KPMG LLP Compu-Max 2552-10

HARVARD MEMORIAL HOSPITAL Provider CCN: 14-1335	In Lieu of Form **CMS-2552-10**	Period : From: 07/01/2016 To: 06/30/2017	Run Date: 11/28/2017 Run Time: 09:16 Version: 2017.10 (11/19/2017)

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. [X] Electronically filed cost report Date: 11/28/2017 Time: 09:16 2. [ ] Manually submitted cost report 3. [ ] If this is an amended report enter the number of times the provider resubmitted the cost report 4. [F] Medicare Utilization. Enter 'F' for full or 'L' for low.		
Contractor use only	5. [ ] Cost Report Status (1) As Submitted (2) Settled without audit (3) Settled with audit (4) Reopened (5) Amended	6. Date Received: _____ 7. Contractor No.: _____ 8. [ ] Initial Report for this Provider CCN 9. [ ] Final Report for this Provider CCN	10. NPR Date: _____ 11. Contractor's Vendor Code: ___ 12. [ ] If line 5, column 1 is 4: Enter number of times reopened = 0-9.

PART II - CERTIFICATION

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

CERTIFICATION BY OFFICER OR ADMINISTRATOR OF PROVIDER(S)

I HEREBY CERTIFY that I have read the above certification statement and that I have examined the accompanying electronically filed or manually submitted cost report and the Balance Sheet and Statement of Revenue and Expenses prepared by HARVARD MEMORIAL HOSPITAL (14-1335) {(Provider Name(s) and Number(s)} for the cost reporting period beginning 07/01/2016 and ending 06/30/2017, and to the best of my knowledge and belief, this report and statement are true, correct, complete and prepared from the books and records of the provider in accordance with applicable instructions, except as noted. I further certify that I am familiar with the laws and regulations regarding the provision of health care services, and that the services identified in this cost report were provided in compliance with such laws and regulations.

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

_____
Title

_____
Date

PART III - SETTLEMENT SUMMARY

			TITLE XVIII				
		TITLE V	PART A	PART B	HIT	TITLE XIX	
		1	2	3	4	5	
1	HOSPITAL		84,748	471,267			1
2	SUBPROVIDER - IPF						2
3	SUBPROVIDER - IRF						3
4	SUBPROVIDER (OTHER)						4
5	SWING BED - SNF						5
6	SWING BED - NF						6
7	SKILLED NURSING FACILITY		-1	-667			7
8	NURSING FACILITY						8
9	HOME HEALTH AGENCY						9
10	HEALTH CLINIC - RHC						10
11	HEALTH CLINIC - FQHC						11
12	OUTPATIENT REHABILITATION PROVIDER						12
200	TOTAL		84,747	470,600			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 resopnd to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0938-0050. The time required to complete this information collection is estimated 673 hours per response, including the time to review instructions, search existing resources, gather the data needed, and complete and review the information collection. If you have any comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Report Clearance Officer, Mail Stop C4-26-05, Baltimore, Maryland 21244-1850.
Please do not send appilcations, claims, payments, medical records or any documents containing sensitive information to the PRA Reports Clearance Office. Please note that any corresponence not pertaining to the information collection burden approved under the associated OMB control number listed on this form will not be reviewed, forwarded, or retained. If you have questions or concerns regarding where to submit your documents, please contact 1-800-MEDICARE.

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA

WORKSHEET S-2
PART I

Hospital and Hospital Health Care Complex Address:

1	Street: 901 GRANT STREET	P.O. Box:			1
2	City: HARVARD	State: IL	ZIP Code: 60033-	County: MC HENRY	2

Hospital and Hospital-Based Component Identification:

	Component	Component Name	CCN Number	CBSA Number	Provider Type	Date Certified	Payment System (P, T, O, or N) V	XVIII	XIX	
	0	1	2	3	4	5	6	7	8	
3	Hospital	HARVARD MEMORIAL HOSPITAL	14-1335	16974	1	01 / 01 / 2004	N	O	O	3
4	Subprovider - IPF									4
5	Subprovider - IRF									5
6	Subprovider - (OTHER)									6
7	Swing Beds - SNF									7
8	Swing Beds - NF									8
9	Hospital-Based SNF	CARE CENTER	14-6014	99914		01 / 01 / 2002	N	P	N	9
10	Hospital-Based NF									10
11	Hospital-Based OLTC									11
12	Hospital-Based HHA									12
13	Separately Certified ASC									13
14	Hospital-Based Hospice									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: 07 / 01 / 2016	To: 06 / 30 / 2017	20
21	Type of control (see instructions)	2		21

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

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

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA

WORKSHEET S-2
PART I

		1	2	
39	Does this facility qualify for the inpatient hospital payment adjustment for low volume hospitals in accordance with 42 CFR §412.101(b)(2)(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
40	Is this hospital subject to the HAC program reduction adjustment? Enter 'Y' for yes or 'N' for no in column 1, for discharges prior to October 1. Enter 'Y' for yes or 'N' for no in column 2, for discharges on or after October 1. (see instructions)	N	N	40

		V	XVIII	XIX	
Prospective Payment System (PPS)-Capital		1	2	3	
45	Does this facility qualify and receive capital payment for disproportionate share in accordance with 42 CFR §412.320?	N	N	N	45
46	Is this facility eligible for additional payment exception for extraordinary circumstances pursuant to 42 CFR §412.348(f)? If yes, complete Wkst. L, Pt. III and Wkst. L-1, Pt. I through Pt. III.	N	N	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 Wkst. E-4. If column 2 is 'N', complete Wkst. D, Part III & IV and D-2, Pt. II, if applicable.	N			57
58	If line 56 is yes, did this facility elect cost reimbursement for physicians' services ad defined in CMS Pub 15-1, chapter 21, section 2148? If yes, complete Wkst. D-5.	N			58
59	Are costs claimed on line 100 of Worksheet A? If yes, complete Wkst. D-2, Pt. I.	N			59
60	Are you claiming nursing school and/or allied health costs for a program that meets the provider-operated criteria under §413.85? Enter 'Y' for yes or 'N' for no. (see instructions)	N			60
		Y/N	IME	Direct GME	
61	Did your hospital receive FTE slots under ACA section 5503? Enter 'Y' for yes or 'N' for no in column 1.)(see instructions)	N			61
61.01	Enter the average number of unweighted primary care FTEs from the hospital's 3 most recent cost reports ending and submitted before March 23, 2010. (see instructions)				61.01
61.02	Enter the current year total unweighted primary care FTE count (excluding OB/GYN, general surgery FTEs, and primary care FTEs added under section 5503 of ACA). (see instructions)				61.02
61.03	Enter the baseline FTE count for primary care and/or general surgery residents, which is used for determining compliance with the 75% test. (see instructions)				61.03
61.04	Enter the number of unweighted primary care/or surgery allopathic and/or osteopathci 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 reseived HRSA PCRE funding (see instructions)				62
62.01	Enter the number of FTE residents that rotated from a teaching health center (THC) into your hospital in this cost reporting period of HRSA THC program. (see instructions)				62.01

Teaching Hospitals that Claim Residents in Nonprovider Settings

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA

WORKSHEET S-2
PART I

	Section 5504 of the ACA Base Year FTE Residents in Nonprovider Settings--This base year is your cost reporting period that begins on or after July 1, 2009 and before June 30, 2010.	Unweighted FTEs Nonprovider Site	Unweighted FTEs in Hospital	Ratio (col. 1/ col. 1 + col. 2))	
64	Enter in column 1, if line 63 is yes, or your facility trained residents in the base year period, the number of unweighted non-primary care resident FTEs attributable to rotations occurring in all nonprovider settings. Enter in column 2 the number of unweighted non-primary care resident FTEs that trained in your hospital. Enter in oolumn 3 the ratio of (column 1 divided by (column 1 + column 2)). (see instructions)				64

Enter in lines 65-65.49 in column 1, if line 63 is yes, or your facility trained residents in the base year period, the program name. Enter in column 2 the program code. Enter in column 3 the number of unweighted primary care FTE residents attributable to rotations occurring in all non-provider settings. Enter in column 4 the number of unweighted primary care resident FTEs that trained in your hospital. Enter in column 5 the ratio of (column 3 divided by (column 3 ÷ column 4)). (see instructions)

		Program Name	Program Code	Unweighted FTEs Nonprovider Site	Unweighted FTEs in Hospital	Ratio (col. 3/ col. 3 + col. 4))	
		1	2	3	4	5	
65							65

	Section 5504 of the ACA Current Year FTE Residents in Nonprovider Settings--Effective for cost reporting periods beginning on or after July 1, 2010	Unweighted FTEs Nonprovider Site	Unweighted FTEs in Hospital	Ratio (col. 1/ col. 1 + col. 2))	
66	Enter in column 1, the number of unweighted non-primary care resident FTEs attributable to rotations occurring in all nonprovider settings. Enter in column 2 the number of unweighted non-primary care resident FTEs that trained in your hospital. Enter in column 3 the ratio of (column 1 divided by (column 1 + column 2)). (see instructions)				66

Enter in lines 67-67.49, column 1 the program name. Enter in column 2 the program code. Enter in column 3 the number of unweighted primary care FTE residents attributable to rotations occurring in all non-provider settings. Enter in column 4 the number of unweighted primary care resident FTEs that trained in your hospital. Enter in column 5 the ratio of (column 3 divided by (column 3 ÷ column 4)). (see instructions)

		Program Name	Program Code	Unweighted FTEs Nonprovider Site	Unweighted FTEs in Hospital	Ratio (col. 3/ col. 3 + col. 4))	
		1	2	3	4	5	
67							67

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

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

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

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA

WORKSHEET S-2
PART I

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

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

		Physical	Occupational	Speech	Respiratory	
109	If this hospital qualifies as a CAH or a cost provider, are therapy services provided by outside supplier? Enter 'Y' for yes or 'N' for each therapy.	N	N	N	N	109
110	Did this hospital participate in the Rural Community Hospital Demonstration project (410A Demo) for the current cost reporting period? Enter 'Y' for yes or 'N' for no.				N	110

Miscellaneous Cost Reporting Information

115	Is this an all-inclusive rate provider? Enter 'Y' for yes or 'N' for no in column 1. If column 1 is yes, enter the method used (A, B, or E only) in column 2. If column 2 is 'E', enter in column 3 either '93' percent for short term hospital or '98' percent for long term care (includes psychiatric, rehabilitation and long term hospitals providers) based on the definition in CMS Pub. 15-I, chapter 22, section 2208.1.	N			115
116	Is this facility classified as a referral center? Enter 'Y' for yes or 'N' for no.		N		116
117	Is this facility legally required to carry malpractice insurance? Enter 'Y' for yes or 'N' for no.		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.		2		118
		Premiums	Paid Losses	Self Insurance	
118.01	List amounts of malpractice premiums and paid losses:	278,236			118.01
118.02	Are malpractice premiums and paid losses reported in a cost center other than the Administrative and General cost center? If yes, submit supporting schedule listing cost centers and amounts contained therein.		N		118.02
120	Is this a SCH or EACH that qualifies for the Outpatient Hold Harmless provision in ACA §3121 and applicable amendments? (see instructions). Enter in column 1 'Y' for yes or 'N' for no. Is this a rural hospital with < 100 beds that qualifies for the Outpatient Hold Harmless provision in ACA §3121 and applicable amendments? (see instructions). Enter in column 2 'Y' for yes or 'N' for no.		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
122	Does the cost report contain state health or similar taxes? Enter 'Y' for yes or 'N' for no in column 1. If column 1 is 'Y', enter in column 2 the Worksheet A line number where these taxes are included.		N		122

Transplant Center Information

125	Does this facility operate a transplant center? Enter 'Y' for yes or 'N' for no. If yes, enter certification date(s)(mm/dd/yyyy) below.		N	125
126	If this is a Medicare certified kidney transplant center enter the certification date in column 1 and termination date, 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 cetfified 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 cetfified 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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA

WORKSHEET S-2
PART I

All Providers

		1	2	
140	Are there any related organization or home office costs as defined in CMS Pub 15-1, Chapter 10? Enter 'Y' for yes, or 'N' for no in column 1. If yes, and home office costs are claimed, enter in column 2 the home office chain number (see instructions)	Y	901041	140

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

141	Name: MERCY HOME OFFICE	Contractor's Name: NGS	Contractor's Number: 00450	141
142	Street: 1000 MINERAL POINT AVE	P.O. Box:		142
143	City: JANESVILLE	State: WI	ZIP Code: 53547	143

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

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

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

Multicampus

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

	Name	County	State	ZIP Code	CBSA	FTE/Campus	
	0	1	2	3	4	5	

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

167	Is this provider a meaningful user under §1886(n)? Enter 'Y' for yes or 'N' for no.	Y			167
168	If this provider is a CAH (line 105 is 'Y') and is a meaningful user (line 167 is 'Y'), enter the reasonable cost incurred for the HIT assets. (see instructions)				168
168.01	If this provider is a CAH and is not a meaningful user, does this provider qualify for a hardship exception under §413.70(a)(6)(ii)? Enter 'Y' for yes or 'N' for no. (see instructions)				168.01
169	If this provider is a meaningful user (line 167 is 'Y') and is not a CAH (line 105 is 'N'), enter the transition factor. (see instructions)				169
170	Enter in columns 1 and 2 the EHR beginning date and ending date for the reporting period respectively (mm/dd/yyyy)		10 / 01 / 2016	09 / 30 / 2017	170
171	If line 167 is 'Y', does this provider have any days for individuals enrolled in section 1876 Medicare cost plans reported on Wkst. S-3, Pt. I, line 2, col. 6? Enter 'Y' for yes and 'N' for no in column 1. If column 1 is 'Y', enter the number of section 1876 Medicare days in column 2. (see instructions)		N	0	171

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)	Y			3

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

		Y/N	Y/N	
Approved Educational Activities		1	2	
6	Column 1: Are costs claimed for nursing school? Column 2: If yes, is the provider the legal operator of the program?	N		6
7	Are costs claimed for allied health programs? If yes, see instructions.	N		7
8	Were nursing school and/or allied health programs approved and/or renewed during the cost reporting period?	N		8
9	Are costs claimed for Interns and Residents in approved GME programs claimed on the current cost report? If yes, see instructions.	N		9
10	Was an approved Intern and Resident GME program initiated or renewed in the current cost reporting period? If yes, see instructinos.	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	
PS&R Report Data		1	2	3	4	
16	Was the cost report prepared using the PS&R Report only? If either column 1 or 3 is yes, enter the paid-through date of the PS&R Report used in columns 2 and 4. (see instructions)	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	10/23/2017	Y	10/23/2017	17
18	If line 16 or 17 is yes, were adjustments made to PS&R Report data for additional claims that have been billed but are not included on the PS&R Report used to file the cost report? If yes, see instructions.	N		N		18
19	If line 16 or 17 is yes, were adjustments made to PS&R Report data for corrections of other PS&R Report information? If yes, see instructions.	N		N		19
20	If line 16 or 17 is yes, were adjustments made to PS&R Reoprt 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

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

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

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

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

Interest Expense			
28	Were new loans, mortgage agreements or letters of credit entered into during the cost reporting period? If yes, see instructions.	Y	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.	N	29
30	Has existing debt been replaced prior to its scheduled maturity with new debt? If yes, see instructions.	Y	30
31	Has debt been recalled before scheduled maturity without issuance of new debt? If yes, see instructions.	N	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.	N	32
33	If line 32 is yes, were the requirements of Sec. 2135.2 applied pertaining to competitive bidding? If no, see instructions.	N	33

Provider-Based Physicians			
34	Are services furnished at the provider facility under an arrangement with provider-based physicians? If yes, see instructions.	Y	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.	Y	35

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

Cost Report Preparer Contact Information				
41	First name: JENNY	Last name: DABROWSKI	Title: MANAGER	41
42	Employer: STRATEGIC REIMBURSEMENT GROUP, LLC			42
43	Phone number: 630-530-7100	E-mail Address: KBETH@WIPFLI.COM		43

HARVARD MEMORIAL HOSPITAL Provider CCN: 14-1335	In Lieu of Form **CMS-2552-10**	Period : From: 07/01/2016 To: 06/30/2017	Run Date: 11/28/2017 Run Time: 09:16 Version: 2017.10 (11/19/2017)

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA

WORKSHEET S-3
PART I

						Inpatient Days / Outpatient Visits / Trips				
	Component	Wkst A Line No.	No. of Beds	Bed Days Available	CAH Hours	Title V	Title XVIII	Title XIX	Total All Patients	
		1	2	3	4	5	6	7	8	
1	Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days) (see instructions for col. 2 for the portion of LDP room available beds)	30	10	3,650	29,033.00		651	13	1,105	1
2	HMO and other (see instructions)						37	100		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)		10	3,650	29,033.00		651	13	1,105	7
8	Intensive Care Unit	31	3	1,095			25	1	43	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								13
14	Total (see instructions)		13	4,745	29,033.00		676	14	1,148	14
15	CAH Visits									15
16	Subprovider - IPF	40								16
17	Subprovider - IRF	41								17
18	Subprovider I	42								18
19	Skilled Nursing Facility	44	13	4,576			1,935		2,510	19
20	Nursing Facility	45								20
21	Other Long Term Care	46	32	11,849					6,500	21
22	Home Health Agency	101								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)		58							27
28	Observation Bed Days								267	28
29	Ambulance Trips									29
30	Employee discount days (see instructions)									30
31	Employee discount days-IRF									31
32	Labor & delivery (see instructions)									32
32.01	Total ancillary labor & delivery room outpatient days (see instructions)									32.01
33	LTCH non-covered days									33

HARVARD MEMORIAL HOSPITAL Provider CCN: 14-1335	In Lieu of Form **CMS-2552-10**	Period : From: 07/01/2016 To: 06/30/2017	Run Date: 11/28/2017 Run Time: 09:16 Version: 2017.10 (11/19/2017)

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA

WORKSHEET S-3
PART I

		Full Time Equivalents			DISCHARGES				
	Component	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)					225	7	398	1
2	HMO and other (see instructions)					10	37		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)		138.27			225	7	398	14
15	CAH Visits								15
16	Subprovider - IPF								16
17	Subprovider - IRF								17
18	Subprovider I								18
19	Skilled Nursing Facility		13.59						19
20	Nursing Facility								20
21	Other Long Term Care		16.99						21
22	Home Health Agency								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)		168.85						27
32.01	Total ancillary labor & delivery room outpatient days (see instructions)								32

HARVARD MEMORIAL HOSPITAL Provider CCN: 14-1335	In Lieu of Form **CMS-2552-10**	Period : From: 07/01/2016 To: 06/30/2017	Run Date: 11/28/2017 Run Time: 09:16 Version: 2017.10 (11/19/2017)

PROSPECTIVE PAYMENT FOR SNF STATISTICAL DATA **WORKSHEET S-7**

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

	Group	SNF Days	Swing Bed SNF Days	Total (sum of col. 2 + 3)	
	1	2	3	4	
3	RUX				3
4	RUL				4
5	RVX				5
6	RVL				6
7	RHX				7
8	RHL				8
9	RMX				9
10	RML				10
11	RLX				11
12	RUC				12
13	RUB	70		70	13
14	RUA	50		50	14
15	RVC	280		280	15
16	RVB	286		286	16
17	RVA	367		367	17
18	RHC	166		166	18
19	RHB	249		249	19
20	RHA	168		168	20
21	RMC	42		42	21
22	RMB	67		67	22
23	RMA	59		59	23
24	RLB				24
25	RLA				25
26	ES3				26
27	ES2				27
28	ES1				28
29	HE2				29
30	HE1				30
31	HD2				31
32	HD1				32
33	HC2				33
34	HC1	4		4	34
35	HB2	14		14	35
36	HB1				36
37	LE2				37
38	LE1				38
39	LD2	14		14	39
40	LD1	38		38	40
41	LC2				41
42	LC1	5		5	42
43	LB2				43
44	LB1				44
45	CE2	8		8	45
46	CE1				46
47	CD2				47
48	CD1	6		6	48
49	CC2				49
50	CC1	8		8	50
51	CB2				51
52	CB1				52
53	CA2				53
54	CA1	14		14	54
55	SE3				55
56	SE2				56
57	SE1				57
58	SSC				58
59	SSB				59
60	SSA				60
61	IB2				61
62	IB1				62
63	IA1				63
64	IA2				64
65	BB2				65
66	BB1				66
67	BA2				67
68	BA1				68
69	PE2				69
70	PE1	4		4	70
71	PD2				71

PROSPECTIVE PAYMENT FOR SNF STATISTICAL DATA **WORKSHEET S-7**

	Group	SNF Days	Swing Bed SNF Days	Total (sum of col. 2 + 3)	
	1	2	3	4	
72	PD1				72
73	PC2				73
74	PC1				74
75	PB2				75
76	PB1	15		15	76
77	PA2				77
78	PA1	1		1	78
199	AAA				199
200	TOTAL	1,935		1,935	200

SNF SERVICES

		CBSA at Beginning of Cost Reporting Period	CBSA on/after October 1 of the Cost Reporting Period (if applicable)	
		1	2	
201	Enter in column 1 the SNF CBSA code, or 5 character non-CBSA code if a rural facility, in effect at the beginning of the cost reporting period. Enter in column 2 the code in effect on or after October 1 of the cost reporting period (if applicable).	99914	99914	201

A notice published in the Federal Register Volume 68, No. 149 August 4, 2003 provided for an increase in the RUG payments beginning 10/01/2003. Congress expected this increase to be used for direct patient care and related expenses. For lines 202 through 207: Enter in column 1 the amount of the expense for each catetory. Enter in column 2 the percentage of total expenses for each category to total SNF revenue from Worksheet G-2, Part I, line 7, column 3. In column 3, enter 'Y' or 'N' for no if the spending reflects increases associated with direct patient care and related expenses for each category. (see instructions)

		Expenses	Percentage	Associated with Direct Patient Care and Related Expenses?	
		1	2	3	
202	Staffing				202
203	Recruitment				203
204	Retention of employees				204
205	Training				205
206	Other (specify)				206
207	Total SNF Revenue (Worksheet G-2, Part I, line 7, column 3)	910,638			207

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)	0.376691	1

Medicaid (see instructions for each line)

2	Net revenue from Medicaid	2,048,058	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	962,342	5
6	Medicaid charges	10,266,377	6
7	Medicaid cost (line 1 times line 6)	3,867,252	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.	856,852	8

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

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

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

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

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

17	Private grants, donations, or endowment income restricted to fundnig 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)	856,852	19

Uncompensated care (see instructions for each line)

		Uninsured patients	Insured patients	TOTAL (col. 1 + col. 2)	
		1	2	3	
20	Charity care charges and uninsured discounts for the entire facility (see instructions)	37,610	25,723	63,333	20
21	Cost of patients approved for charity care and uninsured discounts (see instructions)	14,167	25,723	39,890	21
22	Payments received from patients for amounts previously written off as charity care		190	190	22
23	Cost of charity care (line 21 minus line 22)	14,167	25,533	39,700	23

24	Does the amount in line 20, column 2 include charges for patient days beyond a length of stay limit imposed on patients covered by Medicaid or other indigent care program?	N	24
25	If line 24 is yes, charges for patient days beyond the indigent care program's length of stay limit		25
26	Total bad debt expense for the entire hospital complex (see instructions)	1,477,246	26
27	Medicare reimbursable bad debts for the entire hospital complex (see instructions)	156,144	27
27.01	Medicare allowable bad debts for the entire hospital complex (see instructions)	240,222	27.01
28	Non-Medicare and non-reimbursable Medicare bad debt expense (line 26 minus line 27.01)	1,237,024	28
29	Cost of non-Medicare and non-reimbursable Medicare bad debt expense (line 1 times line 28)	550,054	29
30	Cost of uncompensated care (line 23, column 3 plus line 29)	589,754	30
31	Total unreimbursed and uncompensated care cost (line 19 plus line 30)	1,446,606	31

RECLASSIFICATION AND ADJUSTMENT OF TRIAL BALANCE OF EXPENSES **WORKSHEET A**

		COST CENTER DESCRIPTIONS	SALARIES	OTHER	TOTAL (col. 1 + col. 2)	RECLASSI-FICATIONS	RECLASSI-FIED TRIAL BALANCE (col. 3 ± col. 4)	ADJUST-MENTS	NET EXPENSES FOR ALLOC-ATION (col. 5 ± col. 6)	
			1	2	3	4	5	6	7	
		GENERAL SERVICE COST CENTERS								
1	00100	Cap Rel Costs-Bldg & Fixt				1,126,178	1,126,178	-22,243	1,103,935	1
2	00200	Cap Rel Costs-Mvble Equip		1,997,008	1,997,008	-1,126,178	870,830	-170,021	700,809	2
3	00300	Other Cap Rel Costs							-0-	3
4	00400	Employee Benefits Department		1,781,000	1,781,000		1,781,000	469,781	2,250,781	4
5	00500	Administrative & General	759,955	1,765,603	2,525,558	-475,782	2,049,776	755,376	2,805,152	5
6	00600	Maintenance & Repairs								6
7	00700	Operation of Plant		662,328	662,328		662,328	174,553	836,881	7
8	00800	Laundry & Linen Service		-586	-586		-586		-586	8
9	00900	Housekeeping	191,615	78,312	269,927		269,927		269,927	9
10	01000	Dietary	410,166	191,173	601,339		601,339	-93,916	507,423	10
11	01100	Cafeteria								11
12	01200	Maintenance of Personnel								12
13	01300	Nursing Administration	655,147	69,708	724,855	249,163	974,018	2,548	976,566	13
14	01400	Central Services & Supply								14
15	01500	Pharmacy								15
16	01600	Medical Records & Library	159,641	16,761	176,402	114,615	291,017	69,749	360,766	16
17	01700	Social Service								17
19	01900	Nonphysician Anesthetists								19
20	02000	Nursing School								20
21	02100	I&R Services-Salary & Fringes Apprvd								21
22	02200	I&R Services-Other Prgm Costs Apprvd								22
23	02300	Paramed Ed Prgm-(specify)								23
		INPATIENT ROUTINE SERVICE COST CENTERS								
30	03000	Adults & Pediatrics	784,754	186,108	970,862	-14,000	956,862	11,667	968,529	30
31	03100	Intensive Care Unit	128,829	7,916	136,745	-815	135,930		135,930	31
44	04400	Skilled Nursing Facility				975,956	975,956	-4,197	971,759	44
46	04600	Other Long Term Care	1,668,320	527,537	2,195,857	-1,380,932	814,925	-61,260	753,665	46
		ANCILLARY SERVICE COST CENTERS								
50	05000	Operating Room	598,833	1,339,169	1,938,002	-664,720	1,273,282	-598	1,272,684	50
51	05100	Recovery Room	494,552	217,923	712,475	-22,270	690,205		690,205	51
53	05300	Anesthesiology	89,424	1,355,329	1,444,753		1,444,753	-1,205,657	239,096	53
54	05400	Radiology-Diagnostic	703,994	509,830	1,213,824	-9,359	1,204,465		1,204,465	54
60	06000	Laboratory	532,576	565,957	1,098,533	55,041	1,153,574	-15,000	1,138,574	60
60.01	06001	BLOOD LABORATORY								60.01
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS								62.30
65	06500	Respiratory Therapy	192,207	74,889	267,096	-1,611	265,485		265,485	65
66	06600	Physical Therapy	171,265	21,369	192,634	166,586	359,220		359,220	66
67	06700	Occupational Therapy				152,184	152,184		152,184	67
68	06800	Speech Pathology				9,748	9,748		9,748	68
71	07100	Medical Supplies Charged to Patients	63,359	15,227	78,586	492,095	570,681		570,681	71
72	07200	Impl. Dev. Charged to Patients				301,210	301,210		301,210	72
73	07300	Drugs Charged to Patients	227,875	499,768	727,643	79,153	806,796		806,796	73
76.97	07697	CARDIAC REHABILITATION	39,027	4,505	43,532	15,955	59,487		59,487	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY								76.98
76.99	07699	LITHOTRIPSY								76.99
		OUTPATIENT SERVICE COST CENTERS								
91	09100	Emergency	805,466	2,070,313	2,875,779	-42,217	2,833,562	-286,296	2,547,266	91
92	09200	Observation Beds (Non-Distinct Part)								92
		OTHER REIMBURSABLE COST CENTERS								
99.10	09910	CORF								99.10
		SPECIAL PURPOSE COST CENTERS								
118		SUBTOTALS (sum of lines 1-117)	8,677,005	13,957,147	22,634,152		22,634,152	-375,514	22,258,638	118
		NONREIMBURSABLE COST CENTERS								
192	19200	Physicians' Private Offices								192
200		TOTAL (sum of lines 118-199)	8,677,005	13,957,147	22,634,152		22,634,152	-375,514	22,258,638	200

			INCREASES				
	EXPLANATION OF RECLASSIFICATION(S)	CODE (1)	COST CENTER	LINE #	SALARY	OTHER	
		1	2	3	4	5	
1	SNF/LONG TERM CARE EXP RECLASS	A	Skilled Nursing Facility	44	741,490	234,466	1
500	Total reclassifications				741,490	234,466	500
	Code Letter - A						
1	IMPLANTABLE DEVICES	B	Impl. Dev. Charged to Patient	72		301,210	1
500	Total reclassifications					301,210	500
	Code Letter - B						
1	MANAGER/DIRECTOR RECLASS	C	Nursing Administration	13	144,404	14,714	1
2	MANAGER/DIRECTOR RECLASS	C	Medical Records & Library	16	104,017	10,598	2
3	MANAGER/DIRECTOR RECLASS	C	Other Long Term Care	46	87,167	8,882	3
4	MANAGER/DIRECTOR RECLASS	C	CARDIAC REHABILITATION	76.97	14,480	1,475	4
500	Total reclassifications				350,068	35,669	500
	Code Letter - C						
1	INTERCOMPANY TRANSACTIONS	D	Employee Benefits Department	4	58,293		1
2	INTERCOMPANY TRANSACTIONS	D	Administrative & General	5	568,581		2
3	INTERCOMPANY TRANSACTIONS	D	Operation of Plant	7	168,968		3
4	INTERCOMPANY TRANSACTIONS	D	Drugs Charged to Patients	73	99,945		4
500	Total reclassifications				895,787		500
	Code Letter - D						
1	SNF AND LTC RECLASS	E	Radiology-Diagnostic	54	23,038	6,320	1
2	SNF AND LTC RECLASS	E	Laboratory	60	43,192	11,849	2
3	SNF AND LTC RECLASS	E	Respiratory Therapy	65	207	123	3
4	SNF AND LTC RECLASS	E	Physical Therapy	66	104,829	62,055	4
5	SNF AND LTC RECLASS	E	Occupational Therapy	67	95,595	56,589	5
6	SNF AND LTC RECLASS	E	Speech Pathology	68	6,123	3,625	6
7	SNF AND LTC RECLASS	E	Medical Supplies Charged to P	71	6,534	1,793	7
8	SNF AND LTC RECLASS	E	Drugs Charged to Patients	73	62,113	17,040	8
500	Total reclassifications				341,631	159,394	500
	Code Letter - E						
1	DEPRECIATION	F	Cap Rel Costs-Bldg & Fixt	1		1,126,178	1
500	Total reclassifications					1,126,178	500
	Code Letter - F						
1	LOCUM SALARY RECLASS	G	Anesthesiology	53	1,186,274		1
2	LOCUM SALARY RECLASS	G	Emergency	91	1,307,666		2
500	Total reclassifications				2,493,940		500
	Code Letter - G						
1	MEDICAL SUPPLIES CHARGED TO PATIENT	H	Medical Supplies Charged to P	71		483,768	1
2							2
3							3
4							4
5							5
6							6
7							7
8							8
500	Total reclassifications					483,768	500
	Code Letter - H						
1	NURSING ADMIN	I	Nursing Administration	13	63,873	26,172	1
500	Total reclassifications				63,873	26,172	500
	Code Letter - I						
	GRAND TOTAL (Increases)				4,886,789	2,366,857	

(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.

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	SNF/LONG TERM CARE EXP RECLASS	A	Other Long Term Care	46	741,490	234,466		1
500	Total reclassifications				741,490	234,466		500
	Code letter - A							
1	IMPLANTABLE DEVICES	B	Operating Room	50		301,210		1
500	Total reclassifications					301,210		500
	Code letter - B							
1	MANAGER/DIRECTOR RECLASS	C	Administrative & General	5	350,068	35,669		1
2	MANAGER/DIRECTOR RECLASS	C						2
3	MANAGER/DIRECTOR RECLASS	C						3
4	MANAGER/DIRECTOR RECLASS	C						4
500	Total reclassifications				350,068	35,669		500
	Code letter - C							
1	INTERCOMPANY TRANSACTIONS	D	Employee Benefits Department	4		58,293		1
2	INTERCOMPANY TRANSACTIONS	D	Administrative & General	5		568,581		2
3	INTERCOMPANY TRANSACTIONS	D	Operation of Plant	7		168,968		3
4	INTERCOMPANY TRANSACTIONS	D	Drugs Charged to Patients	73		99,945		4
500	Total reclassifications					895,787		500
	Code letter - D							
1	SNF AND LTC RECLASS	E	Other Long Term Care	46	341,631	159,394		1
2	SNF AND LTC RECLASS	E						2
3	SNF AND LTC RECLASS	E						3
4	SNF AND LTC RECLASS	E						4
5	SNF AND LTC RECLASS	E						5
6	SNF AND LTC RECLASS	E						6
7	SNF AND LTC RECLASS	E						7
8	SNF AND LTC RECLASS	E						8
500	Total reclassifications				341,631	159,394		500
	Code letter - E							
1	DEPRECIATION	F	Cap Rel Costs-Mvble Equip	2		1,126,178	9	1
500	Total reclassifications					1,126,178		500
	Code letter - F							
1	LOCUM SALARY RECLASS	G	Anesthesiology	53		1,186,274		1
2	LOCUM SALARY RECLASS	G	Emergency	91		1,307,666		2
500	Total reclassifications					2,493,940		500
	Code letter - G							
1	MEDICAL SUPPLIES CHARGED TO PATIENT	H	Adults & Pediatrics	30		14,000		1
2			Intensive Care Unit	31		815		2
3			Operating Room	50		363,510		3
4			Recovery Room	51		22,270		4
5			Radiology-Diagnostic	54		38,717		5
6			Respiratory Therapy	65		1,941		6
7			Physical Therapy	66		298		7
8			Emergency	91		42,217		8
500	Total reclassifications					483,768		500
	Code letter - H							
1	NURSING ADMIN	I	Administrative & General	5	63,873	26,172		1
500	Total reclassifications				63,873	26,172		500
	Code letter - I							
	GRAND TOTAL (Decreases)				1,497,062	5,756,584		

(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.

RECONCILIATION OF CAPITAL COST CENTERS

WORKSHEET A-7
PARTS I, II & III

PART I - ANALYSIS OF CHANGES IN CAPITAL ASSETS BALANCES

			Acquisitions						
	Description	Beginning Balances	Purchases	Donation	Total	Disposals and Retirements	Ending Balance	Fully Depreciated Assets	
		1	2	3	4	5	6	7	
1	Land	222,604					222,604		1
2	Land Improvements	801,679	5,750		5,750		807,429		2
3	Buildings and Fixtures								3
4	Building Improvements	20,549,412	213,454		213,454		20,762,866		4
5	Fixed Equipment								5
6	Movable Equipment	13,200,544	429,659		429,659		13,630,203		6
7	HIT-designated Assets	1,470,955					1,470,955		7
8	Subtotal (sum of lines 1-7)	36,245,194	648,863		648,863		36,894,057		8
9	Reconciling Items								9
10	Total (line 7 minus line 9)	36,245,194	648,863		648,863		36,894,057		10

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

		SUMMARY OF CAPITAL							
	Description	Depreciation	Lease	Interest	Insurance (see instructions)	Taxes (see instructions)	Other Capital-Related Costs (see instructions)	Total (1) (sum of cols. 9 through 14)	
*		9	10	11	12	13	14	15	
1	Cap Rel Costs-Bldg & Fixt								1
2	Cap Rel Costs-Mvble Equip	1,997,008						1,997,008	2
3	Total (sum of lines 1-2)	1,997,008						1,997,008	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 lines numbers are to be consistent with Worksheet A line numbers for capital cost centers.

PART III - RECONCILIATION OF CAPITAL COST CENTERS

		COMPUTATION OF RATIOS				ALLOCATION OF OTHER CAPITAL				
	Description	Gross Assets	Capitalized Leases	Gross Assets for Ratio (col. 1 - col. 2)	Ratio (see instructions)	Insurance	Taxes	Other Capital-Related Costs	Total (sum of cols. 5 through 7)	
*		1	2	3	4	5	6	7	8	
1	Cap Rel Costs-Bldg & Fi	21,792,899		21,792,899	0.590689					1
2	Cap Rel Costs-Mvble Equ	15,101,158		15,101,158	0.409311					2
3	Total (sum of lines 1-2)	36,894,057		36,894,057	1.000000					3

		SUMMARY OF CAPITAL							
	Description	Depreciation	Lease	Interest	Insurance (see instructions)	Taxes (see instructions)	Other Capital-Related Costs (see instructions)	Total (2) (sum of cols. 9 through 14)	
*		9	10	11	12	13	14	15	
1	Cap Rel Costs-Bldg & Fixt	1,126,178		-22,243				1,103,935	1
2	Cap Rel Costs-Mvble Equip	700,809						700,809	2
3	Total (sum of lines 1-2)	1,826,987		-22,243				1,804,744	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.)

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	
1	Investment income-buildings & fixtures (chapter 2)	B	-1,491	Cap Rel Costs-Bldg & Fixt	1	11	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)	A	-4,265	Operation of Plant	7		8
9	Parking lot (chapter 21)						9
10	Provider-based physician adjustment	Wkst A-8-2	-1,579,319				10
11	Sale of scrap, waste, etc. (chapter 23)						11
12	Related organization transactions (chapter 10)	Wkst A-8-1	2,150,810				12
13	Laundry and linen service						13
14	Cafeteria - employees and guests	B	-93,916	Dietary	10		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	-34	Medical Records & Library	16		18
19	Nursing school (tuition,fees,books,etc.)						19
20	Vending machines						20
21	Income from imposition of interest, finance or penalty charges (chapter 21)						21
22	Interest exp on Medicare overpayments & borrowings to repay Medicare overpayments						22
23	Adj for respiratory therapy costs in excess of limitation (chapter 14)	Wkst A-8-3		Respiratory Therapy	65		23
24	Adj for physical therapy costs in excess of limitation (chapter 14)	Wkst A-8-3		Physical Therapy	66		24
25	Util review-physicians' compensation (chapter 21)			Utilization Review-SNF	114		25
26	Depreciation--buildings & fixtures			Cap Rel Costs-Bldg & Fixt	1		26
27	Depreciation--movable equipment			Cap Rel Costs-Mvble Equip	2		27
28	Non-physician anesthetist			Nonphysician Anesthetists	19		28
29	Physicians' assistant						29
30	Adj for occupational therapy costs in excess of limitation (chapter 14)	Wkst A-8-3		Occupational Therapy	67		30
31	Adj for speech pathology costs in excess of limitation (chapter 14)	Wkst A-8-3		Speech Pathology	68		31
32	CAH HIT Adj for Depreciation	A	-210,136	Cap Rel Costs-Mvble Equip	2	9	32
33	OTHER OPERATING REVENUE	B	-2,681	Administrative & General	5		33
34	ILLINOIS UNALLOWABLE REAL ESTATE T	A	-7,515	Operation of Plant	7		34
35	LOBBYING EXPENSE	A	-7,500	Administrative & General	5		35
36							36
37	HOSPITAL TAX	A	-527,042	Administrative & General	5		37
38							38
39	CASH DISCOUNTS	B	-216	Administrative & General	5		39
40	HOME OFFICE INTEREST EXPENSE	A	-20,752	Cap Rel Costs-Bldg & Fixt	1	11	40
41							41
42	SNF TAX	A	-6,864	Skilled Nursing Facility	44		42
43	CARE CENTER TAX	A	-64,513	Other Long Term Care	46		43
44	OTHER OPERATING	B	-80	Other Long Term Care	46		44
45							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)		-375,514				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.

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	4	Employee Benefits Department	HOME OFFICE EMPLOYEE BENEFITS	537,281	67,500	469,781		1
2	5	Administrative & General	HOME OFFICE ADMIN & GENERAL	2,136,594	955,632	1,180,962		2
3	7	Operation of Plant	HOME OFFICE OPERATION OF PLANT	186,333		186,333		3
3.01	16	Medical Records & Library	HOME OFFICE MEDICAL RECOR	69,783		69,783		3.01
3.05	13	Nursing Administration	HOME OFFICE NURSING ADMIN	2,548		2,548		3.05
3.07	5	Administrative & General	MED DIRECTOR DIRECT ALLOC	111,853		111,853		3.07
3.08	30	Adults & Pediatrics	MED DIRECTOR DIRECT ALLOC	11,667		11,667		3.08
3.09	53	Anesthesiology	MED DIRECTOR DIRECT ALLOC	32,769		32,769		3.09
3.10	91	Emergency	MED DIRECTOR DIRECT ALLOC	76,667		76,667		3.10
3.11	44	Skilled Nursing Facility	MED DIRECTOR DIRECT ALLOC	2,667		2,667		3.11
3.12	46	Other Long Term Care	MED DIRECTOR DIRECT ALLOC	3,333		3,333		3.12
3.14	2	Cap Rel Costs-Mvble Equip	HIT ASSETS FROM JVL	250,251	210,136	40,115	9	3.14
3.16	53	Anesthesiology	PHYSICIAN BENEFITS	104,058		104,058		3.16
3.17	91	Emergency	PHYSICIAN BENEFITS	136,510		136,510		3.17
3.19	53	Anesthesiology	MALPRACTICE ADJ	-60,621		-60,621		3.19
3.20	91	Emergency	MALPRACTICE ADJ	-217,615		-217,615		3.20
4								4
5	TOTALS (sum of lines 1-4) Transfer column 6, line 5 to Worksheet A-8, column 2, line 12			3,384,078	1,233,268	2,150,810		5

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

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

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

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

				Related Organization(s) and/or Home Office			
	Symbol (1)	Name	Percentage of Ownership	Name	Percentage of Ownership	Type of Business	
	1	2	3	4	5	6	
6	B			MERCY HOME OFFI	100.00	HEALTH SYSTEM	6
7							7
8							8
9							9
10							10

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

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

HARVARD MEMORIAL HOSPITAL Provider CCN: 14-1335	In Lieu of Form **CMS-2552-10**	Period : From: 07/01/2016 To: 06/30/2017	Run Date: 11/28/2017 Run Time: 09:16 Version: 2017.10 (11/19/2017)

PROVIDER-BASED PHYSICIANS ADJUSTMENTS **WORKSHEET A-8-2**

	Wkst A Line #	Cost Center/ Physician Identifier	Total Remun-eration	Professional Component	Provider Component	RCE Amount	Physician/ Provider Component Hours	Unadjusted RCE Limit	5 Percent of Unadjusted RCE Limit	
	1	2	3	4	5	6	7	8	9	
1	50	Operating Room AGGREGATE-OPERA	44,142	598	43,544					1
2	60	Laboratory AGGREGATE-LABOR	15,000	15,000						2
3	53	Anesthesiology AGGREGATE-ANEST	1,281,863	1,281,863						3
4	91	Emergency AGGREGATE-EMERG	1,423,525	281,858	1,141,667					4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
200		TOTAL	2,764,530	1,579,319	1,185,211					200

PROVIDER-BASED PHYSICIANS ADJUSTMENTS **WORKSHEET A-8-2**

	Wkst A Line #	Cost Center/ Physician Identifier	Cost of Memberships & Continuing Education	Provider Component Share of col. 12	Physician Cost of Malpractice Insurance	Provider Component Share of col. 14	Adjusted RCE Limit	RCE Disallowance	Adjustment	
	10	11	12	13	14	15	16	17	18	
1	50	Operating Room AGGREGATE-OPERA							598	1
2	60	Laboratory AGGREGATE-LABOR							15,000	2
3	53	Anesthesiology AGGREGATE-ANEST							1,281,863	3
4	91	Emergency AGGREGATE-EMERG							281,858	4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
200		TOTAL							1,579,319	200

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	
	GENERAL SERVICE COST CENTERS							
1	Cap Rel Costs-Bldg & Fixt	1,103,935	1,103,935					1
2	Cap Rel Costs-Mvble Equip	700,809		700,809				2
4	Employee Benefits Department	2,250,781			2,250,781			4
5	Administrative & General	2,805,152	132,367	6,912	443,030	3,387,461	3,387,461	5
6	Maintenance & Repairs							6
7	Operation of Plant	836,881	219,560	120,395	37,659	1,214,495	218,007	7
8	Laundry & Linen Service	-586	12,742	1,271		13,427	2,410	8
9	Housekeeping	269,927	5,019	1,179	41,454	317,579	57,007	9
10	Dietary	507,423	33,964	16,669	88,734	646,790	116,101	10
11	Cafeteria		18,258			18,258	3,277	11
12	Maintenance of Personnel							12
13	Nursing Administration	976,566	6,123	1,373	172,973	1,157,035	207,692	13
14	Central Services & Supply							14
15	Pharmacy							15
16	Medical Records & Library	360,766	23,511		61,359	445,636	79,993	16
17	Social Service							17
19	Nonphysician Anesthetists							19
20	Nursing School							20
21	I&R Services-Salary & Fringes Apprvd							21
22	I&R Services-Other Prgm Costs Apprvd							22
23	Paramed Ed Prgm-(specify)							23
	INPATIENT ROUTINE SERV COST CENTERS							
30	Adults & Pediatrics	968,529	92,033	12,945	169,772	1,243,279	223,174	30
31	Intensive Care Unit	135,930	25,345	397	27,871	189,543	34,024	31
44	Skilled Nursing Facility	971,759	65,818	11,952	160,412	1,209,941	217,189	44
46	Other Long Term Care	753,665	113,062	14,938	145,459	1,027,124	184,373	46
	ANCILLARY SERVICE COST CENTERS							
50	Operating Room	1,272,684	108,056	201,724	129,421	1,711,885	307,290	50
51	Recovery Room	690,205	4,413	4,071	106,990	805,679	144,623	51
53	Anesthesiology	239,096		9,464		248,560	44,618	53
54	Radiology-Diagnostic	1,204,465	31,509	227,109	157,285	1,620,368	290,863	54
60	Laboratory	1,138,574	21,057	14,304	121,315	1,295,250	232,503	60
60.01	BLOOD LABORATORY							60.01
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
65	Respiratory Therapy	265,485	17,789	11,755	41,626	336,655	60,431	65
66	Physical Therapy	359,220	49,795	2,747	59,730	471,492	84,635	66
67	Occupational Therapy	152,184			20,681	172,865	31,030	67
68	Speech Pathology	9,748			1,325	11,073	1,988	68
71	Medical Supplies Charged to Patients	570,681		23,196	15,121	608,998	109,318	71
72	Impl. Dev. Charged to Patients	301,210				301,210	54,068	72
73	Drugs Charged to Patients	806,796	7,446	1,568	62,735	878,545	157,702	73
76.97	CARDIAC REHABILITATION	59,487	6,895	8,644	11,576	86,602	15,545	76.97
76.98	HYPERBARIC OXYGEN THERAPY							76.98
76.99	LITHOTRIPSY							76.99
	OUTPATIENT SERVICE COST CENTERS							
91	Emergency	2,547,266	20,036	8,196	174,253	2,749,751	493,600	91
92	Observation Beds (Non-Distinct Part)							92
	OTHER REIMBURSABLE COST CENTERS							
99.10	CORF							99.10
	SPECIAL PURPOSE COST CENTERS							
118	SUBTOTALS (sum of lines 1-117)	22,258,638	1,014,798	700,809	2,250,781	22,169,501	3,371,461	118
	NONREIMBURSABLE COST CENTERS							
192	Physicians' Private Offices		89,137			89,137	16,000	192
200	Cross Foot Adjustments							200
201	Negative Cost Centers							201
202	TOTAL (sum of lines 118-201)	22,258,638	1,103,935	700,809	2,250,781	22,258,638	3,387,461	202

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

	COST CENTER DESCRIPTIONS	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSE-KEEPING	DIETARY	CAFETERIA	NURSING ADMINIS-TRATION	
		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	1,432,502						7
8	Laundry & Linen Service	24,272	40,109					8
9	Housekeeping	9,562		384,148				9
10	Dietary	64,698		17,770	845,359			10
11	Cafeteria	34,779		9,552	176,351	242,217		11
12	Maintenance of Personnel							12
13	Nursing Administration	11,663		3,203		14,942	1,394,535	13
14	Central Services & Supply							14
15	Pharmacy							15
16	Medical Records & Library	44,787		12,301		6,404		16
17	Social Service							17
19	Nonphysician Anesthetists							19
20	Nursing School							20
21	I&R Services-Salary & Fringes Apprvd							21
22	I&R Services-Other Prgm Costs Apprvd							22
23	Paramed Ed Prgm-(specify)							23
	INPATIENT ROUTINE SERV COST CENTERS							
30	Adults & Pediatrics	175,313	8,938	48,150	51,344	22,115	255,716	30
31	Intensive Care Unit	48,281	83	13,260	1,866	2,818	20,343	31
44	Skilled Nursing Facility	125,377	7,628	34,435	170,207	29,010	248,512	44
46	Other Long Term Care	215,371	9,535	59,152	440,769	36,266	310,628	46
	ANCILLARY SERVICE COST CENTERS							
50	Operating Room	205,836	6,243	56,534		17,013	194,425	50
51	Recovery Room	8,406	524	2,309		14,964	133,800	51
53	Anesthesiology					10,097	30,293	53
54	Radiology-Diagnostic	60,023	2,435	16,485		19,020		54
60	Laboratory	40,111		11,017		18,230		60
60.01	BLOOD LABORATORY							60.01
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
65	Respiratory Therapy	33,886		9,307		6,126		65
66	Physical Therapy	94,854	740	26,052		5,785		66
67	Occupational Therapy					3,245		67
68	Speech Pathology							68
71	Medical Supplies Charged to Patients					3,245		71
72	Impl. Dev. Charged to Patients							72
73	Drugs Charged to Patients	14,185		3,896		4,760		73
76.97	CARDIAC REHABILITATION	13,134	11	3,607		2,156		76.97
76.98	HYPERBARIC OXYGEN THERAPY							76.98
76.99	LITHOTRIPSY							76.99
	OUTPATIENT SERVICE COST CENTERS							
91	Emergency	38,167	3,801	10,483	4,822	26,021	200,818	91
92	Observation Beds (Non-Distinct Part)							92
	OTHER REIMBURSABLE COST CENTERS							
99.10	CORF							99.10
	SPECIAL PURPOSE COST CENTERS							
118	SUBTOTALS (sum of lines 1-117)	1,262,705	39,938	337,513	845,359	242,217	1,394,535	118
	NONREIMBURSABLE COST CENTERS							
192	Physicians' Private Offices	169,797	171	46,635				192
200	Cross Foot Adjustments							200
201	Negative Cost Centers							201
202	TOTAL (sum of lines 118-201)	1,432,502	40,109	384,148	845,359	242,217	1,394,535	202

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

	COST CENTER DESCRIPTIONS	MEDICAL RECORDS & LIBRARY	SUBTOTAL	I&R COST & POST STEP-DOWN ADJS	TOTAL			
		16	24	25	26			
	GENERAL SERVICE COST CENTERS							
1	Cap Rel Costs-Bldg & Fixt							1
2	Cap Rel Costs-Mvble Equip							2
4	Employee Benefits Department							4
5	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	589,121						16
17	Social Service							17
19	Nonphysician Anesthetists							19
20	Nursing School							20
21	I&R Services-Salary & Fringes Apprvd							21
22	I&R Services-Other Prgm Costs Apprvd							22
23	Paramed Ed Prgm-(specify)							23
	INPATIENT ROUTINE SERV COST CENTERS							
30	Adults & Pediatrics	15,748	2,043,777		2,043,777			30
31	Intensive Care Unit	1,211	311,429		311,429			31
44	Skilled Nursing Facility		2,042,299		2,042,299			44
46	Other Long Term Care		2,283,218		2,283,218			46
	ANCILLARY SERVICE COST CENTERS							
50	Operating Room	65,252	2,564,478		2,564,478			50
51	Recovery Room		1,110,305		1,110,305			51
53	Anesthesiology		333,568		333,568			53
54	Radiology-Diagnostic	462,817	2,472,011		2,472,011			54
60	Laboratory		1,597,111		1,597,111			60
60.01	BLOOD LABORATORY							60.01
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
65	Respiratory Therapy		446,405		446,405			65
66	Physical Therapy	4,845	688,403		688,403			66
67	Occupational Therapy		207,140		207,140			67
68	Speech Pathology		13,061		13,061			68
71	Medical Supplies Charged to Patients		721,561		721,561			71
72	Impl. Dev. Charged to Patients		355,278		355,278			72
73	Drugs Charged to Patients		1,059,088		1,059,088			73
76.97	CARDIAC REHABILITATION	21,239	142,294		142,294			76.97
76.98	HYPERBARIC OXYGEN THERAPY							76.98
76.99	LITHOTRIPSY							76.99
	OUTPATIENT SERVICE COST CENTERS							
91	Emergency	18,009	3,545,472		3,545,472			91
92	Observation Beds (Non-Distinct Part)							92
	OTHER REIMBURSABLE COST CENTERS							
99.10	CORF							99.10
	SPECIAL PURPOSE COST CENTERS							
118	SUBTOTALS (sum of lines 1-117)	589,121	21,936,898		21,936,898			118
	NONREIMBURSABLE COST CENTERS							
192	Physicians' Private Offices		321,740		321,740			192
200	Cross Foot Adjustments							200
201	Negative Cost Centers							201
202	TOTAL (sum of lines 118-201)	589,121	22,258,638		22,258,638			202

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	1,061			1,061	1,061		4
5	Administrative & General	148,563	132,367	6,912	287,842	207	288,049	5
6	Maintenance & Repairs							6
7	Operation of Plant	20,745	219,560	120,395	360,700	18	18,538	7
8	Laundry & Linen Service		12,742	1,271	14,013		205	8
9	Housekeeping	1,441	5,019	1,179	7,639	20	4,848	9
10	Dietary	2,197	33,964	16,669	52,830	42	9,873	10
11	Cafeteria		18,258		18,258		279	11
12	Maintenance of Personnel							12
13	Nursing Administration	5,651	6,123	1,373	13,147	82	17,661	13
14	Central Services & Supply							14
15	Pharmacy							15
16	Medical Records & Library	1,061	23,511		24,572	29	6,802	16
17	Social Service							17
19	Nonphysician Anesthetists							19
20	Nursing School							20
21	I&R Services-Salary & Fringes Apprvd							21
22	I&R Services-Other Prgm Costs Apprvd							22
23	Paramed Ed Prgm-(specify)							23
	INPATIENT ROUTINE SERV COST CENTERS							
30	Adults & Pediatrics	4,695	92,033	12,945	109,673	80	18,977	30
31	Intensive Care Unit	128	25,345	397	25,870	13	2,893	31
44	Skilled Nursing Facility	6,187	65,818	11,952	83,957	76	18,469	44
46	Other Long Term Care	7,734	113,062	14,938	135,734	69	15,678	46
	ANCILLARY SERVICE COST CENTERS							
50	Operating Room	47,367	108,056	201,724	357,147	61	26,130	50
51	Recovery Room	2,425	4,413	4,071	10,909	50	12,298	51
53	Anesthesiology	49		9,464	9,513		3,794	53
54	Radiology-Diagnostic	8,915	31,509	227,109	267,533	74	24,733	54
60	Laboratory	5,753	21,057	14,304	41,114	57	19,771	60
60.01	BLOOD LABORATORY							60.01
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
65	Respiratory Therapy	4,033	17,789	11,755	33,577	20	5,139	65
66	Physical Therapy	477	49,795	2,747	53,019	28	7,197	66
67	Occupational Therapy					10	2,639	67
68	Speech Pathology					1	169	68
71	Medical Supplies Charged to Patients			23,196	23,196	7	9,296	71
72	Impl. Dev. Charged to Patients						4,598	72
73	Drugs Charged to Patients	55,264	7,446	1,568	64,278	30	13,410	73
76.97	CARDIAC REHABILITATION	264	6,895	8,644	15,803	5	1,322	76.97
76.98	HYPERBARIC OXYGEN THERAPY							76.98
76.99	LITHOTRIPSY							76.99
	OUTPATIENT SERVICE COST CENTERS							
91	Emergency	2,302	20,036	8,196	30,534	82	41,969	91
92	Observation Beds (Non-Distinct Part)							92
	OTHER REIMBURSABLE COST CENTERS							
99.10	CORF							99.10
	SPECIAL PURPOSE COST CENTERS							
118	SUBTOTALS (sum of lines 1-117)	326,312	1,014,798	700,809	2,041,919	1,061	286,688	118
	NONREIMBURSABLE COST CENTERS							
192	Physicians' Private Offices		89,137		89,137		1,361	192
200	Cross Foot Adjustments							200
201	Negative Cost Centers							201
202	TOTAL (sum of lines 118-201)	326,312	1,103,935	700,809	2,131,056	1,061	288,049	202

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

	COST CENTER DESCRIPTIONS	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSE-KEEPING	DIETARY	CAFETERIA	NURSING ADMINIS-TRATION	
		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	379,256						7
8	Laundry & Linen Service	6,426	20,347					8
9	Housekeeping	2,531		15,038				9
10	Dietary	17,129		696	80,570			10
11	Cafeteria	9,208		374	16,808	44,927		11
12	Maintenance of Personnel							12
13	Nursing Administration	3,088		125		2,772	36,875	13
14	Central Services & Supply							14
15	Pharmacy							15
16	Medical Records & Library	11,857		482		1,188		16
17	Social Service							17
19	Nonphysician Anesthetists							19
20	Nursing School							20
21	I&R Services-Salary & Fringes Apprvd							21
22	I&R Services-Other Prgm Costs Apprvd							22
23	Paramed Ed Prgm-(specify)							23
	INPATIENT ROUTINE SERV COST CENTERS							
30	Adults & Pediatrics	46,414	4,534	1,885	4,893	4,102	6,762	30
31	Intensive Care Unit	12,782	42	519	178	523	538	31
44	Skilled Nursing Facility	33,194	3,870	1,348	16,222	5,381	6,571	44
46	Other Long Term Care	57,021	4,836	2,316	42,009	6,725	8,214	46
	ANCILLARY SERVICE COST CENTERS							
50	Operating Room	54,495	3,167	2,213		3,156	5,141	50
51	Recovery Room	2,225	266	90		2,776	3,538	51
53	Anesthesiology					1,873	801	53
54	Radiology-Diagnostic	15,891	1,235	645		3,528		54
60	Laboratory	10,620		431		3,381		60
60.01	BLOOD LABORATORY							60.01
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
65	Respiratory Therapy	8,971		364		1,136		65
66	Physical Therapy	25,113	376	1,020		1,073		66
67	Occupational Therapy					602		67
68	Speech Pathology							68
71	Medical Supplies Charged to Patients					602		71
72	Impl. Dev. Charged to Patients							72
73	Drugs Charged to Patients	3,755		153		883		73
76.97	CARDIAC REHABILITATION	3,477	6	141		400		76.97
76.98	HYPERBARIC OXYGEN THERAPY							76.98
76.99	LITHOTRIPSY							76.99
	OUTPATIENT SERVICE COST CENTERS							
91	Emergency	10,105	1,928	410	460	4,826	5,310	91
92	Observation Beds (Non-Distinct Part)							92
	OTHER REIMBURSABLE COST CENTERS							
99.10	CORF							99.10
	SPECIAL PURPOSE COST CENTERS							
118	SUBTOTALS (sum of lines 1-117)	334,302	20,260	13,212	80,570	44,927	36,875	118
	NONREIMBURSABLE COST CENTERS							
192	Physicians' Private Offices	44,954	87	1,826				192
200	Cross Foot Adjustments							200
201	Negative Cost Centers		297					201
202	TOTAL (sum of lines 118-201)	379,256	20,644	15,038	80,570	44,927	36,875	202

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

	COST CENTER DESCRIPTIONS	MEDICAL RECORDS & LIBRARY	SUBTOTAL	I&R COST & POST STEP-DOWN ADJS	TOTAL			
		16	24	25	26			
	GENERAL SERVICE COST CENTERS							
1	Cap Rel Costs-Bldg & Fixt							1
2	Cap Rel Costs-Mvble Equip							2
4	Employee Benefits Department							4
5	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	44,930						16
17	Social Service							17
19	Nonphysician Anesthetists							19
20	Nursing School							20
21	I&R Services-Salary & Fringes Apprvd							21
22	I&R Services-Other Prgm Costs Apprvd							22
23	Paramed Ed Prgm-(specify)							23
	INPATIENT ROUTINE SERV COST CENTERS							
30	Adults & Pediatrics	1,201	198,521		198,521			30
31	Intensive Care Unit	92	43,450		43,450			31
44	Skilled Nursing Facility		169,088		169,088			44
46	Other Long Term Care		272,602		272,602			46
	ANCILLARY SERVICE COST CENTERS							
50	Operating Room	4,976	456,486		456,486			50
51	Recovery Room		32,152		32,152			51
53	Anesthesiology		15,981		15,981			53
54	Radiology-Diagnostic	35,298	348,937		348,937			54
60	Laboratory		75,374		75,374			60
60.01	BLOOD LABORATORY							60.01
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
65	Respiratory Therapy		49,207		49,207			65
66	Physical Therapy	370	88,196		88,196			66
67	Occupational Therapy		3,251		3,251			67
68	Speech Pathology		170		170			68
71	Medical Supplies Charged to Patients		33,101		33,101			71
72	Impl. Dev. Charged to Patients		4,598		4,598			72
73	Drugs Charged to Patients		82,509		82,509			73
76.97	CARDIAC REHABILITATION	1,620	22,774		22,774			76.97
76.98	HYPERBARIC OXYGEN THERAPY							76.98
76.99	LITHOTRIPSY							76.99
	OUTPATIENT SERVICE COST CENTERS							
91	Emergency	1,373	96,997		96,997			91
92	Observation Beds (Non-Distinct Part)							92
	OTHER REIMBURSABLE COST CENTERS							
99.10	CORF							99.10
	SPECIAL PURPOSE COST CENTERS							
118	SUBTOTALS (sum of lines 1-117)	44,930	1,993,394		1,993,394			118
	NONREIMBURSABLE COST CENTERS							
192	Physicians' Private Offices		137,365		137,365			192
200	Cross Foot Adjustments							200
201	Negative Cost Centers		297		297			201
202	TOTAL (sum of lines 118-201)	44,930	2,131,056		2,131,056			202

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	RECON-CILIATION	ADMINIS-TRATIVE & GENERAL ACCUM COST	OPERATION OF PLANT SQUARE FEET	
		1	2	4	5A	5	7	
	GENERAL SERVICE COST CENTERS							
1	Cap Rel Costs-Bldg & Fixt	80,055						1
2	Cap Rel Costs-Mvble Equip		657,208					2
4	Employee Benefits Department			10,403,986				4
5	Administrative & General	9,599	6,482	2,047,845	-3,387,461	18,871,177		5
6	Maintenance & Repairs							6
7	Operation of Plant	15,922	112,905	174,076		1,214,495	54,534	7
8	Laundry & Linen Service	924	1,192			13,427	924	8
9	Housekeeping	364	1,106	191,615		317,579	364	9
10	Dietary	2,463	15,632	410,166		646,790	2,463	10
11	Cafeteria	1,324				18,258	1,324	11
12	Maintenance of Personnel							12
13	Nursing Administration	444	1,288	799,551		1,157,035	444	13
14	Central Services & Supply							14
15	Pharmacy							15
16	Medical Records & Library	1,705		283,626		445,636	1,705	16
17	Social Service							17
19	Nonphysician Anesthetists							19
20	Nursing School							20
21	I&R Services-Salary & Fringes Apprvd							21
22	I&R Services-Other Prgm Costs Apprvd							22
23	Paramed Ed Prgm-(specify)							23
	INPATIENT ROUTINE SERV COST CENTERS							
30	Adults & Pediatrics	6,674	12,140	784,754		1,243,279	6,674	30
31	Intensive Care Unit	1,838	372	128,829		189,543	1,838	31
44	Skilled Nursing Facility	4,773	11,208	741,490		1,209,941	4,773	44
46	Other Long Term Care	8,199	14,009	672,367		1,027,124	8,199	46
	ANCILLARY SERVICE COST CENTERS							
50	Operating Room	7,836	189,174	598,235		1,711,885	7,836	50
51	Recovery Room	320	3,818	494,552		805,679	320	51
53	Anesthesiology		8,875			248,560		53
54	Radiology-Diagnostic	2,285	212,978	727,032		1,620,368	2,285	54
60	Laboratory	1,527	13,414	560,768		1,295,250	1,527	60
60.01	BLOOD LABORATORY							60.01
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
65	Respiratory Therapy	1,290	11,024	192,414		336,655	1,290	65
66	Physical Therapy	3,611	2,576	276,094		471,492	3,611	66
67	Occupational Therapy			95,595		172,865		67
68	Speech Pathology			6,123		11,073		68
71	Medical Supplies Charged to Patients		21,753	69,893		608,998		71
72	Impl. Dev. Charged to Patients					301,210		72
73	Drugs Charged to Patients	540	1,470	289,988		878,545	540	73
76.97	CARDIAC REHABILITATION	500	8,106	53,507		86,602	500	76.97
76.98	HYPERBARIC OXYGEN THERAPY							76.98
76.99	LITHOTRIPSY							76.99
	OUTPATIENT SERVICE COST CENTERS							
91	Emergency	1,453	7,686	805,466		2,749,751	1,453	91
92	Observation Beds (Non-Distinct Part)							92
	OTHER REIMBURSABLE COST CENTERS							
99.10	CORF							99.10
	SPECIAL PURPOSE COST CENTERS							
118	SUBTOTALS (sum of lines 1-117)	73,591	657,208	10,403,986	-3,387,461	18,782,040	48,070	118
	NONREIMBURSABLE COST CENTERS							
192	Physicians' Private Offices	6,464				89,137	6,464	192
200	Cross foot adjustments							200
201	Negative cost centers							201
202	Cost to be allocated (Per Wkst. B, Part I)	1,103,935	700,809	2,250,781		3,387,461	1,432,502	202
203	Unit Cost Multiplier (Wkst. B, Part I)	13.789707	1.066343	0.216338		0.179504	26.268053	203
204	Cost to be allocated (Per Wkst. B, Part II)			1,061		288,049	379,256	204
205	Unit Cost Multiplier (Wkst. B, Part II)			0.000102		0.015264	6.954487	205

COST ALLOCATION - STATISTICAL BASIS **WORKSHEET B-1**

	COST CENTER DESCRIPTIONS	LAUNDRY & LINEN SERVICE POUNDS OF LAUNDR	HOUSE-KEEPING SQUARE FEET	DIETARY MEALS SERVED	CAFETERIA FULL TIME EQUIVALE	NURSING ADMINIS-TRATION DIRECT NRSING HR	MEDICAL RECORDS & LIBRARY TIME SPENT	
		8	9	10	11	13	16	
	GENERAL SERVICE COST CENTERS							
1	Cap Rel Costs-Bldg & Fixt							1
2	Cap Rel Costs-Mvble Equip							2
4	Employee Benefits Department							4
5	Administrative & General							5
6	Maintenance & Repairs							6
7	Operation of Plant							7
8	Laundry & Linen Service	155,207						8
9	Housekeeping		53,246					9
10	Dietary		2,463	54,350				10
11	Cafeteria		1,324	11,338	11,347			11
12	Maintenance of Personnel							12
13	Nursing Administration		444		700	106,664		13
14	Central Services & Supply							14
15	Pharmacy							15
16	Medical Records & Library		1,705		300		7,295	16
17	Social Service							17
19	Nonphysician Anesthetists							19
20	Nursing School							20
21	I&R Services-Salary & Fringes Apprvd							21
22	I&R Services-Other Prgm Costs Apprvd							22
23	Paramed Ed Prgm-(specify)							23
	INPATIENT ROUTINE SERV COST CENTERS							
30	Adults & Pediatrics	34,586	6,674	3,301	1,036	19,559	195	30
31	Intensive Care Unit	320	1,838	120	132	1,556	15	31
44	Skilled Nursing Facility	29,518	4,773	10,943	1,359	19,008		44
46	Other Long Term Care	36,896	8,199	28,338	1,699	23,759		46
	ANCILLARY SERVICE COST CENTERS							
50	Operating Room	24,157	7,836		797	14,871	808	50
51	Recovery Room	2,029	320		701	10,234		51
53	Anesthesiology				473	2,317		53
54	Radiology-Diagnostic	9,423	2,285		891		5,731	54
60	Laboratory		1,527		854			60
60.01	BLOOD LABORATORY							60.01
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
65	Respiratory Therapy		1,290		287			65
66	Physical Therapy	2,865	3,611		271		60	66
67	Occupational Therapy				152			67
68	Speech Pathology							68
71	Medical Supplies Charged to Patients				152			71
72	Impl. Dev. Charged to Patients							72
73	Drugs Charged to Patients		540		223			73
76.97	CARDIAC REHABILITATION	43	500		101		263	76.97
76.98	HYPERBARIC OXYGEN THERAPY							76.98
76.99	LITHOTRIPSY							76.99
	OUTPATIENT SERVICE COST CENTERS							
91	Emergency	14,707	1,453	310	1,219	15,360	223	91
92	Observation Beds (Non-Distinct Part)							92
	OTHER REIMBURSABLE COST CENTERS							
99.10	CORF							99.10
	SPECIAL PURPOSE COST CENTERS							
118	SUBTOTALS (sum of lines 1-117)	154,544	46,782	54,350	11,347	106,664	7,295	118
	NONREIMBURSABLE COST CENTERS							
192	Physicians' Private Offices	663	6,464					192
200	Cross foot adjustments							200
201	Negative cost centers							201
202	Cost to be allocated (Per Wkst. B, Part I)	40,109	384,148	845,359	242,217	1,394,535	589,121	202
203	Unit Cost Multiplier (Wkst. B, Part I)	0.258423	7.214589	15.553983	21.346347	13.074092	80.756820	203
204	Cost to be allocated (Per Wkst. B, Part II)	20,347	15,038	80,570	44,927	36,875	44,930	204
205	Unit Cost Multiplier (Wkst. B, Part II)	0.131096	0.282425	1.482429	3.959373	0.345712	6.159013	205

HARVARD MEMORIAL HOSPITAL Provider CCN: 14-1335	In Lieu of Form **CMS-2552-10**	Period : From: 07/01/2016 To: 06/30/2017	Run Date: 11/28/2017 Run Time: 09:16 Version: 2017.10 (11/19/2017)

COST ALLOCATION - STATISTICAL BASIS **WORKSHEET B-1**

	COST CENTER DESCRIPTIONS							

	GENERAL SERVICE COST CENTERS							
1	Cap Rel Costs-Bldg & Fixt							1
2	Cap Rel Costs-Mvble Equip							2
4	Employee Benefits Department							4
5	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
	INPATIENT ROUTINE SERV COST CENTERS							
30	Adults & Pediatrics							30
31	Intensive Care Unit							31
44	Skilled Nursing Facility							44
46	Other Long Term Care							46
	ANCILLARY SERVICE COST CENTERS							
50	Operating Room							50
51	Recovery Room							51
53	Anesthesiology							53
54	Radiology-Diagnostic							54
60	Laboratory							60
60.01	BLOOD LABORATORY							60.01
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
65	Respiratory Therapy							65
66	Physical Therapy							66
67	Occupational Therapy							67
68	Speech Pathology							68
71	Medical Supplies Charged to Patients							71
72	Impl. Dev. Charged to Patients							72
73	Drugs Charged to Patients							73
76.97	CARDIAC REHABILITATION							76.97
76.98	HYPERBARIC OXYGEN THERAPY							76.98
76.99	LITHOTRIPSY							76.99
	OUTPATIENT SERVICE COST CENTERS							
91	Emergency							91
92	Observation Beds (Non-Distinct Part)							92
	OTHER REIMBURSABLE COST CENTERS							
99.10	CORF							99.10
	SPECIAL PURPOSE COST CENTERS							
118	SUBTOTALS (sum of lines 1-117)							118
	NONREIMBURSABLE COST CENTERS							
192	Physicians' Private Offices							192
200	Cross foot adjustments							200
201	Negative cost centers							201
202	Cost to be allocated (Per Wkst. B, Part I)							202
203	Unit Cost Multiplier (Wkst. B, Part I)							203
204	Cost to be allocated (Per Wkst. B, Part II)							204
205	Unit Cost Multiplier (Wkst. B, Part II)							205

HARVARD MEMORIAL HOSPITAL Provider CCN: 14-1335	In Lieu of Form **CMS-2552-10**	Period : From: 07/01/2016 To: 06/30/2017	Run Date: 11/28/2017 Run Time: 09:16 Version: 2017.10 (11/19/2017)

POST STEPDOWN ADJUSTMENTS **WORKSHEET B-2**

		WORKSHEET			
	DESCRIPTION	PART	LINE NO.	AMOUNT	
	1	2	3	4	

HARVARD MEMORIAL HOSPITAL Provider CCN: 14-1335	In Lieu of Form **CMS-2552-10**	Period : From: 07/01/2016 To: 06/30/2017	Run Date: 11/28/2017 Run Time: 09:16 Version: 2017.10 (11/19/2017)

COMPUTATION OF RATIO OF COST TO CHARGES **WORKSHEET C**
PART I

				COSTS			
	COST CENTER DESCRIPTIONS	Total Cost (from Wkst. B, Part I, col. 26)	Therapy Limit Adj.	Total Costs	RCE Dis-allowance	Total Costs	
		1	2	3	4	5	
	INPATIENT ROUTINE SERVICE COST CENTERS						
30	Adults & Pediatrics	2,043,777		2,043,777		2,043,777	30
31	Intensive Care Unit	311,429		311,429		311,429	31
44	Skilled Nursing Facility	2,042,299		2,042,299		2,042,299	44
46	Other Long Term Care	2,283,218		2,283,218		2,283,218	46
	ANCILLARY SERVICE COST CENTERS						
50	Operating Room	2,564,478		2,564,478		2,564,478	50
51	Recovery Room	1,110,305		1,110,305		1,110,305	51
53	Anesthesiology	333,568		333,568		333,568	53
54	Radiology-Diagnostic	2,472,011		2,472,011		2,472,011	54
60	Laboratory	1,597,111		1,597,111		1,597,111	60
60.01	BLOOD LABORATORY						60.01
62.30	BLOOD CLOTTING FOR HEMOPHILIACS						62.30
65	Respiratory Therapy	446,405		446,405		446,405	65
66	Physical Therapy	688,403		688,403		688,403	66
67	Occupational Therapy	207,140		207,140		207,140	67
68	Speech Pathology	13,061		13,061		13,061	68
71	Medical Supplies Charged to Patients	721,561		721,561		721,561	71
72	Impl. Dev. Charged to Patients	355,278		355,278		355,278	72
73	Drugs Charged to Patients	1,059,088		1,059,088		1,059,088	73
76.97	CARDIAC REHABILITATION	142,294		142,294		142,294	76.97
76.98	HYPERBARIC OXYGEN THERAPY						76.98
76.99	LITHOTRIPSY						76.99
	OUTPATIENT SERVICE COST CENTERS						
91	Emergency	3,545,472		3,545,472		3,545,472	91
92	Observation Beds (Non-Distinct Part)	397,731		397,731		397,731	92
	OTHER REIMBURSABLE COST CENTERS						
99.10	CORF						99.10
200	Subtotal (sum of lines 30 thru 199)	22,334,629		22,334,629		22,334,629	200
201	Less Observation Beds	397,731		397,731		397,731	201
202	Total (line 200 minus line 201)	21,936,898		21,936,898		21,936,898	202

HARVARD MEMORIAL HOSPITAL Provider CCN: 14-1335	In Lieu of Form **CMS-2552-10**	Period : From: 07/01/2016 To: 06/30/2017	Run Date: 11/28/2017 Run Time: 09:16 Version: 2017.10 (11/19/2017)

COMPUTATION OF RATIO OF COST TO CHARGES

WORKSHEET C
PART I

		CHARGES						
	COST CENTER DESCRIPTIONS	Inpatient	Outpatient	Total (column 6 + column 7)	Cost or Other Ratio	TEFRA Inpatient Ratio	PPS Inpatient Ratio	
		6	7	8	9	10	11	
	INPATIENT ROUTINE SERVICE COST CENTERS							
30	Adults & Pediatrics	3,166,741		3,166,741				30
31	Intensive Care Unit	276,440		276,440				31
44	Skilled Nursing Facility	910,638		910,638				44
46	Other Long Term Care	1,138,258		1,138,258				46
	ANCILLARY SERVICE COST CENTERS							
50	Operating Room	2,088,919	13,864,181	15,953,100	0.160751	0.160751	0.160751	50
51	Recovery Room	210,641	2,978,530	3,189,171	0.348148	0.348148	0.348148	51
53	Anesthesiology		104,168	104,168	3.202212	3.202212	3.202212	53
54	Radiology-Diagnostic	927,865	10,131,177	11,059,042	0.223528	0.223528	0.223528	54
60	Laboratory	824,151	3,879,124	4,703,275	0.339574	0.339574	0.339574	60
60.01	BLOOD LABORATORY							60.01
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
65	Respiratory Therapy	64,229	1,218,771	1,283,000	0.347938	0.347938	0.347938	65
66	Physical Therapy	615,555	1,031,315	1,646,870	0.418007	0.418007	0.418007	66
67	Occupational Therapy	456,585		456,585	0.453672	0.453672	0.453672	67
68	Speech Pathology	29,246		29,246	0.446591	0.446591	0.446591	68
71	Medical Supplies Charged to Patients	755,702	2,418,867	3,174,569	0.227294	0.227294	0.227294	71
72	Impl. Dev. Charged to Patients	606,005	746,920	1,352,925	0.262600	0.262600	0.262600	72
73	Drugs Charged to Patients	1,495,363	3,473,812	4,969,175	0.213132	0.213132	0.213132	73
76.97	CARDIAC REHABILITATION		219,738	219,738	0.647562	0.647562	0.647562	76.97
76.98	HYPERBARIC OXYGEN THERAPY							76.98
76.99	LITHOTRIPSY							76.99
	OUTPATIENT SERVICE COST CENTERS							
91	Emergency	193,421	3,894,622	4,088,043	0.867279	0.867279	0.867279	91
92	Observation Beds (Non-Distinct Part)	24,681	490,072	514,753	0.772664	0.772664	0.772664	92
	OTHER REIMBURSABLE COST CENTERS							
99.10	CORF							99.10
200	Subtotal (sum of lines 30 thru 199)	13,784,440	44,451,297	58,235,737				200
201	Less Observation Beds							201
202	Total (line 200 minus line 201)	13,784,440	44,451,297	58,235,737				202

APPORTIONMENT OF MEDICAL AND OTHER HEALTH SERVICE COSTS **COMPONENT CCN: 14-1335** **WORKSHEET D PART V**

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

			Program Charges			Program Cost			
		Cost to Charge Ratio (from Wkst C, Part I, col. 9)	PPS Reim-bursed Services (see inst.)	Cost Reim-bursed Subject to Ded. & Coins. (see inst.)	Cost Reim-bursed Not Subject to Ded. & Coins. (see inst.)	PPS Services (see inst.)	Cost Reim-bursed Subject to Ded. & Coins. (see inst.)	Cost Reim-bursed Not Subject to Ded. & Coins. (see inst.)	
(A)	Cost Center Description	1	2	3	4	5	6	7	
	ANCILLARY SERVICE COST CENTERS								
50	Operating Room	0.160751		3,329,425			535,208		50
51	Recovery Room	0.348148		681,944			237,417		51
53	Anesthesiology	3.202212		84,596			270,894		53
54	Radiology-Diagnostic	0.223528		2,759,814			616,896		54
60	Laboratory	0.339574		1,094,152			371,546		60
60.01	BLOOD LABORATORY								60.01
62.30	BLOOD CLOTTING FOR HEMOPHILIACS								62.30
65	Respiratory Therapy	0.347938		355,896			123,830		65
66	Physical Therapy	0.418007		286,136			119,607		66
67	Occupational Therapy	0.453672							67
68	Speech Pathology	0.446591							68
71	Medical Supplies Charged to Pat	0.227294		725,741			164,957		71
72	Impl. Dev. Charged to Patients	0.262600		190,612			50,055		72
73	Drugs Charged to Patients	0.213132		1,084,676	4,589		231,179	978	73
76.97	CARDIAC REHABILITATION	0.647562		148,481			96,151		76.97
76.98	HYPERBARIC OXYGEN THERAPY								76.98
76.99	LITHOTRIPSY								76.99
	OUTPATIENT SERVICE COST CENTERS								
91	Emergency	0.867279		1,096,556			951,020		91
92	Observation Beds (Non-Distinct	0.772664		201,687			155,836		92
	OTHER REIMBURSABLE COST CENTERS								
200	Subtotal (see instructions)			12,039,716	4,589		3,924,596	978	200
201	Less PBP Clinic Lab. Services-Program Only Charges								201
202	Net Charges (line 200 - line 201)			12,039,716	4,589		3,924,596	978	202

(A) Worksheet A line numbers

HARVARD MEMORIAL HOSPITAL Provider CCN: 14-1335	In Lieu of Form **CMS-2552-10**	Period : From: 07/01/2016 To: 06/30/2017	Run Date: 11/28/2017 Run Time: 09:16 Version: 2017.10 (11/19/2017)

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS **COMPONENT CCN: 14-6014** **WORKSHEET D PART IV**

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

		Non Physician Anesth-etist 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)	
(A)	Cost Center Description	1	2	3	4	5	6	
	ANCILLARY SERVICE COST CENTERS							
50	Operating Room							50
51	Recovery Room							51
53	Anesthesiology							53
54	Radiology-Diagnostic							54
60	Laboratory							60
60.01	BLOOD LABORATORY							60.01
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
65	Respiratory Therapy							65
66	Physical Therapy							66
67	Occupational Therapy							67
68	Speech Pathology							68
71	Medical Supplies Charged to Pat							71
72	Impl. Dev. Charged to Patients							72
73	Drugs Charged to Patients							73
76.97	CARDIAC REHABILITATION							76.97
76.98	HYPERBARIC OXYGEN THERAPY							76.98
76.99	LITHOTRIPSY							76.99
	OUTPATIENT SERVICE COST CENTERS							
91	Emergency							91
92	Observation Beds (Non-Distinct							92
	OTHER REIMBURSABLE COST CENTERS							
200	Total (sum of lines 50-199)							200

(A) Worksheet A line numbers

HARVARD MEMORIAL HOSPITAL Provider CCN: 14-1335	In Lieu of Form **CMS-2552-10**	Period : From: 07/01/2016 To: 06/30/2017	Run Date: 11/28/2017 Run Time: 09:16 Version: 2017.10 (11/19/2017)

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS | **COMPONENT CCN: 14-6014** | **WORKSHEET D PART IV**

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

		Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 5÷ col. 7)	Outpatient Ratio of Cost to Charges (col. 6÷ col. 7)	Inpatient Program Charges	Inpatient Program Pass-Through Costs (col. 8 x col. 10)	Outpatient Program Charges	Outpatient Program Pass-Through Costs (col. 9 x col. 12)	
(A)	Cost Center Description	7	8	9	10	11	12	13	
	ANCILLARY SERVICE COST CENTERS								
50	Operating Room	15,953,100							50
51	Recovery Room	3,189,171							51
53	Anesthesiology	104,168							53
54	Radiology-Diagnostic	11,059,042			29,009				54
60	Laboratory	4,703,275			46,873				60
60.01	BLOOD LABORATORY								60.01
62.30	BLOOD CLOTTING FOR HEMOPHILIACS								62.30
65	Respiratory Therapy	1,283,000							65
66	Physical Therapy	1,646,870			430,581				66
67	Occupational Therapy	456,585			384,374				67
68	Speech Pathology	29,246			24,189				68
71	Medical Supplies Charged to Pat	3,174,569			32,961				71
72	Impl. Dev. Charged to Patients	1,352,925							72
73	Drugs Charged to Patients	4,969,175			78,243				73
76.97	CARDIAC REHABILITATION	219,738							76.97
76.98	HYPERBARIC OXYGEN THERAPY								76.98
76.99	LITHOTRIPSY								76.99
	OUTPATIENT SERVICE COST CENTERS								
91	Emergency	4,088,043							91
92	Observation Beds (Non-Distinct	514,753							92
	OTHER REIMBURSABLE COST CENTERS								
200	Total (sum of lines 50-199)	52,743,660			1,026,230				200

(A) Worksheet A line numbers

HARVARD MEMORIAL HOSPITAL Provider CCN: 14-1335	In Lieu of Form **CMS-2552-10**	Period : From: 07/01/2016 To: 06/30/2017	Run Date: 11/28/2017 Run Time: 09:16 Version: 2017.10 (11/19/2017)

APPORTIONMENT OF MEDICAL AND OTHER HEALTH SERVICE COSTS **COMPONENT CCN: 14-6014** **WORKSHEET D PART V**

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

			Program Charges			Program Cost			
		Cost to Charge Ratio (from Wkst C, Part I, col. 9)	PPS Reim-bursed Services (see inst.)	Cost Reim-bursed Subject to Ded. & Coins. (see inst.)	Cost Reim-bursed Not Subject to Ded. & Coins. (see inst.)	PPS Services (see inst.)	Cost Reim-bursed Subject to Ded. & Coins. (see inst.)	Cost Reim-bursed Not Subject to Ded. & Coins. (see inst.)	
(A)	Cost Center Description	1	2	3	4	5	6	7	
	ANCILLARY SERVICE COST CENTERS								
50	Operating Room	0.160751							50
51	Recovery Room	0.348148							51
53	Anesthesiology	3.202212							53
54	Radiology-Diagnostic	0.223528							54
60	Laboratory	0.339574							60
60.01	BLOOD LABORATORY								60.01
62.30	BLOOD CLOTTING FOR HEMOPHILIACS								62.30
65	Respiratory Therapy	0.347938							65
66	Physical Therapy	0.418007							66
67	Occupational Therapy	0.453672							67
68	Speech Pathology	0.446591							68
71	Medical Supplies Charged to Pat	0.227294							71
72	Impl. Dev. Charged to Patients	0.262600							72
73	Drugs Charged to Patients	0.213132			866			185	73
76.97	CARDIAC REHABILITATION	0.647562							76.97
76.98	HYPERBARIC OXYGEN THERAPY								76.98
76.99	LITHOTRIPSY								76.99
	OUTPATIENT SERVICE COST CENTERS								
91	Emergency	0.867279							91
92	Observation Beds (Non-Distinct	0.772664							92
	OTHER REIMBURSABLE COST CENTERS								
200	Subtotal (see instructions)				866			185	200
201	Less PBP Clinic Lab. Services-Program Only Charges								201
202	Net Charges (line 200 - line 201)				866			185	202

(A) Worksheet A line numbers

HARVARD MEMORIAL HOSPITAL Provider CCN: 14-1335	In Lieu of Form **CMS-2552-10**	Period : From: 07/01/2016 To: 06/30/2017	Run Date: 11/28/2017 Run Time: 09:16 Version: 2017.10 (11/19/2017)

APPORTIONMENT OF INPATIENT ROUTINE SERVICE CAPITAL COSTS

WORKSHEET D
PART I

Check Applicable Boxes:
[ ] Title V
[ ] Title XVIII, Part A
[XX] Title XIX

		Capital Related Cost (from Wkst. B, Part II, (col. 26)	Swing Bed Adjust-ment	Reduced Capital Related Cost (col. 1 minus col. 2)	Total Patient Days	Per Diem (col. 3 ÷ col. 4)	Inpatient Program Days	Inpatient Program Capital Cost (col. 5 x col. 6)	
(A)	Cost Center Description	1	2	3	4	5	6	7	
	INPATIENT ROUTINE SERVICE COST CENTERS								
30	Adults & Pediatrics General Routine Care)	198,521		198,521	1,372	144.69	13	1,881	30
31	Intensive Care Unit	43,450		43,450	43	1,010.47	1	1,010	31
32	Coronary Care Unit								32
33	Burn Intensive Care Unit								33
34	Surgical Intensive Care Unit								34
35	Other Special Care (specify)								35
40	Subprovider - IPF								40
41	Subprovider - IRF								41
42	Subprovider I								42
43	Nursery								43
44	Skilled Nursing Facility	169,088		169,088	2,510	67.37			44
45	Nursing Facility								45
200	Total (lines 30-199)	411,059		411,059	3,925		14	2,891	200

(A) Worksheet A line numbers

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS **COMPONENT CCN: 14-1335** **WORKSHEET D PART II**

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

		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	456,486	15,953,100	0.028614			50
51	Recovery Room	32,152	3,189,171	0.010082			51
53	Anesthesiology	15,981	104,168	0.153416			53
54	Radiology-Diagnostic	348,937	11,059,042	0.031552			54
60	Laboratory	75,374	4,703,275	0.016026			60
60.01	BLOOD LABORATORY						60.01
62.30	BLOOD CLOTTING FOR HEMOPHILIACS						62.30
65	Respiratory Therapy	49,207	1,283,000	0.038353			65
66	Physical Therapy	88,196	1,646,870	0.053554			66
67	Occupational Therapy	3,251	456,585	0.007120			67
68	Speech Pathology	170	29,246	0.005813			68
71	Medical Supplies Charged to Pat	33,101	3,174,569	0.010427			71
72	Impl. Dev. Charged to Patients	4,598	1,352,925	0.003399			72
73	Drugs Charged to Patients	82,509	4,969,175	0.016604			73
76.97	CARDIAC REHABILITATION	22,774	219,738	0.103642			76.97
76.98	HYPERBARIC OXYGEN THERAPY						76.98
76.99	LITHOTRIPSY						76.99
	OUTPATIENT SERVICE COST CENTERS						
91	Emergency	96,997	4,088,043	0.023727			91
92	Observation Beds (Non-Distinct	38,633	514,753	0.075052			92
	OTHER REIMBURSABLE COST CENTERS						
200	Total (sum of lines 50-199)	1,348,366	52,743,660				200

(A) Worksheet A line numbers

HARVARD MEMORIAL HOSPITAL Provider CCN: 14-1335	In Lieu of Form **CMS-2552-10**	Period : From: 07/01/2016 To: 06/30/2017	Run Date: 11/28/2017 Run Time: 09:16 Version: 2017.10 (11/19/2017)

APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PASS THROUGH COSTS

WORKSHEET D
PART III

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

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

(A) Worksheet A line numbers

HARVARD MEMORIAL HOSPITAL Provider CCN: 14-1335	In Lieu of Form **CMS-2552-10**	Period : From: 07/01/2016 To: 06/30/2017	Run Date: 11/28/2017 Run Time: 09:16 Version: 2017.10 (11/19/2017)

APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PASS THROUGH COSTS

WORKSHEET D
PART III

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

		Total Patient Days	Per Diem (col. 5÷ col. 6)	Inpatient Program Days	Inpatient Program Pass-Through Cost (col. 7 x col. 8)	
(A)	Cost Center Description	6	7	8	9	
	INPATIENT ROUTINE SERVICE COST CENTERS					
30	Adults & Pediatrics (General Routine Care)	1,372		13		30
31	Intensive Care Unit	43		1		31
32	Coronary Care Unit					32
33	Burn Intensive Care Unit					33
34	Surgical Intensive Care Unit					34
35	Other Special Care (specify)					35
40	Subprovider - IPF					40
41	Subprovider - IRF					41
42	Subprovider I					42
43	Nursery					43
44	Skilled Nursing Facility	2,510				44
45	Nursing Facility					45
200	Total (lines 30-199)	3,925		14		200

(A) Worksheet A line numbers

HARVARD MEMORIAL HOSPITAL Provider CCN: 14-1335	In Lieu of Form **CMS-2552-10**	Period : From: 07/01/2016 To: 06/30/2017	Run Date: 11/28/2017 Run Time: 09:16 Version: 2017.10 (11/19/2017)

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS | **COMPONENT CCN: 14-1335** | **WORKSHEET D PART IV**

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

		Non Physician Anesth-etist 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)	
(A)	Cost Center Description	1	2	3	4	5	6	
	ANCILLARY SERVICE COST CENTERS							
50	Operating Room							50
51	Recovery Room							51
53	Anesthesiology							53
54	Radiology-Diagnostic							54
60	Laboratory							60
60.01	BLOOD LABORATORY							60.01
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
65	Respiratory Therapy							65
66	Physical Therapy							66
67	Occupational Therapy							67
68	Speech Pathology							68
71	Medical Supplies Charged to Pat							71
72	Impl. Dev. Charged to Patients							72
73	Drugs Charged to Patients							73
76.97	CARDIAC REHABILITATION							76.97
76.98	HYPERBARIC OXYGEN THERAPY							76.98
76.99	LITHOTRIPSY							76.99
	OUTPATIENT SERVICE COST CENTERS							
91	Emergency							91
92	Observation Beds (Non-Distinct							92
	OTHER REIMBURSABLE COST CENTERS							
200	Total (sum of lines 50-199)							200

(A) Worksheet A line numbers

HARVARD MEMORIAL HOSPITAL Provider CCN: 14-1335	In Lieu of Form **CMS-2552-10**	Period : From: 07/01/2016 To: 06/30/2017	Run Date: 11/28/2017 Run Time: 09:16 Version: 2017.10 (11/19/2017)

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS | **COMPONENT CCN: 14-1335** | **WORKSHEET D PART IV**

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

		Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 5÷ col. 7)	Outpatient Ratio of Cost to Charges (col. 6÷ col. 7)	Inpatient Program Charges	Inpatient Program Pass-Through Costs (col. 8 x col. 10)	Outpatient Program Charges	Outpatient Program Pass-Through Costs (col. 9 x col. 12)	
(A)	Cost Center Description	7	8	9	10	11	12	13	
	ANCILLARY SERVICE COST CENTERS								
50	Operating Room	15,953,100							50
51	Recovery Room	3,189,171							51
53	Anesthesiology	104,168							53
54	Radiology-Diagnostic	11,059,042							54
60	Laboratory	4,703,275							60
60.01	BLOOD LABORATORY								60.01
62.30	BLOOD CLOTTING FOR HEMOPHILIACS								62.30
65	Respiratory Therapy	1,283,000							65
66	Physical Therapy	1,646,870							66
67	Occupational Therapy	456,585							67
68	Speech Pathology	29,246							68
71	Medical Supplies Charged to Pat	3,174,569							71
72	Impl. Dev. Charged to Patients	1,352,925							72
73	Drugs Charged to Patients	4,969,175							73
76.97	CARDIAC REHABILITATION	219,738							76.97
76.98	HYPERBARIC OXYGEN THERAPY								76.98
76.99	LITHOTRIPSY								76.99
	OUTPATIENT SERVICE COST CENTERS								
91	Emergency	4,088,043							91
92	Observation Beds (Non-Distinct	514,753							92
	OTHER REIMBURSABLE COST CENTERS								
200	Total (sum of lines 50-199)	52,743,660							200

(A) Worksheet A line numbers

HARVARD MEMORIAL HOSPITAL Provider CCN: 14-1335	In Lieu of Form **CMS-2552-10**	Period : From: 07/01/2016 To: 06/30/2017	Run Date: 11/28/2017 Run Time: 09:16 Version: 2017.10 (11/19/2017)

APPORTIONMENT OF MEDICAL AND OTHER HEALTH SERVICE COSTS **COMPONENT CCN: 14-1335** **WORKSHEET D PART V**

Check Applicable Boxes:

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

			Program Charges			Program Cost			
		Cost to Charge Ratio (from Wkst C, Part I, col. 9)	PPS Reim-bursed Services (see inst.)	Cost Reim-bursed Subject to Ded. & Coins. (see inst.)	Cost Reim-bursed Not Subject to Ded. & Coins. (see inst.)	PPS Services (see inst.)	Cost Reim-bursed Subject to Ded. & Coins. (see inst.)	Cost Reim-bursed Not Subject to Ded. & Coins. (see inst.)	
(A)	Cost Center Description	1	2	3	4	5	6	7	
	ANCILLARY SERVICE COST CENTERS								
50	Operating Room	0.160751							50
51	Recovery Room	0.348148							51
53	Anesthesiology	3.202212							53
54	Radiology-Diagnostic	0.223528							54
60	Laboratory	0.339574							60
60.01	BLOOD LABORATORY								60.01
62.30	BLOOD CLOTTING FOR HEMOPHILIACS								62.30
65	Respiratory Therapy	0.347938							65
66	Physical Therapy	0.418007							66
67	Occupational Therapy	0.453672							67
68	Speech Pathology	0.446591							68
71	Medical Supplies Charged to Pat	0.227294							71
72	Impl. Dev. Charged to Patients	0.262600							72
73	Drugs Charged to Patients	0.213132							73
76.97	CARDIAC REHABILITATION	0.647562							76.97
76.98	HYPERBARIC OXYGEN THERAPY								76.98
76.99	LITHOTRIPSY								76.99
	OUTPATIENT SERVICE COST CENTERS								
91	Emergency	0.867279							91
92	Observation Beds (Non-Distinct	0.772664							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

HARVARD MEMORIAL HOSPITAL Provider CCN: 14-1335	In Lieu of Form **CMS-2552-10**	Period : From: 07/01/2016 To: 06/30/2017	Run Date: 11/28/2017 Run Time: 09:16 Version: 2017.10 (11/19/2017)

COMPUTATION OF INPATIENT OPERATING COST **COMPONENT CCN: 14-1335** **WORKSHEET D-1 PART I**

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

PART I - ALL PROVIDER COMPONENTS

	INPATIENT DAYS		
1	Inpatient days (including private room days and swing-bed days, excluding newborn)	1,372	1
2	Inpatient days (including private room days, excluding swing-bed and newborn days)	1,372	2
3	Private room days (excluding swing-bed private room days). If you have only private room days, do not complete this line.		3
4	Semi-private room days (excluding swing-bed private room days)	1,105	4
5	Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost reporting period		5
6	Total swing-bed SNF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		6
7	Total swing-bed NF type inpatient days (including private room days) through December 31 of the cost reporting period		7
8	Total swing-bed NF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		8
9	Total inpatient days including private room days applicable to the Program (excluding swing-bed and newborn days)	651	9
10	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) through December 31 of the cost reporting period (see instructions)		10
11	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		11
12	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) through December 31 of the cost reporting period		12
13	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		13
14	Medically necessary private room days applicable to the program (excluding swing-bed days)		14
15	Total nursery days (title V or XIX only)		15
16	Nursery days (title V or XIX only)		16
	SWING-BED ADJUSTMENT		
17	Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost reporting period		17
18	Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period		18
19	Medicaid rate for swing-bed NF services applicable to services through December 31 of the cost reporting period		19
20	Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period		20
21	Total general inpatient routine service cost (see instructions)	2,043,777	21
22	Swing-bed cost applicable to SNF type services through December 31 of the cost reporting period (line 5 x line 17)		22
23	Swing-bed cost applicable to SNF type services after December 31 of the cost reporting period (line 6 x line 18)		23
24	Swing-bed cost applicable to NF type services through December 31 of the cost reporting period (line 7 x line 19)		24
25	Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8 x line 20)		25
26	Total swing-bed cost (see instructions)		26
27	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)	2,043,777	27
	PRIVATE ROOM DIFFERENTIAL ADJUSTMENT		
28	General inpatient routine service charges (excluding swing-bed and observation bed charges)		28
29	Private room charges (excluding swing-bed charges)		29
30	Semi-private room charges (excluding swing-bed charges)		30
31	General inpatient routine service cost/charge ratio (line 27 ÷ line 28)		31
32	Average private room per diem charge (line 29 ÷ line 3)		32
33	Average semi-private room per diem charge (line 30 ÷ line 4)		33
34	Average per diem private room charge differential (line 32 minus line 33) (see instructions)		34
35	Average per diem private room cost differential (line 34 x line 31)		35
36	Private room cost differential adjustment (line 3 x line 35)		36
37	General inpatient routine service cost net of swing-bed cost and private room cost differential (line 27 minus line 36)	2,043,777	37

COMPUTATION OF INPATIENT OPERATING COST **COMPONENT CCN: 14-1335** **WORKSHEET D-1 PART II**

Check Applicable Boxes: **[ ] Title V - I/P** **[XX] Title XVIII, Part A** **[ ] Title XIX - I/P** **[XX] Hospital** **[ ] IPF** **[ ] IRF** **[ ] SUB (Other)** **[ ] PPS** **[ ] TEFRA** **[XX] 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)					1,489.63	38
39	Program general inpatient routine service cost (line 9 x line 38)					969,749	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)					969,749	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	311,429	43	7,242.53	25	181,063	43
44	Coronary Care Unit						44
45	Burn Intensive Care Unit						45
46	Surgical Intensive Care Unit						46
47	Other Special Care (specify)						47
						1	
48	Program inpatient ancillary service cost (Wkst. D-3, col. 3, line 200)					773,675	48
49	Total program inpatient costs (sum of lines 41 through 48)(see instructions)					1,924,487	49

PASS THROUGH COST ADJUSTMENTS

50	Pass through costs applicable to Program inpatient routine services (from Wkst. D, sum of Parts I and III)		50
51	Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)		51
52	Total Program excludable cost (sum of lines 50 and 51)		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 etner 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

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

PART IV - COMPUTATION OF OBSERVATION BED PASS-THROUGH COST

87	Total observation bed days (see instructions)					267	87
88	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)					1,489.63	88
89	Observation bed cost (line 87 x line 88) (see instructions)					397,731	89
		Cost	Routine Cost (from line 21)	col. 1÷col. 2	Total Observation Bed Cost (from line 89)	Observation Bed Pass Through Cost col. 3 x col. 4) (see instructions)	
		1	2	3	4	5	
90	Capital-related cost	198,521	2,043,777	0.097134	397,731	38,633	90
91	Nursing School						91
92	Allied Health						92
93	Other Medical Education						93

HARVARD MEMORIAL HOSPITAL Provider CCN: 14-1335	In Lieu of Form **CMS-2552-10**	Period : From: 07/01/2016 To: 06/30/2017	Run Date: 11/28/2017 Run Time: 09:16 Version: 2017.10 (11/19/2017)

COMPUTATION OF INPATIENT OPERATING COST **COMPONENT CCN: 14-6014** **WORKSHEET D-1**
PART I

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

PART I - ALL PROVIDER COMPONENTS

	INPATIENT DAYS		
1	Inpatient days (including private room days and swing-bed days, excluding newborn)	2,510	1
2	Inpatient days (including private room days, excluding swing-bed and newborn days)	2,510	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)	2,510	4
5	Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost reporting period		5
6	Total swing-bed SNF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		6
7	Total swing-bed NF type inpatient days (including private room days) through December 31 of the cost reporting period		7
8	Total swing-bed NF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		8
9	Total inpatient days including private room days applicable to the Program (excluding swing-bed and newborn days)	1,935	9
10	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) through December 31 of the cost reporting period (see instructions)		10
11	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		11
12	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) through December 31 of the cost reporting period		12
13	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		13
14	Medically necessary private room days applicable to the program (excluding swing-bed days)		14
15	Total nursery days (title V or XIX only)		15
16	Nursery days (title V or XIX only)		16
	SWING-BED ADJUSTMENT		
17	Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost reporting period		17
18	Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period		18
19	Medicaid rate for swing-bed NF services applicable to services through December 31 of the cost reporting period		19
20	Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period		20
21	Total general inpatient routine service cost (see instructions)	2,042,299	21
22	Swing-bed cost applicable to SNF type services through December 31 of the cost reporting period (line 5 x line 17)		22
23	Swing-bed cost applicable to SNF type services after December 31 of the cost reporting period (line 6 x line 18)		23
24	Swing-bed cost applicable to NF type services through December 31 of the cost reporting period (line 7 x line 19)		24
25	Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8 x line 20)		25
26	Total swing-bed cost (see instructions)		26
27	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)	2,042,299	27
	PRIVATE ROOM DIFFERENTIAL ADJUSTMENT		
28	General inpatient routine service charges (excluding swing-bed and observation bed charges)		28
29	Private room charges (excluding swing-bed charges)		29
30	Semi-private room charges (excluding swing-bed charges)		30
31	General inpatient routine service cost/charge ratio (line 27 ÷ line 28)		31
32	Average private room per diem charge (line 29 ÷ line 3)		32
33	Average semi-private room per diem charge (line 30 ÷ line 4)		33
34	Average per diem private room charge differential (line 32 minus line 33) (see instructions)		34
35	Average per diem private room cost differential (line 34 x line 31)		35
36	Private room cost differential adjustment (line 3 x line 35)		36
37	General inpatient routine service cost net of swing-bed cost and private room cost differential (line 27 minus line 36)	2,042,299	37

HARVARD MEMORIAL HOSPITAL Provider CCN: 14-1335	In Lieu of Form **CMS-2552-10**	Period : From: 07/01/2016 To: 06/30/2017	Run Date: 11/28/2017 Run Time: 09:16 Version: 2017.10 (11/19/2017)

COMPUTATION OF INPATIENT OPERATING COST **COMPONENT CCN: 14-6014** **WORKSHEET D-1**
PARTS III & IV

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

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

70	Skilled nursing facility/other nursing facility/ICF/IID routine service cost (line 37)	2,042,299	70
71	Adjusted general inpatient routine service cost per diem (line 70 ÷ line 2)	813.66	71
72	Program routine service cost (line 9 x line 71)	1,574,432	72
73	Medically necessary private room cost applicable to Program (line 14 x line 35)		73
74	Total Program general inpatient routine service costs (line 72 + line 73)	1,574,432	74
75	Capital-related cost allocated to inpatient routine service costs (from Worksheet B, Part II, column 26)		75
76	Per diem capital-related costs (line 75 ÷ line 2)		76
77	Program capital-related costs (line 9 x line 76)		77
78	Inpatient routine service cost (line 74 minus line 77)		78
79	Aggregate charges to beneficiaries for excess costs (from provider records)		79
80	Total Program routine service costs for comparison to the cost limitation (line 78 minus line 79)		80
81	Inpatient routine service cost per diem limitation		81
82	Inpatient routine service cost limitation (line 9 x line 81)		82
83	Reasonable inpatient routine service costs (see instructions)	1,574,432	83
84	Program inpatient ancillary services (see instructions)	411,738	84
85	Utilization review - physician compensation (see instructions)		85
86	Total Program inpatient operating costs (sum of lines 83 through 85)	1,986,170	86

HARVARD MEMORIAL HOSPITAL Provider CCN: 14-1335	In Lieu of Form **CMS-2552-10**	Period : From: 07/01/2016 To: 06/30/2017	Run Date: 11/28/2017 Run Time: 09:16 Version: 2017.10 (11/19/2017)

COMPUTATION OF INPATIENT OPERATING COST **COMPONENT CCN: 14-1335** **WORKSHEET D-1 PART I**

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

PART I - ALL PROVIDER COMPONENTS

	INPATIENT DAYS		
1	Inpatient days (including private room days and swing-bed days, excluding newborn)	1,372	1
2	Inpatient days (including private room days, excluding swing-bed and newborn days)	1,372	2
3	Private room days (excluding swing-bed private room days). If you have only private room days, do not complete this line.		3
4	Semi-private room days (excluding swing-bed private room days)	1,105	4
5	Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost reporting period		5
6	Total swing-bed SNF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		6
7	Total swing-bed NF type inpatient days (including private room days) through December 31 of the cost reporting period		7
8	Total swing-bed NF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		8
9	Total inpatient days including private room days applicable to the Program (excluding swing-bed and newborn days)	13	9
10	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) through December 31 of the cost reporting period (see instructions)		10
11	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		11
12	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) through December 31 of the cost reporting period		12
13	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		13
14	Medically necessary private room days applicable to the program (excluding swing-bed days)		14
15	Total nursery days (title V or XIX only)		15
16	Nursery days (title V or XIX only)		16
	SWING-BED ADJUSTMENT		
17	Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost reporting period		17
18	Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period		18
19	Medicaid rate for swing-bed NF services applicable to services through December 31 of the cost reporting period		19
20	Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period		20
21	Total general inpatient routine service cost (see instructions)	2,043,777	21
22	Swing-bed cost applicable to SNF type services through December 31 of the cost reporting period (line 5 x line 17)		22
23	Swing-bed cost applicable to SNF type services after December 31 of the cost reporting period (line 6 x line 18)		23
24	Swing-bed cost applicable to NF type services through December 31 of the cost reporting period (line 7 x line 19)		24
25	Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8 x line 20)		25
26	Total swing-bed cost (see instructions)		26
27	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)	2,043,777	27
	PRIVATE ROOM DIFFERENTIAL ADJUSTMENT		
28	General inpatient routine service charges (excluding swing-bed and observation bed charges)		28
29	Private room charges (excluding swing-bed charges)		29
30	Semi-private room charges (excluding swing-bed charges)		30
31	General inpatient routine service cost/charge ratio (line 27 ÷ line 28)		31
32	Average private room per diem charge (line 29 ÷ line 3)		32
33	Average semi-private room per diem charge (line 30 ÷ line 4)		33
34	Average per diem private room charge differential (line 32 minus line 33) (see instructions)		34
35	Average per diem private room cost differential (line 34 x line 31)		35
36	Private room cost differential adjustment (line 3 x line 35)		36
37	General inpatient routine service cost net of swing-bed cost and private room cost differential (line 27 minus line 36)	2,043,777	37

COMPUTATION OF INPATIENT OPERATING COST **COMPONENT CCN: 14-1335** **WORKSHEET D-1 PART II**

Check Applicable Boxes: **[ ] Title V - I/P** **[XX] Hospital** **[ ] SUB (Other)** **[ ] PPS** **[ ] Title XVIII, Part A** **[ ] IPF** **[ ] TEFRA** **[XX] Title XIX - I/P** **[ ] IRF** **[XX] 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)	1,489.63	38
39	Program general inpatient routine service cost (line 9 x line 38)	19,365	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)	19,365	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	311,429	43	7,242.53	1	7,243	43
44	Coronary Care Unit						44
45	Burn Intensive Care Unit						45
46	Surgical Intensive Care Unit						46
47	Other Special Care (specify)						47

		1	
48	Program inpatient ancillary service cost (Wkst. D-3, col. 3, line 200)		48
49	Total program inpatient costs (sum of lines 41 through 48)(see instructions)	26,608	49

PASS THROUGH COST ADJUSTMENTS

50	Pass through costs applicable to Program inpatient routine services (from Wkst. D, sum of Parts I and III)	2,891	50
51	Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)		51
52	Total Program excludable cost (sum of lines 50 and 51)	2,891	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 etner 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

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

PART IV - COMPUTATION OF OBSERVATION BED PASS-THROUGH COST

87	Total observation bed days (see instructions)					267	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 21)	col. 1÷col. 2	Total Observation Bed Cost (from line 89)	Observation Bed Pass Through Cost col. 3 x col. 4) (see instructions)	
		1	2	3	4	5	
90	Capital-related cost						90
91	Nursing School						91
92	Allied Health						92
93	Other Medical Education						93

HARVARD MEMORIAL HOSPITAL Provider CCN: 14-1335	In Lieu of Form **CMS-2552-10**	Period : From: 07/01/2016 To: 06/30/2017	Run Date: 11/28/2017 Run Time: 09:16 Version: 2017.10 (11/19/2017)

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT **COMPONENT CCN: 14-1335** **WORKSHEET D-3**

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

		Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
(A)	COST CENTER DESCRIPTION	1	2	3	
	INPATIENT ROUTINE SERVICE COST CENTERS				
30	Adults & Pediatrics		1,880,256		30
31	Intensive Care Unit		162,685		31
	ANCILLARY SERVICE COST CENTERS				
50	Operating Room	0.160751	1,003,492	161,312	50
51	Recovery Room	0.348148	86,231	30,021	51
53	Anesthesiology	3.202212			53
54	Radiology-Diagnostic	0.223528	323,212	72,247	54
60	Laboratory	0.339574	343,893	116,777	60
60.01	BLOOD LABORATORY				60.01
62.30	BLOOD CLOTTING FOR HEMOPHILIACS				62.30
65	Respiratory Therapy	0.347938	45,042	15,672	65
66	Physical Therapy	0.418007	84,049	35,133	66
67	Occupational Therapy	0.453672			67
68	Speech Pathology	0.446591			68
71	Medical Supplies Charged to Patients	0.227294	444,339	100,996	71
72	Impl. Dev. Charged to Patients	0.262600	353,413	92,806	72
73	Drugs Charged to Patients	0.213132	677,198	144,333	73
76.97	CARDIAC REHABILITATION	0.647562			76.97
76.98	HYPERBARIC OXYGEN THERAPY				76.98
76.99	LITHOTRIPSY				76.99
	OUTPATIENT SERVICE COST CENTERS				
91	Emergency	0.867279	5,048	4,378	91
92	Observation Beds (Non-Distinct Part)	0.772664			92
	OTHER REIMBURSABLE COST CENTERS				
200	Total (sum of lines 50-94, and 96-98)		3,365,917	773,675	200
201	Less PBP Clinic Laboratory Services-Program only charges (line 61)				201
202	Net Charges (line 200 minus line 201)		3,365,917		202

(A) Worksheet A line numbers

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT **COMPONENT CCN: 14-6014** **WORKSHEET D-3**

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

(A)	COST CENTER DESCRIPTION	Ratio of Cost To Charges 1	Inpatient Program Charges 2	Inpatient Program Costs (col. 1 x col. 2) 3	
	INPATIENT ROUTINE SERVICE COST CENTERS				
30	Adults & Pediatrics				30
31	Intensive Care Unit				31
	ANCILLARY SERVICE COST CENTERS				
50	Operating Room	0.160751			50
51	Recovery Room	0.348148			51
53	Anesthesiology	3.202212			53
54	Radiology-Diagnostic	0.223528	29,009	6,484	54
60	Laboratory	0.339574	46,873	15,917	60
60.01	BLOOD LABORATORY				60.01
62.30	BLOOD CLOTTING FOR HEMOPHILIACS				62.30
65	Respiratory Therapy	0.347938			65
66	Physical Therapy	0.418007	430,581	179,986	66
67	Occupational Therapy	0.453672	384,374	174,380	67
68	Speech Pathology	0.446591	24,189	10,803	68
71	Medical Supplies Charged to Patients	0.227294	32,961	7,492	71
72	Impl. Dev. Charged to Patients	0.262600			72
73	Drugs Charged to Patients	0.213132	78,243	16,676	73
76.97	CARDIAC REHABILITATION	0.647562			76.97
76.98	HYPERBARIC OXYGEN THERAPY				76.98
76.99	LITHOTRIPSY				76.99
	OUTPATIENT SERVICE COST CENTERS				
91	Emergency	0.867279			91
92	Observation Beds (Non-Distinct Part)	0.772664			92
	OTHER REIMBURSABLE COST CENTERS				
200	Total (sum of lines 50-94, and 96-98)		1,026,230	411,738	200
201	Less PBP Clinic Laboratory Services-Program only charges (line 61)				201
202	Net Charges (line 200 minus line 201)		1,026,230		202

(A) Worksheet A line numbers

HARVARD MEMORIAL HOSPITAL Provider CCN: 14-1335	In Lieu of Form **CMS-2552-10**	Period : From: 07/01/2016 To: 06/30/2017	Run Date: 11/28/2017 Run Time: 09:16 Version: 2017.10 (11/19/2017)

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT **COMPONENT CCN: 14-1335** **WORKSHEET D-3**

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

		Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
(A)	COST CENTER DESCRIPTION	1	2	3	
	INPATIENT ROUTINE SERVICE COST CENTERS				
30	Adults & Pediatrics				30
31	Intensive Care Unit				31
	ANCILLARY SERVICE COST CENTERS				
50	Operating Room	0.160751			50
51	Recovery Room	0.348148			51
53	Anesthesiology	3.202212			53
54	Radiology-Diagnostic	0.223528			54
60	Laboratory	0.339574			60
60.01	BLOOD LABORATORY				60.01
62.30	BLOOD CLOTTING FOR HEMOPHILIACS				62.30
65	Respiratory Therapy	0.347938			65
66	Physical Therapy	0.418007			66
67	Occupational Therapy	0.453672			67
68	Speech Pathology	0.446591			68
71	Medical Supplies Charged to Patients	0.227294			71
72	Impl. Dev. Charged to Patients	0.262600			72
73	Drugs Charged to Patients	0.213132			73
76.97	CARDIAC REHABILITATION	0.647562			76.97
76.98	HYPERBARIC OXYGEN THERAPY				76.98
76.99	LITHOTRIPSY				76.99
	OUTPATIENT SERVICE COST CENTERS				
91	Emergency	0.867279			91
92	Observation Beds (Non-Distinct Part)	0.772664			92
	OTHER REIMBURSABLE COST CENTERS				
200	Total (sum of lines 50-94, and 96-98)				200
201	Less PBP Clinic Laboratory Services-Program only charges (line 61)				201
202	Net Charges (line 200 minus line 201)				202

(A) Worksheet A line numbers

HARVARD MEMORIAL HOSPITAL Provider CCN: 14-1335	In Lieu of Form **CMS-2552-10**	Period : From: 07/01/2016 To: 06/30/2017	Run Date: 11/28/2017 Run Time: 09:16 Version: 2017.10 (11/19/2017)

CALCULATION OF REIMBURSEMENT SETTLEMENT **COMPONENT CCN: 14-1335** **WORKSHEET E PART B**

Check applicable box: [XX] 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)	3,925,574			1
2	Medical and other services reimbursed under OPPS (see instructions)				2
3	PPS payments				3
4	Outlier payment (see instructions)				4
5	Enter the hospital specific payment to cost ratio (see instructions)				5
6	Line 2 times line 5				6
7	Sum of line 3 and line 4 divided by line 6				7
8	Transitional corridor payment (see instructions)				8
9	Ancillary service other pass through costs from Wkst. D, Pt. IV, col. 13, line 200				9
10	Organ acquisition				10
11	Total cost (sum of lines 1 and 10) (see instructions)	3,925,574			11
	COMPUTATION OF LESSER OF COST OR CHARGES				
	REASONABLE CHARGES				
12	Ancillary service charges				12
13	Organ acquisition charges (from Wkst. D-4, Part III, col. 4, line 69)				13
14	Total reasonable charges (sum of lines 12 and 13)				14
	CUSTOMARY CHARGES				
15	Aggregate amount actually collected from patients liable for payment for services on a charge basis				15
16	Amounts that would have been realized from patients liable for payment for services on a charge basis had such payment been made in accordance with 42 CFR §413.13(e)				16
17	Ratio of line 15 to line 16 (not to exceed 1.000000)				17
18	Total customary charges (see instructions)				18
19	Excess of customary charges over ressonable 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)	3,964,830			21
22	Interns and residents (see instructions)				22
23	Cost of physicians' services in a teaching hospital (see instructions)				23
24	Total prospective payment (sum of lines 3, 4, 8 and 9)				24
	COMPUTATION OF REIMBURSEMENT SETTLEMENT				
25	Deductibles and coinsurance (see instructions)	15,824			25
26	Deductibles and coinsurance relating to amount on line 24 (see instructions)	2,201,867			26
27	Subtotal [(lines 21 and 24 minus the sum of lines 25 and 26) plus the sum of lines 22 and 23] (see instructions)	1,747,139			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)	1,747,139			30
31	Primary payer payments	348			31
32	Subtotal (line 30 minus line 31)	1,746,791			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)	238,962			34
35	Adjusted reimbursable bad debts (see instructions)	155,325			35
36	Allowable bad debts for dual eligible beneficiaries (see instructions)	220,003			36
37	Subtotal (see instructions)	1,902,116			37
38	MSP-LCC reconciliation amount from PS&R				38
39	Other adjustments (specify) (see instructions)				39
39.50	Pioneer ACO demonstration payment adjustment (see instructions)				39.50
40	Subtotal (see instructions)	1,902,116			40
40.01	Sequestration adjustment (see instructions)	38,042			40.01
41	Interim payments	1,392,807			41
42	Tentative settlement (for contractors use only)				42
43	Balance due provider/program (see instructions)	471,267			43
44	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2				44

TO BE COMPLETED BY CONTRACTOR

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

HARVARD MEMORIAL HOSPITAL Provider CCN: 14-1335	In Lieu of Form **CMS-2552-10**	Period : From: 07/01/2016 To: 06/30/2017	Run Date: 11/28/2017 Run Time: 09:16 Version: 2017.10 (11/19/2017)

CALCULATION OF REIMBURSEMENT SETTLEMENT **COMPONENT CCN: 14-6014** **WORKSHEET E PART B**

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

PART B - MEDICAL AND OTHER HEALTH SERVICES

		1	1.01	1.02	
1	Medical and other services (see instructions)	185			1
2	Medical and other services reimbursed under OPPS (see instructions)				2
3	PPS payments				3
4	Outlier payment (see instructions)				4
5	Enter the hospital specific payment to cost ratio (see instructions)				5
6	Line 2 times line 5				6
7	Sum of line 3 and line 4 divided by line 6				7
8	Transitional corridor payment (see instructions)				8
9	Ancillary service other pass through costs from Wkst. D, Pt. IV, col. 13, line 200				9
10	Organ acquisition				10
11	Total cost (sum of lines 1 and 10) (see instructions)	185			11
	COMPUTATION OF LESSER OF COST OR CHARGES				
	REASONABLE CHARGES				
12	Ancillary service charges	866			12
13	Organ acquisition charges (from Wkst. D-4, Part III, col. 4, line 69)				13
14	Total reasonable charges (sum of lines 12 and 13)	866			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)	866			18
19	Excess of customary charges over ressonable cost (complete only if line 18 exceeds line 11 (see instructions)	681			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)	185			21
22	Interns and residents (see instructions)				22
23	Cost of physicians' services in a teaching hospital (see instructions)				23
24	Total prospective payment (sum of lines 3, 4, 8 and 9)				24
	COMPUTATION OF REIMBURSEMENT SETTLEMENT				
25	Deductibles and coinsurance (see instructions)				25
26	Deductibles and coinsurance relating to amount on line 24 (see instructions)				26
27	Subtotal [(lines 21 and 24 minus the sum of lines 25 and 26) plus the sum of lines 22 and 23] (see instructions)	185			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)	185			30
31	Primary payer payments				31
32	Subtotal (line 30 minus line 31)	185			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)	185			37
38	MSP-LCC reconciliation amount from PS&R				38
39	Other adjustments (specify) (see instructions)				39
39.50	Pioneer ACO demonstration payment adjustment (see instructions)				39.50
40	Subtotal (see instructions)	185			40
40.01	Sequestration adjustment (see instructions)	4			40.01
41	Interim payments	848			41
42	Tentative settlement (for contractors use only)				42
43	Balance due provider/program (see instructions)	-667			43
44	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2				44

TO BE COMPLETED BY CONTRACTOR

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

HARVARD MEMORIAL HOSPITAL Provider CCN: 14-1335	In Lieu of Form **CMS-2552-10**	Period : From: 07/01/2016 To: 06/30/2017	Run Date: 11/28/2017 Run Time: 09:16 Version: 2017.10 (11/19/2017)

ANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED **COMPONENT CCN: 14-1335** **WORKSHEET E-1 PART I**

Check Applicable Boxes: **[XX] Hospital** **[ ] IPF** **[ ] IRF** **[ ] SUB (Other)** **[ ] SNF** **[ ] Swing Bed SNF**

				INPATIENT PART A		PART B		
				mm/dd/yyyy	AMOUNT	mm/dd/yyyy	AMOUNT	
	DESCRIPTION			1	2	3	4	
1	Total interim payments paid to provider				1,677,665		1,470,947	1
2	Interim payments payable on individual bills, eitehr submitted or to be submitted to the intermediary for services rendered in the cost reporting period. If none, write 'NONE' or enter a zero							2
3	List separately each retroactive lump sum adjustment		.01					3.01
	amount based on subsequent revision of the interim		.02					3.02
	rate for the cost reporting period. Also show date of	Program	.03					3.03
	each payment. If none, write 'NONE' or enter a zero. (1)	to	.04					3.04
		Provider	.05					3.05
			.06					3.06
			.07					3.07
			.08					3.08
			.09					3.09
			.10					3.10
			.50	02/02/2017	31,859	02/02/2017	58,091	3.50
			.51	06/23/2017	17,660	06/23/2017	20,049	3.51
		Provider	.52					3.52
		to	.53					3.53
		Program	.54					3.54
			.55					3.55
			.56					3.56
			.57					3.57
			.58					3.58
			.59					3.59
	Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98)		.99		-49,519		-78,140	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)				1,628,146		1,392,807	4
	TO BE COMPLETED BY CONTRACTOR							
5	List separately each tentative settlement payment		.01					5.01
	after desk review. Also show date of each payment.		.02					5.02
	If none, write 'NONE' or enter a zero. (1)	Program	.03					5.03
		to	.04					5.04
		Provider	.05					5.05
			.06					5.06
			.07					5.07
			.08					5.08
			.09					5.09
			.10					5.10
			.50					5.50
			.51					5.51
		Provider	.52					5.52
		to	.53					5.53
		Program	.54					5.54
			.55					5.55
			.56					5.56
			.57					5.57
			.58					5.58
			.59					5.59
	Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98)		.99					5.99
6	Determined net settlement amount (balance due)		.01		84,748		471,267	6.01
	based on the cost report (1)		.02					6.02
7	Total Medicare program liability (see instructions)				1,712,894		1,864,074	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.

HARVARD MEMORIAL HOSPITAL Provider CCN: 14-1335	In Lieu of Form **CMS-2552-10**	Period : From: 07/01/2016 To: 06/30/2017	Run Date: 11/28/2017 Run Time: 09:16 Version: 2017.10 (11/19/2017)

ANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED **COMPONENT CCN: 14-6014** **WORKSHEET E-1 PART I**

Check Applicable Boxes: **[ ] Hospital [ ] IPF [ ] IRF [ ] SUB (Other) [XX] SNF [ ] Swing Bed SNF**

				INPATIENT PART A		PART B		
				mm/dd/yyyy	AMOUNT	mm/dd/yyyy	AMOUNT	
	DESCRIPTION			1	2	3	4	
1	Total interim payments paid to provider				705,583		848	1
2	Interim payments payable on individual bills, eitehr submitted or to be submitted to the intermediary for services rendered in the cost reporting period. If none, write 'NONE' or enter a zero							2
3	List separately each retroactive lump sum adjustment		.01					3.01
	amount based on subsequent revision of the interim		.02					3.02
	rate for the cost reporting period. Also show date of	Program	.03					3.03
	each payment. If none, write 'NONE' or enter a zero. (1)	to	.04					3.04
		Provider	.05					3.05
			.06					3.06
			.07					3.07
			.08					3.08
			.09					3.09
			.10					3.10
			.50					3.50
			.51					3.51
		Provider	.52					3.52
		to	.53					3.53
		Program	.54					3.54
			.55					3.55
			.56					3.56
			.57					3.57
			.58					3.58
			.59					3.59
	Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98)		.99					3.99
4	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Wkst. E or Wkst. E-3, line and column as appropriate)				705,583		848	4
	TO BE COMPLETED BY CONTRACTOR							
5	List separately each tentative settlement payment		.01					5.01
	after desk review. Also show date of each payment.		.02					5.02
	If none, write 'NONE' or enter a zero. (1)	Program	.03					5.03
		to	.04					5.04
		Provider	.05					5.05
			.06					5.06
			.07					5.07
			.08					5.08
			.09					5.09
			.10					5.10
			.50					5.50
			.51					5.51
		Provider	.52					5.52
		to	.53					5.53
		Program	.54					5.54
			.55					5.55
			.56					5.56
			.57					5.57
			.58					5.58
			.59					5.59
	Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98)		.99					5.99
6	Determined net settlement amount (balance due)		.01					6.01
	based on the cost report (1)		.02		-1		-667	6.02
7	Total Medicare program liability (see instructions)				705,582		181	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.

CALCULATION OF REIMBURSEMENT SETTLEMENT FOR HIT

WORKSHEET E-1
PART II

Check applicable box: **[XX] Hospital** **[ ] CAH**

TO BE COMPLETED BY CONTRACTOR FOR NONSTANDARD COST REPORTS

HEALTH INFORMATION TECHNOLOGY DATA COLLECTION AND CALCULATION

1	Total hospital discharges as defined in AARA §4102 (Wkst. S-3, Pt. I, col. 15, line 14)	398	1
2	Medicare days (Wkst. S-3, Pt. I, col. 6, sum of lines 1, 8-12)	676	2
3	Medicare HMO days (Wkst. S-3, Pt. I, col. 6, line 2)	37	3
4	Total inpatient days (Wkst. S-3, Pt. I, col. 8, sum of lines 1, 8-12)	1,148	4
5	Total hospital charges (Wkst. C, Pt. I, col. 8, line 200)	58,235,737	5
6	Total hospital charity care charges (Wkst. S-10, col. 3, line 20)	63,333	6
7	CAH only - The reasonable cost incurred for the purchase of certified HIT technology (Wkst. S-2, Pt. I, line 168)		7
8	Calculation of the HIT incentive payment (see instructions)		8
9	Sequestration adjustment amount (see instructions)		9
10	Calculation of the HIT incentive payment after sequestration (see instructions)		10

INPATIENT HOSPITAL SERVICES UNDER THE IPPS & CAH

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

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

PART V - CALCULATION OF REIMBURSEMENT SETTLEMENT FOR MEDICARE PART A SERVICES - COST REIMBURSEMENT

1	Inpatient services	1,924,487	1
2	Nursing an dallied health managed care payment (see instructions)		2
3	Organ acquisition		3
4	Subtotal (sum of lines 1-3)	1,924,487	4
5	Primary payer payments		5
6	Total cost (see instructions)	1,943,732	6
	COMPUTATION OF LESSER OF COST OR CHARGES		
	REASONABLE CHARGES		
7	Routine service charges		7
8	Ancillary service charges		8
9	Organ acquisition charges, net of revenue		9
10	Total reasonable charges		10
	CUSTOMARY CHARGES		
11	Aggregate amount actually collected from patients liable for payment for services on a charge basis		11
12	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)		12
13	Ratio of line 11 to line 12 (not to exceed 1.000000)	0.000000	13
14	Total customary charges (see instructions)		14
15	Excess of customary charges over reasonable cost (complete only if line 14 exceeds line 6) (see instructions)		15
16	Excess of reasonable cost over customary charges (complete only if line 6 exceeds line 14) (see instructions)		16
17	Cost of physicians' services in a teaching hospital (see instructions)		17
	COMPUTATION OF REIMBURSEMENT SETTLEMENT		
18	Direct graduate medical education payments		18
19	Cost of covered services (sum of lines 6 and 17)	1,943,732	19
20	Deductibles (exclude professional component)	196,700	20
21	Excess reasonable cost (from line 16)		21
22	Subtotal (line 19 minus the sum of lines 20 and 21)	1,747,032	22
23	Coinsurance		23
24	Subtotal (line 22 minus line 23)	1,747,032	24
25	Allowable bad debts (exclude bad debts for professional services) (see instructions)	1,260	25
26	Adjusted reimbursable bad debts (see instructions)	819	26
27	Allowable bad debts for dual eligible beneficiaries (see instructions)		27
28	Subtotal (sum of lines 24 and 26)	1,747,851	28
29	Other adjustments (specify) (see instructions)		29
29.50	Pioneer ACO demonstration payment adjustment (see instructions)		29.50
30	Subtotal (see instructions)	1,747,851	30
30.01	Sequestration adjustment (see instructions)	34,957	30.01
31	Interim payments	1,628,146	31
32	Tentative settlement (for contractor use only)		32
33	Balance due provider/program (line 30 minus lines 30.01, 31 and 32)	84,748	33
34	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2		34

CALCULATION OF REIMBURSEMENT SETTLEMENT **WORKSHEET E-3 PART VI**

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

	PROSPECTIVE PAYMENT AMOUNT (see instructions)		
1	Resource Utilization Group (RUGS) payment	873,307	1
2	Routine service other pass through costs		2
3	Ancillary service other pass through costs		3
4	Subtotal (sum of lines 1-3)	873,307	4
	COMPUTATION OF NET COST OF COVERED SERVICES		
5	Medical and other services. Do not use this line. (see instructions)		5
6	Deductibles		6
7	Coinsurance	153,325	7
8	Allowable bad debts (see instructions)		8
9	Reimbursable bad debts for dual eligible beneficiaries (see instructions)		9
10	Adjusted reimbursable bad debts (see instructions)		10
11	Utilization review		11
12	Subtotal (sum of lines 4 and 5, minus lines 6 and 7, plus lines 10 and 11) (see instructions)	719,982	12
13	Inpatient primary payer payments		13
14	Other adjustments (specify) (see instructions)		14
14.50	Pioneer ACO demonstration payment adjustment (see instructions)		14.50
15	Subtotal (see instructions)	719,982	15
15.01	Sequestration adjustment (see instructions)	14,400	15.01
16	Interim payments	705,583	16
17	Tentative settlement (for contractor use only)		17
18	Balance due provider/program (line 15 minus lines 15.01, 16 and 17)	-1	18
19	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2		19

Check Applicable Boxes: [ ] Title V [XX] Title XIX [XX] Hospital [ ] SUB (Other) [ ] SNF [ ] NF [ ] ICF/IID [ ] PPS [ ] TEFRA [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	Inpatient hospital/SNF/NF services	26,608		1
2	Medical and other services			2
3	Organ acquisition (certified transplant centers only)			3
4	Subtotal (sum of lines 1, 2 and 3)	26,608		4
5	Inpatient primary payer payments			5
6	Outpatient primary payer payments			6
7	Subtotal (line 4 less sum of lines 5 and 6)	26,608		7
	COMPUTATION OF LESSER OF COST OR CHARGES			
	REASONABLE CHARGES			
8	Routine service charges			8
9	Ancillary service charges			9
10	Organ acquisition charges, net of revenue			10
11	Incentive from target amount computation			11
12	Total reasonable charges (sum of lines 8-11)			12
	CUSTOMARY CHARGES			
13	Amount actually collected from patients liable for payment for services on a cahrge basis			13
14	Amounts that would have been realized from patients liable for payment for services on a charge basis had such payment been made in accordance with 42 CFR §413.13(e)			14
15	Ratio of line 13 to line 14 (not to exceed 1.000000)	1.000000	1.000000	15
16	Total customary charges (see instructions)			16
17	Excess of customary charges over reasonable cost (complete only if line 16 exceeds line 4) (see instructions)			17
18	Excess of reasonable cost over customary charges (complete only if line 4 exceeds line 16) (see instructions)			18
19	Interns and residents (see instructions)			19
20	Cost of physicians' services in a teaching hospital (see instructions)			20
21	Cost of covered services (lesser of line 4 or line 16)	26,608		21
	PROSPECTIVE PAYMENT AMOUNT			
22	Other than outlier payments			22
23	Outlier payments			23
24	Program capital payments			24
25	Capital exception payments (see instructions)			25
26	Routine and ancillary service other pass through costs			26
27	Subtotal (sum of lines 22 through 26)			27
28	Customary charges (Titles V or XIX PPS covered services only)			28
29	Titles V or XIX (sum of lines 21 and 27)	26,608		29
	COMPUTATION OF REIMBURSEMENT SETTLEMENT			
30	Excess of reasonable cost (from line 18)			30
31	Subtotal (sum of lines 19 and 20, plus 29 minus lines 5 and 6)	26,608		31
32	Deductibles			32
33	Coinsurance			33
34	Allowable bad debts (see instructions)			34
35	Utilization review			35
36	Subtotal (sum of lines 31, 34 and 35 minus the sum of lines 32 and 33)	26,608		36
37	OTHER ADJUSTMENTS (SPECIFY) (see instructions)	-26,608		37
38	Subtotal (line 36 ± line 37)			38
39	Direct graduate medical education payments (from Wkst. E-4)			39
40	Total amount payable to the provider (sum of lines 38 and 39)			40
41	Interim payments			41
42	Balance due provider/program (line 40 minus line 41)			42
43	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2			43

BALANCE SHEET **WORKSHEET G**

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

	Assets	General Fund	Specific Purpose Fund	Endowment Fund	Plant Fund	
	(Omit Cents)	1	2	3	4	
	CURRENT ASSETS					
1	Cash on hand and in banks	797,865				1
2	Temporary investments					2
3	Notes receivable					3
4	Accounts receivable	11,920,552				4
5	Other receivables	124,213				5
6	Allowances for uncollectible notes and accounts receivable	-11,343,702				6
7	Inventory	887,980				7
8	Prepaid expenses	170,650				8
9	Other current assets					9
10	Due from other funds	30,491				10
11	Total current assets (sum of lines 1-10)	2,588,049				11
	FIXED ASSETS					
12	Land	222,604				12
13	Land improvements	807,429				13
14	Accumulated depreciation	-605,895				14
15	Buildings	20,765,366				15
16	Accumulated depreciation	-14,148,577				16
17	Leasehold improvements					17
18	Accumulated depreciation					18
19	Fixed equipment					19
20	Accumulated depreciation					20
21	Audomobiles and trucks					21
22	Accumulated depreciation					22
23	Major movable equipment	15,101,158				23
24	Accumulated depreciation	-12,130,963				24
25	Minor equipment depreciable					25
26	Accumulated depreciation					26
27	HIT designated assets					27
28	Accumulated depreciation					28
29	Minor equipment-nondepreciable					29
30	Total fixed assets (sum of lines 12-29)	10,011,122				30
	OTHER ASSETS					
31	Investments					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)					35
36	Total assets (sum of lines 11, 30 and 35)	12,599,171				36

	Liabilities and Fund Balances	General Fund	Specific Purpose Fund	Endowment Fund	Plant Fund	
	(Omit Cents)	1	2	3	4	
	CURRENT LIABILITIES					
37	Accounts payable	239,739				37
38	Salaries, wages and fees payable	727,892				38
39	Payroll taxes payable					39
40	Notes and loans payable (short term)	-54,717				40
41	Deferred income					41
42	Accelerated payments					42
43	Due to other funds	870,548				43
44	Other current liabilities	202,319				44
45	Total current liabilities (sum of lines 37 thru 44)	1,985,781				45
	LONG TERM LIABILITIES					
46	Mortgage payable					46
47	Notes payable					47
48	Unsecured loans					48
49	Other long term liabilities	6,567,171				49
50	Total long term liabilities (sum of lines 46 thru 49)	6,567,171				50
51	Total liabilities (sum of lines 45 and 50)	8,552,952				51
	CAPITAL ACCOUNTS					
52	General fund balance	4,046,219				52
53	Specific purpose fund					53
54	Donor created - endowment fund balance - restricted					54
55	Donor created - endowment fund balance - unrestricted					55
56	Governing body created - endowment fund balance					56
57	Plant fund balance - invested in plant					57
58	Plant fund balance - reserve for plant improvement, replacement, and expansion					58
59	Total fund balances (sum of lines 52 thru 58)	4,046,219				59
60	Total liabilities and fund balances (sum of lines 51 and 59)	12,599,171				60

HARVARD MEMORIAL HOSPITAL Provider CCN: 14-1335	In Lieu of Form **CMS-2552-10**	Period : From: 07/01/2016 To: 06/30/2017	Run Date: 11/28/2017 Run Time: 09:16 Version: 2017.10 (11/19/2017)

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		5,236,193			1
2	Net income (loss) (from Worksheet G-3, line 29)		2,191,259			2
3	Total (sum of line 1 and line 2)		7,427,452			3
4	Additions (credit adjustments) (specify)	5				4
5						5
6						6
7						7
8						8
9						9
10	Total additions (sum of lines 4-9)		5			10
11	Subtotal (line 3 plus line 10)		7,427,457			11
12	Deductions (debit adjustments) (specify)	3,381,238				12
13						13
14						14
15						15
16						16
17						17
18	Total deductions (sum of lines 12-17)		3,381,238			18
19	Fund balance at end of period per balance sheet (line 11 minus line 18)		4,046,219			19

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

HARVARD MEMORIAL HOSPITAL Provider CCN: 14-1335	In Lieu of Form **CMS-2552-10**	Period : From: 07/01/2016 To: 06/30/2017	Run Date: 11/28/2017 Run Time: 09:16 Version: 2017.10 (11/19/2017)

STATEMENT OF PATIENT REVENUES AND OPERATING EXPENSES

WORKSHEET G-2
PARTS I & II

PART I - PATIENT REVENUES

		INPATIENT	OUTPATIENT	TOTAL	
	REVENUE CENTER	1	2	3	
	GENERAL INPATIENT ROUTINE CARE SERVICES				
1	Hospital	3,752,847		3,752,847	1
2	Subprovider IPF				2
3	Subprovider IRF				3
5	Swing Bed - SNF				5
6	Swing Bed - NF				6
7	Skilled nursing facility	910,638		910,638	7
8	Nursing facility				8
9	Other long term care	1,138,258		1,138,258	9
10	Total general inpatient care services (sum of lines 1-9)	5,801,743		5,801,743	10
	INTENSIVE CARE TYPE INPATIENT HOSPITAL SERVICES				
11	Intensive Care Unit	287,250		287,250	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)	287,250		287,250	16
17	Total inpatient routine care services (sum of lines 10 and 16)	6,088,993		6,088,993	17
18	Ancillary services	7,097,475	41,079,833	48,177,308	18
19	Outpatient services	195,116	4,096,772	4,291,888	19
20	Rural Health Clinic (RHC)				20
21	Federally Qualified Health Center (FQHC)				21
22	Home health agency				22
23	Ambulance				23
25	ASC				25
26	Hospice				26
27	RECLASS TO IP	186,627	-186,627		27
27.01	PROFESSIONAL FEES		2,852,970	2,852,970	27.01
28	Total patient revenues (sum of lines 17-27) (transfer column 3 to Worksheet G-3, line 1)	13,568,211	47,842,948	61,411,159	28

PART II - OPERATING EXPENSES

		1	2	
29	Operating expenses (per Worksheet A, column 3, line 200)		22,634,152	29
30	Add (specify)			30
31	BAD DEBTS	1,604,023		31
32				32
33				33
34				34
35				35
36	Total additions (sum of lines 30-35)		1,604,023	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)		24,238,175	43

HARVARD MEMORIAL HOSPITAL Provider CCN: 14-1335	In Lieu of Form **CMS-2552-10**	Period : From: 07/01/2016 To: 06/30/2017	Run Date: 11/28/2017 Run Time: 09:16 Version: 2017.10 (11/19/2017)

STATEMENT OF REVENUES AND EXPENSES **WORKSHEET G-3**

	DESCRIPTION		
1	Total patient revenues (from Worksheet G-2, Part I, column 3, line 28)	61,411,159	1
2	Less contractual allowances and discounts on patients' accounts	35,098,659	2
3	Net patient revenues (line 1 minus line 2)	26,312,500	3
4	Less total operating expenses (from Worksheet G-2, Part II, line 43)	24,238,175	4
5	Net income from service to patients (line 3 minus line 4)	2,074,325	5

OTHER INCOME

6	Contributions, donations, bequests, etc.		6
7	Income from investments	1,491	7
8	Revenues from telephone and other miscellaneous communication services		8
9	Revenue from television and radio service		9
10	Purchase discounts		10
11	Rebates and refunds of expenses		11
12	Parking lot receipts		12
13	Revenue from laundry and linen service		13
14	Revenue from meals sold to employees and guests	84,680	14
15	Revenue from rental of living quarters		15
16	Revenue from sale of medical and surgical supplies to otehr than patients		16
17	Revenue from sale of drugs to other than patients		17
18	Revenue from sale of medical records and abstracts		18
19	Tuition (fees, sale of textbooks, uniforms, etc.)		19
20	Revenue from gifts, flowers, coffee shops and canteen		20
21	Rental of vending machines		21
22	Rental of hosptial space		22
23	Governmental appropriations		23
24	Other (OTHER OPERATING REVENUE)	30,763	24
25	Total other income (sum of lines 6-24)	116,934	25
26	Total (line 5 plus line 25)	2,191,259	26
29	Net income (or loss) for the period (line 26 minus line 28)	2,191,259	29

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ALLOCATION OF ALLOWABLE COSTS FOR EXTRAORDINARY CIRCUMSTANCES

WORKSHEET L-1
PART I

	COST CENTER DESCRIPTIONS	EXTRAORDI-NARY CAP-REL COSTS	SUBTOTAL (cols.0-4)	SUBTOTAL	I&R COST & POST STEP-DOWN ADJS	TOTAL		
		0	2A	24	25	26		
	GENERAL SERVICE COST CENTERS							
1	Cap Rel Costs-Bldg & Fixt							1
2	Cap Rel Costs-Mvble Equip							2
4	Employee Benefits Department							4
5	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
	INPATIENT ROUTINE SERVICE COST CENTERS							
30	Adults & Pediatrics							30
31	Intensive Care Unit							31
44	Skilled Nursing Facility							44
46	Other Long Term Care							46
	ANCILLARY SERVICE COST CENTERS							
50	Operating Room							50
51	Recovery Room							51
53	Anesthesiology							53
54	Radiology-Diagnostic							54
60	Laboratory							60
60.01	BLOOD LABORATORY							60.01
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
65	Respiratory Therapy							65
66	Physical Therapy							66
67	Occupational Therapy							67
68	Speech Pathology							68
71	Medical Supplies Charged to Patients							71
72	Impl. Dev. Charged to Patients							72
73	Drugs Charged to Patients							73
76.97	CARDIAC REHABILITATION							76.97
76.98	HYPERBARIC OXYGEN THERAPY							76.98
76.99	LITHOTRIPSY							76.99
	OUTPATIENT SERVICE COST CENTERS							
91	Emergency							91
92	Observation Beds (Non-Distinct Part)							92
	OTHER REIMBURSABLE COST CENTERS							
99.10	CORF							99.10
	SPECIAL PURPOSE COST CENTERS							
118	SUBTOTALS (sum of lines 1-117)							118
	NONREIMBURSABLE COST CENTERS							
192	Physicians' Private Offices							192
200	Cross Foot Adjustments							200
201	Negative Cost Centers							201
202	TOTAL (sum of lines 118-201)							202