b>INPATIENT ROUTINE SERV COST CENTERS</b>							
30	Adults & Pediatrics	1,952,522	138,361	78,689	266,033	45,736	3,173	30
43	Nursery	243,915	4,676	2,975	33,363	1,673		43
44	Skilled Nursing Facility	1,223,954	80,141	18,421	148,842	19,427	4,321	44
	<b>ANCILLARY SERVICE COST CENTERS</b>							
50	Operating Room	981,672	136,336	110,337	105,943	56,718	1,444	50
52	Delivery Room & Labor Room	172,451	1,867		23,926	1,183		52
53	Anesthesiology	81	917	11,103		2,537	607	53
54	Radiology-Diagnostic	1,115,050	38,174	229,411	107,506	72,283	7,078	54
57	CT Scan	235,210	7,618	171,728	15,980	63,363		57
58	MRI	253,465			7,297	19,137		58
60	Laboratory	1,528,807	29,348	27,766	91,444	85,892	26,947	60
62.30	<b>BLOOD CLOTTING FOR HEMOPHILIACS</b>							62.30
65	Respiratory Therapy	459,823	24,847	21,654	62,576	11,095	4,621	65
66	Physical Therapy	714,587	103,046	18,840	93,884	27,670	480	66
69	Electrocardiology	91,306	5,001	10,680	8,065	5,889	30	69
71	Medical Supplies Charged to Patients	664,576				20,443	45,482	71
72	Impl. Dev. Charged to Patients	1,082,758				19,416	74,057	72
73	Drugs Charged to Patients	1,981,755	15,603	37,457	67,549	57,457	584	73
76.97	CARDIAC REHABILITATION							76.97
76.98	HYPERBARIC OXYGEN THERAPY							76.98
76.99	LITHOTRIPSY							76.99
	<b>OUTPATIENT SERVICE COST CENTERS</b>							
88	Rural Health Clinic	886,253	21,671	63	115,890		542	88
88.01	RHC II	385,604	23,005		46,365		333	88.01
88.02	RHC III	1,009,830	35,107	3,609	127,716		746	88.02
90	Clinic	207,325	22,946	10,406	88,146	4,771	1,098	90
91	Emergency	953,850	24,713	26,734	127,543	60,755	3,849	91
92	Observation Beds (Non-Distinct Part)							92
	<b>OTHER REIMBURSABLE COST CENTERS</b>							
95	Ambulance Services	859,359	1,725	21,259	109,989	32,479	1,110	95
101	Home Health Agency	672,906	10,619	456	83,560		619	101
	<b>SPECIAL PURPOSE COST CENTERS</b>							
113	Interest Expense							113
116	Hospice	1,261,155	10,685	663	131,324		5,084	116
118	SUBTOTALS (sum of lines 1-117)	30,681,492	1,058,287	931,964	2,445,538	607,924	193,919	118
	<b>NONREIMBURSABLE COST CENTERS</b>							
190	Gift, Flower, Coffee Shop & Canteen	39,777	7,652				43	190
194	IROQUOIS WOMEN'S HEALTH	2,246,368	52,911	3,509	254,848	17,895	1,184	194
194.01	OTHER NON-REIMBURSABLE COSTS	469,094	18,037	655	51,057		707	194.01
200	Cross Foot Adjustments							200
201	Negative Cost Centers							201
202	TOTAL (sum of lines 118-201)	33,436,731	1,136,887	936,128	2,751,443	625,819	195,853	202

IROQUOIS MEMORIAL HOSPITAL Provider CCN: 14-0167	In Lieu of Form CMS-2552-10	Period : From: 10/01/2014 To: 09/30/2015	Run Date: 02/24/2016 Run Time: 16:14 Version: 2015.10 (12/18/2015)
---	--------------------------------	--	--

COST ALLOCATION - GENERAL SERVICE COSTS

WORKSHEET B  
PART I

	COST CENTER DESCRIPTIONS	DATA PROCESSING	COMMUNICATIONS	BUSINESS OFFICE	SUBTOTAL (cols.0-4)	OTHER ADMINISTRATIVE AND GENERAL	OPERATION OF PLANT	
		5.03	5.04	5.05	4A	5.06	7	
	<b>GENERAL SERVICE COST CENTERS</b>							
1	Cap Rel Costs-Bldg & Fixt							1
2	Cap Rel Costs-Mvble Equip							2
4	Employee Benefits Department							4
5.01	ADMISSIONS							5.01
5.02	PURCHASING, RECEIVING, AND STORES							5.02
5.03	DATA PROCESSING	813,487						5.03
5.04	COMMUNICATIONS		256,174					5.04
5.05	BUSINESS OFFICE	24,358	8,422	475,937				5.05
5.06	OTHER ADMINISTRATIVE AND GENERAL	26,338	13,335		1,772,220	1,772,220		5.06
6	Maintenance & Repairs							6
7	Operation of Plant	17,779	7,720		1,417,711	79,348	1,497,059	7
8	Laundry & Linen Service	4,331	702		80,494	4,505	31,673	8
9	Housekeeping	33,638	702		434,716	24,331	9,173	9
10	Dietary	20,500	3,509		456,756	25,564	44,343	10
11	Cafeteria	16,961	2,106		202,799	11,350	14,260	11
12	Maintenance of Personnel							12
13	Nursing Administration	12,498	9,124		639,708	35,804	12,738	13
14	Central Services & Supply				52,834	2,957	20,636	14
15	Pharmacy							15
16	Medical Records & Library	29,586	32,285		804,111	45,005	23,515	16
17	Social Service							17
19	Nonphysician Anesthetists							19
20	Nursing School							20
21	I&R Services-Salary & Fringes Apprvd							21
22	I&R Services-Other Prgm Costs Apprvd							22
23	Paramed Ed Prgm-(specify)							23
	<b>INPATIENT ROUTINE SERV COST CENTERS</b>							
30	Adults & Pediatrics	76,052	65,272	33,655	2,659,493	148,837	227,611	30
43	Nursery	8,155	3,509	1,231	299,497	16,763	7,692	43
44	Skilled Nursing Facility	69,157	8,422	14,295	1,586,980	88,822	131,836	44
	<b>ANCILLARY SERVICE COST CENTERS</b>							
50	Operating Room	29,812	25,266	41,736	1,489,264	83,353	224,278	50
52	Delivery Room & Labor Room	5,765	2,106	870	208,168	11,651	3,071	52
53	Anesthesiology			1,867	17,112	958	1,508	53
54	Radiology-Diagnostic	34,023	8,422	53,190	1,665,137	93,196	62,799	54
57	CT Scan	4,121	1,404	46,626	546,050	30,562	12,532	57
58	MRI	2,547	6,317	14,082	302,845	16,950		58
60	Laboratory	34,794	10,528	63,166	1,898,692	106,268	48,278	60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
65	Respiratory Therapy	20,705	7,018	8,164	620,503	34,729	40,874	65
66	Physical Therapy	27,067	702	20,361	1,006,637	56,340	169,515	66
69	Electrocardiology	2,400	2,807	4,333	130,511	7,305	8,227	69
71	Medical Supplies Charged to Patients			15,043	745,544	41,727		71
72	Impl. Dev. Charged to Patients			14,288	1,190,519	66,632		72
73	Drugs Charged to Patients	18,033	5,615	42,280	2,226,333	124,606	25,668	73
76.97	CARDIAC REHABILITATION							76.97
76.98	HYPERBARIC OXYGEN THERAPY							76.98
76.99	LITHOTRIPSY							76.99
	<b>OUTPATIENT SERVICE COST CENTERS</b>							
88	Rural Health Clinic	18,219		5,060	1,047,698	58,639	35,650	88
88.01	RHC II	11,017		3,161	469,485	26,277	37,844	88.01
88.02	RHC III	26,496		7,244	1,210,748	67,764	57,753	88.02
90	Clinic	25,774	9,826	3,510	373,802	20,921	37,748	90
91	Emergency	38,193	11,931	44,707	1,292,275	72,327	40,654	91
92	Observation Beds (Non-Distinct Part)							92
	<b>OTHER REIMBURSABLE COST CENTERS</b>							
95	Ambulance Services	53,060		23,900	1,102,881	61,727	2,838	95
101	Home Health Agency	23,176			791,336	44,290	17,468	101
	<b>SPECIAL PURPOSE COST CENTERS</b>							
113	Interest Expense							113
116	Hospice	39,691			1,448,602	81,077	17,578	116
118	SUBTOTALS (sum of lines 1-117)	754,246	247,050	462,769	30,191,461	1,590,585	1,367,760	118
	<b>NONREIMBURSABLE COST CENTERS</b>							
190	Gift, Flower, Coffee Shop & Canteen	1,505	3,509		52,486	2,938	12,587	190
194	IROQUOIS WOMEN'S HEALTH	36,502		13,168	2,626,385	146,996	87,040	194
194.01	OTHER NON-REIMBURSABLE COSTS	21,234	5,615		566,399	31,701	29,672	194.01
200	Cross Foot Adjustments							200
201	Negative Cost Centers							201
202	TOTAL (sum of lines 118-201)	813,487	256,174	475,937	33,436,731	1,772,220	1,497,059	202

IROQUOIS MEMORIAL HOSPITAL Provider CCN: 14-0167	In Lieu of Form CMS-2552-10	Period : From: 10/01/2014 To: 09/30/2015	Run Date: 02/24/2016 Run Time: 16:14 Version: 2015.10 (12/18/2015)
---	--------------------------------	--	--

COST ALLOCATION - GENERAL SERVICE COSTS

WORKSHEET B  
PART I

	COST CENTER DESCRIPTIONS	LAUNDRY & LINEN SERVICE	HOUSE-KEEPING	DIETARY	CAFETERIA	NURSING ADMINISTRATION	CENTRAL SERVICES & SUPPLY	
		8	9	10	11	13	14	
	<b>GENERAL SERVICE COST CENTERS</b>							
1	Cap Rel Costs-Bldg & Fixt							1
2	Cap Rel Costs-Mvble Equip							2
4	Employee Benefits Department							4
5.01	ADMISSIONS							5.01
5.02	PURCHASING, RECEIVING, AND STORES							5.02
5.03	DATA PROCESSING							5.03
5.04	COMMUNICATIONS							5.04
5.05	BUSINESS OFFICE							5.05
5.06	OTHER ADMINISTRATIVE AND GENERAL							5.06
6	Maintenance & Repairs							6
7	Operation of Plant							7
8	Laundry & Linen Service	116,672						8
9	Housekeeping	4,727	472,947					9
10	Dietary	800	15,828	543,291				10
11	Cafeteria		5,090		233,499			11
12	Maintenance of Personnel							12
13	Nursing Administration		4,547		5,963	698,760		13
14	Central Services & Supply	4	7,366				83,797	14
15	Pharmacy							15
16	Medical Records & Library		8,394		14,117			16
17	Social Service							17
19	Nonphysician Anesthetists							19
20	Nursing School							20
21	I&R Services-Salary & Fringes Apprvd							21
22	I&R Services-Other Prgm Costs Apprvd							22
23	Paramed Ed Prgm-(specify)							23
	<b>INPATIENT ROUTINE SERV COST CENTERS</b>							
30	Adults & Pediatrics	18,876	81,246	102,611	36,294	259,915	5,490	30
43	Nursery	234	2,746		3,889	27,873		43
44	Skilled Nursing Facility	52,244	47,059	400,960	33,007			44
	<b>ANCILLARY SERVICE COST CENTERS</b>							
50	Operating Room	11,819	80,056	454	14,235	101,888	51,795	50
52	Delivery Room & Labor Room		1,096		2,757	19,703		52
53	Anesthesiology		538					53
54	Radiology-Diagnostic	5,789	22,416		16,238		1,963	54
57	CT Scan		4,473		1,968			57
58	MRI				1,214			58
60	Laboratory	138	17,233		16,604			60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
65	Respiratory Therapy		14,590		9,887	70,762	97	65
66	Physical Therapy	5,182	60,508		12,915			66
69	Electrocardiology		2,937		1,143			69
71	Medical Supplies Charged to Patients							71
72	Impl. Dev. Charged to Patients							72
73	Drugs Charged to Patients		9,162		8,602			73
76.97	CARDIAC REHABILITATION							76.97
76.98	HYPERBARIC OXYGEN THERAPY							76.98
76.99	LITHOTRIPSY							76.99
	<b>OUTPATIENT SERVICE COST CENTERS</b>							
88	Rural Health Clinic						762	88
88.01	RHC II						387	88.01
88.02	RHC III						1,604	88.02
90	Clinic	1,931	13,474	909	12,302	88,088	370	90
91	Emergency	14,393	14,512	5,656	18,230	130,531	1,417	91
92	Observation Beds (Non-Distinct Part)							92
	<b>OTHER REIMBURSABLE COST CENTERS</b>							
95	Ambulance Services	535	1,013					95
101	Home Health Agency		6,235					101
	<b>SPECIAL PURPOSE COST CENTERS</b>							
113	Interest Expense							113
116	Hospice		6,275					116
118	SUBTOTALS (sum of lines 1-117)	116,672	426,794	510,590	209,365	698,760	63,885	118
	<b>NONREIMBURSABLE COST CENTERS</b>							
190	Gift, Flower, Coffee Shop & Canteen		4,493		719			190
194	IROQUOIS WOMEN'S HEALTH		31,069		13,281		19,912	194
194.01	OTHER NON-REIMBURSABLE COSTS		10,591	32,701	10,134			194.01
200	Cross Foot Adjustments							200
201	Negative Cost Centers							201
202	TOTAL (sum of lines 118-201)	116,672	472,947	543,291	233,499	698,760	83,797	202

IROQUOIS MEMORIAL HOSPITAL Provider CCN: 14-0167	In Lieu of Form CMS-2552-10	Period : From: 10/01/2014 To: 09/30/2015	Run Date: 02/24/2016 Run Time: 16:14 Version: 2015.10 (12/18/2015)
---	--------------------------------	--	--

COST ALLOCATION - GENERAL SERVICE COSTS

WORKSHEET B  
PART I

	COST CENTER DESCRIPTIONS	MEDICAL RECORDS & LIBRARY	SUBTOTAL	I&R COST & POST STEP-DOWN ADJS	TOTAL		
		16	24	25	26		
	<b>GENERAL SERVICE COST CENTERS</b>						
1	Cap Rel Costs-Bldg & Fixt						1
2	Cap Rel Costs-Mvble Equip						2
4	Employee Benefits Department						4
5.01	ADMISSIONS						5.01
5.02	PURCHASING, RECEIVING, AND STORES						5.02
5.03	DATA PROCESSING						5.03
5.04	COMMUNICATIONS						5.04
5.05	BUSINESS OFFICE						5.05
5.06	OTHER ADMINISTRATIVE AND GENERAL						5.06
6	Maintenance & Repairs						6
7	Operation of Plant						7
8	Laundry & Linen Service						8
9	Housekeeping						9
10	Dietary						10
11	Cafeteria						11
12	Maintenance of Personnel						12
13	Nursing Administration						13
14	Central Services & Supply						14
15	Pharmacy						15
16	Medical Records & Library	895,142					16
17	Social Service						17
19	Nonphysician Anesthetists						19
20	Nursing School						20
21	I&R Services-Salary & Fringes Apprvd						21
22	I&R Services-Other Prgm Costs Apprvd						22
23	Paramed Ed Prgm-(specify)						23
	<b>INPATIENT ROUTINE SERV COST CENTERS</b>						
30	Adults & Pediatrics	73,629	3,614,002		3,614,002		30
43	Nursery	2,694	361,388		361,388		43
44	Skilled Nursing Facility		2,340,908		2,340,908		44
	<b>ANCILLARY SERVICE COST CENTERS</b>						
50	Operating Room	91,310	2,148,452		2,148,452		50
52	Delivery Room & Labor Room	1,904	248,350		248,350		52
53	Anesthesiology	4,084	24,200		24,200		53
54	Radiology-Diagnostic	116,368	1,983,906		1,983,906		54
57	CT Scan	102,008	697,593		697,593		57
58	MRI	30,809	351,818		351,818		58
60	Laboratory	138,291	2,225,504		2,225,504		60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS						62.30
65	Respiratory Therapy	17,861	809,303		809,303		65
66	Physical Therapy	44,546	1,355,643		1,355,643		66
69	Electrocardiology	9,480	159,603		159,603		69
71	Medical Supplies Charged to Patients	32,911	820,182		820,182		71
72	Impl. Dev. Charged to Patients	31,258	1,288,409		1,288,409		72
73	Drugs Charged to Patients	92,500	2,486,871		2,486,871		73
76.97	CARDIAC REHABILITATION						76.97
76.98	HYPERBARIC OXYGEN THERAPY						76.98
76.99	LITHOTRIPSY						76.99
	<b>OUTPATIENT SERVICE COST CENTERS</b>						
88	Rural Health Clinic		1,142,749		1,142,749		88
88.01	RHC II		533,993		533,993		88.01
88.02	RHC III		1,337,869		1,337,869		88.02
90	Clinic	7,680	557,225		557,225		90
91	Emergency	97,809	1,687,804		1,687,804		91
92	Observation Beds (Non-Distinct Part)						92
	<b>OTHER REIMBURSABLE COST CENTERS</b>						
95	Ambulance Services		1,168,994		1,168,994		95
101	Home Health Agency		859,329		859,329		101
	<b>SPECIAL PURPOSE COST CENTERS</b>						
113	Interest Expense						113
116	Hospice		1,553,532		1,553,532		116
118	SUBTOTALS (sum of lines 1-117)	895,142	29,757,627		29,757,627		118
	<b>NONREIMBURSABLE COST CENTERS</b>						
190	Gift, Flower, Coffee Shop & Canteen		73,223		73,223		190
194	IROQUOIS WOMEN'S HEALTH		2,924,683		2,924,683		194
194.01	OTHER NON-REIMBURSABLE COSTS		681,198		681,198		194.01
200	Cross Foot Adjustments						200
201	Negative Cost Centers						201
202	TOTAL (sum of lines 118-201)	895,142	33,436,731		33,436,731		202

IROQUOIS MEMORIAL HOSPITAL Provider CCN: 14-0167	In Lieu of Form CMS-2552-10	Period : From: 10/01/2014 To: 09/30/2015	Run Date: 02/24/2016 Run Time: 16:14 Version: 2015.10 (12/18/2015)
---	--------------------------------	--	--

ALLOCATION OF CAPITAL-RELATED COSTS

WORKSHEET B  
PART II

	COST CENTER DESCRIPTIONS	DIR ASSGND CAP-REL COSTS	CAP BLDGS & FIXTURES	CAP MOVABLE EQUIPMENT	SUBTOTAL	EMPLOYEE BENEFITS DEPARTMENT	ADMITTING	
		0	1	2	2A	4	5.01	
	<b>GENERAL SERVICE COST CENTERS</b>							
1	Cap Rel Costs-Bldg & Fixt							1
2	Cap Rel Costs-Mvble Equip							2
4	Employee Benefits Department	32	4,893	91	5,016	5,016		4
5.01	ADMISSIONS	4,651	9,610		14,261	96	14,357	5.01
5.02	PURCHASING, RECEIVING, AND STORES	1,129	12,494		13,623	31		5.02
5.03	DATA PROCESSING	2,254	3,751	94,869	100,874	91		5.03
5.04	COMMUNICATIONS		2,501		2,501	10		5.04
5.05	BUSINESS OFFICE		10,685	573	11,258	82		5.05
5.06	OTHER ADMINISTRATIVE AND GENERAL	579	71,698	2,252	74,529	228		5.06
6	Maintenance & Repairs							6
7	Operation of Plant	22	111,214	17,513	128,749	71		7
8	Laundry & Linen Service		19,254		19,254	12		8
9	Housekeeping		5,576		5,576	83		9
10	Dietary	1,638	26,955	3,931	32,524	55		10
11	Cafeteria	1,477	8,668		10,145	45		11
12	Maintenance of Personnel							12
13	Nursing Administration	7,120	7,743		14,863	112		13
14	Central Services & Supply		12,544	9,199	21,743			14
15	Pharmacy							15
16	Medical Records & Library	3,916	14,295	1,285	19,496	145		16
17	Social Service							17
19	Nonphysician Anesthetists							19
20	Nursing School							20
21	I&R Services-Salary & Fringes Apprvd							21
22	I&R Services-Other Prgm Costs Apprvd							22
23	Paramed Ed Prgm-(specify)							23
	<b>INPATIENT ROUTINE SERV COST CENTERS</b>							
30	Adults & Pediatrics	11,503	138,361	78,689	228,553	492	1,049	30
43	Nursery		4,676	2,975	7,651	61	38	43
44	Skilled Nursing Facility	2,577	80,141	18,421	101,139	271	446	44
	<b>ANCILLARY SERVICE COST CENTERS</b>							
50	Operating Room	7,152	136,336	110,337	253,825	193	1,301	50
52	Delivery Room & Labor Room		1,867		1,867	44	27	52
53	Anesthesiology		917	11,103	12,020		58	53
54	Radiology-Diagnostic	162,423	38,174	229,411	430,008	196	1,658	54
57	CT Scan		7,618	171,728	179,346	29	1,453	57
58	MRI					13	439	58
60	Laboratory	3,772	29,348	27,766	60,886	166	1,975	60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
65	Respiratory Therapy	7,334	24,847	21,654	53,835	114	254	65
66	Physical Therapy	4,525	103,046	18,840	126,411	171	635	66
69	Electrocardiology	177	5,001	10,680	15,858	15	135	69
71	Medical Supplies Charged to Patients						469	71
72	Impl. Dev. Charged to Patients						445	72
73	Drugs Charged to Patients	1,538	15,603	37,457	54,598	123	1,318	73
76.97	CARDIAC REHABILITATION							76.97
76.98	HYPERBARIC OXYGEN THERAPY							76.98
76.99	LITHOTRIPSY							76.99
	<b>OUTPATIENT SERVICE COST CENTERS</b>							
88	Rural Health Clinic	1,411	21,671	63	23,145	211		88
88.01	RHC II	1,591	23,005		24,596	84		88.01
88.02	RHC III	4,341	35,107	3,609	43,057	232		88.02
90	Clinic	1,776	22,946	10,406	35,128	160	109	90
91	Emergency	2,645	24,713	26,734	54,092	232	1,393	91
92	Observation Beds (Non-Distinct Part)							92
	<b>OTHER REIMBURSABLE COST CENTERS</b>							
95	Ambulance Services	27,240	1,725	21,259	50,224	200	745	95
101	Home Health Agency	5,724	10,619	456	16,799	152		101
	<b>SPECIAL PURPOSE COST CENTERS</b>							
113	Interest Expense							113
116	Hospice	106,852	10,685	663	118,200	239		116
118	SUBTOTALS (sum of lines 1-117)	375,399	1,058,287	931,964	2,365,650	4,459	13,947	118
	<b>NONREIMBURSABLE COST CENTERS</b>							
190	Gift, Flower, Coffee Shop & Canteen		7,652		7,652			190
194	IROQUOIS WOMEN'S HEALTH	33,184	52,911	3,509	89,604	464	410	194
194.01	OTHER NON-REIMBURSABLE COSTS		18,037	655	18,692	93		194.01
200	Cross Foot Adjustments							200
201	Negative Cost Centers							201
202	TOTAL (sum of lines 118-201)	408,583	1,136,887	936,128	2,481,598	5,016	14,357	202

IROQUOIS MEMORIAL HOSPITAL Provider CCN: 14-0167	In Lieu of Form <b>CMS-2552-10</b>	Period : From: 10/01/2014 To: 09/30/2015	Run Date: 02/24/2016 Run Time: 16:14 Version: 2015.10 (12/18/2015)
---	---------------------------------------	--	--

ALLOCATION OF CAPITAL-RELATED COSTS

WORKSHEET B  
PART II

	COST CENTER DESCRIPTIONS	PURCHASING RECEIVING AND STORES	DATA PROCESSING	COMMUNICATIONS	BUSINESS OFFICE	OTHER ADMINISTRATIVE AND GENERAL	OPERATION OF PLANT	
		5.02	5.03	5.04	5.05	5.06	7	
	<b>GENERAL SERVICE COST CENTERS</b>							
1	Cap Rel Costs-Bldg & Fixt							1
2	Cap Rel Costs-Mvble Equip							2
4	Employee Benefits Department							4
5.01	ADMISSIONS							5.01
5.02	PURCHASING, RECEIVING, AND STORES	13,654						5.02
5.03	DATA PROCESSING	5	100,970					5.03
5.04	COMMUNICATIONS			2,511				5.04
5.05	BUSINESS OFFICE	18	3,023	83	14,464			5.05
5.06	OTHER ADMINISTRATIVE AND GENERAL	64	3,269	131		78,221		5.06
6	Maintenance & Repairs							6
7	Operation of Plant	215	2,207	76		3,502	134,820	7
8	Laundry & Linen Service	17	538	7		199	2,852	8
9	Housekeeping	152	4,175	7		1,074	826	9
10	Dietary	97	2,544	34		1,128	3,993	10
11	Cafeteria	80	2,105	21		501	1,284	11
12	Maintenance of Personnel							12
13	Nursing Administration	2	1,551	89		1,580	1,147	13
14	Central Services & Supply	143				130	1,858	14
15	Pharmacy							15
16	Medical Records & Library	23	3,672	316		1,986	2,118	16
17	Social Service							17
19	Nonphysician Anesthetists							19
20	Nursing School							20
21	I&R Services-Salary & Fringes Apprvd							21
22	I&R Services-Other Prgm Costs Apprvd							22
23	Paramed Ed Prgm-(specify)							23
	<b>INPATIENT ROUTINE SERV COST CENTERS</b>							
30	Adults & Pediatrics	221	9,438	638	1,023	6,578	20,496	30
43	Nursery		1,012	34	37	740	693	43
44	Skilled Nursing Facility	301	8,584	83	434	3,920	11,873	44
	<b>ANCILLARY SERVICE COST CENTERS</b>							
50	Operating Room	101	3,700	248	1,268	3,678	20,198	50
52	Delivery Room & Labor Room		716	21	26	514	277	52
53	Anesthesiology	42			57	42	136	53
54	Radiology-Diagnostic	493	4,223	83	1,616	4,113	5,655	54
57	CT Scan		512	14	1,417	1,349	1,129	57
58	MRI		316	62	428	748		58
60	Laboratory	1,879	4,319	103	1,922	4,690	4,348	60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
65	Respiratory Therapy	322	2,570	69	248	1,533	3,681	65
66	Physical Therapy	33	3,360	7	619	2,486	15,266	66
69	Electrocardiology	2	298	28	132	322	741	69
71	Medical Supplies Charged to Patients	3,171			457	1,841		71
72	Impl. Dev. Charged to Patients	5,165			434	2,941		72
73	Drugs Charged to Patients	41	2,238	55	1,285	5,499	2,312	73
76.97	CARDIAC REHABILITATION							76.97
76.98	HYPERBARIC OXYGEN THERAPY							76.98
76.99	LITHOTRIPSY							76.99
	<b>OUTPATIENT SERVICE COST CENTERS</b>							
88	Rural Health Clinic	38	2,261		154	2,588	3,211	88
88.01	RHC II	23	1,367		96	1,160	3,408	88.01
88.02	RHC III	52	3,289		220	2,991	5,201	88.02
90	Clinic	77	3,199	96	107	923	3,399	90
91	Emergency	268	4,741	117	1,358	3,192	3,661	91
92	Observation Beds (Non-Distinct Part)							92
	<b>OTHER REIMBURSABLE COST CENTERS</b>							
95	Ambulance Services	77	6,586		726	2,724	256	95
101	Home Health Agency	43	2,877			1,955	1,573	101
	<b>SPECIAL PURPOSE COST CENTERS</b>							
113	Interest Expense							113
116	Hospice	354	4,926			3,578	1,583	116
118	SUBTOTALS (sum of lines 1-117)	13,519	93,616	2,422	14,064	70,205	123,175	118
	<b>NONREIMBURSABLE COST CENTERS</b>							
190	Gift, Flower, Coffee Shop & Canteen	3	187	34		130	1,134	190
194	IROQUOIS WOMEN'S HEALTH	83	4,531		400	6,487	7,839	194
194.01	OTHER NON-REIMBURSABLE COSTS	49	2,636	55		1,399	2,672	194.01
200	Cross Foot Adjustments							200
201	Negative Cost Centers							201
202	TOTAL (sum of lines 118-201)	13,654	100,970	2,511	14,464	78,221	134,820	202

IROQUOIS MEMORIAL HOSPITAL Provider CCN: 14-0167	In Lieu of Form <b>CMS-2552-10</b>	Period : From: 10/01/2014 To: 09/30/2015	Run Date: 02/24/2016 Run Time: 16:14 Version: 2015.10 (12/18/2015)
---	---------------------------------------	--	--

ALLOCATION OF CAPITAL-RELATED COSTS

WORKSHEET B  
PART II

	COST CENTER DESCRIPTIONS	LAUNDRY & LINEN SERVICE	HOUSE-KEEPING	DIETARY	CAFETERIA	NURSING ADMINISTRATION	CENTRAL SERVICES & SUPPLY	
		8	9	10	11	13	14	
	<b>GENERAL SERVICE COST CENTERS</b>							
1	Cap Rel Costs-Bldg & Fixt							1
2	Cap Rel Costs-Mvble Equip							2
4	Employee Benefits Department							4
5.01	ADMISSIONS							5.01
5.02	PURCHASING, RECEIVING, AND STORES							5.02
5.03	DATA PROCESSING							5.03
5.04	COMMUNICATIONS							5.04
5.05	BUSINESS OFFICE							5.05
5.06	OTHER ADMINISTRATIVE AND GENERAL							5.06
6	Maintenance & Repairs							6
7	Operation of Plant							7
8	Laundry & Linen Service	22,879						8
9	Housekeeping	927	12,820					9
10	Dietary	157	429	40,961				10
11	Cafeteria		138		14,319			11
12	Maintenance of Personnel							12
13	Nursing Administration		123		366	19,833		13
14	Central Services & Supply	1	200				24,075	14
15	Pharmacy							15
16	Medical Records & Library		228		866			16
17	Social Service							17
19	Nonphysician Anesthetists							19
20	Nursing School							20
21	I&R Services-Salary & Fringes Apprvd							21
22	I&R Services-Other Prgm Costs Apprvd							22
23	Paramed Ed Prgm-(specify)							23
	<b>INPATIENT ROUTINE SERV COST CENTERS</b>							
30	Adults & Pediatrics	3,701	2,203	7,736	2,227	7,378	1,577	30
43	Nursery	46	74		238	791		43
44	Skilled Nursing Facility	10,245	1,276	30,231	2,024			44
	<b>ANCILLARY SERVICE COST CENTERS</b>							
50	Operating Room	2,318	2,170	34	873	2,892	14,881	50
52	Delivery Room & Labor Room		30		169	559		52
53	Anesthesiology		15					53
54	Radiology-Diagnostic	1,135	608		996		564	54
57	CT Scan		121		121			57
58	MRI				74			58
60	Laboratory	27	467		1,018			60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
65	Respiratory Therapy		395		606	2,008	28	65
66	Physical Therapy	1,016	1,640		792			66
69	Electrocardiology		80		70			69
71	Medical Supplies Charged to Patients							71
72	Impl. Dev. Charged to Patients							72
73	Drugs Charged to Patients		248		528			73
76.97	CARDIAC REHABILITATION							76.97
76.98	HYPERBARIC OXYGEN THERAPY							76.98
76.99	LITHOTRIPSY							76.99
	<b>OUTPATIENT SERVICE COST CENTERS</b>							
88	Rural Health Clinic						219	88
88.01	RHC II						111	88.01
88.02	RHC III						461	88.02
90	Clinic	379	365	69	754	2,500	106	90
91	Emergency	2,822	393	426	1,118	3,705	407	91
92	Observation Beds (Non-Distinct Part)							92
	<b>OTHER REIMBURSABLE COST CENTERS</b>							
95	Ambulance Services	105	27					95
101	Home Health Agency		169					101
	<b>SPECIAL PURPOSE COST CENTERS</b>							
113	Interest Expense							113
116	Hospice		170					116
118	SUBTOTALS (sum of lines 1-117)	22,879	11,569	38,496	12,840	19,833	18,354	118
	<b>NONREIMBURSABLE COST CENTERS</b>							
190	Gift, Flower, Coffee Shop & Canteen		122		44			190
194	IROQUOIS WOMEN'S HEALTH		842		814		5,721	194
194.01	OTHER NON-REIMBURSABLE COSTS		287	2,465	621			194.01
200	Cross Foot Adjustments							200
201	Negative Cost Centers							201
202	TOTAL (sum of lines 118-201)	22,879	12,820	40,961	14,319	19,833	24,075	202

IROQUOIS MEMORIAL HOSPITAL Provider CCN: 14-0167	In Lieu of Form <b>CMS-2552-10</b>	Period : From: 10/01/2014 To: 09/30/2015	Run Date: 02/24/2016 Run Time: 16:14 Version: 2015.10 (12/18/2015)
---	---------------------------------------	--	--

ALLOCATION OF CAPITAL-RELATED COSTS

WORKSHEET B  
PART II

	COST CENTER DESCRIPTIONS	MEDICAL RECORDS & LIBRARY	SUBTOTAL	I&R COST & POST STEP-DOWN ADJS	TOTAL		
		16	24	25	26		
	<b>GENERAL SERVICE COST CENTERS</b>						
1	Cap Rel Costs-Bldg & Fixt						1
2	Cap Rel Costs-Mvble Equip						2
4	Employee Benefits Department						4
5.01	ADMISSIONS						5.01
5.02	PURCHASING, RECEIVING, AND STORES						5.02
5.03	DATA PROCESSING						5.03
5.04	COMMUNICATIONS						5.04
5.05	BUSINESS OFFICE						5.05
5.06	OTHER ADMINISTRATIVE AND GENERAL						5.06
6	Maintenance & Repairs						6
7	Operation of Plant						7
8	Laundry & Linen Service						8
9	Housekeeping						9
10	Dietary						10
11	Cafeteria						11
12	Maintenance of Personnel						12
13	Nursing Administration						13
14	Central Services & Supply						14
15	Pharmacy						15
16	Medical Records & Library	28,850					16
17	Social Service						17
19	Nonphysician Anesthetists						19
20	Nursing School						20
21	I&R Services-Salary & Fringes Apprvd						21
22	I&R Services-Other Prgm Costs Apprvd						22
23	Paramed Ed Prgm-(specify)						23
	<b>INPATIENT ROUTINE SERV COST CENTERS</b>						
30	Adults & Pediatrics	2,372	295,682		295,682		30
43	Nursery	87	11,502		11,502		43
44	Skilled Nursing Facility		170,827		170,827		44
	<b>ANCILLARY SERVICE COST CENTERS</b>						
50	Operating Room	2,941	310,621		310,621		50
52	Delivery Room & Labor Room	61	4,311		4,311		52
53	Anesthesiology	132	12,502		12,502		53
54	Radiology-Diagnostic	3,749	455,097		455,097		54
57	CT Scan	3,286	188,777		188,777		57
58	MRI	992	3,072		3,072		58
60	Laboratory	4,470	86,270		86,270		60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS						62.30
65	Respiratory Therapy	575	66,238		66,238		65
66	Physical Therapy	1,435	153,871		153,871		66
69	Electrocardiology	305	17,986		17,986		69
71	Medical Supplies Charged to Patients	1,060	6,998		6,998		71
72	Impl. Dev. Charged to Patients	1,007	9,992		9,992		72
73	Drugs Charged to Patients	2,980	71,225		71,225		73
76.97	CARDIAC REHABILITATION						76.97
76.98	HYPERBARIC OXYGEN THERAPY						76.98
76.99	LITHOTRIPSY						76.99
	<b>OUTPATIENT SERVICE COST CENTERS</b>						
88	Rural Health Clinic		31,827		31,827		88
88.01	RHC II		30,845		30,845		88.01
88.02	RHC III		55,503		55,503		88.02
90	Clinic	247	47,618		47,618		90
91	Emergency	3,151	81,076		81,076		91
92	Observation Beds (Non-Distinct Part)						92
	<b>OTHER REIMBURSABLE COST CENTERS</b>						
95	Ambulance Services		61,670		61,670		95
101	Home Health Agency		23,568		23,568		101
	<b>SPECIAL PURPOSE COST CENTERS</b>						
113	Interest Expense						113
116	Hospice		129,050		129,050		116
118	SUBTOTALS (sum of lines 1-117)	28,850	2,326,128		2,326,128		118
	<b>NONREIMBURSABLE COST CENTERS</b>						
190	Gift, Flower, Coffee Shop & Canteen		9,306		9,306		190
194	IROQUOIS WOMEN'S HEALTH		117,195		117,195		194
194.01	OTHER NON-REIMBURSABLE COSTS		28,969		28,969		194.01
200	Cross Foot Adjustments						200
201	Negative Cost Centers						201
202	TOTAL (sum of lines 118-201)	28,850	2,481,598		2,481,598		202

IROQUOIS MEMORIAL HOSPITAL Provider CCN: 14-0167	In Lieu of Form CMS-2552-10	Period : From: 10/01/2014 To: 09/30/2015	Run Date: 02/24/2016 Run Time: 16:14 Version: 2015.10 (12/18/2015)
---	--------------------------------	--	--

COST ALLOCATION - STATISTICAL BASIS

WORKSHEET B-1

	COST CENTER DESCRIPTIONS	CAP BLDGS & FIXTURES SQUARE FEET	CAP MOVABLE EQUIPMENT DOLLAR VALUE NEW	EMPLOYEE BENEFITS DEPARTMENT GROSS SAL	ADMITTING GROSS CHARGES	PURCHASING RECEIVING AND STORES COST REQ'S	DATA PROCESSING TIME SPENT	
		1	2	4	5.01	5.02	5.03	
	<b>GENERAL SERVICE COST CENTERS</b>							
1	Cap Rel Costs-Bldg & Fixt	136,399						1
2	Cap Rel Costs-Mvble Equip		887,220					2
4	Employee Benefits Department	587	86	17,824,771				4
5.01	ADMISSIONS	1,153		343,185	72,123,378			5.01
5.02	PURCHASING, RECEIVING, AND STORES	1,499		110,549		2,863,497		5.02
5.03	DATA PROCESSING	450	89,913	324,991		1,137	685,368	5.03
5.04	COMMUNICATIONS	300		34,589				5.04
5.05	BUSINESS OFFICE	1,282	543	293,144		3,851	20,522	5.05
5.06	OTHER ADMINISTRATIVE AND GENERAL	8,602	2,134	810,791		13,374	22,190	5.06
6	Maintenance & Repairs							6
7	Operation of Plant	13,343	16,598	251,569		45,049	14,979	7
8	Laundry & Linen Service	2,310		41,450		3,578	3,649	8
9	Housekeeping	669		296,208		31,905	28,340	9
10	Dietary	3,234	3,726	196,324		20,261	17,271	10
11	Cafeteria	1,040		158,433		16,765	14,290	11
12	Maintenance of Personnel							12
13	Nursing Administration	929		396,857		484	10,530	13
14	Central Services & Supply	1,505	8,718			30,074		14
15	Pharmacy							15
16	Medical Records & Library	1,715	1,218	516,167		4,779	24,926	16
17	Social Service							17
19	Nonphysician Anesthetists							19
20	Nursing School							20
21	I&R Services-Salary & Fringes Apprvd							21
22	I&R Services-Other Prgm Costs Apprvd							22
23	Paramed Ed Prgm-(specify)							23
	<b>INPATIENT ROUTINE SERV COST CENTERS</b>							
30	Adults & Pediatrics	16,600	74,578	1,723,486	5,270,891	46,387	64,073	30
43	Nursery	561	2,820	216,137	192,831		6,871	43
44	Skilled Nursing Facility	9,615	17,459	964,245	2,238,875	63,173	58,265	44
	<b>ANCILLARY SERVICE COST CENTERS</b>							
50	Operating Room	16,357	104,572	686,331	6,536,634	21,119	25,117	50
52	Delivery Room & Labor Room	224		155,003	136,334		4,857	52
53	Anesthesiology	110	10,523		292,354	8,868		53
54	Radiology-Diagnostic	4,580	217,426	696,460	8,330,431	103,487	28,665	54
57	CT Scan	914	162,756	103,524	7,302,438		3,472	57
58	MRI			47,271	2,205,524		2,146	58
60	Laboratory	3,521	26,315	592,403	9,898,319	393,984	29,314	60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
65	Respiratory Therapy	2,981	20,523	405,390	1,278,618	67,563	17,444	65
66	Physical Therapy	12,363	17,856	608,208	3,188,912	7,024	22,804	66
69	Electrocardiology	600	10,122	52,250	678,664	433	2,022	69
71	Medical Supplies Charged to Patients				2,356,027	664,975		71
72	Impl. Dev. Charged to Patients				2,237,684	1,082,758		72
73	Drugs Charged to Patients	1,872	35,500	437,604	6,621,798	8,534	15,193	73
76.97	CARDIAC REHABILITATION							76.97
76.98	HYPERBARIC OXYGEN THERAPY							76.98
76.99	LITHOTRIPSY							76.99
	<b>OUTPATIENT SERVICE COST CENTERS</b>							
88	Rural Health Clinic	2,600	60	750,771		7,927	15,350	88
88.01	RHC II	2,760		300,365		4,874	9,282	88.01
88.02	RHC III	4,212	3,420	827,388		10,912	22,323	88.02
90	Clinic	2,753	9,862	571,041	549,794	16,053	21,715	90
91	Emergency	2,965	25,337	826,262	7,001,833	56,280	32,178	91
92	Observation Beds (Non-Distinct Part)							92
	<b>OTHER REIMBURSABLE COST CENTERS</b>							
95	Ambulance Services	207	20,148	712,541	3,743,102	16,228	44,703	95
101	Home Health Agency	1,274	432	541,329		9,050	19,526	101
	<b>SPECIAL PURPOSE COST CENTERS</b>							
116	Hospice	1,282	628	850,759		74,327	33,440	116
118	SUBTOTALS (sum of lines 1-117)	126,969	883,273	15,843,025	70,061,063	2,835,213	635,457	118
	<b>NONREIMBURSABLE COST CENTERS</b>							
190	Gift, Flower, Coffee Shop & Canteen	918				626	1,268	190
194	IROQUOIS WOMEN'S HEALTH	6,348	3,326	1,650,984	2,062,315	17,314	30,753	194
194.01	OTHER NON-REIMBURSABLE COSTS	2,164	621	330,762		10,344	17,890	194.01
200	Cross foot adjustments							200
201	Negative cost centers							201
202	Cost to be allocated (Per Wkst. B, Part I)	1,136,887	936,128	2,751,443	625,819	195,853	813,487	202
203	Unit Cost Multiplier (Wkst. B, Part I)	8.335010	1.055125	0.154361	0.008677	0.068396	1.186935	203
204	Cost to be allocated (Per Wkst. B, Part II)			5,016	14,357	13,654	100,970	204
205	Unit Cost Multiplier (Wkst. B, Part II)			0.000281	0.000199	0.004768	0.147322	205

IROQUOIS MEMORIAL HOSPITAL Provider CCN: 14-0167	In Lieu of Form CMS-2552-10	Period : From: 10/01/2014 To: 09/30/2015	Run Date: 02/24/2016 Run Time: 16:14 Version: 2015.10 (12/18/2015)
---	--------------------------------	--	--

COST ALLOCATION - STATISTICAL BASIS

WORKSHEET B-1

	COST CENTER DESCRIPTIONS	COMMUNICATIONS # OF PHONES	BUSINESS OFFICE GROSS CHARGES	RECONCILIATION	OTHER ADMINISTRATIVE AND GENERAL ACCUM COST	OPERATION OF PLANT SQUARE FEET	LAUNDRY & LINEN SERVICE POUNDS	
		5.04	5.05	5A.06	5.06	7	8	
	<b>GENERAL SERVICE COST CENTERS</b>							
1	Cap Rel Costs-Bldg & Fixt							1
2	Cap Rel Costs-Mvble Equip							2
4	Employee Benefits Department							4
5.01	ADMISSIONS							5.01
5.02	PURCHASING, RECEIVING, AND STORES							5.02
5.03	DATA PROCESSING							5.03
5.04	COMMUNICATIONS	365						5.04
5.05	BUSINESS OFFICE	12	74,545,369					5.05
5.06	OTHER ADMINISTRATIVE AND GENERAL	19		-1,772,220	31,664,511			5.06
6	Maintenance & Repairs							6
7	Operation of Plant	11				1,417,711	109,183	7
8	Laundry & Linen Service	1			80,494	2,310	312,085	8
9	Housekeeping	1			434,716	669	12,645	9
10	Dietary	5			456,756	3,234	2,140	10
11	Cafeteria	3			202,799	1,040		11
12	Maintenance of Personnel							12
13	Nursing Administration	13			639,708	929		13
14	Central Services & Supply				52,834	1,505	10	14
15	Pharmacy							15
16	Medical Records & Library	46			804,111	1,715		16
17	Social Service							17
19	Nonphysician Anesthetists							19
20	Nursing School							20
21	I&R Services-Salary & Fringes Apprvd							21
22	I&R Services-Other Prgm Costs Apprvd							22
23	Paramed Ed Prgm-(specify)							23
	<b>INPATIENT ROUTINE SERV COST CENTERS</b>							
30	Adults & Pediatrics	93	5,270,891		2,659,493	16,600	50,490	30
43	Nursery	5	192,831		299,497	561	625	43
44	Skilled Nursing Facility	12	2,238,875		1,586,980	9,615	139,750	44
	<b>ANCILLARY SERVICE COST CENTERS</b>							
50	Operating Room	36	6,536,634		1,489,264	16,357	31,615	50
52	Delivery Room & Labor Room	3	136,334		208,168	224		52
53	Anesthesiology		292,354		17,112	110		53
54	Radiology-Diagnostic	12	8,330,431		1,665,137	4,580	15,485	54
57	CT Scan	2	7,302,438		546,050	914		57
58	MRI	9	2,205,524		302,845			58
60	Laboratory	15	9,898,319		1,898,692	3,521	370	60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
65	Respiratory Therapy	10	1,278,618		620,503	2,981		65
66	Physical Therapy	1	3,188,912		1,006,637	12,363	13,860	66
69	Electrocardiology	4	678,664		130,511	600		69
71	Medical Supplies Charged to Patients		2,356,027		745,544			71
72	Impl. Dev. Charged to Patients		2,237,684		1,190,519			72
73	Drugs Charged to Patients	8	6,621,798		2,226,333	1,872		73
76.97	CARDIAC REHABILITATION							76.97
76.98	HYPERBARIC OXYGEN THERAPY							76.98
76.99	LITHOTRIPSY							76.99
	<b>OUTPATIENT SERVICE COST CENTERS</b>							
88	Rural Health Clinic		792,480		1,047,698	2,600		88
88.01	RHC II		495,029		469,485	2,760		88.01
88.02	RHC III		1,134,482		1,210,748	4,212		88.02
90	Clinic	14	549,794		373,802	2,753	5,165	90
91	Emergency	17	7,001,833		1,292,275	2,965	38,500	91
92	Observation Beds (Non-Distinct Part)							92
	<b>OTHER REIMBURSABLE COST CENTERS</b>							
95	Ambulance Services		3,743,102		1,102,881	207	1,430	95
101	Home Health Agency				791,336	1,274		101
	<b>SPECIAL PURPOSE COST CENTERS</b>							
116	Hospice				1,448,602	1,282		116
118	SUBTOTALS (sum of lines 1-117)	352	72,483,054	-1,772,220	28,419,241	99,753	312,085	118
	<b>NONREIMBURSABLE COST CENTERS</b>							
190	Gift, Flower, Coffee Shop & Canteen	5			52,486	918		190
194	IROQUOIS WOMEN'S HEALTH		2,062,315		2,626,385	6,348		194
194.01	OTHER NON-REIMBURSABLE COSTS	8			566,399	2,164		194.01
200	Cross foot adjustments							200
201	Negative cost centers							201
202	Cost to be allocated (Per Wkst. B, Part I)	256,174	475,937		1,772,220	1,497,059	116,672	202
203	Unit Cost Multiplier (Wkst. B, Part I)	701.846575	0.006385		0.055969	13.711466	0.373847	203
204	Cost to be allocated (Per Wkst. B, Part II)	2,511	14,464		78,221	134,820	22,879	204
205	Unit Cost Multiplier (Wkst. B, Part II)	6.879452	0.000194		0.002470	1.234808	0.073310	205

IROQUOIS MEMORIAL HOSPITAL Provider CCN: 14-0167	In Lieu of Form CMS-2552-10	Period : From: 10/01/2014 To: 09/30/2015	Run Date: 02/24/2016 Run Time: 16:14 Version: 2015.10 (12/18/2015)
---	--------------------------------	--	--

COST ALLOCATION - STATISTICAL BASIS

WORKSHEET B-1

	COST CENTER DESCRIPTIONS	HOUSE-KEEPING SQUARE FEET	DIETARY MEALS	CAFETERIA FTE'S	NURSING ADMINISTRATION NURSING HOURS	CENTRAL SERVICES & SUPPLY CSS CSTED REQ'	MEDICAL RECORDS & LIBRARY GROSS REVENUE	
		9	10	11	13	14	16	
	<b>GENERAL SERVICE COST CENTERS</b>							
1	Cap Rel Costs-Bldg & Fixt							1
2	Cap Rel Costs-Mvble Equip							2
4	Employee Benefits Department							4
5.01	ADMISSIONS							5.01
5.02	PURCHASING, RECEIVING, AND STORES							5.02
5.03	DATA PROCESSING							5.03
5.04	COMMUNICATIONS							5.04
5.05	BUSINESS OFFICE							5.05
5.06	OTHER ADMINISTRATIVE AND GENERAL							5.06
6	Maintenance & Repairs							6
7	Operation of Plant							7
8	Laundry & Linen Service							8
9	Housekeeping	96,632						9
10	Dietary	3,234	47,832					10
11	Cafeteria	1,040		19,815				11
12	Maintenance of Personnel							12
13	Nursing Administration	929		506	172,255			13
14	Central Services & Supply	1,505				14,729		14
15	Pharmacy							15
16	Medical Records & Library	1,715		1,198			64,079,086	16
17	Social Service							17
19	Nonphysician Anesthetists							19
20	Nursing School							20
21	I&R Services-Salary & Fringes Apprvd							21
22	I&R Services-Other Prgm Costs Apprvd							22
23	Paramed Ed Prgm-(specify)							23
	<b>INPATIENT ROUTINE SERV COST CENTERS</b>							
30	Adults & Pediatrics	16,600	9,034	3,080	64,073	965	5,270,891	30
43	Nursery	561		330	6,871		192,831	43
44	Skilled Nursing Facility	9,615	35,301	2,801				44
	<b>ANCILLARY SERVICE COST CENTERS</b>							
50	Operating Room	16,357	40	1,208	25,117	9,104	6,536,634	50
52	Delivery Room & Labor Room	224		234	4,857		136,334	52
53	Anesthesiology	110					292,354	53
54	Radiology-Diagnostic	4,580		1,378		345	8,330,431	54
57	CT Scan	914		167			7,302,438	57
58	MRI			103			2,205,524	58
60	Laboratory	3,521		1,409			9,898,319	60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
65	Respiratory Therapy	2,981		839	17,444	17	1,278,618	65
66	Physical Therapy	12,363		1,096			3,188,912	66
69	Electrocardiology	600		97			678,664	69
71	Medical Supplies Charged to Patients						2,356,027	71
72	Impl. Dev. Charged to Patients						2,237,684	72
73	Drugs Charged to Patients	1,872		730			6,621,798	73
76.97	CARDIAC REHABILITATION							76.97
76.98	HYPERBARIC OXYGEN THERAPY							76.98
76.99	LITHOTRIPSY							76.99
	<b>OUTPATIENT SERVICE COST CENTERS</b>							
88	Rural Health Clinic					134		88
88.01	RHC II					68		88.01
88.02	RHC III					282		88.02
90	Clinic	2,753	80	1,044	21,715	65	549,794	90
91	Emergency	2,965	498	1,547	32,178	249	7,001,833	91
92	Observation Beds (Non-Distinct Part)							92
	<b>OTHER REIMBURSABLE COST CENTERS</b>							
95	Ambulance Services	207						95
101	Home Health Agency	1,274						101
	<b>SPECIAL PURPOSE COST CENTERS</b>							
116	Hospice	1,282						116
118	SUBTOTALS (sum of lines 1-117)	87,202	44,953	17,767	172,255	11,229	64,079,086	118
	<b>NONREIMBURSABLE COST CENTERS</b>							
190	Gift, Flower, Coffee Shop & Canteen	918		61				190
194	IROQUOIS WOMEN'S HEALTH	6,348		1,127		3,500		194
194.01	OTHER NON-REIMBURSABLE COSTS	2,164	2,879	860				194.01
200	Cross foot adjustments							200
201	Negative cost centers							201
202	Cost to be allocated (Per Wkst. B, Part I)	472,947	543,291	233,499	698,760	83,797	895,142	202
203	Unit Cost Multiplier (Wkst. B, Part I)	4.894310	11.358317	11.783952	4.056544	5.689252	0.013969	203
204	Cost to be allocated (Per Wkst. B, Part II)	12,820	40,961	14,319	19,833	24,075	28,850	204
205	Unit Cost Multiplier (Wkst. B, Part II)	0.132668	0.856351	0.722634	0.115137	1.634531	0.000450	205

IROQUOIS MEMORIAL HOSPITAL Provider CCN: 14-0167	In Lieu of Form CMS-2552-10	Period : From: 10/01/2014 To: 09/30/2015	Run Date: 02/24/2016 Run Time: 16:14 Version: 2015.10 (12/18/2015)
---	--------------------------------	--	--

COST ALLOCATION - STATISTICAL BASIS

WORKSHEET B-1

	COST CENTER DESCRIPTIONS							
--	--------------------------	--	--	--	--	--	--	--

	<b>GENERAL SERVICE COST CENTERS</b>							
1	Cap Rel Costs-Bldg & Fixt							1
2	Cap Rel Costs-Mvble Equip							2
4	Employee Benefits Department							4
5.01	ADMISSIONS							5.01
5.02	PURCHASING, RECEIVING, AND STORES							5.02
5.03	DATA PROCESSING							5.03
5.04	COMMUNICATIONS							5.04
5.05	BUSINESS OFFICE							5.05
5.06	OTHER ADMINISTRATIVE AND GENERAL							5.06
6	Maintenance & Repairs							6
7	Operation of Plant							7
8	Laundry & Linen Service							8
9	Housekeeping							9
10	Dietary							10
11	Cafeteria							11
12	Maintenance of Personnel							12
13	Nursing Administration							13
14	Central Services & Supply							14
15	Pharmacy							15
16	Medical Records & Library							16
17	Social Service							17
19	Nonphysician Anesthetists							19
20	Nursing School							20
21	I&R Services-Salary & Fringes Apprvd							21
22	I&R Services-Other Prgm Costs Apprvd							22
23	Paramed Ed Prgm-(specify)							23
	<b>INPATIENT ROUTINE SERV COST CENTERS</b>							
30	Adults & Pediatrics							30
43	Nursery							43
44	Skilled Nursing Facility							44
	<b>ANCILLARY SERVICE COST CENTERS</b>							
50	Operating Room							50
52	Delivery Room & Labor Room							52
53	Anesthesiology							53
54	Radiology-Diagnostic							54
57	CT Scan							57
58	MRI							58
60	Laboratory							60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
65	Respiratory Therapy							65
66	Physical Therapy							66
69	Electrocardiology							69
71	Medical Supplies Charged to Patients							71
72	Impl. Dev. Charged to Patients							72
73	Drugs Charged to Patients							73
76.97	CARDIAC REHABILITATION							76.97
76.98	HYPERBARIC OXYGEN THERAPY							76.98
76.99	LITHOTRIPSY							76.99
	<b>OUTPATIENT SERVICE COST CENTERS</b>							
88	Rural Health Clinic							88
88.01	RHC II							88.01
88.02	RHC III							88.02
90	Clinic							90
91	Emergency							91
92	Observation Beds (Non-Distinct Part)							92
	<b>OTHER REIMBURSABLE COST CENTERS</b>							
95	Ambulance Services							95
101	Home Health Agency							101
	<b>SPECIAL PURPOSE COST CENTERS</b>							
116	Hospice							116
118	SUBTOTALS (sum of lines 1-117)							118
	<b>NONREIMBURSABLE COST CENTERS</b>							
190	Gift, Flower, Coffee Shop & Canteen							190
194	IROQUOIS WOMEN'S HEALTH							194
194.01	OTHER NON-REIMBURSABLE COSTS							194.01
200	Cross foot adjustments							200
201	Negative cost centers							201
202	Cost to be allocated (Per Wkst. B, Part I)							202
203	Unit Cost Multiplier (Wkst. B, Part I)							203
204	Cost to be allocated (Per Wkst. B, Part II)							204
205	Unit Cost Multiplier (Wkst. B, Part II)							205

IROQUOIS MEMORIAL HOSPITAL Provider CCN: 14-0167	In Lieu of Form <b>CMS-2552-10</b>	Period : From: 10/01/2014 To: 09/30/2015	Run Date: 02/24/2016 Run Time: 16:14 Version: 2015.10 (12/18/2015)
---	---------------------------------------	--	--

**POST STEPDOWN ADJUSTMENTS**

**WORKSHEET B-2**

	DESCRIPTION	WORKSHEET		
		PART	LINE NO.	AMOUNT
	1	2	3	4

IROQUOIS MEMORIAL HOSPITAL Provider CCN: 14-0167	In Lieu of Form CMS-2552-10	Period : From: 10/01/2014 To: 09/30/2015	Run Date: 02/24/2016 Run Time: 16:14 Version: 2015.10 (12/18/2015)
---	--------------------------------	--	--

COMPUTATION OF RATIO OF COST TO CHARGES

WORKSHEET C  
PART I

	COST CENTER DESCRIPTIONS	COSTS					
		Total Cost (from Wkst. B, Part I, col. 26)	Therapy Limit Adj.	Total Costs	RCE Dis- allowance	Total Costs	
		1	2	3	4	5	
	<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>						
30	Adults & Pediatrics	3,614,002		3,614,002		3,614,002	30
43	Nursery	361,388		361,388		361,388	43
44	Skilled Nursing Facility	2,340,908		2,340,908		2,340,908	44
	<b>ANCILLARY SERVICE COST CENTERS</b>						
50	Operating Room	2,148,452		2,148,452		2,148,452	50
52	Delivery Room & Labor Room	248,350		248,350		248,350	52
53	Anesthesiology	24,200		24,200		24,200	53
54	Radiology-Diagnostic	1,983,906		1,983,906		1,983,906	54
57	CT Scan	697,593		697,593		697,593	57
58	MRI	351,818		351,818		351,818	58
60	Laboratory	2,225,504		2,225,504		2,225,504	60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS						62.30
65	Respiratory Therapy	809,303		809,303		809,303	65
66	Physical Therapy	1,355,643		1,355,643		1,355,643	66
69	Electrocardiology	159,603		159,603		159,603	69
71	Medical Supplies Charged to Patients	820,182		820,182		820,182	71
72	Impl. Dev. Charged to Patients	1,288,409		1,288,409		1,288,409	72
73	Drugs Charged to Patients	2,486,871		2,486,871		2,486,871	73
76.97	CARDIAC REHABILITATION						76.97
76.98	HYPERBARIC OXYGEN THERAPY						76.98
76.99	LITHOTRIPSY						76.99
	<b>OUTPATIENT SERVICE COST CENTERS</b>						
88	Rural Health Clinic	1,142,749		1,142,749		1,142,749	88
88.01	RHC II	533,993		533,993		533,993	88.01
88.02	RHC III	1,337,869		1,337,869		1,337,869	88.02
90	Clinic	557,225		557,225		557,225	90
91	Emergency	1,687,804		1,687,804		1,687,804	91
92	Observation Beds (Non-Distinct Part)	1,084,082		1,084,082		1,084,082	92
	<b>OTHER REIMBURSABLE COST CENTERS</b>						
95	Ambulance Services	1,168,994		1,168,994		1,168,994	95
101	Home Health Agency	859,329		859,329		859,329	101
113	Interest Expense						113
116	Hospice	1,553,532		1,553,532		1,553,532	116
200	Subtotal (sum of lines 30 thru 199)	30,841,709		30,841,709		30,841,709	200
201	Less Observation Beds	1,084,082		1,084,082		1,084,082	201
202	Total (line 200 minus line 201)	29,757,627		29,757,627		29,757,627	202

IROQUOIS MEMORIAL HOSPITAL Provider CCN: 14-0167	In Lieu of Form <b>CMS-2552-10</b>	Period : From: 10/01/2014 To: 09/30/2015	Run Date: 02/24/2016 Run Time: 16:14 Version: 2015.10 (12/18/2015)
---	---------------------------------------	--	--

COMPUTATION OF RATIO OF COST TO CHARGES

WORKSHEET C  
PART I

	COST CENTER DESCRIPTIONS	CHARGES			Cost or Other Ratio	TEFRA Inpatient Ratio	PPS Inpatient Ratio	
		Inpatient	Outpatient	Total (column 6 + column 7)				
		6	7	8	9	10	11	
	<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>							
30	Adults & Pediatrics	3,505,874		3,505,874				30
43	Nursery	192,831		192,831				43
44	Skilled Nursing Facility	2,238,875		2,238,875				44
	<b>ANCILLARY SERVICE COST CENTERS</b>							
50	Operating Room	1,076,936	5,459,698	6,536,634	0.328679	0.328679	0.328679	50
52	Delivery Room & Labor Room	131,343	4,991	136,334	1.821629	1.821629	1.821629	52
53	Anesthesiology	73,870	218,484	292,354	0.082776	0.082776	0.082776	53
54	Radiology-Diagnostic	746,486	7,583,945	8,330,431	0.238152	0.238152	0.238152	54
57	CT Scan	627,632	6,674,806	7,302,438	0.095529	0.095529	0.095529	57
58	MRI	18,622	2,186,902	2,205,524	0.159517	0.159517	0.159517	58
60	Laboratory	1,214,947	8,683,372	9,898,319	0.224837	0.224837	0.224837	60
62.30	<b>BLOOD CLOTTING FOR HEMOPHILIACS</b>							62.30
65	Respiratory Therapy	401,751	876,867	1,278,618	0.632951	0.632951	0.632951	65
66	Physical Therapy	467,763	2,720,518	3,188,281	0.425196	0.425196	0.425196	66
69	Electrocardiology	329,826	348,838	678,664	0.235172	0.235172	0.235172	69
71	Medical Supplies Charged to Patients	1,032,838	1,323,189	2,356,027	0.348121	0.348121	0.348121	71
72	Impl. Dev. Charged to Patients	772,157	1,465,527	2,237,684	0.575778	0.575778	0.575778	72
73	Drugs Charged to Patients	2,296,773	4,325,025	6,621,798	0.375558	0.375558	0.375558	73
76.97	<b>CARDIAC REHABILITATION</b>							76.97
76.98	<b>HYPERBARIC OXYGEN THERAPY</b>							76.98
76.99	<b>LITHOTRIPSY</b>							76.99
	<b>OUTPATIENT SERVICE COST CENTERS</b>							
88	Rural Health Clinic		792,480	792,480				88
88.01	RHC II		495,029	495,029				88.01
88.02	RHC III		1,134,482	1,134,482				88.02
90	Clinic		549,794	549,794	1.013516	1.013516	1.013516	90
91	Emergency	629,481	6,372,352	7,001,833	0.241052	0.241052	0.241052	91
92	Observation Beds (Non-Distinct Part)	334,945	1,430,072	1,765,017	0.614205	0.614205	0.614205	92
	<b>OTHER REIMBURSABLE COST CENTERS</b>							
95	Ambulance Services	2,403	3,740,699	3,743,102	0.312306	0.312306	0.312306	95
101	Home Health Agency		762,312	762,312				101
113	Interest Expense							113
116	Hospice		1,721,196	1,721,196				116
200	Subtotal (sum of lines 30 thru 199)	16,095,353	58,870,578	74,965,931				200
201	Less Observation Beds							201
202	Total (line 200 minus line 201)	16,095,353	58,870,578	74,965,931				202

IROQUOIS MEMORIAL HOSPITAL Provider CCN: 14-0167	In Lieu of Form <b>CMS-2552-10</b>	Period : From: 10/01/2014 To: 09/30/2015	Run Date: 02/24/2016 Run Time: 16:14 Version: 2015.10 (12/18/2015)
---	---------------------------------------	--	--

APPORTIONMENT OF INPATIENT ROUTINE SERVICE CAPITAL COSTS

**WORKSHEET D  
PART I**

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

(A)	Cost Center Description	Capital Related Cost (from Wkst. B, Part II, (col. 26))	Swing Bed Adjustment	Reduced Capital Related Cost (col. 1 minus col. 2)	Total Patient Days	Per Diem (col. 3 ÷ col. 4)	Inpatient Program Days	Inpatient Program Capital Cost (col. 5 x col. 6)	
	<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>								
30	Adults & Pediatrics General Routine Care)	295,682		295,682	3,077	96.09	1,387	133,277	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	11,502		11,502	125	92.02			43
44	Skilled Nursing Facility	170,827		170,827	11,920	14.33	1,046	14,989	44
45	Nursing Facility								45
200	Total (lines 30-199)	478,011		478,011	15,122		2,433	148,266	200

(A) Worksheet A line numbers

IROQUOIS MEMORIAL HOSPITAL Provider CCN: 14-0167	In Lieu of Form <b>CMS-2552-10</b>	Period : From: 10/01/2014 To: 09/30/2015	Run Date: 02/24/2016 Run Time: 16:14 Version: 2015.10 (12/18/2015)
---	---------------------------------------	--	--

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS

COMPONENT CCN: 14-0167

WORKSHEET D  
PART II

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

(A)	Cost Center Description	Capital Related Cost (from Wkst. B, Part II (col. 26))	Total Charges (from Wkst. C, Part I, (col. 8))	Ratio of Cost to Charges (col. 1 ÷ col. 2)	Inpatient Program Charges	Capital Costs (col. 3 x col. 4)	
		1	2	3	4	5	
	<b>ANCILLARY SERVICE COST CENTERS</b>						
50	Operating Room	310,621	6,536,634	0.047520	852,924	40,531	50
52	Delivery Room & Labor Room	4,311	136,334	0.031621			52
53	Anesthesiology	12,502	292,354	0.042763	38,792	1,659	53
54	Radiology-Diagnostic	455,097	8,330,431	0.054631	486,827	26,596	54
57	CT Scan	188,777	7,302,438	0.025851	568,424	14,694	57
58	MRI	3,072	2,205,524	0.001393	18,331	26	58
60	Laboratory	86,270	9,898,319	0.008716	998,806	8,706	60
62.30	<b>BLOOD CLOTTING FOR HEMOPHILIACS</b>						62.30
65	Respiratory Therapy	66,238	1,278,618	0.051804	365,223	18,920	65
66	Physical Therapy	153,871	3,188,281	0.048261	106,409	5,135	66
69	Electrocardiology	17,986	678,664	0.026502	314,042	8,323	69
71	Medical Supplies Charged to Pat	6,998	2,356,027	0.002970	290,767	864	71
72	Impl. Dev. Charged to Patients	9,992	2,237,684	0.004465	441,873	1,973	72
73	Drugs Charged to Patients	71,225	6,621,798	0.010756	1,574,876	16,939	73
76.97	CARDIAC REHABILITATION						76.97
76.98	HYPERBARIC OXYGEN THERAPY						76.98
76.99	LITHOTRIPSY						76.99
	<b>OUTPATIENT SERVICE COST CENTERS</b>						
88	Rural Health Clinic	31,827	792,480	0.040161			88
88.01	RHC II	30,845	495,029	0.062309			88.01
88.02	RHC III	55,503	1,134,482	0.048924			88.02
90	Clinic	47,618	549,794	0.086611			90
91	Emergency	81,076	7,001,833	0.011579	419,257	4,855	91
92	Observation Beds (Non-Distinct	88,695	1,765,017	0.050252	247,774	12,451	92
	<b>OTHER REIMBURSABLE COST CENTERS</b>						
95	Ambulance Services						95
200	Total (sum of lines 50-199)	1,722,524	62,801,741		6,724,325	161,672	200

(A) Worksheet A line numbers

IROQUOIS MEMORIAL HOSPITAL Provider CCN: 14-0167	In Lieu of Form <b>CMS-2552-10</b>	Period : From: 10/01/2014 To: 09/30/2015	Run Date: 02/24/2016 Run Time: 16:14 Version: 2015.10 (12/18/2015)
---	---------------------------------------	--	--

APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PASS THROUGH COSTS

**WORKSHEET D  
PART III**

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

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

(A) Worksheet A line numbers

IROQUOIS MEMORIAL HOSPITAL Provider CCN: 14-0167	In Lieu of Form <b>CMS-2552-10</b>	Period : From: 10/01/2014 To: 09/30/2015	Run Date: 02/24/2016 Run Time: 16:14 Version: 2015.10 (12/18/2015)
---	---------------------------------------	--	--

APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PASS THROUGH COSTS

**WORKSHEET D  
PART III**

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

		Total Patient Days	Per Diem (col. 5 ÷ col. 6)	Inpatient Program Days	Inpatient Program Pass-Through Cost (col. 7 x col. 8)	
(A)	Cost Center Description	6	7	8	9	
	<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>					
30	Adults & Pediatrics (General Routine Care)	3,077		1,387		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	125				43
44	Skilled Nursing Facility	11,920		1,046		44
45	Nursing Facility					45
200	Total (lines 30-199)	15,122		2,433		200

(A) Worksheet A line numbers

IROQUOIS MEMORIAL HOSPITAL Provider CCN: 14-0167	In Lieu of Form <b>CMS-2552-10</b>	Period : From: 10/01/2014 To: 09/30/2015	Run Date: 02/24/2016 Run Time: 16:14 Version: 2015.10 (12/18/2015)
---	---------------------------------------	--	--

**APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE  
OTHER PASS THROUGH COSTS**

COMPONENT CCN: 14-0167

**WORKSHEET D  
PART IV**

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

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

(A) Worksheet A line numbers

IROQUOIS MEMORIAL HOSPITAL Provider CCN: 14-0167	In Lieu of Form CMS-2552-10	Period : From: 10/01/2014 To: 09/30/2015	Run Date: 02/24/2016 Run Time: 16:14 Version: 2015.10 (12/18/2015)
---	--------------------------------	--	--

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE  
OTHER PASS THROUGH COSTS

COMPONENT CCN: 14-0167

WORKSHEET D  
PART IV

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

(A)	Cost Center Description	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 5÷ col. 7)	Outpatient Ratio of Cost to Charges (col. 6÷ col. 7)	Inpatient Program Charges	Inpatient Program Pass-Through Costs (col. 8 x col. 10)	Outpatient Program Charges	Outpatient Program Pass-Through Costs (col. 9 x col. 12)	
7	8	9	10	11	12	13			
	<b>ANCILLARY SERVICE COST CENTERS</b>								
50	Operating Room	6,536,634			852,924		2,394,027		50
52	Delivery Room & Labor Room	136,334							52
53	Anesthesiology	292,354			38,792		58,689		53
54	Radiology-Diagnostic	8,330,431			486,827		3,143,753		54
57	CT Scan	7,302,438			568,424		2,688,441		57
58	MRI	2,205,524			18,331		687,692		58
60	Laboratory	9,898,319			998,806		1,534,873		60
62.30	<b>BLOOD CLOTTING FOR HEMOPHILIACS</b>								62.30
65	Respiratory Therapy	1,278,618			365,223		400,673		65
66	Physical Therapy	3,188,281			106,409				66
69	Electrocardiology	678,664			314,042		615,256		69
71	Medical Supplies Charged to Pat	2,356,027			290,767		249,631		71
72	Impl. Dev. Charged to Patients	2,237,684			441,873		1,041,194		72
73	Drugs Charged to Patients	6,621,798			1,574,876		2,510,657		73
76.97	CARDIAC REHABILITATION								76.97
76.98	HYPERBARIC OXYGEN THERAPY								76.98
76.99	LITHOTRIPSY								76.99
	<b>OUTPATIENT SERVICE COST CENTERS</b>								
88	Rural Health Clinic	792,480							88
88.01	RHC II	495,029							88.01
88.02	RHC III	1,134,482							88.02
90	Clinic	549,794					1,445		90
91	Emergency	7,001,833			419,257		1,740,461		91
92	Observation Beds (Non-Distinct	1,765,017			247,774		940,818		92
	<b>OTHER REIMBURSABLE COST CENTERS</b>								
95	Ambulance Services								95
200	Total (sum of lines 50-199)	62,801,741			6,724,325		18,007,610		200

(A) Worksheet A line numbers

IROQUOIS MEMORIAL HOSPITAL Provider CCN: 14-0167	In Lieu of Form CMS-2552-10	Period : From: 10/01/2014 To: 09/30/2015	Run Date: 02/24/2016 Run Time: 16:14 Version: 2015.10 (12/18/2015)
---	--------------------------------	--	--

APPORTIONMENT OF MEDICAL AND OTHER HEALTH SERVICE COSTS

COMPONENT CCN: 14-0167

WORKSHEET D  
PART V

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

(A)	Cost Center Description	Program Charges				Program Cost			
		Cost to Charge Ratio (from Wkst C, Part I, col. 9)	PPS Reim-bursed Services (see inst.)	Cost Reim-bursed Subject to Ded. & Coins. (see inst.)	Cost Reim-bursed Not Subject to Ded. & Coins. (see inst.)	PPS Services (see inst.)	Cost Reim-bursed Subject to Ded. & Coins. (see inst.)	Cost Reim-bursed Not Subject to Ded. & Coins. (see inst.)	
		1	2	3	4	5	6	7	
	<b>ANCILLARY SERVICE COST CENTERS</b>								
50	Operating Room	0.328679	2,394,027			786,866			50
52	Delivery Room & Labor Room	1.821629							52
53	Anesthesiology	0.082776	58,689			4,858			53
54	Radiology-Diagnostic	0.238152	3,143,753			748,691			54
57	CT Scan	0.095529	2,688,441			256,824			57
58	MRI	0.159517	687,692			109,699			58
60	Laboratory	0.224837	1,534,873			345,096			60
62.30	<b>BLOOD CLOTTING FOR HEMOPHILIACS</b>								62.30
65	Respiratory Therapy	0.632951	400,673			253,606			65
66	Physical Therapy	0.425196							66
69	Electrocardiology	0.235172	615,256			144,691			69
71	Medical Supplies Charged to Pat	0.348121	249,631			86,902			71
72	Impl. Dev. Charged to Patients	0.575778	1,041,194			599,497			72
73	Drugs Charged to Patients	0.375558	2,510,657			942,897			73
76.97	CARDIAC REHABILITATION								76.97
76.98	HYPERBARIC OXYGEN THERAPY								76.98
76.99	LITHOTRIPSY								76.99
	<b>OUTPATIENT SERVICE COST CENTERS</b>								
88	Rural Health Clinic								88
88.01	RHC II								88.01
88.02	RHC III								88.02
90	Clinic	1.013516	1,445			1,465			90
91	Emergency	0.241052	1,740,461			419,542			91
92	Observation Beds (Non-Distinct	0.614205	940,818			577,855			92
	<b>OTHER REIMBURSABLE COST CENTERS</b>								
95	Ambulance Services	0.312306							95
200	Subtotal (see instructions)		18,007,610			5,278,489			200
201	Less PBP Clinic Lab. Services-Program Only Charges								201
202	Net Charges (line 200 - line 201)		18,007,610			5,278,489			202

(A) Worksheet A line numbers

IROQUOIS MEMORIAL HOSPITAL Provider CCN: 14-0167	In Lieu of Form <b>CMS-2552-10</b>	Period : From: 10/01/2014 To: 09/30/2015	Run Date: 02/24/2016 Run Time: 16:14 Version: 2015.10 (12/18/2015)
---	---------------------------------------	--	--

APPORTIONMENT OF MEDICAL AND OTHER HEALTH SERVICE COSTS

COMPONENT CCN: 14-U167

WORKSHEET D  
PART V

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

(A)	Cost Center Description	Program Charges				Program Cost			
		Cost to Charge Ratio (from Wkst C, Part I, col. 9)	PPS Reim-bursed Services (see inst.)	Cost Reim-bursed Subject to Ded. & Coins. (see inst.)	Cost Reim-bursed Not Subject to Ded. & Coins. (see inst.)	PPS Services (see inst.)	Cost Reim-bursed Subject to Ded. & Coins. (see inst.)	Cost Reim-bursed Not Subject to Ded. & Coins. (see inst.)	
		1	2	3	4	5	6	7	
	<b>ANCILLARY SERVICE COST CENTERS</b>								
50	Operating Room	0.328679							50
52	Delivery Room & Labor Room	1.821629							52
53	Anesthesiology	0.082776							53
54	Radiology-Diagnostic	0.238152							54
57	CT Scan	0.095529							57
58	MRI	0.159517							58
60	Laboratory	0.224837							60
62.30	<b>BLOOD CLOTTING FOR HEMOPHILIACS</b>								62.30
65	Respiratory Therapy	0.632951							65
66	Physical Therapy	0.425196							66
69	Electrocardiology	0.235172							69
71	Medical Supplies Charged to Pat	0.348121							71
72	Impl. Dev. Charged to Patients	0.575778							72
73	Drugs Charged to Patients	0.375558							73
76.97	<b>CARDIAC REHABILITATION</b>								76.97
76.98	<b>HYPERBARIC OXYGEN THERAPY</b>								76.98
76.99	<b>LITHOTRIPSY</b>								76.99
	<b>OUTPATIENT SERVICE COST CENTERS</b>								
88	Rural Health Clinic								88
88.01	RHC II								88.01
88.02	RHC III								88.02
90	Clinic	1.013516							90
91	Emergency	0.241052							91
92	Observation Beds (Non-Distinct)	0.614205							92
	<b>OTHER REIMBURSABLE COST CENTERS</b>								
95	Ambulance Services	0.312306							95
200	Subtotal (see instructions)								200
201	Less PBP Clinic Lab. Services-Program Only Charges								201
202	Net Charges (line 200 - line 201)								202

(A) Worksheet A line numbers

IROQUOIS MEMORIAL HOSPITAL Provider CCN: 14-0167	In Lieu of Form <b>CMS-2552-10</b>	Period : From: 10/01/2014 To: 09/30/2015	Run Date: 02/24/2016 Run Time: 16:14 Version: 2015.10 (12/18/2015)
---	---------------------------------------	--	--

**APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE  
OTHER PASS THROUGH COSTS**

**COMPONENT CCN: 14-6049**

**WORKSHEET D  
PART IV**

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

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

(A) Worksheet A line numbers

IROQUOIS MEMORIAL HOSPITAL Provider CCN: 14-0167	In Lieu of Form CMS-2552-10	Period : From: 10/01/2014 To: 09/30/2015	Run Date: 02/24/2016 Run Time: 16:14 Version: 2015.10 (12/18/2015)
---	--------------------------------	--	--

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE  
OTHER PASS THROUGH COSTS

COMPONENT CCN: 14-6049

WORKSHEET D  
PART IV

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

(A)	Cost Center Description	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 5÷ col. 7)	Outpatient Ratio of Cost to Charges (col. 6÷ col. 7)	Inpatient Program Charges	Inpatient Program Pass-Through Costs (col. 8 x col. 10)	Outpatient Program Charges	Outpatient Program Pass-Through Costs (col. 9 x col. 12)	
7	8	9	10	11	12	13			
	<b>ANCILLARY SERVICE COST CENTERS</b>								
50	Operating Room	6,536,634							50
52	Delivery Room & Labor Room	136,334							52
53	Anesthesiology	292,354							53
54	Radiology-Diagnostic	8,330,431			10,323				54
57	CT Scan	7,302,438							57
58	MRI	2,205,524							58
60	Laboratory	9,898,319			19,158				60
62.30	<b>BLOOD CLOTTING FOR HEMOPHILIACS</b>								62.30
65	Respiratory Therapy	1,278,618			301				65
66	Physical Therapy	3,188,281			312,490				66
69	Electrocardiology	678,664							69
71	Medical Supplies Charged to Pat	2,356,027			6,375				71
72	Impl. Dev. Charged to Patients	2,237,684							72
73	Drugs Charged to Patients	6,621,798			57,525				73
76.97	CARDIAC REHABILITATION								76.97
76.98	HYPERBARIC OXYGEN THERAPY								76.98
76.99	LITHOTRIPSY								76.99
	<b>OUTPATIENT SERVICE COST CENTERS</b>								
88	Rural Health Clinic	792,480							88
88.01	RHC II	495,029							88.01
88.02	RHC III	1,134,482							88.02
90	Clinic	549,794							90
91	Emergency	7,001,833							91
92	Observation Beds (Non-Distinct	1,765,017							92
	<b>OTHER REIMBURSABLE COST CENTERS</b>								
95	Ambulance Services								95
200	Total (sum of lines 50-199)	62,801,741			406,172				200

(A) Worksheet A line numbers

IROQUOIS MEMORIAL HOSPITAL Provider CCN: 14-0167	In Lieu of Form CMS-2552-10	Period : From: 10/01/2014 To: 09/30/2015	Run Date: 02/24/2016 Run Time: 16:14 Version: 2015.10 (12/18/2015)
---	--------------------------------	--	--

APPORTIONMENT OF MEDICAL AND OTHER HEALTH SERVICE COSTS

COMPONENT CCN: 14-6049

WORKSHEET D  
PART V

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

(A)	Cost Center Description	Program Charges				Program Cost			
		Cost to Charge Ratio (from Wkst C, Part I, col. 9)	PPS Reim-bursed Services (see inst.)	Cost Reim-bursed Subject to Ded. & Coins. (see inst.)	Cost Reim-bursed Not Subject to Ded. & Coins. (see inst.)	PPS Services (see inst.)	Cost Reim-bursed Subject to Ded. & Coins. (see inst.)	Cost Reim-bursed Not Subject to Ded. & Coins. (see inst.)	
		1	2	3	4	5	6	7	
	<b>ANCILLARY SERVICE COST CENTERS</b>								
50	Operating Room	0.328679							50
52	Delivery Room & Labor Room	1.821629							52
53	Anesthesiology	0.082776							53
54	Radiology-Diagnostic	0.238152							54
57	CT Scan	0.095529							57
58	MRI	0.159517							58
60	Laboratory	0.224837							60
62.30	<b>BLOOD CLOTTING FOR HEMOPHILIACS</b>								62.30
65	Respiratory Therapy	0.632951							65
66	Physical Therapy	0.425196							66
69	Electrocardiology	0.235172							69
71	Medical Supplies Charged to Pat	0.348121							71
72	Impl. Dev. Charged to Patients	0.575778							72
73	Drugs Charged to Patients	0.375558							73
76.97	<b>CARDIAC REHABILITATION</b>								76.97
76.98	<b>HYPERBARIC OXYGEN THERAPY</b>								76.98
76.99	<b>LITHOTRIPSY</b>								76.99
	<b>OUTPATIENT SERVICE COST CENTERS</b>								
88	Rural Health Clinic								88
88.01	RHC II								88.01
88.02	RHC III								88.02
90	Clinic	1.013516							90
91	Emergency	0.241052							91
92	Observation Beds (Non-Distinct)	0.614205							92
	<b>OTHER REIMBURSABLE COST CENTERS</b>								
95	Ambulance Services	0.312306							95
200	Subtotal (see instructions)								200
201	Less PBP Clinic Lab. Services-Program Only Charges								201
202	Net Charges (line 200 - line 201)								202

(A) Worksheet A line numbers

IROQUOIS MEMORIAL HOSPITAL Provider CCN: 14-0167	In Lieu of Form <b>CMS-2552-10</b>	Period : From: 10/01/2014 To: 09/30/2015	Run Date: 02/24/2016 Run Time: 16:14 Version: 2015.10 (12/18/2015)
---	---------------------------------------	--	--

APPORTIONMENT OF INPATIENT ROUTINE SERVICE CAPITAL COSTS

**WORKSHEET D  
PART I**

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

(A)	Cost Center Description	Capital Related Cost (from Wkst. B, Part II, (col. 26))	Swing Bed Adjustment	Reduced Capital Related Cost (col. 1 minus col. 2)	Total Patient Days	Per Diem (col. 3 ÷ col. 4)	Inpatient Program Days	Inpatient Program Capital Cost (col. 5 x col. 6)	
		1	2	3	4	5	6	7	
	<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>								
30	Adults & Pediatrics General Routine Care)	295,682		295,682	3,077	96.09	342	32,863	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	11,502		11,502	125	92.02			43
44	Skilled Nursing Facility	170,827		170,827	11,920	14.33			44
45	Nursing Facility								45
200	Total (lines 30-199)	478,011		478,011	15,122		342	32,863	200

(A) Worksheet A line numbers

IROQUOIS MEMORIAL HOSPITAL Provider CCN: 14-0167	In Lieu of Form <b>CMS-2552-10</b>	Period : From: 10/01/2014 To: 09/30/2015	Run Date: 02/24/2016 Run Time: 16:14 Version: 2015.10 (12/18/2015)
---	---------------------------------------	--	--

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS

COMPONENT CCN: 14-0167

WORKSHEET D  
PART II

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

(A)	Cost Center Description	Capital Related Cost (from Wkst. B, Part II (col. 26))	Total Charges (from Wkst. C, Part I, (col. 8))	Ratio of Cost to Charges (col. 1 ÷ col. 2)	Inpatient Program Charges	Capital Costs (col. 3 x col. 4)	
		1	2	3	4	5	
	<b>ANCILLARY SERVICE COST CENTERS</b>						
50	Operating Room	310,621	6,536,634	0.047520	223,820	10,636	50
52	Delivery Room & Labor Room	4,311	136,334	0.031621	73,801	2,334	52
53	Anesthesiology	12,502	292,354	0.042763	15,083	645	53
54	Radiology-Diagnostic	455,097	8,330,431	0.054631	56,883	3,108	54
57	CT Scan	188,777	7,302,438	0.025851	55,611	1,438	57
58	MRI	3,072	2,205,524	0.001393			58
60	Laboratory	86,270	9,898,319	0.008716	194,693	1,697	60
62.30	<b>BLOOD CLOTTING FOR HEMOPHILIACS</b>						62.30
65	Respiratory Therapy	66,238	1,278,618	0.051804	35,221	1,825	65
66	Physical Therapy	153,871	3,188,281	0.048261	8,032	388	66
69	Electrocardiology	17,986	678,664	0.026502	13,740	364	69
71	Medical Supplies Charged to Pat	6,998	2,356,027	0.002970	47,711	142	71
72	Impl. Dev. Charged to Patients	9,992	2,237,684	0.004465	30,320	135	72
73	Drugs Charged to Patients	71,225	6,621,798	0.010756	254,558	2,738	73
76.97	CARDIAC REHABILITATION						76.97
76.98	HYPERBARIC OXYGEN THERAPY						76.98
76.99	LITHOTRIPSY						76.99
	<b>OUTPATIENT SERVICE COST CENTERS</b>						
88	Rural Health Clinic	31,827	792,480	0.040161			88
88.01	RHC II	30,845	495,029	0.062309			88.01
88.02	RHC III	55,503	1,134,482	0.048924			88.02
90	Clinic	47,618	549,794	0.086611			90
91	Emergency	81,076	7,001,833	0.011579	764	9	91
92	Observation Beds (Non-Distinct	88,695	1,765,017	0.050252			92
	<b>OTHER REIMBURSABLE COST CENTERS</b>						
95	Ambulance Services						95
200	Total (sum of lines 50-199)	1,722,524	62,801,741		1,010,237	25,459	200

(A) Worksheet A line numbers

IROQUOIS MEMORIAL HOSPITAL Provider CCN: 14-0167	In Lieu of Form <b>CMS-2552-10</b>	Period : From: 10/01/2014 To: 09/30/2015	Run Date: 02/24/2016 Run Time: 16:14 Version: 2015.10 (12/18/2015)
---	---------------------------------------	--	--

APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PASS THROUGH COSTS

**WORKSHEET D  
PART III**

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

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

(A) Worksheet A line numbers

IROQUOIS MEMORIAL HOSPITAL Provider CCN: 14-0167	In Lieu of Form <b>CMS-2552-10</b>	Period : From: 10/01/2014 To: 09/30/2015	Run Date: 02/24/2016 Run Time: 16:14 Version: 2015.10 (12/18/2015)
---	---------------------------------------	--	--

APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PASS THROUGH COSTS

**WORKSHEET D  
PART III**

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

		Total Patient Days	Per Diem (col. 5 ÷ col. 6)	Inpatient Program Days	Inpatient Program Pass-Through Cost (col. 7 x col. 8)	
(A)	Cost Center Description	6	7	8	9	
	<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>					
30	Adults & Pediatrics (General Routine Care)	3,077		342		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	125				43
44	Skilled Nursing Facility	11,920				44
45	Nursing Facility					45
200	Total (lines 30-199)	15,122		342		200

(A) Worksheet A line numbers

IROQUOIS MEMORIAL HOSPITAL Provider CCN: 14-0167	In Lieu of Form CMS-2552-10	Period : From: 10/01/2014 To: 09/30/2015	Run Date: 02/24/2016 Run Time: 16:14 Version: 2015.10 (12/18/2015)
---	--------------------------------	--	--

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE  
OTHER PASS THROUGH COSTS

COMPONENT CCN: 14-0167

WORKSHEET D  
PART IV

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

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

(A) Worksheet A line numbers

IROQUOIS MEMORIAL HOSPITAL Provider CCN: 14-0167	In Lieu of Form CMS-2552-10	Period : From: 10/01/2014 To: 09/30/2015	Run Date: 02/24/2016 Run Time: 16:14 Version: 2015.10 (12/18/2015)
---	--------------------------------	--	--

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE  
OTHER PASS THROUGH COSTS

COMPONENT CCN: 14-0167

WORKSHEET D  
PART IV

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

(A)	Cost Center Description	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 5÷ col. 7)	Outpatient Ratio of Cost to Charges (col. 6÷ col. 7)	Inpatient Program Charges	Inpatient Program Pass-Through Costs (col. 8 x col. 10)	Outpatient Program Charges	Outpatient Program Pass-Through Costs (col. 9 x col. 12)	
7	8	9	10	11	12	13			
	<b>ANCILLARY SERVICE COST CENTERS</b>								
50	Operating Room	6,536,634			223,820				50
52	Delivery Room & Labor Room	136,334			73,801				52
53	Anesthesiology	292,354			15,083				53
54	Radiology-Diagnostic	8,330,431			56,883				54
57	CT Scan	7,302,438			55,611				57
58	MRI	2,205,524							58
60	Laboratory	9,898,319			194,693				60
62.30	<b>BLOOD CLOTTING FOR HEMOPHILIACS</b>								62.30
65	Respiratory Therapy	1,278,618			35,221				65
66	Physical Therapy	3,188,281			8,032				66
69	Electrocardiology	678,664			13,740				69
71	Medical Supplies Charged to Pat	2,356,027			47,711				71
72	Impl. Dev. Charged to Patients	2,237,684			30,320				72
73	Drugs Charged to Patients	6,621,798			254,558				73
76.97	CARDIAC REHABILITATION								76.97
76.98	HYPERBARIC OXYGEN THERAPY								76.98
76.99	LITHOTRIPSY								76.99
	<b>OUTPATIENT SERVICE COST CENTERS</b>								
88	Rural Health Clinic	792,480							88
88.01	RHC II	495,029							88.01
88.02	RHC III	1,134,482							88.02
90	Clinic	549,794							90
91	Emergency	7,001,833			764				91
92	Observation Beds (Non-Distinct	1,765,017							92
	<b>OTHER REIMBURSABLE COST CENTERS</b>								
95	Ambulance Services								95
200	Total (sum of lines 50-199)	62,801,741			1,010,237				200

(A) Worksheet A line numbers

IROQUOIS MEMORIAL HOSPITAL Provider CCN: 14-0167	In Lieu of Form CMS-2552-10	Period : From: 10/01/2014 To: 09/30/2015	Run Date: 02/24/2016 Run Time: 16:14 Version: 2015.10 (12/18/2015)
---	--------------------------------	--	--

APPORTIONMENT OF MEDICAL AND OTHER HEALTH SERVICE COSTS

COMPONENT CCN: 14-0167

WORKSHEET D  
PART V

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

(A)	Cost Center Description	Program Charges				Program Cost		
		Cost to Charge Ratio (from Wkst C, Part I, col. 9)	PPS Reim-bursed Services (see inst.)	Cost Reim-bursed Subject to Ded. & Coins. (see inst.)	Cost Reim-bursed Not Subject to Ded. & Coins. (see inst.)	PPS Services (see inst.)	Cost Reim-bursed Subject to Ded. & Coins. (see inst.)	Cost Reim-bursed Not Subject to Ded. & Coins. (see inst.)
		1	2	3	4	5	6	7
	<b>ANCILLARY SERVICE COST CENTERS</b>							
50	Operating Room	0.328679		1,109,560			364,689	50
52	Delivery Room & Labor Room	1.821629						52
53	Anesthesiology	0.082776		63,114			5,224	53
54	Radiology-Diagnostic	0.238152		1,248,109			297,240	54
57	CT Scan	0.095529		1,223,261			116,857	57
58	MRI	0.159517		644,200			102,761	58
60	Laboratory	0.224837		1,372,923			308,684	60
62.30	<b>BLOOD CLOTTING FOR HEMOPHILIACS</b>							62.30
65	Respiratory Therapy	0.632951		78,960			49,978	65
66	Physical Therapy	0.425196		2,851			1,212	66
69	Electrocardiology	0.235172		173,197			40,731	69
71	Medical Supplies Charged to Pat	0.348121		102,614			35,722	71
72	Impl. Dev. Charged to Patients	0.575778		122,832			70,724	72
73	Drugs Charged to Patients	0.375558		812,914			305,296	73
76.97	CARDIAC REHABILITATION							76.97
76.98	HYPERBARIC OXYGEN THERAPY							76.98
76.99	LITHOTRIPSY							76.99
	<b>OUTPATIENT SERVICE COST CENTERS</b>							
88	Rural Health Clinic							88
88.01	RHC II							88.01
88.02	RHC III							88.02
90	Clinic	1.013516						90
91	Emergency	0.241052		1,762,082			424,753	91
92	Observation Beds (Non-Distinct	0.614205						92
	<b>OTHER REIMBURSABLE COST CENTERS</b>							
95	Ambulance Services	0.312306						95
200	Subtotal (see instructions)			8,716,617			2,123,871	200
201	Less PBP Clinic Lab. Services-Program Only Charges							201
202	Net Charges (line 200 - line 201)			8,716,617			2,123,871	202

(A) Worksheet A line numbers

IROQUOIS MEMORIAL HOSPITAL Provider CCN: 14-0167	In Lieu of Form CMS-2552-10	Period : From: 10/01/2014 To: 09/30/2015	Run Date: 02/24/2016 Run Time: 16:14 Version: 2015.10 (12/18/2015)
---	--------------------------------	--	--

COMPUTATION OF INPATIENT OPERATING COST

COMPONENT CCN: 14-0167

WORKSHEET D-1  
PART I

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

PART I - ALL PROVIDER COMPONENTS

INPATIENT DAYS

1	Inpatient days (including private room days and swing-bed days, excluding newborn)	3,077	1
2	Inpatient days (including private room days, excluding swing-bed and newborn days)	3,077	2
3	Private room days (excluding swing-bed private room days). If you have only private room days, do not complete this line.		3
4	Semi-private room days (excluding swing-bed private room days)	2,154	4
5	Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost reporting period		5
6	Total swing-bed SNF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		6
7	Total swing-bed NF type inpatient days (including private room days) through December 31 of the cost reporting period		7
8	Total swing-bed NF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		8
9	Total inpatient days including private room days applicable to the Program (excluding swing-bed and newborn days)	1,387	9
10	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) through December 31 of the cost reporting period (see instructions)		10
11	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		11
12	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) through December 31 of the cost reporting period		12
13	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		13
14	Medically necessary private room days applicable to the program (excluding swing-bed days)		14
15	Total nursery days (title V or XIX only)		15
16	Nursery days (title V or XIX only)		16

SWING-BED ADJUSTMENT

17	Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost reporting period	202.51	17
18	Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period	207.37	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)	3,614,002	21
22	Swing-bed cost applicable to SNF type services through December 31 of the cost reporting period (line 5 x line 17)		22
23	Swing-bed cost applicable to SNF type services after December 31 of the cost reporting period (line 6 x line 18)		23
24	Swing-bed cost applicable to NF type services through December 31 of the cost reporting period (line 7 x line 19)		24
25	Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8 x line 20)		25
26	Total swing-bed cost (see instructions)		26
27	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)	3,614,002	27

PRIVATE ROOM DIFFERENTIAL ADJUSTMENT

28	General inpatient routine service charges (excluding swing-bed and observation bed charges)		28
29	Private room charges (excluding swing-bed charges)		29
30	Semi-private room charges (excluding swing-bed charges)		30
31	General inpatient routine service cost/charge ratio (line 27 ÷ line 28)		31
32	Average private room per diem charge (line 29 ÷ line 3)		32
33	Average semi-private room per diem charge (line 30 ÷ line 4)		33
34	Average per diem private room charge differential (line 32 minus line 33) (see instructions)		34
35	Average per diem private room cost differential (line 34 x line 31)		35
36	Private room cost differential adjustment (line 3 x line 35)		36
37	General inpatient routine service cost net of swing-bed cost and private room cost differential (line 27 minus line 36)	3,614,002	37

IROQUOIS MEMORIAL HOSPITAL Provider CCN: 14-0167	In Lieu of Form CMS-2552-10	Period : From: 10/01/2014 To: 09/30/2015	Run Date: 02/24/2016 Run Time: 16:14 Version: 2015.10 (12/18/2015)
---	--------------------------------	--	--

COMPUTATION OF INPATIENT OPERATING COST

COMPONENT CCN: 14-0167

WORKSHEET D-1  
PART II

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

PART II - HOSPITALS AND SUBPROVIDERS ONLY

PROGRAM INPATIENT OPERATING COST BEFORE PASS-THROUGH COST ADJUSTMENTS

							1	
		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		
38	Adjusted general inpatient routine service cost per diem (see instructions)					1,174.52	38	
39	Program general inpatient routine service cost (line 9 x line 38)					1,629,059	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)					1,629,059	41	
42	Nursery (Titles V and XIX only)						42	
	<b>Intensive Care Type Inpatient Hospital Units</b>							
43	Intensive Care Unit						43	
44	Coronary Care Unit						44	
45	Burn Intensive Care Unit						45	
46	Surgical Intensive Care Unit						46	
47	Other Special Care (specify)						47	
							1	
48	Program inpatient ancillary service cost (Wkst. D-3, col. 3, line 200)					2,231,896	48	
49	Total program inpatient costs (sum of lines 41 through 48)(see instructions)					3,860,955	49	

PASS THROUGH COST ADJUSTMENTS

50	Pass through costs applicable to Program inpatient routine services (from Wkst. D, sum of Parts I and III)					133,277	50
51	Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)					161,672	51
52	Total Program excludable cost (sum of lines 50 and 51)					294,949	52
53	Total Program inpatient operating cost excluding capital related, nonphysician anesthetist and medical education costs (line 49 minus line 52)					3,566,006	53

TARGET AMOUNT AND LIMIT COMPUTATION

54	Program discharges						54
55	Target amount per discharge						55
56	Target amount (line 54 x line 55)						56
57	Difference between adjusted inpatient operating cost and target amount (line 56 minus line 53)						57
58	Bonus payment (see instructions)						58
59	Lesser of line 53 ÷ line 54 or line 55 from the cost reporting period ending 1996, updated and compounded by the market basket.						59
60	Lesser of line 53 ÷ line 54 or line 55 from prior year cost report, updated by the market basket.						60
61	If line 53 ÷ 54 is less than the lower of lines 55, 59 or 60 enter the lesser of 50% of the amount by which operating costs (line 53) are less than expected costs (line 54 x 60), or 1% of the target amount (line 56), otherwise 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

IROQUOIS MEMORIAL HOSPITAL Provider CCN: 14-0167	In Lieu of Form <b>CMS-2552-10</b>	Period : From: 10/01/2014 To: 09/30/2015	Run Date: 02/24/2016 Run Time: 16:14 Version: 2015.10 (12/18/2015)
---	---------------------------------------	--	--

COMPUTATION OF INPATIENT OPERATING COST

COMPONENT CCN: 14-0167

WORKSHEET D-1  
PARTS III & IV

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

PART IV - COMPUTATION OF OBSERVATION BED PASS-THROUGH COST

87	Total observation bed days (see instructions)					923	87
88	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)					1,174.52	88
89	Observation bed cost (line 87 x line 88) (see instructions)					1,084,082	89
		Cost	Routine Cost (from line 27)	col. 1÷col. 2	Total Observation Bed Cost (from line 89)	Observation Bed Pass Through Cost col. 3 x col. 4 (see instructions)	
		1	2	3	4	5	
90	Capital-related cost	295,682	3,614,002	0.081816	1,084,082	88,695	90
91	Nursing School						91
92	Allied Health						92
93	Other Medical Education						93

IROQUOIS MEMORIAL HOSPITAL Provider CCN: 14-0167	In Lieu of Form <b>CMS-2552-10</b>	Period : From: 10/01/2014 To: 09/30/2015	Run Date: 02/24/2016 Run Time: 16:14 Version: 2015.10 (12/18/2015)
---	---------------------------------------	--	--

COMPUTATION OF INPATIENT OPERATING COST

COMPONENT CCN: 14-6049

WORKSHEET D-1  
PART I

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

PART I - ALL PROVIDER COMPONENTS

**INPATIENT DAYS**

1	Inpatient days (including private room days and swing-bed days, excluding newborn)	11,920	1
2	Inpatient days (including private room days, excluding swing-bed and newborn days)	11,920	2
3	Private room days (excluding swing-bed private room days). If you have only private room days, do not complete this line.		3
4	Semi-private room days (excluding swing-bed private room days)	11,920	4
5	Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost reporting period		5
6	Total swing-bed SNF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		6
7	Total swing-bed NF type inpatient days (including private room days) through December 31 of the cost reporting period		7
8	Total swing-bed NF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		8
9	Total inpatient days including private room days applicable to the Program (excluding swing-bed and newborn days)	1,046	9
10	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) through December 31 of the cost reporting period (see instructions)		10
11	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		11
12	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) through December 31 of the cost reporting period		12
13	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		13
14	Medically necessary private room days applicable to the program (excluding swing-bed days)		14
15	Total nursery days (title V or XIX only)		15
16	Nursery days (title V or XIX only)		16

**SWING-BED ADJUSTMENT**

17	Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost reporting period		17
18	Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period		18
19	Medicaid rate for swing-bed NF services applicable to services through December 31 of the cost reporting period		19
20	Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period		20
21	Total general inpatient routine service cost (see instructions)	2,340,908	21
22	Swing-bed cost applicable to SNF type services through December 31 of the cost reporting period (line 5 x line 17)		22
23	Swing-bed cost applicable to SNF type services after December 31 of the cost reporting period (line 6 x line 18)		23
24	Swing-bed cost applicable to NF type services through December 31 of the cost reporting period (line 7 x line 19)		24
25	Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8 x line 20)		25
26	Total swing-bed cost (see instructions)		26
27	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)	2,340,908	27

**PRIVATE ROOM DIFFERENTIAL ADJUSTMENT**

28	General inpatient routine service charges (excluding swing-bed and observation bed charges)		28
29	Private room charges (excluding swing-bed charges)		29
30	Semi-private room charges (excluding swing-bed charges)		30
31	General inpatient routine service cost/charge ratio (line 27 ÷ line 28)		31
32	Average private room per diem charge (line 29 ÷ line 3)		32
33	Average semi-private room per diem charge (line 30 ÷ line 4)		33
34	Average per diem private room charge differential (line 32 minus line 33) (see instructions)		34
35	Average per diem private room cost differential (line 34 x line 31)		35
36	Private room cost differential adjustment (line 3 x line 35)		36
37	General inpatient routine service cost net of swing-bed cost and private room cost differential (line 27 minus line 36)	2,340,908	37

IROQUOIS MEMORIAL HOSPITAL Provider CCN: 14-0167	In Lieu of Form <b>CMS-2552-10</b>	Period : From: 10/01/2014 To: 09/30/2015	Run Date: 02/24/2016 Run Time: 16:14 Version: 2015.10 (12/18/2015)
---	---------------------------------------	--	--

COMPUTATION OF INPATIENT OPERATING COST

COMPONENT CCN: 14-6049

WORKSHEET D-1  
PARTS III & IV

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

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

70	Skilled nursing facility/other nursing facility/ICF/IID routine service cost (line 37)	2,340,908	70
71	Adjusted general inpatient routine service cost per diem (line 70 ÷ line 2)	196.38	71
72	Program routine service cost (line 9 x line 71)	205,413	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)	205,413	74
75	Capital-related cost allocated to inpatient routine service costs (from Worksheet B, Part II, column 26)		75
76	Per diem capital-related costs (line 75 ÷ line 2)		76
77	Program capital-related costs (line 9 x line 76)		77
78	Inpatient routine service cost (line 74 minus line 77)		78
79	Aggregate charges to beneficiaries for excess costs (from provider records)		79
80	Total Program routine service costs for comparison to the cost limitation (line 78 minus line 79)		80
81	Inpatient routine service cost per diem limitation		81
82	Inpatient routine service cost limitation (line 9 x line 81)		82
83	Reasonable inpatient routine service costs (see instructions)	205,413	83
84	Program inpatient ancillary services (see instructions)	163,648	84
85	Utilization review - physician compensation (see instructions)		85
86	Total Program inpatient operating costs (sum of lines 83 through 85)	369,061	86

IROQUOIS MEMORIAL HOSPITAL Provider CCN: 14-0167	In Lieu of Form <b>CMS-2552-10</b>	Period : From: 10/01/2014 To: 09/30/2015	Run Date: 02/24/2016 Run Time: 16:14 Version: 2015.10 (12/18/2015)
---	---------------------------------------	--	--

COMPUTATION OF INPATIENT OPERATING COST

COMPONENT CCN: 14-0167

WORKSHEET D-1  
PART I

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

PART I - ALL PROVIDER COMPONENTS

**INPATIENT DAYS**

1	Inpatient days (including private room days and swing-bed days, excluding newborn)	3,077	1
2	Inpatient days (including private room days, excluding swing-bed and newborn days)	3,077	2
3	Private room days (excluding swing-bed private room days). If you have only private room days, do not complete this line.		3
4	Semi-private room days (excluding swing-bed private room days)	2,154	4
5	Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost reporting period		5
6	Total swing-bed SNF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		6
7	Total swing-bed NF type inpatient days (including private room days) through December 31 of the cost reporting period		7
8	Total swing-bed NF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		8
9	Total inpatient days including private room days applicable to the Program (excluding swing-bed and newborn days)	342	9
10	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) through December 31 of the cost reporting period (see instructions)		10
11	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		11
12	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) through December 31 of the cost reporting period		12
13	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		13
14	Medically necessary private room days applicable to the program (excluding swing-bed days)		14
15	Total nursery days (title V or XIX only)	125	15
16	Nursery days (title V or XIX only)		16

**SWING-BED ADJUSTMENT**

17	Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost reporting period	202.51	17
18	Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period	207.37	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)	3,614,002	21
22	Swing-bed cost applicable to SNF type services through December 31 of the cost reporting period (line 5 x line 17)		22
23	Swing-bed cost applicable to SNF type services after December 31 of the cost reporting period (line 6 x line 18)		23
24	Swing-bed cost applicable to NF type services through December 31 of the cost reporting period (line 7 x line 19)		24
25	Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8 x line 20)		25
26	Total swing-bed cost (see instructions)		26
27	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)	3,614,002	27

**PRIVATE ROOM DIFFERENTIAL ADJUSTMENT**

28	General inpatient routine service charges (excluding swing-bed and observation bed charges)		28
29	Private room charges (excluding swing-bed charges)		29
30	Semi-private room charges (excluding swing-bed charges)		30
31	General inpatient routine service cost/charge ratio (line 27 ÷ line 28)		31
32	Average private room per diem charge (line 29 ÷ line 3)		32
33	Average semi-private room per diem charge (line 30 ÷ line 4)		33
34	Average per diem private room charge differential (line 32 minus line 33) (see instructions)		34
35	Average per diem private room cost differential (line 34 x line 31)		35
36	Private room cost differential adjustment (line 3 x line 35)		36
37	General inpatient routine service cost net of swing-bed cost and private room cost differential (line 27 minus line 36)	3,614,002	37

IROQUOIS MEMORIAL HOSPITAL Provider CCN: 14-0167	In Lieu of Form CMS-2552-10	Period : From: 10/01/2014 To: 09/30/2015	Run Date: 02/24/2016 Run Time: 16:14 Version: 2015.10 (12/18/2015)
---	--------------------------------	--	--

COMPUTATION OF INPATIENT OPERATING COST

COMPONENT CCN: 14-0167

WORKSHEET D-1  
PART II

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

PART II - HOSPITALS AND SUBPROVIDERS ONLY

PROGRAM INPATIENT OPERATING COST BEFORE PASS-THROUGH COST ADJUSTMENTS

							1	
		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		
38	Adjusted general inpatient routine service cost per diem (see instructions)					1,174.52	38	
39	Program general inpatient routine service cost (line 9 x line 38)					401,686	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)					401,686	41	
42	Nursery (Titles V and XIX only)	361,388	125	2,891.10			42	
	<b>Intensive Care Type Inpatient Hospital Units</b>							
43	Intensive Care Unit						43	
44	Coronary Care Unit						44	
45	Burn Intensive Care Unit						45	
46	Surgical Intensive Care Unit						46	
47	Other Special Care (specify)						47	
							1	
48	Program inpatient ancillary service cost (Wkst. D-3, col. 3, line 200)					430,676	48	
49	Total program inpatient costs (sum of lines 41 through 48)(see instructions)					832,362	49	
	<b>PASS THROUGH COST ADJUSTMENTS</b>							
50	Pass through costs applicable to Program inpatient routine services (from Wkst. D, sum of Parts I and III)					32,863	50	
51	Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)					25,459	51	
52	Total Program excludable cost (sum of lines 50 and 51)					58,322	52	
53	Total Program inpatient operating cost excluding capital related, nonphysician anesthetist and medical education costs (line 49 minus line 52)					774,040	53	
	<b>TARGET AMOUNT AND LIMIT COMPUTATION</b>							
54	Program discharges						54	
55	Target amount per discharge						55	
56	Target amount (line 54 x line 55)						56	
57	Difference between adjusted inpatient operating cost and target amount (line 56 minus line 53)						57	
58	Bonus payment (see instructions)						58	
59	Lesser of line 53 ÷ line 54 or line 55 from the cost reporting period ending 1996, updated and compounded by the market basket.						59	
60	Lesser of line 53 ÷ line 54 or line 55 from prior year cost report, updated by the market basket.						60	
61	If line 53 ÷ 54 is less than the lower of lines 55, 59 or 60 enter the lesser of 50% of the amount by which operating costs (line 53) are less than expected costs (line 54 x 60), or 1% of the target amount (line 56), otherwise enter zero (see instructions)						61	
62	Relief payment (see instructions)						62	
63	Allowable Inpatient cost plus incentive payment (see instructions)						63	
	<b>PROGRAM INPATIENT ROUTINE SWING BED COST</b>							
64	Medicare swing-bed SNF inpatient routine costs through December 31 of the cost reporting period (See instructions) (title XVIII only)						64	
65	Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (See instructions) (title XVIII only)						65	
66	Total Medicare swing-bed SNF inpatient routine costs (title XVIII only. For CAH, see instructions)						66	
67	Title V or XIX swing-bed NF inpatient routine costs through December 31 of the cost reporting period (line 12 x line 19)						67	
68	Title V or XIX swing-bed NF inpatient routine costs after December 31 of the cost reporting period (line 13 x line 20)						68	
69	Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68)						69	

IROQUOIS MEMORIAL HOSPITAL Provider CCN: 14-0167	In Lieu of Form <b>CMS-2552-10</b>	Period : From: 10/01/2014 To: 09/30/2015	Run Date: 02/24/2016 Run Time: 16:14 Version: 2015.10 (12/18/2015)
---	---------------------------------------	--	--

COMPUTATION OF INPATIENT OPERATING COST

COMPONENT CCN: 14-0167

WORKSHEET D-1  
PARTS III & IV

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

PART IV - COMPUTATION OF OBSERVATION BED PASS-THROUGH COST

87	Total observation bed days (see instructions)	923	87				
88	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)		88				
89	Observation bed cost (line 87 x line 88) (see instructions)		89				
		Cost	Routine Cost (from line 27)	col. 1 ÷ col. 2	Total Observation Bed Cost (from line 89)	Observation Bed Pass Through Cost col. 3 x col. 4 (see instructions)	
		1	2	3	4	5	
90	Capital-related cost						90
91	Nursing School						91
92	Allied Health						92
93	Other Medical Education						93

IROQUOIS MEMORIAL HOSPITAL Provider CCN: 14-0167	In Lieu of Form CMS-2552-10	Period : From: 10/01/2014 To: 09/30/2015	Run Date: 02/24/2016 Run Time: 16:14 Version: 2015.10 (12/18/2015)
---	--------------------------------	--	--

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT

COMPONENT CCN: 14-0167

WORKSHEET D-3

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

(A)	COST CENTER DESCRIPTION	Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
1	2	3			
	<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>				
30	Adults & Pediatrics		1,467,264		30
	<b>ANCILLARY SERVICE COST CENTERS</b>				
50	Operating Room	0.328679	852,924	280,338	50
52	Delivery Room & Labor Room	1.821629			52
53	Anesthesiology	0.082776	38,792	3,211	53
54	Radiology-Diagnostic	0.238152	486,827	115,939	54
57	CT Scan	0.095529	568,424	54,301	57
58	MRI	0.159517	18,331	2,924	58
60	Laboratory	0.224837	998,806	224,569	60
62.30	<b>BLOOD CLOTTING FOR HEMOPHILIACS</b>				62.30
65	Respiratory Therapy	0.632951	365,223	231,168	65
66	Physical Therapy	0.425196	106,409	45,245	66
69	Electrocardiology	0.235172	314,042	73,854	69
71	Medical Supplies Charged to Patients	0.348121	290,767	101,222	71
72	Impl. Dev. Charged to Patients	0.575778	441,873	254,421	72
73	Drugs Charged to Patients	0.375558	1,574,876	591,457	73
76.97	CARDIAC REHABILITATION				76.97
76.98	HYPERBARIC OXYGEN THERAPY				76.98
76.99	LITHOTRIPSY				76.99
	<b>OUTPATIENT SERVICE COST CENTERS</b>				
88	Rural Health Clinic				88
88.01	RHC II				88.01
88.02	RHC III				88.02
90	Clinic	1.013516			90
91	Emergency	0.241052	419,257	101,063	91
92	Observation Beds (Non-Distinct Part)	0.614205	247,774	152,184	92
	<b>OTHER REIMBURSABLE COST CENTERS</b>				
95	Ambulance Services				95
200	Total (sum of lines 50-94, and 96-98)		6,724,325	2,231,896	200
201	Less PBP Clinic Laboratory Services-Program only charges (line 61)				201
202	Net Charges (line 200 minus line 201)		6,724,325		202

(A) Worksheet A line numbers

IROQUOIS MEMORIAL HOSPITAL Provider CCN: 14-0167	In Lieu of Form CMS-2552-10	Period : From: 10/01/2014 To: 09/30/2015	Run Date: 02/24/2016 Run Time: 16:14 Version: 2015.10 (12/18/2015)
---	--------------------------------	--	--

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT

COMPONENT CCN: 14-U167

WORKSHEET D-3

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

(A)	COST CENTER DESCRIPTION	Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
		1	2	3	
	<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>				
30	Adults & Pediatrics				30
	<b>ANCILLARY SERVICE COST CENTERS</b>				
50	Operating Room	0.328679			50
52	Delivery Room & Labor Room	1.821629			52
53	Anesthesiology	0.082776			53
54	Radiology-Diagnostic	0.238152			54
57	CT Scan	0.095529			57
58	MRI	0.159517			58
60	Laboratory	0.224837			60
62.30	<b>BLOOD CLOTTING FOR HEMOPHILIACS</b>				62.30
65	Respiratory Therapy	0.632951			65
66	Physical Therapy	0.425196			66
69	Electrocardiology	0.235172			69
71	Medical Supplies Charged to Patients	0.348121			71
72	Impl. Dev. Charged to Patients	0.575778			72
73	Drugs Charged to Patients	0.375558			73
76.97	<b>CARDIAC REHABILITATION</b>				76.97
76.98	<b>HYPERBARIC OXYGEN THERAPY</b>				76.98
76.99	<b>LITHOTRIPSY</b>				76.99
	<b>OUTPATIENT SERVICE COST CENTERS</b>				
88	Rural Health Clinic				88
88.01	RHC II				88.01
88.02	RHC III				88.02
90	Clinic	1.013516			90
91	Emergency	0.241052			91
92	Observation Beds (Non-Distinct Part)	0.614205			92
	<b>OTHER REIMBURSABLE COST CENTERS</b>				
95	Ambulance Services				95
200	Total (sum of lines 50-94, and 96-98)				200
201	Less PBP Clinic Laboratory Services-Program only charges (line 61)				201
202	Net Charges (line 200 minus line 201)				202

(A) Worksheet A line numbers

IROQUOIS MEMORIAL HOSPITAL Provider CCN: 14-0167	In Lieu of Form CMS-2552-10	Period : From: 10/01/2014 To: 09/30/2015	Run Date: 02/24/2016 Run Time: 16:14 Version: 2015.10 (12/18/2015)
---	--------------------------------	--	--

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT

COMPONENT CCN: 14-6049

WORKSHEET D-3

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

(A)	COST CENTER DESCRIPTION	Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
		1	2	3	
	<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>				
30	Adults & Pediatrics				30
	<b>ANCILLARY SERVICE COST CENTERS</b>				
50	Operating Room	0.328679			50
52	Delivery Room & Labor Room	1.821629			52
53	Anesthesiology	0.082776			53
54	Radiology-Diagnostic	0.238152	10,323	2,458	54
57	CT Scan	0.095529			57
58	MRI	0.159517			58
60	Laboratory	0.224837	19,158	4,307	60
62.30	<b>BLOOD CLOTTING FOR HEMOPHILIACS</b>				62.30
65	Respiratory Therapy	0.632951	301	191	65
66	Physical Therapy	0.425196	312,490	132,869	66
69	Electrocardiology	0.235172			69
71	Medical Supplies Charged to Patients	0.348121	6,375	2,219	71
72	Impl. Dev. Charged to Patients	0.575778			72
73	Drugs Charged to Patients	0.375558	57,525	21,604	73
76.97	CARDIAC REHABILITATION				76.97
76.98	HYPERBARIC OXYGEN THERAPY				76.98
76.99	LITHOTRIPSY				76.99
	<b>OUTPATIENT SERVICE COST CENTERS</b>				
88	Rural Health Clinic				88
88.01	RHC II				88.01
88.02	RHC III				88.02
90	Clinic	1.013516			90
91	Emergency	0.241052			91
92	Observation Beds (Non-Distinct Part)	0.614205			92
	<b>OTHER REIMBURSABLE COST CENTERS</b>				
95	Ambulance Services				95
200	Total (sum of lines 50-94, and 96-98)		406,172	163,648	200
201	Less PBP Clinic Laboratory Services-Program only charges (line 61)				201
202	Net Charges (line 200 minus line 201)		406,172		202

(A) Worksheet A line numbers

IROQUOIS MEMORIAL HOSPITAL Provider CCN: 14-0167	In Lieu of Form CMS-2552-10	Period : From: 10/01/2014 To: 09/30/2015	Run Date: 02/24/2016 Run Time: 16:14 Version: 2015.10 (12/18/2015)
---	--------------------------------	--	--

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT

COMPONENT CCN: 14-0167

WORKSHEET D-3

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

(A)	COST CENTER DESCRIPTION	Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
		1	2	3	
	<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>				
30	Adults & Pediatrics		233,957		30
43	Nursery		51,298		43
	<b>ANCILLARY SERVICE COST CENTERS</b>				
50	Operating Room	0.328679	223,820	73,565	50
52	Delivery Room & Labor Room	1.821629	73,801	134,438	52
53	Anesthesiology	0.082776	15,083	1,249	53
54	Radiology-Diagnostic	0.238152	56,883	13,547	54
57	CT Scan	0.095529	55,611	5,312	57
58	MRI	0.159517			58
60	Laboratory	0.224837	194,693	43,774	60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS				62.30
65	Respiratory Therapy	0.632951	35,221	22,293	65
66	Physical Therapy	0.425196	8,032	3,415	66
69	Electrocardiology	0.235172	13,740	3,231	69
71	Medical Supplies Charged to Patients	0.348121	47,711	16,609	71
72	Impl. Dev. Charged to Patients	0.575778	30,320	17,458	72
73	Drugs Charged to Patients	0.375558	254,558	95,601	73
76.97	CARDIAC REHABILITATION				76.97
76.98	HYPERBARIC OXYGEN THERAPY				76.98
76.99	LITHOTRIPSY				76.99
	<b>OUTPATIENT SERVICE COST CENTERS</b>				
88	Rural Health Clinic				88
88.01	RHC II				88.01
88.02	RHC III				88.02
90	Clinic	1.013516			90
91	Emergency	0.241052	764	184	91
92	Observation Beds (Non-Distinct Part)	0.614205			92
	<b>OTHER REIMBURSABLE COST CENTERS</b>				
95	Ambulance Services				95
200	Total (sum of lines 50-94, and 96-98)		1,010,237	430,676	200
201	Less PBP Clinic Laboratory Services-Program only charges (line 61)				201
202	Net Charges (line 200 minus line 201)		1,010,237		202

(A) Worksheet A line numbers

IROQUOIS MEMORIAL HOSPITAL Provider CCN: 14-0167	In Lieu of Form CMS-2552-10	Period : From: 10/01/2014 To: 09/30/2015	Run Date: 02/24/2016 Run Time: 16:14 Version: 2015.10 (12/18/2015)
---	--------------------------------	--	--

CALCULATION OF REIMBURSEMENT SETTLEMENT

WORKSHEET E  
PART A

PART A - INPATIENT HOSPITAL SERVICES UNDER PPS

		1	1.01	1.02	
1	DRG amounts other than outlier payments				1
1.01	DRG amounts other than outlier payments for discharges occurring prior to October 1 (see instructions)				1.01
1.02	DRG amounts other than outlier payments for discharges occurring on or after October 1 (see instructions)	3,102,299			1.02
1.03	DRG for federal specific operating payment for Model 4 BPCI for discharges occurring prior to October 1 (see instructions)				1.03
1.04	DRG for federal specific operating payment for Model 4 BPCI for discharges occurring on or after October 1 (see instructions)				1.04
2	Outlier payments for discharges (see instructions)	11,348			2
2.01	Outlier reconciliation amount				2.01
2.02	Outlier payment for discharges for Model 4 BPCI (see instructions)				2.02
3	Managed care simulated payments				3
4	Bed days available divided by number of days in the cost reporting period (see instructions)	22.47			4
<b>Indirect Medical Education Adjustment Calculation for Hospitals</b>					
5	FTE count for allopathic and osteopathic programs for the most recent cost reporting period ending on or before 12/31/1996 (see instructions)				5
6	FTE count for allopathic and osteopathic programs which meet the criteria for an add-on to the cap for new programs in accordance with 42 CFR 413.79(e)				6
7	MMA Section 422 reduction amount to the IME cap as specified under 42 CFR §412.105(f)(1)(iv)(B)(1)				7
7.01	ACA Section 5503 reduction amount to the IME cap as specified under 42 CFR §412.105(f)(1)(iv)(B)(2). If the cost report straddles July 1, 2011 then see instructions.				7.01
8	Adjustment (increase or decrease) to the FTE count for allopathic and osteopathic programs for affiliated programs in accordance with 42 CFR §413.75(b), §413.79(c)(2)(iv) 64 FR 26340 (May 12, 1998), and 67 FR 50069 (August 1, 2002).				8
8.01	The amount of increase if the hospital was awarded FTE cap slots under section 5503 of the ACA. If the cost report straddles July 1, 2011, see instructions.				8.01
8.02	The amount of increase if the hospital was awarded FTE cap slots from a closed teaching hospital under section 5506 of ACA. (see instructions)				8.02
9	Sum of lines 5 plus 6 minus lines (7 and 7.01) plus/minus line 8 plus lines (8.01 and 8.02) (see instructions)				9
10	FTE count for allopathic and osteopathic programs in the current year from your records				10
11	FTE count for residents in dental and podiatric programs				11
12	Current year allowable FTE (see instructions)				12
13	Total allowable FTE count for the prior year				13
14	Total allowable FTE count for the penultimate year if that year ended on or after September 30, 1997, otherwise enter zero				14
15	Sum of lines 12 through 14 divided by 3				15
16	Adjustment for residents in initial years of the program				16
17	Adjustment for residents displaced by program or hospital closure				17
18	Adjusted rolling average FTE count				18
19	Current year resident to bed ratio (line 18 divided by line 4)				19
20	Prior year resident to bed ratio (see instructions)				20
21	Enter the lesser of lines 19 or 20 (see instructions)				21
22	IME payment adjustment (see instructions)				22
22.01	IME payment adjustment - Managed Care (see instructions)				22.01
<b>Indirect Medical Education Adjustment for the Add-on for Section 422 of the MMA</b>					
23	Number of additional allopathic and osteopathic IME FTE resident cap slots under 42 Sec. 412.105(f)(1)(iv)(C)				23
24	IME FTE resident count over cap (see instructions)				24
25	If the amount on line 24 is greater than -0-, then enter the lower of line 23 or line 24 (see instructions)				25
26	Resident to bed ratio (divide line 25 by line 4)				26
27	IME payments adjustment factor (see instructions)				27
28	IME add-on adjustment amount (see instructions)				28
28.01	IME add-on adjustment amount - Managed Care (see instructions)				28.01
29	Total IME payment (sum of lines 22 and 28)				29
29.01	Total IME payment - Managed Care (sum of lines 22.01 and 28.01)				29.01
<b>Disproportionate Share Adjustment</b>					
30	Percentage of SSI recipient patient days to Medicare Part A patient days (see instructions)	0.1906			30
31	Percentage of Medicaid patient days to total patient days (see instructions)	0.1880			31
32	Sum of lines 30 and 31	0.3786			32
33	Allowable disproportionate share percentage (see instructions)	0.1200			33
34	Disproportionate share adjustment (see instructions)	93,069			34
<b>Uncompensated Care Adjustment</b>					
35	Total uncompensated care amount (see instructions)			7,647,644,885	35
35.01	Factor 3 (see instructions)			0.000018528	35.01
35.02	Hospital uncompensated care payment (If line 34 is zero, enter zero on this line) (see instructions)			141,696	35.02
35.03	Pro rata share of the hospital uncompensated care payment amount (see instructions)			141,696	35.03
36	Total uncompensated care (sum of columns 1 and 2 on line 35.03)	141,696			36
<b>Additional Payment for High Percentage of ESRD Beneficiary Discharges (lines 40 through 46)</b>					
40	Total Medicare discharges, excluding discharges for MS-DRGs 652, 682, 683, 684 and 685 (see instructions)				40
41	Total ESRD Medicare discharges excluding MS-DRGs 652, 682, 683, 684 and 685 (see instructions)				41
41.01	Total ESRD Medicare covered and paid discharges excluding MS-DRGs 652, 682, 683, 684 and 685 (see instructions)				41.01
42	Divide line 41 by line 40 (if less than 10%, you do not qualify for adjustment)				42
43	Total Medicare ESRD inpatient days excluding MS-DRGs 652, 682, 683, 684 and 685 (see instructions)				43
44	Ratio of average length of stay to one week (line 43 divided by line 41.01 divided by 7 days)				44
45	Average weekly cost for dialysis treatments (see instructions)				45
46	Total additional payment (line 45 times line 44 times line 41.01)				46

IROQUOIS MEMORIAL HOSPITAL Provider CCN: 14-0167	In Lieu of Form CMS-2552-10	Period : From: 10/01/2014 To: 09/30/2015	Run Date: 02/24/2016 Run Time: 16:14 Version: 2015.10 (12/18/2015)
---	--------------------------------	--	--

CALCULATION OF REIMBURSEMENT SETTLEMENT

WORKSHEET E  
PART A

PART A - INPATIENT HOSPITAL SERVICES UNDER PPS

		1	1.01	1.02	
47	Subtotal (see instructions)	3,348,412			47
48	Hospital specific payments (to be completed by SCH and MDH, small rural hospitals only (see instructions)	3,925,677			48
49	Total payment for inpatient operating costs (see instructions)	3,925,677			49
50	Payment for inpatient program capital (from Wkst. L, Pt. I and Pt. II, as applicable)	246,487			50
51	Exception payment for inpatient program capital (Wkst. L, Pt. III) (see instructions)				51
52	Direct graduate medical education payment (from Wkst. E-4, line 49) (see instructions)				52
53	Nursing and allied health managed care payment				53
54	Special add-on payments for new technologies				54
55	Net organ acquisition cost (Wkst. D-4 Pt. III, col. 1, line 69)				55
56	Cost of physicians' services in a teaching hospital (see instructions)				56
57	Routine service other pass through costs (from Wkst. D, Pt. III, col. 9, lines 30 through 35).				57
58	Ancillary service other pass through costs (from Wkst. D, Pt. IV, col. 11, line 200)				58
59	Total (sum of amounts on lines 49 through 58)	4,172,164			59
60	Primary payer payments				60
61	Total amount payable for program beneficiaries (line 59 minus line 60)	4,172,164			61
62	Deductibles billed to program beneficiaries	426,784			62
63	Coinsurance billed to program beneficiaries	1,260			63
64	Allowable bad debts (see instructions)	72,206			64
65	Adjusted reimbursable bad debts (see instructions)	46,934			65
66	Allowable bad debts for dual eligible beneficiaries (see instructions)	72,206			66
67	Subtotal (line 61 plus line 65 minus lines 62 and 63)	3,791,054			67
68	Credits received from manufacturers for replaced devices for applicable MS-DRGs (see instructions)				68
69	Outlier payments reconciliation (sum of lines 93, 95 and 96) (for SCH see instructions)				69
70	Other adjustments (specify) (see instructions)				70
70.93	HVBP payment adjustment amount (see instructions)	2,012			70.93
70.96	Low volume adjustment for federal fiscal year (2014)				70.96
70.97	Low volume adjustment for federal fiscal year (2015)	737,580			70.97
71	Amount due provider (see instructions)	4,530,646			71
71.01	Sequestration adjustment (see instructions)	90,613			71.01
72	Interim payments	4,430,088			72
73	Tentative settlement (for contractor use only)				73
74	Balance due provider (Program) (line 71 minus lines 71.01, 72 and 73)	9,945			74
75	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, §115.2	42,308			75

TO BE COMPLETED BY CONTRACTOR (lines 90 through 96)

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

HSP Bonus Payment Amount

Prior to 10/1      On or After 10/1

100	HSP bonus amount (see instructions)				100
-----	-------------------------------------	--	--	--	-----

HVBP Adjustment for HSP Bonus Payment

Prior to 10/1      On or After 10/1

101	HVBP adjustment factor (see instructions)	0.0000000000	0.0000000000		101
102	HVBP adjustment amount for HSP bonus payment (see instructions)				102

HRR Adjustment for HSP Bonus Payment

Prior to 10/1      On or After 10/1

103	HRR adjustment factor (see instructions)	0.0000	0.0000		103
104	HRR adjustment amount for HSP bonus payment (see instructions)				104

IROQUOIS MEMORIAL HOSPITAL Provider CCN: 14-0167	Supporting Exhibit for Form <b>CMS-2552-10</b>	Period : From: 10/01/2014 To: 09/30/2015	Run Date: 02/24/2016 Run Time: 16:14 Version: 2015.10 (12/18/2015)
---	---	--	--

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

EXHIBIT 4

		(Amt. from Wkst. E, Pt. A or L Pt. I)	Pre/Post Entitlement	NOT APPLICABLE	3.01	4	4.01	Total (col. 2 through 4)	5
		1	2	3					
1	DRG Amounts Other Than Outlier Payments								1
1.01	DRG amounts other than outlier payments for discharges occurring prior to October 1								1.01
1.02	DRG amounts other than outlier payments for discharges occurring on or after October 1	3,102,299				3,102,299		3,102,299	1.02
1.03	DRG for Federal specific operating payment for Model 4 BPCI occurring prior to October 1								1.03
1.04	DRG for Federal specific operating payment for Model 4 BPCI occurring on or after October 1								1.04
2	Outlier payments for discharges	11,348				11,348		11,348	2
2.01	Outlier payment for discharges for Model 4 BPCI								2.01
3	Operating outlier reconciliation								3
4	Managed Care Simulated Payments								4
	<b>Indirect Medical Education Adjustment</b>								
5	Amount from Worksheet E Part A, line 21								5
6	IME payment adjustment								6
6.01	IME payment adjustment for managed care								6.01
	<b>Indirect Medical Education Adjustment for the Add-on for Section 422 of the MMA</b>								
7	IME payment adjustment factor								7
8	IME add-on adjustment amount								8
8.01	IME payment adjustment add-on for managed care								8.01
9	Total IME payment (sum of lines 6 and 8)								9
9.01	Total IME payment for managed care (sum of lines 6.01 and 8.01)								9.01
	<b>Disproportionate Share Adjustment</b>								
10	Allowable disproportionate share percentage	0.1200	0.1200	0.1200	0.1200	0.1200	0.1200		10
11	Disproportionate share adjustment	93,069				93,069		93,069	11
11.01	Uncompensated care payments	141,696				141,696		141,696	11.01
	<b>Additional payment for high percentage of ESRD beneficiary discharges</b>								
12	Total ESRD additional payment								12
13	Subtotal	3,348,412				3,348,412		3,348,412	13
14	Hospital specific payments (to be completed by SCH and MDH, small rural hospitals only.)	3,925,677				3,925,677		3,925,677	14
15	Total payment for inpatient operating costs SCH and MDH only	3,925,677				3,925,677		3,925,677	15
16	Payment for inpatient program capital (from Worksheet L, Parts I, as applicable)	246,487				246,487		246,487	16
17	Special add-on payments for new technologies								17
17.01	Net organ acquisition cost (Wkst. D-4 Pt. III, col 1, line 69)								17.01
17.02	Credits received from manufacturers for replaced devices applicable to MS-DRG								17.02
18	Capital outlier reconciliation adjustment amount								18
19	<b>SUBTOTAL</b>					4,172,164		4,172,164	19
20	Capital DRG other than outlier	245,471				245,471		245,471	20
20.01	Model 4 BPCI Capital DRG other than outlier								20.01
21	Capital DRG outlier payments	1,016				1,016		1,016	21
21.01	Model 4 BPCI Capital DRG outlier payments								21.01
22	Indirect medical education percentage								22
23	Indirect medical education adjustment								23
24	Allowable disproportionate share percentage								24
25	Disproportionate share adjustment								25
26	Total prospective capital payments	246,487				246,487		246,487	26
27	<b>Low volume adjustment factor</b>			0.178036		0.176786			27
28	Low volume adjustment (transfer amount to Worksheet E, Part A, line 70.96)(prior to 10/1)								28
29	Low Volume Adjustment (transfer amount to Worksheet E, Part A, line 70.97)(on/after 10/1)					737,580		737,580	29

IROQUOIS MEMORIAL HOSPITAL Provider CCN: 14-0167	In Lieu of Form CMS-2552-10	Period : From: 10/01/2014 To: 09/30/2015	Run Date: 02/24/2016 Run Time: 16:14 Version: 2015.10 (12/18/2015)
---	--------------------------------	--	--

CALCULATION OF REIMBURSEMENT SETTLEMENT

COMPONENT CCN: 14-0167

WORKSHEET E  
PART B

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

PART B - MEDICAL AND OTHER HEALTH SERVICES

	1	1.01	1.02	
1	Medical and other services (see instructions)			1
2	Medical and other services reimbursed under OPPTS (see instructions)	5,278,489		2
3	PPS payments	4,770,633		3
4	Outlier payment (see instructions)	3,319		4
5	Enter the hospital specific payment to cost ratio (see instructions)	0.805		5
6	Line 2 times line 5	4,249,184		6
7	Sum of line 3 and line 4 divided by line 6			7
8	Transitional corridor payment (see instructions)			8
9	Ancillary service other pass through costs from Wkst. D, Pt. IV, col. 13, line 200			9
10	Organ acquisition			10
11	Total cost (sum of lines 1 and 10) (see instructions)			11
	<b>COMPUTATION OF LESSER OF COST OR CHARGES</b>			
	<b>REASONABLE CHARGES</b>			
12	Ancillary service charges			12
13	Organ acquisition charges (from Wkst. D-4, Part III, col. 4, line 69)			13
14	Total reasonable charges (sum of lines 12 and 13)			14
	<b>CUSTOMARY CHARGES</b>			
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 physicians' services in a teaching hospital (see instructions)			23
24	Total prospective payment (sum of lines 3, 4, 8 and 9)	4,773,952		24
	<b>COMPUTATION OF REIMBURSEMENT SETTLEMENT</b>			
25	Deductibles and coinsurance (see instructions)			25
26	Deductibles and coinsurance relating to amount on line 24 (see instructions)	966,536		26
27	Subtotal ((lines 21 and 24 minus the sum of lines 25 and 26) plus the sum of lines 22 and 23) (see instructions)	3,807,416		27
28	Direct graduate medical education payments (from Wkst. E-4, line 50)			28
29	ESRD direct medical education costs (from Wkst. E-4, line 36)			29
30	Subtotal (sum of lines 27 through 29)	3,807,416		30
31	Primary payer payments			31
32	Subtotal (line 30 minus line 31)	3,807,416		32
	<b>ALLOWABLE BAD DEBTS (EXCLUDE BAD DEBTS FOR PROFESSIONAL SERVICES)</b>			
33	Composite rate ESRD (from Wkst. I-5, line 11)			33
34	Allowable bad debts (see instructions)	200,784		34
35	Adjusted reimbursable bad debts (see instructions)	130,510		35
36	Allowable bad debts for dual eligible beneficiaries (see instructions)	200,784		36
37	Subtotal (see instructions)	3,937,926		37
38	MSP-LCC reconciliation amount from PS&R			38
39	Other adjustments (specify) (see instructions)			39
39.50	Pioneer ACO demonstration payment adjustment (see instructions)			39.50
40	Subtotal (see instructions)	3,937,926		40
40.01	Sequestration adjustment (see instructions)	78,759		40.01
41	Interim payments	3,789,792		41
42	Tentative settlement (for contractors use only)			42
43	Balance due provider/program (see instructions)	69,375		43
44	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2			44

TO BE COMPLETED BY CONTRACTOR

90	Original outlier amount (see instructions)			90
91	Outlier reconciliation adjustment amount (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

IROQUOIS MEMORIAL HOSPITAL Provider CCN: 14-0167	In Lieu of Form CMS-2552-10	Period : From: 10/01/2014 To: 09/30/2015	Run Date: 02/24/2016 Run Time: 16:14 Version: 2015.10 (12/18/2015)
---	--------------------------------	--	--

CALCULATION OF REIMBURSEMENT SETTLEMENT

COMPONENT CCN: 14-6049

WORKSHEET E  
PART B

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

PART B - MEDICAL AND OTHER HEALTH SERVICES

		1	1.01	1.02	
1	Medical and other services (see instructions)				1
2	Medical and other services reimbursed under 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 and line 4 divided by line 6				7
8	Transitional corridor payment (see instructions)				8
9	Ancillary service other pass through costs from Wkst. D, Pt. IV, col. 13, line 200				9
10	Organ acquisition				10
11	Total cost (sum of lines 1 and 10) (see instructions)				11
	<b>COMPUTATION OF LESSER OF COST OR CHARGES</b>				
	<b>REASONABLE CHARGES</b>				
12	Ancillary service charges				12
13	Organ acquisition charges (from Wkst. D-4, Part III, col. 4, line 69)				13
14	Total reasonable charges (sum of lines 12 and 13)				14
	<b>CUSTOMARY CHARGES</b>				
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 physicians' services in a teaching hospital (see instructions)				23
24	Total prospective payment (sum of lines 3, 4, 8 and 9)				24
	<b>COMPUTATION OF REIMBURSEMENT SETTLEMENT</b>				
25	Deductibles and coinsurance (see instructions)				25
26	Deductibles and coinsurance relating to amount on line 24 (see instructions)				26
27	Subtotal [(lines 21 and 24 minus the sum of lines 25 and 26) plus the sum of lines 22 and 23] (see instructions)				27
28	Direct graduate medical education payments (from Wkst. E-4, line 50)				28
29	ESRD direct medical education costs (from Wkst. E-4, line 36)				29
30	Subtotal (sum of lines 27 through 29)				30
31	Primary payer payments				31
32	Subtotal (line 30 minus line 31)				32
	<b>ALLOWABLE BAD DEBTS (EXCLUDE BAD DEBTS FOR PROFESSIONAL SERVICES)</b>				
33	Composite rate ESRD (from Wkst. I-5, line 11)				33
34	Allowable bad debts (see instructions)				34
35	Adjusted reimbursable bad debts (see instructions)				35
36	Allowable bad debts for dual eligible beneficiaries (see instructions)				36
37	Subtotal (see instructions)				37
38	MSP-LCC reconciliation amount from PS&R				38
39	Other adjustments (specify) (see instructions)				39
39.50	Pioneer ACO demonstration payment adjustment (see instructions)				39.50
40	Subtotal (see instructions)				40
40.01	Sequestration adjustment (see instructions)				40.01
41	Interim payments				41
42	Tentative settlement (for contractors use only)				42
43	Balance due provider/program (see instructions)				43
44	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2				44

TO BE COMPLETED BY CONTRACTOR

90	Original outlier amount (see instructions)				90
91	Outlier reconciliation adjustment amount (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

IROQUOIS MEMORIAL HOSPITAL Provider CCN: 14-0167	In Lieu of Form CMS-2552-10	Period : From: 10/01/2014 To: 09/30/2015	Run Date: 02/24/2016 Run Time: 16:14 Version: 2015.10 (12/18/2015)
---	--------------------------------	--	--

ANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED

COMPONENT CCN: 14-0167

WORKSHEET E-1  
PART I

Check  Hospital  SUB (Other)  
 Applicable  IPF  SNF  
 Boxes:  IRF  Swing Bed SNF

	DESCRIPTION	INPATIENT PART A		PART B		
		mm/dd/yyyy	AMOUNT	mm/dd/yyyy	AMOUNT	
		1	2	3	4	
1	Total interim payments paid to provider		4,430,088		3,774,486	1
2	Interim payments payable on individual bills, either submitted or to be submitted to the intermediary for services rendered in the cost reporting period. If none, write 'NONE' or enter a zero					2
3	List separately each retroactive lump sum adjustment amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each payment. If none, write 'NONE' or enter a zero. (1)					
		.01				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
			.10			3.10
			.11	04/30/2015	15,306	3.11
			.50			3.50
			.51			3.51
		Provider	.52			3.52
		to	.53			3.53
		Program	.54			3.54
			.55			3.55
			.56			3.56
			.57			3.57
			.58			3.58
			.59			3.59
	Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98)	.99			15,306	3.99
4	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Wkst. E or Wkst. E-3, line and column as appropriate)		4,430,088		3,789,792	4
	<b>TO BE COMPLETED BY CONTRACTOR</b>					
5	List separately each tentative settlement payment after desk review. Also show date of each payment. If none, write 'NONE' or enter a zero. (1)					
		.01				5.01
		.02				5.02
		Program	.03			5.03
		to	.04			5.04
		Provider	.05			5.05
			.06			5.06
			.07			5.07
			.08			5.08
			.09			5.09
			.10			5.10
			.50			5.50
			.51			5.51
		Provider	.52			5.52
		to	.53			5.53
		Program	.54			5.54
			.55			5.55
			.56			5.56
			.57			5.57
			.58			5.58
			.59			5.59
	Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98)	.99				5.99
6	Determined net settlement amount (balance due) based on the cost report (1)	.01	9,945		69,375	6.01
		.02				6.02
7	Total Medicare program liability (see instructions)		4,440,033		3,859,167	7
8	Name of Contractor			Contractor Number	NPR Date (Month/Day/Year)	8

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

IROQUOIS MEMORIAL HOSPITAL Provider CCN: 14-0167	In Lieu of Form CMS-2552-10	Period : From: 10/01/2014 To: 09/30/2015	Run Date: 02/24/2016 Run Time: 16:14 Version: 2015.10 (12/18/2015)
---	--------------------------------	--	--

ANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED

COMPONENT CCN: 14-6049

WORKSHEET E-1  
PART I

Check  Hospital  SUB (Other)  
 Applicable  IPF  SNF  
 Boxes:  IRF  Swing Bed SNF

	DESCRIPTION	INPATIENT PART A		PART B	
		mm/dd/yyyy 1	AMOUNT 2	mm/dd/yyyy 3	AMOUNT 4
1	Total interim payments paid to provider		278,461		1
2	Interim payments payable on individual bills, either submitted or to be submitted to the intermediary for services rendered in the cost reporting period. If none, write 'NONE' or enter a zero				2
3	List separately each retroactive lump sum adjustment amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each payment. If none, write 'NONE' or enter a zero. (1)				
		.01			3.01
		.02			3.02
	Program to	.03			3.03
	Provider	.04			3.04
		.05			3.05
		.06			3.06
		.07			3.07
		.08			3.08
		.09			3.09
		.10			3.10
		.50			3.50
		.51			3.51
	Provider to	.52			3.52
	Program	.53			3.53
		.54			3.54
		.55			3.55
		.56			3.56
		.57			3.57
		.58			3.58
		.59			3.59
	Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98)	.99			3.99
4	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Wkst. E or Wkst. E-3, line and column as appropriate)		278,461		4
<b>TO BE COMPLETED BY CONTRACTOR</b>					
5	List separately each tentative settlement payment after desk review. Also show date of each payment. If none, write 'NONE' or enter a zero. (1)				
		.01			5.01
		.02			5.02
	Program to	.03			5.03
	Provider	.04			5.04
		.05			5.05
		.06			5.06
		.07			5.07
		.08			5.08
		.09			5.09
		.10			5.10
		.50			5.50
		.51			5.51
	Provider to	.52			5.52
	Program	.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	Determined net settlement amount (balance due) based on the cost report (1)	.01			6.01
		.02			6.02
7	Total Medicare program liability (see instructions)		278,461		7
8	Name of Contractor	Contractor Number		NPR Date (Month/Day/Year)	
					8

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

IROQUOIS MEMORIAL HOSPITAL Provider CCN: 14-0167	In Lieu of Form <b>CMS-2552-10</b>	Period : From: 10/01/2014 To: 09/30/2015	Run Date: 02/24/2016 Run Time: 16:14 Version: 2015.10 (12/18/2015)
---	---------------------------------------	--	--

**CALCULATION OF REIMBURSEMENT SETTLEMENT FOR HIT**

**WORKSHEET E-1  
PART II**

Check applicable box:             Hospital             CAH

**TO BE COMPLETED BY CONTRACTOR FOR NONSTANDARD COST REPORTS**

**HEALTH INFORMATION TECHNOLOGY DATA COLLECTION AND CALCULATION**

1	Total hospital discharges as defined in AARA §4102 (Wkst. S-3, Pt. I, col. 15, line 14)	798	1
2	Medicare days (Wkst. S-3, Pt. I, col. 6, sum of lines 1, 8-12)	1,387	2
3	Medicare HMO days (Wkst. S-3, Pt. I, col. 6, line 2)	50	3
4	Total inpatient days (Wkst. S-3, Pt. I, col. 8, sum of lines 1, 8-12)	2,154	4
5	Total hospital charges (Wkst. C, Pt. I, col. 8, line 200)	74,965,931	5
6	Total hospital charity care charges (Wkst. S-10, col. 3, line 20)	931,424	6
7	CAH only - The reasonable cost incurred for the purchase of certified HIT technology (Wkst. S-2, Pt. I, line 168)		7
8	Calculation of the HIT incentive payment (see instructions)	337,750	8
9	Sequestration adjustment amount (see instructions)	6,755	9
10	Calculation of the HIT incentive payment after sequestration (see instructions)	330,995	10

**INPATIENT HOSPITAL SERVICES UNDER THE IPPS & CAH**

30	Initial/interim HIT payment(s)	331,730	30
31	OTHER ADJUSTMENTS ()		31
32	Balance due provider (line 8 or line 10 minus line 30 and line 31) (see instructions)	-735	32

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

IROQUOIS MEMORIAL HOSPITAL Provider CCN: 14-0167	In Lieu of Form <b>CMS-2552-10</b>	Period : From: 10/01/2014 To: 09/30/2015	Run Date: 02/24/2016 Run Time: 16:14 Version: 2015.10 (12/18/2015)
---	---------------------------------------	--	--

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**

<b>PROSPECTIVE PAYMENT AMOUNT (see instructions)</b>			
1	Resource Utilization Group (RUGS) payment	379,840	1
2	Routine service other pass through costs		2
3	Ancillary service other pass through costs		3
4	Subtotal (sum of lines 1-3)	379,840	4
<b>COMPUTATION OF NET COST OF COVERED SERVICES</b>			
5	Medical and other services. Do not use this line. (see instructions)		5
6	Deductibles		6
7	Coinsurance	95,696	7
8	Allowable bad debts (see instructions)		8
9	Reimbursable bad debts for dual eligible beneficiaries (see instructions)		9
10	Adjusted reimbursable bad debts (see instructions)		10
11	Utilization review		11
12	Subtotal (sum of lines 4 and 5, minus lines 6 and 7, plus lines 10 and 11) (see instructions)	284,144	12
13	Inpatient primary payer payments		13
14	Other adjustments (specify) (see instructions)		14
14.50	Pioneer ACO demonstration payment adjustment (see instructions)		14.50
15	Subtotal (see instructions)	284,144	15
15.01	Sequestration adjustment (see instructions)	5,683	15.01
16	Interim payments	278,461	16
17	Tentative settlement (for contractor use only)		17
18	Balance due provider/program (line 15 minus lines 15.01, 16 and 17)		18
19	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2		19

IROQUOIS MEMORIAL HOSPITAL Provider CCN: 14-0167	In Lieu of Form CMS-2552-10	Period : From: 10/01/2014 To: 09/30/2015	Run Date: 02/24/2016 Run Time: 16:14 Version: 2015.10 (12/18/2015)
---	--------------------------------	--	--

CALCULATION OF REIMBURSEMENT SETTLEMENT

COMPONENT CCN: 14-0167

WORKSHEET E-3  
PART VII

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

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

	INPATIENT TITLE V OR TITLE XIX	OUTPAT- IENT TITLE V OR TITLE XIX	
<b>COMPUTATION OF NET COST OF COVERED SERVICES</b>			
1			1
2		2,123,871	2
3			3
4		2,123,871	4
5			5
6			6
7		2,123,871	7
<b>COMPUTATION OF LESSER OF COST OR CHARGES</b>			
<b>REASONABLE CHARGES</b>			
8			8
9	1,010,237	8,716,617	9
10			10
11			11
12	1,010,237	8,716,617	12
<b>CUSTOMARY CHARGES</b>			
13			13
14			14
15	1.000000	1.000000	15
16	1,010,237	8,716,617	16
17	1,010,237	6,592,746	17
18			18
19			19
20			20
21		2,123,871	21
<b>PROSPECTIVE PAYMENT AMOUNT</b>			
22			22
23			23
24			24
25			25
26			26
27			27
28			28
29		2,123,871	29
<b>COMPUTATION OF REIMBURSEMENT SETTLEMENT</b>			
30			30
31		2,123,871	31
32			32
33			33
34			34
35			35
36		2,123,871	36
37			37
38		2,123,871	38
39			39
40		2,123,871	40
41		2,123,871	41
42			42
43			43

IROQUOIS MEMORIAL HOSPITAL Provider CCN: 14-0167	In Lieu of Form CMS-2552-10	Period : From: 10/01/2014 To: 09/30/2015	Run Date: 02/24/2016 Run Time: 16:14 Version: 2015.10 (12/18/2015)
---	--------------------------------	--	--

**BALANCE SHEET**

**WORKSHEET G**

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

		General Fund	Specific Purpose Fund	Endowment Fund	Plant Fund	
<b>Assets</b> (Omit Cents)		1	2	3	4	
<b>CURRENT ASSETS</b>						
1	Cash on hand and in banks	598,043				1
2	Temporary investments					2
3	Notes receivable					3
4	Accounts receivable	5,843,980				4
5	Other receivables					5
6	Allowances for uncollectible notes and accounts receivable	-1,210,000				6
7	Inventory	1,087,834				7
8	Prepaid expenses	1,493,936				8
9	Other current assets	823,024				9
10	Due from other funds					10
11	Total current assets (sum of lines 1-10)	8,636,817				11
<b>FIXED ASSETS</b>						
12	Land	291,325				12
13	Land improvements					13
14	Accumulated depreciation					14
15	Buildings	25,394,186				15
16	Accumulated depreciation	-15,811,638				16
17	Leasehold improvements	483,750				17
18	Accumulated depreciation	-463,081				18
19	Fixed equipment					19
20	Accumulated depreciation					20
21	Automobiles and trucks					21
22	Accumulated depreciation					22
23	Major movable equipment	15,546,819				23
24	Accumulated depreciation	-12,816,593				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)	12,624,768				30
<b>OTHER ASSETS</b>						
31	Investments	938,090				31
32	Deposits on leases					32
33	Due from owners/officers					33
34	Other assets	8,369,071				34
35	Total other assets (sum of lines 31-34)	9,307,161				35
36	Total assets (sum of lines 11, 30 and 35)	30,568,746				36
<b>Liabilities and Fund Balances</b> (Omit Cents)						
		1	2	3	4	
<b>CURRENT LIABILITIES</b>						
37	Accounts payable	1,539,934				37
38	Salaries, wages and fees payable	3,082,324				38
39	Payroll taxes payable					39
40	Notes and loans payable (short term)	883,098				40
41	Deferred income					41
42	Accelerated payments					42
43	Due to other funds					43
44	Other current liabilities	790,000				44
45	Total current liabilities (sum of lines 37 thru 44)	6,295,356				45
<b>LONG TERM LIABILITIES</b>						
46	Mortgage payable					46
47	Notes payable	4,315,611				47
48	Unsecured loans					48
49	Other long term liabilities					49
50	Total long term liabilities (sum of lines 46 thru 49)	4,315,611				50
51	Total liabilities (sum of lines 45 and 50)	10,610,967				51
<b>CAPITAL ACCOUNTS</b>						
52	General fund balance	19,957,779				52
53	Specific purpose fund					53
54	Donor created - endowment fund balance - restricted					54
55	Donor created - endowment fund balance - unrestricted					55
56	Governing body created - endowment fund balance					56
57	Plant fund balance - invested in plant					57
58	Plant fund balance - reserve for plant improvement, replacement, and expansion					58
59	Total fund balances (sum of lines 52 thru 58)	19,957,779				59
60	Total liabilities and fund balances (sum of lines 51 and 59)	30,568,746				60

IROQUOIS MEMORIAL HOSPITAL Provider CCN: 14-0167	In Lieu of Form <b>CMS-2552-10</b>	Period : From: 10/01/2014 To: 09/30/2015	Run Date: 02/24/2016 Run Time: 16:14 Version: 2015.10 (12/18/2015)
---	---------------------------------------	--	--

STATEMENT OF CHANGES IN FUND BALANCES

WORKSHEET G-1

		GENERAL FUND		SPECIFIC PURPOSE FUND	
		1	2	3	4
1	Fund balances at beginning of period		20,802,555		1
2	Net income (loss) (from Worksheet G-3, line 29)		-844,776		2
3	Total (sum of line 1 and line 2)		19,957,779		3
4	Additions (credit adjustments) (specify)				4
5	INCREASE IN PERPETUAL TRUST				5
6					6
7					7
8					8
9					9
10	Total additions (sum of lines 4-9)				10
11	Subtotal (line 3 plus line 10)		19,957,779		11
12	Deductions (debit adjustments) (specify)				12
13					13
14					14
15					15
16					16
17					17
18	Total deductions (sum of lines 12-17)				18
19	Fund balance at end of period per balance sheet (line 11 minus line 18)		19,957,779		19

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

IROQUOIS MEMORIAL HOSPITAL Provider CCN: 14-0167	In Lieu of Form CMS-2552-10	Period : From: 10/01/2014 To: 09/30/2015	Run Date: 02/24/2016 Run Time: 16:14 Version: 2015.10 (12/18/2015)
---	--------------------------------	--	--

STATEMENT OF PATIENT REVENUES AND OPERATING EXPENSES

WORKSHEET G-2  
PARTS I & II

PART I - PATIENT REVENUES

	REVENUE CENTER	INPATIENT	OUTPATIENT	TOTAL	
		1	2	3	
	<b>GENERAL INPATIENT ROUTINE CARE SERVICES</b>				
1	Hospital	3,549,623		3,549,623	1
2	Subprovider IPF				2
3	Subprovider IRF				3
5	Swing Bed - SNF				5
6	Swing Bed - NF				6
7	Skilled nursing facility	2,238,875		2,238,875	7
8	Nursing facility				8
9	Other long term care				9
10	Total general inpatient care services (sum of lines 1-9)	5,788,498		5,788,498	10
	<b>INTENSIVE CARE TYPE INPATIENT HOSPITAL SERVICES</b>				
11	Intensive Care Unit				11
12	Coronary Care Unit				12
13	Burn Intensive Care Unit				13
14	Surgical Intensive Care Unit				14
15	Other Special Care (specify)				15
16	Total intensive care type inpatient hospital services (sum of lines 11-15)				16
17	Total inpatient routine care services (sum of lines 10 and 16)	5,788,498		5,788,498	17
18	Ancillary services	8,042,387	43,138,080	51,180,467	18
19	Outpatient services	985,286	8,404,473	9,389,759	19
20	Rural Health Clinic (RHC)		792,480	792,480	20
20.01	RHC II		495,029	495,029	20.01
20.02	RHC III		1,134,482	1,134,482	20.02
21	Federally Qualified Health Center (FQHC)				21
22	Home health agency		762,312	762,312	22
23	Ambulance	2,403	3,470,699	3,473,102	23
25	ASC				25
26	Hospice		1,721,196	1,721,196	26
27	IROQUOIS WOMENS HEALTH		2,062,315	2,062,315	27
27.01	NURSERY	192,831		192,831	27.01
27.03	PROFESSIONAL FEES	295,792	971,311	1,267,103	27.03
28	Total patient revenues (sum of lines 17-27) (transfer column 3 to Worksheet G-3, line 1)	15,307,197	62,952,377	78,259,574	28

PART II - OPERATING EXPENSES

		1	2	
29	Operating expenses (per Worksheet A, column 3, line 200)		37,603,173	29
30	Add (specify)			30
31				31
32				32
33				33
34				34
35				35
36	Total additions (sum of lines 30-35)			36
37	Deduct (specify)			37
38				38
39				39
40				40
41				41
42	Total deductions (sum of lines 37-41)			42
43	Total operating expenses (sum of lines 29 and 36 minus line 42) (transfer to Worksheet G-3, line 4)		37,603,173	43

IROQUOIS MEMORIAL HOSPITAL Provider CCN: 14-0167	In Lieu of Form CMS-2552-10	Period : From: 10/01/2014 To: 09/30/2015	Run Date: 02/24/2016 Run Time: 16:14 Version: 2015.10 (12/18/2015)
---	--------------------------------	--	--

## STATEMENT OF REVENUES AND EXPENSES

## WORKSHEET G-3

	DESCRIPTION		
1	Total patient revenues (from Worksheet G-2, Part I, column 3, line 28)	78,259,574	1
2	Less contractual allowances and discounts on patients' accounts	44,594,600	2
3	Net patient revenues (line 1 minus line 2)	33,664,974	3
4	Less total operating expenses (from Worksheet G-2, Part II, line 43)	37,603,173	4
5	Net income from service to patients (line 3 minus line 4)	-3,938,199	5

## OTHER INCOME

6	Contributions, donations, bequests, etc.	534,539	6
7	Income from investments	11,199	7
8	Revenues from telephone and other miscellaneous communication services		8
9	Revenue from television and radio service		9
10	Purchase discounts	404	10
11	Rebates and refunds of expenses		11
12	Parking lot receipts		12
13	Revenue from laundry and linen service		13
14	Revenue from meals sold to employees and guests	156,832	14
15	Revenue from rental of living quarters		15
16	Revenue from sale of medical and surgical supplies to other than patients	446	16
17	Revenue from sale of drugs to other than patients		17
18	Revenue from sale of medical records and abstracts	820	18
19	Tuition (fees, sale of textbooks, uniforms, etc.)		19
20	Revenue from gifts, flowers, coffee shops and canteen		20
21	Rental of vending machines		21
22	Rental of hospital space		22
23	Governmental appropriations		23
24	Other (EHR MEDICARE AND MEDICAID)	444,570	24
24.01	Other (TRUST DONATION)	230,678	24.01
24.02	Other (UNREALIZED GAINS)		24.02
24.03	Other (OTHER)	1,713,745	24.03
24.04	Other (GAIN ON DISPOSAL)	190	24.04
25	Total other income (sum of lines 6-24)	3,093,423	25
26	Total (line 5 plus line 25)	-844,776	26
29	Net income (or loss) for the period (line 26 minus line 28)	-844,776	29

IROQUOIS MEMORIAL HOSPITAL Provider CCN: 14-0167	In Lieu of Form <b>CMS-2552-10</b>	Period : From: 10/01/2014 To: 09/30/2015	Run Date: 02/24/2016 Run Time: 16:14 Version: 2015.10 (12/18/2015)
---	---------------------------------------	--	--

ANALYSIS OF PROVIDER-BASED HOME HEALTH AGENCY COSTS

HHH CCN: 14-7586

WORKSHEET H

	COST CENTER DESCRIPTIONS (omit cents)	SALARIES	EMPLOYEE BENEFITS	TRANSPOR- TATION (see ins- tructions)	CONTRACTED/ PURCHASED SERVICES	OTHER COSTS	
		1	2	3	4	5	
	<b>GENERAL SERVICE COST CENTERS</b>						
1	Capital Related-Bldgs and Fixtures						1
2	Capital Related-Movable Equipment						2
3	Plant Operation & Maintenance						3
4	Transportation (see instructions)						4
5	Administrative and General	128,006	8,678			82,350	5
	<b>HHH REIMBURSABLE SERVICES</b>						
6	Skilled Nursing Care	223,257	15,136				6
7	Physical Therapy	119,581	8,107		13,309		7
8	Occupational Therapy	25,835	1,751		2,518		8
9	Speech Pathology	1,476	100		112		9
10	Medical Social Services	739	50				10
11	Home Health Aide	42,436	2,877				11
12	Supplies (see instructions)					5,762	12
13	Drugs					10	13
14	DME						14
	<b>HHH NONREIMBURSABLE SERVICES</b>						
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)	541,330	36,699		15,939	88,122	24

IROQUOIS MEMORIAL HOSPITAL Provider CCN: 14-0167	In Lieu of Form <b>CMS-2552-10</b>	Period : From: 10/01/2014 To: 09/30/2015	Run Date: 02/24/2016 Run Time: 16:14 Version: 2015.10 (12/18/2015)
---	---------------------------------------	--	--

ANALYSIS OF PROVIDER-BASED HOME HEALTH AGENCY COSTS

HHA CCN: 14-7586

WORKSHEET H

	COST CENTER DESCRIPTIONS (omit cents)	TOTAL (sum of cols. 1 thru 5)	RECLASS- IFICATIONS	RECLASSIFIED TRIAL BALANCE (col. 6 + col. 7)	ADJUSTMENTS	NET EXPENSES FOR ALLOCATION (col. 8 + col. 9)	
		6	7	8	9	10	
	<b>GENERAL SERVICE COST CENTERS</b>						
1	Capital Related-Bldgs and Fixtures						1
2	Capital Related-Movable Equipment						2
3	Plant Operation & Maintenance						3
4	Transportation (see instructions)						4
5	Administrative and General	219,034	-3,422	215,612		215,612	5
	<b>HHA REIMBURSABLE SERVICES</b>						
6	Skilled Nursing Care	238,393		238,393		238,393	6
7	Physical Therapy	140,997		140,997		140,997	7
8	Occupational Therapy	30,104		30,104		30,104	8
9	Speech Pathology	1,688		1,688		1,688	9
10	Medical Social Services	789		789		789	10
11	Home Health Aide	45,313		45,313		45,313	11
12	Supplies (see instructions)	5,762	-5,762				12
13	Drugs	10		10		10	13
14	DME						14
	<b>HHA NONREIMBURSABLE SERVICES</b>						
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)	682,090	-9,184	672,906		672,906	24

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

IROQUOIS MEMORIAL HOSPITAL Provider CCN: 14-0167	In Lieu of Form <b>CMS-2552-10</b>	Period : From: 10/01/2014 To: 09/30/2015	Run Date: 02/24/2016 Run Time: 16:14 Version: 2015.10 (12/18/2015)
---	---------------------------------------	--	--

ANALYSIS OF PROVIDER-BASED HOME HEALTH AGENCY COSTS

HHA CCN: 14-7586

WORKSHEET H-1  
PART I

		CAPITAL RELATED COSTS				
		NET EXPENSES FOR COST ALLOCATION (from Wkst. H, col. 10)	BLDGS. & FIXTURES	MOVABLE EQUIPMENT	PLANT OPERATION & MAINTENANCE	
		0	1	2	3	
<b>GENERAL SERVICE COST CENTERS</b>						
1	Capital Related-Bldgs. and Fixtures					1
2	Capital Related-Movable Equipment					2
3	Plant Operation & Maintenance					3
4	Transportation (see instructions)					4
5	Administrative and General	215,612				5
<b>HHA REIMBURSABLE SERVICES</b>						
6	Skilled Nursing Care	238,393				6
7	Physical Therapy	140,997				7
8	Occupational Therapy	30,104				8
9	Speech Pathology	1,688				9
10	Medical Social Services	789				10
11	Home Health Aide	45,313				11
12	Supplies (see instructions)					12
13	Drugs	10				13
14	DME					14
<b>HHA NONREIMBURSABLE SERVICES</b>						
15	Home Dialysis Aide Services					15
16	Respiratory Therapy					16
17	Private Duty Nursing					17
18	Clinic					18
19	Health Promotion Activities					19
20	Day Care Program					20
21	Home Delivered Means Program					21
22	Homemaker Service					22
23	All Others					23
23.50	Telemedicine					23.50
24	Totals (sum of lines 1-23)	672,906				24

IROQUOIS MEMORIAL HOSPITAL Provider CCN: 14-0167	In Lieu of Form <b>CMS-2552-10</b>	Period : From: 10/01/2014 To: 09/30/2015	Run Date: 02/24/2016 Run Time: 16:14 Version: 2015.10 (12/18/2015)
---	---------------------------------------	--	--

ANALYSIS OF PROVIDER-BASED HOME HEALTH AGENCY COSTS

HHA CCN: 14-7586

WORKSHEET H-1  
PART I

		TRANSPORT- ATION	SUBTOTAL (cols. 0-4)	ADMINI- STRATIVE & GENERAL	TOTAL (col. 4A + 5)	
		4	4A	5	6	
	<b>GENERAL SERVICE COST CENTERS</b>					
1	Capital Related-Bldgs. and Fixtures					1
2	Capital Related-Movable Equipment					2
3	Plant Operation & Maintenance					3
4	Transportation (see instructions)					4
5	Administrative and General		215,612	215,612		5
	<b>HHA REIMBURSABLE SERVICES</b>					
6	Skilled Nursing Care		238,393	111,322	349,715	6
7	Physical Therapy		140,997	65,842	206,839	7
8	Occupational Therapy		30,104	14,058	44,162	8
9	Speech Pathology		1,688	788	2,476	9
10	Medical Social Services		789	368	1,157	10
11	Home Health Aide		45,313	21,160	66,473	11
12	Supplies (see instructions)			2,068	2,068	12
13	Drugs		10	6	16	13
14	DME					14
	<b>HHA NONREIMBURSABLE SERVICES</b>					
15	Home Dialysis Aide Services					15
16	Respiratory Therapy					16
17	Private Duty Nursing					17
18	Clinic					18
19	Health Promotion Activities					19
20	Day Care Program					20
21	Home Delivered Means Program					21
22	Homemaker Service					22
23	All Others					23
23.50	Telemedicine					23.50
24	Totals (sum of lines 1-23)		672,906		672,906	24

IROQUOIS MEMORIAL HOSPITAL Provider CCN: 14-0167	In Lieu of Form <b>CMS-2552-10</b>	Period : From: 10/01/2014 To: 09/30/2015	Run Date: 02/24/2016 Run Time: 16:14 Version: 2015.10 (12/18/2015)
---	---------------------------------------	--	--

**COST ALLOCATION - HHA STATISTICAL BASIS**

**HHA CCN: 14-7586**

**WORKSHEET H-1  
PART II**

		CAPITAL RELATED COSTS						
		BLDGS. & FIXTURES (Square Feet)	MOVABLE EQUIPMENT (Dollar Value)	PLANT OPERATION & MAINTENANCE (Square Feet)	TRANSPORTATION (Mileage)	RECONCILIATION	ADMINISTRATIVE & GENERAL (Accum. Cost)	
		1	2	3	4	5A	5	
<b>GENERAL SERVICE COST CENTERS</b>								
1	Capital Related-Bldgs. and Fixtures							1
2	Capital Related-Movable Equipment							2
3	Plant Operation & Maintenance							3
4	Transportation (see instructions)							4
5	Administrative and General					-215,612	461,725	5
<b>HHA REIMBURSABLE SERVICES</b>								
6	Skilled Nursing Care						238,393	6
7	Physical Therapy						140,997	7
8	Occupational Therapy						30,104	8
9	Speech Pathology						1,688	9
10	Medical Social Services						789	10
11	Home Health Aide						45,313	11
12	Supplies (see instructions)					4,429	4,429	12
13	Drugs					2	12	13
14	DME							14
<b>HHA NONREIMBURSABLE SERVICES</b>								
15	Home Dialysis Aide Services							15
16	Respiratory Therapy							16
17	Private Duty Nursing							17
18	Clinic							18
19	Health Promotion Activities							19
20	Day Care Program							20
21	Home Delivered Means Program							21
22	Homemaker Service							22
23	All Others							23
23.50	Telemedicine							23.50
24	Totals (sum of lines 1-23)					-211,181	461,725	24
25	Cost To Be Allocated (per Worksheet H-1, Part I)						215,612	25
26	Unit Cost Multiplier						0.466971	26

IROQUOIS MEMORIAL HOSPITAL Provider CCN: 14-0167	In Lieu of Form <b>CMS-2552-10</b>	Period : From: 10/01/2014 To: 09/30/2015	Run Date: 02/24/2016 Run Time: 16:14 Version: 2015.10 (12/18/2015)
---	---------------------------------------	--	--

ALLOCATION OF GENERAL SERVICE COSTS TO HHA COST CENTERS

HHA CCN: 14-7586

WORKSHEET H-2  
PART I

	HHA COST CENTER (omit cents)	HHA TRIAL BALANCE(1)	CAP BLDGS & FIXTURES	CAP MOVABLE EQUIPMENT	EMPLOYEE BENEFITS DEPARTMENT	ADMITTING	PURCHASING RECEIVING AND STORES	
		0	1	2	4	5.01	5.02	
1	Administrative and General		10,619	456	19,759		619	1
2	Skilled Nursing Care	349,715			34,462			2
3	Physical Therapy	206,839			18,459			3
4	Occupational Therapy	44,162			3,988			4
5	Speech Pathology	2,476			228			5
6	Medical Social Services	1,157			114			6
7	Home Health Aide	66,473			6,550			7
8	Supplies	2,068						8
9	Drugs	16						9
10	DME							10
11	Home Dialysis Aide Services							11
12	Respiratory Therapy							12
13	Private Duty Nursing							13
14	Clinic							14
15	Health Promotion Activities							15
16	Day Care Program							16
17	Home Delivered Meals Program							17
18	Homemaker Service							18
19	All Others							19
20	Totals (sum of lines 1-19)(2)	672,906	10,619	456	83,560		619	20
21	Unit Cost Multiplier: column 26, line 1 divided by the sum of column 26, line 20 minus column 26, line 1, rounded to 6 decimal places.							21

(1) Column 0, line 20 must agree with Wkst. A, column 7, line 101.

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

IROQUOIS MEMORIAL HOSPITAL Provider CCN: 14-0167	In Lieu of Form <b>CMS-2552-10</b>	Period : From: 10/01/2014 To: 09/30/2015	Run Date: 02/24/2016 Run Time: 16:14 Version: 2015.10 (12/18/2015)
---	---------------------------------------	--	--

ALLOCATION OF GENERAL SERVICE COSTS TO HHA COST CENTERS

HHA CCN: 14-7586

WORKSHEET H-2  
PART I

	HHA COST CENTER (omit cents)	DATA PROCESSING	COMMUNICAT IONS	BUSINESS OFFICE	SUBTOTAL (cols.0-4) 4A	OTHER ADMI NISTRATIVE AND GENER	MAIN- TENANCE & REPAIRS	
		5.03	5.04	5.05		5.06	6	
1	Administrative and General	23,176			54,629	3,058		1
2	Skilled Nursing Care				384,177	21,501		2
3	Physical Therapy				225,298	12,610		3
4	Occupational Therapy				48,150	2,695		4
5	Speech Pathology				2,704	151		5
6	Medical Social Services				1,271	71		6
7	Home Health Aide				73,023	4,087		7
8	Supplies				2,068	116		8
9	Drugs				16	1		9
10	DME							10
11	Home Dialysis Aide Services							11
12	Respiratory Therapy							12
13	Private Duty Nursing							13
14	Clinic							14
15	Health Promotion Activities							15
16	Day Care Program							16
17	Home Delivered Meals Program							17
18	Homemaker Service							18
19	All Others							19
20	Totals (sum of lines 1-19)(2)	23,176			791,336	44,290		20
21	Unit Cost Multiplier: column 26, line 1 divided by the sum of column 26, line 20 minus column 26, line 1, rounded to 6 decimal places.							21

(1) Column 0, line 20 must agree with Wkst. A, column 7, line 101.

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

IROQUOIS MEMORIAL HOSPITAL Provider CCN: 14-0167	In Lieu of Form <b>CMS-2552-10</b>	Period : From: 10/01/2014 To: 09/30/2015	Run Date: 02/24/2016 Run Time: 16:14 Version: 2015.10 (12/18/2015)
---	---------------------------------------	--	--

**ALLOCATION OF GENERAL SERVICE COSTS TO HHA COST CENTERS**

**HHA CCN: 14-7586**

**WORKSHEET H-2  
PART I**

	HHA COST CENTER (omit cents)	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSE- KEEPING	DIETARY	CAFETERIA	MAIN- TENANCE OF PERSONNEL	
		7	8	9	10	11	12	
1	Administrative and General	17,468		6,235				1
2	Skilled Nursing Care							2
3	Physical Therapy							3
4	Occupational Therapy							4
5	Speech Pathology							5
6	Medical Social Services							6
7	Home Health Aide							7
8	Supplies							8
9	Drugs							9
10	DME							10
11	Home Dialysis Aide Services							11
12	Respiratory Therapy							12
13	Private Duty Nursing							13
14	Clinic							14
15	Health Promotion Activities							15
16	Day Care Program							16
17	Home Delivered Meals Program							17
18	Homemaker Service							18
19	All Others							19
20	Totals (sum of lines 1-19)(2)	17,468		6,235				20
21	Unit Cost Multiplier: column 26, line 1 divided by the sum of column 26, line 20 minus column 26, line 1, rounded to 6 decimal places.							21

(1) Column 0, line 20 must agree with Wkst. A, column 7, line 101.

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

IROQUOIS MEMORIAL HOSPITAL Provider CCN: 14-0167	In Lieu of Form <b>CMS-2552-10</b>	Period : From: 10/01/2014 To: 09/30/2015	Run Date: 02/24/2016 Run Time: 16:14 Version: 2015.10 (12/18/2015)
---	---------------------------------------	--	--

ALLOCATION OF GENERAL SERVICE COSTS TO HHA COST CENTERS

HHA CCN: 14-7586

WORKSHEET H-2  
PART I

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

(1) Column 0, line 20 must agree with Wkst. A, column 7, line 101.

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

IROQUOIS MEMORIAL HOSPITAL Provider CCN: 14-0167	In Lieu of Form <b>CMS-2552-10</b>	Period : From: 10/01/2014 To: 09/30/2015	Run Date: 02/24/2016 Run Time: 16:14 Version: 2015.10 (12/18/2015)
---	---------------------------------------	--	--

ALLOCATION OF GENERAL SERVICE COSTS TO HHA COST CENTERS

HHA CCN: 14-7586

WORKSHEET H-2  
PART I

	HHA COST CENTER (omit cents)	NURSING SCHOOL	I&R SALARY & FRINGES	I&R PROGRAM COSTS	PARAMED EDUCATION	SUBTOTAL (sum of col.4A-23)	I&R COST & POST STEP- DOWN ADJS	
		20	21	22	23	24	25	
1	Administrative and General					81,390		1
2	Skilled Nursing Care					405,678		2
3	Physical Therapy					237,908		3
4	Occupational Therapy					50,845		4
5	Speech Pathology					2,855		5
6	Medical Social Services					1,342		6
7	Home Health Aide					77,110		7
8	Supplies					2,184		8
9	Drugs					17		9
10	DME							10
11	Home Dialysis Aide Services							11
12	Respiratory Therapy							12
13	Private Duty Nursing							13
14	Clinic							14
15	Health Promotion Activities							15
16	Day Care Program							16
17	Home Delivered Meals Program							17
18	Homemaker Service							18
19	All Others							19
20	Totals (sum of lines 1-19)(2)					859,329		20
21	Unit Cost Multiplier: column 26, line 1 divided by the sum of column 26, line 20 minus column 26, line 1, rounded to 6 decimal places.							21

(1) Column 0, line 20 must agree with Wkst. A, column 7, line 101.

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

IROQUOIS MEMORIAL HOSPITAL Provider CCN: 14-0167	In Lieu of Form <b>CMS-2552-10</b>	Period : From: 10/01/2014 To: 09/30/2015	Run Date: 02/24/2016 Run Time: 16:14 Version: 2015.10 (12/18/2015)
---	---------------------------------------	--	--

ALLOCATION OF GENERAL SERVICE COSTS TO HHA COST CENTERS

HHA CCN: 14-7586

WORKSHEET H-2  
PART I

	HHA COST CENTER (omit cents)	SUBTOTAL (cols 23 +/- 24) 26	ALLOCATED HHA A&G (see PtlI) 27	TOTAL HHA COSTS 28			
1	Administrative and General	81,390					1
2	Skilled Nursing Care	405,678	42,443	448,121			2
3	Physical Therapy	237,908	24,891	262,799			3
4	Occupational Therapy	50,845	5,320	56,165			4
5	Speech Pathology	2,855	299	3,154			5
6	Medical Social Services	1,342	140	1,482			6
7	Home Health Aide	77,110	8,067	85,177			7
8	Supplies	2,184	228	2,412			8
9	Drugs	17	2	19			9
10	DME						10
11	Home Dialysis Aide Services						11
12	Respiratory Therapy						12
13	Private Duty Nursing						13
14	Clinic						14
15	Health Promotion Activities						15
16	Day Care Program						16
17	Home Delivered Meals Program						17
18	Homemaker Service						18
19	All Others						19
20	Totals (sum of lines 1-19)(2)	859,329	81,390	859,329			20
21	Unit Cost Multiplier: column 26, line 1 divided by the sum of column 26, line 20 minus column 26, line 1, rounded to 6 decimal places.		0.104623				21

(1) Column 0, line 20 must agree with Wkst. A, column 7, line 101.

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

IROQUOIS MEMORIAL HOSPITAL Provider CCN: 14-0167	In Lieu of Form <b>CMS-2552-10</b>	Period : From: 10/01/2014 To: 09/30/2015	Run Date: 02/24/2016 Run Time: 16:14 Version: 2015.10 (12/18/2015)
---	---------------------------------------	--	--

ALLOCATION OF GENERAL SERVICE COSTS TO HHA COST CENTERS STATISTICAL BASIS

HHA CCN: 14-7586

WORKSHEET H-2  
PART II

	HHA COST CENTER	CAP BLDGS & FIXTURES SQUARE FEET	CAP MOVABLE EQUIPMENT DOLLAR VALUE NEW	EMPLOYEE BENEFITS DEPARTMENT GROSS SAL	ADMITTING  GROSS CHARGES	PURCHASING RECEIVING AND STORES COST REQ'S	DATA PROCESSING  TIME SPENT	
		1	2	4	5.01	5.02	5.03	
1	Administrative and General	1,274	432	128,006		9,050	19,526	1
2	Skilled Nursing Care			223,257				2
3	Physical Therapy			119,581				3
4	Occupational Therapy			25,835				4
5	Speech Pathology			1,476				5
6	Medical Social Services			738				6
7	Home Health Aide			42,436				7
8	Supplies							8
9	Drugs							9
10	DME							10
11	Home Dialysis Aide Services							11
12	Respiratory Therapy							12
13	Private Duty Nursing							13
14	Clinic							14
15	Health Promotion Activities							15
16	Day Care Program							16
17	Home Delivered Meals Program							17
18	Homemaker Service							18
19	All Others							19
19.50	Telemedicine							19.50
20	Totals (sum of lines 1-19)	1,274	432	541,329		9,050	19,526	20
21	Total cost to be allocated	10,619	456	83,560		619	23,176	21
22	Unit Cost Multiplier	8.335165		0.154361		0.068398		22
22	Unit Cost Multiplier		1.055556				1.186930	22

IROQUOIS MEMORIAL HOSPITAL Provider CCN: 14-0167	In Lieu of Form <b>CMS-2552-10</b>	Period : From: 10/01/2014 To: 09/30/2015	Run Date: 02/24/2016 Run Time: 16:14 Version: 2015.10 (12/18/2015)
---	---------------------------------------	--	--

ALLOCATION OF GENERAL SERVICE COSTS TO HHA COST CENTERS STATISTICAL BASIS

HHA CCN: 14-7586

WORKSHEET H-2  
PART II

	HHA COST CENTER	COMMUNICAT IONS  # OF PHONES	BUSINESS OFFICE  GROSS CHARGES	RECON- CILIATION  4A.06	OTHER ADMI NISTRATIVE AND GENER ACCUM COST  5.06	MAIN- TENANCE & REPAIRS SQUARE FEET  6	OPERATION OF PLANT  SQUARE FEET  7	
1	Administrative and General	5.04	5.05	4A.06	5.06	6	7	1
2	Skilled Nursing Care				54,629		1,274	2
3	Physical Therapy				384,177			3
4	Occupational Therapy				225,298			4
5	Speech Pathology				48,150			5
6	Medical Social Services				2,704			6
7	Home Health Aide				1,271			7
8	Supplies				73,023			8
9	Drugs				2,068			9
10	DME				16			10
11	Home Dialysis Aide Services							11
12	Respiratory Therapy							12
13	Private Duty Nursing							13
14	Clinic							14
15	Health Promotion Activities							15
16	Day Care Program							16
17	Home Delivered Meals Program							17
18	Homemaker Service							18
19	All Others							19
19.50	Telemedicine							19.50
20	Totals (sum of lines 1-19)				791,336		1,274	20
21	Total cost to be allocated				44,290		17,468	21
22	Unit Cost Multiplier							22
22	Unit Cost Multiplier				0.055969		13.711146	22

IROQUOIS MEMORIAL HOSPITAL Provider CCN: 14-0167	In Lieu of Form <b>CMS-2552-10</b>	Period : From: 10/01/2014 To: 09/30/2015	Run Date: 02/24/2016 Run Time: 16:14 Version: 2015.10 (12/18/2015)
---	---------------------------------------	--	--

ALLOCATION OF GENERAL SERVICE COSTS TO HHA COST CENTERS STATISTICAL BASIS

HHA CCN: 14-7586

WORKSHEET H-2  
PART II

	HHA COST CENTER	LAUNDRY & LINEN SERVICE POUNDS	HOUSE-KEEPING SQUARE FEET	DIETARY MEALS	CAFETERIA FTE'S	MAINTENANCE OF PERSONNEL NUMBER HOUSED	NURSING ADMINISTRATION NURSING HOURS	
		8	9	10	11	12	13	
1	Administrative and General		1,274					1
2	Skilled Nursing Care							2
3	Physical Therapy							3
4	Occupational Therapy							4
5	Speech Pathology							5
6	Medical Social Services							6
7	Home Health Aide							7
8	Supplies							8
9	Drugs							9
10	DME							10
11	Home Dialysis Aide Services							11
12	Respiratory Therapy							12
13	Private Duty Nursing							13
14	Clinic							14
15	Health Promotion Activities							15
16	Day Care Program							16
17	Home Delivered Meals Program							17
18	Homemaker Service							18
19	All Others							19
19.50	Telemedicine							19.50
20	Totals (sum of lines 1-19)		1,274					20
21	Total cost to be allocated		6,235					21
22	Unit Cost Multiplier							22
22	Unit Cost Multiplier		4.894035					22

IROQUOIS MEMORIAL HOSPITAL Provider CCN: 14-0167	In Lieu of Form <b>CMS-2552-10</b>	Period : From: 10/01/2014 To: 09/30/2015	Run Date: 02/24/2016 Run Time: 16:14 Version: 2015.10 (12/18/2015)
---	---------------------------------------	--	--

ALLOCATION OF GENERAL SERVICE COSTS TO HHA COST CENTERS STATISTICAL BASIS

HHA CCN: 14-7586

WORKSHEET H-2  
PART II

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

IROQUOIS MEMORIAL HOSPITAL Provider CCN: 14-0167	In Lieu of Form <b>CMS-2552-10</b>	Period : From: 10/01/2014 To: 09/30/2015	Run Date: 02/24/2016 Run Time: 16:14 Version: 2015.10 (12/18/2015)
---	---------------------------------------	--	--

ALLOCATION OF GENERAL SERVICE COSTS TO HHA COST CENTERS STATISTICAL BASIS

HHA CCN: 14-7586

**WORKSHEET H-2  
PART II**

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

IROQUOIS MEMORIAL HOSPITAL Provider CCN: 14-0167	In Lieu of Form CMS-2552-10	Period : From: 10/01/2014 To: 09/30/2015	Run Date: 02/24/2016 Run Time: 16:14 Version: 2015.10 (12/18/2015)
---	--------------------------------	--	--

APPORTIONMENT OF PATIENT SERVICE COSTS

HHA CCN: 14-7586

WORKSHEET H-3  
PARTS I & II

Check applicable box:         Title V         Title XVIII         Title XIX

PART I - COMPUTATION OF THE AGGREGATE PROGRAM COST

Cost Per Visit Computation								
	Patient Services	From Wkst. H-2, Part I, col. 28, line	Facility Costs (from Wkst. H-2, Part I)	Shared Ancillary Costs (from Part II)	Total HHA COSTS (cols. 1 + 2)	Total Visits	Average Cost Per Visit (col. 3 ÷ col. 4)	
		1	2	3	4	5		
1	Skilled Nursing Care	2	448,121		448,121	2,580	173.69	1
2	Physical Therapy	3	262,799		262,799	1,429	183.90	2
3	Occupational Therapy	4	56,165		56,165	270	208.02	3
4	Speech Pathology	5	3,154		3,154	111	28.41	4
5	Medical Social Services	6	1,482		1,482	8	185.25	5
6	Home Health Aide	7	85,177		85,177	1,040	81.90	6
7	Total (sum of lines 1-6)		856,898		856,898	5,438		7

Limitation Cost Computation			Program Visits		
	Patient Services	CBSA No.	Part A	Not Subject to Deductibles & Coinsurance	Subject to Deductibles & Coinsurance
		1	2	3	4
8	Skilled Nursing Care	99914		1,746	8
8.01	Skilled Nursing Care	16580		18	8.01
8.02	Skilled Nursing Care	19180		30	8.02
9	Physical Therapy	99914		1,148	9
9.01	Physical Therapy	16580		30	9.01
9.02	Physical Therapy	19180		29	9.02
10	Occupational Therapy	99914		255	10
10.01	Occupational Therapy	16580		4	10.01
10.02	Occupational Therapy	19180			10.02
11	Speech Pathology	99914		89	11
11.01	Speech Pathology	16580		2	11.01
11.02	Speech Pathology	19180			11.02
12	Medical Social Services	99914		8	12
12.01	Medical Social Services	16580			12.01
12.02	Medical Social Services	19180			12.02
13	Home Health Aide	99914		713	13
13.01	Home Health Aide	16580		6	13.01
13.02	Home Health Aide	19180			13.02
14	Total (sum of lines 8-13)			4,078	14

Supplies and Drugs Cost Computations								
	Other Patient Services	From Wkst. H-2, Part I, col. 28, line	Facility Costs (from Wkst. H-2, Part I)	Shared Ancillary Costs (from Part II)	Total HHA Costs (cols. 1 + 2)	Total Charges (from HHA Records)	Ratio (col. 3 ÷ col. 4)	
		1	2	3	4	5		
15	Cost of Medical Supplies	8	2,412	1,032	3,444	2,936	1.173025	15
16	Cost of Drugs	9	19		19			16

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

		From Wkst. C, Part I, col. 9, line	Cost to Charge Ratio	Total HHA Charges (from provider records)	HHA Shared Ancillary Costs (col. 1 x col. 2)	Transfer to Part I as Indicated
		1	2	3	4	
1	Physical Therapy	66	0.425196			col. 2, line 2
2	Occupational Therapy	67				col. 2, line 3
3	Speech Pathology	68				col. 2, line 4
4	Medical Supplies Charged to Pat	71	0.348121	2,964	1,032	col. 2, line 15
5	Drugs Charged to Patients	73	0.375558			col. 2, line 16

IROQUOIS MEMORIAL HOSPITAL Provider CCN: 14-0167	In Lieu of Form <b>CMS-2552-10</b>	Period : From: 10/01/2014 To: 09/30/2015	Run Date: 02/24/2016 Run Time: 16:14 Version: 2015.10 (12/18/2015)
---	---------------------------------------	--	--

**APPORTIONMENT OF PATIENT SERVICE COSTS**

**HHA CCN: 14-7586**

**WORKSHEET H-3  
PARTS I & II**

Check applicable box:       Title V       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)	
Patient Services	Part A	Part B		Part A	Part B				
		Not Subject to Deductibles & Coinsurance	Subject to Deductibles & Coinsurance		Not Subject to Deductibles & Coinsurance	Subject to Deductibles & Coinsurance			
	6	7	8	9	10	11	12		
1 Skilled Nursing Care		1,794			311,600		311,600	1	
2 Physical Therapy		1,207			221,967		221,967	2	
3 Occupational Therapy		259			53,877		53,877	3	
4 Speech Pathology		91			2,585		2,585	4	
5 Medical Social Services		8			1,482		1,482	5	
6 Home Health Aide		719			58,886		58,886	6	
7 Total (sum of lines 1-6)		4,078			650,397		650,397	7	

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

IROQUOIS MEMORIAL HOSPITAL Provider CCN: 14-0167	In Lieu of Form CMS-2552-10	Period : From: 10/01/2014 To: 09/30/2015	Run Date: 02/24/2016 Run Time: 16:14 Version: 2015.10 (12/18/2015)
---	--------------------------------	--	--

CALCULATION OF HHA REIMBURSEMENT SETTLEMENT

HHA CCN: 14-7586

WORKSHEET H-4  
PARTS I & II

Check applicable box:         Title V         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	
	Reasonable Cost of Part A & Part B Services				
1	Reasonable cost of services (see instructions)				1
2	Total charges				2
	Customary Charges				
3	Amount actually collected from patients liable for payment for services on a charge basis (from your records)				3
4	Amount that would have been realized from patients liable for payment for services on a charge basis had such payment been made in accordance with 42 CFR 413.13(b)				4
5	Ratio of line 3 to line 4 (not to 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 amounts				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		579,019	11
12	Total PPS Reimbursement - Full Episodes with Outliers			12
13	Total PPS Reimbursement - LUPA Episodes		5,425	13
14	Total PPS Reimbursement - PEP Episodes		1,019	14
15	Total PPS Outlier Reimbursement - Full Episodes with Outliers			15
16	Total PPS Outlier Reimbursement - PSP Episodes			16
17	Total Other Payments			17
18	DME Payments			18
19	Oxygen Payments			19
20	Prosthetic and Orthotic Payments			20
21	Part B deductibles billed to Medicare patients (exclude coinsurance)			21
22	Subtotal (sum of lines 10 thru 20 minus line 21)		585,463	22
23	Excess reasonable cost (from line 8)			23
24	Subtotal (line 22 minus line 23)		585,463	24
25	Coinsurance billed to program patients (from your records)			25
26	Net cost (line 24 minus line 25)		585,463	26
27	Reimbursable bad debts (from your records)			27
28	Reimbursable bad debts for dual eligible (see instructions)			28
29	Total costs - current cost reporting period (line 26 plus line 27)		585,463	29
30	Other adjustments (see instructions) (specify)			30
30.50	Pioneer ACO demonstration payment adjustment (see instructions)			30.50
31	Subtotal (see instructions)		585,463	31
31.01	Sequestration adjustment (see instructions)		11,948	31.01
32	Interim payments (see instructions)		585,463	32
33	Tentative settlement (for contractor use only)			33
34	Balance due provider/program (line 31 minus lines 31.01, 32 and 33)		-11,948	34
35	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, §115-2			35

IROQUOIS MEMORIAL HOSPITAL Provider CCN: 14-0167	In Lieu of Form CMS-2552-10	Period : From: 10/01/2014 To: 09/30/2015	Run Date: 02/24/2016 Run Time: 16:14 Version: 2015.10 (12/18/2015)
---	--------------------------------	--	--

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

WORKSHEET H-5

	DESCRIPTION	Part A		Part B		
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount	
		1	2	3	4	
1	Total interim payments paid to provider				585,463	1
2	Interim payments payable on individual bills, either submitted or to be submitted to the intermediary for services rendered in the cost reporting period. If none, write 'NONE' or enter a zero.					2
3	List separately each retroactive lump sum adjustment amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each payment. If none, write 'NONE' or enter a zero. (1)					
		.01				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
		.10				3.10
		.50				3.50
		.51				3.51
	Provider	.52				3.52
	To	.53				3.53
	Program	.54				3.54
		.55				3.55
		.56				3.56
		.57				3.57
		.58				3.58
		.59				3.59
	Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98)	.99				3.99
4	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Wkst. H-4, Part II, column as appropriate, line 32)				585,463	4
	<b>TO BE COMPLETED BY CONTRACTOR</b>					
5	List separately each tentative settlement payment after desk review. Also show date of each payment. If none, write 'NONE' or enter a zero. (1)					
		.01				5.01
		.02				5.02
	Program	.03				5.03
	To	.04				5.04
	Provider	.05				5.05
		.06				5.06
		.07				5.07
		.08				5.08
		.09				5.09
		.10				5.10
		.50				5.50
		.51				5.51
	Provider	.52				5.52
	To	.53				5.53
	Program	.54				5.54
		.55				5.55
		.56				5.56
		.57				5.57
		.58				5.58
		.59				5.59
	Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98)	.99				5.99
6	Determine net settlement amount (balance due) based on the cost report (see instructions)	.01				6.01
		.02			-11,948	6.02
7	<b>TOTAL MEDICARE PROGRAM LIABILITY (see instructions)</b>				573,515	7
8	Name of Contractor		Contractor Number		NPR Date: Month, Day, Year	8

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

IROQUOIS MEMORIAL HOSPITAL Provider CCN: 14-0167	In Lieu of Form CMS-2552-10	Period : From: 10/01/2014 To: 09/30/2015	Run Date: 02/24/2016 Run Time: 16:14 Version: 2015.10 (12/18/2015)
---	--------------------------------	--	--

ANALYSIS OF PROVIDER-BASED HOSPICE COSTS

HOSPICE CCN: 14-1616

WORKSHEET K

	COST CENTER DESCRIPTIONS	SALARIES (from Wkst. K-1)	EMPLOYEE BENEFITS (from Wkst. K-2)	TRANSPOR- TATION (see inst.)	CONTRACTED SERVICES (from Wkst. K-3)	OTHER	
		1	2	3	4	5	
	<b>GENERAL SERVICE COST CENTER</b>						
1	Capital Related Costs-Bldg and Fixt.						1
2	Capital Related Costs-Movable Equip.						2
3	Plant Operation and Maintenance					3,013	3
4	Transportation - Staff						4
5	Volunteer Service Coordination						5
6	Administrative and General	132,885	9,740		39,813	251,907	6
	<b>INPATIENT CARE SERVICE</b>						
7	Inpatient - General Care						7
8	Inpatient - Respite Care						8
	<b>VISITING SERVICES</b>						
9	Physician Services						9
10	Nursing Care	631,535	46,328		44,112	242,049	10
11	Nursing Care-Continuous Home Care						11
12	Physical Therapy						12
13	Occupational Therapy						13
14	Speech / Language Pathology						14
15	Medical Social Services						15
16	Spiritual Counseling						16
17	Dietary Counseling						17
18	Counseling - Other						18
19	Home Health Aide and Homemaker						19
20	HH Aide & Homemaker - Cont. Home Care						20
21	Other	86,339	6,369				21
	<b>OTHER HOSPICE SERVICE COSTS</b>						
22	Drugs, Biological and Infusion Therapy						22
23	Analgesics						23
24	Sedatives / Hypnotics						24
25	Other - Specify						25
26	Durable Medical Equipment/Oxygen						26
27	Patient Transportation						27
28	Imaging Services						28
29	Labs and Diagnostics						29
30	Medical Supplies						30
31	Outpatient Services (including E/R Dept.)						31
32	Radiation Therapy						32
33	Chemotherapy						33
34	Other						34
	<b>HOSPICE NONREIMBURSABLE SERVICE</b>						
35	Bereavement Program Costs						35
36	Volunteer Program Costs						36
37	Fundraising						37
38	Other Program Costs						38
39	Total (sum of lines 1-38)	850,759	62,437		83,925	496,969	39

IROQUOIS MEMORIAL HOSPITAL Provider CCN: 14-0167	In Lieu of Form <b>CMS-2552-10</b>	Period : From: 10/01/2014 To: 09/30/2015	Run Date: 02/24/2016 Run Time: 16:14 Version: 2015.10 (12/18/2015)
---	---------------------------------------	--	--

ANALYSIS OF PROVIDER-BASED HOSPICE COSTS

HOSPICE CCN: 14-1616

WORKSHEET K

	TOTAL (cols. 1-5)	RECLASSI- FICATION	SUBTOTAL (col. 6 ± col. 7)	ADJUST- MENTS	TOTAL (col. 8 ± col. 9)	
	6	7	8	9	10	
<b>GENERAL SERVICE COST CENTER</b>						
1						1
2						2
3	3,013	-3,013				3
4						4
5						5
6	434,345	-3,190	431,155	-30,590	400,565	6
<b>INPATIENT CARE SERVICE</b>						
7						7
8						8
<b>VISITING SERVICES</b>						
9						9
10	964,024	-196,142	767,882		767,882	10
11						11
12						12
13						13
14						14
15						15
16						16
17						17
18						18
19						19
20						20
21	92,708		92,708		92,708	21
<b>OTHER HOSPICE SERVICE COSTS</b>						
22						22
23						23
24						24
25						25
26						26
27						27
28						28
29						29
30						30
31						31
32						32
33						33
34						34
<b>HOSPICE NONREIMBURSABLE SERVICE</b>						
35						35
36						36
37						37
38						38
39	1,494,090	-404,690	1,291,745	-61,180	1,261,155	39

IROQUOIS MEMORIAL HOSPITAL Provider CCN: 14-0167	In Lieu of Form CMS-2552-10	Period : From: 10/01/2014 To: 09/30/2015	Run Date: 02/24/2016 Run Time: 16:14 Version: 2015.10 (12/18/2015)
---	--------------------------------	--	--

HOSPICE COMPENSATION ANALYSIS SALARIES AND WAGES

HOSPICE CCN: 14-1616

WORKSHEET K-1

	COST CENTER DESCRIPTIONS (omit cents)	ADMINIS- TRATOR	DIRECTOR	MEDICAL SOCIAL WORKERS	SUPERVISORS	NURSES	
		1	2	3	4	5	
	<b>GENERAL SERVICE COST CENTER</b>						
1	Capital Related Costs-Bldg and Fixt.						1
2	Capital Related Costs-Movable Equip.						2
3	Plant Operation and Maintenance						3
4	Transportation - Staff						4
5	Volunteer Service Coordination						5
6	Administrative and General	132,885					6
	<b>INPATIENT CARE SERVICE</b>						
7	Inpatient - General Care						7
8	Inpatient - Respite Care						8
	<b>VISITING SERVICES</b>						
9	Physician Services						9
10	Nursing Care	631,535					10
11	Nursing Care-Continuous Home Care						11
12	Physical Therapy						12
13	Occupational Therapy						13
14	Speech / Language Pathology						14
15	Medical Social Services						15
16	Spiritual Counseling						16
17	Dietary Counseling						17
18	Counseling - Other						18
19	Home Health Aide and Homemaker						19
20	HH Aide & Homemaker - Cont. Home Care						20
21	Other	86,339					21
	<b>OTHER HOSPICE SERVICE COSTS</b>						
22	Drugs, Biological and Infusion Therapy						22
23	Analgesics						23
24	Sedatives / Hypnotics						24
25	Other - Specify						25
26	Durable Medical Equipment/Oxygen						26
27	Patient Transportation						27
28	Imaging Services						28
29	Labs and Diagnostics						29
30	Medical Supplies						30
31	Outpatient Services (including E/R Dept.)						31
32	Radiation Therapy						32
33	Chemotherapy						33
34	Other						34
	<b>HOSPICE NONREIMBURSABLE SERVICE</b>						
35	Bereavement Program Costs						35
36	Volunteer Program Costs						36
37	Fundraising						37
38	Other Program Costs						38
39	Total (sum of lines 1-38)	850,759					39

(1) Transfer the amount in column 9 to Wkst. K, column 1.

IROQUOIS MEMORIAL HOSPITAL Provider CCN: 14-0167	In Lieu of Form CMS-2552-10	Period : From: 10/01/2014 To: 09/30/2015	Run Date: 02/24/2016 Run Time: 16:14 Version: 2015.10 (12/18/2015)
---	--------------------------------	--	--

HOSPICE COMPENSATION ANALYSIS SALARIES AND WAGES

HOSPICE CCN: 14-1616

WORKSHEET K-1

	TOTAL THERAPISTS	AIDES	ALL OTHER	TOTAL (1)	
	6	7	8	9	
<b>GENERAL SERVICE COST CENTER</b>					
1					1
2					2
3					3
4					4
5					5
6				132,885	6
<b>INPATIENT CARE SERVICE</b>					
7					7
8					8
<b>VISITING SERVICES</b>					
9					9
10				631,535	10
11					11
12					12
13					13
14					14
15					15
16					16
17					17
18					18
19					19
20					20
21				86,339	21
<b>OTHER HOSPICE SERVICE COSTS</b>					
22					22
23					23
24					24
25					25
26					26
27					27
28					28
29					29
30					30
31					31
32					32
33					33
34					34
<b>HOSPICE NONREIMBURSABLE SERVICE</b>					
35					35
36					36
37					37
38					38
39				850,759	39

(1) Transfer the amount in column 9 to Wkst. K, column 1.

IROQUOIS MEMORIAL HOSPITAL Provider CCN: 14-0167	In Lieu of Form CMS-2552-10	Period : From: 10/01/2014 To: 09/30/2015	Run Date: 02/24/2016 Run Time: 16:14 Version: 2015.10 (12/18/2015)
---	--------------------------------	--	--

HOSPICE COMPENSATION ANALYSIS EMPLOYEE BENEFITS (PAYROLL RELATED)

HOSPICE CCN: 14-1616

WORKSHEET K-2

	COST CENTER DESCRIPTIONS (omit cents)	ADMINIS- TRATOR	DIRECTOR	MEDICAL SOCIAL WORKERS	SUPERVISORS	NURSES	
		1	2	3	4	5	
	<b>GENERAL SERVICE COST CENTER</b>						
1	Capital Related Costs-Bldg and Fixt.						1
2	Capital Related Costs-Movable Equip.						2
3	Plant Operation and Maintenance						3
4	Transportation - Staff						4
5	Volunteer Service Coordination						5
6	Administrative and General	9,740					6
	<b>INPATIENT CARE SERVICE</b>						
7	Inpatient - General Care						7
8	Inpatient - Respite Care						8
	<b>VISITING SERVICES</b>						
9	Physician Services						9
10	Nursing Care	46,328					10
11	Nursing Care-Continuous Home Care						11
12	Physical Therapy						12
13	Occupational Therapy						13
14	Speech / Language Pathology						14
15	Medical Social Services						15
16	Spiritual Counseling						16
17	Dietary Counseling						17
18	Counseling - Other						18
19	Home Health Aide and Homemaker						19
20	HH Aide & Homemaker - Cont. Home Care						20
21	Other	6,369					21
	<b>OTHER HOSPICE SERVICE COSTS</b>						
22	Drugs, Biological and Infusion Therapy						22
23	Analgesics						23
24	Sedatives / Hypnotics						24
25	Other - Specify						25
26	Durable Medical Equipment/Oxygen						26
27	Patient Transportation						27
28	Imaging Services						28
29	Labs and Diagnostics						29
30	Medical Supplies						30
31	Outpatient Services (including E/R Dept.)						31
32	Radiation Therapy						32
33	Chemotherapy						33
34	Other						34
	<b>HOSPICE NONREIMBURSABLE SERVICE</b>						
35	Bereavement Program Costs						35
36	Volunteer Program Costs						36
37	Fundraising						37
38	Other Program Costs						38
39	Total (sum of lines 1-38)	62,437					39

(1) Transfer the amount in column 9 to Wkst. K, column 2.

IROQUOIS MEMORIAL HOSPITAL Provider CCN: 14-0167	In Lieu of Form CMS-2552-10	Period : From: 10/01/2014 To: 09/30/2015	Run Date: 02/24/2016 Run Time: 16:14 Version: 2015.10 (12/18/2015)
---	--------------------------------	--	--

HOSPICE COMPENSATION ANALYSIS EMPLOYEE BENEFITS (PAYROLL RELATED)

HOSPICE CCN: 14-1616

WORKSHEET K-2

	TOTAL THERAPISTS	AIDES	ALL OTHER	TOTAL (1)	
	6	7	8	9	
<b>GENERAL SERVICE COST CENTER</b>					
1					1
2					2
3					3
4					4
5					5
6				9,740	6
<b>INPATIENT CARE SERVICE</b>					
7					7
8					8
<b>VISITING SERVICES</b>					
9					9
10				46,328	10
11					11
12					12
13					13
14					14
15					15
16					16
17					17
18					18
19					19
20					20
21				6,369	21
<b>OTHER HOSPICE SERVICE COSTS</b>					
22					22
23					23
24					24
25					25
26					26
27					27
28					28
29					29
30					30
31					31
32					32
33					33
34					34
<b>HOSPICE NONREIMBURSABLE SERVICE</b>					
35					35
36					36
37					37
38					38
39				62,437	39

(1) Transfer the amount in column 9 to Wkst. K, column 2.

IROQUOIS MEMORIAL HOSPITAL Provider CCN: 14-0167	In Lieu of Form CMS-2552-10	Period : From: 10/01/2014 To: 09/30/2015	Run Date: 02/24/2016 Run Time: 16:14 Version: 2015.10 (12/18/2015)
---	--------------------------------	--	--

HOSPICE COMPENSATION ANALYSIS CONTRACTED SERVICES/PURCHASED SERVICES

HOSPICE CCN: 14-1616

WORKSHEET K-3

	COST CENTER DESCRIPTIONS (omit cents)	ADMINISTRATOR	DIRECTOR	MEDICAL SOCIAL WORKERS	SUPERVISORS	NURSES	
		1	2	3	4	5	
	<b>GENERAL SERVICE COST CENTER</b>						
1	Capital Related Costs-Bldg and Fixt.						1
2	Capital Related Costs-Movable Equip.						2
3	Plant Operation and Maintenance						3
4	Transportation - Staff						4
5	Volunteer Service Coordination						5
6	Administrative and General						6
	<b>INPATIENT CARE SERVICE</b>						
7	Inpatient - General Care						7
8	Inpatient - Respite Care						8
	<b>VISITING SERVICES</b>						
9	Physician Services						9
10	Nursing Care					44,112	10
11	Nursing Care-Continuous Home Care						11
12	Physical Therapy						12
13	Occupational Therapy						13
14	Speech / Language Pathology						14
15	Medical Social Services						15
16	Spiritual Counseling						16
17	Dietary Counseling						17
18	Counseling - Other						18
19	Home Health Aide and Homemaker						19
20	HH Aide & Homemaker - Cont. Home Care						20
21	Other						21
	<b>OTHER HOSPICE SERVICE COSTS</b>						
22	Drugs, Biological and Infusion Therapy						22
23	Analgesics						23
24	Sedatives / Hypnotics						24
25	Other - Specify						25
26	Durable Medical Equipment/Oxygen						26
27	Patient Transportation						27
28	Imaging Services						28
29	Labs and Diagnostics						29
30	Medical Supplies						30
31	Outpatient Services (including E/R Dept.)						31
32	Radiation Therapy						32
33	Chemotherapy						33
34	Other						34
	<b>HOSPICE NONREIMBURSABLE SERVICE</b>						
35	Bereavement Program Costs						35
36	Volunteer Program Costs						36
37	Fundraising						37
38	Other Program Costs						38
39	Total (sum of lines 1-38)					44,112	39

(1) Transfer the amount in column 9 to Wkst. K, column 4.

IROQUOIS MEMORIAL HOSPITAL Provider CCN: 14-0167	In Lieu of Form CMS-2552-10	Period : From: 10/01/2014 To: 09/30/2015	Run Date: 02/24/2016 Run Time: 16:14 Version: 2015.10 (12/18/2015)
---	--------------------------------	--	--

HOSPICE COMPENSATION ANALYSIS CONTRACTED SERVICES/PURCHASED SERVICES

HOSPICE CCN: 14-1616

WORKSHEET K-3

	TOTAL THERAPISTS	AIDES	ALL OTHER	TOTAL (1)	
	6	7	8	9	
<b>GENERAL SERVICE COST CENTER</b>					
1					1
2					2
3					3
4					4
5					5
6			39,813	39,813	6
<b>INPATIENT CARE SERVICE</b>					
7					7
8					8
<b>VISITING SERVICES</b>					
9					9
10				44,112	10
11					11
12					12
13					13
14					14
15					15
16					16
17					17
18					18
19					19
20					20
21					21
<b>OTHER HOSPICE SERVICE COSTS</b>					
22					22
23					23
24					24
25					25
26					26
27					27
28					28
29					29
30					30
31					31
32					32
33					33
34					34
<b>HOSPICE NONREIMBURSABLE SERVICE</b>					
35					35
36					36
37					37
38					38
39			39,813	83,925	39

(1) Transfer the amount in column 9 to Wkst. K, column 4.

IROQUOIS MEMORIAL HOSPITAL Provider CCN: 14-0167	In Lieu of Form CMS-2552-10	Period : From: 10/01/2014 To: 09/30/2015	Run Date: 02/24/2016 Run Time: 16:14 Version: 2015.10 (12/18/2015)
---	--------------------------------	--	--

COST ALLOCATION - HOSPICE GENERAL SERVICE COST

HOSPICE CCN: 14-1616

WORKSHEET K-4  
PART I

	COST CENTER DESCRIPTIONS	NET EXPENSES FOR COST ALLOCATION	CAPITAL RELATED COSTS			TRANS- PORTATION	
			BUILDINGS & FIXTURES	MOVABLE EQUIPMENT	PLANT OPERATION & MAINT.		
		0	1	2	3	4	
	<b>GENERAL SERVICE COST CENTER</b>						
1	Capital Related Costs-Bldg and Fixt.						1
2	Capital Related Costs-Movable Equip.						2
3	Plant Operation and Maintenance						3
4	Transportation - Staff						4
5	Volunteer Service Coordination						5
6	Administrative and General	400,565					6
	<b>INPATIENT CARE SERVICE</b>						
7	Inpatient - General Care						7
8	Inpatient - Respite Care						8
	<b>VISITING SERVICES</b>						
9	Physician Services						9
10	Nursing Care	767,882					10
11	Nursing Care-Continuous Home Care						11
12	Physical Therapy						12
13	Occupational Therapy						13
14	Speech / Language Pathology						14
15	Medical Social Services						15
16	Spiritual Counseling						16
17	Dietary Counseling						17
18	Counseling - Other						18
19	Home Health Aide and Homemaker						19
20	HH Aide & Homemaker - Cont. Home Care						20
21	Other	92,708					21
	<b>OTHER HOSPICE SERVICE COSTS</b>						
22	Drugs, Biological and Infusion Therapy						22
23	Analgesics						23
24	Sedatives / Hypnotics						24
25	Other - Specify						25
26	Durable Medical Equipment/Oxygen						26
27	Patient Transportation						27
28	Imaging Services						28
29	Labs and Diagnostics						29
30	Medical Supplies						30
31	Outpatient Services (including E/R Dept.)						31
32	Radiation Therapy						32
33	Chemotherapy						33
34	Other						34
	<b>HOSPICE NONREIMBURSABLE SERVICE</b>						
35	Bereavement Program Costs						35
36	Volunteer Program Costs						36
37	Fundraising						37
38	Other Program Costs						38
39	Total (sum of lines 1-38)	1,261,155					39

IROQUOIS MEMORIAL HOSPITAL Provider CCN: 14-0167	In Lieu of Form CMS-2552-10	Period : From: 10/01/2014 To: 09/30/2015	Run Date: 02/24/2016 Run Time: 16:14 Version: 2015.10 (12/18/2015)
---	--------------------------------	--	--

COST ALLOCATION - HOSPICE GENERAL SERVICE COST

HOSPICE CCN: 14-1616

WORKSHEET K-4  
PART I

	VOLUNTEER SERVICES COORDINATOR	SUBTOTAL (cols. 0 - 5)	ADMINISTRATIVE & GENERAL	TOTAL (col. 5 ± col. 6)	
	5	5A	6	7	
<b>GENERAL SERVICE COST CENTER</b>					
1	Capital Related Costs-Bldg and Fixt.				1
2	Capital Related Costs-Movable Equip.				2
3	Plant Operation and Maintenance				3
4	Transportation - Staff				4
5	Volunteer Service Coordination				5
6	Administrative and General	400,565	400,565		6
<b>INPATIENT CARE SERVICE</b>					
7	Inpatient - General Care				7
8	Inpatient - Respite Care				8
<b>VISITING SERVICES</b>					
9	Physician Services				9
10	Nursing Care	767,882	357,414	1,125,296	10
11	Nursing Care-Continuous Home Care				11
12	Physical Therapy				12
13	Occupational Therapy				13
14	Speech / Language Pathology				14
15	Medical Social Services				15
16	Spiritual Counseling				16
17	Dietary Counseling				17
18	Counseling - Other				18
19	Home Health Aide and Homemaker				19
20	HH Aide & Homemaker - Cont. Home Care				20
21	Other	92,708	43,151	135,859	21
<b>OTHER HOSPICE SERVICE COSTS</b>					
22	Drugs, Biological and Infusion Therapy				22
23	Analgesics				23
24	Sedatives / Hypnotics				24
25	Other - Specify				25
26	Durable Medical Equipment/Oxygen				26
27	Patient Transportation				27
28	Imaging Services				28
29	Labs and Diagnostics				29
30	Medical Supplies				30
31	Outpatient Services (including E/R Dept.)				31
32	Radiation Therapy				32
33	Chemotherapy				33
34	Other				34
<b>HOSPICE NONREIMBURSABLE SERVICE</b>					
35	Bereavement Program Costs				35
36	Volunteer Program Costs				36
37	Fundraising				37
38	Other Program Costs				38
39	Total (sum of lines 1-38)	1,261,155		1,261,155	39

IROQUOIS MEMORIAL HOSPITAL Provider CCN: 14-0167	In Lieu of Form CMS-2552-10	Period : From: 10/01/2014 To: 09/30/2015	Run Date: 02/24/2016 Run Time: 16:14 Version: 2015.10 (12/18/2015)
---	--------------------------------	--	--

COST ALLOCATION - HOSPICE STATISTICAL BASIS

HOSPICE CCN: 14-1616

WORKSHEET K-4  
PART II

	COST CENTER DESCRIPTIONS	CAPITAL RELATED COSTS				VOLUNTEER SERVICES COORDINATOR (Hours)	RECONCILIATION	ADMINISTRATIVE & GENERAL (Acc. Cost)	
		BUILDINGS & FIXTURES (Sq. Ft.)	MOVABLE EQUIPMENT (\$ Value)	PLANT OPERATION & MAINT. (Sq. Ft.)	TRANSPORTATION (Mileage)				
		1	2	3	4	5	6A	6	
	<b>GENERAL SERVICE COST CENTER</b>								
1	Capital Related Costs-Bldg and Fixt.								1
2	Capital Related Costs-Movable Equip.								2
3	Plant Operation and Maintenance								3
4	Transportation - Staff								4
5	Volunteer Service Coordination								5
6	Administrative and General						-400,565	860,590	6
	<b>INPATIENT CARE SERVICE</b>								
7	Inpatient - General Care								7
8	Inpatient - Respite Care								8
	<b>VISITING SERVICES</b>								
9	Physician Services								9
10	Nursing Care							767,882	10
11	Nursing Care-Continuous Home Care								11
12	Physical Therapy								12
13	Occupational Therapy								13
14	Speech / Language Pathology								14
15	Medical Social Services								15
16	Spiritual Counseling								16
17	Dietary Counseling								17
18	Counseling - Other								18
19	Home Health Aide and Homemaker								19
20	HH Aide & Homemaker - Cont. Home Care								20
21	Other							92,708	21
	<b>OTHER HOSPICE SERVICE COSTS</b>								
22	Drugs, Biological and Infusion Therapy								22
23	Analgesics								23
24	Sedatives / Hypnotics								24
25	Other - Specify								25
26	Durable Medical Equipment/Oxygen								26
27	Patient Transportation								27
28	Imaging Services								28
29	Labs and Diagnostics								29
30	Medical Supplies								30
31	Outpatient Services (including E/R Dept.)								31
32	Radiation Therapy								32
33	Chemotherapy								33
34	Other								34
	<b>HOSPICE NONREIMBURSABLE SERVICE</b>								
35	Bereavement Program Costs								35
36	Volunteer Program Costs								36
37	Fundraising								37
38	Other Program Costs								38
39	Cost to be Allocated (per Wskt K-4, Part I)							400,565	39
40	Unit Cost Multiplier							0.465454	40

IROQUOIS MEMORIAL HOSPITAL Provider CCN: 14-0167	In Lieu of Form CMS-2552-10	Period : From: 10/01/2014 To: 09/30/2015	Run Date: 02/24/2016 Run Time: 16:14 Version: 2015.10 (12/18/2015)
---	--------------------------------	--	--

ALLOCATION OF GENERAL SERVICE COSTS TO HOSPICE COST CENTERS

HOSPICE CCN: 14-1616

WORKSHEET K-5  
PART I

PART I - ALLOCATION OF GENERAL SERVICE COSTS TO HOSPICE COST CENTERS

	HOSPICE COST CENTER (omit cents)	HOSPICE TRIAL BALANCE(1)	CAP BLDGS & FIXTURES	CAP MOVABLE EQUIPMENT	EMPLOYEE BENEFITS DEPARTMENT	ADMITTING	PURCHASING RECEIVING AND STORES	
		0	1	2	4	5.01	5.02	
1	Administrative and General		10,685	663	20,512		5,084	1
2	Inpatient - General Care							2
3	Inpatient - Respite Care							3
4	Physician Services							4
5	Nursing Care	1,125,296			97,485			5
6	Nursing Care-Continuous Home Care							6
7	Physical Therapy							7
8	Occupational Therapy							8
9	Speech / Language Pathology							9
10	Medical Social Services							10
11	Spiritual Counseling							11
12	Dietary Counseling							12
13	Counseling - Other							13
14	Home Health Aide and Homemaker							14
15	HH Aide & Homemaker - Cont. Home Care							15
16	Other	135,859			13,327			16
17	Drugs, Biological and Infusion Therapy							17
18	Analgesics							18
19	Sedatives / Hypnotics							19
20	Other - Specify							20
21	Durable Medical Equipment/Oxygen							21
22	Patient Transportation							22
23	Imaging Services							23
24	Labs and Diagnostics							24
25	Medical Supplies							25
26	Outpatient Services (including 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) (2)	1,261,155	10,685	663	131,324		5,084	34
35	Unit Cost Multiplier (see instructions)							35

(1) Column 0, line 34 must agree with Wkst. A, column 7, line 116.

(2) Columns 0 through 25, line 34 must agree with the corresponding columns of Wkst. B, Part I, line 116.

IROQUOIS MEMORIAL HOSPITAL Provider CCN: 14-0167	In Lieu of Form CMS-2552-10	Period : From: 10/01/2014 To: 09/30/2015	Run Date: 02/24/2016 Run Time: 16:14 Version: 2015.10 (12/18/2015)
---	--------------------------------	--	--

ALLOCATION OF GENERAL SERVICE COSTS TO HOSPICE COST CENTERS

HOSPICE CCN: 14-1616

WORKSHEET K-5  
PART I

PART I - ALLOCATION OF GENERAL SERVICE COSTS TO HOSPICE COST CENTERS

	HOSPICE COST CENTER (omit cents)	DATA PROCESSING	COMMUNICAT IONS	BUSINESS OFFICE	SUBTOTAL	OTHER ADMI NISTRATIVE AND GENER	MAIN- TENANCE & REPAIRS	
		5.03	5.04	5.05	4A	5.06	6	
1	Administrative and General	39,691			76,635	4,289		1
2	Inpatient - General Care							2
3	Inpatient - Respite Care							3
4	Physician Services							4
5	Nursing Care				1,222,781	68,438		5
6	Nursing Care-Continuous Home Care							6
7	Physical Therapy							7
8	Occupational Therapy							8
9	Speech / Language Pathology							9
10	Medical Social Services							10
11	Spiritual Counseling							11
12	Dietary Counseling							12
13	Counseling - Other							13
14	Home Health Aide and Homemaker							14
15	HH Aide & Homemaker - Cont. Home Care							15
16	Other				149,186	8,350		16
17	Drugs, Biological and Infusion Therapy							17
18	Analgesics							18
19	Sedatives / Hypnotics							19
20	Other - Specify							20
21	Durable Medical Equipment/Oxygen							21
22	Patient Transportation							22
23	Imaging Services							23
24	Labs and Diagnostics							24
25	Medical Supplies							25
26	Outpatient Services (including 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) (2)	39,691			1,448,602	81,077		34
35	Unit Cost Multiplier (see instructions)							35

(1) Column 0, line 34 must agree with Wkst. A, column 7, line 116.

(2) Columns 0 through 25, line 34 must agree with the corresponding columns of Wkst. B, Part I, line 116.

IROQUOIS MEMORIAL HOSPITAL Provider CCN: 14-0167	In Lieu of Form CMS-2552-10	Period : From: 10/01/2014 To: 09/30/2015	Run Date: 02/24/2016 Run Time: 16:14 Version: 2015.10 (12/18/2015)
---	--------------------------------	--	--

ALLOCATION OF GENERAL SERVICE COSTS TO HOSPICE COST CENTERS

HOSPICE CCN: 14-1616

WORKSHEET K-5  
PART I

PART I - ALLOCATION OF GENERAL SERVICE COSTS TO HOSPICE COST CENTERS

	HOSPICE COST CENTER (omit cents)	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSE- KEEPING	DIETARY	CAFETERIA	MAIN- TENANCE OF PERSONNEL	
		7	8	9	10	11	12	
1	Administrative and General	17,578		6,275				1
2	Inpatient - General Care							2
3	Inpatient - Respite Care							3
4	Physician Services							4
5	Nursing Care							5
6	Nursing Care-Continuous Home Care							6
7	Physical Therapy							7
8	Occupational Therapy							8
9	Speech / Language Pathology							9
10	Medical Social Services							10
11	Spiritual Counseling							11
12	Dietary Counseling							12
13	Counseling - Other							13
14	Home Health Aide and Homemaker							14
15	HH Aide & Homemaker - Cont. Home Care							15
16	Other							16
17	Drugs, Biological and Infusion Therapy							17
18	Analgesics							18
19	Sedatives / Hypnotics							19
20	Other - Specify							20
21	Durable Medical Equipment/Oxygen							21
22	Patient Transportation							22
23	Imaging Services							23
24	Labs and Diagnostics							24
25	Medical Supplies							25
26	Outpatient Services (including 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) (2)	17,578		6,275				34
35	Unit Cost Multiplier (see instructions)							35

(1) Column 0, line 34 must agree with Wkst. A, column 7, line 116.

(2) Columns 0 through 25, line 34 must agree with the corresponding columns of Wkst. B, Part I, line 116.

IROQUOIS MEMORIAL HOSPITAL Provider CCN: 14-0167	In Lieu of Form CMS-2552-10	Period : From: 10/01/2014 To: 09/30/2015	Run Date: 02/24/2016 Run Time: 16:14 Version: 2015.10 (12/18/2015)
---	--------------------------------	--	--

ALLOCATION OF GENERAL SERVICE COSTS TO HOSPICE COST CENTERS

HOSPICE CCN: 14-1616

WORKSHEET K-5  
PART I

PART I - ALLOCATION OF GENERAL SERVICE COSTS TO HOSPICE COST CENTERS

	HOSPICE COST CENTER (omit cents)	NURSING ADMINIS- TRATION	CENTRAL SERVICES & SUPPLY	PHARMACY	MEDICAL RECORDS & LIBRARY	SOCIAL SERVICE	NONPHYSIC. ANESTHET.	
		13	14	15	16	17	19	
1	Administrative and General							1
2	Inpatient - General Care							2
3	Inpatient - Respite Care							3
4	Physician Services							4
5	Nursing Care							5
6	Nursing Care-Continuous Home Care							6
7	Physical Therapy							7
8	Occupational Therapy							8
9	Speech / Language Pathology							9
10	Medical Social Services							10
11	Spiritual Counseling							11
12	Dietary Counseling							12
13	Counseling - Other							13
14	Home Health Aide and Homemaker							14
15	HH Aide & Homemaker - Cont. Home Care							15
16	Other							16
17	Drugs, Biological and Infusion Therapy							17
18	Analgesics							18
19	Sedatives / Hypnotics							19
20	Other - Specify							20
21	Durable Medical Equipment/Oxygen							21
22	Patient Transportation							22
23	Imaging Services							23
24	Labs and Diagnostics							24
25	Medical Supplies							25
26	Outpatient Services (including 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) (2)							34
35	Unit Cost Multiplier (see instructions)							35

(1) Column 0, line 34 must agree with Wkst. A, column 7, line 116.  
 (2) Columns 0 through 25, line 34 must agree with the corresponding columns of Wkst. B, Part I, line 116.

IROQUOIS MEMORIAL HOSPITAL Provider CCN: 14-0167	In Lieu of Form CMS-2552-10	Period : From: 10/01/2014 To: 09/30/2015	Run Date: 02/24/2016 Run Time: 16:14 Version: 2015.10 (12/18/2015)
---	--------------------------------	--	--

ALLOCATION OF GENERAL SERVICE COSTS TO HOSPICE COST CENTERS

HOSPICE CCN: 14-1616

WORKSHEET K-5  
PART I

PART I - ALLOCATION OF GENERAL SERVICE COSTS TO HOSPICE COST CENTERS

	HOSPICE COST CENTER (omit cents)	NURSING SCHOOL	I&R SALARY & FRINGES	I&R PROGRAM COSTS	PARAMED EDUCATION	SUBTOTAL (cols. 4A-23) 24	I&R COST & POST STEP- DOWN ADJS 25	
1	Administrative and General	20	21	22	23	104,777		1
2	Inpatient - General Care							2
3	Inpatient - Respite Care							3
4	Physician Services							4
5	Nursing Care					1,291,219		5
6	Nursing Care-Continuous Home Care							6
7	Physical Therapy							7
8	Occupational Therapy							8
9	Speech / Language Pathology							9
10	Medical Social Services							10
11	Spiritual Counseling							11
12	Dietary Counseling							12
13	Counseling - Other							13
14	Home Health Aide and Homemaker							14
15	HH Aide & Homemaker - Cont. Home Care							15
16	Other					157,536		16
17	Drugs, Biological and Infusion Therapy							17
18	Analgesics							18
19	Sedatives / Hypnotics							19
20	Other - Specify							20
21	Durable Medical Equipment/Oxygen							21
22	Patient Transportation							22
23	Imaging Services							23
24	Labs and Diagnostics							24
25	Medical Supplies							25
26	Outpatient Services (including 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) (2)					1,553,532		34
35	Unit Cost Multiplier (see instructions)							35

(1) Column 0, line 34 must agree with Wkst. A, column 7, line 116.

(2) Columns 0 through 25, line 34 must agree with the corresponding columns of Wkst. B, Part I, line 116.

IROQUOIS MEMORIAL HOSPITAL Provider CCN: 14-0167	In Lieu of Form CMS-2552-10	Period : From: 10/01/2014 To: 09/30/2015	Run Date: 02/24/2016 Run Time: 16:14 Version: 2015.10 (12/18/2015)
---	--------------------------------	--	--

ALLOCATION OF GENERAL SERVICE COSTS TO HOSPICE COST CENTERS

HOSPICE CCN: 14-1616

WORKSHEET K-5  
PART I

PART I - ALLOCATION OF GENERAL SERVICE COSTS TO HOSPICE COST CENTERS

	HOSPICE COST CENTER (omit cents)	SUBTOTAL (cols. 24 ± 25) 26	ALLOC HOSP A&G (See Part II) 27	TOTAL HOSP COSTS (col 26 ± 27) 28			
1	Administrative and General	104,777					1
2	Inpatient - General Care						2
3	Inpatient - Respite Care						3
4	Physician Services						4
5	Nursing Care	1,291,219	93,384	1,384,603			5
6	Nursing Care-Continuous Home Care						6
7	Physical Therapy						7
8	Occupational Therapy						8
9	Speech / Language Pathology						9
10	Medical Social Services						10
11	Spiritual Counseling						11
12	Dietary Counseling						12
13	Counseling - Other						13
14	Home Health Aide and Homemaker						14
15	HH Aide & Homemaker - Cont. Home Care						15
16	Other	157,536	11,393	168,929			16
17	Drugs, Biological and Infusion Therapy						17
18	Analgesics						18
19	Sedatives / Hypnotics						19
20	Other - Specify						20
21	Durable Medical Equipment/Oxygen						21
22	Patient Transportation						22
23	Imaging Services						23
24	Labs and Diagnostics						24
25	Medical Supplies						25
26	Outpatient Services (including 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) (2)	1,553,532		1,553,532			34
35	Unit Cost Multiplier (see instructions)		0.072322				35

(1) Column 0, line 34 must agree with Wkst. A, column 7, line 116.

(2) Columns 0 through 25, line 34 must agree with the corresponding columns of Wkst. B, Part I, line 116.

IROQUOIS MEMORIAL HOSPITAL Provider CCN: 14-0167	In Lieu of Form CMS-2552-10	Period : From: 10/01/2014 To: 09/30/2015	Run Date: 02/24/2016 Run Time: 16:14 Version: 2015.10 (12/18/2015)
---	--------------------------------	--	--

ALLOCATION OF GENERAL SERVICE COSTS TO HOSPICE COST CENTERS - STATISTICAL BASIS HOSPICE CCN: 14-1616

WORKSHEET K-5  
PART II

PART II - ALLOCATION OF GENERAL SERVICE COSTS TO HOSPICE COST CENTERS - STATISTICAL BASIS

	HOSPICE COST CENTER	CAP BLDGS & FIXTURES SQUARE FEET	CAP MOVABLE EQUIPMENT DOLLAR VALUE NEW	EMPLOYEE BENEFITS DEPARTMENT GROSS SAL	ADMITTING  GROSS CHARGES	PURCHASING RECEIVING AND STORES COST REQ'S	DATA PROCESSING  TIME SPENT	
		1	2	4	5.01	5.02	5.03	
1	Administrative and General	1,282	628	132,885		74,326	33,440	1
2	Inpatient - General Care							2
3	Inpatient - Respite Care							3
4	Physician Services							4
5	Nursing Care			631,535				5
6	Nursing Care-Continuous Home Care							6
7	Physical Therapy							7
8	Occupational Therapy							8
9	Speech / Language Pathology							9
10	Medical Social Services							10
11	Spiritual Counseling							11
12	Dietary Counseling							12
13	Counseling - Other							13
14	Home Health Aide and Homemaker							14
15	HH Aide & Homemaker - Cont. Home Care							15
16	Other			86,339				16
17	Drugs, Biological and Infusion Therapy							17
18	Analgesics							18
19	Sedatives / Hypnotics							19
20	Other - Specify							20
21	Durable Medical Equipment/Oxygen							21
22	Patient Transportation							22
23	Imaging Services							23
24	Labs and Diagnostics							24
25	Medical Supplies							25
26	Outpatient Services (including 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)	1,282	628	850,759		74,326	33,440	34
35	Total cost to be allocated	10,685	663	131,324		5,084	39,691	35
36	Unit Cost Multiplier (see instructions)	8.334633		0.154361		0.068401		36
36	Unit Cost Multiplier (see instructions)		1.055732				1.186932	36

IROQUOIS MEMORIAL HOSPITAL Provider CCN: 14-0167	In Lieu of Form CMS-2552-10	Period : From: 10/01/2014 To: 09/30/2015	Run Date: 02/24/2016 Run Time: 16:14 Version: 2015.10 (12/18/2015)
---	--------------------------------	--	--

ALLOCATION OF GENERAL SERVICE COSTS TO HOSPICE COST CENTERS - STATISTICAL BASIS HOSPICE CCN: 14-1616

WORKSHEET K-5  
PART II

PART II - ALLOCATION OF GENERAL SERVICE COSTS TO HOSPICE COST CENTERS - STATISTICAL BASIS

	HOSPICE COST CENTER	COMMUNICAT IONS  # OF PHONES	BUSINESS OFFICE  GROSS CHARGES	RECON- CILIATION  4A.06	OTHER ADMI NISTRATIVE AND GENER ACCUM COST  5.06	MAIN- TENANCE & REPAIRS SQUARE FEET  6	OPERATION OF PLANT  SQUARE FEET  7	
1	Administrative and General	5.04	5.05	4A.06	5.06	6	7	1
2	Inpatient - General Care				76,635		1,282	2
3	Inpatient - Respite Care							3
4	Physician Services							4
5	Nursing Care				1,222,781			5
6	Nursing Care-Continuous Home Care							6
7	Physical Therapy							7
8	Occupational Therapy							8
9	Speech / Language Pathology							9
10	Medical Social Services							10
11	Spiritual Counseling							11
12	Dietary Counseling							12
13	Counseling - Other							13
14	Home Health Aide and Homemaker							14
15	HH Aide & Homemaker - Cont. Home Care							15
16	Other				149,186			16
17	Drugs, Biological and Infusion Therapy							17
18	Analgesics							18
19	Sedatives / Hypnotics							19
20	Other - Specify							20
21	Durable Medical Equipment/Oxygen							21
22	Patient Transportation							22
23	Imaging Services							23
24	Labs and Diagnostics							24
25	Medical Supplies							25
26	Outpatient Services (including 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)				1,448,602		1,282	34
35	Total cost to be allocated				81,077		17,578	35
36	Unit Cost Multiplier (see instructions)							36
36	Unit Cost Multiplier (see instructions)				0.055969		13.711388	36

IROQUOIS MEMORIAL HOSPITAL Provider CCN: 14-0167	In Lieu of Form CMS-2552-10	Period : From: 10/01/2014 To: 09/30/2015	Run Date: 02/24/2016 Run Time: 16:14 Version: 2015.10 (12/18/2015)
---	--------------------------------	--	--

ALLOCATION OF GENERAL SERVICE COSTS TO HOSPICE COST CENTERS - STATISTICAL BASIS HOSPICE CCN: 14-1616

WORKSHEET K-5  
PART II

PART II - ALLOCATION OF GENERAL SERVICE COSTS TO HOSPICE COST CENTERS - STATISTICAL BASIS

	HOSPICE COST CENTER	LAUNDRY & LINEN SERVICE POUNDS	HOUSE-KEEPING SQUARE FEET	DIETARY MEALS	CAFETERIA FTE'S	MAINTENANCE OF PERSONNEL NUMBER HOUSED	NURSING ADMINISTRATION NURSING HOURS	
		8	9	10	11	12	13	
1	Administrative and General		1,282					1
2	Inpatient - General Care							2
3	Inpatient - Respite Care							3
4	Physician Services							4
5	Nursing Care							5
6	Nursing Care-Continuous Home Care							6
7	Physical Therapy							7
8	Occupational Therapy							8
9	Speech / Language Pathology							9
10	Medical Social Services							10
11	Spiritual Counseling							11
12	Dietary Counseling							12
13	Counseling - Other							13
14	Home Health Aide and Homemaker							14
15	HH Aide & Homemaker - Cont. Home Care							15
16	Other							16
17	Drugs, Biological and Infusion Therapy							17
18	Analgesics							18
19	Sedatives / Hypnotics							19
20	Other - Specify							20
21	Durable Medical Equipment/Oxygen							21
22	Patient Transportation							22
23	Imaging Services							23
24	Labs and Diagnostics							24
25	Medical Supplies							25
26	Outpatient Services (including 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)		1,282					34
35	Total cost to be allocated		6,275					35
36	Unit Cost Multiplier (see instructions)							36
36	Unit Cost Multiplier (see instructions)		4.894696					36

IROQUOIS MEMORIAL HOSPITAL Provider CCN: 14-0167	In Lieu of Form CMS-2552-10	Period : From: 10/01/2014 To: 09/30/2015	Run Date: 02/24/2016 Run Time: 16:14 Version: 2015.10 (12/18/2015)
---	--------------------------------	--	--

ALLOCATION OF GENERAL SERVICE COSTS TO HOSPICE COST CENTERS - STATISTICAL BASIS HOSPICE CCN: 14-1616

WORKSHEET K-5  
PART II

PART II - ALLOCATION OF GENERAL SERVICE COSTS TO HOSPICE COST CENTERS - STATISTICAL BASIS

	HOSPICE COST CENTER	CENTRAL SERVICES & SUPPLY CSS CSTED REQ'	PHARMACY COSTED REQUIS.	MEDICAL RECORDS & LIBRARY GROSS REVENUE	SOCIAL SERVICE TIME SPENT	NONPHYSIC. ANESTHET. ASSIGNED TIME	NURSING SCHOOL ASSIGNED TIME	
		14	15	16	17	19	20	
1	Administrative and General							1
2	Inpatient - General Care							2
3	Inpatient - Respite Care							3
4	Physician Services							4
5	Nursing Care							5
6	Nursing Care-Continuous Home Care							6
7	Physical Therapy							7
8	Occupational Therapy							8
9	Speech / Language Pathology							9
10	Medical Social Services							10
11	Spiritual Counseling							11
12	Dietary Counseling							12
13	Counseling - Other							13
14	Home Health Aide and Homemaker							14
15	HH Aide & Homemaker - Cont. Home Care							15
16	Other							16
17	Drugs, Biological and Infusion Therapy							17
18	Analgesics							18
19	Sedatives / Hypnotics							19
20	Other - Specify							20
21	Durable Medical Equipment/Oxygen							21
22	Patient Transportation							22
23	Imaging Services							23
24	Labs and Diagnostics							24
25	Medical Supplies							25
26	Outpatient Services (including 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 (see instructions)							36
36	Unit Cost Multiplier (see instructions)							36

IROQUOIS MEMORIAL HOSPITAL Provider CCN: 14-0167	In Lieu of Form CMS-2552-10	Period : From: 10/01/2014 To: 09/30/2015	Run Date: 02/24/2016 Run Time: 16:14 Version: 2015.10 (12/18/2015)
---	--------------------------------	--	--

ALLOCATION OF GENERAL SERVICE COSTS TO HOSPICE COST CENTERS - STATISTICAL BASIS HOSPICE CCN: 14-1616

WORKSHEET K-5  
PART II

PART II - ALLOCATION OF GENERAL SERVICE COSTS TO HOSPICE COST CENTERS - STATISTICAL BASIS

	HOSPICE COST CENTER	I&R SALARY & FRINGES ASSIGNED TIME	I&R PROGRAM COSTS ASSIGNED TIME	PARAMED EDUCATION ASSIGNED TIME				
		21	22	23				
1	Administrative and General							1
2	Inpatient - General Care							2
3	Inpatient - Respite Care							3
4	Physician Services							4
5	Nursing Care							5
6	Nursing Care-Continuous Home Care							6
7	Physical Therapy							7
8	Occupational Therapy							8
9	Speech / Language Pathology							9
10	Medical Social Services							10
11	Spiritual Counseling							11
12	Dietary Counseling							12
13	Counseling - Other							13
14	Home Health Aide and Homemaker							14
15	HH Aide & Homemaker - Cont. Home Care							15
16	Other							16
17	Drugs, Biological and Infusion Therapy							17
18	Analgesics							18
19	Sedatives / Hypnotics							19
20	Other - Specify							20
21	Durable Medical Equipment/Oxygen							21
22	Patient Transportation							22
23	Imaging Services							23
24	Labs and Diagnostics							24
25	Medical Supplies							25
26	Outpatient Services (including 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 (see instructions)							36
36	Unit Cost Multiplier (see instructions)							36

IROQUOIS MEMORIAL HOSPITAL Provider CCN: 14-0167	In Lieu of Form <b>CMS-2552-10</b>	Period : From: 10/01/2014 To: 09/30/2015	Run Date: 02/24/2016 Run Time: 16:14 Version: 2015.10 (12/18/2015)
---	---------------------------------------	--	--

APPORTIONMENT OF HOSPICE SHARED SERVICES

HOSPICE CCN: 14-1616

WORKSHEET K-5  
PART III

PART III - COMPUTATION OF TOTAL HOSPICE SHARED COSTS

	COST CENTER	Wkst C, Part I, col. 9, line	Cost to Charge Ratio	Total Hospice Charges (Provider Records)	Hospice Shared Ancillary Costs (cols. 1 x 2)	
		0	1	2	3	
	<b>ANCILLARY SERVICE COST CENTERS</b>					
1	Physical Therapy	66	0.425196			1
2	Occupational Therapy	67				2
3	Speech / Language Pathology	68				3
4	Drugs, Biological and Infusion Therapy	73	0.375558			4
5	Durable Medical Equipment/Oxygen	96				5
6	Labs and Diagnostics	60	0.224837			6
7	Medical Supplies	71	0.348121			7
8	Outpatient Services (including E/R Dept.)	93				8
9	Radiation Therapy	55				9
10	Other	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

IROQUOIS MEMORIAL HOSPITAL Provider CCN: 14-0167	In Lieu of Form <b>CMS-2552-10</b>	Period : From: 10/01/2014 To: 09/30/2015	Run Date: 02/24/2016 Run Time: 16:14 Version: 2015.10 (12/18/2015)
---	---------------------------------------	--	--

**CALCULATION OF HOSPICE PER DIEM COST**

**HOSPICE CCN: 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)				1,553,532	1
2	Total unduplicated days (Worksheet S-9, column 6, line 5)				5,154	2
3	Average cost per diem (line 1 divided by line 2)				301.42	3
4	Unduplicated Medicare days (Worksheet S-9, column 1, line 5)	4,734				4
5	Aggregate Medicare cost (line 3 times line 4)	1,426,922				5
6	Unduplicated Medicaid days (Worksheet S-9, column 2, line 5)		82			6
7	Aggregate Medicaid cost (line 3 times line 6)		24,716			7
8	Unduplicated SNF days (Worksheet S-9, column 3, line 5)	6,239				8
9	Aggregate SNF cost (line 3 times line 8)	1,880,559				9
10	Unduplicated NF days (Worksheet S-9, column 4, line 5)		71			10
11	Aggregate NF cost (line 3 times line 10)		21,401			11
12	Other Unduplicated days (Worksheet S-9, column 5, line 5)			338		12
13	Aggregate cost for other days (line 3 times line 12)			101,880		13

Note: The data for the SNF and NF on lines 8 through 11 are included in the Medicare and Medicaid lines 4 through 7.

IROQUOIS MEMORIAL HOSPITAL Provider CCN: 14-0167	In Lieu of Form <b>CMS-2552-10</b>	Period : From: 10/01/2014 To: 09/30/2015	Run Date: 02/24/2016 Run Time: 16:14 Version: 2015.10 (12/18/2015)
---	---------------------------------------	--	--

**CALCULATION OF CAPITAL PAYMENT**

**COMPONENT CCN: 14-0167**

**WORKSHEET L**

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

**PART I - FULLY PROSPECTIVE METHOD**

CAPITAL FEDERAL AMOUNT			
1	Capital DRG other than outlier	245,471	1
1.01	Model 4 BPCI Capital DRG other than outlier		1.01
2	Capital DRG outlier payments	1,016	2
2.01	Model 4 BPCI Capital DRG outlier payments		2.01
3	Total inpatient days divided by number of days in the cost reporting period (see instructions)	5.98	3
4	Number of interns & residents (see instructions)		4
5	Indirect medical education percentage (see instructions)		5
6	Indirect medical education adjustment (see instructions)		6
7	Percentage of SSI recipient patient days to Medicare Part A patient days (Worksheet E, Part A line 30) (see instructions)		7
8	Percentage of Medicaid patient days to total days (see instructions)		8
9	Sum of lines 7 and 8		9
10	Allowable disproportionate share percentage (see instructions)		10
11	Disproportionate share adjustment (see instructions)		11
12	Total prospective capital payments (see instructions)	246,487	12

**PART II - PAYMENT UNDER REASONABLE COST**

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

**PART III - COMPUTATION OF EXCEPTION PAYMENTS**

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

IROQUOIS MEMORIAL HOSPITAL Provider CCN: 14-0167	In Lieu of Form <b>CMS-2552-10</b>	Period : From: 10/01/2014 To: 09/30/2015	Run Date: 02/24/2016 Run Time: 16:14 Version: 2015.10 (12/18/2015)
---	---------------------------------------	--	--

**CALCULATION OF CAPITAL PAYMENT**

**COMPONENT CCN: 14-0167**

**WORKSHEET L**

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

**PART I - FULLY PROSPECTIVE METHOD**

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

**PART II - PAYMENT UNDER REASONABLE COST**

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

**PART III - COMPUTATION OF EXCEPTION PAYMENTS**

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

IROQUOIS MEMORIAL HOSPITAL Provider CCN: 14-0167	In Lieu of Form CMS-2552-10	Period : From: 10/01/2014 To: 09/30/2015	Run Date: 02/24/2016 Run Time: 16:14 Version: 2015.10 (12/18/2015)
---	--------------------------------	--	--

ALLOCATION OF ALLOWABLE COSTS FOR EXTRAORDINARY CIRCUMSTANCES

WORKSHEET L-1  
PART I

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

IROQUOIS MEMORIAL HOSPITAL Provider CCN: 14-0167	In Lieu of Form CMS-2552-10	Period : From: 10/01/2014 To: 09/30/2015	Run Date: 02/24/2016 Run Time: 16:14 Version: 2015.10 (12/18/2015)
---	--------------------------------	--	--

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

COMPONENT CCN: 14-3424

WORKSHEET M-1

Check applicable box:       RHC I                                       FQHC

	COMPENSATION	OTHER COSTS	TOTAL (col. 1 + col. 2)	RECLASSIFICATIONS	RECLASSIFIED TRIAL BALANCE (col. 3 + col. 4)	ADJUSTMENTS	NET EXPENSES FOR ALLOCATION (col. 5 + col. 6)	
	1	2	3	4	5	6	7	
<b>FACILITY HEALTH CARE STAFF COSTS</b>								
1	Physician	385,509	385,509		385,509		385,509	1
2	Physician Assistant							2
3	Nurse Practitioner	160,474	160,474		160,474		160,474	3
4	Visiting Nurse							4
5	Other Nurse	154,031	154,031		154,031		154,031	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 through 9)	700,014	700,014		700,014		700,014	10
<b>COSTS UNDER AGREEMENT</b>								
11	Physician Services Under Agreement							11
12	Physician Supervision Under Agreement							12
13	Other Costs Under Agreement							13
14	Subtotal (sum of lines 11 through 13)							14
<b>OTHER HEALTH CARE COSTS</b>								
15	Medical Supplies		4,900	4,900	4,900		4,900	15
16	Transportation (Health Care Staff)							16
17	Depreciation-Medical Equipment							17
18	Professional Liability Insurance		13,402	13,402	13,402		13,402	18
19	Other Health Care Costs		19,403	19,403	19,403		19,403	19
20	Allowable GME Costs							20
21	Subtotal (sum of lines 15 through 20)		37,705	37,705	37,705		37,705	21
22	Total Cost of Health Care Services (sum of lines 10, 14, and 21)	700,014	37,705	737,719	737,719		737,719	22
<b>COSTS OTHER THAN RHC/FQHC SERVICES</b>								
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 through 27)							28
<b>FACILITY OVERHEAD</b>								
29	Facility Costs		8,446	8,446	8,446		8,446	29
30	Administrative Costs	71,718	128,139	199,857	-20,960	178,897	-38,809	140,088
31	Total Facility Overhead (sum of lines 29 and 30)	71,718	136,585	208,303	-20,960	187,343	-38,809	148,534
32	Total facility costs (sum of lines 22, 28 and 31)	771,732	174,290	946,022	-20,960	925,062	-38,809	886,253

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

IROQUOIS MEMORIAL HOSPITAL Provider CCN: 14-0167	In Lieu of Form CMS-2552-10	Period : From: 10/01/2014 To: 09/30/2015	Run Date: 02/24/2016 Run Time: 16:14 Version: 2015.10 (12/18/2015)
---	--------------------------------	--	--

ALLOCATION OF OVERHEAD TO RHC/FQHC SERVICES

COMPONENT CCN: 14-3424

WORKSHEET M-2

Check applicable box:       RHC I                               FQHC

**VISITS AND PRODUCTIVITY**

		Number of FTE Personnel	Total Visits	Productivity Standard (1)	Minimum Visits (col. 1 x col. 3)	Greater of col. 2 or col. 4	
	Positions	1	2	3	4	5	
1	Physicians	1.34	3,569	4,200	5,628		1
2	Physician Assistants			2,100			2
3	Nurse Practitioners	1.00	2,091	2,100	2,100		3
4	Subtotal (sum of lines 1 through 3)	2.34	5,660		7,728	7,728	4
5	Visiting Nurse						5
6	Clinical Psychologist						6
7	Clinical Social Worker						7
7.01	Medical Nutrition Therapist (FQHC only)						7.01
7.02	Diabetes Self Management Training (FQHC only)						7.02
8	Total FTEs and Visits (sum of lines 4 through 7)	2.34	5,660			7,728	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)					737,719	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)					737,719	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)					148,534	14
15	Parent provider overhead allocated to facility (see instructions)					256,496	15
16	Total overhead (sum of lines 14 and 15)					405,030	16
17	Allowable Direct GME overhead (see instructions)						17
18	Subtotal (see instructions)					405,030	18
19	Overhead applicable to RHC/FQHC services (line 13 x line 18)					405,030	19
20	Total allowable cost of RHC/FQHC services(sum of lines 10 and 19)					1,142,749	20

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



IROQUOIS MEMORIAL HOSPITAL Provider CCN: 14-0167	In Lieu of Form <b>CMS-2552-10</b>	Period : From: 10/01/2014 To: 09/30/2015	Run Date: 02/24/2016 Run Time: 16:14 Version: 2015.10 (12/18/2015)
---	---------------------------------------	--	--

CALCULATION OF PNEUMOCOCCAL AND INFLUENZA VACCINE COST

COMPONENT CCN: 14-3424

WORKSHEET M-4

Check applicable boxes:     
  RHC I                     
  Title V                     
  Title XIX  
   
  FQHC                             
  Title XVIII

		PNEUMO-COCCAL	INFLUENZA	
		1	2	
1	Health care staff cost (from Wkst. M-1, col. 7, line 10)	700,014	700,014	1
2	Ratio of pneumococcal and influenza vaccine staff time to total health care staff time	0.000116	0.002013	2
3	Pneumococcal and influenza vaccine health care staff cost (line 1 x line 2)	81	1,409	3
4	Medical supplies cost - pneumococcal and influenza vaccine (from your records)	1,190	2,033	4
5	Direct cost of pneumococcal and influenza vaccine (line 3 plus line 4)	1,271	3,442	5
6	Total direct cost of the facility (from Wkst. M-1, col. 7, line 22)	737,719	737,719	6
7	Total overhead (from Wkst. M-2, line 16)	405,030	405,030	7
8	Ratio of pneumococcal and influenza vaccine direct cost to total direct cost (line 5 divided by line 6)	0.001723	0.004666	8
9	Overhead cost - pneumococcal and influenza vaccine (line 7 x line 8)	698	1,890	9
10	Total pneumococcal and influenza vaccine costs and their administration costs (sum of lines 5 and 9)	1,969	5,332	10
11	Total number of pneumococcal and influenza vaccine injections (from your records)	19	121	11
12	Cost per pneumococcal and influenza vaccing injection (line 10/line 11)	103.63	44.07	12
13	Number of pneumococcal and influenza vaccine injections administered to program beneficiaries	18	92	13
14	Program cost of pneumococcal and influenza vaccines and their administration costs (line 12 x line 13)	1,865	4,054	14
15	Total cost of pneumococcal and influenza vaccines and their administration costs (sum of cols. 1 and 2, line 10) (transfer this amount to Wkst. M-3, line 2)		7,301	15
16	Total Program cost of pneumococcal and influenza vaccines and their administration costs (sum of cols. 1 and 2, line 14) (transfer this amount to Wkst. M-3, line 21)		5,919	16

IROQUOIS MEMORIAL HOSPITAL Provider CCN: 14-0167	In Lieu of Form <b>CMS-2552-10</b>	Period : From: 10/01/2014 To: 09/30/2015	Run Date: 02/24/2016 Run Time: 16:14 Version: 2015.10 (12/18/2015)
---	---------------------------------------	--	--

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

**COMPONENT CCN: 14-3424**

**WORKSHEET M-5**

Check applicable box:       RHC I                               FQHC

		Part B		
DESCRIPTION		mm/dd/yyyy	Amount	
		1	2	
1	Total interim payments paid to provider		248,085	1
2	Interim payments payable on individual bills, either submitted or to be submitted to the intermediary, for services rendered in the cost reporting period. If none, write 'NONE' or enter zero			2
3	List separately each retroactive lump sum adjustment 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 zero (1)	.01	16,419	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
		.10		3.10
		.50		3.50
		.51		3.51
	Provider	.52		3.52
	to	.53		3.53
	Program	.54		3.54
		.55		3.55
		.56		3.56
		.57		3.57
		.58		3.58
		.59		3.59
	Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98)	.99	16,419	3.99
4	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Wkst. M-3, line 27)		264,504	
<b>TO BE COMPLETED BY CONTRACTOR</b>				
5	List separately each tentative settlement payment after desk review. Also show date of each payment. If none, write 'NONE' or enter zero (1)	.01		5.01
		.02		5.02
	Program	.03		5.03
	to	.04		5.04
	Provider	.05		5.05
		.06		5.06
		.07		5.07
		.08		5.08
		.09		5.09
		.10		5.10
		.50		5.50
		.51		5.51
	Provider	.52		5.52
	to	.53		5.53
	Program	.54		5.54
		.55		5.55
		.56		5.56
		.57		5.57
		.58		5.58
		.59		5.59
	Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98)	.99		5.99
6	Determine net settlement amount (balance due) based on the cost report (1)	.01		6.01
		.02	-18,694	6.02
7	Total Medicare program liability (see instructions)		245,810	
8	Name of Contractor	Contractor Number	NPR Date (Month/Day/Year)	8

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

IROQUOIS MEMORIAL HOSPITAL Provider CCN: 14-0167	In Lieu of Form CMS-2552-10	Period : From: 10/01/2014 To: 09/30/2015	Run Date: 02/24/2016 Run Time: 16:14 Version: 2015.10 (12/18/2015)
---	--------------------------------	--	--

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

COMPONENT CCN: 14-3425

WORKSHEET M-1

Check applicable box:       RHC II                       FQHC

		COMPENS- ATION	OTHER COSTS	TOTAL (col. 1 + col. 2)	RECLASS- IFICATIONS	RECLASS- IFIED TRIAL BALANCE (col. 3 + col. 4)	ADJUST- MENTS	NET EXPENSES FOR ALLOCATION (col. 5 + col. 6)	
		1	2	3	4	5	6	7	
	<b>FACILITY HEALTH CARE STAFF COSTS</b>								
1	Physician	59,709		59,709		59,709		59,709	1
2	Physician Assistant								2
3	Nurse Practitioner	91,549		91,549		91,549		91,549	3
4	Visiting Nurse								4
5	Other Nurse	114,749		114,749		114,749		114,749	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 through 9)	266,007		266,007		266,007		266,007	10
	<b>COSTS UNDER AGREEMENT</b>								
11	Physician Services Under Agreement								11
12	Physician Supervision Under Agreement								12
13	Other Costs Under Agreement								13
14	Subtotal (sum of lines 11 through 13)								14
	<b>OTHER HEALTH CARE COSTS</b>								
15	Medical Supplies		2,825	2,825		2,825		2,825	15
16	Transportation (Health Care Staff)								16
17	Depreciation-Medical Equipment								17
18	Professional Liability Insurance		3,010	3,010		3,010		3,010	18
19	Other Health Care Costs		10,165	10,165		10,165		10,165	19
20	Allowable GME Costs								20
21	Subtotal (sum of lines 15 through 20)		16,000	16,000		16,000		16,000	21
22	Total Cost of Health Care Services (sum of lines 10, 14, and 21)	266,007	16,000	282,007		282,007		282,007	22
	<b>COSTS OTHER THAN RHC/FQHC SERVICES</b>								
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 through 27)								28
	<b>FACILITY OVERHEAD</b>								
29	Facility Costs		-448	-448		-448		-448	29
30	Administrative Costs	34,358	97,046	131,404		131,404	-27,359	104,045	30
31	Total Facility Overhead (sum of lines 29 and 30)	34,358	96,598	130,956		130,956	-27,359	103,597	31
32	Total facility costs (sum of lines 22, 28 and 31)	300,365	112,598	412,963		412,963	-27,359	385,604	32

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

IROQUOIS MEMORIAL HOSPITAL Provider CCN: 14-0167	In Lieu of Form CMS-2552-10	Period : From: 10/01/2014 To: 09/30/2015	Run Date: 02/24/2016 Run Time: 16:14 Version: 2015.10 (12/18/2015)
---	--------------------------------	--	--

ALLOCATION OF OVERHEAD TO RHC/FQHC SERVICES

COMPONENT CCN: 14-3425

WORKSHEET M-2

Check applicable box:       RHC II                       FQHC

**VISITS AND PRODUCTIVITY**

		Number of FTE Personnel	Total Visits	Productivity Standard (1)	Minimum Visits (col. 1 x col. 3)	Greater of col. 2 or col. 4	
	Positions	1	2	3	4	5	
1	Physicians	0.24	1,234	4,200	1,008		1
2	Physician Assistants			2,100			2
3	Nurse Practitioners	1.00	1,968	2,100	2,100		3
4	Subtotal (sum of lines 1 through 3)	1.24	3,202		3,108	3,202	4
5	Visiting Nurse						5
6	Clinical Psychologist						6
7	Clinical Social Worker						7
7.01	Medical Nutrition Therapist (FQHC only)						7.01
7.02	Diabetes Self Management Training (FQHC only)						7.02
8	Total FTEs and Visits (sum of lines 4 through 7)	1.24	3,202			3,202	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)					282,007	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)					282,007	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)					103,597	14
15	Parent provider overhead allocated to facility (see instructions)					148,389	15
16	Total overhead (sum of lines 14 and 15)					251,986	16
17	Allowable Direct GME overhead (see instructions)						17
18	Subtotal (see instructions)					251,986	18
19	Overhead applicable to RHC/FQHC services (line 13 x line 18)					251,986	19
20	Total allowable cost of RHC/FQHC services(sum of lines 10 and 19)					533,993	20

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

IROQUOIS MEMORIAL HOSPITAL Provider CCN: 14-0167	In Lieu of Form CMS-2552-10	Period : From: 10/01/2014 To: 09/30/2015	Run Date: 02/24/2016 Run Time: 16:14 Version: 2015.10 (12/18/2015)
---	--------------------------------	--	--

CALCULATION OF REIMBURSEMENT SETTLEMENT FOR RHC/FQHC SERVICES

COMPONENT CCN: 14-3425

WORKSHEET M-3

Check applicable boxes:  RHC II  Title V  Title XIX  
 FQHC  Title XVIII

DETERMINATION OF RATE FOR RHC/FQHC SERVICES

1	Total allowable cost of RHC/FQHC services (from Wkst. M-2, line 20)	533,993	1
2	Cost of vaccines and their administratino (from Wkst. M-4, line 15)	7,618	2
3	Total allowable cost excluding vaccine (line 1 minus line 2)	526,375	3
4	Total visits (from Wkst. M-2, col. 5, line 8)	3,202	4
5	Physicians visits under agreement (from Wkst. M-2, col. 5, line 9)		5
6	Total adjusted visits (line 4 plus line 5)	3,202	6
7	Adjusted cost per visit (line 3 divided by line 6)	164.39	7

		Calculation of Limit (1)			
		Prior to January 1	On or after January 1	(See instr.)	
		1	2	3	
8	Per visit payment limit (from CMS Pub. 100-04, chapter 9, §20.6 or your contractor)				8
9	Rate for program covered visits (see instructions)	164.39	164.39	164.39	9
<b>CALCULATION OF SETTLEMENT</b>					
10	Program covered visits excluding mental health services (from contractor records)	363	1,090		10
11	Program cost excluding costs for mental health services (line 9 x line 10)	59,674	179,185		11
12	Program covered visits for mental health services (from contractor records)				12
13	Program covered cost from mental health services (line 9 x line 12)				13
14	Limit adjustment for mental health services (see instructions)				14
15	Graduate Medical Education pass-through cost (see instructions)				15
16	Total Program cost (see instructions)		238,859		16
16.01	Total program charges (see instructions)(from contractor's records)		161,006		16.01
16.02	Total program preventive charges (see instructions)(from provider's records)				16.02
16.03	Total program preventive costs (see instructions)				16.03
16.04	Total program non-preventive costs (see instructions)		178,958		16.04
16.05	Total program cost (see instructions)		178,958		16.05
17	Primary payer payments				17
18	Less: Beneficiary deductible for RHC only (see instructions)(from contractor records)		15,161		18
19	Less: Beneficiary coinsurance for RHC/FQHC services (see instructions) (from contractor records)		29,263		19
20	Net Medicare cost excluding vaccines (see instructions)		178,958		20
21	Program cost of vaccines and their administration (from Wkst. M-4, line 16)		5,880		21
22	Total reimbursable Program cost (line 20 plus line 21)		184,838		22
23	Allowable bad debts (see instructions)		3,420		23
23.01	Adjusted reimbursable bad debts (see instructions)		2,223		23.01
24	Allowable bad debts for dual eligible beneficiaries (see instructions)		3,420		24
25	Other adjustments (specify) (see instructions)				25
26	Net reimbursable amount (see instructions)		187,061		26
26.01	Sequestration adjustment (see instructions)		3,741		26.01
27	Interim payments		154,244		27
28	Tentative settlement (for contractor use only)				28
29	Balance due component/program (line 26 minus lines 26.01, 27 and 28)		29,076		29
30	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2				30

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

IROQUOIS MEMORIAL HOSPITAL Provider CCN: 14-0167	In Lieu of Form <b>CMS-2552-10</b>	Period : From: 10/01/2014 To: 09/30/2015	Run Date: 02/24/2016 Run Time: 16:14 Version: 2015.10 (12/18/2015)
---	---------------------------------------	--	--

CALCULATION OF PNEUMOCOCCAL AND INFLUENZA VACCINE COST

COMPONENT CCN: 14-3425

WORKSHEET M-4

Check applicable boxes:     
  RHC II                     
  Title V                     
  Title XIX  
   
  FQHC                             
  Title XVIII

		PNEUMO-COCCAL	INFLUENZA	
		1	2	
1	Health care staff cost (from Wkst. M-1, col. 7, line 10)	266,007	266,007	1
2	Ratio of pneumococcal and influenza vaccine staff time to total health care staff time	0.000232	0.003950	2
3	Pneumococcal and influenza vaccine health care staff cost (line 1 x line 2)	62	1,051	3
4	Medical supplies cost - pneumococcal and influenza vaccine (from your records)	877	2,033	4
5	Direct cost of pneumococcal and influenza vaccine (line 3 plus line 4)	939	3,084	5
6	Total direct cost of the facility (from Wkst. M-1, col. 7, line 22)	282,007	282,007	6
7	Total overhead (from Wkst. M-2, line 16)	251,986	251,986	7
8	Ratio of pneumococcal and influenza vaccine direct cost to total direct cost (line 5 divided by line 6)	0.003330	0.010936	8
9	Overhead cost - pneumococcal and influenza vaccine (line 7 x line 8)	839	2,756	9
10	Total pneumococcal and influenza vaccine costs and their administration costs (sum of lines 5 and 9)	1,778	5,840	10
11	Total number of pneumococcal and influenza vaccine injections (from your records)	14	121	11
12	Cost per pneumococcal and influenza vaccing injection (line 10/line 11)	127.00	48.26	12
13	Number of pneumococcal and influenza vaccine injections administered to program beneficiaries	14	85	13
14	Program cost of pneumococcal and influenza vaccines and their administration costs (line 12 x line 13)	1,778	4,102	14
15	Total cost of pneumococcal and influenza vaccines and their administration costs (sum of cols. 1 and 2, line 10) (transfer this amount to Wkst. M-3, line 2)		7,618	15
16	Total Program cost of pneumococcal and influenza vaccines and their administration costs (sum of cols. 1 and 2, line 14) (transfer this amount to Wkst. M-3, line 21)		5,880	16

IROQUOIS MEMORIAL HOSPITAL Provider CCN: 14-0167	In Lieu of Form <b>CMS-2552-10</b>	Period : From: 10/01/2014 To: 09/30/2015	Run Date: 02/24/2016 Run Time: 16:14 Version: 2015.10 (12/18/2015)
---	---------------------------------------	--	--

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

**COMPONENT CCN: 14-3425**

**WORKSHEET M-5**

Check applicable box:       RHC II                               FQHC

		Part B		
DESCRIPTION		mm/dd/yyyy	Amount	
		1	2	
1	Total interim payments paid to provider		143,368	1
2	Interim payments payable on individual bills, either submitted or to be submitted to the intermediary, for services rendered in the cost reporting period. If none, write 'NONE' or enter zero			2
3	List separately each retroactive lump sum adjustment 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 zero (1)	.01	10,876	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
		.10		3.10
		.50		3.50
		.51		3.51
	Provider	.52		3.52
	to	.53		3.53
	Program	.54		3.54
		.55		3.55
		.56		3.56
		.57		3.57
		.58		3.58
		.59		3.59
	Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98)	.99	10,876	3.99
4	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Wkst. M-3, line 27)		154,244	
<b>TO BE COMPLETED BY CONTRACTOR</b>				
5	List separately each tentative settlement payment after desk review. Also show date of each payment. If none, write 'NONE' or enter zero (1)	.01		5.01
		.02		5.02
	Program	.03		5.03
	to	.04		5.04
	Provider	.05		5.05
		.06		5.06
		.07		5.07
		.08		5.08
		.09		5.09
		.10		5.10
		.50		5.50
		.51		5.51
	Provider	.52		5.52
	to	.53		5.53
	Program	.54		5.54
		.55		5.55
		.56		5.56
		.57		5.57
		.58		5.58
		.59		5.59
	Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98)	.99		5.99
6	Determine net settlement amount (balance due) based on the cost report (1)	.01	29,076	6.01
		.02		6.02
7	Total Medicare program liability (see instructions)		183,320	
8	Name of Contractor	Contractor Number	NPR Date (Month/Day/Year)	8

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

IROQUOIS MEMORIAL HOSPITAL Provider CCN: 14-0167	In Lieu of Form CMS-2552-10	Period : From: 10/01/2014 To: 09/30/2015	Run Date: 02/24/2016 Run Time: 16:14 Version: 2015.10 (12/18/2015)
---	--------------------------------	--	--

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

COMPONENT CCN: 15-3979

WORKSHEET M-1

Check applicable box:       RHC III                       FQHC

	COMPENSATION	OTHER COSTS	TOTAL (col. 1 + col. 2)	RECLASSIFICATIONS	RECLASSIFIED TRIAL BALANCE (col. 3 + col. 4)	ADJUSTMENTS	NET EXPENSES FOR ALLOCATION (col. 5 + col. 6)	
	1	2	3	4	5	6	7	
<b>FACILITY HEALTH CARE STAFF COSTS</b>								
1	Physician	256,754	256,754		256,754		256,754	1
2	Physician Assistant							2
3	Nurse Practitioner	218,640	218,640		218,640		218,640	3
4	Visiting Nurse							4
5	Other Nurse	282,569	282,569		282,569		282,569	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 through 9)	757,963	757,963		757,963		757,963	10
<b>COSTS UNDER AGREEMENT</b>								
11	Physician Services Under Agreement							11
12	Physician Supervision Under Agreement							12
13	Other Costs Under Agreement							13
14	Subtotal (sum of lines 11 through 13)							14
<b>OTHER HEALTH CARE COSTS</b>								
15	Medical Supplies		6,623	6,623	6,623		6,623	15
16	Transportation (Health Care Staff)							16
17	Depreciation-Medical Equipment							17
18	Professional Liability Insurance		8,601	8,601	8,601		8,601	18
19	Other Health Care Costs		21,085	21,085	21,085		21,085	19
20	Allowable GME Costs							20
21	Subtotal (sum of lines 15 through 20)		36,309	36,309	36,309		36,309	21
22	Total Cost of Health Care Services (sum of lines 10, 14, and 21)	757,963	36,309	794,272	794,272		794,272	22
<b>COSTS OTHER THAN RHC/FQHC SERVICES</b>								
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 through 27)							28
<b>FACILITY OVERHEAD</b>								
29	Facility Costs		10,553	10,553	10,553		10,553	29
30	Administrative Costs	69,425	201,962	271,387	271,387	-66,382	205,005	30
31	Total Facility Overhead (sum of lines 29 and 30)	69,425	212,515	281,940	281,940	-66,382	215,558	31
32	Total facility costs (sum of lines 22, 28 and 31)	827,388	248,824	1,076,212	1,076,212	-66,382	1,009,830	32

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

IROQUOIS MEMORIAL HOSPITAL Provider CCN: 14-0167	In Lieu of Form <b>CMS-2552-10</b>	Period : From: 10/01/2014 To: 09/30/2015	Run Date: 02/24/2016 Run Time: 16:14 Version: 2015.10 (12/18/2015)
---	---------------------------------------	--	--

**ALLOCATION OF OVERHEAD TO RHC/FQHC SERVICES**

**COMPONENT CCN: 15-3979**

**WORKSHEET M-2**

Check applicable box:       RHC III                       FQHC

**VISITS AND PRODUCTIVITY**

		Number of FTE Personnel	Total Visits	Productivity Standard (1)	Minimum Visits (col. 1 x col. 3)	Greater of col. 2 or col. 4	
	Positions	1	2	3	4	5	
1	Physicians	0.60	3,774	4,200	2,520		1
2	Physician Assistants			2,100			2
3	Nurse Practitioners	2.14	5,163	2,100	4,494		3
4	Subtotal (sum of lines 1 through 3)	2.74	8,937		7,014	8,937	4
5	Visiting Nurse						5
6	Clinical Psychologist						6
7	Clinical Social Worker						7
7.01	Medical Nutrition Therapist (FQHC only)						7.01
7.02	Diabetes Self Management Training (FQHC only)						7.02
8	Total FTEs and Visits (sum of lines 4 through 7)	2.74	8,937			8,937	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)					794,272	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)					794,272	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)					215,558	14
15	Parent provider overhead allocated to facility (see instructions)					328,039	15
16	Total overhead (sum of lines 14 and 15)					543,597	16
17	Allowable Direct GME overhead (see instructions)						17
18	Subtotal (see instructions)					543,597	18
19	Overhead applicable to RHC/FQHC services (line 13 x line 18)					543,597	19
20	Total allowable cost of RHC/FQHC services(sum of lines 10 and 19)					1,337,869	20

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



IROQUOIS MEMORIAL HOSPITAL Provider CCN: 14-0167	In Lieu of Form <b>CMS-2552-10</b>	Period : From: 10/01/2014 To: 09/30/2015	Run Date: 02/24/2016 Run Time: 16:14 Version: 2015.10 (12/18/2015)
---	---------------------------------------	--	--

CALCULATION OF PNEUMOCOCCAL AND INFLUENZA VACCINE COST

COMPONENT CCN: 15-3979

WORKSHEET M-4

Check applicable boxes:     
  RHC III                     
  Title V                     
  Title XIX  
   
  FQHC                             
  Title XVIII

		PNEUMO-COCCAL	INFLUENZA	
		1	2	
1	Health care staff cost (from Wkst. M-1, col. 7, line 10)	757,963	757,963	1
2	Ratio of pneumococcal and influenza vaccine staff time to total health care staff time	0.000412	0.002371	2
3	Pneumococcal and influenza vaccine health care staff cost (line 1 x line 2)	312	1,797	3
4	Medical supplies cost - pneumococcal and influenza vaccine (from your records)	1,508	2,288	4
5	Direct cost of pneumococcal and influenza vaccine (line 3 plus line 4)	1,820	4,085	5
6	Total direct cost of the facility (from Wkst. M-1, col. 7, line 22)	794,272	794,272	6
7	Total overhead (from Wkst. M-2, line 16)	543,597	543,597	7
8	Ratio of pneumococcal and influenza vaccine direct cost to total direct cost (line 5 divided by line 6)	0.002291	0.005143	8
9	Overhead cost - pneumococcal and influenza vaccine (line 7 x line 8)	1,245	2,796	9
10	Total pneumococcal and influenza vaccine costs and their administration costs (sum of lines 5 and 9)	3,065	6,881	10
11	Total number of pneumococcal and influenza vaccine injections (from your records)	25	144	11
12	Cost per pneumococcal and influenza vaccing injection (line 10/line 11)	122.60	47.78	12
13	Number of pneumococcal and influenza vaccine injections administered to program beneficiaries	22	91	13
14	Program cost of pneumococcal and influenza vaccines and their administration costs (line 12 x line 13)	2,697	4,348	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)		9,946	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)		7,045	16

IROQUOIS MEMORIAL HOSPITAL Provider CCN: 14-0167	In Lieu of Form <b>CMS-2552-10</b>	Period : From: 10/01/2014 To: 09/30/2015	Run Date: 02/24/2016 Run Time: 16:14 Version: 2015.10 (12/18/2015)
---	---------------------------------------	--	--

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

**COMPONENT CCN: 15-3979**

**WORKSHEET M-5**

Check applicable box:       RHC III                       FQHC

		Part B	
DESCRIPTION		mm/dd/yyyy	Amount
		1	2
1	Total interim payments paid to provider		391,503
2	Interim payments payable on individual bills, either submitted or to be submitted to the intermediary, for services rendered in the cost reporting period. If none, write 'NONE' or enter zero		
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 zero (1)		
		.01	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
		.10	3.10
		.50	3.50
		.51	3.51
	Provider	.52	3.52
	to	.53	3.53
	Program	.54	3.54
		.55	3.55
		.56	3.56
		.57	3.57
		.58	3.58
		.59	3.59
	Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98)	.99	3.99
4	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Wkst. M-3, line 27)		391,503
<b>TO BE COMPLETED BY CONTRACTOR</b>			
5	List separately each tentative settlement payment after desk review. Also show date of each payment. If none, write 'NONE' or enter zero (1)		
		.01	5.01
		.02	5.02
	Program	.03	5.03
	to	.04	5.04
	Provider	.05	5.05
		.06	5.06
		.07	5.07
		.08	5.08
		.09	5.09
		.10	5.10
		.50	5.50
		.51	5.51
	Provider	.52	5.52
	to	.53	5.53
	Program	.54	5.54
		.55	5.55
		.56	5.56
		.57	5.57
		.58	5.58
		.59	5.59
	Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98)	.99	5.99
6	Determine net settlement amount (balance due) based on the cost report (1)	.01	12,727
		.02	6.02
7	Total Medicare program liability (see instructions)		404,230
8	Name of Contractor	Contractor Number	NPR Date (Month/Day/Year)
			8

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