

KPMG LLP Compu-Max 2552-10

HARVARD MEMORIAL HOSPITAL Provider CCN: 14-1335	In Lieu of Form CMS-2552-10	Period : From: 07/01/2017 To: 06/30/2018	Run Date: 11/28/2018 Run Time: 12:39 Version: 2018.04 (09/26/2018)
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HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX COST REPORT CERTIFICATION AND SETTLEMENT SUMMARY**WORKSHEET S
PARTS I, II & III****PART I - COST REPORT STATUS**

Provider use only		1. ☒ Electronically filed cost report Date: 11/28/2018 Time: 12:39 2. ☐ Manually submitted cost report 3. ☐ If this is an amended report enter the number of times the provider resubmitted the cost report 4. ☒ Medicare Utilization. Enter 'F' for full or 'L' for low.	
Contractor use only	5. ☐ Cost Report Status (1) As Submitted (2) Settled without audit (3) Settled with audit (4) Reopened (5) Amended	6. Date Received: _____ 7. Contractor No.: _____ 8. ☐ Initial Report for this Provider CCN 9. ☐ Final Report for this Provider CCN	10. NPR Date: _____ 11. Contractor's Vendor Code: ____ 12. ☐ If line 5, column 1 is 4: Enter number of times reopened = 0-9.

PART II - CERTIFICATION

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

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

I HEREBY CERTIFY that I have read the above certification statement and that I have examined the accompanying electronically filed or manually submitted cost report and the Balance Sheet and Statement of Revenue and Expenses prepared by HARVARD MEMORIAL HOSPITAL (14-1335) {(Provider Name(s) and Number(s)} for the cost reporting period beginning 07/01/2017 and ending 06/30/2018, and to the best of my knowledge and belief, this report and statement are true, correct, complete and prepared from the books and records of the provider in accordance with applicable instructions, except as noted. I further certify that I am familiar with the laws and regulations regarding the provision of health care services, and that the services identified in this cost report were provided in compliance with such laws and regulations.

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

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

Title

Date

PART III - SETTLEMENT SUMMARY

		TITLE XVIII		HIT	TITLE XIX	
	TITLE V	PART A	PART B			
	1	2	3	4	5	
1	HOSPITAL	4,323	-207,759			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	-256			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	4,322	-208,015			200

The above amounts represent 'due to' or 'due from' the applicable program for the element of the above complex indicated.

According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0938-0050. The time required to complete this information collection is estimated 673 hours per response, including the time to review instructions, search existing resources, gather the data needed, and complete and review the information collection. If you have any comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Report Clearance Officer, Mail Stop C4-26-05, Baltimore, Maryland 21244-1850.

Please do not send applications, claims, payments, medical records or any documents containing sensitive information to the PRA Reports Clearance Office. Please note that any correspondence not pertaining to the information collection burden approved under the associated OMB control number listed on this form will not be reviewed, forwarded, or retained. If you have questions or concerns regarding where to submit your documents, please contact 1-800-MEDICARE.

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

Hospital and Hospital Health Care Complex Address:

1	Street: 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)			
	0	1	2	3	4	5	V	XVIII	XIX	
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 / 2017	To: 06 / 30 / 2018		20
21	Type of control (see instructions)	2			21

Inpatient PPS Information

		1	2	3	
22	Does this facility qualify for and receive disproportionate share hospital payments in accordance with 42 CFR §412.106? In column 1, enter 'Y' for yes or 'N' for no. Is this facility subject to 42 CFR §412.06(c)(2)(Pickle amendment hospital)? In column 2, enter 'Y' for yes or 'N' for no.	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 eligible for the MDH transitional payment in accordance with the FY 2016 OPSS 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

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

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

		1	2	3	
56	Teaching Hospitals Is this a hospital involved in training residents in approved GME programs? Enter 'Y' for yes or 'N' for no.	N			56
57	If line 56 is yes, is this the first cost reporting period during which residents in approved GME programs trained at this facility? Enter 'Y' for yes or 'N' for no in column 1. If column 1 is 'Y' did residents start training in the first month of this cost reporting period? Enter 'Y' for yes or 'N' for no in column 2. If column 2 is 'Y', complete Wkst. E-4. If column 2 is 'N', complete Wkst. D, Part III & IV and D-2, Pt. II, if applicable.	N			57
58	If line 56 is yes, did this facility elect cost reimbursement for physicians' services as defined in CMS Pub 15-1, chapter 21, section 2148? If yes, complete Wkst. D-5.	N			58
59	Are costs claimed on line 100 of Worksheet A? If yes, complete Wkst. D-2, Pt. I.	N			59
		NAHE 413.85 Y/N 1	Worksheet A Line # 2	Pass-Through Qualification Criteria Code 3	
60	Are you claiming nursing and allied health education (NAHE) costs for any program(s) that meet the criteria under 42 CFR 413.85? (see instructions)	N			60
		Y/N 1	IME 4	Direct GME 5	
61	Did your hospital receive FTE slots under ACA section 5503? Enter 'Y' for yes or 'N' for no in column 1.(see instructions)	N			61
61.01	Enter the average number of unweighted primary care FTEs from the hospital's 3 most recent cost reports ending and submitted before March 23, 2010. (see instructions)				61.01
61.02	Enter the current year total unweighted primary care FTE count (excluding OB/GYN, general surgery FTEs, and primary care FTEs added under section 5503 of ACA). (see instructions)				61.02
61.03	Enter the baseline FTE count for primary care and/or general surgery residents, which is used for determining compliance with the 75% test. (see instructions)				61.03
61.04	Enter the number of unweighted primary care/or surgery allopathic and/or osteopathic FTEs in the current cost reporting period. (see instructions)				61.04
61.05	Enter the difference between the baseline primary and/or general surgery FTEs and the current year's primary care and/or general surgery FTE counts (line 61.04 minus line 61.03). (see instructions)				61.05
61.06	Enter the amount of ACA §5503 award that is being used for cap relief and/or FTEs that are nonprimary care or general surgery. (see instructions)				61.06

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

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

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

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

62	Enter the number of FTE residents that your hospital trained in this cost reporting period for which your hospital received HRSA PCRE funding (see instructions)				62
62.01	Enter the number of FTE residents that rotated from a teaching health center (THC) into your hospital in this cost reporting period of HRSA THC program. (see instructions)				62.01

Teaching Hospitals that Claim Residents in Nonprovider Settings

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

Section 5504 of the ACA Base Year FTE Residents in Nonprovider Settings--This base year is your cost reporting period that begins on or after July 1, 2009 and before June 30, 2010.				Unweighted FTEs Nonprovider Site	Unweighted FTEs in Hospital	Ratio (col. 1/ col. 1 + col. 2))	
64	Enter in column 1, if line 63 is yes, or your facility trained residents in the base year period, the number of unweighted non-primary care resident FTEs attributable to rotations occurring in all nonprovider settings. Enter in column 2 the number of unweighted non-primary care resident FTEs that trained in your hospital. Enter in column 3 the ratio of (column 1 divided by (column 1 + column 2)). (see instructions)						64
Enter in lines 65-65.49 in column 1, if line 63 is yes, or your facility trained residents in the base year period, the program name. Enter in column 2 the program code. Enter in column 3 the number of unweighted primary care FTE residents attributable to rotations occurring in all non-provider settings. Enter in column 4 the number of unweighted primary care resident FTEs that trained in your hospital. Enter in column 5 the ratio of (column 3 divided by (column 3 ÷ column 4)). (see instructions)							
		Program Name	Program Code	Unweighted FTEs Nonprovider Site	Unweighted FTEs in Hospital	Ratio (col. 3/ col. 3 + col. 4))	
		1	2	3	4	5	
65							65
Section 5504 of the ACA Current Year FTE Residents in Nonprovider Settings--Effective for cost reporting periods beginning on or after July 1, 2010				Unweighted FTEs Nonprovider Site	Unweighted FTEs in Hospital	Ratio (col. 1/ col. 1 + col. 2))	
66	Enter in column 1, the number of unweighted non-primary care resident FTEs attributable to rotations occurring in all nonprovider settings. Enter in column 2 the number of unweighted non-primary care resident FTEs that trained in your hospital. Enter in column 3 the ratio of (column 1 divided by (column 1 + column 2)). (see instructions)						66
Enter in lines 67-67.49, column 1 the program name. Enter in column 2 the program code. Enter in column 3 the number of unweighted primary care FTE residents attributable to rotations occurring in all non-provider settings. Enter in column 4 the number of unweighted primary care resident FTEs that trained in your hospital. Enter in column 5 the ratio of (column 3 divided by (column 3 ÷ column 4)). (see instructions)							
		Program Name	Program Code	Unweighted FTEs Nonprovider Site	Unweighted FTEs in Hospital	Ratio (col. 3/ col. 3 + col. 4))	
		1	2	3	4	5	
67							67

Inpatient Psychiatric Facility PPS

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

Inpatient Rehabilitation Facility PPS

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

Long Term Care Hospital PPS

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

TEFRA Providers

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

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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
98	Does title V or XIX follow Medicare (title XVIII) for the interns and residents post stepdown adjustments on Wkst. B, Pt. I, col. 25? Enter 'Y' for yes or 'N' for no in column 1 for title V, and in column 2 for title XIX.	N	N	98
98.01	Does title V or XIX follow Medicare (title XVIII) for the reporting of charges on Wkst. C, Pt. I? Enter 'Y' for yes or 'N' for no in column 1 for title V, and in column 2 for title XIX.	N	N	98.01
98.02	Does title V or XIX follow Medicare (title XVIII) for the calculation of observation bed costs on Wkst. D-1, Pt. IV, line 89? Enter 'Y' for yes or 'N' for no in column 1 for title V, and in column 2 for title XIX.	N	N	98.02
98.03	Does title V or XIX follow Medicare (title XVIII) for a critical access hospital (CAH) reimbursed 101% of inpatient services cost? Enter 'Y' for yes or 'N' for no in column 1 for title V, and in column 2 for title XIX.	N	N	98.03
98.04	Does title V or XIX follow Medicare (title XVIII) for a CAH reimbursed 101% of outpatient services cost? Enter 'Y' for yes or 'N' for no in column 1 for title V, and in column 2 for title XIX.	N	N	98.04
98.05	Does title V or XIX follow Medicare (title XVIII) and add back the RCE disallowance on Wkst. C, Pt. I, col. 4? Enter 'Y' for yes or 'N' for no in column 1 for title V, and in column 2 for title XIX.	N	N	98.05
98.06	Does title V or XIX follow Medicare (title XVIII) when cost reimbursed for Wkst. D, Pts. I through IV? Enter 'Y' for yes or 'N' for no in column 1 for title V, and in column 2 for title XIX.	N	N	98.06

Rural Providers

		1	2	
105	Does this hospital qualify as a 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 elimination is not made on Wkst. B, Pt. I, col. 25 and the program is cost reimbursed. If yes, complete Wkst. D-2, Pt. II.	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
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	Physical Occupational Speech Respiratory	109

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

Miscellaneous Cost Reporting Information

115	Is this an all-inclusive rate provider? Enter 'Y' for yes or 'N' for no in column 1. If column 1 is yes, enter the method used (A, B, or E only) in column 2. If column 2 is 'E', enter in column 3 either '93' percent for short term hospital or '98' percent for long term care (includes psychiatric, rehabilitation and long term hospitals providers) based on the definition in CMS Pub. 15-L, 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
118.01	List amounts of malpractice premiums and paid losses:	Premiums 169,020	Paid Losses Self Insurance	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 care related taxes as defined in §1983(w)(3) of the Act? Enter 'Y' for yes or 'N' for no in column 1. If column 1 is 'Y', enter in column 2 the Worksheet A line number where these taxes are included.	N		122

Transplant Center Information

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

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

All Providers

		1	2	
140	Are there any related organization or home office costs as defined in CMS Pub 15-1, Chapter 10? Enter 'Y' for yes, or 'N' for no in column 1. If yes, and home office costs are claimed, enter in column 2 the home office chain number (see instructions)	Y	HB0764	140

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

141	Name: 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 / 2017	09 / 30 / 2018		170
171	If line 167 is 'Y', does this provider have any days for individuals enrolled in section 1876 Medicare cost plans reported on Wkst. S-3, Pt. I, line 2, col. 6? Enter 'Y' for yes and 'N' for no in column 1. If column 1 is 'Y', enter the number of section 1876 Medicare days in column 2. (see instructions)	N	0		171

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

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

COMPLETED BY ALL HOSPITALS

		Y/N	Date		
Provider Organization and Operation		1	2		
1	Has the provider changed ownership immediately prior to the beginning of the cost reporting period? If yes, enter the date of the change in column 2. (see instructions)	N			1
		Y/N	Date	V/I	
		1	2	3	
2	Has the provider terminated participation in the Medicare program? If yes, enter in column 2 the date of termination and in column 3, 'V' for voluntary or 'I' for involuntary.	N			2
3	Is the provider involved in business transactions, including management contracts, with individuals or entities (e.g., chain home offices, drug or medical supply companies) that are related to the provider or its officers, medical staff, management personnel, or members of the board of directors through ownership, control, or family and other similar relationships? (see instructions)	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 instructions.	N		10
11	Are GME costs directly assigned to cost centers other than I & R in an Approved Teaching Program on Worksheet A? If yes, see instructions.	N		11

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

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

		Part A		Part B		
		Y/N	Date	Y/N	Date	
PS&R Report Data		1	2	3	4	
16	Was the cost report prepared using the PS&R Report only? If either column 1 or 3 is yes, enter the paid-through date of the PS&R Report used in columns 2 and 4. (see instructions)	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	11/06/2018	Y	11/06/2018	17
18	If line 16 or 17 is yes, were adjustments made to PS&R Report data for additional claims that have been billed but are not included on the PS&R Report used to file the cost report? If yes, see instructions.	N		N		18
19	If line 16 or 17 is yes, were adjustments made to PS&R Report data for corrections of other PS&R Report information? If yes, see instructions.	N		N		19
20	If line 16 or 17 is yes, were adjustments made to PS&R Report data for Other? Describe the other adjustments:	N		N		20
21	Was the cost report prepared only using the provider's records? If yes, see instructions.	N		N		21

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

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

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

Capital Related Cost		
22	Have assets been relifed for Medicare purposes? If yes, see instructions.	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: JENNY.DABROWSKI@SRGROUPLLC.COM	43

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

		Inpatient Days / Outpatient Visits / Trips								
	Component	Wkst A Line No.	No. of Beds	Bed Days Available	CAH Hours	Title V	Title XVIII	Title XIX	Total All Patients	
		1	2	3	4	5	6	7	8	
1	Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days) (see instructions for col. 2 for the portion of LDP room available beds)	30	10	3,650	28,296.00		528	20	1,053	1
2	HMO and other (see instructions)						38	80		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	28,296.00		528	20	1,053	7
8	Intensive Care Unit	31	3	1,095			18	1	36	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	28,296.00		546	21	1,089	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			1,830		2,300	19
20	Nursing Facility	45								20
21	Other Long Term Care	46	32	11,849					5,505	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								213	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
33.01	LTCH site neutral days and discharges									33.01

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

	Component	Full Time Equivalents			DISCHARGES				
		Total Interns & Residents	Employees On Payroll	Nonpaid Workers	Title V	Title XVIII	Title XIX	Total All Patients	
		9	10	11	12	13	14	15	
1	Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days) (see instructions for col. 2 for the portion of LDP room available beds)					212	10	444	1
2	HMO and other (see instructions)					10	29		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)		140.55			212	10	444	14
15	CAH Visits								15
16	Subprovider - IPF								16
17	Subprovider - IRF								17
18	Subprovider I								18
19	Skilled Nursing Facility		14.07						19
20	Nursing Facility								20
21	Other Long Term Care		16.26						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)		170.88						27
32.01	Total ancillary labor & delivery room outpatient days (see instructions)								32.01
33	LTCH non-covered days								33
33.01	LTCH site neutral days and discharges								33.01

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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	11		11	13
14	RUA	42		42	14
15	RVC	140		140	15
16	RVB	578		578	16
17	RVA	370		370	17
18	RHC	122		122	18
19	RHB	109		109	19
20	RHA	169		169	20
21	RMC	120		120	21
22	RMB	58		58	22
23	RMA	46		46	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	1		1	32
33	HC2				33
34	HC1				34
35	HB2				35
36	HB1				36
37	LE2				37
38	LE1				38
39	LD2				39
40	LD1				40
41	LC2				41
42	LC1				42
43	LB2				43
44	LB1				44
45	CE2				45
46	CE1				46
47	CD2	4		4	47
48	CD1	8		8	48
49	CC2				49
50	CC1	3		3	50
51	CB2				51
52	CB1	18		18	52
53	CA2				53
54	CA1	19		19	54
55	SE3				55
56	SE2				56
57	SE1				57
58	SSC				58
59	SSB				59
60	SSA				60
61	IB2				61
62	IB1				62
63	IA1				63
64	IA2				64
65	BB2				65
66	BB1				66
67	BA2				67
68	BA1				68
69	PE2				69
70	PE1				70
71	PD2				71

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PROSPECTIVE PAYMENT FOR SNF STATISTICAL DATA

WORKSHEET S-7

	Group	SNF Days	Swing Bed SNF Days	Total (sum of col. 2 + 3)	
	1	2	3	4	
72	PD1				72
73	PC2				73
74	PC1	2		2	74
75	PB2				75
76	PB1	8		8	76
77	PA2				77
78	PA1	1		1	78
199	AAA	1		1	199
200	TOTAL	1,830		1,830	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 category. Enter in column 2 the percentage of total expenses for each category to total SNF revenue from Worksheet G-2, Part I, line 7, column 3. In column 3, enter 'Y' or 'N' for no if the spending reflects increases associated with direct patient care and related expenses for each category. (see instructions)

		Expenses	Percentage	Associated with Direct Patient Care and Related Expenses?	
		1	2	3	
202	Staffing				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)	806,669			207

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HOSPITAL UNCOMPENSATED AND INDIGENT CARE DATA**WORKSHEET S-10**

Uncompensated and indigent care cost computation

1	Cost to charge ratio (Worksheet C, Part I, line 202, column 3 divided by line 202, column 8)	0.347899	1
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Medicaid (see instructions for each line)

2	Net revenue from Medicaid	2,764,014	2
3	Did you receive DSH or supplemental payments from Medicaid?	Y	3
4	If line 3 is yes, does line 2 include all DSH and/or supplemental payments from Medicaid?	N	4
5	If line 4 is no, enter DSH and/or supplemental payments from Medicaid	1,180,406	5
6	Medicaid charges	11,372,266	6
7	Medicaid cost (line 1 times line 6)	3,956,400	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.	11,980	8

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

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

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

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

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

17	Private grants, donations, or endowment income restricted to fundng charity care		17
18	Government grants, appropriations of transfers for support of hospital operations	21,146	18
19	Total unreimbursed cost for Medicaid, SCHIP and state and local indigent care programs (sum of lines 8, 12 and 16)	11,980	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)	18,394	40,208	58,602	20
21	Cost of patients approved for charity care and uninsured discounts (see instructions)	6,399	40,208	46,607	21
22	Payments received from patients for amounts previously written off as charity care	328	129	457	22
23	Cost of charity care (line 21 minus line 22)	6,071	40,079	46,150	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)	1,918,851	26
27	Medicare reimbursable bad debts for the entire hospital complex (see instructions)	139,125	27
27.01	Medicare allowable bad debts for the entire hospital complex (see instructions)	214,038	27.01
28	Non-Medicare and non-reimbursable Medicare bad debt expense (see instructions)	1,704,813	28
29	Cost of non-Medicare and non-reimbursable Medicare bad debt expense (line 1 times line 28)	668,016	29
30	Cost of uncompensated care (line 23, column 3 plus line 29)	714,166	30
31	Total unreimbursed and uncompensated care cost (line 19 plus line 30)	726,146	31

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RECLASSIFICATION AND ADJUSTMENT OF TRIAL BALANCE OF EXPENSES
WORKSHEET A

		COST CENTER DESCRIPTIONS	SALARIES	OTHER	TOTAL (col. 1 + col. 2)	RECLASSI- FICATIONS	RECLASSI- FIED TRIAL BALANCE (col. 3 ± col. 4)	ADJUST- MENTS	NET EXPENSES FOR ALLOC- ATION (col. 5 ± col. 6)	
			1	2	3	4	5	6	7	
		GENERAL SERVICE COST CENTERS								
1	00100	Cap Rel Costs-Bldg & Fixt				1,094,169	1,094,169	-291,538	802,631	1
2	00200	Cap Rel Costs-Mvble Equip		1,979,788	1,979,788	-1,094,169	885,619	-268,185	617,434	2
3	00300	Other Cap Rel Costs							-0-	3
4	00400	Employee Benefits Department		1,790,869	1,790,869		1,790,869	195,941	1,986,810	4
5	00500	Administrative & General	849,632	1,828,459	2,678,091	-441,910	2,236,181	1,429,462	3,665,643	5
6	00600	Maintenance & Repairs								6
7	00700	Operation of Plant		726,332	726,332		726,332	-11,406	714,926	7
8	00800	Laundry & Linen Service		6,926	6,926		6,926		6,926	8
9	00900	Housekeeping	210,854	81,499	292,353		292,353		292,353	9
10	01000	Dietary	433,131	200,271	633,402		633,402	-93,659	539,743	10
11	01100	Cafeteria								11
12	01200	Maintenance of Personnel								12
13	01300	Nursing Administration	721,102	82,820	803,922	157,836	961,758		961,758	13
14	01400	Central Services & Supply								14
15	01500	Pharmacy								15
16	01600	Medical Records & Library	161,893	16,496	178,389	112,263	290,652	78,630	369,282	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	797,716	162,670	960,386	-15,154	945,232	3,141	948,373	30
31	03100	Intensive Care Unit	115,767	29,418	145,185	-432	144,753		144,753	31
44	04400	Skilled Nursing Facility				1,161,032	1,161,032	-4,477	1,156,555	44
46	04600	Other Long Term Care	1,652,083	513,676	2,165,759	-1,743,676	422,083	-48,647	373,436	46
		ANCILLARY SERVICE COST CENTERS								
50	05000	Operating Room	675,913	1,593,254	2,269,167	-833,379	1,435,788	-119	1,435,669	50
51	05100	Recovery Room	546,401	137,417	683,818		683,818		683,818	51
53	05300	Anesthesiology	94,971	1,419,310	1,514,281		1,514,281	-1,261,237	253,044	53
54	05400	Radiology-Diagnostic	685,727	526,425	1,212,152	-22,669	1,189,483		1,189,483	54
60	06000	Laboratory	513,634	473,678	987,312	39,625	1,026,937	-16,320	1,010,617	60
60.01	06001	BLOOD LABORATORY								60.01
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS								62.30
65	06500	Respiratory Therapy	170,159	83,295	253,454	-715	252,739		252,739	65
66	06600	Physical Therapy	197,723	18,125	215,848	262,386	478,234		478,234	66
67	06700	Occupational Therapy				267,035	267,035		267,035	67
68	06800	Speech Pathology				22,233	22,233		22,233	68
71	07100	Medical Supplies Charged to Patients	65,148	8,609	73,757	605,710	679,467		679,467	71
72	07200	Impl. Dev. Charged to Patients				396,195	396,195		396,195	72
73	07300	Drugs Charged to Patients	209,259	728,874	938,133	63,143	1,001,276		1,001,276	73
76.97	07697	CARDIAC REHABILITATION	38,928	5,528	44,456	16,602	61,058		61,058	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY								76.98
76.99	07699	LITHOTRIPSY								76.99
		OUTPATIENT SERVICE COST CENTERS								
91	09100	Emergency	918,179	2,151,746	3,069,925	-46,125	3,023,800	-139,127	2,884,673	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)	9,058,220	14,565,485	23,623,705		23,623,705	-427,541	23,196,164	118
		NONREIMBURSABLE COST CENTERS								
192	19200	Physicians' Private Offices								192
200		TOTAL (sum of lines 118-199)	9,058,220	14,565,485	23,623,705		23,623,705	-427,541	23,196,164	200

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RECLASSIFICATIONS
WORKSHEET A-6

	EXPLANATION OF RECLASSIFICATION(S)	CODE (1)	INCREASES				
			COST CENTER	LINE #	SALARY	OTHER	
1	SNF/LONG TERM CARE EXP RECLASS	A	Skilled Nursing Facility	44	885,658	275,374	1
500	Total reclassifications				885,658	275,374	500
	Code Letter - A						
1	IMPLANTABLE DEVICES	B	Impl. Dev. Charged to Patient	72		396,195	1
500	Total reclassifications					396,195	500
	Code Letter - B						
1	MANAGER/DIRECTOR RECLASS	C	Nursing Administration	13	145,198	12,638	1
2	MANAGER/DIRECTOR RECLASS	C	Medical Records & Library	16	103,274	8,989	2
3	MANAGER/DIRECTOR RECLASS	C	Other Long Term Care	46	142,781	12,428	3
4	MANAGER/DIRECTOR RECLASS	C	CARDIAC REHABILITATION	76.97	15,273	1,329	4
500	Total reclassifications				406,526	35,384	500
	Code Letter - C						
1	INTERCOMPANY TRANSACTIONS	D	Employee Benefits Department	4	58,293		1
2	INTERCOMPANY TRANSACTIONS	D	Administrative & General	5	391,427		2
3	INTERCOMPANY TRANSACTIONS	D	Operation of Plant	7	175,662		3
4			Adults & Pediatrics	30	12,636		4
5			Intensive Care Unit	31	12,636		5
6			Operating Room	50		828	6
7			Radiology-Diagnostic	54		3,607	7
8			Respiratory Therapy	65	1,162		8
9	INTERCOMPANY TRANSACTIONS	D	Drugs Charged to Patients	73	82,604		9
10			Emergency	91	12,636		10
500	Total reclassifications				747,056	4,435	500
	Code Letter - D						
1	SNF AND LTC RECLASS	E	Radiology-Diagnostic	54	15,297	4,516	1
2	SNF AND LTC RECLASS	E	Laboratory	60	33,604	9,920	2
3	SNF AND LTC RECLASS	E	Respiratory Therapy	65	550	162	3
4	SNF AND LTC RECLASS	E	Physical Therapy	66	190,356	72,085	4
5	SNF AND LTC RECLASS	E	Occupational Therapy	67	198,814	68,221	5
6	SNF AND LTC RECLASS	E	Speech Pathology	68	16,570	5,663	6
7	SNF AND LTC RECLASS	E	Medical Supplies Charged to P	71	45,516	13,436	7
8	SNF AND LTC RECLASS	E	Drugs Charged to Patients	73	48,752	14,391	8
500	Total reclassifications				549,459	188,394	500
	Code Letter - E						
1	DEPRECIATION	F	Cap Rel Costs-Bldg & Fixt	1		1,094,169	1
500	Total reclassifications					1,094,169	500
	Code Letter - F						
1	LOCUM SALARY RECLASS	G	Anesthesiology	53	1,247,490		1
2	LOCUM SALARY RECLASS	G	Emergency	91	1,243,373		2
500	Total reclassifications				2,490,863		500
	Code Letter - G						
1	MEDICAL SUPPLIES CHARGED TO PATIENT	H	Medical Supplies Charged to P	71		546,758	1
2							2
3							3
4							4
5							5
6							6
7							7
8							8
9							9
500	Total reclassifications					546,758	500
	Code Letter - H						
	GRAND TOTAL (Increases)				5,079,562	2,540,709	

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

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RECLASSIFICATIONS
WORKSHEET A-6

	EXPLANATION OF RECLASSIFICATION(S)	CODE (1)	DECREASES				Wkst A-7 Ref.	
			COST CENTER	LINE #	SALARY	OTHER		
		1	6	7	8	9	10	
1	SNF/LONG TERM CARE EXP RECLASS	A	Other Long Term Care	46	885,658	275,374		1
500	Total reclassifications				885,658	275,374		500
	Code letter - A							
1	IMPLANTABLE DEVICES	B	Operating Room	50		396,195		1
500	Total reclassifications					396,195		500
	Code letter - B							
1	MANAGER/DIRECTOR RECLASS	C	Administrative & General	5	406,526	35,384		1
2	MANAGER/DIRECTOR RECLASS	C						2
3	MANAGER/DIRECTOR RECLASS	C						3
4	MANAGER/DIRECTOR RECLASS	C						4
500	Total reclassifications				406,526	35,384		500
	Code letter - C							
1	INTERCOMPANY TRANSACTIONS	D	Employee Benefits Department	4		58,293		1
2	INTERCOMPANY TRANSACTIONS	D	Administrative & General	5		391,427		2
3	INTERCOMPANY TRANSACTIONS	D	Operation of Plant	7		175,662		3
4			Adults & Pediatrics	30		12,636		4
5			Intensive Care Unit	31		12,636		5
6			Operating Room	50	828			6
7			Radiology-Diagnostic	54	3,607			7
8			Respiratory Therapy	65		1,162		8
9	INTERCOMPANY TRANSACTIONS	D	Drugs Charged to Patients	73		82,604		9
10			Emergency	91		12,636		10
500	Total reclassifications				4,435	747,056		500
	Code letter - D							
1	SNF AND LTC RECLASS	E	Other Long Term Care	46	549,459	188,394		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				549,459	188,394		500
	Code letter - E							
1	DEPRECIATION	F	Cap Rel Costs-Mvble Equip	2		1,094,169	9	1
500	Total reclassifications					1,094,169		500
	Code letter - F							
1	LOCUM SALARY RECLASS	G	Anesthesiology	53		1,247,490		1
2	LOCUM SALARY RECLASS	G	Emergency	91		1,243,373		2
500	Total reclassifications					2,490,863		500
	Code letter - G							
1	MEDICAL SUPPLIES CHARGED TO PATIENT	H	Adults & Pediatrics	30		15,154		1
2			Intensive Care Unit	31		432		2
3			Operating Room	50		437,184		3
4								4
5			Radiology-Diagnostic	54		42,482		5
6			Laboratory	60		3,899		6
7			Respiratory Therapy	65		1,427		7
8			Physical Therapy	66		55		8
9			Emergency	91		46,125		9
500	Total reclassifications					546,758		500
	Code letter - H							
	GRAND TOTAL (Decreases)				1,846,078	5,774,193		

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

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RECONCILIATION OF CAPITAL COST CENTERS**WORKSHEET A-7
PARTS I, II & III****PART I - ANALYSIS OF CHANGES IN CAPITAL ASSETS BALANCES**

	Description	Beginning Balances	Acquisitions			Disposals and Retirements	Ending Balance	Fully Depreciated Assets	
			Purchases	Donation	Total				
		1	2	3	4	5	6	7	
1	Land	222,604					222,604		1
2	Land Improvements	807,429	27,930		27,930		835,359		2
3	Buildings and Fixtures								3
4	Building Improvements	20,762,866	211,378		211,378		20,974,244		4
5	Fixed Equipment								5
6	Movable Equipment	15,101,158	532,821		532,821		15,633,979		6
7	HIT-designated Assets								7
8	Subtotal (sum of lines 1-7)	36,894,057	772,129		772,129		37,666,186		8
9	Reconciling Items								9
10	Total (line 7 minus line 9)	36,894,057	772,129		772,129		37,666,186		10

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

	Description	SUMMARY OF CAPITAL							
		Depreciation	Lease	Interest	Insurance (see instructions)	Taxes (see instructions)	Other Capital-Related Costs (see instructions)	Total (1) (sum of cols. 9 through 14)	
*		9	10	11	12	13	14	15	
1	Cap Rel Costs-Bldg & Fixt								1
2	Cap Rel Costs-Mvble Equip	1,979,788						1,979,788	2
3	Total (sum of lines 1-2)	1,979,788						1,979,788	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

	Description	COMPUTATION OF RATIOS				ALLOCATION OF OTHER CAPITAL				
		Gross Assets	Capitalized Leases	Gross Assets for Ratio (col. 1 - col. 2)	Ratio (see instructions)	Insurance	Taxes	Other Capital-Related Costs	Total (sum of cols. 5 through 7)	
*		1	2	3	4	5	6	7	8	
1	Cap Rel Costs-Bldg & Fi	22,032,207		22,032,207	0.584933					1
2	Cap Rel Costs-Mvble Equip	15,633,979		15,633,979	0.415067					2
3	Total (sum of lines 1-2)	37,666,186		37,666,186	1.000000					3

	Description	SUMMARY OF CAPITAL							
		Depreciation	Lease	Interest	Insurance (see instructions)	Taxes (see instructions)	Other Capital-Related Costs (see instructions)	Total (2) (sum of cols. 9 through 14)	
*		9	10	11	12	13	14	15	
1	Cap Rel Costs-Bldg & Fixt	1,094,169		-291,538				802,631	1
2	Cap Rel Costs-Mvble Equip	617,434						617,434	2
3	Total (sum of lines 1-2)	1,711,603		-291,538				1,420,065	3

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

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ADJUSTMENTS TO EXPENSES**WORKSHEET A-8**

	DESCRIPTION(1)	BASIS/ CODE (2)	AMOUNT	EXPENSE CLASSIFICATION ON WORKSHEET A TO/FROM WHICH THE AMOUNT IS TO BE ADJUSTED		Wkst. A-7 Ref.	
				COST CENTER	LINE#		
		1	2	3	4	5	
1	Investment income-buildings & fixtures (chapter 2)			Cap Rel Costs-Bldg & Fixt	1		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	-4,293	Operation of Plant	7		8
9	Parking lot (chapter 21)						9
10	Provider-based physician adjustment	Wkst A-8-2	-1,743,758				10
11	Sale of scrap, waste, etc. (chapter 23)						11
12	Related organization transactions (chapter 10)	Wkst A-8-1	2,539,436				12
13	Laundry and linen service						13
14	Cafeteria - employees and guests	B	-93,659	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	-60	Medical Records & Library	16		18
19	Nursing and allied health education (tuition, fees, books, etc.)						19
20	Vending machines						20
21	Income from imposition of interest, finance or penalty charges (chapter 21)						21
22	Interest exp on Medicare overpayments & borrowings to repay Medicare overpayments						22
23	Adj for respiratory therapy costs in excess of limitation (chapter 14)	Wkst A-8-3		Respiratory Therapy	65		23
24	Adj for physical therapy costs in excess of limitation (chapter 14)	Wkst A-8-3		Physical Therapy	66		24
25	Util review-physicians' compensation (chapter 21)			Utilization Review-SNF	114		25
26	Depreciation--buildings & fixtures			Cap Rel Costs-Bldg & Fixt	1		26
27	Depreciation--movable equipment			Cap Rel Costs-Mvble Equip	2		27
28	Non-physician anesthetist			Nonphysician Anesthetists	19		28
29	Physicians' assistant						29
30	Adj for occupational therapy costs in excess of limitation (chapter 14)	Wkst A-8-3		Occupational Therapy	67		30
31	Adj for speech pathology costs in excess of limitation (chapter 14)	Wkst A-8-3		Speech Pathology	68		31
32	CAH HIT Adj for Depreciation	A	-210,136	Cap Rel Costs-Mvble Equip	2	9	32
33	OTHER OPERATING REVENUE	B	-1,489	Administrative & General	5		33
34	ILLINOIS UNALLOWABLE REAL ESTAT	A	-7,788	Operation of Plant	7		34
35	LOBBYING EXPENSE	A	-11,972	Administrative & General	5		35
36							36
37	HOSPITAL TAX	A	-542,759	Administrative & General	5		37
38							38
39	CASH DISCOUNTS	B	-401	Administrative & General	5		39
40	HOME OFFICE INTEREST EXPENSE	A	-291,538	Cap Rel Costs-Bldg & Fixt	1	11	40
41							41
42	SNF TAX	A	-7,260	Skilled Nursing Facility	44		42
43	CARE CENTER TAX	A	-51,728	Other Long Term Care	46		43
44	OTHER OPERATING	B	-136	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)		-427,541				50

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

(2) Basis for adjustment (see instructions)

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

B. Amount Received - if cost cannot be determined

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

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

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

WORKSHEET A-8-1

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

	Line No.	Cost Center	Expense Items	Amount of Allowable Cost	Amount Included in Wkst. A column 5	Net Adjustments (col. 4 minus col. 5)*	Wkst. A-7 Ref.	
	1	2	3	4	5	6	7	
1	4	Employee Benefits Department	HOME OFFICE EMPLOYEE BENEFITS	262,380	66,439	195,941		1
2	5	Administrative & General	HOME OFFICE ADMIN & GENERAL	3,008,024	1,077,488	1,930,536		2
3	7	Operation of Plant	HOME OFFICE OPERATION OF PLANT	675		675		3
3.01	16	Medical Records & Library	HOME OFFICE MEDICAL RECOR	78,690		78,690		3.01
3.07	5	Administrative & General	MED DIRECTOR DIRECT ALLOC	55,547		55,547		3.07
3.08	30	Adults & Pediatrics	MED DIRECTOR DIRECT ALLOC	3,141		3,141		3.08
3.09	53	Anesthesiology	MED DIRECTOR DIRECT ALLOC	33,333		33,333		3.09
3.10	91	Emergency	MED DIRECTOR DIRECT ALLOC	58,746		58,746		3.10
3.11	44	Skilled Nursing Facility	MED DIRECTOR DIRECT ALLOC	2,783		2,783		3.11
3.12	46	Other Long Term Care	MED DIRECTOR DIRECT ALLOC	3,217		3,217		3.12
3.14	2	Cap Rel Costs-Mvble Equip	HIT ASSETS FROM JVL	152,087	210,136	-58,049	9	3.14
3.16	53	Anesthesiology	PHYSICIAN BENEFITS	112,095		112,095		3.16
3.17	91	Emergency	PHYSICIAN BENEFITS	122,781		122,781		3.17
4								4
5	TOTALS (sum of lines 1-4) Transfer column 6, line 5 to Worksheet A-8, column 2, line 12			3,893,499	1,354,063	2,539,436		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:

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PROVIDER-BASED PHYSICIANS ADJUSTMENTS

WORKSHEET A-8-2

	Wkst A Line #	Cost Center/ Physician Identifier	Total Remun- eration	Professional Component	Provider Component	RCE Amount	Physician/ Provider Component Hours	Unadjusted RCE Limit	5 Percent of Unadjusted RCE Limit	
	1	2	3	4	5	6	7	8	9	
1	50	Operating Room AGGREGATE-OPERA	43,639	119	43,520					1
2	60	Laboratory AGGREGATE-LABOR	16,320	16,320						2
3	53	Anesthesiology AGGREGATE-ANEST	1,406,665	1,406,665						3
4	91	Emergency AGGREGATE-EMERG	1,352,790	320,654	1,032,136					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	2,819,414	1,743,758	1,075,656					200

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PROVIDER-BASED PHYSICIANS ADJUSTMENTS

WORKSHEET A-8-2

	Wkst A Line #	Cost Center/ Physician Identifier	Cost of Memberships & Continuing Education	Provider Component Share of col. 12	Physician Cost of Malpractice Insurance	Provider Component Share of col. 14	Adjusted RCE Limit	RCE Disallowance	Adjustment	
	10	11	12	13	14	15	16	17	18	
1	50	Operating Room AGGREGATE-OPERA							119	1
2	60	Laboratory AGGREGATE-LABOR							16,320	2
3	53	Anesthesiology AGGREGATE-ANEST							1,406,665	3
4	91	Emergency AGGREGATE-EMERG							320,654	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							1,743,758	200

KPMG LLP Compu-Max 2552-10

HARVARD MEMORIAL HOSPITAL Provider CCN: 14-1335	In Lieu of Form CMS-2552-10	Period : From: 07/01/2017 To: 06/30/2018	Run Date: 11/28/2018 Run Time: 12:39 Version: 2018.04 (09/26/2018)
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COST ALLOCATION - GENERAL SERVICE COSTS

WORKSHEET B PART I

	COST CENTER DESCRIPTIONS	NET EXP FOR COST ALLOCATION (from Wkst A, col.7)	CAP BLDGS & FIXTURES	CAP MOVABLE EQUIPMENT	EMPLOYEE BENEFITS DEPARTMENT	SUBTOTAL (cols.0-4)	ADMINIS- TRATIVE & GENERAL	
		0	1	2	4	4A	5	
	GENERAL SERVICE COST CENTERS							
1	Cap Rel Costs-Bldg & Fixt	802,631	802,631					1
2	Cap Rel Costs-Mvble Equip	617,434		617,434				2
4	Employee Benefits Department	1,986,810			1,986,810			4
5	Administrative & General	3,665,643	96,240	6,035	405,152	4,173,070	4,173,070	5
6	Maintenance & Repairs							6
7	Operation of Plant	714,926	159,634	97,901		972,461	213,328	7
8	Laundry & Linen Service	6,926	9,264	1,093		17,283	3,791	8
9	Housekeeping	292,353	3,649	1,014	35,221	332,237	72,882	9
10	Dietary	539,743	24,694	14,631	72,351	651,419	142,901	10
11	Cafeteria		13,274			13,274	2,912	11
12	Maintenance of Personnel							12
13	Nursing Administration	961,758	4,452	1,754	144,708	1,112,672	244,086	13
14	Central Services & Supply							14
15	Pharmacy							15
16	Medical Records & Library	369,282	17,094		44,294	430,670	94,476	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	948,373	66,913	11,255	133,251	1,159,792	254,422	30
31	Intensive Care Unit	144,753	18,428	529	19,338	183,048	40,155	31
44	Skilled Nursing Facility	1,156,555	47,854	5,344	147,941	1,357,694	297,836	44
46	Other Long Term Care	373,436	82,203	12,646	60,092	528,377	115,910	46
	ANCILLARY SERVICE COST CENTERS							
50	Operating Room	1,435,669	78,564	201,415	112,887	1,828,535	401,124	50
51	Recovery Room	683,818	3,208	5,212	91,271	783,509	171,878	51
53	Anesthesiology	253,044		8,139		261,183	57,295	53
54	Radiology-Diagnostic	1,189,483	22,909	187,871	117,100	1,517,363	332,862	54
60	Laboratory	1,010,617	15,310	9,777	91,411	1,127,115	247,254	60
60.01	BLOOD LABORATORY							60.01
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
65	Respiratory Therapy	252,739	12,934	8,281	28,515	302,469	66,352	65
66	Physical Therapy	478,234	36,204	3,470	64,825	582,733	127,834	66
67	Occupational Therapy	267,035			33,210	300,245	65,864	67
68	Speech Pathology	22,233		171	2,768	25,172	5,522	68
71	Medical Supplies Charged to Patients	679,467		20,691	18,485	718,643	157,648	71
72	Impl. Dev. Charged to Patients	396,195				396,195	86,913	72
73	Drugs Charged to Patients	1,001,276	5,414	2,117	43,098	1,051,905	230,755	73
76.97	CARDIAC REHABILITATION	61,058	5,013	8,648	9,054	83,773	18,377	76.97
76.98	HYPERBARIC OXYGEN THERAPY							76.98
76.99	LITHOTRIPSY							76.99
	OUTPATIENT SERVICE COST CENTERS							
91	Emergency	2,884,673	14,568	9,440	311,838	3,220,519	706,476	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)	23,196,164	737,823	617,434	1,986,810	23,131,356	4,158,853	118
	NONREIMBURSABLE COST CENTERS							
192	Physicians' Private Offices		64,808			64,808	14,217	192
200	Cross Foot Adjustments							200
201	Negative Cost Centers							201
202	TOTAL (sum of lines 118-201)	23,196,164	802,631	617,434	1,986,810	23,196,164	4,173,070	202

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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	1,185,789						7
8	Laundry & Linen Service	20,091	41,165					8
9	Housekeeping	7,915		413,034				9
10	Dietary	53,556		19,106	866,982			10
11	Cafeteria	28,789		10,270	192,391	247,636		11
12	Maintenance of Personnel							12
13	Nursing Administration	9,654		3,444		16,907	1,386,763	13
14	Central Services & Supply							14
15	Pharmacy							15
16	Medical Records & Library	37,074		13,226		7,616		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	145,120	5,472	51,771	55,648	22,803	275,257	30
31	Intensive Care Unit	39,966	197	14,258		2,524	25,523	31
44	Skilled Nursing Facility	103,784	8,599	37,025	285,412	31,312	145,316	44
46	Other Long Term Care	178,279	9,937	63,598	329,801	36,200	167,914	46
	ANCILLARY SERVICE COST CENTERS							
50	Operating Room	170,386	7,907	60,785		18,046	208,336	50
51	Recovery Room	6,958	640	2,482		16,013	205,410	51
53	Anesthesiology					10,542	35,006	53
54	Radiology-Diagnostic	49,685	2,829	17,725		18,671		54
60	Laboratory	33,203		11,845		17,510		60
60.01	BLOOD LABORATORY							60.01
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
65	Respiratory Therapy	28,050		10,007		5,025		65
66	Physical Therapy	78,518	438	28,011		6,343		66
67	Occupational Therapy							67
68	Speech Pathology							68
71	Medical Supplies Charged to Patients					3,372		71
72	Impl. Dev. Charged to Patients							72
73	Drugs Charged to Patients	11,742		4,189		4,467		73
76.97	CARDIAC REHABILITATION	10,872	390	3,879		2,256		76.97
76.98	HYPERBARIC OXYGEN THERAPY							76.98
76.99	LITHOTRIPSY							76.99
	OUTPATIENT SERVICE COST CENTERS							
91	Emergency	31,594	4,644	11,271	3,730	28,029	324,001	91
92	Observation Beds (Non-Distinct Part)							92
	OTHER REIMBURSABLE COST CENTERS							
99.10	CORE							99.10
	SPECIAL PURPOSE COST CENTERS							
118	SUBTOTALS (sum of lines 1-117)	1,045,236	41,053	362,892	866,982	247,636	1,386,763	118
	NONREIMBURSABLE COST CENTERS							
192	Physicians' Private Offices	140,553	112	50,142				192
200	Cross Foot Adjustments							200
201	Negative Cost Centers							201
202	TOTAL (sum of lines 118-201)	1,185,789	41,165	413,034	866,982	247,636	1,386,763	202

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HARVARD MEMORIAL HOSPITAL Provider CCN: 14-1335	In Lieu of Form CMS-2552-10	Period : From: 07/01/2017 To: 06/30/2018	Run Date: 11/28/2018 Run Time: 12:39 Version: 2018.04 (09/26/2018)
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COST ALLOCATION - GENERAL SERVICE COSTS
**WORKSHEET B
PART I**

	COST CENTER DESCRIPTIONS	MEDICAL RECORDS & LIBRARY	SUBTOTAL	I&R COST & POST STEP- DOWN ADJS	TOTAL		
		16	24	25	26		
	GENERAL SERVICE COST CENTERS						
1	Cap Rel Costs-Bldg & Fixt						1
2	Cap Rel Costs-Mvble Equip						2
4	Employee Benefits Department						4
5	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	583,062					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	26,848	1,997,133		1,997,133		30
31	Intensive Care Unit	1,666	307,337		307,337		31
44	Skilled Nursing Facility		2,266,978		2,266,978		44
46	Other Long Term Care		1,430,016		1,430,016		46
	ANCILLARY SERVICE COST CENTERS						
50	Operating Room	163,494	2,858,613		2,858,613		50
51	Recovery Room		1,186,890		1,186,890		51
53	Anesthesiology		364,026		364,026		53
54	Radiology-Diagnostic	329,026	2,268,161		2,268,161		54
60	Laboratory		1,436,927		1,436,927		60
60.01	BLOOD LABORATORY						60.01
62.30	BLOOD CLOTTING FOR HEMOPHILIACS						62.30
65	Respiratory Therapy		411,903		411,903		65
66	Physical Therapy	8,888	832,765		832,765		66
67	Occupational Therapy		366,109		366,109		67
68	Speech Pathology		30,694		30,694		68
71	Medical Supplies Charged to Patients		879,663		879,663		71
72	Impl. Dev. Charged to Patients		483,108		483,108		72
73	Drugs Charged to Patients		1,303,058		1,303,058		73
76.97	CARDIAC REHABILITATION	17,405	136,952		136,952		76.97
76.98	HYPERBARIC OXYGEN THERAPY						76.98
76.99	LITHOTRIPSY						76.99
	OUTPATIENT SERVICE COST CENTERS						
91	Emergency	35,735	4,365,999		4,365,999		91
92	Observation Beds (Non-Distinct Part)						92
	OTHER REIMBURSABLE COST CENTERS						
99.10	CORE						99.10
	SPECIAL PURPOSE COST CENTERS						
118	SUBTOTALS (sum of lines 1-117)	583,062	22,926,332		22,926,332		118
	NONREIMBURSABLE COST CENTERS						
192	Physicians' Private Offices		269,832		269,832		192
200	Cross Foot Adjustments						200
201	Negative Cost Centers						201
202	TOTAL (sum of lines 118-201)	583,062	23,196,164		23,196,164		202

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HARVARD MEMORIAL HOSPITAL Provider CCN: 14-1335	In Lieu of Form CMS-2552-10	Period : From: 07/01/2017 To: 06/30/2018	Run Date: 11/28/2018 Run Time: 12:39 Version: 2018.04 (09/26/2018)
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ALLOCATION OF CAPITAL-RELATED COSTS
**WORKSHEET B
PART II**

	COST CENTER DESCRIPTIONS	DIR ASSGND CAP-REL COSTS	CAP BLDGS & FIXTURES	CAP MOVABLE EQUIPMENT	SUBTOTAL	EMPLOYEE BENEFITS DEPARTMENT	ADMINIS- TRATIVE & GENERAL	
		0	1	2	2A	4	5	
	GENERAL SERVICE COST CENTERS							
1	Cap Rel Costs-Bldg & Fixt							1
2	Cap Rel Costs-Mvble Equip							2
4	Employee Benefits Department	1,061			1,061	1,061		4
5	Administrative & General	153,596	96,240	6,035	255,871	217	256,088	5
6	Maintenance & Repairs							6
7	Operation of Plant	33,635	159,634	97,901	291,170		13,091	7
8	Laundry & Linen Service		9,264	1,093	10,357		233	8
9	Housekeeping	2,271	3,649	1,014	6,934	19	4,473	9
10	Dietary	1,969	24,694	14,631	41,294	39	8,769	10
11	Cafeteria		13,274		13,274		179	11
12	Maintenance of Personnel							12
13	Nursing Administration	463	4,452	1,754	6,669	77	14,979	13
14	Central Services & Supply							14
15	Pharmacy							15
16	Medical Records & Library	1,061	17,094		18,155	24	5,798	16
17	Social Service							17
19	Nonphysician Anesthetists							19
20	Nursing School							20
21	I&R Services-Salary & Fringes Apprvd							21
22	I&R Services-Other Prgm Costs Apprvd							22
23	Paramed Ed Prgm-(specify)							23
	INPATIENT ROUTINE SERV COST CENTERS							
30	Adults & Pediatrics	3,958	66,913	11,255	82,126	71	15,613	30
31	Intensive Care Unit	1,151	18,428	529	20,108	10	2,464	31
44	Skilled Nursing Facility	15,146	47,854	5,344	68,344	79	18,277	44
46	Other Long Term Care	17,502	82,203	12,646	112,351	32	7,113	46
	ANCILLARY SERVICE COST CENTERS							
50	Operating Room	32,059	78,564	201,415	312,038	60	24,616	50
51	Recovery Room	801	3,208	5,212	9,221	49	10,548	51
53	Anesthesiology			8,139	8,139		3,516	53
54	Radiology-Diagnostic	9,421	22,909	187,871	220,201	62	20,427	54
60	Laboratory	6,734	15,310	9,777	31,821	49	15,173	60
60.01	BLOOD LABORATORY							60.01
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
65	Respiratory Therapy	5,631	12,934	8,281	26,846	15	4,072	65
66	Physical Therapy	1,133	36,204	3,470	40,807	35	7,845	66
67	Occupational Therapy					18	4,042	67
68	Speech Pathology			171	171	1	339	68
71	Medical Supplies Charged to Patients			20,691	20,691	10	9,674	71
72	Impl. Dev. Charged to Patients						5,334	72
73	Drugs Charged to Patients	58,704	5,414	2,117	66,235	23	14,161	73
76.97	CARDIAC REHABILITATION	144	5,013	8,648	13,805	5	1,128	76.97
76.98	HYPERBARIC OXYGEN THERAPY							76.98
76.99	LITHOTRIPSY							76.99
	OUTPATIENT SERVICE COST CENTERS							
91	Emergency	2,596	14,568	9,440	26,604	166	43,352	91
92	Observation Beds (Non-Distinct Part)							92
	OTHER REIMBURSABLE COST CENTERS							
99.10	CORE							99.10
	SPECIAL PURPOSE COST CENTERS							
118	SUBTOTALS (sum of lines 1-117)	349,036	737,823	617,434	1,704,293	1,061	255,216	118
	NONREIMBURSABLE COST CENTERS							
192	Physicians' Private Offices		64,808		64,808		872	192
200	Cross Foot Adjustments							200
201	Negative Cost Centers							201
202	TOTAL (sum of lines 118-201)	349,036	802,631	617,434	1,769,101	1,061	256,088	202

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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	304,261						7
8	Laundry & Linen Service	5,155	15,745					8
9	Housekeeping	2,031		13,457				9
10	Dietary	13,742		622	64,466			10
11	Cafeteria	7,387		335	14,306	35,481		11
12	Maintenance of Personnel							12
13	Nursing Administration	2,477		112		2,422	26,736	13
14	Central Services & Supply							14
15	Pharmacy							15
16	Medical Records & Library	9,513		431		1,091		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	37,236	2,093	1,687	4,138	3,267	5,307	30
31	Intensive Care Unit	10,255	75	465		362	492	31
44	Skilled Nursing Facility	26,630	3,289	1,206	21,222	4,486	2,802	44
46	Other Long Term Care	45,743	3,802	2,073	24,523	5,188	3,237	46
	ANCILLARY SERVICE COST CENTERS							
50	Operating Room	43,719	3,024	1,980		2,586	4,017	50
51	Recovery Room	1,785	245	81		2,294	3,960	51
53	Anesthesiology					1,510	675	53
54	Radiology-Diagnostic	12,749	1,082	577		2,675		54
60	Laboratory	8,520		386		2,509		60
60.01	BLOOD LABORATORY							60.01
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
65	Respiratory Therapy	7,197		326		720		65
66	Physical Therapy	20,147	167	913		909		66
67	Occupational Therapy							67
68	Speech Pathology							68
71	Medical Supplies Charged to Patients					483		71
72	Impl. Dev. Charged to Patients							72
73	Drugs Charged to Patients	3,013		136		640		73
76.97	CARDIAC REHABILITATION	2,790	149	126		323		76.97
76.98	HYPERBARIC OXYGEN THERAPY							76.98
76.99	LITHOTRIPSY							76.99
	OUTPATIENT SERVICE COST CENTERS							
91	Emergency	8,107	1,776	367	277	4,016	6,246	91
92	Observation Beds (Non-Distinct Part)							92
	OTHER REIMBURSABLE COST CENTERS							
99.10	CORE							99.10
	SPECIAL PURPOSE COST CENTERS							
118	SUBTOTALS (sum of lines 1-117)	268,196	15,702	11,823	64,466	35,481	26,736	118
	NONREIMBURSABLE COST CENTERS							
192	Physicians' Private Offices	36,065	43	1,634				192
200	Cross Foot Adjustments							200
201	Negative Cost Centers							201
202	TOTAL (sum of lines 118-201)	304,261	15,745	13,457	64,466	35,481	26,736	202

KPMG LLP Compu-Max 2552-10

HARVARD MEMORIAL HOSPITAL Provider CCN: 14-1335	In Lieu of Form CMS-2552-10	Period : From: 07/01/2017 To: 06/30/2018	Run Date: 11/28/2018 Run Time: 12:39 Version: 2018.04 (09/26/2018)
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ALLOCATION OF CAPITAL-RELATED COSTS
**WORKSHEET B
PART II**

	COST CENTER DESCRIPTIONS	MEDICAL RECORDS & LIBRARY	SUBTOTAL	I&R COST & POST STEP- DOWN ADJS	TOTAL			
		16	24	25	26			
	GENERAL SERVICE COST CENTERS							
1	Cap Rel Costs-Bldg & Fixt							1
2	Cap Rel Costs-Mvble Equip							2
4	Employee Benefits Department							4
5	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	35,012						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	1,612	153,150		153,150			30
31	Intensive Care Unit	100	34,331		34,331			31
44	Skilled Nursing Facility		146,335		146,335			44
46	Other Long Term Care		204,062		204,062			46
	ANCILLARY SERVICE COST CENTERS							
50	Operating Room	9,818	401,858		401,858			50
51	Recovery Room		28,183		28,183			51
53	Anesthesiology		13,840		13,840			53
54	Radiology-Diagnostic	19,757	277,530		277,530			54
60	Laboratory		58,458		58,458			60
60.01	BLOOD LABORATORY							60.01
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
65	Respiratory Therapy		39,176		39,176			65
66	Physical Therapy	534	71,357		71,357			66
67	Occupational Therapy		4,060		4,060			67
68	Speech Pathology		511		511			68
71	Medical Supplies Charged to Patients		30,858		30,858			71
72	Impl. Dev. Charged to Patients		5,334		5,334			72
73	Drugs Charged to Patients		84,208		84,208			73
76.97	CARDIAC REHABILITATION	1,045	19,371		19,371			76.97
76.98	HYPERBARIC OXYGEN THERAPY							76.98
76.99	LITHOTRIPSY							76.99
	OUTPATIENT SERVICE COST CENTERS							
91	Emergency	2,146	93,057		93,057			91
92	Observation Beds (Non-Distinct Part)							92
	OTHER REIMBURSABLE COST CENTERS							
99.10	CORE							99.10
	SPECIAL PURPOSE COST CENTERS							
118	SUBTOTALS (sum of lines 1-117)	35,012	1,665,679		1,665,679			118
	NONREIMBURSABLE COST CENTERS							
192	Physicians' Private Offices		103,422		103,422			192
200	Cross Foot Adjustments							200
201	Negative Cost Centers							201
202	TOTAL (sum of lines 118-201)	35,012	1,769,101		1,769,101			202

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COST ALLOCATION - STATISTICAL BASIS
WORKSHEET B-1

	COST CENTER DESCRIPTIONS	CAP BLDGS & FIXTURES SQUARE FEET	CAP MOVABLE EQUIPMENT DOLLAR VALUE	EMPLOYEE BENEFITS DEPARTMENT GROSS SALARIES	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		673,279					2
4	Employee Benefits Department			11,894,112				4
5	Administrative & General	9,599	6,581	2,425,423	-4,173,070	19,023,094		5
6	Maintenance & Repairs							6
7	Operation of Plant	15,922	106,756			972,461	54,534	7
8	Laundry & Linen Service	924	1,192			17,283	924	8
9	Housekeeping	364	1,106	210,854		332,237	364	9
10	Dietary	2,463	15,954	433,131		651,419	2,463	10
11	Cafeteria	1,324				13,274	1,324	11
12	Maintenance of Personnel							12
13	Nursing Administration	444	1,913	866,300		1,112,672	444	13
14	Central Services & Supply							14
15	Pharmacy							15
16	Medical Records & Library	1,705		265,167		430,670	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	12,273	797,716		1,159,792	6,674	30
31	Intensive Care Unit	1,838	577	115,767		183,048	1,838	31
44	Skilled Nursing Facility	4,773	5,827	885,658		1,357,694	4,773	44
46	Other Long Term Care	8,199	13,790	359,747		528,377	8,199	46
	ANCILLARY SERVICE COST CENTERS							
50	Operating Room	7,836	219,632	675,803		1,828,535	7,836	50
51	Recovery Room	320	5,683	546,401		783,509	320	51
53	Anesthesiology		8,875			261,183		53
54	Radiology-Diagnostic	2,285	204,863	701,024		1,517,363	2,285	54
60	Laboratory	1,527	10,661	547,238		1,127,115	1,527	60
60.01	BLOOD LABORATORY							60.01
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
65	Respiratory Therapy	1,290	9,030	170,709		302,469	1,290	65
66	Physical Therapy	3,611	3,784	388,079		582,733	3,611	66
67	Occupational Therapy			198,814		300,245		67
68	Speech Pathology		187	16,570		25,172		68
71	Medical Supplies Charged to Patients		22,562	110,664		718,643		71
72	Impl. Dev. Charged to Patients					396,195		72
73	Drugs Charged to Patients	540	2,309	258,011		1,051,905	540	73
76.97	CARDIAC REHABILITATION	500	9,430	54,202		83,773	500	76.97
76.98	HYPERBARIC OXYGEN THERAPY							76.98
76.99	LITHOTRIPSY							76.99
	OUTPATIENT SERVICE COST CENTERS							
91	Emergency	1,453	10,294	1,866,834		3,220,519	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	673,279	11,894,112	-4,173,070	18,958,286	48,070	118
	NONREIMBURSABLE COST CENTERS							
192	Physicians' Private Offices	6,464				64,808	6,464	192
200	Cross foot adjustments							200
201	Negative cost centers							201
202	Cost to be allocated (Per Wkst. B, Part I)	802,631	617,434	1,986,810		4,173,070	1,185,789	202
203	Unit Cost Multiplier (Wkst. B, Part I)	10.025995	0.917055	0.167041		0.219369	21.744031	203
204	Cost to be allocated (Per Wkst. B, Part II)			1,061		256,088	304,261	204
205	Unit Cost Multiplier (Wkst. B, Part II)			0.000089		0.013462	5.579290	205
206	NAHE adjustment amount to be allocated (per Wkst. B-2)							206
207	NAHE Unit Cost Multiplier (Wkst. D, Parts III and IV)							207

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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	134,346						8
9	Housekeeping		53,246					9
10	Dietary		2,463	50,665				10
11	Cafeteria		1,324	11,243	11,088			11
12	Maintenance of Personnel							12
13	Nursing Administration		444		757	66,830		13
14	Central Services & Supply							14
15	Pharmacy							15
16	Medical Records & Library		1,705		341		3,149	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	17,859	6,674	3,252	1,021	13,265	145	30
31	Intensive Care Unit	642	1,838		113	1,230	9	31
44	Skilled Nursing Facility	28,064	4,773	16,679	1,402	7,003		44
46	Other Long Term Care	32,430	8,199	19,273	1,621	8,092		46
	ANCILLARY SERVICE COST CENTERS							
50	Operating Room	25,804	7,836		808	10,040	883	50
51	Recovery Room	2,088	320		717	9,899		51
53	Anesthesiology				472	1,687		53
54	Radiology-Diagnostic	9,233	2,285		836		1,777	54
60	Laboratory		1,527		784			60
60.01	BLOOD LABORATORY							60.01
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
65	Respiratory Therapy		1,290		225			65
66	Physical Therapy	1,429	3,611		284		48	66
67	Occupational Therapy							67
68	Speech Pathology							68
71	Medical Supplies Charged to Patients				151			71
72	Impl. Dev. Charged to Patients							72
73	Drugs Charged to Patients		540		200			73
76.97	CARDIAC REHABILITATION	1,274	500		101		94	76.97
76.98	HYPERBARIC OXYGEN THERAPY							76.98
76.99	LITHOTRIPSY							76.99
	OUTPATIENT SERVICE COST CENTERS							
91	Emergency	15,157	1,453	218	1,255	15,614	193	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)	133,980	46,782	50,665	11,088	66,830	3,149	118
	NONREIMBURSABLE COST CENTERS							
192	Physicians' Private Offices	366	6,464					192
200	Cross foot adjustments							200
201	Negative cost centers							201
202	Cost to be allocated (Per Wkst. B, Part I)	41,165	413,034	866,982	247,636	1,386,763	583,062	202
203	Unit Cost Multiplier (Wkst. B, Part I)	0.306410	7.757090	17.112050	22.333694	20.750606	185.157828	203
204	Cost to be allocated (Per Wkst. B, Part II)	15,745	13,457	64,466	35,481	26,736	35,012	204
205	Unit Cost Multiplier (Wkst. B, Part II)	0.117197	0.252733	1.272397	3.199946	0.400060	11.118450	205
206	NAHE adjustment amount to be allocated (per Wkst. B-2)							206
207	NAHE Unit Cost Multiplier (Wkst. D, Parts III and IV)							207

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

	COST CENTER DESCRIPTIONS							

	GENERAL SERVICE COST CENTERS							
1	Cap Rel Costs-Bldg & Fixt							1
2	Cap Rel Costs-Mvble Equip							2
4	Employee Benefits Department							4
5	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	CORE							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
206	NAHE adjustment amount to be allocated (per Wkst. B-2)							206
207	NAHE Unit Cost Multiplier (Wkst. D, Parts III and IV)							207

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POST STEPDOWN ADJUSTMENTS

WORKSHEET B-2

	DESCRIPTION	WORKSHEET		AMOUNT	
		CODE	LINE NO.		
	1	2	3	4	

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

				COSTS			
	COST CENTER DESCRIPTIONS	Total Cost (from Wkst. B, Part I, col. 26)	Therapy Limit Adj.	Total Costs	RCE Dis- allowance	Total Costs	
		1	2	3	4	5	
	INPATIENT ROUTINE SERVICE COST CENTERS						
30	Adults & Pediatrics	1,997,133		1,997,133		1,997,133	30
31	Intensive Care Unit	307,337		307,337		307,337	31
44	Skilled Nursing Facility	2,266,978		2,266,978		2,266,978	44
46	Other Long Term Care	1,430,016		1,430,016		1,430,016	46
	ANCILLARY SERVICE COST CENTERS						
50	Operating Room	2,858,613		2,858,613		2,858,613	50
51	Recovery Room	1,186,890		1,186,890		1,186,890	51
53	Anesthesiology	364,026		364,026		364,026	53
54	Radiology-Diagnostic	2,268,161		2,268,161		2,268,161	54
60	Laboratory	1,436,927		1,436,927		1,436,927	60
60.01	BLOOD LABORATORY						60.01
62.30	BLOOD CLOTTING FOR HEMOPHILIACS						62.30
65	Respiratory Therapy	411,903		411,903		411,903	65
66	Physical Therapy	832,765		832,765		832,765	66
67	Occupational Therapy	366,109		366,109		366,109	67
68	Speech Pathology	30,694		30,694		30,694	68
71	Medical Supplies Charged to Patients	879,663		879,663		879,663	71
72	Impl. Dev. Charged to Patients	483,108		483,108		483,108	72
73	Drugs Charged to Patients	1,303,058		1,303,058		1,303,058	73
76.97	CARDIAC REHABILITATION	136,952		136,952		136,952	76.97
76.98	HYPERBARIC OXYGEN THERAPY						76.98
76.99	LITHOTRIPSY						76.99
	OUTPATIENT SERVICE COST CENTERS						
91	Emergency	4,365,999		4,365,999		4,365,999	91
92	Observation Beds (Non-Distinct Part)	336,010		336,010		336,010	92
	OTHER REIMBURSABLE COST CENTERS						
99.10	CORF						99.10
200	Subtotal (sum of lines 30 thru 199)	23,262,342		23,262,342		23,262,342	200
201	Less Observation Beds	336,010		336,010		336,010	201
202	Total (line 200 minus line 201)	22,926,332		22,926,332		22,926,332	202

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HARVARD MEMORIAL HOSPITAL Provider CCN: 14-1335	In Lieu of Form CMS-2552-10	Period : From: 07/01/2017 To: 06/30/2018	Run Date: 11/28/2018 Run Time: 12:39 Version: 2018.04 (09/26/2018)
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COMPUTATION OF RATIO OF COST TO CHARGES
**WORKSHEET C
PART I**

		CHARGES						
	COST CENTER DESCRIPTIONS	Inpatient	Outpatient	Total (column 6 + column 7)	Cost or Other Ratio	TEFRA Inpatient Ratio	PPS Inpatient Ratio	
		6	7	8	9	10	11	
	INPATIENT ROUTINE SERVICE COST CENTERS							
30	Adults & Pediatrics	3,325,168		3,325,168				30
31	Intensive Care Unit	230,611		230,611				31
44	Skilled Nursing Facility	806,669		806,669				44
46	Other Long Term Care	932,415		932,415				46
	ANCILLARY SERVICE COST CENTERS							
50	Operating Room	2,039,644	16,043,548	18,083,192	0.158081	0.158081	0.158081	50
51	Recovery Room	176,388	3,614,702	3,791,090	0.313074	0.313074	0.313074	51
53	Anesthesiology		93,488	93,488	3.893826	3.893826	3.893826	53
54	Radiology-Diagnostic	788,988	10,739,422	11,528,410	0.196745	0.196745	0.196745	54
60	Laboratory	554,094	2,828,519	3,382,613	0.424798	0.424798	0.424798	60
60.01	BLOOD LABORATORY							60.01
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
65	Respiratory Therapy	51,761	1,615,751	1,667,512	0.247017	0.247017	0.247017	65
66	Physical Therapy	621,533	1,197,016	1,818,549	0.457928	0.457928	0.457928	66
67	Occupational Therapy	452,412		452,412	0.809238	0.809238	0.809238	67
68	Speech Pathology	37,383		37,383	0.821068	0.821068	0.821068	68
71	Medical Supplies Charged to Patients	968,809	4,654,815	5,623,624	0.156423	0.156423	0.156423	71
72	Impl. Dev. Charged to Patients	503,061	1,317,431	1,820,492	0.265372	0.265372	0.265372	72
73	Drugs Charged to Patients	1,427,036	5,284,725	6,711,761	0.194145	0.194145	0.194145	73
76.97	CARDIAC REHABILITATION		242,649	242,649	0.564404	0.564404	0.564404	76.97
76.98	HYPERBARIC OXYGEN THERAPY							76.98
76.99	LITHOTRIPSY							76.99
	OUTPATIENT SERVICE COST CENTERS							
91	Emergency	251,628	4,669,713	4,921,341	0.887156	0.887156	0.887156	91
92	Observation Beds (Non-Distinct Part)	20,363	409,724	430,087	0.781261	0.781261	0.781261	92
	OTHER REIMBURSABLE COST CENTERS							
99.10	CORF							99.10
200	Subtotal (sum of lines 30 thru 199)	13,187,963	52,711,503	65,899,466				200
201	Less Observation Beds							201
202	Total (line 200 minus line 201)	13,187,963	52,711,503	65,899,466				202

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HARVARD MEMORIAL HOSPITAL Provider CCN: 14-1335	In Lieu of Form CMS-2552-10	Period : From: 07/01/2017 To: 06/30/2018	Run Date: 11/28/2018 Run Time: 12:39 Version: 2018.04 (09/26/2018)
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COMPUTATION OF RATIO OF COST TO CHARGES - TITLE XIX (NOT AN OFFICIAL FORM CMS-2552-10 WORKSHEET)
**WORKSHEET C
PART I**

				COSTS			
	COST CENTER DESCRIPTIONS	Total Cost (B Part I col 26 plus sum of cols 21 & 22)	Therapy Limit Adj.	Total Costs	RCE Dis- allowance	Total Costs	
		1	2	3	4	5	
	INPATIENT ROUTINE SERVICE COST CENTERS						
30	Adults & Pediatrics	1,997,133		1,997,133		1,997,133	30
31	Intensive Care Unit	307,337		307,337		307,337	31
44	Skilled Nursing Facility	2,266,978		2,266,978		2,266,978	44
46	Other Long Term Care	1,430,016		1,430,016		1,430,016	46
	ANCILLARY SERVICE COST CENTERS						
50	Operating Room	2,858,613		2,858,613		2,858,613	50
51	Recovery Room	1,186,890		1,186,890		1,186,890	51
53	Anesthesiology	364,026		364,026		364,026	53
54	Radiology-Diagnostic	2,268,161		2,268,161		2,268,161	54
60	Laboratory	1,436,927		1,436,927		1,436,927	60
60.01	BLOOD LABORATORY						60.01
62.30	BLOOD CLOTTING FOR HEMOPHILIACS						62.30
65	Respiratory Therapy	411,903		411,903		411,903	65
66	Physical Therapy	832,765		832,765		832,765	66
67	Occupational Therapy	366,109		366,109		366,109	67
68	Speech Pathology	30,694		30,694		30,694	68
71	Medical Supplies Charged to Patients	879,663		879,663		879,663	71
72	Impl. Dev. Charged to Patients	483,108		483,108		483,108	72
73	Drugs Charged to Patients	1,303,058		1,303,058		1,303,058	73
76.97	CARDIAC REHABILITATION	136,952		136,952		136,952	76.97
76.98	HYPERBARIC OXYGEN THERAPY						76.98
76.99	LITHOTRIPSY						76.99
	OUTPATIENT SERVICE COST CENTERS						
91	Emergency	4,365,999		4,365,999		4,365,999	91
92	Observation Beds (Non-Distinct Part)	336,010		336,010		336,010	92
	OTHER REIMBURSABLE COST CENTERS						
99.10	CORF						99.10
200	Subtotal (sum of lines 30 thru 199)	23,262,342		23,262,342		23,262,342	200
201	Less Observation Beds	336,010		336,010		336,010	201
202	Total (line 200 minus line 201)	22,926,332		22,926,332		22,926,332	202

KPMG LLP Compu-Max 2552-10

HARVARD MEMORIAL HOSPITAL Provider CCN: 14-1335	In Lieu of Form CMS-2552-10	Period : From: 07/01/2017 To: 06/30/2018	Run Date: 11/28/2018 Run Time: 12:39 Version: 2018.04 (09/26/2018)
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COMPUTATION OF RATIO OF COST TO CHARGES - TITLE XIX (NOT AN OFFICIAL FORM CMS-2552-10 WORKSHEET)**WORKSHEET C
PART I**

		CHARGES						
	COST CENTER DESCRIPTIONS	Inpatient	Outpatient	Total (column 6 + column 7)	Cost or Other Ratio	TEFRA Inpatient Ratio	PPS Inpatient Ratio	
		6	7	8	9	10	11	
	INPATIENT ROUTINE SERVICE COST CENTERS							
30	Adults & Pediatrics							30
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
200	Subtotal (sum of lines 30 thru 199)							200
201	Less Observation Beds							201
202	Total (line 200 minus line 201)							202

KPMG LLP Compu-Max 2552-10

HARVARD MEMORIAL HOSPITAL Provider CCN: 14-1335	In Lieu of Form CMS-2552-10	Period : From: 07/01/2017 To: 06/30/2018	Run Date: 11/28/2018 Run Time: 12:39 Version: 2018.04 (09/26/2018)
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CALCULATION OF OUTPATIENT SERVICE COST TO CHARGE RATIOS NET OF REDUCTIONS FOR MEDICAID ONLY
**WORKSHEET C
PART II**
[] Title V
[XX] Title XIX

	COST CENTER DESCRIPTIONS	Total Cost (Wkst B, Part I, col. 26)	Capital Cost (Wkst B, Part II, col. 26)	Operating Cost Net of Capital Cost (col. 1 - col. 2)	Capital Reduction	
		1	2	3	4	
	ANCILLARY SERVICE COST CENTERS					
50	Operating Room	2,858,613	401,858	2,456,755		50
51	Recovery Room	1,186,890	28,183	1,158,707		51
53	Anesthesiology	364,026	13,840	350,186		53
54	Radiology-Diagnostic	2,268,161	277,530	1,990,631		54
60	Laboratory	1,436,927	58,458	1,378,469		60
60.01	BLOOD LABORATORY					60.01
62.30	BLOOD CLOTTING FOR HEMOPHILIACS					62.30
65	Respiratory Therapy	411,903	39,176	372,727		65
66	Physical Therapy	832,765	71,357	761,408		66
67	Occupational Therapy	366,109	4,060	362,049		67
68	Speech Pathology	30,694	511	30,183		68
71	Medical Supplies Charged to Patients	879,663	30,858	848,805		71
72	Impl. Dev. Charged to Patients	483,108	5,334	477,774		72
73	Drugs Charged to Patients	1,303,058	84,208	1,218,850		73
76.97	CARDIAC REHABILITATION	136,952	19,371	117,581		76.97
76.98	HYPERBARIC OXYGEN THERAPY					76.98
76.99	LITHOTRIPSY					76.99
	OUTPATIENT SERVICE COST CENTERS					
91	Emergency	4,365,999	93,057	4,272,942		91
92	Observation Beds (Non-Distinct Part)	336,010	25,767	310,243		92
	OTHER REIMBURSABLE COST CENTERS					
99.10	CORF					99.10
200	Subtotal	17,260,878	1,153,568	16,107,310		200
201	Less Observation Beds	336,010	25,767	310,243		201
202	Total	16,924,868	1,127,801	15,797,067		202

KPMG LLP Compu-Max 2552-10

HARVARD MEMORIAL HOSPITAL Provider CCN: 14-1335	In Lieu of Form CMS-2552-10	Period : From: 07/01/2017 To: 06/30/2018	Run Date: 11/28/2018 Run Time: 12:39 Version: 2018.04 (09/26/2018)
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CALCULATION OF OUTPATIENT SERVICE COST TO CHARGE RATIOS NET OF REDUCTIONS FOR MEDICAID ONLY
**WORKSHEET C
PART II**
[] Title V
[XX] Title XIX

	COST CENTER DESCRIPTIONS	Operating Cost Reduction Amount	Cost Net of Capital and Operating Cost Reduction	Total Charges (Wkst C, Part I, col. 8)	Outpatient Cost to Charge Ratio(col. 6 ÷ col. 7)	
		5	6	7	8	
	ANCILLARY SERVICE COST CENTERS					
50	Operating Room		2,858,613			50
51	Recovery Room		1,186,890			51
53	Anesthesiology		364,026			53
54	Radiology-Diagnostic		2,268,161			54
60	Laboratory		1,436,927			60
60.01	BLOOD LABORATORY					60.01
62.30	BLOOD CLOTING FOR HEMOPHILIACS					62.30
65	Respiratory Therapy		411,903			65
66	Physical Therapy		832,765			66
67	Occupational Therapy		366,109			67
68	Speech Pathology		30,694			68
71	Medical Supplies Charged to Patients		879,663			71
72	Impl. Dev. Charged to Patients		483,108			72
73	Drugs Charged to Patients		1,303,058			73
76.97	CARDIAC REHABILITATION		136,952			76.97
76.98	HYPERBARIC OXYGEN THERAPY					76.98
76.99	LITHOTRIPSY					76.99
	OUTPATIENT SERVICE COST CENTERS					
91	Emergency		4,365,999			91
92	Observation Beds (Non-Distinct Part)		336,010	430,087	0.781261	92
	OTHER REIMBURSABLE COST CENTERS					
99.10	CORF					99.10
200	Subtotal		17,260,878	430,087		200
201	Less Observation Beds		336,010	430,087		201
202	Total		16,924,868			202

KPMG LLP Compu-Max 2552-10

HARVARD MEMORIAL HOSPITAL Provider CCN: 14-1335	In Lieu of Form CMS-2552-10	Period : From: 07/01/2017 To: 06/30/2018	Run Date: 11/28/2018 Run Time: 12:39 Version: 2018.04 (09/26/2018)
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APPORTIONMENT OF MEDICAL AND OTHER HEALTH SERVICE COSTS

COMPONENT CCN: 14-1335

WORKSHEET D
PART V

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

(A)	Cost Center Description	Program Charges				Program Cost			
		Cost to Charge Ratio (from Wkst C, Part I, col. 9)	PPS Reim-bursed Services (see inst.)	Cost Reim-bursed Subject to Ded. & Coins. (see inst.)	Cost Reim-bursed Not Subject to Ded. & Coins. (see inst.)	PPS Services (see inst.)	Cost Reim-bursed Subject to Ded. & Coins. (see inst.)	Cost Reim-bursed Not Subject to Ded. & Coins. (see inst.)	
(A)	Cost Center Description	1	2	3	4	5	6	7	
	ANCILLARY SERVICE COST CENTERS								
50	Operating Room	0.158081		4,573,416			722,970		50
51	Recovery Room	0.313074		969,614			303,561		51
53	Anesthesiology	3.893826		93,488			364,026		53
54	Radiology-Diagnostic	0.196745		3,174,369			624,541		54
60	Laboratory	0.424798		1,685,002			715,785		60
60.01	BLOOD LABORATORY								60.01
62.30	BLOOD CLOTTING FOR HEMOPHILIACS								62.30
65	Respiratory Therapy	0.247017		368,311			90,979		65
66	Physical Therapy	0.457928		380,726			174,345		66
67	Occupational Therapy	0.809238							67
68	Speech Pathology	0.821068							68
71	Medical Supplies Charged to Pat	0.156423		1,354,384			211,857		71
72	Impl. Dev. Charged to Patients	0.265372		477,709			126,771		72
73	Drugs Charged to Patients	0.194145		2,081,937	6,539		404,198	1,270	73
76.97	CARDIAC REHABILITATION	0.564404		126,663			71,489		76.97
76.98	HYPERBARIC OXYGEN THERAPY								76.98
76.99	LITHOTRIPSY								76.99
	OUTPATIENT SERVICE COST CENTERS								
91	Emergency	0.887156		1,331,318			1,181,087		91
92	Observation Beds (Non-Distinct	0.781261		186,418			145,641		92
	OTHER REIMBURSABLE COST CENTERS								
200	Subtotal (see instructions)			16,803,355	6,539		5,137,250	1,270	200
201	Less PBP Clinic Lab. Services-Program Only Charges								201
202	Net Charges (line 200 - line 201)			16,803,355	6,539		5,137,250	1,270	202

(A) Worksheet A line numbers

KPMG LLP Compu-Max 2552-10

HARVARD MEMORIAL HOSPITAL Provider CCN: 14-1335	In Lieu of Form CMS-2552-10	Period : From: 07/01/2017 To: 06/30/2018	Run Date: 11/28/2018 Run Time: 12:39 Version: 2018.04 (09/26/2018)
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APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE
OTHER PASS THROUGH COSTS

COMPONENT CCN: 14-6014

WORKSHEET D
PART IV

Check
Applicable
Boxes:

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

☐ Hospital
☐ IPF
☐ IRF

☐ SUB (Other)
☒ SNF
☐ NF

☐ ICF/IID

☒ PPS
☐ TEFRA
☐ Other

		Non Physician Anesth- etist Cost	Nursing School Post- Stepdown Adjustments	Nursing School	Allied Health Post- Stepdown Adjustments	Allied Health	All Other Medical Education Cost	Total Cost (sum of col. 1 through col. 4)	Total Outpatient Cost (sum of col. 2, 3, and 4)	
(A)	Cost Center Description	1	2A	2	3A	3	4	5	6	
	ANCILLARY SERVICE COST CENTERS									
50	Operating Room									50
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

KPMG LLP Compu-Max 2552-10

HARVARD MEMORIAL HOSPITAL Provider CCN: 14-1335	In Lieu of Form CMS-2552-10	Period : From: 07/01/2017 To: 06/30/2018	Run Date: 11/28/2018 Run Time: 12:39 Version: 2018.04 (09/26/2018)
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APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE
OTHER PASS THROUGH COSTS

COMPONENT CCN: 14-6014

WORKSHEET D
PART IV

Check
Applicable
Boxes:

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

☐ Hospital
☐ IPF
☐ IRF

☐ SUB (Other)
☒ SNF
☐ NF

☐ ICF/IID

☒ PPS
☐ TEFRA
☐ Other

		Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 5÷ col. 7)	Outpatient Ratio of Cost to Charges (col. 6÷ col. 7)	Inpatient Program Charges	Inpatient Program Pass- Through Costs (col. 8 x col. 10)	Outpatient Program Charges	Outpatient Program Pass- Through Costs (col. 9 x col. 12)	
(A)	Cost Center Description	7	8	9	10	11	12	13	
	ANCILLARY SERVICE COST CENTERS								
50	Operating Room	18,083,192							50
51	Recovery Room	3,791,090							51
53	Anesthesiology	93,488							53
54	Radiology-Diagnostic	11,528,410			18,639				54
60	Laboratory	3,382,613			42,592				60
60.01	BLOOD LABORATORY								60.01
62.30	BLOOD CLOTTING FOR HEMOPHILIACS								62.30
65	Respiratory Therapy	1,667,512							65
66	Physical Therapy	1,818,549			406,769				66
67	Occupational Therapy	452,412			360,273				67
68	Speech Pathology	37,383			26,031				68
71	Medical Supplies Charged to Pat	5,623,624			42,608				71
72	Impl. Dev. Charged to Patients	1,820,492			540				72
73	Drugs Charged to Patients	6,711,761			60,425				73
76.97	CARDIAC REHABILITATION	242,649							76.97
76.98	HYPERBARIC OXYGEN THERAPY								76.98
76.99	LITHOTRIPSY								76.99
	OUTPATIENT SERVICE COST CENTERS								
91	Emergency	4,921,341							91
92	Observation Beds (Non-Distinct	430,087							92
	OTHER REIMBURSABLE COST CENTERS								
200	Total (sum of lines 50-199)	60,604,603			957,877				200

(A) Worksheet A line numbers

KPMG LLP Compu-Max 2552-10

HARVARD MEMORIAL HOSPITAL Provider CCN: 14-1335	In Lieu of Form CMS-2552-10	Period : From: 07/01/2017 To: 06/30/2018	Run Date: 11/28/2018 Run Time: 12:39 Version: 2018.04 (09/26/2018)
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APPORTIONMENT OF MEDICAL AND OTHER HEALTH SERVICE COSTS

COMPONENT CCN: 14-6014

WORKSHEET D PART V

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

(A)	Cost Center Description	Cost to Charge Ratio (from Wkst C, Part I, col. 9)	Program Charges			Program Cost			
			PPS Reim-bursed Services (see inst.)	Cost Reim-bursed Subject to Ded. & Coins. (see inst.)	Cost Reim-bursed Not Subject to Ded. & Coins. (see inst.)	PPS Services (see inst.)	Cost Reim-bursed Subject to Ded. & Coins. (see inst.)	Cost Reim-bursed Not Subject to Ded. & Coins. (see inst.)	
	ANCILLARY SERVICE COST CENTERS	1	2	3	4	5	6	7	
50	Operating Room	0.158081							50
51	Recovery Room	0.313074							51
53	Anesthesiology	3.893826							53
54	Radiology-Diagnostic	0.196745							54
60	Laboratory	0.424798							60
60.01	BLOOD LABORATORY								60.01
62.30	BLOOD CLOTTING FOR HEMOPHILIACS								62.30
65	Respiratory Therapy	0.247017							65
66	Physical Therapy	0.457928							66
67	Occupational Therapy	0.809238							67
68	Speech Pathology	0.821068							68
71	Medical Supplies Charged to Pat	0.156423							71
72	Impl. Dev. Charged to Patients	0.265372							72
73	Drugs Charged to Patients	0.194145			325			63	73
76.97	CARDIAC REHABILITATION	0.564404							76.97
76.98	HYPERBARIC OXYGEN THERAPY								76.98
76.99	LITHOTRIPSY								76.99
	OUTPATIENT SERVICE COST CENTERS								
91	Emergency	0.887156							91
92	Observation Beds (Non-Distinct	0.781261							92
	OTHER REIMBURSABLE COST CENTERS								
200	Subtotal (see instructions)				325			63	200
201	Less PBP Clinic Lab. Services-Program Only Charges								201
202	Net Charges (line 200 - line 201)				325			63	202

(A) Worksheet A line numbers

KPMG LLP Compu-Max 2552-10

HARVARD MEMORIAL HOSPITAL Provider CCN: 14-1335	In Lieu of Form CMS-2552-10	Period : From: 07/01/2017 To: 06/30/2018	Run Date: 11/28/2018 Run Time: 12:39 Version: 2018.04 (09/26/2018)
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APPORTIONMENT OF INPATIENT ROUTINE SERVICE CAPITAL COSTS

WORKSHEET D
PART I

Check [] Title V
Applicable [] Title XVIII, Part A
Boxes: [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)	153,150		153,150	1,266	120.97	20	2,419	30
31	Intensive Care Unit	34,331		34,331	36	953.64	1	954	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	146,335		146,335	2,300	63.62			44
45	Nursing Facility								45
200	Total (lines 30-199)	333,816		333,816	3,602		21	3,373	200

(A) Worksheet A line numbers

KPMG LLP Compu-Max 2552-10

HARVARD MEMORIAL HOSPITAL Provider CCN: 14-1335	In Lieu of Form CMS-2552-10	Period : From: 07/01/2017 To: 06/30/2018	Run Date: 11/28/2018 Run Time: 12:39 Version: 2018.04 (09/26/2018)
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APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS**COMPONENT CCN: 14-1335****WORKSHEET D
PART II**

Check ☐ Title V ☒ Hospital ☐ SUB (Other)
Applicable ☐ Title XVIII, Part A ☐ IPF
Boxes: ☒ Title XIX ☐ IRF

		Capital Related Cost (from Wkst. B, Part II (col. 26)	Total Charges (from Wkst. C, Part I, (col. 8)	Ratio of Cost to Charges (col. 1 ÷ col. 2)	Inpatient Program Charges	Capital Costs (col. 3 x col. 4)	
(A)	Cost Center Description	1	2	3	4	5	
	ANCILLARY SERVICE COST CENTERS						
50	Operating Room	401,858	18,083,192	0.022223			50
51	Recovery Room	28,183	3,791,090	0.007434			51
53	Anesthesiology	13,840	93,488	0.148040			53
54	Radiology-Diagnostic	277,530	11,528,410	0.024074			54
60	Laboratory	58,458	3,382,613	0.017282			60
60.01	BLOOD LABORATORY						60.01
62.30	BLOOD CLOTTING FOR HEMOPHILIACS						62.30
65	Respiratory Therapy	39,176	1,667,512	0.023494			65
66	Physical Therapy	71,357	1,818,549	0.039238			66
67	Occupational Therapy	4,060	452,412	0.008974			67
68	Speech Pathology	511	37,383	0.013669			68
71	Medical Supplies Charged to Pat	30,858	5,623,624	0.005487			71
72	Impl. Dev. Charged to Patients	5,334	1,820,492	0.002930			72
73	Drugs Charged to Patients	84,208	6,711,761	0.012546			73
76.97	CARDIAC REHABILITATION	19,371	242,649	0.079831			76.97
76.98	HYPERBARIC OXYGEN THERAPY						76.98
76.99	LITHOTRIPSY						76.99
	OUTPATIENT SERVICE COST CENTERS						
91	Emergency	93,057	4,921,341	0.018909			91
92	Observation Beds (Non-Distinct	25,767	430,087	0.059911			92
	OTHER REIMBURSABLE COST CENTERS						
200	Total (sum of lines 50-199)	1,153,568	60,604,603				200

(A) Worksheet A line numbers

KPMG LLP Compu-Max 2552-10

HARVARD MEMORIAL HOSPITAL Provider CCN: 14-1335	In Lieu of Form CMS-2552-10	Period : From: 07/01/2017 To: 06/30/2018	Run Date: 11/28/2018 Run Time: 12:39 Version: 2018.04 (09/26/2018)
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APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PASS THROUGH COSTS

WORKSHEET D
PART III

Check
Applicable
Boxes:

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

☐ PPS
☐ TEFRA
☒ Other

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

(A) Worksheet A line numbers

KPMG LLP Compu-Max 2552-10

HARVARD MEMORIAL HOSPITAL Provider CCN: 14-1335	In Lieu of Form CMS-2552-10	Period : From: 07/01/2017 To: 06/30/2018	Run Date: 11/28/2018 Run Time: 12:39 Version: 2018.04 (09/26/2018)
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APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PASS THROUGH COSTS

WORKSHEET D
PART III

Check
Applicable
Boxes:

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

☐ PPS
☐ TEFRA
☒ Other

		Total Patient Days	Per Diem (col. 5÷ col. 6)	Inpatient Program Days	Inpatient Program Pass- Through Cost (col. 7 x col. 8)	
(A)	Cost Center Description	6	7	8	9	
	INPATIENT ROUTINE SERVICE COST CENTERS					
30	Adults & Pediatrics (General Routine Care)	1,266		20		30
31	Intensive Care Unit	36		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	2,300				44
45	Nursing Facility					45
200	Total (lines 30-199)	3,602		21		200

(A) Worksheet A line numbers

KPMG LLP Compu-Max 2552-10

HARVARD MEMORIAL HOSPITAL Provider CCN: 14-1335	In Lieu of Form CMS-2552-10	Period : From: 07/01/2017 To: 06/30/2018	Run Date: 11/28/2018 Run Time: 12:39 Version: 2018.04 (09/26/2018)
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APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE
OTHER PASS THROUGH COSTS

COMPONENT CCN: 14-1335

WORKSHEET D
PART IV

Check
Applicable
Boxes:

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

☒ Hospital
☐ IPF
☐ IRF

☐ SUB (Other)
☐ SNF
☐ NF

☐ ICF/IID

☐ PPS
☐ TEFRA
☒ Other

		Non Physician Anesth- etist Cost	Nursing School Post- Stepdown Adjustments	Nursing School	Allied Health Post- Stepdown Adjustments	Allied Health	All Other Medical Education Cost	Total Cost (sum of col. 1 through col. 4)	Total Outpatient Cost (sum of col. 2, 3, and 4)	
(A)	Cost Center Description	1	2A	2	3A	3	4	5	6	
	ANCILLARY SERVICE COST CENTERS									
50	Operating Room									50
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

KPMG LLP Compu-Max 2552-10

HARVARD MEMORIAL HOSPITAL Provider CCN: 14-1335	In Lieu of Form CMS-2552-10	Period : From: 07/01/2017 To: 06/30/2018	Run Date: 11/28/2018 Run Time: 12:39 Version: 2018.04 (09/26/2018)
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APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE
OTHER PASS THROUGH COSTS

COMPONENT CCN: 14-1335

WORKSHEET D
PART IV

Check
Applicable
Boxes:

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

☒ Hospital
☐ IPF
☐ IRF

☐ SUB (Other)
☐ SNF
☐ NF

☐ ICF/IID

☐ PPS
☐ TEFRA
☒ Other

		Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 5÷ col. 7)	Outpatient Ratio of Cost to Charges (col. 6÷ col. 7)	Inpatient Program Charges	Inpatient Program Pass- Through Costs (col. 8 x col. 10)	Outpatient Program Charges	Outpatient Program Pass- Through Costs (col. 9 x col. 12)	
(A)	Cost Center Description	7	8	9	10	11	12	13	
	ANCILLARY SERVICE COST CENTERS								
50	Operating Room								50
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

KPMG LLP Compu-Max 2552-10

HARVARD MEMORIAL HOSPITAL Provider CCN: 14-1335	In Lieu of Form CMS-2552-10	Period : From: 07/01/2017 To: 06/30/2018	Run Date: 11/28/2018 Run Time: 12:39 Version: 2018.04 (09/26/2018)
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APPORTIONMENT OF MEDICAL AND OTHER HEALTH SERVICE COSTS

COMPONENT CCN: 14-1335

WORKSHEET D
PART V

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

(A)	Cost Center Description	Program Charges				Program Cost			
		Cost to Charge Ratio (from Wkst C, Part I, col. 9)	PPS Reim-bursed Services (see inst.)	Cost Reim-bursed Subject to Ded. & Coins. (see inst.)	Cost Reim-bursed Not Subject to Ded. & Coins. (see inst.)	PPS Services (see inst.)	Cost Reim-bursed Subject to Ded. & Coins. (see inst.)	Cost Reim-bursed Not Subject to Ded. & Coins. (see inst.)	
(A)	Cost Center Description	1	2	3	4	5	6	7	
	ANCILLARY SERVICE COST CENTERS								
50	Operating Room								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	Subtotal (see instructions)								200
201	Less PBP Clinic Lab. Services-Program Only Charges								201
202	Net Charges (line 200 - line 201)								202

(A) Worksheet A line numbers

KPMG LLP Compu-Max 2552-10

HARVARD MEMORIAL HOSPITAL Provider CCN: 14-1335	In Lieu of Form CMS-2552-10	Period : From: 07/01/2017 To: 06/30/2018	Run Date: 11/28/2018 Run Time: 12:39 Version: 2018.04 (09/26/2018)
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COMPUTATION OF INPATIENT OPERATING COST**COMPONENT CCN: 14-1335****WORKSHEET D-1
PART I**

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

PART I - ALL PROVIDER COMPONENTS**INPATIENT DAYS**

1	Inpatient days (including private room days and swing-bed days, excluding newborn)	1,266	1
2	Inpatient days (including private room days, excluding swing-bed and newborn days)	1,266	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)	1,053	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)	528	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)	1,997,133	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)	1,997,133	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 31)		32
33	Average semi-private room per diem charge (line 30 ÷ line 31)		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)	1,997,133	37

KPMG LLP Compu-Max 2552-10

HARVARD MEMORIAL HOSPITAL Provider CCN: 14-1335	In Lieu of Form CMS-2552-10	Period : From: 07/01/2017 To: 06/30/2018	Run Date: 11/28/2018 Run Time: 12:39 Version: 2018.04 (09/26/2018)
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COMPUTATION OF INPATIENT OPERATING COST**COMPONENT CCN: 14-1335****WORKSHEET D-1
PART II**

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

PART II - HOSPITALS AND SUBPROVIDERS ONLY

PROGRAM INPATIENT OPERATING COST BEFORE PASS-THROUGH COST ADJUSTMENTS							1
38	Adjusted general inpatient routine service cost per diem (see instructions)						1,577.51 38
39	Program general inpatient routine service cost (line 9 x line 38)						832,925 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)						832,925 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	307,337	36	8,537.14	18	153,669	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)					566,676	48
49	Total program inpatient costs (sum of lines 41 through 48)(see instructions)					1,553,270	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 enter zero (see instructions)						61
62	Relief payment (see instructions)						62
63	Allowable Inpatient cost plus incentive payment (see instructions)						63
PROGRAM INPATIENT ROUTINE SWING BED COST							
64	Medicare swing-bed SNF inpatient routine costs through December 31 of the cost reporting period (See instructions) (title XVIII only)						64
65	Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (See instructions) (title XVIII only)						65
66	Total Medicare swing-bed SNF inpatient routine costs (title XVIII only. For CAH, see instructions)						66
67	Title V or XIX swing-bed NF inpatient routine costs through December 31 of the cost reporting period (line 12 x line 19)						67
68	Title V or XIX swing-bed NF inpatient routine costs after December 31 of the cost reporting period (line 13 x line 20)						68
69	Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68)						69

KPMG LLP Compu-Max 2552-10

HARVARD MEMORIAL HOSPITAL Provider CCN: 14-1335	In Lieu of Form CMS-2552-10	Period : From: 07/01/2017 To: 06/30/2018	Run Date: 11/28/2018 Run Time: 12:39 Version: 2018.04 (09/26/2018)
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COMPUTATION OF INPATIENT OPERATING COST

COMPONENT CCN: 14-1335

WORKSHEET D-1
PARTS III & IV

Check
Applicable
Boxes:

☐ Title V - I/P

☒ Title XVIII, Part A

☐ Title XIX - I/P

☒ Hospital

☐ IPF

☐ IRF

☐ SUB (Other)

☐ SNF

☐ NF

☐ ICF/IID

☐ PPS

☐ TEFRA

☒ Other

PART IV - COMPUTATION OF OBSERVATION BED PASS-THROUGH COST

87	Total observation bed days (see instructions)					213	87
88	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)					1,577.51	88
89	Observation bed cost (line 87 x line 88) (see instructions)					336,010	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	153,150	1,997,133	0.076685	336,010	25,767	90
91	Nursing School						91
92	Allied Health						92
93	Other Medical Education						93

KPMG LLP Compu-Max 2552-10

HARVARD MEMORIAL HOSPITAL Provider CCN: 14-1335	In Lieu of Form CMS-2552-10	Period : From: 07/01/2017 To: 06/30/2018	Run Date: 11/28/2018 Run Time: 12:39 Version: 2018.04 (09/26/2018)
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COMPUTATION OF INPATIENT OPERATING COST**COMPONENT CCN: 14-6014****WORKSHEET D-1
PART I**

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

PART I - ALL PROVIDER COMPONENTS**INPATIENT DAYS**

1	Inpatient days (including private room days and swing-bed days, excluding newborn)	2,300	1
2	Inpatient days (including private room days, excluding swing-bed and newborn days)	2,300	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)	2,300	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)	1,830	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)	2,266,978	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)	2,266,978	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)	2,266,978	37

KPMG LLP Compu-Max 2552-10

HARVARD MEMORIAL HOSPITAL Provider CCN: 14-1335	In Lieu of Form CMS-2552-10	Period : From: 07/01/2017 To: 06/30/2018	Run Date: 11/28/2018 Run Time: 12:39 Version: 2018.04 (09/26/2018)
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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** ☒ **PPS**
Applicable ☒ **Title XVIII, Part A** ☐ **IPF** ☒ **SNF** ☐ **TEFRA**
Boxes: ☐ **Title XIX - I/P** ☐ **IRF** ☐ **NF** ☐ **Other**

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

70	Skilled nursing facility/other nursing facility/ICF/IID routine service cost (line 37)	2,266,978	70
71	Adjusted general inpatient routine service cost per diem (line 70 ÷ line 2)	985.64	71
72	Program routine service cost (line 9 x line 71)	1,803,721	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)	1,803,721	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)	1,803,721	83
84	Program inpatient ancillary services (see instructions)	539,490	84
85	Utilization review - physician compensation (see instructions)		85
86	Total Program inpatient operating costs (sum of lines 83 through 85)	2,343,211	86

KPMG LLP Compu-Max 2552-10

HARVARD MEMORIAL HOSPITAL Provider CCN: 14-1335	In Lieu of Form CMS-2552-10	Period : From: 07/01/2017 To: 06/30/2018	Run Date: 11/28/2018 Run Time: 12:39 Version: 2018.04 (09/26/2018)
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COMPUTATION OF INPATIENT OPERATING COST**COMPONENT CCN: 14-1335****WORKSHEET D-1
PART I**

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

PART I - ALL PROVIDER COMPONENTS**INPATIENT DAYS**

1	Inpatient days (including private room days and swing-bed days, excluding newborn)	1,266	1
2	Inpatient days (including private room days, excluding swing-bed and newborn days)	1,266	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)	1,053	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)	20	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)	1,997,133	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)	1,997,133	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)	1,997,133	37

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HARVARD MEMORIAL HOSPITAL Provider CCN: 14-1335	In Lieu of Form CMS-2552-10	Period : From: 07/01/2017 To: 06/30/2018	Run Date: 11/28/2018 Run Time: 12:39 Version: 2018.04 (09/26/2018)
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COMPUTATION OF INPATIENT OPERATING COST**COMPONENT CCN: 14-1335****WORKSHEET D-1
PART II**

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

PART II - HOSPITALS AND SUBPROVIDERS ONLY

PROGRAM INPATIENT OPERATING COST BEFORE PASS-THROUGH COST ADJUSTMENTS							1	
38	Adjusted general inpatient routine service cost per diem (see instructions)						1,577.51	38
39	Program general inpatient routine service cost (line 9 x line 38)						31,550	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)						31,550	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	307,337	36	8,537.14	1	8,537		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)						40,087	49
PASS THROUGH COST ADJUSTMENTS								
50	Pass through costs applicable to Program inpatient routine services (from Wkst. D, sum of Parts I and III)						3,373	50
51	Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)							51
52	Total Program excludable cost (sum of lines 50 and 51)						3,373	52
53	Total Program inpatient operating cost excluding capital related, nonphysician anesthetist and medical education costs (line 49 minus line 52)							53
TARGET AMOUNT AND LIMIT COMPUTATION								
54	Program discharges							54
55	Target amount per discharge							55
56	Target amount (line 54 x line 55)							56
57	Difference between adjusted inpatient operating cost and target amount (line 56 minus line 53)							57
58	Bonus payment (see instructions)							58
59	Lesser of line 53 ÷ line 54 or line 55 from the cost reporting period ending 1996, updated and compounded by the market basket.							59
60	Lesser of line 53 ÷ line 54 or line 55 from prior year cost report, updated by the market basket.							60
61	If line 53 ÷ 54 is less than the lower of lines 55, 59 or 60 enter the lesser of 50% of the amount by which operating costs (line 53) are less than expected costs (line 54 x 60), or 1% of the target amount (line 56), otherwise enter zero (see instructions)							61
62	Relief payment (see instructions)							62
63	Allowable Inpatient cost plus incentive payment (see instructions)							63
PROGRAM INPATIENT ROUTINE SWING BED COST								
64	Medicare swing-bed SNF inpatient routine costs through December 31 of the cost reporting period (See instructions) (title XVIII only)							64
65	Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (See instructions) (title XVIII only)							65
66	Total Medicare swing-bed SNF inpatient routine costs (title XVIII only. For CAH, see instructions)							66
67	Title V or XIX swing-bed NF inpatient routine costs through December 31 of the cost reporting period (line 12 x line 19)							67
68	Title V or XIX swing-bed NF inpatient routine costs after December 31 of the cost reporting period (line 13 x line 20)							68
69	Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68)							69

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COMPUTATION OF INPATIENT OPERATING COST

COMPONENT CCN: 14-1335

WORKSHEET D-1
PARTS III & IV

Check
Applicable
Boxes:

☐ Title V - I/P

☐ Title XVIII, Part A

☒ Title XIX - I/P

☒ Hospital

☐ IPF

☐ IRF

☐ SUB (Other)

☐ SNF

☐ NF

☐ ICF/IID

☐ PPS

☐ TEFRA

☒ Other

PART IV - COMPUTATION OF OBSERVATION BED PASS-THROUGH COST

87	Total observation bed days (see instructions)					213	87
88	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)					1,577.51	88
89	Observation bed cost (line 87 x line 88) (see instructions)					336,010	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	153,150	1,997,133	0.076685	336,010	25,767	90
91	Nursing School						91
92	Allied Health						92
93	Other Medical Education						93

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HARVARD MEMORIAL HOSPITAL Provider CCN: 14-1335	In Lieu of Form CMS-2552-10	Period : From: 07/01/2017 To: 06/30/2018	Run Date: 11/28/2018 Run Time: 12:39 Version: 2018.04 (09/26/2018)
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INPATIENT ANCILLARY SERVICE COST APPORTIONMENT

COMPONENT CCN: 14-1335

WORKSHEET D-3

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

		Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
(A)	COST CENTER DESCRIPTION	1	2	3	
	INPATIENT ROUTINE SERVICE COST CENTERS				
30	Adults & Pediatrics		1,506,054		30
31	Intensive Care Unit		119,462		31
	ANCILLARY SERVICE COST CENTERS				
50	Operating Room	0.158081	763,542	120,701	50
51	Recovery Room	0.313074	57,369	17,961	51
53	Anesthesiology	3.893826			53
54	Radiology-Diagnostic	0.196745	252,514	49,681	54
60	Laboratory	0.424798	284,905	121,027	60
60.01	BLOOD LABORATORY				60.01
62.30	BLOOD CLOTTING FOR HEMOPHILIACS				62.30
65	Respiratory Therapy	0.247017	19,181	4,738	65
66	Physical Therapy	0.457928	51,477	23,573	66
67	Occupational Therapy	0.809238			67
68	Speech Pathology	0.821068			68
71	Medical Supplies Charged to Patients	0.156423	371,714	58,145	71
72	Impl. Dev. Charged to Patients	0.265372	219,170	58,162	72
73	Drugs Charged to Patients	0.194145	553,864	107,530	73
76.97	CARDIAC REHABILITATION	0.564404			76.97
76.98	HYPERBARIC OXYGEN THERAPY				76.98
76.99	LITHOTRIPSY				76.99
	OUTPATIENT SERVICE COST CENTERS				
91	Emergency	0.887156	5,814	5,158	91
92	Observation Beds (Non-Distinct Part)	0.781261			92
	OTHER REIMBURSABLE COST CENTERS				
200	Total (sum of lines 50-94, and 96-98)		2,579,550	566,676	200
201	Less PBP Clinic Laboratory Services-Program only charges (line 61)				201
202	Net Charges (line 200 minus line 201)		2,579,550		202

(A) Worksheet A line numbers

KPMG LLP Compu-Max 2552-10

HARVARD MEMORIAL HOSPITAL Provider CCN: 14-1335	In Lieu of Form CMS-2552-10	Period : From: 07/01/2017 To: 06/30/2018	Run Date: 11/28/2018 Run Time: 12:39 Version: 2018.04 (09/26/2018)
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INPATIENT ANCILLARY SERVICE COST APPORTIONMENT

COMPONENT CCN: 14-6014

WORKSHEET D-3

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

		Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
(A)	COST CENTER DESCRIPTION	1	2	3	
	INPATIENT ROUTINE SERVICE COST CENTERS				
30	Adults & Pediatrics				30
31	Intensive Care Unit				31
	ANCILLARY SERVICE COST CENTERS				
50	Operating Room	0.158081			50
51	Recovery Room	0.313074			51
53	Anesthesiology	3.893826			53
54	Radiology-Diagnostic	0.196745	18,639	3,667	54
60	Laboratory	0.424798	42,592	18,093	60
60.01	BLOOD LABORATORY				60.01
62.30	BLOOD CLOTTING FOR HEMOPHILIACS				62.30
65	Respiratory Therapy	0.247017			65
66	Physical Therapy	0.457928	406,769	186,271	66
67	Occupational Therapy	0.809238	360,273	291,547	67
68	Speech Pathology	0.821068	26,031	21,373	68
71	Medical Supplies Charged to Patients	0.156423	42,608	6,665	71
72	Impl. Dev. Charged to Patients	0.265372	540	143	72
73	Drugs Charged to Patients	0.194145	60,425	11,731	73
76.97	CARDIAC REHABILITATION	0.564404			76.97
76.98	HYPERBARIC OXYGEN THERAPY				76.98
76.99	LITHOTRIPSY				76.99
	OUTPATIENT SERVICE COST CENTERS				
91	Emergency	0.887156			91
92	Observation Beds (Non-Distinct Part)	0.781261			92
	OTHER REIMBURSABLE COST CENTERS				
200	Total (sum of lines 50-94, and 96-98)		957,877	539,490	200
201	Less PBP Clinic Laboratory Services-Program only charges (line 61)				201
202	Net Charges (line 200 minus line 201)		957,877		202

(A) Worksheet A line numbers

KPMG LLP Compu-Max 2552-10

HARVARD MEMORIAL HOSPITAL Provider CCN: 14-1335	In Lieu of Form CMS-2552-10	Period : From: 07/01/2017 To: 06/30/2018	Run Date: 11/28/2018 Run Time: 12:39 Version: 2018.04 (09/26/2018)
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CALCULATION OF REIMBURSEMENT SETTLEMENT**COMPONENT CCN: 14-1335****WORKSHEET E
PART B**Check applicable box: ☒ **Hospital** ☐ **IPF** ☐ **IRF** ☐ **SUB (Other)** ☐ **SNF****PART B - MEDICAL AND OTHER HEALTH SERVICES**

		1	1.01	1.02	
1	Medical and other services (see instructions)	5,138,520			1
2	Medical and other services reimbursed under OPPS (see instructions)				2
3	OPPS payments				3
4	Outlier payment (see instructions)				4
4.01	Outlier reconciliation amount (see instructions)				4.01
5	Enter the hospital specific payment to cost ratio (see instructions)				5
6	Line 2 times line 5				6
7	Sum of lines 3, 4, and 4.01, divided by line 6				7
8	Transitional corridor payment (see instructions)				8
9	Ancillary service other pass through costs from Wkst. D, Pt. IV, col. 13, line 200				9
10	Organ acquisition				10
11	Total cost (sum of lines 1 and 10) (see instructions)	5,138,520			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 reasonable cost (complete only if line 18 exceeds line 11 (see instructions)				19
20	Excess of reasonable cost over customary charges (complete only if line 11 exceeds line 18 (see instructions)				20
21	Lesser of cost or charges (see instructions)	5,189,905			21
22	Interns and residents (see instructions)				22
23	Cost of physicians' services in a teaching hospital (see instructions)				23
24	Total prospective payment (sum of lines 3, 4, 4.01, 8 and 9)				24
	COMPUTATION OF REIMBURSEMENT SETTLEMENT				
25	Deductibles and coinsurance (see instructions)	20,445			25
26	Deductibles and coinsurance relating to amount on line 24 (see instructions)	3,047,191			26
27	Subtotal [(lines 21 and 24 minus the sum of lines 25 and 26) plus the sum of lines 22 and 23] (see instructions)	2,122,269			27
28	Direct graduate medical education payments (from Wkst. E-4, line 50)				28
29	ESRD direct medical education costs (from Wkst. E-4, line 36)				29
30	Subtotal (sum of lines 27 through 29)	2,122,269			30
31	Primary payer payments	601			31
32	Subtotal (line 30 minus line 31)	2,121,668			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)	204,057			34
35	Adjusted reimbursable bad debts (see instructions)	132,637			35
36	Allowable bad debts for dual eligible beneficiaries (see instructions)	161,744			36
37	Subtotal (see instructions)	2,254,305			37
38	MSP-LCC reconciliation amount from PS&R				38
39	Other adjustments (specify) (see instructions)				39
39.50	Pioneer ACO demonstration payment adjustment (see instructions)				39.50
40	Subtotal (see instructions)	2,254,305			40
40.01	Sequestration adjustment (see instructions)	45,086			40.01
40.02	Demonstration payment adjustment amount after sequestration				40.02
41	Interim payments	2,416,978			41
42	Tentative settlement (for contractors use only)				42
43	Balance due provider/program (see instructions)	-207,759			43
44	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2				44

TO BE COMPLETED BY CONTRACTOR

90	Original outlier amount (see instructions)				90
91	Outlier reconciliation adjustment amount (see instructions)				91
92	The rate used to calculate the Time Value of Money				92
93	Time Value of Money (see instructions)				93
94	Total (sum of lines 91 and 93)				94

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CALCULATION OF REIMBURSEMENT SETTLEMENT**COMPONENT CCN: 14-6014****WORKSHEET E
PART B**Check applicable box: ☐ Hospital ☐ IPF ☐ IRF ☐ SUB (Other) ☒ SNF**PART B - MEDICAL AND OTHER HEALTH SERVICES**

		1	1.01	1.02	
1	Medical and other services (see instructions)	63			1
2	Medical and other services reimbursed under OPPS (see instructions)				2
3	OPPS payments				3
4	Outlier payment (see instructions)				4
4.01	Outlier reconciliation amount (see instructions)				4.01
5	Enter the hospital specific payment to cost ratio (see instructions)				5
6	Line 2 times line 5				6
7	Sum of lines 3, 4, and 4.01, divided by line 6				7
8	Transitional corridor payment (see instructions)				8
9	Ancillary service other pass through costs from Wkst. D, Pt. IV, col. 13, line 200				9
10	Organ acquisition				10
11	Total cost (sum of lines 1 and 10) (see instructions)	63			11
	COMPUTATION OF LESSER OF COST OR CHARGES				
	REASONABLE CHARGES				
12	Ancillary service charges	325			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)	325			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)	325			18
19	Excess of customary charges over reasonable cost (complete only if line 18 exceeds line 11 (see instructions)	262			19
20	Excess of reasonable cost over customary charges (complete only if line 11 exceeds line 18 (see instructions)				20
21	Lesser of cost or charges (see instructions)	63			21
22	Interns and residents (see instructions)				22
23	Cost of physicians' services in a teaching hospital (see instructions)				23
24	Total prospective payment (sum of lines 3, 4, 4.01, 8 and 9)				24
	COMPUTATION OF REIMBURSEMENT SETTLEMENT				
25	Deductibles and coinsurance (see instructions)				25
26	Deductibles and coinsurance relating to amount on line 24 (see instructions)				26
27	Subtotal [(lines 21 and 24 minus the sum of lines 25 and 26) plus the sum of lines 22 and 23] (see instructions)	63			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)	63			30
31	Primary payer payments				31
32	Subtotal (line 30 minus line 31)	63			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)	63			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)	63			40
40.01	Sequestration adjustment (see instructions)	1			40.01
40.02	Demonstration payment adjustment amount after sequestration				40.02
41	Interim payments	318			41
42	Tentative settlement (for contractors use only)				42
43	Balance due provider/program (see instructions)	-256			43
44	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2				44

TO BE COMPLETED BY CONTRACTOR

90	Original outlier amount (see instructions)				90
91	Outlier reconciliation adjustment amount (see instructions)				91
92	The rate used to calculate the Time Value of Money				92
93	Time Value of Money (see instructions)				93
94	Total (sum of lines 91 and 93)				94

HARVARD MEMORIAL HOSPITAL Provider CCN: 14-1335	In Lieu of Form CMS-2552-10	Period : From: 07/01/2017 To: 06/30/2018	Run Date: 11/28/2018 Run Time: 12:39 Version: 2018.04 (09/26/2018)
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WORKSHEET E-1
PART I

				INPATIENT PART A		PART B		
DESCRIPTION				mm/dd/yyyy	AMOUNT	mm/dd/yyyy	AMOUNT	
				1	2	3	4	
1	Total interim payments paid to provider				1,338,730		2,165,445	1
2	Interim payments payable on individual bills, either submitted or to be submitted to the intermediary for services rendered in the cost reporting period. If none, write 'NONE' or enter a zero							2
3	List separately each retroactive lump sum adjustment amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each payment. If none, write 'NONE' or enter a zero. (1)			01/11/2018	22,819	01/11/2018	165,304	3.01
				06/13/2018	11,094	06/13/2018	86,229	3.02
		Program	.03					3.03
		to	.04					3.04
		Provider	.05					3.05
			.06					3.06
			.07					3.07
			.08					3.08
			.09					3.09
			.10					3.10
			.50					3.50
			.51					3.51
		Provider	.52					3.52
		to	.53					3.53
		Program	.54					3.54
			.55					3.55
			.56					3.56
			.57					3.57
			.58					3.58
			.59					3.59
	Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98)			.99	33,913		251,533	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)				1,372,643		2,416,978	4
TO BE COMPLETED BY CONTRACTOR								
5	List separately each tentative settlement payment after desk review. Also show date of each payment. If none, write 'NONE' or enter a zero. (1)		.01					5.01
			.02					5.02
		Program	.03					5.03
		to	.04					5.04
		Provider	.05					5.05
			.06					5.06
			.07					5.07
			.08					5.08
			.09					5.09
			.10					5.10
			.50					5.50
			.51					5.51
		Provider	.52					5.52
		to	.53					5.53
		Program	.54					5.54
			.55					5.55
			.56					5.56
			.57					5.57
			.58					5.58
			.59					5.59
	Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98)			.99				5.99
6	Determined net settlement amount (balance due) based on the cost report (1)			.01	4,323			6.01
			.02				-207,759	6.02
7	Total Medicare program liability (see instructions)				1,376,966		2,209,219	7
8	Name of Contractor			Contractor Number		NPR Date (Month/Day/Year)		8

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

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

			INPATIENT PART A		PART B	
			mm/dd/yyyy	AMOUNT	mm/dd/yyyy	AMOUNT
DESCRIPTION			1	2	3	4
1	Total interim payments paid to provider			665,989		318
2	Interim payments payable on individual bills, either submitted or to be submitted to the intermediary for services rendered in the cost reporting period. If none, write 'NONE' or enter a zero					2
3	List separately each retroactive lump sum adjustment		.01			3.01
	amount based on subsequent revision of the interim		.02			3.02
	rate for the cost reporting period. Also show date of	Program	.03			3.03
	each payment. If none, write 'NONE' or enter a zero. (1)	to	.04			3.04
		Provider	.05			3.05
			.06			3.06
			.07			3.07
			.08			3.08
			.09			3.09
			.10			3.10
			.50			3.50
			.51			3.51
		Provider	.52			3.52
		to	.53			3.53
		Program	.54			3.54
			.55			3.55
			.56			3.56
			.57			3.57
			.58			3.58
			.59			3.59
	Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98)		.99			3.99
4	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Wkst. E or Wkst. E-3, line and column as appropriate)			665,989		318
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		-256
7	Total Medicare program liability (see instructions)			665,988		62
8	Name of Contractor		Contractor Number		NPR Date (Month/Day/Year)	

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

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CALCULATION OF REIMBURSEMENT SETTLEMENT**WORKSHEET E-3
PART V****PART V - CALCULATION OF REIMBURSEMENT SETTLEMENT FOR MEDICARE PART A SERVICES - COST REIMBURSEMENT**

1	Inpatient services	1,553,270	1
2	Nursing an dallied health managed care payment (see instructions)		2
3	Organ acquisition		3
4	Subtotal (sum of lines 1-3)	1,553,270	4
5	Primary payer payments		5
6	Total cost (see instructions)	1,568,803	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)	1,568,803	19
20	Deductibles (exclude professional component)	170,224	20
21	Excess reasonable cost (from line 16)		21
22	Subtotal (line 19 minus the sum of lines 20 and 21)	1,398,579	22
23	Coinsurance		23
24	Subtotal (line 22 minus line 23)	1,398,579	24
25	Allowable bad debts (exclude bad debts for professional services) (see instructions)	9,981	25
26	Adjusted reimbursable bad debts (see instructions)	6,488	26
27	Allowable bad debts for dual eligible beneficiaries (see instructions)		27
28	Subtotal (sum of lines 24 and 26)	1,405,067	28
29	Other adjustments (specify) (see instructions)		29
29.50	Pioneer ACO demonstration payment adjustment (see instructions)		29.50
30	Subtotal (see instructions)	1,405,067	30
30.01	Sequestration adjustment (see instructions)	28,101	30.01
30.02	Demonstration payment adjustment amount after sequestration		30.02
31	Interim payments	1,372,643	31
32	Tentative settlement (for contractor use only)		32
33	Balance due provider/program (line 30 minus lines 30.01, 30.02, 31 and 32)	4,323	33
34	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2		34

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CALCULATION OF REIMBURSEMENT SETTLEMENT

**WORKSHEET E-3
PART VI****PART VI - CALCULATION OF REIMBURSEMENT SETTLEMENT - ALL OTHER HEALTH SERVICES FOR TITLE XVIII PART A PPS SNF SERVICES**

	PROSPECTIVE PAYMENT AMOUNT (see instructions)		
1	Resource Utilization Group (RUGS) payment	803,901	1
2	Routine service other pass through costs		2
3	Ancillary service other pass through costs		3
4	Subtotal (sum of lines 1-3)	803,901	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	124,321	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)	679,580	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)	679,580	15
15.01	Sequestration adjustment (see instructions)	13,592	15.01
15.02	Demonstration payment adjustment amount after sequestration		15.02
16	Interim payments	665,989	16
17	Tentative settlement (for contractor use only)		17
18	Balance due provider/program (line 15 minus lines 15.01, 15.02, 16 and 17)	-1	18
19	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2		19

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CALCULATION OF REIMBURSEMENT SETTLEMENT

COMPONENT CCN: 14-1335

WORKSHEET E-3
PART VII

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

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

		INPATIENT TITLE V OR TITLE XIX	OUTPAT- IENT TITLE V OR TITLE XIX	
	COMPUTATION OF NET COST OF COVERED SERVICES			
1	Inpatient hospital/SNF/NF services	40,087		1
2	Medical and other services			2
3	Organ acquisition (certified transplant centers only)			3
4	Subtotal (sum of lines 1, 2 and 3)	40,087		4
5	Inpatient primary payer payments			5
6	Outpatient primary payer payments			6
7	Subtotal (line 4 less sum of lines 5 and 6)	40,087		7
	COMPUTATION OF LESSER OF COST OR CHARGES			
	REASONABLE CHARGES			
8	Routine service charges			8
9	Ancillary service charges			9
10	Organ acquisition charges, net of revenue			10
11	Incentive from target amount computation			11
12	Total reasonable charges (sum of lines 8-11)			12
	CUSTOMARY CHARGES			
13	Amount actually collected from patients liable for payment for services on a cahрге basis			13
14	Amounts that would have been realized from patients liable for payment for services on a charge basis had such payment been made in accordance with 42 CFR §413.13(e)			14
15	Ratio of line 13 to line 14 (not to exceed 1.000000)	1.000000	1.000000	15
16	Total customary charges (see instructions)			16
17	Excess of customary charges over reasonable cost (complete only if line 16 exceeds line 4) (see instructions)			17
18	Excess of reasonable cost over customary charges (complete only if line 4 exceeds line 16) (see instructions)			18
19	Interns and residents (see instructions)			19
20	Cost of physicians' services in a teaching hospital (see instructions)			20
21	Cost of covered services (lesser of line 4 or line 16)	40,087		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)	40,087		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)	40,087		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)	40,087		36
37	OTHER ADJUSTMENTS (SPECIFY) (see instructions)	-40,087		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

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HARVARD MEMORIAL HOSPITAL Provider CCN: 14-1335	In Lieu of Form CMS-2552-10	Period : From: 07/01/2017 To: 06/30/2018	Run Date: 11/28/2018 Run Time: 12:39 Version: 2018.04 (09/26/2018)
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BALANCE SHEET**WORKSHEET G**

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

		General Fund	Specific Purpose Fund	Endowment Fund	Plant Fund	
	Assets (Omit Cents)	1	2	3	4	
	CURRENT ASSETS					
1	Cash on hand and in banks	1,553,272				1
2	Temporary investments					2
3	Notes receivable					3
4	Accounts receivable	18,918,497				4
5	Other receivables	353,884				5
6	Allowances for uncollectible notes and accounts receivable	-13,241,616				6
7	Inventory	993,227				7
8	Prepaid expenses	48,817				8
9	Other current assets					9
10	Due from other funds					10
11	Total current assets (sum of lines 1-10)	8,626,081				11
	FIXED ASSETS					
12	Land	222,604				12
13	Land improvements	835,359				13
14	Accumulated depreciation	-635,074				14
15	Buildings	20,974,244				15
16	Accumulated depreciation	-14,918,944				16
17	Leasehold improvements					17
18	Accumulated depreciation					18
19	Fixed equipment					19
20	Accumulated depreciation					20
21	Automobiles and trucks					21
22	Accumulated depreciation					22
23	Major movable equipment	15,633,979				23
24	Accumulated depreciation	-13,016,581				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)	9,095,587				30
	OTHER ASSETS					
31	Investments					31
32	Deposits on leases					32
33	Due from owners/officers					33
34	Other assets	423				34
35	Total other assets (sum of lines 31-34)	423				35
36	Total assets (sum of lines 11, 30 and 35)	17,722,091				36
		General Fund	Specific Purpose Fund	Endowment Fund	Plant Fund	
	Liabilities and Fund Balances (Omit Cents)	1	2	3	4	
	CURRENT LIABILITIES					
37	Accounts payable	271,450				37
38	Salaries, wages and fees payable	888,377				38
39	Payroll taxes payable					39
40	Notes and loans payable (short term)	-51,900				40
41	Deferred income					41
42	Accelerated payments					42
43	Due to other funds	1,367,239				43
44	Other current liabilities	212,318				44
45	Total current liabilities (sum of lines 37 thru 44)	2,687,484				45
	LONG TERM LIABILITIES					
46	Mortgage payable					46
47	Notes payable					47
48	Unsecured loans					48
49	Other long term liabilities	7,241,524				49
50	Total long term liabilities (sum of lines 46 thru 49)	7,241,524				50
51	Total liabilities (sum of lines 45 and 50)	9,929,008				51
	CAPITAL ACCOUNTS					
52	General fund balance	7,793,083				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)	7,793,083				59
60	Total liabilities and fund balances (sum of lines 51 and 59)	17,722,091				60

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STATEMENT OF CHANGES IN FUND BALANCES**WORKSHEET G-1**

		GENERAL FUND		SPECIFIC PURPOSE FUND	
		1	2	3	4
1	Fund balances at beginning of period		4,046,219		1
2	Net income (loss) (from Worksheet G-3, line 29)		3,746,863		2
3	Total (sum of line 1 and line 2)		7,793,082		3
4	Additions (credit adjustments) (specify)	1			4
5					5
6					6
7					7
8					8
9					9
10	Total additions (sum of lines 4-9)		1		10
11	Subtotal (line 3 plus line 10)		7,793,083		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)		7,793,083		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

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HARVARD MEMORIAL HOSPITAL Provider CCN: 14-1335	In Lieu of Form CMS-2552-10	Period : From: 07/01/2017 To: 06/30/2018	Run Date: 11/28/2018 Run Time: 12:39 Version: 2018.04 (09/26/2018)
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STATEMENT OF PATIENT REVENUES AND OPERATING EXPENSES**WORKSHEET G-2
PARTS I & II****PART I - PATIENT REVENUES**

	REVENUE CENTER	INPATIENT	OUTPATIENT	TOTAL	
		1	2	3	
	GENERAL INPATIENT ROUTINE CARE SERVICES				
1	Hospital	3,194,723		3,194,723	1
2	Subprovider IPF				2
3	Subprovider IRF				3
5	Swing Bed - SNF				5
6	Swing Bed - NF				6
7	Skilled nursing facility	806,669		806,669	7
8	Nursing facility				8
9	Other long term care	932,163		932,163	9
10	Total general inpatient care services (sum of lines 1-9)	4,933,555		4,933,555	10
	INTENSIVE CARE TYPE INPATIENT HOSPITAL SERVICES				
11	Intensive Care Unit	234,158		234,158	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)	234,158		234,158	16
17	Total inpatient routine care services (sum of lines 10 and 16)	5,167,713		5,167,713	17
18	Ancillary services	7,730,283	48,328,712	56,058,995	18
19	Outpatient services		5,051,181	5,051,181	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	Other (specify)				27
27.01	PROFESSIONAL FEES		3,552,942	3,552,942	27.01
28	Total patient revenues (sum of lines 17-27) (transfer column 3 to Worksheet G-3, line 1)	12,897,996	56,932,835	69,830,831	28

PART II - OPERATING EXPENSES

		1	2	
29	Operating expenses (per Worksheet A, column 3, line 200)		23,623,705	29
30	Add (specify)			30
31		2,106,286		31
32				32
33				33
34				34
35				35
36	Total additions (sum of lines 30-35)		2,106,286	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)		25,729,991	43

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

	DESCRIPTION		
1	Total patient revenues (from Worksheet G-2, Part I, column 3, line 28)	69,830,831	1
2	Less contractual allowances and discounts on patients' accounts	40,457,786	2
3	Net patient revenues (line 1 minus line 2)	29,373,045	3
4	Less total operating expenses (from Worksheet G-2, Part II, line 43)	25,729,991	4
5	Net income from service to patients (line 3 minus line 4)	3,643,054	5

OTHER INCOME

6	Contributions, donations, bequests, etc.		6
7	Income from investments	21,313	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	93,953	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)	1,793	24
25	Total other income (sum of lines 6-24)	117,059	25
26	Total (line 5 plus line 25)	3,760,113	26
27	Other expenses (GRANT)	13,250	27
28	Total other expenses (sum of line 27 and subscripts)	13,250	28
29	Net income (or loss) for the period (line 26 minus line 28)	3,746,863	29

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HARVARD MEMORIAL HOSPITAL Provider CCN: 14-1335	In Lieu of Form CMS-2552-10	Period : From: 07/01/2017 To: 06/30/2018	Run Date: 11/28/2018 Run Time: 12:39 Version: 2018.04 (09/26/2018)
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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	CORE							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