In Lieu of Form CMS-2552-10

This report is required by Law (42 USC 1395g; 42 CFR 413.20(b)). Failure to report can result in all interim FORM APPROVED payments made since the beginning of the cost reporting period being deemed overpayments (42 USC 1395g). OMB NO. 0938-0

OMB NO. 0938-0050 EXPIRES 09-30-2025

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX COST REPORT CERTIFICATION Provider CCN: 14-1353 Period: From 07/17/2023 To 09/30/2023 Parts I-III Prepared: 2/17/2024 1/42 PP.

		2/26/2024 1:42 pm
PART I - COST	REPORT STATUS	
Provi der	 [X] Electronically prepared cost report 	Date: 2/26/2024 Time: 1:42 pm
use only	2. [] Manually prepared cost report	
	3. [0] If this is an amended report enter the number of 4. [F] Medicare Utilization. Enter "F" for full, "L" for	
Contractor use only	5. [1]Cost Report Status 6. Date Received: (1) As Submitted 7. Contractor No. (2) Settled without Audit 8. [N] Initial Report for t (3) Settled with Audit 9. [N] Final Report for thi (4) Reopened (5) Amended	10. NPR Date: 11. Contractor's Vendor Code: 4 this Provider CCN 12. [0]If line 5, column 1 is 4: Enter number of times reopened = 0-9.

PART II - CERTIFICATION BY A CHIEF FINANCIAL OFFICER OR ADMINISTRATOR OR PROVIDER(S)

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 submitted cost report and the Balance Sheet and Statement of Revenue and Expenses prepared by IROQUOIS MEMORIAL HOSPITAL (14-1353) for the cost reporting period beginning 07/17/2023 and ending 09/30/2023 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.

	SIGNATURE OF CHIEF FINA	NCIAL OFFICER OR ADMINISTRATOR	CHECKBOX	ELECTRONI C	
	1			SI GNATURE STATEMENT	
1	Shav	vn Bransky	Y	I have read and agree with the above certification statement. I certify that I intend my electronic signature on this certification be the legally binding equivalent of my original signature.	1
2	Signatory Printed Name	Shawn Bransky			2
3	Signatory Title	C00/CF0			3
4	Date	(Dated when report is electronica			4

			Title XVIII				
		Title V	Part A	Part B	HIT	Title XIX	
		1.00	2.00	3. 00	4. 00	5. 00	
	PART III - SETTLEMENT SUMMARY						
1.00	HOSPI TAL	0	-97, 313	169, 263	0	0	1.00
2.00	SUBPROVI DER - I PF	0	0	0		0	2. 00
3.00	SUBPROVI DER - I RF	0	0	0		0	3. 00
5.00	SWING BED - SNF	0	-21, 126	0		0	5. 00
6.00	SWING BED - NF	0				0	6. 00
7.00	SKILLED NURSING FACILITY	0	0	0		0	7. 00
9.00	HOME HEALTH AGENCY I	0	0	0		0	9. 00
10.00	RURAL HEALTH CLINIC I	0		-11, 326		0	10.00
10.01	RURAL HEALTH CLINIC II	0		3, 546		0	10. 01
10.02	RURAL HEALTH CLINIC III	0		-10, 307		0	10. 02
10. 03	RURAL HEALTH CLINIC IV	0		15, 088		0	10. 03
200.00	TOTAL	0	-118, 439		0		200. 00

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 number for this information collection is OMB 0938-0050 and the number for the Supplement to Form CMS 2552-10, Worksheet N95, is OMB 0938-1425. The time required to complete and review the information collection is estimated 675 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 the 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.

Peri od: From 07/17/2023 To 09/30/2023

| In Lieu of Form CMS-2552-10 | Worksheet S-2 | Part | | | 30/2023 | Date/Time Prepared: | 2/26/2024 | 1:42 pm

	1.00	2. 00		3. 00			4. 00	2/26/20)24 1:4	2 pm
	Hospital and Hospital Health Care Co									
1. 00 2. 00	Street: 200 FAIRMAN AVENUE	PO Box: State: IL	7in Cod	o. 40070	Count	Fs.11				1. 00 2. 00
2.00	City: WATSEKA	Component Name	CCN	e: 60970 CBSA	Count Provi der		Pavme	nt Syst	em (P.	2.00
			Number	Number		Certi fi ed		0, or	N)	
		1.00	0.00				V	XVIII		
	Hospital and Hospital-Based Componen	1.00	2. 00	3. 00	4.00	5. 00	6. 00	7. 00	8.00	
3.00	Hospi tal	I ROQUOI S MEMORI AL	141353	99914	1	07/17/2023	N	0	Р	3. 00
4 00		HOSPI TAL								4.00
4. 00 5. 00	Subprovi der - IPF Subprovi der - IRF									4. 00 5. 00
6.00	Subprovi der - (Other)									6. 00
7. 00	Swing Beds - SNF	I ROQUOIS MEMORIAL	14Z353	99914		07/17/2023	N	0	N	7. 00
8. 00	Swing Beds - NF	HOSPI TAL								8. 00
9.00	Hospi tal -Based SNF	I ROQUOIS RESIDENT HOME	146049	99914		08/18/2003	N	P	N	9. 00
10.00	Hospi tal -Based NF									10.00
11. 00 12. 00	Hospi tal -Based OLTC Hospi tal -Based HHA	IROQUOIS HOME HEALTH	147586	99914		09/30/1994	N	P	N	12.00
13. 00	Separately Certified ASC									13. 00
14. 00	Hospi tal -Based Hospi ce	I ROQUOIS MEMORIAL HOSPICE	141616	99914		11/04/2004				14. 00
15. 00	Hospital-Based Health Clinic - RHC	GILMAN CLINIC	143424	99914		09/04/1996	N	0	N	15. 00
15. 01	Hospital-Based Health Clinic - RHC	MILFORD CLINIC	143425	99914		10/09/1996		0	N	15. 01
15. 02	 Hospital-Based Health Clinic - RHC	KENTLAND CLINIC	153979	99915		10/29/1996	N	0	N	15. 02
15. 02		KLIVILAND CLINIC	133777	77713		10/29/1990	IN IN		I IN	15.02
15. 03	Hospital-Based Health Clinic - RHC	MPS CLINIC	148551	99914		02/05/2016	N	0	N	15. 03
16. 00	Hospital-Based Health Clinic - FQHC									16. 00
17. 00	Hospital -Based (CMHC) I									17. 00
18. 00	Renal Dialysis									18. 00
19.00	Other					From:		To		19. 00
						1. 00		2. (
20.00	Cost Reporting Period (mm/dd/yyyy)					07/17/2	023	09/30/	/2023	20.00
21.00	Type of Control (see instructions)					2				21. 00
					1. 00	2. 00		3. (00	
22.00	Inpatient PPS Information				N.	- N				22.00
22. 00	Does this facility qualify and is it disproportionate share hospital adju				N	N				22. 00
	§412.106? In column 1, enter "Y" fo	r yes or "N" for no. Is	thi s							
	facility subject to 42 CFR Section § hospital?) In column 2, enter "Y" fo		endment							
22. 01	Did this hospital receive interim UC		tal UCPs,	for	N	N				22. 01
	this cost reporting period? Enter in									
	for the portion of the cost reportin 1. Enter in column 2, "Y" for yes or									
	cost reporting period occurring on o									
	instructions)	61 1 1100 1								
22. 02	Is this a newly merged hospital that determined at cost report settlement			ump	N	N				22. 02
	1, "Y" for yes or "N" for no, for th	e portion of the cost re	eporti ng							
	period prior to October 1. Enter in for the portion of the cost reportin			no,						
22. 03	Did this hospital receive a geograph	5 1		,	N	N		N		22. 03
	rural as a result of the OMB standar	ds for delineating stati	istical ar	eas						
	adopted by CMS in FY2015? Enter in c for the portion of the cost reportin									
	in column 2, "Y" for yes or "N" for			71						
	reporting period occurring on or aft									
	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.	•	•							
22. 04	Did this hospital receive a geograph									22. 04
	rural as a result of the revised OMB adopted by CMS in FY 2021? Enter in									
	for the portion of the cost reportin	g period prior to Octob	er 1. Ente							
	in column 2, "Y" for yes or "N" for reporting period occurring on or aft									
	Does this hospital contain at least			as						
	counted in accordance with 42 CFR 41	2.105)? Enter in column	n 3, "Y" 1	or						
	yes or "N" for no.			I		I	1			I

Health Financial Systems In Lieu of Form CMS-2552-10 HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA Provider CCN: 14-1353 Peri od: Worksheet S-2 From 07/17/2023 Part I 09/30/2023 Date/Time Prepared: 2/26/2024 1:42 pm 1. 00 2. 00 3. 00 23.00 Which method is used to determine Medicaid days on lines 24 and/or 25 Ν 23.00 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. In-State In-State Out-of Out-of Medi cai d 0ther HMO days Medi cai d Medi cai d State State Medi cai d Medi cai d Medi cai d paid days eligible days unpai d paid days eligible days unpai d 3. 00 4. 00 5.00 1.00 2.00 6.00 24.00 If this provider is an IPPS hospital, enter the 0 24.00 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. 25.00 If this provider is an IRF, enter the in-state 0 0 25.00 0 0 Medicaid paid days in column 1, the 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. Urban/Rural S Date of Geogr 1.00 2.00 26.00 Enter your standard geographic classification (not wage) status at the beginning of the 26 00 cost reporting period. Enter "1" for urban or "2" for rural. 27.00 Enter your standard geographic classification (not wage) status at the end of the cost 27.00 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. If this is a sole community hospital (SCH), enter the number of periods SCH status in 35.00 effect in the cost reporting period. Begi nni ng: Endi ng: 2.00 36.00 Enter applicable beginning and ending dates of SCH status. Subscript line 36 for number 36.00 of periods in excess of one and enter subsequent dates. If this is a Medicare dependent hospital (MDH), enter the number of periods MDH status 37.00 is in effect in the cost reporting period. Is this hospital a former MDH that is eligible for the MDH transitional payment in 37.01 accordance with FY 2016 OPPS final rule? Enter "Y" for yes or "N" for no. (see instructions) If line 37 is 1, enter the beginning and ending dates of MDH status. If line 37 is 38 00 38 00 greater than 1, subscript this line for the number of periods in excess of one and enter subsequent dates. Y/N Y/N 2.00 1.00 39.00 Does this facility qualify for the inpatient hospital payment adjustment for low volume Ν Ν 39.00 hospitals in accordance with 42 CFR §412.101(b)(2)(i), (ii), or (iii)? 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), (ii), or (iii)? Enter in column 2 "Y" for yes or "N" for no. (see instructions) 40.00 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 Ν Ν 40.00 no in column 2, for discharges on or after October 1. (see instructions) XVIII XI X 1.00 2.00 3.00 Prospective Payment System (PPS)-Capital 45.00 Does this facility qualify and receive Capital payment for disproportionate share in accordance 45.00 Ν Ν N with 42 CFR Section §412.320? (see instructions) Is this facility eligible for additional payment exception for extraordinary circumstances Ν Ν Ν 46.00 pursuant to 42 CFR §412.348(f)? If yes, complete Wkst. L, Pt. III and Wkst. L-1, Pt. I through Pt. III. 47.00 | Is this a new hospital under 42 CFR §412.300(b) PPS capital? Enter "Y for yes or "N" for no. 47.00 Ν Ν Ν 48.00 Is the facility electing full federal capital payment? Enter "Y" for yes or "N" for no. N N N 48.00 Teaching Hospitals Is this a hospital involved in training residents in approved GME programs? For cost reporting 56.00 periods beginning prior to December 27, 2020, enter "Y" for yes or "N" for no in column 1. For cost reporting periods beginning on or after December 27, 2020, under 42 CFR 413.78(b)(2), see the instructions. For column 2, if the response to column 1 is "Y", or if this hospital was

involved in training residents in approved GME programs in the prior year or penultimate year, and are you are impacted by CR 11642 (or applicable CRs) MA direct GME payment reduction? Enter

'Y" for yes; otherwise, enter "N" for no in column 2.

In Lieu of Form CMS-2552-10

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA

Provi der CCN: 14-1353

Peri od: Worksheet S-2 From 07/17/2023 Part I

09/30/2023 Date/Time Prepared: 2/26/2024 1: 42 pm XVIII XIX 1. 00 2.00 3.00 57.00 For cost reporting periods beginning prior to December 27, 2020, if line 56, column 1, is yes, 57.00 is this the first cost reporting period during which residents in approved GME programs trained at this facility? Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y", did residents start training in the first month of this cost reporting period? Enter "Y" for yes or "N" for no in column 2. If column 2 is "Y", complete Worksheet E-4. If column 2 is "N", complete Wkst. D, Parts III & IV and D-2, Pt. II, if applicable. For cost reporting periods beginning on or after December 27, 2020, under 42 CFR 413.77(e)(1)(iv) and (v), regardless of which month(s) of the cost report the residents were on duty, if the response to line 56 is "Y" for yes, enter "Y" for yes in column 1, do not complete column 2, and complete Worksheet E-4. If line 56 is yes, did this facility elect cost reimbursement for physicians' services as Ν 58.00 defined in CMS Pub. 15-1, chapter 21, §2148? If yes, complete Wkst. D-5. 59.00 Are costs claimed on line 100 of Worksheet A? If yes, complete Wkst. D-2. 59.00 NAHE 413.85 Worksheet A Pass-Through Y/N Line # Qual i fi cati on Criterion Code 2.00 3.00 1.00 60.00 Are you claiming nursing and allied health education (NAHE) costs for Ν 60.00 any programs that meet the criteria under 42 CFR 413.85? (see instructions) Enter "Y" for yes or "N" for no in column 1. If column 1

	is "Y", are you impacted by CR 11642 (or subsequent C adjustment? Enter "Y" for yes or "N" for no in colum		E MA payment				
	<u> </u>	Y/N	IME	Direct GME	IME	Direct GME	
		1. 00	2. 00	3. 00	4.00	5. 00	
61. 00	Did your hospital receive FTE slots under ACA section 5503? Enter "Y" for yes or "N" for no in column 1. (see instructions)	N			0.00	0. 00	61. 00
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 base line 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

		Program Name	Program Code	junwei gn tea i ME	unwei gnitea	
				FTE Count	Direct GME FTE	
					Count	
		1. 00	2. 00	3. 00	4. 00	
61. 10	Of the FTEs in line 61.05, specify each new program			0. 00	0.00	61. 10
	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.					
61. 20	Of the FTEs in line 61.05, specify each expanded			0.00	0. 00	61. 20
	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,					
	the direct GME FTE unweighted count.					

0.000000 66.00

Ratio (col. 3/ (col. 3 + col.

4))

5. 00

0.00

Unwei ghted

FTEs

Nonprovi der

Si te

3.00

0.00

Unwei ghted

FTEs in

Hospi tal

4.00

Health Financial Systems In Lieu of Form CMS-2552-10 HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA Provi der CCN: 14-1353 Peri od: Worksheet S-2 From 07/17/2023 Part I 09/30/2023 Date/Time Prepared: 2/26/2024 1:42 pm 1. 00 ACA Provisions Affecting the Health Resources and Services Administration (HRSA) 0.00 62.00 62.00 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) Enter the number of FTE residents that rotated from a Teaching Health Center (THC) into your hospital 0.00 62.01 62.01 during in this cost reporting period of HRSA THC program. (see instructions) Teaching Hospitals that Claim Residents in Nonprovider Settings Has your facility trained residents in nonprovider settings during this cost reporting period? Enter "Y" for yes or "N" for no in column 1. If yes, complete lines 64 through 67. (see instructions) 63.00 63.00 Unwei ghted Unwei ghted Ratio (col. 1/ FTEs FTEs in (col. 1 + col Nonprovi der Hospi tal 2)) Si te 1. 00 2.00 3.00 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. 64 00 Enter in column 1, if line 63 is yes, or your facility trained residents 0 00 0.00 0 000000 64 00 n the base year period, the number of unweighted non-primary care resident FTEs attributable to rotations occurring in all nonprovider 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) Unwei ghted Program Name Program Code Unwei ghted Ratio (col. 3/ (col. 3 + col FTEs FTEs in Nonprovi der Hospi tal 4)) Si te 3. 00 1.00 2.00 4.00 5.00 65.00 Enter in column 1, 0.000000 65.00 0.00 is yes, or your facility trained residents in the base year period, the program name associated with primary care FTEs for each primary care program in which you trained residents. 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) Unwei ghted Unwei ghted Ratio (col. 1/ **FTEs** FTEs in (col. 1 + col Nonprovi der Hospi tal 2)) Si te 1.00 2.00 Section 5504 of the ACA Current Year FTE Residents in Nonprovider Settings--Effective for cost reporting periods

Program Code

2.00

beginning on or after July 1, 2010

Enter in column 1 the number of unweighted non-primary care resident

FTEs attributable to rotations occurring in all 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)

Program Name

1.00

In Lieu of Form CMS-2552-10

Peri od: Worksheet S-2 From 07/17/2023 Part I To 09/30/2023 Date/Time Prepared:

			T	o 09/30/2023	Date/Time Pro 2/26/2024 1:4		
	Program Name	Program Code	Unwei ghted	Unwei ghted	Ratio (col. 3	/	
			FTES	FTEs in	(col. 3 + col		
			Nonprovi der Si te	Hospi tal	4))		
	1. 00	2. 00	3. 00	4.00	5. 00	1	
67.00 Enter in column 1, the program name associated with each of your primary care programs in which you trained residents. 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)			0. 00	0.00	0. 00000	0 67.00	
11)): (666 11.61.461.61.6)					1. 00		
Direct GME in Accordance with th							
8.00 For a cost reporting period beging MAC to apply the new DGME formul (August 10, 2022)?						68. 00	
				1.0	0 2.00 3.00		
Inpatient Psychiatric Facility P 0.00 Is this facility an Inpatient Ps	ychiatric Facility (I	PF), or does it conta	ain an IPF subp	provi der? N		70. 00	
71.00 If line 70 is yes: Column 1: Did recent cost report filed on or b 42 CFR 412.424(d)(1)(iii)(c)) Co program in accordance with 42 CF	Enter "Y" for yes or "N" for no. If line 70 is yes: Column 1: Did the facility have an approved GME teaching program in the most recent cost report filed on or before November 15, 2004? Enter "Y" for yes or "N" for no. (see 42 CFR 412.424(d)(1)(iii)(c)) 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 or "N" for no. Column 3: If column 2 is Y, indicate which program year began during this cost reporting period.						
Inpatient Rehabilitation Facilit		(1.2.2)				I	
5.00 Is this facility an Inpatient Re subprovider? Enter "Y" for yes		y (IRF), or does it co	ontain an IRF	N		75. 00	
6.00 If line 75 is yes: Column 1: Did recent cost reporting period end no. Column 2: Did this facility CFR 412.424 (d)(1)(iii)(D)? Ente indicate which program year bega	the facility have ar ing on or before Nove train residents in a r "Y" for yes or "N"	ember 15, 2004? Enter new teaching program for no. Column 3: If	"Y" for yes or in accordance column 2 is Y,	"N" for with 42	0	76. 00	
					1. 00		
Long Term Care Hospital PPS 0.00 Is this a long term care hospita	I (ITCH)? Enter "V"	for yes and "N" for r	20		N	80.00	
B1.00 Is this a LTCH co-located within "Y" for yes and "N" for no.				period? Enter	N	81.00	
TEFRA Providers 15.00 Is this a new hospital under 42	CER Section 8413 40(1	F)(1)(i) TEERA2 Enter	r "V" for ves o	or "N" for no	N	85. 00	
B6.00 Did this facility establish a ne §413.40(f)(1)(ii)? Enter "Y" fo	w Other subprovider (r yes and "N" for no.	(excluded unit) under	42 CFR Section			86. 00	
7.00 Is this hospital an extended neo 1886(d)(1)(B)(vi)? Enter "Y" for		hospital classified ι	under section		N	87. 00	
				Approved for Permanent Adjustment (Y/N)	Number of Approved Permanent Adjustments		
	ved for a nermanent a	adjustment to the TEE	DA target	1. 00 N	2. 00	0 88.00	
38.00 Column 1: Is this hospital appro							

In Lieu of Form CMS-2552-10

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA

Provider CCN: 14-1353

Peri od: Worksheet S-2 From 07/17/2023 Part I 09/30/2023 Date/Time Prepared:

2/26/2024 1:42 pm Wkst. A Line Effective Date Approved Permanent Adjustment Amount Per Di scharge 1. 00 2.00 3. 00 89.00 Column 1: If line 88, column 1 is Y, enter the Worksheet A line number 0 00 0 89 00 on which the per discharge permanent adjustment approval was based. Column 2: Enter the effective date (i.e., the cost reporting period beginning date) for the permanent adjustment to the TEFRA target amount per di scharge. Column 3: Enter the amount of the approved permanent adjustment to the TEFRA target amount per discharge. V XI X 1. 00 2.00 Title V and XIX Services 90.00 Does this facility have title V and/or XIX inpatient hospital services? Enter "Y" for 90 00 Ν yes or "N" for no in the applicable column. 91.00 Is this hospital reimbursed for title V and/or XIX through the cost report either in Ν Υ 91.00 full or in part? Enter "Y" for yes or "N" for no in the applicable column. Are title XIX NF patients occupying title XVIII SNF beds (dual certification)? (see instructions) Enter "Y" for yes or "N" for no in the applicable column. 92.00 Ν 92.00 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. 93.00 Ν N 93.00 Does title V or XIX reduce capital cost? Enter "Y" for yes, and "N" for no in the 94.00 Ν N 94.00 If line 94 is "Y", enter the reduction percentage in the applicable column. 95.00 0.00 0.00 Does title V or XIX reduce operating cost? Enter "Y" for yes or "N" for no in the 96.00 96.00 N N applicable column. 97.00 0, 00 0 00 If line 96 is "Y", enter the reduction percentage in the applicable column. 97 00 Does title V or XIX follow Medicare (title XVIII) for the interns and residents post Ν Ν 98.00 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. Does title V or XIX follow Medicare (title XVIII) for the reporting of charges on Wkst. 98 01 98 01 N C, Pt. I? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX. 98.02 Does title V or XIX follow Medicare (title XVIII) for the calculation of observation 98.02 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. 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 Ν 98 03 N for title V, and in column 2 for title XIX. 98.04 Does title V or XIX follow Medicare (title XVIII) for a CAH reimbursed 101% of Ν 98.04 outpatient services cost? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX. 98.05 Does title V or XIX follow Medicare (title XVIII) and add back the RCE disallowance on 98.05 Ν 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. Does title V or XIX follow Medicare (title XVIII) when cost reimbursed for Wkst. D, Ν Υ 98.06 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. Rural Providers 105.00 Does this hospital qualify as a CAH? 105.00 106.00 If this facility qualifies as a CAH, has it elected the all-inclusive method of payment 106.00 for outpatient services? (see instructions) 107.00 Column 1: If line 105 is Y, is this facility eligible for cost reimbursement for I&R 107.00 training programs? Enter "Y" for yes or "N" for no in column 1. (see instructions) Column 2: If column 1 is Y and line 70 or line 75 is Y, do you train I&Rs in an approved medical education program in the CAH's excluded IPF and/or IRF unit(s)? Enter "Y" for yes or "N" for no in column 2. (see instructions) 108.00 Is this a rural hospital qualifying for an exception to the CRNA fee schedule? See 42 CFR Section §412.113(c). Enter "Y" for yes or "N" for no. Ν 108.00 Physi cal Occupati onal Speech Respi ratory 1.00 2.00 3.00 4.00 109.00 If this hospital qualifies as a CAH or a cost provider, are 109. 00 therapy services provided by outside supplier? Enter "Y'

for yes or "N" for no for each therapy.

		09/30/2023	Date/Time P 2/26/2024 1	
			1. 00	
10.00 Did this hospital participate in the Rural Community Hospital Demonstration Demonstration) for the current cost reporting period? Enter "Y" for yes or complete Worksheet E, Part A, lines 200 through 218, and Worksheet E-2, I applicable.	"N" for no. If	yes,	N	110.
		1. 00	2. 00	
11.00 If this facility qualifies as a CAH, did it participate in the Frontier Combined Health Integration Project (FCHIP) demonstration for this cost reporting "Y" for yes or "N" for no in column 1. If the response to column 1 is Y, integration prong of the FCHIP demo in which this CAH is participating in Enter all that apply: "A" for Ambulance services; "B" for additional beds for tele-health services.	period? Enter enter the column 2.	N		111. (
	1. 00	2. 00	3. 00	
12.00 Did this hospital participate in the Pennsylvania Rural Health Model (PARHM) demonstration for any portion of the current cost reporting period? Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y", enter in column 2, the date the hospital began participating in the demonstration. In column 3, enter the date the hospital ceased participation in the demonstration, if applicable. Miscellaneous Cost Reporting Information	N			112. (
15.00 s 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.15-1, chapter 22, §2208.1. 16.00 s this facility classified as a referral center? Enter "Y" for yes or	N			116.0
"N" for no.	Y			117. (
"Y" for yes or "N" for no.	Ť			
18.00 s 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.
	1.00	2. 00	3. 00	
18.01 List amounts of malpractice premiums and paid losses:	111, 033	0)	0 118.
		1. 00	2. 00	
Administrative and General? If yes, submit supporting schedule listing or and amounts contained therein.		1. 00 Y	2.00	
and amounts contained therein. 19.00 DO NOT USE THIS LINE 20.00 Is this a SCH or EACH that qualifies for the Outpatient Hold Harmless prosecution of Sal21 and applicable amendments? (see instructions) Enter in column 1, "Y" "N" for no. Is this a rural hospital with < 100 beds that qualifies for the Hold Harmless provision in ACA §3121 and applicable amendments? (see instructions)	ost centers vision in ACA " for yes or he Outpatient		2. 00 N	118. 119. 120.
Administrative and General? If yes, submit supporting schedule listing or and amounts contained therein. 19.00 DO NOT USE THIS LINE 20.00 Is this a SCH or EACH that qualifies for the Outpatient Hold Harmless prov §3121 and applicable amendments? (see instructions) Enter in column 1, "Y"N" for no. Is this a rural hospital with < 100 beds that qualifies for the Hold Harmless provision in ACA §3121 and applicable amendments? (see instructions) Enter in column 2, "Y" for yes or "N" for no. 21.00 Did this facility incur and report costs for high cost implantable devices	ost centers vision in ACA " for yes or he Outpatient ructions)	Y		119.
Administrative and General? If yes, submit supporting schedule listing or and amounts contained therein. 19.00 DO NOT USE THIS LINE 20.00 Is this a SCH or EACH that qualifies for the Outpatient Hold Harmless prome \$3121 and applicable amendments? (see instructions) Enter in column 1, "Y" "N" for no. Is this a rural hospital with < 100 beds that qualifies for the Hold Harmless provision in ACA \$3121 and applicable amendments? (see instructions) Enter in column 2, "Y" for yes or "N" for no. 21.00 Did this facility incur and report costs for high cost implantable devices patients? Enter "Y" for yes or "N" for no. 22.00 Does the cost report contain healthcare related taxes as defined in \$1903 Act?Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y", enter	vision in ACA " for yes or he Outpatient ructions) s charged to (w)(3) of the	Y N		119. 120.
Administrative and General? If yes, submit supporting schedule listing of and amounts contained therein. 19.00 DO NOT USE THIS LINE 20.00 Is this a SCH or EACH that qualifies for the Outpatient Hold Harmless prospective states and applicable amendments? (see instructions) Enter in column 1, "Y" "N" for no. Is this a rural hospital with < 100 beds that qualifies for the Hold Harmless provision in ACA §3121 and applicable amendments? (see instructions) Enter in column 2, "Y" for yes or "N" for no. 21.00 Did this facility incur and report costs for high cost implantable device patients? Enter "Y" for yes or "N" for no. 22.00 Does the cost report contain healthcare related taxes as defined in §1903 Act?Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y", enter the Worksheet A line number where these taxes are included. 23.00 Did the facility and/or its subproviders (if applicable) purchase profess services, e.g., legal, accounting, tax preparation, bookkeeping, payroll, management/consulting services, from an unrelated organization? In column for yes or "N" for no. If column 1 is "Y", were the majority of the expenses, i.e., greater than	vision in ACA " for yes or he Outpatient ructions) s charged to (w)(3) of the r in column 2 ional and/or 1, enter "Y"	Y N Y		119. 120. 121. 122.
Administrative and General? If yes, submit supporting schedule listing of and amounts contained therein. 19.00 DO NOT USE THIS LINE 20.00 Is this a SCH or EACH that qualifies for the Outpatient Hold Harmless prosports in Size and applicable amendments? (see instructions) Enter in column 1, "Y" "N" for no. Is this a rural hospital with < 100 beds that qualifies for the Hold Harmless provision in ACA §3121 and applicable amendments? (see instructions) Enter in column 2, "Y" for yes or "N" for no. 21.00 Did this facility incur and report costs for high cost implantable devices patients? Enter "Y" for yes or "N" for no. 22.00 Does the cost report contain healthcare related taxes as defined in §1903 Act?Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y", enter the Worksheet A line number where these taxes are included. 23.00 Did the facility and/or its subproviders (if applicable) purchase profess services, e.g., legal, accounting, tax preparation, bookkeeping, payroll, management/consulting services, from an unrelated organization? In column for yes or "N" for no. If column 1 is "Y", were the majority of the expenses, i.e., greater than professional services expenses, for services purchased from unrelated organization? In column 2, enter "N" for no.	vision in ACA " for yes or he Outpatient ructions) s charged to (w)(3) of the r in column 2 ional and/or 1, enter "Y" 50% of total anizations	Y N Y		119. 120. 121. 122.
Administrative and General? If yes, submit supporting schedule listing of and amounts contained therein. 19.00 DO NOT USE THIS LINE 20.00 Is this a SCH or EACH that qualifies for the Outpatient Hold Harmless prome \$3121 and applicable amendments? (see instructions) Enter in column 1, "Y" "N" for no. Is this a rural hospital with < 100 beds that qualifies for the Hold Harmless provision in ACA \$3121 and applicable amendments? (see instructions) Enter in column 2, "Y" for yes or "N" for no. 21.00 Did this facility incur and report costs for high cost implantable device patients? Enter "Y" for yes or "N" for no. 22.00 Does the cost report contain healthcare related taxes as defined in \$1903 Act?Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y", enter the Worksheet A line number where these taxes are included. 23.00 Did the facility and/or its subproviders (if applicable) purchase profess services, e.g., legal, accounting, tax preparation, bookkeeping, payroll, management/consulting services, from an unrelated organization? In column for yes or "N" for no. If column 1 is "Y", were the majority of the expenses, i.e., greater than professional services expenses, for services purchased from unrelated organization accounting tax preparation. Certified Transplant Center Information 25.00 Does this facility operate a Medicare-certified transplant center? Enter and "N" for no. If yes, enter certification date(s) (mm/dd/yyyy) below.	vision in ACA " for yes or he Outpatient ructions) s charged to (w)(3) of the r in column 2 ional and/or 1, enter "Y" 50% of total anizations Y" for yes or	Y N Y		119. 120. 121. 122. 123.
Administrative and General? If yes, submit supporting schedule listing of and amounts contained therein. 19.00 DO NOT USE THIS LINE 20.00 Is this a SCH or EACH that qualifies for the Outpatient Hold Harmless prome \$3121 and applicable amendments? (see instructions) Enter in column 1, "Y" "N" for no. Is this a rural hospital with < 100 beds that qualifies for the Hold Harmless provision in ACA \$3121 and applicable amendments? (see instructions) Enter in column 2, "Y" for yes or "N" for no. 21.00 Did this facility incur and report costs for high cost implantable devices patients? Enter "Y" for yes or "N" for no. 22.00 Does the cost report contain healthcare related taxes as defined in \$1903 Act?Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y", enter the Worksheet A line number where these taxes are included. 23.00 Did the facility and/or its subproviders (if applicable) purchase profess services, e.g., legal, accounting, tax preparation, bookkeeping, payroll, management/consulting services, from an unrelated organization? In column for yes or "N" for no. If column 1 is "Y", were the majority of the expenses, i.e., greater than professional services expenses, for services purchased from unrelated organizated in a CBSA outside of the main hospital CBSA? In column 2, enter "N" for no. Certified Transplant Center Information 25.00 Does this facility operate a Medicare-certified transplant center? Enter and "N" for no. If yes, enter certification date(s) (mm/dd/yyyy) below. 26.00 If this is a Medicare-certified kidney transplant program, enter the certific column 1 and termination date, if applicable, in column 2.	vision in ACA " for yes or he Outpatient ructions) s charged to (w)(3) of the r in column 2 ional and/or 1, enter "Y" 50% of total anizations Y" for yes or "Y" for yes i fication date	Y N Y N		119. 120. 121. 122. 123.
Administrative and General? If yes, submit supporting schedule listing of and amounts contained therein. 19.00 19.00 19.00 19.00 10.00 1	vision in ACA " for yes or he Outpatient ructions) s charged to (w)(3) of the r in column 2 ional and/or 1, enter "Y" 50% of total anizations Y" for yes or "Y" for yes i fication date fication date	Y N Y N		119. 120. 121. 122. 123.
Administrative and General? If yes, submit supporting schedule listing of and amounts contained therein. 19.00 DO NOT USE THIS LINE 20.00 Is this a SCH or EACH that qualifies for the Outpatient Hold Harmless proves \$3121 and applicable amendments? (see instructions) Enter in column 1, "Y" "N" for no. Is this a rural hospital with < 100 beds that qualifies for the Hold Harmless provision in ACA \$3121 and applicable amendments? (see instructions) Enter in column 2, "Y" for yes or "N" for no. 21.00 Did this facility incur and report costs for high cost implantable devices patients? Enter "Y" for yes or "N" for no. 22.00 Does the cost report contain healthcare related taxes as defined in \$1903 Act?Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y", enter the Worksheet A line number where these taxes are included. 23.00 Did the facility and/or its subproviders (if applicable) purchase profess services, e.g., legal, accounting, tax preparation, bookkeeping, payroll, management/consulting services, from an unrelated organization? In column for yes or "N" for no. If column 1 is "Y", were the majority of the expenses, i.e., greater than professional services expenses, for services purchased from unrelated organizated in a CBSA outside of the main hospital CBSA? In column 2, enter "N" for no. Certified Transplant Center Information 25.00 Does this facility operate a Medicare-certified transplant center? Enter and "N" for no. If yes, enter certification date(s) (mm/dd/yyyy) below. 26.00 If this is a Medicare-certified kidney transplant program, enter the certifical column 1 and termination date, if applicable, in column 2.	vision in ACA " for yes or he Outpatient ructions) s charged to (w)(3) of the r in column 2 ional and/or 1, enter "Y" 50% of total anizations Y" for yes or "Y" for yes i fication date fication date	Y N Y N		119. 120. 121. 122. 123.

In Lieu of Form CMS-2552-10 Worksheet S-2

From 07/17/2023 Part I 09/30/2023 Date/Time Prepared: 2/26/2024 1:42 pm 1. 00 2.00 131.00 \mid If this is a Medicare-certified intestinal transplant program, enter the certification 131.00 date in column 1 and termination date, if applicable, in column 2. 132.00|If this is a Medicare-certified islet transplant program, enter the certification date 132.00 in column 1 and termination date, if applicable, in column 2. 133.00 Removed and reserved 133.00 134.00|If this is a hospital-based organ procurement organization (OPO), enter the OPO number 134.00 in column 1 and termination date, if applicable, in column 2 All Providers 140.00 Are there any related organization or home office costs as defined in CMS Pub. 15-1, N 140.00 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) 3.00 1.00 2.00 If this facility is part of a chain organization, enter on lines 141 through 143 the name and address of the home office and enter the home office contractor name and contractor number 141. 00 Name: Contractor's Name: Contractor's Number: 141.00 142.00 Street: 142.00 PO Box: 143.00 Ci ty: State: Zip Code: 143. 00 1.00 144.00 Are provider based physicians' costs included in Worksheet A? 144.00 Υ 1. 00 2.00 145.00 If costs for renal services are claimed on Wkst. A, line 74, are the costs for 145. 00 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. 146.00 Has the cost allocation methodology changed from the previously filed cost report? Ν 146. 00 Enter "Y" for yes or "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. 1.00 147.00 Was there a change in the statistical basis? Enter "Y" for yes or "N" for no. 148.00 Was there a change in the order of allocation? Enter "Y" for yes or "N" for no. 147.00 N 148. 00 149.00 Was there a change to the simplified cost finding method? Enter "Y" for yes or "N" for no 149.00 N Title XIX Part A Part B Title V 1.00 2.00 4.00 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) 155.00 Hospi tal Ν N 155.00 156.00 Subprovi der - IPF Ν Ν Ν Ν 156.00 157.00 Subprovi der - IRF Ν Ν Ν Ν 157. 00 158. 00 SUBPROVI DER 158 00 159.00 SNF Ν Ν Ν Ν 159.00 160.00 HOME HEALTH AGENCY 160. 00 Ν Ν Ν Ν 161.00 CMHC 161.00 Ν Ν Ν 1.00 Mul ti campus 165. 00 165,00 s this hospital part of a Multicampus hospital that has one or more campuses in different CBSAs? Enter "Y" for yes or "N" for no. Name County State Zip Code **CBSA** FTE/Campus 0 1.00 2.00 3.00 4.00 5.00 166.00 If line 165 is yes, for each 0.00166.00 campus enter the name in column O, county in column 1, state in column 2, zip code in column 3, CBSA in column 4, FTE/Campus in column 5 (see instructions) 1. 00 Health Information Technology (HIT) incentive in the American Recovery and Reinvestment Act 167.00 is this provider a meaningful user under §1886(n)? Enter "Y" for yes or "N" for no. 167.00 168.00 of this provider is a CAH (line 105 is "Y") and is a meaningful user (line 167 is "Y"), enter the 168.00 reasonable cost incurred for the HIT assets (see instructions) 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. 01 169.00 If this provider is a meaningful user (line 167 is "Y") and is not a CAH (line 105 is "N"), enter the 0.00169.00 transition factor. (see instructions)

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I ROQUOIS MEMORIAL HOSPITAL

HOSPITAL AND HOSPITAL HEALTH CAPE COMPLEY LICENTIFICATION DATA

Provider CON: 14.1353 Period:

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA Provi der CCN: 14-1353 Worksheet S-2 Peri od: From 07/17/2023 To 09/30/2023 Part I Date/Time Prepared: 2/26/2024 1:42 pm Begi nni ng Endi ng 1. 00 2. 00 170.00 Enter in columns 1 and 2 the EHR beginning date and ending date for the reporting 170. 00 period respectively (mm/dd/yyyy) 1. 00 2. 00 171.00 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 yes, enter the number of section 0 171. 00 N 1876 Medicare days in column 2. (see instructions)

In Lieu of Form CMS-2552-10

In Lieu of Form CMS-2552-10

Period: Worksheet S-2

From 07/17/2023 Part II

To 09/30/2023 Date/Time Prepared: 2/26/2024 1:42 pm

					2/26/2024 1:4	42 pm
				Y/N	Date	
	DART II. HOCDITAL AND HOCDITAL HEATHOADE CONDUCY DELADIDOCEM	AENT OUECTLONE	ALDE	1. 00	2.00	
	PART II - HOSPITAL AND HOSPITAL HEATHCARE COMPLEX REIMBURSEM General Instruction: Enter Y for all YES responses. Enter N			all dates in	tho.	+
	mm/dd/yyyy format.	TOT ALL NO LE	sponses. Enter	all dates ill	trie	
	COMPLETED BY ALL HOSPITALS					
	Provider Organization and Operation					
1.00	Has the provider changed ownership immediately prior to the	beginning of	the cost	N		1.00
	reporting period? If yes, enter the date of the change in co	olumn 2. (see				
			Y/N	Date	V/I	
	In		1.00	2. 00	3.00	
2. 00	Has the provider terminated participation in the Medicare Pr		N			2.00
	yes, enter in column 2 the date of termination and in column voluntary or "I" for involuntary.	1 3, V TOF				
3.00	Is the provider involved in business transactions, including	n management	l N			3.00
0.00	contracts, with individuals or entities (e.g., chain home of		"			0.00
	or medical supply companies) that are related to the provide					
	officers, medical staff, management personnel, or members of	f the board				
	of directors through ownership, control, or family and other	similar				
	relationships? (see instructions)		V (8)	-	.	
			Y/N	Type	Date	
	Financial Data and Danorts		1.00	2. 00	3. 00	-
4.00	Financial Data and Reports Column 1: Were the financial statements prepared by a Certi	fied Public	l N			4.00
4.00	Accountant? Column 2: If yes, enter "A" for Audited, "C" for					1 7.00
	or "R" for Reviewed. Submit complete copy or enter date avai					
	column 3. (see instructions) If no, see instructions.					
5.00	Are the cost report total expenses and total revenues differ		N			5.00
	those on the filed financial statements? If yes, submit reco	onciliation.				
				Y/N	Legal Oper.	
	Approved Educational Activities			1. 00	2.00	
6. 00	Approved Educational Activities Column 1: Are costs claimed for a nursing program? Column 2). If you is	the provider	N	T	6.00
0.00	the legal operator of the program?	2. 11 yes, 13	the provider	IN		0.00
7.00	Are costs claimed for Allied Health Programs? If "Y" see ins	structions		N		7.00
8. 00	Were nursing programs and/or allied health programs approved		ed during the	N		8.00
	cost reporting period? If yes, see instructions.		J			
9.00	Are costs claimed for Interns and Residents in an approved g		al education	N		9. 00
	program in the current cost report? If yes, see instructions					1
10. 00	Was an approved Intern and Resident GME program initiated or	renewed in t	he current	N		10.00
11. 00	cost reporting period? If yes, see instructions. Are GME cost directly assigned to cost centers other than I	& Pin an Ann	roved	N		11.00
11.00	Teaching Program on Worksheet A? If yes, see instructions.	a k iii aii App	n oved	IN		11.00
	Treatment of the treatm				Y/N	
					1.00	
	Bad Debts					
12.00	Is the provider seeking reimbursement for bad debts? If yes,				Y	12.00
13. 00	If line 12 is yes, did the provider's bad debt collection po	olicy change o	luring this cos	t reporting	N	13.00
14 00	period? If yes, submit copy.		ived2 LE vec		N	14.00
14. 00	If line 12 is yes, were patient deductibles and/or coinsuran instructions.	ice alliounts wa	iivea? II yes, :	see	N	14.00
	Bed Complement					
15. 00	Did total beds available change from the prior cost reporting	ng period? If	yes, see instr	uctions.	N	15.00
		Par	t A		rt B	
		Y/N	Date	Y/N	Date	
		1. 00	2. 00	3. 00	4.00	
4, 00	PS&R Data		ı	•••		٠,
16. 00	Was the cost report prepared using the PS&R Report only?	N		N		16. 00
	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)					
17. 00	Was the cost report prepared using the PS&R Report for	Υ	01/29/2024	Υ	01/29/2024	17. 00
	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)					
18. 00	If line 16 or 17 is yes, were adjustments made to PS&R	N		N		18. 00
	Report data for additional claims that have been billed					
	but are not included on the PS&R Report used to file this					
19. 00	cost report? If yes, see instructions.	N		NI.		19.00
17.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for corrections of other PS&R Report	IN		N		19.00
	information? If yes, see instructions.					
	1		ı	İ	1	1

In Lieu of Form CMS-2552-10

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE Provider CCN: 14-1353 Peri od: Worksheet S-2 From 07/17/2023 Part II Date/Time Prepared: 09/30/2023 2/26/2024 1:42 pm Description Y/N 1. 00 3.00 20.00 | If line 16 or 17 is yes, were adjustments made to PS&R N Ν 20.00 Report data for Other? Describe the other adjustments: Y/N Date Y/N Date 1.00 3.00 4.00 21.00 Was the cost report prepared only using the provider's Ν N 21.00 records? If yes, see instructions. 1.00 COMPLETED BY COST REIMBURSED AND TEFRA HOSPITALS ONLY (EXCEPT CHILDRENS HOSPITALS) Capital Related Cost 22.00 Have assets been relifed for Medicare purposes? If yes, see instructions Ν 22 00 Have changes occurred in the Medicare depreciation expense due to appraisals made during the cost Ν 23.00 reporting period? If yes, see instructions. 24 00 Were new leases and/or amendments to existing leases entered into during this cost reporting period? Ν 24 00 If ves. see instructions 25 00 Have there been new capitalized leases entered into during the cost reporting period? If yes, see Ν 25 00 26.00 Were assets subject to Sec. 2314 of DEFRA acquired during the cost reporting period? If yes, see Ν 26.00 instructions. 27.00 Has the provider's capitalization policy changed during the cost reporting period? If yes, submit Ν 27.00 сору. Interest Expense Were new loans, mortgage agreements or letters of credit entered into during the cost reporting 28.00 28.00 Ν period? If yes, see instructions. 29.00 Did the provider have a funded depreciation account and/or bond funds (Debt Service Reserve Fund) Ν 29.00 treated as a funded depreciation account? If yes, see instructions Has existing debt been replaced prior to its scheduled maturity with new debt? If yes, see 30.00 Ν 30.00 instructions. 31.00 Has debt been recalled before scheduled maturity without issuance of new debt? If yes, see Ν 31.00 instructions. Purchased Services 32.00 Have changes or new agreements occurred in patient care services furnished through contractual N 32 00 arrangements with suppliers of services? If yes, see instructions. If line 32 is yes, were the requirements of Sec. 2135.2 applied pertaining to competitive bidding? If 33.00 Ν 33.00 no, see instructions. Provi der-Based Physicians 34.00 Were services furnished at the provider facility under an arrangement with provider-based physicians? Ν 34 00 If yes, see instructions. 35.00 If line 34 is yes, were there new agreements or amended existing agreements with the provider-based Ν 35.00 physicians during the cost reporting period? If yes, see instructions Date 1.00 2.00 Home Office Costs 36.00 Were home office costs claimed on the cost report? 36.00 N 37.00 If line 36 is yes, has a home office cost statement been prepared by the home office? N 37.00 If yes, see instructions. If line 36 is yes, was the fiscal year end of the home office different from that of 38.00 38 00 N the provider? If yes, enter in column 2 the fiscal year end of the home office. 39.00 If line 36 is yes, did the provider render services to other chain components? If yes, N 39.00 see instructions. 40.00 If line 36 is yes, did the provider render services to the home office? If yes, see N 40.00 instructions.

1.00

DAVI D

WIPFLI LLP

608. 270. 2962

2.00

DGOODMAN@WI PFLI . COM

41.00

42.00

43.00

GOODMAN

MCRI F32 - 21, 3, 178	ລ າ

41.00

42.00

43.00

respecti vel y

preparer.

Cost Report Preparer Contact Information

Enter the first name, last name and the title/position

Enter the employer/company name of the cost report

report preparer in columns 1 and 2, respectively.

held by the cost report preparer in columns 1, 2, and 3,

Enter the telephone number and email address of the cost

I ROQUOIS MEMORIAL HOSPITAL
STIONNAIRE Provider CCN: 14-1353 Health Financial Systems IROQUOIS M
HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE

In Lieu of Form CMS-2552-10

Period:
From 07/17/2023 Part II
To 09/30/2023 Date/Time Prepared:
2/26/2024 1:42 pm

			2/20/2024 1.4	z piii
		3. 00		
	Cost Report Preparer Contact Information			
41. 0	Enter the first name, last name and the title/position	CPA		41. 00
	held by the cost report preparer in columns 1, 2, and 3,			
	respecti vel y.			
42. 0	Enter the employer/company name of the cost report			42. 00
	preparer.			
43.0	Enter the telephone number and email address of the cost			43. 00
	report preparer in columns 1 and 2, respectively.			

In Lieu of Form CMS-2552-10

Period: Worksheet S-3

From 07/17/2023 Part I

To 09/30/2023 Date/Time Prepared: 2/26/2024 1:42 pm

							2/26/2024 1: 4:	2 pm
							I/P Days / O/P	
							Visits / Trips	
	Component	Worksheet A	No.	of Beds	Bed Days	CAH/REH Hours	Title V	
		Li ne No.			Avai I abl e			
	DADT I OTATIOTICAL DATA	1. 00		2. 00	3. 00	4. 00	5. 00	
4 00	PART I - STATISTICAL DATA	20.00		0.5	1 000	4 440 00	0	4 00
1.00	Hospi tal Adul ts & Peds. (columns 5, 6, 7 and	30. 00		25	1, 900	4, 449. 00	0	1. 00
	8 exclude Swing Bed, Observation Bed and							
	Hospice days) (see instructions for col. 2 for the portion of LDP room available beds)							
2 00	1							2. 00
2. 00 3. 00	HMO and other (see instructions)							3. 00
4.00	HMO I PF Subprovi der							4. 00
4. 00 5. 00	HMO I RF Subprovi der						14	4. 00 5. 00
6.00	Hospital Adults & Peds. Swing Bed SNF						0	6. 00
7. 00	Hospital Adults & Peds. Swing Bed NF Total Adults and Peds. (exclude observation			25	1, 900	4, 449. 00	14	7. 00
7.00	beds) (see instructions)			23	1, 900	4, 449. 00	14	7.00
8. 00	INTENSIVE CARE UNIT							8. 00
9. 00	CORONARY CARE UNIT							9. 00
10.00	BURN INTENSIVE CARE UNIT							10. 00
11. 00	SURGICAL INTENSIVE CARE UNIT							11. 00
12. 00	OTHER SPECIAL CARE (SPECIFY)							12. 00
13. 00	NURSERY							13. 00
14. 00	Total (see instructions)			25	1, 900	4, 449. 00	14	14. 00
15. 00	CAH visits			20	1, 700	1, 117.00	0	15. 00
15. 10	REH hours and visits					0.00	Ö	15. 10
16. 00	SUBPROVIDER - I PF					0.00		16. 00
17. 00	SUBPROVI DER - I RF							17. 00
18. 00	SUBPROVI DER							18. 00
19. 00	SKILLED NURSING FACILITY	44. 00		35	2, 660		0	19. 00
20.00	NURSING FACILITY							20.00
21. 00	OTHER LONG TERM CARE							21.00
22. 00	HOME HEALTH AGENCY	101. 00					0	22.00
23.00	AMBULATORY SURGICAL CENTER (D. P.)							23.00
24.00	HOSPI CE	116. 00		1	76			24.00
24. 10	HOSPICE (non-distinct part)	30. 00						24. 10
25.00	CMHC - CMHC							25.00
26.00	RURAL HEALTH CLINIC	88. 00					0	26.00
26. 01	RURAL HEALTH CLINIC II	88. 01					0	26. 01
26. 02	RURAL HEALTH CLINIC III	88. 02					0	26. 02
26. 03	RURAL HEALTH CLINIC IV	88. 03					0	26. 03
26. 25	FEDERALLY QUALIFIED HEALTH CENTER	89. 00					0	26. 25
27. 00	Total (sum of lines 14-26)			61				27. 00
28. 00	Observation Bed Days						0	28.00
29. 00	Ambul ance Tri ps							29. 00
30.00	Employee discount days (see instruction)							30.00
31. 00	Employee discount days - IRF							31. 00
32. 00	Labor & delivery days (see instructions)			0	0			32.00
32. 01	Total ancillary labor & delivery room							32. 01
00.05	outpatient days (see instructions)							00.00
33. 00	LTCH non-covered days							33. 00
33. 01	LTCH site neutral days and discharges							33. 01
34.00	Temporary Expansion COVID-19 PHE Acute Care				I			34. 00

I ROOUOIS MEMORIAL HOSPITAL
AL DATA Provider CCN: 14-1353 Heal th Financial Systems IROQUOIS MOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA

Peri od: From 07/17/2023 To 09/30/2023

In Lieu of Form CMS-2552-10
Worksheet S-3
Part I
80/2023 Date/Time Prepared:
2/26/2024 1:42 pm

		I/P Days	/ O/P Visits	/ Trips	Full Time I	<u> 2/26/2024 1:4</u> Equi val ents	2 piii
	Component	Title XVIII	Title XIX	Total All Patients	Total Interns & Residents	Employees On Payroll	
		6.00	7. 00	8. 00	9. 00	10.00	
	PART I - STATISTICAL DATA	2.00		5, 55			
1. 00	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)	69	0	174			1.00
2.00	HMO and other (see instructions)	19	15				2. 00
3.00	HMO IPF Subprovider	l o	0				3. 00
4. 00	HMO IRF Subprovider	o o	0			•	4. 00
5. 00	Hospital Adults & Peds. Swing Bed SNF	o o	0	22			5. 00
6. 00	Hospital Adults & Peds. Swing Bed NF		0	30			6. 00
7. 00	Total Adults and Peds. (exclude observation	69	0	226			7. 00
7.00	beds) (see instructions)		Ŭ	220			7.00
8.00	INTENSIVE CARE UNIT						8. 00
9. 00	CORONARY CARE UNIT						9. 00
10.00	BURN INTENSIVE CARE UNIT						10.00
11. 00	SURGI CAL INTENSI VE CARE UNI T						11. 00
12. 00	OTHER SPECIAL CARE (SPECIFY)						12.00
13. 00	NURSERY						13. 00
14. 00	Total (see instructions)	69	0	226	0.00	150. 90	
15. 00	CAH visits	0	0	0		130.70	15. 00
15. 10	REH hours and visits	o o	0	0			15. 10
16. 00	SUBPROVIDER - I PF	٩	O .	0			16. 00
17. 00							17. 00
18. 00							18. 00
19. 00		47	0	2, 004	0.00	26. 20	
20. 00	NURSING FACILITY	47	U	2,004	0.00	20. 20	20.00
21. 00	OTHER LONG TERM CARE						21.00
22. 00	HOME HEALTH AGENCY	509	0	1, 502	0.00	7. 40	
23. 00	AMBULATORY SURGICAL CENTER (D. P.)	309	U	1, 302	0.00	7.40	23. 00
24. 00		0	0	0	0.00	9. 40	
24. 00		۷	U	0		9.40	24. 00
25. 00	HOSPICE (non-distinct part) CMHC - CMHC			U			25. 00
26. 00	RURAL HEALTH CLINIC	201	0	848	0.00	4. 80	
26. 00	RURAL HEALTH CLINIC	155	0	794		3. 10	
26. 01		354	0	1, 351		8. 30	
26. 02	RURAL HEALTH CLINIC IV	425	0	1, 843			
26. 03	FEDERALLY QUALIFIED HEALTH CENTER	425	0	1, 643		0.00	
		۷	U	U			
27. 00	,		0	1.41	0.00	226. 20	
28. 00	1		U	141			28. 00
29. 00		0		•			29. 00
30.00				0			30.00
31.00				-			31.00
32. 00		0	0	0			32.00
32. 01	Total ancillary labor & delivery room			0			32. 01
22.00	outpatient days (see instructions)						22.00
33.00	1	0					33.00
33. 01	7						33. 01
34.00	Temporary Expansion COVID-19 PHE Acute Care	ı İ					34. 00

Peri od: From 07/17/2023 To 09/30/2023

| In Lieu of Form CMS-2552-10 | Worksheet S-3 | Part | | Date/Time Prepared: | 2/26/2024 1:42 pm

						2/26/2024 1:42	z piii
		Full Time		Di sch	arges		
		Equi val ents					
	Component	Nonpai d	Title V	Title XVIII	Title XIX	Total All	
		Workers				Pati ents	
		11. 00	12. 00	13. 00	14. 00	15. 00	
	PART I - STATISTICAL DATA						
1.00	Hospital Adults & Peds. (columns 5, 6, 7 and		C	22	0	65	1. 00
	8 exclude Swing Bed, Observation Bed and						
	Hospice days) (see instructions for col. 2						
	for the portion of LDP room available beds)				_		
2.00	HMO and other (see instructions)			11	7		2. 00
3.00	HMO IPF Subprovider				0		3. 00
4.00	HMO IRF Subprovider				0		4. 00
5.00	Hospital Adults & Peds. Swing Bed SNF						5. 00
6.00	Hospital Adults & Peds. Swing Bed NF						6. 00
7. 00	Total Adults and Peds. (exclude observation						7. 00
	beds) (see instructions)						
8.00	INTENSIVE CARE UNIT						8. 00
9.00	CORONARY CARE UNIT						9. 00
10. 00	BURN INTENSIVE CARE UNIT						10. 00
11. 00	SURGICAL INTENSIVE CARE UNIT						11. 00
12. 00	OTHER SPECIAL CARE (SPECIFY)						12. 00
13. 00	NURSERY						13. 00
14. 00	Total (see instructions)	0. 00	C	22	0	65	14. 00
15. 00	CAH visits						15. 00
15. 10	REH hours and visits						15. 10
16.00	SUBPROVIDER - I PF						16.00
17. 00	SUBPROVIDER - IRF						17. 00
18.00	SUBPROVI DER	0.00					18. 00
19. 00	SKILLED NURSING FACILITY	0. 00					19. 00
20.00	NURSING FACILITY						20.00
21. 00	OTHER LONG TERM CARE	0.00					21. 00
22. 00	HOME HEALTH AGENCY	0. 00					22. 00
23. 00	AMBULATORY SURGICAL CENTER (D. P.)	0.00					23. 00
24. 00 24. 10	HOSPICE	0. 00					24. 00 24. 10
25. 00	HOSPICE (non-distinct part) CMHC - CMHC						25. 00
26. 00	RURAL HEALTH CLINIC	0. 00					26. 00
26. 00	RURAL HEALTH CLINIC	0.00					26. 00
26. 01	RURAL HEALTH CLINIC III	0.00					26. 01
26. 02	RURAL HEALTH CLINIC IV	0.00					26. 02
26. 03	FEDERALLY QUALIFIED HEALTH CENTER	0.00					26. 03
27. 00		0.00					20. 23
	Total (sum of lines 14-26)	0.00					28.00
28. 00 29. 00	Observation Bed Days						29. 00
	Ambulance Trips						30.00
30. 00 31. 00	Employee discount days (see instruction) Employee discount days - IRF						30.00
32.00	Labor & delivery days (see instructions)						32.00
32. 00	Total ancillary labor & delivery room						32. 00 32. 01
J∠. U I	outpatient days (see instructions)						JZ. U1
33. 00	LTCH non-covered days			0			33. 00
33. 01	LTCH site neutral days and discharges						33. 00
	Temporary Expansion COVID-19 PHE Acute Care						34. 00
5 50	The first of the f	ı		1		'	

In Lieu of Form CMS-2552-10 Worksheet S-4

Peri od: From 07/17/2023 To 09/30/2023 Component CCN: 14-7586

Date/Time Prepared: 2/26/2024 1:42 pm

Home Health	PPS
Agency I	

					Home Health Agency I	PPS	
					1.	00	
0.00	County						0.00
		Title V	Title XVIII	Title XIX	Other	Total	
	HOME HEALTH AGENCY STATISTICAL DATA	1.00	2. 00	3.00	4. 00	5. 00	
1. 00	Home Health Aide Hours	0	230		60	290	1.00
2.00	Unduplicated Census Count (see instructions)	0. 00	26. 00	-	9. 00	35.00	2. 00
				Number of Empl	oyees (Full Ti	me Equivalent)	
		Enter the numb		Staff	Contract	Total	
		your normal	work week				
				1.00	0.00	2.00	
	HOME HEALTH AGENCY - NUMBER OF EMPLOYEES	C)	1.00	2. 00	3. 00	
3.00	Administrator and Assistant Administrator(s)		0.00	0.00	0.00	0.00	3.00
4.00	Director(s) and Assistant Director(s)			1.00		l .	4. 00
5.00	Other Administrative Personnel			1.62		l .	5. 00
6. 00 7. 00	Direct Nursing Service Nursing Supervisor			3. 16 1. 00		l .	6. 00 7. 00
8. 00	Physical Therapy Service			0. 72	0.00	1	8. 00
9.00	Physical Therapy Supervisor			0.00			
10.00	Occupational Therapy Service			0.15		l .	
11. 00 12. 00	Occupational Therapy Supervisor Speech Pathology Service			0. 00 0. 02	0. 00 0. 00	l .	1
13. 00	Speech Pathology Supervisor			0.00	0. 00		
14. 00	Medical Social Service			0.00	0.00		
15. 00	Medical Social Service Supervisor			0.00	0.00		
16. 00 17. 00	Home Health Aide Home Health Aide Supervisor			0. 30 0. 00	0. 00 0. 00		
18. 00	Other (specify)			0.00			
	· · · · · · · · · · · · · · · · · · ·					CBSA Data	
	HOME HEALTH AGENCY CBSA CODES					1.00	
19. 00	Enter in column 1 the number of CBSAs where	you provided se	rvices during	the cost repor	ting period.	3	19. 00
20. 00	List those CBSA code(s) in column 1 serviced					19180	20. 00
20. 01	first code).					99914	20. 01
20. 01						16580	20. 01
		Full Ep	oi sodes				
		Wi thout	With Outliers	LUPA Epi sodes	PEP Only	Total (col s.	
		0utliers 1.00	2. 00	3.00	Epi sodes 4. 00	1-4) 5. 00	
	PPS ACTIVITY DATA	1.00	2.00	3.00	4.00	3.00	
21. 00	Skilled Nursing Visits	210	65	1	0		
22. 00	Skilled Nursing Visit Charges	37, 382	11, 571	1			1
23. 00 24. 00	Physical Therapy Visits Physical Therapy Visit Charges	65 11, 571	36 6, 408	1	0	101 17, 979	1
25. 00	Occupational Therapy Visits	13	8	ő	0	21	25. 00
26. 00	Occupational Therapy Visit Charges	2, 314	1, 424	1	0	3, 738	1
27. 00	Speech Pathology Visits	0	0	0	0	ή	27. 00
28. 00 29. 00	Speech Pathology Visit Charges Medical Social Service Visits	0	0	_	0	0	1
30. 00	Medical Social Service Visit Charges	l o	0		0	o o	30.00
31. 00	Home Health Aide Visits	70	54	1	0	124	1
32.00	Home Health Aide Visit Charges	7, 650	5, 967		0	13, 617	
33. 00	Total visits (sum of lines 21, 23, 25, 27, 29, and 31)	358	163	2	0	523	33. 00
34. 00	Other Charges	0	0	О	0	0	34.00
35. 00	Total Charges (sum of lines 22, 24, 26, 28,	58, 917	25, 370	356	0	84, 643	
24 00	30, 32, and 34)	20			_	35	24 00
36. 00	Total Number of Episodes (standard/non outlier)	33		2	0	35	36. 00
37. 00	Total Number of Outlier Episodes		7		0	1	37. 00
38. 00	Total Non-Routine Medical Supply Charges	2, 779	227	0	0	3, 006	38. 00

Component CCN: 14-3424 09/30/2023 Date/Time Prepared: 2/26/2024 1:42 pm RHC I Cost 1.00 Clinic Address and Identification 1.00 Street 508 E CRESENT 1.00 City ZIP Code State 1.00 2.00 2.00 City, State, ZIP Code, County GI LMAN IL 60938 2.00 1.00 3.00 HOSPITAL-BASED FQHCs ONLY: Designation - Enter "R" for rural or "U" for urban 0 3.00 Grant Award Date 1.00 2.00 Source of Federal Funds Community Health Center (Section 330(d), PHS Act) 4.00 4.00 5.00 Migrant Health Center (Section 329(d), PHS Act) 5.00 Health Services for the Homeless (Section 340(d), PHS Act) 6.00 6.00 Appalachian Regional Commission 7 00 7 00 8.00 Look-Alikes 8.00 9.00 OTHER (SPECIFY) 9. 00 1. 00 2.00 10.00 Does this facility operate as other than a hospital-based RHC or FQHC? Enter "Y" for 0 10.00 yes or "N" for no in column 1. If yes, indicate number of other operations in column 2. (Enter in subscripts of line 11 the type of other operation(s) and the operating hours.) Sunday Monday Tuesday from to from to from 1.00 2.00 3.00 4.00 5.00 Facility hours of operations (1) 11. 00 CLINIC 08: 30 07: 00 18: 30 11.00 1.00 2.00 12.00 Have you received an approval for an exception to the productivity standard? 12 00 Is this a consolidated cost report as defined in CMS Pub. 100-04, chapter 9, section N 0 13.00 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 report. List the names of all providers and numbers below. Provi der name CCN 1.00 2.00 14.00 RHC/FQHC name, CCN 14.00 Y/N XVIII XIX Total Visits 2.00 5 00 1 00 3 00 4 00 15.00 Have you provided all or substantially all 15.00 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) County 4. 00 2.00 City, State, ZIP Code, County I ROQUOI S 2.00 Tuesday Wednesday Thursday to from from to to 6.00 7. 00 8.00 9. 00 10.00

17: 00

07: 00

17: 00

08: 30

18: 30

11.00

In Lieu of Form CMS-2552-10

Worksheet S-8

11. 00 CLINIC

Facility hours of operations (1)

Health Financial Systems
HOSPITAL-BASED RHC/FQHC STATISTICAL DATA IROQUOIS MEMORIAL HOSPITAL In Lieu of Form CMS-2552-10

		Component	3014. 14 3424	10 07/30/2023	2/26/2024 1: 4:	
				RHC I	Cost	
	Fri	day	Sat	turday		
	from	to	from	to		
	11. 00	12. 00	13. 00	14. 00		
Facility hours of operations (1)						
11. 00 CLINIC	08: 30	17: 00				11. 00

Worksheet S-8

In Lieu of Form CMS-2552-10 Peri od: Worksheet S-8 From 07/17/2023 Component CCN: 14-3425 09/30/2023 Date/Time Prepared: 2/26/2024 1:42 pm RHC II Cost 1.00 Clinic Address and Identification 1.00 Street 207 N AXTEL 1.00 City ZIP Code State 1.00 2.00 3.00 2.00 City, State, ZIP Code, County MI LFORD IL 60983 2.00 1.00 3.00 HOSPITAL-BASED FQHCs ONLY: Designation - Enter "R" for rural or "U" for urban 0 3.00 Grant Award Date 1.00 2.00 Source of Federal Funds Community Health Center (Section 330(d), PHS Act) 4.00 4.00 5.00 Migrant Health Center (Section 329(d), PHS Act) 5.00 Health Services for the Homeless (Section 340(d), PHS Act) 6.00 6.00 Appalachian Regional Commission 7 00 7 00 8.00 Look-Alikes 8.00 9.00 OTHER (SPECIFY) 9. 00 1. 00 2.00 10.00 Does this facility operate as other than a hospital-based RHC or FQHC? Enter "Y" for 0 10.00 yes or "N" for no in column 1. If yes, indicate number of other operations in column 2. (Enter in subscripts of line 11 the type of other operation(s) and the operating hours.) Sunday Monday Tuesday from to from to from 1.00 2.00 3.00 4.00 5.00 Facility hours of operations (1) 11. 00 CLINIC 08: 30 17: 00 07: 00 11.00 1.00 2.00 12.00 Have you received an approval for an exception to the productivity standard? 12 00 Ν Is this a consolidated cost report as defined in CMS Pub. 100-04, chapter 9, section N 0 13.00 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 report. List the names of all providers and numbers below. Provi der name CCN 1.00 2.00 14.00 RHC/FQHC name, CCN 14.00 Y/N XVIII XIX Total Visits 2.00 5 00 1 00 3 00 4 00 15.00 Have you provided all or substantially all 15.00 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) County

4. 00

Wednesday

18: 30

to

8.00

2.00

11.00

Thursday

17: 00

to

10.00

from

9. 00

08: 30

I ROQUOI S

08: 30

from

7. 00

Tuesday

to

6.00

17: 00

11. 00 CLINIC

2.00 City, State, ZIP Code, County

Facility hours of operations (1)

Heal th Financial Systems IROQUOIS MEMORIAL HOSPITAL In Lieu of Form CMS-2552-10
HOSPITAL-BASED RHC/FQHC STATISTICAL DATA

Provider CCN: 14-1353 Period: Worksheet S-8
From 07/17/2023 To 09/30/2023 Date/Time Prepared: 2/26/2024 1:42 pm
RHC II Cost

				RHC II	Cost	
	Fri	day	Sat	urday		
	from	to	from	to		
	11. 00	12.00	13. 00	14. 00		
Facility hours of operations (1)						
11. 00 CLINIC	07: 00	17: 00				11.00

In Lieu of Form CMS-2552-10 Worksheet S-8

Component CCN: 15-3979 09/30/2023 Date/Time Prepared: 2/26/2024 1:42 pm RHC III Cost 1.00 Clinic Address and Identification 1.00 Street 303 N SEVENTH 1.00 City ZIP Code State 1.00 2.00 2.00 City, State, ZIP Code, County KENTLAND IN 47951 2.00 1.00 3.00 HOSPITAL-BASED FQHCs ONLY: Designation - Enter "R" for rural or "U" for urban 0 3.00 Grant Award Date 1.00 2.00 Source of Federal Funds Community Health Center (Section 330(d), PHS Act) 4.00 4.00 5.00 Migrant Health Center (Section 329(d), PHS Act) 5.00 Health Services for the Homeless (Section 340(d), PHS Act) 6.00 6.00 Appalachian Regional Commission 7 00 7 00 8.00 Look-Alikes 8.00 9.00 OTHER (SPECIFY) 9. 00 1. 00 2.00 10.00 Does this facility operate as other than a hospital-based RHC or FQHC? Enter "Y" for 0 10.00 yes or "N" for no in column 1. If yes, indicate number of other operations in column 2. (Enter in subscripts of line 11 the type of other operation(s) and the operating hours.) Sunday Monday Tuesday from to from to from 1.00 2.00 3.00 4.00 5.00 Facility hours of operations (1) 11. 00 CLINIC 07: 00 17: 00 08: 30 11.00 1.00 2.00 Have you received an approval for an exception to the productivity standard? 12 00 Is this a consolidated cost report as defined in CMS Pub. 100-04, chapter 9, section N 0 13.00 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 report. List the names of all providers and numbers below. Provi der name CCN 1.00 2.00 14.00 RHC/FQHC name, CCN 14.00 Y/N XVIII XIX Total Visits 2.00 5 00 1 00 3 00 4 00 15.00 Have you provided all or substantially all 15.00 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) County 4. 00 2.00 City, State, ZIP Code, County NEWTON 2.00 Tuesday Wednesday Thursday from to from to to 6.00 7. 00 8.00 9. 00 10.00 Facility hours of operations (1)

18: 30

07: 00

17: 00

08: 30

18: 30

11.00

11. 00 CLINIC

Health Financial Systems
HOSPITAL-BASED RHC/FOHC STATISTICAL DATA I ROQUOIS MEMORIAL HOSPITAL In Lieu of Form CMS-2552-10 Provider CCN: 14-1353 Peri od: From 07/17/2023 To 09/30/2023 Worksheet S-8 Date/Time Prepared: 2/26/2024 1:42 pm Component CCN: 15-3979 RHC III Cost Fri day Saturday to 12.00 from from to

17: 00

13.00

14.00

11. 00

11.00

07: 00

Facility hours of operations (1)

From 07/17/2023 Component CCN: 14-8551 09/30/2023 Date/Time Prepared: 2/26/2024 1:42 pm RHC IV Cost 1.00 Clinic Address and Identification 1.00 Street 200 FAIRMAN AVE 1.00 City ZIP Code State 1.00 2.00 I L 60970 2.00 City, State, ZIP Code, County WATSEKA 2.00 1.00 3.00 HOSPITAL-BASED FQHCs ONLY: Designation - Enter "R" for rural or "U" for urban 0 3.00 Grant Award Date 1.00 2.00 Source of Federal Funds Community Health Center (Section 330(d), PHS Act) 4.00 4.00 5.00 Migrant Health Center (Section 329(d), PHS Act) 5.00 Health Services for the Homeless (Section 340(d), PHS Act) 6.00 6.00 Appalachian Regional Commission 7 00 7 00 8.00 Look-Alikes 8.00 9.00 OTHER (SPECIFY) 9. 00 1. 00 2.00 10.00 Does this facility operate as other than a hospital-based RHC or FQHC? Enter "Y" for 0 10.00 yes or "N" for no in column 1. If yes, indicate number of other operations in column 2. (Enter in subscripts of line 11 the type of other operation(s) and the operating hours.) Sunday Monday Tuesday from to from to from 1.00 2.00 3.00 4.00 5.00 Facility hours of operations (1) 11. 00 CLINIC 07: 00 17: 00 08: 30 11.00 1.00 2.00 12.00 Have you received an approval for an exception to the productivity standard? 12 00 Is this a consolidated cost report as defined in CMS Pub. 100-04, chapter 9, section N 0 13.00 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 report. List the names of all providers and numbers below. Provi der name CCN 1.00 2.00 14.00 RHC/FQHC name, CCN 14.00 Y/N XVIII XIX Total Visits 2.00 5 00 1 00 3 00 4 00 15.00 Have you provided all or substantially all 15.00 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) County 4. 00 2.00 City, State, ZIP Code, County I ROQUOI S 2.00 Tuesday Wednesday Thursday to from from to to 6.00 7. 00 8.00 9. 00 10.00

18: 30

07: 00

17: 00

08: 30

18: 30

11.00

In Lieu of Form CMS-2552-10

Worksheet S-8

11. 00 CLINIC

Facility hours of operations (1)

Heal th Financial Systems I ROOUDIS MEMORIAL HOSPITAL In Lieu of Form CMS-2552-10
HOSPITAL-BASED RHC/FQHC STATISTICAL DATA

Provider CCN: 14-1353
Component CCN: 14-8551
To 09/30/2023
Date/Time Prepared: 2/26/2024 1: 42 pm
RHC IV Cost

				INTO I V	0031	
	Fri	day	Satu	ırday		
	from	to	from	to		
	11. 00	12. 00	13. 00	14. 00		
Facility hours of operations (1)						
11. 00 CLINIC	07: 00	17: 00				11. 00

In Lieu of Form CMS-2552-10
Worksheet S-9

Hospice CCN: 14	I-1616	From To	07/1 09/3	0/2023	PARTS I THROUGH IV Date/Time Prepared: 2/26/2024 1:42 pm

						Hospi ce I		
		Unduplicated						
		Days						
		Title XVIII	Title XIX	Title XVIII	Title XIX	All Other	Total (sum of	
				Skilled	Nursi ng		col s. 1, 2 &	
				Nursi ng	Facility		5)	
				Facility			·	
		1. 00	2. 00	3. 00	4. 00	5. 00	6. 00	
	PART I - ENROLLMENT DAYS FOR CO	OST REPORTING F	PERI ODS BEGINNI	NG BEFORE OCTO	BER 1, 2015			
1.00	Hospice Continuous Home Care							1. 00
2.00	Hospice Routine Home Care							2. 00
3.00	Hospice Inpatient Respite Care							3. 00
4.00	Hospice General Inpatient Care							4. 00
5.00	Total Hospice Days							5. 00
	Part II - CENSUS DATA FOR COST	REPORTING PERI	ODS BEGINNING	BEFORE OCTOBER	1, 2015			
6.00	Number of patients receiving							6. 00
	hospi ce care							
7.00	Total number of unduplicated							7. 00
	Continuous Care hours billable							
	to Medicare							
8.00	Average Length of Stay (line 5							8. 00
	/ line 6)							
9.00	Unduplicated census count							9. 00

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

		Title XVIII	Title XIX	Other	Total (sum of	
					col s. 1	
					through 3)	
		1. 00	2.00	3. 00	4. 00	
	PART III - ENROLLMENT DAYS FOR COST REPORTING PERIODS BEGIN	INING ON OR AFT	ER OCTOBER 1, 2	2015		
10.00	Hospi ce Conti nuous Home Care	0	0	0	0	10.00
11. 00	Hospice Routine Home Care	2, 875	0	76	2, 951	11.00
12.00	Hospice Inpatient Respite Care	16	0	0	16	12.00
13.00	Hospice General Inpatient Care	7	0	2	9	13.00
14.00	Total Hospi ce Days	2, 898	0	78	2, 976	14.00
Col s. 1						
15.00	Hospice Inpatient Respite Care	0	0	0	0	15.00
16.00	Hospice General Inpatient Care	0	0	0	0	16.00

In Lieu of Form CMS-2552-10

Worksheet S-10 Parts I & II Date/Time Prepared: 2/26/2024 1:42 pm Peri od: From 07/17/2023 To 09/30/2023

		·		1.00	
	PART I - HOSPITAL AND HOSPITAL COMPLEX DATA			1.00	
	Uncompensated and Indigent Care Cost-to-Charge Ratio				
1. 00	Cost to charge ratio (see instructions)			0. 487797	1. 00
1.00	Medicaid (see instructions for each line)			0.407777	1.00
2.00	Net revenue from Medicaid			1, 104, 301	2. 00
3.00	Did you receive DSH or supplemental payments from Medicaid?			Υ Υ	3.00
4. 00	If line 3 is yes, does line 2 include all DSH and/or supplemental payment	s from Medicaid	?	Ϋ́	4. 00
5. 00	If line 4 is no, then enter DSH and/or supplemental payments from Medicai			0	5. 00
6.00	Medi cai d charges			3, 049, 032	6. 00
7.00	Medicaid cost (line 1 times line 6)			1, 487, 309	7. 00
8.00	Difference between net revenue and costs for Medicaid program (see instru	ıcti ons)		383, 008	8. 00
	Children's Health Insurance Program (CHIP) (see instructions for each lin	e)			
9.00	Net revenue from stand-alone CHIP			0	
10.00	Stand-alone CHIP charges			0	
11. 00	Stand-alone CHIP cost (line 1 times line 10)			0	
12. 00	Difference between net revenue and costs for stand-alone CHIP (see instru			0	12. 00
40.00	Other state or local government indigent care program (see instructions f				40.00
13.00	Net revenue from state or local indigent care program (Not included on li		Lines / en	0	13. 00 14. 00
14. 00	Charges for patients covered under state or local indigent care program (Not included in	Titles 6 01	U	14.00
15. 00	State or local indigent care program cost (line 1 times line 14)			0	15. 00
16. 00	Difference between net revenue and costs for state or local indigent care	program (see i	nstructions)	0	
	Grants, donations and total unreimbursed cost for Medicaid, CHIP and stat	_		ns (see	
	instructions for each line)	3		`	
17. 00	Private grants, donations, or endowment income restricted to funding char	ity care		0	17. 00
18. 00	Government grants, appropriations or transfers for support of hospital op			0	
19. 00	Total unreimbursed cost for Medicaid , CHIP and state and local indigent	care programs (sum of lines	383, 008	19. 00
	8, 12 and 16)	Uni nsured	Insured	Total (col. 1	
		patients	pati ents	+ col . 2)	
		1, 00	2. 00	3.00	
	Uncompensated care cost (see instructions for each line)	11.00	2.00	0.00	
20.00	Charity care charges and uninsured discounts (see instructions)	16, 177	0	16, 177	20. 00
21.00	Cost of patients approved for charity care and uninsured discounts (see	7, 891	0	7, 891	21.00
	instructions)				
22. 00	Payments received from patients for amounts previously written off as	0	0	0	22. 00
22 00	charity care Cost of charity care (see instructions)	7, 891	0	7 001	23. 00
23.00	cost of charity care (see firstructions)	7,091	0	7,091	23.00
				1.00	
24. 00	Does the amount on line 20 col. 2, include charges for patient days beyon	d a length of s	tay limit	N	24. 00
	imposed on patients covered by Medicaid or other indigent care program?	· ·	,		
25.00	If line 24 is yes, enter the charges for patient days beyond the indigent	care program's	length of	0	25. 00
	stay limit				
25. 01	Charges for insured patients' liability (see instructions)			0	
26. 00	Bad debt amount (see instructions)			1	26. 00
27. 00	Medicare reimbursable bad debts (see instructions)			0	
27. 01	Medicare allowable bad debts (see instructions)			0	
28. 00 29. 00	Non-Medicare bad debt amount (see instructions) Cost of non-Medicare and non-reimbursable Medicare bad debt amounts (see	instructions)		1 0	
30.00	Cost of uncompensated care (line 23, col. 3, plus line 29)	instructions)		7, 891	
	Total unreimbursed and uncompensated care cost (line 19 plus line 30)			390, 899	
31.00	1.5ta. a.m.s. maa. 55a ana anomponsatoa care cost (11116-17 pras 11116-50)			3,0,077	31.00

| In Lieu of Form CMS-2552-10 | Worksheet S-10 | Parts | & | | | 30/2023 | Date/Time Prepared: | 2/26/2024 | 1:42 pm Peri od: From 07/17/2023 To 09/30/2023

				7 27 207 2024 1.4	-z piii
				1.00	
	PART II - HOSPITAL DATA				
	Uncompensated and Indigent Care Cost-to-Charge Ratio				1
. 00	Cost to charge ratio (see instructions)				1. (
	Medicaid (see instructions for each line)				1
. 00	Net revenue from Medicaid				2. (
. 00	Did you receive DSH or supplemental payments from Medicaid?				3. (
. 00	If line 3 is yes, does line 2 include all DSH and/or supplemental payment	ts from Medicai	d?		4. (
. 00	If line 4 is no, then enter DSH and/or supplemental payments from Medicai	d			5. (
. 00	Medi cai d charges				6.0
. 00	Medicaid cost (line 1 times line 6)				7.0
. 00	Difference between net revenue and costs for Medicaid program (see instru				8. (
	Children's Health Insurance Program (CHIP) (see instructions for each lin	ne)			
. 00	Net revenue from stand-alone CHIP				9. (
0. 00	Stand-alone CHIP charges				10. (
1. 00	Stand-alone CHIP cost (line 1 times line 10)				11. (
2. 00	Difference between net revenue and costs for stand-alone CHIP (see instru				12. (
	Other state or local government indigent care program (see instructions f				
3. 00	Net revenue from state or local indigent care program (Not included on li				13. (
4. 00	Charges for patients covered under state or local indigent care program ((Not included i	n lines 6 or		14. (
F 00					1
5.00					15. (
6. 00					16. (
	Grants, donations and total unreimbursed cost for Medicaid, CHIP and stat	.e/rocar rndrge	ent care progra	ims (see	
7. 00	<pre>instructions for each line) Private grants, donations, or endowment income restricted to funding char</pre>	rity caro			17. (
8. 00	Government grants, appropriations or transfers for support of hospital op	,			18. (
9. 00	Total unreimbursed cost for Medicaid , CHIP and state and local indigent		(sum of lines		19. (
7. 00	8, 12 and 16)	care programs	(Sum of Titles		' ' '
		Uni nsured	Insured	Total (col. 1	
		pati ents	pati ents	+ col . 2)	
		1. 00	2. 00	3. 00	
	Uncompensated care cost (see instructions for each line)				
0. 00	Charity care charges and uninsured discounts (see instructions)				20. (
1. 00	Cost of patients approved for charity care and uninsured discounts (see				21. (
	instructions)				l
2. 00	Payments received from patients for amounts previously written off as				22. (
0.00	charity care				
3. 00	Cost of charity care (see instructions)				23. (
				1.00	
4. 00	Does the amount on line 20 col. 2, include charges for patient days beyor	nd a Longth of	ctav limit	1.00	24. (
4.00	imposed on patients covered by Medicaid or other indigent care program?	id a religiti or	Stay IIIII t		24. (
5. 00	If line 24 is yes, enter the charges for patient days beyond the indigent	care program'	s Langth of		25. (
3. 00	stay limit	care program	3 religiti or		25.
5. 01	Charges for insured patients' liability (see instructions)				25.
6. 00	Bad debt amount (see instructions)				26.
7. 00	Medicare reimbursable bad debts (see instructions)				27.
7. 01	Medicare allowable bad debts (see instructions)				27.
8. 00	Non-Medicare bad debt amount (see instructions)				28.
	· · · · · · · · · · · · · · · · · · ·	instructions)			29. (
9.00	Cost of non-Medicare and non-reimbursable Medicare bad debt amounts (see Cost of uncompensated care (line 23, col. 3, plus line 29)	instructions)			29. 30.

I ROQUOI S MEMORIAL HOSPITAL

OF EXPENSES

Provider CCN: 14-1353 Health Financial Systems IROQUOIS M
RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES In Lieu of Form CMS-2552-10
Worksheet A Peri od: From 07/17/2023 To 09/30/2023 Date/Time Prepared: 2/26/2024 1:42 pm

	Cost Contor Description	Calarias	Othor	Total (col 1	Dool acci fi cati	Doct acci fi ad	z piii
	Cost Center Description	Sal ari es	Other		Reclassificati		
				+ col . 2)	ons (See A-6)		
						(col. 3 +-	
						col . 4)	
		1.00	2. 00	3. 00	4. 00	5. 00	
	GENERAL SERVICE COST CENTERS						
1.00	00100 CAP REL COSTS-BLDG & FLXT		307, 649	307, 649	-97, 150	210, 499	1. 00
	00200 CAP REL COSTS-MVBLE EQUIP		0	0	152, 428	152, 428	2. 00
4.00	00400 EMPLOYEE BENEFITS DEPARTMENT	34, 773	1, 069, 609	1, 104, 382	-243	1, 104, 139	4. 00
5.01	00570 ADMITTING	56, 886	2, 092	58, 978	o	58, 978	5. 01
	00560 PURCHASING RECEIVING AND STORES	15, 529	-144			15, 301	5. 02
5. 03	00550 DATA PROCESSING	47, 295	78, 233			125, 340	5. 03
5. 04	01160 COMMUNI CATI ONS	0	20, 997			32, 052	5. 04
	00590 BUSI NESS OFFI CE	55, 898	44, 460			100, 155	5. 05
	ł					-112, 313	
5.06	00591 OTHER ADMINISTRATIVE & GENERAL	191, 681	-304, 029				5. 06
7. 00	00700 OPERATION OF PLANT	78, 004	258, 387			335, 767	7. 00
8.00	00800 LAUNDRY & LINEN SERVICE	15, 218	328			15, 546	8. 00
9.00	00900 HOUSEKEEPI NG	70, 510	1, 833			72, 343	9. 00
10.00	01000 DI ETARY	62, 660	128, 129	190, 789	-119, 102	71, 687	10. 00
11. 00	01100 CAFETERI A	0	0	0	119, 102	119, 102	11. 00
13.00	01300 NURSING ADMINISTRATION	33, 510	12	33, 522	0	33, 522	13.00
14.00	01400 CENTRAL SERVICES & SUPPLY	0	-62, 771	-62, 771	64, 097	1, 326	14.00
	01600 MEDICAL RECORDS & LIBRARY	34, 574	4, 011			38, 367	16. 00
. 0. 00	I NPATI ENT ROUTI NE SERVI CE COST CENTERS	01/071	.,	00,000	2.0	00,007	
30. 00	03000 ADULTS & PEDIATRICS	163, 125	512, 779	675, 904	-1, 540	674, 364	30. 00
	04400 SKILLED NURSING FACILITY	309, 853				373, 875	44. 00
		309, 603	64, 022	373, 875	l	3/3, 6/3	44.00
	ANCILLARY SERVICE COST CENTERS	400 7/5	00 (11			105.040	
	05000 OPERATING ROOM	109, 765	90, 641			185, 862	50. 00
	05300 ANESTHESI OLOGY	0	54, 369			54, 262	53.00
54.00	05400 RADI OLOGY-DI AGNOSTI C	147, 051	144, 078	291, 129	1, 325	292, 454	54.00
57.00	05700 CT SCAN	0	0	0	0	0	57.00
58.00	05800 MRI	0	0	0	0	0	58. 00
60.00	06000 LABORATORY	166, 893	81, 139	248, 032	36, 565	284, 597	60.00
65.00	06500 RESPI RATORY THERAPY	94, 933	25, 346			107, 405	
66. 00	06600 PHYSI CAL THERAPY	156, 701	151, 653			308, 354	
69. 00	06900 ELECTROCARDI OLOGY	130, 701	936			936	69. 00
	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0	0		1	-83, 295	
		0					
	07200 I MPL. DEV. CHARGED TO PATIENTS	440.474	0		13, 686	13, 686	72. 00
73. 00	07300 DRUGS CHARGED TO PATIENTS	110, 171	384, 666	494, 837	1, 116	495, 953	73. 00
	OUTPATIENT SERVICE COST CENTERS						
	08800 RURAL HEALTH CLINIC	85, 466	7, 320			79, 776	
88. 01	08801 RURAL HEALTH CLINIC II	67, 051	14, 759	81, 810	9, 510	91, 320	88. 01
88. 02	08802 RURAL HEALTH CLINIC III	187, 026	13, 834	200, 860	15, 014	215, 874	88. 02
88. 03	08803 RURAL HEALTH CLINIC IV	403, 499	21, 949	425, 448	-16, 596	408, 852	88. 03
90.00	09000 CLI NI C	33, 092	76, 699			109, 400	90.00
	09001 ST ANNE CLINIC	45, 678	27, 300			69, 127	90. 01
91. 00	09100 EMERGENCY	265, 617	567, 307			829, 443	
92. 00	09200 OBSERVATION BEDS (NON-DISTINCT PART	203, 017	307, 307	032, 724	-3, 401	027, 443	92. 00
92.00				L			92.00
	OTHER REIMBURSABLE COST CENTERS						
	09500 AMBULANCE SERVICES	0	0			0	
101. 00	10100 HOME HEALTH AGENCY	105, 961	7, 877	113, 838	-579	113, 259	101. 00
	SPECIAL PURPOSE COST CENTERS						
	11300 INTEREST EXPENSE		55, 278				113. 00
116.00	11600 HOSPI CE	98, 179	143, 273	241, 452	-575	240, 877	116. 00
118.00	SUBTOTALS (SUM OF LINES 1 through 117)	3, 246, 599	3, 994, 021			7, 240, 620	118. 00
	NONREI MBURSABLE COST CENTERS	.,,	-, -, -, -,,	, , , , , , , , , , , , ,			
190 00	19000 GIFT FLOWER COFFEE SHOP & CANTEEN	n	0	0	0	Λ	190. 00
	07950 I ROQUOI S WOMENS HEALTH	0	0				194. 00
	07951 OTHER NONREIMBURSABLE DEPTS	9, 298	7, 586		0	16. 884	
		7, 298			-		194. 01 194. 02
	07952 REFERENCE LAB	2 255 227	4 001 407		0		
200.00	TOTAL (SUM OF LINES 118 through 199)	3, 255, 897	4, 001, 607	7, 257, 504	0	7, 257, 504	200.00

In Lieu of Form CMS-2552-10

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES

Peri od: From 07/17/2023

Worksheet A

Date/Time Prepared: 2/26/2024 1:42 pm

09/30/2023

Cost Center Description Adjustments Net Expenses (See A-8) For Allocation 6.00 7.00 GENERAL SERVICE COST CENTERS 1.00 00100 CAP REL COSTS-BLDG & FLXT 0 210, 499 1.00 00200 CAP REL COSTS-MVBLE EQUIP 0 152, 428 2.00 2.00 00400 EMPLOYEE BENEFITS DEPARTMENT 4.00 -490 1, 103, 649 4.00 5.01 00570 ADMITTING 58, 978 5 01 0 5.02 00560 PURCHASING RECEIVING AND STORES -589 14, 712 5.02 00550 DATA PROCESSING 125, 340 5.03 5.03 5.04 01160 COMMUNI CATI ONS -2, 233 29, 819 5.04 00590 BUSINESS OFFICE 99, 891 5.05 -264 5.05 5.06 00591 OTHER ADMINISTRATIVE & GENERAL 317, 439 205, 126 5.06 7.00 00700 OPERATION OF PLANT -2,065 333, 702 7 00 00800 LAUNDRY & LINEN SERVICE 8 00 15, 546 8 00 0 9.00 00900 HOUSEKEEPI NG 72, 343 9.00 10.00 01000 DI ETARY -3, 245 68, 442 10.00 01100 CAFETERI A -32, 967 11.00 86, 135 11.00 01300 NURSING ADMINISTRATION 13.00 27 33, 549 13.00 1, 326 14.00 01400 CENTRAL SERVICES & SUPPLY 14.00 01600 MEDICAL RECORDS & LIBRARY 16.00 -37 38, 330 16.00 INPATIENT ROUTINE SERVICE COST CENTERS 30.00 03000 ADULTS & PEDIATRICS -167, 832 506, 532 30.00 04400 SKILLED NURSING FACILITY 44.00 -13, 601 360, 274 44.00 ANCILLARY SERVICE COST CENTERS 05000 OPERATING ROOM 50.00 185, 862 50.00 53.00 05300 ANESTHESI OLOGY -47, 682 6,580 53.00 54.00 05400 RADI OLOGY-DI AGNOSTI C -8, 811 283, 643 54.00 57.00 05700 CT SCAN 57.00 05800 MRI 58.00 58 00 60.00 06000 LABORATORY -1, 792 282, 805 60.00 06500 RESPIRATORY THERAPY 65.00 107, 405 65.00 06600 PHYSI CAL THERAPY 256 66.00 308, 610 66.00 06900 ELECTROCARDI OLOGY 69.00 936 69.00 71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT 82, 396 -899 71.00 07200 IMPL. DEV. CHARGED TO PATIENTS 72.00 13,686 72.00 73 00 07300 DRUGS CHARGED TO PATIENTS 10 495, 963 73 00 OUTPATIENT SERVICE COST CENTERS 88.00 08800 RURAL HEALTH CLINIC -3, 378 76, 398 88.00 88. 01 08801 RURAL HEALTH CLINIC II 91, 320 88. 01 0 08802 RURAL HEALTH CLINIC III 88.02 0 215, 874 88.02 88.03 08803 RURAL HEALTH CLINIC IV 0 408, 852 88.03 90.00 09000 CLI NI C -79, 195 30, 205 90.00 90 01 09001 ST ANNE CLINIC -55 569 13, 558 90 01 91.00 09100 EMERGENCY -121, 173 708, 270 91.00 09200 OBSERVATION BEDS (NON-DISTINCT PART 92.00 92.00 OTHER REIMBURSABLE COST CENTERS 95. 00 09500 AMBULANCE SERVICES 95 00 101.00 10100 HOME HEALTH AGENCY 113, 259 101.00 SPECIAL PURPOSE COST CENTERS 113. 00 11300 | INTEREST EXPENSE 113. 00 116. 00 11600 HOSPI CE -176 240, 701 116. 00 118.00 SUBTOTALS (SUM OF LINES 1 through 117) -140, 971 7, 099, 649 118.00 NONREI MBURSABLE COST CENTERS 190.00 19000 GIFT FLOWER COFFEE SHOP & CANTEEN 190. 00 0 194. 00 07950 I ROQUOI S WOMENS HEALTH 0 Ω 194 00 194. 01 07951 OTHER NONREIMBURSABLE DEPTS 0 16, 884 194. 01 194. 02 07952 REFERENCE LAB 194. 02 TOTAL (SUM OF LINES 118 through 199) -140, 971 7, 116, 533 200.00 200.00

In Lieu of Form CMS-2552-10 Worksheet A-6

Period: W From 07/17/2023 To 09/30/2023 D

Date/Time Prepared: 2/26/2024 1:42 pm

	Increases				
	Cost Center	Li ne #	Sal ary	0ther	
	2. 00	3. 00	4. 00	5. 00	
	A - MEDICAL SUPPLIES				
1.00	CENTRAL SERVICES & SUPPLY	14.00	0	64, 097	1.00
2.00	RADI OLOGY-DI AGNOSTI C	54.00	o	1, 288	2.00
3.00	LABORATORY	60.00	o	36, 668	3.00
4.00	DRUGS CHARGED TO PATIENTS	73.00	o	1	4.00
5.00	IMPL. DEV. CHARGED TO	72.00	o	13, 686	5.00
	PATI ENTS				
6.00		0.00	0	0	6.00
7.00		0.00	0	0	7.00
8.00		0.00	0	0	8.00
	TOTALS		0	115, 740	
	B - DRUGS				Ī
1.00	DRUGS CHARGED TO PATIENTS	73. 00	0	1, 115	1.00
2.00	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	17	2.00
3.00	OTHER ADMINISTRATIVE &	5. 06	o	184	3.00
	GENERAL				
4.00	RADI OLOGY-DI AGNOSTI C	54.00	0	108	4. 00
5.00		0.00	0	0	5. 00
6.00		0.00	0	0	6.00
7.00		0.00	$\frac{0}{0}$	0	7. 00
	TOTALS		o	1, 424	
	C - DEPRECIATION				
1.00	CAP REL COSTS-MVBLE EQUIP	2.00	0	129, 212	1.00
	TOTALS		o	129, 212	
	D - INTEREST				
1.00	CAP REL COSTS-BLDG & FIXT	1.00	0	32, 062	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	2.00	0	23, 216	2.00
	TOTALS		0	55, 278	
	E - TELEPHONE				
1.00	COMMUNI CATI ONS	5. 04	0	11, 055	1.00
2.00		0.00	0	0	2. 00
3.00		0.00	0	0	3. 00
4.00		0.00	0	0	4. 00
5.00		0.00	0	0	5. 00
6.00		0.00	0	0	6.00
7.00		0.00	0	0	7.00
8.00		0.00	0	0	8.00
9.00		0.00	0	0	9. 00
10.00		0.00	0	0	10.00
11.00		0.00	o	0	11.00
12.00		0.00	o	0	12.00
13.00		0.00	o	0	13.00
14.00		0.00	o	0	14. 00
	TOTALS			11, 055	
	G - CAFETERIA	· · · · · · · · · · · · · · · · · · ·			1
1.00	CAFETERI A	11.00	38, 611	80, 491	1.00
	TOTALS		38, 611	80, 491	
	H - RHC SALARIES	<u> </u>			1
1.00	RURAL HEALTH CLINIC II	88. 01	11, 582	0	1.00
2.00	RURAL HEALTH CLINIC III	88. 02	16, 596	0	2. 00
	TOTALS		28, 178	— — <u> </u>	
500.00	Grand Total: Increases		66, 789		500.00
	1	1	, ,	2.2,200	

	Financial Systems	\mathcal{A}	I RO <mark>Q</mark> UOIS MEMOR				of Form CMS-	
RECLAS	SI FI CATI ONS			Provi der (eriod: From 07/17/2023	Worksheet A-6	5
						To 09/30/2023	Date/Time Pre	
		Docroscos					2/26/2024 1:4	12 pm
	Cost Center	Decreases Li ne #	Sal ary	Other	Wkst. A-7 Ref.	1		
	6.00	7. 00	8. 00	9. 00	10.00			
	A - MEDICAL SUPPLIES	71.00	0.00	7.00	10.00			
1.00		0.00	0	0	0			1.00
2.00	ADULTS & PEDIATRICS	30.00	О	1, 540	0			2. 00
3.00	OPERATING ROOM	50.00	O	14, 503	0			3. 00
4.00	ANESTHESI OLOGY	53.00	0	107	0			4. 00
5.00	RESPIRATORY THERAPY	65. 00	0	12, 874	0			5. 00
6.00	CLINIC	90.00	0	125				6. 00
7. 00	EMERGENCY	91. 00	0	3, 296		1		7. 00
8. 00	MEDICAL SUPPLIES CHARGED TO	71. 00	0	83, 295	0			8. 00
	PATI ENT							
	TOTALS		0	115, 740				
1 00	B - DRUGS	0.00	0		0			1 00
1. 00 2. 00		0.00	0	0				1. 00 2. 00
3. 00	OPERATING ROOM	50.00	0	41		1		3. 00
4. 00	LABORATORY	60.00	0	103		1		4. 00
5. 00	CLINIC	90.00	0	266		1		5. 00
6. 00	ST ANNE CLINIC	90. 01	ő	829				6. 00
7. 00	EMERGENCY	91.00	ő	185				7. 00
	TOTALS		— — -	1, 424		1		
	C - DEPRECIATION			·				
1.00	CAP REL COSTS-BLDG & FIXT	1.00	0	129, 212	9			1.00
	TOTALS		0	129, 212				
	D - INTEREST				ı			
1.00	I NTEREST EXPENSE	113. 00	0	55, 278				1.00
2.00				0		_		2. 00
	TOTALS E - TELEPHONE		0	55, 278				
1. 00	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	260	0			1.00
2. 00	PURCHASI NG RECEI VI NG AND	5. 02	o	84				2. 00
2.00	STORES	0.02	Ĭ	01				2.00
3.00	DATA PROCESSING	5. 03	o	188	0			3. 00
4.00	BUSINESS OFFICE	5. 05	o	203	0			4. 00
5.00	OTHER ADMINISTRATIVE &	5. 06	О	149	0			5. 00
	GENERAL							
6.00	OPERATION OF PLANT	7. 00	0	624				6. 00
7. 00	MEDICAL RECORDS & LIBRARY	16. 00	0	218		1		7. 00
8. 00	RADI OLOGY-DI AGNOSTI C	54.00	0	71				8. 00
9.00	HOME HEALTH AGENCY	101.00	0	579				9. 00
10.00	HOSPI CE	116.00	0	575				10.00
11. 00	RURAL HEALTH CLINIC	88. 00	0	1, 428				11.00
12. 00 13. 00	RURAL HEALTH CLINIC III	88. 02	0	1, 582				12.00
14. 00	RURAL HEALTH CLINIC II ST ANNE CLINIC	88. 01 90. 01	0	2, 072 3, 022				13. 00 14. 00
14.00	TOTALS	90.01		<u>3, 022</u> 11, 055				14.00
	G - CAFETERIA		<u> </u>	11, 033				-
1.00	DI ETARY	10. 00	38, 611	80, 491	0			1.00
55	TOTALS		38, 611	80, 491		1		
	H - RHC SALARIES							1
1.00	RURAL HEALTH CLINIC	88. 00	11, 582	0	0			1. 00
2.00	RURAL HEALTH CLINIC IV		1 <u>6, 5</u> 96	0	0			2. 00
	TOTALS		28, 178	0		1		
500.00	Grand Total: Decreases		66, 789	393, 200				500.00

						2/26/2024 1: 4:	2 pm
				Acqui si ti ons			
		Begi nni ng	Purchases	Donati on	Total	Di sposal s and	
		Bal ances				Retirements	
		1.00	2.00	3.00	4. 00	5. 00	
	PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET						
1.00	Land	332, 950	0	0	0	0	1. 00
2.00	Land Improvements	483, 750	0	0	0	0	2. 00
3.00	Buildings and Fixtures	26, 876, 675	0	0	0	0	3. 00
4.00	Building Improvements	0	0	0	0	0	4. 00
5.00	Fixed Equipment	16, 726, 644	0	0	0	0	5. 00
6.00	Movable Equipment	0	0	0	0	0	6. 00
7.00	HIT designated Assets	0	0	0	0	0	7. 00
8.00	Subtotal (sum of lines 1-7)	44, 420, 019	0	0	0	0	8. 00
9.00	Reconciling Items	0	0	0	0	0	9. 00
10.00	Total (line 8 minus line 9)	44, 420, 019	0	0	0	0	10.00
		Endi ng Bal ance	Ful I y				
			Depreci ated				
			Assets				
		6. 00	7. 00				
	PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET						
1.00	Land	332, 950	0)			1. 00
2.00	Land Improvements	483, 750	0)			2. 00
3.00	Buildings and Fixtures	26, 876, 675	0)			3. 00
4.00	Building Improvements	0	0)			4. 00
5.00	Fixed Equipment	16, 726, 644	0)			5. 00
6.00	Movable Equipment	0	0)			6. 00
7.00	HIT designated Assets	0	0)			7. 00
8.00	Subtotal (sum of lines 1-7)	44, 420, 019	0)			8. 00
9.00	Reconciling Items	0	0)			9. 00
10.00	Total (line 8 minus line 9)	44, 420, 019	0)			10.00

In Lieu of Form CMS-2552-10
Period: Worksheet A-7
From 07/17/2023 Part II
To 09/30/2023 Date/Time Prepared: 2/26/2024 1:42 pm

						2/26/2024 1: 42	2 pm
			SU	IMMARY OF CAPI	ΓAL		
	Cost Center Description	Depreciation	Lease	Interest	Insurance (see	Taxes (see	
					instructions)	instructions)	
		9. 00	10.00	11. 00	12.00	13. 00	
	PART II - RECONCILIATION OF AMOUNTS FROM WORK	KSHEET A, COLUM	N 2, LINES 1 a	nd 2			
1.00	CAP REL COSTS-BLDG & FLXT	307, 649	0	(0	0	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	0	(o	0	2.00
3.00	Total (sum of lines 1-2)	307, 649	0	(o	0	3.00
		SUMMARY 0	F CAPITAL				
	Cost Center Description	Other	Total (1) (sum				
		Capi tal -Relate	of cols. 9				
		d Costs (see	through 14)				
		instructions)					
		14.00	15. 00				
	PART II - RECONCILIATION OF AMOUNTS FROM WORK	SHEET A, COLUM	N 2, LINES 1 a	nd 2			
1.00	CAP REL COSTS-BLDG & FLXT	0	307, 649				1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	0				2.00
3.00	Total (sum of lines 1-2)	0	307, 649				3. 00
	,			'			

In Lieu of Form CMS-2552-10

Peri od: Worksheet A-7
From 07/17/2023 Part III
To 09/30/2023 Date/Time Prepared:

				'	0 09/30/2023	2/26/2024 1: 42	
		COMF	PUTATION OF RAT	TI OS	ALLOCATION OF	OTHER CAPITAL	
	Cost Center Description	Gross Assets	Capi tal i zed Leases	Gross Assets for Ratio (col. 1 - col.	Ratio (see instructions)	Insurance	
		1.00	2.00	2)	4.00	F 00	
	PART III - RECONCILIATION OF CAPITAL COSTS CE	1.00	2. 00	3. 00	4. 00	5.00	
1. 00	CAP REL COSTS-BLDG & FIXT	27, 360, 425	0	27, 360, 425	0. 620600	0	1. 00
2.00	CAP REL COSTS-MVBLE EQUIP	16, 726, 644		16, 726, 644		Ö	2. 00
3.00	Total (sum of lines 1-2)	44, 087, 069		44, 087, 069		0	3. 00
		ALLOCAT	TION OF OTHER (CAPI TAL	SUMMARY 0	F CAPITAL	
	Cost Center Description	Taxes	0ther	Total (sum of	Depreciation	Lease	
			Capi tal -Relate				
		6. 00	d Costs 7.00	through 7) 8.00	9. 00	10. 00	
	PART III - RECONCILIATION OF CAPITAL COSTS CE		7.00	0.00	7. 00	10.00	
1.00	CAP REL COSTS-BLDG & FIXT	0	0	0	178, 437	0	1. 00
2.00	CAP REL COSTS-MVBLE EQUIP	0	0	0	129, 212	0	2.00
3.00	Total (sum of lines 1-2)	0	0	0	307, 649	0	3.00
			SL	JMMARY OF CAPIT	AL		
	Cost Center Description	Interest	Insurance (see	Taxes (see	Other	Total (2) (sum	
	·				Capi tal -Relate	of cols. 9	
					d Costs (see	through 14)	
					instructions)		
	DART III DECONOLILATION OF CARLTAL COCTO OF	11. 00	12. 00	13. 00	14. 00	15. 00	
1. 00	PART III - RECONCILIATION OF CAPITAL COSTS CE		0		0	210, 400	1. 00
2.00	CAP REL COSTS-BLDG & FIXI	32, 062 23, 216			0	210, 499 152, 428	2. 00
3.00	Total (sum of lines 1-2)	55, 278			0	362, 927	3. 00
5.00	1.014. (04 0. 1.1.00 . 2)	00, 2, 0	٠ -	١ ~	١	302, 727	5.00

	Financial Systems	A	I RO <mark>Q</mark> UOI S MEMOF			eu of Form CMS-2	2552-10
ADJUST	TMENTS TO EXPENSES				<mark>P</mark> eriod: From 07/17/2023	Worksheet A-8	
					To 09/30/2023		
				Expense Classification or			Z piii
				To/From Which the Amount is	to be Adjusted		
	Cost Center Description			Cost Center	Li ne #	Wkst. A-7 Ref.	
1.00	Investment income - CAP REL	1.00	2.00	3.00 CAP REL COSTS-BLDG & FIXT	4. 00	5.00	1. 00
	COSTS-BLDG & FIXT (chapter 2)						
2. 00	Investment income - CAP REL COSTS-MVBLE EQUIP (chapter 2)		C	CAP REL COSTS-MVBLE EQUIP	2.00	0	2. 00
3.00	Investment income - other		C		0.00	О	3. 00
4.00	(chapter 2) Trade, quantity, and time				0.00	0	4. 00
	di scounts (chapter 8)						
5. 00	Refunds and rebates of expenses (chapter 8)		C		0.00	0	5. 00
6.00	Rental of provider space by		C		0.00	О	6. 00
7. 00	suppliers (chapter 8) Telephone services (pay	A	-2 233	COMMUNI CATI ONS	5. 04	0	7. 00
7.00	stations excluded) (chapter		2,200				7.00
8. 00	21) Television and radio service	A	-2 065	OPERATION OF PLANT	7. 00	0	8. 00
	(chapter 21)	, ,	2,000	The state of the			
9. 00 10. 00	Parking Lot (chapter 21) Provider-based physician	A-8-2	-460, 580		0.00	0	9. 00 10. 00
	adjustment	7 0 2					
11. 00	Sale of scrap, waste, etc. (chapter 23)		C		0.00	0	11. 00
12.00	Related organization	A-8-1	C			О	12. 00
13. 00	transactions (chapter 10) Laundry and Linen service				0.00	0	13. 00
14. 00	Cafeteria-employees and guests	В	-32, 967	CAFETERI A	11.00		14. 00
15. 00	Rental of quarters to employee and others		C		0.00	0	15. 00
16. 00	Sale of medical and surgical		C	ol .	0.00	0	16. 00
	supplies to other than patients						
17. 00	Sale of drugs to other than		C		0.00	О	17. 00
18. 00	patients Sale of medical records and				0.00	0	18. 00
	abstracts						
19. 00	Nursing and allied health education (tuition, fees,		C		0.00	0	19. 00
	books, etc.)						
20. 00 21. 00	Vending machines Income from imposition of				0. 00 0. 00		20. 00 21. 00
200	interest, finance or penalty				0.00		200
22. 00	charges (chapter 21) Interest expense on Medicare				0.00	0	22. 00
22.00	overpayments and borrowings to				0.00		22.00
23. 00	repay Medicare overpayments Adjustment for respiratory	A-8-3		RESPIRATORY THERAPY	65. 00		23. 00
	therapy costs in excess of						
24. 00	limitation (chapter 14) Adjustment for physical	A-8-3	C	 PHYSICAL THERAPY	66. 00	,	24. 00
	therapy costs in excess of						
25. 00	limitation (chapter 14) Utilization review -		C	 *** Cost Center Deleted ***	114.00	į	25. 00
	physicians' compensation						
26. 00	(chapter 21) Depreciation - CAP REL		C	CAP REL COSTS-BLDG & FLXT	1.00	o	26. 00
	COSTS-BLDG & FIXT				0.00		07.00
27. 00	Depreciation - CAP REL COSTS-MVBLE EQUIP			CAP REL COSTS-MVBLE EQUIP	2. 00	0	27. 00
28. 00	Non-physician Anesthetist		C	*** Cost Center Deleted ***	19. 00		28. 00
29. 00 30. 00	Physicians' assistant Adjustment for occupational	A-8-3) *** Cost Center Deleted ***	0. 00 67. 00		29. 00 30. 00
	therapy costs in excess of						
30. 99	Himitation (chapter 14) Hospice (non-distinct) (see		c	ADULTS & PEDIATRICS	30.00		30. 99
	instructions)						
31. 00	Adjustment for speech pathology costs in excess of	A-8-3	C	*** Cost Center Deleted ***	68. 00		31. 00
22.00	limitation (chapter 14)				0.00		22.00
32. 00	CAH HIT Adjustment for Depreciation and Interest		C	,	0.00	0	32. 00
			•	•	•	. '	-

In Lieu of Form CMS-2552-10 Worksheet A-8

Peri od: From 07/17/2023 To 09/30/2023 Date/Time Prepared: 2/26/2024 1: 42 pm

						2/26/2024 1: 4	2 pm
				Expense Classification on	Worksheet A		
				To/From Which the Amount is			
					,		
	Cost Center Description		Amount	Cost Center	Li ne #	Wkst. A-7 Ref.	
		1.00	2.00	3. 00	4. 00	5. 00	
33.00	OTHER ADJUSTMENTS (SPECIFY)		0		0. 00	0	33.00
	(3)						
33. 01	NON-PATIENT REVENUE	В	-19 249	OTHER ADMINISTRATIVE &	5. 06	0	33. 01
00.0.	Not Title it Nevertoe		.,, ,	GENERAL	0.00	Ĭ	00.0.
33. 02	NON-PATIENT REVENUE	В	_178	HOSPI CE	116. 00	0	33. 02
33. 02	II	В		DRUGS CHARGED TO PATIENTS			
	NON-PATIENT REVENUE	1			73. 00		33. 03
33. 04	NON-PATIENT REVENUE	В		MEDICAL RECORDS & LIBRARY	16. 00	0	33. 04
33. 05	NON-PATIENT REVENUE	В		DI ETARY	10. 00	0	33. 05
33. 06	NON-PATIENT REVENUE	В	-3, 378	RURAL HEALTH CLINIC	88. 00	0	33. 06
33. 07	RENTAL INCOME	В	-15, 650	CLINIC	90.00	0	33. 07
33. 08	RENTAL INCOME	В		OTHER ADMINISTRATIVE &	5. 06	0	33. 08
00.00	THE THOUSE		02.	GENERAL	0.00	Ĭ	00.00
33. 09	MARKETING EXPENSES	A	400	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	33. 09
		1					
33. 10	MARKETING EXPENSES	A	ļ	PURCHASING RECEIVING AND	5. 02	0	33. 10
				STORES			
33. 11	MARKETING EXPENSES	A	-16, 880	OTHER ADMINISTRATIVE &	5. 06	0	33. 11
				GENERAL			
33. 12	MARKETING EXPENSES	A	10	CLINIC	90.00	0	33. 12
33. 13	MARKETING EXPENSES	A	2	HOSPI CE	116. 00	0	33. 13
33. 14	PHYSICIAN RECRUITMENT	A		OTHER ADMINISTRATIVE &	5. 06		33. 14
33. 14	THISTOTAN REGROTTMENT	^	7	GENERAL	3.00	٥	33. 14
33. 15	OUTDEACH EXPENSES		F 007	OTHER ADMINISTRATIVE &	F 0/	0	22 15
33. 15	OUTREACH EXPENSES	A	-5, 897		5. 06	U	33. 15
		_		GENERAL		_	
33. 16	MARKETING EXPENSES	A		ST ANNE CLINIC	90. 01	0	33. 16
33. 17	BUSINESS OFFICE INCOME	A		BUSINESS OFFICE	5. 05	0	33. 17
33. 18	COGS	A	-590	PURCHASING RECEIVING AND	5. 02	0	33. 18
				STORES			
33. 19	NURSING HOME BED TAX	A	-13, 760	SKILLED NURSING FACILITY	44.00	0	33. 19
33. 20	INVENTORY ADJ SPLIT BTW PPS &	A		OTHER ADMINISTRATIVE &	5. 06		33. 20
33. 20	CAH	^	010, 040	GENERAL	3.00	٥	33. 20
22 21	INVENTORY ADJ SPLIT BTW PPS &		27	NURSING ADMINISTRATION	12.00	0	33. 21
33. 21		A	21	NURSING ADMINISTRATION	13. 00	U	33. 21
	CAH	_				_	
33. 22	INVENTORY ADJ SPLIT BTW PPS &	A	159	SKILLED NURSING FACILITY	44. 00	0	33. 22
	CAH						
33. 23	INVENTORY ADJ SPLIT BTW PPS &	A	256	PHYSICAL THERAPY	66.00	0	33. 23
	CAH						
33. 24	INVENTORY ADJ SPLIT BTW PPS &	A	82, 396	MEDICAL SUPPLIES CHARGED TO	71. 00	0	33. 24
	CAH		,	PATI ENT			
33. 25	INVENTORY ADJ SPLIT BTW PPS &	A	5.4	ST ANNE CLINIC	90. 01	0	33. 25
55. 25	CAH	^	34	SI ANNE CEINIC	70.01	٥	33. 23
22.27			70	EMEDOENCY	01 00		22.27
33. 26	INVENTORY ADJ SPLIT BTW PPS &	A	70	EMERGENCY	91. 00	0	33. 26
	CAH						
34. 00	HOSPITAL MEDICALD ASSESSMENT	A	-259, 506	OTHER ADMINISTRATIVE &	5. 06	0	34. 00
				GENERAL			
50.00	TOTAL (sum of lines 1 thru 49)		-140, 971				50.00
	(Transfer to Worksheet A,						
	column 6, line 200.)						
				1			

(1) Description - all chapter references in this column pertain to CMS Pub. 15-1.

(2) Basis for adjustment (see instructions).

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

A. Costs - if cost, including applicable overhead, can be determined.

B. Amount Received - if cost cannot be determined.

(3) Additional adjustments may be made on lines 33 thru 49 and subscripts thereof.

I ROQUOI S MEMORI AL HOSPI TAL

Provi der CCN: 14-1353 Health Financial Systems
PROVIDER BASED PHYSICIAN ADJUSTMENT

In Lieu of Form CMS-2552-10

Peri od: Worksheet A-8-2 From 07/17/2023 To 09/30/2023 Date/Time Prepared:

					'	10 07/30/202	2/26/2024 1: 4	
	Wkst. A Line #	Cost Center/Physician	Total	Professi onal	Provi der	RCE Amount	Physi ci an/Prov	
		I denti fi er	Remuneration	Component	Component		ider Component	
				'	•		Hours	
	1. 00	2.00	3. 00	4. 00	5. 00	6. 00	7. 00	
1.00	91. 00	EMERGENCY	455, 629	121, 243	334, 386	C	0	1. 00
2.00	30.00	ADULTS & PEDIATRICS	167, 832	167, 832	0	C	0	2. 00
3.00	0.00		0	0	0	C	0	3. 00
4.00	53. 00	ANESTHESI OLOGY	47, 682	47, 682	0	C	0	4. 00
5.00	54.00	RADI OLOGY-DI AGNOSTI C	8, 811	8, 811	0	l	o l	5. 00
6.00	0. 00		0	0	0	C	o o	6. 00
7.00	60.00	LABORATORY	1, 792	1, 792	0	l	o l	7. 00
8.00	90.00	CLI NI C	63, 555	63, 555	0	l	o l	8. 00
9.00	90. 01	ST ANNE CLINIC	49, 665	49, 665	0	l	ار	9. 00
10.00	0.00		0	0	0	l	ار	10.00
200.00			794, 966	460, 580	334, 386		0	200. 00
	Wkst. A Line #	Cost Center/Physician	Unadjusted RCE	5 Percent of	Cost of	Provi der	Physician Cost	
		Identifier		Unadjusted RCE		Component	of Malpractice	
				Limit	Conti nui ng	Share of col.	Insurance	
					Educati on	12		
	1. 00	2.00	8. 00	9. 00	12. 00	13. 00	14.00	
1. 00		EMERGENCY	0	0	0	[C	0	
2.00		ADULTS & PEDIATRICS	0	0	0	[C	0	00
3.00	0. 00	1	0	0	0	(0	3. 00
4.00		ANESTHESI OLOGY	0	0	0	(0	4. 00
5.00		RADI OLOGY-DI AGNOSTI C	0	0	0	(0	5. 00
6. 00	0. 00	1	0	0	0	(0	6. 00
7. 00		LABORATORY	0	0	0	(0	7. 00
8. 00		CLINIC	0	0	0	(0	8. 00
9.00		ST ANNE CLINIC	0	0	0	(0	9. 00
10.00	0. 00		0	0	0	(0	
200.00			0	0	0	C	0	200.00
	Wkst. A Line #		Provi der	Adjusted RCE	RCE	Adjustment		
		I denti fi er	Component	Limit	Di sal I owance			
			Share of col.					
	1. 00	2.00	14 15. 00	16. 00	17. 00	18. 00	-	
1. 00		EMERGENCY	15.00	10.00	17.00	121, 243	,	1. 00
2.00		ADULTS & PEDIATRICS	0	0	0	167, 832	1	2.00
3. 00	0.00	MI	0	0	0	107, 032		3.00
4. 00		ANESTHESI OLOGY	0	0	0	47, 682	,	4.00
5. 00		RADI OLOGY-DI AGNOSTI C	0	0	0	8, 811		5.00
5. 00 6. 00	0.00	MI.			0	0,811		6. 00
7. 00		LABORATORY	0	0	0	1, 792	,	7. 00
8.00		CLI NI C	0	0	0	63, 555		8.00
9. 00		ST ANNE CLINIC	0	·	0	49, 665		9.00
	0. 00	MI CONTRACTOR OF THE CONTRACTO] 0] 0	0	49, 665	1	1
10.00	0.00			_	0	· ·	1	10. 00 200. 00
200. 00	I	I	ı	ı	l 0	1 400, 580	1	200. 00

In Lieu of Form CMS-2552-10

Period: Worksheet B
From 07/17/2023 Part I
To 09/30/2023 Date/Time Prepared: 2/26/2024 1:42 pm

			10	09/30/2023	2/26/2024 1: 4	
		CAPI TAL REL	ATED COSTS		, = , = 0, = 0 = 1	
Cost Center Description	Net Expenses	BLDG & FIXT	MVBLE EQUIP	EMPLOYEE	ADMI TTI NG	
cost center bescription	for Cost	DEDU & TIXI	WVDLL LQ011	BENEFITS	ADMITTING	
	Allocation			DEPARTMENT		
	(from Wkst A					
	col. 7) 0	1. 00	2.00	4. 00	5. 01	
GENERAL SERVICE COST CENTERS	<u> </u>	1. 00	2.00	1. 00	0.01	
1.00 O0100 CAP REL COSTS-BLDG & FLXT	210, 499	210, 499				1. 00
2.00 00200 CAP REL COSTS-MVBLE EQUIP	152, 428		152, 428			2. 00
4.00 00400 EMPLOYEE BENEFITS DEPARTMENT	1, 103, 649	2, 713	354	1, 106, 716	00.400	4. 00
5. 01 00570 ADMITTING 5. 02 00560 PURCHASING RECEIVING AND STORES	58, 978 14, 712	1, 285 1, 466	300 201	19, 545 5, 335	80, 108 0	5. 01 5. 02
5. 03 00550 DATA PROCESSING	125, 340	3, 754	9, 668	16, 250	0	5. 02
5. 04 01160 COMMUNI CATI ONS	29, 819	270	,, 555	10, 230	0	5. 04
5. 05 00590 BUSINESS OFFICE	99, 891	13, 746	88	19, 205	0	5. 05
5.06 00591 OTHER ADMINISTRATIVE & GENERAL	205, 126	11, 129	1, 331	65, 858	0	5. 06
7.00 O0700 OPERATION OF PLANT	333, 702	22, 546	18, 428	26, 801	0	7. 00
8.00 00800 LAUNDRY & LINEN SERVICE	15, 546	3, 485	19	5, 229	0	8. 00
9. 00 00900 HOUSEKEEPI NG	72, 343	1, 016	21	24, 226	0	9. 00
10. 00 01000 DI ETARY	68, 442	5, 078	355 0	8, 263	0	10.00
11. 00 01100 CAFETERI A 13. 00 01300 NURSI NG ADMI NI STRATI ON	86, 135 33, 549	1, 580 1, 615	0	13, 266 11, 513	0	11. 00 13. 00
14. 00 01400 CENTRAL SERVICES & SUPPLY	1, 326	2, 286	1, 047	11, 313	0	14. 00
16. 00 01600 MEDI CAL RECORDS & LI BRARY	38, 330	2, 043	13	11, 879	0	16. 00
INPATIENT ROUTINE SERVICE COST CENTERS				·		
30. 00 03000 ADULTS & PEDIATRICS	506, 532	14, 104	8, 753		4, 451	30. 00
44. 00 04400 SKILLED NURSING FACILITY	360, 274	14, 873	4, 263	106, 460	3, 797	44. 00
ANCILLARY SERVICE COST CENTERS 50.00 OPERATING ROOM	185, 862	24, 746	37, 197	37, 713	11, 258	50.00
53. 00 05300 OPERATTING ROOM 53. 00 05300 ANESTHESI OLOGY	6, 580	24, 746 167	125	37, 713	11, 256	53. 00
54. 00 05400 RADI OLOGY - DI AGNOSTI C	283, 643	8, 346	34, 279	50, 524	19, 417	54. 00
57. 00 05700 CT SCAN	0	0	0	0	0	57. 00
58. 00 05800 MRI	o	0	0	o	0	58. 00
60. 00 06000 LABORATORY	282, 805	5, 349		57, 341	14, 357	60. 00
65. 00 06500 RESPI RATORY THERAPY	107, 405	3, 117	2, 775		593	65. 00
66. 00 06600 PHYSI CAL THERAPY	308, 610	18, 780	5, 312	53, 839	4, 519	66.00
69. 00 06900 ELECTROCARDI OLOGY 71. 00 07100 MEDI CAL SUPPLI ES CHARGED TO PATI ENT	936 -899	1, 106 0	1, 138 0	0	527 1, 564	69. 00 71. 00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	13, 686	0	0	0	217	71.00
73. 00 07300 DRUGS CHARGED TO PATIENTS	495, 963	5, 349	887	37, 853	6, 369	73. 00
OUTPATIENT SERVICE COST CENTERS	,	27 2		2.7 222	2, 22.	
88.00 08800 RURAL HEALTH CLINIC	76, 398	2, 002	96	25, 385	0	88. 00
88.01 08801 RURAL HEALTH CLINIC II	91, 320	4, 264	3, 332	27, 017	0	88. 01
88. 02 08802 RURAL HEALTH CLINIC III	215, 874	6, 470	1, 738	69, 961	0	88. 02
88. 03 08803 RURAL HEALTH CLINIC IV	408, 852	3, 665	2, 784	132, 931	1, 390	88. 03
90. 00 09000 CLINIC 90. 01 09001 ST ANNE CLINIC	30, 205 13, 558	9, 883 2, 282	655 169	11, 370 15, 694	1, 305 0	90. 00 90. 01
91. 00 09100 EMERGENCY	708, 270	7, 020		91, 261	10, 189	91.00
92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART	700,270	7,020	0, 100	71, 201	10, 107	92. 00
OTHER REIMBURSABLE COST CENTERS				,		
95. 00 09500 AMBULANCE SERVICES	0	0	0	0	0	95. 00
101.00 10100 HOME HEALTH AGENCY	113, 259	3, 570	3, 166	36, 406	0	101. 00
SPECIAL PURPOSE COST CENTERS						140.00
113. 00 11300 INTEREST EXPENSE	240 701	0	2 224	22 722	0	113. 00 116. 00
116.00 11600 HOSPICE 118.00 SUBTOTALS (SUM OF LINES 1 through 117)	240, 701 7, 099, 649	0 209, 105	3, 224 151, 001	33, 732 1, 103, 521	80, 108	
NONREI MBURSABLE COST CENTERS	7,077,047	207, 103	131,001	1, 103, 321	00, 100	1110.00
190. 00 19000 GIFT FLOWER COFFEE SHOP & CANTEEN	ol	1, 394	0	0	0	190. 00
194.00 07950 I ROQUOIS WOMENS HEALTH	o	0	0	o		194. 00
194. 01 07951 OTHER NONREIMBURSABLE DEPTS	16, 884	0	918	3, 195		194. 01
194. 02 07952 REFERENCE LAB	0	0	509	0	0	194. 02
200.00 Cross Foot Adjustments		_1		_	_	200. 00
201.00 Negative Cost Centers	7 11/ 500	0	150 400	1 104 714	0 80, 108	201.00
202.00 TOTAL (sum lines 118 through 201)	7, 116, 533	210, 499	152, 428	1, 106, 716	80, 108	2U2. UU

Health Financial Systems IROQUOIS MEMORIAL HOSPITAL COST ALLOCATION - GENERAL SERVICE COSTS Provi der CCN: 14-1353

In Lieu of Form CMS-2552-10 Period: Worksheet B From 07/17/2023 Part I To 09/30/2023 Date/Time Prepa

				То	09/30/2023	Date/Time Pre 2/26/2024 1:4	
	Cost Center Description	PURCHASI NG RECEI VI NG AND STORES	DATA PROCESSI NG	COMMUNI CATI ONS	BUSI NESS OFFI CE	Subtotal	2 piii
		5. 02	5. 03	5. 04	5. 05	5A. 05	
	GENERAL SERVICE COST CENTERS						
1. 00	00100 CAP REL COSTS-BLDG & FIXT						1. 00
2.00	00200 CAP REL COSTS-MVBLE EQUIP						2. 00
4. 00	00400 EMPLOYEE BENEFITS DEPARTMENT						4. 00
5. 01	00570 ADMITTING						5. 01
5. 02	00560 PURCHASING RECEIVING AND STORES	21, 714					5. 02
5. 03	00550 DATA PROCESSI NG	0	155, 012				5. 03
5.04	01160 COMMUNI CATI ONS	0	0	,	100 100		5. 04
5. 05	00590 BUSINESS OFFICE	16	4, 795		138, 123	004 007	5. 05
5.06	00591 OTHER ADMINISTRATIVE & GENERAL	0	5, 268		0	291, 387	5. 06
7.00	00700 OPERATION OF PLANT	1, 430	4, 668		O O	408, 339	7. 00
8. 00 9. 00	00800 LAUNDRY & LINEN SERVICE 00900 HOUSEKEEPING	160	684		0	25, 219	
10. 00	01000 DI ETARY	64	7, 360 4, 556			105, 126 86, 694	9. 00 10. 00
11. 00	01100 CAFETERI A		3, 769	_		104, 750	11.00
13. 00	01300 NURSING ADMINISTRATION	1	2, 829		0	49, 698	1
14. 00	01400 CENTRAL SERVICES & SUPPLY	107	2, 029		0	4, 766	1
16. 00	01600 MEDICAL RECORDS & LIBRARY	5	4, 953	_	0	57, 605	ı
10.00	I NPATI ENT ROUTI NE SERVI CE COST CENTERS	١	4, 755	302	<u> </u>	37,003	10.00
30. 00	03000 ADULTS & PEDI ATRI CS	548	15, 313	4, 490	7, 443	617, 681	30. 00
44. 00	04400 SKILLED NURSING FACILITY	3, 006	17, 148		6, 349	517, 221	1
	ANCILLARY SERVICE COST CENTERS			.,	2, 2		
50.00	05000 OPERATING ROOM	440	7, 007	2, 770	18, 827	325, 820	50.00
53.00	05300 ANESTHESI OLOGY	15	0	0	259	7, 301	53.00
54.00	05400 RADI OLOGY-DI AGNOSTI C	445	9, 065	1, 433	32, 488	439, 640	54.00
57.00	05700 CT SCAN	o	0	0	0	0	57.00
58. 00	05800 MRI	0	0	0	0	0	58. 00
60.00	06000 LABORATORY	130	8, 307	1, 433	24, 011	397, 556	60.00
65. 00	06500 RESPI RATORY THERAPY	480	4, 873		991	153, 424	65. 00
66. 00	06600 PHYSI CAL THERAPY	10, 970	5, 369		7, 557	416, 293	
69. 00	06900 ELECTROCARDI OLOGY	0	658		882	5, 247	
71. 00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0	0		2, 616	3, 281	71. 00
72. 00	07200 I MPL. DEV. CHARGED TO PATIENTS	1, 101	0	-	363	15, 367	72. 00
73. 00	07300 DRUGS CHARGED TO PATIENTS	25	3, 729	573	10, 651	561, 399	73. 00
00 00	OUTPATIENT SERVICE COST CENTERS	100	2 025	F 7.0	1 1/0	100 (00	00 00
88. 00	08800 RURAL HEALTH CLINIC	122	2, 935		1, 169	108, 680	88. 00
88. 01	08801 RURAL HEALTH CLINIC II	254	2, 459		1, 225	131, 017	88. 01
88. 02 88. 03	08802 RURAL HEALTH CLINIC III 08803 RURAL HEALTH CLINIC IV	63 237	4, 364 4, 869		1, 581 2, 325	302, 343 559, 154	
90. 00	09000 CLINIC	86	3, 642		2, 183	60, 571	90.00
90. 00	09001 ST ANNE CLINIC	242	3, 042		164	33, 064	90.00
91. 00	09100 EMERGENCY	1, 606	9, 346		17, 039	851, 815	1
92. 00	09200 OBSERVATION BEDS (NON-DISTINCT PART	1,000	7, 340	1,024	17,037	031, 013	ı
72.00	OTHER REIMBURSABLE COST CENTERS						72.00
95. 00	09500 AMBULANCE SERVICES	0	0	O	0	0	95. 00
	10100 HOME HEALTH AGENCY	128	4, 087		o	161, 189	1
	SPECIAL PURPOSE COST CENTERS	.==,	.,,		-1		
113.00	11300 NTEREST EXPENSE						113. 00
116.00	11600 HOSPI CE	0	8, 732	955	0	287, 344	116. 00
118.00	SUBTOTALS (SUM OF LINES 1 through 117)	21, 681	150, 785		138, 123	7, 088, 991	
	NONREI MBURSABLE COST CENTERS						
	19000 GIFT FLOWER COFFEE SHOP & CANTEEN	0	0		0		190. 00
	07950 I ROQUOIS WOMENS HEALTH	0	0		0		194. 00
	07951 OTHER NONREIMBURSABLE DEPTS	33	4, 180		0		194. 01
	07952 REFERENCE LAB	0	47	0	0		194. 02
200.00	Cross Foot Adjustments					0	200. 00

155, 012

30, 089

138, 123

556 194. 02 0 200. 00

0 201. 00 7, 116, 533 202. 00

200.00

201.00

202.00

Cross Foot Adjustments

TOTAL (sum lines 118 through 201)

Negative Cost Centers

I ROQUOI S MEMORI AL HOSPI TAL

Provi der CCN: 14-1353 Health Financial Systems
COST ALLOCATION - GENERAL SERVICE COSTS

						2/26/2024 1:4	2 pm
	Cost Center Description	OTHER ADMI NI STRATI VE & GENERAL	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPI NG	DI ETARY	
		5. 06	7. 00	8. 00	9. 00	10. 00	
	GENERAL SERVICE COST CENTERS						
1.00 2.00 4.00 5.01 5.02 5.03	00100 CAP REL COSTS-BLDG & FIXT 00200 CAP REL COSTS-MVBLE EQUIP 00400 EMPLOYEE BENEFITS DEPARTMENT 00570 ADMITTING 00560 PURCHASING RECEIVING AND STORES 00550 DATA PROCESSING						1. 00 2. 00 4. 00 5. 01 5. 02 5. 03
5. 04 5. 05 5. 06 7. 00 8. 00 9. 00 10. 00 11. 00 13. 00 14. 00	01160 COMMUNI CATIONS 00590 BUSINESS OFFICE 00591 OTHER ADMINISTRATIVE & GENERAL 00700 OPERATION OF PLANT 00800 LAUNDRY & LINEN SERVICE 00900 HOUSEKEEPING 01000 DIETARY 01100 CAFETERIA 01300 NURSING ADMINISTRATION 01400 CENTRAL SERVICES & SUPPLY	291, 387 17, 433 1, 077 4, 488 3, 701 4, 472 2, 122 203	425, 772 9, 660 2, 817 14, 077 4, 379 4, 476 6, 338	35, 956 0 0 0 0	112, 431 4, 258 1, 325 1, 354	108, 730 0 0 0	5. 04 5. 05 5. 06 7. 00 8. 00 9. 00 10. 00 11. 00 13. 00 14. 00
16. 00	01600 MEDI CAL RECORDS & LI BRARY	2, 459	5, 664			0	16. 00
10.00	I NPATI ENT ROUTI NE SERVI CE COST CENTERS	2,437	5, 004		1, 713	0	10.00
30. 00 44. 00	03000 ADULTS & PEDIATRICS 04400 SKILLED NURSING FACILITY	26, 371 22, 082	39, 099 41, 230			14, 264 93, 996	30. 00 44. 00
FO 00	ANCI LLARY SERVI CE COST CENTERS	12.010	(0. (04	2 077	20. 75.4	/2	FO 00
50. 00 53. 00	05000 OPERATI NG ROOM 05300 ANESTHESI OLOGY	13, 910 312	68, 604 463	3, 077	20, 754 140	63 0	50. 00 53. 00
54. 00	05400 RADI OLOGY-DI AGNOSTI C	18, 770	23, 135			0	54.00
57. 00	05700 CT SCAN	10,770	23, 133		0, 777	0	57. 00
58. 00	05800 MRI	0	0	0	٥	0	58. 00
60. 00	06000 LABORATORY	16, 973	14, 827	58	-	0	60. 00
65. 00	06500 RESPIRATORY THERAPY	6, 550		0		0	65. 00
	I I		8, 641	_	-,		
66.00	06600 PHYSI CAL THERAPY	17, 773	52, 060		15, 749	0	66. 00
69. 00	06900 ELECTROCARDI OLOGY	224	3, 066	1	927	0	69. 00
71. 00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	140	0	0	0	0	71. 00
72. 00	07200 I MPL. DEV. CHARGED TO PATIENTS	656	0	0	_	0	72. 00
73. 00	07300 DRUGS CHARGED TO PATIENTS	23, 968	14, 827	0	4, 485	0	73. 00
	OUTPATIENT SERVICE COST CENTERS						
88. 00	08800 RURAL HEALTH CLINIC	4, 640	5, 550	0	0	0	88. 00
88. 01	08801 RURAL HEALTH CLINIC II	5, 594	11, 820	0	0	0	88. 01
88. 02	08802 RURAL HEALTH CLINIC III	12, 908	17, 935	0	0	0	88. 02
88. 03	08803 RURAL HEALTH CLINIC IV	23, 872	10, 161	0	3, 074	0	88. 03
90.00	09000 CLI NI C	2, 586	27, 397	255	8, 288	125	90.00
90. 01	09001 ST ANNE CLINIC	1, 412	6, 325	0	0	0	90. 01
91.00	09100 EMERGENCY	36, 364	19, 459	8, 780	5, 886	282	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART						92.00
	OTHER REIMBURSABLE COST CENTERS						
95.00	09500 AMBULANCE SERVICES	0	0	0	0	0	95. 00
101.00	10100 HOME HEALTH AGENCY	6, 882	9, 896	0	2, 994	0	101. 00
	SPECIAL PURPOSE COST CENTERS				·		
113.00	11300 I NTEREST EXPENSE						113. 00
	11600 HOSPI CE	12, 268	0	0	ol	0	116. 00
118.00		290, 210	421, 906	35, 956	111, 262	108, 730	
	NONREI MBURSABLE COST CENTERS	,			, - 1		
190 00	19000 GIFT FLOWER COFFEE SHOP & CANTEEN	60	3, 866	0	1, 169	0	190. 00
	07950 I ROQUOI S WOMENS HEALTH	0	0, 300	Ö	l		194. 00
	07951 OTHER NONREIMBURSABLE DEPTS	1, 093	n	0			194. 01
	07952 REFERENCE LAB	24	0	0			194. 02
200.00		24	O			O	200. 00
201.00		0	n	n	ا	Λ	200.00
202.00		291, 387	425, 772	35, 956	112, 431		
202.00	/ 1701/12 (3dill 111103 110 till bugil 201)	271,307	725, 112	1 33, 730	112,431	100, 730	202.00

Heal th Financial Systems

COST ALLOCATION - GENERAL SERVICE COSTS

IROQUOIS MEMORIAL HOSPITAL

Provider CCN: 14-1353

				To	09/30/2023	Date/Time Pre 2/26/2024 1:4	
	Cost Center Description	CAFETERI A	NURSI NG	CENTRAL	MEDI CAL	Subtotal	Z piii
	oust deliter bescription	ON ETERNIA	ADMI NI STRATI ON	SERVICES &	RECORDS &	Subtotal	
				SUPPLY	LI BRARY		
		11.00	13.00	14. 00	16.00	24. 00	
	GENERAL SERVICE COST CENTERS						
1.00	00100 CAP REL COSTS-BLDG & FIXT						1. 00
2.00	00200 CAP REL COSTS-MVBLE EQUIP						2. 00
4.00	00400 EMPLOYEE BENEFITS DEPARTMENT						4. 00
5.01	00570 ADMITTING						5. 01
5.02	00560 PURCHASING RECEIVING AND STORES						5. 02
5.03	00550 DATA PROCESSING						5. 03
5.04	01160 COMMUNI CATI ONS						5. 04
5.05	00590 BUSINESS OFFICE						5. 05
5.06	00591 OTHER ADMINISTRATIVE & GENERAL						5. 06
7.00	00700 OPERATION OF PLANT						7. 00
8.00	00800 LAUNDRY & LINEN SERVICE						8. 00
9.00	00900 HOUSEKEEPI NG						9. 00
10. 00	01000 DI ETARY						10. 00
11. 00	01100 CAFETERI A	114, 926	l I				11. 00
13. 00	01300 NURSING ADMINISTRATION	1, 541	59, 191				13. 00
14. 00	01400 CENTRAL SERVICES & SUPPLY	0	0	13, 224			14. 00
16. 00	01600 MEDI CAL RECORDS & LI BRARY	3, 852	0	4	71, 297		16. 00
	I NPATI ENT ROUTI NE SERVI CE COST CENTERS	r	I	1			
30. 00	03000 ADULTS & PEDI ATRI CS	11, 074		364	3, 842	747, 360	1
44. 00	04400 SKILLED NURSING FACILITY	26, 190	0	1, 994	3, 277	731, 540	44. 00
	ANCILLARY SERVICE COST CENTERS			000	0 740	157 770	
50. 00	05000 OPERATING ROOM	5, 874	8, 556	292	9, 718	456, 668	50.00
53.00	05300 ANESTHESI OLOGY	0	_	10	134	8, 360	1
54.00	05400 RADI OLOGY-DI AGNOSTI C	11, 700		295	16, 769	519, 927	54.00
57. 00	05700 CT SCAN	0	0	0	0	0	57.00
58.00	05800 MRI	12 422	0	0	12 204	450.013	58. 00
60.00	06000 LABORATORY	13, 433		86	12, 394	459, 812	60.00
65. 00	06500 RESPIRATORY THERAPY	7, 896	1	319	512	191, 458	1
66.00	06600 PHYSI CAL THERAPY	10, 737	0	7, 275	3, 901	525, 170	1
69. 00	06900 ELECTROCARDI OLOGY	0		0	455	9, 919	1
71. 00 72. 00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT 07200 IMPL. DEV. CHARGED TO PATIENTS		-	-	1, 350 187	4, 771	71. 00 72. 00
72.00	07300 DRUGS CHARGED TO PATIENTS	6, 548		730 17	5, 498	16, 940 616, 742	73.00
73.00	OUTPATIENT SERVICE COST CENTERS	0, 340	ı y	17]	3, 490	010, 742	73.00
88. 00	08800 RURAL HEALTH CLINIC	0	ol	81	603	119, 554	88. 00
88. 01	08801 RURAL HEALTH CLINIC II			168	633	149, 232	88. 01
88. 02	08802 RURAL HEALTH CLINIC III			42	816	334, 044	88. 02
88. 03	08803 RURAL HEALTH CLINIC IV			157	1, 200	597, 618	1
90. 00	09000 CLINIC	1, 733	2, 525	57	1, 127	104, 664	90.00
90. 01	09001 ST ANNE CLINIC	1,750		161	85	41, 047	90. 01
91. 00	09100 EMERGENCY	14, 059		1, 065	8, 796	966, 984	91.00
92. 00	09200 OBSERVATION BEDS (NON-DISTINCT PART	11,007	20, 170	1, 000	0, 7,0	700, 701	92. 00
72.00	OTHER REIMBURSABLE COST CENTERS						72.00
95. 00	09500 AMBULANCE SERVICES	0	O	0	O	0	95. 00
	10100 HOME HEALTH AGENCY			85	o	181, 046	1
	SPECIAL PURPOSE COST CENTERS	_	-1		-1	101/010	
113.00	11300 I NTEREST EXPENSE						113. 00
	11600 HOSPI CE	0	ol	0	o	299, 612	
118.00		114, 637	59, 191	13, 202	71, 297	7, 082, 468	
	NONREI MBURSABLE COST CENTERS			•	· · ·		
190.00	19000 GIFT FLOWER COFFEE SHOP & CANTEEN	0	0	0	O	6, 489	190. 00
	07950 I ROQUOIS WOMENS HEALTH	0	0	0	o		194. 00
	07951 OTHER NONREIMBURSABLE DEPTS	289	o	22	o		194. 01
194. 02	07952 REFERENCE LAB	0	О	0	ol	580	194. 02
200.00						0	200. 00
201.00	Negative Cost Centers	0	o	0	o	0	201. 00
202.00	TOTAL (sum lines 118 through 201)	114, 926	59, 191	13, 224	71, 297	7, 116, 533	202. 00

			2/26/2024 1: 42	pm
Cost Center Description	Intern &	Total		
	Residents Cost			
	& Post			
	Stepdown			
	Adjustments			
	25. 00	26. 00		
GENERAL SERVICE COST CENTERS	<u> </u>			
1.00 O0100 CAP REL COSTS-BLDG & FLXT				1.00
2.00 00200 CAP REL COSTS-MVBLE EQUIP		1		2.00
4.00 00400 EMPLOYEE BENEFITS DEPARTMENT		1		4.00
5. 01 00570 ADMI TTI NG				5. 01
5.02 00560 PURCHASING RECEIVING AND STORES				5. 02
5. 03 00550 DATA PROCESSING				5.03
5. 04 01160 COMMUNI CATI ONS				5.04
5. 05 00590 BUSI NESS OFFI CE				5.05
5.06 00591 OTHER ADMINISTRATIVE & GENERAL				5.06
7.00 00700 OPERATION OF PLANT				7.00
8.00 00800 LAUNDRY & LINEN SERVICE				8.00
9. 00 00900 HOUSEKEEPI NG				9.00
10. 00 01000 DI ETARY				10.00
11. 00 01100 CAFETERI A				11.00
13.00 01300 NURSING ADMINISTRATION				13.00
14.00 01400 CENTRAL SERVICES & SUPPLY				14.00
16.00 01600 MEDICAL RECORDS & LIBRARY				16.00
INPATIENT ROUTINE SERVICE COST CENTERS				
30. 00 03000 ADULTS & PEDI ATRI CS	0	747, 360		30. 00
44.00 04400 SKILLED NURSING FACILITY	o	731, 540		44. 00
ANCILLARY SERVICE COST CENTERS	-			
50. 00 05000 OPERATING ROOM	0	456, 668		50.00
53. 00 05300 ANESTHESI OLOGY	o	8, 360		53.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	O	519, 927		54.00
57. 00 05700 CT SCAN	o	0		57.00
58. 00 05800 MRI	o	o		58. 00
60. 00 06000 LABORATORY	o	459, 812		60.00
65. 00 06500 RESPIRATORY THERAPY	o	191, 458		65. 00
66. 00 06600 PHYSI CAL THERAPY	o	525, 170		66. 00
69. 00 06900 ELECTROCARDI OLOGY	o	9, 919		69.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	O	4, 771		71. 00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	O	16, 940		72. 00
73.00 07300 DRUGS CHARGED TO PATIENTS	O	616, 742		73.00
OUTPATIENT SERVICE COST CENTERS	-1			
88. 00 08800 RURAL HEALTH CLINIC	0	119, 554		88. 00
88. 01 08801 RURAL HEALTH CLINIC II	0	149, 232		88. 01
88.02 08802 RURAL HEALTH CLINIC III	0	334, 044		88. 02
88.03 08803 RURAL HEALTH CLINIC IV	0	597, 618		88. 03
90. 00 09000 CLI NI C	0	104, 664		90.00
90. 01 09001 ST ANNE CLINIC	0	41, 047		90. 01
91. 00 09100 EMERGENCY	0	966, 984		91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART	0			92.00
OTHER REIMBURSABLE COST CENTERS	<u> </u>	'		
95. 00 09500 AMBULANCE SERVICES	0	0		95.00
101.00 10100 HOME HEALTH AGENCY	О	181, 046	1	01.00
SPECIAL PURPOSE COST CENTERS	'			
113. 00 11300 INTEREST EXPENSE			1	13. 00
116. 00 11600 HOSPI CE	0	299, 612		16.00
118.00 SUBTOTALS (SUM OF LINES 1 through 117)	O	7, 082, 468		18.00
NONREI MBURSABLE COST CENTERS		, ,		
190. 00 19000 GIFT FLOWER COFFEE SHOP & CANTEEN	0	6, 489	1	90.00
194. 00 07950 I ROQUOI S WOMENS HEALTH	o	0		94. 00
194. 01 07951 OTHER NONREI MBURSABLE DEPTS	o	26, 996		94. 01
194. 02 07952 REFERENCE LAB	o	580		94. 02
200.00 Cross Foot Adjustments	o	0		200.00
201.00 Negative Cost Centers	o	o		201.00
202.00 TOTAL (sum lines 118 through 201)	o	7, 116, 533		202.00
1 - Car	٩		l -	

In Lieu of Form CMS-2552-10

Period: Worksheet B

From 07/17/2023 Part II

To 09/30/2023 Date/Time Prepared: 2/26/2024 1:42 pm

					0 77 307 2023	2/26/2024 1: 4	
			CAPI TAL REI	ATED COSTS		,	
	Cost Center Description	Directly	BLDG & FIXT	MVBLE EQUIP	Subtotal	EMPLOYEE	
		Assigned New Capital				BENEFITS DEPARTMENT	
		Related Costs				DEPARTMENT	
		0	1. 00	2.00	2A	4. 00	
	GENERAL SERVICE COST CENTERS	-					
1.00	00100 CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200 CAP REL COSTS-MVBLE EQUIP						2. 00
4.00	00400 EMPLOYEE BENEFITS DEPARTMENT	0	2, 713	354	3, 067	3, 067	4. 00
5. 01	00570 ADMITTI NG	0	1, 285	300	1, 585	54	5. 01
5. 02	00560 PURCHASING RECEIVING AND STORES	0	1, 466	201	1, 667	15	5. 02
5. 03	00550 DATA PROCESSING	0	3, 754	9, 668	13, 422	45	5. 03
5. 04	01160 COMMUNI CATI ONS	0	270	0	270	0	5. 04
5. 05	00590 BUSINESS OFFICE	0	13, 746	88	13, 834	53	5. 05
5. 06 7. 00	00591 OTHER ADMINISTRATIVE & GENERAL 00700 OPERATION OF PLANT	0	11, 129 22, 546	1, 331 18, 428	12, 460 40, 974	182 74	5. 06 7. 00
8. 00	00800 LAUNDRY & LINEN SERVICE	0	3, 485	10, 428	3, 504	14	8.00
9. 00	00900 HOUSEKEEPI NG	0	1, 016	21	1, 037	67	9. 00
10. 00	01000 DI ETARY	0	5, 078		5, 433	23	10.00
11. 00	01100 CAFETERI A	0	1, 580	0	1, 580	37	11.00
13. 00	01300 NURSI NG ADMI NI STRATI ON	0	1, 615	0	1, 615	32	13.00
14.00	01400 CENTRAL SERVICES & SUPPLY	0	2, 286	1, 047	3, 333	0	14. 00
16.00	01600 MEDICAL RECORDS & LIBRARY	0	2, 043	13	2, 056	33	16. 00
	INPATIENT ROUTINE SERVICE COST CENTERS						
30. 00	03000 ADULTS & PEDI ATRI CS	0		8, 753	22, 857	155	
44.00	04400 SKILLED NURSING FACILITY	0	14, 873	4, 263	19, 136	295	44. 00
FO 00	ANCI LLARY SERVI CE COST CENTERS		24.74/	27 107	(1.042	104	FO 00
50.00	05000 OPERATI NG ROOM	0	24, 746	37, 197	61, 943	104	
53. 00 54. 00	05300 ANESTHESI OLOGY 05400 RADI OLOGY-DI AGNOSTI C	0	167 8, 346	125 34, 279	292 42, 625	0 140	53. 00 54. 00
57. 00	05700 CT SCAN	0	0, 340	34, 279	42, 625	0	57.00
58. 00	05800 MRI	0	0	0	0	0	
60. 00	06000 LABORATORY	0	5, 349	3, 823	9, 172	159	
65. 00	06500 RESPI RATORY THERAPY	0	3, 117	2, 775	5, 892	90	
66. 00	06600 PHYSI CAL THERAPY	0	18, 780	5, 312	24, 092	149	66. 00
69. 00	06900 ELECTROCARDI OLOGY	0	1, 106	1, 138	2, 244	0	69. 00
71. 00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	0	71. 00
72. 00	07200 I MPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72. 00
73. 00	07300 DRUGS CHARGED TO PATIENTS	0	5, 349	887	6, 236	105	73. 00
00.00	OUTPATIENT SERVICE COST CENTERS		0.000	0./	0.000	70	00.00
88. 00 88. 01	08800 RURAL HEALTH CLINIC 08801 RURAL HEALTH CLINIC II	0	2, 002	96	2, 098	70	
88. 02	08802 RURAL HEALTH CLINIC III	0	4, 264 6, 470	3, 332 1, 738	7, 596 8, 208	75 194	
88. 03	08803 RURAL HEALTH CLINIC IV	0	3, 665		6, 449	371	88. 03
90. 00	09000 CLINIC	0	9, 883	655	10, 538	32	90.00
90. 01	09001 ST ANNE CLINIC	0	2, 282	169	2, 451	43	
91.00	09100 EMERGENCY	0	7, 020	5, 460	12, 480	253	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART				0		92.00
	OTHER REIMBURSABLE COST CENTERS						
	09500 AMBULANCE SERVICES	0			0		95. 00
101.00	10100 HOME HEALTH AGENCY	0	3, 570	3, 166	6, 736	101	101. 00
112 00	SPECIAL PURPOSE COST CENTERS						112 00
	11300 I NTEREST EXPENSE 11600 HOSPI CE	0	0	3, 224	3, 224	0.2	113. 00 116. 00
118.00		0	209, 105		3, 224 360, 106		118.00
110.00	NONREI MBURSABLE COST CENTERS	U	207, 103	131,001	300, 100	3,030	110.00
190 00	19000 GIFT FLOWER COFFEE SHOP & CANTEEN	0	1, 394	0	1, 394	0	190. 00
	07950 I ROQUOI S WOMENS HEALTH	0		0	0		194. 00
	07951 OTHER NONREIMBURSABLE DEPTS	0	0	918	918		194. 01
	07952 REFERENCE LAB	0	0	509	509	0	194. 02
200.00	, ,				0		200. 00
201.00			0	0	0		201. 00
202.00	TOTAL (sum lines 118 through 201)	0	210, 499	152, 428	362, 927	3, 067	202. 00

I ROQUOI S MEMORI AL HOSPI TAL
Provi der CCN: 14-1353 Health Financial Systems
ALLOCATION OF CAPITAL RELATED COSTS

1	In Li	eı	u of Form CMS-2552-10
	Period: From 07/17/202 To 09/30/202	3	Worksheet B Part II Date/Time Prepared: 2/26/2024 1:42 pm

				'	0 77 307 2023	2/26/2024 1: 4	
	Cost Center Description	ADMITTING	PURCHASI NG	DATA	COMMUNI CATI ONS	BUSI NESS	•
			RECEIVING AND	PROCESSI NG		OFFI CE	
			STORES				
		5. 01	5. 02	5. 03	5. 04	5. 05	
	GENERAL SERVICE COST CENTERS						
1.00	00100 CAP REL COSTS-BLDG & FIXT						1. 00
2.00	00200 CAP REL COSTS-MVBLE EQUIP						2. 00
4.00	00400 EMPLOYEE BENEFITS DEPARTMENT						4. 00
5. 01	00570 ADMI TTI NG	1, 639					5. 01
5. 02	00560 PURCHASING RECEIVING AND STORES	0	1, 682				5. 02
5.03	00550 DATA PROCESSING	0	0	13, 467			5. 03
5. 04	01160 COMMUNI CATI ONS	0	0	(5. 04
5. 05	00590 BUSINESS OFFICE	0	1	417		14, 308	5. 05
5. 06	00591 OTHER ADMINISTRATIVE & GENERAL	0	0	458		0	5. 06
7. 00	00700 OPERATION OF PLANT	0	111	406		0	7. 00
8. 00	00800 LAUNDRY & LINEN SERVICE	0	12			0	8. 00
9.00	00900 HOUSEKEEPI NG	0	5			0	9.00
10.00	01000 DI ETARY	0	0	396		0	10.00
11.00	01100 CAFETERI A	0	0			0	11.00
13.00	01300 NURSING ADMINISTRATION	0	0	246	_	0	13.00
14.00	01400 CENTRAL SERVICES & SUPPLY	0	8	(-	0	14.00
16. 00	01600 MEDI CAL RECORDS & LI BRARY	0	0	430	ال 3	0	16. 00
20.00	I NPATI ENT ROUTI NE SERVI CE COST CENTERS	01	40	1 22/	10	771	1 20 00
30.00	03000 ADULTS & PEDIATRICS	91	42			771	30.00
44. 00	04400 SKILLED NURSING FACILITY	78	233	1, 490	ا ا	658	44. 00
50. 00	ANCILLARY SERVICE COST CENTERS 05000 OPERATING ROOM	230	2.4	609) 2E	1, 950	E0 00
53. 00	05300 ANESTHESI OLOGY	3	34 1	609		1, 950	50. 00 53. 00
54. 00	05400 RADI OLOGY-DI AGNOSTI C	400	34	788		3, 365	•
57. 00	05700 CT SCAN	0	0			3, 303	57.00
58. 00	05800 MRI	0	0		-	0	58. 00
60.00	06000 LABORATORY	293	10		-	2, 487	60.00
65. 00	06500 RESPI RATORY THERAPY	12	37	423		103	65. 00
66. 00	06600 PHYSI CAL THERAPY	92	852	466		783	1
69. 00	06900 ELECTROCARDI OLOGY	11	0	1		91	69. 00
	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	32	Ö			271	71. 00
72. 00	07200 IMPL. DEV. CHARGED TO PATIENTS	4	85		-	38	72. 00
73. 00	07300 DRUGS CHARGED TO PATIENTS	130	2	324	-	1, 103	1
	OUTPATIENT SERVICE COST CENTERS		_		-1	.,	
88. 00	08800 RURAL HEALTH CLINIC	0	9	255	5 5	121	88. 00
88. 01	08801 RURAL HEALTH CLINIC II	0	20	214	10	127	88. 01
88. 02	08802 RURAL HEALTH CLINIC III	0	5		21	164	88. 02
88. 03	08803 RURAL HEALTH CLINIC IV	28	18	423	19	241	88. 03
90.00	09000 CLI NI C	27	7	316	5 11	226	90.00
90. 01	09001 ST ANNE CLINIC	0	19	(9	17	90. 01
91.00	09100 EMERGENCY	208	124	812	15	1, 765	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART						92. 00
	OTHER REIMBURSABLE COST CENTERS						
95.00	09500 AMBULANCE SERVICES	0	0	(0	0	95. 00
101.00	10100 HOME HEALTH AGENCY	0	10	355	5	0	101. 00
	SPECIAL PURPOSE COST CENTERS						
113.00	11300 INTEREST EXPENSE						113. 00
	11600 HOSPI CE	0	0				116. 00
118.00	, ,	1, 639	1, 679	13, 100	267	14, 308	118. 00
	NONREI MBURSABLE COST CENTERS						
	19000 GIFT FLOWER COFFEE SHOP & CANTEEN	0	0				190. 00
	07950 ROQUOIS WOMENS HEALTH	0	0				194. 00
	07951 OTHER NONREI MBURSABLE DEPTS	0	3	363			194. 01
	07952 REFERENCE LAB	0	0	4	1 0	0	194. 02
200.00							200. 00
201.00	1 3	0	0		0		201. 00
202.00	TOTAL (sum lines 118 through 201)	1, 639	1, 682	13, 467	7 270	14, 308	202. 00

I ROQUOI S MEMORI AL HOSPI TAL
Provi der CCN: 14-1353 Health Financial Systems
ALLOCATION OF CAPITAL RELATED COSTS

In Lieu of Form CMS-2552-10

Period: Worksheet B

From 07/17/2023 Part II

To 09/30/2023 Date/Time Prepared: 2/26/2024 1:42 pm

				''	0 77 307 2023	2/26/2024 1: 4	
	Cost Center Description	OTHER	OPERATION OF	LAUNDRY &	HOUSEKEEPI NG	DI ETARY	
	· · · · · · · · · · · · · · · · · · ·	ADMI NI STRATI VE	PLANT	LINEN SERVICE			
		& GENERAL					
		5. 06	7. 00	8. 00	9. 00	10.00	
	GENERAL SERVICE COST CENTERS						
1.00	00100 CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200 CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400 EMPLOYEE BENEFITS DEPARTMENT						4.00
5. 01	00570 ADMI TTI NG						5. 01
5. 02	00560 PURCHASING RECEIVING AND STORES						5. 02
5. 03	00550 DATA PROCESSING						5. 03
5.04	01160 COMMUNI CATI ONS						5. 04
5.05	00590 BUSINESS OFFICE						5. 05
5.06	00591 OTHER ADMINISTRATIVE & GENERAL	13, 124					5. 06
7.00	00700 OPERATION OF PLANT	785	42, 357				7. 00
8.00	00800 LAUNDRY & LINEN SERVICE	48	961	4, 599			8. 00
9.00	00900 HOUSEKEEPI NG	202	280	0	2, 231		9. 00
10.00	01000 DI ETARY	167	1, 400	0	85	7, 504	10.00
11.00	01100 CAFETERI A	201	436	0	26	0	11. 00
13.00	01300 NURSING ADMINISTRATION	96	445	0	27	0	13. 00
14.00	01400 CENTRAL SERVICES & SUPPLY	9	630	0	38	0	14. 00
16.00	01600 MEDICAL RECORDS & LIBRARY	111	563	0	34	0	16. 00
	INPATIENT ROUTINE SERVICE COST CENTERS						1
30.00	03000 ADULTS & PEDIATRICS	1, 188	3, 890	858	235	984	30.00
44.00	04400 SKILLED NURSING FACILITY	995	4, 102	1, 672	247	6, 488	44. 00
	ANCILLARY SERVICE COST CENTERS						
50.00	05000 OPERATI NG ROOM	627	6, 826	394	413	4	50.00
53.00	05300 ANESTHESI OLOGY	14	46	0	3	0	53. 00
54.00	05400 RADI OLOGY-DI AGNOSTI C	845	2, 302	335	139	0	54.00
57.00	05700 CT SCAN	0	0		0	0	57. 00
58. 00	05800 MRI	0	0	0	0	0	58. 00
60.00	06000 LABORATORY	765	1, 475	7	89	0	60.00
65. 00	06500 RESPI RATORY THERAPY	295	860	0	52	0	65. 00
66. 00	06600 PHYSI CAL THERAPY	801	5, 179	177	312	0	66. 00
69. 00	06900 ELECTROCARDI OLOGY	10	305		18	0	69. 00
71. 00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	6	0	0	0	0	71. 00
72. 00	07200 I MPL. DEV. CHARGED TO PATIENTS	30	0	_	0	0	72. 00
73. 00	07300 DRUGS CHARGED TO PATIENTS	1, 080	1, 475	0	89	0	73. 00
	OUTPATIENT SERVICE COST CENTERS						
88. 00	08800 RURAL HEALTH CLINIC	209	552		0	0	
88. 01	08801 RURAL HEALTH CLINIC II	252	1, 176		0	0	
88. 02	08802 RURAL HEALTH CLINIC III	581	1, 784	0	0	0	88. 02
88. 03	08803 RURAL HEALTH CLINIC IV	1, 075	1, 011	0	61	0	
90.00	09000 CLI NI C	116	2, 725		164	9	90.00
90. 01	09001 ST ANNE CLINIC	64	629		0	0	
91. 00	09100 EMERGENCY	1, 636	1, 936	1, 123	117	19	
92. 00	09200 OBSERVATION BEDS (NON-DISTINCT PART						92. 00
	OTHER REIMBURSABLE COST CENTERS						
95. 00	09500 AMBULANCE SERVICES	0	0		0	0	
101.00	10100 HOME HEALTH AGENCY	310	984	0	59	0	101. 00
	SPECIAL PURPOSE COST CENTERS						
	11300 I NTEREST EXPENSE						113. 00
	11600 H0SPI CE	553	0	0	0		116. 00
118.00		13, 071	41, 972	4, 599	2, 208	7, 504	118. 00
	NONREI MBURSABLE COST CENTERS						
	19000 GIFT FLOWER COFFEE SHOP & CANTEEN	3	385		23		190. 00
	0 07950 IROQUOIS WOMENS HEALTH	0	0	0	0		194. 00
	07951 OTHER NONREI MBURSABLE DEPTS	49	0		0		194. 01
	07952 REFERENCE LAB	1	0	0	0	0	194. 02
200.00							200. 00
201.00		0	0	0	0		201. 00
202.00	TOTAL (sum lines 118 through 201)	13, 124	42, 357	4, 599	2, 231	7, 504	202. 00

Heal th Financial Systems

ALLOCATION OF CAPITAL RELATED COSTS

I ROQUOIS MEMORIAL HOSPITAL

Provider CCN: 14-1353

						2/26/2024 1:4	2 pm
	Cost Center Description	CAFETERI A	NURSI NG ADMI NI STRATI ON	CENTRAL SERVICES & SUPPLY	MEDI CAL RECORDS & LI BRARY	Subtotal	
		11. 00	13.00	14.00	16. 00	24.00	
	GENERAL SERVICE COST CENTERS						
1.00	00100 CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200 CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400 EMPLOYEE BENEFITS DEPARTMENT						4. 00
5. 01	00570 ADMI TTI NG						5. 01
5.02	00560 PURCHASING RECEIVING AND STORES						5. 02
5.03	00550 DATA PROCESSING						5. 03
5.04	01160 COMMUNI CATI ONS						5. 04
5.05	00590 BUSINESS OFFICE						5. 05
5.06	00591 OTHER ADMINISTRATIVE & GENERAL						5. 06
7.00	00700 OPERATION OF PLANT						7. 00
8.00	00800 LAUNDRY & LINEN SERVICE						8. 00
9.00	00900 HOUSEKEEPI NG						9. 00
10. 00	01000 DI ETARY						10.00
11. 00	01100 CAFETERI A	2, 607					11. 00
13. 00	01300 NURSING ADMINISTRATION	35					13. 00
14. 00	01400 CENTRAL SERVICES & SUPPLY	0		4, 018			14. 00
16. 00	01600 MEDICAL RECORDS & LIBRARY	87	0	1	3, 318		16. 00
	INPATIENT ROUTINE SERVICE COST CENTERS						
30. 00	03000 ADULTS & PEDI ATRI CS	251	681	111	179	33, 663	1
44. 00	04400 SKILLED NURSING FACILITY	594	0	606	153	36, 756	44. 00
	ANCILLARY SERVICE COST CENTERS		1		T		
50.00	05000 OPERATING ROOM	133		89	452	74, 194	1
53. 00	05300 ANESTHESI OLOGY	0		3	6	395	1
54.00	05400 RADI OLOGY-DI AGNOSTI C	265		90	780	52, 121	1
57. 00	05700 CT SCAN	0		0	0	0	
58. 00	05800 MRI	0		0	0	0	
60.00	06000 LABORATORY	305		26	577	16, 100	1
65. 00	06500 RESPIRATORY THERAPY	179		97	24	8, 554	1
66.00	06600 PHYSI CAL THERAPY	244		2, 208	182	35, 549	1
69. 00	06900 ELECTROCARDI OLOGY	0	0	0	21	2, 757	1
71. 00 72. 00	07100 MEDI CAL SUPPLI ES CHARGED TO PATI ENT		0	222	63	372	1
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	149		222	256	388 10, 959	1
73.00	07300 DRUGS CHARGED TO PATIENTS OUTPATIENT SERVICE COST CENTERS	147	U	<u> </u>	250	10, 757	73.00
88. 00	08800 RURAL HEALTH CLINIC	0	0	25	28	3, 372	88. 00
88. 01	08801 RURAL HEALTH CLINIC II	0	o o	51	29	9, 550	1
88. 02	08802 RURAL HEALTH CLINIC III	0	0	13	38	11, 387	1
88. 03	08803 RURAL HEALTH CLINIC IV	0	0	48	56	9, 800	1
90. 00	09000 CLI NI C	39	107	17	52	14, 419	1
90. 01	09001 ST ANNE CLINIC	0	0	49	4	3, 285	1
91. 00	09100 EMERGENCY	319	864	324	409	22, 404	1
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART					,	92.00
	OTHER REIMBURSABLE COST CENTERS						
95.00	09500 AMBULANCE SERVI CES	0	0	0	0	0	95. 00
	10100 HOME HEALTH AGENCY	0	0		o	8, 586	101.00
	SPECIAL PURPOSE COST CENTERS	<u>'</u>					1
113.00	11300 I NTEREST EXPENSE						113. 00
	11600 HOSPI CE	0	0	0	o		116. 00
118.00	SUBTOTALS (SUM OF LINES 1 through 117)	2, 600	2, 498	4, 011	3, 318	359, 249	118. 00
	NONREI MBURSABLE COST CENTERS						1
190.00	19000 GIFT FLOWER COFFEE SHOP & CANTEEN	0	0	0	0	1, 805	190. 00
194.00	07950 ROQUOIS WOMENS HEALTH	0	0	0	0	0	194. 00
	07951 OTHER NONREIMBURSABLE DEPTS	7	0	7	0		194. 01
	07952 REFERENCE LAB	0	0	0	0		194. 02
200.00							200. 00
201.00		0	0	0	0		201. 00
202.00	TOTAL (sum lines 118 through 201)	2, 607	2, 498	4, 018	3, 318	362, 927	202. 00

In Lieu of Form CMS-2552-10

Period:
From 07/17/2023 | Part II
To 09/30/2023 | Date/Time Prepared:
2/26/2024 1:42 pm

			2/26/2024 1: 42	pm
Cost Center Description	Intern &	Total		
	Residents Cost			
	& Post			
	Stepdown			
	Adjustments			
	25. 00	26.00		
GENERAL SERVICE COST CENTERS				
1.00 O0100 CAP REL COSTS-BLDG & FLXT				1.00
2.00 00200 CAP REL COSTS-MVBLE EQUIP				2.00
4.00 00400 EMPLOYEE BENEFITS DEPARTMENT				4.00
5. 01 00570 ADMI TTI NG				5. 01
5.02 00560 PURCHASING RECEIVING AND STORES				5. 02
5. 03 00550 DATA PROCESSING				5. 03
5. 04 01160 COMMUNI CATI ONS				5.04
5. 05 00590 BUSI NESS OFFI CE				5. 05
5.06 00591 OTHER ADMINISTRATIVE & GENERAL				5.06
7.00 00700 OPERATION OF PLANT				7.00
8.00 00800 LAUNDRY & LINEN SERVICE				8.00
9. 00 00900 HOUSEKEEPI NG				9.00
10. 00 01000 DI ETARY				10.00
11. 00 01100 CAFETERI A				11.00
13.00 01300 NURSING ADMINISTRATION				13.00
14.00 01400 CENTRAL SERVICES & SUPPLY				14.00
16.00 01600 MEDICAL RECORDS & LIBRARY				16.00
INPATIENT ROUTINE SERVICE COST CENTERS				
30. 00 03000 ADULTS & PEDIATRICS	0	33, 663		30.00
44.00 04400 SKILLED NURSING FACILITY	o	36, 756		44. 00
ANCILLARY SERVICE COST CENTERS	-1	227.22		
50. 00 05000 OPERATING ROOM	0	74, 194		50.00
53. 00 05300 ANESTHESI OLOGY	o	395		53.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	o	52, 121		54.00
57. 00 05700 CT SCAN	o	0		57.00
58. 00 05800 MRI	o	o		58. 00
60. 00 06000 LABORATORY	o	16, 100		60.00
65. 00 06500 RESPIRATORY THERAPY	o	8, 554		65.00
66. 00 06600 PHYSI CAL THERAPY	o	35, 549		66.00
69. 00 06900 ELECTROCARDI OLOGY	o	2, 757		69. 00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	o	372		71. 00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	o	388		72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	o	10, 959		73.00
OUTPATIENT SERVICE COST CENTERS	<u>'</u>			
88. 00 08800 RURAL HEALTH CLINIC	0	3, 372		88. 00
88.01 08801 RURAL HEALTH CLINIC II	0	9, 550		88. 01
88.02 08802 RURAL HEALTH CLINIC III	o	11, 387		88. 02
88.03 08803 RURAL HEALTH CLINIC IV	o	9, 800		88. 03
90. 00 09000 CLI NI C	o	14, 419		90.00
90. 01 09001 ST ANNE CLINIC	o	3, 285		90. 01
91. 00 09100 EMERGENCY	o	22, 404		91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART	o			92.00
OTHER REIMBURSABLE COST CENTERS	<u>'</u>			
95. 00 09500 AMBULANCE SERVICES	0	0		95.00
101.00 10100 HOME HEALTH AGENCY	o	8, 586	1	101. 00
SPECIAL PURPOSE COST CENTERS				
113. 00 11300 NTEREST EXPENSE				113. 00
116. 00 11600 HOSPI CE	o	4, 638		116. 00
118.00 SUBTOTALS (SUM OF LINES 1 through 117)	o	359, 249		118. 00
NONREI MBURSABLE COST CENTERS	<u>'</u>			
190. 00 19000 GIFT FLOWER COFFEE SHOP & CANTEEN	0	1, 805	1	190. 00
194.00 07950 I ROQUOI S WOMENS HEALTH	o	0		194. 00
194.01 07951 OTHER NONREIMBURSABLE DEPTS	o	1, 359		194. 01
194. 02 07952 REFERENCE LAB	o	514		194. 02
200.00 Cross Foot Adjustments	o	0		200.00
201.00 Negative Cost Centers	o	o	2	201. 00
202.00 TOTAL (sum lines 118 through 201)	o	362, 927		202. 00
	1		ı	

In Lieu of Form CMS-2552-10
Worksheet B-1

Peri od: Worksheet B-1 From 07/17/2023 To 09/30/2023 Date/Time Prepared:

					09/30/2023	2/26/2024 1: 4	
		CAPI TAL REI	LATED COSTS				
	Cost Center Description	BLDG & FIXT (SQUARE FEET)	MVBLE EQUIP (DOLLAR VALUE)	EMPLOYEE BENEFITS DEPARTMENT (GROSS	ADMITTING (GROSS CHAR GES)	PURCHASI NG RECEI VI NG AND STORES (COSTED	
		1.00	2.00	SALARI ES) 4. 00	5. 01	REQUI S.) 5. 02	
	GENERAL SERVICE COST CENTERS	1.00	2.00	4.00	5. 01	5.02	
1.00	00100 CAP REL COSTS-BLDG & FIXT	138, 573					1.00
2.00	00200 CAP REL COSTS-MVBLE EQUIP		1, 356, 007				2. 00
4.00	00400 EMPLOYEE BENEFITS DEPARTMENT	1, 786	3, 146	3, 221, 124			4. 00
5.01	00570 ADMITTING	846	2, 667	56, 886	13, 523, 496		5. 01
5.02	00560 PURCHASING RECEIVING AND STORES	965			0	270, 019	5. 02
5. 03	00550 DATA PROCESSI NG	2, 471			0	6	5. 03
5. 04	01160 COMMUNI CATI ONS	178	l .	-	0	0	5. 04
5. 05 5. 06	00590 BUSINESS OFFICE 00591 OTHER ADMINISTRATIVE & GENERAL	9, 049 7, 326			0	198 0	5. 05 5. 06
7. 00	00700 OPERATION OF PLANT	14, 842			0	17, 778	7. 00
8. 00	00800 LAUNDRY & LINEN SERVICE	2, 294			0	1, 994	8.00
9.00	00900 HOUSEKEEPI NG	669	l .		0	793	9. 00
10.00	01000 DI ETARY	3, 343	3, 162	24, 049	0	0	10.00
11. 00	01100 CAFETERI A	1, 040	l .		0	0	11. 00
13.00	01300 NURSI NG ADMI NI STRATI ON	1, 063	l .	33, 510	0	12	13.00
14.00	01400 CENTRAL SERVI CES & SUPPLY	1, 505			0	1, 326	
16. 00	01600 MEDICAL RECORDS & LIBRARY INPATIENT ROUTINE SERVICE COST CENTERS	1, 345	112	34, 574	0	66	16. 00
30. 00	03000 ADULTS & PEDIATRICS	9, 285	77, 871	163, 125	751, 314	6, 820	30.00
44. 00	04400 SKILLED NURSING FACILITY	9, 791	37, 928		640, 881	37, 378	44. 00
	ANCILLARY SERVICE COST CENTERS						
50.00	05000 OPERATI NG ROOM	16, 292	330, 898	109, 765	1, 900, 363	5, 477	50. 00
53. 00	05300 ANESTHESI OLOGY	110			26, 126	181	1
54. 00	05400 RADI OLOGY-DI AGNOSTI C	5, 494			3, 278, 586		
57. 00 58. 00	05700 CT SCAN 05800 MRI	0		0	0	0	57. 00 58. 00
60.00	06000 LABORATORY	3, 521	34, 012	166, 893	2, 423, 593	1, 611	1
65. 00	06500 RESPIRATORY THERAPY	2, 052			100, 039	5, 972	
66. 00	06600 PHYSI CAL THERAPY	12, 363			762, 832	136, 422	
69. 00	06900 ELECTROCARDI OLOGY	728			88, 978		69. 00
71. 00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	264, 059	0	71. 00
72. 00	07200 IMPL. DEV. CHARGED TO PATIENTS	0	0	0	36, 624	13, 686	
73. 00	07300 DRUGS CHARGED TO PATIENTS OUTPATIENT SERVICE COST CENTERS	3, 521	7, 893	110, 171	1, 075, 127	313	73. 00
88. 00	08800 RURAL HEALTH CLINIC	1, 318	854	73, 884	0	1, 513	88. 00
88. 01	08801 RURAL HEALTH CLINIC II	2, 807			0	3, 155	
88. 02	08802 RURAL HEALTH CLINIC III	4, 259	15, 457	203, 622	0	785	88. 02
88. 03	08803 RURAL HEALTH CLINIC IV	2, 413			234, 680		
90.00	09000 CLI NI C	6, 506			220, 358		
90. 01	09001 ST ANNE CLINIC	1, 502			0	3, 009	90. 01
91. 00 92. 00	09100 EMERGENCY 09200 OBSERVATION BEDS (NON-DISTINCT PART	4, 621	48, 577	265, 617	1, 719, 936	19, 974	91. 00 92. 00
72.00	OTHER REIMBURSABLE COST CENTERS						72.00
95. 00	09500 AMBULANCE SERVICES	0	0	0	0	0	95. 00
101.00	10100 HOME HEALTH AGENCY	2, 350	28, 165	105, 961	0	1, 591	101. 00
	SPECIAL PURPOSE COST CENTERS		1				
	11300 I NTEREST EXPENSE 11600 HOSPI CE		20 (02	00 170	0		113.00
118.00		137, 655			13, 523, 496		116.00
110.00	NONREI MBURSABLE COST CENTERS	137,033	1, 343, 310	3, 211, 020	13, 323, 470	207, 004	1110.00
190.00	19000 GIFT FLOWER COFFEE SHOP & CANTEEN	918	0	0	0	0	190. 00
	07950 IROQUOIS WOMENS HEALTH	0	0	0	0		194. 00
	07951 OTHER NONREIMBURSABLE DEPTS	0			0		194. 01
	07952 REFERENCE LAB	0	4, 532	0	0	0	194. 02
200.00							200.00
201. 00 202. 00		210, 499	152, 428	1, 106, 716	80, 108	21 714	201. 00 202. 00
202.00	Part I)	210, 477	102, 420	1, 100, 710	00, 100	21, 714	202.00
203.00		1. 519048	0. 112409	0. 343581	0. 005924	0. 080417	
204.00				3, 067	1, 639	1, 682	204. 00
205.01	Part II)	1		0.000050	0.000101	0.00(333	205 00
205.00	Unit cost multiplier (Wkst. B, Part			0. 000952	0. 000121	0. 006229	205.00
206.00	NAHE adjustment amount to be allocated	1					206. 00
207.00	(per Wkst. B-2) NAHE unit cost multiplier (Wkst. D,	1					207. 00
207. U	Parts III and IV)						207.00
		•	•	. '	!		•

In Lieu of Form CMS-2552-10
Worksheet B-1

Peri od: Worksheet B-1 From 07/17/2023 To 09/30/2023 Date/Time Prepared:

					Т	0 09/30/2023	Date/Time Pre 2/26/2024 1:4	
		Cost Center Description	DATA	COMMUNI CATI ONS		Reconciliation	OTHER	Z piii
			PROCESSI NG	(# OF DUONE C)	OFFI CE		ADMI NI STRATI VE	
			(TIME SPENT)	(# OF PHONE S)	(GROSS CHAR GES)		& GENERAL (ACCUM. COST)	
			5. 03	5. 04	5. 05	5A. 06	5. 06	
		AL SERVICE COST CENTERS			l			
1. 00 2. 00		CAP REL COSTS-BLDG & FIXT CAP REL COSTS-MVBLE EQUIP						1. 00 2. 00
4.00		EMPLOYEE BENEFITS DEPARTMENT						4. 00
5. 01		ADMI TTI NG						5. 01
5. 02	1	PURCHASING RECEIVING AND STORES						5. 02
5. 03 5. 04	1	DATA PROCESSING COMMUNICATIONS	586, 698	315				5. 03 5. 04
5. 05		BUSINESS OFFICE	18, 147	313				5. 04
5.06	00591	OTHER ADMINISTRATIVE & GENERAL	19, 939	1		-291, 387	6, 825, 146	5. 06
7.00		OPERATION OF PLANT	17, 669	8	0	0	408, 339	7. 00
8. 00 9. 00		LAUNDRY & LINEN SERVICE HOUSEKEEPING	2, 590 27, 858		0	0	25, 219 105, 126	8. 00 9. 00
10. 00		DI ETARY	17, 243			0	86, 694	
11. 00	1	CAFETERI A	14, 267	0	0	0	104, 750	
13. 00		NURSI NG ADMI NI STRATI ON	10, 706		0	0	49, 698	
14. 00 16. 00	1	CENTRAL SERVICES & SUPPLY MEDICAL RECORDS & LIBRARY	0 18, 745		0		4, 766 57, 605	14. 00 16. 00
10.00		I ENT ROUTINE SERVICE COST CENTERS	10, 743	4		J O	37,003	10.00
30.00		ADULTS & PEDIATRICS	57, 959	47	751, 314	0	617, 681	30. 00
44. 00		SKILLED NURSING FACILITY	64, 903	11	640, 881	0	517, 221	44. 00
50. 00		LARY SERVICE COST CENTERS OPERATING ROOM	24 520	20	1, 900, 363	0	325, 820	50. 00
53. 00	1	ANESTHESI OLOGY	26, 520 0	29			7, 301	53. 00
54. 00		RADI OLOGY-DI AGNOSTI C	34, 308				439, 640	
57. 00		CT SCAN	0	0		_	0	57. 00
58.00	05800	l .	21 420	0		0	207 554	58. 00
60. 00 65. 00		LABORATORY RESPI RATORY THERAPY	31, 439 18, 445	15 6			397, 556 153, 424	•
66. 00		PHYSI CAL THERAPY	20, 322				416, 293	
69. 00		ELECTROCARDI OLOGY	2, 490				5, 247	69. 00
71. 00		MEDICAL SUPPLIES CHARGED TO PATIENT	0	0			3, 281	
72. 00 73. 00		IMPL. DEV. CHARGED TO PATIENTS DRUGS CHARGED TO PATIENTS	0 14, 112	0			15, 367 561, 399	72. 00 73. 00
73.00		TIENT SERVICE COST CENTERS	14, 112	0	1, 075, 127	0	301, 344	73.00
88. 00		RURAL HEALTH CLINIC	11, 110	6	118, 008	0	108, 680	88. 00
88. 01		RURAL HEALTH CLINIC II	9, 307	12			131, 017	88. 01
88. 02		RURAL HEALTH CLINIC III	16, 518				302, 343	
88. 03 90. 00		RURAL HEALTH CLINIC IV CLINIC	18, 427 13, 784	22 13			559, 154 60, 571	88. 03 90. 00
90. 00	1	ST ANNE CLINIC	13, 704	10			33, 064	90.00
91.00		EMERGENCY	35, 375	17			851, 815	91. 00
92. 00		OBSERVATION BEDS (NON-DISTINCT PART						92. 00
95. 00		REI MBURSABLE COST CENTERS AMBULANCE SERVI CES	0	0	0	0	0	95. 00
		HOME HEALTH AGENCY	15, 468					
	SPECI	AL PURPOSE COST CENTERS						
		I NTEREST EXPENSE HOSPI CE	22 040	10		0	207 244	113.00
118.00	1	SUBTOTALS (SUM OF LINES 1 through 117)	33, 048 570, 699			-291, 387	287, 344 6, 797, 604	
		IMBURSABLE COST CENTERS	0.0,0,,	<u> </u>	10/ / 11/ 000	271,7007	0,777,001	
		GIFT FLOWER COFFEE SHOP & CANTEEN	0					190. 00
	1	I ROQUOI S WOMENS HEALTH	15 020	0				194. 00
		OTHER NONREIMBURSABLE DEPTS REFERENCE LAB	15, 820 179		0	0	25, 592 556	194. 01
200.00		Cross Foot Adjustments	1,7,			J	000	200. 00
201.00	1	Negative Cost Centers						201. 00
202.00)	Cost to be allocated (per Wkst. B,	155, 012	30, 089	138, 123		291, 387	202. 00
203. 00		Part I) Unit cost multiplier (Wkst. B, Part I)	0. 264211	95. 520635	0. 009907		0. 042693	203 00
204.00	1	Cost to be allocated (per Wkst. B,	13, 467	270			13, 124	
		Part II)						
205.00		Unit cost multiplier (Wkst. B, Part	0. 022954	0. 857143	0. 001026		0. 001923	205. 00
206. 00		NAHE adjustment amount to be allocated						206. 00
		(per Wkst. B-2)						
207.00)	NAHE unit cost multiplier (Wkst. D,						207. 00
	1	Parts III and IV)	l	I I	I			I

Heal th Financial Systems IROQUOIS MEMORIAL HOSPITAL
COST ALLOCATION - STATISTICAL BASIS Provider CCN: 14-1353 Per

In Lieu of Form CMS-2552-10

					0 09/30/2023	2/26/2024 1:4	
	Cost Center Description	OPERATION OF	LAUNDRY &	HOUSEKEEPI NG	DI ETARY	CAFETERI A	
			LINEN SERVICE	(SQUARE FEET)	(MEALS SERVED)	(FTES)	
		(SQUARE FEET)	(POUNDS OF LAUNDRY)				
		7. 00	8. 00	9. 00	10.00	11. 00	
	GENERAL SERVICE COST CENTERS						
1.00	00100 CAP REL COSTS-BLDG & FIXT						1. 00
2.00	00200 CAP REL COSTS-MVBLE EQUIP						2.00
4. 00 5. 01	OO400 EMPLOYEE BENEFITS DEPARTMENT OO570 ADMITTING						4. 00 5. 01
5. 02	00560 PURCHASING RECEIVING AND STORES						5. 02
5. 03	00550 DATA PROCESSING						5. 03
5.04	01160 COMMUNI CATI ONS						5. 04
5. 05	00590 BUSI NESS OFFI CE						5. 05
5. 06 7. 00	OO591 OTHER ADMINISTRATIVE & GENERAL OO700 OPERATION OF PLANT	101, 110					5. 06 7. 00
8. 00	00800 LAUNDRY & LINEN SERVICE	2, 294	24, 715				8.00
9. 00	00900 HOUSEKEEPING	669	0	88, 261			9. 00
10.00	01000 DI ETARY	3, 343	0	3, 343			10. 00
11.00	01100 CAFETERI A	1, 040	0	1, 040	I I	11, 935	1
13. 00 14. 00	O1300 NURSI NG ADMI NI STRATI ON O1400 CENTRAL SERVI CES & SUPPLY	1, 063 1, 505	0	1, 063 1, 505	I I	160 0	1
16. 00	01600 MEDICAL RECORDS & LI BRARY	1, 345	0	1, 345	I I	400	1
.0.00	I NPATI ENT ROUTI NE SERVI CE COST CENTERS	1,010		1,010	1 9	100	10.00
30.00	03000 ADULTS & PEDI ATRI CS	9, 285	4, 610	·	912	1, 150	30. 00
44.00	04400 SKILLED NURSING FACILITY	9, 791	8, 990	9, 791	6, 010	2, 720	44. 00
FO 00	ANCI LLARY SERVI CE COST CENTERS	17, 202	2 115	1/ 202	ا	/10	F0 00
50. 00 53. 00	05000 OPERATI NG ROOM 05300 ANESTHESI OLOGY	16, 292 110	2, 115 0	16, 292 110	I .	610 0	1
54. 00	05400 RADI OLOGY-DI AGNOSTI C	5, 494	1, 800	5, 494		1, 215	1
57. 00	05700 CT SCAN	0	0	C	I I	0	1
58. 00	05800 MRI	0	0	C	0	0	
60.00	06000 LABORATORY	3, 521	40	3, 521		1, 395	
65. 00 66. 00	06500 RESPI RATORY THERAPY 06600 PHYSI CAL THERAPY	2, 052 12, 363	950	2, 052 12, 363	I I	820 1, 115	
69. 00	06900 ELECTROCARDI OLOGY	728	750	728	I I	1, 113	1
71. 00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0	0		I I	0	71. 00
72. 00	07200 IMPL. DEV. CHARGED TO PATIENTS	0	0	C	- 1	0	
73. 00	07300 DRUGS CHARGED TO PATIENTS	3, 521	0	3, 521	0	680	73. 00
88. 00	OUTPATIENT SERVICE COST CENTERS 08800 RURAL HEALTH CLINIC	1, 318	0		ol	0	88. 00
88. 01	08801 RURAL HEALTH CLINIC II	2, 807	0	1	I .	0	
88. 02	08802 RURAL HEALTH CLINIC III	4, 259	0	1	- 1	0	1
88. 03	08803 RURAL HEALTH CLINIC IV	2, 413	0	2, 413		0	88. 03
90.00	09000 CLINIC	6, 506	175	6, 506	I I	180	1
90. 01 91. 00	O9001 ST ANNE CLINIC O9100 EMERGENCY	1, 502 4, 621	6, 035	4, 621	0 18	0 1, 460	90. 01
92. 00	09200 OBSERVATION BEDS (NON-DISTINCT PART	4,021	0, 033	4, 02 1	10	1, 400	92.00
	OTHER REIMBURSABLE COST CENTERS			'	<u>'</u>		
	09500 AMBULANCE SERVICES	0	0			0	
101.00	10100 HOME HEALTH AGENCY	2, 350	0	2, 350	0	0	101. 00
113 00	SPECIAL PURPOSE COST CENTERS 11300 INTEREST EXPENSE						113. 00
	11600 HOSPI CE	o	0	C	ol	0	116. 00
118.00		100, 192	24, 715	87, 343	6, 952		118. 00
	NONREI MBURSABLE COST CENTERS						
190.00	19000 GIFT FLOWER COFFEE SHOP & CANTEEN 07950 IROQUOIS WOMENS HEALTH	918	0				190.00
	07950 TROQUOIS WOMENS HEALTH	0 0	0	·	1		194. 00 194. 01
	07952 REFERENCE LAB	0	0				194. 02
200.00				_			200.00
201.00	1 1 3						201. 00
202.00		425, 772	35, 956	112, 431	108, 730	114, 926	202. 00
203.00	Part I) Unit cost multiplier (Wkst. B, Part I)	4. 210978	1. 454825	1. 273847	15. 640104	9. 629326	203 00
204.00		42, 357	4, 599		I I		204. 00
	Part II)						
205.00		0. 418920	0. 186081	0. 025277	1. 079402	0. 218433	205. 00
206. 00							206. 00
200. UC	(per Wkst. B-2)						200.00
207.00	NAHE unit cost multiplier (Wkst. D,						207. 00
	Parts III and IV)			1			I

In Lieu of Form CMS-2552-10

Worksheet B-1

Peri od: Worksheet B-1 From 07/17/2023 To 09/30/2023 Date/Time Prepared:

Cost Center Pascription					Ic	09/30/2023 Date/lime Pre 2/26/2024 1:4	
CONTROL CONT		Cost Center Description	NURSI NG	CENTRAL	MEDI CAL	272072021 1. 1	Į piii
			ADMI NI STRATI ON				
### 1800 S PROUCE COST CENTERS 1.00			(DI DECT NDSI NC				
13.00 14.00 16.0							
0.000 COMP REL COSTS-BLID & PINT							
2.00							
4.00 00000 EMPTOVER BENEFITS DEPARTMENT 5.02 000000 AMITTING 5.03 000000 AMITTING 5.04 010000 COMMUNICATIONS 5.05 000000 DESCRIPTIONS 5.06 000000 DEPARTMENT OF STATE							1
5.01 COSPO							1
5.02 00560 PURCHAST NO RECEIVING AND STORES 5.03 00550 00760 COMMINICATIONS 5.04 5.05							1
5.03 00550 DATA PROCESSING 0 00570 DATA PROCESSING 0 0							
5.05 0.00991 QUSINESS OFFICE 0.000000 QUSINESS OFFICE 0.000000 QUSINESS OFFICE							
5.06	5.04						5. 04
2,00 000000							
8.00							1
9.00 00000 DISTERY							1
10.00 01000 DIELARY							
11.00 01100 CAPETERIA 11.00 13.00 01300 UNISH NO ADMINISTRATION 87.776 247,912 1.00 13.00 13.00 13.00 13.00 01300 UNISH NO ADMINISTRATION 97.776 0 66 13.941,383 16.00 10.00 01.00 UNISH NO ADMINISTRATION 14.00 14.00 16.00 16.00 16.00 01.00 UNISH NET SERVICE COST CENTERS 18.00 03.00 UNISH NO ADMINISTRATION 18.00 18.00 UNISH NET SERVICE COST CENTERS 23.920 6.820 751,314 30.00 30.00 UNISH NO ADMINISTRATION 37.378 640,881 44.00 37.378 640,881 44.00 37.378 640,881 45.00 37.378 640,881 45.00 37.378 640,881 45.00 37.378 640,881 45.00 37.378 640,881 45.00 37.378 640,881 45.00 37.378 640,881 45.00 37.378 640,881 45.00 37.378 56.00 37.3							1
14. 00 01400 (ENTRAL SERVICES & SUPPLY 0 247, 912 14. 00 15. 00 16.00 16.00 (DELOCA RECORDES & LIBRARY 0 0 6.6 13, 941, 383 16. 00 10. 00 0000 (DRILT & PERDICES & LIBRARY 0 37, 378 040, 381 30. 00 0. 0000 (DAUITS & PERDICES 17. 00 37, 378 040, 381 30. 00 0. 0000 (DAUITS & PERDICES 17. 00 37, 378 040, 381 30. 00 0. 0000 (DRIBATI NO ROUND 12, 688 5, 477 1, 900, 363 50. 00 0.							1
16. 00	13.00	01300 NURSING ADMINISTRATION	87, 776				13. 00
INPART IENT ROUTINE SERVICE COST CENTERS 23,920 6,820 751,314 30,00 44.00			1				1
30.00	16. 00		0	66	13, 941, 383		16. 00
44. 00 04.00 SKILLED NURSING FACILITY 0 37, 378 64.0,881 44.00	30 00		23 920	6 820	751 314		30 00
MACILLARY SERVICE COST CENTERS 50.00 50.00 05.			1				1
53.00 05300 ANSTHESIOLOCY 0 181 26, 126 53.00	00		<u> </u>	0.70.0	0.107.00.1		1
54.00 05400 ARDIOLOGY-DIAGNOSTIC 0 5,528 3,278,566 54.00 57.00	50.00		12, 688	5, 477	1, 900, 363		50.00
57.00 05700 CT SCAN 0			1 -1				
S8. 00 05800 MRI 0		1 1	1				1
60.00 0.0000 LABORATORY 1.00 1.611 2.423.593 66.00 65.00 65.00 0.650 RESPIRATORY THERAPY 17,056 5.972 100.039 65.00 66.00 0.6600 PEYSI CAL THERAPY 0.0 136.422 762.832 66.00 70.00 70.00 1.00			1	0	_		1
65.00 06500 RESPIRATORY THERAPY 17, 056 5, 972 100, 039 65.00 66.00 66.00 06500 PMYSI CAL THERAPY 0 136, 422 77, 28, 832 66.00 66.00 06500 PMYSI CAL THERAPY 0 0 0 88, 978 69.00 71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT 0 0 0 0 0.0			1 -1	1 611	_		1
66.00 06600 PHYSI CAL THERAPY 0 136, 422 762, 832 66.00 67.00 07000 ELECTROCARDIOLOGY 0 0 88, 978 69.00 71.00 07100 M2DI CAL SUPPLIES CHARGED TO PATIENT 0 0 264, 059 71.00 72.00 07200 IMPL DEV CHARGED TO PATIENTS 0 313 1, 075, 127 73.00 73.00 07300 DRUGS CHARGED TO PATIENTS 0 313 1, 075, 127 73.00 73.00 07300 DRUGS CHARGED TO PATIENTS 0 3.155 118, 008 88.00 73.00 08800 RURAL HEALTH CLINIC 0 1,513 118, 008 88.00 73.00 08800 RURAL HEALTH CLINIC 1 0 3,155 123, 697 88.01 73.00 07300 DRUGS CHARGED TO PATIENTS 0 788 159, 955 88.02 73.00 07300 DRUGS RURAL HEALTH CLINIC 1 0 788 159, 955 88.02 73.00 07300 DRUGS RURAL HEALTH CLINIC 1 0 788 159, 955 88.02 73.00 07300 DRUGS RURAL HEALTH CLINIC 1 0 788 159, 955 88.02 73.00 07300 DRUGS RURAL HEALTH CLINIC 1 0 3,3744 1,064 220, 358 90.00 70.00 0700 0700 CLINIC 0 3,744 1,064 220, 358 90.00 70.00 0700 DELEGENCY 30,368 19,974 1,719,936 91.00 70 0700 0700 DELEGENCY 30,368 19,974 1,719,936 91.00 70 0700 0700 DELEGENCY 30,368 19,974 1,719,936 92.00 70 0700 0700 DELEGENCY 0 1,591 0 95.00 70 0700 0700 0700 0700 0700 0700 70 0700 0700 0700 0700 0700 0700 70 0700 0700 0700 0700 0700 70 0700 0700 0700 0700 0700 70 0700 0700 0700 0700 0700 70 0700 0700 0700 0700 0700 70 0700 0700 0700 0700 0700 70 0700 0700 0700 0700 0700 70 0700 0700 0700 0700 0700 70 0700 0700 0700 0700 0700 70 0700 0700 0700 0700 0700 70 0700 0700 0700 0700 0700 70 0700 0700 0700 0700 0700 70 0700 0700 0700 0700 0700 70 0700 0700 0700 0700 0700 70 0700 0700 0700 0700 0700 70 0700 0700 0700 0700 0700 70 0700 0700 0700 0700 0700 70 0			1				1
171.00			1				1
12, 00 07200 IMPL DEV. CHARGED TO PATIENTS 0 313, 886 36, 624 72, 00 73, 00	69. 00		0	0	88, 978		69. 00
3300 DASO DRUSC CHARGED TO PATIENTS 0 3131 1,075,127 73.00			1	0			1
OUTPATLENT SERVICE COST CENTERS 88. 00 8800 RURAL HEALTH CLINIC 11 0 1, 513 118, 008 88. 01 88. 01 88. 01 880 RURAL HEALTH CLINIC 11 0 785 159, 595 88. 02 880. 02 880. 03 808. 03 808. 03 808. 04 80. 04 80. 05 80. 05 80. 02 80. 05 80. 02 80. 03 808. 03 808. 04 80. 04 80. 05 80. 03 90. 05 80. 03 90. 05 9			1				1
88. 00 08800 RURAL HEALTH CLINIC 0 1,513 118,008 88. 01 08801 RURAL HEALTH CLINIC 11 0 785 159,595 88. 01 89. 01 99.	73.00		l ol	313	1,075,127		/3.00
88. 01 08801 RURAL HEALTH CLINIC II 0 785 123,697 88. 02 88. 02 08802 RURAL HEALTH CLINIC III 0 785 159,595 88. 02 88. 03 08803 RURAL HEALTH CLINIC III 0 785 159,595 88. 03 90. 00 09000 CLINIC 0 3,744 1,064 220,358 90. 00 90. 01 09000 ST ANNE CLINIC 0 0 3,009 16,587 90. 01 91. 00 09100 EMERGENCY 30,368 19,974 1,719,936 91. 00 92. 00 09200 OBSERVATI ON BEDS (NON-DISTINCT PART 0) 0 14,719,936 92. 00 92. 00 09200 OBSERVATI ON BEDS (NON-DISTINCT PART 0) 0 0 0 0 9500 AMBULANCE SERVICES 0 0 0 0 0 0 9500 AMBULANCE SERVICES 0 0 1,591 0 101. 00 101. 00 10100 (HOME HEALTH ACENCY 0 0 1,591 0 0 116. 00	88. 00		0	1, 513	118, 008		88. 00
88. 03	88. 01		O				88. 01
90. 00 09000 CLI NI C 0 3,744 1,064 220,358 90.00 90. 01 09001 ST ANNE CLINI C 0 3.009 16,587 91.00 91. 00 09100 EMERGENCY 30,368 19,974 1,719,936 91.00 92. 00 09200 08SERVATI ON BEDS (NON-DISTINCT PART 0THER REIMBURSABLE COST CENTERS 92.00 95. 00 09500 AMBULANCE SERVI CES 0 0 0 0 95.00 101. 00 10100 HOME HEALTH AGENCY 0 1,591 0 101.00 113. 00 11300 INTEREST EXPENSE 113.00 11300 INTEREST EXPENSE 113.00 11600 HOSPI CE 0 0 0 0 116.00 116. 00 11600 HOSPI CE 0 0 0 0 0 116.00 118. 00 SUBTOTALS (SUM OF LINES 1 through 117) 87,776 247,497 13,941,383 118.00 101. 00 19000 GIFT FLOWER COFFEE SHOP & CANTEEN 0 0 0 0 194.00 194. 00 79950 ROQUOLIS WOMENS HEALTH 0 0 0 0 194.00 194. 01 07951 THER NONREI MBURSABLE DEPTS 0 415 0 0 194.00 194. 02 07952 REFERENCE LAB 0 0 0 0 194.00 200. 00 Cross Foot Adjustments 200.00 201. 00 Negative Cost Centers 201.00 202. 00 Cost to be allocated (per Wkst. B, 59, 191 13,224 71,297 203. 00 Unit cost multiplier (Wkst. B, Part I) 0.674342 0.053342 0.005114 203.00 204. 00 Cost to be allocated (per Wkst. B, 2,498 4,018 3,318 204.00 205. 00 MAHE adjustment amount to be allocated (per Wkst. B, 2) 0.00238 205.00 207. 00 NAHE and unitiplier (Wkst. B, Part I) 0.028459 0.016207 0.000238 205.00 207. 00 NAHE and unitiplier (Wkst. B, Part II) 0.0200.00 0.00238 205.00 207. 00 NAHE and unitiplier (Wkst. B, Part II) 0.028459 0.016207 0.000238 205.00 207. 00 NAHE and unitiplier (Wkst. B, Part II) 0.0200.00 0.00238 205.00 207. 00 NAHE and unitiplier (Wkst. B, Part II) 0.0200.00 0.00238 205.00 207. 00 NAHE and unitiplier (Wkst. B, Part II) 0.0200.00 0.00238 205.00 207. 00 NAHE and unitiplier (Wkst. B, Part II) 0.0200.00 0.00238 205.00 207. 00 NAHE and unitiplier (Wkst. B, Part III)			0				
90. 01 09001 ST ANNE CLINIC 0 3,009 16,587 90. 01 91. 00 91.00 EMERGENCY 97. 00 92.00 O9200 EMERGENCY 97. 00 92.00 O9200 OSERVATION BEDS (NON-DISTINCT PART 97. 00 92.00 O9200 OSERVATION BEDS (NON-DISTINCT PART 97. 00 9			0				1
91. 00 09100 EMERGENCY 09200 OBSERVATION BEDS (NON-DISTINCT PART 09500 OBSERVATION BEDS (NON-DISTINCT			3, /44				
92. 00 071HER REIMBURSABLE COST CENTERS 95. 00 07500 AMBULANCE SERVICES 0710. 00 07500 AMBULANCE SERVICES 0710. 00 07500 AMBULANCE SERVICES 075. 00 07500 AMBULANCE SERVICES 075. 00 0			30 368				1
OTHER REIMBURSABLE COST CENTERS 0			30, 300	17, 774	1, 719, 930		1
101. 00 10100 HOME HEALTH AGENCY SPECIAL PURPOSE COST CENTERS SPECIAL PURPOSE COST CENTERS SPECIAL PURPOSE COST CENTERS SUBTOTALS (SUM OF LINES 1 through 117) 87,776 247,497 13,941,383 118. 00 11800 NONREI MBURSABLE COST CENTERS SUBTOTALS (SUM OF LINES 1 through 117) 87,776 247,497 13,941,383 118. 00 NONREI MBURSABLE COST CENTERS SUBTOTALS (SUM OF LINES 1 through 117) 87,776 247,497 13,941,383 118. 00 NONREI MBURSABLE COST CENTERS SUBTOTALS (SUM OF LINES 1 through 117) 87,776 247,497 13,941,383 118. 00 NONREI MBURSABLE COST CENTERS SUBTOTALS (SUM OF LINES 1 through 117) 87,776 247,497 13,941,383 118. 00 NONREI MBURSABLE COST CENTERS SUBTOTALS (SUM OF LINES 1 through 117) SUBTOTALS (SUM OF LINES 1 through 118. 00 O							1
SPECIAL PURPOSE COST CENTERS 113.00 11300 INTEREST EXPENSE 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	95.00	09500 AMBULANCE SERVI CES	1		0		95. 00
113. 00 11300 INTEREST EXPENSE	101.00		0	1, 591	0		101. 00
116.00 11600 HOSPICE SUBTOTALS (SUM OF LINES 1 through 117) 87,776 247,497 13,941,383 118.00 18.00 NONREI MBURSABLE COST CENTERS 190.00 19700	112 0						112 00
118. 00 SUBTOTALS (SUM OF LINES 1 through 117) 87,776 247,497 13,941,383 118. 00			0	0	0		1
NONRE MBURSABLE COST CENTERS 190. 00 19000 GIFT FLOWER COFFEE SHOP & CANTEEN 0 0 0 0 0 194. 00 194. 00 07950 ROQUOI S WOMENS HEALTH 0 0 0 0 0 194. 00 194. 01 07951 0THER NONREI MBURSABLE DEPTS 0 415 0 0 194. 01 194. 02			87. 776	247. 497	13, 941, 383		
194. 00 07950 ROQUOIS WOMENS HEALTH							
194. 01 07951 OTHER NONREIMBURSABLE DEPTS 0 415 0 194. 02 07952 REFERENCE LAB 0 0 0 194. 02 200. 00 Cross Foot Adjustments 200. 00 Negative Cost Centers 201. 00 Cost to be allocated (per Wkst. B, Part I) 13, 224 71, 297 202. 00 Unit cost multiplier (Wkst. B, Part II) 0. 674342 0. 053342 0. 005114 203. 00 Cost to be allocated (per Wkst. B, Part II) 0. 0. 005114 204. 00 Part II) 0. 0053342 0. 005114 204. 00 Part II) 0. 0053342 0. 005114 204. 00 Part II) 0. 0053342 0. 005114 204. 00 Part II) 0. 0053342 0. 005114 205. 00 Unit cost multiplier (Wkst. B, Part II) 0. 0053342 0. 005114 204. 00 Part II) 0. 0053342 0. 005114 205. 00 Part II) 0. 0053342 0. 005114 206. 00 Part II) 0. 0053342 0. 005114 206. 00 Part II) 0. 0053342 0. 0053342 0. 005514 206. 00 Part II) 0. 0053342 0. 005514 206. 00 Part II) 0. 0053342 0. 005514 206. 00 Part II) 0. 0053342 0. 005514 206. 00 Part II) 0. 0053342 0. 005514 206. 00 Part II) 0. 0053342 0. 005514 206. 00 Part II) 0. 0053342 0. 005514 206. 00 Part II) 0. 0055342 0. 005514 206. 00 Part II) 0. 0055342 0. 005514 206. 00 Part II) 0. 0055342 0. 0055342 0. 005514 206. 00 Part II) 0. 0055454 0. 00			0	0	0		
194. 02 07952 REFERENCE LAB			1	- 1	-		
200.00 201.00 Negative Cost Centers 202.00 Cost to be allocated (per Wkst. B, Part I) Unit cost multiplier (Wkst. B, Part II) 205.00 Unit cost multiplier (Wkst. B, Part II) 206.00 NAHE adjustment amount to be allocated (per Wkst. B, Part II) NAHE unit cost multiplier (Wkst. B, Part III) NAHE unit cost multiplier (Wkst. B, Part IIII) NAHE unit cost multiplier (Wkst. B, Part IIIIIIIIIIIIIIIIIIIIIIIIIIIIIIIIIIII			0	415	_		
201.00 Negative Cost Centers 201.00 Cost to be allocated (per Wkst. B, Part I) 13,224 71,297 202.00 203.00 Unit cost multiplier (Wkst. B, Part I) 0.674342 0.053342 0.005114 203.00 204.00 Cost to be allocated (per Wkst. B, Part II) 205.00 Unit cost multiplier (Wkst. B, Part II) 205.00 Unit cost multiplier (Wkst. B, Part II) 206.00 NAHE adjustment amount to be allocated (per Wkst. B, Part II) 206.00 NAHE unit cost multiplier (Wkst. D, Part III) 207.00 NAHE unit cost multiplier (Wkst. D, Part III) 207.00 20			0	U	U		
202.00 Cost to be allocated (per Wkst. B, Part I) 13, 224 71, 297 202.00 Part I) Unit cost multiplier (Wkst. B, Part I) Cost to be allocated (per Wkst. B, Part II) Cost to be allocated (per Wkst. B, Part III) 205.00 Unit cost multiplier (Wkst. B, Part III) 206.00 NAHE adjustment amount to be allocated (per Wkst. B, Part III) NAHE unit cost multiplier (Wkst. D, Part III) 207.00 NAHE unit cost multiplier (Wkst. D, Part IIIIIIIIIIIIIIIIIIIIIIIIIIIIIIIIIIII							
Part I) 203.00 Unit cost multiplier (Wkst. B, Part I) 204.00 Cost to be allocated (per Wkst. B, Part II) 205.00 Unit cost multiplier (Wkst. B, Part II) 206.00 NAHE adjustment amount to be allocated (per Wkst. B, Part II) 206.00 NAHE unit cost multiplier (Wkst. D, Part II) 207.00 NAHE unit cost multiplier (Wkst. D, Part II) 208.00 NAHE unit cost multiplier (Wkst. D, Part II) 209.00 NAHE unit cost multiplier (Wkst. D, Part III) 209.00 NAHE unit cost multiplier (Wkst. D, Part IIII) 200.0053342 0.0053342 0.005114 203.00 0.005342 0.005114 203.00 0.005342 0.005114 203.00 0.005342 0.005114 204.00 0.00638		1 1 9	59, 191	13, 224	71, 297		
204.00 Cost to be allocated (per Wkst. B, Part II) 205.00 Unit cost multiplier (Wkst. B, Part II) 206.00 NAHE adjustment amount to be allocated (per Wkst. B-2) NAHE unit cost multiplier (Wkst. D, Part II) 207.00 NAHE unit cost multiplier (Wkst. D, Part II) 208.00 207.00							
Part II) Unit cost multiplier (Wkst. B, Part 0.028459 0.016207 0.000238 205.00 II) 206.00 NAHE adjustment amount to be allocated (per Wkst. B-2) 207.00 NAHE unit cost multiplier (Wkst. D, 207.00			1				
205.00 Unit cost multiplier (Wkst. B, Part 1) 0.028459 0.016207 0.000238 205.00 11	204.00		2, 498	4, 018	3, 318		204. 00
206.00 NAHE adjustment amount to be allocated (per Wkst. B-2) NAHE unit cost multiplier (Wkst. D, 207.00	205 00		0 038450	0 016207	0 000339		205 00
206.00 NAHE adjustment amount to be allocated (per Wkst. B-2) 207.00 NAHE unit cost multiplier (Wkst. D, 207.00	200.00	1 7	0. 020439	0.010207	0.000236		203.00
(per Wkst. B-2) 207.00 NAHE unit cost multiplier (Wkst. D, 207.00	206.00		1				206. 00
		(per Wkst. B-2)					
	207. 00						207. 00
		raitS iii allu iv)	ı	ı	ı		I

Heal th Financial Systems

I ROOUDIS MEMORIAL HOSPITAL

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 14-1353

In Lieu of Form CMS-2552-10

Period: Worksheet C
From 07/17/2023 Part I
To 09/30/2023 Date/Time Prepared: 2/26/2024 1:42 pm

						2/26/2024 1:4	<u> 2 pm</u>
			Title	XVIII	Hospi tal	Cost	
					Costs		
	Cost Center Description	Total Cost	Therapy Limit	Total Costs	RCE	Total Costs	
		(from Wkst. B,	Adj .		Di sal I owance		
		Part I, col.	,				
		26)					
		1.00	2. 00	3.00	4. 00	5. 00	
IN	PATIENT ROUTINE SERVICE COST CENTERS	1.00	2.00	0.00	1. 00	0.00	
	000 ADULTS & PEDI ATRI CS	747, 360		747, 360	0	747, 360	30.00
	400 SKILLED NURSING FACILITY	731, 540		731, 540		731, 540	
	CILLARY SERVICE COST CENTERS				-		
	000 OPERATING ROOM	456, 668		456, 668	0	456, 668	50.00
	300 ANESTHESI OLOGY	8, 360		8, 360		8, 360	
	400 RADI OLOGY-DI AGNOSTI C	519, 927		519, 927		519, 927	
	700 CT SCAN	0.7,727		0.7,727		0.77,727	57. 00
	800 MRI	0			i o	0	58. 00
	000 LABORATORY	459, 812		459, 812	0	459, 812	60.00
	500 RESPIRATORY THERAPY	191, 458	0	191, 458		191, 458	
	600 PHYSI CAL THERAPY	525, 170		525, 170		525, 170	
	900 ELECTROCARDI OLOGY	9, 919		9, 919		9, 919	
	100 MEDICAL SUPPLIES CHARGED TO PATIENT	4, 771		4, 771		4, 771	
		1					
	200 I MPL. DEV. CHARGED TO PATIENTS	16, 940		16, 940		16, 940	
	300 DRUGS CHARGED TO PATIENTS	616, 742		616, 742	. 0	616, 742	73. 00
	TPATIENT SERVICE COST CENTERS	440 554		440 55		440 554	00.00
	800 RURAL HEALTH CLINIC	119, 554		119, 554		119, 554	
	801 RURAL HEALTH CLINIC II	149, 232		149, 232		149, 232	
	802 RURAL HEALTH CLINIC III	334, 044		334, 044		334, 044	
	803 RURAL HEALTH CLINIC IV	597, 618		597, 618		597, 618	
	000 CLI NI C	104, 664		104, 664		104, 664	
	001 ST ANNE CLINIC	41, 047		41, 047		41, 047	
	100 EMERGENCY	966, 984		966, 984		966, 984	
	200 OBSERVATION BEDS (NON-DISTINCT PART	309, 932		309, 932		309, 932	92. 00
	HER REIMBURSABLE COST CENTERS						
	500 AMBULANCE SERVICES	0		(_	
101.00 10	100 HOME HEALTH AGENCY	181, 046		181, 046		181, 046	101. 00
SPI	ECIAL PURPOSE COST CENTERS						
113.00 11	300 INTEREST EXPENSE						113. 00
116. 00 11	600 HOSPI CE	299, 612		299, 612	!	299, 612	116. 00
200.00	Subtotal (see instructions)	7, 392, 400	0	7, 392, 400	0	7, 392, 400	200.00
201.00	Less Observation Beds	309, 932		309, 932		309, 932	201.00
202. 00	Total (see instructions)	7, 082, 468	0	7, 082, 468	0	7, 082, 468	202.00
		•	•	•		•	•

Heal th Financial Systems

I ROOUDIS MEMORIAL HOSPITAL

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 14-1353

Peri od: Worksheet C From 07/17/2023 Part I To 09/30/2023 Date/Time Prepared: 2/26/2024 1:42 pm

In Lieu of Form CMS-2552-10

					2/26/2024 1: 4	2 pm
		Title	XVIII	Hospi tal	Cost	
		Charges				
Cost Center Description	I npati ent	Outpati ent	Total (col. 6	Cost or Other	TEFRA	
	·	·	+ col. 7)	Rati o	Inpati ent	
			<u> </u>		Rati o	
	6.00	7. 00	8. 00	9. 00	10. 00	
INPATIENT ROUTINE SERVICE COST CENTERS						
30. 00 03000 ADULTS & PEDIATRICS	446, 806		446, 806			30.00
44.00 04400 SKILLED NURSING FACILITY	640, 881		640, 881			44.00
ANCI LLARY SERVI CE COST CENTERS			2.0,00.			
50. 00 05000 OPERATING ROOM	40, 813	1, 859, 550	1, 900, 363	0. 240306	0.000000	50. 00
53. 00 05300 ANESTHESI OLOGY	0	26, 126				
54. 00 05400 RADI OLOGY - DI AGNOSTI C	111, 708	3, 166, 879		0. 158583		
57. 00 05700 CT SCAN	111,700	0, 100, 077	0,270,007	0. 000000		
58. 00 05800 MRI		0	ľ	0. 000000		
60. 00 06000 LABORATORY	72, 468	2, 351, 124	2, 423, 592	0. 189723	0. 000000	
65. 00 06500 RESPIRATORY THERAPY	52, 194	63, 853	116, 047	1. 649832	0. 000000	
66. 00 06600 PHYSI CAL THERAPY	18, 228	744, 604	762, 832	0. 688448		
69. 00 06900 ELECTROCARDI OLOGY	3, 644	85, 335		0. 111476		
71. 00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	58, 339	205, 720	· ·	0. 111470		
72. 00 07200 IMPL. DEV. CHARGED TO PATIENTS	1, 000	35, 624	· ·	0. 462538		
			· ·			
73. 00 O7300 DRUGS CHARGED TO PATIENTS	114, 789	960, 338	1, 075, 127	0. 573646	0. 000000	73. 00
OUTPATIENT SERVICE COST CENTERS		440.000	440.000			00.00
88. 00 08800 RURAL HEALTH CLINIC	0	118, 008				88. 00
88. 01 08801 RURAL HEALTH CLINIC II	0	123, 697	123, 697			88. 01
88.02 08802 RURAL HEALTH CLINIC III	0	159, 595				88. 02
88.03 08803 RURAL HEALTH CLINIC IV	0	234, 680				88. 03
90. 00 09000 CLI NI C	1, 000	219, 358				
90. 01 09001 ST ANNE CLINIC	0	16, 587	16, 587	2. 474649		
91. 00 09100 EMERGENCY	5, 000	1, 698, 928	1, 703, 928	0. 567503	0.000000	91. 00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART	4, 509	300, 000	304, 509	1. 017809	0.000000	92.00
OTHER REIMBURSABLE COST CENTERS						
95. 00 09500 AMBULANCE SERVICES	0	0	0	0.000000	0. 000000	95. 00
101.00 10100 HOME HEALTH AGENCY	o	166, 387	166, 387			101. 00
SPECIAL PURPOSE COST CENTERS	'					
113. 00 11300 NTEREST EXPENSE						113. 00
116. 00 11600 HOSPI CE	0	411, 523	411, 523			116. 00
200.00 Subtotal (see instructions)	1, 571, 379	12, 947, 916				200. 00
201. 00 Less Observation Beds	., ., ., .,	.2, , , , 10	, 5, 2,6			201. 00
202.00 Total (see instructions)	1, 571, 379	12, 947, 916	14, 519, 295			202. 00
202. 00 10 tal (300 1113 ti doti 0113)	1,3/1,3/7	12, 771, 710	17,517,275	1	1	1202.00

In Lieu of Form CMS-2552-10

Peri od: From 07/17/2023 To 09/30/2023

Worksheet C Part I Date/Time Prepared: 2/26/2024 1:42 pm

		Title XVIII	Hospi tal	Cost
Cost Center Description	PPS Inpatient	THE XVIII	поэрт саг	3631
555t 5511tG. 555511 pt. 511	Ratio			
	11. 00			
INPATIENT ROUTINE SERVICE COST CENTERS	111.00			
30. 00 03000 ADULTS & PEDIATRICS				30.00
44. 00 04400 SKILLED NURSING FACILITY				44.00
ANCILLARY SERVICE COST CENTERS				99
50. 00 05000 OPERATI NG ROOM	0. 240306			50.00
53. 00 05300 ANESTHESI OLOGY	0. 319988			53. 00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	0. 158583			54.00
57. 00 05700 CT SCAN	0. 000000			57. 00
58. 00 05800 MRI	0. 000000			58.00
60. 00 06000 LABORATORY	0. 189723			60.00
65. 00 06500 RESPIRATORY THERAPY	1. 649832			65. 00
66. 00 06600 PHYSI CAL THERAPY	0. 688448			66. 00
69. 00 06900 ELECTROCARDI OLOGY	0. 111476			69.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0. 018068			71. 00
72. 00 07200 IMPL. DEV. CHARGED TO PATIENTS	0. 462538			72.00
73. 00 07300 DRUGS CHARGED TO PATIENTS	0. 573646			73.00
OUTPATIENT SERVICE COST CENTERS	0. 373040			73.00
88. 00 08800 RURAL HEALTH CLINIC				88. 00
88. 01 08801 RURAL HEALTH CLINIC II				88. 01
88. 02 08802 RURAL HEALTH CLINIC III				88. 02
88. 03 08803 RURAL HEALTH CLINIC IV				88. 03
90. 00 09000 CLINIC	0. 474973			90.00
90. 01 09001 ST ANNE CLINIC	2. 474649			90. 01
91. 00 09100 EMERGENCY	0. 567503			91.00
92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART	1. 017809			92.00
OTHER REIMBURSABLE COST CENTERS	1.017007			72.00
95. 00 09500 AMBULANCE SERVICES	0. 000000			95, 00
101.00 10100 HOME HEALTH AGENCY	0.000000			101.00
SPECIAL PURPOSE COST CENTERS				101.00
113. 00 11300 NTEREST EXPENSE				113. 00
116. 00 11600 HOSPI CE				116. 00
200.00 Subtotal (see instructions)				200. 00
201.00 Less Observation Beds				201. 00
202.00 Total (see instructions)				202. 00
202.00 Total (See HISTI UCTIONS)				J202. 00

Heal th Financial Systems

I ROOUDIS MEMORIAL HOSPITAL

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 14-1353

In Lieu of Form CMS-2552-10

Period: Worksheet C
From 07/17/2023 Part I
To 09/30/2023 Date/Time Prepared: 2/26/2024 1:42 pm

						2/20/2024 1.4	Ζ μιιι
			Titl	e XIX	Hospi tal	PPS	
					Costs		
	Cost Center Description	Total Cost	Therapy Limit	Total Costs	RCE	Total Costs	
		(from Wkst. B,			Di sal I owance		
		Part I, col.	, ,		Brodi rollanos		
		26)					
		1.00	2.00	3.00	4. 00	5. 00	
1. 51	IDATI FAIT POLITIAIS CERVILOS COCT OFAITERS	1.00	2.00	3.00	4.00	5.00	
	IPATI ENT ROUTI NE SERVI CE COST CENTERS	7.7.040				7.7.070	
	3000 ADULTS & PEDIATRICS	747, 360		747, 360		747, 360	
	1400 SKILLED NURSING FACILITY	731, 540		731, 540	0	731, 540	44. 00
	ICI LLARY SERVI CE COST CENTERS						
50.00 05	5000 OPERATING ROOM	456, 668		456, 668	0	456, 668	50.00
53.00 05	5300 ANESTHESI OLOGY	8, 360		8, 360	0	8, 360	53. 00
54.00 05	5400 RADI OLOGY-DI AGNOSTI C	519, 927		519, 927	0	519, 927	54.00
57.00 05	5700 CT SCAN	0			0	0	57. 00
	5800 MRI	0		1	0	0	58. 00
	5000 LABORATORY	459, 812		459, 812	0	459, 812	
	5500 RESPIRATORY THERAPY	191, 458		191, 458		191, 458	
	6600 PHYSI CAL THERAPY	525, 170		525, 170		525, 170	
	5900 ELECTROCARDI OLOGY			9, 919		9, 919	
		9, 919					
	7100 MEDICAL SUPPLIES CHARGED TO PATIENT	4, 771	l .	4, 771		4, 771	
	200 IMPL. DEV. CHARGED TO PATIENTS	16, 940		16, 940		16, 940	
	7300 DRUGS CHARGED TO PATIENTS	616, 742		616, 742	0	616, 742	73. 00
	ITPATIENT SERVICE COST CENTERS						
	3800 RURAL HEALTH CLINIC	119, 554		119, 554	0	119, 554	88. 00
88. 01 08	8801 RURAL HEALTH CLINIC II	149, 232		149, 232	. 0	149, 232	88. 01
88. 02 08	8802 RURAL HEALTH CLINIC III	334, 044		334, 044	. 0	334, 044	88. 02
88. 03 08	8803 RURAL HEALTH CLINIC IV	597, 618		597, 618	0	597, 618	88. 03
	POOO CLINIC	104, 664		104, 664		104, 664	
	2001 ST ANNE CLINIC	41, 047	l e	41, 047		41, 047	
	2100 EMERGENCY	966, 984		966, 984		966, 984	
	2200 OBSERVATION BEDS (NON-DISTINCT PART	309, 932		309, 932		309, 932	
	THER REIMBURSABLE COST CENTERS	307, 732		307, 732		307, 732	92.00
				1			05 00
	2500 AMBULANCE SERVICES	0	1	C		_	
	0100 HOME HEALTH AGENCY	181, 046		181, 046		181, 046	101.00
	PECIAL PURPOSE COST CENTERS	1	ı				
	300 INTEREST EXPENSE						113. 00
	600 HOSPI CE	299, 612		299, 612	1	299, 612	
200.00	Subtotal (see instructions)	7, 392, 400	0	7, 392, 400	0	7, 392, 400	200.00
201.00	Less Observation Beds	309, 932		309, 932		309, 932	201.00
202.00	Total (see instructions)	7, 082, 468		7, 082, 468	0		
ı,	,				1	,	•

Heal th Financial Systems

I ROOUDIS MEMORIAL HOSPITAL

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 14-1353

Peri od: Worksheet C From 07/17/2023 Part I To 09/30/2023 Date/Time Prepared: 2/26/2024 1:42 pm

In Lieu of Form CMS-2552-10

Cost Center Description							2/26/2024 1: 4:	2 pm
Cost Center Description				Ti tl	e XIX	Hospi tal	PPS	
INPATI ENT ROUTI NE SERVICE COST CENTERS				Charges				
INPATI ENT ROUTI NE SERVI CE COST CENTERS		Cost Center Description	I npati ent	Outpati ent	Total (col. 6	Cost or Other	TEFRA	
INPATIENT ROUTINE SERVICE COST CENTERS 30.00 7.00 8.00 9.00 10.00		·		·			Inpati ent	
INPATIENT ROUTINE SERVICE COST CENTERS 30.00 300.00					,		Rati o	
30.00			6.00	7. 00	8.00	9. 00	10.00	
44.00		INPATIENT ROUTINE SERVICE COST CENTERS			•			
ANCILLARY SERVICE COST CENTERS	30.00	03000 ADULTS & PEDIATRICS	446, 806		446, 806			30. 00
ANCILLARY SERVICE COST CENTERS	44.00	04400 SKILLED NURSING FACILITY	640, 881		640, 881			44.00
50.00								
53.00 05300 ANESTHESI OLOGY 0 26, 126 26, 126 0. 319988 0. 000000 53.00 54.00 54.00 54.00 54.00 54.00 54.00 54.00 54.00 54.00 55.00 55.00 55.00 55.00 55.00 55.00 55.00 55.00 55.00 60	50.00		40, 813	1, 859, 550	1, 900, 363	0, 240306	0.000000	50.00
54.00 05400 RADI OLOGY-DI AGNOSTI C 111, 708 3, 166, 879 3, 278, 587 0. 158583 0. 000000 54.00 57.00 0. 000000 0. 0000000 0. 0000000 58.00 0. 0000000 0. 0000000 0. 0000000 58.00 0. 000000 0. 0000000 0. 0000000 58.00 0. 000000 0. 0000000 0. 000000 0. 000000 58.00 0. 0000000 0. 000000 0. 000000 0. 0000000 0. 0000000 0. 0000000								
57.00 05700 CT SCAN 0 0 0 0 0 0 0 0 0			1					
58.00 05800 MRI 0 0 0 0.000000 0.000000 58.00 60.00 06000 LABORATORY 72, 468 2, 351, 124 2, 423, 592 0.189723 0.000000 60.00 66.00 06500 RESPI RATORY THERAPY 52, 194 63, 853 116, 047 1.649832 0.000000 66.00 66.00 06600 PHYSI CAL THERAPY 18, 228 744, 604 762, 832 0.688448 0.000000 66.00 69.00 06900 ELECTROCARDI OLOGY 3, 644 85, 335 88, 979 0.1111476 0.000000 69.00 71.00 07100 MEDI CAL SUPPLIES CHARGED TO PATI ENTS 1,000 35, 624 36, 624 0.462538 0.000000 71.00 73.00 07200 I MPL. DEV. CHARGED TO PATI ENTS 114, 789 960, 338 1,075, 127 0.573646 0.000000 72.00 73.00 07300 DRUGS CHARGED TO PATI ENTS 114, 789 960, 338 1,075, 127 0.573646 0.000000 73.00 88.01 08800 RUGAL HEALTH CLINIC 0 118, 008 118, 008			0	0, 100, 011				
60. 00 06000 LABORATORY 72, 468 2, 351, 124 2, 423, 592 0. 189723 0. 000000 60. 00 65. 00 06500 RESPIRATORY THERAPY 52, 194 63, 853 116, 047 1. 649832 0. 000000 65. 00 66. 00 06600 PHYSI CAL THERAPY 18, 228 744, 604 762, 832 0. 688448 0. 000000 65. 00 69. 00 06900 ELECTROCARDIO LOGY 3, 644 85, 335 88, 979 0. 111476 0. 000000 69. 00 71. 00 07100 MEDI CAL SUPPLIES CHARGED TO PATI ENT 58, 339 205, 720 264, 059 0. 018068 0. 000000 71. 00 72. 00 07200 IMPL. DEV. CHARGED TO PATI ENTS 1, 000 35, 624 36, 624 0. 462538 0. 000000 72. 00 73. 00 07300 DRUGS CHARGED TO PATI ENTS 114, 789 960, 338 1, 075, 127 0. 573646 0. 000000 72. 00 73. 00 07300 DRUGS CHARGED TO PATI ENTS 114, 789 960, 338 1, 075, 127 0. 573646 0. 000000 88. 00 88. 01 08801 RURAL HEALTH CLINIC 0 118, 008 118, 008 1. 013101 0. 000000 88. 00 88. 01 08802 RURAL HEALTH CLINIC 1 0 123, 697 123, 697 1. 206432 0. 000000 88. 00 88. 02 08802 RURAL HEALTH CLINIC 1 0 159, 595 159, 595 2. 093073 0. 000000 88. 02 88. 03 08803 RURAL HEALTH CLINIC 1 0 234, 680 234, 680 2. 546523 0. 000000 88. 03 90. 01 09900 CLINIC 0 16, 587 16, 587 2. 474649 0. 000000 90. 00 90. 01 09900 DEBERGENCY 5, 000 1, 698, 928 1, 703, 928 0. 567503 0. 000000 91. 00 91. 00 09500 AMBULANCE SERVICES 0 0 0 0. 000000 0. 000000 92. 00 09500 AMBULANCE SERVICES 0 0 0 0. 000000 0. 000000 95. 00 101. 00 10100 HOME HEALTH AGENCY 0 166, 387 166			0	0	1			
65. 00 06500 RESPIRATORY THERAPY 52, 194 63, 853 116, 047 1. 649832 0. 000000 65. 00 66. 00 06600 PHYSI CAL THERAPY 18, 228 744, 604 762, 832 0. 688448 0. 000000 66. 00 69. 00 06900 ELECTROCARDI OLOGY 3, 644 85, 335 88, 979 0. 111476 0. 000000 69. 00 71. 00 07100 MEDI CAL SUPPLIES CHARGED TO PATI ENT 58, 339 205, 720 264, 059 0. 018068 0. 000000 71. 00 72. 00 07200 IMPL. DEV. CHARGED TO PATI ENTS 1, 000 35, 624 36, 624 0. 462538 0. 000000 72. 00 73. 00 07300 DRUGS CHARGED TO PATI ENTS 114, 789 960, 338 1, 075, 127 0. 573646 0. 000000 73. 00 0017PATI ENT SERVI CE COST CENTERS			72 468	2 351 124	2 423 592			
66. 00 06600 PHYSI CAL THERAPY 18, 228 744, 604 762, 832 0. 688448 0. 000000 66. 00 69. 00 06900 ELECTROCARDI OLOGY 3, 644 85, 335 88, 979 0. 111476 0. 000000 69. 00 71. 00 07100 MEDI CAL SUPPLI ES CHARGED TO PATI ENT 58, 339 205, 720 264, 059 0. 018068 0. 000000 71. 00 72. 00 07200 IMPL. DEV. CHARGED TO PATI ENTS 1, 000 35, 624 36, 624 0. 462538 0. 000000 72. 00 73. 00 07300 DRUGS CHARGED TO PATI ENTS 114, 789 960, 338 1, 075, 127 0. 573646 0. 000000 73. 00 00179ATI ENT SERVI CE COST CENTERS 88. 00 08800 RURAL HEALTH CLINIC 1 0 113, 008 118, 008 1. 013101 0. 000000 88. 00 88. 01 08801 RURAL HEALTH CLINIC 1 0 123, 697 1. 206432 0. 000000 88. 02 88. 02 08802 RURAL HEALTH CLINIC 1 0 159, 595 159, 595 2. 093073 0. 000000 88. 02 88. 03 08803 RURAL HEALTH CLINIC 1 0 234, 680 234, 680 2.546523 0. 000000 88. 03 89. 01 09000 CLINIC 0 1,000 219, 358 220, 358 0. 474973 0. 000000 90. 01 90. 01 09001 ST ANNE CLINIC 0 16, 587 16, 587 2. 474649 0. 000000 90. 01 91. 00 09100 EMERGENCY 5,000 1,698, 928 1,703, 928 0. 567503 0. 000000 92. 00 09SERVATI ON BEDS (NON-DISTINCT PART 4,509 300,000 304,509 1. 017809 0. 000000 95. 00 09500 AMBULANCE SERVI CES 0 0 0 0. 000000 0. 000000 95. 00 09500 AMBULANCE SERVI CES 0 0 0 0. 000000 0. 000000 95. 00 101. 00 10300 INTEREST EXPENSE 113. 00 11300 INTEREST EXPENSE 113. 00 11300 INTEREST EXPENSE 113. 00 1160. 0000000 1160. 000000000000000000000000000000000								
69. 00 06900 ELECTROCARDI OLOGY 3, 644 85, 335 88, 979 0. 111476 0. 000000 69. 00 71. 00 71. 00 71000 MEDI CAL SUPPLIES CHARGED TO PATIENT 58, 339 205, 720 264, 059 0. 018068 0. 000000 71. 00 72. 00 72.00 1MPL. DEV. CHARGED TO PATIENTS 1, 000 35, 624 36, 624 0. 462538 0. 000000 72. 00 73. 00 07300 DRUGS CHARGED TO PATIENTS 114, 789 960, 338 1, 075, 127 0. 573646 0. 000000 73. 00 000000 74. 00 000000 74. 00 000000 75. 00 00000000 75. 00 0000000 75. 00 0000000 75. 00 0000000 75. 00 0000000 75. 00 0000000 75. 00 0000000 75. 00 0000000 75. 00 0000000 75. 00 0000000 75. 00 000000000 75. 00 0000000 75. 00 0000000 75. 00 0000000 75. 00 0000000 75. 00 0000000 75. 00 0000000 75. 00 0000000 75. 00 0000000 75. 00 0000000 75. 00 0000000000 75. 00 0000000 75. 00 0000000 75. 00 0000000 0000000000 75. 00 00000000000000000000000000000000								
71. 00								
72. 00								
73. 00		l l						1
SECOND S		l l						
88. 00	73.00		114,707	700, 330	1,075,127	0.373040	0.000000	73.00
88. 01	88 00			119 009	118 008	1 013101	0.000000	99 00
88. 02 08802 RURAL HEALTH CLINIC III 0 159, 595 159, 595 2. 093073 0. 000000 88. 02 88. 03 08803 RURAL HEALTH CLINIC IV 0 234, 680 234, 680 2. 546523 0. 000000 88. 03 90. 00 09000 CLINIC 1,000 219, 358 220, 358 0. 474973 0. 000000 90. 00 90. 01 09001 ST ANNE CLINIC 0 16, 587 16, 587 2. 474649 0. 000000 90. 01 91. 00 09100 EMERGENCY 5,000 1, 698, 928 1, 703, 928 0. 567503 0. 000000 91. 00 92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART 4, 509 300, 000 304, 509 1. 017809 0. 000000 92. 00 ODITION OF THE REIMBURSABLE COST CENTERS 0 0 0 0. 000000 95. 00 101. 00 10100 HOME HEALTH AGENCY 0 166, 387 166, 387 166, 387 113. 00 11300 INTEREST EXPENSE 113. 00 116. 00 11600 HOSPICE 0 411, 523 411, 523 411, 523 116. 00			0					
88. 03			0					
90. 00			0					
90. 01			1 000					
91. 00			1					
92. 00 09200 0BSERVATI ON BEDS (NON-DI STI NCT PART 4, 509 300, 000 304, 509 1. 017809 0. 000000 92. 00			١					1
OTHER REIMBURSABLE COST CENTERS 95.00 09500 AMBULANCE SERVI CES 0 0 0 0 0.000000 0.000000 95.00 0.0000000 0.000000 0.000000 0.000000 0.000000 0.000000 0.0000000 0.0000000 0.0000000 0.0000000 0.0000000 0.0000000 0.0000000 0.000000 0.000000 0.0000000 0.0000000 0.0000000 0.0000000 0.0000000 0.0000000 0.0000000 0.0000000 0.0000000 0.00000000								
95. 00	92.00		4, 509	300, 000	304, 509	1.01/809	0.000000	92.00
101.00	05 00					0.000000	0.000000	05 00
SPECIAL PURPOSE COST CENTERS 113.00 11300 INTEREST EXPENSE 113.00 11600 HOSPI CE 0 411, 523 411, 523 116.00			1				0.000000	1
113. 00 11300 NTEREST EXPENSE 113. 00 116. 00 11600 HOSPI CE 0 411, 523 411, 523 116. 00	101.00		0	166, 387	166, 387			101.00
116. 00 11600 HOSPI CE 0 411, 523 411, 523 116. 00						1		
			0					
200.00 Subtotal (see instructions) 1,571,379 12,947,916 14,519,295 200.00			1, 571, 379	12, 947, 916	14, 519, 295			
201.00 Less Observation Beds 201.00								
202. 00 Total (see instructions) 1,571,379 12,947,916 14,519,295	202.00		1, 571, 379	12, 947, 916	14, 519, 295			202. 00

In Lieu of Form CMS-2552-10

				2/26/2024 1: 42 pill
		Title XIX	Hospi tal	PPS
Cost Center Description	PPS Inpatient			
	Ratio			
	11. 00			
INPATIENT ROUTINE SERVICE COST CENTERS				
30. 00 03000 ADULTS & PEDI ATRI CS				30.00
44.00 O4400 SKILLED NURSING FACILITY				44. 00
ANCILLARY SERVICE COST CENTERS				
50.00 05000 OPERATING ROOM	0. 240306			50.00
53. 00 05300 ANESTHESI OLOGY	0. 319988			53.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	0. 158583			54.00
57.00 05700 CT SCAN	0. 000000			57. 00
58. 00 05800 MRI	0. 000000			58.00
60. 00 06000 LABORATORY	0. 189723			60.00
65. 00 06500 RESPIRATORY THERAPY	1. 649832			65. 00
66. 00 06600 PHYSI CAL THERAPY	0. 688448			66. 00
69. 00 06900 ELECTROCARDI OLOGY	0. 111476			69. 00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0. 018068			71. 00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0. 462538			72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	0. 573646			73. 00
OUTPATIENT SERVICE COST CENTERS				
88. 00 08800 RURAL HEALTH CLINIC	1. 013101			88. 00
88.01 08801 RURAL HEALTH CLINIC II	1. 206432			88. 01
88.02 08802 RURAL HEALTH CLINIC III	2. 093073			88. 02
88. 03 08803 RURAL HEALTH CLINIC IV	2. 546523			88. 03
90. 00 09000 CLI NI C	0. 474973			90.00
90. 01 09001 ST ANNE CLINIC	2. 474649			90. 01
91. 00 09100 EMERGENCY	0. 567503			91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART	1. 017809			92.00
OTHER REIMBURSABLE COST CENTERS				
95. 00 09500 AMBULANCE SERVI CES	0. 000000			95. 00
101.00 10100 HOME HEALTH AGENCY				101.00
SPECIAL PURPOSE COST CENTERS				
113. 00 11300 I NTEREST EXPENSE				113. 00
116. 00 11600 H0SPI CE				116. 00
200.00 Subtotal (see instructions)				200. 00
201.00 Less Observation Beds				201. 00
202.00 Total (see instructions)				202. 00
	1			1232.00

Heal th Financial Systems I ROQUOIS MEMORIAL HOSPITAL

Health Financial Systems IROQUOIS MEMORIAL HOSPITAL In Lieu of Form CMS-2552-10
CALCULATION OF OUTPATIENT SERVICE COST TO CHARGE RATIOS NET OF Provider CCN: 14-1353 Period: Worksheet C
REDUCTIONS FOR MEDICAID ONLY

09/30/2023

Date/Time Prepared: 2/26/2024 1:42 pm

Title XIX Hospi tal PPS Total Cost Capital Cost Operating Cost Operating Cost Cost Center Description Capi tal (Wkst. B, Part (Wkst. B, Part Net of Capital Reducti on Reducti on Cost (col. 1 II col. 26) Amount I, col. 26) col. 2) 1.00 2.00 3.00 4.00 5.00 ANCILLARY SERVICE COST CENTERS 74, 194 50.00 05000 OPERATING ROOM 456, 668 382, 474 50.00 0 0 0 0 0 0 0 0 0 0 0 05300 ANESTHESI OLOGY 395 7, 965 53.00 53.00 8, 360 0 54.00 05400 RADI OLOGY-DI AGNOSTI C 519, 927 52, 121 467, 806 54.00 05700 CT SCAN 57.00 0 C 0 0 57.00 05800 MRI 58.00 0 0 58.00 0 06000 LABORATORY 459, 812 60.00 16, 100 443, 712 0 60.00 65.00 06500 RESPIRATORY THERAPY 191, 458 8, 554 182, 904 0 65.00 66.00 06600 PHYSI CAL THERAPY 525, 170 35, 549 489, 621 0 66.00 9, 919 2, 757 06900 ELECTROCARDI OLOGY 69.00 7, 162 0 69.00 71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT 4,771 372 4, 399 0 71.00 72.00 07200 IMPL. DEV. CHARGED TO PATIENTS 16, 940 388 16, 552 0 72.00 07300 DRUGS CHARGED TO PATIENTS 73.00 616, 742 10, 959 605, 783 0 73.00 OUTPATIENT SERVICE COST CENTERS 88.00 08800 RURAL HEALTH CLINIC 119, 554 3, 372 116, 182 0 0 88.00 08801 RURAL HEALTH CLINIC II 149, 232 9, 550 139, 682 88. 01 88. 01 0 0 0 0 0 0 08802 RURAL HEALTH CLINIC III 334, 044 11, 387 322, 657 88.02 88 02 0 08803 RURAL HEALTH CLINIC IV 9, 800 88. 03 597, 618 587, 818 0 88.03 90.00 09000 CLI NI C 104, 664 14, 419 90, 245 0 90.00 09001 ST ANNE CLINIC 90.01 41,047 3, 285 37, 762 0 90.01 09100 EMERGENCY 966, 984 91.00 91 00 22, 404 944, 580 Ω 09200 OBSERVATION BEDS (NON-DISTINCT PART 92.00 309, 932 13, 960 295, 972 0 0 92.00 OTHER REIMBURSABLE COST CENTERS 09500 AMBULANCE SERVICES 95 00 0 0 95.00 101.00 10100 HOME HEALTH AGENCY 181, 046 8, 586 172, 460 0 0 101.00 SPECIAL PURPOSE COST CENTERS 113. 00 11300 I NTEREST EXPENSE 113.00 299, 612 0 116.00 116. 00 11600 HOSPI CE 4, 638 294, 974 0 200.00 0 Subtotal (sum of lines 50 thru 199) 5, 913, 500 302, 790 5, 610, 710 0 200. 00 201.00 Less Observation Beds 309, 932 13, 960 295, 972 0 0 201.00 Total (line 200 minus line 201) 0 202.00 5, 603, 568 288, 830 5, 314, 738 0 202. 00 IROQUOIS MEMORIAL HOSPITAL

Total (line 200 minus line 201)

Less Observation Beds

Health Financial Systems IROQUOIS ME CALCULATION OF OUTPATIENT SERVICE COST TO CHARGE RATIOS NET OF In Lieu of Form CMS-2552-10 Peri od: Worksheet C From 07/17/2023 To 09/30/2023 Date/Ti me Prepared: 2/26/2024 1: 42 pm Provi der CCN: 14-1353 REDUCTIONS FOR MEDICALD ONLY

						2/26/2024 1: 42	pm
				e XIX	Hospi tal	PPS	
	Cost Center Description		Total Charges				
			(Worksheet C,				
		Operating Cost	Part I, column	Ratio (col. 6	5		
		Reduction	8)	/ col. 7)			
		6. 00	7. 00	8. 00			
1A	NCILLARY SERVICE COST CENTERS						
50.00 0	5000 OPERATING ROOM	456, 668	1, 900, 363	0. 24030	6		50.00
53.00 0	5300 ANESTHESI OLOGY	8, 360	26, 126	0. 31998	8		53.00
54. 00 0	5400 RADI OLOGY-DI AGNOSTI C	519, 927	3, 278, 587	0. 15858	3		54.00
57. 00 0	5700 CT SCAN	0	0	0. 00000	0		57.00
58. 00 0	5800 MRI	0	0	0. 00000	0		58.00
60.00 0	6000 LABORATORY	459, 812	2, 423, 592	0. 18972	3		60.00
65. 00 0	6500 RESPI RATORY THERAPY	191, 458	116, 047	1. 64983	2		65.00
66.00 0	16600 PHYSI CAL THERAPY	525, 170	762, 832	0. 68844	8		66.00
69.00 0	6900 ELECTROCARDI OLOGY	9, 919	88, 979	0. 11147	6		69.00
71.00 0	7100 MEDICAL SUPPLIES CHARGED TO PATIENT	4, 771	264, 059	0. 01806	8		71.00
72. 00 0	7200 IMPL. DEV. CHARGED TO PATIENTS	16, 940	36, 624	0. 46253	8		72.00
73.00 0	7300 DRUGS CHARGED TO PATIENTS	616, 742	1, 075, 127	0. 57364	6		73.00
Ol	UTPATIENT SERVICE COST CENTERS						
88. 00 0	8800 RURAL HEALTH CLINIC	119, 554	118, 008	1. 01310	1		88.00
88. 01 0	8801 RURAL HEALTH CLINIC II	149, 232	123, 697	1. 20643	2		88.01
88. 02 0	8802 RURAL HEALTH CLINIC III	334, 044	159, 595	2. 09307	3		88.02
88. 03 0	8803 RURAL HEALTH CLINIC IV	597, 618	234, 680	2. 54652	3		88.03
90.00 0	9000 CLI NI C	104, 664	220, 358	0. 47497	3		90.00
90. 01 0	9001 ST ANNE CLINIC	41, 047	16, 587	2. 47464	9		90.01
91.00 0	9100 EMERGENCY	966, 984	1, 703, 928	0. 56750	3		91.00
92.00 0	9200 OBSERVATION BEDS (NON-DISTINCT PART	309, 932	304, 509	1. 01780	9		92.00
0	THER REIMBURSABLE COST CENTERS						
95. 00 0	9500 AMBULANCE SERVICES	0	0	0.00000	0		95.00
101.001	0100 HOME HEALTH AGENCY	181, 046	166, 387	1. 08810	2	1	101. 00
SI	PECIAL PURPOSE COST CENTERS			-	·		
113.001	1300 I NTEREST EXPENSE					1	13.00
116.001	1600 HOSPI CE	299, 612	411, 523	0. 72805	7	1	116. 00
200.00	Subtotal (sum of lines 50 thru 199)	5, 913, 500	13, 431, 608			2	200.00
201 00	l Obti D	200 022	_	I	1	l _a	001 00

309, 932

5, 603, 568

13, 431, 608

200. 00 201. 00 202. 00

201.00

202.00

I ROOUOIS MEMORIAL HOSPITAL L COSTS Provider CCN: 14-1353 In Lieu of Form CMS-2552-10

Period: Worksheet D

From 07/17/2023 Part II

To 09/30/2023 Date/Time Prepared: 2/26/2024 1:42 pm Health Financial Systems IROQUOIS MAPPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS

						2/26/2024 1:4	2 pm
				XVIII	Hospi tal	Cost	
	Cost Center Description	Capi tal	Total Charges	Ratio of Cost	I npati ent	Capital Costs	
			(from Wkst. C,	to Charges	Program	(column 3 x	
		(from Wkst. B,	Part I, col.	(col. 1 + col.	Charges	column 4)	
		Part II, col.	8)	2)			
		26)					
		1.00	2. 00	3. 00	4. 00	5. 00	
	ANCILLARY SERVICE COST CENTERS	1		,			
50.00	05000 OPERATING ROOM	74, 194			·	287	50.00
53.00	05300 ANESTHESI OLOGY	395	26, 126	0. 015119	0	0	53. 00
54.00	05400 RADI OLOGY-DI AGNOSTI C	52, 121	3, 278, 587	0. 015897	50, 613	805	54.00
57.00	05700 CT SCAN	0	0	0.000000	0	0	57. 00
58. 00	05800 MRI	0	0	0.000000		0	58. 00
60.00	06000 LABORATORY	16, 100	2, 423, 592	0.006643	35, 097	233	60.00
65.00	06500 RESPI RATORY THERAPY	8, 554	116, 047	0. 073712	577	43	65. 00
66.00	06600 PHYSI CAL THERAPY	35, 549	762, 832	0. 046601	8, 319	388	66. 00
69. 00	06900 ELECTROCARDI OLOGY	2, 757	88, 979	0. 030985	421	13	69. 00
71. 00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	372	264, 059	0. 001409	24, 347	34	71. 00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	388	36, 624	0. 010594	697	7	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	10, 959	1, 075, 127	0. 010193	44, 756	456	73.00
	OUTPATIENT SERVICE COST CENTERS						
88. 00	08800 RURAL HEALTH CLINIC	3, 372	118, 008	0. 028574	0	0	88. 00
88. 01	08801 RURAL HEALTH CLINIC II	9, 550	123, 697	0. 077205	0	0	88. 01
88. 02	08802 RURAL HEALTH CLINIC III	11, 387	159, 595	0. 071349	0	0	88. 02
88. 03	08803 RURAL HEALTH CLINIC IV	9, 800	234, 680	0. 041759	0	0	88. 03
90.00	09000 CLI NI C	14, 419	220, 358	0.065434	95	6	90.00
90. 01	09001 ST ANNE CLINIC	3, 285	16, 587	0. 198047	0	0	90. 01
91.00	09100 EMERGENCY	22, 404	1, 703, 928	0. 013148	2, 609	34	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART	13, 960	304, 509	0. 045844	1, 578	72	92. 00
	OTHER REIMBURSABLE COST CENTERS						
95.00	09500 AMBULANCE SERVICES						95. 00
200.00	Total (lines 50 through 199)	289, 566	12, 853, 698		176, 467	2, 378	200. 00

I ROQUOIS MEMORIAL HOSPITAL Health Financial Systems

In Lieu of Form CMS-2552-10 APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PASS THROUGH COSTS | Provider CCN: 14-1353 Worksheet D Part III Date/Time Prepared: Peri od: From 07/17/2023 09/30/2023 2/26/2024 1:42 pm Title XVIII Hospi tal Cost Cost Center Description Nursi ng Nursi ng Allied Health Allied Health All Other Post-Stepdown Medi cal Cost Program Program Education Cost Post-Stepdown Adjustments Adjustments 1A 1.00 2A 2.00 3.00 INPATIENT ROUTINE SERVICE COST CENTERS 30.00 03000 ADULTS & PEDIATRICS 0 0 30.00 0 0 44.00 04400 SKILLED NURSING FACILITY 44.00 200.00 Total (lines 30 through 199) 200.00 Cost Center Description Swi ng-Bed Total Costs Total Patient Per Diem (col Inpati ent Adjustment (sum of cols. Days Program Days $5 \div col. 6$ Amount (see 1 through 3, <u>i nstructi ons)</u> minus col. 4) 4.00 5.00 6.00 7.00 8.00 INPATIENT ROUTINE SERVICE COST CENTERS 30. 00 03000 ADULTS & PEDIATRICS 315 0.00 69 30.00 44.00 |04400 | SKILLED NURSING FACILITY 0.00 C 2,004 47 44.00 200.00 Total (lines 30 through 199) 2, 319 116 200. 00 Cost Center Description I npati ent Program Pass-Through Cost (col. 7 x col. 8) 9.00 INPATIENT ROUTINE SERVICE COST CENTERS 30. 00 03000 ADULTS & PEDIATRICS 30.00 0 0 44.00 04400 SKILLED NURSING FACILITY 44.00

200.00

200.00

Total (lines 30 through 199)

Health Financial Systems IROQUOIS MEMORIAL HOSPITAL
APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS Provider CCN: 14-1353 | In Lieu of Form CMS-2552-10 | Worksheet D | Part IV | 10/2023 | Date/Time Prepared: | 2/26/2024 1:42 pm Peri od: From 07/17/2023 To 09/30/2023 THROUGH COSTS

			Ti tl e	XVIII	Hospi tal	Cost	
	Cost Center Description	Non Physician	Nursi ng	Nursi ng	Allied Health	Allied Health	
	·	Anestheti st	Program	Program	Post-Stepdown		
		Cost	Post-Stepdown		Adjustments		
			Adjustments				
		1. 00	2A	2.00	3A	3. 00	
	ANCILLARY SERVICE COST CENTERS						
50.00	05000 OPERATING ROOM	0	C	1	0 0	0	50.00
53.00	05300 ANESTHESI OLOGY	0	C	1	0 0	0	53.00
54.00	05400 RADI OLOGY-DI AGNOSTI C	0	C	1	0 0	0	54.00
57.00	05700 CT SCAN	0	C		0	0	57. 00
58. 00	05800 MRI	0	C	1	0 0	0	58. 00
60.00	06000 LABORATORY	0	[C)	0	0	60.00
65. 00	06500 RESPI RATORY THERAPY	0	[C)	0	0	65. 00
66. 00	06600 PHYSI CAL THERAPY	0	[C)	0	0	66. 00
69. 00	06900 ELECTROCARDI OLOGY	0	(C)	0	0	69. 00
71. 00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0	(C)	0	0	71. 00
72. 00	07200 I MPL. DEV. CHARGED TO PATIENTS	0	C)	0	0	72. 00
73. 00	07300 DRUGS CHARGED TO PATIENTS	0	C		0 0	0	73. 00
	OUTPATIENT SERVICE COST CENTERS						
88. 00		0	C)	0	0	88. 00
88. 01	08801 RURAL HEALTH CLINIC II	0	C	1	0	0	88. 01
88. 02	08802 RURAL HEALTH CLINIC III	0	C	1	0	0	88. 02
88. 03	08803 RURAL HEALTH CLINIC IV	0	C	1	0	0	88. 03
90.00	09000 CLI NI C	0	C	1	0	0	90. 00
90. 01	09001 ST ANNE CLINIC	0	C)	0	0	90. 01
91. 00	09100 EMERGENCY	0	C	1	0	0	91. 00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART	0			0	0	92.00
	OTHER REIMBURSABLE COST CENTERS						
95. 00							95. 00
200. 0	Total (lines 50 through 199)	0	(1	0 0	0	200. 00

Health Financial Systems IROQUOIS MEMORIAL HOSPITAL
APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS Provider CCN: 14-1353 | In Lieu of Form CMS-2552-10 | Worksheet D | Part IV | 10/2023 | Date/Time Prepared: | 2/26/2024 1:42 pm Peri od: From 07/17/2023 To 09/30/2023 THROUGH COSTS

			Title	XVIII	Hospi tal	Cost	
	Cost Center Description	All Other	Total Cost	Total		Ratio of Cost	
	·	Medi cal	(sum of cols.	Outpati ent	(from Wkst. C,		
		Education Cost	1, 2, 3, and	Cost (sum of		(col. 5 ÷ col.	
			4)	col s. 2, 3,	8)	7)	
				and 4)		(see	
						instructions)	
		4. 00	5. 00	6. 00	7. 00	8. 00	
	ANCILLARY SERVICE COST CENTERS						
50. 00	05000 OPERATI NG ROOM	0	0	C	1, 900, 363		
53.00	05300 ANESTHESI OLOGY	0	0	0	26, 126		
54.00	05400 RADI OLOGY-DI AGNOSTI C	0	0	0	3, 278, 587		
57. 00	05700 CT SCAN	0	0	0	0	0. 000000	
58. 00	05800 MRI	0	0	0	0	0. 000000	
60.00	06000 LABORATORY	0	0	0	2, 423, 592	0. 000000	
65. 00	06500 RESPI RATORY THERAPY	0	0	0	116, 047		
66. 00	06600 PHYSI CAL THERAPY	0	0	0	762, 832		
69. 00	06900 ELECTROCARDI OLOGY	0	0	C	88, 979	0.000000	69. 00
71. 00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	C	264, 059		71. 00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0	0	C	36, 624	0.000000	72. 00
73.00	07300 DRUGS CHARGED TO PATIENTS	0	0	C	1, 075, 127	0.000000	73. 00
	OUTPAȚI ENT SERVI CE COST CENTERS						
88. 00	08800 RURAL HEALTH CLINIC	0	0	0	118, 008		
88. 01	08801 RURAL HEALTH CLINIC II	0	0	0	123, 697	0.000000	
88. 02	08802 RURAL HEALTH CLINIC III	0	0	C	159, 595		
88. 03	08803 RURAL HEALTH CLINIC IV	0	0	C	234, 680	0.000000	88. 03
90.00	09000 CLI NI C	0	0	C	220, 358		90. 00
90. 01	09001 ST ANNE CLINIC	0	0	C	16, 587	0.000000	90. 01
91.00	09100 EMERGENCY	0	0	C	1, 703, 928	0.000000	91. 00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART	0	0	C	304, 509	0.000000	92. 00
	OTHER REIMBURSABLE COST CENTERS						
95. 00							95. 00
200.00	Total (lines 50 through 199)	0	0	c	12, 853, 698		200. 00

Health Financial Systems IROQUOIS MEMORIAL HOSPITAL

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS Provider CCN: 14-1353 Period:

From 07/17/2023 Part IV THROUGH COSTS 09/30/2023 Date/Time Prepared: 2/26/2024 1:42 pm Title XVIII Hospi tal Cost Cost Center Description Outpati ent Inpati ent Outpati ent Inpatient Outpati ent Ratio of Cost Program Program Program Program Pass-Through Pass-Through to Charges Charges Charges Costs (col. Costs (col. $(col. 6 \div col$ x col. 10) 11.00 x col. 12) 13.00 7) 9.00 10.00 12.00 ANCILLARY SERVICE COST CENTERS 05000 OPERATING ROOM 50.00 50.00 0.000000 7, 358 0 0 0 0 0 0 0 0 0 0 05300 ANESTHESI OLOGY 53.00 0.000000 0 53.00 54.00 05400 RADI OLOGY-DI AGNOSTI C 0.000000 0 0 54.00 50, 613 57.00 05700 CT SCAN 0.000000 0 0 57.00 0 05800 MRI 0.000000 58.00 0 58.00 06000 LABORATORY 0 60.00 0.000000 35, 097 0 60.00 65.00 06500 RESPIRATORY THERAPY 0.000000 577 0 0 65.00 0 66.00 06600 PHYSI CAL THERAPY 0.000000 0 66.00 8, 319 0 06900 ELECTROCARDI OLOGY 0.000000 69.00 69.00 421 0 71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT 0.000000 24, 347 0 0 71.00 07200 IMPL. DEV. CHARGED TO PATIENTS 0.000000 0 0 72.00 697 0 72.00 07300 DRUGS CHARGED TO PATIENTS 0.000000 0 44, 756 73.00 73.00 0 OUTPATIENT SERVICE COST CENTERS 88.00 08800 RURAL HEALTH CLINIC 0 0 88.00 0.000000 0 0 0 0 0 0 08801 RURAL HEALTH CLINIC II 0.000000 88. 01 0 88. 01 Ω 08802 RURAL HEALTH CLINIC III 88.02 0.000000 0 0 88.02 88. 03 08803 RURAL HEALTH CLINIC IV 0.000000 C 0 0 88.03 09000 CLI NI C 0 90.00 0.000000 95 0 90.00 0 09001 ST ANNE CLINIC 90. 01 90 01 0.000000 C Ω 09100 EMERGENCY 0 91.00 0.000000 2,609 0 91.00 09200 OBSERVATION BEDS (NON-DISTINCT PART 0.000000 1, 578 0 0 0 92.00 OTHER REIMBURSABLE COST CENTERS

In Lieu of Form CMS-2552-10

95.00

0 200.00

0

0

176, 467

Worksheet D

95. 00 09500 AMBULANCE SERVICES

Total (lines 50 through 199)

200.00

Health Financial Systems IROQUOIS MEMORIAL HOSPITAL
APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST Provider CCN: 14-1353

| In Lieu of Form CMS-2552-10 | Worksheet D | Part V | B0/2023 | Date/Time Prepared: | 2/26/2024 1:42 pm Period: From 07/17/2023 To 09/30/2023

			Ti tl e	e XVIII	Hospi tal	Cost	
	·			Charges		Costs	
	Cost Center Description	Cost to Charge	PPS Reimbursed	Cost	Cost	PPS Services	
		Ratio From	Services (see	Rei mbursed	Rei mbursed	(see inst.)	
		Worksheet C,	inst.)	Servi ces	Services Not		
		Part I, col. 9		Subject To	Subject To		
				Ded. & Coins.	Ded. & Coins.		
				(see inst.)	(see inst.)		
		1.00	2.00	3. 00	4. 00	5. 00	
	ANCILLARY SERVICE COST CENTERS						
50.00	05000 OPERATING ROOM	0. 240306				0	
53.00	05300 ANESTHESI OLOGY	0. 319988		6, 199		0	
54.00	05400 RADI OLOGY-DI AGNOSTI C	0. 158583		950, 992	. 0	0	
57.00	05700 CT SCAN	0. 000000) c	0	0	57. 00
58. 00	05800 MRI	0. 000000	() c	0	0	58. 00
60.00	06000 LABORATORY	0. 189723	C	707, 073	0	0	60.00
65.00	06500 RESPIRATORY THERAPY	1. 649832	C	35, 708	0	0	65.00
66.00	06600 PHYSI CAL THERAPY	0. 688448	C	251, 159	0	0	66.00
69. 00	06900 ELECTROCARDI OLOGY	0. 111476	C	20, 020	0	0	69.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0. 018068	C	73, 855	0	0	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0. 462538	C	7, 337	0	0	72. 00
73.00	07300 DRUGS CHARGED TO PATIENTS	0. 573646	(316, 445	3, 106	0	73. 00
	OUTPATIENT SERVICE COST CENTERS						
88. 00	08800 RURAL HEALTH CLINIC						88. 00
88. 01	08801 RURAL HEALTH CLINIC II						88. 01
88. 02	08802 RURAL HEALTH CLINIC III						88. 02
88. 03	08803 RURAL HEALTH CLINIC IV						88. 03
90.00	09000 CLI NI C	0. 474973	(67, 171	115	0	90.00
90. 01	09001 ST ANNE CLINIC	2. 474649	() c	0	0	90. 01
91.00	09100 EMERGENCY	0. 567503	l c	359, 807	0	0	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART	1. 017809	l c	178, 679	0	0	92.00
	OTHER REIMBURSABLE COST CENTERS	•		•			
95.00	09500 AMBULANCE SERVI CES	0. 000000		C			95. 00
200.00	Subtotal (see instructions)			3, 525, 527	3, 221	0	200. 00
201.00	Less PBP Clinic Lab. Services-Program				0		201. 00
	Only Charges						
202.00	Net Charges (line 200 - line 201)		(3, 525, 527	3, 221	0	202. 00

Peri od: From 07/17/2023 To 09/30/2023

| In Lieu of Form CMS-2552-10 | Worksheet D | Part V | B0/2023 | Date/Time Prepared: | 2/26/2024 1:42 pm

			Title	XVIII	Hospi tal	Cost	
			sts				
	Cost Center Description	Cost	Cost				
		Reimbursed	Reimbursed				
		Servi ces	Servi ces Not				
		Subject To	Subject To				
			Ded. & Coins.				
		(see inst.)	(see inst.)				
		6. 00	7. 00				
	ANCILLARY SERVICE COST CENTERS						
50. 00	05000 OPERATING ROOM	132, 428		•			50. 00
53.00	05300 ANESTHESI OLOGY	1, 984	0				53. 00
54.00	05400 RADI OLOGY-DI AGNOSTI C	150, 811	0				54.00
57.00	05700 CT SCAN	0	0				57. 00
58. 00	05800 MRI	0	0				58. 00
60.00	06000 LABORATORY	134, 148	0				60.00
65.00	06500 RESPI RATORY THERAPY	58, 912	0				65. 00
66.00	06600 PHYSI CAL THERAPY	172, 910	0				66. 00
69.00	06900 ELECTROCARDI OLOGY	2, 232	0				69. 00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	1, 334	0				71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	3, 394	0				72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	181, 527	1, 782				73.00
	OUTPATIENT SERVICE COST CENTERS						
88. 00	08800 RURAL HEALTH CLINIC						88. 00
88. 01	08801 RURAL HEALTH CLINIC II						88. 01
88. 02	08802 RURAL HEALTH CLINIC III						88. 02
88. 03	08803 RURAL HEALTH CLINIC IV						88. 03
90.00	09000 CLI NI C	31, 904	55				90.00
90. 01	09001 ST ANNE CLINIC	0	0				90. 01
91.00	09100 EMERGENCY	204, 192	0				91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART	181, 861	0				92.00
	OTHER REIMBURSABLE COST CENTERS		•				
95.00	09500 AMBULANCE SERVICES	0					95. 00
200.00	Subtotal (see instructions)	1, 257, 637	1, 837				200. 00
201.00	,	0					201. 00
	Only Charges						
202.00		1, 257, 637	1, 837				202. 00

		Т	Λ									
Health Financial Systems					I RO <mark>Q</mark> UOI S	MEMORI A	L HOSPI	TAL			In Lie	u of Form CMS-2552-10
APPORTIONMENT OF INPATIENT	ROUTIN	IE SERVI	CE CA	PI TAL	COSTS		Provi	der CCN:	14-1353	Peri od:		Worksheet D

Worksheet D Part I Date/Time Prepared: From 07/17/2023 To 09/30/2023 2/26/2024 1: 42 pm Title XIX Hospi tal PPS Total Patient Per Diem (col. Days 3 / col. 4) Cost Center Description Capi tal Swing Bed Reduced Related Cost Adjustment Capi tal (from Wkst. B, Part II, col. Related Cost (col . 1 - col 26) 2) 1.00 2.00 3.00 4.00 5.00 INPATIENT ROUTINE SERVICE COST CENTERS 30. 00 ADULTS & PEDIATRICS 31, 465 99. 89 33, 663 2, 198 315 30.00 36, 756 70, 419 2, 004 44.00 SKILLED NURSING FACILITY 36, 756 18. 34 44. 00 200.00 Total (lines 30 through 199)

Cost Center Description 68, 221 2, 319 200. 00 I npati ent Inpati ent Program days Program Capital Cost (col. 5 x col 6) 6.00 7.00 INPATIENT ROUTINE SERVICE COST CENTERS 30. 00 ADULTS & PEDI ATRI CS 30.00 0 44.00 SKILLED NURSING FACILITY 0 44.00 200.00 Total (lines 30 through 199) 200. 00

I ROOUOIS MEMORIAL HOSPITAL L COSTS Provider CCN: 14-1353 In Lieu of Form CMS-2552-10

Peri od: Worksheet D
From 07/17/2023 Part II
To 09/30/2023 Date/Time Prepared: Health Financial Systems IROQUOIS NAPPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS

					10 07/30/2023	2/26/2024 1: 4	
			Ti tl	e XIX	Hospi tal	PPS	
	Cost Center Description	Capi tal	Total Charges	Ratio of Cost	I npati ent	Capital Costs	
		Related Cost	(from Wkst. C,	to Charges	Program	(column 3 x	
		(from Wkst. B,	Part I, col.	(col. 1 ÷ col	Charges	column 4)	
		Part II, col.	8)	2)			
		26)					
		1.00	2. 00	3.00	4. 00	5. 00	
	ANCI LLARY SERVI CE COST CENTERS						
		74, 194	1, 900, 363	•		0	50. 00
53.00		395	26, 126	l .		0	53. 00
		52, 121	3, 278, 587	0. 01589	7 0	0	54.00
57.00		0	0	0.00000		0	57. 00
58. 00	05800 MRI	0	0	0.00000	0	0	58. 00
60.00	06000 LABORATORY	16, 100	2, 423, 592	0.00664	3 0	0	60.00
65.00	06500 RESPI RATORY THERAPY	8, 554	116, 047	0. 07371	2 0	0	65. 00
66. 00	06600 PHYSI CAL THERAPY	35, 549	762, 832		1 0	0	66. 00
	06900 ELECTROCARDI OLOGY	2, 757	88, 979	0. 03098	5 0	0	69. 00
71. 00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	372	264, 059	0.00140	9 0	0	71. 00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	388	36, 624	0. 01059	4 0	0	72. 00
73.00		10, 959	1, 075, 127	0. 01019	3 0	0	73. 00
	OUTPATIENT SERVICE COST CENTERS						
88. 00	08800 RURAL HEALTH CLINIC	3, 372	118, 008	0. 02857	4 0	0	88. 00
88. 01	08801 RURAL HEALTH CLINIC II	9, 550	123, 697	0. 07720	5 0	0	88. 01
88. 02	08802 RURAL HEALTH CLINIC III	11, 387	159, 595	0. 07134	9 0	0	88. 02
88. 03	08803 RURAL HEALTH CLINIC IV	9, 800	234, 680	0. 04175	9 0	0	88. 03
90.00	09000 CLI NI C	14, 419	220, 358	0.06543	4 0	0	90.00
90. 01	09001 ST ANNE CLINIC	3, 285	16, 587	0. 19804	7 0	0	90. 01
91.00	09100 EMERGENCY	22, 404	1, 703, 928	0. 01314	8 0	0	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART	13, 960	304, 509	0. 04584	4 0	0	92.00
	OTHER REIMBURSABLE COST CENTERS						
95.00	09500 AMBULANCE SERVICES						95. 00
200.00	Total (lines 50 through 199)	289, 566	12, 853, 698		0	0	200. 00

I ROQUOIS MEMORIAL HOSPITAL Health Financial Systems

APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PASS THROUGH COSTS | Provider CCN: 14-1353 Worksheet D Part III Date/Time Prepared: Peri od: From 07/17/2023 09/30/2023 2/26/2024 1:42 pm Title XIX Hospi tal PPS Cost Center Description Nursi ng Nursi ng Allied Health Allied Health All Other Post-Stepdown Medi cal Cost Program Program Education Cost Post-Stepdown Adjustments Adjustments 1A 1.00 2A 2.00 3.00 INPATIENT ROUTINE SERVICE COST CENTERS 30.00 03000 ADULTS & PEDIATRICS 0 0 30.00 0 0 44.00 04400 SKILLED NURSING FACILITY 44.00 200.00 Total (lines 30 through 199) 200.00 Cost Center Description Swi ng-Bed Total Costs Total Patient Per Diem (col Inpati ent Adjustment (sum of cols. Days Program Days $5 \div col. 6$ Amount (see 1 through 3, <u>i nstructi ons)</u> minus col. 4) 4.00 5.00 6.00 7.00 8.00 INPATIENT ROUTINE SERVICE COST CENTERS 30. 00 03000 ADULTS & PEDIATRICS 315 0.00 0 30.00 44.00 |04400 | SKILLED NURSING FACILITY 0.00 C 2,004 Ω 44.00 200.00 Total (lines 30 through 199) 2, 319 0 200. 00 Cost Center Description I npati ent Program Pass-Through Cost (col. 7 x col . 8) 9.00 INPATIENT ROUTINE SERVICE COST CENTERS 30. 00 03000 ADULTS & PEDIATRICS 30.00 0 0 44.00 04400 SKILLED NURSING FACILITY 44.00

In Lieu of Form CMS-2552-10

200.00

200.00

Total (lines 30 through 199)

Heal th Financial Systems IROQUOIS MEMORIAL HOSPITAL

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS Provider CCN: 14-1353

In Lieu of Form CMS-2552-10 Peri od: Worksheet D From 07/17/2023 Part IV To 09/30/2023 Date/Time Prepared:

				10 07/30/2023	2/26/2024 1: 4	
		Ti tl	e XIX	Hospi tal	PPS	
Cost Center Description	Non Physician	Nursi ng	Nursi ng	Allied Health	Allied Health	
	Anestheti st	Program	Program	Post-Stepdown		
	Cost	Post-Stepdown		Adjustments		
		Adjustments				
	1.00	2A	2. 00	3A	3. 00	
ANCILLARY SERVICE COST CENTERS	1					
50. 00 05000 OPERATI NG ROOM	0	0		0	0	50. 00
53. 00 05300 ANESTHESI OLOGY	0	0		0	0	53. 00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	0	0		0	0	54. 00
57. 00 05700 CT SCAN	0	0		0	0	57. 00
58. 00 05800 MRI	0	0		0	0	58. 00
60. 00 06000 LABORATORY	0	0		0	0	60. 00
65. 00 06500 RESPI RATORY THERAPY	0	0		0	0	65. 00
66. 00 06600 PHYSI CAL THERAPY	0	0		0	0	66. 00
69. 00 06900 ELECTROCARDI OLOGY	0	0		0	0	69. 00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0	0		0	0	71. 00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0	0		0	0	72. 00
73.00 O7300 DRUGS CHARGED TO PATIENTS	0	0		0 0	0	73. 00
OUTPATIENT SERVICE COST CENTERS						
88. 00 08800 RURAL HEALTH CLINIC	0	0		0	0	88. 00
88.01 08801 RURAL HEALTH CLINIC II	0	0		0	0	88. 01
88.02 08802 RURAL HEALTH CLINIC III	0	0		0	0	88. 02
88.03 08803 RURAL HEALTH CLINIC IV	0	0		0	0	88. 03
90. 00 09000 CLI NI C	0	0		0	0	90. 00
90. 01 09001 ST ANNE CLINIC	0	0		0	0	90. 01
91. 00 09100 EMERGENCY	0	0		0	0	91. 00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART	0			0	0	92.00
OTHER REIMBURSABLE COST CENTERS						
95. 00 09500 AMBULANCE SERVI CES						95. 00
200.00 Total (lines 50 through 199)	0	0	1	0 0	0	200. 00

THROUGH COSTS

Health Financial Systems IROQUOIS MEMORIAL HOSPITAL
APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS Provider CCN: 14-1353 | In Lieu of Form CMS-2552-10 | Worksheet D | Part IV | 10/2023 | Date/Time Prepared: | 2/26/2024 1:42 pm Peri od: From 07/17/2023 To 09/30/2023 THROUGH COSTS

			Titl	e XIX	Hospi tal	PPS	
	Cost Center Description	All Other	Total Cost	Total	Total Charges	Ratio of Cost	
		Medi cal	(sum of cols.	Outpati ent	(from Wkst. C,		
		Education Cost	1, 2, 3, and	Cost (sum of		(col. 5 ÷ col.	
			4)	col s. 2, 3,	8)	7)	
				and 4)		(see	
						instructions)	
	1	4. 00	5. 00	6. 00	7. 00	8. 00	
	ANCILLARY SERVICE COST CENTERS		T		1		
50.00	05000 OPERATING ROOM	0	0	C	1, 900, 363		
53. 00	05300 ANESTHESI OLOGY	0	0	C	26, 126		
54.00	05400 RADI OLOGY-DI AGNOSTI C	0	0	0	3, 278, 587		
57. 00	05700 CT SCAN	0	0	0	0	0. 000000	
58. 00	05800 MRI	0	0	0	0	0. 000000	58. 00
60.00	06000 LABORATORY	0	0	0	2, 423, 592	0. 000000	
65. 00	06500 RESPI RATORY THERAPY	0	0	0	116, 047		
66. 00	06600 PHYSI CAL THERAPY	0	0	0	762, 832		
69. 00	06900 ELECTROCARDI OLOGY	0	0	C	88, 979	0.000000	69. 00
71. 00		0	0	C	264, 059		
72.00		0	0	C	36, 624		72. 00
73.00	07300 DRUGS CHARGED TO PATIENTS	0	0	C	1, 075, 127	0.000000	73. 00
	OUTPAȚI ENT SERVI CE COST CENTERS						
88. 00	08800 RURAL HEALTH CLINIC	0	0	0	118, 008		
88. 01	08801 RURAL HEALTH CLINIC II	0	0	C	123, 697	0.000000	88. 01
88. 02	08802 RURAL HEALTH CLINIC III	0	0	C	159, 595	0.000000	88. 02
88. 03	08803 RURAL HEALTH CLINIC IV	0	0	C	234, 680	0.000000	88. 03
90.00	09000 CLI NI C	0	0	C	220, 358	0.000000	90. 00
90. 01	09001 ST ANNE CLINIC	0	0	C	16, 587	0.000000	90. 01
91.00	09100 EMERGENCY	0	0	C	1, 703, 928	0.000000	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART	0	0	C	304, 509	0.000000	92.00
	OTHER REIMBURSABLE COST CENTERS						
95. 00							95. 00
200.00	Total (lines 50 through 199)	0	0	C	12, 853, 698		200. 00

I ROQUOIS MEMORIAL HOSPITAL Health Financial Systems APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS | Provider CCN: 14-1353 Peri od: From 07/17/2023

09/30/2023 Date/Time Prepared: 2/26/2024 1:42 pm Title XIX Hospi tal PPS Cost Center Description Outpati ent I npati ent Outpati ent Inpatient Outpati ent Ratio of Cost Program Program Program Program Pass-Through Pass-Through to Charges Charges Charges Costs (col. Costs (col. (col. 6 ÷ col x col. 10) 11.00 x col. 12) 13.00 7) 9.00 10.00 12.00 ANCILLARY SERVICE COST CENTERS 05000 OPERATING ROOM 50.00 50.00 0.000000 0 0 0 0 0 0 0 0 0 0 0 05300 ANESTHESI OLOGY 0.000000 53.00 0 0 53.00 54.00 05400 RADI OLOGY-DI AGNOSTI C 0.000000 0 0 0 54.00 57.00 05700 CT SCAN 0.000000 0 0 0 57.00 0 05800 MRI 0.000000 0 58.00 0 58.00 06000 LABORATORY 0 60.00 0.000000 0 0 60.00 65.00 06500 RESPIRATORY THERAPY 0.000000 0 0 65.00 06600 PHYSI CAL THERAPY 0 0 66.00 0.000000 0 66.00 0 06900 ELECTROCARDI OLOGY 0.000000 0 69.00 69.00 0 07100 MEDICAL SUPPLIES CHARGED TO PATIENT 71.00 0.000000 0 0 71.00 07200 IMPL. DEV. CHARGED TO PATIENTS 0.000000 0 0 72.00 0 72.00 07300 DRUGS CHARGED TO PATIENTS 0.000000 0 73.00 73.00 0 0 OUTPATIENT SERVICE COST CENTERS 88.00 08800 RURAL HEALTH CLINIC 0 0 88.00 0.000000 0 0 0 0 0 0 08801 RURAL HEALTH CLINIC II 0.000000 88. 01 0 0 88. 01 08802 RURAL HEALTH CLINIC III 88.02 0.000000 0 0 88.02 88. 03 08803 RURAL HEALTH CLINIC IV 0.000000 0 0 0 88.03 09000 CLI NI C 0.000000 0 90.00 0 0 90.00 0 09001 ST ANNE CLINIC 0 90. 01 90 01 0.000000 Ω 09100 EMERGENCY 0 91.00 0.000000 0 0 91.00 09200 OBSERVATION BEDS (NON-DISTINCT PART 0.000000 0 0 92.00 OTHER REIMBURSABLE COST CENTERS 95. 00 09500 AMBULANCE SERVICES 95.00

0

0

0

0 200.00

In Lieu of Form CMS-2552-10

Worksheet D

Part IV

THROUGH COSTS

200.00

Total (lines 50 through 199)

Health Financial Systems IROQUOIS MEMORIAL HOSPITAL
APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST Provider CCN: 14-1353 In Lieu of Form CMS-2552-10

Period: Worksheet D
From 07/17/2023 Part V
To 09/30/2023 Date/Time Prepared: 2/26/2024 1:42 pm

Title XIX Hospital PPS Cost Center Description Cost to Charges Cost Center Description Cost to Charge PPS Reimbursed Services (see Inst.) Services (see inst.) Services Subject To Ded. & Coins. (see inst.) Subject To Ded. & Coins. (see inst.) Services Subject To Ded. & Coins. (see inst.) Subject To Ded. & Coins. (see inst.
Cost Center Description Cost to Charge Ratio From Worksheet C, Part I, col. 9 PS Reimbursed Services (see inst.) Services Subject To Ded. & Coins. (see inst.) Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.) Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.) Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.) Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.) Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.) Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.) Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.) Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.) Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.) Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.) Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.) Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.) Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.) Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.) Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.) Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.) Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.) Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.) Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.) Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.) Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.) Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.) Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.) Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.) Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.) Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.) Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.) Cost Reimbursed Services Not Subject To D
Ratio From Worksheet C, Part I, col. 9 Services (see inst.) Subject To (see inst.) Ded. & Coins. (see inst.) Ded. & Coins. (see inst.) Services (see inst.) Subject To (see inst.) Ded. & Coins. (see inst.) Services (see inst.) Subject To (see inst.) Services (see inst.) Serv
Worksheet C, Part I, col. 9 inst.) Services Subject To Ded. & Coins. (see inst.) Services Subject To Ded. & Coins. (see inst.) Services Subject To Ded. & Coins. (see inst.) Services Subject To Ded. & Coins. (see inst.) Services Subject To Ded. & Coins. (see inst.) Services Subject To Ded. & Coins. (see inst.) Services Subject To Ded. & Coins. (see inst.) Services Not Subject To Ded. & Coins. (see inst.) Servi
Part I, col. 9 Subject To Ded. & Coins. (see inst.)
Ded. & Coins. (see inst.) Ded. & Coins. (see inst.)
See inst. See inst.
1.00 2.00 3.00 4.00 5.00
ANCI LLARY SERVI CE COST CENTERS
50. 00 05000 OPERATI NG ROOM 0. 240306 0 0 0 0 50. 00 53. 00 05300 ANESTHESI OLOGY 0. 319988 0 0 0 0 0 53. 00 54. 00 05400 RADI OLOGY-DI AGNOSTI C 0. 158583 0 0 0 0 54. 00
53. 00 05300 ANESTHESI OLOGY
54. 00 05400 RADI OLOGY-DI AGNOSTI C 0. 158583 0 0 0 0 54. 00
== aa a==aa a= aa a a a a a a a a a a a a
57. 00 05700 CT SCAN 0.000000 0 0 0 57. 00
58. 00 05800 MRI 0. 000000 0 0 0 58. 00
60. 00 06000 LABORATORY 0. 189723 0 0 0 60. 00
65. 00 06500 RESPI RATORY THERAPY
66. 00 06600 PHYSI CAL THERAPY
69. 00 06900 ELECTROCARDI OLOGY 0. 111476 0 0 0 69. 00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT 0.018068 0 0 0 0 71.00
72. 00 07200 I MPL. DEV. CHARGED TO PATIENTS 0. 462538 0 0 0 0 72. 00
73. 00 07300 DRUGS CHARGED TO PATIENTS 0. 573646 0 0 0 0 73. 00
OUTPATIENT SERVICE COST CENTERS
88. 00 08800 RURAL HEALTH CLINIC 88. 00
88. 01 08801 RURAL HEALTH CLINIC II
88. 02 08802 RURAL HEALTH CLINIC III
88. 03 08803 RURAL HEALTH CLINIC IV 88. 03
90. 00 09000 CLI NI C 0. 474973 0 0 0 0 90. 00
90. 01 09001 ST ANNE CLINIC 2. 474649 0 0 0 90. 01
91. 00 09100 EMERGENCY 0. 567503 0 0 0 0 0 91. 00
92. 00 09200 0BSERVATI ON BEDS (NON-DISTINCT PART 1. 017809 0 0 0 0 92. 00
OTHER REI MBURSABLE COST CENTERS
95. 00
200.00 Subtotal (see instructions) 0 0 0 0 200.00
201.00 Less PBP Clinic Lab. Services-Program 0 0 201.00
Only Charges
202.00 Net Charges (line 200 - line 201) 0 0 0 0 0 202.00

Period: From 07/17/2023 To 09/30/2023

Cost Center Description				Ti tl	e XIX	Hospi tal	PPS	
Rel imbursed Services Not Subject To Ded. & Colins.			Cos	sts				
ANCILLARY SERVICE COST CENTERS SerVI Ces Not Subject To Ded. & Colns. (see Inst.) (see Inst.)	Cos	st Center Description	Cost	Cost				
Subject To Ded. & Coin s. Cose Inst. Subject To Ded. & Coin s. Cose Ded. & Coin s.			Rei mbursed	Reimbursed				
Ded, & Colins. Csee inst. Ded, & Colins. Csee inst. Ded, & Colins. Csee inst. Ded, & Colins. Csee inst. Ded, & Colins. Csee inst. Ded, & Colins. Ded, &			Servi ces	Servi ces Not				
See inst. See inst. See inst.			Subject To	Subject To				
ANCI LLARY SERVICE COST CENTERS			Ded. & Coins.	Ded. & Coins.				
ANCILLARY SERVICE COST CENTERS			(see inst.)					
50. 00 05000 OPERATING ROOM 0 0 0 0 53. 00 05300 AMBESTHESI OLOGY 0 0 0 0 0 53. 00 05400 RADI OLOGY-DI AGNOSTI C 0 0 0 0 0 0 0 0 0			6. 00	7. 00				
53. 00 54. 00 55. 00 66. 00 66. 00 66. 00 66. 00 66. 00 66. 00 66. 00 66. 00 66. 00 66. 00 67. 00	ANCI LLAR	Y SERVICE COST CENTERS						
54. 00			0	C)			50.00
57. 00 05700 CT SCAN 0 0 0 0 58. 00 58. 00 60. 0	53. 00 05300 ANE	ESTHESI OLOGY	0	C				53.00
58. 00 05800 MRI 0 0 0 0 60. 00	54. 00 05400 RAD	DI OLOGY-DI AGNOSTI C	0	C				54.00
60. 00 06000 LABORATORY 0 0 0 0 650.00 RESPIRATORY THERAPY 0 0 0 0 0 650.00 665.00 06600 PHYSI CAL THERAPY 0 0 0 0 0 665.00 06900 ELECTROCARDI OLOGY 0 0 0 66.00 71.00 07100 MEDI CAL SUPPLIES CHARGED TO PATIENT 0 0 0 72.00 1MPL. DEV. CHARGED TO PATIENTS 0 0 0 0 0 73.00 DRUGS CHARGED TO PATIENTS 0 0 0 0 73.00 DRUGS CHARGED TO PATIENTS 0 0 0 0 73.00 DRUGS CHARGED TO PATIENTS 0 0 0 0 73.00 DRUGS CHARGED TO PATIENTS 0 0 0 0 73.00 DRUGS CHARGED TO PATIENTS 0 0 0 0 73.00 DRUGS CHARGED TO PATIENTS 0 0 0 0 73.00 DRUGS CHARGED TO PATIENTS 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	57. 00 05700 CT	SCAN	0	C				57.00
65. 00 06500 RESPIRATORY THERAPY 0 0 0 0 66.00 PHYSI CAL THERAPY 0 0 0 0 66.00 PHYSI CAL THERAPY 0 0 0 0 66.00 PHYSI CAL THERAPY 0 0 0 0 66.00 PHYSI CAL THERAPY 0 0 0 0 66.00 PHYSI CAL THERAPY 0 0 0 0 66.00 PHYSI CAL THERAPY 0 0 0 0 69.00 ELECTROCARDIOLOGY 0 0 0 69.00 71.00 PLOCATED THE TOTAL SUPPLIES CHARGED TO PATIENT 0 0 0 0 71.00 PLOCATED THE THE TOTAL SUPPLIES CHARGED TO PATIENT 0 0 0 0 72.00 PLOCATED THE THE SERVICE COST CENTERS 72.00 PLOCATED THE THE SERVICE COST CENTERS 73.00 PLOCATED THE THE SERVICE COST CENTERS 74.00 PLOCATED THE THE SERVICE COST CENTERS 75.00 PLOCATED THE THE PART PLOCATED THE PART PLOCATE	58. 00 05800 MRI	I	0	C				58.00
66. 00 06600 PHYSICAL THERAPY 0 0 0 0 69.00 69. 00 06900 ELECTROCARDIOLOGY 0 0 0 69.00 71. 00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT 0 0 0 771.00 72. 00 07200 IMPL. DEV. CHARGED TO PATIENTS 0 0 0 73.00 073.00 DRUGS CHARGED TO PATIENTS 0 0 0 0 73.00 073.00 DUTPATIENT SERVICE COST CENTERS 88. 00 08800 RURAL HEALTH CLINIC III 88. 02 08802 RURAL HEALTH CLINIC III 88. 01 88. 03 08803 RURAL HEALTH CLINIC III 88. 02 88. 03 08803 RURAL HEALTH CLINIC IV 88. 03 90. 00 09900 CLINIC 0 0 0 9900 CLINIC 0 90.00 90. 01 09901 ST ANNE CLINIC 0 0 0 99.00 91. 00 09900 ST ANNE CLINIC 0 0 0 99.00 92. 00 09500 PERCENCY 0 0 0 9900 DESERVATION BEDS (NON-DISTINCT PART 0 992.00 075. 00 09500 AMBULANCE SERVICES 0 09500 AMBULANCE SERVICES 0 000.00 000 CLINIC 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	60. 00 06000 LAE	BORATORY	0	C				60.00
69. 00 71	65. 00 06500 RES	SPI RATORY THERAPY	0	C				65.00
71. 00	66. 00 06600 PHY	YSI CAL THERAPY	0	C				66.00
72. 00	69. 00 06900 ELE	ECTROCARDI OLOGY	0	C				69.00
73. 00 07300 DRUGS CHARGED TO PATIENTS 0 0 0 0	71. 00 07100 MED	DICAL SUPPLIES CHARGED TO PATIENT	0	C				71.00
SECTION SUBSIDIES	72. 00 07200 I MF	PL. DEV. CHARGED TO PATIENTS	0	C				72.00
88. 00 88. 01 88. 01 88. 01 88. 02 88. 02 88. 03 89. 00 90. 01 90. 00 90. 01 90. 01 91. 00 91. 00 92. 00 92. 00 92. 00 94. 00 95. 00 95. 00 95. 00 95. 00 95. 00 95. 00 95. 00 95. 00 96. 01 96. 00 97. 00 98. 00 99. 01 90. 01	73. 00 07300 DRL	UGS CHARGED TO PATIENTS	0	C				73.00
88. 01 08801 RURAL HEALTH CLINIC II 88. 02 88. 03 RURAL HEALTH CLINIC II 88. 02 88. 03 08803 RURAL HEALTH CLINIC IV 88. 03 90. 00 09000 CLINIC 0 0 0 0 0 0 0 0 0	OUTPATI EN	NT SERVICE COST CENTERS						
88. 02	88. 00 08800 RUF	RAL HEALTH CLINIC						88.00
88. 03	88. 01 08801 RUF	RAL HEALTH CLINIC II						88. 01
90. 00 990.00 09000 CLINIC 0 0 0 0 990.00 90. 01 09001 ST ANNE CLINIC 0 0 0 0 91. 00 09100 EMERGENCY 0 0 0 92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART 0 0 0 0THER REIMBURSABLE COST CENTERS 95. 00 95. 00 09500 AMBULANCE SERVICES 0 0 200. 00 Subtotal (see instructions) 0 0 0 201. 00 Less PBP Clinic Lab. Services-Program 0 0 0 0nl y Charges 0 0 0 0nl y Charges	88. 02 08802 RUF	RAL HEALTH CLINIC III						88. 02
90. 01 09001 ST ANNE CLINIC 0 0 0 91. 00 91. 00 91. 00 92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART 0 0 0 0 0 0 0 0 0	88. 03 08803 RUF	RAL HEALTH CLINIC IV						88. 03
91. 00 09100 EMERGENCY 0 0 0 0 0 0 0 0 0	90. 00 09000 CLI	INIC	0	C				90.00
92. 00 09200 0BSERVATI ON BEDS (NON-DISTINCT PART 0 0 0 0 0 0 0 0 0	90. 01 09001 ST	ANNE CLINIC	0	C				90. 01
OTHER REIMBURSABLE COST CENTERS 95. 00 200. 00 201. 00 Uses PBP Clinic Lab. Services-Program Only Charges OTHER REIMBURSABLE COST CENTERS OD 95. 00 95. 00 95. 00 95. 00 200. 00 201. 00	91.00 09100 EME	ERGENCY	0	C				91.00
95. 00	92. 00 09200 OBS	SERVATION BEDS (NON-DISTINCT PART	0	C				92.00
200.00 Subtotal (see instructions)	OTHER REI	I MBURSABLE COST CENTERS			•			
201.00 Less PBP Ĉlinic Lab. Servićes-Program 0 0 201.00	95. 00 09500 AME	BULANCE SERVICES	0					95.00
201.00 Less PBP Clinic Lab. Services-Program 0 201.00 Only Charges	200. 00 Sub	btotal (see instructions)	0	C			2	200.00
Only Charges			0				2	201. 00
	202.00 Net	t Charges (line 200 - line 201)	0	C			2	202.00

In Lieu of Form CMS-2552-10 Worksheet D-1

Peri od: From 07/17/2023 To 09/30/2023 Date/Time Prepared: 2/26/2024 1:42 pm

		Title XVIII	Hospi tal	2/26/2024 1: 4: Cost	2 pm
	Cost Center Description	THE XVIII	nospi tai	0031	
				1. 00	
	PART I - ALL PROVIDER COMPONENTS INPATIENT DAYS				
1.00 2.00 3.00	Inpatient days (including private room days and swing-bed days Inpatient days (including private room days, excluding swing-bed and observation bed days)	vate room days.	367 315 0	1. 00 2. 00 3. 00	
	do not complete this line.				
4. 00 5. 00	Semi-private room days (excluding swing-bed and observation be Total swing-bed SNF type inpatient days (including private roo reporting period		31 of the cost	174 14	4. 00 5. 00
6. 00	Total swing-bed SNF type inpatient days (including private rooreporting period (if calendar year, enter 0 on this line)	8	6. 00		
7. 00	Total swing-bed NF type inpatient days (including private room reporting period	n days) through December	31 of the cost	30	7. 00
8. 00	Total swing-bed NF type inpatient days (including private room reporting period (if calendar year, enter 0 on this line)	n days) after December 31	of the cost	0	8. 00
9. 00	Total inpatient days including private room days applicable to newborn days) (see instructions)	0 ,		69	9. 00
10. 00	Swing-bed SNF type inpatient days applicable to title XVIII or through December 31 of the cost reporting period (see instruct	i ons)	,	14	10. 00
11. 00	Swing-bed SNF type inpatient days applicable to title XVIII or December 31 of the cost reporting period (if calendar year, er	nter O on this line)	,		11. 00
12. 00	Swing-bed NF type inpatient days applicable to titles V or XI) through December 31 of the cost reporting period	3	,	0	12. 00
13. 00	Swing-bed NF type inpatient days applicable to titles V or XI) after December 31 of the cost reporting period (if calendar ye	ear, enter O on this line	e)	0	13. 00
14. 00 15. 00	Medically necessary private room days applicable to the Progra Total nursery days (title V or XIX only)	am (excluding swing-bed o	lays)	0	14. 00 15. 00
16. 00	Nursery days (title V or XIX only)			0	16. 00
17. 00	SWING BED ADJUSTMENT Medicare rate for swing-bed SNF services applicable to service	es through December 31 of	the cost		17. 00
18. 00	reporting period Medicare rate for swing-bed SNF services applicable to service	es after December 31 of t	he cost		18. 00
19. 00	reporting period Medicaid rate for swing-bed NF services applicable to services reporting period	s through December 31 of	the cost	220. 00	19. 00
20. 00	Medicald rate for swing-bed NF services applicable to services reporting period	s after December 31 of th	e cost	220. 00	20. 00
21. 00 22. 00	Total general inpatient routine service cost (see instructions Swing-bed cost applicable to SNF type services through Decembe		ng period (line	747, 360 0	21. 00 22. 00
23. 00	5 x line 17) Swing-bed cost applicable to SNF type services after December x line 18)	31 of the cost reporting	period (line 6	0	23. 00
24. 00	Swing-bed cost applicable to NF type services through December 7×1 ine 19)	31 of the cost reportir	g period (line	6, 600	24. 00
25. 00	Swing-bed cost applicable to NF type services after December 3 x line 20)	31 of the cost reporting	period (line 8	0	25. 00
26. 00 27. 00	Total swing-bed cost (see instructions) General inpatient routine service cost net of swing-bed cost (PRIVATE ROOM DIFFERENTIAL ADJUSTMENT	(line 21 minus line 26)		54, 958 692, 402	
28. 00	General inpatient routine service charges (excluding swing-bed	and observation bed cha	irges)	0	28. 00
29. 00	Private room charges (excluding swing-bed charges)			0	29. 00
30.00	Semi-private room charges (excluding swing-bed charges)	line 20)		0 000000	30.00
31. 00 32. 00	General inpatient routine service cost/charge ratio (line 27 - Average private room per diem charge (line 29 - line 3)	- Tine 28)		0. 000000 0. 00	31. 00 32. 00
33. 00	Average semi-private room per diem charge (line 30 ÷ line 4)			0.00	33. 00
34. 00	Average per diem private room charge differential (line 32 mir	nus line 33)(see instruct	ions)	0.00	
35. 00	Average per diem private room cost differential (line 34 x lin		1 0113)	0.00	
36. 00	Private room cost differential adjustment (line 3 x line 35)			0	36. 00
37. 00	General inpatient routine service cost net of swing-bed cost a	and private room cost dif	ferential (line	692, 402	37. 00
	27 minus line 36)		•		
	PART II - HOSPITAL AND SUBPROVIDERS ONLY	ICTMENTO			
20.00	PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJU		Т	2 100 10	20.00
38.00	Adjusted general inpatient routine service cost per diem (see Program general inpatient routine service cost (line 9 x line			2, 198. 10	38.00
39. 00 40. 00	Medically necessary private room cost applicable to the Progra	,		151, 669 0	39. 00 40. 00
	Total Program general inpatient routine service cost (line 39	,		151, 669	
	, J. J. J. J. J. J. J. J. J. J. J. J. J.	/	'	, ,	

In Lieu of Form CMS-2552-10

82.00

83.00

84.00

85.00

86.00

87.00

141

2. 198. 10 88. 00

309, 932 89. 00

Peri od: Worksheet D-1 From 07/17/2023 09/30/2023 Date/Time Prepared: 2/26/2024 1:42 pm Title XVIII Hospi tal Cost Cost Center Description Total Total Average Per Program Days Program Cost (col. 3 x col. npatient Cost Inpatient Days Diem (col. col. 4) 1.00 3.00 2.00 4.00 5.00 42.00 NURSERY (title V & XIX only) 42.00 Intensive Care Type Inpatient Hospital Units INTENSIVE CARE UNIT 43.00 43.00 44.00 CORONARY CARE UNIT 44.00 BURN INTENSIVE CARE UNIT 45.00 45.00 46.00 SURGICAL INTENSIVE CARE UNIT 46.00 OTHER SPECIAL CARE (SPECIFY) 47.00 47.00 Cost Center Description 1 00 48.00 Program inpatient ancillary service cost (Wkst. D-3, col. 3, line 200) 52, 747 48.00 48.01 Program inpatient cellular therapy acquisition cost (Worksheet D-6, Part III, line 10, column 1) Λ 48 01 Total Program inpatient costs (sum of lines 41 through 48.01) (see instructions) 204, 416 49.00 PASS THROUGH COST ADJUSTMENTS Pass through costs applicable to Program inpatient routine services (from Wkst. D, sum of Parts I and 50.00 50.00 0 $\Pi\Pi$ 51.00 Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II 0 51.00 and IV) 52.00 Total Program excludable cost (sum of lines 50 and 51) 0 52.00 53.00 Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and 0 53.00 medical education costs (line 49 minus line 52) TARGET AMOUNT AND LIMIT COMPUTATION 54.00 Program discharges 54.00 Target amount per discharge 0.00 55.00 55.00 Permanent adjustment amount per discharge 0.00 55.01 55.01 Adjustment amount per discharge (contractor use only) 0.00 55.02 55.02 Target amount (line 54 x sum of lines 55, 55.01, and 55.02) 56.00 56.00 0 57.00 Difference between adjusted inpatient operating cost and target amount (line 56 minus line 53) 0 57.00 58.00 Bonus payment (see instructions) Λ 58.00 Trended costs (lesser of line 53 - line 54, or line 55 from the cost reporting period ending 1996, 0.00 59.00 updated and compounded by the market basket) 60.00 Expected costs (lesser of line 53 ÷ line 54, or line 55 from prior year cost report, updated by the 0.00 60.00 market basket) Continuous improvement bonus payment (if line 53 ÷ line 54 is less than the lowest of lines 55 plus 61.00 0 61.00 55.01, or line 59, or line 60, enter the lesser of 50% of the amount by which operating costs (line 53) are less than expected costs (lines 54 x 60), or 1 % of the target amount (line 56), otherwise enter zero. (see instructions) 62 00 Relief payment (see instructions) 62.00 Allowable Inpatient cost plus incentive payment (see instructions) 63.00 0 63.00 PROGRAM INPATIENT ROUTINE SWING BED COST Medicare swing-bed SNF inpatient routine costs through December 31 of the cost reporting period (See 30, 773 64.00 64.00 instructions)(title XVIII only) Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (See 65 00 -30, 773 65 00 instructions)(title XVIII only) 66.00 Total Medicare swing-bed SNF inpatient routine costs (line 64 plus line 65)(title XVIII only); for 0 66.00 CAH, see instructions 67.00 Title V or XIX swing-bed NF inpatient routine costs through December 31 of the cost reporting period 0 67.00 (line 12 x line 19) 68.00 Title V or XIX swing-bed NF inpatient routine costs after December 31 of the cost reporting period 0 68.00 (line 13 x line 20) Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68) 69.00 0 69.00 PART III - SKILLED NURSING FACILITY, OTHER NURSING FACILITY, AND ICF/IID ONLY 70.00 Skilled nursing facility/other nursing facility/ICF/IID routine service cost (line 37) 70.00 Adjusted general inpatient routine service cost per diem (line 70 \div line 2) 71.00 71.00 72.00 Program routine service cost (line 9 x line 71) 72.00 73.00 Medically necessary private room cost applicable to Program (line 14 x line 35) 73.00 74.00 Total Program general inpatient routine service costs (line 72 + line 73) 74.00 Capital-related cost allocated to inpatient routine service costs (from Worksheet B, Part II, column 75.00 75.00 26, line 45) Per diem capital-related costs (line 75 ÷ line 2) 76.00 77.00 Program capital-related costs (line 9 x line 76) 77.00 Inpatient routine service cost (line 74 minus line 77) 78 00 78 00 79.00 Aggregate charges to beneficiaries for excess costs (from provider records) 79.00 80.00 Total Program routine service costs for comparison to the cost limitation (line 78 minus line 79) 80.00 81.00 Inpatient routine service cost per diem limitation 81.00

82. 00 83. 00

84.00

85.00

86.00

87 00

88.00

Inpatient routine service cost limitation (line 9 x line 81)

Program inpatient ancillary services (see instructions)

89.00 Observation bed cost (line 87 x line 88) (see instructions)

Total observation bed days (see instructions)

PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST

Reasonable inpatient routine service costs (see instructions)

Utilization review - physician compensation (see instructions)

Total Program inpatient operating costs (sum of lines 83 through 85)

Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)

COMPUT	TATION OF INPATIENT OPERATING COST		Provi der Co		eriod: From 07/17/2023	Worksheet D-1	
					To 09/30/2023	Date/Time Prep 2/26/2024 1:43	
			Title	XVIII	Hospi tal	Cost	
	Cost Center Description	Cost	Routine Cost	column 1 ÷	Total	Observati on	
			(from line 21)	column 2	Observati on	Bed Pass	
					Bed Cost (from	Through Cost	
					line 89)	(col. 3 x col.	
						4) (see	
						instructions)	
		1.00	2. 00	3. 00	4. 00	5. 00	
	COMPUTATION OF OBSERVATION BED PASS THROUGH (COST					
90.00	Capi tal -rel ated cost	33, 663	747, 360	0. 04504	309, 932	13, 960	90.00
91.00	Nursing Program cost	0	747, 360	0.00000	309, 932	0	91.00
92.00	Allied health cost	0	747, 360	0.00000	309, 932	0	92.00
93.00	All other Medical Education	0	747, 360	0.00000	309, 932	0	93.00

In Lieu of Form CMS-2552-10 Worksheet D-1

Component CCN: 14-6049

Period: From 07/17/2023 To 09/30/2023

Date/Time Prepared: 2/26/2024 1:42 pm

Title XVIII

Skilled Nursing Facility PPS

		Facility		
	Cost Center Description	-	1. 00	
	PART I - ALL PROVIDER COMPONENTS		1.00	
	I NPATI ENT DAYS			
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)		2, 004	1. 00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)		2, 004	2.00
3. 00	Private room days (excluding swing-bed and observation bed days). If you have only private not complete this line.	ate room days,	0	3. 00
4.00	Semi-private room days (excluding swing-bed and observation bed days)		2, 004	4. 00
5. 00	Total swing-bed SNF type inpatient days (including private room days) through December	31 of the cost	0	5. 00
	reporting period			
6. 00	Total swing-bed SNF type inpatient days (including private room days) after December 31	of the cost	0	6. 00
7. 00	reporting period (if calendar year, enter 0 on this line) Total swing-bed NF type inpatient days (including private room days) through December 3	1 of the cost	0	7. 00
7.00	reporting period	1 of the cost	O	7.00
8.00	Total swing-bed NF type inpatient days (including private room days) after December 31	of the cost	0	8. 00
	reporting period (if calendar year, enter 0 on this line)			
9. 00	Total inpatient days including private room days applicable to the Program (excluding sinewborn days) (see instructions)	wing-bed and	47	9. 00
10. 00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room	m davs)	0	10.00
	through December 31 of the cost reporting period (see instructions)	,		
11. 00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room	m days) after	0	11. 00
12. 00	December 31 of the cost reporting period (if calendar year, enter 0 on this line) Swing-bed NF type inpatient days applicable to titles V or XIX only (including private)	room days)	0	12. 00
12.00	through December 31 of the cost reporting period	1 doil days)	O	12.00
13.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private	room days)	0	13.00
	after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		_	
14.00	Medically necessary private room days applicable to the Program (excluding swing-bed day Total nursery days (title V or XIX only)	ys)	0	14. 00 15. 00
15. 00 16. 00	Nursery days (title V or XIX only)		0	
10.00	SWING BED ADJUSTMENT		0	10.00
17. 00	Medicare rate for swing-bed SNF services applicable to services through December 31 of	the cost		17. 00
18. 00	reporting period Medicare rate for swing-bed SNF services applicable to services after December 31 of the	0.0001		18. 00
10.00	reporting period	e cost		10.00
19. 00	Medicaid rate for swing-bed NF services applicable to services through December 31 of the	he cost	0.00	19. 00
	reporting period			
20. 00	Medicald rate for swing-bed NF services applicable to services after December 31 of the reporting period	COST	0. 00	20. 00
21. 00	Total general inpatient routine service cost (see instructions)		731, 540	21. 00
22. 00	Swing-bed cost applicable to SNF type services through December 31 of the cost reporting	g period (line	0	22. 00
23. 00	5 x line 17)	noriad (line 4	0	23. 00
23.00	Swing-bed cost applicable to SNF type services after December 31 of the cost reporting $ x $ line 18)	perrou (Trile 6	U	23.00
24.00	Swing-bed cost applicable to NF type services through December 31 of the cost reporting	period (line	0	24.00
	7 x line 19)			
25. 00	Swing-bed cost applicable to NF type services after December 31 of the cost reporting $p(x)$ line 20)	eriod (line 8	0	25. 00
26. 00	Total swing-bed cost (see instructions)		0	26. 00
27. 00	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)		731, 540	27. 00
	PRIVATE ROOM DIFFERENTIAL ADJUSTMENT			
28. 00 29. 00	General inpatient routine service charges (excluding swing-bed and observation bed charger private room charges (excluding swing-bed charges)	ges)	0	28. 00 29. 00
30. 00	Semi -pri vate room charges (excluding swing-bed charges)		0	30. 00
31. 00	General inpatient routine service cost/charge ratio (line 27 ÷ line 28)		0. 000000	31. 00
32.00	Average private room per diem charge (line 29 ÷ line 3)		0.00	32.00
33. 00	Average semi-private room per diem charge (line 30 ÷ line 4)		0. 00	
34. 00	Average per diem private room charge differential (line 32 minus line 33)(see instruction	ons)	0.00	
35. 00 36. 00	Average per diem private room cost differential (line 34 x line 31) Private room cost differential adjustment (line 3 x line 35)		0. 00	35. 00 36. 00
37. 00	General inpatient routine service cost net of swing-bed cost and private room cost diffe	erential (line	731, 540	37.00
	27 minus line 36)	(2.72.00	
	PART II - HOSPITAL AND SUBPROVIDERS ONLY			
38. 00	PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS Adjusted general inpatient routine service cost per diem (see instructions)			38. 00
39. 00	Program general inpatient routine service cost (line 9 x line 38)			39. 00
40. 00	Medically necessary private room cost applicable to the Program (line 14 x line 35)			40. 00
41. 00	Total Program general inpatient routine service cost (line 39 + line 40)			41.00

Health Financial Systems
COMPUTATION OF INPATIENT OPERATING COST IROQUOIS MEMORIAL HOSPITAL Provi der CCN: 14-1353

In Lieu of Form CMS-2552-10
Worksheet D-1 Peri od: From 07/17/2023 To 09/30/2023 Date/Time Prepared: 2/26/2024 1:42 pm PPS Component CCN: 14-6049

Title XVIII Skilled Nursing

			11 11	e XVIII	Facility	PP3						
	Cost Center Description	Total	Total	Average Per	Program Days	Program Cost						
		Inpatient Cost	Inpatient Days		÷	(col. 3 x col.						
		1. 00	2.00	col . 2) 3.00	4. 00	4) 5. 00						
42. 00	NURSERY (title V & XIX only)	1.00	2.00	0.00	1. 00	0.00	42. 00					
	Intensive Care Type Inpatient Hospital Units											
43.00	INTENSIVE CARE UNIT						43. 00					
44. 00	CORONARY CARE UNIT						44. 00					
45. 00 46. 00	BURN INTENSIVE CARE UNIT SURGICAL INTENSIVE CARE UNIT			45. 00 46. 00								
47. 00	1						47. 00					
	Cost Center Description				,							
						1.00	48. 00					
48. 00												
48. 01 49. 00	Total Program inpatient certurar therapy acquisition of lines 4	,			corumn 1)		48. 01 49. 00					
47.00	PASS THROUGH COST ADJUSTMENTS	ri tili ougii 40. 0	1) (300 111311 40	. (1 0113)			47.00					
50.00	Pass through costs applicable to Program inpa	atient routine	services (from	n Wkst. D, sum	of Parts I and		50.00					
	111)											
51. 00	Pass through costs applicable to Program inpa	atient ancillar	y services (fr	om Wkst. D, si	um of Parts II		51. 00					
52. 00	and IV) Total Program excludable cost (sum of lines 5	50 and 51)					52. 00					
53. 00	Total Program inpatient operating cost exclude		lated, non-phy	sician anesth	etist, and		53.00					
	medical education costs (line 49 minus line 5											
	TARGET AMOUNT AND LIMIT COMPUTATION					Г						
54. 00 55. 00	Program di scharges						54. 00 55. 00					
55. 00	Target amount per discharge Permanent adjustment amount per discharge						55. 01					
55. 02	Adjustment amount per discharge (contractor u	use only)					55. 02					
56.00	Target amount (line 54 x sum of lines 55, 55.						56. 00					
57. 00	Difference between adjusted inpatient operati	ng cost and ta	rget amount (I	ine 56 minus	line 53)		57. 00					
58. 00 59. 00	Bonus payment (see instructions) Trended costs (lesser of line 53 ÷ line 54, c	ur line EE from	the east mans	usting popied	andina 100/		58.00					
59.00	updated and compounded by the market basket)	i ille 55 iloll	the cost repo	orting period (enarng 1996,		59. 00					
60. 00	Expected costs (lesser of line 53 ÷ line 54,	pdated by the		60.00								
	market basket)	,										
61. 00	Continuous improvement bonus payment (if line						61. 00					
	55.01, or line 59, or line 60, enter the less 53) are less than expected costs (lines 54 x											
	enter zero. (see instructions)), Otherwise										
62.00												
63. 00			63. 00									
	PROGRAM INPATIENT ROUTINE SWING BED COST		1 24 6 11			1						
64. 00	Medicare swing-bed SNF inpatient routine cost instructions)(title XVIII only)	s through Dece	mber 31 of the	e cost reportii	ng period (See		64. 00					
65.00	Medicare swing-bed SNF inpatient routine cost	s after Decemb	er 31 of the c	ost reporting	period (See		65. 00					
	instructions)(title XVIII only)											
66. 00	Total Medicare swing-bed SNF inpatient routin	ne costs (line	64 plus line 6	5)(title XVII	l only); for		66. 00					
67. 00	CAH, see instructions Title V or XIX swing-bed NF inpatient routine	costs through	December 31 c	of the cost re	norting period		67. 00					
07.00	(line 12 x line 19)	costs through	December 51 c	ine cost rep	por tring period		07.00					
68. 00	Title V or XIX swing-bed NF inpatient routine	costs after D	ecember 31 of	the cost repor	rting period		68. 00					
	(line 13 x line 20)											
69. 00	Total title V or XIX swing-bed NF inpatient r						69. 00					
70. 00	PART III - SKILLED NURSING FACILITY, OTHER NU Skilled nursing facility/other nursing facili					731, 540	70. 00					
71. 00	Adjusted general inpatient routine service co	,				365.04	71.00					
72. 00	Program routine service cost (line 9 x line 7					17, 157	72. 00					
73.00	Medically necessary private room cost applica	-	•			0	73. 00					
74. 00 75. 00	Total Program general inpatient routine servi Capital-related cost allocated to inpatient r				ort II column	17, 157 0	74. 00 75. 00					
75.00	26, line 45)	outine service	COSES (TOIL II	IOI KSHEEL D, F	art II, Corumii		75.00					
76.00	Per diem capital-related costs (line 75 ÷ lir		0.00	76. 00								
77. 00	Program capital-related costs (line 9 x line	,				0	77. 00					
78. 00	Inpatient routine service cost (line 74 minus	,		1-2		0	78. 00					
79. 00 80. 00	Aggregate charges to beneficiaries for excess Total Program routine service costs for compa				us line 70)	0	79. 00 80. 00					
81.00	Inpatient routine service costs for compa		ost rimitatiOl	. (1116 /0 111111	us 11110 /7)	0.00						
82. 00	Inpatient routine service cost limitation (li	0	82. 00									
83. 00												
84.00												
85. 00 86. 00	Utilization review - physician compensation (0 17, 479	85. 00 86. 00					
86. 00	Total Program inpatient operating costs (sum PART IV - COMPUTATION OF OBSERVATION BED PASS		rough 65)			17,479	30.00					
87. 00	Total observation bed days (see instructions)					0	87. 00					
88. 00	Adjusted general inpatient routine cost per o	diem (line 27 ÷	line 2)			0.00	88. 00					

СТЛТ						
Health Financial Systems	I ROQUOIS MEMOR	IAL HOSPITAL		In Lie	u of Form CMS-2	2552-10
COMPUTATION OF INPATIENT OPERATING COST		Provi der CC		Peri od:	Worksheet D-1	
				From 07/17/2023		
		Component C	CCN: 14-6049	To 09/30/2023	Date/Time Prep 2/26/2024 1:42	
		Title	XVIII	Skilled Nursing	PPS	
				Facility		
Cost Center Description						
		1. 00				
89.00 Observation bed cost (line 87 x line 88) (see		0	89. 00			
Cost Center Description	Cost	Routine Cost	column 1 ÷	Total	Observation	
		(from line 21)	column 2	Observati on	Bed Pass	
				Bed Cost (from	Through Cost	
				line 89)	(col. 3 x col.	
					4) (see	
					instructions)	
	1.00	2.00	3.00	4. 00	5. 00	
COMPUTATION OF OBSERVATION BED PASS THROUGH (COST					
90.00 Capital -related cost	0	0	0.00000	0 0	0	90.00
91.00 Nursing Program cost	o	ol	0.00000	o o	0	91.00
92.00 Allied health cost	o	ol	0.00000	ol o	0	92.00
93.00 All other Medical Education	o	o	0. 00000	ol ol	0	93. 00

In Lieu of Form CMS-2552-10
Period: Worksheet D-1
From 07/17/2023

		To 09/30/2023	Date/Time Pre 2/26/2024 1:4	
	Title XIX	Hospi tal	PPS	
Cost Center Description				
			1 00	

PART 1 - ALL PROVIDER COMPONENTS		litie XIX Hospital	PPS	
PART - ALL PROVIDER COMPONENTS		Cost Center Description	1 00	
Inpatient days (including private room days and swing-bod days, excluding newborn) 367 1.00 Inpatient days (including private room days, switching swing-bod and exhebron days) 318 2.00 Private room days (excluding swing-bod and observation bed days). If you have only private room days, 318 2.00 2		PART I - ALL PROVIDER COMPONENTS	1.00	
Impatient days (including private room days, excluding saing-bed and nebborn days) 315 2.00				
3.00 A	1.00			
do not complete this I I ne. Seel-private room days (excluding swing-bed and observation bed days) 174 4.00 175 5.00 176 105 105 105 105 105 105 105 105 105 105				
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41.00 Total Program general inpatient routine service cost (line 39 + line 40) 0 41.00	40.00	Medically necessary private room cost applicable to the Program (line 14 x line 35)		40.00
	41. 00	Total Program general inpatient routine service cost (line 39 + line 40)	, 0	41. 00

In Lieu of Form CMS-2552-10
Worksheet D-1

COMPUT	ATION OF INPATIENT OPERATING COST		Provi der C		Period: From 07/17/2023 To 09/30/2023	Date/Time Prep	
			Ti +I	e XIX	Hospi tal	2/26/2024 1: 42 PPS	2 pm
	Cost Center Description	Total Inpatient Cost	Total Inpatient Days	Average Per Diem (col. 1	Program Days	Program Cost (col. 3 x col.	
		1.00	2.00	col. 2) 3.00	4. 00	4) 5. 00	
42. 00	NURSERY (title V & XIX only)	1.00	2.00	3.00	4.00	3.00	42. 00
	Intensive Care Type Inpatient Hospital Units						
43. 00	INTENSIVE CARE UNIT		43. 00				
44. 00 45. 00	CORONARY CARE UNIT BURN INTENSIVE CARE UNIT		44. 00 45. 00				
46. 00	SURGICAL INTENSIVE CARE UNIT		46. 00				
47. 00	OTHER SPECIAL CARE (SPECIFY)						47. 00
	Cost Center Description					1.00	
48. 00	Program inpatient ancillary service cost (Wk	st. D-3, col. 3	3, line 200)			0	48. 00
48. 01	Program inpatient cellular therapy acquisiti	on cost (Worksh	neet D-6, Part		column 1)	0	
49. 00	`	41 through 48.0	01)(see instruc	tions)		0	49. 00
50. 00	PASS THROUGH COST ADJUSTMENTS Pass through costs applicable to Program inp	atient routine	services (from	ı Wkst. D. sum	of Parts I and	0	50. 00
51. 00	Pass through costs applicable to Program inp	atient ancilla	ry services (fr	om Wkst. D, s	um of Parts II	0	51. 00
52. 00	and IV) Total Program excludable cost (sum of lines	50 and 51)				ol	52. 00
53. 00	Total Program inpatient operating cost exclu		elated, non-phy	sician anesth	etist, and	0	53. 00
	medical education costs (line 49 minus line	52)					
54. 00	TARGET AMOUNT AND LIMIT COMPUTATION Program discharges					0	54. 00
55. 00	Target amount per discharge					0.00	
55. 01	Permanent adjustment amount per discharge					0.00	
55. 02 56. 00	Adjustment amount per discharge (contractor Target amount (line 54 x sum of lines 55, 55	J /				0.00	55. 02 56. 00
57. 00	Difference between adjusted inpatient operat			ine 56 minus	line 53)		57. 00
58. 00	Bonus payment (see instructions)		0	58. 00			
59. 00	Trended costs (lesser of line 53 ÷ line 54,	endi ng 1996,	0. 00	59. 00			
60. 00	updated and compounded by the market basket) Expected costs (lesser of line 53 ÷ line 54,	0.00	60. 00				
	market basket)						
61. 00	Continuous improvement bonus payment (if lin 55.01, or line 59, or line 60, enter the les		0	61. 00			
	53) are less than expected costs (lines 54 x						
	enter zero. (see instructions)	, ,	3	•			
62.00	Relief payment (see instructions) Allowable Inpatient cost plus incentive paym		0 0	62. 00 63. 00			
03.00	PROGRAM INPATIENT ROUTINE SWING BED COST	ent (see mstr	actions)			0	03.00
64. 00	Medicare swing-bed SNF inpatient routine cos	ts through Dece	ember 31 of the	cost reporti	ng period (See	0	64. 00
65. 00	<pre>instructions)(title XVIII only) Medicare swing-bed SNF inpatient routine cos</pre>	ts after Necemb	ner 31 of the c	ost reporting	neriod (See	o	65. 00
03.00	instructions)(title XVIII only)	its after beceili	bei 31 di the c	ost reporting	perrou (see	o l	03.00
66. 00	Total Medicare swing-bed SNF inpatient routi	ne costs (line	64 plus line 6	5)(title XVII	l only); for	0	66. 00
67. 00	CAH, see instructions Title V or XIX swing-bed NF inpatient routin	a costs through	n December 31 o	of the cost re	norting period		67. 00
07.00	(line 12 x line 19)	e costs thi ougi	i becember 31 c	i the cost re	por tring perrou	٥	07.00
68. 00	Title V or XIX swing-bed NF inpatient routin	e costs after l	December 31 of	the cost repo	rting period	0	68. 00
69. 00	(line 13 x line 20) Total title V or XIX swing-bed NF inpatient	routine costs	(line 67 ± line	68)		o	69. 00
07.00	PART III - SKILLED NURSING FACILITY, OTHER N						07.00
70. 00	Skilled nursing facility/other nursing facil	ity/ICF/IID row	utine service c	ost (line 37)			70. 00
71. 00 72. 00	Adjusted general inpatient routine service c Program routine service cost (line 9 x line		ine 70 ÷ line	2)			71. 00 72. 00
73. 00	Medically necessary private room cost applic		m (line 14 x li	ne 35)			73. 00
74. 00	Total Program general inpatient routine serv						74. 00
75. 00	Capital -related cost allocated to inpatient	routine service	e costs (from W	orksheet B, P	art II, column		75. 00
76. 00	26, line 45) Per diem capital-related costs (line 75 ÷ li	ne 2)					76. 00
77. 00	Program capital -related costs (line 9 x line	,					77. 00
78. 00	Inpatient routine service cost (line 74 minu						78. 00
79. 00 80. 00	Aggregate charges to beneficiaries for exces Total Program routine service costs for comp	, ,			us line 70)		79. 00 80. 00
81. 00	Inpatient routine service cost per diem limi		bost IIIII tation	(11116 70 111111	us Tine 77)		81. 00
82. 00	Inpatient routine service cost limitation (I		1)				82. 00
83.00	Reasonable inpatient routine service costs (ns)				83. 00
84. 00 85. 00	Program inpatient ancillary services (see in Utilization review - physician compensation		ons)				84. 00 85. 00
86. 00	Total Program inpatient operating costs (sum						86. 00
	PART IV - COMPUTATION OF OBSERVATION BED PAS	S THROUGH COST					
87. 00 88. 00	Total observation bed days (see instructions Adjusted general inpatient routine cost per	•	Line 2			141 2, 217. 69	87. 00 88. 00
89. 00	Observation bed cost (line 87 x line 88) (se		,			312, 694	

				Λ										
Health Financial Systems				\vdash	I RO	QUOIS M	EMOR <mark>I</mark> AL	_ HOSPI	TAL		T	In Lie	u of Form CMS-2552-10	0
COMPUTATION OF INPATIENT	OPERA	TI NG	COST					Provi	der CCN:	<mark>1</mark> 4-1353	Peri od:		Worksheet D-1	_

COMPUTATION OF INPATIENT OPERATING COST		Provi der CC		eriod: -rom 07/17/2023	Worksheet D-1	
				Γο 09/30/2023	Date/Time Pre	
					2/26/2024 1: 4:	2 pm
		Ti tl	e XIX	Hospi tal	PPS	
Cost Center Description	Cost	Routine Cost	column 1 ÷	Total	Observation	
		(from line 21)	column 2	Observati on	Bed Pass	
				Bed Cost (from	Through Cost	
				line 89)	(col. 3 x col.	
					4) (see	
					instructions)	
	1.00	2.00	3.00	4. 00	5. 00	
COMPUTATION OF OBSERVATION BED PASS THROUGH	COST					
90.00 Capital -related cost	33, 663	747, 360	0. 045043	3 312, 694	14, 085	90.00
91.00 Nursing Program cost	0	747, 360	0.000000	312, 694	0	91.00
92.00 Allied health cost	0	747, 360	0. 000000	312, 694	0	92.00
93.00 All other Medical Education	0	747, 360	0. 000000	312, 694	0	93. 00

Total (sum of lines 50 through 94 and 96 through 98)

Net charges (line 200 minus line 201)

Less PBP Clinic Laboratory Services-Program only charges (line 61)

In Lieu of Form CMS-2552-10 Peri od: Worksheet D-3

From 07/17/2023 09/30/2023 Date/Time Prepared: 2/26/2024 1:42 pm Title XVIII Hospi tal Cost Ratio of Cost Inpati ent Cost Center Description Inpati ent To Charges Program Costs Program (col. 1 x col. Charges 1.00 2.00 3.00 INPATIENT ROUTINE SERVICE COST CENTERS 30.00 03000 ADULTS & PEDIATRICS 92, 528 30.00 ANCILLARY SERVICE COST CENTERS 7, 358 50.00 05000 OPERATING ROOM 0.240306 1, 768 50.00 05300 ANESTHESI OLOGY 0. 319988 53.00 53.00 05400 RADI OLOGY-DI AGNOSTI C 0.158583 50, 613 54.00 8,026 54.00 05700 CT SCAN 0.000000 57.00 0 57.00 58.00 05800 MRI 0.000000 0 58.00 60.00 06000 LABORATORY 0.189723 35, 097 6, 659 60.00 06500 RESPIRATORY THERAPY 1.649832 952 65.00 577 65.00 06600 PHYSI CAL THERAPY 66.00 0.688448 8, 319 5, 727 66.00 69.00 06900 ELECTROCARDI OLOGY 0.111476 421 69.00 71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT 0.018068 24, 347 440 71.00 07200 IMPL. DEV. CHARGED TO PATIENTS 72.00 0.462538 697 322 72.00 73.00 07300 DRUGS CHARGED TO PATIENTS 0.573646 44, 756 25, 674 73.00 OUTPATIENT SERVICE COST CENTERS 08800 RURAL HEALTH CLINIC 88.00 0.000000 88.00 0 88. 01 08801 RURAL HEALTH CLINIC II 0.000000 0 88.01 88. 02 08802 RURAL HEALTH CLINIC III 0.000000 0 88.02 08803 RURAL HEALTH CLINIC IV 0.000000 88. 03 88.03 0 09000 CLI NI C 90 00 0.474973 95 45 90 00 90.01 09001 ST ANNE CLINIC 2.474649 0 0 90.01 09100 EMERGENCY 0.567503 91.00 2,609 1, 481 91.00 09200 OBSERVATION BEDS (NON-DISTINCT PART 92 00 1.017809 1, 578 1, 606 92.00 OTHER REIMBURSABLE COST CENTERS 95.00 09500 AMBULANCE SERVICES 95.00

200.00

201. 00

202.00

52, 747

176, 467

176, 467

200.00

201.00

202.00

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Provi der CCN: 14-1353 Health Financial Systems
INPATIENT ANCILLARY SERVICE COST APPORTIONMENT

In Lieu of Form CMS-2552-10
Worksheet D-3

		'			2/26/2024 1: 4:	2 pm
		Title	XVIII	Swing Beds - SNF	Cost	
Cost Center	Description Description		Ratio of Cos	t Inpatient	I npati ent	
			To Charges	Program	Program Costs	
				Charges	(col. 1 x col.	
					2)	
			1. 00	2. 00	3.00	
	SERVICE COST CENTERS					
30. 00 03000 ADULTS & PE						30. 00
ANCI LLARY SERVI CE						
50. 00 05000 OPERATING F			0. 24030		0	50.00
53. 00 05300 ANESTHESI OL	.OGY		0. 31998	88 0	0	53.00
54. 00 05400 RADI OLOGY-E	I AGNOSTI C		0. 15858	330	52	54.00
57.00 05700 CT SCAN			0.00000	0 0	0	57.00
58. 00 05800 MRI			0.00000	0 0	0	58. 00
60. 00 06000 LABORATORY			0. 18972	1, 207	229	60.00
65. 00 06500 RESPI RATORY	THERAPY		1. 64983	32 0	0	65. 00
66. 00 06600 PHYSI CAL TH	ERAPY		0. 68844	4, 484	3, 087	66. 00
69. 00 06900 ELECTROCARD	I OLOGY		0. 11147	'6 0	0	69. 00
71.00 07100 MEDICAL SUF	PLIES CHARGED TO PATIENT		0. 01806	9, 343	169	71. 00
72.00 07200 I MPL. DEV.	CHARGED TO PATIENTS		0. 46253	88 0	0	72. 00
73.00 07300 DRUGS CHARG	ED TO PATIENTS		0. 57364	6, 053	3, 472	73. 00
OUTPATIENT SERVIO	CE COST CENTERS					
88. 00 08800 RURAL HEALT	TH CLINIC		0.00000	00	0	88. 00
88. 01 08801 RURAL HEALT	H CLINIC II		0.00000	00	0	88. 01
88. 02 08802 RURAL HEALT	H CLINIC III		0.00000	00	0	88. 02
88. 03 08803 RURAL HEALT	H CLINIC IV		0.00000	00	0	88. 03
90. 00 09000 CLINIC			0. 47497	'3 0	0	90. 00
90. 01 09001 ST ANNE CLI	NI C		2. 47464	9 0	0	90. 01
91.00 09100 EMERGENCY			0. 56750	0	0	91. 00
92. 00 09200 OBSERVATI ON	BEDS (NON-DISTINCT PART		1. 01780	0	0	92.00
OTHER REIMBURSABL	LE COST CENTERS					
95. 00 09500 AMBULANCE S	ERVI CES					95. 00
200.00 Total (sum	of lines 50 through 94 and 96 through 98)			21, 417	7, 009	200. 00
201.00 Less PBP CI	inic Laboratory Services-Program only charges	(line 61)		0		201. 00
202.00 Net charges	(line 200 minus line 201)			21, 417		202. 00

Heal th Financial Systems IROQUOIS MEMORIAL HOSPITAL
INPATIENT ANCILLARY SERVICE COST APPORTIONMENT Provider CCN: 14-1353 Peri

L HOSPITAL In Lieu of Form CMS-2552-10
Provi der CCN: 14-1353 Peri od:
From 07/17/2023 Worksheet D-3
To 09/30/2023 Date/Time Prepared:
2/26/2024 1: 42 pm

95.00

201.00

202. 00

322 200. 00

467

467

Title XVIII Skilled Nursing PPS Facility Cost Center Description Ratio of Cost Inpati ent Inpati ent To Charges Program Program Costs Charges (col. 1 x col. 2) 1.00 2.00 3.00 INPATIENT ROUTINE SERVICE COST CENTERS 30.00 03000 ADULTS & PEDIATRICS 30.00 ANCILLARY SERVICE COST CENTERS 50.00 05000 OPERATING ROOM 0. 240306 0 50.00 53.00 05300 ANESTHESI OLOGY 0.319988 0 0 53.00 54. 00 05400 RADI OLOGY-DI AGNOSTI C 0 158583 54 00 0 05700 CT SCAN 57.00 0.000000 0 57.00 58. 00 | 05800 MRI 0.000000 0 58.00 0 60.00 06000 LABORATORY 0.189723 0 60.00 06500 RESPIRATORY THERAPY 1.649832 0 65.00 0 65.00 66.00 06600 PHYSI CAL THERAPY 0.688448 322 66.00 06900 ELECTROCARDI OLOGY 0 69.00 0.111476 0 69.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT 0.018068 71.00 71 00 0 07200 I MPL. DEV. CHARGED TO PATIENTS 72.00 0.462538 0 0 72.00 73.00 07300 DRUGS CHARGED TO PATIENTS 0.573646 0 73.00 OUTPATIENT SERVICE COST CENTERS 88. 00 0.000000 88 00 08800 RURAL HEALTH CLINIC 0 88. 01 08801 RURAL HEALTH CLINIC II 0.000000 0 88.01 08802 RURAL HEALTH CLINIC III 0.000000 0 88. 02 88. 02 88. 03 08803 RURAL HEALTH CLINIC IV 0.000000 0 88. 03 09000 CLI NI C 0.474973 90.00 90.00 0 90.01 09001 ST ANNE CLINIC 2.474649 0 0 90.01 09100 EMERGENCY 0.567503 0 91.00 91.00 0 09200 OBSERVATION BEDS (NON-DISTINCT PART 1.017809 92.00 92.00 0 0 OTHER REIMBURSABLE COST CENTERS

95.00

200.00

201.00

202.00

09500 AMBULANCE SERVICES

Total (sum of lines 50 through 94 and 96 through 98)

Net charges (line 200 minus line 201)

Less PBP Clinic Laboratory Services-Program only charges (line 61)

I ROQUOI S MEMORI AL HOSPI TAL

Provi der CCN: 14-1353 Health Financial Systems
INPATIENT ANCILLARY SERVICE COST APPORTIONMENT In Lieu of Form CMS-2552-10
Worksheet D-3 Peri od: Worksheet D-3 From 07/17/2023 To 09/30/2023 Date/Time Prepared:

				10 077 007 2020	2/26/2024 1: 4	
		Ti tl	e XIX	Hospi tal	PPS	
	Cost Center Description		Ratio of Cos	t Inpatient	I npati ent	
			To Charges	Program	Program Costs	
				Charges	(col. 1 x col.	
					2)	
			1. 00	2. 00	3. 00	
	I NPATI ENT ROUTI NE SERVI CE COST CENTERS		1		1	
30. 00	03000 ADULTS & PEDI ATRI CS)	30. 00
	ANCILLARY SERVICE COST CENTERS		1		_	
	05000 OPERATI NG ROOM		0. 24030		0	50. 00
			0. 31998		0	53. 00
			0. 15858		0	54. 00
	05700 CT SCAN		0.00000		0	57. 00
	05800 MRI		0.00000		0	58. 00
	06000 LABORATORY		0. 18972		0	60. 00
65.00			1. 64983		0	65. 00
			0. 68844		0	66. 00
			0. 11147		0	69. 00
	07100 MEDICAL SUPPLIES CHARGED TO PATIENT		0. 01806		0	71. 00
			0. 46253		0	72. 00
73. 00	07300 DRUGS CHARGED TO PATIENTS		0. 57364	16 C	0	73. 00
	OUTPATIENT SERVICE COST CENTERS					
	08800 RURAL HEALTH CLINIC		1. 01310		0	88. 00
	08801 RURAL HEALTH CLINIC II		1. 20643		0	88. 01
	08802 RURAL HEALTH CLINIC III		2. 09307		0	88. 02
	08803 RURAL HEALTH CLINIC IV		2. 54652		0	88. 03
	09000 CLI NI C		0. 47497	73 0	0	90. 00
	09001 ST ANNE CLINIC		2. 47464	19 C	0	90. 01
91. 00	09100 EMERGENCY		0. 56750	03	0	91. 00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART		1. 01780	09 0	0	92. 00
	OTHER REIMBURSABLE COST CENTERS					
	09500 AMBULANCE SERVI CES					95. 00
200.00				(C	0	200. 00
201.00		s (line 61)		(C)	201. 00
202.00	Net charges (line 200 minus line 201)			C)	202. 00

In Lieu of Form CMS-2552-10

Peri od: Worksheet E From 07/17/2023 | Worksheet E Part A Exhi bit 4 Date/Ti me Prepared: 2/26/2024 1:42 pm

No. Process						0 77 307 2023	2/26/2024 1: 4		
1.00 DRC grownts other than outlier 0.00 0.00 2.00 3.00 4.00 5.00 5.00 1.00			l ,				Hospi tal	Cost	
1.00 Des anounts other than outlier 1.00 0 0 0 0 0 0 0 0 0									
1.00 DRC amounts other than outlier 1.00 0 0 0 0 0 0 0 1.00									
1.01 PRG mounts other than nutlier 1.01 0 0 0 0 0 0 1.02	1.00	DRG amounts other than outlier							1. 00
Description Description									
1.00 1.00	1. 01		1. 01	0	0	(0	1. 01
1.02 DRG amounts other than outlier 1.02 0 0 0 0 0 0 1.02									
Degree Federal specific 1.03 0 0 0 0 0 0 0 0 0	1 00		1.00		0				1 00
1.03 100	1.02		1.02	U	U		0	0	1.02
1.05 Ref For Federal specific 1.03 0 0 0 0 0 0 0 1.03									
Departing payment for Model 4 BPC1 occurring prior to Colober 1 Colober		1							
BPCL occurring prior to	1.03		1. 03	0	0	(0	1. 03
October 1									
1.04 DRS for Federal Specific 1.04 0 0 0 0 0 0 1.04									
operating payment for Model 4 8PCL Occourring on a rafter 0.00 0.0000000 0.00000000	1 04		1 04	0	0		0	0	1 04
BPC occurring on or after	1.04		1.04	J	O			0	1.04
2.00 Outlier payments for 2.00 Outlier payments for 2.02 Outlier payments for 2.02 Outlier payments for 2.02 Outlier payments for 2.03 Outlier payments for 2.03 Outlier payments for 2.03 Outlier payments for 2.04 Outlier payments for 2.05 Outlier payments for 2.01 Outlier payments 2.01 Outlier payment									
discharges (see instructions) 2.00 0 0 0 0 0 0 2.01		October 1							
2.01 Outlier payments for	2.00		2. 00						2. 00
dischargies for Model 4 BPC 2.03	2 01		2 02	0	0	,	0	0	2 01
2.02 Outlier payments for	2.01		2.02	J	U			0	2.01
discharges occurring prior to 0	2. 02	, 3	2. 03	0	0	(0	2. 02
2.03 Outlier payments for disknesses occurring on or after October 1 (see instructions) 3.00 Operating outlier 2.01 O O O O O O O O O									
discharges occurring on or after October 1 (see instructions)			_						
after October 1 (see instructions) 3.00 0 0 0 0 0 0 0 0 0	2. 03		2. 04	0	0		0	0	2. 03
Instructions 0									
3.00 Operating outlier 2.01 0 0 0 0 0 0 0 0 0		`							
A.00 Managed care simulated 3.00 0 0 0 0 0 0 0 0 0	3.00		2. 01	0	0	(0	0	3. 00
Dayments Dayments Dayments Dayments Dayments Dayments Dayments Dayments Dayments Dayment Dayme									
Indi rect Medical Education Adjustment S.00	4. 00	_	3. 00	0	0	(0	0	4. 00
5.00 Amount from Worksheet E, Part 21.00 0.00000 0.000000 0.000000 0.000000 0.000000 0.00000000			ictmont						
A. line 21 (see instructions) Color Co	5. 00			0. 000000	0.000000	0. 000000	0.00000		5.00
Instructions									
Section Sect	6. 00		22. 00	0	0	(0	0	6. 00
managed care (see	6 01	1	22 01	0	0	,	0	0	6 01
Instructions Indirect Medical Education Adjustment for the Add-on for Section 422 of the MMA IME payment adjustment factor (see instructions)	0.01		22.01	J	O			0	0.01
10.00 ME payment adjustment factor (see instructions) 27.00 0.00000 0.000000 0.000000 0.000000 0.000000 0.000000 0.000000 0.000000 0.000000 0.000000 0.000000 0.000000 0.000000 0.000000 0.000000 0.000000 0.00000000									
See instructions See 28.00 0 0 0 0 0 0 0 0 0									
8.00 IME adjustment (see 28.00 0 0 0 0 0 0 8.00	7. 00		27. 00	0. 000000	0. 000000	0. 000000	0. 000000		7. 00
Instructions IME payment adjustment add on 28.01 0 0 0 0 0 0 0 8.01	8 00	,	28 00	0	0	(0	0	8 00
ME payment adjustment add on commanaged care (see instructions) 0	0.00		20.00	Ğ	J	`	1		0.00
Instructions	8. 01		28. 01	0	0	(0	0	8. 01
9.00 Total IME payment (sum of lines 6 and 8) 9.01 Total IME payment for managed care (sum of lines 6.01 and 8.01) 9.01 Total IME payment for managed care (sum of lines 6.01 and 8.01) 9.01 0 0 0 0 0 0 0 0 0									
I ines 6 and 8)	0.00		20.00		0	,			0.00
9.01 Total IME payment for managed care (sum of lines 6.01 and 8.01) Disproportionate Share Adjustment 10.00 Allowable disproportionate share aspectate (see instructions) 11.00 Disproportionate share aspectate (see instructions) 11.01 Uncompensated care payments	9.00		29.00	U	U) U	0	9.00
Care (sum of lines 6.01 and 8.01) Di sproporti onate Share Adjustment Di sproporti onate Share Adjustment Di sproporti onate share percentage (see instructi ons) Di sproporti onate share 34.00 0 0 0 0 0 0 0 0 0	9. 01		29. 01	0	0	(0	0	9. 01
Disproportionate Share Adjustment									
10.00 Allowable disproportionate share greentage (see instructions) 11.00 Disproportionate share adjustment (see instructions) 11.01 Uncompensated care payments 36.00 0 0 0 0 0 0 0 11.00 additional payment for high percentage of ESRD beneficiary discharges 12.00 Total ESRD additional payment (see instructions) 13.00 Subtotal (see instructions) 47.00 0 0 0 0 0 12.00 (see instructions) 14.00 Hospital specific payments 48.00 0 0 0 0 0 1,043,977 1,043,977 14.00 (completed by SCH and MDH, small rural hospitals only.) (see instructions) 15.00 Total payment for inpatient 49.00 0 0 0 0 0 0 0 0 15.00 operating costs (see instructions) 16.00 Payment for inpatient program 50.00 0 0 0 0 0 0 0 0 0 16.00 capital (from Wkst. L, Pt. I,									
Share percentage (see	10 00			0.0000	0 0000	0.000	0.0000		10 00
11.00 Disproportionate share 34.00 0 0 0 0 0 0 11.00	10.00		33.00	0.0000	0.0000	0.0000	0.0000		10.00
11.00 Disproportionate share 34.00 0 0 0 0 0 0 0 11.00									
11. 01 Uncompensated care payments 36. 00 0 0 0 0 0 11. 01 Additional payment for high percentage of ESRD beneficiary discharges 12. 00 Total ESRD additional payment 46. 00 0 0 0 0 0 12. 00 (see instructions) 13. 00 Subtotal (see instructions) 47. 00 0 0 0 0 0 0 13. 00 14. 00 Hospital specific payments 48. 00 0 0 0 1, 043, 977 1, 043, 977 14. 00 (completed by SCH and MDH, small rural hospitals only.) (see instructions) 15. 00 Total payment for inpatient 49. 00 0 0 0 0 0 0 0 15. 00 operating costs (see instructions) 16. 00 Payment for inpatient program 50. 00 0 0 0 0 0 0 0 16. 00 capital (from Wkst. L, Pt. I,	11. 00		34.00	0	0	(0	0	11. 00
Additional payment for high percentage of ESRD beneficiary discharges 12.00 Total ESRD additional payment			0,4 00						
12.00 Total ESRD additional payment (see instructions) 46.00 0 0 0 0 0 0 0 12.00 13.00 Subtotal (see instructions) 47.00 0 0 0 0 0 0 13.00 14.00 Hospital specific payments (completed by SCH and MDH, small rural hospitals only.) (see instructions) 15.00 Total payment for inpatient 49.00 0 0 0 0 0 0 0 15.00 16.00 Payment for inpatient program 50.00 0 0 0 0 0 0 16.00 16.00 Payment for inpatient program 50.00 0 0 0 0 0 0 16.00 16.00 O O O O O O O O O	11. 01			0	0) 0	0	11.01
(see instructions) 13.00 Subtotal (see instructions) 14.00 Hospital specific payments (completed by SCH and MDH, small rural hospitals only.) (see instructions) 15.00 Total payment for inpatient operating costs (see instructions) 16.00 Payment for inpatient program capital (from Wkst. L, Pt. I,	12 00			beneficiary o					12 00
13.00 Subtotal (see instructions) 47.00 0 0 0 0 13.00 14.00 Hospital specific payments (completed by SCH and MDH, small rural hospitals only.) (see instructions) 15.00 Total payment for inpatient operating costs (see instructions) 16.00 Payment for inpatient program 50.00 0 0 0 0 0 0 16.00 16.00 Payment for inpatient program 50.00 0 0 0 0 0 0 16.00 16.00 O O O O O O O O O	12.00		70.00	٩	U		_		12.00
14.00 Hospital specific payments (completed by SCH and MDH, small rural hospitals only.) (see instructions) 15.00 Total payment for inpatient operating costs (see instructions) 16.00 Payment for inpatient program capital (from Wkst. L, Pt. I,	13.00		47. 00	0	0		0	0	13. 00
small rural hospitals only.) (see instructions) 15.00 Total payment for inpatient 49.00 0 0 0 0 0 15.00 operating costs (see instructions) 16.00 Payment for inpatient program 50.00 0 0 0 0 0 0 16.00 capital (from Wkst. L, Pt. I,	14.00	Hospital specific payments	48. 00	0	0	(1, 043, 977	1, 043, 977	14. 00
(see instructions) 15.00 Total payment for inpatient 49.00 0 0 0 0 0 15.00 operating costs (see instructions) 16.00 Payment for inpatient program 50.00 0 0 0 0 0 16.00 capital (from Wkst. L, Pt. I,									
15.00 Total payment for inpatient 49.00 0 0 0 0 0 15.00 operating costs (see instructions) 16.00 Payment for inpatient program capital (from Wkst. L, Pt. I,									
operating costs (see instructions) 16.00 Payment for inpatient program capital (from Wkst. L, Pt. I,	15 00		49 00	0	0	,		^	15 00
instructions) 16.00 Payment for inpatient program 50.00 0 0 0 0 16.00 capital (from Wkst. L, Pt. I,	. 5. 00		77.00	٩	O				13.00
capital (from Wkst. L, Pt. I,		instructions)							
	16. 00		50.00	0	0	(0	0	16. 00
applicable)									
		μι αρμιτοαυίο)	ı	ı		ı	1	ı	ı

Heal th Financial Systems

LOW VOLUME CALCULATION EXHIBIT 4

IROQUOIS MEMORIAL HOSPITAL

Provider CCN: 14-1353 Per

In Lieu of Form CMS-2552-10

Peri od: Worksheet E
From 07/17/2023 Part A Exhibit 4
Date/Time Prepared: 2/26/2024 1:42 pm

							2/26/2024 1: 4:	2 pm
				Title	xVIII	Hospi tal	Cost	
		W/S E, Part A	Amounts (from	Pre/Post	Period Prior	Peri od	Total (Col 2	
		line	E, Part A)	Entitlement	to 10/01	On/After 10/01	through 4)	
		0	1, 00	2.00	3.00	4. 00	5, 00	
17. 00	Special add-on payments for	54.00	0	0		5, 917		17. 00
	new technologies			_			-,	
17. 01	Net organ aquisition cost							17. 01
17. 01	Credits received from	68.00	0	0		0	0	
17.02	manufacturers for replaced	00.00	O	0		3	O	17.02
	devices for applicable MS-DRGs							
18. 00			0	0				18. 00
18.00	Capital outlier reconciliation	93.00	U	U		J 0	0	18.00
	adjustment amount (see							
40.00	instructions)					5 047	F 047	40.00
19.00	SUBTOTAL			0		5, 917	5, 917	19. 00
		W/S L, line	(Amounts from					
			L)					
		0	1.00	2. 00	3. 00	4. 00	5. 00	
20.00	Capital DRG other than outlier		0	0		0	0	
20. 01	Model 4 BPCI Capital DRG other	1. 01	0	0		0	0	20. 01
	than outlier							
21.00	Capital DRG outlier payments	2. 00	0	0		0 0	0	21. 00
21. 01	Model 4 BPCI Capital DRG	2. 01	0	0		0	0	21. 01
	outlier payments							
22.00	Indirect medical education	5. 00	0. 0000	0.0000	0.000	0.0000		22. 00
	percentage (see instructions)							
23.00	Indirect medical education	6. 00	0	0		0	0	23. 00
	adjustment (see instructions)							
24.00	Allowable disproportionate	10.00	0. 0000	0.0000	0.000	0.0000		24. 00
	share percentage (see							
	instructions)							
25. 00	Di sproporti onate share	11. 00	0	0		0	0	25. 00
20.00	adjustment (see instructions)	11.00	J				Ŭ	20.00
26. 00	Total prospective capital	12.00	0	0		0	0	26. 00
20.00	payments (see instructions)	12.00	O	0		3	O	20.00
	payments (see mistructions)	W/S E, Part A	(Amounts to F					
		line	Part A)					
		0	1.00	2.00	3.00	4. 00	5. 00	
27. 00	Low volume adjustment factor	U	1.00	2.00	0.00000			27. 00
		70.0/			1			
28. 00	Low volume adjustment	70. 96				0	0	28. 00
	(transfer amount to Wkst. E,							
	Pt. A, line)					_	_	
29. 00	Low volume adjustment	70. 97				0	0	29. 00
	(transfer amount to Wkst. E,							
	Pt. A, line)							
100.00	Transfer low volume		Υ					100. 00
	adjustments to Wkst. E, Pt. A.							

I ROQUOI S MEMORI AL HOSPI TAL

Provi der CCN: 14-1353 Health Financial Systems
CALCULATION OF REIMBURSEMENT SETTLEMENT

In Lieu of Form CMS-2552-10

Worksheet E
17/2023 Part B
30/2023 Date/Time Prepared: 2/26/2024 1:42 pm
tal Cost Peri od: From 07/17/2023 To 09/30/2023 Title XVIII Hospi tal

	litle XVIII Hospital	Cost	
		1 00	
	DADT D. HEDIOAL AND CTUED HEALTH OFFICE	1. 00	
4 00	PART B - MEDICAL AND OTHER HEALTH SERVICES	4 050 474	4 00
1.00	Medical and other services (see instructions)	1, 259, 474	1. 00
2.00	Medical and other services reimbursed under OPPS (see instructions)	0	2. 00
3.00	OPPS or REH payments	0	3. 00
4.00	Outlier payment (see instructions)	0	4. 00
4. 01	Outlier reconciliation amount (see instructions)	0	4. 01
5.00	Enter the hospital specific payment to cost ratio (see instructions)	0. 000	5. 00
6.00	Line 2 times line 5	0	6. 00
7.00	Sum of lines 3, 4, and 4.01, divided by line 6	0.00	
8.00	Transitional corridor payment (see instructions)	0	8. 00
9.00	Ancillary service other pass through costs from Wkst. D, Pt. IV, col. 13, line 200	0	9. 00
10. 00	Organ acqui si ti ons	0	10. 00
11. 00	Total cost (sum of lines 1 and 10) (see instructions)	1, 259, 474	11. 00
	COMPUTATION OF LESSER OF COST OR CHARGES		
	Reasonable charges		
12. 00	Ancillary service charges		12. 00
13. 00	Organ acquisition charges (from Wkst. D-4, Pt. III, col. 4, line 69)	0	
14. 00	Total reasonable charges (sum of lines 12 and 13)	0	14. 00
	Customary charges		
15. 00	Aggregate amount actually collected from patients liable for payment for services on a charge basis	0	
16. 00	Amounts that would have been realized from patients liable for payment for services on a chargebasis	0	16. 00
47.00	had such payment been made in accordance with 42 CFR §413.13(e)		47.00
17. 00	Ratio of line 15 to line 16 (not to exceed 1.000000)	0. 000000	
18. 00	Total customary charges (see instructions)	0	18. 00
19. 00	Excess of customary charges over reasonable cost (complete only if line 18 exceeds line 11) (see	0	19. 00
	instructions)	_	
20. 00	Excess of reasonable cost over customary charges (complete only if line 11 exceeds line 18) (see	0	20. 00
	instructions)	4 070 0/0	
21. 00	Lesser of cost or charges (see instructions)	1, 272, 069	
22. 00	Interns and residents (see instructions)	0	
23. 00	Cost of physicians' services in a teaching hospital (see instructions)	0	23. 00
24. 00	Total prospective payment (sum of lines 3, 4, 4.01, 8 and 9)	0	24. 00
	COMPUTATION OF REIMBURSEMENT SETTLEMENT	400	
25. 00	Deductibles and coinsurance amounts (for CAH, see instructions)	409	
26. 00	Deductibles and Coinsurance amounts relating to amount on line 24 (for CAH, see instructions)	566, 258	
27. 00	Subtotal [(lines 21 and 24 minus the sum of lines 25 and 26) plus the sum of lines 22 and 23] (see	705, 402	27. 00
00.00	instructions)		00.00
28. 00	Direct graduate medical education payments (from Wkst. E-4, line 50)	0	28. 00
28. 50	REH facility payment amount		28. 50
29. 00	ESRD direct medical education costs (from Wkst. E-4, line 36)	705 400	
30.00	Subtotal (sum of lines 27, 28, 28.50 and 29)	705, 402	
31.00	Primary payer payments	0	
32. 00	Subtotal (line 30 minus line 31)	705, 402	32. 00
	ALLOWABLE BAD DEBTS (EXCLUDE BAD DEBTS FOR PROFESSIONAL SERVICES)		
33. 00		0	
34. 00	Allowable bad debts (see instructions)	0	34.00
35. 00	Adjusted reimbursable bad debts (see instructions)	0	35. 00
36.00	Allowable bad debts for dual eligible beneficiaries (see instructions)	0	36. 00
37. 00	Subtotal (see instructions)	705, 402	
	MSP-LCC reconciliation amount from PS&R		38. 00
39. 00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	0	
39. 50	Pioneer ACO demonstration payment adjustment (see instructions)		39. 50
39. 75	N95 respirator payment adjustment amount (see instructions)	0	
39. 97	Demonstration payment adjustment amount before sequestration	0	39. 97
39. 98	Partial or full credits received from manufacturers for replaced devices (see instructions)	0	39. 98
39. 99	RECOVERY OF ACCELERATED DEPRECIATION	0	39. 99
40. 00	Subtotal (see instructions)	705, 402	40. 00
40. 01	Sequestration adjustment (see instructions)	14, 108	40. 01
40. 02	Demonstration payment adjustment amount after sequestration	0	40. 02
40. 03	Sequestration adjustment-PARHM pass-throughs		40. 03
41.00	Interim payments	522, 031	41.00
41. 01	Interim payments-PARHM		41. 01
42.00	Tentative settlement (for contractors use only)	0	42.00
42. 01	Tentative settlement-PARHM (for contractor use only)		42. 01
43.00	Balance due provider/program (see instructions)	169, 263	
43. 01	Balance due provider/program-PARHM (see instructions)		43. 01
44.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1,	0	44.00
	§115. 2		
	TO BE COMPLETED BY CONTRACTOR		
90.00	Original outlier amount (see instructions)	94, 918	90. 00
91.00	Outlier reconciliation adjustment amount (see instructions)	0	91.00
92.00	The rate used to calculate the Time Value of Money	0.00	92.00
93.00	Time Value of Money (see instructions)	0	
94.00	Total (sum of lines 91 and 93)	0	
			·

Heal th Financial Systems IROQUOIS MEMORIAL HOSPITAL In Lieu of Form CMS-2552-10
CALCULATION OF REIMBURSEMENT SETTLEMENT

Provider CCN: 14-1353 Period:
From 07/17/2023 To 09/30/2023 Part B Date/Time Prepared: 2/26/2024 1: 42 pm

Title XVIII Hospital Cost

MEDICARE PART B ANCILLARY COSTS

200. 00 Part B Combined Billed Days

In Lieu of Form CMS-2552-10

Period:
From 07/17/2023 Part I
To 09/30/2023 Date/Time Prepared:
2/26/2024 1:42 pm
Cost

					2/26/2024 1: 42	2 pm
			XVIII	Hospi tal	Cost	
		I npati en	t Part A	Pai	rt B	
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount	
		1.00	2.00	3. 00	4.00	
1.00	Total interim payments paid to provider		276, 18	2	522, 031	1. 0
2. 00	Interim payments payable on individual bills, either			0	0	2. 0
	submitted or to be submitted to the contractor for					
	services rendered in the cost reporting period. If none,					
	write "NONE" or enter a zero					
3. 00	List separately each retroactive lump sum adjustment					3. 0
	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)					
	Program to Provider					
3. 01	ADJUSTMENTS TO PROVIDER			0	0	3.0
3. 02				0	0	3.0
3. 03				0	0	3. C
3. 04				0	0	3.0
3. 05				0	0	3.0
	Provider to Program					
3. 50	ADJUSTMENTS TO PROGRAM			0	0	3. 5
3. 51				0	0	3. 5
. 52				0	0	3. 5
. 53				0	0	3. !
3. 54				0	0	3. 5
3. 99	Subtotal (sum of lines 3.01-3.49 minus sum of lines			0	0	3. 9
	3. 50-3. 98)					
1.00	Total interim payments (sum of lines 1, 2, and 3.99)		276, 18	2	522, 031	4. 0
	(transfer to Wkst. E or Wkst. E-3, line and column as					
	appropri ate)					
5. 00	TO BE COMPLETED BY CONTRACTOR List separately each tentative settlement payment after	T	Ι	T		5. C
. 00	desk review. Also show date of each payment. If none,					5. 0
	write "NONE" or enter a zero. (1)					
	Program to Provider					
. 01	TENTATI VE TO PROVI DER			ol	1 0	5. 0
. 02	TENTATIVE TO TROVIDER			Ö		5. (
. 03				Ö		5. 0
. 03	Provider to Program			0		5. 0
. 50	TENTATI VE TO PROGRAM			ol	0	5. 5
. 51				Ö	0	5. 5
. 52				Ö		5. 5
5. 99	Subtotal (sum of lines 5.01-5.49 minus sum of lines			0		5. 9
	5. 50-5. 98)					0
. 00	Determined net settlement amount (balance due) based on					6. (
	the cost report. (1)					
. 01	SETTLEMENT TO PROVIDER			О	169, 263	6. (
. 02	SETTLEMENT TO PROGRAM		97, 31	3	0	6. C
7.00	Total Medicare program liability (see instructions)		178, 86		691, 294	7. 0
				Contractor	NPR Date	
				Number	(Mo/Day/Yr)	
)	1. 00	2.00	
3. 00	Name of Contractor	NATI ONAL GOVER	NMENT SERVICES	S 06101		8.0
		I NC.				

Heal th Financial Systems IROOL
ANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED IROQUOIS MEMORIAL HOSPITAL

In Lieu of Form CMS-2552-10 Provi der CCN: 14-1353 Peri od: From 07/17/2023 To 09/30/2023

Worksheet E-1 Part I Date/Time Prepared: 2/26/2024 1: 42 pm Component CCN: 14-Z353

		Title	XVIII Sv	ving Beds - SNF	Cost	
		Inpatien	t Part A		t B	
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount	
		1. 00	2. 00	3. 00	4. 00	
1.00	Total interim payments paid to provider		28, 063		0	1.00
2.00	Interim payments payable on individual bills, either		0		0	2. 00
	submitted or to be submitted to the contractor for					
	services rendered in the cost reporting period. If none,					
	write "NONE" or enter a zero					
3.00	List separately each retroactive lump sum adjustment					3.00
	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)					
	Program to Provider					
3. 01	ADJUSTMENTS TO PROVIDER		0		0	3. 01
3.02			0		0	3. 02
3.03			0		0	3. 03
3.04			0		0	3. 04
3.05			0		0	3. 05
	Provider to Program					
3.50	ADJUSTMENTS TO PROGRAM		0		0	3. 50
3. 51			0		0	3. 51
3.52			0		0	3. 52
3.53			0		0	3. 53
3.54			0		0	3.54
3.99	Subtotal (sum of lines 3.01-3.49 minus sum of lines		0		0	3. 99
	3. 50-3. 98)					
4.00	Total interim payments (sum of lines 1, 2, and 3.99)		28, 063		0	4.00
	(transfer to Wkst. E or Wkst. E-3, line and column as					
	appropri ate)					
	TO BE COMPLETED BY CONTRACTOR					
5.00	List separately each tentative settlement payment after					5. 00
	desk review. Also show date of each payment. If none,					
	write "NONE" or enter a zero. (1)					
	Program to Provider	Г	T	T		
5. 01	TENTATI VE TO PROVI DER		0		0	5. 01
5.02			0		0	5. 02
5.03			0		0	5. 03
	Provi der to Program	Г	1 -		_	
5. 50	TENTATI VE TO PROGRAM		0		0	5. 50
5. 51			0		0	5. 51
5. 52			0		0	5. 52
5. 99	Subtotal (sum of lines 5.01-5.49 minus sum of lines		0		0	5. 99
	5. 50-5. 98)					
6.00	Determined net settlement amount (balance due) based on					6. 00
. 01	the cost report. (1)					. 01
6. 01	SETTLEMENT TO PROVIDER		0		0	6. 01
6. 02	SETTLEMENT TO PROGRAM		21, 126		0	6. 02
7. 00	Total Medicare program liability (see instructions)		6, 937		0	7. 00
				Contractor	NPR Date	
			2	Number	(Mo/Day/Yr)	
8. 00	Name of Contractor		0	1. 00	2.00	8. 00
0.00	Inalie of Contractor	I			1	0.00

Heal th Financial Systems IROOL
ANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED IROQUOIS MEMORIAL HOSPITAL

Provi der CCN: 14-1353

Component CCN: 14-6049

In Lieu of Form CMS-2552-10
Worksheet E-1
17/2023 Part I
30/2023 Date/Time Prepared:
2/26/2024 1:42 pm
PPS Period: From 07/17/2023 To 09/30/2023

Title XVIII

Skilled Nursing

Inpatient Part A	
1.00 2.00 3.00 4.00	
1.00 2.00 3.00 4.00	
Interim payments payable on individual bills, either submitted or to be submitted to the contractor for services rendered in the cost reporting period. If none, write "NONE" or enter a zero	
submitted or to be submitted to the contractor for services rendered in the cost reporting period. If none, write "NONE" or enter a zero 3.00 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) Program to Provider 3.01 3.02 0 0 0 3.03 0 0 0 0 3.04 0 0 0 3.05 Provider to Program 3.50 ADJUSTMENTS TO PROGRAM 0 0 0 3.51 0 0 0 3.51 0 0 0 0 3.52 0 0 0 0 3.53 0 0 0 0 3.53 0 0 0 0 3.54 0 0 0 0 3.55 0 0 0 0 3.59 Subtotal (sum of lines 3.01-3.49 minus sum of lines 0 0 0 3.50-3.98) 0 0 0 0 4.00 0 0 0 5.50 0	1. 00
Services rendered in the cost reporting period. If none, write "NONE" or enter a zero 3.00 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) Program to Provider 3.01 ADJUSTMENTS TO PROVIDER 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	2. 00
write "NONE" or enter a zero 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) Program to Provider 3. 01 3. 02 3. 03 3. 04 4. 00 0 3. 05 Provider to Program ADJUSTMENTS TO PROGRAM 0 0 0 3. 50 3. 51 3. 52 3. 53 3. 54 4. 00 3. 59 Subtotal (sum of lines 3. 01-3. 49 minus sum of lines 3. 50-3. 98) 4. 00 Total interim payments (sum of lines 1, 2, and 3. 99) (transfer to Wkst. E or Wkst. E-3, line and column as appropriate) To BE COMPLETED BY CONTRACTOR List separately each tentative settlement payment after	
3.00 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) Program to Provider 3.01 ADJUSTMENTS TO PROVIDER 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	
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) Program to Provider 3.01 3.02 3.03 0 0 0 0 3.04 3.05 Provider to Program ADJUSTMENTS TO PROGRAM 3.50 3.51 3.52 3.53 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	
For the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1)	3. 00
payment. If none, write "NONE" or enter a zero. (1)	
Program to Provider ADJUSTMENTS TO PROVIDER O O O	
3.01	
3.02 3.03 3.04 3.04 3.05 Provider to Program ADJUSTMENTS TO PROGRAM 3.50 3.51 3.52 3.53 3.54 3.99 Subtotal (sum of lines 3.01-3.49 minus sum of lines 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	3. 01
3. 03 3. 04 3. 05 Provider to Program 3. 50 ADJUSTMENTS TO PROGRAM O 0 0 0 3. 51 3. 52 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	3. 02
3. 04 3. 05 Provider to Program 3. 50 ADJUSTMENTS TO PROGRAM O 0. 0 0. 0 0. 3. 51 3. 52 3. 53 0. 0 0. 0 0. 0 0. 0 0. 0 0. 0 0. 0 0.	3. 03
3. 05 Provider to Program	3. 04
Provider to Program	3. 05
3.50 ADJUSTMENTS TO PROGRAM 0 0 0 3.51 0 0 0 3.52 0 0 0 0 3.53 0 0 0 0 3.54 0 0 0 0 3.79 Subtotal (sum of lines 3.01-3.49 minus sum of lines 0 0 0 0 3.50-3.98) 4.00 Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Wkst. E or Wkst. E-3, line and column as appropriate) TO BE COMPLETED BY CONTRACTOR List separately each tentative settlement payment after	0.00
3. 52 3. 53 3. 54 3. 59 3. 59 3. 50-3. 98) 4. 00 Total interim payments (sum of lines 1, 2, and 3. 99) (transfer to Wkst. E or Wkst. E-3, line and column as appropriate) TO BE COMPLETED BY CONTRACTOR List separately each tentative settlement payment after	3. 50
3.53 3.54 3.99 Subtotal (sum of lines 3.01-3.49 minus sum of lines 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	3. 51
3.54 3.99 Subtotal (sum of lines 3.01-3.49 minus sum of lines 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	3. 52
3. 99 Subtotal (sum of lines 3.01-3.49 minus sum of lines 0 0 3.50-3.98) 4. 00 Total interim payments (sum of lines 1, 2, and 3.99) 23,339 0 (transfer to Wkst. E or Wkst. E-3, line and column as appropriate) TO BE COMPLETED BY CONTRACTOR List separately each tentative settlement payment after	3. 53
3.50-3.98) 4.00 Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Wkst. E or Wkst. E-3, line and column as appropriate) TO BE COMPLETED BY CONTRACTOR List separately each tentative settlement payment after	3. 54
4.00 Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Wkst. E or Wkst. E-3, line and column as appropriate) TO BE COMPLETED BY CONTRACTOR 5.00 List separately each tentative settlement payment after	3. 99
(transfer to Wkst. E-3, line and column as appropriate) TO BE COMPLETED BY CONTRACTOR List separately each tentative settlement payment after	
appropriate) TO BE COMPLETED BY CONTRACTOR 5.00 List separately each tentative settlement payment after	4. 00
TO BE COMPLETED BY CONTRACTOR 5.00 List separately each tentative settlement payment after	
5.00 List separately each tentative settlement payment after	
	5. 00
desk review. Also show date of each payment. If none, write "NONE" or enter a zero. (1)	
Program to Provider	
5. 01 TENTATI VE TO PROVI DER 0 0	5. 01
5. 02 0 0 0	5. 02
5.03	5. 02
Provider to Program	0.00
5.50 TENTATIVE TO PROGRAM OI 0	5. 50
5.51	5. 51
5.52	5. 52
5. 99 Subtotal (sum of lines 5. 01-5. 49 minus sum of lines 0 0 5. 50-5. 98)	5. 99
6.00 Determined net settlement amount (balance due) based on	6. 00
the cost report. (1)	3. 50
6.01 SETTLEMENT TO PROVIDER 0	6. 01
6.02 SETTLEMENT TO PROGRAM 0 0	6. 02
7.00 Total Medicare program liability (see instructions) 23,339 0	7. 00
Contractor NPR Date	
Number (Mo/Day/Yr)	
0 1.00 2.00	
8.00 Name of Contractor NATIONAL GOVERNMENT SERVICES 06101	8. 00
I NC.	

Health Financial Systems
CALCULATION OF REIMBURSEMENT SETTLEMENT FOR HIT I ROQUOIS MEMORIAL HOSPITAL

In Lieu of Form CMS-2552-10 Worksheet E-1

ALCOLATION OF RETWINDING SETTLEMENT FOR THE	Frovider Colv. 14-1333	From 07/17/2023 To 09/30/2023	Part II Date/Time Prep 2/26/2024 1:42	
	Title XVIII	Hospi tal	Cost	
			1.00	
TO BE COMPLETED BY CONTRACTOR FOR MONSTANDARD COST REPORTS				

				2/26/2024 1:	: 42 pm
		Title XVIII	Hospi tal	Cost	
				1. 00	
	TO BE COMPLETED BY CONTRACTOR FOR NONSTANDARD COST REPORTS				
	HEALTH INFORMATION TECHNOLOGY DATA COLLECTION AND CALCULATION				
1.00	Total hospital discharges as defined in AARA §4102 from Wkst.	S-3, Pt. I col. 15 line	e 14		1. 00
2.00	Medicare days (see instructions)				2. 00
3.00	Medicare HMO days from Wkst. S-3, Pt. I, col. 6. line 2				3. 00
4.00	Total inpatient days (see instructions)				4. 00
5.00	Total hospital charges from Wkst C, Pt. I, col. 8 line 200				5. 00
6.00	Total hospital charity care charges from Wkst. S-10, col. 3 l				6. 00
7.00	CAH only - The reasonable cost incurred for the purchase of co	ertified HIT technology	Wkst. S-2, Pt. I	1	7. 00
	line 168				
8. 00	Calculation of the HIT incentive payment (see instructions)				8. 00
9.00	Sequestration adjustment amount (see instructions)				9. 00
10.00	Calculation of the HIT incentive payment after sequestration	(see instructions)			10. 00
	INPATIENT HOSPITAL SERVICES UNDER THE IPPS & CAH				
30.00	Initial/interim HIT payment adjustment (see instructions)				30. 00
31. 00	Other Adjustment (specify)				31. 00
32.00	Balance due provider (line 8 (or line 10) minus line 30 and l	ine 31) (see instruction	ns)		32.00

IROQUOIS MEMORIAL HOSPITAL

Health Financial Systems

CALCULATION OF REIMBURSEMENT SETTLEMENT -In Lieu of Form CMS-2552-10
Worksheet E-2 Peri od: From 07/17/2023 To 09/30/2023 Date/Ti me Prepared: 2/26/2024 1: 42 pm Cost SWING BEDS Provi der CCN: 14-1353 Component CCN: 14-Z353

	oomponent som 11 2500	7,7 00,7 2020	2/26/2024 1: 4	2 pm
	Title XVIII	Swing Beds - SNF		
		Part A	Part B	
	COMPUTATION OF NET COST OF COVERED SERVICES	1. 00	2. 00	
1.00	Inpatient routine services - swing bed-SNF (see instructions)	0	0	1.00
2.00	Inpatient routine services - swing bed-NF (see instructions)			2. 00
3.00	Ancillary services (from Wkst. D-3, col. 3, line 200, for Part A, and sum of Wkst. [), 7,079	0	3. 00
	Part V, cols. 6 and 7, line 202, for Part B) (For CAH and swing-bed pass-through, se	ee		
	instructions)			
3. 01	Nursing and allied health payment-PARHM (see instructions)			3. 01
4. 00	Per diem cost for interns and residents not in approved teaching program (see		0. 00	4. 00
5. 00	instructions) Program days	0	0	5. 00
6. 00	Interns and residents not in approved teaching program (see instructions)		0	
7. 00	Utilization review - physician compensation - SNF optional method only	0	Ü	7. 00
8.00	Subtotal (sum of lines 1 through 3 plus lines 6 and 7)	7, 079	0	8. 00
9.00	Primary payer payments (see instructions)	0	0	9. 00
10.00	Subtotal (line 8 minus line 9)	7, 079	0	10.00
11. 00	Deductibles billed to program patients (exclude amounts applicable to physician	0	0	11. 00
	professional services)		_	
12.00	Subtotal (line 10 minus line 11)	7, 079	0	1
13. 00	Coinsurance billed to program patients (from provider records) (exclude coinsurance	0	0	13. 00
14. 00	for physician professional services) 80% of Part B costs (line 12 x 80%)		0	14. 00
15. 00	Subtotal (see instructions)	7, 079	0	15. 00
16. 00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	0	0	16. 00
16. 50	Pioneer ACO demonstration payment adjustment (see instructions)			16. 50
16. 55	Rural community hospital demonstration project (§410A Demonstration) payment	0		16. 55
	adjustment (see instructions)			
16. 99	Demonstration payment adjustment amount before sequestration	0	0	16. 99
17. 00	Allowable bad debts (see instructions)	0	0	
17. 01	Adjusted reimbursable bad debts (see instructions)	0	0	1
18. 00 19. 00	Allowable bad debts for dual eligible beneficiaries (see instructions) Total (see instructions)	7, 079	0	
19. 00	Sequestration adjustment (see instructions)	142	0	
19. 02	Demonstration payment adjustment amount after sequestration)	0	0	
19. 03	Sequestration adjustment-PARHM pass-throughs		Ü	19. 03
19. 25	Sequestration for non-claims based amounts (see instructions)	0	0	
20.00	Interim payments	28, 063	0	20.00
20. 01	Interim payments-PARHM			20. 01
21. 00	Tentative settlement (for contractor use only)	0	0	21. 00
21. 01	Tentative settlement-PARHM (for contractor use only)		_	21. 01
22. 00	Balance due provider/program (line 19 minus lines 19.01, 19.02, 19.25, 20, and 21)	-21, 126	0	
22. 01	Balance due provider/program-PARHM (see instructions)	0	0	22. 01
23. 00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2	0	U	23. 00
	Rural Community Hospital Demonstration Project (§410A Demonstration) Adjustment			
200.00	Is this the first year of the current 5-year demonstration period under the 21st			200. 00
	Century Cures Act? Enter "Y" for yes or "N" for no.			
	Cost Reimbursement			
201.00	Medicare swing-bed SNF inpatient routine service costs (from Wkst. D-1, Pt. II, line)		201. 00
000 00	66 (title XVIII hospital))			000 00
202.00	Medicare swing-bed SNF inpatient ancillary service costs (from Wkst. D-3, col. 3, li 200 (title XVIII swing-bed SNF))	ne		202. 00
203 OC	Total (sum of lines 201 and 202)			203. 00
	Medicare swing-bed SNF discharges (see instructions)			204.00
20 00	Computation of Demonstration Target Amount Limitation (N/A in first year of the curr	rent 5-year demonst	ration	20 11 00
	peri od)			
205.00	Medicare swing-bed SNF target amount			205. 00
206.00	Medicare swing-bed SNF inpatient routine cost cap (line 205 times line 204)			206. 00
	Adjustment to Medicare Part A Swing-Bed SNF Inpatient Reimbursement			
	Program reimbursement under the §410A Demonstration (see instructions)			207. 00
208.00	Medicare swing-bed SNF inpatient service costs (from Wkst. E-2, col. 1, sum of lines	5 1		208. 00
200 00	and 3) Adjustment to Medicare swips had SNE DDS payments (see instructions)			209. 00
	Adjustment to Medicare swing-bed SNF PPS payments (see instructions) Reserved for future use			210. 00
£ 10. 00	Comparision of PPS versus Cost Reimbursement			12.00
215. 00	Total adjustment to Medicare swing-bed SNF PPS payment (line 209 plus line 210) (see			215. 00
	instructions)			
		•		-

In Lieu of Form CMS-2552-10

Worksheet E-3

17/2023 Part V

30/2023 Date/Time Prepared: 2/26/2024 1:42 pm

tal Cost Peri od: From 07/17/2023 To 09/30/2023

Hospi tal

Title XVIII

	Ittle AVIII nospital	COST	
		1. 00	
	PART V - CALCULATION OF REIMBURSEMENT SETTLEMENT FOR MEDICARE PART A SERVICES - COST REIMBURSEMENT	1.00	
1.00	Inpatient services	204, 416	1. 00
2.00		204, 416	2. 00
3.00	Nursing and Allied Health Managed Care payment (see instructions)	0	3. 00
	Organ acquisition	0	
3. 01	Cellular therapy acquisition cost (see instructions)		3. 01
4.00	Subtotal (sum of lines 1 through 3.01)	204, 416	4. 00
5.00	Primary payer payments	0	5. 00
6.00	Total cost (line 4 less line 5). For CAH (see instructions) COMPUTATION OF LESSER OF COST OR CHARGES	206, 460	6. 00
	Reasonable charges		ı
7. 00	Routine service charges	0	7. 00
8.00	Ancillary service charges	0	8. 00
		0	
9.00	Organ acquisition charges, net of revenue	0	9.00
10. 00	Total reasonable charges	U	10. 00
11 00	Customary charges	0	11 00
11.00	Aggregate amount actually collected from patients liable for payment for services on a charge basis	0	11.00
12. 00	Amounts that would have been realized from patients liable for payment for services on a charge basis	0	12. 00
40.00	had such payment been made in accordance with 42 CFR 413.13(e)	0.000000	40.00
13.00	Ratio of line 11 to line 12 (not to exceed 1.000000)	0. 000000	13.00
14.00	Total customary charges (see instructions)	0	14.00
15. 00	Excess of customary charges over reasonable cost (complete only if line 14 exceeds line 6) (see	0	15. 00
1/ 00	instructions)	0	1/ 00
16. 00	Excess of reasonable cost over customary charges (complete only if line 6 exceeds line 14) (see	0	16. 00
17 00	instructions)	0	17.00
17. 00	Cost of physicians' services in a teaching hospital (see instructions) COMPUTATION OF REIMBURSEMENT SETTLEMENT	0	17. 00
10 00	Direct graduate medical education payments (from Worksheet E-4, line 49)	0	18. 00
18. 00 19. 00	Cost of covered services (sum of lines 6, 17 and 18)	206, 460	
20.00	Deductibles (exclude professional component)	23, 941	
21. 00	Excess reasonable cost (from line 16)	100 510	21. 00
22. 00	Subtotal (line 19 minus line 20 and 21)	182, 519	22. 00
23. 00	Coinsurance	0	23. 00
24. 00	Subtotal (line 22 minus line 23)	182, 519	
25. 00	Allowable bad debts (exclude bad debts for professional services) (see instructions)	0	25. 00
26. 00	Adjusted reimbursable bad debts (see instructions)	0	26. 00
27. 00	Allowable bad debts for dual eligible beneficiaries (see instructions)	0	27. 00
28. 00	Subtotal (sum of lines 24 and 25, or line 26)	182, 519	28. 00
29. 00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	0	29. 00
29. 50	Pioneer ACO demonstration payment adjustment (see instructions)	0	29. 50
29. 98	Recovery of accelerated depreciation.	0	29. 98
29. 99	Demonstration payment adjustment amount before sequestration	0	29. 99
30.00	Subtotal (see instructions)	182, 519	30. 00
30. 01	Sequestration adjustment (see instructions)	3, 650	30. 01
30. 02	Demonstration payment adjustment amount after sequestration	0	30. 02
30. 03	Sequestration adjustment-PARHM		30. 03
31.00	Interim payments	276, 182	31.00
31. 01	Interim payments-PARHM		31. 01
32.00	Tentative settlement (for contractor use only)	0	32.00
32. 01	Tentative settlement-PARHM (for contractor use only)		32. 01
33.00	Balance due provider/program (line 30 minus lines 30.01, 30.02, 31, and 32)	-97, 313	33. 00
33. 01	Balance due provider/program-PARHM (lines 2, 3, 18, and 26, minus lines 30.03, 31.01, and 32.01)		33. 01
34.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1,	0	34.00
	§115. 2		
	· '		

Health Financial Systems
CALCULATION OF REIMBURSEMENT SETTLEMENT I ROQUOIS MEMORIAL HOSPITAL Provi der CCN: 14-1353

In Lieu of Form CMS-2552-10
Worksheet E-3
17/2023 Part VI
30/2023 Date/Time Prepared:
2/26/2024 1:42 pm
PPS Peri od: From 07/17/2023 To 09/30/2023 Component CCN: 14-6049

				2/26/2024 1: 4:	2 pm
<u></u>		Title XVIII	Skilled Nursing	PPS	
			Facility		
			-	1. 00	
	PART VI - CALCULATION OF REIMBURSEMENT SETTLEMEMENT - ALL OTHE	ER HEALTH SERVICES FOR T	TITLE XVILL PART A		
	SERVICES	IN HEAETH SERVICES FOR T	TILL AVIII TAKE A	1113 3111	
	PROSPECTIVE PAYMENT AMOUNT (SEE INSTRUCTIONS)				
1.00	Resource Utilization Group Payment (RUGS)			24, 215	1.00
2.00	Routine service other pass through costs			0	2. 00
3.00	Ancillary service other pass through costs			0	3. 00
4.00	Subtotal (sum of lines 1 through 3)			24, 215	4. 00
	COMPUTATION OF NET COST OF COVERED SERVICES				
5.00	Medical and other services (Do not use this line as vaccine co	osts are included in lin	ne 1 of W/S E,		5. 00
	Part B. This line is now shaded.)				,
6.00	Deducti bl e			0	6. 00
7.00	Coinsurance		400	7. 00	
8.00	Allowable bad debts (see instructions)		0	8. 00	
9. 00 10. 00	Reimbursable bad debts for dual eligible beneficiaries (see in		0	9. 00 10. 00	
11. 00	Adjusted reimbursable bad debts (see instructions) Utilization review			0	11. 00
12.00	Subtotal (sum of lines 4, 5 minus lines 6 and 7, plus lines 10	and 11)(soo instruction	nne)	23, 815	
13. 00	Inpatient primary payer payments	and II)(see Instruction	1115)	23, 813	13. 00
14. 00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)			0	14. 00
14. 50	Pioneer ACO demonstration payment adjustment (see instructions	5)		0	14. 50
14. 98	Recovery of accelerated depreciation.	-)		0	14. 98
14. 99	Demonstration payment adjustment amount before sequestration			0	14. 99
15.00	Subtotal (see instructions			23, 815	15. 00
15. 01	Sequestration adjustment (see instructions)			476	15. 01
15. 02	Demonstration payment adjustment amount after sequestration			0	15. 02
15. 75	Sequestration for non-claims based amounts (see instructions)			0	15. 75
16.00	Interim payments			23, 339	16. 00
17.00	,			0	17. 00
18. 00	Balance due provider/program (line 15 minus lines 15.01, 15.02			0	18. 00
19. 00	Protested amounts (nonallowable cost report items) in accordar §115.2	nce with CMS 19 Pub. 15-	2, chapter 1,	0	19. 00

Heal th Financial Systems IROQUOIS MEMORIAL HOSPITAL
CALCULATION OF REIMBURSEMENT SETTLEMENT Provider CCN: 14-1353 Per

In Lieu of Form CMS-2552-10

				2/26/2024 1: 4	2 pm
		Title XIX	Hospi tal	PPS	
			I npati ent	Outpati ent	
			1. 00	2. 00	
	PART VII - CALCULATION OF REIMBURSEMENT - ALL OTHER HEALTH SER	VICES FOR TITLES V OR XIX	SERVI CES		
	COMPUTATION OF NET COST OF COVERED SERVICES				
1.00	Inpatient hospital/SNF/NF services		0		1. 00
2.00	Medical and other services			0	2. 00
3.00	Organ acquisition (certified transplant programs only)		0		3. 00
4.00	Subtotal (sum of lines 1, 2 and 3)		O	0	4. 00
5.00	Inpatient primary payer payments		O		5. 00
6.00	Outpatient primary payer payments			0	6. 00
7. 00	Subtotal (line 4 less sum of lines 5 and 6)		o	0	
	COMPUTATION OF LESSER OF COST OR CHARGES		-1		
	Reasonable Charges				
8. 00	Routine service charges		0		8. 00
9. 00	Ancillary service charges		o	0	
10. 00	Organ acquisition charges, net of revenue		o	Ü	10.00
11. 00	Incentive from target amount computation		o o		11. 00
12. 00	Total reasonable charges (sum of lines 8 through 11)		o o	0	
12.00	CUSTOMARY CHARGES		<u> </u>		12.00
13. 00	Amount actually collected from patients liable for payment for	services on a charge	0	0	13. 00
13.00	basis	services on a charge	ı	O	13.00
14. 00	Amounts that would have been realized from patients liable for	navment for services on	0	0	14. 00
1 1. 00	a charge basis had such payment been made in accordance with 4		Ĭ	· ·	11.00
15. 00	Ratio of line 13 to line 14 (not to exceed 1.000000)	2 011 3110. 10(0)	0. 000000	0.000000	15. 00
16. 00	Total customary charges (see instructions)		0.00000	0	
17. 00	Excess of customary charges over reasonable cost (complete onl	v if line 16 exceeds	o o	0	17. 00
17.00	line 4) (see instructions)	y II IIIIc To exceeds	ı	O	17.00
18. 00	Excess of reasonable cost over customary charges (complete onl	vifline 4 exceeds line	0	0	18. 00
10.00	16) (see instructions)	y II IIIIc 4 caccas IIIIc	ı	O	10.00
19. 00	Interns and Residents (see instructions)		0	0	19. 00
20. 00	Cost of physicians' services in a teaching hospital (see instr	ructions)	o	0	20.00
21. 00	Cost of covered services (enter the lesser of line 4 or line 1			0	
21.00	PROSPECTIVE PAYMENT AMOUNT - Lines 22 through 26 must only be			0	21.00
22. 00	Other than outlier payments	compreted for 113 provider	0	0	22. 00
23. 00	Outlier payments		o	0	23. 00
24. 00	Program capital payments		0	O	24. 00
25. 00	Capital exception payments (see instructions)		0		25. 00
26. 00	Routine and Ancillary service other pass through costs		0	0	
27. 00	Subtotal (sum of lines 22 through 26)		0	0	
28. 00	Customary charges (title V or XIX PPS covered services only)		0	0	28.00
	, , , , , , , , , , , , , , , , , , , ,		· ·		
29. 00	Titles V or XIX (sum of lines 21 and 27)		0	0	29. 00
30. 00	COMPUTATION OF REIMBURSEMENT SETTLEMENT		O	0	30. 00
	Excess of reasonable cost (from line 18)		0	0	30.00
31.00	Subtotal (sum of lines 19 and 20, plus 29 minus lines 5 and 6)			-	
32.00	Deducti bl es		0	0	
33. 00	Coinsurance		0	0	33. 00
34. 00	Allowable bad debts (see instructions)		0	0	34.00
35. 00	Utilization review		0	_	35. 00
36. 00	Subtotal (sum of lines 31, 34 and 35 minus sum of lines 32 and	1 33)	0	0	
37. 00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)		0	0	37. 00
38. 00	Subtotal (line 36 ± line 37)		0	0	38. 00
39. 00	Direct graduate medical education payments (from Wkst. E-4)		0		39. 00
40. 00	Total amount payable to the provider (sum of lines 38 and 39)		0	0	
41. 00	Interim payments		0	0	
42.00	Balance due provider/program (line 40 minus line 41)		0	0	
43.00	Protested amounts (nonallowable cost report items) in accordan	ice with CMS Pub 15-2,	0	0	43. 00
	chapter 1, §115.2				

In Lieu of Form CMS-2552-10
Worksheet E-5 Peri od: From 07/17/2023 To 09/30/2023 Date/Time Prepared: 2/26/2024 1:42 pm Cost Title XVIII

	THE AVITT	0031	
		1.00	
	TO BE COMPLETED BY CONTRACTOR		
1.00	Operating outlier amount from Wkst. E, Pt. A, line 2, or sum of 2.03 plus 2.04 (see instructions)	207, 054	1. 00
2.00	Capital outlier from Wkst. L, Pt. I, line 2	17, 120	2. 00
3.00	Operating outlier reconciliation adjustment amount (see instructions)	0	3. 00
4.00	Capital outlier reconciliation adjustment amount (see instructions)	0	4. 00
5.00	The rate used to calculate the time value of money (see instructions)	0.00	5. 00
6.00	Time value of money for operating expenses (see instructions)	0	6. 00
7.00	Time value of money for capital related expenses (see instructions)	0	7. 00

Heal th Financial Systems I ROOUDIS MEMORIAL HOSPITAL

Health Financial Systems IROOUOIS ME BALANCE SHEET (If you are nonproprietary and do not maintain fund-type accounting records, complete the General Fund column only)

HOSPITAL In Lieu of Form CMS-2552-10

Provider CCN: 14-1353 | Period: From 07/17/2023 | To 09/30/2023 | Date/Time Prepared: 2/26/2024 1: 42 pm

		General Fund	Specific Purpose Fund	Endowment Fund	Plant Fund	Z piii
		1.00	2. 00	3. 00	4. 00	
	CURRENT ASSETS	0.500.500	1			
1. 00 2. 00	Cash on hand in banks Temporary investments	3, 590, 533 79, 625		0	0	1. 00 2. 00
3.00	Notes receivable	79,025	0		0	ł
4. 00	Accounts receivable	14, 028, 713		Ö	0	
5.00	Other recei vabl e	630, 974		o	0	
6.00	Allowances for uncollectible notes and accounts receivable	-33, 756		0	0	•
7. 00 8. 00	Inventory Prepaid expenses	1, 615, 728 129, 889		0	0	7. 00 8. 00
9. 00	Other current assets	696, 372			0	9.00
10.00	Due from other funds	0		Ö	0	10.00
11. 00	Total current assets (sum of lines 1-10)	20, 738, 078	0	0	0	11. 00
	FI XED ASSETS		_	_1		
12. 00 13. 00	Land	332, 950		0	0	•
14. 00	Land improvements Accumulated depreciation	483, 750 -482, 316			0	
15. 00	Bui I di ngs	25, 787, 398		o	0	15. 00
16.00	Accumul ated depreciation	-21, 421, 747		o	0	16. 00
17. 00	Leasehold improvements	0	0	0	0	17. 00
18. 00	Accumulated depreciation	0	0	0	0	18.00
19.00	Fixed equipment	16, 726, 644 -16, 992, 641	0	0	0	19. 00 20. 00
20. 00 21. 00	Accumulated depreciation Automobiles and trucks	-10, 992, 041	0		0	•
22. 00	Accumulated depreciation		Ö	l ől	0	22. 00
23. 00	Maj or movable equipment	0	0	o	0	23. 00
24. 00	Accumul ated depreciation	0	0	0	0	24. 00
25. 00	Mi nor equi pment depreci abl e	0	0	0	0	25. 00
26. 00	Accumulated depreciation	0	0	0	0	26. 00
27. 00 28. 00	HIT designated Assets Accumulated depreciation	0	0		0	27. 00 28. 00
29. 00	Mi nor equi pment-nondepreci abl e	968, 885		l ől	0	ł
30. 00	Total fixed assets (sum of lines 12-29)	5, 402, 923		ō	0	ł
	OTHER ASSETS					
31. 00	Investments	478, 839		0	0	
32. 00 33. 00	Deposits on Leases Due from owners/officers	0	0	0	0	32. 00 33. 00
34. 00	Other assets	6, 079, 148	0		0	34.00
35. 00	Total other assets (sum of lines 31-34)	6, 557, 987		l ől	0	35. 00
36.00	Total assets (sum of lines 11, 30, and 35)	32, 698, 988		О	0	36. 00
	CURRENT LIABILITIES	1				
37. 00	Accounts payable	4, 741, 325		0	0	•
38. 00 39. 00	Salaries, wages, and fees payable Payroll taxes payable	1, 307, 679 482, 684		0	0	38. 00 39. 00
40. 00	Notes and Loans payable (short term)	0	Ö	l ől	0	40.00
41.00	Deferred income	3, 126, 453	0	o	0	41.00
42. 00	Accel erated payments	0				42. 00
43. 00	Due to other funds	0	0	0	0	
44.00	Other current liabilities Total current liabilities (sum of lines 37 thru 44)	-20, 250 9, 637, 891		0	0	•
43.00	LONG TERM LIABILITIES	9,037,091		<u> </u>		45.00
46.00	Mortgage payable	0	0	0	0	46. 00
47. 00	Notes payable	3, 578, 003	0	o	0	1
48. 00	Unsecured Loans	0	0	0	0	1
49. 00	Other long term liabilities	228, 204		0	0	
50. 00 51. 00	Total long term liabilities (sum of lines 46 thru 49) Total liabilities (sum of lines 45 and 50)	3, 806, 207 13, 444, 098		0	0	ł
31.00	CAPITAL ACCOUNTS	13, 444, 070		<u> </u>		31.00
52.00	General fund balance	19, 254, 890				52. 00
53.00	Specific purpose fund		0			53. 00
54. 00	Donor created - endowment fund balance - restricted			0		54. 00
55. 00 56. 00	Donor created - endowment fund balance - unrestricted			0		55. 00 56. 00
56. 00 57. 00	Governing body created - endowment fund balance Plant fund balance - invested in plant				0	1
58. 00	Plant fund balance - reserve for plant improvement,				0	
	repl acement, and expansi on					
59.00	Total fund balances (sum of lines 52 thru 58)	19, 254, 890		0	0	ł
60. 00	Total liabilities and fund balances (sum of lines 51 and 59)	32, 698, 988		0	0	60. 00
	1~'/	I	ı	ı I		ı

In Lieu of Form CMS-2552-10 Worksheet G-1

Peri od: Worksheet G-1 From 07/17/2023 To 09/30/2023 Date/Time Prepared:

					10 077 307 2023	2/26/2024 1: 4:	
		General	Fund	Speci al	Purpose Fund	Endowment Fund	,
		1.00	2. 00	3.00	4. 00	5. 00	
1.00	Fund balances at beginning of period		14, 981, 230		C		1. 00
2.00	Net income (loss) (from Wkst. G-3, line 29)		4, 717, 546				2. 00
3.00	Total (sum of line 1 and line 2)		19, 698, 776		C		3.00
4.00	CHANGE IN UNRESTRICTED NET ASSETS	110, 229			0	0	4.00
5.00		0			0	0	5. 00
6.00		0			0	0	6. 00
7.00		0			0	0	7. 00
8.00		0			0	0	8. 00
9.00		0			0	0	9. 00
10.00	Total additions (sum of line 4-9)		110, 229		C		10.00
11.00	Subtotal (line 3 plus line 10)		19, 809, 005		C		11.00
12.00	CHANGE IN DONOR RESTRICTED	554, 115			0	0	12.00
13.00		0			0	0	13.00
14.00		0			0	0	14.00
15.00		0			0	0	15. 00
16.00		0			0	0	16. 00
17.00		0			0	0	17. 00
18. 00	Total deductions (sum of lines 12-17)		554, 115		C)	18. 00
19. 00	Fund balance at end of period per balance		19, 254, 890		C		19. 00
	sheet (line 11 minus line 18)	F 1 . F 1	DI 1				
		Endowment Fund	PI ant	Funa			
		6.00	7. 00	8. 00	_		
1.00	Fund balances at beginning of period	0.00	7.00	0.00	0		1. 00
2. 00	Net income (loss) (from Wkst. G-3, line 29)						2. 00
3. 00	Total (sum of line 1 and line 2)	0			0		3. 00
4. 00	CHANGE IN UNRESTRICTED NET ASSETS		0				4. 00
5. 00	STANGE THE STANGESTANGED WET AGGETS		0				5. 00
6. 00			0				6. 00
7. 00			0				7. 00
8.00			0				8. 00
9.00	1	1	-				
			0				9. 00
10.00	Total additions (sum of line 4-9)	0	0		0		9. 00 10. 00
		0	0		0		10. 00
10. 00 11. 00 12. 00	Total additions (sum of line 4-9) Subtotal (line 3 plus line 10) CHANGE IN DONOR RESTRICTED	0	0		0		
11. 00	Subtotal (line 3 plus line 10)	0	0		0 0		10. 00 11. 00
11. 00 12. 00	Subtotal (line 3 plus line 10)	0	0 0 0		0 0		10. 00 11. 00 12. 00
11. 00 12. 00 13. 00	Subtotal (line 3 plus line 10)	0	0 0 0 0		0		10. 00 11. 00 12. 00 13. 00
11. 00 12. 00 13. 00 14. 00	Subtotal (line 3 plus line 10)	0	0 0 0 0		0		10. 00 11. 00 12. 00 13. 00 14. 00
11. 00 12. 00 13. 00 14. 00 15. 00	Subtotal (line 3 plus line 10)	0	0 0 0 0 0		0		10. 00 11. 00 12. 00 13. 00 14. 00 15. 00
11. 00 12. 00 13. 00 14. 00 15. 00 16. 00	Subtotal (line 3 plus line 10)	0 0	0 0 0 0 0		0 0		10. 00 11. 00 12. 00 13. 00 14. 00 15. 00 16. 00
11. 00 12. 00 13. 00 14. 00 15. 00 16. 00 17. 00	Subtotal (line 3 plus line 10) CHANGE IN DONOR RESTRICTED	0 0	0 0 0 0 0		0		10. 00 11. 00 12. 00 13. 00 14. 00 15. 00 16. 00 17. 00
11. 00 12. 00 13. 00 14. 00 15. 00 16. 00 17. 00 18. 00	Subtotal (line 3 plus line 10) CHANGE IN DONOR RESTRICTED Total deductions (sum of lines 12-17)	1	0 0 0 0 0		0		10. 00 11. 00 12. 00 13. 00 14. 00 15. 00 16. 00 17. 00 18. 00

Health Financial Systems I
STATEMENT OF PATIENT REVENUES AND OPERATING EXPENSES IROQUOIS MEMORIAL HOSPITAL

In Lieu of Form CMS-2552-10

Provi der CCN: 14-1353

Peri od: Worksheet G-2
From 07/17/2023 Parts I & II
Date/Time Prepared: 2/26/2024 1: 42 pm

				2/26/2024 1: 42	2 pm
	Cost Center Description	Inpatient	Outpati ent	Total	
		1.00	2. 00	3. 00	
	PART I - PATIENT REVENUES				
	General Inpatient Routine Services				
1.00	Hospi tal	423, 738		423, 738	1. 00
2.00	SUBPROVI DER - I PF				2.00
3.00	SUBPROVI DER - I RF				3. 00
4.00	SUBPROVI DER				4. 00
5.00	Swing bed - SNF	23, 068		23, 068	5. 00
6.00	Swing bed - NF	1 0		0	6. 00
7.00	SKILLED NURSING FACILITY	640, 881		640, 881	7. 00
8.00	NURSING FACILITY				8. 00
9.00	OTHER LONG TERM CARE				9. 00
10.00	Total general inpatient care services (sum of lines 1-9)	1, 087, 687		1, 087, 687	10.00
	Intensive Care Type Inpatient Hospital Services	, , , , , , , , , , , , , , , , , , , ,		, , , , , ,	
11. 00	INTENSIVE CARE UNIT				11. 00
12.00	CORONARY CARE UNIT				12.00
13. 00	BURN INTENSIVE CARE UNIT				13. 00
14. 00	SURGI CAL INTENSIVE CARE UNIT				14. 00
15. 00	OTHER SPECIAL CARE (SPECIFY)				15. 00
16. 00	Total intensive care type inpatient hospital services (sum of line	s 0		0	16. 00
	11-15)			Ĭ	
17. 00	Total inpatient routine care services (sum of lines 10 and 16)	1, 087, 687		1, 087, 687	17. 00
18. 00	Ancillary services	473, 183		9, 972, 336	18. 00
19. 00	Outpati ent servi ces	10, 509		2, 245, 382	19. 00
20. 00	RURAL HEALTH CLINIC	1 0	118, 008	118, 008	20. 00
20. 01	RURAL HEALTH CLINIC II			123, 697	20. 01
20. 02	RURAL HEALTH CLINIC III			159, 595	20. 02
20. 03	RURAL HEALTH CLINIC IV			234, 680	20. 03
21. 00	FEDERALLY QUALIFIED HEALTH CENTER			254, 666	21. 00
22. 00	HOME HEALTH AGENCY	Ĭ	166, 387	166, 387	22. 00
23. 00	AMBULANCE SERVICES	0	100, 307	0	23. 00
24. 00	CMHC	Ĭ	Ĭ	, of	24. 00
25. 00	AMBULATORY SURGICAL CENTER (D. P.)				25. 00
26. 00	HOSPI CE		411, 523	411, 523	26. 00
27. 00	2532	2, 532		355, 105	27. 00
28. 00	Total patient revenues (sum of lines 17-27)(transfer column 3 to W			14, 874, 400	28. 00
20.00	G-3. Line 1)	1, 575, 711	13, 300, 407	14, 074, 400	20.00
	PART II - OPERATING EXPENSES	I			
29. 00	Operating expenses (per Wkst. A, column 3, line 200)		7, 257, 504		29. 00
30. 00	ADD (SPECIFY)	l 0			30. 00
31. 00	(6. 2611 1)				31. 00
32. 00					32. 00
33. 00					33. 00
34. 00					34. 00
35. 00					35. 00
36. 00	Total additions (sum of lines 30-35)	· · · · · · · · ·	0		36. 00
37. 00	PROVISION FOR BAD DEBTS	18, 180	-		37. 00
38. 00	TROVISION FOR DAD DEDIS	10, 100			38. 00
39. 00					39. 00
40. 00					40.00
40.00					40.00
	Total deductions (sum of lines 27 41)	1	10 100		41.00
42. 00 43. 00	Total deductions (sum of lines 37-41)	encfor	18, 180		42. 00 43. 00
43.00	Total operating expenses (sum of lines 29 and 36 minus line 42)(tr to Wkst. G-3, line 4)	alistel	7, 239, 324		43.00
	10 WKSt. 0-3, TINE 4)	1	ı	ı	l

Heal th Financial Systems

I ROQUOIS MEMORIAL HOSPITAL

STATEMENT OF REVENUES AND EXPENSES

Provider CCN: 14-1353 Period:

From 07/17/2023 09/30/2023 Date/Time Prepared: 2/26/2024 1:42 pm 1.00 1.00 Total patient revenues (from Wkst. G-2, Part I, column 3, line 28) 14, 874, 400 1.00 2.00 Less contractual allowances and discounts on patients' accounts 4, 552, 003 2.00 3.00 Net patient revenues (line 1 minus line 2) 10, 322, 397 3.00 Less total operating expenses (from Wkst. G-2, Part II, line 43) 7, 239, 324 4.00 4.00 Net income from service to patients (line 3 minus line 4) 5.00 3, 083, 073 5.00 OTHER INCOME 6.00 Contributions, donations, bequests, etc 6.00 7.00 Income from investments 7.00 0 8.00 Revenues from telephone and other miscellaneous communication services 0 8.00 9.00 Revenue from television and radio service 0 9.00 10.00 Purchase di scounts 0 10.00 Rebates and refunds of expenses 11 00 11.00 0 12.00 Parking lot receipts 0 12.00 13.00 Revenue from laundry and linen service 0 13.00 14.00 Revenue from meals sold to employees and guests 32, 967 14.00 Revenue from rental of living quarters 15 00 15.00 Ω Revenue from sale of medical and surgical supplies to other than patients 16.00 37 16.00 17.00 Revenue from sale of drugs to other than patients 0 17.00 Revenue from sale of medical records and abstracts 18.00 18.00 0 Tuition (fees, sale of textbooks, uniforms, etc.) 19.00 0 19.00 20.00 Revenue from gifts, flowers, coffee shops, and canteen 0 20.00 Rental of vending machines 21.00 21.00 Rental of hospital space 22.00 15, 650 22.00 23.00 Governmental appropriations 0 23.00 MISC NON-PATIENT REVENUE 1, 370, 296 24.00 24.00 OTHER MISCELLANOUS REVENUE 20, 249 24.01 24.01 24.02 GRANT REVENUE 195, 274 24.02 24. 50 COVI D-19 PHE Funding 0 24.50 1, 634, 473 25.00 Total other income (sum of lines 6-24) 25.00 Total (line 5 plus line 25) 26, 00 4, 717, 546 26,00 27.00 OTHER EXPENSES (SPECIFY) 0 27 00

In Lieu of Form CMS-2552-10

Worksheet G-3

0 28.00

4, 717, 546 29. 00

28. 00

Total other expenses (sum of line 27 and subscripts)

29.00 Net income (or loss) for the period (line 26 minus line 28)

I ROQUOIS MEMORIAL HOSPITAL

Heal th Financial Systems

ANALYSIS OF HOSPITAL-BASED HOME HEALTH AGENCY COSTS In Lieu of Form CMS-2552-10 Peri od: From 07/17/2023 To 09/30/2023 Provi der CCN: 14-1353 Worksheet H Date/Time Prepared: 2/26/2024 1:42 pm
PPS HHA CCN: 14-7586

							2/26/2024 1: 4	2 pm
						Home Health	PPS	
		Sal ari es	Employee	Transportation	Contracted/Pur	Agency I Other Costs	Total (sum of	
		Sar ar res	Benefits	(see	chased	011101 00313	cols. 1 thru	
				instructions)	Servi ces		5)	
		1. 00	2. 00	3. 00	4. 00	5. 00	6. 00	
	GENERAL SERVICE COST CENTERS							
1. 00	Capital Related - Bldg. &			0		0	0	1. 00
0.00	Fixtures							0.00
2. 00	Capital Related - Movable			0		0	0	2. 00
3. 00	Equipment Plant Operation & Maintenance	0	0	0	0	0	_	3.00
4. 00	Transportation	0		1		0	0	4. 00
5. 00	Administrative and General	37, 390	Ö	1	Ö	6, 416	43, 806	
	HHA REIMBURSABLE SERVICES	,			,			
6.00	Skilled Nursing Care	50, 427	0	0	0	0	50, 427	6. 00
7.00	Physi cal Therapy	13, 783	0	0	0	0	13, 783	
8.00	Occupational Therapy	0	0		741	0	741	1
9. 00	Speech Pathology	0	0	0	0	0	0	
10.00	Medical Social Services	0	0	0	0	0	0	10.00
11.00	Home Heal th Aide	4, 361	0	· -	0	(40	4, 361	1
12. 00 13. 00	Supplies (see instructions) Drugs	0	0	· -	0	648 72	648 72	1
14. 00	DME			•		72	0	1
14.00	HHA NONREI MBURSABLE SERVI CES	0			<u> </u>	0	0	14.00
15. 00	Home Dialysis Aide Services	0	0	0	0	0	0	15. 00
16. 00	Respiratory Therapy	0	0		o	0	Ö	16. 00
17. 00	Private Duty Nursing	0	0	0	o	0	0	17. 00
18. 00	Clinic	0	0	0	0	0	0	18. 00
19. 00	Health Promotion Activities	0	0	0	0	0	0	19. 00
20.00	Day Care Program	0	0	0	0	0	0	20. 00
21. 00	Home Delivered Meals Program	0	0	0	0	0	0	21. 00
22. 00	Homemaker Service	0	0	0	0	0	0	22. 00
23. 00	All Others (specify)	0	0	0	0	0	0	23. 00
23. 50	Tel emedi ci ne	105.0(1	0	0	0	7 12(112 020	23. 50
24. 00	Total (sum of lines 1-23)	105, 961 Recl assi fi cati	Reclassi fi ed	Adjustments	741 Net Expenses	7, 136	113, 838	24. 00
		on	Trial Balance	Aujustillerits	for Allocation			
		0	(col . 6 +		(col . 8 + col .			
			col . 7)		9)			
		7. 00	8. 00	9. 00	10.00			
	GENERAL SERVICE COST CENTERS		<u> </u>					1
1. 00	Capital Related - Bldg. &	0	0	0	0			1. 00
2 00	Fixtures							2 00
2.00	Capital Related - Movable Equipment	0	0	0	٥			2. 00
3.00	Plant Operation & Maintenance	0	0	0	0			3. 00
4. 00	Transportation	l o		ĺ	Ö			4. 00
5.00	Administrative and General	-579	43, 227	0	43, 227			5. 00
	HHA REIMBURSABLE SERVICES							
6.00	Skilled Nursing Care	0	50, 427					6. 00
7. 00	Physi cal Therapy	0	13, 783	0				7. 00
8. 00	Occupational Therapy	0	741	0	741			8. 00
9.00	Speech Pathology	0	0	0	0			9.00
10.00	Medical Social Services	0	4 2/1	0	4 2/1			10.00
11. 00 12. 00	Home Health Aide Supplies (see instructions)	0	4, 361 648		4, 361 648			11. 00 12. 00
13. 00	Drugs	0	72		1			13.00
14. 00	DME	0	,2		1			14. 00
00	HHA NONREIMBURSABLE SERVICES				<u> </u>			1 55
15. 00	Home Dialysis Aide Services	0	0	0	0			15. 00
16. 00	Respiratory Therapy	0	0	0	0			16. 00
17. 00	Private Duty Nursing	0	0	0	О			17. 00
18. 00	Clinic	0	0	0	0			18. 00
19. 00	Health Promotion Activities	0	0	•	0			19. 00
20.00	Day Care Program	0	0	1	이			20.00
21. 00	Home Delivered Meals Program	0	0	0	0			21. 00
22. 00	Homemaker Service	0	0	0] 0			22. 00
23. 00	All Others (specify)	1 0	1 0	1 0	ı o			23. 00
33 EV	Tal amadi ci na	^	^	l ^	ا ما			33 EU
23. 50 24. 00	Telemedicine Total (sum of lines 1-23)	0 -579	0 113, 259	0	1			23. 50 24. 00

Heal th Fi nanci al Systems I ROCUOIS MEMORIAL HOSPITAL

COST ALLOCATION - HHA GENERAL SERVICE COST Provider CCN: 14-1353 Peri

Peri od: Worksheet H-1 From 07/17/2023 Part I HHA CCN: 14-7586 09/30/2023 Date/Time Prepared: 2/26/2024 1:42 pm Home Health PPS Agency I Capital Related Costs BI dgs & Subtotal Net Expenses Movable PI ant Transportati on for Cost Fi xtures Equi pment Operation & (cols. 0-4)All ocation Mai ntenance (from Wkst. H, 10) col. 1.00 2.00 3. 00 4.00 4A. 00 0 GENERAL SERVICE COST CENTERS 1.00 Capital Related - Bldg. & 0 0 1.00 Fi xtures 2.00 Capital Related - Movable 0 2.00 Equi pment 3 00 Plant Operation & Maintenance 0 0 0 3 00 4.00 Transportation 0 0 C 0 4.00 0 0 5.00 Administrative and General 43, 227 0 43, 227 5.00 HHA REIMBURSABLE SERVICES 6.00 Skilled Nursing Care 50.427 0 0 0 0 50, 427 6.00 Physical Therapy 7.00 13, 783 00000 0 0 0 13, 783 7.00 0 8.00 Occupational Therapy 741 0 741 8.00 Speech Pathology 0 9.00 0 0 9.00 0 0 10.00 Medical Social Services 0 0 10.00 4, 361 Home Heal th Aide 0 0 11.00 11.00 4, 361 0 0 0 0 12.00 Supplies (see instructions) 648 648 12.00 0 13.00 Drugs 72 Ω 72 13.00 14.00 DME 14.00 HHA NONREIMBURSABLE SERVICES 0 0 0 15.00 Home Dialysis Aide Services 15.00 0 0 0 16.00 Respiratory Therapy Ω O 16.00 17.00 Private Duty Nursing 0 0 0 17.00 0000000 0 0 0 0 0 0 18.00 Clinic 0 18.00 0 Health Promotion Activities 0 0 19.00 19.00 0 20.00 Day Care Program 0 20.00 21.00 Home Delivered Meals Program 0 0 21.00 22.00 Homemaker Service 0 0 0 22.00 0 All Others (specify) 0 23.00 23.00 C 23.50 Tel emedi ci ne 0 0 23.50 24. 00 Total (sum of lines 1-23) 113, 259 113, 259 24.00 Admi ni strati ve Total (cols. & General 4A + 5)5.00 6.00 GENERAL SERVICE COST CENTERS 1.00 1.00 Capital Related - Bldg. & Fi xtures 2.00 Capital Related - Movable 2.00 Equi pment 3.00 Plant Operation & Maintenance 3.00 4.00 Transportati on 4.00 5 00 Administrative and General 43, 227 5 00 HHA REIMBURSABLE SERVICES 6.00 Skilled Nursing Care 31, 126 81, 553 6.00 7.00 Physical Therapy 8,508 22, 291 7.00 8.00 1, 198 Occupational Therapy 457 8 00 9.00 Speech Pathology 0 0 9.00 Medical Social Services 10.00 0 10.00 11.00 Home Health Aide 2,692 7,053 11.00 12.00 Supplies (see instructions) 400 1,048 12.00 13.00 Drugs 44 116 13.00 14.00 DME 0 0 14.00 HHA NONREIMBURSABLE SERVICES 15.00 Home Dialysis Aide Services 0 0 15 00 16.00 Respiratory Therapy 0 0 16.00 0 17.00 Private Duty Nursing 0 17.00 0 18.00 18.00 Clinic 0 0 19.00 Health Promotion Activities 19.00 Day Care Program 0 20.00 20.00 0 0 Home Delivered Meals Program 21.00 21.00 Homemaker Service 0 22 00 22 00 All Others (specify) 0 23.00 23.00 23.50 Tel emedi ci ne 0 0 23.50

113, 259

In Lieu of Form CMS-2552-10

24.00

Total (sum of lines 1-23)

24.00

Health Financial Systems
COST ALLOCATION - HHA STATISTICAL BASIS IROQUOIS MEMORIAL HOSPITAL Provi der CCN: 14-1353

In Lieu of Form CMS-2552-10 Peri od: Worksheet H-1
From 07/17/2023 Part II
Date/Time Prepared: 2/26/2024 1: 42 pm

HHA CCN: 14-7586

> Home Health PPS

						Agency I	FF3	
		Canital Pol	ated Costs			Agency		
		Capital Kel	ateu costs					
		BI dgs &	Movabl e	PI ant	Transportation	Reconciliation	Admi ni strati va	
		Fixtures	Equi pment	Operation &	(MI LEAGE)	Reconciliation	& General	
			(DOLLAR VALUE)	Mai ntenance	(WIT LEAGE)		(ACCUM. COST)	
		(SQUARE TEET)	(DOLLAIK VALUE)	(SQUARE FEET)			(ACCOM. COST)	
		1.00	2.00	3.00	4.00	5A. 00	5. 00	
	GENERAL SERVICE COST CENTERS	11.00	2.00	0.00	11.00	07.1.00	0.00	
1.00	Capital Related - Bldg. &	2, 350				0		1.00
	Fixtures	_, -, -, -						
2.00	Capital Related - Movable		28, 165			ol		2. 00
	Equi pment							
3.00	Plant Operation & Maintenance	0	0	2, 350		o		3. 00
4.00	Transportation (see	0	0	C	100)		4. 00
	instructions)							
5.00	Administrative and General	2, 350	28, 165	2, 350	100	-43, 227	70, 032	5. 00
	HHA REIMBURSABLE SERVICES							
6.00	Skilled Nursing Care	0	0	C) C	0	50, 427	6. 00
7.00	Physical Therapy	0	0	C	0	o	13, 783	7. 00
8.00	Occupational Therapy	0	0	C	0	o	741	8. 00
9.00	Speech Pathology	0	0	C	0	o	0	9. 00
10.00	Medical Social Services	0	0	C	0	0	0	10.00
11.00	Home Health Aide	0	0	C	0	0	4, 361	11. 00
12.00	Supplies (see instructions)	0	0	C) c	o	648	12. 00
13.00	Drugs	0	0	C		o	72	13.00
14.00	DME	0	0	C) c	o	0	14. 00
	HHA NONREIMBURSABLE SERVICES							
15.00	Home Dialysis Aide Services	0	0	C	0	0	0	15. 00
16.00	Respiratory Therapy	0	0	C	0	0	0	16. 00
17.00	Private Duty Nursing	0	0	C	0	0	0	17. 00
18.00	Clinic	0	0	C	0	0	0	18. 00
19.00	Health Promotion Activities	0	0	C) c	o	0	19. 00
20.00	Day Care Program	0	0	C) c	o	0	20. 00
21.00	Home Delivered Meals Program	0	0	C) c	o	0	21. 00
22.00	Homemaker Service	0	0	C) c	o	0	22. 00
23.00	All Others (specify)	0	0	C	0	o	0	23. 00
23. 50	Tel emedi ci ne	0	0	C) c	o	0	23. 50
24.00	Total (sum of lines 1-23)	2, 350	28, 165	2, 350	100	-43, 227	70, 032	24. 00
25.00	Cost To Be Allocated (per	0	0	C	0)	43, 227	25. 00
	Worksheet H-1, Part I)							
26. 00	Unit Cost Multiplier	0. 000000	0. 000000	0. 000000	0. 000000		0. 617246	26. 00

Health Financial Systems IROO ALLOCATION OF GENERAL SERVICE COSTS TO HAA COST CENTERS I ROQUOIS MEMORIAL HOSPITAL

In Lieu of Form CMS-2552-10

Worksheet H-2 Part I Date/Time Prepared: 2/26/2024 1:42 pm Provi der CCN: 14-1353 Peri od: From 07/17/2023 To 09/30/2023 HHA CCN: 14-7586 Home Health PPS Agency I

						Agency i		
			CAPITAL REL	LATED COSTS				
	Cost Center Description	HHA Trial Balance (1)	BLDG & FIXT	MVBLE EQUIP	EMPLOYEE BENEFITS DEPARTMENT	ADMI TTI NG	PURCHASI NG RECEI VI NG AND STORES	
		0	1. 00	2.00	4. 00	5. 01	5. 02	
1. 00 2. 00 3. 00 4. 00 5. 00 6. 00 7. 00 8. 00 10. 00 11. 00 12. 00 13. 00 14. 00 15. 00 16. 00 17. 00 18. 00 19. 50 20. 00 21. 00	Administrative and General Skilled Nursing Care Physical Therapy Occupational Therapy Speech Pathology Medical Social Services Home Health Aide Supplies (see instructions) Drugs DME Home Dialysis Aide Services Respiratory Therapy Private Duty Nursing Clinic Health Promotion Activities Day Care Program Home Delivered Meals Program Homemaker Service All Others (specify) Telemedicine Total (sum of lines 1-19) (2) Unit Cost Multiplier: column 26, line 1 divided by the sum of column 26, line 20 minus column 26, line 1, rounded to	0 81, 553 22, 291 1, 198 0 0 7, 053 1, 048 116 0 0 0 0 0 0 0 0 0	3, 570 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	3, 166 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	12, 846 17, 326 4, 736 0 0 1, 498 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	128 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	1. 00 2. 00 3. 00 4. 00 5. 00 6. 00 7. 00 8. 00 9. 00 10. 00 11. 00 12. 00 13. 00 14. 00 15. 00 16. 00 17. 00 18. 00 19. 50 20. 00 21. 00
	6 decimal places. Cost Center Description	DATA PROCESSI NG	COMMUNI CATI ONS	BUSI NESS OFFI CE	Subtotal	OTHER ADMINISTRATIVE & GENERAL	OPERATION OF PLANT	
		5. 03	5. 04	5. 05	5A. 05	5. 06	7. 00	
1. 00 2. 00 3. 00 4. 00 5. 00 6. 00 7. 00 8. 00 9. 00 10. 00 11. 00 12. 00 13. 00 14. 00 15. 00 17. 00 18. 00 19. 00 20. 00 21. 00	Home Delivered Meals Program Homemaker Service All Others (specify)	4, 087	573 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	0 0 0 0 0 0 0 0 0 0 0 0 0	24, 370 98, 879 27, 027 1, 198 0 0 8, 551 1, 048 116 0 0 0 0 0 0 0 0 0 0 0 0 161, 189 0. 0000000	1, 040 4, 222 1, 154 51 0 365 45 5 0 0 0 0 0 0 0 0	9, 896 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	1. 00 2. 00 3. 00 4. 00 5. 00 7. 00 8. 00 9. 00 10. 00 11. 00 12. 00 13. 00 14. 00 15. 00 16. 00 17. 00 18. 00 19. 00 19. 00 20. 00 21. 00

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

Health Financial Systems IROO ALLOCATION OF GENERAL SERVICE COSTS TO HAA COST CENTERS I ROQUOIS MEMORIAL HOSPITAL

In Lieu of Form CMS-2552-10

Worksheet H-2 Part I Date/Time Prepared: 2/26/2024 1:42 pm Provi der CCN: 14-1353 Peri od: From 07/17/2023 To 09/30/2023 HHA CCN: 14-7586 Home Health PPS

						Agency I	113	
	Cost Center Description	LAUNDRY &	HOUSEKEEPI NG	DI ETARY	CAFETERI A	NURSI NG	CENTRAL	
		LINEN SERVICE				ADMI NI STRATI ON	SERVICES &	
		0.00	0.00	10.00	11 00	12.00	SUPPLY	
1.00	Administrative and General	8.00	9. 00 2, 994	10.00	11.00	13.00	14.00	1. 00
2. 00	Skilled Nursing Care	0	2, 7,74	0		1	0	2. 00
3. 00	Physical Therapy	l o	0	Ö	· ·	1	0	3. 00
4.00	Occupational Therapy	0	0	0	C	o	0	4. 00
5.00	Speech Pathology	0	0	0	C	0	0	5. 00
6.00	Medical Social Services	0	0	0	C	0	0	6. 00
7. 00	Home Health Aide	0	0	0	C	0	0	7. 00
8.00	Supplies (see instructions)	0	0	0	C	0	85	8. 00
9. 00 10. 00	Drugs DME	0	0	0			0	9. 00 10. 00
11. 00	Home Dialysis Aide Services	0	0			1	0	11.00
12. 00	Respiratory Therapy	0	0			1	0	12. 00
13. 00	Private Duty Nursing	0	0	Ö			0	13. 00
14.00	Clinic	0	0	0	C	o	0	14. 00
15. 00	Health Promotion Activities	0	0	0	C	0	0	15. 00
16. 00	Day Care Program	0	0	0	C	0	0	16. 00
17. 00	Home Delivered Meals Program	0	0	0	C	0	0	17. 00
18. 00	Homemaker Service	0	0	0] (0	18.00
19. 00 19. 50	All Others (specify) Telemedicine	0	0	0		-	0	19. 00 19. 50
20. 00	Total (sum of lines 1-19) (2)	0	2, 994	0			85	20. 00
21. 00	Unit Cost Multiplier: column	Ĭ	2, ,,,			1	00	21. 00
	26, line 1 divided by the sum							
	of column 26, line 20 minus							
	column 26, line 1, rounded to							
	6 decimal places. Cost Center Description	MEDI CAL	Subtotal	Intern &	Subtotal	Allocated HHA	Total HHA	
	cost center beserver on	RECORDS &	Subtotal	Residents Cost		A&G (see Part	Costs	
		LI BRARY		& Post		11)		
				Stepdown				
		1/ 00	24.00	Adjustments	27, 00	27.00	20.00	
1.00	Administrative and General	16. 00	24. 00 38, 300	25. 00	26. 00 38, 300	27. 00	28. 00	1. 00
2. 00	Skilled Nursing Care	0	103, 101	0	103, 101		130, 765	2.00
3. 00	Physical Therapy	0	28, 181	o	28, 181		35, 742	3. 00
4.00	Occupational Therapy	0	1, 249	0	1, 249	335	1, 584	4. 00
5.00	Speech Pathology	0	0	0	C	0	0	5. 00
6.00	Medical Social Services	0	0	0	C	0	0	6. 00
7.00	Home Health Aide	0	8, 916		8, 916		11, 308	7. 00
8. 00 9. 00	Supplies (see instructions) Drugs	0	1, 178 121	0	1, 178 121		1, 494 153	8. 00 9. 00
10.00	DME	0	0	0	121		0	10.00
11. 00	Home Dialysis Aide Services	0	0	Ö		ol ol	0	11. 00
12.00	Respiratory Therapy	0	0	0	C	o	0	12.00
13.00	Private Duty Nursing	0	0	0	C	0	0	13. 00
14.00	Clinic	0	0		C	0	0	14. 00
15. 00	Health Promotion Activities	0	0	0	C	0	0	
16.00	Day Care Program	0	0	0			0	16.00
17. 00 18. 00	Home Delivered Meals Program Homemaker Service	0	0	0			0	17. 00 18. 00
19. 00	All Others (specify)	0	0				0	19.00
19. 50	Tel emedi ci ne	0	0				0	19. 50
20. 00	Total (sum of lines 1-19) (2)	0	181, 046	1	181, 046	38, 300	181, 046	
21. 00	Unit Cost Multiplier: column					0. 268309		21. 00
	26. line 1 divided by the sum							
	of column 26, line 20 minus							
	column 26, line 1, rounded to 6 decimal places.							
	10 door man pridoos.	I	l	1	1	1	ļ	ı

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

Heal th Financial Systems IROQUOIS MEMORIAL HOSPITAL In Lieu of Form CMS-2552-10
ALLOCATION OF GENERAL SERVICE COSTS TO HHA COST CENTERS STATISTICAL Provider CCN: 14-1353 Period: Worksheet H-2

From 07/17/2023 BASIS Part II HHA CCN: 14-7586 09/30/2023 Date/Time Prepared: 2/26/2024 1:42 pm Home Health PPS Agency I CAPITAL RELATED COSTS MVBLE EQUIP **EMPLOYEE** ADMI TTI NG **PURCHASI NG** Cost Center Description BLDG & FIXT DATA (GROSS CHAR RECEIVING AND PROCESSI NG (SQUARE FEET) (DOLLAR VALUE) **BENEFITS DEPARTMENT** GES) **STORES** (TIME SPENT) (GROSS (COSTED SALARI ES) REQUIS.) 1.00 2.00 5.01 5.03 5.02 4.00 1.00 Administrative and General 2, 350 28, 165 37, 390 0 1, 591 15, 468 1.00 2.00 Skilled Nursing Care 50, 427 2.00 3.00 Physical Therapy 0 0 13, 783 0 3.00 0 Occupational Therapy 0 0 0 4.00 0 4.00 5.00 Speech Pathology r 5.00 6.00 Medical Social Services 0 6.00 0000000 0 0 0 0 7.00 Home Heal th Aide 4, 361 7.00 0 0 8.00 Supplies (see instructions) C 0 8.00 9.00 Drugs C 0 9.00 10.00 DME 0 0 0 10.00 0 0 11.00 Home Dialysis Aide Services 0 11.00 0 0 12.00 Respiratory Therapy C 12.00 13.00 Private Duty Nursing 13.00 0 0 14.00 Clinic 0 0 0 0 14.00 0 0 15.00 Health Promotion Activities 15.00 16.00 Day Care Program 16.00 0 17.00 Home Delivered Meals Program 0 17.00 0 0 Homemaker Service 18.00 18.00 0 All Others (specify) 0 C 0 19.00 19.00 19.50 Tel emedi ci ne 0 0 0 0 19.50 Total (sum of lines 1-19) 2, 350 105, 961 1, 591 20.00 28, 165 15, 468 20.00 4, 087 21.00 Total cost to be allocated 3.570 3 166 36, 406 128 21.00 0. 264223 1.519149 0. 112409 0.080453 22.00 Unit cost multiplier 0.343579 0.000000 22.00 Cost Center Description COMMUNI CATI ONS **BUSI NESS** Reconciliation OTHER OPERATION OF LAUNDRY & OFFI CE ADMI NI STRATI VE PLANT LINEN SERVICE (# OF PHONE S) (GROSS CHAR & GENERAL (SQUARE FEET) (POUNDS OF (ACCUM. COST) LAUNDRY) GES) 5A. 06 5.04 5.05 5.06 7.00 8.00 1.00 Administrative and General 6 0 24, 370 2, 350 0 1.00

2.00	Skilled Nursing Care	0	O	O	98, 879	O	0 2.00
3.00	Physi cal Therapy	0	0	0	27, 027	0	0 3.00
4.00	Occupational Therapy	0	0	0	1, 198	0	0 4.00
5.00	Speech Pathology	0	0	0	0	0	0 5.00
6.00	Medical Social Services	0	0	0	0	0	0 6.00
7.00	Home Health Aide	0	0	0	8, 551	0	0 7.00
8.00	Supplies (see instructions)	0	0	0	1, 048	0	0 8.00
9.00	Drugs	0	0	0	116	0	0 9.00
10.00	DME	0	0	0	0	0	0 10.00
11. 00	Home Dialysis Aide Services	0	0	0	0	0	0 11.00
12.00	Respiratory Therapy	0	0	0	0	0	0 12.00
13.00	Private Duty Nursing	0	0	0	0	0	0 13.00
14.00	Clinic	0	0	0	0	0	0 14.00
15. 00	Health Promotion Activities	0	0	0	0	0	0 15.00
16.00	Day Care Program	0	0	0	0	0	0 16.00
17.00	Home Delivered Meals Program	0	0	0	0	0	0 17.00
18. 00	Homemaker Service	0	0	0	0	0	0 18.00
19.00	All Others (specify)	0	0	0	0	0	0 19.00
19. 50	Tel emedi ci ne	0	0	0	0	0	0 19.50
20.00	Total (sum of lines 1-19)	6	0		161, 189	2, 350	0 20.00
21. 00	Total cost to be allocated	573	0		6, 882	9, 896	0 21.00
22. 00	Unit cost multiplier	95. 500000	0. 000000		0. 042695	4. 211064	0. 000000 22. 00

Heal th Financial Systems IROQUOIS MEMORIAL HOSPITAL In Lieu of Form CMS-2552-10
ALLOCATION OF GENERAL SERVICE COSTS TO HAA COST CENTERS STATISTICAL Provider CCN: 14-1353 Period: Form CMS-2552-10 Provider CCN: 14-

ALLOCATION OF GENERAL SERVICE COSTS TO HHA COST CENTERS STATISTICAL Provider CCN: 14-1353

HHA CCN: 14-7586

Peri od:
From 07/17/2023
To 09/30/2023

Basis

Home Health
PPS

							2/20/2024 1.4.	z piii
						Home Health	PPS	
						Agency I		
	Cost Center Description	HOUSEKEEPI NG	DI ETARY	CAFETERI A	NURSI NG	CENTRAL	MEDI CAL	
	·	(SQUARE FEET)	(MEALS SERVED)	(FTES)	ADMI NI STRATI ON	SERVICES &	RECORDS &	
		,	,			SUPPLY	LI BRARY	
					(DIRECT NRSING	(COSTED	(GROSS	
					HRS)	REQUIS.)	CHARGES)	
		9. 00	10.00	11. 00	13. 00	14. 00	16. 00	
1.00	Administrative and General	2, 350	0	0	0	0	0	1. 00
2.00	Skilled Nursing Care	0	0	0	0	0	0	2. 00
3.00	Physical Therapy	0	0	0	0	0	0	3. 00
4.00	Occupational Therapy	0	0	0	0	0	0	4. 00
5.00	Speech Pathology	0	0	0	0	0	0	5. 00
6.00	Medical Social Services	0	0	0	0	0	0	6. 00
7.00	Home Health Aide	0	0	0	0	0	0	7. 00
8.00	Supplies (see instructions)	0	0	0) c	1, 591	0	8. 00
9.00	Drugs	0	0	0) c	0	0	9. 00
10.00	DME	0	0	0) c	0	0	10. 00
11. 00	Home Dialysis Aide Services	0	0	0) c	0	0	11. 00
12.00	Respiratory Therapy	0	0	0) c	0	0	12. 00
13.00	Private Duty Nursing	0	0	0	0	0	0	13. 00
14.00	Clinic	0	0	0) C	0	0	14. 00
15. 00	Health Promotion Activities	0	0	0) C	0	0	15. 00
16. 00	Day Care Program	0	0	0) C	0	0	16. 00
17. 00	Home Delivered Meals Program	0	0	0) C	0	0	17. 00
18. 00	Homemaker Service	0	0	0) C	0	0	18. 00
19. 00	All Others (specify)	0	0	0) C	0	0	19. 00
19. 50	Tel emedi ci ne	0	0	0	0	0	0	19. 50
20. 00	Total (sum of lines 1-19)	2, 350		0) C	1, 591	0	20. 00
21. 00	Total cost to be allocated	2, 994	0	0) C	85	0	21. 00
22. 00	Unit cost multiplier	1. 274043	0. 000000	0. 000000	0.000000	0. 053426	0. 000000	22. 00

Heal th Financial Systems

APPORTIONMENT OF PATIENT SERVICE COSTS

I ROQUOIS MEMORIAL HOSPITAL

Provider CCN: 14-1353 Period:

Worksheet H-3 From 07/17/2023 Part I HHA CCN: 14-7586 09/30/2023 Date/Time Prepared: 2/26/2024 1:42 pm Title XVIII Home Health PPS Agency I Cost Center Description From, Wkst. Facility Costs Shared Total HHA Total Visits Average Cost H-2, Part I, Per Visit (from Wkst. Anci I I ary Costs (cols. H-2, Part I) (col. 3 ÷ col. col. 28, line Costs (from + 2) Part II) 4) 0 1.00 2.00 3.00 4.00 5.00 - COMPUTATION OF LESSER OF AGGREGATE PROGRAM COST, AGGREGATE OF THE PROGRAM LIMITATION COST, OR BENEFICIARY COST LIMITATION Cost Per Visit Computation 1.00 Skilled Nursing Care 2.00 130, 765 130, 765 1.018 128, 45 1.00 2.00 Physical Therapy 3.00 35, 742 35, 742 245 145. 89 2.00 3.00 Occupational Therapy 4. 00 1,584 0 1, 584 49. 50 3.00 32 Speech Pathology 0.00 5.00 4.00 4.00 0 C 0 6.00 5.00 Medical Social Services 0 0.00 5.00 Home Heal th Aide 7. 00 54.89 6.00 11, 308 11, 308 206 6.00 Total (sum of lines 1-6) 179, 399 179.399 1,502 7.00 7.00 Program Visits Part Cost Center Description Cost Limits CBSA No. (1) Part A Not Subject to Subject to Deductibles & Deducti bl es Coi nsurance 0 1.00 2.00 3.00 4.00 5.00 Limitation Cost Computation 8.00 Skilled Nursing Care 19180 25 8.00 Skilled Nursing Care 247 8 01 99914 Ω 8 01 8.02 Skilled Nursing Care 16580 0 5 8.02 Physical Therapy 19180 0 9.00 9.00 9.01 Physical Therapy 99914 0 95 9.01 Physical Therapy 9.02 16580 9 02 6 10.00 Occupational Therapy 19180 0 10.00 Occupational Therapy 99914 10.01 20 10.01 Occupational Therapy 10.02 16580 10.02 11.00 Speech Pathology 19180 0 11.00 11.01 Speech Pathology 99914 0 11.01 Speech Pathology 11.02 16580 11.02 Medical Social Services 12.00 19180 0 12.00 12.01 Medical Social Services 99914 0 12.01 12.02 Medical Social Services 16580 0 12.02 Home Heal th Aide 19180 0 0 13.00 13.00 13 01 Home Health Aide 99914 C 124 13 01 13.02 Home Health Aide 16580 0 13.02 14.00 Total (sum of lines 8-13) 523 14.00 Total Charges Ratio (col. 3 Cost Center Description From Wkst. H-2Facility Costs Total HHA Shared Part I, col. 28, line (from Wkst Anci I I ary Costs (cols. 1 (from HHA ÷ col. 4) H-2, Part I) Costs (from + 2) Records) Part II) 1.00 3. 00 4. 00 5.00 Supplies and Drugs Cost Computations 15 00 0.499165 15 00 Cost of Medical Supplies 8.00 1, 494 1, 494 2.993 16.00 Cost of Drugs 9.00 153 153 0.000000 16.00 Program Visits Cost of Servi ces Part B Part B Cost Center Description Part A Not Subject to Subject to Part A Not Subject to Subject to Deductibles & Deductibles & Deductibles & Deductibles & Coi nsurance Coi nsurance Coi nsurance Coi nsurance 6.00 7.00 8.00 9.00 10.00 11. 00 PART I - COMPUTATION OF LESSER OF AGGREGATE PROGRAM COST, AGGREGATE OF THE PROGRAM LIMITATION COST, OR BENEFICIARY COST LIMITATION Cost Per Visit Computation 1.00 Skilled Nursing Care 277 35, 581 1.00 Physical Therapy 0 101 0 14.735 2.00 2.00 0 Occupational Therapy 0 3.00 21 1, 040 3.00 4.00 Speech Pathology 0 0 0 4.00 0 0 5.00 Medical Social Services 0 0 5.00 0 0 Home Health Aide 6,806 6.00 6 00 124 7.00 Total (sum of lines 1-6) 523 58, 162 7.00

In Lieu of Form CMS-2552-10

Heal th Financial Systems IROQUOIS MEMORIAL HOSPITAL In Lie
APPORTIONMENT OF PATIENT SERVICE COSTS Provider CCN: 14-1353 Period:
From 07/17/2023

14-7586 09/30/2023 Date/Time Prepared: HHA CCN: 2/26/2024 1:42 pm Title XVIII Home Health PPS Agency I Cost Center Description 6.00 7.00 8.00 9.00 10.00 11. 00 Limitation Cost Computation 8.00 8.00 Skilled Nursing Care 8.01 Skilled Nursing Care 8.01 8.02 Skilled Nursing Care 8 02 9.00 Physical Therapy 9.00 9.01 Physical Therapy 9.01 9.02 Physical Therapy 9. 02 Occupational Therapy 10 00 10.00 10.01 Occupational Therapy 10.01 10.02 Occupational Therapy 10.02 Speech Pathology 11 00 11.00 11.01 Speech Pathology 11.01 11.02 Speech Pathology 11.02 Medical Social Services 12.00 12.00 12.01 Medical Social Services 12.01 12.02 Medical Social Services 12.02 13.00 Home Heal th Aide 13.00 13.01 Home Health Aide 13.01 13.02 Home Health Aide 13.02 14.00 Total (sum of lines 8-13) 14.00 Program Covered Charges Cost of Servi ces Part B Part B Cost Center Description Not Subject to Subject to Not Subject to Subject to Part A Part A Deductibles & Deductibles & Deductibles & Deductibles & Coi nsurance Coi nsurance Coi nsurance Coi nsurance 6.00 9.00 7.00 8.00 10.00 11.00 Supplies and Drugs Cost Computations Cost of Medical Supplies 2, 993 1, 494 15.00 0 16.00 Cost of Drugs 16.00 Total Program Cost Center Description Cost (sum of 9-10) col s. 12. 00 PART I - COMPUTATION OF LESSER OF AGGREGATE PROGRAM COST, AGGREGATE OF THE PROGRAM LIMITATION COST, OR BENEFICIARY COST LIMITATION Cost Per Visit Computation 1.00 Skilled Nursing Care 35, 581 1.00 Physical Therapy 2.00 14,735 2.00 3.00 Occupational Therapy 1,040 3.00 4.00 Speech Pathology 0 4.00 5.00 Medical Social Services 0 5.00 6.00 Home Heal th Aide 6,806 6.00 Total (sum of lines 1-6) 7.00 58, 162 7.00 Cost Center Description 12.00 Limitation Cost Computation 8.00 Skilled Nursing Care 8.00 8.01 Skilled Nursing Care 8.01 8.02 Skilled Nursing Care 8.02 9 00 Physical Therapy 9 00 9.01 Physical Therapy 9.01 9.02 Physical Therapy 9.02 Occupational Therapy 10.00 10.00 Occupational Therapy 10.01 10 01 10.02 Occupational Therapy 10.02 Speech Pathology 11.00 11.00 Speech Pathology 11.01 11.01 Speech Pathology 11.02 11.02 12.00 Medical Social Services 12.00 12.01 Medical Social Services 12.01 Medical Social Services 12.02 12.02 13.00 Home Health Aide 13.00 13.01 13.01 Home Heal th Aide 13.02 Home Health Aide 13.02 14.00 Total (sum of lines 8-13) 14.00

In Lieu of Form CMS-2552-10

Worksheet H-3

Part I

	Financial Systems		I ROQUOIS MEMOR) P '		u of Form CMS-	
APPOR	TIONMENT OF PATIENT SERVICE COST	S		Provi der C	CN: 14-1353	Period: From 07/17/2023	Worksheet H-3 Part	
				HHA CCN:	14-7586	To 09/30/2023	Date/Time Pre 2/26/2024 1:4	
						Home Health	PPS	
		1				Agency I		
	Cost Center Description	From Wkst. C,	Cost to Charge		HHA Shared	Transfer to		
		Part I, col.	Ratio	Charge (from	Ancillary	Part I as		
		9, line		provi der	Costs (col.	1 Indicated		
				records)	x col. 2)			
		0	1.00	2.00	3. 00	4. 00		
	PART II - APPORTIONMENT OF COS	T OF HHA SERVIC	ES FURNI SHED B'	Y SHARED HOSPI	TAL DEPARTMEN	NTS		
1.00	Physi cal Therapy	66. 00	0. 688448	0		0 col. 2, line 2	. 00	1. 00
2.00	Occupational Therapy							2. 00
3.00	Speech Pathology							3. 00
4.00	Cost of Medical Supplies	71.00	0. 018068	0		Ocol. 2, line 1	5. 00	4. 00
5.00	Cost of Drugs	73. 00	0. 573646	0		0 col. 2, line 1	6. 00	5. 00

Health Financial Systems
CALCULATION OF HHA REIMBURSEMENT SETTLEMENT I ROQUOIS MEMORIAL HOSPITAL

In Lieu of Form CMS-2552-10

Period:
From 07/17/2023 Part I-II
To 09/30/2023 Part I-II
Date/Time Prepared:
2/26/2024 1:42 pm

Home Health PPS Provider CCN: 14-1353 HHA CCN: 14-7586 Title XVIII

		Title	XVIII	Home Health	PPS	
				Agency I	_t B	
			Part A	Not Subject to		
			Tart A		Deductibles &	
				Coi nsurance	Coi nsurance	
			1. 00	2. 00	3.00	
	PART I - COMPUTATION OF THE LESSER OF REASONABLE COST OR CUSTON	IARY CHARGES	<u> </u>	-	•	
	Reasonable Cost of Part A & Part B Services					
1.00	Reasonable cost of services (see instructions)			0 0		1. 00
2.00	Total charges			0 0	0	2. 00
	Customary Charges					
3.00	Amount actually collected from patients liable for payment for	servi ces		0	0	3. 00
4 00	on a charge basis (from your records) Amount that would have been realized from patients liable for p	.c.mont		0	0	4 00
4. 00	for services on a charge basis had such payment been made in ac	,		0	0	4. 00
	with 42 CFR §413.13(b)	coi dance				
5. 00	Ratio of line 3 to line 4 (not to exceed 1.000000)		0. 00000	0. 000000	0. 000000	5. 00
6. 00	Total customary charges (see instructions)		0.0000	0 0.000000	0.00000	6. 00
7. 00	Excess of total customary charges over total reasonable cost (c	complete		o o		7. 00
	only if line 6 exceeds line 1)					
8.00	Excess of reasonable cost over customary charges (complete only	/if line		0 0	0	8. 00
	1 exceeds line 6)					
9. 00	Primary payer amounts			0 0		9. 00
				Part A	Part B	
				Servi ces	Servi ces	
	PART II - COMPUTATION OF HHA REIMBURSEMENT SETTLEMENT			1. 00	2.00	
10. 00	Total reasonable cost (see instructions)			0	0	10.00
11. 00	Total PPS Reimbursement - Full Episodes without Outliers					
12. 00	Total PPS Reimbursement - Full Episodes with Outliers			0	12, 352	
13.00	Total PPS Reimbursement - LUPA Episodes			0	288	
14.00	Total PPS Reimbursement - PEP Epi sodes			0	0	14. 00
15.00	Total PPS Outlier Reimbursement - Full Episodes with Outliers			0	6, 149	15. 00
16.00	Total PPS Outlier Reimbursement - PEP Episodes			0	0	16. 00
17. 00	Total Other Payments			0	0	17. 00
18. 00	DME Payments			0	0	18. 00
19. 00	Oxygen Payments			0	_	19. 00
20. 00	Prosthetic and Orthotic Payments			0	_	20. 00
21. 00	Part B deductibles billed to Medicare patients (exclude coinsur	ance)		_	0	21. 00
22. 00	Subtotal (sum of lines 10 thru 20 minus line 21)			0		
23. 00	Excess reasonable cost (from line 8)			0	_	
24. 00 25. 00	Subtotal (line 22 minus line 23)			0	87, 296 0	24. 00 25. 00
26. 00	Coinsurance billed to program patients (from your records) Net cost (line 24 minus line 25)			0		
27. 00	Allowable bad debts (from your records)				07,270	27. 00
27. 01	Adjusted reimbursable bad debts (see instructions)				0	27. 01
28. 00	Allowable bad debts for dual eligible (see instructions)				Ö	28. 00
29. 00	Total costs - current cost reporting period (see instructions)			0		
30. 00	ADJUSTMENT			0	0	1
30. 50	Pioneer ACO demonstration payment adjustment (see instructions)			0	0	30. 50
30. 99	Demonstration payment adjustment amount before sequestration			0	0	30. 99
31. 00	Subtotal (see instructions)			0	87, 296	31.00
31. 01	Sequestration adjustment (see instructions)			0		31. 01
31. 02	Demonstration payment adjustment amount after sequestration			0	_	1
31. 75	Sequestration adjustment for non-claims based amounts (see inst	ructions)		0		1
32.00	Interim payments (see instructions)			0		1
33.00	Tentative settlement (for contractor use only)	04 75 00		0	0	1
34.00	Balance due provider/program (line 31 minus lines 31.01, 31.02,			0		1
35. 00	Protested amounts (nonallowable cost report items) in accordance chapter 1, §115.2	e with CMS	rub. 15-2,	0	0	35. 00
	Gridptor 1, \$110.2			1	I	I

I ROQUOIS MEMORIAL HOSPITAL

Health Financial Systems IROQUOIS MEMOR
ANALYSIS OF PAYMENTS TO HOSPITAL-BASED HHAS FOR SERVICES RENDERED In Lieu of Form CMS-2552-10 Provi der CCN: 14-1353 Peri od: From 07/17/2023 To 09/30/2023 Worksheet H-5 TO PROGRAM BENEFICIARIES

Date/Time Prepared: 2/26/2024 1:42 pm HHA CCN: 14-7586 Home Health PPS

				Agency I		
		I npati en	t Part A	Par	t B	
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount	
		1. 00	2.00	3. 00	4. 00	
1. 00 2. 00 3. 00	Total interim payments paid to provider Interim payments payable on individual bills, either submitted or to be submitted to the contractor for services rendered in the cost reporting period. If none, write "NONE" or enter a zero List separately each retroactive lump sum adjustment amount based on subsequent revision of the interim rate		0		85, 550 0	1. 00 2. 00 3. 00
	for the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1) Program to Provider					
3. 01			0		0	3. 01
3.02			0		0	3. 02
3. 03			0		0	3. 03
3.04			0		0	3. 04
3. 05	Provider to Program		0		U	3. 05
3. 50	Flovider to Flogram		0		0	3. 50
3. 51			Ö		Ö	3. 51
3.52			0		0	3. 52
3.53			0		0	3. 53
3.54			0		0	3. 54
3. 99	Subtotal (sum of lines 3.01-3.49 minus sum of lines		0		0	3. 99
4. 00	3.50-3.98) Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Wkst. H-4, Part II, column as appropriate,		0		85, 550	4. 00
	line 32)					
	TO BE COMPLETED BY CONTRACTOR	'	'			
5. 00	List separately each tentative settlement payment after desk review. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					5. 00
	Program to Provider	•	'			
5. 01			0		0	5. 01
5.02			0		0	5. 02
5.03			0		0	5. 03
F F0	Provi der to Program					F F0
5. 50 5. 51			0		0	5. 50 5. 51
5. 51					0	5. 51
5. 99	Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98)		ő		0	5. 99
6. 00	Determined net settlement amount (balance due) based on the cost report. (1)					6. 00
6. 01	SETTLEMENT TO PROVIDER		0		0	6. 01
6. 02	SETTLEMENT TO PROGRAM		0		0	6. 02
7.00	Total Medicare program liability (see instructions)		0		85, 550	7. 00
				Contractor	NPR Date	
)	Number 1.00	(Mo/Day/Yr) 2.00	
8. 00	Name of Contractor		NMENT SERVICES		2.00	8. 00
	1	1		I .	' '	

Hospi ce CCN: 14-1616

Peri od: From 07/17/2023 To 09/30/2023 Worksheet 0

Date/Time Prepared: 2/26/2024 1:42 pm

						2/26/2024 1: 4	2 pm
		CALADIEC	OTHER	CURTOTAL ()	Hospi ce I	CURTOTAL	
		SALARI ES	OTHER	SUBTOTAL (col.	RECLASSIFI -	SUBTOTAL	
		1 00	2.00	1 plus col. 2)	4. 00	E 00	
	CENEDAL SEDVICE COST CENTERS	1.00	2. 00	3. 00	4.00	5. 00	
1 00	GENERAL SERVICE COST CENTERS CAP REL COSTS-BLDG & FIXT*	T T	0		O	0	1 00
1.00			-	O	-		1.00
2.00	CAP REL COSTS-MVBLE EQUIP*		0			0	2.00
3.00	EMPLOYEE BENEFITS DEPARTMENT*	0	0	05.70	0	0	3.00
4. 00	ADMINISTRATIVE & GENERAL*	12, 768	22, 958			35, 151	4. 00
5. 00	PLANT OPERATION & MAINTENANCE*	0	2, 327		0	2, 327	5. 00
6. 00	LAUNDRY & LINEN SERVICE*	0	0	C	0	0	6. 00
7. 00	HOUSEKEEPI NG*	0	0	0	0	0	7. 00
8.00	DI ETARY*	0	0	0	0	0	8. 00
9.00	NURSING ADMINISTRATION*	0	0	0	0	0	9. 00
10. 00	ROUTINE MEDICAL SUPPLIES*	0	0	C	0	0	10.00
11. 00	MEDI CAL RECORDS*	0	0		0	0	11. 00
12. 00	STAFF TRANSPORTATION*	0	21	21	0	21	12. 00
13.00	VOLUNTEER SERVICE COORDINATION*	0	0	C	0	0	13. 00
14.00	PHARMACY*	0	0	C	0	0	14. 00
15.00	PHYSICIAN ADMINISTRATIVE SERVICES*	0	0	C	0	0	15. 00
16.00	OTHER GENERAL SERVICE*	0	0	C	0	0	16.00
17.00	PATIENT/RESIDENTIAL CARE SERVICES						17. 00
	DIRECT PATIENT CARE SERVICE COST CENTERS						
25.00	INPATIENT CARE-CONTRACTED**		77, 722	77, 722	0	77, 722	25. 00
26.00	PHYSI CI AN SERVI CES**	o	0	l c	0	0	26. 00
27.00	NURSE PRACTITIONER**	768	0	768	0	768	27. 00
28. 00	REGI STERED NURSE**	25, 667	8, 415	34, 082	0	34, 082	28. 00
29. 00	LPN/LVN**	0	0		O	0	29. 00
30.00	PHYSI CAL THERAPY**	o	0	l c	O	0	30.00
31.00	OCCUPATI ONAL THERAPY**	o	0	l c	O	0	31.00
32.00	SPEECH/LANGUAGE PATHOLOGY**	o	0	l c	O	0	32. 00
33. 00	MEDICAL SOCIAL SERVICES**	17, 970	0	17, 970	0	17, 970	ł
34. 00	SPIRITUAL COUNSELING**	11, 349	0	11, 349		11, 349	34. 00
35. 00	DI ETARY COUNSELI NG**	0	0	0	0	0	35. 00
36. 00	COUNSELING - OTHER**	أم	0		0	0	36. 00
37. 00	HOSPICE AIDE & HOMEMAKER SERVICES**	24, 455	0	24, 455	0	24, 455	37. 00
38. 00	DURABLE MEDICAL EQUIPMENT/OXYGEN**	21,100	0	2.7.00	0	0	38. 00
39. 00	PATIENT TRANSPORTATION**	0	0		0	0	39. 00
40. 00	IMAGING SERVICES**	0	0		0	0	40.00
41. 00	LABS & DI AGNOSTI CS**		0		0	0	41.00
42. 00	MEDICAL SUPPLIES-NON-ROUTINE**		0		0	0	42.00
42. 50	DRUGS CHARGED TO PATIENTS**		31, 830	·	0	31, 830	•
43. 00	OUTPATIENT SERVICES**		31, 030	31,030	0	0 0	43. 00
44. 00	PALLIATIVE RADIATION THERAPY**		0		0	0	44.00
45. 00	PALLIATIVE CHEMOTHERAPY**		0		0	0	45.00
46. 00	OTHER PATIENT CARE SERVICES (SPECIFY)**		0		0	0	46.00
40.00		J U	0		ı v		40.00
40.00	NONREI MBURSABLE COST CENTERS BEREAVEMENT PROGRAM *	O	0	0	O	0	60.00
60.00			0	5, 202			ı
61.00	VOLUNTEER PROGRAM *	5, 202	0	5, 202	0	5, 202	61.00
62.00	FUNDRAL SI NG*	0	0		U	0	62.00
63.00	HOSPICE/PALLIATIVE MEDICINE FELLOWS*	0	0		0	0	63.00
	PALLIATIVE CARE PROGRAM*	0	0		0	0	64.00
	OTHER PHYSI CI AN SERVI CES*	0	0		0	0	
	RESI DENTI AL CARE*	0	0		0	0	
	ADVERTI SI NG*	0	0		0	0	
	TELEHEALTH/TELEMONI TORI NG*	0	0		0	0	
	THRI FT STORE*	0	0	l c	0		69. 00
	NURSING FACILITY ROOM & BOARD*	0	0	C	0	0	70. 00
	OTHER NONREIMBURSABLE (SPECIFY)*	0	0	C	0	0	
	TOTAL	98, 179	143, 273	241, 452	-575	240, 877	100. 00
* Tron	sfer the amounts in column 7 to Wkst 0.5 co	lumn 1 line as	annronri ate				

^{*} Transfer the amounts in column 7 to Wkst. 0-5, column 1, line as appropriate.
** See instructions. Do not transfer the amounts in column 7 to Wkst. 0-5.

In Lieu of Form CMS-2552-10 Worksheet 0

Hospi ce CCN: 14-1616

Peri od: From 07/17/2023 To 09/30/2023

Date/Time Prepared: 2/26/2024 1:42 pm

				Hospi ce I	2/20/2024 1.	42 piii
		ADJUSTMENTS	TOTAL (col. 5	l llospi ce i		
		ADJUSTINILINIS	± col. 6)			
		6. 00	7.00			
	GENERAL SERVICE COST CENTERS	0.00	7.00			
1.00	CAP REL COSTS-BLDG & FLXT*		0			1.00
2.00	CAP REL COSTS-BLDG & TTXT	0	0			2.00
3.00	EMPLOYEE BENEFITS DEPARTMENT*	0				1
4.00	ADMINISTRATIVE & GENERAL*	17/	1			3.00
5.00	PLANT OPERATION & MAINTENANCE*	-176 0	1			4.00
6. 00	LAUNDRY & LINEN SERVICE*	0	2, 327			5. 00 6. 00
	HOUSEKEEPING*	0	0			
7.00		0				7.00
8.00	DI ETARY*	0	· -			8.00
9.00	NURSING ADMINISTRATION*	0	0			9. 00
10.00	ROUTINE MEDICAL SUPPLIES*	0	0			10.00
11.00	MEDICAL RECORDS*	0	0			11.00
12.00	STAFF TRANSPORTATION*	0	21			12.00
13.00	VOLUNTEER SERVI CE COORDI NATI ON*	0	0			13.00
14. 00	PHARMACY*	0	0			14. 00
15. 00	PHYSICIAN ADMINISTRATIVE SERVICES*	0	0			15. 00
16. 00	OTHER GENERAL SERVICE*	0	0			16. 00
17. 00	PATIENT/RESIDENTIAL CARE SERVICES					17. 00
	DIRECT PATIENT CARE SERVICE COST CENTERS					
25. 00	I NPATI ENT CARE-CONTRACTED**	0	77, 722			25. 00
26. 00	PHYSI CI AN SERVI CES**	0	. 0			26. 00
27. 00	NURSE PRACTITIONER**	0	768			27. 00
28. 00	REGI STERED NURSE**	0	34, 082			28. 00
29. 00	LPN/LVN**	0	0			29. 00
30. 00	PHYSI CAL THERAPY**	0	0			30. 00
31. 00	OCCUPATI ONAL THERAPY**	0	0			31. 00
32. 00	SPEECH/LANGUAGE PATHOLOGY**	0	0			32. 00
33. 00	MEDICAL SOCIAL SERVICES**	0	17, 970			33. 00
34. 00	SPI RI TUAL COUNSELI NG**	0	11, 349			34. 00
35. 00	DI ETARY COUNSELI NG**	0	0			35. 00
36. 00	COUNSELING - OTHER**	0	0			36. 00
37. 00	HOSPICE AIDE & HOMEMAKER SERVICES**	0	24, 455			37. 00
38. 00	DURABLE MEDICAL EQUIPMENT/OXYGEN**	0	0			38. 00
39. 00	PATI ENT TRANSPORTATION**	0	0			39. 00
40. 00	I MAGING SERVI CES**	0	0			40. 00
41. 00	LABS & DIAGNOSTICS**	0	0			41. 00
42. 00	MEDI CAL SUPPLI ES-NON-ROUTI NE**	0	0			42. 00
42. 50	DRUGS CHARGED TO PATIENTS**	0	31, 830			42. 50
43. 00	OUTPATIENT SERVICES**	0	0			43. 00
44. 00	PALLIATIVE RADIATION THERAPY**	0	0			44. 00
45. 00	PALLIATIVE CHEMOTHERAPY**	0	0			45. 00
46. 00	OTHER PATIENT CARE SERVICES (SPECIFY)**	0	0			46. 00
	NONREI MBURSABLE COST CENTERS		ı			
60. 00	BEREAVEMENT PROGRAM *	0	0			60. 00
61. 00	VOLUNTEER PROGRAM *	0	5, 202			61. 00
62. 00	FUNDRAI SI NG*	0	0			62. 00
63.00	HOSPICE/PALLIATIVE MEDICINE FELLOWS*	0	0			63. 00
64. 00	PALLIATIVE CARE PROGRAM*	0	0			64. 00
65. 00	OTHER PHYSICIAN SERVICES*	0	0			65. 00
66. 00	RESI DENTI AL CARE*	0	0			66. 00
67. 00	ADVERTI SI NG*	0	0			67. 00
68. 00	TELEHEALTH/TELEMONI TORI NG*	0	0			68. 00
69. 00	THRI FT STORE*	0	0			69. 00
70. 00	NURSING FACILITY ROOM & BOARD*	0	0			70. 00
71. 00	OTHER NONREIMBURSABLE (SPECIFY)*	0	0			71. 00
100.00	TOTAL	-176	240, 701	 		100. 00
₊ -	6 11 7 1 7 0 5					

^{*} Transfer the amounts in column 7 to Wkst. 0-5, column 1, line as appropriate.
** See instructions. Do not transfer the amounts in column 7 to Wkst. 0-5.

Date/Time Prepared: 2/26/2024 1:42 pm

> 0 44.00

0 45.00

0 46.00

119, 444 100. 00

Hospi ce CCN: 14-1616

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39, 908

To

0

0

0

119, 444

Peri od: Worksheet 0-2 From 07/17/2023 09/30/2023

0

Hospi ce I SALARI ES SUBTOTAL (col RECLASSIFI -SUBTOTAL OTHER CATI ONS 1 + col.2) 1.00 2.00 5.00 3 00 4.00 DIRECT PATIENT CARE SERVICE COST CENTERS 25.00 INPATIENT CARE-CONTRACTED 25.00 PHYSICIAN SERVICES 26.00 0 26.00 0 NURSE PRACTITIONER 762 27.00 762 762 27.00 o 28.00 REGISTERED NURSE 25, 451 8, 345 33, 796 33, 796 28.00 29.00 LPN/LVN 29.00 30.00 PHYSI CAL THERAPY 0 0 0 0 0 0 0 0 0 30.00 OCCUPATIONAL THERAPY 0 31.00 0 0 0 31.00 32.00 SPEECH/LANGUAGE PATHOLOGY 32.00 33.00 MEDICAL SOCIAL SERVICES 17, 819 17, 819 17, 819 33.00 SPIRITUAL COUNSELING 34.00 0 11, 254 11, 254 11, 254 34.00 35.00 DIETARY COUNSELING 35.00 36.00 COUNSELING - OTHER 0 0 0 0 0 0 0 0 0 0 36.00 HOSPICE AIDE & HOMEMAKER SERVICES 37.00 24, 250 24, 250 37.00 24, 250 38.00 DURABLE MEDICAL EQUIPMENT/OXYGEN 0 0 0 38.00 39.00 PATIENT TRANSPORTATION 0 0 0 39.00 40.00 I MAGING SERVICES 0 0 40.00 0 0 41.00 LABS & DIAGNOSTICS 0 41.00 0 MEDICAL SUPPLIES-NON-ROUTINE 42.00 0 Λ 42.00 42.50 DRUGS CHARGED TO PATIENTS 0 31, 563 31, 563 31, 563 42.50 OUTPATIENT SERVICES 43.00 0 0 43.00

0

79.536

PALLIATIVE RADIATION THERAPY

OTHER PATIENT CARE SERVICES (SPECIFY)

PALLIATIVE CHEMOTHERAPY

		ADJUSTMENTS	TOTAL (col. 5	
			± col. 6)	
		6.00	7. 00	
	DIRECT PATIENT CARE SERVICE COST CENTERS			
25. 00	I NPATIENT CARE-CONTRACTED			25.00
26.00	PHYSI CI AN SERVI CES	0	0	26.00
27. 00	NURSE PRACTITIONER	0	762	27.00
28. 00	REGI STERED NURSE	0	33, 796	28. 00
29. 00	LPN/LVN	0	0	29. 00
30.00	PHYSI CAL THERAPY	0	0	30.00
31.00	OCCUPATI ONAL THERAPY	0	0	31.00
32.00	SPEECH/LANGUAGE PATHOLOGY	0	0	32.00
33.00	MEDICAL SOCIAL SERVICES	0	17, 819	33.00
34.00	SPIRITUAL COUNSELING	0	11, 254	34.00
35.00	DI ETARY COUNSELI NG	0	0	35.00
36.00	COUNSELING - OTHER	0	0	36.00
37.00	HOSPICE AIDE & HOMEMAKER SERVICES	0	24, 250	37.00
38. 00	DURABLE MEDICAL EQUIPMENT/OXYGEN	0	0	38.00
39.00	PATIENT TRANSPORTATION	0	0	39.00
40.00	I MAGING SERVICES	0	0	40.00
41.00	LABS & DIAGNOSTICS	0	0	41.00
42.00	MEDICAL SUPPLIES-NON-ROUTINE	0	o	42.00
42.50	DRUGS CHARGED TO PATIENTS	0	31, 563	42.50
43.00	OUTPATIENT SERVICES	0	0	43.00
44.00	PALLIATIVE RADIATION THERAPY	0	0	44.00
45.00	PALLIATIVE CHEMOTHERAPY	0	o	45.00
46.00	OTHER PATIENT CARE SERVICES (SPECIFY)	0	o o	46.00
100.00	TOTAL *	0	119, 444	100.00

^{*} Transfer the amount in column 7 to Wkst. 0-5, column 1, line 51.

CARE

44.00

45.00

46.00

100.00 TOTAL *

^{*} Transfer the amount in column 7 to Wkst. 0-5, column 1, line 51

RESPITE CARE

Hospi ce CCN: 14-1616

Peri od: From 07/17/2023 To 09/30/2023 Date/Ti me Prepared: 2/26/2024 1:42 pm

					Hospi ce I		
		SALARI ES	OTHER	SUBTOTAL (col.	RECLASSIFI -	SUBTOTAL	
				1 + col. 2)	CATI ONS		
		1.00	2.00	3. 00	4. 00	5. 00	
	DIRECT PATIENT CARE SERVICE COST CENTERS						
25.00	I NPATI ENT CARE-CONTRACTED		49, 742	49, 742	0	49, 742	25. 00
26.00	PHYSI CI AN SERVI CES	0	0	0	0	0	26. 00
27.00	NURSE PRACTITIONER	4	0	4	0	4	27. 00
28.00	REGI STERED NURSE	138	45	183	0	183	28. 00
29. 00	LPN/LVN	0	0	0	0	0	29. 00
30.00	PHYSI CAL THERAPY	0	0	0	0	0	30. 00
31.00	OCCUPATI ONAL THERAPY	0	0	0	0	0	31. 00
32.00	SPEECH/LANGUAGE PATHOLOGY	0	0	0	0	0	32. 00
33.00	MEDICAL SOCIAL SERVICES	97	0	97	0	97	33. 00
34.00	SPIRITUAL COUNSELING	61	0	61	0	61	34. 00
35.00	DI ETARY COUNSELI NG	0	0	0	0	0	35. 00
36.00	COUNSELING - OTHER	0	0	0	0	0	36. 00
37.00	HOSPICE AIDE & HOMEMAKER SERVICES	131	0	131	0	131	37. 00
38.00	DURABLE MEDICAL EQUIPMENT/OXYGEN	0	0	0	0	0	38. 00
39.00	PATI ENT TRANSPORTATION	0	0	0	0	0	39. 00
40.00	I MAGING SERVICES	0	0	0	0	0	40.00
41.00	LABS & DIAGNOSTICS	0	0	0	0	0	41. 00
42.00	MEDICAL SUPPLIES-NON-ROUTINE	0	0	0	0	0	42. 00
42. 50	DRUGS CHARGED TO PATIENTS	0	171	171	0	171	42. 50
43.00	OUTPATIENT SERVICES	0	0	0	0	0	43.00
44.00	PALLIATIVE RADIATION THERAPY	0	0	0	0	0	44. 00
45.00	PALLIATIVE CHEMOTHERAPY	0	0	0	0	0	45. 00
46.00	OTHER PATIENT CARE SERVICES (SPECIFY)	0	0	0	0	0	46. 00
100.00	TOTAL *	431	49, 958	50, 389	0	50, 389	100. 00

^{*} Transfer the amount in column 7 to Wkst. 0-5, column 1, line 52.

^ Iran	ster the amount in column / to Wkst. U-5, col	umn I, IIne 52.		
		ADJUSTMENTS	TOTAL (col. 5	
			± col. 6)	
		6. 00	7.00	
	DIRECT PATIENT CARE SERVICE COST CENTERS			
25. 00	I NPATIENT CARE-CONTRACTED	0	49, 742	25. 00
26. 00	PHYSI CI AN SERVI CES	0	0	26. 00
27. 00	NURSE PRACTITIONER	0	4	27. 00
28. 00	REGI STERED NURSE	0	183	28. 00
29. 00	LPN/LVN	0	0	29. 00
30.00	PHYSI CAL THERAPY	0	0	30.00
31. 00	OCCUPATI ONAL THERAPY	0	0	31. 00
32.00	SPEECH/LANGUAGE PATHOLOGY	0	0	32. 00
33.00	MEDICAL SOCIAL SERVICES	0	97	33. 00
34.00	SPIRITUAL COUNSELING	0	61	34.00
35.00	DI ETARY COUNSELING	0	0	35. 00
36.00	COUNSELING - OTHER	0	0	36. 00
37.00	HOSPICE AIDE & HOMEMAKER SERVICES	0	131	37. 00
38. 00	DURABLE MEDICAL EQUIPMENT/OXYGEN	0	0	38. 00
39. 00	PATIENT TRANSPORTATION	0	0	39. 00
40.00	I MAGI NG SERVI CES	0	0	40. 00
41.00	LABS & DIAGNOSTICS	0	0	41. 00
42.00	MEDICAL SUPPLIES-NON-ROUTINE	0	0	42. 00
42. 50	DRUGS CHARGED TO PATIENTS	0	171	42. 50
43.00	OUTPATIENT SERVICES	0	0	43. 00
44.00	PALLIATIVE RADIATION THERAPY	0	0	44. 00
45.00	PALLI ATI VE CHEMOTHERAPY	0	0	45. 00
46.00	OTHER PATIENT CARE SERVICES (SPECIFY)	0	0	46. 00
100.00	TOTAL *	0	50, 389	100.00

^{*} Transfer the amount in column 7 to Wkst. 0-5, column 1, line 52.

INPATIENT CARE

Provi der CCN: 14-1353

Peri od: Worksheet 0-4 From 07/17/2023 To 09/30/2023

Date/Time Prepared: 2/26/2024 1:42 pm Hospi ce CCN: 14-1616 Hosni ce I

					Hospi ce I		
		SALARI ES	OTHER	SUBTOTAL (col.	RECLASSIFI -	SUBTOTAL	
				1 + col. 2)	CATI ONS		
		1.00	2.00	3. 00	4. 00	5.00	
	DIRECT PATIENT CARE SERVICE COST CENTERS						
25.00	I NPATIENT CARE-CONTRACTED		27, 980	27, 980	0	27, 980	25. 00
26.00	PHYSI CI AN SERVI CES	0	0	0	0	0	26. 00
27.00	NURSE PRACTITIONER	2	0	2	0	2	27. 00
28. 00	REGI STERED NURSE	78	25	103	0	103	28. 00
29. 00	LPN/LVN	0	0	0	0	0	29. 00
30.00	PHYSI CAL THERAPY	0	0	0	0	0	30. 00
31.00	OCCUPATI ONAL THERAPY	0	0	0	0	0	31. 00
32.00	SPEECH/LANGUAGE PATHOLOGY	0	0	0	0	0	32. 00
33.00	MEDICAL SOCIAL SERVICES	54	0	54	0	54	33. 00
34.00	SPIRITUAL COUNSELING	34	0	34	0	34	34.00
35.00	DI ETARY COUNSELI NG	0	0	0	0	0	35. 00
36.00	COUNSELING - OTHER	0	0	0	0	0	36. 00
37.00	HOSPICE AIDE & HOMEMAKER SERVICES	74	0	74	0	74	37.00
38.00	DURABLE MEDICAL EQUIPMENT/OXYGEN	0	0	0	0	0	38. 00
39.00	PATI ENT TRANSPORTATION	0	0	0	0	0	39. 00
40.00	I MAGI NG SERVI CES	0	0	0	0	0	40.00
41.00	LABS & DIAGNOSTICS	0	0	0	0	0	41.00
42.00	MEDICAL SUPPLIES-NON-ROUTINE	0	0	0	0	0	42.00
42.50	DRUGS CHARGED TO PATIENTS	0	96	96	0	96	42. 50
43.00	OUTPATIENT SERVICES	0	0	0	0	0	43.00
44.00	PALLIATIVE RADIATION THERAPY	0	0	0	0	0	44. 00
45.00	PALLI ATI VE CHEMOTHERAPY	0	0	0	0	0	45. 00
46.00	OTHER PATIENT CARE SERVICES (SPECIFY)	0	0	0	0	0	46. 00
100.00	TOTAL *	242	28, 101	28, 343	0	28, 343	100.00
		4 11 50					

^{*} Transfer the amount in column 7 to Wkst. 0-5, column 1, line 53.

		AD ILICTMENTS	TOTAL (I F	
		ADJUSTMENTS	TOTAL (col. 5 ± col. 6)	
		6. 00	7.00	
	DIRECT PATIENT CARE SERVICE COST CENTERS	0.00	7.00	
25. 00	INPATIENT CARE-CONTRACTED	0	27, 980	25. 00
	PHYSI CI AN SERVI CES		0	26. 00
	NURSE PRACTITIONER		2	27. 00
	REGI STERED NURSE		103	28. 00
	LPN/LVN		0	29. 00
30. 00	PHYSI CAL THERAPY	0	o	30.00
31. 00	OCCUPATI ONAL THERAPY	0	o	31.00
32. 00	SPEECH/LANGUAGE PATHOLOGY	0	o	32.00
33. 00	MEDICAL SOCIAL SERVICES	0	54	33.00
34. 00	SPIRITUAL COUNSELING	0	34	34.00
35. 00	DI ETARY COUNSELI NG	0	o	35. 00
36. 00	COUNSELING - OTHER	0	O	36. 00
37. 00	HOSPICE AIDE & HOMEMAKER SERVICES	0	74	37.00
38. 00	DURABLE MEDICAL EQUIPMENT/OXYGEN	0	O	38.00
39. 00	PATIENT TRANSPORTATION	0	o	39.00
40.00	I MAGING SERVICES	0	o	40.00
41.00	LABS & DIAGNOSTICS	0	O	41.00
42.00	MEDICAL SUPPLIES-NON-ROUTINE	0	O	42.00
42. 50	DRUGS CHARGED TO PATIENTS	0	96	42.50
43.00	OUTPATI ENT SERVI CES	0	0	43.00
44. 00	PALLIATIVE RADIATION THERAPY	0	o	44.00
45.00	PALLI ATI VE CHEMOTHERAPY	0	0	45.00
46.00	OTHER PATIENT CARE SERVICES (SPECIFY)	0	0	46.00
100.00	TOTAL *	0	28, 343	100.00

^{*} Transfer the amount in column 7 to Wkst. 0-5, column 1, line 53.

Heal th Financial Systems IROQUOIS M
COST ALLOCATION - DETERMINATION OF HOSPITAL-BASED HOSPICE NET IROQUOIS MEMORIAL HOSPITAL

In Lieu of Form CMS-2552-10
Worksheet 0-5 Peri od: From 07/17/2023 To 09/30/2023 Provi der CCN: 14-1353 EXPENSES FOR ALLOCATION Date/Time Prepared: 2/26/2024 1:42 pm Hospi ce CCN: 14-1616

				2/20/2024 1.42	z piii
			Hospi ce I		
	Descriptions	HOSPICE DIRECT	GENERAL	TOTAL EXPENSES	
		EXPENSES (see	SERVI CE	(sum of cols.	
		instructions)	EXPENSES FROM	1 + 2)	
			WKST B PART I		
			(see		
			instructions)		
		1.00	2. 00	3.00	
	GENERAL SERVICE COST CENTERS				
1.00	CAP REL COSTS-BLDG & FIXT	0	0	0	1. 00
2.00	CAP REL COSTS-MVBLE EQUIP	0	3, 224	3, 224	2. 00
3.00	EMPLOYEE BENEFITS DEPARTMENT	0	33, 732	33, 732	3. 00
4.00	ADMI NI STRATI VE & GENERAL	34, 975	21, 955	56, 930	4. 00
5.00	PLANT OPERATION & MAINTENANCE	2, 327	0	2, 327	5. 00
6.00	LAUNDRY & LINEN SERVICE	0	0	ol	6. 00
7. 00	HOUSEKEEPING	0	0	ol	7. 00
8. 00	DI ETARY	١	0	ő	8. 00
9. 00	NURSI NG ADMINI STRATI ON	0	0	Ö	9. 00
10.00	ROUTI NE MEDI CAL SUPPLI ES	0	0	Ö	10. 00
11. 00	MEDICAL RECORDS	0	0	0	11. 00
12. 00	STAFF TRANSPORTATION	21	O	21	12. 00
13. 00	VOLUNTEER SERVICE COORDINATION	21		0	13. 00
14. 00	PHARMACY	0	0	0	14. 00
15. 00	PHYSICIAN ADMINISTRATIVE SERVICES	0	U	0	15. 00
		0	0	0	
16.00	OTHER GENERAL SERVICE	0	0	0	16.00
17. 00	PATI ENT/RESI DENTI AL CARE SERVI CES LEVEL OF CARE		U		17. 00
FO 00					F0 00
50.00	HOSPI CE CONTI NUOUS HOME CARE	0		0	50.00
51.00	HOSPICE ROUTINE HOME CARE	119, 444		119, 444	51.00
52. 00	HOSPICE INPATIENT RESPITE CARE	50, 389		50, 389	52. 00
53. 00	HOSPI CE GENERAL I NPATI ENT CARE	28, 343		28, 343	53. 00
	NONREI MBURSABLE COST CENTERS		T T		
60.00	BEREAVEMENT PROGRAM	0		0	60. 00
61. 00	VOLUNTEER PROGRAM	5, 202		5, 202	61. 00
62. 00	FUNDRAI SI NG	0		0	62. 00
63. 00	HOSPI CE/PALLI ATI VE MEDI CI NE FELLOWS	0		0	63. 00
64. 00	PALLIATIVE CARE PROGRAM	0		0	64. 00
65. 00	OTHER PHYSI CI AN SERVI CES	0		0	65. 00
66.00	RESI DENTI AL CARE	0		0	66. 00
67.00	ADVERTI SI NG	0		0	67. 00
68.00	TELEHEALTH/TELEMONI TORI NG	0		0	68. 00
69.00	THRI FT STORE	0		0	69. 00
70.00	NURSING FACILITY ROOM & BOARD	0		0	70. 00
71.00	OTHER NONREIMBURSABLE (SPECIFY)	0		0	71. 00
99. 00	NEGATI VE COST CENTER	0		0	99. 00
100.00	TOTAL	240, 701	58, 911	299, 612	100.00
	•	•			

Health Financial Systems IROQUOIS ME
COST ALLOCATION - HOSPITAL-BASED HOSPICE GENERAL SERVICE COSTS I ROQUOIS MEMORIAL HOSPITAL

In Lieu of Form CMS-2552-10

Peri od: Worksheet 0-6
From 07/17/2023 Part I
To 09/30/2023 Date/Time Prepared: 2/26/2024 1: 42 pm Provi der CCN: 14-1353 Hospi ce CCN: 14-1616

						2/26/2024 1: 4:	2 pm
					Hospi ce I		
	Descriptions	TOTAL EXPENSES	CAP REL BLDG 8	CAP REL MVBLI	EMPLOYEE	SUBTOTAL	
			FIX	EQUI P	BENEFI TS		
					DEPARTMENT		
		0	1.00	2.00	3. 00	3A	
	GENERAL SERVICE COST CENTERS						
1.00	CAP REL COSTS-BLDG & FIXT	0	C)			1. 00
2.00	CAP REL COSTS-MVBLE EQUIP	3, 224		3, 22	4		2. 00
3.00	EMPLOYEE BENEFITS DEPARTMENT	33, 732	C		0 33, 732		3. 00
4. 00	ADMINISTRATIVE & GENERAL	56, 930	Ċ	3, 22		64, 541	4. 00
5. 00	PLANT OPERATION & MAINTENANCE	2, 327	Č	0, 22	0 0	2, 327	5. 00
6. 00	LAUNDRY & LINEN SERVICE	2,327			0	2, 327	6. 00
7. 00	HOUSEKEEPI NG	0			0	0	7. 00
8. 00	DI ETARY				0	0	8. 00
	4			(0	_	
9.00	NURSI NG ADMINI STRATI ON	0	C	<u>'</u>	0	0	9.00
10.00	ROUTINE MEDICAL SUPPLIES	0	()	0	0	10.00
11. 00	MEDI CAL RECORDS	0	C)	0	0	11. 00
12. 00	STAFF TRANSPORTATION	21	C)	0	21	12. 00
13.00	VOLUNTEER SERVICE COORDINATION	0	C)	0 0	0	13. 00
14. 00	PHARMACY	0	C)	0	0	14. 00
15. 00	PHYSICIAN ADMINISTRATIVE SERVICES	0	C)	0	0	15. 00
16. 00	OTHER GENERAL SERVICE	0	C)	0	0	16. 00
17. 00	PATIENT/RESIDENTIAL CARE SERVICES		C)	0	0	17. 00
	LEVEL OF CARE						
50.00	HOSPICE CONTINUOUS HOME CARE	0			0	_	50.00
51.00	HOSPICE ROUTINE HOME CARE	119, 444			27, 327	146, 771	51.00
52.00	HOSPICE INPATIENT RESPITE CARE	50, 389	C		0 148	50, 537	52.00
53.00	HOSPICE GENERAL INPATIENT CARE	28, 343	C		0 83	28, 426	53. 00
	NONREI MBURSABLE COST CENTERS						
60.00	BEREAVEMENT PROGRAM	0	C		0 0	0	60.00
61.00	VOLUNTEER PROGRAM	5, 202	C		0 1, 787	6, 989	61. 00
62.00	FUNDRAI SI NG	0	C		0	0	62. 00
63.00	HOSPICE/PALLIATIVE MEDICINE FELLOWS	0	C		0 0	0	63.00
64.00	PALLIATIVE CARE PROGRAM	o	C		0 0	0	64. 00
65. 00	OTHER PHYSICIAN SERVICES	0	C		0	0	65. 00
66. 00	RESI DENTI AL CARE	0	Ċ		0	0	66. 00
67. 00	ADVERTI SI NG		Č		0	0	67. 00
68. 00	TELEHEALTH/TELEMONI TORI NG		Č		0	0	68. 00
69. 00	THRIFT STORE		Č		0	0	69. 00
70. 00	NURSING FACILITY ROOM & BOARD			1		0	70. 00
71. 00	OTHER NONREIMBURSABLE (SPECIFY)		^			0	71.00
99. 00	NEGATIVE COST CENTER				0	0	99.00
	TOTAL	299, 612	C	3, 22	4 33, 732	299, 612	
100.00	TOTAL	277,012	C	ار ع, 22	ا عن الح	277,012	100.00

Heal th Financial Systems IROQUOIS MEMORIAL HOSPITAL
COST ALLOCATION - HOSPITAL-BASED HOSPICE GENERAL SERVICE COSTS Provider CCN: 14-1353 Peri

In Lieu of Form CMS-2552-10

		·			2/26/2024 1:4	2 pm	
					Hospi ce I		
	Descriptions	ADMI NI STRATI VE	PLANT	LAUNDRY &	HOUSEKEEPI NG	DI ETARY	
		& GENERAL	OPERATION &	LINEN SERVICE			
			MAI NTENANCE				
		4. 00	5. 00	6. 00	7. 00	8. 00	
	GENERAL SERVICE COST CENTERS						
1.00	CAP REL COSTS-BLDG & FLXT						1. 00
2.00	CAP REL COSTS-MVBLE EQUIP						2. 00
3.00	EMPLOYEE BENEFITS DEPARTMENT						3. 00
4.00	ADMINISTRATIVE & GENERAL	64, 541					4. 00
5.00	PLANT OPERATION & MAINTENANCE	639	2, 966				5. 00
6.00	LAUNDRY & LINEN SERVICE	o	O				6. 00
7.00	HOUSEKEEPI NG	o	0		0		7. 00
8.00	DI ETARY	o	0		0	0	8. 00
9.00	NURSI NG ADMINI STRATI ON	o	0		0		9. 00
10.00	ROUTINE MEDICAL SUPPLIES	o	0		0		10.00
11. 00	MEDI CAL RECORDS	o	0		0		11.00
12. 00	STAFF TRANSPORTATION	6	0		0		12.00
13. 00	VOLUNTEER SERVICE COORDINATION	0	0		0		13. 00
14. 00	PHARMACY	o	0		0		14. 00
15. 00	PHYSICIAN ADMINISTRATIVE SERVICES	0	0		0		15. 00
16. 00	OTHER GENERAL SERVICE	0	2, 966		0		16. 00
17. 00	PATIENT/RESIDENTIAL CARE SERVICES	0	_,		0		17. 00
	LEVEL OF CARE				-1		
50.00	HOSPI CE CONTI NUOUS HOME CARE	0					50.00
51.00	HOSPICE ROUTINE HOME CARE	40, 297					51.00
52.00	HOSPICE INPATIENT RESPITE CARE	13, 875	0		ol	0	52. 00
53.00	HOSPICE GENERAL INPATIENT CARE	7, 805	0		ol	0	53. 00
	NONREI MBURSABLE COST CENTERS						1
60.00	BEREAVEMENT PROGRAM	0	C		0		60.00
61.00	VOLUNTEER PROGRAM	1, 919	0		0		61. 00
62.00	FUNDRAI SI NG	0	0		0		62. 00
63.00	HOSPICE/PALLIATIVE MEDICINE FELLOWS	0	0		0		63. 00
64.00	PALLIATIVE CARE PROGRAM	o	O		0		64.00
65.00	OTHER PHYSICIAN SERVICES	o	O		0		65. 00
66.00	RESI DENTI AL CARE	o	O		o	0	66. 00
67.00	ADVERTI SI NG	o	0		0		67. 00
68.00	TELEHEALTH/TELEMONI TORI NG	o	O		0		68. 00
69.00	THRI FT STORE	o	O		0		69. 00
70.00	NURSING FACILITY ROOM & BOARD						70. 00
71. 00	OTHER NONREIMBURSABLE (SPECIFY)	0	0	(ol	0	71. 00
99. 00	NEGATIVE COST CENTER	0	0	(ol	0	99. 00
100.00	TOTAL	64, 541	2, 966	(o	0	100.00
				•	•		

Health Financial Systems IROQUOIS ME
COST ALLOCATION - HOSPITAL-BASED HOSPICE GENERAL SERVICE COSTS IROQUOIS MEMORIAL HOSPITAL

In Lieu of Form CMS-2552-10 Worksheet 0-6 Part I Date/Time Prepared: 2/26/2024 1:42 pm Provider CCN: 14-1353 Peri od: From 07/17/2023 To 09/30/2023 Hospi ce CCN: 14-1616

						2/20/2024 1.4	z piii
					Hospi ce I		
	Descriptions	NURSI NG	ROUTI NE	MEDI CAL	STAFF	VOLUNTEER	
		ADMI NI STRATI ON	MEDI CAL	RECORDS	TRANSPORTATI ON	SERVI CE	
			SUPPLI ES			COORDI NATI ON	
		9. 00	10. 00	11. 00	12.00	13. 00	
	GENERAL SERVICE COST CENTERS			_			
1.00	CAP REL COSTS-BLDG & FLXT						1. 00
2.00	CAP REL COSTS-MVBLE EQUIP						2. 00
3.00	EMPLOYEE BENEFITS DEPARTMENT						3. 00
4.00	ADMINISTRATIVE & GENERAL						4.00
5.00	PLANT OPERATION & MAINTENANCE						5. 00
6.00	LAUNDRY & LINEN SERVICE						6. 00
7.00	HOUSEKEEPI NG						7. 00
8.00	DI ETARY						8. 00
9.00	NURSING ADMINISTRATION	0					9. 00
10.00	ROUTINE MEDICAL SUPPLIES	0	C	ol			10.00
11.00	MEDI CAL RECORDS	0)		11. 00
12.00	STAFF TRANSPORTATION	o			27		12.00
13. 00	VOLUNTEER SERVICE COORDINATION	O			ol	0	1
14. 00	PHARMACY	O			o	0	1
15. 00	PHYSICIAN ADMINISTRATIVE SERVICES	0			o	0	1
16. 00	OTHER GENERAL SERVICE	0			ol	0	
17. 00	PATIENT/RESIDENTIAL CARE SERVICES					ŭ	17. 00
	LEVEL OF CARE	1		1			1
50.00	HOSPICE CONTINUOUS HOME CARE	0	C	0	0	0	50.00
51.00	HOSPICE ROUTINE HOME CARE	0	C	ol c	27	0	51.00
52.00	HOSPICE INPATIENT RESPITE CARE	0	C	ol c	o	0	52. 00
53.00	HOSPICE GENERAL INPATIENT CARE	0	C	ol c	o	0	53. 00
	NONREI MBURSABLE COST CENTERS						
60.00	BEREAVEMENT PROGRAM	0			0	0	60.00
61.00	VOLUNTEER PROGRAM	0			0	0	61.00
62.00	FUNDRAI SI NG	0			0	0	62.00
63.00	HOSPICE/PALLIATIVE MEDICINE FELLOWS	0			0	0	63. 00
64.00	PALLIATIVE CARE PROGRAM	0			o	0	64.00
65.00	OTHER PHYSICIAN SERVICES	0			o	0	65. 00
66.00	RESI DENTI AL CARE	0			o	0	66. 00
67.00	ADVERTI SI NG	0			o	0	67. 00
68.00	TELEHEALTH/TELEMONI TORI NG	0			o	0	68. 00
69.00	THRI FT STORE	0			o	0	69. 00
70.00	NURSING FACILITY ROOM & BOARD						70. 00
71. 00	OTHER NONREIMBURSABLE (SPECIFY)	0			0	0	1
99. 00	NEGATIVE COST CENTER		C		ol	0	1
	TOTAL	o	C	1	1	0	100.00
	1	-1	_	'	1	_	

Heal th Financial Systems IROQUOIS MEMORIAL HOSPITAL
COST ALLOCATION - HOSPITAL-BASED HOSPICE GENERAL SERVICE COSTS Provider CCN: 14-1353 Period

Hospi ce I		
Descriptions PHARMACY PHYSICIAN OTHER GENERAL PATIENT/	TOTAL	
ADMINISTRATIVE SERVICE RESIDENTIAL		
SERVI CES CARE SERVI CES		
14. 00 15. 00 16. 00 17. 00	18. 00	
GENERAL SERVICE COST CENTERS		
1.00 CAP REL COSTS-BLDG & FIXT		1.00
2.00 CAP REL COSTS-MVBLE EQUIP		2.00
3.00 EMPLOYEE BENEFITS DEPARTMENT		3.00
4.00 ADMINISTRATIVE & GENERAL		4.00
5.00 PLANT OPERATION & MAINTENANCE		5.00
6.00 LAUNDRY & LINEN SERVICE		6.00
7. 00 HOUSEKEEPI NG		7.00
8. 00 DI ETARY		8.00
9.00 NURSING ADMINISTRATION		9.00
10.00 ROUTINE MEDICAL SUPPLIES		10.00
11.00 MEDICAL RECORDS		11.00
12.00 STAFF TRANSPORTATION		12.00
13.00 VOLUNTEER SERVICE COORDINATION		13.00
14.00 PHARMACY 0		14.00
15.00 PHYSICIAN ADMINISTRATIVE SERVICES 0 0		15.00
16. 00 OTHER GENERAL SERVICE 0 2, 966		16.00
17.00 PATIENT/RESIDENTIAL CARE SERVICES 0		17.00
LEVEL OF CARE		
50. 00 HOSPICE CONTINUOUS HOME CARE 0 0 0	0	50.00
51.00 HOSPICE ROUTINE HOME CARE 0 0 2, 941	190, 036	51.00
52.00 HOSPICE INPATIENT RESPITE CARE 0 0 16 0	64, 428	52.00
53.00 HOSPICE GENERAL INPATIENT CARE 0 0 9 0	36, 240	53.00
NONREI MBURSABLE COST CENTERS		
60.00 BEREAVEMENT PROGRAM 0 0	0	60.00
61.00 VOLUNTEER PROGRAM 0 0	8, 908	61.00
62. 00 FUNDRAI SI NG 0 0	0	62.00
63.00 HOSPICE/PALLIATIVE MEDICINE FELLOWS 0 0	0	63.00
64.00 PALLIATIVE CARE PROGRAM 0 0 0	0	64.00
65.00 OTHER PHYSICIAN SERVICES 0 0	0	65.00
66. 00 RESI DENTI AL CARE 0 0 0 0	0	66.00
67. 00 ADVERTI SI NG 0 0	0	67.00
68. 00 TELEHEALTH/TELEMONI TORI NG 0 0	0	68.00
69. 00 THRI FT STORE 0 0 0	0	69.00
70.00 NURSING FACILITY ROOM & BOARD	0	70.00
71.00 OTHER NONREIMBURSABLE (SPECIFY) 0 0 0	0	71.00
99.00 NEGATIVE COST CENTER 0 0 0	0	99. 00
100. 00 TOTAL 0 0 2, 966 0	299, 612	100. 00

Heal th Financial Systems IROQUOIS MEMORIAL HOSPITAL In Lieu of Form CMS-2552-10

COST ALLOCATION - HOSPITAL-BASED HOSPICE GENERAL SERVICE COSTS
STATISTICAL BASIS

Hospice CCN: 14-1353
Hospice CCN: 14-1616

Period:
From 07/17/2023
To 09/30/2023
Date/Time Prepared:
2/26/2024 1: 42 pm

						2/20/2024 1: 4.	z piii
					Hospi ce I		
	Cost Center Descriptions	CAP REL BLDG &	CAP REL MVBLE	EMPLOYEE	RECONCI LI ATI ON	ADMI NI STRATI VE	
	'	FLX	EQUI P	BENEFITS		& GENERAL	
		(SOUARE FEFT)	(DOLLAR VALUE)	DEPARTMENT		(ACCUMULATED	
		(000/1112 1221)	(5022/11 7/1202)	(GROSS		COSTS)	
				SALARI ES)		00010)	
		1.00	2.00	3. 00	4A	4. 00	
	GENERAL SERVICE COST CENTERS	1.00	2.00	0.00	17.	1.00	
1.00	CAP REL COSTS-BLDG & FLXT	2, 350					1. 00
2. 00	CAP REL COSTS-MVBLE EQUIP	2,000	28, 682				2. 00
3.00	EMPLOYEE BENEFITS DEPARTMENT	2, 350	20,002	98, 179			3. 00
4. 00	ADMINISTRATIVE & GENERAL	2, 330	28, 682	12, 768	1	235, 071	4. 00
		0	28, 082	12, 708	-04, 541		
5.00	PLANT OPERATION & MAINTENANCE	0	0		0	2, 327	5. 00
6. 00	LAUNDRY & LINEN SERVICE	0	0		0	0	6. 00
7.00	HOUSEKEEPI NG	0	0	0	0	0	7. 00
8.00	DI ETARY	0	0	0	0	0	8. 00
9.00	NURSI NG ADMI NI STRATI ON	0	0	0	0	0	9. 00
10. 00	ROUTINE MEDICAL SUPPLIES	0	0	0	0	0	10.00
11.00	MEDI CAL RECORDS	0	0	C	0	0	11.00
12.00	STAFF TRANSPORTATION	0	0	C	0	21	12.00
13.00	VOLUNTEER SERVICE COORDINATION	0	0		o	0	13. 00
14.00	PHARMACY	0	0	0	o	0	14. 00
15. 00	PHYSICIAN ADMINISTRATIVE SERVICES	0	n		0	0	15. 00
16. 00	OTHER GENERAL SERVICE	o o	n	Ö		0	16. 00
17. 00	PATIENT/RESIDENTIAL CARE SERVICES	0	l o	۲	0	0	17. 00
17.00	LEVEL OF CARE		0		<u> </u>	0	17.00
50.00	HOSPICE CONTINUOUS HOME CARE	1		C	0	0	50. 00
51. 00	HOSPICE CONTINUOUS HOME CARE			79, 535		146, 771	51. 00
	4		_		1		
52. 00	HOSPICE INPATIENT RESPITE CARE	0	0	431		50, 537	52. 00
53. 00	HOSPICE GENERAL INPATIENT CARE	0	0	243	0	28, 426	53. 00
	NONREI MBURSABLE COST CENTERS	1					
60.00	BEREAVEMENT PROGRAM	0	0		-	0	60.00
61. 00	VOLUNTEER PROGRAM	0	0	5, 202	1	6, 989	61. 00
62. 00	FUNDRAI SI NG	0	0	0	0	0	62. 00
63.00	HOSPICE/PALLIATIVE MEDICINE FELLOWS	0	0	0	0	0	63.00
64. 00	PALLIATIVE CARE PROGRAM	0	0	0	0	0	64. 00
65.00	OTHER PHYSICIAN SERVICES	0	0	C	0	0	65.00
66.00	RESI DENTI AL CARE	0	0	C	0	0	66.00
67.00	ADVERTI SI NG	0	0		o	0	67. 00
68.00	TELEHEALTH/TELEMONI TORI NG	0	0		o	0	68. 00
69. 00	THRIFT STORE	0	0		ol	0	69. 00
	NURSING FACILITY ROOM & BOARD]	n		70. 00
71. 00	OTHER NONREIMBURSABLE (SPECIFY)	0	n	0	l ol	0	71.00
	NEGATI VE COST CENTER			Ĭ	Ĭ		99. 00
	COST TO BE ALLOCATED (per Wkst. 0-6, Part I)		3, 224	33, 732	,	64, 541	
	UNIT COST MULTIPLIER	0. 000000				0. 274560	
101.00	ONT OUST WOLITTEIEN	0.000000	0.112403	0.545577	1	0.274300	101.00

Health Financial Systems

I ROQUOIS MEMORIAL HOSPITAL

In Lieu of Form CMS-2552-10

COST ALLOCATION - MOSPITAL PARED MOSPICE CONTRAL STRUCTS C

COST ALLOCATION - HOSPITAL BASED HOSPICE GENERAL SERVICE COSTS
STATISTICAL BASIS

Hospice CCN: 14-1353
Hospice CCN: 14-1616

Peri od:
From 07/17/2023
To 09/30/2023
Date/Time Prepared:
2/26/2024 1: 42 pm

						2/26/2024 1: 4	2 pm
					Hospi ce I		
	Cost Center Descriptions	PLANT	LAUNDRY &	HOUSEKEEPI NG	DI ETARY	NURSI NG	
	'	OPERATION &	LINEN SERVICE	(SQUARE FEET)	(IN-FACILITY	ADMI NI STRATI ON	
		MAI NTENANCE	(IN-FACILITY	(DAYS)		
		(SQUARE FEET)	DAYS)			(DIRECT NURS.	
		,				HRS.)	
		5. 00	6.00	7. 00	8. 00	9.00	
	GENERAL SERVICE COST CENTERS						
1.00	CAP REL COSTS-BLDG & FLXT		I				1.00
2. 00	CAP REL COSTS-MVBLE EQUIP	4					2.00
3.00	EMPLOYEE BENEFITS DEPARTMENT						3.00
4. 00	ADMI NI STRATI VE & GENERAL	•					4. 00
	1	2, 350					5.00
5.00	PLANT OPERATION & MAINTENANCE	2, 350					
6.00	LAUNDRY & LINEN SERVICE	0	0				6.00
7. 00	HOUSEKEEPI NG	0		2, 350			7. 00
8.00	DI ETARY	0		0	C		8. 00
9.00	NURSING ADMINISTRATION	0		0		2, 976	•
10. 00	ROUTINE MEDICAL SUPPLIES	0		0		0	10. 00
11. 00	MEDI CAL RECORDS	0		0		0	11. 00
12.00	STAFF TRANSPORTATION	0		0		0	12. 00
13.00	VOLUNTEER SERVICE COORDINATION	0		0		0	13.00
14.00	PHARMACY	0		0		0	14.00
15.00	PHYSICIAN ADMINISTRATIVE SERVICES	0		0		0	15. 00
16.00	OTHER GENERAL SERVICE	2, 350		2, 350		0	16. 00
17.00	PATIENT/RESIDENTIAL CARE SERVICES			l			17. 00
	LEVEL OF CARE			•			1
50.00	HOSPICE CONTINUOUS HOME CARE					0	50.00
51.00	HOSPICE ROUTINE HOME CARE					2, 951	51.00
52. 00	HOSPICE INPATIENT RESPITE CARE	1	0	0	C	1	1
53. 00	HOSPICE GENERAL INPATIENT CARE		Ö	•			
00.00	NONREI MBURSABLE COST CENTERS					1	00.00
60.00	BEREAVEMENT PROGRAM			0		0	60.00
61. 00	VOLUNTEER PROGRAM					0	61.00
62.00	FUNDRAI SI NG					0	62.00
63. 00	HOSPICE/PALLIATIVE MEDICINE FELLOWS					0	63.00
64. 00	1					0	64.00
	PALLIATIVE CARE PROGRAM						
65. 00	OTHER PHYSI CI AN SERVI CES			0		0	65.00
66.00	RESI DENTI AL CARE	0	0	0	C	1	66.00
67. 00	ADVERTI SI NG	0		0		0	67. 00
68. 00	TELEHEALTH/TELEMONI TORI NG	0		0		0	68. 00
69. 00	THRI FT STORE	0		0		0	69. 00
70. 00	NURSING FACILITY ROOM & BOARD						70. 00
71. 00	OTHER NONREIMBURSABLE (SPECIFY)	0	0	0	C	0	
99. 00	NEGATIVE COST CENTER						99. 00
	COST TO BE ALLOCATED (per Wkst. 0-6, Part I)	2, 966		0	(C		100. 00
101.00	UNIT COST MULTIPLIER	1. 262128	0. 000000	0. 000000	0.000000	0.000000	101. 00

Heal th Financial Systems IROQUOIS MEMORIAL HOSPITAL In Lieu of Form CMS-2552-10

COST ALLOCATION - HOSPITAL BASED HOSPICE GENERAL SERVICE COSTS
STATISTICAL BASIS

Provider CCN: 14-1353
Hospice CCN: 14-1616

Period:
From 07/17/2023
To 09/30/2023

Worksheet 0-6
Part II
Date/Time Prepared:
2/26/2024 1: 42 pm

						27 207 202 1 1. 12	2 0111
					Hospi ce I		
	Cost Center Descriptions	ROUTI NE	MEDI CAL	STAFF	VOLUNTEER	PHARMACY	
		MEDI CAL	RECORDS	TRANSPORTATI ON		(CHARGES)	
		SUPPLI ES	(PATIENT DAYS)		COORDI NATI ON		
		(PATIENT DAYS)		(MI LEAGE)	(HOURS OF		
		10.00	11.00	10.00	SERVICE)	44.00	
	GENERAL SERVICE COST CENTERS	10. 00	11.00	12.00	13. 00	14. 00	
1. 00	CAP REL COSTS-BLDG & FLXT			I			1.00
2.00	1		•				1
3.00	CAP REL COSTS-MVBLE EQUIP EMPLOYEE BENEFITS DEPARTMENT		•				2.00
	4		•				3.00
4.00	ADMI NI STRATI VE & GENERAL						4. 00
5.00	PLANT OPERATION & MAINTENANCE						5. 00
6.00	LAUNDRY & LINEN SERVICE						6.00
7.00	HOUSEKEEPI NG						7. 00
8.00	DI ETARY						8. 00
9.00	NURSING ADMINISTRATION	0.07/					9. 00
10.00	ROUTINE MEDICAL SUPPLIES	2, 976					10.00
11. 00	MEDI CAL RECORDS		2, 976				11. 00
12. 00	STAFF TRANSPORTATION			2, 976	_		12.00
13. 00	VOLUNTEER SERVICE COORDINATION			0	0		13. 00
14. 00	PHARMACY			0	0	0	
15. 00	PHYSICIAN ADMINISTRATIVE SERVICES			0	0	0	15. 00
16. 00	OTHER GENERAL SERVICE			0	0	0	16. 00
17. 00	PATIENT/RESIDENTIAL CARE SERVICES						17. 00
	LEVEL OF CARE	_	1	1	_	_	
50. 00	HOSPICE CONTINUOUS HOME CARE	C		1		0	
51.00	HOSPICE ROUTINE HOME CARE	2, 951	2, 951	1	0	0	51.00
52.00	HOSPICE INPATIENT RESPITE CARE	16				0	
53. 00	HOSPICE GENERAL INPATIENT CARE	9	9	9	0	0	53. 00
	NONREI MBURSABLE COST CENTERS	1	1	1	T	_	
60. 00	BEREAVEMENT PROGRAM			0	_	0	
61. 00	VOLUNTEER PROGRAM			0	0	0	61. 00
62. 00	FUNDRAI SI NG			0	0	0	
63. 00	HOSPICE/PALLIATIVE MEDICINE FELLOWS			0	0	0	63. 00
64. 00	PALLIATIVE CARE PROGRAM			0	0	0	
65. 00	OTHER PHYSICIAN SERVICES			0	0	0	65. 00
66. 00	RESI DENTI AL CARE			0	0	0	66. 00
67. 00	ADVERTI SI NG			0	0	0	
68. 00	TELEHEALTH/TELEMONI TORI NG			0	0	0	68. 00
69. 00	THRI FT STORE			0	0	0	
70. 00	NURSING FACILITY ROOM & BOARD						70. 00
71. 00	OTHER NONREIMBURSABLE (SPECIFY)			0	0	0	
99. 00	NEGATI VE COST CENTER						99. 00
	COST TO BE ALLOCATED (per Wkst. 0-6, Part I)	C	0	27	0		100. 00
101.00	UNIT COST MULTIPLIER	0. 000000	0. 000000	0. 009073	0. 000000	0. 000000	101. 00

Heal th Financial Systems IROQUOIS MEMORIAL HOSPITAL In Lieu of Form CMS-2552-10

COST ALLOCATION - HOSPITAL BASED HOSPICE GENERAL SERVICE COSTS
STATISTICAL BASIS

Provider CCN: 14-1353
Hospice CCN: 14-1616

Period:
From 07/17/2023
To 09/30/2023
To 09/30/2023
Hospice L
Hospice L
Hospice L

					Hospi ce I	
	Cost Center Descriptions	PHYSI CI AN	OTHER GENERAL	PATI ENT/		
		ADMI NI STRATI VE	SERVI CE	RESI DENTI AL		
		SERVI CES	(SPECI FY	CARE SERVICES		
		(PATIENT DAYS)	BASIS)	(IN-FACILITY		
				DAYS)		
		15. 00	16. 00	17. 00		
	GENERAL SERVICE COST CENTERS					
1.00	CAP REL COSTS-BLDG & FLXT					1. 00
2.00	CAP REL COSTS-MVBLE EQUIP					2. 00
3.00	EMPLOYEE BENEFITS DEPARTMENT					3. 00
4.00	ADMINISTRATIVE & GENERAL					4. 00
5.00	PLANT OPERATION & MAINTENANCE					5. 00
6.00	LAUNDRY & LINEN SERVICE					6. 00
7.00	HOUSEKEEPI NG					7. 00
8.00	DI ETARY					8. 00
9.00	NURSING ADMINISTRATION					9.00
10.00	ROUTINE MEDICAL SUPPLIES					10.00
11. 00	MEDI CAL RECORDS					11. 00
12. 00	STAFF TRANSPORTATION					12.00
13. 00	VOLUNTEER SERVICE COORDINATION					13. 00
14. 00	PHARMACY					14. 00
15. 00	PHYSICIAN ADMINISTRATIVE SERVICES	0				15. 00
16. 00	OTHER GENERAL SERVICE		2, 976			16.00
17. 00	PATIENT/RESIDENTIAL CARE SERVICES		2, 770	0		17. 00
17.00	LEVEL OF CARE					17.00
50.00	HOSPICE CONTINUOUS HOME CARE	0	0			50.00
51. 00	HOSPICE ROUTINE HOME CARE	0	2, 951			51.00
52. 00	HOSPICE INPATIENT RESPITE CARE	0	16			52. 00
53. 00	HOSPICE GENERAL INPATIENT CARE	0	9			53. 00
00.00	NONREI MBURSABLE COST CENTERS	J	,			00.00
60.00	BEREAVEMENT PROGRAM		0			60.00
61. 00	VOLUNTEER PROGRAM		0			61. 00
62. 00	FUNDRAI SI NG		0			62.00
63. 00	HOSPICE/PALLIATIVE MEDICINE FELLOWS		0			63.00
64. 00	PALLIATIVE CARE PROGRAM		0			64.00
65. 00	OTHER PHYSICIAN SERVICES		0			65. 00
66. 00	RESI DENTI AL CARE	0	0	0		66. 00
67. 00	ADVERTI SI NG		0	Ĭ		67. 00
68. 00	TELEHEALTH/TELEMONI TORI NG		0			68. 00
69. 00	THRIFT STORE		0			69.00
70. 00	NURSING FACILITY ROOM & BOARD		0			70.00
71.00	OTHER NONREIMBURSABLE (SPECIFY)	0	0	0		71.00
	NEGATIVE COST CENTER		0			99.00
	COST TO BE ALLOCATED (per Wkst. 0-6, Part I)	0	2, 966	1		100.00
	UNIT COST MULTIPLIER	0. 000000				100.00
101.00	UNIT COST WOLFFELER	0.000000	0. 770040	1 0.00000	l	1101.00

IROQUOIS MEMORIAL HOSPITAL

Heal th Financial Systems IROQUOIS MEM
APPORTIONMENT OF HOSPITAL-BASED HOSPICE SHARED SERVICE COSTS BY In Lieu of Form CMS-2552-10 Provi der CCN: 14-1353 Peri od: From 07/17/2023 To 09/30/2023 Worksheet 0-7 LEVEL OF CARE Date/Time Prepared: 2/26/2024 1:42 pm Hospi ce CCN: 14-1616

						2/26/2024 1:4	2 pm
					Hospi ce I		
	·			Charges by	LOC (from Provi	der Records)	
	Cost Center Descriptions	From Wkst. C, C		HCHC	HRHC	HI RC	
		Part I, Col. 9	Ratio				
		line	4 00				
	ANOLILIADY OFFICE COOT OFFITTED	0	1. 00	2.00	3. 00	4. 00	
	ANCILLARY SERVICE COST CENTERS		0 / 00 / 10	ı		_	
1.00	PHYSI CAL THERAPY	66. 00	0. 688448		0	0	1.00
2.00	OCCUPATIONAL THERAPY	67. 00					2.00
3.00	SPEECH PATHOLOGY	68. 00	0.570/4/				3. 00
4.00	DRUGS CHARGED TO PATIENTS	73. 00	0. 573646		0	0	
5.00	DURABLE MEDICAL EQUIP-RENTED	96. 00	0.400700				5. 00
6. 00	LABORATORY	60. 00	0. 189723		0	0	
	MEDICAL SUPPLIES CHARGED TO PATIENT	71. 00	0. 018068		0	0	7. 00
	OTHER OUTPATIENT SERVICE COST CENTER	93. 00					8. 00
	RADI OLOGY-THERAPEUTI C	55. 00					9. 00
	OTHER ANCILLARY SERVICE COST CENTERS	76. 00					10.00
11. 00	Totals (sum of lines 1-11)	01 1 100			2		11. 00
		Charges by LOC		Shared Servi	ce Costs by LOC		
		(from Provider					
	Coot Conton Decement one	Records) HGIP H	ICUC (col 1 v	UDUC (aal 1	xHIRC (col. 1 x	UCLD (ast 1 v	
	Cost Center Descriptions	HGI P H	col. 2)	col. 3)	col. 4)	col. 5)	
		5.00	6. 00	7.00	8. 00	9.00	
	ANCILLARY SERVICE COST CENTERS	3.00	0.00	7.00	0.00	7.00	
1. 00	PHYSI CAL THERAPY	0	0		0 0	0	1.00
	OCCUPATI ONAL THERAPY		J		ŭ .	Ŭ	2. 00
3. 00	SPEECH PATHOLOGY						3.00
4. 00	DRUGS CHARGED TO PATIENTS	0	0		0	0	4. 00
5. 00	DURABLE MEDICAL EQUIP-RENTED		J		ŭ .	Ŭ	5.00
6. 00	LABORATORY	0	0		0	0	6. 00
7. 00	MEDICAL SUPPLIES CHARGED TO PATIENT		0		0 0	o o	7. 00
	OTHER OUTPATIENT SERVICE COST CENTER		ŭ			Ĭ	8.00
	RADI OLOGY-THERAPEUTI C						9. 00
	OTHER ANCILLARY SERVICE COST CENTERS						10.00
	Totals (sum of lines 1-11)		0		0 0	0	
00	101010 (00 01 1100 1 11)	1	· ·	1	51		, 00

Heal th Financial Systems IROQUOIS MEMORIAL HOSPITAL
CALCULATION OF HOSPITAL-BASED HOSPICE PER DIEM COST Provider CCN: 14-1353 Per

			Hospi ce I		
		TITLE XVIII	TITLE XIX	TOTAL	
		MEDI CARE	MEDI CAI D		
		1.00	2. 00	3.00	
	HOSPICE CONTINUOUS HOME CARE				
1.00	Total cost (Wkst. 0-6, Part I, col. 18, line 50 plus Wkst. 0-7, col. 6,			0	1.00
	line 11)				
2.00	Total unduplicated days (Wkst. S-9, col. 4, line 10)			0	2.00
3.00	Total average cost per diem (line 1 divided by line 2)			0.00	3.00
4.00	Unduplicated program days (Wkst. S-9 col. as appropriate, line 10)	O	ol		4.00
5.00	Program cost (line 3 times line 4)	l o	ol		5.00
	HOSPICE ROUTINE HOME CARE		<u> </u>		
6.00	Total cost (Wkst. 0-6, Part I, col. 18, line 51 plus Wkst. 0-7, col. 7,			190, 036	6.00
	line 11)				
7.00	Total unduplicated days (Wkst. S-9, col. 4, line 11)			2, 951	7.00
8.00	Total average cost per diem (line 6 divided by line 7)			64. 40	8.00
9.00	Unduplicated program days (Wkst. S-9, col. as appropriate, line 11)	2, 875	ol		9. 00
10.00	Program cost (line 8 times line 9)	185, 150	o		10.00
	HOSPICE INPATIENT RESPITE CARE				
11.00	Total cost (Wkst. 0-6, Part I, col. 18, line 52 plus Wkst. 0-7, col. 8,			64, 428	11.00
	line 11)				
12.00	Total unduplicated days (Wkst. S-9, col. 4, line 12)			16	12.00
13.00	Total average cost per diem (line 11 divided by line 12)			4, 026. 75	13.00
14.00	Unduplicated program days (Wkst. S-9, col. as appropriate, line 12)	16	0		14.00
15.00	Program cost (line 13 times line 14)	64, 428	o		15.00
	HOSPICE GENERAL INPATIENT CARE				
16.00	Total cost (Wkst. 0-6, Part I, col. 18, line 53 plus Wkst. 0-7, col. 9,			36, 240	16.00
	line 11)				
17.00	Total unduplicated days (Wkst. S-9, col. 4, line 13)			9	17.00
18.00	Total average cost per diem (line 16 divided by line 17)			4, 026. 67	18.00
19.00	Unduplicated program days (Wkst. S-9, col. as appropriate, line 13)	7	0		19.00
20.00	Program cost (line 18 times line 19)	28, 187	0		20.00
	TOTAL HOSPICE CARE				
21.00	Total cost (sum of line 1 + line 6 + line 11 + line 16)			290, 704	21.00
22.00	Total unduplicated days (Wkst. S-9, col. 4, line 14)			2, 976	22.00
23.00	Average cost per diem (line 21 divided by line 22)			97. 68	23.00
			·	·	

IROQUOIS MEMORIAL HOSPITAL Health Financial Systems

In Lieu of Form CMS-2552-10 ANALYSIS OF HOSPITAL-BASED RHC/FOHC COSTS Provi der CCN: 14-1353 Peri od: Worksheet M-1 From 07/17/2023 Component CCN: 14-3424 09/30/2023 To Date/Time Prepared: 2/26/2024 1:42 pm RHC I Cost 1 Reclassi fi cati Recl assi fi ed Compensation Other Costs Total (col. + col . 2) Trial Balance ons (col. 3 + col.4) 1.00 2.00 3.00 4.00 5.00 FACILITY HEALTH CARE STAFF COSTS 1.00 -10, 932 15, 434 26, 366 26, 366 1.00 Physi ci an 2.00 Physician Assistant 0 0 2.00 30, 677 3.00 Nurse Practitioner 30, 677 650 30, 027 3.00 0 4.00 Visiting Nurse 0 4.00 Other Nurse 5.00 18,582 0 18, 582 0 18, 582 5.00 6.00 Clinical Psychologist 0 0 6.00 7.00 Clinical Social Worker 0 0 0 0 7.00 8.00 Laboratory Techni ci an 0 0 8.00 0 9.00 Other Facility Health Care Staff Costs 0 0 9 00 Λ 10.00 Subtotal (sum of lines 1 through 9) 75, 625 0 75, 625 -11, 582 64,043 10.00 11.00 Physician Services Under Agreement 0 0 11.00 0 0 Physician Supervision Under Agreement 0 0 12.00 0 12.00 Other Costs Under Agreement 13.00 C 0 0 13.00 14.00 Subtotal (sum of lines 11 through 13) 0 0 0 0 14.00 Medical Supplies 0 15.00 0 0 0 1, 305 1, 305 1, 305 15.00 Transportation (Health Care Staff) 16 00 50 50 50 16 00 17.00 Depreciation-Medical Equipment C 0 0 0 17.00 18.00 Professional Liability Insurance 0 0 0 18.00 C Other Health Care Costs 0 0 19.00 0 19.00 0

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-11, 582

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-1, 428

-13, 010

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14, 378

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24.00

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25.01

25.02

26.00 27.00

28.00

29.00

30.00

31.00

32.00

Allowable GME Costs

Chronic Care Management

Nonallowable GME costs

Administrative Costs

Pharmacy

Optometry

Tel eheal th

through 27) FACILITY OVERHEAD

and 31)

Facility Costs

Dental

Subtotal (sum of lines 15 through 20)

lines 10, 14, and 21)
COSTS OTHER THAN RHC/FQHC SERVICES

All other nonreimbursable costs

Total Cost of Health Care Services (sum of

Total Nonreimbursable Costs (sum of lines 23

Total Facility Overhead (sum of lines 29 and

Total facility costs (sum of lines 22, 28

Health Financial Systems
ANALYSIS OF HOSPITAL-BASED RHC/FOHC COSTS IROQUOIS MEMORIAL HOSPITAL

In Lieu of Form CMS-2552-10
Worksheet M-1 Peri od: From 07/17/2023 To 09/30/2023 Provi der CCN: 14-1353 Date/Time Prepared: 2/26/2024 1:42 pm Component CCN: 14-3424

Adj ustments						RHC I	Cost	Σ μ
FACILITY HEALTH CARE STAFF COSTS			Adiustments	Net Expenses		1410 1	0031	
FACILITY HEALTH CARE STAFF COSTS								
FACILITY HEALTH CARE STAFF COSTS								
FACILITY HEALTH CARE STAFF COSTS								
1.00			6. 00					
2.00		FACILITY HEALTH CARE STAFF COSTS		•				
3.00	1.00	Physi ci an	0	15, 434				1.00
4.00	2.00	Physician Assistant	0	0				2. 00
4.00	3.00	Nurse Practitioner	0	30, 027				3. 00
6.00	4.00	Visiting Nurse	0	0				4. 00
6.00	5.00	Other Nurse	0	18, 582				5. 00
8.00	6.00	Clinical Psychologist	0					6. 00
9.00 Other Facility Health Care Staff Costs 0 0 0 0 0 0 10.00 10.00 Subtotal (sum of lines 1 through 9) 0 0 64,043 10.00 11.00 Physician Supervision Under Agreement 0 0 0 11.00 11.	7.00	Clinical Social Worker	0	0				7. 00
10.00 Subtotal (sum of lines 1 through 9) 0 64,043 10.00 11.00 12.00 12.00 12.00 12.00 12.00 13.00 0 0 0 0 0 12.00 13.00 0 0 0 0 0 13.00 0 14.00 0 0 0 0 13.00 14.00 0 0 0 0 0 13.00 14.00 0 0 0 0 0 0 0 15.00 15.00 Medical Supplies 0 0 0 0 0 0 15.00 15	8.00	Laboratory Techni ci an	0	0				8. 00
11.00 Physician Services Under Agreement 0 0 0 12.00 13.00 14.00 15.00 16.00 17.00 17.00 18.	9.00	Other Facility Health Care Staff Costs	0	0				9. 00
11.00 Physician Services Under Agreement 0 0 0 12.00 13.00 14.00 15.00 16.00 17.00 17.00 18.	10.00	Subtotal (sum of lines 1 through 9)	0	64, 043				10.00
13.00 Other Costs Under Agreement 0 0 0 14.00 14.00 15.00 16.00 Medical Supplies 0 0 1,305 15.00 16.00 Transportation (Heal th Care Staff) 0 50 16.00 17.00 Depreciation-Medical Equipment 0 0 0 17.00 18.00 Professional Liability Insurance 0 0 0 17.00 18.00 19.00 Other Heal th Care Costs 0 0 0 0 19.00 19.00 19.00 Other Heal th Care Costs 0 0 0 0 19.00	11.00	Physician Services Under Agreement	0					11. 00
14.00 Subtotal (sum of lines 11 through 13) 0 0 0 14.00 15.00 Medical Supplies 0 1,305 15.00 16.00 Transportation (Health Care Staff) 0 50 16.00 17.00 Depreciation-Medical Equipment 0 0 0 18.00 Professional Liability Insurance 0 0 0 19.00 Other Health Care Costs 0 0 0 20.00 Allowable GME Costs 20.00 21.00 Subtotal (sum of lines 15 through 20) 0 1,355 21.00 22.00 Total Cost of Health Care Services (sum of lines 10, 14, and 21) 20.00 23.00 Pharmacy 0 0 0 24.00 Dental 0 0 0 25.00 Optometry 0 0 0 25.01 Telehealth 0 0 0 25.01 Telehealth 0 0 0 25.02 Chronic Care Management 0 0 0 26.00 All other nonreimbursable costs 0 0 27.00 Nonallowable GME costs (sum of lines 23 0 0 27.00 Total Nonreimbursable Costs (sum of lines 23 0 0 27.00 Total Nonreimbursable Costs (sum of lines 29 and 30) 30 30.00 Administrative Costs 30 0 31.00 Total Facility Overhead (sum of lines 29 and 30) 30 32.00 Total facility costs (sum of lines 22, 28 -3,378 76,398 32.00	12.00	Physician Supervision Under Agreement	0	0				12. 00
15.00 Medical Supplies	13.00	Other Costs Under Agreement	0	0				13. 00
16. 00 Transportation (Health Care Staff) 0 50 17. 00 Depreciation-Medical Equipment 0 0 0 17. 00 18. 00 17. 00 18. 00 17. 00 18. 00 17. 00 18. 00 19. 00 0 0 18. 00 19. 00 0 0 18. 00 19. 00 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	14.00	Subtotal (sum of lines 11 through 13)	0	0				14. 00
17. 00 Depreciation-Medical Equipment 0 0 0 18. 00 Professional Liability Insurance 0 0 0 0 18. 00 19. 00 10 19. 00 10 19. 00 10 19. 00 10 19. 00 19.	15.00	Medical Supplies	0	1, 305				15. 00
18.00 Professional Liability Insurance 0 0 0 0 19.00 0 19.00 0 0 0 0 0 0 0 0 0	16.00	Transportation (Health Care Staff)	0	50				16. 00
18.00 Professional Liability Insurance 0 0 0 0 18.00 19.00 Other Heal th Care Costs 0 0 0 20.00 All lowable GME Costs 20.00 21.00 Subtotal (sum of lines 15 through 20) 0 1,355 21.00 22.00 Total Cost of Heal th Care Services (sum of lines 10, 14, and 21) 23.00 Pharmacy 0 0 24.00 Dental 0 0 25.00 Optometry 0 0 25.01 Tel eheal th 0 0 25.01 Tel eheal th 0 0 25.02 Chronic Care Management 0 0 26.00 All other nonreimbursable costs 0 27.00 Nonal lowable GME costs (sum of lines 23 0 28.00 Total Nonreimbursable Costs (sum of lines 23 0 29.00 Facility Costs 0 30.00 Administrative Costs 30.00 31.00 Total Facility Overhead (sum of lines 29 and 30.00 32.00 Total facility costs (sum of lines 22, 28 -3,378 76,398 32.00	17.00	Depreciation-Medical Equipment	0	0				17. 00
20.00 Allowable GME Costs 21.00 Subtotal (sum of lines 15 through 20) 0 1,355 21.00 22.00 Total Cost of Health Care Services (sum of lines 10, 14, and 21) COSTS OTHER THAN RHC/FOHC SERVICES 23.00 Pharmacy 0 0 0 24.00 Dental 0 0 25.00 Optometry 0 0 0 25.01 Teleheal th 0 0 0 25.01 Teleheal th 0 0 0 25.02 Chronic Care Management 0 0 0 26.00 All other nonreimbursable costs 0 0 27.00 Nonallowable GME costs (sum of lines 23 0 0 28.00 Total Nonreimbursable Costs (sum of lines 29 and 30.00 31.00 Total Facility Overhead (sum of lines 29 and 30.00 32.00 Total facility costs (sum of lines 22, 28 -3,378 76,398 76,398 32.00	18.00		0	0				18. 00
21.00 Subtotal (sum of lines 15 through 20) 0 1,355 22.00 Total Cost of Heal th Care Services (sum of lines 10, 14, and 21) 22.00	19.00	Other Health Care Costs	0	0				19. 00
22.00 Total Cost of Health Care Services (sum of lines 10, 14, and 21) COSTS OTHER THAN RHC/FQHC SERVICES	20.00	Allowable GME Costs						20. 00
Li nes 10, 14, and 21) COSTS OTHER THAN RHC/FOHC SERVICES 23.00	21. 00		0					21. 00
23.00 Pharmacy 0 0 0 23.00	22. 00		0	65, 398				22. 00
23.00 Pharmacy								
24.00 Dental				1				
25. 00 Optometry 0 0 0 0 25. 00 25. 01 Tel eheal th 0 0 0 0 25. 02 Chronic Care Management 0 0 0 0 26. 00 All other nonreimbursable costs 0 0 0 27. 00 Nonallowable GME costs 20 28. 00 Total Nonreimbursable Costs (sum of lines 23 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0			0	1				
25. 01 Telehealth 0 0 0 0 25. 01 25. 02 Chronic Care Management 0 0 0 0 25. 02 26. 00 All other nonreimbursable costs 0 0 0 27. 00 27. 00 Nonallowable GME costs (sum of lines 23 0 0 0 0 27. 00 28. 00 Total Nonreimbursable Costs (sum of lines 23 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0		· ·	0					
25. 02 26. 00 27. 00 Nonallowable GME costs		1 '	0	1				
26.00			0	1				
27. 00 Nonallowable GME costs 27. 00 28. 00 27. 00 28. 00 28.		3	0	1				
28.00 Total Nonreimbursable Costs (sum of lines 23 0 0 0 1 through 27) FACILITY OVERHEAD 29.00 Facility Costs 0 2,800 29.00 30.00 Administrative Costs -3,378 8,200 30.00 31.00 Total Facility Overhead (sum of lines 29 and 30) 32.00 Total facility costs (sum of lines 22, 28 -3,378 76,398 32.00			0	0				
through 27) FACILITY OVERHEAD 29.00 Facility Costs 0 2,800 30.00 30.00 Administrative Costs -3,378 8,200 30.00 31.00 Total Facility Overhead (sum of lines 29 and 30) 31.00 32.00 Total facility costs (sum of lines 22, 28 -3,378 76,398 32.00		l I						
FACILITY OVERHEAD 29.00 Facility Costs	28.00		0	0				28.00
29.00 Facility Costs 0 2,800 30.00 30.00 Administrative Costs -3,378 8,200 31.00 Total Facility Overhead (sum of lines 29 and 30) 32.00 Total facility costs (sum of lines 22, 28 -3,378 76,398 32.00 32.00 32.00 32.00 33.00								
30.00 Administrative Costs	20.00		^	2 000				20.00
31.00 Total Facility Overhead (sum of lines 29 and 30) 32.00 Total facility costs (sum of lines 22, 28 -3,378 76,398 32.00			ŭ					
30) 32.00 Total facility costs (sum of lines 22, 28 -3,378 76,398 32.00			·		1			
32.00 Total facility costs (sum of lines 22, 28 -3,378 76,398 32.00	31.00	,	-3,378	11,000				31.00
	32 00	1 1	-3 378	76 308				32 00
	32. 00	and 31)	5,576	, 5, 576				32.00

IROQUOIS MEMORIAL HOSPITAL

Health Financial Systems
ANALYSIS OF HOSPITAL-BASED RHC/FOHC COSTS In Lieu of Form CMS-2552-10
Worksheet M-1 Provi der CCN: 14-1353 Peri od: From 07/17/2023 To 09/30/2023 Date/Time Prepared: 2/26/2024 1:42 pm Component CCN: 14-3425

					5110 11	2/20/2024 1.4.	z piii
					RHC II	Cost	
		Compensation	Other Costs		Recl assi fi cati		
				+ col . 2)	ons	Trial Balance	
						(col. 3 + col.	
						4)	
		1.00	2. 00	3.00	4. 00	5. 00	
	FACILITY HEALTH CARE STAFF COSTS						
1.00	Physi ci an	17, 581	0	17, 581	10, 932	28, 513	1.00
2.00	Physician Assistant	0	Ö	1	0	0	2. 00
3.00	Nurse Practitioner	22, 653	0	22, 653	650	23, 303	3.00
4. 00	Visiting Nurse	22,033		22,000	030	23, 303	4. 00
		20 141	0	20 141	0	1	
5.00	Other Nurse	20, 141	U	20, 141	0	20, 141	5. 00
6.00	Clinical Psychologist	0	U	1	0	0	6. 00
7.00	Clinical Social Worker	0	0	0	0	0	7. 00
8.00	Laboratory Techni ci an	0	0	0	0	0	8. 00
9.00	Other Facility Health Care Staff Costs	0	0	0	0	0	9. 00
10.00	Subtotal (sum of lines 1 through 9)	60, 375	0	60, 375	11, 582	71, 957	10.00
11.00	Physician Services Under Agreement	o	0	l c	0	0	11.00
12.00	Physician Supervision Under Agreement	0	0		0	0	12.00
13. 00	Other Costs Under Agreement	0	Ô		0	0	13. 00
14. 00	Subtotal (sum of lines 11 through 13)	0	0		0	Ö	14. 00
15. 00	Medical Supplies	0	3, 670	3, 670	0	3, 670	15. 00
		0	· ·				
16.00	Transportation (Health Care Staff)	U	24	24	0	24	16.00
17. 00	Depreciation-Medical Equipment	0	U		0	0	17. 00
18. 00	Professional Liability Insurance	0	0	1	0	0	18. 00
19. 00	Other Health Care Costs	0	0	1	0	0	19. 00
20. 00	Allowable GME Costs						20. 00
21. 00	Subtotal (sum of lines 15 through 20)	0	3, 694	3, 694		3, 694	21. 00
22.00	Total Cost of Health Care Services (sum of	60, 375	3, 694	64, 069	11, 582	75, 651	22. 00
	lines 10, 14, and 21)						
	COSTS OTHER THAN RHC/FQHC SERVICES						
23.00	Pharmacy	0	0	C	0	0	23. 00
24.00	Dental	0	0	l c	0	0	24. 00
25.00	Optometry	0	O		0	0	25. 00
25. 01	Tel eheal th	0	0		0	0	25. 01
25. 02	Chronic Care Management	0	0		0	0	25. 02
26. 00	All other nonreimbursable costs	0	0		o o	0	26. 00
27. 00	Nonal I owable GME costs	J		1		Ĭ	27. 00
28. 00	Total Nonreimbursable Costs (sum of lines 23	0	0		_	0	28. 00
26.00		U	0	1	U	0	20.00
	through 27)						
00.00	FACILITY OVERHEAD		4 450		_	4.50	00.00
29. 00	Facility Costs	0	1, 159			.,	
30.00	Administrative Costs	6, 676	9, 906	1			•
31. 00	Total Facility Overhead (sum of lines 29 and	6, 676	11, 065	17, 741	-2, 072	15, 669	31. 00
	30)						
32.00	Total facility costs (sum of lines 22, 28	67, 051	14, 759	81, 810	9, 510	91, 320	32. 00
	and 31)						

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Provi der CCN: 14-1353 Health Financial Systems
ANALYSIS OF HOSPITAL-BASED RHC/FOHC COSTS

In Lieu of Form CMS-2552-10
Worksheet M-1

							RHC II	Cost	
			Component	CCN:	: 14-3425		07/17/2023 09/30/2023	Date/Time Pre 2/26/2024 1:4	
MALISIS OF HOSELTAL-DASED MICH COSTS		_	I OVI GET	JUIN.	H-1333	CIII		MOLKSHEET M-1	

FACILITY HEALTH CARE STAFF COSTS					RHC I I	Cost
FACILITY HEALTH CARE STAFF COSTS			Adjustments	Net Expenses		
Cool. 5 + col. 6 Cool. 5 + col. 6 Cool. 7 Cool. 6 Cool. 7 Cool. 6 Cool. 7 Cool.				for Allocation		
FACILITY HEALTH CARE STAFF COSTS						
FACILITY HEALTH CARE STAFF COSTS				`		
FACILITY HEALTH CARE STAFF COSTS			6.00			
1.00		EACILITY HEALTH CADE STAFE COSTS	0.00	7.00		
2.00	1 00			20 E12		1 00
3.00			0			
4.00			0		l .	l l
5.00 Other Nurse 0 20,141 6.00 6.00 7.00 6.00 7.00 8.00 7.00 7.00 8.00 7.00 8.00 7.00 7.00 8.00 7.00 8.00 9.00		1	0		•	
6.00			0		l .	
7.00		4	0			•
8.00 Caboratory Technician 0 0 0 0 0 0 0 0 0			0	0		
9.00 Other Facility Health Care Staff Costs 0 0 0 0 0 0 0 0 0 0		Clinical Social Worker	0	0		
10. 00 Subtotal (sum of lines 1 through 9) 0 71,957 10. 00	8.00	Laboratory Techni ci an	0	0		8. 00
11. 00 Physician Services Under Agreement 0 0 0 0 12. 00 13. 00 14. 00 15. 00 15. 00 16. 00 17. 00 17. 00 17. 00 18	9.00	Other Facility Health Care Staff Costs	0	0		9. 00
12.00	10.00	Subtotal (sum of lines 1 through 9)	0	71, 957		10.00
12.00	11.00	Physician Services Under Agreement	0	0		11.00
13. 00 Other Costs Under Agreement 0 0 0 13. 00			0	0		
14. 00 Subtotal (sum of lines 11 through 13) 0 0 0 0 14. 00			0		l .	
15.00			0	-	l .	
16. 00 Transportation (Health Care Staff) 0 24 16. 00 17. 00 Depreciation-Medical Equipment 0 0 0 18. 00 17. 00 18. 00 19. 00 18. 00 19			0			
17. 00			0		l control of the cont	
18. 00 Professional Liability Insurance 0 0 0 0 19. 00 19. 00 0 19. 00 0 19. 00 0 0 19. 00 0 0 0 0 0 0 0 0 0			0			
19.00 Other Health Care Costs 0 0 0 0 0 20.00 0 20.00 0 0 20.00 0 0 20.00 0 0 20.00 0 0 0 0 0 0 0 0 0			0	-	l .	
20.00 Allowable GME Costs 20.00 21.00 Subtotal (sum of lines 15 through 20) 0 3,694 21.00 22.00 Total Cost of Heal th Care Services (sum of lines 10, 14, and 21) COSTS OTHER THAN RHC/FOHC SERVICES			0	-	l .	
21.00 Subtotal (sum of lines 15 through 20) 0 3,694 21.00			0	0		
22.00 Total Cost of Health Care Services (sum of lines 10, 14, and 21) COSTS OTHER THAN RHC/FOHC SERVICES 23.00 Pharmacy		· I				
Iines 10, 14, and 21) COSTS OTHER THAN RHC/FOHC SERVICES		,	0		l control of the cont	
COSTS OTHER THAN RHC/FOHC SERVICES 23.00 Pharmacy 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	22. 00		0	75, 651		22. 00
Pharmacy						
24.00 25.00 26.00 27.00 27.00 28.00 28.00 29.0						
25. 00	23.00	Pharmacy	0	0		23. 00
25. 01 Tell eheal th	24.00	Dental	0	0		24. 00
25. 02 Chronic Care Management 0 0 0 0 25. 02 26. 00 All other nonreimbursable costs 0 0 0 0 27. 00 27. 00 Nonallowable GME costs 27. 00 28. 00 Total Nonreimbursable Costs (sum of lines 23 0 0 0 28. 00 29. 00 FACILITY OVERHEAD 29. 00 Administrative Costs 0 14, 510 30. 00 31. 00 Total Facility Overhead (sum of lines 29 and 30) 32. 00 Total facility costs (sum of lines 22, 28 0 91, 320 32. 00	25.00	Optometry	0	0		25. 00
26. 00 27. 00 Nonallowable GME costs Total Nonreimbursable Costs (sum of lines 23 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	25. 01	Tel eheal th	0	0		25. 01
26. 00 27. 00 Nonallowable GME costs Total Nonreimbursable Costs (sum of lines 23 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	25. 02	Chronic Care Management	0	0		25. 02
27. 00 28. 00 Total Nonreimbursable Costs (sum of lines 23 0 0 0 28. 00 through 27) FACILITY OVERHEAD 29. 00 30. 00 Administrative Costs Total Facility Overhead (sum of lines 29 and 30) Total Facility Costs (sum of lines 29 and 30) Total facility costs (sum of lines 22, 28 0 91, 320 32. 00			0	0		26.00
28.00 Total Nonreimbursable Costs (sum of lines 23 0 0 0 28.00			_	_		
through 27) FACILITY OVERHEAD 29.00 Facility Costs 30.00 Administrative Costs Total Facility Overhead (sum of lines 29 and 30) 32.00 Total facility costs (sum of lines 22, 28 0 91, 320 32.00		· ·	0	0		
FACILITY OVERHEAD 29. 00 30. 00 31. 00 31. 00 32. 00 Total facility costs (sum of lines 29 and 30) Total facility costs (sum of lines 22, 28 Total facility costs (sum of lines 29 and 30) Total facility costs (sum of lines 22, 28 Total facility costs (sum of lines 22, 28 Total facility costs (sum of lines 22, 28 Total facility costs (sum of lines 22, 28 Total facility costs (sum of lines 22, 28 Total facility costs (sum of lines 22, 28 Total facility costs (sum of lines 22, 28 Total facility costs (sum of lines 22, 28	20.00		0			20.00
29.00 Facility Costs 0 1,159 29.00 30.00 31.00 31.00 Total Facility Costs (sum of lines 29 and 30) Total facility costs (sum of lines 22, 28 0 91,320 32.00 32.00						
30.00 Administrative Costs	20 00			1 150		20.00
31.00 Total Facility Overhead (sum of lines 29 and 30) 32.00 Total facility costs (sum of lines 22, 28 0 91, 320 32.00		1 ,	0			•
30) 32.00 Total facility costs (sum of lines 22, 28 0 91, 320 32.00			0			
32.00 Total facility costs (sum of lines 22, 28 0 91, 320 32.00	31.00		0	15, 669		31.00
	00.00	1 '	•	04 000		00.00
land 31)	32.00		0	91, 320		32.00
		and 31)		I	I	I

Health Financial Systems
ANALYSIS OF HOSPITAL-BASED RHC/FOHC COSTS IROQUOIS MEMORIAL HOSPITAL

In Lieu of Form CMS-2552-10
Worksheet M-1 Peri od:
From 07/17/2023
To 09/30/2023
Date/Time Prepared: 2/26/2024 1: 42 pm

Cost
Cost Provi der CCN: 14-1353 Component CCN: 15-3979

					RHC III	Cost	
		Compensation	Other Costs	Total (col. 1	Recl assi fi cati	Recl assi fi ed	
				+ col . 2)	ons	Trial Balance	
						(col. 3 + col.	
						4)	
		1.00	2. 00	3.00	4. 00	5. 00	
	FACILITY HEALTH CARE STAFF COSTS						
1.00	Physi ci an	130, 985	0	130, 985	0	130, 985	1. 00
2.00	Physician Assistant	o	0		0	0	2. 00
3.00	Nurse Practitioner	ol	0	0	16, 596	16, 596	3. 00
4.00	Visiting Nurse	ol	0	l 0	0	l ol	4. 00
5.00	Other Nurse	45, 549	0	45, 549	0	45, 549	5. 00
6.00	Clinical Psychologist	0	0	0	0	0	6. 00
7. 00	Clinical Social Worker	ol	0	0	0	o	7. 00
8. 00	Laboratory Techni ci an	Ö	0	١	0	0	8. 00
9. 00	Other Facility Health Care Staff Costs	0	0	0	0	0	9. 00
10.00	Subtotal (sum of lines 1 through 9)	176, 534	0	176, 534	16, 596		
11. 00	Physician Services Under Agreement	170, 334	0	170, 334	10, 370	173, 130	11. 00
12. 00	Physician Supervision Under Agreement	0	0		0		12.00
13. 00	Other Costs Under Agreement	0	0		0	0	13.00
14. 00		o o	0		0		14. 00
	Subtotal (sum of lines 11 through 13)	U O	2 705	2 705	0	_	
15.00	Medical Supplies	U	3, 795			3, 795	
16.00	Transportation (Health Care Staff)	U	637		0	637	16.00
17. 00	Depreciation-Medical Equipment	O ₁	0		0	0	17. 00
18. 00	Professional Liability Insurance	0	1, 157	1, 157	0	1, 157	18. 00
19. 00	Other Health Care Costs	o	0	0	0	0	19. 00
20. 00	Allowable GME Costs						20. 00
21. 00	Subtotal (sum of lines 15 through 20)	0	5, 589			5, 589	
22. 00	Total Cost of Health Care Services (sum of	176, 534	5, 589	182, 123	16, 596	198, 719	22. 00
	lines 10, 14, and 21)						
	COSTS OTHER THAN RHC/FOHC SERVICES			T	T		
23. 00	Pharmacy	0	0			0	23. 00
24. 00	Dental	0	0	0	0	0	24. 00
25. 00	Optometry	0	0	0	0	0	25. 00
25. 01	Tel eheal th	0	0	0	0	0	25. 01
25. 02	Chronic Care Management	0	0	0	0	0	25. 02
26.00	All other nonreimbursable costs	0	0	0	0	0	26. 00
27. 00	Nonallowable GME costs						27. 00
28. 00	Total Nonreimbursable Costs (sum of lines 23	0	0	0	0	0	28. 00
	through 27)						
	FACILITY OVERHEAD						
29. 00	Facility Costs	0	3, 100	3, 100		3, 100	29. 00
30.00	Administrative Costs	10, 492	5, 145	15, 637	-1, 582	14, 055	30. 00
31.00	Total Facility Overhead (sum of lines 29 and	10, 492	8, 245	18, 737	-1, 582	17, 155	31. 00
	30)						
32.00	Total facility costs (sum of lines 22, 28	187, 026	13, 834	200, 860	15, 014	215, 874	32. 00
	and 31)						

Health Financial Systems
ANALYSIS OF HOSPITAL-BASED RHC/FOHC COSTS IROQUOIS MEMORIAL HOSPITAL

In Lieu of Form CMS-2552-10
Worksheet M-1 Provi der CCN: 14-1353 Peri od: From 07/17/2023 To 09/30/2023 Date/Time Prepared: 2/26/2024 1:42 pm Component CCN: 15-3979

					RHC III	Cost	
		Adjustments	Net Expenses		I MIC III	0031	
		Auj us tillerits	for Allocation				
			(col . 5 + col .				
			6)				
		6. 00	7.00				
	FACILITY HEALTH CARE STAFF COSTS	0.00	7.00	l			
1.00	Physi ci an	0	130, 985				1.00
2.00	Physician Assistant	0	0				2. 00
3.00	Nurse Practitioner	0	16, 596				3.00
4. 00	Visiting Nurse	0	10,070				4. 00
5.00	Other Nurse	0	45, 549				5.00
6. 00	Clinical Psychologist	0	0	i			6.00
7. 00	Clinical Social Worker	0	0	1			7. 00
8. 00	Laboratory Techni ci an	0	0	1			8.00
9. 00	Other Facility Health Care Staff Costs	0	0	ł			9. 00
10. 00	Subtotal (sum of lines 1 through 9)	0	193, 130	1			10.00
11. 00	Physician Services Under Agreement	0	173, 130	i			11.00
12. 00	Physician Supervision Under Agreement	0	0				12.00
13. 00	Other Costs Under Agreement	0					13. 00
14. 00	Subtotal (sum of lines 11 through 13)	0					14. 00
15. 00	Medical Supplies	0	3, 795				15. 00
16. 00	Transportation (Health Care Staff)	0	637	•			16. 00
17. 00	Depreciation-Medical Equipment	0	037	•			17. 00
18. 00	Professional Liability Insurance	0	1, 157				18.00
19. 00	Other Health Care Costs	0	1, 137	1			19. 00
20. 00	Allowable GME Costs	0					20.00
21. 00	Subtotal (sum of lines 15 through 20)	0	5, 589				21.00
22. 00	Total Cost of Health Care Services (sum of	0	198, 719				22.00
22.00	lines 10, 14, and 21)	0	170, 717				22.00
	COSTS OTHER THAN RHC/FQHC SERVICES						
23. 00	Pharmacy	0	0				23. 00
24. 00	Dental	0	0				24. 00
25. 00	Optometry	0	0				25. 00
25. 01	Tel eheal th	0	0				25. 01
25. 02	Chronic Care Management	0	0				25. 02
26. 00	All other nonreimbursable costs	0	0				26. 00
27. 00	Nonallowable GME costs	_	_				27. 00
28. 00	Total Nonreimbursable Costs (sum of lines 23	0	0				28. 00
	through 27)	_	_				
	FACILITY OVERHEAD						
29. 00	Facility Costs	0	3, 100				29. 00
30.00	Admi ni strati ve Costs	0	14, 055				30.00
31. 00	Total Facility Overhead (sum of lines 29 and	0	17, 155	1			31. 00
-	30)	_	, ,,,,,				
32.00	Total facility costs (sum of lines 22, 28	0	215, 874				32. 00
	and 31)						

I ROQUOIS MEMORIAL HOSPITAL

Health Financial Systems
ANALYSIS OF HOSPITAL-BASED RHC/FOHC COSTS In Lieu of Form CMS-2552-10
Worksheet M-1 Peri od: From 07/17/2023 To 09/30/2023 Date/Ti me Prepared: 2/26/2024 1:42 pm Cost Provi der CCN: 14-1353 Component CCN: 14-8551

					KHC I V	COST	
		Compensation	Other Costs	Total (col. 1	Recl assi fi cati	Recl assi fi ed	
				+ col . 2)	ons	Trial Balance	
				_		(col. 3 + col.	
						4)	
		1. 00	2.00	3.00	4. 00	5. 00	
	FACILITY HEALTH CARE STAFF COSTS	1.00	2.00	0.00	1. 00	0.00	
1.00	Physi ci an	227, 576	63	227, 639	0	227, 639	1. 00
2. 00	Physician Assistant	227, 070	0			0	2. 00
3.00	Nurse Practitioner	66, 177	0	· -	_		3. 00
4. 00	Visiting Nurse	62, 423	0	62, 423		62, 423	4. 00
		02, 423	0	02, 423	0		
5.00	Other Nurse	0	0	0	0	0	5. 00
6.00	Clinical Psychologist	0	0	0	0	0	6. 00
7. 00	Clinical Social Worker	0	0	0	0	0	7. 00
8.00	Laboratory Techni ci an	0	0	0	0	0	8. 00
9.00	Other Facility Health Care Staff Costs	0	0	0	0	0	9. 00
10.00	Subtotal (sum of lines 1 through 9)	356, 176	63	356, 239	-16, 596	339, 643	10.00
11.00	Physician Services Under Agreement	0	0	0	0	0	11. 00
12.00	Physician Supervision Under Agreement	0	0	0	0	0	12. 00
13.00	Other Costs Under Agreement	0	0	l 0	0	ol	13. 00
14.00	Subtotal (sum of lines 11 through 13)	0	0		0	0	14. 00
15. 00	Medical Supplies	0	5, 374	5, 374	0	5, 374	15. 00
16. 00	Transportation (Health Care Staff)	0	179			179	16. 00
17. 00	Depreciation-Medical Equipment	0	1//	'''	0	1,7	17. 00
18. 00	Professional Liability Insurance	0	0		0		18. 00
	1	0	0		0		
19. 00	Other Health Care Costs	U	0		0	0	19. 00
20. 00	Allowable GME Costs	_			_		20. 00
21. 00	Subtotal (sum of lines 15 through 20)	0	5, 553			5, 553	
22. 00	Total Cost of Health Care Services (sum of	356, 176	5, 616	361, 792	-16, 596	345, 196	22. 00
	lines 10, 14, and 21)						
	COSTS OTHER THAN RHC/FQHC SERVICES				1		
23. 00	Pharmacy	0	0		0	0	23. 00
24. 00	Dental	0	0	0	0	0	24.00
25. 00	Optometry	0	0	0	0	0	25. 00
25. 01	Tel eheal th	0	0	0	0	0	25. 01
25. 02	Chronic Care Management	0	0	0	0	0	25. 02
26.00	All other nonreimbursable costs	0	0	0	0	0	26. 00
27.00	Nonallowable GME costs						27. 00
28. 00	Total Nonreimbursable Costs (sum of lines 23	0	0	0	0	0	28. 00
	through 27)	-	_	_	_	_	
	FACILITY OVERHEAD			l .			
29. 00	Facility Costs	0	0	0	0	0	29. 00
30. 00	Administrative Costs	47, 323	_		_	63, 656	
31. 00	Total Facility Overhead (sum of lines 29 and	47, 323				63, 656	
31.00	30)	41,323	10, 333	03, 030		03, 030	31.00
32. 00	Total facility costs (sum of lines 22, 28	403, 499	21, 949	425, 448	-16, 596	408, 852	32. 00
ა∠. 00	and 31)	403, 499	21, 949	425, 448	-10, 596	408, 852	ა∠. ∪∪
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Health Financial Systems
ANALYSIS OF HOSPITAL-BASED RHC/FOHC COSTS IROQUOIS MEMORIAL HOSPITAL

In Lieu of Form CMS-2552-10
Worksheet M-1 Provi der CCN: 14-1353 Peri od: From 07/17/2023 To 09/30/2023 Date/Time Prepared: 2/26/2024 1:42 pm Component CCN: 14-8551

				RHC IV	Cost	
		Adjustments	Net Expenses			
			for Allocation			
			(col. 5 + col.			
			6)			
		6. 00	7. 00			
	FACILITY HEALTH CARE STAFF COSTS					
1.00	Physi ci an	0	227, 639			1.00
2.00	Physician Assistant	0	0			2.00
3.00	Nurse Practitioner	0	49, 581			3.00
4.00	Visiting Nurse	0	62, 423			4.00
5.00	Other Nurse	0	0			5.00
6.00	Clinical Psychologist	0	0			6, 00
7. 00	Clinical Social Worker	0	0			7. 00
8.00	Laboratory Techni ci an	0	0			8.00
9. 00	Other Facility Health Care Staff Costs	0	0			9. 00
10. 00	Subtotal (sum of lines 1 through 9)	0	339, 643			10.00
11. 00	Physician Services Under Agreement	0	007,010			11.00
12. 00	Physician Supervision Under Agreement	0	0			12. 00
13. 00	Other Costs Under Agreement	0	0			13. 00
14. 00	Subtotal (sum of lines 11 through 13)	0	0			14. 00
15. 00	Medical Supplies	0	5, 374			15. 00
16. 00	Transportation (Health Care Staff)	0	179			16.00
17. 00	Depreciation-Medical Equipment	0	0			17. 00
18. 00	Professional Liability Insurance	0	0			18.00
19. 00	Other Health Care Costs	0	0			19. 00
20.00	Allowable GME Costs	U	U			20.00
21. 00	Subtotal (sum of lines 15 through 20)	0	5, 553			21. 00
		0				21.00
22. 00	Total Cost of Health Care Services (sum of	U	345, 196			22.00
	lines 10, 14, and 21) COSTS OTHER THAN RHC/FQHC SERVICES					
23. 00	Pharmacy	0	0			23. 00
24. 00	Dental	0	0			24. 00
25. 00	1	0	0			25. 00
25. 00	Optometry	0	0			25. 00
25. 01	Tel eheal th	0	_			25. 01
	Chronic Care Management	0	0			
26. 00	All other nonreimbursable costs	U	U			26. 00
27. 00	Nonallowable GME costs	0				27. 00
28. 00	Total Nonreimbursable Costs (sum of lines 23	U	0			28. 00
	through 27)					
20.00	FACILITY OVERHEAD		^			20.00
29. 00	Facility Costs	0	-			29. 00
30.00	Administrative Costs	0	63, 656			30.00
31. 00	Total Facility Overhead (sum of lines 29 and	0	63, 656			31. 00
22.00	30)	0	400.050			22.00
32. 00	Total facility costs (sum of lines 22, 28	0	408, 852			32. 00
	and 31)		I			l

Heal th Financial Systems

I ROQUOIS MEMORIAL HOSPITAL

ALLOCATION OF OVERHEAD TO HOSPITAL PASED PHY COURS SERVICES

PROVIDES A PROVIDED TO HOSPITAL PASED PHY COURS SERVICES

20.00 Total allowable cost of hospital-based RHC/FQHC services (sum of lines 10 and 19)

In Lieu of Form CMS-2552-10 ALLOCATION OF OVERHEAD TO HOSPITAL-BASED RHC/FOHC SERVICES Provi der CCN: 14-1353 Peri od: Worksheet M-2 From 07/17/2023 Component CCN: 14-3424 09/30/2023 To Date/Time Prepared: 2/26/2024 1:42 pm RHC I Cost Number of FTE Productivity Minimum Visits Total Visits Greater of Standard (1) col. 2 or col. Personnel (col. 1 x col. 1.00 2.00 3.00 5.00 4.00 VISITS AND PRODUCTIVITY Posi ti ons 1.00 0. 07 293 2, 200 154 1.00 Physi ci an 2.00 Physician Assistant 0.00 2, 100 2.00 3.00 Nurse Practitioner 555 2, 100 336 3.00 0.16 4.00 Subtotal (sum of lines 1 through 3) 0.23 848 490 848 4.00 5.00 Visitina Nurse 0.00 C 0 5.00 6.00 Clinical Psychologist 0.00 0 6.00 7.00 Clinical Social Worker 0.00 0 0 7.00 7.01 Medical Nutrition Therapist (FQHC only) 7. 01 0.00 C 0 Diabetes Self Management Training (FQHC 7.02 0.00 C 0 7.02 8.00 Total FTEs and Visits (sum of lines 4 0.23 848 848 8.00 through 7) 9.00 Physician Services Under Agreements 0 9. 00 1.00 DETERMINATION OF ALLOWABLE COST APPLICABLE TO HOSPITAL-BASED RHC/FQHC SERVICES Total costs of health care services (from Wkst. M-1, col. 7, line 22) 10.00 65, 398 10.00 11.00 Total nonreimbursable costs (from Wkst. M-1, col. 7, line 28) 0 11.00 Cost of all services (excluding overhead) (sum of lines 10 and 11) 65, 398 12.00 13.00 Ratio of hospital-based RHC/FQHC services (line 10 divided by line 12) 1.000000 13.00 Total hospital-based RHC/FQHC overhead - (from Worksheet. M-1, col. 7, line 31) 14.00 11,000 14.00 Parent provider overhead allocated to facility (see instructions) 15.00 43, 156 15.00 16.00 Total overhead (sum of lines 14 and 15) 54, 156 16.00 Allowable GME overhead (see instructions) 17.00 17.00 0 Enter the amount from line 16 18.00 54, 156 18.00 Overhead applicable to hospital-based RHC/FQHC services (line 13 x line 18) 19.00 54, 156 19.00

119, 554 20.00

I ROQUOIS MEMORIAL HOSPITAL Health Financial Systems

In Lieu of Form CMS-2552-10 ALLOCATION OF OVERHEAD TO HOSPITAL-BASED RHC/FOHC SERVICES Provi der CCN: 14-1353 Peri od: Worksheet M-2 From 07/17/2023 Component CCN: 14-3425 09/30/2023 To Date/Time Prepared: 2/26/2024 1:42 pm RHC II Cost Number of FTE Productivity Minimum Visits Total Visits Greater of Standard (1) (col. 1 x col. col. 2 or col. Personnel 1.00 2.00 3.00 5.00 4.00 VISITS AND PRODUCTIVITY Posi ti ons 1.00 0. 05 224 4, 200 210 1.00 Physi ci an 2.00 Physician Assistant 0.00 2, 100 2.00 3.00 Nurse Practitioner 0.11 570 2, 100 231 3.00 4.00 Subtotal (sum of lines 1 through 3) 0.16 794 441 794 4.00 5.00 Visitina Nurse 0.00 C 0 5.00 6.00 Clinical Psychologist 0.00 0 6.00 7.00 Clinical Social Worker 0.00 0 0 7.00 7.01 Medical Nutrition Therapist (FQHC only) 7. 01 0.00 C 0 Diabetes Self Management Training (FQHC 7.02 0.00 C 0 7.02 8.00 Total FTEs and Visits (sum of lines 4 0.16 794 794 8.00 through 7) 9.00 Physician Services Under Agreements 0 9. 00 1.00 DETERMINATION OF ALLOWABLE COST APPLICABLE TO HOSPITAL-BASED RHC/FQHC SERVICES Total costs of health care services (from Wkst. M-1, col. 7, line 22) 10.00 10.00 75, 651 11.00 Total nonreimbursable costs (from Wkst. M-1, col. 7, line 28) Ω 11.00 Cost of all services (excluding overhead) (sum of lines 10 and 11) 75, 651 12.00 13.00 Ratio of hospital-based RHC/FQHC services (line 10 divided by line 12) 1.000000 13.00 Total hospital-based RHC/FQHC overhead - (from Worksheet. M-1, col. 7, line 31) 14.00 14.00 15, 669 Parent provider overhead allocated to facility (see instructions) 15.00 57, 912 15.00 16.00 16.00 Total overhead (sum of lines 14 and 15) 73, 581 Allowable GME overhead (see instructions) 17.00 17.00 0 Enter the amount from line 16 18.00 73.581 18.00 Overhead applicable to hospital-based RHC/FQHC services (line 13 x line 18) 19.00 73, 581 19.00 20.00 Total allowable cost of hospital-based RHC/FQHC services (sum of lines 10 and 19)

149, 232 20. 00

Heal th Financial Systems IROQUOIS MEMORIAL HOSPITAL

ALLOCATION OF OVERHEAD TO HOSPITAL PASED PHO (FONC SERVICES PROVIDER CON: 14.1353 Period

In Lieu of Form CMS-2552-10 ALLOCATION OF OVERHEAD TO HOSPITAL-BASED RHC/FOHC SERVICES Provi der CCN: 14-1353 Peri od: Worksheet M-2 From 07/17/2023 Component CCN: 15-3979 09/30/2023 To Date/Time Prepared: 2/26/2024 1:42 pm RHC III Cost Number of FTE Producti vi ty Minimum Visits Total Visits Greater of col. 2 or col. Standard (1) (col. 1 x col. Personnel 1.00 2.00 3.00 5.00 4.00 VISITS AND PRODUCTIVITY Posi ti ons 1.00 0. 18 1, 049 2, 800 504 1.00 Physi ci an 2.00 Physician Assistant 0.00 2, 100 2.00 3.00 Nurse Practitioner 0.18 302 2, 100 378 3.00 4.00 Subtotal (sum of lines 1 through 3) 0.36 1, 351 882 1, 351 4.00 5.00 Visitina Nurse 0.00 C 0 5.00 6.00 Clinical Psychologist 0.00 0 6.00 7.00 Clinical Social Worker 0.00 0 0 7.00 7.01 Medical Nutrition Therapist (FQHC only) 7. 01 0.00 C 0 Diabetes Self Management Training (FQHC 7.02 0.00 r 0 7.02 8.00 Total FTEs and Visits (sum of lines 4 0.36 1, 351 1, 351 8.00 through 7) 9.00 Physician Services Under Agreements 0 9.00 1.00 DETERMINATION OF ALLOWABLE COST APPLICABLE TO HOSPITAL-BASED RHC/FQHC SERVICES Total costs of health care services (from Wkst. M-1, col. 7, line 22) 10.00 198, 719 10.00 11.00 Total nonreimbursable costs (from Wkst. M-1, col. 7, line 28) 0 11.00 Cost of all services (excluding overhead) (sum of lines 10 and 11) 198, 719 12.00 13.00 Ratio of hospital-based RHC/FQHC services (line 10 divided by line 12) 1.000000 13.00 Total hospital-based RHC/FQHC overhead - (from Worksheet. M-1, col. 7, line 31) 14.00 17, 155 14.00 Parent provider overhead allocated to facility (see instructions) 15.00 118, 170 15.00 16.00 Total overhead (sum of lines 14 and 15) 135, 325 16.00 Allowable GME overhead (see instructions) 17.00 17.00 Enter the amount from line 16 18.00 135, 325 18.00 Overhead applicable to hospital-based RHC/FQHC services (line 13 x line 18) 19.00 135, 325 19.00 20.00 Total allowable cost of hospital-based RHC/FQHC services (sum of lines 10 and 19) 334, 044 20. 00

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I ROQUOIS MEMORIAL HOSPITAL

ALLOCATION OF OVERHEAD TO MOSPITAL PASED PLACES PROVIDES TO MOSPITAL PASED PLACES PROVIDES TO MOSPITAL PASED PLACES PROVIDES TO MOSPITAL PASED PLACES PROVIDES TO MOSPITAL PASED PLACES PROVIDES TO MOSPITAL PASED PLACES PROVIDES TO MOSPITAL PASED PLACES PROVIDES TO MOSPITAL PASED PLACES PROVIDES TO MOSPITAL PASED PLACES PROVIDES TO MOSPITAL PASED PLACES PROVIDES TO MOSPITAL PASED PLACES PROVIDES TO MOSPITAL PASED PLACES PROVIDES TO MOSPITAL PASED PLACES PROVIDES TO MOSPITAL PASED PLACES PLACES PROVIDES PLACES
20.00 Total allowable cost of hospital-based RHC/FQHC services (sum of lines 10 and 19)

In Lieu of Form CMS-2552-10 ALLOCATION OF OVERHEAD TO HOSPITAL-BASED RHC/FOHC SERVICES Provi der CCN: 14-1353 Peri od: Worksheet M-2 From 07/17/2023 Component CCN: 14-8551 09/30/2023 To Date/Time Prepared: 2/26/2024 1:42 pm RHC IV Cost Number of FTE Productivity Minimum Visits Total Visits Greater of col. 2 or col. Standard (1) (col. 1 x col. Personnel 1.00 2.00 3.00 5.00 4.00 VISITS AND PRODUCTIVITY Posi ti ons 1.00 0. 16 771 3, 000 480 1.00 Physi ci an 2.00 Physician Assistant 0.00 2, 100 2.00 3.00 Nurse Practitioner 0.20 1,072 2, 100 420 3.00 4.00 Subtotal (sum of lines 1 through 3) 0.36 1, 843 900 1,843 4.00 5.00 Visitina Nurse 0.00 C 0 5.00 6.00 Clinical Psychologist 0.00 0 6.00 7.00 Clinical Social Worker 0.00 0 0 7.00 7.01 Medical Nutrition Therapist (FQHC only) 7. 01 0.00 C 0 7.02 Diabetes Self Management Training (FQHC 0.00 r 0 7.02 8.00 Total FTEs and Visits (sum of lines 4 0.36 1,843 1,843 8.00 through 7) 9.00 Physician Services Under Agreements 0 9. 00 1.00 DETERMINATION OF ALLOWABLE COST APPLICABLE TO HOSPITAL-BASED RHC/FQHC SERVICES Total costs of health care services (from Wkst. M-1, col. 7, line 22) 10.00 345, 196 10.00 11.00 Total nonreimbursable costs (from Wkst. M-1, col. 7, line 28) Ω 11.00 Cost of all services (excluding overhead) (sum of lines 10 and 11) 345, 196 12.00 13.00 Ratio of hospital-based RHC/FQHC services (line 10 divided by line 12) 1.000000 13.00 Total hospital-based RHC/FQHC overhead - (from Worksheet. M-1, col. 7, line 31) 14.00 14.00 63, 656 Parent provider overhead allocated to facility (see instructions) 15.00 188, 766 15.00 16.00 Total overhead (sum of lines 14 and 15) 252, 422 16.00 Allowable GME overhead (see instructions) 17.00 17.00 0 18.00 Enter the amount from line 16 252, 422 18.00 Overhead applicable to hospital-based RHC/FQHC services (line 13 x line 18) 19.00 252, 422 19.00

597, 618 20.00

Component CCN: 14-3424 To 09/30/2023 Date/Time Prepared: 2/26/2024 1:42 pm Title XVIII RHC I Cost 1.00 DETERMINATION OF RATE FOR HOSPITAL-BASED RHC/FQHC SERVICES Total Allowable Cost of hospital-based RHC/FQHC Services (from Wkst. M-2, line 20) 119, 554 Cost of injections/infusions and their administration (from Wkst. M-4, line 15) 2.00 678 2.00 Total allowable cost excluding injections/infusions (line 1 minus line 2) 3.00 118, 876 3 00 4.00 Total Visits (from Wkst. M-2, column 5, line 8) 848 4.00 5.00 Physicians visits under agreement (from Wkst. M-2, column 5, line 9) 5.00 Total adjusted visits (line 4 plus line 5) 848 6.00 6.00 140.18 Adjusted cost per visit (line 3 divided by line 6) 7.00 7.00 Calculation of Limit (1) Rate Period Rate Period 1 (07/17/2023 N/A through 09/30/2023) 1. 00 2.00 8.00 Per visit payment limit (from CMS Pub. 100-04, chapter 9, §20.6 or your contractor) 0.00 8.00 263.63 Rate for Program covered visits (see instructions) 0.00 140. 18 9 00 9 00 CALCULATION OF SETTLEMENT 10.00 Program covered visits excluding mental health services (from contractor records) 10.00 201 0 Program cost excluding costs for mental health services (line 9 x line 10) 11.00 28.176 11.00 12.00 Program covered visits for mental health services (from contractor records) 0 12.00 13.00 Program covered cost from mental health services (line 9 x line 12) 0 0 13.00 Limit adjustment for mental health services (see instructions) 0 14.00 14.00 Graduate Medical Education Pass Through Cost (see instructions) 15.00 15.00 Total Program cost (sum of lines 11, 14, and 15, columns 1, 2 and 3) 0 16.00 28, 176 16.00 Total program charges (see instructions)(from contractor's records) 29, 011 16.01 16.01 16.02 Total program preventive charges (see instructions)(from provider's records) 3,640 16.02 Total program preventive costs ((line 16.02/line 16.01) times line 16) 16.03 3, 535 16.03 16.04 Total Program non-preventive costs ((line 16 minus lines 16.03 and 18) times .80) 18, 747 16.04 (Titles V and XIX see instructions.) Total program cost (see instructions) 0 22, 282 16.05 17.00 Primary payer amounts 17.00 0 Less: Beneficiary deductible for RHC only (see instructions) (from contractor 18.00 1, 207 18.00 records) 19.00 Beneficiary coinsurance for RHC/FQHC services (see instructions) (from contractor 4,833 19.00 20.00 Net Medicare cost excluding vaccines (see instructions) 22, 282 20.00 21.00 Program cost of vaccines and their administration (from Wkst. M-4, line 16) 678 21.00 22.00 Total reimbursable Program cost (line 20 plus line 21) 22, 960 22.00 23.00 Allowable bad debts (see instructions) 0 23.00 Adjusted reimbursable bad debts (see instructions) 23.01 23.01 0 Allowable bad debts for dual eligible beneficiaries (see instructions) 24.00 Λ 24.00 25.00 OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY) 0 25.00 Pioneer ACO demonstration payment adjustment (see instructions) 25, 50 0 25.50 Demonstration payment adjustment amount before sequestration 25.99 25.99 0 26.00 Net reimbursable amount (see instructions) 22, 960 26.00 26.01 Sequestration adjustment (see instructions) 459 26.01 26. 02 Demonstration payment adjustment amount after sequestration 26.02 0 33, 827 27 00 27 00 Interim payments 28.00 Tentative settlement (for contractor use only) 0 28.00 Balance due component/program (line 26 minus lines 26.01, 26.02, 27, and 28) -11, 326 29.00 29.00

> 0 30.00

Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-II,

30.00

chapter I, §115.2

Component CCN: 14-3425

09/30/2023

Date/Time Prepared:

0 30.00

2/26/2024 1:42 pm Title XVIII RHC II Cost 1.00 DETERMINATION OF RATE FOR HOSPITAL-BASED RHC/FQHC SERVICES Total Allowable Cost of hospital-based RHC/FQHC Services (from Wkst. M-2, line 20) 149, 232 Cost of injections/infusions and their administration (from Wkst. M-4, line 15) 5, 147 2.00 2.00 Total allowable cost excluding injections/infusions (line 1 minus line 2) 3.00 144, 085 3 00 4.00 Total Visits (from Wkst. M-2, column 5, line 8) 794 4.00 5.00 Physicians visits under agreement (from Wkst. M-2, column 5, line 9) 0 5.00 Total adjusted visits (line 4 plus line 5) 794 6.00 6.00 Adjusted cost per visit (line 3 divided by line 6) 181.47 7.00 7.00 Calculation of Limit (1) Rate Period Rate Period 1 (07/17/2023 N/A through 09/30/2023) 1. 00 2.00 8.00 Per visit payment limit (from CMS Pub. 100-04, chapter 9, §20.6 or your contractor) 0.00 175.35 8.00 175. 35 Rate for Program covered visits (see instructions) 0.00 9 00 9 00 CALCULATION OF SETTLEMENT 10.00 Program covered visits excluding mental health services (from contractor records) 10.00 155 0 Program cost excluding costs for mental health services (line 9 x line 10) 27, 179 11.00 11.00 12.00 12.00 Program covered visits for mental health services (from contractor records) 0 13.00 Program covered cost from mental health services (line 9 x line 12) 0 0 13.00 Limit adjustment for mental health services (see instructions) 0 14.00 14.00 Graduate Medical Education Pass Through Cost (see instructions) 15.00 15.00 Total Program cost (sum of lines 11, 14, and 15, columns 1, 2 and 3) 0 27, 179 16.00 16.00 Total program charges (see instructions)(from contractor's records) 22, 668 16.01 16.01 16.02 Total program preventive charges (see instructions)(from provider's records) 5, 894 16.02 Total program preventive costs ((line 16.02/line 16.01) times line 16) 16.03 7.067 16.03 16.04 Total Program non-preventive costs ((line 16 minus lines 16.03 and 18) times .80) 15, 838 16.04 (Titles V and XIX see instructions.) Total program cost (see instructions) 0 22, 905 16.05 17.00 Primary payer amounts 17.00 0 Less: Beneficiary deductible for RHC only (see instructions) (from contractor 18.00 314 18.00 records) 19.00 Beneficiary coinsurance for RHC/FQHC services (see instructions) (from contractor 3, 292 19.00 20.00 Net Medicare cost excluding vaccines (see instructions) 22, 905 20.00 21.00 Program cost of vaccines and their administration (from Wkst. M-4, line 16) 2.941 21.00 22.00 Total reimbursable Program cost (line 20 plus line 21) 25, 846 22.00 23.00 Allowable bad debts (see instructions) 0 23.00 Adjusted reimbursable bad debts (see instructions) 23.01 23.01 0 Allowable bad debts for dual eligible beneficiaries (see instructions) 24.00 Λ 24.00 25.00 OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY) 0 25.00 Pioneer ACO demonstration payment adjustment (see instructions) 25, 50 0 25.50 Demonstration payment adjustment amount before sequestration 25.99 25.99 0 26.00 Net reimbursable amount (see instructions) 25,846 26.00 26.01 Sequestration adjustment (see instructions) 517 26.01 26. 02 Demonstration payment adjustment amount after sequestration 26.02 0 21, 783 27 00 27 00 Interim payments 28.00 Tentative settlement (for contractor use only) 0 28.00 Balance due component/program (line 26 minus lines 26.01, 26.02, 27, and 28) 29.00 29.00 3, 546

Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-II,

30.00

chapter I, §115.2

Component CCN: 15-3979 09/30/2023 Date/Time Prepared: 2/26/2024 1:42 pm Title XVIII RHC III Cost 1.00 DETERMINATION OF RATE FOR HOSPITAL-BASED RHC/FQHC SERVICES Total Allowable Cost of hospital-based RHC/FQHC Services (from Wkst. M-2, line 20) 334.044 Cost of injections/infusions and their administration (from Wkst. M-4, line 15) 2, 548 2.00 2.00 Total allowable cost excluding injections/infusions (line 1 minus line 2) 331, 496 3.00 3 00 4.00 Total Visits (from Wkst. M-2, column 5, line 8) 1, 351 4.00 5.00 Physicians visits under agreement (from Wkst. M-2, column 5, line 9) 5.00 Total adjusted visits (line 4 plus line 5) 1.351 6.00 6.00 Adjusted cost per visit (line 3 divided by line 6) 7.00 245.37 7.00 Calculation of Limit (1) Rate Period Rate Period 1 (07/17/2023 N/A through 09/30/2023) 1. 00 2.00 8.00 Per visit payment limit (from CMS Pub. 100-04, chapter 9, §20.6 or your contractor) 0.00 307.59 8.00 Rate for Program covered visits (see instructions) 0.00 245.37 9 00 9 00 CALCULATION OF SETTLEMENT 10.00 Program covered visits excluding mental health services (from contractor records) 10.00 354 0 Program cost excluding costs for mental health services (line 9 x line 10) 11.00 86.861 11.00 12.00 12.00 Program covered visits for mental health services (from contractor records) 0 13.00 Program covered cost from mental health services (line 9 x line 12) 0 0 13.00 Limit adjustment for mental health services (see instructions) 0 14.00 14.00 Graduate Medical Education Pass Through Cost (see instructions) 15.00 15.00 Total Program cost (sum of lines 11, 14, and 15, columns 1, 2 and 3) 0 16.00 86, 861 16.00 Total program charges (see instructions)(from contractor's records) 58, 587 16.01 16.01 16.02 Total program preventive charges (see instructions)(from provider's records) 8,806 16.02 Total program preventive costs ((line 16.02/line 16.01) times line 16) 13, 056 16.03 16.03 16.04 Total Program non-preventive costs ((line 16 minus lines 16.03 and 18) times .80) 57, 450 16.04 (Titles V and XIX see instructions.) Total program cost (see instructions) 0 70, 506 16.05 17.00 Primary payer amounts 17.00 0 Less: Beneficiary deductible for RHC only (see instructions) (from contractor 18.00 1, 993 18.00 records) 19.00 Beneficiary coinsurance for RHC/FQHC services (see instructions) (from contractor 9, 557 19.00 20.00 Net Medicare cost excluding vaccines (see instructions) 70, 506 20.00 21.00 Program cost of vaccines and their administration (from Wkst. M-4, line 16) 1.593 21.00 22.00 Total reimbursable Program cost (line 20 plus line 21) 72, 099 22.00 23.00 Allowable bad debts (see instructions) 0 23.00 Adjusted reimbursable bad debts (see instructions) 23.01 23.01 0 Allowable bad debts for dual eligible beneficiaries (see instructions) 24.00 Λ 24.00 25.00 OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY) 0 25.00 Pioneer ACO demonstration payment adjustment (see instructions) 25, 50 0 25.50 25.99 Demonstration payment adjustment amount before sequestration 25.99 0 26.00 Net reimbursable amount (see instructions) 72,099 26.00 1, 442 26.01 Sequestration adjustment (see instructions) 26.01 26. 02 Demonstration payment adjustment amount after sequestration 0 26.02 80, 964 27 00 27 00 Interim payments 28.00 Tentative settlement (for contractor use only) 0 28.00 Balance due component/program (line 26 minus lines 26.01, 26.02, 27, and 28) -10, 307 29.00 29.00 Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-II, 30.00 0 30.00

chapter I, §115.2

Component CCN: 14-8551 09/30/2023 Date/Time Prepared: 2/26/2024 1:42 pm Title XVIII RHC IV Cost 1.00 DETERMINATION OF RATE FOR HOSPITAL-BASED RHC/FQHC SERVICES Total Allowable Cost of hospital-based RHC/FQHC Services (from Wkst. M-2, line 20) 597, 618 6, 219 Cost of injections/infusions and their administration (from Wkst. M-4, line 15) 2.00 2.00 Total allowable cost excluding injections/infusions (line 1 minus line 2) 591, 399 3.00 3 00 4.00 Total Visits (from Wkst. M-2, column 5, line 8) 1,843 4.00 5.00 Physicians visits under agreement (from Wkst. M-2, column 5, line 9) 5.00 Total adjusted visits (line 4 plus line 5) 1.843 6.00 6.00 Adjusted cost per visit (line 3 divided by line 6) 7.00 320.89 7.00 Calculation of Limit (1) Rate Period Rate Period 1 (07/17/2023 N/A through 09/30/2023) 1. 00 2.00 8.00 Per visit payment limit (from CMS Pub. 100-04, chapter 9, §20.6 or your contractor) 0.00 176.70 8.00 Rate for Program covered visits (see instructions) 0.00 176.70 9 00 9 00 CALCULATION OF SETTLEMENT 10.00 Program covered visits excluding mental health services (from contractor records) 10.00 425 0 Program cost excluding costs for mental health services (line 9 x line 10) 11.00 75.098 11.00 12.00 12.00 Program covered visits for mental health services (from contractor records) 0 13.00 Program covered cost from mental health services (line 9 x line 12) 0 0 13.00 Limit adjustment for mental health services (see instructions) 0 14.00 14.00 Graduate Medical Education Pass Through Cost (see instructions) 15.00 15.00 Total Program cost (sum of lines 11, 14, and 15, columns 1, 2 and 3) 0 75,098 16.00 16.00 Total program charges (see instructions)(from contractor's records) 57, 400 16.01 16.01 16.02 Total program preventive charges (see instructions)(from provider's records) 6,837 16.02 Total program preventive costs ((line 16.02/line 16.01) times line 16) 16.03 8.945 16.03 16.04 Total Program non-preventive costs ((line 16 minus lines 16.03 and 18) times .80) 51, 677 16.04 (Titles V and XIX see instructions.) Total program cost (see instructions) 0 60, 622 16.05 17.00 Primary payer amounts 17.00 Less: Beneficiary deductible for RHC only (see instructions) (from contractor 18.00 1, 557 18.00 records) 19.00 Beneficiary coinsurance for RHC/FQHC services (see instructions) (from contractor 9, 801 19.00 20.00 Net Medicare cost excluding vaccines (see instructions) 60, 622 20.00 21.00 Program cost of vaccines and their administration (from Wkst. M-4, line 16) 2, 783 21.00 22.00 Total reimbursable Program cost (line 20 plus line 21) 63, 405 22.00 23.00 Allowable bad debts (see instructions) 0 23.00 Adjusted reimbursable bad debts (see instructions) 23.01 23.01 0 Allowable bad debts for dual eligible beneficiaries (see instructions) 24.00 Λ 24.00 25.00 OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY) 0 25.00 Pioneer ACO demonstration payment adjustment (see instructions) 25, 50 0 25.50 25.99 Demonstration payment adjustment amount before sequestration 25.99 0 26.00 Net reimbursable amount (see instructions) 63, 405 26.00 1, 268 26.01 Sequestration adjustment (see instructions) 26.01 26. 02 Demonstration payment adjustment amount after sequestration 26.02 0 47, 049 27 00 27 00 Interim payments 28.00 Tentative settlement (for contractor use only) 0 28.00 15, 088 Balance due component/program (line 26 minus lines 26.01, 26.02, 27, and 28) 29.00 29.00

0 30.00

Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-II,

30.00

chapter I, §115.2

From 07/17/2023 Component CCN: 14-3424 09/30/2023 Date/Time Prepared: 2/26/2024 1:42 pm Title XVIII RHC I Cost PNEUMOCOCCAL INFLUENZA COVI D-19 MONOCLONAL **VACCINES VACCINES** VACCI NES ANTI BODY **PRODUCTS** 1.00 2.00 2.01 2.02 1.00 Health care staff cost (from Wkst. M-1, col. 64, 043 64, 043 64, 043 64, 043 1. 00 Ratio of injection/infusion staff time to total health 0.000000 0.000000 0.000000 2.00 0.000158 2.00 care staff time 3.00 Injection/infusion health care staff cost (line 1 x line 10 0 0 3.00 2) 4.00 Injections/infusions and related medical supplies costs 361 0 0 4.00 (from your records) 5.00 Direct cost of injections/infusions (line 3 plus line 4) 371 O 5.00 Total direct cost of the hospital-based RHC/FQHC (from 65, 398 65, 398 65, 398 6.00 65, 398 6.00 Worksheet M-1, col. 7, line 22) 7.00 Total overhead (from Wkst. M-2, line 19) 54, 156 54, 156 54, 156 54, 156 7.00 Ratio of injection/infusion direct cost to total direct 0.000000 0.000000 8.00 0.005673 0.000000 8.00 cost (line 5 divided by line 6) 9.00 Overhead cost - injection/infusion (line 7 x line 8) 9.00 307 Total injection/infusion costs and their administration 0 10.00 678 0 0 10.00 costs (sum of lines 5 and 9) Total number of injections/infusions (from your records) 11.00 12.00 Cost per injection/infusion (line 10/line 11) 339.00 0.00 0.00 0.00 12.00 Number of injection/infusion administered to Program 13.00 Ω 13.00 benefi ci ari es 13.01 Number of COVID-19 vaccine injections/infusions 0 13.01 administered to MA enrollees 14.00 Program cost of injections/infusions and their 678 0 0 14.00 administration costs (line 12 times the sum of lines 13 and 13.01, as applicable) COST OF INJECTIONS / INFUSIONS AND ADMI NI STRATI ON 1. 00 2.00 Total cost of injections/infusions and their administration costs (sum of columns 1, 678 15.00 2, 2.01, and 2.02, line 10) (transfer this amount to Wkst. M-3, line 2) Total Program cost of injections/infusions and their administration costs (sum of 678 16.00

In Lieu of Form CMS-2552-10

Worksheet M-4

From 07/17/2023 Component CCN: 14-3425 09/30/2023 Date/Time Prepared: 2/26/2024 1:42 pm Title XVIII RHC II Cost PNEUMOCOCCAL INFLUENZA COVI D-19 MONOCLONAL ANTI BODY **VACCINES** VACCI NES VACCI NES **PRODUCTS** 1.00 2.00 2.01 2.02 1.00 Health care staff cost (from Wkst. M-1, col. 71, 957 71, 957 71, 957 71, 957 1. 00 Ratio of injection/infusion staff time to total health 0.000000 0.000000 0.000000 2.00 0.001106 2.00 care staff time 3.00 Injection/infusion health care staff cost (line 1 x line 80 0 0 3.00 2) 4.00 Injections/infusions and related medical supplies costs 2, 529 0 0 4.00 (from your records) 5.00 Direct cost of injections/infusions (line 3 plus line 4) 2, 609 5.00 Total direct cost of the hospital-based RHC/FQHC (from 75, 651 75, 651 75, 651 6.00 75, 651 6.00 Worksheet M-1, col. 7, line 22) 7.00 Total overhead (from Wkst. M-2, line 19) 73, 581 73, 581 73, 581 73, 581 7.00 Ratio of injection/infusion direct cost to total direct 0.000000 0.000000 8.00 0.034487 0.000000 8.00 cost (line 5 divided by line 6) 9.00 Overhead cost - injection/infusion (line 7 x line 8) 9.00 2.538 Total injection/infusion costs and their administration 0 10.00 5, 147 0 0 10.00 costs (sum of lines 5 and 9) Total number of injections/infusions (from your records) 11.00 12.00 Cost per injection/infusion (line 10/line 11) 367.64 0.00 0.00 0.00 12.00 Number of injection/infusion administered to Program 13.00 Ω 13.00 benefi ci ari es Number of COVID-19 vaccine injections/infusions 13.01 0 13.01 administered to MA enrollees Program cost of injections/infusions and their 2, 941 0 0 14.00 administration costs (line 12 times the sum of lines 13 and 13.01, as applicable) COST OF INJECTIONS / INFUSIONS AND ADMI NI STRATI ON 1. 00 2.00 Total cost of injections/infusions and their administration costs (sum of columns 1, 5.147 15.00 2, 2.01, and 2.02, line 10) (transfer this amount to Wkst. M-3, line 2) Total Program cost of injections/infusions and their administration costs (sum of 2, 941 16.00

In Lieu of Form CMS-2552-10

Worksheet M-4

Worksheet M-4 From 07/17/2023 Component CCN: 15-3979 09/30/2023 Date/Time Prepared: 2/26/2024 1:42 pm Title XVIII RHC III Cost PNEUMOCOCCAL INFLUENZA COVI D-19 MONOCLONAL ANTI BODY **VACCINES** VACCI NES VACCI NES **PRODUCTS** 1.00 2.00 2.01 2.02 1.00 Health care staff cost (from Wkst. M-1, col. 193, 130 193, 130 193, 130 193, 130 1. 00 Ratio of injection/infusion staff time to total health 0.000370 0.000000 0.000000 0.000000 2.00 2.00 care staff time 3.00 Injection/infusion health care staff cost (line 1 x line 71 0 0 0 3.00 2) 4.00 Injections/infusions and related medical supplies costs 1, 445 0 0 4.00 (from your records) 5.00 Direct cost of injections/infusions (line 3 plus line 4) 1, 516 5.00 Total direct cost of the hospital-based RHC/FQHC (from 198, 719 198.719 198, 719 198, 719 6.00 6.00 Worksheet M-1, col. 7, line 22) 7.00 Total overhead (from Wkst. M-2, line 19) 135, 325 135, 325 135, 325 135, 325 7.00 Ratio of injection/infusion direct cost to total direct 0.000000 0.000000 8.00 0.007629 0.000000 8.00 cost (line 5 divided by line 6) 9.00 Overhead cost - injection/infusion (line 7 x line 8) 9.00 1.032 Total injection/infusion costs and their administration 0 10.00 2, 548 0 0 10.00 costs (sum of lines 5 and 9) Total number of injections/infusions (from your records) 11.00 12.00 Cost per injection/infusion (line 10/line 11) 318.50 0.00 0.00 0.00 12.00 Number of injection/infusion administered to Program 13.00 Ω 13.00 benefi ci ari es Number of COVID-19 vaccine injections/infusions 13.01 0 13.01 administered to MA enrollees Program cost of injections/infusions and their 1, 593 0 0 14.00 administration costs (line 12 times the sum of lines 13 and 13.01, as applicable) COST OF INJECTIONS / INFUSIONS AND ADMI NI STRATI ON 1. 00 2.00 Total cost of injections/infusions and their administration costs (sum of columns 1, 2,548 15.00 2, 2.01, and 2.02, line 10) (transfer this amount to Wkst. M-3, line 2) Total Program cost of injections/infusions and their administration costs (sum of 1,593 16.00

In Lieu of Form CMS-2552-10

From 07/17/2023 Component CCN: 14-8551 09/30/2023 Date/Time Prepared: 2/26/2024 1:42 pm Title XVIII RHC IV Cost PNEUMOCOCCAL INFLUENZA COVI D-19 MONOCLONAL VACCI NES VACCI NES VACCI NES ANTI BODY **PRODUCTS** 1.00 2.00 2.01 2.02 1.00 Health care staff cost (from Wkst. M-1, col. 339, 643 339, 643 339, 643 339, 643 1. 00 Ratio of injection/infusion staff time to total health 0.000434 0.000097 0.000000 0.000000 2.00 2.00 care staff time 3.00 Injection/infusion health care staff cost (line 1 x line 33 147 0 0 3.00 2) 4.00 Injections/infusions and related medical supplies costs 3, 251 161 0 4.00 (from your records) 5.00 Direct cost of injections/infusions (line 3 plus line 4) 3, 398 194 O 5.00 345, 196 Total direct cost of the hospital-based RHC/FQHC (from 345, 196 345, 196 345, 196 6.00 6.00 Worksheet M-1, col. 7, line 22) 7.00 Total overhead (from Wkst. M-2, line 19) 252, 422 252, 422 252, 422 252, 422 7.00 Ratio of injection/infusion direct cost to total direct 0.000562 0.000000 8.00 0.009844 0.000000 8.00 cost (line 5 divided by line 6) 9.00 Overhead cost - injection/infusion (line 7 x line 8) 9.00 2.485 142 Total injection/infusion costs and their administration 10.00 5, 883 336 0 0 10.00 costs (sum of lines 5 and 9) Total number of injections/infusions (from your records) 11.00 12.00 Cost per injection/infusion (line 10/line 11) 326.83 84.00 0.00 0.00 12.00 Number of injection/infusion administered to Program 13.00 Ω 13.00 benefi ci ari es 13.01 Number of COVID-19 vaccine injections/infusions 0 0 13.01 administered to MA enrollees 14.00 Program cost of injections/infusions and their 2, 615 168 0 14.00 administration costs (line 12 times the sum of lines 13 and 13.01, as applicable) COST OF INJECTIONS / INFUSIONS AND ADMI NI STRATI ON 1. 00 2.00 Total cost of injections/infusions and their administration costs (sum of columns 1, 6, 219 15.00 2, 2.01, and 2.02, line 10) (transfer this amount to Wkst. M-3, line 2) Total Program cost of injections/infusions and their administration costs (sum of 2, 783 16.00

In Lieu of Form CMS-2552-10

Worksheet M-4

Health Financial Systems IROQUOIS MANALYSIS OF PAYMENTS TO HOSPITAL-BASED RHC/FQHC PROVIDER FOR I ROQUOIS MEMORIAL HOSPITAL

SERVICES RENDERED TO PROGRAM BENEFICIARIES

Provi der CCN: 14-1353

Peri od: From 07/17/2023 To 09/30/2023 Worksheet M-5

In Lieu of Form CMS-2552-10

Date/Time Prepared: 2/26/2024 1:42 pm Component CCN: 14-3424

			RHC I	Cost	
			Par	t B	
			mm/dd/yyyy	Amount	
			1.00	2.00	
1.00	Total interim payments paid to hospital-based RHC/FQHC			33, 827	1. 00
2.00	Interim payments payable on individual bills, either submitt	ted or to be submitted to		0	2. 00
2.00	the contractor for services rendered in the cost reporting p				2.00
	"NONE" or enter a zero				
3.00	List separately each retroactive lump sum adjustment amount	based on subsequent			3.00
0.00	revision of the interim rate for the cost reporting period.				0.00
	payment. If none, write "NONE" or enter a zero. (1)	7. So Shew date of Sach			
	Program to Provider				
3. 01				0	3. 01
3. 02				0	3. 02
3. 03				0	3. 03
3. 04				Ö	3. 04
3. 05				0	3. 05
3.03	Provider to Program			U	3. 03
3. 50	Frovider to Frogram			0	3. 50
3. 51				0	3. 50
3. 52				0	3. 51
3. 52				0	3. 52
3. 54				0	3. 54
	Subtatal (sum of lines 2 01 2 40 minus sum of lines 2 EO 2 6	00)		0	3. 54
3. 99	Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.9			- 1	
4. 00	Total interim payments (sum of lines 1, 2, and 3.99) (transf 27)	rer to worksheet M-3, line		33, 827	4. 00
	TO BE COMPLETED BY CONTRACTOR				
5. 00	List separately each tentative settlement payment after desk	k roviou Alco chow data of			5. 00
5.00	each payment. If none, write "NONE" or enter a zero. (1)	K review. Also show date of			5.00
	Program to Provider				
5. 01	Flogialii to Flovidei			0	5. 01
5. 02				0	5. 01
5. 02				0	5. 02
5.03	Dravi dan ta Draggam			U	5. 03
E E0	Provider to Program			0	E E0
5.50				0	5. 50
5. 51				0	5. 51
5. 52		99)		0	5. 52
5. 99	Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.9			0	5. 99
6.00	Determined net settlement amount (balance due) based on the	cost report. (1)		_	6.00
6. 01	SETTLEMENT TO PROVI DER			0	6. 01
6. 02	SETTLEMENT TO PROGRAM			11, 326	6. 02
7. 00	Total Medicare program liability (see instructions)			22, 501	7. 00
			Contractor	NPR Date	
			Number	(Mo/Day/Yr)	
		0	1.00	2. 00	
		-		2.00	
8. 00		NATIONAL GOVERNMENT SERVICES		2.00	8. 00

Health Financial Systems IROQUOIS MANALYSIS OF PAYMENTS TO HOSPITAL-BASED RHC/FQHC PROVIDER FOR I ROQUOIS MEMORIAL HOSPITAL

SERVICES RENDERED TO PROGRAM BENEFICIARIES

In Lieu of Form CMS-2552-10 Peri od: From 07/17/2023 To 09/30/2023 Worksheet M-5 Provi der CCN: 14-1353

Date/Time Prepared: 2/26/2024 1:42 pm Cost Component CCN: 14-3425 RHC II

			RHC II	Cost	
			Par	rt B	
			mm/dd/yyyy	Amount	
			1. 00	2,00	
. 00	Total interim payments paid to hospital-based RHC/FQHC			21, 783	1. (
. 00	Interim payments payable on individual bills, either submit	tted or to be submitted to		0	2. (
. 00	the contractor for services rendered in the cost reporting			Ĭ	
	"NONE" or enter a zero	perrod. Tr none, write			
. 00	List separately each retroactive lump sum adjustment amount	t based on subsequent			3. (
. 00	revision of the interim rate for the cost reporting period.				3. (
	payment. If none, write "NONE" or enter a zero. (1)	ALSO SHOW date of each			
	Program to Provider				
	Program to Provider			0	2
. 01					3.
. 02				0	3.
. 03				0	3. (
. 04				0	3. (
. 05				0	3.
	Provider to Program				
. 50				0	3.
. 51				0	3.
52				0	3.
53				l ol	3.
. 54				0	3.
. 99	Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.	98)		0	3.
. 00	Total interim payments (sum of lines 1, 2, and 3.99) (trans			21, 783	
. 00	27)	ster to worksheet m s, title		21,700	
	TO BE COMPLETED BY CONTRACTOR				
. 00	List separately each tentative settlement payment after des	sk review Also show date of			5.
. 00	each payment. If none, write "NONE" or enter a zero. (1)	sk review. 74 30 show date of			0.
	Program to Provider				
. 01	11 ogram to 11 ovi dei			0	5.
. 02					5. 5.
03					5. 5.
	Describility to Describe			U	٦.
	Provider to Program				_
50				0	5.
51				0	5.
52		>		0	5.
				ا ۱	
	Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.			١	
00	Determined net settlement amount (balance due) based on the				6.
00	Determined net settlement amount (balance due) based on the SETTLEMENT TO PROVIDER			3, 546	6. 6.
. 00 . 01	Determined net settlement amount (balance due) based on the			3, 546	6. 6.
. 00 . 01 . 02	Determined net settlement amount (balance due) based on the SETTLEMENT TO PROVIDER			3, 546	6. 6. 6.
. 00 . 01 . 02	Determined net settlement amount (balance due) based on the SETTLEMENT TO PROVIDER SETTLEMENT TO PROGRAM		Contractor	3, 546 0 25, 329	6. 6. 6.
. 00 . 01 . 02	Determined net settlement amount (balance due) based on the SETTLEMENT TO PROVIDER SETTLEMENT TO PROGRAM		Contractor Number	3, 546 0 25, 329 NPR Date	6. 6. 6.
0.00 0.01 0.02	Determined net settlement amount (balance due) based on the SETTLEMENT TO PROVIDER SETTLEMENT TO PROGRAM		Number	3, 546 0 25, 329 NPR Date (Mo/Day/Yr)	6. 6. 6.
5. 99 5. 00 5. 01 5. 02 7. 00	Determined net settlement amount (balance due) based on the SETTLEMENT TO PROVIDER SETTLEMENT TO PROGRAM Total Medicare program liability (see instructions)	e cost report. (1)	Number 1.00	3, 546 0 25, 329 NPR Date	5. 6. 6. 6. 6. 7. 6

In Lieu of Form CMS-2552-10

SERVICES RENDERED TO PROGRAM BENEFICIARIES

Provi der CCN: 14-1353 Component CCN: 15-3979 Peri od: From 07/17/2023 To 09/30/2023 Worksheet M-5

Date/Time Prepared: 2/26/2024 1:42 pm

Reficility Cost					2/26/2024 1: 42	2 pm
1.00				RHC III	Cost	
Total interIm payments paid to hospital-based RHC/FOHC 1.00 2.00 1.00				Par	t B	
Total interIm payments paid to hospital-based RHC/FOHC 1.00 2.00 1.00				mm/dd/vvvv	Amount	
Total interim payments paid to hospital-based RIC/FDMC South Program Sou						
Interim payments payable on individual bills, either submitted or to be submitted to the contractor for services rendered in the cost reporting period. If none, write "NONE" or enter a zero. 3.00	1 00	Total interim nayments haid to boshital based RHC/EOHC		11.00		1 00
the contractor for Services rendered in the cost reporting period. If none, write "NONE" or enter a zero 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) Program to Provider 3.00 3.01 3.03 3.04 3.05 Provider to Program 3.50 3.51 3.51 3.52 3.53 3.54 3.99 Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98) 3.64 3.99 Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Worksheet M-3, line 27) TO BE COMPLETED BY CONTRACTOR List separately each tentative settlement payment after desk review. Also show date of each payment. If none, write "NONE" or enter a zero. (1) Program to Provider 5.00 5.01 5.01 5.02 5.03 5.03 5.04 5.05 6.00 5.01 5.01 6.01 5.01 6.00 6.01 5.01 6.00 6.01 5.01 6.00 6.01 6.00 6.00 6.00 6.00 6.00 6			or to be submitted to			
NONE" or enter a zero	2.00				٧	2.00
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)			rod. II none, write			
revision of the interim rate for the cost reporting period. Also show date of each papement. If none, write "NONE" or enter a zero. (1)						
payment. If none, write "NONE" or enter a zero. (1)	3.00					3.00
Program to Provider			so show date of each			
3.01 3.02 3.03 3.04 3.05 3.05 3.50 3.50 3.51 3.52 3.53 3.54 3.99 3.54 3.99 3.55 3.50 3.50 3.50 3.50 3.50 3.50 3.50						
3.02 3.03 3.04 3.05 3.03 3.04 3.05		Program to Provider				
3. 03 0 0 3. 03 0 0 3. 04 0 0 3. 05 0 0 3. 05 0 0 3. 05 0 0 3. 05 0 0 0 0 0 0 0 0 0	3.01				0	3. 01
3.04 3.05 Provider to Program	3.02				0	3.02
3.05 Provider to Program	3.03				o	3. 03
3.05 Provider to Program	3 04				0	3 04
Provider to Program						
3.50 3.51 3.52 3.53 3.54 3.55	5.05	Provider to Program			0	5. 05
3.51 3.52 3.53 0 3.53 0 3.53 0 3.53 3.54 0 3.53 3.54 0 3.53 3.54 0 3.53 3.54 0 3.53 3.54 0 3.53 3.54 0 3.53 3.54 0 3.54 3.59 0 3.54 3.59 0 3.54 3.59 0 3.54 3.59 0 3.59 3.54 0 3.59 3.54 0 3.59 3.54 0 3.59 3.54 0 3.59 3.54 0 3.59 3.54 0 3.59 3.54 0 3.59 3.59 0 3.54 3.59 3.5	2 EO	Frovider to Frogram				2 E0
3.52 3.53 3.54 3.54 3.54 3.54 3.54 3.54 3.54 3.54 3.54 3.54 3.54 3.54 3.54 3.54 3.54 3.54 3.55 3.54 3.54 3.55 3.54 3.55 3.54 3.55					- 1	
3.53 3.54					- 1	
3.54 3.99 Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98) 0 3.54 3.99 Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Worksheet M-3, line 27) 10 BE COMPLETED BY CONTRACTOR					- 1	
3.99 Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98) 0 3.99 4.00 70tal interim payments (sum of lines 1, 2, and 3.99) (transfer to Worksheet M-3, line 27) 80,964 4.00 27) 70 BE COMPLETED BY CONTRACTOR 5.00 List separately each tentative settlement payment after desk review. Also show date of each payment. If none, write "NONE" or enter a zero. (1) Program to Provider 0 5.01 5.02 5.03 7.00 7.0					- 1	
Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Worksheet M-3, line 80,964 4.00	3.54				0	3. 54
27) TO BE COMPLETED BY CONTRACTOR	3.99	Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98)			0	3. 99
To BE COMPLETED BY CONTRACTOR	4.00	Total interim payments (sum of lines 1, 2, and 3.99) (transfer	to Worksheet M-3, line		80, 964	4.00
5.00 List separately each tentative settlement payment after desk review. Also show date of each payment. If none, write "NONE" or enter a zero. (1) Program to Provider		27)				
each payment. If none, write "NONE" or enter a zero. (1) Program to Provider		TO BE COMPLETED BY CONTRACTOR				
each payment. If none, write "NONE" or enter a zero. (1) Program to Provider	5.00	List separately each tentative settlement payment after desk re	eview. Also show date of			5. 00
Program to Provider S. 01 S. 02 S. 03 S. 04 S. 05						
5. 01 0 5. 01 0 5. 02 0 5. 02 0 5. 03 0 5. 03 0 5. 03 0 5. 03 0 5. 03 0 5. 03 0 5. 03 0 5. 50 0 5. 50 0 5. 51 0 5. 51 0 5. 51 5. 52 0 5. 52 0 5. 52 5. 99 Subtotal (sum of lines 5. 01-5. 49 minus sum of lines 5. 50-5. 98) 0 5. 99 6. 00 Determined net settlement amount (balance due) based on the cost report. (1) 6. 00 6. 01 SETTLEMENT TO PROVIDER 0 6. 01 6. 02 SETTLEMENT TO PROGRAM 10, 307 6. 02 7. 00 Total Medicare program liability (see instructions) Total Medicare program liability (see instructions) NPR Date (Mo/Day/Yr) Number (Mo/Day/Yr) 0 1. 00 2. 00 8. 00 Name of Contractor NATIONAL GOVERNMENT SERVICES 06101 8. 00 8. 00 Name of Contractor NATIONAL GOVERNMENT SERVICES 06101 8. 00 1. 00						
5. 02	5 O1	i rogram to rrovider		T	0	5 O1
S. 50 Provider to Program S. 50						
Provider to Program					- 1	
5.50 0 5.50 0 5.51 0 5.51 0 5.51 0 5.51 0 5.51 0 5.52 0 0 0 5.52 0 5	5.03				U	5. 03
5.51 0 5.51 0 5.52 0 5.52 0 5.52 0 5.52 0 5.52 0 5.52 0 5.52 0 5.52 0 5.52 0 5.52 0 5.52 0 5.52 0 5.52 0 5.52 0 5.52 0 5.52 0 5.52 0 5.52 0 5.52 0 5.59 0 5.59 0 5.59 0 5.59 0 6.00 6.01 6.01 6.02 SETTLEMENT TO PROVIDER 0 6.01 6.02 SETTLEMENT TO PROGRAM 10,307 6.02 7.00 Total Medicare program liability (see instructions) Contractor Number (Mo/Day/Yr) 0 1.00 2.00 8.00 Name of Contractor Number National Government Services 0.6101 8.00 0 1.00 0.00 1.00 0.00 1.00 0.00 1.00 0.00 1.00 0.00 1.00 0.00 1.00 0.00 1.00 0.00		Provider to Program				
5.52 Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98)					- 1	
Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98) 0 5.99					0	
6.00 Determined net settlement amount (balance due) based on the cost report. (1) 6.00 6.01 SETTLEMENT TO PROVIDER 6.02 SETTLEMENT TO PROGRAM 7.00 Total Medicare program liability (see instructions) 70,657 7.00 Contractor Number (Mo/Day/Yr) (Mo/Day/Yr) 1.00 2.00 8.00 Name of Contractor NATIONAL GOVERNMENT SERVICES 06101 8.00	5.52				0	5. 52
6. 01 SETTLEMENT TO PROVIDER 6. 02 SETTLEMENT TO PROGRAM 7. 00 Total Medicare program liability (see instructions) Contractor NPR Date (Mo/Day/Yr) Number (Mo/Day/Yr) 8. 00 Name of Contractor NATIONAL GOVERNMENT SERVICES 06101 8. 00	5.99	Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98)			0	5. 99
6. 01 SETTLEMENT TO PROVIDER 6. 02 SETTLEMENT TO PROGRAM 7. 00 Total Medicare program liability (see instructions) Contractor NPR Date (Mo/Day/Yr) Number (Mo/Day/Yr) 8. 00 Name of Contractor NATIONAL GOVERNMENT SERVICES 06101 8. 00	6.00	Determined net settlement amount (balance due) based on the cos	st report. (1)			6.00
6. 02 SETTLEMENT TO PROGRAM 10, 307 6. 02 7, 00 Total Medicare program liability (see instructions) 70, 657 7. 00	6. 01	,			0	6, 01
7. 00 Total Medicare program liability (see instructions) 70, 657 7. 00 Contractor Number (Mo/Day/Yr) 0 1. 00 2. 00 8. 00 Name of Contractor NATIONAL GOVERNMENT SERVICES 06101 8. 00					- 1	
Contractor NPR Date (Mo/Day/Yr) 0 1.00 2.00 8.00 Name of Contractor NATIONAL GOVERNMENT SERVICES 06101 8.00						
Number (Mo/Day/Yr) 0 1.00 2.00 8.00 Name of Contractor NATI ONAL GOVERNMENT SERVI CES 06101 8.00	7.00	Total modicale program frability (see Histractions)		Contractor		7.00
0 1.00 2.00 8.00 Name of Contractor NATI ONAL GOVERNMENT SERVI CES 06101 8.00						
8.00 Name of Contractor NATIONAL GOVERNMENT SERVICES 06101 8.00			0			
	0.00	III			2.00	0.00
I INC.	8.00			06101		8.00
		I NC.				

I ROQUOIS MEMORIAL HOSPITAL

Health Financial Systems IROQUOIS MANALYSIS OF PAYMENTS TO HOSPITAL-BASED RHC/FQHC PROVIDER FOR In Lieu of Form CMS-2552-10 Peri od: From 07/17/2023 To 09/30/2023 Date/Ti me Prepared: 2/26/2024 1: 42 pm Cost Provi der CCN: 14-1353 SERVICES RENDERED TO PROGRAM BENEFICIARIES Component CCN: 14-8551

Interim payments payable on individual bills, either submitted or to be submitted to the contractor for services rendered in the cost reporting period. If none, write "NONE" or enter a zero 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) Program to Provider Provider to Program Provider to Program O Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98) O Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Worksheet M-3, line 27) TO BE COMPLETED BY CONTRACTOR List separately each tentative settlement payment after desk review. Also show date of each payment. If none, write "NONE" or enter a zero. (1) Program to Provider Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98) Determined net settlement amount (balance due) based on the cost report. (1) SETTLEMENT TO PROGRAM O Contractor Number (Mo/Day/Yr) Ner Date (Mo/Day/Yr) NPR Date (Mo/Day/Yr)				RHC I V	Cost	
Total Interim payments paid to hospital-based RHC/FOHC Interim payments payable on individual bills, either submitted or to be submitted to the contractor for services rendered in the cost reporting period. If none, write "NONE" or enter a zero 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) Program to Provider Program to Provider Provider to Program Provider to Program On a subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98) Total Interim payments (sum of lines 1, 2, and 3.99) (transfer to Worksheet M-3, line 27) To BE COMPLETED BY CONTRACTOR List separately each tentative settlement payment after desk review. Also show date of each payment. If none, write "NONE" or enter a zero. (1) Program to Provider Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98) Determined net settlement amount (balance due) based on the cost report. (1) SETILEMENT TO PROGRAM On Total Medicare program liability (see instructions) On Name of Contractor NATIONAL GOVERNMENT SERVICES On Name of Contractor				Par	⁻t B	
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