



COMPU-MAX

INGALLS MEMORIAL HOSPITAL Provider CCN: 14-0191	In Lieu of Form CMS-2552-10	Period : From: 10/01/2013 To: 09/30/2014	Run Date: 03/02/2015 Run Time: 10:44 Version: 2014.10
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HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX COST REPORT CERTIFICATION AND SETTLEMENT SUMMARY

WORKSHEET S
PARTS I, II & III

PART I - COST REPORT STATUS

PROVIDER USE ONLY	1. <input checked="" type="checkbox"/> ELECTRONICALLY FILED COST REPORT	DATE: 03/02/2015	TIME: 10:44
	2. <input type="checkbox"/> MANUALLY SUBMITTED COST REPORT		
	3. <input type="checkbox"/> IF THIS IS AN AMENDED REPORT ENTER THE NUMBER OF TIMES THE PROVIDER RESUBMITTED THE COST REPORT		
	4. <input checked="" type="checkbox"/> MEDICARE UTILIZATION. ENTER 'F' FOR FULL OR 'L' FOR LOW.		
CONTRACTOR USE ONLY	5. <input type="checkbox"/> COST REPORT STATUS	6. DATE RECEIVED: _____	10. NPR DATE: _____
	1 -AS SUBMITTED	7. CONTRACTOR NO: _____	11. CONTRACTOR'S VENDOR CODE: _____
	2 -SETTLED WITHOUT AUDIT	8. <input type="checkbox"/> INITIAL REPORT FOR THIS PROVIDER CCN	12. <input type="checkbox"/> IF LINE 5, COLUMN 1 IS 4: ENTER NUMBER OF TIMES REOPENED = 0-9.
	3 -SETTLED WITH AUDIT	9. <input type="checkbox"/> FINAL REPORT FOR THIS PROVIDER CCN	
	4 -REOPENED		
	5 -AMENDED		

PART II - CERTIFICATION

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

CERTIFICATION BY OFFICER OR ADMINISTRATOR OF PROVIDER(S)

I HEREBY CERTIFY THAT I HAVE READ THE ABOVE STATEMENT AND THAT I HAVE EXAMINED THE ACCOMPANYING ELECTRONICALLY FILED OR MANUALLY SUBMITTED COST REPORT AND THE BALANCE SHEET AND STATEMENT OF REVENUE AND EXPENSES PREPARED BY INGALLS MEMORIAL HOSPITAL. (14-0191) ((PROVIDER NAME(S) AND NUMBER(S)) FOR THE COST REPORTING PERIOD BEGINNING 10/01/2013 AND ENDING 09/30/2014, AND TO THE BEST OF MY KNOWLEDGE AND BELIEF, IT IS A TRUE, CORRECT AND COMPLETE STATEMENT PREPARED FROM THE BOOKS AND RECORDS OF THE PROVIDER IN ACCORDANCE WITH APPLICABLE INSTRUCTIONS, EXCEPT AS NOTED. I FURTHER CERTIFY THAT I AM FAMILIAR WITH THE LAWS AND REGULATIONS REGARDING THE PROVISION OF HEALTH CARE SERVICES, AND THAT THE SERVICES IDENTIFIED IN THIS COST REPORT WERE PROVIDED IN COMPLIANCE WITH SUCH LAWS AND REGULATIONS.

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

TITLE

DATE

PART III - SETTLEMENT SUMMARY

		TITLE XVIII			HIT	TITLE XIX	
		TITLE V	PART A	PART B			
		1	2	3	4	5	
1	HOSPITAL		408,159	-217,347	92,841	45,178,454	1
2	SUBPROVIDER - IPF		10,761			343,332	2
3	SUBPROVIDER - IRF		41,874			411,094	3
4	SUBPROVIDER (OTHER)						4
5	SWING BED - SNF						5
6	SWING BED - NF						6
7	SKILLED NURSING FACILITY						7
8	NURSING FACILITY						8
9	HOME HEALTH AGENCY		1	1			9
10	HEALTH CLINIC - RHC						10
11	HEALTH CLINIC - FQHC						11
12	OUTPATIENT REHABILITATION PROVIDER						12
200	TOTAL		460,795	-217,346	92,841	45,932,880	200

THE ABOVE AMOUNTS REPRESENT 'DUE TO' OR 'DUE FROM' THE APPLICABLE PROGRAM FOR THE ELEMENT OF THE ABOVE COMPLEX INDICATED.

ACCORDING TO THE PAPERWORK REDUCTION ACT OF 1995, NO PERSONS ARE REQUIRED TO RESPOND TO A COLLECTION OF INFORMATION UNLESS IT DISPLAYS A VALID OMB CONTROL NUMBER. THE VALID OMB CONTROL NUMBER FOR THIS INFORMATION COLLECTION IS 0938-0050. THE TIME REQUIRED TO COMPLETE THIS INFORMATION COLLECTION IS ESTIMATED 673 HOURS PER RESPONSE, INCLUDING THE TIME TO REVIEW INSTRUCTIONS, SEARCH EXISTING RESOURCES, GATHER THE DATA NEEDED, AND COMPLETE AND REVIEW THE INFORMATION COLLECTION. IF YOU HAVE ANY COMMENTS CONCERNING THE ACCURACY OF THE TIME ESTIMATE(S) OR SUGGESTIONS FOR IMPROVING THIS FORM, PLEASE WRITE TO: CMS, 7500 SECURITY BOULEVARD, ATTN: PRA REPORT CLEARANCE OFFICER, MAIL STOP C4-26-05, BALTIMORE, MARYLAND 21244-1850.



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HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA

WORKSHEET S-2
PART I

Hospital and Hospital Health Care Complex Address:										
1	Street: ONE INGALLS DRIVE	P.O. Box:							1	
2	City: HARVEY	State: IL	ZIP Code: 60426	County: COOK					2	
Hospital and Hospital-Based Component Identification:										
							Payment System (P, T, O, or N)			
	Component	Component Name	CCN Number	CBSA Number	Provider Type	Date Certified	V	XVIII	XIX	
	0	1	2	3	4	5	6	7	8	
3	Hospital	INGALLS MEMORIAL HOSPITAL	14-0191	16974	1	07/01/1966	N	P	O	3
4	Subprovider - IPF	PSYCH UNIT OF INGALLS MEMORIAL HOSPI	14-S191	16974	4	01/01/1984	N	P	O	4
5	Subprovider - IRF	REHAB UNIT OF INGALLS MEMORIAL HOSPI	14-T191	16974	5	11/02/1989	N	P	O	5
6	Subprovider - (OTHER)									6
7	Swing Beds - SNF									7
8	Swing Beds - NF									8
9	Hospital-Based SNF									9
10	Hospital-Based NF									10
11	Hospital-Based OLTC									11
12	Hospital-Based HHA	INGALLS HOME CARE	14-7435	16974		07/24/1985	N	P	N	12
13	Separately Certified ASC									13
14	Hospital-Based Hospice	INGALLS HOME CARE HOSPICE	14-1535	16974		02/28/1990				14
15	Hospital-Based Health Clinic - RHC									15
16	Hospital-Based Health Clinic - FQHC									16
17	Hospital-Based (CMHC)									17
18	Renal Dialysis									18
19	Other									19
20	Cost Reporting Period (mm/dd/yyyy)	From: 10 / 01 / 2013	To: 09 / 30 / 2014							20
21	Type of control (see instructions)	2								21
Inpatient PPS Information								1	2	
22	Does this facility qualify for and receive disproportionate share hospital payments in accordance with 42 CFR §412.106? In column 1, enter 'Y' for yes or 'N' for no. Is this facility subject to 42 CFR §412.06(c)(2)(Pickle amendment hospital)? In column 2, enter 'Y' for yes or 'N' for no.							Y	N	22
22.01	Did this hospital receive interim uncompensated care payments for this cost reporting period? Enter in column 1, 'Y' for yes or 'N' for no for the portion of the cost reporting period occurring prior to October 1. Enter in column 2 'Y' for yes or 'N' for no for the portion of the cost reporting period occurring on or after October 1. (see instructions)							N	N	22.01
23	Which method is used to determine Medicaid days on lines 24 and/or 25 below? In column 1, enter 1 if date of admission, 2 if census days, or 3 if date of discharge. Is the method of identifying the days in this cost reporting period different from the method used in the prior cost reporting period? In column 2, enter 'Y' for yes or 'N' for no.							3	N	23
		In-State Medicaid paid days	In-State Medicaid eligible unpaid days	Out-of-State Medicaid paid days	Out-of-State Medicaid eligible unpaid days	Medicaid HMO days	Other Medicaid days			
		1	2	3	4	5	6			
24	If this provider is an IPPS hospital, enter the in-state Medicaid paid days in col. 1, in-state Medicaid eligible unpaid days in col. 2, out-of-state Medicaid paid days in col. 3, out-of-state Medicaid eligible unpaid days in col. 4, Medicaid HMO paid and eligible but unpaid days in col. 5, and other Medicaid days in col. 6.	14,951	987	138		5,775			24	
25	If this provider is an IRF, enter the in-state Medicaid paid days in col. 1, in-state Medicaid eligible unpaid days in col. 2, out-of-state Medicaid days in col. 3, out-of-state Medicaid eligible unpaid days in col. 4, Medicaid HMO paid and eligible but unpaid days in col. 5, and other Medicaid days in col. 6.	162				51			25	
26	Enter your standard geographic classification (not wage) status at the beginning of the cost reporting period. Enter '1' for urban and '2' for rural.			1					26	
27	Enter your standard geographic classification (not wage) status at the end of the cost reporting period. Enter in column 1, '1' for urban or '2' for rural. If applicable, enter the effective date of the geographic reclassification in column 2.			1					27	
35	If this is a sole community hospital (SCH), enter the number of periods SCH status in effect in the cost reporting period.								35	
36	Enter applicable beginning and ending dates of SCH status. Subscript line 36 for number of periods in excess of one and enter subsequent dates.			Beginning:		Ending:			36	
37	If this is a Medicare dependent hospital (MDH), enter the number of periods MDH status in effect in the cost reporting period.								37	
38	Enter applicable beginning and ending dates of MDH status. Subscript line 38 for number of periods in excess of one and enter subsequent dates.			Beginning:		Ending:			38	
							1	2		
39	Does this facility qualify for the inpatient hospital payment adjustment for low volume hospitals in accordance with 42 CFR §412.101(b)(2)(ii)? Enter in column 1 'Y' for yes or 'N' for no. Does the facility meet the mileage requirements in accordance with 42 CFR 412.101(b)(2)(ii)? Enter in column 2 'Y' for yes or 'N' for no. (see instructions)						N	N	39	



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HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA

WORKSHEET S-2
PART I

		V	XVIII	XIX	
Prospective Payment System (PPS)-Capital		1	2	3	
45	Does this facility qualify and receive capital payment for disproportionate share in accordance with 42 CFR §412.320?	Y	Y	N	45
46	Is this facility eligible for additional payment exception for extraordinary circumstances pursuant to 42 CFR §412.348(f)? If yes, complete Worksheet L, Part III and L-1, Parts I through III.	N	N	N	46
47	Is this a new hospital under 42 CFR §412.300 PPS capital? Enter 'Y' for yes or 'N' for no.	N	N	N	47
48	Is the facility electing full federal capital payment? Enter 'Y' for yes or 'N' for no.	N	N	N	48
Teaching Hospitals		1	2	3	
56	Is this a hospital involved in training residents in approved GME programs? Enter 'Y' for yes or 'N' for no.	N			56
57	If line 56 is yes, is this the first cost reporting period during which residents in approved GME programs trained at this facility? Enter 'Y' for yes or 'N' for no in column 1. If column 1 is 'Y' did residents start training in the first month of this cost reporting period? Enter 'Y' for yes or 'N' for no in column 2. If column 2 is 'Y', complete Worksheet E-4. If column 2 is 'N', complete Worksheet D, Part III & IV and D-2, Part II, if applicable.	N			57
58	If line 56 is yes, did this facility elect cost reimbursement for physicians' services as defined in CMS Pub 15-1, section 2148? If yes, complete Worksheet D-5.	N			58
59	Are costs claimed on line 100 of Worksheet A? If yes, complete Worksheet D-2, Part I.	N			59
60	Are you claiming nursing school and/or allied health costs for a program that meets the provider-operated criteria under §413.85? Enter 'Y' for yes or 'N' for no. (see instructions)	Y			60
		Y/N	IME	Direct GME	
61	Did your hospital receive FTE slots under ACA section 5503? Enter 'Y' for yes or 'N' for no in column 1.(see instructions)	N			61
61.01	Enter the average number of unweighted primary care FTEs from the hospital's 3 most recent cost reports ending and submitted before March 23, 2010. (see instructions)				61.01
61.02	Enter the current year total unweighted primary care FTE count (excluding OB/GYN, general surgery FTEs, and primary care FTEs added under section 5503 of ACA). (see instructions)				61.02
61.03	Enter the baseline FTE count for primary care and/or general surgery residents, which is used for determining compliance with the 75% test. (see instructions)				61.03
61.04	Enter the number of unweighted primary care/or surgery allopathic and/or osteopathic FTEs in the current cost reporting period. (see instructions)				61.04
61.05	Enter the difference between the baseline primary and/or general surgery FTEs and the current year's primary care and/or general surgery FTE counts (line 61.04 minus line 61.03). (see instructions)				61.05
61.06	Enter the amount of ACA §5503 award that is being used for cap relief and/or FTEs that are nonprimary care or general surgery. (see instructions)				61.06
Of the FTEs in line 61.05, specify each new program specialty, if any, and the number of FTE residents for each new program (see instructions). Enter in column 1 the program name, enter in column 2 the program code, enter in column 3 the IME FTE unweighted count and enter in column 4 direct GME FTE unweighted count.					
		Program Name	Program Code	Unweighted IME FTE Count	Unweighted Direct GME FTE Count
		1	2	3	4
Of the FTEs in line 61.05, specify each expanded program specialty, if any, and the number of FTE residents for each expanded program (see instructions). Enter in column 1 the program name, enter in column 2 the program code, enter in column 3 the IME FTE unweighted count and enter in column 4 direct GME FTE unweighted count.					
ACA Provisions Affecting the Health Resources and Services Administration (HRSA)					
62	Enter the number of FTE residents that your hospital trained in this cost reporting period for which your hospital received HRSA PCRE funding (see instructions)				62
62.01	Enter the number of FTE residents that rotated from a teaching health center (THC) into your hospital in this cost reporting period of HRSA THC program. (see instructions)				62.01
Teaching Hospitals that Claim Residents in Non-Provider Settings					
63	Has your facility trained residents in non-provider settings during this cost reporting period? Enter 'Y' for yes or 'N' for no. If yes, complete lines 64-67. (see instructions)	N			63



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HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA

WORKSHEET S-2
PART I

Section 5504 of the ACA Base Year FTE Residents in Nonprovider settings-This base year is your cost reporting period that begins on or after July 1, 2009 and before June 30, 2010.				Unweighted FTEs Nonprovider Site	Unweighted FTEs in Hospital	RATIO (col. 1/ col. 1 + col. 2))	
64	Enter in column 1, if line 63 is yes, or your facility trained residents in the base year period, the number of unweighted non-primary care resident FTEs attributable to rotations occurring in all non-provider settings. Enter in column 2 the number of unweighted non-primary care resident FTEs that trained in your hospital. Enter in column 3 the ratio of (column 1 divided by (column 1 + column 2)). (see instructions)						64
Enter in lines 65-65.49 in column 1, if line 63 is yes, or your facility trained residents in the base year period, the program name. Enter in column 2 the program code. Enter in column 3 the number of unweighted primary care FTE residents attributable to rotations occurring in all non-provider settings. Enter in column 4 the number of unweighted primary care resident FTEs that trained in your hospital. Enter in column 5 the ratio of (column 3 divided by (column 3 ÷ column 4)). (see instructions)							
	Program Name	Program Code		Unweighted FTEs Nonprovider Site	Unweighted FTEs in Hospital	Ratio (col. 3/ col. 3 + col. 4))	
	1	2		3	4	5	
65							65
Section 5504 of the ACA Current Year FTE Residents in Nonprovider settings-Effective for cost reporting periods beginning on or after July 1, 2010				Unweighted FTEs Nonprovider Site	Unweighted FTEs in Hospital	RATIO (col. 1/ col. 1 + col. 2))	
66	Enter in column 1, the number of unweighted non-primary care resident FTEs attributable to rotations occurring in all non-provider settings. Enter in column 2 the number of unweighted non-primary care resident FTEs that trained in your hospital. Enter in column 3 the ratio of (column 1 + column 2)). (see instructions)						66
Enter in lines 67-67.49, column 1 the program name. Enter in column 2 the program code. Enter in column 3 the number of unweighted primary care FTE residents attributable to rotations occurring in all non-provider settings. Enter in column 4 the number of unweighted primary care resident FTEs that trained in your hospital. Enter in column 5 the ratio of (column 3 divided by (column 3 ÷ column 4)). (see instructions)							
	Program Name	Program Code		Unweighted FTEs Nonprovider Site	Unweighted FTEs in Hospital	Ratio (col. 3/ col. 3 + col. 4))	
	1	2		3	4	5	
67							67
Inpatient Psychiatric Facility PPS				1	2	3	
70	Is this facility an Inpatient Psychiatric Facility (IPF), or does it contain an IPF subprovider? Enter 'Y' for yes or 'N' for no.			Y			70
71	If line 70 yes: Column 1: Did the facility have a teaching program in the most recent cost report filed on or before November 15, 2004? Enter 'Y' for yes or 'N' for no. Column 2: Did this facility train residents in a new teaching program in accordance with 42 CFR §412.424(d)(1)(iii)(D)? Enter 'Y' for yes and 'N' for no. Column 3: If column 2 is Y, enter 1, 2, or 3 respectively in column 3. If this cost reporting period covers the beginning of the fourth year, enter 4 in column 3, or if the 5th or subsequent academic years of the new teaching program in existence, enter 5.			N			71
Inpatient Rehabilitation Facility PPS				1	2	3	
75	Is this facility an Inpatient Rehabilitation Facility (IRF), or does it contain an IRF subprovider? Enter 'Y' for yes or 'N' for no.			Y			75
76	If line 75 yes: Column 1: Did the facility have a teaching program in the most recent cost reporting period ending on or before November 15, 2004? Enter 'Y' for yes or 'N' for no. Column 2: Did this facility train residents in a new teaching program in accordance with 42 CFR §412.424(d)(1)(iii)(D)? Enter 'Y' for yes and 'N' for no. Column 3: If column 2 is Y, enter 1, 2, or 3 respectively in column 3. If this cost reporting period covers the beginning of the fourth year, enter 4 in column 3, or if the 5th or subsequent academic years of the new teaching program in existence, enter 5.			N			76
Long Term Care Hospital PPS							
80	Is this a Long Term Care Hospital (LTCH)? Enter 'Y' for yes or 'N' for no.				N		80
TEFRA Providers							
85	Is this a new hospital under 42 CFR §413.40(f)(1)(i) TEFRA? Enter 'Y' for yes or 'N' for no.				N		85
86	Did this facility establish a new Other subprovider (excluded unit) under 42 CFR §413.40(f)(1)(ii)? Enter 'Y' for yes, or 'N' for no.						86



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WORKSHEET S-2
PART I

		V	XIX	
Title V and XIX Services		1	2	
90	Does this facility have title V and/or XIX inpatient hospital services? Enter 'Y' for yes, or 'N' for no in applicable column.	N	Y	90
91	Is this hospital reimbursed for title V and/or XIX through the cost report either in full or in part? Enter 'Y' for yes, or 'N' for no in the applicable column.	N	N	91
92	Are title XIX NF patients occupying title XVIII SNF beds (dual certification)? Enter 'Y' for yes or 'N' for no in the applicable column.		N	92
93	Does this facility operate an ICF/MR facility for purposes of title V and XIX? Enter 'Y' for yes or 'N' for no in the applicable column.	N	N	93
94	Does title V or title XIX reduce capital cost? Enter 'Y' for yes or 'N' for no in the applicable column.	N	N	94
95	If line 94 is 'Y', enter the reduction percentage in the applicable column.			95
96	Does title V or title XIX reduce operating cost? Enter 'Y' for yes or 'N' for no in the applicable column.	N	N	96
97	If line 96 is 'Y', enter the reduction percentage in the applicable column.			97
Rural Providers		1	2	
105	Does this hospital qualify as a Critical Access Hospital (CAH)?	N		105
106	If this facility qualifies as a CAH, has it elected the all-inclusive method of payment for outpatient services? (see instructions)			106
107	Column 1: If this facility qualifies as a CAH, is it eligible for cost reimbursement for I&R training programs? Enter 'Y' for yes and 'N' for no in column 1. If yes, the GME elimination would not be on Worksheet B, Part I, column 25 and the program would be cost reimbursed. If yes, complete Worksheet D-2, Part II. Column 2: If this facility is a CAH, do I&Rs in an approved medical education program train in the CAH's excluded IPF and/or IRF unit? Enter 'Y' for yes or 'N' for no in column 2.			107
108	Is this a rural hospital qualifying for an exception to the CRNA fee schedule? See 42 CFR §412.113(c). Enter 'Y' for yes or 'N' for no.	N		108
109	If this hospital qualifies as a CAH or a cost provider, are therapy services provided by outside supplier? Enter 'Y' for yes or 'N' for each therapy.	Physical	Occupational Speech Respiratory	109
Miscellaneous Cost Reporting Information				
115	Is this an all-inclusive rate provider? Enter 'Y' for yes or 'N' for no in column 1. If yes, enter the method used (A, B, or E only) in column 2. If column 2 is 'E', enter in column 3 either '93' percent for short term hospital or '98'	N		115
116	Is this facility classified as a referral center? Enter 'Y' for yes or 'N' for no.	N		116
117	Is this facility legally required to carry malpractice insurance? Enter 'Y' for yes or 'N' for no.	Y		117
118	Is the malpractice insurance a claims-made or occurrence policy? Enter 1 if the policy is claim-made. Enter 2 if the policy is occurrence.	1		118
		Premiums	Paid Losses	Self Insurance
118.01	List amounts of malpractice premiums and paid losses:	1	1	1
118.02	Are malpractice premiums and paid losses reported in a cost center other than the Administrative and General cost center? If yes, submit supporting schedule listing cost centers and amounts contained therein.	N		118.02
120	Is this a SCH or EACH that qualifies for the Outpatient Hold Harmless provision in ACA §3121 and applicable amendments? (see instructions). Enter in column 1 'Y' for yes or 'N' for no. Is this a rural hospital with < 100 beds that qualifies for the Outpatient Hold Harmless provision in ACA §3121 and applicable amendments? (see instructions). Enter in column 2 'Y' for yes or 'N' for no.	N	N	120
121	Did this facility incur and report costs for high cost implantable devices charged to patients? Enter 'Y' for yes or 'N' for no.	Y		121
Transplant Center Information				
125	Does this facility operate a transplant center? Enter 'Y' for yes or 'N' for no. If yes, enter certification date(s)(mm/dd/yyyy) below.	N		125
126	If this is a Medicare certified kidney transplant center enter the certification date in column 1 and termination date, if applicable in column 2.			126
127	If this is a Medicare certified heart transplant center enter the certification date in column 1 and termination date, if applicable in column 2.			127
128	If this is a Medicare certified liver transplant center enter the certification date in column 1 and termination date, if applicable in column 2.			128
129	If this is a Medicare certified lung transplant center enter the certification date in column 1 and termination date, if applicable in column 2.			129
130	If this is a Medicare certified pancreas transplant center enter the certification date in column 1 and termination date, if applicable in column 2.			130
131	If this is a Medicare certified intestinal transplant center enter the certification date in column 1 and termination date, if applicable in column 2.			131
132	If this is a Medicare certified islet transplant center enter the certification date in column 1 and termination date, if applicable in column 2.			132
133	If this is a Medicare certified other transplant center enter the certification date in column 1 and termination date, if applicable in column 2.			133
134	If this is an organ procurement organization (OPO), enter the OPO number in column 1 and termination date, if applicable in column 2.			134



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WORKSHEET S-2
PART I

All Providers						
140	Are there any related organization or home office costs as defined in CMS Pub 15-1, Chapter 10? Enter 'Y' for yes, or 'N' for no in column 1. If yes, and home office costs are claimed, enter in column 2 the home office chain number (see instructions)	1	2		140	
		Y				
If this facility is part of a chain organization, enter on lines 141 through 143 the name and address of the home office and enter the home office contractor name and contractor number.						
141	Name:	Contractor's Name:	Contractor's Number:		141	
142	Street:	P.O. Box:			142	
143	City:	State:	ZIP Code:		143	
144	Are provider based physicians' costs included in Worksheet A?	Y			144	
145	If costs for renal services are claimed on Worksheet A, line 74 are they costs for inpatient services only? Enter 'Y' for yes, or 'N' for no.	Y			145	
146	Has the cost allocation methodology changed from the previously filed cost report? Enter 'Y' for yes and 'N' for no in column 1. (see CMS Pub. 15-2, section 4020). If yes, enter the approval date (mm/dd/yyyy) in column 2.	N			146	
147	Was there a change in the statistical basis? Enter 'Y' for yes or 'N' for no.	N			147	
148	Was there a change in the order of allocation? Enter 'Y' for yes or 'N' for no.	N			148	
149	Was there a change to the simplified cost finding method? Enter 'Y' for yes or 'N' for no.	N			149	
Does this facility contain a provider that qualifies for an exemption from the application of the lower of costs or charges? Enter 'Y' for yes or 'N' for no for each component for Part A and Part B. See 42 CFR §413.13)						
		Title XVIII		Title V	Title XIX	
		Part A	Part B	2	3	
155	Hospital	N	N	N	N	
156	Subprovider - IPF	N	N	N	N	
157	Subprovider - IRF	N	N	N	N	
158	Subprovider - Other					
159	SNF	N	N			
160	HHA	N	N	N	N	
161	CMHC		N			
161.10	CORF					
Multicampus						
165	Is this hospital part of a multicampus hospital that has one or more campuses in different CBSAs? Enter 'Y' for yes or 'N' for no.	N			165	
166	If line 165 is yes, for each campus, enter the name in column 0, county in column 1, state in column 2, ZIP in column 3, CBSA in column 4, FTE/campus in column 5.				166	
	Name	County	State	ZIP Code	CBSA	FTE/Campus
	0	1	2	3	4	5
Health Information Technology (HIT) incentive in the American Recovery and Reinvestment Act						
167	Is this provider a meaningful user under §1886(n)? Enter 'Y' for yes or 'N' for no.	Y			167	
168	If this provider is a CAH (line 105 is 'Y') and is a meaningful user (line 167 is 'Y'), enter the reasonable cost incurred for the HIT assets. (see instructions)				168	
169	If this provider is a meaningful user (line 167 is 'Y') and is not a CAH (line 105 is 'N'), enter the transitional factor. (see instructions)	1.00			169	
170	Enter in columns 1 and 2 the EHR beginning date and ending date for the reporting period respectively (mm/dd/yyyy)	10/01/2013	09/30/2014		170	



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HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX REIMBURSEMENT QUESTIONNAIRE

WORKSHEET S-2
PART II

GENERAL INSTRUCTION: ENTER Y FOR ALL YES RESPONSES. ENTER N FOR ALL NO RESPONSES.
ENTER ALL DATES IN THE MM/DD/YYYY FORMAT.

COMPLETED BY ALL HOSPITALS

		Y/N	DATE		
PROVIDER ORGANIZATION AND OPERATION		1	2		
1	HAS THE PROVIDER CHANGED OWNERSHIP IMMEDIATELY PRIOR TO THE BEGINNING OF THE COST REPORTING PERIOD? IF YES, ENTER THE DATE OF THE CHANGE IN COLUMN 2. (see instructions)	N			1
		Y/N	DATE	V/I	
		1	2	3	
2	HAS THE PROVIDER TERMINATED PARTICIPATION IN THE MEDICARE PROGRAM? IF YES, ENTER IN COLUMN 2 THE DATE OF TERMINATION AND IN COLUMN 3, 'V' FOR VOLUNTARY OR 'I' FOR INVOLUNTARY.	N			2
3	IS THE PROVIDER INVOLVED IN BUSINESS TRANSACTIONS, INCLUDING MANAGEMENT CONTRACTS, WITH INDIVIDUALS OR ENTITIES (e.g., chain home offices, drug or medical supply companies) THAT ARE RELATED TO THE PROVIDER OR ITS OFFICERS, MEDICAL STAFF, MANAGEMENT PERSONNEL, OR MEMBERS OF THE BOARD OF DIRECTORS THROUGH OWNERSHIP, CONTROL, OR FAMILY AND OTHER SIMILAR RELATIONSHIPS? (see instructions)	N			3
FINANCIAL DATA AND REPORTS		Y/N	TYPE	DATE	
		1	2	3	
4	COLUMN 1: WERE THE FINANCIAL STATEMENTS PREPARED BY A CERTIFIED PUBLIC ACCOUNTANT? COLUMN 2: IF YES, ENTER 'A' FOR AUDITED, 'C' FOR COMPILED, OR 'R' FOR REVIEWED. SUBMIT COMPLETE COPY OR ENTER DATE AVAILABLE IN COLUMN 3. (see instructions). IF NO, SEE INSTRUCTIONS.	N			4
5	ARE THE COST REPORT TOTAL EXPENSES AND TOTAL REVENUES DIFFERENT FROM THOSE ON THE FILED FINANCIAL STATEMENTS? IF YES, SUBMIT RECONCILIATION.	N			5
APPROVED EDUCATIONAL ACTIVITIES		Y/N	Y/N		
		1	2		
6	COLUMN 1: ARE COSTS CLAIMED FOR NURSING SCHOOL? COLUMN 2: IF YES, IS THE PROVIDER THE LEGAL OPERATOR OF THE PROGRAM?	N			6
7	ARE COSTS CLAIMED FOR ALLIED HEALTH PROGRAMS? IF YES, SEE INSTRUCTIONS.	Y			7
8	WERE NURSING SCHOOL AND/OR ALLIED HEALTH PROGRAMS APPROVED AND/OR RENEWED DURING THE COST REPORTING PERIOD?	Y			8
9	ARE COSTS CLAIMED FOR INTERN-RESIDENT PROGRAMS CLAIMED ON THE CURRENT COST REPORT? IF YES, SEE INSTRUCTIONS.	N			9
10	WAS AN INTERN-RESIDENT PROGRAM INITIATED OR RENEWED IN THE CURRENT COST REPORTING PERIOD? IF YES, SEE INSTRUCTIONS.	N			10
11	ARE GME COSTS DIRECTLY ASSIGNED TO COST CENTERS OTHER THAN I & R IN AN APPROVED TEACHING PROGRAM ON WORKSHEET A? IF YES, SEE INSTRUCTIONS.	N			11
BAD DEBTS				Y/N	
12	IS THE PROVIDER SEEKING REIMBURSEMENT FOR BAD DEBTS? IF YES, SEE INSTRUCTIONS.			Y	12
13	IF LINE 12 IS YES, DID THE PROVIDER'S BAD DEBT COLLECTION POLICY CHANGE DURING THIS COST REPORTING PERIOD? IF YES, SUBMIT COPY.			N	13
14	IF LINE 12 IS YES, WERE PATIENT DEDUCTIBLES AND/OR CO-PAYMENTS WAIVED? IF YES, SEE INSTRUCTIONS.			N	14
BED COMPLEMENT					
15	DID TOTAL BEDS AVAILABLE CHANGE FROM THE PRIOR COST REPORTING PERIOD? IF YES, SEE INSTRUCTIONS.			N	15
		PART A		PART B	
		Y/N	DATE	Y/N	DATE
		1	2	3	4
PS&R REPORT DATA					
16	WAS THE COST REPORT PREPARED USING THE PS&R REPORT ONLY? IF EITHER COLUMN 1 OR 3 IS YES, ENTER THE PAID-THROUGH DATE OF THE PS&R REPORT USED IN COLUMNS 2 AND 4. (see instructions)	N		N	16
17	WAS THE COST REPORT PREPARED USING THE PS&R REPORT FOR TOTALS AND THE PROVIDER'S RECORDS FOR ALLOCATION? IF EITHER COLUMN 1 OR 3 IS YES, ENTER THE PAID-THROUGH DATE IN COLUMNS 2 AND 4. (see instructions)	Y	02/16/2014	Y	02/16/2014
18	IF LINE 16 OR 17 IS YES, WERE ADJUSTMENTS MADE TO PS&R REPORT DATA FOR ADDITIONAL CLAIMS THAT HAVE BEEN BILLED BUT ARE NOT INCLUDED ON THE PS&R REPORT USED TO FILE THE COST REPORT? IF YES, SEE INSTRUCTIONS.	N		N	18
19	IF LINE 16 OR 17 IS YES, WERE ADJUSTMENTS MADE TO PS&R REPORT DATA FOR CORRECTIONS OF OTHER PS&R REPORT INFORMATION? IF YES, SEE INSTRUCTIONS.	N		N	19
20	IF LINE 16 OR 17 IS YES, WERE ADJUSTMENTS MADE TO PS&R REPORT DATA FOR OTHER? DESCRIBE THE OTHER ADJUSTMENTS:	N		N	20
21	WAS THE COST REPORT PREPARED ONLY USING THE PROVIDER'S RECORDS? IF YES, SEE INSTRUCTIONS.	N		N	21



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HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX REIMBURSEMENT QUESTIONNAIRE

WORKSHEET S-2
PART II

GENERAL INSTRUCTION: ENTER Y FOR ALL YES RESPONSES. ENTER N FOR ALL NO RESPONSES.
ENTER ALL DATES IN THE MM/DD/YYYY FORMAT.

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

CAPITAL RELATED COSTS			
22	HAVE ASSETS BEEN RELIEVED FOR MEDICARE PURPOSES? IF YES, SEE INSTRUCTIONS.		22
23	HAVE CHANGES OCCURRED IN THE MEDICARE DEPRECIATION EXPENSE DUE TO APPRAISALS MADE DURING THE COST REPORTING PERIOD? IF YES, SEE INSTRUCTIONS.		23
24	WERE NEW LEASES AND/OR AMENDMENTS TO EXISTING LEASES ENTERED INTO DURING THIS COST REPORTING PERIOD? IF YES, SEE INSTRUCTIONS.		24
25	HAVE THERE BEEN NEW CAPITALIZED LEASES ENTERED INTO DURING THE COST REPORTING PERIOD? IF YES, SEE INSTRUCTIONS.		25
26	WERE ASSETS SUBJECT TO SEC. 2314 OF DEFRA ACQUIRED DURING THE COST REPORTING PERIOD? IF YES, SEE INSTRUCTIONS.		26
27	HAS THE PROVIDER'S CAPITALIZED POLICY CHANGED DURING THE COST REPORTING PERIOD? IF YES, SEE INSTRUCTIONS.		27
INTEREST EXPENSE			
28	WERE NEW LOANS, MORTGAGE AGREEMENTS OR LETTERS OF CREDIT ENTERED INTO DURING THE COST REPORTING PERIOD? IF YES, SEE INSTRUCTIONS.		28
29	DID THE PROVIDER HAVE A FUNDED DEPRECIATION ACCOUNT AND/OR BOND FUNDS (debt service reserve fund) TREATED AS A FUNDED DEPRECIATION ACCOUNT? IF YES, SEE INSTRUCTIONS.		29
30	HAS EXISTING DEBT BEEN REPLACED PRIOR TO ITS SCHEDULED MATURITY WITH NEW DEBT? IF YES, SEE INSTRUCTIONS.		30
31	HAS DEBT BEEN RECALLED BEFORE SCHEDULED MATURITY WITHOUT ISSUANCE OF NEW DEBT? IF YES, SEE INSTRUCTIONS.		31
PURCHASED SERVICES			
32	HAVE CHANGES OR NEW AGREEMENTS OCCURRED IN PATIENT CARE SERVICES FURNISHED THROUGH CONTRACTUAL ARRANGEMENTS WITH SUPPLIERS OF SERVICES? IF YES, SEE INSTRUCTIONS.		32
33	IF LINE 32 IS YES, WERE THE REQUIREMENTS OF SEC. 2135.2 APPLIED PERTAINING TO COMPETITIVE BIDDING? IF NO, SEE INSTRUCTIONS.		33
PROVIDER-BASED PHYSICIANS			
34	ARE SERVICES FURNISHED AT THE PROVIDER FACILITY UNDER AN ARRANGEMENT WITH PROVIDER-BASED PHYSICIANS? IF YES, SEE INSTRUCTIONS.		34
35	IF LINE 34 IS YES, WERE THERE NEW AGREEMENTS OR AMENDED EXISTING AGREEMENTS WITH THE PROVIDER-BASED PHYSICIANS DURING THE COST REPORTING PERIOD? IF YES, SEE INSTRUCTIONS.		35
HOME OFFICE COSTS		Y/N	DATE
36	WERE HOME OFFICE COSTS CLAIMED ON THE COST REPORT?	1	2
37	IF LINE 36 IS YES, HAS A HOME OFFICE COST STATEMENT BEEN PREPARED BY THE HOME OFFICE? IF YES, SEE INSTRUCTIONS.		
38	IF LINE 36 IS YES, WAS THE FISCAL YEAR END OF THE HOME OFFICE DIFFERENT FROM THAT OF THE PROVIDER? IF YES, ENTER IN COLUMN 2 THE FISCAL YEAR END OF THE HOME OFFICE.		
39	IF LINE 36 IS YES, DID THE PROVIDER RENDER SERVICES TO OTHER CHAIN COMPONENTS? IF YES, SEE INSTRUCTIONS.		
40	IF LINE 36 IS YES, DID THE PROVIDER RENDER SERVICES TO THE HOME OFFICE? IF YES, SEE INSTRUCTIONS.		
COST REORT PREPARER INFORMATION			
41	FIRST NAME: DANIEL	LAST NAME: MRUZ	TITLE: REIMBURSEMENT DIRECTOR
42	EMPLOYER: INGALLS MEMORIAL HOSPITAL		
43	PHONE NUMBER: 708-915-6107	E-MAIL ADDRESS: DMRUZ@INGALLS.ORG	



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HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA

WORKSHEET S-3
PART I

	COMPONENT	WKST A LINE NO.	NO. OF BEDS	BED DAYS AVAILABLE	CAH HOURS	INPATIENT DAYS/OUTPATIENT VISITS/TRIPS				
						TITLE V	TITLE XVIII	TITLE XIX	TOTAL ALL PATIENTS	
		1	2	3	4	5	6	7	8	
1	HOSPITAL ADULTS & PEDS. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days) (see instructions for col. 2 for the portion of LDP room available beds)	30	243	88,695			24,107	11,563	55,264	1
2	HMO AND OTHER (see instructions)						2,260	6,689		2
3	HMO IPF SUBPROVIDER						122	533		3
4	HMO IRF SUBPROVIDER						229	213		4
5	HOSPITAL ADULTS & PEDS. SWING BED SNF									5
6	HOSPITAL ADULTS & PEDS. SWING BED NF									6
7	TOTAL ADULTS & PEDS. (exclude observation beds)(see instructions)		243	88,695			24,107	11,563	55,264	7
8	INTENSIVE CARE UNIT	31	25	9,125			2,375	517	4,333	8
9	CORONARY CARE UNIT	32								9
10	BURN INTENSIVE CARE UNIT	33								10
11	SURGICAL INTENSIVE CARE UNIT	34								11
12	OTHER SPECIAL CARE (SPECIFY)	35								12
13	NURSERY	43						2,764	3,782	13
14	TOTAL (see instructions)		268	97,820			26,482	14,844	63,379	14
15	CAH VISITS									15
16	SUBPROVIDER - IPF	40	16	5,840			1,872	388	2,890	16
17	SUBPROVIDER - IRF	41	42	15,330			6,422	279	8,022	17
18	SUBPROVIDER I	42								18
19	SKILLED NURSING FACILITY	44								19
20	NURSING FACILITY	45								20
21	OTHER LONG TERM CARE	46								21
22	HOME HEALTH AGENCY	101					37,892	1,256	47,246	22
23	ASC (Distinct Part)	115								23
24	HOSPICE (Distinct Part)	116								24
24.10	HOSPICE (non-distinct part)	30								24.10
25	CMHC	99								25
26	RHC	88								26
27	TOTAL (sum of lines 14-26)		326							27
28	OBSERVATION BED DAYS								4,676	28
29	AMBULANCE TRIPS									29
30	EMPLOYEE DISCOUNT DAYS (see instructions)									30
31	EMPLOYEE DISCOUNT DAYS-IRF									31
32	LABOR & DELIVERY DAYS (see instructions)							318	415	32
32.01	TOTAL ANCILLARY LABOR & DELIVERY ROOM OUTPATIENT DAYS (see instructions)									32.01
33	LTCH NON-COVERED DAYS									33



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HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA

WORKSHEET S-3
PART I

	COMPONENT	FULL TIME EQUIVALENTS			DISCHARGES				
		TOTAL INTERNS & RESIDENTS	EMPLOYEES ON PAYROLL	NONPAID WORKERS	TITLE V	TITLE XVIII	TITLE XIX	TOTAL ALL PATIENTS	
		9	10	11	12	13	14	15	
1	HOSPITAL ADULTS & PEDS. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days) (see instructions for col. 2 for the portion of LDP room available beds)					5,236	4,023	13,830	1
2	HMO AND OTHER (see instructions)					501			2
3	HMO IPF SUBPROVIDER								3
4	HMO IRF SUBPROVIDER								4
5	HOSPITAL ADULTS & PEDS. SWING BED SNF								5
6	HOSPITAL ADULTS & PEDS. SWING BED NF								6
7	TOTAL ADULTS & PEDS. (exclude observation beds)(see instructions)								7
8	INTENSIVE CARE UNIT								8
9	CORONARY CARE UNIT								9
10	BURN INTENSIVE CARE UNIT								10
11	SURGICAL INTENSIVE CARE UNIT								11
12	OTHER SPECIAL CARE (SPECIFY)								12
13	NURSERY								13
14	TOTAL (see instructions)		1,643.28			5,236	4,023	13,830	14
15	CAH VISITS								15
16	SUBPROVIDER - IPF		12.95			188	64	952	16
17	SUBPROVIDER - IRF		49.88			482	17	611	17
18	SUBPROVIDER I								18
19	SKILLED NURSING FACILITY								19
20	NURSING FACILITY								20
21	OTHER LONG TERM CARE								21
22	HOME HEALTH AGENCY		123.34						22
23	ASC (Distinct Part)								23
24	HOSPICE (Distinct Part)								24
24.10	HOSPICE (non-distinct part)								24.10
25	CMHC								25
26	RHC								26
27	TOTAL (sum of lines 14-26)		1,829.45						27
32.01	TOTAL ANCILLARY LABOR & DELIVERY ROOM OUTPATIENT DAYS (see instructions)								32



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HOSPITAL WAGE INDEX INFORMATION

WORKSHEET S-3
PARTS II-III

PART II - WAGE DATA

	WKST A LINE NO.	AMOUNT REPORTED	RECLASSIF- ICATION OF SALARIES (from Worksheet A-6)	ADJUSTED SALARIES (column 2 ± column 3)	PAID HOURS RELATED TO SALARIES IN COLUMN 4	AVERAGE HOURLY WAGE (column 4 ± column 5)	
	1	2	3	4	5	6	
SALARIES							
1	200	107,350,928	-9,077,311	98,273,617	3,443,740.00	28.54	1
2							2
3							3
4							4
4.01							4.01
5							5
6							6
7	21						7
7.01							7.01
8							8
9	44						9
10		12,542,936	-8,338,618	4,204,318	150,489.00	27.94	10
OTHER WAGES & RELATED COSTS							
11		4,087,928		4,087,928	139,796.00	29.24	11
12							12
13		1,873,947		1,873,947	11,980.00	156.42	13
14		5,587,214		5,587,214	47,549.00	117.50	14
15							15
16							16
WAGE-RELATED COSTS							
17		20,141,891		20,141,891			17
18							18
19		820,926		820,926			19
20							20
21							21
22							22
22.01							22.01
23							23
24							24
25							25
OVERHEAD COSTS - DIRECT SALARIES							
26		876,504	177,909	1,054,413	26,792.00	39.36	26
27		13,053,969	-177,909	12,876,060	491,536.00	26.20	27
28							28
29							29
30		819,593		819,593	44,217.00	18.54	30
31		88,528		88,528	6,131.00	14.44	31
32		915		915	42.00	21.79	32
33		3,193,262		3,193,262	211,148.00	15.12	33
34							34
35		2,919,862		2,919,862	129,804.00	22.49	35
36							36
37							37
38		2,915,308		2,915,308	104,303.00	27.95	38
39		255,824		255,824	16,278.00	15.72	39
40		3,646,483	-140,763	3,505,720	92,286.00	37.99	40
41		2,571,712		2,571,712	99,761.00	25.78	41
42							42
43							43

PART III - HOSPITAL WAGE INDEX SUMMARY

1	NET SALARIES (see instructions)	113,464,052	-9,077,311	104,386,741	3,784,692.00	27.58	1
2	EXCLUDED AREA SALARIES (see instructions)	12,542,936	-8,338,618	4,204,318	150,489.00	27.94	2
3	SUBTOTAL SALARIES (line 1 minus line 2)	100,921,116	-738,693	100,182,423	3,634,203.00	27.57	3
4	SUBTOTAL OTHER WAGES & RELATED COSTS (see instructions)	11,549,089		11,549,089	199,325.00	57.94	4
5	SUBTOTAL WAGE-RELATED COSTS (see instructions)	20,141,891		20,141,891		20.11%	5
6	TOTAL (sum of lines 3 through 5)	132,612,096	-738,693	131,873,403	3,833,528.00	34.40	6
7	TOTAL OVERHEAD COST (see instructions)	30,341,960	-140,763	30,201,197	1,222,298.00	24.71	7



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HOSPITAL WAGE RELATED COSTS

WORKSHEET S-3
PART IV

PART IV - WAGE RELATED COST

PART A - CORE LIST

		AMOUNT REPORTED	
	RETIREMENT COST		
1	401K EMPLOYER CONTRIBUTIONS	3,028,336	1
2	TAX SHELTERED ANNUITY (TSA) EMPLOYER CONTRIBUTION		2
3	NONQUALIFIED DEFINED BENEFIT PLAN COST (see instructions)		3
4	QUALIFIED DEFINED BENEFIT PLAN COST (see instructions)		4
	PLAN ADMINISTRATIVE COSTS (Paid to External Organization):		
5	401k/TSA PLAN ADMINISTRATION FEES		5
6	LEGAL/ACCOUNTING/MANAGEMENT FEES-PENSION PLAN		6
7	EMPLOYEE MANAGED CARE PROGRAM ADMINISTRATION FEES		7
	HEALTH AND INSURANCE COST		
8	HEALTH INSURANCE (Purchased or Self Funded)	9,375,966	8
9	PRESCRIPTION DRUG PLAN		9
10	DENTAL, HEARING AND VISION PLAN	321,605	10
11	LIFE INSURANCE (If employee is owner or beneficiary)	127,877	11
12	ACCIDENTAL INSURANCE (If employee is owner or beneficiary)		12
13	DISABILITY INSURANCE (If employee is owner or beneficiary)	258,727	13
14	LONG-TERM CARE INSURANCE (If employee is owner or beneficiary)		14
15	WORKERS' COMPENSATION INSURANCE	721,988	15
16	RETIREMENT HEALTH CARE COST (Only current year, not the extraordinary accrual required by FASB 106. Non cumulative portion)		16
	TAXES		
17	FICA-EMPLOYERS PORTION ONLY	7,526,643	17
18	MEDICARE TAXES - EMPLOYERS PORTION ONLY		18
19	UNEMPLOYMENT INSURANCE	322,759	19
20	STATE OR FEDERAL UNEMPLOYMENT TAXES		20
	OTHER		
21	EXECUTIVE DEFERRED COMPENSATION (Other Than Retirement Cost Reported on lines 1 through 4 above)(see instructions)		21
22	DAY CARE COSTS AND ALLOWANCES		22
23	TUITION REIMBURSEMENT	486,780	23
24	TOTAL WAGE RELATED COST (Sum of lines 1-23)	22,170,681	24

PART B - OTHER THAN CORE RELATED COST

25	OTHER WAGE RELATED (OTHER WAGE REL		25
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WAGE INDEX PENSION COST SCHEDULE (For Worksheet S-3, Part IV, Line 4)

EXHIBIT 3

STEP 2: DETERMINE THE 3-YEAR AVERAGING PERIOD			
1	WAGE INDEX FISCAL YEAR ENDING DATE		1
2	PROVIDER'S COST REPORTING PERIOD USED FOR WAGE INDEX YEAR ON LINE 1 (FYB in Col. 1, FYE in Col. 2)		2
3	MIDPOINT OF PROVIDER'S COST REPORTING PERIOD SHOWN ON LINE 2, ADJUSTED TO FIRST OF MONTH		3
4	DATE BEGINNING THE 3-YEAR AVERAGING PERIOD (subtract 18 months from midpoint shown on Line 3)		4
5	DATE ENDING THE 3-YEAR AVERAGING PERIOD (add 18 months to midpoint shown on Line 3)		5
STEP 2 (OPTIONAL): ADJUST AVERAGING PERIOD FOR A NEW PLAN (see instructions)			
6	EFFECTIVE DATE OF PENSION PLAN		6
7	FIRST DAY OF THE PROVIDER COST REPORTING PERIOD CONTAINING THE PENSION PLAN EFFECTIVE DATE		7
8	STARTING DATE OF THE ADJUSTED AVERAGING PERIOD (date on Line 7, adjusted to first of month)		8

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

STEP 3: AVERAGE PENSION CONTRIBUTIONS DURING THE AVERAGING PERIOD			
9	BEGINNING DATE OF AVERAGING PERIOD FROM LINE 4 OR LINE 8, AS APPLICABLE		9
10	ENDING DATE OF AVERAGING PERIOD FROM LINE 5		10
11	ENTER PROVIDER CONTRIBUTIONS MADE DURING AVERAGING PERIOD ON LINES 9 & 10	DEPOSIT DATE(S)	CONTRIBUTION(S)
12	TOTAL CALENDAR MONTHS INCLUDED IN AVERAGING PERIOD (36 unless Step 2 completed)		12
13	TOTAL CONTRIBUTIONS MADE DURING AVERAGING PERIOD		13
14	AVERAGE MONTHLY CONTRIBUTION (Line 13 divided by Line 12)		14
15	NUMBER OF MONTHS IN PROVIDER COST REPORTING PERIOD ON LINE 2		15
16	AVERAGE PENSION CONTRIBUTIONS (Line 14 times Line 15)		16
STEP 4: TOTAL PENSION COST FOR WAGE INDEX			
17	ANNUAL PREFUNDING INSTALLMENT (see instructions)		17
18	REPORTABLE PREFUNDING INSTALLMENT ((Line 17 times Line 15) divided by 12)		18
19	TOTAL PENSION COST FOR WAGE INDEX (Line 16 plus Line 18 - transfers to S-3 Part IV Line 4)		19



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HOSPITAL CONTRACT LABOR AND BENEFIT COST

WORKSHEET S-3
PART V

PART V - CONTRACT LABOR AND BENEFIT COST

HOSPITAL AND HOSPITAL-BASED COMPONENT IDENTIFICATION:

	COMPONENT	CONTRACT LABOR	BENEFIT COST	
	0	1	2	
1	TOTAL FACILITY CONTRACT LABOR AND BENEFIT COST			1
2	HOSPITAL			2
3	SUBPROVIDER - IPF			3
4	SUBPROVIDER - IRF			4
5	SUBPROVIDER - (OTHER)			5
6	SWING BEDS - SNF			6
7	SWING BEDS - NF			7
8	HOSPITAL-BASED SNF			8
9	HOSPITAL-BASED NF			9
10	HOSPITAL-BASED OLTC			10
11	HOSPITAL-BASED HHA			11
12	SEPARATELY CERTIFIED ASC			12
13	HOSPITAL-BASED HOSPICE			13
14	HOSPITAL-BASED HEALTH CLINIC - RHC			14
15	HOSPITAL-BASED HEALTH CLINIC - FQHC			15
16	HOSPITAL-BASED (CMHC)			16
17	RENAL DIALYSIS			17
18	OTHER			18



COMPU-MAX

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HOSPITAL-BASED HOME HEALTH AGENCY STATISTICAL DATA

HHA CCN: 14-7435

WORKSHEET S-4

HOME HEALTH AGENCY STATISTICAL DATA

COUNTY: COOK COUNTY

	DESCRIPTION	TITLE V 1	TITLE XVIII 2	TITLE XIX 3	OTHER 4	TOTAL 5	
1	HOME HEALTH AIDE HOURS		2,421	8	13	2,442	1
2	UNDUPLICATED CENSUS COUNT (see instructions)		1,095.00	159.00	579.00	1,883.00	2

HOME HEALTH AGENCY - NUMBER OF EMPLOYEES

	ENTER THE NUMBER OF HOURS IN YOUR NORMAL WORK WEEK 40.00	NUMBER OF EMPLOYEES (Full Time Equivalent)			
		STAFF 1	CONTRACT 2	TOTAL 3	
3	ADMINISTRATOR AND ASSISTANT ADMINISTRATOR(S)	1.00		1.00	3
4	DIRECTOR(S) AND ASSISTANT DIRECTOR(S)	1.00		1.00	4
5	OTHER ADMINISTRATIVE PERSONNEL	27.72		27.72	5
6	DIRECT NURSING SERVICE	26.40		26.40	6
7	NURSING SUPERVISOR	5.00		5.00	7
8	PHYSICAL THERAPY SERVICE	5.77		5.77	8
9	PHYSICAL THERAPY SUPERVISOR				9
10	OCCUPATIONAL THERAPY SERVICE	1.36		1.36	10
11	OCCUPATIONAL THERAPY SUPERVISOR				11
12	SPEECH PATHOLOGY SERVICE	0.17		0.17	12
13	SPEECH PATHOLOGY SUPERVISOR				13
14	MEDICAL SOCIAL SERVICE	1.00		1.00	14
15	MEDICAL SOCIAL SERVICE SUPERVISOR				15
16	HOME HEALTH AIDE	2.30		2.30	16
17	HOME HEALTH AIDE SUPERVISOR				17
18	OTHER (SPECIFY)	51.96		51.96	18

HOME HEALTH AGENCY - CBSA CODES

19	ENTER IN COLUMN 1 THE NUMBER OF CBSAs WHERE YOU PROVIDED SERVICES DURING THE COST REPORTING PERIOD.	1	19
20	LIST THOSE CBSA CODE(S) IN COLUMN 1 SERVICED DURING THIS COST REPORTING PERIOD (line 20 contains the first code).	16974	20

PPS ACTIVITY

	FULL EPISODES	WITHOUT OUTLIERS 1	WITH OUTLIERS 2	LUPA EPISODES 3	PEP ONLY EPISODES 4	TOTAL (columns 1 through 4) 5	
22	SKILLED NURSING VISIT CHARGES	3,645,450	114,570	109,012	32,490	3,901,522	22
23	PHYSICAL THERAPY VISITS	8,939	48	67	113	9,167	23
24	PHYSICAL THERAPY VISIT CHARGES	1,682,831	8,930	11,590	21,090	1,724,441	24
25	OCCUPATIONAL THERAPY VISITS	2,366	17	11	24	2,418	25
26	OCCUPATIONAL THERAPY VISIT CHARGES	447,450	3,230	2,090	4,560	457,330	26
27	SPEECH PATHOLOGY VISITS	357			11	368	27
28	SPEECH PATHOLOGY VISIT CHARGES	67,640			1,710	69,350	28
29	MEDICAL SOCIAL SERVICE VISITS	445	3	12	11	471	29
30	MEDICAL SOCIAL SERVICE VISIT CHARGES	99,450	675	270	2,475	102,870	30
31	HOME HEALTH AIDE VISITS	2,583	67		10	2,660	31
32	HOME HEALTH AIDE VISIT CHARGES	328,511	8,580		1,300	338,391	32
33	TOTAL VISITS (sum of lines 21, 23, 25, 27, 29, and 31)	35,838	753	908	373	37,872	33
34	OTHER CHARGES						34
35	TOTAL CHARGES (sum of lines 22, 24, 26, 28, 30, 32 and 34)	6,271,332	135,985	122,962	63,625	6,593,904	35
36	TOTAL NUMBER OF EPISODES (standard/non-outlier)	2,083		248	36	2,367	36
37	TOTAL NUMBER OF OUTLIER EPISODES		17			17	37
38	TOTAL NON-ROUTINE MEDICAL SUPPLY CHARGES	363,999	20,291	13,144	1,965	399,399	38



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HOSPICE IDENTIFICATION DATA

HOSPICE CCN: 14-1535

WORKSHEET S-9
PARTS I & II

PART I - ENROLLMENT DAYS

		UNDUPLICATED DAYS					TOTAL (sum of cols. 1, 2, & 5)	
		TITLE XVIII	TITLE XIX	TITLE XVIII SKILLED NURSING FACILITY	TITLE XIX NURSING FACILITY	ALL OTHER		
		1	2	3	4	5		
1	CONTINUOUS HOME CARE							1
2	ROUTINE HOME CARE	10,471	403	428	166	387	11,261	2
3	INPATIENT RESPITE CARE	105	29		10	5	139	3
4	GENERAL INPATIENT CARE	1,373	141		3	82	1,596	4
5	TOTAL HOSPICE DAYS	11,949	573	428	179	474	12,996	5

PART II - CENSUS DATA

		TITLE XVIII	TITLE XIX	TITLE XVIII SKILLED NURSING FACILITY	TITLE XIX NURSING FACILITY	ALL OTHER	TOTAL (sum of cols. 1, 2, & 5)	
		1	2	3	4	5	6	
		6	NUMBER OF PATIENTS RECEIVING HOSPICE CARE	369	30	3	2	
7	TOTAL NUMBER OF UNDUPLICATED CONTINUOUS C							7
8	AVERAGE LENGTH OF STAY (line 5/line 6)	32.38	19.10	142.67	89.50	15.80	30.29	8
9	UNDUPLICATED CENSUS COUNT	352	30	3	2	29	411	9

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



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HOSPITAL UNCOMPENSATED AND INDIGENT CARE DATA

WORKSHEET S-10

UNCOMPENSATED AND INDIGENT CARE COST COMPUTATION

1	COST TO CHARGE RATIO (Worksheet C, Part I, line 202, column 3 divided by line 202, column 8)		0.236596	1
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MEDICAID (see instructions for each line)

2	NET REVENUE FROM MEDICAID		32,669,378	2
3	DID YOU RECEIVE DSH OR SUPPLEMENTAL PAYMENTS FROM MEDICAID?		Y	3
4	IF LINE 3 IS YES, DOES LINE 2 INCLUDE ALL DSH OR SUPPLEMENTAL PAYMENTS FROM MEDICAID?		N	4
5	IF LINE 4 IS NO, ENTER DSH OR SUPPLEMENTAL PAYMENTS FROM MEDICAID		18,286,168	5
6	MEDICAID CHARGES		143,088,756	6
7	MEDICAID COST (line 1 times line 6)		33,854,227	7
8	DIFFERENCE BETWEEN NET REVENUE AND COSTS FOR MEDICAID PROGRAM (line 7 minus the sum of lines 2 and 5) IF LINE 7 IS LESS THAN THE SUM OF LINES 2 AND 5, THEN ENTER ZERO.			8

STATE CHILDREN'S HEALTH INSURANCE PROGRAM (SCHIP)(see instructions for each line)

9	NET REVENUE FROM STAND-ALONE SCHIP		300,648	9
10	STAND-ALONE SCHIP CHARGES		1,353,296	10
11	STAND-ALONE SCHIP COST (line 1 times line 10)		320,184	11
12	DIFFERENCE BETWEEN NET REVENUE AND COSTS FOR STAND-ALONE SCHIP (line 11 minus line 9) IF LINE 11 IS LESS THAN LINE 9, THEN ENTER ZERO.		19,536	12

OTHER STATE OR LOCAL GOVERNMENT INDIGENT CARE PROGRAM (see instructions for each line)

13	NET REVENUE FROM STATE OR LOCAL INDIGENT CARE PROGRAM (not included on lines 2, 5, or 9)			13
14	CHARGES FOR PATIENTS COVERED UNDER STATE OR LOCAL INDIGENT CARE PROGRAM (not included in lines 6 or 10)			14
15	STATE OR LOCAL INDIGENT CARE PROGRAM COST (line 1 times line 14)			15
16	DIFFERENCE BETWEEN NET REVENUE AND COSTS FOR STATE OR LOCAL INDIGENT CARE PROGRAM (line 15 minus line 13) IF LINE 15 IS LESS THAN LINE 13, THEN ENTER ZERO.			16

UNCOMPENSATED AND INDIGENT CARE COST COMPUTATION

17	PRIVATE GRANTS, DONATIONS, OR ENDOWMENT INCOME RESTRICTED TO FUNDING CHARITY CARE			17
18	GOVERNMENT GRANTS, APPROPRIATIONS OF TRANSFERS FOR SUPPORT OF HOSPITAL OPERATIONS			18
19	TOTAL UNREIMBURSED COST FOR MEDICAID, SCHIP AND STATE AND LOCAL INDIGENT CARE PROGRAMS (sum of lines 8, 12 and 16)		19,536	19
		UNINSURED PATIENTS	INSURED PATIENTS	TOTAL (col. 1 + col. 2)
		1	2	3
20	TOTAL INITIAL OBLIGATION OF PATIENTS APPROVED FOR CHARITY CARE (at full charges excluding non-reimbursable cost centers) FOR THE ENTIRE FACILITY	33,014,053	2,072,753	35,086,806
21	COST OF INITIAL OBLIGATION OF PATIENTS APPROVED FOR CHARITY CARE (line 1 times line 20)	7,810,993	490,405	8,301,398
22	PARTIAL PAYMENT BY PATIENTS APPROVED FOR CHARITY CARE		347,471	347,471
23	COST OF CHARITY CARE (line 21 minus line 22)	7,810,993	142,934	7,953,927

24	DOES THE AMOUNT IN LINE 20, COLUMN 2 INCLUDE CHARGES FOR PATIENT DAYS BEYOND A LENGTH OF STAY LIMIT IMPOSED ON PATIENTS COVERED BY MEDICAID OR OTHER INDIGENT CARE PROGRAM?		N	24
25	IF LINE 24 IS YES, ENTER CHARGES FOR PATIENT DAYS BEYOND AN INDIGENT CARE PROGRAM'S LENGTH OF STAY LIMIT (see instructions)			25
26	TOTAL BAD DEBT EXPENSE FOR THE ENTIRE HOSPITAL COMPLEX (see instructions)		22,329,236	26
27	MEDICARE BAD DEBTS FOR THE ENTIRE HOSPITAL COMPLEX (see instructions)		1,226,394	27
28	NON-MEDICARE AND NON-REIMBURSABLE MEDICARE BAD DEBT EXPENSE (line 26 minus line 27)		21,102,842	28
29	COST OF NON-MEDICARE AND NON-REIMBURSABLE MEDICARE BAD DEBT EXPENSE (line 1 times line 28)		4,992,848	29
30	COST OF UNCOMPENSATED CARE (line 23, column 3 plus line 29)		12,946,775	30
31	TOTAL UNREIMBURSED AND UNCOMPENSATED CARE COST (line 19 plus line 30)		12,966,311	31



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RECLASSIFICATION AND ADJUSTMENT OF TRIAL BALANCE OF EXPENSES

WORKSHEET A

		COST CENTER DESCRIPTIONS	SALARIES	OTHER	TOTAL (col. 1 + col. 2)	RECLASSI- FICATIONS	RECLASSI- FIED TRIAL BALANCE (col. 3 ± col. 4)	ADJUST- MENTS	NET EXPENSES FOR ALLOC- ATION (col. 5 ± col. 6)	
			1	2	3	4	5	6	7	
		GENERAL SERVICE COST CENTERS								
1	00100	CAP REL COSTS-BLDG & FIXT		6,569,328	6,569,328	257,604	6,826,932	-288,628	6,538,304	1
2	00200	CAP REL COSTS-MVBLE EQUIP		8,572,261	8,572,261		8,572,261		8,572,261	2
3	00300	OTHER CAP REL COSTS							-0-	3
4	00400	EMPLOYEE BENEFITS DEPARTMENT	876,504	20,608,435	21,484,939	934,045	22,418,984	-21,768	22,397,216	4
5	00500	ADMINISTRATIVE & GENERAL	13,053,969	54,899,987	67,953,956	-1,191,649	66,762,307	-4,568,031	62,194,276	5
6	00600	MAINTENANCE & REPAIRS		3,730,347	3,730,347		3,730,347		3,730,347	6
7	00700	OPERATION OF PLANT	819,593	6,629,468	7,449,061	-340,350	7,108,711		7,108,711	7
8	00800	LAUNDRY & LINEN SERVICE	88,528	1,029,962	1,118,490		1,118,490		1,118,490	8
9	00900	HOUSEKEEPING	915	4,326,550	4,327,465	-255,739	4,071,726	-124,648	3,947,078	9
10	01000	DIETARY		3,972,993	3,972,993	-1,722,989	2,250,004		2,250,004	10
11	01100	CAFETERIA		237	237	1,601,894	1,602,131		1,602,131	11
12	01200	MAINTENANCE OF PERSONNEL								12
13	01300	NURSING ADMINISTRATION	2,915,308	252,549	3,167,857		3,167,857	-15,519	3,152,338	13
14	01400	CENTRAL SERVICES & SUPPLY	255,824	702,209	958,033	-589,629	368,404	-17,125	351,279	14
15	01500	PHARMACY	3,646,483	13,353,507	16,999,990	-13,263,788	3,736,202		3,736,202	15
16	01600	MEDICAL RECORDS & LIBRARY	2,571,712	1,646,704	4,218,416		4,218,416	-95,464	4,122,952	16
17	01700	SOCIAL SERVICE								17
19	01900	NONPHYSICIAN ANESTHETISTS								19
20	02000	NURSING SCHOOL								20
21	02100	I&R SERVICES-SALARY & FRINGES APPRVD								21
22	02200	I&R SERVICES-OTHER PRGM COSTS APPRVD								22
23	02300	PARAMED ED PRGM-(SPECIFY)				179,499	179,499		179,499	23
23.01	02301	PARAMED ED PRGM - EMS	149,368	33,645	183,013	597,930	780,943	-259,315	521,628	23.01
23.02	02302	PARAMED ED PRGM - DIETETICS	17,113	5,881	22,994	121,095	144,089	-91,128	52,961	23.02
		INPATIENT ROUTINE SERV COST CENTERS								
30	03000	ADULTS & PEDIATRICS	19,532,166	6,970,387	26,502,553	-3,358,202	23,144,351	-862,672	22,281,679	30
31	03100	INTENSIVE CARE UNIT	3,020,500	504,679	3,525,179	-41,508	3,483,671		3,483,671	31
40	04000	SUBPROVIDER - IPF	713,689	713,164	1,426,853		1,426,853		1,426,853	40
41	04100	SUBPROVIDER - IRF	2,564,621	247,800	2,812,421		2,812,421	-23,533	2,788,888	41
43	04300	NURSERY	1,293,642	527,781	1,821,423		1,821,423		1,821,423	43
		ANCILLARY SERVICE COST CENTERS								
50	05000	OPERATING ROOM	3,929,223	13,894,948	17,824,171	-7,165,236	10,658,935	-301,604	10,357,331	50
51	05100	RECOVERY ROOM	711,285	136,347	847,632		847,632		847,632	51
53	05300	ANESTHESIOLOGY	500,690	875,612	1,376,302		1,376,302	-618,050	758,252	53
54	05400	RADIOLOGY-DIAGNOSTIC	2,666,469	2,502,293	5,168,762		5,168,762	-1,099,353	4,069,409	54
54.01	03630	ULTRASOUND	1,006,386	87,001	1,093,387		1,093,387		1,093,387	54.01
54.02	05401	SPECIAL PROCEDURES	1,131,734	2,197,822	3,329,556	-2,123,977	1,205,579		1,205,579	54.02
56	05600	RADIOISOTOPE	443,713	774,687	1,218,400		1,218,400		1,218,400	56
57	05700	CT SCAN	683,994	377,651	1,061,645		1,061,645		1,061,645	57
58	05800	MRI	505,621	169,819	675,440		675,440		675,440	58
59	05900	CARDIAC CATHETERIZATION	701,015	3,265,456	3,966,471	-1,956,881	2,009,590	-29,102	1,980,488	59
60	06000	LABORATORY	5,725,508	4,907,153	10,632,661	-33,094	10,599,567	-418,512	10,181,055	60
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS								62.30
63	06300	BLOOD STORING, PROCESSING & TRANS.	324,493	953,061	1,277,554	33,094	1,310,648		1,310,648	63
65	06500	RESPIRATORY THERAPY	1,585,871	438,376	2,024,247	-10,593	2,013,654	-25,200	1,988,454	65
65.01	03560	PULMONARY FUNCTION	68,254	11,126	79,380		79,380		79,380	65.01
66	06600	PHYSICAL THERAPY	4,111,799	199,112	4,310,911		4,310,911	-2,281,599	2,029,312	66
67	06700	OCCUPATIONAL THERAPY	1,301,217	142,621	1,443,838		1,443,838		1,443,838	67
68	06800	SPEECH PATHOLOGY	412,861	12,233	425,094		425,094	-4,925	420,169	68
69	06900	ELECTROCARDIOLOGY	713,027	923,170	1,636,197		1,636,197	-394,861	1,241,336	69
70	07000	ELECTROENCEPHALOGRAPHY	93,081	86,656	179,737		179,737	-82,056	97,681	70
70.01	03280	SLEEP LAB	128,638	5,148	133,786		133,786		133,786	70.01
70.02	03550	PSYCH				1,676,314	1,676,314		1,676,314	70.02
71	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS				589,629	589,629		589,629	71
72	07200	IMPL. DEV. CHARGED TO PATIENTS				11,618,667	11,618,667		11,618,667	72
73	07300	DRUGS CHARGED TO PATIENTS				13,011,255	13,011,255		13,011,255	73
73.01	03190	INFUSION THERAPY	458,678	117,224	575,902		575,902	-40,291	535,611	73.01
73.02	03191	IFCC INFUSION THERAPY	559,151	128,729	687,880		687,880	-22,316	665,564	73.02
73.03	07301	PHARMACY VACCINE				73,034	73,034		73,034	73.03
74	07400	RENAL DIALYSIS	552,844	98,267	651,111		651,111	-6,000	645,111	74
76.97	07697	CARDIAC REHABILITATION	428,788	181,970	610,758		610,758	-201,615	409,143	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	857,637	389,702	1,247,339		1,247,339		1,247,339	76.98
76.99	07699	LITHOTRIPSY								76.99
		OUTPATIENT SERVICE COST CENTERS								
90.02	09001	PSYCH ANCILLARY		679,611	679,611	1,229,944	1,909,555		1,909,555	90.02
90.03	09002	RETINAL VASCULAR	212,178	124,502	336,680		336,680	-25,605	311,075	90.03
91	09100	EMERGENCY	3,922,956	1,782,222	5,705,178	-466,458	5,238,720	-530,640	4,708,080	91
91.01	09101	IFCC	12,995,737	9,994,320	22,990,057	-855,344	22,134,713	-4,758,224	17,376,489	91.01
92	09200	OBSERVATION BEDS (NON-DISTINCT PART)								92
		OTHER REIMBURSABLE COST CENTERS								
100	10000	I&R SERVICES-NOT APPRVD PRGM		862,953	862,953		862,953		862,953	100
101	10100	HOME HEALTH AGENCY	7,579,490	2,951,616	10,531,106		10,531,106	-49,419	10,481,687	101



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RECLASSIFICATION AND ADJUSTMENT OF TRIAL BALANCE OF EXPENSES

WORKSHEET A

COST CENTER DESCRIPTIONS		SALARIES	OTHER	TOTAL (col. 1 + col. 2)	RECLASSI- FICATIONS	RECLASSI- FIED TRIAL BALANCE (col. 3 ± col. 4)	ADJUST- MENTS	NET EXPENSES FOR ALLOC- ATION (col. 5 ± col. 6)	
		1	2	3	4	5	6	7	
SPECIAL PURPOSE COST CENTERS									
116	11600	HOSPICE	1,497,821	974,900	2,472,721	2,472,721		2,472,721	116
118		SUBTOTALS (sum of lines 1-117)	107,330,094	185,544,182	292,874,276	-1,606,702	291,267,574	-17,257,203	274,010,371
NONREIMBURSABLE COST CENTERS									
192	19200	PHYSICIANS' PRIVATE OFFICES	20,834	109,553	130,387	1,606,702	1,737,089	1,737,089	192
192.01	19201	REFERENCE LAB							192.01
192.02	19202	OP PHARMACY							192.02
192.03	19203	RETINAL VASCULAR GRANTS							192.03
192.04	19204	AMBULANCE		2,311,491	2,311,491	2,311,491		2,311,491	192.04
200		TOTAL (sum of lines 118-199)	107,350,928	187,965,226	295,316,154	295,316,154	-17,257,203	278,058,951	200



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RECLASSIFICATIONS

WORKSHEET A-6

		INCREASES					
	EXPLANATION OF RECLASSIFICATION(S)	CODE (1)	COST CENTER	LINE #	SALARY	OTHER	
		1	2	3	4	5	
1	RECLASS NON CAP INSURANCE	A	CAP REL COSTS-BLDG & FIXT	1		257,604	1
2			EMPLOYEE BENEFITS DEPARTMENT	4		756,136	2
500	TOTAL RECLASSIFICATIONS					1,013,740	500
	CODE LETTER - A						
1	RECALLS CAFETERIA COSTS	B	CAFETERIA	11		1,601,894	1
2			PARAMED ED PRGM - DIETETICS	23.02		121,095	2
500	TOTAL RECLASSIFICATIONS					1,722,989	500
	CODE LETTER - B						
1	RECLASS VACATION ACCRUAL	C	EMPLOYEE BENEFITS DEPARTMENT	4	177,909		1
500	TOTAL RECLASSIFICATIONS				177,909		500
	CODE LETTER - C						
1	RECLASS CHARGEABLE MEDICAL SUPPLIES	D	MEDICAL SUPPLIES CHARGED TO P	71		589,629	1
2	RECLASS IMPLANT EXPENSE	D	IMPL. DEV. CHARGED TO PATIENT	72		11,618,667	2
3							3
4							4
500	TOTAL RECLASSIFICATIONS					12,208,296	500
	CODE LETTER - D						
1	RECLASS DRUGS CHARGED TO PATIENTS	E	DRUGS CHARGED TO PATIENTS	73		13,084,289	1
500	TOTAL RECLASSIFICATIONS					13,084,289	500
	CODE LETTER - E						
1	POB COST OFFSET	F	PHYSICIANS' PRIVATE OFFICES	192		751,358	1
2							2
3							3
4							4
500	TOTAL RECLASSIFICATIONS					751,358	500
	CODE LETTER - F						
1	LAB ADMIN	G	BLOOD STORING, PROCESSING & T	63	17,241	15,853	1
500	TOTAL RECLASSIFICATIONS				17,241	15,853	500
	CODE LETTER - G						
1	RECLASS RECOVERY COSTS	H	OPERATING ROOM	50	364,217	38,318	1
500	TOTAL RECLASSIFICATIONS				364,217	38,318	500
	CODE LETTER - H						
1	RECLASS EMT PRECEPTOR COSTS	I	PARAMED ED PRGM - EMS	23.01	597,930		1
2							2
3							3
4							4
5							5
6							6
500	TOTAL RECLASSIFICATIONS				597,930		500
	CODE LETTER - I						
1	RECLASS PSYCH ANCILLARY SERVICES	J	PSYCH ANCILLARY	90.02		1,229,944	1
2	RECLASS PSYCH IP ANCILLARY SERVICES	J	PSYCH	70.02	808,785	867,529	2
500	TOTAL RECLASSIFICATIONS				808,785	2,097,473	500
	CODE LETTER - J						
1	RECLASS VACCINE DRUG COSTS	K	PHARMACY VACCINE	73.03		73,034	1
500	TOTAL RECLASSIFICATIONS					73,034	500
	CODE LETTER - K						
1	HOME HEALTH SALARIES	L	HOME HEALTH AGENCY	101		7,579,490	1
2			HOSPICE	116		1,497,821	2
500	TOTAL RECLASSIFICATIONS					9,077,311	500
	CODE LETTER - L						
1	RECLASS FCC ADMIN COSTS	M	PHYSICIANS' PRIVATE OFFICES	192		855,344	1
500	TOTAL RECLASSIFICATIONS					855,344	500
	CODE LETTER - M						
1	PHARMACY RESIDENCY	N	PARAMED ED PRGM-(SPECIFY)	23	140,763	38,736	1
500	TOTAL RECLASSIFICATIONS				140,763	38,736	500
	CODE LETTER - N						
	GRAND TOTAL (INCREASES)				2,106,845	40,976,741	

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



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RECLASSIFICATIONS

WORKSHEET A-6

	EXPLANATION OF RECLASSIFICATION(S)	CODE (1)	INCREASES				
			COST CENTER	LINE #	SALARY	OTHER	
		1	2	3	4	5	



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RECLASSIFICATIONS

WORKSHEET A-6

		DECREASES						
	EXPLANATION OF RECLASSIFICATION(S)	CODE (1)	COST CENTER	LINE #	SALARY	OTHER	WKST A-7 REF.	
		1	6	7	8	9	10	
1	RECLASS NON CAP INSURANCE	A	ADMINISTRATIVE & GENERAL	5		1,013,740	9	
2								
500	TOTAL RECLASSIFICATIONS					1,013,740	500	
	CODE LETTER - A							
1	RECALLS CAFETERIA COSTS	B	DIETARY	10		1,601,894	1	
2			DIETARY	10		121,095	2	
500	TOTAL RECLASSIFICATIONS					1,722,989	500	
	CODE LETTER - B							
1	RECLASS VACATION ACCRUAL	C	ADMINISTRATIVE & GENERAL	5	177,909		1	
500	TOTAL RECLASSIFICATIONS				177,909		500	
	CODE LETTER - C							
1	RECLASS CHARGEABLE MEDICAL SUPPLIES	D	CENTRAL SERVICES & SUPPLY	14		589,629	1	
2	RECLASS IMPLANT EXPENSE	D	OPERATING ROOM	50		7,553,127	2	
3			CARDIAC CATHETERIZATION	59		1,941,563	3	
4			SPECIAL PROCEDURES	54.02		2,123,977	4	
500	TOTAL RECLASSIFICATIONS					12,208,296	500	
	CODE LETTER - D							
1	RECALSS DRUGS CHARGED TO PATIENTS	E	PHARMACY	15		13,084,289	1	
500	TOTAL RECLASSIFICATIONS					13,084,289	500	
	CODE LETTER - E							
1	POB COST OFFSET	F					1	
2			MAINTENANCE & REPAIRS	6		155,269	2	
3			OPERATION OF PLANT	7		340,350	3	
4			HOUSEKEEPING	9		255,739	4	
500	TOTAL RECLASSIFICATIONS					751,358	500	
	CODE LETTER - F							
1	LAB ADMIN	G	LABORATORY	60	17,241	15,853	1	
500	TOTAL RECLASSIFICATIONS				17,241	15,853	500	
	CODE LETTER - G							
1	RECLASS RECOVERY COSTS	H	ADULTS & PEDIATRICS	30	364,217	38,318	1	
500	TOTAL RECLASSIFICATIONS				364,217	38,318	500	
	CODE LETTER - H							
1	RECLASS EMT PRECEPTOR COSTS	I	ADULTS & PEDIATRICS	30	49,409		1	
2			INTENSIVE CARE UNIT	31	41,508		2	
3			OPERATING ROOM	50	14,644		3	
4			RESPIRATORY THERAPY	65	10,593		4	
5			CARDIAC CATHETERIZATION	59	15,318		5	
6			EMERGENCY	91	466,458		6	
500	TOTAL RECLASSIFICATIONS				597,930		500	
	CODE LETTER - I							
1	RECLASS PSYCH ANCILLARY SERVICES	J	ADULTS & PEDIATRICS	30	808,785	2,097,473	1	
2	RECLASS PSYCH IP ANCILLARY SERVICES	J					2	
500	TOTAL RECLASSIFICATIONS				808,785	2,097,473	500	
	CODE LETTER - J							
1	RECLASS VACCINE DRUG COSTS	K	DRUGS CHARGED TO PATIENTS	73		73,034	1	
500	TOTAL RECLASSIFICATIONS					73,034	500	
	CODE LETTER - K							
1	HOME HEALTH SALARIES	L	HOME HEALTH AGENCY	101	7,579,490		1	
2			HOSPICE	116	1,497,821		2	
500	TOTAL RECLASSIFICATIONS				9,077,311		500	
	CODE LETTER - L							
1	RECLASS FCC ADMIN COSTS	M	IFCC	91.01		855,344	1	
500	TOTAL RECLASSIFICATIONS					855,344	500	
	CODE LETTER - M							
1	PHARMACY RESIDENCY	N	PHARMACY	15	140,763	38,736	1	
500	TOTAL RECLASSIFICATIONS				140,763	38,736	500	
	CODE LETTER - N							
	GRAND TOTAL (DECREASES)				11,184,156	31,899,430		

(1) A letter (A, B, etc.) must be entered on each line to identify each reclassification entry.



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RECLASSIFICATIONS

WORKSHEET A-6

EXPLANATION OF RECLASSIFICATION(S)	CODE (1)	DECREASES				WKST A-7 REF.
		COST CENTER	LINE #	SALARY	OTHER	
	1	6	7	8	9	10

Transfer the amounts in columns 4, 5, 8, and 9 to Worksheet A, column 4, lines as appropriate.



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RECONCILIATION OF CAPITAL COST CENTERS

WORKSHEET A-7
PARTS I, II & III

PART I - ANALYSIS OF CHANGES IN CAPITAL ASSETS BALANCES

	DESCRIPTION	BEGINNING BALANCES	ACQUISITIONS			DISPOSALS AND RETIRE- MENTS	ENDING BALANCE	FULLY DEPREC- IATED ASSETS	
			PURCHASES	DONATION	TOTAL				
		1	2	3	4	5	6	7	
1	LAND	16,214,056	82,201		82,201		16,296,257		1
2	LAND IMPROVEMENTS	12,211,665					12,211,665		2
3	BUILDINGS AND FIXTURES	255,433,788	20,941,192		20,941,192	214,634	276,160,346		3
4	BUILDING IMPROVEMENTS								4
5	FIXED EQUIPMENT								5
6	MOVABLE EQUIPMENT	183,883,537	3,710,949		3,710,949		187,594,486		6
7	HIT DESIGNATED ASSETS								7
8	SUBTOTAL (sum of lines 1-7)	467,743,046	24,734,342		24,734,342	214,634	492,262,754		8
9	RECONCILING ITEMS								9
10	TOTAL (line 7 minus line 9)	467,743,046	24,734,342		24,734,342	214,634	492,262,754		10

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

	DESCRIPTION	SUMMARY OF CAPITAL							TOTAL(1) (Sum of (cols. 9 through 14)	
		DEPREC- IATION	LEASE	INTEREST	INSURANCE (see instr.)	TAXES (see instr.)	OTHER CAPITAL- RELATED COSTS (see instr.)			
*		9	10	11	12	13	14	15		
1	CAP REL COSTS-BLDG & FIXT	6,569,328							6,569,328	1
2	CAP REL COSTS-MVBLE EQUIP	8,572,261							8,572,261	2
3	TOTAL (sum of lines 1-2)	15,141,589							15,141,589	3

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

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

PART III - RECONCILIATION OF CAPITAL COST CENTERS

	DESCRIPTION	COMPUTATION OF RATIOS				ALLOCATION OF OTHER CAPITAL				
		GROSS ASSETS	CAPITAL- IZED LEASES	GROSS ASSETS FOR RATIO (col. 1 - col. 2)	RATIO (see instr.)	INSURANCE	TAXES	OTHER CAPITAL- RELATED COSTS	TOTAL (sum of (cols. 5 through 7)	
*		9	10	11	12	13	14	15	16	
1	CAP REL COSTS-BLDG & FI	263,668,310		263,668,310	0.590955					1
2	CAP REL COSTS-MVBLE EQU	182,505,060		182,505,060	0.409045					2
3	TOTAL (sum of lines 1-2)	446,173,370		446,173,370	1.000000					3

	DESCRIPTION	SUMMARY OF CAPITAL							TOTAL(2) (sum of (cols. 9 through 14)	
		DEPREC- IATION	LEASE	INTEREST	INSURANCE (see instr.)	TAXES (see instr.)	OTHER CAPITAL- RELATED COSTS (see instr.)			
*		9	10	11	12	13	14	15		
1	CAP REL COSTS-BLDG & FIXT	6,538,304							6,538,304	1
2	CAP REL COSTS-MVBLE EQUIP	8,572,261							8,572,261	2
3	TOTAL (sum of lines 1-2)	15,110,565							15,110,565	3

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



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ADJUSTMENTS TO EXPENSES

WORKSHEET A-8

	DESCRIPTION(1)	BASIS/ CODE (2)	AMOUNT	EXPENSE CLASSIFICATION ON WORKSHEET A TO/FROM WHICH THE AMOUNT IS TO BE ADJUSTED			WKST A-7 REF.	
				COST CENTER		LINE#		
				1	2	3		4
1	INVESTMENT INCOME-BUILDINGS & FIXTURES (chapter 2)	B	-288,628	CAP REL COSTS-BLDG & FIXT		1	9	1
2	INVESTMENT INCOME-MOVABLE EQUIPMENT (chapter 2)			CAP REL COSTS-MVBLE EQUIP		2		2
3	INVESTMENT INCOME-OTHER (chapter 2)							3
4	TRADE, QUANTITY, AND TIME DISCOUNTS (chapter 8)							4
5	REFUNDS AND REBATES OF EXPENSES (chapter 8)							5
6	RENTAL OF PROVIDER SPACE BY SUPPLIERS (chapter 8)							6
7	TELEPHONE SERVICES (PAY STATIONS EXCL) (chapter 21)							7
8	TELEVISION AND RADIO SERVICE (chapter 21)							8
9	PARKING LOT (chapter 21)	B	-124,648	HOUSEKEEPING		9		9
10	PROVIDER-BASED PHYSICIAN ADJUSTMENT	WKST A-8-2	-7,747,554					10
11	SALE OF SCRAP, WASTE, ETC. (chapter 23)							11
12	RELATED ORGANIZATION TRANSACTIONS (chapter 10)	WKST A-8-1	2,003,821					12
13	LAUNDRY AND LINEN SERVICE							13
14	CAFETERIA - EMPLOYEES AND GUESTS							14
15	RENTAL OF QUARTERS TO EMPLOYEES & OTHERS							15
16	SALE OF MEDICAL AND SURGICAL SUPPLIES TO OTHER THAN PATIENTS							16
17	SALE OF DRUGS TO OTHER THAN PATIENTS							17
18	SALE OF MEDICAL RECORDS AND ABSTRACTS	B	-3,645	MEDICAL RECORDS & LIBRARY		16		18
19	NURSING SCHOOL (TUITION,FEES,BOOKS,ETC.)	B	-246,565	PARAMED ED PRGM - EMS		23.01		19
20	VENDING MACHINES							20
21	INCOME FROM IMPOSITION OF INTEREST, FINANCE OR PENALTY CHARGES (chapter 21)							21
22	INTEREST EXP ON MEDICARE OVERPAYMENTS & BORROWINGS TO REPAY MEDICARE OVERPAYMENTS							22
23	ADJ FOR RESPIRATORY THERAPY COSTS IN EXCESS OF LIMITATION (chapter 14)	WKST A-8-3		RESPIRATORY THERAPY		65		23
24	ADJ FOR PHYSICAL THERAPY COSTS IN EXCESS OF LIMITATION (chapter 14)	WKST A-8-3		PHYSICAL THERAPY		66		24
25	UTIL REVIEW-PHYSICIANS' COMPENSATION (chapter 21)			UTILIZATION REVIEW-SNF		114		25
26	DEPRECIATION--BUILDINGS & FIXTURES			CAP REL COSTS-BLDG & FIXT		1		26
27	DEPRECIATION--MOVABLE EQUIPMENT			CAP REL COSTS-MVBLE EQUIP		2		27
28	NON-PHYSICIAN ANESTHETIST			NONPHYSICIAN ANESTHETISTS		19		28
29	PHYSICIANS' ASSISTANT							29
30	ADJ FOR OCCUPATIONAL THERAPY COSTS IN EXCESS OF LIMITATION (chapter 14)	WKST A-8-3		OCCUPATIONAL THERAPY		67		30
31	ADJ FOR SPEECH PATHOLOGY COSTS IN EXCESS OF LIMITATION (chapter 14)	WKST A-8-3		SPEECH PATHOLOGY		68		31
32	CAH HIT ADJ FOR DEPRECIATION AND							32
33								33
34	INVESTMENT INCOME	B	-1,742,009	ADMINISTRATIVE & GENERAL		5		34
34.06	DAY CARE CENTER	B	-484,411	ADMINISTRATIVE & GENERAL		5		34.06
34.09	DIETARY TUITION REVENUE	B	-91,128	PARAMED ED PRGM - DIETETICS		23.02		34.09
35	POB RENT EXPENSE	A	-75,828	ADMINISTRATIVE & GENERAL		5		35
35.01	POB RENT EXPENSE	A	-21,768	EMPLOYEE BENEFITS DEPARTMENT		4		35.01
35.02	POB RENT EXPENSE	A	-5,700	MEDICAL RECORDS & LIBRARY		16		35.02
35.03	POB RENT EXPENSE	A	-20,076	RADIOLOGY-DIAGNOSTIC		54		35.03
35.04	POB RENT EXPENSE	A	-600	LABORATORY		60		35.04
35.05	POB RENT EXPENSE	A	-39,856	INFUSION THERAPY		73.01		35.05
35.06	POB RENT EXPENSE	A	-21,328	IFCC INFUSION THERAPY		73.02		35.06
35.07	POB RENT EXPENSE	A	-56,187	CARDIAC REHABILITATION		76.97		35.07
35.19	POB DEPT RENTAL - RETINAL	B	-13,605	RETINAL VASCULAR		90.03		35.19
35.20	MISC REVENUE	B	-14,102	CARDIAC CATHETERIZATION		59		35.20
35.21	MISC REVENUE	B	-15,519	NURSING ADMINISTRATION		13		35.21
35.22	MISC REVENUE	B	-172	ADULTS & PEDIATRICS		30		35.22
35.43	OTHER INCOME	B	-4,925	SPEECH PATHOLOGY		68		35.43
35.44	OTHER INCOME	B	-389,220	LABORATORY		60		35.44
35.45	MISC REVENUE	B	-148,515	ELECTROCARDIOLOGY		69		35.45
35.47	OTHER INCOME	B	-3,702,108	IFCC		91.01		35.47
35.48	OTHER INCOME	B	-137,245	CARDIAC REHABILITATION		76.97		35.48
35.51	OTHER INCOME	B	-2,789	RADIOLOGY-DIAGNOSTIC		54		35.51
35.53	OTHER INCOME	B	-17,125	CENTRAL SERVICES & SUPPLY		14		35.53
35.55	OTHER INCOME	B	-2,155,535	PHYSICAL THERAPY		66		35.55
36	REMOVE LOBBYING EXPENSE	A	-77,333	ADMINISTRATIVE & GENERAL		5		36
37	NONALLOWABLE MARKETING EXPENSE	A	-1,599,245	ADMINISTRATIVE & GENERAL		5		37
38	NONALLOWABLE MARKETING EXPENSE	A	-544	MEDICAL RECORDS & LIBRARY		16		38
39	NONALLOWABLE MARKETING EXPENSE	A	-517	SUBPROVIDER - IRF		41		39
40	NONALLOWABLE MARKETING EXPENSE	A	-3,696	LABORATORY		60		40
41	NONALLOWABLE MARKETING EXPENSE	A	-131	PHYSICAL THERAPY		66		41
42	NONALLOWABLE MARKETING EXPENSE	A	-435	INFUSION THERAPY		73.01		42



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ADJUSTMENTS TO EXPENSES

WORKSHEET A-8

		EXPENSE CLASSIFICATION ON WORKSHEET A TO/FROM WHICH THE AMOUNT IS TO BE ADJUSTED					
	DESCRIPTION(1)	BASIS/ CODE (2)	AMOUNT	COST CENTER	LINE#	WKST A-7 REF.	
		1	2	3	4	5	
43	NONALLOWABLE MARKETING EXPENSE	A	-988	IFCC INFUSION THERAPY	73.02	43	
44	NONALLOWABLE MARKETING EXPENSE	A	-3,333	CARDIAC REHABILITATION	76.97	44	
45	NONALLOWABLE MARKETING EXPENSE	A	-4,011	IFCC	91.01	45	
46						46	
47						47	
48						48	
49						49	
50	TOTAL (sum of lines 1 thru 49) (Transfer to worksheet A, column 6, line 200)		-17,257,203			50	

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

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



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

WORKSHEET A-8-1

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

	LINE NO.	COST CENTER	EXPENSE ITEMS	AMOUNT OF ALLOWABLE COST	AMOUNT INCLUDED IN WKST. A COLUMN 5	NET ADJUSTMENTS (col. 4 minus col. 5)*	WKST. A-7 REF.
	1	2	3	4	5	6	7
1	5	ADMINISTRATIVE & GENERAL	MANAGEMENT FEE	8,592,662	6,539,422	2,053,240	1
2	101	HOME HEALTH AGENCY	MANAGEMENT FEE	395,935	445,354	-49,419	2
3							3
4							4
5	TOTALS (SUM OF LINES 1-4) TRANSFER COLUMN 6, LINE 5 TO WORKSHEET A-8, COLUMN 2, LINE 12			8,988,597	6,984,776	2,003,821	5

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

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

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

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

	SYMBOL (1)	NAME	PERCENTAGE OF OWNERSHIP	RELATED ORGANIZATION(S) AND/OR HOME OFFICE			
				NAME	PERCENTAGE OF OWNERSHIP		TYPE OF BUSINESS
	1	2	3	4	5	6	
6						6	
7	B	INGALLS HEALTH SYSTEM	100.00			ACUTE	7
8	C			INGALLS HOME CARE	100.00	HOME CARE	8
9							9
10							10

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

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



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PROVIDER-BASED PHYSICIANS ADJUSTMENTS

WORKSHEET A-8-2

WKST A LINE #	COST CENTER/ PHYSICIAN IDENTIFIER	TOTAL REMUNERATION	PROFESSIONAL COMPONENT	PROVIDER COMPONENT	RCE AMOUNT	PHYSICIAN/ PROVIDER COMPONENT HOURS	UNADJUSTED RCE LIMIT	5 PERCENT OF UNADJUSTED RCE LIMIT	
1	2	3	4	5	6	7	8	9	
1	5 ADMINISTRATIVE & GEN AGGREGATE	2,824,605	2,481,411	343,194	165,600	2,288	182,160	9,108	1
2	16 MEDICAL RECORDS & LI	182,626		182,626	165,600	1,219	97,051	4,853	2
3	23.01 PARAMED ED PRGM - EM	38,250		38,250	208,000	255	25,500	1,275	3
4	30 ADULTS & PEDIATRICS AGGREGATE	862,500	862,500		165,600				4
5	41 SUBPROVIDER - IRF	49,050		49,050	165,600	327	26,034	1,302	5
6	65 RESPIRATORY THERAPY AGGREGATE	25,200	25,200		208,000	128	12,800	640	6
7	50 OPERATING ROOM AGGREGATE	314,904	275,004	39,900	208,000	133	13,300	665	7
8	53 ANESTHESIOLOGY AGGREGATE	618,050	618,050		208,000				8
9	54 RADIOLOGY-DIAGNOSTIC AGGREGATE	1,099,338	950,000	149,338	165,600	287	22,850	1,143	9
10	56 RADIOISOTOPE				208,000				10
11	59 CARDIAC CATHETERIZAT	45,000		45,000	208,000	300	30,000	1,500	11
12	60 LABORATORY AGGREGATE	24,996	24,996		208,000				12
13	66 PHYSICAL THERAPY AGGREGATE	125,933	125,933		208,000				13
14	69 ELECTROCARDIOLOGY	739,146		739,146	208,000	4,928	492,800	24,640	14
15	70 ELECTROENCEPHALOGRAP AGGREGATE	82,056	82,056		208,000				15
16	74 RENAL DIALYSIS	18,000		18,000	208,000	120	12,000	600	16
17	76.97 CARDIAC REHABILITATI	14,550		14,550	208,000	97	9,700	485	17
18	90.03 RETINAL VASCULAR	36,000		36,000	208,000	240	24,000	1,200	18
19	91 EMERGENCY VARIOUS	530,640	530,640		225,300				19
20	91.01 IFCC AGGREGATE	1,052,105	1,052,105		225,300				20
200	TOTAL	8,682,949	7,027,895	1,655,054		10,322	948,195	47,411	200



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PROVIDER-BASED PHYSICIANS ADJUSTMENTS

WORKSHEET A-8-2

	WKST A LINE #	COST CENTER/ PHYSICIAN IDENTIFIER	COST OF MEMBER- SHIPS & CONTIN- UING EDUCATION	PROVIDER COMPON- ENT SHARE OF COL. 12	PHYSICIAN COST OF MALPRACT- ICE INSURANCE	PROVIDER COMPON- ENT SHARE OF COL. 14	ADJUSTED RCE LIMIT	RCE DISALLOW- ANCE	ADJUST- MENT	
	10	11	12	13	14	15	16	17	18	
1	5	ADMINISTRATIVE & GEN AGGREGATE					182,160	161,034	2,642,445	1
2	16	MEDICAL RECORDS & LI					97,051	85,575	85,575	2
3	23.01	PARAMED ED PRGM - EM					25,500	12,750	12,750	3
4	30	ADULTS & PEDIATRICS AGGREGATE							862,500	4
5	41	SUBPROVIDER - IRF					26,034	23,016	23,016	5
6	65	RESPIRATORY THERAPY AGGREGATE					12,800		25,200	6
7	50	OPERATING ROOM AGGREGATE					13,300	26,600	301,604	7
8	53	ANESTHESIOLOGY AGGREGATE							618,050	8
9	54	RADIOLOGY-DIAGNOSTIC AGGREGATE					22,850	126,488	1,076,488	9
10	56	RADIOISOTOPE								10
11	59	CARDIAC CATHETERIZAT					30,000	15,000	15,000	11
12	60	LABORATORY AGGREGATE							24,996	12
13	66	PHYSICAL THERAPY AGGREGATE							125,933	13
14	69	ELECTROCARDIOLOGY					492,800	246,346	246,346	14
15	70	ELECTROENCEPHALOGRAP AGGREGATE							82,056	15
16	74	RENAL DIALYSIS					12,000	6,000	6,000	16
17	76.97	CARDIAC REHABILITATI					9,700	4,850	4,850	17
18	90.03	RETINAL VASCULAR					24,000	12,000	12,000	18
19	91	EMERGENCY VARIOUS							530,640	19
20	91.01	IFCC AGGREGATE							1,052,105	20
200		TOTAL					948,195	719,659	7,747,554	200



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COST ALLOCATION - GENERAL SERVICE COSTS

**WORKSHEET B
PART I**

	COST CENTER DESCRIPTIONS	NET EXP FOR COST ALLOCATION (from Wkst A, col.7)	CAP BLDGS & FIXTURES	CAP MOVABLE EQUIPMENT	EMPLOYEE BENEFITS DEPARTMENT	SUBTOTAL (cols.0-4)	ADMINISTRATIVE & GENERAL	
		0	1	2	4	4A	5	
	GENERAL SERVICE COST CENTERS							
1	CAP REL COSTS-BLDG & FIXT	6,538,304	6,538,304					1
2	CAP REL COSTS-MVBLE EQUIP	8,572,261		8,572,261				2
4	EMPLOYEE BENEFITS DEPARTMENT	22,397,216	35,363		22,432,579			4
5	ADMINISTRATIVE & GENERAL	62,194,276	1,998,790	2,600,285	2,971,048	69,764,399	69,764,399	5
6	MAINTENANCE & REPAIRS	3,575,078	166,979	6,754		3,748,811	1,255,593	6
7	OPERATION OF PLANT	7,108,711	475,347	41,626	189,115	7,814,799	2,617,418	7
8	LAUNDRY & LINEN SERVICE	1,118,490	32,747	937	20,427	1,172,601	392,740	8
9	HOUSEKEEPING	3,947,078	38,838	25,629	211	4,011,756	1,343,661	9
10	DIETARY	2,250,004	119,175	43,162		2,412,341	807,968	10
11	CAFETERIA	1,602,131	56,878	701		1,659,710	555,888	11
12	MAINTENANCE OF PERSONNEL							12
13	NURSING ADMINISTRATION	3,152,338	23,074	1,592,773	672,684	5,440,869	1,822,316	13
14	CENTRAL SERVICES & SUPPLY	351,279	43,003	62,671	59,029	515,982	172,818	14
15	PHARMACY	3,736,202	62,073	199,792	808,917	4,806,984	1,610,008	15
16	MEDICAL RECORDS & LIBRARY	4,122,952	89,984	3,620	593,402	4,809,958	1,611,004	16
17	SOCIAL SERVICE							17
19	NONPHYSICIAN ANESTHETISTS							19
20	NURSING SCHOOL							20
21	I&R SERVICES-SALARY & FRINGES APPRVD							21
22	I&R SERVICES-OTHER PRGM COSTS APPRVD							22
23	PARAMED ED PRGM-(SPECIFY)	179,499	1,344		32,480	213,323	71,448	23
23.01	PARAMED ED PRGM - EMS	521,628	6,718	13,924	172,433	714,703	239,376	23.01
23.02	PARAMED ED PRGM - DIETETICS	52,961	20,718		3,949	77,628	26,000	23.02
	INPATIENT ROUTINE SERV COST CENTERS							
30	ADULTS & PEDIATRICS	22,281,679	1,183,850	305,913	4,224,856	27,996,298	9,376,926	30
31	INTENSIVE CARE UNIT	3,483,671	113,944	96,972	687,379	4,381,966	1,467,656	31
40	SUBPROVIDER - IPF	1,426,853	35,775	5,011	164,678	1,632,317	546,714	40
41	SUBPROVIDER - IRF	2,788,888	452,650	7,511	591,766	3,840,815	1,286,408	41
43	NURSERY	1,821,423	53,295	5,640	298,498	2,178,856	729,766	43
	ANCILLARY SERVICE COST CENTERS							
50	OPERATING ROOM	10,357,331	396,354	401,000	987,298	12,141,983	4,066,727	50
51	RECOVERY ROOM	847,632	29,800	22,632	164,123	1,064,187	356,429	51
53	ANESTHESIOLOGY	758,252	3,861	57,877	115,530	935,520	313,335	53
54	RADIOLOGY-DIAGNOSTIC	4,069,409	235,448	505,946	615,266	5,426,069	1,817,359	54
54.01	ULTRASOUND	1,093,387	25,555	51,179	232,216	1,402,337	469,686	54.01
54.02	SPECIAL PROCEDURES	1,205,579	16,418	135,939	261,139	1,619,075	542,278	54.02
56	RADIOISOTOPE	1,218,400	17,243	38,178	102,383	1,376,204	460,933	56
57	CT SCAN	1,061,645	18,407	67,528	157,826	1,305,406	437,221	57
58	MRI	675,440	48,610	18,070	116,668	858,788	287,635	58
59	CARDIAC CATHETERIZATION	1,980,488	32,873	280,584	158,219	2,452,164	821,306	59
60	LABORATORY	10,181,055	123,349	161,465	1,317,137	11,783,006	3,946,494	60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
63	BLOOD STORING, PROCESSING & TRANS.	1,310,648	4,703	1,722	78,852	1,395,925	467,539	63
65	RESPIRATORY THERAPY	1,988,454	14,770	40,057	363,483	2,406,764	806,100	65
65.01	PULMONARY FUNCTION	79,380	7,112	4,093	15,749	106,334	35,615	65.01
66	PHYSICAL THERAPY	2,029,312	57,084	42,989	948,765	3,078,150	1,030,968	66
67	OCCUPATIONAL THERAPY	1,443,838	9,477	993	300,245	1,754,553	587,654	67
68	SPEECH PATHOLOGY	420,169	6,485	7,651	95,264	529,569	177,369	68
69	ELECTROCARDIOLOGY	1,241,336	33,607	115,104	164,525	1,554,572	520,674	69
70	ELECTROENCEPHALOGRAPHY	97,681	18,282	17,553	21,478	154,994	51,912	70
70.01	SLEEP LAB	133,786		10,415	29,682	173,883	58,239	70.01
70.02	PSYCH	1,676,314			186,621	1,862,935	623,955	70.02
71	MEDICAL SUPPLIES CHARGED TO PATIENTS	589,629				589,629	197,485	71
72	IMPL. DEV. CHARGED TO PATIENTS	11,618,667				11,618,667	3,891,452	72
73	DRUGS CHARGED TO PATIENTS	13,011,255				13,011,255	4,357,873	73
73.01	INFUSION THERAPY	535,611	13,919	1,923	105,836	657,289	220,146	73.01
73.02	IFCC INFUSION THERAPY	665,564	5,777		129,020	800,361	268,066	73.02
73.03	PHARMACY VACCINE	73,034				73,034	24,461	73.03
74	RENAL DIALYSIS	645,111	16,132	18,993	127,564	807,800	270,557	74
76.97	CARDIAC REHABILITATION	409,143	18,264	10,746	98,939	537,092	179,889	76.97
76.98	HYPERBARIC OXYGEN THERAPY	1,247,339		1,505	197,893	1,446,737	484,557	76.98
76.99	LITHOTRIPSY							76.99
	OUTPATIENT SERVICE COST CENTERS							
90.02	PSYCH ANCILLARY	1,909,555	125,391			2,034,946	681,566	90.02
90.03	RETINAL VASCULAR	311,075	97,131	14,769	48,958	471,933	158,065	90.03
91	EMERGENCY	4,708,080	83,946	65,767	797,559	5,655,352	1,894,153	91
91.01	IFCC	17,376,489		1,463,016	2,998,662	21,838,167	7,314,279	91.01
92	OBSERVATION BEDS (NON-DISTINCT PART)							92
	OTHER REIMBURSABLE COST CENTERS							
100	I&R SERVICES-NOT APPRVD PRGM	862,953				862,953	289,030	100
101	HOME HEALTH AGENCY	10,481,687	55,364			10,537,051	3,529,185	101
	SPECIAL PURPOSE COST CENTERS							



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COST ALLOCATION - GENERAL SERVICE COSTS

WORKSHEET B
PART I

	COST CENTER DESCRIPTIONS	NET EXP FOR COST ALLOCATION (from Wkst A, col.7)	CAP BLDGS & FIXTURES	CAP MOVABLE EQUIPMENT	EMPLOYEE BENEFITS DEPARTMENT	SUBTOTAL (cols.0-4)	ADMINIS- TRATIVE & GENERAL	
		0	1	2	4	4A	5	
116	HOSPICE	2,472,721				2,472,721	828,191	116
118	SUBTOTALS (sum of lines 1-117)	274,010,371	6,525,907	8,570,615	22,427,772	273,991,521	68,402,091	118
	NONREIMBURSABLE COST CENTERS							
192	PHYSICIANS' PRIVATE OFFICES	1,737,089		1,646	4,807	1,743,542	583,966	192
192.01	REFERENCE LAB							192.01
192.02	OP PHARMACY		7,918			7,918	2,652	192.02
192.03	RETINAL VASCULAR GRANTS		4,479			4,479	1,500	192.03
192.04	AMBULANCE	2,311,491				2,311,491	774,190	192.04
200	CROSS FOOT ADJUSTMENTS							200
201	NEGATIVE COST CENTER							201
202	TOTAL (sum of lines 118-201)	278,058,951	6,538,304	8,572,261	22,432,579	278,058,951	69,764,399	202



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COST ALLOCATION - GENERAL SERVICE COSTS

WORKSHEET B
PART I

	COST CENTER DESCRIPTIONS	MAIN- TENANCE & REPAIRS	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSE- KEEPING	DIETARY	CAFETERIA	
		6	7	8	9	10	11	
	GENERAL SERVICE COST CENTERS							
1	CAP REL COSTS-BLDG & FIXT							1
2	CAP REL COSTS-MVBLE EQUIP							2
4	EMPLOYEE BENEFITS DEPARTMENT							4
5	ADMINISTRATIVE & GENERAL							5
6	MAINTENANCE & REPAIRS	5,004,404						6
7	OPERATION OF PLANT	548,475	10,980,692					7
8	LAUNDRY & LINEN SERVICE	37,785	93,114	1,696,240				8
9	HOUSEKEEPING	44,813	110,432		5,510,662			9
10	DIETARY	137,509	338,862		173,270	3,869,950		10
11	CAFETERIA	65,628	161,726		82,695		2,525,647	11
12	MAINTENANCE OF PERSONNEL							12
13	NURSING ADMINISTRATION	26,623	65,607		33,547		91,618	13
14	CENTRAL SERVICES & SUPPLY	49,619	122,275	3,488	62,523		14,304	14
15	PHARMACY	71,622	176,498		90,249			15
16	MEDICAL RECORDS & LIBRARY	103,827	255,859		130,828		87,617	16
17	SOCIAL SERVICE							17
19	NONPHYSICIAN ANESTHETISTS							19
20	NURSING SCHOOL							20
21	I&R SERVICES-SALARY & FRINGES APPRVD							21
22	I&R SERVICES-OTHER PRGM COSTS APPRVD							22
23	PARAMED ED PRGM-(SPECIFY)	1,550	3,820		1,953		4,275	23
23.01	PARAMED ED PRGM - EMS	7,751	19,102		9,767		20,589	23.01
23.02	PARAMED ED PRGM - DIETETICS	23,905	58,909		30,122		384	23.02
	INPATIENT ROUTINE SERV COST CENTERS							
30	ADULTS & PEDIATRICS	1,365,975	3,366,157	830,475	1,721,210	2,803,133	584,219	30
31	INTENSIVE CARE UNIT	131,473	323,988	100,819	165,664	251,190	76,893	31
40	SUBPROVIDER - IPF	41,279	101,722	33,393	52,013	296,442	24,188	40
41	SUBPROVIDER - IRF	522,286	1,287,062	87,942	658,112	470,073	77,021	41
43	NURSERY	61,494	151,539	21,791	77,486		35,770	43
	ANCILLARY SERVICE COST CENTERS							
50	OPERATING ROOM	457,329	1,126,991	191,493	576,263		144,123	50
51	RECOVERY ROOM	34,385	84,734	21,934	43,327		14,980	51
53	ANESTHESIOLOGY	4,454	10,977		5,613		6,924	53
54	RADIOLOGY-DIAGNOSTIC	271,669	669,471	54,480	342,320		77,496	54
54.01	ULTRASOUND	29,486	72,662	26,462	37,154		23,914	54.01
54.02	SPECIAL PROCEDURES	18,944	46,684	3,309	23,871		27,166	54.02
56	RADIOISOTOPE	19,895	49,027	5,350	25,069		9,482	56
57	CT SCAN	21,239	52,338	23,119	26,762		17,666	57
58	MRI	56,089	138,219	11,086	70,675		12,788	58
59	CARDIAC CATHETERIZATION	37,930	93,470	3,276	47,794		14,743	59
60	LABORATORY	142,325	350,730		179,338		202,419	60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
63	BLOOD STORING, PROCESSING & TRANS.	5,426	13,371		6,837		9,372	63
65	RESPIRATORY THERAPY	17,043	41,998		21,475		47,225	65
65.01	PULMONARY FUNCTION	8,206	20,222		10,340		1,955	65.01
66	PHYSICAL THERAPY	65,866	162,312	40,007	82,995		115,002	66
67	OCCUPATIONAL THERAPY	10,935	26,946		13,778		49,198	67
68	SPEECH PATHOLOGY	7,483	18,439		9,429		10,706	68
69	ELECTROCARDIOLOGY	38,777	95,559	17,857	48,862		19,493	69
70	ELECTROENCEPHALOGRAPHY	21,094	51,982	2,767	26,580		3,106	70
70.01	SLEEP LAB						3,836	70.01
70.02	PSYCH						10,760	70.02
71	MEDICAL SUPPLIES CHARGED TO PATIENTS							71
72	IMPL. DEV. CHARGED TO PATIENTS							72
73	DRUGS CHARGED TO PATIENTS						81,059	73
73.01	INFUSION THERAPY	16,061	39,578	4,419	20,238		12,971	73.01
73.02	IFCC INFUSION THERAPY	6,666	16,427		8,400		8,349	73.02
73.03	PHARMACY VACCINE							73.03
74	RENAL DIALYSIS	18,614	45,869		23,454		13,428	74
76.97	CARDIAC REHABILITATION	21,073	51,931	9,321	26,554		11,966	76.97
76.98	HYPERBARIC OXYGEN THERAPY			403			20,826	76.98
76.99	LITHOTRIPSY							76.99
	OUTPATIENT SERVICE COST CENTERS							
90.02	PSYCH ANCILLARY	144,681	356,537	20,343	182,307	24,556		90.02
90.03	RETINAL VASCULAR	112,074	276,183		141,220		9,445	90.03
91	EMERGENCY	96,861	238,693	182,706	122,051	24,556	97,793	91
91.01	IFCC						430,578	91.01
92	OBSERVATION BEDS (NON-DISTINCT PART)							92
	OTHER REIMBURSABLE COST CENTERS							
100	I&R SERVICES-NOT APPRVD PRGM							100
101	HOME HEALTH AGENCY	63,881	157,422		80,494			101
	SPECIAL PURPOSE COST CENTERS							
116	HOSPICE							116
118	SUBTOTALS (sum of lines 1-117)	4,990,100	10,945,444	1,696,240	5,492,639	3,869,950	2,525,647	118



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COST ALLOCATION - GENERAL SERVICE COSTS

WORKSHEET B
PART I

	COST CENTER DESCRIPTIONS	MAIN-TENANCE & REPAIRS	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSE-KEEPING	DIETARY	CAFETERIA	
		6	7	8	9	10	11	
	NONREIMBURSABLE COST CENTERS							
192	PHYSICIANS' PRIVATE OFFICES							192
192.01	REFERENCE LAB							192.01
192.02	OP PHARMACY	9,136	22,514		11,512			192.02
192.03	RETINAL VASCULAR GRANTS	5,168	12,734		6,511			192.03
192.04	AMBULANCE							192.04
200	CROSS FOOT ADJUSTMENTS							200
201	NEGATIVE COST CENTER							201
202	TOTAL (sum of lines 118-201)	5,004,404	10,980,692	1,696,240	5,510,662	3,869,950	2,525,647	202



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COST ALLOCATION - GENERAL SERVICE COSTS

WORKSHEET B
PART I

	COST CENTER DESCRIPTIONS	NURSING ADMINISTRATION	CENTRAL SERVICES & SUPPLY	PHARMACY	MEDICAL RECORDS & LIBRARY	PARAMED EDUCATION		
		13	14	15	16	23	23.01	
	GENERAL SERVICE COST CENTERS							
1	CAP REL COSTS-BLDG & FIXT							1
2	CAP REL COSTS-MVBLE EQUIP							2
4	EMPLOYEE BENEFITS DEPARTMENT							4
5	ADMINISTRATIVE & GENERAL							5
6	MAINTENANCE & REPAIRS							6
7	OPERATION OF PLANT							7
8	LAUNDRY & LINEN SERVICE							8
9	HOUSEKEEPING							9
10	DIETARY							10
11	CAFETERIA							11
12	MAINTENANCE OF PERSONNEL							12
13	NURSING ADMINISTRATION	7,480,580						13
14	CENTRAL SERVICES & SUPPLY		941,009					14
15	PHARMACY			6,755,361				15
16	MEDICAL RECORDS & LIBRARY				6,999,112			16
17	SOCIAL SERVICE							17
19	NONPHYSICIAN ANESTHETISTS							19
20	NURSING SCHOOL							20
21	I&R SERVICES-SALARY & FRINGES APPRVD							21
22	I&R SERVICES-OTHER PRGM COSTS APPRVD							22
23	PARAMED ED PRGM-(SPECIFY)					296,369		23
23.01	PARAMED ED PRGM - EMS		121	1,318			1,012,727	23.01
23.02	PARAMED ED PRGM - DIETETICS							23.02
	INPATIENT ROUTINE SERV COST CENTERS							
30	ADULTS & PEDIATRICS	4,242,490	44,282	2,648	2,893,130		135,030	30
31	INTENSIVE CARE UNIT	534,790	12,273	1,061	267,173		101,273	31
40	SUBPROVIDER - IPF	168,226	94	25	292,927			40
41	SUBPROVIDER - IRF	535,679	3,877	90	468,590			41
43	NURSERY	248,781	1,398		187,669			43
	ANCILLARY SERVICE COST CENTERS							
50	OPERATING ROOM	823,086	150,858	1,374	275,355		33,758	50
51	RECOVERY ROOM	104,188	3,834		17,942			51
53	ANESTHESIOLOGY		7,522		47,534			53
54	RADIOLOGY-DIAGNOSTIC		2,618	6,750	144,211			54
54.01	ULTRASOUND		1,958	3	49,862			54.01
54.02	SPECIAL PROCEDURES		62,476	10,759	87,076			54.02
56	RADIOISOTOPE		22,572	339,781	38,591			56
57	CT SCAN		6,641	44,198	183,850			57
58	MRI		4,158		55,251			58
59	CARDIAC CATHETERIZATION		35,317	25,764	58,263			59
60	LABORATORY		98,423	154,959	421,994			60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
63	BLOOD STORING, PROCESSING & TRANS.		27,822	12,303	20,887			63
65	RESPIRATORY THERAPY		10,893	12	46,350		33,758	65
65.01	PULMONARY FUNCTION		59		3,271			65.01
66	PHYSICAL THERAPY		2,977	2,721	134,220			66
67	OCCUPATIONAL THERAPY		103		27,569			67
68	SPEECH PATHOLOGY		62		26,743			68
69	ELECTROCARDIOLOGY		2,809	35,341	97,583		33,758	69
70	ELECTROENCEPHALOGRAPHY		95		3,191			70
70.01	SLEEP LAB		143		3,705			70.01
70.02	PSYCH				10,759			70.02
71	MEDICAL SUPPLIES CHARGED TO PATIENTS		17,309		13,923			71
72	IMPL. DEV. CHARGED TO PATIENTS		341,080		87,973			72
73	DRUGS CHARGED TO PATIENTS			5,944,582	250,313	296,369		73
73.01	INFUSION THERAPY		1,781		18,184			73.01
73.02	IFCC INFUSION THERAPY		2,535		6,675			73.02
73.03	PHARMACY VACCINE			33,182	67			73.03
74	RENAL DIALYSIS		1,657	2				74
76.97	CARDIAC REHABILITATION		170	686	3,680			76.97
76.98	HYPERBARIC OXYGEN THERAPY		4,105	2,200	13,186			76.98
76.99	LITHOTRIPSY							76.99
	OUTPATIENT SERVICE COST CENTERS							
90.02	PSYCH ANCILLARY		2		19,007			90.02
90.03	RETINAL VASCULAR		210	577	2,749			90.03
91	EMERGENCY	823,340	24,709	52	222,439		675,150	91
91.01	IFCC		44,046	134,973	497,220			91.01
92	OBSERVATION BEDS (NON-DISTINCT PART)							92
	OTHER REIMBURSABLE COST CENTERS							
100	I&R SERVICES-NOT APPRVD PRGM							100
101	HOME HEALTH AGENCY							101
	SPECIAL PURPOSE COST CENTERS							
116	HOSPICE							116
118	SUBTOTALS (sum of lines 1-117)	7,480,580	941,008	6,755,361	6,999,112	296,369	1,012,727	118



COMPU-MAX

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COST ALLOCATION - GENERAL SERVICE COSTS

WORKSHEET B
PART I

	COST CENTER DESCRIPTIONS	NURSING ADMINIS-TRATION	CENTRAL SERVICES & SUPPLY	PHARMACY	MEDICAL RECORDS & LIBRARY	PARAMED EDUCATION		
		13	14	15	16	23	23.01	
	NONREIMBURSABLE COST CENTERS							
192	PHYSICIANS' PRIVATE OFFICES		1					192
192.01	REFERENCE LAB							192.01
192.02	OP PHARMACY							192.02
192.03	RETINAL VASCULAR GRANTS							192.03
192.04	AMBULANCE							192.04
200	CROSS FOOT ADJUSTMENTS							200
201	NEGATIVE COST CENTER							201
202	TOTAL (sum of lines 118-201)	7,480,580	941,009	6,755,361	6,999,112	296,369	1,012,727	202



INGALLS MEMORIAL HOSPITAL Provider CCN: 14-0191	In Lieu of Form CMS-2552-10	Period : From: 10/01/2013 To: 09/30/2014	Run Date: 03/02/2015 Run Time: 10:44 Version: 2014.10
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COST ALLOCATION - GENERAL SERVICE COSTS

**WORKSHEET B
PART I**

	COST CENTER DESCRIPTIONS		SUBTOTAL	I&R COST & POST STEP-DOWN ADJS	TOTAL		
		23.02	24	25	26		
	GENERAL SERVICE COST CENTERS						
1	CAP REL COSTS-BLDG & FIXT						1
2	CAP REL COSTS-MVBLE EQUIP						2
4	EMPLOYEE BENEFITS DEPARTMENT						4
5	ADMINISTRATIVE & GENERAL						5
6	MAINTENANCE & REPAIRS						6
7	OPERATION OF PLANT						7
8	LAUNDRY & LINEN SERVICE						8
9	HOUSEKEEPING						9
10	DIETARY						10
11	CAFETERIA						11
12	MAINTENANCE OF PERSONNEL						12
13	NURSING ADMINISTRATION						13
14	CENTRAL SERVICES & SUPPLY						14
15	PHARMACY						15
16	MEDICAL RECORDS & LIBRARY						16
17	SOCIAL SERVICE						17
19	NONPHYSICIAN ANESTHETISTS						19
20	NURSING SCHOOL						20
21	I&R SERVICES-SALARY & FRINGES APPRVD						21
22	I&R SERVICES-OTHER PRGM COSTS APPRVD						22
23	PARAMED ED PRGM-(SPECIFY)						23
23.01	PARAMED ED PRGM - EMS						23.01
23.02	PARAMED ED PRGM - DIETETICS	216,948					23.02
	INPATIENT ROUTINE SERV COST CENTERS						
30	ADULTS & PEDIATRICS	115,398	55,477,371		55,477,371		30
31	INTENSIVE CARE UNIT	28,849	7,845,068		7,845,068		31
40	SUBPROVIDER - IPF	17,310	3,206,650		3,206,650		40
41	SUBPROVIDER - IRF	50,775	9,288,730		9,288,730		41
43	NURSERY		3,694,550		3,694,550		43
	ANCILLARY SERVICE COST CENTERS						
50	OPERATING ROOM		19,989,340		19,989,340		50
51	RECOVERY ROOM		1,745,940		1,745,940		51
53	ANESTHESIOLOGY		1,331,879		1,331,879		53
54	RADIOLOGY-DIAGNOSTIC		8,812,443		8,812,443		54
54.01	ULTRASOUND		2,113,524		2,113,524		54.01
54.02	SPECIAL PROCEDURES		2,441,638		2,441,638		54.02
56	RADIOISOTOPE		2,346,904		2,346,904		56
57	CT SCAN		2,118,440		2,118,440		57
58	MRI		1,494,689		1,494,689		58
59	CARDIAC CATHETERIZATION		3,590,027		3,590,027		59
60	LABORATORY		17,279,688		17,279,688		60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS						62.30
63	BLOOD STORING, PROCESSING & TRANS.		1,959,482		1,959,482		63
65	RESPIRATORY THERAPY		3,431,618		3,431,618		65
65.01	PULMONARY FUNCTION		186,002		186,002		65.01
66	PHYSICAL THERAPY		4,715,218		4,715,218		66
67	OCCUPATIONAL THERAPY		2,470,736		2,470,736		67
68	SPEECH PATHOLOGY		779,800		779,800		68
69	ELECTROCARDIOLOGY		2,465,285		2,465,285		69
70	ELECTROENCEPHALOGRAPHY		315,721		315,721		70
70.01	SLEEP LAB		239,806		239,806		70.01
70.02	PSYCH	2,308	2,510,717		2,510,717		70.02
71	MEDICAL SUPPLIES CHARGED TO PATIENTS		818,346		818,346		71
72	IMPL. DEV. CHARGED TO PATIENTS		15,939,172		15,939,172		72
73	DRUGS CHARGED TO PATIENTS		23,941,451		23,941,451		73
73.01	INFUSION THERAPY		990,667		990,667		73.01
73.02	IFCC INFUSION THERAPY		1,117,479		1,117,479		73.02
73.03	PHARMACY VACCINE		130,744		130,744		73.03
74	RENAL DIALYSIS		1,181,381		1,181,381		74
76.97	CARDIAC REHABILITATION		842,362		842,362		76.97
76.98	HYPERBARIC OXYGEN THERAPY		1,972,014		1,972,014		76.98
76.99	LITHOTRIPSY						76.99
	OUTPATIENT SERVICE COST CENTERS						
90.02	PSYCH ANCILLARY		3,463,945		3,463,945		90.02
90.03	RETINAL VASCULAR		1,172,456		1,172,456		90.03
91	EMERGENCY	2,308	10,060,163		10,060,163		91
91.01	IFCC		30,259,263		30,259,263		91.01
92	OBSERVATION BEDS (NON-DISTINCT PART)						92
	OTHER REIMBURSABLE COST CENTERS						
100	I&R SERVICES-NOT APPRVD PRGM		1,151,983		1,151,983		100
101	HOME HEALTH AGENCY		14,368,033		14,368,033		101
	SPECIAL PURPOSE COST CENTERS						
116	HOSPICE		3,300,912		3,300,912		116
118	SUBTOTALS (sum of lines 1-117)	216,948	272,561,637		272,561,637		118



COMPU-MAX

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COST ALLOCATION - GENERAL SERVICE COSTS

WORKSHEET B
PART I

	COST CENTER DESCRIPTIONS		SUBTOTAL	I&R COST & POST STEP-DOWN ADJS	TOTAL		
		23.02	24	25	26		
	NONREIMBURSABLE COST CENTERS						
192	PHYSICIANS' PRIVATE OFFICES		2,327,509		2,327,509		192
192.01	REFERENCE LAB						192.01
192.02	OP PHARMACY		53,732		53,732		192.02
192.03	RETINAL VASCULAR GRANTS		30,392		30,392		192.03
192.04	AMBULANCE		3,085,681		3,085,681		192.04
200	CROSS FOOT ADJUSTMENTS						200
201	NEGATIVE COST CENTER						201
202	TOTAL (sum of lines 118-201)	216,948	278,058,951		278,058,951		202



COMPU-MAX

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ALLOCATION OF CAPITAL-RELATED COSTS

WORKSHEET B
PART II

	COST CENTER DESCRIPTIONS	DIR ASSGND CAP-REL COSTS	CAP BLDGS & FIXTURES	CAP MOVABLE EQUIPMENT	SUBTOTAL	EMPLOYEE BENEFITS DEPARTMENT	ADMINIS- TRATIVE & GENERAL	
		0	1	2	2A	4	5	
	GENERAL SERVICE COST CENTERS							
1	CAP REL COSTS-BLDG & FIXT							1
2	CAP REL COSTS-MVBLE EQUIP							2
4	EMPLOYEE BENEFITS DEPARTMENT		35,363		35,363	35,363		4
5	ADMINISTRATIVE & GENERAL		1,998,790	2,600,285	4,599,075	4,687	4,603,762	5
6	MAINTENANCE & REPAIRS		166,979	6,754	173,733		82,856	6
7	OPERATION OF PLANT		475,347	41,626	516,973	298	172,723	7
8	LAUNDRY & LINEN SERVICE		32,747	937	33,684	32	25,917	8
9	HOUSEKEEPING		38,838	25,629	64,467		88,668	9
10	DIETARY		119,175	43,162	162,337		53,318	10
11	CAFETERIA		56,878	701	57,579		36,683	11
12	MAINTENANCE OF PERSONNEL							12
13	NURSING ADMINISTRATION		23,074	1,592,773	1,615,847	1,061	120,254	13
14	CENTRAL SERVICES & SUPPLY		43,003	62,671	105,674	93	11,404	14
15	PHARMACY		62,073	199,792	261,865	1,276	106,244	15
16	MEDICAL RECORDS & LIBRARY		89,984	3,620	93,604	936	106,310	16
17	SOCIAL SERVICE							17
19	NONPHYSICIAN ANESTHETISTS							19
20	NURSING SCHOOL							20
21	I&R SERVICES-SALARY & FRINGES APPRVD							21
22	I&R SERVICES-OTHER PRGM COSTS APPRVD							22
23	PARAMED ED PRGM-(SPECIFY)		1,344		1,344	51	4,715	23
23.01	PARAMED ED PRGM - EMS		6,718	13,924	20,642	272	15,796	23.01
23.02	PARAMED ED PRGM - DIETETICS		20,718		20,718	6	1,716	23.02
	INPATIENT ROUTINE SERV COST CENTERS							
30	ADULTS & PEDIATRICS		1,183,850	305,913	1,489,763	6,641	618,807	30
31	INTENSIVE CARE UNIT		113,944	96,972	210,916	1,084	96,850	31
40	SUBPROVIDER - IPF		35,775	5,011	40,786	260	36,077	40
41	SUBPROVIDER - IRF		452,650	7,511	460,161	934	84,890	41
43	NURSERY		53,295	5,640	58,935	471	48,157	43
	ANCILLARY SERVICE COST CENTERS							
50	OPERATING ROOM		396,354	401,000	797,354	1,557	268,362	50
51	RECOVERY ROOM		29,800	22,632	52,432	259	23,521	51
53	ANESTHESIOLOGY		3,861	57,877	61,738	182	20,677	53
54	RADIOLOGY-DIAGNOSTIC		235,448	505,946	741,394	971	119,927	54
54.01	ULTRASOUND		25,555	51,179	76,734	366	30,994	54.01
54.02	SPECIAL PROCEDURES		16,418	135,939	152,357	412	35,785	54.02
56	RADIOISOTOPE		17,243	38,178	55,421	162	30,417	56
57	CT SCAN		18,407	67,528	85,935	249	28,852	57
58	MRI		48,610	18,070	66,680	184	18,981	58
59	CARDIAC CATHETERIZATION		32,873	280,584	313,457	250	54,198	59
60	LABORATORY		123,349	161,465	284,814	2,078	260,428	60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
63	BLOOD STORING, PROCESSING & TRANS.		4,703	1,722	6,425	124	30,853	63
65	RESPIRATORY THERAPY		14,770	40,057	54,827	573	53,194	65
65.01	PULMONARY FUNCTION		7,112	4,093	11,205	25	2,350	65.01
66	PHYSICAL THERAPY		57,084	42,989	100,073	1,497	68,033	66
67	OCCUPATIONAL THERAPY		9,477	993	10,470	474	38,779	67
68	SPEECH PATHOLOGY		6,485	7,651	14,136	150	11,705	68
69	ELECTROCARDIOLOGY		33,607	115,104	148,711	260	34,359	69
70	ELECTROENCEPHALOGRAPHY		18,282	17,553	35,835	34	3,426	70
70.01	SLEEP LAB			10,415	10,415	47	3,843	70.01
70.02	PSYCH					294	41,175	70.02
71	MEDICAL SUPPLIES CHARGED TO PATIENTS						13,032	71
72	IMPL. DEV. CHARGED TO PATIENTS						256,796	72
73	DRUGS CHARGED TO PATIENTS						287,575	73
73.01	INFUSION THERAPY		13,919	1,923	15,842	167	14,527	73.01
73.02	IFCC INFUSION THERAPY		5,777		5,777	204	17,690	73.02
73.03	PHARMACY VACCINE						1,614	73.03
74	RENAL DIALYSIS		16,132	18,993	35,125	201	17,854	74
76.97	CARDIAC REHABILITATION		18,264	10,746	29,010	156	11,871	76.97
76.98	HYPERBARIC OXYGEN THERAPY			1,505	1,505	312	31,976	76.98
76.99	LITHOTRIPSY							76.99
	OUTPATIENT SERVICE COST CENTERS							
90.02	PSYCH ANCILLARY		125,391		125,391		44,976	90.02
90.03	RETINAL VASCULAR		97,131	14,769	111,900	77	10,431	90.03
91	EMERGENCY		83,946	65,767	149,713	1,258	124,995	91
91.01	IFCC			1,463,016	1,463,016	4,730	482,667	91.01
92	OBSERVATION BEDS (NON-DISTINCT PART)							92
	OTHER REIMBURSABLE COST CENTERS							
100	I&R SERVICES-NOT APPRVD PRGM						19,073	100
101	HOME HEALTH AGENCY		55,364		55,364		232,890	101
	SPECIAL PURPOSE COST CENTERS							
116	HOSPICE						54,652	116
118	SUBTOTALS (sum of lines 1-117)		6,525,907	8,570,615	15,096,522	35,355	4,513,863	118



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ALLOCATION OF CAPITAL-RELATED COSTS

WORKSHEET B
PART II

	COST CENTER DESCRIPTIONS	DIR ASSGND CAP-REL COSTS	CAP BLDGS & FIXTURES	CAP MOVABLE EQUIPMENT	SUBTOTAL	EMPLOYEE BENEFITS DEPARTMENT	ADMINIS- TRATIVE & GENERAL	
		0	1	2	2A	4	5	
	NONREIMBURSABLE COST CENTERS							
192	PHYSICIANS' PRIVATE OFFICES			1,646	1,646	8	38,536	192
192.01	REFERENCE LAB							192.01
192.02	OP PHARMACY		7,918		7,918		175	192.02
192.03	RETINAL VASCULAR GRANTS		4,479		4,479		99	192.03
192.04	AMBULANCE						51,089	192.04
200	CROSS FOOT ADJUSTMENTS							200
201	NEGATIVE COST CENTER							201
202	TOTAL (sum of lines 118-201)		6,538,304	8,572,261	15,110,565	35,363	4,603,762	202



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ALLOCATION OF CAPITAL-RELATED COSTS

WORKSHEET B
PART II

	COST CENTER DESCRIPTIONS	MAIN- TENANCE & REPAIRS	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSE- KEEPING	DIETARY	CAFETERIA	
		6	7	8	9	10	11	
	GENERAL SERVICE COST CENTERS							
1	CAP REL COSTS-BLDG & FIXT							1
2	CAP REL COSTS-MVBLE EQUIP							2
4	EMPLOYEE BENEFITS DEPARTMENT							4
5	ADMINISTRATIVE & GENERAL							5
6	MAINTENANCE & REPAIRS	256,589						6
7	OPERATION OF PLANT	28,122	718,116					7
8	LAUNDRY & LINEN SERVICE	1,937	6,089	67,659				8
9	HOUSEKEEPING	2,298	7,222		162,655			9
10	DIETARY	7,050	22,161		5,114	249,980		10
11	CAFETERIA	3,365	10,577		2,441		110,645	11
12	MAINTENANCE OF PERSONNEL							12
13	NURSING ADMINISTRATION	1,365	4,291		990		4,014	13
14	CENTRAL SERVICES & SUPPLY	2,544	7,997	139	1,845		627	14
15	PHARMACY	3,672	11,543		2,664			15
16	MEDICAL RECORDS & LIBRARY	5,323	16,733		3,862		3,838	16
17	SOCIAL SERVICE							17
19	NONPHYSICIAN ANESTHETISTS							19
20	NURSING SCHOOL							20
21	I&R SERVICES-SALARY & FRINGES APPRVD							21
22	I&R SERVICES-OTHER PRGM COSTS APPRVD							22
23	PARAMED ED PRGM-(SPECIFY)	79	250		58		187	23
23.01	PARAMED ED PRGM - EMS	397	1,249		288		902	23.01
23.02	PARAMED ED PRGM - DIETETICS	1,226	3,853		889		17	23.02
	INPATIENT ROUTINE SERV COST CENTERS							
30	ADULTS & PEDIATRICS	70,042	220,141	33,127	50,804	181,069	25,594	30
31	INTENSIVE CARE UNIT	6,741	21,188	4,021	4,890	16,226	3,369	31
40	SUBPROVIDER - IPF	2,116	6,652	1,332	1,535	19,149	1,060	40
41	SUBPROVIDER - IRF	26,779	84,171	3,508	19,425	30,364	3,374	41
43	NURSERY	3,153	9,910	869	2,287		1,567	43
	ANCILLARY SERVICE COST CENTERS							
50	OPERATING ROOM	23,448	73,703	7,638	17,009		6,314	50
51	RECOVERY ROOM	1,763	5,541	875	1,279		656	51
53	ANESTHESIOLOGY	228	718		166		303	53
54	RADIOLOGY-DIAGNOSTIC	13,929	43,782	2,173	10,104		3,395	54
54.01	ULTRASOUND	1,512	4,752	1,056	1,097		1,048	54.01
54.02	SPECIAL PROCEDURES	971	3,053	132	705		1,190	54.02
56	RADIOISOTOPE	1,020	3,206	213	740		415	56
57	CT SCAN	1,089	3,423	922	790		774	57
58	MRI	2,876	9,039	442	2,086		560	58
59	CARDIAC CATHETERIZATION	1,945	6,113	131	1,411		646	59
60	LABORATORY	7,297	22,937		5,293		8,868	60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
63	BLOOD STORING, PROCESSING & TRANS.	278	874		202		411	63
65	RESPIRATORY THERAPY	874	2,747		634		2,069	65
65.01	PULMONARY FUNCTION	421	1,322		305		86	65.01
66	PHYSICAL THERAPY	3,377	10,615	1,596	2,450		5,038	66
67	OCCUPATIONAL THERAPY	561	1,762		407		2,155	67
68	SPEECH PATHOLOGY	384	1,206		278		469	68
69	ELECTROCARDIOLOGY	1,988	6,249	712	1,442		854	69
70	ELECTROENCEPHALOGRAPHY	1,082	3,400	110	785		136	70
70.01	SLEEP LAB						168	70.01
70.02	PSYCH						471	70.02
71	MEDICAL SUPPLIES CHARGED TO PATIENTS							71
72	IMPL. DEV. CHARGED TO PATIENTS							72
73	DRUGS CHARGED TO PATIENTS						3,551	73
73.01	INFUSION THERAPY	823	2,588	176	597		568	73.01
73.02	IFCC INFUSION THERAPY	342	1,074		248		366	73.02
73.03	PHARMACY VACCINE							73.03
74	RENAL DIALYSIS	954	3,000		692		588	74
76.97	CARDIAC REHABILITATION	1,080	3,396	372	784		524	76.97
76.98	HYPERBARIC OXYGEN THERAPY			16			912	76.98
76.99	LITHOTRIPSY							76.99
	OUTPATIENT SERVICE COST CENTERS							
90.02	PSYCH ANCILLARY	7,418	23,317	811	5,381	1,586		90.02
90.03	RETINAL VASCULAR	5,746	18,062		4,168		414	90.03
91	EMERGENCY	4,966	15,610	7,288	3,602	1,586	4,284	91
91.01	IFCC						18,863	91.01
92	OBSERVATION BEDS (NON-DISTINCT PART)							92
	OTHER REIMBURSABLE COST CENTERS							
100	I&R SERVICES-NOT APPRVD PRGM							100
101	HOME HEALTH AGENCY	3,275	10,295		2,376			101
	SPECIAL PURPOSE COST CENTERS							
116	HOSPICE							116
118	SUBTOTALS (sum of lines 1-117)	255,856	715,811	67,659	162,123	249,980	110,645	118



COMPU-MAX

INGALLS MEMORIAL HOSPITAL Provider CCN: 14-0191	In Lieu of Form CMS-2552-10	Period : From: 10/01/2013 To: 09/30/2014	Run Date: 03/02/2015 Run Time: 10:44 Version: 2014.10
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ALLOCATION OF CAPITAL-RELATED COSTS

WORKSHEET B
PART II

	COST CENTER DESCRIPTIONS	MAIN-TENANCE & REPAIRS	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSE-KEEPING	DIETARY	CAFETERIA	
		6	7	8	9	10	11	
	NONREIMBURSABLE COST CENTERS							
192	PHYSICIANS' PRIVATE OFFICES							192
192.01	REFERENCE LAB							192.01
192.02	OP PHARMACY	468	1,472		340			192.02
192.03	RETINAL VASCULAR GRANTS	265	833		192			192.03
192.04	AMBULANCE							192.04
200	CROSS FOOT ADJUSTMENTS							200
201	NEGATIVE COST CENTER							201
202	TOTAL (sum of lines 118-201)	256,589	718,116	67,659	162,655	249,980	110,645	202



INGALLS MEMORIAL HOSPITAL Provider CCN: 14-0191	In Lieu of Form CMS-2552-10	Period : From: 10/01/2013 To: 09/30/2014	Run Date: 03/02/2015 Run Time: 10:44 Version: 2014.10
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ALLOCATION OF CAPITAL-RELATED COSTS

WORKSHEET B
PART II

	COST CENTER DESCRIPTIONS	NURSING ADMINISTRATION	CENTRAL SERVICES & SUPPLY	PHARMACY	MEDICAL RECORDS & LIBRARY	PARAMED EDUCATION		
		13	14	15	16	23	23.01	
	GENERAL SERVICE COST CENTERS							
1	CAP REL COSTS-BLDG & FIXT							1
2	CAP REL COSTS-MVBLE EQUIP							2
4	EMPLOYEE BENEFITS DEPARTMENT							4
5	ADMINISTRATIVE & GENERAL							5
6	MAINTENANCE & REPAIRS							6
7	OPERATION OF PLANT							7
8	LAUNDRY & LINEN SERVICE							8
9	HOUSEKEEPING							9
10	DIETARY							10
11	CAFETERIA							11
12	MAINTENANCE OF PERSONNEL							12
13	NURSING ADMINISTRATION	1,747,822						13
14	CENTRAL SERVICES & SUPPLY		130,323					14
15	PHARMACY			387,264				15
16	MEDICAL RECORDS & LIBRARY		3		230,609			16
17	SOCIAL SERVICE							17
19	NONPHYSICIAN ANESTHETISTS							19
20	NURSING SCHOOL							20
21	I&R SERVICES-SALARY & FRINGES APPRVD							21
22	I&R SERVICES-OTHER PRGM COSTS APPRVD							22
23	PARAMED ED PRGM-(SPECIFY)					6,684		23
23.01	PARAMED ED PRGM - EMS		17	76			39,639	23.01
23.02	PARAMED ED PRGM - DIETETICS							23.02
	INPATIENT ROUTINE SERV COST CENTERS							
30	ADULTS & PEDIATRICS	991,249	6,133	152	95,326			30
31	INTENSIVE CARE UNIT	124,953	1,700	61	8,803			31
40	SUBPROVIDER - IPF	39,306	13	1	9,651			40
41	SUBPROVIDER - IRF	125,160	537	5	15,439			41
43	NURSERY	58,127	194		6,183			43
	ANCILLARY SERVICE COST CENTERS							
50	OPERATING ROOM	192,312	20,895	79	9,072			50
51	RECOVERY ROOM	24,343	531		591			51
53	ANESTHESIOLOGY		1,042		1,566			53
54	RADIOLOGY-DIAGNOSTIC		363	387	4,752			54
54.01	ULTRASOUND		271		1,643			54.01
54.02	SPECIAL PROCEDURES		8,653	617	2,869			54.02
56	RADIOISOTOPE		3,126	19,478	1,272			56
57	CT SCAN		920	2,534	6,058			57
58	MRI		576		1,820			58
59	CARDIAC CATHETERIZATION		4,892	1,477	1,920			59
60	LABORATORY		13,632	8,883	13,904			60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
63	BLOOD STORING, PROCESSING & TRANS.		3,854	705	688			63
65	RESPIRATORY THERAPY		1,509	1	1,527			65
65.01	PULMONARY FUNCTION		8		108			65.01
66	PHYSICAL THERAPY		412	156	4,422			66
67	OCCUPATIONAL THERAPY		14		908			67
68	SPEECH PATHOLOGY		9		881			68
69	ELECTROCARDIOLOGY		389	2,026	3,215			69
70	ELECTROENCEPHALOGRAPHY		13		105			70
70.01	SLEEP LAB		20		122			70.01
70.02	PSYCH				354			70.02
71	MEDICAL SUPPLIES CHARGED TO PATIENTS		2,397		459			71
72	IMPL. DEV. CHARGED TO PATIENTS		47,229		2,899			72
73	DRUGS CHARGED TO PATIENTS			340,786	8,247			73
73.01	INFUSION THERAPY		247		599			73.01
73.02	IFCC INFUSION THERAPY		351		220			73.02
73.03	PHARMACY VACCINE			1,902	2			73.03
74	RENAL DIALYSIS		229					74
76.97	CARDIAC REHABILITATION		23	39	121			76.97
76.98	HYPERBARIC OXYGEN THERAPY		569	126	434			76.98
76.99	LITHOTRIPSY							76.99
	OUTPATIENT SERVICE COST CENTERS							
90.02	PSYCH ANCILLARY				626			90.02
90.03	RETINAL VASCULAR		29	33	91			90.03
91	EMERGENCY	192,372	3,422	3	7,329			91
91.01	IFCC		6,101	7,737	16,383			91.01
92	OBSERVATION BEDS (NON-DISTINCT PART)							92
	OTHER REIMBURSABLE COST CENTERS							
100	I&R SERVICES-NOT APPRVD PRGM							100
101	HOME HEALTH AGENCY							101
	SPECIAL PURPOSE COST CENTERS							
116	HOSPICE							116
118	SUBTOTALS (sum of lines 1-117)	1,747,822	130,323	387,264	230,609			118



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ALLOCATION OF CAPITAL-RELATED COSTS

WORKSHEET B
PART II

	COST CENTER DESCRIPTIONS	NURSING ADMINIS-TRATION	CENTRAL SERVICES & SUPPLY	PHARMACY	MEDICAL RECORDS & LIBRARY	PARAMED EDUCATION		
		13	14	15	16	23	23.01	
	NONREIMBURSABLE COST CENTERS							
192	PHYSICIANS' PRIVATE OFFICES							192
192.01	REFERENCE LAB							192.01
192.02	OP PHARMACY							192.02
192.03	RETINAL VASCULAR GRANTS							192.03
192.04	AMBULANCE							192.04
200	CROSS FOOT ADJUSTMENTS					6,684	39,639	200
201	NEGATIVE COST CENTER							201
202	TOTAL (sum of lines 118-201)	1,747,822	130,323	387,264	230,609	6,684	39,639	202



COMPU-MAX

INGALLS MEMORIAL HOSPITAL Provider CCN: 14-0191	In Lieu of Form CMS-2552-10	Period : From: 10/01/2013 To: 09/30/2014	Run Date: 03/02/2015 Run Time: 10:44 Version: 2014.10
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ALLOCATION OF CAPITAL-RELATED COSTS

WORKSHEET B
PART II

	COST CENTER DESCRIPTIONS		SUBTOTAL	I&R COST & POST STEP-DOWN ADJS	TOTAL		
		23.02	24	25	26		
	GENERAL SERVICE COST CENTERS						
1	CAP REL COSTS-BLDG & FIXT						1
2	CAP REL COSTS-MVBLE EQUIP						2
4	EMPLOYEE BENEFITS DEPARTMENT						4
5	ADMINISTRATIVE & GENERAL						5
6	MAINTENANCE & REPAIRS						6
7	OPERATION OF PLANT						7
8	LAUNDRY & LINEN SERVICE						8
9	HOUSEKEEPING						9
10	DIETARY						10
11	CAFETERIA						11
12	MAINTENANCE OF PERSONNEL						12
13	NURSING ADMINISTRATION						13
14	CENTRAL SERVICES & SUPPLY						14
15	PHARMACY						15
16	MEDICAL RECORDS & LIBRARY						16
17	SOCIAL SERVICE						17
19	NONPHYSICIAN ANESTHETISTS						19
20	NURSING SCHOOL						20
21	I&R SERVICES-SALARY & FRINGES APPRVD						21
22	I&R SERVICES-OTHER PRGM COSTS APPRVD						22
23	PARAMED ED PRGM-(SPECIFY)						23
23.01	PARAMED ED PRGM - EMS						23.01
23.02	PARAMED ED PRGM - DIETETICS	28,425					23.02
	INPATIENT ROUTINE SERV COST CENTERS						
30	ADULTS & PEDIATRICS		3,788,848		3,788,848		30
31	INTENSIVE CARE UNIT		500,802		500,802		31
40	SUBPROVIDER - IPF		157,938		157,938		40
41	SUBPROVIDER - IRF		854,747		854,747		41
43	NURSERY		189,853		189,853		43
	ANCILLARY SERVICE COST CENTERS						
50	OPERATING ROOM		1,417,743		1,417,743		50
51	RECOVERY ROOM		111,791		111,791		51
53	ANESTHESIOLOGY		86,620		86,620		53
54	RADIOLOGY-DIAGNOSTIC		941,177		941,177		54
54.01	ULTRASOUND		119,473		119,473		54.01
54.02	SPECIAL PROCEDURES		206,744		206,744		54.02
56	RADIOISOTOPE		115,470		115,470		56
57	CT SCAN		131,546		131,546		57
58	MRI		103,244		103,244		58
59	CARDIAC CATHETERIZATION		386,440		386,440		59
60	LABORATORY		628,134		628,134		60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS						62.30
63	BLOOD STORING, PROCESSING & TRANS.		44,414		44,414		63
65	RESPIRATORY THERAPY		117,955		117,955		65
65.01	PULMONARY FUNCTION		15,830		15,830		65.01
66	PHYSICAL THERAPY		197,669		197,669		66
67	OCCUPATIONAL THERAPY		55,530		55,530		67
68	SPEECH PATHOLOGY		29,218		29,218		68
69	ELECTROCARDIOLOGY		200,205		200,205		69
70	ELECTROENCEPHALOGRAPHY		44,926		44,926		70
70.01	SLEEP LAB		14,615		14,615		70.01
70.02	PSYCH		42,294		42,294		70.02
71	MEDICAL SUPPLIES CHARGED TO PATIENTS		15,888		15,888		71
72	IMPL. DEV. CHARGED TO PATIENTS		306,924		306,924		72
73	DRUGS CHARGED TO PATIENTS		640,159		640,159		73
73.01	INFUSION THERAPY		36,134		36,134		73.01
73.02	IFCC INFUSION THERAPY		26,272		26,272		73.02
73.03	PHARMACY VACCINE		3,518		3,518		73.03
74	RENAL DIALYSIS		58,643		58,643		74
76.97	CARDIAC REHABILITATION		47,376		47,376		76.97
76.98	HYPERBARIC OXYGEN THERAPY		35,850		35,850		76.98
76.99	LITHOTRIPSY						76.99
	OUTPATIENT SERVICE COST CENTERS						
90.02	PSYCH ANCILLARY		209,506		209,506		90.02
90.03	RETINAL VASCULAR		150,951		150,951		90.03
91	EMERGENCY		516,428		516,428		91
91.01	IFCC		1,999,497		1,999,497		91.01
92	OBSERVATION BEDS (NON-DISTINCT PART)						92
	OTHER REIMBURSABLE COST CENTERS						
100	I&R SERVICES-NOT APPRVD PRGM		19,073		19,073		100
101	HOME HEALTH AGENCY		304,200		304,200		101
	SPECIAL PURPOSE COST CENTERS						
116	HOSPICE		54,652		54,652		116
118	SUBTOTALS (sum of lines 1-117)		14,928,297		14,928,297		118



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ALLOCATION OF CAPITAL-RELATED COSTS

WORKSHEET B
PART II

	COST CENTER DESCRIPTIONS		SUBTOTAL	I&R COST & POST STEP-DOWN ADJS	TOTAL		
		23.02	24	25	26		
	NONREIMBURSABLE COST CENTERS						
192	PHYSICIANS' PRIVATE OFFICES		40,190		40,190		192
192.01	REFERENCE LAB						192.01
192.02	OP PHARMACY		10,373		10,373		192.02
192.03	RETINAL VASCULAR GRANTS		5,868		5,868		192.03
192.04	AMBULANCE		51,089		51,089		192.04
200	CROSS FOOT ADJUSTMENTS	28,425	74,748		74,748		200
201	NEGATIVE COST CENTER						201
202	TOTAL (sum of lines 118-201)	28,425	15,110,565		15,110,565		202



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COST ALLOCATION - STATISTICAL BASIS

WORKSHEET B-1

	COST CENTER DESCRIPTIONS	CAP BLDGS & FIXTURES SQUARE FEET	CAP MOVABLE EQUIPMENT DOLLAR VALUE	EMPLOYEE BENEFITS DEPARTMENT GROSS SALARIES	RECONCILIATION	ADMINISTRATIVE & GENERAL ACCUM COST	MAINTENANCE & REPAIRS SQUARE FEET	
		1	2	4	5A	5	6	
	GENERAL SERVICE COST CENTERS							
1	CAP REL COSTS-BLDG & FIXT	729,953						1
2	CAP REL COSTS-MVBLE EQUIP		10,386,830					2
4	EMPLOYEE BENEFITS DEPARTMENT	3,948		97,219,204				4
5	ADMINISTRATIVE & GENERAL	223,150	3,150,711	12,876,060	-69,764,399	208,294,552		5
6	MAINTENANCE & REPAIRS	18,642	8,184			3,748,811	484,213	6
7	OPERATION OF PLANT	53,069	50,437	819,593		7,814,799	53,069	7
8	LAUNDRY & LINEN SERVICE	3,656	1,135	88,528		1,172,601	3,656	8
9	HOUSEKEEPING	4,336	31,054	915		4,011,756	4,336	9
10	DIETARY	13,305	52,299			2,412,341	13,305	10
11	CAFETERIA	6,350	849			1,659,710	6,350	11
12	MAINTENANCE OF PERSONNEL							12
13	NURSING ADMINISTRATION	2,576	1,929,930	2,915,308		5,440,869	2,576	13
14	CENTRAL SERVICES & SUPPLY	4,801	75,937	255,824		515,982	4,801	14
15	PHARMACY	6,930	242,084	3,505,720		4,806,984	6,930	15
16	MEDICAL RECORDS & LIBRARY	10,046	4,386	2,571,712		4,809,958	10,046	16
17	SOCIAL SERVICE							17
19	NONPHYSICIAN ANESTHETISTS							19
20	NURSING SCHOOL							20
21	I&R SERVICES-SALARY & FRINGES APPRVD							21
22	I&R SERVICES-OTHER PRGM COSTS APPRVD							22
23	PARAMED ED PRGM-(SPECIFY)	150		140,763		213,323	150	23
23.01	PARAMED ED PRGM - EMS	750	16,872	747,298		714,703	750	23.01
23.02	PARAMED ED PRGM - DIETETICS	2,313		17,113		77,628	2,313	23.02
	INPATIENT ROUTINE SERV COST CENTERS							
30	ADULTS & PEDIATRICS	132,168	370,668	18,309,755		27,996,298	132,168	30
31	INTENSIVE CARE UNIT	12,721	117,499	2,978,992		4,381,966	12,721	31
40	SUBPROVIDER - IPF	3,994	6,072	713,689		1,632,317	3,994	40
41	SUBPROVIDER - IRF	50,535	9,101	2,564,621		3,840,815	50,535	41
43	NURSERY	5,950	6,834	1,293,642		2,178,856	5,950	43
	ANCILLARY SERVICE COST CENTERS							
50	OPERATING ROOM	44,250	485,883	4,278,796		12,141,983	44,250	50
51	RECOVERY ROOM	3,327	27,423	711,285		1,064,187	3,327	51
53	ANESTHESIOLOGY	431	70,128	500,690		935,520	431	53
54	RADIOLOGY-DIAGNOSTIC	26,286	613,044	2,666,469		5,426,069	26,286	54
54.01	ULTRASOUND	2,853	62,012	1,006,386		1,402,337	2,853	54.01
54.02	SPECIAL PROCEDURES	1,833	164,715	1,131,734		1,619,075	1,833	54.02
56	RADIOISOTOPE	1,925	46,259	443,713		1,376,204	1,925	56
57	CT SCAN	2,055	81,822	683,994		1,305,406	2,055	57
58	MRI	5,427	21,895	505,621		858,788	5,427	58
59	CARDIAC CATHETERIZATION	3,670	339,978	685,697		2,452,164	3,670	59
60	LABORATORY	13,771	195,644	5,708,267		11,783,006	13,771	60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
63	BLOOD STORING, PROCESSING & TRANS.	525	2,087	341,734		1,395,925	525	63
65	RESPIRATORY THERAPY	1,649	48,536	1,575,278		2,406,764	1,649	65
65.01	PULMONARY FUNCTION	794	4,960	68,254		106,334	794	65.01
66	PHYSICAL THERAPY	6,373	52,089	4,111,799		3,078,150	6,373	66
67	OCCUPATIONAL THERAPY	1,058	1,203	1,301,217		1,754,553	1,058	67
68	SPEECH PATHOLOGY	724	9,270	412,861		529,569	724	68
69	ELECTROCARDIOLOGY	3,752	139,469	713,027		1,554,572	3,752	69
70	ELECTROENCEPHALOGRAPHY	2,041	21,268	93,081		154,994	2,041	70
70.01	SLEEP LAB		12,620	128,638		173,883		70.01
70.02	PSYCH			808,785		1,862,935		70.02
71	MEDICAL SUPPLIES CHARGED TO PATIENTS					589,629		71
72	IMPL. DEV. CHARGED TO PATIENTS					11,618,667		72
73	DRUGS CHARGED TO PATIENTS					13,011,255		73
73.01	INFUSION THERAPY	1,554	2,330	458,678		657,289	1,554	73.01
73.02	IFCC INFUSION THERAPY	645		559,151		800,361	645	73.02
73.03	PHARMACY VACCINE					73,034		73.03
74	RENAL DIALYSIS	1,801	23,014	552,844		807,800	1,801	74
76.97	CARDIAC REHABILITATION	2,039	13,021	428,788		537,092	2,039	76.97
76.98	HYPERBARIC OXYGEN THERAPY		1,824	857,637		1,446,737		76.98
76.99	LITHOTRIPSY							76.99
	OUTPATIENT SERVICE COST CENTERS							
90.02	PSYCH ANCILLARY	13,999				2,034,946	13,999	90.02
90.03	RETINAL VASCULAR	10,844	17,895	212,178		471,933	10,844	90.03
91	EMERGENCY	9,372	79,688	3,456,498		5,655,352	9,372	91
91.01	IFCC		1,772,706	12,995,737		21,838,167		91.01
92	OBSERVATION BEDS (NON-DISTINCT PART)							92
	OTHER REIMBURSABLE COST CENTERS							
100	I&R SERVICES-NOT APPRVD PRGM					862,953		100
101	HOME HEALTH AGENCY	6,181				10,537,051	6,181	101
	SPECIAL PURPOSE COST CENTERS							
116	HOSPICE					2,472,721		116



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COST ALLOCATION - STATISTICAL BASIS

WORKSHEET B-1

	COST CENTER DESCRIPTIONS	CAP BLDGS & FIXTURES SQUARE FEET	CAP MOVABLE EQUIPMENT DOLLAR VALUE	EMPLOYEE BENEFITS DEPARTMENT GROSS SALARIES	RECONCILIATION	ADMINISTRATIVE & GENERAL ACCUM COST	MAINTENANCE & REPAIRS SQUARE FEET	
		1	2	4	5A	5	6	
118	SUBTOTALS (sum of lines 1-117)	728,569	10,384,835	97,198,370	-69,764,399	204,227,122	482,829	118
	NONREIMBURSABLE COST CENTERS							
192	PHYSICIANS' PRIVATE OFFICES		1,995	20,834		1,743,542		192
192.01	REFERENCE LAB							192.01
192.02	OP PHARMACY	884				7,918	884	192.02
192.03	RETINAL VASCULAR GRANTS	500				4,479	500	192.03
192.04	AMBULANCE					2,311,491		192.04
200	CROSS FOOT ADJUSTMENTS							200
201	NEGATIVE COST CENTER							201
202	COST TO BE ALLOC PER B PT I	6,538,304	8,572,261	22,432,579		69,764,399	5,004,404	202
203	UNIT COST MULT-WS B PT I	8.957158	0.825301	0.230742		0.334931	10.335129	203
204	COST TO BE ALLOC PER B PT II			35,363		4,603,762	256,589	204
205	UNIT COST MULT-WS B PT II			0.000364		0.022102	0.529909	205



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COST ALLOCATION - STATISTICAL BASIS

WORKSHEET B-1

	COST CENTER DESCRIPTIONS	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSE-KEEPING	DIETARY	CAFETERIA	NURSING ADMINISTRATION	
		SQUARE FEET	POUNDS OF LAUNDRY	SQUARE FEET	MEALS SERVED	FTES	DIRECT NRSING HRS	
		7	8	9	10	11	13	
	GENERAL SERVICE COST CENTERS							
1	CAP REL COSTS-BLDG & FIXT							1
2	CAP REL COSTS-MVBLE EQUIP							2
4	EMPLOYEE BENEFITS DEPARTMENT							4
5	ADMINISTRATIVE & GENERAL							5
6	MAINTENANCE & REPAIRS							6
7	OPERATION OF PLANT	431,144						7
8	LAUNDRY & LINEN SERVICE	3,656	1,610,869					8
9	HOUSEKEEPING	4,336		423,152				9
10	DIETARY	13,305		13,305	371,927			10
11	CAFETERIA	6,350		6,350		138,249		11
12	MAINTENANCE OF PERSONNEL							12
13	NURSING ADMINISTRATION	2,576		2,576		5,015	58,875	13
14	CENTRAL SERVICES & SUPPLY	4,801	3,312	4,801		783		14
15	PHARMACY	6,930		6,930				15
16	MEDICAL RECORDS & LIBRARY	10,046		10,046		4,796		16
17	SOCIAL SERVICE							17
19	NONPHYSICIAN ANESTHETISTS							19
20	NURSING SCHOOL							20
21	I&R SERVICES-SALARY & FRINGES APPRVD							21
22	I&R SERVICES-OTHER PRGM COSTS APPRVD							22
23	PARAMED ED PRGM-(SPECIFY)	150		150		234		23
23.01	PARAMED ED PRGM - EMS	750		750		1,127		23.01
23.02	PARAMED ED PRGM - DIETETICS	2,313		2,313		21		23.02
	INPATIENT ROUTINE SERV COST CENTERS							
30	ADULTS & PEDIATRICS	132,168	788,680	132,168	269,399	31,979	33,390	30
31	INTENSIVE CARE UNIT	12,721	95,745	12,721	24,141	4,209	4,209	31
40	SUBPROVIDER - IPF	3,994	31,712	3,994	28,490	1,324	1,324	40
41	SUBPROVIDER - IRF	50,535	83,516	50,535	45,177	4,216	4,216	41
43	NURSERY	5,950	20,694	5,950		1,958	1,958	43
	ANCILLARY SERVICE COST CENTERS							
50	OPERATING ROOM	44,250	181,855	44,250		7,889	6,478	50
51	RECOVERY ROOM	3,327	20,830	3,327		820	820	51
53	ANESTHESIOLOGY	431		431		379		53
54	RADIOLOGY-DIAGNOSTIC	26,286	51,738	26,286		4,242		54
54.01	ULTRASOUND	2,853	25,130	2,853		1,309		54.01
54.02	SPECIAL PROCEDURES	1,833	3,142	1,833		1,487		54.02
56	RADIOISOTOPE	1,925	5,081	1,925		519		56
57	CT SCAN	2,055	21,955	2,055		967		57
58	MRI	5,427	10,528	5,427		700		58
59	CARDIAC CATHETERIZATION	3,670	3,111	3,670		807		59
60	LABORATORY	13,771		13,771		11,080		60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
63	BLOOD STORING, PROCESSING & TRANS.	525		525		513		63
65	RESPIRATORY THERAPY	1,649		1,649		2,585		65
65.01	PULMONARY FUNCTION	794		794		107		65.01
66	PHYSICAL THERAPY	6,373	37,993	6,373		6,295		66
67	OCCUPATIONAL THERAPY	1,058		1,058		2,693		67
68	SPEECH PATHOLOGY	724		724		586		68
69	ELECTROCARDIOLOGY	3,752	16,958	3,752		1,067		69
70	ELECTROENCEPHALOGRAPHY	2,041	2,628	2,041		170		70
70.01	SLEEP LAB					210		70.01
70.02	PSYCH					589		70.02
71	MEDICAL SUPPLIES CHARGED TO PATIENTS							71
72	IMPL. DEV. CHARGED TO PATIENTS							72
73	DRUGS CHARGED TO PATIENTS					4,437		73
73.01	INFUSION THERAPY	1,554	4,197	1,554		710		73.01
73.02	IFCC INFUSION THERAPY	645		645		457		73.02
73.03	PHARMACY VACCINE							73.03
74	RENAL DIALYSIS	1,801		1,801		735		74
76.97	CARDIAC REHABILITATION	2,039	8,852	2,039		655		76.97
76.98	HYPERBARIC OXYGEN THERAPY		383			1,140		76.98
76.99	LITHOTRIPSY							76.99
	OUTPATIENT SERVICE COST CENTERS							
90.02	PSYCH ANCILLARY	13,999	19,319	13,999	2,360			90.02
90.03	RETINAL VASCULAR	10,844		10,844		517		90.03
91	EMERGENCY	9,372	173,510	9,372	2,360	5,353	6,480	91
91.01	IFCC					23,569		91.01
92	OBSERVATION BEDS (NON-DISTINCT PART)							92
	OTHER REIMBURSABLE COST CENTERS							
100	I&R SERVICES-NOT APPRVD PRGM							100
101	HOME HEALTH AGENCY	6,181		6,181				101
	SPECIAL PURPOSE COST CENTERS							
116	HOSPICE							116



COMPU-MAX

INGALLS MEMORIAL HOSPITAL Provider CCN: 14-0191	In Lieu of Form CMS-2552-10	Period : From: 10/01/2013 To: 09/30/2014	Run Date: 03/02/2015 Run Time: 10:44 Version: 2014.10
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COST ALLOCATION - STATISTICAL BASIS

WORKSHEET B-1

	COST CENTER DESCRIPTIONS	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSE- KEEPING	DIETARY	CAFETERIA	NURSING ADMINIS- TRATION DIRECT	
		SQUARE FEET	POUNDS OF LAUNDRY	SQUARE FEET	MEALS SERVED	FTES	NRSING HRS	
		7	8	9	10	11	13	
118	SUBTOTALS (sum of lines 1-117)	429,760	1,610,869	421,768	371,927	138,249	58,875	118
	NONREIMBURSABLE COST CENTERS							
192	PHYSICIANS' PRIVATE OFFICES							192
192.01	REFERENCE LAB							192.01
192.02	OP PHARMACY	884		884				192.02
192.03	RETINAL VASCULAR GRANTS	500		500				192.03
192.04	AMBULANCE							192.04
200	CROSS FOOT ADJUSTMENTS							200
201	NEGATIVE COST CENTER							201
202	COST TO BE ALLOC PER B PT I	10,980,692	1,696,240	5,510,662	3,869,950	2,525,647	7,480,580	202
203	UNIT COST MULT-WS B PT I	25,468,734	1,052,997	13,022,890	10,405,133	18,268,827	127,058,684	203
204	COST TO BE ALLOC PER B PT II	718,116	67,659	162,655	249,980	110,645	1,747,822	204
205	UNIT COST MULT-WS B PT II	1,665,606	0.042002	0.384389	0.672121	0.800331	29,686,998	205



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COST ALLOCATION - STATISTICAL BASIS

WORKSHEET B-1

	COST CENTER DESCRIPTIONS	CENTRAL SERVICES & SUPPLY COSTED REQUIS.	PHARMACY COSTED REQUIS.	MEDICAL RECORDS & LIBRARY TIME SPENT	PARAMED EDUCATION ASSIGNED TIME	TIME SPENT	MEALS SERVED	
		14	15	16	23	23.01	23.02	
	SPECIAL PURPOSE COST CENTERS							
116	HOSPICE							116
118	SUBTOTALS (sum of lines 1-117)	32,054,905	14,868,846	3,324,810	100	120	188	118
	NONREIMBURSABLE COST CENTERS							
192	PHYSICIANS' PRIVATE OFFICES	38						192
192.01	REFERENCE LAB							192.01
192.02	OP PHARMACY							192.02
192.03	RETINAL VASCULAR GRANTS							192.03
192.04	AMBULANCE							192.04
200	CROSS FOOT ADJUSTMENTS							200
201	NEGATIVE COST CENTER							201
202	COST TO BE ALLOC PER B PT I	941,009	6,755,361	6,999,112	296,369	1,012,727	216,948	202
203	UNIT COST MULT-WS B PT I	0.029356	0.454330	2.105116	2,963.690000	8,439.391667	1,153.978723	203
204	COST TO BE ALLOC PER B PT II	130,323	387,264	230,609	6,684	39,639	28,425	204
205	UNIT COST MULT-WS B PT II	0.004066	0.026045	0.069360	66.840000	330.325000	151.196809	205



COMPU-MAX

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POST STEPDOWN ADJUSTMENTS

WORKSHEET B-2

	DESCRIPTION	WORKSHEET		
		PART	LINE NO.	AMOUNT
	1	2	3	4



COMPU-MAX

INGALLS MEMORIAL HOSPITAL Provider CCN: 14-0191	In Lieu of Form CMS-2552-10	Period : From: 10/01/2013 To: 09/30/2014	Run Date: 03/02/2015 Run Time: 10:44 Version: 2014.10
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COMPUTATION OF RATIO OF COST TO CHARGES

WORKSHEET C
PART I

	COST CENTER DESCRIPTIONS	COSTS					
		TOTAL COST (from Wkst. B, Part I, col. 26)	THERAPY LIMIT ADJ.	TOTAL COSTS	RCE DISALLOW- ANCE	TOTAL COSTS	
		1	2	3	4	5	
	INPATIENT ROUTINE SERV COST CENTERS						
30	ADULTS & PEDIATRICS	55,477,371		55,477,371		55,477,371	30
31	INTENSIVE CARE UNIT	7,845,068		7,845,068		7,845,068	31
40	SUBPROVIDER - IPF	3,206,650		3,206,650		3,206,650	40
41	SUBPROVIDER - IRF	9,288,730		9,288,730	23,016	9,311,746	41
43	NURSERY	3,694,550		3,694,550		3,694,550	43
	ANCILLARY SERVICE COST CENTERS						
50	OPERATING ROOM	19,989,340		19,989,340	26,600	20,015,940	50
51	RECOVERY ROOM	1,745,940		1,745,940		1,745,940	51
53	ANESTHESIOLOGY	1,331,879		1,331,879		1,331,879	53
54	RADIOLOGY-DIAGNOSTIC	8,812,443		8,812,443	126,488	8,938,931	54
54.01	ULTRASOUND	2,113,524		2,113,524		2,113,524	54.01
54.02	SPECIAL PROCEDURES	2,441,638		2,441,638		2,441,638	54.02
56	RADIOISOTOPE	2,346,904		2,346,904		2,346,904	56
57	CT SCAN	2,118,440		2,118,440		2,118,440	57
58	MRI	1,494,689		1,494,689		1,494,689	58
59	CARDIAC CATHETERIZATION	3,590,027		3,590,027	15,000	3,605,027	59
60	LABORATORY	17,279,688		17,279,688		17,279,688	60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS						62.30
63	BLOOD STORING, PROCESSING & TRANS.	1,959,482		1,959,482		1,959,482	63
65	RESPIRATORY THERAPY	3,431,618		3,431,618		3,431,618	65
65.01	PULMONARY FUNCTION	186,002		186,002		186,002	65.01
66	PHYSICAL THERAPY	4,715,218		4,715,218		4,715,218	66
67	OCCUPATIONAL THERAPY	2,470,736		2,470,736		2,470,736	67
68	SPEECH PATHOLOGY	779,800		779,800		779,800	68
69	ELECTROCARDIOLOGY	2,465,285		2,465,285	246,346	2,711,631	69
70	ELECTROENCEPHALOGRAPHY	315,721		315,721		315,721	70
70.01	SLEEP LAB	239,806		239,806		239,806	70.01
70.02	PSYCH	2,510,717		2,510,717		2,510,717	70.02
71	MEDICAL SUPPLIES CHARGED TO PATIENTS	818,346		818,346		818,346	71
72	IMPL. DEV. CHARGED TO PATIENTS	15,939,172		15,939,172		15,939,172	72
73	DRUGS CHARGED TO PATIENTS	23,941,451		23,941,451		23,941,451	73
73.01	INFUSION THERAPY	990,667		990,667		990,667	73.01
73.02	IFCC INFUSION THERAPY	1,117,479		1,117,479		1,117,479	73.02
73.03	PHARMACY VACCINE	130,744		130,744		130,744	73.03
74	RENAL DIALYSIS	1,181,381		1,181,381	6,000	1,187,381	74
76.97	CARDIAC REHABILITATION	842,362		842,362	4,850	847,212	76.97
76.98	HYPERBARIC OXYGEN THERAPY	1,972,014		1,972,014		1,972,014	76.98
76.99	LITHOTRIPSY						76.99
	OUTPATIENT SERVICE COST CENTERS						
90.02	PSYCH ANCILLARY	3,463,945		3,463,945		3,463,945	90.02
90.03	RETINAL VASCULAR	1,172,456		1,172,456	12,000	1,184,456	90.03
91	EMERGENCY	10,060,163		10,060,163		10,060,163	91
91.01	IFCC	30,259,263		30,259,263		30,259,263	91.01
92	OBSERVATION BEDS (NON-DISTINCT PART)	4,327,872		4,327,872		4,327,872	92
	OTHER REIMBURSABLE COST CENTERS						
100	I&R SERVICES-NOT APPRVD PRGM	1,151,983		1,151,983		1,151,983	100
101	HOME HEALTH AGENCY	14,368,033		14,368,033		14,368,033	101
116	HOSPICE	3,300,912		3,300,912		3,300,912	116
200	SUBTOTAL (SEE INSTRUCTIONS)	276,889,509		276,889,509	460,300	277,349,809	200
201	LESS OBSERVATION BEDS	4,327,872		4,327,872		4,327,872	201
202	TOTAL (SEE INSTRUCTIONS)	272,561,637		272,561,637		273,021,937	202



COMPU-MAX

INGALLS MEMORIAL HOSPITAL Provider CCN: 14-0191	In Lieu of Form CMS-2552-10	Period : From: 10/01/2013 To: 09/30/2014	Run Date: 03/02/2015 Run Time: 10:44 Version: 2014.10
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COMPUTATION OF RATIO OF COST TO CHARGES

WORKSHEET C
PART I

	COST CENTER DESCRIPTIONS	CHARGES			COST OR OTHER RATIO	TEFRA INPATIENT RATIO	PPS INPATIENT RATIO	
		INPATIENT	OUTPATIENT	TOTAL (column 6 + column 7)				
		6	7	8	9	10	11	
	INPATIENT ROUTINE SERV COST CENTERS							
30	ADULTS & PEDIATRICS	79,036,769		79,036,769				30
31	INTENSIVE CARE UNIT	9,210,287		9,210,287				31
40	SUBPROVIDER - IPF	3,686,900		3,686,900				40
41	SUBPROVIDER - IRF	7,755,863		7,755,863				41
43	NURSERY	3,539,784		3,539,784				43
	ANCILLARY SERVICE COST CENTERS							
50	OPERATING ROOM	52,262,780	47,599,559	99,862,339	0.200169	0.200169	0.200435	50
51	RECOVERY ROOM	2,847,726	3,563,359	6,411,085	0.272331	0.272331	0.272331	51
53	ANESTHESIOLOGY	9,171,925	7,888,169	17,060,094	0.078070	0.078070	0.078070	53
54	RADIOLOGY-DIAGNOSTIC	7,766,039	25,845,146	33,611,185	0.262188	0.262188	0.265951	54
54.01	ULTRASOUND	4,128,660	9,112,064	13,240,724	0.159623	0.159623	0.159623	54.01
54.02	SPECIAL PROCEDURES	14,219,484	19,599,669	33,819,153	0.072197	0.072197	0.072197	54.02
56	RADIOISOTOPE	3,180,435	7,489,168	10,669,603	0.219962	0.219962	0.219962	56
57	CT SCAN	23,572,627	41,667,429	65,240,056	0.032471	0.032471	0.032471	57
58	MRI	7,900,627	11,348,156	19,248,783	0.077651	0.077651	0.077651	58
59	CARDIAC CATHETERIZATION	10,227,908	9,009,781	19,237,689	0.186614	0.186614	0.187394	59
60	LABORATORY	53,201,956	105,079,530	158,281,486	0.109171	0.109171	0.109171	60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
63	BLOOD STORING, PROCESSING & TRANS.	4,419,617	1,846,136	6,265,753	0.312729	0.312729	0.312729	63
65	RESPIRATORY THERAPY	16,860,523	2,411,985	19,272,508	0.178058	0.178058	0.178058	65
65.01	PULMONARY FUNCTION	297,152	854,381	1,151,533	0.161526	0.161526	0.161526	65.01
66	PHYSICAL THERAPY	7,117,593	14,843,112	21,960,705	0.214712	0.214712	0.214712	66
67	OCCUPATIONAL THERAPY	5,994,713	1,112	5,995,825	0.412076	0.412076	0.412076	67
68	SPEECH PATHOLOGY	3,008,871		3,008,871	0.259167	0.259167	0.259167	68
69	ELECTROCARDIOLOGY	12,672,364	10,680,648	23,353,012	0.105566	0.105566	0.116115	69
70	ELECTROENCEPHALOGRAPHY	799,653	365,230	1,164,883	0.271032	0.271032	0.271032	70
70.01	SLEEP LAB	493,255	925,403	1,418,658	0.169037	0.169037	0.169037	70.01
70.02	PSYCH	5,406,160		5,406,160	0.464418	0.464418	0.464418	70.02
71	MEDICAL SUPPLIES CHARGED TO PATIENTS	2,921,693	2,112,671	5,034,364	0.162552	0.162552	0.162552	71
72	IMPL. DEV. CHARGED TO PATIENTS	20,574,153	9,333,732	29,907,885	0.532942	0.532942	0.532942	72
73	DRUGS CHARGED TO PATIENTS	46,951,518	74,976,901	121,928,419	0.196357	0.196357	0.196357	73
73.01	INFUSION THERAPY	42,568	4,486,644	4,529,212	0.218728	0.218728	0.218728	73.01
73.02	IFCC INFUSION THERAPY	34,645	4,780,262	4,814,907	0.232087	0.232087	0.232087	73.02
73.03	PHARMACY VACCINE		147,919	147,919	0.883889	0.883889	0.883889	73.03
74	RENAL DIALYSIS	1,573,248	319,793	1,893,041	0.624065	0.624065	0.627235	74
76.97	CARDIAC REHABILITATION	81,801	754,566	836,367	1.007168	1.007168	1.012967	76.97
76.98	HYPERBARIC OXYGEN THERAPY	1,678,069	6,532,634	8,210,703	0.240176	0.240176	0.240176	76.98
76.99	LITHOTRIPSY							76.99
	OUTPATIENT SERVICE COST CENTERS							
90.02	PSYCH ANCILLARY	1,599,675	6,423,914	8,023,589	0.431720	0.431720	0.431720	90.02
90.03	RETINAL VASCULAR	6,657	821,380	828,037	1.415946	1.415946	1.430438	90.03
91	EMERGENCY	15,732,267	68,642,113	84,374,380	0.119232	0.119232	0.119232	91
91.01	IFCC	3,741,931	181,794,071	185,536,002	0.163091	0.163091	0.163091	91.01
92	OBSERVATION BEDS (NON-DISTINCT PART)		6,754,808	6,754,808	0.640710	0.640710	0.640710	92
	OTHER REIMBURSABLE COST CENTERS							
100	I&R SERVICES-NOT APPRVD PRGM							100
101	HOME HEALTH AGENCY		15,742,183	15,742,183				101
116	HOSPICE		4,540,430	4,540,430				116
200	SUBTOTAL (SEE INSTRUCTIONS)	443,717,896	708,294,058	1,152,011,954				200
201	LESS OBSERVATION BEDS							201
202	TOTAL (SEE INSTRUCTIONS)	443,717,896	708,294,058	1,152,011,954				202



COMPU-MAX

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APPORTIONMENT OF INPATIENT ROUTINE SERVICE CAPITAL COSTS

WORKSHEET D
PART I

CHECK TITLE V PPS
 APPLICABLE TITLE XVIII, PART A TEFRA
 BOXES: TITLE XIX

(A)	COST CENTER DESCRIPTION	CAPITAL RELATED COST (from Wkst. B, Part II, (col. 26))	SWING BED ADJUSTMENT	REDUCED CAPITAL RELATED COST (col. 1 minus col. 2)	TOTAL PATIENT DAYS	PER DIEM (col. 3 ÷ col. 4)	INPATIENT PROGRAM DAYS	INPATIENT PROGRAM CAPITAL COST (col. 5 x col. 6)	
	INPATIENT ROUTINE SERV COST CENTERS	1	2	3	4	5	6	7	
30	ADULTS & PEDIATRICS (General Routine Care)	3,788,848		3,788,848	59,940	63.21	24,107	1,523,803	30
31	INTENSIVE CARE UNIT	500,802		500,802	4,333	115.58	2,375	274,503	31
32	CORONARY CARE UNIT								32
33	BURN INTENSIVE CARE UNIT								33
34	SURGICAL INTENSIVE CARE UNIT								34
35	OTHER SPECIAL CARE (SPECIFY)								35
40	SUBPROVIDER - IPF	157,938		157,938	2,890	54.65	1,872	102,305	40
41	SUBPROVIDER - IRF	854,747		854,747	8,022	106.55	6,422	684,264	41
42	SUBPROVIDER I								42
43	NURSERY	189,853		189,853	3,782	50.20			43
44	SKILLED NURSING FACILITY								44
45	NURSING FACILITY								45
200	TOTAL (lines 30-199)	5,492,188		5,492,188	78,967		34,776	2,584,875	200

(A) Worksheet A line numbers



COMPU-MAX

INGALLS MEMORIAL HOSPITAL Provider CCN: 14-0191	In Lieu of Form CMS-2552-10	Period : From: 10/01/2013 To: 09/30/2014	Run Date: 03/02/2015 Run Time: 10:44 Version: 2014.10
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APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS

COMPONENT CCN: 14-0191

WORKSHEET D
PART II

CHECK [] TITLE V [XX] HOSPITAL [] SUB (OTHER) [XX] PPS
 APPLICABLE [XX] TITLE XVIII, PART A [] IPF [] TEFRA
 BOXES: [] TITLE XIX [] IRF

		CAPITAL RELATED COST (from Wkst. B, Part II (col. 26))	TOTAL CHARGES (from Wkst. C, Part I, (col. 8))	RATIO OF COST TO CHARGES (col. 1 ÷ col. 2)	INPATIENT PROGRAM CHARGES	CAPITAL COSTS (col. 3 x col. 4)	
(A)	COST CENTER DESCRIPTION	1	2	3	4	5	
	ANCILLARY SERVICE COST CENTERS						
50	OPERATING ROOM	1,417,743	99,862,339	0.014197	23,152,647	328,698	50
51	RECOVERY ROOM	111,791	6,411,085	0.017437	1,190,161	20,753	51
53	ANESTHESIOLOGY	86,620	17,060,094	0.005077	4,010,052	20,359	53
54	RADIOLOGY-DIAGNOSTIC	941,177	33,611,185	0.028002	4,386,472	122,830	54
54.01	ULTRASOUND	119,473	13,240,724	0.009023	2,143,999	19,345	54.01
54.02	SPECIAL PROCEDURES	206,744	33,819,153	0.006113	7,874,273	48,135	54.02
56	RADIOISOTOPE	115,470	10,669,603	0.010822	1,790,599	19,378	56
57	CT SCAN	131,546	65,240,056	0.002016	13,179,901	26,571	57
58	MRI	103,244	19,248,783	0.005364	3,843,482	20,616	58
59	CARDIAC CATHETERIZATION	386,440	19,237,689	0.020088	5,006,220	100,565	59
60	LABORATORY	628,134	158,281,486	0.003968	26,786,223	106,288	60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS						62.30
63	BLOOD STORING, PROCESSING & TRANS.	44,414	6,265,753	0.007088	2,396,618	16,987	63
65	RESPIRATORY THERAPY	117,955	19,272,508	0.006120	8,807,193	53,900	65
65.01	PULMONARY FUNCTION	15,830	1,151,533	0.013747	145,287	1,997	65.01
66	PHYSICAL THERAPY	197,669	21,960,705	0.009001	1,805,465	16,251	66
67	OCCUPATIONAL THERAPY	55,530	5,995,825	0.009261	1,218,044	11,280	67
68	SPEECH PATHOLOGY	29,218	3,008,871	0.009711	680,021	6,604	68
69	ELECTROCARDIOLOGY	200,205	23,353,012	0.008573	6,921,999	59,342	69
70	ELECTROENCEPHALOGRAPHY	44,926	1,164,883	0.038567	488,808	18,852	70
70.01	SLEEP LAB	14,615	1,418,658	0.010302	175,081	1,804	70.01
70.02	PSYCH	42,294	5,406,160	0.007823	53,265	417	70.02
71	MEDICAL SUPPLIES CHARGED TO PATIENTS	15,888	5,034,364	0.003156	1,336,130	4,217	71
72	IMPL. DEV. CHARGED TO PATIENTS	306,924	29,907,885	0.010262	10,607,930	108,859	72
73	DRUGS CHARGED TO PATIENTS	640,159	121,928,419	0.005250	21,616,825	113,488	73
73.01	INFUSION THERAPY	36,134	4,529,212	0.007978	40,546	323	73.01
73.02	IFCC INFUSION THERAPY	26,272	4,814,907	0.005456	3,197	17	73.02
73.03	PHARMACY VACCINE	3,518	147,919	0.023783			73.03
74	RENAL DIALYSIS	58,643	1,893,041	0.030978	929,020	28,779	74
76.97	CARDIAC REHABILITATION	47,376	836,367	0.056645	41,051	2,325	76.97
76.98	HYPERBARIC OXYGEN THERAPY	35,850	8,210,703	0.004366	915,537	3,997	76.98
76.99	LITHOTRIPSY						76.99
	OUTPATIENT SERVICE COST CENTERS						
90.02	PSYCH ANCILLARY	209,506	8,023,589	0.026111	3,486	91	90.02
90.03	RETINAL VASCULAR	150,951	828,037	0.182300	2,857	521	90.03
91	EMERGENCY	516,428	84,374,380	0.006121	9,080,418	55,581	91
91.01	IFCC	1,999,497	185,536,002	0.010777	1,813,895	19,548	91.01
92	OBSERVATION BEDS (NON-DISTINCT PART)	295,572	6,754,808	0.043757			92
	OTHER REIMBURSABLE COST CENTERS						
200	TOTAL (sum of lines 50-199)	9,353,756	1,028,499,738		162,446,702	1,358,718	200

(A) Worksheet A line numbers



COMPU-MAX

INGALLS MEMORIAL HOSPITAL Provider CCN: 14-0191	In Lieu of Form CMS-2552-10	Period : From: 10/01/2013 To: 09/30/2014	Run Date: 03/02/2015 Run Time: 10:44 Version: 2014.10
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APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PASS THROUGH COSTS

WORKSHEET D
PART III

CHECK TITLE V PPS
 APPLICABLE TITLE XVIII, PART A TEFRA
 BOXES: TITLE XIX

		NURSING SCHOOL	ALLIED HEALTH COST	ALL OTHER MEDICAL EDUCATION COST	SWING-BED ADJUSTMENT AMOUNT (see instructions)	TOTAL COSTS (sum of cols. 1 through 3 minus col 4.)	
(A)	COST CENTER DESCRIPTION	1	2	3	4	5	
	INPATIENT ROUTINE SERV COST CENTERS						
30	ADULTS & PEDIATRICS (General Routine Care)		250,428			250,428	30
31	INTENSIVE CARE UNIT		130,122			130,122	31
32	CORONARY CARE UNIT						32
33	BURN INTENSIVE CARE UNIT						33
34	SURGICAL INTENSIVE CARE UNIT						34
35	OTHER SPECIAL CARE (SPECIFY)						35
40	SUBPROVIDER - IPF		17,310			17,310	40
41	SUBPROVIDER - IRF		50,775			50,775	41
42	SUBPROVIDER I						42
43	NURSERY						43
44	SKILLED NURSING FACILITY						44
45	NURSING FACILITY						45
200	TOTAL (lines 30-199)		448,635			448,635	200

(A) Worksheet A line numbers



COMPU-MAX

INGALLS MEMORIAL HOSPITAL Provider CCN: 14-0191	In Lieu of Form CMS-2552-10	Period : From: 10/01/2013 To: 09/30/2014	Run Date: 03/02/2015 Run Time: 10:44 Version: 2014.10
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APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PASS THROUGH COSTS

WORKSHEET D
PART III

CHECK TITLE V PPS
 APPLICABLE TITLE XVIII, PART A TEFRA
 BOXES: TITLE XIX

		TOTAL PATIENT DAYS	PER DIEM (col. 5 ÷ col. 6)	INPATIENT PROGRAM DAYS	INPATIENT PROGRAM PASS THRU COST (col. 7 x col. 8)	
(A)	COST CENTER DESCRIPTION	6	7	8	9	
	INPATIENT ROUTINE SERV COST CENTERS					
30	ADULTS & PEDIATRICS (General Routine Care)	59,940	4.18	24,107	100,767	30
31	INTENSIVE CARE UNIT	4,333	30.03	2,375	71,321	31
32	CORONARY CARE UNIT					32
33	BURN INTENSIVE CARE UNIT					33
34	SURGICAL INTENSIVE CARE UNIT					34
35	OTHER SPECIAL CARE (SPECIFY)					35
40	SUBPROVIDER - IPF	2,890	5.99	1,872	11,213	40
41	SUBPROVIDER - IRF	8,022	6.33	6,422	40,651	41
42	SUBPROVIDER I					42
43	NURSERY	3,782				43
44	SKILLED NURSING FACILITY					44
45	NURSING FACILITY					45
200	TOTAL (lines 30-199)	78,967		34,776	223,952	200

(A) Worksheet A line numbers



COMPU-MAX

INGALLS MEMORIAL HOSPITAL Provider CCN: 14-0191	In Lieu of Form CMS-2552-10	Period : From: 10/01/2013 To: 09/30/2014	Run Date: 03/02/2015 Run Time: 10:44 Version: 2014.10
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APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE
OTHER PASS THROUGH COSTS

COMPONENT CCN: 14-0191

WORKSHEET D
PART IV

CHECK [] TITLE V [XX] HOSPITAL [] SUB (OTHER) [] ICF/MR [XX] PPS
 APPLICABLE [XX] TITLE XVIII, PART A [] IPF [] SNF [] TEFRA
 BOXES: [] TITLE XIX [] IRF [] NF

(A)	COST CENTER DESCRIPTION	NON PHYSICIAN ANESTHETIST COST	NURSING SCHOOL	ALLIED HEALTH	ALL OTHER MEDICAL EDUCATION COST	TOTAL COST (sum of col. 1 through col. 4)	TOTAL OUTPATIENT COST (sum of col. 2, 3, and 4)	
		1	2	3	4	5	6	
	ANCILLARY SERVICE COST CENTERS							
50	OPERATING ROOM			33,758		33,758	33,758	50
51	RECOVERY ROOM							51
53	ANESTHESIOLOGY							53
54	RADIOLOGY-DIAGNOSTIC							54
54.01	ULTRASOUND							54.01
54.02	SPECIAL PROCEDURES							54.02
56	RADIOISOTOPE							56
57	CT SCAN							57
58	MRI							58
59	CARDIAC CATHETERIZATION							59
60	LABORATORY							60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
63	BLOOD STORING, PROCESSING & TRANS.							63
65	RESPIRATORY THERAPY			33,758		33,758	33,758	65
65.01	PULMONARY FUNCTION							65.01
66	PHYSICAL THERAPY							66
67	OCCUPATIONAL THERAPY							67
68	SPEECH PATHOLOGY							68
69	ELECTROCARDIOLOGY			33,758		33,758	33,758	69
70	ELECTROENCEPHALOGRAPHY							70
70.01	SLEEP LAB							70.01
70.02	PSYCH			2,308		2,308	2,308	70.02
71	MEDICAL SUPPLIES CHARGED TO PATIENTS							71
72	IMPL. DEV. CHARGED TO PATIENTS							72
73	DRUGS CHARGED TO PATIENTS			296,369		296,369	296,369	73
73.01	INFUSION THERAPY							73.01
73.02	IFCC INFUSION THERAPY							73.02
73.03	PHARMACY VACCINE							73.03
74	RENAL DIALYSIS							74
76.97	CARDIAC REHABILITATION							76.97
76.98	HYPERBARIC OXYGEN THERAPY							76.98
76.99	LITHOTRIPSY							76.99
	OUTPATIENT SERVICE COST CENTERS							
90.02	PSYCH ANCILLARY							90.02
90.03	RETINAL VASCULAR							90.03
91	EMERGENCY			677,458		677,458	677,458	91
91.01	IFCC							91.01
92	OBSERVATION BEDS (NON-DISTINCT PART)			19,536		19,536	19,536	92
	OTHER REIMBURSABLE COST CENTERS							
200	TOTAL (sum of lines 50-199)			1,096,945		1,096,945	1,096,945	200

(A) Worksheet A line numbers



COMPU-MAX

INGALLS MEMORIAL HOSPITAL Provider CCN: 14-0191	In Lieu of Form CMS-2552-10	Period : From: 10/01/2013 To: 09/30/2014	Run Date: 03/02/2015 Run Time: 10:44 Version: 2014.10
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APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE
OTHER PASS THROUGH COSTS

COMPONENT CCN: 14-0191

WORKSHEET D
PART IV

CHECK [] TITLE V [XX] HOSPITAL [] SUB (OTHER) [] ICF/MR [XX] PPS
 APPLICABLE [XX] TITLE XVIII, PART A [] IPF [] SNF [] TEFRA
 BOXES: [] TITLE XIX [] IRF [] NF

(A)	COST CENTER DESCRIPTION	TOTAL CHARGES (from Wkst. C, Part I, col. 8)	RATIO OF COST TO CHARGES (col. 5÷ col. 7)	OUTPAT-IENT RATIO OF COST TO CHARGES (col. 6÷ col. 7)	INPATIENT PROGRAM CHARGES	INPATIENT PROGRAM PASS-THROUGH COSTS (col. 8 x col. 10)	OUTPAT-IENT PROGRAM CHARGES	OUTPAT-IENT PROGRAM PASS-THROUGH COSTS (col. 9 x col. 12)	
7	8	9	10	11	12	13			
	ANCILLARY SERVICE COST CENTERS								
50	OPERATING ROOM	99,862,339	0.000338	0.000338	23,152,647	7,826	13,605,336	4,599	50
51	RECOVERY ROOM	6,411,085			1,190,161		956,655		51
53	ANESTHESIOLOGY	17,060,094			4,010,052		2,116,748		53
54	RADIOLOGY-DIAGNOSTIC	33,611,185			4,386,472		7,877,365		54
54.01	ULTRASOUND	13,240,724			2,143,999		2,027,209		54.01
54.02	SPECIAL PROCEDURES	33,819,153			7,874,273		13,813,205		54.02
56	RADIOISOTOPE	10,669,603			1,790,599		2,666,204		56
57	CT SCAN	65,240,056			13,179,901		10,699,370		57
58	MRI	19,248,783			3,843,482		3,985,894		58
59	CARDIAC CATHETERIZATION	19,237,689			5,006,220		4,927,222		59
60	LABORATORY	158,281,486			26,786,223		9,843,935		60
62.30	BLOOD CLOTING FOR HEMOPHILIACS								62.30
63	BLOOD STORING, PROCESSING & TRANS.	6,265,753			2,396,618		473,802		63
65	RESPIRATORY THERAPY	19,272,508	0.001752	0.001752	8,807,193	15,430	650,649	1,140	65
65.01	PULMONARY FUNCTION	1,151,533			145,287		252,579		65.01
66	PHYSICAL THERAPY	21,960,705			1,805,465		89,401		66
67	OCCUPATIONAL THERAPY	5,995,825			1,218,044				67
68	SPEECH PATHOLOGY	3,008,871			680,021				68
69	ELECTROCARDIOLOGY	23,353,012	0.001446	0.001446	6,921,999	10,009	3,283,598	4,748	69
70	ELECTROENCEPHALOGRAPHY	1,164,883			488,808		131,556		70
70.01	SLEEP LAB	1,418,658			175,081		309,337		70.01
70.02	PSYCH	5,406,160	0.000427	0.000427	53,265	23			70.02
71	MEDICAL SUPPLIES CHARGED TO PATIENTS	5,034,364			1,336,130		268,714		71
72	IMPL. DEV. CHARGED TO PATIENTS	29,907,885			10,607,930		4,196,321		72
73	DRUGS CHARGED TO PATIENTS	121,928,419	0.002431	0.002431	21,616,825	52,551	36,594,162	88,960	73
73.01	INFUSION THERAPY	4,529,212			40,546		2,198,014		73.01
73.02	IFCC INFUSION THERAPY	4,814,907			3,197		297,862		73.02
73.03	PHARMACY VACCINE	147,919							73.03
74	RENAL DIALYSIS	1,893,041			929,020		185,343		74
76.97	CARDIAC REHABILITATION	836,367			41,051		277,750		76.97
76.98	HYPERBARIC OXYGEN THERAPY	8,210,703			915,537		1,937,126		76.98
76.99	LITHOTRIPSY								76.99
	OUTPATIENT SERVICE COST CENTERS								
90.02	PSYCH ANCILLARY	8,023,589			3,486		190,922		90.02
90.03	RETINAL VASCULAR	828,037			2,857		447,753		90.03
91	EMERGENCY	84,374,380	0.008029	0.008029	9,080,418	72,907	8,857,511	71,117	91
91.01	IFCC	185,536,002			1,813,895		37,114,686		91.01
92	OBSERVATION BEDS (NON-DISTINCT PART)	6,754,808	0.002892	0.002892			1,780,026	5,148	92
	OTHER REIMBURSABLE COST CENTERS								
200	TOTAL (sum of lines 50-199)	1,028,499,738			162,446,702	158,746	172,056,255	175,712	200

(A) Worksheet A line numbers



INGALLS MEMORIAL HOSPITAL Provider CCN: 14-0191	In Lieu of Form CMS-2552-10	Period : From: 10/01/2013 To: 09/30/2014	Run Date: 03/02/2015 Run Time: 10:44 Version: 2014.10
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APPORTIONMENT OF MEDICAL AND OTHER HEALTH SERVICE COSTS

COMPONENT CCN: 14-0191

WORKSHEET D
PART V

CHECK [] TITLE V - O/P [XX] HOSPITAL [] SUB (OTHER) [] SWING BED SNF
 APPLICABLE [XX] TITLE XVIII, PART B [] IPF [] SNF [] SWING BED NF
 BOXES: [] TITLE XIX - O/P [] IRF [] NF [] ICF/MR

(A)	COST CENTER DESCRIPTION	PROGRAM CHARGES				PROGRAM COST			
		COST TO CHARGE RATIO (from Wkst C, Part I, col. 9)	PPS REIM-BURSED SERVICES (see inst.)	COST REIM-BURSED SUBJECT TO DED. & COINS. (see inst.)	COST REIM-BURSED NOT SUBJECT TO DED. & COINS. (see inst.)	PPS SERVICES (see inst.)	COST REIM-BURSED SUBJECT TO DED. & COINS. (see inst.)	COST REIM-BURSED NOT SUBJECT TO DED. & COINS. (see inst.)	
		1	2	3	4	5	6	7	
	ANCILLARY SERVICE COST CENTERS								
50	OPERATING ROOM	0.200169	13,605,336			2,723,367			50
51	RECOVERY ROOM	0.272331	956,655			260,527			51
53	ANESTHESIOLOGY	0.078070	2,116,748			165,255			53
54	RADIOLOGY-DIAGNOSTIC	0.262188	7,877,365			2,065,351			54
54.01	ULTRASOUND	0.159623	2,027,209			323,589			54.01
54.02	SPECIAL PROCEDURES	0.072197	13,813,205			997,272			54.02
56	RADIOISOTOPE	0.219962	2,666,204			586,464			56
57	CT SCAN	0.032471	10,699,370			347,419			57
58	MRI	0.077651	3,985,894			309,509			58
59	CARDIAC CATHETERIZATION	0.186614	4,927,222			919,489			59
60	LABORATORY	0.109171	9,843,935			1,074,672			60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS								62.30
63	BLOOD STORING, PROCESSING & TRANS.	0.312729	473,802	1,120		148,172	350		63
65	RESPIRATORY THERAPY	0.178058	650,649			115,853			65
65.01	PULMONARY FUNCTION	0.161526	252,579			40,798			65.01
66	PHYSICAL THERAPY	0.214712	89,401			19,195			66
67	OCCUPATIONAL THERAPY	0.412076							67
68	SPEECH PATHOLOGY	0.259167							68
69	ELECTROCARDIOLOGY	0.105566	3,283,598			346,636			69
70	ELECTROENCEPHALOGRAPHY	0.271032	131,556			35,656			70
70.01	SLEEP LAB	0.169037	309,337			52,289			70.01
70.02	PSYCH	0.464418							70.02
71	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.162552	268,714			43,680			71
72	IMPL. DEV. CHARGED TO PATIENTS	0.532942	4,196,321			2,236,396			72
73	DRUGS CHARGED TO PATIENTS	0.196357	36,594,162			7,185,520			73
73.01	INFUSION THERAPY	0.218728	2,198,014			480,767			73.01
73.02	IFCC INFUSION THERAPY	0.232087	297,862			69,130			73.02
73.03	PHARMACY VACCINE	0.883889				100,513		88,842	73.03
74	RENAL DIALYSIS	0.624065	185,343			115,666			74
76.97	CARDIAC REHABILITATION	1.007168	277,750			279,741			76.97
76.98	HYPERBARIC OXYGEN THERAPY	0.240176	1,937,126			465,251			76.98
76.99	LITHOTRIPSY								76.99
	OUTPATIENT SERVICE COST CENTERS								
90.02	PSYCH ANCILLARY	0.431720	190,922	35,604		82,425	15,371		90.02
90.03	RETINAL VASCULAR	1.415946	447,753			633,994			90.03
91	EMERGENCY	0.119232	8,857,511			1,056,099			91
91.01	IFCC	0.163091	37,114,686	2,672		6,053,071	436		91.01
92	OBSERVATION BEDS (NON-DISTINCT PART)	0.640710	1,780,026			1,140,480			92
	OTHER REIMBURSABLE COST CENTERS								
200	SUBTOTAL (see instructions)		172,056,255	39,396	100,513	30,373,733	16,157	88,842	200
201	LESS PBP CLINIC LAB. SERVICES PROGRAM ONLY CHARGES								201
202	NET CHARGES (line 200 - line 201)		172,056,255	39,396	100,513	30,373,733	16,157	88,842	202

(A) Worksheet A line numbers



COMPU-MAX

INGALLS MEMORIAL HOSPITAL Provider CCN: 14-0191	In Lieu of Form CMS-2552-10	Period : From: 10/01/2013 To: 09/30/2014	Run Date: 03/02/2015 Run Time: 10:44 Version: 2014.10
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APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS

COMPONENT CCN: 14-S191

WORKSHEET D
PART II

CHECK [] TITLE V [] HOSPITAL [] SUB (OTHER) [XX] PPS
 APPLICABLE [XX] TITLE XVIII, PART A [XX] IPF [] TEFRA
 BOXES: [] TITLE XIX [] IRF

(A)	COST CENTER DESCRIPTION	CAPITAL RELATED COST (from Wkst. B, Part II (col. 26))	TOTAL CHARGES (from Wkst. C, Part I, (col. 8))	RATIO OF COST TO CHARGES (col. 1 ÷ col. 2)	INPATIENT PROGRAM CHARGES	CAPITAL COSTS (col. 3 x col. 4)	
		1	2	3	4	5	
	ANCILLARY SERVICE COST CENTERS						
50	OPERATING ROOM	1,417,743	99,862,339	0.014197	7,476	106	50
51	RECOVERY ROOM	111,791	6,411,085	0.017437			51
53	ANESTHESIOLOGY	86,620	17,060,094	0.005077			53
54	RADIOLOGY-DIAGNOSTIC	941,177	33,611,185	0.028002	20,146	564	54
54.01	ULTRASOUND	119,473	13,240,724	0.009023	8,420	76	54.01
54.02	SPECIAL PROCEDURES	206,744	33,819,153	0.006113			54.02
56	RADIOISOTOPE	115,470	10,669,603	0.010822	2,347	25	56
57	CT SCAN	131,546	65,240,056	0.002016	66,594	134	57
58	MRI	103,244	19,248,783	0.005364	63,948	343	58
59	CARDIAC CATHETERIZATION	386,440	19,237,689	0.020088			59
60	LABORATORY	628,134	158,281,486	0.003968	419,848	1,666	60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS						62.30
63	BLOOD STORING, PROCESSING & TRANS.	44,414	6,265,753	0.007088			63
65	RESPIRATORY THERAPY	117,955	19,272,508	0.006120	36,825	225	65
65.01	PULMONARY FUNCTION	15,830	1,151,533	0.013747			65.01
66	PHYSICAL THERAPY	197,669	21,960,705	0.009001	14,015	126	66
67	OCCUPATIONAL THERAPY	55,530	5,995,825	0.009261	6,035	56	67
68	SPEECH PATHOLOGY	29,218	3,008,871	0.009711	4,396	43	68
69	ELECTROCARDIOLOGY	200,205	23,353,012	0.008573	53,621	460	69
70	ELECTROENCEPHALOGRAPHY	44,926	1,164,883	0.038567	4,196	162	70
70.01	SLEEP LAB	14,615	1,418,658	0.010302	2,041	21	70.01
70.02	PSYCH	42,294	5,406,160	0.007823	545,779	4,270	70.02
71	MEDICAL SUPPLIES CHARGED TO PATIENTS	15,888	5,034,364	0.003156	1,845	6	71
72	IMPL., DEV. CHARGED TO PATIENTS	306,924	29,907,885	0.010262			72
73	DRUGS CHARGED TO PATIENTS	640,159	121,928,419	0.005250	211,730	1,112	73
73.01	INFUSION THERAPY	36,134	4,529,212	0.007978			73.01
73.02	IFCC INFUSION THERAPY	26,272	4,814,907	0.005456			73.02
73.03	PHARMACY VACCINE	3,518	147,919	0.023783			73.03
74	RENAL DIALYSIS	58,643	1,893,041	0.030978	3,065	95	74
76.97	CARDIAC REHABILITATION	47,376	836,367	0.056645			76.97
76.98	HYPERBARIC OXYGEN THERAPY	35,850	8,210,703	0.004366	7,140	31	76.98
76.99	LITHOTRIPSY						76.99
	OUTPATIENT SERVICE COST CENTERS						
90.02	PSYCH ANCILLARY	209,506	8,023,589	0.026111			90.02
90.03	RETINAL VASCULAR	150,951	828,037	0.182300			90.03
91	EMERGENCY	516,428	84,374,380	0.006121	240,970	1,475	91
91.01	IFCC	1,999,497	185,536,002	0.010777			91.01
92	OBSERVATION BEDS (NON-DISTINCT PART)		6,754,808				92
	OTHER REIMBURSABLE COST CENTERS						
200	TOTAL (sum of lines 50-199)	9,058,184	1,028,499,738		1,720,437	10,996	200

(A) Worksheet A line numbers



COMPU-MAX

INGALLS MEMORIAL HOSPITAL Provider CCN: 14-0191	In Lieu of Form CMS-2552-10	Period : From: 10/01/2013 To: 09/30/2014	Run Date: 03/02/2015 Run Time: 10:44 Version: 2014.10
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APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE
OTHER PASS THROUGH COSTS

COMPONENT CCN: 14-S191

WORKSHEET D
PART IV

CHECK [] TITLE V [] HOSPITAL [] SUB (OTHER) [] ICF/MR [XX] PPS
 APPLICABLE [XX] TITLE XVIII, PART A [XX] IPF [] SNF [] TEFRA
 BOXES: [] TITLE XIX [] IRF [] NF

(A)	COST CENTER DESCRIPTION	NON PHYSICIAN ANESTHETIST COST	NURSING SCHOOL	ALLIED HEALTH	ALL OTHER MEDICAL EDUCATION COST	TOTAL COST (sum of col. 1 through col. 4)	TOTAL OUTPATIENT COST (sum of col. 2, 3, and 4)	
	ANCILLARY SERVICE COST CENTERS	1	2	3	4	5	6	
50	OPERATING ROOM			33,758		33,758	33,758	50
51	RECOVERY ROOM							51
53	ANESTHESIOLOGY							53
54	RADIOLOGY-DIAGNOSTIC							54
54.01	ULTRASOUND							54.01
54.02	SPECIAL PROCEDURES							54.02
56	RADIOISOTOPE							56
57	CT SCAN							57
58	MRI							58
59	CARDIAC CATHETERIZATION							59
60	LABORATORY							60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
63	BLOOD STORING, PROCESSING & TRANS.							63
65	RESPIRATORY THERAPY			33,758		33,758	33,758	65
65.01	PULMONARY FUNCTION							65.01
66	PHYSICAL THERAPY							66
67	OCCUPATIONAL THERAPY							67
68	SPEECH PATHOLOGY							68
69	ELECTROCARDIOLOGY			33,758		33,758	33,758	69
70	ELECTROENCEPHALOGRAPHY							70
70.01	SLEEP LAB							70.01
70.02	PSYCH			2,308		2,308	2,308	70.02
71	MEDICAL SUPPLIES CHARGED TO PATIENTS							71
72	IMPL. DEV. CHARGED TO PATIENTS							72
73	DRUGS CHARGED TO PATIENTS			296,369		296,369	296,369	73
73.01	INFUSION THERAPY							73.01
73.02	IFCC INFUSION THERAPY							73.02
73.03	PHARMACY VACCINE							73.03
74	RENAL DIALYSIS							74
76.97	CARDIAC REHABILITATION							76.97
76.98	HYPERBARIC OXYGEN THERAPY							76.98
76.99	LITHOTRIPSY							76.99
	OUTPATIENT SERVICE COST CENTERS							
90.02	PSYCH ANCILLARY							90.02
90.03	RETINAL VASCULAR							90.03
91	EMERGENCY			677,458		677,458	677,458	91
91.01	IFCC							91.01
92	OBSERVATION BEDS (NON-DISTINCT PART)							92
	OTHER REIMBURSABLE COST CENTERS							
200	TOTAL (sum of lines 50-199)			1,077,409		1,077,409	1,077,409	200

(A) Worksheet A line numbers



COMPU-MAX

INGALLS MEMORIAL HOSPITAL Provider CCN: 14-0191	In Lieu of Form CMS-2552-10	Period : From: 10/01/2013 To: 09/30/2014	Run Date: 03/02/2015 Run Time: 10:44 Version: 2014.10
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APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE
OTHER PASS THROUGH COSTS

COMPONENT CCN: 14-S191

WORKSHEET D
PART IV

CHECK [] TITLE V [] HOSPITAL [] SUB (OTHER) [] ICF/MR [XX] PPS
 APPLICABLE [XX] TITLE XVIII, PART A [XX] IPF [] SNF [] TEFRA
 BOXES: [] TITLE XIX [] IRF [] NF

(A)	COST CENTER DESCRIPTION	TOTAL CHARGES (from Wkst. C, Part I, col. 8)	RATIO OF COST TO CHARGES (col. 5÷ col. 7)	OUTPAT-IENT RATIO OF COST TO CHARGES (col. 6÷ col. 7)	INPATIENT PROGRAM CHARGES	INPATIENT PROGRAM PASS-THROUGH COSTS (col. 8 x col. 10)	OUTPAT-IENT PROGRAM CHARGES	OUTPAT-IENT PROGRAM PASS-THROUGH COSTS (col. 9 x col. 12)
	ANCILLARY SERVICE COST CENTERS							
50	OPERATING ROOM	99,862,339	0.000338	0.000338	7,476	3		50
51	RECOVERY ROOM	6,411,085						51
53	ANESTHESIOLOGY	17,060,094						53
54	RADIOLOGY-DIAGNOSTIC	33,611,185			20,146			54
54.01	ULTRASOUND	13,240,724			8,420			54.01
54.02	SPECIAL PROCEDURES	33,819,153						54.02
56	RADIOISOTOPE	10,669,603			2,347			56
57	CT SCAN	65,240,056			66,594			57
58	MRI	19,248,783			63,948			58
59	CARDIAC CATHETERIZATION	19,237,689						59
60	LABORATORY	158,281,486			419,848			60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
63	BLOOD STORING, PROCESSING & TRANS.	6,265,753						63
65	RESPIRATORY THERAPY	19,272,508	0.001752	0.001752	36,825	65		65
65.01	PULMONARY FUNCTION	1,151,533						65.01
66	PHYSICAL THERAPY	21,960,705			14,015			66
67	OCCUPATIONAL THERAPY	5,995,825			6,035			67
68	SPEECH PATHOLOGY	3,008,871			4,396			68
69	ELECTROCARDIOLOGY	23,353,012	0.001446	0.001446	53,621	78		69
70	ELECTROENCEPHALOGRAPHY	1,164,883			4,196			70
70.01	SLEEP LAB	1,418,658			2,041			70.01
70.02	PSYCH	5,406,160	0.000427	0.000427	545,779	233		70.02
71	MEDICAL SUPPLIES CHARGED TO PATIENTS	5,034,364			1,845			71
72	IMPL. DEV. CHARGED TO PATIENTS	29,907,885						72
73	DRUGS CHARGED TO PATIENTS	121,928,419	0.002431	0.002431	211,730	515		73
73.01	INFUSION THERAPY	4,529,212						73.01
73.02	IFCC INFUSION THERAPY	4,814,907						73.02
73.03	PHARMACY VACCINE	147,919						73.03
74	RENAL DIALYSIS	1,893,041			3,065			74
76.97	CARDIAC REHABILITATION	836,367						76.97
76.98	HYPERBARIC OXYGEN THERAPY	8,210,703			7,140			76.98
76.99	LITHOTRIPSY							76.99
	OUTPATIENT SERVICE COST CENTERS							
90.02	PSYCH ANCILLARY	8,023,589						90.02
90.03	RETINAL VASCULAR	828,037						90.03
91	EMERGENCY	84,374,380	0.008029	0.008029	240,970	1,935		91
91.01	IFCC	185,536,002						91.01
92	OBSERVATION BEDS (NON-DISTINCT PART)	6,754,808						92
	OTHER REIMBURSABLE COST CENTERS							
200	TOTAL (sum of lines 50-199)	1,028,499,738			1,720,437	2,829		200

(A) Worksheet A line numbers



COMPU-MAX

INGALLS MEMORIAL HOSPITAL Provider CCN: 14-0191	In Lieu of Form CMS-2552-10	Period : From: 10/01/2013 To: 09/30/2014	Run Date: 03/02/2015 Run Time: 10:44 Version: 2014.10
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APPORTIONMENT OF MEDICAL AND OTHER HEALTH SERVICE COSTS

COMPONENT CCN: 14-S191

WORKSHEET D
PART V

CHECK [] TITLE V - O/P [] HOSPITAL [] SUB (OTHER) [] SWING BED SNF
 APPLICABLE [XX] TITLE XVIII, PART B [XX] IPF [] SNF [] SWING BED NF
 BOXES: [] TITLE XIX - O/P [] IRF [] NF [] ICF/MR

(A)	COST CENTER DESCRIPTION	COST TO CHARGE RATIO (from Wkst C, Part I, col. 9)	PROGRAM CHARGES			PROGRAM COST			
			PPS REIM-BURSED SERVICES (see inst.)	COST REIM-BURSED SUBJECT TO DED. & COINS. (see inst.)	COST REIM-BURSED NOT SUBJECT TO DED. & COINS. (see inst.)	PPS SERVICES (see inst.)	COST REIM-BURSED SUBJECT TO DED. & COINS. (see inst.)	COST REIM-BURSED NOT SUBJECT TO DED. & COINS. (see inst.)	
		1	2	3	4	5	6	7	
	ANCILLARY SERVICE COST CENTERS								
50	OPERATING ROOM	0.200169							50
51	RECOVERY ROOM	0.272331							51
53	ANESTHESIOLOGY	0.078070							53
54	RADIOLOGY-DIAGNOSTIC	0.262188							54
54.01	ULTRASOUND	0.159623							54.01
54.02	SPECIAL PROCEDURES	0.072197							54.02
56	RADIOISOTOPE	0.219962							56
57	CT SCAN	0.032471							57
58	MRI	0.077651							58
59	CARDIAC CATHETERIZATION	0.186614							59
60	LABORATORY	0.109171							60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS								62.30
63	BLOOD STORING, PROCESSING & TRANS.	0.312729							63
65	RESPIRATORY THERAPY	0.178058							65
65.01	PULMONARY FUNCTION	0.161526							65.01
66	PHYSICAL THERAPY	0.214712							66
67	OCCUPATIONAL THERAPY	0.412076							67
68	SPEECH PATHOLOGY	0.259167							68
69	ELECTROCARDIOLOGY	0.105566							69
70	ELECTROENCEPHALOGRAPHY	0.271032							70
70.01	SLEEP LAB	0.169037							70.01
70.02	PSYCH	0.464418							70.02
71	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.162552							71
72	IMPL. DEV. CHARGED TO PATIENTS	0.532942							72
73	DRUGS CHARGED TO PATIENTS	0.196357							73
73.01	INFUSION THERAPY	0.218728							73.01
73.02	IFCC INFUSION THERAPY	0.232087							73.02
73.03	PHARMACY VACCINE	0.883889							73.03
74	RENAL DIALYSIS	0.624065							74
76.97	CARDIAC REHABILITATION	1.007168							76.97
76.98	HYPERBARIC OXYGEN THERAPY	0.240176							76.98
76.99	LITHOTRIPSY								76.99
	OUTPATIENT SERVICE COST CENTERS								
90.02	PSYCH ANCILLARY	0.431720							90.02
90.03	RETINAL VASCULAR	1.415946							90.03
91	EMERGENCY	0.119232							91
91.01	IFCC	0.163091							91.01
92	OBSERVATION BEDS (NON-DISTINCT PART)	0.640710							92
	OTHER REIMBURSABLE COST CENTERS								
200	SUBTOTAL (see instructions)								200
201	LESS PBP CLINIC LAB. SERVICES PROGRAM ONLY CHARGES								201
202	NET CHARGES (line 200 - line 201)								202

(A) Worksheet A line numbers



COMPU-MAX

INGALLS MEMORIAL HOSPITAL Provider CCN: 14-0191	In Lieu of Form CMS-2552-10	Period : From: 10/01/2013 To: 09/30/2014	Run Date: 03/02/2015 Run Time: 10:44 Version: 2014.10
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APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS

COMPONENT CCN: 14-T191

WORKSHEET D
PART II

CHECK [] TITLE V [] HOSPITAL [] SUB (OTHER) [XX] PPS
 APPLICABLE [XX] TITLE XVIII, PART A [] IPF [] TEFRA
 BOXES: [] TITLE XIX [XX] IRF

		CAPITAL RELATED COST (from Wkst. B, Part II (col. 26))	TOTAL CHARGES (from Wkst. C, Part I, (col. 8))	RATIO OF COST TO CHARGES (col. 1 ÷ col. 2)	INPATIENT PROGRAM CHARGES	CAPITAL COSTS (col. 3 x col. 4)	
(A)	COST CENTER DESCRIPTION	1	2	3	4	5	
	ANCILLARY SERVICE COST CENTERS						
50	OPERATING ROOM	1,417,743	99,862,339	0.014197	74,791	1,062	50
51	RECOVERY ROOM	111,791	6,411,085	0.017437	4,368	76	51
53	ANESTHESIOLOGY	86,620	17,060,094	0.005077	8,397	43	53
54	RADIOLOGY-DIAGNOSTIC	941,177	33,611,185	0.028002	204,583	5,729	54
54.01	ULTRASOUND	119,473	13,240,724	0.009023	84,052	758	54.01
54.02	SPECIAL PROCEDURES	206,744	33,819,153	0.006113	137,638	841	54.02
56	RADIOISOTOPE	115,470	10,669,603	0.010822	10,366	112	56
57	CT SCAN	131,546	65,240,056	0.002016	265,509	535	57
58	MRI	103,244	19,248,783	0.005364	124,231	666	58
59	CARDIAC CATHETERIZATION	386,440	19,237,689	0.020088			59
60	LABORATORY	628,134	158,281,486	0.003968	1,208,808	4,797	60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS						62.30
63	BLOOD STORING, PROCESSING & TRANS.	44,414	6,265,753	0.007088	60,781	431	63
65	RESPIRATORY THERAPY	117,955	19,272,508	0.006120	694,898	4,253	65
65.01	PULMONARY FUNCTION	15,830	1,151,533	0.013747	660	9	65.01
66	PHYSICAL THERAPY	197,669	21,960,705	0.009001	3,195,400	28,762	66
67	OCCUPATIONAL THERAPY	55,530	5,995,825	0.009261	3,157,043	29,237	67
68	SPEECH PATHOLOGY	29,218	3,008,871	0.009711	1,253,175	12,170	68
69	ELECTROCARDIOLOGY	200,205	23,353,012	0.008573	57,923	497	69
70	ELECTROENCEPHALOGRAPHY	44,926	1,164,883	0.038567	11,953	461	70
70.01	SLEEP LAB	14,615	1,418,658	0.010302	3,063	32	70.01
70.02	PSYCH	42,294	5,406,160	0.007823			70.02
71	MEDICAL SUPPLIES CHARGED TO PATIENTS	15,888	5,034,364	0.003156	36,825	116	71
72	IMPL., DEV. CHARGED TO PATIENTS	306,924	29,907,885	0.010262			72
73	DRUGS CHARGED TO PATIENTS	640,159	121,928,419	0.005250	2,135,547	11,212	73
73.01	INFUSION THERAPY	36,134	4,529,212	0.007978			73.01
73.02	IFCC INFUSION THERAPY	26,272	4,814,907	0.005456			73.02
73.03	PHARMACY VACCINE	3,518	147,919	0.023783			73.03
74	RENAL DIALYSIS	58,643	1,893,041	0.030978	218,274	6,762	74
76.97	CARDIAC REHABILITATION	47,376	836,367	0.056645			76.97
76.98	HYPERBARIC OXYGEN THERAPY	35,850	8,210,703	0.004366	183,056	799	76.98
76.99	LITHOTRIPSY						76.99
	OUTPATIENT SERVICE COST CENTERS						
90.02	PSYCH ANCILLARY	209,506	8,023,589	0.026111			90.02
90.03	RETINAL VASCULAR	150,951	828,037	0.182300			90.03
91	EMERGENCY	516,428	84,374,380	0.006121	26,097	160	91
91.01	IFCC	1,999,497	185,536,002	0.010777			91.01
92	OBSERVATION BEDS (NON-DISTINCT PART)		6,754,808				92
	OTHER REIMBURSABLE COST CENTERS						
200	TOTAL (sum of lines 50-199)	9,058,184	1,028,499,738		13,157,438	109,520	200

(A) Worksheet A line numbers



COMPU-MAX

INGALLS MEMORIAL HOSPITAL Provider CCN: 14-0191	In Lieu of Form CMS-2552-10	Period : From: 10/01/2013 To: 09/30/2014	Run Date: 03/02/2015 Run Time: 10:44 Version: 2014.10
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APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE
OTHER PASS THROUGH COSTS

COMPONENT CCN: 14-T191

WORKSHEET D
PART IV

CHECK [] TITLE V [] HOSPITAL [] SUB (OTHER) [] ICF/MR [XX] PPS
 APPLICABLE [XX] TITLE XVIII, PART A [] IPF [] SNF [] TEFRA
 BOXES: [] TITLE XIX [XX] IRF [] NF

(A)	COST CENTER DESCRIPTION	NON PHYSICIAN ANESTHETIST COST	NURSING SCHOOL	ALLIED HEALTH	ALL OTHER MEDICAL EDUCATION COST	TOTAL COST (sum of col. 1 through col. 4)	TOTAL OUTPATIENT COST (sum of col. 2, 3, and 4)	
		1	2	3	4	5	6	
	ANCILLARY SERVICE COST CENTERS							
50	OPERATING ROOM			33,758		33,758	33,758	50
51	RECOVERY ROOM							51
53	ANESTHESIOLOGY							53
54	RADIOLOGY-DIAGNOSTIC							54
54.01	ULTRASOUND							54.01
54.02	SPECIAL PROCEDURES							54.02
56	RADIOISOTOPE							56
57	CT SCAN							57
58	MRI							58
59	CARDIAC CATHETERIZATION							59
60	LABORATORY							60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
63	BLOOD STORING, PROCESSING & TRANS.							63
65	RESPIRATORY THERAPY			33,758		33,758	33,758	65
65.01	PULMONARY FUNCTION							65.01
66	PHYSICAL THERAPY							66
67	OCCUPATIONAL THERAPY							67
68	SPEECH PATHOLOGY							68
69	ELECTROCARDIOLOGY			33,758		33,758	33,758	69
70	ELECTROENCEPHALOGRAPHY							70
70.01	SLEEP LAB							70.01
70.02	PSYCH			2,308		2,308	2,308	70.02
71	MEDICAL SUPPLIES CHARGED TO PATIENTS							71
72	IMPL. DEV. CHARGED TO PATIENTS							72
73	DRUGS CHARGED TO PATIENTS			296,369		296,369	296,369	73
73.01	INFUSION THERAPY							73.01
73.02	IFCC INFUSION THERAPY							73.02
73.03	PHARMACY VACCINE							73.03
74	RENAL DIALYSIS							74
76.97	CARDIAC REHABILITATION							76.97
76.98	HYPERBARIC OXYGEN THERAPY							76.98
76.99	LITHOTRIPSY							76.99
	OUTPATIENT SERVICE COST CENTERS							
90.02	PSYCH ANCILLARY							90.02
90.03	RETINAL VASCULAR							90.03
91	EMERGENCY			677,458		677,458	677,458	91
91.01	IFCC							91.01
92	OBSERVATION BEDS (NON-DISTINCT PART)							92
	OTHER REIMBURSABLE COST CENTERS							
200	TOTAL (sum of lines 50-199)			1,077,409		1,077,409	1,077,409	200

(A) Worksheet A line numbers



COMPU-MAX

INGALLS MEMORIAL HOSPITAL Provider CCN: 14-0191	In Lieu of Form CMS-2552-10	Period : From: 10/01/2013 To: 09/30/2014	Run Date: 03/02/2015 Run Time: 10:44 Version: 2014.10
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APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE
OTHER PASS THROUGH COSTS

COMPONENT CCN: 14-T191

WORKSHEET D
PART IV

CHECK [] TITLE V [] HOSPITAL [] SUB (OTHER) [] ICF/MR [XX] PPS
 APPLICABLE [XX] TITLE XVIII, PART A [] IPF [] SNF [] TEFRA
 BOXES: [] TITLE XIX [XX] IRF [] NF

(A)	COST CENTER DESCRIPTION	TOTAL CHARGES (from Wkst. C, Part I, col. 8)	RATIO OF COST TO CHARGES (col. 5÷ col. 7)	OUTPAT-IENT RATIO OF COST TO CHARGES (col. 6÷ col. 7)	INPATIENT PROGRAM CHARGES	INPATIENT PROGRAM PASS-THROUGH COSTS (col. 8 x col. 10)	OUTPAT-IENT PROGRAM CHARGES	OUTPAT-IENT PROGRAM PASS-THROUGH COSTS (col. 9 x col. 12)
7	8	9	10	11	12	13		
	ANCILLARY SERVICE COST CENTERS							
50	OPERATING ROOM	99,862,339	0.000338	0.000338	74,791	25		50
51	RECOVERY ROOM	6,411,085			4,368			51
53	ANESTHESIOLOGY	17,060,094			8,397			53
54	RADIOLOGY-DIAGNOSTIC	33,611,185			204,583			54
54.01	ULTRASOUND	13,240,724			84,052			54.01
54.02	SPECIAL PROCEDURES	33,819,153			137,638			54.02
56	RADIOISOTOPE	10,669,603			10,366			56
57	CT SCAN	65,240,056			265,509			57
58	MRI	19,248,783			124,231			58
59	CARDIAC CATHETERIZATION	19,237,689						59
60	LABORATORY	158,281,486			1,208,808			60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
63	BLOOD STORING, PROCESSING & TRANS.	6,265,753			60,781			63
65	RESPIRATORY THERAPY	19,272,508	0.001752	0.001752	694,898	1,217		65
65.01	PULMONARY FUNCTION	1,151,533			660			65.01
66	PHYSICAL THERAPY	21,960,705			3,195,400			66
67	OCCUPATIONAL THERAPY	5,995,825			3,157,043			67
68	SPEECH PATHOLOGY	3,008,871			1,253,175			68
69	ELECTROCARDIOLOGY	23,353,012	0.001446	0.001446	57,923	84		69
70	ELECTROENCEPHALOGRAPHY	1,164,883			11,953			70
70.01	SLEEP LAB	1,418,658			3,063			70.01
70.02	PSYCH	5,406,160	0.000427	0.000427				70.02
71	MEDICAL SUPPLIES CHARGED TO PATIENTS	5,034,364			36,825			71
72	IMPL. DEV. CHARGED TO PATIENTS	29,907,885						72
73	DRUGS CHARGED TO PATIENTS	121,928,419	0.002431	0.002431	2,135,547	5,192		73
73.01	INFUSION THERAPY	4,529,212						73.01
73.02	IFCC INFUSION THERAPY	4,814,907						73.02
73.03	PHARMACY VACCINE	147,919						73.03
74	RENAL DIALYSIS	1,893,041			218,274			74
76.97	CARDIAC REHABILITATION	836,367						76.97
76.98	HYPERBARIC OXYGEN THERAPY	8,210,703			183,056			76.98
76.99	LITHOTRIPSY							76.99
	OUTPATIENT SERVICE COST CENTERS							
90.02	PSYCH ANCILLARY	8,023,589						90.02
90.03	RETINAL VASCULAR	828,037						90.03
91	EMERGENCY	84,374,380	0.008029	0.008029	26,097	210		91
91.01	IFCC	185,536,002						91.01
92	OBSERVATION BEDS (NON-DISTINCT PART)	6,754,808						92
	OTHER REIMBURSABLE COST CENTERS							
200	TOTAL (sum of lines 50-199)	1,028,499,738			13,157,438	6,728		200

(A) Worksheet A line numbers



INGALLS MEMORIAL HOSPITAL Provider CCN: 14-0191	In Lieu of Form CMS-2552-10	Period : From: 10/01/2013 To: 09/30/2014	Run Date: 03/02/2015 Run Time: 10:44 Version: 2014.10
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APPORTIONMENT OF MEDICAL AND OTHER HEALTH SERVICE COSTS

COMPONENT CCN: 14-T191

WORKSHEET D
PART V

CHECK [] TITLE V - O/P [] HOSPITAL [] SUB (OTHER) [] SWING BED SNF
 APPLICABLE [XX] TITLE XVIII, PART B [] IPF [] SNF [] SWING BED NF
 BOXES: [] TITLE XIX - O/P [XX] IRF [] NF [] ICF/MR

(A)	COST CENTER DESCRIPTION	COST TO CHARGE RATIO (from Wkst C, Part I, col. 9)	PROGRAM CHARGES			PROGRAM COST			
			PPS REIM-BURSED SERVICES (see inst.)	COST REIM-BURSED SUBJECT TO DED. & COINS. (see inst.)	COST REIM-BURSED NOT SUBJECT TO DED. & COINS. (see inst.)	PPS SERVICES (see inst.)	COST REIM-BURSED SUBJECT TO DED. & COINS. (see inst.)	COST REIM-BURSED NOT SUBJECT TO DED. & COINS. (see inst.)	
		1	2	3	4	5	6	7	
	ANCILLARY SERVICE COST CENTERS								
50	OPERATING ROOM	0.200169							50
51	RECOVERY ROOM	0.272331							51
53	ANESTHESIOLOGY	0.078070							53
54	RADIOLOGY-DIAGNOSTIC	0.262188							54
54.01	ULTRASOUND	0.159623							54.01
54.02	SPECIAL PROCEDURES	0.072197							54.02
56	RADIOISOTOPE	0.219962							56
57	CT SCAN	0.032471							57
58	MRI	0.077651							58
59	CARDIAC CATHETERIZATION	0.186614							59
60	LABORATORY	0.109171							60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS								62.30
63	BLOOD STORING, PROCESSING & TRANS.	0.312729							63
65	RESPIRATORY THERAPY	0.178058							65
65.01	PULMONARY FUNCTION	0.161526							65.01
66	PHYSICAL THERAPY	0.214712							66
67	OCCUPATIONAL THERAPY	0.412076							67
68	SPEECH PATHOLOGY	0.259167							68
69	ELECTROCARDIOLOGY	0.105566							69
70	ELECTROENCEPHALOGRAPHY	0.271032							70
70.01	SLEEP LAB	0.169037							70.01
70.02	PSYCH	0.464418							70.02
71	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.162552							71
72	IMPL. DEV. CHARGED TO PATIENTS	0.532942							72
73	DRUGS CHARGED TO PATIENTS	0.196357							73
73.01	INFUSION THERAPY	0.218728							73.01
73.02	IFCC INFUSION THERAPY	0.232087							73.02
73.03	PHARMACY VACCINE	0.883889							73.03
74	RENAL DIALYSIS	0.624065							74
76.97	CARDIAC REHABILITATION	1.007168							76.97
76.98	HYPERBARIC OXYGEN THERAPY	0.240176							76.98
76.99	LITHOTRIPSY								76.99
	OUTPATIENT SERVICE COST CENTERS								
90.02	PSYCH ANCILLARY	0.431720							90.02
90.03	RETINAL VASCULAR	1.415946							90.03
91	EMERGENCY	0.119232							91
91.01	IFCC	0.163091							91.01
92	OBSERVATION BEDS (NON-DISTINCT PART)	0.640710							92
	OTHER REIMBURSABLE COST CENTERS								
200	SUBTOTAL (see instructions)								200
201	LESS PBP CLINIC LAB. SERVICES PROGRAM ONLY CHARGES								201
202	NET CHARGES (line 200 - line 201)								202

(A) Worksheet A line numbers



COMPU-MAX

INGALLS MEMORIAL HOSPITAL Provider CCN: 14-0191	In Lieu of Form CMS-2552-10	Period : From: 10/01/2013 To: 09/30/2014	Run Date: 03/02/2015 Run Time: 10:44 Version: 2014.10
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APPORTIONMENT OF INPATIENT ROUTINE SERVICE CAPITAL COSTS

WORKSHEET D
PART I

CHECK TITLE V
 APPLICABLE TITLE XVIII, PART A
 BOXES: TITLE XIX

(A)	COST CENTER DESCRIPTION	CAPITAL RELATED COST (from Wkst. B, Part II, (col. 26))	SWING BED ADJUSTMENT	REDUCED CAPITAL RELATED COST (col. 1 minus col. 2)	TOTAL PATIENT DAYS	PER DIEM (col. 3 ÷ col. 4)	INPATIENT PROGRAM DAYS	INPATIENT PROGRAM CAPITAL COST (col. 5 x col. 6)	
	INPATIENT ROUTINE SERV COST CENTERS	1	2	3	4	5	6	7	
30	ADULTS & PEDIATRICS (General Routine Care)	3,788,848		3,788,848	59,940	63.21	11,563	730,897	30
31	INTENSIVE CARE UNIT	500,802		500,802	4,333	115.58	517	59,755	31
32	CORONARY CARE UNIT								32
33	BURN INTENSIVE CARE UNIT								33
34	SURGICAL INTENSIVE CARE UNIT								34
35	OTHER SPECIAL CARE (SPECIFY)								35
40	SUBPROVIDER - IPF	157,938		157,938	2,890	54.65	388	21,204	40
41	SUBPROVIDER - IRF	854,747		854,747	8,022	106.55	279	29,727	41
42	SUBPROVIDER I								42
43	NURSERY	189,853		189,853	3,782	50.20	2,764	138,753	43
44	SKILLED NURSING FACILITY								44
45	NURSING FACILITY								45
200	TOTAL (lines 30-199)	5,492,188		5,492,188	78,967		15,511	980,336	200

(A) Worksheet A line numbers



COMPU-MAX

INGALLS MEMORIAL HOSPITAL Provider CCN: 14-0191	In Lieu of Form CMS-2552-10	Period : From: 10/01/2013 To: 09/30/2014	Run Date: 03/02/2015 Run Time: 10:44 Version: 2014.10
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APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS

COMPONENT CCN: 14-0191

WORKSHEET D
PART II

CHECK [] TITLE V [XX] HOSPITAL [] SUB (OTHER)
 APPLICABLE [] TITLE XVIII, PART A [] IPF
 BOXES: [XX] TITLE XIX [] IRF

(A)	COST CENTER DESCRIPTION	CAPITAL RELATED COST (from Wkst. B, Part II (col. 26))	TOTAL CHARGES (from Wkst. C, Part I, (col. 8))	RATIO OF COST TO CHARGES (col. 1 ÷ col. 2)	INPATIENT PROGRAM CHARGES	CAPITAL COSTS (col. 3 x col. 4)	
		1	2	3	4	5	
	ANCILLARY SERVICE COST CENTERS						
50	OPERATING ROOM	1,417,743	99,862,339	0.014197	4,320,307	61,335	50
51	RECOVERY ROOM	111,791	6,411,085	0.017437	347,555	6,060	51
53	ANESTHESIOLOGY	86,620	17,060,094	0.005077	861,795	4,375	53
54	RADIOLOGY-DIAGNOSTIC	941,177	33,611,185	0.028002	1,272,907	35,644	54
54.01	ULTRASOUND	119,473	13,240,724	0.009023	912,435	8,233	54.01
54.02	SPECIAL PROCEDURES	206,744	33,819,153	0.006113	2,156,532	13,183	54.02
56	RADIOISOTOPE	115,470	10,669,603	0.010822	444,297	4,808	56
57	CT SCAN	131,546	65,240,056	0.002016	5,249,160	10,582	57
58	MRI	103,244	19,248,783	0.005364	1,365,234	7,323	58
59	CARDIAC CATHETERIZATION	386,440	19,237,689	0.020088	1,425,381	28,633	59
60	LABORATORY	628,134	158,281,486	0.003968	12,770,370	50,673	60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS						62.30
63	BLOOD STORING, PROCESSING & TRANS.	44,414	6,265,753	0.007088	979,467	6,942	63
65	RESPIRATORY THERAPY	117,955	19,272,508	0.006120	3,344,808	20,470	65
65.01	PULMONARY FUNCTION	15,830	1,151,533	0.013747	62,314	857	65.01
66	PHYSICAL THERAPY	197,669	21,960,705	0.009001	199,076	1,792	66
67	OCCUPATIONAL THERAPY	55,530	5,995,825	0.009261	155,806	1,443	67
68	SPEECH PATHOLOGY	29,218	3,008,871	0.009711	375,458	3,646	68
69	ELECTROCARDIOLOGY	200,205	23,353,012	0.008573	2,305,371	19,764	69
70	ELECTROENCEPHALOGRAPHY	44,926	1,164,883	0.038567	128,323	4,949	70
70.01	SLEEP LAB	14,615	1,418,658	0.010302	14,335	148	70.01
70.02	PSYCH	42,294	5,406,160	0.007823			70.02
71	MEDICAL SUPPLIES CHARGED TO PATIENTS	15,888	5,034,364	0.003156	642,418	2,027	71
72	IMPL., DEV. CHARGED TO PATIENTS	306,924	29,907,885	0.010262	908,298	9,321	72
73	DRUGS CHARGED TO PATIENTS	640,159	121,928,419	0.005250	9,240,574	48,513	73
73.01	INFUSION THERAPY	36,134	4,529,212	0.007978			73.01
73.02	IFCC INFUSION THERAPY	26,272	4,814,907	0.005456			73.02
73.03	PHARMACY VACCINE	3,518	147,919	0.023783			73.03
74	RENAL DIALYSIS	58,643	1,893,041	0.030978	232,778	7,211	74
76.97	CARDIAC REHABILITATION	47,376	836,367	0.056645	13,108	743	76.97
76.98	HYPERBARIC OXYGEN THERAPY	35,850	8,210,703	0.004366	178,165	778	76.98
76.99	LITHOTRIPSY						76.99
	OUTPATIENT SERVICE COST CENTERS						
90.02	PSYCH ANCILLARY	209,506	8,023,589	0.026111			90.02
90.03	RETINAL VASCULAR	150,951	828,037	0.182300	3,356	612	90.03
91	EMERGENCY	516,428	84,374,380	0.006121	5,613,944	34,363	91
91.01	IFCC	1,999,497	185,536,002	0.010777	1,685,203	18,161	91.01
92	OBSERVATION BEDS (NON-DISTINCT PART)	295,572	6,754,808	0.043757			92
	OTHER REIMBURSABLE COST CENTERS						
200	TOTAL (sum of lines 50-199)	9,353,756	1,028,499,738		57,208,775	412,589	200

(A) Worksheet A line numbers



COMPU-MAX

INGALLS MEMORIAL HOSPITAL Provider CCN: 14-0191	In Lieu of Form CMS-2552-10	Period : From: 10/01/2013 To: 09/30/2014	Run Date: 03/02/2015 Run Time: 10:44 Version: 2014.10
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APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PASS THROUGH COSTS

WORKSHEET D
PART III

CHECK TITLE V
 APPLICABLE TITLE XVIII, PART A
 BOXES: TITLE XIX

		NURSING SCHOOL	ALLIED HEALTH COST	ALL OTHER MEDICAL EDUCATION COST	SWING-BED ADJUST-MENT AMOUNT (see instructions)	TOTAL COSTS (sum of cols. 1 through 3 minus col 4.)	
(A)	COST CENTER DESCRIPTION	1	2	3	4	5	
	INPATIENT ROUTINE SERV COST CENTERS						
30	ADULTS & PEDIATRICS (General Routine Care)		250,428			250,428	30
31	INTENSIVE CARE UNIT		130,122			130,122	31
32	CORONARY CARE UNIT						32
33	BURN INTENSIVE CARE UNIT						33
34	SURGICAL INTENSIVE CARE UNIT						34
35	OTHER SPECIAL CARE (SPECIFY)						35
40	SUBPROVIDER - IPF		17,310			17,310	40
41	SUBPROVIDER - IRF		50,775			50,775	41
42	SUBPROVIDER I						42
43	NURSERY						43
44	SKILLED NURSING FACILITY						44
45	NURSING FACILITY						45
200	TOTAL (lines 30-199)		448,635			448,635	200

(A) Worksheet A line numbers



COMPU-MAX

INGALLS MEMORIAL HOSPITAL Provider CCN: 14-0191	In Lieu of Form CMS-2552-10	Period : From: 10/01/2013 To: 09/30/2014	Run Date: 03/02/2015 Run Time: 10:44 Version: 2014.10
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APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PASS THROUGH COSTS

WORKSHEET D
PART III

CHECK TITLE V
 APPLICABLE TITLE XVIII, PART A
 BOXES: TITLE XIX

		TOTAL PATIENT DAYS	PER DIEM (col. 5 ÷ col. 6)	INPATIENT PROGRAM DAYS	INPATIENT PROGRAM PASS THRU COST (col. 7 x col. 8)	
(A)	COST CENTER DESCRIPTION	6	7	8	9	
	INPATIENT ROUTINE SERV COST CENTERS					
30	ADULTS & PEDIATRICS (General Routine Care)	59,940	4.18	11,563	48,333	30
31	INTENSIVE CARE UNIT	4,333	30.03	517	15,526	31
32	CORONARY CARE UNIT					32
33	BURN INTENSIVE CARE UNIT					33
34	SURGICAL INTENSIVE CARE UNIT					34
35	OTHER SPECIAL CARE (SPECIFY)					35
40	SUBPROVIDER - IPF	2,890	5.99	388	2,324	40
41	SUBPROVIDER - IRF	8,022	6.33	279	1,766	41
42	SUBPROVIDER I					42
43	NURSERY	3,782		2,764		43
44	SKILLED NURSING FACILITY					44
45	NURSING FACILITY					45
200	TOTAL (lines 30-199)	78,967		15,511	67,949	200

(A) Worksheet A line numbers



COMPU-MAX

INGALLS MEMORIAL HOSPITAL Provider CCN: 14-0191	In Lieu of Form CMS-2552-10	Period : From: 10/01/2013 To: 09/30/2014	Run Date: 03/02/2015 Run Time: 10:44 Version: 2014.10
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APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE
OTHER PASS THROUGH COSTS

COMPONENT CCN: 14-0191

WORKSHEET D
PART IV

CHECK [] TITLE V [XX] HOSPITAL [] SUB (OTHER) [] ICF/MR
 APPLICABLE [] TITLE XVIII, PART A [] IPF [] SNF
 BOXES: [XX] TITLE XIX [] IRF [] NF

(A)	COST CENTER DESCRIPTION	NON PHYSICIAN ANESTHETIST COST	NURSING SCHOOL	ALLIED HEALTH	ALL OTHER MEDICAL EDUCATION COST	TOTAL COST (sum of col. 1 through col. 4)	TOTAL OUTPATIENT COST (sum of col. 2, 3, and 4)	
	ANCILLARY SERVICE COST CENTERS	1	2	3	4	5	6	
50	OPERATING ROOM			33,758		33,758	33,758	50
51	RECOVERY ROOM							51
53	ANESTHESIOLOGY							53
54	RADIOLOGY-DIAGNOSTIC							54
54.01	ULTRASOUND							54.01
54.02	SPECIAL PROCEDURES							54.02
56	RADIOISOTOPE							56
57	CT SCAN							57
58	MRI							58
59	CARDIAC CATHETERIZATION							59
60	LABORATORY							60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
63	BLOOD STORING, PROCESSING & TRANS.							63
65	RESPIRATORY THERAPY			33,758		33,758	33,758	65
65.01	PULMONARY FUNCTION							65.01
66	PHYSICAL THERAPY							66
67	OCCUPATIONAL THERAPY							67
68	SPEECH PATHOLOGY							68
69	ELECTROCARDIOLOGY			33,758		33,758	33,758	69
70	ELECTROENCEPHALOGRAPHY							70
70.01	SLEEP LAB							70.01
70.02	PSYCH			2,308		2,308	2,308	70.02
71	MEDICAL SUPPLIES CHARGED TO PATIENTS							71
72	IMPL. DEV. CHARGED TO PATIENTS							72
73	DRUGS CHARGED TO PATIENTS			296,369		296,369	296,369	73
73.01	INFUSION THERAPY							73.01
73.02	IFCC INFUSION THERAPY							73.02
73.03	PHARMACY VACCINE							73.03
74	RENAL DIALYSIS							74
76.97	CARDIAC REHABILITATION							76.97
76.98	HYPERBARIC OXYGEN THERAPY							76.98
76.99	LITHOTRIPSY							76.99
	OUTPATIENT SERVICE COST CENTERS							
90.02	PSYCH ANCILLARY							90.02
90.03	RETINAL VASCULAR							90.03
91	EMERGENCY			677,458		677,458	677,458	91
91.01	IFCC							91.01
92	OBSERVATION BEDS (NON-DISTINCT PART)							92
	OTHER REIMBURSABLE COST CENTERS							
200	TOTAL (sum of lines 50-199)			1,077,409		1,077,409	1,077,409	200

(A) Worksheet A line numbers



COMPU-MAX

INGALLS MEMORIAL HOSPITAL Provider CCN: 14-0191	In Lieu of Form CMS-2552-10	Period : From: 10/01/2013 To: 09/30/2014	Run Date: 03/02/2015 Run Time: 10:44 Version: 2014.10
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APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE
OTHER PASS THROUGH COSTS

COMPONENT CCN: 14-0191

WORKSHEET D
PART IV

CHECK [] TITLE V [XX] HOSPITAL [] SUB (OTHER) [] ICF/MR
 APPLICABLE [] TITLE XVIII, PART A [] IPF [] SNF
 BOXES: [XX] TITLE XIX [] IRF [] NF

(A)	COST CENTER DESCRIPTION	TOTAL CHARGES (from Wkst. C, Part I, col. 8)	RATIO OF COST TO CHARGES (col. 5÷ col. 7)	OUTPAT-IENT RATIO OF COST TO CHARGES (col. 6÷ col. 7)	INPATIENT PROGRAM CHARGES	INPATIENT PROGRAM PASS-THROUGH COSTS (col. 8 x col. 10)	OUTPAT-IENT PROGRAM CHARGES	OUTPAT-IENT PROGRAM PASS-THROUGH COSTS (col. 9 x col. 12)
7	8	9	10	11	12	13		
	ANCILLARY SERVICE COST CENTERS							
50	OPERATING ROOM	99,862,339	0.000338	0.000338	4,320,307	1,460		50
51	RECOVERY ROOM	6,411,085			347,555			51
53	ANESTHESIOLOGY	17,060,094			861,795			53
54	RADIOLOGY-DIAGNOSTIC	33,611,185			1,272,907			54
54.01	ULTRASOUND	13,240,724			912,435			54.01
54.02	SPECIAL PROCEDURES	33,819,153			2,156,532			54.02
56	RADIOISOTOPE	10,669,603			444,297			56
57	CT SCAN	65,240,056			5,249,160			57
58	MRI	19,248,783			1,365,234			58
59	CARDIAC CATHETERIZATION	19,237,689			1,425,381			59
60	LABORATORY	158,281,486			12,770,370			60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
63	BLOOD STORING, PROCESSING & TRANS.	6,265,753			979,467			63
65	RESPIRATORY THERAPY	19,272,508	0.001752	0.001752	3,344,808	5,860		65
65.01	PULMONARY FUNCTION	1,151,533			62,314			65.01
66	PHYSICAL THERAPY	21,960,705			199,076			66
67	OCCUPATIONAL THERAPY	5,995,825			155,806			67
68	SPEECH PATHOLOGY	3,008,871			375,458			68
69	ELECTROCARDIOLOGY	23,353,012	0.001446	0.001446	2,305,371	3,334		69
70	ELECTROENCEPHALOGRAPHY	1,164,883			128,323			70
70.01	SLEEP LAB	1,418,658			14,335			70.01
70.02	PSYCH	5,406,160	0.000427	0.000427				70.02
71	MEDICAL SUPPLIES CHARGED TO PATIENTS	5,034,364			642,418			71
72	IMPL. DEV. CHARGED TO PATIENTS	29,907,885			908,298			72
73	DRUGS CHARGED TO PATIENTS	121,928,419	0.002431	0.002431	9,240,574	22,464		73
73.01	INFUSION THERAPY	4,529,212						73.01
73.02	IFCC INFUSION THERAPY	4,814,907						73.02
73.03	PHARMACY VACCINE	147,919						73.03
74	RENAL DIALYSIS	1,893,041			232,778			74
76.97	CARDIAC REHABILITATION	836,367			13,108			76.97
76.98	HYPERBARIC OXYGEN THERAPY	8,210,703			178,165			76.98
76.99	LITHOTRIPSY							76.99
	OUTPATIENT SERVICE COST CENTERS							
90.02	PSYCH ANCILLARY	8,023,589						90.02
90.03	RETINAL VASCULAR	828,037			3,356			90.03
91	EMERGENCY	84,374,380	0.008029	0.008029	5,613,944	45,074		91
91.01	IFCC	185,536,002			1,685,203			91.01
92	OBSERVATION BEDS (NON-DISTINCT PART)	6,754,808						92
	OTHER REIMBURSABLE COST CENTERS							
200	TOTAL (sum of lines 50-199)	1,028,499,738			57,208,775	78,192		200

(A) Worksheet A line numbers



INGALLS MEMORIAL HOSPITAL Provider CCN: 14-0191	In Lieu of Form CMS-2552-10	Period : From: 10/01/2013 To: 09/30/2014	Run Date: 03/02/2015 Run Time: 10:44 Version: 2014.10
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APPORTIONMENT OF MEDICAL AND OTHER HEALTH SERVICE COSTS

COMPONENT CCN: 14-0191

WORKSHEET D
PART V

CHECK [] TITLE V - O/P [XX] HOSPITAL [] SUB (OTHER) [] SWING BED SNF
 APPLICABLE [] TITLE XVIII, PART B [] IPF [] SNF [] SWING BED NF
 BOXES: [XX] TITLE XIX - O/P [] IRF [] NF [] ICF/MR

(A)	COST CENTER DESCRIPTION	COST TO CHARGE RATIO (from Wkst C, Part I, col. 9)	PROGRAM CHARGES			PROGRAM COST			
			PPS REIM-BURSED SERVICES (see inst.)	COST REIM-BURSED SUBJECT TO DED. & COINS. (see inst.)	COST REIM-BURSED NOT SUBJECT TO DED. & COINS. (see inst.)	PPS SERVICES (see inst.)	COST REIM-BURSED SUBJECT TO DED. & COINS. (see inst.)	COST REIM-BURSED NOT SUBJECT TO DED. & COINS. (see inst.)	
		1	2	3	4	5	6	7	
	ANCILLARY SERVICE COST CENTERS								
50	OPERATING ROOM	0.200169			3,829,095			766,466	50
51	RECOVERY ROOM	0.272331			400,092			108,957	51
53	ANESTHESIOLOGY	0.078070			737,775			57,598	53
54	RADIOLOGY-DIAGNOSTIC	0.262188			5,947,826			1,559,449	54
54.01	ULTRASOUND	0.159623			3,604,249			575,321	54.01
54.02	SPECIAL PROCEDURES	0.072197			1,799,601			129,926	54.02
56	RADIOISOTOPE	0.219962			998,659			219,667	56
57	CT SCAN	0.032471			15,251,428			495,229	57
58	MRI	0.077651			1,850,757			143,713	58
59	CARDIAC CATHETERIZATION	0.186614			866,603			161,720	59
60	LABORATORY	0.109171			21,320,125			2,327,539	60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS								62.30
63	BLOOD STORING, PROCESSING & TRANS.	0.312729			725,902			227,011	63
65	RESPIRATORY THERAPY	0.178058			1,550,335			276,050	65
65.01	PULMONARY FUNCTION	0.161526			145,121			23,441	65.01
66	PHYSICAL THERAPY	0.214712			1,655,548			355,466	66
67	OCCUPATIONAL THERAPY	0.412076							67
68	SPEECH PATHOLOGY	0.259167							68
69	ELECTROCARDIOLOGY	0.105566			2,973,147			313,863	69
70	ELECTROENCEPHALOGRAPHY	0.271032			116,901			31,684	70
70.01	SLEEP LAB	0.169037			102,884			17,391	70.01
70.02	PSYCH	0.464418							70.02
71	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.162552			597,703			97,158	71
72	IMPL. DEV. CHARGED TO PATIENTS	0.532942			559,902			298,395	72
73	DRUGS CHARGED TO PATIENTS	0.196357			6,025,372			1,183,124	73
73.01	INFUSION THERAPY	0.218728			512,389			112,074	73.01
73.02	IFCC INFUSION THERAPY	0.232087			38,724			8,987	73.02
73.03	PHARMACY VACCINE	0.883889							73.03
74	RENAL DIALYSIS	0.624065			107,540			67,112	74
76.97	CARDIAC REHABILITATION	1.007168			1,302			1,311	76.97
76.98	HYPERBARIC OXYGEN THERAPY	0.240176			519,215			124,703	76.98
76.99	LITHOTRIPSY								76.99
	OUTPATIENT SERVICE COST CENTERS								
90.02	PSYCH ANCILLARY	0.431720			1,905,102			822,471	90.02
90.03	RETINAL VASCULAR	1.415946			37,300			52,815	90.03
91	EMERGENCY	0.119232			37,290,195			4,446,185	91
91.01	IFCC	0.163091			33,490,642			5,462,022	91.01
92	OBSERVATION BEDS (NON-DISTINCT PART)	0.640710			2,695,844			1,727,254	92
	OTHER REIMBURSABLE COST CENTERS								
200	SUBTOTAL (see instructions)				147,657,278			22,194,102	200
201	LESS PBP CLINIC LAB. SERVICES PROGRAM ONLY CHARGES								201
202	NET CHARGES (line 200 - line 201)				147,657,278			22,194,102	202

(A) Worksheet A line numbers



COMPU-MAX

INGALLS MEMORIAL HOSPITAL Provider CCN: 14-0191	In Lieu of Form CMS-2552-10	Period : From: 10/01/2013 To: 09/30/2014	Run Date: 03/02/2015 Run Time: 10:44 Version: 2014.10
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APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS

COMPONENT CCN: 14-S191

WORKSHEET D
PART II

CHECK [] TITLE V [] HOSPITAL [] SUB (OTHER)
 APPLICABLE [] TITLE XVIII, PART A [XX] IPF
 BOXES: [XX] TITLE XIX [] IRF

(A)	COST CENTER DESCRIPTION	CAPITAL RELATED COST (from Wkst. B, Part II (col. 26))	TOTAL CHARGES (from Wkst. C, Part I, (col. 8))	RATIO OF COST TO CHARGES (col. 1 ÷ col. 2)	INPATIENT PROGRAM CHARGES	CAPITAL COSTS (col. 3 x col. 4)	
		1	2	3	4	5	
	ANCILLARY SERVICE COST CENTERS						
50	OPERATING ROOM	1,417,743	99,862,339	0.014197			50
51	RECOVERY ROOM	111,791	6,411,085	0.017437			51
53	ANESTHESIOLOGY	86,620	17,060,094	0.005077			53
54	RADIOLOGY-DIAGNOSTIC	941,177	33,611,185	0.028002	5,104	143	54
54.01	ULTRASOUND	119,473	13,240,724	0.009023	3,324	30	54.01
54.02	SPECIAL PROCEDURES	206,744	33,819,153	0.006113			54.02
56	RADIOISOTOPE	115,470	10,669,603	0.010822			56
57	CT SCAN	131,546	65,240,056	0.002016	18,092	36	57
58	MRI	103,244	19,248,783	0.005364	4,204	23	58
59	CARDIAC CATHETERIZATION	386,440	19,237,689	0.020088			59
60	LABORATORY	628,134	158,281,486	0.003968	128,882	511	60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS						62.30
63	BLOOD STORING, PROCESSING & TRANS.	44,414	6,265,753	0.007088	304	2	63
65	RESPIRATORY THERAPY	117,955	19,272,508	0.006120	8,951	55	65
65.01	PULMONARY FUNCTION	15,830	1,151,533	0.013747			65.01
66	PHYSICAL THERAPY	197,669	21,960,705	0.009001	733	7	66
67	OCCUPATIONAL THERAPY	55,530	5,995,825	0.009261	413	4	67
68	SPEECH PATHOLOGY	29,218	3,008,871	0.009711			68
69	ELECTROCARDIOLOGY	200,205	23,353,012	0.008573	23,795	204	69
70	ELECTROENCEPHALOGRAPHY	44,926	1,164,883	0.038567			70
70.01	SLEEP LAB	14,615	1,418,658	0.010302			70.01
70.02	PSYCH	42,294	5,406,160	0.007823			70.02
71	MEDICAL SUPPLIES CHARGED TO PATIENTS	15,888	5,034,364	0.003156	299	1	71
72	IMPL., DEV. CHARGED TO PATIENTS	306,924	29,907,885	0.010262			72
73	DRUGS CHARGED TO PATIENTS	640,159	121,928,419	0.005250	48,929	257	73
73.01	INFUSION THERAPY	36,134	4,529,212	0.007978			73.01
73.02	IFCC INFUSION THERAPY	26,272	4,814,907	0.005456			73.02
73.03	PHARMACY VACCINE	3,518	147,919	0.023783			73.03
74	RENAL DIALYSIS	58,643	1,893,041	0.030978			74
76.97	CARDIAC REHABILITATION	47,376	836,367	0.056645			76.97
76.98	HYPERBARIC OXYGEN THERAPY	35,850	8,210,703	0.004366	1,236	5	76.98
76.99	LITHOTRIPSY						76.99
	OUTPATIENT SERVICE COST CENTERS						
90.02	PSYCH ANCILLARY	209,506	8,023,589	0.026111			90.02
90.03	RETINAL VASCULAR	150,951	828,037	0.182300			90.03
91	EMERGENCY	516,428	84,374,380	0.006121	99,066	606	91
91.01	IFCC	1,999,497	185,536,002	0.010777			91.01
92	OBSERVATION BEDS (NON-DISTINCT PART)		6,754,808				92
	OTHER REIMBURSABLE COST CENTERS						
200	TOTAL (sum of lines 50-199)	9,058,184	1,028,499,738		343,332	1,884	200

(A) Worksheet A line numbers



COMPU-MAX

INGALLS MEMORIAL HOSPITAL Provider CCN: 14-0191	In Lieu of Form CMS-2552-10	Period : From: 10/01/2013 To: 09/30/2014	Run Date: 03/02/2015 Run Time: 10:44 Version: 2014.10
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APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE
OTHER PASS THROUGH COSTS

COMPONENT CCN: 14-S191

WORKSHEET D
PART IV

CHECK TITLE V HOSPITAL SUB (OTHER) ICF/MR
 APPLICABLE TITLE XVIII, PART A IPF SNF
 BOXES: TITLE XIX IRF NF

(A)	COST CENTER DESCRIPTION	NON PHYSICIAN ANESTHETIST COST	NURSING SCHOOL	ALLIED HEALTH	ALL OTHER MEDICAL EDUCATION COST	TOTAL COST (sum of col. 1 through col. 4)	TOTAL OUTPATIENT COST (sum of col. 2, 3, and 4)	
	ANCILLARY SERVICE COST CENTERS	1	2	3	4	5	6	
50	OPERATING ROOM			33,758		33,758	33,758	50
51	RECOVERY ROOM							51
53	ANESTHESIOLOGY							53
54	RADIOLOGY-DIAGNOSTIC							54
54.01	ULTRASOUND							54.01
54.02	SPECIAL PROCEDURES							54.02
56	RADIOISOTOPE							56
57	CT SCAN							57
58	MRI							58
59	CARDIAC CATHETERIZATION							59
60	LABORATORY							60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
63	BLOOD STORING, PROCESSING & TRANS.							63
65	RESPIRATORY THERAPY			33,758		33,758	33,758	65
65.01	PULMONARY FUNCTION							65.01
66	PHYSICAL THERAPY							66
67	OCCUPATIONAL THERAPY							67
68	SPEECH PATHOLOGY							68
69	ELECTROCARDIOLOGY			33,758		33,758	33,758	69
70	ELECTROENCEPHALOGRAPHY							70
70.01	SLEEP LAB							70.01
70.02	PSYCH			2,308		2,308	2,308	70.02
71	MEDICAL SUPPLIES CHARGED TO PATIENTS							71
72	IMPL. DEV. CHARGED TO PATIENTS							72
73	DRUGS CHARGED TO PATIENTS			296,369		296,369	296,369	73
73.01	INFUSION THERAPY							73.01
73.02	IFCC INFUSION THERAPY							73.02
73.03	PHARMACY VACCINE							73.03
74	RENAL DIALYSIS							74
76.97	CARDIAC REHABILITATION							76.97
76.98	HYPERBARIC OXYGEN THERAPY							76.98
76.99	LITHOTRIPSY							76.99
	OUTPATIENT SERVICE COST CENTERS							
90.02	PSYCH ANCILLARY							90.02
90.03	RETINAL VASCULAR							90.03
91	EMERGENCY			677,458		677,458	677,458	91
91.01	IFCC							91.01
92	OBSERVATION BEDS (NON-DISTINCT PART)							92
	OTHER REIMBURSABLE COST CENTERS							
200	TOTAL (sum of lines 50-199)			1,077,409		1,077,409	1,077,409	200

(A) Worksheet A line numbers



COMPU-MAX

INGALLS MEMORIAL HOSPITAL Provider CCN: 14-0191	In Lieu of Form CMS-2552-10	Period : From: 10/01/2013 To: 09/30/2014	Run Date: 03/02/2015 Run Time: 10:44 Version: 2014.10
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APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE
OTHER PASS THROUGH COSTS

COMPONENT CCN: 14-S191

WORKSHEET D
PART IV

CHECK [] TITLE V [] HOSPITAL [] SUB (OTHER) [] ICF/MR
 APPLICABLE [] TITLE XVIII, PART A [XX] IPF [] SNF
 BOXES: [XX] TITLE XIX [] IRF [] NF

(A)	COST CENTER DESCRIPTION	TOTAL CHARGES (from Wkst. C, Part I, col. 8)	RATIO OF COST TO CHARGES (col. 5÷ col. 7)	OUTPAT-IENT RATIO OF COST TO CHARGES (col. 6÷ col. 7)	INPATIENT PROGRAM CHARGES	INPATIENT PROGRAM PASS-THROUGH COSTS (col. 8 x col. 10)	OUTPAT-IENT PROGRAM CHARGES	OUTPAT-IENT PROGRAM PASS-THROUGH COSTS (col. 9 x col. 12)
	ANCILLARY SERVICE COST CENTERS							
50	OPERATING ROOM	99,862,339	0.000338	0.000338				50
51	RECOVERY ROOM	6,411,085						51
53	ANESTHESIOLOGY	17,060,094						53
54	RADIOLOGY-DIAGNOSTIC	33,611,185			5,104			54
54.01	ULTRASOUND	13,240,724			3,324			54.01
54.02	SPECIAL PROCEDURES	33,819,153						54.02
56	RADIOISOTOPE	10,669,603						56
57	CT SCAN	65,240,056			18,092			57
58	MRI	19,248,783			4,204			58
59	CARDIAC CATHETERIZATION	19,237,689						59
60	LABORATORY	158,281,486			128,882			60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
63	BLOOD STORING, PROCESSING & TRANS.	6,265,753			304			63
65	RESPIRATORY THERAPY	19,272,508	0.001752	0.001752	8,951	16		65
65.01	PULMONARY FUNCTION	1,151,533						65.01
66	PHYSICAL THERAPY	21,960,705			733			66
67	OCCUPATIONAL THERAPY	5,995,825			413			67
68	SPEECH PATHOLOGY	3,008,871						68
69	ELECTROCARDIOLOGY	23,353,012	0.001446	0.001446	23,795	34		69
70	ELECTROENCEPHALOGRAPHY	1,164,883						70
70.01	SLEEP LAB	1,418,658						70.01
70.02	PSYCH	5,406,160	0.000427	0.000427				70.02
71	MEDICAL SUPPLIES CHARGED TO PATIENTS	5,034,364			299			71
72	IMPL. DEV. CHARGED TO PATIENTS	29,907,885						72
73	DRUGS CHARGED TO PATIENTS	121,928,419	0.002431	0.002431	48,929	119		73
73.01	INFUSION THERAPY	4,529,212						73.01
73.02	IFCC INFUSION THERAPY	4,814,907						73.02
73.03	PHARMACY VACCINE	147,919						73.03
74	RENAL DIALYSIS	1,893,041						74
76.97	CARDIAC REHABILITATION	836,367						76.97
76.98	HYPERBARIC OXYGEN THERAPY	8,210,703			1,236			76.98
76.99	LITHOTRIPSY							76.99
	OUTPATIENT SERVICE COST CENTERS							
90.02	PSYCH ANCILLARY	8,023,589						90.02
90.03	RETINAL VASCULAR	828,037						90.03
91	EMERGENCY	84,374,380	0.008029	0.008029	99,066	795		91
91.01	IFCC	185,536,002						91.01
92	OBSERVATION BEDS (NON-DISTINCT PART)	6,754,808						92
	OTHER REIMBURSABLE COST CENTERS							
200	TOTAL (sum of lines 50-199)	1,028,499,738			343,332	964		200

(A) Worksheet A line numbers



INGALLS MEMORIAL HOSPITAL Provider CCN: 14-0191	In Lieu of Form CMS-2552-10	Period : From: 10/01/2013 To: 09/30/2014	Run Date: 03/02/2015 Run Time: 10:44 Version: 2014.10
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APPORTIONMENT OF MEDICAL AND OTHER HEALTH SERVICE COSTS

COMPONENT CCN: 14-S191

WORKSHEET D
PART V

CHECK [] TITLE V - O/P [] HOSPITAL [] SUB (OTHER) [] SWING BED SNF
 APPLICABLE [] TITLE XVIII, PART B [XX] IPF [] SNF [] SWING BED NF
 BOXES: [XX] TITLE XIX - O/P [] IRF [] NF [] ICF/MR

(A)	COST CENTER DESCRIPTION	COST TO CHARGE RATIO (from Wkst C, Part I, col. 9)	PROGRAM CHARGES			PROGRAM COST			
			PPS REIM-BURSED SERVICES (see inst.)	COST REIM-BURSED SUBJECT TO DED. & COINS. (see inst.)	COST REIM-BURSED NOT SUBJECT TO DED. & COINS. (see inst.)	PPS SERVICES (see inst.)	COST REIM-BURSED SUBJECT TO DED. & COINS. (see inst.)	COST REIM-BURSED NOT SUBJECT TO DED. & COINS. (see inst.)	
		1	2	3	4	5	6	7	
	ANCILLARY SERVICE COST CENTERS								
50	OPERATING ROOM	0.200169							50
51	RECOVERY ROOM	0.272331							51
53	ANESTHESIOLOGY	0.078070							53
54	RADIOLOGY-DIAGNOSTIC	0.262188							54
54.01	ULTRASOUND	0.159623							54.01
54.02	SPECIAL PROCEDURES	0.072197							54.02
56	RADIOISOTOPE	0.219962							56
57	CT SCAN	0.032471							57
58	MRI	0.077651							58
59	CARDIAC CATHETERIZATION	0.186614							59
60	LABORATORY	0.109171							60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS								62.30
63	BLOOD STORING, PROCESSING & TRANS.	0.312729							63
65	RESPIRATORY THERAPY	0.178058							65
65.01	PULMONARY FUNCTION	0.161526							65.01
66	PHYSICAL THERAPY	0.214712							66
67	OCCUPATIONAL THERAPY	0.412076							67
68	SPEECH PATHOLOGY	0.259167							68
69	ELECTROCARDIOLOGY	0.105566							69
70	ELECTROENCEPHALOGRAPHY	0.271032							70
70.01	SLEEP LAB	0.169037							70.01
70.02	PSYCH	0.464418							70.02
71	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.162552							71
72	IMPL. DEV. CHARGED TO PATIENTS	0.532942							72
73	DRUGS CHARGED TO PATIENTS	0.196357							73
73.01	INFUSION THERAPY	0.218728							73.01
73.02	IFCC INFUSION THERAPY	0.232087							73.02
73.03	PHARMACY VACCINE	0.883889							73.03
74	RENAL DIALYSIS	0.624065							74
76.97	CARDIAC REHABILITATION	1.007168							76.97
76.98	HYPERBARIC OXYGEN THERAPY	0.240176							76.98
76.99	LITHOTRIPSY								76.99
	OUTPATIENT SERVICE COST CENTERS								
90.02	PSYCH ANCILLARY	0.431720							90.02
90.03	RETINAL VASCULAR	1.415946							90.03
91	EMERGENCY	0.119232							91
91.01	IFCC	0.163091							91.01
92	OBSERVATION BEDS (NON-DISTINCT PART)	0.640710							92
	OTHER REIMBURSABLE COST CENTERS								
200	SUBTOTAL (see instructions)								200
201	LESS PBP CLINIC LAB. SERVICES PROGRAM ONLY CHARGES								201
202	NET CHARGES (line 200 - line 201)								202

(A) Worksheet A line numbers



COMPU-MAX

INGALLS MEMORIAL HOSPITAL Provider CCN: 14-0191	In Lieu of Form CMS-2552-10	Period : From: 10/01/2013 To: 09/30/2014	Run Date: 03/02/2015 Run Time: 10:44 Version: 2014.10
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APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS

COMPONENT CCN: 14-T191

WORKSHEET D
PART II

CHECK [] TITLE V [] HOSPITAL [] SUB (OTHER)
 APPLICABLE [] TITLE XVIII, PART A [] IPF
 BOXES: [XX] TITLE XIX [XX] IRF

(A)	COST CENTER DESCRIPTION	CAPITAL RELATED COST (from Wkst. B, Part II (col. 26))	TOTAL CHARGES (from Wkst. C, Part I, (col. 8))	RATIO OF COST TO CHARGES (col. 1 ÷ col. 2)	INPATIENT PROGRAM CHARGES	CAPITAL COSTS (col. 3 x col. 4)	
		1	2	3	4	5	
	ANCILLARY SERVICE COST CENTERS						
50	OPERATING ROOM	1,417,743	99,862,339	0.014197			50
51	RECOVERY ROOM	111,791	6,411,085	0.017437			51
53	ANESTHESIOLOGY	86,620	17,060,094	0.005077			53
54	RADIOLOGY-DIAGNOSTIC	941,177	33,611,185	0.028002	4,897	137	54
54.01	ULTRASOUND	119,473	13,240,724	0.009023	1,899	17	54.01
54.02	SPECIAL PROCEDURES	206,744	33,819,153	0.006113			54.02
56	RADIOISOTOPE	115,470	10,669,603	0.010822			56
57	CT SCAN	131,546	65,240,056	0.002016	6,303	13	57
58	MRI	103,244	19,248,783	0.005364			58
59	CARDIAC CATHETERIZATION	386,440	19,237,689	0.020088			59
60	LABORATORY	628,134	158,281,486	0.003968	25,771	102	60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS						62.30
63	BLOOD STORING, PROCESSING & TRANS.	44,414	6,265,753	0.007088	5,702	40	63
65	RESPIRATORY THERAPY	117,955	19,272,508	0.006120	18,283	112	65
65.01	PULMONARY FUNCTION	15,830	1,151,533	0.013747			65.01
66	PHYSICAL THERAPY	197,669	21,960,705	0.009001	107,584	968	66
67	OCCUPATIONAL THERAPY	55,530	5,995,825	0.009261	103,938	963	67
68	SPEECH PATHOLOGY	29,218	3,008,871	0.009711	39,528	384	68
69	ELECTROCARDIOLOGY	200,205	23,353,012	0.008573	282	2	69
70	ELECTROENCEPHALOGRAPHY	44,926	1,164,883	0.038567			70
70.01	SLEEP LAB	14,615	1,418,658	0.010302			70.01
70.02	PSYCH	42,294	5,406,160	0.007823			70.02
71	MEDICAL SUPPLIES CHARGED TO PATIENTS	15,888	5,034,364	0.003156	385	1	71
72	IMPL., DEV. CHARGED TO PATIENTS	306,924	29,907,885	0.010262			72
73	DRUGS CHARGED TO PATIENTS	640,159	121,928,419	0.005250	94,668	497	73
73.01	INFUSION THERAPY	36,134	4,529,212	0.007978			73.01
73.02	IFCC INFUSION THERAPY	26,272	4,814,907	0.005456			73.02
73.03	PHARMACY VACCINE	3,518	147,919	0.023783			73.03
74	RENAL DIALYSIS	58,643	1,893,041	0.030978	1,854	57	74
76.97	CARDIAC REHABILITATION	47,376	836,367	0.056645			76.97
76.98	HYPERBARIC OXYGEN THERAPY	35,850	8,210,703	0.004366			76.98
76.99	LITHOTRIPSY						76.99
	OUTPATIENT SERVICE COST CENTERS						
90.02	PSYCH ANCILLARY	209,506	8,023,589	0.026111			90.02
90.03	RETINAL VASCULAR	150,951	828,037	0.182300			90.03
91	EMERGENCY	516,428	84,374,380	0.006121			91
91.01	IFCC	1,999,497	185,536,002	0.010777			91.01
92	OBSERVATION BEDS (NON-DISTINCT PART)		6,754,808				92
	OTHER REIMBURSABLE COST CENTERS						
200	TOTAL (sum of lines 50-199)	9,058,184	1,028,499,738		411,094	3,293	200

(A) Worksheet A line numbers



COMPU-MAX

INGALLS MEMORIAL HOSPITAL Provider CCN: 14-0191	In Lieu of Form CMS-2552-10	Period : From: 10/01/2013 To: 09/30/2014	Run Date: 03/02/2015 Run Time: 10:44 Version: 2014.10
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APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE
OTHER PASS THROUGH COSTS

COMPONENT CCN: 14-T191

WORKSHEET D
PART IV

CHECK [] TITLE V [] HOSPITAL [] SUB (OTHER) [] ICF/MR
 APPLICABLE [] TITLE XVIII, PART A [] IPF [] SNF
 BOXES: [XX] TITLE XIX [XX] IRF [] NF

(A)	COST CENTER DESCRIPTION	NON PHYSICIAN ANESTHETIST COST	NURSING SCHOOL	ALLIED HEALTH	ALL OTHER MEDICAL EDUCATION COST	TOTAL COST (sum of col. 1 through col. 4)	TOTAL OUTPATIENT COST (sum of col. 2, 3, and 4)	
	ANCILLARY SERVICE COST CENTERS	1	2	3	4	5	6	
50	OPERATING ROOM			33,758		33,758	33,758	50
51	RECOVERY ROOM							51
53	ANESTHESIOLOGY							53
54	RADIOLOGY-DIAGNOSTIC							54
54.01	ULTRASOUND							54.01
54.02	SPECIAL PROCEDURES							54.02
56	RADIOISOTOPE							56
57	CT SCAN							57
58	MRI							58
59	CARDIAC CATHETERIZATION							59
60	LABORATORY							60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
63	BLOOD STORING, PROCESSING & TRANS.							63
65	RESPIRATORY THERAPY			33,758		33,758	33,758	65
65.01	PULMONARY FUNCTION							65.01
66	PHYSICAL THERAPY							66
67	OCCUPATIONAL THERAPY							67
68	SPEECH PATHOLOGY							68
69	ELECTROCARDIOLOGY			33,758		33,758	33,758	69
70	ELECTROENCEPHALOGRAPHY							70
70.01	SLEEP LAB							70.01
70.02	PSYCH			2,308		2,308	2,308	70.02
71	MEDICAL SUPPLIES CHARGED TO PATIENTS							71
72	IMPL. DEV. CHARGED TO PATIENTS							72
73	DRUGS CHARGED TO PATIENTS			296,369		296,369	296,369	73
73.01	INFUSION THERAPY							73.01
73.02	IFCC INFUSION THERAPY							73.02
73.03	PHARMACY VACCINE							73.03
74	RENAL DIALYSIS							74
76.97	CARDIAC REHABILITATION							76.97
76.98	HYPERBARIC OXYGEN THERAPY							76.98
76.99	LITHOTRIPSY							76.99
	OUTPATIENT SERVICE COST CENTERS							
90.02	PSYCH ANCILLARY							90.02
90.03	RETINAL VASCULAR							90.03
91	EMERGENCY			677,458		677,458	677,458	91
91.01	IFCC							91.01
92	OBSERVATION BEDS (NON-DISTINCT PART)							92
	OTHER REIMBURSABLE COST CENTERS							
200	TOTAL (sum of lines 50-199)			1,077,409		1,077,409	1,077,409	200

(A) Worksheet A line numbers



COMPU-MAX

INGALLS MEMORIAL HOSPITAL Provider CCN: 14-0191	In Lieu of Form CMS-2552-10	Period : From: 10/01/2013 To: 09/30/2014	Run Date: 03/02/2015 Run Time: 10:44 Version: 2014.10
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APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE
OTHER PASS THROUGH COSTS

COMPONENT CCN: 14-T191

WORKSHEET D
PART IV

CHECK [] TITLE V [] HOSPITAL [] SUB (OTHER) [] ICF/MR
 APPLICABLE [] TITLE XVIII, PART A [] IPF [] SNF
 BOXES: [XX] TITLE XIX [XX] IRF [] NF

(A)	COST CENTER DESCRIPTION	TOTAL CHARGES (from Wkst. C, Part I, col. 8)	RATIO OF COST TO CHARGES (col. 5÷ col. 7)	OUTPAT-IENT RATIO OF COST TO CHARGES (col. 6÷ col. 7)	INPATIENT PROGRAM CHARGES	INPATIENT PROGRAM PASS-THROUGH COSTS (col. 8 x col. 10)	OUTPAT-IENT PROGRAM CHARGES	OUTPAT-IENT PROGRAM PASS-THROUGH COSTS (col. 9 x col. 12)	
7	8	9	10	11	12	13			
	ANCILLARY SERVICE COST CENTERS								
50	OPERATING ROOM	99,862,339	0.000338	0.000338					50
51	RECOVERY ROOM	6,411,085							51
53	ANESTHESIOLOGY	17,060,094							53
54	RADIOLOGY-DIAGNOSTIC	33,611,185			4,897				54
54.01	ULTRASOUND	13,240,724			1,899				54.01
54.02	SPECIAL PROCEDURES	33,819,153							54.02
56	RADIOISOTOPE	10,669,603							56
57	CT SCAN	65,240,056			6,303				57
58	MRI	19,248,783							58
59	CARDIAC CATHETERIZATION	19,237,689							59
60	LABORATORY	158,281,486			25,771				60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS								62.30
63	BLOOD STORING, PROCESSING & TRANS.	6,265,753			5,702				63
65	RESPIRATORY THERAPY	19,272,508	0.001752	0.001752	18,283	32			65
65.01	PULMONARY FUNCTION	1,151,533							65.01
66	PHYSICAL THERAPY	21,960,705			107,584				66
67	OCCUPATIONAL THERAPY	5,995,825			103,938				67
68	SPEECH PATHOLOGY	3,008,871			39,528				68
69	ELECTROCARDIOLOGY	23,353,012	0.001446	0.001446	282				69
70	ELECTROENCEPHALOGRAPHY	1,164,883							70
70.01	SLEEP LAB	1,418,658							70.01
70.02	PSYCH	5,406,160	0.000427	0.000427					70.02
71	MEDICAL SUPPLIES CHARGED TO PATIENTS	5,034,364			385				71
72	IMPL. DEV. CHARGED TO PATIENTS	29,907,885							72
73	DRUGS CHARGED TO PATIENTS	121,928,419	0.002431	0.002431	94,668	230			73
73.01	INFUSION THERAPY	4,529,212							73.01
73.02	IFCC INFUSION THERAPY	4,814,907							73.02
73.03	PHARMACY VACCINE	147,919							73.03
74	RENAL DIALYSIS	1,893,041			1,854				74
76.97	CARDIAC REHABILITATION	836,367							76.97
76.98	HYPERBARIC OXYGEN THERAPY	8,210,703							76.98
76.99	LITHOTRIPSY								76.99
	OUTPATIENT SERVICE COST CENTERS								
90.02	PSYCH ANCILLARY	8,023,589							90.02
90.03	RETINAL VASCULAR	828,037							90.03
91	EMERGENCY	84,374,380	0.008029	0.008029					91
91.01	IFCC	185,536,002							91.01
92	OBSERVATION BEDS (NON-DISTINCT PART)	6,754,808							92
	OTHER REIMBURSABLE COST CENTERS								
200	TOTAL (sum of lines 50-199)	1,028,499,738			411,094	262			200

(A) Worksheet A line numbers



INGALLS MEMORIAL HOSPITAL Provider CCN: 14-0191	In Lieu of Form CMS-2552-10	Period : From: 10/01/2013 To: 09/30/2014	Run Date: 03/02/2015 Run Time: 10:44 Version: 2014.10
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APPORTIONMENT OF MEDICAL AND OTHER HEALTH SERVICE COSTS

COMPONENT CCN: 14-T191

WORKSHEET D
PART V

CHECK [] TITLE V - O/P [] HOSPITAL [] SUB (OTHER) [] SWING BED SNF
 APPLICABLE [] TITLE XVIII, PART B [] IPF [] SNF [] SWING BED NF
 BOXES: [XX] TITLE XIX - O/P [XX] IRF [] NF [] ICF/MR

(A)	COST CENTER DESCRIPTION	COST TO CHARGE RATIO (from Wkst C, Part I, col. 9)	PROGRAM CHARGES			PROGRAM COST			
			PPS REIM-BURSED SERVICES (see inst.)	COST REIM-BURSED SUBJECT TO DED. & COINS. (see inst.)	COST REIM-BURSED NOT SUBJECT TO DED. & COINS. (see inst.)	PPS SERVICES (see inst.)	COST REIM-BURSED SUBJECT TO DED. & COINS. (see inst.)	COST REIM-BURSED NOT SUBJECT TO DED. & COINS. (see inst.)	
		1	2	3	4	5	6	7	
	ANCILLARY SERVICE COST CENTERS								
50	OPERATING ROOM	0.200169							50
51	RECOVERY ROOM	0.272331							51
53	ANESTHESIOLOGY	0.078070							53
54	RADIOLOGY-DIAGNOSTIC	0.262188							54
54.01	ULTRASOUND	0.159623							54.01
54.02	SPECIAL PROCEDURES	0.072197							54.02
56	RADIOISOTOPE	0.219962							56
57	CT SCAN	0.032471							57
58	MRI	0.077651							58
59	CARDIAC CATHETERIZATION	0.186614							59
60	LABORATORY	0.109171							60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS								62.30
63	BLOOD STORING, PROCESSING & TRANS.	0.312729							63
65	RESPIRATORY THERAPY	0.178058							65
65.01	PULMONARY FUNCTION	0.161526							65.01
66	PHYSICAL THERAPY	0.214712							66
67	OCCUPATIONAL THERAPY	0.412076							67
68	SPEECH PATHOLOGY	0.259167							68
69	ELECTROCARDIOLOGY	0.105566							69
70	ELECTROENCEPHALOGRAPHY	0.271032							70
70.01	SLEEP LAB	0.169037							70.01
70.02	PSYCH	0.464418							70.02
71	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.162552							71
72	IMPL. DEV. CHARGED TO PATIENTS	0.532942							72
73	DRUGS CHARGED TO PATIENTS	0.196357							73
73.01	INFUSION THERAPY	0.218728							73.01
73.02	IFCC INFUSION THERAPY	0.232087							73.02
73.03	PHARMACY VACCINE	0.883889							73.03
74	RENAL DIALYSIS	0.624065							74
76.97	CARDIAC REHABILITATION	1.007168							76.97
76.98	HYPERBARIC OXYGEN THERAPY	0.240176							76.98
76.99	LITHOTRIPSY								76.99
	OUTPATIENT SERVICE COST CENTERS								
90.02	PSYCH ANCILLARY	0.431720							90.02
90.03	RETINAL VASCULAR	1.415946							90.03
91	EMERGENCY	0.119232							91
91.01	IFCC	0.163091							91.01
92	OBSERVATION BEDS (NON-DISTINCT PART)	0.640710							92
	OTHER REIMBURSABLE COST CENTERS								
200	SUBTOTAL (see instructions)								200
201	LESS PBP CLINIC LAB. SERVICES PROGRAM ONLY CHARGES								201
202	NET CHARGES (line 200 - line 201)								202

(A) Worksheet A line numbers



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INGALLS MEMORIAL HOSPITAL Provider CCN: 14-0191	In Lieu of Form CMS-2552-10	Period : From: 10/01/2013 To: 09/30/2014	Run Date: 03/02/2015 Run Time: 10:44 Version: 2014.10
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COMPUTATION OF INPATIENT OPERATING COST

COMPONENT CCN: 14-0191

WORKSHEET D-1
PART I

CHECK TITLE V - I/P HOSPITAL SUB (OTHER) ICF/MR PPS
 APPLICABLE TITLE XVIII, PART A IPF SNF TEFRA
 BOXES: TITLE XIX - I/P IRF NF OTHER

PART I - ALL PROVIDER COMPONENTS

INPATIENT DAYS

1	INPATIENT DAYS (including private room days and swing-bed days, excluding newborn)	59,940	1
2	INPATIENT DAYS (including private room days, excluding swing-bed and newborn days)	59,940	2
3	PRIVATE ROOM DAYS (excluding swing-bed private room days). IF YOU HAVE ONLY PRIVATE ROOM DAYS, DO NOT COMPLETE THIS LINE.		3
4	SEMI-PRIVATE ROOM DAYS (excluding swing-bed private room days)	55,264	4
5	TOTAL SWING-BED SNF-TYPE INPATIENT DAYS (including private room days) THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD		5
6	TOTAL SWING-BED SNF-TYPE INPATIENT DAYS (including private room days) AFTER DECEMBER 31 OF THE COST REPORTING PERIOD (if calendar year, enter 0 on this line)		6
7	TOTAL SWING-BED NF-TYPE INPATIENT DAYS (including private room days) THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD		7
8	TOTAL SWING-BED NF-TYPE INPATIENT DAYS (including private room days) AFTER DECEMBER 31 OF THE COST REPORTING PERIOD (if calendar year, enter 0 on this line)		8
9	INPATIENT DAYS INCLUDING PRIVATE ROOM DAYS APPLICABLE TO THE PROGRAM (excluding swing-bed and newborn days)	24,107	9
10	SWING-BED SNF-TYPE INPATIENT DAYS APPLICABLE TO TITLE XVIII ONLY (including private room days) THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD (see instructions)		10
11	SWING-BED SNF-TYPE INPATIENT DAYS APPLICABLE TO TITLE XVIII ONLY (including private room days) AFTER DECEMBER 31 OF THE COST REPORTING PERIOD (if calendar year, enter 0 on this line)		11
12	SWING-BED NF-TYPE INPATIENT DAYS APPLICABLE TO TITLES V OR XIX ONLY (including private room days) THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD		12
13	SWING-BED NF-TYPE INPATIENT DAYS APPLICABLE TO TITLES V OR XIX ONLY (including private room days) AFTER DECEMBER 31 OF THE COST REPORTING PERIOD (if calendar year, enter 0 on this line)		13
14	MEDICALLY NECESSARY PRIVATE ROOM DAYS APPLICABLE TO THE PROGRAM (excluding swing-bed days)		14
15	TOTAL NURSERY DAYS (Title V or Title XIX only)		15
16	TITLE V OR XIX NURSERY DAYS (Title V or Title XIX only)		16

SWING-BED ADJUSTMENT

17	MEDICARE RATE FOR SWING-BED SNF SERVICES APPLICABLE TO SERVICES THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD		17
18	MEDICARE RATE FOR SWING-BED SNF SERVICES APPLICABLE TO SERVICES AFTER DECEMBER 31 OF THE COST REPORTING PERIOD		18
19	MEDICAID RATE FOR SWING-BED NF SERVICES APPLICABLE TO SERVICES THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD		19
20	MEDICAID RATE FOR SWING-BED NF SERVICES APPLICABLE TO SERVICES AFTER DECEMBER 31 OF THE COST REPORTING PERIOD		20
21	TOTAL GENERAL INPATIENT ROUTINE SERVICE COST (see instructions)	55,477,371	21
22	SWING-BED COST APPLICABLE TO SNF-TYPE SERVICES THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD (line 5 x line 17)		22
23	SWING-BED COST APPLICABLE TO SNF-TYPE SERVICES AFTER DECEMBER 31 OF THE COST REPORTING PERIOD (line 6 x line 18)		23
24	SWING-BED COST APPLICABLE TO NF-TYPE SERVICES THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD (line 7 x line 19)		24
25	SWING-BED COST APPLICABLE TO NF-TYPE SERVICES AFTER DECEMBER 31 OF THE COST REPORTING PERIOD (line 8 x line 20)		25
26	TOTAL SWING-BED COST (see instructions)		26
27	GENERAL INPATIENT ROUTINE SERVICE COST NET OF SWING-BED COST	55,477,371	27

PRIVATE ROOM DIFFERENTIAL ADJUSTMENT

28	GENERAL INPATIENT ROUTINE SERVICE CHARGES (excluding swing-bed and observation bed charges)		28
29	PRIVATE ROOM CHARGES (excluding swing-bed charges)		29
30	SEMI-PRIVATE ROOM CHARGES (excluding swing-bed charges)		30
31	GENERAL INPATIENT ROUTINE SERVICE COST/CHARGE RATIO (line 27 ÷ line 28)		31
32	AVERAGE PRIVATE ROOM PER DIEM CHARGE (line 29 ÷ line 3)		32
33	AVERAGE SEMI-PRIVATE ROOM PER DIEM CHARGE (line 30 ÷ line 4)		33
34	AVERAGE PER DIEM PRIVATE ROOM CHARGE DIFFERENTIAL (line 32 minus line 33) (see instructions)		34
35	AVERAGE PER DIEM PRIVATE ROOM COST DIFFERENTIAL (line 34 x line 31)		35
36	PRIVATE ROOM COST DIFFERENTIAL ADJUSTMENT (line 3 x line 35)		36
37	GENERAL INPATIENT ROUTINE SERVICE COST NET OF SWING-BED COST AND PRIVATE ROOM COST DIFFERENTIAL (line 27 - line 36)	55,477,371	37



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COMPUTATION OF INPATIENT OPERATING COST

COMPONENT CCN: 14-0191

WORKSHEET D-1
PART II

CHECK [] TITLE V - I/P [XX] HOSPITAL [] SUB (OTHER) [XX] PPS
 APPLICABLE [XX] TITLE XVIII, PART A [] IPF [] TEFRA
 BOXES: [] TITLE XIX - I/P [] IRF [] OTHER

PART II - HOSPITALS AND SUBPROVIDERS ONLY

PROGRAM INPATIENT OPERATING COST BEFORE PASS-THROUGH COST ADJUSTMENTS

38	ADJUSTED GENERAL INPATIENT ROUTINE SERVICE COST PER DIEM (see instructions)					925.55	38
39	PROGRAM GENERAL INPATIENT ROUTINE SERVICE COST (line 9 x line 38)					22,312,234	39
40	MEDICALLY NECESSARY PRIVATE ROOM COST APPLICABLE TO THE PROGRAM (line 14 x line 35)						40
41	TOTAL PROGRAM GENERAL INPATIENT ROUTINE SERVICE COST (line 39 + line 40)					22,312,234	41
		TOTAL INPATIENT COST	TOTAL INPATIENT DAYS	AVERAGE PER DIEM (col. 1 ÷ col. 2)	PROGRAM DAYS	PROGRAM COST (col. 3 x col. 4)	
		1	2	3	4	5	
42	NURSERY (Titles V and XIX only)						42
	INTENSIVE CARE TYPE INPATIENT HOSPITAL UNITS						
43	INTENSIVE CARE UNIT	7,845,068	4,333	1,810.54	2,375	4,300,033	43
44	CORONARY CARE UNIT						44
45	BURN INTENSIVE CARE UNIT						45
46	SURGICAL INTENSIVE CARE UNIT						46
47	OTHER SPECIAL CARE (SPECIFY)						47

48	PROGRAM INPATIENT ANCILLARY SERVICE COST (Worksheet D-3, column 3, line 200)					29,088,444	48
49	TOTAL PROGRAM INPATIENT COSTS (sum of lines 41 through 48)(see instructions)					55,700,711	49

PASS-THROUGH COST ADJUSTMENTS

50	PASS THROUGH COSTS APPLICABLE TO PROGRAM INPATIENT ROUTINE SERVICES (from Worksheet D, sum of Parts I and III)					1,970,394	50
51	PASS THROUGH COSTS APPLICABLE TO PROGRAM INPATIENT ANCILLARY SERVICES (from Worksheet D, sum of Parts II and IV)					1,517,464	51
52	TOTAL PROGRAM EXCLUDABLE COST (sum of lines 50 and 51)					3,487,858	52
53	TOTAL PROGRAM INPATIENT OPERATING COST EXCLUDING CAPITAL RELATED, NONPHYSICIAN ANESTHETIST AND MEDICAL EDUCATION COSTS (line 49 minus line 52)					52,212,853	53

TARGET AMOUNT AND LIMIT COMPUTATION

54	PROGRAM DISCHARGES						54
55	TARGET AMOUNT PER DISCHARGE						55
56	TARGET AMOUNT (line 54 x line 55)						56
57	DIFFERENCE BETWEEN ADJUSTED INPATIENT OPERATING COST AND TARGET AMOUNT (line 56 minus line 53)						57
58	BONUS PAYMENT (see instructions)						58
59	LESSER OF LINE 53 ÷ LINE 54 OR LINE 55 FROM THE COST REPORTING PERIOD ENDING 1996, UPDATED AND COMPOUNDED BY THE MARKET BASKET						59
60	LESSER OF LINE 53 ÷ LINE 54 OR LINE 55 FROM PRIOR YEAR COST REPORT, UPDATED BY THE MARKET BASKET						60
61	IF LINE 53 ÷ 54 IS LESS THAN THE LOWER OF LINES 55, 59 OR 60 ENTER THE LESSER OF 50% OF THE AMOUNT BY WHICH OPERATING COSTS (line 53) ARE LESS THAN EXPECTED COSTS (line 54 x 60), OR 1% OF THE TARGET AMOUNT (line 56), OTHERWISE ENTER ZERO (see instructions)						61
62	RELIEF PAYMENT (see instructions)						62
63	ALLOWABLE INPATIENT COST PLUS INCENTIVE PAYMENT (see instructions)						63

PROGRAM INPATIENT ROUTINE SWING BED COST

64	MEDICARE SWING-BED SNF INPATIENT ROUTINE COSTS THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD (see instructions) (Title XVIII only)						64
65	MEDICARE SWING-BED SNF INPATIENT ROUTINE COSTS AFTER DECEMBER 31 OF THE COST REPORTING PERIOD (see instructions) (Title XVIII only)						65
66	TOTAL MEDICARE SWING-BED SNF INPATIENT ROUTINE COSTS (Title XVIII only. For CAH, see instructions)						66
67	TITLE V OR XIX SWING-BED NF INPATIENT ROUTINE COSTS THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD (line 12 x line 19)						67
68	TITLE V OR XIX SWING-BED NF INPATIENT ROUTINE COSTS AFTER DECEMBER 31 OF THE COST REPORTING PERIOD (line 13 x line 20)						68
69	TOTAL TITLE V OR XIX SWING-BED NF INPATIENT ROUTINE COSTS (line 67 + line 68)						69



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COMPUTATION OF INPATIENT OPERATING COST

COMPONENT CCN: 14-0191

WORKSHEET D-1
PARTS III & IV

CHECK TITLE V - I/P HOSPITAL SUB (OTHER) ICF/MR PPS
 APPLICABLE TITLE XVIII, PART A IPF SNF TEFRA
 BOXES: TITLE XIX - I/P IRF NF OTHER

PART IV - COMPUTATION OF OBSERVATION BED PASS-THROUGH COST

87	TOTAL OBSERVATION BED DAYS (see instructions)					4,676	87
88	ADJUSTED GENERAL INPATIENT ROUTINE COST PER DIEM (line 27 ÷ line 2)					925.55	88
89	OBSERVATION BED COST (line 87 x line 88) (see instructions)					4,327,872	89
		COST	ROUTINE COST (from line 27)	column 1 ÷ column 2	TOTAL OBSERVATION BED COST (from line 89)	OBSERVATION BED PASS-THROUGH COST col. 3 x col. 4 (see instructions)	
		1	2	3	4	5	
90	CAPITAL-RELATED COST	3,788,848	55,477,371	0.068295	4,327,872	295,572	90
91	NURSING SCHOOL COST						91
92	ALLIED HEALTH COST	250,428	55,477,371	0.004514	4,327,872	19,536	92
93	ALL OTHER MEDICAL EDUCATION						93



COMPU-MAX

INGALLS MEMORIAL HOSPITAL Provider CCN: 14-0191	In Lieu of Form CMS-2552-10	Period : From: 10/01/2013 To: 09/30/2014	Run Date: 03/02/2015 Run Time: 10:44 Version: 2014.10
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COMPUTATION OF INPATIENT OPERATING COST

COMPONENT CCN: 14-S191

WORKSHEET D-1
PART I

CHECK [] TITLE V - I/P [] HOSPITAL [] SUB (OTHER) [] ICF/MR [XX] PPS
 APPLICABLE [XX] TITLE XVIII, PART A [XX] IPF [] SNF [] TEFRA
 BOXES: [] TITLE XIX - I/P [] IRF [] NF [] OTHER

PART I - ALL PROVIDER COMPONENTS

INPATIENT DAYS

1	INPATIENT DAYS (including private room days and swing-bed days, excluding newborn)	2,890	1
2	INPATIENT DAYS (including private room days, excluding swing-bed and newborn days)	2,890	2
3	PRIVATE ROOM DAYS (excluding swing-bed private room days). IF YOU HAVE ONLY PRIVATE ROOM DAYS, DO NOT COMPLETE THIS LINE.		3
4	SEMI-PRIVATE ROOM DAYS (excluding swing-bed private room days)	2,890	4
5	TOTAL SWING-BED SNF-TYPE INPATIENT DAYS (including private room days) THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD		5
6	TOTAL SWING-BED SNF-TYPE INPATIENT DAYS (including private room days) AFTER DECEMBER 31 OF THE COST REPORTING PERIOD (if calendar year, enter 0 on this line)		6
7	TOTAL SWING-BED NF-TYPE INPATIENT DAYS (including private room days) THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD		7
8	TOTAL SWING-BED NF-TYPE INPATIENT DAYS (including private room days) AFTER DECEMBER 31 OF THE COST REPORTING PERIOD (if calendar year, enter 0 on this line)		8
9	INPATIENT DAYS INCLUDING PRIVATE ROOM DAYS APPLICABLE TO THE PROGRAM (excluding swing-bed and newborn days)	1,872	9
10	SWING-BED SNF-TYPE INPATIENT DAYS APPLICABLE TO TITLE XVIII ONLY (including private room days) THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD (see instructions)		10
11	SWING-BED SNF-TYPE INPATIENT DAYS APPLICABLE TO TITLE XVIII ONLY (including private room days) AFTER DECEMBER 31 OF THE COST REPORTING PERIOD (if calendar year, enter 0 on this line)		11
12	SWING-BED NF-TYPE INPATIENT DAYS APPLICABLE TO TITLES V OR XIX ONLY (including private room days) THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD		12
13	SWING-BED NF-TYPE INPATIENT DAYS APPLICABLE TO TITLES V OR XIX ONLY (including private room days) AFTER DECEMBER 31 OF THE COST REPORTING PERIOD (if calendar year, enter 0 on this line)		13
14	MEDICALLY NECESSARY PRIVATE ROOM DAYS APPLICABLE TO THE PROGRAM (excluding swing-bed days)		14
15	TOTAL NURSERY DAYS (Title V or Title XIX only)		15
16	TITLE V OR XIX NURSERY DAYS (Title V or Title XIX only)		16

SWING-BED ADJUSTMENT

17	MEDICARE RATE FOR SWING-BED SNF SERVICES APPLICABLE TO SERVICES THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD		17
18	MEDICARE RATE FOR SWING-BED SNF SERVICES APPLICABLE TO SERVICES AFTER DECEMBER 31 OF THE COST REPORTING PERIOD		18
19	MEDICAID RATE FOR SWING-BED NF SERVICES APPLICABLE TO SERVICES THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD		19
20	MEDICAID RATE FOR SWING-BED NF SERVICES APPLICABLE TO SERVICES AFTER DECEMBER 31 OF THE COST REPORTING PERIOD		20
21	TOTAL GENERAL INPATIENT ROUTINE SERVICE COST (see instructions)	3,206,650	21
22	SWING-BED COST APPLICABLE TO SNF-TYPE SERVICES THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD (line 5 x line 17)		22
23	SWING-BED COST APPLICABLE TO SNF-TYPE SERVICES AFTER DECEMBER 31 OF THE COST REPORTING PERIOD (line 6 x line 18)		23
24	SWING-BED COST APPLICABLE TO NF-TYPE SERVICES THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD (line 7 x line 19)		24
25	SWING-BED COST APPLICABLE TO NF-TYPE SERVICES AFTER DECEMBER 31 OF THE COST REPORTING PERIOD (line 8 x line 20)		25
26	TOTAL SWING-BED COST (see instructions)		26
27	GENERAL INPATIENT ROUTINE SERVICE COST NET OF SWING-BED COST	3,206,650	27

PRIVATE ROOM DIFFERENTIAL ADJUSTMENT

28	GENERAL INPATIENT ROUTINE SERVICE CHARGES (excluding swing-bed and observation bed charges)		28
29	PRIVATE ROOM CHARGES (excluding swing-bed charges)		29
30	SEMI-PRIVATE ROOM CHARGES (excluding swing-bed charges)		30
31	GENERAL INPATIENT ROUTINE SERVICE COST/CHARGE RATIO (line 27 ÷ line 28)		31
32	AVERAGE PRIVATE ROOM PER DIEM CHARGE (line 29 ÷ line 3)		32
33	AVERAGE SEMI-PRIVATE ROOM PER DIEM CHARGE (line 30 ÷ line 4)		33
34	AVERAGE PER DIEM PRIVATE ROOM CHARGE DIFFERENTIAL (line 32 minus line 33) (see instructions)		34
35	AVERAGE PER DIEM PRIVATE ROOM COST DIFFERENTIAL (line 34 x line 31)		35
36	PRIVATE ROOM COST DIFFERENTIAL ADJUSTMENT (line 3 x line 35)		36
37	GENERAL INPATIENT ROUTINE SERVICE COST NET OF SWING-BED COST AND PRIVATE ROOM COST DIFFERENTIAL (line 27 - line 36)	3,206,650	37



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COMPUTATION OF INPATIENT OPERATING COST

COMPONENT CCN: 14-S191

WORKSHEET D-1
PART II

CHECK [] TITLE V - I/P [] HOSPITAL [] SUB (OTHER) [XX] PPS
 APPLICABLE [XX] TITLE XVIII, PART A [XX] IPF [] TEFRA
 BOXES: [] TITLE XIX - I/P [] IRF [] OTHER

PART II - HOSPITALS AND SUBPROVIDERS ONLY

PROGRAM INPATIENT OPERATING COST BEFORE PASS-THROUGH COST ADJUSTMENTS

1

38	ADJUSTED GENERAL INPATIENT ROUTINE SERVICE COST PER DIEM (see instructions)	1,109.57	38
39	PROGRAM GENERAL INPATIENT ROUTINE SERVICE COST (line 9 x line 38)	2,077,115	39
40	MEDICALLY NECESSARY PRIVATE ROOM COST APPLICABLE TO THE PROGRAM (line 14 x line 35)		40
41	TOTAL PROGRAM GENERAL INPATIENT ROUTINE SERVICE COST (line 39 + line 40)	2,077,115	41
48	PROGRAM INPATIENT ANCILLARY SERVICE COST (Worksheet D-3, column 3, line 200)	410,292	48
49	TOTAL PROGRAM INPATIENT COSTS (sum of lines 41 through 48)(see instructions)	2,487,407	49

PASS-THROUGH COST ADJUSTMENTS

50	PASS THROUGH COSTS APPLICABLE TO PROGRAM INPATIENT ROUTINE SERVICES (from Worksheet D, sum of Parts I and III)	113,518	50
51	PASS THROUGH COSTS APPLICABLE TO PROGRAM INPATIENT ANCILLARY SERVICES (from Worksheet D, sum of Parts II and IV)	13,825	51
52	TOTAL PROGRAM EXCLUDABLE COST (sum of lines 50 and 51)	127,343	52
53	TOTAL PROGRAM INPATIENT OPERATING COST EXCLUDING CAPITAL RELATED, NONPHYSICIAN ANESTHETIST AND MEDICAL EDUCATION COSTS (line 49 minus line 52)	2,360,064	53

TARGET AMOUNT AND LIMIT COMPUTATION

54	PROGRAM DISCHARGES		54
55	TARGET AMOUNT PER DISCHARGE		55
56	TARGET AMOUNT (line 54 x line 55)		56
57	DIFFERENCE BETWEEN ADJUSTED INPATIENT OPERATING COST AND TARGET AMOUNT (line 56 minus line 53)		57
58	BONUS PAYMENT (see instructions)		58
59	LESSER OF LINE 53 ÷ LINE 54 OR LINE 55 FROM THE COST REPORTING PERIOD ENDING 1996, UPDATED AND COMPOUNDED BY THE MARKET BASKET		59
60	LESSER OF LINE 53 ÷ LINE 54 OR LINE 55 FROM PRIOR YEAR COST REPORT, UPDATED BY THE MARKET BASKET		60
61	IF LINE 53 ÷ 54 IS LESS THAN THE LOWER OF LINES 55, 59 OR 60 ENTER THE LESSER OF 50% OF THE AMOUNT BY WHICH OPERATING COSTS (line 53) ARE LESS THAN EXPECTED COSTS (line 54 x 60), OR 1% OF THE TARGET AMOUNT (line 56), OTHERWISE ENTER ZERO (see instructions)		61
62	RELIEF PAYMENT (see instructions)		62
63	ALLOWABLE INPATIENT COST PLUS INCENTIVE PAYMENT (see instructions)		63

PROGRAM INPATIENT ROUTINE SWING BED COST

64	MEDICARE SWING-BED SNF INPATIENT ROUTINE COSTS THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD (see instructions) (Title XVIII only)		64
65	MEDICARE SWING-BED SNF INPATIENT ROUTINE COSTS AFTER DECEMBER 31 OF THE COST REPORTING PERIOD (see instructions) (Title XVIII only)		65
66	TOTAL MEDICARE SWING-BED SNF INPATIENT ROUTINE COSTS (Title XVIII only, For CAH, see instructions)		66
67	TITLE V OR XIX SWING-BED NF INPATIENT ROUTINE COSTS THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD (line 12 x line 19)		67
68	TITLE V OR XIX SWING-BED NF INPATIENT ROUTINE COSTS AFTER DECEMBER 31 OF THE COST REPORTING PERIOD (line 13 x line 20)		68
69	TOTAL TITLE V OR XIX SWING-BED NF INPATIENT ROUTINE COSTS (line 67 + line 68)		69



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COMPUTATION OF INPATIENT OPERATING COST

COMPONENT CCN: 14-T191

WORKSHEET D-1
PART I

CHECK TITLE V - I/P HOSPITAL SUB (OTHER) ICF/MR PPS
 APPLICABLE TITLE XVIII, PART A IPF SNF TEFRA
 BOXES: TITLE XIX - I/P IRF NF OTHER

PART I - ALL PROVIDER COMPONENTS

INPATIENT DAYS

1	INPATIENT DAYS (including private room days and swing-bed days, excluding newborn)	8,022	1
2	INPATIENT DAYS (including private room days, excluding swing-bed and newborn days)	8,022	2
3	PRIVATE ROOM DAYS (excluding swing-bed private room days). IF YOU HAVE ONLY PRIVATE ROOM DAYS, DO NOT COMPLETE THIS LINE.		3
4	SEMI-PRIVATE ROOM DAYS (excluding swing-bed private room days)	8,022	4
5	TOTAL SWING-BED SNF-TYPE INPATIENT DAYS (including private room days) THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD		5
6	TOTAL SWING-BED SNF-TYPE INPATIENT DAYS (including private room days) AFTER DECEMBER 31 OF THE COST REPORTING PERIOD (if calendar year, enter 0 on this line)		6
7	TOTAL SWING-BED NF-TYPE INPATIENT DAYS (including private room days) THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD		7
8	TOTAL SWING-BED NF-TYPE INPATIENT DAYS (including private room days) AFTER DECEMBER 31 OF THE COST REPORTING PERIOD (if calendar year, enter 0 on this line)		8
9	INPATIENT DAYS INCLUDING PRIVATE ROOM DAYS APPLICABLE TO THE PROGRAM (excluding swing-bed and newborn days)	6,422	9
10	SWING-BED SNF-TYPE INPATIENT DAYS APPLICABLE TO TITLE XVIII ONLY (including private room days) THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD (see instructions)		10
11	SWING-BED SNF-TYPE INPATIENT DAYS APPLICABLE TO TITLE XVIII ONLY (including private room days) AFTER DECEMBER 31 OF THE COST REPORTING PERIOD (if calendar year, enter 0 on this line)		11
12	SWING-BED NF-TYPE INPATIENT DAYS APPLICABLE TO TITLES V OR XIX ONLY (including private room days) THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD		12
13	SWING-BED NF-TYPE INPATIENT DAYS APPLICABLE TO TITLES V OR XIX ONLY (including private room days) AFTER DECEMBER 31 OF THE COST REPORTING PERIOD (if calendar year, enter 0 on this line)		13
14	MEDICALLY NECESSARY PRIVATE ROOM DAYS APPLICABLE TO THE PROGRAM (excluding swing-bed days)		14
15	TOTAL NURSERY DAYS (Title V or Title XIX only)		15
16	TITLE V OR XIX NURSERY DAYS (Title V or Title XIX only)		16

SWING-BED ADJUSTMENT

17	MEDICARE RATE FOR SWING-BED SNF SERVICES APPLICABLE TO SERVICES THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD		17
18	MEDICARE RATE FOR SWING-BED SNF SERVICES APPLICABLE TO SERVICES AFTER DECEMBER 31 OF THE COST REPORTING PERIOD		18
19	MEDICAID RATE FOR SWING-BED NF SERVICES APPLICABLE TO SERVICES THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD		19
20	MEDICAID RATE FOR SWING-BED NF SERVICES APPLICABLE TO SERVICES AFTER DECEMBER 31 OF THE COST REPORTING PERIOD		20
21	TOTAL GENERAL INPATIENT ROUTINE SERVICE COST (see instructions)	9,311,746	21
22	SWING-BED COST APPLICABLE TO SNF-TYPE SERVICES THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD (line 5 x line 17)		22
23	SWING-BED COST APPLICABLE TO SNF-TYPE SERVICES AFTER DECEMBER 31 OF THE COST REPORTING PERIOD (line 6 x line 18)		23
24	SWING-BED COST APPLICABLE TO NF-TYPE SERVICES THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD (line 7 x line 19)		24
25	SWING-BED COST APPLICABLE TO NF-TYPE SERVICES AFTER DECEMBER 31 OF THE COST REPORTING PERIOD (line 8 x line 20)		25
26	TOTAL SWING-BED COST (see instructions)		26
27	GENERAL INPATIENT ROUTINE SERVICE COST NET OF SWING-BED COST	9,311,746	27

PRIVATE ROOM DIFFERENTIAL ADJUSTMENT

28	GENERAL INPATIENT ROUTINE SERVICE CHARGES (excluding swing-bed and observation bed charges)		28
29	PRIVATE ROOM CHARGES (excluding swing-bed charges)		29
30	SEMI-PRIVATE ROOM CHARGES (excluding swing-bed charges)		30
31	GENERAL INPATIENT ROUTINE SERVICE COST/CHARGE RATIO (line 27 ÷ line 28)		31
32	AVERAGE PRIVATE ROOM PER DIEM CHARGE (line 29 ÷ line 3)		32
33	AVERAGE SEMI-PRIVATE ROOM PER DIEM CHARGE (line 30 ÷ line 4)		33
34	AVERAGE PER DIEM PRIVATE ROOM CHARGE DIFFERENTIAL (line 32 minus line 33) (see instructions)		34
35	AVERAGE PER DIEM PRIVATE ROOM COST DIFFERENTIAL (line 34 x line 31)		35
36	PRIVATE ROOM COST DIFFERENTIAL ADJUSTMENT (line 3 x line 35)		36
37	GENERAL INPATIENT ROUTINE SERVICE COST NET OF SWING-BED COST AND PRIVATE ROOM COST DIFFERENTIAL (line 27 - line 36)	9,311,746	37



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COMPUTATION OF INPATIENT OPERATING COST

COMPONENT CCN: 14-T191

WORKSHEET D-1
PART II

CHECK [] TITLE V - I/P [] HOSPITAL [] SUB (OTHER) [XX] PPS
 APPLICABLE [XX] TITLE XVIII, PART A [] IPF [] TEFRA
 BOXES: [] TITLE XIX - I/P [XX] IRF [] OTHER

PART II - HOSPITALS AND SUBPROVIDERS ONLY

PROGRAM INPATIENT OPERATING COST BEFORE PASS-THROUGH COST ADJUSTMENTS

1

38	ADJUSTED GENERAL INPATIENT ROUTINE SERVICE COST PER DIEM (see instructions)	1,160.78	38
39	PROGRAM GENERAL INPATIENT ROUTINE SERVICE COST (line 9 x line 38)	7,454,529	39
40	MEDICALLY NECESSARY PRIVATE ROOM COST APPLICABLE TO THE PROGRAM (line 14 x line 35)		40
41	TOTAL PROGRAM GENERAL INPATIENT ROUTINE SERVICE COST (line 39 + line 40)	7,454,529	41
48	PROGRAM INPATIENT ANCILLARY SERVICE COST (Worksheet D-3, column 3, line 200)	3,321,564	48
49	TOTAL PROGRAM INPATIENT COSTS (sum of lines 41 through 48)(see instructions)	10,776,093	49

PASS-THROUGH COST ADJUSTMENTS

50	PASS THROUGH COSTS APPLICABLE TO PROGRAM INPATIENT ROUTINE SERVICES (from Worksheet D, sum of Parts I and III)	724,915	50
51	PASS THROUGH COSTS APPLICABLE TO PROGRAM INPATIENT ANCILLARY SERVICES (from Worksheet D, sum of Parts II and IV)	116,248	51
52	TOTAL PROGRAM EXCLUDABLE COST (sum of lines 50 and 51)	841,163	52
53	TOTAL PROGRAM INPATIENT OPERATING COST EXCLUDING CAPITAL RELATED, NONPHYSICIAN ANESTHETIST AND MEDICAL EDUCATION COSTS (line 49 minus line 52)	9,934,930	53

TARGET AMOUNT AND LIMIT COMPUTATION

54	PROGRAM DISCHARGES		54
55	TARGET AMOUNT PER DISCHARGE		55
56	TARGET AMOUNT (line 54 x line 55)		56
57	DIFFERENCE BETWEEN ADJUSTED INPATIENT OPERATING COST AND TARGET AMOUNT (line 56 minus line 53)		57
58	BONUS PAYMENT (see instructions)		58
59	LESSER OF LINE 53 ÷ LINE 54 OR LINE 55 FROM THE COST REPORTING PERIOD ENDING 1996, UPDATED AND COMPOUNDED BY THE MARKET BASKET		59
60	LESSER OF LINE 53 ÷ LINE 54 OR LINE 55 FROM PRIOR YEAR COST REPORT, UPDATED BY THE MARKET BASKET		60
61	IF LINE 53 ÷ 54 IS LESS THAN THE LOWER OF LINES 55, 59 OR 60 ENTER THE LESSER OF 50% OF THE AMOUNT BY WHICH OPERATING COSTS (line 53) ARE LESS THAN EXPECTED COSTS (line 54 x 60), OR 1% OF THE TARGET AMOUNT (line 56), OTHERWISE ENTER ZERO (see instructions)		61
62	RELIEF PAYMENT (see instructions)		62
63	ALLOWABLE INPATIENT COST PLUS INCENTIVE PAYMENT (see instructions)		63

PROGRAM INPATIENT ROUTINE SWING BED COST

64	MEDICARE SWING-BED SNF INPATIENT ROUTINE COSTS THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD (see instructions) (Title XVIII only)		64
65	MEDICARE SWING-BED SNF INPATIENT ROUTINE COSTS AFTER DECEMBER 31 OF THE COST REPORTING PERIOD (see instructions) (Title XVIII only)		65
66	TOTAL MEDICARE SWING-BED SNF INPATIENT ROUTINE COSTS (Title XVIII only, For CAH, see instructions)		66
67	TITLE V OR XIX SWING-BED NF INPATIENT ROUTINE COSTS THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD (line 12 x line 19)		67
68	TITLE V OR XIX SWING-BED NF INPATIENT ROUTINE COSTS AFTER DECEMBER 31 OF THE COST REPORTING PERIOD (line 13 x line 20)		68
69	TOTAL TITLE V OR XIX SWING-BED NF INPATIENT ROUTINE COSTS (line 67 + line 68)		69



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COMPUTATION OF INPATIENT OPERATING COST

COMPONENT CCN: 14-0191

WORKSHEET D-1
PART I

CHECK TITLE V - I/P HOSPITAL SUB (OTHER) ICF/MR PPS
 APPLICABLE TITLE XVIII, PART A IPF SNF TEFRA
 BOXES: TITLE XIX - I/P IRF NF OTHER

PART I - ALL PROVIDER COMPONENTS

INPATIENT DAYS

1	INPATIENT DAYS (including private room days and swing-bed days, excluding newborn)	59,940	1
2	INPATIENT DAYS (including private room days, excluding swing-bed and newborn days)	59,940	2
3	PRIVATE ROOM DAYS (excluding swing-bed private room days). IF YOU HAVE ONLY PRIVATE ROOM DAYS, DO NOT COMPLETE THIS LINE.		3
4	SEMI-PRIVATE ROOM DAYS (excluding swing-bed private room days)	55,264	4
5	TOTAL SWING-BED SNF-TYPE INPATIENT DAYS (including private room days) THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD		5
6	TOTAL SWING-BED SNF-TYPE INPATIENT DAYS (including private room days) AFTER DECEMBER 31 OF THE COST REPORTING PERIOD (if calendar year, enter 0 on this line)		6
7	TOTAL SWING-BED NF-TYPE INPATIENT DAYS (including private room days) THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD		7
8	TOTAL SWING-BED NF-TYPE INPATIENT DAYS (including private room days) AFTER DECEMBER 31 OF THE COST REPORTING PERIOD (if calendar year, enter 0 on this line)		8
9	INPATIENT DAYS INCLUDING PRIVATE ROOM DAYS APPLICABLE TO THE PROGRAM (excluding swing-bed and newborn days)	11,563	9
10	SWING-BED SNF-TYPE INPATIENT DAYS APPLICABLE TO TITLE XVIII ONLY (including private room days) THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD (see instructions)		10
11	SWING-BED SNF-TYPE INPATIENT DAYS APPLICABLE TO TITLE XVIII ONLY (including private room days) AFTER DECEMBER 31 OF THE COST REPORTING PERIOD (if calendar year, enter 0 on this line)		11
12	SWING-BED NF-TYPE INPATIENT DAYS APPLICABLE TO TITLES V OR XIX ONLY (including private room days) THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD		12
13	SWING-BED NF-TYPE INPATIENT DAYS APPLICABLE TO TITLES V OR XIX ONLY (including private room days) AFTER DECEMBER 31 OF THE COST REPORTING PERIOD (if calendar year, enter 0 on this line)		13
14	MEDICALLY NECESSARY PRIVATE ROOM DAYS APPLICABLE TO THE PROGRAM (excluding swing-bed days)		14
15	TOTAL NURSERY DAYS (Title V or Title XIX only)	3,782	15
16	TITLE V OR XIX NURSERY DAYS (Title V or Title XIX only)	2,764	16

SWING-BED ADJUSTMENT

17	MEDICARE RATE FOR SWING-BED SNF SERVICES APPLICABLE TO SERVICES THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD		17
18	MEDICARE RATE FOR SWING-BED SNF SERVICES APPLICABLE TO SERVICES AFTER DECEMBER 31 OF THE COST REPORTING PERIOD		18
19	MEDICAID RATE FOR SWING-BED NF SERVICES APPLICABLE TO SERVICES THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD		19
20	MEDICAID RATE FOR SWING-BED NF SERVICES APPLICABLE TO SERVICES AFTER DECEMBER 31 OF THE COST REPORTING PERIOD		20
21	TOTAL GENERAL INPATIENT ROUTINE SERVICE COST (see instructions)	55,477,371	21
22	SWING-BED COST APPLICABLE TO SNF-TYPE SERVICES THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD (line 5 x line 17)		22
23	SWING-BED COST APPLICABLE TO SNF-TYPE SERVICES AFTER DECEMBER 31 OF THE COST REPORTING PERIOD (line 6 x line 18)		23
24	SWING-BED COST APPLICABLE TO NF-TYPE SERVICES THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD (line 7 x line 19)		24
25	SWING-BED COST APPLICABLE TO NF-TYPE SERVICES AFTER DECEMBER 31 OF THE COST REPORTING PERIOD (line 8 x line 20)		25
26	TOTAL SWING-BED COST (see instructions)		26
27	GENERAL INPATIENT ROUTINE SERVICE COST NET OF SWING-BED COST	55,477,371	27

PRIVATE ROOM DIFFERENTIAL ADJUSTMENT

28	GENERAL INPATIENT ROUTINE SERVICE CHARGES (excluding swing-bed and observation bed charges)		28
29	PRIVATE ROOM CHARGES (excluding swing-bed charges)		29
30	SEMI-PRIVATE ROOM CHARGES (excluding swing-bed charges)		30
31	GENERAL INPATIENT ROUTINE SERVICE COST/CHARGE RATIO (line 27 ÷ line 28)		31
32	AVERAGE PRIVATE ROOM PER DIEM CHARGE (line 29 ÷ line 3)		32
33	AVERAGE SEMI-PRIVATE ROOM PER DIEM CHARGE (line 30 ÷ line 4)		33
34	AVERAGE PER DIEM PRIVATE ROOM CHARGE DIFFERENTIAL (line 32 minus line 33) (see instructions)		34
35	AVERAGE PER DIEM PRIVATE ROOM COST DIFFERENTIAL (line 34 x line 31)		35
36	PRIVATE ROOM COST DIFFERENTIAL ADJUSTMENT (line 3 x line 35)		36
37	GENERAL INPATIENT ROUTINE SERVICE COST NET OF SWING-BED COST AND PRIVATE ROOM COST DIFFERENTIAL (line 27 - line 36)	55,477,371	37



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COMPUTATION OF INPATIENT OPERATING COST

COMPONENT CCN: 14-0191

WORKSHEET D-1
PART II

CHECK TITLE V - I/P HOSPITAL SUB (OTHER) PPS
 APPLICABLE TITLE XVIII, PART A IPF TEFRA
 BOXES: TITLE XIX - I/P IRF OTHER

PART II - HOSPITALS AND SUBPROVIDERS ONLY

PROGRAM INPATIENT OPERATING COST BEFORE PASS-THROUGH COST ADJUSTMENTS

38	ADJUSTED GENERAL INPATIENT ROUTINE SERVICE COST PER DIEM (see instructions)					925.55	38
39	PROGRAM GENERAL INPATIENT ROUTINE SERVICE COST (line 9 x line 38)					10,702,135	39
40	MEDICALLY NECESSARY PRIVATE ROOM COST APPLICABLE TO THE PROGRAM (line 14 x line 35)						40
41	TOTAL PROGRAM GENERAL INPATIENT ROUTINE SERVICE COST (line 39 + line 40)					10,702,135	41
		TOTAL INPATIENT COST	TOTAL INPATIENT DAYS	AVERAGE PER DIEM (col. 1 ÷ col. 2)	PROGRAM DAYS	PROGRAM COST (col. 3 x col. 4)	
		1	2	3	4	5	
42	NURSERY (Titles V and XIX only)	3,694,550	3,782	976.88	2,764	2,700,096	42
	INTENSIVE CARE TYPE INPATIENT HOSPITAL UNITS						
43	INTENSIVE CARE UNIT	7,845,068	4,333	1,810.54	517	936,049	43
44	CORONARY CARE UNIT						44
45	BURN INTENSIVE CARE UNIT						45
46	SURGICAL INTENSIVE CARE UNIT						46
47	OTHER SPECIAL CARE (SPECIFY)						47

48	PROGRAM INPATIENT ANCILLARY SERVICE COST (Worksheet D-3, column 3, line 200)					8,646,072	48
49	TOTAL PROGRAM INPATIENT COSTS (sum of lines 41 through 48)(see instructions)					22,984,352	49

PASS-THROUGH COST ADJUSTMENTS

50	PASS THROUGH COSTS APPLICABLE TO PROGRAM INPATIENT ROUTINE SERVICES (from Worksheet D, sum of Parts I and III)					993,264	50
51	PASS THROUGH COSTS APPLICABLE TO PROGRAM INPATIENT ANCILLARY SERVICES (from Worksheet D, sum of Parts II and IV)					490,781	51
52	TOTAL PROGRAM EXCLUDABLE COST (sum of lines 50 and 51)					1,484,045	52
53	TOTAL PROGRAM INPATIENT OPERATING COST EXCLUDING CAPITAL RELATED, NONPHYSICIAN ANESTHETIST AND MEDICAL EDUCATION COSTS (line 49 minus line 52)						53

TARGET AMOUNT AND LIMIT COMPUTATION

54	PROGRAM DISCHARGES						54
55	TARGET AMOUNT PER DISCHARGE						55
56	TARGET AMOUNT (line 54 x line 55)						56
57	DIFFERENCE BETWEEN ADJUSTED INPATIENT OPERATING COST AND TARGET AMOUNT (line 56 minus line 53)						57
58	BONUS PAYMENT (see instructions)						58
59	LESSER OF LINE 53 ÷ LINE 54 OR LINE 55 FROM THE COST REPORTING PERIOD ENDING 1996, UPDATED AND COMPOUNDED BY THE MARKET BASKET						59
60	LESSER OF LINE 53 ÷ LINE 54 OR LINE 55 FROM PRIOR YEAR COST REPORT, UPDATED BY THE MARKET BASKET						60
61	IF LINE 53 ÷ 54 IS LESS THAN THE LOWER OF LINES 55, 59 OR 60 ENTER THE LESSER OF 50% OF THE AMOUNT BY WHICH OPERATING COSTS (line 53) ARE LESS THAN EXPECTED COSTS (line 54 x 60), OR 1% OF THE TARGET AMOUNT (line 56), OTHERWISE ENTER ZERO (see instructions)						61
62	RELIEF PAYMENT (see instructions)						62
63	ALLOWABLE INPATIENT COST PLUS INCENTIVE PAYMENT (see instructions)						63

PROGRAM INPATIENT ROUTINE SWING BED COST

64	MEDICARE SWING-BED SNF INPATIENT ROUTINE COSTS THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD (see instructions) (Title XVIII only)						64
65	MEDICARE SWING-BED SNF INPATIENT ROUTINE COSTS AFTER DECEMBER 31 OF THE COST REPORTING PERIOD (see instructions) (Title XVIII only)						65
66	TOTAL MEDICARE SWING-BED SNF INPATIENT ROUTINE COSTS (Title XVIII only. For CAH, see instructions)						66
67	TITLE V OR XIX SWING-BED NF INPATIENT ROUTINE COSTS THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD (line 12 x line 19)						67
68	TITLE V OR XIX SWING-BED NF INPATIENT ROUTINE COSTS AFTER DECEMBER 31 OF THE COST REPORTING PERIOD (line 13 x line 20)						68
69	TOTAL TITLE V OR XIX SWING-BED NF INPATIENT ROUTINE COSTS (line 67 + line 68)						69



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COMPUTATION OF INPATIENT OPERATING COST

COMPONENT CCN: 14-0191

WORKSHEET D-1
PARTS III & IV

CHECK TITLE V - I/P HOSPITAL SUB (OTHER) ICF/MR PPS
 APPLICABLE TITLE XVIII, PART A IPF SNF TEFRA
 BOXES: TITLE XIX - I/P IRF NF OTHER

PART IV - COMPUTATION OF OBSERVATION BED PASS-THROUGH COST

87	TOTAL OBSERVATION BED DAYS (see instructions)					4,676	87
88	ADJUSTED GENERAL INPATIENT ROUTINE COST PER DIEM (line 27 ÷ line 2)						88
89	OBSERVATION BED COST (line 87 x line 88) (see instructions)						89
		COST	ROUTINE COST (from line 27)	column 1 ÷ column 2	TOTAL OBSERVATION BED COST (from line 89)	OBSERVATION BED PASS-THROUGH COST col. 3 x col. 4 (see instructions)	
		1	2	3	4	5	
90	CAPITAL-RELATED COST						90
91	NURSING SCHOOL COST						91
92	ALLIED HEALTH COST						92
93	ALL OTHER MEDICAL EDUCATION						93



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COMPUTATION OF INPATIENT OPERATING COST

COMPONENT CCN: 14-S191

WORKSHEET D-1
PART I

CHECK TITLE V - I/P HOSPITAL SUB (OTHER) ICF/MR PPS
 APPLICABLE TITLE XVIII, PART A IPF SNF TEFRA
 BOXES: TITLE XIX - I/P IRF NF OTHER

PART I - ALL PROVIDER COMPONENTS

INPATIENT DAYS

1	INPATIENT DAYS (including private room days and swing-bed days, excluding newborn)	2,890	1
2	INPATIENT DAYS (including private room days, excluding swing-bed and newborn days)	2,890	2
3	PRIVATE ROOM DAYS (excluding swing-bed private room days). IF YOU HAVE ONLY PRIVATE ROOM DAYS, DO NOT COMPLETE THIS LINE.		3
4	SEMI-PRIVATE ROOM DAYS (excluding swing-bed private room days)	2,890	4
5	TOTAL SWING-BED SNF-TYPE INPATIENT DAYS (including private room days) THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD		5
6	TOTAL SWING-BED SNF-TYPE INPATIENT DAYS (including private room days) AFTER DECEMBER 31 OF THE COST REPORTING PERIOD (if calendar year, enter 0 on this line)		6
7	TOTAL SWING-BED NF-TYPE INPATIENT DAYS (including private room days) THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD		7
8	TOTAL SWING-BED NF-TYPE INPATIENT DAYS (including private room days) AFTER DECEMBER 31 OF THE COST REPORTING PERIOD (if calendar year, enter 0 on this line)		8
9	INPATIENT DAYS INCLUDING PRIVATE ROOM DAYS APPLICABLE TO THE PROGRAM (excluding swing-bed and newborn days)	388	9
10	SWING-BED SNF-TYPE INPATIENT DAYS APPLICABLE TO TITLE XVIII ONLY (including private room days) THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD (see instructions)		10
11	SWING-BED SNF-TYPE INPATIENT DAYS APPLICABLE TO TITLE XVIII ONLY (including private room days) AFTER DECEMBER 31 OF THE COST REPORTING PERIOD (if calendar year, enter 0 on this line)		11
12	SWING-BED NF-TYPE INPATIENT DAYS APPLICABLE TO TITLES V OR XIX ONLY (including private room days) THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD		12
13	SWING-BED NF-TYPE INPATIENT DAYS APPLICABLE TO TITLES V OR XIX ONLY (including private room days) AFTER DECEMBER 31 OF THE COST REPORTING PERIOD (if calendar year, enter 0 on this line)		13
14	MEDICALLY NECESSARY PRIVATE ROOM DAYS APPLICABLE TO THE PROGRAM (excluding swing-bed days)		14
15	TOTAL NURSERY DAYS (Title V or Title XIX only)		15
16	TITLE V OR XIX NURSERY DAYS (Title V or Title XIX only)		16

SWING-BED ADJUSTMENT

17	MEDICARE RATE FOR SWING-BED SNF SERVICES APPLICABLE TO SERVICES THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD		17
18	MEDICARE RATE FOR SWING-BED SNF SERVICES APPLICABLE TO SERVICES AFTER DECEMBER 31 OF THE COST REPORTING PERIOD		18
19	MEDICAID RATE FOR SWING-BED NF SERVICES APPLICABLE TO SERVICES THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD		19
20	MEDICAID RATE FOR SWING-BED NF SERVICES APPLICABLE TO SERVICES AFTER DECEMBER 31 OF THE COST REPORTING PERIOD		20
21	TOTAL GENERAL INPATIENT ROUTINE SERVICE COST (see instructions)	3,206,650	21
22	SWING-BED COST APPLICABLE TO SNF-TYPE SERVICES THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD (line 5 x line 17)		22
23	SWING-BED COST APPLICABLE TO SNF-TYPE SERVICES AFTER DECEMBER 31 OF THE COST REPORTING PERIOD (line 6 x line 18)		23
24	SWING-BED COST APPLICABLE TO NF-TYPE SERVICES THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD (line 7 x line 19)		24
25	SWING-BED COST APPLICABLE TO NF-TYPE SERVICES AFTER DECEMBER 31 OF THE COST REPORTING PERIOD (line 8 x line 20)		25
26	TOTAL SWING-BED COST (see instructions)		26
27	GENERAL INPATIENT ROUTINE SERVICE COST NET OF SWING-BED COST	3,206,650	27

PRIVATE ROOM DIFFERENTIAL ADJUSTMENT

28	GENERAL INPATIENT ROUTINE SERVICE CHARGES (excluding swing-bed and observation bed charges)		28
29	PRIVATE ROOM CHARGES (excluding swing-bed charges)		29
30	SEMI-PRIVATE ROOM CHARGES (excluding swing-bed charges)		30
31	GENERAL INPATIENT ROUTINE SERVICE COST/CHARGE RATIO (line 27 ÷ line 28)		31
32	AVERAGE PRIVATE ROOM PER DIEM CHARGE (line 29 ÷ line 3)		32
33	AVERAGE SEMI-PRIVATE ROOM PER DIEM CHARGE (line 30 ÷ line 4)		33
34	AVERAGE PER DIEM PRIVATE ROOM CHARGE DIFFERENTIAL (line 32 minus line 33) (see instructions)		34
35	AVERAGE PER DIEM PRIVATE ROOM COST DIFFERENTIAL (line 34 x line 31)		35
36	PRIVATE ROOM COST DIFFERENTIAL ADJUSTMENT (line 3 x line 35)		36
37	GENERAL INPATIENT ROUTINE SERVICE COST NET OF SWING-BED COST AND PRIVATE ROOM COST DIFFERENTIAL (line 27 - line 36)	3,206,650	37



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COMPUTATION OF INPATIENT OPERATING COST

COMPONENT CCN: 14-S191

WORKSHEET D-1
PART II

CHECK TITLE V - I/P HOSPITAL SUB (OTHER) PPS
 APPLICABLE TITLE XVIII, PART A IPF TEFRA
 BOXES: TITLE XIX - I/P IRF OTHER

PART II - HOSPITALS AND SUBPROVIDERS ONLY

PROGRAM INPATIENT OPERATING COST BEFORE PASS-THROUGH COST ADJUSTMENTS

1

38	ADJUSTED GENERAL INPATIENT ROUTINE SERVICE COST PER DIEM (see instructions)	1,109.57	38
39	PROGRAM GENERAL INPATIENT ROUTINE SERVICE COST (line 9 x line 38)	430,513	39
40	MEDICALLY NECESSARY PRIVATE ROOM COST APPLICABLE TO THE PROGRAM (line 14 x line 35)		40
41	TOTAL PROGRAM GENERAL INPATIENT ROUTINE SERVICE COST (line 39 + line 40)	430,513	41
48	PROGRAM INPATIENT ANCILLARY SERVICE COST (Worksheet D-3, column 3, line 200)	43,146	48
49	TOTAL PROGRAM INPATIENT COSTS (sum of lines 41 through 48)(see instructions)	473,659	49

PASS-THROUGH COST ADJUSTMENTS

50	PASS THROUGH COSTS APPLICABLE TO PROGRAM INPATIENT ROUTINE SERVICES (from Worksheet D, sum of Parts I and III)	23,528	50
51	PASS THROUGH COSTS APPLICABLE TO PROGRAM INPATIENT ANCILLARY SERVICES (from Worksheet D, sum of Parts II and IV)	2,848	51
52	TOTAL PROGRAM EXCLUDABLE COST (sum of lines 50 and 51)	26,376	52
53	TOTAL PROGRAM INPATIENT OPERATING COST EXCLUDING CAPITAL RELATED, NONPHYSICIAN ANESTHETIST AND MEDICAL EDUCATION COSTS (line 49 minus line 52)		53

TARGET AMOUNT AND LIMIT COMPUTATION

54	PROGRAM DISCHARGES		54
55	TARGET AMOUNT PER DISCHARGE		55
56	TARGET AMOUNT (line 54 x line 55)		56
57	DIFFERENCE BETWEEN ADJUSTED INPATIENT OPERATING COST AND TARGET AMOUNT (line 56 minus line 53)		57
58	BONUS PAYMENT (see instructions)		58
59	LESSER OF LINE 53 ÷ LINE 54 OR LINE 55 FROM THE COST REPORTING PERIOD ENDING 1996, UPDATED AND COMPOUNDED BY THE MARKET BASKET		59
60	LESSER OF LINE 53 ÷ LINE 54 OR LINE 55 FROM PRIOR YEAR COST REPORT, UPDATED BY THE MARKET BASKET		60
61	IF LINE 53 ÷ 54 IS LESS THAN THE LOWER OF LINES 55, 59 OR 60 ENTER THE LESSER OF 50% OF THE AMOUNT BY WHICH OPERATING COSTS (line 53) ARE LESS THAN EXPECTED COSTS (line 54 x 60), OR 1% OF THE TARGET AMOUNT (line 56), OTHERWISE ENTER ZERO (see instructions)		61
62	RELIEF PAYMENT (see instructions)		62
63	ALLOWABLE INPATIENT COST PLUS INCENTIVE PAYMENT (see instructions)		63

PROGRAM INPATIENT ROUTINE SWING BED COST

64	MEDICARE SWING-BED SNF INPATIENT ROUTINE COSTS THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD (see instructions) (Title XVIII only)		64
65	MEDICARE SWING-BED SNF INPATIENT ROUTINE COSTS AFTER DECEMBER 31 OF THE COST REPORTING PERIOD (see instructions) (Title XVIII only)		65
66	TOTAL MEDICARE SWING-BED SNF INPATIENT ROUTINE COSTS (Title XVIII only, For CAH, see instructions)		66
67	TITLE V OR XIX SWING-BED NF INPATIENT ROUTINE COSTS THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD (line 12 x line 19)		67
68	TITLE V OR XIX SWING-BED NF INPATIENT ROUTINE COSTS AFTER DECEMBER 31 OF THE COST REPORTING PERIOD (line 13 x line 20)		68
69	TOTAL TITLE V OR XIX SWING-BED NF INPATIENT ROUTINE COSTS (line 67 + line 68)		69



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COMPUTATION OF INPATIENT OPERATING COST

COMPONENT CCN: 14-T191

WORKSHEET D-1
PART I

CHECK [] TITLE V - I/P [] HOSPITAL [] SUB (OTHER) [] ICF/MR [] PPS
 APPLICABLE [] TITLE XVIII, PART A [] IPF [] SNF [] TEFRA
 BOXES: [XX] TITLE XIX - I/P [XX] IRF [] NF [XX] OTHER

PART I - ALL PROVIDER COMPONENTS

INPATIENT DAYS

1	INPATIENT DAYS (including private room days and swing-bed days, excluding newborn)	8,022	1
2	INPATIENT DAYS (including private room days, excluding swing-bed and newborn days)	8,022	2
3	PRIVATE ROOM DAYS (excluding swing-bed private room days). IF YOU HAVE ONLY PRIVATE ROOM DAYS, DO NOT COMPLETE THIS LINE.		3
4	SEMI-PRIVATE ROOM DAYS (excluding swing-bed private room days)	8,022	4
5	TOTAL SWING-BED SNF-TYPE INPATIENT DAYS (including private room days) THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD		5
6	TOTAL SWING-BED SNF-TYPE INPATIENT DAYS (including private room days) AFTER DECEMBER 31 OF THE COST REPORTING PERIOD (if calendar year, enter 0 on this line)		6
7	TOTAL SWING-BED NF-TYPE INPATIENT DAYS (including private room days) THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD		7
8	TOTAL SWING-BED NF-TYPE INPATIENT DAYS (including private room days) AFTER DECEMBER 31 OF THE COST REPORTING PERIOD (if calendar year, enter 0 on this line)		8
9	INPATIENT DAYS INCLUDING PRIVATE ROOM DAYS APPLICABLE TO THE PROGRAM (excluding swing-bed and newborn days)	279	9
10	SWING-BED SNF-TYPE INPATIENT DAYS APPLICABLE TO TITLE XVIII ONLY (including private room days) THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD (see instructions)		10
11	SWING-BED SNF-TYPE INPATIENT DAYS APPLICABLE TO TITLE XVIII ONLY (including private room days) AFTER DECEMBER 31 OF THE COST REPORTING PERIOD (if calendar year, enter 0 on this line)		11
12	SWING-BED NF-TYPE INPATIENT DAYS APPLICABLE TO TITLES V OR XIX ONLY (including private room days) THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD		12
13	SWING-BED NF-TYPE INPATIENT DAYS APPLICABLE TO TITLES V OR XIX ONLY (including private room days) AFTER DECEMBER 31 OF THE COST REPORTING PERIOD (if calendar year, enter 0 on this line)		13
14	MEDICALLY NECESSARY PRIVATE ROOM DAYS APPLICABLE TO THE PROGRAM (excluding swing-bed days)		14
15	TOTAL NURSERY DAYS (Title V or Title XIX only)		15
16	TITLE V OR XIX NURSERY DAYS (Title V or Title XIX only)		16

SWING-BED ADJUSTMENT

17	MEDICARE RATE FOR SWING-BED SNF SERVICES APPLICABLE TO SERVICES THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD		17
18	MEDICARE RATE FOR SWING-BED SNF SERVICES APPLICABLE TO SERVICES AFTER DECEMBER 31 OF THE COST REPORTING PERIOD		18
19	MEDICAID RATE FOR SWING-BED NF SERVICES APPLICABLE TO SERVICES THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD		19
20	MEDICAID RATE FOR SWING-BED NF SERVICES APPLICABLE TO SERVICES AFTER DECEMBER 31 OF THE COST REPORTING PERIOD		20
21	TOTAL GENERAL INPATIENT ROUTINE SERVICE COST (see instructions)	9,288,730	21
22	SWING-BED COST APPLICABLE TO SNF-TYPE SERVICES THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD (line 5 x line 17)		22
23	SWING-BED COST APPLICABLE TO SNF-TYPE SERVICES AFTER DECEMBER 31 OF THE COST REPORTING PERIOD (line 6 x line 18)		23
24	SWING-BED COST APPLICABLE TO NF-TYPE SERVICES THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD (line 7 x line 19)		24
25	SWING-BED COST APPLICABLE TO NF-TYPE SERVICES AFTER DECEMBER 31 OF THE COST REPORTING PERIOD (line 8 x line 20)		25
26	TOTAL SWING-BED COST (see instructions)		26
27	GENERAL INPATIENT ROUTINE SERVICE COST NET OF SWING-BED COST	9,288,730	27

PRIVATE ROOM DIFFERENTIAL ADJUSTMENT

28	GENERAL INPATIENT ROUTINE SERVICE CHARGES (excluding swing-bed and observation bed charges)		28
29	PRIVATE ROOM CHARGES (excluding swing-bed charges)		29
30	SEMI-PRIVATE ROOM CHARGES (excluding swing-bed charges)		30
31	GENERAL INPATIENT ROUTINE SERVICE COST/CHARGE RATIO (line 27 ÷ line 28)		31
32	AVERAGE PRIVATE ROOM PER DIEM CHARGE (line 29 ÷ line 3)		32
33	AVERAGE SEMI-PRIVATE ROOM PER DIEM CHARGE (line 30 ÷ line 4)		33
34	AVERAGE PER DIEM PRIVATE ROOM CHARGE DIFFERENTIAL (line 32 minus line 33) (see instructions)		34
35	AVERAGE PER DIEM PRIVATE ROOM COST DIFFERENTIAL (line 34 x line 31)		35
36	PRIVATE ROOM COST DIFFERENTIAL ADJUSTMENT (line 3 x line 35)		36
37	GENERAL INPATIENT ROUTINE SERVICE COST NET OF SWING-BED COST AND PRIVATE ROOM COST DIFFERENTIAL (line 27 - line 36)	9,288,730	37



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COMPUTATION OF INPATIENT OPERATING COST

COMPONENT CCN: 14-T191

WORKSHEET D-1
PART II

CHECK TITLE V - I/P HOSPITAL SUB (OTHER) PPS
 APPLICABLE TITLE XVIII, PART A IPF TEFRA
 BOXES: TITLE XIX - I/P IRF OTHER

PART II - HOSPITALS AND SUBPROVIDERS ONLY

PROGRAM INPATIENT OPERATING COST BEFORE PASS-THROUGH COST ADJUSTMENTS

1

38	ADJUSTED GENERAL INPATIENT ROUTINE SERVICE COST PER DIEM (see instructions)	1,157.91	38
39	PROGRAM GENERAL INPATIENT ROUTINE SERVICE COST (line 9 x line 38)	323,057	39
40	MEDICALLY NECESSARY PRIVATE ROOM COST APPLICABLE TO THE PROGRAM (line 14 x line 35)		40
41	TOTAL PROGRAM GENERAL INPATIENT ROUTINE SERVICE COST (line 39 + line 40)	323,057	41
48	PROGRAM INPATIENT ANCILLARY SERVICE COST (Worksheet D-3, column 3, line 200)	105,656	48
49	TOTAL PROGRAM INPATIENT COSTS (sum of lines 41 through 48)(see instructions)	428,713	49

PASS-THROUGH COST ADJUSTMENTS

50	PASS THROUGH COSTS APPLICABLE TO PROGRAM INPATIENT ROUTINE SERVICES (from Worksheet D, sum of Parts I and III)	31,493	50
51	PASS THROUGH COSTS APPLICABLE TO PROGRAM INPATIENT ANCILLARY SERVICES (from Worksheet D, sum of Parts II and IV)	3,555	51
52	TOTAL PROGRAM EXCLUDABLE COST (sum of lines 50 and 51)	35,048	52
53	TOTAL PROGRAM INPATIENT OPERATING COST EXCLUDING CAPITAL RELATED, NONPHYSICIAN ANESTHETIST AND MEDICAL EDUCATION COSTS (line 49 minus line 52)		53

TARGET AMOUNT AND LIMIT COMPUTATION

54	PROGRAM DISCHARGES		54
55	TARGET AMOUNT PER DISCHARGE		55
56	TARGET AMOUNT (line 54 x line 55)		56
57	DIFFERENCE BETWEEN ADJUSTED INPATIENT OPERATING COST AND TARGET AMOUNT (line 56 minus line 53)		57
58	BONUS PAYMENT (see instructions)		58
59	LESSER OF LINE 53 ÷ LINE 54 OR LINE 55 FROM THE COST REPORTING PERIOD ENDING 1996, UPDATED AND COMPOUNDED BY THE MARKET BASKET		59
60	LESSER OF LINE 53 ÷ LINE 54 OR LINE 55 FROM PRIOR YEAR COST REPORT, UPDATED BY THE MARKET BASKET		60
61	IF LINE 53 ÷ 54 IS LESS THAN THE LOWER OF LINES 55, 59 OR 60 ENTER THE LESSER OF 50% OF THE AMOUNT BY WHICH OPERATING COSTS (line 53) ARE LESS THAN EXPECTED COSTS (line 54 x 60), OR 1% OF THE TARGET AMOUNT (line 56), OTHERWISE ENTER ZERO (see instructions)		61
62	RELIEF PAYMENT (see instructions)		62
63	ALLOWABLE INPATIENT COST PLUS INCENTIVE PAYMENT (see instructions)		63

PROGRAM INPATIENT ROUTINE SWING BED COST

64	MEDICARE SWING-BED SNF INPATIENT ROUTINE COSTS THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD (see instructions) (Title XVIII only)		64
65	MEDICARE SWING-BED SNF INPATIENT ROUTINE COSTS AFTER DECEMBER 31 OF THE COST REPORTING PERIOD (see instructions) (Title XVIII only)		65
66	TOTAL MEDICARE SWING-BED SNF INPATIENT ROUTINE COSTS (Title XVIII only, For CAH, see instructions)		66
67	TITLE V OR XIX SWING-BED NF INPATIENT ROUTINE COSTS THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD (line 12 x line 19)		67
68	TITLE V OR XIX SWING-BED NF INPATIENT ROUTINE COSTS AFTER DECEMBER 31 OF THE COST REPORTING PERIOD (line 13 x line 20)		68
69	TOTAL TITLE V OR XIX SWING-BED NF INPATIENT ROUTINE COSTS (line 67 + line 68)		69



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INPATIENT ANCILLARY SERVICE COST APPORTIONMENT

COMPONENT CCN: 14-0191

WORKSHEET D-3

CHECK [] TITLE V [XX] HOSPITAL [] SUB (OTHER) [] SWING BED SNF [XX] PPS
 APPLICABLE [XX] TITLE XVIII, PART A [] IPF [] SNF [] SWING BED NF [] TEFRA
 BOXES: [] TITLE XIX [] IRF [] NF [] ICF/MR [] OTHER

(A)	COST CENTER DESCRIPTION	RATIO OF COST TO CHARGES	INPATIENT PROGRAM CHARGES	INPATIENT PROGRAM COSTS (col. 1 x col. 2)	
		1	2	3	
	INPATIENT ROUTINE SERVICE COST CENTERS				
30	ADULTS & PEDIATRICS		35,822,862		30
31	INTENSIVE CARE UNIT		5,342,006		31
40	SUBPROVIDER - IPF				40
41	SUBPROVIDER - IRF				41
	ANCILLARY SERVICE COST CENTERS				
50	OPERATING ROOM	0.200435	23,152,647	4,640,601	50
51	RECOVERY ROOM	0.272331	1,190,161	324,118	51
53	ANESTHESIOLOGY	0.078070	4,010,052	313,065	53
54	RADIOLOGY-DIAGNOSTIC	0.265951	4,386,472	1,166,587	54
54.01	ULTRASOUND	0.159623	2,143,999	342,232	54.01
54.02	SPECIAL PROCEDURES	0.072197	7,874,273	568,499	54.02
56	RADIOISOTOPE	0.219962	1,790,599	393,864	56
57	CT SCAN	0.032471	13,179,901	427,965	57
58	MRI	0.077651	3,843,482	298,450	58
59	CARDIAC CATHETERIZATION	0.187394	5,006,220	938,136	59
60	LABORATORY	0.109171	26,786,223	2,924,279	60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS				62.30
63	BLOOD STORING, PROCESSING & TRANS.	0.312729	2,396,618	749,492	63
65	RESPIRATORY THERAPY	0.178058	8,807,193	1,568,191	65
65.01	PULMONARY FUNCTION	0.161526	145,287	23,468	65.01
66	PHYSICAL THERAPY	0.214712	1,805,465	387,655	66
67	OCCUPATIONAL THERAPY	0.412076	1,218,044	501,927	67
68	SPEECH PATHOLOGY	0.259167	680,021	176,239	68
69	ELECTROCARDIOLOGY	0.116115	6,921,999	803,748	69
70	ELECTROENCEPHALOGRAPHY	0.271032	488,808	132,483	70
70.01	SLEEP LAB	0.169037	175,081	29,595	70.01
70.02	PSYCH	0.464418	53,265	24,737	70.02
71	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.162552	1,336,130	217,191	71
72	IMPL. DEV. CHARGED TO PATIENTS	0.532942	10,607,930	5,653,411	72
73	DRUGS CHARGED TO PATIENTS	0.196357	21,616,825	4,244,615	73
73.01	INFUSION THERAPY	0.218728	40,546	8,869	73.01
73.02	IFCC INFUSION THERAPY	0.232087	3,197	742	73.02
73.03	PHARMACY VACCINE	0.883889			73.03
74	RENAL DIALYSIS	0.627235	929,020	582,714	74
76.97	CARDIAC REHABILITATION	1.012967	41,051	41,583	76.97
76.98	HYPERBARIC OXYGEN THERAPY	0.240176	915,537	219,890	76.98
76.99	LITHOTRIPSY				76.99
	OUTPATIENT SERVICE COST CENTERS				
90.02	PSYCH ANCILLARY	0.431720	3,486	1,505	90.02
90.03	RETINAL VASCULAR	1.430438	2,857	4,087	90.03
91	EMERGENCY	0.119232	9,080,418	1,082,676	91
91.01	IFCC	0.163091	1,813,895	295,830	91.01
92	OBSERVATION BEDS (NON-DISTINCT PART)	0.640710			92
	OTHER REIMBURSABLE COST CENTERS				
200	TOTAL (sum of lines 50-94, and 96-98)		162,446,702	29,088,444	200
201	LESS PBP CLINIC LABORATORY SERVICES-PROGRAM ONLY CHARGES (line 61)				201
202	NET CHARGES (line 200 minus line 201)		162,446,702		202

(A) Worksheet A line numbers



COMPU-MAX

INGALLS MEMORIAL HOSPITAL Provider CCN: 14-0191	In Lieu of Form CMS-2552-10	Period : From: 10/01/2013 To: 09/30/2014	Run Date: 03/02/2015 Run Time: 10:44 Version: 2014.10
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INPATIENT ANCILLARY SERVICE COST APPORTIONMENT

COMPONENT CCN: 14-S191

WORKSHEET D-3

CHECK [] TITLE V [] HOSPITAL [] SUB (OTHER) [] SWING BED SNF [XX] PPS
 APPLICABLE [XX] TITLE XVIII, PART A [XX] IPF [] SNF [] SWING BED NF [] TEFRA
 BOXES: [] TITLE XIX [] IRF [] NF [] ICF/MR [] OTHER

(A)	COST CENTER DESCRIPTION	RATIO OF COST TO CHARGES	INPATIENT PROGRAM CHARGES	INPATIENT PROGRAM COSTS (col. 1 x col. 2)	
		1	2	3	
	INPATIENT ROUTINE SERVICE COST CENTERS				
30	ADULTS & PEDIATRICS				30
31	INTENSIVE CARE UNIT				31
40	SUBPROVIDER - IPF		1,905,566		40
41	SUBPROVIDER - IRF				41
	ANCILLARY SERVICE COST CENTERS				
50	OPERATING ROOM	0.200435	7,476	1,498	50
51	RECOVERY ROOM	0.272331			51
53	ANESTHESIOLOGY	0.078070			53
54	RADIOLOGY-DIAGNOSTIC	0.265951	20,146	5,358	54
54.01	ULTRASOUND	0.159623	8,420	1,344	54.01
54.02	SPECIAL PROCEDURES	0.072197			54.02
56	RADIOISOTOPE	0.219962	2,347	516	56
57	CT SCAN	0.032471	66,594	2,162	57
58	MRI	0.077651	63,948	4,966	58
59	CARDIAC CATHETERIZATION	0.187394			59
60	LABORATORY	0.109171	419,848	45,835	60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS				62.30
63	BLOOD STORING, PROCESSING & TRANS.	0.312729			63
65	RESPIRATORY THERAPY	0.178058	36,825	6,557	65
65.01	PULMONARY FUNCTION	0.161526			65.01
66	PHYSICAL THERAPY	0.214712	14,015	3,009	66
67	OCCUPATIONAL THERAPY	0.412076	6,035	2,487	67
68	SPEECH PATHOLOGY	0.259167	4,396	1,139	68
69	ELECTROCARDIOLOGY	0.116115	53,621	6,226	69
70	ELECTROENCEPHALOGRAPHY	0.271032	4,196	1,137	70
70.01	SLEEP LAB	0.169037	2,041	345	70.01
70.02	PSYCH	0.464418	545,779	253,470	70.02
71	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.162552	1,845	300	71
72	IMPL. DEV. CHARGED TO PATIENTS	0.532942			72
73	DRUGS CHARGED TO PATIENTS	0.196357	211,730	41,575	73
73.01	INFUSION THERAPY	0.218728			73.01
73.02	IFCC INFUSION THERAPY	0.232087			73.02
73.03	PHARMACY VACCINE	0.883889			73.03
74	RENAL DIALYSIS	0.627235	3,065	1,922	74
76.97	CARDIAC REHABILITATION	1.012967			76.97
76.98	HYPERBARIC OXYGEN THERAPY	0.240176	7,140	1,715	76.98
76.99	LITHOTRIPSY				76.99
	OUTPATIENT SERVICE COST CENTERS				
90.02	PSYCH ANCILLARY	0.431720			90.02
90.03	RETINAL VASCULAR	1.430438			90.03
91	EMERGENCY	0.119232	240,970	28,731	91
91.01	IFCC	0.163091			91.01
92	OBSERVATION BEDS (NON-DISTINCT PART)	0.640710			92
	OTHER REIMBURSABLE COST CENTERS				
200	TOTAL (sum of lines 50-94, and 96-98)		1,720,437	410,292	200
201	LESS PBP CLINIC LABORATORY SERVICES-PROGRAM ONLY CHARGES (line 61)				201
202	NET CHARGES (line 200 minus line 201)		1,720,437		202

(A) Worksheet A line numbers



COMPU-MAX

INGALLS MEMORIAL HOSPITAL Provider CCN: 14-0191	In Lieu of Form CMS-2552-10	Period : From: 10/01/2013 To: 09/30/2014	Run Date: 03/02/2015 Run Time: 10:44 Version: 2014.10
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INPATIENT ANCILLARY SERVICE COST APPORTIONMENT

COMPONENT CCN: 14-T191

WORKSHEET D-3

CHECK [] TITLE V [] HOSPITAL [] SUB (OTHER) [] SWING BED SNF [XX] PPS
 APPLICABLE [XX] TITLE XVIII, PART A [] IPF [] SNF [] SWING BED NF [] TEFRA
 BOXES: [] TITLE XIX [XX] IRF [] NF [] ICF/MR [] OTHER

(A)	COST CENTER DESCRIPTION	RATIO OF COST TO CHARGES	INPATIENT PROGRAM CHARGES	INPATIENT PROGRAM COSTS (col. 1 x col. 2)	
		1	2	3	
	INPATIENT ROUTINE SERVICE COST CENTERS				
30	ADULTS & PEDIATRICS				30
31	INTENSIVE CARE UNIT				31
40	SUBPROVIDER - IPF				40
41	SUBPROVIDER - IRF		6,266,441		41
	ANCILLARY SERVICE COST CENTERS				
50	OPERATING ROOM	0.200435	74,791	14,991	50
51	RECOVERY ROOM	0.272331	4,368	1,190	51
53	ANESTHESIOLOGY	0.078070	8,397	656	53
54	RADIOLOGY-DIAGNOSTIC	0.265951	204,583	54,409	54
54.01	ULTRASOUND	0.159623	84,052	13,417	54.01
54.02	SPECIAL PROCEDURES	0.072197	137,638	9,937	54.02
56	RADIOISOTOPE	0.219962	10,366	2,280	56
57	CT SCAN	0.032471	265,509	8,621	57
58	MRI	0.077651	124,231	9,647	58
59	CARDIAC CATHETERIZATION	0.187394			59
60	LABORATORY	0.109171	1,208,808	131,967	60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS				62.30
63	BLOOD STORING, PROCESSING & TRANS.	0.312729	60,781	19,008	63
65	RESPIRATORY THERAPY	0.178058	694,898	123,732	65
65.01	PULMONARY FUNCTION	0.161526	660	107	65.01
66	PHYSICAL THERAPY	0.214712	3,195,400	686,091	66
67	OCCUPATIONAL THERAPY	0.412076	3,157,043	1,300,942	67
68	SPEECH PATHOLOGY	0.259167	1,253,175	324,782	68
69	ELECTROCARDIOLOGY	0.116115	57,923	6,726	69
70	ELECTROENCEPHALOGRAPHY	0.271032	11,953	3,240	70
70.01	SLEEP LAB	0.169037	3,063	518	70.01
70.02	PSYCH	0.464418			70.02
71	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.162552	36,825	5,986	71
72	IMPL. DEV. CHARGED TO PATIENTS	0.532942			72
73	DRUGS CHARGED TO PATIENTS	0.196357	2,135,547	419,330	73
73.01	INFUSION THERAPY	0.218728			73.01
73.02	IFCC INFUSION THERAPY	0.232087			73.02
73.03	PHARMACY VACCINE	0.883889			73.03
74	RENAL DIALYSIS	0.627235	218,274	136,909	74
76.97	CARDIAC REHABILITATION	1.012967			76.97
76.98	HYPERBARIC OXYGEN THERAPY	0.240176	183,056	43,966	76.98
76.99	LITHOTRIPSY				76.99
	OUTPATIENT SERVICE COST CENTERS				
90.02	PSYCH ANCILLARY	0.431720			90.02
90.03	RETINAL VASCULAR	1.430438			90.03
91	EMERGENCY	0.119232	26,097	3,112	91
91.01	IFCC	0.163091			91.01
92	OBSERVATION BEDS (NON-DISTINCT PART)	0.640710			92
	OTHER REIMBURSABLE COST CENTERS				
200	TOTAL (sum of lines 50-94, and 96-98)		13,157,438	3,321,564	200
201	LESS PBP CLINIC LABORATORY SERVICES-PROGRAM ONLY CHARGES (line 61)				201
202	NET CHARGES (line 200 minus line 201)		13,157,438		202

(A) Worksheet A line numbers



COMPU-MAX

INGALLS MEMORIAL HOSPITAL Provider CCN: 14-0191	In Lieu of Form CMS-2552-10	Period : From: 10/01/2013 To: 09/30/2014	Run Date: 03/02/2015 Run Time: 10:44 Version: 2014.10
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INPATIENT ANCILLARY SERVICE COST APPORTIONMENT

COMPONENT CCN: 14-0191

WORKSHEET D-3

CHECK [] TITLE V [XX] HOSPITAL [] SUB (OTHER) [] SWING BED SNF [] PPS
 APPLICABLE [] TITLE XVIII, PART A [] IPF [] SNF [] SWING BED NF [] TEFRA
 BOXES: [XX] TITLE XIX [] IRF [] NF [] ICF/MR [XX] OTHER

(A)	COST CENTER DESCRIPTION	RATIO OF COST TO CHARGES	INPATIENT PROGRAM CHARGES	INPATIENT PROGRAM COSTS (col. 1 x col. 2)	
		1	2	3	
INPATIENT ROUTINE SERVICE COST CENTERS					
30	ADULTS & PEDIATRICS		27,789,364		30
31	INTENSIVE CARE UNIT		1,581,938		31
40	SUBPROVIDER - IPF				40
41	SUBPROVIDER - IRF				41
43	NURSERY		2,480,197		43
ANCILLARY SERVICE COST CENTERS					
50	OPERATING ROOM	0.200169	4,320,307	864,792	50
51	RECOVERY ROOM	0.272331	347,555	94,650	51
53	ANESTHESIOLOGY	0.078070	861,795	67,280	53
54	RADIOLOGY-DIAGNOSTIC	0.262188	1,272,907	333,741	54
54.01	ULTRASOUND	0.159623	912,435	145,646	54.01
54.02	SPECIAL PROCEDURES	0.072197	2,156,532	155,695	54.02
56	RADIOISOTOPE	0.219962	444,297	97,728	56
57	CT SCAN	0.032471	5,249,160	170,445	57
58	MRI	0.077651	1,365,234	106,012	58
59	CARDIAC CATHETERIZATION	0.186614	1,425,381	265,996	59
60	LABORATORY	0.109171	12,770,370	1,394,154	60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS				62.30
63	BLOOD STORING, PROCESSING & TRANS.	0.312729	979,467	306,308	63
65	RESPIRATORY THERAPY	0.178058	3,344,808	595,570	65
65.01	PULMONARY FUNCTION	0.161526	62,314	10,065	65.01
66	PHYSICAL THERAPY	0.214712	199,076	42,744	66
67	OCCUPATIONAL THERAPY	0.412076	155,806	64,204	67
68	SPEECH PATHOLOGY	0.259167	375,458	97,306	68
69	ELECTROCARDIOLOGY	0.105566	2,305,371	243,369	69
70	ELECTROENCEPHALOGRAPHY	0.271032	128,323	34,780	70
70.01	SLEEP LAB	0.169037	14,335	2,423	70.01
70.02	PSYCH	0.464418			70.02
71	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.162552	642,418	104,426	71
72	IMPL. DEV. CHARGED TO PATIENTS	0.532942	908,298	484,070	72
73	DRUGS CHARGED TO PATIENTS	0.196357	9,240,574	1,814,451	73
73.01	INFUSION THERAPY	0.218728			73.01
73.02	IFCC INFUSION THERAPY	0.232087			73.02
73.03	PHARMACY VACCINE	0.883889			73.03
74	RENAL DIALYSIS	0.624065	232,778	145,269	74
76.97	CARDIAC REHABILITATION	1.007168	13,108	13,202	76.97
76.98	HYPERBARIC OXYGEN THERAPY	0.240176	178,165	42,791	76.98
76.99	LITHOTRIPSY				76.99
OUTPATIENT SERVICE COST CENTERS					
90.02	PSYCH ANCILLARY	0.431720			90.02
90.03	RETINAL VASCULAR	1.415946	3,356	4,752	90.03
91	EMERGENCY	0.119232	5,613,944	669,362	91
91.01	IFCC	0.163091	1,685,203	274,841	91.01
92	OBSERVATION BEDS (NON-DISTINCT PART)	0.640710			92
OTHER REIMBURSABLE COST CENTERS					
200	TOTAL (sum of lines 50-94, and 96-98)		57,208,775	8,646,072	200
201	LESS PBP CLINIC LABORATORY SERVICES-PROGRAM ONLY CHARGES (line 61)				201
202	NET CHARGES (line 200 minus line 201)		57,208,775		202

(A) Worksheet A line numbers



COMPU-MAX

INGALLS MEMORIAL HOSPITAL Provider CCN: 14-0191	In Lieu of Form CMS-2552-10	Period : From: 10/01/2013 To: 09/30/2014	Run Date: 03/02/2015 Run Time: 10:44 Version: 2014.10
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INPATIENT ANCILLARY SERVICE COST APPORTIONMENT

COMPONENT CCN: 14-S191

WORKSHEET D-3

CHECK [] TITLE V [] HOSPITAL [] SUB (OTHER) [] SWING BED SNF [] PPS
 APPLICABLE [] TITLE XVIII, PART A [XX] IPF [] SNF [] SWING BED NF [] TEFRA
 BOXES: [XX] TITLE XIX [] IRF [] NF [] ICF/MR [XX] OTHER

(A)	COST CENTER DESCRIPTION	RATIO OF COST TO CHARGES	INPATIENT PROGRAM CHARGES	INPATIENT PROGRAM COSTS (col. 1 x col. 2)	
		1	2	3	
	INPATIENT ROUTINE SERVICE COST CENTERS				
30	ADULTS & PEDIATRICS				30
31	INTENSIVE CARE UNIT				31
40	SUBPROVIDER - IPF		710,304		40
41	SUBPROVIDER - IRF				41
	ANCILLARY SERVICE COST CENTERS				
50	OPERATING ROOM	0.200169			50
51	RECOVERY ROOM	0.272331			51
53	ANESTHESIOLOGY	0.078070			53
54	RADIOLOGY-DIAGNOSTIC	0.262188	5,104	1,338	54
54.01	ULTRASOUND	0.159623	3,324	531	54.01
54.02	SPECIAL PROCEDURES	0.072197			54.02
56	RADIOISOTOPE	0.219962			56
57	CT SCAN	0.032471	18,092	587	57
58	MRI	0.077651	4,204	326	58
59	CARDIAC CATHETERIZATION	0.186614			59
60	LABORATORY	0.109171	128,882	14,070	60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS				62.30
63	BLOOD STORING, PROCESSING & TRANS.	0.312729	304	95	63
65	RESPIRATORY THERAPY	0.178058	8,951	1,594	65
65.01	PULMONARY FUNCTION	0.161526			65.01
66	PHYSICAL THERAPY	0.214712	733	157	66
67	OCCUPATIONAL THERAPY	0.412076	413	170	67
68	SPEECH PATHOLOGY	0.259167			68
69	ELECTROCARDIOLOGY	0.105566	23,795	2,512	69
70	ELECTROENCEPHALOGRAPHY	0.271032			70
70.01	SLEEP LAB	0.169037			70.01
70.02	PSYCH	0.464418			70.02
71	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.162552	299	49	71
72	IMPL. DEV. CHARGED TO PATIENTS	0.532942			72
73	DRUGS CHARGED TO PATIENTS	0.196357	48,929	9,608	73
73.01	INFUSION THERAPY	0.218728			73.01
73.02	IFCC INFUSION THERAPY	0.232087			73.02
73.03	PHARMACY VACCINE	0.883889			73.03
74	RENAL DIALYSIS	0.624065			74
76.97	CARDIAC REHABILITATION	1.007168			76.97
76.98	HYPERBARIC OXYGEN THERAPY	0.240176	1,236	297	76.98
76.99	LITHOTRIPSY				76.99
	OUTPATIENT SERVICE COST CENTERS				
90.02	PSYCH ANCILLARY	0.431720			90.02
90.03	RETINAL VASCULAR	1.415946			90.03
91	EMERGENCY	0.119232	99,066	11,812	91
91.01	IFCC	0.163091			91.01
92	OBSERVATION BEDS (NON-DISTINCT PART)	0.640710			92
	OTHER REIMBURSABLE COST CENTERS				
200	TOTAL (sum of lines 50-94, and 96-98)		343,332	43,146	200
201	LESS PBP CLINIC LABORATORY SERVICES-PROGRAM ONLY CHARGES (line 61)				201
202	NET CHARGES (line 200 minus line 201)		343,332		202

(A) Worksheet A line numbers



COMPU-MAX

INGALLS MEMORIAL HOSPITAL Provider CCN: 14-0191	In Lieu of Form CMS-2552-10	Period : From: 10/01/2013 To: 09/30/2014	Run Date: 03/02/2015 Run Time: 10:44 Version: 2014.10
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INPATIENT ANCILLARY SERVICE COST APPORTIONMENT

COMPONENT CCN: 14-T191

WORKSHEET D-3

CHECK [] TITLE V [] HOSPITAL [] SUB (OTHER) [] SWING BED SNF [] PPS
 APPLICABLE [] TITLE XVIII, PART A [] IPF [] SNF [] SWING BED NF [] TEFRA
 BOXES: [XX] TITLE XIX [XX] IRF [] NF [] ICF/MR [XX] OTHER

(A)	COST CENTER DESCRIPTION	RATIO OF COST TO CHARGES	INPATIENT PROGRAM CHARGES	INPATIENT PROGRAM COSTS (col. 1 x col. 2)	
		1	2	3	
	INPATIENT ROUTINE SERVICE COST CENTERS				
30	ADULTS & PEDIATRICS				30
31	INTENSIVE CARE UNIT				31
40	SUBPROVIDER - IPF				40
41	SUBPROVIDER - IRF		205,758		41
	ANCILLARY SERVICE COST CENTERS				
50	OPERATING ROOM	0.200169			50
51	RECOVERY ROOM	0.272331			51
53	ANESTHESIOLOGY	0.078070			53
54	RADIOLOGY-DIAGNOSTIC	0.262188	4,897	1,284	54
54.01	ULTRASOUND	0.159623	1,899	303	54.01
54.02	SPECIAL PROCEDURES	0.072197			54.02
56	RADIOISOTOPE	0.219962			56
57	CT SCAN	0.032471	6,303	205	57
58	MRI	0.077651			58
59	CARDIAC CATHETERIZATION	0.186614			59
60	LABORATORY	0.109171	25,771	2,813	60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS				62.30
63	BLOOD STORING, PROCESSING & TRANS.	0.312729	5,702	1,783	63
65	RESPIRATORY THERAPY	0.178058	18,283	3,255	65
65.01	PULMONARY FUNCTION	0.161526			65.01
66	PHYSICAL THERAPY	0.214712	107,584	23,100	66
67	OCCUPATIONAL THERAPY	0.412076	103,938	42,830	67
68	SPEECH PATHOLOGY	0.259167	39,528	10,244	68
69	ELECTROCARDIOLOGY	0.105566	282	30	69
70	ELECTROENCEPHALOGRAPHY	0.271032			70
70.01	SLEEP LAB	0.169037			70.01
70.02	PSYCH	0.464418			70.02
71	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.162552	385	63	71
72	IMPL. DEV. CHARGED TO PATIENTS	0.532942			72
73	DRUGS CHARGED TO PATIENTS	0.196357	94,668	18,589	73
73.01	INFUSION THERAPY	0.218728			73.01
73.02	IFCC INFUSION THERAPY	0.232087			73.02
73.03	PHARMACY VACCINE	0.883889			73.03
74	RENAL DIALYSIS	0.624065	1,854	1,157	74
76.97	CARDIAC REHABILITATION	1.007168			76.97
76.98	HYPERBARIC OXYGEN THERAPY	0.240176			76.98
76.99	LITHOTRIPSY				76.99
	OUTPATIENT SERVICE COST CENTERS				
90.02	PSYCH ANCILLARY	0.431720			90.02
90.03	RETINAL VASCULAR	1.415946			90.03
91	EMERGENCY	0.119232			91
91.01	IFCC	0.163091			91.01
92	OBSERVATION BEDS (NON-DISTINCT PART)	0.640710			92
	OTHER REIMBURSABLE COST CENTERS				
200	TOTAL (sum of lines 50-94, and 96-98)		411,094	105,656	200
201	LESS PBP CLINIC LABORATORY SERVICES-PROGRAM ONLY CHARGES (line 61)				201
202	NET CHARGES (line 200 minus line 201)		411,094		202

(A) Worksheet A line numbers



COMPU-MAX

INGALLS MEMORIAL HOSPITAL Provider CCN: 14-0191	In Lieu of Form CMS-2552-10	Period : From: 10/01/2013 To: 09/30/2014	Run Date: 03/02/2015 Run Time: 10:44 Version: 2014.10
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CALCULATION OF REIMBURSEMENT SETTLEMENT

WORKSHEET E
PART A

CHECK

APPLICABLE BOX:

PART A - INPATIENT HOSPITAL SERVICES UNDER PPS

		1	1.01	1.02	
1	DRG AMOUNTS OTHER THAN OUTLIER PAYMENTS	42,616,942			1
1.01	DRG AMOUNTS OTHER THAN OUTLIER PAYMENTS FOR DISCHARGES OCCURRING PRIOR TO OCTOBER 1, 2013 (see instructions)				1.01
1.02	DRG AMOUNTS OTHER THAN OUTLIER PAYMENTS FOR DISCHARGES OCCURRING ON OR AFTER OCTOBER 1, 2013 (see instructions)				1.02
1.03	DRG FOR FEDERAL SPECIFIC OPERATING PAYMENT FOR MODEL 4 BPCI (see instructions)				1.03
2	OUTLIER PAYMENTS FOR DISCHARGES (see instructions)	685,154			2
2.01	OUTLIER RECONCILIATION AMOUNT				2.01
2.02	OUTLIER PAYMENT FOR MODEL 4 BPCI (see instructions)				
3	MANAGED CARE SIMULATED PAYMENTS				3
4	BED DAYS AVAILABLE DIVIDED BY NUMBER OF DAYS IN THE COST REPORTING PERIOD (see instructions)	255.19			4
	INDIRECT MEDICAL EDUCATION ADJUSTMENT CALCULATION FOR HOSPITALS				
5	FTE COUNT FOR ALLOPATHIC AND OSTEOPATHIC PROGRAMS FOR THE MOST RECENT COST REPORTING PERIOD ENDING ON OR BEFORE 12/31/1996 (see instructions)				5
6	FTE COUNT FOR ALLOPATHIC AND OSTEOPATHIC PROGRAMS WHICH MEET THE CRITERIA FOR AN ADD-ON TO THE CAP FOR NEW PROGRAMS IN ACCORDANCE WITH 42 CFR 413.79(e)				6
7	MMA SECTION 422 REDUCTION AMOUNT TO THE IME CAP AS SPECIFIED UNDER 42 CFR §412.105(f)(1)(iv)(B)(1)				7
7.01	ACA SECTION 5503 REDUCTION AMOUNT TO THE IME CAP AS SPECIFIED UNDER 42 CFR §412.105(f)(1)(iv)(B)(2). IF THE COST REPORT STRADDLES JULY 1, 2011 THEN SEE INSTRUCTIONS				7.01
8	ADJUSTMENT (INCREASE OR DECREASE) TO THE FTE COUNT FOR ALLOPATHIC AND OSTEOPATHIC PROGRAMS FOR AFFILIATED PROGRAMS IN ACCORDANCE WITH 42 CFR §413.75(b), §413.79(c)(2)(iv) AND VOL. 64 FEDERAL REGISTER, MAY 12, 1998, PAGE 26340 AND VOL. 67 FEDERAL REGISTER, PAGE 50069, AUGUST 1, 2002				8
8.01	THE AMOUNT OF INCREASE IF THE HOSPITAL WAS AWARDED FTE CAP SLOTS UNDER SECTION 5503 OF THE ACA. IF THE COST REPORT STRADDLES JULY 1, 2011, SEE INSTRUCTIONS				8.01
8.02	THE AMOUNT OF INCREASE IF THE HOSPITAL WAS AWARDED FTE CAP SLOTS FROM A CLOSED TEACHING HOSPITAL UNDER SECTION 5506 OF ACA. (see instructions)				8.02
9	SUM OF LINES 5 PLUS 6 MINUS LINES (7 AND 7.01) PLUS/MINUS LINES (8, 8.01 AND 8.02) (see instructions)				9
10	FTE COUNT FOR ALLOPATHIC AND OSTEOPATHIC PROGRAMS IN THE CURRENT YEAR FROM YOUR RECORDS				10
11	FTE COUNT FOR RESIDENTS IN DENTAL AND AND PODIATRIC PROGRAMS				11
12	CURRENT YEAR ALLOWABLE FTE (see instructions)				12
13	TOTAL ALLOWABLE FTE COUNT FOR THE PRIOR YEAR				13
14	TOTAL ALLOWABLE FTE COUNT FOR THE PENULTIMATE YEAR IF THAT YEAR ENDED ON OR AFTER SEPTEMBER 30, 1997, OTHERWISE ENTER ZERO				14
15	SUM OF LINES 12 THROUGH 14 DIVIDED BY 3				15
16	ADJUSTMENT FOR RESIDENTS IN INITIAL YEARS OF THE PROGRAM				16
17	ADJUSTMENT FOR RESIDENTS DISPLACED BY PROGRAM OR HOSPITAL CLOSURE				17
18	ADJUSTED ROLLING AVERAGE FTE COUNT				18
19	CURRENT YEAR RESIDENT TO BED RATIO (line 18 divided by line 4)				19
20	PRIOR YEAR RESIDENT TO BED RATIO (see instructions)				20
21	ENTER THE LESSER OF LINES 19 OR 20 (see instructions)				21
22	IME PAYMENT ADJUSTMENT (see instructions)				22
	INDIRECT MEDICAL EDUCATION ADJUSTMENT FOR THE ADD-ON				
23	NUMBER OF ADDITIONAL ALLOPATHIC AND OSTEOPATHIC IME FTE RESIDENT CAP SLOTS UNDER 42 SEC. 412.105(f)(1)(iv)(C)				23
24	IME FTE RESIDENT COUNT OVER CAP (see instructions)				24
25	IF THE AMOUNT ON LINE 24 IS GREATER THAN -0-, THEN ENTER THE LOWER OF LINE 23 OR LINE 24 (see instructions)				25
26	RESIDENT TO BED RATIO (divide line 25 by line 4)				26
27	IME PAYMENTS ADJUSTMENT (see instructions)				27
28	IME ADJUSTMENT (see instructions)				28
29	TOTAL IME PAYMENT (sum of lines 22 and 28)				29
	DISPROPORTIONATE SHARE ADJUSTMENT				
30	PERCENTAGE OF SSI RECIPIENT PATIENT DAYS TO MEDICARE PART A PATIENT DAYS (see instructions)	0.0901			30
31	PERCENTAGE OF MEDICAID PATIENT DAYS TO TOTAL (see instructions)	0.3425			31
32	SUM OF LINES 30 AND 31	0.4326			32
33	ALLOWABLE DISPROPORTIONATE SHARE PERCENTAGE (see instructions)	0.2490			33
34	DISPROPORTIONATE SHARE ADJUSTMENT (see instructions)	2,652,905			34
		PRIOR TO	ON OR AFTER		
		OCTOBER 1	OCTOBER 1		
	UNCOMPENSATED CARE ADJUSTMENT				
35	TOTAL UNCOMPENSATED CARE AMOUNT (see instructions)		9,046,380,143		35
35.01	FACTOR 3 (see instructions)		0.000667394		35.01
35.02	HOSPITAL UNCOMPENSATED CARE PAYMENT (if line 34 is zero, enter zero on this line) (see instructions)		6,037,500		35.02
35.03	PRO RATA SHARE OF THE HOSPITAL UNCOMPENSATED CARE PAYMENT AMOUNT (see instructions)		6,037,500		35.03
36	TOTAL UNCOMPENSATED CARE (sum of columns 1 and 2 on line 35.03)	6,037,500			36
	ADDITIONAL PAYMENT FOR HIGH PERCENTAGE OF ESRD BENEFICIARY DISCHARGES				
40	TOTAL MEDICARE DISCHARGES ON WORKSHEET S-3, PART 1 EXCLUDING DISCHARGES FOR MS-DRGs 652, 682, 683, 684 AND 685 (see instructions)				40



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CALCULATION OF REIMBURSEMENT SETTLEMENT

WORKSHEET E
PART A

CHECK

APPLICABLE BOX:

PART A - INPATIENT HOSPITAL SERVICES UNDER PPS

		1	1.01	1.02	
41	TOTAL ESRD MEDICARE DISCHARGES EXCLUDING MS-DRGs 652, 682, 683, 684 AND 685 (see instructions)				41
41.01	TOTAL ESRD MEDICARE COVERED AND PAID DISCHARGES EXCLUDING MS-DRGs 652, 682, 683, 684 AND 685 (see instructions)				41.01
42	DIVIDE LINE 41 BY LINE 40 (if less than 10%, you do not qualify for adjustment)				42
43	TOTAL MEDICARE ESRD INPATIENT DAYS EXCLUDING MS-DRGs 652, 682, 683, 684 AND 685 (see instructions)				43
44	RATIO OF AVERAGE LENGTH OF STAY TO ONE WEEK (line 43 divided by line 41.01 divided by 7 days)				44
45	AVERAGE WEEKLY COST FOR DIALYSIS TREATMENTS (see instructions)				45
46	TOTAL ADDITIONAL PAYMENT (line 45 times line 44 times line 41.01)				46
47	SUBTOTAL (see instructions)	51,992,501			47
48	HOSPITAL SPECIFIC PAYMENTS (to be completed by SCH and MDH, small rural hospitals only (see instructions)				48
49	TOTAL PAYMENT FOR INPATIENT OPERATING COSTS SCH AND MDH ONLY (see instructions)	51,992,501			49
50	PAYMENT FOR INPATIENT PROGRAM CAPITAL (from Wkst L, Parts I, II, as applicable)	3,987,054			50
51	EXCEPTION PAYMENT FOR INPATIENT PROGRAM CAPITAL (Wkst L, Part III) (see instructions)				51
52	DIRECT GRADUATE MEDICAL EDUCATION PAYMENT (from Wkst E-4, line 49) (see instructions)				52
53	NURSING AND ALLIED HEALTH MANAGED CARE PAYMENT	19,549			53
54	SPECIAL ADD-ON PAYMENTS FOR NEW TECHNOLOGIES				54
55	NET ORGAN ACQUISITION COST (Wkst D-4, Part III, col. 1, line 69)				55
56	COST OF TEACHING PHYSICIANS (Wkst D-5, Part II, col. 3, line 20)				56
57	ROUTINE SERVICE OTHER PASS THROUGH COSTS	172,088			57
58	ANCILLARY SERVICE OTHER PASS THROUGH COSTS (Wkst D, Part IV, col. 11, line 200)	158,746			58
59	TOTAL (sum of amounts on lines 49 through 58)	56,329,938			59
60	PRIMARY PAYER PAYMENTS	62,705			60
61	TOTAL AMOUNT PAYABLE FOR PROGRAM BENEFICIARIES (line 59 minus line 60)	56,267,233			61
62	DEDUCTIBLES BILLED TO PROGRAM BENEFICIARIES	4,247,947			62
63	COINSURANCE BILLED TO PROGRAM BENEFICIARIES	224,016			63
64	ALLOWABLE BAD DEBTS (see instructions)	1,182,304			64
65	ADJUSTED REIMBURSABLE BAD DEBTS (see instructions)	768,498			65
66	ALLOWABLE BAD DEBTS FOR DUAL ELIGIBLE BENEFICIARIES (see instructions)	1,182,304			66
67	SUBTOTAL (line 61 plus line 65 minus lines 62 and 63)	52,563,768			67
68	CREDITS RECEIVED FROM MANUFACTURERS FOR REPLACED DEVICES APPLICABLE TO MS-DRG (see instructions)				68
69	OUTLIER PAYMENTS RECONCILIATION				69
70	OTHER ADJUSTMENTS (SPECIFY) (see instructions)				70
71	AMOUNT DUE PROVIDER (see instructions)	52,563,768			71
71.01	SEQUESTRATION ADJUSTMENT (see instructions)	1,051,275			71.01
72	INTERIM PAYMENTS	51,104,334			72
73	TENTATIVE SETTLEMENT (for contractor use only)				73
74	BALANCE DUE PROVIDER/PROGRAM (line 71 minus lines 71.01, 72 and 73)	408,159			74
75	PROTESTED AMOUNTS (nonallowable cost report items) IN ACCORDANCE WITH CMS PUB. 15-2, SECTION 115.2	720,120			75

TO BE COMPLETED BY CONTRACTOR

90	OPERATING OUTLIER AMOUNT FROM WORKSHEET E, PART A, LINE 2				90
91	CAPITAL OUTLIER FROM WORKSHEET L, PART I, LINE 2				91
92	OPERATING OUTLIER RECONCILIATION ADJUSTMENT AMOUNT (see instructions)				92
93	CAPITAL OUTLIER RECONCILIATION ADJUSTMENT AMOUNT (see instructions)				93
94	THE RATE USED TO CALCULATE THE TIME VALUE OF MONEY (see instructions)				94
95	TIME VALUE OF MONEY FOR OPERATING EXPENSES (see instructions)				95
96	TIME VALUE OF MONEY FOR CAPITAL RELATED EXPENSES (see instructions)				96



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CALCULATION OF REIMBURSEMENT SETTLEMENT

COMPONENT CCN: 14-0191

WORKSHEET E
PART B

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

PART B - MEDICAL AND OTHER HEALTH SERVICES

		1	1.01	1.02	
1	MEDICAL AND OTHER SERVICES (see instructions)	104,999			1
2	MEDICAL AND OTHER SERVICES REIMBURSED UNDER OPPTS (see instructions)	30,198,021			2
3	PPS PAYMENTS	30,309,292			3
4	OUTLIER PAYMENT (see instructions)	29,495			4
5	ENTER THE HOSPITAL SPECIFIC PAYMENT TO COST RATIO (see instructions)				5
6	LINE 2 TIMES LINE 5				6
7	SUM OF LINE 3 PLUS LINE 4 DIVIDED BY LINE 6				7
8	TRANSITIONAL CORRIDOR PAYMENT (see instructions)				8
9	ANCILLARY SERVICE OTHER PASS THROUGH COSTS FROM WKST D, PART IV, COL. 13, LINE 200	175,712			9
10	ORGAN ACQUISITION				10
11	TOTAL COST (sum of lines 1 and 10) (see instructions)	104,999			11
	COMPUTATION OF LESSER OF COST OR CHARGES				
	REASONABLE CHARGES				
12	ANCILLARY SERVICE CHARGES	139,909			12
13	ORGAN ACQUISITION CHARGES (from Wkst D-4, Part III, line 69, col. 4)				13
14	TOTAL REASONABLE CHARGES (sum of lines 12 and 13)	139,909			14
	CUSTOMARY CHARGES				
15	AGGREGATE AMOUNT ACTUALLY COLLECTED FROM PATIENTS LIABLE FOR PAYMENT FOR SERVICES ON A CHARGE BASIS				15
16	AMOUNTS THAT WOULD HAVE BEEN REALIZED FROM PATIENTS LIABLE FOR PAYMENT FOR SERVICES ON A CHARGE BASIS HAD SUCH PAYMENT BEEN MADE IN ACCORDANCE WITH 42 CFR 413.13(e)				16
17	RATIO OF LINE 15 TO LINE 16 (not to exceed 1.000000)	1.000000			17
18	TOTAL CUSTOMARY CHARGES (see instructions)	139,909			18
19	EXCESS OF CUSTOMARY CHARGES OVER REASONABLE COST (complete only if line 18 exceeds line 11 (see instructions))	34,910			19
20	EXCESS OF REASONABLE COST OVER CUSTOMARY CHARGES (complete only if line 11 exceeds line 18 (see instructions))				20
21	LESSER OF COST OR CHARGES (line 11 minus line 20) (for CAH, see instructions)	104,999			21
22	INTERNS AND RESIDENTS (see instructions)				22
23	COST OF TEACHING PHYSICIANS (see instructions, 42 CFR 415.160 and CMS PUB. 15-1 §2148)				23
24	TOTAL PROSPECTIVE PAYMENT (sum of lines 3, 4, 8 and 9)	30,514,499			24
	COMPUTATION OF REIMBURSEMENT SETTLEMENT				
25	DEDUCTIBLES AND COINSURANCE (see instructions)	6,489,018			25
26	DEDUCTIBLES AND COINSURANCE RELATING TO AMOUNT ON LINE 24 (see instructions)				26
27	SUBTOTAL {(lines 21 and 24 - the sum of lines 25 and 26) plus the sum of lines 22 and 23} (see instructions)	24,130,480			27
28	DIRECT GRADUATE MEDICAL EDUCATION PAYMENTS (from Wkst E-4, line 50)				28
29	ESRD DIRECT MEDICAL EDUCATION COSTS (from Wkst E-4, line 36)				29
30	SUBTOTAL (sum of lines 27 through 29)	24,130,480			30
31	PRIMARY PAYER PAYMENTS	180			31
32	SUBTOTAL (line 30 minus line 31)	24,130,300			32
	ALLOWABLE BAD DEBTS (EXCLUDE BAD DEBTS FOR PROFESSIONAL SERVICES)				
33	COMPOSITE RATE ESRD (from Wkst I-5, line 11)				33
34	ALLOWABLE BAD DEBTS (see instructions)	704,455			34
35	ADJUSTED REIMBURSABLE BAD DEBTS (see instructions)	457,896			35
36	ALLOWABLE BAD DEBTS FOR DUAL ELIGIBLE BENEFICIARIES (see instructions)	704,455			36
37	SUBTOTAL (see instructions)	24,588,196			37
38	MSP-LCC RECONCILIATION AMOUNT FROM PS&R				38
39	OTHER ADJUSTMENTS (SPECIFY) (see instructions)				39
40	SUBTOTAL (see instructions)	24,588,196			40
40.01	SEQUESTRATION ADJUSTMENT (see instructions)	491,764			40.01
41	INTERIM PAYMENTS	24,313,779			41
42	TENTATIVE SETTLEMENT (for contractor use only)				42
43	BALANCE DUE PROVIDER/PROGRAM (see instructions)	-217,347			43
44	PROTESTED AMOUNTS (nonallowable cost report items) IN ACCORDANCE WITH CMS PUB. 15-II, SECTION 115.2				44

TO BE COMPLETED BY CONTRACTOR

90	ORIGINAL OUTLIER AMOUNT (see instructions)				90
91	OUTLIER RECONCILIATION ADJUSTMENT AMOUNT (see instructions)				91
92	THE RATE USED TO CALCULATE THE TIME VALUE OF MONEY				92
93	TIME VALUE OF MONEY (see instructions)				93
94	TOTAL (sum of lines 91 and 93)				94



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CALCULATION OF REIMBURSEMENT SETTLEMENT

COMPONENT CCN: 14-S191

WORKSHEET E
PART B

CHECK APPLICABLE BOX: [] HOSPITAL [XX] IPF [] IRF [] SUB (OTHER) [] SNF

PART B - MEDICAL AND OTHER HEALTH SERVICES

		1	1.01	1.02	
1	MEDICAL AND OTHER SERVICES (see instructions)				1
2	MEDICAL AND OTHER SERVICES REIMBURSED UNDER OPPTS (see instructions)				2
3	PPS PAYMENTS				3
4	OUTLIER PAYMENT (see instructions)				4
5	ENTER THE HOSPITAL SPECIFIC PAYMENT TO COST RATIO (see instructions)				5
6	LINE 2 TIMES LINE 5				6
7	SUM OF LINE 3 PLUS LINE 4 DIVIDED BY LINE 6				7
8	TRANSITIONAL CORRIDOR PAYMENT (see instructions)				8
9	ANCILLARY SERVICE OTHER PASS THROUGH COSTS FROM WKST D, PART IV, COL. 13, LINE 200				9
10	ORGAN ACQUISITION				10
11	TOTAL COST (sum of lines 1 and 10) (see instructions)				11
	COMPUTATION OF LESSER OF COST OR CHARGES				
	REASONABLE CHARGES				
12	ANCILLARY SERVICE CHARGES				12
13	ORGAN ACQUISITION CHARGES (from Wkst D-4, Part III, line 69, col. 4)				13
14	TOTAL REASONABLE CHARGES (sum of lines 12 and 13)				14
	CUSTOMARY CHARGES				
15	AGGREGATE AMOUNT ACTUALLY COLLECTED FROM PATIENTS LIABLE FOR PAYMENT FOR SERVICES ON A CHARGE BASIS				15
16	AMOUNTS THAT WOULD HAVE BEEN REALIZED FROM PATIENTS LIABLE FOR PAYMENT FOR SERVICES ON A CHARGE BASIS HAD SUCH PAYMENT BEEN MADE IN ACCORDANCE WITH 42 CFR 413.13(e)				16
17	RATIO OF LINE 15 TO LINE 16 (not to exceed 1.000000)	1.000000			17
18	TOTAL CUSTOMARY CHARGES (see instructions)				18
19	EXCESS OF CUSTOMARY CHARGES OVER REASONABLE COST (complete only if line 18 exceeds line 11 (see instructions))				19
20	EXCESS OF REASONABLE COST OVER CUSTOMARY CHARGES (complete only if line 11 exceeds line 18 (see instructions))				20
21	LESSER OF COST OR CHARGES (line 11 minus line 20) (for CAH, see instructions)				21
22	INTERNS AND RESIDENTS (see instructions)				22
23	COST OF TEACHING PHYSICIANS (see instructions, 42 CFR 415.160 and CMS PUB. 15-1 §2148)				23
24	TOTAL PROSPECTIVE PAYMENT (sum of lines 3, 4, 8 and 9)				24
	COMPUTATION OF REIMBURSEMENT SETTLEMENT				
25	DEDUCTIBLES AND COINSURANCE (see instructions)				25
26	DEDUCTIBLES AND COINSURANCE RELATING TO AMOUNT ON LINE 24 (see instructions)				26
27	SUBTOTAL {(lines 21 and 24 - the sum of lines 25 and 26) plus the sum of lines 22 and 23} (see instructions)				27
28	DIRECT GRADUATE MEDICAL EDUCATION PAYMENTS (from Wkst E-4, line 50)				28
29	ESRD DIRECT MEDICAL EDUCATION COSTS (from Wkst E-4, line 36)				29
30	SUBTOTAL (sum of lines 27 through 29)				30
31	PRIMARY PAYER PAYMENTS				31
32	SUBTOTAL (line 30 minus line 31)				32
	ALLOWABLE BAD DEBTS (EXCLUDE BAD DEBTS FOR PROFESSIONAL SERVICES)				
33	COMPOSITE RATE ESRD (from Wkst I-5, line 11)				33
34	ALLOWABLE BAD DEBTS (see instructions)				34
35	ADJUSTED REIMBURSABLE BAD DEBTS (see instructions)				35
36	ALLOWABLE BAD DEBTS FOR DUAL ELIGIBLE BENEFICIARIES (see instructions)				36
37	SUBTOTAL (see instructions)				37
38	MSP-LCC RECONCILIATION AMOUNT FROM PS&R				38
39	OTHER ADJUSTMENTS (SPECIFY) (see instructions)				39
40	SUBTOTAL (see instructions)				40
40.01	SEQUESTRATION ADJUSTMENT (see instructions)				40.01
41	INTERIM PAYMENTS				41
42	TENTATIVE SETTLEMENT (for contractor use only)				42
43	BALANCE DUE PROVIDER/PROGRAM (see instructions)				43
44	PROTESTED AMOUNTS (nonallowable cost report items) IN ACCORDANCE WITH CMS PUB. 15-II, SECTION 115.2				44

TO BE COMPLETED BY CONTRACTOR

90	ORIGINAL OUTLIER AMOUNT (see instructions)				90
91	OUTLIER RECONCILIATION ADJUSTMENT AMOUNT (see instructions)				91
92	THE RATE USED TO CALCULATE THE TIME VALUE OF MONEY				92
93	TIME VALUE OF MONEY (see instructions)				93
94	TOTAL (sum of lines 91 and 93)				94



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CALCULATION OF REIMBURSEMENT SETTLEMENT

COMPONENT CCN: 14-T191

WORKSHEET E
PART B

CHECK APPLICABLE BOX: [] HOSPITAL [] IPF [XX] IRF [] SUB (OTHER) [] SNF

PART B - MEDICAL AND OTHER HEALTH SERVICES

		1	1.01	1.02	
1	MEDICAL AND OTHER SERVICES (see instructions)				1
2	MEDICAL AND OTHER SERVICES REIMBURSED UNDER OPPTS (see instructions)				2
3	PPS PAYMENTS				3
4	OUTLIER PAYMENT (see instructions)				4
5	ENTER THE HOSPITAL SPECIFIC PAYMENT TO COST RATIO (see instructions)				5
6	LINE 2 TIMES LINE 5				6
7	SUM OF LINE 3 PLUS LINE 4 DIVIDED BY LINE 6				7
8	TRANSITIONAL CORRIDOR PAYMENT (see instructions)				8
9	ANCILLARY SERVICE OTHER PASS THROUGH COSTS FROM WKST D, PART IV, COL. 13, LINE 200				9
10	ORGAN ACQUISITION				10
11	TOTAL COST (sum of lines 1 and 10) (see instructions)				11
	COMPUTATION OF LESSER OF COST OR CHARGES				
	REASONABLE CHARGES				
12	ANCILLARY SERVICE CHARGES				12
13	ORGAN ACQUISITION CHARGES (from Wkst D-4, Part III, line 69, col. 4)				13
14	TOTAL REASONABLE CHARGES (sum of lines 12 and 13)				14
	CUSTOMARY CHARGES				
15	AGGREGATE AMOUNT ACTUALLY COLLECTED FROM PATIENTS LIABLE FOR PAYMENT FOR SERVICES ON A CHARGE BASIS				15
16	AMOUNTS THAT WOULD HAVE BEEN REALIZED FROM PATIENTS LIABLE FOR PAYMENT FOR SERVICES ON A CHARGE BASIS HAD SUCH PAYMENT BEEN MADE IN ACCORDANCE WITH 42 CFR 413.13(e)				16
17	RATIO OF LINE 15 TO LINE 16 (not to exceed 1.000000)	1.000000			17
18	TOTAL CUSTOMARY CHARGES (see instructions)				18
19	EXCESS OF CUSTOMARY CHARGES OVER REASONABLE COST (complete only if line 18 exceeds line 11 (see instructions))				19
20	EXCESS OF REASONABLE COST OVER CUSTOMARY CHARGES (complete only if line 11 exceeds line 18 (see instructions))				20
21	LESSER OF COST OR CHARGES (line 11 minus line 20) (for CAH, see instructions)				21
22	INTERNS AND RESIDENTS (see instructions)				22
23	COST OF TEACHING PHYSICIANS (see instructions, 42 CFR 415.160 and CMS PUB. 15-1 §2148)				23
24	TOTAL PROSPECTIVE PAYMENT (sum of lines 3, 4, 8 and 9)				24
	COMPUTATION OF REIMBURSEMENT SETTLEMENT				
25	DEDUCTIBLES AND COINSURANCE (see instructions)				25
26	DEDUCTIBLES AND COINSURANCE RELATING TO AMOUNT ON LINE 24 (see instructions)				26
27	SUBTOTAL {(lines 21 and 24 - the sum of lines 25 and 26) plus the sum of lines 22 and 23} (see instructions)				27
28	DIRECT GRADUATE MEDICAL EDUCATION PAYMENTS (from Wkst E-4, line 50)				28
29	ESRD DIRECT MEDICAL EDUCATION COSTS (from Wkst E-4, line 36)				29
30	SUBTOTAL (sum of lines 27 through 29)				30
31	PRIMARY PAYER PAYMENTS				31
32	SUBTOTAL (line 30 minus line 31)				32
	ALLOWABLE BAD DEBTS (EXCLUDE BAD DEBTS FOR PROFESSIONAL SERVICES)				
33	COMPOSITE RATE ESRD (from Wkst I-5, line 11)				33
34	ALLOWABLE BAD DEBTS (see instructions)				34
35	ADJUSTED REIMBURSABLE BAD DEBTS (see instructions)				35
36	ALLOWABLE BAD DEBTS FOR DUAL ELIGIBLE BENEFICIARIES (see instructions)				36
37	SUBTOTAL (see instructions)				37
38	MSP-LCC RECONCILIATION AMOUNT FROM PS&R				38
39	OTHER ADJUSTMENTS (SPECIFY) (see instructions)				39
40	SUBTOTAL (see instructions)				40
40.01	SEQUESTRATION ADJUSTMENT (see instructions)				40.01
41	INTERIM PAYMENTS				41
42	TENTATIVE SETTLEMENT (for contractor use only)				42
43	BALANCE DUE PROVIDER/PROGRAM (see instructions)				43
44	PROTESTED AMOUNTS (nonallowable cost report items) IN ACCORDANCE WITH CMS PUB. 15-II, SECTION 115.2				44

TO BE COMPLETED BY CONTRACTOR

90	ORIGINAL OUTLIER AMOUNT (see instructions)				90
91	OUTLIER RECONCILIATION ADJUSTMENT AMOUNT (see instructions)				91
92	THE RATE USED TO CALCULATE THE TIME VALUE OF MONEY				92
93	TIME VALUE OF MONEY (see instructions)				93
94	TOTAL (sum of lines 91 and 93)				94



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ANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED

COMPONENT CCN: 14-0191

WORKSHEET E-1
PART I

CHECK HOSPITAL SUB (OTHER)
 APPLICABLE IPF SNF
 BOXES: IRF SWING BED SNF

	DESCRIPTION	INPATIENT PART A		PART B		
		mm/dd/yyyy	AMOUNT	mm/dd/yyyy	AMOUNT	
		1	2	3	4	
1	TOTAL INTERIM PAYMENTS PAID TO PROVIDER		1,559,618		1,184,744	1
2	INTERIM PAYMENTS PAYABLE ON INDIVIDUAL BILLS, EITHER SUBMITTED OR TO BE SUBMITTED TO THE INTERMEDIARY FOR SERVICES RENDERED IN THE COST REPORTING PERIOD. IF NONE, WRITE 'NONE' OR ENTER A ZERO		50,066,449		23,372,638	2
3	LIST SEPARATELY EACH RETROACTIVE LUMP SUM ADJUSTMENT					
	AMOUNT BASED ON SUBSEQUENT REVISION OF THE INTERIM RATE FOR THE COST REPORTING PERIOD. ALSO SHOW DATE OF EACH PAYMENT. IF NONE, WRITE 'NONE' OR ENTER A ZERO. (1)					
						3.01
						3.02
						3.03
						3.04
						3.05
						3.06
						3.07
						3.08
						3.09
						3.10
						3.50
						3.51
						3.52
						3.53
						3.54
						3.55
						3.56
						3.57
						3.58
						3.59
	SUBTOTAL (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98)		-521,733		-243,603	3.99
4	TOTAL INTERIM PAYMENTS (sum of lines 1, 2, and 3.99) (transfer to Wkst. E or Wkst. E-3, line and column as appropriate)		51,104,334		24,313,779	4
TO BE COMPLETED BY CONTRACTOR						
5	LIST SEPARATELY EACH TENTATIVE SETTLEMENT PAYMENT AFTER DESK REVIEW. ALSO SHOW DATE OF EACH PAYMENT. IF NONE, WRITE 'NONE' OR ENTER A ZERO. (1)					
						5.01
						5.02
						5.03
						5.04
						5.05
						5.06
						5.07
						5.08
						5.09
						5.10
						5.50
						5.51
						5.52
						5.53
						5.54
						5.55
						5.56
						5.57
						5.58
						5.59
	SUBTOTAL (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98)					5.99
6	DETERMINED NET SETTLEMENT AMOUNT (balance due) BASED ON THE COST REPORT (1)					6.01
						6.02
7	TOTAL MEDICARE PROGRAM LIABILITY (see instructions)					7
8	NAME OF CONTRACTOR	CONTRACTOR NUMBER		NPR DATE (Month/Day/Year)		8

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



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CALCULATION OF REIMBURSEMENT SETTLEMENT FOR HIT

WORKSHEET E-1
PART II

CHECK HOSPITAL CAH
APPLICABLE BOX:

TO BE COMPLETED BY CONTRACTOR FOR NONSTANDARD COST REPORTS

HEALTH INFORMATION TECHNOLOGY DATA COLLECTION AND CALCULATION

1	TOTAL HOSPITAL DISCHARGES AS DEFINED IN AARA §4102 FROM WKST S-3, PART I, COLUMN 15, LINE 14	13,830	1
2	MEDICARE DAYS FROM WKST S-3, PART I, COLUMN 6, SUM OF LINES 1, 8-12	26,482	2
3	MEDICARE HMO DAYS FROM WKST S-3, PART I, COLUMN 6, LINE 2	2,260	3
4	TOTAL INPATIENT DAYS FROM S-3, PART I, COLUMN 8, SUM OF LINES 1, 8-12	59,597	4
5	TOTAL HOSPITAL CHARGES FROM WKST C, PART I, COLUMN 8, LINE 200	1,152,011,954	5
6	TOTAL HOSPITAL CHARITY CARE CHARGES FROM WKST S-10, COLUMN 3, LINE 20	35,086,806	6
7	CAH ONLY - THE REASONABLE COST INCURRED FOR THE PURCHASE OF CERTIFIED HIT TECHNOLOGY FROM WORKSHEET S-2, PART I, LINE 168		7
8	CALCULATION OF THE HIT INCENTIVE PAYMENT (see instructions)	2,256,306	8
9	SEQUESTRATION ADJUSTMENT AMOUNT (see instructions)	45,126	9
10	CALCULATION OF THE HIT INCENTIVE PAYMENT AFTER SEQUESTRATION (see instructions)	2,211,180	10

INPATIENT HOSPITAL SERVICES UNDER PPS & CAH

30	INITIAL/INTERIM HIT PAYMENT(S)	2,118,339	30
31	OTHER ADJUSTMENTS ()		31
32	BALANCE DUE PROVIDER (line 8 (or line 10) minus line 30 and line 31) (see instructions)	92,841	32



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CALCULATION OF REIMBURSEMENT SETTLEMENT

COMPONENT CCN: 14-S191

WORKSHEET E-3
PART II

CHECK [] HOSPITAL
 APPLICABLE [XX] SUBPROVIDER IPF
 BOX:

PART II - CALCULATION OF MEDICARE REIMBURSEMENT SETTLEMENT UNDER IPF PPS

1	NET FEDERAL IPF PPS PAYMENT (excluding outlier, ECT, and medical education payments)	1,675,359	1
2	NET IPF PPS OUTLIER PAYMENT	5,706	2
3	NET IPF PPS ECT PAYMENT		3
4	UNWEIGHTED INTERN AND RESIDENT FTE COUNT IN THE MOST RECENT COST REPORT FILED ON OR BEFORE NOVEMBER 15, 2004		4
4.01	CAP INCREASES FOR THE UNWEIGHTED INTERN AND RESIDENT FTE COUNT FOR RESIDENTS THAT WERE DISPLACED BY PROGRAM OR HOSPITAL CLOSURE, THAT WOULD NOT BE COUNTED WITHOUT A TEMPORARY CAP ADJUSTMENT UNDER §412.424(d)(1)(iii)(F)(1) OR (2) (see instructions)		4.01
5	NEW TEACHING PROGRAM ADJUSTMENT (see instructions)		5
6	CURRENT YEAR UNWEIGHTED FTE COUNT OF I&R EXCLUDING FTEs IN THE NEW PROGRAM GROWTH PERIOD OF A 'NEW TEACHING PROGRAM (see instructions)		6
7	CURRENT YEAR UNWEIGHTED I&R FTE COUNT FOR RESIDENTS WITHIN THE NEW PROGRAM GROWTH PERIOD OF A 'NEW TEACHING PROGRAM (see instructions)		7
8	INTERN AND RESIDENT COUNT FOR IPF PPS MEDICAL EDUCATION ADJUSTMENT (see instructions)		8
9	AVERAGE DAILY CENSUS (see instructions)	7,917,808	9
10	TEACHING ADJUSTMENT FACTOR $\{(1 + (\text{line } 8/\text{line } 9)) \text{ raised to the power of } .5150 - 1\}$		10
11	TEACHING ADJUSTMENT (line 1 multiplied by line 10)		11
12	ADJUSTED NET IPF PPS PAYMENTS (sum of lines 1, 2, 3 and 11)	1,681,065	12
13	NURSING AND ALLIED HEALTH MANAGED CARE PAYMENT (see instructions)		13
14	ORGAN ACQUISITION		14
15	COST OF TEACHING PHYSICIANS (from Worksheet D-5, Part II, col. 3, line 20) (see instructions)		15
16	SUBTOTAL (see instructions)	1,681,065	16
17	PRIMARY PAYER PAYMENTS		17
18	SUBTOTAL (line 16 less line 17)	1,681,065	18
19	DEDUCTIBLES	133,856	19
20	SUBTOTAL (line 18 minus line 19)	1,547,209	20
21	COINSURANCE	13,376	21
22	SUBTOTAL (line 20 minus line 21)	1,533,833	22
23	ALLOWABLE BAD DEBTS (exclude bad debts for professional services) (see instructions)		23
24	ADJUSTED REIMBURSABLE BAD DEBTS (see instructions)		24
25	ALLOWABLE BAD DEBTS FOR DUAL ELIGIBLE BENEFICIARIES (see instructions)		25
26	SUBTOTAL (sum of lines 22 and 24)	1,533,833	26
27	DIRECT GRADUATE MEDICAL EDUCATION PAYMENTS (from Worksheet E-4, line 49) (for freestanding IPF only)		27
28	OTHER PASS THROUGH COSTS (see instructions)	14,042	28
29	OUTLIER PAYMENTS RECONCILIATION		29
30	OTHER ADJUSTMENTS (SPECIFY) (see instructions)		30
31	TOTAL AMOUNT PAYABLE TO THE PROVIDER (see instructions)	1,547,875	31
31.01	SEQUESTRATION ADJUSTMENT (see instructions)	30,958	31.01
32	INTERIM PAYMENTS	1,506,156	32
33	TENTATIVE SETTLEMENT (for contractor use only)		33
34	BALANCE DUE PROVIDER/PROGRAM (line 31 minus lines 31.01, 32 and 33)	10,761	34
35	PROTESTED AMOUNTS (nonallowable cost report items) IN ACCORDANCE WITH CMS PUB 15-2, SECTION 115.2		35

TO BE COMPLETED BY CONTRACTOR

50	ORIGINAL OUTLIER AMOUNT FROM WORKSHEET E-3, PART II, LINE 2 (see instructions)		50
51	OUTLIER RECONCILIATION ADJUSTMENT AMOUNT (see instructions)		51
52	THE RATE USED TO CALCULATE THE TIME VALUE OF MONEY (see instructions)		52
53	TIME VALUE OF MONEY (see instructions)		53



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CALCULATION OF REIMBURSEMENT SETTLEMENT

COMPONENT CCN: 14-T191

WORKSHEET E-3
PART III

CHECK [] HOSPITAL
 APPLICABLE [XX] SUBPROVIDER IRF
 BOX:

PART III - CALCULATION OF MEDICARE REIMBURSEMENT SETTLEMENT UNDER IRF PPS

		1	1.01	
1	NET FEDERAL PPS PAYMENT (see instructions)	8,611,935		1
2	MEDICARE SSI RATIO (see instructions)	0.041500		2
3	INPATIENT REHABILITATION LIP PAYMENTS (see instructions)	181,712		3
4	OUTLIER PAYMENTS	336,045		4
5	UNWEIGHTED INTERN AND RESIDENT FTE COUNT IN THE MOST RECENT COST REPORTING PERIOD ENDING ON OR PRIOR TO NOVEMBER 15, 2004 (see instructions)			5
5.01	CAP INCREASES FOR THE UNWEIGHTED INTERN AND RESIDENT FTE COUNT FOR RESIDENTS THAT WERE DISPLACED BY PROGRAM OR HOSPITAL CLOSURE, THAT WOULD NOT BE COUNTED WITHOUT A TEMPORARY CAP ADJUSTMENT UNDER §412.424(d)(1)(iii)(F)(1) OR (2) (SEE INSTRUCTIONS)			5.01
6	NEW TEACHING PROGRAM ADJUSTMENT (see instructions)			6
7	CURRENT YEAR UNWEIGHTED FTE COUNT OF I&R EXCLUDING FTEs IN THE NEW PROGRAM GROWTH PERIOD OF A 'NEW TEACHING PROGRAM' (see instructions)			7
8	CURRENT YEAR UNWEIGHTED I&R FTE COUNT FOR RESIDENTS WITHIN THE NEW PROGRAM GROWTH PERIOD OF A 'NEW TEACHING PROGRAM' (see instructions)			8
9	INTERN AND RESIDENT COUNT FOR IRF PPS MEDICAL EDUCATION ADJUSTMENT (see instructions)			9
10	AVERAGE DAILY CENSUS (see instructions)	21.978082		10
11	TEACHING ADJUSTMENT FACTOR (see instructions)			11
12	TEACHING ADJUSTMENT (see instructions)			12
13	TOTAL PPS PAYMENT (see instructions)	9,129,692		13
14	NURSING AND ALLIED HEALTH MANAGED CARE PAYMENTS (see instructions)			14
15	ORGAN ACQUISITION			15
16	COST OF TEACHING PHYSICIANS (from Worksheet D-5, Part II, col. 3, line 20) (see instructions)			16
17	SUBTOTAL (see instructions)	9,129,692		17
18	PRIMARY PAYER PAYMENTS			18
19	SUBTOTAL (line 17 less line 18)	9,129,692		19
20	DEDUCTIBLES	65,162		20
21	SUBTOTAL (line 19 minus line 20)	9,064,530		21
22	COINSURANCE	32,616		22
23	SUBTOTAL (line 21 minus line 22)	9,031,914		23
24	ALLOWABLE BAD DEBTS (exclude bad debts for professional services) (see instructions)			24
25	ADJUSTED REIMBURSABLE BAD DEBTS (see instructions)			25
26	ALLOWABLE BAD DEBTS FOR DUAL ELIGIBLE BENEFICIARIES (see instructions)			26
27	SUBTOTAL (sum of lines 23 and 25)	9,031,914		27
28	DIRECT GRADUATE MEDICAL EDUCATION PAYMENTS (from Worksheet E-4, line 49) (for freestanding IRF only)			28
29	OTHER PASS THROUGH COSTS (see instructions)	47,379		29
30	OUTLIER PAYMENTS RECONCILIATION			30
31	OTHER ADJUSTMENTS (SPECIFY) (see instructions)			31
32	TOTAL AMOUNT PAYABLE TO THE PROVIDER (see instructions)	9,079,293		32
32.01	SEQUESTRATION ADJUSTMENT (see instructions)	181,586		32.01
33	INTERIM PAYMENTS	8,855,833		33
34	TENTATIVE SETTLEMENT (for contractor use only)			34
35	BALANCE DUE PROVIDER/PROGRAM (line 32 minus lines 32.01, 33 and 34)	41,874		35
36	PROTESTED AMOUNTS (nonallowable cost report items) IN ACCORDANCE WITH CMS PUB 15-2, SECTION 115.2			36

TO BE COMPLETED BY CONTRACTOR

50	ORIGINAL OUTLIER AMOUNT FROM WORKSHEET E-3, PART III, LINE 4 (see instructions)			50
51	OUTLIER RECONCILIATION ADJUSTMENT AMOUNT (see instructions)			51
52	THE RATE USED TO CALCULATE THE TIME VALUE OF MONEY (see instructions)			52
53	TIME VALUE OF MONEY (see instructions)			53



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CALCULATION OF REIMBURSEMENT SETTLEMENT

COMPONENT CCN: 14-0191

WORKSHEET E-3
PART VII

CHECK TITLE V HOSPITAL NF PPS
 APPLICABLE TITLE XIX SUB (OTHER) ICF/MR TEFRA
 BOXES: SNF OTHER

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

	INPATIENT TITLE V OR TITLE XIX	OUTPAT- IENT TITLE V OR TITLE XIX	
COMPUTATION OF NET COST OF COVERED SERVICES			
1	22,984,352		1
2		22,194,102	2
3			3
4	22,984,352	22,194,102	4
5			5
6			6
7	22,984,352	22,194,102	7
COMPUTATION OF LESSER OF COST OR CHARGES			
REASONABLE CHARGES			
8			8
9	57,208,775	147,657,278	9
10			10
11			11
12	57,208,775	147,657,278	12
CUSTOMARY CHARGES			
13			13
14			14
15	1.000000	1.000000	15
16	57,208,775	147,657,278	16
17	34,224,423	125,463,176	17
18			18
19			19
20			20
21	22,984,352	22,194,102	21
PROSPECTIVE PAYMENT AMOUNT			
22			22
23			23
24			24
25			25
26			26
27			27
28			28
29	22,984,352	22,194,102	29
COMPUTATION OF REIMBURSEMENT SETTLEMENT			
30			30
31	22,984,352	22,194,102	31
32			32
33			33
34			34
35			35
36	22,984,352	22,194,102	36
37			37
38	22,984,352	22,194,102	38
39			39
40	22,984,352	22,194,102	40
41			41
42	22,984,352	22,194,102	42
43			43



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CALCULATION OF REIMBURSEMENT SETTLEMENT

COMPONENT CCN: 14-S191

WORKSHEET E-3
PART VII

CHECK [] TITLE V [] HOSPITAL [] NF [] PPS
 APPLICABLE [XX] TITLE XIX [XX] SUBPROVIDER IPF [] ICF/MR [] TEFRA
 BOXES: [] SNF [XX] OTHER

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

	INPATIENT TITLE V OR TITLE XIX	OUTPAT- IENT TITLE V OR TITLE XIX	
COMPUTATION OF NET COST OF COVERED SERVICES			
1	473,659		1
2			2
3			3
4	473,659		4
5			5
6			6
7	473,659		7
COMPUTATION OF LESSER OF COST OR CHARGES			
REASONABLE CHARGES			
8			8
9	343,332		9
10			10
11			11
12	343,332		12
CUSTOMARY CHARGES			
13			13
14			14
15	1.000000	1.000000	15
16	343,332		16
17			17
18	130,327		18
19			19
20			20
21	343,332		21
PROSPECTIVE PAYMENT AMOUNT			
22			22
23			23
24			24
25			25
26			26
27			27
28			28
29	343,332		29
COMPUTATION OF REIMBURSEMENT SETTLEMENT			
30	130,327		30
31	343,332		31
32			32
33			33
34			34
35			35
36	343,332		36
37			37
38	343,332		38
39			39
40	343,332		40
41			41
42	343,332		42
43			43



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CALCULATION OF REIMBURSEMENT SETTLEMENT

COMPONENT CCN: 14-T191

WORKSHEET E-3
PART VII

CHECK [] TITLE V [] HOSPITAL [] NF [] PPS
 APPLICABLE [XX] TITLE XIX [XX] SUBPROVIDER IRF [] ICF/MR [] TEFRA
 BOXES: [] SNF [XX] OTHER

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

	INPATIENT TITLE V OR TITLE XIX	OUTPAT- IENT TITLE V OR TITLE XIX	
COMPUTATION OF NET COST OF COVERED SERVICES			
1	428,713		1
2			2
3			3
4	428,713		4
5			5
6			6
7	428,713		7
COMPUTATION OF LESSER OF COST OR CHARGES			
REASONABLE CHARGES			
8			8
9	411,094		9
10			10
11			11
12	411,094		12
CUSTOMARY CHARGES			
13			13
14			14
15	1.000000	1.000000	15
16	411,094		16
17			17
18	17,619		18
19			19
20			20
21	411,094		21
PROSPECTIVE PAYMENT AMOUNT			
22			22
23			23
24			24
25			25
26			26
27			27
28			28
29	411,094		29
COMPUTATION OF REIMBURSEMENT SETTLEMENT			
30	17,619		30
31	411,094		31
32			32
33			33
34			34
35			35
36	411,094		36
37			37
38	411,094		38
39			39
40	411,094		40
41			41
42	411,094		42
43			43



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BALANCE SHEET

WORKSHEET G

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

	ASSETS (Omit Cents)	GENERAL FUND	SPECIFIC PURPOSE FUND	ENDOWMENT FUND	PLANT FUND	
		1	2	3	4	
CURRENT ASSETS						
1	CASH ON HAND AND IN BANKS	5,693,103				1
2	TEMPORARY INVESTMENTS					2
3	NOTES RECEIVABLE					3
4	ACCOUNTS RECEIVABLE	128,344,903				4
5	OTHER RECEIVABLES	7,236,251				5
6	ALLOWANCES FOR UNCOLLECTIBLE NOTES AND ACCOUNTS RECEIVABLE	-82,653,952				6
7	INVENTORY	5,304,088				7
8	PREPAID EXPENSES	3,368,564				8
9	OTHER CURRENT ASSETS					9
10	DUE FROM OTHER FUNDS					10
11	TOTAL CURRENT ASSETS (sum of lines 1-10)	67,292,957				11
FIXED ASSETS						
12	LAND	16,296,256				12
13	LAND IMPROVEMENTS	12,211,664				13
14	ACCUMULATED DEPRECIATION	-9,764,468				14
15	BUILDINGS	267,797,437				15
16	ACCUMULATED DEPRECIATION	-141,732,082				16
17	LEASEHOLD IMPROVEMENTS	2,539,085				17
18	ACCUMULATED AMORTIZATION					18
19	FIXED EQUIPMENT					19
20	ACCUMULATED DEPRECIATION					20
21	AUTOMOBILES AND TRUCKS					21
22	ACCUMULATED DEPRECIATION					22
23	MAJOR MOVABLE EQUIPMENT	187,594,486				23
24	ACCUMULATED DEPRECIATION	-156,176,062				24
25	MINOR EQUIPMENT DEPRECIABLE					25
26	ACCUMULATED DEPRECIATION					26
27	HIT DESIGNATED ASSETS	5,823,826				27
28	ACCUMULATED DEPRECIATION					28
29	MINOR EQUIPMENT-NONDEPRECIABLE					29
30	TOTAL FIXED ASSETS (sum of lines 12-29)	184,590,142				30
OTHER ASSETS						
31	INVESTMENTS	270,168,165	4,354,168			31
32	DEPOSITS ON LEASES					32
33	DUE FROM OWNERS/OFFICERS					33
34	OTHER ASSETS					34
35	TOTAL OTHER ASSETS (sum of lines 31-34)	270,168,165	4,354,168			35
36	TOTAL ASSETS (sum of lines 11, 30 and 35)	522,051,264	4,354,168			36
LIABILITIES AND FUND BALANCES						
	(Omit Cents)	1	2	3	4	
CURRENT LIABILITIES						
37	ACCOUNTS PAYABLE	21,959,020				37
38	SALARIES, WAGES & FEES PAYABLE	6,956,328				38
39	PAYROLL TAXES PAYABLE	452,612				39
40	NOTES & LOANS PAYABLE (short term)					40
41	DEFERRED INCOME					41
42	ACCELERATED PAYMENTS					42
43	DUE TO OTHER FUNDS	24,552,914				43
44	OTHER CURRENT LIABILITIES	513,315				44
45	TOTAL CURRENT LIABILITIES (sum of lines 37 thru 44)	54,434,189				45
LONG TERM LIABILITIES						
46	MORTGAGE PAYABLE					46
47	NOTES PAYABLE					47
48	UNSECURED LOANS					48
49	OTHER LONG TERM LIABILITIES	156,985,557				49
50	TOTAL LONG TERM LIABILITIES (sum of lines 46 thru 49)	156,985,557				50
51	TOTAL LIABILITIES (sum of lines 45 and 50)	211,419,746				51
CAPITAL ACCOUNTS						
52	GENERAL FUND BALANCE	310,631,518				52
53	SPECIFIC PURPOSE FUND BALANCE		4,354,168			53
54	DONOR CREATED - ENDOWMENT FUND BALANCE - RESTRICTED					54
55	DONOR CREATED - ENDOWMENT FUND BALANCE - UNRESTRICTED					55
56	GOVERNING BODY CREATED - ENDOWMENT FUND BALANCE					56
57	PLANT FUND BALANCE - INVESTED IN PLANT					57
58	PLANT FUND BALANCE - RESERVE FOR PLANT IMPROVEMENT, REPLACEMENT, AND EXPANSION					58
59	TOTAL FUND BALANCES (sum of lines 52-58)	310,631,518	4,354,168			59
60	TOTAL LIABILITIES AND FUND BALANCES (sum of lines 51 and 59)	522,051,264	4,354,168			60



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STATEMENT OF CHANGES IN FUND BALANCES

WORKSHEET G-1

		GENERAL FUND		SPECIFIC PURPOSE FUND		
		1	2	3	4	
1	FUND BALANCES AT BEGINNING OF PERIOD		289,272,398		4,435,860	1
2	NET INCOME (loss) (from Worksheet G-3, line 29)		26,766,553			2
3	TOTAL (sum of line 1 and line 2)		316,038,951		4,435,860	3
4	ADDITIONS (credit adjustments)					4
5						5
6						6
7						7
8						8
9						9
10	TOTAL ADDITIONS (sum of lines 4-9)					10
11	SUBTOTAL (line 3 plus line 10)		316,038,951		4,435,860	11
12	DEDUCTIONS (debit adjustments)					12
13		5,407,433		81,692		13
14						14
15						15
16						16
17						17
18	TOTAL DEDUCTIONS (sum of lines 12-17)		5,407,433		81,692	18
19	FUND BALANCE AT END OF PERIOD PER BALANCE SHEET (line 11 minus line 18)		310,631,518		4,354,168	19

		ENDOWMENT FUND		PLANT FUND		
		5	6	7	8	
1	FUND BALANCES AT BEGINNING OF PERIOD					1
2	NET INCOME (loss) (from Worksheet G-3, line 29)					2
3	TOTAL (sum of line 1 and line 2)					3
4	ADDITIONS (credit adjustments)					4
5						5
6						6
7						7
8						8
9						9
10	TOTAL ADDITIONS (sum of lines 4-9)					10
11	SUBTOTAL (line 3 plus line 10)					11
12	DEDUCTIONS (debit adjustments)					12
13						13
14						14
15						15
16						16
17						17
18	TOTAL DEDUCTIONS (sum of lines 12-17)					18
19	FUND BALANCE AT END OF PERIOD PER BALANCE SHEET (line 11 minus line 18)					19



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STATEMENT OF PATIENT REVENUES AND OPERATING EXPENSES

WORKSHEET G-2
PARTS I & II

PART I - PATIENT REVENUES

	REVENUE CENTER	INPATIENT	OUTPATIENT	TOTAL	
		1	2	3	
	GENERAL INPATIENT ROUTINE CARE SERVICES				
1	HOSPITAL	72,094,527		72,094,527	1
2	SUBPROVIDER IPF	4,489,178		4,489,178	2
3	SUBPROVIDER IRF	8,631,716		8,631,716	3
5	SWING BED - SNF				5
6	SWING BED - NF				6
7	SKILLED NURSING FACILITY				7
8	NURSING FACILITY				8
9	OTHER LONG TERM CARE				9
10	TOTAL GENERAL INPATIENT CARE SERVICES (sum of lines 1-9)	85,215,421		85,215,421	10
	INTENSIVE CARE TYPE INPATIENT HOSPITAL SERVICES				
11	INTENSIVE CARE UNIT	10,766,847		10,766,847	11
12	CORONARY CARE UNIT				12
13	BURN INTENSIVE CARE UNIT				13
14	SURGICAL INTENSIVE CARE UNIT				14
15	OTHER SPECIAL CARE (SPECIFY)				15
16	TOTAL INTENSIVE CARE TYPE INPATIENT HOSPITAL SERVICES (sum of lines 11-15)	10,766,847		10,766,847	16
17	TOTAL INPATIENT ROUTINE CARE SERVICES (sum of lines 10 and 16)	95,982,268		95,982,268	17
18	ANCILLARY SERVICES	348,749,988		348,749,988	18
19	OUTPATIENT SERVICES		687,045,722	687,045,722	19
20	RHC				20
21	FQHC				21
22	HOME HEALTH AGENCY		14,128,646	14,128,646	22
23	AMBULANCE				23
25	ASC				25
26	HOSPICE				26
27	OTHER PATIENT REVENUES		6,496,786	6,496,786	27
27.01	AMBULANCE REVENUE		2,207,669	2,207,669	27.01
27.02	MED/SERVICE CAR TRIPS		19,818	19,818	27.02
28	TOTAL PATIENT REVENUES (sum of lines 17-27) (transfer column 3 to Worksheet G-3, line 1)	444,732,256	709,898,641	1,154,630,897	28

PART II - OPERATING EXPENSES

		1	2	
29	OPERATING EXPENSES (per Worksheet A, column 3, line 200)		295,316,154	29
30	ADD (SPECIFY)			30
31				31
32				32
33				33
34				34
35				35
36	TOTAL ADDITIONS (sum of lines 30-35)			36
37	DEDUCT (SPECIFY)			37
38				38
39				39
40				40
41				41
42	TOTAL DEDUCTIONS (sum of lines 37-41)			42
43	TOTAL OPERATING EXPENSES (sum of lines 29 and 36 minus line 42) (transfer to Worksheet G-3, line 4)		295,316,154	43



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STATEMENT OF REVENUES AND EXPENSES

WORKSHEET G-3

	DESCRIPTION		
1	TOTAL PATIENT REVENUES (from Worksheet G-2, Part I, column 3, line 28)	1,154,630,897	1
2	LESS - CONTRACTUAL ALLOWANCES AND DISCOUNTS ON PATIENTS' ACCOUNTS	862,617,110	2
3	NET PATIENT REVENUES (line 1 minus line 2)	292,013,787	3
4	LESS - TOTAL OPERATING EXPENSES (from Worksheet G-2, Part II, line 43)	295,316,154	4
5	NET INCOME FROM SERVICE TO PATIENTS (line 3 minus line 4)	-3,302,367	5

OTHER INCOME

6	CONTRIBUTIONS, DONATIONS, BEQUESTS, ETC.		6
7	INCOME FROM INVESTMENTS	17,399,325	7
8	REVENUES FROM TELEPHONE AND OTHER MISCELLANEOUS COMMUNICATION SERVICES	11,470	8
9	REVENUE FROM TELEVISION AND RADIO SERVICE		9
10	PURCHASE DISCOUNTS		10
11	REBATES AND REFUNDS OF EXPENSES		11
12	PARKING LOT RECEIPTS	118,690	12
13	REVENUE FROM LAUNDRY AND LINEN SERVICE		13
14	REVENUE FROM MEALS SOLD TO EMPLOYEES AND GUESTS		14
15	REVENUE FROM RENTAL OF LIVING QUARTERS		15
16	REVENUE FROM SALE OF MEDICAL AND SURGICAL SUPPLIES TO OTHER THAN PATIENTS		16
17	REVENUE FROM SALE OF DRUGS TO OTHER THAN PATIENTS		17
18	REVENUE FROM SALE OF MEDICAL RECORDS AND ABSTRACTS		18
19	TUITION (fees, sale of textbooks, uniforms, etc.)		19
20	REVENUE FROM GIFTS, FLOWER, COFFEE SHOPS, CANTEEN		20
21	RENTAL OF VENDING MACHINES		21
22	RENTAL OF HOSPITAL SPACE	2,597,269	22
23	GOVERNMENTAL APPROPRIATIONS		23
24	OTHER (MEDICARE/MEDICAID EHR FUNDS)	3,000,000	24
24.01	OTHER (CHILD CARE REVENUE)	484,381	24.01
24.02	OTHER (DIETARY TUITION REVENUE)		24.02
24.03	OTHER (MEDICAL STAFF REVENUE)	1,199,476	24.03
24.04	OTHER (RETINAL REVENUE)	13,497	24.04
24.05	OTHER (HRSA GRANT)	14,575	24.05
24.06	OTHER (LAB CLIENT REVENUE)	349,156	24.06
24.07	OTHER (HEALTH FAIR REVENUE)	21,030	24.07
24.08	OTHER (MANAGEMENT FEE REVENUE)	563,276	24.08
24.09	OTHER (MISC REVENUE)	3,543,011	24.09
24.10	OTHER (LAMAZE REVENUE)	1,080	24.10
24.11	OTHER (MANAGEMENT FEE POB)	278,568	24.11
24.12	OTHER (DISCOUNT EARNINGS)	18,095	24.12
24.13	OTHER (MOBILE INTENSIVE CARE)	235,431	24.13
24.14	OTHER (INTEREST INCOME)	220,590	24.14
25	TOTAL OTHER INCOME (sum of lines 6-24)	30,068,920	25
26	TOTAL (line 5 plus line 25)	26,766,553	26
29	NET INCOME (or loss) FOR THE PERIOD (line 26 minus line 28)	26,766,553	29



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ANALYSIS OF PROVIDER-BASED HOME HEALTH AGENCY COSTS

HHA CCN: 14-7435

WORKSHEET H

	COST CENTER DESCRIPTIONS (omit cents)	SALARIES	EMPLOYEE BENEFITS	TRANSPOR- TATION (see ins- tructions)	CONTRACTED/ PURCHASED SERVICES	OTHER COSTS	
		1	2	3	4	5	
	GENERAL SERVICE COST CENTER						
1	CAPITAL RELATED-BLDGS & FIXTURES						1
2	CAPITAL RELATED-MOVABLE EQUIPMENT						2
3	PLANT OPERATION & MAINTENANCE						3
4	TRANSPORTATION (see instructions)						4
5	ADMINISTRATIVE AND GENERAL	2,095,840	362,414	5,509	188,588	1,408,499	5
	HHA REIMBURSABLE SERVICES						
6	SKILLED NURSING CARE	1,968,266	326,620	98,057		250	6
7	PHYSICAL THERAPY	889,929	167,219	7,639			7
8	OCCUPATIONAL THERAPY	23,249	2,519				8
9	SPEECH PATHOLOGY						9
10	MEDICAL SOCIAL SERVICES	75,154	18,620	1,724			10
11	HOME HEALTH AIDE	191,631	45,836				11
12	SUPPLIES (see instructions)						12
13	DRUGS						13
14	DME						14
	HHA NONREIMBURSABLE SERVICES						
15	HOME DIALYSIS AIDE SERVICES						15
16	RESPIRATORY THERAPY						16
17	PRIVATE DUTY NURSING	2,335,421	306,684	1,989		9,449	17
18	CLINIC						18
19	HEALTH PROMOTION ACTIVITIES						19
20	DAY CARE PROGRAM						20
21	HOME DELIVERED MEALS PROGRAM						21
22	HOMEMAKER SERVICE						22
23	ALL OTHERS						23
23.50	TELEMEDICINE						23.50
24	TOTAL (sum of lines 1-23)	7,579,490	1,229,912	114,918	188,588	1,418,198	24



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ANALYSIS OF PROVIDER-BASED HOME HEALTH AGENCY COSTS

HHA CCN: 14-7435

WORKSHEET H

	COST CENTER DESCRIPTIONS (omit cents)	TOTAL (sum of cols. 1 thru 5)	RECLASS- IFICATIONS	RECLASSIFIED TRIAL BALANCE (col. 6 + col. 7)	ADJUSTMENTS	NET EXPENSES FOR ALLOCATION (col. 8 + col. 9)	
		6	7	8	9	10	
	GENERAL SERVICE COST CENTER						
1	CAPITAL RELATED-BLDGS & FIXTURES						1
2	CAPITAL RELATED-MOVABLE EQUIPMENT						2
3	PLANT OPERATION & MAINTENANCE						3
4	TRANSPORTATION (see instructions)						4
5	ADMINISTRATIVE AND GENERAL	4,060,850		4,060,850	-49,419	4,011,431	5
	HHA REIMBURSABLE SERVICES						
6	SKILLED NURSING CARE	2,393,193		2,393,193		2,393,193	6
7	PHYSICAL THERAPY	1,064,787		1,064,787		1,064,787	7
8	OCCUPATIONAL THERAPY	25,768		25,768		25,768	8
9	SPEECH PATHOLOGY						9
10	MEDICAL SOCIAL SERVICES	95,498		95,498		95,498	10
11	HOME HEALTH AIDE	237,467		237,467		237,467	11
12	SUPPLIES (see instructions)						12
13	DRUGS						13
14	DME						14
	HHA NONREIMBURSABLE SERVICES						
15	HOME DIALYSIS AIDE SERVICES						15
16	RESPIRATORY THERAPY						16
17	PRIVATE DUTY NURSING	2,653,543		2,653,543		2,653,543	17
18	CLINIC						18
19	HEALTH PROMOTION ACTIVITIES						19
20	DAY CARE PROGRAM						20
21	HOME DELIVERED MEALS PROGRAM						21
22	HOMEMAKER SERVICE						22
23	ALL OTHERS						23
23.50	TELEMEDICINE						23.50
24	TOTAL (sum of lines 1-23)	10,531,106		10,531,106	-49,419	10,481,687	24

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



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ANALYSIS OF PROVIDER-BASED HOME HEALTH AGENCY COSTS

HHA CCN: 14-7435

WORKSHEET H-1
PART I

		CAPITAL RELATED COSTS				
		NET EXPENSES FOR COST ALLOCATION (from Wkst. H, col. 10)	BLDGS. & FIXTURES	MOVABLE EQUIPMENT	PLANT OPERATION & MAINTENANCE	
		0	1	2	3	
GENERAL SERVICE COST CENTER						
1	CAPITAL RELATED-BLDGS & FIXTURES					1
2	CAPITAL RELATED-MOVABLE EQUIPMENT					2
3	PLANT OPERATION & MAINTENANCE					3
4	TRANSPORTATION (see instructions)					4
5	ADMINISTRATIVE AND GENERAL	4,011,431				5
HHA REIMBURSABLE SERVICES						
6	SKILLED NURSING CARE	2,393,193				6
7	PHYSICAL THERAPY	1,064,787				7
8	OCCUPATIONAL THERAPY	25,768				8
9	SPEECH PATHOLOGY					9
10	MEDICAL SOCIAL SERVICES	95,498				10
11	HOME HEALTH AIDE	237,467				11
12	SUPPLIES (see instructions)					12
13	DRUGS					13
14	DME					14
HHA NONREIMBURSABLE SERVICES						
15	HOME DIALYSIS AIDE SERVICES					15
16	RESPIRATORY THERAPY					16
17	PRIVATE DUTY NURSING	2,653,543				17
18	CLINIC					18
19	HEALTH PROMOTION ACTIVITIES					19
20	DAY CARE PROGRAM					20
21	HOME DELIVERED MEALS PROGRAM					21
22	HOMEMAKER SERVICE					22
23	ALL OTHERS					23
23.50	TELEMEDICINE					23.50
24	TOTAL (sum of lines 1-23)	10,481,687				24



COMPU-MAX

INGALLS MEMORIAL HOSPITAL Provider CCN: 14-0191	In Lieu of Form CMS-2552-10	Period : From: 10/01/2013 To: 09/30/2014	Run Date: 03/02/2015 Run Time: 10:44 Version: 2014.10
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ANALYSIS OF PROVIDER-BASED HOME HEALTH AGENCY COSTS

HHA CCN: 14-7435

WORKSHEET H-1
PART I

		TRANSPORT- ATION	SUBTOTAL (cols. 0-4)	ADMINI- STRATIVE & GENERAL	TOTAL (col. 4A + 5)	
		4	4A	5	6	
	GENERAL SERVICE COST CENTER					
1	CAPITAL RELATED-BLDGS & FIXTURES					1
2	CAPITAL RELATED-MOVABLE EQUIPMENT					2
3	PLANT OPERATION & MAINTENANCE					3
4	TRANSPORTATION (see instructions)					4
5	ADMINISTRATIVE AND GENERAL		4,011,431	4,011,431		5
	HHA REIMBURSABLE SERVICES					
6	SKILLED NURSING CARE		2,393,193	1,483,732	3,876,925	6
7	PHYSICAL THERAPY		1,064,787	660,147	1,724,934	7
8	OCCUPATIONAL THERAPY		25,768	15,976	41,744	8
9	SPEECH PATHOLOGY					9
10	MEDICAL SOCIAL SERVICES		95,498	59,207	154,705	10
11	HOME HEALTH AIDE		237,467	147,225	384,692	11
12	SUPPLIES (see instructions)					12
13	DRUGS					13
14	DME					14
	HHA NONREIMBURSABLE SERVICES					
15	HOME DIALYSIS AIDE SERVICES					15
16	RESPIRATORY THERAPY					16
17	PRIVATE DUTY NURSING		2,653,543	1,645,144	4,298,687	17
18	CLINIC					18
19	HEALTH PROMOTION ACTIVITIES					19
20	DAY CARE PROGRAM					20
21	HOME DELIVERED MEALS PROGRAM					21
22	HOMEMAKER SERVICE					22
23	ALL OTHERS					23
23.50	TELEMEDICINE					23.50
24	TOTAL (sum of lines 1-23)		10,481,687		10,481,687	24



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INGALLS MEMORIAL HOSPITAL Provider CCN: 14-0191	In Lieu of Form CMS-2552-10	Period : From: 10/01/2013 To: 09/30/2014	Run Date: 03/02/2015 Run Time: 10:44 Version: 2014.10
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COST ALLOCATION - HHA STATISTICAL BASIS

HHA CCN: 14-7435

WORKSHEET H-1
PART II

		CAPITAL RELATED COSTS						
		BLDGS. & FIXTURES (Square Feet)	MOVABLE EQUIPMENT (Dollar Value)	PLANT OPERATION & MAINTENANCE (Square Feet)	TRANSPORTATION (Mileage)	RECONCILIATION	ADMINISTRATIVE & GENERAL (Accum. Cost)	
		1	2	3	4	5A	5	
GENERAL SERVICE COST CENTER								
1	CAPITAL RELATED-BLDGS & FIXTURES							1
2	CAPITAL RELATED-MOVABLE EQUIPMENT							2
3	PLANT OPERATION & MAINTENANCE							3
4	TRANSPORTATION (see instructions)							4
5	ADMINISTRATIVE AND GENERAL					-4,011,431	6,470,256	5
HHA REIMBURSABLE SERVICES								
6	SKILLED NURSING CARE						2,393,193	6
7	PHYSICAL THERAPY						1,064,787	7
8	OCCUPATIONAL THERAPY						25,768	8
9	SPEECH PATHOLOGY							9
10	MEDICAL SOCIAL SERVICES						95,498	10
11	HOME HEALTH AIDE						237,467	11
12	SUPPLIES (see instructions)							12
13	DRUGS							13
14	DME							14
HHA NONREIMBURSABLE SERVICES								
15	HOME DIALYSIS AIDE SERVICES							15
16	RESPIRATORY THERAPY							16
17	PRIVATE DUTY NURSING						2,653,543	17
18	CLINIC							18
19	HEALTH PROMOTION ACTIVITIES							19
20	DAY CARE PROGRAM							20
21	HOME DELIVERED MEALS PROGRAM							21
22	HOMEMAKER SERVICE							22
23	ALL OTHERS							23
23.50	TELEMEDICINE							23.50
24	TOTAL (sum of lines 1-23)					-4,011,431	6,470,256	24
25	COST TO BE ALLOC (per Worksheet H-1, Part I)						4,011,431	25
26	UNIT COST MULTIPLIER						0.619980	26



COMPU-MAX

INGALLS MEMORIAL HOSPITAL Provider CCN: 14-0191	In Lieu of Form CMS-2552-10	Period : From: 10/01/2013 To: 09/30/2014	Run Date: 03/02/2015 Run Time: 10:44 Version: 2014.10
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ALLOCATION OF GENERAL SERVICE COSTS TO HHA COST CENTERS

HHA CCN: 14-7435

WORKSHEET H-2
PART I

	HHA COST CENTER (omit cents)	HHA TRIAL BALANCE(1)	CAP BLDGS & FIXTURES	CAP MOVABLE EQUIPMENT	EMPLOYEE BENEFITS DEPARTMENT	SUBTOTAL (cols.0-4)	ADMINIS- TRATIVE & GENERAL	
		0	1	2	4	4A	5	
1	ADMINISTRATIVE AND GENERAL		55,364			55,364	18,543	1
2	SKILLED NURSING CARE	3,876,925				3,876,925	1,298,502	2
3	PHYSICAL THERAPY	1,724,934				1,724,934	577,734	3
4	OCCUPATIONAL THERAPY	41,744				41,744	13,981	4
5	SPEECH PATHOLOGY							5
6	MEDICAL SOCIAL SERVICES	154,705				154,705	51,816	6
7	HOME HEALTH AIDE	384,692				384,692	128,845	7
8	SUPPLIES							8
9	DRUGS							9
10	DME							10
11	HOME DIALYSIS AIDE SERVICES							11
12	RESPIRATORY THERAPY							12
13	PRIVATE DUTY NURSING	4,298,687				4,298,687	1,439,764	13
14	CLINIC							14
15	HEALTH PROMOTION ACTIVITIES							15
16	DAY CARE PROGRAM							16
17	HOME DELIVERED MEALS PROGRAM							17
18	HOMEMAKER SERVICE							18
19	ALL OTHERS							19
20	TOTALS (sum of lines 1-19)(2)	10,481,687	55,364			10,537,051	3,529,185	20
21	UNIT COST MULTIPLIER: COLUMN 26, LINE 1 DIVIDED BY THE SUM OF COLUMN 26, LINE 20 MINUS COLUMN 26, LINE 1, ROUNDED TO 6 DECIMAL PLACES.							21

(1) Column 0, line 20 must agree with Wkst. A, column 7, line 101.
 (2) Columns 0 through 26, line 20 must agree with the corresponding columns of Wkst. B, Part I, line 101.



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ALLOCATION OF GENERAL SERVICE COSTS TO HHA COST CENTERS

HHA CCN: 14-7435

WORKSHEET H-2
PART I

	HHA COST CENTER (omit cents)	MAIN- TENANCE & REPAIRS	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSE- KEEPING	DIETARY	CAFETERIA	
		6	7	8	9	10	11	
1	ADMINISTRATIVE AND GENERAL	63,881	157,422		80,494			1
2	SKILLED NURSING CARE							2
3	PHYSICAL THERAPY							3
4	OCCUPATIONAL THERAPY							4
5	SPEECH PATHOLOGY							5
6	MEDICAL SOCIAL SERVICES							6
7	HOME HEALTH AIDE							7
8	SUPPLIES							8
9	DRUGS							9
10	DME							10
11	HOME DIALYSIS AIDE SERVICES							11
12	RESPIRATORY THERAPY							12
13	PRIVATE DUTY NURSING							13
14	CLINIC							14
15	HEALTH PROMOTION ACTIVITIES							15
16	DAY CARE PROGRAM							16
17	HOME DELIVERED MEALS PROGRAM							17
18	HOMEMAKER SERVICE							18
19	ALL OTHERS							19
20	TOTALS (sum of lines 1-19)(2)	63,881	157,422		80,494			20
21	UNIT COST MULTIPLIER: COLUMN 26, LINE 1 DIVIDED BY THE SUM OF COLUMN 26, LINE 20 MINUS COLUMN 26, LINE 1, ROUNDED TO 6 DECIMAL PLACES.							21

- (1) Column 0, line 20 must agree with Wkst. A, column 7, line 101.
- (2) Columns 0 through 26, line 20 must agree with the corresponding columns of Wkst. B, Part I, line 101.



COMPU-MAX

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ALLOCATION OF GENERAL SERVICE COSTS TO HHA COST CENTERS

HHA CCN: 14-7435

WORKSHEET H-2
PART I

	HHA COST CENTER (omit cents)	MAIN- TENANCE OF PERSONNEL	NURSING ADMINIS- TRATION	CENTRAL SERVICES & SUPPLY	PHARMACY	MEDICAL RECORDS & LIBRARY	SOCIAL SERVICE	
		12	13	14	15	16	17	
1	ADMINISTRATIVE AND GENERAL							1
2	SKILLED NURSING CARE							2
3	PHYSICAL THERAPY							3
4	OCCUPATIONAL THERAPY							4
5	SPEECH PATHOLOGY							5
6	MEDICAL SOCIAL SERVICES							6
7	HOME HEALTH AIDE							7
8	SUPPLIES							8
9	DRUGS							9
10	DME							10
11	HOME DIALYSIS AIDE SERVICES							11
12	RESPIRATORY THERAPY							12
13	PRIVATE DUTY NURSING							13
14	CLINIC							14
15	HEALTH PROMOTION ACTIVITIES							15
16	DAY CARE PROGRAM							16
17	HOME DELIVERED MEALS PROGRAM							17
18	HOMEMAKER SERVICE							18
19	ALL OTHERS							19
20	TOTALS (sum of lines 1-19)(2)							20
21	UNIT COST MULTIPLIER: COLUMN 26, LINE 1 DIVIDED BY THE SUM OF COLUMN 26, LINE 20 MINUS COLUMN 26, LINE 1, ROUNDED TO 6 DECIMAL PLACES.							21

- (1) Column 0, line 20 must agree with Wkst. A, column 7, line 101.
- (2) Columns 0 through 26, line 20 must agree with the corresponding columns of Wkst. B, Part I, line 101.



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ALLOCATION OF GENERAL SERVICE COSTS TO HHA COST CENTERS

HHA CCN: 14-7435

WORKSHEET H-2
PART I

	HHA COST CENTER (omit cents)	NONPHYSIC. ANESTHET.	NURSING SCHOOL	I&R SALARY & FRINGES	I&R PROGRAM COSTS	PARAMED EDUCATION		
		19	20	21	22	23	23.01	
1	ADMINISTRATIVE AND GENERAL							1
2	SKILLED NURSING CARE							2
3	PHYSICAL THERAPY							3
4	OCCUPATIONAL THERAPY							4
5	SPEECH PATHOLOGY							5
6	MEDICAL SOCIAL SERVICES							6
7	HOME HEALTH AIDE							7
8	SUPPLIES							8
9	DRUGS							9
10	DME							10
11	HOME DIALYSIS AIDE SERVICES							11
12	RESPIRATORY THERAPY							12
13	PRIVATE DUTY NURSING							13
14	CLINIC							14
15	HEALTH PROMOTION ACTIVITIES							15
16	DAY CARE PROGRAM							16
17	HOME DELIVERED MEALS PROGRAM							17
18	HOMEMAKER SERVICE							18
19	ALL OTHERS							19
20	TOTALS (sum of lines 1-19)(2)							20
21	UNIT COST MULTIPLIER: COLUMN 26, LINE 1 DIVIDED BY THE SUM OF COLUMN 26, LINE 20 MINUS COLUMN 26, LINE 1, ROUNDED TO 6 DECIMAL PLACES.							21

- (1) Column 0, line 20 must agree with Wkst. A, column 7, line 101.
- (2) Columns 0 through 26, line 20 must agree with the corresponding columns of Wkst. B, Part I, line 101.



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ALLOCATION OF GENERAL SERVICE COSTS TO HHA COST CENTERS

HHA CCN: 14-7435

WORKSHEET H-2
PART I

	HHA COST CENTER (omit cents)		SUBTOTAL (sum of col.4A-23) 24	I&R COST & POST STEP- DOWN ADJS 25	SUBTOTAL (sum of col.4A-23) 26	ALLOCATED HHA A&G (see Pt.2) 27	TOTAL HHA COSTS 28	
1	ADMINISTRATIVE AND GENERAL	23.02	375,704		375,704			1
2	SKILLED NURSING CARE		5,175,427		5,175,427	138,965	5,314,392	2
3	PHYSICAL THERAPY		2,302,668		2,302,668	61,829	2,364,497	3
4	OCCUPATIONAL THERAPY		55,725		55,725	1,496	57,221	4
5	SPEECH PATHOLOGY							5
6	MEDICAL SOCIAL SERVICES		206,521		206,521	5,545	212,066	6
7	HOME HEALTH AIDE		513,537		513,537	13,789	527,326	7
8	SUPPLIES							8
9	DRUGS							9
10	DME							10
11	HOME DIALYSIS AIDE SERVICES							11
12	RESPIRATORY THERAPY							12
13	PRIVATE DUTY NURSING		5,738,451		5,738,451	154,080	5,892,531	13
14	CLINIC							14
15	HEALTH PROMOTION ACTIVITIES							15
16	DAY CARE PROGRAM							16
17	HOME DELIVERED MEALS PROGRAM							17
18	HOMEMAKER SERVICE							18
19	ALL OTHERS							19
20	TOTALS (sum of lines 1-19)(2)		14,368,033		14,368,033	375,704	14,368,033	20
21	UNIT COST MULTIPLIER: COLUMN 26, LINE 1 DIVIDED BY THE SUM OF COLUMN 26, LINE 20 MINUS COLUMN 26, LINE 1, ROUNDED TO 6 DECIMAL PLACES.					0.026851		21

- (1) Column 0, line 20 must agree with Wkst. A, column 7, line 101.
- (2) Columns 0 through 26, line 20 must agree with the corresponding columns of Wkst. B, Part I, line 101.



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ALLOCATION OF GENERAL SERVICE COSTS TO HHA COST CENTERS STATISTICAL BASIS

HHA CCN: 14-7435

WORKSHEET H-2
PART II

	HHA COST CENTER	CAP BLDGS & FIXTURES SQUARE FEET	CAP MOVABLE EQUIPMENT DOLLAR VALUE	EMPLOYEE BENEFITS DEPARTMENT GROSS SALARIES	RECON- CILIATION	ADMINIS- TRATIVE & GENERAL ACCUM COST	MAIN- TENANCE & REPAIRS SQUARE FEET	
		1	2	4	4A	5	6	
1	ADMINISTRATIVE AND GENERAL	6,181				55,364	6,181	1
2	SKILLED NURSING CARE					3,876,925		2
3	PHYSICAL THERAPY					1,724,934		3
4	OCCUPATIONAL THERAPY					41,744		4
5	SPEECH PATHOLOGY							5
6	MEDICAL SOCIAL SERVICES					154,705		6
7	HOME HEALTH AIDE					384,692		7
8	SUPPLIES							8
9	DRUGS							9
10	DME							10
11	HOME DIALYSIS AIDE SERVICES							11
12	RESPIRATORY THERAPY							12
13	PRIVATE DUTY NURSING					4,298,687		13
14	CLINIC							14
15	HEALTH PROMOTION ACTIVITIES							15
16	DAY CARE PROGRAM							16
17	HOME DELIVERED MEALS PROGRAM							17
18	HOMEMAKER SERVICE							18
19	ALL OTHERS							19
19.50	TELEMEDICINE							19.50
20	TOTALS (sum of lines 1-19)	6,181				10,537,051	6,181	20
21	TOTAL COST TO BE ALLOCATED	55,364				3,529,185	63,881	21
22	UNIT COST MULTIPLIER	8.957127				0.334931		22
22	UNIT COST MULTIPLIER						10.335059	22



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ALLOCATION OF GENERAL SERVICE COSTS TO HHA COST CENTERS STATISTICAL BASIS

HHA CCN: 14-7435

WORKSHEET H-2
PART II

	HHA COST CENTER	OPERATION OF PLANT SQUARE FEET	LAUNDRY & LINEN SERVICE POUNDS OF LAUNDRY	HOUSE- KEEPING SQUARE FEET	DIETARY MEALS SERVED	CAFETERIA FTES	MAIN- TENANCE OF PERSONNEL NUMBER HOUSED	
		7	8	9	10	11	12	
1	ADMINISTRATIVE AND GENERAL	6,181		6,181				1
2	SKILLED NURSING CARE							2
3	PHYSICAL THERAPY							3
4	OCCUPATIONAL THERAPY							4
5	SPEECH PATHOLOGY							5
6	MEDICAL SOCIAL SERVICES							6
7	HOME HEALTH AIDE							7
8	SUPPLIES							8
9	DRUGS							9
10	DME							10
11	HOME DIALYSIS AIDE SERVICES							11
12	RESPIRATORY THERAPY							12
13	PRIVATE DUTY NURSING							13
14	CLINIC							14
15	HEALTH PROMOTION ACTIVITIES							15
16	DAY CARE PROGRAM							16
17	HOME DELIVERED MEALS PROGRAM							17
18	HOMEMAKER SERVICE							18
19	ALL OTHERS							19
19.50	TELEMEDICINE							19.50
20	TOTALS (sum of lines 1-19)	6,181		6,181				20
21	TOTAL COST TO BE ALLOCATED	157,422		80,494				21
22	UNIT COST MULTIPLIER	25.468694		13.022812				22
22	UNIT COST MULTIPLIER							22



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ALLOCATION OF GENERAL SERVICE COSTS TO HHA COST CENTERS STATISTICAL BASIS

HHA CCN: 14-7435

WORKSHEET H-2
PART II

	HHA COST CENTER	NURSING ADMINISTRATION DIRECT NRSING HRS	CENTRAL SERVICES & SUPPLY COSTED REQUIS.	PHARMACY COSTED REQUIS.	MEDICAL RECORDS & LIBRARY TIME SPENT	SOCIAL SERVICE TIME SPENT	NONPHYSIC. ANESTHET. ASSIGNED TIME	
		13	14	15	16	17	19	
1	ADMINISTRATIVE AND GENERAL							1
2	SKILLED NURSING CARE							2
3	PHYSICAL THERAPY							3
4	OCCUPATIONAL THERAPY							4
5	SPEECH PATHOLOGY							5
6	MEDICAL SOCIAL SERVICES							6
7	HOME HEALTH AIDE							7
8	SUPPLIES							8
9	DRUGS							9
10	DME							10
11	HOME DIALYSIS AIDE SERVICES							11
12	RESPIRATORY THERAPY							12
13	PRIVATE DUTY NURSING							13
14	CLINIC							14
15	HEALTH PROMOTION ACTIVITIES							15
16	DAY CARE PROGRAM							16
17	HOME DELIVERED MEALS PROGRAM							17
18	HOMEMAKER SERVICE							18
19	ALL OTHERS							19
19.50	TELEMEDICINE							19.50
20	TOTALS (sum of lines 1-19)							20
21	TOTAL COST TO BE ALLOCATED							21
22	UNIT COST MULTIPLIER							22
22	UNIT COST MULTIPLIER							22



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ALLOCATION OF GENERAL SERVICE COSTS TO HHA COST CENTERS STATISTICAL BASIS

HHA CCN: 14-7435

WORKSHEET H-2
PART II

	HHA COST CENTER	NURSING SCHOOL ASSIGNED TIME	I&R SALARY & FRINGES ASSIGNED TIME	I&R PROGRAM COSTS ASSIGNED TIME	PARAMED EDUCATION ASSIGNED TIME	TIME SPENT	MEALS SERVED	
		20	21	22	23	23.01	23.02	
1	ADMINISTRATIVE AND GENERAL							1
2	SKILLED NURSING CARE							2
3	PHYSICAL THERAPY							3
4	OCCUPATIONAL THERAPY							4
5	SPEECH PATHOLOGY							5
6	MEDICAL SOCIAL SERVICES							6
7	HOME HEALTH AIDE							7
8	SUPPLIES							8
9	DRUGS							9
10	DME							10
11	HOME DIALYSIS AIDE SERVICES							11
12	RESPIRATORY THERAPY							12
13	PRIVATE DUTY NURSING							13
14	CLINIC							14
15	HEALTH PROMOTION ACTIVITIES							15
16	DAY CARE PROGRAM							16
17	HOME DELIVERED MEALS PROGRAM							17
18	HOMEMAKER SERVICE							18
19	ALL OTHERS							19
19.50	TELEMEDICINE							19.50
20	TOTALS (sum of lines 1-19)							20
21	TOTAL COST TO BE ALLOCATED							21
22	UNIT COST MULTIPLIER							22
22	UNIT COST MULTIPLIER							22



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APPORTIONMENT OF PATIENT SERVICE COSTS

HHA CCN: 14-7435

WORKSHEET H-3
PARTS I & II

CHECK APPLICABLE BOX: [] TITLE V [XX] TITLE XVIII [] TITLE XIX

PART I - COMPUTATION OF THE AGGREGATE PROGRAM COST

COST PER VISIT COMPUTATION								
	PATIENT SERVICES	FROM WKST. H-2, PART I, COL. 28, LINE	FACILITY COSTS (from Wkst. H-2, Part I)	SHARED ANCILLARY COSTS (from Part II)	TOTAL HHA COSTS (cols. 1 + 2)	TOTAL VISITS	AVERAGE COST PER VISIT (col. 3 ÷ col. 4)	
			1	2	3	4	5	
1	SKILLED NURSING CARE	2	5,314,392		5,314,392	28,686	185.26	1
2	PHYSICAL THERAPY	3	2,364,497	477,713	2,842,210	12,129	234.33	2
3	OCCUPATIONAL THERAPY	4	57,221	227,906	285,127	2,809	101.50	3
4	SPEECH PATHOLOGY	5		13,788	13,788	318	43.36	4
5	MEDICAL SOCIAL SERVICES	6	212,066		212,066	562	377.34	5
6	HOME HEALTH AIDE	7	527,326		527,326	2,742	192.31	6
7	TOTAL (sum of lines 1-6)		8,475,502	719,407	9,194,909	47,246		7

LIMITATION COST COMPUTATION				PROGRAM VISITS			
	PATIENT SERVICES	CBSA NO.	PART A	PART B			
		1	2	3	4		
				NOT SUBJECT TO DEDUCTIBLES & COINSURANCE	SUBJECT TO DEDUCTIBLES & COINSURANCE		
8	SKILLED NURSING CARE	16974	1,628	21,160		8	
9	PHYSICAL THERAPY	16974	551	8,616		9	
10	OCCUPATIONAL THERAPY	16974	166	2,252		10	
11	SPEECH PATHOLOGY	16974	44	324		11	
12	MEDICAL SOCIAL SERVICES	16974	32	439		12	
13	HOME HEALTH AIDE	16974	104	2,556		13	
14	TOTAL (sum of lines 8-13)		2,525	35,347		14	

SUPPLIES AND DRUGS COSTS COMPUTATIONS								
	OTHER PATIENT SERVICES	FROM WKST. H-2, PART I, COL. 28, LINE	FACILITY COSTS (from Wkst. H-2, Part I)	SHARED ANCILLARY COSTS (from Part II)	TOTAL HHA COSTS (cols. 1 + 2)	TOTAL CHARGES (from HHA Record)	RATIO (col. 3 ÷ col. 4)	
			1	2	3	4	5	
15	COST OF MEDICAL SUPPLIES	8		61,298	61,298	377,095	0.162553	15
16	COST OF DRUGS	9						16

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

		FROM WKST. C, PART I, COL. 9, LINE	COST TO CHARGE RATIO	TOTAL HHA CHARGES (from provider records)	HHA SHARED ANCILLARY COSTS (col. 1 x col. 2)	TRANSFER TO PART I AS INDICATED	
			1	2	3	4	
1	PHYSICAL THERAPY	66	0.214712	2,224,900	477,713	col. 2, line 2	1
2	OCCUPATIONAL THERAPY	67	0.412076	553,067	227,906	col. 2, line 3	2
3	SPEECH PATHOLOGY	68	0.259167	53,200	13,788	col. 2, line 4	3
4	MEDICAL SUPPLIES CHARGED TO PAT	71	0.162552	377,095	61,298	col. 2, line 15	4
5	DRUGS CHARGED TO PATIENTS	73	0.196357			col. 2, line 16	5
5.01	INFUSION THERAPY	73.01	0.218728			col. 2, line 16	5.01
5.02	IFCC INFUSION THERAPY	73.02	0.232087			col. 2, line 16	5.02
5.03	PHARMACY VACCINE	73.03	0.883889			col. 2, line 16	5.03



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APPORTIONMENT OF PATIENT SERVICE COSTS

HHA CCN: 14-7435

WORKSHEET H-3
PARTS I & II

CHECK APPLICABLE BOX: [] TITLE V [XX] TITLE XVIII [] TITLE XIX

PART I - COMPUTATION OF THE AGGREGATE PROGRAM COST

COST PER VISIT COMPUTATION		PROGRAM VISITS			COST OF SERVICES			TOTAL PROGRAM COST (sum of cols 9-10)	
		PART B			PART B				
PATIENT SERVICES	PART A	NOT SUBJECT TO DEDUCTIBLES & COINSURANCE	SUBJECT TO DEDUCTIBLES & COINSURANCE	PART A	NOT SUBJECT TO DEDUCTIBLES & COINSURANCE	SUBJECT TO DEDUCTIBLES & COINSURANCE			
	6	7	8	9	10	11	12		
1 SKILLED NURSING CARE	1,628	21,160		301,603	3,920,102		4,221,705	1	
2 PHYSICAL THERAPY	551	8,616		129,116	2,018,987		2,148,103	2	
3 OCCUPATIONAL THERAPY	166	2,252		16,849	228,578		245,427	3	
4 SPEECH PATHOLOGY	44	324		1,908	14,049		15,957	4	
5 MEDICAL SOCIAL SERVICES	32	439		12,075	165,652		177,727	5	
6 HOME HEALTH AIDE	104	2,556		20,000	491,544		511,544	6	
7 TOTAL (sum of lines 1-6)	2,525	35,347		481,551	6,838,912		7,320,463	7	

SUPPLIES AND DRUGS COSTS COMPUTATIONS		PROGRAM COVERED CHARGES			COST OF SERVICES			
		PART B			PART B			
OTHER PATIENT SERVICES	PART A	NOT SUBJECT TO DEDUCTIBLES & COINSURANCE	SUBJECT TO DEDUCTIBLES & COINSURANCE	PART A	NOT SUBJECT TO DEDUCTIBLES & COINSURANCE	SUBJECT TO DEDUCTIBLES & COINSURANCE		
	6	7	8	9	10	11		
15 COST OF MEDICAL SUPPLIES							15	
16 COST OF DRUGS							16	



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CALCULATION OF HHA REIMBURSEMENT SETTLEMENT

HHA CCN: 14-7435

WORKSHEET H-4
PARTS I & II

CHECK APPLICABLE BOX: [] TITLE V [XX] TITLE XVIII [] TITLE XIX

PART I - COMPUTATION OF THE LESSER OF REASONABLE COST OR CUSTOMARY CHARGES

	DESCRIPTION	PART A 1	PART B		
			NOT SUBJECT TO DEDUCTIBLES & COINSURANCE 2	SUBJECT TO DEDUCTIBLES & COINSURANCE 3	
	REASONABLE COST OF PART A & PART B SERVICES				
1	REASONABLE COST OF SERVICES (see instructions)				1
2	TOTAL CHARGES	6,769,756			2
	CUSTOMARY CHARGES				
3	AMOUNT ACTUALLY COLLECTED FROM PATIENTS LIABLE FOR PAYMENT FOR SERVICES ON A CHARGE BASIS (from your records)				3
4	AMOUNT THAT WOULD HAVE BEEN REALIZED FROM PATIENTS LIABLE FOR PAYMENT FOR SERVICES ON A CHARGE BASIS HAD SUCH PAYMENT BEEN MADE IN ACCORDANCE WITH 42 CFR 413.13(b)				4
5	RATIO OF LINE 3 TO LINE 4 (not to exceed 1.000000)				5
6	TOTAL CUSTOMARY CHARGES (see instructions)	6,769,756			6
7	EXCESS OF TOTAL CUSTOMARY CHARGES OVER TOTAL REASONABLE COST (complete only if line 6 exceeds line 1)	6,769,756			7
8	EXCESS OF REASONABLE COST OVER CUSTOMARY CHARGES (complete only if line 1 exceeds line 6)				8
9	PRIMARY PAYER PAYMENTS				9

COMPUTATION OF HHA REIMBURSEMENT SETTLEMENT

	DESCRIPTION	PART A SERVICES	PART B SERVICES	
		1	2	
10	TOTAL REASONABLE COST (see instructions)			10
11	TOTAL PPS REIMBURSEMENT - FULL EPISODES WITHOUT OUTLIERS	3,446,834	3,117,489	11
12	TOTAL PPS REIMBURSEMENT - FULL EPISODES WITH OUTLIERS	24,220	38,807	12
13	TOTAL PPS REIMBURSEMENT - LUPA EPISODES	50,112	42,513	13
14	TOTAL PPS REIMBURSEMENT - PEP EPISODES	28,983	38,803	14
15	TOTAL PPS OUTLIER REIMBURSEMENT - FULL EPISODES WITH OUTLIERS	4,635	6,381	15
16	TOTAL PPS OUTLIER REIMBURSEMENT - PEP EPISODES	545	955	16
17	TOTAL OTHER PAYMENTS	52		17
18	DME PAYMENTS			18
19	OXYGEN PAYMENTS			19
20	PROSTHETIC AND ORTHOTIC PAYMENTS			20
21	PART B DEDUCTIBLES BILLED TO MEDICARE PATIENTS (exclude coinsurance)			21
22	SUBTOTAL (sum of lines 10-20 minus line 21)	3,555,381	3,244,948	22
23	EXCESS REASONABLE COST (from line 8)			23
24	SUBTOTAL (line 22 minus line 23)	3,555,381	3,244,948	24
25	COINSURANCE BILLED TO PROGRAM PATIENTS (from your records)			25
26	NET COST (line 24 minus line 25)	3,555,381	3,244,948	26
27	REIMBURSABLE BAD DEBTS (from your records)			27
28	REIMBURSABLE BAD DEBTS FOR DUAL ELIGIBLE BENEFICIARIES (see instructions)			28
29	TOTAL COSTS - CURRENT COST REPORTING PERIOD (line 26 plus line 27)	3,555,381	3,244,948	29
30	OTHER ADJUSTMENTS (SPECIFY) (see instructions)			30
31	SUBTOTAL (line 29 plus/minus line 30)	3,555,381	3,244,948	31
31.01	SEQUESTRATION ADJUSTMENT (see instructions)	34,737	32,108	31.01
32	INTERIM PAYMENTS (see instructions)	3,520,643	3,212,839	32
33	TENTATIVE SETTLEMENT (for contractor use only)			33
34	BALANCE DUE PROVIDER/PROGRAM (line 31 minus lines 31.01, 32 and 33)	1	1	34
35	PROTESTED AMOUNTS (nonallowable cost report items) IN ACCORDANCE WITH CMS PUB 15-2, SECTION 115-2			35



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ANALYSIS OF PAYMENTS TO PROVIDER-BASED HHAs FOR SERVICES RENDERED TO PROGRAM HHA CCN: 14-7435
BENEFICIARIES

WORKSHEET H-5

	DESCRIPTION	PART A		PART B		
		mm/dd/yyyy 1	AMOUNT 2	mm/dd/yyyy 3	AMOUNT 4	
1	TOTAL INTERIM PAYMENTS PAID TO PROVIDER		3,520,643		3,212,839	1
2	INTERIM PAYMENTS PAYABLE ON INDIVIDUAL BILLS, EITHER SUBMITTED OR TO BE SUBMITTED TO THE INTERMEDIARY FOR SERVICES RENDERED IN THE COST REPORTING PERIOD. IF NONE, WRITE 'NONE' OR ENTER A ZERO					2
3	LIST SEPARATELY EACH RETROACTIVE LUMP SUM ADJUSTMENT					3.01
	AMOUNT BASED ON SUBSEQUENT REVISION OF THE INTERIM					3.02
	RATE FOR THE COST REPORTING PERIOD. ALSO SHOW DATE OF	PROGRAM				3.03
	EACH PAYMENT. IF NONE, WRITE 'NONE' OR ENTER A ZERO. (1)	TO				3.04
		PROVIDER				3.05
						3.06
						3.07
						3.08
						3.09
						3.10
						3.50
						3.51
		PROVIDER				3.52
		TO				3.53
		PROGRAM				3.54
						3.55
						3.56
						3.57
						3.58
						3.59
	SUBTOTAL (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98)					3.99
4	TOTAL INTERIM PAYMENTS (sum of lines 1, 2, and 3.99) (transfer to Wkst. H-4, Part II, column as appropriate, line 32)		3,520,643		3,212,839	4
TO BE COMPLETED BY CONTRACTOR						
5	LIST SEPARATELY EACH TENTATIVE SETTLEMENT PAYMENT					5.01
	AFTER DESK REVIEW. ALSO SHOW DATE OF EACH PAYMENT.					5.02
	IF NONE, WRITE 'NONE' OR ENTER A ZERO. (1)	PROGRAM				5.03
		TO				5.04
		PROVIDER				5.05
						5.06
						5.07
						5.08
						5.09
						5.10
						5.50
						5.51
		PROVIDER				5.52
		TO				5.53
		PROGRAM				5.54
						5.55
						5.56
						5.57
						5.58
						5.59
	SUBTOTAL (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98)					5.99
6	DETERMINED NET SETTLEMENT AMOUNT (balance due)					6.01
	BASED ON THE COST REPORT (1)					6.02
7	TOTAL MEDICARE PROGRAM LIABILITY (see instructions)					7
8	NAME OF CONTRACTOR	CONTRACTOR NUMBER		NPR DATE (Month/Day/Year)		8

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



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ANALYSIS OF PROVIDER-BASED HOSPICE COSTS

HOSPICE CCN: 14-1535

WORKSHEET K

	COST CENTER DESCRIPTIONS	SALARIES (from Wkst. K-1)	EMPLOYEE BENEFITS (from Wkst. K-2)	TRANSPOR- TATION (see inst.)	CONTRACTED SERVICES (from Wkst. K-3)	OTHER	
		1	2	3	4	5	
	GENERAL SERVICE COST CENTER						
1	CAPITAL RELATED COSTS-BLDG AND FIXT.						1
2	CAPITAL RELATED COSTS-MOVABLE EQUIP.						2
3	PLANT OPERATION AND MAINTENANCE						3
4	TRANSPORTATION - STAFF						4
5	VOLUNTEER SERVICE COORDINATION						5
6	ADMINISTRATIVE AND GENERAL	480,302	95,429	465	29,379	337,471	6
	INPATIENT CARE SERVICE						
7	INPATIENT - GENERAL CARE	565,667					7
8	INPATIENT - RESPITE CARE						8
	VISITING SERVICES						
9	PHYSICIAN SERVICES						9
10	NURSING CARE	451,852	121,552	28,854	300	361,450	10
11	NURSING CARE-CONTINUOUS HOME CARE						11
12	PHYSICAL THERAPY						12
13	OCCUPATIONAL THERAPY						13
14	SPEECH/LANGUAGE PATHOLOGY						14
15	MEDICAL SOCIAL SERVICES						15
16	SPIRITUAL COUNSELING						16
17	DIETARY COUNSELING						17
18	COUNSELING - OTHER						18
19	HOME HEALTH AIDE AND HOME MAKER						19
20	HH AIDE & HOME MAKER - CONT. HOME CARE						20
21	OTHER						21
	OTHER HOSPICE SERVICE COSTS						
22	DRUGS, BIOLOGICAL AND INFUSION THERAPY						22
23	ANALGESICS						23
24	SEDATIVES/HYPNOTICS						24
25	OTHER - SPECIFY						25
26	DURABLE MEDICAL EQUIPMENT/OXYGEN						26
27	PATIENT TRANSPORTATION						27
28	IMAGING SERVICES						28
29	LABS AND DIAGNOSTICS						29
30	MEDICAL SUPPLIES						30
31	OUTPATIENT SERVICES (including E/R Dept.)						31
32	RADIATION THERAPY						32
33	CHEMOTHERAPY						33
34	OTHER						34
	HOSPICE NONREIMBURSABLE SERVICE						
35	BEREAVEMENT PROGRAM COSTS						35
36	VOLUNTEER PROGRAM COSTS						36
37	FUNDRAISING						37
38	OTHER PROGRAM COSTS						38
39	TOTAL (sum of lines 1-38)	1,497,821	216,981	29,319	29,679	698,921	39



COMPU-MAX

INGALLS MEMORIAL HOSPITAL Provider CCN: 14-0191	In Lieu of Form CMS-2552-10	Period : From: 10/01/2013 To: 09/30/2014	Run Date: 03/02/2015 Run Time: 10:44 Version: 2014.10
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ANALYSIS OF PROVIDER-BASED HOSPICE COSTS

HOSPICE CCN: 14-1535

WORKSHEET K

	TOTAL (cols. 1-5) 6	RECLASSI- FICATION 7	SUBTOTAL (col. 6 ± col. 7) 8	ADJUST- MENTS 9	TOTAL (col. 8 ± col. 9) 10	
GENERAL SERVICE COST CENTER						
1 CAPITAL RELATED COSTS-BLDG AND FIXT.						1
2 CAPITAL RELATED COSTS-MOVABLE EQUIP.						2
3 PLANT OPERATION AND MAINTENANCE						3
4 TRANSPORTATION - STAFF						4
5 VOLUNTEER SERVICE COORDINATION						5
6 ADMINISTRATIVE AND GENERAL	943,046		943,046		943,046	6
INPATIENT CARE SERVICE						
7 INPATIENT - GENERAL CARE	565,667		565,667		565,667	7
8 INPATIENT - RESPITE CARE						8
VISITING SERVICES						
9 PHYSICIAN SERVICES						9
10 NURSING CARE	964,008		964,008		964,008	10
11 NURSING CARE-CONTINUOUS HOME CARE						11
12 PHYSICAL THERAPY						12
13 OCCUPATIONAL THERAPY						13
14 SPEECH/LANGUAGE PATHOLOGY						14
15 MEDICAL SOCIAL SERVICES						15
16 SPIRITUAL COUNSELING						16
17 DIETARY COUNSELING						17
18 COUNSELING - OTHER						18
19 HOME HEALTH AIDE AND HOMEMAKER						19
20 HH AIDE & HOMEMAKER - CONT. HOME CARE						20
21 OTHER						21
OTHER HOSPICE SERVICE COSTS						
22 DRUGS, BIOLOGICAL AND INFUSION THERAPY						22
23 ANALGESICS						23
24 SEDATIVES/HYPNOTICS						24
25 OTHER - SPECIFY						25
26 DURABLE MEDICAL EQUIPMENT/OXYGEN						26
27 PATIENT TRANSPORTATION						27
28 IMAGING SERVICES						28
29 LABS AND DIAGNOSTICS						29
30 MEDICAL SUPPLIES						30
31 OUTPATIENT SERVICES (including E/R Dept.)						31
32 RADIATION THERAPY						32
33 CHEMOTHERAPY						33
34 OTHER						34
HOSPICE NONREIMBURSABLE SERVICE						
35 BEREAVEMENT PROGRAM COSTS						35
36 VOLUNTEER PROGRAM COSTS						36
37 FUNDRAISING						37
38 OTHER PROGRAM COSTS						38
39 TOTAL (sum of lines 1-38)	2,472,721		2,472,721		2,472,721	39



INGALLS MEMORIAL HOSPITAL Provider CCN: 14-0191	In Lieu of Form CMS-2552-10	Period : From: 10/01/2013 To: 09/30/2014	Run Date: 03/02/2015 Run Time: 10:44 Version: 2014.10
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HOSPICE COMPENSATION ANALYSIS SALARIES AND WAGES

HOSPICE CCN: 14-1535

WORKSHEET K-1

	COST CENTER DESCRIPTIONS (omit cents)	ADMINIS- TRATOR	DIRECTOR	MEDICAL SOCIAL WORKERS	SUPERVISORS	NURSES	
		1	2	3	4	5	
	GENERAL SERVICE COST CENTER						
1	CAPITAL RELATED COSTS-BLDG AND FIX						1
2	CAPITAL RELATED COSTS-MOVABLE EQUI						2
3	PLANT OPERATION AND MAINTENANCE						3
4	TRANSPORTATION - STAFF						4
5	VOLUNTEER SERVICE COORDINATION						5
6	ADMINISTRATIVE AND GENERAL				480,302		6
	INPATIENT CARE SERVICE						
7	INPATIENT - GENERAL CARE					565,667	7
8	INPATIENT - RESPITE CARE						8
	VISITING SERVICES						
9	PHYSICIAN SERVICES						9
10	NURSING CARE						10
11	NURSING CARE-CONTINUOUS HOME CARE						11
12	PHYSICAL THERAPY						12
13	OCCUPATIONAL THERAPY						13
14	SPEECH/LANGUAGE PATHOLOGY						14
15	MEDICAL SOCIAL SERVICES						15
16	SPIRITUAL COUNSELING						16
17	DIETARY COUNSELING						17
18	COUNSELING - OTHER						18
19	HOME HEALTH AIDE AND HOMEMAKER						19
20	HH AIDE & HOMEMAKER - CONT. HOME C						20
21	OTHER						21
	OTHER HOSPICE SERVICE COSTS						
22	DRUGS, BIOLOGICAL AND INFUSION THE						22
23	ANALGESICS						23
24	SEDATIVES/HYPNOTICS						24
25	OTHER - SPECIFY						25
26	DURABLE MEDICAL EQUIPMENT/OXYGEN						26
27	PATIENT TRANSPORTATION						27
28	IMAGING SERVICES						28
29	LABS AND DIAGNOSTICS						29
30	MEDICAL SUPPLIES						30
31	OUTPATIENT SERVICES (including E/R						31
32	RADIATION THERAPY						32
33	CHEMOTHERAPY						33
34	OTHER						34
	HOSPICE NONREIMBURSABLE SERVICE						
35	BEREAVEMENT PROGRAM COSTS						35
36	VOLUNTEER PROGRAM COSTS						36
37	FUNDRAISING						37
38	OTHER PROGRAM COSTS						38
39	TOTAL (sum of lines 1-38)				480,302	565,667	39

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



INGALLS MEMORIAL HOSPITAL Provider CCN: 14-0191	In Lieu of Form CMS-2552-10	Period : From: 10/01/2013 To: 09/30/2014	Run Date: 03/02/2015 Run Time: 10:44 Version: 2014.10
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HOSPICE COMPENSATION ANALYSIS SALARIES AND WAGES

HOSPICE CCN: 14-1535

WORKSHEET K-1

	TOTAL THERAPISTS	AIDES	ALL OTHER	TOTAL (1)	
	6	7	8	9	
GENERAL SERVICE COST CENTER					
1 CAPITAL RELATED COSTS-BLDG AND FIX					1
2 CAPITAL RELATED COSTS-MOVABLE EQUI					2
3 PLANT OPERATION AND MAINTENANCE					3
4 TRANSPORTATION - STAFF					4
5 VOLUNTEER SERVICE COORDINATION					5
6 ADMINISTRATIVE AND GENERAL				480,302	6
INPATIENT CARE SERVICE					
7 INPATIENT - GENERAL CARE				565,667	7
8 INPATIENT - RESPITE CARE					8
VISITING SERVICES					
9 PHYSICIAN SERVICES					9
10 NURSING CARE			451,852	451,852	10
11 NURSING CARE-CONTINUOUS HOME CARE					11
12 PHYSICAL THERAPY					12
13 OCCUPATIONAL THERAPY					13
14 SPEECH/LANGUAGE PATHOLOGY					14
15 MEDICAL SOCIAL SERVICES					15
16 SPIRITUAL COUNSELING					16
17 DIETARY COUNSELING					17
18 COUNSELING - OTHER					18
19 HOME HEALTH AIDE AND HOMEMAKER					19
20 HH AIDE & HOMEMAKER - CONT. HOME C					20
21 OTHER					21
OTHER HOSPICE SERVICE COSTS					
22 DRUGS, BIOLOGICAL AND INFUSION THE					22
23 ANALGESICS					23
24 SEDATIVES/HYPNOTICS					24
25 OTHER - SPECIFY					25
26 DURABLE MEDICAL EQUIPMENT/OXYGEN					26
27 PATIENT TRANSPORTATION					27
28 IMAGING SERVICES					28
29 LABS AND DIAGNOSTICS					29
30 MEDICAL SUPPLIES					30
31 OUTPATIENT SERVICES (including E/R					31
32 RADIATION THERAPY					32
33 CHEMOTHERAPY					33
34 OTHER					34
HOSPICE NONREIMBURSABLE SERVICE					
35 BEREAVEMENT PROGRAM COSTS					35
36 VOLUNTEER PROGRAM COSTS					36
37 FUNDRAISING					37
38 OTHER PROGRAM COSTS					38
39 TOTAL (sum of lines 1-38)			451,852	1,497,821	39

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



INGALLS MEMORIAL HOSPITAL Provider CCN: 14-0191	In Lieu of Form CMS-2552-10	Period : From: 10/01/2013 To: 09/30/2014	Run Date: 03/02/2015 Run Time: 10:44 Version: 2014.10
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HOSPICE COMPENSATION ANALYSIS EMPLOYEE BENEFITS (PAYROLL RELATED)

HOSPICE CCN: 14-1535

WORKSHEET K-2

	COST CENTER DESCRIPTIONS (omit cents)	ADMINIS- TRATOR	DIRECTOR	MEDICAL SOCIAL WORKERS	SUPERVISORS	NURSES	
		1	2	3	4	5	
	GENERAL SERVICE COST CENTER						
1	CAPITAL RELATED COSTS-BLDG AND FIX						1
2	CAPITAL RELATED COSTS-MOVABLE EQUI						2
3	PLANT OPERATION AND MAINTENANCE						3
4	TRANSPORTATION - STAFF						4
5	VOLUNTEER SERVICE COORDINATION						5
6	ADMINISTRATIVE AND GENERAL	95,429					6
	INPATIENT CARE SERVICE						
7	INPATIENT - GENERAL CARE						7
8	INPATIENT - RESPITE CARE						8
	VISITING SERVICES						
9	PHYSICIAN SERVICES						9
10	NURSING CARE	121,552					10
11	NURSING CARE-CONTINUOUS HOME CARE						11
12	PHYSICAL THERAPY						12
13	OCCUPATIONAL THERAPY						13
14	SPEECH/LANGUAGE PATHOLOGY						14
15	MEDICAL SOCIAL SERVICES						15
16	SPIRITUAL COUNSELING						16
17	DIETARY COUNSELING						17
18	COUNSELING - OTHER						18
19	HOME HEALTH AIDE AND HOMEMAKER						19
20	HH AIDE & HOMEMAKER - CONT. HOME C						20
21	OTHER						21
	OTHER HOSPICE SERVICE COSTS						
22	DRUGS, BIOLOGICAL AND INFUSION THE						22
23	ANALGESICS						23
24	SEDATIVES/HYPNOTICS						24
25	OTHER - SPECIFY						25
26	DURABLE MEDICAL EQUIPMENT/OXYGEN						26
27	PATIENT TRANSPORTATION						27
28	IMAGING SERVICES						28
29	LABS AND DIAGNOSTICS						29
30	MEDICAL SUPPLIES						30
31	OUTPATIENT SERVICES (including E/R						31
32	RADIATION THERAPY						32
33	CHEMOTHERAPY						33
34	OTHER						34
	HOSPICE NONREIMBURSABLE SERVICE						
35	BEREAVEMENT PROGRAM COSTS						35
36	VOLUNTEER PROGRAM COSTS						36
37	FUNDRAISING						37
38	OTHER PROGRAM COSTS						38
39	TOTAL (sum of lines 1-38)	216,981					39

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



INGALLS MEMORIAL HOSPITAL Provider CCN: 14-0191	In Lieu of Form CMS-2552-10	Period : From: 10/01/2013 To: 09/30/2014	Run Date: 03/02/2015 Run Time: 10:44 Version: 2014.10
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HOSPICE COMPENSATION ANALYSIS EMPLOYEE BENEFITS (PAYROLL RELATED)

HOSPICE CCN: 14-1535

WORKSHEET K-2

	TOTAL THERAPISTS	AIDES	ALL OTHER	TOTAL (1)	
	6	7	8	9	
GENERAL SERVICE COST CENTER					
1					1
2					2
3					3
4					4
5					5
6				95,429	6
INPATIENT CARE SERVICE					
7					7
8					8
VISITING SERVICES					
9					9
10				121,552	10
11					11
12					12
13					13
14					14
15					15
16					16
17					17
18					18
19					19
20					20
21					21
OTHER HOSPICE SERVICE COSTS					
22					22
23					23
24					24
25					25
26					26
27					27
28					28
29					29
30					30
31					31
32					32
33					33
34					34
HOSPICE NONREIMBURSABLE SERVICE					
35					35
36					36
37					37
38					38
39				216,981	39

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



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INGALLS MEMORIAL HOSPITAL Provider CCN: 14-0191	In Lieu of Form CMS-2552-10	Period : From: 10/01/2013 To: 09/30/2014	Run Date: 03/02/2015 Run Time: 10:44 Version: 2014.10
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HOSPICE COMPENSATION ANALYSIS CONTRACTED SERVICES/PURCHASED SERVICES

HOSPICE CCN: 14-1535

WORKSHEET K-3

	COST CENTER DESCRIPTIONS (omit cents)	ADMINIS- TRATOR	DIRECTOR	MEDICAL SOCIAL WORKERS	SUPERVISORS	NURSES	
		1	2	3	4	5	
	GENERAL SERVICE COST CENTER						
1	CAPITAL RELATED COSTS-BLDG AND FIX						1
2	CAPITAL RELATED COSTS-MOVABLE EQUI						2
3	PLANT OPERATION AND MAINTENANCE						3
4	TRANSPORTATION - STAFF						4
5	VOLUNTEER SERVICE COORDINATION						5
6	ADMINISTRATIVE AND GENERAL	29,379					6
	INPATIENT CARE SERVICE						
7	INPATIENT - GENERAL CARE						7
8	INPATIENT - RESPITE CARE						8
	VISITING SERVICES						
9	PHYSICIAN SERVICES						9
10	NURSING CARE	300					10
11	NURSING CARE-CONTINUOUS HOME CARE						11
12	PHYSICAL THERAPY						12
13	OCCUPATIONAL THERAPY						13
14	SPEECH/LANGUAGE PATHOLOGY						14
15	MEDICAL SOCIAL SERVICES						15
16	SPIRITUAL COUNSELING						16
17	DIETARY COUNSELING						17
18	COUNSELING - OTHER						18
19	HOME HEALTH AIDE AND HOMEMAKER						19
20	HH AIDE & HOMEMAKER - CONT. HOME C						20
21	OTHER						21
	OTHER HOSPICE SERVICE COSTS						
22	DRUGS, BIOLOGICAL AND INFUSION THE						22
23	ANALGESICS						23
24	SEDATIVES/HYPNOTICS						24
25	OTHER - SPECIFY						25
26	DURABLE MEDICAL EQUIPMENT/OXYGEN						26
27	PATIENT TRANSPORTATION						27
28	IMAGING SERVICES						28
29	LABS AND DIAGNOSTICS						29
30	MEDICAL SUPPLIES						30
31	OUTPATIENT SERVICES (including E/R						31
32	RADIATION THERAPY						32
33	CHEMOTHERAPY						33
34	OTHER						34
	HOSPICE NONREIMBURSABLE SERVICE						
35	BEREAVEMENT PROGRAM COSTS						35
36	VOLUNTEER PROGRAM COSTS						36
37	FUNDRAISING						37
38	OTHER PROGRAM COSTS						38
39	TOTAL (sum of lines 1-38)	29,679					39

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



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INGALLS MEMORIAL HOSPITAL Provider CCN: 14-0191	In Lieu of Form CMS-2552-10	Period : From: 10/01/2013 To: 09/30/2014	Run Date: 03/02/2015 Run Time: 10:44 Version: 2014.10
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HOSPICE COMPENSATION ANALYSIS CONTRACTED SERVICES/PURCHASED SERVICES

HOSPICE CCN: 14-1535

WORKSHEET K-3

	TOTAL THERAPISTS	AIDES	ALL OTHER	TOTAL (1)	
	6	7	8	9	
GENERAL SERVICE COST CENTER					
1					1
2					2
3					3
4					4
5					5
6				29,379	6
INPATIENT CARE SERVICE					
7					7
8					8
VISITING SERVICES					
9					9
10				300	10
11					11
12					12
13					13
14					14
15					15
16					16
17					17
18					18
19					19
20					20
21					21
OTHER HOSPICE SERVICE COSTS					
22					22
23					23
24					24
25					25
26					26
27					27
28					28
29					29
30					30
31					31
32					32
33					33
34					34
HOSPICE NONREIMBURSABLE SERVICE					
35					35
36					36
37					37
38					38
39				29,679	39

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



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INGALLS MEMORIAL HOSPITAL Provider CCN: 14-0191	In Lieu of Form CMS-2552-10	Period : From: 10/01/2013 To: 09/30/2014	Run Date: 03/02/2015 Run Time: 10:44 Version: 2014.10
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COST ALLOCATION - HOSPICE GENERAL SERVICE COST

HOSPICE CCN: 14-1535

WORKSHEET K-4
PART I

	COST CENTER DESCRIPTIONS	CAPITAL RELATED COSTS				
		NET EXPENSES FOR COST ALLOCATION	BUILDINGS & FIXTURES	MOVABLE EQUIPMENT	PLANT OPERATION & MAINT.	
		0	1	2	3	4
	GENERAL SERVICE COST CENTER					
1	CAPITAL RELATED COSTS-BLDG AND FIX					1
2	CAPITAL RELATED COSTS-MOVABLE EQUI					2
3	PLANT OPERATION AND MAINTENANCE					3
4	TRANSPORTATION - STAFF					4
5	VOLUNTEER SERVICE COORDINATION					5
6	ADMINISTRATIVE AND GENERAL	943,046				6
	INPATIENT CARE SERVICE					
7	INPATIENT - GENERAL CARE	565,667				7
8	INPATIENT - RESPITE CARE					8
	VISITING SERVICES					
9	PHYSICIAN SERVICES					9
10	NURSING CARE	964,008				10
11	NURSING CARE-CONTINUOUS HOME CARE					11
12	PHYSICAL THERAPY					12
13	OCCUPATIONAL THERAPY					13
14	SPEECH/LANGUAGE PATHOLOGY					14
15	MEDICAL SOCIAL SERVICES					15
16	SPIRITUAL COUNSELING					16
17	DIETARY COUNSELING					17
18	COUNSELING - OTHER					18
19	HOME HEALTH AIDE AND HOMEMAKER					19
20	HH AIDE & HOMEMAKER - CONT. HOME C					20
21	OTHER					21
	OTHER HOSPICE SERVICE COSTS					
22	DRUGS, BIOLOGICAL AND INFUSION THE					22
23	ANALGESICS					23
24	SEDATIVES/HYPNOTICS					24
25	OTHER - SPECIFY					25
26	DURABLE MEDICAL EQUIPMENT/OXYGEN					26
27	PATIENT TRANSPORTATION					27
28	IMAGING SERVICES					28
29	LABS AND DIAGNOSTICS					29
30	MEDICAL SUPPLIES					30
31	OUTPATIENT SERVICES (including E/R					31
32	RADIATION THERAPY					32
33	CHEMOTHERAPY					33
34	OTHER					34
	HOSPICE NONREIMBURSABLE SERVICE					
35	BEREAVEMENT PROGRAM COSTS					35
36	VOLUNTEER PROGRAM COSTS					36
37	FUNDRAISING					37
38	OTHER PROGRAM COSTS					38
39	TOTAL (sum of lines 1-38)	2,472,721				39



COMPU-MAX

INGALLS MEMORIAL HOSPITAL Provider CCN: 14-0191	In Lieu of Form CMS-2552-10	Period : From: 10/01/2013 To: 09/30/2014	Run Date: 03/02/2015 Run Time: 10:44 Version: 2014.10
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COST ALLOCATION - HOSPICE GENERAL SERVICE COST

HOSPICE CCN: 14-1535

WORKSHEET K-4
PART I

	VOLUNTEER SERVICES COORDINATOR	SUBTOTAL (cols. 0 - 5)	ADMINISTRATIVE & GENERAL	TOTAL (col. 5 ± col. 6)	
	5	5A	6	7	
GENERAL SERVICE COST CENTER					
1	CAPITAL RELATED COSTS-BLDG AND FIX				1
2	CAPITAL RELATED COSTS-MOVABLE EQUI				2
3	PLANT OPERATION AND MAINTENANCE				3
4	TRANSPORTATION - STAFF				4
5	VOLUNTEER SERVICE COORDINATION				5
6	ADMINISTRATIVE AND GENERAL		943,046	943,046	6
INPATIENT CARE SERVICE					
7	INPATIENT - GENERAL CARE		565,667	348,734	914,401
8	INPATIENT - RESPITE CARE				8
VISITING SERVICES					
9	PHYSICIAN SERVICES				9
10	NURSING CARE		964,008	594,312	1,558,320
11	NURSING CARE-CONTINUOUS HOME CARE				11
12	PHYSICAL THERAPY				12
13	OCCUPATIONAL THERAPY				13
14	SPEECH/LANGUAGE PATHOLOGY				14
15	MEDICAL SOCIAL SERVICES				15
16	SPIRITUAL COUNSELING				16
17	DIETARY COUNSELING				17
18	COUNSELING - OTHER				18
19	HOME HEALTH AIDE AND HOMEMAKER				19
20	HH AIDE & HOMEMAKER - CONT. HOME C				20
21	OTHER				21
OTHER HOSPICE SERVICE COSTS					
22	DRUGS, BIOLOGICAL AND INFUSION THE				22
23	ANALGESICS				23
24	SEDATIVES/HYPNOTICS				24
25	OTHER - SPECIFY				25
26	DURABLE MEDICAL EQUIPMENT/OXYGEN				26
27	PATIENT TRANSPORTATION				27
28	IMAGING SERVICES				28
29	LABS AND DIAGNOSTICS				29
30	MEDICAL SUPPLIES				30
31	OUTPATIENT SERVICES (including E/R				31
32	RADIATION THERAPY				32
33	CHEMOTHERAPY				33
34	OTHER				34
HOSPICE NONREIMBURSABLE SERVICE					
35	BEREAVEMENT PROGRAM COSTS				35
36	VOLUNTEER PROGRAM COSTS				36
37	FUNDRAISING				37
38	OTHER PROGRAM COSTS				38
39	TOTAL (sum of lines 1-38)		2,472,721		2,472,721



INGALLS MEMORIAL HOSPITAL Provider CCN: 14-0191	In Lieu of Form CMS-2552-10	Period : From: 10/01/2013 To: 09/30/2014	Run Date: 03/02/2015 Run Time: 10:44 Version: 2014.10
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COST ALLOCATION - HOSPICE STATISTICAL BASIS

HOSPICE CCN: 14-1535

WORKSHEET K-4
PART II

	COST CENTER DESCRIPTIONS	CAPITAL RELATED COSTS					RECONCILIATION	ADMINISTRATIVE & GENERAL (Acc. Cost)	
		BUILDINGS & FIXTURES (Sq. Ft.)	MOVABLE EQUIPMENT (\$ Value)	PLANT OPERATION & MAINT. (Sq. Ft.)	TRANSPORTATION (Mileage)	VOLUNTEER SERVICES COORDINATOR (Hours)			
		1	2	3	4	5	6A	6	
	GENERAL SERVICE COST CENTER								
1	CAPITAL RELATED COSTS-BLDG AND FIX								1
2	CAPITAL RELATED COSTS-MOVABLE EQUI								2
3	PLANT OPERATION AND MAINTENANCE								3
4	TRANSPORTATION - STAFF								4
5	VOLUNTEER SERVICE COORDINATION								5
6	ADMINISTRATIVE AND GENERAL						-943,046	1,529,675	6
	INPATIENT CARE SERVICE								
7	INPATIENT - GENERAL CARE							565,667	7
8	INPATIENT - RESPITE CARE								8
	VISITING SERVICES								
9	PHYSICIAN SERVICES								9
10	NURSING CARE							964,008	10
11	NURSING CARE-CONTINUOUS HOME CARE								11
12	PHYSICAL THERAPY								12
13	OCCUPATIONAL THERAPY								13
14	SPEECH/LANGUAGE PATHOLOGY								14
15	MEDICAL SOCIAL SERVICES								15
16	SPIRITUAL COUNSELING								16
17	DIETARY COUNSELING								17
18	COUNSELING - OTHER								18
19	HOME HEALTH AIDE AND HOME MAKER								19
20	HH AIDE & HOME MAKER - CONT. HOME C								20
21	OTHER								21
	OTHER HOSPICE SERVICE COSTS								
22	DRUGS, BIOLOGICAL AND INFUSION THE								22
23	ANALGESICS								23
24	SEDATIVES/HYPNOTICS								24
25	OTHER - SPECIFY								25
26	DURABLE MEDICAL EQUIPMENT/OXYGEN								26
27	PATIENT TRANSPORTATION								27
28	IMAGING SERVICES								28
29	LABS AND DIAGNOSTICS								29
30	MEDICAL SUPPLIES								30
31	OUTPATIENT SERVICES (including E/R								31
32	RADIATION THERAPY								32
33	CHEMOTHERAPY								33
34	OTHER								34
	HOSPICE NONREIMBURSABLE SERVICE								
35	BEREAVEMENT PROGRAM COSTS								35
36	VOLUNTEER PROGRAM COSTS								36
37	FUNDRAISING								37
38	OTHER PROGRAM COSTS								38
39	TOTAL (sum of lines 1-38)							943,046	39
40	UNIT COST MULTIPLIER							0.616501	40



INGALLS MEMORIAL HOSPITAL Provider CCN: 14-0191	In Lieu of Form CMS-2552-10	Period : From: 10/01/2013 To: 09/30/2014	Run Date: 03/02/2015 Run Time: 10:44 Version: 2014.10
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ALLOCATION OF GENERAL SERVICE COSTS TO HOSPICE COST CENTERS

HOSPICE CCN: 14-1535

WORKSHEET K-5
PART I

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

	HOSPICE COST CENTER (omit cents)	HOSPICE TRIAL BALANCE(1)	CAP BLDGS & FIXTURES	CAP MOVABLE EQUIPMENT	EMPLOYEE BENEFITS DEPARTMENT	SUBTOTAL	ADMINIS- TRATIVE & GENERAL	
		0	1	2	4	4A	5	
1	ADMINISTRATIVE AND GENERAL							1
2	INPATIENT - GENERAL CARE	914,401				914,401	306,261	2
3	INPATIENT - RESPITE CARE							3
4	PHYSICIAN SERVICES							4
5	NURSING CARE	1,558,320				1,558,320	521,930	5
6	NURSING CARE-CONTINUOUS HOME CARE							6
7	PHYSICAL THERAPY							7
8	OCCUPATIONAL THERAPY							8
9	SPEECH/LANGUAGE PATHOLOGY							9
10	MEDICAL SOCIAL SERVICES							10
11	SPIRITUAL COUNSELING							11
12	DIETARY COUNSELING							12
13	COUNSELING - OTHER							13
14	HOME HEALTH AIDE AND HOMEMAKER							14
15	HH AIDE & HOMEMAKER - CONT. HOME							15
16	OTHER							16
17	DRUGS, BIOLOGICAL AND INFUSION TH							17
18	ANALGESICS							18
19	SEDATIVES / HYPNOTICS							19
20	OTHER - SPECIFY							20
21	DURABLE MED. EQUIPMENT/OXYGEN							21
22	PATIENT TRANSPORTATION							22
23	IMAGING SERVICES							23
24	LABS AND DIAGNOSTICS							24
25	MEDICAL SUPPLIES							25
26	OUTPATIENT SERVICES (including E/							26
27	RADIATION THERAPY							27
28	CHEMOTHERAPY							28
29	OTHER							29
30	BEREAVEMENT PROGRAM COSTS							30
31	VOLUNTEER PROGRAM COSTS							31
32	FUNDRAISING							32
33	OTHER PROGRAM COSTS							33
34	TOTALS (sum of lines 1-33) (2)	2,472,721				2,472,721	828,191	34
35	UNIT COST MULTIPLIER (see instruc							35

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



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ALLOCATION OF GENERAL SERVICE COSTS TO HOSPICE COST CENTERS

HOSPICE CCN: 14-1535

WORKSHEET K-5
PART I

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

	HOSPICE COST CENTER (omit cents)	MAIN- TENANCE & REPAIRS	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSE- KEEPING	DIETARY	CAFETERIA	
		6	7	8	9	10	11	
1	ADMINISTRATIVE AND GENERAL							1
2	INPATIENT - GENERAL CARE							2
3	INPATIENT - RESPITE CARE							3
4	PHYSICIAN SERVICES							4
5	NURSING CARE							5
6	NURSING CARE-CONTINUOUS HOME CARE							6
7	PHYSICAL THERAPY							7
8	OCCUPATIONAL THERAPY							8
9	SPEECH/LANGUAGE PATHOLOGY							9
10	MEDICAL SOCIAL SERVICES							10
11	SPIRITUAL COUNSELING							11
12	DIETARY COUNSELING							12
13	COUNSELING - OTHER							13
14	HOME HEALTH AIDE AND HOMEMAKER							14
15	HH AIDE & HOMEMAKER - CONT. HOME							15
16	OTHER							16
17	DRUGS, BIOLOGICAL AND INFUSION TH							17
18	ANALGESICS							18
19	SEDATIVES / HYPNOTICS							19
20	OTHER - SPECIFY							20
21	DURABLE MED. EQUIPMENT/OXYGEN							21
22	PATIENT TRANSPORTATION							22
23	IMAGING SERVICES							23
24	LABS AND DIAGNOSTICS							24
25	MEDICAL SUPPLIES							25
26	OUTPATIENT SERVICES (including E/							26
27	RADIATION THERAPY							27
28	CHEMOTHERAPY							28
29	OTHER							29
30	BEREAVEMENT PROGRAM COSTS							30
31	VOLUNTEER PROGRAM COSTS							31
32	FUNDRAISING							32
33	OTHER PROGRAM COSTS							33
34	TOTALS (sum of lines 1-33) (2)							34
35	UNIT COST MULTIPLIER (see instruc							35

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



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ALLOCATION OF GENERAL SERVICE COSTS TO HOSPICE COST CENTERS

HOSPICE CCN: 14-1535

WORKSHEET K-5
PART I

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

	HOSPICE COST CENTER (omit cents)	MAIN- TENANCE OF PERSONNEL	NURSING ADMINIS- TRATION	CENTRAL SERVICES & SUPPLY	PHARMACY	MEDICAL RECORDS & LIBRARY	SOCIAL SERVICE	
		12	13	14	15	16	17	
1	ADMINISTRATIVE AND GENERAL							1
2	INPATIENT - GENERAL CARE							2
3	INPATIENT - RESPITE CARE							3
4	PHYSICIAN SERVICES							4
5	NURSING CARE							5
6	NURSING CARE-CONTINUOUS HOME CARE							6
7	PHYSICAL THERAPY							7
8	OCCUPATIONAL THERAPY							8
9	SPEECH/LANGUAGE PATHOLOGY							9
10	MEDICAL SOCIAL SERVICES							10
11	SPIRITUAL COUNSELING							11
12	DIETARY COUNSELING							12
13	COUNSELING - OTHER							13
14	HOME HEALTH AIDE AND HOMEMAKER							14
15	HH AIDE & HOMEMAKER - CONT. HOME							15
16	OTHER							16
17	DRUGS, BIOLOGICAL AND INFUSION TH							17
18	ANALGESICS							18
19	SEDATIVES / HYPNOTICS							19
20	OTHER - SPECIFY							20
21	DURABLE MED. EQUIPMENT/OXYGEN							21
22	PATIENT TRANSPORTATION							22
23	IMAGING SERVICES							23
24	LABS AND DIAGNOSTICS							24
25	MEDICAL SUPPLIES							25
26	OUTPATIENT SERVICES (including E/							26
27	RADIATION THERAPY							27
28	CHEMOTHERAPY							28
29	OTHER							29
30	BEREAVEMENT PROGRAM COSTS							30
31	VOLUNTEER PROGRAM COSTS							31
32	FUNDRAISING							32
33	OTHER PROGRAM COSTS							33
34	TOTALS (sum of lines 1-33) (2)							34
35	UNIT COST MULTIPLIER (see instruc							35

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

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



INGALLS MEMORIAL HOSPITAL Provider CCN: 14-0191	In Lieu of Form CMS-2552-10	Period : From: 10/01/2013 To: 09/30/2014	Run Date: 03/02/2015 Run Time: 10:44 Version: 2014.10
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ALLOCATION OF GENERAL SERVICE COSTS TO HOSPICE COST CENTERS

HOSPICE CCN: 14-1535

WORKSHEET K-5
PART I

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

	HOSPICE COST CENTER (omit cents)	NONPHYSIC. ANESTHET.	NURSING SCHOOL	I&R SALARY & FRINGES	I&R PROGRAM COSTS	PARAMED EDUCATION		
		19	20	21	22	23	23.01	
1	ADMINISTRATIVE AND GENERAL							1
2	INPATIENT - GENERAL CARE							2
3	INPATIENT - RESPITE CARE							3
4	PHYSICIAN SERVICES							4
5	NURSING CARE							5
6	NURSING CARE-CONTINUOUS HOME CARE							6
7	PHYSICAL THERAPY							7
8	OCCUPATIONAL THERAPY							8
9	SPEECH/LANGUAGE PATHOLOGY							9
10	MEDICAL SOCIAL SERVICES							10
11	SPIRITUAL COUNSELING							11
12	DIETARY COUNSELING							12
13	COUNSELING - OTHER							13
14	HOME HEALTH AIDE AND HOMEMAKER							14
15	HH AIDE & HOMEMAKER - CONT. HOME							15
16	OTHER							16
17	DRUGS, BIOLOGICAL AND INFUSION TH							17
18	ANALGESICS							18
19	SEDATIVES / HYPNOTICS							19
20	OTHER - SPECIFY							20
21	DURABLE MED. EQUIPMENT/OXYGEN							21
22	PATIENT TRANSPORTATION							22
23	IMAGING SERVICES							23
24	LABS AND DIAGNOSTICS							24
25	MEDICAL SUPPLIES							25
26	OUTPATIENT SERVICES (including E/							26
27	RADIATION THERAPY							27
28	CHEMOTHERAPY							28
29	OTHER							29
30	BEREAVEMENT PROGRAM COSTS							30
31	VOLUNTEER PROGRAM COSTS							31
32	FUNDRAISING							32
33	OTHER PROGRAM COSTS							33
34	TOTALS (sum of lines 1-33) (2)							34
35	UNIT COST MULTIPLIER (see instruc							35

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



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ALLOCATION OF GENERAL SERVICE COSTS TO HOSPICE COST CENTERS

HOSPICE CCN: 14-1535

WORKSHEET K-5
PART I

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

	HOSPICE COST CENTER (omit cents)		SUBTOTAL (cols. 4A-23) 24	I&R COST & POST STEP- DOWN ADJS 25	SUBTOTAL (cols. 24 ± 25) 26	ALLOC HOSP A&G (See Part II) 27	TOTAL HOSP COSTS (col 26 ± 27) 28	
		23.02						
1	ADMINISTRATIVE AND GENERAL							1
2	INPATIENT - GENERAL CARE		1,220,662		1,220,662		1,220,662	2
3	INPATIENT - RESPITE CARE							3
4	PHYSICIAN SERVICES							4
5	NURSING CARE		2,080,250		2,080,250		2,080,250	5
6	NURSING CARE-CONTINUOUS HOME CARE							6
7	PHYSICAL THERAPY							7
8	OCCUPATIONAL THERAPY							8
9	SPEECH/LANGUAGE PATHOLOGY							9
10	MEDICAL SOCIAL SERVICES							10
11	SPIRITUAL COUNSELING							11
12	DIETARY COUNSELING							12
13	COUNSELING - OTHER							13
14	HOME HEALTH AIDE AND HOMEMAKER							14
15	HH AIDE & HOMEMAKER - CONT. HOME							15
16	OTHER							16
17	DRUGS, BIOLOGICAL AND INFUSION TH							17
18	ANALGESICS							18
19	SEDATIVES / HYPNOTICS							19
20	OTHER - SPECIFY							20
21	DURABLE MED. EQUIPMENT/OXYGEN							21
22	PATIENT TRANSPORTATION							22
23	IMAGING SERVICES							23
24	LABS AND DIAGNOSTICS							24
25	MEDICAL SUPPLIES							25
26	OUTPATIENT SERVICES (including E/							26
27	RADIATION THERAPY							27
28	CHEMOTHERAPY							28
29	OTHER							29
30	BEREAVEMENT PROGRAM COSTS							30
31	VOLUNTEER PROGRAM COSTS							31
32	FUNDRAISING							32
33	OTHER PROGRAM COSTS							33
34	TOTALS (sum of lines 1-33) (2)		3,300,912		3,300,912		3,300,912	34
35	UNIT COST MULTIPLIER (see instruc							35

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



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ALLOCATION OF GENERAL SERVICE COSTS TO HOSPICE COST CENTERS - STATISTICAL BASIS HOSPICE CCN: 14-1535

WORKSHEET K-5
PART II

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

	HOSPICE COST CENTER	CAP BLDGS & FIXTURES SQUARE FEET	CAP MOVABLE EQUIPMENT DOLLAR VALUE	EMPLOYEE BENEFITS DEPARTMENT GROSS SALARIES	RECONCILIATION	ADMINISTRATIVE & GENERAL ACCUM COST	MAINTENANCE & REPAIRS SQUARE FEET	
		1	2	4	4A	5	6	
1	ADMINISTRATIVE AND GENERAL							1
2	INPATIENT - GENERAL CARE					914,401		2
3	INPATIENT - RESPITE CARE							3
4	PHYSICIAN SERVICES							4
5	NURSING CARE					1,558,320		5
6	NURSING CARE-CONTINUOUS HOME CARE							6
7	PHYSICAL THERAPY							7
8	OCCUPATIONAL THERAPY							8
9	SPEECH/LANGUAGE PATHOLOGY							9
10	MEDICAL SOCIAL SERVICES							10
11	SPIRITUAL COUNSELING							11
12	DIETARY COUNSELING							12
13	COUNSELING - OTHER							13
14	HOME HEALTH AIDE AND HOMEMAKER							14
15	HH AIDE & HOMEMAKER - CONT. HOME							15
16	OTHER							16
17	DRUGS, BIOLOGICAL AND INFUSION TH							17
18	ANALGESICS							18
19	SEDATIVES / HYPNOTICS							19
20	OTHER - SPECIFY							20
21	DURABLE MED. EQUIPMENT/OXYGEN							21
22	PATIENT TRANSPORTATION							22
23	IMAGING SERVICES							23
24	LABS AND DIAGNOSTICS							24
25	MEDICAL SUPPLIES							25
26	OUTPATIENT SERVICES (including E/							26
27	RADIATION THERAPY							27
28	CHEMOTHERAPY							28
29	OTHER							29
30	BEREAVEMENT PROGRAM COSTS							30
31	VOLUNTEER PROGRAM COSTS							31
32	FUNDRAISING							32
33	OTHER PROGRAM COSTS							33
34	TOTALS (sum of lines 1-33)					2,472,721		34
35	TOTAL COST TO BE ALLOCATED					828,191		35
36	UNIT COST MULTIPLIER					0.334931		36
36	UNIT COST MULTIPLIER							36



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ALLOCATION OF GENERAL SERVICE COSTS TO HOSPICE COST CENTERS - STATISTICAL BASIS HOSPICE CCN: 14-1535

WORKSHEET K-5
PART II

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

	HOSPICE COST CENTER	OPERATION OF PLANT SQUARE FEET	LAUNDRY & LINEN SERVICE POUNDS OF LAUNDRY	HOUSE-KEEPING SQUARE FEET	DIETARY MEALS SERVED	CAFETERIA FTES	MAIN-TENANCE OF PERSONNEL NUMBER HOUSED	
		7	8	9	10	11	12	
1	ADMINISTRATIVE AND GENERAL							1
2	INPATIENT - GENERAL CARE							2
3	INPATIENT - RESPITE CARE							3
4	PHYSICIAN SERVICES							4
5	NURSING CARE							5
6	NURSING CARE-CONTINUOUS HOME CARE							6
7	PHYSICAL THERAPY							7
8	OCCUPATIONAL THERAPY							8
9	SPEECH/LANGUAGE PATHOLOGY							9
10	MEDICAL SOCIAL SERVICES							10
11	SPIRITUAL COUNSELING							11
12	DIETARY COUNSELING							12
13	COUNSELING - OTHER							13
14	HOME HEALTH AIDE AND HOMEMAKER							14
15	HH AIDE & HOMEMAKER - CONT. HOME							15
16	OTHER							16
17	DRUGS, BIOLOGICAL AND INFUSION TH							17
18	ANALGESICS							18
19	SEDATIVES / HYPNOTICS							19
20	OTHER - SPECIFY							20
21	DURABLE MED. EQUIPMENT/OXYGEN							21
22	PATIENT TRANSPORTATION							22
23	IMAGING SERVICES							23
24	LABS AND DIAGNOSTICS							24
25	MEDICAL SUPPLIES							25
26	OUTPATIENT SERVICES (including E/							26
27	RADIATION THERAPY							27
28	CHEMOTHERAPY							28
29	OTHER							29
30	BEREAVEMENT PROGRAM COSTS							30
31	VOLUNTEER PROGRAM COSTS							31
32	FUNDRAISING							32
33	OTHER PROGRAM COSTS							33
34	TOTALS (sum of lines 1-33)							34
35	TOTAL COST TO BE ALLOCATED							35
36	UNIT COST MULTIPLIER							36
36	UNIT COST MULTIPLIER							36



INGALLS MEMORIAL HOSPITAL Provider CCN: 14-0191	In Lieu of Form CMS-2552-10	Period : From: 10/01/2013 To: 09/30/2014	Run Date: 03/02/2015 Run Time: 10:44 Version: 2014.10
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ALLOCATION OF GENERAL SERVICE COSTS TO HOSPICE COST CENTERS - STATISTICAL BASIS HOSPICE CCN: 14-1535

WORKSHEET K-5
PART II

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

	HOSPICE COST CENTER	NURSING ADMINISTRATION DIRECT NRSNG HRS	CENTRAL SERVICES & SUPPLY COSTED REQUIS.	PHARMACY COSTED REQUIS.	MEDICAL RECORDS & LIBRARY TIME SPENT	SOCIAL SERVICE TIME SPENT	NONPHYSIC. ANESTHET. ASSIGNED TIME	
		13	14	15	16	17	19	
1	ADMINISTRATIVE AND GENERAL							1
2	INPATIENT - GENERAL CARE							2
3	INPATIENT - RESPITE CARE							3
4	PHYSICIAN SERVICES							4
5	NURSING CARE							5
6	NURSING CARE-CONTINUOUS HOME CARE							6
7	PHYSICAL THERAPY							7
8	OCCUPATIONAL THERAPY							8
9	SPEECH/LANGUAGE PATHOLOGY							9
10	MEDICAL SOCIAL SERVICES							10
11	SPIRITUAL COUNSELING							11
12	DIETARY COUNSELING							12
13	COUNSELING - OTHER							13
14	HOME HEALTH AIDE AND HOME MAKER							14
15	HH AIDE & HOME MAKER - CONT. HOME							15
16	OTHER							16
17	DRUGS, BIOLOGICAL AND INFUSION TH							17
18	ANALGESICS							18
19	SEDATIVES / HYPNOTICS							19
20	OTHER - SPECIFY							20
21	DURABLE MED. EQUIPMENT/OXYGEN							21
22	PATIENT TRANSPORTATION							22
23	IMAGING SERVICES							23
24	LABS AND DIAGNOSTICS							24
25	MEDICAL SUPPLIES							25
26	OUTPATIENT SERVICES (including E/							26
27	RADIATION THERAPY							27
28	CHEMOTHERAPY							28
29	OTHER							29
30	BEREAVEMENT PROGRAM COSTS							30
31	VOLUNTEER PROGRAM COSTS							31
32	FUNDRAISING							32
33	OTHER PROGRAM COSTS							33
34	TOTALS (sum of lines 1-33)							34
35	TOTAL COST TO BE ALLOCATED							35
36	UNIT COST MULTIPLIER							36
36	UNIT COST MULTIPLIER							36



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ALLOCATION OF GENERAL SERVICE COSTS TO HOSPICE COST CENTERS - STATISTICAL BASIS HOSPICE CCN: 14-1535

WORKSHEET K-5
PART II

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

	HOSPICE COST CENTER	NURSING SCHOOL ASSIGNED TIME	I&R SALARY & FRINGES ASSIGNED TIME	I&R PROGRAM COSTS ASSIGNED TIME	PARAMED EDUCATION ASSIGNED TIME	TIME SPENT	MEALS SERVED	
		20	21	22	23	23.01	23.02	
1	ADMINISTRATIVE AND GENERAL							1
2	INPATIENT - GENERAL CARE							2
3	INPATIENT - RESPITE CARE							3
4	PHYSICIAN SERVICES							4
5	NURSING CARE							5
6	NURSING CARE-CONTINUOUS HOME CARE							6
7	PHYSICAL THERAPY							7
8	OCCUPATIONAL THERAPY							8
9	SPEECH/LANGUAGE PATHOLOGY							9
10	MEDICAL SOCIAL SERVICES							10
11	SPIRITUAL COUNSELING							11
12	DIETARY COUNSELING							12
13	COUNSELING - OTHER							13
14	HOME HEALTH AIDE AND HOMEMAKER							14
15	HH AIDE & HOMEMAKER - CONT. HOME							15
16	OTHER							16
17	DRUGS, BIOLOGICAL AND INFUSION TH							17
18	ANALGESICS							18
19	SEDATIVES / HYPNOTICS							19
20	OTHER - SPECIFY							20
21	DURABLE MED. EQUIPMENT/OXYGEN							21
22	PATIENT TRANSPORTATION							22
23	IMAGING SERVICES							23
24	LABS AND DIAGNOSTICS							24
25	MEDICAL SUPPLIES							25
26	OUTPATIENT SERVICES (including E/							26
27	RADIATION THERAPY							27
28	CHEMOTHERAPY							28
29	OTHER							29
30	BEREAVEMENT PROGRAM COSTS							30
31	VOLUNTEER PROGRAM COSTS							31
32	FUNDRAISING							32
33	OTHER PROGRAM COSTS							33
34	TOTALS (sum of lines 1-33)							34
35	TOTAL COST TO BE ALLOCATED							35
36	UNIT COST MULTIPLIER							36
36	UNIT COST MULTIPLIER							36



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INGALLS MEMORIAL HOSPITAL Provider CCN: 14-0191	In Lieu of Form CMS-2552-10	Period : From: 10/01/2013 To: 09/30/2014	Run Date: 03/02/2015 Run Time: 10:44 Version: 2014.10
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APPORTIONMENT OF HOSPICE SHARED SERVICES

HOSPICE CCN: 14-1535

WORKSHEET K-5
PART III

PART III - COMPUTATION OF TOTAL HOSPICE SHARED COSTS

	COST CENTER	WKST C, PART I, COL. 9, LINE	COST TO CHARGE RATIO	TOTAL HOSPICE CHARGES (Provider Records)	HOSPICE SHARED ANCILLARY COSTS (cols. 1 x 2)	
		0	1	2	3	
	ANCILLARY SERVICE COST CENTERS					
1	PHYSICAL THERAPY	66	0.214712			1
2	OCCUPATIONAL THERAPY	67	0.412076			2
3	SPEECH/LANGUAGE PATHOLOGY	68	0.259167			3
4	DRUGS, BIOLOGICAL AND INFUSION THERAPY	73	0.196357			4
4.01	INFUSION THERAPY	73.01	0.218728			4.01
4.02	IFCC INFUSION THERAPY	73.02	0.232087			4.02
4.03	PHARMACY VACCINE	73.03	0.883889			4.03
5	DURABLE MEDICAL EQUIPMENT/OXYGEN	96				5
6	LABS AND DIAGNOSTICS	60	0.109171			6
7	MEDICAL SUPPLIES	71	0.162552			7
8	OUTPATIENT SERVICES (including E/R Dept.)	93				8
9	RADIATION THERAPY	55				9
10	OTHER ANCILLARY (SPECIFY)	76				10
10.97	CARDIAC REHABILITATION	76.97	1.007168			10.97
10.98	HYPERBARIC OXYGEN THERAPY	76.98	0.240176			10.98
10.99	LITHOTRIPSY	76.99				10.99
11	TOTALS (sum of lines 1-10)					11



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CALCULATION OF HOSPICE PER DIEM COST

HOSPICE CCN: 14-1535

WORKSHEET K-6

COMPUTATION OF PER DIEM COSTS		TITLE XVIII	TITLE XIX	OTHER	TOTAL	
		1	2	3	4	
1	TOTAL COST (see instructions)				3,300,912	1
2	TOTAL UNDUPLICATED DAYS (Worksheet S-9, column 6, line 5)				12,996	2
3	AVERAGE COST PER DIEM (line 1 divided by line 2)				253.99	3
4	UNDUPLICATED MEDICARE DAYS (Worksheet S-9, column 1, line 5)	11,949				4
5	AGGREGATE MEDICARE COST (line 3 times line 4)	3,034,927				5
6	UNDUPLICATED MEDICAID DAYS (Worksheet S-9, column 2, line 5)		573			6
7	AGGREGATE MEDICAID COST (line 3 times line 6)		145,536			7
8	UNDUPLICATED SNF DAYS (Worksheet S-9, column 3, line 5)	428				8
9	AGGREGATE SNF COST (line 3 times line 8)	108,708				9
10	UNDUPLICATED NF DAYS (Worksheet S-9, column 4, line 5)		179			10
11	AGGREGATE NF COST (line 3 times line 10)		45,464			11
12	OTHER UNDUPLICATED DAYS (Worksheet S-9, column 5, line 5)			474		12
13	AGGREGATE COST FOR OTHER DAYS (line 3 times line 12)			120,391		13

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



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CALCULATION OF CAPITAL PAYMENT

COMPONENT CCN: 14-0191

WORKSHEET L

CHECK [] TITLE V [XX] HOSPITAL [XX] PPS
 APPLICABLE [XX] TITLE XVIII, PART A [] SUB (OTHER) [] COST METHOD
 BOXES: [] TITLE XIX

PART I - FULLY PROSPECTIVE METHOD

	CAPITAL FEDERAL AMOUNT		
1	CAPITAL DRG OTHER THAN OUTLIER	3,405,628	1
1.01	MODEL 4 BPCI CAPITAL DRG OTHER THAN OUTLIER		1.01
2	CAPITAL DRG OUTLIER PAYMENTS	269,470	2
2.01	MODEL 4 BPCI CAPITAL DRG OUTLIER PAYMENTS		2.01
3	TOTAL INPATIENT DAYS DIVIDED BY NUMBER OF DAYS IN THE COST REPORTING PERIOD (see instructions)	163.28	3
4	NUMBER OF INTERNS & RESIDENTS (see instructions)		4
5	INDIRECT MEDICAL EDUCATION PERCENTAGE (see instructions)		5
6	INDIRECT MEDICAL EDUCATION ADJUSTMENT (multiply line 5 by the sum of lines 1 and 1.01)		6
7	PERCENTAGE OF SSI RECIPIENT PATIENT DAYS TO MEDICARE PART A PATIENT DAYS (Worksheet E, Part A line 30) (see instructions)	0.0901	7
8	PERCENTAGE OF MEDICAID PATIENT DAYS TO TOTAL DAYS (see instructions)	0.3425	8
9	SUM OF LINES 7 AND 8	0.4326	9
10	ALLOWABLE DISPROPORTIONATE SHARE PERCENTAGE (see instructions)	0.0916	10
11	DISPROPORTIONATE SHARE ADJUSTMENT (line 10 times the sum of lines 1 and 1.01)	311,956	11
12	TOTAL PROSPECTIVE CAPITAL PAYMENTS (sum of lines 1, 1.01, 2, 2.01, 6 and 11)	3,987,054	12

PART II - PAYMENT UNDER REASONABLE COST

1	PROGRAM INPATIENT ROUTINE CAPITAL COST (see instructions)		1
2	PROGRAM INPATIENT ANCILLARY CAPITAL COST (see instructions)		2
3	TOTAL INPATIENT PROGRAM CAPITAL COST (line 1 plus line 2)		3
4	CAPITAL COST PAYMENT FACTOR (see instructions)		4
5	TOTAL INPATIENT PROGRAM CAPITAL COST (line 3 times line 4)		5

PART III - COMPUTATION OF EXCEPTION PAYMENTS

1	PROGRAM INPATIENT CAPITAL COSTS (see instructions)		1
2	PROGRAM INPATIENT CAPITAL COSTS FOR EXTRAORDINARY CIRCUMSTANCES (see instructions)		2
3	NET PROGRAM INPATIENT CAPITAL COSTS (line 1 minus line 2)		3
4	APPLICABLE EXCEPTION PERCENTAGE (see instructions)		4
5	CAPITAL COST FOR COMPARISON TO PAYMENTS (line 3 x line 4)		5
6	PERCENTAGE ADJUSTMENT FOR EXTRAORDINARY CIRCUMSTANCES (see instructions)		6
7	ADJUSTMENT TO CAPITAL MINIMUM PAYMENT LEVEL FOR EXTRAORDINARY CIRCUMSTANCES (line 2 x line 6)		7
8	CAPITAL MINIMUM PAYMENT LEVEL (line 5 plus line 7)		8
9	CURRENT YEAR CAPITAL PAYMENTS (from Part I, line 12 as applicable)		9
10	CURRENT YEAR COMPARISON OF CAPITAL MINIMUM PAYMENT LEVEL TO CAPITAL PAYMENTS (line 8 less line 9)		10
11	CARRYOVER OF ACCUMULATED CAPITAL MINIMUM PAYMENT LEVEL OVER CAPITAL PAYMENT (from prior year Worksheet L, Part III, line 14)		11
12	NET COMPARISON OF CAPITAL MINIMUM PAYMENT LEVEL TO CAPITAL PAYMENTS (line 10 plus line 11)		12
13	CURRENT YEAR EXCEPTION PAYMENT (if line 12 is positive, enter the amount on this line)		13
14	CARRYOVER OF ACCUMULATED CAPITAL MINIMUM PAYMENT LEVEL OVER CAPITAL PAYMENT FOR THE FOLLOWING PERIOD (if line 12 is negative, enter the amount on this line)		14
15	CURRENT YEAR ALLOWABLE OPERATING AND CAPITAL PAYMENT (see instructions)		15
16	CURRENT YEAR OPERATING AND CAPITAL COSTS (see instructions)		16
17	CURRENT YEAR EXCEPTION OFFSET AMOUNT (see instructions)		17



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ALLOCATION OF ALLOWABLE COSTS FOR EXTRAORDINARY CIRCUMSTANCES

WORKSHEET L-1
PART I

	COST CENTER DESCRIPTIONS	EXTRAORDINARY CAP-REL COSTS	SUBTOTAL (cols.0-4)	SUBTOTAL	I&R COST & POST STEP-DOWN ADJS	TOTAL		
		0	2A	24	25	26		
	GENERAL SERVICE COST CENTERS							
1	CAP REL COSTS-BLDG & FIXT							1
2	CAP REL COSTS-MVBLE EQUIP							2
4	EMPLOYEE BENEFITS DEPARTMENT							4
5	ADMINISTRATIVE & GENERAL							5
6	MAINTENANCE & REPAIRS							6
7	OPERATION OF PLANT							7
8	LAUNDRY & LINEN SERVICE							8
9	HOUSEKEEPING							9
10	DIETARY							10
11	CAFETERIA							11
12	MAINTENANCE OF PERSONNEL							12
13	NURSING ADMINISTRATION							13
14	CENTRAL SERVICES & SUPPLY							14
15	PHARMACY							15
16	MEDICAL RECORDS & LIBRARY							16
17	SOCIAL SERVICE							17
19	NONPHYSICIAN ANESTHETISTS							19
20	NURSING SCHOOL							20
21	I&R SERVICES-SALARY & FRINGES APPRVD							21
22	I&R SERVICES-OTHER PRGM COSTS APPRVD							22
23	PARAMED ED PRGM-(SPECIFY)							23
23.01	PARAMED ED PRGM - EMS							23.01
23.02	PARAMED ED PRGM - DIETETICS							23.02
	INPATIENT ROUTINE SERV COST CENTERS							
30	ADULTS & PEDIATRICS							30
31	INTENSIVE CARE UNIT							31
40	SUBPROVIDER - IPF							40
41	SUBPROVIDER - IRF							41
43	NURSERY							43
	ANCILLARY SERVICE COST CENTERS							
50	OPERATING ROOM							50
51	RECOVERY ROOM							51
53	ANESTHESIOLOGY							53
54	RADIOLOGY-DIAGNOSTIC							54
54.01	ULTRASOUND							54.01
54.02	SPECIAL PROCEDURES							54.02
56	RADIOISOTOPE							56
57	CT SCAN							57
58	MRI							58
59	CARDIAC CATHETERIZATION							59
60	LABORATORY							60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
63	BLOOD STORING, PROCESSING & TRANS.							63
65	RESPIRATORY THERAPY							65
65.01	PULMONARY FUNCTION							65.01
66	PHYSICAL THERAPY							66
67	OCCUPATIONAL THERAPY							67
68	SPEECH PATHOLOGY							68
69	ELECTROCARDIOLOGY							69
70	ELECTROENCEPHALOGRAPHY							70
70.01	SLEEP LAB							70.01
70.02	PSYCH							70.02
71	MEDICAL SUPPLIES CHARGED TO PATIENTS							71
72	IMPL. DEV. CHARGED TO PATIENTS							72
73	DRUGS CHARGED TO PATIENTS							73
73.01	INFUSION THERAPY							73.01
73.02	IFCC INFUSION THERAPY							73.02
73.03	PHARMACY VACCINE							73.03
74	RENAL DIALYSIS							74
76.97	CARDIAC REHABILITATION							76.97
76.98	HYPERBARIC OXYGEN THERAPY							76.98
76.99	LITHOTRIPSY							76.99
	OUTPATIENT SERVICE COST CENTERS							
90.02	PSYCH ANCILLARY							90.02
90.03	RETINAL VASCULAR							90.03
91	EMERGENCY							91
91.01	IFCC							91.01
92	OBSERVATION BEDS (NON-DISTINCT PART)							92
	OTHER REIMBURSABLE COST CENTERS							
100	I&R SERVICES-NOT APPRVD PRGM							100
101	HOME HEALTH AGENCY							101
	SPECIAL PURPOSE COST CENTERS							
116	HOSPICE							116
118	SUBTOTALS (sum of lines 1-117)							118



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ALLOCATION OF ALLOWABLE COSTS FOR EXTRAORDINARY CIRCUMSTANCES

WORKSHEET L-1
PART I

	COST CENTER DESCRIPTIONS	EXTRAORDINARY CAP-REL COSTS	SUBTOTAL (cols.0-4)	SUBTOTAL	I&R COST & POST STEP-DOWN ADJS	TOTAL		
		0	2A	24	25	26		
	NONREIMBURSABLE COST CENTERS							
192	PHYSICIANS' PRIVATE OFFICES							192
192.01	REFERENCE LAB							192.01
192.02	OP PHARMACY							192.02
192.03	RETINAL VASCULAR GRANTS							192.03
192.04	AMBULANCE							192.04
200	CROSS FOOT ADJUSTMENTS							200
201	NEGATIVE COST CENTER							201
202	TOTAL (sum of lines 118-201)							202