

HARRISBURG MEDICAL CENTER
HARRISBURG, ILLINOIS
MEDICARE COST REPORT
YEAR ENDED JUNE 30, 2014

Wisconsin Physician Services
Medicare Part A Reimbursement
3333 Farnam Street, Suite 700
Omaha, NE 68131

RE: Provider # 14-0210

Dear Mr. Don O'Neal

The Medicare Cost Report of Harrisburg Medical Center, Inc. for the year ended June 30, 2014, includes one level II exception.

20210S – The DRG payments for federal specific operating payment for model 4 BPCI (Wkst. E Part A, Column 1, Line 1.03) should be greater than the outlier payment for discharges for discharges for BPCI (Wkst. E Part A, Column 1, Line 2.02).

Harrisburg Medical Center does not participate in the Bundled Payments for Care Improvement (BPCI) initiative. Therefore, the hospital did not receive any Model 4 bundled payments for care improvement initiative. As such, Worksheet E Part A, Column 1, Lines 1.03 and 2.02 do not include any payment amounts.

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HARRISBURG MEDICAL CENTER, INC. Provider CCN: 14-0210	In Lieu of Form CMS-2552-10	Period: From: 07/01/2013 To: 06/30/2014	Run Date: 11/11/2014 Run Time: 13:12 Version: 2014.10
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HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX COST REPORT CERTIFICATION AND SETTLEMENT SUMMARY

WORKSHEET S
PARTS I, II & III

PART I - COST REPORT STATUS

PROVIDER USE ONLY	1. <input checked="" type="checkbox"/> ELECTRONICALLY FILED COST REPORT	DATE: 11/11/2014	TIME: 13:12
	2. <input type="checkbox"/> MANUALLY SUBMITTED COST REPORT		
	3. <input type="checkbox"/> IF THIS IS AN AMENDED REPORT ENTER THE NUMBER OF TIMES THE PROVIDER RESUBMITTED THE COST REPORT		
	4. <input checked="" type="checkbox"/> MEDICARE UTILIZATION. ENTER 'F' FOR FULL OR 'L' FOR LOW.		
CONTRACTOR USE ONLY	5. <input type="checkbox"/> COST REPORT STATUS	6. DATE RECEIVED: _____	10. NPR DATE: _____
	1 -AS SUBMITTED	7. CONTRACTOR NO: _____	11. CONTRACTOR'S VENDOR CODE: _____
	2 -SETTLED WITHOUT AUDIT	8. <input type="checkbox"/> INITIAL REPORT FOR THIS PROVIDER CCN	12. <input type="checkbox"/> IF LINE 5, COLUMN 1 IS 4: ENTER NUMBER OF TIMES REOPENED = 0-9.
	3 -SETTLED WITH AUDIT	9. <input type="checkbox"/> FINAL REPORT FOR THIS PROVIDER CCN	
	4 -REOPENED		
	5 -AMENDED		

PART II - CERTIFICATION

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

CERTIFICATION BY OFFICER OR ADMINISTRATOR OF PROVIDER(S)

I HEREBY CERTIFY THAT I HAVE READ THE ABOVE STATEMENT AND THAT I HAVE EXAMINED THE ACCOMPANYING ELECTRONICALLY FILED OR MANUALLY SUBMITTED COST REPORT AND THE BALANCE SHEET AND STATEMENT OF REVENUE AND EXPENSES PREPARED BY HARRISBURG MEDICAL CENTER, INC. (14-0210) (PROVIDER NAME(S) AND NUMBER(S)) FOR THE COST REPORTING PERIOD BEGINNING 07/01/2013 AND ENDING 06/30/2014, AND TO THE BEST OF MY KNOWLEDGE AND BELIEF, IT IS A TRUE, CORRECT AND COMPLETE STATEMENT PREPARED FROM THE BOOKS AND RECORDS OF THE PROVIDER IN ACCORDANCE WITH APPLICABLE INSTRUCTIONS, EXCEPT AS NOTED. I FURTHER CERTIFY THAT I AM FAMILIAR WITH THE LAWS AND REGULATIONS REGARDING THE PROVISION OF HEALTH CARE SERVICES, AND THAT THE SERVICES IDENTIFIED IN THIS COST REPORT WERE PROVIDED IN COMPLIANCE WITH SUCH LAWS AND REGULATIONS.

ECR Encryption: 11/11/2014 13:12
U1:vmGtMFWFaStel.fIBheO0ndjPo0
FOIX051VBq0VRhUppRNUUnN7XxUF
p.Fs1gzPIX08MkHi

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

TITLE

DATE

PI Encryption: 11/11/2014 13:12
Wjz:g7IsOaxfMPdGkEcxY0HkJO0
11:Ph00m8MIXZMFUR2.LapKL3vYSkQ
9SyF0tubNq0XZQIs

PART III - SETTLEMENT SUMMARY

	TITLE V	TITLE XVIII		HIT	TITLE XIX
		PART A	PART B		
	1	2	3	4	5
1	HOSPITAL	98,499	-30,698	-90,087	1
2	SUBPROVIDER - IPF	-29,336			2
3	SUBPROVIDER - IRF				3
4	SUBPROVIDER (OTHER)				4
5	SWING BED - SNF				5
6	SWING BED - NF				6
7	SKILLED NURSING FACILITY				7
8	NURSING FACILITY				8
9	HOME HEALTH AGENCY				9
10	HEALTH CLINIC - RHC		-10,536		10
10.01	HEALTH CLINIC - RHC II		-22,568		10.01
11	HEALTH CLINIC - FOHC				11
12	OUTPATIENT REHABILITATION PROVIDER				12
200	TOTAL	69,163	-63,802	-90,087	200

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

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

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HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA

WORKSHEET S-2
PART I

Hospital and Hospital Health Care Complex Address:										
1	Street: 100 DR WARREN TUTTLE DRIVE			P.O. Box:				1		
2	City: HARRISBURG			State: IL		ZIP Code: 62946		County: SALINE		
Hospital and Hospital-Based Component Identification:										
Payment System (P, T, O, or N)										
	Component	Component Name	CCN Number	CBSA Number	Provider Type	Date Certified	V	XVIII	XIX	
	0	1	2	3	4	5	6	7	8	
3	Hospital	HARRISBURG MEDICAL CENTER, INC.	14-0210	99914	1	07/01/1966	N	P	O	
4	Subprovider - IPF	HARRISBURG MEDICAL CENTER, INC.	14-S210	99914	4	06/19/1989	N	P	O	
5	Subprovider - IRF									
6	Subprovider - (OTHER)									
7	Swing Beds - SNF	HARRISBURG MEDICAL CENTER, INC.	14-U210	99914		11/03/1988	N	P	N	
8	Swing Beds - NF									
9	Hospital-Based SNF									
10	Hospital-Based NF									
11	Hospital-Based OLTC									
12	Hospital-Based HHA	HARRISBURG MEDICAL CENTER, INC.	14-7419	99914		08/15/1985	N	P	N	
13	Separately Certified ASC									
14	Hospital-Based Hospice									
15	Hospital-Based Health Clinic - RHC	ELDORADO PRIMARY CARE	14-3473	99914		12/31/2001	N	O	N	
15.01	Hospital-Based Health Clinic - RHC II	EQUALITY FAMILY PRACTICE	14-8518	99914		09/27/2011	N	O	N	
16	Hospital-Based Health Clinic - FOHC									
17	Hospital-Based (CMHC)									
18	Renal Dialysis									
19	Other									
20	Cost Reporting Period (mm/dd/yyyy)		From: 07 / 01 / 2013		To: 06 / 30 / 2014		20			
21	Type of control (see instructions)		2				21			
Inpatient PPS Information										
22	Does this facility qualify for and receive disproportionate share hospital payments in accordance with 42 CFR §412.106? In column 1, enter 'Y' for yes or 'N' for no. Is this facility subject to 42 CFR §412.06(c)(2)(Pickle amendment hospital)? In column 2, enter 'Y' for yes or 'N' for no.							Y	N	22
22.01	Did this hospital receive interim uncompensated care payments for this cost reporting period? Enter in column 1, 'Y' for yes or 'N' for no for the portion of the cost reporting period occurring prior to October 1. Enter in column 2 'Y' for yes or 'N' for no for the portion of the cost reporting period occurring on or after October 1. (see instructions)							N	N	22.01
23	Which method is used to determine Medicaid days on lines 24 and/or 25 below? In column 1, enter 1 if date of admission, 2 if census days, or 3 if date of discharge. Is the method of identifying the days in this cost reporting period different from the method used in the prior cost reporting period? In column 2, enter 'Y' for yes or 'N' for no.							3	N	23
		In-State Medicaid paid days	In-State Medicaid eligible unpaid days	Out-of-State Medicaid paid days	Out-of-State Medicaid eligible unpaid days	Medicaid HMO days	Other Medicaid days			
		1	2	3	4	5	6			
24	If this provider is an IPPS hospital, enter the in-state Medicaid paid days in col. 1, in-state Medicaid eligible unpaid days in col. 2, out-of-state Medicaid paid days in col. 3, out-of-state Medicaid eligible unpaid days in col. 4, Medicaid HMO paid and eligible but unpaid days in col. 5, and other Medicaid days in col. 6.		488						24	
25	If this provider is an IRF, enter the in-state Medicaid paid days in col. 1, in-state Medicaid eligible unpaid days in col. 2, out-of-state Medicaid days in col. 3, out-of-state Medicaid eligible unpaid days in col. 4, Medicaid HMO paid and eligible but unpaid days in col. 5, and other Medicaid days in col. 6.								25	
26	Enter your standard geographic classification (not wage) status at the beginning of the cost reporting period. Enter '1' for urban and '2' for rural.				2				26	
27	Enter your standard geographic classification (not wage) status at the end of the cost reporting period. Enter in column 1, '1' for urban or '2' for rural. If applicable, enter the effective date of the geographic reclassification in column 2.				2				27	
35	If this is a sole community hospital (SCH), enter the number of periods SCH status in effect in the cost reporting period.				1				35	
36	Enter applicable beginning and ending dates of SCH status. Subscript line 36 for number of periods in excess of one and enter subsequent dates.				Beginning: 07 / 01 / 2013		Ending: 06 / 30 / 2014		36	
37	If this is a Medicare dependent hospital (MDH), enter the number of periods MDH status in effect in the cost reporting period.								37	
38	Enter applicable beginning and ending dates of MDH status. Subscript line 38 for number of periods in excess of one and enter subsequent dates.				Beginning:		Ending:		38	
39	Does this facility qualify for the inpatient hospital payment adjustment for low volume hospitals in accordance with 42 CFR §412.101(b)(2)(ii)? Enter in column 1 'Y' for yes or 'N' for no. Does the facility meet the mileage requirements in accordance with 42 CFR 412.101(b)(2)(ii)? Enter in column 2 'Y' for yes or 'N' for no. (see instructions)							Y	Y	39

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HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA

WORKSHEET S-2
PART I

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

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WORKSHEET S-2
PART I

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

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WORKSHEET S-2
PART I

		V	XIX	
Title V and XIX Services		1	2	
90	Does this facility have title V and/or XIX inpatient hospital services? Enter 'Y' for yes, or 'N' for no in applicable column.	N	Y	90
91	Is this hospital reimbursed for title V and/or XIX through the cost report either in full or in part? Enter 'Y' for yes, or 'N' for no in the applicable column.	N	N	91
92	Are title XIX NF patients occupying title XVIII SNF beds (dual certification)? Enter 'Y' for yes or 'N' for no in the applicable column.	N	N	92
93	Does this facility operate an ICF/MR facility for purposes of title V and XIX? Enter 'Y' for yes or 'N' for no in the applicable column.	N	N	93
94	Does title V or title XIX reduce capital cost? Enter 'Y' for yes or 'N' for no in the applicable column.	N	N	94
95	If line 94 is 'Y', enter the reduction percentage in the applicable column.			95
96	Does title V or title XIX reduce operating cost? Enter 'Y' for yes or 'N' for no in the applicable column.	N	N	96
97	If line 96 is 'Y', enter the reduction percentage in the applicable column.			97
Rural Providers		1	2	
105	Does this hospital qualify as a Critical Access Hospital (CAH)?	N		105
106	If this facility qualifies as a CAH, has it elected the all-inclusive method of payment for outpatient services? (see instructions)			106
107	Column 1: If this facility qualifies as a CAH, is it eligible for cost reimbursement for I&R training programs? Enter 'Y' for yes and 'N' for no in column 1. If yes, the GME elimination would not be on Worksheet B, Part I, column 25 and the program would be cost reimbursed. If yes, complete Worksheet D-2, Part II. Column 2: If this facility is a CAH, do I&Rs in an approved medical education program train in the CAH's excluded IPF and/or IRF unit? Enter 'Y' for yes or 'N' for no in column 2.			107
108	Is this a rural hospital qualifying for an exception to the CRNA fee schedule? See 42 CFR §412.113(c). Enter 'Y' for yes or 'N' for no.	N		108
109	If this hospital qualifies as a CAH or a cost provider, are therapy services provided by outside supplier? Enter 'Y' for yes or 'N' for each therapy.	Physical	Occupational Speech Respiratory	109
		N	N	
Miscellaneous Cost Reporting Information				
115	Is this an all-inclusive rate provider? Enter 'Y' for yes or 'N' for no in column 1. If yes, enter the method used (A, B, or E only) in column 2. If column 2 is 'E', enter in column 3 either '93' percent for short term hospital or '98'	N		115
116	Is this facility classified as a referral center? Enter 'Y' for yes or 'N' for no.	N		116
117	Is this facility legally required to carry malpractice insurance? Enter 'Y' for yes or 'N' for no.	Y		117
118	Is the malpractice insurance a claims-made or occurrence policy? Enter 1 if the policy is claim-made Enter 2 if the policy is occurrence.	2		118
118.01	List amounts of malpractice premiums and paid losses:	Premiums	Paid Losses	Self Insurance
		290,000		
118.02	Are malpractice premiums and paid losses reported in a cost center other than the Administrative and General cost center? If yes, submit supporting schedule listing cost centers and amounts contained therein.	N		118.02
120	Is this a SCH or EACH that qualifies for the Outpatient Hold Harmless provision in ACA §3121 and applicable amendments? (see instructions). Enter in column 1 'Y' for yes or 'N' for no. Is this a rural hospital with < 100 beds that qualifies for the Outpatient Hold Harmless provision in ACA §3121 and applicable amendments? (see instructions). Enter in column 2 'Y' for yes or 'N' for no.	Y	Y	120
121	Did this facility incur and report costs for high cost implantable devices charged to patients? Enter 'Y' for yes or 'N' for no.	Y		121
Transplant Center Information				
125	Does this facility operate a transplant center? Enter 'Y' for yes or 'N' for no. If yes, enter certification date(s)(mm/dd/yyyy) below.	N		125
126	If this is a Medicare certified kidney transplant center enter the certification date in column 1 and termination date, if applicable in column 2.			126
127	If this is a Medicare certified heart transplant center enter the certification date in column 1 and termination date, if applicable in column 2.			127
128	If this is a Medicare certified liver transplant center enter the certification date in column 1 and termination date, if applicable in column 2.			128
129	If this is a Medicare certified lung transplant center enter the certification date in column 1 and termination date, if applicable in column 2.			129
130	If this is a Medicare certified pancreas transplant center enter the certification date in column 1 and termination date, if applicable in column 2.			130
131	If this is a Medicare certified intestinal transplant center enter the certification date in column 1 and termination date, if applicable in column 2.			131
132	If this is a Medicare certified islet transplant center enter the certification date in column 1 and termination date, if applicable in column 2.			132
133	If this is a Medicare certified other transplant center enter the certification date in column 1 and termination date, if applicable in column 2.			133
134	If this is an organ procurement organization (OPO), enter the OPO number in column 1 and termination date, if applicable in column 2.			134

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WORKSHEET S-2
PART I

All Providers							
140	Are there any related organization or home office costs as defined in CMS Pub 15-1, Chapter 10? Enter 'Y' for yes, or 'N' for no in column 1. If yes, and home office costs are claimed, enter in column 2 the home office chain number (see instructions)		1	2		140	
		N					
If this facility is part of a chain organization, enter on lines 141 through 143 the name and address of the home office and enter the home office contractor name and contractor number.							
141	Name:	Contractor's Name:	Contractor's Number:			141	
142	Street:	P.O. Box:				142	
143	City:	State:	ZIP Code:			143	
144	Are provider based physicians' costs included in Worksheet A?		Y			144	
145	If costs for renal services are claimed on Worksheet A, line 74 are they costs for inpatient services only? Enter 'Y' for yes, or 'N' for no.		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, section 4020). If yes, enter the approval date (mm/dd/yyyy) in column 2.		N			146	
147	Was there a change in the statistical basis? Enter 'Y' for yes or 'N' for no.		N			147	
148	Was there a change in the order of allocation? Enter 'Y' for yes or 'N' for no.		N			148	
149	Was there a change to the simplified cost finding method? Enter 'Y' for yes or 'N' for no.		N			149	
Does this facility contain a provider that qualifies for an exemption from the application of the lower of costs or charges? Enter 'Y' for yes or 'N' for no for each component for Part A and Part B. See 42 CFR §413.133							
		Title XVIII		Title V	Title XIX		
		Part A	Part B	1	2	3	
155	Hospital	N	N	N	N	155	
156	Subprovider - IPF	N	N	N	N	156	
157	Subprovider - IRF	N	N			157	
158	Subprovider - Other					158	
159	SNF	N	N			159	
160	HHA	N	N	N	N	160	
161	CMHC		N			161	
161.10	CORF					161.10	
Multicampus							
165	Is this hospital part of a multicampus hospital that has one or more campuses in different CBSAs? Enter 'Y' for yes or 'N' for no.	N				165	
166	If line 165 is yes, for each campus, enter the name in column 0, county in column 1, state in column 2, ZIP in column 3, CBSA in column 4, FTE/campus in column 5.						166
	Name	County	State	ZIP Code	CBSA	FTE/Campus	
	0	1	2	3	4	5	
Health Information Technology (HIT) incentive in the American Recovery and Reinvestment Act							
167	Is this provider a meaningful user under §1886(n)? Enter 'Y' for yes or 'N' for no.		Y			167	
168	If this provider is a CAH (line 105 is 'Y') and is a meaningful user (line 167 is 'Y'), enter the reasonable cost incurred for the HIT assets. (see instructions)					168	
169	If this provider is a meaningful user (line 167 is 'Y') and is not a CAH (line 105 is 'N'), enter the transitional factor. (see instructions)		0.50			169	
170	Enter in columns 1 and 2 the EHR beginning date and ending date for the reporting period respectively (mm/dd/yyyy)			07/01/2013	06/30/2014	170	

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HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX REIMBURSEMENT QUESTIONNAIRE

WORKSHEET S-2
PART IIGENERAL 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	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	
2	HAS THE PROVIDER TERMINATED PARTICIPATION IN THE MEDICARE PROGRAM? IF YES, ENTER IN COLUMN 2 THE DATE OF TERMINATION AND IN COLUMN 3, 'V' FOR VOLUNTARY OR 'I' FOR INVOLUNTARY.	N		2	
3	IS THE PROVIDER INVOLVED IN BUSINESS TRANSACTIONS, INCLUDING MANAGEMENT CONTRACTS, WITH INDIVIDUALS OR ENTITIES (e.g., chain home offices, drug or medical supply companies) THAT ARE RELATED TO THE PROVIDER OR ITS OFFICERS, MEDICAL STAFF, MANAGEMENT PERSONNEL, OR MEMBERS OF THE BOARD OF DIRECTORS THROUGH OWNERSHIP, CONTROL, OR FAMILY AND OTHER SIMILAR RELATIONSHIPS? (see instructions)	N		3	
FINANCIAL DATA AND REPORTS					
		Y/N	TYPE	DATE	
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 ON THE FILED FINANCIAL STATEMENTS? IF YES, SUBMIT RECONCILIATION.	Y		5	
APPROVED EDUCATIONAL ACTIVITIES					
		Y/N		Y/N	
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 INTERN-RESIDENT PROGRAMS CLAIMED ON THE CURRENT COST REPORT? IF YES, SEE INSTRUCTIONS.	N		9	
10	WAS AN INTERN-RESIDENT PROGRAM INITIATED OR RENEWED IN THE CURRENT COST REPORTING PERIOD? IF YES, SEE INSTRUCTIONS.	N		10	
11	ARE GME COSTS DIRECTLY ASSIGNED TO COST CENTERS OTHER THAN I & R IN AN APPROVED TEACHING PROGRAM ON WORKSHEET A7 IF YES, SEE INSTRUCTIONS.	N		11	
BAD DEBTS					
				Y/N	
12	IS THE PROVIDER SEEKING REIMBURSEMENT FOR BAD DEBTS? IF YES, SEE INSTRUCTIONS.			Y	
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	
14	IF LINE 12 IS YES, WERE PATIENT DEDUCTIBLES AND/OR CO-PAYMENTS WAIVED? IF YES, SEE INSTRUCTIONS.			N	
BED COMPLEMENT					
15	DID TOTAL BEDS AVAILABLE CHANGE FROM THE PRIOR COST REPORTING PERIOD? IF YES, SEE INSTRUCTIONS.			Y	
PS&R REPORT DATA					
		PART A		PART B	
		Y/N	DATE	Y/N	DATE
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	
17	WAS THE COST REPORT PREPARED USING THE PS&R REPORT FOR TOTALS AND THE PROVIDER'S RECORDS FOR ALLOCATION? IF EITHER COLUMN 1 OR 3 IS YES, ENTER THE PAID-THROUGH DATE IN COLUMNS 2 AND 4. (see instructions)	Y	10/01/2014	Y	10/01/2014
18	IF LINE 16 OR 17 IS YES, WERE ADJUSTMENTS MADE TO PS&R REPORT DATA FOR ADDITIONAL CLAIMS THAT HAVE BEEN BILLED BUT ARE NOT INCLUDED ON THE PS&R REPORT USED TO FILE THE COST REPORT? IF YES, SEE INSTRUCTIONS.	N		N	
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	
20	IF LINE 16 OR 17 IS YES, WERE ADJUSTMENTS MADE TO PS&R REPORT DATA FOR OTHER? DESCRIBE THE OTHER ADJUSTMENTS:	N		N	
21	WAS THE COST REPORT PREPARED ONLY USING THE PROVIDER'S RECORDS? IF YES, SEE INSTRUCTIONS.	N		N	

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HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX REIMBURSEMENT QUESTIONNAIRE

WORKSHEET S-2
PART IIGENERAL INSTRUCTION: ENTER Y FOR ALL YES RESPONSES. ENTER N FOR ALL NO RESPONSES.
ENTER ALL DATES IN THE MM/DD/YYYY FORMAT.

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

CAPITAL RELATED COSTS			
22	HAVE ASSETS BEEN RELIEFED FOR MEDICARE PURPOSES? IF YES, SEE INSTRUCTIONS.		22
23	HAVE CHANGES OCCURRED IN THE MEDICARE DEPRECIATION EXPENSE DUE TO APPRAISALS MADE DURING THE COST REPORTING PERIOD? IF YES, SEE INSTRUCTIONS.		23
24	WERE NEW LEASES AND/OR AMENDMENTS TO EXISTING LEASES ENTERED INTO DURING THIS COST REPORTING PERIOD? IF YES, SEE INSTRUCTIONS.		24
25	HAVE THERE BEEN NEW CAPITALIZED LEASES ENTERED INTO DURING THE COST REPORTING PERIOD? IF YES, SEE INSTRUCTIONS.		25
26	WERE ASSETS SUBJECT TO SEC. 2314 OF DEFRA ACQUIRED DURING THE COST REPORTING PERIOD? IF YES, SEE INSTRUCTIONS.		26
27	HAS THE PROVIDER'S CAPITALIZED POLICY CHANGED DURING THE COST REPORTING PERIOD? IF YES, SEE INSTRUCTIONS.		27
INTEREST EXPENSE			
28	WERE NEW LOANS, MORTGAGE AGREEMENTS OR LETTERS OF CREDIT ENTERED INTO DURING THE COST REPORTING PERIOD? IF YES, SEE INSTRUCTIONS.		28
29	DID THE PROVIDER HAVE A FUNDED DEPRECIATION ACCOUNT AND/OR BOND FUNDS (debt service reserve fund) TREATED AS A FUNDED DEPRECIATION ACCOUNT? IF YES, SEE INSTRUCTIONS.		29
30	HAS EXISTING DEBT BEEN REPLACED PRIOR TO ITS SCHEDULED MATURITY WITH NEW DEBT? IF YES, SEE INSTRUCTIONS.		30
31	HAS DEBT BEEN RECALLED BEFORE SCHEDULED MATURITY WITHOUT ISSUANCE OF NEW DEBT? IF YES, SEE INSTRUCTIONS.		31
PURCHASED SERVICES			
32	HAVE CHANGES OR NEW AGREEMENTS OCCURRED IN PATIENT CARE SERVICES FURNISHED THROUGH CONTRACTUAL ARRANGEMENTS WITH SUPPLIERS OF SERVICES? IF YES, SEE INSTRUCTIONS.		32
33	IF LINE 32 IS YES, WERE THE REQUIREMENTS OF SEC. 2135.2 APPLIED PERTAINING TO COMPETITIVE BIDDING? IF NO, SEE INSTRUCTIONS.		33
PROVIDER-BASED PHYSICIANS			
34	ARE SERVICES FURNISHED AT THE PROVIDER FACILITY UNDER AN ARRANGEMENT WITH PROVIDER-BASED PHYSICIANS? IF YES, SEE INSTRUCTIONS.		34
35	IF LINE 34 IS YES, WERE THERE NEW AGREEMENTS OR AMENDED EXISTING AGREEMENTS WITH THE PROVIDER-BASED PHYSICIANS DURING THE COST REPORTING PERIOD? IF YES, SEE INSTRUCTIONS.		35
HOME OFFICE COSTS		Y/N	DATE
36	WERE HOME OFFICE COSTS CLAIMED ON THE COST REPORT?	1	2
37	IF LINE 36 IS YES, HAS A HOME OFFICE COST STATEMENT BEEN PREPARED BY THE HOME OFFICE? IF YES, SEE INSTRUCTIONS.		
38	IF LINE 36 IS YES, WAS THE FISCAL YEAR END OF THE HOME OFFICE DIFFERENT FROM THAT OF THE PROVIDER? IF YES, ENTER IN COLUMN 2 THE FISCAL YEAR END OF THE HOME OFFICE.		
39	IF LINE 36 IS YES, DID THE PROVIDER RENDER SERVICES TO OTHER CHAIN COMPONENTS? IF YES, SEE INSTRUCTIONS.		
40	IF LINE 36 IS YES, DID THE PROVIDER RENDER SERVICES TO THE HOME OFFICE? IF YES, SEE INSTRUCTIONS.		
COST REPORT PREPARER INFORMATION			
41	FIRST NAME: MARK	LAST NAME: DALLAS	TITLE: PARTNER
42	EMPLOYER: KERBER, ECK & BRAECKEL LLP		
43	PHONE NUMBER: 618-529-1040	E-MAIL ADDRESS: MARKD@KEBCPA.COM	

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HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA

WORKSHEET S-3
PART I

	COMPONENT	WKST A LINE NO.	NO. OF BEDS	BED DAYS AVAILABLE	CAH HOURS	INPATIENT DAYS/OUTPATIENT VISITS/TRIPS				
						TITLE V	TITLE XVIII	TITLE XIX	TOTAL ALL PATIENTS	
		1	2	3	4	5	6	7	8	
1	HOSPITAL ADULTS & PEDS. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days) (see instructions for col. 2 for the portion of LDP room available beds)	30	37	13,505			2,459	488	3,900	1
2	HMO AND OTHER (see instructions)						228			2
3	HMO IPF SUBPROVIDER						79			3
4	HMO IRF SUBPROVIDER									4
5	HOSPITAL ADULTS & PEDS. SWING BED SNF						166			5
6	HOSPITAL ADULTS & PEDS. SWING BED NF									6
7	TOTAL ADULTS & PEDS. (exclude observation beds)(see instructions)		37	13,505			2,625	488	4,097	7
8	INTENSIVE CARE UNIT	31								8
9	CORONARY CARE UNIT	32								9
10	BURN INTENSIVE CARE UNIT	33								10
11	SURGICAL INTENSIVE CARE UNIT	34								11
12	OTHER SPECIAL CARE (SPECIFY)	35								12
13	NURSERY	43								13
14	TOTAL (see instructions)		37	13,505			2,625	488	4,097	14
15	CAH VISITS									15
16	SUBPROVIDER - IPF	40	28	10,220			3,556	3,051	9,210	16
17	SUBPROVIDER - IRF	41								17
18	SUBPROVIDER I	42								18
19	SKILLED NURSING FACILITY	44								19
20	NURSING FACILITY	45								20
21	OTHER LONG TERM CARE	46								21
22	HOME HEALTH AGENCY	101					2,614		4,348	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					3,975		15,896	26
26.01	RHC II	88.01					495		1,985	26.01
27	TOTAL (sum of lines 14-26)		65						1,614	27
28	OBSERVATION BED DAYS									28
29	AMBULANCE TRIPS									29
30	EMPLOYEE DISCOUNT DAYS (see instructions)									30
31	EMPLOYEE DISCOUNT DAYS-IRF									31
32	LABOR & DELIVERY DAYS (see instructions)									32
32.01	TOTAL ANCILLARY LABOR & DELIVERY ROOM OUTPATIENT DAYS (see instructions)									32.01
33	LTCH NON-COVERED DAYS									33

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HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA

WORKSHEET S-3
PART I

	COMPONENT	FULL TIME EQUIVALENTS			DISCHARGES			TOTAL ALL PATIENTS	
		TOTAL INTERNS & RESIDENTS	EMPLOYEES ON PAYROLL	NONPAID WORKERS	TITLE V	TITLE XVIII	TITLE XIX		
		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)					830	210	1,446	1
2	HMO AND OTHER (see instructions)					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)								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)		335.97			830	210	1,446	14
15	CAH VISITS								15
16	SUBPROVIDER - IPF		60.56			374	503	1,293	16
17	SUBPROVIDER - IRF								17
18	SUBPROVIDER I								18
19	SKILLED NURSING FACILITY								19
20	NURSING FACILITY								20
21	OTHER LONG TERM CARE								21
22	HOME HEALTH AGENCY		12.58						22
23	ASC (Distinct Part)								23
24	HOSPICE (Distinct Part)								24
24.10	HOSPICE (non-distinct part)								24.10
25	CMHC								25
26	RHC		23.48						26
26.01	RHC II		2.70						26.01
27	TOTAL (sum of lines 14-26)		435.29						27
32.01	TOTAL ANCILLARY LABOR & DELIVERY ROOM OUTPATIENT DAYS (see instructions)								32

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HOSPITAL WAGE INDEX INFORMATION

WORKSHEET S-3
PARTS II-III

PART II - WAGE DATA

	WKST A LINE NO.	AMOUNT REPORTED	RECLASSIF- ICATION OF SALARIES (from Worksheet A-6)	ADJUSTED SALARIES (column 2 ± column 3)	PAID HOURS RELATED TO SALARIES IN COLUMN 4	AVERAGE HOURLY WAGE (column 4 ± column 5)	
	1	2	3	4	5	6	
SALARIES							
1	200	20,669,013		20,669,013	905,399.00	22.83	1
2							2
3		689,251		689,251	6,448.00	106.89	3
4							4
4.01							4.01
5		2,376,743		2,376,743	23,891.00	99.48	5
6		797,441	-104,968	692,473	35,715.00	19.39	6
7	21						7
7.01							7.01
8							8
9	44						9
10		3,368,078	-99,878	3,268,200	161,166.00	20.28	10
OTHER WAGES & RELATED COSTS							
11		299,801		299,801	5,004.00	59.91	11
12							12
13							13
14							14
15							15
16							16
WAGE-RELATED COSTS							
17		4,422,779		4,422,779			17
18							18
19		1,059,528		1,059,528			19
20							20
21		223,450		223,450			21
22							22
22.01							22.01
23		770,524		770,524			23
24		224,495		224,495			24
25							25
OVERHEAD COSTS - DIRECT SALARIES							
26							26
27		3,173,716	50,198	3,223,914	129,163.00	24.96	27
28		70,308		70,308	1,486.00	47.31	28
29							29
30		491,023		491,023	32,196.00	15.25	30
31		37,297		37,297	3,607.00	10.34	31
32		492,034		492,034	43,894.00	11.21	32
33							33
34		498,885		498,885	40,924.00	12.19	34
35							35
36							36
37							37
38		92,929		92,929	4,442.00	20.92	38
39		192,390		192,390	13,338.00	14.42	39
40		549,432		549,432	13,298.00	41.32	40
41		419,031		419,031	27,316.00	15.34	41
42							42
43							43

PART III - HOSPITAL WAGE INDEX SUMMARY

1	NET SALARIES (see instructions)	16,875,886	104,968	16,980,854	840,831.00	20.20	1
2	EXCLUDED AREA SALARIES (see instructions)	3,368,078	-99,878	3,268,200	161,166.00	20.28	2
3	SUBTOTAL SALARIES (line 1 minus line 2)	13,507,808	204,846	13,712,654	679,665.00	20.18	3
4	SUBTOTAL OTHER WAGES & RELATED COSTS (see instructions)	299,801		299,801	5,004.00	59.91	4
5	SUBTOTAL WAGE-RELATED COSTS (see instructions)	4,422,779		4,422,779		32.25%	5
6	TOTAL (sum of lines 3 through 5)	18,230,388	204,846	18,435,234	684,669.00	26.93	6
7	TOTAL OVERHEAD COST (see instructions)	6,017,045	50,198	6,067,243	309,664.00	19.59	7

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WORKSHEET S-3
PART IV

HOSPITAL WAGE RELATED COSTS

PART IV - WAGE RELATED COST

PART A - CORE LIST

		AMOUNT REPORTED	
	RETIREMENT COST		
1	401K EMPLOYER CONTRIBUTIONS	611,276	1
2	TAX SHELTERED ANNUITY (TSA) EMPLOYER CONTRIBUTION		2
3	NONQUALIFIED DEFINED BENEFIT PLAN COST (see instructions)		3
4	QUALIFIED DEFINED BENEFIT PLAN COST (see instructions)		4
	PLAN ADMINISTRATIVE COSTS (Paid to External Organization):		
5	401k/TSA PLAN ADMINISTRATION FEES		5
6	LEGAL/ACCOUNTING/MANAGEMENT FEES-PENSION PLAN		6
7	EMPLOYEE MANAGED CARE PROGRAM ADMINISTRATION FEES		7
	HEALTH AND INSURANCE COST	3,901,539	8
8	HEALTH INSURANCE (Purchased or Self Funded)		9
9	PRESCRIPTION DRUG PLAN	58,353	10
10	DENTAL, HEARING AND VISION PLAN	35,419	11
11	LIFE INSURANCE (If employee is owner or beneficiary)		12
12	ACCIDENTAL INSURANCE (If employee is owner or beneficiary)		13
13	DISABILITY INSURANCE (If employee is owner or beneficiary)		14
14	LONG-TERM CARE INSURANCE (If employee is owner or beneficiary)	383,904	15
15	WORKERS' COMPENSATION INSURANCE		16
16	RETIREMENT HEALTH CARE COST (Only current year, not the extraordinary accrual required by FASB 106. Non cumulative portion)		
	TAXES	1,217,866	17
17	FICA-EMPLOYERS PORTION ONLY	284,823	18
18	MEDICARE TAXES - EMPLOYERS PORTION ONLY		19
19	UNEMPLOYMENT INSURANCE	191,811	20
20	STATE OR FEDERAL UNEMPLOYMENT TAXES		
	OTHER		
21	EXECUTIVE DEFERRED COMPENSATION (Other Than Retirement Cost Reported on lines 1 through 4 above)(see instructions)		21
22	DAY CARE COSTS AND ALLOWANCES	15,785	22
23	TUITION REIMBURSEMENT	6,700,776	23
24	TOTAL WAGE RELATED COST (Sum of lines 1-23)		24
	PART B - OTHER THAN CORE RELATED COST	7,892	25
25	OTHER WAGE RELATED (OTHER WAGE REL		

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

EXHIBIT 3

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

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

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

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HOSPITAL CONTRACT LABOR AND BENEFIT COST

WORKSHEET S-3
PART V

PART V - CONTRACT LABOR AND BENEFIT COST

HOSPITAL AND HOSPITAL-BASED COMPONENT IDENTIFICATION:

	COMPONENT	CONTRACT LABOR	BENEFIT COST	
	0	1	2	
1	TOTAL FACILITY CONTRACT LABOR AND BENEFIT COST	299,801		1
2	HOSPITAL	299,801		2
3	SUBPROVIDER - IPF			3
4	SUBPROVIDER - IRF			4
5	SUBPROVIDER - (OTHER)			5
6	SWING BEDS - SNF			6
7	SWING BEDS - NF			7
8	HOSPITAL-BASED SNF			8
9	HOSPITAL-BASED NF			9
10	HOSPITAL-BASED OLTG			10
11	HOSPITAL-BASED HHA			11
12	SEPARATELY CERTIFIED ASC			12
13	HOSPITAL-BASED HOSPICE			13
14	HOSPITAL-BASED HEALTH CLINIC - RHC			14
14.01	HOSPITAL-BASED HEALTH CLINIC - RHC II			14.01
15	HOSPITAL-BASED HEALTH CLINIC - FQHC			15
16	HOSPITAL-BASED (CMHC)			16
17	RENAL DIALYSIS			17
18	OTHER			18

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HOSPITAL-BASED HOME HEALTH AGENCY STATISTICAL DATA

HHA CCN: 14-7419

WORKSHEET S-4

HOME HEALTH AGENCY STATISTICAL DATA

COUNTY: SALINE

	DESCRIPTION	TITLE V 1	TITLE XVIII 2	TITLE XIX 3	OTHER 4	TOTAL 5	
1	HOME HEALTH AIDE HOURS						1
2	UNDUPLICATED CENSUS COUNT (see instructions)		160.00			160.00	2

HOME HEALTH AGENCY - NUMBER OF EMPLOYEES

	ENTER THE NUMBER OF HOURS IN YOUR NORMAL WORK WEEK	NUMBER OF EMPLOYEES (Full Time Equivalent)			
		STAFF	CONTRACT	TOTAL	
		1	2	3	
3	ADMINISTRATOR AND ASSISTANT ADMINISTRATOR(S)				3
4	DIRECTOR(S) AND ASSISTANT DIRECTOR(S)	1.00		1.00	4
5	OTHER ADMINISTRATIVE PERSONNEL	0.06		0.06	5
6	DIRECT NURSING SERVICE	6.01		6.01	6
7	NURSING SUPERVISOR	1.53		1.53	7
8	PHYSICAL THERAPY SERVICE	1.83		1.83	8
9	PHYSICAL THERAPY SUPERVISOR				9
10	OCCUPATIONAL THERAPY SERVICE	0.04		0.04	10
11	OCCUPATIONAL THERAPY SUPERVISOR				11
12	SPEECH PATHOLOGY SERVICE	0.12		0.12	12
13	SPEECH PATHOLOGY SUPERVISOR				13
14	MEDICAL SOCIAL SERVICE				14
15	MEDICAL SOCIAL SERVICE SUPERVISOR				15
16	HOME HEALTH AIDE				16
17	HOME HEALTH AIDE SUPERVISOR				17
18	OTHER (SPECIFY)				18

HOME HEALTH AGENCY - CBSA CODES

19	ENTER IN COLUMN 1 THE NUMBER OF CBSAs WHERE YOU PROVIDED SERVICES DURING THE COST REPORTING PERIOD.		1	19
20	LIST THOSE CBSA CODE(S) IN COLUMN 1 SERVICED DURING THIS COST REPORTING PERIOD (line 20 contains the first code).	99914	20	

PPS ACTIVITY

		FULL EPISODES				TOTAL (columns 1 through 4)	
		WITHOUT OUTLIERS	WITH OUTLIERS	LUPA EPISODES	PEP ONLY EPISODES		
		1	2	3	4	5	
21	SKILLED NURSING VISITS	1,178		134	17	1,329	21
22	SKILLED NURSING VISIT CHARGES	238,945		22,572	3,420	264,937	22
23	PHYSICAL THERAPY VISITS	1,116		19	14	1,149	23
24	PHYSICAL THERAPY VISIT CHARGES	252,358		3,664	3,206	259,228	24
25	OCCUPATIONAL THERAPY VISITS	43			10	53	25
26	OCCUPATIONAL THERAPY VISIT CHARGES	10,621			2,470	13,091	26
27	SPEECH PATHOLOGY VISITS	75		6		81	27
28	SPEECH PATHOLOGY VISIT CHARGES	18,278		1,235		19,513	28
29	MEDICAL SOCIAL SERVICE VISITS						29
30	MEDICAL SOCIAL SERVICE VISIT CHARGES						30
31	HOME HEALTH AIDE VISITS	2				2	31
32	HOME HEALTH AIDE VISIT CHARGES	234				234	32
33	TOTAL VISITS (sum of lines 21, 23, 25, 27, 29, and 31)	2,414		159	41	2,614	33
34	OTHER CHARGES						34
35	TOTAL CHARGES (sum of lines 22, 24, 26, 28, 30, 32 and 34)	\$20,436		27,471	9,096	57,003	35
36	TOTAL NUMBER OF EPISODES (standard/non-outlier)	156		43	2	201	36
37	TOTAL NUMBER OF OUTLIER EPISODES						37
38	TOTAL NON-ROUTINE MEDICAL SUPPLY CHARGES	10,867		2,915		13,782	38

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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 IN COLUMN 1 AND DO NOT COMPLETE THE REST OF THIS WORKSHEET.	N		1
2	DOES THIS HOSPITAL HAVE AN AGREEMENT UNDER EITHER SECTION 1883 OR SECTION 1913 FOR SWING BEDS? ENTER 'Y' FOR YES OR 'N' FOR NO IN COLUMN 1. IF YES, ENTER THE AGREEMENT DATE (mm/dd/yyyy) IN COLUMN 2.	Y	11/03/1988	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				13
14	RUA				14
15	RVC				15
16	RVB				16
17	RVA				17
18	RHC				18
19	RHB		11	11	19
20	RHA		51	51	20
21	RMC		10	10	21
22	RMB		12	12	22
23	RMA		25	25	23
24	RLB				24
25	RLA				25
26	ES3				26
27	ES2				27
28	ES1				28
29	HE2				29
30	HE1				30
31	HD2				31
32	HD1				32
33	HC2				33
34	HC1				34
35	HB2				35
36	HB1				36
37	LE2				37
38	LE1				38
39	LD2				39
40	LD1		13	13	40
41	LC2				41
42	LC1				42
43	LB2		11	11	43
44	LB1				44
45	CE2				45
46	CE1				46
47	CD2				47
48	CD1				48
49	CC2				49
50	CC1		4	4	50
51	CB2				51
52	CB1		29	29	52
53	CA2				53
54	CA1				54
55	SE3				55
56	SE2				56
57	SE1				57
58	SSC				58
59	SSB				59
60	SSA				60
61	JB2				61
62	JB1				62
63	JA1				63
64	JA2				64
65	BB2				65
66	BB1				66
67	BA2				67
68	BA1				68
69	PE2				69
70	PE1				70

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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	
71	PD2				71
72	PD1				72
73	PC2				73
74	PC1				74
75	PB2				75
76	PB1				76
77	PA2				77
78	PA1				78
199	AAA				199
200	TOTAL		166	166	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).			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)				207

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HOSPITAL-BASED RURAL HEALTH CLINIC/FEDERALLY QUALIFIED HEALTH CENTER
STATISTICAL DATA

COMPONENT CCN: 14-3473

WORKSHEET S-8

CHECK [XX] RHC [] FQHC
APPLICABLE BOX:

CLINIC ADDRESS AND IDENTIFICATION:

1	STREET: 1007 US ROUTE 45				1
2	CITY: ELDORADO	STATE: IL	ZIP CODE: 62930	COUNTY: SALINE	2
3	FQHCs ONLY: DESIGNATION - ENTER 'R' FOR RURAL OR 'U' FOR URBAN				3

SOURCE OF FEDERAL FUNDS:

		GRANT AWARD	DATE	
		1	2	
4	COMMUNITY HEALTH CENTER (Section 330(d), PHS Act)			4
5	MIGRANT HEALTH CENTER (Section 329(d), PHS Act)			5
6	HEALTH SERVICES FOR HOMELESS (Section 340(d), PHS Act)			6
7	APPALACHIAN REGIONAL COMMISSION			7
8	LOOK-ALIKES			8
9	OTHER			9

10	DOES THIS FACILITY OPERATE AS OTHER THAN AN RHC OR FQHC? ENTER 'Y' FOR YES OR 'N' FOR NO IN COLUMN 1. IF YES, INDICATE THE NUMBER OF OTHER OPERATIONS IN COLUMN 2.	1 N	2	10
----	---	--------	---	----

FACILITY HOURS OF OPERATIONS(1)

	TYPE OPERATION	SUNDAY		MONDAY		TUESDAY		WEDNESDAY		THURSDAY		FRIDAY		SATURDAY		
		FROM	TO	FROM	TO	FROM	TO	FROM	TO	FROM	TO	FROM	TO	FROM	TO	
11	CLINIC	1	2	0008	0005	0008	0005	0008	0005	0008	0005	0008	0005	0008	0005	11

(1) ENTER CLINIC HOURS OF OPERATION ON LINE 11 AND OTHER TYPE OPERATIONS ON SUBSCRIPTS OF LINE 11 (both type and hours of operation). LIST HOURS OF OPERATION BASED ON A 24 HOUR CLOCK. FOR EXAMPLE: 8:00AM IS 0800, 6:30PM IS 1830, AND MIDNIGHT IS 2400.

12	HAVE YOU RECEIVED AN APPROVAL FOR AN EXCEPTION TO THE PRODUCTIVITY STANDARD?	1 N	2	12
13	IS THIS A CONSOLIDATED COST REPORT AS DEFINED IN CMS PUB. 27, SECTION 508(D)?	N		13
14	PROVIDER NAME: _____ CCN NUMBER: _____			14

		Y/N	V	XVIII	XIX	TOTAL VISITS	
		1	2	3	4	5	
15	HAVE YOU PROVIDED ALL OR SUBSTANTIALLY ALL GME COST? ENTER 'Y' FOR YES OR 'N' FOR NO IN COLUMN 1. IF YES, ENTER IN COLUMNS 2, 3, AND 4 THE NUMBER OF PROGRAM VISITS PERFORMED IN COLUMN 1. IF YES, ENTER IN 2, 3, AND 4 THE NUMBER OF PROGRAM VISITS PERFORMED BY INTERNS AND RESIDENTS FOR TITLES V, XVIII, AND XIX, AS APPLICABLE. (see instructions)	N					15

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HOSPITAL-BASED RURAL HEALTH CLINIC/FEDERALLY QUALIFIED HEALTH CENTER
STATISTICAL DATA

COMPONENT CCN: 14-8518

WORKSHEET S-8

CHECK RHC FQHC
 APPLICABLE BOX:

CLINIC ADDRESS AND IDENTIFICATION:

1	STREET: 183 WEST LN ST																	1
2	CITY: EQUALITY	STATE: IL	ZIP CODE: 62934	COUNTY: SALINE														2
3	FQHCs ONLY: DESIGNATION - ENTER 'R' FOR RURAL OR 'U' FOR URBAN																	3

SOURCE OF FEDERAL FUNDS:

		GRANT AWARD	DATE	
		1	2	
4	COMMUNITY HEALTH CENTER (Section 330(d), PHS Act)			4
5	MIGRANT HEALTH CENTER (Section 329(d), PHS Act)			5
6	HEALTH SERVICES FOR HOMELESS (Section 340(d), PHS Act)			6
7	APPALACHIAN REGIONAL COMMISSION			7
8	LOOK-ALIKES			8
9	OTHER (SPECIFY)			9

10	DOES THIS FACILITY OPERATE AS OTHER THAN AN RHC OR FQHC? ENTER 'Y' FOR YES OR 'N' FOR NO IN COLUMN 1. IF YES, INDICATE THE NUMBER OF OTHER OPERATIONS IN COLUMN 2.	1 N	2 10
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FACILITY HOURS OF OPERATIONS(1)

	TYPE OPERATION	SUNDAY		MONDAY		TUESDAY		WEDNESDAY		THURSDAY		FRIDAY		SATURDAY		
		FROM	TO	FROM	TO	FROM	TO	FROM	TO	FROM	TO	FROM	TO	FROM	TO	
11	CLINIC	1	2	3	4	5	6	7	8	9	10	11	12	13	14	11

(1) ENTER CLINIC HOURS OF OPERATION ON LINE 11 AND OTHER TYPE OPERATIONS ON SUBSCRIPTS OF LINE 11 (both type and hours of operation). LIST HOURS OF OPERATION BASED ON A 24 HOUR CLOCK. FOR EXAMPLE: 8:00AM IS 0800, 6:30PM IS 1830, AND MIDNIGHT IS 2400.

12	HAVE YOU RECEIVED AN APPROVAL FOR AN EXCEPTION TO THE PRODUCTIVITY STANDARD?	1 N	2 12
13	IS THIS A CONSOLIDATED COST REPORT AS DEFINED IN CMS PUB. 27, SECTION 508(D)?	N	13
14	PROVIDER NAME: _____ CCN NUMBER: _____		14

		Y/N	V	XVIII	XIX	TOTAL VISITS
		1	2	3	4	5
15	HAVE YOU PROVIDED ALL OR SUBSTANTIALLY ALL GME COST? ENTER 'Y' FOR YES OR 'N' FOR NO IN COLUMN 1. IF YES, ENTER IN COLUMNS 2, 3, AND 4 THE NUMBER OF PROGRAM VISITS PERFORMED IN COLUMN 1. IF YES, ENTER IN 2, 3, AND 4 THE NUMBER OF PROGRAM VISITS PERFORMED BY INTERNS AND RESIDENTS FOR TITLES V, XVIII, AND XIX, AS APPLICABLE. (see instructions)	N				15

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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)	0.323694	1
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MEDICAID (see instructions for each line)

2	NET REVENUE FROM MEDICAID	5,009,985	2
3	DID YOU RECEIVE DSH OR SUPPLEMENTAL PAYMENTS FROM MEDICAID?	Y	3
4	IF LINE 3 IS YES, DOES LINE 2 INCLUDE ALL DSH OR SUPPLEMENTAL PAYMENTS FROM MEDICAID?	Y	4
5	IF LINE 4 IS NO, ENTER DSH OR SUPPLEMENTAL PAYMENTS FROM MEDICAID		5
6	MEDICAID CHARGES	25,446,882	6
7	MEDICAID COST (line 1 times line 6)	8,237,003	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.	3,227,018	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

UNCOMPENSATED AND INDIGENT CARE COST COMPUTATION

17	PRIVATE GRANTS, DONATIONS, OR ENDOWMENT INCOME RESTRICTED TO FUNDING CHARITY CARE		17
18	GOVERNMENT GRANTS, APPROPRIATIONS OF TRANSFERS FOR SUPPORT OF HOSPITAL OPERATIONS		18
19	TOTAL UNREIMBURSED COST FOR MEDICAID, SCHIP AND STATE AND LOCAL INDIGENT CARE PROGRAMS (sum of lines 8, 12 and 16)	3,227,018	19

		UNINSURED PATIENTS	INSURED PATIENTS	TOTAL (col. 1 + col. 2)	
		1	2	3	
20	TOTAL INITIAL OBLIGATION OF PATIENTS APPROVED FOR CHARITY CARE (at full charges excluding non-reimbursable cost centers) FOR THE ENTIRE FACILITY	1,272,102	344,092	1,616,194	20
21	COST OF INITIAL OBLIGATION OF PATIENTS APPROVED FOR CHARITY CARE (line 1 times line 20)	411,772	111,381	523,153	21
22	PARTIAL PAYMENT BY PATIENTS APPROVED FOR CHARITY CARE	47,539		47,539	22
23	COST OF CHARITY CARE (line 21 minus line 22)	364,233	111,381	475,614	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, ENTER CHARGES FOR PATIENT DAYS BEYOND AN INDIGENT CARE PROGRAM'S LENGTH OF STAY LIMIT (see instructions)		25
26	TOTAL BAD DEBT EXPENSE FOR THE ENTIRE HOSPITAL COMPLEX (see instructions)	5,279,505	26
27	MEDICARE BAD DEBTS FOR THE ENTIRE HOSPITAL COMPLEX (see instructions)	509,219	27
28	NON-MEDICARE AND NON-REIMBURSABLE MEDICARE BAD DEBT EXPENSE (line 26 minus line 27)	4,770,286	28
29	COST OF NON-MEDICARE AND NON-REIMBURSABLE MEDICARE BAD DEBT EXPENSE (line 1 times line 28)	1,544,113	29
30	COST OF UNCOMPENSATED CARE (line 23, column 3 plus line 29)	2,019,727	30
31	TOTAL UNREIMBURSED AND UNCOMPENSATED CARE COST (line 19 plus line 30)	5,246,745	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		1,792,086	1,792,086	-947,376	844,710	-57,104	787,606	1
2	00200	CAP REL COSTS-MVBLE EQUIP				974,205	974,205		974,205	2
3	00300	OTHER CAP REL COSTS							-0-	3
4	00400	EMPLOYEE BENEFITS DEPARTMENT		6,692,760	6,692,760		6,692,760	-1,272,946	5,419,814	4
5	00500	ADMINISTRATIVE & GENERAL	3,173,716	5,008,352	8,182,068	-100,830	8,081,238	-2,411,937	5,666,301	5
6	00600	MAINTENANCE & REPAIRS								6
7	00700	OPERATION OF PLANT	491,023	597,921	1,088,944		1,088,944	-73,591	1,015,353	7
8	00800	LAUNDRY & LINEN SERVICE	37,297	101,966	139,263		139,263		139,263	8
9	00900	HOUSEKEEPING	492,034	109,674	601,708		601,708	-29,145	572,563	9
10	01000	DIETARY	498,885	349,574	848,459		848,459	-152,452	696,007	10
11	01100	CAFETERIA								11
12	01200	MAINTENANCE OF PERSONNEL								12
13	01300	NURSING ADMINISTRATION	92,929	-22,891	70,038		70,038	-8,092	61,946	13
14	01400	CENTRAL SERVICES & SUPPLY	192,390	130,996	323,386		323,386		323,386	14
15	01500	PHARMACY	549,432	18,955	568,387		568,387	-36,625	531,762	15
16	01600	MEDICAL RECORDS & LIBRARY	419,031	229,300	648,331		648,331	-73	648,258	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 SERV COST CENTERS										
30	03000	ADULTS & PEDIATRICS	2,549,060	1,459,406	4,008,466		4,008,466	-1,163,439	2,845,027	30
40	04000	SUBPROVIDER - IPF	2,513,868	359,395	2,873,263		2,873,263	-218,127	2,655,136	40
ANCILLARY SERVICE COST CENTERS										
50	05000	OPERATING ROOM	485,019	171,955	656,974	-91,228	565,746	138	565,884	50
53	05300	ANESTHESIOLOGY	689,251	35,041	724,292		724,292	-689,251	35,041	53
54	05400	RADIOLOGY-DIAGNOSTIC	398,621	170,444	569,065	108,421	677,486		677,486	54
57	05700	CT SCAN	179,098	134,480	313,578		313,578	26	313,604	57
60	06000	LABORATORY	646,128	1,233,610	1,879,738	54,133	1,933,871	-1,600	1,932,271	60
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS								62.30
64	06400	INTRAVENOUS THERAPY	28,629	49,671	78,300		78,300		78,300	64
65	06500	RESPIRATORY THERAPY	458,929	88,750	547,679		547,679	-9,000	538,679	65
66	06600	PHYSICAL THERAPY	621,883	25,938	645,821		645,821	272	646,093	66
69	06900	ELECTROCARDIOLOGY	55,189	81,882	137,071		137,071	-53,814	83,257	69
71	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS		619,954	619,954		619,954		619,954	71
72	07200	IMPL. DEV. CHARGED TO PATIENTS				91,228	91,228		91,228	72
73	07300	DRUGS CHARGED TO PATIENTS		1,783,878	1,783,878		1,783,878		1,783,878	73
75	07500	ASC (NON-DISTINCT PART)	447,886	121,586	569,472		569,472	184	569,656	75
76	03450	NUCLEAR MEDICINE	125,632	187,219	312,851		312,851		312,851	76
76.01	03631	ULTRASOUND	194,117	30,137	224,254		224,254		224,254	76.01
76.02	03441	MAMMOGRAPHY	59,151	60,838	119,989		119,989		119,989	76.02
76.03	03141	CARDIAC REHABILITATION	76,781	21,230	98,011		98,011	-18,231	79,780	76.03
76.04	03190	FAITH CENTER CHEMOTHERAPY	106,169	6,670	112,839		112,839		112,839	76.04
76.06	03950	ROUTINE ANCILLARY								76.06
76.97	07697	CARDIAC REHABILITATION								76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY								76.98
76.99	07699	LITHOTRIPSY								76.99
OUTPATIENT SERVICE COST CENTERS										
88	08800	RURAL HEALTH CLINIC	1,597,669	244,348	1,842,017	-4,916	1,837,101	-38,099	1,799,002	88
88.01	08801	RHC II	179,813	43,698	223,511	-7,306	216,205		216,205	88.01
91	09100	EMERGENCY	2,284,199	564,131	2,848,330		2,848,330	-1,669,929	1,178,401	91
92	09200	OBSERVATION BEDS (NON-DISTINCT PART)								92
93	04950	DAY PSYCHIATRIC	170,974	59,732	230,706		230,706		230,706	93
OTHER REIMBURSABLE COST CENTERS										
99.10	09910	CORF								99.10
99.20	09920	OUTPATIENT PHYSICAL THERAPY								99.20
99.30	09930	OUTPATIENT OCCUPATIONAL THERAPY								99.30
99.40	09940	OUTPATIENT SPEECH PATHOLOGY								99.40
101	10100	HOME HEALTH AGENCY	501,769	68,871	570,640	-40,439	530,201		530,201	101
SPECIAL PURPOSE COST CENTERS										
118		SUBTOTALS (sum of lines 1-117)	20,316,572	22,629,357	42,946,129	35,892	42,982,021	-7,905,835	35,076,186	118
NONREIMBURSABLE COST CENTERS										
190	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	70,360	125,558	195,918		195,918		195,918	190
192	19200	PHYSICIANS' PRIVATE OFFICES	282,081	41,949	324,030	-47,268	276,762		276,762	192
192.01	19201	DIALYSIS								192.01
192.03	19202	ORTHO CLINIC				11,376	11,376		11,376	192.03
200		TOTAL (sum of lines 118-199)	20,669,013	22,797,064	43,466,077		43,466,077	-7,905,835	35,560,242	200

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RECLASSIFICATIONS

WORKSHEET A-6

	EXPLANATION OF RECLASSIFICATION(S)	CODE (1)	INCREASES				
			COST CENTER	LINE #	SALARY	OTHER	
		1	2	3	4	5	
1	DEPRECIATION	A	CAP REL COSTS-MVBLE EQUIP	2		915,836	1
2			HOME HEALTH AGENCY	101		7,275	2
3			RURAL HEALTH CLINIC	88		110,411	3
4			ADMINISTRATIVE & GENERAL	5		698	4
5			ORTHO CLINIC	192.03		11,376	5
6			PHYSICIANS' PRIVATE OFFICES	192		4,896	6
500	TOTAL RECLASSIFICATIONS					1,050,492	500
	CODE LETTER - A						
1	IMPLANTABLE SUPPLIES	B	IMPL. DEV. CHARGED TO PATIENT	72		91,228	1
500	TOTAL RECLASSIFICATIONS					91,228	500
	CODE LETTER - B						
1	HHA BILLER	C	ADMINISTRATIVE & GENERAL	5		47,714	1
500	TOTAL RECLASSIFICATIONS					47,714	500
	CODE LETTER - C						
1	INSURANCE	D	CAP REL COSTS-BLDG & FIXT	1		103,116	1
2			CAP REL COSTS-MVBLE EQUIP	2		58,369	2
500	TOTAL RECLASSIFICATIONS					161,485	500
	CODE LETTER - D						
1	EPC BILLING & ADMITTING	E	ADMINISTRATIVE & GENERAL	5		2,484	1
500	TOTAL RECLASSIFICATIONS					2,484	500
	CODE LETTER - E						
1	RHC LAB	F	LABORATORY	60		51,984	1
2							2
3							3
500	TOTAL RECLASSIFICATIONS					51,984	500
	CODE LETTER - F						
1	RADIOLOGY	G	RADIOLOGY-DIAGNOSTIC	54		102,664	1
2							2
500	TOTAL RECLASSIFICATIONS					102,664	500
	CODE LETTER - G						
1	EPC APARTMENT	H	ADMINISTRATIVE & GENERAL	5		9,759	1
500	TOTAL RECLASSIFICATIONS					9,759	500
	CODE LETTER - H						
1	RCH/EPC BUILDING EXPENSE	I	LABORATORY	60		2,149	1
2			RADIOLOGY-DIAGNOSTIC	54		5,757	2
500	TOTAL RECLASSIFICATIONS					7,906	500
	CODE LETTER - I						
	GRAND TOTAL (INCREASES)					204,846	1,320,870

(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

		DECREASES						
	EXPLANATION OF RECLASSIFICATION(S)	CODE (1)	COST CENTER	LINE #	SALARY	OTHER	WKST A-7 REF.	
		1	6	7	8	9	10	
1	DEPRECIATION	A	CAP REL COSTS-BLDG & FIXT	1		915,836	9 1	
2			CAP REL COSTS-BLDG & FIXT	1		7,275	9 2	
3			CAP REL COSTS-BLDG & FIXT	1		698	9 3	
4			CAP REL COSTS-BLDG & FIXT	1		110,411	9 4	
5			CAP REL COSTS-BLDG & FIXT	1		11,376	9 5	
6			CAP REL COSTS-BLDG & FIXT	1		4,896	9 6	
500	TOTAL RECLASSIFICATIONS CODE LETTER - A					1,050,492	500	
1	IMPLANTABLE SUPPLIES	B	OPERATING ROOM	50		91,228	1	
500	TOTAL RECLASSIFICATIONS CODE LETTER - B					91,228	500	
1	HHA BILLER	C	HOME HEALTH AGENCY	101	47,714		1	
500	TOTAL RECLASSIFICATIONS CODE LETTER - C				47,714		500	
1	INSURANCE	D	ADMINISTRATIVE & GENERAL	5		103,116	12 1	
2			ADMINISTRATIVE & GENERAL	5		58,369	12 2	
500	TOTAL RECLASSIFICATIONS CODE LETTER - D					161,485	500	
1	EPC BILLING & ADMITTING	E	RURAL HEALTH CLINIC	88	2,484		1	
500	TOTAL RECLASSIFICATIONS CODE LETTER - E				2,484		500	
1	RHC LAB	F	PHYSICIANS' PRIVATE OFFICES	192	1,187		1	
2			RURAL HEALTH CLINIC	88	43,491		2	
3			RHC II	88.01	7,306		3	
500	TOTAL RECLASSIFICATIONS CODE LETTER - F				51,984		500	
1	RADIOLOGY	G	RURAL HEALTH CLINIC	88	51,687		1	
2			PHYSICIANS' PRIVATE OFFICES	192	50,977		2	
500	TOTAL RECLASSIFICATIONS CODE LETTER - G				102,664		500	
1	EPC APARTMENT	H	RURAL HEALTH CLINIC	88		9,759	1	
500	TOTAL RECLASSIFICATIONS CODE LETTER - H					9,759	500	
1	RCH/EPC BUILDING EXPENSE	I	RURAL HEALTH CLINIC	88		2,149	1	
2			RURAL HEALTH CLINIC	88		5,757	2	
500	TOTAL RECLASSIFICATIONS CODE LETTER - I					7,906	500	
GRAND TOTAL (DECREASES)					204,846	1,320,870		

(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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Micro System

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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	520,932				19,000	501,932	1
2	LAND IMPROVEMENTS	699,733	86,491		86,491	10,970	775,254	2
3	BUILDINGS AND FIXTURES	20,675,813	4,571,875		4,571,875	1,455,679	23,792,009	3
4	BUILDING IMPROVEMENTS							4
5	FIXED EQUIPMENT							5
6	MOVABLE EQUIPMENT	11,250,649	1,050,250		1,050,250	587,097	11,713,802	6
7	HIT DESIGNATED ASSETS	643,652	311,111		311,111		954,763	7
8	SUBTOTAL (sum of lines 1-7)	33,790,779	6,019,727		6,019,727	2,072,746	37,737,760	8
9	RECONCILING ITEMS							9
10	TOTAL (line 7 minus line 9)	33,790,779	6,019,727		6,019,727	2,072,746	37,737,760	10

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

	DESCRIPTION	DEPRECIATION	LEASE	INTEREST	INSURANCE (see instr.)	TAXES (see instr.)	OTHER CAPITAL-RELATED COSTS (see instr.)	TOTAL(1)
								(Sum of cols. 9 through 14)
*		9	10	11	12	13	14	15
1	CAP REL COSTS-BLDG & FIXT	1,553,746		238,340				1,792,086
2	CAP REL COSTS-MVBLE EQUIP							
3	TOTAL (sum of lines 1-2)	1,553,746		238,340				1,792,086

(1) The amount in columns 9 through 14 must equal the amount on Worksheet A, column 2, lines 1 and 2. Enter in each column the appropriate amounts including any directly assigned cost that may have been included in Worksheet A, column 2, lines 1 and 2.
* All line numbers are to be consistent with Worksheet A line numbers for capital cost centers.

PART III - RECONCILIATION OF CAPITAL COST CENTERS

	DESCRIPTION	COMPUTATION OF RATIOS				ALLOCATION OF OTHER CAPITAL			
		GROSS ASSETS	CAPITALIZED LEASES	GROSS ASSETS FOR RATIO (col. 1 - col. 2)	RATIO (see instr.)	INSURANCE	TAXES	OTHER CAPITAL-RELATED COSTS	TOTAL (sum of cols. 5 through 7)
*		9	10	11	12	13	14	15	16
1	CAP REL COSTS-BLDG & FI	25,069,195		25,069,195	0.664300				
2	CAP REL COSTS-MVBLE EQUIP	12,668,565		12,668,565	0.335700				
3	TOTAL (sum of lines 1-2)	37,737,760		37,737,760	1.000000				

	DESCRIPTION	DEPRECIATION	LEASE	INTEREST	INSURANCE (see instr.)	TAXES (see instr.)	OTHER CAPITAL-RELATED COSTS (see instr.)	TOTAL(2)
								(sum of cols. 9 through 14)
*		9	10	11	12	13	14	15
1	CAP REL COSTS-BLDG & FIXT	503,254		181,236	103,116			787,606
2	CAP REL COSTS-MVBLE EQUIP	915,836			58,369			974,205
3	TOTAL (sum of lines 1-2)	1,419,090		181,236	161,485			1,761,811

(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. 5
				COST CENTER	LINE#		
		1	2	3	4		
1	INVESTMENT INCOME-BUILDINGS & FIXTURES (chapter 2)	B	-57,104	CAP REL COSTS-BLDG & FIXT	1	11	1
2	INVESTMENT INCOME-MOVABLE EQUIPMENT (chapter 2)			CAP REL COSTS-MVBLE EQUIP	2		2
3	INVESTMENT INCOME-OTHER (chapter 2)						3
4	TRADE, QUANTITY, AND TIME DISCOUNTS (chapter 8)	B	-4,276	ADMINISTRATIVE & GENERAL	5		4
5	REFUNDS AND REBATES OF EXPENSES (chapter 8)						5
6	RENTAL OF PROVIDER SPACE BY SUPPLIERS (chapter 8)						6
7	TELEPHONE SERVICES (PAY STATIONS EXCL) (chapter 21)						7
8	TELEVISION AND RADIO SERVICE (chapter 21)						8
9	PARKING LOT (chapter 21)						9
10	PROVIDER-BASED PHYSICIAN ADJUSTMENT	WKST A-8-2	-3,117,129				10
11	SALE OF SCRAP, WASTE, ETC. (chapter 23)						11
12	RELATED ORGANIZATION TRANSACTIONS (chapter 10)	WKST A-8-1					12
13	LAUNDRY AND LINEN SERVICE						13
14	CAFETERIA - EMPLOYEES AND GUESTS	B	-91,734	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	-73	MEDICAL RECORDS & LIBRARY	16		18
19	NURSING SCHOOL (TUITION, FEES, BOOKS, ETC.)						19
20	VENDING MACHINES	B	-3,530	ADMINISTRATIVE & GENERAL	5		20
21	INCOME FROM IMPOSITION OF INTEREST, FINANCE OR PENALTY CHARGES (chapter 21)						21
22	INTEREST EXP ON MEDICARE OVERPAYMENTS & BORROWINGS TO REPAY MEDICARE OVERPAYMENTS						22
23	ADJ FOR RESPIRATORY THERAPY COSTS IN EXCESS OF LIMITATION (chapter 14)	WKST A-8-3		RESPIRATORY THERAPY	65		23
24	ADJ FOR PHYSICAL THERAPY COSTS IN EXCESS OF LIMITATION (chapter 14)	WKST A-8-3		PHYSICAL THERAPY	66		24
25	UTIL REVIEW-PHYSICIANS' COMPENSATION (chapter 21)			UTILIZATION REVIEW-SNF	114		25
26	DEPRECIATION-BUILDINGS & FIXTURES			CAP REL COSTS-BLDG & FIXT	1		26
27	DEPRECIATION-MOVABLE EQUIPMENT			CAP REL COSTS-MVBLE EQUIP	2		27
28	NON-PHYSICIAN ANESTHETIST			NONPHYSICIAN ANESTHETISTS	19		28
29	PHYSICIANS' ASSISTANT						29
30	ADJ FOR OCCUPATIONAL THERAPY COSTS IN EXCESS OF LIMITATION (chapter 14)	WKST A-8-3		OCCUPATIONAL THERAPY	67		30
31	ADJ FOR SPEECH PATHOLOGY COSTS IN EXCESS OF LIMITATION (chapter 14)	WKST A-8-3		SPEECH PATHOLOGY	68		31
32	CAH HIT ADJ FOR DEPRECIATION AND						32
33							33
34	PHYSICIAN RECRUITMENT	A	-232,384	ADMINISTRATIVE & GENERAL	5		34
34.01	PHYSICIAN LOANS	A	-12,462	ADMINISTRATIVE & GENERAL	5		34.01
35	CRNA WAGES	A	-689,251	ANESTHESIOLOGY	53		35
35.01	CRNA BENEFITS	A	-223,435	EMPLOYEE BENEFITS DEPARTMENT	4		35.01
36	PHYSICIAN BENEFITS	A	-426,257	EMPLOYEE BENEFITS DEPARTMENT	4		36
37	PSYCH SALARY REIMBURSEMENT	B	-20,800	RURAL HEALTH CLINIC	88		37
38	ER PHYSICIAN MISC. EXPENSE	A	-15,097	EMERGENCY	91		38
39							39
40							40
41							41
42	OTHER INCOME	B	-268,988	ADMINISTRATIVE & GENERAL	5		42
43	MEDICAID ASSESSMENT	A	-1,550,781	ADMINISTRATIVE & GENERAL	5		43
44	MISSIONS EXPENSE	A	-1,054	ADMINISTRATIVE & GENERAL	5		44
45							45
45.02	CAPITALIZED INTEREST	A	62	OPERATION OF PLANT	7		45.02
45.03	CAPITALIZED INTEREST	A	272	PHYSICAL THERAPY	66		45.03
45.04	CAPITALIZED INTEREST	A	184	ASC (NON-DISTINCT PART)	75		45.04
45.05	CAPITALIZED INTEREST	A	161	EMERGENCY	91		45.05
45.06	CAPITALIZED INTEREST	A	26	CT SCAN	57		45.06
45.07	CAPITALIZED INTEREST	A	138	OPERATING ROOM	50		45.07
45.20	PHYSICIAN BILLING WAGES	A	-10,468	ADMINISTRATIVE & GENERAL	5		45.20
45.21	PHYSICIAN BILLING FRINGE BENEFIT	A	-3,394	EMPLOYEE BENEFITS DEPARTMENT	4		45.21
45.22	DONATED MEALS	A	-60,718	DIETARY	10		45.22
45.24	COMM RELATIONS	A	-19,709	ADMINISTRATIVE & GENERAL	5		45.24
45.25	ALCOHOL	A	-422	ADMINISTRATIVE & GENERAL	5		45.25
45.26	IHA LOBBYING	A	-18,049	ADMINISTRATIVE & GENERAL	5		45.26
45.27	AHA LOBBYING	A	-4,114	ADMINISTRATIVE & GENERAL	5		45.27
45.28	ADVERTISING	A	-91,571	ADMINISTRATIVE & GENERAL	5		45.28
45.32	MISC INCOME	A	-2,075	RESPIRATORY THERAPY	65		45.32
45.34	DUE - ROTARY CLUB	A	-220	EMPLOYEE BENEFITS DEPARTMENT	4		45.34

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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
45.35	OTHER ADMIN DUES	A	-2,530	ADMINISTRATIVE & GENERAL	5	45.35
45.38	INSURANCE SETTLEMENTS	A	-126,638	ADMINISTRATIVE & GENERAL	5	45.38
45.39	IHREF CONTRIBUTION EXPENSE	A	-16,068	ADMINISTRATIVE & GENERAL	5	45.39
45.40	LLC OVERHEAD FRINGE BENEFIT	A	-619,620	EMPLOYEE BENEFITS DEPARTMENT	4	45.40
45.41	LLC OVERHEAD A&G	A	-51,893	ADMINISTRATIVE & GENERAL	5	45.41
45.42	LLC OVERHEAD PLANT	A	-73,653	OPERATION OF PLANT	7	45.42
45.43	LLC OVERHEAD HOUSEKEEPING	A	-29,145	HOUSEKEEPING	9	45.43
45.44	LLC OVERHEAD NURSING ADMIN	A	-8,092	NURSING ADMINISTRATION	13	45.44
45.46	LLC OVERHEAD PHARMACY	A	-36,625	PHARMACY	15	45.46
45.47	LLC OVERHEAD RHC 1	A	-17,299	RURAL HEALTH CLINIC	88	45.47
46						46
47						47
48						48
49						49
50	TOTAL (sum of lines 1 thru 49) (Transfer to worksheet A, column 6, line 200)		-7,905,835			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.

Optimizer Systems, Inc.

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

WORKSHEET A-8-1

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

LINE NO.	COST CENTER	EXPENSE ITEMS	AMOUNT OF ALLOWABLE COST	AMOUNT INCLUDED IN WKST. A COLUMN 5	NET ADJUSTMENTS (col. 4 minus col. 5)*	WKST. A-7 REF.	
1	2	3	4	5	6	7	
1						1	
2						2	
3						3	
4						4	
5	TOTALS (SUM OF LINES 1-4) TRANSFER COLUMN 6, LINE 5 TO WORKSHEET A-8, COLUMN 2, LINE 12						5

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

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

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

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

	SYMBOL (1)	NAME	PERCENTAGE OF OWNERSHIP	RELATED ORGANIZATION(S) AND/OR HOME OFFICE		
				NAME	PERCENTAGE OF OWNERSHIP	TYPE OF BUSINESS
	1	2	3	4	5	6
6						6
7						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	PROFESS- IONAL COMPON- ENT	PROVIDER COMPON- ENT	RCE AMOUNT	PHYSICIAN/ PROVIDER COMPON- ENT HOURS	UNADJ- USTED RCE LIMIT	5 PERCENT OF UNADJ- USTED RCE LIMIT	
	1	2	3	4	5	6	7	8	9	
1	40	SUBPROVIDER - IPF MEDICAL FEES	265,538		265,538	138,700	711	47,411	2,371	1
2	40	SUBPROVIDER - IPF SALARIED-DR				138,700				2
3	91	EMERGENCY SALARIED-DR	1,354,795	1,314,795	40,000	159,800	290	22,280	1,114	3
4	60	LABORATORY MEDICAL FEES	9,600		9,600	208,000	80	8,000	400	4
5	69	ELECTROCARDIOLOGY MEDICAL FEES	53,814	53,814						5
6	76.03	CARDIAC REHABILITATI MEDICAL FEES DI	18,231	18,231						6
7	91	EMERGENCY MEDICAL FEES #4	322,478	322,478						7
8	30	ADULTS & PEDIATRICS HOSPITALISTS ME	1,079,853	1,079,853						8
9	30	ADULTS & PEDIATRICS HOSPITALISTS PU	78,000	78,000						9
10	65	RESPIRATORY THERAPY RESP THER MEDIC	6,925	6,925						10
11	30	ADULTS & PEDIATRICS HOSPITALISTS -	12,500		12,500	159,800	90	6,914	346	11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
200		TOTAL	3,201,734	2,874,096	327,638		1,171	84,605	4,231	200

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PROVIDER-BASED PHYSICIANS ADJUSTMENTS

WORKSHEET A-8-2

	WKST A LINE #	COST CENTER/ PHYSICIAN IDENTIFIER	COST OF MEMBER- SHIPS & CONTIN- UING EDUCATION	PROVIDER COMPON- ENT SHARE OF COL. 12	PHYSICIAN COST OF MALPRACT- ICE INSURANCE	PROVIDER COMPON- ENT SHARE OF COL. 14	ADJUSTED RCE LIMIT	RCE DISALLOW- ANCE	ADJUST- MENT	
	10	11	12	13	14	15	16	17	18	
1	40	SUBPROVIDER - IPF MEDICAL FEES					47,411	218,127	218,127	1
2	40	SUBPROVIDER - IPF SALARIED-DR								2
3	91	EMERGENCY SALARIED-DR					22,280	17,720	1,332,515	3
4	60	LABORATORY MEDICAL FEES					8,000	1,600	1,600	4
5	69	ELECTROCARDIOLOGY MEDICAL FEES							53,814	5
6	76.03	CARDIAC REHABILITATI MEDICAL FEES DI							18,231	6
7	91	EMERGENCY MEDICAL FEES #4							322,478	7
8	30	ADULTS & PEDIATRICS HOSPITALISTS ME							1,079,853	8
9	30	ADULTS & PEDIATRICS HOSPITALISTS PU							78,000	9
10	65	RESPIRATORY THERAPY RESP THER MEDIC							6,925	10
11	30	ADULTS & PEDIATRICS HOSPITALISTS -					6,914	5,586	5,586	11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
200		TOTAL					84,605	243,033	3,117,129	200

Optimizer Systems, Inc.

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Micro System

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COST ALLOCATION - GENERAL SERVICE COSTS

WORKSHEET B
PART I

	COST CENTER DESCRIPTIONS	NET EXP FOR COST ALLOCATION (from Wkst A, col.7)	CAP BLDGS & FIXTURES	CAP MOVABLE EQUIPMENT	EMPLOYEE BENEFITS DEPARTMENT	SUBTOTAL (cols.0-4)	ADMINISTRATIVE & GENERAL	
		0	1	2	4	4A	5	
	GENERAL SERVICE COST CENTERS							
1	CAP REL COSTS-BLDG & FLXT	787,606	787,606					1
2	CAP REL COSTS-MVBLE EQUIP	974,205		974,205				2
4	EMPLOYEE BENEFITS DEPARTMENT	5,419,814	6,096	9,913	5,435,823			4
5	ADMINISTRATIVE & GENERAL	5,666,301	121,375	451,396	847,368	7,086,940	7,086,940	5
6	MAINTENANCE & REPAIRS							6
7	OPERATION OF PLANT	1,015,353	31,040	13,460	129,136	1,188,989	295,937	7
8	LAUNDRY & LINEN SERVICE	139,263	15,160	6,397	9,809	170,629	42,469	8
9	HOUSEKEEPING	572,563	3,881	1,812	129,402	707,658	176,135	9
10	DIETARY	696,007	17,638	8,073	131,204	852,922	212,291	10
11	CAFETERIA		10,103			10,103	2,515	11
12	MAINTENANCE OF PERSONNEL							12
13	NURSING ADMINISTRATION	61,946		6,233	24,440	92,619	23,053	13
14	CENTRAL SERVICES & SUPPLY	323,386	6,792	10,141	50,597	390,916	97,298	14
15	PHARMACY	531,762	13,300	24,758	144,497	714,317	177,792	15
16	MEDICAL RECORDS & LIBRARY	648,258	9,281	35,413	110,203	803,155	199,904	16
17	SOCIAL SERVICE							17
19	NONPHYSICIAN ANESTHETISTS							19
20	NURSING SCHOOL							20
21	I&R SERVICES-SALARY & FRINGES APRVD							21
22	I&R SERVICES-OTHER PRGM COSTS APRVD							22
23	PARAMED ED PRGM-(SPECIFY)							23
	INPATIENT ROUTINE SERV COST CENTERS							
30	ADULTS & PEDIATRICS	2,345,027	109,193	60,302	670,387	3,684,909	917,155	30
40	SUBPROVIDER - IPF	2,653,136	107,218	9,510	661,132	3,432,996	854,466	40
	ANCILLARY SERVICE COST CENTERS							
50	OPERATING ROOM	565,884	70,904	52,611	127,557	816,956	203,339	50
53	ANESTHESIOLOGY	35,041		7,739	181,269	224,049	55,765	53
54	RADIOLOGY-DIAGNOSTIC	677,486	45,435	65,577	131,835	920,333	229,069	54
57	CT SCAN	313,604	5,183	1,268	47,102	367,157	91,385	57
60	LABORATORY	1,932,271	26,542	38,077	183,599	2,180,489	542,719	60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
64	INTRAVENOUS THERAPY	78,300			7,529	85,829	21,363	64
65	RESPIRATORY THERAPY	538,679	10,571	18,343	120,696	688,289	171,314	65
66	PHYSICAL THERAPY	646,093	53,746	12,956	163,551	876,346	218,121	66
69	ELECTROCARDIOLOGY	83,257		6,008	14,514	103,779	25,830	69
71	MEDICAL SUPPLIES CHARGED TO PATIENTS	619,954				619,954	154,305	71
72	IMPL. DEV. CHARGED TO PATIENTS	91,228				91,228	22,706	72
73	DRUGS CHARGED TO PATIENTS	1,783,878				1,783,878	444,004	73
75	ASC (NON-DISTINCT PART)	569,656	47,330	9,791	117,791	744,568	185,321	75
76	NUCLEAR MEDICINE	312,851		58,044	33,040	403,935	100,539	76
76.01	ULTRASOUND	224,254	5,742	17,097	51,052	298,145	74,208	76.01
76.02	MAMMOGRAPHY	119,989	3,459	2,555	15,556	141,559	35,234	76.02
76.03	CARDIAC REHABILITATION	79,780		7,728	20,193	107,701	26,807	76.03
76.04	FAITH CENTER CHEMOTHERAPY	112,839	10,651	1,451	27,922	152,863	38,047	76.04
76.06	ROUTINE ANCILLARY							76.06
76.97	CARDIAC REHABILITATION							76.97
76.98	HYPERBARIC OXYGEN THERAPY							76.98
76.99	LITHOTRIPSY							76.99
	OUTPATIENT SERVICE COST CENTERS							
88	RURAL HEALTH CLINIC	1,799,002			394,493	2,193,495	545,957	88
88.01	RHC II	216,205			45,368	261,573	65,105	88.01
91	EMERGENCY	1,178,401	22,193	36,683	600,731	1,838,008	457,477	91
92	OBSERVATION BEDS (NON-DISTINCT PART)							92
93	DAY PSYCHIATRIC	230,706	27,398	869	44,965	303,938	75,650	93
	OTHER REIMBURSABLE COST CENTERS							
99.10	CORF							99.10
99.20	OUTPATIENT PHYSICAL THERAPY							99.20
99.30	OUTPATIENT OCCUPATIONAL THERAPY							99.30
99.40	OUTPATIENT SPEECH PATHOLOGY							99.40
101	HOME HEALTH AGENCY	530,201			119,414	649,615	161,688	101
	SPECIAL PURPOSE COST CENTERS							
118	SUBTOTALS (sum of lines 1-117)	35,076,186	780,231	974,205	5,356,852	34,989,840	6,944,968	118
	NONREIMBURSABLE COST CENTERS							
190	GIFT, FLOWER, COFFEE SHOP & CANTEEN	195,918	7,375		18,504	221,797	55,205	190
192	PHYSICIANS' PRIVATE OFFICES	276,762			60,467	337,229	83,936	192
192.01	DIALYSIS							192.01
192.03	ORTHO CLINIC	11,376				11,376	2,831	192.03
200	CROSS FOOT ADJUSTMENTS							200
201	NEGATIVE COST CENTER							201
202	TOTAL (sum of lines 118-201)	35,560,242	787,606	974,205	5,435,823	35,560,242	7,086,940	202

Optimizer Systems, Inc.

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Micro System

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COST ALLOCATION - GENERAL SERVICE COSTS

WORKSHEET B
PART I

	COST CENTER DESCRIPTIONS	OPERATION	LAUNDRY	HOUSE-	DIETARY	CAFETERIA	NURSING	
		OF PLANT	& LINEN	KEEPING			ADMINIS-	
		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	1,484,926						7
8	LAUNDRY & LINEN SERVICE	35,785	248,883					8
9	HOUSEKEEPING	9,162		892,955				9
10	DIETARY	41,632			1,106,845			10
11	CAFETERIA	23,847			512,351	548,816		11
12	MAINTENANCE OF PERSONNEL							12
13	NURSING ADMINISTRATION					4,368	120,040	13
14	CENTRAL SERVICES & SUPPLY	16,033				5,332		14
15	PHARMACY	31,392		9,136		13,075		15
16	MEDICAL RECORDS & LIBRARY	21,907				26,859		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	257,741	77,615	258,778	256,342	112,216	30,430	30
40	SUBPROVIDER - IPF	253,079	23,277	115,818	328,423	123,854	33,588	40
	ANCILLARY SERVICE COST CENTERS							
50	OPERATING ROOM	167,363	20,085	94,052		38,058	10,320	50
53	ANESTHESIOLOGY					6,340		53
54	RADIOLOGY-DIAGNOSTIC	107,246	11,444			17,705		54
57	CT SCAN	12,234				7,779		57
60	LABORATORY	62,650		17,467		32,938		60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
64	INTRAVENOUS THERAPY							64
65	RESPIRATORY THERAPY	24,952	11,950	16,929		23,258		65
66	PHYSICAL THERAPY	126,863	12,417	19,885		19,669		66
69	ELECTROCARDIOLOGY					2,827		69
71	MEDICAL SUPPLIES CHARGED TO PATIENTS							71
72	IMPL. DEV. CHARGED TO PATIENTS							72
73	DRUGS CHARGED TO PATIENTS							73
75	ASC (NON-DISTINCT PART)	111,719	38,224	95,664		34,640	9,393	75
76	NUCLEAR MEDICINE					3,901		76
76.01	ULTRASOUND	13,554				11,651		76.01
76.02	MAMMOGRAPHY	8,165				2,496		76.02
76.03	CARDIAC REHABILITATION					2,996	812	76.03
76.04	FAITH CENTER CHEMOTHERAPY	25,141				3,903	1,058	76.04
76.06	ROUTINE ANCILLARY							76.06
76.97	CARDIAC REHABILITATION							76.97
76.98	HYPERBARIC OXYGEN THERAPY							76.98
76.99	LITHOTRIPSY							76.99
	OUTPATIENT SERVICE COST CENTERS							
88	RURAL HEALTH CLINIC		15,336	128,985			14,518	88
88.01	RHC II							88.01
91	EMERGENCY	52,383	24,055	124,417		47,734	12,944	91
92	OBSERVATION BEDS (NON-DISTINCT PART)							92
93	DAY PSYCHIATRIC	64,671				7,217		93
	OTHER REIMBURSABLE COST CENTERS							
99.10	CORF							99.10
99.20	OUTPATIENT PHYSICAL THERAPY							99.20
99.30	OUTPATIENT OCCUPATIONAL THERAPY							99.30
99.40	OUTPATIENT SPEECH PATHOLOGY							99.40
101	HOME HEALTH AGENCY			11,824			6,977	101
	SPECIAL PURPOSE COST CENTERS							
118	SUBTOTALS (sum of lines 1-117)	1,467,519	234,403	892,955	1,097,116	548,816	120,040	118
	NONREIMBURSABLE COST CENTERS							
190	GIFT, FLOWER, COFFEE SHOP & CANTEEN	17,407						190
192	PHYSICIANS' PRIVATE OFFICES		14,480		9,729			192
192.01	DIALYSIS							192.01
192.03	ORTHO CLINIC							192.03
200	CROSS FOOT ADJUSTMENTS							200
201	NEGATIVE COST CENTER							201
202	TOTAL (sum of lines 118-201)	1,484,926	248,883	892,955	1,106,845	548,816	120,040	202

Optimizer Systems, Inc.

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COST ALLOCATION - GENERAL SERVICE COSTS

WORKSHEET B
PART I

	COST CENTER DESCRIPTIONS	CENTRAL SERVICES & SUPPLY 14	PHARMACY 15	MEDICAL RECORDS & LIBRARY 16	SUBTOTAL 24	I&R COST & POST STEP-DOWN ADJS 25	TOTAL 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	509,579						14
15	PHARMACY		945,712					15
16	MEDICAL RECORDS & LIBRARY			1,051,825				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	10,759		70,642	5,676,587		5,676,587	30
40	SUBPROVIDER - IPF	77		105,115	5,270,693		5,270,693	40
	ANCILLARY SERVICE COST CENTERS							
50	OPERATING ROOM	393,691		22,085	1,765,949		1,765,949	50
53	ANESTHESIOLOGY	995		19,755	306,904		306,904	53
54	RADIOLOGY-DIAGNOSTIC	26,870		40,337	1,353,004		1,353,004	54
57	CT SCAN			151,976	630,531		630,531	57
60	LABORATORY			173,285	3,009,548		3,009,548	60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
64	INTRAVENOUS THERAPY			64,470	171,662		171,662	64
65	RESPIRATORY THERAPY	69		31,037	967,798		967,798	65
66	PHYSICAL THERAPY	1,010		30,150	1,304,461		1,304,461	66
69	ELECTROCARDIOLOGY	13		15,556	148,005		148,005	69
71	MEDICAL SUPPLIES CHARGED TO PATIENTS			20,498	794,757		794,757	71
72	IMPL. DEV. CHARGED TO PATIENTS			2,589	116,523		116,523	72
73	DRUGS CHARGED TO PATIENTS		906,093	77,802	3,211,777		3,211,777	73
75	ASC (NON-DISTINCT PART)	32,141		37,667	1,289,337		1,289,337	75
76	NUCLEAR MEDICINE			21,557	529,932		529,932	76
76.01	ULTRASOUND			35,419	432,977		432,977	76.01
76.02	MAMMOGRAPHY	43		7,316	194,813		194,813	76.02
76.03	CARDIAC REHABILITATION			3,953	142,269		142,269	76.03
76.04	FAITH CENTER CHEMOTHERAPY	4,998		2,251	228,261		228,261	76.04
76.06	ROUTINE ANCILLARY							76.06
76.97	CARDIAC REHABILITATION							76.97
76.98	HYPERBARIC OXYGEN THERAPY							76.98
76.99	LITHOTRIPSY							76.99
	OUTPATIENT SERVICE COST CENTERS							
88	RURAL HEALTH CLINIC		31,306	24,094	2,953,691		2,953,691	88
88.01	RHC II			2,259	328,937		328,937	88.01
91	EMERGENCY	38,913		71,435	2,667,366		2,667,366	91
92	OBSERVATION BEDS (NON-DISTINCT PART)							92
93	DAY PSYCHIATRIC			11,066	462,542		462,542	93
	OTHER REIMBURSABLE COST CENTERS							
99.10	CORF							99.10
99.20	OUTPATIENT PHYSICAL THERAPY							99.20
99.30	OUTPATIENT OCCUPATIONAL THERAPY							99.30
99.40	OUTPATIENT SPEECH PATHOLOGY							99.40
101	HOME HEALTH AGENCY			9,511	839,615		839,615	101
	SPECIAL PURPOSE COST CENTERS							
118	SUBTOTALS (sum of lines 1-117)	509,579	937,399	1,051,825	34,797,939		34,797,939	118
	NONREIMBURSABLE COST CENTERS							
190	GIFT, FLOWER, COFFEE SHOP & CANTEEN				294,409		294,409	190
192	PHYSICIANS' PRIVATE OFFICES		8,313		453,687		453,687	192
192.01	DIALYSIS							192.01
192.03	ORTHO CLINIC				14,207		14,207	192.03
200	CROSS FOOT ADJUSTMENTS							200
201	NEGATIVE COST CENTER							201
202	TOTAL (sum of lines 118-201)	509,579	945,712	1,051,825	35,560,242		35,560,242	202

Optimizer Systems, Inc.

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Micro System

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ALLOCATION OF CAPITAL-RELATED COSTS

WORKSHEET B
PART II

	COST CENTER DESCRIPTIONS	DIR ASSGND CAP-REL COSTS 0	CAP BLDGS & FIXTURES 1	CAP MOVABLE EQUIPMENT 2	SUBTOTAL 2A	EMPLOYEE BENEFITS DEPARTMENT 4	ADMINIS- TRATIVE & GENERAL 5	
GENERAL SERVICE COST CENTERS								
1	CAP REL COSTS-BLDG & FIXT							1
2	CAP REL COSTS-MVBLE EQUIP							2
4	EMPLOYEE BENEFITS DEPARTMENT		6,096	9,913	16,009	16,009		4
5	ADMINISTRATIVE & GENERAL	3,585	121,375	451,396	576,356	2,487	578,843	5
6	MAINTENANCE & REPAIRS							6
7	OPERATION OF PLANT	2,775	31,940	13,460	47,275	381	24,171	7
8	LAUNDRY & LINEN SERVICE		15,160	6,397	21,557	29	3,469	8
9	HOUSEKEEPING		3,881	1,812	5,693	381	14,386	9
10	DIETARY		17,638	8,073	25,711	387	17,339	10
11	CAFETERIA		10,103		10,103		205	11
12	MAINTENANCE OF PERSONNEL							12
13	NURSING ADMINISTRATION			6,233	6,233	72	1,883	13
14	CENTRAL SERVICES & SUPPLY		6,792	10,141	16,933	149	7,947	14
15	PHARMACY		13,300	24,758	38,058	426	14,521	15
16	MEDICAL RECORDS & LIBRARY		9,281	35,413	44,694	325	16,327	16
17	SOCIAL SERVICE							17
19	NONPHYSICIAN ANESTHETISTS							19
20	NURSING SCHOOL							20
21	I&R SERVICES-SALARY & FRINGES APPRVD							21
22	I&R SERVICES-OTHER PRGM COSTS APPRVD							22
23	PARAMED ED PRGM-(SPECIFY)							23
INPATIENT ROUTINE SERV COST CENTERS								
30	ADULTS & PEDIATRICS		109,193	60,302	169,495	1,976	74,919	30
40	SUBPROVIDER - IPF		107,218	9,510	116,728	1,948	69,789	40
ANCILLARY SERVICE COST CENTERS								
50	OPERATING ROOM	74,136	70,904	52,611	197,651	376	16,608	50
53	ANESTHESIOLOGY	650		7,739	8,389	534	4,555	53
54	RADIOLOGY-DIAGNOSTIC		45,435	65,577	111,012	388	18,709	54
57	CT SCAN		5,183	1,268	6,451	139	7,464	57
60	LABORATORY		26,542	38,077	64,619	541	44,327	60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
64	INTRAVENOUS THERAPY					22	1,745	64
65	RESPIRATORY THERAPY	20,902	10,571	18,343	49,816	356	13,992	65
66	PHYSICAL THERAPY	3,627	53,746	12,956	70,329	482	17,815	66
69	ELECTROCARDIOLOGY	22,510		6,008	28,518	43	2,110	69
71	MEDICAL SUPPLIES CHARGED TO PATIENTS						1,855	71
72	IMPL. DEV. CHARGED TO PATIENTS							72
73	DRUGS CHARGED TO PATIENTS						36,264	73
75	ASC (NON-DISTINCT PART)		47,330	9,791	57,121	347	15,136	75
76	NUCLEAR MEDICINE			58,044	58,044	97	8,212	76
76.01	ULTRASOUND		5,742	17,097	22,839	150	6,061	76.01
76.02	MAMMOGRAPHY		3,459	2,555	6,014	46	2,878	76.02
76.03	CARDIAC REHABILITATION			7,728	7,728	60	2,189	76.03
76.04	FAITH CENTER CHEMOTHERAPY		10,651	1,451	12,102	82	3,108	76.04
76.06	ROUTINE ANCILLARY							76.06
76.07	CARDIAC REHABILITATION							76.07
76.98	HYPERBARIC OXYGEN THERAPY							76.98
76.99	LITHOTRIPSY							76.99
OUTPATIENT SERVICE COST CENTERS								
88	RURAL HEALTH CLINIC	2,004			2,004	1,163	44,592	88
88.01	RHC II					134	5,318	88.01
91	EMERGENCY		22,193	36,683	58,876	1,770	37,365	91
92	OBSERVATION BEDS (NON-DISTINCT PART)							92
95	DAY PSYCHIATRIC		27,398	869	28,267	133	6,179	95
OTHER REIMBURSABLE COST CENTERS								
99.10	CORF							99.10
99.20	OUTPATIENT PHYSICAL THERAPY							99.20
99.30	OUTPATIENT OCCUPATIONAL THERAPY							99.30
99.40	OUTPATIENT SPEECH PATHOLOGY							99.40
101	HOME HEALTH AGENCY					352	13,206	101
SPECIAL PURPOSE COST CENTERS								
118	SUBTOTALS (sum of lines 1-117)	130,189	780,231	974,205	1,884,625	15,776	567,247	118
NONREIMBURSABLE COST CENTERS								
190	GIFT, FLOWER, COFFEE SHOP & CANTEEN		7,375		7,375	55	4,509	190
192	PHYSICIANS' PRIVATE OFFICES	84			84	178	6,856	192
192.01	DIALYSIS							192.01
192.03	ORTHO CLINIC						231	192.03
200	CROSS FOOT ADJUSTMENTS							200
201	NEGATIVE COST CENTER							201
202	TOTAL (sum of lines 118-201)	130,273	787,606	974,205	1,892,084	16,009	578,843	202

Optimizer Systems, Inc.

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Micro System

HARRISBURG MEDICAL CENTER, INC. Provider CCN: 14-0210	In Lieu of Form CMS-2552-10	Period : From: 07/01/2013 To: 06/30/2014	Run Date: 11/11/2014 Run Time: 12:00 Version: 2014.10
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ALLOCATION OF CAPITAL-RELATED COSTS

WORKSHEET B
PART II

	COST CENTER DESCRIPTIONS	OPERATION	LAUNDRY	HOUSE-	DIETARY	CAFETERIA	NURSING	
		OF PLANT	& LINEN	KEEPING			ADMINIS-	
		7	8	9	10	11	TRATION	
			SERVICE				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	71,827						7
8	LAUNDRY & LINEN SERVICE	1,731	26,786					8
9	HOUSEKEEPING	443		20,903				9
10	DIETARY	2,014			45,451			10
11	CAFETERIA	1,154			21,039	32,501		11
12	MAINTENANCE OF PERSONNEL							12
13	NURSING ADMINISTRATION					259	8,447	13
14	CENTRAL SERVICES & SUPPLY	776				316		14
15	PHARMACY	1,518		214		774		15
16	MEDICAL RECORDS & LIBRARY	1,060				1,591		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	12,466	8,353	6,059	10,526	6,646	2,141	30
40	SUBPROVIDER - IPF	12,242	2,505	2,711	13,486	7,334	2,364	40
	ANCILLARY SERVICE COST CENTERS							
50	OPERATING ROOM	8,095	2,162	2,202		2,254	726	50
53	ANESTHESIOLOGY					375		53
54	RADIOLOGY-DIAGNOSTIC	5,188	1,232			1,049		54
57	CT SCAN	592				461		57
60	LABORATORY	3,030		409		1,951		60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
64	INTRAVENOUS THERAPY							64
65	RESPIRATORY THERAPY	1,207	1,286	396		1,377		65
66	PHYSICAL THERAPY	6,136	1,336	465		1,165		66
69	ELECTROCARDIOLOGY					167		69
71	MEDICAL SUPPLIES CHARGED TO PATIENTS							71
72	IMPL. DEV. CHARGED TO PATIENTS							72
73	DRUGS CHARGED TO PATIENTS							73
75	ASC (NON-DISTINCT PART)	5,404	4,114	2,239		2,051	661	75
76	NUCLEAR MEDICINE					231		76
76.01	ULTRASOUND	656				690		76.01
76.02	MAMMOGRAPHY	395				148		76.02
76.03	CARDIAC REHABILITATION					177	57	76.03
76.04	FAITH CENTER CHEMOTHERAPY	1,216				231	74	76.04
76.06	ROUTINE ANCILLARY							76.06
76.97	CARDIAC REHABILITATION							76.97
76.98	HYPERBARIC OXYGEN THERAPY							76.98
76.99	LITHOTRIPSY							76.99
	OUTPATIENT SERVICE COST CENTERS							
88	RURAL HEALTH CLINIC		1,651	3,019			1,022	88
88.01	RHC II							88.01
91	EMERGENCY	2,534	2,589	2,912		2,827	911	91
92	OBSERVATION BEDS (NON-DISTINCT PART)							92
93	DAY PSYCHIATRIC	3,128				427		93
	OTHER REIMBURSABLE COST CENTERS							
99.10	CORF							99.10
99.20	OUTPATIENT PHYSICAL THERAPY							99.20
99.30	OUTPATIENT OCCUPATIONAL THERAPY							99.30
99.40	OUTPATIENT SPEECH PATHOLOGY							99.40
101	HOME HEALTH AGENCY			277			491	101
	SPECIAL PURPOSE COST CENTERS							
118	SUBTOTALS (sum of lines 1-117)	70,985	25,228	20,903	45,051	32,501	8,447	118
	NONREIMBURSABLE COST CENTERS							
190	GIFT, FLOWER, COFFEE SHOP & CANTEEN	842						190
192	PHYSICIANS' PRIVATE OFFICES		1,558		400			192
192.01	DIALYSIS							192.01
192.03	ORTHO CLINIC							192.03
200	CROSS FOOT ADJUSTMENTS							200
201	NEGATIVE COST CENTER							201
202	TOTAL (sum of lines 118-201)	71,827	26,786	20,903	45,451	32,501	8,447	202

Optimizer Systems, Inc.

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Micro System

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ALLOCATION OF CAPITAL-RELATED COSTS

WORKSHEET B
PART II

	COST CENTER DESCRIPTIONS	CENTRAL SERVICES & SUPPLY 14	PHARMACY 15	MEDICAL RECORDS & LIBRARY 16	SUBTOTAL 24	I&R COST & POST STEP-DOWN ADJS 25	TOTAL 26	
	GENERAL SERVICE COST CENTERS							
1	CAP REL COSTS-BLDG & FLXT							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	26,121						14
15	PHARMACY		55,511					15
16	MEDICAL RECORDS & LIBRARY			63,997				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	552		4,296	297,429		297,429	30
40	SUBPROVIDER - IPF	4		6,392	235,503		235,503	40
	ANCILLARY SERVICE COST CENTERS							
50	OPERATING ROOM	20,179		1,343	251,596		251,596	50
53	ANESTHESIOLOGY	51		1,201	15,105		15,105	53
54	RADIOLOGY-DIAGNOSTIC	1,377		2,453	141,408		141,408	54
57	CT SCAN			9,242	24,349		24,349	57
60	LABORATORY			10,572	125,449		125,449	60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
64	INTRAVENOUS THERAPY			3,921	5,688		5,688	64
65	RESPIRATORY THERAPY	4		1,887	70,321		70,321	65
66	PHYSICAL THERAPY	52		1,834	99,614		99,614	66
69	ELECTROCARDIOLOGY	1		946	31,785		31,785	69
71	MEDICAL SUPPLIES CHARGED TO PATIENTS			1,247	13,850		13,850	71
72	IMPL DEV. CHARGED TO PATIENTS			157	2,012		2,012	72
73	DRUGS CHARGED TO PATIENTS		53,185	4,731	94,180		94,180	73
75	ASC (NON-DISTINCT PART)	1,648		2,291	91,012		91,012	75
76	NUCLEAR MEDICINE			1,311	67,895		67,895	76
76.01	ULTRASOUND			2,154	32,550		32,550	76.01
76.02	MAMMOGRAPHY	2		445	9,928		9,928	76.02
76.03	CARDIAC REHABILITATION			240	10,451		10,451	76.03
76.04	FAITH CENTER CHEMOTHERAPY	256		137	17,206		17,206	76.04
76.06	ROUTINE ANCILLARY							76.06
76.97	CARDIAC REHABILITATION							76.97
76.98	HYPERBARIC OXYGEN THERAPY							76.98
76.99	LITHOTRIPSY							76.99
	OUTPATIENT SERVICE COST CENTERS							
88	RURAL HEALTH CLINIC		1,838	1,465	56,754		56,754	88
88.01	RHC II			137	5,589		5,589	88.01
91	EMERGENCY	1,995		4,344	116,123		116,123	91
92	OBSERVATION BEDS (NON-DISTINCT PART)							92
93	DAY PSYCHIATRIC			673	38,807		38,807	93
	OTHER REIMBURSABLE COST CENTERS							
99.10	CORF							99.10
99.20	OUTPATIENT PHYSICAL THERAPY							99.20
99.30	OUTPATIENT OCCUPATIONAL THERAPY							99.30
99.40	OUTPATIENT SPEECH PATHOLOGY							99.40
101	HOME HEALTH AGENCY			578	14,904		14,904	101
	SPECIAL PURPOSE COST CENTERS							
118	SUBTOTALS (sum of lines 1-117)	26,121	55,023	63,997	1,869,508		1,869,508	118
	NONREIMBURSABLE COST CENTERS							
190	GIFT, FLOWER, COFFEE SHOP & CANTEN				12,781		12,781	190
192	PHYSICIANS' PRIVATE OFFICES		488		9,564		9,564	192
192.01	DIALYSIS							192.01
192.03	ORTHO CLINIC				231		231	192.03
200	CROSS FOOT ADJUSTMENTS							200
201	NEGATIVE COST CENTER							201
202	TOTAL (sum of lines 118-201)	26,121	55,511	63,997	1,892,084		1,892,084	202

Optimizer Systems, Inc.

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Micro System

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COST ALLOCATION - STATISTICAL BASIS

WORKSHEET B-1

	COST CENTER DESCRIPTIONS	CAP BLDGS & FIXTURES SQUARE FEET	CAP MOVABLE EQUIPMENT DOLLAR VALUE	EMPLOYEE BENEFITS DEPARTMENT GROSS SALARIES	RECONCILIATION	ADMINISTRATIVE & GENERAL ACCUM COST	OPERATION OF PLANT SQUARE FEET	
		1	2	4	5A	5	7	
	GENERAL SERVICE COST CENTERS							
1	CAP REL COSTS-BLDG & FIXT	68,992						1
2	CAP REL COSTS-MVBLE EQUIP		915,836					2
4	EMPLOYEE BENEFITS DEPARTMENT	534	9,319	20,669,013				4
5	ADMINISTRATIVE & GENERAL	10,632	424,351	3,223,914	-7,086,940	28,473,302		5
6	MAINTENANCE & REPAIRS							6
7	OPERATION OF PLANT	2,719	12,654	491,023		1,188,989	55,107	7
8	LAUNDRY & LINEN SERVICE	1,328	6,014	37,297		170,629	1,328	8
9	HOUSEKEEPING	340	1,703	492,034		707,658	340	9
10	DIETARY	1,545	7,589	498,885		852,922	1,545	10
11	CAFETERIA	885				10,103	885	11
12	MAINTENANCE OF PERSONNEL							12
13	NURSING ADMINISTRATION		5,860	92,929		92,619		13
14	CENTRAL SERVICES & SUPPLY	595	9,533	192,390		390,916	595	14
15	PHARMACY	1,165	23,275	549,432		714,317	1,165	15
16	MEDICAL RECORDS & LIBRARY	813	33,291	419,031		803,155	813	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	9,565	56,689	2,549,060		3,684,909	9,565	30
40	SUBPROVIDER - IPF	9,392	8,940	2,513,868		3,432,996	9,392	40
	ANCILLARY SERVICE COST CENTERS							
50	OPERATING ROOM	6,211	49,459	485,019		816,956	6,211	50
53	ANESTHESIOLOGY		7,275	689,251		224,049		53
54	RADIOLOGY-DIAGNOSTIC	3,980	61,648	501,285		920,333	3,980	54
57	CT SCAN	454	1,192	179,098		367,157	454	57
60	LABORATORY	2,325	35,796	698,112		2,180,489	2,325	60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
64	INTRAVENOUS THERAPY			28,629		85,829		64
65	RESPIRATORY THERAPY	926	17,244	458,929		688,289	926	65
66	PHYSICAL THERAPY	4,708	12,180	621,883		876,346	4,708	66
69	ELECTROCARDIOLOGY		5,648	55,189		103,779		69
71	MEDICAL SUPPLIES CHARGED TO PATIENTS					619,954		71
72	IMPL. DEV. CHARGED TO PATIENTS					91,228		72
73	DRUGS CHARGED TO PATIENTS					1,783,878		73
75	ASC (NON-DISTINCT PART)	4,146	9,204	447,886		744,568	4,146	75
76	NUCLEAR MEDICINE		54,566	125,632		403,935		76
76.01	ULTRASOUND	503	16,073	194,117		298,145	503	76.01
76.02	MAMMOGRAPHY	303	2,402	59,151		141,559	303	76.02
76.03	CARDIAC REHABILITATION		7,265	76,781		107,701		76.03
76.04	FAITH CENTER CHEMOTHERAPY	933	1,364	106,169		152,863	933	76.04
76.06	ROUTINE ANCILLARY							76.06
76.97	CARDIAC REHABILITATION							76.97
76.98	HYPERBARIC OXYGEN THERAPY							76.98
76.99	LITHOTRIPSY							76.99
	OUTPATIENT SERVICE COST CENTERS							
88	RURAL HEALTH CLINIC			1,500,007		2,193,495		88
88.01	RHC II			172,507		261,573		88.01
91	EMERGENCY	1,944	34,485	2,284,199		1,838,008	1,944	91
92	OBSERVATION BEDS (NON-DISTINCT PART)							92
93	DAY PSYCHIATRIC	2,400	817	170,974		303,938	2,400	93
	OTHER REIMBURSABLE COST CENTERS							
99.10	CORF							99.10
99.20	OUTPATIENT PHYSICAL THERAPY							99.20
99.30	OUTPATIENT OCCUPATIONAL THERAPY							99.30
99.40	OUTPATIENT SPEECH PATHOLOGY							99.40
101	HOME HEALTH AGENCY			454,055		649,615		101
	SPECIAL PURPOSE COST CENTERS							
118	SUBTOTALS (sum of lines 1-117)	68,346	915,836	20,368,736	-7,086,940	27,902,900	54,461	118
	NONREIMBURSABLE COST CENTERS							
190	GIFT, FLOWER, COFFEE SHOP & CANTEEN	646		70,360		221,797	646	190
192	PHYSICIANS' PRIVATE OFFICES			229,917		337,229		192
192.01	DIALYSIS							192.01
192.03	ORTHO CLINIC					11,376		192.03
200	CROSS FOOT ADJUSTMENTS							200
201	NEGATIVE COST CENTER							201
202	COST TO BE ALLOC PER B PT I	787,606	974,205	5,435,823		7,086,940	1,484,926	202
203	UNIT COST MULTI-WS B PT I	11.415903	1.063733	0.262994		0.248398	26.946232	203
204	COST TO BE ALLOC PER B PT II			16,009		578,343	71,827	204
205	UNIT COST MULTI-WS B PT II			0.000775		0.020329	1.303410	205

Optimizer Systems, Inc.

Win LASH

Micro System

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COST ALLOCATION - STATISTICAL BASIS

WORKSHEET B-1

	COST CENTER DESCRIPTIONS	LAUNDRY & LINEN SERVICE POUNDS OF LAUNDRY 8	HOUSE-KEEPING HOURS OF SERVICE 9	DIETARY MEALS SERVED 10	CAFETERIA MEALS SERVED 11	NURSING ADMINISTRATION DIRECT NRSING HRS 13	CENTRAL SERVICES & SUPPLY COSTED REQUIS. 14	
	GENERAL SERVICE COST CENTERS							
1	CAP REL COSTS-BLDG & FIXT							1
2	CAP REL COSTS-MVBLE EQUIP							2
4	EMPLOYEE BENEFITS DEPARTMENT							4
5	ADMINISTRATIVE & GENERAL							5
6	MAINTENANCE & REPAIRS							6
7	OPERATION OF PLANT							7
8	LAUNDRY & LINEN SERVICE	31,970						8
9	HOUSEKEEPING		3,323					9
10	DIETARY			150,054				10
11	CAFETERIA			69,459	558,163			11
12	MAINTENANCE OF PERSONNEL					4,442		12
13	NURSING ADMINISTRATION					450,210		13
14	CENTRAL SERVICES & SUPPLY					5,423	345,219	14
15	PHARMACY		34			13,298		15
16	MEDICAL RECORDS & LIBRARY					27,316		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	9,970	963	34,752	114,127	114,127	7,289	30
40	SUBPROVIDER - IPF	2,990	431	44,524	125,965	125,965	52	40
	ANCILLARY SERVICE COST CENTERS							
50	OPERATING ROOM	2,580	350		38,706	38,706	266,710	50
53	ANESTHESIOLOGY				6,448		674	53
54	RADIOLOGY-DIAGNOSTIC	1,470			18,007		18,203	54
57	CT SCAN				7,911			57
60	LABORATORY		65		33,499			60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
64	INTRAVENOUS THERAPY							64
65	RESPIRATORY THERAPY	1,535	63		23,654		47	65
66	PHYSICAL THERAPY	1,595	74		20,004		684	66
69	ELECTROCARDIOLOGY				2,875		9	69
71	MEDICAL SUPPLIES CHARGED TO PATIENTS							71
72	IMPL. DEV. CHARGED TO PATIENTS							72
73	DRUGS CHARGED TO PATIENTS							73
75	ASC (NON-DISTINCT PART)	4,910	356		35,230	35,230	21,774	75
76	NUCLEAR MEDICINE				3,967			76
76.01	ULTRASOUND				11,849			76.01
76.02	MAMMOGRAPHY				2,539		29	76.02
76.03	CARDIAC REHABILITATION				3,047	3,047		76.03
76.04	FAITH CENTER CHEMOTHERAPY				3,969	3,969	3,386	76.04
76.06	ROUTINE ANCILLARY							76.06
76.97	CARDIAC REHABILITATION							76.97
76.98	HYPERBARIC OXYGEN THERAPY							76.98
76.99	LITHOTRIPSY							76.99
	OUTPATIENT SERVICE COST CENTERS							
88	RURAL HEALTH CLINIC	1,970	480			54,450		88
88.01	RHC II							88.01
91	EMERGENCY	3,090	463		48,547	48,547	26,362	91
92	OBSERVATION BEDS (NON-DISTINCT PART)							92
93	DAY PSYCHIATRIC				7,340			93
	OTHER REIMBURSABLE COST CENTERS							
99.10	CORF							99.10
99.20	OUTPATIENT PHYSICAL THERAPY							99.20
99.30	OUTPATIENT OCCUPATIONAL THERAPY							99.30
99.40	OUTPATIENT SPEECH PATHOLOGY							99.40
101	HOME HEALTH AGENCY		44			26,169		101
	SPECIAL PURPOSE COST CENTERS							
118	SUBTOTALS (sum of lines 1-117)	30,110	3,323	148,735	558,163	450,210	345,219	118
	NONREIMBURSABLE COST CENTERS							
190	GIFT, FLOWER, COFFEE SHOP & CANTEEN							190
192	PHYSICIANS' PRIVATE OFFICES	1,860		1,319				192
192.01	DIALYSIS							192.01
192.03	ORTHO CLINIC							192.03
200	CROSS FOOT ADJUSTMENTS							200
201	NEGATIVE COST CENTER							201
202	COST TO BE ALLOC PER B PT I	248,883	892,955	1,106,845	548,816	120,040	509,579	202
203	UNIT COST MULT-WS B PT I	7,784,892	268,719,531	7,376,511	0,983,254	0,266,631	1,476,104	203
204	COST TO BE ALLOC PER B PT II	26,786	20,903	45,451	32,501	8,447	26,121	204
205	UNIT COST MULT-WS B PT II	0.837848	6.290400	0.302898	0.058229	0.018762	0.075665	205

Optimizer Systems, Inc.

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Micro System

HARRISBURG MEDICAL CENTER, INC. Provider CCN: 14-0210	In Lieu of Form CMS-2552-10	Period : From: 07/01/2013 To: 06/30/2014	Run Date: 11/11/2014 Run Time: 12:00 Version: 2014.10
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COST ALLOCATION - STATISTICAL BASIS

WORKSHEET B-1

COST CENTER DESCRIPTIONS	PHARMACY COSTED REQUIS.	MEDICAL RECORDS & LIBRARY GROSS REVENUE				
	15	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					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	1,783,878				15
16	MEDICAL RECORDS & LIBRARY		107,502,502			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		7,220,191			30
40	SUBPROVIDER - IPF		10,743,399			40
ANCILLARY SERVICE COST CENTERS						
50	OPERATING ROOM		2,257,297			50
53	ANESTHESIOLOGY		2,019,118			53
54	RADIOLOGY-DIAGNOSTIC		4,122,715			54
57	CT SCAN		15,533,072			57
60	LABORATORY		17,709,082			60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS					62.30
64	INTRAVENOUS THERAPY		6,589,363			64
65	RESPIRATORY THERAPY		3,172,254			65
66	PHYSICAL THERAPY		3,081,555			66
69	ELECTROCARDIOLOGY		1,589,907			69
71	MEDICAL SUPPLIES CHARGED TO PATIENTS		2,095,025			71
72	IMPL. DEV. CHARGED TO PATIENTS		264,644			72
73	DRUGS CHARGED TO PATIENTS	1,709,145	7,951,976			73
75	ASC (NON-DISTINCT PART)		3,849,891			75
76	NUCLEAR MEDICINE		2,203,244			76
76.01	ULTRASOUND		3,620,055			76.01
76.02	MAMMOGRAPHY		747,744			76.02
76.03	CARDIAC REHABILITATION		404,021			76.03
76.04	FAITH CENTER CHEMOTHERAPY		230,020			76.04
76.06	ROUTINE ANCILLARY					76.06
76.97	CARDIAC REHABILITATION					76.97
76.98	HYPERBARIC OXYGEN THERAPY					76.98
76.99	LITHOTRIPSY					76.99
OUTPATIENT SERVICE COST CENTERS						
88	RURAL HEALTH CLINIC	59,052	2,462,553			88
88.01	RHC II		230,862			88.01
91	EMERGENCY		7,301,177			91
92	OBSERVATION BEDS (NON-DISTINCT PART)					92
93	DAY PSYCHIATRIC		1,131,023			93
OTHER REIMBURSABLE COST CENTERS						
99.10	CORF					99.10
99.20	OUTPATIENT PHYSICAL THERAPY					99.20
99.30	OUTPATIENT OCCUPATIONAL THERAPY					99.30
99.40	OUTPATIENT SPEECH PATHOLOGY					99.40
101	HOME HEALTH AGENCY		972,114			101
SPECIAL PURPOSE COST CENTERS						
118	SUBTOTALS (sum of lines 1-117)	1,768,197	107,502,502			118
NONREIMBURSABLE COST CENTERS						
190	GIFT, FLOWER, COFFEE SHOP & CANTEEN					190
192	PHYSICIANS' PRIVATE OFFICES	15,681				192
192.01	DIALYSIS					192.01
192.03	ORTHO CLINIC					192.03
200	CROSS FOOT ADJUSTMENTS					200
201	NEGATIVE COST CENTER					201
202	COST TO BE ALLOC PER B PT I	945,712	1,051,825			202
203	UNIT COST MULTI-WS B PT I	0.530144	0.009784			203

Optimizer Systems, Inc.

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Micro System

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COST ALLOCATION - STATISTICAL BASIS

WORKSHEET B-1

	COST CENTER DESCRIPTIONS	PHARMACY COSTED REQUIS. 15	MEDICAL RECORDS & LIBRARY GROSS REVENUE 16				
204	COST TO BE ALLOC PER B PT II	55,511	63,997				204
205	UNIT COST MULT-WS B PT II	0.031118	0.000595				205

Optimizer Systems, Inc.

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Micro System

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POST STEPDOWN ADJUSTMENTS

WORKSHEET B-2

	DESCRIPTION	WORKSHEET		AMOUNT
		PART	LINE NO.	
	1	2	3	4

Optimizer Systems, Inc.

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Micro System

HARRISBURG MEDICAL CENTER, INC. Provider CCN: 14-0210	In Lieu of Form CMS-2552-10	Period : From: 07/01/2013 To: 06/30/2014	Run Date: 11/11/2014 Run Time: 12:00 Version: 2014.10
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COMPUTATION OF RATIO OF COST TO CHARGES

WORKSHEET C
PART I

	COST CENTER DESCRIPTIONS	TOTAL COST (from Wkst. B, Part I, col. 26)	THERAPY LIMIT ADJ.	COSTS			
				TOTAL COSTS	RCE DISALLOW- ANCE	TOTAL COSTS	
		1	2	3	4	5	
	INPATIENT ROUTINE SERV COST CENTERS						
30	ADULTS & PEDIATRICS	5,676,587		5,676,587	5,586	5,682,173	30
40	SUBPROVIDER - IPF	5,270,693		5,270,693	218,127	5,488,820	40
	ANCILLARY SERVICE COST CENTERS						
50	OPERATING ROOM	1,765,949		1,765,949		1,765,949	50
53	ANESTHESIOLOGY	306,904		306,904		306,904	53
54	RADIOLOGY-DIAGNOSTIC	1,353,004		1,353,004		1,353,004	54
57	CT SCAN	630,531		630,531		630,531	57
60	LABORATORY	3,009,548		3,009,548	1,600	3,011,148	60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS						62.30
64	INTRAVENOUS THERAPY	171,662		171,662		171,662	64
65	RESPIRATORY THERAPY	967,798		967,798		967,798	65
66	PHYSICAL THERAPY	1,304,461		1,304,461		1,304,461	66
69	ELECTROCARDIOLOGY	148,005		148,005		148,005	69
71	MEDICAL SUPPLIES CHARGED TO PATIENTS	794,757		794,757		794,757	71
72	IMPL. DEV. CHARGED TO PATIENTS	116,523		116,523		116,523	72
73	DRUGS CHARGED TO PATIENTS	3,211,777		3,211,777		3,211,777	73
75	ASC (NON-DISTINCT PART)	1,289,337		1,289,337		1,289,337	75
76	NUCLEAR MEDICINE	529,932		529,932		529,932	76
76.01	ULTRASOUND	432,977		432,977		432,977	76.01
76.02	MAMMOGRAPHY	194,813		194,813		194,813	76.02
76.03	CARDIAC REHABILITATION	142,269		142,269		142,269	76.03
76.04	FAITH CENTER CHEMOTHERAPY	228,261		228,261		228,261	76.04
76.06	ROUTINE ANCILLARY						76.06
76.97	CARDIAC REHABILITATION						76.97
76.98	HYPERBARIC OXYGEN THERAPY						76.98
76.99	LITHOTRIPSY						76.99
	OUTPATIENT SERVICE COST CENTERS						
88	RURAL HEALTH CLINIC	2,953,691		2,953,691		2,953,691	88
88.01	RHC II	328,937		328,937		328,937	88.01
91	EMERGENCY	2,667,366		2,667,366	17,720	2,685,086	91
92	OBSERVATION BEDS (NON-DISTINCT PART)	1,651,687		1,651,687		1,651,687	92
93	DAY PSYCHIATRIC	462,542		462,542		462,542	93
	OTHER REIMBURSABLE COST CENTERS						
99.10	CORF						99.10
99.20	OUTPATIENT PHYSICAL THERAPY						99.20
99.30	OUTPATIENT OCCUPATIONAL THERAPY						99.30
99.40	OUTPATIENT SPEECH PATHOLOGY						99.40
101	HOME HEALTH AGENCY	839,615		839,615		839,615	101
200	SUBTOTAL (SEE INSTRUCTIONS)	36,449,626		36,449,626	243,033	36,692,659	200
201	LESS OBSERVATION BEDS	1,651,687		1,651,687		1,651,687	201
202	TOTAL (SEE INSTRUCTIONS)	34,797,939		34,797,939		35,040,972	202

Optimizer Systems, Inc.

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Micro System

HARRISBURG MEDICAL CENTER, INC. Provider CCN: 14-0210	In Lieu of Form CMS-2552-10	Period : From: 07/01/2013 To: 06/30/2014	Run Date: 11/11/2014 Run Time: 12:00 Version: 2014.10
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COMPUTATION OF RATIO OF COST TO CHARGES

WORKSHEET C
PART I

	COST CENTER DESCRIPTIONS	CHARGES			COST OR OTHER RATIO	TEFRA INPATIENT RATIO	PPS INPATIENT RATIO	
		INPATIENT	OUTPATIENT	TOTAL (column 6 + column 7)				
		6	7	8	9	10	11	
	INPATIENT ROUTINE SERV COST CENTERS							
30	ADULTS & PEDIATRICS	3,878,359		3,878,359				30
40	SUBPROVIDER - IPF	10,743,599		10,743,599				40
	ANCILLARY SERVICE COST CENTERS							
50	OPERATING ROOM	348,987	1,908,310	2,257,297	0.782329	0.782329	0.782329	50
53	ANESTHESIOLOGY	321,972	1,697,146	2,019,118	0.151999	0.151999	0.151999	53
54	RADIOLOGY-DIAGNOSTIC	373,350	3,749,365	4,122,715	0.328183	0.328183	0.328183	54
57	CT SCAN	1,638,016	13,895,056	15,533,072	0.040593	0.040593	0.040593	57
60	LABORATORY	2,788,747	14,920,335	17,709,082	0.169944	0.169944	0.170034	60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
64	INTRAVENOUS THERAPY	4,298,595	2,290,768	6,589,363	0.026051	0.026051	0.026051	64
65	RESPIRATORY THERAPY	1,232,182	1,940,072	3,172,254	0.305082	0.305082	0.305082	65
66	PHYSICAL THERAPY	448,641	2,632,914	3,081,555	0.423313	0.423313	0.423313	66
69	ELECTROCARDIOLOGY	242,111	1,347,796	1,589,907	0.093090	0.093090	0.093090	69
71	MEDICAL SUPPLIES CHARGED TO PATIENTS	778,911	1,316,114	2,095,025	0.379354	0.379354	0.379354	71
72	IMPL. DEV. CHARGED TO PATIENTS	10,053	254,591	264,644	0.440301	0.440301	0.440301	72
73	DRUGS CHARGED TO PATIENTS	2,675,233	5,276,743	7,951,976	0.403897	0.403897	0.403897	73
75	ASC (NON-DISTINCT PART)	235,739	3,614,152	3,849,891	0.334902	0.334902	0.334902	75
76	NUCLEAR MEDICINE	59,281	2,143,963	2,203,244	0.240524	0.240524	0.240524	76
76.01	ULTRASOUND	558,348	3,061,707	3,620,055	0.119605	0.119605	0.119605	76.01
76.02	MAMMOGRAPHY	1,503	746,241	747,744	0.260534	0.260534	0.260534	76.02
76.03	CARDIAC REHABILITATION	1,710	402,311	404,021	0.352133	0.352133	0.352133	76.03
76.04	FAITH CENTER CHEMOTHERAPY	4,149	225,871	230,020	0.992353	0.992353	0.992353	76.04
76.06	ROUTINE ANCILLARY							76.06
76.97	CARDIAC REHABILITATION							76.97
76.98	HYPERBARIC OXYGEN THERAPY							76.98
76.99	LITHOTRIPSY							76.99
	OUTPATIENT SERVICE COST CENTERS							
88	RURAL HEALTH CLINIC		2,462,553	2,462,553				88
88.01	RHC II		230,862	230,862				88.01
91	EMERGENCY	810,425	6,490,752	7,301,177	0.365334	0.365334	0.367761	91
92	OBSERVATION BEDS (NON-DISTINCT PART)	619,434	2,722,398	3,341,832	0.494246	0.494246	0.494246	92
93	DAY PSYCHIATRIC		1,131,023	1,131,023	0.408959	0.408959	0.408959	93
	OTHER REIMBURSABLE COST CENTERS							
99.10	CORF							99.10
99.20	OUTPATIENT PHYSICAL THERAPY							99.20
99.30	OUTPATIENT OCCUPATIONAL THERAPY							99.30
99.40	OUTPATIENT SPEECH PATHOLOGY							99.40
101	HOME HEALTH AGENCY		972,114	972,114				101
200	SUBTOTAL (SEE INSTRUCTIONS)	32,069,345	75,433,157	107,502,502				200
201	LESS OBSERVATION BEDS							201
202	TOTAL (SEE INSTRUCTIONS)	32,069,345	75,433,157	107,502,502				202

Optimizer Systems, Inc.

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Micro System

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APPORTIONMENT OF INPATIENT ROUTINE SERVICE CAPITAL COSTS

WORKSHEET D
PART I

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

(A)	COST CENTER DESCRIPTION	CAPITAL RELATED COST (from Wkst. B, Part II, (col. 26))	SWING BED ADJUSTMENT	REDUCED CAPITAL RELATED COST (col. 1 minus col. 2)	TOTAL PATIENT DAYS	PER DIEM (col. 3 + col. 4)	INPATIENT PROGRAM DAYS	INPATIENT PROGRAM CAPITAL COST (col. 5 x col. 6)	
1	2	3	4	5	6	7	8	9	
	INPATIENT ROUTINE SERV COST CENTERS								
30	ADULTS & PEDIATRICS (General Routine Care)	297,429	2,064	295,365	5,514	53.57	2,459	131,729	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	235,503		235,503	9,210	25.57	3,556	90,927	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)	532,932		530,868	14,724		6,015	222,656	200

(A) Worksheet A line numbers

Optimizer Systems, Inc.

WinLASH

Micro System

HARRISBURG MEDICAL CENTER, INC. Provider CCN: 14-0210	In Lieu of Form CMS-2552-10	Period: From: 07/01/2013 To: 06/30/2014	Run Date: 11/11/2014 Run Time: 12:00 Version: 2014.10
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APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS

COMPONENT CCN: 14-0210

WORKSHEET D
PART II

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

(A)	COST CENTER DESCRIPTION	CAPITAL RELATED COST (from Wkst. B, Part II (col. 26))	TOTAL CHARGES (from Wkst. C, Part I, (col. 8))	RATIO OF COST TO CHARGES (col. 1 + col. 2)	INPATIENT PROGRAM CHARGES	CAPITAL COSTS (col. 3 x col. 4)	
		1	2	3	4	5	
	ANCILLARY SERVICE COST CENTERS						
50	OPERATING ROOM	251,596	2,257,297	0.111459	166,979	18,611	50
53	ANESTHESIOLOGY	15,105	2,019,118	0.007481	161,777	1,210	53
54	RADIOLOGY-DIAGNOSTIC	141,408	4,122,715	0.034300	331,882	11,384	54
57	CT SCAN	24,349	15,533,072	0.001568	1,466,969	2,300	57
60	LABORATORY	125,449	17,709,082	0.007084	2,314,993	16,399	60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS						62.30
64	INTRAVENOUS THERAPY	5,688	6,589,363	0.000863	2,626,258	2,266	64
65	RESPIRATORY THERAPY	70,321	3,172,254	0.022168	756,729	16,775	65
66	PHYSICAL THERAPY	99,614	3,081,555	0.032326	301,533	9,747	66
69	ELECTROCARDIOLOGY	31,785	1,589,907	0.019992	211,719	4,233	69
71	MEDICAL SUPPLIES CHARGED TO PATIENTS	13,850	2,095,025	0.006611	504,529	3,355	71
72	IMPL. DEV. CHARGED TO PATIENTS	2,012	264,644	0.007603	9,588	73	72
73	DRUGS CHARGED TO PATIENTS	94,180	7,951,976	0.011844	913,513	10,820	73
75	ASC (NON-DISTINCT PART)	91,012	3,849,891	0.023640	185,030	4,374	75
76	NUCLEAR MEDICINE	67,895	2,203,244	0.030816	26,721	823	76
76.01	ULTRASOUND	32,550	3,620,055	0.008992	458,476	4,123	76.01
76.02	MAMMOGRAPHY	9,928	747,744	0.013277			76.02
76.03	CARDIAC REHABILITATION	10,451	404,021	0.025867	1,286	33	76.03
76.04	FAITH CENTER CHEMOTHERAPY	17,206	230,020	0.074802			76.04
76.06	ROUTINE ANCILLARY						76.06
76.97	CARDIAC REHABILITATION						76.97
76.98	HYPERBARIC OXYGEN THERAPY						76.98
76.99	LITHOTRIPSY						76.99
	OUTPATIENT SERVICE COST CENTERS						
88	RURAL HEALTH CLINIC	56,754	2,462,553	0.023047			88
88.01	RHC II	5,589	230,862	0.024209			88.01
91	EMERGENCY	116,123	7,301,177	0.015905	504,850	8,030	91
92	OBSERVATION BEDS (NON-DISTINCT PART)	87,060	3,341,832	0.026052	425,411	11,083	92
93	DAY PSYCHIATRIC	38,807	1,131,023	0.034311			93
	OTHER REIMBURSABLE COST CENTERS						
200	TOTAL (sum of lines 50-199)	1,408,732	91,908,430		11,368,243	125,619	200

(A) Worksheet A line numbers

Optimizer Systems, Inc.

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Micro System

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APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PASS THROUGH COSTS

WORKSHEET D
PART III

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

		NURSING SCHOOL	ALLIED HEALTH COST	ALL OTHER MEDICAL EDUCATION COST	SWING-BED ADJUSTMENT AMOUNT (see instructions)	TOTAL COSTS (sum of cols. 1 through 3 minus col 4.)	
(A)	COST CENTER DESCRIPTION	1	2	3	4	5	
	INPATIENT ROUTINE SERV COST CENTERS						
30	ADULTS & PEDIATRICS (General Routine Care)						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

Optimizer Systems, Inc.

WinLASH

Micro System

HARRISBURG MEDICAL CENTER, INC. Provider CCN: 14-0210	In Lieu of Form CMS-2552-10	Period : From: 07/01/2013 To: 06/30/2014	Run Date: 11/11/2014 Run Time: 12:00 Version: 2014.10
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APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PASS THROUGH COSTS

WORKSHEET D
PART III

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

		TOTAL PATIENT DAYS	PER DIEM (col. 5+ col. 6)	INPATIENT PROGRAM DAYS	INPATIENT PROGRAM PASS THRU COST (col. 7 x col. 8)	
(A)	COST CENTER DESCRIPTION	6	7	8	9	
	INPATIENT ROUTINE SERV COST CENTERS					
30	ADULTS & PEDIATRICS (General Routine Care)	5,514		2,459		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	9,210		3,556		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)	14,724		6,015		200

(A) Worksheet A line numbers

Optimizer Systems, Inc.

WinLASH

Micro System

HARRISBURG MEDICAL CENTER, INC. Provider CCN: 14-0210	In Lieu of Form CMS-2552-10	Period: From: 07/01/2013 To: 06/30/2014	Run Date: 11/11/2014 Run Time: 12:00 Version: 2014.10
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APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE
OTHER PASS THROUGH COSTS

COMPONENT CCN: 14-0210

WORKSHEET D
PART IV

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

(A)	COST CENTER DESCRIPTION	1	2	3	4	5	6
		NON PHYSICIAN ANESTHETIST COST	NURSING SCHOOL	ALLIED HEALTH	ALL OTHER MEDICAL EDUCATION COST	TOTAL COST (sum of col. 1 through col. 4)	TOTAL OUTPATIENT COST (sum of col. 2, 3, and 4)
	ANCILLARY SERVICE COST CENTERS						
50	OPERATING ROOM						50
53	ANESTHESIOLOGY						53
54	RADIOLOGY-DIAGNOSTIC						54
57	CT SCAN						57
60	LABORATORY						60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS						62.30
64	INTRAVENOUS THERAPY						64
65	RESPIRATORY THERAPY						65
66	PHYSICAL THERAPY						66
69	ELECTROCARDIOLOGY						69
71	MEDICAL SUPPLIES CHARGED TO PATIENTS						71
72	IMPL. DEV. CHARGED TO PATIENTS						72
73	DRUGS CHARGED TO PATIENTS						73
75	ASC (NON-DISTINCT PART)						75
76	NUCLEAR MEDICINE						76
76.01	ULTRASOUND						76.01
76.02	MAMMOGRAPHY						76.02
76.03	CARDIAC REHABILITATION						76.03
76.04	FAITH CENTER CHEMOTHERAPY						76.04
76.06	ROUTINE ANCILLARY						76.06
76.97	CARDIAC REHABILITATION						76.97
76.98	HYPERBARIC OXYGEN THERAPY						76.98
76.99	LITHOTRIPSY						76.99
	OUTPATIENT SERVICE COST CENTERS						
88	RURAL HEALTH CLINIC						88
88.01	RHC II						88.01
91	EMERGENCY						91
92	OBSERVATION BEDS (NON-DISTINCT PART)						92
93	DAY PSYCHIATRIC						93
	OTHER REIMBURSABLE COST CENTERS						
200	TOTAL (sum of lines 50-199)						200

(A) Worksheet A line numbers

Optimizer Systems, Inc.

WinLASH

Micro System

HARRISBURG MEDICAL CENTER, INC. Provider CCN: 14-0210	In Lieu of Form CMS-2552-10	Period: From: 07/01/2013 To: 06/30/2014	Run Date: 11/11/2014 Run Time: 12:00 Version: 2014.10
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APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE
OTHER PASS THROUGH COSTS

COMPONENT CCN: 14-0210

WORKSHEET D
PART IV

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

(A)	COST CENTER DESCRIPTION	TOTAL CHARGES (from Wkst. C, Part I, col. 8)	RATIO OF COST TO CHARGES (col. 5+ col. 7)	OUTPAT-IENT RATIO OF COST TO CHARGES (col. 6+ col. 7)	INPATIENT PROGRAM CHARGES	INPATIENT PROGRAM PASS-THROUGH COSTS (col. 8 x col. 10)	OUTPAT-IENT PROGRAM CHARGES	OUTPAT-IENT PROGRAM PASS-THROUGH COSTS (col. 9 x col. 12)	
		7	8	9	10	11	12	13	
	ANCILLARY SERVICE COST CENTERS								
50	OPERATING ROOM	2,257,297			166,979		550,429		50
53	ANESTHESIOLOGY	2,019,118			161,777		567,895		53
54	RADIOLOGY-DIAGNOSTIC	4,122,715			331,882		1,232,469		54
57	CT SCAN	15,533,072			1,466,969		4,476,506		57
60	LABORATORY	17,709,082			2,314,993		1,707,518		60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS								62.30
64	INTRAVENOUS THERAPY	6,589,363			2,626,258		929,843		64
65	RESPIRATORY THERAPY	3,172,254			756,729		782,957		65
66	PHYSICAL THERAPY	3,081,555			301,533		1,168		66
69	ELECTROCARDIOLOGY	1,589,907			211,719		448,393		69
71	MEDICAL SUPPLIES CHARGED TO PATIENTS	2,095,025			504,529		394,060		71
72	IMPL. DEV. CHARGED TO PATIENTS	264,644			9,588		144,369		72
73	DRUGS CHARGED TO PATIENTS	7,951,976			913,513		2,860,390		73
75	ASC (NON-DISTINCT PART)	3,849,891			185,030		1,532,162		75
76	NUCLEAR MEDICINE	2,203,244			26,721		924,096		76
76.01	ULTRASOUND	3,620,055			458,476		846,088		76.01
76.02	MAMMOGRAPHY	747,744							76.02
76.03	CARDIAC REHABILITATION	404,021			1,286		231,105		76.03
76.04	FAITH CENTER CHEMOTHERAPY	230,020					49,786		76.04
76.06	ROUTINE ANCILLARY								76.06
76.97	CARDIAC REHABILITATION								76.97
76.98	HYPERBARIC OXYGEN THERAPY								76.98
76.99	LITHOTRIPSY								76.99
	OUTPATIENT SERVICE COST CENTERS								
88	RURAL HEALTH CLINIC	2,462,553							88
88.01	RHC II	230,862							88.01
91	EMERGENCY	7,901,177			504,850		1,531,903		91
92	OBSERVATION BEDS (NON-DISTINCT PART)	3,341,832			425,411		1,086,737		92
93	DAY PSYCHIATRIC	1,131,023					263,778		93
	OTHER REIMBURSABLE COST CENTERS								
200	TOTAL (sum of lines 50-199)	91,908,430			11,368,243		20,581,652		200

(A) Worksheet A line numbers

Optimizer Systems, Inc.

Win LASH

Micro System

HARRISBURG MEDICAL CENTER, INC. Provider CCN: 14-0210	In Lieu of Form CMS-2552-10	Period : From: 07/01/2013 To: 06/30/2014	Run Date: 11/11/2014 Run Time: 12:00 Version: 2014.10
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APPORTIONMENT OF MEDICAL AND OTHER HEALTH SERVICE COSTS

COMPONENT CCN: 14-0210

WORKSHEET D
PART V

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

(A)	COST CENTER DESCRIPTION	PROGRAM CHARGES				PROGRAM COST			
		COST TO CHARGE RATIO (from Wkst C, Part I, col. 9)	PPS REIM-BURSED SERVICES (see inst.)	COST REIM-BURSED SUBJECT TO DED. & COINS. (see inst.)	COST REIM-BURSED NOT SUBJECT TO DED. & COINS. (see inst.)	PPS SERVICES (see inst.)	COST REIM-BURSED SUBJECT TO DED. & COINS. (see inst.)	COST REIM-BURSED NOT SUBJECT TO DED. & COINS. (see inst.)	
1	2	3	4	5	6	7			
ANCILLARY SERVICE COST CENTERS									
50	OPERATING ROOM	0.782329	550,429			430,617		50	
53	ANESTHESIOLOGY	0.151999	567,895			86,319		53	
54	RADIOLOGY-DIAGNOSTIC	0.328183	1,232,469			404,475		54	
57	CT SCAN	0.040593	4,476,506			181,715		57	
60	LABORATORY	0.169944	1,707,518			290,182		60	
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30	
64	INTRAVENOUS THERAPY	0.026051	929,843			24,223		64	
65	RESPIRATORY THERAPY	0.305082	782,957			238,866		65	
66	PHYSICAL THERAPY	0.423313	1,168			494		66	
69	ELECTROCARDIOLOGY	0.093090	448,393			41,741		69	
71	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.379354	394,060			149,488		71	
72	IMPL. DEV. CHARGED TO PATIENTS	0.440301	144,369			63,566		72	
73	DRUGS CHARGED TO PATIENTS	0.403897	2,860,390			1,155,303		73	
75	ASC (NON-DISTINCT PART)	0.334902	1,532,162			513,124		75	
76	NUCLEAR MEDICINE	0.240524	924,096			222,267		76	
76.01	ULTRASOUND	0.119605	846,088			101,196		76.01	
76.02	MAMMOGRAPHY	0.260534						76.02	
76.03	CARDIAC REHABILITATION	0.352133	251,105			88,422		76.03	
76.04	FAITH CENTER CHEMOTHERAPY	0.992353	49,786			49,405		76.04	
76.06	ROUTINE ANCILLARY							76.06	
76.97	CARDIAC REHABILITATION							76.97	
76.98	HYPERBARIC OXYGEN THERAPY							76.98	
76.99	LITHOTRIPSY							76.99	
OUTPATIENT SERVICE COST CENTERS									
88	RURAL HEALTH CLINIC							88	
88.01	RHC II							88.01	
91	EMERGENCY	0.365334	1,531,903			559,656		91	
92	OBSERVATION BEDS (NON-DISTINCT PART)	0.494246	1,086,737			537,115		92	
93	DAY PSYCHIATRIC	0.408959	263,778			107,874		93	
OTHER REIMBURSABLE COST CENTERS									
200	SUBTOTAL (see instructions)		20,581,652			5,246,048		200	
201	LESS PBP CLINIC LAB. SERVICES PROGRAM ONLY CHARGES							201	
202	NET CHARGES (line 200 - line 201)		20,581,652			5,246,048		202	

(A) Worksheet A line numbers

Optimizer Systems, Inc.

WinLASH

Micro System

HARRISBURG MEDICAL CENTER, INC. Provider CCN: 14-0210	In Lieu of Form CMS-2552-10	Period: From: 07/01/2013 To: 06/30/2014	Run Date: 11/11/2014 Run Time: 12:00 Version: 2014.10
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APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS

COMPONENT CCN: 14-S210

WORKSHEET D
PART II

CHECK TITLE V HOSPITAL SUB (OTHER) PPS
 APPLICABLE TITLE XVIII, PART A IFF TEFRA
 BOXES: TITLE XIX IRF

(A)	COST CENTER DESCRIPTION	CAPITAL RELATED COST (from Wkst. B, Part II (col. 26))	TOTAL CHARGES (from Wkst. C, Part I, (col. 8))	RATIO OF COST TO CHARGES (col. 1 ÷ col. 2)	INPATIENT PROGRAM CHARGES	CAPITAL COSTS (col. 3 x col. 4)	
		1	2	3	4	5	
	ANCILLARY SERVICE COST CENTERS						
50	OPERATING ROOM	251,596	2,257,297	0.111459			30
53	ANESTHESIOLOGY	15,105	2,019,118	0.007481	21,578	161	53
54	RADIOLOGY-DIAGNOSTIC	141,408	4,122,715	0.034300	34,767	1,193	54
57	CT SCAN	24,349	15,533,072	0.001568	147,215	231	57
60	LABORATORY	125,449	17,709,082	0.007084	323,461	2,291	60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS						62.30
64	INTRAVENOUS THERAPY	5,688	6,589,363	0.000863	48,425	42	64
65	RESPIRATORY THERAPY	70,321	3,172,234	0.022168	156,690	3,474	65
66	PHYSICAL THERAPY	99,614	3,081,555	0.032326	43,449	1,405	66
69	ELECTROCARDIOLOGY	31,785	1,589,907	0.019992	27,937	559	69
71	MEDICAL SUPPLIES CHARGED TO PATIENTS	13,850	2,095,025	0.006611	63,028	417	71
72	IMPL. DEV. CHARGED TO PATIENTS	2,012	264,644	0.007603			72
73	DRUGS CHARGED TO PATIENTS	94,180	7,951,976	0.011844	636,285	7,536	73
75	ASC (NON-DISTINCT PART)	91,012	3,849,891	0.023640	2,648	63	75
76	NUCLEAR MEDICINE	67,895	2,203,244	0.030816			76
76.01	ULTRASOUND	32,550	3,620,055	0.008992	12,137	109	76.01
76.02	MAMMOGRAPHY	9,928	747,744	0.013277			76.02
76.03	CARDIAC REHABILITATION	10,451	404,021	0.025867			76.03
76.04	FAITH CENTER CHEMOTHERAPY	17,206	230,020	0.074802			76.04
76.06	ROUTINE ANCILLARY						76.06
76.97	CARDIAC REHABILITATION						76.97
76.98	HYPERBARIC OXYGEN THERAPY						76.98
76.99	LITHOTRIPSY						76.99
	OUTPATIENT SERVICE COST CENTERS						
88	RURAL HEALTH CLINIC	56,754	2,462,553	0.023047			88
88.01	RHC II	5,589	230,862	0.024209			88.01
91	EMERGENCY	116,123	7,301,177	0.015905	95,828	1,524	91
92	OBSERVATION BEDS (NON-DISTINCT PART)						92
93	DAY PSYCHIATRIC	38,807	1,131,023	0.034311			93
	OTHER REIMBURSABLE COST CENTERS						
200	TOTAL (sum of lines 50-199)	1,321,672	91,908,430		1,613,448	19,005	200

(A) Worksheet A line numbers

Optimizer Systems, Inc.

WinLASH

Micro System

HARRISBURG MEDICAL CENTER, INC. Provider CCN: 14-0210	In Lieu of Form CMS-2552-10	Period: From: 07/01/2013 To: 06/30/2014	Run Date: 11/11/2014 Run Time: 12:00 Version: 2014.10
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APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE
OTHER PASS THROUGH COSTS

COMPONENT CCN: 14-S210

WORKSHEET D
PART IV

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

(A)	COST CENTER DESCRIPTION	NON PHYSICIAN ANESTHETIST COST	NURSING SCHOOL	ALLIED HEALTH	ALL OTHER MEDICAL EDUCATION COST	TOTAL COST (sum of col. 1 through col. 4)	TOTAL OUTPATIENT COST (sum of col. 2, 3, and 4)
		1	2	3	4	5	6
	ANCILLARY SERVICE COST CENTERS						
50	OPERATING ROOM						30
53	ANESTHESIOLOGY						53
54	RADIOLOGY-DIAGNOSTIC						54
57	CT SCAN						57
60	LABORATORY						60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS						62.30
64	INTRAVENOUS THERAPY						64
65	RESPIRATORY THERAPY						65
66	PHYSICAL THERAPY						66
69	ELECTROCARDIOLOGY						69
71	MEDICAL SUPPLIES CHARGED TO PATIENTS						71
72	IMPL. DEV. CHARGED TO PATIENTS						72
73	DRUGS CHARGED TO PATIENTS						73
75	ASC (NON-DISTINCT PART)						75
76	NUCLEAR MEDICINE						76
76.01	ULTRASOUND						76.01
76.02	MAMMOGRAPHY						76.02
76.03	CARDIAC REHABILITATION						76.03
76.04	FAITH CENTER CHEMOTHERAPY						76.04
76.06	ROUTINE ANCILLARY						76.06
76.97	CARDIAC REHABILITATION						76.97
76.98	HYPERBARIC OXYGEN THERAPY						76.98
76.99	LITHOTRIPSY						76.99
	OUTPATIENT SERVICE COST CENTERS						
88	RURAL HEALTH CLINIC						88
88.01	RHC II						88.01
91	EMERGENCY						91
92	OBSERVATION BEDS (NON-DISTINCT PART)						92
93	DAY PSYCHIATRIC						93
	OTHER REIMBURSABLE COST CENTERS						
200	TOTAL (sum of lines 50-199)						200

(A) Worksheet A line numbers

Optimizer Systems, Inc.

Win L A S H

Micro System

HARRISBURG MEDICAL CENTER, INC. Provider CCN: 14-0210	In Lieu of Form CMS-2552-10	Period : From: 07/01/2013 To: 06/30/2014	Run Date: 11/11/2014 Run Time: 12:00 Version: 2014.10
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APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE
OTHER PASS THROUGH COSTS

COMPONENT CCN: 14-S210

WORKSHEET D
PART IV

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

(A)	COST CENTER DESCRIPTION	7	8	9	10	11	12	13
	ANCILLARY SERVICE COST CENTERS	TOTAL CHARGES (from Wkst. C, Part I, col. 8)	RATIO OF COST TO CHARGES (col. 5+ col. 7)	OUTPAT- IENT RATIO OF COST TO CHARGES (col. 6+ col. 7)	INPATIENT PROGRAM CHARGES	INPATIENT PROGRAM PASS- THROUGH COSTS (col. 8 x col. 10)	OUTPAT- IENT PROGRAM CHARGES	OUTPAT- IENT PROGRAM PASS- THROUGH COSTS (col. 9 x col. 12)
50	OPERATING ROOM	2,257,297						50
53	ANESTHESIOLOGY	2,019,118			21,578			53
54	RADIOLOGY-DIAGNOSTIC	4,122,715			34,767		1,379	54
57	CT SCAN	15,533,072			147,215		4,779	57
60	LABORATORY	17,709,082			323,461			60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
64	INTRAVENOUS THERAPY	6,589,363			48,425		1,826	64
65	RESPIRATORY THERAPY	3,172,254			156,690		2,761	65
66	PHYSICAL THERAPY	3,081,555			43,449			66
69	ELECTROCARDIOLOGY	1,589,907			27,937		538	69
71	MEDICAL SUPPLIES CHARGED TO PATIENTS	2,095,025			63,028		4,092	71
72	IMPL. DEV. CHARGED TO PATIENTS	264,644						72
73	DRUGS CHARGED TO PATIENTS	7,931,976			636,285		432	73
75	ASC (NON-DISTINCT PART)	3,849,891			2,648			75
76	NUCLEAR MEDICINE	2,203,244						76
76.01	ULTRASOUND	3,620,055			12,137			76.01
76.02	MAMMOGRAPHY	747,744						76.02
76.03	CARDIAC REHABILITATION	404,021						76.03
76.04	FAITH CENTER CHEMOTHERAPY	230,020						76.04
76.06	ROUTINE ANCILLARY							76.06
76.97	CARDIAC REHABILITATION							76.97
76.98	HYPERBARIC OXYGEN THERAPY							76.98
76.99	LITHOTRIPSY							76.99
	OUTPATIENT SERVICE COST CENTERS							
88	RURAL HEALTH CLINIC	2,462,553						88
88.01	RHC II	230,862						88.01
91	EMERGENCY	7,301,177			95,828			91
92	OBSERVATION BEDS (NON-DISTINCT PART)	3,341,832						92
93	DAY PSYCHIATRIC	1,131,023						93
	OTHER REIMBURSABLE COST CENTERS							
200	TOTAL (sum of lines 50-199)	91,908,430			1,613,448		15,807	200

(A) Worksheet A line numbers

Optimizer Systems, Inc.

WinLASH

Micro System

HARRISBURG MEDICAL CENTER, INC. Provider CCN: 14-0210	In Lieu of Form CMS-2552-10	Period: From: 07/01/2013 To: 06/30/2014	Run Date: 11/11/2014 Run Time: 12:00 Version: 2014.10
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APPORTIONMENT OF MEDICAL AND OTHER HEALTH SERVICE COSTS

COMPONENT CCN: 14-S210

WORKSHEET D
PART V

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

(A)	COST CENTER DESCRIPTION	PROGRAM CHARGES				PROGRAM COST		
		COST TO CHARGE RATIO (from Wkst C, Part I, col. 9)	PPS REIM-BURSED SERVICES (see inst.)	COST REIM-BURSED SUBJECT TO DED. & COINS. (see inst.)	COST REIM-BURSED NOT SUBJECT TO DED. & COINS. (see inst.)	PPS SERVICES (see inst.)	COST REIM-BURSED SUBJECT TO DED. & COINS. (see inst.)	COST REIM-BURSED NOT SUBJECT TO DED. & COINS. (see inst.)
		1	2	3	4	5	6	7
	ANCILLARY SERVICE COST CENTERS							
50	OPERATING ROOM	0.782329						50
53	ANESTHESIOLOGY	0.151999						53
54	RADIOLOGY-DIAGNOSTIC	0.329183	1,379			453		54
57	CT SCAN	0.040593	4,779			194		57
60	LABORATORY	0.169944						60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
64	INTRAVENOUS THERAPY	0.026051	1,826			48		64
65	RESPIRATORY THERAPY	0.305082	2,761			842		65
66	PHYSICAL THERAPY	0.423313						66
69	ELECTROCARDIOLOGY	0.093090	538			50		69
71	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.379354	4,092			1,552		71
72	IMPL. DEV. CHARGED TO PATIENTS	0.440301						72
73	DRUGS CHARGED TO PATIENTS	0.403897	432			174		73
75	ASC (NON-DISTINCT PART)	0.354902						75
76	NUCLEAR MEDICINE	0.240524						76
76.01	ULTRASOUND	0.119605						76.01
76.02	MAMMOGRAPHY	0.260534						76.02
76.03	CARDIAC REHABILITATION	0.552133						76.03
76.04	FAITH CENTER CHEMOTHERAPY	0.992353						76.04
76.06	ROUTINE ANCILLARY							76.06
76.97	CARDIAC REHABILITATION							76.97
76.98	HYPERBARIC OXYGEN THERAPY							76.98
76.99	LITHOTRIPSY							76.99
	OUTPATIENT SERVICE COST CENTERS							
88	RURAL HEALTH CLINIC							88
88.01	RHC II							88.01
91	EMERGENCY	0.365934						91
92	OBSERVATION BEDS (NON-DISTINCT PART)	0.494246						92
93	DAY PSYCHIATRIC	0.408959						93
	OTHER REIMBURSABLE COST CENTERS							
200	SUBTOTAL (see instructions)		15,807			3,313		200
201	LESS PBP CLINIC LAB. SERVICES PROGRAM ONLY CHARGES							201
202	NET CHARGES (line 200 - line 201)		15,807			3,313		202

(A) Worksheet A line numbers

Optimizer Systems, Inc.

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Micro System

HARRISBURG MEDICAL CENTER, INC. Provider CCN: 14-0210	In Lieu of Form CMS-2552-10	Period : From: 07/01/2013 To: 06/30/2014	Run Date: 11/11/2014 Run Time: 12:00 Version: 2014.10
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APPORTIONMENT OF MEDICAL AND OTHER HEALTH SERVICE COSTS

COMPONENT CCN: 14-U210

WORKSHEET D
PART V

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

(A)	COST CENTER DESCRIPTION	COST TO CHARGE RATIO (from Wkst C, Part I, col. 9)	PROGRAM CHARGES			PROGRAM COST			
			PPS REIM-BURSED SERVICES (see inst.)	COST REIM-BURSED SUBJECT TO DED. & COINS. (see inst.)	COST REIM-BURSED NOT SUBJECT TO DED. & COINS. (see inst.)	PPS SERVICES (see inst.)	COST REIM-BURSED SUBJECT TO DED. & COINS. (see inst.)	COST REIM-BURSED NOT SUBJECT TO DED. & COINS. (see inst.)	
		1	2	3	4	5	6	7	
	ANCILLARY SERVICE COST CENTERS								
50	OPERATING ROOM	0.782329							50
53	ANESTHESIOLOGY	0.151999							53
54	RADIOLOGY-DIAGNOSTIC	0.528183							54
57	CT SCAN	0.040593							57
60	LABORATORY	0.169944							60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS								62.30
64	INTRAVENOUS THERAPY	0.026051							64
65	RESPIRATORY THERAPY	0.305082							65
66	PHYSICAL THERAPY	0.423313							66
69	ELECTROCARDIOLOGY	0.093090							69
71	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.379354							71
72	IMPL. DEV. CHARGED TO PATIENTS	0.440301							72
73	DRUGS CHARGED TO PATIENTS	0.403897							73
75	ASC (NON-DISTINCT PART)	0.334902							75
76	NUCLEAR MEDICINE	0.240524							76
76.01	ULTRASOUND	0.119605							76.01
76.02	MAMMOGRAPHY	0.260534							76.02
76.03	CARDIAC REHABILITATION	0.352133							76.03
76.04	FAITH CENTER CHEMOTHERAPY	0.992353							76.04
76.06	ROUTINE ANCILLARY								76.06
76.97	CARDIAC REHABILITATION								76.97
76.98	HYPERBARIC OXYGEN THERAPY								76.98
76.99	LITHOTRIPSY								76.99
	OUTPATIENT SERVICE COST CENTERS								
88	RURAL HEALTH CLINIC								88
88.01	RHC II								88.01
91	EMERGENCY	0.365334							91
92	OBSERVATION BEDS (NON-DISTINCT PART)	0.494246							92
93	DAY PSYCHIATRIC	0.408959							93
	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

Optimizer Systems, Inc.

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HARRISBURG MEDICAL CENTER, INC. Provider CCN: 14-0210	In Lieu of Form CMS-2552-10	Period : From: 07/01/2013 To: 06/30/2014	Run Date: 11/11/2014 Run Time: 12:00 Version: 2014.10
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COMPUTATION OF INPATIENT OPERATING COST

COMPONENT CCN: 14-0210

WORKSHEET D-1
PART I

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

PART I - ALL PROVIDER COMPONENTS

INPATIENT DAYS			
1	INPATIENT DAYS (including private room days and swing-bed days, excluding newborn)	5,711	1
2	INPATIENT DAYS (including private room days, excluding swing-bed and newborn days)	5,514	2
3	PRIVATE ROOM DAYS (excluding swing-bed private room days). IF YOU HAVE ONLY PRIVATE ROOM DAYS, DO NOT COMPLETE THIS LINE.	369	3
4	SEMI-PRIVATE ROOM DAYS (excluding swing-bed private room days)	3,531	4
5	TOTAL SWING-BED SNF-TYPE INPATIENT DAYS (including private room days) THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD	99	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)	98	6
7	TOTAL SWING-BED NF-TYPE INPATIENT DAYS (including private room days) THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD		7
8	TOTAL SWING-BED NF-TYPE INPATIENT DAYS (including private room days) AFTER DECEMBER 31 OF THE COST REPORTING PERIOD (if calendar year, enter 0 on this line)		8
9	INPATIENT DAYS INCLUDING PRIVATE ROOM DAYS APPLICABLE TO THE PROGRAM (excluding swing-bed and newborn days)	2,459	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)	83	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)	83	11
12	SWING-BED NF-TYPE INPATIENT DAYS APPLICABLE TO TITLES V OR XIX ONLY (including private room days) THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD		12
13	SWING-BED NF-TYPE INPATIENT DAYS APPLICABLE TO TITLES V OR XIX ONLY (including private room days) AFTER DECEMBER 31 OF THE COST REPORTING PERIOD (if calendar year, enter 0 on this line)		13
14	MEDICALLY NECESSARY PRIVATE ROOM DAYS APPLICABLE TO THE PROGRAM (excluding swing-bed days)		14
15	TOTAL NURSERY DAYS (Title V or Title XIX only)		15
16	TITLE V OR XIX NURSERY DAYS (Title V or Title XIX only)		16
SWING-BED ADJUSTMENT			
17	MEDICARE RATE FOR SWING-BED SNF SERVICES APPLICABLE TO SERVICES THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD	197.90	17
18	MEDICARE RATE FOR SWING-BED SNF SERVICES APPLICABLE TO SERVICES AFTER DECEMBER 31 OF THE COST REPORTING PERIOD	202.51	18
19	MEDICAID RATE FOR SWING-BED NF SERVICES APPLICABLE TO SERVICES THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD	132.03	19
20	MEDICAID RATE FOR SWING-BED NF SERVICES APPLICABLE TO SERVICES AFTER DECEMBER 31 OF THE COST REPORTING PERIOD	132.03	20
21	TOTAL GENERAL INPATIENT ROUTINE SERVICE COST (see instructions)	5,682,173	21
22	SWING-BED COST APPLICABLE TO SNF-TYPE SERVICES THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD (line 5 x line 17)	19,592	22
23	SWING-BED COST APPLICABLE TO SNF-TYPE SERVICES AFTER DECEMBER 31 OF THE COST REPORTING PERIOD (line 6 x line 18)	19,846	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)	39,438	26
27	GENERAL INPATIENT ROUTINE SERVICE COST NET OF SWING-BED COST	5,642,735	27
PRIVATE ROOM DIFFERENTIAL ADJUSTMENT			
28	GENERAL INPATIENT ROUTINE SERVICE CHARGES (excluding swing-bed and observation bed charges)	2,871,524	28
29	PRIVATE ROOM CHARGES (excluding swing-bed charges)	344,432	29
30	SEMI-PRIVATE ROOM CHARGES (excluding swing-bed charges)	2,527,092	30
31	GENERAL INPATIENT ROUTINE SERVICE COST/CHARGE RATIO (line 27 ÷ line 28)	1.965066	31
32	AVERAGE PRIVATE ROOM PER DIEM CHARGE (line 29 ÷ line 3)	933.42	32
33	AVERAGE SEMI-PRIVATE ROOM PER DIEM CHARGE (line 30 ÷ line 4)	715.69	33
34	AVERAGE PER DIEM PRIVATE ROOM CHARGE DIFFERENTIAL (line 32 minus line 33) (see instructions)	217.73	34
35	AVERAGE PER DIEM PRIVATE ROOM COST DIFFERENTIAL (line 34 x line 31)	427.85	35
36	PRIVATE ROOM COST DIFFERENTIAL ADJUSTMENT (line 3 x line 35)	157,877	36
37	GENERAL INPATIENT ROUTINE SERVICE COST NET OF SWING-BED COST AND PRIVATE ROOM COST DIFFERENTIAL (line 27 - line 36)	5,484,858	37

Optimizer Systems, Inc.

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Micro System

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COMPUTATION OF INPATIENT OPERATING COST

COMPONENT CCN: 14-0210

WORKSHEET D-1
PART II

CHECK TITLE V - I/P HOSPITAL SUB (OTHER) PPS
 APPLICABLE TITLE XVIII, PART A IPF TEFFRA
 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)						1,023.35	38
39	PROGRAM GENERAL INPATIENT ROUTINE SERVICE COST (line 9 x line 38)						2,516,418	39
40	MEDICALLY NECESSARY PRIVATE ROOM COST APPLICABLE TO THE PROGRAM (line 14 x line 35)							40
41	TOTAL PROGRAM GENERAL INPATIENT ROUTINE SERVICE COST (line 39 + line 40)						2,516,418	41
		TOTAL INPATIENT COST	TOTAL INPATIENT DAYS	AVERAGE PER DIEM (col. 1 + col. 2)	PROGRAM DAYS	PROGRAM COST (col. 3 x col. 4)		
		1	2	3	4	5		
42	NURSERY (Titles V and XIX only)							42
	INTENSIVE CARE TYPE INPATIENT HOSPITAL UNITS							
43	INTENSIVE CARE UNIT							43
44	CORONARY CARE UNIT							44
45	BURN INTENSIVE CARE UNIT							45
46	SURGICAL INTENSIVE CARE UNIT							46
47	OTHER SPECIAL CARE (SPECIFY)							47

							1	
48	PROGRAM INPATIENT ANCILLARY SERVICE COST (Worksheet D-3, column 3, line 200)						2,248,138	48
49	TOTAL PROGRAM INPATIENT COSTS (sum of lines 41 through 48)(see instructions)						4,764,556	49

PASS-THROUGH COST ADJUSTMENTS

50	PASS THROUGH COSTS APPLICABLE TO PROGRAM INPATIENT ROUTINE SERVICES (from Worksheet D, sum of Parts I and III)						131,729	50
51	PASS THROUGH COSTS APPLICABLE TO PROGRAM INPATIENT ANCILLARY SERVICES (from Worksheet D, sum of Parts II and IV)						125,619	51
52	TOTAL PROGRAM EXCLUDABLE COST (sum of lines 50 and 51)						257,348	52
53	TOTAL PROGRAM INPATIENT OPERATING COST EXCLUDING CAPITAL RELATED, NONPHYSICIAN ANESTHETIST AND MEDICAL EDUCATION COSTS (line 49 minus line 52)						4,507,208	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)						16,426	64
65	MEDICARE SWING-BED SNF INPATIENT ROUTINE COSTS AFTER DECEMBER 31 OF THE COST REPORTING PERIOD (see instructions) (Title XVIII only)						16,808	65
66	TOTAL MEDICARE SWING-BED SNF INPATIENT ROUTINE COSTS (Title XVIII only For CAH, see instructions)						33,234	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

Optimizer Systems, Inc.

Win L A S H

Micro System

HARRISBURG MEDICAL CENTER, INC. Provider CCN: 14-0210	In Lieu of Form CMS-2552-10	Period : From: 07/01/2013 To: 06/30/2014	Run Date: 11/11/2014 Run Time: 12:00 Version: 2014.10
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COMPUTATION OF INPATIENT OPERATING COST

COMPONENT CCN: 14-0210

WORKSHEET D-1
PARTS III & IV

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

PART IV - COMPUTATION OF OBSERVATION BED PASS-THROUGH COST

87	TOTAL OBSERVATION BED DAYS (see instructions)					1,614	87
88	ADJUSTED GENERAL INPATIENT ROUTINE COST PER DIEM (line 27 + line 2)					1,023.35	88
89	OBSERVATION BED COST (line 87 x line 88) (see instructions)					1,651,687	89
		COST	ROUTINE COST (from line 27)	column 1 + column 2	TOTAL OBSERVATION BED COST (from line 89)		OBSERVATION BED PASS-THROUGH COST col. 3 x col. 4 (see instructions)
		1	2	3	4	5	
90	CAPITAL-RELATED COST	297,429	5,642,735	0.052710	1,651,687	87,060	90
91	NURSING SCHOOL COST						91
92	ALLIED HEALTH COST						92
93	ALL OTHER MEDICAL EDUCATION						93

Optimizer Systems, Inc.

Win L A S H

Micro System

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COMPUTATION OF INPATIENT OPERATING COST

COMPONENT CCN: 14-S210

WORKSHEET D-1
PART I

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

PART I - ALL PROVIDER COMPONENTS

INPATIENT DAYS

1	INPATIENT DAYS (including private room days and swing-bed days, excluding newborn)	9,210	1
2	INPATIENT DAYS (including private room days, excluding swing-bed and newborn days)	9,210	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)	9,210	4
5	TOTAL SWING-BED SNF-TYPE INPATIENT DAYS (including private room days) THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD		5
6	TOTAL SWING-BED SNF-TYPE INPATIENT DAYS (including private room days) AFTER DECEMBER 31 OF THE COST REPORTING PERIOD (if calendar year, enter 0 on this line)		6
7	TOTAL SWING-BED NF-TYPE INPATIENT DAYS (including private room days) THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD		7
8	TOTAL SWING-BED NF-TYPE INPATIENT DAYS (including private room days) AFTER DECEMBER 31 OF THE COST REPORTING PERIOD (if calendar year, enter 0 on this line)		8
9	INPATIENT DAYS INCLUDING PRIVATE ROOM DAYS APPLICABLE TO THE PROGRAM (excluding swing-bed and newborn days)	3,556	9
10	SWING-BED SNF-TYPE INPATIENT DAYS APPLICABLE TO TITLE XVIII ONLY (including private room days) THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD (see instructions)		10
11	SWING-BED SNF-TYPE INPATIENT DAYS APPLICABLE TO TITLE XVIII ONLY (including private room days) AFTER DECEMBER 31 OF THE COST REPORTING PERIOD (if calendar year, enter 0 on this line)		11
12	SWING-BED NF-TYPE INPATIENT DAYS APPLICABLE TO TITLES V OR XIX ONLY (including private room days) THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD		12
13	SWING-BED NF-TYPE INPATIENT DAYS APPLICABLE TO TITLES V OR XIX ONLY (including private room days) AFTER DECEMBER 31 OF THE COST REPORTING PERIOD (if calendar year, enter 0 on this line)		13
14	MEDICALLY NECESSARY PRIVATE ROOM DAYS APPLICABLE TO THE PROGRAM (excluding swing-bed days)		14
15	TOTAL NURSERY DAYS (Title V or Title XIX only)		15
16	TITLE V OR XIX NURSERY DAYS (Title V or Title XIX only)		16

SWING-BED ADJUSTMENT

17	MEDICARE RATE FOR SWING-BED SNF SERVICES APPLICABLE TO SERVICES THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD		17
18	MEDICARE RATE FOR SWING-BED SNF SERVICES APPLICABLE TO SERVICES AFTER DECEMBER 31 OF THE COST REPORTING PERIOD		18
19	MEDICAID RATE FOR SWING-BED NF SERVICES APPLICABLE TO SERVICES THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD		19
20	MEDICAID RATE FOR SWING-BED NF SERVICES APPLICABLE TO SERVICES AFTER DECEMBER 31 OF THE COST REPORTING PERIOD		20
21	TOTAL GENERAL INPATIENT ROUTINE SERVICE COST (see instructions)	5,488,820	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	5,488,820	27

PRIVATE ROOM DIFFERENTIAL ADJUSTMENT

28	GENERAL INPATIENT ROUTINE SERVICE CHARGES (excluding swing-bed and observation bed charges)		28
29	PRIVATE ROOM CHARGES (excluding swing-bed charges)		29
30	SEMI-PRIVATE ROOM CHARGES (excluding swing-bed charges)		30
31	GENERAL INPATIENT ROUTINE SERVICE COST/CHARGE RATIO (line 27 ÷ line 28)		31
32	AVERAGE PRIVATE ROOM PER DIEM CHARGE (line 29 ÷ line 3)		32
33	AVERAGE SEMI-PRIVATE ROOM PER DIEM CHARGE (line 30 ÷ line 4)		33
34	AVERAGE PER DIEM PRIVATE ROOM CHARGE DIFFERENTIAL (line 32 minus line 33) (see instructions)		34
35	AVERAGE PER DIEM PRIVATE ROOM COST DIFFERENTIAL (line 34 x line 31)		35
36	PRIVATE ROOM COST DIFFERENTIAL ADJUSTMENT (line 3 x line 35)		36
37	GENERAL INPATIENT ROUTINE SERVICE COST NET OF SWING-BED COST AND PRIVATE ROOM COST DIFFERENTIAL (line 27 - line 36)	5,488,820	37

Optimizer Systems, Inc.

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Micro System

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COMPUTATION OF INPATIENT OPERATING COST

COMPONENT CCN: 14-S210

WORKSHEET D-1
PART II

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

PART II - HOSPITALS AND SUBPROVIDERS ONLY

PROGRAM INPATIENT OPERATING COST BEFORE PASS-THROUGH COST ADJUSTMENTS

38	ADJUSTED GENERAL INPATIENT ROUTINE SERVICE COST PER DIEM (see instructions)	595.96	38
39	PROGRAM GENERAL INPATIENT ROUTINE SERVICE COST (line 9 x line 38)	2,119,234	39
40	MEDICALLY NECESSARY PRIVATE ROOM COST APPLICABLE TO THE PROGRAM (line 14 x line 35)		40
41	TOTAL PROGRAM GENERAL INPATIENT ROUTINE SERVICE COST (line 39 + line 40)	2,119,234	41
48	PROGRAM INPATIENT ANCILLARY SERVICE COST (Worksheet D-3, column 3, line 200)	464,209	48
49	TOTAL PROGRAM INPATIENT COSTS (sum of lines 41 through 48)(see instructions)	2,583,443	49

PASS-THROUGH COST ADJUSTMENTS

50	PASS THROUGH COSTS APPLICABLE TO PROGRAM INPATIENT ROUTINE SERVICES (from Worksheet D, sum of Parts I and III)	90,927	50
51	PASS THROUGH COSTS APPLICABLE TO PROGRAM INPATIENT ANCILLARY SERVICES (from Worksheet D, sum of Parts II and IV)	19,005	51
52	TOTAL PROGRAM EXCLUDABLE COST (sum of lines 50 and 51)	109,932	52
53	TOTAL PROGRAM INPATIENT OPERATING COST EXCLUDING CAPITAL RELATED, NONPHYSICIAN ANESTHETIST AND MEDICAL EDUCATION COSTS (line 49 minus line 52)	2,473,511	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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Micro System

HARRISBURG MEDICAL CENTER, INC. Provider CCN: 14-0210	In Lieu of Form CMS-2552-10	Period : From: 07/01/2013 To: 06/30/2014	Run Date: 11/11/2014 Run Time: 12:00 Version: 2014.10
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INPATIENT ANCILLARY SERVICE COST APPORTIONMENT

COMPONENT CCN: 14-0210

WORKSHEET D-3

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

(A)	COST CENTER DESCRIPTION	RATIO OF COST TO CHARGES	INPATIENT PROGRAM CHARGES	INPATIENT PROGRAM COSTS (col. 1 x col. 2)	
		1	2	3	
	INPATIENT ROUTINE SERVICE COST CENTERS				
30	ADULTS & PEDIATRICS		2,337,175		30
40	SUBPROVIDER - IPF				40
	ANCILLARY SERVICE COST CENTERS				
50	OPERATING ROOM	0.782329	166,979	130,633	50
53	ANESTHESIOLOGY	0.151999	161,777	24,590	53
54	RADIOLOGY-DIAGNOSTIC	0.328183	331,882	108,918	54
57	CT SCAN	0.040593	1,466,969	59,549	57
60	LABORATORY	0.170034	2,314,993	393,628	60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS				62.30
64	INTRAVENOUS THERAPY	0.026051	2,626,258	68,417	64
65	RESPIRATORY THERAPY	0.305082	756,729	230,864	65
66	PHYSICAL THERAPY	0.423313	301,533	127,643	66
69	ELECTROCARDIOLOGY	0.093090	211,719	19,709	69
71	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.379354	504,529	191,395	71
72	IMPL. DEV. CHARGED TO PATIENTS	0.440301	9,588	4,222	72
73	DRUGS CHARGED TO PATIENTS	0.403897	913,513	368,965	73
75	ASC (NON-DISTINCT PART)	0.334902	185,030	61,967	75
76	NUCLEAR MEDICINE	0.240524	26,721	6,427	76
76.01	ULTRASOUND	0.119605	458,476	54,836	76.01
76.02	MAMMOGRAPHY	0.260534			76.02
76.03	CARDIAC REHABILITATION	0.352133	1,286	453	76.03
76.04	FAITH CENTER CHEMOTHERAPY	0.992353			76.04
76.06	ROUTINE ANCILLARY				76.06
76.97	CARDIAC REHABILITATION				76.97
76.98	HYPERBARIC OXYGEN THERAPY				76.98
76.99	LITHOTRIPSY				76.99
	OUTPATIENT SERVICE COST CENTERS				
88	RURAL HEALTH CLINIC				88
88.01	RHC II				88.01
91	EMERGENCY	0.367761	504,850	185,664	91
92	OBSERVATION BEDS (NON-DISTINCT PART)	0.494246	425,411	210,258	92
93	DAY PSYCHIATRIC	0.408959			93
	OTHER REIMBURSABLE COST CENTERS				
200	TOTAL (sum of lines 50-94, and 96-98)		11,368,243	2,248,138	200
201	LESS PBP CLINIC LABORATORY SERVICES-PROGRAM ONLY CHARGES (line 61)				201
202	NET CHARGES (line 200 minus line 201)		11,368,243		202

(A) Worksheet A line numbers

Optimizer Systems, Inc.

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Micro System

HARRISBURG MEDICAL CENTER, INC. Provider CCN: 14-0210	In Lieu of Form CMS-2552-10	Period : From: 07/01/2013 To: 06/30/2014	Run Date: 11/11/2014 Run Time: 12:00 Version: 2014.10
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INPATIENT ANCILLARY SERVICE COST APPORTIONMENT

COMPONENT CCN: 14-S210

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/MR OTHER

(A)	COST CENTER DESCRIPTION	RATIO OF COST TO CHARGES	INPATIENT PROGRAM CHARGES	INPATIENT PROGRAM COSTS (col. 1 x col. 2)	
		1	2	3	
	INPATIENT ROUTINE SERVICE COST CENTERS				
30	ADULTS & PEDIATRICS				30
40	SUBPROVIDER - IPF		4,119,704		40
	ANCILLARY SERVICE COST CENTERS				
50	OPERATING ROOM	0.782329			50
53	ANESTHESIOLOGY	0.151999	21,578	3,280	53
54	RADIOLOGY-DIAGNOSTIC	0.328183	34,767	11,410	54
57	CT SCAN	0.040593	147,215	5,976	57
60	LABORATORY	0.170034	323,461	54,999	60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS				62.30
64	INTRAVENOUS THERAPY	0.026051	48,425	1,262	64
65	RESPIRATORY THERAPY	0.305082	156,690	47,803	65
66	PHYSICAL THERAPY	0.423313	43,449	18,393	66
69	ELECTROCARDIOLOGY	0.093090	27,937	2,601	69
71	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.379354	63,028	23,910	71
72	IMPL. DEV CHARGED TO PATIENTS	0.440301			72
73	DRUGS CHARGED TO PATIENTS	0.403897	636,285	256,994	73
75	ASC (NON-DISTINCT PART)	0.334902	2,648	887	75
76	NUCLEAR MEDICINE	0.240524			76
76.01	ULTRASOUND	0.119605	12,137	1,452	76.01
76.02	MAMMOGRAPHY	0.260534			76.02
76.03	CARDIAC REHABILITATION	0.352133			76.03
76.04	FAITH CENTER CHEMOTHERAPY	0.992355			76.04
76.06	ROUTINE ANCILLARY				76.06
76.97	CARDIAC REHABILITATION				76.97
76.98	HYPERBARIC OXYGEN THERAPY				76.98
76.99	LITHOTRIPSY				76.99
	OUTPATIENT SERVICE COST CENTERS				
88	RURAL HEALTH CLINIC				88
88.01	RHC II				88.01
91	EMERGENCY	0.367761	95,828	35,242	91
92	OBSERVATION BEDS (NON-DISTINCT PART)	0.494246			92
93	DAY PSYCHIATRIC	0.408959			93
	OTHER REIMBURSABLE COST CENTERS				
200	TOTAL (sum of lines 50-94, and 96-98)		1,613,448	464,209	200
201	LESS PBP CLINIC LABORATORY SERVICES-PROGRAM ONLY CHARGES (line 61)				201
202	NET CHARGES (line 200 minus line 201)		1,613,448		202

(A) Worksheet A line numbers

Optimizer Systems, Inc.

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Micro System

HARRISBURG MEDICAL CENTER, INC. Provider CCN: 14-0210	In Lieu of Form CMS-2552-10	Period : From: 07/01/2013 To: 06/30/2014	Run Date: 11/11/2014 Run Time: 12:00 Version: 2014.10
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INPATIENT ANCILLARY SERVICE COST APPORTIONMENT

COMPONENT CCN: 14-0210

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/MR OTHER

(A)	COST CENTER DESCRIPTION	RATIO OF COST TO CHARGES	INPATIENT PROGRAM CHARGES	INPATIENT PROGRAM COSTS (col. 1 x col. 2)	
		1	2	3	
	INPATIENT ROUTINE SERVICE COST CENTERS				
30	ADULTS & PEDIATRICS				30
40	SUBPROVIDER - IPF				40
	ANCILLARY SERVICE COST CENTERS				
50	OPERATING ROOM	0.782329			50
53	ANESTHESIOLOGY	0.151999			53
54	RADIOLOGY-DIAGNOSTIC	0.328183	2,708	889	54
57	CT SCAN	0.040593			57
60	LABORATORY	0.169944	27,046	4,596	60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS				62.30
64	INTRAVENOUS THERAPY	0.026051	12,423	324	64
65	RESPIRATORY THERAPY	0.305082	24,635	7,516	65
66	PHYSICAL THERAPY	0.423313	83,403	35,306	66
69	ELECTROCARDIOLOGY	0.093090	538	50	69
71	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.379354	9,625	3,631	71
72	IMPL. DEV. CHARGED TO PATIENTS	0.440301			72
73	DRUGS CHARGED TO PATIENTS	0.403897	24,890	10,053	73
75	ASC (NON-DISTINCT PART)	0.334902	1,823	611	75
76	NUCLEAR MEDICINE	0.240524			76
76.01	ULTRASOUND	0.119605	366	44	76.01
76.02	MAMMOGRAPHY	0.260534			76.02
76.03	CARDIAC REHABILITATION	0.352133			76.03
76.04	FAITH CENTER CHEMOTHERAPY	0.992353			76.04
76.06	ROUTINE ANCILLARY				76.06
76.97	CARDIAC REHABILITATION				76.97
76.98	HYPERBARIC OXYGEN THERAPY				76.98
76.99	LITHOTRIPSY				76.99
	OUTPATIENT SERVICE COST CENTERS				
88	RURAL HEALTH CLINIC				88
88.01	RHC II				88.01
91	EMERGENCY	0.365334			91
92	OBSERVATION BEDS (NON-DISTINCT PART)	0.494246			92
93	DAY PSYCHIATRIC	0.408959			93
	OTHER REIMBURSABLE COST CENTERS				
200	TOTAL (sum of lines 50-94, and 96-98)		187,457	63,040	200
201	LESS PBP CLINIC LABORATORY SERVICES-PROGRAM ONLY CHARGES (line 61)				201
202	NET CHARGES (line 200 minus line 201)		187,457		202

(A) Worksheet A line numbers

Optimizer Systems, Inc.

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Micro System

HARRISBURG MEDICAL CENTER, INC. Provider CCN: 14-0210	In Lieu of Form CMS-2552-10	Period : From: 07/01/2013 To: 06/30/2014	Run Date: 11/11/2014 Run Time: 12:00 Version: 2014.10
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CALCULATION OF REIMBURSEMENT SETTLEMENT

WORKSHEET E
PART A

CHECK HOSPITAL
APPLICABLE BOX:

PART A - INPATIENT HOSPITAL SERVICES UNDER PPS

		1	1.01	1.02	
1	DRG AMOUNTS OTHER THAN OUTLIER PAYMENTS				1
1.01	DRG AMOUNTS OTHER THAN OUTLIER PAYMENTS FOR DISCHARGES OCCURRING PRIOR TO OCTOBER 1, 2013 (see instructions)	833,250			1.01
1.02	DRG AMOUNTS OTHER THAN OUTLIER PAYMENTS FOR DISCHARGES OCCURRING ON OR AFTER OCTOBER 1, 2013 (see instructions)	3,154,022			1.02
1.03	DRG FOR FEDERAL SPECIFIC OPERATING PAYMENT FOR MODEL 4 BPCI (see instructions)				1.03
2	OUTLIER PAYMENTS FOR DISCHARGES (see instructions)	4,747			2
2.01	OUTLIER RECONCILIATION AMOUNT				2.01
2.02	OUTLIER PAYMENT FOR MODEL 4 BPCI (see instructions)				
3	MANAGED CARE SIMULATED PAYMENTS				3
4	BED DAYS AVAILABLE DIVIDED BY NUMBER OF DAYS IN THE COST REPORTING PERIOD (see instructions)	32.04			4
INDIRECT MEDICAL EDUCATION ADJUSTMENT CALCULATION FOR HOSPITALS					
5	FTE COUNT FOR ALLOPATHIC AND OSTEOPATHIC PROGRAMS FOR THE MOST RECENT COST REPORTING PERIOD ENDING ON OR BEFORE 12/31/1996 (see instructions)				5
6	FTE COUNT FOR ALLOPATHIC AND OSTEOPATHIC PROGRAMS WHICH MEET THE CRITERIA FOR AN ADD-ON TO THE CAP FOR NEW PROGRAMS IN ACCORDANCE WITH 42 CFR 413.79(e)				6
7	MMA SECTION 422 REDUCTION AMOUNT TO THE IME CAP AS SPECIFIED UNDER 42 CFR §412.105(p)(1)(iv)(B)(1)				7
7.01	ACA SECTION 5503 REDUCTION AMOUNT TO THE IME CAP AS SPECIFIED UNDER 42 CFR §412.105(p)(1)(iv)(B)(2). IF THE COST REPORT STRADDLES JULY 1, 2011 THEN SEE INSTRUCTIONS				7.01
8	ADJUSTMENT (INCREASE OR DECREASE) TO THE FTE COUNT FOR ALLOPATHIC AND OSTEOPATHIC PROGRAMS FOR AFFILIATED PROGRAMS IN ACCORDANCE WITH 42 CFR §413.75(b), §413.79(e)(2)(iv) AND VOL. 64 FEDERAL REGISTER, MAY 12, 1998, PAGE 26340 AND VOL. 67 FEDERAL REGISTER, PAGE 50069, AUGUST 1, 2002				8
8.01	THE AMOUNT OF INCREASE IF THE HOSPITAL WAS AWARDED FTE CAP SLOTS UNDER SECTION 5503 OF THE ACA. IF THE COST REPORT STRADDLES JULY 1, 2011, SEE INSTRUCTIONS				8.01
8.02	THE AMOUNT OF INCREASE IF THE HOSPITAL WAS AWARDED FTE CAP SLOTS FROM A CLOSED TEACHING HOSPITAL UNDER SECTION 5506 OF ACA. (see instructions)				8.02
9	SUM OF LINES 5 PLUS 6 MINUS LINES (7 AND 7.01) PLUS/MINUS LINES (8, 8.01 AND 8.02) (see instructions)				9
10	FTE COUNT FOR ALLOPATHIC AND OSTEOPATHIC PROGRAMS IN THE CURRENT YEAR FROM YOUR RECORDS				10
11	FTE COUNT FOR RESIDENTS IN DENTAL AND AND PODIATRIC PROGRAMS				11
12	CURRENT YEAR ALLOWABLE FTE (see instructions)				12
13	TOTAL ALLOWABLE FTE COUNT FOR THE PRIOR YEAR				13
14	TOTAL ALLOWABLE FTE COUNT FOR THE PENULTIMATE YEAR IF THAT YEAR ENDED ON OR AFTER SEPTEMBER 30, 1997, OTHERWISE ENTER ZERO				14
15	SUM OF LINES 12 THROUGH 14 DIVIDED BY 3				15
16	ADJUSTMENT FOR RESIDENTS IN INITIAL YEARS OF THE PROGRAM				16
17	ADJUSTMENT FOR RESIDENTS DISPLACED BY PROGRAM OR HOSPITAL CLOSURE				17
18	ADJUSTED ROLLING AVERAGE FTE COUNT				18
19	CURRENT YEAR RESIDENT TO BED RATIO (line 18 divided by line 4)				19
20	PRIOR YEAR RESIDENT TO BED RATIO (see instructions)				20
21	ENTER THE LESSER OF LINES 19 OR 20 (see instructions)				21
22	IME PAYMENT ADJUSTMENT (see instructions)				22
INDIRECT MEDICAL EDUCATION ADJUSTMENT FOR THE ADD-ON					
23	NUMBER OF ADDITIONAL ALLOPATHIC AND OSTEOPATHIC IME FTE RESIDENT CAP SLOTS UNDER 42 SEC. 412.105(p)(1)(iv)(C)				23
24	IME FTE RESIDENT COUNT OVER CAP (see instructions)				24
25	IF THE AMOUNT ON LINE 24 IS GREATER THAN -0-, THEN ENTER THE LOWER OF LINE 23 OR LINE 24 (see instructions)				25
26	RESIDENT TO BED RATIO (divide line 25 by line 4)				26
27	IME PAYMENTS ADJUSTMENT (see instructions)				27
28	IME ADJUSTMENT (see instructions)				28
29	TOTAL IME PAYMENT (sum of lines 22 and 28)				29
DISPROPORTIONATE SHARE ADJUSTMENT					
30	PERCENTAGE OF SSI RECIPIENT PATIENT DAYS TO MEDICARE PART A PATIENT DAYS (see instructions)	-0.0622			30
31	PERCENTAGE OF MEDICAID PATIENT DAYS TO TOTAL (see instructions)	0.1251			31
32	SUM OF LINES 30 AND 31	0.1873			32
33	ALLOWABLE DISPROPORTIONATE SHARE PERCENTAGE (see instructions)	0.0492			33
34	DISPROPORTIONATE SHARE ADJUSTMENT (see instructions)	79,790			34
UNCOMPENSATED CARE ADJUSTMENT					
		PRIOR TO	ON OR AFTER		
		OCTOBER 1	OCTOBER 1		
35	TOTAL UNCOMPENSATED CARE AMOUNT (see instructions)		9,046,380,143		35
35.01	FACTOR 3 (see instructions)		0.000152760		35.01
35.02	HOSPITAL UNCOMPENSATED CARE PAYMENT (if line 34 is zero, enter zero on this line) (see instructions)		1,381,925		35.02
35.03	PRO RATA SHARE OF THE HOSPITAL UNCOMPENSATED CARE PAYMENT AMOUNT (see instructions)		1,033,604		35.03
36	TOTAL UNCOMPENSATED CARE (sum of columns 1 and 2 on line 35.03)	1,033,604			36
ADDITIONAL PAYMENT FOR HIGH PERCENTAGE OF ESRD BENEFICIARY DISCHARGES					
40	TOTAL MEDICARE DISCHARGES ON WORKSHEET S-3, PART I EXCLUDING DISCHARGES FOR MS-DRGs 652, 682, 683, 684 AND 685 (see instructions)				40

Optimizer Systems, Inc.

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Micro System

HARRISBURG MEDICAL CENTER, INC. Provider CCN: 14-0210	In Lieu of Form CMS-2552-10	Period : From: 07/01/2013 To: 06/30/2014	Run Date: 11/11/2014 Run Time: 12:00 Version: 2014.10
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CALCULATION OF REIMBURSEMENT SETTLEMENT

WORKSHEET E
PART A

CHECK HOSPITAL
APPLICABLE BOX:

PART A - INPATIENT HOSPITAL SERVICES UNDER PPS

		1	1.01	1.02	
41	TOTAL ESRD MEDICARE DISCHARGES EXCLUDING MS-DRGs 652, 682, 683, 684 AND 685 (see instructions)				41
41.01	TOTAL ESRD MEDICARE COVERED AND PAID DISCHARGES EXCLUDING MS-DRGs 652, 682, 683, 684 AND 685 (see instructions)				41.01
42	DIVIDE LINE 41 BY LINE 40 (if less than 10%, you do not qualify for adjustment)				42
43	TOTAL MEDICARE ESRD INPATIENT DAYS EXCLUDING MS-DRGs 652, 682, 683, 684 AND 685 (see instructions)				43
44	RATIO OF AVERAGE LENGTH OF STAY TO ONE WEEK (line 43 divided by line 41.01 divided by 7 days)				44
45	AVERAGE WEEKLY COST FOR DIALYSIS TREATMENTS (see instructions)				45
46	TOTAL ADDITIONAL PAYMENT (line 45 times line 44 times line 41.01)				46
47	SUBTOTAL (see instructions)	5,105,413			47
48	HOSPITAL SPECIFIC PAYMENTS (to be completed by SCH and MDH, small rural hospitals only (see instructions)	4,692,291			48
49	TOTAL PAYMENT FOR INPATIENT OPERATING COSTS SCH AND MDH ONLY (see instructions)	5,105,413			49
50	PAYMENT FOR INPATIENT PROGRAM CAPITAL (from Wkst L, Parts I, II, as applicable)	313,836			50
51	EXCEPTION PAYMENT FOR INPATIENT PROGRAM CAPITAL (Wkst L, Part III) (see instructions)				51
52	DIRECT GRADUATE MEDICAL EDUCATION PAYMENT (from Wkst E-4, line 49) (see instructions)				52
53	NURSING AND ALLIED HEALTH MANAGED CARE PAYMENT				53
54	SPECIAL ADD-ON PAYMENTS FOR NEW TECHNOLOGIES				54
55	NET ORGAN ACQUISITION COST (Wkst D-4, Part III, col. 1, line 69)				55
56	COST OF TEACHING PHYSICIANS (Wkst D-5, Part II, col. 3, line 20)				56
57	ROUTINE SERVICE OTHER PASS THROUGH COSTS				57
58	ANCILLARY SERVICE OTHER PASS THROUGH COSTS (Wkst D, Part IV, col. 11, line 200)				58
59	TOTAL (sum of amounts on lines 49 through 58)	5,419,249			59
60	PRIMARY PAYER PAYMENTS				60
61	TOTAL AMOUNT PAYABLE FOR PROGRAM BENEFICIARIES (line 59 minus line 60)	5,419,249			61
62	DEDUCTIBLES BILLED TO PROGRAM BENEFICIARIES	675,392			62
63	COINSURANCE BILLED TO PROGRAM BENEFICIARIES	6,032			63
64	ALLOWABLE BAD DEBTS (see instructions)	205,729			64
65	ADJUSTED REIMBURSABLE BAD DEBTS (see instructions)	133,724			65
66	ALLOWABLE BAD DEBTS FOR DUAL ELIGIBLE BENEFICIARIES (see instructions)	180,260			66
67	SUBTOTAL (line 61 plus line 65 minus lines 62 and 63)	4,871,549			67
68	CREDITS RECEIVED FROM MANUFACTURERS FOR REPLACED DEVICES APPLICABLE TO MS-DRG (see instructions)				68
69	OUTLIER PAYMENTS RECONCILIATION				69
70	OTHER ADJUSTMENTS (SPECIFY) (see instructions)				70
70.93	HVBP PAYMENT ADJUSTMENT (see instructions)	-13,611			70.93
70.94	HOSPITAL READMISSIONS REDUCTION ADJUSTMENT (see instructions)	-28,845			70.94
70.96	LOW VOLUME ADJUSTMENT FOR FEDERAL FISCAL YEAR (2013)	81,539			70.96
70.97	LOW VOLUME ADJUSTMENT FOR FEDERAL FISCAL YEAR (2014)	682,354			70.97
71	AMOUNT DUE PROVIDER (see instructions)	5,592,986			71
71.01	SEQUESTRATION ADJUSTMENT (see instructions)	111,860			71.01
72	INTERIM PAYMENTS	5,382,627			72
73	TENTATIVE SETTLEMENT (for contractor use only)				73
74	BALANCE DUE PROVIDER/PROGRAM (line 71 minus lines 71.01, 72 and 73)	98,499			74
75	PROTESTED AMOUNTS (nonallowable cost report items) IN ACCORDANCE WITH CMS PUB. 15-2, SECTION 115.2				75

TO BE COMPLETED BY CONTRACTOR

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

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Micro System

HARRISBURG MEDICAL CENTER, INC. Provider CCN: 14-0210	Supporting Exhibit for Form CMS-2552-10	Period : From: 07/01/2013 To: 06/30/2014	Run Date: 11/11/2014 Run Time: 12:00 Version: 2014.10
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LOW VOLUME ADJUSTMENT CALCULATION SCHEDULE (For Worksheet E Part A, Lines 70.96 and 70.97)

EXHIBIT 4

	AMOUNTS FROM E PART A	PRIOR TO 10/1/2010 OR AFTER 3/31/2015 PRE/POST ENTITLEMENT	10/01/2012 through 09/30/2013	3.01	10/01/2013 through 09/30/2014	4.01	(COLUMNS 2 THROUGH 4) TOTAL	
	1	2	3		4		5	
1	DRG Amounts Other Than Outlier Payments							1
1.01	DRG Amounts Other Than Outlier Payments for Discharges prior to 10/1/2013	833,250		833,250			833,250	1.01
1.02	DRG Amounts Other Than Outlier Payments for Discharges on/after 10/1/2013	3,154,022			3,154,022		3,154,022	1.02
1.03	DRG for Federal Specific Operating Payment for Model 4 BPCI							1.03
2	Outlier Payments for Discharges	4,747			4,747		4,747	2
2.01	Outlier Payment for Discharges for Model 4 BPCI							2.01
3	Operating Outlier Reconciliation							3
4	Managed Care Simulated Payments							4
	INDIRECT MEDICAL EDUCATION ADJUSTMENT							
5	Amount from Worksheet E Part A, Line 21							5
6	IME Payment Adjustment							6
	INDIRECT MEDICAL EDUCATION ADJUSTMENT FOR THE ADD-ON FOR MME SECTION 422							
7	Amount from Worksheet E Part A, Line 27							7
8	IME Add-on Adjustment							8
9	Total IME Payment							9
	DISPROPORTIONATE SHARE ADJUSTMENT							
10	Allowable Disproportionate Share Percentage	0.0492	0.0492	0.0492	0.0492	0.0492	0.0492	10
11	Disproportionate Share Adjustment	79,790		40,995			79,790	11
11.01	Uncompensated Care Payments	1,033,604				1,033,604	1,033,604	11.01
	ADDITIONAL PAYMENT FOR HIGH PERCENTAGE OF ESRD BENEFICIARY DISCHARGES							
12	Total ESRD Additional Payment							12
13	Subtotal	5,105,413		874,245		4,231,168	5,105,413	13
14	Hospital Specific Payments	4,692,291		1,173,073		3,519,218	4,692,291	14
15	Total Payment for Inpatient Operating Costs - E Part A Line 49	5,105,413		874,245		4,231,168	5,105,413	15
16	Payment for Inpatient Program Capital	313,836		65,296		248,540	313,836	16
17	Special Add-on Payments for New Technologies							17
18	Capital Outlier Reconciliation Adjustment Amount							18
19	Subtotal			939,541		4,479,708	5,419,249	19
	CAPITAL PAYMENTS							
20	Capital DRG Other Than Outlier	313,651		65,296		248,355	313,651	20
20.01	Model 4 BPCI Capital DRG Other Than Outlier							20.01
21	Capital DRG Outlier Payments	185				185	185	21
21.01	Model 4 BPCI Capital DRG Outlier Payments							21.01
22	Indirect Medical Education Percentage							22
23	Indirect Medical Education Adjustment							23
24	Allowable Disproportionate Share Percentage							24
25	Disproportionate Share Adjustment							25
26	Total Prospective Capital Payments	313,836		65,296		248,540	313,836	26
	LOW VOLUME ADJUSTMENT							
27	Low Volume Adjustment Factor			0.086786		0.152321		27
28	Low Volume Adjustment			81,539			81,539	28
29	Low Volume Adjustment					682,354	682,354	29

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HARRISBURG MEDICAL CENTER, INC. Provider CCN: 14-0210	In Lieu of Form CMS-2552-10	Period : From: 07/01/2013 To: 06/30/2014	Run Date: 11/11/2014 Run Time: 12:00 Version: 2014.10
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CALCULATION OF REIMBURSEMENT SETTLEMENT

COMPONENT CCN: 14-0210

WORKSHEET E
PART B

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

PART B - MEDICAL AND OTHER HEALTH SERVICES

	1	1.01	1.02	
1	MEDICAL AND OTHER SERVICES (see instructions)			1
2	MEDICAL AND OTHER SERVICES REIMBURSED UNDER OPPTS (see instructions)	5,246,048		2
3	PPS PAYMENTS	4,652,869		3
4	OUTLIER PAYMENT (see instructions)	3,045		4
5	ENTER THE HOSPITAL SPECIFIC PAYMENT TO COST RATIO (see instructions)	0.850		5
6	LINE 2 TIMES LINE 5	4,459,141		6
7	SUM OF LINE 3 PLUS LINE 4 DIVIDED BY LINE 6			7
8	TRANSITIONAL CORRIDOR PAYMENT (see instructions)			8
9	ANCILLARY SERVICE OTHER PASS THROUGH COSTS FROM WKST D, PART IV, COL. 13, LINE 200			9
10	ORGAN ACQUISITION			10
11	TOTAL COST (sum of lines 1 and 10) (see instructions)			11
	COMPUTATION OF LESSER OF COST OR CHARGES			
	REASONABLE CHARGES			12
12	ANCILLARY SERVICE CHARGES			13
13	ORGAN ACQUISITION CHARGES (from Wkst D-4, Part III, line 69, col. 4)			14
14	TOTAL REASONABLE CHARGES (sum of lines 12 and 13)			14
	CUSTOMARY CHARGES			
15	AGGREGATE AMOUNT ACTUALLY COLLECTED FROM PATIENTS LIABLE FOR PAYMENT FOR SERVICES ON A CHARGE BASIS			15
16	AMOUNTS THAT WOULD HAVE BEEN REALIZED FROM PATIENTS LIABLE FOR PAYMENT FOR SERVICES ON A CHARGE BASIS HAD SUCH PAYMENT BEEN MADE IN ACCORDANCE WITH 42 CFR 413.13(e)			16
17	RATIO OF LINE 15 TO LINE 16 (not to exceed 1.000000)	1.000000		17
18	TOTAL CUSTOMARY CHARGES (see instructions)			18
19	EXCESS OF CUSTOMARY CHARGES OVER REASONABLE COST (complete only if line 18 exceeds line 11 (see instructions))			19
20	EXCESS OF REASONABLE COST OVER CUSTOMARY CHARGES (complete only if line 11 exceeds line 18 (see instructions))			20
21	LESSER OF COST OR CHARGES (line 11 minus line 20) (for CAH, see instructions)			21
22	INTERNS AND RESIDENTS (see instructions)			22
23	COST OF TEACHING PHYSICIANS (see instructions, 42 CFR 415.160 and CMS PUB. 15-1 \$2148)			23
24	TOTAL PROSPECTIVE PAYMENT (sum of lines 3, 4, 8 and 9)	4,655,914		24
	COMPUTATION OF REIMBURSEMENT SETTLEMENT			
25	DEDUCTIBLES AND COINSURANCE (see instructions)			25
26	DEDUCTIBLES AND COINSURANCE RELATING TO AMOUNT ON LINE 24 (see instructions)	1,078,059		26
27	SUBTOTAL (lines 21 and 24 - the sum of lines 25 and 26) plus the sum of lines 22 and 23) (see instructions)	3,577,855		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)	3,577,855		29
30	SUBTOTAL (sum of lines 27 through 29)	185		30
31	PRIMARY PAYER PAYMENTS	3,577,670		31
32	SUBTOTAL (line 30 minus line 31)			32
	ALLOWABLE BAD DEBTS (EXCLUDE BAD DEBTS FOR PROFESSIONAL SERVICES)			
33	COMPOSITE RATE ESRD (from Wkst I-5, line 11)			33
34	ALLOWABLE BAD DEBTS (see instructions)	332,647		34
35	ADJUSTED REIMBURSABLE BAD DEBTS (see instructions)	216,221		35
36	ALLOWABLE BAD DEBTS FOR DUAL ELIGIBLE BENEFICIARIES (see instructions)	294,897		36
37	SUBTOTAL (see instructions)	3,793,891		37
38	MSP-LCC RECONCILIATION AMOUNT FROM PS&R	148		38
39	OTHER ADJUSTMENTS (SPECIFY) (see instructions)			39
40	SUBTOTAL (see instructions)	3,793,743		40
40.01	SEQUESTRATION ADJUSTMENT (see instructions)	75,875		40.01
41	INTERIM PAYMENTS	3,748,566		41
42	TENTATIVE SETTLEMENT (for contractor use only)			42
43	BALANCE DUE PROVIDER/PROGRAM (see instructions)	-30,698		43
44	PROTESTED AMOUNTS (nonallowable cost report items) IN ACCORDANCE WITH CMS PUB. 15-11, SECTION 115.2			44

TO BE COMPLETED BY CONTRACTOR

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

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CALCULATION OF REIMBURSEMENT SETTLEMENT

COMPONENT CCN: 14-5210

WORKSHEET E
PART B

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

PART B - MEDICAL AND OTHER HEALTH SERVICES

	1	1.01	1.02	
1	MEDICAL AND OTHER SERVICES (see instructions)			1
2	MEDICAL AND OTHER SERVICES REIMBURSED UNDER OPPS (see instructions)	3,313		2
3	PPS PAYMENTS	3,440		3
4	OUTLIER PAYMENT (see instructions)			4
5	ENTER THE HOSPITAL SPECIFIC PAYMENT TO COST RATIO (see instructions)			5
6	LINE 2 TIMES LINE 5			6
7	SUM OF LINE 3 PLUS LINE 4 DIVIDED BY LINE 6			7
8	TRANSITIONAL CORRIDOR PAYMENT (see instructions)			8
9	ANCILLARY SERVICE OTHER PASS THROUGH COSTS FROM WKST D, PART IV, COL. 13, LINE 200			9
10	ORGAN ACQUISITION			10
11	TOTAL COST (sum of lines 1 and 10) (see instructions)			11
	COMPUTATION OF LESSER OF COST OR CHARGES			
	REASONABLE CHARGES			
12	ANCILLARY SERVICE CHARGES			12
13	ORGAN ACQUISITION CHARGES (from Wkst D-4, Part III, line 69, col. 4)			13
14	TOTAL REASONABLE CHARGES (sum of lines 12 and 13)			14
	CUSTOMARY CHARGES			
15	AGGREGATE AMOUNT ACTUALLY COLLECTED FROM PATIENTS LIABLE FOR PAYMENT FOR SERVICES ON A CHARGE BASIS			15
16	AMOUNTS THAT WOULD HAVE BEEN REALIZED FROM PATIENTS LIABLE FOR PAYMENT FOR SERVICES ON A CHARGE BASIS HAD SUCH PAYMENT BEEN MADE IN ACCORDANCE WITH 42 CFR 413.13(e)			16
17	RATIO OF LINE 15 TO LINE 16 (not to exceed 1.000000)	1.000000		17
18	TOTAL CUSTOMARY CHARGES (see instructions)			18
19	EXCESS OF CUSTOMARY CHARGES OVER REASONABLE COST (complete only if line 18 exceeds line 11 (see instructions))			19
20	EXCESS OF REASONABLE COST OVER CUSTOMARY CHARGES (complete only if line 11 exceeds line 18 (see instructions))			20
21	LESSER OF COST OR CHARGES (line 11 minus line 20) (for CAH, see instructions)			21
22	INTERNS AND RESIDENTS (see instructions)			22
23	COST OF TEACHING PHYSICIANS (see instructions, 42 CFR 415.160 and CMS PUB. 15-1 §2148)			23
24	TOTAL PROSPECTIVE PAYMENT (sum of lines 3, 4, 8 and 9)	3,440		24
	COMPUTATION OF REIMBURSEMENT SETTLEMENT			
25	DEDUCTIBLES AND COINSURANCE (see instructions)			25
26	DEDUCTIBLES AND COINSURANCE RELATING TO AMOUNT ON LINE 24 (see instructions)	761		26
27	SUBTOTAL ((lines 21 and 24 - the sum of lines 25 and 26) plus the sum of lines 22 and 23) (see instructions)	2,679		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)	2,679		30
31	PRIMARY PAYER PAYMENTS			31
32	SUBTOTAL (line 30 minus line 31)	2,679		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)	2,679		37
38	MSP-LCC RECONCILIATION AMOUNT FROM PS&R			38
39	OTHER ADJUSTMENTS (SPECIFY) (see instructions)			39
40	SUBTOTAL (see instructions)	2,679		40
40.01	SEQUESTRATION ADJUSTMENT (see instructions)	54		40.01
41	INTERIM PAYMENTS	2,625		41
42	TENTATIVE SETTLEMENT (for contractor use only)			42
43	BALANCE DUE PROVIDER/PROGRAM (see instructions)			43
44	PROTESTED AMOUNTS (nonallowable cost report items) IN ACCORDANCE WITH CMS PUB. 15-II, SECTION 115.2			44

TO BE COMPLETED BY CONTRACTOR

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

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ANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED

COMPONENT CCN: 14-0210

WORKSHEET E-1
PART 1

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

DESCRIPTION	INPATIENT PART A		PART B		
	mm/dd/yyyy	AMOUNT	mm/dd/yyyy	AMOUNT	
1 TOTAL INTERIM PAYMENTS PAID TO PROVIDER		5,382,627		3,748,566	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					3.01
RATE FOR THE COST REPORTING PERIOD. ALSO SHOW DATE OF EACH PAYMENT. IF NONE, WRITE 'NONE' OR ENTER A ZERO. (1)					3.02
	PROGRAM				3.03
	TO				3.04
	PROVIDER				3.05
					3.06
					3.07
					3.08
					3.09
					3.10
					3.50
					3.51
	PROVIDER				3.52
	TO				3.53
	PROGRAM				3.54
					3.55
					3.56
					3.57
					3.58
					3.59
SUBTOTAL (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98)					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)		5,382,627		3,748,566	4
TO BE COMPLETED BY CONTRACTOR					
5 LIST SEPARATELY EACH TENTATIVE SETTLEMENT PAYMENT					5.01
AFTER DESK REVIEW. ALSO SHOW DATE OF EACH PAYMENT.					5.02
IF NONE, WRITE 'NONE' OR ENTER A ZERO. (1)					5.03
	PROGRAM				5.04
	TO				5.05
	PROVIDER				5.06
					5.07
					5.08
					5.09
					5.10
					5.50
					5.51
	PROVIDER				5.52
	TO				5.53
	PROGRAM				5.54
					5.55
					5.56
					5.57
					5.58
					5.59
SUBTOTAL (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98)					5.99
6 DETERMINED NET SETTLEMENT AMOUNT (balance due) BASED ON THE COST REPORT (1)		210,359		45,177	6.01
					6.02
7 TOTAL MEDICARE PROGRAM LIABILITY (see instructions)		5,592,986		3,793,743	7
8 NAME OF CONTRACTOR	CONTRACTOR NUMBER		NPR DATE (Month/Day/Year)		8

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

Optimizer Systems, Inc.

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Micro System

HARRISBURG MEDICAL CENTER, INC. Provider CCN: 14-0210	In Lieu of Form CMS-2552-10	Period : From: 07/01/2013 To: 06/30/2014	Run Date: 11/11/2014 Run Time: 12:00 Version: 2014.10
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ANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED

COMPONENT CCN: 14-S210

WORKSHEET E-1
PART I

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

DESCRIPTION	INPATIENT PART A		PART B		
	mm/dd/yyyy	AMOUNT	mm/dd/yyyy	AMOUNT	
	1	2	3	4	
1 TOTAL INTERIM PAYMENTS PAID TO PROVIDER		2,658,529		2,625	1
2 INTERIM PAYMENTS PAYABLE ON INDIVIDUAL BILLS, EITHER SUBMITTED OR TO BE SUBMITTED TO THE INTERMEDIARY FOR SERVICES RENDERED IN THE COST REPORTING PERIOD. IF NONE, WRITE 'NONE' OR ENTER A ZERO					2
3 LIST SEPARATELY EACH RETROACTIVE LUMP SUM ADJUSTMENT	.01	01/29/2014		49,600	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		49,600		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)			2,708,129		4
TO BE COMPLETED BY CONTRACTOR					
5 LIST SEPARATELY EACH TENTATIVE SETTLEMENT PAYMENT	.01				5.01
AFTER DESK REVIEW. ALSO SHOW DATE OF EACH PAYMENT.	.02				5.02
IF NONE, WRITE 'NONE' OR ENTER A ZERO. (1)	PROGRAM .03				5.03
	TO .04				5.04
	PROVIDER .05				5.05
	.06				5.06
	.07				5.07
	.08				5.08
	.09				5.09
	.10				5.10
	.50				5.50
	.51				5.51
	PROVIDER .52				5.52
	TO .53				5.53
	PROGRAM .54				5.54
	.55				5.55
	.56				5.56
	.57				5.57
	.58				5.58
	.59				5.59
SUBTOTAL (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98)	.99				5.99
6 DETERMINED NET SETTLEMENT AMOUNT (balance due)	.01		25,333		54 6.01
BASED ON THE COST REPORT (1)	.02				6.02
7 TOTAL MEDICARE PROGRAM LIABILITY (see instructions)			2,733,462		2,679 7
8 NAME OF CONTRACTOR		CONTRACTOR NUMBER		NPR DATE (Month/Day/Year)	8

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

Optimizer Systems, Inc.

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Micro System

HARRISBURG MEDICAL CENTER, INC. Provider CCN: 14-0210	In Lieu of Form CMS-2552-10	Period : From: 07/01/2013 To: 06/30/2014	Run Date: 11/11/2014 Run Time: 12:00 Version: 2014.10
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ANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED

COMPONENT CCN: 14-U210

WORKSHEET E-1
PART I

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

	DESCRIPTION	INPATIENT PART A		PART B	
		mm/dd/yyyy	AMOUNT	mm/dd/yyyy	AMOUNT
1	TOTAL INTERIM PAYMENTS PAID TO PROVIDER	1	2	3	4
1	TOTAL INTERIM PAYMENTS PAID TO PROVIDER		46,137		1
2	INTERIM PAYMENTS PAYABLE ON INDIVIDUAL BILLS, EITHER SUBMITTED OR TO BE SUBMITTED TO THE INTERMEDIARY FOR SERVICES RENDERED IN THE COST REPORTING PERIOD. IF NONE, WRITE 'NONE' OR ENTER A ZERO				2
3	LIST SEPARATELY EACH RETROACTIVE LUMP SUM ADJUSTMENT				3.01
	AMOUNT BASED ON SUBSEQUENT REVISION OF THE INTERIM				3.02
	RATE FOR THE COST REPORTING PERIOD. ALSO SHOW DATE OF	PROGRAM	.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)		46,137		4
TO BE COMPLETED BY CONTRACTOR					
5	LIST SEPARATELY EACH TENTATIVE SETTLEMENT PAYMENT		.01		5.01
	AFTER DESK REVIEW. ALSO SHOW DATE OF EACH PAYMENT.		.02		5.02
	IF NONE, WRITE 'NONE' OR ENTER A ZERO. (1)	PROGRAM	.03		5.03
		TO	.04		5.04
		PROVIDER	.05		5.05
			.06		5.06
			.07		5.07
			.08		5.08
			.09		5.09
			.10		5.10
			.50		5.50
			.51		5.51
		PROVIDER	.52		5.52
		TO	.53		5.53
		PROGRAM	.54		5.54
			.55		5.55
			.56		5.56
			.57		5.57
			.58		5.58
			.59		5.59
	SUBTOTAL (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98)		.99		5.99
6	DETERMINED NET SETTLEMENT AMOUNT (balance due) BASED ON THE COST REPORT (1)		.01	942	6.01
			.02		6.02
7	TOTAL MEDICARE PROGRAM LIABILITY (see instructions)			47,079	7
8	NAME OF CONTRACTOR	CONTRACTOR NUMBER		NPR DATE (Month/Day/Year)	
					8

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

Optimizer Systems, Inc.

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CALCULATION OF REIMBURSEMENT SETTLEMENT FOR HIT

WORKSHEET E-1
PART IICHECK HOSPITAL CAH
APPLICABLE BOX:

TO BE COMPLETED BY CONTRACTOR FOR NONSTANDARD COST REPORTS

HEALTH INFORMATION TECHNOLOGY DATA COLLECTION AND CALCULATION

1	TOTAL HOSPITAL DISCHARGES AS DEFINED IN AARA §4102 FROM WKST S-3, PART I, COLUMN 15, LINE 14	1,446	1
2	MEDICARE DAYS FROM WKST S-3, PART I, COLUMN 6, SUM OF LINES 1, 8-12	2,439	2
3	MEDICARE HMO DAYS FROM WKST S-3, PART I, COLUMN 6, LINE 2	228	3
4	TOTAL INPATIENT DAYS FROM S-3, PART I, COLUMN 8, SUM OF LINES 1, 8-12	3,900	4
5	TOTAL HOSPITAL CHARGES FROM WKST C, PART I, COLUMN 8, LINE 200	107,502,502	5
6	TOTAL HOSPITAL CHARITY CARE CHARGES FROM WKST S-10, COLUMN 3, LINE 20	1,616,194	6
7	CAH ONLY - THE REASONABLE COST INCURRED FOR THE PURCHASE OF CERTIFIED HIT TECHNOLOGY FROM WORKSHEET S-2, PART I, LINE 168		7
8	CALCULATION OF THE HIT INCENTIVE PAYMENT (see instructions)	720,275	8
9	SEQUESTRATION ADJUSTMENT AMOUNT (see instructions)	14,406	9
10	CALCULATION OF THE HIT INCENTIVE PAYMENT AFTER SEQUESTRATION (see instructions)	705,869	10

INPATIENT HOSPITAL SERVICES UNDER PPS & CAH

30	INITIAL/INTERIM HIT PAYMENT(S)	795,956	30
31	OTHER ADJUSTMENTS (-)		31
32	BALANCE DUE PROVIDER (line 8 (or line 10) minus line 30 and line 31) (see instructions)	-90,087	32

Optimizer Systems, Inc.

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Micro System

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CALCULATION OF REIMBURSEMENT SETTLEMENT - SWING BEDS

COMPONENT CCN: 14-U210

WORKSHEET E-2

CHECK TITLE V SWING BED - SNF
 APPLICABLE TITLE XVIII SWING BED - NF
 BOXES: TITLE XIX

COMPUTATION OF NET COSTS OF COVERED SERVICES

		PART A	PART B	
		1	2	
1	INPATIENT ROUTINE SERVICES - SWING BED-SNF (see instructions)	48,751		1
2	INPATIENT ROUTINE SERVICES - SWING BED-NF (see instructions)			2
3	ANCILLARY SERVICES (from Wkst D-3, col. 3, line 200 for Part A, and sum of Wkst D, Part V, cols. 5 and 7, line 202 for Part B) (for CAH, see instructions)			3
4	PER DIEM COST FOR INTERNS AND RESIDENTS NOT IN APPROVED TEACHING PROGRAM (see instructions)			4
5	PROGRAM DAYS	166		5
6	INTERNS AND RESIDENTS NOT IN APPROVED TEACHING PROGRAM (see instructions)			6
7	UTILIZATION REVIEW - PHYSICIAN COMPENSATION - SNF OPTIONAL METHOD ONLY			7
8	SUBTOTAL (sum of lines 1-3 plus lines 6 and 7)	48,751		8
9	PRIMARY PAYER PAYMENTS (see instructions)			9
10	SUBTOTAL (line 8 minus line 9)	48,751		10
11	DEDUCTIBLES BILLED TO PROGRAM PATIENTS (exclude amounts applicable to physician professional services)			11
12	SUBTOTAL (line 10 minus line 11)	48,751		12
13	COINSURANCE BILLED TO PROGRAM PATIENTS (exclude coinsurance for physician professional services)	1,672		13
14	80% OF PART B COSTS (line 12 x 80%)			14
15	SUBTOTAL (enter the lesser of line 12 minus line 13, or line 14)	47,079		15
16	OTHER ADJUSTMENTS (SPECIFY) (see instructions)			16
17	ALLOWABLE BAD DEBTS (see instructions)			17
17.01	ADJUSTED REIMBURSABLE BAD DEBTS (see instructions)			17.01
18	ALLOWABLE BAD DEBTS FOR DUAL ELIGIBLE BENEFICIARIES (see instructions)			18
19	TOTAL (see instructions)	47,079		19
19.01	SEQUESTRATION ADJUSTMENT (see instructions)	942		19.01
20	INTERIM PAYMENTS	46,137		20
21	TENTATIVE SETTLEMENT (for contractor use only)			21
22	BALANCE DUE PROVIDER/PROGRAM (line 19 minus lines 19.01, 20 and 21)			22
23	PROTESTED AMOUNTS (nonallowable cost report items) IN ACCORDANCE WITH CMS PUB 15-2, SECTION 115.2			23

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CALCULATION OF REIMBURSEMENT SETTLEMENT

COMPONENT CCN: 14-5210

WORKSHEET E-3
PART II

CHECK HOSPITAL
 APPLICABLE SUBPROVIDER IPF
 BOX:

PART II - CALCULATION OF MEDICARE REIMBURSEMENT SETTLEMENT UNDER IPF PPS

1	NET FEDERAL IPF PPS PAYMENT (excluding outlier, ECT, and medical education payments)	2,959,733	1
2	NET IPF PPS OUTLIER PAYMENT	2,150	2
3	NET IPF PPS ECT PAYMENT	12,238	3
4	UNWEIGHTED INTERN AND RESIDENT FTE COUNT IN THE MOST RECENT COST REPORT FILED ON OR BEFORE NOVEMBER 15, 2004		4
4.01	CAP INCREASES FOR THE UNWEIGHTED INTERN AND RESIDENT FTE COUNT FOR RESIDENTS THAT WERE DISPLACED BY PROGRAM OR HOSPITAL CLOSURE, THAT WOULD NOT BE COUNTED WITHOUT A TEMPORARY CAP ADJUSTMENT UNDER §412.424(d)(1)(iii)(F)(1) OR (2) (see instructions)		4.01
5	NEW TEACHING PROGRAM ADJUSTMENT (see instructions)		5
6	CURRENT YEAR UNWEIGHTED FTE COUNT OF I&R EXCLUDING FTEs IN THE NEW PROGRAM GROWTH PERIOD OF A NEW TEACHING PROGRAM (see instructions)		6
7	CURRENT YEAR UNWEIGHTED I&R FTE COUNT FOR RESIDENTS WITHIN THE NEW PROGRAM GROWTH PERIOD OF A NEW TEACHING PROGRAM (see instructions)		7
8	INTERN AND RESIDENT COUNT FOR IPF PPS MEDICAL EDUCATION ADJUSTMENT (see instructions)		8
9	AVERAGE DAILY CENSUS (see instructions)	25,232,877	9
10	TEACHING ADJUSTMENT FACTOR $\{((1 + (\text{line 8}/\text{line 9})) \text{ raised to the power of } .5150 - 1)\}$		10
11	TEACHING ADJUSTMENT (line 1 multiplied by line 10)		11
12	ADJUSTED NET IPF PPS PAYMENTS (sum of lines 1, 2, 3 and 11)	2,974,121	12
13	NURSING AND ALLIED HEALTH MANAGED CARE PAYMENT (see instructions)		13
14	ORGAN ACQUISITION		14
15	COST OF TEACHING PHYSICIANS (from Worksheet D-5, Part II, col. 3, line 20) (see instructions)		15
16	SUBTOTAL (see instructions)	2,974,121	16
17	PRIMARY PAYER PAYMENTS		17
18	SUBTOTAL (line 16 less line 17)	2,974,121	18
19	DEDUCTIBLES	261,184	19
20	SUBTOTAL (line 18 minus line 19)	2,712,937	20
21	COINSURANCE	98,232	21
22	SUBTOTAL (line 20 minus line 21)	2,614,705	22
23	ALLOWABLE BAD DEBTS (exclude bad debts for professional services) (see instructions)	182,703	23
24	ADJUSTED REIMBURSABLE BAD DEBTS (see instructions)	118,757	24
25	ALLOWABLE BAD DEBTS FOR DUAL ELIGIBLE BENEFICIARIES (see instructions)	155,863	25
26	SUBTOTAL (sum of lines 22 and 24)	2,733,462	26
27	DIRECT GRADUATE MEDICAL EDUCATION PAYMENTS (from Worksheet E-4, line 49) (for freestanding IPF only)		27
28	OTHER PASS THROUGH COSTS (see instructions)		28
29	OUTLIER PAYMENTS RECONCILIATION		29
30	OTHER ADJUSTMENTS (SPECIFY) (see instructions)		30
31	TOTAL AMOUNT PAYABLE TO THE PROVIDER (see instructions)	2,733,462	31
31.01	SEQUESTRATION ADJUSTMENT (see instructions)	54,669	31.01
32	INTERIM PAYMENTS	2,708,129	32
33	TENTATIVE SETTLEMENT (for contractor use only)		33
34	BALANCE DUE PROVIDER/PROGRAM (line 31 minus lines 31.01, 32 and 33)	-29,336	34
35	PROTESTED AMOUNTS (nonallowable cost report items) IN ACCORDANCE WITH CMS PUB 15-2, SECTION 115.2		35

TO BE COMPLETED BY CONTRACTOR

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

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BALANCE SHEET

WORKSHEET G

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

ASSETS (Omit Cents)		GENERAL FUND	SPECIFIC PURPOSE FUND	ENDOWMENT FUND	PLANT FUND
		1	2	3	4
CURRENT ASSETS					
1	CASH ON HAND AND IN BANKS	3,054,682			1
2	TEMPORARY INVESTMENTS				2
3	NOTES RECEIVABLE				3
4	ACCOUNTS RECEIVABLE	8,178,806			4
5	OTHER RECEIVABLES	2,152,292			5
6	ALLOWANCES FOR UNCOLLECTIBLE NOTES AND ACCOUNTS RECEIVABLE				6
7	INVENTORY	602,300			7
8	PREPAID EXPENSES	672,981			8
9	OTHER CURRENT ASSETS	68,685			9
10	DUE FROM OTHER FUNDS				10
11	TOTAL CURRENT ASSETS (sum of lines 1-10)	14,729,746			11
FIXED ASSETS					
12	LAND	501,932			12
13	LAND IMPROVEMENTS	775,255			13
14	ACCUMULATED DEPRECIATION				14
15	BUILDINGS	23,721,442			15
16	ACCUMULATED DEPRECIATION				16
17	LEASEHOLD IMPROVEMENTS				17
18	ACCUMULATED AMORTIZATION				18
19	FIXED EQUIPMENT	11,713,802			19
20	ACCUMULATED DEPRECIATION				20
21	AUTOMOBILES AND TRUCKS				21
22	ACCUMULATED DEPRECIATION				22
23	MAJOR MOVABLE EQUIPMENT				23
24	ACCUMULATED DEPRECIATION				24
25	MINOR EQUIPMENT DEPRECIABLE				25
26	ACCUMULATED DEPRECIATION				26
27	HIT DESIGNATED ASSETS	954,763			27
28	ACCUMULATED DEPRECIATION	-20,214,259			28
29	MINOR EQUIPMENT-NONDEPRECIABLE				29
30	TOTAL FIXED ASSETS (sum of lines 12-29)	17,452,935			30
OTHER ASSETS					
31	INVESTMENTS	8,425,844			31
32	DEPOSITS ON LEASES				32
33	DUE FROM OWNERS/OFFICERS				33
34	OTHER ASSETS	485,103			34
35	TOTAL OTHER ASSETS (sum of lines 31-34)	8,910,947			35
36	TOTAL ASSETS (sum of lines 11, 30 and 35)	41,093,628			36
LIABILITIES AND FUND BALANCES (Omit Cents)					
		1	2	3	4
CURRENT LIABILITIES					
37	ACCOUNTS PAYABLE	904,188			37
38	SALARIES, WAGES & FEES PAYABLE	2,598,707			38
39	PAYROLL TAXES PAYABLE				39
40	NOTES & LOANS PAYABLE (short term)	89,778			40
41	DEFERRED INCOME				41
42	ACCELERATED PAYMENTS				42
43	DUE TO OTHER FUNDS				43
44	OTHER CURRENT LIABILITIES	1,774,481			44
45	TOTAL CURRENT LIABILITIES (sum of lines 37 thru 44)	5,367,154			45
LONG TERM LIABILITIES					
46	MORTGAGE PAYABLE				46
47	NOTES PAYABLE	9,315,761			47
48	UNSECURED LOANS				48
49	OTHER LONG TERM LIABILITIES	200,000			49
50	TOTAL LONG TERM LIABILITIES (sum of lines 46 thru 49)	9,515,761			50
51	TOTAL LIABILITIES (sum of lines 45 and 50)	14,882,915			51
CAPITAL ACCOUNTS					
52	GENERAL FUND BALANCE	26,210,713			52
53	SPECIFIC PURPOSE FUND BALANCE				53
54	DONOR CREATED - ENDOWMENT FUND BALANCE - RESTRICTED				54
55	DONOR CREATED - ENDOWMENT FUND BALANCE - UNRESTRICTED				55
56	GOVERNING BODY CREATED - ENDOWMENT FUND BALANCE				56
57	PLANT FUND BALANCE - INVESTED IN PLANT				57
58	PLANT FUND BALANCE - RESERVE FOR PLANT IMPROVEMENT, REPLACEMENT, AND EXPANSION				58
59	TOTAL FUND BALANCES (sum of lines 52-58)	26,210,713			59
60	TOTAL LIABILITIES AND FUND BALANCES (sum of lines 51 and 59)	41,093,628			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		24,772,589			1
2	NET INCOME (loss) (from Worksheet G-3, line 29)		1,438,124			2
3	TOTAL (sum of line 1 and line 2)		26,210,713			3
4	ADDITIONS (credit adjustments)					4
5						5
6						6
7						7
8						8
9						9
10	TOTAL ADDITIONS (sum of lines 4-9)					10
11	SUBTOTAL (line 3 plus line 10)		26,210,713			11
12	DEDUCTIONS (debit adjustments)					12
13						13
14						14
15						15
16						16
17						17
18	TOTAL DEDUCTIONS (sum of lines 12-17)					18
19	FUND BALANCE AT END OF PERIOD PER BALANCE SHEET (line 11 minus line 18)		26,210,713			19

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

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STATEMENT OF PATIENT REVENUES AND OPERATING EXPENSES

WORKSHEET G-2
PARTS I & II

PART I - PATIENT REVENUES

	REVENUE CENTER	INPATIENT 1	OUTPATIENT 2	TOTAL 3	
	GENERAL INPATIENT ROUTINE CARE SERVICES				
1	HOSPITAL	4,210,137		4,210,137	1
2	SUBPROVIDER IPF	14,157,939		14,157,939	2
3	SUBPROVIDER IRF				3
5	SWING BED - SNF	233,693		233,693	5
6	SWING BED - NF				6
7	SKILLED NURSING FACILITY				7
8	NURSING FACILITY				8
9	OTHER LONG TERM CARE				9
10	TOTAL GENERAL INPATIENT CARE SERVICES (sum of lines 1-9)	18,601,769		18,601,769	10
	INTENSIVE CARE TYPE INPATIENT HOSPITAL SERVICES				
11	INTENSIVE CARE UNIT				11
12	CORONARY CARE UNIT				12
13	BURN INTENSIVE CARE UNIT				13
14	SURGICAL INTENSIVE CARE UNIT				14
15	OTHER SPECIAL CARE (SPECIFY)				15
16	TOTAL INTENSIVE CARE TYPE INPATIENT HOSPITAL SERVICES (sum of lines 11-15)				16
17	TOTAL INPATIENT ROUTINE CARE SERVICES (sum of lines 10 and 16)	18,601,769		18,601,769	17
18	ANCILLARY SERVICES	13,966,304		13,966,304	18
19	OUTPATIENT SERVICES		79,672,457	79,672,457	19
20	RHC		2,868,973	2,868,973	20
20.01	RHC II				20.01
21	FOHC				21
22	HOME HEALTH AGENCY		972,114	972,114	22
23	AMBULANCE				23
25	ASC				25
26	HOSPICE				26
27	OTHER (SPECIFY)				27
28	TOTAL PATIENT REVENUES (sum of lines 17-27) (transfer column 3 to Worksheet G-3, line 1)	32,568,073	83,513,544	116,081,617	28

PART II - OPERATING EXPENSES

		1	2	
29	OPERATING EXPENSES (per Worksheet A, column 3, line 200)		43,466,077	29
30	ADD (SPECIFY)			30
31				31
32				32
33				33
34				34
35	OVER/SHORT			35
36	TOTAL ADDITIONS (sum of lines 30-35)			36
37	DEDUCT (SPECIFY)			37
38				38
39				39
40				40
41				41
42	TOTAL DEDUCTIONS (sum of lines 37-41)			42
43	TOTAL OPERATING EXPENSES (sum of lines 29 and 36 minus line 42) (transfer to Worksheet G-3, line 4)		43,466,077	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 25)	116,081,617	1
2	LESS - CONTRACTUAL ALLOWANCES AND DISCOUNTS ON PATIENTS' ACCOUNTS	72,880,967	2
3	NET PATIENT REVENUES (line 1 minus line 2)	43,200,650	3
4	LESS - TOTAL OPERATING EXPENSES (from Worksheet G-2, Part II, line 43)	43,466,077	4
5	NET INCOME FROM SERVICE TO PATIENTS (line 3 minus line 4)	-265,427	5

OTHER INCOME

6	CONTRIBUTIONS, DONATIONS, BEQUESTS, ETC.		6
7	INCOME FROM INVESTMENTS	57,104	7
8	REVENUES FROM TELEPHONE AND OTHER MISCELLANEOUS COMMUNICATION SERVICES		8
9	REVENUE FROM TELEVISION AND RADIO SERVICE	3,530	9
10	PURCHASE DISCOUNTS	4,276	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	91,605	14
15	REVENUE FROM RENTAL OF LIVING QUARTERS		15
16	REVENUE FROM SALE OF MEDICAL AND SURGICAL SUPPLIES TO OTHER THAN PATIENTS		16
17	REVENUE FROM SALE OF DRUGS TO OTHER THAN PATIENTS		17
18	REVENUE FROM SALE OF MEDICAL RECORDS AND ABSTRACTS	75	18
19	TUITION (fees, sale of textbooks, uniforms, etc.)		19
20	REVENUE FROM GIFTS, FLOWER, COFFEE SHOPS, CANTEEN		20
21	RENTAL OF VENDING MACHINES		21
22	RENTAL OF HOSPITAL SPACE	51,921	22
23	GOVERNMENTAL APPROPRIATIONS		23
24	OTHER (PSYCH REIMBURSEMENT)	20,800	24
24.01	OTHER (MEANINGFUL USE)	927,353	24.01
24.02	OTHER (OTHER MISC INCOME)	285,355	24.02
24.03	OTHER (UNREALIZED GAIN ON INVESTMENT)	499,644	24.03
24.04	OTHER (GRANT RECEIPTS)	236,232	24.04
24.05	OTHER (DONATIONS)	52,938	24.05
25	TOTAL OTHER INCOME (sum of lines 6-24)	2,230,831	25
26	TOTAL (line 5 plus line 25)	1,965,404	26
27	OTHER EXPENSES (UNDISTRIBUTED LOSS OF SUBSIDIARY)	466,217	27
27.01	OTHER EXPENSES (LOSS ON DISPOSAL OF ASSETS)	22,796	27.01
27.02	OTHER EXPENSES (EXTRAORDINARY LOSS)	38,069	27.02
27.03	OTHER EXPENSES (MISC EXPENSE)	198	27.03
28	TOTAL OTHER EXPENSES (sum of line 27 and subscripts)	527,280	28
29	NET INCOME (or loss) FOR THE PERIOD (line 26 minus line 28)	1,438,124	29

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ANALYSIS OF PROVIDER-BASED HOME HEALTH AGENCY COSTS

HHA CCN: 14-7419

WORKSHEET H

	COST CENTER DESCRIPTIONS (omit cents)	SALARIES	EMPLOYEE BENEFITS	TRANSPOR- TATION (see ins- tructions)	CONTRACTED/ PURCHASED SERVICES	OTHER COSTS	
		1	2	3	4	5	
	GENERAL SERVICE COST CENTER						
1	CAPITAL RELATED-BLDGS & FIXTURES						1
2	CAPITAL RELATED-MOVABLE EQUIPMENT						2
3	PLANT OPERATION & MAINTENANCE						3
4	TRANSPORTATION (see instructions)						4
5	ADMINISTRATIVE AND GENERAL	137,552			3,546	20,286	5
	HHA REIMBURSABLE SERVICES						
6	SKILLED NURSING CARE	232,208		24,177			6
7	PHYSICAL THERAPY	113,913		18,417			7
8	OCCUPATIONAL THERAPY	3,710		1,036			8
9	SPEECH PATHOLOGY	12,386		1,336			9
10	MEDICAL SOCIAL SERVICES						10
11	HOME HEALTH AIDE			73			11
12	SUPPLIES (see instructions)						12
13	DRUGS						13
14	DME						14
	HHA NONREIMBURSABLE SERVICES						
15	HOME DIALYSIS AIDE SERVICES						15
16	RESPIRATORY THERAPY						16
17	PRIVATE DUTY NURSING						17
18	CLINIC						18
19	HEALTH PROMOTION ACTIVITIES						19
20	DAY CARE PROGRAM						20
21	HOME DELIVERED MEALS PROGRAM						21
22	HOMEMAKER SERVICE						22
23	ALL OTHERS						23
23.50	TELEMEDICINE						23.50
24	TOTAL (sum of lines 1-23)	501,769		45,039	3,546	20,286	24

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ANALYSIS OF PROVIDER-BASED HOME HEALTH AGENCY COSTS

HHA CCN: 14-7419

WORKSHEET H

	COST CENTER DESCRIPTIONS (omit cents)	TOTAL (sum of cols. 1 thru 5)	RECLASS- IFICATIONS	RECLASSIFIED TRIAL BALANCE (col. 6 + col. 7)	ADJUSTMENTS	NET EXPENSES FOR ALLOCATION (col. 8 + col. 9)	
		6	7	8	9	10	
	GENERAL SERVICE COST CENTER						
1	CAPITAL RELATED-BLDGS & FIXTURES						1
2	CAPITAL RELATED-MOVABLE EQUIPMENT						2
3	PLANT OPERATION & MAINTENANCE						3
4	TRANSPORTATION (see instructions)						4
5	ADMINISTRATIVE AND GENERAL	161,384	-40,439	120,945		120,945	5
	HHA REIMBURSABLE SERVICES						
6	SKILLED NURSING CARE	256,385		256,385		256,385	6
7	PHYSICAL THERAPY	134,330		134,330		134,330	7
8	OCCUPATIONAL THERAPY	4,746		4,746		4,746	8
9	SPEECH PATHOLOGY	13,722		13,722		13,722	9
10	MEDICAL SOCIAL SERVICES						10
11	HOME HEALTH AIDE	73		73		73	11
12	SUPPLIES (see instructions)						12
13	DRUGS						13
14	DME						14
	HHA NONREIMBURSABLE SERVICES						
15	HOME DIALYSIS AIDE SERVICES						15
16	RESPIRATORY THERAPY						16
17	PRIVATE DUTY NURSING						17
18	CLINIC						18
19	HEALTH PROMOTION ACTIVITIES						19
20	DAY CARE PROGRAM						20
21	HOME DELIVERED MEALS PROGRAM						21
22	HOMEMAKER SERVICE						22
23	ALL OTHERS						23
23.50	TELEMEDICINE						23.50
24	TOTAL (sum of lines 1-23)	570,640	-40,439	530,201		530,201	24

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

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ANALYSIS OF PROVIDER-BASED HOME HEALTH AGENCY COSTS

BHA CCN: 14-7419

WORKSHEET H-1
PART I

	NET EXPENSES FOR COST ALLOCATION (from Wkst. H, col. 10)	CAPITAL RELATED COSTS			
		BLDGS. & FIXTURES	MOVABLE EQUIPMENT	PLANT OPERATION & MAINTENANCE	
	0	1	2	3	
GENERAL SERVICE COST CENTER					
1 CAPITAL RELATED-BLDGS & FIXTURES					1
2 CAPITAL RELATED-MOVABLE EQUIPMENT					2
3 PLANT OPERATION & MAINTENANCE					3
4 TRANSPORTATION (see instructions)					4
5 ADMINISTRATIVE AND GENERAL	120,945				5
HHA REIMBURSABLE SERVICES					
6 SKILLED NURSING CARE	256,385				6
7 PHYSICAL THERAPY	134,330				7
8 OCCUPATIONAL THERAPY	4,746				8
9 SPEECH PATHOLOGY	13,722				9
10 MEDICAL SOCIAL SERVICES					10
11 HOME HEALTH AIDE	73				11
12 SUPPLIES (see instructions)					12
13 DRUGS					13
14 DME					14
HHA NONREIMBURSABLE SERVICES					
15 HOME DIALYSIS AIDE SERVICES					15
16 RESPIRATORY THERAPY					16
17 PRIVATE DUTY NURSING					17
18 CLINIC					18
19 HEALTH PROMOTION ACTIVITIES					19
20 DAY CARE PROGRAM					20
21 HOME DELIVERED MEALS PROGRAM					21
22 HOMEMAKER SERVICE					22
23 ALL OTHERS					23
23.50 TELEMEDICINE					23.50
24 TOTAL (sum of lines 1-23)	530,201				24

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ANALYSIS OF PROVIDER-BASED HOME HEALTH AGENCY COSTS

HHH CCN: 14-7419

WORKSHEET H-1
PART I

		TRANSPORT- ATION	SUBTOTAL (cols. 0-4)	ADMINI- STRATIVE & GENERAL	TOTAL (col. 4A + 5)	
		4	4A	5	6	
	GENERAL SERVICE COST CENTER					
1	CAPITAL RELATED-BLDGS & FIXTURES					1
2	CAPITAL RELATED-MOVABLE EQUIPMENT					2
3	PLANT OPERATION & MAINTENANCE					3
4	TRANSPORTATION (see instructions)					4
5	ADMINISTRATIVE AND GENERAL		120,945	120,945		5
	HHH REIMBURSABLE SERVICES					
6	SKILLED NURSING CARE		256,385	74,828	331,213	6
7	PHYSICAL THERAPY		154,330	34,716	169,046	7
8	OCCUPATIONAL THERAPY		4,746	1,854	6,600	8
9	SPEECH PATHOLOGY		13,722	4,648	18,370	9
10	MEDICAL SOCIAL SERVICES					10
11	HOME HEALTH AIDE		73	4,899	4,972	11
12	SUPPLIES (see instructions)					12
13	DRUGS					13
14	DME					14
	HHH NONREIMBURSABLE SERVICES					
15	HOME DIALYSIS AIDE SERVICES					15
16	RESPIRATORY THERAPY					16
17	PRIVATE DUTY NURSING					17
18	CLINIC					18
19	HEALTH PROMOTION ACTIVITIES					19
20	DAY CARE PROGRAM					20
21	HOME DELIVERED MEALS PROGRAM					21
22	HOMEMAKER SERVICE					22
23	ALL OTHERS					23
23.50	TELEMEDICINE					23.50
24	TOTAL (sum of lines 1-23)		530,201		530,201	24

Optimizer Systems, Inc.

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Micro System

HARRISBURG MEDICAL CENTER, INC. Provider CCN: 14-0210	In Lieu of Form CMS-2552-10	Period : From: 07/01/2013 To: 06/30/2014	Run Date: 11/11/2014 Run Time: 12:00 Version: 2014.10
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COST ALLOCATION - HHA STATISTICAL BASIS

HHA CCN: 14-7419

WORKSHEET H-1
PART II

		CAPITAL RELATED COSTS					
		BLDGS. & FIXTURES (Square Feet)	MOVABLE EQUIPMENT (Dollar Value)	PLANT OPERATION & MAINTENANCE (Square Feet)	TRANSPORTATION (Mileage)	RECONCILIATION	ADMINISTRATIVE & GENERAL (Accum. Cost)
		1	2	3	4	5A	5
GENERAL SERVICE COST CENTER							
1	CAPITAL RELATED-BLDGS & FIXTURES						1
2	CAPITAL RELATED-MOVABLE EQUIPMENT						2
3	PLANT OPERATION & MAINTENANCE						3
4	TRANSPORTATION (see instructions)						4
5	ADMINISTRATIVE AND GENERAL					-120,945	913,661
HHA REIMBURSABLE SERVICES							
6	SKILLED NURSING CARE					308,892	565,277
7	PHYSICAL THERAPY					127,927	262,237
8	OCCUPATIONAL THERAPY					9,257	14,003
9	SPEECH PATHOLOGY					21,394	35,116
10	MEDICAL SOCIAL SERVICES						
11	HOME HEALTH AIDE					36,935	37,008
12	SUPPLIES (see instructions)						
13	DRUGS						
14	DME						
HHA NONREIMBURSABLE SERVICES							
15	HOME DIALYSIS AIDE SERVICES						
16	RESPIRATORY THERAPY						
17	PRIVATE DUTY NURSING						
18	CLINIC						
19	HEALTH PROMOTION ACTIVITIES						
20	DAY CARE PROGRAM						
21	HOME DELIVERED MEALS PROGRAM						
22	HOMEMAKER SERVICE						
23	ALL OTHERS						
23.50	TELEMEDICINE						
24	TOTAL (sum of lines 1-23)					383,460	913,661
25	COST TO BE ALLOC (per Worksheet H-1, Part I)						120,945
26	UNIT COST MULTIPLIER						0.132374

Optimizer Systems, Inc.

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Micro System

HARRISBURG MEDICAL CENTER, INC. Provider CCN: 14-0210	In Lieu of Form CMS-2552-10	Period : From: 07/01/2013 To: 06/30/2014	Run Date: 11/11/2014 Run Time: 12:00 Version: 2014.10
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ALLOCATION OF GENERAL SERVICE COSTS TO HHA COST CENTERS

HHA CCN: 14-7419

WORKSHEET H-2
PART I

	HHA COST CENTER (omit cents)	HHA TRIAL BALANCE(1)	CAP BLDGS & FIXTURES	CAP MOVABLE EQUIPMENT	EMPLOYEE BENEFITS DEPARTMENT	SUBTOTAL (cols.0-4)	ADMINIS- TRATIVE & GENERAL	
		0	1	2	4	4A	5	
1	ADMINISTRATIVE AND GENERAL				23,627	23,627	5,881	1
2	SKILLED NURSING CARE	331,213			61,069	392,282	97,637	2
3	PHYSICAL THERAPY	169,046			30,485	199,531	49,663	3
4	OCCUPATIONAL THERAPY	6,600			976	7,576	1,886	4
5	SPEECH PATHOLOGY	18,370			3,257	21,627	5,383	5
6	MEDICAL SOCIAL SERVICES							6
7	HOME HEALTH AIDE	4,972				4,972	1,238	7
8	SUPPLIES							8
9	DRUGS							9
10	DME							10
11	HOME DIALYSIS AIDE SERVICES							11
12	RESPIRATORY THERAPY							12
13	PRIVATE DUTY NURSING							13
14	CLINIC							14
15	HEALTH PROMOTION ACTIVITIES							15
16	DAY CARE PROGRAM							16
17	HOME DELIVERED MEALS PROGRAM							17
18	HOMEMAKER SERVICE							18
19	ALL OTHERS							19
20	TOTALS (sum of lines 1-19)(2)	530,201			119,414	649,615	161,688	20
21	UNIT COST MULTIPLIER: COLUMN 26, LINE 1 DIVIDED BY THE SUM OF COLUMN 26, LINE 20 MINUS COLUMN 26, LINE 1, ROUNDED TO 6 DECIMAL PLACES.							21

(1) Column 0, line 20 must agree with Wkst. A, column 7, line 101.

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

Optimizer Systems, Inc.

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Micro System

HARRISBURG MEDICAL CENTER, INC. Provider CCN: 14-0210	In Lieu of Form CMS-2552-10	Period : From: 07/01/2013 To: 06/30/2014	Run Date: 11/11/2014 Run Time: 12:00 Version: 2014.10
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ALLOCATION OF GENERAL SERVICE COSTS TO HHA COST CENTERS

HHA CCN: 14-7419

WORKSHEET H-2
PART I

	HHA COST CENTER (omit cents)	MAIN- TENANCE & REPAIRS 6	OPERATION OF PLANT 7	LAUNDRY & LINEN SERVICE 8	HOUSE- KEEPING 9	DIETARY 10	CAFETERIA 11	
1	ADMINISTRATIVE AND GENERAL				11,824			1
2	SKILLED NURSING CARE							2
3	PHYSICAL THERAPY							3
4	OCCUPATIONAL THERAPY							4
5	SPEECH PATHOLOGY							5
6	MEDICAL SOCIAL SERVICES							6
7	HOME HEALTH AIDE							7
8	SUPPLIES							8
9	DRUGS							9
10	DME							10
11	HOME DIALYSIS AIDE SERVICES							11
12	RESPIRATORY THERAPY							12
13	PRIVATE DUTY NURSING							13
14	CLINIC							14
15	HEALTH PROMOTION ACTIVITIES							15
16	DAY CARE PROGRAM							16
17	HOME DELIVERED MEALS PROGRAM							17
18	HOMEMAKER SERVICE							18
19	ALL OTHERS							19
20	TOTALS (sum of lines 1-19)(2)				11,824			20
21	UNIT COST MULTIPLIER: COLUMN 26, LINE 1 DIVIDED BY THE SUM OF COLUMN 26, LINE 20 MINUS COLUMN 26, LINE 1, ROUNDED TO 6 DECIMAL PLACES.							21

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

Optimizer Systems, Inc.

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Micro System

HARRISBURG MEDICAL CENTER, INC. Provider CCN: 14-0210	In Lieu of Form CMS-2552-10	Period : From: 07/01/2013 To: 06/30/2014	Run Date: 11/11/2014 Run Time: 12:00 Version: 2014.10
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ALLOCATION OF GENERAL SERVICE COSTS TO HHA COST CENTERS

HHA CCN: 14-7419

WORKSHEET H-2
PART I

	HHA COST CENTER (omit cents)	MAIN- TENANCE OF PERSONNEL 12	NURSING ADMINIS- TRATION 13	CENTRAL SERVICES & SUPPLY 14	PHARMACY 15	MEDICAL RECORDS & LIBRARY 16	SOCIAL SERVICE 17	
1	ADMINISTRATIVE AND GENERAL		6,977			9,511		1
2	SKILLED NURSING CARE							2
3	PHYSICAL THERAPY							3
4	OCCUPATIONAL THERAPY							4
5	SPEECH PATHOLOGY							5
6	MEDICAL SOCIAL SERVICES							6
7	HOME HEALTH AIDE							7
8	SUPPLIES							8
9	DRUGS							9
10	DME							10
11	HOME DIALYSIS AIDE SERVICES							11
12	RESPIRATORY THERAPY							12
13	PRIVATE DUTY NURSING							13
14	CLINIC							14
15	HEALTH PROMOTION ACTIVITIES							15
16	DAY CARE PROGRAM							16
17	HOME DELIVERED MEALS PROGRAM							17
18	HOMEMAKER SERVICE							18
19	ALL OTHERS							19
20	TOTALS (sum of lines 1-19)(2)		6,977			9,511		20
21	UNIT COST MULTIPLIER: COLUMN 26, LINE 1 DIVIDED BY THE SUM OF COLUMN 26, LINE 20 MINUS COLUMN 26, LINE 1, ROUNDED TO 6 DECIMAL PLACES.							21

(1) Column 0, line 20 must agree with Wkst. A, column 7, line 101.

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

Optimizer Systems, Inc.

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Micro System

HARRISBURG MEDICAL CENTER, INC. Provider CCN: 14-0210	in Lieu of Form CMS-2552-10	Period : From: 07/01/2013 To: 06/30/2014	Run Date: 11/11/2014 Run Time: 12:00 Version: 2014.10
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ALLOCATION OF GENERAL SERVICE COSTS TO HHA COST CENTERS

HHA CCN: 14-7419

WORKSHEET H-2
PART I

	HHA COST CENTER (omit cents)	NONPHYSIC. ANESTHET.	NURSING SCHOOL	I&R SALARY & FRINGES	I&R PROGRAM COSTS	PARAMED EDUCATION	SUBTOTAL (sum of col.4A-23)	
		19	20	21	22	23	24	
1	ADMINISTRATIVE AND GENERAL						57,820	1
2	SKILLED NURSING CARE						489,919	2
3	PHYSICAL THERAPY						249,194	3
4	OCCUPATIONAL THERAPY						9,462	4
5	SPEECH PATHOLOGY						27,010	5
6	MEDICAL SOCIAL SERVICES							6
7	HOME HEALTH AIDE						6,210	7
8	SUPPLIES							8
9	DRUGS							9
10	DME							10
11	HOME DIALYSIS AIDE SERVICES							11
12	RESPIRATORY THERAPY							12
13	PRIVATE DUTY NURSING							13
14	CLINIC							14
15	HEALTH PROMOTION ACTIVITIES							15
16	DAY CARE PROGRAM							16
17	HOME DELIVERED MEALS PROGRAM							17
18	HOMEMAKER SERVICE							18
19	ALL OTHERS							19
20	TOTALS (sum of lines 1-19)(2)						839,615	20
21	UNIT COST MULTIPLIER: COLUMN 26, LINE 1 DIVIDED BY THE SUM OF COLUMN 26, LINE 20 MINUS COLUMN 26, LINE 1, ROUNDED TO 6 DECIMAL PLACES.							21

(1) Column 0, line 20 must agree with Wkst. A, column 7, line 101.

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

Optimizer Systems, Inc.

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Micro System

HARRISBURG MEDICAL CENTER, INC. Provider CCN: 14-0210	In Lieu of Form CMS-2552-10	Period : From: 07/01/2013 To: 06/30/2014	Run Date: 11/11/2014 Run Time: 12:00 Version: 2014.10
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ALLOCATION OF GENERAL SERVICE COSTS TO HHA COST CENTERS

HHA CCN: 14-7419

WORKSHEET H-2
PART I

	HHA COST CENTER (omit cents)	I&R COST & POST STEP- DOWN ADJS	SUBTOTAL (sum of col.4A-23)	ALLOCATED HHA A&G (see PL.2)	TOTAL HHA COSTS	
		25	26	27	28	
1	ADMINISTRATIVE AND GENERAL		57,820			1
2	SKILLED NURSING CARE		489,919	36,233	526,152	2
3	PHYSICAL THERAPY		249,194	18,430	267,624	3
4	OCCUPATIONAL THERAPY		9,462	700	10,162	4
5	SPEECH PATHOLOGY		27,010	1,998	29,008	5
6	MEDICAL SOCIAL SERVICES					6
7	HOME HEALTH AIDE		6,210	459	6,669	7
8	SUPPLIES					8
9	DRUGS					9
10	DME					10
11	HOME DIALYSIS AIDE SERVICES					11
12	RESPIRATORY THERAPY					12
13	PRIVATE DUTY NURSING					13
14	CLINIC					14
15	HEALTH PROMOTION ACTIVITIES					15
16	DAY CARE PROGRAM					16
17	HOME DELIVERED MEALS PROGRAM					17
18	HOMEMAKER SERVICE					18
19	ALL OTHERS					19
20	TOTALS (sum of lines 1-19)(2)		839,615	57,820	839,615	20
21	UNIT COST MULTIPLIER: COLUMN 26, LINE 1 DIVIDED BY THE SUM OF COLUMN 26, LINE 20 MINUS COLUMN 26, LINE 1, ROUNDED TO 6 DECIMAL PLACES.			0.073958		21

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

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Micro System

HARRISBURG MEDICAL CENTER, INC. Provider CCN: 14-0210	In Lieu of Form CMS-2552-10	Period : From: 07/01/2013 To: 06/30/2014	Run Date: 11/11/2014 Run Time: 12:00 Version: 2014.10
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ALLOCATION OF GENERAL SERVICE COSTS TO HHA COST CENTERS STATISTICAL BASIS

HHA CCN: 14-7419

WORKSHEET H-2
PART II

	HHA COST CENTER	CAP BLDGS & FIXTURES SQUARE FEET	CAP MOVABLE EQUIPMENT DOLLAR VALUE	EMPLOYEE BENEFITS DEPARTMENT GROSS SALARIES	RECON- CILIATION	ADMINIS- TRATIVE & GENERAL ACCUM COST	MAIN- TENANCE & REPAIRS SQUARE FEET	
		1	2	4	4A	5	6	
1	ADMINISTRATIVE AND GENERAL			89,838		23,627		1
2	SKILLED NURSING CARE			232,208		392,282		2
3	PHYSICAL THERAPY			115,913		199,531		3
4	OCCUPATIONAL THERAPY			3,710		7,576		4
5	SPEECH PATHOLOGY			12,386		21,627		5
6	MEDICAL SOCIAL SERVICES							6
7	HOME HEALTH AIDE					4,972		7
8	SUPPLIES							8
9	DRUGS							9
10	DME							10
11	HOME DIALYSIS AIDE SERVICES							11
12	RESPIRATORY THERAPY							12
13	PRIVATE DUTY NURSING							13
14	CLINIC							14
15	HEALTH PROMOTION ACTIVITIES							15
16	DAY CARE PROGRAM							16
17	HOME DELIVERED MEALS PROGRAM							17
18	HOMEMAKER SERVICE							18
19	ALL OTHERS							19
19.50	TELEMEDICINE							19.50
20	TOTALS (sum of lines 1-19)			454,055		649,615		20
21	TOTAL COST TO BE ALLOCATED			119,414		161,688		21
22	UNIT COST MULTIPLIER			0.262995		0.248898		22
22	UNIT COST MULTIPLIER							22

Optimizer Systems, Inc.

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Micro System

HARRISBURG MEDICAL CENTER, INC. Provider CCN: 14-0210	In Lieu of Form CMS-2552-10	Period : From: 07/01/2013 To: 06/30/2014	Run Date: 11/11/2014 Run Time: 12:00 Version: 2014.10
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ALLOCATION OF GENERAL SERVICE COSTS TO HHA COST CENTERS STATISTICAL BASIS

HHA CCN: 14-7419

WORKSHEET H-2
PART II

	HHA COST CENTER	OPERATION OF PLANT SQUARE FEET	LAUNDRY & LINEN SERVICE POUNDS OF LAUNDRY	HOUSE- KEEPING HOURS OF SERVICE	DIETARY MEALS SERVED	CAFETERIA MEALS SERVED	MAIN- TENANCE OF PERSONNEL NUMBER HOUSED	
		7	8	9	10	11	12	
1	ADMINISTRATIVE AND GENERAL			44				1
2	SKILLED NURSING CARE							2
3	PHYSICAL THERAPY							3
4	OCCUPATIONAL THERAPY							4
5	SPEECH PATHOLOGY							5
6	MEDICAL SOCIAL SERVICES							6
7	HOME HEALTH AIDE							7
8	SUPPLIES							8
9	DRUGS							9
10	DME							10
11	HOME DIALYSIS AIDE SERVICES							11
12	RESPIRATORY THERAPY							12
13	PRIVATE DUTY NURSING							13
14	CLINIC							14
15	HEALTH PROMOTION ACTIVITIES							15
16	DAY CARE PROGRAM							16
17	HOME DELIVERED MEALS PROGRAM							17
18	HOMEMAKER SERVICE							18
19	ALL OTHERS							19
19.50	TELEMEDICINE							19.50
20	TOTALS (sum of lines 1-19)			44				20
21	TOTAL COST TO BE ALLOCATED			11,824				21
22	UNIT COST MULTIPLIER			268.727273				22
22	UNIT COST MULTIPLIER							22

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HARRISBURG MEDICAL CENTER, INC. Provider CCN: 14-0210	In Lieu of Form CMS-2552-10	Period : From: 07/01/2013 To: 06/30/2014	Run Date: 11/11/2014 Run Time: 12:00 Version: 2014.10
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ALLOCATION OF GENERAL SERVICE COSTS TO HHA COST CENTERS STATISTICAL BASIS

HHA CCN: 14-7419

WORKSHEET H-2
PART II

	HHA COST CENTER	NURSING ADMINIS- TRATION DIRECT NRSING HRS	CENTRAL SERVICES & SUPPLY COSTED REQUIS.	PHARMACY COSTED REQUIS.	MEDICAL RECORDS & LIBRARY GROSS REVENUE	SOCIAL SERVICE TIME SPENT	NONPHYSIC. ANESTHET. ASSIGNED TIME	
		13	14	15	16	17	19	
1	ADMINISTRATIVE AND GENERAL	26,169			972,114			1
2	SKILLED NURSING CARE							2
3	PHYSICAL THERAPY							3
4	OCCUPATIONAL THERAPY							4
5	SPEECH PATHOLOGY							5
6	MEDICAL SOCIAL SERVICES							6
7	HOME HEALTH AIDE							7
8	SUPPLIES							8
9	DRUGS							9
10	DME							10
11	HOME DIALYSIS AIDE SERVICES							11
12	RESPIRATORY THERAPY							12
13	PRIVATE DUTY NURSING							13
14	CLINIC							14
15	HEALTH PROMOTION ACTIVITIES							15
16	DAY CARE PROGRAM							16
17	HOME DELIVERED MEALS PROGRAM							17
18	HOMEMAKER SERVICE							18
19	ALL OTHERS							19
19.50	TELEMEDICINE							19.50
20	TOTALS (sum of lines 1-19)	26,169			972,114			20
21	TOTAL COST TO BE ALLOCATED	6,977			9,511			21
22	UNIT COST MULTIPLIER	0.266613						22
22	UNIT COST MULTIPLIER				0.009784			22

Optimizer Systems, Inc.

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Micro System

HARRISBURG MEDICAL CENTER, INC. Provider CCN: 14-0210	In Lieu of Form CMS-2552-10	Period : From: 07/01/2013 To: 06/30/2014	Run Date: 11/11/2014 Run Time: 12:00 Version: 2014.10
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ALLOCATION OF GENERAL SERVICE COSTS TO HHA COST CENTERS STATISTICAL BASIS

HHA CCN: 14-7419

WORKSHEET H-2
PART II

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

Optimizer Systems, Inc.

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Micro System

HARRISBURG MEDICAL CENTER, INC. Provider CCN: 14-0210	In Lieu of Form CMS-2552-10	Period : From: 07/01/2013 To: 06/30/2014	Run Date: 11/11/2014 Run Time: 12:00 Version: 2014.10
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APPORTIONMENT OF PATIENT SERVICE COSTS

HHA CCN: 14-7419

WORKSHEET H-3
PARTS I & II

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

PART I - COMPUTATION OF THE AGGREGATE PROGRAM COST

COST PER VISIT COMPUTATION							
	PATIENT SERVICES	FROM WKST. H-2, PART I, COL. 28, LINE	FACILITY COSTS (from Wkst. H-2, Part I)	SHARED ANCILLARY COSTS (from Part II)	TOTAL HHA COSTS (cols. 1 + 2)	TOTAL VISITS	AVERAGE COST PER VISIT (col. 3 + col. 4)
		1	2	3	4	5	
1	SKILLED NURSING CARE	2	526,152		526,152	2,334	225.43
2	PHYSICAL THERAPY	3	267,624		267,624	1,778	150.52
3	OCCUPATIONAL THERAPY	4	10,162		10,162	100	101.62
4	SPEECH PATHOLOGY	5	29,008		29,008	129	224.87
5	MEDICAL SOCIAL SERVICES	6					5
6	HOME HEALTH AIDE	7	6,669		6,669	7	952.71
7	TOTAL (sum of lines 1-6)		839,615		839,615	4,348	

LIMITATION COST COMPUTATION				PROGRAM VISITS			
	PATIENT SERVICES	CBSA NO.	PART A	NOT SUBJECT TO DEDUCTIBLES & COINSURANCE	SUBJECT TO DEDUCTIBLES & COINSURANCE		
		1	2	3	4		
8	SKILLED NURSING CARE	99914	315	1,014			8
9	PHYSICAL THERAPY	99914	272	877			9
10	OCCUPATIONAL THERAPY	99914	14	39			10
11	SPEECH PATHOLOGY	99914	18	63			11
12	MEDICAL SOCIAL SERVICES	99914					12
13	HOME HEALTH AIDE	99914	2				13
14	TOTAL (sum of lines 8-13)		621	1,993			14

SUPPLIES AND DRUGS COSTS COMPUTATIONS							
	OTHER PATIENT SERVICES	FROM WKST. H-2, PART I, COL. 28, LINE	FACILITY COSTS (from Wkst. H-2, Part I)	SHARED ANCILLARY COSTS (from Part II)	TOTAL HHA COSTS (cols. 1 + 2)	TOTAL CHARGES (from HHA Record)	RATIO (col. 3 + col. 4)
		1	2	3	4	5	
15	COST OF MEDICAL SUPPLIES	8				11,903	15
16	COST OF DRUGS	9					16

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

		FROM WKST. C, PART I, COL. 9, LINE	COST TO CHARGE RATIO	TOTAL HHA CHARGES (from provider records)	HHA SHARED ANCILLARY COSTS (col. 1 x col. 2)	TRANSFER TO PART I AS INDICATED
		1	2	3	4	
1	PHYSICAL THERAPY	66	0.423313			col. 2, line 2
2	OCCUPATIONAL THERAPY	67				col. 2, line 3
3	SPEECH PATHOLOGY	68				col. 2, line 4
4	MEDICAL SUPPLIES CHARGED TO PAT	71	0.379354			col. 2, line 15
5	DRUGS CHARGED TO PATIENTS	73	0.403897			col. 2, line 16

Optimizer Systems, Inc.

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Micro System

HARRISBURG MEDICAL CENTER, INC. Provider CCN: 14-0210	In Lieu of Form CMS-2552-10	Period : From: 07/01/2013 To: 06/30/2014	Run Date: 11/11/2014 Run Time: 12:00 Version: 2014.10
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APPORTIONMENT OF PATIENT SERVICE COSTS

HHA CCN: 14-7419

WORKSHEET H-3
PARTS I & II

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

PART I - COMPUTATION OF THE AGGREGATE PROGRAM COST

COST PER VISIT COMPUTATION		PROGRAM VISITS				COST OF SERVICES			
		PART B				PART B			
	PATIENT SERVICES	PART A	NOT SUBJECT TO DEDUCTIBLES & COINSURANCE	SUBJECT TO DEDUCTIBLES & COINSURANCE	PART A	NOT SUBJECT TO DEDUCTIBLES & COINSURANCE	SUBJECT TO DEDUCTIBLES & COINSURANCE	TOTAL PROGRAM COST (sum of cols 9-10)	
		6	7	8	9	10	11	12	
1	SKILLED NURSING CARE	315	1,014		71,010	228,586		299,596	1
2	PHYSICAL THERAPY	272	877		40,941	132,006		172,947	2
3	OCCUPATIONAL THERAPY	14	39		1,423	3,963		5,386	3
4	SPEECH PATHOLOGY	18	63		4,048	14,167		18,215	4
5	MEDICAL SOCIAL SERVICES								5
6	HOME HEALTH AIDE	2			1,905			1,905	6
7	TOTAL (sum of lines 1-6)	621	1,993		119,327	378,722		498,049	7

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

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CALCULATION OF HHA REIMBURSEMENT SETTLEMENT

HHA CCN: 14-7419

WORKSHEET H-4
PARTS I & II

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

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

	DESCRIPTION	PART A 1	PART B		
			NOT SUBJECT TO DEDUCTIBLES & COINSURANCE 2	SUBJECT TO DEDUCTIBLES & COINSURANCE 3	
	REASONABLE COST OF PART A & PART B SERVICES				
1	REASONABLE COST OF SERVICES (see instructions)				1
2	TOTAL CHARGES	138,187			2
	CUSTOMARY CHARGES				
3	AMOUNT ACTUALLY COLLECTED FROM PATIENTS LIABLE FOR PAYMENT FOR SERVICES ON A CHARGE BASIS (from your records)				3
4	AMOUNT THAT WOULD HAVE BEEN REALIZED FROM PATIENTS LIABLE FOR PAYMENT FOR SERVICES ON A CHARGE BASIS HAD SUCH PAYMENT BEEN MADE IN ACCORDANCE WITH 42 CFR 413.13(b)				4
5	RATIO OF LINE 3 TO LINE 4 (not to exceed 1.000000)				5
6	TOTAL CUSTOMARY CHARGES (see instructions)	138,187			6
7	EXCESS OF TOTAL CUSTOMARY CHARGES OVER TOTAL REASONABLE COST (complete only if line 6 exceeds line 1)	138,187			7
8	EXCESS OF REASONABLE COST OVER CUSTOMARY CHARGES (complete only if line 1 exceeds line 6)				8
9	PRIMARY PAYER PAYMENTS				9

COMPUTATION OF HHA REIMBURSEMENT SETTLEMENT

	DESCRIPTION	PART A SERVICES 1	PART B SERVICES 2	
10	TOTAL REASONABLE COST (see instructions)			10
11	TOTAL PPS REIMBURSEMENT - FULL EPISODES WITHOUT OUTLIERS	102,027	336,229	11
12	TOTAL PPS REIMBURSEMENT - FULL EPISODES WITH OUTLIERS			12
13	TOTAL PPS REIMBURSEMENT - LUPA EPISODES	1,716	12,862	13
14	TOTAL PPS REIMBURSEMENT - PEP EPISODES	217	3,721	14
15	TOTAL PPS OUTLIER REIMBURSEMENT - FULL EPISODES WITH OUTLIERS			15
16	TOTAL PPS OUTLIER REIMBURSEMENT - PEP EPISODES			16
17	TOTAL OTHER PAYMENTS			17
18	DME PAYMENTS			18
19	OXYGEN PAYMENTS			19
20	PROSTHETIC AND ORTHOTIC PAYMENTS			20
21	PART B DEDUCTIBLES BILLED TO MEDICARE PATIENTS (exclude coinsurance)			21
22	SUBTOTAL (sum of lines 10-20 minus line 21)	103,960	352,812	22
23	EXCESS REASONABLE COST (from line 8)			23
24	SUBTOTAL (line 22 minus line 23)	103,960	352,812	24
25	COINSURANCE BILLED TO PROGRAM PATIENTS (from your records)			25
26	NET COST (line 24 minus line 25)	103,960	352,812	26
27	REIMBURSABLE BAD DEBTS (from your records)			27
28	REIMBURSABLE BAD DEBTS FOR DUAL ELIGIBLE BENEFICIARIES (see instructions)			28
29	TOTAL COSTS - CURRENT COST REPORTING PERIOD (line 26 plus line 27)	103,960	352,812	29
30	OTHER ADJUSTMENTS (SPECIFY) (see instructions)		-217	30
31	SUBTOTAL (line 29 plus/minus line 30)	103,960	352,595	31
31.01	SEQUESTRATION ADJUSTMENT (see instructions)	2,079	7,052	31.01
32	INTERIM PAYMENTS (see instructions)	101,881	345,543	32
33	TENTATIVE SETTLEMENT (for contractor use only)			33
34	BALANCE DUE PROVIDER/PROGRAM (line 31 minus lines 31.01, 32 and 33)			34
35	PROTESTED AMOUNTS (nonallowable cost report items) IN ACCORDANCE WITH CMS PUB 15-2, SECTION 115-2			35

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ANALYSIS OF PAYMENTS TO PROVIDER-BASED HHAs FOR SERVICES RENDERED TO PROGRAM BENEFICIARIES HHA CCN: 14-7419

WORKSHEET H-5

	DESCRIPTION	PART A		PART B		
		mm/dd/yyyy 1	AMOUNT 2	mm/dd/yyyy 3	AMOUNT 4	
1	TOTAL INTERIM PAYMENTS PAID TO PROVIDER		101,881		345,543	1
2	INTERIM PAYMENTS PAYABLE ON INDIVIDUAL BILLS, EITHER SUBMITTED OR TO BE SUBMITTED TO THE INTERMEDIARY FOR SERVICES RENDERED IN THE COST REPORTING PERIOD. IF NONE, WRITE 'NONE' OR ENTER A ZERO					2
3	LIST SEPARATELY EACH RETROACTIVE LUMP SUM ADJUSTMENT AMOUNT BASED ON SUBSEQUENT REVISION OF THE INTERIM RATE FOR THE COST REPORTING PERIOD. ALSO SHOW DATE OF EACH PAYMENT. IF NONE, WRITE 'NONE' OR ENTER A ZERO. (1)					
		.01				3.01
		.02				3.02
		.03				3.03
		.04				3.04
		.05				3.05
		.06				3.06
		.07				3.07
		.08				3.08
		.09				3.09
		.10				3.10
		.50				3.50
		.51				3.51
		.52				3.52
		.53				3.53
		.54				3.54
		.55				3.55
		.56				3.56
		.57				3.57
		.58				3.58
		.59				3.59
	SUBTOTAL (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98)	.99				3.99
4	TOTAL INTERIM PAYMENTS (sum of lines 1, 2, and 3.99) (transfer to Wkst. H-4, Part II, column as appropriate, line 32)		101,881		345,543	4
	TO BE COMPLETED BY CONTRACTOR					
5	LIST SEPARATELY EACH TENTATIVE SETTLEMENT PAYMENT AFTER DESK REVIEW. ALSO SHOW DATE OF EACH PAYMENT. IF NONE, WRITE 'NONE' OR ENTER A ZERO. (1)					
		.01				5.01
		.02				5.02
		.03				5.03
		.04				5.04
		.05				5.05
		.06				5.06
		.07				5.07
		.08				5.08
		.09				5.09
		.10				5.10
		.50				5.50
		.51				5.51
		.52				5.52
		.53				5.53
		.54				5.54
		.55				5.55
		.56				5.56
		.57				5.57
		.58				5.58
		.59				5.59
	SUBTOTAL (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98)	.99				5.99
6	DETERMINED NET SETTLEMENT AMOUNT (balance due) BASED ON THE COST REPORT (1)	.01	2,079		7,052	6.01
		.02				6.02
7	TOTAL MEDICARE PROGRAM LIABILITY (see instructions)		103,960		352,595	7
8	NAME OF CONTRACTOR		CONTRACTOR NUMBER		NPR DATE (Month/Day/Year)	8

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

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CALCULATION OF CAPITAL PAYMENT

COMPONENT CCN: 14-0210

WORKSHEET L

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

PART I - FULLY PROSPECTIVE METHOD

	CAPITAL FEDERAL AMOUNT		
1	CAPITAL DRG OTHER THAN OUTLIER	313,651	1
1.01	MODEL 4 BPCI CAPITAL DRG OTHER THAN OUTLIER		1.01
2	CAPITAL DRG OUTLIER PAYMENTS	185	2
2.01	MODEL 4 BPCI CAPITAL DRG OUTLIER PAYMENTS		2.01
3	TOTAL INPATIENT DAYS DIVIDED BY NUMBER OF DAYS IN THE COST REPORTING PERIOD (see instructions)	10.68	3
4	NUMBER OF INTERNS & RESIDENTS (see instructions)		4
5	INDIRECT MEDICAL EDUCATION PERCENTAGE (see instructions)		5
6	INDIRECT MEDICAL EDUCATION ADJUSTMENT (multiply line 5 by the sum of lines 1 and 1.01)		6
7	PERCENTAGE OF SSI RECIPIENT PATIENT DAYS TO MEDICARE PART A PATIENT DAYS (Worksheet E, Part A line 30) (see instructions)		7
8	PERCENTAGE OF MEDICAID PATIENT DAYS TO TOTAL DAYS (see instructions)		8
9	SUM OF LINES 7 AND 8		9
10	ALLOWABLE DISPROPORTIONATE SHARE PERCENTAGE (see instructions)		10
11	DISPROPORTIONATE SHARE ADJUSTMENT (line 10 times the sum of lines 1 and 1.01)		11
12	TOTAL PROSPECTIVE CAPITAL PAYMENTS (sum of lines 1, 1.01, 2, 2.01, 6 and 11)	313,836	12

PART II - PAYMENT UNDER REASONABLE COST

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

PART III - COMPUTATION OF EXCEPTION PAYMENTS

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

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ALLOCATION OF ALLOWABLE COSTS FOR EXTRAORDINARY CIRCUMSTANCES

WORKSHEET L-1
PART I

	COST CENTER DESCRIPTIONS	EXTRAORDINARY CAP-REL COSTS	SUBTOTAL (cols.0-4)	SUBTOTAL	I&R COST & POST STEP-DOWN ADJS	TOTAL		
		0	2A	24	25	26		
	GENERAL SERVICE COST CENTERS							
1	CAP REL COSTS-BLDG & FIXT							1
2	CAP REL COSTS-MVBLE EQUIP							2
4	EMPLOYEE BENEFITS DEPARTMENT							4
5	ADMINISTRATIVE & GENERAL							5
6	MAINTENANCE & REPAIRS							6
7	OPERATION OF PLANT							7
8	LAUNDRY & LINEN SERVICE							8
9	HOUSEKEEPING							9
10	DIETARY							10
11	CAFETERIA							11
12	MAINTENANCE OF PERSONNEL							12
13	NURSING ADMINISTRATION							13
14	CENTRAL SERVICES & SUPPLY							14
15	PHARMACY							15
16	MEDICAL RECORDS & LIBRARY							16
17	SOCIAL SERVICE							17
19	NONPHYSICIAN ANESTHETISTS							19
20	NURSING SCHOOL							20
21	I&R SERVICES-SALARY & FRINGES APPRVD							21
22	I&R SERVICES-OTHER PRGM COSTS APPRVD							22
23	PARAMED ED PRGM-(SPECIFY)							23
	INPATIENT ROUTINE SERV COST CENTERS							
30	ADULTS & PEDIATRICS							30
40	SUBPROVIDER - IPF							40
	ANCILLARY SERVICE COST CENTERS							
50	OPERATING ROOM							50
53	ANESTHESIOLOGY							53
54	RADIOLOGY-DIAGNOSTIC							54
57	CT SCAN							57
60	LABORATORY							60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
64	INTRAVENOUS THERAPY							64
65	RESPIRATORY THERAPY							65
66	PHYSICAL THERAPY							66
69	ELECTROCARDIOLOGY							69
71	MEDICAL SUPPLIES CHARGED TO PATIENTS							71
72	IMPL. DEV. CHARGED TO PATIENTS							72
73	DRUGS CHARGED TO PATIENTS							73
75	ASC (NON-DISTINCT PART)							75
76	NUCLEAR MEDICINE							76
76.01	ULTRASOUND							76.01
76.02	MAMMOGRAPHY							76.02
76.03	CARDIAC REHABILITATION							76.03
76.04	FAITH CENTER CHEMOTHERAPY							76.04
76.06	ROUTINE ANCILLARY							76.06
76.97	CARDIAC REHABILITATION							76.97
76.98	HYPERBARIC OXYGEN THERAPY							76.98
76.99	LITHOTRIPSY							76.99
	OUTPATIENT SERVICE COST CENTERS							
88	RURAL HEALTH CLINIC							88
88.01	RHC II							88.01
91	EMERGENCY							91
92	OBSERVATION BEDS (NON-DISTINCT PART)							92
93	DAY PSYCHIATRIC							93
	OTHER REIMBURSABLE COST CENTERS							
99.10	CORF							99.10
99.20	OUTPATIENT PHYSICAL THERAPY							99.20
99.30	OUTPATIENT OCCUPATIONAL THERAPY							99.30
99.40	OUTPATIENT SPEECH PATHOLOGY							99.40
101	HOME HEALTH AGENCY							101
	SPECIAL PURPOSE COST CENTERS							
118	SUBTOTALS (sum of lines 1-117)							118
	NONREIMBURSABLE COST CENTERS							
190	GIFT, FLOWER, COFFEE SHOP & CANTEEN							190
192	PHYSICIANS' PRIVATE OFFICES							192
192.01	DIALYSIS							192.01
192.03	ORTHO CLINIC							192.03
200	CROSS FOOT ADJUSTMENTS							200
201	NEGATIVE COST CENTER							201
202	TOTAL (sum of lines 118-201)							202

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ANALYSIS OF PROVIDER-BASED RURAL HEALTH CLINIC/
FEDERALLY QUALIFIED HEALTH CENTER COSTS

COMPONENT CCN: 14-3473

WORKSHEET M-1

CHECK APPLICABLE BOX: RHC I FQHC

	COMPENSATION	OTHER COSTS	TOTAL (col. 1 + col. 2)	RECLASSIFICATIONS	RECLASSIFIED TRIAL BALANCE (col. 3 + col. 4)	ADJUSTMENTS	NET EXPENSES FOR ALLOCATION (col. 5 + col. 6)		
	1	2	3	4	5	6	7		
FACILITY HEALTH CARE STAFF COSTS									
1	PHYSICIAN	499,022	499,022		499,022		499,022	1	
2	PHYSICIAN ASSISTANT							2	
3	NURSE PRACTITIONER	339,130	339,130		339,130		339,130	3	
4	VISITING NURSE							4	
5	OTHER NURSE	171,242	171,242		171,242		171,242	5	
6	CLINICAL PSYCHOLOGIST	119,198	119,198		119,198	-20,800	98,398	6	
7	CLINICAL SOCIAL WORKER	55,936	55,936		55,936		55,936	7	
8	LABORATORY TECHNICIAN	66,436	66,436	-43,491	22,945		22,945	8	
9	OTHER FACILITY HEALTH CARE STAFF COSTS	51,954	51,954	-51,687	267		267	9	
10	SUBTOTAL (sum of lines 1-9)	1,302,918	1,302,918	-95,178	1,207,740	-20,800	1,186,940	10	
COSTS UNDER AGREEMENT									
11	PHYSICIAN SERVICES UNDER AGREEMENT							11	
12	PHYSICIAN SUPERVISION UNDER AGREEMENT							12	
13	OTHER COSTS UNDER AGREEMENT							13	
14	SUBTOTAL (sum of lines 11-13)							14	
OTHER HEALTH CARE COSTS									
15	MEDICAL SUPPLIES		22,912	22,912			22,912	15	
16	TRANSPORTATION (Health Care Staff)		5,514	5,514			5,514	16	
17	DEPRECIATION-MEDICAL EQUIPMENT				110,411		110,411	17	
18	PROFESSIONAL LIABILITY INSURANCE							18	
19	OTHER HEALTH CARE COSTS							19	
20	ALLOWABLE GME COSTS							20	
21	SUBTOTAL (sum of lines 15-20)		28,426	28,426	110,411		138,837	21	
22	TOTAL COST OF HEALTH CARE SERVICES (sum of lines 10, 14, and 21)	1,302,918	28,426	1,331,344	15,233	1,346,577	-20,800	1,325,777	22
COSTS OTHER THAN RHC/FQHC SERVICES									
23	PHARMACY							23	
24	DENTAL							24	
25	OPTOMETRY							25	
26	ALL OTHER NONREIMBURSABLE COSTS							26	
27	NONALLOWABLE GME COSTS							27	
28	TOTAL NONREIMBURSABLE COSTS (sum of lines 23-27)							28	
FACILITY OVERHEAD									
29	FACILITY COSTS		129,229	129,229	-17,665	111,564	111,564	29	
30	ADMINISTRATIVE COSTS	294,751	86,693	381,444	-2,484	378,960	-17,299	361,661	30
31	TOTAL FACILITY OVERHEAD (sum of lines 29 and 30)	294,751	215,922	510,673	-20,149	490,524	-17,299	473,225	31
32	TOTAL FACILITY COSTS (sum of lines 22, 28 and 31)	1,597,669	244,348	1,842,017	-4,916	1,837,101	-38,099	1,799,002	32

The net expenses for cost allocation on Worksheet A for the RHC/FQHC cost center line must equal the total facility costs in column 7, line 32 of this worksheet.

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ALLOCATION OF OVERHEAD TO RHC/FOHC SERVICES

COMPONENT CCN: 14-3473

WORKSHEET M-2

CHECK APPLICABLE BOX: RHC FQHC

VISITS AND PRODUCTIVITY

		NUMBER OF FTE PERSONNEL	TOTAL VISITS	PRODUCTIVITY STANDARD (1)	MINIMUM VISITS (col. 1 x col. 3)	GREATER OF COL. 2 OR COL. 4	
	POSITIONS	1	2	3	4	5	
1	PHYSICIANS	1.70	6,232	4,200	7,140		1
2	PHYSICIAN ASSISTANTS			2,100			2
3	NURSE PRACTITIONERS	2.53	7,246	2,100	5,313		3
4	SUBTOTAL (sum of lines 1-3)	4.23	13,478		12,453	13,478	4
5	VISITING NURSE						5
6	CLINICAL PSYCHOLOGIST	1.39	1,570			1,570	6
7	CLINICAL SOCIAL WORKER	0.87	848			848	7
7.01	MEDICAL NUTRITION THERAPIST (FOHC only)						7.01
7.02	DIABETES SELF MANAGEMENT TRAINING (FOHC only)						7.02
8	TOTAL FTEs AND VISITS (sum of lines 4-7)	6.49	15,896			15,896	8
9	PHYSICIAN SERVICES UNDER AGREEMENTS						9

DETERMINATION OF ALLOWABLE COST APPLICABLE TO RHC/FOHC SERVICES

10	TOTAL COSTS OF HEALTH CARE SERVICES (from Worksheet M-1, column 7, line 22)		1,325,777	10
11	TOTAL NONREIMBURSABLE COSTS (from Worksheet M-1, column 7, line 28)			11
12	COST OF ALL SERVICES (excluding overhead) (sum of lines 10 and 11)		1,325,777	12
13	RATIO OF RHC/FOHC SERVICES (line 10 divided by line 12)		1.000000	13
14	TOTAL FACILITY OVERHEAD (from Worksheet M-1, column 7, line 31)		473,225	14
15	PARENT PROVIDER OVERHEAD ALLOCATED TO FACILITY (see instructions)		1,154,689	15
16	TOTAL OVERHEAD (sum of lines 14 and 15)		1,627,914	16
17	ALLOWABLE DIRECT GME OVERHEAD (see instructions)			17
18	SUBTRACT LINE 17 FROM LINE 16		1,627,914	18
19	OVERHEAD APPLICABLE TO RHC/FOHC SERVICES (line 13 x line 18)		1,627,914	19
20	TOTAL ALLOWABLE COST OF RHC/FOHC SERVICES (sum of lines 10 and 19)		2,953,691	20

(1) The productivity standard for physicians is 4,200 and 2,100 for physician assistants and nurse practitioners. If an exception to the standard has been granted (Worksheet S-8, line 12 equals 'Y'), column 3, lines 1 thru 3 of this worksheet should contain, at a minimum, one element that is different than the standard.

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CALCULATION OF REIMBURSEMENT SETTLEMENT FOR RHC/FQHC SERVICES

COMPONENT CCN: 14-3473

WORKSHEET M-3

CHECK [XX] RHC I [] TITLE V [] TITLE XIX
 APPLICABLE BOXES: [] FQHC [XX] TITLE XVIII

DETERMINATION OF RATE FOR RHC/FQHC SERVICES

1	TOTAL ALLOWABLE COST OF RHC/FQHC SERVICES (from Worksheet M-2, line 20)	2,953,691	1
2	COST OF VACCINES AND THEIR ADMINISTRATION (from Worksheet M-4, line 15)	53,098	2
3	TOTAL ALLOWABLE COST EXCLUDING VACCINE (line 1 minus line 2)	2,900,593	3
4	TOTAL VISITS (from Worksheet M-2, column 5, line 8)	15,896	4
5	PHYSICIANS VISITS UNDER AGREEMENT (from Worksheet M-2, column 5, line 9)		5
6	TOTAL ADJUSTED VISITS (line 4 plus line 5)	15,896	6
7	ADJUSTED COST PER VISIT (line 3 divided by line 6)	182.47	7

		CALCULATION OF LIMIT (1)		
		PRIOR TO JANUARY 1	ON OR AFTER JANUARY 1	(SEE INSTR.)
		1	2	3
8	PER VISIT PAYMENT LIMIT (from CMS Pub. 100-04, chapter 9, §20.6 or your contractor)			8
9	RATE FOR PROGRAM COVERED VISITS (see instructions)	182.47	182.47	9
CALCULATION OF SETTLEMENT				
10	PROGRAM COVERED VISITS EXCLUDING MENTAL HEALTH SERVICES (from contractor records)		3,733	10
11	PROGRAM COST EXCLUDING COSTS FOR MENTAL HEALTH SERVICES (line 9 x line 10)		681,161	11
12	PROGRAM COVERED VISITS FOR MENTAL HEALTH SERVICES (from contractor records)		243	12
13	PROGRAM COVERED COST FROM MENTAL HEALTH SERVICES (line 9 x line 12)		44,340	13
14	LIMIT ADJUSTMENT FOR MENTAL HEALTH SERVICES (see instructions)		44,340	14
15	GRADUATE MEDICAL EDUCATION PASS-THROUGH COST (see instructions)			15
16	TOTAL PROGRAM COST (sum of lines 11, 14, and 15, columns 1, 2, and 3)		725,501	16
16.01	TOTAL PROGRAM CHARGES (see instructions)(from contractor's records)		601,141	16.01
16.02	TOTAL PROGRAM PREVENTIVE CHARGES (see instructions)(from provider's records)		217	16.02
16.03	TOTAL PROGRAM PREVENTIVE COSTS (see instructions)		262	16.03
16.04	TOTAL PROGRAM NON-PREVENTIVE COSTS (see instructions)		538,158	16.04
16.05	TOTAL PROGRAM COST (see instructions)		538,420	16.05
17	PRIMARY PAYER PAYMENTS		663	17
18	LESS: BENEFICIARY DEDUCTIBLE FOR RHC ONLY (see instructions)(from contractor records)		52,541	18
19	LESS: BENEFICIARY COINSURANCE FOR RHC/FQHC SERVICES (see instructions) (from contractor records)		113,652	19
20	NET MEDICARE COST EXCLUDING VACCINES (see instructions)		537,757	20
21	PROGRAM COST OF VACCINES AND THEIR ADMINISTRATION (from Worksheet M-4, line 16)		10,477	21
22	TOTAL REIMBURSABLE PROGRAM COST (line 20 plus line 21)		548,234	22
23	ALLOWABLE BAD DEBTS (see instructions)		39,214	23
24	ALLOWABLE BAD DEBTS FOR DUAL ELIGIBLE BENEFICIARIES (see instructions)		32,386	24
25	OTHER ADJUSTMENTS (SPECIFY) (see instructions)			25
26	NET REIMBURSABLE AMOUNT (see instructions)		582,742	26
26.01	SEQUESTRATION ADJUSTMENT (see instructions)		11,655	26.01
27	INTERIM PAYMENTS		581,623	27
28	TENTATIVE SETTLEMENT (for contractor use only)			28
29	BALANCE DUE COMPONENT/PROGRAM (line 26 minus lines 26.01, 27 and 28)		-10,536	29
30	PROTESTED AMOUNTS (nonallowable cost report items) IN ACCORDANCE WITH CMS PUB. 15-2, CHAPTER 1, SECTION 115.2			30

(1) Lines 8 through 14: Fiscal year providers use columns 1 & 2, calendar year providers use column 2 only.

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CALCULATION OF PNEUMOCOCCAL AND INFLUENZA VACCINE COST

COMPONENT CCN: 14-3473

WORKSHEET M-4

CHECK [XX] RHC I [] TITLE V [] TITLE XIX
 APPLICABLE BOXES: [] FQHC [XX] TITLE XVIII

		PNEUMO- COCCAL	INFLUENZA	
		1	2	
1	HEALTH CARE STAFF COST (from Worksheet M-1, column 7, line 10)	1,186,940	1,186,940	1
2	RATIO OF PNEUMOCOCCAL AND INFLUNZA VACCINE STAFF TIME TO TOTAL HEALTH CARE STAFF TIME	0.000402	0.004503	2
3	PNEUMOCOCCAL AND INFLUNZA VACCINE HEALTH CARE STAFF COST (line 1 x line 2)	477	5,345	3
4	MEDICAL SUPPLIES COST - PNEUMOCOCCAL AND INFLUNZA VACCINE (from your records)	6,174	11,837	4
5	DIRECT COST OF PNEUMOCOCCAL AND INFLUNZA VACCINE (line 3 plus line 4)	6,651	17,182	5
6	TOTAL DIRECT COST OF THE FACILITY (from Worksheet M-1, column 7, line 22)	1,325,777	1,325,777	6
7	TOTAL OVERHEAD (from Worksheet M-2, line 16)	1,627,914	1,627,914	7
8	RATIO OF PNEUMOCOCCAL AND INFLUNZA VACCINE DIRECT COST TO TOTAL DIRECT COST (line 5 divided by line 6)	0.005017	0.012960	8
9	OVERHEAD COST - PNEUMOCOCCAL AND INFLUNZA VACCINE (line 7 x line 8)	8,167	21,098	9
10	TOTAL PNEUMOCOCCAL AND INFLUNZA VACCINE COSTS AND THEIR ADMINISTRATION COSTS (sum of lines 5 and 9)	14,818	38,280	10
11	TOTAL NUMBER OF PNEUMOCOCCAL AND INFLUNZA VACCINE INJECTIONS (from your records)	98	1,012	11
12	COST PER PNEUMOCOCCAL AND INFLUNZA VACCINE INJECTION (line 10/line 11)	151.20	37.83	12
13	NUMBER OF PNEUMOCOCCAL AND INFLUNZA VACCINE INJECTIONS ADMINISTERED TO PROGRAM BENEFICIARIES	14	221	13
14	PROGRAM COST OF PNEUMOCOCCAL AND INFLUNZA VACCINES AND THEIR ADMINISTRATION COSTS (line 12 x line 13)	2,117	8,360	14
15	TOTAL COST OF PNEUMOCOCCAL AND INFLUNZA VACCINES AND THEIR ADMINISTRATION COSTS (sum of columns 1 and 2, line 10) (transfer this amount to Worksheet M-3, line 2)		53,098	15
16	TOTAL PROGRAM COST OF PNEUMOCOCCAL AND INFLUNZA VACCINES AND THEIR ADMINISTRATION COSTS (sum of columns 1 and 2, line 14) (transfer this amount to Worksheet M-3, line 21)		10,477	16

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ANALYSIS OF PROVIDER-BASED RURAL HEALTH CLINIC/
FEDERALLY QUALIFIED HEALTH CENTER COSTS

COMPONENT CCN: 14-8518

WORKSHEET M-1

CHECK APPLICABLE BOX: RHC II

FQHC

		COMPENSATION	OTHER COSTS	TOTAL (col. 1 + col. 2)	RECLASSIFICATIONS	RECLASSIFIED TRIAL BALANCE (col. 3 + col. 4)	ADJUSTMENTS	NET EXPENSES FOR ALLOCATION (col. 5 + col. 6)	
		1	2	3	4	5	6	7	
	FACILITY HEALTH CARE STAFF COSTS								
1	PHYSICIAN	35,319		35,319		35,319		35,319	1
2	PHYSICIAN ASSISTANT								2
3	NURSE PRACTITIONER	100,404		100,404		100,404		100,404	3
4	VISITING NURSE								4
5	OTHER NURSE	14,597		14,597		14,597		14,597	5
6	CLINICAL PSYCHOLOGIST								6
7	CLINICAL SOCIAL WORKER								7
8	LABORATORY TECHNICIAN	7,812		7,812	-7,306	506		506	8
9	OTHER FACILITY HEALTH CARE STAFF COSTS								9
10	SUBTOTAL (sum of lines 1-9)	158,132		158,132	-7,306	150,826		150,826	10
	COSTS UNDER AGREEMENT								
11	PHYSICIAN SERVICES UNDER AGREEMENT								11
12	PHYSICIAN SUPERVISION UNDER AGREEMENT								12
13	OTHER COSTS UNDER AGREEMENT								13
14	SUBTOTAL (sum of lines 11-13)								14
	OTHER HEALTH CARE COSTS								
15	MEDICAL SUPPLIES		2,876	2,876		2,876		2,876	15
16	TRANSPORTATION (Health Care Staff)		3,044	3,044		3,044		3,044	16
17	DEPRECIATION-MEDICAL EQUIPMENT								17
18	PROFESSIONAL LIABILITY INSURANCE								18
19	OTHER HEALTH CARE COSTS								19
20	ALLOWABLE GME COSTS								20
21	SUBTOTAL (sum of lines 15-20)		5,920	5,920		5,920		5,920	21
22	TOTAL COST OF HEALTH CARE SERVICES (sum of lines 10, 14, and 21)	158,132	5,920	164,052	-7,306	156,746		156,746	22
	COSTS OTHER THAN RHC/FQHC SERVICES								
23	PHARMACY								23
24	DENTAL								24
25	OPTOMETRY								25
26	ALL OTHER NONREIMBURSABLE COSTS								26
27	NONALLOWABLE GME COSTS								27
28	TOTAL NONREIMBURSABLE COSTS (sum of lines 23-27)								28
	FACILITY OVERHEAD								
29	FACILITY COSTS		34,922	34,922		34,922		34,922	29
30	ADMINISTRATIVE COSTS	21,681	2,856	24,537		24,537		24,537	30
31	TOTAL FACILITY OVERHEAD (sum of lines 29 and 30)	21,681	37,778	59,459		59,459		59,459	31
32	TOTAL FACILITY COSTS (sum of lines 22, 28 and 31)	179,813	43,698	223,511	-7,306	216,205		216,205	32

The net expenses for cost allocation on Worksheet A for the RHC/FQHC cost center line must equal the total facility costs in column 7, line 32 of this worksheet.

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ALLOCATION OF OVERHEAD TO RHC/FQHC SERVICES

COMPONENT CCN: 14-8518

WORKSHEET M-2

CHECK APPLICABLE BOX: RHC II

FQHC

VISITS AND PRODUCTIVITY

		NUMBER OF FTE PERSONNEL	TOTAL VISITS	PRODUCTIVITY STANDARD (1)	MINIMUM VISITS (col. 1 x col. 3)	GREATER OF COL. 2 OR COL. 4	
	POSITIONS	1	2	3	4	5	
1	PHYSICIANS	0.05	272	4,200	210		1
2	PHYSICIAN ASSISTANTS			2,100			2
3	NURSE PRACTITIONERS	0.84	1,713	2,100	1,764		3
4	SUBTOTAL (sum of lines 1-3)	0.89	1,985		1,974	1,985	4
5	VISITING NURSE						5
6	CLINICAL PSYCHOLOGIST						6
7	CLINICAL SOCIAL WORKER						7
7.01	MEDICAL NUTRITION THERAPIST (FQHC only)						7.01
7.02	DIABETES SELF MANAGEMENT TRAINING (FQHC only)						7.02
8	TOTAL FTEs AND VISITS (sum of lines 4-7)	0.89	1,985			1,985	8
9	PHYSICIAN SERVICES UNDER AGREEMENTS						9
DETERMINATION OF ALLOWABLE COST APPLICABLE TO RHC/FQHC SERVICES							
10	TOTAL COSTS OF HEALTH CARE SERVICES (from Worksheet M-1, column 7, line 22)					156,746	10
11	TOTAL NONREIMBURSABLE COSTS (from Worksheet M-1, column 7, line 28)						11
12	COST OF ALL SERVICES (excluding overhead) (sum of lines 10 and 11)					156,746	12
13	RATIO OF RHC/FQHC SERVICES (line 10 divided by line 12)					1.000000	13
14	TOTAL FACILITY OVERHEAD (from Worksheet M-1, column 7, line 31)					59,459	14
15	PARENT PROVIDER OVERHEAD ALLOCATED TO FACILITY (see instructions)					112,732	15
16	TOTAL OVERHEAD (sum of lines 14 and 15)					172,191	16
17	ALLOWABLE DIRECT GME OVERHEAD (see instructions)						17
18	SUBTRACT LINE 17 FROM LINE 16					172,191	18
19	OVERHEAD APPLICABLE TO RHC/FQHC SERVICES (line 13 x line 18)					172,191	19
20	TOTAL ALLOWABLE COST OF RHC/FQHC SERVICES (sum of lines 10 and 19)					328,937	20

(1) The productivity standard for physicians is 4,200 and 2,100 for physician assistants and nurse practitioners. If an exception to the standard has been granted (Worksheet S-8, line 12 equals 'Y'), column 3, lines 1 thru 3 of this worksheet should contain, at a minimum, one element that is different than the standard.

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CALCULATION OF REIMBURSEMENT SETTLEMENT FOR RHC/FQHC SERVICES

COMPONENT CCN: 14-8518

WORKSHEET M-3

CHECK [XX] RHC II [] TITLE V [] TITLE XIX
 APPLICABLE BOXES: [] FQHC [XX] TITLE XVIII

DETERMINATION OF RATE FOR RHC/FQHC SERVICES

1	TOTAL ALLOWABLE COST OF RHC/FQHC SERVICES (from Worksheet M-2, line 20)	328,937	1
2	COST OF VACCINES AND THEIR ADMINISTRATION (from Worksheet M-4, line 15)	6,725	2
3	TOTAL ALLOWABLE COST EXCLUDING VACCINE (line 1 minus line 2)	322,212	3
4	TOTAL VISITS (from Worksheet M-2, column 5, line 8)	1,985	4
5	PHYSICIANS VISITS UNDER AGREEMENT (from Worksheet M-2, column 5, line 9)		5
6	TOTAL ADJUSTED VISITS (line 4 plus line 5)	1,985	6
7	ADJUSTED COST PER VISIT (line 3 divided by line 6)	162.32	7

		CALCULATION OF LIMIT (1)		
		PRIOR TO JANUARY 1	ON OR AFTER JANUARY 1	(SEE INSTR.)
		1	2	3
8	PER VISIT PAYMENT LIMIT (from CMS Pub. 100-04, chapter 9, §20.6 or your contractor)			8
9	RATE FOR PROGRAM COVERED VISITS (see instructions)	162.32	162.32	9
CALCULATION OF SETTLEMENT				
10	PROGRAM COVERED VISITS EXCLUDING MENTAL HEALTH SERVICES (from contractor records)		495	10
11	PROGRAM COST EXCLUDING COSTS FOR MENTAL HEALTH SERVICES (line 9 x line 10)		80,348	11
12	PROGRAM COVERED VISITS FOR MENTAL HEALTH SERVICES (from contractor records)			12
13	PROGRAM COVERED COST FROM MENTAL HEALTH SERVICES (line 9 x line 12)			13
14	LIMIT ADJUSTMENT FOR MENTAL HEALTH SERVICES (see instructions)			14
15	GRADUATE MEDICAL EDUCATION PASS-THROUGH COST (see instructions)			15
16	TOTAL PROGRAM COST (sum of lines 11, 14, and 15, columns 1, 2, and 3)		80,348	16
16.01	TOTAL PROGRAM CHARGES (see instructions)(from contractor's records)		76,217	16.01
16.02	TOTAL PROGRAM PREVENTIVE CHARGES (see instructions)(from provider's records)			16.02
16.03	TOTAL PROGRAM PREVENTIVE COSTS (see instructions)			16.03
16.04	TOTAL PROGRAM NON-PREVENTIVE COSTS (see instructions)		58,920	16.04
16.05	TOTAL PROGRAM COST (see instructions)		58,920	16.05
17	PRIMARY PAYER PAYMENTS			17
18	LESS: BENEFICIARY DEDUCTIBLE FOR RHC ONLY (see instructions)(from contractor records)		6,698	18
19	LESS: BENEFICIARY COINSURANCE FOR RHC/FQHC SERVICES (see instructions) (from contractor records)		13,904	19
20	NET MEDICARE COST EXCLUDING VACCINES (see instructions)		58,920	20
21	PROGRAM COST OF VACCINES AND THEIR ADMINISTRATION (from Worksheet M-4, line 16)		1,327	21
22	TOTAL REIMBURSABLE PROGRAM COST (line 20 plus line 21)		60,247	22
23	ALLOWABLE BAD DEBTS (see instructions)		6,828	23
24	ALLOWABLE BAD DEBTS FOR DUAL ELIGIBLE BENEFICIARIES (see instructions)		6,828	24
25	OTHER ADJUSTMENTS (SPECIFY) (see instructions)			25
26	NET REIMBURSABLE AMOUNT (see instructions)		66,256	26
26.01	SEQUESTRATION ADJUSTMENT (see instructions)		1,325	26.01
27	INTERIM PAYMENTS		87,499	27
28	TENTATIVE SETTLEMENT (for contractor use only)			28
29	BALANCE DUE COMPONENT/PROGRAM (line 26 minus lines 26.01, 27 and 28)		-22,568	29
30	PROTESTED AMOUNTS (nonallowable cost report items) IN ACCORDANCE WITH CMS PUB. 15-2, CHAPTER 1, SECTION 115.2			30

(1) Lines 8 through 14: Fiscal year providers use columns 1 & 2, calendar year providers use column 2 only.

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CALCULATION OF PNEUMOCOCCAL AND INFLUENZA VACCINE COST

COMPONENT CCN: 14-8518

WORKSHEET M-4

CHECK [XX] RHC II [] TITLE V [] TITLE XIX
 APPLICABLE BOXES: [] FQHC [XX] TITLE XVIII

		PNEUMO- COCCAL	INFLUENZA	
		1	2	
1	HEALTH CARE STAFF COST (from Worksheet M-1, column 7, line 10)	150,826	150,826	1
2	RATIO OF PNEUMOCOCCAL AND INFLUNZA VACCINE STAFF TIME TO TOTAL HEALTH CARE STAFF TIME	0.000485	0.004233	2
3	PNEUMOCOCCAL AND INFLUENZA VACCINE HEALTH CARE STAFF COST (line 1 x line 2)	75	638	3
4	MEDICAL SUPPLIES COST - PNEUMOCOCCAL AND INFLUENZA VACCINE (from your records)	986	1,508	4
5	DIRECT COST OF PNEUMOCOCCAL AND INFLUENZA VACCINE (line 3 plus line 4)	1,059	2,146	5
6	TOTAL DIRECT COST OF THE FACILITY (from Worksheet M-1, column 7, line 22)	156,746	156,746	6
7	TOTAL OVERHEAD (from Worksheet M-2, line 16)	172,191	172,191	7
8	RATIO OF PNEUMOCOCCAL AND INFLUENZA VACCINE DIRECT COST TO TOTAL DIRECT COST (line 5 divided by line 6)	0.006756	0.013691	8
9	OVERHEAD COST - PNEUMOCOCCAL AND INFLUENZA VACCINE (line 7 x line 8)	1,163	2,357	9
10	TOTAL PNEUMOCOCCAL AND INFLUENZA VACCINE COSTS AND THEIR ADMINISTRATION COSTS (sum of lines 5 and 9)	2,222	4,303	10
11	TOTAL NUMBER OF PNEUMOCOCCAL AND INFLUENZA VACCINE INJECTIONS (from your records)	15	131	11
12	COST PER PNEUMOCOCCAL AND INFLUENZA VACCINE INJECTION (line 10/line 11)	148.13	34.37	12
13	NUMBER OF PNEUMOCOCCAL AND INFLUENZA VACCINE INJECTIONS ADMINISTERED TO PROGRAM BENEFICIARIES	2	30	13
14	PROGRAM COST OF PNEUMOCOCCAL AND INFLUENZA VACCINES AND THEIR ADMINISTRATION COSTS (line 12 x line 13)	296	1,031	14
15	TOTAL COST OF PNEUMOCOCCAL AND INFLUENZA VACCINES AND THEIR ADMINISTRATION COSTS (sum of columns 1 and 2, line 10) (transfer this amount to Worksheet M-3, line 2)		6,725	15
16	TOTAL PROGRAM COST OF PNEUMOCOCCAL AND INFLUENZA VACCINES AND THEIR ADMINISTRATION COSTS (sum of columns 1 and 2, line 14) (transfer this amount to Worksheet M-3, line 21)		1,327	16

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HARRISBURG MEDICAL CENTER, INC. Provider CCN: 14-0210	Non CMS worksheet CMS-2552-10	Period : From: 07/01/2013 To: 06/30/2014	Run Date: 11/11/2014 Run Time: 12:00 Version: 2014.10
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REPORT 97 - UTILIZATION STATISTICS - HOSPITAL

	COST CENTERS	TITLE XVIII		TITLE XIX		TITLE V		TOTAL THIRD PARTY UTIL	
		PART A	PART B	INPATIENT	OUTPAT- IENT	INPATIENT	OUTPAT- IENT		
		1	2	3	4	5	6	7	
	UTILIZATION PERCENTAGES BASED ON DAYS								
30	ADULTS & PEDIATRICS	44.60		8.85				53.45	30
	UTILIZATION PERCENTAGES BASED ON CHARGES								
50	OPERATING ROOM	7.40	24.38					31.78	50
53	ANESTHESIOLOGY	8.01	28.13					36.14	53
54	RADIOLOGY-DIAGNOSTIC	8.05	29.89					37.94	54
57	CT SCAN	9.44	28.82					38.26	57
60	LABORATORY	13.07	9.64					22.71	60
64	INTRAVENOUS THERAPY	39.86	14.11					53.97	64
65	RESPIRATORY THERAPY	23.85	24.68					48.53	65
66	PHYSICAL THERAPY	9.79	0.04					9.83	66
69	ELECTROCARDIOLOGY	13.32	28.20					41.52	69
71	MEDICAL SUPPLIES CHARGED TO PAT	24.08	18.81					42.89	71
72	IMPL. DEV. CHARGED TO PATIENTS	3.62	54.55					58.17	72
73	DRUGS CHARGED TO PATIENTS	11.49	35.97					47.46	73
75	ASC (NON-DISTINCT PART)	4.81	39.80					44.61	75
76	NUCLEAR MEDICINE	1.21	41.94					43.15	76
76.01	ULTRASOUND	12.66	23.37					36.03	76.01
76.03	CARDIAC REHABILITATION	0.32	62.15					62.47	76.03
76.04	FAITH CENTER CHEMOTHERAPY		21.64					21.64	76.04
91	EMERGENCY	6.91	20.98					27.89	91
92	OBSERVATION BEDS (NON-DISTINCT	12.73	32.52					45.25	92
93	DAY PSYCHIATRIC		23.32					23.32	93
200	TOTAL CHARGES	12.37	22.39					34.76	200

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HARRISBURG MEDICAL CENTER, INC. Provider CCN: 14-0210	Non CMS worksheet CMS-2552-10	Period : From: 07/01/2013 To: 06/30/2014	Run Date: 11/11/2014 Run Time: 12:00 Version: 2014.10
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REPORT 97 - UTILIZATION STATISTICS - SUBPROVIDER-IPF

	COST CENTERS	TITLE XVIII		TITLE XIX		TITLE V		TOTAL THIRD PARTY UTIL	
		PART A	PART B	INPATIENT	OUTPAT- IENT	INPATIENT	OUTPAT- IENT		
		1	2	3	4	5	6	7	
	UTILIZATION PERCENTAGES BASED ON DAYS								
40	SUBPROVIDER - IPF	38.61		33.13				71.74	40
	UTILIZATION PERCENTAGES BASED ON CHARGES								
53	ANESTHESIOLOGY	1.07						1.07	53
54	RADIOLOGY-DIAGNOSTIC	0.84	0.03					0.87	54
57	CT SCAN	0.95	0.03					0.98	57
60	LABORATORY	1.83						1.83	60
64	INTRAVENOUS THERAPY	0.73	0.03					0.76	64
65	RESPIRATORY THERAPY	4.94	0.09					5.03	65
66	PHYSICAL THERAPY	1.41						1.41	66
69	ELECTROCARDIOLOGY	1.76	0.03					1.79	69
71	MEDICAL SUPPLIES CHARGED TO PAT	3.01	0.20					3.21	71
73	DRUGS CHARGED TO PATIENTS	8.00	0.01					8.01	73
75	ASC (NON-DISTINCT PART)	0.07						0.07	75
76.01	ULTRASOUND	0.34						0.34	76.01
91	EMERGENCY	1.31						1.31	91
200	TOTAL CHARGES	1.76	0.02					1.78	200

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REPORT 97 - UTILIZATION STATISTICS - SWING-BED SNF / NF

COST CENTERS	TITLE XVIII		TITLE XIX		TITLE V		TOTAL THIRD PARTY UTIL	
	PART A	PART B	INPATIENT	OUTPAT- IENT	INPATIENT	OUTPAT- IENT		
	1	2	3	4	5	6	7	
UTILIZATION PERCENTAGES BASED ON CHARGES								
54	RADIOLOGY-DIAGNOSTIC	0.07					0.07	54
60	LABORATORY	0.15					0.15	60
64	INTRAVENOUS THERAPY	0.19					0.19	64
65	RESPIRATORY THERAPY	0.78					0.78	65
66	PHYSICAL THERAPY	2.71					2.71	66
69	ELECTROCARDIOLOGY	0.03					0.03	69
71	MEDICAL SUPPLIES CHARGED TO PAT	0.46					0.46	71
73	DRUGS CHARGED TO PATIENTS	0.31					0.31	73
75	ASC (NON-DISTINCT PART)	0.05					0.05	75
76.01	ULTRASOUND	0.01					0.01	76.01
200	TOTAL CHARGES	0.20					0.20	200

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REPORT 98 - COST ALLOCATION SUMMARY

	COST CENTERS	DIRECT COSTS		ALLOCATED OVERHEAD		TOTAL COSTS		
		AMOUNT	%	AMOUNT	%	AMOUNT	%	
		1	2	3	4	5	6	
GENERAL SERVICE COST CENTERS								
1	CAP REL COSTS-BLDG & FIXT	787,606	2.21	-787,606	-4.68			1
2	CAP REL COSTS-MVBLE EQUIP	974,205	2.74	-974,205	-5.79			2
3	OTHER CAP REL COSTS							3
4	EMPLOYEE BENEFITS DEPARTMENT	5,419,814	15.24	-5,419,814	-32.19			4
5	ADMINISTRATIVE & GENERAL	5,666,301	15.93	-5,666,301	-33.65			5
6	MAINTENANCE & REPAIRS							6
7	OPERATION OF PLANT	1,015,353	2.86	-1,015,353	-6.03			7
8	LAUNDRY & LINEN SERVICE	139,263	0.39	-139,263	-0.83			8
9	HOUSEKEEPING	572,563	1.61	-572,563	-3.40			9
10	DIETARY	696,007	1.96	-696,007	-4.13			10
11	CAFETERIA							11
12	MAINTENANCE OF PERSONNEL							12
13	NURSING ADMINISTRATION	61,946	0.17	-61,946	-0.37			13
14	CENTRAL SERVICES & SUPPLY	323,386	0.91	-323,386	-1.92			14
15	PHARMACY	531,762	1.50	-531,762	-3.16			15
16	MEDICAL RECORDS & LIBRARY	648,258	1.82	-648,258	-3.85			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	2,815,027	8.00	2,831,560	16.82	5,676,587	15.96	30
40	SUBPROVIDER - IPF	2,655,136	7.47	2,615,557	15.54	5,270,693	14.82	40
ANCILLARY SERVICE COST CENTERS								
50	OPERATING ROOM	565,884	1.59	1,200,065	7.13	1,765,949	4.97	50
53	ANESTHESIOLOGY	35,041	0.10	271,863	1.61	306,904	0.86	53
54	RADIOLOGY-DIAGNOSTIC	677,486	1.91	675,518	4.01	1,353,004	3.80	54
57	CT SCAN	313,604	0.88	516,927	1.88	630,531	1.77	57
60	LABORATORY	1,932,271	5.43	1,077,277	6.40	3,009,548	8.46	60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
64	INTRAVENOUS THERAPY	78,300	0.22	93,362	0.55	171,662	0.48	64
65	RESPIRATORY THERAPY	538,679	1.51	429,119	2.55	967,798	2.72	65
66	PHYSICAL THERAPY	646,093	1.82	658,368	3.91	1,304,461	3.67	66
69	ELECTROCARDIOLOGY	83,257	0.23	64,748	0.38	148,005	0.42	69
71	MEDICAL SUPPLIES CHARGED TO PATIENTS	619,954	1.74	174,803	1.04	794,757	2.23	71
72	IMPL. DEV. CHARGED TO PATIENTS	91,228	0.26	25,295	0.15	116,523	0.33	72
73	DRUGS CHARGED TO PATIENTS	1,783,878	5.02	1,427,899	8.48	3,211,777	9.03	73
75	ASC (NON-DISTINCT PART)	569,656	1.60	719,681	4.27	1,289,337	3.63	75
76	NUCLEAR MEDICINE	312,851	0.88	217,081	1.29	529,932	1.49	76
76.01	ULTRASOUND	224,254	0.63	208,723	1.24	432,977	1.22	76.01
76.02	MAMMOGRAPHY	119,989	0.34	74,824	0.44	194,813	0.55	76.02
76.03	CARDIAC REHABILITATION	79,780	0.22	62,489	0.37	142,269	0.40	76.03
76.04	FAITH CENTER CHEMOTHERAPY	112,839	0.32	115,422	0.69	228,261	0.64	76.04
76.06	ROUTINE ANCILLARY							76.06
76.97	CARDIAC REHABILITATION							76.97
76.98	HYPERBARIC OXYGEN THERAPY							76.98
76.99	LITHOTRIPSY							76.99
88	RURAL HEALTH CLINIC	1,799,002	5.06	1,154,689	6.86	2,953,691	8.31	88
88.01	RHC II	216,205	0.61	112,732	0.67	328,937	0.93	88.01
91	EMERGENCY	1,178,401	3.31	1,488,965	8.84	2,667,366	7.50	91
92	OBSERVATION BEDS (NON-DISTINCT PART)							92
93	DAY PSYCHIATRIC	230,706	0.65	231,836	1.38	462,542	1.30	93
OTHER REIMBURSABLE COST CENTERS								
OUTPATIENT SERVICE COST CENTERS								
99.10	CORF							99.10
99.20	OUTPATIENT PHYSICAL THERAPY							99.20
99.30	OUTPATIENT OCCUPATIONAL THERAPY							99.30
99.40	OUTPATIENT SPEECH PATHOLOGY							99.40
101	HOME HEALTH AGENCY	530,201	1.49	309,414	1.84	839,615	2.36	101
SPECIAL PURPOSE COST CENTERS								
NONREIMBURSABLE COST CENTERS								
190	GIFT, FLOWER, COFFEE SHOP & CANTEEN	195,918	0.55	98,491	0.58	294,409	0.83	190
192	PHYSICIANS' PRIVATE OFFICES	276,762	0.78	176,925	1.05	453,687	1.28	192
192.0	DIALYSIS							192.0
1								1
192.0	ORTHO CLINIC	11,376	0.03	2,831	0.02	14,207	0.04	192.0
3								3
200	CROSS FOOT ADJUSTMENTS							200
201	NEGATIVE COST CENTER							201
202	TOTAL	35,560,242	100.00			35,560,242	100.00	202

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REPORT 99 - APPORTIONMENT OF INPATIENT MEDICARE ANCILLARY SERVICE PPS CAPITAL COSTS

	COST CENTER DESCRIPTION	CAPITAL RELATED COSTS	TOTAL CHARGES	RATIO OF CAPITAL COSTS TO CHARGES	INPATIENT PROGRAM CHARGES	MEDICARE INPATIENT PPS CAPITAL COSTS	
		1	2	3	4	5	
	ANCILLARY SERVICE COST CENTERS						
50	OPERATING ROOM	251,596	2,257,297	0.111459	166,979	18,611	50
53	ANESTHESIOLOGY	15,105	2,019,118	0.007481	161,777	1,210	53
54	RADIOLOGY-DIAGNOSTIC	141,408	4,122,715	0.034300	331,882	11,384	54
57	CT SCAN	24,349	15,533,072	0.001568	1,466,969	2,300	57
60	LABORATORY	125,449	17,709,082	0.007084	2,314,993	16,399	60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS						62.30
64	INTRAVENOUS THERAPY	5,688	6,589,363	0.000863	2,626,258	2,266	64
65	RESPIRATORY THERAPY	70,321	3,172,254	0.022168	756,729	16,775	65
66	PHYSICAL THERAPY	99,614	3,081,555	0.032526	301,533	9,747	66
69	ELECTROCARDIOLOGY	31,785	1,589,907	0.019992	211,719	4,233	69
71	MEDICAL SUPPLIES CHARGED TO PAT	13,850	2,095,025	0.006611	504,529	3,335	71
72	IMPL. DEV. CHARGED TO PATIENTS	2,012	264,644	0.007603	9,588	73	72
73	DRUGS CHARGED TO PATIENTS	94,180	7,951,976	0.011844	913,513	10,820	73
75	ASC (NON-DISTINCT PART)	91,012	3,849,891	0.023640	185,030	4,374	75
76	NUCLEAR MEDICINE	67,895	2,203,244	0.030816	26,721	823	76
76.01	ULTRASOUND	32,550	3,620,055	0.008992	458,476	4,123	76.01
76.02	MAMMOGRAPHY	9,928	747,744	0.013277			76.02
76.03	CARDIAC REHABILITATION	10,451	404,021	0.025867	1,286	33	76.03
76.04	FAITH CENTER CHEMOTHERAPY	17,206	230,020	0.074802			76.04
76.06	ROUTINE ANCILLARY						76.06
76.97	CARDIAC REHABILITATION						76.97
76.98	HYPERBARIC OXYGEN THERAPY						76.98
76.99	LITHOTRIPSY						76.99
88	RURAL HEALTH CLINIC	56,754	2,462,553	0.023047			88
88.01	RHC II	5,589	230,862	0.024209			88.01
	OUTPATIENT SERVICE COST CENTERS						
91	EMERGENCY	116,123	7,301,177	0.015905	504,850	8,030	91
92	OBSERVATION BEDS (NON-DISTINCT	87,060	3,341,832	0.026052	425,411	11,083	92
93	DAY PSYCHIATRIC	38,807	1,131,023	0.034311			93
	OTHER REIMBURSABLE COST CENTERS						
200	TOTAL	1,408,732	91,908,430		11,368,243	125,619	200

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REPORT 99 - APPORTIONMENT OF INPATIENT MEDICARE ROUTINE SERVICE PPS CAPITAL COSTS

	COST CENTER DESCRIPTION	CAPITAL RELATED COSTS	SWING-BED ADJUSTMENT AMOUNT	REDUCED CAPITAL RELATED COST	TOTAL PATIENT DAYS	PER DIEM	INPATIENT PROGRAM DAYS	MEDICARE INPATIENT PPS CAPITAL COSTS	
		1	2	3	4	5	6	7	
	INPATIENT ROUTINE SERVICE COST CENTERS								
30	ADULTS & PEDIATRICS	297,429	2,064	295,365	5,514	53.57	2,459	131,729	30
200	TOTAL	297,429	2,064	295,365	5,514		2,459	131,729	200

MEDICARE INPATIENT ROUTINE SERVICE PPS CAPITAL COSTS	131,729
MEDICARE INPATIENT ANCILLARY SERVICE PPS CAPITAL COSTS	125,619
TOTAL MEDICARE INPATIENT PPS CAPITAL COSTS	257,348
MEDICARE DISCHARGES (Worksheet S-3, Part I, line 14, column 13)	830
MEDICARE PATIENT DAYS (Worksheet S-3, Part I, line 14, column 6 - Worksheet S-3, Part I, line 5, column 6)	2,459
PER DISCHARGE CAPITAL COSTS	310.06

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I. COST TO CHARGE RATIO FOR PPS HOSPITALS

1. TOTAL PROGRAM (Title XVIII) INPATIENT OPERATING COST EXCLUDING CAPITAL RELATED, NONPHYSICIAN ANESTHETIST AND MEDICAL EDUCATION COST. (Worksheet D-1, Part II, line 53)	4,507,208
2. HOSPITAL PART A TITLE XVIII CHARGES (sum of inpatient charges and ancillary charges on Worksheet D-3 for hospital Title XVIII component)	13,705,418
3. RATIO OF COST TO CHARGES (line 1 / line 2)	0.329

COST TO CHARGE RATIO FOR PSYCH SUBPROVIDER

1. TOTAL MEDICARE COSTS (Worksheet D-1, Part II, line 49 - (Worksheet D, Part III, column 9, line 40 + Worksheet D, Part IV, column 11, line 200))	2,583,443
2. TOTAL MEDICARE CHARGES (Worksheet D-3, line 40, column 2 plus Worksheet D-3, line 202, column 2) (see CR 5619)	5,733,152
3. RATIO OF COST TO CHARGES (line 1 / line 2)	0.451

II. COST TO CHARGE RATIO FOR CAPITAL

1. TOTAL MEDICARE INPATIENT PPS CAPITAL RELATED COSTS (Worksheet D, Part I, lines 30-35, column 7 + Worksheet D, Part II, line 200, column 5)	257,348
2. RATIO OF COST TO CHARGES (line II-1 / line I-2)	0.019

III. COST TO CHARGE RATIO FOR OUTPATIENT SERVICES

1. TOTAL PROGRAM (Title XVIII) OUTPATIENT COST EXCLUDING SERVICES NOT SUBJECT TO OPPTS. (Worksheet D, Part V, columns 2, 2.01, 2.02 x column 1 less lines 61, 66-68, 74, 94, 95 & 96)	5,245,554
2. TOTAL PROGRAM (TITLE XVIII) OUTPATIENT CHARGES EXCLUDING SERVICES NOT SUBJECT TO OPPTS. (Worksheet D, Part V, line 202, columns 2, 2.01, & 2.02 less lines 61, 66-68, 74, 94, 95 & 96)	20,580,484
3. RATIO OF COST TO CHARGES (line 1 / line 2)	0.255