

HARRISBURG MEDICAL CENTER

HARRISBURG, ILLINOIS

MEDICARE COST REPORT

YEAR ENDED JUNE 30, 2016

HARRISBURG MEDICAL CENTER, INC. Provider CCN: 14-0210	In Lieu of Form CMS-2552-10	Period : From: 07/01/2015 To: 06/30/2016	Run Date: 11/20/2016 Run Time: 11:51 Version: 2016.05 (11/01/2016)
--	--------------------------------	--	--

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX COST REPORT CERTIFICATION AND SETTLEMENT SUMMARY

WORKSHEET S  
PARTS I, II & III

PART I - COST REPORT STATUS

Provider use only	1. <input checked="" type="checkbox"/> Electronically filed cost report Date: 11/20/2016 Time: 11:51	
	2. <input type="checkbox"/> Manually submitted cost report	
	3. <input type="checkbox"/> If this is an amended report enter the number of times the provider resubmitted the cost report	
	4. <input checked="" type="checkbox"/> Medicare Utilization. Enter 'F' for full or 'L' for low.	
Contractor use only	5. <input type="checkbox"/> Cost Report Status (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 HARRISBURG MEDICAL CENTER, INC. (14-0210) (Provider Name(s) and Number(s)) for the cost reporting period beginning 07/01/2015 and ending 06/30/2016, and to the best of my knowledge and belief, this report and statement are true, correct, complete and prepared from the books and records of the provider in accordance with applicable instructions, except as noted. I further certify that I am familiar with the laws and regulations regarding the provision of health care services, and that the services identified in this cost report were provided in compliance with such laws and regulations.

ECR Encryption: 11/20/2016 11:51  
jEz6GzAKykNXbE:CHJwBaDdITjYd0  
CKsOu0hbaLkpDhxgkCm2tEKSwVK2JA  
vXLO1S5cnb0ol.mN

(Signed) \_\_\_\_\_  
Officer or Administrator of Provider(s)

\_\_\_\_\_  
Title

\_\_\_\_\_  
Date

PI Encryption: 11/20/2016 11:51  
a7PUN9qCEqiQcALQRIS6MnO0ps5Yd0  
kaNQo9N9W1dgK5WhQsU.aGmPF0NzmR  
qF900dy2lb0:ly6D

PART III - SETTLEMENT SUMMARY

		TITLE XVIII			HIT	TITLE XIX	
		TITLE V	PART A	PART B			
		1	2	3	4	5	
1	HOSPITAL						1
2	SUBPROVIDER - IPF		-29,808	-19,983			2
3	SUBPROVIDER - IRF		-22,345				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			-229			9
10	HEALTH CLINIC - RHC			34,121			10
10.01	HEALTH CLINIC - RHC II			4,687			10.01
11	HEALTH CLINIC - FOHC						11
12	OUTPATIENT REHABILITATION PROVIDER						12
200	TOTAL		-52,153	18,596			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: 07/01/2015 To: 06/30/2016	Run Date: 11/19/2016 Run Time: 10:33 Version: 2016.05 (11/01/2016)
--	--------------------------------	--	--

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX COST REPORT CERTIFICATION AND SETTLEMENT SUMMARY

WORKSHEET S  
PARTS I, II & III

PART I - COST REPORT STATUS

Provider use only	1. <input checked="" type="checkbox"/> Electronically filed cost report Date: _____ Time: _____	
	2. <input type="checkbox"/> Manually submitted cost report	
	3. <input type="checkbox"/> If this is an amended report enter the number of times the provider resubmitted the cost report	
	4. <input checked="" type="checkbox"/> Medicare Utilization. Enter 'F' for full or 'L' for low.	
Contractor use only	5. <input type="checkbox"/> Cost Report Status (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 HARRISBURG MEDICAL CENTER, INC. (14-0210) (Provider Name(s) and Number(s)) for the cost reporting period beginning 07/01/2015 and ending 06/30/2016, and to the best of my knowledge and belief, this report and statement are true, correct, complete and prepared from the books and records of the provider in accordance with applicable instructions, except as noted. I further certify that I am familiar with the laws and regulations regarding the provision of health care services, and that the services identified in this cost report were provided in compliance with such laws and regulations.

(Signed) \_\_\_\_\_  
Officer or Administrator of Provider(s)  
  
\_\_\_\_\_  
Title  
  
\_\_\_\_\_  
Date

PART III - SETTLEMENT SUMMARY

		TITLE XVIII			HIT	TITLE XIX	
		TITLE V	PART A	PART B			
		1	2	3	4	5	
1	HOSPITAL		-29,808	-19,983			1
2	SUBPROVIDER - IPF		-22,345				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			-229			9
10	HEALTH CLINIC - RHC			34,121			10
10.01	HEALTH CLINIC - RHC II			4,687			10.01
11	HEALTH CLINIC - FQHC						11
12	OUTPATIENT REHABILITATION PROVIDER						12
200	TOTAL		-52,153	18,596			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: 07/01/2015 To: 06/30/2016	Run Date: 11/19/2016 Run Time: 10:33 Version: 2016.05 (11/01/2016)
--	--------------------------------	--	--

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA

WORKSHEET S-2  
PART I

Hospital and Hospital Health Care Complex Address:

1	Street: 100 DR WARREN TUTTLE DRIVE	P.O. Box:		1
2	City: HARRISBURG	State: IL	ZIP Code: 62946	County: SALINE

Hospital and Hospital-Based Component Identification:

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 / 2015	To: 06 / 30 / 2016	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.	716					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 / 2015		Ending: 06 / 30 / 2016			36
37	If this is a Medicare dependent hospital (MDH), enter the number of periods MDH status is in effect in the cost reporting period.						37
37.01	Is this hospital a former MDH that is eligible for the MDH transitional payment in accordance with the FY 2016 OPPS final rule? Enter 'Y' for yes or 'N' for no. (see instructions)	N					37.01

HARRISBURG MEDICAL CENTER, INC. Provider CCN: 14-0210	In Lieu of Form <b>CMS-2552-10</b>	Period : From: 07/01/2015 To: 06/30/2016	Run Date: 11/19/2016 Run Time: 10:33 Version: 2016.05 (11/01/2016)
--	---------------------------------------	--	--

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA

WORKSHEET S-2  
PART I

38	If line 37 is 1, enter the beginning and ending dates of MDH status. If line 37 is greater than 1, subscript this line for the number of periods in excess of one and enter subsequent dates.	Beginning:	Ending:	38
----	---	------------	---------	----

HARRISBURG MEDICAL CENTER, INC. Provider CCN: 14-0210	In Lieu of Form CMS-2552-10	Period : From: 07/01/2015 To: 06/30/2016	Run Date: 11/19/2016 Run Time: 10:33 Version: 2016.05 (11/01/2016)
--	--------------------------------	--	--

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)	1	2	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
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		1	2	3	
56	Is this a hospital involved in training residents in approved GME programs? Enter 'Y' for yes or 'N' for no.	N			56
57	If line 56 is yes, is this the first cost reporting period during which residents in approved GME programs trained at this facility? Enter 'Y' for yes or 'N' for no in column 1. If column 1 is 'Y' did residents start training in the first month of this cost reporting period? Enter 'Y' for yes or 'N' for no in column 2. If column 2 is 'Y', complete Wkst. E-4. If column 2 is 'N', complete Wkst. D, Part III & IV and D-2, Pt. II, if applicable.	N			57
58	If line 56 is yes, did this facility elect cost reimbursement for physicians' services as defined in CMS Pub 15-1, chapter 21, section 2148? If yes, complete Wkst. D-5.	N			58
59	Are costs claimed on line 100 of Worksheet A? If yes, complete Wkst. D-2, Pt. I.	N			59
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
----	--	---	--	--	----

HARRISBURG MEDICAL CENTER, INC. Provider CCN: 14-0210	In Lieu of Form CMS-2552-10	Period : From: 07/01/2015 To: 06/30/2016	Run Date: 11/19/2016 Run Time: 10:33 Version: 2016.05 (11/01/2016)
--	--------------------------------	--	--

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, indicate which program year began during this cost reporting period. (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, indicate which program year began during this cost reporting period. (see instructions)				76

Long Term Care Hospital PPS

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

TEFRA Providers

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

HARRISBURG MEDICAL CENTER, INC. Provider CCN: 14-0210	In Lieu of Form CMS-2552-10	Period : From: 07/01/2015 To: 06/30/2016	Run Date: 11/19/2016 Run Time: 10:33 Version: 2016.05 (11/01/2016)
--	--------------------------------	--	--

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA

WORKSHEET S-2  
PART I

Title V and XIX Services		V	XIX	
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/IID facility for purposes of title V and XIX? Enter 'Y' for yes or 'N' for no in the applicable column.	N	N	93
94	Does title V or title XIX reduce capital cost? Enter 'Y' for yes or 'N' for no in the applicable column.	N	N	94
95	If line 94 is 'Y', enter the reduction percentage in the applicable column.			95
96	Does title V or title XIX reduce operating cost? Enter 'Y' for yes or 'N' for no in the applicable column.	N	N	96
97	If line 96 is 'Y', enter the reduction percentage in the applicable column.			97

Rural Providers

		1	2			
105	Does this hospital qualify as a critical access hospital (CAH)?	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)			107		
108	Is this a rural hospital qualifying for an exception to the CRNA fee schedule? See 42 CFR §412.113(c). Enter 'Y' for yes or 'N' for no.	N		108		
109	If this hospital qualifies as a CAH or a cost provider, are therapy services provided by outside supplier? Enter 'Y' for yes or 'N' for each therapy.	Physical N	Occupational N	Speech N	Respiratory N	109
110	Did this hospital participate in the Rural Community Hospital Demonstration project (410A Demo) for the current cost reporting period? Enter 'Y' for yes or 'N' for no.			N		110

Miscellaneous Cost Reporting Information

115	Is this an all-inclusive rate provider? Enter 'Y' for yes or 'N' for no in column 1. If column 1 is yes, enter the method used (A, B, or E only) in column 2. If column 2 is 'E', enter in column 3 either '93' percent for short term hospital or '98' percent for long term care (includes psychiatric, rehabilitation and long term hospitals providers) based on the definition in CMS Pub. 15-I, chapter 22, section 2208.1.	N				115
116	Is this facility classified as a referral center? Enter 'Y' for yes or 'N' for no.	N				116
117	Is this facility legally required to carry malpractice insurance? Enter 'Y' for yes or 'N' for no.	Y				117
118	Is the malpractice insurance a claims-made or occurrence policy? Enter 1 if the policy is claim-made. Enter 2 if the policy is occurrence.	2				118
118.01	List amounts of malpractice premiums and paid losses:	Premiums 320,370	Paid Losses 36,508	Self Insurance		118.01
118.02	Are malpractice premiums and paid losses reported in a cost center other than the Administrative and General cost center? If yes, submit supporting schedule listing cost centers and amounts contained therein.	N				118.02
120	Is this a SCH or EACH that qualifies for the Outpatient Hold Harmless provision in ACA §3121 and applicable amendments? (see instructions). Enter in column 1 'Y' for yes or 'N' for no. Is this a rural hospital with < 100 beds that qualifies for the Outpatient Hold Harmless provision in ACA §3121 and applicable amendments? (see instructions). Enter in column 2 'Y' for yes or 'N' for no.		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
122	Does the cost report contain state health or similar taxes? Enter 'Y' for yes or 'N' for no in column 1. If column 1 is 'Y', enter in column 2 the Worksheet A line number where these taxes are included.	N				122

Transplant Center Information

125	Does this facility operate a transplant center? Enter 'Y' for yes or 'N' for no. If yes, enter certification date(s)(mm/dd/yyyy) below.	N				125
126	If this is a Medicare certified kidney transplant center enter the certification date in column 1 and termination date, if applicable in column 2.					126
127	If this is a Medicare certified heart transplant center enter the certification date in column 1 and termination date, if applicable in column 2.					127
128	If this is a Medicare certified liver transplant center enter the certification date in column 1 and termination date, if applicable in column 2.					128
129	If this is a Medicare certified lung transplant center enter the certification date in column 1 and termination date, if applicable in column 2.					129
130	If this is a Medicare 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

HARRISBURG MEDICAL CENTER, INC. Provider CCN: 14-0210	In Lieu of Form CMS-2552-10	Period : From: 07/01/2015 To: 06/30/2016	Run Date: 11/19/2016 Run Time: 10:33 Version: 2016.05 (11/01/2016)
--	--------------------------------	--	--

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA

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
-----	--	--------	---	-----

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

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

		Title XVIII		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.	N				167
168	If this provider is a CAH (line 105 is 'Y') and is a meaningful user (line 167 is 'Y'), enter the reasonable cost incurred for the HIT assets. (see instructions)					168
168.01	If this provider is a CAH and is not a meaningful user, does this provider qualify for a hardship exception under §413.70(a)(6)(ii)? Enter 'Y' for yes or 'N' for no. (see instructions)					168.01
169	If this provider is a meaningful user (line 167 is 'Y') and is not a CAH (line 105 is 'N'), enter the transition factor. (see instructions)					169
170	Enter in columns 1 and 2 the EHR beginning date and ending date for the reporting period respectively (mm/dd/yyyy)					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)				N	171

HARRISBURG MEDICAL CENTER, INC. Provider CCN: 14-0210	In Lieu of Form CMS-2552-10	Period : From: 07/01/2015 To: 06/30/2016	Run Date: 11/19/2016 Run Time: 10:33 Version: 2016.05 (11/01/2016)
--	--------------------------------	--	--

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		6
7	Are costs claimed for allied health programs? If yes, see instructions.	N		7
8	Were nursing school and/or allied health programs approved and/or renewed during the cost reporting period?	N		8
9	Are costs claimed for Interns and Residents in approved GME programs claimed on the current cost report? If yes, see instructions.	N		9
10	Was an approved Intern and Resident GME program initiated or renewed in the current cost reporting period? If yes, see instructions.	N		10
11	Are GME costs directly assigned to cost centers other than I & R in an Approved Teaching Program on Worksheet A? If yes, see instructions.	N		11

Bad Debts		Y/N	
		1	2
12	Is the provider seeking reimbursement for bad debts? If yes, see instructions.	Y	12
13	If line 12 is yes, did the provider's bad debt collection policy change during this cost reporting period? If yes, submit copy.	N	13
14	If line 12 is yes, were patient deductibles and/or co-payments waived? If yes, see instructions.	N	14

Bed Complement		Y/N	
		1	2
15	Did total beds available change from the prior cost reporting period? If yes, see instructions.	Y	15

		Part A		Part B	
		Y/N	Date	Y/N	Date
PS&R Report Data		1	2	3	4
16	Was the cost report prepared using the PS&R Report only? If either column 1 or 3 is yes, enter the paid-through date of the PS&R Report used in columns 2 and 4. (see instructions)	N		N	
17	Was the cost report prepared using the PS&R Report for totals and the provider's records for allocation? If either column 1 or 3 is yes, enter the paid-through date in columns 2 and 4. (see instructions)	Y	10/25/2016	Y	10/25/2016
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: 07/01/2015 To: 06/30/2016	Run Date: 11/19/2016 Run Time: 10:33 Version: 2016.05 (11/01/2016)
--	--------------------------------	--	--

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
42	Employer: KERBER, ECK & BRAECKEL LLP		
43	Phone number: 618-529-1040	E-mail Address: MARKD@KEBCPA.COM	

HARRISBURG MEDICAL CENTER, INC. Provider CCN: 14-0210	In Lieu of Form CMS-2552-10	Period : From: 07/01/2015 To: 06/30/2016	Run Date: 11/19/2016 Run Time: 10:33 Version: 2016.05 (11/01/2016)
--	--------------------------------	--	--

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	16,836			2,426	716	4,063	1
2	HMO and other (see instructions)						438			2
3	HMO IPF Subprovider						53			3
4	HMO IRF Subprovider									4
5	Hospital Adults & Peds. Swing Bed SNF						144			5
6	Hospital Adults & Peds. Swing Bed NF									6
7	Total Adults & Peds. (exclude observation beds) (see instructions)		46	16,836			2,570	716	4,251	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	16,836			2,570	716	4,251	14
15	CAH Visits									15
16	Subprovider - IPF	40	30	10,980			3,223	4,906	9,892	16
17	Subprovider - IRF	41								17
18	Subprovider I	42								18
19	Skilled Nursing Facility	44								19
20	Nursing Facility	45								20
21	Other Long Term Care	46								21
22	Home Health Agency	101					2,032		4,275	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					4,071		17,839	26
26.01	RHC II	88.01					462		2,424	26.01
27	Total (sum of lines 14-26)		76							27
28	Observation Bed Days								2,086	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: 07/01/2015 To: 06/30/2016	Run Date: 11/19/2016 Run Time: 10:33 Version: 2016.05 (11/01/2016)
--	--------------------------------	--	--

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA

WORKSHEET S-3  
PART I

	Component	Full Time Equivalents			DISCHARGES				
		Total Interns & Residents 9	Employees On Payroll 10	Nonpaid Workers 11	Title V 12	Title XVIII 13	Title XIX 14	Total All Patients 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)					863	323	1,546	1
2	HMO and other (see instructions)					131			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)		386.25			863	323	1,546	14
15	CAH Visits								15
16	Subprovider - IPF		61.85			366	794	1,462	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		12.55						22
23	ASC (Distinct Part)								23
24	Hospice (Distinct Part)								24
24.10	Hospice (non-distinct part)								24.10
25	CMHC								25
26	RHC		26.93						26
26.01	RHC II		3.15						26.01
27	Total (sum of lines 14-26)		490.73						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: 07/01/2015 To: 06/30/2016	Run Date: 11/19/2016 Run Time: 10:33 Version: 2016.05 (11/01/2016)
--	--------------------------------	--	--

HOSPITAL WAGE INDEX INFORMATION

WORKSHEET S-3  
PARTS II-III

Part II - Wage Data

		Wkst A Line No.	Amount Reported	Reclassif- ication of Salaries (from Worksheet A-6)	Adjusted Salaries (column 2 ± column 3)	Paid Hours Related to Salaries in Column 4	Average Hourly wage (column 4 ± column 5)	
		1	2	3	4	5	6	
<b>SALARIES</b>								
1	Total salaries (see instructions)	200	22,914,549		22,914,549	1,022,731.00	22.41	1
2	Non-physician anesthetist Part A							2
3	Non-physician anesthetist Part B		742,492		742,492	6,670.00	111.32	3
4	Physician-Part A - Administrative							4
4.01	Physician-Part A - Teaching							4.01
5	Physician-Part B		2,692,491		2,692,491	28,258.00	95.28	5
6	Non-physician-Part B		942,961	-105,078	837,883	44,627.00	18.78	6
7	Interns & residents (in an approved program)	21						7
7.01	Contracted interns & residents (in an approved program)							7.01
8	Home office personnel							8
9	SNF	44						9
10	Excluded area salaries (see instructions)		3,804,411	-100,075	3,704,336	165,450.00	22.39	10
<b>OTHER WAGES &amp; RELATED COSTS</b>								
11	Contract labor (see instructions)		265,301		265,301	2,926.00	90.67	11
12	Contract management and administrative services							12
13	Contract labor: Physician-Part A - Administrative							13
14	Home office salaries & wage-related costs							14
15	Home office: Physician Part A - Administrative							15
16	Home office & Contract Physicians Part A - Teaching							16
<b>WAGE-RELATED COSTS</b>								
17	Wage-related costs (core)(see instructions)		5,897,229		5,897,229			17
18	Wage-related costs (other)(see instructions)							18
19	Excluded areas		1,462,463		1,462,463			19
20	Non-physician anesthetist Part A							20
21	Non-physician anesthetist Part B		293,134		293,134			21
22	Physician Part A - Administrative							22
22.01	Physician Part A - Teaching							22.01
23	Physician Part B		1,062,989		1,062,989			23
24	Wage-related costs (RHC/FQHC)		330,794		330,794			24
25	Interns & residents (in an approved program)							25
<b>OVERHEAD COSTS - DIRECT SALARIES</b>								
26	Employee Benefits Department							26
27	Administrative & General		3,210,698	53,473	3,264,171	141,872.00	23.01	27
28	Administrative & General under contract (see instructions)		133,538		133,538	2,841.00	47.00	28
29	Maintenance & Repairs							29
30	Operation of Plant		478,059		478,059	29,350.00	16.29	30
31	Laundry & Linen Service		59,002		59,002	5,071.00	11.64	31
32	Housekeeping		586,503		586,503	49,202.00	11.92	32
33	Housekeeping under contract (see instructions)							33
34	Dietary		613,079		613,079	47,336.00	12.95	34
35	Dietary under contract (see instructions)							35
36	Cafeteria							36
37	Maintenance of Personnel							37
38	Nursing Administration		105,978		105,978	4,161.00	25.47	38
39	Central Services and Supply		212,790		212,790	17,288.00	12.31	39
40	Pharmacy		596,091		596,091	13,426.00	44.40	40
41	Medical Records & Medical Records Library		537,337		537,337	33,696.00	15.95	41
42	Social Service							42
43	Other General Service							43

Part III - Hospital Wage Index Summary

1	Net salaries (see instructions)		18,670,143	105,078	18,775,221	946,017.00	19.85	1
2	Excluded area salaries (see instructions)		3,804,411	-100,075	3,704,336	165,450.00	22.39	2
3	Subtotal salaries (line 1 minus line 2)		14,865,732	205,153	15,070,885	780,567.00	19.31	3
4	Subtotal other wages & related costs (see instructions)		265,301		265,301	2,926.00	90.67	4
5	Subtotal wage-related costs (see instructions)		5,897,229		5,897,229		39.13%	5
6	Total (sum of lines 3 through 5)		21,028,262	205,153	21,233,415	783,493.00	27.10	6
7	Total overhead cost (see instructions)		6,533,075	53,473	6,586,548	344,243.00	19.13	7

HARRISBURG MEDICAL CENTER, INC. Provider CCN: 14-0210	In Lieu of Form CMS-2552-10	Period : From: 07/01/2015 To: 06/30/2016	Run Date: 11/19/2016 Run Time: 10:33 Version: 2016.05 (11/01/2016)
--	--------------------------------	--	--

HOSPITAL WAGE RELATED COSTS

WORKSHEET S-3  
PART IV

Part IV - Wage Related Cost

Part A - Core List

		Amount Reported	
	<b>RETIREMENT COST</b>		
1	401K Employer Contributions		1
2	Tax Sheltered Annuity (TSA) Employer Contribution	707,709	2
3	Nonqualified Defined Benefit Plan Cost (see instructions)		3
4	Qualified Defined Benefit Plan Cost (see instructions)		4
	<b>PLAN ADMINISTRATIVE COSTS (Paid to External Organization):</b>		
5	401k/TSA Plan Administration Fees		5
6	Legal/Accounting/Management Fees-Pension Plan		6
7	Employee Managed Care Program Administration Fees		7
	<b>HEALTH AND INSURANCE COST</b>		
8	Health Insurance (Purchased or Self Funded)	6,007,254	8
9	Prescription Drug Plan		9
10	Dental, Hearing and Vision Plan	48,249	10
11	Life Insurance (If employee is owner or beneficiary)	38,027	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	254,826	15
16	Retirement Health Care Cost (Only current year, not the extraordinary accrual required by FASB 106. Non cumulative portion)		16
	<b>TAXES</b>		
17	FICA-Employers Portion Only	1,392,945	17
18	Medicare Taxes - Employers Portion Only	325,769	18
19	Unemployment Insurance		19
20	State or Federal Unemployment Taxes	245,766	20
	<b>OTHER</b>		
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	26,064	23
24	Total Wage Related cost (Sum of lines 1-23)	9,046,609	24

Part B - Other Than Core Related Cost

25	OTHER WAGE RELATED COSTs (SPECIFY)	26,064	25
----	------------------------------------	--------	----

HARRISBURG MEDICAL CENTER, INC. Provider CCN: 14-0210	In Lieu of Form CMS-2552-10	Period : From: 07/01/2015 To: 06/30/2016	Run Date: 11/19/2016 Run Time: 10:33 Version: 2016.05 (11/01/2016)
--	--------------------------------	--	--

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	265,301		1
2	Hospital	102,149		2
3	Subprovider - IPF	163,152		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: 07/01/2015 To: 06/30/2016	Run Date: 11/19/2016 Run Time: 10:33 Version: 2016.05 (11/01/2016)
--	--------------------------------	--	--

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)		157.00			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 1	Contract 2	Total 3	
3	Administrator and Assistant Administrator(s)				3
4	Director(s) and Assistant Director(s)		1.06		1.06
5	Other Administrative Personnel				5
6	Direct Nursing Service		6.19		6.19
7	Nursing Supervisor		1.54		1.54
8	Physical Therapy Service		1.62		1.62
9	Physical Therapy Supervisor				9
10	Occupational Therapy Service		0.07		0.07
11	Occupational Therapy Supervisor				11
12	Speech Pathology Service		0.05		0.05
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		LUPA Episodes	PEP only Episodes	Total (columns 1 through 4)	
		Without Outliers	With Outliers				
		1	2	3	4	5	
21	Skilled Nursing Visits	886		71	21	978	21
22	Skilled Nursing Visit Charges	202,008		16,188	4,788	222,984	22
23	Physical Therapy Visits	944		21	12	977	23
24	Physical Therapy Visit Charges	216,176		4,809	2,748	223,733	24
25	Occupational Therapy Visits	36		1		37	25
26	Occupational Therapy Visit Charges	8,892		247		9,139	26
27	Speech Pathology Visits	40				40	27
28	Speech Pathology Visit Charges	9,880				9,880	28
29	Medical Social Service Visits						29
30	Medical Social Service Visit Charges						30
31	Home Health Aide Visits						31
32	Home Health Aide Visit Charges						32
33	Total visits (sum of lines 21, 23, 25, 27, 29, and 31)	1,906		93	33	2,032	33
34	Other Charges						34
35	Total Charges (sum of lines 22, 24, 26, 28, 30, 32 and 34)	436,956		21,244	7,536	465,736	35
36	Total Number of Episodes (standard/non-outlier)	150		35	4	189	36
37	Total Number of Outlier Episodes						37
38	Total Non-Routine Medical Supply Charges	16,037		3,309	589	19,935	38

HARRISBURG MEDICAL CENTER, INC. Provider CCN: 14-0210	In Lieu of Form CMS-2552-10	Period : From: 07/01/2015 To: 06/30/2016	Run Date: 11/19/2016 Run Time: 10:33 Version: 2016.05 (11/01/2016)
--	--------------------------------	--	--

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				16
17	RVA				17
18	RHC				18
19	RHB		20	20	19
20	RHA		22	22	20
21	RMC		11	11	21
22	RMB				22
23	RMA				23
24	RLB				24
25	RLA				25
26	ES3				26
27	ES2				27
28	ES1		7	7	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		9	9	40
41	LC2				41
42	LC1				42
43	LB2				43
44	LB1				44
45	CE2				45
46	CE1				46
47	CD2				47
48	CD1		12	12	48
49	CC2				49
50	CC1		12	12	50
51	CB2				51
52	CB1		23	23	52
53	CA2		4	4	53
54	CA1				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: 07/01/2015 To: 06/30/2016	Run Date: 11/19/2016 Run Time: 10:33 Version: 2016.05 (11/01/2016)
--	--------------------------------	--	--

PROSPECTIVE PAYMENT FOR SNF STATISTICAL DATA

WORKSHEET S-7

	Group	SNF Days	Swing Bed SNF Days	Total (sum of col. 2 + 3)	
	1	2	3	4	
72	PD1				72
73	PC2				73
74	PC1				74
75	PB2				75
76	PB1		24	24	76
77	PA2				77
78	PA1				78
199	AAA				199
200	TOTAL		144	144	200

SNF SERVICES

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

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

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

HARRISBURG MEDICAL CENTER, INC. Provider CCN: 14-0210	In Lieu of Form CMS-2552-10	Period : From: 07/01/2015 To: 06/30/2016	Run Date: 11/19/2016 Run Time: 10:33 Version: 2016.05 (11/01/2016)
--	--------------------------------	--	--

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: 07/01/2015 To: 06/30/2016	Run Date: 11/19/2016 Run Time: 10:33 Version: 2016.05 (11/01/2016)
--	--------------------------------	--	--

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)			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	from	to	
0	1	2	3	4	5	6	7	8	9	10	11	12	13	14	
11	Clinic			0008	0005	0008	0005	0008	0005	0008	0005	0008	0005		11

(1) Enter clinic hours of operation on line 11 and other type operations on subscripts of line 11 (both type and hours of operation). List hours of operation based on a 24 hour clock. For example: 8:00am is 0800, 6:30pm is 1830, and midnight is 2400.

12	Have you received an approval for an exception to the productivity standard?	1 N	2 	12
13	Is this a consolidated cost report as defined in CMS Pub. 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.	N		13
14	Provider name: _____ CCN number: _____			14

	Y/N	V	XVIII	XIX	Total Visits	
	1	2	3	4	5	
15	Have you provided all or substantially all GME cost? Enter 'Y' for yes or 'N' for no in column 1. If yes, enter in columns 2, 3, and 4 the number of program visits performed 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: 07/01/2015 To: 06/30/2016	Run Date: 11/19/2016 Run Time: 10:33 Version: 2016.05 (11/01/2016)
--	--------------------------------	--	--

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)	0.312186	1
---	--	----------	---

Medicaid (see instructions for each line)

2	Net revenue from Medicaid	9,987,875	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	40,057,275	6
7	Medicaid cost (line 1 times line 6)	12,505,320	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.	2,517,445	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 fundnig charity care		17
18	Government grants, appropriations of transfers for support of hospital operations		18
19	Total unreimbursed cost for Medicaid, SCHIP and state and local indigent care programs (sum of lines 8, 12 and 16)	2,517,445	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	631,139	3,696,099	4,327,238	20
21	Cost of initial obligation of patients approved for charity care (line 1 times line 20)	197,033	1,153,870	1,350,903	21
22	Partial payment by patients approved for charity care	4,338	31,074	35,412	22
23	Cost of charity care (line 21 minus line 22)	192,695	1,122,796	1,315,491	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)	882,110	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)	489,534	27
28	Non-Medicare and non-reimbursable Medicare bad debt expense (line 26 minus line 27)	2,805,648	28
29	Cost of non-Medicare and non-reimbursable Medicare bad debt expense (line 1 times line 28)	875,884	29
30	Cost of uncompensated care (line 23, column 3 plus line 29)	2,191,375	30
31	Total unreimbursed and uncompensated care cost (line 19 plus line 30)	4,708,820	31

HARRISBURG MEDICAL CENTER, INC. Provider CCN: 14-0210	In Lieu of Form CMS-2552-10	Period : From: 07/01/2015 To: 06/30/2016	Run Date: 11/19/2016 Run Time: 10:33 Version: 2016.05 (11/01/2016)
--	--------------------------------	--	--

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	
		<b>GENERAL SERVICE COST CENTERS</b>								
1	00100	Cap Rel Costs-Bldg & Fixt		2,610,771	2,610,771	-1,436,851	1,173,920	-11,544	1,162,376	1
2	00200	Cap Rel Costs-Mvble Equip				1,344,541	1,344,541		1,344,541	2
3	00300	Other Cap Rel Costs							-0-	3
4	00400	Employee Benefits Department		9,039,751	9,039,751		9,039,751	-1,631,430	7,408,321	4
5	00500	Administrative & General	3,210,698	5,298,569	8,509,267	-94,243	8,415,024	-2,112,127	6,302,897	5
6	00600	Maintenance & Repairs								6
7	00700	Operation of Plant	478,059	647,850	1,125,909		1,125,909	-23,841	1,102,068	7
8	00800	Laundry & Linen Service	59,002	100,164	159,166		159,166		159,166	8
9	00900	Housekeeping	586,503	116,744	703,247		703,247	-48,965	654,282	9
10	01000	Dietary	613,079	376,201	989,280		989,280	-206,156	783,124	10
11	01100	Cafeteria								11
12	01200	Maintenance of Personnel								12
13	01300	Nursing Administration	105,978	4,849	110,827		110,827	-17,025	93,802	13
14	01400	Central Services & Supply	212,790	247,287	460,077		460,077	-17,080	442,997	14
15	01500	Pharmacy	596,091	28,436	624,527		624,527	-31,444	593,083	15
16	01600	Medical Records & Library	537,337	216,097	753,434		753,434	-130	753,304	16
17	01700	Social Service								17
19	01900	Nonphysician Anesthetists								19
20	02000	Nursing School								20
21	02100	I&R Services-Salary & Fringes Apprvd								21
22	02200	I&R Services-Other Prgm Costs Apprvd								22
23	02300	Paramed Ed Prgm-(specify)								23
		<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>								
30	03000	Adults & Pediatrics	2,930,252	2,187,457	5,117,709		5,117,709	-1,930,776	3,186,933	30
40	04000	Subprovider - IPF	2,753,728	574,984	3,328,712		3,328,712	-242,263	3,086,449	40
		<b>ANCILLARY SERVICE COST CENTERS</b>								
50	05000	Operating Room	511,680	358,799	870,479	-775,902	94,577	138	94,715	50
53	05300	Anesthesiology	742,492	43,547	786,039		786,039	-742,492	43,547	53
54	05400	Radiology-Diagnostic	439,060	182,082	621,142	112,453	733,595		733,595	54
57	05700	CT Scan	197,477	64,221	261,698		261,698	26	261,724	57
60	06000	Laboratory	836,744	1,459,693	2,296,437	54,350	2,350,787		2,350,787	60
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS								62.30
64	06400	Intravenous Therapy	25,378	99,818	125,196		125,196		125,196	64
65	06500	Respiratory Therapy	585,885	106,166	692,051		692,051	-9,345	682,706	65
66	06600	Physical Therapy	831,746	74,239	905,985		905,985	272	906,257	66
69	06900	Electrocardiology	89,114	233,206	322,320		322,320	-191,970	130,350	69
71	07100	Medical Supplies Charged to Patients		1,577,337	1,577,337		1,577,337		1,577,337	71
72	07200	Impl. Dev. Charged to Patients				779,027	779,027		779,027	72
73	07300	Drugs Charged to Patients		3,079,804	3,079,804		3,079,804		3,079,804	73
75	07500	ASC (Non-Distinct Part)	503,675	105,359	609,034		609,034	184	609,218	75
76	03450	NUCLEAR MEDICINE	147,684	264,891	412,575		412,575		412,575	76
76.01	03630	ULTRASOUND	221,004	27,743	248,747		248,747		248,747	76.01
76.02	03440	MAMMOGRAPHY	64,770	65,306	130,076		130,076		130,076	76.02
76.03	03951	CARDIAC REHABILITATION								76.03
76.04	03190	FAITH CENTER CHEMOTHERAPY	141,173	7,971	149,144		149,144		149,144	76.04
76.06	03950	ROUTINE ANCILLARY								76.06
76.97	07697	CARDIAC REHABILITATION	87,787	24,529	112,316		112,316	-21,366	90,950	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY								76.98
76.99	07699	LITHOTRIPSY								76.99
		<b>OUTPATIENT SERVICE COST CENTERS</b>								
88	08800	Rural Health Clinic	1,766,258	262,003	2,028,261	66,697	2,094,958	-21,784	2,073,174	88
88.01	08801	RHC II	204,562	57,004	261,566		261,566		261,566	88.01
91	09100	Emergency	2,288,031	1,029,001	3,317,032	-3,125	3,313,907	-2,078,606	1,235,301	91
92	09200	Observation Beds (Non-Distinct Part)								92
93	04950	DAY PSYCHIATRIC	95,829	2,238	98,067		98,067		98,067	93
		<b>OTHER REIMBURSABLE COST CENTERS</b>								
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	521,813	77,768	599,581	-46,059	553,522	-45	553,477	101
		<b>SPECIAL PURPOSE COST CENTERS</b>								
118		SUBTOTALS (sum of lines 1-117)	22,385,679	30,651,885	53,037,564	888	53,038,452	-9,337,769	43,700,683	118
		<b>NONREIMBURSABLE COST CENTERS</b>								
190	19000	Gift, Flower, Coffee Shop & Canteen	88,155	170,256	258,411		258,411		258,411	190
192	19200	Physicians' Private Offices	389,032	260,225	649,257	-21,479	627,778		627,778	192
192.01	19201	DIALYSIS								192.01
192.02	19203	GALATIA CLINIC	51,683	8,694	60,377	20,591	80,968		80,968	192.02
192.03	19202	ORTHO CLINIC								192.03
200		TOTAL (sum of lines 118-199)	22,914,549	31,091,060	54,005,609		54,005,609	-9,337,769	44,667,840	200

HARRISBURG MEDICAL CENTER, INC. Provider CCN: 14-0210	In Lieu of Form CMS-2552-10	Period : From: 07/01/2015 To: 06/30/2016	Run Date: 11/19/2016 Run Time: 10:33 Version: 2016.05 (11/01/2016)
--	--------------------------------	--	--

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		1,274,681	1
2			Home Health Agency	101		7,414	2
3			Administrative & General	5		26,670	3
4			Rural Health Clinic	88		211,584	4
5			Physicians' Private Offices	192		25,123	5
6			GALATIA CLINIC	192.02		20,591	6
500	Total reclassifications					1,566,063	500
	Code Letter - A						
1	IMPLANTABLE SUPPLIES	B	Impl. Dev. Charged to Patient	72		779,027	1
2							2
500	Total reclassifications					779,027	500
	Code Letter - B						
1	HHA BILER	C	Administrative & General	5		53,473	1
500	Total reclassifications					53,473	500
	Code Letter - C						
1	INSURANCE	D	Cap Rel Costs-Bldg & Fixt	1		129,212	1
2			Cap Rel Costs-Mvble Equip	2		69,860	2
500	Total reclassifications					199,072	500
	Code Letter - D						
1	RHC LAB	E	Laboratory	60		50,239	1
2							2
500	Total reclassifications					50,239	500
	Code Letter - E						
1	RADIOLOGY	F	Radiology-Diagnostic	54		101,441	1
2							2
500	Total reclassifications					101,441	500
	Code Letter - F						
1	EPC APARTMENT	G	Administrative & General	5		24,686	1
500	Total reclassifications					24,686	500
	Code Letter - G						
1	RHC BUILDING EXPENSE	H	Laboratory	60		4,111	1
2			Radiology-Diagnostic	54		11,012	2
500	Total reclassifications					15,123	500
	Code Letter - H						
	GRAND TOTAL (Increases)					205,153	2,583,971

(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: 07/01/2015 To: 06/30/2016	Run Date: 11/19/2016 Run Time: 10:33 Version: 2016.05 (11/01/2016)
--	--------------------------------	--	--

RECLASSIFICATIONS

WORKSHEET A-6

		DECREASES						
	EXPLANATION OF RECLASSIFICATION(S)	CODE (1)	COST CENTER	LINE #	SALARY	OTHER	Wkst A-7 Ref.	
		1	6	7	8	9	10	
1	DEPRECIATION	A	Cap Rel Costs-Bldg & Fixt	1		1,274,681	9	1
2			Cap Rel Costs-Bldg & Fixt	1		7,414	9	2
3			Cap Rel Costs-Bldg & Fixt	1		26,670	9	3
4			Cap Rel Costs-Bldg & Fixt	1		211,584	9	4
5			Cap Rel Costs-Bldg & Fixt	1		25,123	9	5
6			Cap Rel Costs-Bldg & Fixt	1		20,591	9	6
500	Total reclassifications					1,566,063		500
	Code letter - A							
1	IMPLANTABLE SUPPLIES	B	Operating Room	50		775,902		1
2			Emergency	91		3,125		2
500	Total reclassifications					779,027		500
	Code letter - B							
1	HHA BILLER	C	Home Health Agency	101	53,473			1
500	Total reclassifications				53,473			500
	Code letter - C							
1	INSURANCE	D	Administrative & General	5		129,212	12	1
2			Administrative & General	5		69,860	12	2
500	Total reclassifications					199,072		500
	Code letter - D							
1	RHC LAB	E	Rural Health Clinic	88	49,490			1
2			Physicians' Private Offices	192	749			2
500	Total reclassifications				50,239			500
	Code letter - E							
1	RADIOLOGY	F	Rural Health Clinic	88	55,588			1
2			Physicians' Private Offices	192	45,853			2
500	Total reclassifications				101,441			500
	Code letter - F							
1	EPC APARTMENT	G	Rural Health Clinic	88		24,686		1
500	Total reclassifications					24,686		500
	Code letter - G							
1	RHC BUILDING EXPENSE	H	Rural Health Clinic	88		4,111		1
2			Rural Health Clinic	88		11,012		2
500	Total reclassifications					15,123		500
	Code letter - H							
	GRAND TOTAL (Decreases)				205,153	2,583,971		

(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: 07/01/2015 To: 06/30/2016	Run Date: 11/19/2016 Run Time: 10:33 Version: 2016.05 (11/01/2016)
--	--------------------------------	--	--

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	660,437					660,437		1
2	Land Improvements	805,579	36,489		36,489	8,660	833,408		2
3	Buildings and Fixtures	25,568,559	2,874,223		2,874,223	2,522,222	25,920,560		3
4	Building Improvements								4
5	Fixed Equipment								5
6	Movable Equipment	12,252,124	183,677		183,677	1,310,927	11,124,874		6
7	HIT-designated Assets	1,032,011	2,665,114		2,665,114		3,697,125		7
8	Subtotal (sum of lines 1-7)	40,318,710	5,759,503		5,759,503	3,841,809	42,236,404		8
9	Reconciling Items								9
10	Total (line 7 minus line 9)	40,318,710	5,759,503		5,759,503	3,841,809	42,236,404		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	2,178,998		431,773					2,610,771	1
2	Cap Rel Costs-Mvble Equip									2
3	Total (sum of lines 1-2)	2,178,998		431,773					2,610,771	3

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

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

PART III - RECONCILIATION OF CAPITAL COST CENTERS

	Description	COMPUTATION OF RATIOS				ALLOCATION OF OTHER CAPITAL				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	27,414,405		27,414,405	0.649071					1	
2	Cap Rel Costs-Mvble Equ	14,821,999		14,821,999	0.350929					2	
3	Total (sum of lines 1-2)	42,236,404		42,236,404	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	612,935		420,229	129,212				1,162,376	1
2	Cap Rel Costs-Mvble Equip	1,274,681			69,860				1,344,541	2
3	Total (sum of lines 1-2)	1,887,616		420,229	199,072				2,506,917	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: 07/01/2015 To: 06/30/2016	Run Date: 11/19/2016 Run Time: 10:33 Version: 2016.05 (11/01/2016)
--	--------------------------------	--	--

ADJUSTMENTS TO EXPENSES

WORKSHEET A-8

		EXPENSE CLASSIFICATION ON WORKSHEET A TO/FROM WHICH THE AMOUNT IS TO BE ADJUSTED				
	DESCRIPTION(1)	BASIS/ CODE (2)	AMOUNT	COST CENTER	LINE#	Wkst. A-7 Ref.
		1	2	3	4	5
1	Investment income-buildings & fixtures (chapter 2)	B	-11,544	Cap Rel Costs-Bldg & Fixt	1	11
2	Investment income-movable equipment (chapter 2)			Cap Rel Costs-Mvble Equip	2	2
3	Investment income-other (chapter 2)					3
4	Trade, quantity, and time discounts (chapter 8)	B	-3,802	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	-4,446,951			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	-113,122	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	-130	Medical Records & Library	16	18
19	Nursing school (tuition,fees,books,etc.)					19
20	Vending machines	B	-5,707	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	LIFELINE	A	-45	Home Health Agency	101	33
34	PHYSICIAN RECRUITMENT	A	-31,043	Administrative & General	5	34
34.01	PHYSICIAN LOANS	A	-96,105	Administrative & General	5	34.01
35	CRNA WAGES	A	-742,492	Anesthesiology	53	35
35.01	CRNA BENEFITS	A	-293,136	Employee Benefits Department	4	35.01
36	PHYSICIAN BENEFITS	A	-477,188	Employee Benefits Department	4	36
37						37
38	ER PHYSICIAN MISC. EXPENSE	A	-25,261	Emergency	91	38
39						39
40						40
41						41
42	OTHER INCOME	B	-80,882	Administrative & General	5	42
43	MEDICAID ASSESSMENT	A	-1,550,780	Administrative & General	5	43
44						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	-9,135	Administrative & General	5	45.20
45.21	PHYSICIAN BILLING FRINGE BENEFIT	A	-3,607	Employee Benefits Department	4	45.21
45.22	DONATED MEALS	A	-93,034	Dietary	10	45.22
45.24	COMM RELATIONS	A	-41,770	Administrative & General	5	45.24
45.26	IHA LOBBYING	A	-18,049	Administrative & General	5	45.26
45.27	AHA LOBBYING	A	-3,974	Administrative & General	5	45.27
45.28	ADVERTISING	A	-115,933	Administrative & General	5	45.28
45.32	MISC INCOME	A	-2,275	Respiratory Therapy	65	45.32
45.34	HR DUES	A	-450	Employee Benefits Department	4	45.34
45.35	OTHER ADMIN DUES	A	-2,425	Administrative & General	5	45.35
45.38	INSURANCE SETTLEMENTS	A	-36,508	Administrative & General	5	45.38
45.39	IHREF CONTRIBUTION EXPENSE	A	-8,730	Administrative & General	5	45.39

HARRISBURG MEDICAL CENTER, INC. Provider CCN: 14-0210	In Lieu of Form CMS-2552-10	Period : From: 07/01/2015 To: 06/30/2016	Run Date: 11/19/2016 Run Time: 10:33 Version: 2016.05 (11/01/2016)
--	--------------------------------	--	--

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
45.40	LLC OVERHEAD FRINGE BENEFIT	A	-857,049	Employee Benefits Department	4	45.40
45.41	LLC OVERHEAD A&G	A	-107,284	Administrative & General	5	45.41
45.42	LLC OVERHEAD PLANT	A	-23,903	Operation of Plant	7	45.42
45.43	LLC OVERHEAD HOUSEKEEPING	A	-48,965	Housekeeping	9	45.43
45.44	LLC OVERHEAD NURSING ADMIN	A	-17,025	Nursing Administration	13	45.44
45.45	LLC OVERHEAD CENTRAL SUPPLY	A	-17,080	Central Services & Supply	14	45.45
45.46	LLC OVERHEAD PHARMACY	A	-31,444	Pharmacy	15	45.46
45.47	LLC OVERHEAD RHC I	A	-21,784	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)		-9,337,769			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: 07/01/2015 To: 06/30/2016	Run Date: 11/19/2016 Run Time: 10:33 Version: 2016.05 (11/01/2016)
--	--------------------------------	--	--

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: 07/01/2015 To: 06/30/2016	Run Date: 11/19/2016 Run Time: 10:33 Version: 2016.05 (11/01/2016)
--	--------------------------------	--	--

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	311,645		311,645	181,300	796	69,382	3,469	1
2	40	Subprovider - IPF SALARIED-DR				181,300				2
3	91	Emergency SALARIED-DR	1,248,683	1,208,683	40,000	211,500	325	33,047	1,652	3
4	60	Laboratory MEDICAL FEES	6,000		6,000	260,300	60	7,509	375	4
5	69	Electrocardiology MEDICAL FEES	191,970	191,970						5
6	76.97	CARDIAC REHABILITATI MEDICAL FEES DI	21,366	21,366						6
7	91	Emergency MEDICAL FEES #4	837,870	837,870		211,500				7
8	30	Adults & Pediatrics HOSPITALISTS ME	1,921,579	1,921,571		211,500				8
9	30	Adults & Pediatrics HOSPITALISTS PU				211,500				9
10	65	Respiratory Therapy RESP THER MEDIC	7,070	7,070						10
11	30	Adults & Pediatrics HOSPITALISTS -	27,500		27,500	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	4,573,683	4,188,530	385,145		1,361	128,241	6,411	200

HARRISBURG MEDICAL CENTER, INC. Provider CCN: 14-0210	In Lieu of Form CMS-2552-10	Period : From: 07/01/2015 To: 06/30/2016	Run Date: 11/19/2016 Run Time: 10:33 Version: 2016.05 (11/01/2016)
--	--------------------------------	--	--

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					69,382	242,263	242,263	1
2	40	Subprovider - IPF SALARIED-DR								2
3	91	Emergency SALARIED-DR					33,047	6,953	1,215,636	3
4	60	Laboratory MEDICAL FEES					7,509			4
5	69	Electrocardiology MEDICAL FEES							191,970	5
6	76.97	CARDIAC REHABILITATI MEDICAL FEES DI							21,366	6
7	91	Emergency MEDICAL FEES #4							837,870	7
8	30	Adults & Pediatrics HOSPITALISTS ME							1,921,579	8
9	30	Adults & Pediatrics HOSPITALISTS PU								9
10	65	Respiratory Therapy RESP THER MEDIC							7,070	10
11	30	Adults & Pediatrics HOSPITALISTS -					18,303	9,197	9,197	11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
200		TOTAL					128,241	258,413	4,446,951	200

HARRISBURG MEDICAL CENTER, INC. Provider CCN: 14-0210	In Lieu of Form CMS-2552-10	Period : From: 07/01/2015 To: 06/30/2016	Run Date: 11/19/2016 Run Time: 10:33 Version: 2016.05 (11/01/2016)
--	--------------------------------	--	--

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	
	<b>GENERAL SERVICE COST CENTERS</b>							
1	Cap Rel Costs-Bldg & Fixt	1,162,376	1,162,376					1
2	Cap Rel Costs-Mvble Equip	1,344,541		1,344,541				2
4	Employee Benefits Department	7,408,321	8,536	11,269	7,428,126			4
5	Administrative & General	6,302,897	202,887	461,843	1,058,144	8,025,771	8,025,771	5
6	Maintenance & Repairs							6
7	Operation of Plant	1,102,068	43,464	11,061	154,970	1,311,563	287,274	7
8	Laundry & Linen Service	159,166	21,229	9,083	19,126	208,604	45,691	8
9	Housekeeping	654,282	5,435	1,774	190,124	851,615	186,531	9
10	Dietary	783,124	24,697	7,884	198,739	1,014,444	222,196	10
11	Cafeteria		14,147			14,147	3,099	11
12	Maintenance of Personnel							12
13	Nursing Administration	93,802		141	34,354	128,297	28,101	13
14	Central Services & Supply	442,997	9,511	6,139	68,979	527,626	115,567	14
15	Pharmacy	593,083	18,623	54,029	193,232	858,967	188,141	15
16	Medical Records & Library	753,304	12,996	30,870	174,186	971,356	212,758	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
	<b>INPATIENT ROUTINE SERV COST CENTERS</b>							
30	Adults & Pediatrics	3,186,933	160,285	94,777	949,888	4,391,883	961,948	30
40	Subprovider - IPF	3,086,449	150,135	13,144	892,665	4,142,393	907,317	40
	<b>ANCILLARY SERVICE COST CENTERS</b>							
50	Operating Room	94,715	99,285	126,863	165,869	486,732	106,610	50
53	Anesthesiology	43,547		16,643	240,691	300,881	65,903	53
54	Radiology-Diagnostic	733,595	63,622	147,698	175,212	1,120,127	245,344	54
57	CT Scan	261,724	7,257	67,627	64,015	400,623	87,749	57
60	Laboratory	2,350,787	37,166	47,182	287,530	2,722,665	596,351	60
62.30	<b>BLOOD CLOTTING FOR HEMOPHILIACS</b>							62.30
64	Intravenous Therapy	125,196			8,227	133,423	29,224	64
65	Respiratory Therapy	682,706	14,802	26,308	189,924	913,740	200,138	65
66	Physical Therapy	906,257	70,160	14,574	269,624	1,260,615	276,115	66
69	Electrocardiology	130,350	9,655	8,162	28,888	177,055	38,781	69
71	Medical Supplies Charged to Patients	1,577,337				1,577,337	345,487	71
72	Impl. Dev. Charged to Patients	779,027				779,027	170,632	72
73	Drugs Charged to Patients	3,079,804				3,079,804	674,576	73
75	ASC (Non-Distinct Part)	609,218	66,275	42,243	163,274	881,010	192,969	75
76	NUCLEAR MEDICINE	412,575	6,218	60,362	47,874	527,029	115,436	76
76.01	ULTRASOUND	248,747	8,041	2,929	71,642	331,359	72,578	76.01
76.02	MAMMOGRAPHY	130,076	4,844	33,148	20,996	189,064	41,411	76.02
76.03	CARDIAC REHABILITATION							76.03
76.04	FAITH CENTER CHEMOTHERAPY	149,144	14,914	1,287	45,763	211,108	46,239	76.04
76.06	ROUTINE ANCILLARY							76.06
76.97	CARDIAC REHABILITATION	90,950	8,424	7,144	28,458	134,976	29,564	76.97
76.98	HYPERBARIC OXYGEN THERAPY							76.98
76.99	LITHOTRIPSY							76.99
	<b>OUTPATIENT SERVICE COST CENTERS</b>							
88	Rural Health Clinic	2,073,174			538,498	2,611,672	572,040	88
88.01	RHC II	261,566			66,312	327,878	71,816	88.01
91	Emergency	1,235,301	31,076	40,357	741,702	2,048,436	448,673	91
92	Observation Beds (Non-Distinct Part)							92
93	DAY PSYCHIATRIC	98,067	38,365		31,065	167,497	36,687	93
	<b>OTHER REIMBURSABLE COST CENTERS</b>							
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	553,477			151,820	705,297	154,483	101
	<b>SPECIAL PURPOSE COST CENTERS</b>							
118	SUBTOTALS (sum of lines 1-117)	43,700,683	1,152,049	1,344,541	7,271,791	43,534,021	7,777,429	118
	<b>NONREIMBURSABLE COST CENTERS</b>							
190	Gift, Flower, Coffee Shop & Canteen	258,411	10,327		28,577	297,315	65,121	190
192	Physicians' Private Offices	627,778			111,004	738,782	161,817	192
192.01	DIALYSIS							192.01
192.02	GALATIA CLINIC	80,968			16,754	97,722	21,404	192.02
192.03	ORTHO CLINIC							192.03
200	Cross Foot Adjustments							200
201	Negative Cost Centers							201
202	TOTAL (sum of lines 118-201)	44,667,840	1,162,376	1,344,541	7,428,126	44,667,840	8,025,771	202

HARRISBURG MEDICAL CENTER, INC. Provider CCN: 14-0210	In Lieu of Form CMS-2552-10	Period : From: 07/01/2015 To: 06/30/2016	Run Date: 11/19/2016 Run Time: 10:33 Version: 2016.05 (11/01/2016)
--	--------------------------------	--	--

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	
	<b>GENERAL SERVICE COST CENTERS</b>							
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	1,598,837						7
8	Laundry & Linen Service	37,401	291,696					8
9	Housekeeping	9,576		1,047,722				9
10	Dietary	43,512			1,280,152			10
11	Cafeteria	24,925			278,789	320,960		11
12	Maintenance of Personnel							12
13	Nursing Administration			15,959		3,404	175,761	13
14	Central Services & Supply	16,757				4,087		14
15	Pharmacy	32,810		8,536		11,234		15
16	Medical Records & Library	22,897				22,177		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
	<b>INPATIENT ROUTINE SERV COST CENTERS</b>							
30	Adults & Pediatrics	282,394	87,376	380,045	289,546	57,442	39,048	30
40	Subprovider - IPF	264,511	40,091	128,414	327,190	66,163	44,976	40
	<b>ANCILLARY SERVICE COST CENTERS</b>							
50	Operating Room	174,923	25,861	67,176		16,359	11,121	50
53	Anesthesiology					5,745		53
54	Radiology-Diagnostic	112,090	16,373			8,597		54
57	CT Scan	12,786				4,651		57
60	Laboratory	65,480		27,464		24,460		60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
64	Intravenous Therapy							64
65	Respiratory Therapy	26,079	8,454	20,413		11,332		65
66	Physical Therapy	123,609	18,554	22,268		22,677		66
69	Electrocardiology	17,011				2,906		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)	116,766	46,480	73,114		12,369	8,408	75
76	NUCLEAR MEDICINE	10,956				2,990		76
76.01	ULTRASOUND	14,166				3,691		76.01
76.02	MAMMOGRAPHY	8,534				2,019		76.02
76.03	CARDIAC REHABILITATION							76.03
76.04	FAITH CENTER CHEMOTHERAPY	26,276				3,838	2,609	76.04
76.06	ROUTINE ANCILLARY							76.06
76.97	CARDIAC REHABILITATION	14,842				2,935	1,995	76.97
76.98	HYPERBARIC OXYGEN THERAPY							76.98
76.99	LITHOTRIPSY							76.99
	<b>OUTPATIENT SERVICE COST CENTERS</b>							
88	Rural Health Clinic		16,105	113,197			36,803	88
88.01	RHC II			21,155				88.01
91	Emergency	54,750	23,336	156,991		28,404	19,308	91
92	Observation Beds (Non-Distinct Part)							92
93	DAY PSYCHIATRIC	67,592				3,480		93
	<b>OTHER REIMBURSABLE COST CENTERS</b>							
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			12,990			11,493	101
	<b>SPECIAL PURPOSE COST CENTERS</b>							
118	SUBTOTALS (sum of lines 1-117)	1,580,643	282,630	1,047,722	895,525	320,960	175,761	118
	<b>NONREIMBURSABLE COST CENTERS</b>							
190	Gift, Flower, Coffee Shop & Canteen	18,194						190
192	Physicians' Private Offices		9,066		384,627			192
192.01	DIALYSIS							192.01
192.02	GALATIA CLINIC							192.02
192.03	ORTHO CLINIC							192.03
200	Cross Foot Adjustments							200
201	Negative Cost Centers							201
202	TOTAL (sum of lines 118-201)	1,598,837	291,696	1,047,722	1,280,152	320,960	175,761	202

HARRISBURG MEDICAL CENTER, INC. Provider CCN: 14-0210	In Lieu of Form CMS-2552-10	Period : From: 07/01/2015 To: 06/30/2016	Run Date: 11/19/2016 Run Time: 10:33 Version: 2016.05 (11/01/2016)
--	--------------------------------	--	--

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	
<b>GENERAL SERVICE COST CENTERS</b>								
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	664,037						14
15	Pharmacy	4,285	1,103,973					15
16	Medical Records & Library	4,466		1,233,654				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
<b>INPATIENT ROUTINE SERV COST CENTERS</b>								
30	Adults & Pediatrics	197,200		78,037	6,764,919		6,764,919	30
40	Subprovider - IPF	36,220		106,613	6,063,888		6,063,888	40
<b>ANCILLARY SERVICE COST CENTERS</b>								
50	Operating Room	106,432		30,865	1,026,079		1,026,079	50
53	Anesthesiology	6,003		24,030	402,562		402,562	53
54	Radiology-Diagnostic	3,707		42,748	1,548,986		1,548,986	54
57	CT Scan	5,787		149,835	661,431		661,431	57
60	Laboratory	23,418		199,061	3,658,899		3,658,899	60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
64	Intravenous Therapy	34,383		85,013	282,043		282,043	64
65	Respiratory Therapy	8,785		72,652	1,261,593		1,261,593	65
66	Physical Therapy	3,060		34,430	1,761,328		1,761,328	66
69	Electrocardiology	2,268		17,818	255,839		255,839	69
71	Medical Supplies Charged to Patients			21,058	1,943,882		1,943,882	71
72	Impl. Dev. Charged to Patients			11,519	961,178		961,178	72
73	Drugs Charged to Patients		1,064,639	116,479	4,935,498		4,935,498	73
75	ASC (Non-Distinct Part)	70,017		38,020	1,439,153		1,439,153	75
76	NUCLEAR MEDICINE	3,800		29,892	690,103		690,103	76
76.01	ULTRASOUND	5,644		44,344	471,782		471,782	76.01
76.02	MAMMOGRAPHY	689		6,589	248,306		248,306	76.02
76.03	CARDIAC REHABILITATION							76.03
76.04	FAITH CENTER CHEMOTHERAPY	14,061		2,948	307,079		307,079	76.04
76.06	ROUTINE ANCILLARY							76.06
76.97	CARDIAC REHABILITATION	1,755		4,664	190,731		190,731	76.97
76.98	HYPERBARIC OXYGEN THERAPY							76.98
76.99	LITHOTRIPSY							76.99
<b>OUTPATIENT SERVICE COST CENTERS</b>								
88	Rural Health Clinic	17,580	24,106	27,911	3,419,414		3,419,414	88
88.01	RHC II			3,186	424,035		424,035	88.01
91	Emergency	97,457		73,618	2,950,973		2,950,973	91
92	Observation Beds (Non-Distinct Part)							92
93	DAY PSYCHIATRIC	481		3,613	279,350		279,350	93
<b>OTHER REIMBURSABLE COST CENTERS</b>								
99.10	CORF							99.10
99.20	OUTPATIENT PHYSICAL THERAPY							99.20
99.30	OUTPATIENT OCCUPATIONAL THERAPY							99.30
99.40	OUTPATIENT SPEECH PATHOLOGY							99.40
101	Home Health Agency	9,062		8,711	902,036		902,036	101
<b>SPECIAL PURPOSE COST CENTERS</b>								
118	SUBTOTALS (sum of lines 1-117)	656,560	1,088,745	1,233,654	42,851,087		42,851,087	118
<b>NONREIMBURSABLE COST CENTERS</b>								
190	Gift, Flower, Coffee Shop & Canteen	984			381,614		381,614	190
192	Physicians' Private Offices	4,231	14,957		1,313,480		1,313,480	192
192.01	DIALYSIS							192.01
192.02	GALATIA CLINIC	2,262	271		121,659		121,659	192.02
192.03	ORTHO CLINIC							192.03
200	Cross Foot Adjustments							200
201	Negative Cost Centers							201
202	TOTAL (sum of lines 118-201)	664,037	1,103,973	1,233,654	44,667,840		44,667,840	202

HARRISBURG MEDICAL CENTER, INC. Provider CCN: 14-0210	In Lieu of Form CMS-2552-10	Period : From: 07/01/2015 To: 06/30/2016	Run Date: 11/19/2016 Run Time: 10:33 Version: 2016.05 (11/01/2016)
--	--------------------------------	--	--

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	
<b>GENERAL SERVICE COST CENTERS</b>								
1	Cap Rel Costs-Bldg & Fixt							1
2	Cap Rel Costs-Mvble Equip							2
4	Employee Benefits Department		8,536	11,269	19,805	19,805		4
5	Administrative & General	3,663	202,887	461,843	668,393	2,824	671,217	5
6	Maintenance & Repairs							6
7	Operation of Plant	12,729	43,464	11,061	67,254	413	24,025	7
8	Laundry & Linen Service		21,229	9,083	30,312	51	3,821	8
9	Housekeeping		5,435	1,774	7,209	507	15,600	9
10	Dietary	600	24,697	7,884	33,181	530	18,583	10
11	Cafeteria		14,147		14,147		259	11
12	Maintenance of Personnel							12
13	Nursing Administration			141	141	92	2,350	13
14	Central Services & Supply		9,511	6,139	15,650	184	9,665	14
15	Pharmacy		18,623	54,029	72,652	515	15,735	15
16	Medical Records & Library		12,996	30,870	43,866	464	17,793	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
<b>INPATIENT ROUTINE SERV COST CENTERS</b>								
30	Adults & Pediatrics	2,117	160,285	94,777	257,179	2,532	80,459	30
40	Subprovider - IPF	620	150,135	13,144	163,899	2,379	75,880	40
<b>ANCILLARY SERVICE COST CENTERS</b>								
50	Operating Room	163,090	99,285	126,863	389,238	442	8,916	50
53	Anesthesiology			16,643	16,643	642	5,512	53
54	Radiology-Diagnostic		63,622	147,698	211,320	467	20,518	54
57	CT Scan	13,650	7,257	67,627	88,534	171	7,339	57
60	Laboratory	750	37,166	47,182	85,098	766	49,874	60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
64	Intravenous Therapy					22	2,444	64
65	Respiratory Therapy	22,123	14,802	26,308	63,233	506	16,738	65
66	Physical Therapy		70,160	14,574	84,734	719	23,092	66
69	Electrocardiology	35,705	9,655	8,162	53,522	77	3,243	69
71	Medical Supplies Charged to Patients						28,894	71
72	Impl. Dev. Charged to Patients						14,270	72
73	Drugs Charged to Patients						56,416	73
75	ASC (Non-Distinct Part)		66,275	42,243	108,518	435	16,138	75
76	NUCLEAR MEDICINE		6,218	60,362	66,580	128	9,654	76
76.01	ULTRASOUND		8,041	2,929	10,970	191	6,070	76.01
76.02	MAMMOGRAPHY	195	4,844	33,148	38,187	56	3,463	76.02
76.03	CARDIAC REHABILITATION							76.03
76.04	FAITH CENTER CHEMOTHERAPY		14,914	1,287	16,201	122	3,867	76.04
76.06	ROUTINE ANCILLARY							76.06
76.97	CARDIAC REHABILITATION		8,424	7,144	15,568	76	2,472	76.97
76.98	HYPERBARIC OXYGEN THERAPY							76.98
76.99	LITHOTRIPSY							76.99
<b>OUTPATIENT SERVICE COST CENTERS</b>								
88	Rural Health Clinic	1,896			1,896	1,435	47,841	88
88.01	RHC II					177	6,006	88.01
91	Emergency		31,076	40,357	71,433	1,977	37,523	91
92	Observation Beds (Non-Distinct Part)							92
93	DAY PSYCHIATRIC		38,365		38,365	83	3,068	93
<b>OTHER REIMBURSABLE COST CENTERS</b>								
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	45			45	405	12,920	101
<b>SPECIAL PURPOSE COST CENTERS</b>								
118	SUBTOTALS (sum of lines 1-117)	257,183	1,152,049	1,344,541	2,753,773	19,388	650,448	118
<b>NONREIMBURSABLE COST CENTERS</b>								
190	Gift, Flower, Coffee Shop & Canteen		10,327		10,327	76	5,446	190
192	Physicians' Private Offices	147			147	296	13,533	192
192.01	DIALYSIS							192.01
192.02	GALATIA CLINIC					45	1,790	192.02
192.03	ORTHO CLINIC							192.03
200	Cross Foot Adjustments							200
201	Negative Cost Centers							201
202	TOTAL (sum of lines 118-201)	257,330	1,162,376	1,344,541	2,764,247	19,805	671,217	202

HARRISBURG MEDICAL CENTER, INC. Provider CCN: 14-0210	In Lieu of Form CMS-2552-10	Period : From: 07/01/2015 To: 06/30/2016	Run Date: 11/19/2016 Run Time: 10:33 Version: 2016.05 (11/01/2016)
--	--------------------------------	--	--

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	
	<b>GENERAL SERVICE COST CENTERS</b>							
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	91,692						7
8	Laundry & Linen Service	2,145	36,329					8
9	Housekeeping	549		23,865				9
10	Dietary	2,495			54,789			10
11	Cafeteria	1,429			11,932	27,767		11
12	Maintenance of Personnel							12
13	Nursing Administration			364		294	3,241	13
14	Central Services & Supply	961				354		14
15	Pharmacy	1,882		194		972		15
16	Medical Records & Library	1,313				1,919		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
	<b>INPATIENT ROUTINE SERV COST CENTERS</b>							
30	Adults & Pediatrics	16,198	10,882	8,657	12,392	4,970	720	30
40	Subprovider - IPF	15,169	4,993	2,925	14,003	5,724	829	40
	<b>ANCILLARY SERVICE COST CENTERS</b>							
50	Operating Room	10,032	3,221	1,530		1,415	205	50
53	Anesthesiology					497		53
54	Radiology-Diagnostic	6,428	2,039			744		54
57	CT Scan	733				402		57
60	Laboratory	3,755		626		2,116		60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
64	Intravenous Therapy							64
65	Respiratory Therapy	1,496	1,053	465		980		65
66	Physical Therapy	7,089	2,311	507		1,962		66
69	Electrocardiology	976				251		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)	6,696	5,789	1,665		1,070	155	75
76	NUCLEAR MEDICINE	628				259		76
76.01	ULTRASOUND	812				319		76.01
76.02	MAMMOGRAPHY	489				175		76.02
76.03	CARDIAC REHABILITATION							76.03
76.04	FAITH CENTER CHEMOTHERAPY	1,507				332	48	76.04
76.06	ROUTINE ANCILLARY							76.06
76.97	CARDIAC REHABILITATION	851				254	37	76.97
76.98	HYPERBARIC OXYGEN THERAPY							76.98
76.99	LITHOTRIPSY							76.99
	<b>OUTPATIENT SERVICE COST CENTERS</b>							
88	Rural Health Clinic		2,006	2,578			679	88
88.01	RHC II			482				88.01
91	Emergency	3,140	2,906	3,576		2,457	356	91
92	Observation Beds (Non-Distinct Part)							92
93	DAY PSYCHIATRIC	3,876				301		93
	<b>OTHER REIMBURSABLE COST CENTERS</b>							
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			296			212	101
	<b>SPECIAL PURPOSE COST CENTERS</b>							
118	SUBTOTALS (sum of lines 1-117)	90,649	35,200	23,865	38,327	27,767	3,241	118
	<b>NONREIMBURSABLE COST CENTERS</b>							
190	Gift, Flower, Coffee Shop & Canteen	1,043						190
192	Physicians' Private Offices		1,129		16,462			192
192.01	DIALYSIS							192.01
192.02	GALATIA CLINIC							192.02
192.03	ORTHO CLINIC							192.03
200	Cross Foot Adjustments							200
201	Negative Cost Centers							201
202	TOTAL (sum of lines 118-201)	91,692	36,329	23,865	54,789	27,767	3,241	202

HARRISBURG MEDICAL CENTER, INC. Provider CCN: 14-0210	In Lieu of Form CMS-2552-10	Period : From: 07/01/2015 To: 06/30/2016	Run Date: 11/19/2016 Run Time: 10:33 Version: 2016.05 (11/01/2016)
--	--------------------------------	--	--

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	
	<b>GENERAL SERVICE COST CENTERS</b>							
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	26,814						14
15	Pharmacy	173	92,123					15
16	Medical Records & Library	180		65,535				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
	<b>INPATIENT ROUTINE SERV COST CENTERS</b>							
30	Adults & Pediatrics	7,962		4,141	406,092		406,092	30
40	Subprovider - IPF	1,463		5,658	292,922		292,922	40
	<b>ANCILLARY SERVICE COST CENTERS</b>							
50	Operating Room	4,298		1,638	420,935		420,935	50
53	Anesthesiology	242		1,275	24,811		24,811	53
54	Radiology-Diagnostic	150		2,269	243,935		243,935	54
57	CT Scan	234		7,952	105,365		105,365	57
60	Laboratory	946		10,628	153,809		153,809	60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
64	Intravenous Therapy	1,388		4,512	8,366		8,366	64
65	Respiratory Therapy	355		3,856	88,682		88,682	65
66	Physical Therapy	124		1,827	122,365		122,365	66
69	Electrocardiology	92		946	59,107		59,107	69
71	Medical Supplies Charged to Patients			1,118	30,012		30,012	71
72	Impl. Dev. Charged to Patients			611	14,881		14,881	72
73	Drugs Charged to Patients		88,840	6,182	151,438		151,438	73
75	ASC (Non-Distinct Part)	2,827		2,018	145,311		145,311	75
76	NUCLEAR MEDICINE	153		1,586	78,988		78,988	76
76.01	ULTRASOUND	228		2,353	20,943		20,943	76.01
76.02	MAMMOGRAPHY	28		350	42,748		42,748	76.02
76.03	CARDIAC REHABILITATION							76.03
76.04	FAITH CENTER CHEMOTHERAPY	568		156	22,801		22,801	76.04
76.06	ROUTINE ANCILLARY							76.06
76.97	CARDIAC REHABILITATION	71		248	19,577		19,577	76.97
76.98	HYPERBARIC OXYGEN THERAPY							76.98
76.99	LITHOTRIPSY							76.99
	<b>OUTPATIENT SERVICE COST CENTERS</b>							
88	Rural Health Clinic	710	2,012	1,481	60,638		60,638	88
88.01	RHC II			169	6,834		6,834	88.01
91	Emergency	3,935		3,907	131,210		131,210	91
92	Observation Beds (Non-Distinct Part)							92
93	DAY PSYCHIATRIC	19		192	45,904		45,904	93
	<b>OTHER REIMBURSABLE COST CENTERS</b>							
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	366		462	14,706		14,706	101
	<b>SPECIAL PURPOSE COST CENTERS</b>							
118	SUBTOTALS (sum of lines 1-117)	26,512	90,852	65,535	2,712,380		2,712,380	118
	<b>NONREIMBURSABLE COST CENTERS</b>							
190	Gift, Flower, Coffee Shop & Canteen	40			16,932		16,932	190
192	Physicians' Private Offices	171	1,248		32,986		32,986	192
192.01	DIALYSIS							192.01
192.02	GALATIA CLINIC	91	23		1,949		1,949	192.02
192.03	ORTHO CLINIC							192.03
200	Cross Foot Adjustments							200
201	Negative Cost Centers							201
202	TOTAL (sum of lines 118-201)	26,814	92,123	65,535	2,764,247		2,764,247	202

HARRISBURG MEDICAL CENTER, INC. Provider CCN: 14-0210	In Lieu of Form CMS-2552-10	Period : From: 07/01/2015 To: 06/30/2016	Run Date: 11/19/2016 Run Time: 10:33 Version: 2016.05 (11/01/2016)
--	--------------------------------	--	--

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	
	<b>GENERAL SERVICE COST CENTERS</b>							
1	Cap Rel Costs-Bldg & Fixt	72,715						1
2	Cap Rel Costs-Mvble Equip		1,290,487					2
4	Employee Benefits Department	534	10,816	22,914,549				4
5	Administrative & General	12,692	443,276	3,264,171	-8,025,771	36,642,069		5
6	Maintenance & Repairs							6
7	Operation of Plant	2,719	10,616	478,059		1,311,563	56,770	7
8	Laundry & Linen Service	1,328	8,718	59,002		208,604	1,328	8
9	Housekeeping	340	1,703	586,503		851,615	340	9
10	Dietary	1,545	7,567	613,079		1,014,444	1,545	10
11	Cafeteria	885				14,147	885	11
12	Maintenance of Personnel							12
13	Nursing Administration		135	105,978		128,297		13
14	Central Services & Supply	595	5,892	212,790		527,626	595	14
15	Pharmacy	1,165	51,857	596,091		858,967	1,165	15
16	Medical Records & Library	813	29,629	537,337		971,356	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
	<b>INPATIENT ROUTINE SERV COST CENTERS</b>							
30	Adults & Pediatrics	10,027	90,967	2,930,252		4,391,883	10,027	30
40	Subprovider - IPF	9,392	12,616	2,753,728		4,142,393	9,392	40
	<b>ANCILLARY SERVICE COST CENTERS</b>							
50	Operating Room	6,211	121,763	511,680		486,732	6,211	50
53	Anesthesiology		15,974	742,492		300,881		53
54	Radiology-Diagnostic	3,980	141,760	540,501		1,120,127	3,980	54
57	CT Scan	454	64,908	197,477		400,623	454	57
60	Laboratory	2,325	45,285	886,983		2,722,665	2,325	60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
64	Intravenous Therapy			25,378		133,423		64
65	Respiratory Therapy	926	25,250	585,885		913,740	926	65
66	Physical Therapy	4,389	13,988	831,746		1,260,615	4,389	66
69	Electrocardiology	604	7,834	89,114		177,055	604	69
71	Medical Supplies Charged to Patients					1,577,337		71
72	Impl. Dev. Charged to Patients					779,027		72
73	Drugs Charged to Patients					3,079,804		73
75	ASC (Non-Distinct Part)	4,146	40,545	503,675		881,010	4,146	75
76	NUCLEAR MEDICINE	389	57,935	147,684		527,029	389	76
76.01	ULTRASOUND	503	2,811	221,004		331,359	503	76.01
76.02	MAMMOGRAPHY	303	31,815	64,770		189,064	303	76.02
76.03	CARDIAC REHABILITATION							76.03
76.04	FAITH CENTER CHEMOTHERAPY	933	1,235	141,173		211,108	933	76.04
76.06	ROUTINE ANCILLARY							76.06
76.97	CARDIAC REHABILITATION	527	6,857	87,787		134,976	527	76.97
76.98	HYPERBARIC OXYGEN THERAPY							76.98
76.99	LITHOTRIPSY							76.99
	<b>OUTPATIENT SERVICE COST CENTERS</b>							
88	Rural Health Clinic			1,661,180		2,611,672		88
88.01	RHC II			204,562		327,878		88.01
91	Emergency	1,944	38,735	2,288,031		2,048,436	1,944	91
92	Observation Beds (Non-Distinct Part)							92
93	DAY PSYCHIATRIC	2,400		95,829		167,497	2,400	93
	<b>OTHER REIMBURSABLE COST CENTERS</b>							
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			468,340		705,297		101
	<b>SPECIAL PURPOSE COST CENTERS</b>							
118	SUBTOTALS (sum of lines 1-117)	72,069	1,290,487	22,432,281	-8,025,771	35,508,250	56,124	118
	<b>NONREIMBURSABLE COST CENTERS</b>							
190	Gift, Flower, Coffee Shop & Canteen	646		88,155		297,315	646	190
192	Physicians' Private Offices			342,430		738,782		192
192.01	DIALYSIS							192.01
192.02	GALATIA CLINIC			51,683		97,722		192.02
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)	1,162,376	1,344,541	7,428,126		8,025,771	1,598,837	202
203	Unit Cost Multiplier (Wkst. B, Part I)	15.985368	1.041887	0.324166		0.219032	28.163414	203
204	Cost to be allocated (Per Wkst. B, Part II)			19,805		671,217	91,692	204

HARRISBURG MEDICAL CENTER, INC. Provider CCN: 14-0210	In Lieu of Form <b>CMS-2552-10</b>	Period : From: 07/01/2015 To: 06/30/2016	Run Date: 11/19/2016 Run Time: 10:33 Version: 2016.05 (11/01/2016)
--	---------------------------------------	--	--

COST ALLOCATION - STATISTICAL BASIS

WORKSHEET B-1

	COST CENTER DESCRIPTIONS	CAP BLDGS & FIXTURES SQUARE FEET	CAP MOVABLE EQUIPMENT DOLLAR VALUE	EMPLOYEE BENEFITS DEPARTMENT GROSS SALARIES	RECON- CILIATION	ADMINIS- TRATIVE & GENERAL ACCUM COST	OPERATION OF PLANT SQUARE FEET	
		1	2	4	5A	5	7	
205	Unit Cost Multiplier (Wkst. B, Part II)			0.000864		0.018318	1.615149	205

HARRISBURG MEDICAL CENTER, INC. Provider CCN: 14-0210	In Lieu of Form CMS-2552-10	Period : From: 07/01/2015 To: 06/30/2016	Run Date: 11/19/2016 Run Time: 10:33 Version: 2016.05 (11/01/2016)
--	--------------------------------	--	--

COST ALLOCATION - STATISTICAL BASIS

WORKSHEET B-1

	COST CENTER DESCRIPTIONS	LAUNDRY & LINEN SERVICE POUNDS OF LAUNDRY 8	HOUSE-KEEPING HOURS OF SERVICE 9	DIETARY MEALS SERVED 10	CAFETERIA MEALS SERVED 11	NURSING ADMINISTRATION DIRECT NRSING HRS 13	CENTRAL SERVICES & SUPPLY COSTED REQUIS. 14	
	<b>GENERAL SERVICE COST CENTERS</b>							
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	38,125						8
9	Housekeeping		2,823					9
10	Dietary			239,101				10
11	Cafeteria			52,071	319,460			11
12	Maintenance of Personnel							12
13	Nursing Administration		43		3,388	257,348		13
14	Central Services & Supply				4,068		630,155	14
15	Pharmacy		23		11,182		4,066	15
16	Medical Records & Library				22,073		4,238	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
	<b>INPATIENT ROUTINE SERV COST CENTERS</b>							
30	Adults & Pediatrics	11,420	1,024	54,080	57,174	57,174	187,138	30
40	Subprovider - IPF	5,240	346	61,111	65,853	65,853	34,372	40
	<b>ANCILLARY SERVICE COST CENTERS</b>							
50	Operating Room	3,380	181		16,283	16,283	101,001	50
53	Anesthesiology				5,718		5,697	53
54	Radiology-Diagnostic	2,140			8,557		3,518	54
57	CT Scan				4,629		5,492	57
60	Laboratory		74		24,346		22,223	60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
64	Intravenous Therapy						32,629	64
65	Respiratory Therapy	1,105	55		11,279		8,337	65
66	Physical Therapy	2,425	60		22,571		2,904	66
69	Electrocardiology				2,892		2,152	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)	6,075	197		12,311	12,311	66,444	75
76	NUCLEAR MEDICINE				2,976		3,606	76
76.01	ULTRASOUND				3,674		5,356	76.01
76.02	MAMMOGRAPHY				2,010		654	76.02
76.03	CARDIAC REHABILITATION							76.03
76.04	FAITH CENTER CHEMOTHERAPY				3,820	3,820	13,344	76.04
76.06	ROUTINE ANCILLARY							76.06
76.97	CARDIAC REHABILITATION				2,921	2,921	1,665	76.97
76.98	HYPERBARIC OXYGEN THERAPY							76.98
76.99	LITHOTRIPSY							76.99
	<b>OUTPATIENT SERVICE COST CENTERS</b>							
88	Rural Health Clinic	2,105	305			53,887	16,683	88
88.01	RHC II		57					88.01
91	Emergency	3,050	423		28,271	28,271	92,484	91
92	Observation Beds (Non-Distinct Part)							92
93	DAY PSYCHIATRIC				3,464		456	93
	<b>OTHER REIMBURSABLE COST CENTERS</b>							
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		35			16,828	8,600	101
	<b>SPECIAL PURPOSE COST CENTERS</b>							
118	SUBTOTALS (sum of lines 1-117)	36,940	2,823	167,262	319,460	257,348	623,059	118
	<b>NONREIMBURSABLE COST CENTERS</b>							
190	Gift, Flower, Coffee Shop & Canteen						934	190
192	Physicians' Private Offices	1,185		71,839			4,015	192
192.01	DIALYSIS							192.01
192.02	GALATIA CLINIC						2,147	192.02
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)	291,696	1,047,722	1,280,152	320,960	175,761	664,037	202
203	Unit Cost Multiplier (Wkst. B, Part I)	7.651043	371.137797	5.354022	1.004695	0.682970	1.053768	203
204	Cost to be allocated (Per Wkst. B, Part II)	36,329	23,865	54,789	27,767	3,241	26,814	204

HARRISBURG MEDICAL CENTER, INC. Provider CCN: 14-0210	In Lieu of Form <b>CMS-2552-10</b>	Period : From: 07/01/2015 To: 06/30/2016	Run Date: 11/19/2016 Run Time: 10:33 Version: 2016.05 (11/01/2016)
--	---------------------------------------	--	--

COST ALLOCATION - STATISTICAL BASIS

WORKSHEET B-1

	COST CENTER DESCRIPTIONS	LAUNDRY & LINEN SERVICE POUNDS OF LAUNDRY	HOUSE-KEEPING HOURS OF SERVICE	DIETARY MEALS SERVED	CAFETERIA MEALS SERVED	NURSING ADMINISTRATION DIRECT NRSING HRS	CENTRAL SERVICES & SUPPLY COSTED REQUIS.	
		8	9	10	11	13	14	
205	Unit Cost Multiplier (Wkst. B, Part II)	0.952892	8.453773	0.229146	0.086919	0.012594	0.042551	205

HARRISBURG MEDICAL CENTER, INC. Provider CCN: 14-0210	In Lieu of Form CMS-2552-10	Period : From: 07/01/2015 To: 06/30/2016	Run Date: 11/19/2016 Run Time: 10:33 Version: 2016.05 (11/01/2016)
--	--------------------------------	--	--

COST ALLOCATION - STATISTICAL BASIS

WORKSHEET B-1

COST CENTER DESCRIPTIONS	PHARMACY COSTED REQUIS.	MEDICAL RECORDS & LIBRARY GROSS REVENUE					
	15	16					

GENERAL SERVICE COST CENTERS							
1	Cap Rel Costs-Bldg & Fixt						1
2	Cap Rel Costs-Mvble Equip						2
4	Employee Benefits Department						4
5	Administrative & General						5
6	Maintenance & Repairs						6
7	Operation of Plant						7
8	Laundry & Linen Service						8
9	Housekeeping						9
10	Dietary						10
11	Cafeteria						11
12	Maintenance of Personnel						12
13	Nursing Administration						13
14	Central Services & Supply						14
15	Pharmacy	3,079,804					15
16	Medical Records & Library		137,261,369				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		8,682,334				30
40	Subprovider - IPF		11,861,685				40
ANCILLARY SERVICE COST CENTERS							
50	Operating Room		3,434,044				50
53	Anesthesiology		2,673,568				53
54	Radiology-Diagnostic		4,756,107				54
57	CT Scan		16,670,615				57
60	Laboratory		22,153,037				60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS						62.30
64	Intravenous Therapy		9,458,450				64
65	Respiratory Therapy		8,083,270				65
66	Physical Therapy		3,830,613				66
69	Electrocardiology		1,982,473				69
71	Medical Supplies Charged to Patients		2,342,942				71
72	Impl. Dev. Charged to Patients		1,281,571				72
73	Drugs Charged to Patients	2,970,074	12,959,439				73
75	ASC (Non-Distinct Part)		4,230,052				75
76	NUCLEAR MEDICINE		3,325,789				76
76.01	ULTRASOUND		4,933,672				76.01
76.02	MAMMOGRAPHY		733,112				76.02
76.03	CARDIAC REHABILITATION						76.03
76.04	FAITH CENTER CHEMOTHERAPY		328,018				76.04
76.06	ROUTINE ANCILLARY						76.06
76.97	CARDIAC REHABILITATION		518,888				76.97
76.98	HYPERBARIC OXYGEN THERAPY						76.98
76.99	LITHOTRIPSY						76.99
OUTPATIENT SERVICE COST CENTERS							
88	Rural Health Clinic	67,249	3,105,361				88
88.01	RHC II		354,462				88.01
91	Emergency		8,190,660				91
92	Observation Beds (Non-Distinct Part)						92
93	DAY PSYCHIATRIC		402,005				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		969,202				101
SPECIAL PURPOSE COST CENTERS							
118	SUBTOTALS (sum of lines 1-117)	3,037,323	137,261,369				118
NONREIMBURSABLE COST CENTERS							
190	Gift, Flower, Coffee Shop & Canteen						190
192	Physicians' Private Offices	41,726					192
192.01	DIALYSIS						192.01
192.02	GALATIA CLINIC	755					192.02
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)	1,103,973	1,233,654				202

HARRISBURG MEDICAL CENTER, INC. Provider CCN: 14-0210	In Lieu of Form <b>CMS-2552-10</b>	Period : From: 07/01/2015 To: 06/30/2016	Run Date: 11/19/2016 Run Time: 10:33 Version: 2016.05 (11/01/2016)
--	---------------------------------------	--	--

COST ALLOCATION - STATISTICAL BASIS

WORKSHEET B-1

	COST CENTER DESCRIPTIONS	PHARMACY  COSTED REQUIS.	MEDICAL RECORDS & LIBRARY GROSS REVENUE				
		15	16				
203	Unit Cost Multiplier (Wkst. B, Part I)	0.358456	0.008988				203
204	Cost to be allocated (Per Wkst. B, Part II)	92,123	65,535				204
205	Unit Cost Multiplier (Wkst. B, Part II)	0.029912	0.000477				205

HARRISBURG MEDICAL CENTER, INC. Provider CCN: 14-0210	In Lieu of Form <b>CMS-2552-10</b>	Period : From: 07/01/2015 To: 06/30/2016	Run Date: 11/19/2016 Run Time: 10:33 Version: 2016.05 (11/01/2016)
--	---------------------------------------	--	--

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: 07/01/2015 To: 06/30/2016	Run Date: 11/19/2016 Run Time: 10:33 Version: 2016.05 (11/01/2016)
--	--------------------------------	--	--

COMPUTATION OF RATIO OF COST TO CHARGES

WORKSHEET C  
PART I

	COST CENTER DESCRIPTIONS	COSTS					
		Total Cost (from Wkst. B, Part I, col. 26)	Therapy Limit Adj.	Total Costs	RCE Dis- allowance	Total Costs	
		1	2	3	4	5	
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>							
30	Adults & Pediatrics	6,764,919		6,764,919	9,197	6,774,116	30
40	Subprovider - IPF	6,063,888		6,063,888	242,263	6,306,151	40
<b>ANCILLARY SERVICE COST CENTERS</b>							
50	Operating Room	1,026,079		1,026,079		1,026,079	50
53	Anesthesiology	402,562		402,562		402,562	53
54	Radiology-Diagnostic	1,548,986		1,548,986		1,548,986	54
57	CT Scan	661,431		661,431		661,431	57
60	Laboratory	3,658,899		3,658,899		3,658,899	60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS						62.30
64	Intravenous Therapy	282,043		282,043		282,043	64
65	Respiratory Therapy	1,261,593		1,261,593		1,261,593	65
66	Physical Therapy	1,761,328		1,761,328		1,761,328	66
69	Electrocardiology	255,839		255,839		255,839	69
71	Medical Supplies Charged to Patients	1,943,882		1,943,882		1,943,882	71
72	Impl. Dev. Charged to Patients	961,178		961,178		961,178	72
73	Drugs Charged to Patients	4,935,498		4,935,498		4,935,498	73
75	ASC (Non-Distinct Part)	1,439,153		1,439,153		1,439,153	75
76	NUCLEAR MEDICINE	690,103		690,103		690,103	76
76.01	ULTRASOUND	471,782		471,782		471,782	76.01
76.02	MAMMOGRAPHY	248,306		248,306		248,306	76.02
76.03	CARDIAC REHABILITATION						76.03
76.04	FAITH CENTER CHEMOTHERAPY	307,079		307,079		307,079	76.04
76.06	ROUTINE ANCILLARY						76.06
76.97	CARDIAC REHABILITATION	190,731		190,731		190,731	76.97
76.98	HYPERBARIC OXYGEN THERAPY						76.98
76.99	LITHOTRIPSY						76.99
<b>OUTPATIENT SERVICE COST CENTERS</b>							
88	Rural Health Clinic	3,419,414		3,419,414		3,419,414	88
88.01	RHC II	424,035		424,035		424,035	88.01
91	Emergency	2,950,973		2,950,973	6,953	2,957,926	91
92	Observation Beds (Non-Distinct Part)	2,284,671		2,284,671		2,284,671	92
93	DAY PSYCHIATRIC	279,350		279,350		279,350	93
<b>OTHER REIMBURSABLE COST CENTERS</b>							
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	902,036		902,036		902,036	101
200	Subtotal (sum of lines 30 thru 199)	45,135,758		45,135,758	258,413	45,394,171	200
201	Less Observation Beds	2,284,671		2,284,671		2,284,671	201
202	Total (line 200 minus line 201)	42,851,087		42,851,087		43,109,500	202

HARRISBURG MEDICAL CENTER, INC. Provider CCN: 14-0210	In Lieu of Form CMS-2552-10	Period : From: 07/01/2015 To: 06/30/2016	Run Date: 11/19/2016 Run Time: 10:33 Version: 2016.05 (11/01/2016)
--	--------------------------------	--	--

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	
	<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>							
30	Adults & Pediatrics	4,344,430		4,344,430				30
40	Subprovider - IPF	11,861,685		11,861,685				40
	<b>ANCILLARY SERVICE COST CENTERS</b>							
50	Operating Room	764,722	2,669,322	3,434,044	0.298796	0.298796	0.298796	50
53	Anesthesiology	448,683	2,224,885	2,673,568	0.150571	0.150571	0.150571	53
54	Radiology-Diagnostic	369,834	4,386,273	4,756,107	0.325684	0.325684	0.325684	54
57	CT Scan	1,516,163	15,154,452	16,670,615	0.039676	0.039676	0.039676	57
60	Laboratory	3,153,054	18,999,983	22,153,037	0.165165	0.165165	0.165165	60
62.30	<b>BLOOD CLOTTING FOR HEMOPHILIACS</b>							62.30
64	Intravenous Therapy	5,754,864	3,703,586	9,458,450	0.029819	0.029819	0.029819	64
65	Respiratory Therapy	4,549,891	3,533,379	8,083,270	0.156075	0.156075	0.156075	65
66	Physical Therapy	824,245	3,006,368	3,830,613	0.459803	0.459803	0.459803	66
69	Electrocardiology	256,966	1,725,507	1,982,473	0.129050	0.129050	0.129050	69
71	Medical Supplies Charged to Patients	943,654	1,399,288	2,342,942	0.829676	0.829676	0.829676	71
72	Impl. Dev. Charged to Patients	718,275	563,296	1,281,571	0.750000	0.750000	0.750000	72
73	Drugs Charged to Patients	3,217,413	9,742,026	12,959,439	0.380842	0.380842	0.380842	73
75	ASC (Non-Distinct Part)	183,175	4,046,877	4,230,052	0.340221	0.340221	0.340221	75
76	<b>NUCLEAR MEDICINE</b>	143,521	3,182,268	3,325,789	0.207501	0.207501	0.207501	76
76.01	ULTRASOUND	769,367	4,164,305	4,933,672	0.095625	0.095625	0.095625	76.01
76.02	MAMMOGRAPHY	349	732,763	733,112	0.338701	0.338701	0.338701	76.02
76.03	CARDIAC REHABILITATION							76.03
76.04	FAITH CENTER CHEMOTHERAPY	3,680	324,338	328,018	0.936165	0.936165	0.936165	76.04
76.06	ROUTINE ANCILLARY							76.06
76.97	CARDIAC REHABILITATION	9,323	509,565	518,888	0.367576	0.367576	0.367576	76.97
76.98	HYPERBARIC OXYGEN THERAPY							76.98
76.99	LITHOTRIPSY							76.99
	<b>OUTPATIENT SERVICE COST CENTERS</b>							
88	Rural Health Clinic		3,105,361	3,105,361				88
88.01	RHC II		354,462	354,462				88.01
91	Emergency	738,620	7,452,040	8,190,660	0.360285	0.360285	0.361134	91
92	Observation Beds (Non-Distinct Part)	818,406	3,519,498	4,337,904	0.526676	0.526676	0.526676	92
93	DAY PSYCHIATRIC		402,005	402,005	0.694892	0.694892	0.694892	93
	<b>OTHER REIMBURSABLE COST CENTERS</b>							
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		969,202	969,202				101
200	Subtotal (sum of lines 30 thru 199)	41,390,320	95,871,049	137,261,369				200
201	Less Observation Beds							201
202	Total (line 200 minus line 201)	41,390,320	95,871,049	137,261,369				202

HARRISBURG MEDICAL CENTER, INC. Provider CCN: 14-0210	In Lieu of Form CMS-2552-10	Period : From: 07/01/2015 To: 06/30/2016	Run Date: 11/19/2016 Run Time: 10:33 Version: 2016.05 (11/01/2016)
--	--------------------------------	--	--

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	
	<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>								
30	Adults & Pediatrics General Routine Care)	406,092	2,366	403,726	6,149	65.66	2,426	159,291	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	292,922		292,922	9,892	29.61	3,223	95,433	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)	699,014		696,648	16,041		5,649	254,724	200

(A) Worksheet A line numbers

HARRISBURG MEDICAL CENTER, INC. Provider CCN: 14-0210	In Lieu of Form CMS-2552-10	Period : From: 07/01/2015 To: 06/30/2016	Run Date: 11/19/2016 Run Time: 10:33 Version: 2016.05 (11/01/2016)
--	--------------------------------	--	--

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS

COMPONENT CCN: 14-0210

WORKSHEET D  
PART II

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

(A)	Cost Center Description	Capital Related Cost (from Wkst. B, Part II (col. 26))	Total Charges (from Wkst. C, Part I, (col. 8))	Ratio of Cost to Charges (col. 1 + col. 2)	Inpatient Program Charges	Capital Costs (col. 3 x col. 4)	
		1	2	3	4	5	
	<b>ANCILLARY SERVICE COST CENTERS</b>						
50	Operating Room	420,935	3,434,044	0.122577	217,357	26,643	50
53	Anesthesiology	24,811	2,673,568	0.009280	166,140	1,542	53
54	Radiology-Diagnostic	243,935	4,756,107	0.051289	338,407	17,357	54
57	CT Scan	105,365	16,670,615	0.006320	1,411,858	8,923	57
60	Laboratory	153,809	22,153,037	0.006943	2,760,685	19,167	60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS						62.30
64	Intravenous Therapy	8,366	9,458,450	0.000885	3,132,700	2,772	64
65	Respiratory Therapy	88,682	8,083,270	0.010971	2,891,351	31,721	65
66	Physical Therapy	122,365	3,830,613	0.031944	554,913	17,726	66
69	Electrocardiology	59,107	1,982,473	0.029815	232,857	6,943	69
71	Medical Supplies Charged to Pat	30,012	2,342,942	0.012810	571,149	7,316	71
72	Impl. Dev. Charged to Patients	14,881	1,281,571	0.011612	287,717	3,341	72
73	Drugs Charged to Patients	151,438	12,959,439	0.011686	1,165,038	13,615	73
75	ASC (Non-Distinct Part)	145,311	4,230,052	0.034352	112,990	3,881	75
76	NUCLEAR MEDICINE	78,988	3,325,789	0.023750	74,962	1,780	76
76.01	ULTRASOUND	20,943	4,933,672	0.004245	700,205	2,972	76.01
76.02	MAMMOGRAPHY	42,748	733,112	0.058310			76.02
76.03	CARDIAC REHABILITATION						76.03
76.04	FAITH CENTER CHEMOTHERAPY	22,801	328,018	0.069511			76.04
76.06	ROUTINE ANCILLARY						76.06
76.97	CARDIAC REHABILITATION	19,577	518,888	0.037729	8,551	323	76.97
76.98	HYPERBARIC OXYGEN THERAPY						76.98
76.99	LITHOTRIPSY						76.99
	<b>OUTPATIENT SERVICE COST CENTERS</b>						
88	Rural Health Clinic	60,638	3,105,361	0.019527			88
88.01	RHC II	6,834	354,462	0.019280			88.01
91	Emergency	131,210	8,190,660	0.016019	642,705	10,295	91
92	Observation Beds (Non-Distinct	136,961	4,337,904	0.031573	451,248	14,247	92
93	DAY PSYCHIATRIC	45,904	402,005	0.114188			93
	<b>OTHER REIMBURSABLE COST CENTERS</b>						
200	Total (sum of lines 50-199)	2,135,621	120,086,052		15,720,833	190,564	200

(A) Worksheet A line numbers

HARRISBURG MEDICAL CENTER, INC. Provider CCN: 14-0210	In Lieu of Form CMS-2552-10	Period : From: 07/01/2015 To: 06/30/2016	Run Date: 11/19/2016 Run Time: 10:33 Version: 2016.05 (11/01/2016)
--	--------------------------------	--	--

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

(A)	Cost Center Description	Nursing School	Allied Health Cost	All Other Medical Education Cost	Swing-Bed Adjustment Amount (see instructions)	Total Costs (sum of cols. 1 through 3 minus col 4.)
		1	2	3	4	5
	<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>					
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: 07/01/2015 To: 06/30/2016	Run Date: 11/19/2016 Run Time: 10:33 Version: 2016.05 (11/01/2016)
--	--------------------------------	--	--

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

(A)	Cost Center Description	Total Patient Days	Per Diem (col. 5 ÷ col. 6)	Inpatient Program Days	Inpatient Program Pass-Through Cost (col. 7 x col. 8)	
6		7		8	9	
	<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>					
30	Adults & Pediatrics (General Routine Care)	6,149		2,426		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	9,892		3,223		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)	16,041		5,649		200

(A) Worksheet A line numbers

HARRISBURG MEDICAL CENTER, INC. Provider CCN: 14-0210	In Lieu of Form CMS-2552-10	Period : From: 07/01/2015 To: 06/30/2016	Run Date: 11/19/2016 Run Time: 10:33 Version: 2016.05 (11/01/2016)
--	--------------------------------	--	--

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/IID  PPS  
 Applicable  Title XVIII, Part A  IPF  SNF  TEFFRA  
 Boxes:  Title XIX  IRF  NF  Other

(A)	Cost Center Description	1	2	3	4	5	6
	<b>ANCILLARY SERVICE COST CENTERS</b>						
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 Pat						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
	<b>OUTPATIENT SERVICE COST CENTERS</b>						
88	Rural Health Clinic						88
88.01	RHC II						88.01
91	Emergency						91
92	Observation Beds (Non-Distinct)						92
93	DAY PSYCHIATRIC						93
	<b>OTHER REIMBURSABLE COST CENTERS</b>						
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: 07/01/2015 To: 06/30/2016	Run Date: 11/19/2016 Run Time: 10:33 Version: 2016.05 (11/01/2016)
--	--------------------------------	--	--

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/IID  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)	
		7	8	9	10	11	12	13	
	<b>ANCILLARY SERVICE COST CENTERS</b>								
50	Operating Room	3,434,044			217,357		819,137		50
53	Anesthesiology	2,673,568			166,140		797,457		53
54	Radiology-Diagnostic	4,756,107			338,407		1,432,374		54
57	CT Scan	16,670,615			1,411,858		4,969,499		57
60	Laboratory	22,153,037			2,760,685		3,229,542		60
62.30	<b>BLOOD CLOTTING FOR HEMOPHILIACS</b>								62.30
64	Intravenous Therapy	9,458,450			3,132,700		1,459,202		64
65	Respiratory Therapy	8,083,270			2,891,351		1,018,661		65
66	Physical Therapy	3,830,613			554,913		45,674		66
69	Electrocardiology	1,982,473			232,857		508,928		69
71	Medical Supplies Charged to Pat	2,342,942			571,149		419,853		71
72	Impl. Dev. Charged to Patients	1,281,571			287,717		250,092		72
73	Drugs Charged to Patients	12,959,439			1,165,038		3,731,264		73
75	ASC (Non-Distinct Part)	4,230,052			112,990		1,601,986		75
76	NUCLEAR MEDICINE	3,325,789			74,962		1,260,231		76
76.01	ULTRASOUND	4,933,672			700,205		1,109,087		76.01
76.02	MAMMOGRAPHY	733,112							76.02
76.03	CARDIAC REHABILITATION								76.03
76.04	FAITH CENTER CHEMOTHERAPY	328,018					67,513		76.04
76.06	ROUTINE ANCILLARY								76.06
76.97	CARDIAC REHABILITATION	518,888			8,551		368,093		76.97
76.98	HYPERBARIC OXYGEN THERAPY								76.98
76.99	LITHOTRIPSY								76.99
	<b>OUTPATIENT SERVICE COST CENTERS</b>								
88	Rural Health Clinic	3,105,361							88
88.01	RHC II	354,462							88.01
91	Emergency	8,190,660			642,705		1,655,246		91
92	Observation Beds (Non-Distinct	4,337,904			451,248		1,353,245		92
93	DAY PSYCHIATRIC	402,005					35,829		93
	<b>OTHER REIMBURSABLE COST CENTERS</b>								
200	Total (sum of lines 50-199)	120,086,052			15,720,833		26,132,913		200

(A) Worksheet A line numbers

HARRISBURG MEDICAL CENTER, INC. Provider CCN: 14-0210	In Lieu of Form CMS-2552-10	Period : From: 07/01/2015 To: 06/30/2016	Run Date: 11/19/2016 Run Time: 10:33 Version: 2016.05 (11/01/2016)
--	--------------------------------	--	--

APPORTIONMENT OF MEDICAL AND OTHER HEALTH SERVICE COSTS

COMPONENT CCN: 14-0210

WORKSHEET D  
PART V

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

(A)	Cost Center Description	Program Charges				Program Cost		
		Cost to Charge Ratio (from Wkst C, Part I, col. 9)	PPS Reim-bursed Services (see inst.)	Cost Reim-bursed Subject to Ded. & Coins. (see inst.)	Cost Reim-bursed Not Subject to Ded. & Coins. (see inst.)	PPS Services (see inst.)	Cost Reim-bursed Subject to Ded. & Coins. (see inst.)	Cost Reim-bursed Not Subject to Ded. & Coins. (see inst.)
		1	2	3	4	5	6	7
	<b>ANCILLARY SERVICE COST CENTERS</b>							
50	Operating Room	0.298796	819,137			244,755		50
53	Anesthesiology	0.150571	797,457			120,074		53
54	Radiology-Diagnostic	0.325684	1,432,374			466,501		54
57	CT Scan	0.039676	4,969,499			197,170		57
60	Laboratory	0.165165	3,229,542			533,407		60
62.30	<b>BLOOD CLOTTING FOR HEMOPHILIACS</b>							62.30
64	Intravenous Therapy	0.029819	1,459,202			43,512		64
65	Respiratory Therapy	0.156075	1,018,661			158,988		65
66	Physical Therapy	0.459803	45,674			21,001		66
69	Electrocardiology	0.129050	508,928			65,677		69
71	Medical Supplies Charged to Pat	0.829676	419,853			348,342		71
72	Impl. Dev. Charged to Patients	0.750000	250,092			187,569		72
73	Drugs Charged to Patients	0.380842	3,731,264			1,421,022		73
75	ASC (Non-Distinct Part)	0.340221	1,601,986			545,029		75
76	NUCLEAR MEDICINE	0.207501	1,260,231			261,499		76
76.01	ULTRASOUND	0.095625	1,109,087			106,056		76.01
76.02	MAMMOGRAPHY	0.338701						76.02
76.03	CARDIAC REHABILITATION							76.03
76.04	FAITH CENTER CHEMOTHERAPY	0.936165	67,513			63,203		76.04
76.06	ROUTINE ANCILLARY							76.06
76.97	CARDIAC REHABILITATION	0.367576	368,093			135,302		76.97
76.98	HYPERBARIC OXYGEN THERAPY							76.98
76.99	LITHOTRIPSY							76.99
	<b>OUTPATIENT SERVICE COST CENTERS</b>							
88	Rural Health Clinic							88
88.01	RHC II							88.01
91	Emergency	0.360285	1,655,246			596,360		91
92	Observation Beds (Non-Distinct)	0.526676	1,353,245			712,722		92
93	DAY PSYCHIATRIC	0.694892	35,829			24,897		93
	<b>OTHER REIMBURSABLE COST CENTERS</b>							
200	Subtotal (see instructions)		26,132,913			6,253,086		200
201	Less PBP Clinic Lab. Services-Program Only Charges							201
202	Net Charges (line 200 - line 201)		26,132,913			6,253,086		202

(A) Worksheet A line numbers

HARRISBURG MEDICAL CENTER, INC. Provider CCN: 14-0210	In Lieu of Form CMS-2552-10	Period : From: 07/01/2015 To: 06/30/2016	Run Date: 11/19/2016 Run Time: 10:33 Version: 2016.05 (11/01/2016)
--	--------------------------------	--	--

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS

COMPONENT CCN: 14-S210

WORKSHEET D  
PART II

Check  Title V  Hospital  SUB (Other)  PPS  
 Applicable  Title XVIII, Part A  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	
	<b>ANCILLARY SERVICE COST CENTERS</b>						
50	Operating Room	420,935	3,434,044	0.122577			50
53	Anesthesiology	24,811	2,673,568	0.009280	529	5	53
54	Radiology-Diagnostic	243,935	4,756,107	0.051289	29,456	1,511	54
57	CT Scan	105,365	16,670,615	0.006320	102,433	647	57
60	Laboratory	153,809	22,153,037	0.006943	366,561	2,545	60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS						62.30
64	Intravenous Therapy	8,366	9,458,450	0.000885	68,191	60	64
65	Respiratory Therapy	88,682	8,083,270	0.010971	330,189	3,623	65
66	Physical Therapy	122,365	3,830,613	0.031944	48,887	1,562	66
69	Electrocardiology	59,107	1,982,473	0.029815	22,572	673	69
71	Medical Supplies Charged to Pat	30,012	2,342,942	0.012810	39,141	501	71
72	Impl. Dev. Charged to Patients	14,881	1,281,571	0.011612			72
73	Drugs Charged to Patients	151,438	12,959,439	0.011686	560,984	6,556	73
75	ASC (Non-Distinct Part)	145,311	4,230,052	0.034352			75
76	NUCLEAR MEDICINE	78,988	3,325,789	0.023750	5,235	124	76
76.01	ULTRASOUND	20,943	4,933,672	0.004245	19,554	83	76.01
76.02	MAMMOGRAPHY	42,748	733,112	0.058310			76.02
76.03	CARDIAC REHABILITATION						76.03
76.04	FAITH CENTER CHEMOTHERAPY	22,801	328,018	0.069511			76.04
76.06	ROUTINE ANCILLARY						76.06
76.97	CARDIAC REHABILITATION	19,577	518,888	0.037729			76.97
76.98	HYPERBARIC OXYGEN THERAPY						76.98
76.99	LITHOTRIPSY						76.99
	<b>OUTPATIENT SERVICE COST CENTERS</b>						
88	Rural Health Clinic	60,638	3,105,361	0.019527			88
88.01	RHC II	6,834	354,462	0.019280			88.01
91	Emergency	131,210	8,190,660	0.016019	93,480	1,497	91
92	Observation Beds (Non-Distinct		4,337,904				92
93	DAY PSYCHIATRIC	45,904	402,005	0.114188			93
	<b>OTHER REIMBURSABLE COST CENTERS</b>						
200	Total (sum of lines 50-199)	1,998,660	120,086,052		1,687,212	19,387	200

(A) Worksheet A line numbers

HARRISBURG MEDICAL CENTER, INC. Provider CCN: 14-0210	In Lieu of Form CMS-2552-10	Period : From: 07/01/2015 To: 06/30/2016	Run Date: 11/19/2016 Run Time: 10:33 Version: 2016.05 (11/01/2016)
--	--------------------------------	--	--

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/IID  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
	<b>ANCILLARY SERVICE COST CENTERS</b>						
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 Pat						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
	<b>OUTPATIENT SERVICE COST CENTERS</b>						
88	Rural Health Clinic						88
88.01	RHC II						88.01
91	Emergency						91
92	Observation Beds (Non-Distinct						92
93	DAY PSYCHIATRIC						93
	<b>OTHER REIMBURSABLE COST CENTERS</b>						
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: 07/01/2015 To: 06/30/2016	Run Date: 11/19/2016 Run Time: 10:33 Version: 2016.05 (11/01/2016)
--	--------------------------------	--	--

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/IID  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)	
		7	8	9	10	11	12	13	
	<b>ANCILLARY SERVICE COST CENTERS</b>								
50	Operating Room	3,434,044							50
53	Anesthesiology	2,673,568			529				53
54	Radiology-Diagnostic	4,756,107			29,456		360		54
57	CT Scan	16,670,615			102,433		6,558		57
60	Laboratory	22,153,037			366,561				60
62.30	<b>BLOOD CLOTTING FOR HEMOPHILIACS</b>								62.30
64	Intravenous Therapy	9,458,450			68,191		486		64
65	Respiratory Therapy	8,083,270			330,189				65
66	Physical Therapy	3,830,613			48,887				66
69	Electrocardiology	1,982,473			22,572		594		69
71	Medical Supplies Charged to Pat	2,342,942			39,141		16		71
72	Impl. Dev. Charged to Patients	1,281,571							72
73	Drugs Charged to Patients	12,959,439			560,984		344		73
75	ASC (Non-Distinct Part)	4,230,052							75
76	NUCLEAR MEDICINE	3,325,789			5,235				76
76.01	ULTRASOUND	4,933,672			19,554				76.01
76.02	MAMMOGRAPHY	733,112							76.02
76.03	CARDIAC REHABILITATION								76.03
76.04	FAITH CENTER CHEMOTHERAPY	328,018							76.04
76.06	ROUTINE ANCILLARY								76.06
76.97	CARDIAC REHABILITATION	518,888							76.97
76.98	HYPERBARIC OXYGEN THERAPY								76.98
76.99	LITHOTRIPSY								76.99
	<b>OUTPATIENT SERVICE COST CENTERS</b>								
88	Rural Health Clinic	3,105,361							88
88.01	RHC II	354,462							88.01
91	Emergency	8,190,660			93,480				91
92	Observation Beds (Non-Distinct)	4,337,904							92
93	DAY PSYCHIATRIC	402,005							93
	<b>OTHER REIMBURSABLE COST CENTERS</b>								
200	Total (sum of lines 50-199)	120,086,052			1,687,212		8,358		200

(A) Worksheet A line numbers

HARRISBURG MEDICAL CENTER, INC. Provider CCN: 14-0210	In Lieu of Form CMS-2552-10	Period : From: 07/01/2015 To: 06/30/2016	Run Date: 11/19/2016 Run Time: 10:33 Version: 2016.05 (11/01/2016)
--	--------------------------------	--	--

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  Title XVIII, Part B  IPF  SNF  
 Boxes:  Title XIX - O/P  IRF  NF  ICF/IID

(A)	Cost Center Description	Cost to Charge Ratio (from Wkst C, Part I, col. 9)	Program Charges			Program Cost			
			PPS Reim-bursed Services (see inst.)	Cost Reim-bursed Subject to Ded. & Coins. (see inst.)	Cost Reim-bursed Not Subject to Ded. & Coins. (see inst.)	PPS Services (see inst.)	Cost Reim-bursed Subject to Ded. & Coins. (see inst.)	Cost Reim-bursed Not Subject to Ded. & Coins. (see inst.)	
		1	2	3	4	5	6	7	
	<b>ANCILLARY SERVICE COST CENTERS</b>								
50	Operating Room	0.298796							50
53	Anesthesiology	0.150571							53
54	Radiology-Diagnostic	0.325684	360			117			54
57	CT Scan	0.039676	6,558			260			57
60	Laboratory	0.165165							60
62.30	<b>BLOOD CLOTTING FOR HEMOPHILIACS</b>								62.30
64	Intravenous Therapy	0.029819	486			14			64
65	Respiratory Therapy	0.156075							65
66	Physical Therapy	0.459803							66
69	Electrocardiology	0.129050	594			77			69
71	Medical Supplies Charged to Pat	0.829676	16			13			71
72	Impl. Dev. Charged to Patients	0.750000							72
73	Drugs Charged to Patients	0.380842	344			131			73
75	ASC (Non-Distinct Part)	0.340221							75
76	NUCLEAR MEDICINE	0.207501							76
76.01	ULTRASOUND	0.095625							76.01
76.02	MAMMOGRAPHY	0.338701							76.02
76.03	CARDIAC REHABILITATION								76.03
76.04	FAITH CENTER CHEMOTHERAPY	0.936165							76.04
76.06	ROUTINE ANCILLARY								76.06
76.97	CARDIAC REHABILITATION	0.367576							76.97
76.98	HYPERBARIC OXYGEN THERAPY								76.98
76.99	LITHOTRIPSY								76.99
	<b>OUTPATIENT SERVICE COST CENTERS</b>								
88	Rural Health Clinic								88
88.01	RHC II								88.01
91	Emergency	0.360285							91
92	Observation Beds (Non-Distinct)	0.526676							92
93	DAY PSYCHIATRIC	0.694892							93
	<b>OTHER REIMBURSABLE COST CENTERS</b>								
200	Subtotal (see instructions)		8,358			612			200
201	Less PBP Clinic Lab. Services-Program Only Charges								201
202	Net Charges (line 200 - line 201)		8,358			612			202

(A) Worksheet A line numbers

HARRISBURG MEDICAL CENTER, INC. Provider CCN: 14-0210	In Lieu of Form CMS-2552-10	Period : From: 07/01/2015 To: 06/30/2016	Run Date: 11/19/2016 Run Time: 10:33 Version: 2016.05 (11/01/2016)
--	--------------------------------	--	--

APPORTIONMENT OF MEDICAL AND OTHER HEALTH SERVICE COSTS

COMPONENT CCN: 14-U210

WORKSHEET D  
PART V

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

(A)	Cost Center Description	Cost to Charge Ratio (from Wkst C, Part I, col. 9)	Program Charges			Program Cost			
			PPS Reim-bursed Services (see inst.)	Cost Reim-bursed Subject to Ded. & Coins. (see inst.)	Cost Reim-bursed Not Subject to Ded. & Coins. (see inst.)	PPS Services (see inst.)	Cost Reim-bursed Subject to Ded. & Coins. (see inst.)	Cost Reim-bursed Not Subject to Ded. & Coins. (see inst.)	
		1	2	3	4	5	6	7	
	<b>ANCILLARY SERVICE COST CENTERS</b>								
50	Operating Room	0.298796							50
53	Anesthesiology	0.150571							53
54	Radiology-Diagnostic	0.325684							54
57	CT Scan	0.039676							57
60	Laboratory	0.165165							60
62.30	<b>BLOOD CLOTTING FOR HEMOPHILIACS</b>								62.30
64	Intravenous Therapy	0.029819							64
65	Respiratory Therapy	0.156075							65
66	Physical Therapy	0.459803							66
69	Electrocardiology	0.129050							69
71	Medical Supplies Charged to Pat	0.829676							71
72	Impl. Dev. Charged to Patients	0.750000							72
73	Drugs Charged to Patients	0.380842							73
75	ASC (Non-Distinct Part)	0.340221							75
76	<b>NUCLEAR MEDICINE</b>	0.207501							76
76.01	ULTRASOUND	0.095625							76.01
76.02	MAMMOGRAPHY	0.338701							76.02
76.03	CARDIAC REHABILITATION								76.03
76.04	FAITH CENTER CHEMOTHERAPY	0.936165							76.04
76.06	ROUTINE ANCILLARY								76.06
76.97	CARDIAC REHABILITATION	0.367576							76.97
76.98	HYPERBARIC OXYGEN THERAPY								76.98
76.99	LITHOTRIPSY								76.99
	<b>OUTPATIENT SERVICE COST CENTERS</b>								
88	Rural Health Clinic								88
88.01	RHC II								88.01
91	Emergency	0.360285							91
92	Observation Beds (Non-Distinct	0.526676							92
93	DAY PSYCHIATRIC	0.694892							93
	<b>OTHER REIMBURSABLE COST CENTERS</b>								
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: 07/01/2015 To: 06/30/2016	Run Date: 11/19/2016 Run Time: 10:33 Version: 2016.05 (11/01/2016)
--	--------------------------------	--	--

COMPUTATION OF INPATIENT OPERATING COST

COMPONENT CCN: 14-0210

WORKSHEET D-1  
PART I

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

PART I - ALL PROVIDER COMPONENTS

INPATIENT DAYS

1	Inpatient days (including private room days and swing-bed days, excluding newborn)	6,337	1
2	Inpatient days (including private room days, excluding swing-bed and newborn days)	6,149	2
3	Private room days (excluding swing-bed private room days). If you have only private room days, do not complete this line.	587	3
4	Semi-private room days (excluding swing-bed private room days)	3,476	4
5	Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost reporting period	94	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)	94	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)	2,426	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)	72	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)	72	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	207.37	17
18	Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period	212.56	18
19	Medicaid rate for swing-bed NF services applicable to services through December 31 of the cost reporting period	139.98	19
20	Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period	147.50	20
21	Total general inpatient routine service cost (see instructions)	6,774,116	21
22	Swing-bed cost applicable to SNF type services through December 31 of the cost reporting period (line 5 x line 17)	19,493	22
23	Swing-bed cost applicable to SNF type services after December 31 of the cost reporting period (line 6 x line 18)	19,981	23
24	Swing-bed cost applicable to NF type services through December 31 of the cost reporting period (line 7 x line 19)		24
25	Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8 x line 20)		25
26	Total swing-bed cost (see instructions)	39,474	26
27	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)	6,734,642	27

PRIVATE ROOM DIFFERENTIAL ADJUSTMENT

28	General inpatient routine service charges (excluding swing-bed and observation bed charges)	4,249,528	28
29	Private room charges (excluding swing-bed charges)	604,105	29
30	Semi-private room charges (excluding swing-bed charges)	3,645,423	30
31	General inpatient routine service cost/charge ratio (line 27 ÷ line 28)	1,584,798	31
32	Average private room per diem charge (line 29 ÷ line 3)	1,029.14	32
33	Average semi-private room per diem charge (line 30 ÷ line 4)	1,048.74	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)	6,734,642	37

HARRISBURG MEDICAL CENTER, INC. Provider CCN: 14-0210	In Lieu of Form CMS-2552-10	Period : From: 07/01/2015 To: 06/30/2016	Run Date: 11/19/2016 Run Time: 10:33 Version: 2016.05 (11/01/2016)
--	--------------------------------	--	--

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

							1	
38	Adjusted general inpatient routine service cost per diem (see instructions)						1,095.24	38
39	Program general inpatient routine service cost (line 9 x line 38)						2,657,052	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)						2,657,052	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
	<b>Intensive Care Type Inpatient Hospital Units</b>							
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)						3,269,257	48
49	Total program inpatient costs (sum of lines 41 through 48)(see instructions)						5,926,309	49

PASS THROUGH COST ADJUSTMENTS

50	Pass through costs applicable to Program inpatient routine services (from Wkst. D, sum of Parts I and III)						159,291	50
51	Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)						190,564	51
52	Total Program excludable cost (sum of lines 50 and 51)						349,855	52
53	Total Program inpatient operating cost excluding capital related, nonphysician anesthetist and medical education costs (line 49 minus line 52)						5,576,454	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)						14,931	64
65	Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (See instructions) (title XVIII only)						15,304	65
66	Total Medicare swing-bed SNF inpatient routine costs (title XVIII only. For CAH, see instructions)						30,235	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: 07/01/2015 To: 06/30/2016	Run Date: 11/19/2016 Run Time: 10:33 Version: 2016.05 (11/01/2016)
--	--------------------------------	--	--

COMPUTATION OF INPATIENT OPERATING COST

COMPONENT CCN: 14-0210

WORKSHEET D-1  
PARTS III & IV

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

PART IV - COMPUTATION OF OBSERVATION BED PASS-THROUGH COST

87	Total observation bed days (see instructions)					2,086	87
88	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)					1,095.24	88
89	Observation bed cost (line 87 x line 88) (see instructions)					2,284,671	89
		Cost	Routine Cost (from line 21)	col. 1+col. 2	Total Observation Bed Cost (from line 89)	Observation Bed Pass Through Cost col. 3 x col. 4 (see instructions)	
		1	2	3	4	5	
90	Capital-related cost	406,092	6,774,116	0.059948	2,284,671	136,961	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: 07/01/2015 To: 06/30/2016	Run Date: 11/19/2016 Run Time: 10:33 Version: 2016.05 (11/01/2016)
--	--------------------------------	--	--

COMPUTATION OF INPATIENT OPERATING COST

COMPONENT CCN: 14-S210

WORKSHEET D-1  
PART I

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

PART I - ALL PROVIDER COMPONENTS

INPATIENT DAYS

1	Inpatient days (including private room days and swing-bed days, excluding newborn)	9,892	1
2	Inpatient days (including private room days, excluding swing-bed and newborn days)	9,892	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)	9,892	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)	3,223	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)	6,306,151	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)	6,306,151	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)	6,306,151	37

HARRISBURG MEDICAL CENTER, INC. Provider CCN: 14-0210	In Lieu of Form CMS-2552-10	Period : From: 07/01/2015 To: 06/30/2016	Run Date: 11/19/2016 Run Time: 10:33 Version: 2016.05 (11/01/2016)
--	--------------------------------	--	--

COMPUTATION OF INPATIENT OPERATING COST

COMPONENT CCN: 14-S210

WORKSHEET D-1  
PART II

Check  Title V - I/P  Hospital  SUB (Other)  PPS  
 Applicable  Title XVIII, Part A  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)	637.50	38
39	Program general inpatient routine service cost (line 9 x line 38)	2,054,663	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)	2,054,663	41
48	Program inpatient ancillary service cost (Wkst. D-3, col. 3, line 200)	436,073	48
49	Total program inpatient costs (sum of lines 41 through 48)(see instructions)	2,490,736	49

PASS THROUGH COST ADJUSTMENTS

50	Pass through costs applicable to Program inpatient routine services (from Wkst. D, sum of Parts I and III)	95,433	50
51	Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)	19,387	51
52	Total Program excludable cost (sum of lines 50 and 51)	114,820	52
53	Total Program inpatient operating cost excluding capital related, nonphysician anesthetist and medical education costs (line 49 minus line 52)	2,375,916	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: 07/01/2015 To: 06/30/2016	Run Date: 11/19/2016 Run Time: 10:33 Version: 2016.05 (11/01/2016)
--	--------------------------------	--	--

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT

COMPONENT CCN: 14-0210

WORKSHEET D-3

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

(A)	COST CENTER DESCRIPTION	Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
		1	2	3	
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>					
30	Adults & Pediatrics		2,452,560		30
40	Subprovider - IPF				40
<b>ANCILLARY SERVICE COST CENTERS</b>					
50	Operating Room	0.298796	217,357	64,945	50
53	Anesthesiology	0.150571	166,140	25,016	53
54	Radiology-Diagnostic	0.325684	338,407	110,214	54
57	CT Scan	0.039676	1,411,858	56,017	57
60	Laboratory	0.165165	2,760,685	455,969	60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS				62.30
64	Intravenous Therapy	0.029819	3,132,700	93,414	64
65	Respiratory Therapy	0.156075	2,891,351	451,268	65
66	Physical Therapy	0.459803	554,913	255,151	66
69	Electrocardiology	0.129050	232,857	30,050	69
71	Medical Supplies Charged to Patients	0.829676	571,149	473,869	71
72	Impl. Dev. Charged to Patients	0.750000	287,717	215,788	72
73	Drugs Charged to Patients	0.380842	1,165,038	443,695	73
75	ASC (Non-Distinct Part)	0.340221	112,990	38,442	75
76	NUCLEAR MEDICINE	0.207501	74,962	15,555	76
76.01	ULTRASOUND	0.095625	700,205	66,957	76.01
76.02	MAMMOGRAPHY	0.338701			76.02
76.03	CARDIAC REHABILITATION				76.03
76.04	FAITH CENTER CHEMOTHERAPY	0.936165			76.04
76.06	ROUTINE ANCILLARY				76.06
76.97	CARDIAC REHABILITATION	0.367576	8,551	3,143	76.97
76.98	HYPERBARIC OXYGEN THERAPY				76.98
76.99	LITHOTRIPSY				76.99
<b>OUTPATIENT SERVICE COST CENTERS</b>					
88	Rural Health Clinic				88
88.01	RHC II				88.01
91	Emergency	0.361134	642,705	232,103	91
92	Observation Beds (Non-Distinct Part)	0.526676	451,248	237,661	92
93	DAY PSYCHIATRIC	0.694892			93
<b>OTHER REIMBURSABLE COST CENTERS</b>					
200	Total (sum of lines 50-94, and 96-98)		15,720,833	3,269,257	200
201	Less PBP Clinic Laboratory Services-Program only charges (line 61)				201
202	Net Charges (line 200 minus line 201)		15,720,833		202

(A) Worksheet A line numbers

HARRISBURG MEDICAL CENTER, INC. Provider CCN: 14-0210	In Lieu of Form CMS-2552-10	Period : From: 07/01/2015 To: 06/30/2016	Run Date: 11/19/2016 Run Time: 10:33 Version: 2016.05 (11/01/2016)
--	--------------------------------	--	--

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT

COMPONENT CCN: 14-S210

WORKSHEET D-3

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

(A)	COST CENTER DESCRIPTION	Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
		1	2	3	
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>					
30	Adults & Pediatrics				30
40	Subprovider - IPF		3,878,749		40
<b>ANCILLARY SERVICE COST CENTERS</b>					
50	Operating Room	0.298796			50
53	Anesthesiology	0.150571	529	80	53
54	Radiology-Diagnostic	0.325684	29,456	9,593	54
57	CT Scan	0.039676	102,433	4,064	57
60	Laboratory	0.165165	366,561	60,543	60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS				62.30
64	Intravenous Therapy	0.029819	68,191	2,033	64
65	Respiratory Therapy	0.156075	330,189	51,534	65
66	Physical Therapy	0.459803	48,887	22,478	66
69	Electrocardiology	0.129050	22,572	2,913	69
71	Medical Supplies Charged to Patients	0.829676	39,141	32,474	71
72	Impl. Dev. Charged to Patients	0.750000			72
73	Drugs Charged to Patients	0.380842	560,984	213,646	73
75	ASC (Non-Distinct Part)	0.340221			75
76	NUCLEAR MEDICINE	0.207501	5,235	1,086	76
76.01	ULTRASOUND	0.095625	19,554	1,870	76.01
76.02	MAMMOGRAPHY	0.338701			76.02
76.03	CARDIAC REHABILITATION				76.03
76.04	FAITH CENTER CHEMOTHERAPY	0.936165			76.04
76.06	ROUTINE ANCILLARY				76.06
76.97	CARDIAC REHABILITATION	0.367576			76.97
76.98	HYPERBARIC OXYGEN THERAPY				76.98
76.99	LITHOTRIPSY				76.99
<b>OUTPATIENT SERVICE COST CENTERS</b>					
88	Rural Health Clinic				88
88.01	RHC II				88.01
91	Emergency	0.361134	93,480	33,759	91
92	Observation Beds (Non-Distinct Part)	0.526676			92
93	DAY PSYCHIATRIC	0.694892			93
<b>OTHER REIMBURSABLE COST CENTERS</b>					
200	Total (sum of lines 50-94, and 96-98)		1,687,212	436,073	200
201	Less PBP Clinic Laboratory Services-Program only charges (line 61)				201
202	Net Charges (line 200 minus line 201)		1,687,212		202

(A) Worksheet A line numbers

HARRISBURG MEDICAL CENTER, INC. Provider CCN: 14-0210	In Lieu of Form CMS-2552-10	Period : From: 07/01/2015 To: 06/30/2016	Run Date: 11/19/2016 Run Time: 10:33 Version: 2016.05 (11/01/2016)
--	--------------------------------	--	--

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT

COMPONENT CCN: 14-U210

WORKSHEET D-3

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

(A)	COST CENTER DESCRIPTION	Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
		1	2	3	
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>					
30	Adults & Pediatrics				30
40	Subprovider - IPF				40
<b>ANCILLARY SERVICE COST CENTERS</b>					
50	Operating Room	0.298796			50
53	Anesthesiology	0.150571			53
54	Radiology-Diagnostic	0.325684	1,417	461	54
57	CT Scan	0.039676			57
60	Laboratory	0.165165	25,133	4,151	60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS				62.30
64	Intravenous Therapy	0.029819	39,699	1,184	64
65	Respiratory Therapy	0.156075	59,058	9,217	65
66	Physical Therapy	0.459803	76,305	35,085	66
69	Electrocardiology	0.129050	594	77	69
71	Medical Supplies Charged to Patients	0.829676	10,603	8,797	71
72	Impl. Dev. Charged to Patients	0.750000			72
73	Drugs Charged to Patients	0.380842	35,434	13,495	73
75	ASC (Non-Distinct Part)	0.340221	55	19	75
76	NUCLEAR MEDICINE	0.207501			76
76.01	ULTRASOUND	0.095625	1,728	165	76.01
76.02	MAMMOGRAPHY	0.338701			76.02
76.03	CARDIAC REHABILITATION				76.03
76.04	FAITH CENTER CHEMOTHERAPY	0.936165			76.04
76.06	ROUTINE ANCILLARY				76.06
76.97	CARDIAC REHABILITATION	0.367576			76.97
76.98	HYPERBARIC OXYGEN THERAPY				76.98
76.99	LITHOTRIPSY				76.99
<b>OUTPATIENT SERVICE COST CENTERS</b>					
88	Rural Health Clinic				88
88.01	RHC II				88.01
91	Emergency	0.360285			91
92	Observation Beds (Non-Distinct Part)	0.526676			92
93	DAY PSYCHIATRIC	0.694892			93
<b>OTHER REIMBURSABLE COST CENTERS</b>					
200	Total (sum of lines 50-94, and 96-98)		250,026	72,651	200
201	Less PBP Clinic Laboratory Services-Program only charges (line 61)				201
202	Net Charges (line 200 minus line 201)		250,026		202

(A) Worksheet A line numbers

HARRISBURG MEDICAL CENTER, INC. Provider CCN: 14-0210	In Lieu of Form CMS-2552-10	Period : From: 07/01/2015 To: 06/30/2016	Run Date: 11/19/2016 Run Time: 10:33 Version: 2016.05 (11/01/2016)
--	--------------------------------	--	--

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)	1,060,207			1.01
1.02	DRG amounts other than outlier payments for discharges occurring on or after October 1 (see instructions)	3,180,621			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)	736			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)	39.79			4
<b>Indirect Medical Education Adjustment Calculation for Hospitals</b>					
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
<b>Indirect Medical Education Adjustment for the Add-on for Section 422 of the MMA</b>					
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
<b>Disproportionate Share Adjustment</b>					
30	Percentage of SSI recipient patient days to Medicare Part A patient days (see instructions)	0.0697			30
31	Percentage of Medicaid patient days to total patient days (see instructions)	0.1762			31
32	Sum of lines 30 and 31	0.2459			32
33	Allowable disproportionate share percentage (see instructions)	0.0874			33
34	Disproportionate share adjustment (see instructions)	92,663			34
		<b>Prior to</b>		<b>On or after</b>	
		<b>October 1 (1.00)</b>	<b>(1.01)</b>	<b>October 1 (2.00)</b>	
35	Total uncompensated care amount (see instructions)	7,647,644,885		6,406,145,534	35
35.01	Factor 3 (see instructions)	0.000012882		0.000013277	35.01
35.02	Hospital uncompensated care payment (If line 34 is zero, enter zero on this line) (see instructions)	98,517		85,054	35.02
35.03	Pro rata share of the hospital uncompensated care payment amount (see instructions)	24,832		63,674	35.03
36	Total uncompensated care (sum of columns 1 and 2 on line 35.03)	88,506			36
<b>Additional Payment for High Percentage of ESRD Beneficiary Discharges (lines 40 through 46)</b>					
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: 07/01/2015 To: 06/30/2016	Run Date: 11/19/2016 Run Time: 10:33 Version: 2016.05 (11/01/2016)
--	--------------------------------	--	--

CALCULATION OF REIMBURSEMENT SETTLEMENT

WORKSHEET E  
PART A

PART A - INPATIENT HOSPITAL SERVICES UNDER PPS

		1	1.01	1.02	
47	Subtotal (see instructions)	4,422,733			47
48	Hospital specific payments (to be completed by SCH and MDH, small rural hospitals only (see instructions)	5,024,301			48
49	Total payment for inpatient operating costs (see instructions)	5,024,301			49
50	Payment for inpatient program capital (from Wkst. L, Pt. I and Pt. II, as applicable)	334,910			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)	5,359,211			59
60	Primary payer payments	1,552			60
61	Total amount payable for program beneficiaries (line 59 minus line 60)	5,357,659			61
62	Deductibles billed to program beneficiaries	722,484			62
63	Coinsurance billed to program beneficiaries	10,556			63
64	Allowable bad debts (see instructions)	230,820			64
65	Adjusted reimbursable bad debts (see instructions)	150,033			65
66	Allowable bad debts for dual eligible beneficiaries (see instructions)	208,760			66
67	Subtotal (line 61 plus line 65 minus lines 62 and 63)	4,774,652			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)	33,752			70.93
70.94	HRR adjustment amount (see instructions)	-49,864			70.94
70.96	Low volume adjustment for federal fiscal year (2015)	196,424			70.96
70.97	Low volume adjustment for federal fiscal year (2016)	442,854			70.97
71	Amount due provider (see instructions)	5,397,818			71
71.01	Sequestration adjustment (see instructions)	107,956			71.01
72	Interim payments	5,319,670			72
73	Tentative settlement (for contractor use only)				73
74	Balance due provider (Program) (line 71 minus lines 71.01, 72 and 73)	-29,808			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: 07/01/2015 To: 06/30/2016	Run Date: 11/19/2016 Run Time: 10:33 Version: 2016.05 (11/01/2016)
--	--	--	--

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					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	1,060,207		1,060,207				1,060,207	1.01
1.02	DRG amounts other than outlier payments for discharges occurring on or after October 1	3,180,621				3,180,621		3,180,621	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	736				736		736	2
2.01	Outlier payment for discharges for Model 4 BPCI								2.01
3	Operating outlier reconciliation								3
4	Managed Care Simulated Payments								4
	<b>Indirect Medical Education Adjustment</b>								
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
	<b>Indirect Medical Education Adjustment for the Add-on for Section 422 of the MMA</b>								
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
	<b>Disproportionate Share Adjustment</b>								
10	Allowable disproportionate share percentage	0.0874	0.0874	0.0874	0.0874	0.0874	0.0874		10
11	Disproportionate share adjustment	92,663		23,166		69,497		92,663	11
11.01	Uncompensated care payments	88,506		24,832		63,674		88,506	11.01
	<b>Additional payment for high percentage of ESRD beneficiary discharges</b>								
12	Total ESRD additional payment								12
13	Subtotal	4,422,733		1,108,205		3,314,528		4,422,733	13
14	Hospital specific payments (to be completed by SCH and MDH, small rural hospitals only.)	5,024,301		1,256,075		3,768,226		5,024,301	14
15	Total payment for inpatient operating costs SCH and MDH only	5,024,301		1,256,075		3,768,226		5,024,301	15
16	Payment for inpatient program capital (from Worksheet L, Parts I, as applicable)	334,910		83,728		251,182		334,910	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	<b>SUBTOTAL</b>			1,339,803		4,019,408		5,359,211	19
20	Capital DRG other than outlier	334,910		83,728		251,182		334,910	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	334,910		83,728		251,182		334,910	26
27	<b>Low volume adjustment factor</b>			0.146607		0.110179			27
28	Low volume adjustment (transfer amount to Worksheet E, Part A, line 70.96)(prior to 10/1)			196,424				196,424	28
29	Low Volume Adjustment (transfer amount to Worksheet E, Part A, line 70.97)(on/after 10/1)					442,854		442,854	29

HARRISBURG MEDICAL CENTER, INC. Provider CCN: 14-0210	In Lieu of Form CMS-2552-10	Period : From: 07/01/2015 To: 06/30/2016	Run Date: 11/19/2016 Run Time: 10:33 Version: 2016.05 (11/01/2016)
--	--------------------------------	--	--

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)	6,253,086			2
3	PPS payments	5,683,738			3
4	Outlier payment (see instructions)	1,910			4
5	Enter the hospital specific payment to cost ratio (see instructions)	0.850			5
6	Line 2 times line 5	5,315,123			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
	<b>COMPUTATION OF LESSER OF COST OR CHARGES</b>				
	<b>REASONABLE CHARGES</b>				
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
	<b>CUSTOMARY CHARGES</b>				
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)	5,685,648			24
	<b>COMPUTATION OF REIMBURSEMENT SETTLEMENT</b>				
25	Deductibles and coinsurance (see instructions)				25
26	Deductibles and coinsurance relating to amount on line 24 (see instructions)	1,215,816			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)	4,469,832			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)	4,469,832			30
31	Primary payer payments	992			31
32	Subtotal (line 30 minus line 31)	4,468,840			32
	<b>ALLOWABLE BAD DEBTS (EXCLUDE BAD DEBTS FOR PROFESSIONAL SERVICES)</b>				
33	Composite rate ESRD (from Wkst. I-5, line 11)				33
34	Allowable bad debts (see instructions)	323,426			34
35	Adjusted reimbursable bad debts (see instructions)	210,227			35
36	Allowable bad debts for dual eligible beneficiaries (see instructions)	298,138			36
37	Subtotal (see instructions)	4,679,067			37
38	MSP-LCC reconciliation amount from PS&R	-73			38
39	Other adjustments (specify) (see instructions)	4,233			39
39.50	Pioneer ACO demonstration payment adjustment (see instructions)				39.50
40	Subtotal (see instructions)	4,683,373			40
40.01	Sequestration adjustment (see instructions)	93,667			40.01
41	Interim payments	4,609,689			41
42	Tentative settlement (for contractors use only)				42
43	Balance due provider/program (see instructions)	-19,983			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: 07/01/2015 To: 06/30/2016	Run Date: 11/19/2016 Run Time: 10:33 Version: 2016.05 (11/01/2016)
--	--------------------------------	--	--

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)	612		2
3	PPS payments	845		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
<b>COMPUTATION OF LESSER OF COST OR CHARGES</b>				
<b>REASONABLE CHARGES</b>				
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
<b>CUSTOMARY CHARGES</b>				
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)	845		24
<b>COMPUTATION OF REIMBURSEMENT SETTLEMENT</b>				
25	Deductibles and coinsurance (see instructions)			25
26	Deductibles and coinsurance relating to amount on line 24 (see instructions)	209		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)	636		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)	636		30
31	Primary payer payments			31
32	Subtotal (line 30 minus line 31)	636		32
<b>ALLOWABLE BAD DEBTS (EXCLUDE BAD DEBTS FOR PROFESSIONAL SERVICES)</b>				
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)	636		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)	636		40
40.01	Sequestration adjustment (see instructions)	13		40.01
41	Interim payments	623		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: 07/01/2015 To: 06/30/2016	Run Date: 11/19/2016 Run Time: 10:33 Version: 2016.05 (11/01/2016)
--	--------------------------------	--	--

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 1	AMOUNT 2	mm/dd/yyyy 3	AMOUNT 4	
1 Total interim payments paid to provider		5,319,670		4,609,689	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)		5,319,670		4,609,689	4
<b>TO BE COMPLETED BY CONTRACTOR</b>					
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				6.01
	.02		-29,808	-19,983	6.02
7 Total Medicare program liability (see instructions)		5,289,862		4,589,706	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: 07/01/2015 To: 06/30/2016	Run Date: 11/19/2016 Run Time: 10:33 Version: 2016.05 (11/01/2016)
--	--------------------------------	--	--

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 1	AMOUNT 2	mm/dd/yyyy 3	AMOUNT 4	
1	Total interim payments paid to provider		2,501,143		623	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)		2,501,143		623	4
<b>TO BE COMPLETED BY CONTRACTOR</b>						
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				6.01
		.02				6.02
7	Total Medicare program liability (see instructions)		-22,345			6.02
8	Name of Contractor		2,478,798		623	7
			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: 07/01/2015 To: 06/30/2016	Run Date: 11/19/2016 Run Time: 10:33 Version: 2016.05 (11/01/2016)
--	--------------------------------	--	--

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 1	AMOUNT 2	mm/dd/yyyy 3	AMOUNT 4
1	Total interim payments paid to provider		41,023		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)		41,023		4
<b>TO BE COMPLETED BY CONTRACTOR</b>					
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			6.01
		.02			6.02
7	Total Medicare program liability (see instructions)		41,023		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: 07/01/2015 To: 06/30/2016	Run Date: 11/19/2016 Run Time: 10:33 Version: 2016.05 (11/01/2016)
--	--------------------------------	--	--

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)	1,546	1
2	Medicare days (Wkst. S-3, Pt. I, col. 6, sum of lines 1, 8-12)	2,426	2
3	Medicare HMO days (Wkst. S-3, Pt. I, col. 6, line 2)	438	3
4	Total inpatient days (Wkst. S-3, Pt. I, col. 8, sum of lines 1, 8-12)	4,063	4
5	Total hospital charges (Wkst. C, Pt. I, col. 8, line 200)	137,261,369	5
6	Total hospital charity care charges (Wkst. S-10, col. 3, line 20)	4,327,238	6
7	CAH only - The reasonable cost incurred for the purchase of certified HIT technology (Wkst. S-2, Pt. I, line 168)		7
8	Calculation of the HIT incentive payment (see instructions)		8
9	Sequestration adjustment amount (see instructions)		9
10	Calculation of the HIT incentive payment after sequestration (see instructions)		10

INPATIENT HOSPITAL SERVICES UNDER THE IPPS & CAH

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

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

HARRISBURG MEDICAL CENTER, INC. Provider CCN: 14-0210	In Lieu of Form CMS-2552-10	Period : From: 07/01/2015 To: 06/30/2016	Run Date: 11/19/2016 Run Time: 10:33 Version: 2016.05 (11/01/2016)
--	--------------------------------	--	--

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)	42,333		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. 6 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	144		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)	42,333		8
9	Primary payer payments (see instructions)			9
10	Subtotal (line 8 minus line 9)	42,333		10
11	Deductibles billed to program patients (exclude amounts applicable to physician professional services)			11
12	Subtotal (line 10 minus line 11)	42,333		12
13	Coinsurance billed to program patients (from provider records) (exclude coinsurance for physician professional services)	473		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)	41,860		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)	41,860		19
19.01	Sequestration adjustment (see instructions)	837		19.01
20	Interim payments	41,023		20
21	Tentative settlement (for contractor use only)			21
22	Balance due provider/program (line 19 minus lines 19.01, 20 and 21)			22
23	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2			23

HARRISBURG MEDICAL CENTER, INC. Provider CCN: 14-0210	In Lieu of Form CMS-2552-10	Period : From: 07/01/2015 To: 06/30/2016	Run Date: 11/19/2016 Run Time: 10:33 Version: 2016.05 (11/01/2016)
--	--------------------------------	--	--

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)	2,746,924	1
2	Net IPF PPS Outlier payment	526	2
3	Net IPF PPS ECT payment	281	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)	27,027,322	9
10	Teaching adjustment factor $\{(1 + (\text{line 8}/\text{line 9}))\}$ raised to the power of .5150 -1)		10
11	Teaching adjustment (line 1 multiplied by line 10)		11
12	Adjusted Net IPF PPS Payments (sum of lines 1, 2, 3 and 11)	2,747,731	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)	2,747,731	16
17	Primary payer payments		17
18	Subtotal (line 16 less line 17)	2,747,731	18
19	Deductibles	281,454	19
20	Subtotal (line 18 minus line 19)	2,466,277	20
21	Coinsurance	45,332	21
22	Subtotal (line 20 minus line 21)	2,420,945	22
23	Allowable bad debts (exclude bad debts for professional services) (see instructions)	166,832	23
24	Adjusted reimbursable bad debts (see instructions)	108,441	24
25	Allowable bad debts for dual eligible beneficiaries (see instructions)	137,976	25
26	Subtotal (sum of lines 22 and 24)	2,529,386	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)	2,529,386	31
31.01	Sequestration adjustment (see instructions)	50,588	31.01
32	Interim payments	2,501,143	32
33	Tentative settlement (for contractor use only)		33
34	Balance due provider/program (line 31 minus lines 31.01, 32 and 33)	-22,345	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: 07/01/2015 To: 06/30/2016	Run Date: 11/19/2016 Run Time: 10:33 Version: 2016.05 (11/01/2016)
--	--------------------------------	--	--

BALANCE SHEET

WORKSHEET G

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

Assets (Omit Cents)		General Fund	Specific Purpose Fund	Endowment Fund	Plant Fund
		1	2	3	4
<b>CURRENT ASSETS</b>					
1	Cash on hand and in banks	2,887,355			1
2	Temporary investments				2
3	Notes receivable				3
4	Accounts receivable	8,140,321			4
5	Other receivables	2,334,829			5
6	Allowances for uncollectible notes and accounts receivable				6
7	Inventory	1,147,919			7
8	Prepaid expenses	932,545			8
9	Other current assets	96,983			9
10	Due from other funds				10
11	Total current assets (sum of lines 1-10)	15,539,952			11
<b>FIXED ASSETS</b>					
12	Land	810,438			12
13	Land improvements	833,407			13
14	Accumulated depreciation				14
15	Buildings	24,828,549			15
16	Accumulated depreciation				16
17	Leasehold improvements				17
18	Accumulated depreciation				18
19	Fixed equipment	11,923,366			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	3,697,125			27
28	Accumulated depreciation	-21,822,756			28
29	Minor equipment-nondepreciable				29
30	Total fixed assets (sum of lines 12-29)	20,270,129			30
<b>OTHER ASSETS</b>					
31	Investments	5,543,448			31
32	Deposits on leases				32
33	Due from owners/officers				33
34	Other assets	411,415			34
35	Total other assets (sum of lines 31-34)	5,954,863			35
36	Total assets (sum of lines 11, 30 and 35)	41,764,944			36
<b>Liabilities and Fund Balances (Omit Cents)</b>					
		General Fund	Specific Purpose Fund	Endowment Fund	Plant Fund
		1	2	3	4
<b>CURRENT LIABILITIES</b>					
37	Accounts payable	1,849,161			37
38	Salaries, wages and fees payable	2,021,542			38
39	Payroll taxes payable				39
40	Notes and loans payable (short term)	343,584			40
41	Deferred income				41
42	Accelerated payments				42
43	Due to other funds				43
44	Other current liabilities	2,299,338			44
45	Total current liabilities (sum of lines 37 thru 44)	6,513,625			45
<b>LONG TERM LIABILITIES</b>					
46	Mortgage payable				46
47	Notes payable	9,748,715			47
48	Unsecured loans				48
49	Other long term liabilities	200,000			49
50	Total long term liabilities (sum of lines 46 thru 49)	9,948,715			50
51	Total liabilities (sum of lines 45 and 50)	16,462,340			51
<b>CAPITAL ACCOUNTS</b>					
52	General fund balance	25,302,604			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)	25,302,604			59
60	Total liabilities and fund balances (sum of lines 51 and 59)	41,764,944			60

HARRISBURG MEDICAL CENTER, INC. Provider CCN: 14-0210	In Lieu of Form CMS-2552-10	Period : From: 07/01/2015 To: 06/30/2016	Run Date: 11/19/2016 Run Time: 10:33 Version: 2016.05 (11/01/2016)
--	--------------------------------	--	--

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		29,875,935		1
2	Net income (loss) (from Worksheet G-3, line 29)		-4,573,331		2
3	Total (sum of line 1 and line 2)		25,302,604		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)		25,302,604		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)		25,302,604		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: 07/01/2015 To: 06/30/2016	Run Date: 11/19/2016 Run Time: 10:33 Version: 2016.05 (11/01/2016)
--	--------------------------------	--	--

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	
	<b>GENERAL INPATIENT ROUTINE CARE SERVICES</b>				
1	Hospital	5,145,152		5,145,152	1
2	Subprovider IPF	15,836,401		15,836,401	2
3	Subprovider IRF				3
5	Swing Bed - SNF	375,555		375,555	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)	21,357,108		21,357,108	10
	<b>INTENSIVE CARE TYPE INPATIENT HOSPITAL SERVICES</b>				
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)	21,357,108		21,357,108	17
18	Ancillary services	20,603,434		20,603,434	18
19	Outpatient services		99,862,254	99,862,254	19
20	Rural Health Clinic (RHC)		4,604,069	4,604,069	20
20.01	RHC II				20.01
21	Federally Qualified Health Center (FQHC)				21
22	Home health agency		969,202	969,202	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)	41,960,542	105,435,525	147,396,067	28

PART II - OPERATING EXPENSES

		1	2	
29	Operating expenses (per Worksheet A, column 3, line 200)		54,005,609	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)		54,005,609	43

HARRISBURG MEDICAL CENTER, INC. Provider CCN: 14-0210	In Lieu of Form CMS-2552-10	Period : From: 07/01/2015 To: 06/30/2016	Run Date: 11/19/2016 Run Time: 10:33 Version: 2016.05 (11/01/2016)
--	--------------------------------	--	--

STATEMENT OF REVENUES AND EXPENSES

WORKSHEET G-3

	DESCRIPTION		
1	Total patient revenues (from Worksheet G-2, Part I, column 3, line 28)	147,396,067	1
2	Less contractual allowances and discounts on patients' accounts	97,548,350	2
3	Net patient revenues (line 1 minus line 2)	49,847,717	3
4	Less total operating expenses (from Worksheet G-2, Part II, line 43)	54,005,609	4
5	Net income from service to patients (line 3 minus line 4)	-4,157,892	5

OTHER INCOME

6	Contributions, donations, bequests, etc.		6
7	Income from investments	11,544	7
8	Revenues from telephone and other miscellaneous communication services		8
9	Revenue from television and radio service	5,707	9
10	Purchase discounts	3,801	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	113,052	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	131	18
19	Tuition (fees, sale of textbooks, uniforms, etc.)		19
20	Revenue from gifts, flowers, coffee shops and canteen		20
21	Rental of vending machines		21
22	Rental of hosptial space	98,347	22
23	Governmental appropriations		23
24	Other (PSYCH REIMBURSEMENT)	2,345	24
24.01	Other (MEANINGFUL USE)	118,331	24.01
24.02	Other (OTHER MISC INCOME)	59,555	24.02
24.03	Other (UNREALIZED GAIN ON INVESTMENT)		24.03
24.04	Other (GRANT RECEIPTS)	150	24.04
24.05	Other (DONATIONS)		24.05
24.06	Other (MISC REVENUE)	1	24.06
25	Total other income (sum of lines 6-24)	412,964	25
26	Total (line 5 plus line 25)	-3,744,928	26
27	Other expenses (UNDISTRIBUTED LOSS OF SUBSIDIARY)	719,271	27
27.01	Other expenses (LOSS ON DISPOSAL OF ASSETS)	19,750	27.01
27.02	Other expenses (EXTRAORDINARY LOSS)		27.02
27.03	Other expenses (UNREALIZED LOSS ON INVESTMENTS)	86,737	27.03
27.04	Other expenses (MISC EXPENSE)	2,645	27.04
28	Total other expenses (sum of line 27 and subscripts)	828,403	28
29	Net income (or loss) for the period (line 26 minus line 28)	-4,573,331	29

HARRISBURG MEDICAL CENTER, INC. Provider CCN: 14-0210	In Lieu of Form CMS-2552-10	Period : From: 07/01/2015 To: 06/30/2016	Run Date: 11/19/2016 Run Time: 10:33 Version: 2016.05 (11/01/2016)
--	--------------------------------	--	--

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	
	<b>GENERAL SERVICE COST CENTERS</b>						
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	142,664			4,120	20,283	5
	<b>HHA REIMBURSABLE SERVICES</b>						
6	Skilled Nursing Care	261,414		31,170			6
7	Physical Therapy	107,866		20,634			7
8	Occupational Therapy	5,078		1,024			8
9	Speech Pathology	4,791		537			9
10	Medical Social Services						10
11	Home Health Aide						11
12	Supplies (see instructions)						12
13	Drugs						13
14	DME						14
	<b>HHA NONREIMBURSABLE SERVICES</b>						
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)	521,813		53,365	4,120	20,283	24

HARRISBURG MEDICAL CENTER, INC. Provider CCN: 14-0210	In Lieu of Form CMS-2552-10	Period : From: 07/01/2015 To: 06/30/2016	Run Date: 11/19/2016 Run Time: 10:33 Version: 2016.05 (11/01/2016)
--	--------------------------------	--	--

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	
	<b>GENERAL SERVICE COST CENTERS</b>						
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	167,067	-46,059	121,008	-45	120,963	5
	<b>HHA REIMBURSABLE SERVICES</b>						
6	Skilled Nursing Care	292,584		292,584		292,584	6
7	Physical Therapy	128,500		128,500		128,500	7
8	Occupational Therapy	6,102		6,102		6,102	8
9	Speech Pathology	5,328		5,328		5,328	9
10	Medical Social Services						10
11	Home Health Aide						11
12	Supplies (see instructions)						12
13	Drugs						13
14	DME						14
	<b>HHA NONREIMBURSABLE SERVICES</b>						
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)	599,581	-46,059	553,522	-45	553,477	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: 07/01/2015 To: 06/30/2016	Run Date: 11/19/2016 Run Time: 10:33 Version: 2016.05 (11/01/2016)
--	--------------------------------	--	--

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	
<b>GENERAL SERVICE COST CENTERS</b>						
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	120,963				5
<b>HHA REIMBURSABLE SERVICES</b>						
6	Skilled Nursing Care	292,584				6
7	Physical Therapy	128,500				7
8	Occupational Therapy	6,102				8
9	Speech Pathology	5,328				9
10	Medical Social Services					10
11	Home Health Aide					11
12	Supplies (see instructions)					12
13	Drugs					13
14	DME					14
<b>HHA NONREIMBURSABLE SERVICES</b>						
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)	553,477				24

HARRISBURG MEDICAL CENTER, INC. Provider CCN: 14-0210	In Lieu of Form CMS-2552-10	Period : From: 07/01/2015 To: 06/30/2016	Run Date: 11/19/2016 Run Time: 10:33 Version: 2016.05 (11/01/2016)
--	--------------------------------	--	--

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	
	<b>GENERAL SERVICE COST CENTERS</b>					
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		120,963	120,963		5
	<b>HHA REIMBURSABLE SERVICES</b>					
6	Skilled Nursing Care		292,584	77,654	370,238	6
7	Physical Therapy		128,500	33,107	161,607	7
8	Occupational Therapy		6,102	1,983	8,085	8
9	Speech Pathology		5,328	3,450	8,778	9
10	Medical Social Services					10
11	Home Health Aide			4,769	4,769	11
12	Supplies (see instructions)					12
13	Drugs					13
14	DME					14
	<b>HHA NONREIMBURSABLE SERVICES</b>					
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)		553,477		553,477	24

HARRISBURG MEDICAL CENTER, INC. Provider CCN: 14-0210	In Lieu of Form CMS-2552-10	Period : From: 07/01/2015 To: 06/30/2016	Run Date: 11/19/2016 Run Time: 10:33 Version: 2016.05 (11/01/2016)
--	--------------------------------	--	--

COST ALLOCATION - HHA STATISTICAL BASIS

HHA CCN: 14-7419

WORKSHEET H-1  
PART II

		CAPITAL RELATED COSTS		PLANT OPERATION & MAINTENANCE (Square Feet)	TRANSPORT- ATION (Mileage)	RECONCIL- IATION	ADMINI- STRATIVE & GENERAL (Accum. Cost)	
		BLDGS. & FIXTURES (Square Feet)	MOVABLE EQUIPMENT (Dollar Value)					
		1	2	3	4	5A	5	
	<b>GENERAL SERVICE COST CENTERS</b>							
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					-120,963	936,919	5
	<b>HHA REIMBURSABLE SERVICES</b>							
6	Skilled Nursing Care					308,892	601,476	6
7	Physical Therapy					127,927	256,427	7
8	Occupational Therapy					9,257	15,359	8
9	Speech Pathology					21,394	26,722	9
10	Medical Social Services							10
11	Home Health Aide					36,935	36,935	11
12	Supplies (see instructions)							12
13	Drugs							13
14	DME							14
	<b>HHA NONREIMBURSABLE SERVICES</b>							
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)					383,442	936,919	24
25	Cost To Be Allocated (per Worksheet H-1, Part I)						120,963	25
26	Unit Cost Multiplier						0.129107	26

HARRISBURG MEDICAL CENTER, INC. Provider CCN: 14-0210	In Lieu of Form CMS-2552-10	Period : From: 07/01/2015 To: 06/30/2016	Run Date: 11/19/2016 Run Time: 10:33 Version: 2016.05 (11/01/2016)
--	--------------------------------	--	--

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				28,913	28,913	6,333	1
2	Skilled Nursing Care	370,238			84,742	454,980	99,655	2
3	Physical Therapy	161,607			34,966	196,573	43,056	3
4	Occupational Therapy	8,085			1,646	9,731	2,131	4
5	Speech Pathology	8,778			1,553	10,331	2,263	5
6	Medical Social Services							6
7	Home Health Aide	4,769				4,769	1,045	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)	553,477			151,820	705,297	154,483	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: 07/01/2015 To: 06/30/2016	Run Date: 11/19/2016 Run Time: 10:33 Version: 2016.05 (11/01/2016)
--	--------------------------------	--	--

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				12,990			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)				12,990			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: 07/01/2015 To: 06/30/2016	Run Date: 11/19/2016 Run Time: 10:33 Version: 2016.05 (11/01/2016)
--	--------------------------------	--	--

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	NURSING ADMINIS- TRATION	CENTRAL SERVICES & SUPPLY	PHARMACY	MEDICAL RECORDS & LIBRARY	SOCIAL SERVICE	
		12	13	14	15	16	17	
1	Administrative and General		11,493	9,062		8,711		1
2	Skilled Nursing Care							2
3	Physical Therapy							3
4	Occupational Therapy							4
5	Speech Pathology							5
6	Medical Social Services							6
7	Home Health Aide							7
8	Supplies							8
9	Drugs							9
10	DME							10
11	Home Dialysis Aide Services							11
12	Respiratory Therapy							12
13	Private Duty Nursing							13
14	Clinic							14
15	Health Promotion Activities							15
16	Day Care Program							16
17	Home Delivered Meals Program							17
18	Homemaker Service							18
19	All Others							19
20	Totals (sum of lines 1-19)(2)		11,493	9,062		8,711		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: 07/01/2015 To: 06/30/2016	Run Date: 11/19/2016 Run Time: 10:33 Version: 2016.05 (11/01/2016)
--	--------------------------------	--	--

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						77,502	1
2	Skilled Nursing Care						554,635	2
3	Physical Therapy						239,629	3
4	Occupational Therapy						11,862	4
5	Speech Pathology						12,594	5
6	Medical Social Services							6
7	Home Health Aide						5,814	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)						902,036	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: 07/01/2015 To: 06/30/2016	Run Date: 11/19/2016 Run Time: 10:33 Version: 2016.05 (11/01/2016)
--	--------------------------------	--	--

ALLOCATION OF GENERAL SERVICE COSTS TO HHA COST CENTERS

HHA CCN: 14-7419

WORKSHEET H-2  
PART I

	HHA COST CENTER (omit cents)	I&R COST & POST STEP- DOWN ADJS	SUBTOTAL (cols 23 +/- 24)	ALLOCATED HHA A&G (see PtlI)	TOTAL HHA COSTS		
		25	26	27	28		
1	Administrative and General		77,502				1
2	Skilled Nursing Care		554,635	52,133	606,768		2
3	Physical Therapy		239,629	22,524	262,153		3
4	Occupational Therapy		11,862	1,115	12,977		4
5	Speech Pathology		12,594	1,184	13,778		5
6	Medical Social Services						6
7	Home Health Aide		5,814	546	6,360		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)		902,036	77,502	902,036		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.			0.093995			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: 07/01/2015 To: 06/30/2016	Run Date: 11/19/2016 Run Time: 10:33 Version: 2016.05 (11/01/2016)
--	--------------------------------	--	--

ALLOCATION OF GENERAL SERVICE COSTS TO HHA COST CENTERS STATISTICAL BASIS

HHA CCN: 14-7419

WORKSHEET H-2  
PART II

	HHA COST CENTER	CAP BLDGS & FIXTURES SQUARE FEET	CAP MOVABLE EQUIPMENT DOLLAR VALUE	EMPLOYEE BENEFITS DEPARTMENT GROSS SALARIES	RECON- CILIATION	ADMINIS- TRATIVE & GENERAL ACCUM COST	MAIN- TENANCE & REPAIRS SQUARE FEET	
		1	2	4	4A	5	6	
1	Administrative and General			89,191		28,913		1
2	Skilled Nursing Care			261,414		454,980		2
3	Physical Therapy			107,866		196,573		3
4	Occupational Therapy			5,078		9,731		4
5	Speech Pathology			4,791		10,331		5
6	Medical Social Services							6
7	Home Health Aide					4,769		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)			468,340		705,297		20
21	Total cost to be allocated			151,820		154,483		21
22	Unit Cost Multiplier			0.324166		0.219033		22
22	Unit Cost Multiplier							22

HARRISBURG MEDICAL CENTER, INC. Provider CCN: 14-0210	In Lieu of Form CMS-2552-10	Period : From: 07/01/2015 To: 06/30/2016	Run Date: 11/19/2016 Run Time: 10:33 Version: 2016.05 (11/01/2016)
--	--------------------------------	--	--

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			35				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)			35				20
21	Total cost to be allocated			12,990				21
22	Unit Cost Multiplier			371.142857				22
22	Unit Cost Multiplier							22

HARRISBURG MEDICAL CENTER, INC. Provider CCN: 14-0210	In Lieu of Form CMS-2552-10	Period : From: 07/01/2015 To: 06/30/2016	Run Date: 11/19/2016 Run Time: 10:33 Version: 2016.05 (11/01/2016)
--	--------------------------------	--	--

ALLOCATION OF GENERAL SERVICE COSTS TO HHA COST CENTERS STATISTICAL BASIS

HHA CCN: 14-7419

WORKSHEET H-2  
PART II

	HHA COST CENTER	NURSING ADMINISTRATION DIRECT NRSING HRS 13	CENTRAL SERVICES & SUPPLY COSTED REQUIS. 14	PHARMACY COSTED REQUIS. 15	MEDICAL RECORDS & LIBRARY GROSS REVENUE 16	SOCIAL SERVICE TIME SPENT 17	NONPHYSIC. ANESTHET. ASSIGNED TIME 19	
1	Administrative and General	16,828	8,600		969,202			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)	16,828	8,600		969,202			20
21	Total cost to be allocated	11,493	9,062		8,711			21
22	Unit Cost Multiplier	0.682969						22
22	Unit Cost Multiplier		1.053721		0.008988			22

HARRISBURG MEDICAL CENTER, INC. Provider CCN: 14-0210	In Lieu of Form CMS-2552-10	Period : From: 07/01/2015 To: 06/30/2016	Run Date: 11/19/2016 Run Time: 10:33 Version: 2016.05 (11/01/2016)
--	--------------------------------	--	--

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: 07/01/2015 To: 06/30/2016	Run Date: 11/19/2016 Run Time: 10:33 Version: 2016.05 (11/01/2016)
--	--------------------------------	--	--

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								
	Patient Services	From Wkst. H-2, Part I, col. 28, line	Facility Costs (from Wkst. H-2, Part I)	Shared Ancillary Costs (from Part II)	Total HHA COSTS (cols. 1 + 2)	Total Visits	Average Cost Per Visit (col. 3 ÷ col. 4)	
		1	2	3	4	5		
1	Skilled Nursing Care	2	606,768		606,768	2,497	243.00	1
2	Physical Therapy	3	262,153		262,153	1,653	158.59	2
3	Occupational Therapy	4	12,977		12,977	82	158.26	3
4	Speech Pathology	5	13,778		13,778	43	320.42	4
5	Medical Social Services	6						5
6	Home Health Aide	7	6,360		6,360			6
7	Total (sum of lines 1-6)		902,036		902,036	4,275		7

Limitation Cost Computation			Program Visits		
	Patient Services	CBSA No.	Part A	Not Subject to Deductibles & Coinsurance	Subject to Deductibles & Coinsurance
		1	2	3	4
8	Skilled Nursing Care	99914		978	8
9	Physical Therapy	99914		977	9
10	Occupational Therapy	99914		37	10
11	Speech Pathology	99914		40	11
12	Medical Social Services	99914			12
13	Home Health Aide	99914			13
14	Total (sum of lines 8-13)			2,032	14

Supplies and Drugs Cost Computations							
	Other Patient Services	From Wkst. H-2, Part I, col. 28, line	Facility Costs (from Wkst. H-2, Part I)	Shared Ancillary Costs (from Part II)	Total HHA COSTS (cols. 1 + 2)	Total Charges (from HHA Records)	Ratio (col. 3 ÷ col. 4)
		1	2	3	4	5	
15	Cost of Medical Supplies	8				18,526	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	0.459803			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	0.829676			col. 2, line 15	4
5	Drugs Charged to Patients	73	0.380842			col. 2, line 16	5

HARRISBURG MEDICAL CENTER, INC. Provider CCN: 14-0210	In Lieu of Form CMS-2552-10	Period : From: 07/01/2015 To: 06/30/2016	Run Date: 11/19/2016 Run Time: 10:33 Version: 2016.05 (11/01/2016)
--	--------------------------------	--	--

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				
		Part B		Part B					
	Patient Services	Part A	Not Subject to Deductibles & Coinsurance	Subject to Deductibles & Coinsurance	Part A	Not Subject to Deductibles & Coinsurance	Subject to Deductibles & Coinsurance	Total Program Cost (sum of cols 9-10)	
		6	7	8	9	10	11	12	
1	Skilled Nursing Care		978			237,654		237,654	1
2	Physical Therapy		977			154,942		154,942	2
3	Occupational Therapy		37			5,856		5,856	3
4	Speech Pathology		40			12,817		12,817	4
5	Medical Social Services								5
6	Home Health Aide								6
7	Total (sum of lines 1-6)		2,032			411,269		411,269	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: 07/01/2015 To: 06/30/2016	Run Date: 11/19/2016 Run Time: 10:33 Version: 2016.05 (11/01/2016)
--	--------------------------------	--	--

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 B		
		Part A	Not Subject to Deductibles & Coinsurance	
		1	2	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	Part B Services	
		1	2	
10	Total reasonable cost (see instructions)			10
11	Total PPS Reimbursement - Full Episodes without Outliers		395,941	11
12	Total PPS Reimbursement - Full Episodes with Outliers			12
13	Total PPS Reimbursement - LUPA Episodes		12,975	13
14	Total PPS Reimbursement - PEP Episodes		2,991	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)		411,907	22
23	Excess reasonable cost (from line 8)			23
24	Subtotal (line 22 minus line 23)		411,907	24
25	Coinsurance billed to program patients (from your records)			25
26	Net cost (line 24 minus line 25)		411,907	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)		411,907	29
30	Other adjustments (see instructions) (specify)		-229	30
30.50	Pioneer ACO demonstration payment adjustment (see instructions)			30.50
31	Subtotal (see instructions)		411,678	31
31.01	Sequestration adjustment (see instructions)		8,238	31.01
32	Interim payments (see instructions)		403,669	32
33	Tentative settlement (for contractor use only)			33
34	Balance due provider/program (line 31 minus lines 31.01, 32 and 33)		-229	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: 07/01/2015 To: 06/30/2016	Run Date: 11/19/2016 Run Time: 10:33 Version: 2016.05 (11/01/2016)
--	--------------------------------	--	--

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	Amount	mm/dd/yyyy	Amount	
	1	2	3	4	
1 Total interim payments paid to provider				403,669	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)				403,669	4
<b>TO BE COMPLETED BY CONTRACTOR</b>					
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				6.01
	.02			-229	6.02
7 TOTAL MEDICARE PROGRAM LIABILITY (see instructions)				403,440	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: 07/01/2015 To: 06/30/2016	Run Date: 11/19/2016 Run Time: 10:33 Version: 2016.05 (11/01/2016)
--	--------------------------------	--	--

CALCULATION OF CAPITAL PAYMENT

COMPONENT CCN: 14-0210

WORKSHEET L

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

PART I - FULLY PROSPECTIVE METHOD

CAPITAL FEDERAL AMOUNT			
1	Capital DRG other than outlier	334,910	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)	11.10	3
4	Number of interns & residents (see instructions)		4
5	Indirect medical education percentage (see instructions)		5
6	Indirect medical education adjustment (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 (see instructions)		11
12	Total prospective capital payments (see instructions)	334,910	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: 07/01/2015 To: 06/30/2016	Run Date: 11/19/2016 Run Time: 10:33 Version: 2016.05 (11/01/2016)
--	--------------------------------	--	--

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	
	<b>GENERAL SERVICE COST CENTERS</b>						
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
	<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>						
30	Adults & Pediatrics						30
40	Subprovider - IPF						40
	<b>ANCILLARY SERVICE COST CENTERS</b>						
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
	<b>OUTPATIENT SERVICE COST CENTERS</b>						
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
	<b>OTHER REIMBURSABLE COST CENTERS</b>						
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
	<b>SPECIAL PURPOSE COST CENTERS</b>						
118	SUBTOTALS (sum of lines 1-117)						118
	<b>NONREIMBURSABLE COST CENTERS</b>						
190	Gift, Flower, Coffee Shop & Canteen						190
192	Physicians' Private Offices						192
192.01	DIALYSIS						192.01
192.02	GALATIA CLINIC						192.02
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: 07/01/2015 To: 06/30/2016	Run Date: 11/19/2016 Run Time: 10:33 Version: 2016.05 (11/01/2016)
--	--------------------------------	--	--

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	
<b>FACILITY HEALTH CARE STAFF COSTS</b>								
1	Physician	438,494	438,494		438,494		438,494	1
2	Physician Assistant							2
3	Nurse Practitioner	455,221	455,221		455,221		455,221	3
4	Visiting Nurse							4
5	Other Nurse	210,870	210,870		210,870		210,870	5
6	Clinical Psychologist	117,820	117,820		117,820		117,820	6
7	Clinical Social Worker	59,767	59,767		59,767		59,767	7
8	Laboratory Technician	49,286	49,286	-49,490	-204		-204	8
9	Other Facility Health Care Staff Costs	55,358	55,358	-55,588	-230		-230	9
10	Subtotal (sum of lines 1 through 9)	1,386,816	1,386,816	-105,078	1,281,738		1,281,738	10
<b>COSTS UNDER AGREEMENT</b>								
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
<b>OTHER HEALTH CARE COSTS</b>								
15	Medical Supplies		23,275		23,275		23,275	15
16	Transportation (Health Care Staff)		14,401		14,401		14,401	16
17	Depreciation-Medical Equipment			211,584	211,584		211,584	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)		37,676	211,584	249,260		249,260	21
22	Total Cost of Health Care Services (sum of lines 10, 14, and 21)	1,386,816	37,676	1,424,492	106,506	1,530,998	1,530,998	22
<b>COSTS OTHER THAN RHC/FQHC SERVICES</b>								
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
<b>FACILITY OVERHEAD</b>								
29	Facility Costs		114,017	-39,809	74,208		74,208	29
30	Administrative Costs	379,441	110,311	489,752	489,752	-21,784	467,968	30
31	Total Facility Overhead (sum of lines 29 and 30)	379,441	224,328	603,769	-39,809	563,960	-21,784	542,176
32	Total facility costs (sum of lines 22, 28 and 31)	1,766,257	262,004	2,028,261	66,697	2,094,958	-21,784	2,073,174

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: 07/01/2015 To: 06/30/2016	Run Date: 11/19/2016 Run Time: 10:33 Version: 2016.05 (11/01/2016)
--	--------------------------------	--	--

ALLOCATION OF OVERHEAD TO RHC/FQHC SERVICES

COMPONENT CCN: 14-3473

WORKSHEET M-2

Check applicable box:       RHC I                       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	1.67	5,329	4,200	7,014		1
2	Physician Assistants			2,100			2
3	Nurse Practitioners	4.03	9,678	2,100	8,463		3
4	Subtotal (sum of lines 1 through 3)	5.70	15,007		15,477	15,477	4
5	Visiting Nurse						5
6	Clinical Psychologist	1.68	1,757			1,757	6
7	Clinical Social Worker	0.87	1,075			1,075	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)	8.25	17,839			18,309	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)					1,530,998	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)					1,530,998	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)					542,176	14
15	Parent provider overhead allocated to facility (see instructions)					1,346,240	15
16	Total overhead (sum of lines 14 and 15)					1,888,416	16
17	Allowable Direct GME overhead (see instructions)						17
18	Subtotal (see instructions)					1,888,416	18
19	Overhead applicable to RHC/FQHC services (line 13 x line 18)					1,888,416	19
20	Total allowable cost of RHC/FQHC services (sum of lines 10 and 19)					3,419,414	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: 07/01/2015 To: 06/30/2016	Run Date: 11/19/2016 Run Time: 10:33 Version: 2016.05 (11/01/2016)
--	--------------------------------	--	--

CALCULATION OF REIMBURSEMENT SETTLEMENT FOR RHC/FQHC SERVICES

COMPONENT CCN: 14-3473

WORKSHEET M-3

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

DETERMINATION OF RATE FOR RHC/FQHC SERVICES

1	Total allowable cost of RHC/FQHC services (from Wkst. M-2, line 20)	3,419,414	1
2	Cost of vaccines and their administration (from Wkst. M-4, line 15)	36,215	2
3	Total allowable cost excluding vaccine (line 1 minus line 2)	3,383,199	3
4	Total visits (from Wkst. M-2, col. 5, line 8)	18,309	4
5	Physicians visits under agreement (from Wkst. M-2, col. 5, line 9)		5
6	Total adjusted visits (line 4 plus line 5)	18,309	6
7	Adjusted cost per visit (line 3 divided by line 6)	184.78	7

		Calculation of Limit (1)		
		Prior to January 1	On or after January 1	(See instr.)
		1	2	3
8	Per visit payment limit (from CMS Pub. 100-04, chapter 9, §20.6 or your contractor)			8
9	Rate for program covered visits (see instructions)	184.78	184.78	9
<b>CALCULATION OF SETTLEMENT</b>				
10	Program covered visits excluding mental health services (from contractor records)		3,631	10
11	Program cost excluding costs for mental health services (line 9 x line 10)		670,936	11
12	Program covered visits for mental health services (from contractor records)		440	12
13	Program covered cost from mental health services (line 9 x line 12)		81,303	13
14	Limit adjustment for mental health services (see instructions)		81,303	14
15	Graduate Medical Education pass-through cost (see instructions)			15
16	Total Program cost (see instructions)		752,239	16
16.01	Total program charges (see instructions)(from contractor's records)		689,578	16.01
16.02	Total program preventive charges (see instructions)(from provider's records)		4,091	16.02
16.03	Total program preventive costs (see instructions)		4,463	16.03
16.04	Total program non-preventive costs (see instructions)		550,570	16.04
16.05	Total program cost (see instructions)		555,033	16.05
17	Primary payer payments			17
18	Less: Beneficiary deductible for RHC only (see instructions)(from contractor records)		59,564	18
19	Less: Beneficiary coinsurance for RHC/FQHC services (see instructions) (from contractor records)		126,003	19
20	Net Medicare cost excluding vaccines (see instructions)		555,033	20
21	Program cost of vaccines and their administration (from Wkst. M-4, line 16)		3,729	21
22	Total reimbursable Program cost (line 20 plus line 21)		558,762	22
23	Allowable bad debts (see instructions)		28,703	23
23.01	Adjusted reimbursable bad debts (see instructions)		18,657	23.01
24	Allowable bad debts for dual eligible beneficiaries (see instructions)		28,703	24
25	Other adjustments (specify) (see instructions)			25
26	Net reimbursable amount (see instructions)		577,419	26
26.01	Sequestration adjustment (see instructions)		11,548	26.01
27	Interim payments		531,750	27
28	Tentative settlement (for contractor use only)			28
29	Balance due component/program (line 26 minus lines 26.01, 27 and 28)		34,121	29
30	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2			30

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

HARRISBURG MEDICAL CENTER, INC. Provider CCN: 14-0210	In Lieu of Form CMS-2552-10	Period : From: 07/01/2015 To: 06/30/2016	Run Date: 11/19/2016 Run Time: 10:33 Version: 2016.05 (11/01/2016)
--	--------------------------------	--	--

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)	1,281,738	1,281,738	1
2	Ratio of pneumococcal and influenza vaccine staff time to total health care staff time	0.000282	0.002730	2
3	Pneumococcal and influenza vaccine health care staff cost (line 1 x line 2)	361	3,499	3
4	Medical supplies cost - pneumococcal and influenza vaccine (from your records)	5,249	7,106	4
5	Direct cost of pneumococcal and influenza vaccine (line 3 plus line 4)	5,610	10,605	5
6	Total direct cost of the facility (from Wkst. M-1, col. 7, line 22)	1,530,998	1,530,998	6
7	Total overhead (from Wkst. M-2, line 16)	1,888,416	1,888,416	7
8	Ratio of pneumococcal and influenza vaccine direct cost to total direct cost (line 5 divided by line 6)	0.003664	0.006927	8
9	Overhead cost - pneumococcal and influenza vaccine (line 7 x line 8)	6,919	13,081	9
10	Total pneumococcal and influenza vaccine costs and their administration costs (sum of lines 5 and 9)	12,529	23,686	10
11	Total number of pneumococcal and influenza vaccine injections (from your records)	78	756	11
12	Cost per pneumococcal and influenza vaccing injection (line 10/line 11)	160.63	31.33	12
13	Number of pneumococcal and influenza vaccine injections administered to program beneficiaries	8	78	13
14	Program cost of pneumococcal and influenza vaccines and their administration costs (line 12 x line 13)	1,285	2,444	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)		36,215	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)		3,729	16



HARRISBURG MEDICAL CENTER, INC. Provider CCN: 14-0210	In Lieu of Form CMS-2552-10	Period : From: 07/01/2015 To: 06/30/2016	Run Date: 11/19/2016 Run Time: 10:33 Version: 2016.05 (11/01/2016)
--	--------------------------------	--	--

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

		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	
<b>FACILITY HEALTH CARE STAFF COSTS</b>									
1	Physician	41,159		41,159		41,159		41,159	1
2	Physician Assistant								2
3	Nurse Practitioner	96,539		96,539		96,539		96,539	3
4	Visiting Nurse								4
5	Other Nurse	43,755		43,755		43,755		43,755	5
6	Clinical Psychologist								6
7	Clinical Social Worker								7
8	Laboratory Technician								8
9	Other Facility Health Care Staff Costs								9
10	Subtotal (sum of lines 1 through 9)	181,453		181,453		181,453		181,453	10
<b>COSTS UNDER AGREEMENT</b>									
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
<b>OTHER HEALTH CARE COSTS</b>									
15	Medical Supplies		3,122	3,122		3,122		3,122	15
16	Transportation (Health Care Staff)		1,996	1,996		1,996		1,996	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)		5,118	5,118		5,118		5,118	21
22	Total Cost of Health Care Services (sum of lines 10, 14, and 21)	181,453	5,118	186,571		186,571		186,571	22
<b>COSTS OTHER THAN RHC/FQHC SERVICES</b>									
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
<b>FACILITY OVERHEAD</b>									
29	Facility Costs		49,464	49,464		49,464		49,464	29
30	Administrative Costs	23,109	2,422	25,531		25,531		25,531	30
31	Total Facility Overhead (sum of lines 29 and 30)	23,109	51,886	74,995		74,995		74,995	31
32	Total facility costs (sum of lines 22, 28 and 31)	204,562	57,004	261,566		261,566		261,566	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: 07/01/2015 To: 06/30/2016	Run Date: 11/19/2016 Run Time: 10:33 Version: 2016.05 (11/01/2016)
--	--------------------------------	--	--

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	0.06	261	4,200	252		1
2	Physician Assistants			2,100			2
3	Nurse Practitioners	0.83	2,163	2,100	1,743		3
4	Subtotal (sum of lines 1 through 3)	0.89	2,424		1,995	2,424	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	2,424			2,424	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)					186,571	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)					186,571	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)					74,995	14
15	Parent provider overhead allocated to facility (see instructions)					162,469	15
16	Total overhead (sum of lines 14 and 15)					237,464	16
17	Allowable Direct GME overhead (see instructions)						17
18	Subtotal (see instructions)					237,464	18
19	Overhead applicable to RHC/FQHC services (line 13 x line 18)					237,464	19
20	Total allowable cost of RHC/FQHC services (sum of lines 10 and 19)					424,035	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: 07/01/2015 To: 06/30/2016	Run Date: 11/19/2016 Run Time: 10:33 Version: 2016.05 (11/01/2016)
--	--------------------------------	--	--

CALCULATION OF PNEUMOCOCCAL AND INFLUENZA VACCINE COST

COMPONENT CCN: 14-8518

WORKSHEET M-4

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

		PNEUMO-	INFLUENZA	
		COCCAL		
		1	2	
1	Health care staff cost (from Wkst. M-1, col. 7, line 10)	181,453	181,453	1
2	Ratio of pneumococcal and influenza vaccine staff time to total health care staff time	0.000340	0.003766	2
3	Pneumococcal and influenza vaccine health care staff cost (line 1 x line 2)	62	683	3
4	Medical supplies cost - pneumococcal and influenza vaccine (from your records)	1,077	1,664	4
5	Direct cost of pneumococcal and influenza vaccine (line 3 plus line 4)	1,139	2,347	5
6	Total direct cost of the facility (from Wkst. M-1, col. 7, line 22)	186,571	186,571	6
7	Total overhead (from Wkst. M-2, line 16)	237,464	237,464	7
8	Ratio of pneumococcal and influenza vaccine direct cost to total direct cost (line 5 divided by line 6)	0.006105	0.012580	8
9	Overhead cost - pneumococcal and influenza vaccine (line 7 x line 8)	1,450	2,987	9
10	Total pneumococcal and influenza vaccine costs and their administration costs (sum of lines 5 and 9)	2,589	5,334	10
11	Total number of pneumococcal and influenza vaccine injections (from your records)	16	177	11
12	Cost per pneumococcal and influenza vaccing injection (line 10/line 11)	161.81	30.14	12
13	Number of pneumococcal and influenza vaccine injections administered to program beneficiaries	1	16	13
14	Program cost of pneumococcal and influenza vaccines and their administration costs (line 12 x line 13)	162	482	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)		7,923	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)		644	16



HARRISBURG MEDICAL CENTER, INC. Provider CCN: 14-0210	Non CMS worksheet CMS-2552-10	Period : From: 07/01/2015 To: 06/30/2016	Run Date: 11/19/2016 Run Time: 10:33 Version: 2016.05 (11/01/2016)
--	----------------------------------	--	--

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		
<b>UTILIZATION PERCENTAGES BASED ON DAYS</b>								
30	Adults & Pediatrics	39.45		11.64			51.09	30
<b>UTILIZATION PERCENTAGES BASED ON CHARGES</b>								
50	Operating Room	6.33	23.85				30.18	50
53	Anesthesiology	6.21	29.83				36.04	53
54	Radiology-Diagnostic	7.12	30.12				37.24	54
57	CT Scan	8.47	29.81				38.28	57
60	Laboratory	12.46	14.58				27.04	60
64	Intravenous Therapy	33.12	15.43				48.55	64
65	Respiratory Therapy	35.77	12.60				48.37	65
66	Physical Therapy	14.49	1.19				15.68	66
69	Electrocardiology	11.75	25.67				37.42	69
71	Medical Supplies Charged to Pat	24.38	17.92				42.30	71
72	Impl. Dev. Charged to Patients	22.45	19.51				41.96	72
73	Drugs Charged to Patients	8.99	28.79				37.78	73
75	ASC (Non-Distinct Part)	2.67	37.87				40.54	75
76	NUCLEAR MEDICINE	2.25	37.89				40.14	76
76.01	ULTRASOUND	14.19	22.48				36.67	76.01
76.04	FAITH CENTER CHEMOTHERAPY		20.58				20.58	76.04
76.97	CARDIAC REHABILITATION	1.65	70.94				72.59	76.97
91	Emergency	7.85	20.21				28.06	91
92	Observation Beds (Non-Distinct	10.40	31.20				41.60	92
93	DAY PSYCHIATRIC		8.91				8.91	93
200	TOTAL CHARGES	13.09	21.76				34.85	200

HARRISBURG MEDICAL CENTER, INC. Provider CCN: 14-0210	Non CMS worksheet CMS-2552-10	Period : From: 07/01/2015 To: 06/30/2016	Run Date: 11/19/2016 Run Time: 10:33 Version: 2016.05 (11/01/2016)
--	----------------------------------	--	--

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	
<b>UTILIZATION PERCENTAGES BASED ON DAYS</b>								
40 Subprovider - IPF	32.58		49.60				82.18	40
<b>UTILIZATION PERCENTAGES BASED ON CHARGES</b>								
53 Anesthesiology	0.02						0.02	53
54 Radiology-Diagnostic	0.62	0.01					0.63	54
57 CT Scan	0.61	0.04					0.65	57
60 Laboratory	1.65						1.65	60
64 Intravenous Therapy	0.72	0.01					0.73	64
65 Respiratory Therapy	4.08						4.08	65
66 Physical Therapy	1.28						1.28	66
69 Electrocardiology	1.14	0.03					1.17	69
71 Medical Supplies Charged to Pat	1.67						1.67	71
73 Drugs Charged to Patients	4.33						4.33	73
76 NUCLEAR MEDICINE	0.16						0.16	76
76.01 ULTRASOUND	0.40						0.40	76.01
91 Emergency	1.14						1.14	91
200 TOTAL CHARGES	1.41	0.01					1.42	200

HARRISBURG MEDICAL CENTER, INC. Provider CCN: 14-0210	Non CMS worksheet <b>CMS-2552-10</b>	Period : From: 07/01/2015 To: 06/30/2016	Run Date: 11/19/2016 Run Time: 10:33 Version: 2016.05 (11/01/2016)
--	---	--	--

**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		
<b>UTILIZATION PERCENTAGES BASED ON CHARGES</b>								
54	Radiology-Diagnostic	0.03					0.03	54
60	Laboratory	0.11					0.11	60
64	Intravenous Therapy	0.42					0.42	64
65	Respiratory Therapy	0.73					0.73	65
66	Physical Therapy	1.99					1.99	66
69	Electrocardiology	0.03					0.03	69
71	Medical Supplies Charged to Pat	0.45					0.45	71
73	Drugs Charged to Patients	0.27					0.27	73
76.01	ULTRASOUND	0.04					0.04	76.01
200	TOTAL CHARGES	0.21					0.21	200

HARRISBURG MEDICAL CENTER, INC. Provider CCN: 14-0210	Non CMS worksheet CMS-2552-10	Period : From: 07/01/2015 To: 06/30/2016	Run Date: 11/19/2016 Run Time: 10:33 Version: 2016.05 (11/01/2016)
--	----------------------------------	--	--

REPORT 98 - COST ALLOCATION SUMMARY

	COST CENTERS	DIRECT COSTS		ALLOCATED OVERHEAD		TOTAL COSTS		
		AMOUNT	%	AMOUNT	%	AMOUNT	%	
		1	2	3	4	5	6	
<b>GENERAL SERVICE COST CENTERS</b>								
1	Cap Rel Costs-Bldg & Fixt	1,162,376	2.60	-1,162,376	-5.59			1
2	Cap Rel Costs-Mvble Equip	1,344,541	3.01	-1,344,541	-6.46			2
3	Other Cap Rel Costs							3
4	Employee Benefits Department	7,408,321	16.59	-7,408,321	-35.62			4
5	Administrative & General	6,302,897	14.11	-6,302,897	-30.30			5
6	Maintenance & Repairs							6
7	Operation of Plant	1,102,068	2.47	-1,102,068	-5.30			7
8	Laundry & Linen Service	159,166	0.36	-159,166	-0.77			8
9	Housekeeping	654,282	1.46	-654,282	-3.15			9
10	Dietary	783,124	1.75	-783,124	-3.77			10
11	Cafeteria							11
12	Maintenance of Personnel							12
13	Nursing Administration	93,802	0.21	-93,802	-0.45			13
14	Central Services & Supply	442,997	0.99	-442,997	-2.13			14
15	Pharmacy	593,083	1.33	-593,083	-2.85			15
16	Medical Records & Library	753,304	1.69	-753,304	-3.62			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
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>								
30	Adults & Pediatrics	3,186,933	7.13	3,577,986	17.20	6,764,919	15.14	30
40	Subprovider - IPF	3,086,449	6.91	2,977,439	14.31	6,063,888	13.58	40
<b>ANCILLARY SERVICE COST CENTERS</b>								
50	Operating Room	94,715	0.21	931,364	4.48	1,026,079	2.30	50
53	Anesthesiology	43,547	0.10	359,015	1.73	402,562	0.90	53
54	Radiology-Diagnostic	733,595	1.64	815,391	3.92	1,548,986	3.47	54
57	CT Scan	261,724	0.59	399,707	1.92	661,431	1.48	57
60	Laboratory	2,350,787	5.26	1,308,112	6.29	3,658,899	8.19	60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
64	Intravenous Therapy	125,196	0.28	156,847	0.75	282,043	0.63	64
65	Respiratory Therapy	682,706	1.53	578,887	2.78	1,261,593	2.82	65
66	Physical Therapy	906,257	2.03	855,071	4.11	1,761,328	3.94	66
69	Electrocardiology	130,350	0.29	125,489	0.60	255,839	0.57	69
71	Medical Supplies Charged to Patients	1,577,337	3.53	366,545	1.76	1,943,882	4.35	71
72	Impl. Dev. Charged to Patients	779,027	1.74	182,151	0.88	961,178	2.15	72
73	Drugs Charged to Patients	3,079,804	6.89	1,855,694	8.92	4,935,498	11.05	73
75	ASC (Non-Distinct Part)	609,218	1.36	829,935	3.99	1,439,153	3.22	75
76	NUCLEAR MEDICINE	412,575	0.92	277,528	1.33	690,103	1.54	76
76.01	ULTRASOUND	248,747	0.56	223,035	1.07	471,782	1.06	76.01
76.02	MAMMOGRAPHY	130,076	0.29	118,230	0.57	248,306	0.56	76.02
76.03	CARDIAC REHABILITATION							76.03
76.04	FAITH CENTER CHEMOTHERAPY	149,144	0.33	157,935	0.76	307,079	0.69	76.04
76.06	ROUTINE ANCILLARY							76.06
76.97	CARDIAC REHABILITATION	90,950	0.20	99,781	0.48	190,731	0.43	76.97
76.98	HYPERBARIC OXYGEN THERAPY							76.98
76.99	LITHOTRIPSY							76.99
<b>OUTPATIENT SERVICE COST CENTERS</b>								
88	Rural Health Clinic	2,073,174	4.64	1,346,240	6.47	3,419,414	7.66	88
88.01	RHC II	261,566	0.59	162,469	0.78	424,035	0.95	88.01
91	Emergency	1,235,301	2.77	1,715,672	8.25	2,950,973	6.61	91
92	Observation Beds (Non-Distinct Part)							92
93	DAY PSYCHIATRIC	98,067	0.22	181,283	0.87	279,350	0.63	93
<b>OTHER REIMBURSABLE COST CENTERS</b>								
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	553,477	1.24	348,559	1.68	902,036	2.02	101
<b>SPECIAL PURPOSE COST CENTERS</b>								
<b>NONREIMBURSABLE COST CENTERS</b>								
190	Gift, Flower, Coffee Shop & Canteen	258,411	0.58	123,203	0.59	381,614	0.85	190
192	Physicians' Private Offices	627,778	1.41	685,702	3.30	1,313,480	2.94	192
192.01	DIALYSIS							192.01
192.02	GALATIA CLINIC	80,968	0.18	40,691	0.20	121,659	0.27	192.02
192.03	ORTHO CLINIC							192.03
200	Cross Foot Adjustments							200
201	Negative Cost Centers							201
202	TOTAL	44,667,840	100.00			44,667,840	100.00	202

HARRISBURG MEDICAL CENTER, INC. Provider CCN: 14-0210	Non CMS worksheet CMS-2552-10	Period : From: 07/01/2015 To: 06/30/2016	Run Date: 11/19/2016 Run Time: 10:33 Version: 2016.05 (11/01/2016)
--	----------------------------------	--	--

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	
	<b>ANCILLARY SERVICE COST CENTERS</b>						
50	Operating Room	420,935	3,434,044	0.122577	217,357	26,643	50
53	Anesthesiology	24,811	2,673,568	0.009280	166,140	1,542	53
54	Radiology-Diagnostic	243,935	4,756,107	0.051289	338,407	17,357	54
57	CT Scan	105,365	16,670,615	0.006320	1,411,858	8,923	57
60	Laboratory	153,809	22,153,037	0.006943	2,760,685	19,167	60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS						62.30
64	Intravenous Therapy	8,366	9,458,450	0.000885	3,132,700	2,772	64
65	Respiratory Therapy	88,682	8,083,270	0.010971	2,891,351	31,721	65
66	Physical Therapy	122,365	3,830,613	0.031944	554,913	17,726	66
69	Electrocardiology	59,107	1,982,473	0.029815	232,857	6,943	69
71	Medical Supplies Charged to Pat	30,012	2,342,942	0.012810	571,149	7,316	71
72	Impl. Dev. Charged to Patients	14,881	1,281,571	0.011612	287,717	3,341	72
73	Drugs Charged to Patients	151,438	12,959,439	0.011686	1,165,038	13,615	73
75	ASC (Non-Distinct Part)	145,311	4,230,052	0.034352	112,990	3,881	75
76	NUCLEAR MEDICINE	78,988	3,325,789	0.023750	74,962	1,780	76
76.01	ULTRASOUND	20,943	4,933,672	0.004245	700,205	2,972	76.01
76.02	MAMMOGRAPHY	42,748	733,112	0.058310			76.02
76.03	CARDIAC REHABILITATION						76.03
76.04	FAITH CENTER CHEMOTHERAPY	22,801	328,018	0.069511			76.04
76.06	ROUTINE ANCILLARY						76.06
76.97	CARDIAC REHABILITATION	19,577	518,888	0.037729	8,551	323	76.97
76.98	HYPERBARIC OXYGEN THERAPY						76.98
76.99	LITHOTRIPSY						76.99
88	Rural Health Clinic	60,638	3,105,361	0.019527			88
88.01	RHC II	6,834	354,462	0.019280			88.01
	<b>OUTPATIENT SERVICE COST CENTERS</b>						
91	Emergency	131,210	8,190,660	0.016019	642,705	10,295	91
92	Observation Beds (Non-Distinct	136,961	4,337,904	0.031573	451,248	14,247	92
93	DAY PSYCHIATRIC	45,904	402,005	0.114188			93
	<b>OTHER REIMBURSABLE COST CENTERS</b>						
200	TOTAL	2,135,621	120,086,052		15,720,833	190,564	200

HARRISBURG MEDICAL CENTER, INC. Provider CCN: 14-0210	Non CMS worksheet <b>CMS-2552-10</b>	Period : From: 07/01/2015 To: 06/30/2016	Run Date: 11/19/2016 Run Time: 10:33 Version: 2016.05 (11/01/2016)
--	---	--	--

**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	
	<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>								
30	Adults & Pediatrics	406,092	2,366	403,726	6,149	65.66	2,426	159,291	30
200	TOTAL	406,092	2,366	403,726	6,149		2,426	159,291	200

MEDICARE INPATIENT ROUTINE SERVICE PPS CAPITAL COSTS	159,291
MEDICARE INPATIENT ANCILLARY SERVICE PPS CAPITAL COSTS	190,564
TOTAL MEDICARE INPATIENT PPS CAPITAL COSTS	349,855
MEDICARE DISCHARGES (Worksheet S-3, Part I, line 14, column 13)	863
MEDICARE PATIENT DAYS (Worksheet S-3, Part I, line 14, column 6 - Worksheet S-3, Part I, line 5, column 6)	2,426
PER DISCHARGE CAPITAL COSTS	405.39

HARRISBURG MEDICAL CENTER, INC. Provider CCN: 14-0210	Non CMS worksheet <b>CMS-2552-10</b>	Period : From: 07/01/2015 To: 06/30/2016	Run Date: 11/19/2016 Run Time: 10:33 Version: 2016.05 (11/01/2016)
--	---	--	--

**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)	5,576,454
2. HOSPITAL PART A TITLE XVIII CHARGES (sum of inpatient charges and ancillary charges on Worksheet D-3 for hospital Title XVIII component)	18,173,393
3. RATIO OF COST TO CHARGES (line 1 / line 2)	0.307

**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))	2,490,736
2. TOTAL MEDICARE CHARGES (Worksheet D-3, line 40, column 2 plus Worksheet D-3, line 202, column 2) (see CR 5619)	5,565,961
3. RATIO OF COST TO CHARGES (line 1 / line 2)	0.447

**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)	349,855
2. RATIO OF COST TO CHARGES (line II-1 / line I-2)	0.019

**III. COST TO CHARGE RATIO FOR OUTPATIENT SERVICES**

1. TOTAL PROGRAM (Title XVIII) OUTPATIENT COST EXCLUDING SERVICES NOT SUBJECT TO OPPTS. (Worksheet D, Part V, columns 2, 2.01, 2.02 x column 1 less lines 61, 66-68, 74, 94, 95 & 96)	6,232,085
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)	26,087,239
3. RATIO OF COST TO CHARGES (line 1 / line 2)	0.239