

KPMG LLP Compu-Max 2552-10

IROQUOIS MEMORIAL HOSPITAL Provider CCN: 14-0167	In Lieu of Form CMS-2552-10	Period : From: 10/01/2017 To: 09/30/2018	Run Date: 02/25/2019 Run Time: 14:01 Version: 2018.12 (02/24/2019)
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HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX COST REPORT CERTIFICATION AND SETTLEMENT SUMMARY**WORKSHEET S
PARTS I, II & III****PART I - COST REPORT STATUS**

Provider use only		1. ☒ Electronically filed cost report Date: 02/25/2019 Time: 14:01 2. ☐ Manually submitted cost report 3. ☐ If this is an amended report enter the number of times the provider resubmitted the cost report 4. ☐ Medicare Utilization. Enter 'F' for full or 'L' for low.	
Contractor use only	5. ☐ Cost Report Status (1) As Submitted (2) Settled without audit (3) Settled with audit (4) Reopened (5) Amended	6. Date Received: _____ 7. Contractor No.: _____ 8. ☐ Initial Report for this Provider CCN 9. ☐ Final Report for this Provider CCN	10. NPR Date: _____ 11. Contractor's Vendor Code: ____ 12. ☐ If line 5, column 1 is 4: Enter number of times reopened = 0-9.

PART II - CERTIFICATION

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

CERTIFICATION BY CHIEF FINANCIAL OFFICER OR ADMINISTRATOR OF PROVIDER(S)

I HEREBY CERTIFY that I have read the above certification statement and that I have examined the accompanying electronically filed or manually submitted cost report and the Balance Sheet and Statement of Revenue and Expenses prepared by IROQUOIS MEMORIAL HOSPITAL (14-0167) {(Provider Name(s) and Number(s)} for the cost reporting period beginning 10/01/2017 and ending 09/30/2018, and to the best of my knowledge and belief, this report and statement are true, correct, complete and prepared from the books and records of the provider in accordance with applicable instructions, except as noted. I further certify that I am familiar with the laws and regulations regarding the provision of health care services, and that the services identified in this cost report were provided in compliance with such laws and regulations.

☐ I have read and agree with the above certification statement. I certify that I intend my electronic signature on this certification statement to be the legally binding equivalent of my original signature.

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

N.
Title

Date

PART III - SETTLEMENT SUMMARY

		TITLE XVIII					
		TITLE V	PART A	PART B	HIT	TITLE XIX	
		1	2	3	4	5	
1	HOSPITAL		-47,072	-75,793			1
2	SUBPROVIDER - IPF						2
3	SUBPROVIDER - IRF						3
4	SUBPROVIDER (OTHER)						4
5	SWING BED - SNF						5
6	SWING BED - NF						6
7	SKILLED NURSING FACILITY						7
8	NURSING FACILITY						8
9	HOME HEALTH AGENCY						9
10	HEALTH CLINIC - RHC			-32,525			10
10.01	HEALTH CLINIC - RHC II			1,462			10.01
10.02	HEALTH CLINIC - RHC III			56,380			10.02
10.03	HEALTH CLINIC - RHC IV			99			10.03
11	HEALTH CLINIC - FQHC						11
12	OUTPATIENT REHABILITATION PROVIDER						12
200	TOTAL		-47,072	-50,377			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.

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HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA

WORKSHEET S-2 PART I

Hospital and Hospital Health Care Complex Address:

1	Street: 200 FAIRMAN AVENUE	P.O. Box:	1
2	City: WATSEKA	State: IL	2

Hospital and Hospital-Based Component Identification:

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

20	Cost Reporting Period (mm/dd/yyyy)	From: 10 / 01 / 2017	To: 09 / 30 / 2018	20
21	Type of control (see instructions)	2		21

Inpatient PPS Information

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

	In-State Medicaid paid days	In-State Medicaid eligible unpaid days	Out-of-State Medicaid paid days	Out-of-State Medicaid eligible unpaid days	Medicaid HMO days	Other Medicaid days	
	1	2	3	4	5	6	
24	If this provider is an IPPS hospital, enter the in-state Medicaid paid days in column 1, in-state Medicaid eligible unpaid days in column 2, out-of-state Medicaid paid days in column 3, out-of-state Medicaid eligible unpaid days in column 4, Medicaid HMO paid and eligible but unpaid days in column 5, and other Medicaid days in column 6.	45			113		24
25	If this provider is an IRF, enter the in-state Medicaid paid days in column 1, in-state Medicaid eligible unpaid days in column 2, out-of-state Medicaid days in column 3, out-of-state Medicaid eligible unpaid days in column 4, Medicaid HMO paid and eligible but unpaid days in column 5.						25

26	Enter your standard geographic classification (not wage) status at the beginning of the cost reporting period. Enter '1' for urban and '2' for rural.	2	26
27	Enter your standard geographic classification (not wage) status at the end of the cost reporting period. Enter in column 1, '1' for urban or '2' for rural. If applicable, enter the effective date of the geographic reclassification in column 2.	2	27
35	If this is a sole community hospital (SCH), enter the number of periods SCH status in effect in the cost reporting period.	1	35
36	Enter applicable beginning and ending dates of SCH status. Subscript line 36 for number of periods in excess of one and enter subsequent dates.	Beginning: 10 / 01 / 2017	36
37	If this is a Medicare dependent hospital (MDH), enter the number of periods MDH status is in effect in the cost reporting period.		37
37.01	Is this hospital a former MDH that is eligible for the MDH transitional payment in accordance with the FY 2016 OPPS final rule? Enter 'Y' for yes or 'N' for no. (see instructions)		37.01
38	If line 37 is 1, enter the beginning and ending dates of MDH status. If line 37 is greater than 1, subscript this line for the number of periods in excess of one and enter subsequent dates.	Beginning:	38

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HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA

WORKSHEET S-2 PART I

		1	2	
39	Does this facility qualify for the inpatient hospital payment adjustment for low volume hospitals in accordance with 42 CFR §412.101(b)(2)(i) or (ii)? Enter in column 1 'Y' for yes or 'N' for no. Does the facility meet the mileage requirements in accordance with 42 CFR 412.101(b)(2)(i) or (ii)? Enter in column 2 'Y' for yes or 'N' for no. (see instructions)	Y	Y	39
40	Is this hospital subject to the HAC program reduction adjustment? Enter 'Y' for yes or 'N' for no in column 1, for discharges prior to October 1. Enter 'Y' for yes or 'N' for no in column 2, for discharges on or after October 1. (see instructions)	N	Y	40
		V	XVIII	XIX
	Prospective Payment System (PPS)-Capital	1	2	3
45	Does this facility qualify and receive capital payment for disproportionate share in accordance with 42 CFR §412.320?	N	N	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
		NAHE 413.85 Y/N 1	Worksheet A Line # 2	Pass-Through Qualification Criteria Code 3
60	Are you claiming nursing and allied health education (NAHE) costs for any program(s) that meet the criteria under 42 CFR 413.85? (see instructions)	N		60
		Y/N 1	IME 4	Direct GME 5
61	Did your hospital receive FTE slots under ACA section 5503? Enter 'Y' for yes or 'N' for no in column 1.(see instructions)	N		61
61.01	Enter the average number of unweighted primary care FTEs from the hospital's 3 most recent cost reports ending and submitted before March 23, 2010. (see instructions)			61.01
61.02	Enter the current year total unweighted primary care FTE count (excluding OB/GYN, general surgery FTEs, and primary care FTEs added under section 5503 of ACA). (see instructions)			61.02
61.03	Enter the baseline FTE count for primary care and/or general surgery residents, which is used for determining compliance with the 75% test. (see instructions)			61.03
61.04	Enter the number of unweighted primary care/or surgery allopathic and/or 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. Enter in column 4, the direct GME FTE unweighted count.

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

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

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

62	Enter the number of FTE residents that your hospital trained in this cost reporting period for which your hospital 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 through 67. (see instructions)	N		63
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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

Inpatient Psychiatric Facility PPS

		1	2	3	
70	Is this facility an Inpatient Psychiatric Facility (IPF), or does it contain an IPF subprovider? Enter 'Y' for yes or 'N' for no.	N			70
71	If line 70 is yes: Column 1: Did the facility have a teaching program in the most recent cost report filed on or before November 15, 2004? Enter 'Y' for yes or 'N' for no. Column 2: Did this facility train residents in a new teaching program in accordance with 42 CFR §412.424(d)(1)(iii)(D)? Enter 'Y' for yes and 'N' for no. Column 3: If column 2 is Y, indicate which program year began during this cost reporting period. (see instructions)				71

Inpatient Rehabilitation Facility PPS

		1	2	3	
75	Is this facility an Inpatient Rehabilitation Facility (IRF), or does it contain an IRF subprovider? Enter 'Y' for yes or 'N' for no.	N			75
76	If line 75 is yes: Column 1: Did the facility have a teaching program in the most recent cost reporting period ending on or before November 15, 2004? Enter 'Y' for yes or 'N' for no. Column 2: Did this facility train residents in a new teaching program in accordance with 42 CFR §412.424(d)(1)(iii)(D)? Enter 'Y' for yes and 'N' for no. Column 3: If column 2 is Y, indicate which program year began during this cost reporting period. (see instructions)				76

Long Term Care Hospital PPS

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

TEFRA Providers

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

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WORKSHEET S-2 PART I

		V	XIX	
Title V and XIX Services		1	2	
90	Does this facility have title V and/or XIX inpatient hospital services? Enter 'Y' for yes, or 'N' for no in applicable column.	N	Y	90
91	Is this hospital reimbursed for title V and/or XIX through the cost report either in full or in part? Enter 'Y' for yes, or 'N' for no in the applicable column.	N	N	91
92	Are title XIX NF patients occupying title XVIII SNF beds (dual certification)? Enter 'Y' for yes or 'N' for no in the applicable column.		N	92
93	Does this facility operate an ICF/IID facility for purposes of title V and XIX? Enter 'Y' for yes or 'N' for no in the applicable column.	N	N	93
94	Does title V or title XIX reduce capital cost? Enter 'Y' for yes or 'N' for no in the applicable column.	N	N	94
95	If line 94 is 'Y', enter the reduction percentage in the applicable column.			95
96	Does title V or title XIX reduce operating cost? Enter 'Y' for yes or 'N' for no in the applicable column.	N	N	96
97	If line 96 is 'Y', enter the reduction percentage in the applicable column.			97
98	Does title V or XIX follow Medicare (title XVIII) for the interns and residents post stepdown adjustments on Wkst. B, Pt. I, col. 25? Enter 'Y' for yes or 'N' for no in column 1 for title V, and in column 2 for title XIX.	N	N	98
98.01	Does title V or XIX follow Medicare (title XVIII) for the reporting of charges on Wkst. C, Pt. I? Enter 'Y' for yes or 'N' for no in column 1 for title V, and in column 2 for title XIX.	N	N	98.01
98.02	Does title V or XIX follow Medicare (title XVIII) for the calculation of observation bed costs on Wkst. D-1, Pt. IV, line 89? Enter 'Y' for yes or 'N' for no in column 1 for title V, and in column 2 for title XIX.	N	N	98.02
98.03	Does title V or XIX follow Medicare (title XVIII) for a critical access hospital (CAH) reimbursed 101% of inpatient services cost? Enter 'Y' for yes or 'N' for no in column 1 for title V, and in column 2 for title XIX.	N	N	98.03
98.04	Does title V or XIX follow Medicare (title XVIII) for a CAH reimbursed 101% of outpatient services cost? Enter 'Y' for yes or 'N' for no in column 1 for title V, and in column 2 for title XIX.	N	N	98.04
98.05	Does title V or XIX follow Medicare (title XVIII) and add back the RCE disallowance on Wkst. C, Pt. I, col. 4? Enter 'Y' for yes or 'N' for no in column 1 for title V, and in column 2 for title XIX.	N	N	98.05
98.06	Does title V or XIX follow Medicare (title XVIII) when cost reimbursed for Wkst. D, Pts. I through IV? Enter 'Y' for yes or 'N' for no in column 1 for title V, and in column 2 for title XIX.	N	N	98.06

Rural Providers

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

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

Miscellaneous Cost Reporting Information

115	Is this an all-inclusive rate provider? Enter 'Y' for yes or 'N' for no in column 1. If column 1 is yes, enter the method used (A, B, or E only) in column 2. If column 2 is 'E', enter in column 3 either '93' percent for short term hospital or '98' percent for long term care (includes psychiatric, rehabilitation and long term hospitals providers) based on the definition in CMS Pub. 15-I, chapter 22, section 2208.1.	N			115
116	Is this facility classified as a referral center? Enter 'Y' for yes or 'N' for no.	N			116
117	Is this facility legally required to carry malpractice insurance? Enter 'Y' for yes or 'N' for no.	N			117
118	Is the malpractice insurance a claims-made or occurrence policy? Enter 1 if the policy is claim-made. Enter 2 if the policy is occurrence.	1			118
		Premiums	Paid Losses	Self Insurance	
118.01	List amounts of malpractice premiums and paid losses:	425,429			118.01
118.02	Are malpractice premiums and paid losses reported in a cost center other than the Administrative and General cost center? If yes, submit supporting schedule listing cost centers and amounts contained therein.	N			118.02
120	Is this a SCH or EACH that qualifies for the Outpatient Hold Harmless provision in ACA §3121 and applicable amendments? (see instructions). Enter in column 1 'Y' for yes or 'N' for no. Is this a rural hospital with < 100 beds that qualifies for the Outpatient Hold Harmless provision in ACA §3121 and applicable amendments? (see instructions). Enter in column 2 'Y' for yes or 'N' for no.	Y	N		120
121	Did this facility incur and report costs for high cost implantable devices charged to patients? Enter 'Y' for yes or 'N' for no.	Y			121
122	Does the cost report contain state health care related taxes as defined in §1903(w)(3) of the Act? Enter 'Y' for yes or 'N' for no in column 1. If column 1 is 'Y', enter in column 2 the Worksheet A line number where these taxes are included.	N			122

Transplant Center Information

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

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HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA**WORKSHEET S-2
PART I**

All Providers

		1	2	
140	Are there any related organization or home office costs as defined in CMS Pub 15-1, Chapter 10? Enter 'Y' for yes, or 'N' for no in column 1. If yes, and home office costs are claimed, enter in column 2 the home office chain number (see instructions)	N		140

If this facility is part of a chain organization, enter the name of the home office, the home office contractor name, and home office contractor number on line 141. Enter the address of the home office on lines 142 and 143.

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

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

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

Multicampus

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

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

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

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HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX REIMBURSEMENT QUESTIONNAIRE**WORKSHEET S-2
PART II**

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

COMPLETED BY ALL HOSPITALS

		Y/N	Date		
Provider Organization and Operation		1	2		
1	Has the provider changed ownership immediately prior to the beginning of the cost reporting period? If yes, enter the date of the change in column 2. (see instructions)	N			1
		Y/N	Date	V/I	
		1	2	3	
2	Has the provider terminated participation in the Medicare program? If yes, enter in column 2 the date of termination and in column 3, 'V' for voluntary or 'I' for involuntary.	N			2
3	Is the provider involved in business transactions, including management contracts, with individuals or entities (e.g., chain home offices, drug or medical supply companies) that are related to the provider or its officers, medical staff, management personnel, or members of the board of directors through ownership, control, or family and other similar relationships? (see instructions)	N			3

		Y/N	Type	Date	
Financial Data and Reports		1	2	3	
4	Column 1: Were the financial statements prepared by a Certified Public Accountant? Column 2: If yes, enter 'A' for Audited, 'C' for Compiled, or 'R' for Reviewed. Submit complete copy or enter date available in column 3. (see instructions). If no, see instructions.	Y	A		4
5	Are the cost report total expenses and total revenues different from those in the filed financial statements? If yes, submit reconciliation.	N			5

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

		Y/N	
Bad Debts		Y	
12	Is the provider seeking reimbursement for bad debts? If yes, see instructions.	Y	12
13	If line 12 is yes, did the provider's bad debt collection policy change during this cost reporting period? If yes, submit copy.	N	13
14	If line 12 is yes, were patient deductibles and/or co-payments waived? If yes, see instructions.	N	14

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

		Part A		Part B		
		Y/N	Date	Y/N	Date	
PS&R Report Data		1	2	3	4	
16	Was the cost report prepared using the PS&R Report only? If either column 1 or 3 is yes, enter the paid-through date of the PS&R Report used in columns 2 and 4. (see instructions)	Y	01/02/2019	Y	01/02/2019	16
17	Was the cost report prepared using the PS&R Report for totals and the provider's records for allocation? If either column 1 or 3 is yes, enter the paid-through date in columns 2 and 4. (see instructions)	N		N		17
18	If line 16 or 17 is yes, were adjustments made to PS&R Report data for additional claims that have been billed but are not included on the PS&R Report used to file the cost report? If yes, see instructions.	N		N		18
19	If line 16 or 17 is yes, were adjustments made to PS&R Report data for corrections of other PS&R Report information? If yes, see instructions.	N		N		19
20	If line 16 or 17 is yes, were adjustments made to PS&R 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

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HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX REIMBURSEMENT QUESTIONNAIRE**WORKSHEET S-2
PART II**

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

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

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

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

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

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

	Y/N	Date	
	1	2	
Home Office Costs			
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	

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HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA
**WORKSHEET S-3
PART I**

		Inpatient Days / Outpatient Visits / Trips								
	Component	Wkst A Line No.	No. of Beds	Bed Days Available	CAH Hours	Title V	Title XVIII	Title XIX	Total All Patients	
		1	2	3	4	5	6	7	8	
1	Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days) (see instructions for col. 2 for the portion of LDP room available beds)	30	25	9,125			1,086	45	1,391	1
2	HMO and other (see instructions)						247	113		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			1,086	45	1,391	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							132	13
14	Total (see instructions)		25	9,125			1,086	45	1,523	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			1,535		10,219	19
20	Nursing Facility	45								20
21	Other Long Term Care	46								21
22	Home Health Agency	101					2,522		3,786	22
23	ASC (Distinct Part)	115								23
24	Hospice (Distinct Part)	116	1	365						24
24.10	Hospice (non-distinct part)	30								24.10
25	CMHC	99								25
26	RHC	88					1,714		4,469	26
26.01	RHC II	88.01					1,032		2,825	26.01
26.02	RHC III	88.02					3,308		7,195	26.02
26.03	RHC IV	88.03					2,104		7,083	26.03
27	Total (sum of lines 14-26)		61							27
28	Observation Bed Days							102	536	28
29	Ambulance Trips						1,639			29
30	Employee discount days (see instructions)									30
31	Employee discount days-IRF									31
32	Labor & delivery (see instructions)									32
32.01	Total ancillary labor & delivery room outpatient days (see instructions)									32.01
33	LTCH non-covered days									33
33.01	LTCH site neutral days and discharges									33.01

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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)					382	19	575	1
2	HMO and other (see instructions)					24			2
3	HMO IPF Subprovider								3
4	HMO IRF Subprovider								4
5	Hospital Adults & Peds. Swing Bed SNF								5
6	Hospital Adults & Peds. Swing Bed NF								6
7	Total Adults & Peds. (exclude observation beds) (see instructions)								7
8	Intensive Care Unit								8
9	Coronary Care Unit								9
10	Burn Intensive Care Unit								10
11	Surgical Intensive Care Unit								11
12	Other Special Care (specify)								12
13	Nursery								13
14	Total (see instructions)		248.38			382	19	575	14
15	CAH Visits								15
16	Subprovider - IPF								16
17	Subprovider - IRF								17
18	Subprovider I								18
19	Skilled Nursing Facility		30.05						19
20	Nursing Facility								20
21	Other Long Term Care								21
22	Home Health Agency		7.16						22
23	ASC (Distinct Part)								23
24	Hospice (Distinct Part)		15.30						24
24.10	Hospice (non-distinct part)								24.10
25	CMHC								25
26	RHC		5.14						26
26.01	RHC II		4.31						26.01
26.02	RHC III		7.65						26.02
26.03	RHC IV		8.53						26.03
27	Total (sum of lines 14-26)		326.52						27
32.01	Total ancillary labor & delivery room outpatient days (see instructions)								32.01
33	LTCH non-covered days								33
33.01	LTCH site neutral days and discharges								33.01

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HOSPITAL WAGE INDEX INFORMATION**WORKSHEET S-3
PARTS II-III****Part II - Wage Data**

	Wkst A Line No.	Amount Reported	Reclass- ification of Salaries (from Worksheet A-6)	Adjusted Salaries (column 2 ± column 3)	Paid Hours Related to Salaries in Column 4	Average Hourly wage (column 4 ± column 5)	
	1	2	3	4	5	6	
SALARIES							
1 Total salaries (see instructions)	200	16,613,677		16,613,677	661,494.00	25.12	1
2 Non-physician anesthetist Part A							2
3 Non-physician anesthetest Part B							3
4 Physician-Part A - Administrative							4
4.01 Physician-Part A - Teaching							4.01
5 Physician-Part B		1,165,121		1,165,121	8,184.00	142.37	5
6 Non-physician-Part B		702,663		702,663	13,384.00	52.50	6
7 Interns & residents (in an approved program)	21						7
7.01 Contracted interns & residents (in an approved program)							7.01
8 Home office and/or related organization personnel							8
9 SNF	44	1,351,679		1,351,679	62,956.00	21.47	9
10 Excluded area salaries (see instructions)		2,535,045		2,535,045	113,491.00	22.34	10
OTHER WAGES & RELATED COSTS							
11 Contract labor (see instructions)		467,594		467,594	6,536.00	71.54	11
12 Contract management and administrative services							12
13 Contract labor: Physician-Part A - Administrative							13
14 Home office salaries & wage-related costs							14
14.01 Home office salaries							14.01
14.02 Related organization salaries							14.02
15 Home office: Physician Part A - Administrative							15
16 Home office & Contract Physicians Part A - Teaching							16
WAGE-RELATED COSTS							
17 Wage-related costs (core)(see instructions)		2,073,669		2,073,669			17
18 Wage-related costs (other)(see instructions)							18
19 Excluded areas		771,718		771,718			19
20 Non-physician anesthetist Part A							20
21 Non-physician anesthetist Part B							21
22 Physician Part A - Administrative							22
22.01 Physician Part A - Teaching							22.01
23 Physician Part B		105,893		105,893			23
24 Wage-related costs (RHC/FQHC)		87,573		87,573			24
25 Interns & residents (in an approved program)							25
25.50 Home office wage-related							25.50
25.51 Related organization wage-related							25.51
25.52 Home office: Physician Part A - Administrative - wage-related							25.52
25.53 Home office & Contract Physicians Part A - Teaching - wage-related							25.53
OVERHEAD COSTS - DIRECT SALARIES							
26 Employee Benefits Department		230,739		230,739	5,649.75	40.84	26
27 Administrative & General		1,708,931		1,708,931	82,983.42	20.59	27
28 Administrative & General under contract (see instructions)		104,483		104,483	742.55	140.71	28
29 Maintenance & Repairs							29
30 Operation of Plant		299,394		299,394	17,669.25	16.94	30
31 Laundry & Linen Service		35,256		35,256	2,589.71	13.61	31
32 Housekeeping		275,128		275,128	27,858.03	9.88	32
33 Housekeeping under contract (see instructions)							33
34 Dietary		379,746	-169,060	210,686	17,243.92	12.22	34
35 Dietary under contract (see instructions)							35
36 Cafeteria			169,060	169,060	14,267.00	11.85	36
37 Maintenance of Personnel							37
38 Nursing Administration		366,636		366,636	10,706.00	34.25	38
39 Central Services and Supply							39
40 Pharmacy							40
41 Medical Records & Medical Records Library		412,270		412,270	18,745.09	21.99	41
42 Social Service							42
43 Other General Service							43

Part III - Hospital Wage Index Summary

1 Net salaries (see instructions)		14,850,376		14,850,376	640,668.55	23.18	1
2 Excluded area salaries (see instructions)		3,886,724		3,886,724	176,447.00	22.03	2
3 Subtotal salaries (line 1 minus line 2)		10,963,652		10,963,652	464,221.55	23.62	3
4 Subtotal other wages & related costs (see instructions)		467,594		467,594	6,536.00	71.54	4
5 Subtotal wage-related costs (see instructions)		2,073,669		2,073,669		18.91%	5
6 Total (sum of lines 3 through 5)		13,504,915		13,504,915	470,757.55	28.69	6
7 Total overhead cost (see instructions)		3,812,583		3,812,583	198,454.72	19.21	7

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HOSPITAL WAGE RELATED COSTS**WORKSHEET S-3****Part IV - Wage Related Cost****PART IV****Part A - Core List**

		Amount Reported	
	RETIREMENT COST		
1	401K Employer Contributions		1
2	Tax Sheltered Annuity (TSA) Employer Contribution		2
3	Nonqualified Defined Benefit Plan Cost (see instructions)		3
4	Qualified Defined Benefit Plan Cost (see instructions)		4
	PLAN ADMINISTRATIVE COSTS (Paid to External Organization):		
5	401k/TSA Plan Administration Fees		5
6	Legal/Accounting/Management Fees-Pension Plan		6
7	Employee Managed Care Program Administration Fees		7
	HEALTH AND INSURANCE COST		
8	Health Insurance (Purchased or Self Funded)		8
8.01	Health Insurance (Self Funded without a Third Party Administrator)	1,608,357	8.01
8.02	Health Insurance (Self Funded with a Third Party Administrator)		8.02
8.03	Health Insurance (Purchased)		8.03
9	Prescription Drug Plan		9
10	Dental, Hearing and Vision Plan		10
11	Life Insurance (If employee is owner or beneficiary)		11
12	Accident Insurance (If employee is owner or beneficiary)		12
13	Disability Insurance (If employee is owner or beneficiary)		13
14	Long-Term Care Insurance (If employee is owner or beneficiary)		14
15	Workers' Compensation Insurance	209,642	15
16	Retirement Health Care Cost (Only current year, not the extraordinary accrual required by FASB 106. Non cumulative portion)		16
	TAXES		
17	FICA-Employers Portion Only	958,325	17
18	Medicare Taxes - Employers Portion Only	224,124	18
19	Unemployment Insurance	38,404	19
20	State or Federal Unemployment Taxes		20
	OTHER		
21	Executive Deferred Compensation (Other Than Retirement Cost Reported on lines 1 through 4 above)(see instructions)		21
22	Day Care Costs and Allowances		22
23	Tuition Reimbursement		23
24	Total Wage Related cost (Sum of lines 1-23)	3,038,852	24

Part B - Other Than Core Related Cost

25	OTHER WAGE RELATED COSTs (SPECIFY)		25
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IROQUOIS MEMORIAL HOSPITAL Provider CCN: 14-0167	In Lieu of Form CMS-2552-10	Period : From: 10/01/2017 To: 09/30/2018	Run Date: 02/25/2019 Run Time: 14:01 Version: 2018.12 (02/24/2019)
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HOSPITAL CONTRACT LABOR AND BENEFIT COST**WORKSHEET S-3****Part V - Contract Labor and Benefit Cost****PART V****Hospital and Hospital-Based Component Identification:**

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

KPMG LLP Compu-Max 2552-10

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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		2,867			2,867	1
2	Unduplicated Census Count (see instructions)		181.00	12.00	41.00	204.00	2

HOME HEALTH AGENCY - NUMBER OF EMPLOYEES

	Enter the number of hours in your normal work week 40.00	Number of Employees (Full Time Equivalent)			
		Staff 1	Contract 2	Total 3	
3	Administrator and Assistant Administrator(s)	0.12		0.12	3
4	Director(s) and Assistant Director(s)				4
5	Other Administrative Personnel	0.84		0.84	5
6	Direct Nursing Service	2.51		2.51	6
7	Nursing Supervisor	0.63		0.63	7
8	Physical Therapy Service	0.82		0.82	8
9	Physical Therapy Supervisor				9
10	Occupational Therapy Service	0.22		0.22	10
11	Occupational Therapy Supervisor				11
12	Speech Pathology Service	0.05		0.05	12
13	Speech Pathology Supervisor				13
14	Medical Social Service	0.01		0.01	14
15	Medical Social Service Supervisor				15
16	Home Health Aide	1.33		1.33	16
17	Home Health Aide Supervisor				17
18	Other (specify)				18

HOME HEALTH AGENCY CBSA CODES

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

PPS ACTIVITY

		Full Episodes		LUPA Episodes	PEP only Episodes	Total (columns 1 through 4)	
		Without Outliers 1	With Outliers 2	3	4	5	
21	Skilled Nursing Visits	938	18		34	990	21
22	Skilled Nursing Visit Charges	151,506	2,907		5,492	159,905	22
23	Physical Therapy Visits	786	5			791	23
24	Physical Therapy Visit Charges	126,955	808			127,763	24
25	Occupational Therapy Visits	106				106	25
26	Occupational Therapy Visit Charges	17,121				17,121	26
27	Speech Pathology Visits	11				11	27
28	Speech Pathology Visit Charges	1,777				1,777	28
29	Medical Social Service Visits	3				3	29
30	Medical Social Service Visit Charges	602				602	30
31	Home Health Aide Visits	347				347	31
32	Home Health Aide Visit Charges	34,690				34,690	32
33	Total visits (sum of lines 21, 23, 25, 27, 29, and 31)	2,191	23		34	2,248	33
34	Other Charges	2,366				2,366	34
35	Total Charges (sum of lines 22, 24, 26, 28, 30, 32 and 34)	335,017	3,715		5,492	344,224	35
36	Total Number of Episodes (standard/non-outlier)	123		19	6	148	36
37	Total Number of Ourlier Episodes						37
38	Total Non-Routine Medical Supply Charges	528	129	197		854	38

KPMG LLP Compu-Max 2552-10

IROQUOIS MEMORIAL HOSPITAL Provider CCN: 14-0167	In Lieu of Form CMS-2552-10	Period : From: 10/01/2017 To: 09/30/2018	Run Date: 02/25/2019 Run Time: 14:01 Version: 2018.12 (02/24/2019)
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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	17		17	5
6	RVL				6
7	RHX				7
8	RHL	5		5	8
9	RMX				9
10	RML	7		7	10
11	RLX				11
12	RUC	41		41	12
13	RUB	20		20	13
14	RUA	52		52	14
15	RVC	140		140	15
16	RVB	141		141	16
17	RVA	309		309	17
18	RHC	248		248	18
19	RHB	96		96	19
20	RHA	198		198	20
21	RMC	41		41	21
22	RMB	39		39	22
23	RMA	8		8	23
24	RLB	9		9	24
25	RLA				25
26	ES3				26
27	ES2				27
28	ES1				28
29	HE2				29
30	HE1				30
31	HD2				31
32	HD1				32
33	HC2				33
34	HC1				34
35	HB2	14		14	35
36	HB1	20		20	36
37	LE2				37
38	LE1				38
39	LD2	14		14	39
40	LD1	71		71	40
41	LC2				41
42	LC1				42
43	LB2				43
44	LB1	12		12	44
45	CE2				45
46	CE1				46
47	CD2				47
48	CD1	12		12	48
49	CC2				49
50	CC1				50
51	CB2				51
52	CB1				52
53	CA2				53
54	CA1	7		7	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

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IROQUOIS MEMORIAL HOSPITAL Provider CCN: 14-0167	In Lieu of Form CMS-2552-10	Period : From: 10/01/2017 To: 09/30/2018	Run Date: 02/25/2019 Run Time: 14:01 Version: 2018.12 (02/24/2019)
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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	2		2	72
73	PC2				73
74	PC1				74
75	PB2				75
76	PB1	1		1	76
77	PA2				77
78	PA1				78
199	AAA	11		11	199
200	TOTAL	1,535		1,535	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	1,205,103	47.11%	Y	202
203	Recruitment				203
204	Retention of employees				204
205	Training	1,113	0.04%	Y	205
206	Other (specify)				206
207	Total SNF Revenue (Worksheet G-2, Part I, line 7, column 3)	2,558,215			207

KPMG LLP Compu-Max 2552-10

IROQUOIS MEMORIAL HOSPITAL Provider CCN: 14-0167	In Lieu of Form CMS-2552-10	Period : From: 10/01/2017 To: 09/30/2018	Run Date: 02/25/2019 Run Time: 14:01 Version: 2018.12 (02/24/2019)
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HOSPITAL-BASED RHC/FQHC STATISTICAL DATA

COMPONENT CCN: 14-3424

WORKSHEET S-8

Check applicable box: ☒ Hospital-Based RHC ☐ Hospital-Based FQHC

Clinic Address and Identification:

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

Source of Federal Funds:

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

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

Facility hours of operations (1)

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

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

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

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

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IROQUOIS MEMORIAL HOSPITAL Provider CCN: 14-0167	In Lieu of Form CMS-2552-10	Period : From: 10/01/2017 To: 09/30/2018	Run Date: 02/25/2019 Run Time: 14:01 Version: 2018.12 (02/24/2019)
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HOSPITAL-BASED RHC/FQHC STATISTICAL DATA

COMPONENT CCN: 14-3425

WORKSHEET S-8

Check applicable box: ☒ Hospital-Based RHC ☐ Hospital-Based FQHC

Clinic Address and Identification:

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

Source of Federal Funds:

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

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

Facility hours of operations (1)

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

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

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

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

IROQUOIS MEMORIAL HOSPITAL Provider CCN: 14-0167	In Lieu of Form CMS-2552-10	Period : From: 10/01/2017 To: 09/30/2018	Run Date: 02/25/2019 Run Time: 14:01 Version: 2018.12 (02/24/2019)
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WORKSHEET S-8

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

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

Facility hours of operations (1)

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

		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

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IROQUOIS MEMORIAL HOSPITAL Provider CCN: 14-0167	In Lieu of Form CMS-2552-10	Period : From: 10/01/2017 To: 09/30/2018	Run Date: 02/25/2019 Run Time: 14:01 Version: 2018.12 (02/24/2019)
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HOSPITAL-BASED RHC/FQHC STATISTICAL DATA

COMPONENT CCN: 14-8551

WORKSHEET S-8

Check applicable box: ☒ Hospital-Based RHC ☐ Hospital-Based FQHC

Clinic Address and Identification:

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

Source of Federal Funds:

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

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

Facility hours of operations (1)

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

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

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

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

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IROQUOIS MEMORIAL HOSPITAL Provider CCN: 14-0167	In Lieu of Form CMS-2552-10	Period : From: 10/01/2017 To: 09/30/2018	Run Date: 02/25/2019 Run Time: 14:01 Version: 2018.12 (02/24/2019)
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HOSPITAL-BASED HOSPICE IDENTIFICATION DATA**HOSPICE CCN: 14-1616****WORKSHEET S-9
PARTS I THROUGH IV****PART I - ENROLLMENT DAYS FOR COST REPORTING PERIODS BEGINNING BEFORE OCTOBER 1, 2015**

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

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

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

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

		Unduplicated Days				
		Title XVIII	Title XIX	Other	Total (sum of cols. 1 through 3)	
		1	2	3	4	
10	Hospice Continuous Home Care					10
11	Hospice Routine Home Care	6,837	224	175	7,236	11
12	Hospice Inpatient Respite Care	30			30	12
13	Hospice General Inpatient Care	21			21	13
14	Total Hospice Days	6,888	224	175	7,287	14

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

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

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

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IROQUOIS MEMORIAL HOSPITAL Provider CCN: 14-0167	In Lieu of Form CMS-2552-10	Period : From: 10/01/2017 To: 09/30/2018	Run Date: 02/25/2019 Run Time: 14:01 Version: 2018.12 (02/24/2019)
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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)	0.421048	1
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Medicaid (see instructions for each line)

2	Net revenue from Medicaid	4,048,646	2
3	Did you receive DSH or supplemental payments from Medicaid?	Y	3
4	If line 3 is yes, does line 2 include all DSH and/or supplemental payments from Medicaid?	Y	4
5	If line 4 is no, enter DSH and/or supplemental payments from Medicaid		5
6	Medicaid charges	11,251,535	6
7	Medicaid cost (line 1 times line 6)	4,737,436	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.	688,790	8

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

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

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

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

Grants, donations and total unreimbursed cost for Medicaid, CHIP and state/local indigent programs (see instructions for each line)

17	Private grants, donations, or endowment income restricted to 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)	688,790	19

Uncompensated care (see instructions for each line)

		Uninsured patients	Insured patients	TOTAL (col. 1 + col. 2)	
		1	2	3	
20	Charity care charges and uninsured discounts for the entire facility (see instructions)	314,185	227,513	541,698	20
21	Cost of patients approved for charity care and uninsured discounts (see instructions)	132,287	227,513	359,800	21
22	Payments received from patients for amounts previously written off as charity care				22
23	Cost of charity care (line 21 minus line 22)	132,287	227,513	359,800	23

24	Does the amount in line 20, column 2 include charges for patient days beyond a length of stay limit imposed on patients covered by Medicaid or other indigent care program?	N	24
25	If line 24 is yes, charges for patient days beyond the indigent care program's length of stay limit		25
26	Total bad debt expense for the entire hospital complex (see instructions)	2,128,508	26
27	Medicare reimbursable bad debts for the entire hospital complex (see instructions)	43,599	27
27.01	Medicare allowable bad debts for the entire hospital complex (see instructions)	67,075	27.01
28	Non-Medicare and non-reimbursable Medicare bad debt expense (see instructions)	2,061,433	28
29	Cost of non-Medicare and non-reimbursable Medicare bad debt expense (line 1 times line 28)	891,438	29
30	Cost of uncompensated care (line 23, column 3 plus line 29)	1,251,238	30
31	Total unreimbursed and uncompensated care cost (line 19 plus line 30)	1,940,028	31

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RECLASSIFICATION AND ADJUSTMENT OF TRIAL BALANCE OF EXPENSES

WORKSHEET A

		COST CENTER DESCRIPTIONS	SALARIES	OTHER	TOTAL (col. 1 + col. 2)	RECLASSI- FICATIONS	RECLASSI- FIED TRIAL BALANCE (col. 3 ± col. 4)	ADJUST- MENTS	NET EXPENSES FOR ALLOC- ATION (col. 5 ± col. 6)	
			1	2	3	4	5	6	7	
		GENERAL SERVICE COST CENTERS								
1	00100	Cap Rel Costs-Bldg & Fixt		1,556,294	1,556,294	-521,419	1,034,875	-58,385	976,490	1
2	00200	Cap Rel Costs-Mvble Equip				837,995	837,995	-16,959	821,036	2
3	00300	Other Cap Rel Costs							-0-	3
4	00400	Employee Benefits Department	230,739	2,158,960	2,389,699	182,980	2,572,679	-9,576	2,563,103	4
5.01	00540	ADMISSIONS	323,667	57,569	381,236	-1,556	379,680		379,680	5.01
5.02	00550	PURCHASING, RECEIVING, AND STORES	82,850	27,909	110,759	-54,315	56,444		56,444	5.02
5.03	00560	DATA PROCESSING	367,061	726,493	1,093,554	4,472	1,098,026		1,098,026	5.03
5.04	00570	COMMUNICATIONS		71,442	71,442	11,406	82,848		82,848	5.04
5.05	00580	BUSINESS OFFICE	283,989	53,036	337,025	-1,167	335,858		335,858	5.05
5.06	00590	OTHER ADMINISTRATIVE AND GENERAL	651,364	2,012,576	2,663,940	-77,334	2,586,606	-1,451,443	1,135,163	5.06
6	00600	Maintenance & Repairs								6
7	00700	Operation of Plant	299,394	982,806	1,282,200		1,282,200	-12,785	1,269,415	7
8	00800	Laundry & Linen Service	35,256	3,340	38,596		38,596		38,596	8
9	00900	Housekeeping	275,128	39,293	314,421		314,421		314,421	9
10	01000	Dietary	379,746	347,043	726,789	-323,729	403,060		403,060	10
11	01100	Cafeteria				323,560	323,560	-145,417	178,143	11
12	01200	Maintenance of Personnel								12
13	01300	Nursing Administration	366,636	37,321	403,957		403,957		403,957	13
14	01400	Central Services & Supply		19,574	19,574		19,574		19,574	14
15	01500	Pharmacy								15
16	01600	Medical Records & Library	412,270	59,477	471,747		471,747		471,747	16
17	01700	Social Service								17
19	01900	Nonphysician Anesthetists								19
20	02000	Nursing School								20
21	02100	I&R Services-Salary & Fringes Apprvd								21
22	02200	I&R Services-Other Prgm Costs Apprvd								22
23	02300	Paramed Ed Prgm-(specify)								23
		INPATIENT ROUTINE SERVICE COST CENTERS								
30	03000	Adults & Pediatrics	1,383,770	418,525	1,802,295	-45,827	1,756,468	-13,173	1,743,295	30
43	04300	Nursery								43
44	04400	Skilled Nursing Facility	1,351,679	199,054	1,550,733	-25,771	1,524,962		1,524,962	44
		ANCILLARY SERVICE COST CENTERS								
50	05000	Operating Room	698,972	754,529	1,453,501	-544,723	908,778	-54,357	854,421	50
53	05300	Anesthesiology		612,535	612,535	-5,092	607,443	-606,340	1,103	53
54	05400	Radiology-Diagnostic	643,092	858,578	1,501,670	-194,142	1,307,528	-51,410	1,256,118	54
57	05700	CT Scan	172,281	5,437	177,718		177,718	-2,265	175,453	57
58	05800	MRI	39,989	196,627	236,616		236,616		236,616	58
60	06000	Laboratory	664,662	887,344	1,552,006	-1,985	1,550,021	-156,834	1,393,187	60
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS								62.30
65	06500	Respiratory Therapy	442,269	150,640	592,909	-75,290	517,619	-25,420	492,199	65
66	06600	Physical Therapy	724,914	69,095	794,009	-5,215	788,794		788,794	66
69	06900	Electrocardiology	69,577	7,596	77,173	-296	76,877		76,877	69
71	07100	Medical Supplies Charged to Patients				567,328	567,328		567,328	71
72	07200	Impl. Dev. Charged to Patients				438,764	438,764		438,764	72
73	07300	Drugs Charged to Patients	450,322	1,166,340	1,616,662	130,347	1,747,009	-216,558	1,530,451	73
76.97	07697	CARDIAC REHABILITATION								76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY								76.98
76.99	07699	LITHOTRIPSY								76.99
		OUTPATIENT SERVICE COST CENTERS								
88	08800	Rural Health Clinic	393,078	75,137	468,215	-15,116	453,099		453,099	88
88.01	08801	RHC II	308,709	112,761	421,470	-58,204	363,266		363,266	88.01
88.02	08802	RHC III	797,205	259,512	1,056,717	-80,324	976,393		976,393	88.02
88.03	08803	RHC IV	1,033,309	394,725	1,428,034	-106	1,427,928		1,427,928	88.03
90	09000	Clinic	294,376	48,525	342,901	-27,039	315,862	-165,932	149,930	90
91	09100	Emergency	902,328	1,296,251	2,198,579	-41,080	2,157,499	-625,547	1,531,952	91
92	09200	Observation Beds (Non-Distinct Part)								92
93.99	09399	PARTIAL HOSPITALIZATION PROGRAM								93.99
		OTHER REIMBURSABLE COST CENTERS								
95	09500	Ambulance Services	1,070,983	216,122	1,287,105	-40,284	1,246,821	-58,998	1,187,823	95
101	10100	Home Health Agency	395,132	210,277	605,409	-4,915	600,494		600,494	101
		SPECIAL PURPOSE COST CENTERS								
113	11300	Interest Expense		232,362	232,362	-232,362				113
116	11600	Hospice	778,204	346,427	1,124,631	-128,677	995,954	-36,618	959,336	116
118		SUBTOTALS (sum of lines 1-117)	16,322,951	16,671,532	32,994,483	-9,116	32,985,367	-3,708,017	29,277,350	118
		NONREIMBURSABLE COST CENTERS								
190	19000	Gift, Flower, Coffee Shop & Canteen		402	402	16,961	17,363		17,363	190
194	07950	IROQUOIS WOMEN'S HEALTH	3,676	29,779	33,455	-4,560	28,895		28,895	194
194.01	07951	OTHER NON-REIMBURSABLE COSTS	96,231	84,125	180,356	-3,285	177,071		177,071	194.01
194.02	07952	REFERENCE LAB	190,819	582,952	773,771		773,771		773,771	194.02
200		TOTAL (sum of lines 118-199)	16,613,677	17,368,790	33,982,467		33,982,467	-3,708,017	30,274,450	200

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RECLASSIFICATIONS**WORKSHEET A-6**

		INCREASES				
	EXPLANATION OF RECLASSIFICATION(S)	CODE (1)	COST CENTER	LINE #	SALARY	OTHER
		1	2	3	4	5
1	RECLASS MOVEABLE EQUIP DEPR	A	Cap Rel Costs-Mvble Equip	2		753,151
500	Total reclassifications					753,151
	Code Letter - A					
1	RECLASS MEDICAL SUPPLIES	C	Medical Supplies Charged to P	71		567,328
2						
3						
4						
5						
6						
7						
8						
9						
10						
11						
12						
13						
14						
15						
500	Total reclassifications					567,328
	Code Letter - C					
1	RECLASS DRUGS CHARGED TO PATIENTS	D	Drugs Charged to Patients	73		130,347
2						
3						
4						
5						
6						
7						
8						
9						
10						
500	Total reclassifications					130,347
	Code Letter - D					
1	RECLASS TELEPHONE EXPENSE	E	COMMUNICATIONS	5.04		11,406
2						
3						
4						
5						
6						
7						
500	Total reclassifications					11,406
	Code Letter - E					
1	RECLASS INTEREST EXPENSE	F	Cap Rel Costs-Bldg & Fixt	1		180,061
2			Cap Rel Costs-Mvble Equip	2		52,301
500	Total reclassifications					232,362
	Code Letter - F					
1	RECLASS CAFETERIA	G	Cafeteria	11	169,060	154,500
500	Total reclassifications				169,060	154,500
	Code Letter - G					
1	RECLASS TRANSPORTATION	J	OTHER ADMINISTRATIVE AND GENE	5.06		26,229
2						
500	Total reclassifications					26,229
	Code Letter - J					
1	RECLASS IT COST	K	DATA PROCESSING	5.03		8,021
2						
3						
4						
5						
6						
7						
8						
9						
10						
11						
12						
13						
14						
15						
16						
500	Total reclassifications					8,021

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IROQUOIS MEMORIAL HOSPITAL Provider CCN: 14-0167	In Lieu of Form CMS-2552-10	Period : From: 10/01/2017 To: 09/30/2018	Run Date: 02/25/2019 Run Time: 14:01 Version: 2018.12 (02/24/2019)
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RECLASSIFICATIONS**WORKSHEET A-6**

		INCREASES				
	EXPLANATION OF RECLASSIFICATION(S)	CODE (1)	COST CENTER	LINE #	SALARY	OTHER
		1	2	3	4	5
	Code Letter - K					
1	RECLASS GIFT SHOP	L	Gift, Flower, Coffee Shop & C	190		16,961
500	Total reclassifications					16,961
	Code Letter - L					
1	RECLASS OTHER CAP RELATED COST	N	Other Cap Rel Costs	3		84,214
500	Total reclassifications					84,214
	Code Letter - N					
1	RECLASS EMPLOYEE BENEFITS	O	Employee Benefits Department	4		183,222
2						
3						
4						
5						
500	Total reclassifications					183,222
	Code Letter - O					
1	RECLASS IMPL MED SUPPLIES	P	Impl. Dev. Charged to Patient	72		438,764
2						
500	Total reclassifications					438,764
	Code Letter - P					
1	TO RECLASS GENERAL SURGEON	R	RHC IV	88.03	5,149	
500	Total reclassifications				5,149	
	Code Letter - R					
	GRAND TOTAL (Increases)				174,209	2,606,505

(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.

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IROQUOIS MEMORIAL HOSPITAL Provider CCN: 14-0167	In Lieu of Form CMS-2552-10	Period : From: 10/01/2017 To: 09/30/2018	Run Date: 02/25/2019 Run Time: 14:01 Version: 2018.12 (02/24/2019)
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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		753,151	9	1
500	Total reclassifications					753,151		500
	Code letter - A							
1	RECLASS MEDICAL SUPPLIES	C	PURCHASING, RECEIVING, AND ST	5.02		54,137		1
2			Adults & Pediatrics	30		45,821		2
3			Skilled Nursing Facility	44		23,237		3
4			Operating Room	50		214,324		4
5			Anesthesiology	53		5,092		5
6			Radiology-Diagnostic	54		76,455		6
7			Respiratory Therapy	65		75,258		7
8			Physical Therapy	66		2,479		8
9			Electrocardiology	69		296		9
10			Clinic	90		176		10
11			Emergency	91		38,676		11
12			Ambulance Services	95		16,440		12
13			Home Health Agency	101		4,267		13
14			Hospice	116		6,992		14
15			IROQUOIS WOMEN'S HEALTH	194		3,678		15
500	Total reclassifications					567,328		500
	Code letter - C							
1	RECLASS DRUGS CHARGED TO PATIENTS	D	Adults & Pediatrics	30		6		1
2			Skilled Nursing Facility	44		2,491		2
3			Operating Room	50		1,405		3
4			Radiology-Diagnostic	54		875		4
5			Laboratory	60		1,985		5
6			Respiratory Therapy	65		32		6
7			Emergency	91		700		7
8			Ambulance Services	95		900		8
9			Home Health Agency	101		298		9
10			Hospice	116		121,655		10
500	Total reclassifications					130,347		500
	Code letter - D							
1	RECLASS TELEPHONE EXPENSE	E	PURCHASING, RECEIVING, AND ST	5.02		178		1
2			DATA PROCESSING	5.03		3,549		2
3			OTHER ADMINISTRATIVE AND GENE	5.06		2,045		3
4			BUSINESS OFFICE	5.05		565		4
5			Radiology-Diagnostic	54		1,361		5
6			Physical Therapy	66		2,347		6
7			Emergency	91		1,361		7
500	Total reclassifications					11,406		500
	Code letter - E							
1	RECLASS INTEREST EXPENSE	F	Interest Expense	113		232,362	11	1
2							11	2
500	Total reclassifications					232,362		500
	Code letter - F							
1	RECLASS CAFETERIA	G	Dietary	10	169,060	154,500		1
500	Total reclassifications				169,060	154,500		500
	Code letter - G							
1	RECLASS TRANSPORTATION	J	Ambulance Services	95		22,944		1
2			OTHER NON-REIMBURSABLE COSTS	194.01		3,285		2
500	Total reclassifications					26,229		500
	Code letter - J							
1	RECLASS IT COST	K	Employee Benefits Department	4		242		1
2			ADMISSIONS	5.01		1,556		2
3			BUSINESS OFFICE	5.05		602		3
4			OTHER ADMINISTRATIVE AND GENE	5.06		343		4
5			Dietary	10		169		5
6			Skilled Nursing Facility	44		43		6
7			Radiology-Diagnostic	54		532		7
8			Physical Therapy	66		389		8
9			Rural Health Clinic	88		395		9
10			RHC II	88.01		784		10
11			RHC III	88.02		395		11
12			Clinic	90		966		12
13			Emergency	91		343		13
14			Home Health Agency	101		350		14
15			Hospice	116		30		15
16			IROQUOIS WOMEN'S HEALTH	194		882		16

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RECLASSIFICATIONS**WORKSHEET A-6**

	EXPLANATION OF RECLASSIFICATION(S)	CODE (1)	DECREASES				Wkst A-7 Ref. 10	
			COST CENTER	LINE #	SALARY	OTHER		
		1	6	7	8	9		
500	Total reclassifications					8,021		500
	Code letter - K							
1	RECLASS GIFT SHOP	L	OTHER ADMINISTRATIVE AND GENE	5.06		16,961		1
500	Total reclassifications					16,961		500
	Code letter - L							
1	RECLASS OTHER CAP RELATED COST	N	OTHER ADMINISTRATIVE AND GENE	5.06		84,214	14	1
500	Total reclassifications					84,214		500
	Code letter - N							
1	RECLASS EMPLOYEE BENEFITS	O	Rural Health Clinic	88		14,721		1
2			RHC II	88.01		57,420		2
3			RHC III	88.02		79,929		3
4			Clinic	90		25,897		4
5			RHC IV	88.03		5,255		5
500	Total reclassifications					183,222		500
	Code letter - O							
1	RECLASS IMPL MED SUPPLIES	P	Operating Room	50		323,845		1
2			Radiology-Diagnostic	54		114,919		2
500	Total reclassifications					438,764		500
	Code letter - P							
1	TO RECLASS GENERAL SURGEON	R	Operating Room	50	5,149			1
500	Total reclassifications				5,149			500
	Code letter - R							
	GRAND TOTAL (Decreases)				174,209	2,606,505		

(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.

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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	
		1	Purchases	Donation	Total	5	6	7	
		2		3	4				
1	Land	319,450					319,450		1
2	Land Improvements								2
3	Buildings and Fixtures	25,771,631	169,047		169,047		25,940,678		3
4	Building Improvements	483,750					483,750		4
5	Fixed Equipment								5
6	Movable Equipment	16,737,093	58,255		58,255		16,795,348		6
7	HIT-designated Assets								7
8	Subtotal (sum of lines 1-7)	43,311,924	227,302		227,302		43,539,226		8
9	Reconciling Items								9
10	Total (line 7 minus line 9)	43,311,924	227,302		227,302		43,539,226		10

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

	Description	SUMMARY OF CAPITAL							
		Depreciation	Lease	Interest	Insurance (see instructions)	Taxes (see instructions)	Other Capital-Related Costs (see instructions)	Total (1) (sum of cols. 9 through 14)	
		9	10	11	12	13	14	15	
*									
1	Cap Rel Costs-Bldg & Fixt	1,556,294						1,556,294	1
2	Cap Rel Costs-Mvble Equip								2
3	Total (sum of lines 1-2)	1,556,294						1,556,294	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	26,574,831		26,574,831	0.613568			51,671	51,671	1
2	Cap Rel Costs-Mvble Equip	16,737,093		16,737,093	0.386432			32,543	32,543	2
3	Total (sum of lines 1-2)	43,311,924		43,311,924	1.000000			84,214	84,214	3

	Description	SUMMARY OF CAPITAL							
		Depreciation	Lease	Interest	Insurance (see instructions)	Taxes (see instructions)	Other Capital-Related Costs (see instructions)	Total (2) (sum of cols. 9 through 14)	
		9	10	11	12	13	14	15	
*									
1	Cap Rel Costs-Bldg & Fixt	803,143		121,676			51,671	976,490	1
2	Cap Rel Costs-Mvble Equip	753,151		35,342			32,543	821,036	2
3	Total (sum of lines 1-2)	1,556,294		157,018			84,214	1,797,526	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.)

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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	4	5	
1	Investment income-buildings & fixtures (chapter 2)	B	-58,385	Cap Rel Costs-Bldg & Fixt	1	11	1
2	Investment income-movable equipment (chapter 2)	B	-16,959	Cap Rel Costs-Mvble Equip	2	11	2
3	Investment income-other (chapter 2)						3
4	Trade, quantity, and time discounts (chapter 8)	B					4
5	Refunds and rebates of expenses (chapter 8)						5
6	Rental of provider space by suppliers (chapter 8)						6
7	Telephone services (pay stations excl) (chapter 21)						7
8	Television and radio service (chapter 21)	A	-12,785	Operation of Plant	7		8
9	Parking lot (chapter 21)						9
10	Provider-based physician adjustment	Wkst A-8-2	-1,535,346				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	-145,417	Cafeteria	11		14
15	Rental of quarters to employees & others						15
16	Sale of medical and surgical supplies to other than patients	B					16
17	Sale of drugs to other than patients						17
18	Sale of medical records and abstracts	B					18
19	Nursing and allied health education (tuition, fees, books, etc.)						19
20	Vending machines						20
21	Income from imposition of interest, finance or penalty charges (chapter 21)						21
22	Interest exp on Medicare overpayments & borrowings to repay Medicare overpayments						22
23	Adj for respiratory therapy costs in excess of limitation (chapter 14)	Wkst A-8-3		Respiratory Therapy	65		23
24	Adj for physical therapy costs in excess of limitation (chapter 14)	Wkst A-8-3		Physical Therapy	66		24
25	Util review-physicians' compensation (chapter 21)			Utilization Review-SNF	114		25
26	Depreciation--buildings & fixtures			Cap Rel Costs-Bldg & Fixt	1		26
27	Depreciation--movable equipment			Cap Rel Costs-Mvble Equip	2		27
28	Non-physician anesthetist			Nonphysician Anesthetists	19		28
29	Physicians' assistant						29
30	Adj for occupational therapy costs in excess of limitation (chapter 14)	Wkst A-8-3		Occupational Therapy	67		30
31	Adj for speech pathology costs in excess of limitation (chapter 14)	Wkst A-8-3		Speech Pathology	68		31
32	CAH HIT Adj for Depreciation						32
33	CNA CLASS REVENUE	B					33
34							34
35							35
36	AMBULANCE TOWNSHIP INCOME	B	-58,395	Ambulance Services	95		36
37							37
38	RENTAL INCOME	B	-165,932	Clinic	90		38
39							39
40	COLLECTION FEES REVENUE	B					40
41	OTHER REVENUE HSKP	B					41
42	OTHER REVENUE-CENTRAL SUPPLY	B					42
43	OTHER REVENUE-EDUCATION	B					43
44							44
45	MISC INCOME A&G	B	-117,634	OTHER ADMINISTRATIVE AND GENERAL	5.06		45
46	MISC INCOME AUXILIARY	B					46
47	MISC INCOME MED STAFF	B					47
48	MISC INCOME EMPL COMMITTEE	B					48
49	LOBBYING EXPENSE	A					49
49.02	PHYSICIAN BENEFIT OFFSET	A	-9,576	Employee Benefits Department	4		49.02
49.08	ADVERTISING EXPENSE	A	-126,966	OTHER ADMINISTRATIVE AND GENERAL	5.06		49.08
49.09	PHYSICIAN RECRUITMENT	A	-74,211	OTHER ADMINISTRATIVE AND GENERAL	5.06		49.09
49.11	LOBBYING EXPENSE	A	-16,118	OTHER ADMINISTRATIVE AND GENERAL	5.06		49.11
49.12	PROVIDER TAX EXPENSE	A	-1,115,825	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	-36,618	Hospice	116		49.15
49.21	340B DRUGS	A	-118,630	Drugs Charged to Patients	73		49.21
49.22	340B PURCHASED SERVICES	A	-97,928	Drugs Charged to Patients	73		49.22
50	TOTAL (sum of lines 1 thru 49) (Transfer to worksheet A, column 6, line 200)		-3,708,017				50

(1) Description - all chapter references in this column pertain to CMS Pub. 15-1
(2) Basis for adjustment (see instructions)

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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	

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 subscripits thereof.

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

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

WORKSHEET A-8-1

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

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

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

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

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

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

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

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

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

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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	13,173	13,173						1
2	50	Operating Room AGGREGATE	54,357	54,357						2
3	53	Anesthesiology AGGREGATE	606,340	606,340						3
4	54	Radiology-Diagnostic AGGREGATE	51,410	51,410						4
5	57	CT Scan AGGREGATE	2,265	2,265						5
6	65	Respiratory Therapy AGGREGATE	25,420	25,420						6
7	91	Emergency AGGREGATE	625,547	625,547						7
8	60	Laboratory AGGREGATE	156,834	156,834						8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
200		TOTAL	1,535,346	1,535,346						200

KPMG LLP Compu-Max 2552-10

IROQUOIS MEMORIAL HOSPITAL Provider CCN: 14-0167	In Lieu of Form CMS-2552-10	Period : From: 10/01/2017 To: 09/30/2018	Run Date: 02/25/2019 Run Time: 14:01 Version: 2018.12 (02/24/2019)
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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							13,173	1
2	50	Operating Room AGGREGATE							54,357	2
3	53	Anesthesiology AGGREGATE							606,340	3
4	54	Radiology-Diagnostic AGGREGATE							51,410	4
5	57	CT Scan AGGREGATE							2,265	5
6	65	Respiratory Therapy AGGREGATE							25,420	6
7	91	Emergency AGGREGATE							625,547	7
8	60	Laboratory AGGREGATE							156,834	8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
200		TOTAL							1,535,346	200

KPMG LLP Compu-Max 2552-10

IROQUOIS MEMORIAL HOSPITAL Provider CCN: 14-0167	In Lieu of Form CMS-2552-10	Period : From: 10/01/2017 To: 09/30/2018	Run Date: 02/25/2019 Run Time: 14:01 Version: 2018.12 (02/24/2019)
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COST ALLOCATION - GENERAL SERVICE COSTS
**WORKSHEET B
PART I**

	COST CENTER DESCRIPTIONS	NET EXP FOR COST ALLOCATION (from Wkst A, col.7)	CAP BLDGS & FIXTURES	CAP MOVABLE EQUIPMENT	EMPLOYEE BENEFITS DEPARTMENT	ADMITTING	PURCHASING RECEIVING AND STORES	
		0	1	2	4	5.01	5.02	
	GENERAL SERVICE COST CENTERS							
1	Cap Rel Costs-Bldg & Fixt	976,490	976,490					1
2	Cap Rel Costs-Mvble Equip	821,036		821,036				2
4	Employee Benefits Department	2,563,103	12,665	1,825	2,577,593			4
5.01	ADMISSIONS	379,680	4,092	1,548	50,924	436,244		5.01
5.02	PURCHASING, RECEIVING, AND STORES	56,444	6,843	1,038	13,035		77,360	5.02
5.03	DATA PROCESSING	1,098,026	9,927	49,904	57,751		754	5.03
5.04	COMMUNICATIONS	82,848	6,623					5.04
5.05	BUSINESS OFFICE	335,858	9,587	454	44,681		91	5.05
5.06	OTHER ADMINISTRATIVE AND GENERAL	1,135,163	80,150	6,869	102,482		338	5.06
6	Maintenance & Repairs							6
7	Operation of Plant	1,269,415	91,893	95,125	47,105		1,285	7
8	Laundry & Linen Service	38,596	16,267	98	5,547		100	8
9	Housekeeping	314,421	4,744	110	43,287		1,675	9
10	Dietary	403,060	24,351	1,835	33,148		1,372	10
11	Cafeteria	178,143	7,375		26,599		1,101	11
12	Maintenance of Personnel							12
13	Nursing Administration	403,957	6,219		57,684		7	13
14	Central Services & Supply	19,574	10,672	5,407			913	14
15	Pharmacy							15
16	Medical Records & Library	471,747	11,665	65	64,864		69	16
17	Social Service							17
19	Nonphysician Anesthetists							19
20	Nursing School							20
21	I&R Services-Salary & Fringes Apprvd							21
22	I&R Services-Other Prgm Costs Apprvd							22
23	Paramed Ed Prgm-(specify)							23
	INPATIENT ROUTINE SERV COST CENTERS							
30	Adults & Pediatrics	1,743,295	61,068	45,185	217,714	24,501	4,227	30
43	Nursery							43
44	Skilled Nursing Facility	1,524,962	68,181	22,008	212,665	17,411	2,176	44
	ANCILLARY SERVICE COST CENTERS							
50	Operating Room	854,421	115,528	192,005	109,162	32,403	14,335	50
53	Anesthesiology	1,103	2,368	643			290	53
54	Radiology-Diagnostic	1,256,118	33,470	74,839	101,180	50,310	2,749	54
57	CT Scan	175,453	5,488	101,789	27,106	53,153		57
58	MRI	236,616		323	6,292	11,272		58
60	Laboratory	1,393,187	24,968	19,736	104,574	74,448	21,662	60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
65	Respiratory Therapy	492,199	17,791	14,322	69,584	5,560	3,649	65
66	Physical Therapy	788,794	87,667	27,419	114,054	21,961	417	66
69	Electrocardiology	76,877	1,588	5,873	10,947	3,839	35	69
71	Medical Supplies Charged to Patients	567,328				17,111		71
72	Impl. Dev. Charged to Patients	438,764				4,832		72
73	Drugs Charged to Patients	1,530,451	13,274	4,580	70,851	40,455	4,411	73
76.97	CARDIAC REHABILITATION							76.97
76.98	HYPERBARIC OXYGEN THERAPY							76.98
76.99	LITHOTRIPSY							76.99
	OUTPATIENT SERVICE COST CENTERS							
88	Rural Health Clinic	453,099	18,437	496	61,845		168	88
88.01	RHC II	363,266	19,571	17,201	48,570		167	88.01
88.02	RHC III	976,393	29,868	8,969	125,427		1,258	88.02
88.03	RHC IV	1,427,928	20,869	14,373	163,385		1,577	88.03
90	Clinic	149,930	47,461	3,381	46,315	1,761	759	90
91	Emergency	1,531,952	21,025	28,187	141,967	48,625	5,602	91
92	Observation Beds (Non-Distinct Part)							92
93.99	PARTIAL HOSPITALIZATION PROGRAM							93.99
	OTHER REIMBURSABLE COST CENTERS							
95	Ambulance Services	1,187,823	1,468	35,075	168,502	28,602	972	95
101	Home Health Agency	600,494	25,726	16,343	62,168		223	101
	SPECIAL PURPOSE COST CENTERS							
113	Interest Expense							113
116	Hospice	959,336	25,726	16,643	122,438		3,644	116
118	SUBTOTALS (sum of lines 1-117)	29,277,350	944,615	813,668	2,531,853	436,244	76,026	118
	NONREIMBURSABLE COST CENTERS							
190	Gift, Flower, Coffee Shop & Canteen	17,363	6,510				17	190
194	IROQUOIS WOMEN'S HEALTH	28,895	11,686		578			194
194.01	OTHER NON-REIMBURSABLE COSTS	177,071	13,679	4,738	15,140		853	194.01
194.02	REFERENCE LAB	773,771		2,630	30,022		464	194.02
200	Cross Foot Adjustments							200
201	Negative Cost Centers							201
202	TOTAL (sum of lines 118-201)	30,274,450	976,490	821,036	2,577,593	436,244	77,360	202

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

	COST CENTER DESCRIPTIONS	DATA PROCESSING	COMMUNICAT IONS	BUSINESS OFFICE	SUBTOTAL (cols.0-4)	OTHER ADMI NISTRATIVE AND GENER	OPERATION OF PLANT	
		5.03	5.04	5.05	4A	5.06	7	
	GENERAL SERVICE COST CENTERS							
1	Cap Rel Costs-Bldg & Fixt							1
2	Cap Rel Costs-Mvble Equip							2
4	Employee Benefits Department							4
5.01	ADMISSIONS							5.01
5.02	PURCHASING, RECEIVING, AND STORES							5.02
5.03	DATA PROCESSING	1,216,362						5.03
5.04	COMMUNICATIONS		89,471					5.04
5.05	BUSINESS OFFICE	34,268	2,746	427,685				5.05
5.06	OTHER ADMINISTRATIVE AND GENERAL	37,652	4,348		1,367,002	1,367,002		5.06
6	Maintenance & Repairs							6
7	Operation of Plant	33,365	2,517		1,540,705	72,858	1,613,563	7
8	Laundry & Linen Service	4,891	229		65,728	3,108	34,779	8
9	Housekeeping	52,606	458		417,301	19,734	10,142	9
10	Dietary	32,561	915		497,242	23,514	52,062	10
11	Cafeteria	26,941	1,144		241,303	11,411	15,767	11
12	Maintenance of Personnel							12
13	Nursing Administration	20,217	3,204		491,288	23,233	13,296	13
14	Central Services & Supply				36,566	1,729	22,817	14
15	Pharmacy							15
16	Medical Records & Library	35,397	10,526		594,333	28,105	24,939	16
17	Social Service							17
19	Nonphysician Anesthetists							19
20	Nursing School							20
21	I&R Services-Salary & Fringes Apprvd							21
22	I&R Services-Other Prgm Costs Apprvd							22
23	Paramed Ed Prgm-(specify)							23
	INPATIENT ROUTINE SERV COST CENTERS							
30	Adults & Pediatrics	109,447	18,534	22,392	2,246,363	106,226	130,564	30
43	Nursery							43
44	Skilled Nursing Facility	122,561	2,746	15,912	1,988,622	94,040	145,770	44
	ANCILLARY SERVICE COST CENTERS							
50	Operating Room	50,079	8,924	29,232	1,406,089	66,493	246,996	50
53	Anesthesiology			381	4,785	226	5,064	53
54	Radiology-Diagnostic	51,922	2,746	45,725	1,619,059	76,564	71,558	54
57	CT Scan	7,746	458	47,543	418,736	19,802	11,734	57
58	MRI	5,117	2,059	10,343	272,022	12,864		58
60	Laboratory	59,368	3,204	67,991	1,769,138	83,661	53,381	60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
65	Respiratory Therapy	34,831	2,288	5,082	645,306	30,516	38,038	65
66	Physical Therapy	38,375	3,661	20,070	1,102,418	52,132	187,431	66
69	Electrocardiology	4,702	915	4,752	109,528	5,179	3,396	69
71	Medical Supplies Charged to Patients			12,217	596,656	28,215		71
72	Impl. Dev. Charged to Patients			7,837	451,433	21,348		72
73	Drugs Charged to Patients	26,648	2,288	36,972	1,729,930	81,807	28,381	73
76.97	CARDIAC REHABILITATION							76.97
76.98	HYPERBARIC OXYGEN THERAPY							76.98
76.99	LITHOTRIPSY							76.99
	OUTPATIENT SERVICE COST CENTERS							
88	Rural Health Clinic	20,980		3,324	558,349	26,404	39,418	88
88.01	RHC II	17,575		2,119	468,469	22,153	41,843	88.01
88.02	RHC III	31,192		6,672	1,179,779	55,791	63,857	88.02
88.03	RHC IV	34,797		4,715	1,667,644	78,861	44,618	88.03
90	Clinic	26,029	3,204	1,609	280,449	13,262	101,470	90
91	Emergency	66,801	3,661	44,635	1,892,455	89,492	44,951	91
92	Observation Beds (Non-Distinct Part)							92
93.99	PARTIAL HOSPITALIZATION PROGRAM							93.99
	OTHER REIMBURSABLE COST CENTERS							
95	Ambulance Services	98,083		26,139	1,546,664	73,140	3,138	95
101	Home Health Agency	29,209		3,487	737,650	34,883	55,003	101
	SPECIAL PURPOSE COST CENTERS							
113	Interest Expense							113
116	Hospice	62,406	3,204	8,536	1,201,933	56,838	55,003	116
118	SUBTOTALS (sum of lines 1-117)	1,175,766	83,979	427,685	29,144,945	1,313,589	1,545,416	118
	NONREIMBURSABLE COST CENTERS							
190	Gift, Flower, Coffee Shop & Canteen		1,144		25,034	1,184	13,917	190
194	IROQUOIS WOMEN'S HEALTH	10,384			51,543	2,437	24,985	194
194.01	OTHER NON-REIMBURSABLE COSTS	29,874	4,348		245,703	11,619	29,245	194.01
194.02	REFERENCE LAB	338			807,225	38,173		194.02
200	Cross Foot Adjustments							200
201	Negative Cost Centers							201
202	TOTAL (sum of lines 118-201)	1,216,362	89,471	427,685	30,274,450	1,367,002	1,613,563	202

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

	COST CENTER DESCRIPTIONS	LAUNDRY & LINEN SERVICE	HOUSE- KEEPING	DIETARY	CAFETERIA	NURSING ADMINIS- TRATION	CENTRAL SERVICES & SUPPLY	
		8	9	10	11	13	14	
	GENERAL SERVICE COST CENTERS							
1	Cap Rel Costs-Bldg & Fixt							1
2	Cap Rel Costs-Mvble Equip							2
4	Employee Benefits Department							4
5.01	ADMISSIONS							5.01
5.02	PURCHASING, RECEIVING, AND STORES							5.02
5.03	DATA PROCESSING							5.03
5.04	COMMUNICATIONS							5.04
5.05	BUSINESS OFFICE							5.05
5.06	OTHER ADMINISTRATIVE AND GENERAL							5.06
6	Maintenance & Repairs							6
7	Operation of Plant							7
8	Laundry & Linen Service	103,615						8
9	Housekeeping		447,177					9
10	Dietary		14,841	587,659				10
11	Cafeteria		4,495		272,976			11
12	Maintenance of Personnel							12
13	Nursing Administration		3,790		7,360	538,967		13
14	Central Services & Supply		6,504				67,616	14
15	Pharmacy							15
16	Medical Records & Library		7,110		13,941		67	16
17	Social Service							17
19	Nonphysician Anesthetists							19
20	Nursing School							20
21	I&R Services-Salary & Fringes Apprvd							21
22	I&R Services-Other Prgm Costs Apprvd							22
23	Paramed Ed Prgm-(specify)							23
	INPATIENT ROUTINE SERV COST CENTERS							
30	Adults & Pediatrics	19,201	37,220	81,535	36,183	205,402	4,099	30
43	Nursery							43
44	Skilled Nursing Facility	37,010	41,555	454,320	49,070		2,110	44
	ANCILLARY SERVICE COST CENTERS							
50	Operating Room	6,398	70,414	593	15,546	93,984	13,902	50
53	Anesthesiology		1,444				282	53
54	Radiology-Diagnostic	8,209	20,399		18,562		2,666	54
57	CT Scan		3,345		4,539			57
58	MRI				1,427			58
60	Laboratory	201	15,217		25,224		21,007	60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
65	Respiratory Therapy		10,844		12,693	65,367	3,539	65
66	Physical Therapy	7,855	53,431		17,994		404	66
69	Electrocardiology		968		1,751		33	69
71	Medical Supplies Charged to Patients							71
72	Impl. Dev. Charged to Patients							72
73	Drugs Charged to Patients		8,091		10,699		4,277	73
76.97	CARDIAC REHABILITATION							76.97
76.98	HYPERBARIC OXYGEN THERAPY							76.98
76.99	LITHOTRIPSY							76.99
	OUTPATIENT SERVICE COST CENTERS							
88	Rural Health Clinic		11,237				163	88
88.01	RHC II		11,928				162	88.01
88.02	RHC III		18,204				1,220	88.02
88.03	RHC IV		12,719		17,589		1,529	88.03
90	Clinic	2,287	28,926	1,185	8,689	48,849	736	90
91	Emergency	20,635	12,814	7,377	24,592	125,365	5,433	91
92	Observation Beds (Non-Distinct Part)							92
93.99	PARTIAL HOSPITALIZATION PROGRAM							93.99
	OTHER REIMBURSABLE COST CENTERS							
95	Ambulance Services	1,819	895				943	95
101	Home Health Agency		15,680				216	101
	SPECIAL PURPOSE COST CENTERS							
113	Interest Expense							113
116	Hospice		15,680				3,534	116
118	SUBTOTALS (sum of lines 1-117)	103,615	427,751	545,010	265,859	538,967	66,322	118
	NONREIMBURSABLE COST CENTERS							
190	Gift, Flower, Coffee Shop & Canteen		3,967				17	190
194	IROQUOIS WOMEN'S HEALTH		7,122		130			194
194.01	OTHER NON-REIMBURSABLE COSTS		8,337	42,649	6,906		827	194.01
194.02	REFERENCE LAB				81		450	194.02
200	Cross Foot Adjustments							200
201	Negative Cost Centers							201
202	TOTAL (sum of lines 118-201)	103,615	447,177	587,659	272,976	538,967	67,616	202

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IROQUOIS MEMORIAL HOSPITAL Provider CCN: 14-0167	In Lieu of Form CMS-2552-10	Period : From: 10/01/2017 To: 09/30/2018	Run Date: 02/25/2019 Run Time: 14:01 Version: 2018.12 (02/24/2019)
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COST ALLOCATION - GENERAL SERVICE COSTS
**WORKSHEET B
PART I**

	COST CENTER DESCRIPTIONS	MEDICAL RECORDS & LIBRARY	SUBTOTAL	I&R COST & POST STEP- DOWN ADJS	TOTAL			
		16	24	25	26			
	GENERAL SERVICE COST CENTERS							
1	Cap Rel Costs-Bldg & Fixt							1
2	Cap Rel Costs-Mvble Equip							2
4	Employee Benefits Department							4
5.01	ADMISSIONS							5.01
5.02	PURCHASING, RECEIVING, AND STORES							5.02
5.03	DATA PROCESSING							5.03
5.04	COMMUNICATIONS							5.04
5.05	BUSINESS OFFICE							5.05
5.06	OTHER ADMINISTRATIVE AND GENERAL							5.06
6	Maintenance & Repairs							6
7	Operation of Plant							7
8	Laundry & Linen Service							8
9	Housekeeping							9
10	Dietary							10
11	Cafeteria							11
12	Maintenance of Personnel							12
13	Nursing Administration							13
14	Central Services & Supply							14
15	Pharmacy							15
16	Medical Records & Library	668,495						16
17	Social Service							17
19	Nonphysician Anesthetists							19
20	Nursing School							20
21	I&R Services-Salary & Fringes Apprvd							21
22	I&R Services-Other Prgm Costs Apprvd							22
23	Paramed Ed Prgm-(specify)							23
	INPATIENT ROUTINE SERV COST CENTERS							
30	Adults & Pediatrics	34,999	2,901,792		2,901,792			30
43	Nursery							43
44	Skilled Nursing Facility	24,871	2,837,368		2,837,368			44
	ANCILLARY SERVICE COST CENTERS							
50	Operating Room	45,690	1,966,105		1,966,105			50
53	Anesthesiology	596	12,397		12,397			53
54	Radiology-Diagnostic	71,469	1,888,486		1,888,486			54
57	CT Scan	74,311	532,467		532,467			57
58	MRI	16,167	302,480		302,480			58
60	Laboratory	106,286	2,074,115		2,074,115			60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
65	Respiratory Therapy	7,943	814,246		814,246			65
66	Physical Therapy	31,370	1,453,035		1,453,035			66
69	Electrocardiology	7,428	128,283		128,283			69
71	Medical Supplies Charged to Patients	19,095	643,966		643,966			71
72	Impl. Dev. Charged to Patients	12,249	485,030		485,030			72
73	Drugs Charged to Patients	57,788	1,920,973		1,920,973			73
76.97	CARDIAC REHABILITATION							76.97
76.98	HYPERBARIC OXYGEN THERAPY							76.98
76.99	LITHOTRIPSY							76.99
	OUTPATIENT SERVICE COST CENTERS							
88	Rural Health Clinic	5,195	640,766		640,766			88
88.01	RHC II	3,312	547,867		547,867			88.01
88.02	RHC III	10,429	1,329,280		1,329,280			88.02
88.03	RHC IV	7,369	1,830,329		1,830,329			88.03
90	Clinic	2,515	488,368		488,368			90
91	Emergency	69,766	2,292,880		2,292,880			91
92	Observation Beds (Non-Distinct Part)							92
93.99	PARTIAL HOSPITALIZATION PROGRAM							93.99
	OTHER REIMBURSABLE COST CENTERS							
95	Ambulance Services	40,856	1,667,455		1,667,455			95
101	Home Health Agency	5,450	848,882		848,882			101
	SPECIAL PURPOSE COST CENTERS							
113	Interest Expense							113
116	Hospice	13,341	1,346,329		1,346,329			116
118	SUBTOTALS (sum of lines 1-117)	668,495	28,952,899		28,952,899			118
	NONREIMBURSABLE COST CENTERS							
190	Gift, Flower, Coffee Shop & Canteen		44,119		44,119			190
194	IROQUOIS WOMEN'S HEALTH		86,217		86,217			194
194.01	OTHER NON-REIMBURSABLE COSTS		345,286		345,286			194.01
194.02	REFERENCE LAB		845,929		845,929			194.02
200	Cross Foot Adjustments							200
201	Negative Cost Centers							201
202	TOTAL (sum of lines 118-201)	668,495	30,274,450		30,274,450			202

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IROQUOIS MEMORIAL HOSPITAL Provider CCN: 14-0167	In Lieu of Form CMS-2552-10	Period : From: 10/01/2017 To: 09/30/2018	Run Date: 02/25/2019 Run Time: 14:01 Version: 2018.12 (02/24/2019)
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ALLOCATION OF CAPITAL-RELATED COSTS
**WORKSHEET B
PART II**

	COST CENTER DESCRIPTIONS	DIR ASSGND CAP-REL COSTS	CAP BLDGs & FIXTURES	CAP MOVABLE EQUIPMENT	SUBTOTAL	EMPLOYEE BENEFITS DEPARTMENT	ADMITTING	
		0	1	2	2A	4	5.01	
	GENERAL SERVICE COST CENTERS							
1	Cap Rel Costs-Bldg & Fixt							1
2	Cap Rel Costs-Mvble Equip							2
4	Employee Benefits Department	2,012	12,665	1,825	16,502	16,502		4
5.01	ADMISSIONS	7,854	4,092	1,548	13,494	326	13,820	5.01
5.02	PURCHASING, RECEIVING, AND STORES	1,185	6,843	1,038	9,066	83		5.02
5.03	DATA PROCESSING	2,404	9,927	49,904	62,235	370		5.03
5.04	COMMUNICATIONS		6,623		6,623			5.04
5.05	BUSINESS OFFICE		9,587	454	10,041	286		5.05
5.06	OTHER ADMINISTRATIVE AND GENERAL	1,184	80,150	6,869	88,203	656		5.06
6	Maintenance & Repairs							6
7	Operation of Plant	720	91,893	95,125	187,738	301		7
8	Laundry & Linen Service		16,267	98	16,365	36		8
9	Housekeeping		4,744	110	4,854	277		9
10	Dietary	2,149	24,351	1,835	28,335	212		10
11	Cafeteria	1,778	7,375		9,153	170		11
12	Maintenance of Personnel							12
13	Nursing Administration	6,175	6,219		12,394	369		13
14	Central Services & Supply		10,672	5,407	16,079			14
15	Pharmacy							15
16	Medical Records & Library	3,483	11,665	65	15,213	415		16
17	Social Service							17
19	Nonphysician Anesthetists							19
20	Nursing School							20
21	I&R Services-Salary & Fringes Apprvd							21
22	I&R Services-Other Prgm Costs Apprvd							22
23	Paramed Ed Prgm-(specify)							23
	INPATIENT ROUTINE SERV COST CENTERS							
30	Adults & Pediatrics	6,971	61,068	45,185	113,224	1,399	778	30
43	Nursery							43
44	Skilled Nursing Facility	7,526	68,181	22,008	97,715	1,361	553	44
	ANCILLARY SERVICE COST CENTERS							
50	Operating Room	8,973	115,528	192,005	316,506	699	1,028	50
53	Anesthesiology		2,368	643	3,011			53
54	Radiology-Diagnostic	42,924	33,470	74,839	151,233	648	1,597	54
57	CT Scan		5,488	101,789	107,277	173	1,687	57
58	MRI			323	323	40	358	58
60	Laboratory	15,974	24,968	19,736	60,678	669	2,337	60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
65	Respiratory Therapy	5,633	17,791	14,322	37,746	445	176	65
66	Physical Therapy	4,384	87,667	27,419	119,470	730	697	66
69	Electrocardiology	343	1,588	5,873	7,804	70	122	69
71	Medical Supplies Charged to Patients						543	71
72	Impl. Dev. Charged to Patients						153	72
73	Drugs Charged to Patients	2,415	13,274	4,580	20,269	453	1,284	73
76.97	CARDIAC REHABILITATION							76.97
76.98	HYPERBARIC OXYGEN THERAPY							76.98
76.99	LITHOTRIPSY							76.99
	OUTPATIENT SERVICE COST CENTERS							
88	Rural Health Clinic	3,637	18,437	496	22,570	396		88
88.01	RHC II	1,941	19,571	17,201	38,713	311		88.01
88.02	RHC III	3,875	29,868	8,969	42,712	803		88.02
88.03	RHC IV	5,564	20,869	14,373	40,806	1,046		88.03
90	Clinic	1,868	47,461	3,381	52,710	296	56	90
91	Emergency	2,332	21,025	28,187	51,544	909	1,543	91
92	Observation Beds (Non-Distinct Part)							92
93.99	PARTIAL HOSPITALIZATION PROGRAM							93.99
	OTHER REIMBURSABLE COST CENTERS							
95	Ambulance Services	27,154	1,468	35,075	63,697	1,078	908	95
101	Home Health Agency	5,880	25,726	16,343	47,949	398		101
	SPECIAL PURPOSE COST CENTERS							
113	Interest Expense							113
116	Hospice	99,860	25,726	16,643	142,229	784		116
118	SUBTOTALS (sum of lines 1-117)	276,198	944,615	813,668	2,034,481	16,209	13,820	118
	NONREIMBURSABLE COST CENTERS							
190	Gift, Flower, Coffee Shop & Canteen		6,510		6,510			190
194	IROQUOIS WOMEN'S HEALTH	30,466	11,686		42,152	4		194
194.01	OTHER NON-REIMBURSABLE COSTS		13,679	4,738	18,417	97		194.01
194.02	REFERENCE LAB			2,630	2,630	192		194.02
200	Cross Foot Adjustments							200
201	Negative Cost Centers							201
202	TOTAL (sum of lines 118-201)	306,664	976,490	821,036	2,104,190	16,502	13,820	202

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ALLOCATION OF CAPITAL-RELATED COSTS

WORKSHEET B PART II

	COST CENTER DESCRIPTIONS	PURCHASING RECEIVING AND STORES	DATA PROCESSING	COMMUNICAT IONS	BUSINESS OFFICE	OTHER ADMI NISTRATIVE AND GENER	OPERATION OF PLANT	
		5.02	5.03	5.04	5.05	5.06	7	
	GENERAL SERVICE COST CENTERS							
1	Cap Rel Costs-Bldg & Fixt							1
2	Cap Rel Costs-Mvble Equip							2
4	Employee Benefits Department							4
5.01	ADMISSIONS							5.01
5.02	PURCHASING, RECEIVING, AND STORES	9,149						5.02
5.03	DATA PROCESSING	89	62,694					5.03
5.04	COMMUNICATIONS			6,623				5.04
5.05	BUSINESS OFFICE	11	1,766	203	12,307			5.05
5.06	OTHER ADMINISTRATIVE AND GENERAL	40	1,941	322		91,162		5.06
6	Maintenance & Repairs							6
7	Operation of Plant	152	1,720	186		4,859	194,956	7
8	Laundry & Linen Service	12	252	17		207	4,202	8
9	Housekeeping	198	2,711	34		1,316	1,225	9
10	Dietary	162	1,678	68		1,568	6,290	10
11	Cafeteria	130	1,389	85		761	1,905	11
12	Maintenance of Personnel							12
13	Nursing Administration	1	1,042	237		1,550	1,606	13
14	Central Services & Supply	108				115	2,757	14
15	Pharmacy							15
16	Medical Records & Library	8	1,824	779		1,875	3,013	16
17	Social Service							17
19	Nonphysician Anesthetists							19
20	Nursing School							20
21	I&R Services-Salary & Fringes Apprvd							21
22	I&R Services-Other Prgm Costs Apprvd							22
23	Paramed Ed Prgm-(specify)							23
	INPATIENT ROUTINE SERV COST CENTERS							
30	Adults & Pediatrics	500	5,641	1,373	644	7,071	15,775	30
43	Nursery							43
44	Skilled Nursing Facility	257	6,318	203	458	6,272	17,612	44
	ANCILLARY SERVICE COST CENTERS							
50	Operating Room	1,695	2,581	661	841	4,435	29,843	50
53	Anesthesiology	34			11	15	612	53
54	Radiology-Diagnostic	325	2,676	203	1,316	5,107	8,646	54
57	CT Scan		399	34	1,368	1,321	1,418	57
58	MRI		264	152	298	858		58
60	Laboratory	2,561	3,060	237	1,954	5,580	6,450	60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
65	Respiratory Therapy	432	1,795	169	146	2,035	4,596	65
66	Physical Therapy	49	1,978	271	578	3,477	22,646	66
69	Electrocardiology	4	242	68	137	345	410	69
71	Medical Supplies Charged to Patients				352	1,882		71
72	Impl. Dev. Charged to Patients				226	1,424		72
73	Drugs Charged to Patients	522	1,374	169	1,064	5,456	3,429	73
76.97	CARDIAC REHABILITATION							76.97
76.98	HYPERBARIC OXYGEN THERAPY							76.98
76.99	LITHOTRIPSY							76.99
	OUTPATIENT SERVICE COST CENTERS							
88	Rural Health Clinic	20	1,081		96	1,761	4,763	88
88.01	RHC II	20	906		61	1,478	5,056	88.01
88.02	RHC III	149	1,608		192	3,721	7,715	88.02
88.03	RHC IV	187	1,793		136	5,260	5,391	88.03
90	Clinic	90	1,342	237	46	885	12,260	90
91	Emergency	663	3,443	271	1,285	5,969	5,431	91
92	Observation Beds (Non-Distinct Part)							92
93.99	PARTIAL HOSPITALIZATION PROGRAM							93.99
	OTHER REIMBURSABLE COST CENTERS							
95	Ambulance Services	115	5,055		752	4,878	379	95
101	Home Health Agency	26	1,506		100	2,327	6,646	101
	SPECIAL PURPOSE COST CENTERS							
113	Interest Expense							113
116	Hospice	431	3,217	237	246	3,791	6,646	116
118	SUBTOTALS (sum of lines 1-117)	8,991	60,602	6,216	12,307	87,599	186,722	118
	NONREIMBURSABLE COST CENTERS							
190	Gift, Flower, Coffee Shop & Canteen	2		85		79	1,682	190
194	IROQUOIS WOMEN'S HEALTH		535			163	3,019	194
194.01	OTHER NON-REIMBURSABLE COSTS	101	1,540	322		775	3,533	194.01
194.02	REFERENCE LAB	55	17			2,546		194.02
200	Cross Foot Adjustments							200
201	Negative Cost Centers							201
202	TOTAL (sum of lines 118-201)	9,149	62,694	6,623	12,307	91,162	194,956	202

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

	COST CENTER DESCRIPTIONS	LAUNDRY & LINEN SERVICE	HOUSE- KEEPING	DIETARY	CAFETERIA	NURSING ADMINIS- TRATION	CENTRAL SERVICES & SUPPLY	
		8	9	10	11	13	14	
	GENERAL SERVICE COST CENTERS							
1	Cap Rel Costs-Bldg & Fixt							1
2	Cap Rel Costs-Mvble Equip							2
4	Employee Benefits Department							4
5.01	ADMISSIONS							5.01
5.02	PURCHASING, RECEIVING, AND STORES							5.02
5.03	DATA PROCESSING							5.03
5.04	COMMUNICATIONS							5.04
5.05	BUSINESS OFFICE							5.05
5.06	OTHER ADMINISTRATIVE AND GENERAL							5.06
6	Maintenance & Repairs							6
7	Operation of Plant							7
8	Laundry & Linen Service	21,091						8
9	Housekeeping		10,615					9
10	Dietary		352	38,665				10
11	Cafeteria		107		13,700			11
12	Maintenance of Personnel							12
13	Nursing Administration		90		369	17,658		13
14	Central Services & Supply		154				19,213	14
15	Pharmacy							15
16	Medical Records & Library		169		700		19	16
17	Social Service							17
19	Nonphysician Anesthetists							19
20	Nursing School							20
21	I&R Services-Salary & Fringes Apprvd							21
22	I&R Services-Other Prgm Costs Apprvd							22
23	Paramed Ed Prgm-(specify)							23
	INPATIENT ROUTINE SERV COST CENTERS							
30	Adults & Pediatrics	3,908	884	5,365	1,816	6,730	1,165	30
43	Nursery							43
44	Skilled Nursing Facility	7,535	986	29,892	2,461		600	44
	ANCILLARY SERVICE COST CENTERS							
50	Operating Room	1,302	1,674	39	780	3,079	3,950	50
53	Anesthesiology		34				80	53
54	Radiology-Diagnostic	1,671	484		932		758	54
57	CT Scan		79		228			57
58	MRI				72			58
60	Laboratory	41	361		1,266		5,967	60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
65	Respiratory Therapy		257		637	2,142	1,006	65
66	Physical Therapy	1,599	1,268		903		115	66
69	Electrocardiology		23		88		10	69
71	Medical Supplies Charged to Patients							71
72	Impl. Dev. Charged to Patients							72
73	Drugs Charged to Patients		192		537		1,215	73
76.97	CARDIAC REHABILITATION							76.97
76.98	HYPERBARIC OXYGEN THERAPY							76.98
76.99	LITHOTRIPSY							76.99
	OUTPATIENT SERVICE COST CENTERS							
88	Rural Health Clinic		267				46	88
88.01	RHC II		283				46	88.01
88.02	RHC III		432				347	88.02
88.03	RHC IV		302		883		435	88.03
90	Clinic	465	687	78	436	1,600	209	90
91	Emergency	4,200	304	485	1,234	4,107	1,544	91
92	Observation Beds (Non-Distinct Part)							92
93.99	PARTIAL HOSPITALIZATION PROGRAM							93.99
	OTHER REIMBURSABLE COST CENTERS							
95	Ambulance Services	370	21				268	95
101	Home Health Agency		372				61	101
	SPECIAL PURPOSE COST CENTERS							
113	Interest Expense							113
116	Hospice		372				1,004	116
118	SUBTOTALS (sum of lines 1-117)	21,091	10,154	35,859	13,342	17,658	18,845	118
	NONREIMBURSABLE COST CENTERS							
190	Gift, Flower, Coffee Shop & Canteen		94				5	190
194	IROQUOIS WOMEN'S HEALTH		169		7			194
194.01	OTHER NON-REIMBURSABLE COSTS		198	2,806	347		235	194.01
194.02	REFERENCE LAB				4		128	194.02
200	Cross Foot Adjustments							200
201	Negative Cost Centers							201
202	TOTAL (sum of lines 118-201)	21,091	10,615	38,665	13,700	17,658	19,213	202

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IROQUOIS MEMORIAL HOSPITAL Provider CCN: 14-0167	In Lieu of Form CMS-2552-10	Period : From: 10/01/2017 To: 09/30/2018	Run Date: 02/25/2019 Run Time: 14:01 Version: 2018.12 (02/24/2019)
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ALLOCATION OF CAPITAL-RELATED COSTS
**WORKSHEET B
PART II**

	COST CENTER DESCRIPTIONS	MEDICAL RECORDS & LIBRARY	SUBTOTAL	I&R COST & POST STEP- DOWN ADJS	TOTAL			
		16	24	25	26			
	GENERAL SERVICE COST CENTERS							
1	Cap Rel Costs-Bldg & Fixt							1
2	Cap Rel Costs-Mvble Equip							2
4	Employee Benefits Department							4
5.01	ADMISSIONS							5.01
5.02	PURCHASING, RECEIVING, AND STORES							5.02
5.03	DATA PROCESSING							5.03
5.04	COMMUNICATIONS							5.04
5.05	BUSINESS OFFICE							5.05
5.06	OTHER ADMINISTRATIVE AND GENERAL							5.06
6	Maintenance & Repairs							6
7	Operation of Plant							7
8	Laundry & Linen Service							8
9	Housekeeping							9
10	Dietary							10
11	Cafeteria							11
12	Maintenance of Personnel							12
13	Nursing Administration							13
14	Central Services & Supply							14
15	Pharmacy							15
16	Medical Records & Library	24,015						16
17	Social Service							17
19	Nonphysician Anesthetists							19
20	Nursing School							20
21	I&R Services-Salary & Fringes Apprvd							21
22	I&R Services-Other Prgm Costs Apprvd							22
23	Paramed Ed Prgm-(specify)							23
	INPATIENT ROUTINE SERV COST CENTERS							
30	Adults & Pediatrics	1,256	167,529		167,529			30
43	Nursery							43
44	Skilled Nursing Facility	893	173,116		173,116			44
	ANCILLARY SERVICE COST CENTERS							
50	Operating Room	1,640	370,753		370,753			50
53	Anesthesiology	21	3,818		3,818			53
54	Radiology-Diagnostic	2,566	178,162		178,162			54
57	CT Scan	2,668	116,652		116,652			57
58	MRI	580	2,945		2,945			58
60	Laboratory	3,834	94,995		94,995			60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
65	Respiratory Therapy	285	51,867		51,867			65
66	Physical Therapy	1,126	154,907		154,907			66
69	Electrocardiology	267	9,590		9,590			69
71	Medical Supplies Charged to Patients	685	3,462		3,462			71
72	Impl. Dev. Charged to Patients	440	2,243		2,243			72
73	Drugs Charged to Patients	2,074	38,038		38,038			73
76.97	CARDIAC REHABILITATION							76.97
76.98	HYPERBARIC OXYGEN THERAPY							76.98
76.99	LITHOTRIPSY							76.99
	OUTPATIENT SERVICE COST CENTERS							
88	Rural Health Clinic	186	31,186		31,186			88
88.01	RHC II	119	46,993		46,993			88.01
88.02	RHC III	374	58,053		58,053			88.02
88.03	RHC IV	265	56,504		56,504			88.03
90	Clinic	90	71,487		71,487			90
91	Emergency	2,504	85,436		85,436			91
92	Observation Beds (Non-Distinct Part)							92
93.99	PARTIAL HOSPITALIZATION PROGRAM							93.99
	OTHER REIMBURSABLE COST CENTERS							
95	Ambulance Services	1,467	78,988		78,988			95
101	Home Health Agency	196	59,581		59,581			101
	SPECIAL PURPOSE COST CENTERS							
113	Interest Expense							113
116	Hospice	479	159,436		159,436			116
118	SUBTOTALS (sum of lines 1-117)	24,015	2,015,741		2,015,741			118
	NONREIMBURSABLE COST CENTERS							
190	Gift, Flower, Coffee Shop & Canteen		8,457		8,457			190
194	IROQUOIS WOMEN'S HEALTH		46,049		46,049			194
194.01	OTHER NON-REIMBURSABLE COSTS		28,371		28,371			194.01
194.02	REFERENCE LAB		5,572		5,572			194.02
200	Cross Foot Adjustments							200
201	Negative Cost Centers							201
202	TOTAL (sum of lines 118-201)	24,015	2,104,190		2,104,190			202

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IROQUOIS MEMORIAL HOSPITAL Provider CCN: 14-0167	In Lieu of Form CMS-2552-10	Period : From: 10/01/2017 To: 09/30/2018	Run Date: 02/25/2019 Run Time: 14:01 Version: 2018.12 (02/24/2019)
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COST ALLOCATION - STATISTICAL BASIS

WORKSHEET B-1

	COST CENTER DESCRIPTIONS	CAP BLDGS & FIXTURES SQUARE FEET	CAP MOVABLE EQUIPMENT DOLLAR VALUE NEW	EMPLOYEE BENEFITS DEPARTMENT GROSS SAL	ADMITTING GROSS CHARGES	PURCHASING RECEIVING AND STORES COST REQ'S	DATA PROCESSING TIME SPENT	
		1	2	4	5.01	5.02	5.03	
	GENERAL SERVICE COST CENTERS							
1	Cap Rel Costs-Bldg & Fixt	137,707						1
2	Cap Rel Costs-Mvble Equip		1,414,952					2
4	Employee Benefits Department	1,786	3,146	16,382,938				4
5.01	ADMISSIONS	577	2,667	323,667	64,093,847			5.01
5.02	PURCHASING, RECEIVING, AND STORES	965	1,789	82,850		1,650,135		5.02
5.03	DATA PROCESSING	1,400	86,003	367,061		16,080	644,138	5.03
5.04	COMMUNICATIONS	934						5.04
5.05	BUSINESS OFFICE	1,352	783	283,989		1,939	18,147	5.05
5.06	OTHER ADMINISTRATIVE AND GENERAL	11,303	11,838	651,364		7,214	19,939	5.06
6	Maintenance & Repairs							6
7	Operation of Plant	12,959	163,936	299,394		27,404	17,669	7
8	Laundry & Linen Service	2,294	169	35,256		2,138	2,590	8
9	Housekeeping	669	189	275,128		35,728	27,858	9
10	Dietary	3,434	3,162	210,686		29,273	17,243	10
11	Cafeteria	1,040		169,060		23,490	14,267	11
12	Maintenance of Personnel							12
13	Nursing Administration	877		366,636		158	10,706	13
14	Central Services & Supply	1,505	9,318			19,474		14
15	Pharmacy							15
16	Medical Records & Library	1,645	112	412,270		1,475	18,745	16
17	Social Service							17
19	Nonphysician Anesthetists							19
20	Nursing School							20
21	I&R Services-Salary & Fringes Apprvd							21
22	I&R Services-Other Prgm Costs Apprvd							22
23	Paramed Ed Prgm-(specify)							23
	INPATIENT ROUTINE SERV COST CENTERS							
30	Adults & Pediatrics	8,612	77,871	1,383,770	3,599,980	90,154	57,959	30
43	Nursery							43
44	Skilled Nursing Facility	9,615	37,928	1,351,679	2,558,215	46,410	64,903	44
	ANCILLARY SERVICE COST CENTERS							
50	Operating Room	16,292	330,898	693,823	4,760,936	305,780	26,520	50
53	Anesthesiology	334	1,108			6,195		53
54	Radiology-Diagnostic	4,720	128,976	643,092	7,392,030	58,648	27,496	54
57	CT Scan	774	175,420	172,281	7,809,690		4,102	57
58	MRI		557	39,989	1,656,129		2,710	58
60	Laboratory	3,521	34,012	664,662	10,935,348	462,010	31,439	60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
65	Respiratory Therapy	2,509	24,683	442,269	816,991	77,845	18,445	65
66	Physical Therapy	12,363	47,253	724,914	3,226,742	8,893	20,322	66
69	Electrocardiology	224	10,122	69,577	564,011	736	2,490	69
71	Medical Supplies Charged to Patients				2,514,143			71
72	Impl. Dev. Charged to Patients				709,974			72
73	Drugs Charged to Patients	1,872	7,893	450,322	5,944,002	94,083	14,112	73
76.97	CARDIAC REHABILITATION							76.97
76.98	HYPERBARIC OXYGEN THERAPY							76.98
76.99	LITHOTRIPSY							76.99
	OUTPATIENT SERVICE COST CENTERS							
88	Rural Health Clinic	2,600	854	393,078		3,590	11,110	88
88.01	RHC II	2,760	29,643	308,709		3,561	9,307	88.01
88.02	RHC III	4,212	15,457	797,205		26,841	16,518	88.02
88.03	RHC IV	2,943	24,770	1,038,458		33,641	18,427	88.03
90	Clinic	6,693	5,827	294,376	258,727	16,198	13,784	90
91	Emergency	2,965	48,577	902,328	7,144,477	119,499	35,375	91
92	Observation Beds (Non-Distinct Part)							92
93.99	PARTIAL HOSPITALIZATION PROGRAM							93.99
	OTHER REIMBURSABLE COST CENTERS							
95	Ambulance Services	207	60,447	1,070,983	4,202,452	20,739	51,941	95
101	Home Health Agency	3,628	28,165	395,132		4,753	15,468	101
	SPECIAL PURPOSE COST CENTERS							
116	Hospice	3,628	28,682	778,204		77,733	33,048	116
118	SUBTOTALS (sum of lines 1-117)	133,212	1,402,255	16,092,212	64,093,847	1,621,682	622,640	118
	NONREIMBURSABLE COST CENTERS							
190	Gift, Flower, Coffee Shop & Canteen	918				364		190
194	IROQUOIS WOMEN'S HEALTH	1,648		3,676			5,499	194
194.01	OTHER NON-REIMBURSABLE COSTS	1,929	8,165	96,231		18,196	15,820	194.01
194.02	REFERENCE LAB		4,532	190,819		9,893	179	194.02
200	Cross foot adjustments							200
201	Negative cost centers							201
202	Cost to be allocated (Per Wkst. B, Part I)	976,490	821,036	2,577,593	436,244	77,360	1,216,362	202
203	Unit Cost Multiplier (Wkst. B, Part I)	7.091070	0.580257	0.157334	0.006806	0.046881	1.888356	203
204	Cost to be allocated (Per Wkst. B, Part II)			16,502	13,820	9,149	62,694	204
205	Unit Cost Multiplier (Wkst. B, Part II)			0.001007	0.000216	0.005544	0.097330	205

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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	
206	NAHE adjustment amount to be allocated (per Wkst. B-2)							206
207	NAHE Unit Cost Multiplier (Wkst. D, Parts III and IV)							207

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IROQUOIS MEMORIAL HOSPITAL Provider CCN: 14-0167	In Lieu of Form CMS-2552-10	Period : From: 10/01/2017 To: 09/30/2018	Run Date: 02/25/2019 Run Time: 14:01 Version: 2018.12 (02/24/2019)
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COST ALLOCATION - STATISTICAL BASIS
WORKSHEET B-1

	COST CENTER DESCRIPTIONS	COMMUNICAT IONS # OF PHONES	BUSINESS OFFICE GROSS REVENUE	RECON- CILIATION	OTHER ADMI NISTRATIVE AND GENER ACCUM COST	OPERATION OF PLANT SQUARE FEET	LAUNDRY & LINEN SERVICE POUNDS	
		5.04	5.05	5A.06	5.06	7	8	
	GENERAL SERVICE COST CENTERS							
1	Cap Rel Costs-Bldg & Fixt							1
2	Cap Rel Costs-Mvble Equip							2
4	Employee Benefits Department							4
5.01	ADMISSIONS							5.01
5.02	PURCHASING, RECEIVING, AND STORES							5.02
5.03	DATA PROCESSING							5.03
5.04	COMMUNICATIONS	391						5.04
5.05	BUSINESS OFFICE	12	68,763,941					5.05
5.06	OTHER ADMINISTRATIVE AND GENERAL	19		-1,367,002	28,907,448			5.06
6	Maintenance & Repairs							6
7	Operation of Plant	11			1,540,705	106,431		7
8	Laundry & Linen Service	1			65,728	2,294	182,830	8
9	Housekeeping	2			417,301	669		9
10	Dietary	4			497,242	3,434		10
11	Cafeteria	5			241,303	1,040		11
12	Maintenance of Personnel							12
13	Nursing Administration	14			491,288	877		13
14	Central Services & Supply				36,566	1,505		14
15	Pharmacy							15
16	Medical Records & Library	46			594,333	1,645		16
17	Social Service							17
19	Nonphysician Anesthetists							19
20	Nursing School							20
21	I&R Services-Salary & Fringes Apprvd							21
22	I&R Services-Other Prgm Costs Apprvd							22
23	Paramed Ed Prgm-(specify)							23
	INPATIENT ROUTINE SERV COST CENTERS							
30	Adults & Pediatrics	81	3,599,980		2,246,363	8,612	33,880	30
43	Nursery							43
44	Skilled Nursing Facility	12	2,558,215		1,988,622	9,615	65,305	44
	ANCILLARY SERVICE COST CENTERS							
50	Operating Room	39	4,699,623		1,406,089	16,292	11,290	50
53	Anesthesiology		61,313		4,785	334		53
54	Radiology-Diagnostic	12	7,351,294		1,619,059	4,720	14,485	54
57	CT Scan	2	7,643,626		418,736	774		57
58	MRI	9	1,662,929		272,022			58
60	Laboratory	14	10,935,348		1,769,138	3,521	355	60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
65	Respiratory Therapy	10	816,991		645,306	2,509		65
66	Physical Therapy	16	3,226,742		1,102,418	12,363	13,860	66
69	Electrocardiology	4	764,011		109,528	224		69
71	Medical Supplies Charged to Patients		1,964,143		596,656			71
72	Impl. Dev. Charged to Patients		1,259,974		451,433			72
73	Drugs Charged to Patients	10	5,944,002		1,729,930	1,872		73
76.97	CARDIAC REHABILITATION							76.97
76.98	HYPERBARIC OXYGEN THERAPY							76.98
76.99	LITHOTRIPSY							76.99
	OUTPATIENT SERVICE COST CENTERS							
88	Rural Health Clinic		534,326		558,349	2,600		88
88.01	RHC II		340,632		468,469	2,760		88.01
88.02	RHC III		1,072,715		1,179,779	4,212		88.02
88.03	RHC IV		757,994		1,667,644	2,943		88.03
90	Clinic	14	258,727		280,449	6,693	4,035	90
91	Emergency	16	7,176,075		1,892,455	2,965	36,410	91
92	Observation Beds (Non-Distinct Part)							92
93.99	PARTIAL HOSPITALIZATION PROGRAM							93.99
	OTHER REIMBURSABLE COST CENTERS							
95	Ambulance Services		4,202,452		1,546,664	207	3,210	95
101	Home Health Agency		560,540		737,650	3,628		101
	SPECIAL PURPOSE COST CENTERS							
116	Hospice	14	1,372,289		1,201,933	3,628		116
118	SUBTOTALS (sum of lines 1-117)	367	68,763,941	-1,367,002	27,777,943	101,936	182,830	118
	NONREIMBURSABLE COST CENTERS							
190	Gift, Flower, Coffee Shop & Canteen	5			25,034	918		190
194	IROQUOIS WOMEN'S HEALTH				51,543	1,648		194
194.01	OTHER NON-REIMBURSABLE COSTS	19			245,703	1,929		194.01
194.02	REFERENCE LAB				807,225			194.02
200	Cross foot adjustments							200
201	Negative cost centers							201
202	Cost to be allocated (Per Wkst. B, Part I)	89,471	427,685		1,367,002	1,613,563	103,615	202
203	Unit Cost Multiplier (Wkst. B, Part I)	228.826087	0.006220		0.047289	15.160649	0.566729	203
204	Cost to be allocated (Per Wkst. B, Part II)	6,623	12,307		91,162	194,956	21,091	204
205	Unit Cost Multiplier (Wkst. B, Part II)	16.938619	0.000179		0.003154	1.831760	0.115359	205

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COST ALLOCATION - STATISTICAL BASIS

WORKSHEET B-1

	COST CENTER DESCRIPTIONS	COMMUNICAT IONS # OF PHONES	BUSINESS OFFICE GROSS REVENUE	RECON- CILIATION	OTHER ADMI NISTRATIVE AND GENER ACCUM COST	OPERATION OF PLANT SQUARE FEET	LAUNDRY & LINEN SERVICE POUNDS	
		5.04	5.05	5A.06	5.06	7	8	
206	NAHE adjustment amount to be allocated (per Wkst. B-2)							206
207	NAHE Unit Cost Multiplier (Wkst. D, Parts III and IV)							207

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IROQUOIS MEMORIAL HOSPITAL Provider CCN: 14-0167	In Lieu of Form CMS-2552-10	Period : From: 10/01/2017 To: 09/30/2018	Run Date: 02/25/2019 Run Time: 14:01 Version: 2018.12 (02/24/2019)
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COST ALLOCATION - STATISTICAL BASIS

WORKSHEET B-1

	COST CENTER DESCRIPTIONS	HOUSE-KEEPING SQUARE FEET	DIETARY MEALS	CAFETERIA FTE'S	NURSING ADMINIS- TRATION NURSING HOURS	CENTRAL SERVICES & SUPPLY COST REQ'S	MEDICAL RECORDS & LIBRARY GROSS REVENUE	
		9	10	11	13	14	16	
	GENERAL SERVICE COST CENTERS							
1	Cap Rel Costs-Bldg & Fixt							1
2	Cap Rel Costs-Mvble Equip							2
4	Employee Benefits Department							4
5.01	ADMISSIONS							5.01
5.02	PURCHASING, RECEIVING, AND STORES							5.02
5.03	DATA PROCESSING							5.03
5.04	COMMUNICATIONS							5.04
5.05	BUSINESS OFFICE							5.05
5.06	OTHER ADMINISTRATIVE AND GENERAL							5.06
6	Maintenance & Repairs							6
7	Operation of Plant							7
8	Laundry & Linen Service							8
9	Housekeeping	103,468						9
10	Dietary	3,434	39,670					10
11	Cafeteria	1,040		16,839				11
12	Maintenance of Personnel							12
13	Nursing Administration	877		454	152,083			13
14	Central Services & Supply	1,505				1,487,237		14
15	Pharmacy							15
16	Medical Records & Library	1,645		860		1,475	68,763,941	16
17	Social Service							17
19	Nonphysician Anesthetists							19
20	Nursing School							20
21	I&R Services-Salary & Fringes Apprvd							21
22	I&R Services-Other Prgm Costs Apprvd							22
23	Paramed Ed Prgm-(specify)							23
	INPATIENT ROUTINE SERV COST CENTERS							
30	Adults & Pediatrics	8,612	5,504	2,232	57,959	90,154	3,599,980	30
43	Nursery							43
44	Skilled Nursing Facility	9,615	30,669	3,027		46,410	2,558,215	44
	ANCILLARY SERVICE COST CENTERS							
50	Operating Room	16,292	40	959	26,520	305,780	4,699,623	50
53	Anesthesiology	334				6,195	61,313	53
54	Radiology-Diagnostic	4,720		1,145		58,648	7,351,294	54
57	CT Scan	774		280			7,643,626	57
58	MRI			88			1,662,929	58
60	Laboratory	3,521		1,556		462,010	10,935,348	60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
65	Respiratory Therapy	2,509		783	18,445	77,845	816,991	65
66	Physical Therapy	12,363		1,110		8,893	3,226,742	66
69	Electrocardiology	224		108		736	764,011	69
71	Medical Supplies Charged to Patients						1,964,143	71
72	Impl. Dev. Charged to Patients						1,259,974	72
73	Drugs Charged to Patients	1,872		660		94,083	5,944,002	73
76.97	CARDIAC REHABILITATION							76.97
76.98	HYPERBARIC OXYGEN THERAPY							76.98
76.99	LITHOTRIPSY							76.99
	OUTPATIENT SERVICE COST CENTERS							
88	Rural Health Clinic	2,600				3,590	534,326	88
88.01	RHC II	2,760				3,561	340,632	88.01
88.02	RHC III	4,212				26,841	1,072,715	88.02
88.03	RHC IV	2,943		1,085		33,641	757,994	88.03
90	Clinic	6,693	80	536	13,784	16,198	258,727	90
91	Emergency	2,965	498	1,517	35,375	119,499	7,176,075	91
92	Observation Beds (Non-Distinct Part)							92
93.99	PARTIAL HOSPITALIZATION PROGRAM							93.99
	OTHER REIMBURSABLE COST CENTERS							
95	Ambulance Services	207				20,739	4,202,452	95
101	Home Health Agency	3,628				4,753	560,540	101
	SPECIAL PURPOSE COST CENTERS							
116	Hospice	3,628				77,733	1,372,289	116
118	SUBTOTALS (sum of lines 1-117)	98,973	36,791	16,400	152,083	1,458,784	68,763,941	118
	NONREIMBURSABLE COST CENTERS							
190	Gift, Flower, Coffee Shop & Canteen	918				364		190
194	IROQUOIS WOMEN'S HEALTH	1,648		8				194
194.01	OTHER NON-REIMBURSABLE COSTS	1,929	2,879	426		18,196		194.01
194.02	REFERENCE LAB			5		9,893		194.02
200	Cross foot adjustments							200
201	Negative cost centers							201
202	Cost to be allocated (Per Wkst. B, Part I)	447,177	587,659	272,976	538,967	67,616	668,495	202
203	Unit Cost Multiplier (Wkst. B, Part I)	4.321887	14.813688	16.210939	3.543900	0.045464	0.009722	203
204	Cost to be allocated (Per Wkst. B, Part II)	10,615	38,665	13,700	17,658	19,213	24,015	204
205	Unit Cost Multiplier (Wkst. B, Part II)	0.102592	0.974666	0.813588	0.116108	0.012919	0.000349	205

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COST ALLOCATION - STATISTICAL BASIS

WORKSHEET B-1

	COST CENTER DESCRIPTIONS	HOUSE-KEEPING SQUARE FEET	DIETARY MEALS	CAFETERIA FTE'S	NURSING ADMINIS-TRATION NURSING HOURS	CENTRAL SERVICES & SUPPLY COST REQ'S	MEDICAL RECORDS & LIBRARY GROSS REVENUE	
		9	10	11	13	14	16	
206	NAHE adjustment amount to be allocated (per Wkst. B-2)							206
207	NAHE Unit Cost Multiplier (Wkst. D, Parts III and IV)							207

KPMG LLP Compu-Max 2552-10

IROQUOIS MEMORIAL HOSPITAL Provider CCN: 14-0167	In Lieu of Form CMS-2552-10	Period : From: 10/01/2017 To: 09/30/2018	Run Date: 02/25/2019 Run Time: 14:01 Version: 2018.12 (02/24/2019)
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COST ALLOCATION - STATISTICAL BASIS**WORKSHEET B-1**

	COST CENTER DESCRIPTIONS							

	GENERAL SERVICE COST CENTERS							
1	Cap Rel Costs-Bldg & Fixt							1
2	Cap Rel Costs-Mvble Equip							2
4	Employee Benefits Department							4
5.01	ADMISSIONS							5.01
5.02	PURCHASING, RECEIVING, AND STORES							5.02
5.03	DATA PROCESSING							5.03
5.04	COMMUNICATIONS							5.04
5.05	BUSINESS OFFICE							5.05
5.06	OTHER ADMINISTRATIVE AND GENERAL							5.06
6	Maintenance & Repairs							6
7	Operation of Plant							7
8	Laundry & Linen Service							8
9	Housekeeping							9
10	Dietary							10
11	Cafeteria							11
12	Maintenance of Personnel							12
13	Nursing Administration							13
14	Central Services & Supply							14
15	Pharmacy							15
16	Medical Records & Library							16
17	Social Service							17
19	Nonphysician Anesthetists							19
20	Nursing School							20
21	I&R Services-Salary & Fringes Apprvd							21
22	I&R Services-Other Prgm Costs Apprvd							22
23	Paramed Ed Prgm-(specify)							23
	INPATIENT ROUTINE SERV COST CENTERS							
30	Adults & Pediatrics							30
43	Nursery							43
44	Skilled Nursing Facility							44
	ANCILLARY SERVICE COST CENTERS							
50	Operating Room							50
53	Anesthesiology							53
54	Radiology-Diagnostic							54
57	CT Scan							57
58	MRI							58
60	Laboratory							60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
65	Respiratory Therapy							65
66	Physical Therapy							66
69	Electrocardiology							69
71	Medical Supplies Charged to Patients							71
72	Impl. Dev. Charged to Patients							72
73	Drugs Charged to Patients							73
76.97	CARDIAC REHABILITATION							76.97
76.98	HYPERBARIC OXYGEN THERAPY							76.98
76.99	LITHOTRIPSY							76.99
	OUTPATIENT SERVICE COST CENTERS							
88	Rural Health Clinic							88
88.01	RHC II							88.01
88.02	RHC III							88.02
88.03	RHC IV							88.03
90	Clinic							90
91	Emergency							91
92	Observation Beds (Non-Distinct Part)							92
93.99	PARTIAL HOSPITALIZATION PROGRAM							93.99
	OTHER REIMBURSABLE COST CENTERS							
95	Ambulance Services							95
101	Home Health Agency							101
	SPECIAL PURPOSE COST CENTERS							
116	Hospice							116
118	SUBTOTALS (sum of lines 1-117)							118
	NONREIMBURSABLE COST CENTERS							
190	Gift, Flower, Coffee Shop & Canteen							190
194	IROQUOIS WOMEN'S HEALTH							194
194.01	OTHER NON-REIMBURSABLE COSTS							194.01
194.02	REFERENCE LAB							194.02
200	Cross foot adjustments							200
201	Negative cost centers							201
202	Cost to be allocated (Per Wkst. B, Part I)							202
203	Unit Cost Multiplier (Wkst. B, Part I)							203

KPMG LLP Compu-Max 2552-10

IROQUOIS MEMORIAL HOSPITAL Provider CCN: 14-0167	In Lieu of Form CMS-2552-10	Period : From: 10/01/2017 To: 09/30/2018	Run Date: 02/25/2019 Run Time: 14:01 Version: 2018.12 (02/24/2019)
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COST ALLOCATION - STATISTICAL BASIS

WORKSHEET B-1

	COST CENTER DESCRIPTIONS							
204	Cost to be allocated (Per Wkst. B, Part II)							204
205	Unit Cost Multiplier (Wkst. B, Part II)							205
206	NAHE adjustment amount to be allocated (per Wkst. B-2)							206
207	NAHE Unit Cost Multiplier (Wkst. D, Parts III and IV)							207

KPMG LLP Compu-Max 2552-10

IROQUOIS MEMORIAL HOSPITAL Provider CCN: 14-0167	In Lieu of Form CMS-2552-10	Period : From: 10/01/2017 To: 09/30/2018	Run Date: 02/25/2019 Run Time: 14:01 Version: 2018.12 (02/24/2019)
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POST STEPDOWN ADJUSTMENTS

WORKSHEET B-2

		WORKSHEET			
	DESCRIPTION	CODE	LINE NO.	AMOUNT	
	1	2	3	4	

KPMG LLP Compu-Max 2552-10

IROQUOIS MEMORIAL HOSPITAL Provider CCN: 14-0167	In Lieu of Form CMS-2552-10	Period : From: 10/01/2017 To: 09/30/2018	Run Date: 02/25/2019 Run Time: 14:01 Version: 2018.12 (02/24/2019)
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COMPUTATION OF RATIO OF COST TO CHARGES
**WORKSHEET C
PART I**

				COSTS			
	COST CENTER DESCRIPTIONS	Total Cost (from Wkst. B, Part I, col. 26)	Therapy Limit Adj.	Total Costs	RCE Dis- allowance	Total Costs	
		1	2	3	4	5	
	INPATIENT ROUTINE SERVICE COST CENTERS						
30	Adults & Pediatrics	2,901,792		2,901,792		2,901,792	30
43	Nursery						43
44	Skilled Nursing Facility	2,837,368		2,837,368		2,837,368	44
	ANCILLARY SERVICE COST CENTERS						
50	Operating Room	1,966,105		1,966,105		1,966,105	50
53	Anesthesiology	12,397		12,397		12,397	53
54	Radiology-Diagnostic	1,888,486		1,888,486		1,888,486	54
57	CT Scan	532,467		532,467		532,467	57
58	MRI	302,480		302,480		302,480	58
60	Laboratory	2,074,115		2,074,115		2,074,115	60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS						62.30
65	Respiratory Therapy	814,246		814,246		814,246	65
66	Physical Therapy	1,453,035		1,453,035		1,453,035	66
69	Electrocardiology	128,283		128,283		128,283	69
71	Medical Supplies Charged to Patients	643,966		643,966		643,966	71
72	Impl. Dev. Charged to Patients	485,030		485,030		485,030	72
73	Drugs Charged to Patients	1,920,973		1,920,973		1,920,973	73
76.97	CARDIAC REHABILITATION						76.97
76.98	HYPERBARIC OXYGEN THERAPY						76.98
76.99	LITHOTRIPSY						76.99
	OUTPATIENT SERVICE COST CENTERS						
88	Rural Health Clinic	640,766		640,766		640,766	88
88.01	RHC II	547,867		547,867		547,867	88.01
88.02	RHC III	1,329,280		1,329,280		1,329,280	88.02
88.03	RHC IV	1,830,329		1,830,329		1,830,329	88.03
90	Clinic	488,368		488,368		488,368	90
91	Emergency	2,292,880		2,292,880		2,292,880	91
92	Observation Beds (Non-Distinct Part)	807,141		807,141		807,141	92
93.99	PARTIAL HOSPITALIZATION PROGRAM						93.99
	OTHER REIMBURSABLE COST CENTERS						
95	Ambulance Services	1,667,455		1,667,455		1,667,455	95
101	Home Health Agency	848,882		848,882		848,882	101
113	Interest Expense						113
116	Hospice	1,346,329		1,346,329		1,346,329	116
200	Subtotal (sum of lines 30 thru 199)	29,760,040		29,760,040		29,760,040	200
201	Less Observation Beds	807,141		807,141		807,141	201
202	Total (line 200 minus line 201)	28,952,899		28,952,899		28,952,899	202

KPMG LLP Compu-Max 2552-10

IROQUOIS MEMORIAL HOSPITAL Provider CCN: 14-0167	In Lieu of Form CMS-2552-10	Period : From: 10/01/2017 To: 09/30/2018	Run Date: 02/25/2019 Run Time: 14:01 Version: 2018.12 (02/24/2019)
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COMPUTATION OF RATIO OF COST TO CHARGES
**WORKSHEET C
PART I**

		CHARGES						
	COST CENTER DESCRIPTIONS	Inpatient	Outpatient	Total (column 6 + column 7)	Cost or Other Ratio	TEFRA Inpatient Ratio	PPS Inpatient Ratio	
		6	7	8	9	10	11	
	INPATIENT ROUTINE SERVICE COST CENTERS							
30	Adults & Pediatrics	2,272,825		2,272,825				30
43	Nursery							43
44	Skilled Nursing Facility	2,558,215		2,558,215				44
	ANCILLARY SERVICE COST CENTERS							
50	Operating Room	1,133,342	3,566,281	4,699,623	0.418354	0.418354	0.418354	50
53	Anesthesiology	35,927	25,386	61,313	0.202192	0.202192	0.202192	53
54	Radiology-Diagnostic	535,064	6,816,230	7,351,294	0.256892	0.256892	0.256892	54
57	CT Scan	665,960	6,977,666	7,643,626	0.069662	0.069662	0.069662	57
58	MRI	98,415	1,564,514	1,662,929	0.181896	0.181896	0.181896	58
60	Laboratory	893,408	10,041,940	10,935,348	0.189671	0.189671	0.189671	60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
65	Respiratory Therapy	300,955	516,036	816,991	0.996640	0.996640	0.996640	65
66	Physical Therapy	370,986	2,855,756	3,226,742	0.450310	0.450310	0.450310	66
69	Electrocardiology	261,201	502,810	764,011	0.167907	0.167907	0.167907	69
71	Medical Supplies Charged to Patients	1,168,564	795,579	1,964,143	0.327861	0.327861	0.327861	71
72	Impl. Dev. Charged to Patients	576,709	683,265	1,259,974	0.384952	0.384952	0.384952	72
73	Drugs Charged to Patients	1,611,501	4,332,501	5,944,002	0.323178	0.323178	0.323178	73
76.97	CARDIAC REHABILITATION							76.97
76.98	HYPERBARIC OXYGEN THERAPY							76.98
76.99	LITHOTRIPSY							76.99
	OUTPATIENT SERVICE COST CENTERS							
88	Rural Health Clinic		534,326	534,326				88
88.01	RHC II		340,632	340,632				88.01
88.02	RHC III		1,072,715	1,072,715				88.02
88.03	RHC IV	138	757,856	757,994				88.03
90	Clinic	784	257,943	258,727	1.887580	1.887580	1.887580	90
91	Emergency	431,598	6,744,477	7,176,075	0.319517	0.319517	0.319517	91
92	Observation Beds (Non-Distinct Part)	342,716	984,439	1,327,155	0.608174	0.608174	0.608174	92
93.99	PARTIAL HOSPITALIZATION PROGRAM							93.99
	OTHER REIMBURSABLE COST CENTERS							
95	Ambulance Services		4,202,452	4,202,452	0.396781	0.396781	0.396781	95
101	Home Health Agency		560,540	560,540				101
113	Interest Expense							113
116	Hospice		1,372,289	1,372,289				116
200	Subtotal (sum of lines 30 thru 199)	13,258,308	55,505,633	68,763,941				200
201	Less Observation Beds							201
202	Total (line 200 minus line 201)	13,258,308	55,505,633	68,763,941				202

KPMG LLP Compu-Max 2552-10

IROQUOIS MEMORIAL HOSPITAL Provider CCN: 14-0167	In Lieu of Form CMS-2552-10	Period : From: 10/01/2017 To: 09/30/2018	Run Date: 02/25/2019 Run Time: 14:01 Version: 2018.12 (02/24/2019)
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COMPUTATION OF RATIO OF COST TO CHARGES - TITLE XIX (NOT AN OFFICIAL FORM CMS-2552-10 WORKSHEET)
**WORKSHEET C
PART I**

		COSTS					
	COST CENTER DESCRIPTIONS	Total Cost (B Part I col 26 plus sum of cols 21 & 22)	Therapy Limit Adj.	Total Costs	RCE Dis- allowance	Total Costs	
		1	2	3	4	5	
	INPATIENT ROUTINE SERVICE COST CENTERS						
30	Adults & Pediatrics	2,901,792		2,901,792		2,901,792	30
43	Nursery						43
44	Skilled Nursing Facility	2,837,368		2,837,368		2,837,368	44
	ANCILLARY SERVICE COST CENTERS						
50	Operating Room	1,966,105		1,966,105		1,966,105	50
53	Anesthesiology	12,397		12,397		12,397	53
54	Radiology-Diagnostic	1,888,486		1,888,486		1,888,486	54
57	CT Scan	532,467		532,467		532,467	57
58	MRI	302,480		302,480		302,480	58
60	Laboratory	2,074,115		2,074,115		2,074,115	60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS						62.30
65	Respiratory Therapy	814,246		814,246		814,246	65
66	Physical Therapy	1,453,035		1,453,035		1,453,035	66
69	Electrocardiology	128,283		128,283		128,283	69
71	Medical Supplies Charged to Patients	643,966		643,966		643,966	71
72	Impl. Dev. Charged to Patients	485,030		485,030		485,030	72
73	Drugs Charged to Patients	1,920,973		1,920,973		1,920,973	73
76.97	CARDIAC REHABILITATION						76.97
76.98	HYPERBARIC OXYGEN THERAPY						76.98
76.99	LITHOTRIPSY						76.99
	OUTPATIENT SERVICE COST CENTERS						
88	Rural Health Clinic	640,766		640,766		640,766	88
88.01	RHC II	547,867		547,867		547,867	88.01
88.02	RHC III	1,329,280		1,329,280		1,329,280	88.02
88.03	RHC IV	1,830,329		1,830,329		1,830,329	88.03
90	Clinic	488,368		488,368		488,368	90
91	Emergency	2,292,880		2,292,880		2,292,880	91
92	Observation Beds (Non-Distinct Part)	807,141		807,141		807,141	92
93.99	PARTIAL HOSPITALIZATION PROGRAM						93.99
	OTHER REIMBURSABLE COST CENTERS						
95	Ambulance Services	1,667,455		1,667,455		1,667,455	95
101	Home Health Agency	848,882		848,882		848,882	101
113	Interest Expense						113
116	Hospice	1,346,329		1,346,329		1,346,329	116
200	Subtotal (sum of lines 30 thru 199)	29,760,040		29,760,040		29,760,040	200
201	Less Observation Beds	807,141		807,141		807,141	201
202	Total (line 200 minus line 201)	28,952,899		28,952,899		28,952,899	202

KPMG LLP Compu-Max 2552-10

IROQUOIS MEMORIAL HOSPITAL Provider CCN: 14-0167	In Lieu of Form CMS-2552-10	Period : From: 10/01/2017 To: 09/30/2018	Run Date: 02/25/2019 Run Time: 14:01 Version: 2018.12 (02/24/2019)
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COMPUTATION OF RATIO OF COST TO CHARGES - TITLE XIX (NOT AN OFFICIAL FORM CMS-2552-10 WORKSHEET)
**WORKSHEET C
PART I**

		CHARGES						
	COST CENTER DESCRIPTIONS	Inpatient	Outpatient	Total (column 6 + column 7)	Cost or Other Ratio	TEFRA Inpatient Ratio	PPS Inpatient Ratio	
		6	7	8	9	10	11	
	INPATIENT ROUTINE SERVICE COST CENTERS							
30	Adults & Pediatrics							30
43	Nursery							43
44	Skilled Nursing Facility							44
	ANCILLARY SERVICE COST CENTERS							
50	Operating Room							50
53	Anesthesiology							53
54	Radiology-Diagnostic							54
57	CT Scan							57
58	MRI							58
60	Laboratory							60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
65	Respiratory Therapy							65
66	Physical Therapy							66
69	Electrocardiology							69
71	Medical Supplies Charged to Patients							71
72	Impl. Dev. Charged to Patients							72
73	Drugs Charged to Patients							73
76.97	CARDIAC REHABILITATION							76.97
76.98	HYPERBARIC OXYGEN THERAPY							76.98
76.99	LITHOTRIPSY							76.99
	OUTPATIENT SERVICE COST CENTERS							
88	Rural Health Clinic							88
88.01	RHC II							88.01
88.02	RHC III							88.02
88.03	RHC IV							88.03
90	Clinic							90
91	Emergency							91
92	Observation Beds (Non-Distinct Part)							92
93.99	PARTIAL HOSPITALIZATION PROGRAM							93.99
	OTHER REIMBURSABLE COST CENTERS							
95	Ambulance Services							95
101	Home Health Agency							101
113	Interest Expense							113
116	Hospice							116
200	Subtotal (sum of lines 30 thru 199)							200
201	Less Observation Beds							201
202	Total (line 200 minus line 201)							202

KPMG LLP Compu-Max 2552-10

IROQUOIS MEMORIAL HOSPITAL Provider CCN: 14-0167	In Lieu of Form CMS-2552-10	Period : From: 10/01/2017 To: 09/30/2018	Run Date: 02/25/2019 Run Time: 14:01 Version: 2018.12 (02/24/2019)
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CALCULATION OF OUTPATIENT SERVICE COST TO CHARGE RATIOS NET OF REDUCTIONS FOR MEDICAID ONLY
**WORKSHEET C
PART II**
☐ Title V

☒ Title XIX

	COST CENTER DESCRIPTIONS	Total Cost (Wkst B, Part I, col. 26)	Capital Cost (Wkst B, Part II, col. 26)	Operating Cost Net of Capital Cost (col. 1 - col. 2)	Capital Reduction	
		1	2	3	4	
	ANCILLARY SERVICE COST CENTERS					
50	Operating Room	1,966,105	370,753	1,595,352		50
53	Anesthesiology	12,397	3,818	8,579		53
54	Radiology-Diagnostic	1,888,486	178,162	1,710,324		54
57	CT Scan	532,467	116,652	415,815		57
58	MRI	302,480	2,945	299,535		58
60	Laboratory	2,074,115	94,995	1,979,120		60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS					62.30
65	Respiratory Therapy	814,246	51,867	762,379		65
66	Physical Therapy	1,453,035	154,907	1,298,128		66
69	Electrocardiology	128,283	9,590	118,693		69
71	Medical Supplies Charged to Patients	643,966	3,462	640,504		71
72	Impl. Dev. Charged to Patients	485,030	2,243	482,787		72
73	Drugs Charged to Patients	1,920,973	38,038	1,882,935		73
76.97	CARDIAC REHABILITATION					76.97
76.98	HYPERBARIC OXYGEN THERAPY					76.98
76.99	LITHOTRIPSY					76.99
	OUTPATIENT SERVICE COST CENTERS					
88	Rural Health Clinic	640,766	31,186	609,580		88
88.01	RHC II	547,867	46,993	500,874		88.01
88.02	RHC III	1,329,280	58,053	1,271,227		88.02
88.03	RHC IV	1,830,329	56,504	1,773,825		88.03
90	Clinic	488,368	71,487	416,881		90
91	Emergency	2,292,880	85,436	2,207,444		91
92	Observation Beds (Non-Distinct Part)	807,141	46,599	760,542		92
93.99	PARTIAL HOSPITALIZATION PROGRAM					93.99
	OTHER REIMBURSABLE COST CENTERS					
95	Ambulance Services	1,667,455	78,988	1,588,467		95
101	Home Health Agency	848,882	59,581	789,301		101
113	Interest Expense					113
116	Hospice	1,346,329	159,436	1,186,893		116
200	Subtotal	24,020,880	1,721,695	22,299,185		200
201	Less Observation Beds	807,141	46,599	760,542		201
202	Total	23,213,739	1,675,096	21,538,643		202

KPMG LLP Compu-Max 2552-10

IROQUOIS MEMORIAL HOSPITAL Provider CCN: 14-0167	In Lieu of Form CMS-2552-10	Period : From: 10/01/2017 To: 09/30/2018	Run Date: 02/25/2019 Run Time: 14:01 Version: 2018.12 (02/24/2019)
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CALCULATION OF OUTPATIENT SERVICE COST TO CHARGE RATIOS NET OF REDUCTIONS FOR MEDICAID ONLY
**WORKSHEET C
PART II**
☐ Title V

☒ Title XIX

	COST CENTER DESCRIPTIONS	Operating Cost Reduction Amount	Cost Net of Capital and Operating Cost Reduction	Total Charges (Wkst C, Part I, col. 8)	Outpatient Cost to Charge Ratio(col. 6 ÷ col. 7)	
		5	6	7	8	
	ANCILLARY SERVICE COST CENTERS					
50	Operating Room		1,966,105			50
53	Anesthesiology		12,397			53
54	Radiology-Diagnostic		1,888,486			54
57	CT Scan		532,467			57
58	MRI		302,480			58
60	Laboratory		2,074,115			60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS					62.30
65	Respiratory Therapy		814,246			65
66	Physical Therapy		1,453,035			66
69	Electrocardiology		128,283			69
71	Medical Supplies Charged to Patients		643,966			71
72	Impl. Dev. Charged to Patients		485,030			72
73	Drugs Charged to Patients		1,920,973			73
76.97	CARDIAC REHABILITATION					76.97
76.98	HYPERBARIC OXYGEN THERAPY					76.98
76.99	LITHOTRIPSY					76.99
	OUTPATIENT SERVICE COST CENTERS					
88	Rural Health Clinic		640,766			88
88.01	RHC II		547,867			88.01
88.02	RHC III		1,329,280			88.02
88.03	RHC IV		1,830,329			88.03
90	Clinic		488,368			90
91	Emergency		2,292,880			91
92	Observation Beds (Non-Distinct Part)		807,141	1,327,155	0.608174	92
93.99	PARTIAL HOSPITALIZATION PROGRAM					93.99
	OTHER REIMBURSABLE COST CENTERS					
95	Ambulance Services		1,667,455			95
101	Home Health Agency		848,882			101
113	Interest Expense					113
116	Hospice		1,346,329			116
200	Subtotal		24,020,880	1,327,155		200
201	Less Observation Beds		807,141	1,327,155		201
202	Total		23,213,739			202

KPMG LLP Compu-Max 2552-10

IROQUOIS MEMORIAL HOSPITAL Provider CCN: 14-0167	In Lieu of Form CMS-2552-10	Period : From: 10/01/2017 To: 09/30/2018	Run Date: 02/25/2019 Run Time: 14:01 Version: 2018.12 (02/24/2019)
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APPORTIONMENT OF INPATIENT ROUTINE SERVICE CAPITAL COSTS**WORKSHEET D
PART I**

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

		Capital Related Cost (from Wkst. B, Part II, (col. 26)	Swing Bed Adjust- ment	Reduced Capital Related Cost (col. 1 minus col. 2)	Total Patient Days	Per Diem (col. 3 ÷ col. 4)	Inpatient Program Days	Inpatient Program Capital Cost (col. 5 x col. 6)	
(A)	Cost Center Description	1	2	3	4	5	6	7	
	INPATIENT ROUTINE SERVICE COST CENTERS								
30	Adults & Pediatrics General Routine Care)	167,529		167,529	1,927	86.94	1,086	94,417	30
31	Intensive Care Unit								31
32	Coronary Care Unit								32
33	Burn Intensive Care Unit								33
34	Surgical Intensive Care Unit								34
35	Other Special Care (specify)								35
40	Subprovider - IPF								40
41	Subprovider - IRF								41
42	Subprovider I								42
43	Nursery				132				43
44	Skilled Nursing Facility	173,116		173,116	10,219	16.94	1,535	26,003	44
45	Nursing Facility								45
200	Total (lines 30-199)	340,645		340,645	12,278		2,621	120,420	200

(A) Worksheet A line numbers

KPMG LLP Compu-Max 2552-10

IROQUOIS MEMORIAL HOSPITAL Provider CCN: 14-0167	In Lieu of Form CMS-2552-10	Period : From: 10/01/2017 To: 09/30/2018	Run Date: 02/25/2019 Run Time: 14:01 Version: 2018.12 (02/24/2019)
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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

		Capital Related Cost (from Wkst. B, Part II (col. 26)	Total Charges (from Wkst. C, Part I, (col. 8)	Ratio of Cost to Charges (col. 1 ÷ col. 2)	Inpatient Program Charges	Capital Costs (col. 3 x col. 4)	
(A)	Cost Center Description	1	2	3	4	5	
	ANCILLARY SERVICE COST CENTERS						
50	Operating Room	370,753	4,699,623	0.078890	771,075	60,830	50
53	Anesthesiology	3,818	61,313	0.062271	33,927	2,113	53
54	Radiology-Diagnostic	178,162	7,351,294	0.024235	525,145	12,727	54
57	CT Scan	116,652	7,643,626	0.015261	656,945	10,026	57
58	MRI	2,945	1,662,929	0.001771	29,257	52	58
60	Laboratory	94,995	10,935,348	0.008687	877,667	7,624	60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS						62.30
65	Respiratory Therapy	51,867	816,991	0.063485	277,618	17,625	65
66	Physical Therapy	154,907	3,226,742	0.048007	104,164	5,001	66
69	Electrocardiology	9,590	764,011	0.012552	252,306	3,167	69
71	Medical Supplies Charged to Pat	3,462	1,964,143	0.001763	605,078	1,067	71
72	Impl. Dev. Charged to Patients	2,243	1,259,974	0.001780	525,948	936	72
73	Drugs Charged to Patients	38,038	5,944,002	0.006399	1,448,078	9,266	73
76.97	CARDIAC REHABILITATION						76.97
76.98	HYPERBARIC OXYGEN THERAPY						76.98
76.99	LITHOTRIPSY						76.99
	OUTPATIENT SERVICE COST CENTERS						
88	Rural Health Clinic	31,186	534,326	0.058365			88
88.01	RHC II	46,993	340,632	0.137958			88.01
88.02	RHC III	58,053	1,072,715	0.054118			88.02
88.03	RHC IV	56,504	757,994	0.074544			88.03
90	Clinic	71,487	258,727	0.276303			90
91	Emergency	85,436	7,176,075	0.011906	401,102	4,776	91
92	Observation Beds (Non-Distinct	46,599	1,327,155	0.035112	224,300	7,876	92
93.99	PARTIAL HOSPITALIZATION PROGRAM						93.99
	OTHER REIMBURSABLE COST CENTERS						
95	Ambulance Services						95
200	Total (sum of lines 50-199)	1,423,690	57,797,620		6,732,610	143,086	200

(A) Worksheet A line numbers

KPMG LLP Compu-Max 2552-10

IROQUOIS MEMORIAL HOSPITAL Provider CCN: 14-0167	In Lieu of Form CMS-2552-10	Period : From: 10/01/2017 To: 09/30/2018	Run Date: 02/25/2019 Run Time: 14:01 Version: 2018.12 (02/24/2019)
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APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PASS THROUGH COSTS

WORKSHEET D PART III

Check ☐ Title V
Applicable ☒ Title XVIII, Part A
Boxes: ☐ Title XIX

☒ PPS
☐ TEFRA
☐ Other

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

(A) Worksheet A line numbers

KPMG LLP Compu-Max 2552-10

IROQUOIS MEMORIAL HOSPITAL Provider CCN: 14-0167	In Lieu of Form CMS-2552-10	Period : From: 10/01/2017 To: 09/30/2018	Run Date: 02/25/2019 Run Time: 14:01 Version: 2018.12 (02/24/2019)
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APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PASS THROUGH COSTS

WORKSHEET D
PART III

Check
Applicable
Boxes:

☐ Title V
☒ Title XVIII, Part A
☐ Title XIX

☒ PPS
☐ TEFRA
☐ Other

		Total Patient Days	Per Diem (col. 5÷ col. 6)	Inpatient Program Days	Inpatient Program Pass- Through Cost (col. 7 x col. 8)	
(A)	Cost Center Description	6	7	8	9	
	INPATIENT ROUTINE SERVICE COST CENTERS					
30	Adults & Pediatrics (General Routine Care)	1,927		1,086		30
31	Intensive Care Unit					31
32	Coronary Care Unit					32
33	Burn Intensive Care Unit					33
34	Surgical Intensive Care Unit					34
35	Other Special Care (specify)					35
40	Subprovider - IPF					40
41	Subprovider - IRF					41
42	Subprovider I					42
43	Nursery	132				43
44	Skilled Nursing Facility	10,219		1,535		44
45	Nursing Facility					45
200	Total (lines 30-199)	12,278		2,621		200

(A) Worksheet A line numbers

KPMG LLP Compu-Max 2552-10

IROQUOIS MEMORIAL HOSPITAL Provider CCN: 14-0167	In Lieu of Form CMS-2552-10	Period : From: 10/01/2017 To: 09/30/2018	Run Date: 02/25/2019 Run Time: 14:01 Version: 2018.12 (02/24/2019)
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APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE
OTHER PASS THROUGH COSTS

COMPONENT CCN: 14-0167

WORKSHEET D
PART IV

Check
Applicable
Boxes:

☐ Title V
☒ Title XVIII, Part A
☐ Title XIX

☒ Hospital
☐ IPF
☐ IRF

☐ SUB (Other)
☐ SNF
☐ NF

☐ ICF/IID

☒ PPS
☐ TEFRA
☐ Other

		Non Physician Anesth- etist Cost	Nursing School Post- Stepdown Adjustments	Nursing School	Allied Health Post- Stepdown Adjustments	Allied Health	All Other Medical Education Cost	Total Cost (sum of col. 1 through col. 4)	Total Outpatient Cost (sum of col. 2, 3, and 4)	
(A)	Cost Center Description	1	2A	2	3A	3	4	5	6	
	ANCILLARY SERVICE COST CENTERS									
50	Operating Room									50
53	Anesthesiology									53
54	Radiology-Diagnostic									54
57	CT Scan									57
58	MRI									58
60	Laboratory									60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS									62.30
65	Respiratory Therapy									65
66	Physical Therapy									66
69	Electrocardiology									69
71	Medical Supplies Charged to Pat									71
72	Impl. Dev. Charged to Patients									72
73	Drugs Charged to Patients									73
76.97	CARDIAC REHABILITATION									76.97
76.98	HYPERBARIC OXYGEN THERAPY									76.98
76.99	LITHOTRIPSY									76.99
	OUTPATIENT SERVICE COST CENTERS									
88	Rural Health Clinic									88
88.01	RHC II									88.01
88.02	RHC III									88.02
88.03	RHC IV									88.03
90	Clinic									90
91	Emergency									91
92	Observation Beds (Non-Distinct									92
93.99	PARTIAL HOSPITALIZATION PROGRAM									93.99
	OTHER REIMBURSABLE COST CENTERS									
95	Ambulance Services									95
200	Total (sum of lines 50-199)									200

(A) Worksheet A line numbers

KPMG LLP Compu-Max 2552-10

IROQUOIS MEMORIAL HOSPITAL Provider CCN: 14-0167	In Lieu of Form CMS-2552-10	Period : From: 10/01/2017 To: 09/30/2018	Run Date: 02/25/2019 Run Time: 14:01 Version: 2018.12 (02/24/2019)
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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)	
	ANCILLARY SERVICE COST CENTERS								
50	Operating Room	4,699,623			771,075		1,339,612		50
53	Anesthesiology	61,313			33,927		24,386		53
54	Radiology-Diagnostic	7,351,294			525,145		2,974,194		54
57	CT Scan	7,643,626			656,945		2,763,921		57
58	MRI	1,662,929			29,257		552,225		58
60	Laboratory	10,935,348			877,667		1,374,678		60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS								62.30
65	Respiratory Therapy	816,991			277,618		343,103		65
66	Physical Therapy	3,226,742			104,164		12,012		66
69	Electrocardiology	764,011			252,306		488,826		69
71	Medical Supplies Charged to Pat	1,964,143			605,078		210,777		71
72	Impl. Dev. Charged to Patients	1,259,974			525,948		666,244		72
73	Drugs Charged to Patients	5,944,002			1,448,078		2,643,876		73
76.97	CARDIAC REHABILITATION								76.97
76.98	HYPERBARIC OXYGEN THERAPY								76.98
76.99	LITHOTRIPSY								76.99
	OUTPATIENT SERVICE COST CENTERS								
88	Rural Health Clinic	534,326							88
88.01	RHC II	340,632							88.01
88.02	RHC III	1,072,715							88.02
88.03	RHC IV	757,994							88.03
90	Clinic	258,727					892		90
91	Emergency	7,176,075			401,102		1,660,733		91
92	Observation Beds (Non-Distinct	1,327,155			224,300		554,298		92
93.99	PARTIAL HOSPITALIZATION PROGRAM								93.99
	OTHER REIMBURSABLE COST CENTERS								
95	Ambulance Services								95
200	Total (sum of lines 50-199)	57,797,620			6,732,610		15,609,777		200

(A) Worksheet A line numbers

KPMG LLP Compu-Max 2552-10

IROQUOIS MEMORIAL HOSPITAL Provider CCN: 14-0167	In Lieu of Form CMS-2552-10	Period : From: 10/01/2017 To: 09/30/2018	Run Date: 02/25/2019 Run Time: 14:01 Version: 2018.12 (02/24/2019)
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APPORTIONMENT OF MEDICAL AND OTHER HEALTH SERVICE COSTS

COMPONENT CCN: 14-0167

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.)	
(A)	Cost Center Description	1	2	3	4	5	6	7	
	ANCILLARY SERVICE COST CENTERS								
50	Operating Room	0.418354	1,339,612			560,432			50
53	Anesthesiology	0.202192	24,386			4,931			53
54	Radiology-Diagnostic	0.256892	2,974,194			764,047			54
57	CT Scan	0.069662	2,763,921			192,540			57
58	MRI	0.181896	552,225			100,448			58
60	Laboratory	0.189671	1,374,678			260,737			60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS								62.30
65	Respiratory Therapy	0.996640	343,103			341,950			65
66	Physical Therapy	0.450310	12,012			5,409			66
69	Electrocardiology	0.167907	488,826			82,077			69
71	Medical Supplies Charged to Pat	0.327861	210,777			69,106			71
72	Impl. Dev. Charged to Patients	0.384952	666,244			256,472			72
73	Drugs Charged to Patients	0.323178	2,643,876			854,443			73
76.97	CARDIAC REHABILITATION								76.97
76.98	HYPERBARIC OXYGEN THERAPY								76.98
76.99	LITHOTRIPSY								76.99
	OUTPATIENT SERVICE COST CENTERS								
88	Rural Health Clinic								88
88.01	RHC II								88.01
88.02	RHC III								88.02
88.03	RHC IV								88.03
90	Clinic	1.887580	892			1,684			90
91	Emergency	0.319517	1,660,733			530,632			91
92	Observation Beds (Non-Distinct	0.608174	554,298			337,110			92
93.99	PARTIAL HOSPITALIZATION PROGRAM								93.99
	OTHER REIMBURSABLE COST CENTERS								
95	Ambulance Services	0.396781							95
200	Subtotal (see instructions)		15,609,777			4,362,018			200
201	Less PBP Clinic Lab. Services-Program Only Charges								201
202	Net Charges (line 200 - line 201)		15,609,777			4,362,018			202

(A) Worksheet A line numbers

KPMG LLP Compu-Max 2552-10

IROQUOIS MEMORIAL HOSPITAL Provider CCN: 14-0167	In Lieu of Form CMS-2552-10	Period : From: 10/01/2017 To: 09/30/2018	Run Date: 02/25/2019 Run Time: 14:01 Version: 2018.12 (02/24/2019)
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APPORTIONMENT OF MEDICAL AND OTHER HEALTH SERVICE COSTS

COMPONENT CCN: 14-U167

WORKSHEET D PART V

Check [] Title V - O/P [] Hospital [] SUB (Other) [XX] 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	Cost to Charge Ratio (from Wkst C, Part I, col. 9)	Program Charges			Program Cost			
			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.)	
	ANCILLARY SERVICE COST CENTERS								
50	Operating Room	0.418354							50
53	Anesthesiology	0.202192							53
54	Radiology-Diagnostic	0.256892							54
57	CT Scan	0.069662							57
58	MRI	0.181896							58
60	Laboratory	0.189671							60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS								62.30
65	Respiratory Therapy	0.996640							65
66	Physical Therapy	0.450310							66
69	Electrocardiology	0.167907							69
71	Medical Supplies Charged to Pat	0.327861							71
72	Impl. Dev. Charged to Patients	0.384952							72
73	Drugs Charged to Patients	0.323178							73
76.97	CARDIAC REHABILITATION								76.97
76.98	HYPERBARIC OXYGEN THERAPY								76.98
76.99	LITHOTRIPSY								76.99
	OUTPATIENT SERVICE COST CENTERS								
88	Rural Health Clinic								88
88.01	RHC II								88.01
88.02	RHC III								88.02
88.03	RHC IV								88.03
90	Clinic	1.887580							90
91	Emergency	0.319517							91
92	Observation Beds (Non-Distinct	0.608174							92
93.99	PARTIAL HOSPITALIZATION PROGRAM								93.99
	OTHER REIMBURSABLE COST CENTERS								
95	Ambulance Services	0.396781							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

KPMG LLP Compu-Max 2552-10

IROQUOIS MEMORIAL HOSPITAL Provider CCN: 14-0167	In Lieu of Form CMS-2552-10	Period : From: 10/01/2017 To: 09/30/2018	Run Date: 02/25/2019 Run Time: 14:01 Version: 2018.12 (02/24/2019)
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APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE
OTHER PASS THROUGH COSTS

COMPONENT CCN: 14-6049

WORKSHEET D
PART IV

Check
Applicable
Boxes:

☐ Title V
☒ Title XVIII, Part A
☐ Title XIX

☐ Hospital
☐ IPF
☐ IRF

☐ SUB (Other)
☒ SNF
☐ NF

☐ ICF/IID

☒ PPS
☐ TEFRA
☐ Other

		Non Physician Anesth- etist Cost	Nursing School Post- Stepdown Adjustments	Nursing School	Allied Health Post- Stepdown Adjustments	Allied Health	All Other Medical Education Cost	Total Cost (sum of col. 1 through col. 4)	Total Outpatient Cost (sum of col. 2, 3, and 4)	
(A)	Cost Center Description	1	2A	2	3A	3	4	5	6	
	ANCILLARY SERVICE COST CENTERS									
50	Operating Room									50
53	Anesthesiology									53
54	Radiology-Diagnostic									54
57	CT Scan									57
58	MRI									58
60	Laboratory									60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS									62.30
65	Respiratory Therapy									65
66	Physical Therapy									66
69	Electrocardiology									69
71	Medical Supplies Charged to Pat									71
72	Impl. Dev. Charged to Patients									72
73	Drugs Charged to Patients									73
76.97	CARDIAC REHABILITATION									76.97
76.98	HYPERBARIC OXYGEN THERAPY									76.98
76.99	LITHOTRIPSY									76.99
	OUTPATIENT SERVICE COST CENTERS									
88	Rural Health Clinic									88
88.01	RHC II									88.01
88.02	RHC III									88.02
88.03	RHC IV									88.03
90	Clinic									90
91	Emergency									91
92	Observation Beds (Non-Distinct									92
93.99	PARTIAL HOSPITALIZATION PROGRAM									93.99
	OTHER REIMBURSABLE COST CENTERS									
95	Ambulance Services									95
200	Total (sum of lines 50-199)									200

(A) Worksheet A line numbers

KPMG LLP Compu-Max 2552-10

IROQUOIS MEMORIAL HOSPITAL Provider CCN: 14-0167	In Lieu of Form CMS-2552-10	Period : From: 10/01/2017 To: 09/30/2018	Run Date: 02/25/2019 Run Time: 14:01 Version: 2018.12 (02/24/2019)
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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

		Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 5 ÷ col. 7)	Outpatient Ratio of Cost to Charges (col. 6 ÷ col. 7)	Inpatient Program Charges	Inpatient Program Pass- Through Costs (col. 8 x col. 10)	Outpatient Program Charges	Outpatient Program Pass- Through Costs (col. 9 x col. 12)	
(A)	Cost Center Description	7	8	9	10	11	12	13	
	ANCILLARY SERVICE COST CENTERS								
50	Operating Room	4,699,623							50
53	Anesthesiology	61,313							53
54	Radiology-Diagnostic	7,351,294			3,163				54
57	CT Scan	7,643,626							57
58	MRI	1,662,929							58
60	Laboratory	10,935,348			3,704				60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS								62.30
65	Respiratory Therapy	816,991			2,471				65
66	Physical Therapy	3,226,742			264,566				66
69	Electrocardiology	764,011			1,697				69
71	Medical Supplies Charged to Pat	1,964,143			2,774				71
72	Impl. Dev. Charged to Patients	1,259,974							72
73	Drugs Charged to Patients	5,944,002			83,428				73
76.97	CARDIAC REHABILITATION								76.97
76.98	HYPERBARIC OXYGEN THERAPY								76.98
76.99	LITHOTRIPSY								76.99
	OUTPATIENT SERVICE COST CENTERS								
88	Rural Health Clinic	534,326							88
88.01	RHC II	340,632							88.01
88.02	RHC III	1,072,715							88.02
88.03	RHC IV	757,994							88.03
90	Clinic	258,727							90
91	Emergency	7,176,075							91
92	Observation Beds (Non-Distinct	1,327,155							92
93.99	PARTIAL HOSPITALIZATION PROGRAM								93.99
	OTHER REIMBURSABLE COST CENTERS								
95	Ambulance Services								95
200	Total (sum of lines 50-199)	57,797,620			361,803				200

(A) Worksheet A line numbers

KPMG LLP Compu-Max 2552-10

IROQUOIS MEMORIAL HOSPITAL Provider CCN: 14-0167	In Lieu of Form CMS-2552-10	Period : From: 10/01/2017 To: 09/30/2018	Run Date: 02/25/2019 Run Time: 14:01 Version: 2018.12 (02/24/2019)
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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 ☒ Title XVIII, Part B ☐ IPF ☒ SNF ☐ Swing Bed NF
 Boxes: ☐ Title XIX - O/P ☐ IRF ☐ NF ☐ ICF/IID

(A)	Cost Center Description	Cost to Charge Ratio (from Wkst C, Part I, col. 9)	Program Charges			Program Cost			
			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.)	
	ANCILLARY SERVICE COST CENTERS								
50	Operating Room	0.418354							50
53	Anesthesiology	0.202192							53
54	Radiology-Diagnostic	0.256892							54
57	CT Scan	0.069662							57
58	MRI	0.181896							58
60	Laboratory	0.189671							60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS								62.30
65	Respiratory Therapy	0.996640							65
66	Physical Therapy	0.450310							66
69	Electrocardiology	0.167907							69
71	Medical Supplies Charged to Pat	0.327861							71
72	Impl. Dev. Charged to Patients	0.384952							72
73	Drugs Charged to Patients	0.323178							73
76.97	CARDIAC REHABILITATION								76.97
76.98	HYPERBARIC OXYGEN THERAPY								76.98
76.99	LITHOTRIPSY								76.99
	OUTPATIENT SERVICE COST CENTERS								
88	Rural Health Clinic								88
88.01	RHC II								88.01
88.02	RHC III								88.02
88.03	RHC IV								88.03
90	Clinic	1.887580							90
91	Emergency	0.319517							91
92	Observation Beds (Non-Distinct	0.608174							92
93.99	PARTIAL HOSPITALIZATION PROGRAM								93.99
	OTHER REIMBURSABLE COST CENTERS								
95	Ambulance Services	0.396781							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

KPMG LLP Compu-Max 2552-10

IROQUOIS MEMORIAL HOSPITAL Provider CCN: 14-0167	In Lieu of Form CMS-2552-10	Period : From: 10/01/2017 To: 09/30/2018	Run Date: 02/25/2019 Run Time: 14:01 Version: 2018.12 (02/24/2019)
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APPORTIONMENT OF INPATIENT ROUTINE SERVICE CAPITAL COSTS

WORKSHEET D PART I

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

		Capital Related Cost (from Wkst. B, Part II, (col. 26)	Swing Bed Adjust- ment	Reduced Capital Related Cost (col. 1 minus col. 2)	Total Patient Days	Per Diem (col. 3 ÷ col. 4)	Inpatient Program Days	Inpatient Program Capital Cost (col. 5 x col. 6)	
(A)	Cost Center Description	1	2	3	4	5	6	7	
	INPATIENT ROUTINE SERVICE COST CENTERS								
30	Adults & Pediatrics General Routine Care)	167,529		167,529	1,927	86.94	45	3,912	30
31	Intensive Care Unit								31
32	Coronary Care Unit								32
33	Burn Intensive Care Unit								33
34	Surgical Intensive Care Unit								34
35	Other Special Care (specify)								35
40	Subprovider - IPF								40
41	Subprovider - IRF								41
42	Subprovider I								42
43	Nursery				132				43
44	Skilled Nursing Facility	173,116		173,116	10,219	16.94			44
45	Nursing Facility								45
200	Total (lines 30-199)	340,645		340,645	12,278		45	3,912	200

(A) Worksheet A line numbers

KPMG LLP Compu-Max 2552-10

IROQUOIS MEMORIAL HOSPITAL Provider CCN: 14-0167	In Lieu of Form CMS-2552-10	Period : From: 10/01/2017 To: 09/30/2018	Run Date: 02/25/2019 Run Time: 14:01 Version: 2018.12 (02/24/2019)
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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

		Capital Related Cost (from Wkst. B, Part II (col. 26)	Total Charges (from Wkst. C, Part I, (col. 8)	Ratio of Cost to Charges (col. 1 ÷ col. 2)	Inpatient Program Charges	Capital Costs (col. 3 x col. 4)	
(A)	Cost Center Description	1	2	3	4	5	
	ANCILLARY SERVICE COST CENTERS						
50	Operating Room	370,753	4,699,623	0.078890			50
53	Anesthesiology	3,818	61,313	0.062271			53
54	Radiology-Diagnostic	178,162	7,351,294	0.024235			54
57	CT Scan	116,652	7,643,626	0.015261			57
58	MRI	2,945	1,662,929	0.001771			58
60	Laboratory	94,995	10,935,348	0.008687			60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS						62.30
65	Respiratory Therapy	51,867	816,991	0.063485			65
66	Physical Therapy	154,907	3,226,742	0.048007			66
69	Electrocardiology	9,590	764,011	0.012552			69
71	Medical Supplies Charged to Pat	3,462	1,964,143	0.001763			71
72	Impl. Dev. Charged to Patients	2,243	1,259,974	0.001780			72
73	Drugs Charged to Patients	38,038	5,944,002	0.006399			73
76.97	CARDIAC REHABILITATION						76.97
76.98	HYPERBARIC OXYGEN THERAPY						76.98
76.99	LITHOTRIPSY						76.99
	OUTPATIENT SERVICE COST CENTERS						
88	Rural Health Clinic	31,186	534,326	0.058365			88
88.01	RHC II	46,993	340,632	0.137958			88.01
88.02	RHC III	58,053	1,072,715	0.054118			88.02
88.03	RHC IV	56,504	757,994	0.074544			88.03
90	Clinic	71,487	258,727	0.276303			90
91	Emergency	85,436	7,176,075	0.011906			91
92	Observation Beds (Non-Distinct	46,599	1,327,155	0.035112			92
93.99	PARTIAL HOSPITALIZATION PROGRAM						93.99
	OTHER REIMBURSABLE COST CENTERS						
95	Ambulance Services						95
200	Total (sum of lines 50-199)	1,423,690	57,797,620				200

(A) Worksheet A line numbers

KPMG LLP Compu-Max 2552-10

IROQUOIS MEMORIAL HOSPITAL Provider CCN: 14-0167	In Lieu of Form CMS-2552-10	Period : From: 10/01/2017 To: 09/30/2018	Run Date: 02/25/2019 Run Time: 14:01 Version: 2018.12 (02/24/2019)
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APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PASS THROUGH COSTS

WORKSHEET D
PART III

Check
Applicable
Boxes:

☐ Title V
☐ Title XVIII, Part A
☒ Title XIX

☒ PPS
☐ TEFRA
☐ Other

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

(A) Worksheet A line numbers

KPMG LLP Compu-Max 2552-10

IROQUOIS MEMORIAL HOSPITAL Provider CCN: 14-0167	In Lieu of Form CMS-2552-10	Period : From: 10/01/2017 To: 09/30/2018	Run Date: 02/25/2019 Run Time: 14:01 Version: 2018.12 (02/24/2019)
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APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PASS THROUGH COSTS

WORKSHEET D
PART III

Check
Applicable
Boxes:

☐ Title V
☐ Title XVIII, Part A
☒ Title XIX

☒ PPS
☐ TEFRA
☐ Other

		Total Patient Days	Per Diem (col. 5÷ col. 6)	Inpatient Program Days	Inpatient Program Pass- Through Cost (col. 7 x col. 8)	
(A)	Cost Center Description	6	7	8	9	
	INPATIENT ROUTINE SERVICE COST CENTERS					
30	Adults & Pediatrics (General Routine Care)	1,927		45		30
31	Intensive Care Unit					31
32	Coronary Care Unit					32
33	Burn Intensive Care Unit					33
34	Surgical Intensive Care Unit					34
35	Other Special Care (specify)					35
40	Subprovider - IPF					40
41	Subprovider - IRF					41
42	Subprovider I					42
43	Nursery	132				43
44	Skilled Nursing Facility	10,219				44
45	Nursing Facility					45
200	Total (lines 30-199)	12,278		45		200

(A) Worksheet A line numbers

KPMG LLP Compu-Max 2552-10

IROQUOIS MEMORIAL HOSPITAL Provider CCN: 14-0167	In Lieu of Form CMS-2552-10	Period : From: 10/01/2017 To: 09/30/2018	Run Date: 02/25/2019 Run Time: 14:01 Version: 2018.12 (02/24/2019)
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APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE
OTHER PASS THROUGH COSTS

COMPONENT CCN: 14-0167

WORKSHEET D
PART IV

Check
Applicable
Boxes:

☐ Title V
☐ Title XVIII, Part A
☒ Title XIX

☒ Hospital
☐ IPF
☐ IRF

☐ SUB (Other)
☐ SNF
☐ NF

☐ ICF/IID

☒ PPS
☐ TEFRA
☐ Other

		Non Physician Anesth- etist Cost	Nursing School Post- Stepdown Adjustments	Nursing School	Allied Health Post- Stepdown Adjustments	Allied Health	All Other Medical Education Cost	Total Cost (sum of col. 1 through col. 4)	Total Outpatient Cost (sum of col. 2, 3, and 4)	
(A)	Cost Center Description	1	2A	2	3A	3	4	5	6	
	ANCILLARY SERVICE COST CENTERS									
50	Operating Room									50
53	Anesthesiology									53
54	Radiology-Diagnostic									54
57	CT Scan									57
58	MRI									58
60	Laboratory									60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS									62.30
65	Respiratory Therapy									65
66	Physical Therapy									66
69	Electrocardiology									69
71	Medical Supplies Charged to Pat									71
72	Impl. Dev. Charged to Patients									72
73	Drugs Charged to Patients									73
76.97	CARDIAC REHABILITATION									76.97
76.98	HYPERBARIC OXYGEN THERAPY									76.98
76.99	LITHOTRIPSY									76.99
	OUTPATIENT SERVICE COST CENTERS									
88	Rural Health Clinic									88
88.01	RHC II									88.01
88.02	RHC III									88.02
88.03	RHC IV									88.03
90	Clinic									90
91	Emergency									91
92	Observation Beds (Non-Distinct									92
93.99	PARTIAL HOSPITALIZATION PROGRAM									93.99
	OTHER REIMBURSABLE COST CENTERS									
95	Ambulance Services									95
200	Total (sum of lines 50-199)									200

(A) Worksheet A line numbers

KPMG LLP Compu-Max 2552-10

IROQUOIS MEMORIAL HOSPITAL Provider CCN: 14-0167	In Lieu of Form CMS-2552-10	Period : From: 10/01/2017 To: 09/30/2018	Run Date: 02/25/2019 Run Time: 14:01 Version: 2018.12 (02/24/2019)
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APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE
OTHER PASS THROUGH COSTS

COMPONENT CCN: 14-0167

WORKSHEET D
PART IV

Check
Applicable
Boxes:

☐ Title V
☐ Title XVIII, Part A
☒ Title XIX

☒ Hospital
☐ IPF
☐ IRF

☐ SUB (Other)
☐ SNF
☐ NF

☐ ICF/IID

☒ PPS
☐ TEFRA
☐ Other

		Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 5÷ col. 7)	Outpatient Ratio of Cost to Charges (col. 6÷ col. 7)	Inpatient Program Charges	Inpatient Program Pass- Through Costs (col. 8 x col. 10)	Outpatient Program Charges	Outpatient Program Pass- Through Costs (col. 9 x col. 12)	
(A)	Cost Center Description	7	8	9	10	11	12	13	
	ANCILLARY SERVICE COST CENTERS								
50	Operating Room								50
53	Anesthesiology								53
54	Radiology-Diagnostic								54
57	CT Scan								57
58	MRI								58
60	Laboratory								60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS								62.30
65	Respiratory Therapy								65
66	Physical Therapy								66
69	Electrocardiology								69
71	Medical Supplies Charged to Pat								71
72	Impl. Dev. Charged to Patients								72
73	Drugs Charged to Patients								73
76.97	CARDIAC REHABILITATION								76.97
76.98	HYPERBARIC OXYGEN THERAPY								76.98
76.99	LITHOTRIPSY								76.99
	OUTPATIENT SERVICE COST CENTERS								
88	Rural Health Clinic								88
88.01	RHC II								88.01
88.02	RHC III								88.02
88.03	RHC IV								88.03
90	Clinic								90
91	Emergency								91
92	Observation Beds (Non-Distinct								92
93.99	PARTIAL HOSPITALIZATION PROGRAM								93.99
	OTHER REIMBURSABLE COST CENTERS								
95	Ambulance Services								95
200	Total (sum of lines 50-199)								200

(A) Worksheet A line numbers

KPMG LLP Compu-Max 2552-10

IROQUOIS MEMORIAL HOSPITAL Provider CCN: 14-0167	In Lieu of Form CMS-2552-10	Period : From: 10/01/2017 To: 09/30/2018	Run Date: 02/25/2019 Run Time: 14:01 Version: 2018.12 (02/24/2019)
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APPORTIONMENT OF MEDICAL AND OTHER HEALTH SERVICE COSTS

COMPONENT CCN: 14-0167

WORKSHEET D
PART V

Check
Applicable
Boxes:

[] Title V - O/P

[] Title XVIII, Part B

[XX] Title XIX - O/P

[XX] Hospital

[] IPF

[] IRF

[] SUB (Other)

[] SNF

[] NF

[] Swing Bed SNF

[] Swing Bed NF

[] ICF/IID

(A)	Cost Center Description	Cost to Charge Ratio (from Wkst C, Part I, col. 9)	Program Charges			Program Cost			
			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	
	ANCILLARY SERVICE COST CENTERS								
50	Operating Room								50
53	Anesthesiology								53
54	Radiology-Diagnostic								54
57	CT Scan								57
58	MRI								58
60	Laboratory								60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS								62.30
65	Respiratory Therapy								65
66	Physical Therapy								66
69	Electrocardiology								69
71	Medical Supplies Charged to Pat								71
72	Impl. Dev. Charged to Patients								72
73	Drugs Charged to Patients								73
76.97	CARDIAC REHABILITATION								76.97
76.98	HYPERBARIC OXYGEN THERAPY								76.98
76.99	LITHOTRIPSY								76.99
	OUTPATIENT SERVICE COST CENTERS								
88	Rural Health Clinic								88
88.01	RHC II								88.01
88.02	RHC III								88.02
88.03	RHC IV								88.03
90	Clinic								90
91	Emergency								91
92	Observation Beds (Non-Distinct								92
93.99	PARTIAL HOSPITALIZATION PROGRAM								93.99
	OTHER REIMBURSABLE COST CENTERS								
95	Ambulance Services								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

KPMG LLP Compu-Max 2552-10

IROQUOIS MEMORIAL HOSPITAL Provider CCN: 14-0167	In Lieu of Form CMS-2552-10	Period : From: 10/01/2017 To: 09/30/2018	Run Date: 02/25/2019 Run Time: 14:01 Version: 2018.12 (02/24/2019)
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COMPUTATION OF INPATIENT OPERATING COST**COMPONENT CCN: 14-0167****WORKSHEET D-1
PART I**

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 I - ALL PROVIDER COMPONENTS**INPATIENT DAYS**

1	Inpatient days (including private room days and swing-bed days, excluding newborn)	1,927	1
2	Inpatient days (including private room days, excluding swing-bed and newborn days)	1,927	2
3	Private room days (excluding swing-bed private room days). If you have only private room days, do not complete this line.		3
4	Semi-private room days (excluding swing-bed private room days)	1,391	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)	1,086	9
10	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) through December 31 of the cost reporting period (see instructions)		10
11	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		11
12	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) through December 31 of the cost reporting period		12
13	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		13
14	Medically necessary private room days applicable to the program (excluding swing-bed days)		14
15	Total nursery days (title V or XIX only)		15
16	Nursery days (title V or XIX only)		16

SWING-BED ADJUSTMENT

17	Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost reporting period	212.56	17
18	Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period	218.85	18
19	Medicaid rate for swing-bed NF services applicable to services through December 31 of the cost reporting period		19
20	Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period		20
21	Total general inpatient routine service cost (see instructions)	2,901,792	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)	2,901,792	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)	2,901,792	37

KPMG LLP Compu-Max 2552-10

IROQUOIS MEMORIAL HOSPITAL Provider CCN: 14-0167	In Lieu of Form CMS-2552-10	Period : From: 10/01/2017 To: 09/30/2018	Run Date: 02/25/2019 Run Time: 14:01 Version: 2018.12 (02/24/2019)
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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	
38	Adjusted general inpatient routine service cost per diem (see instructions)						1,505.86	38
39	Program general inpatient routine service cost (line 9 x line 38)						1,635,364	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)						1,635,364	41
		Total Inpatient Cost	Total Inpatient Days	Average Per Diem (col. 1 ÷ col. 2)	Program Days	Program Cost (col. 3 x col. 4)		
		1	2	3	4	5		
42	Nursery (Titles V and XIX only)							42
	Intensive Care Type Inpatient Hospital Units							
43	Intensive Care Unit							43
44	Coronary Care Unit							44
45	Burn Intensive Care Unit							45
46	Surgical Intensive Care Unit							46
47	Other Special Care (specify)							47
							1	
48	Program inpatient ancillary service cost (Wkst. D-3, col. 3, line 200)						2,181,262	48
49	Total program inpatient costs (sum of lines 41 through 48)(see instructions)						3,816,626	49
PASS THROUGH COST ADJUSTMENTS								
50	Pass through costs applicable to Program inpatient routine services (from Wkst. D, sum of Parts I and III)						94,417	50
51	Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)						143,086	51
52	Total Program excludable cost (sum of lines 50 and 51)						237,503	52
53	Total Program inpatient operating cost excluding capital related, nonphysician anesthetist and medical education costs (line 49 minus line 52)						3,579,123	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

KPMG LLP Compu-Max 2552-10

IROQUOIS MEMORIAL HOSPITAL Provider CCN: 14-0167	In Lieu of Form CMS-2552-10	Period : From: 10/01/2017 To: 09/30/2018	Run Date: 02/25/2019 Run Time: 14:01 Version: 2018.12 (02/24/2019)
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COMPUTATION OF INPATIENT OPERATING COST

COMPONENT CCN: 14-0167

WORKSHEET D-1
PARTS III & IV

Check
Applicable
Boxes:

☐ Title V - I/P

☒ Title XVIII, Part A

☐ Title XIX - I/P

☒ Hospital

☐ IPF

☐ IRF

☐ SUB (Other)

☐ SNF

☐ NF

☐ ICF/IID

☒ PPS

☐ TEFRA

☐ Other

PART IV - COMPUTATION OF OBSERVATION BED PASS-THROUGH COST

87	Total observation bed days (see instructions)					536	87
88	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)					1,505.86	88
89	Observation bed cost (line 87 x line 88) (see instructions)					807,141	89
		Cost	Routine Cost (from line 21)	col. 1÷col. 2	Total Observation Bed Cost (from line 89)	Observation Bed Pass Through Cost col. 3 x col. 4) (see instructions)	
		1	2	3	4	5	
90	Capital-related cost	167,529	2,901,792	0.057733	807,141	46,599	90
91	Nursing School						91
92	Allied Health						92
93	Other Medical Education						93

KPMG LLP Compu-Max 2552-10

IROQUOIS MEMORIAL HOSPITAL Provider CCN: 14-0167	In Lieu of Form CMS-2552-10	Period : From: 10/01/2017 To: 09/30/2018	Run Date: 02/25/2019 Run Time: 14:01 Version: 2018.12 (02/24/2019)
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COMPUTATION OF INPATIENT OPERATING COST**COMPONENT CCN: 14-6049****WORKSHEET D-1
PART I**

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 I - ALL PROVIDER COMPONENTS**INPATIENT DAYS**

1	Inpatient days (including private room days and swing-bed days, excluding newborn)	10,219	1
2	Inpatient days (including private room days, excluding swing-bed and newborn days)	10,219	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)	10,219	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)	1,535	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)	2,837,368	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)	2,837,368	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)	2,837,368	37

KPMG LLP Compu-Max 2552-10

IROQUOIS MEMORIAL HOSPITAL Provider CCN: 14-0167	In Lieu of Form CMS-2552-10	Period : From: 10/01/2017 To: 09/30/2018	Run Date: 02/25/2019 Run Time: 14:01 Version: 2018.12 (02/24/2019)
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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)	2,837,368	70
71	Adjusted general inpatient routine service cost per diem (line 70 ÷ line 2)	277.66	71
72	Program routine service cost (line 9 x line 71)	426,208	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)	426,208	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)	426,208	83
84	Program inpatient ancillary services (see instructions)	151,272	84
85	Utilization review - physician compensation (see instructions)		85
86	Total Program inpatient operating costs (sum of lines 83 through 85)	577,480	86

KPMG LLP Compu-Max 2552-10

IROQUOIS MEMORIAL HOSPITAL Provider CCN: 14-0167	In Lieu of Form CMS-2552-10	Period : From: 10/01/2017 To: 09/30/2018	Run Date: 02/25/2019 Run Time: 14:01 Version: 2018.12 (02/24/2019)
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COMPUTATION OF INPATIENT OPERATING COST**COMPONENT CCN: 14-0167****WORKSHEET D-1
PART I**

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 I - ALL PROVIDER COMPONENTS**INPATIENT DAYS**

1	Inpatient days (including private room days and swing-bed days, excluding newborn)	1,927	1
2	Inpatient days (including private room days, excluding swing-bed and newborn days)	1,927	2
3	Private room days (excluding swing-bed private room days). If you have only private room days, do not complete this line.		3
4	Semi-private room days (excluding swing-bed private room days)	1,391	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)	45	9
10	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) through December 31 of the cost reporting period (see instructions)		10
11	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		11
12	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) through December 31 of the cost reporting period		12
13	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		13
14	Medically necessary private room days applicable to the program (excluding swing-bed days)		14
15	Total nursery days (title V or XIX only)	132	15
16	Nursery days (title V or XIX only)		16

SWING-BED ADJUSTMENT

17	Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost reporting period	212.56	17
18	Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period	218.85	18
19	Medicaid rate for swing-bed NF services applicable to services through December 31 of the cost reporting period		19
20	Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period		20
21	Total general inpatient routine service cost (see instructions)	2,901,792	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)	2,901,792	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)	2,901,792	37

KPMG LLP Compu-Max 2552-10

IROQUOIS MEMORIAL HOSPITAL Provider CCN: 14-0167	In Lieu of Form CMS-2552-10	Period : From: 10/01/2017 To: 09/30/2018	Run Date: 02/25/2019 Run Time: 14:01 Version: 2018.12 (02/24/2019)
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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	
38	Adjusted general inpatient routine service cost per diem (see instructions)						1,505.86	38
39	Program general inpatient routine service cost (line 9 x line 38)						67,764	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)						67,764	41
		Total Inpatient Cost	Total Inpatient Days	Average Per Diem (col. 1 ÷ col. 2)	Program Days	Program Cost (col. 3 x col. 4)		
		1	2	3	4	5		
42	Nursery (Titles V and XIX only)		132					42
	Intensive Care Type Inpatient Hospital Units							
43	Intensive Care Unit							43
44	Coronary Care Unit							44
45	Burn Intensive Care Unit							45
46	Surgical Intensive Care Unit							46
47	Other Special Care (specify)							47
							1	
48	Program inpatient ancillary service cost (Wkst. D-3, col. 3, line 200)							48
49	Total program inpatient costs (sum of lines 41 through 48)(see instructions)						67,764	49
PASS THROUGH COST ADJUSTMENTS								
50	Pass through costs applicable to Program inpatient routine services (from Wkst. D, sum of Parts I and III)						3,912	50
51	Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)							51
52	Total Program excludable cost (sum of lines 50 and 51)						3,912	52
53	Total Program inpatient operating cost excluding capital related, nonphysician anesthetist and medical education costs (line 49 minus line 52)						63,852	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

KPMG LLP Compu-Max 2552-10

IROQUOIS MEMORIAL HOSPITAL Provider CCN: 14-0167	In Lieu of Form CMS-2552-10	Period : From: 10/01/2017 To: 09/30/2018	Run Date: 02/25/2019 Run Time: 14:01 Version: 2018.12 (02/24/2019)
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COMPUTATION OF INPATIENT OPERATING COST

COMPONENT CCN: 14-0167

WORKSHEET D-1
PARTS III & IV

Check
Applicable
Boxes:

☐ Title V - I/P

☐ Title XVIII, Part A

☒ Title XIX - I/P

☒ Hospital

☐ IPF

☐ IRF

☐ SUB (Other)

☐ SNF

☐ NF

☐ ICF/IID

☒ PPS

☐ TEFRA

☐ Other

PART IV - COMPUTATION OF OBSERVATION BED PASS-THROUGH COST

87	Total observation bed days (see instructions)					536	87
88	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)					1,505.86	88
89	Observation bed cost (line 87 x line 88) (see instructions)					807,141	89
		Cost	Routine Cost (from line 21)	col. 1÷col. 2	Total Observation Bed Cost (from line 89)	Observation Bed Pass Through Cost col. 3 x col. 4) (see instructions)	
		1	2	3	4	5	
90	Capital-related cost	167,529	2,901,792	0.057733	807,141	46,599	90
91	Nursing School						91
92	Allied Health						92
93	Other Medical Education						93

KPMG LLP Compu-Max 2552-10

IROQUOIS MEMORIAL HOSPITAL Provider CCN: 14-0167	In Lieu of Form CMS-2552-10	Period : From: 10/01/2017 To: 09/30/2018	Run Date: 02/25/2019 Run Time: 14:01 Version: 2018.12 (02/24/2019)
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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

		Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
(A)	COST CENTER DESCRIPTION	1	2	3	
	INPATIENT ROUTINE SERVICE COST CENTERS				
30	Adults & Pediatrics		1,234,545		30
	ANCILLARY SERVICE COST CENTERS				
50	Operating Room	0.418354	771,075	322,582	50
53	Anesthesiology	0.202192	33,927	6,860	53
54	Radiology-Diagnostic	0.256892	525,145	134,906	54
57	CT Scan	0.069662	656,945	45,764	57
58	MRI	0.181896	29,257	5,322	58
60	Laboratory	0.189671	877,667	166,468	60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS				62.30
65	Respiratory Therapy	0.996640	277,618	276,685	65
66	Physical Therapy	0.450310	104,164	46,906	66
69	Electrocardiology	0.167907	252,306	42,364	69
71	Medical Supplies Charged to Patients	0.327861	605,078	198,381	71
72	Impl. Dev. Charged to Patients	0.384952	525,948	202,465	72
73	Drugs Charged to Patients	0.323178	1,448,078	467,987	73
76.97	CARDIAC REHABILITATION				76.97
76.98	HYPERBARIC OXYGEN THERAPY				76.98
76.99	LITHOTRIPSY				76.99
	OUTPATIENT SERVICE COST CENTERS				
88	Rural Health Clinic				88
88.01	RHC II				88.01
88.02	RHC III				88.02
88.03	RHC IV				88.03
90	Clinic	1.887580			90
91	Emergency	0.319517	401,102	128,159	91
92	Observation Beds (Non-Distinct Part)	0.608174	224,300	136,413	92
93.99	PARTIAL HOSPITALIZATION PROGRAM				93.99
	OTHER REIMBURSABLE COST CENTERS				
95	Ambulance Services				95
200	Total (sum of lines 50-94, and 96-98)		6,732,610	2,181,262	200
201	Less PBP Clinic Laboratory Services-Program only charges (line 61)				201
202	Net Charges (line 200 minus line 201)		6,732,610		202

(A) Worksheet A line numbers

KPMG LLP Compu-Max 2552-10

IROQUOIS MEMORIAL HOSPITAL Provider CCN: 14-0167	In Lieu of Form CMS-2552-10	Period : From: 10/01/2017 To: 09/30/2018	Run Date: 02/25/2019 Run Time: 14:01 Version: 2018.12 (02/24/2019)
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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

		Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
(A)	COST CENTER DESCRIPTION	1	2	3	
	INPATIENT ROUTINE SERVICE COST CENTERS				
30	Adults & Pediatrics				30
	ANCILLARY SERVICE COST CENTERS				
50	Operating Room	0.418354			50
53	Anesthesiology	0.202192			53
54	Radiology-Diagnostic	0.256892			54
57	CT Scan	0.069662			57
58	MRI	0.181896			58
60	Laboratory	0.189671			60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS				62.30
65	Respiratory Therapy	0.996640			65
66	Physical Therapy	0.450310			66
69	Electrocardiology	0.167907			69
71	Medical Supplies Charged to Patients	0.327861			71
72	Impl. Dev. Charged to Patients	0.384952			72
73	Drugs Charged to Patients	0.323178			73
76.97	CARDIAC REHABILITATION				76.97
76.98	HYPERBARIC OXYGEN THERAPY				76.98
76.99	LITHOTRIPSY				76.99
	OUTPATIENT SERVICE COST CENTERS				
88	Rural Health Clinic				88
88.01	RHC II				88.01
88.02	RHC III				88.02
88.03	RHC IV				88.03
90	Clinic	1.887580			90
91	Emergency	0.319517			91
92	Observation Beds (Non-Distinct Part)	0.608174			92
93.99	PARTIAL HOSPITALIZATION PROGRAM				93.99
	OTHER REIMBURSABLE COST CENTERS				
95	Ambulance Services				95
200	Total (sum of lines 50-94, and 96-98)				200
201	Less PBP Clinic Laboratory Services-Program only charges (line 61)				201
202	Net Charges (line 200 minus line 201)				202

(A) Worksheet A line numbers

KPMG LLP Compu-Max 2552-10

IROQUOIS MEMORIAL HOSPITAL Provider CCN: 14-0167	In Lieu of Form CMS-2552-10	Period : From: 10/01/2017 To: 09/30/2018	Run Date: 02/25/2019 Run Time: 14:01 Version: 2018.12 (02/24/2019)
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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

		Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
(A)	COST CENTER DESCRIPTION	1	2	3	
	INPATIENT ROUTINE SERVICE COST CENTERS				
30	Adults & Pediatrics				30
	ANCILLARY SERVICE COST CENTERS				
50	Operating Room	0.418354			50
53	Anesthesiology	0.202192			53
54	Radiology-Diagnostic	0.256892	3,163	813	54
57	CT Scan	0.069662			57
58	MRI	0.181896			58
60	Laboratory	0.189671	3,704	703	60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS				62.30
65	Respiratory Therapy	0.996640	2,471	2,463	65
66	Physical Therapy	0.450310	264,566	119,137	66
69	Electrocardiology	0.167907	1,697	285	69
71	Medical Supplies Charged to Patients	0.327861	2,774	909	71
72	Impl. Dev. Charged to Patients	0.384952			72
73	Drugs Charged to Patients	0.323178	83,428	26,962	73
76.97	CARDIAC REHABILITATION				76.97
76.98	HYPERBARIC OXYGEN THERAPY				76.98
76.99	LITHOTRIPSY				76.99
	OUTPATIENT SERVICE COST CENTERS				
88	Rural Health Clinic				88
88.01	RHC II				88.01
88.02	RHC III				88.02
88.03	RHC IV				88.03
90	Clinic	1.887580			90
91	Emergency	0.319517			91
92	Observation Beds (Non-Distinct Part)	0.608174			92
93.99	PARTIAL HOSPITALIZATION PROGRAM				93.99
	OTHER REIMBURSABLE COST CENTERS				
95	Ambulance Services				95
200	Total (sum of lines 50-94, and 96-98)		361,803	151,272	200
201	Less PBP Clinic Laboratory Services-Program only charges (line 61)				201
202	Net Charges (line 200 minus line 201)		361,803		202

(A) Worksheet A line numbers

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CALCULATION OF REIMBURSEMENT SETTLEMENT

WORKSHEET E PART A

PART A - INPATIENT HOSPITAL SERVICES UNDER PPS

		1	1.01	1.02	
1	DRG amounts other than outlier payments				1
1.01	DRG amounts other than outlier payments for discharges occurring prior to October 1 (see instructions)				1.01
1.02	DRG amounts other than outlier payments for discharges occurring on or after October 1 (see instructions)	2,732,643			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)	30,591			2
2.01	Outlier reconciliation amount				2.01
2.02	Outlier payment for discharges for Model 4 BPCI (see instructions)				2.02
2.03	Outlier payment for discharges occurring prior to October 1 (see instructions)				2.03
2.04	Outlier payment for discharges occurring on or after October 1 (see instructions)				2.04
3	Managed care simulated payments				3
4	Bed days available divided by number of days in the cost reporting period (see instructions)	23.53			4
	Indirect Medical Education Adjustment Calculation for Hospitals				
5	FTE count for allopathic and osteopathic programs for the most recent cost reporting period ending on or before 12/31/1996 (see instructions)				5
6	FTE count for allopathic and osteopathic programs which meet the criteria for an add-on to the cap for new programs in accordance with 42 CFR 413.79(e)				6
7	MMA Section 422 reduction amount to the IME cap as specified under 42 CFR §412.105(f)(1)(iv)(B)(1)				7
7.01	ACA Section 5503 reduction amount to the IME cap as specified under 42 CFR §412.105(f)(1)(iv)(B)(2). If the cost report straddles July 1, 2011 then see instructions.				7.01
8	Adjustment (increase or decrease) to the FTE count for allopathic and osteopathic programs for affiliated programs in accordance with 42 CFR §413.75(b), §413.79(c)(2)(iv) 64 FR 26340 (May 12, 1998), and 67 FR 50069 (August 1, 2002).				8
8.01	The amount of increase if the hospital was awarded FTE cap slots under section 5503 of the ACA. If the cost report straddles July 1, 2011, see instructions.				8.01
8.02	The amount of increase if the hospital was awarded FTE cap slots from a closed teaching hospital under section 5506 of ACA. (see instructions)				8.02
9	Sum of lines 5 plus 6 minus lines (7 and 7.01) plus/minus line 8 plus lines (8.01 and 8.02) (see instructions)				9
10	FTE count for allopathic and osteopathic programs in the current year from your records				10
11	FTE count for residents in dental and podiatric programs				11
12	Current year allowable FTE (see instructions)				12
13	Total allowable FTE count for the prior year				13
14	Total allowable FTE count for the penultimate year if that year ended on or after September 30, 1997, otherwise enter zero				14
15	Sum of lines 12 through 14 divided by 3				15
16	Adjustment for residents in initial years of the program				16
17	Adjustment for residents displaced by program or hospital closure				17
18	Adjusted rolling average FTE count				18
19	Current year resident to bed ratio (line 18 divided by line 4)				19
20	Prior year resident to bed ratio (see instructions)				20
21	Enter the lesser of lines 19 or 20 (see instructions)				21
22	IME payment adjustment (see instructions)				22
22.01	IME payment adjustment - Managed Care (see instructions)				22.01
	Indirect Medical Education Adjustment for the Add-on for Section 422 of the MMA				
23	Number of additional allopathic and osteopathic IME FTE resident cap slots under 42 Sec. 412.105(f)(1)(iv)(C)				23
24	IME FTE resident count over cap (see instructions)				24
25	If the amount on line 24 is greater than -0-, then enter the lower of line 23 or line 24 (see instructions)				25
26	Resident to bed ratio (divide line 25 by line 4)				26
27	IME payments adjustment factor (see instructions)				27
28	IME add-on adjustment amount (see instructions)				28
28.01	IME add-on adjustment amount - Managed Care (see instructions)				28.01
29	Total IME payment (sum of lines 22 and 28)				29
29.01	Total IME payment - Managed Care (sum of lines 22.01 and 28.01)				29.01
	Disproportionate Share Adjustment				
30	Percentage of SSI recipient patient days to Medicare Part A patient days (see instructions)	0.0574			30
31	Percentage of Medicaid patient days to total patient days (see instructions)	0.1037			31
32	Sum of lines 30 and 31	0.1611			32
33	Allowable disproportionate share percentage (see instructions)	0.1200			33
34	Disproportionate share adjustment (see instructions)	81,979			34
		Prior to October 1 (1.00)	(1.01)	On or after October 1 (2.00)	
	Uncompensated Care Adjustment				
35	Total uncompensated care amount (see instructions)			6,766,695,164	35
35.01	Factor 3 (see instructions)	0.000000000		0.000025851	35.01
35.02	Hospital uncompensated care payment (If line 34 is zero, enter zero on this line) (see instructions)			174,926	35.02
35.03	Pro rata share of the hospital uncompensated care payment amount (see instructions)			174,926	35.03
36	Total uncompensated care (sum of columns 1 and 2 on line 35.03)	174,926			36
	Additional Payment for High Percentage of ESRD Beneficiary Discharges (lines 40 through 46)				
40	Total Medicare discharges, excluding discharges for MS-DRGs 652, 682, 683, 684 and 685 (see instructions)				40
41	Total ESRD Medicare discharges excluding MS-DRGs 652, 682, 683, 684 and 685 (see instructions)				41
41.01	Total ESRD Medicare covered and paid discharges excluding MS-DRGs 652, 682, 683, 684 and 685 (see instructions)				41.01
42	Divide line 41 by line 40 (if less than 10%, you do not qualify for adjustment)				42
43	Total Medicare ESRD inpatient days excluding MS-DRGs 652, 682, 683, 684 and 685 (see instructions)				43
44	Ratio of average length of stay to one week (line 43 divided by line 41.01 divided by 7 days)				44

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CALCULATION OF REIMBURSEMENT SETTLEMENT**WORKSHEET E
PART A****PART A - INPATIENT HOSPITAL SERVICES UNDER PPS**

		1	1.01	1.02	
45	Average weekly cost for dialysis treatments (see instructions)				45
46	Total additional payment (line 45 times line 44 times line 41.01)				46
47	Subtotal (see instructions)	3,020,139			47
48	Hospital specific payments (to be completed by SCH and MDH, small rural hospitals only (see instructions)	3,494,703			48
49	Total payment for inpatient operating costs (see instructions)	3,494,703			49
50	Payment for inpatient program capital (from Wkst. L, Pt. I and Pt. II, as applicable)	223,467			50
51	Exception payment for inpatient program capital (Wkst. L, Pt. III) (see instructions)				51
52	Direct graduate medical education payment (from Wkst. E-4, line 49) (see instructions)				52
53	Nursing and allied health managed care payment				53
54	Special add-on payments for new technologies				54
55	Net organ acquisition cost (Wkst. D-4 Pt. III, col. 1, line 69)				55
56	Cost of physicians' services in a teaching hospital (see instructions)				56
57	Routine service other pass through costs (from Wkst. D, Pt. III, col. 9, lines 30 through 35).				57
58	Ancillary service other pass through costs (from Wkst. D, Pt. IV, col. 11, line 200)				58
59	Total (sum of amounts on lines 49 through 58)	3,718,170			59
60	Primary payer payments				60
61	Total amount payable for program beneficiaries (line 59 minus line 60)	3,718,170			61
62	Deductibles billed to program beneficiaries	360,288			62
63	Coinsurance billed to program beneficiaries	1,675			63
64	Allowable bad debts (see instructions)	15,817			64
65	Adjusted reimbursable bad debts (see instructions)	10,281			65
66	Allowable bad debts for dual eligible beneficiaries (see instructions)	15,817			66
67	Subtotal (line 61 plus line 65 minus lines 62 and 63)	3,366,488			67
68	Credits received from manufacturers for replaced devices for applicable MS-DRGs (see instructions)				68
69	Outlier payments reconciliation (sum of lines 93, 95 and 96) (for SCH see instructions)				69
70	Other adjustments (specify) (see instructions)				70
70.94	HRR adjustment amount (see instructions)	-6,285			70.94
70.97	Low volume adjustment for federal fiscal year (2018)	791,439			70.97
70.99	HAC adjustment amount (see instructions)	45,089			70.99
71	Amount due provider (see instructions)	4,106,553			71
71.01	Sequestration adjustment (see instructions)	82,131			71.01
71.02	Demonstration payment adjustment amount after sequestration				71.02
72	Interim payments	4,071,494			72
73	Tentative settlement (for contractor use only)				73
74	Balance due provider (Program) (line 71 minus lines 71.01, 72 and 73)	-47,072			74
75	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, §115.2				75
TO BE COMPLETED BY CONTRACTOR (lines 90 through 96)					
90	Operating outlier amount from Wkst. E, Pt. A line 2 (see instructions)				90
91	Capital outlier from Wkst. L, Pt. I, line 2				91
92	Operating outlier reconciliation adjustment amount (see instructions)				92
93	Capital outlier reconciliation adjustment amount (see instructions)				93
94	The rate used to calculate the time value of money (see instructions)				94
95	Time value of money for operating expenses (see instructions)				95
96	Time value of money for capital related expenses (see instructions)				96
HSP Bonus Payment Amount		Prior to 10/1	On or After 10/1		
100	HSP bonus amount (see instructions)				100
HVBP Adjustment for HSP Bonus Payment		Prior to 10/1	On or After 10/1		
101	HVBP adjustment factor (see instructions)	0.0000000000	0.0000000000		101
102	HVBP adjustment amount for HSP bonus payment (see instructions)				102
HRR Adjustment for HSP Bonus Payment		Prior to 10/1	On or After 10/1		
103	HRR adjustment factor (see instructions)	0.0000	0.0000		103
104	HRR adjustment amount for HSP bonus payment (see instructions)				104

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IROQUOIS MEMORIAL HOSPITAL Provider CCN: 14-0167	Supporting Exhibit for Form CMS-2552-10	Period : From: 10/01/2017 To: 09/30/2018	Run Date: 02/25/2019 Run Time: 14:01 Version: 2018.12 (02/24/2019)
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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	Prior to October 1		On or After October 1		Total (col. 2 through 4)	
		1	2	3	3.01	4	4.01	5	
1	DRG Amounts Other Than Outlier Payments								1
1.01	DRG amounts other than outlier payments for discharges occurring prior to October 1								1.01
1.02	DRG amounts other than outlier payments for discharges occurring on or after October 1	2,732,643				2,732,643		2,732,643	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	30,591				30,591		30,591	2
2.01	Outlier payment for discharges for Model 4 BPCI								2.01
2.02	Outlier payments for discharges occurring prior to October 1 (see instructions)								2.02
2.03	Outlier payments for discharges occurring on or after October 1 (see instructions)								2.03
3	Operating outlier reconciliation								3
4	Managed Care Simulated Payments								4
	Indirect Medical Education Adjustment								
5	Amount from Worksheet E, Part A, line 21								5
6	IME payment adjustment								6
6.01	IME payment adjustment for managed care								6.01
	Indirect Medical Education Adjustment for the Add-on for Section 422 of the MMA								
7	IME payment adjustment factor								7
8	IME add-on adjustment amount								8
8.01	IME payment adjustment add-on for managed care								8.01
9	Total IME payment (sum of lines 6 and 8)								9
9.01	Total IME payment for managed care (sum of lines 6.01 and 8.01)								9.01
	Disproportionate Share Adjustment								
10	Allowable disproportionate share percentage	0.1200	0.1200	0.1200	0.1200	0.1200	0.1200		10
11	Disproportionate share adjustment	81,979				81,979		81,979	11
11.01	Uncompensated care payments	174,926				174,926		174,926	11.01
	Additional payment for high percentage of ESRD beneficiary discharges								
12	Total ESRD additional payment								12
13	Subtotal	3,020,139				3,020,139		3,020,139	13
14	Hospital specific payments (to be completed by SCH and MDH, small rural hospitals only.)	3,494,703				3,494,703		3,494,703	14
15	Total payment for inpatient operating costs SCH and MDH only	3,494,703				3,494,703		3,494,703	15
16	Payment for inpatient program capital (from Worksheet L, Parts I, as applicable)	223,467				223,467		223,467	16
17	Special add-on payments for new technologies								17
17.01	DO NOT USE THIS LINE								17.01
17.02	Credits received from manufacturers for replaced devices applicable to MS-DRG								17.02
18	Capital outlier reconciliation adjustment amount								18
19	SUBTOTAL					3,718,170		3,718,170	19
20	Capital DRG other than outlier	220,361				220,361		220,361	20
20.01	Model 4 BPCI Capital DRG other than outlier								20.01
21	Capital DRG outlier payments	3,106				3,106		3,106	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	223,467				223,467		223,467	26
27	Low volume adjustment factor					0.212857			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)					791,439		791,439	29

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HOSPITAL ACQUIRED CONDITION (HAC) REDUCTION CALCULATION
EXHIBIT 5

		(Amt. from Wkst. E, Pt. A or L Pt. I)	Prior to October 1		On or After October 1		Total (cols. 2 and 3)	
		(1)	(2)	(2.01)	(3)	(3.01)	(4)	
1	DRG Amounts Other Than Outlier Payments							1
1.01	DRG amounts other than outlier payments for discharges occurring prior to October 1							1.01
1.02	DRG amounts other than outlier payments for discharges occurring on or after October 1	2,732,643			2,732,643		2,732,643	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	30,591			30,591		30,591	2
2.01	Outlier payment for discharges for Model 4 BPCI							2.01
2.02	Outlier payments for discharges occurring prior to October 1 (see instructions)							2.02
2.03	Outlier payments for discharges occurring on or after October 1 (see instructions)							2.03
3	Operating outlier reconciliation							3
4	Managed Care Simulated Payments							4
	Indirect Medical Education Adjustment							
5	Amount from Worksheet E Part A, line 21							5
6	IME payment adjustment							6
6.01	IME payment adjustment for managed care							6.01
	Indirect Medical Education Adjustment for the Add-on for Section 422 of the MMA							
7	IME payment adjustment factor							7
8	IME add-on adjustment amount							8
8.01	IME payment adjustment add-on for managed care							8.01
9	Total IME payment (sum of lines 6 and 8)							9
9.01	Total IME payment for managed care (sum of lines 6.01 and 8.01)							9.01
	Disproportionate Share Adjustment							
10	Allowable disproportionate share percentage	0.1200	0.1200	0.1200	0.1200	0.1200		10
11	Disproportionate share adjustment	81,979			81,979		81,979	11
11.01	Uncompensated care payments	174,926			174,926		174,926	11.01
	Additional payment for high percentage of ESRD beneficiary discharges							
12	Total ESRD additional payment							12
13	Subtotal	3,020,139			3,020,139		3,020,139	13
14	Hospital specific payments (to be completed by SCH and MDH, small rural hospitals only.)	3,494,703			3,494,703		3,494,703	14
15	Total payment for inpatient operating costs SCH and MDH only	3,494,703			3,494,703		3,494,703	15
16	Payment for inpatient program capital (from Worksheet L, Parts I, as applicable)	223,467			223,467		223,467	16
17	Special add-on payments for new technologies							17
17.01	DO NOT USE THIS LINE							17.01
17.02	Credits received from manufacturers for replaced devices applicable to MS-DRG							17.02
18	Capital outlier reconciliation adjustment amount							18
19	SUBTOTAL				3,718,170		3,718,170	19
20	Capital DRG other than outlier	220,361			220,361		220,361	20
20.01	Model 4 BPCI Capital DRG other than outlier							20.01
21	Capital DRG outlier payments	3,106			3,106		3,106	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	223,467			223,467		223,467	26
27								27
28	Low volume adjustment prior to October 1							28
29	Low volume adjustment on or after October 1	791,439			791,439		791,439	29
30	HVBP payment adjustment							30
30.01	HVBP payment adjustment for HSP bonus payment							30.01
31	HRR adjustment	-6,285			-695		-695	31
31.01	HRR adjustment for HSP bonus payment							31.01
32	HAC Reduction Program adjustment				45,089		45,089	32

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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 OPPS (see instructions)	4,362,018			2
3	OPPS payments	3,553,318			3
4	Outlier payment (see instructions)	6,574			4
4.01	Outlier reconciliation amount (see instructions)				4.01
5	Enter the hospital specific payment to cost ratio (see instructions)	0.805			5
6	Line 2 times line 5	3,511,424			6
7	Sum of lines 3, 4, and 4.01, divided by line 6				7
8	Transitional corridor payment (see instructions)				8
9	Ancillary service other pass through costs from Wkst. D, Pt. IV, col. 13, line 200				9
10	Organ acquisition				10
11	Total cost (sum of lines 1 and 10) (see instructions)				11
	COMPUTATION OF LESSER OF COST OR CHARGES				
	REASONABLE CHARGES				
12	Ancillary service charges				12
13	Organ acquisition charges (from Wkst. D-4, Part III, col. 4, line 69)				13
14	Total reasonable charges (sum of lines 12 and 13)				14
	CUSTOMARY CHARGES				
15	Aggregate amount actually collected from patients liable for payment for services on a charge basis				15
16	Amounts that would have been realized from patients liable for payment for services on a charge basis had such payment been made in accordance with 42 CFR §413.13(e)				16
17	Ratio of line 15 to line 16 (not to exceed 1.000000)	1.000000			17
18	Total customary charges (see instructions)				18
19	Excess of customary charges over 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 (see instructions)				21
22	Interns and residents (see instructions)				22
23	Cost of physicians' services in a teaching hospital (see instructions)				23
24	Total prospective payment (sum of lines 3, 4, 4.01, 8 and 9)	3,559,892			24
	COMPUTATION OF REIMBURSEMENT SETTLEMENT				
25	Deductibles and coinsurance (see instructions)	30,242			25
26	Deductibles and coinsurance relating to amount on line 24 (see instructions)	650,411			26
27	Subtotal [(lines 21 and 24 minus the sum of lines 25 and 26) plus the sum of lines 22 and 23] (see instructions)	2,879,239			27
28	Direct graduate medical education payments (from Wkst. E-4, line 50)				28
29	ESRD direct medical education costs (from Wkst. E-4, line 36)				29
30	Subtotal (sum of lines 27 through 29)	2,879,239			30
31	Primary payer payments				31
32	Subtotal (line 30 minus line 31)	2,879,239			32
	ALLOWABLE BAD DEBTS (EXCLUDE BAD DEBTS FOR PROFESSIONAL SERVICES)				
33	Composite rate ESRD (from Wkst. I-5, line 11)				33
34	Allowable bad debts (see instructions)	44,254			34
35	Adjusted reimbursable bad debts (see instructions)	28,765			35
36	Allowable bad debts for dual eligible beneficiaries (see instructions)	44,254			36
37	Subtotal (see instructions)	2,908,004			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)	2,908,004			40
40.01	Sequestration adjustment (see instructions)	58,160			40.01
40.02	Demonstration payment adjustment amount after sequestration				40.02
41	Interim payments	2,925,637			41
42	Tentative settlement (for contractors use only)				42
43	Balance due provider/program (see instructions)	-75,793			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

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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 OPPS (see instructions)				2
3	OPPS payments				3
4	Outlier payment (see instructions)				4
4.01	Outlier reconciliation amount (see instructions)				4.01
5	Enter the hospital specific payment to cost ratio (see instructions)				5
6	Line 2 times line 5				6
7	Sum of lines 3, 4, and 4.01, divided by line 6				7
8	Transitional corridor payment (see instructions)				8
9	Ancillary service other pass through costs from Wkst. D, Pt. IV, col. 13, line 200				9
10	Organ acquisition				10
11	Total cost (sum of lines 1 and 10) (see instructions)				11
	COMPUTATION OF LESSER OF COST OR CHARGES				
	REASONABLE CHARGES				
12	Ancillary service charges				12
13	Organ acquisition charges (from Wkst. D-4, Part III, col. 4, line 69)				13
14	Total reasonable charges (sum of lines 12 and 13)				14
	CUSTOMARY CHARGES				
15	Aggregate amount actually collected from patients liable for payment for services on a charge basis				15
16	Amounts that would have been realized from patients liable for payment for services on a charge basis had such payment been made in accordance with 42 CFR §413.13(e)				16
17	Ratio of line 15 to line 16 (not to exceed 1.000000)	1.000000			17
18	Total customary charges (see instructions)				18
19	Excess of customary charges over 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 (see instructions)				21
22	Interns and residents (see instructions)				22
23	Cost of physicians' services in a teaching hospital (see instructions)				23
24	Total prospective payment (sum of lines 3, 4, 4.01, 8 and 9)				24
	COMPUTATION OF REIMBURSEMENT SETTLEMENT				
25	Deductibles and coinsurance (see instructions)				25
26	Deductibles and coinsurance relating to amount on line 24 (see instructions)				26
27	Subtotal [(lines 21 and 24 minus the sum of lines 25 and 26) plus the sum of lines 22 and 23] (see instructions)				27
28	Direct graduate medical education payments (from Wkst. E-4, line 50)				28
29	ESRD direct medical education costs (from Wkst. E-4, line 36)				29
30	Subtotal (sum of lines 27 through 29)				30
31	Primary payer payments				31
32	Subtotal (line 30 minus line 31)				32
	ALLOWABLE BAD DEBTS (EXCLUDE BAD DEBTS FOR PROFESSIONAL SERVICES)				
33	Composite rate ESRD (from Wkst. I-5, line 11)				33
34	Allowable bad debts (see instructions)				34
35	Adjusted reimbursable bad debts (see instructions)				35
36	Allowable bad debts for dual eligible beneficiaries (see instructions)				36
37	Subtotal (see instructions)				37
38	MSP-LCC reconciliation amount from PS&R				38
39	Other adjustments (specify) (see instructions)				39
39.50	Pioneer ACO demonstration payment adjustment (see instructions)				39.50
40	Subtotal (see instructions)				40
40.01	Sequestration adjustment (see instructions)				40.01
40.02	Demonstration payment adjustment amount after sequestration				40.02
41	Interim payments				41
42	Tentative settlement (for contractors use only)				42
43	Balance due provider/program (see instructions)				43
44	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2				44

TO BE COMPLETED BY CONTRACTOR

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

KPMG LLP Compu-Max 2552-10

IROQUOIS MEMORIAL HOSPITAL Provider CCN: 14-0167	In Lieu of Form CMS-2552-10	Period : From: 10/01/2017 To: 09/30/2018	Run Date: 02/25/2019 Run Time: 14:01 Version: 2018.12 (02/24/2019)
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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**

			INPATIENT PART A		PART B	
			mm/dd/yyyy	AMOUNT	mm/dd/yyyy	AMOUNT
DESCRIPTION			1	2	3	4
1	Total interim payments paid to provider			4,071,494		2,925,637
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					
3	List separately each retroactive lump sum adjustment		.01			3.01
	amount based on subsequent revision of the interim		.02			3.02
	rate for the cost reporting period. Also show date of	Program	.03			3.03
	each payment. If none, write 'NONE' or enter a zero. (1)	to	.04			3.04
		Provider	.05			3.05
			.06			3.06
			.07			3.07
			.08			3.08
			.09			3.09
			.10			3.10
			.50			3.50
			.51			3.51
		Provider	.52			3.52
		to	.53			3.53
		Program	.54			3.54
			.55			3.55
			.56			3.56
			.57			3.57
			.58			3.58
			.59			3.59
	Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98)		.99			3.99
4	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Wkst. E or Wkst. E-3, line and column as appropriate)			4,071,494		2,925,637
TO BE COMPLETED BY CONTRACTOR						
5	List separately each tentative settlement payment		.01			5.01
	after desk review. Also show date of each payment.		.02			5.02
	If none, write 'NONE' or enter a zero. (1)	Program	.03			5.03
		to	.04			5.04
		Provider	.05			5.05
			.06			5.06
			.07			5.07
			.08			5.08
			.09			5.09
			.10			5.10
			.50			5.50
			.51			5.51
		Provider	.52			5.52
		to	.53			5.53
		Program	.54			5.54
			.55			5.55
			.56			5.56
			.57			5.57
			.58			5.58
			.59			5.59
	Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98)		.99			5.99
6	Determined net settlement amount (balance due)		.01			6.01
	based on the cost report (1)		.02	-47,072		-75,793
7	Total Medicare program liability (see instructions)			4,024,422		2,849,844
8	Name of Contractor		Contractor Number		NPR Date (Month/Day/Year)	

(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.

KPMG LLP Compu-Max 2552-10

IROQUOIS MEMORIAL HOSPITAL Provider CCN: 14-0167	In Lieu of Form CMS-2552-10	Period : From: 10/01/2017 To: 09/30/2018	Run Date: 02/25/2019 Run Time: 14:01 Version: 2018.12 (02/24/2019)
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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**

			INPATIENT PART A		PART B	
DESCRIPTION			mm/dd/yyyy	AMOUNT	mm/dd/yyyy	AMOUNT
1			1	2	3	4
1	Total interim payments paid to provider			508,608		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
		.03				3.03
		.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
		.52				3.52
		.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)			508,608		4
TO BE COMPLETED BY CONTRACTOR						
5	List separately each tentative settlement payment after desk review. Also show date of each payment. If none, write 'NONE' or enter a zero. (1)					
		.01				5.01
		.02				5.02
		.03				5.03
		.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
		.52				5.52
		.53				5.53
		.54				5.54
		.55				5.55
		.56				5.56
		.57				5.57
		.58				5.58
		.59				5.59
	Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98)	.99				5.99
6	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)			508,608		7
8	Name of Contractor		Contractor Number		NPR Date (Month/Day/Year)	

(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.

KPMG LLP Compu-Max 2552-10

IROQUOIS MEMORIAL HOSPITAL Provider CCN: 14-0167	In Lieu of Form CMS-2552-10	Period : From: 10/01/2017 To: 09/30/2018	Run Date: 02/25/2019 Run Time: 14:01 Version: 2018.12 (02/24/2019)
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CALCULATION OF REIMBURSEMENT SETTLEMENT

WORKSHEET E-3
PART VI

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

	PROSPECTIVE PAYMENT AMOUNT (see instructions)		
1	Resource Utilization Group (RUGS) payment	620,761	1
2	Routine service other pass through costs		2
3	Ancillary service other pass through costs		3
4	Subtotal (sum of lines 1-3)	620,761	4
	COMPUTATION OF NET COST OF COVERED SERVICES		
5	Medical and other services. Do not use this line. (see instructions)		5
6	Deductibles		6
7	Coinsurance	101,773	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)	518,988	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)	518,988	15
15.01	Sequestration adjustment (see instructions)	10,380	15.01
15.02	Demonstration payment adjustment amount after sequestration		15.02
16	Interim payments	508,608	16
17	Tentative settlement (for contractor use only)		17
18	Balance due provider/program (line 15 minus lines 15.01, 15.02, 16 and 17)		18
19	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2		19

KPMG LLP Compu-Max 2552-10

IROQUOIS MEMORIAL HOSPITAL Provider CCN: 14-0167	In Lieu of Form CMS-2552-10	Period : From: 10/01/2017 To: 09/30/2018	Run Date: 02/25/2019 Run Time: 14:01 Version: 2018.12 (02/24/2019)
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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	
	COMPUTATION OF NET COST OF COVERED SERVICES			
1	Inpatient hospital/SNF/NF services			1
2	Medical and other services			2
3	Organ acquisition (certified transplant centers only)			3
4	Subtotal (sum of lines 1, 2 and 3)			4
5	Inpatient primary payer payments			5
6	Outpatient primary payer payments			6
7	Subtotal (line 4 less sum of lines 5 and 6)			7
	COMPUTATION OF LESSER OF COST OR CHARGES			
	REASONABLE CHARGES			
8	Routine service charges			8
9	Ancillary service charges			9
10	Organ acquisition charges, net of revenue			10
11	Incentive from target amount computation			11
12	Total reasonable charges (sum of lines 8-11)			12
	CUSTOMARY CHARGES			
13	Amount actually collected from patients liable for payment for services on a cahрге basis			13
14	Amounts that would have been realized from patients liable for payment for services on a charge basis had such payment been made in accordance with 42 CFR §413.13(e)			14
15	Ratio of line 13 to line 14 (not to exceed 1.000000)	1.000000	1.000000	15
16	Total customary charges (see instructions)			16
17	Excess of customary charges over reasonable cost (complete only if line 16 exceeds line 4) (see instructions)			17
18	Excess of reasonable cost over customary charges (complete only if line 4 exceeds line 16) (see instructions)			18
19	Interns and residents (see instructions)			19
20	Cost of physicians' services in a teaching hospital (see instructions)			20
21	Cost of covered services (lesser of line 4 or line 16)			21
	PROSPECTIVE PAYMENT AMOUNT			
22	Other than outlier payments			22
23	Outlier payments			23
24	Program capital payments			24
25	Capital exception payments (see instructions)			25
26	Routine and ancillary service other pass through costs			26
27	Subtotal (sum of lines 22 through 26)			27
28	Customary charges (Titles V or XIX PPS covered services only)			28
29	Titles V or XIX (sum of lines 21 and 27)			29
	COMPUTATION OF REIMBURSEMENT SETTLEMENT			
30	Excess of reasonable cost (from line 18)			30
31	Subtotal (sum of lines 19 and 20, plus 29 minus lines 5 and 6)			31
32	Deductibles			32
33	Coinsurance			33
34	Allowable bad debts (see instructions)			34
35	Utilization review			35
36	Subtotal (sum of lines 31, 34 and 35 minus the sum of lines 32 and 33)			36
37	OTHER ADJUSTMENTS (SPECIFY) (see instructions)			37
38	Subtotal (line 36 ± line 37)			38
39	Direct graduate medical education payments (from Wkst. E-4)			39
40	Total amount payable to the provider (sum of lines 38 and 39)			40
41	Interim payments			41
42	Balance due provider/program (line 40 minus line 41)			42
43	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2			43

KPMG LLP Compu-Max 2552-10

IROQUOIS MEMORIAL HOSPITAL Provider CCN: 14-0167	In Lieu of Form CMS-2552-10	Period : From: 10/01/2017 To: 09/30/2018	Run Date: 02/25/2019 Run Time: 14:01 Version: 2018.12 (02/24/2019)
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BALANCE SHEET**WORKSHEET G**

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

	Assets (Omit Cents)	General Fund	Specific Purpose Fund	Endowment Fund	Plant Fund	
		1	2	3	4	
CURRENT ASSETS						
1	Cash on hand and in banks	822,425				1
2	Temporary investments					2
3	Notes receivable					3
4	Accounts receivable	7,480,377				4
5	Other receivables					5
6	Allowances for uncollectible notes and accounts receivable	-2,550,000				6
7	Inventory	987,401				7
8	Prepaid expenses	434,904				8
9	Other current assets	525,003				9
10	Due from other funds					10
11	Total current assets (sum of lines 1-10)	7,700,110				11
FIXED ASSETS						
12	Land	319,450				12
13	Land improvements					13
14	Accumulated depreciation					14
15	Buildings	25,940,678				15
16	Accumulated depreciation	-18,091,232				16
17	Leasehold improvements	483,750				17
18	Accumulated depreciation	-478,418				18
19	Fixed equipment					19
20	Accumulated depreciation					20
21	Automobiles and trucks					21
22	Accumulated depreciation					22
23	Major movable equipment	16,795,348				23
24	Accumulated depreciation	-13,949,928				24
25	Minor equipment depreciable					25
26	Accumulated depreciation					26
27	HIT designated assets					27
28	Accumulated depreciation					28
29	Minor equipment-nondepreciable					29
30	Total fixed assets (sum of lines 12-29)	11,019,648				30
OTHER ASSETS						
31	Investments					31
32	Deposits on leases					32
33	Due from owners/officers					33
34	Other assets	8,793,079				34
35	Total other assets (sum of lines 31-34)	8,793,079				35
36	Total assets (sum of lines 11, 30 and 35)	27,512,837				36
	Liabilities and Fund Balances (Omit Cents)	General Fund	Specific Purpose Fund	Endowment Fund	Plant Fund	
		1	2	3	4	
CURRENT LIABILITIES						
37	Accounts payable	4,981,193				37
38	Salaries, wages and fees payable	1,903,185				38
39	Payroll taxes payable					39
40	Notes and loans payable (short term)	980,075				40
41	Deferred income					41
42	Accelerated payments					42
43	Due to other funds					43
44	Other current liabilities					44
45	Total current liabilities (sum of lines 37 thru 44)	7,864,453				45
LONG TERM LIABILITIES						
46	Mortgage payable					46
47	Notes payable	3,158,809				47
48	Unsecured loans					48
49	Other long term liabilities					49
50	Total long term liabilities (sum of lines 46 thru 49)	3,158,809				50
51	Total liabilities (sum of lines 45 and 50)	11,023,262				51
CAPITAL ACCOUNTS						
52	General fund balance	16,489,575				52
53	Specific purpose fund					53
54	Donor created - endowment fund balance - restricted					54
55	Donor created - endowment fund balance - unrestricted					55
56	Governing body created - endowment fund balance					56
57	Plant fund balance - invested in plant					57
58	Plant fund balance - reserve for plant improvement, replacement, and expansion					58
59	Total fund balances (sum of lines 52 thru 58)	16,489,575				59
60	Total liabilities and fund balances (sum of lines 51 and 59)	27,512,837				60

KPMG LLP Compu-Max 2552-10

IROQUOIS MEMORIAL HOSPITAL Provider CCN: 14-0167	In Lieu of Form CMS-2552-10	Period : From: 10/01/2017 To: 09/30/2018	Run Date: 02/25/2019 Run Time: 14:01 Version: 2018.12 (02/24/2019)
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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		17,053,048		1
2	Net income (loss) (from Worksheet G-3, line 29)		-563,473		2
3	Total (sum of line 1 and line 2)		16,489,575		3
4	Additions (credit adjustments) (specify)				4
5	INCREASE IN PERPETUAL TRUST				5
6					6
7					7
8					8
9					9
10	Total additions (sum of lines 4-9)				10
11	Subtotal (line 3 plus line 10)		16,489,575		11
12	Deductions (debit adjustments) (specify)				12
13					13
14					14
15					15
16					16
17					17
18	Total deductions (sum of lines 12-17)				18
19	Fund balance at end of period per balance sheet (line 11 minus line 18)		16,489,575		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

KPMG LLP Compu-Max 2552-10

IROQUOIS MEMORIAL HOSPITAL Provider CCN: 14-0167	In Lieu of Form CMS-2552-10	Period : From: 10/01/2017 To: 09/30/2018	Run Date: 02/25/2019 Run Time: 14:01 Version: 2018.12 (02/24/2019)
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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	
	GENERAL INPATIENT ROUTINE CARE SERVICES				
1	Hospital	3,928,198		3,928,198	1
2	Subprovider IPF				2
3	Subprovider IRF				3
5	Swing Bed - SNF				5
6	Swing Bed - NF				6
7	Skilled nursing facility	2,558,215		2,558,215	7
8	Nursing facility				8
9	Other long term care				9
10	Total general inpatient care services (sum of lines 1-9)	6,486,413		6,486,413	10
	INTENSIVE CARE TYPE INPATIENT HOSPITAL SERVICES				
11	Intensive Care Unit				11
12	Coronary Care Unit				12
13	Burn Intensive Care Unit				13
14	Surgical Intensive Care Unit				14
15	Other Special Care (specify)				15
16	Total intensive care type inpatient hospital services (sum of lines 11-15)				16
17	Total inpatient routine care services (sum of lines 10 and 16)	6,486,413		6,486,413	17
18	Ancillary services	6,555,971	46,969,605	53,525,576	18
19	Outpatient services		257,985	257,985	19
20	Rural Health Clinic (RHC)		543,801	543,801	20
20.01	RHC II		340,632	340,632	20.01
20.02	RHC III		1,072,715	1,072,715	20.02
20.03	RHC IV		757,856	757,856	20.03
21	Federally Qualified Health Center (FQHC)				21
22	Home health agency		560,540	560,540	22
23	Ambulance		4,202,452	4,202,452	23
25	ASC				25
26	Hospice		1,372,289	1,372,289	26
27	Other (specify)				27
28	Total patient revenues (sum of lines 17-27) (transfer column 3 to Worksheet G-3, line 1)	13,042,384	56,077,875	69,120,259	28

PART II - OPERATING EXPENSES

		1	2	
29	Operating expenses (per Worksheet A, column 3, line 200)		33,982,467	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)		33,982,467	43

KPMG LLP Compu-Max 2552-10

IROQUOIS MEMORIAL HOSPITAL Provider CCN: 14-0167	In Lieu of Form CMS-2552-10	Period : From: 10/01/2017 To: 09/30/2018	Run Date: 02/25/2019 Run Time: 14:01 Version: 2018.12 (02/24/2019)
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STATEMENT OF REVENUES AND EXPENSES**WORKSHEET G-3**

	DESCRIPTION		
1	Total patient revenues (from Worksheet G-2, Part I, column 3, line 28)	69,120,259	1
2	Less contractual allowances and discounts on patients' accounts	38,701,522	2
3	Net patient revenues (line 1 minus line 2)	30,418,737	3
4	Less total operating expenses (from Worksheet G-2, Part II, line 43)	33,982,467	4
5	Net income from service to patients (line 3 minus line 4)	-3,563,730	5

OTHER INCOME

6	Contributions, donations, bequests, etc.	2,191,920	6
7	Income from investments	289,892	7
8	Revenues from telephone and other miscellaneous communication services		8
9	Revenue from television and radio service	12,785	9
10	Purchase discounts		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	145,417	14
15	Revenue from rental of living quarters		15
16	Revenue from sale of medical and surgical supplies to otehr than patients		16
17	Revenue from sale of drugs to other than patients		17
18	Revenue from sale of medical records and abstracts		18
19	Tuition (fees, sale of textbooks, uniforms, etc.)		19
20	Revenue from gifts, flowers, coffee shops and canteen		20
21	Rental of vending machines		21
22	Rental of hosptial space	165,932	22
23	Governmental appropriations		23
24	Other (EHR MEDICARE AND MEDICAID)		24
24.01	Other (MISC NON PATIENT REVENUE)	117,634	24.01
24.02	Other (AMBULANCE TOWNSHIP INCOME)	58,395	24.02
24.03	Other (OTHER)	18,282	24.03
25	Total other income (sum of lines 6-24)	3,000,257	25
26	Total (line 5 plus line 25)	-563,473	26
29	Net income (or loss) for the period (line 26 minus line 28)	-563,473	29

KPMG LLP Compu-Max 2552-10

IROQUOIS MEMORIAL HOSPITAL Provider CCN: 14-0167	In Lieu of Form CMS-2552-10	Period : From: 10/01/2017 To: 09/30/2018	Run Date: 02/25/2019 Run Time: 14:01 Version: 2018.12 (02/24/2019)
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ANALYSIS OF PROVIDER-BASED HOME HEALTH AGENCY COSTS
HHA CCN: 14-7586
WORKSHEET H

	COST CENTER DESCRIPTIONS (omit cents)	SALARIES	EMPLOYEE BENEFITS	TRANSPOR- TATION (see ins- tructions)	CONTRACTED/ PURCHASED SERVICES	OTHER COSTS	
		1	2	3	4	5	
	GENERAL SERVICE COST CENTERS						
1	Capital Related-Bldgs and Fixtures						1
2	Capital Related-Movable Equipment						2
3	Plant Operation & Maintenance						3
4	Transportation (see instructions)						4
5	Administrative and General	90,880	306			34,162	5
	HHA REIMBURSABLE SERVICES						
6	Skilled Nursing Care	197,566	665				6
7	Physical Therapy	51,367	173		141,591		7
8	Occupational Therapy	7,903	27		26,790		8
9	Speech Pathology	790	3		1,189		9
10	Medical Social Services	316	1				10
11	Home Health Aide	46,310	156				11
12	Supplies (see instructions)					4,915	12
13	Drugs					299	13
14	DME						14
	HHA NONREIMBURSABLE SERVICES						
15	Home Dialysis Aide Services						15
16	Respiratory Therapy						16
17	Private Duty Nursing						17
18	Clinic						18
19	Health Promotion Activities						19
20	Day Care Program						20
21	Home Delivered Meals Program						21
22	Homemaker Service						22
23	All Others						23
23.50	Telemedicine						23.50
24	Total (sum of lines 1-23)	395,132	1,331		169,570	39,376	24

KPMG LLP Compu-Max 2552-10

IROQUOIS MEMORIAL HOSPITAL Provider CCN: 14-0167	In Lieu of Form CMS-2552-10	Period : From: 10/01/2017 To: 09/30/2018	Run Date: 02/25/2019 Run Time: 14:01 Version: 2018.12 (02/24/2019)
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ANALYSIS OF PROVIDER-BASED HOME HEALTH AGENCY COSTS
HHA CCN: 14-7586
WORKSHEET H

	COST CENTER DESCRIPTIONS (omit cents)	TOTAL (sum of cols. 1 thru 5)	RECLASS- IFICATIONS	RECLASSIFIED TRIAL BALANCE (col. 6 + col. 7)	ADJUSTMENTS	NET EXPENSES FOR ALLOCATION (col. 8 + col. 9)	
		6	7	8	9	10	
	GENERAL SERVICE COST CENTERS						
1	Capital Related-Bldgs and Fixtures						1
2	Capital Related-Movable Equipment						2
3	Plant Operation & Maintenance						3
4	Transportation (see instructions)						4
5	Administrative and General	125,348		125,348		125,348	5
	HHA REIMBURSABLE SERVICES						
6	Skilled Nursing Care	198,231		198,231		198,231	6
7	Physical Therapy	193,131		193,131		193,131	7
8	Occupational Therapy	34,720		34,720		34,720	8
9	Speech Pathology	1,982		1,982		1,982	9
10	Medical Social Services	317		317		317	10
11	Home Health Aide	46,466		46,466		46,466	11
12	Supplies (see instructions)	4,915	-4,915				12
13	Drugs	299		299		299	13
14	DME						14
	HHA NONREIMBURSABLE SERVICES						
15	Home Dialysis Aide Services						15
16	Respiratory Therapy						16
17	Private Duty Nursing						17
18	Clinic						18
19	Health Promotion Activities						19
20	Day Care Program						20
21	Home Delivered Meals Program						21
22	Homemaker Service						22
23	All Others						23
23.50	Telemedicine						23.50
24	Total (sum of lines 1-23)	605,409	-4,915	600,494		600,494	24

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

KPMG LLP Compu-Max 2552-10

IROQUOIS MEMORIAL HOSPITAL Provider CCN: 14-0167	In Lieu of Form CMS-2552-10	Period : From: 10/01/2017 To: 09/30/2018	Run Date: 02/25/2019 Run Time: 14:01 Version: 2018.12 (02/24/2019)
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ANALYSIS OF PROVIDER-BASED HOME HEALTH AGENCY COSTS**HHA CCN: 14-7586****WORKSHEET H-1
PART I**

			CAPITAL RELATED COSTS			
		NET EXPENSES FOR COST ALLOCATION (from Wkst. H, col. 10)	BLDGS. & FIXTURES	MOVABLE EQUIPMENT	PLANT OPERATION & MAINTENANCE	
		0	1	2	3	
	GENERAL SERVICE COST CENTERS					
1	Capital Related-Bldgs. and Fixtures					1
2	Capital Related-Movable Equipment					2
3	Plant Operation & Maintenance					3
4	Transportation (see instructions)					4
5	Administrative and General	125,348				5
	HHA REIMBURSABLE SERVICES					
6	Skilled Nursing Care	198,231				6
7	Physical Therapy	193,131				7
8	Occupational Therapy	34,720				8
9	Speech Pathology	1,982				9
10	Medical Social Services	317				10
11	Home Health Aide	46,466				11
12	Supplies (see instructions)					12
13	Drugs	299				13
14	DME					14
	HHA NONREIMBURSABLE SERVICES					
15	Home Dialysis Aide Services					15
16	Respiratory Therapy					16
17	Private Duty Nursing					17
18	Clinic					18
19	Health Promotion Activities					19
20	Day Care Program					20
21	Home Delivered Means Program					21
22	Homemaker Service					22
23	All Others					23
23.50	Telemedicine					23.50
24	Totals (sum of lines 1-23)	600,494				24

KPMG LLP Compu-Max 2552-10

IROQUOIS MEMORIAL HOSPITAL Provider CCN: 14-0167	In Lieu of Form CMS-2552-10	Period : From: 10/01/2017 To: 09/30/2018	Run Date: 02/25/2019 Run Time: 14:01 Version: 2018.12 (02/24/2019)
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ANALYSIS OF PROVIDER-BASED HOME HEALTH AGENCY COSTS**HHA CCN: 14-7586****WORKSHEET H-1
PART I**

		TRANSPORT- ATION	SUBTOTAL (cols. 0-4)	ADMINI- STRATIVE & GENERAL	TOTAL (col. 4A + 5)	
		4	4A	5	6	
	GENERAL SERVICE COST CENTERS					
1	Capital Related-Bldgs. and Fixtures					1
2	Capital Related-Movable Equipment					2
3	Plant Operation & Maintenance					3
4	Transportation (see instructions)					4
5	Administrative and General		125,348	125,348		5
	HHA REIMBURSABLE SERVICES					
6	Skilled Nursing Care		198,231	51,872	250,103	6
7	Physical Therapy		193,131	50,540	243,671	7
8	Occupational Therapy		34,720	9,086	43,806	8
9	Speech Pathology		1,982	519	2,501	9
10	Medical Social Services		317	83	400	10
11	Home Health Aide		46,466	12,160	58,626	11
12	Supplies (see instructions)			1,003	1,003	12
13	Drugs		299	85	384	13
14	DME					14
	HHA NONREIMBURSABLE SERVICES					
15	Home Dialysis Aide Services					15
16	Respiratory Therapy					16
17	Private Duty Nursing					17
18	Clinic					18
19	Health Promotion Activities					19
20	Day Care Program					20
21	Home Delivered Means Program					21
22	Homemaker Service					22
23	All Others					23
23.50	Telemedicine					23.50
24	Totals (sum of lines 1-23)		600,494		600,494	24

KPMG LLP Compu-Max 2552-10

IROQUOIS MEMORIAL HOSPITAL Provider CCN: 14-0167	In Lieu of Form CMS-2552-10	Period : From: 10/01/2017 To: 09/30/2018	Run Date: 02/25/2019 Run Time: 14:01 Version: 2018.12 (02/24/2019)
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COST ALLOCATION - HHA STATISTICAL BASIS
HHA CCN: 14-7586
**WORKSHEET H-1
PART II**

		CAPITAL RELATED COSTS						
		BLDGS. & FIXTURES (Square Feet)	MOVABLE EQUIPMENT (Dollar Value)	PLANT OPERATION & MAINTENANCE (Square Feet)	TRANSPORT- ATION (Mileage)	RECONCIL- IATION	ADMINI- STRATIVE & GENERAL (Accum. Cost)	
		1	2	3	4	5A	5	
	GENERAL SERVICE COST CENTERS							
1	Capital Related-Bldgs. and Fixtures							1
2	Capital Related-Movable Equipment							2
3	Plant Operation & Maintenance							3
4	Transportation (see instructions)							4
5	Administrative and General					-125,348	479,002	5
	HHA REIMBURSABLE SERVICES							
6	Skilled Nursing Care						198,231	6
7	Physical Therapy						193,131	7
8	Occupational Therapy						34,720	8
9	Speech Pathology						1,982	9
10	Medical Social Services						317	10
11	Home Health Aide						46,466	11
12	Supplies (see instructions)					3,832	3,832	12
13	Drugs					24	323	13
14	DME							14
	HHA NONREIMBURSABLE SERVICES							
15	Home Dialysis Aide Services							15
16	Respiratory Therapy							16
17	Private Duty Nursing							17
18	Clinic							18
19	Health Promotion Activities							19
20	Day Care Program							20
21	Home Delivered Means Program							21
22	Homemaker Service							22
23	All Others							23
23.50	Telemedicine							23.50
24	Totals (sum of lines 1-23)					-121,492	479,002	24
25	Cost To Be Allocated (per Worksheet H-1, Part I)						125,348	25
26	Unit Cost Multiplier						0.261686	26

KPMG LLP Compu-Max 2552-10

IROQUOIS MEMORIAL HOSPITAL Provider CCN: 14-0167	In Lieu of Form CMS-2552-10	Period : From: 10/01/2017 To: 09/30/2018	Run Date: 02/25/2019 Run Time: 14:01 Version: 2018.12 (02/24/2019)
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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		25,726	16,343	14,299		223	1
2	Skilled Nursing Care	250,103			31,084			2
3	Physical Therapy	243,671			8,082			3
4	Occupational Therapy	43,806			1,243			4
5	Speech Pathology	2,501			124			5
6	Medical Social Services	400			50			6
7	Home Health Aide	58,626			7,286			7
8	Supplies	1,003						8
9	Drugs	384						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)	600,494	25,726	16,343	62,168		223	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.

KPMG LLP Compu-Max 2552-10

IROQUOIS MEMORIAL HOSPITAL Provider CCN: 14-0167	In Lieu of Form CMS-2552-10	Period : From: 10/01/2017 To: 09/30/2018	Run Date: 02/25/2019 Run Time: 14:01 Version: 2018.12 (02/24/2019)
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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)	OTHER ADMI NISTRATIVE AND GENER	MAIN- TENANCE & REPAIRS	
		5.03	5.04	5.05	4A	5.06	6	
1	Administrative and General	29,209		3,487	89,287	4,222		1
2	Skilled Nursing Care				281,187	13,299		2
3	Physical Therapy				251,753	11,905		3
4	Occupational Therapy				45,049	2,130		4
5	Speech Pathology				2,625	124		5
6	Medical Social Services				450	21		6
7	Home Health Aide				65,912	3,117		7
8	Supplies				1,003	47		8
9	Drugs				384	18		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)	29,209		3,487	737,650	34,883		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.

KPMG LLP Compu-Max 2552-10

IROQUOIS MEMORIAL HOSPITAL Provider CCN: 14-0167	In Lieu of Form CMS-2552-10	Period : From: 10/01/2017 To: 09/30/2018	Run Date: 02/25/2019 Run Time: 14:01 Version: 2018.12 (02/24/2019)
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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	55,003		15,680				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)	55,003		15,680				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.

KPMG LLP Compu-Max 2552-10

IROQUOIS MEMORIAL HOSPITAL Provider CCN: 14-0167	In Lieu of Form CMS-2552-10	Period : From: 10/01/2017 To: 09/30/2018	Run Date: 02/25/2019 Run Time: 14:01 Version: 2018.12 (02/24/2019)
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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		216		5,450			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)		216		5,450			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.

KPMG LLP Compu-Max 2552-10

IROQUOIS MEMORIAL HOSPITAL Provider CCN: 14-0167	In Lieu of Form CMS-2552-10	Period : From: 10/01/2017 To: 09/30/2018	Run Date: 02/25/2019 Run Time: 14:01 Version: 2018.12 (02/24/2019)
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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					169,858		1
2	Skilled Nursing Care					294,486		2
3	Physical Therapy					263,658		3
4	Occupational Therapy					47,179		4
5	Speech Pathology					2,749		5
6	Medical Social Services					471		6
7	Home Health Aide					69,029		7
8	Supplies					1,050		8
9	Drugs					402		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)					848,882		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.

KPMG LLP Compu-Max 2552-10

IROQUOIS MEMORIAL HOSPITAL Provider CCN: 14-0167	In Lieu of Form CMS-2552-10	Period : From: 10/01/2017 To: 09/30/2018	Run Date: 02/25/2019 Run Time: 14:01 Version: 2018.12 (02/24/2019)
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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 PtII) 27	TOTAL HHA COSTS 28				
1	Administrative and General	169,858						1
2	Skilled Nursing Care	294,486	73,664	368,150				2
3	Physical Therapy	263,658	65,954	329,612				3
4	Occupational Therapy	47,179	11,802	58,981				4
5	Speech Pathology	2,749	688	3,437				5
6	Medical Social Services	471	118	589				6
7	Home Health Aide	69,029	17,268	86,297				7
8	Supplies	1,050	263	1,313				8
9	Drugs	402	101	503				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)	848,882	169,858	848,882				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.		0.250150					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.

KPMG LLP Compu-Max 2552-10

IROQUOIS MEMORIAL HOSPITAL Provider CCN: 14-0167	In Lieu of Form CMS-2552-10	Period : From: 10/01/2017 To: 09/30/2018	Run Date: 02/25/2019 Run Time: 14:01 Version: 2018.12 (02/24/2019)
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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	3,628	28,165	90,880		4,753	15,468	1
2	Skilled Nursing Care			197,566				2
3	Physical Therapy			51,367				3
4	Occupational Therapy			7,903				4
5	Speech Pathology			790				5
6	Medical Social Services			316				6
7	Home Health Aide			46,310				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)	3,628	28,165	395,132		4,753	15,468	20
21	Total cost to be allocated	25,726	16,343	62,168		223	29,209	21
22	Unit Cost Multiplier	7.090959		0.157335		0.046918		22
22	Unit Cost Multiplier		0.580259				1.888350	22

KPMG LLP Compu-Max 2552-10

IROQUOIS MEMORIAL HOSPITAL Provider CCN: 14-0167	In Lieu of Form CMS-2552-10	Period : From: 10/01/2017 To: 09/30/2018	Run Date: 02/25/2019 Run Time: 14:01 Version: 2018.12 (02/24/2019)
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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 REVENUE	RECON- CILIATION	OTHER ADMI NISTRATIVE AND GENER ACCUM COST	MAIN- TENANCE & REPAIRS SQUARE FEET	OPERATION OF PLANT SQUARE FEET	
		5.04	5.05	4A.06	5.06	6	7	
1	Administrative and General		560,540		89,287		3,628	1
2	Skilled Nursing Care				281,187			2
3	Physical Therapy				251,753			3
4	Occupational Therapy				45,049			4
5	Speech Pathology				2,625			5
6	Medical Social Services				450			6
7	Home Health Aide				65,912			7
8	Supplies				1,003			8
9	Drugs				384			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)		560,540		737,650		3,628	20
21	Total cost to be allocated		3,487		34,883		55,003	21
22	Unit Cost Multiplier							22
22	Unit Cost Multiplier		0.006221		0.047289		15.160695	22

KPMG LLP Compu-Max 2552-10

IROQUOIS MEMORIAL HOSPITAL Provider CCN: 14-0167	In Lieu of Form CMS-2552-10	Period : From: 10/01/2017 To: 09/30/2018	Run Date: 02/25/2019 Run Time: 14:01 Version: 2018.12 (02/24/2019)
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ALLOCATION OF GENERAL SERVICE COSTS TO HHA COST CENTERS STATISTICAL BASIS
HHA CCN: 14-7586
**WORKSHEET H-2
PART II**

	HHA COST CENTER	LAUNDRY & LINEN SERVICE POUNDS	HOUSE- KEEPING SQUARE FEET	DIETARY MEALS	CAFETERIA FTE'S	MAIN- TENANCE OF PERSONNEL NUMBER HOUSED	NURSING ADMINIS- TRATION NURSING HOURS	
		8	9	10	11	12	13	
1	Administrative and General		3,628					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)		3,628					20
21	Total cost to be allocated		15,680					21
22	Unit Cost Multiplier							22
22	Unit Cost Multiplier		4.321940					22

KPMG LLP Compu-Max 2552-10

IROQUOIS MEMORIAL HOSPITAL Provider CCN: 14-0167	In Lieu of Form CMS-2552-10	Period : From: 10/01/2017 To: 09/30/2018	Run Date: 02/25/2019 Run Time: 14:01 Version: 2018.12 (02/24/2019)
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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 COST REQ'S 14	PHARMACY COSTED REQUIS. 15	MEDICAL RECORDS & LIBRARY GROSS REVENUE 16	SOCIAL SERVICE TIME SPENT 17	NONPHYSIC. ANESTHET. ASSIGNED TIME 19	NURSING SCHOOL ASSIGNED TIME 20	
1	Administrative and General	4,753		560,540				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)	4,753		560,540				20
21	Total cost to be allocated	216		5,450				21
22	Unit Cost Multiplier	0.045445		0.009723				22
22	Unit Cost Multiplier							22

KPMG LLP Compu-Max 2552-10

IROQUOIS MEMORIAL HOSPITAL Provider CCN: 14-0167	In Lieu of Form CMS-2552-10	Period : From: 10/01/2017 To: 09/30/2018	Run Date: 02/25/2019 Run Time: 14:01 Version: 2018.12 (02/24/2019)
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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

KPMG LLP Compu-Max 2552-10

IROQUOIS MEMORIAL HOSPITAL Provider CCN: 14-0167	In Lieu of Form CMS-2552-10	Period : From: 10/01/2017 To: 09/30/2018	Run Date: 02/25/2019 Run Time: 14:01 Version: 2018.12 (02/24/2019)
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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	368,150		368,150	1,855	198.46	1
2	Physical Therapy	3	329,612		329,612	1,106	298.02	2
3	Occupational Therapy	4	58,981		58,981	178	331.35	3
4	Speech Pathology	5	3,437		3,437	29	118.52	4
5	Medical Social Services	6	589		589	7	84.14	5
6	Home Health Aide	7	86,297		86,297	611	141.24	6
7	Total (sum of lines 1-6)		847,066		847,066	3,786		7

Limitation Cost Computation								
				Program Visits				
				PART B				
	Patient Services		CBSA No.	Part A	Not Subject to Deductibles & Coinsurance	Subject to Deductibles & Coinsurance		
			1	2	3	4		
8	Skilled Nursing Care		99914		990			8
8.01	Skilled Nursing Care		16580					8.01
8.02	Skilled Nursing Care		19180					8.02
9	Physical Therapy		99914		791			9
9.01	Physical Therapy		16580					9.01
9.02	Physical Therapy		19180					9.02
10	Occupational Therapy		99914		106			10
10.01	Occupational Therapy		16580					10.01
10.02	Occupational Therapy		19180					10.02
11	Speech Pathology		99914		11			11
11.01	Speech Pathology		16580					11.01
11.02	Speech Pathology		19180					11.02
12	Medical Social Services		99914		3			12
12.01	Medical Social Services		16580					12.01
12.02	Medical Social Services		19180					12.02
13	Home Health Aide		99914		347			13
13.01	Home Health Aide		16580					13.01
13.02	Home Health Aide		19180					13.02
14	Total (sum of lines 8-13)				2,248			14

Supplies and Drugs Cost Computations								
	Other Patient Services	From Wkst. H-2, Part I, col. 28, line	Facility Costs (from Wkst. H-2, Part I)	Shared Ancillary Costs (from Part II)	Total HHA Costs (cols. 1 + 2)	Total Charges (from HHA Records)	Ratio (col. 3 ÷ col. 4)	
			1	2	3	4	5	
15	Cost of Medical Supplies	8	1,313	1,611	2,924	4,965	0.588922	15
16	Cost of Drugs	9	503		503			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	0.450310			col. 2, line 2	1
2	Occupational Therapy	67				col. 2, line 3	2
3	Speech Pathology	68				col. 2, line 4	3
4	Medical Supplies Charged to Pat	71	0.327861	4,915	1,611	col. 2, line 15	4
5	Drugs Charged to Patients	73	0.323178			col. 2, line 16	5

KPMG LLP Compu-Max 2552-10

IROQUOIS MEMORIAL HOSPITAL Provider CCN: 14-0167	In Lieu of Form CMS-2552-10	Period : From: 10/01/2017 To: 09/30/2018	Run Date: 02/25/2019 Run Time: 14:01 Version: 2018.12 (02/24/2019)
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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				
		Part B			Part B			Total Program Cost (sum of cols 9-10)	
	Patient Services	Part A	Not Subject to Deductibles & Coinsurance	Subject to Deductibles & Coinsurance	Part A	Not Subject to Deductibles & Coinsurance	Subject to Deductibles & Coinsurance		
		6	7	8	9	10	11	12	
1	Skilled Nursing Care		990			196,475		196,475	1
2	Physical Therapy		791			235,734		235,734	2
3	Occupational Therapy		106			35,123		35,123	3
4	Speech Pathology		11			1,304		1,304	4
5	Medical Social Services		3			252		252	5
6	Home Health Aide		347			49,010		49,010	6
7	Total (sum of lines 1-6)		2,248			517,898		517,898	7

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

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IROQUOIS MEMORIAL HOSPITAL Provider CCN: 14-0167	In Lieu of Form CMS-2552-10	Period : From: 10/01/2017 To: 09/30/2018	Run Date: 02/25/2019 Run Time: 14:01 Version: 2018.12 (02/24/2019)
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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**

		Part B		
		Part A	Not Subject to Deductibles & Coinsurance	Subject to Deductibles & Coinsurance
	Description	1	2	3
	Reasonable Cost of Part A & Part B Services			
1	Reasonable cost of services (see instructions)			1
2	Total charges			2
	Customary Charges			
3	Amount actually collected from patients liable for payment for services on a charge basis (from your records)			3
4	Amount that would have been realized from patients liable for payment for services on a charge basis had such payment been made in accordance with 42 CFR 413.13(b)			4
5	Ratio of line 3 to line 4 (not to 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	Part B Services	
		1	2	
10	Total reasonable cost (see instructions)			10
11	Total PPS Reimbursement - Full Episodes without Outliers		30,004	11
12	Total PPS Reimbursement - Full Episodes with Outliers		363,900	12
13	Total PPS Reimbursement - LUPA Episodes		3,826	13
14	Total PPS Reimbursement - PEP Episodes		3,367	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)		401,097	22
23	Excess reasonable cost (from line 8)			23
24	Subtotal (line 22 minus line 23)		401,097	24
25	Coinsurance billed to program patients (from your records)			25
26	Net cost (line 24 minus line 25)		401,097	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)		401,097	29
30	Other adjustments (see instructions) (specify)			30
30.50	Pioneer ACO demonstration payment adjustment (see instructions)			30.50
31	Subtotal (see instructions)		401,097	31
31.01	Sequestration adjustment (see instructions)		8,022	31.01
31.02	Demonstration payment adjustment amount after sequestration			31.02
32	Interim payments (see instructions)		393,075	32
33	Tentative settlement (for contractor use only)			33
34	Balance due provider/program (line 31 minus lines 31.01, 31.02, 32 and 33)			34
35	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, §115-2			35

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IROQUOIS MEMORIAL HOSPITAL Provider CCN: 14-0167	In Lieu of Form CMS-2552-10	Period : From: 10/01/2017 To: 09/30/2018	Run Date: 02/25/2019 Run Time: 14:01 Version: 2018.12 (02/24/2019)
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ANALYSIS OF PAYMENTS TO PROVIDER-BASED HHAs FOR SERVICES RENDERED TO PROGRAM HHA CCN: 14-7586
BENEFICIARIES

WORKSHEET H-5

				Part A		Part B		
	DESCRIPTION			mm/dd/yyyy 1	Amount 2	mm/dd/yyyy 3	Amount 4	
1	Total interim payments paid to provider						393,075	1
2	Interim payments payable on individual bills, either submitted or to be submitted to the intermediary for services rendered in the cost reporting period. If none, write 'NONE' or enter a zero.							2
3	List separately each retroactive lump sum adjustment		.01					3.01
	amount based on subsequent revision of the interim		.02					3.02
	rate for the cost reporting period. Also show date of	Program	.03					3.03
	each payment. If none, write 'NONE' or enter a zero. (1)	To	.04					3.04
		Provider	.05					3.05
			.06					3.06
			.07					3.07
			.08					3.08
			.09					3.09
			.10					3.10
			.50					3.50
			.51					3.51
		Provider	.52					3.52
		To	.53					3.53
		Program	.54					3.54
			.55					3.55
			.56					3.56
			.57					3.57
			.58					3.58
			.59					3.59
	Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98)		.99					3.99
4	Total interim payments (sum of lines 1, 2, and 3.99)						393,075	4
	(transfer to Wkst. H-4, Part II, column as appropriate, line 32)							
	TO BE COMPLETED BY CONTRACTOR							
5	List separately each tentative settlement payment		.01					5.01
	after desk review. Also show date of each payment.		.02					5.02
	If none, write 'NONE' or enter a zero. (1)	Program	.03					5.03
		To	.04					5.04
		Provider	.05					5.05
			.06					5.06
			.07					5.07
			.08					5.08
			.09					5.09
			.10					5.10
			.50					5.50
			.51					5.51
		Provider	.52					5.52
		To	.53					5.53
		Program	.54					5.54
			.55					5.55
			.56					5.56
			.57					5.57
			.58					5.58
			.59					5.59
	Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98)		.99					5.99
6	Determine net settlement amount (balance due)		.01					6.01
	based on the cost report (see instructions)		.02					6.02
7	TOTAL MEDICARE PROGRAM LIABILITY (see instructions)						393,075	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.

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IROQUOIS MEMORIAL HOSPITAL Provider CCN: 14-0167	In Lieu of Form CMS-2552-10	Period : From: 10/01/2017 To: 09/30/2018	Run Date: 02/25/2019 Run Time: 14:01 Version: 2018.12 (02/24/2019)
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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	220,361	1
1.01	Model 4 BPCI Capital DRG other than outlier		1.01
2	Capital DRG outlier payments	3,106	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)	3.81	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)	223,467	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

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IROQUOIS MEMORIAL HOSPITAL Provider CCN: 14-0167	In Lieu of Form CMS-2552-10	Period : From: 10/01/2017 To: 09/30/2018	Run Date: 02/25/2019 Run Time: 14:01 Version: 2018.12 (02/24/2019)
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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

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IROQUOIS MEMORIAL HOSPITAL Provider CCN: 14-0167	In Lieu of Form CMS-2552-10	Period : From: 10/01/2017 To: 09/30/2018	Run Date: 02/25/2019 Run Time: 14:01 Version: 2018.12 (02/24/2019)
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ALLOCATION OF ALLOWABLE COSTS FOR EXTRAORDINARY CIRCUMSTANCES
**WORKSHEET L-1
PART I**

	COST CENTER DESCRIPTIONS	EXTRAORDI- NARY CAP- REL COSTS	SUBTOTAL (cols.0-4)	SUBTOTAL	I&R COST & POST STEP- DOWN ADJS	TOTAL		
		0	2A	24	25	26		
	GENERAL SERVICE COST CENTERS							
1	Cap Rel Costs-Bldg & Fixt							1
2	Cap Rel Costs-Mvble Equip							2
4	Employee Benefits Department							4
5.01	ADMISSIONS							5.01
5.02	PURCHASING, RECEIVING, AND STORES							5.02
5.03	DATA PROCESSING							5.03
5.04	COMMUNICATIONS							5.04
5.05	BUSINESS OFFICE							5.05
5.06	OTHER ADMINISTRATIVE AND GENERAL							5.06
6	Maintenance & Repairs							6
7	Operation of Plant							7
8	Laundry & Linen Service							8
9	Housekeeping							9
10	Dietary							10
11	Cafeteria							11
12	Maintenance of Personnel							12
13	Nursing Administration							13
14	Central Services & Supply							14
15	Pharmacy							15
16	Medical Records & Library							16
17	Social Service							17
19	Nonphysician Anesthetists							19
20	Nursing School							20
21	I&R Services-Salary & Fringes Apprvd							21
22	I&R Services-Other Prgm Costs Apprvd							22
23	Paramed Ed Prgm-(specify)							23
	INPATIENT ROUTINE SERVICE COST CENTERS							
30	Adults & Pediatrics							30
43	Nursery							43
44	Skilled Nursing Facility							44
	ANCILLARY SERVICE COST CENTERS							
50	Operating Room							50
53	Anesthesiology							53
54	Radiology-Diagnostic							54
57	CT Scan							57
58	MRI							58
60	Laboratory							60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
65	Respiratory Therapy							65
66	Physical Therapy							66
69	Electrocardiology							69
71	Medical Supplies Charged to Patients							71
72	Impl. Dev. Charged to Patients							72
73	Drugs Charged to Patients							73
76.97	CARDIAC REHABILITATION							76.97
76.98	HYPERBARIC OXYGEN THERAPY							76.98
76.99	LITHOTRIPSY							76.99
	OUTPATIENT SERVICE COST CENTERS							
88	Rural Health Clinic							88
88.01	RHC II							88.01
88.02	RHC III							88.02
88.03	RHC IV							88.03
90	Clinic							90
91	Emergency							91
92	Observation Beds (Non-Distinct Part)							92
93.99	PARTIAL HOSPITALIZATION PROGRAM							93.99
	OTHER REIMBURSABLE COST CENTERS							
95	Ambulance Services							95
101	Home Health Agency							101
	SPECIAL PURPOSE COST CENTERS							
113	Interest Expense							113
116	Hospice							116
118	SUBTOTALS (sum of lines 1-117)							118
	NONREIMBURSABLE COST CENTERS							
190	Gift, Flower, Coffee Shop & Canteen							190
194	IROQUOIS WOMEN'S HEALTH							194
194.01	OTHER NON-REIMBURSABLE COSTS							194.01
194.02	REFERENCE LAB							194.02
200	Cross Foot Adjustments							200
201	Negative Cost Centers							201
202	TOTAL (sum of lines 118-201)							202

KPMG LLP Compu-Max 2552-10

IROQUOIS MEMORIAL HOSPITAL Provider CCN: 14-0167	In Lieu of Form CMS-2552-10	Period : From: 10/01/2017 To: 09/30/2018	Run Date: 02/25/2019 Run Time: 14:01 Version: 2018.12 (02/24/2019)
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**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

		COMPENS- ATION	OTHER COSTS	TOTAL (col. 1 + col. 2)	RECLASS- IFICATIONS	RECLASS- IFIED TRIAL BALANCE (col. 3 + col. 4)	ADJUST- MENTS	NET EXPENSES FOR ALLOCATION (col. 5 + col. 6)	
		1	2	3	4	5	6	7	
	FACILITY HEALTH CARE STAFF COSTS								
1	Physician	162,153		162,153		162,153		162,153	1
2	Physician Assistant								2
3	Nurse Practitioner	118,425		118,425		118,425		118,425	3
4	Visiting Nurse								4
5	Other Nurse	74,431		74,431		74,431		74,431	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)	355,009		355,009		355,009		355,009	10
	COSTS UNDER AGREEMENT								
11	Physician Services Under Agreement								11
12	Physician Supervision Under Agreement								12
13	Other Costs Under Agreement								13
14	Subtotal (sum of lines 11 through 13)								14
	OTHER HEALTH CARE COSTS								
15	Medical Supplies		2,990	2,990		2,990		2,990	15
16	Transportation (Health Care Staff)								16
17	Depreciation-Medical Equipment								17
18	Professional Liability Insurance		8,181	8,181		8,181		8,181	18
19	Other Health Care Costs		4,551	4,551		4,551		4,551	19
20	Allowable GME Costs								20
21	Subtotal (sum of lines 15 through 20)		15,722	15,722		15,722		15,722	21
22	Total Cost of Health Care Services (sum of lines 10, 14, and 21)	355,009	15,722	370,731		370,731		370,731	22
	COSTS OTHER THAN RHC/FQHC SERVICES								
23	Pharmacy								23
24	Dental								24
25	Optometry								25
25.01	Telehealth								25.01
25.02	Chronic Care Management								25.02
26	All other nonreimbursable costs								26
27	Nonallowable GME costs								27
28	Total Nonreimbursable Costs (sum of lines 23 through 27)								28
	FACILITY OVERHEAD								
29	Facility Costs		13,796	13,796		13,796		13,796	29
30	Administrative Costs	38,069	45,619	83,688	-15,116	68,572		68,572	30
31	Total Facility Overhead (sum of lines 29 and 30)	38,069	59,415	97,484	-15,116	82,368		82,368	31
32	Total facility costs (sum of lines 22, 28 and 31)	393,078	75,137	468,215	-15,116	453,099		453,099	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.

KPMG LLP Compu-Max 2552-10

IROQUOIS MEMORIAL HOSPITAL Provider CCN: 14-0167	In Lieu of Form CMS-2552-10	Period : From: 10/01/2017 To: 09/30/2018	Run Date: 02/25/2019 Run Time: 14:01 Version: 2018.12 (02/24/2019)
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ALLOCATION OF OVERHEAD TO RHC/FQHC SERVICES**COMPONENT CCN: 14-3424****WORKSHEET M-2**

Check applicable box: ☒ RHC ☐ 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	0.53	1,694	4,200	2,226		1
2	Physician Assistants			2,100			2
3	Nurse Practitioners	0.83	2,775	2,100	1,743		3
4	Subtotal (sum of lines 1 through 3)	1.36	4,469		3,969	4,469	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)	1.36	4,469			4,469	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)		370,731	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)		370,731	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)		82,368	14
15	Parent provider overhead allocated to facility (see instructions)		187,667	15
16	Total overhead (sum of lines 14 and 15)		270,035	16
17	Allowable Direct GME overhead (see instructions)			17
18	Subtotal (see instructions)		270,035	18
19	Overhead applicable to RHC/FQHC services (line 13 x line 18)		270,035	19
20	Total allowable cost of RHC/FQHC services(sum of lines 10 and 19)		640,766	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.

KPMG LLP Compu-Max 2552-10

IROQUOIS MEMORIAL HOSPITAL Provider CCN: 14-0167	In Lieu of Form CMS-2552-10	Period : From: 10/01/2017 To: 09/30/2018	Run Date: 02/25/2019 Run Time: 14:01 Version: 2018.12 (02/24/2019)
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CALCULATION OF REIMBURSEMENT SETTLEMENT FOR RHC/FQHC SERVICES

COMPONENT CCN: 14-3424

WORKSHEET M-3

Check applicable boxes: ☒ RHC I ☐ 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)	640,766	1
2	Cost of vaccines and their administratino (from Wkst. M-4, line 15)	4,520	2
3	Total allowable cost excluding vaccine (line 1 minus line 2)	636,246	3
4	Total visits (from Wkst. M-2, col. 5, line 8)	4,469	4
5	Physicians visits under agreement (from Wkst. M-2, col. 5, line 9)		5
6	Total adjusted visits (line 4 plus line 5)	4,469	6
7	Adjusted cost per visit (line 3 divided by line 6)	142.37	7

		Calculation of Limit (1)		(See instr.)	
		Prior to January 1	On or after January 1		
		1	2	3	
8	Per visit payment limit (from CMS Pub. 100-04, chapter 9, §20.6 or your contractor)				8
9	Rate for program covered visits (see instructions)	142.37	142.37	142.37	9
CALCULATION OF SETTLEMENT					
10	Program covered visits excluding mental health services (from contractor records)	428	1,286		10
11	Program cost excluding costs for mental health services (line 9 x line 10)	60,934	183,088		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)		244,022		16
16.01	Total program charges (see instructions)(from contractor's records)		205,604		16.01
16.02	Total program preventive charges (see instructions)(from provider's records)		6,525		16.02
16.03	Total program preventive costs (see instructions)		7,744		16.03
16.04	Total program non-preventive costs (see instructions)		166,365		16.04
16.05	Total program cost (see instructions)		174,109		16.05
17	Primary payer payments				17
18	Less: Beneficiary deductible for RHC only (see instructions)(from contractor records)		28,322		18
19	Less: Beneficiary coinsurance for RHC/FQHC services (see instructions) (from contractor records)		35,457		19
20	Net Medicare cost excluding vaccines (see instructions)		174,109		20
21	Program cost of vaccines and their administration (from Wkst. M-4, line 16)		1,395		21
22	Total reimbursable Program cost (line 20 plus line 21)		175,504		22
23	Allowable bad debts (see instructions)		1,352		23
23.01	Adjusted reimbursable bad debts (see instructions)		879		23.01
24	Allowable bad debts for dual eligible beneficiaries (see instructions)		1,352		24
25	Other adjustments (specify) (see instructions)				25
26	Net reimbursable amount (see instructions)		176,383		26
26.01	Sequestration adjustment (see instructions)		3,528		26.01
26.02	Demonstration payment adjustment amount after sequestration				26.02
27	Interim payments		205,380		27
28	Tentative settlement (for contractor use only)				28
29	Balance due component/program (line 26 minus lines 26.01, 27 and 28)		-32,525		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.

KPMG LLP Compu-Max 2552-10

IROQUOIS MEMORIAL HOSPITAL Provider CCN: 14-0167	In Lieu of Form CMS-2552-10	Period : From: 10/01/2017 To: 09/30/2018	Run Date: 02/25/2019 Run Time: 14:01 Version: 2018.12 (02/24/2019)
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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)	355,009	355,009	1
2	Ratio of pneumococcal and influenza vaccine staff time to total health care staff time	0.000027	0.002637	2
3	Pneumococcal and influenza vaccine health care staff cost (line 1 x line 2)	10	936	3
4	Medical supplies cost - pneumococcal and influenza vaccine (from your records)	162	1,507	4
5	Direct cost of pneumococcal and influenza vaccine (line 3 plus line 4)	172	2,443	5
6	Total direct cost of the facility (from Wkst. M-1, col. 7, line 22)	370,731	370,731	6
7	Total overhead (from Wkst. M-2, line 16)	270,035	270,035	7
8	Ratio of pneumococcal and influenza vaccine direct cost to total direct cost (line 5 divided by line 6)	0.000464	0.006590	8
9	Overhead cost - pneumococcal and influenza vaccine (line 7 x line 8)	125	1,780	9
10	Total pneumococcal and influenza vaccine costs and their administration costs (sum of lines 5 and 9)	297	4,223	10
11	Total number of pneumococcal and influenza vaccine injections (from your records)	13	50	11
12	Cost per pneumococcal and influenza vaccing injection (line 10/line 11)	22.85	84.46	12
13	Number of pneumococcal and influenza vaccine injections administered to program beneficiaries	13	13	13
14	Program cost of pneumococcal and influenza vaccines and their administration costs (line 12 x line 13)	297	1,098	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)		4,520	15
16	Total Program cost of pneumococcal and influenza vaccines and their administration costs (sum of cols. 1 and 2, line 14) (transfer this amount to Wkst. M-3, line 21)		1,395	16

KPMG LLP Compu-Max 2552-10

IROQUOIS MEMORIAL HOSPITAL Provider CCN: 14-0167	In Lieu of Form CMS-2552-10	Period : From: 10/01/2017 To: 09/30/2018	Run Date: 02/25/2019 Run Time: 14:01 Version: 2018.12 (02/24/2019)
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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 1	Amount 2	
1	Total interim payments paid to provider				214,799	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			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	05/03/2018	9,419	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		-9,419	3.99
4	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Wkst. M-3, line 27)				205,380	
TO BE COMPLETED BY CONTRACTOR						
5	List separately each tentative settlement payment after desk review. Also show date of each payment. If none, write 'NONE' or enter 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		-32,525	6.02
7	Total Medicare program liability (see instructions)				172,855	
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.

KPMG LLP Compu-Max 2552-10

IROQUOIS MEMORIAL HOSPITAL Provider CCN: 14-0167	In Lieu of Form CMS-2552-10	Period : From: 10/01/2017 To: 09/30/2018	Run Date: 02/25/2019 Run Time: 14:01 Version: 2018.12 (02/24/2019)
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**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	
	FACILITY HEALTH CARE STAFF COSTS								
1	Physician	90,682		90,682		90,682		90,682	1
2	Physician Assistant								2
3	Nurse Practitioner	117,031		117,031		117,031		117,031	3
4	Visiting Nurse								4
5	Other Nurse	54,969		54,969		54,969		54,969	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)	262,682		262,682		262,682		262,682	10
	COSTS UNDER AGREEMENT								
11	Physician Services Under Agreement								11
12	Physician Supervision Under Agreement								12
13	Other Costs Under Agreement								13
14	Subtotal (sum of lines 11 through 13)								14
	OTHER HEALTH CARE COSTS								
15	Medical Supplies		2,872	2,872		2,872		2,872	15
16	Transportation (Health Care Staff)								16
17	Depreciation-Medical Equipment								17
18	Professional Liability Insurance		1,917	1,917		1,917		1,917	18
19	Other Health Care Costs		8,230	8,230		8,230		8,230	19
20	Allowable GME Costs								20
21	Subtotal (sum of lines 15 through 20)		13,019	13,019		13,019		13,019	21
22	Total Cost of Health Care Services (sum of lines 10, 14, and 21)	262,682	13,019	275,701		275,701		275,701	22
	COSTS OTHER THAN RHC/FQHC SERVICES								
23	Pharmacy								23
24	Dental								24
25	Optometry								25
25.01	Telehealth								25.01
25.02	Chronic Care Management								25.02
26	All other nonreimbursable costs								26
27	Nonallowable GME costs								27
28	Total Nonreimbursable Costs (sum of lines 23 through 27)								28
	FACILITY OVERHEAD								
29	Facility Costs		12,566	12,566		12,566		12,566	29
30	Administrative Costs	46,027	87,176	133,203	-58,204	74,999		74,999	30
31	Total Facility Overhead (sum of lines 29 and 30)	46,027	99,742	145,769	-58,204	87,565		87,565	31
32	Total facility costs (sum of lines 22, 28 and 31)	308,709	112,761	421,470	-58,204	363,266		363,266	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.

KPMG LLP Compu-Max 2552-10

IROQUOIS MEMORIAL HOSPITAL Provider CCN: 14-0167	In Lieu of Form CMS-2552-10	Period : From: 10/01/2017 To: 09/30/2018	Run Date: 02/25/2019 Run Time: 14:01 Version: 2018.12 (02/24/2019)
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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	0.35	1,379	4,200	1,470		1
2	Physician Assistants			2,100			2
3	Nurse Practitioners	0.90	1,446	2,100	1,890		3
4	Subtotal (sum of lines 1 through 3)	1.25	2,825		3,360	3,360	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)	1.25	2,825			3,360	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)		275,701	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)		275,701	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)		87,565	14
15	Parent provider overhead allocated to facility (see instructions)		184,601	15
16	Total overhead (sum of lines 14 and 15)		272,166	16
17	Allowable Direct GME overhead (see instructions)			17
18	Subtotal (see instructions)		272,166	18
19	Overhead applicable to RHC/FQHC services (line 13 x line 18)		272,166	19
20	Total allowable cost of RHC/FQHC services(sum of lines 10 and 19)		547,867	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.

KPMG LLP Compu-Max 2552-10

IROQUOIS MEMORIAL HOSPITAL Provider CCN: 14-0167	In Lieu of Form CMS-2552-10	Period : From: 10/01/2017 To: 09/30/2018	Run Date: 02/25/2019 Run Time: 14:01 Version: 2018.12 (02/24/2019)
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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)	547,867	1
2	Cost of vaccines and their administratino (from Wkst. M-4, line 15)	5,918	2
3	Total allowable cost excluding vaccine (line 1 minus line 2)	541,949	3
4	Total visits (from Wkst. M-2, col. 5, line 8)	3,360	4
5	Physicians visits under agreement (from Wkst. M-2, col. 5, line 9)		5
6	Total adjusted visits (line 4 plus line 5)	3,360	6
7	Adjusted cost per visit (line 3 divided by line 6)	161.29	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)	161.29	161.29	9
CALCULATION OF SETTLEMENT				
10	Program covered visits excluding mental health services (from contractor records)	258	774	10
11	Program cost excluding costs for mental health services (line 9 x line 10)	41,613	124,838	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)		166,451	16
16.01	Total program charges (see instructions)(from contractor's records)		122,040	16.01
16.02	Total program preventive charges (see instructions)(from provider's records)		4,727	16.02
16.03	Total program preventive costs (see instructions)		6,447	16.03
16.04	Total program non-preventive costs (see instructions)		111,326	16.04
16.05	Total program cost (see instructions)		117,773	16.05
17	Primary payer payments			17
18	Less: Beneficiary deductible for RHC only (see instructions)(from contractor records)		20,847	18
19	Less: Beneficiary coinsurance for RHC/FQHC services (see instructions) (from contractor records)		20,239	19
20	Net Medicare cost excluding vaccines (see instructions)		117,773	20
21	Program cost of vaccines and their administration (from Wkst. M-4, line 16)		4,185	21
22	Total reimbursable Program cost (line 20 plus line 21)		121,958	22
23	Allowable bad debts (see instructions)		1,086	23
23.01	Adjusted reimbursable bad debts (see instructions)		706	23.01
24	Allowable bad debts for dual eligible beneficiaries (see instructions)		1,086	24
25	Other adjustments (specify) (see instructions)			25
26	Net reimbursable amount (see instructions)		122,664	26
26.01	Sequestration adjustment (see instructions)		2,453	26.01
26.02	Demonstration payment adjustment amount after sequestration			26.02
27	Interim payments		118,749	27
28	Tentative settlement (for contractor use only)			28
29	Balance due component/program (line 26 minus lines 26.01, 27 and 28)		1,462	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.

KPMG LLP Compu-Max 2552-10

IROQUOIS MEMORIAL HOSPITAL Provider CCN: 14-0167	In Lieu of Form CMS-2552-10	Period : From: 10/01/2017 To: 09/30/2018	Run Date: 02/25/2019 Run Time: 14:01 Version: 2018.12 (02/24/2019)
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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)	262,682	262,682	1
2	Ratio of pneumococcal and influenza vaccine staff time to total health care staff time	0.000317	0.003870	2
3	Pneumococcal and influenza vaccine health care staff cost (line 1 x line 2)	83	1,017	3
4	Medical supplies cost - pneumococcal and influenza vaccine (from your records)	100	1,778	4
5	Direct cost of pneumococcal and influenza vaccine (line 3 plus line 4)	183	2,795	5
6	Total direct cost of the facility (from Wkst. M-1, col. 7, line 22)	275,701	275,701	6
7	Total overhead (from Wkst. M-2, line 16)	272,166	272,166	7
8	Ratio of pneumococcal and influenza vaccine direct cost to total direct cost (line 5 divided by line 6)	0.000664	0.010138	8
9	Overhead cost - pneumococcal and influenza vaccine (line 7 x line 8)	181	2,759	9
10	Total pneumococcal and influenza vaccine costs and their administration costs (sum of lines 5 and 9)	364	5,554	10
11	Total number of pneumococcal and influenza vaccine injections (from your records)	8	59	11
12	Cost per pneumococcal and influenza vaccing injection (line 10/line 11)	45.50	94.14	12
13	Number of pneumococcal and influenza vaccine injections administered to program beneficiaries	3	43	13
14	Program cost of pneumococcal and influenza vaccines and their administration costs (line 12 x line 13)	137	4,048	14
15	Total cost of pneumococcal and influenza vaccines and their administration costs (sum of cols. 1 and 2, line 10) (transfer this amount to Wkst. M-3, line 2)		5,918	15
16	Total Program cost of pneumococcal and influenza vaccines and their administration costs (sum of cols. 1 and 2, line 14) (transfer this amount to Wkst. M-3, line 21)		4,185	16

KPMG LLP Compu-Max 2552-10

IROQUOIS MEMORIAL HOSPITAL Provider CCN: 14-0167	In Lieu of Form CMS-2552-10	Period : From: 10/01/2017 To: 09/30/2018	Run Date: 02/25/2019 Run Time: 14:01 Version: 2018.12 (02/24/2019)
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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 1	Amount 2	
1	Total interim payments paid to provider			107,085	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)		05/03/2018	11,664	3.01
					3.02
		Program			3.03
		to			3.04
		Provider			3.05
					3.06
					3.07
					3.08
					3.09
					3.10
					3.50
					3.51
		Provider			3.52
		to			3.53
		Program			3.54
					3.55
					3.56
					3.57
					3.58
					3.59
	Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98)		.99	11,664	3.99
4	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Wkst. M-3, line 27)			118,749	
TO BE COMPLETED BY CONTRACTOR					
5	List separately each tentative settlement payment after desk review. Also show date of each payment. If none, write 'NONE' or enter 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	1,462	6.01
			.02		6.02
7	Total Medicare program liability (see instructions)			120,211	
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.

KPMG LLP Compu-Max 2552-10

IROQUOIS MEMORIAL HOSPITAL Provider CCN: 14-0167	In Lieu of Form CMS-2552-10	Period : From: 10/01/2017 To: 09/30/2018	Run Date: 02/25/2019 Run Time: 14:01 Version: 2018.12 (02/24/2019)
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**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

		COMPENS- ATION	OTHER COSTS	TOTAL (col. 1 + col. 2)	RECLASS- IFICATIONS	RECLASS- IFIED TRIAL BALANCE (col. 3 + col. 4)	ADJUST- MENTS	NET EXPENSES FOR ALLOCATION (col. 5 + col. 6)	
		1	2	3	4	5	6	7	
	FACILITY HEALTH CARE STAFF COSTS								
1	Physician	350,942		350,942		350,942		350,942	1
2	Physician Assistant								2
3	Nurse Practitioner	233,592		233,592		233,592		233,592	3
4	Visiting Nurse								4
5	Other Nurse	114,345		114,345		114,345		114,345	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)	698,879		698,879		698,879		698,879	10
	COSTS UNDER AGREEMENT								
11	Physician Services Under Agreement								11
12	Physician Supervision Under Agreement								12
13	Other Costs Under Agreement								13
14	Subtotal (sum of lines 11 through 13)								14
	OTHER HEALTH CARE COSTS								
15	Medical Supplies		24,047	24,047		24,047		24,047	15
16	Transportation (Health Care Staff)								16
17	Depreciation-Medical Equipment								17
18	Professional Liability Insurance		18,505	18,505		18,505		18,505	18
19	Other Health Care Costs		20,583	20,583		20,583		20,583	19
20	Allowable GME Costs								20
21	Subtotal (sum of lines 15 through 20)		63,135	63,135		63,135		63,135	21
22	Total Cost of Health Care Services (sum of lines 10, 14, and 21)	698,879	63,135	762,014		762,014		762,014	22
	COSTS OTHER THAN RHC/FQHC SERVICES								
23	Pharmacy								23
24	Dental								24
25	Optometry								25
25.01	Telehealth								25.01
25.02	Chronic Care Management								25.02
26	All other nonreimbursable costs								26
27	Nonallowable GME costs								27
28	Total Nonreimbursable Costs (sum of lines 23 through 27)								28
	FACILITY OVERHEAD								
29	Facility Costs		25,198	25,198		25,198		25,198	29
30	Administrative Costs	98,326	171,179	269,505	-80,324	189,181		189,181	30
31	Total Facility Overhead (sum of lines 29 and 30)	98,326	196,377	294,703	-80,324	214,379		214,379	31
32	Total facility costs (sum of lines 22, 28 and 31)	797,205	259,512	1,056,717	-80,324	976,393		976,393	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.

KPMG LLP Compu-Max 2552-10

IROQUOIS MEMORIAL HOSPITAL Provider CCN: 14-0167	In Lieu of Form CMS-2552-10	Period : From: 10/01/2017 To: 09/30/2018	Run Date: 02/25/2019 Run Time: 14:01 Version: 2018.12 (02/24/2019)
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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	0.65	2,659	4,200	2,730		1
2	Physician Assistants			2,100			2
3	Nurse Practitioners	2.00	4,536	2,100	4,200		3
4	Subtotal (sum of lines 1 through 3)	2.65	7,195		6,930	7,195	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)	2.65	7,195			7,195	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)		762,014	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)		762,014	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)		214,379	14
15	Parent provider overhead allocated to facility (see instructions)		352,887	15
16	Total overhead (sum of lines 14 and 15)		567,266	16
17	Allowable Direct GME overhead (see instructions)			17
18	Subtotal (see instructions)		567,266	18
19	Overhead applicable to RHC/FQHC services (line 13 x line 18)		567,266	19
20	Total allowable cost of RHC/FQHC services(sum of lines 10 and 19)		1,329,280	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.

KPMG LLP Compu-Max 2552-10

IROQUOIS MEMORIAL HOSPITAL Provider CCN: 14-0167	In Lieu of Form CMS-2552-10	Period : From: 10/01/2017 To: 09/30/2018	Run Date: 02/25/2019 Run Time: 14:01 Version: 2018.12 (02/24/2019)
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CALCULATION OF REIMBURSEMENT SETTLEMENT FOR RHC/FQHC SERVICES

COMPONENT CCN: 15-3979

WORKSHEET M-3

Check applicable boxes: ☒ RHC III ☐ 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)	1,329,280	1
2	Cost of vaccines and their administratino (from Wkst. M-4, line 15)	3,268	2
3	Total allowable cost excluding vaccine (line 1 minus line 2)	1,326,012	3
4	Total visits (from Wkst. M-2, col. 5, line 8)	7,195	4
5	Physicians visits under agreement (from Wkst. M-2, col. 5, line 9)		5
6	Total adjusted visits (line 4 plus line 5)	7,195	6
7	Adjusted cost per visit (line 3 divided by line 6)	184.30	7

		Calculation of Limit (1)		(See instr.)	
		Prior to January 1	On or after January 1		
		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)	184.30	184.30	184.30	9
CALCULATION OF SETTLEMENT					
10	Program covered visits excluding mental health services (from contractor records)	827	2,481		10
11	Program cost excluding costs for mental health services (line 9 x line 10)	152,416	457,248		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)		609,664		16
16.01	Total program charges (see instructions)(from contractor's records)		4,291,780		16.01
16.02	Total program preventive charges (see instructions)(from provider's records)		2,160		16.02
16.03	Total program preventive costs (see instructions)		307		16.03
16.04	Total program non-preventive costs (see instructions)		446,802		16.04
16.05	Total program cost (see instructions)		447,109		16.05
17	Primary payer payments				17
18	Less: Beneficiary deductible for RHC only (see instructions)(from contractor records)		50,854		18
19	Less: Beneficiary coinsurance for RHC/FQHC services (see instructions) (from contractor records)		75,679		19
20	Net Medicare cost excluding vaccines (see instructions)		447,109		20
21	Program cost of vaccines and their administration (from Wkst. M-4, line 16)		2,233		21
22	Total reimbursable Program cost (line 20 plus line 21)		449,342		22
23	Allowable bad debts (see instructions)		1,323		23
23.01	Adjusted reimbursable bad debts (see instructions)		860		23.01
24	Allowable bad debts for dual eligible beneficiaries (see instructions)		1,323		24
25	Other adjustments (specify) (see instructions)				25
26	Net reimbursable amount (see instructions)		450,202		26
26.01	Sequestration adjustment (see instructions)		9,004		26.01
26.02	Demonstration payment adjustment amount after sequestration				26.02
27	Interim payments		384,818		27
28	Tentative settlement (for contractor use only)				28
29	Balance due component/program (line 26 minus lines 26.01, 27 and 28)		56,380		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.

KPMG LLP Compu-Max 2552-10

IROQUOIS MEMORIAL HOSPITAL Provider CCN: 14-0167	In Lieu of Form CMS-2552-10	Period : From: 10/01/2017 To: 09/30/2018	Run Date: 02/25/2019 Run Time: 14:01 Version: 2018.12 (02/24/2019)
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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)	698,879	698,879	1
2	Ratio of pneumococcal and influenza vaccine staff time to total health care staff time	0.000245	0.001053	2
3	Pneumococcal and influenza vaccine health care staff cost (line 1 x line 2)	171	736	3
4	Medical supplies cost - pneumococcal and influenza vaccine (from your records)	62	904	4
5	Direct cost of pneumococcal and influenza vaccine (line 3 plus line 4)	233	1,640	5
6	Total direct cost of the facility (from Wkst. M-1, col. 7, line 22)	762,014	762,014	6
7	Total overhead (from Wkst. M-2, line 16)	567,266	567,266	7
8	Ratio of pneumococcal and influenza vaccine direct cost to total direct cost (line 5 divided by line 6)	0.000306	0.002152	8
9	Overhead cost - pneumococcal and influenza vaccine (line 7 x line 8)	174	1,221	9
10	Total pneumococcal and influenza vaccine costs and their administration costs (sum of lines 5 and 9)	407	2,861	10
11	Total number of pneumococcal and influenza vaccine injections (from your records)	5	30	11
12	Cost per pneumococcal and influenza vaccing injection (line 10/line 11)	81.40	95.37	12
13	Number of pneumococcal and influenza vaccine injections administered to program beneficiaries	4	20	13
14	Program cost of pneumococcal and influenza vaccines and their administration costs (line 12 x line 13)	326	1,907	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)		3,268	15
16	Total Program cost of pneumococcal and influenza vaccines and their administration costs (sum of cols. 1 and 2, line 14) (transfer this amount to Wkst. M-3, line 21)		2,233	16

KPMG LLP Compu-Max 2552-10

IROQUOIS MEMORIAL HOSPITAL Provider CCN: 14-0167	In Lieu of Form CMS-2552-10	Period : From: 10/01/2017 To: 09/30/2018	Run Date: 02/25/2019 Run Time: 14:01 Version: 2018.12 (02/24/2019)
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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 1	Amount 2	
1	Total interim payments paid to provider			369,748	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)		05/03/2018	15,070	3.01
		.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		15,070	3.99
4	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Wkst. M-3, line 27)			384,818	
TO BE COMPLETED BY CONTRACTOR					
5	List separately each tentative settlement payment after desk review. Also show date of each payment. If none, write 'NONE' or enter 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		56,380	6.01
		.02			6.02
7	Total Medicare program liability (see instructions)			441,198	
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.

KPMG LLP Compu-Max 2552-10

IROQUOIS MEMORIAL HOSPITAL Provider CCN: 14-0167	In Lieu of Form CMS-2552-10	Period : From: 10/01/2017 To: 09/30/2018	Run Date: 02/25/2019 Run Time: 14:01 Version: 2018.12 (02/24/2019)
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**ANALYSIS OF HOSPITAL-BASED RURAL HEALTH CLINIC/
FEDERALLY QUALIFIED HEALTH CENTER COSTS**
COMPONENT CCN: 14-8551
WORKSHEET M-1

Check applicable box: ☒ RHC IV ☐ FQHC

		COMPENS- ATION	OTHER COSTS	TOTAL (col. 1 + col. 2)	RECLASS- IFICATIONS	RECLASS- IFIED TRIAL BALANCE (col. 3 + col. 4)	ADJUST- MENTS	NET EXPENSES FOR ALLOCATION (col. 5 + col. 6)	
		1	2	3	4	5	6	7	
	FACILITY HEALTH CARE STAFF COSTS								
1	Physician	543,212		543,212		543,212		543,212	1
2	Physician Assistant								2
3	Nurse Practitioner	227,604		227,604		227,604		227,604	3
4	Visiting Nurse								4
5	Other Nurse	208,177		208,177		208,177		208,177	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)	978,993		978,993		978,993		978,993	10
	COSTS UNDER AGREEMENT								
11	Physician Services Under Agreement								11
12	Physician Supervision Under Agreement								12
13	Other Costs Under Agreement								13
14	Subtotal (sum of lines 11 through 13)								14
	OTHER HEALTH CARE COSTS								
15	Medical Supplies		3,772	3,772		3,772		3,772	15
16	Transportation (Health Care Staff)								16
17	Depreciation-Medical Equipment								17
18	Professional Liability Insurance		25,150	25,150		25,150		25,150	18
19	Other Health Care Costs								19
20	Allowable GME Costs								20
21	Subtotal (sum of lines 15 through 20)		28,922	28,922		28,922		28,922	21
22	Total Cost of Health Care Services (sum of lines 10, 14, and 21)	978,993	28,922	1,007,915		1,007,915		1,007,915	22
	COSTS OTHER THAN RHC/FQHC SERVICES								
23	Pharmacy								23
24	Dental								24
25	Optometry								25
25.01	Telehealth								25.01
25.02	Chronic Care Management								25.02
26	All other nonreimbursable costs								26
27	Nonallowable GME costs								27
28	Total Nonreimbursable Costs (sum of lines 23 through 27)								28
	FACILITY OVERHEAD								
29	Facility Costs		6,243	6,243		6,243		6,243	29
30	Administrative Costs	54,316	359,560	413,876	-106	413,770		413,770	30
31	Total Facility Overhead (sum of lines 29 and 30)	54,316	365,803	420,119	-106	420,013		420,013	31
32	Total facility costs (sum of lines 22, 28 and 31)	1,033,309	394,725	1,428,034	-106	1,427,928		1,427,928	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.

KPMG LLP Compu-Max 2552-10

IROQUOIS MEMORIAL HOSPITAL Provider CCN: 14-0167	In Lieu of Form CMS-2552-10	Period : From: 10/01/2017 To: 09/30/2018	Run Date: 02/25/2019 Run Time: 14:01 Version: 2018.12 (02/24/2019)
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ALLOCATION OF OVERHEAD TO RHC/FQHC SERVICES**COMPONENT CCN: 14-8551****WORKSHEET M-2**

Check applicable box: ☒ RHC IV ☐ FQHC

VISITS AND PRODUCTIVITY

		Number of FTE Personnel	Total Visits	Productivity Standard (1)	Minimum Visits (col. 1 x col. 3)	Greater of col. 2 or col. 4	
	Positions	1	2	3	4	5	
1	Physicians	1.47	4,175	4,200	6,174		1
2	Physician Assistants			2,100			2
3	Nurse Practitioners	1.75	2,908	2,100	3,675		3
4	Subtotal (sum of lines 1 through 3)	3.22	7,083		9,849	9,849	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)	3.22	7,083			9,849	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)		1,007,915	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)		1,007,915	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)		420,013	14
15	Parent provider overhead allocated to facility (see instructions)		402,401	15
16	Total overhead (sum of lines 14 and 15)		822,414	16
17	Allowable Direct GME overhead (see instructions)			17
18	Subtotal (see instructions)		822,414	18
19	Overhead applicable to RHC/FQHC services (line 13 x line 18)		822,414	19
20	Total allowable cost of RHC/FQHC services(sum of lines 10 and 19)		1,830,329	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.

KPMG LLP Compu-Max 2552-10

IROQUOIS MEMORIAL HOSPITAL Provider CCN: 14-0167	In Lieu of Form CMS-2552-10	Period : From: 10/01/2017 To: 09/30/2018	Run Date: 02/25/2019 Run Time: 14:01 Version: 2018.12 (02/24/2019)
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CALCULATION OF REIMBURSEMENT SETTLEMENT FOR RHC/FQHC SERVICES

COMPONENT CCN: 14-8551

WORKSHEET M-3

Check applicable boxes: ☒ RHC IV ☐ 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)	1,830,329	1
2	Cost of vaccines and their administratino (from Wkst. M-4, line 15)	3,615	2
3	Total allowable cost excluding vaccine (line 1 minus line 2)	1,826,714	3
4	Total visits (from Wkst. M-2, col. 5, line 8)	9,849	4
5	Physicians visits under agreement (from Wkst. M-2, col. 5, line 9)		5
6	Total adjusted visits (line 4 plus line 5)	9,849	6
7	Adjusted cost per visit (line 3 divided by line 6)	185.47	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)	185.47	185.47	9
CALCULATION OF SETTLEMENT				
10	Program covered visits excluding mental health services (from contractor records)	526	1,578	10
11	Program cost excluding costs for mental health services (line 9 x line 10)	97,557	292,672	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)		390,229	16
16.01	Total program charges (see instructions)(from contractor's records)		231,130	16.01
16.02	Total program preventive charges (see instructions)(from provider's records)		10,443	16.02
16.03	Total program preventive costs (see instructions)		17,631	16.03
16.04	Total program non-preventive costs (see instructions)		272,906	16.04
16.05	Total program cost (see instructions)		290,537	16.05
17	Primary payer payments			17
18	Less: Beneficiary deductible for RHC only (see instructions)(from contractor records)		31,465	18
19	Less: Beneficiary coinsurance for RHC/FQHC services (see instructions) (from contractor records)		39,933	19
20	Net Medicare cost excluding vaccines (see instructions)		290,537	20
21	Program cost of vaccines and their administration (from Wkst. M-4, line 16)			21
22	Total reimbursable Program cost (line 20 plus line 21)		290,537	22
23	Allowable bad debts (see instructions)		3,243	23
23.01	Adjusted reimbursable bad debts (see instructions)		2,108	23.01
24	Allowable bad debts for dual eligible beneficiaries (see instructions)		3,243	24
25	Other adjustments (specify) (see instructions)			25
26	Net reimbursable amount (see instructions)		292,645	26
26.01	Sequestration adjustment (see instructions)		5,853	26.01
26.02	Demonstration payment adjustment amount after sequestration			26.02
27	Interim payments		286,693	27
28	Tentative settlement (for contractor use only)			28
29	Balance due component/program (line 26 minus lines 26.01, 27 and 28)		99	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.

KPMG LLP Compu-Max 2552-10

IROQUOIS MEMORIAL HOSPITAL Provider CCN: 14-0167	In Lieu of Form CMS-2552-10	Period : From: 10/01/2017 To: 09/30/2018	Run Date: 02/25/2019 Run Time: 14:01 Version: 2018.12 (02/24/2019)
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CALCULATION OF PNEUMOCOCCAL AND INFLUENZA VACCINE COST**COMPONENT CCN: 14-8551****WORKSHEET M-4**

Check applicable boxes: ☒ RHC IV ☐ 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)	978,993	978,993	1
2	Ratio of pneumococcal and influenza vaccine staff time to total health care staff time	0.000042	0.000463	2
3	Pneumococcal and influenza vaccine health care staff cost (line 1 x line 2)	41	453	3
4	Medical supplies cost - pneumococcal and influenza vaccine (from your records)	412	1,085	4
5	Direct cost of pneumococcal and influenza vaccine (line 3 plus line 4)	453	1,538	5
6	Total direct cost of the facility (from Wkst. M-1, col. 7, line 22)	1,007,915	1,007,915	6
7	Total overhead (from Wkst. M-2, line 16)	822,414	822,414	7
8	Ratio of pneumococcal and influenza vaccine direct cost to total direct cost (line 5 divided by line 6)	0.000449	0.001526	8
9	Overhead cost - pneumococcal and influenza vaccine (line 7 x line 8)	369	1,255	9
10	Total pneumococcal and influenza vaccine costs and their administration costs (sum of lines 5 and 9)	822	2,793	10
11	Total number of pneumococcal and influenza vaccine injections (from your records)	33	36	11
12	Cost per pneumococcal and influenza vaccing injection (line 10/line 11)	24.91	77.58	12
13	Number of pneumococcal and influenza vaccine injections administered to program beneficiaries			13
14	Program cost of pneumococcal and influenza vaccines and their administration costs (line 12 x line 13)			14
15	Total cost of pneumococcal and influenza vaccines and their administration costs (sum of cols. 1 and 2, line 10) (transfer this amount to Wkst. M-3, line 2)		3,615	15
16	Total Program cost of pneumococcal and influenza vaccines and their administration costs (sum of cols. 1 and 2, line 14) (transfer this amount to Wkst. M-3, line 21)			16

KPMG LLP Compu-Max 2552-10

IROQUOIS MEMORIAL HOSPITAL Provider CCN: 14-0167	In Lieu of Form CMS-2552-10	Period : From: 10/01/2017 To: 09/30/2018	Run Date: 02/25/2019 Run Time: 14:01 Version: 2018.12 (02/24/2019)
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ANALYSIS OF PAYMENTS TO HOSPITAL-BASED RHC/FQHC
PROVIDER FOR SERVICES RENDERED TO PROGRAM BENEFICIARIES

COMPONENT CCN: 14-8551

WORKSHEET M-5

Check applicable box: ☒ RHC IV ☐ FQHC

			Part B		
DESCRIPTION			mm/dd/yyyy 1	Amount 2	
1	Total interim payments paid to provider			256,667	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)		05/03/2018	30,026	3.01
					3.02
		Program			3.03
		to			3.04
		Provider			3.05
					3.06
					3.07
					3.08
					3.09
					3.10
					3.50
					3.51
		Provider			3.52
		to			3.53
		Program			3.54
					3.55
					3.56
					3.57
					3.58
					3.59
	Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98)		.99	30,026	3.99
4	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Wkst. M-3, line 27)			286,693	
TO BE COMPLETED BY CONTRACTOR					
5	List separately each tentative settlement payment after desk review. Also show date of each payment. If none, write 'NONE' or enter 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	99	6.01
			.02		6.02
7	Total Medicare program liability (see instructions)			286,792	
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.

KPMG LLP Compu-Max 2552-10

IROQUOIS MEMORIAL HOSPITAL Provider CCN: 14-0167	In Lieu of Form CMS-2552-10	Period : From: 10/01/2017 To: 09/30/2018	Run Date: 02/25/2019 Run Time: 14:01 Version: 2018.12 (02/24/2019)
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ANALYSIS OF HOSPITAL-BASED HOSPICE COSTS
HOSPICE CCN: 14-1616
WORKSHEET O

		SALARIES	OTHER	SUBTOTAL (col. 1 + col. 2)	RECLASSI- FICATIONS	SUBTOTAL	ADJUST- MENTS	TOTAL (col. 5 + col. 6)	
		1	2	3	4	5	6	7	
	GENERAL SERVICE COST CENTERS								
1	Cap Rel Costs-Bldg & Fixt								1
2	Cap Rel Costs-Mvble Equip								2
3	Employee Benefits Department		100	100		100		100	3
4	Administrative & General	220,131	63,096	283,227		283,227		283,227	4
5	Plant Operation & Maintenance		15,316	15,316		15,316		15,316	5
6	Laundry & Linen Service								6
7	Housekeeping								7
8	Dietary								8
9	Nursing Administration	110,465		110,465		110,465		110,465	9
10	Routine Medical Supplies								10
11	Medical Records								11
12	Staff Transportation		7,559	7,559		7,559		7,559	12
13	Volunteer Service Coordination		100	100		100		100	13
14	Pharmacy		100	100		100		100	14
15	Physician Administrative Services								15
16	Other General Service		131,509	131,509	-30	131,479	-36,618	94,861	16
17	Patient/Residential Care Services								17
	DIRECT PATIENT CARE SERVICE COST CENTERS								
25	Inpatient Care - Contracted								25
26	Physician Services								26
27	Nurse Practitioner	3,772		3,772		3,772		3,772	27
28	Registered Nurse	351,685	-100	351,585		351,585		351,585	28
29	LPN/LVN								29
30	Physical Therapy								30
31	Occupational Therapy								31
32	Speech/Language Pathology								32
33	Medical Social Services								33
34	Spiritual Counseling								34
35	Dietary Counseling								35
36	Counseling - Other								36
37	Hospice Aide and Homemaker Services	92,151	-100	92,051		92,051		92,051	37
38	Durable Medical Equipment - Oxygen		100	100		100		100	38
39	Patient Transportation								39
40	Imaging Services								40
41	Labs and Diagnostics		100	100		100		100	41
42	Medical Supplies - Non-routine		6,992	6,992	-6,992				42
42.50	Drugs Charged to Patients		121,655	121,655	-121,655				42.50
43	Outpatient Services								43
44	Palliative Radiation Therapy								44
45	Palliative Chemotherapy								45
46	Other Patient Care Services								46
	NONREIMBURSABLE COST CENTERS								
60	Bereavement Program								60
61	Volunteer Program								61
62	Fundraising								62
63	Hospice/Palliative Medicine Fellows								63
64	Palliative care Program								64
65	Other Physician Services								65
66	Residential Care								66
67	Advertising								67
68	Telehealth / Telemonitoring								68
69	Thrift Store								69
70	Nursing Facility Room & Board								70
71	Other Nonreimbursable								71
100	TOTAL	778,204	346,427	1,124,631	-128,677	995,954	-36,618	959,336	100

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IROQUOIS MEMORIAL HOSPITAL Provider CCN: 14-0167	In Lieu of Form CMS-2552-10	Period : From: 10/01/2017 To: 09/30/2018	Run Date: 02/25/2019 Run Time: 14:01 Version: 2018.12 (02/24/2019)
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ANALYSIS OF HOSPITAL-BASED HOSPICE COSTS
HOSPICE CONTINUOUS HOME CARE
HOSPICE CCN: 14-1616**WORKSHEET O-1**

		SALARIES	OTHER	SUBTOTAL (col. 1 + col. 2)	RECLASSI- FICATIONS	SUBTOTAL	ADJUST- MENTS	TOTAL (col. 5 + col. 6)	
		1	2	3	4	5	6	7	
	DIRECT PATIENT CARE SERVICE COST CENTERS								
25	Inpatient Care - Contracted								25
26	Physician Services								26
27	Nurse Practitioner								27
28	Registered Nurse								28
29	LPN/LVN								29
30	Physical Therapy								30
31	Occupational Therapy								31
32	Speech/Language Pathology								32
33	Medical Social Services								33
34	Spiritual Counseling								34
35	Dietary Counseling								35
36	Counseling - Other								36
37	Hospice Aide and Homemaker Services								37
38	Durable Medical Equipment - Oxygen								38
39	Patient Transportation								39
40	Imaging Services								40
41	Labs and Diagnostics								41
42	Medical Supplies - Non-routine								42
42.50	Drugs Charged to Patients								42.50
43	Outpatient Services								43
44	Palliative Radiation Therapy								44
45	Palliative Chemotherapy								45
46	Other Patient Care Services								46
100	TOTAL								100

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IROQUOIS MEMORIAL HOSPITAL Provider CCN: 14-0167	In Lieu of Form CMS-2552-10	Period : From: 10/01/2017 To: 09/30/2018	Run Date: 02/25/2019 Run Time: 14:01 Version: 2018.12 (02/24/2019)
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**ANALYSIS OF HOSPITAL-BASED HOSPICE COSTS
HOSPICE ROUTINE HOME CARE**
HOSPICE CCN: 14-1616
WORKSHEET O-2

		SALARIES	OTHER	SUBTOTAL (col. 1 + col. 2)	RECLASSI- FICATIONS	SUBTOTAL	ADJUST- MENTS	TOTAL (col. 5 + col. 6)	
		1	2	3	4	5	6	7	
	DIRECT PATIENT CARE SERVICE COST CENTERS								
25	Inpatient Care - Contracted								25
26	Physician Services								26
27	Nurse Practitioner	3,745		3,745		3,745		3,745	27
28	Registered Nurse	349,224		349,224		349,224		349,224	28
29	LPN/LVN								29
30	Physical Therapy								30
31	Occupational Therapy								31
32	Speech/Language Pathology								32
33	Medical Social Services								33
34	Spiritual Counseling								34
35	Dietary Counseling								35
36	Counseling - Other								36
37	Hospice Aide and Homemaker Services	91,506		91,506		91,506		91,506	37
38	Durable Medical Equipment - Oxygen								38
39	Patient Transportation								39
40	Imaging Services								40
41	Labs and Diagnostics								41
42	Medical Supplies - Non-routine		6,992	6,992	-6,992				42
42.50	Drugs Charged to Patients		121,655	121,655	-121,655				42.50
43	Outpatient Services								43
44	Palliative Radiation Therapy								44
45	Palliative Chemotherapy								45
46	Other Patient Care Services								46
100	TOTAL	444,475	128,647	573,122	-128,647	444,475		444,475	100

KPMG LLP Compu-Max 2552-10

IROQUOIS MEMORIAL HOSPITAL Provider CCN: 14-0167	In Lieu of Form CMS-2552-10	Period : From: 10/01/2017 To: 09/30/2018	Run Date: 02/25/2019 Run Time: 14:01 Version: 2018.12 (02/24/2019)
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**ANALYSIS OF HOSPITAL-BASED HOSPICE COSTS
HOSPICE INPATIENT RESPITE CARE**
HOSPICE CCN: 14-1616
WORKSHEET O-3

		SALARIES	OTHER	SUBTOTAL (col. 1 + col. 2)	RECLASSI- FICATIONS	SUBTOTAL	ADJUST- MENTS	TOTAL (col. 5 + col. 6)	
		1	2	3	4	5	6	7	
	DIRECT PATIENT CARE SERVICE COST CENTERS								
25	Inpatient Care - Contracted								25
26	Physician Services								26
27	Nurse Practitioner	16		16		16		16	27
28	Registered Nurse	1,448	-100	1,348		1,348		1,348	28
29	LPN/LVN								29
30	Physical Therapy								30
31	Occupational Therapy								31
32	Speech/Language Pathology								32
33	Medical Social Services								33
34	Spiritual Counseling								34
35	Dietary Counseling								35
36	Counseling - Other								36
37	Hospice Aide and Homemaker Services	379	-100	279		279		279	37
38	Durable Medical Equipment - Oxygen		100	100		100		100	38
39	Patient Transportation								39
40	Imaging Services								40
41	Labs and Diagnostics		100	100		100		100	41
42	Medical Supplies - Non-routine								42
42.50	Drugs Charged to Patients								42.50
43	Outpatient Services								43
44	Palliative Radiation Therapy								44
45	Palliative Chemotherapy								45
46	Other Patient Care Services								46
100	TOTAL	1,843		1,843		1,843		1,843	100

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IROQUOIS MEMORIAL HOSPITAL Provider CCN: 14-0167	In Lieu of Form CMS-2552-10	Period : From: 10/01/2017 To: 09/30/2018	Run Date: 02/25/2019 Run Time: 14:01 Version: 2018.12 (02/24/2019)
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**ANALYSIS OF HOSPITAL-BASED HOSPICE COSTS
HOSPICE GENERAL INPATIENT CARE**
HOSPICE CCN: 14-1616
WORKSHEET O-4

		SALARIES	OTHER	SUBTOTAL (col. 1 + col. 2)	RECLASSI- FICATIONS	SUBTOTAL	ADJUST- MENTS	TOTAL (col. 5 + col. 6)	
		1	2	3	4	5	6	7	
	DIRECT PATIENT CARE SERVICE COST CENTERS								
25	Inpatient Care - Contracted								25
26	Physician Services								26
27	Nurse Practitioner	11		11		11		11	27
28	Registered Nurse	1,013		1,013		1,013		1,013	28
29	LPN/LVN								29
30	Physical Therapy								30
31	Occupational Therapy								31
32	Speech/Language Pathology								32
33	Medical Social Services								33
34	Spiritual Counseling								34
35	Dietary Counseling								35
36	Counseling - Other								36
37	Hospice Aide and Homemaker Services	266		266		266		266	37
38	Durable Medical Equipment - Oxygen								38
39	Patient Transportation								39
40	Imaging Services								40
41	Labs and Diagnostics								41
42	Medical Supplies - Non-routine								42
42.50	Drugs Charged to Patients								42.50
43	Outpatient Services								43
44	Palliative Radiation Therapy								44
45	Palliative Chemotherapy								45
46	Other Patient Care Services								46
100	TOTAL	1,290		1,290		1,290		1,290	100

KPMG LLP Compu-Max 2552-10

IROQUOIS MEMORIAL HOSPITAL Provider CCN: 14-0167	In Lieu of Form CMS-2552-10	Period : From: 10/01/2017 To: 09/30/2018	Run Date: 02/25/2019 Run Time: 14:01 Version: 2018.12 (02/24/2019)
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**COST ALLOCATION - DETERMINATION OF HOSPITAL-BASED HOSPICE
NET EXPENSES FOR ALLOCATION****HOSPICE CCN: 14-1616****WORKSHEET O-5**

	Descriptions	HOSPICE DIRECT EXPENSES (see instructions)	GENERAL SERVICE EXPENSES FROM WKST B PART I (see instructions)	TOTAL EXPENSES (sum of cols 1+2)	
		1	2	3	
	GENERAL SERVICE COST CENTERS				
1	Cap Rel Costs-Bldg & Fixt		25,726	25,726	1
2	Cap Rel Costs-Mvble Equip		16,643	16,643	2
3	Employee Benefits Department	100	122,438	122,538	3
4	Administrative & General	283,227	134,628	417,855	4
5	Plant Operation & Maintenance	15,316	55,003	70,319	5
6	Laundry & Linen Service				6
7	Housekeeping		15,680	15,680	7
8	Dietary				8
9	Nursing Administration	110,465		110,465	9
10	Routine Medical Supplies		3,534	3,534	10
11	Medical Records		13,341	13,341	11
12	Staff Transportation	7,559		7,559	12
13	Volunteer Service Coordination	100		100	13
14	Pharmacy	100		100	14
15	Physician Administrative Services				15
16	Other General Service	94,861		94,861	16
17	Patient/Residential Care Services				17
	LEVEL OF CARE				
50	Hospice Continuous Home Care				50
51	Hospice Routine Home Care	444,475		444,475	51
52	Hospice Inpatient Respite Care	1,843		1,843	52
53	Hospice General Inpatient Care	1,290		1,290	53
	NONREIMBURSABLE COST CENTERS				
60	Bereavement Program				60
61	Volunteer Program				61
62	Fundraising				62
63	Hospice/Palliative Medicine Fellows				63
64	Palliative care Program				64
65	Other Physician Services				65
66	Residential Care				66
67	Advertising				67
68	Telehealth / Telemonitoring				68
69	Thrift Store				69
70	Nursing Facility Room & Board				70
71	Other Nonreimbursable				71
99	Negative Cost Center				99
100	TOTAL	959,336	386,993	1,346,329	100

KPMG LLP Compu-Max 2552-10

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

	Descriptions	TOTAL EXPENSES	CAP REL BLDG & FIX	CAP REL MVBLE EQUIP	EMPLOYEE BENEFITS DEPART- MENT	SUBTOTAL	ADMINI- STRATIVE & GENERAL	PLANT OP & MAINT	
		0	1	2	3	3A	4	5	
	GENERAL SERVICE COST CENTERS								
1	Cap Rel Costs-Bldg & Fixt	25,726	25,726						1
2	Cap Rel Costs-Mvble Equip	16,643		16,643					2
3	Employee Benefits Department	122,538			122,538				3
4	Administrative & General	417,855		16,643		434,498	434,498		4
5	Plant Operation & Maintenance	70,319				70,319	28,706	99,025	5
6	Laundry & Linen Service								6
7	Housekeeping	15,680				15,680	6,401		7
8	Dietary								8
9	Nursing Administration	110,465				110,465	45,095		9
10	Routine Medical Supplies	3,534				3,534	2,926		10
11	Medical Records	13,341				13,341	5,446		11
12	Staff Transportation	7,559				7,559	3,086		12
13	Volunteer Service Coordination	100				100	41		13
14	Pharmacy	100				100	57,820		14
15	Physician Administrative Services								15
16	Other General Service	94,861	25,726			120,587	52,230	99,025	16
17	Patient/Residential Care Services								17
	LEVEL OF CARE								
50	Hospice Continuous Home Care								50
51	Hospice Routine Home Care	444,475			122,538	567,013	231,468		51
52	Hospice Inpatient Respite Care	1,843				1,843	752		52
53	Hospice General Inpatient Care	1,290				1,290	527		53
	NONREIMBURSABLE COST CENTERS								
60	Bereavement Program								60
61	Volunteer Program								61
62	Fundraising								62
63	Hospice/Palliative Medicine Fellows								63
64	Palliative care Program								64
65	Other Physician Services								65
66	Residential Care								66
67	Advertising								67
68	Telehealth / Telemonitoring								68
69	Thrift Store								69
70	Nursing Facility Room & Board								70
71	Other Nonreimbursable								71
99	Negative Cost Center								99
100	TOTAL	1,346,329	25,726	16,643	122,538	1,346,329	434,498	99,025	100

KPMG LLP Compu-Max 2552-10

IROQUOIS MEMORIAL HOSPITAL Provider CCN: 14-0167	In Lieu of Form CMS-2552-10	Period : From: 10/01/2017 To: 09/30/2018	Run Date: 02/25/2019 Run Time: 14:01 Version: 2018.12 (02/24/2019)
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COST ALLOCATION - HOSPITAL-BASED HOSPICE GENERAL SERVICE COSTS
HOSPICE CCN: 14-1616
**WORKSHEET O-6
PART I**

	Descriptions	LAUNDRY & LINEN 6	HOUSE-KEEPING 7	DIETARY 8	NURSING ADMINIS-TRATION 9	ROUTINE MEDICAL SUPPLIES 10	MEDICAL RECORDS 11	STAFF TRANS-PORTATION 12	
	GENERAL SERVICE COST CENTERS								
1	Cap Rel Costs-Bldg & Fixt								1
2	Cap Rel Costs-Mvble Equip								2
3	Employee Benefits Department								3
4	Administrative & General								4
5	Plant Operation & Maintenance								5
6	Laundry & Linen Service								6
7	Housekeeping		22,081						7
8	Dietary								8
9	Nursing Administration				155,560				9
10	Routine Medical Supplies					6,460			10
11	Medical Records						18,787		11
12	Staff Transportation							10,645	12
13	Volunteer Service Coordination								13
14	Pharmacy								14
15	Physician Administrative Services								15
16	Other General Service		22,081						16
17	Patient/Residential Care Services								17
	LEVEL OF CARE								
50	Hospice Continuous Home Care								50
51	Hospice Routine Home Care				154,472	6,414	18,656	10,538	51
52	Hospice Inpatient Respite Care				640	27	77	27	52
53	Hospice General Inpatient Care				448	19	54	80	53
	NONREIMBURSABLE COST CENTERS								
60	Bereavement Program								60
61	Volunteer Program								61
62	Fundraising								62
63	Hospice/Palliative Medicine Fellows								63
64	Palliative care Program								64
65	Other Physician Services								65
66	Residential Care								66
67	Advertising								67
68	Telehealth / Telemonitoring								68
69	Thrift Store								69
70	Nursing Facility Room & Board								70
71	Other Nonreimbursable								71
99	Negative Cost Center								99
100	TOTAL		22,081		155,560	6,460	18,787	10,645	100

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IROQUOIS MEMORIAL HOSPITAL Provider CCN: 14-0167	In Lieu of Form CMS-2552-10	Period : From: 10/01/2017 To: 09/30/2018	Run Date: 02/25/2019 Run Time: 14:01 Version: 2018.12 (02/24/2019)
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COST ALLOCATION - HOSPITAL-BASED HOSPICE GENERAL SERVICE COSTS
HOSPICE CCN: 14-1616
**WORKSHEET O-6
PART I**

	Descriptions	VOLUNTEER SVC COOR- DINATION	PHARMACY	PHYSICIAN ADMIN SERVICES	OTHER GENERAL SERVICE	PATIENT/ RES CARE SVCS	TOTAL	
		13	14	15	16	17	18	
	GENERAL SERVICE COST CENTERS							
1	Cap Rel Costs-Bldg & Fixt							1
2	Cap Rel Costs-Mvble Equip							2
3	Employee Benefits Department							3
4	Administrative & General							4
5	Plant Operation & Maintenance							5
6	Laundry & Linen Service							6
7	Housekeeping							7
8	Dietary							8
9	Nursing Administration							9
10	Routine Medical Supplies							10
11	Medical Records							11
12	Staff Transportation							12
13	Volunteer Service Coordination	141						13
14	Pharmacy		57,920					14
15	Physician Administrative Services							15
16	Other General Service				293,923			16
17	Patient/Residential Care Services							17
	LEVEL OF CARE							
50	Hospice Continuous Home Care							50
51	Hospice Routine Home Care	138	57,343		290,991		1,337,033	51
52	Hospice Inpatient Respite Care	1	144		733		4,244	52
53	Hospice General Inpatient Care	2	433		2,199		5,052	53
	NONREIMBURSABLE COST CENTERS							
60	Bereavement Program							60
61	Volunteer Program							61
62	Fundraising							62
63	Hospice/Palliative Medicine Fellows							63
64	Palliative care Program							64
65	Other Physician Services							65
66	Residential Care							66
67	Advertising							67
68	Telehealth / Telemonitoring							68
69	Thrift Store							69
70	Nursing Facility Room & Board							70
71	Other Nonreimbursable							71
99	Negative Cost Center							99
100	TOTAL	141	57,920		293,923		1,346,329	100

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IROQUOIS MEMORIAL HOSPITAL Provider CCN: 14-0167	In Lieu of Form CMS-2552-10	Period : From: 10/01/2017 To: 09/30/2018	Run Date: 02/25/2019 Run Time: 14:01 Version: 2018.12 (02/24/2019)
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COST ALLOCATION - HOSPITAL-BASED HOSPICE COSTS STATISTICAL BASIS
HOSPICE CCN: 14-1616
**WORKSHEET O-6
PART II**

	Descriptions	CAP REL BLDG & FIX SQUARE FEET	CAP REL MVBLE EQUIP DOLLAR VALUE	EMPLOYEE BENEFITS DEPART- MENT GROSS SALARIES	RECONCIL- IATION	ADMINIS- TRATIVE & GENERAL ACCUM. COST	PLANT OP & MAINT SQUARE FEET	LAUNDRY & LINEN IN-FACIL- ITY DAYS	
		1	2	3	4A	4	5	6	
	GENERAL SERVICE COST CENTERS								
1	Cap Rel Costs-Bldg & Fixt	3,628							1
2	Cap Rel Costs-Mvble Equip		26,002						2
3	Employee Benefits Department			816,495					3
4	Administrative & General		26,002		-434,498	1,064,357			4
5	Plant Operation & Maintenance					70,319	3,628		5
6	Laundry & Linen Service								6
7	Housekeeping					15,680			7
8	Dietary								8
9	Nursing Administration					110,465			9
10	Routine Medical Supplies				3,633	7,167			10
11	Medical Records					13,341			11
12	Staff Transportation					7,559			12
13	Volunteer Service Coordination					100			13
14	Pharmacy				141,537	141,637			14
15	Physician Administrative Services								15
16	Other General Service	3,628			7,356	127,943	3,628		16
17	Patient/Residential Care Services								17
	LEVEL OF CARE								
50	Hospice Continuous Home Care				121,655				50
51	Hospice Routine Home Care			816,495		567,013			51
52	Hospice Inpatient Respite Care					1,843			52
53	Hospice General Inpatient Care					1,290			53
	NONREIMBURSABLE COST CENTERS								
60	Bereavement Program								60
61	Volunteer Program								61
62	Fundraising								62
63	Hospice/Palliative Medicine Fellows								63
64	Palliative care Program								64
65	Other Physician Services								65
66	Residential Care								66
67	Advertising								67
68	Telehealth / Telemonitoring								68
69	Thrift Store								69
70	Nursing Facility Room & Board								70
71	Other Nonreimbursable								71
99	Negative Cost Center								99
100	Cost to be allocated (per O-6 Pt I)	25,726	16,643	122,538		434,498	99,025		100
101	Unit cost multiplier	7.090959	0.640066	0.150078		0.408226	27.294653		101

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IROQUOIS MEMORIAL HOSPITAL Provider CCN: 14-0167	In Lieu of Form CMS-2552-10	Period : From: 10/01/2017 To: 09/30/2018	Run Date: 02/25/2019 Run Time: 14:01 Version: 2018.12 (02/24/2019)
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COST ALLOCATION - HOSPITAL-BASED HOSPICE COSTS STATISTICAL BASIS
HOSPICE CCN: 14-1616
**WORKSHEET O-6
PART II**

	Descriptions	HOUSE-KEEPING SQUARE FEET 7	DIETARY IN-FACILITY DAYS 8	NURSING ADMINISTRATION DIRECT NURS. HRS. 9	ROUTINE MEDICAL SUPPLIES PATIENT DAYS 10	MEDICAL RECORDS PATIENT DAYS 11	STAFF TRANSPORTATION MILEAGE 12	VOLUNTEER SVC COORDINATION HOURS OF SERVICE 13	
	GENERAL SERVICE COST CENTERS								
1	Cap Rel Costs-Bldg & Fixt								1
2	Cap Rel Costs-Mvble Equip								2
3	Employee Benefits Department								3
4	Administrative & General								4
5	Plant Operation & Maintenance								5
6	Laundry & Linen Service								6
7	Housekeeping	3,628							7
8	Dietary		51						8
9	Nursing Administration			7,287					9
10	Routine Medical Supplies				7,287				10
11	Medical Records					7,287			11
12	Staff Transportation						33,692		12
13	Volunteer Service Coordination							141	13
14	Pharmacy								14
15	Physician Administrative Services								15
16	Other General Service	3,628							16
17	Patient/Residential Care Services								17
	LEVEL OF CARE								
50	Hospice Continuous Home Care								50
51	Hospice Routine Home Care			7,236	7,236	7,236	33,356	138	51
52	Hospice Inpatient Respite Care		30	30	30	30	84	1	52
53	Hospice General Inpatient Care		21	21	21	21	252	2	53
	NONREIMBURSABLE COST CENTERS								
60	Bereavement Program								60
61	Volunteer Program								61
62	Fundraising								62
63	Hospice/Palliative Medicine Fellows								63
64	Palliative care Program								64
65	Other Physician Services								65
66	Residential Care								66
67	Advertising								67
68	Telehealth / Telemonitoring								68
69	Thrift Store								69
70	Nursing Facility Room & Board								70
71	Other Nonreimbursable								71
99	Negative Cost Center								99
100	Cost to be allocated (per O-6 Pt I)	22,081		155,560	6,460	18,787	10,645	141	100
101	Unit cost multiplier	6.086273		21.347605	0.886510	2.578153	0.315950	1.000000	101

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IROQUOIS MEMORIAL HOSPITAL Provider CCN: 14-0167	In Lieu of Form CMS-2552-10	Period : From: 10/01/2017 To: 09/30/2018	Run Date: 02/25/2019 Run Time: 14:01 Version: 2018.12 (02/24/2019)
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COST ALLOCATION - HOSPITAL-BASED HOSPICE COSTS STATISTICAL BASIS
HOSPICE CCN: 14-1616
**WORKSHEET O-6
PART II**

		PHARMACY	PHYSICIAN ADMIN SERVICES PATIENT	OTHER GENERAL SERVICE SPECIFY BASIS	PATIENT/ RESIDENT CARE SVCS IN-FACIL- ITY DAYS	
	Descriptions	CHARGES	DAYS			
		14	15	16	17	
	GENERAL SERVICE COST CENTERS					
1	Cap Rel Costs-Bldg & Fixt					1
2	Cap Rel Costs-Mvble Equip					2
3	Employee Benefits Department					3
4	Administrative & General					4
5	Plant Operation & Maintenance					5
6	Laundry & Linen Service					6
7	Housekeeping					7
8	Dietary					8
9	Nursing Administration					9
10	Routine Medical Supplies					10
11	Medical Records					11
12	Staff Transportation					12
13	Volunteer Service Coordination					13
14	Pharmacy	8,420				14
15	Physician Administrative Services		8,420			15
16	Other General Service			8,420		16
17	Patient/Residential Care Services					17
	LEVEL OF CARE					
50	Hospice Continuous Home Care					50
51	Hospice Routine Home Care	8,336	8,336	8,336		51
52	Hospice Inpatient Respite Care	21	21	21		52
53	Hospice General Inpatient Care	63	63	63		53
	NONREIMBURSABLE COST CENTERS					
60	Bereavement Program					60
61	Volunteer Program					61
62	Fundraising					62
63	Hospice/Palliative Medicine Fellows					63
64	Palliative care Program					64
65	Other Physician Services					65
66	Residential Care					66
67	Advertising					67
68	Telehealth / Telemonitoring					68
69	Thrift Store					69
70	Nursing Facility Room & Board					70
71	Other Nonreimbursable					71
99	Negative Cost Center					99
100	Cost to be allocated (per O-6 Pt I)	57,920		293,923		100
101	Unit cost multiplier	6.878860		34.907720		101

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IROQUOIS MEMORIAL HOSPITAL Provider CCN: 14-0167	In Lieu of Form CMS-2552-10	Period : From: 10/01/2017 To: 09/30/2018	Run Date: 02/25/2019 Run Time: 14:01 Version: 2018.12 (02/24/2019)
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**APPORTIONMENT OF HOSPITAL-BASED HOSPICE SHARED
SERVICE COSTS BY LEVEL OF CARE****HOSPICE CCN: 14-1616****WORKSHEET O-7**

			Charges by LOC (from Provider Records)					
		Wkst C Pt 1, col. 9, line	Cost to Charge Ratio	HCHC	HRHC	HIRC	HGIP	
	Cost Center Descriptions	0	1	2	3	4	5	
	ANCILLARY SERVICE COST CENTERS							
1	Physical Therapy	66	0.450310					1
2	Occupational Therapy	67		323				2
3	Speech Language Pathology	68						3
4	Drugs, Biological & Infusion Therapy	73	0.323178	82,336				4
5	Durable Medical Equipment/Oxygen	96						5
6	Labs and Diagnostics	60	0.189671					6
7	Medical Supplies	71	0.327861					7
8	Outpatient Services (incl E/R)	93						8
9	Radiation Therapy	55						9
10	Other	76						10
11	Totals (sum of lines 1-10)							11

		Shared Service Costs by LOC				
		HCHC (col 1 x col 2)	HRHC (col 1 x col 3)	HIRC (col 1 x col 4)	HGIP (col 1 x col 5)	
	Cost Center Descriptions	6	7	8	9	
	ANCILLARY SERVICE COST CENTERS					
1	Physical Therapy					1
2	Occupational Therapy					2
3	Speech Language Pathology					3
4	Drugs, Biological & Infusion Therapy	26,609				4
5	Durable Medical Equipment/Oxygen					5
6	Labs and Diagnostics					6
7	Medical Supplies					7
8	Outpatient Services (incl E/R)					8
9	Radiation Therapy					9
10	Other					10
11	Totals (sum of lines 1-10)	26,609				11

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IROQUOIS MEMORIAL HOSPITAL Provider CCN: 14-0167	In Lieu of Form CMS-2552-10	Period : From: 10/01/2017 To: 09/30/2018	Run Date: 02/25/2019 Run Time: 14:01 Version: 2018.12 (02/24/2019)
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CALCULATION OF HOSPITAL-BASED HOSPICE PER DIEM COST
HOSPICE CCN: 14-1616
WORKSHEET O-8

		TITLE XVIII MEDICARE	TITLE XIX MEDICAID	TOTAL	
		1	2	3	
	HOSPICE CONTINUOUS HOME CARE				
1	Total cost			26,609	1
2	Total unduplicated days				2
3	Total average cost per diem				3
4	Unduplicated program days				4
5	Program cost				5
	HOSPICE ROUTINE HOME CARE				
6	Total cost			1,337,033	6
7	Total unduplicated days			7,236	7
8	Total average cost per diem			184.78	8
9	Unduplicated program days	6,837	224		9
10	Program cost	1,263,341	41,391		10
	HOSPICE INPATIENT RESPITE CARE				
11	Total cost			4,244	11
12	Total unduplicated days			30	12
13	Total average cost per diem			141.47	13
14	Unduplicated program days	30			14
15	Program cost	4,244			15
	HOSPICE GENERAL INPATIENT CARE				
16	Total cost			5,052	16
17	Total unduplicated days			21	17
18	Total average cost per diem			240.57	18
19	Unduplicated program days	21			19
20	Program cost	5,052			20
	TOTAL HOSPICE CARE				
21	Total cost			1,372,938	21
22	Total unduplicated days			7,287	22
23	Average cost per diem			188.41	23