

HARRISBURG MEDICAL CENTER

HARRISBURG, ILLINOIS

MEDICARE COST REPORT

YEAR ENDED JUNE 30, 2015

HARRISBURG MEDICAL CENTER, INC. Provider CCN: 14-0210	In Lieu of Form CMS-2552-10	Period : From: 07/01/2014 To: 06/30/2015	Run Date: 11/04/2015 Run Time: 11:05 Version: 2015.10 (10/27/2015)
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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 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 type="checkbox"/> Medicare Utilization. Enter 'F' for full or 'L' for low.		Date: 11/04/2015 Time: 11:05
Contractor use only	5. <input type="checkbox"/> Cost Report Status (1) As Submitted (2) Settled without audit (3) Settled with audit (4) Reopened (5) Amended	6. Date Received: _____ 7. Contractor No.: _____ 8. <input type="checkbox"/> Initial Report for this Provider CCN 9. <input type="checkbox"/> Final Report for this Provider CCN	10. NPR Date: _____ 11. Contractor's Vendor Code: ____ 12. <input type="checkbox"/> If line 5, column 1 is 4: Enter number of times reopened = 0-9.

PART II - CERTIFICATION

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

CERTIFICATION BY OFFICER OR ADMINISTRATOR OF PROVIDER(S)

I HEREBY CERTIFY that I have read the above certification statement and that I have examined the accompanying electronically filed or manually submitted cost report and the Balance Sheet and Statement of Revenue and Expenses prepared by

ECR Encryption: 11/04/2015 11:05
4HBgNm3N.TzV4LPDsfAimwHemInny0
36cTG0eSlpzD54V5XxBiGFioPf9N4c
AudF1kvsxR0l8SA.

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

Title

Date

PI Encryption: 11/04/2015 11:05
zr9tRqOrFALtnaLz4JHGdts0xyqE0
BRWI207ln44yMR1qVYQ.gfKAI dnCp1
fTwl05lGxo0OzR2y

PART III - SETTLEMENT SUMMARY

		TITLE V	TITLE XVIII		HIT	TITLE XIX	
		1	PART A 2	PART B 3	4	5	
1	HOSPITAL		73,776	25,204	19,807		1
2	SUBPROVIDER - IPF		5,689				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			12,836			10
10.01	HEALTH CLINIC - RHC II			-13,247			10.01
11	HEALTH CLINIC - FQHC						11
12	OUTPATIENT REHABILITATION PROVIDER						12
200	TOTAL		79,465	24,793	19,807		200

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

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

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

HARRISBURG MEDICAL CENTER, INC. Provider CCN: 14-0210	In Lieu of Form CMS-2552-10	Period : From: 07/01/2014 To: 06/30/2015	Run Date: 10/22/2015 Run Time: 16:34 Version: 2015.03 (10/05/2015)
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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						2

Hospital and Hospital-Based Component Identification:

Component	Component Name	CCN Number	CBSA Number	Provider Type	Date Certified	Payment System (P, T, O, or N)				
						V	XVIII	XIX		
0	1	2	3	4	5	6	7	8		
3	Hospital	HARRISBURG MEDICAL CENTER, INC.	14-0210	99914	1	07 / 01 / 1966	N	P	O	3
4	Subprovider - IPF	HARRISBURG MEDICAL CENTER, INC.	14-S210	99914	4	06 / 19 / 1989	N	P	O	4
5	Subprovider - IRF									5
6	Subprovider - (OTHER)									6
7	Swing Beds - SNF	HARRISBURG MEDICAL CENTER, INC.	14-U210	99914		11 / 03 / 1988	N	P	N	7
8	Swing Beds - NF									8
9	Hospital-Based SNF									9
10	Hospital-Based NF									10
11	Hospital-Based OLTC									11
12	Hospital-Based HHA	HARRISBURG MEDICAL CENTER, INC.	14-7419	99914		08 / 15 / 1985	N	P	N	12
13	Separately Certified ASC									13
14	Hospital-Based Hospice									14
15	Hospital-Based Health Clinic - RHC	ELDORADO PRIMARY CARE	14-3473	99914		12 / 31 / 2001	N	O	N	15
15.01	Hospital-Based Health Clinic - RHC II	EQUALITY FAMILY PRACTICE	14-8518	99914		09 / 27 / 2011	N	O	N	15.01
16	Hospital-Based Health Clinic - FQHC									16
17	Hospital-Based (CMHC)									17
18	Renal Dialysis									18
19	Other									19

20	Cost Reporting Period (mm/dd/yyyy)	From: 07 / 01 / 2014	To: 06 / 30 / 2015							20
21	Type of control (see instructions)	2								21

Inpatient PPS Information

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

	In-State Medicaid paid days	In-State Medicaid eligible unpaid days	Out-of-State Medicaid paid days	Out-of-State Medicaid eligible unpaid days	Medicaid HMO days	Other Medicaid days	
	1	2	3	4	5	6	
24	If this provider is an IPPS hospital, enter the in-state Medicaid paid days in column 1, in-state Medicaid eligible unpaid days in column 2, out-of-state Medicaid paid days in column 3, out-of-state Medicaid eligible unpaid days in column 4, Medicaid HMO paid and eligible but unpaid days in column 5, and other Medicaid days in column 6.	693					24
25	If this provider is an IRF, enter the in-state Medicaid paid days in column 1, in-state Medicaid eligible unpaid days in column 2, out-of-state Medicaid days in column 3, out-of-state Medicaid eligible unpaid days in column 4, Medicaid HMO paid and eligible but unpaid days in column 5.						25

26	Enter your standard geographic classification (not wage) status at the beginning of the cost reporting period. Enter '1' for urban and '2' for rural.	2					26
27	Enter your standard geographic classification (not wage) status at the end of the cost reporting period. Enter in column 1, '1' for urban or '2' for rural. If applicable, enter the effective date of the geographic reclassification in column 2.	2					27
35	If this is a sole community hospital (SCH), enter the number of periods SCH status in effect in the cost reporting period.	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 / 2014	Ending: 06 / 30 / 2015				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

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HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA

WORKSHEET S-2
PART I

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
40	Is this hospital subject to the HAC program reduction adjustment? Enter 'Y' for yes or 'N' for no in column 1, for discharges prior to October 1. Enter 'Y' for yes or 'N' for no in column 2, for discharges on or after October 1. (see instructions)	N	N	40
Prospective Payment System (PPS)-Capital		V	XVIII	XIX
45	Does this facility qualify and receive capital payment for disproportionate share in accordance with 42 CFR §412.320?	1	2	3
45	Does this facility qualify and receive capital payment for disproportionate share in accordance with 42 CFR §412.320?	N	N	45
46	Is this facility eligible for additional payment exception for extraordinary circumstances pursuant to 42 CFR §412.348(f)? If yes, complete Wkst. L, Pt. III and Wkst. L-1, Pt. I through Pt. III.	N	N	46
47	Is this a new hospital under 42 CFR §412.300 PPS capital? Enter 'Y' for yes or 'N' for no.	N	N	47
48	Is the facility electing full federal capital payment? Enter 'Y' for yes or 'N' for no.	N	N	48

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

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

WORKSHEET S-2
PART I

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

Inpatient Psychiatric Facility PPS

		1	2	3	
70	Is this facility an Inpatient Psychiatric Facility (IPF), or does it contain an IPF subprovider? Enter 'Y' for yes or 'N' for no.	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 fifth or subsequent academic years of the new teaching program in existence, enter 5. (see instructions) For cost reporting periods beginning on or after October 1, 2012, if this cost reporting period covers the beginning of the sixth or any subsequent academic year of the new teaching program, enter 6 in column 3. (see instructions)	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 fifth or subsequent academic years of the new teaching program in existence, enter 5. (see instructions) For cost reporting periods beginning on or after October 1, 2012, if this cost reporting period covers the beginning of the sixth or any subsequent academic year of the new teaching program, enter 6 in column 3. (see instructions)				76

Long Term Care Hospital PPS

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

TEFRA Providers

85	Is this a new hospital under 42 CFR §413.40(f)(1)(i) TEFRA? Enter 'Y' for yes or 'N' for no.	N			85
86	Did this facility establish a new Other subprovider (excluded unit) under 42 CFR §413.40(f)(1)(ii)? Enter 'Y' for yes, or 'N' for no.				86

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WORKSHEET S-2
PART I

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

Rural Providers

		1	2		
105	Does this hospital qualify as a Critical Access Hospital (CAH)?	N		105	
106	If this facility qualifies as a CAH, has it elected the all-inclusive method of payment for outpatient services? (see instructions)			106	
107	If this facility qualifies as a CAH, is it eligible for cost reimbursement for I&R training programs? Enter 'Y' for yes and 'N' for no in column 1. (see instructions) If yes, the GME elimination would not be on Wkst. B, Pt. I, col. 25 and the program would be cost reimbursed. If yes, complete Wkst. D-2, Pt. II.			107	
108	Is this a rural hospital qualifying for an exception to the CRNA fee schedule? See 42 CFR §412.113(c). Enter 'Y' for yes or 'N' for no.	N		108	
		Physical	Occupational	Speech	Respiratory
109	If this hospital qualifies as a CAH or a cost provider, are therapy services provided by outside supplier? Enter 'Y' for yes or 'N' for each therapy.	N		N	
110	Did this hospital participate in the Rural Community Hospital Demonstration project (410A Demo) for the current cost reporting period? Enter 'Y' for yes or 'N' for no.			N	110

Miscellaneous Cost Reporting Information

115	Is this an all-inclusive rate provider? Enter 'Y' for yes or 'N' for no in column 1. If column 1 is yes, enter the method used (A, B, or E only) in column 2. If column 2 is 'E', enter in column 3 either '93' percent for short term hospital or '98' percent for long term care (includes psychiatric, rehabilitation and long term hospitals providers) based on the definition in CMS Pub. 15-1, Section 2208.1.	N			115
116	Is this facility classified as a referral center? Enter 'Y' for yes or 'N' for no.	N			116
117	Is this facility legally required to carry malpractice insurance? Enter 'Y' for yes or 'N' for no.	Y			117
118	Is the malpractice insurance a claims-made or occurrence policy? Enter 1 if the policy is claim-made. Enter 2 if the policy is occurrence.	2			118
		Premiums	Paid Losses	Self Insurance	
118.01	List amounts of malpractice premiums and paid losses:	303,899	3,139		118.01
118.02	Are malpractice premiums and paid losses reported in a cost center other than the Administrative and General cost center? If yes, submit supporting schedule listing cost centers and amounts contained therein.	N			118.02
120	Is this a SCH or EACH that qualifies for the Outpatient Hold Harmless provision in ACA §3121 and applicable amendments? (see instructions). Enter in column 1 'Y' for yes or 'N' for no. Is this a rural hospital with < 100 beds that qualifies for the Outpatient Hold Harmless provision in ACA §3121 and applicable amendments? (see instructions). Enter in column 2 'Y' for yes or 'N' for no.	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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--	--------------------------------	--	--

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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 N	2	140
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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 the 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 §413.13)

		Title XVIII		Title V	Title XIX	
		Part A	Part B			
		1	2	3	4	
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. (see instructions)						166
	Name	County	State	ZIP Code	CBSA	FTE/Campus	
	0	1	2	3	4	5	

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

167	Is this provider a meaningful user under §1886(n)? Enter 'Y' for yes or 'N' for no.	Y				167
168	If this provider is a CAH (line 105 is 'Y') and is a meaningful user (line 167 is 'Y'), enter the reasonable cost incurred for the HIT assets. (see instructions)					168
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)	0.25				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 / 2014	06 / 30 / 2015	170
171	If line 167 is 'Y', does this provider have any days for individuals enrolled in section 1876 Medicare cost plans reported on Wkst. S-3, Pt. I, line 2, col. 6? Enter 'Y' for yes and 'N' for no. (see instructions)				Y	171

HARRISBURG MEDICAL CENTER, INC. Provider CCN: 14-0210	In Lieu of Form CMS-2552-10	Period : From: 07/01/2014 To: 06/30/2015	Run Date: 10/22/2015 Run Time: 16:34 Version: 2015.03 (10/05/2015)
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HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX REIMBURSEMENT QUESTIONNAIRE

WORKSHEET S-2
PART II

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

COMPLETED BY ALL HOSPITALS

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

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

Approved Educational Activities		Y/N	Y/N
		1	2
6	Column 1: Are costs claimed for nursing school? Column 2: If yes, is the provider the legal operator of the program?	N	
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 A? If yes, see instructions.	N	11

Bad Debts		Y/N
		1
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		Y/N
		1
15	Did total beds available change from the prior cost reporting period? If yes, see instructions.	Y

		Part A		Part B	
		Y/N	Date	Y/N	Date
PS&R Report Data		1	2	3	4
16	Was the cost report prepared using the PS&R Report only? If either column 1 or 3 is yes, enter the paid-through date of the PS&R Report used in columns 2 and 4. (see instructions)	N		N	
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	09/01/2015	Y	09/01/2015
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	

HARRISBURG MEDICAL CENTER, INC. Provider CCN: 14-0210	In Lieu of Form CMS-2552-10	Period : From: 07/01/2014 To: 06/30/2015	Run Date: 10/22/2015 Run Time: 16:34 Version: 2015.03 (10/05/2015)
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HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX REIMBURSEMENT QUESTIONNAIRE

WORKSHEET S-2
PART II

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

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

Capital Related Cost		
22	Have assets been relifed for Medicare purposes? If yes, see instructions.	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 capitalization 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	
		1	2	
36	Are home office costs claimed on the cost report?			36
37	If line 36 is yes, has a home office cost statement been prepared by the home office? If yes, see instructions.			37
38	If line 36 is yes, was the fiscal year end of the home office different from that of the provider? If yes, enter in column 2 the fiscal year end of the home office.			38
39	If line 36 is yes, did the provider render services to other chain components? If yes, see instructions.			39
40	If line 36 is yes, did the provider render services to the home office? If yes, see instructions.			40

Cost Report Preparer Contact Information				
41	First name: MARK	Last name: DALLAS	Title: PARTNER	41
42	Employer: KERBER, ECK & BRAECKEL LLP			42
43	Phone number: 618-529-1040	E-mail Address: MARKD@KEBCPA.COM		43

HARRISBURG MEDICAL CENTER, INC. Provider CCN: 14-0210	In Lieu of Form CMS-2552-10	Period : From: 07/01/2014 To: 06/30/2015	Run Date: 10/22/2015 Run Time: 16:34 Version: 2015.03 (10/05/2015)
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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			Total All Patients	
						Title V	Title XVIII	Title XIX		
		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	46	16,759			2,861	693	4,569	1
2	HMO and other (see instructions)						417			2
3	HMO IPF Subprovider						229			3
4	HMO IRF Subprovider									4
5	Hospital Adults & Peds. Swing Bed SNF						120		176	5
6	Hospital Adults & Peds. Swing Bed NF									6
7	Total Adults & Peds. (exclude observation beds) (see instructions)		46	16,759			2,981	693	4,745	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)		46	16,759			2,981	693	4,745	14
15	CAH Visits									15
16	Subprovider - IPF	40	30	10,950			3,681	4,282	9,995	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					1,777		4,517	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					3,996		17,156	26
26.01	RHC II	88.01					493		2,266	26.01
27	Total (sum of lines 14-26)		76							27
28	Observation Bed Days								2,105	28
29	Ambulance Trips									29
30	Employee discount days (see instructions)									30
31	Employee discount days-IRF									31
32	Labor & delivery (see instructions)									32
32.01	Total ancillary labor & delivery room outpatient days (see instructions)									32.01
33	LTCH non-covered days									33

HARRISBURG MEDICAL CENTER, INC. Provider CCN: 14-0210	In Lieu of Form CMS-2552-10	Period : From: 07/01/2014 To: 06/30/2015	Run Date: 10/22/2015 Run Time: 16:34 Version: 2015.03 (10/05/2015)
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HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA

WORKSHEET S-3
PART I

	Component	Full Time Equivalents			DISCHARGES				
		Total Interns & Residents	Employees On Payroll	Nonpaid Workers	Title V	Title XVIII	Title XIX	Total All Patients	
		9	10	11	12	13	14	15	
1	Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days) (see instructions for col. 2 for the portion of LDP room available beds)					1,008	308	1,723	1
2	HMO and other (see instructions)					134			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)		373.77			1,008	308	1,723	14
15	CAH Visits								15
16	Subprovider - IPF		64.71			415	702	1,434	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		12.93						22
23	ASC (Distinct Part)								23
24	Hospice (Distinct Part)								24
24.10	Hospice (non-distinct part)								24.10
25	CMHC								25
26	RHC		25.14						26
26.01	RHC II		3.10						26.01
27	Total (sum of lines 14-26)		479.65						27
32.01	Total ancillary labor & delivery room outpatient days (see instructions)								32

HARRISBURG MEDICAL CENTER, INC. Provider CCN: 14-0210	In Lieu of Form CMS-2552-10	Period : From: 07/01/2014 To: 06/30/2015	Run Date: 10/22/2015 Run Time: 16:34 Version: 2015.03 (10/05/2015)
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HOSPITAL WAGE INDEX INFORMATION

WORKSHEET S-3
PARTS II-III

Part II - Wage Data

	Wkst A Line No.	Amount Reported	Reclassi- fication 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	22,599,432		22,599,432	997,675.00	22.65	1
2							2
3		720,908		720,908	6,626.00	108.80	3
4				--			4
4.01							4.01
5		2,599,967		2,599,967	26,761.00	97.16	5
6		893,008	-105,576	787,432	42,271.00	18.63	6
7	21						7
7.01							7.01
8							8
9	44						9
10		3,645,198	-106,441	3,538,757	171,321.00	20.66	10
OTHER WAGES & RELATED COSTS							
11		82,211		82,211	1,346.00	61.08	11
12							12
13							13
14							14
15							15
16							16
WAGE-RELATED COSTS							
17		5,292,126		5,292,126			17
18							18
19		1,252,139		1,252,139			19
20							20
21		255,139		255,139			21
22							22
22.01							22.01
23		920,164		920,164			23
24		278,683		278,683			24
25							25
OVERHEAD COSTS - DIRECT SALARIES							
26							26
27		3,419,725	52,033	3,471,758	145,162.00	23.92	27
28		96,895		96,895	2,022.00	47.92	28
29							29
30		502,421		502,421	32,409.00	15.50	30
31		30,287		30,287	2,431.00	12.46	31
32		575,955		575,955	49,913.00	11.54	32
33							33
34		543,195		543,195	43,955.00	12.36	34
35							35
36							36
37							37
38		98,954		98,954	4,171.00	23.72	38
39		200,646		200,646	12,986.00	15.45	39
40		573,668		573,668	13,460.00	42.62	40
41		477,213		477,213	31,052.00	15.37	41
42							42
43							43

Part III - Hospital Wage Index Summary

1	Net salaries (see instructions)	18,482,444	105,576	18,588,020	924,039.00	20.12	1
2	Excluded area salaries (see instructions)	3,645,198	-106,441	3,538,757	171,321.00	20.66	2
3	Subtotal salaries (line 1 minus line 2)	14,837,246	212,017	15,049,263	752,718.00	19.99	3
4	Subtotal other wages & related costs (see instructions)	82,211		82,211	1,346.00	61.08	4
5	Subtotal wage-related costs (see instructions)	5,292,126		5,292,126		35.17%	5
6	Total (sum of lines 3 through 5)	20,211,583	212,017	20,423,600	754,064.00	27.08	6
7	Total overhead cost (see instructions)	6,518,959	52,033	6,570,992	337,561.00	19.47	7

HARRISBURG MEDICAL CENTER, INC. Provider CCN: 14-0210	In Lieu of Form CMS-2552-10	Period : From: 07/01/2014 To: 06/30/2015	Run Date: 10/22/2015 Run Time: 16:34 Version: 2015.03 (10/05/2015)
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HOSPITAL WAGE RELATED COSTS

WORKSHEET S-3
PART IV

Part IV - Wage Related Cost

Part A - Core List

		Amount Reported	
	RETIREMENT COST		
1	401K Employer Contributions		1
2	Tax Sheltered Annuity (TSA) Employer Contribution	668,680	2
3	Nonqualified Defined Benefit Plan Cost (see instructions)		3
4	Qualified Defined Benefit Plan Cost (see instructions)		4
	PLAN ADMINISTRATIVE COSTS (Paid to External Organization):		
5	401k/TSA Plan Administration Fees		5
6	Legal/Accounting/Management Fees-Pension Plan		6
7	Employee Managed Care Program Administration Fees		7
	HEALTH AND INSURANCE COST		
8	Health Insurance (Purchased or Self Funded)	5,051,349	8
9	Prescription Drug Plan		9
10	Dental, Hearing and Vision Plan	54,421	10
11	Life Insurance (If employee is owner or beneficiary)	40,918	11
12	Accident Insurance (If employee is owner or beneficiary)		12
13	Disability Insurance (If employee is owner or beneficiary)		13
14	Long-Term Care Insurance (If employee is owner or beneficiary)		14
15	Workers' Compensation Insurance	209,465	15
16	Retirement Health Care Cost (Only current year, not the extraordinary accrual required by FASB 106. Non cumulative portion)		16
	TAXES		
17	FICA-Employers Portion Only	1,352,024	17
18	Medicare Taxes - Employers Portion Only	316,199	18
19	Unemployment Insurance		19
20	State or Federal Unemployment Taxes	294,964	20
	OTHER		
21	Executive Deferred Compensation (Other Than Retirement Cost Reported on lines 1 through 4 above)(see instructions)		21
22	Day Care Costs and Allowances		22
23	Tuition Reimbursement	10,234	23
24	Total Wage Related cost (Sum of lines 1-23)	7,998,254	24

Part B - Other Than Core Related Cost

25	OTHER WAGE RELATED COSTs (SPECIFY)	5,080	25
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HARRISBURG MEDICAL CENTER, INC. Provider CCN: 14-0210	Supporting Exhibit for Form CMS-2552-10	Period : From: 07/01/2014 To: 06/30/2015	Run Date: 10/22/2015 Run Time: 16:34 Version: 2015.03 (10/05/2015)
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WAGE INDEX PENSION COST SCHEDULE (For Worksheet S-3, Part IV, Line 4)

EXHIBIT 3

STEP 1: 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)	CONTRIB- UTION(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

HARRISBURG MEDICAL CENTER, INC. Provider CCN: 14-0210	In Lieu of Form CMS-2552-10	Period : From: 07/01/2014 To: 06/30/2015	Run Date: 10/22/2015 Run Time: 16:34 Version: 2015.03 (10/05/2015)
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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	82,211		1
2	Hospital	82,211		2
3	Subprovider - IPF			3
4	Subprovider - IRF			4
5	Subprovider - (OTHER)			5
6	Swing Beds - SNF			6
7	Swing Beds - NF			7
8	Hospital-Based SNF			8
9	Hospital-Based NF			9
10	Hospital-Based OLTC			10
11	Hospital-Based HHA			11
12	Separately Certified ASC			12
13	Hospital-Based Hospice			13
14	Hospital-Based Health Clinic - RHC			14
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

HARRISBURG MEDICAL CENTER, INC. Provider CCN: 14-0210	In Lieu of Form CMS-2552-10	Period : From: 07/01/2014 To: 06/30/2015	Run Date: 10/22/2015 Run Time: 16:34 Version: 2015.03 (10/05/2015)
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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)		133.00			133.00	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)			1.08	4
5	Other Administrative Personnel			0.02	5
6	Direct Nursing Service			8.05	6
7	Nursing Supervisor				7
8	Physical Therapy Service			1.68	8
9	Physical Therapy Supervisor				9
10	Occupational Therapy Service			0.01	10
11	Occupational Therapy Supervisor				11
12	Speech Pathology Service			0.04	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 the number of CBSAs where you provided services during the cost reporting period.	1	19
20	List those CBSA code(s) 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 1	With Outliers 2	LUPA Episodes 3	PEP only Episodes 4		
21	Skilled Nursing Visits	826		110	14	950	21
22	Skilled Nursing Visit Charges	164,617		17,556	2,736	184,909	22
23	Physical Therapy Visits	752		27	18	797	23
24	Physical Therapy Visit Charges	168,773		5,038	3,893	177,704	24
25	Occupational Therapy Visits	17				17	25
26	Occupational Therapy Visit Charges	4,199				4,199	26
27	Speech Pathology Visits	12				12	27
28	Speech Pathology Visit Charges	2,717				2,717	28
29	Medical Social Service Visits						29
30	Medical Social Service Visit Charges						30
31	Home Health Aide Visits	1				1	31
32	Home Health Aide Visit Charges	117				117	32
33	Total visits (sum of lines 21, 23, 25, 27, 29, and 31)	1,608		137	32	1,777	33
34	Other Charges						34
35	Total Charges (sum of lines 22, 24, 26, 28, 30, 32 and 34)	340,423		22,594	6,629	369,646	35
36	Total Number of Episodes (standard/non-outlier)	120		38	3	161	36
37	Total Number of Ourlier Episodes						37
38	Total Non-Routine Medical Supply Charges	7,492		3,805	180	11,477	38

HARRISBURG MEDICAL CENTER, INC. Provider CCN: 14-0210	In Lieu of Form CMS-2552-10	Period : From: 07/01/2014 To: 06/30/2015	Run Date: 10/22/2015 Run Time: 16:34 Version: 2015.03 (10/05/2015)
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PROSPECTIVE PAYMENT FOR SNF STATISTICAL DATA

WORKSHEET S-7

		Y/N	DATE	
		1	2	
1	If this facility contains a hospital-based SNF, were all patients under managed care or was there no Medicare utilization? Enter 'Y' for yes and do not complete the rest of this worksheet.	N		1
2	Does this hospital have an agreement under either section 1883 or section 1913 for swing beds? Enter 'Y' for yes or 'N' for no in column 1. If yes, enter the agreement date (mm/dd/yyyy) in column 2.	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		7	7	16
17	RVA		7	7	17
18	RHC				18
19	RHB				19
20	RHA		44	44	20
21	RMC				21
22	RMB				22
23	RMA		2	2	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				40
41	LC2				41
42	LC1				42
43	LB2				43
44	LB1				44
45	CE2				45
46	CE1		4	4	46
47	CD2				47
48	CD1		6	6	48
49	CC2				49
50	CC1		19	19	50
51	CB2				51
52	CB1		25	25	52
53	CA2				53
54	CA1		2	2	54
55	SE3				55
56	SE2				56
57	SE1				57
58	SSC				58
59	SSB				59
60	SSA				60
61	IB2				61
62	IB1				62
63	IA1				63
64	IA2				64
65	BB2				65
66	BB1				66
67	BA2				67
68	BA1				68
69	PE2				69
70	PE1				70
71	PD2				71

HARRISBURG MEDICAL CENTER, INC. Provider CCN: 14-0210	In Lieu of Form CMS-2552-10	Period : From: 07/01/2014 To: 06/30/2015	Run Date: 10/22/2015 Run Time: 16:34 Version: 2015.03 (10/05/2015)
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PROSPECTIVE PAYMENT FOR SNF STATISTICAL DATA

WORKSHEET S-7

	Group	SNF Days 2	Swing Bed SNF Days 3	Total (sum of col. 2 + 3) 4	
	1				
72	PD1				72
73	PC2				73
74	PC1				74
75	PB2				75
76	PB1				76
77	PA2				77
78	PA1		4	4	78
199	AAA				199
200	TOTAL		120	120	200

SNF SERVICES

		CBSA at Beginning of Cost Reporting Period 1	CBSA on/after October 1 of the Cost Reporting Period (if applicable) 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 1	Percentage 2	Associated with Direct Patient Care and Related Expenses? 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

HARRISBURG MEDICAL CENTER, INC. Provider CCN: 14-0210	In Lieu of Form CMS-2552-10	Period : From: 07/01/2014 To: 06/30/2015	Run Date: 10/22/2015 Run Time: 16:34 Version: 2015.03 (10/05/2015)
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HOSPITAL-BASED RURAL HEALTH CLINIC/FEDERALLY QUALIFIED HEALTH CENTER
STATISTICAL DATA

COMPONENT CCN: 14-3473

WORKSHEET S-8

Check applicable box: RHC FQHC

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 the 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			
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. 100-04, chapter 9, section 30.8? Enter 'Y' for yes or 'N' for no in column 1. If yes, enter in column 2 the number of providers included in this cost report. List the names of all providers and numbers below.	1 N	2 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 by Intern & Residents for titles V, XVIII, and XIX as applicable. Enter in column 5 the number of total visits for this provider. (see instructions)						15

HARRISBURG MEDICAL CENTER, INC. Provider CCN: 14-0210	In Lieu of Form CMS-2552-10	Period : From: 07/01/2014 To: 06/30/2015	Run Date: 10/22/2015 Run Time: 16:34 Version: 2015.03 (10/05/2015)
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HOSPITAL-BASED RURAL HEALTH CLINIC/FEDERALLY QUALIFIED HEALTH CENTER
STATISTICAL DATA

COMPONENT CCN: 14-8518

WORKSHEET S-8

Check applicable box: RHC FQHC

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 the 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
----	--	--------	---------

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				
11	Clinic	0	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. 100-04, chapter 9, section 30.8? Enter 'Y' for yes or 'N' for no in column 1. If yes, enter in column 2 the number of providers included in this cost report. List the names of all providers and numbers below.	1 N	2 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 by Intern & Residents for titles V, XVIII, and XIX as applicable. Enter in column 5 the number of total visits for this provider. (see instructions)						15

HARRISBURG MEDICAL CENTER, INC. Provider CCN: 14-0210	In Lieu of Form CMS-2552-10	Period : From: 07/01/2014 To: 06/30/2015	Run Date: 10/22/2015 Run Time: 16:34 Version: 2015.03 (10/05/2015)
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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)	0.292767	1
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Medicaid (see instructions for each line)

2	Net revenue from Medicaid	8,080,340	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	37,452,232	6
7	Medicaid cost (line 1 times line 6)	10,964,780	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.	2,884,440	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 care (see instructions for each line)

17	Private grants, donations, or endowment income restricted to fundng charity care		17
18	Government grants, appropriations of transfers for support of hospital operations		18
19	Total unreimbursed cost for Medicaid, SCHIP and state and local indigent care programs (sum of lines 8, 12 and 16)	2,884,440	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	491,061	1,575,963	2,067,024	20
21	Cost of initial obligation of patients approved for charity care (line 1 times line 20)	143,766	461,390	605,156	21
22	Partial payment by patients approved for charity care	78,426		78,426	22
23	Cost of charity care (line 21 minus line 22)	65,340	461,390	526,730	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?	Y	24
25	If line 24 is yes, enter charges for patient days beyond an indigent care program's length of stay limit (see instructions)	309,521	25
26	Total bad debt expense for the entire hospital complex (see instructions)	3,295,182	26
27	Medicare bad debts for the entire hospital complex (see instructions)	594,305	27
28	Non-Medicare and non-reimbursable Medicare bad debt expense (line 26 minus line 27)	2,700,877	28
29	Cost of non-Medicare and non-reimbursable Medicare bad debt expense (line 1 times line 28)	790,728	29
30	Cost of uncompensated care (line 23, column 3 plus line 29)	1,317,458	30
31	Total unreimbursed and uncompensated care cost (line 19 plus line 30)	4,201,898	31

HARRISBURG MEDICAL CENTER, INC. Provider CCN: 14-0210	In Lieu of Form CMS-2552-10	Period : From: 07/01/2014 To: 06/30/2015	Run Date: 10/22/2015 Run Time: 16:34 Version: 2015.03 (10/05/2015)
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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		2,314,051	2,314,051	-1,141,294	1,172,757	-27,584	1,145,173	1
2	00200	Cap Rel Costs-Mvble Equip				1,093,015	1,093,015		1,093,015	2
3	00300	Other Cap Rel Costs							-0-	3
4	00400	Employee Benefits Department		7,993,098	7,993,098		7,993,098	-1,561,240	6,431,858	4
5	00500	Administrative & General	3,419,725	4,860,985	8,280,710	-116,155	8,164,555	-2,651,298	5,513,257	5
6	00600	Maintenance & Repairs								6
7	00700	Operation of Plant	502,421	626,770	1,129,191		1,129,191	-25,059	1,104,132	7
8	00800	Laundry & Linen Service	30,287	107,790	138,077		138,077		138,077	8
9	00900	Housekeeping	575,955	115,535	691,490		691,490	-48,997	642,493	9
10	01000	Dietary	543,195	380,022	923,217		923,217	-183,978	739,239	10
11	01100	Cafeteria								11
12	01200	Maintenance of Personnel								12
13	01300	Nursing Administration	98,954	7,324	106,278		106,278	-17,543	88,735	13
14	01400	Central Services & Supply	200,646	180,655	381,301		381,301	-20,010	361,291	14
15	01500	Pharmacy	573,668	24,185	597,853		597,853	-38,814	559,039	15
16	01600	Medical Records & Library	477,213	196,930	674,143		674,143	-481	673,662	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 Cost Apprvd								22
23	02300	Paramed Ed Prgm-(specify)								23
INPATIENT ROUTINE SERVICE COST CENTERS										
30	03000	Adults & Pediatrics	2,937,621	2,094,547	5,032,168		5,032,168	-1,853,338	3,178,830	30
40	04000	Subprovider - IPF	2,694,075	401,649	3,095,724		3,095,724	-231,616	2,864,108	40
ANCILLARY SERVICE COST CENTERS										
50	05000	Operating Room	522,004	326,144	848,148	-596,560	251,588	138	251,726	50
53	05300	Anesthesiology	720,908	42,763	763,671		763,671	-720,908	42,763	53
54	05400	Radiology-Diagnostic	429,120	152,343	581,463	119,120	700,583		700,583	54
57	05700	CT Scan	179,099	144,539	323,638		323,638	26	323,664	57
60	06000	Laboratory	778,729	1,482,636	2,261,365	55,495	2,316,860		2,316,860	60
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS								62.30
64	06400	Intravenous Therapy	23,960	88,006	111,966		111,966		111,966	64
65	06500	Respiratory Therapy	540,635	115,998	656,633		656,633	-9,425	647,208	65
66	06600	Physical Therapy	759,115	28,888	788,003		788,003	272	788,275	66
69	06900	Electrocardiology	68,298	130,339	198,637		198,637	-93,419	105,218	69
71	07100	Medical Supplies Charged to Patients		1,344,436	1,344,436		1,344,436		1,344,436	71
72	07200	Impl. Dev. Charged to Patients				598,107	598,107		598,107	72
73	07300	Drugs Charged to Patients		2,400,578	2,400,578		2,400,578		2,400,578	73
75	07500	ASC (Non-Distinct Part)	515,830	127,550	643,380		643,380	184	643,564	75
76	03450	NUCLEAR MEDICINE	133,010	221,995	355,005		355,005		355,005	76
76.01	03630	ULTRASOUND	212,882	29,304	242,186		242,186		242,186	76.01
76.02	03440	MAMMOGRAPHY	59,396	60,274	119,670		119,670		119,670	76.02
76.03	03951	CARDIAC REHABILITATION								76.03
76.04	03190	FAITH CENTER CHEMOTHERAPY	133,076	7,526	140,602		140,602		140,602	76.04
76.06	03950	ROUTINE ANCILLARY								76.06
76.97	07697	CARDIAC REHABILITATION	80,585	21,450	102,035		102,035	-18,487	83,548	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	1,706,383	206,437	1,912,820	76,170	1,988,990	-49,997	1,938,993	88
88.01	08801	RHC II	207,859	49,373	257,232	-3,067	254,165		254,165	88.01
91	09100	Emergency	2,340,278	727,450	3,067,728	-1,547	3,066,181	-1,890,197	1,175,984	91
92	09200	Observation Beds (Non-Distinct Part)								92
93	04950	DAY PSYCHIATRIC	183,382	13,018	196,400		196,400		196,400	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	532,894	80,657	613,551	-44,619	568,932		568,932	101
SPECIAL PURPOSE COST CENTERS										
118		SUBTOTALS (sum of lines 1-117)	22,181,203	27,105,245	49,286,448	38,665	49,325,113	-9,441,771	39,883,342	118
NONREIMBURSABLE COST CENTERS										
190	19000	Gift, Flower, Coffee Shop & Canteen	80,303	157,040	237,343		237,343		237,343	190
192	19200	Physicians' Private Offices	337,926	39,982	377,908	-38,665	339,243		339,243	192
192.01	19201	DIALYSIS								192.01
192.03	19202	ORTHO CLINIC								192.03
200		TOTAL (sum of lines 118-199)	22,599,432	27,302,267	49,901,699		49,901,699	-9,441,771	40,459,928	200

HARRISBURG MEDICAL CENTER, INC. Provider CCN: 14-0210	In Lieu of Form CMS-2552-10	Period : From: 07/01/2014 To: 06/30/2015	Run Date: 10/22/2015 Run Time: 16:34 Version: 2015.03 (10/05/2015)
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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		1,019,237	1
2			Home Health Agency	101		7,414	2
3			Administrative & General	5		25,268	3
4			Rural Health Clinic	88		223,778	4
5			Physicians' Private Offices	192		15,743	5
500	Total reclassifications					1,291,440	500
	Code Letter - A						
1	IMPLANTABLE SUPPLIES	B	Impl. Dev. Charged to Patient	72		598,107	1
2							2
500	Total reclassifications					598,107	500
	Code Letter - B						
1	HHA BILLER	C	Administrative & General	5		52,033	1
500	Total reclassifications					52,033	500
	Code Letter - C						
1	INSURANCE	D	Cap Rel Costs-Bldg & Fixt	1		150,146	1
2			Cap Rel Costs-Mvble Equip	2		73,778	2
500	Total reclassifications					223,924	500
	Code Letter - D						
1	RHC LAB	E	Laboratory	60		51,436	1
2							2
3							3
500	Total reclassifications					51,436	500
	Code Letter - E						
1	RADIOLOGY	F	Radiology-Diagnostic	54		108,548	1
2							2
500	Total reclassifications					108,548	500
	Code Letter - F						
1	EPC APARTMENT	G	Administrative & General	5		30,468	1
500	Total reclassifications					30,468	500
	Code Letter - G						
1	RHC BUILDING EXPENSE	H	Laboratory	60		4,059	1
2			Radiology-Diagnostic	54		10,572	2
500	Total reclassifications					14,631	500
	Code Letter - H						
	GRAND TOTAL (Increases)					212,017	2,158,570

(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.

HARRISBURG MEDICAL CENTER, INC. Provider CCN: 14-0210	In Lieu of Form CMS-2552-10	Period : From: 07/01/2014 To: 06/30/2015	Run Date: 10/22/2015 Run Time: 16:34 Version: 2015.03 (10/05/2015)
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RECLASSIFICATIONS

WORKSHEET A-6

	EXPLANATION OF RECLASSIFICATION(S)	CODE (1)	COST CENTER	DECREASES			Wkst A-7 Ref.	
				LINE #	SALARY	OTHER		
		1	6	7	8	9	10	
1	DEPRECIATION	A	Cap Rel Costs-Bldg & Fixt	1		1,019,237	9	1
2			Cap Rel Costs-Bldg & Fixt	1		7,414	9	2
3			Cap Rel Costs-Bldg & Fixt	1		223,778	9	3
4			Cap Rel Costs-Bldg & Fixt	1		25,268	9	4
5			Cap Rel Costs-Bldg & Fixt	1		15,743	9	5
500	Total reclassifications					1,291,440		500
	Code letter - A							
1	IMPLANTABLE SUPPLIES	B	Operating Room	50		596,560		1
2			Emergency	91		1,547		2
500	Total reclassifications					598,107		500
	Code letter - B							
1	HHA BILLER	C	Home Health Agency	101	52,033			1
500	Total reclassifications				52,033			500
	Code letter - C							
1	INSURANCE	D	Administrative & General	5		150,146	12	1
2			Administrative & General	5		73,778	12	2
500	Total reclassifications					223,924		500
	Code letter - D							
1	RHC LAB	E	Rural Health Clinic	88	46,506			1
2			RHC II	88.01	3,067			2
3			Physicians' Private Offices	192	1,863			3
500	Total reclassifications				51,436			500
	Code letter - E							
1	RADIOLOGY	F	Rural Health Clinic	88	56,003			1
2			Physicians' Private Offices	192	52,545			2
500	Total reclassifications				108,548			500
	Code letter - F							
1	EPC APARTMENT	G	Rural Health Clinic	88		30,468		1
500	Total reclassifications					30,468		500
	Code letter - G							
1	RHC BUILDING EXPENSE	H	Rural Health Clinic	88		4,059		1
2			Rural Health Clinic	88		10,572		2
500	Total reclassifications					14,631		500
	Code letter - H							
	GRAND TOTAL (Decreases)				212,017	2,158,570		

(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.

HARRISBURG MEDICAL CENTER, INC. Provider CCN: 14-0210	In Lieu of Form CMS-2552-10	Period : From: 07/01/2014 To: 06/30/2015	Run Date: 10/22/2015 Run Time: 16:34 Version: 2015.03 (10/05/2015)
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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	501,932	158,505		158,505		660,437		1
2	Land Improvements	775,254	30,325		30,325		805,579		2
3	Buildings and Fixtures	23,792,009	3,285,304		3,285,304	1,508,754	25,568,559		3
4	Building Improvements								4
5	Fixed Equipment								5
6	Movable Equipment	11,713,802	1,740,189		1,740,189	1,201,867	12,252,124		6
7	HIT-designated Assets	954,763	77,248		77,248		1,032,011		7
8	Subtotal (sum of lines 1-7)	37,737,760	5,291,571		5,291,571	2,710,621	40,318,710		8
9	Reconciling Items								9
10	Total (line 7 minus line 9)	37,737,760	5,291,571		5,291,571	2,710,621	40,318,710		10

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

	Description	SUMMARY OF CAPITAL							Total (1) (sum of cols. 9 through 14)	
		Depreciation	Lease	Interest	Insurance (see instructions)	Taxes (see instructions)	Other Capital-Related Costs (see instructions)			
*		9	10	11	12	13	14	15		
1	Cap Rel Costs-Bldg & Fixt	1,894,988		419,063					2,314,051	1
2	Cap Rel Costs-Mvble Equip									2
3	Total (sum of lines 1-2)	1,894,988		419,063					2,314,051	3

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

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

PART III - RECONCILIATION OF CAPITAL COST CENTERS

	Description	COMPUTATION OF RATIOS				ALLOCATION OF OTHER CAPITAL				Total (sum of cols. 5 through 7)	
		Gross Assets	Capitalized Leases	Gross Assets for Ratio (col. 1 - col. 2)	Ratio (see instructions)	Insurance	Taxes	Other Capital-Related Costs			
*		1	2	3	4	5	6	7	8		
1	Cap Rel Costs-Bldg & Fi	27,034,575		27,034,575	0.670522					1	
2	Cap Rel Costs-Mvble Equip	13,284,135		13,284,135	0.329478					2	
3	Total (sum of lines 1-2)	40,318,710		40,318,710	1.000000					3	

	Description	SUMMARY OF CAPITAL							Total (2) (sum of cols. 9 through 14)	
		Depreciation	Lease	Interest	Insurance (see instructions)	Taxes (see instructions)	Other Capital-Related Costs (see instructions)			
*		9	10	11	12	13	14	15		
1	Cap Rel Costs-Bldg & Fixt	603,548		391,479	150,146				1,145,173	1
2	Cap Rel Costs-Mvble Equip	1,019,237			73,778				1,093,015	2
3	Total (sum of lines 1-2)	1,622,785		391,479	223,924				2,238,188	3

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

HARRISBURG MEDICAL CENTER, INC. Provider CCN: 14-0210	In Lieu of Form CMS-2552-10	Period : From: 07/01/2014 To: 06/30/2015	Run Date: 10/22/2015 Run Time: 16:34 Version: 2015.03 (10/05/2015)
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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			
				COST CENTER	LINE#	Wkst. A-7 Ref. 5	
			1	2	3	4	5
1	Investment income-buildings & fixtures (chapter 2)	B	-27,584	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	Trace, quantity, and time discounts (chapter 8)	B	-4,802	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	-4,080,975				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	-97,780	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	-481	Medical Records & Library	16		18
19	Nursing school (tuition,fees,books,etc.)						19
20	Vending machines	B	-9,368	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						32
33							33
34	PHYSICIAN RECRUITMENT	A	-30,500	Administrative & General	5		34
34.01	PHYSICIAN LOANS	A	-36,688	Administrative & General	5		34.01
35	CRNA WAGES	A	-720,908	Anesthesiology	53		35
35.01	CRNA BENEFITS	A	-255,129	Employee Benefits Department	4		35.01
36	PHYSICIAN BENEFITS	A	-458,460	Employee Benefits Department	4		36
37	PSYCH SALARY REIMBURSEMENT	B	-20,800	Rural Health Clinic	88		37
38	ER PHYSICIAN MISC. EXPENSE	A	-13,168	Emergency	91		38
39							39
40							40
41							41
42	OTHER INCOME	B	-550,658	Administrative & General	5		42
43	MEDICAID ASSESSMENT	A	-1,586,166	Administrative & General	5		43
44	MISSIONS EXPENSE	A	-277	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	-11,281	Administrative & General	5		45.20
45.21	PHYSICIAN BILLING FRINGE BENEFI	A	-3,992	Employee Benefits Department	4		45.21
45.22	DONATED MEALS	A	-86,198	Dietary	10		45.22
45.24	COMM RELATIONS	A	-24,420	Administrative & General	5		45.24
45.25	ALCOHOL	A	-5	Administrative & General	5		45.25
45.26	IHA LOBBYING	A	-18,049	Administrative & General	5		45.26
45.27	AHA LOBBYING	A	-4,026	Administrative & General	5		45.27
45.28	ADVERTISING	A	-106,101	Administrative & General	5		45.28
45.32	MISC INCOME	A	-2,500	Respiratory Therapy	65		45.32
45.34	HR DUES	A	-220	Employee Benefits Department	4		45.34
45.35	OTHER ADMIN DUES	A	-2,230	Administrative & General	5		45.35
45.38	INSURANCE SETTLEMENTS	A	-3,139	Administrative & General	5		45.38

HARRISBURG MEDICAL CENTER, INC. Provider CCN: 14-0210	In Lieu of Form CMS-2552-10	Period : From: 07/01/2014 To: 06/30/2015	Run Date: 10/22/2015 Run Time: 16:34 Version: 2015.03 (10/05/2015)
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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	
45.39	IHREF CONTRIBUTION EXPENSE	A	-8,745	Administrative & General	5		45.39
45.40	LLC OVERHEAD FRINGE BENEFIT	A	-843,439	Employee Benefits Department	4		45.40
45.41	LLC OVERHEAD A&G	A	-254,843	Administrative & General	5		45.41
45.42	LLC OVERHEAD PLANT	A	-25,121	Operation of Plant	7		45.42
45.43	LLC OVERHEAD HOUSEKEEPING	A	-48,997	Housekeeping	9		45.43
45.44	LLC OVERHEAD NURSING ADMIN	A	-17,543	Nursing Administration	13		45.44
45.45	LLC OVERHEAD CENTRAL SUPPLY	A	-20,010	Central Services & Supply	14		45.45
45.46	LLC OVERHEAD PHARMACY	A	-38,814	Pharmacy	15		45.46
45.47	LLC OVERHEAD RHC I	A	-29,197	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)		-9,441,771				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.

HARRISBURG MEDICAL CENTER, INC. Provider CCN: 14-0210	In Lieu of Form CMS-2552-10	Period : From: 07/01/2014 To: 06/30/2015	Run Date: 10/22/2015 Run Time: 16:34 Version: 2015.03 (10/05/2015)
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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:

HARRISBURG MEDICAL CENTER, INC. Provider CCN: 14-0210	In Lieu of Form CMS-2552-10	Period : From: 07/01/2014 To: 06/30/2015	Run Date: 10/22/2015 Run Time: 16:34 Version: 2015.03 (10/05/2015)
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PROVIDER-BASED PHYSICIANS ADJUSTMENTS

WORKSHEET A-8-2

	Wkst A Line #	Cost Center/ Physician Identifier	Total Remun- eration	Professional Component	Provider Component	RCE Amount	Physician/ Provider Component Hours	Unadjusted RCE Limit	5 Percent of Unadjusted RCE Limit	
	1	2	3	4	5	6	7	8	9	
1	40	Subprovider - IPF MEDICAL FEES	298,209		298,209	181,300	764	66,593	3,330	1
2	40	Subprovider - IPF SALARIED-DR				181,300				2
3	91	Emergency SALARIED-DR	1,335,451	1,295,451	40,000	211,500	310	31,522	1,576	3
4	60	Laboratory MEDICAL FEES	6,000		6,000	260,300	60	7,509	375	4
5	69	Electrocardiology MEDICAL FEES	93,419	93,419						5
6	76.97	CARDIAC REHABILITATI MEDICAL FEES DI	18,487	18,487						6
7	91	Emergency MEDICAL FEES #4	573,261	573,261		211,500				7
8	30	Adults & Pediatrics HOSPITALISTS ME	1,841,641	1,841,641		211,500				8
9	30	Adults & Pediatrics HOSPITALISTS PU				211,500				9
10	65	Respiratory Therapy RESP THER MEDIC	6,925	6,925						10
11	30	Adults & Pediatrics HOSPITALISTS -	30,000		30,000	211,500	180	18,303	915	11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
200		TOTAL	4,203,393	3,829,184	374,209		1,314	123,927	6,196	200

HARRISBURG MEDICAL CENTER, INC. Provider CCN: 14-0210	In Lieu of Form CMS-2552-10	Period : From: 07/01/2014 To: 06/30/2015	Run Date: 10/22/2015 Run Time: 16:34 Version: 2015.03 (10/05/2015)
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PROVIDER-BASED PHYSICIANS ADJUSTMENTS

WORKSHEET A-8-2

	Wkst A Line #	Cost Center/ Physician Identifier	Cost of Memberships & Continuing Education	Provider Component Share of col. 12	Physician Cost of Malpractice Insurance	Provider Component Share of col. 14	Adjusted RCE Limit	RCE Disallowance	Adjustment	
	10	11	12	13	14	15	16	17	18	
1	40	Subprovider - IPF MEDICAL FEES					66,593	231,616	231,616	1
2	40	Subprovider - IPF SALARIED-DR								2
3	91	Emergency SALARIED-DR					31,522	8,478	1,303,929	3
4	60	Laboratory MEDICAL FEES					7,509			4
5	69	Electrocardiology MEDICAL FEES							93,419	5
6	76.97	CARDIAC REHABILITATI MEDICAL FEES DI							18,487	6
7	91	Emergency MEDICAL FEES #4							573,261	7
8	30	Adults & Pediatrics HOSPITALISTS ME							1,841,641	8
9	30	Adults & Pediatrics HOSPITALISTS PU								9
10	65	Respiratory Therapy RESP THER MEDIC							6,925	10
11	30	Adults & Pediatrics HOSPITALISTS -					18,303	11,697	11,697	11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
200		TOTAL					123,927	251,791	4,080,975	200

HARRISBURG MEDICAL CENTER, INC. Provider CCN: 14-0210	In Lieu of Form CMS-2552-10	Period : From: 07/01/2014 To: 06/30/2015	Run Date: 10/22/2015 Run Time: 16:34 Version: 2015.03 (10/05/2015)
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COST ALLOCATION - GENERAL SERVICE COSTS

WORKSHEET B
PART I

	COST CENTER DESCRIPTIONS	NET EXP FOR COST ALLOCATION (from Wkst A, col.7)	CAP BLDGS & FIXTURES	CAP MOVABLE EQUIPMENT	EMPLOYEE BENEFITS DEPARTMENT	SUBTOTAL (cols.0-4)	ADMINISTRATIVE & GENERAL	
		0	1	2	4	4A	5	
GENERAL SERVICE COST CENTERS								
1	Cap Rel Costs-Bldg & Fixt	1,145,173	1,145,173					1
2	Cap Rel Costs-Mvble Equip	1,093,015		1,093,015				2
4	Employee Benefits Department	6,431,858	8,410	16,506	6,456,774			4
5	Administrative & General	5,513,257	199,882	422,744	991,903	7,127,786	7,127,786	5
6	Maintenance & Repairs							6
7	Operation of Plant	1,104,132	42,821	10,779	143,544	1,301,276	278,266	7
8	Laundry & Linen Service	138,077	20,914	5,519	8,653	173,163	37,029	8
9	Housekeeping	642,493	5,355	1,798	164,553	814,199	174,109	9
10	Dietary	739,239	24,332	7,822	155,194	926,587	198,142	10
11	Cafeteria		13,938			13,938	2,981	11
12	Maintenance of Personnel							12
13	Nursing Administration	88,735		143	28,272	117,150	25,051	13
14	Central Services & Supply	361,291	9,371	9,965	57,326	437,953	93,652	14
15	Pharmacy	559,039	18,347	33,487	163,900	774,773	165,678	15
16	Medical Records & Library	673,662	12,804	31,288	136,342	854,096	182,641	16
17	Social Service							17
19	Nonphysician Anesthetists							19
20	Nursing School							20
21	I&R Services-Salary & Fringes Apprvd							21
22	I&R Services-Other Prgm Costs Apprvd							22
23	Paramed Ed Prgm-(specify)							23
INPATIENT ROUTINE SERV COST CENTERS								
30	Adults & Pediatrics	3,178,830	157,913	86,481	839,293	4,262,517	911,509	30
40	Subprovider - IPF	2,864,108	147,913	11,302	769,711	3,793,034	811,106	40
ANCILLARY SERVICE COST CENTERS								
50	Operating Room	251,726	97,816	99,499	149,139	598,180	127,915	50
53	Anesthesiology	42,763		8,980	205,967	257,710	55,109	53
54	Radiology-Diagnostic	700,583	62,680	113,739	153,614	1,030,616	220,388	54
57	CT Scan	323,664	7,150	1,259	51,169	383,242	81,953	57
60	Laboratory	2,316,860	36,616	41,222	237,182	2,631,880	562,804	60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
64	Intravenous Therapy	111,966			6,845	118,811	25,407	64
65	Respiratory Therapy	647,208	14,583	21,591	154,462	837,844	179,165	65
66	Physical Therapy	788,275	69,121	14,652	216,883	1,088,931	232,858	66
69	Electrocardiology	105,218	9,512	7,609	19,513	141,852	30,334	69
71	Medical Supplies Charged to Patients	1,344,436				1,344,436	287,496	71
72	Impl. Dev. Charged to Patients	598,107				598,107	127,900	72
73	Drugs Charged to Patients	2,400,578				2,400,578	513,342	73
75	ASC (Non-Distinct Part)	643,564	65,294	20,230	147,375	876,463	187,424	75
76	NUCLEAR MEDICINE	355,005	6,126	60,289	38,002	459,422	98,243	76
76.01	ULTRASOUND	242,186	7,922	3,232	60,821	314,161	67,181	76.01
76.02	MAMMOGRAPHY	119,670	4,772	10,160	16,970	151,572	32,412	76.02
76.03	CARDIAC REHABILITATION							76.03
76.04	FAITH CENTER CHEMOTHERAPY	140,602	14,694	1,021	38,020	194,337	41,557	76.04
76.06	ROUTINE ANCILLARY							76.06
76.97	CARDIAC REHABILITATION	83,548	8,300	7,601	23,024	122,473	26,190	76.97
76.98	HYPERBARIC OXYGEN THERAPY							76.98
76.99	LITHOTRIPSY							76.99
OUTPATIENT SERVICE COST CENTERS								
88	Rural Health Clinic	1,938,993			458,235	2,397,228	512,626	88
88.01	RHC II	254,165			58,510	312,675	66,863	88.01
91	Emergency	1,175,984	30,616	43,234	668,629	1,918,463	410,246	91
92	Observation Beds (Non-Distinct Part)							92
93	DAY PSYCHIATRIC	196,400	37,797	863	52,393	287,453	61,469	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	568,932			137,384	706,316	151,039	101
SPECIAL PURPOSE COST CENTERS								
118	SUBTOTALS (sum of lines 1-117)	39,883,342	1,134,999	1,093,015	6,352,828	39,769,222	6,980,085	118
NONREIMBURSABLE COST CENTERS								
190	Gift, Flower, Coffee Shop & Canteen	237,343	10,174		22,943	270,460	57,835	190
192	Physicians' Private Offices	339,243			81,003	420,246	89,866	192
192.01	DIALYSIS							192.01
192.03	ORTHO CLINIC							192.03
200	Cross Foot Adjustments							200
201	Negative Cost Centers							201
202	TOTAL (sum of lines 118-201)	40,459,928	1,145,173	1,093,015	6,456,774	40,459,928	7,127,786	202

HARRISBURG MEDICAL CENTER, INC. Provider CCN: 14-0210	In Lieu of Form CMS-2552-10	Period : From: 07/01/2014 To: 06/30/2015	Run Date: 10/22/2015 Run Time: 16:34 Version: 2015.03 (10/05/2015)
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COST ALLOCATION - GENERAL SERVICE COSTS

WORKSHEET B
PART I

	COST CENTER DESCRIPTIONS	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSE-KEEPING	DIETARY	CAFETERIA	NURSING ADMINISTRATION	
		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	1,579,542						7
8	Laundry & Linen Service	36,950	247,142					8
9	Housekeeping	9,460		997,768				9
10	Dietary	42,987			1,167,716			10
11	Cafeteria	24,624			420,206	461,749		11
12	Maintenance of Personnel							12
13	Nursing Administration			14,636		4,733	161,570	13
14	Central Services & Supply	16,555				5,981		14
15	Pharmacy	32,414		14,279		16,653		15
16	Medical Records & Library	22,621				28,173		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	278,987	77,176	312,005	332,975	85,761	37,208	30
40	Subprovider - IPF	261,319	37,696	124,230	403,129	90,513	39,271	40
	ANCILLARY SERVICE COST CENTERS							
50	Operating Room	172,812	15,130	74,253		25,970	11,267	50
53	Anesthesiology					8,276		53
54	Radiology-Diagnostic	110,738	16,692			13,005		54
57	CT Scan	12,632				6,142		57
60	Laboratory	64,690		22,133		31,110		60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
64	Intravenous Therapy							64
65	Respiratory Therapy	25,765	7,026	15,350		15,258		65
66	Physical Therapy	122,117	7,138	18,563		31,505		66
69	Electrocardiology	16,805				3,681		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)	115,356	35,205	96,742		19,667	8,533	75
76	NUCLEAR MEDICINE	10,823				4,440		76
76.01	ULTRASOUND	13,995				5,376		76.01
76.02	MAMMOGRAPHY	8,431				2,885		76.02
76.03	CARDIAC REHABILITATION							76.03
76.04	FAITH CENTER CHEMOTHERAPY	25,959				5,378	2,333	76.04
76.06	ROUTINE ANCILLARY							76.06
76.97	CARDIAC REHABILITATION	14,663				4,168	1,808	76.97
76.98	HYPERBARIC OXYGEN THERAPY							76.98
76.99	LITHOTRIPSY							76.99
	OUTPATIENT SERVICE COST CENTERS							
88	Rural Health Clinic		23,681	118,875			31,557	88
88.01	RHC II			18,563				88.01
91	Emergency	54,089	16,840	153,146		42,876	18,602	91
92	Observation Beds (Non-Distinct Part)							92
93	DAY PSYCHIATRIC	66,776				10,198		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			14,993			10,991	101
	SPECIAL PURPOSE COST CENTERS							
118	SUBTOTALS (sum of lines 1-117)	1,561,568	236,584	997,768	1,156,310	461,749	161,570	118
	NONREIMBURSABLE COST CENTERS							
190	Gift, Flower, Coffee Shop & Canteen	17,974						190
192	Physicians' Private Offices		10,558		11,406			192
192.01	DIALYSIS							192.01
192.03	ORTHO CLINIC							192.03
200	Cross Foot Adjustments							200
201	Negative Cost Centers							201
202	TOTAL (sum of lines 118-201)	1,579,542	247,142	997,768	1,167,716	461,749	161,570	202

HARRISBURG MEDICAL CENTER, INC. Provider CCN: 14-0210	In Lieu of Form CMS-2552-10	Period : From: 07/01/2014 To: 06/30/2015	Run Date: 10/22/2015 Run Time: 16:34 Version: 2015.03 (10/05/2015)
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COST ALLOCATION - GENERAL SERVICE COSTS

WORKSHEET B
PART I

	COST CENTER DESCRIPTIONS	CENTRAL SERVICES & SUPPLY	PHARMACY	MEDICAL RECORDS & LIBRARY	SUBTOTAL	I&R COST & POST STEP-DOWN ADJS	TOTAL	
		14	15	16	24	25	26	
	GENERAL SERVICE COST CENTERS							
1	Cap Rel Costs-Bldg & Fixt							1
2	Cap Rel Costs-Mvble Equip							2
4	Employee Benefits Department							4
5	Administrative & General							5
6	Maintenance & Repairs							6
7	Operation of Plant							7
8	Laundry & Linen Service							8
9	Housekeeping							9
10	Dietary							10
11	Cafeteria							11
12	Maintenance of Personnel							12
13	Nursing Administration							13
14	Central Services & Supply	554,141						14
15	Pharmacy	4,344	1,008,141					15
16	Medical Records & Library	4,525		1,092,056				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	169,236		77,042	6,544,416		6,544,416	30
40	Subprovider - IPF	36,269		96,968	5,693,535		5,693,535	40
	ANCILLARY SERVICE COST CENTERS							
50	Operating Room	69,702		22,822	1,118,051		1,118,051	50
53	Anesthesiology	6,319		20,818	348,232		348,232	53
54	Radiology-Diagnostic	2,916		38,320	1,432,675		1,432,675	54
57	CT Scan	4,635		150,566	639,170		639,170	57
60	Laboratory	19,537		195,214	3,527,368		3,527,368	60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
64	Intravenous Therapy	29,556		72,756	246,530		246,530	64
65	Respiratory Therapy	7,146		40,072	1,127,626		1,127,626	65
66	Physical Therapy	1,463		30,045	1,532,620		1,532,620	66
69	Electrocardiology	1,999		14,393	209,064		209,064	69
71	Medical Supplies Charged to Patients			18,975	1,650,907		1,650,907	71
72	Impl. Dev. Charged to Patients			8,226	734,233		734,233	72
73	Drugs Charged to Patients		959,281	89,084	3,962,285		3,962,285	73
75	ASC (Non-Distinct Part)	65,671		37,482	1,442,543		1,442,543	75
76	NUCLEAR MEDICINE	3,473		23,641	600,042		600,042	76
76.01	ULTRASOUND	2,230		36,557	439,500		439,500	76.01
76.02	MAMMOGRAPHY	997		6,172	202,469		202,469	76.02
76.03	CARDIAC REHABILITATION							76.03
76.04	FAITH CENTER CHEMOTHERAPY	11,108		2,331	283,003		283,003	76.04
76.06	ROUTINE ANCILLARY							76.06
76.97	CARDIAC REHABILITATION	1,427		3,472	174,201		174,201	76.97
76.98	HYPERBARIC OXYGEN THERAPY							76.98
76.99	LITHOTRIPSY							76.99
	OUTPATIENT SERVICE COST CENTERS							
88	Rural Health Clinic	11,356	35,377	23,188	3,153,888		3,153,888	88
88.01	RHC II	2,187		2,240	402,528		402,528	88.01
91	Emergency	84,420		64,588	2,763,270		2,763,270	91
92	Observation Beds (Non-Distinct Part)							92
93	DAY PSYCHIATRIC	2,574		8,986	437,456		437,456	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	7,562		8,098	898,999		898,999	101
	SPECIAL PURPOSE COST CENTERS							
118	SUBTOTALS (sum of lines 1-117)	550,652	994,658	1,092,056	39,564,611		39,564,611	118
	NONREIMBURSABLE COST CENTERS							
190	Gift, Flower, Coffee Shop & Canteen	388			346,657		346,657	190
192	Physicians' Private Offices	3,101	13,483		548,660		548,660	192
192.01	DIALYSIS							192.01
192.03	ORTHO CLINIC							192.03
200	Cross Foot Adjustments							200
201	Negative Cost Centers							201
202	TOTAL (sum of lines 118-201)	554,141	1,008,141	1,092,056	40,459,928		40,459,928	202

HARRISBURG MEDICAL CENTER, INC. Provider CCN: 14-0210	In Lieu of Form CMS-2552-10	Period : From: 07/01/2014 To: 06/30/2015	Run Date: 10/22/2015 Run Time: 16:34 Version: 2015.03 (10/05/2015)
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ALLOCATION OF CAPITAL-RELATED COSTS

WORKSHEET B
PART II

	COST CENTER DESCRIPTIONS	DIR ASSGND CAP-REL COSTS	CAP BLDGS & FIXTURES	CAP MOVABLE EQUIPMENT	SUBTOTAL	EMPLOYEE BENEFITS DEPARTMENT	ADMINIS- TRATIVE & GENERAL	
		0	1	2	2A	4	5	
	GENERAL SERVICE COST CENTERS							
1	Cap Rel Costs-Bldg & Fixt							1
2	Cap Rel Costs-Mvble Equip							2
4	Employee Benefits Department		8,410	16,506	24,916	24,916		4
5	Administrative & General	3,164	199,882	422,744	625,790	3,819	629,609	5
6	Maintenance & Repairs							6
7	Operation of Plant	10,623	42,821	10,779	64,223	554	24,580	7
8	Laundry & Linen Service		20,914	5,519	26,433	33	3,271	8
9	Housekeeping		5,355	1,798	7,153	635	15,379	9
10	Dietary	100	24,332	7,822	32,254	599	17,502	10
11	Cafeteria		13,938		13,938		263	11
12	Maintenance of Personnel							12
13	Nursing Administration			143	143	109	2,213	13
14	Central Services & Supply		9,371	9,965	19,336	221	8,272	14
15	Pharmacy		18,347	33,487	51,834	633	14,635	15
16	Medical Records & Library		12,804	31,288	44,092	526	16,133	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	536	157,913	86,481	244,930	3,240	80,512	30
40	Subprovider - IPF	400	147,913	11,302	159,615	2,972	71,647	40
	ANCILLARY SERVICE COST CENTERS							
50	Operating Room	138,870	97,816	99,499	336,185	576	11,299	50
53	Anesthesiology			8,980	8,980	795	4,868	53
54	Radiology-Diagnostic		62,680	113,739	176,419	593	19,467	54
57	CT Scan		7,150	1,259	8,409	198	7,239	57
60	Laboratory		36,616	41,222	77,838	916	49,714	60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
64	Intravenous Therapy					26	2,244	64
65	Respiratory Therapy	22,828	14,583	21,591	59,002	596	15,826	65
66	Physical Therapy	1,068	69,121	14,652	84,841	837	20,569	66
69	Electrocardiology	28,815	9,512	7,609	45,936	75	2,679	69
71	Medical Supplies Charged to Patients						25,395	71
72	Impl. Dev. Charged to Patients						11,298	72
73	Drugs Charged to Patients						45,345	73
75	ASC (Non-Distinct Part)		65,294	20,230	85,524	569	16,556	75
76	NUCLEAR MEDICINE		6,126	60,289	66,415	147	8,678	76
76.01	ULTRASOUND		7,922	3,232	11,154	235	5,934	76.01
76.02	MAMMOGRAPHY		4,772	10,160	14,932	66	2,863	76.02
76.03	CARDIAC REHABILITATION							76.03
76.04	FAITH CENTER CHEMOTHERAPY		14,694	1,021	15,715	147	3,671	76.04
76.06	ROUTINE ANCILLARY							76.06
76.97	CARDIAC REHABILITATION		8,300	7,601	15,901	89	2,313	76.97
76.98	HYPERBARIC OXYGEN THERAPY							76.98
76.99	LITHOTRIPSY							76.99
	OUTPATIENT SERVICE COST CENTERS							
88	Rural Health Clinic	1,640			1,640	1,769	45,281	88
88.01	RHC II					226	5,906	88.01
91	Emergency		30,616	43,234	73,850	2,581	36,238	91
92	Observation Beds (Non-Distinct Part)							92
93	DAY PSYCHIATRIC		37,797	863	38,660	202	5,430	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	13,342	101
	SPECIAL PURPOSE COST CENTERS							
118	SUBTOTALS (sum of lines 1-117)	208,044	1,134,999	1,093,015	2,436,058	24,514	616,562	118
	NONREIMBURSABLE COST CENTERS							
190	Gift, Flower, Coffee Shop & Canteen		10,174		10,174	89	5,109	190
192	Physicians' Private Offices	132			132	313	7,938	192
192.01	DIALYSIS							192.01
192.03	ORTHO CLINIC							192.03
200	Cross Foot Adjustments							200
201	Negative Cost Centers							201
202	TOTAL (sum of lines 118-201)	208,176	1,145,173	1,093,015	2,446,364	24,916	629,609	202

HARRISBURG MEDICAL CENTER, INC. Provider CCN: 14-0210	In Lieu of Form CMS-2552-10	Period : From: 07/01/2014 To: 06/30/2015	Run Date: 10/22/2015 Run Time: 16:34 Version: 2015.03 (10/05/2015)
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ALLOCATION OF CAPITAL-RELATED COSTS

WORKSHEET B
PART II

	COST CENTER DESCRIPTIONS	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSE-KEEPING	DIETARY	CAFETERIA	NURSING ADMINISTRATION	
		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	89,357						7
8	Laundry & Linen Service	2,090	31,827					8
9	Housekeeping	535		23,702				9
10	Dietary	2,432			52,787			10
11	Cafeteria	1,393			18,995	34,589		11
12	Maintenance of Personnel							12
13	Nursing Administration			348		355	3,168	13
14	Central Services & Supply	937				448		14
15	Pharmacy	1,834		339		1,247		15
16	Medical Records & Library	1,280				2,110		16
17	Social Service							17
19	Nonphysician Anesthetists							19
20	Nursing School							20
21	I&R Services-Salary & Fringes Apprvd							21
22	I&R Services-Other Prgm Costs Apprvd							22
23	Paramed Ed Prgm-(specify)							23
	INPATIENT ROUTINE SERV COST CENTERS							
30	Adults & Pediatrics	15,779	9,938	7,411	15,052	6,424	730	30
40	Subprovider - IPF	14,783	4,854	2,951	18,224	6,781	769	40
	ANCILLARY SERVICE COST CENTERS							
50	Operating Room	9,776	1,948	1,764		1,945	221	50
53	Anesthesiology					620		53
54	Radiology-Diagnostic	6,265	2,150			974		54
57	CT Scan	715				460		57
60	Laboratory	3,660		526		2,330		60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
64	Intravenous Therapy							64
65	Respiratory Therapy	1,458	905	365		1,143		65
66	Physical Therapy	6,908	919	441		2,360		66
69	Electrocardiology	951				276		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)	6,526	4,534	2,298		1,473	167	75
76	NUCLEAR MEDICINE	612				333		76
76.01	ULTRASOUND	792				403		76.01
76.02	MAMMOGRAPHY	477				216		76.02
76.03	CARDIAC REHABILITATION							76.03
76.04	FAITH CENTER CHEMOTHERAPY	1,469				403	46	76.04
76.06	ROUTINE ANCILLARY							76.06
76.97	CARDIAC REHABILITATION	830				312	35	76.97
76.98	HYPERBARIC OXYGEN THERAPY							76.98
76.99	LITHOTRIPSY							76.99
	OUTPATIENT SERVICE COST CENTERS							
88	Rural Health Clinic		3,050	2,824			619	88
88.01	RHC II			441				88.01
91	Emergency	3,060	2,169	3,638		3,212	365	91
92	Observation Beds (Non-Distinct Part)							92
93	DAY PSYCHIATRIC	3,778				764		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			356			216	101
	SPECIAL PURPOSE COST CENTERS							
118	SUBTOTALS (sum of lines 1-117)	88,340	30,467	23,702	52,271	34,589	3,168	118
	NONREIMBURSABLE COST CENTERS							
190	Gift, Flower, Coffee Shop & Canteen	1,017						190
192	Physicians' Private Offices		1,360		516			192
192.01	DIALYSIS							192.01
192.03	ORTHO CLINIC							192.03
200	Cross Foot Adjustments							200
201	Negative Cost Centers							201
202	TOTAL (sum of lines 118-201)	89,357	31,827	23,702	52,787	34,589	3,168	202

HARRISBURG MEDICAL CENTER, INC. Provider CCN: 14-0210	In Lieu of Form CMS-2552-10	Period : From: 07/01/2014 To: 06/30/2015	Run Date: 10/22/2015 Run Time: 16:34 Version: 2015.03 (10/05/2015)
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ALLOCATION OF CAPITAL-RELATED COSTS

WORKSHEET B
PART II

	COST CENTER DESCRIPTIONS	CENTRAL SERVICES & SUPPLY	PHARMACY	MEDICAL RECORDS & LIBRARY	SUBTOTAL	I&R COST & POST STEP-DOWN ADJS	TOTAL	
		14	15	16	24	25	26	
	GENERAL SERVICE COST CENTERS							
1	Cap Rel Costs-Bldg & Fixt							1
2	Cap Rel Costs-Mvble Equip							2
4	Employee Benefits Department							4
5	Administrative & General							5
6	Maintenance & Repairs							6
7	Operation of Plant							7
8	Laundry & Linen Service							8
9	Housekeeping							9
10	Dietary							10
11	Cafeteria							11
12	Maintenance of Personnel							12
13	Nursing Administration							13
14	Central Services & Supply	29,214						14
15	Pharmacy	229	70,751					15
16	Medical Records & Library	239		64,380				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	8,921		4,538	397,475		397,475	30
40	Subprovider - IPF	1,912		5,712	290,220		290,220	40
	ANCILLARY SERVICE COST CENTERS							
50	Operating Room	3,675		1,344	368,733		368,733	50
53	Anesthesiology	333		1,226	16,822		16,822	53
54	Radiology-Diagnostic	154		2,257	208,279		208,279	54
57	CT Scan	244		8,869	26,134		26,134	57
60	Laboratory	1,030		11,552	147,566		147,566	60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
64	Intravenous Therapy	1,558		4,286	8,114		8,114	64
65	Respiratory Therapy	377		2,360	82,032		82,032	65
66	Physical Therapy	77		1,770	118,722		118,722	66
69	Electrocardiology	105		848	50,870		50,870	69
71	Medical Supplies Charged to Patients			1,118	26,513		26,513	71
72	Impl. Dev. Charged to Patients			485	11,783		11,783	72
73	Drugs Charged to Patients		67,322	5,247	117,914		117,914	73
75	ASC (Non-Distinct Part)	3,462		2,208	123,317		123,317	75
76	NUCLEAR MEDICINE	183		1,393	77,761		77,761	76
76.01	ULTRASOUND	118		2,153	20,789		20,789	76.01
76.02	MAMMOGRAPHY	53		364	18,971		18,971	76.02
76.03	CARDIAC REHABILITATION							76.03
76.04	FAITH CENTER CHEMOTHERAPY	586		137	22,174		22,174	76.04
76.06	ROUTINE ANCILLARY							76.06
76.97	CARDIAC REHABILITATION	75		205	19,760		19,760	76.97
76.98	HYPERBARIC OXYGEN THERAPY							76.98
76.99	LITHOTRIPSY							76.99
	OUTPATIENT SERVICE COST CENTERS							
88	Rural Health Clinic	599	2,483	1,366	59,631		59,631	88
88.01	RHC II	115		132	6,820		6,820	88.01
91	Emergency	4,451		3,804	133,368		133,368	91
92	Observation Beds (Non-Distinct Part)							92
93	DAY PSYCHIATRIC	136		529	49,499		49,499	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	399		477	15,320		15,320	101
	SPECIAL PURPOSE COST CENTERS							
118	SUBTOTALS (sum of lines 1-117)	29,031	69,805	64,380	2,418,587		2,418,587	118
	NONREIMBURSABLE COST CENTERS							
190	Gift, Flower, Coffee Shop & Canteen	20			16,409		16,409	190
192	Physicians' Private Offices	163	946		11,368		11,368	192
192.01	DIALYSIS							192.01
192.03	ORTHO CLINIC							192.03
200	Cross Foot Adjustments							200
201	Negative Cost Centers							201
202	TOTAL (sum of lines 118-201)	29,214	70,751	64,380	2,446,364		2,446,364	202

HARRISBURG MEDICAL CENTER, INC. Provider CCN: 14-0210	In Lieu of Form CMS-2552-10	Period : From: 07/01/2014 To: 06/30/2015	Run Date: 10/22/2015 Run Time: 16:34 Version: 2015.03 (10/05/2015)
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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	72,715						1
2	Cap Rel Costs-Mvble Equip		1,035,043					2
4	Employee Benefits Department	534	15,631	22,599,432				4
5	Administrative & General	12,692	400,322	3,471,758	-7,127,786	33,332,142		5
6	Maintenance & Repairs							6
7	Operation of Plant	2,719	10,207	502,421		1,301,276	56,770	7
8	Laundry & Linen Service	1,328	5,226	30,287		173,163	1,328	8
9	Housekeeping	340	1,703	575,955		814,199	340	9
10	Dietary	1,545	7,407	543,195		926,587	1,545	10
11	Cafeteria	885				13,938	885	11
12	Maintenance of Personnel							12
13	Nursing Administration		135	98,954		117,150		13
14	Central Services & Supply	595	9,436	200,646		437,953	595	14
15	Pharmacy	1,165	31,711	573,668		774,773	1,165	15
16	Medical Records & Library	813	29,629	477,213		854,096	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	10,027	81,894	2,937,621		4,262,517	10,027	30
40	Subprovider - IPF	9,392	10,703	2,694,075		3,793,034	9,392	40
	ANCILLARY SERVICE COST CENTERS							
50	Operating Room	6,211	94,222	522,004		598,180	6,211	50
53	Anesthesiology		8,504	720,908		257,710		53
54	Radiology-Diagnostic	3,980	107,706	537,668		1,030,616	3,980	54
57	CT Scan	454	1,192	179,099		383,242	454	57
60	Laboratory	2,325	39,036	830,165		2,631,880	2,325	60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
64	Intravenous Therapy			23,960		118,811		64
65	Respiratory Therapy	926	20,446	540,635		837,844	926	65
66	Physical Therapy	4,389	13,875	759,115		1,088,931	4,389	66
69	Electrocardiology	604	7,205	68,298		141,852	604	69
71	Medical Supplies Charged to Patients					1,344,436		71
72	Impl. Dev. Charged to Patients					598,107		72
73	Drugs Charged to Patients					2,400,578		73
75	ASC (Non-Distinct Part)	4,146	19,157	515,830		876,463	4,146	75
76	NUCLEAR MEDICINE	389	57,091	133,010		459,422	389	76
76.01	ULTRASOUND	503	3,061	212,882		314,161	503	76.01
76.02	MAMMOGRAPHY	303	9,621	59,396		151,572	303	76.02
76.03	CARDIAC REHABILITATION							76.03
76.04	FAITH CENTER CHEMOTHERAPY	933	967	133,076		194,337	933	76.04
76.06	ROUTINE ANCILLARY							76.06
76.97	CARDIAC REHABILITATION	527	7,198	80,585		122,473	527	76.97
76.98	HYPERBARIC OXYGEN THERAPY							76.98
76.99	LITHOTRIPSY							76.99
	OUTPATIENT SERVICE COST CENTERS							
88	Rural Health Clinic			1,603,874		2,397,228		88
88.01	RHC II			204,792		312,675		88.01
91	Emergency	1,944	40,941	2,340,278		1,918,463	1,944	91
92	Observation Beds (Non-Distinct Part)							92
93	DAY PSYCHIATRIC	2,400	817	183,382		287,453	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			480,861		706,316		101
	SPECIAL PURPOSE COST CENTERS							
118	SUBTOTALS (sum of lines 1-117)	72,069	1,035,043	22,235,611	-7,127,786	32,641,436	56,124	118
	NONREIMBURSABLE COST CENTERS							
190	Gift, Flower, Coffee Shop & Canteen	646		80,303		270,460	646	190
192	Physicians' Private Offices			283,518		420,246		192
192.01	DIALYSIS							192.01
192.03	ORTHO CLINIC							192.03
200	Cross foot adjustments							200
201	Negative cost centers							201
202	Cost to be allocated (Per Wkst. B, Part I)	1,145,173	1,093,015	6,456,774		7,127,786	1,579,542	202
203	Unit Cost Multiplier (Wkst. B, Part I)	15.748786	1.056009	0.285705		0.213841	27.823534	203
204	Cost to be allocated (Per Wkst. B, Part II)			24,916		629,609	89,357	204
205	Unit Cost Multiplier (Wkst. B, Part II)			0.001103		0.018889	1.574018	205

HARRISBURG MEDICAL CENTER, INC. Provider CCN: 14-0210	In Lieu of Form CMS-2552-10	Period : From: 07/01/2014 To: 06/30/2015	Run Date: 10/22/2015 Run Time: 16:34 Version: 2015.03 (10/05/2015)
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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 NRSNG 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	33,240						8
9	Housekeeping		2,795					9
10	Dietary			166,568				10
11	Cafeteria			59,940	317,093			11
12	Maintenance of Personnel							12
13	Nursing Administration		41		3,250	255,736		13
14	Central Services & Supply				4,107		632,190	14
15	Pharmacy		40		11,436		4,956	15
16	Medical Records & Library				19,347		5,162	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	10,380	874	47,497	58,894	58,894	193,073	30
40	Subprovider - IPF	5,070	348	57,504	62,158	62,158	41,377	40
	ANCILLARY SERVICE COST CENTERS							
50	Operating Room	2,035	208		17,834	17,834	79,519	50
53	Anesthesiology				5,683		7,209	53
54	Radiology-Diagnostic	2,245			8,931		3,327	54
57	CT Scan				4,218		5,288	57
60	Laboratory		62		21,364		22,289	60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
64	Intravenous Therapy						33,719	64
65	Respiratory Therapy	945	43		10,478		8,152	65
66	Physical Therapy	960	52		21,635		1,669	66
69	Electrocardiology				2,528		2,280	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)	4,735	271		13,506	13,506	74,921	75
76	NUCLEAR MEDICINE				3,049		3,962	76
76.01	ULTRASOUND				3,692		2,544	76.01
76.02	MAMMOGRAPHY				1,981		1,137	76.02
76.03	CARDIAC REHABILITATION							76.03
76.04	FAITH CENTER CHEMOTHERAPY				3,693	3,693	12,672	76.04
76.06	ROUTINE ANCILLARY							76.06
76.97	CARDIAC REHABILITATION				2,862	2,862	1,628	76.97
76.98	HYPERBARIC OXYGEN THERAPY							76.98
76.99	LITHOTRIPSY							76.99
	OUTPATIENT SERVICE COST CENTERS							
88	Rural Health Clinic	3,185	333			49,949	12,956	88
88.01	RHC II		52				2,495	88.01
91	Emergency	2,265	429		29,444	29,444	96,310	91
92	Observation Beds (Non-Distinct Part)							92
93	DAY PSYCHIATRIC				7,003		2,937	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		42			17,396	8,627	101
	SPECIAL PURPOSE COST CENTERS							
118	SUBTOTALS (sum of lines 1-117)	31,820	2,795	164,941	317,093	255,736	628,209	118
	NONREIMBURSABLE COST CENTERS							
190	Gift, Flower, Coffee Shop & Canteen						443	190
192	Physicians' Private Offices	1,420		1,627			3,538	192
192.01	DIALYSIS							192.01
192.03	ORTHO CLINIC							192.03
200	Cross foot adjustments							200
201	Negative cost centers							201
202	Cost to be allocated (Per Wkst. B, Part I)	247,142	997,768	1,167,716	461,749	161,570	554,141	202
203	Unit Cost Multiplier (Wkst. B, Part I)	7.435078	356.983184	7.010446	1.456194	0.631784	0.876542	203
204	Cost to be allocated (Per Wkst. B, Part II)	31,827	23,702	52,787	34,589	3,168	29,214	204
205	Unit Cost Multiplier (Wkst. B, Part II)	0.957491	8.480143	0.316910	0.109082	0.012388	0.046211	205

HARRISBURG MEDICAL CENTER, INC. Provider CCN: 14-0210	In Lieu of Form CMS-2552-10	Period : From: 07/01/2014 To: 06/30/2015	Run Date: 10/22/2015 Run Time: 16:34 Version: 2015.03 (10/05/2015)
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COST ALLOCATION - STATISTICAL BASIS

WORKSHEET B-1

COST CENTER DESCRIPTIONS	PHARMACY COSTED REQUIS. 15	MEDICAL RECORDS & LIBRARY GROSS REVENUE 16				
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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	2,400,578					15
16	Medical Records & Library		135,140,471				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		9,533,692				30
40	Subprovider - IPF		11,999,493				40
ANCILLARY SERVICE COST CENTERS							
50	Operating Room		2,824,177				50
53	Anesthesiology		2,576,207				53
54	Radiology-Diagnostic		4,742,013				54
57	CT Scan		18,632,152				57
60	Laboratory		24,158,564				60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS						62.30
64	Intravenous Therapy		9,003,353				64
65	Respiratory Therapy		4,958,837				65
66	Physical Therapy		3,718,040				66
69	Electrocardiology		1,781,104				69
71	Medical Supplies Charged to Patients		2,348,091				71
72	Impl. Dev. Charged to Patients		1,017,902				72
73	Drugs Charged to Patients	2,284,233	11,023,852				73
75	ASC (Non-Distinct Part)		4,638,335				75
76	NUCLEAR MEDICINE		2,925,556				76
76.01	ULTRASOUND		4,523,826				76.01
76.02	MAMMOGRAPHY		763,748				76.02
76.03	CARDIAC REHABILITATION						76.03
76.04	FAITH CENTER CHEMOTHERAPY		288,444				76.04
76.06	ROUTINE ANCILLARY						76.06
76.97	CARDIAC REHABILITATION		429,679				76.97
76.98	HYPERBARIC OXYGEN THERAPY						76.98
76.99	LITHOTRIPSY						76.99
OUTPATIENT SERVICE COST CENTERS							
88	Rural Health Clinic	84,239	2,869,457				88
88.01	RHC II		277,251				88.01
91	Emergency		7,992,607				91
92	Observation Beds (Non-Distinct Part)						92
93	DAY PSYCHIATRIC		1,111,980				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		1,002,111				101
SPECIAL PURPOSE COST CENTERS							
118	SUBTOTALS (sum of lines 1-117)	2,368,472	135,140,471				118
NONREIMBURSABLE COST CENTERS							
190	Gift, Flower, Coffee Shop & Canteen						190
192	Physicians' Private Offices	32,106					192
192.01	DIALYSIS						192.01
192.03	ORTHO CLINIC						192.03
200	Cross foot adjustments						200
201	Negative cost centers						201
202	Cost to be allocated (Per Wkst. B, Part I)	1,008,141	1,092,056				202
203	Unit Cost Multiplier (Wkst. B, Part I)	0.419958	0.008081				203

HARRISBURG MEDICAL CENTER, INC. Provider CCN: 14-0210	In Lieu of Form CMS-2552-10	Period : From: 07/01/2014 To: 06/30/2015	Run Date: 10/22/2015 Run Time: 16:34 Version: 2015.03 (10/05/2015)
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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 allocated (Per Wkst. B, Part II)	70,751	64,380					204
205	Unit Cost Multiplier (Wkst. B, Part II)	0.029472	0.000476					205

HARRISBURG MEDICAL CENTER, INC. Provider CCN: 14-0210	In Lieu of Form CMS-2552-10	Period : From: 07/01/2014 To: 06/30/2015	Run Date: 10/22/2015 Run Time: 16:34 Version: 2015.03 (10/05/2015)
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POST STEPDOWN ADJUSTMENTS

WORKSHEET B-2

	DESCRIPTION	WORKSHEET		AMOUNT	
		PART	LINE NO.		
	1	2	3	4	

HARRISBURG MEDICAL CENTER, INC. Provider CCN: 14-0210	In Lieu of Form CMS-2552-10	Period : From: 07/01/2014 To: 06/30/2015	Run Date: 10/22/2015 Run Time: 16:34 Version: 2015.03 (10/05/2015)
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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 Dis- allowance	Total Costs	
		1	2	3	4	5	
	INPATIENT ROUTINE SERVICE COST CENTERS						
30	Adults & Pediatrics	6,544,416		6,544,416	11,697	6,556,113	30
40	Subprovider - IPF	5,693,535		5,693,535	231,616	5,925,151	40
	ANCILLARY SERVICE COST CENTERS						
50	Operating Room	1,118,051		1,118,051		1,118,051	50
53	Anesthesiology	348,232		348,232		348,232	53
54	Radiology-Diagnostic	1,432,675		1,432,675		1,432,675	54
57	CT Scan	639,170		639,170		639,170	57
60	Laboratory	3,527,368		3,527,368		3,527,368	60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS						62.30
64	Intravenous Therapy	246,530		246,530		246,530	64
65	Respiratory Therapy	1,127,626		1,127,626		1,127,626	65
66	Physical Therapy	1,532,620		1,532,620		1,532,620	66
69	Electrocardiology	209,064		209,064		209,064	69
71	Medical Supplies Charged to Patients	1,650,907		1,650,907		1,650,907	71
72	Impl. Dev. Charged to Patients	734,233		734,233		734,233	72
73	Drugs Charged to Patients	3,962,285		3,962,285		3,962,285	73
75	ASC (Non-Distinct Part)	1,442,543		1,442,543		1,442,543	75
76	NUCLEAR MEDICINE	600,042		600,042		600,042	76
76.01	ULTRASOUND	439,500		439,500		439,500	76.01
76.02	MAMMOGRAPHY	202,469		202,469		202,469	76.02
76.03	CARDIAC REHABILITATION						76.03
76.04	FAITH CENTER CHEMOTHERAPY	283,003		283,003		283,003	76.04
76.06	ROUTINE ANCILLARY						76.06
76.97	CARDIAC REHABILITATION	174,201		174,201		174,201	76.97
76.98	HYPERBARIC OXYGEN THERAPY						76.98
76.99	LITHOTRIPSY						76.99
	OUTPATIENT SERVICE COST CENTERS						
88	Rural Health Clinic	3,153,888		3,153,888		3,153,888	88
88.01	RHC II	402,528		402,528		402,528	88.01
91	Emergency	2,763,270		2,763,270	8,478	2,771,748	91
92	Observation Beds (Non-Distinct Part)	2,056,438		2,056,438		2,056,438	92
93	DAY PSYCHIATRIC	437,456		437,456		437,456	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	898,999		898,999		898,999	101
200	Subtotal (sum of lines 30 thru 199)	41,621,049		41,621,049	251,791	41,872,840	200
201	Less Observation Beds	2,056,438		2,056,438		2,056,438	201
202	Total (line 200 minus line 201)	39,564,611		39,564,611		39,816,402	202

HARRISBURG MEDICAL CENTER, INC. Provider CCN: 14-0210	In Lieu of Form CMS-2552-10	Period : From: 07/01/2014 To: 06/30/2015	Run Date: 10/22/2015 Run Time: 16:34 Version: 2015.03 (10/05/2015)
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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 SERVICE COST CENTERS							
30	Adults & Pediatrics	4,806,080		4,806,080				30
40	Subprovider - IPF	11,999,493		11,999,493				40
	ANCILLARY SERVICE COST CENTERS							
50	Operating Room	461,965	2,362,212	2,824,177	0.395886	0.395886	0.395886	50
53	Anesthesiology	411,085	2,165,122	2,576,207	0.135172	0.135172	0.135172	53
54	Radiology-Diagnostic	422,969	4,319,044	4,742,013	0.302124	0.302124	0.302124	54
57	CT Scan	1,959,940	16,672,212	18,632,152	0.034305	0.034305	0.034305	57
60	Laboratory	3,844,990	20,313,574	24,158,564	0.146009	0.146009	0.146009	60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
64	Intravenous Therapy	5,901,830	3,101,523	9,003,353	0.027382	0.027382	0.027382	64
65	Respiratory Therapy	2,255,162	2,703,675	4,958,837	0.227397	0.227397	0.227397	65
66	Physical Therapy	720,569	2,997,471	3,718,040	0.412212	0.412212	0.412212	66
69	Electrocardiology	288,091	1,493,013	1,781,104	0.117379	0.117379	0.117379	69
71	Medical Supplies Charged to Patients	1,004,561	1,343,530	2,348,091	0.703085	0.703085	0.703085	71
72	Impl. Dev. Charged to Patients	480,720	537,182	1,017,902	0.721320	0.721320	0.721320	72
73	Drugs Charged to Patients	3,361,829	7,662,023	11,023,852	0.359428	0.359428	0.359428	73
75	ASC (Non-Distinct Part)	276,995	4,361,340	4,638,335	0.311004	0.311004	0.311004	75
76	NUCLEAR MEDICINE	148,476	2,777,080	2,925,556	0.205104	0.205104	0.205104	76
76.01	ULTRASOUND	862,045	3,661,781	4,523,826	0.097152	0.097152	0.097152	76.01
76.02	MAMMOGRAPHY	861	762,887	763,748	0.265099	0.265099	0.265099	76.02
76.03	CARDIAC REHABILITATION							76.03
76.04	FAITH CENTER CHEMOTHERAPY	3,506	284,938	288,444	0.981137	0.981137	0.981137	76.04
76.06	ROUTINE ANCILLARY							76.06
76.97	CARDIAC REHABILITATION	10,421	419,258	429,679	0.405421	0.405421	0.405421	76.97
76.98	HYPERBARIC OXYGEN THERAPY							76.98
76.99	LITHOTRIPSY							76.99
	OUTPATIENT SERVICE COST CENTERS							
88	Rural Health Clinic		2,869,457	2,869,457				88
88.01	RHC II		277,251	277,251				88.01
91	Emergency	767,580	7,225,027	7,992,607	0.345728	0.345728	0.346789	91
92	Observation Beds (Non-Distinct Part)	1,122,503	3,605,109	4,727,612	0.434985	0.434985	0.434985	92
93	DAY PSYCHIATRIC	1,000	1,110,980	1,111,980	0.393403	0.393403	0.393403	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		1,002,111	1,002,111				101
200	Subtotal (sum of lines 30 thru 199)	41,112,671	94,027,800	135,140,471				200
201	Less Observation Beds							201
202	Total (line 200 minus line 201)	41,112,671	94,027,800	135,140,471				202

HARRISBURG MEDICAL CENTER, INC. Provider CCN: 14-0210	In Lieu of Form CMS-2552-10	Period : From: 07/01/2014 To: 06/30/2015	Run Date: 10/22/2015 Run Time: 16:34 Version: 2015.03 (10/05/2015)
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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	
	INPATIENT ROUTINE SERVICE COST CENTERS								
30	Adults & Pediatrics General Routine Care)	397,475	2,187	395,288	6,674	59.23	2,861	169,457	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	290,220		290,220	9,995	29.04	3,681	106,896	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)	687,695		685,508	16,669		6,542	276,353	200

(A) Worksheet A line numbers

HARRISBURG MEDICAL CENTER, INC. Provider CCN: 14-0210	In Lieu of Form CMS-2552-10	Period : From: 07/01/2014 To: 06/30/2015	Run Date: 10/22/2015 Run Time: 16:34 Version: 2015.03 (10/05/2015)
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APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS

COMPONENT CCN: 14-0210

WORKSHEET D
PART II

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

(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	368,733	2,824,177	0.130563	176,846	23,090	50
53	Anesthesiology	16,822	2,576,207	0.006530	196,087	1,280	53
54	Radiology-Diagnostic	208,279	4,742,013	0.043922	384,933	16,907	54
57	CT Scan	26,134	18,632,152	0.001403	1,792,822	2,515	57
60	Laboratory	147,566	24,158,564	0.006108	3,411,281	20,836	60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS						62.30
64	Intravenous Therapy	8,114	9,003,353	0.000901	3,535,393	3,185	64
65	Respiratory Therapy	82,032	4,958,837	0.016543	1,487,030	24,600	65
66	Physical Therapy	118,722	3,718,040	0.031931	501,470	16,012	66
69	Electrocardiology	50,870	1,781,104	0.028561	260,735	7,447	69
71	Medical Supplies Charged to Patients	26,513	2,348,091	0.011291	620,983	7,012	71
72	Impl. Dev. Charged to Patients	11,783	1,017,902	0.011576	199,463	2,309	72
73	Drugs Charged to Patients	117,914	11,023,852	0.010696	1,343,721	14,372	73
75	ASC (Non-Distinct Part)	123,317	4,638,335	0.026586	215,760	5,736	75
76	NUCLEAR MEDICINE	77,761	2,925,556	0.026580	80,727	2,146	76
76.01	ULTRASOUND	20,789	4,523,826	0.004595	731,968	3,363	76.01
76.02	MAMMOGRAPHY	18,971	763,748	0.024839			76.02
76.03	CARDIAC REHABILITATION						76.03
76.04	FAITH CENTER CHEMOTHERAPY	22,174	288,444	0.076875			76.04
76.06	ROUTINE ANCILLARY						76.06
76.97	CARDIAC REHABILITATION	19,760	429,679	0.045988	8,212	378	76.97
76.98	HYPERBARIC OXYGEN THERAPY						76.98
76.99	LITHOTRIPSY						76.99
	OUTPATIENT SERVICE COST CENTERS						
88	Rural Health Clinic	59,631	2,869,457	0.020781			88
88.01	RHC II	6,820	277,251	0.024599			88.01
91	Emergency	133,368	7,992,607	0.016686	659,028	10,997	91
92	Observation Beds (Non-Distinct Part)	125,365	4,727,612	0.026518	626,979	16,626	92
93	DAY PSYCHIATRIC	49,499	1,111,980	0.044514			93
	OTHER REIMBURSABLE COST CENTERS						
200	Total (sum of lines 50-199)	1,840,937	117,332,787		16,233,438	178,811	200

(A) Worksheet A line numbers

HARRISBURG MEDICAL CENTER, INC. Provider CCN: 14-0210	In Lieu of Form CMS-2552-10	Period : From: 07/01/2014 To: 06/30/2015	Run Date: 10/22/2015 Run Time: 16:34 Version: 2015.03 (10/05/2015)
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APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PASS THROUGH COSTS

WORKSHEET D
PART III

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

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

(A) Worksheet A line numbers

HARRISBURG MEDICAL CENTER, INC. Provider CCN: 14-0210	In Lieu of Form CMS-2552-10	Period : From: 07/01/2014 To: 06/30/2015	Run Date: 10/22/2015 Run Time: 16:34 Version: 2015.03 (10/05/2015)
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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 Other

		Total Patient Days	Per Diem (col. 5+ col. 6)	Inpatient Program Days	Inpatient Program Pass-Through Cost (col. 7 x col. 8)	
(A)	Cost Center Description	6	7	8	9	
	INPATIENT ROUTINE SERVICE COST CENTERS					
30	Adults & Pediatrics (General Routine Care)	6,674		2,861		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	9,995		3,681		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)	16,669		6,542		200

(A) Worksheet A line numbers

HARRISBURG MEDICAL CENTER, INC. Provider CCN: 14-0210	In Lieu of Form CMS-2552-10	Period : From: 07/01/2014 To: 06/30/2015	Run Date: 10/22/2015 Run Time: 16:34 Version: 2015.03 (10/05/2015)
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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 IRF NF Other

(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

HARRISBURG MEDICAL CENTER, INC. Provider CCN: 14-0210	In Lieu of Form CMS-2552-10	Period : From: 07/01/2014 To: 06/30/2015	Run Date: 10/22/2015 Run Time: 16:34 Version: 2015.03 (10/05/2015)
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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 [XX] Hospital [] SUB (Other) [] ICF/MR [XX] PPS
 Applicable [XX] Title XVIII, Part A [] IPF [] SNF [] TEFRA
 Boxes: [] Title XIX [] IRF [] NF [] Other

(A)	Cost Center Description	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 5+ col. 7)	Outpatient Ratio of Cost to Charges (col. 6+ col. 7)	Inpatient Program Charges	Inpatient Program Pass-Through Costs (col. 8 x col. 10)	Outpatient Program Charges	Outpatient Program Pass-Through Costs (col. 9 x col. 12)	
ANCILLARY SERVICE COST CENTERS									
50	Operating Room	2,824,177			176,846		614,142		50
53	Anesthesiology	2,576,207			196,087		709,018		53
54	Radiology-Diagnostic	4,742,013			384,933		1,308,899		54
57	CT Scan	18,632,152			1,792,822		5,103,026		57
60	Laboratory	24,158,564			3,411,281		3,294,024		60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS								62.30
64	Intravenous Therapy	9,003,353			3,535,393		1,144,606		64
65	Respiratory Therapy	4,958,837			1,487,030		824,095		65
66	Physical Therapy	3,718,040			501,470		812		66
69	Electrocardiology	1,781,104			260,735		436,284		69
71	Medical Supplies Charged to Patients	2,348,091			620,983		374,108		71
72	Impl. Dev. Charged to Patients	1,017,902			199,463		194,758		72
73	Drugs Charged to Patients	11,023,852			1,343,721		3,421,153		73
75	ASC (Non-Distinct Part)	4,638,335			215,760		1,663,980		75
76	NUCLEAR MEDICINE	2,925,556			80,727		1,150,317		76
76.01	ULTRASOUND	4,523,826			731,968		949,327		76.01
76.02	MAMMOGRAPHY	763,748							76.02
76.03	CARDIAC REHABILITATION								76.03
76.04	FAITH CENTER CHEMOTHERAPY	288,444					45,145		76.04
76.06	ROUTINE ANCILLARY								76.06
76.97	CARDIAC REHABILITATION	429,679			8,212		308,607		76.97
76.98	HYPERBARIC OXYGEN THERAPY								76.98
76.99	LITHOTRIPSY								76.99
OUTPATIENT SERVICE COST CENTERS									
88	Rural Health Clinic	2,869,457							88
88.01	RHC II	277,251							88.01
91	Emergency	7,992,607			659,028		1,518,162		91
92	Observation Beds (Non-Distinct Part)	4,727,612			626,979		1,282,117		92
93	DAY PSYCHIATRIC	1,111,980					277,429		93
OTHER REIMBURSABLE COST CENTERS									
200	Total (sum of lines 50-199)	117,332,787			16,233,438		24,620,009		200

(A) Worksheet A line numbers

HARRISBURG MEDICAL CENTER, INC. Provider CCN: 14-0210	In Lieu of Form CMS-2552-10	Period : From: 07/01/2014 To: 06/30/2015	Run Date: 10/22/2015 Run Time: 16:34 Version: 2015.03 (10/05/2015)
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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	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	0.395886	614,142			243,130			50
53	Anesthesiology	0.135172	709,018			95,839			53
54	Radiology-Diagnostic	0.302124	1,308,899			395,450			54
57	CT Scan	0.034305	5,103,026			175,059			57
60	Laboratory	0.146009	3,294,024			480,957			60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS								62.30
64	Intravenous Therapy	0.027382	1,144,606			31,342			64
65	Respiratory Therapy	0.227397	824,095			187,397			65
66	Physical Therapy	0.412212	812			335			66
69	Electrocardiology	0.117379	436,284			51,211			69
71	Medical Supplies Charged to Patients	0.703085	374,108			263,030			71
72	Impl. Dev. Charged to Patients	0.721320	194,758			140,483			72
73	Drugs Charged to Patients	0.359428	3,421,153			1,229,658			73
75	ASC (Non-Distinct Part)	0.311004	1,663,980			517,504			75
76	NUCLEAR MEDICINE	0.205104	1,150,317			235,935			76
76.01	ULTRASOUND	0.097152	949,327			92,229			76.01
76.02	MAMMOGRAPHY	0.265099							76.02
76.03	CARDIAC REHABILITATION								76.03
76.04	FAITH CENTER CHEMOTHERAPY	0.981137	45,145			44,293			76.04
76.06	ROUTINE ANCILLARY								76.06
76.97	CARDIAC REHABILITATION	0.405421	308,607			125,116			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	0.345728	1,518,162			524,871			91
92	Observation Beds (Non-Distinct Part)	0.434985	1,282,117			557,702			92
93	DAY PSYCHIATRIC	0.393403	277,429			109,141			93
	OTHER REIMBURSABLE COST CENTERS								
200	Subtotal (see instructions)		24,620,009			5,500,682			200
201	Less PBP Clinic Lab. Services-Program Only Charges								201
202	Net Charges (line 200 - line 201)		24,620,009			5,500,682			202

(A) Worksheet A line numbers

HARRISBURG MEDICAL CENTER, INC. Provider CCN: 14-0210	In Lieu of Form CMS-2552-10	Period : From: 07/01/2014 To: 06/30/2015	Run Date: 10/22/2015 Run Time: 16:34 Version: 2015.03 (10/05/2015)
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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) [XX] PPS-
 Applicable [XX] Title XVIII, Part A [XX] IPF [] TEFRA
 Boxes: [] Title XIX [] IRF

(A)	Cost Center Description	Capital Related Cost (from Wkst. B, Part II (col. 26))	Total Charges (from Wkst. C, Part I, (col. 8))	Ratio of Cost to Charges (col. 1 ÷ col. 2)	Inpatient Program Charges	Capital Costs (col. 3 x col. 4)	
ANCILLARY SERVICE COST CENTERS							
50	Operating Room	368,733	2,824,177	0.130563			50
53	Anesthesiology	16,822	2,576,207	0.006530	10,046	66	53
54	Radiology-Diagnostic	208,279	4,742,013	0.043922	34,439	1,513	54
57	CT Scan	26,134	18,632,152	0.001403	166,938	234	57
60	Laboratory	147,566	24,158,564	0.006108	403,751	2,466	60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS						62.30
64	Intravenous Therapy	8,114	9,003,353	0.000901	63,097	57	64
65	Respiratory Therapy	82,032	4,958,837	0.016543	177,256	2,932	65
66	Physical Therapy	118,722	3,718,040	0.031931	42,959	1,372	66
69	Electrocardiology	50,870	1,781,104	0.028561	23,462	670	69
71	Medical Supplies Charged to Patients	26,513	2,348,091	0.011291	42,117	476	71
72	Impl. Dev. Charged to Patients	11,783	1,017,902	0.011576			72
73	Drugs Charged to Patients	117,914	11,023,852	0.010696	656,708	7,024	73
75	ASC (Non-Distinct Part)	123,317	4,638,335	0.026586	4,485	119	75
76	NUCLEAR MEDICINE	77,761	2,925,556	0.026580	2,100	56	76
76.01	ULTRASOUND	20,789	4,523,826	0.004595	23,994	110	76.01
76.02	MAMMOGRAPHY	18,971	763,748	0.024839			76.02
76.03	CARDIAC REHABILITATION						76.03
76.04	FAITH CENTER CHEMOTHERAPY	22,174	288,444	0.076875			76.04
76.06	ROUTINE ANCILLARY						76.06
76.97	CARDIAC REHABILITATION	19,760	429,679	0.045988			76.97
76.98	HYPERBARIC OXYGEN THERAPY						76.98
76.99	LITHOTRIPSY						76.99
OUTPATIENT SERVICE COST CENTERS							
88	Rural Health Clinic	59,631	2,869,457	0.020781			88
88.01	RHC II	6,820	277,251	0.024599			88.01
91	Emergency	133,368	7,992,607	0.016686	106,507	1,777	91
92	Observation Beds (Non-Distinct Part)		4,727,612				92
93	DAY PSYCHIATRIC	49,499	1,111,980	0.044514			93
OTHER REIMBURSABLE COST CENTERS							
200	Total (sum of lines 50-199)	1,715,572	117,332,787		1,757,859	18,872	200

(A) Worksheet A line numbers

HARRISBURG MEDICAL CENTER, INC. Provider CCN: 14-0210	In Lieu of Form CMS-2552-10	Period : From: 07/01/2014 To: 06/30/2015	Run Date: 10/22/2015 Run Time: 16:34 Version: 2015.03 (10/05/2015)
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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 [XX] PPS
 Applicable [XX] Title XVIII, Part A [XX] IPF [] SNF [] TEFRA
 Boxes: [] Title XIX [] IRF [] NF [] Other

(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

HARRISBURG MEDICAL CENTER, INC. Provider CCN: 14-0210	In Lieu of Form CMS-2552-10	Period : From: 07/01/2014 To: 06/30/2015	Run Date: 10/22/2015 Run Time: 16:34 Version: 2015.03 (10/05/2015)
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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 Other

(A)	Cost Center Description	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 5÷ col. 7)	Outpatient Ratio of Cost to Charges (col. 6÷ col. 7)	Inpatient Program Charges	Inpatient Program Pass-Through Costs (col. 8 x col. 10)	Outpatient Program Charges	Outpatient Program Pass-Through Costs (col. 9 x col. 12)	
	ANCILLARY SERVICE COST CENTERS								
50	Operating Room	2,824,177							50
53	Anesthesiology	2,576,207			10,046				53
54	Radiology-Diagnostic	4,742,013			34,439		693		54
57	CT Scan	18,632,152			166,938				57
60	Laboratory	24,158,564			403,751				60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS								62.30
64	Intravenous Therapy	9,003,353			63,097		946		64
65	Respiratory Therapy	4,958,837			177,256		1,300		65
66	Physical Therapy	3,718,040			42,959				66
69	Electrocardiology	1,781,104			23,462				69
71	Medical Supplies Charged to Patients	2,348,091			42,117		752		71
72	Impl. Dev. Charged to Patients	1,017,902							72
73	Drugs Charged to Patients	11,023,852			656,708				73
75	ASC (Non-Distinct Part)	4,638,335			4,485				75
76	NUCLEAR MEDICINE	2,925,556			2,100				76
76.01	ULTRASOUND	4,523,826			23,994				76.01
76.02	MAMMOGRAPHY	763,748							76.02
76.03	CARDIAC REHABILITATION								76.03
76.04	FAITH CENTER CHEMOTHERAPY	288,444							76.04
76.06	ROUTINE ANCILLARY								76.06
76.97	CARDIAC REHABILITATION	429,679							76.97
76.98	HYPERBARIC OXYGEN THERAPY								76.98
76.99	LITHOTRIPSY								76.99
	OUTPATIENT SERVICE COST CENTERS								
88	Rural Health Clinic	2,869,457							88
88.01	RHC II	277,251							88.01
91	Emergency	7,992,607			106,507				91
92	Observation Beds (Non-Distinct Part)	4,727,612							92
93	DAY PSYCHIATRIC	1,111,980							93
	OTHER REIMBURSABLE COST CENTERS								
200	Total (sum of lines 50-199)	117,332,787			1,757,859		3,691		200

(A) Worksheet A line numbers

HARRISBURG MEDICAL CENTER, INC. Provider CCN: 14-0210	In Lieu of Form CMS-2552-10	Period : From: 07/01/2014 To: 06/30/2015	Run Date: 10/22/2015 Run Time: 16:34 Version: 2015.03 (10/05/2015)
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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	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	0.395886						50
53	Anesthesiology	0.135172						53
54	Radiology-Diagnostic	0.302124	693			209		54
57	CT Scan	0.034305						57
60	Laboratory	0.146009						60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
64	Intravenous Therapy	0.027382	946			26		64
65	Respiratory Therapy	0.227397	1,300			296		65
66	Physical Therapy	0.412212						66
69	Electrocardiology	0.117379						69
71	Medical Supplies Charged to Patients	0.703085	752			529		71
72	Impl. Dev. Charged to Patients	0.721320						72
73	Drugs Charged to Patients	0.359428						73
75	ASC (Non-Distinct Part)	0.311004						75
76	NUCLEAR MEDICINE	0.205104						76
76.01	ULTRASOUND	0.097152						76.01
76.02	MAMMOGRAPHY	0.265099						76.02
76.03	CARDIAC REHABILITATION							76.03
76.04	FAITH CENTER CHEMOTHERAPY	0.981137						76.04
76.06	ROUTINE ANCILLARY							76.06
76.97	CARDIAC REHABILITATION	0.405421						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	0.345728						91
92	Observation Beds (Non-Distinct Part)	0.434985						92
93	DAY PSYCHIATRIC	0.393403						93
	OTHER REIMBURSABLE COST CENTERS							
200	Subtotal (see instructions)		3,691			1,060		200
201	Less PBP Clinic Lab. Services-Program Only Charges							201
202	Net Charges (line 200 - line 201)		3,691			1,060		202

(A) Worksheet A line numbers

HARRISBURG MEDICAL CENTER, INC. Provider CCN: 14-0210	In Lieu of Form CMS-2552-10	Period : From: 07/01/2014 To: 06/30/2015	Run Date: 10/22/2015 Run Time: 16:34 Version: 2015.03 (10/05/2015)
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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.)	
	ANCILLARY SERVICE COST CENTERS								
50	Operating Room	0.395886							50
53	Anesthesiology	0.135172							53
54	Radiology-Diagnostic	0.302124							54
57	CT Scan	0.034305							57
60	Laboratory	0.146009							60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS								62.30
64	Intravenous Therapy	0.027382							64
65	Respiratory Therapy	0.227397							65
66	Physical Therapy	0.412212							66
69	Electrocardiology	0.117379							69
71	Medical Supplies Charged to Patients	0.703085							71
72	Impl. Dev. Charged to Patients	0.721320							72
73	Drugs Charged to Patients	0.359428							73
75	ASC (Non-Distinct Part)	0.311004							75
76	NUCLEAR MEDICINE	0.205104							76
76.01	ULTRASOUND	0.097152							76.01
76.02	MAMMOGRAPHY	0.265099							76.02
76.03	CARDIAC REHABILITATION								76.03
76.04	FAITH CENTER CHEMOTHERAPY	0.981137							76.04
76.06	ROUTINE ANCILLARY								76.06
76.97	CARDIAC REHABILITATION	0.405421							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	0.345728							91
92	Observation Beds (Non-Distinct Part)	0.434985							92
93	DAY PSYCHIATRIC	0.393403							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

HARRISBURG MEDICAL CENTER, INC. Provider CCN: 14-0210	In Lieu of Form CMS-2552-10	Period : From: 07/01/2014 To: 06/30/2015	Run Date: 10/22/2015 Run Time: 16:34 Version: 2015.03 (10/05/2015)
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COMPUTATION OF INPATIENT OPERATING COST

COMPONENT CCN: 14-0210

WORKSHEET D-1
PART I

Check [] Title V - I/P [XX] Hospital [] SUB (Other) [] ICF/MR [XX] PPS
 Applicable [XX] Title XVIII, Part A [] IPF [] SNF [] TEFFRA
 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)	6,850	1
2	Inpatient days (including private room days, excluding swing-bed and newborn days)	6,674	2
3	Private room days (excluding swing-bed private room days). If you have only private room days, do not complete this line.	512	3
4	Semi-private room days (excluding swing-bed private room days)	4,057	4
5	Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost reporting period	88	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)	88	6
7	Total swing-bed NF type inpatient days (including private room days) through December 31 of the cost reporting period		7
8	Total swing-bed NF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		8
9	Total inpatient days including private room days applicable to the Program (excluding swing-bed and newborn days)	2,861	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)	60	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)	60	11
12	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) through December 31 of the cost reporting period		12
13	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		13
14	Medically necessary private room days applicable to the program (excluding swing-bed days)		14
15	Total nursery days (title V or XIX only)		15
16	Nursery days (title V or XIX only)		16

SWING-BED ADJUSTMENT

17	Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost reporting period	202.51	17
18	Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period	207.37	18
19	Medicaid rate for swing-bed NF services applicable to services through December 31 of the cost reporting period	137.24	19
20	Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period	139.98	20
21	Total general inpatient routine service cost (see instructions)	6,556,113	21
22	Swing-bed cost applicable to SNF type services through December 31 of the cost reporting period (line 5 x line 17)	17,821	22
23	Swing-bed cost applicable to SNF type services after December 31 of the cost reporting period (line 6 x line 18)	18,249	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)	36,070	26
27	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)	6,520,043	27

PRIVATE ROOM DIFFERENTIAL ADJUSTMENT

28	General inpatient routine service charges (excluding swing-bed and observation bed charges)	4,726,952	28
29	Private room charges (excluding swing-bed charges)	459,961	29
30	Semi-private room charges (excluding swing-bed charges)	4,266,991	30
31	General inpatient routine service cost/charge ratio (line 27 ÷ line 28)	1.379333	31
32	Average private room per diem charge (line 29 ÷ line 3)	898.36	32
33	Average semi-private room per diem charge (line 30 ÷ line 4)	1,051.76	33
34	Average per diem private room charge differential (line 32 minus line 33) (see instructions)		34
35	Average per diem private room cost differential (line 34 x line 31)		35
36	Private room cost differential adjustment (line 3 x line 35)		36
37	General inpatient routine service cost net of swing-bed cost and private room cost differential (line 27 minus line 36)	6,520,043	37

HARRISBURG MEDICAL CENTER, INC. Provider CCN: 14-0210	In Lieu of Form CMS-2552-10	Period : From: 07/01/2014 To: 06/30/2015	Run Date: 10/22/2015 Run Time: 16:34 Version: 2015.03 (10/05/2015)
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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 TEFRA
 Boxes: Title XIX - I/P IRF Other

PART II - HOSPITALS AND SUBPROVIDERS ONLY

PROGRAM INPATIENT OPERATING COST BEFORE PASS-THROUGH COST ADJUSTMENTS

38	Adjusted general inpatient routine service cost per diem (see instructions)					976.93	38
39	Program general inpatient routine service cost (line 9 x line 38)					2,794,997	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)					2,794,997	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

48	Program inpatient ancillary service cost (Wkst. D-3, col. 3, line 200)					3,167,485	48
49	Total program inpatient costs (sum of lines 41 through 48)(see instructions)					5,962,482	49

PASS THROUGH COST ADJUSTMENTS

50	Pass through costs applicable to Program inpatient routine services (from Wkst. D, sum of Parts I and III)					169,457	50
51	Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)					178,811	51
52	Total Program excludable cost (sum of lines 50 and 51)					348,268	52
53	Total Program inpatient operating cost excluding capital related, nonphysician anesthetist and medical education costs (line 49 minus line 52)					5,614,214	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)					12,151	64
65	Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (See instructions) (title XVIII only)					12,442	65
66	Total Medicare swing-bed SNF inpatient routine costs (title XVIII only. For CAH, see instructions)					24,593	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

HARRISBURG MEDICAL CENTER, INC. Provider CCN: 14-0210	In Lieu of Form CMS-2552-10	Period : From: 07/01/2014 To: 06/30/2015	Run Date: 10/22/2015 Run Time: 16:34 Version: 2015.03 (10/05/2015)
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COMPUTATION OF INPATIENT OPERATING COST

COMPONENT CCN: 14-0210

WORKSHEET D-1
PARTS III & IV

Check [] Title V - I/P [XX] Hospital [] SUB (Other) [] ICF/MR [XX] PPS
 Applicable [XX] 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)					2,105	87
88	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)					976.93	88
89	Observation bed cost (line 87 x line 88) (see instructions)					2,056,438	89
		Cost	Routine Cost (from line 27)	col. 1+col. 2	Total Observation Bed Cost (from line 89)	Observation Bed Pass Through Cost col. 3 x col. 4 (see instructions)	
		1	2	3	4	5	
90	Capital-related cost	397,475	6,520,043	0.060962	2,056,438	125,365	90
91	Nursing School						91
92	Allied Health						92
93	Other Medical Education						93

HARRISBURG MEDICAL CENTER, INC. Provider CCN: 14-0210	In Lieu of Form CMS-2552-10	Period : From: 07/01/2014 To: 06/30/2015	Run Date: 10/22/2015 Run Time: 16:34 Version: 2015.03 (10/05/2015)
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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)	9,995	1
2	Inpatient days (including private room days, excluding swing-bed and newborn days)	9,995	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)	9,995	4
5	Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost reporting period		5
6	Total swing-bed SNF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		6
7	Total swing-bed NF type inpatient days (including private room days) through December 31 of the cost reporting period		7
8	Total swing-bed NF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		8
9	Total inpatient days including private room days applicable to the Program (excluding swing-bed and newborn days)	3,681	9
10	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) through December 31 of the cost reporting period (see instructions)		10
11	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		11
12	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) through December 31 of the cost reporting period		12
13	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		13
14	Medically necessary private room days applicable to the program (excluding swing-bed days)		14
15	Total nursery days (title V or XIX only)		15
16	Nursery days (title V or XIX only)		16

SWING-BED ADJUSTMENT

17	Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost reporting period		17
18	Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period		18
19	Medicaid rate for swing-bed NF services applicable to services through December 31 of the cost reporting period		19
20	Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period		20
21	Total general inpatient routine service cost (see instructions)	5,925,151	21
22	Swing-bed cost applicable to SNF type services through December 31 of the cost reporting period (line 5 x line 17)		22
23	Swing-bed cost applicable to SNF type services after December 31 of the cost reporting period (line 6 x line 18)		23
24	Swing-bed cost applicable to NF type services through December 31 of the cost reporting period (line 7 x line 19)		24
25	Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8 x line 20)		25
26	Total swing-bed cost (see instructions)		26
27	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)	5,925,151	27

PRIVATE ROOM DIFFERENTIAL ADJUSTMENT

28	General inpatient routine service charges (excluding swing-bed and observation bed charges)		28
29	Private room charges (excluding swing-bed charges)		29
30	Semi-private room charges (excluding swing-bed charges)		30
31	General inpatient routine service cost/charge ratio (line 27 ÷ line 28)		31
32	Average private room per diem charge (line 29 ÷ line 3)		32
33	Average semi-private room per diem charge (line 30 ÷ line 4)		33
34	Average per diem private room charge differential (line 32 minus line 33) (see instructions)		34
35	Average per diem private room cost differential (line 34 x line 31)		35
36	Private room cost differential adjustment (line 3 x line 35)		36
37	General inpatient routine service cost net of swing-bed cost and private room cost differential (line 27 minus line 36)	5,925,151	37

HARRISBURG MEDICAL CENTER, INC. Provider CCN: 14-0210	In Lieu of Form CMS-2552-10	Period : From: 07/01/2014 To: 06/30/2015	Run Date: 10/22/2015 Run Time: 16:34 Version: 2015.03 (10/05/2015)
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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) [XX] PPS
 Applicable [XX] Title XVIII, Part A [XX] IPF [] TEFRA
 Boxes: [] Title XIX - I/P [] IRF [] Other

PART II - HOSPITALS AND SUBPROVIDERS ONLY

PROGRAM INPATIENT OPERATING COST BEFORE PASS-THROUGH COST ADJUSTMENTS

1

38	Adjusted general inpatient routine service cost per diem (see instructions)	592.81	38
39	Program general inpatient routine service cost (line 9 x line 38)	2,182,134	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)	2,182,134	41
48	Program inpatient ancillary service cost (Wkst. D-3, col. 3, line 200)	445,681	48
49	Total program inpatient costs (sum of lines 41 through 48)(see instructions)	2,627,815	49

PASS THROUGH COST ADJUSTMENTS

50	Pass through costs applicable to Program inpatient routine services (from Wkst. D, sum of Parts I and III)	106,896	50
51	Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)	18,872	51
52	Total Program excludable cost (sum of lines 50 and 51)	125,768	52
53	Total Program inpatient operating cost excluding capital related, nonphysician anesthetist and medical education costs (line 49 minus line 52)	2,502,047	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

HARRISBURG MEDICAL CENTER, INC. Provider CCN: 14-0210	In Lieu of Form CMS-2552-10	Period : From: 07/01/2014 To: 06/30/2015	Run Date: 10/22/2015 Run Time: 16:34 Version: 2015.03 (10/05/2015)
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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		2,854,584		30
40	Subprovider - IPF				40
	ANCILLARY SERVICE COST CENTERS				
50	Operating Room	0.395886	176,846	70,011	50
53	Anesthesiology	0.135172	196,087	26,505	53
54	Radiology-Diagnostic	0.302124	384,933	116,297	54
57	CT Scan	0.034305	1,792,822	61,503	57
60	Laboratory	0.146009	3,411,281	498,078	60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS				62.30
64	Intravenous Therapy	0.027382	3,535,393	96,806	64
65	Respiratory Therapy	0.227397	1,487,030	338,146	65
66	Physical Therapy	0.412212	501,470	206,712	66
69	Electrocardiology	0.117379	260,735	30,605	69
71	Medical Supplies Charged to Patients	0.703085	620,983	436,604	71
72	Impl. Dev. Charged to Patients	0.721320	199,463	143,877	72
73	Drugs Charged to Patients	0.359428	1,343,721	482,971	73
75	ASC (Non-Distinct Part)	0.311004	215,760	67,102	75
76	NUCLEAR MEDICINE	0.205104	80,727	16,557	76
76.01	ULTRASOUND	0.097152	731,968	71,112	76.01
76.02	MAMMOGRAPHY	0.265099			76.02
76.03	CARDIAC REHABILITATION				76.03
76.04	FAITH CENTER CHEMOTHERAPY	0.981137			76.04
76.06	ROUTINE ANCILLARY				76.06
76.97	CARDIAC REHABILITATION	0.405421	8,212	3,329	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	0.346789	659,028	228,544	91
92	Observation Beds (Non-Distinct Part)	0.434985	626,979	272,726	92
93	DAY PSYCHIATRIC	0.393403			93
	OTHER REIMBURSABLE COST CENTERS				
200	Total (sum of lines 50-94, and 96-98)		16,233,438	3,167,485	200
201	Less PBP Clinic Laboratory Services-Program only charges (line 61)				201
202	Net Charges (line 200 minus line 201)		16,233,438		202

(A) Worksheet A line numbers

HARRISBURG MEDICAL CENTER, INC. Provider CCN: 14-0210	In Lieu of Form CMS-2552-10	Period : From: 07/01/2014 To: 06/30/2015	Run Date: 10/22/2015 Run Time: 16:34 Version: 2015.03 (10/05/2015)
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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 [XX] PPS
 Applicable [XX] Title XVIII, Part A [XX] IPF [] SNF [] Swing Bed NF [] TEFRA
 Boxes: [] Title XIX [] IRF [] NF [] ICF/MR [] Other

(A)	COST CENTER DESCRIPTION	Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
		1	2	3	
	INPATIENT ROUTINE SERVICE COST CENTERS				
30	Adults & Pediatrics				30
40	Subprovider - IPF		4,436,770		40
	ANCILLARY SERVICE COST CENTERS				
50	Operating Room	0.395886			50
53	Anesthesiology	0.135172	10,046	1,358	53
54	Radiology-Diagnostic	0.302124	34,439	10,405	54
57	CT Scan	0.034305	166,938	5,727	57
60	Laboratory	0.146009	403,751	58,951	60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS				62.30
64	Intravenous Therapy	0.027382	63,097	1,728	64
65	Respiratory Therapy	0.227397	177,256	40,307	65
66	Physical Therapy	0.412212	42,959	17,708	66
69	Electrocardiology	0.117379	23,462	2,754	69
71	Medical Supplies Charged to Patients	0.703085	42,117	29,612	71
72	Impl. Dev. Charged to Patients	0.721320			72
73	Drugs Charged to Patients	0.359428	656,708	236,039	73
75	ASC (Non-Distinct Part)	0.311004	4,485	1,395	75
76	NUCLEAR MEDICINE	0.205104	2,100	431	76
76.01	ULTRASOUND	0.097152	23,994	2,331	76.01
76.02	MAMMOGRAPHY	0.265099			76.02
76.03	CARDIAC REHABILITATION				76.03
76.04	FAITH CENTER CHEMOTHERAPY	0.981137			76.04
76.06	ROUTINE ANCILLARY				76.06
76.97	CARDIAC REHABILITATION	0.405421			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	0.346789	106,507	36,935	91
92	Observation Beds (Non-Distinct Part)	0.434985			92
93	DAY PSYCHIATRIC	0.393403			93
	OTHER REIMBURSABLE COST CENTERS				
200	Total (sum of lines 50-94, and 96-98)		1,757,859	445,681	200
201	Less PBP Clinic Laboratory Services-Program only charges (line 61)				201
202	Net Charges (line 200 minus line 201)		1,757,859		202

(A) Worksheet A line numbers

HARRISBURG MEDICAL CENTER, INC. Provider CCN: 14-0210	In Lieu of Form CMS-2552-10	Period : From: 07/01/2014 To: 06/30/2015	Run Date: 10/22/2015 Run Time: 16:34 Version: 2015.03 (10/05/2015)
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INPATIENT ANCILLARY SERVICE COST APPORTIONMENT

COMPONENT CCN: 14-U210

WORKSHEET D-3

Check [] Title V [] Hospital [] SUB (Other) [XX] 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				30
40	Subprovider - IPF				40
	ANCILLARY SERVICE COST CENTERS				
50	Operating Room	0.395886			50
53	Anesthesiology	0.135172			53
54	Radiology-Diagnostic	0.302124	905	273	54
57	CT Scan	0.034305			57
60	Laboratory	0.146009	27,349	3,993	60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS				62.30
64	Intravenous Therapy	0.027382	9,745	267	64
65	Respiratory Therapy	0.227397	9,645	2,193	65
66	Physical Therapy	0.412212	68,962	28,427	66
69	Electrocardiology	0.117379	565	66	69
71	Medical Supplies Charged to Patients	0.703085	5,298	3,725	71
72	Impl. Dev. Charged to Patients	0.721320			72
73	Drugs Charged to Patients	0.359428	18,524	6,658	73
75	ASC (Non-Distinct Part)	0.311004	155	48	75
76	NUCLEAR MEDICINE	0.205104			76
76.01	ULTRASOUND	0.097152	552	54	76.01
76.02	MAMMOGRAPHY	0.265099			76.02
76.03	CARDIAC REHABILITATION				76.03
76.04	FAITH CENTER CHEMOTHERAPY	0.981137			76.04
76.06	ROUTINE ANCILLARY				76.06
76.97	CARDIAC REHABILITATION	0.405421			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	0.345728			91
92	Observation Beds (Non-Distinct Part)	0.434985			92
93	DAY PSYCHIATRIC	0.393403			93
	OTHER REIMBURSABLE COST CENTERS				
200	Total (sum of lines 50-94, and 96-98)		141,700	45,704	200
201	Less PBP Clinic Laboratory Services-Program only charges (line 61)				201
202	Net Charges (line 200 minus line 201)		141,700		202

(A) Worksheet A line numbers

HARRISBURG MEDICAL CENTER, INC. Provider CCN: 14-0210	In Lieu of Form CMS-2552-10	Period : From: 07/01/2014 To: 06/30/2015	Run Date: 10/22/2015 Run Time: 16:34 Version: 2015.03 (10/05/2015)
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CALCULATION OF REIMBURSEMENT SETTLEMENT

WORKSHEET E
PART A

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 (see instructions)	1,275,215			1.01
1.02	DRG amounts other than outlier payments for discharges occurring on or after October 1 (see instructions)	3,825,646			1.02
1.03	DRG for federal specific operating payment for Model 4 BPCI for discharges occurring prior to October 1 (see instructions)				1.03
1.04	DRG for federal specific operating payment for Model 4 BPCI for discharges occurring on or after October 1 (see instructions)				1.04
2	Outlier payments for discharges (see instructions)	4,125			2
2.01	Outlier reconciliation amount				2.01
2.02	Outlier payment for discharges for Model 4 BPCI (see instructions)				2.02
3	Managed care simulated payments				3
4	Bed days available divided by number of days in the cost reporting period (see instructions)	39.67			4
Indirect Medical Education Adjustment Calculation for Hospitals					
5	FTE count for allopathic and osteopathic programs for the most recent cost reporting period ending on or before 12/31/1996 (see instructions)				5
6	FTE count for allopathic and osteopathic programs which meet the criteria for an add-on to the cap for new programs in accordance with 42 CFR 413.79(e)				6
7	MMA Section 422 reduction amount to the IME cap as specified under 42 CFR §412.105(f)(1)(iv)(B)(1)				7
7.01	ACA Section 5503 reduction amount to the IME cap as specified under 42 CFR §412.105(f)(1)(iv)(B)(2). If the cost report straddles July 1, 2011 then see instructions.				7.01
8	Adjustment (increase or decrease) to the FTE count for allopathic and osteopathic programs for affiliated programs in accordance with 42 CFR §413.75(b), §413.79(c)(2)(iv) 64 FR 26340 (May 12, 1998), and 67 FR 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 line 8 plus lines (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 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
22.01	IME payment adjustment - Managed Care (see instructions)				22.01
Indirect Medical Education Adjustment for the Add-on for Section 422 of the MMA					
23	Number of additional allopathic and osteopathic IME FTE resident cap slots under 42 Sec. 412.105(f)(1)(iv)(C)				23
24	IME FTE resident count over cap (see instructions)				24
25	If the amount on line 24 is greater than -0-, then enter the lower of line 23 or line 24 (see instructions)				25
26	Resident to bed ratio (divide line 25 by line 4)				26
27	IME payments adjustment factor (see instructions)				27
28	IME add-on adjustment amount (see instructions)				28
28.01	IME add-on adjustment amount - Managed Care (see instructions)				28.01
29	Total IME payment (sum of lines 22 and 28)				29
29.01	Total IME payment - Managed Care (sum of lines 22.01 and 28.01)				29.01
Disproportionate Share Adjustment					
30	Percentage of SSI recipient patient days to Medicare Part A patient days (see instructions)	0.0688			30
31	Percentage of Medicaid patient days to total patient days (see instructions)	0.1517			31
32	Sum of lines 30 and 31	0.2205			32
33	Allowable disproportionate share percentage (see instructions)	0.0708			33
34	Disproportionate share adjustment (see instructions)	90,285			34
Uncompensated Care Adjustment					
35	Total uncompensated care amount (see instructions)		Prior to October 1	On or after October 1	
			9,046,380,143	7,647,644,885	35
35.01	Factor 3 (see instructions)		0.000152760	0.000012882	35.01
35.02	Hospital uncompensated care payment (If line 34 is zero, enter zero on this line) (see instructions)		1,381,925	98,517	35.02
35.03	Pro rata share of the hospital uncompensated care payment amount (see instructions)		348,321	73,685	35.03
36	Total uncompensated care (sum of columns 1 and 2 on line 35.03)		422,006		36
Additional Payment for High Percentage of ESRD Beneficiary Discharges (lines 40 through 46)					
40	Total Medicare discharges, excluding discharges for MS-DRGs 652, 682, 683, 684 and 685 (see instructions)				40
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

HARRISBURG MEDICAL CENTER, INC. Provider CCN: 14-0210	In Lieu of Form CMS-2552-10	Period : From: 07/01/2014 To: 06/30/2015	Run Date: 10/22/2015 Run Time: 16:34 Version: 2015.03 (10/05/2015)
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CALCULATION OF REIMBURSEMENT SETTLEMENT

WORKSHEET E
PART A

PART A - INPATIENT HOSPITAL SERVICES UNDER PPS

		1	1.01	1.02	
47	Subtotal (see instructions)	5,617,277			47
48	Hospital specific payments (to be completed by SCH and MDH, small rural hospitals only (see instructions)	6,124,437			48
49	Total payment for inpatient operating costs (see instructions)	6,124,437			49
50	Payment for inpatient program capital (from Wkst. L, Pt. I and Pt. II, as applicable)	401,548			50
51	Exception payment for inpatient program capital (Wkst. L, Pt. 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 Pt. III, col. 1, line 69)				55
56	Cost of physicians' services in a teaching hospital (see instructions)				56
57	Routine service other pass through costs (from Wkst. D, Pt. III, col. 9, lines 30 through 35).				57
58	Ancillary service other pass through costs (from Wkst. D, Pt. IV, col. 11, line 200)				58
59	Total (sum of amounts on lines 49 through 58)	6,525,985			59
60	Primary payer payments	278			60
61	Total amount payable for program beneficiaries (line 59 minus line 60)	6,525,707			61
62	Deductibles billed to program beneficiaries	837,108			62
63	Coinurance billed to program beneficiaries	14,647			63
64	Allowable bad debts (see instructions)	270,153			64
65	Adjusted reimbursable bad debts (see instructions)	175,599			65
66	Allowable bad debts for dual eligible beneficiaries (see instructions)	260,765			66
67	Subtotal (line 61 plus line 65 minus lines 62 and 63)	5,849,551			67
68	Credits received from manufacturers for replaced devices for applicable MS-DRGs (see instructions)				68
69	Outlier payments reconciliation (sum of lines 93, 95 and 96) (for SCH see instructions)				69
70	Other adjustments (specify) (see instructions)				70
70.93	HVBP payment adjustment amount (see instructions)	62			70.93
70.94	HRR adjustment amount (see instructions)	-39,661			70.94
70.96	Low volume adjustment for federal fiscal year (2014)	248,511			70.96
70.97	Low volume adjustment for federal fiscal year (2015)	717,566			70.97
71	Amount due provider (see instructions)	6,776,029			71
71.01	Sequestration adjustment (see instructions)	135,521			71.01
72	Interim payments	6,566,732			72
73	Tentative settlement (for contractor use only)				73
74	Balance due provider (Program) (line 71 minus lines 71.01, 72 and 73)	73,776			74
75	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, §115.2				75

TO BE COMPLETED BY CONTRACTOR (lines 90 through 96)

90	Operating outlier amount from Wkst. E, Pt. A line 2 (see instructions)				90
91	Capital outlier from Wkst. L, Pt. 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

HSP Bonus Payment Amount

		Prior to 10/1	On or After 10/1	
100	HSP bonus amount (see instructions)			100

HVBP Adjustment for HSP Bonus Payment

		Prior to 10/1	On or After 10/1	
101	HVBP adjustment factor (see instructions)	0.0000000000	0.0000000000	101
102	HVBP adjustment amount for HSP bonus payment (see instructions)			102

HRR Adjustment for HSP Bonus Payment

		Prior to 10/1	On or After 10/1	
103	HRR adjustment factor (see instructions)	0.0000	0.0000	103
104	HRR adjustment amount for HSP bonus payment (see instructions)			104

HARRISBURG MEDICAL CENTER, INC. Provider CCN: 14-0210	Supporting Exhibit for Form CMS-2552-10	Period : From: 07/01/2014 To: 06/30/2015	Run Date: 10/22/2015 Run Time: 16:34 Version: 2015.03 (10/05/2015)
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LOW VOLUME ADJUSTMENT CALCULATION SCHEDULE (For Worksheet E Part A, Lines 70.96 and 70.97)

EXHIBIT 4

	(Amt. from Wkst. E, Pt. A or L Pt. I)	Pre/Post Entitlement	10/01/2013 through 09/30/2014		10/01/2014 through 09/30/2015		Total (col. 2 through 4)	
	1	2	3	3.01	4	4.01	5	
1	DRG Amounts Other Than Outlier Payments							1
1.01	DRG amounts other than outlier payments for discharges occurring prior to October 1	1,275,215	1,275,215				1,275,215	1.01
1.02	DRG amounts other than outlier payments for discharges occurring on or after October 1	3,825,646			3,825,646		3,825,646	1.02
1.03	DRG for Federal specific operating payment for Model 4 BPCI occurring prior to October 1							1.03
1.04	DRG for Federal specific operating payment for Model 4 BPCI occurring on or after October 1							1.04
2	Outlier payments for discharges	4,125			4,125		4,125	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
6.01	IME payment adjustment for managed care							6.01
	Indirect Medical Education Adjustment for the Add-on for Section 422 of the MMA							
7	IME payment adjustment factor							7
8	IME add-on adjustment amount							8
8.01	IME payment adjustment add-on for managed care							8.01
9	Total IME payment (sum of lines 6 and 8)							9
9.01	Total IME payment for managed care (sum of lines 6.01 and 8.01)							9.01
	Disproportionate Share Adjustment							
10	Allowable disproportionate share percentage	0.0708	0.0708	0.0708	0.0708	0.0708	0.0708	10
11	Disproportionate share adjustment	90,285	22,571		67,714		90,285	11
11.01	Uncompensated care payments	422,006	348,321		73,685		422,006	11.01
	Additional payment for high percentage of ESRD beneficiary discharges							
12	Total ESRD additional payment							12
13	Subtotal	5,617,277	1,646,107		3,971,170		5,617,277	13
14	Hospital specific payments (to be completed by SCH and MDH, small rural hospitals only.)	6,124,437	1,531,109		4,593,328		6,124,437	14
15	Total payment for inpatient operating costs SCH and MDH only	6,124,437	1,531,109		4,593,328		6,124,437	15
16	Payment for inpatient program capital (from Worksheet L, Parts I, as applicable)	401,548	100,387		301,161		401,548	16
17	Special add-on payments for new technologies							17
17.01	Net organ acquisition cost (Wkst. D-4 Pt. III, col 1, line 69)							17.01
17.02	Credits received from manufacturers for replaced devices applicable to MS-DRG							17.02
18	Capital outlier reconciliation adjustment amount							18
19	SUBTOTAL		1,631,496		4,894,489		6,525,985	19
20	Capital DRG other than outlier	401,548	100,387		301,161		401,548	20
20.01	Model 4 BPCI Capital DRG other than outlier							20.01
21	Capital DRG outlier payments							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	401,548	100,387		301,161		401,548	26
27	Low volume adjustment factor		0.152321		0.146607			27
28	Low volume adjustment (transfer amount to Worksheet E, Part A, line 70.96)(prior to 10/1)		248,511				248,511	28
29	Low Volume Adjustment (transfer amount to Worksheet E, Part A, line 70.97)(on/after 10/1)				717,566		717,566	29

HARRISBURG MEDICAL CENTER, INC. Provider CCN: 14-0210	In Lieu of Form CMS-2552-10	Period : From: 07/01/2014 To: 06/30/2015	Run Date: 10/22/2015 Run Time: 16:34 Version: 2015.03 (10/05/2015)
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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 OPPS (see instructions)	5,500,682			2
3	PPS payments	5,367,615			3
4	Outlier payment (see instructions)	5,805			4
5	Enter the hospital specific payment to cost ratio (see instructions)	0.850			5
6	Line 2 times line 5	4,675,580			6
7	Sum of line 3 and line 4 divided by line 6				7
8	Transitional corridor payment (see instructions)				8
9	Ancillary service other pass through costs from Wkst. D, Pt. IV, col. 13, line 200				9
10	Organ acquisition				10
11	Total cost (sum of lines 1 and 10) (see instructions)				11
	COMPUTATION OF LESSER OF COST OR CHARGES				
	REASONABLE CHARGES				
12	Ancillary service charges				12
13	Organ acquisition charges (from Wkst. D-4, Part III, col. 4, line 69)				13
14	Total reasonable charges (sum of lines 12 and 13)				14
	CUSTOMARY CHARGES				
15	Aggregate amount actually collected from patients liable for payment for services on a charge basis				15
16	Amounts that would have been realized from patients liable for payment for services on a charge basis had such payment been made in accordance with 42 CFR §413.13(e)				16
17	Ratio of line 15 to line 16 (not to exceed 1.000000)	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 physicians' services in a teaching hospital (see instructions)				23
24	Total prospective payment (sum of lines 3, 4, 8 and 9)	5,373,420			24
	COMPUTATION OF REIMBURSEMENT SETTLEMENT				
25	Deductibles and coinsurance (see instructions)				25
26	Deductibles and coinsurance relating to amount on line 24 (see instructions)	1,192,815			26
27	Subtotal [(lines 21 and 24 minus the sum of lines 25 and 26) plus the sum of lines 22 and 23] (see instructions)	4,180,605			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)	4,180,605			30
31	Primary payer payments	996			31
32	Subtotal (line 30 minus line 31)	4,179,609			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)	372,996			34
35	Adjusted reimbursable bad debts (see instructions)	242,447			35
36	Allowable bad debts for dual eligible beneficiaries (see instructions)	340,784			36
37	Subtotal (see instructions)	4,422,056			37
38	MSP-LCC reconciliation amount from PS&R	-26			38
39	Other adjustments (specify) (see instructions)				39
39.50	Pioneer ACO demonstration payment adjustment (see instructions)				39.50
40	Subtotal (see instructions)	4,422,082			40
40.01	Sequestration adjustment (see instructions)	88,442			40.01
41	Interim payments	4,308,436			41
42	Tentative settlement (for contractors use only)				42
43	Balance due provider/program (see instructions)	25,204			43
44	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2				44

TO BE COMPLETED BY CONTRACTOR

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

HARRISBURG MEDICAL CENTER, INC. Provider CCN: 14-0210	In Lieu of Form CMS-2552-10	Period : From: 07/01/2014 To: 06/30/2015	Run Date: 10/22/2015 Run Time: 16:34 Version: 2015.03 (10/05/2015)
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CALCULATION OF REIMBURSEMENT SETTLEMENT

COMPONENT CCN: 14-S210

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)	1,060		2
3	PPS payments	1,040		3
4	Outlier payment (see instructions)			4
5	Enter the hospital specific payment to cost ratio (see instructions)			5
6	Line 2 times line 5			6
7	Sum of line 3 and line 4 divided by line 6			7
8	Transitional corridor payment (see instructions)			8
9	Ancillary service other pass through costs from Wkst. D, Pt. IV, col. 13, line 200			9
10	Organ acquisition			10
11	Total cost (sum of lines 1 and 10) (see instructions)			11
	COMPUTATION OF LESSER OF COST OR CHARGES			
	REASONABLE CHARGES			
12	Ancillary service charges			12
13	Organ acquisition charges (from Wkst. D-4, Part III, col. 4, line 69)			13
14	Total reasonable charges (sum of lines 12 and 13)			14
	CUSTOMARY CHARGES			
15	Aggregate amount actually collected from patients liable for payment for services on a charge basis			15
16	Amounts that would have been realized from patients liable for payment for services on a charge basis had such payment been made in accordance with 42 CFR §413.13(e)			16
17	Ratio of line 15 to line 16 (not to exceed 1.000000)	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 physicians' services in a teaching hospital (see instructions)			23
24	Total prospective payment (sum of lines 3, 4, 8 and 9)	1,040		24
	COMPUTATION OF REIMBURSEMENT SETTLEMENT			
25	Deductibles and coinsurance (see instructions)			25
26	Deductibles and coinsurance relating to amount on line 24 (see instructions)	208		26
27	Subtotal [(lines 21 and 24 minus the sum of lines 25 and 26) plus the sum of lines 22 and 23] (see instructions)	832		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)	832		30
31	Primary payer payments			31
32	Subtotal (line 30 minus line 31)	832		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)	832		37
38	MSP-LCC reconciliation amount from PS&R			38
39	Other adjustments (specify) (see instructions)			39
39.50	Pioneer ACO demonstration payment adjustment (see instructions)			39.50
40	Subtotal (see instructions)	832		40
40.01	Sequestration adjustment (see instructions)	17		40.01
41	Interim payments	815		41
42	Tentative settlement (for contractors use only)			42
43	Balance due provider/program (see instructions)			43
44	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2			44

TO BE COMPLETED BY CONTRACTOR

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

HARRISBURG MEDICAL CENTER, INC. Provider CCN: 14-0210	In Lieu of Form CMS-2552-10	Period : From: 07/01/2014 To: 06/30/2015	Run Date: 10/22/2015 Run Time: 16:34 Version: 2015.03 (10/05/2015)
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ANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED

COMPONENT CCN: 14-0210

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		6,566,732		4,308,436	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
	Program .03				3.03
	to .04				3.04
	Provider .05				3.05
	.06				3.06
	.07				3.07
	.08				3.08
	.09				3.09
	.10				3.10
	.50				3.50
	.51				3.51
	Provider .52				3.52
	to .53				3.53
	Program .54				3.54
	.55				3.55
	.56				3.56
	.57				3.57
	.58				3.58
	.59				3.59
Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98)	.99				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)		6,566,732		4,308,436	4
TO BE COMPLETED BY CONTRACTOR					
5 List separately each tentative settlement payment after desk review. Also show date of each payment. If none, write 'NONE' or enter a zero. (1)					
	.01				5.01
	.02				5.02
	Program .03				5.03
	to .04				5.04
	Provider .05				5.05
	.06				5.06
	.07				5.07
	.08				5.08
	.09				5.09
	.10				5.10
	.50				5.50
	.51				5.51
	Provider .52				5.52
	to .53				5.53
	Program .54				5.54
	.55				5.55
	.56				5.56
	.57				5.57
	.58				5.58
	.59				5.59
Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98)	.99				5.99
6 Determined net settlement amount (balance due) based on the cost report (1)	.01	209,297		113,646	6.01
	.02				6.02
7 Total Medicare program liability (see instructions)		6,776,029		4,422,082	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.

HARRISBURG MEDICAL CENTER, INC. Provider CCN: 14-0210	In Lieu of Form CMS-2552-10	Period : From: 07/01/2014 To: 06/30/2015	Run Date: 10/22/2015 Run Time: 16:34 Version: 2015.03 (10/05/2015)
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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		2,836,287		815	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
	Program .03				3.03
	to .04				3.04
	Provider .05				3.05
	.06				3.06
	.07				3.07
	.08				3.08
	.09				3.09
	.10				3.10
	.50				3.50
	.51				3.51
	Provider .52				3.52
	to .53				3.53
	Program .54				3.54
	.55				3.55
	.56				3.56
	.57				3.57
	.58				3.58
	.59				3.59
	.99				3.99
Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98)					
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)		2,836,287		815	4
TO BE COMPLETED BY CONTRACTOR					
5 List separately each tentative settlement payment after desk review. Also show date of each payment. If none, write 'NONE' or enter a zero. (1)					
	.01				5.01
	.02				5.02
	Program .03				5.03
	to .04				5.04
	Provider .05				5.05
	.06				5.06
	.07				5.07
	.08				5.08
	.09				5.09
	.10				5.10
	.50				5.50
	.51				5.51
	Provider .52				5.52
	to .53				5.53
	Program .54				5.54
	.55				5.55
	.56				5.56
	.57				5.57
	.58				5.58
	.59				5.59
	.99				5.99
6 Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98)					
6 Determined net settlement amount (balance due) based on the cost report (1)		63,689		17	6.01
7 Total Medicare program liability (see instructions)		2,899,976		832	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.

HARRISBURG MEDICAL CENTER, INC. Provider CCN: 14-0210	In Lieu of Form CMS-2552-10	Period : From: 07/01/2014 To: 06/30/2015	Run Date: 10/22/2015 Run Time: 16:34 Version: 2015.03 (10/05/2015)
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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	2	3	4	
1 Total interim payments paid to provider		31,773			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	.01				3.01
rate for the cost reporting period. Also show date of	.02				3.02
each payment. If none, write 'NONE' or enter a zero. (1)	Program .03				3.03
to	.04				3.04
Provider	.05				3.05
	.06				3.06
	.07				3.07
	.08				3.08
	.09				3.09
	.10				3.10
	.50				3.50
	.51				3.51
Provider	.52				3.52
to	.53				3.53
Program	.54				3.54
	.55				3.55
	.56				3.56
	.57				3.57
	.58				3.58
	.59				3.59
Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98)	.99				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)		31,773			4
TO BE COMPLETED BY CONTRACTOR					
5 List separately each tentative settlement payment					
after desk review. Also show date of each payment.	.01				5.01
If none, write 'NONE' or enter a zero. (1)	.02				5.02
Program	.03				5.03
to	.04				5.04
Provider	.05				5.05
	.06				5.06
	.07				5.07
	.08				5.08
	.09				5.09
	.10				5.10
	.50				5.50
	.51				5.51
Provider	.52				5.52
to	.53				5.53
Program	.54				5.54
	.55				5.55
	.56				5.56
	.57				5.57
	.58				5.58
	.59				5.59
Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98)	.99				5.99
6 Determined net settlement amount (balance due) based on the cost report (1)	.01	648			6.01
	.02				6.02
7 Total Medicare program liability (see instructions)		32,421			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.

HARRISBURG MEDICAL CENTER, INC. Provider CCN: 14-0210	In Lieu of Form CMS-2552-10	Period : From: 07/01/2014 To: 06/30/2015	Run Date: 10/22/2015 Run Time: 16:34 Version: 2015.03 (10/05/2015)
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CALCULATION OF REIMBURSEMENT SETTLEMENT FOR HIT

WORKSHEET E-1
PART II

Check Hospital CAH
applicable box:

TO BE COMPLETED BY CONTRACTOR FOR NONSTANDARD COST REPORTS

HEALTH INFORMATION TECHNOLOGY DATA COLLECTION AND CALCULATION

1	Total hospital discharges as defined in AARA §4102 (Wkst. S-3, Pt. I, col. 15, line 14)	1,723	1
2	Medicare days (Wkst. S-3, Pt. I, col. 6, sum of lines 1, 8-12)	2,861	2
3	Medicare HMO days (Wkst. S-3, Pt. I, col. 6, line 2)	417	3
4	Total inpatient days (Wkst. S-3, Pt. I, col. 8, sum of lines 1, 8-12)	4,569	4
5	Total hospital charges (Wkst. C, Pt. I, col. 8, line 200)	135,140,471	5
6	Total hospital charity care charges (Wkst. S-10, col. 3, line 20)	2,067,024	6
7	CAH only - The reasonable cost incurred for the purchase of certified HIT technology (Wkst. S-2, Pt. I, line 168)		7
8	Calculation of the HIT incentive payment (see instructions)	385,211	8
9	Sequestration adjustment amount (see instructions)	7,704	9
10	Calculation of the HIT incentive payment after sequestration (see instructions)	377,507	10

INPATIENT HOSPITAL SERVICES UNDER PPS & CAH

30	Initial/interim HIT payment(s)	357,700	30
31	OTHER ADJUSTMENTS ()		31
32	Balance due provider (line 8 or line 10 minus line 30 and line 31) (see instructions)	19,807	32

HARRISBURG MEDICAL CENTER, INC. Provider CCN: 14-0210	In Lieu of Form CMS-2552-10	Period : From: 07/01/2014 To: 06/30/2015	Run Date: 10/22/2015 Run Time: 16:34 Version: 2015.03 (10/05/2015)
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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)	35,163		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, Pt. 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	120		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 through 3 plus lines 6 and 7)	35,163		8
9	Primary payer payments (see instructions)			9
10	Subtotal (line 8 minus line 9)	35,163		10
11	Deductibles billed to program patients (exclude amounts applicable to physician professional services)			11
12	Subtotal (line 10 minus line 11)	35,163		12
13	Coinsurance billed to program patients (from provider records) (exclude coinsurance for physician professional services)	2,742		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)	32,421		15
16	Other Adjustments (specify) (see instructions)			16
16.50	Pioneer ACO demonstration payment adjustment (see instructions)			16.50
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)	32,421		19
19.01	Sequestration adjustment (see instructions)	648		19.01
20	Interim payments	31,773		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 accprdamce with CMS Pub. 15-2, §115.2			23

HARRISBURG MEDICAL CENTER, INC. Provider CCN: 14-0210	In Lieu of Form CMS-2552-10	Period : From: 07/01/2014 To: 06/30/2015	Run Date: 10/22/2015 Run Time: 16:34 Version: 2015.03 (10/05/2015)
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CALCULATION OF REIMBURSEMENT SETTLEMENT

COMPONENT CCN: 14-S210

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)	3,143,604	1
2	Net IPF PPS Outlier payment	1,527	2
3	Net IPF PPS ECT payment	5,573	3
4	Unweighted intern and resident FTE count in the most recent cost report filed on or before November 15, 2004 (see instructions)		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 42 CFR §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)	27.383562	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)	3,150,704	12
13	Nursing and allied health managed care payment (see instructions)		13
14	Organ acquisition DO NOT USE THIS LINE		14
15	Cost of physicians' services in a teaching hospital (see instructions)		15
16	Subtotal (see instructions)	3,150,704	16
17	Primary payer payments		17
18	Subtotal (line 16 less line 17)	3,150,704	18
19	Deductibles	300,964	19
20	Subtotal (line 18 minus line 19)	2,849,740	20
21	Coinsurance	91,878	21
22	Subtotal (line 20 minus line 21)	2,757,862	22
23	Allowable bad debts (exclude bad debts for professional services) (see instructions)	218,637	23
24	Adjusted reimbursable bad debts (see instructions)	142,114	24
25	Allowable bad debts for dual eligible beneficiaries (see instructions)	209,737	25
26	Subtotal (sum of lines 22 and 24)	2,899,976	26
27	Direct graduate medical education payments (from Wkst. 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
30.50	Pioneer ACO demonstration payment adjustment (see instructions)		30.50
31	Total amount payable to the provider (see instructions)	2,899,976	31
31.01	Sequestration adjustment (see instructions)	58,000	31.01
32	Interim payments	2,836,287	32
33	Tentative settlement (for contractor use only)		33
34	Balance due provider/program (line 31 minus lines 31.01, 32 and 33)	5,689	34
35	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §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

HARRISBURG MEDICAL CENTER, INC. Provider CCN: 14-0210	In Lieu of Form CMS-2552-10	Period : From: 07/01/2014 To: 06/30/2015	Run Date: 10/22/2015 Run Time: 16:34 Version: 2015.03 (10/05/2015)
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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 1	Specific Purpose Fund 2	Endowment Fund 3	Plant Fund 4	
CURRENT ASSETS						
1	Cash on hand and in banks	7,256,153				1
2	Temporary investments					2
3	Notes receivable					3
4	Accounts receivable	7,801,018				4
5	Other receivables	2,127,711				5
6	Allowances for uncollectible notes and accounts receivable					6
7	Inventory	690,865				7
8	Prepaid expenses	1,105,550				8
9	Other current assets	68,685				9
10	Due from other funds					10
11	Total current assets (sum of lines 1-10)	19,049,982				11
FIXED ASSETS						
12	Land	660,438				12
13	Land improvements	805,578				13
14	Accumulated depreciation					14
15	Buildings	24,714,949				15
16	Accumulated depreciation					16
17	Leasehold improvements					17
18	Accumulated depreciation					18
19	Fixed equipment	12,962,858				19
20	Accumulated depreciation					20
21	Audomobiles 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	1,032,010				27
28	Accumulated depreciation	-20,969,595				28
29	Minor equipment-nondepreciable					29
30	Total fixed assets (sum of lines 12-29)	19,206,238				30
OTHER ASSETS						
31	Investments	6,917,927				31
32	Deposits on leases					32
33	Due from owners/officers					33
34	Other assets	463,667				34
35	Total other assets (sum of lines 31-34)	7,381,594				35
36	Total assets (sum of lines 11, 30 and 35)	45,637,814				36
Liabilities and Fund Balances (Omit Cents)						
		1	2	3	4	
CURRENT LIABILITIES						
37	Accounts payable	1,169,116				37
38	Salaries, wages and fees payable	3,092,207				38
39	Payroll taxes payable					39
40	Notes and loans payable (short term)	201,792				40
41	Deferred income					41
42	Accelerated payments					42
43	Due to other funds					43
44	Other current liabilities	1,649,418				44
45	Total current liabilities (sum of lines 37 thru 44)	6,112,533				45
LONG TERM LIABILITIES						
46	Mortgage payable					46
47	Notes payable	9,449,346				47
48	Unsecured loans					48
49	Other long term liabilities	200,000				49
50	Total long term liabilities (sum of lines 46 thru 49)	9,649,346				50
51	Total liabilities (sum of lines 45 and 50)	15,761,879				51
CAPITAL ACCOUNTS						
52	General fund balance	29,875,935				52
53	Specific purpose fund					53
54	Donor created - endowment fund balance - restricted					54
55	Donor created - endowment fund balance - unrestricted					55
56	Governing body created - endowment fund balance					56
57	Plant fund balance - invested in plant					57
58	Plant fund balance - reserve for plant improvement, replacement, and expansion					58
59	Total fund balances (sum of lines 52 thru 58)	29,875,935				59
60	Total liabilities and fund balances (sum of lines 51 and 59)	45,637,814				60

HARRISBURG MEDICAL CENTER, INC. Provider CCN: 14-0210	In Lieu of Form CMS-2552-10	Period : From: 07/01/2014 To: 06/30/2015	Run Date: 10/22/2015 Run Time: 16:34 Version: 2015.03 (10/05/2015)
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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		26,210,713			1
2	Net income (loss) (from Worksheet G-3, line 29)		3,665,222			2
3	Total (sum of line 1 and line 2)		29,875,935			3
4	Additions (credit adjustments) (specify)					4
5						5
6						6
7						7
8						8
9						9
10	Total additions (sum of lines 4-9)					10
11	Subtotal (line 3 plus line 10)		29,875,935			11
12	Deductions (debit adjustments) (specify)					12
13						13
14						14
15						15
16						16
17						17
18	Total deductions (sum of lines 12-17)					18
19	Fund balance at end of period per balance sheet (line 11 minus line 18)		29,875,935			19

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

HARRISBURG MEDICAL CENTER, INC. Provider CCN: 14-0210	In Lieu of Form CMS-2552-10	Period : From: 07/01/2014 To: 06/30/2015	Run Date: 10/22/2015 Run Time: 16:34 Version: 2015.03 (10/05/2015)
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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	5,584,103		5,584,103	1
2	Subprovider IPF	15,649,243		15,649,243	2
3	Subprovider IRF				3
5	Swing Bed - SNF	203,588		203,588	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)	21,436,934		21,436,934	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)	21,436,934		21,436,934	17
18	Ancillary services	19,990,490		19,990,490	18
19	Outpatient services		99,624,663	99,624,663	19
20	Rural Health Clinic (RHC)		3,358,955	3,358,955	20
20.01	RHC II				20.01
21	Federally Qualified Health Center (FQHC)				21
22	Home health agency		1,002,111	1,002,111	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)	41,427,424	103,985,729	145,413,153	28

PART II - OPERATING EXPENSES

		1	2	
29	Operating expenses (per Worksheet A, column 3, line 200)		49,901,699	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)		49,901,699	43

HARRISBURG MEDICAL CENTER, INC. Provider CCN: 14-0210	In Lieu of Form CMS-2552-10	Period : From: 07/01/2014 To: 06/30/2015	Run Date: 10/22/2015 Run Time: 16:34 Version: 2015.03 (10/05/2015)
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STATEMENT OF REVENUES AND EXPENSES

WORKSHEET G-3

	DESCRIPTION		
1	Total patient revenues (from Worksheet G-2, Part I, column 3, line 28)	145,413,153	1
2	Less contractual allowances and discounts on patients' accounts	91,978,994	2
3	Net patient revenues (line 1 minus line 2)	53,434,159	3
4	Less total operating expenses (from Worksheet G-2, Part II, line 43)	49,901,699	4
5	Net income from service to patients (line 3 minus line 4)	3,532,460	5

OTHER INCOME

6	Contributions, donations, bequests, etc.		6
7	Income from investments	27,584	7
8	Revenues from telephone and other miscellaneous communication services		8
9	Revenue from television and radio service	9,368	9
10	Purchase discounts	4,802	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	97,594	14
15	Revenue from rental of living quarters		15
16	Revenue from sale of medical and surgical supplies to otehr than patients		16
17	Revenue from sale of drugs to other than patients		17
18	Revenue from sale of medical records and abstracts	481	18
19	Tuition (fees, sale of textbooks, uniforms, etc.)		19
20	Revenue from gifts, flowers, coffee shops and canteen		20
21	Rental of vending machines		21
22	Rental of hospial space	95,651	22
23	Governmental appropriations		23
24	Other (PSYCH REIMBURSEMENT)	5,461	24
24.01	Other (MEANINGFUL USE)	566,500	24.01
24.02	Other (OTHER MISC INCOME)	528,332	24.02
24.03	Other (UNREALIZED GAIN ON INVESTMENT)		24.03
24.04	Other (GRANT RECEIPTS)	16,500	24.04
24.05	Other (DONATIONS)	130,816	24.05
24.06	Other (MISC REVENUE)	3	24.06
25	Total other income (sum of lines 6-24)	1,483,092	25
26	Total (line 5 plus line 25)	5,015,552	26
27	Other expenses (UNDISTRIBUTED LOSS OF SUBSIDIARY)	956,570	27
27.01	Other expenses (LOSS ON DISPOSAL OF ASSETS)	17,199	27.01
27.02	Other expenses (EXTRAORDINARY LOSS)	369,015	27.02
27.03	Other expenses (UNREALIZED LOSS ON INVESTMENTS)	7,546	27.03
27.04	Other expenses (MISC EXPENSE)		27.04
28	Total other expenses (sum of line 27 and subscripts)	1,350,330	28
29	Net income (or loss) for the period (line 26 minus line 28)	3,665,222	29

HARRISBURG MEDICAL CENTER, INC. Provider CCN: 14-0210	In Lieu of Form CMS-2552-10	Period : From: 07/01/2014 To: 06/30/2015	Run Date: 10/22/2015 Run Time: 16:34 Version: 2015.03 (10/05/2015)
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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 CENTERS						
1	Capital Related-Bldgs and Fixtures						1
2	Capital Related-Movable Equipment						2
3	Plant Operation & Maintenance						3
4	Transportation (see instructions)						4
5	Administrative and General	143,772			4,170	21,592	5
	HHA REIMBURSABLE SERVICES						
6	Skilled Nursing Care	272,249		32,448			6
7	Physical Therapy	111,835		21,474			7
8	Occupational Therapy	1,175		450			8
9	Speech Pathology	3,863		474			9
10	Medical Social Services						10
11	Home Health Aide			49			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)	532,894		54,895	4,170	21,592	24

HARRISBURG MEDICAL CENTER, INC. Provider CCN: 14-0210	In Lieu of Form CMS-2552-10	Period : From: 07/01/2014 To: 06/30/2015	Run Date: 10/22/2015 Run Time: 16:34 Version: 2015.03 (10/05/2015)
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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 CENTERS						
1	Capital Related-Bldgs and Fixtures						1
2	Capital Related-Movable Equipment						2
3	Plant Operation & Maintenance						3
4	Transportation (see instructions)						4
5	Administrative and General	169,534	-44,619	124,915		124,915	5
	HHA REIMBURSABLE SERVICES						
6	Skilled Nursing Care	304,697		304,697		304,697	6
7	Physical Therapy	133,309		133,309		133,309	7
8	Occupational Therapy	1,625		1,625		1,625	8
9	Speech Pathology	4,337		4,337		4,337	9
10	Medical Social Services						10
11	Home Health Aide	49		49		49	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)	613,551	-44,619	568,932		568,932	24

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

HARRISBURG MEDICAL CENTER, INC. Provider CCN: 14-0210	In Lieu of Form CMS-2552-10	Period : From: 07/01/2014 To: 06/30/2015	Run Date: 10/22/2015 Run Time: 16:34 Version: 2015.03 (10/05/2015)
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ANALYSIS OF PROVIDER-BASED HOME HEALTH AGENCY COSTS

HHA 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 CENTERS						
1	Capital Related-Bldgs. and Fixtures					1
2	Capital Related-Movable Equipment					2
3	Plant Operation & Maintenance					3
4	Transportation (see instructions)					4
5	Administrative and General	124,915				5
HHA REIMBURSABLE SERVICES						
6	Skilled Nursing Care	304,697				6
7	Physical Therapy	133,309				7
8	Occupational Therapy	1,625				8
9	Speech Pathology	4,337				9
10	Medical Social Services					10
11	Home Health Aide	49				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 Means Program					21
22	Homemaker Service					22
23	All Others					23
23.50	Telemedicine					23.50
24	Totals (sum of lines 1-23)	568,932				24

HARRISBURG MEDICAL CENTER, INC. Provider CCN: 14-0210	In Lieu of Form CMS-2552-10	Period : From: 07/01/2014 To: 06/30/2015	Run Date: 10/22/2015 Run Time: 16:34 Version: 2015.03 (10/05/2015)
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ANALYSIS OF PROVIDER-BASED HOME HEALTH AGENCY COSTS

HHA 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 CENTERS					
1	Capital Related-Bldgs. and Fixtures					1
2	Capital Related-Movable Equipment					2
3	Plant Operation & Maintenance					3
4	Transportation (see instructions)					4
5	Administrative and General		124,915	124,915		5
	HHA REIMBURSABLE SERVICES					
6	Skilled Nursing Care		304,697	80,815	385,512	6
7	Physical Therapy		133,309	34,407	167,716	7
8	Occupational Therapy		1,625	1,433	3,058	8
9	Speech Pathology		4,337	3,389	7,726	9
10	Medical Social Services					10
11	Home Health Aide		49	4,871	4,920	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 Means Program					21
22	Homemaker Service					22
23	All Others					23
23.50	Telemedicine					23.50
24	Totals (sum of lines 1-23)		568,932		568,932	24

HARRISBURG MEDICAL CENTER, INC. Provider CCN: 14-0210	In Lieu of Form CMS-2552-10	Period : From: 07/01/2014 To: 06/30/2015	Run Date: 10/22/2015 Run Time: 16:34 Version: 2015.03 (10/05/2015)
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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 CENTERS								
1	Capital Related-Bldgs. and Fixtures							1
2	Capital Related-Movable Equipment							2
3	Plant Operation & Maintenance							3
4	Transportation (see instructions)							4
5	Administrative and General					-124,915	948,422	5
HHA REIMBURSABLE SERVICES								
6	Skilled Nursing Care					308,892	613,589	6
7	Physical Therapy					127,927	261,236	7
8	Occupational Therapy					9,257	10,882	8
9	Speech Pathology					21,394	25,731	9
10	Medical Social Services							10
11	Home Health Aide					36,935	36,984	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 Means Program							21
22	Homemaker Service							22
23	All Others							23
23.50	Telemedicine							23.50
24	Totals (sum of lines 1-23)					379,490	948,422	24
25	Cost To Be Allocated (per Worksheet H-1, Part I)						124,915	25
26	Unit Cost Multiplier						0.131708	26

HARRISBURG MEDICAL CENTER, INC. Provider CCN: 14-0210	In Lieu of Form CMS-2552-10	Period : From: 07/01/2014 To: 06/30/2015	Run Date: 10/22/2015 Run Time: 16:34 Version: 2015.03 (10/05/2015)
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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				26,210	26,210	5,605	1
2	Skilled Nursing Care	385,512			77,782	463,294	99,071	2
3	Physical Therapy	167,716			31,952	199,668	42,697	3
4	Occupational Therapy	3,058			336	3,394	726	4
5	Speech Pathology	7,726			1,104	8,830	1,888	5
6	Medical Social Services							6
7	Home Health Aide	4,920				4,920	1,052	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)	568,932			137,384	706,316	151,039	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.

HARRISBURG MEDICAL CENTER, INC. Provider CCN: 14-0210	In Lieu of Form CMS-2552-10	Period : From: 07/01/2014 To: 06/30/2015	Run Date: 10/22/2015 Run Time: 16:34 Version: 2015.03 (10/05/2015)
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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	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSE- KEEPING	DIETARY	CAFETERIA	
		6	7	8	9	10	11	
1	Administrative and General				14,993			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)				14,993			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.

HARRISBURG MEDICAL CENTER, INC. Provider CCN: 14-0210	In Lieu of Form CMS-2552-10	Period : From: 07/01/2014 To: 06/30/2015	Run Date: 10/22/2015 Run Time: 16:34 Version: 2015.03 (10/05/2015)
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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		10,991	7,562		8,098		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)		10,991	7,562		8,098		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.

HARRISBURG MEDICAL CENTER, INC. Provider CCN: 14-0210	In Lieu of Form CMS-2552-10	Period : From: 07/01/2014 To: 06/30/2015	Run Date: 10/22/2015 Run Time: 16:34 Version: 2015.03 (10/05/2015)
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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						73,459	1
2	Skilled Nursing Care						562,365	2
3	Physical Therapy						242,365	3
4	Occupational Therapy						4,120	4
5	Speech Pathology						10,718	5
6	Medical Social Services							6
7	Home Health Aide						5,972	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
20	Totals (sum of lines 1-19)(2)						898,999	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.

HARRISBURG MEDICAL CENTER, INC. Provider CCN: 14-0210	In Lieu of Form CMS-2552-10	Period : From: 07/01/2014 To: 06/30/2015	Run Date: 10/22/2015 Run Time: 16:34 Version: 2015.03 (10/05/2015)
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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 25	SUBTOTAL (cols 23 +/- 24) 26	ALLOCATED HHA A&G (see PtlI) 27	TOTAL HHA COSTS 28		
1	Administrative and General		73,459				1
2	Skilled Nursing Care		562,365	50,041	612,406		2
3	Physical Therapy		242,365	21,566	263,931		3
4	Occupational Therapy		4,120	367	4,487		4
5	Speech Pathology		10,718	954	11,672		5
6	Medical Social Services						6
7	Home Health Aide		5,972	531	6,503		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)		898,999	73,459	898,999		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.			0.088983			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.

HARRISBURG MEDICAL CENTER, INC. Provider CCN: 14-0210	In Lieu of Form CMS-2552-10	Period : From: 07/01/2014 To: 06/30/2015	Run Date: 10/22/2015 Run Time: 16:34 Version: 2015.03 (10/05/2015)
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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- CILLATION	ADMINIS- TRATIVE & GENERAL ACCUM COST	MAIN- TENANCE & REPAIRS SQUARE FEET	
		1	2	4	4A	5	6	
1	Administrative and General			91,739		26,210		1
2	Skilled Nursing Care			272,249		463,294		2
3	Physical Therapy			111,835		199,668		3
4	Occupational Therapy			1,175		3,394		4
5	Speech Pathology			3,863		8,830		5
6	Medical Social Services							6
7	Home Health Aide					4,920		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)			480,861		706,316		20
21	Total cost to be allocated			137,384		151,039		21
22	Unit Cost Multiplier			0.285704		0.213841		22
22	Unit Cost Multiplier							22

HARRISBURG MEDICAL CENTER, INC. Provider CCN: 14-0210	In Lieu of Form CMS-2552-10	Period : From: 07/01/2014 To: 06/30/2015	Run Date: 10/22/2015 Run Time: 16:34 Version: 2015.03 (10/05/2015)
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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			42				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)			42				20
21	Total cost to be allocated			14,993				21
22	Unit Cost Multiplier			356.976190				22
22	Unit Cost Multiplier							22

HARRISBURG MEDICAL CENTER, INC. Provider CCN: 14-0210	In Lieu of Form CMS-2552-10	Period : From: 07/01/2014 To: 06/30/2015	Run Date: 10/22/2015 Run Time: 16:34 Version: 2015.03 (10/05/2015)
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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	17,396	8,627		1,002,111			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)	17,396	8,627		1,002,111			20
21	Total cost to be allocated	10,991	7,562		8,098			21
22	Unit Cost Multiplier	0.631812						22
22	Unit Cost Multiplier		0.876550		0.008081			22

HARRISBURG MEDICAL CENTER, INC. Provider CCN: 14-0210	In Lieu of Form CMS-2552-10	Period : From: 07/01/2014 To: 06/30/2015	Run Date: 10/22/2015 Run Time: 16:34 Version: 2015.03 (10/05/2015)
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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

HARRISBURG MEDICAL CENTER, INC. Provider CCN: 14-0210	In Lieu of Form CMS-2552-10	Period : From: 07/01/2014 To: 06/30/2015	Run Date: 10/22/2015 Run Time: 16:34 Version: 2015.03 (10/05/2015)
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APPORTIONMENT OF PATIENT SERVICE COSTS

HHA CCN: 14-7419

WORKSHEET H-3
PARTS I & II

Check applicable box: Title V Title XVIII Title XIX

PART I - COMPUTATION OF THE AGGREGATE PROGRAM COST

Cost Per Visit Computation		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)	
Patient Services			1	2	3	4	5	
1	Skilled Nursing Care	2	612,406		612,406	2,670	229.37	1
2	Physical Therapy	3	263,931		263,931	1,767	149.37	2
3	Occupational Therapy	4	4,487		4,487	37	121.27	3
4	Speech Pathology	5	11,672		11,672	39	299.28	4
5	Medical Social Services	6						5
6	Home Health Aide	7	6,503		6,503	4	1,625.75	6
7	Total (sum of lines 1-6)		898,999		898,999	4,517		7

Limitation Cost Computation		CBSA No.	Part A	Not Subject to Deductibles & Coinsurance	Subject to Deductibles & Coinsurance	
Patient Services		1	2	3	4	
8	Skilled Nursing Care	99914		950		8
9	Physical Therapy	99914		797		9
10	Occupational Therapy	99914		17		10
11	Speech Pathology	99914		12		11
12	Medical Social Services	99914				12
13	Home Health Aide	99914		1		13
14	Total (sum of lines 8-13)			1,777		14

Supplies and Drugs Cost Computations		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 Records)	Ratio (col. 3 ÷ col. 4)	
Other Patient Services			1	2	3	4	5	
15	Cost of Medical Supplies	8				10,296		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	5	
1	Physical Therapy	66	0.412212		col. 2, line 2	1
2	Occupational Therapy	67			col. 2, line 3	2
3	Speech Pathology	68			col. 2, line 4	3
4	Medical Supplies Charged to Pat	71	0.703085		col. 2, line 15	4
5	Drugs Charged to Patients	73	0.359428		col. 2, line 16	5

HARRISBURG MEDICAL CENTER, INC. Provider CCN: 14-0210	In Lieu of Form CMS-2552-10	Period : From: 07/01/2014 To: 06/30/2015	Run Date: 10/22/2015 Run Time: 16:34 Version: 2015.03 (10/05/2015)
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APPORTIONMENT OF PATIENT SERVICE COSTS

HHA CCN: 14-7419

WORKSHEET H-3
PARTS I & II

Check applicable box: Title V Title XVIII Title XIX

PART I - COMPUTATION OF THE AGGREGATE PROGRAM COST

Cost Per Visit Computation		Program Visits			Cost of Services			Total Program Cost (sum of cols 9-10)	
		Part B			Part B				
Patient Services	Part A	Not Subject to Deductibles & Coinsurance	Subject to Deductibles & Coinsurance	Part A	Not Subject to Deductibles & Coinsurance	Subject to Deductibles & Coinsurance			
	6	7	8	9	10	11	12		
1 Skilled Nursing Care		950			217,902		217,902	1	
2 Physical Therapy		797			119,048		119,048	2	
3 Occupational Therapy		17			2,062		2,062	3	
4 Speech Pathology		12			3,591		3,591	4	
5 Medical Social Services								5	
6 Home Health Aide		1			1,626		1,626	6	
7 Total (sum of lines 1-6)		1,777			344,229		344,229	7	

Supplies and Drugs Cost 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	

HARRISBURG MEDICAL CENTER, INC. Provider CCN: 14-0210	In Lieu of Form CMS-2552-10	Period : From: 07/01/2014 To: 06/30/2015	Run Date: 10/22/2015 Run Time: 16:34 Version: 2015.03 (10/05/2015)
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CALCULATION OF HHA REIMBURSEMENT SETTLEMENT

HHA CCN: 14-7419

WORKSHEET H-4
PARTS I & II

Check applicable box: Title V 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				2
	Customary Charges				
3	Amount actually collected from patients liable for payment for services on a charge basis (from your records)				3
4	Amount that would have been realized from patients liable for payment for services on a charge basis had such payment been made in accordance with 42 CFR 413.13(b)				4
5	Ratio of line 3 to line 4 (not to exceed 1.000000)				5
6	Total customary charges (see instructions)				6
7	Excess of total customary charges over total reasonable cost (complete only if line 6 exceeds line 1)				7
8	Excess of reasonable cost over customary charges (complete only if line 1 exceeds line 6)				8
9	Primary payer amounts				9

PART II - 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		307,152	11
12	Total PPS Reimbursement - Full Episodes with Outliers			12
13	Total PPS Reimbursement - LUPA Episodes		13,017	13
14	Total PPS Reimbursement - PEP Episodes		3,944	14
15	Total PPS Outlier Reimbursement - Full Episodes with Outliers			15
16	Total PPS Outlier Reimbursement - PSP 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 thru 20 minus line 21)		324,113	22
23	Excess reasonable cost (from line 8)			23
24	Subtotal (line 22 minus line 23)		324,113	24
25	Coinsurance billed to program patients (from your records)			25
26	Net cost (line 24 minus line 25)		324,113	26
27	Reimbursable bad debts (from your records)			27
28	Reimbursable bad debts for dual eligible (see instructions)			28
29	Total costs - current cost reporting period (line 26 plus line 27)		324,113	29
30	Other adjustments (see instructions) (specify)		-229	30
30.50	Pioneer ACO demonstration payment adjustment (see instructions)			30.50
31	Subtotal (see instructions)		323,884	31
31.01	Sequestration adjustment (see instructions)		6,478	31.01
32	Interim payments (see instructions)		317,406	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, §115-2			35

HARRISBURG MEDICAL CENTER, INC. Provider CCN: 14-0210	In Lieu of Form CMS-2552-10	Period : From: 07/01/2014 To: 06/30/2015	Run Date: 10/22/2015 Run Time: 16:34 Version: 2015.03 (10/05/2015)
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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				317,406	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
	Program	.03				3.03
	To	.04				3.04
	Provider	.05				3.05
		.06				3.06
		.07				3.07
		.08				3.08
		.09				3.09
		.10				3.10
		.50				3.50
		.51				3.51
	Provider	.52				3.52
	To	.53				3.53
	Program	.54				3.54
		.55				3.55
		.56				3.56
		.57				3.57
		.58				3.58
		.59				3.59
	Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98)	.99				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)				317,406	4
TO BE COMPLETED BY CONTRACTOR						
5	List separately each tentative settlement payment after desk review. Also show date of each payment. If none, write 'NONE' or enter a zero. (1)					
		.01				5.01
		.02				5.02
	Program	.03				5.03
	To	.04				5.04
	Provider	.05				5.05
		.06				5.06
		.07				5.07
		.08				5.08
		.09				5.09
		.10				5.10
		.50				5.50
		.51				5.51
	Provider	.52				5.52
	To	.53				5.53
	Program	.54				5.54
		.55				5.55
		.56				5.56
		.57				5.57
		.58				5.58
		.59				5.59
	Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98)	.99				5.99
6	Determine net settlement amount (balance due) based on the cost report (see instructions)	.01			6,478	6.01
		.02				6.02
7	TOTAL MEDICARE PROGRAM LIABILITY (see instructions)				323,884	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.

HARRISBURG MEDICAL CENTER, INC. Provider CCN: 14-0210	In Lieu of Form CMS-2552-10	Period : From: 07/01/2014 To: 06/30/2015	Run Date: 10/22/2015 Run Time: 16:34 Version: 2015.03 (10/05/2015)
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CALCULATION OF CAPITAL PAYMENT

COMPONENT CCN: 14-0210

WORKSHEET L

Check Title V Hospital PPS
 Applicable 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	401,548	1
1.01	Model 4 BPCI Capital DRG other than outlier		1.01
2	Capital DRG outlier payments		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)	12.52	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, columns 1 and 1.01) (see instructions)		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 column 1, 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)	401,548	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

HARRISBURG MEDICAL CENTER, INC. Provider CCN: 14-0210	In Lieu of Form CMS-2552-10	Period : From: 07/01/2014 To: 06/30/2015	Run Date: 10/22/2015 Run Time: 16:34 Version: 2015.03 (10/05/2015)
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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 SERVICE 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 Centers						201
202	TOTAL (sum of lines 118-201)						202

HARRISBURG MEDICAL CENTER, INC. Provider CCN: 14-0210	In Lieu of Form CMS-2552-10	Period : From: 07/01/2014 To: 06/30/2015	Run Date: 10/22/2015 Run Time: 16:34 Version: 2015.03 (10/05/2015)
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ANALYSIS OF HOSPITAL-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	493,865		493,865		493,865		493,865	1
2	Physician Assistant								2
3	Nurse Practitioner	394,077		394,077		394,077		394,077	3
4	Visiting Nurse								4
5	Other Nurse	189,198		189,198		189,198		189,198	5
6	Clinical Psychologist	114,994		114,994		114,994	-20,800	94,194	6
7	Clinical Social Worker	56,563		56,563		56,563		56,563	7
8	Laboratory Technician	59,347		59,347	-46,506	12,841		12,841	8
9	Other Facility Health Care Staff Costs	55,013		55,013	-56,003	-990		-990	9
10	Subtotal (sum of lines 1 through 9)	1,363,057		1,363,057	-102,509	1,260,548	-20,800	1,239,748	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 through 13)								14
	OTHER HEALTH CARE COSTS								
15	Medical Supplies		20,884	20,884		20,884		20,884	15
16	Transportation (Health Care Staff)		7,329	7,329		7,329		7,329	16
17	Depreciation-Medical Equipment				223,778	223,778		223,778	17
18	Professional Liability Insurance								18
19	Other Health Care Costs								19
20	Allowable GME Costs								20
21	Subtotal (sum of lines 15 through 20)		28,213	28,213	223,778	251,991		251,991	21
22	Total Cost of Health Care Services (sum of lines 10, 14, and 21)	1,363,057	28,213	1,391,270	121,269	1,512,539	-20,800	1,491,739	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 through 27)								28
	FACILITY OVERHEAD								
29	Facility Costs		82,919	82,919	-45,099	37,820		37,820	29
30	Administrative Costs	343,326	95,305	438,631		438,631	-29,197	409,434	30
31	Total Facility Overhead (sum of lines 29 and 30)	343,326	178,224	521,550	-45,099	476,451	-29,197	447,254	31
32	Total facility costs (sum of lines 22, 28 and 31)	1,706,383	206,437	1,912,820	76,170	1,988,990	-49,997	1,938,993	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.

HARRISBURG MEDICAL CENTER, INC. Provider CCN: 14-0210	In Lieu of Form CMS-2552-10	Period : From: 07/01/2014 To: 06/30/2015	Run Date: 10/22/2015 Run Time: 16:34 Version: 2015.03 (10/05/2015)
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ALLOCATION OF OVERHEAD TO RHC/FQHC SERVICES

COMPONENT CCN: 14-3473

WORKSHEET M-2

Check applicable box: RHC I 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	1.66	6,217	4,200	6,972		1
2	Physician Assistants			2,100			2
3	Nurse Practitioners	3.24	8,160	2,100	6,804		3
4	Subtotal (sum of lines 1 through 3)	4.90	14,377		13,776	14,377	4
5	Visiting Nurse						5
6	Clinical Psychologist	1.89	1,949			1,949	6
7	Clinical Social Worker	0.89	830			830	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 through 7)	7.68	17,156			17,156	8
9	Physician Services Under Agreements						9

DETERMINATION OF ALLOWABLE COST APPLICABLE TO RHC/FQHC SERVICES

10	Total costs of health care services (from Wkst. M-1, col. 7, line 22)		1,491,739	10
11	Total nonreimbursable costs (from Wkst. M-1, col. 7, line 28)			11
12	Cost of all services (excluding overhead) (sum of lines 10 and 11)		1,491,739	12
13	Ratio of RHC/FQHC services (line 10 divided by line 12)		1.000000	13
14	Total facility overhead (from Wkst. M-1, col. 7, line 31)		447,254	14
15	Parent provider overhead allocated to facility (see instructions)		1,214,895	15
16	Total overhead (sum of lines 14 and 15)		1,662,149	16
17	Allowable Direct GME overhead (see instructions)			17
18	Subtotal (see instructions)		1,662,149	18
19	Overhead applicable to RHC/FQHC services (line 13 x line 18)		1,662,149	19
20	Total allowable cost of RHC/FQHC services (sum of lines 10 and 19)		3,153,888	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.

HARRISBURG MEDICAL CENTER, INC. Provider CCN: 14-0210	In Lieu of Form CMS-2552-10	Period : From: 07/01/2014 To: 06/30/2015	Run Date: 10/22/2015 Run Time: 16:34 Version: 2015.03 (10/05/2015)
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CALCULATION OF PNEUMOCOCCAL AND INFLUENZA VACCINE COST

COMPONENT CCN: 14-3473

WORKSHEET M-4

Check applicable boxes: RHC I Title V Title XIX
 FQHC Title XVIII

		PNEUMO- COCCAL	INFLUENZA	
		1	2	
1	Health care staff cost (from Wkst. M-1, col. 7, line 10)	1,239,748	1,239,748	1
2	Ratio of pneumococcal and influenza vaccine staff time to total health care staff time	0.001070	0.004075	2
3	Pneumococcal and influenza vaccine health care staff cost (line 1 x line 2)	1,327	5,052	3
4	Medical supplies cost - pneumococcal and influenza vaccine (from your records)	18,256	11,993	4
5	Direct cost of pneumococcal and influenza vaccine (line 3 plus line 4)	19,583	17,045	5
6	Total direct cost of the facility (from Wkst. M-1, col. 7, line 22)	1,491,739	1,491,739	6
7	Total overhead (from Wkst. M-2, line 16)	1,662,149	1,662,149	7
8	Ratio of pneumococcal and influenza vaccine direct cost to total direct cost (line 5 divided by line 6)	0.013128	0.011426	8
9	Overhead cost - pneumococcal and influenza vaccine (line 7 x line 8)	21,821	18,992	9
10	Total pneumococcal and influenza vaccine costs and their administration costs (sum of lines 5 and 9)	41,404	36,037	10
11	Total number of pneumococcal and influenza vaccine injections (from your records)	280	1,066	11
12	Cost per pneumococcal and influenza vaccing injection (line 10/line 11)	147.87	33.81	12
13	Number of pneumococcal and influenza vaccine injections administered to program beneficiaries	103	226	13
14	Program cost of pneumococcal and influenza vaccines and their administration costs (line 12 x line 13)	15,231	7,641	14
15	Total cost of pneumococcal and influenza vaccines and their administration costs (sum of cols. 1 and 2, line 10) (transfer this amount to Wkst. M-3, line 2)		77,441	15
16	Total Program cost of pneumococcal and influenza vaccines and their administration costs (sum of cols. 1 and 2, line 14) (transfer this amount to Wkst. M-3, line 21)		22,872	16

HARRISBURG MEDICAL CENTER, INC. Provider CCN: 14-0210	In Lieu of Form CMS-2552-10	Period : From: 07/01/2014 To: 06/30/2015	Run Date: 10/22/2015 Run Time: 16:34 Version: 2015.03 (10/05/2015)
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ANALYSIS OF PAYMENTS TO HOSPITAL-BASED RHC/FQHC
PROVIDER FOR SERVICES RENDERED TO PROGRAM BENEFICIARIES

COMPONENT CCN: 14-3473

WORKSHEET M-5

Check applicable box: RHC I FQHC

DESCRIPTION	Part B	
	mm/dd/yyyy 1	Amount 2
1 Total interim payments paid to provider		557,855
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 zero		
3 List separately each retroactive lump sum adjustment amount based on subsequent revision of the interim period. If none, write 'NONE' or enter zero		
.01		3.01
.02		3.02
.03 Program		3.03
.04 to		3.04
.05 Provider		3.05
.06		3.06
.07		3.07
.08		3.08
.09		3.09
.10		3.10
.50		3.50
.51		3.51
.52 Provider		3.52
.53 to		3.53
.54 Program		3.54
.55		3.55
.56		3.56
.57		3.57
.58		3.58
.59		3.59
.99 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. M-3, line 27)		557,855
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 zero (1)		
.01		5.01
.02		5.02
.03 Program		5.03
.04 to		5.04
.05 Provider		5.05
.06		5.06
.07		5.07
.08		5.08
.09		5.09
.10		5.10
.50		5.50
.51		5.51
.52 Provider		5.52
.53 to		5.53
.54 Program		5.54
.55		5.55
.56		5.56
.57		5.57
.58		5.58
.59		5.59
.99 Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98)		5.99
6 Determine net settlement amount (balance due) based on the cost report (1)		24,483
7 Total Medicare program liability (see instructions)		582,338
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 you agree to the amount of repayment, even though the total repayment is not accomplished until a later date.

HARRISBURG MEDICAL CENTER, INC. Provider CCN: 14-0210	In Lieu of Form CMS-2552-10	Period : From: 07/01/2014 To: 06/30/2015	Run Date: 10/22/2015 Run Time: 16:34 Version: 2015.03 (10/05/2015)
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ANALYSIS OF HOSPITAL-BASED RURAL HEALTH CLINIC/
FEDERALLY QUALIFIED HEALTH CENTER COSTS

COMPONENT CCN: 14-8518

WORKSHEET M-1

Check applicable box: RHC II FQHC

		COMPENS- ATION	OTHER COSTS	TOTAL (col. 1 + col. 2)	RECLASS- IFICATIONS	RECLASS- IFIED TRIAL BALANCE (col. 3 + col. 4)	ADJUST- MENTS	NET EXPENSES FOR ALLOCATION (col. 5 + col. 6)	
		1	2	3	4	5	6	7	
	FACILITY HEALTH CARE STAFF COSTS								
1	Physician	53,131		53,131		53,131		53,131	1
2	Physician Assistant								2
3	Nurse Practitioner	95,305		95,305		95,305		95,305	3
4	Visiting Nurse								4
5	Other Nurse	35,317		35,317		35,317		35,317	5
6	Clinical Psychologist								6
7	Clinical Social Worker								7
8	Laboratory Technician	3,046		3,046	-3,067	-21		-21	8
9	Other Facility Health Care Staff Costs								9
10	Subtotal (sum of lines 1 through 9)	186,799		186,799	-3,067	183,732		183,732	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 through 13)								14
	OTHER HEALTH CARE COSTS								
15	Medical Supplies		3,226	3,226		3,226		3,226	15
16	Transportation (Health Care Staff)		3,537	3,537		3,537		3,537	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 through 20)		6,763	6,763		6,763		6,763	21
22	Total Cost of Health Care Services (sum of lines 10, 14, and 21)	186,799	6,763	193,562	-3,067	190,495		190,495	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 through 27)								28
	FACILITY OVERHEAD								
29	Facility Costs		38,653	38,653		38,653		38,653	29
30	Administrative Costs	21,060	3,957	25,017		25,017		25,017	30
31	Total Facility Overhead (sum of lines 29 and 30)	21,060	42,610	63,670		63,670		63,670	31
32	Total facility costs (sum of lines 22, 28 and 31)	207,859	49,373	257,232	-3,067	254,165		254,165	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.

HARRISBURG MEDICAL CENTER, INC. Provider CCN: 14-0210	In Lieu of Form CMS-2552-10	Period : From: 07/01/2014 To: 06/30/2015	Run Date: 10/22/2015 Run Time: 16:34 Version: 2015.03 (10/05/2015)
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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

	Positions	Number of FTE Personnel	Total Visits	Productivity Standard (1)	Minimum Visits (col. 1 x col. 3)	Greater of col. 2 or col. 4	
		1	2	3	4	5	
1	Physicians	0.08	321	4,200	336		1
2	Physician Assistants			2,100			2
3	Nurse Practitioners	0.81	1,945	2,100	1,701		3
4	Subtotal (sum of lines 1 through 3)	0.89	2,266		2,037	2,266	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 through 7)	0.89	2,266			2,266	8
9	Physician Services Under Agreements						9

DETERMINATION OF ALLOWABLE COST APPLICABLE TO RHC/FQHC SERVICES

10	Total costs of health care services (from Wkst. M-1, col. 7, line 22)					190,495	10
11	Total nonreimbursable costs (from Wkst. M-1, col. 7, line 28)						11
12	Cost of all services (excluding overhead) (sum of lines 10 and 11)					190,495	12
13	Ratio of RHC/FQHC services (line 10 divided by line 12)					1.000000	13
14	Total facility overhead (from Wkst. M-1, col. 7, line 31)					63,670	14
15	Parent provider overhead allocated to facility (see instructions)					148,363	15
16	Total overhead (sum of lines 14 and 15)					212,033	16
17	Allowable Direct GME overhead (see instructions)						17
18	Subtotal (see instructions)					212,033	18
19	Overhead applicable to RHC/FQHC services (line 13 x line 18)					212,033	19
20	Total allowable cost of RHC/FQHC services (sum of lines 10 and 19)					402,528	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.

HARRISBURG MEDICAL CENTER, INC. Provider CCN: 14-0210	In Lieu of Form CMS-2552-10	Period : From: 07/01/2014 To: 06/30/2015	Run Date: 10/22/2015 Run Time: 16:34 Version: 2015.03 (10/05/2015)
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CALCULATION OF PNEUMOCOCCAL AND INFLUENZA VACCINE COST

COMPONENT CCN: 14-8518

WORKSHEET M-4

Check applicable boxes: REC II Title V Title XIX
 FQHC Title XVIII

		PNEUMO-COCCAL	INFLUENZA	
		1	2	
1	Health care staff cost (from Wkst. M-1, col. 7, line 10)	183,732	183,732	1
2	Ratio of pneumococcal and influenza vaccine staff time to total health care staff time	0.000608	0.004278	2
3	Pneumococcal and influenza vaccine health care staff cost (line 1 x line 2)	112	786	3
4	Medical supplies cost - pneumococcal and influenza vaccine (from your records)	1,695	2,059	4
5	Direct cost of pneumococcal and influenza vaccine (line 3 plus line 4)	1,807	2,845	5
6	Total direct cost of the facility (from Wkst. M-1, col. 7, line 22)	190,495	190,495	6
7	Total overhead (from Wkst. M-2, line 16)	212,033	212,033	7
8	Ratio of pneumococcal and influenza vaccine direct cost to total direct cost (line 5 divided by line 6)	0.009486	0.014935	8
9	Overhead cost - pneumococcal and influenza vaccine (line 7 x line 8)	2,011	3,167	9
10	Total pneumococcal and influenza vaccine costs and their administration costs (sum of lines 5 and 9)	3,818	6,012	10
11	Total number of pneumococcal and influenza vaccine injections (from your records)	26	183	11
12	Cost per pneumococcal and influenza vaccing injection (line 10/line 11)	146.85	32.85	12
13	Number of pneumococcal and influenza vaccine injections administered to program beneficiaries	8	35	13
14	Program cost of pneumococcal and influenza vaccines and their administration costs (line 12 x line 13)	1,175	1,150	14
15	Total cost of pneumococcal and influenza vaccines and their administration costs (sum of cols. 1 and 2, line 10) (transfer this amount to Wkst. M-3, line 2)		9,830	15
16	Total Program cost of pneumococcal and influenza vaccines and their administration costs (sum of cols. 1 and 2, line 14) (transfer this amount to Wkst. M-3, line 21)		2,325	16

HARRISBURG MEDICAL CENTER, INC. Provider CCN: 14-0210	In Lieu of Form CMS-2552-10	Period : From: 07/01/2014 To: 06/30/2015	Run Date: 10/22/2015 Run Time: 16:34 Version: 2015.03 (10/05/2015)
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ANALYSIS OF PAYMENTS TO HOSPITAL-BASED RHC/FQHC
PROVIDER FOR SERVICES RENDERED TO PROGRAM BENEFICIARIES

COMPONENT CCN: 14-8518

WORKSHEET M-5

Check applicable box: RHC II FQHC

	DESCRIPTION	Part B		
		mm/dd/yyyy 1	Amount 2	
1	Total interim payments paid to provider		82,340	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 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 zero (1)			
		.01		3.01
		.02		3.02
		Program .03		3.03
		to .04		3.04
		Provider .05		3.05
		.06		3.06
		.07		3.07
		.08		3.08
		.09		3.09
		.10		3.10
		.50		3.50
		.51		3.51
		Provider .52		3.52
		to .53		3.53
		Program .54		3.54
		.55		3.55
		.56		3.56
		.57		3.57
		.58		3.58
		.59		3.59
	Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98)	.99		3.99
4	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Wkst. M-3, line 27)		82,340	
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 zero (1)			
		.01		5.01
		.02		5.02
		Program .03		5.03
		to .04		5.04
		Provider .05		5.05
		.06		5.06
		.07		5.07
		.08		5.08
		.09		5.09
		.10		5.10
		.50		5.50
		.51		5.51
		Provider .52		5.52
		to .53		5.53
		Program .54		5.54
		.55		5.55
		.56		5.56
		.57		5.57
		.58		5.58
		.59		5.59
	Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98)	.99		5.99
6	Determine net settlement amount (balance due) based on the cost report (1)	.01		6.01
		.02		6.02
7	Total Medicare program liability (see instructions)		-11,837	
			70,503	
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 you agree to the amount of repayment, even though the total repayment is not accomplished until a later date.

HARRISBURG MEDICAL CENTER, INC. Provider CCN: 14-0210	Non CMS worksheet CMS-2552-10	Period : From: 07/01/2014 To: 06/30/2015	Run Date: 10/22/2015 Run Time: 16:34 Version: 2015.03 (10/05/2015)
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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	42.87		10.38				53.25	30
	UTILIZATION PERCENTAGES BASED ON CHARGES								
50	Operating Room	6.26	21.75					28.01	50
53	Anesthesiology	7.61	27.52					35.13	53
54	Radiology-Diagnostic	8.12	27.60					35.72	54
57	CT Scan	9.62	27.39					37.01	57
60	Laboratory	14.12	13.64					27.76	60
64	Intravenous Therapy	39.27	12.71					51.98	64
65	Respiratory Therapy	29.99	16.62					46.61	65
66	Physical Therapy	13.49	0.02					13.51	66
69	Electrocardiology	14.64	24.50					39.14	69
71	Medical Supplies Charged to Pat	26.45	15.93					42.38	71
72	Impl. Dev. Charged to Patients	19.60	19.13					38.73	72
73	Drugs Charged to Patients	12.19	31.03					43.22	73
75	ASC (Non-Distinct Part)	4.65	35.87					40.52	75
76	NUCLEAR MEDICINE	2.76	39.32					42.08	76
76.01	ULTRASOUND	16.18	20.99					37.17	76.01
76.04	FAITH CENTER CHEMOTHERAPY		15.65					15.65	76.04
76.97	CARDIAC REHABILITATION	1.91	71.82					73.73	76.97
91	Emergency	8.25	18.99					27.24	91
92	Observation Beds (Non-Distinct	13.26	27.12					40.38	92
93	DAY PSYCHIATRIC		24.95					24.95	93
200	TOTAL CHARGES	13.84	20.98					34.82	200

HARRISBURG MEDICAL CENTER, INC. Provider CCN: 14-0210	Non CMS worksheet CMS-2552-10	Period : From: 07/01/2014 To: 06/30/2015	Run Date: 10/22/2015 Run Time: 16:34 Version: 2015.03 (10/05/2015)
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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	36.83		42.84				79.67	40
	UTILIZATION PERCENTAGES BASED ON CHARGES								
53	Anesthesiology	0.39						0.39	53
54	Radiology-Diagnostic	0.73	0.01					0.74	54
57	CT Scan	0.90						0.90	57
60	Laboratory	1.67						1.67	60
64	Intravenous Therapy	0.70	0.01					0.71	64
65	Respiratory Therapy	3.57	0.03					3.60	65
66	Physical Therapy	1.16						1.16	66
69	Electrocardiology	1.32						1.32	69
71	Medical Supplies Charged to Pat	1.79	0.03					1.82	71
73	Drugs Charged to Patients	5.96						5.96	73
75	ASC (Non-Distinct Part)	0.10						0.10	75
76	NUCLEAR MEDICINE	0.07						0.07	76
76.01	ULTRASOUND	0.53						0.53	76.01
91	Emergency	1.33						1.33	91
200	TOTAL CHARGES	1.50						1.50	200

HARRISBURG MEDICAL CENTER, INC. Provider CCN: 14-0210	Non CMS worksheet CMS-2552-10	Period : From: 07/01/2014 To: 06/30/2015	Run Date: 10/22/2015 Run Time: 16:34 Version: 2015.03 (10/05/2015)
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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	0.02						0.02	54
60	Laboratory	0.11						0.11	60
64	Intravenous Therapy	0.11						0.11	64
65	Respiratory Therapy	0.19						0.19	65
66	Physical Therapy	1.85						1.85	66
69	Electrocardiology	0.03						0.03	69
71	Medical Supplies Charged to Pat	0.23						0.23	71
73	Drugs Charged to Patients	0.17						0.17	73
76.01	ULTRASOUND	0.01						0.01	76.01
200	TOTAL CHARGES	0.12						0.12	200

HARRISBURG MEDICAL CENTER, INC. Provider CCN: 14-0210	Non CMS worksheet CMS-2552-10	Period : From: 07/01/2014 To: 06/30/2015	Run Date: 10/22/2015 Run Time: 16:34 Version: 2015.03 (10/05/2015)
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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	1,145,173	2.83	-1,145,173	-6.19			1
2	Cap Rel Costs-Mvble Equip	1,093,015	2.70	-1,093,015	-5.91			2
3	Other Cap Rel Costs							3
4	Employee Benefits Department	6,431,858	15.90	-6,431,858	-34.79			4
5	Administrative & General	5,513,257	13.63	-5,513,257	-29.82			5
6	Maintenance & Repairs							6
7	Operation of Plant	1,104,132	2.73	-1,104,132	-5.97			7
8	Laundry & Linen Service	138,077	0.34	-138,077	-0.75			8
9	Housekeeping	642,493	1.59	-642,493	-3.47			9
10	Dietary	739,239	1.83	-739,239	-4.00			10
11	Cafeteria							11
12	Maintenance of Personnel							12
13	Nursing Administration	88,735	0.22	-88,735	-0.48			13
14	Central Services & Supply	361,291	0.89	-361,291	-1.95			14
15	Pharmacy	559,039	1.38	-559,039	-3.02			15
16	Medical Records & Library	673,662	1.67	-673,662	-3.64			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	3,178,830	7.86	3,365,586	18.20	6,544,416	16.18	30
40	Subprovider - IPF	2,864,108	7.08	2,829,427	15.30	5,693,535	14.07	40
ANCILLARY SERVICE COST CENTERS								
50	Operating Room	251,726	0.62	866,325	4.69	1,118,051	2.76	50
53	Anesthesiology	42,763	0.11	305,469	1.65	348,232	0.86	53
54	Radiology-Diagnostic	700,583	1.73	732,092	3.96	1,432,675	3.54	54
57	CT Scan	323,664	0.80	315,506	1.71	639,170	1.58	57
60	Laboratory	2,316,860	5.73	1,210,508	6.55	3,527,368	8.72	60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
64	Intravenous Therapy	111,966	0.28	134,564	0.73	246,530	0.61	64
65	Respiratory Therapy	647,208	1.60	480,418	2.60	1,127,626	2.79	65
66	Physical Therapy	788,275	1.95	744,345	4.03	1,532,620	3.79	66
69	Electrocardiology	105,218	0.26	103,846	0.56	209,064	0.52	69
71	Medical Supplies Charged to Patients	1,344,436	3.32	306,471	1.66	1,650,907	4.08	71
72	Impl. Dev. Charged to Patients	598,107	1.48	136,126	0.74	734,233	1.81	72
73	Drugs Charged to Patients	2,400,578	5.93	1,561,707	8.45	3,962,285	9.79	73
75	ASC (Non-Distinct Part)	643,564	1.59	798,979	4.32	1,442,543	3.57	75
76	NUCLEAR MEDICINE	355,005	0.88	245,037	1.33	600,042	1.48	76
76.01	ULTRASOUND	242,186	0.60	197,314	1.07	439,500	1.09	76.01
76.02	MAMMOGRAPHY	119,670	0.30	82,799	0.45	202,469	0.50	76.02
76.03	CARDIAC REHABILITATION							76.03
76.04	FAITH CENTER CHEMOTHERAPY	140,602	0.35	142,401	0.77	283,003	0.70	76.04
76.06	ROUTINE ANCILLARY							76.06
76.97	CARDIAC REHABILITATION	83,548	0.21	90,653	0.49	174,201	0.43	76.97
76.98	HYPERBARIC OXYGEN THERAPY							76.98
76.99	LITHOTRIPSY							76.99
88	Rural Health Clinic	1,938,993	4.79	1,214,895	6.57	3,153,888	7.80	88
88.01	RHC II	254,165	0.63	148,363	0.80	402,528	0.99	88.01
91	Emergency	1,175,984	2.91	1,587,286	8.58	2,763,270	6.83	91
92	Observation Beds (Non-Distinct Part)							92
93	DAY PSYCHIATRIC	196,400	0.49	241,056	1.30	437,456	1.08	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	568,932	1.41	330,067	1.79	898,999	2.22	101
SPECIAL PURPOSE COST CENTERS								
NONREIMBURSABLE COST CENTERS								
190	Gift, Flower, Coffee Shop & Canteen	237,343	0.59	109,314	0.59	346,657	0.86	190
192	Physicians' Private Offices	339,243	0.84	209,417	1.13	548,660	1.36	192
192.0	DIALYSIS							192.0
1								1
192.0	ORTHO CLINIC							192.0
3								3
200	Cross Foot Adjustments							200
201	Negative Cost Centers							201
202	TOTAL	40,459,928	100.00			40,459,928	100.00	202

HARRISBURG MEDICAL CENTER, INC. Provider CCN: 14-0210	Non CMS worksheet CMS-2552-10	Period : From: 07/01/2014 To: 06/30/2015	Run Date: 10/22/2015 Run Time: 16:34 Version: 2015.03 (10/05/2015)
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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	368,733	2,824,177	0.130563	176,846	23,090	50
53	Anesthesiology	16,822	2,576,207	0.006530	196,087	1,280	53
54	Radiology-Diagnostic	208,279	4,742,013	0.043922	384,933	16,907	54
57	CT Scan	26,134	18,632,152	0.001403	1,792,822	2,515	57
60	Laboratory	147,566	24,158,564	0.006108	3,411,281	20,836	60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS						62.30
64	Intravenous Therapy	8,114	9,003,353	0.000901	3,535,393	3,185	64
65	Respiratory Therapy	82,032	4,958,837	0.016543	1,487,030	24,600	65
66	Physical Therapy	118,722	3,718,040	0.031931	501,470	16,012	66
69	Electrocardiology	50,870	1,781,104	0.028561	260,735	7,447	69
71	Medical Supplies Charged to Pat	26,513	2,348,091	0.011291	620,983	7,012	71
72	Impl. Dev. Charged to Patients	11,783	1,017,902	0.011576	199,463	2,309	72
73	Drugs Charged to Patients	117,914	11,023,852	0.010696	1,343,721	14,372	73
75	ASC (Non-Distinct Part)	123,317	4,638,335	0.026586	215,760	5,736	75
76	NUCLEAR MEDICINE	77,761	2,925,556	0.026580	80,727	2,146	76
76.01	ULTRASOUND	20,789	4,523,826	0.004595	731,968	3,363	76.01
76.02	MAMMOGRAPHY	18,971	763,748	0.024839			76.02
76.03	CARDIAC REHABILITATION						76.03
76.04	FAITH CENTER CHEMOTHERAPY	22,174	288,444	0.076875			76.04
76.06	ROUTINE ANCILLARY						76.06
76.97	CARDIAC REHABILITATION	19,760	429,679	0.045988	8,212	378	76.97
76.98	HYPERBARIC OXYGEN THERAPY						76.98
76.99	LITHOTRIPSY						76.99
88	Rural Health Clinic	59,631	2,869,457	0.020781			88
88.01	RHC II	6,820	277,251	0.024599			88.01
	OUTPATIENT SERVICE COST CENTERS						
91	Emergency	133,368	7,992,607	0.016686	659,028	10,997	91
92	Observation Beds (Non-Distinct	125,365	4,727,612	0.026518	626,979	16,626	92
93	DAY PSYCHIATRIC	49,499	1,111,980	0.044514			93
	OTHER REIMBURSABLE COST CENTERS						
200	TOTAL	1,840,937	117,332,787		16,233,438	178,811	200

HARRISBURG MEDICAL CENTER, INC. Provider CCN: 14-0210	Non CMS worksheet CMS-2552-10	Period : From: 07/01/2014 To: 06/30/2015	Run Date: 10/22/2015 Run Time: 16:34 Version: 2015.03 (10/05/2015)
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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	397,475	2,187	395,288	6,674	59.23	2,861	169,457	30
200	TOTAL	397,475	2,187	395,288	6,674		2,861	169,457	200

MEDICARE INPATIENT ROUTINE SERVICE PPS CAPITAL COSTS	169,457
MEDICARE INPATIENT ANCILLARY SERVICE PPS CAPITAL COSTS	178,811
TOTAL MEDICARE INPATIENT PPS CAPITAL COSTS	348,268
MEDICARE DISCHARGES (Worksheet S-3, Part I, line 14, column 13)	1,008
MEDICARE PATIENT DAYS (Worksheet S-3, Part I, line 14, column 6 - Worksheet S-3, Part I, line 5, column 6)	2,861
PER DISCHARGE CAPITAL COSTS	345.50

HARRISBURG MEDICAL CENTER, INC. Provider CCN: 14-0210	Non CMS worksheet CMS-2552-10	Period : From: 07/01/2014 To: 06/30/2015	Run Date: 10/22/2015 Run Time: 16:34 Version: 2015.03 (10/05/2015)
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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)	5,614,214
2. HOSPITAL PART A TITLE XVIII CHARGES (sum of inpatient charges and ancillary charges on Worksheet D-3 for hospital Title XVIII component)	19,088,022
3. RATIO OF COST TO CHARGES (line 1 / line 2)	0.294

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))	2,627,815
2. TOTAL MEDICARE CHARGES (Worksheet D-3, line 40, column 2 plus Worksheet D-3, line 202, column 2) (see CR 5619)	6,194,629
3. RATIO OF COST TO CHARGES (line 1 / line 2)	0.424

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)	348,268
2. RATIO OF COST TO CHARGES (line II-1 / line 1-2)	0.018

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)	5,500,347
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)	24,619,197
3. RATIO OF COST TO CHARGES (line 1 / line 2)	0.223