

KPMG LLP Compu-Max 2552-10

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

**WORKSHEET S
PARTS I, II & III**

PART I - COST REPORT STATUS

| | | | | |
|---------------------|--|---|--|------------------------------|
| Provider use only | | 1. <input checked="" type="checkbox"/> Electronically filed cost report 2. <input type="checkbox"/> Manually submitted cost report 3. <input type="checkbox"/> If this is an amended report enter the number of times the provider resubmitted the cost report 4. <input checked="" type="checkbox"/> Medicare Utilization. Enter 'F' for full or 'L' for low. | | Date: 11/28/2018 Time: 12:39 |
| 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 CHIEF FINANCIAL OFFICER OR ADMINISTRATOR OF PROVIDER(S)

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

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

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

Title

Date

PART III - SETTLEMENT SUMMARY

| | | TITLE XVIII | | | | | |
|-----|------------------------------------|-------------|--------|----------|-----|-----------|-----|
| | | TITLE V | PART A | PART B | HIT | TITLE XIX | |
| | | 1 | 2 | 3 | 4 | 5 | |
| 1 | HOSPITAL | | 4,323 | -207,759 | | | 1 |
| 2 | SUBPROVIDER - IPF | | | | | | 2 |
| 3 | SUBPROVIDER - IRF | | | | | | 3 |
| 4 | SUBPROVIDER (OTHER) | | | | | | 4 |
| 5 | SWING BED - SNF | | | | | | 5 |
| 6 | SWING BED - NF | | | | | | 6 |
| 7 | SKILLED NURSING FACILITY | | -1 | -256 | | | 7 |
| 8 | NURSING FACILITY | | | | | | 8 |
| 9 | HOME HEALTH AGENCY | | | | | | 9 |
| 10 | HEALTH CLINIC - RHC | | | | | | 10 |
| 11 | HEALTH CLINIC - FQHC | | | | | | 11 |
| 12 | OUTPATIENT REHABILITATION PROVIDER | | | | | | 12 |
| 200 | TOTAL | | 4,322 | -208,015 | | | 200 |

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

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

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

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HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA

**WORKSHEET S-2
PART I**

Hospital and Hospital Health Care Complex Address:

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

Hospital and Hospital-Based Component Identification:

| Component | Component Name | CCN Number | CBSA Number | Provider Type | Date Certified | Payment System (P, T, O, or N) | | | | |
|-----------|-------------------------------------|---------------------------|-------------|---------------|----------------|--------------------------------|-------|-----|---|----|
| | | | | | | V | XVIII | XIX | | |
| 0 | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | | |
| 3 | Hospital | HARVARD MEMORIAL HOSPITAL | 14-1335 | 16974 | 1 | 01 / 01 / 2004 | N | O | O | 3 |
| 4 | Subprovider - IPF | | | | | | | | | 4 |
| 5 | Subprovider - IRF | | | | | | | | | 5 |
| 6 | Subprovider - (OTHER) | | | | | | | | | 6 |
| 7 | Swing Beds - SNF | | | | | | | | | 7 |
| 8 | Swing Beds - NF | | | | | | | | | 8 |
| 9 | Hospital-Based SNF | CARE CENTER | 14-6014 | 99914 | | 01 / 01 / 2002 | N | P | N | 9 |
| 10 | Hospital-Based NF | | | | | | | | | 10 |
| 11 | Hospital-Based OLTC | | | | | | | | | 11 |
| 12 | Hospital-Based HHA | | | | | | | | | 12 |
| 13 | Separately Certified ASC | | | | | | | | | 13 |
| 14 | Hospital-Based Hospice | | | | | | | | | 14 |
| 15 | Hospital-Based Health Clinic - RHC | | | | | | | | | 15 |
| 16 | Hospital-Based Health Clinic - FQHC | | | | | | | | | 16 |
| 17 | Hospital-Based (CMHC) | | | | | | | | | 17 |
| 18 | Renal Dialysis | | | | | | | | | 18 |
| 19 | Other | | | | | | | | | 19 |

| | | | | | | | | | | |
|----|------------------------------------|----------------------|--------------------|--|--|--|--|--|--|----|
| 20 | Cost Reporting Period (mm/dd/yyyy) | From: 07 / 01 / 2017 | To: 06 / 30 / 2018 | | | | | | | 20 |
| 21 | Type of control (see instructions) | 2 | | | | | | | | 21 |

Inpatient PPS Information

| | | 1 | 2 | 3 | |
|-------|---|---|---|---|-------|
| 22 | Does this facility qualify for and receive disproportionate share hospital payments in accordance with 42 CFR §412.106? In column 1, enter 'Y' for yes or 'N' for no. Is this facility subject to 42 CFR§412.06(c)(2)(Pickle amendment hospital)? In column 2, enter 'Y' for yes or 'N' for no. | N | N | | 22 |
| 22.01 | Did this hospital receive interim uncompensated care payments for this cost reporting period? Enter in column 1, 'Y' for yes or 'N' for no for the portion of the cost reporting period occurring prior to October 1. Enter in column 2 'Y' for yes or 'N' for no for the portion of the cost reporting period occurring on or after October 1. (see instructions) | N | N | | 22.01 |
| 22.02 | Is this a newly merged hospital that requires final uncompensated care payments to be determined at cost report settlement? (see instructions) Enter in column 1, 'Y' for yes or 'N' for no, for the portion of the cost reporting period prior to October 1. Enter in column 2, 'Y' for yes or 'N' for no, for the portion of the cost reporting period on or after October 1. | N | N | | 22.02 |
| 22.03 | Did this hospital receive a geographic reclassification from urban to rural as a result of the OMB standards for delineating statistical areas adopted by CMS in FY2015? Enter in column 1, 'Y' for yes or 'N' for no for the portion of the cost reporting period prior to October 1. Enter in column 2, 'Y' for yes or 'N' for no for the portion of the cost reporting period occurring on or after October 1. (see instructions) Does this hospital contain at least 100 but not more than 499 beds (as counted in accordance with 42 CFR 412.105)? Enter in column 3, 'Y' for yes or 'N' for no. | N | N | N | 22.03 |
| 23 | Which method is used to determine Medicaid days on lines 24 and/or 25 below? In column 1, enter 1 if date of admission, 2 if census days, or 3 if date of discharge. Is the method of identifying the days in this cost reporting period different from the method used in the prior cost reporting period? In column 2, enter 'Y' for yes or 'N' for no. | 3 | N | | 23 |

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

| | | | | | | | | |
|-------|---|------------|--|---------|--|--|--|-------|
| 26 | Enter your standard geographic classification (not wage) status at the beginning of the cost reporting period. Enter '1' for urban and '2' for rural. | 2 | | | | | | 26 |
| 27 | Enter your standard geographic classification (not wage) status at the end of the cost reporting period. Enter in column 1, '1' for urban or '2' for rural. If applicable, enter the effective date of the geographic reclassification in column 2. | 2 | | | | | | 27 |
| 35 | If this is a sole community hospital (SCH), enter the number of periods SCH status in effect in the cost reporting period. | | | | | | | 35 |
| 36 | Enter applicable beginning and ending dates of SCH status. Subscript line 36 for number of periods in excess of one and enter subsequent dates. | Beginning: | | Ending: | | | | 36 |
| 37 | If this is a Medicare dependent hospital (MDH), enter the number of periods MDH status is in effect in the cost reporting period. | | | | | | | 37 |
| 37.01 | Is this hospital a former MDH that is eligible for the MDH transitional payment in accordance with the FY 2016 OPSS final rule? Enter 'Y' for yes or 'N' for no. (see instructions) | N | | | | | | 37.01 |
| 38 | If line 37 is 1, enter the beginning and ending dates of MDH status. If line 37 is greater than 1, subscript this line for the number of periods in excess of one and enter subsequent dates. | Beginning: | | Ending: | | | | 38 |

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HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA

**WORKSHEET S-2
PART I**

| | | 1 | 2 | |
|--|---|---|-------|-----|
| 39 | Does this facility qualify for the inpatient hospital payment adjustment for low volume hospitals in accordance with 42 CFR §412.101(b)(2)(i) or (ii)? Enter in column 1 'Y' for yes or 'N' for no. Does the facility meet the mileage requirements in accordance with 42 CFR 412.101(b)(2)(i) or (ii)? Enter in column 2 'Y' for yes or 'N' for no. (see instructions) | N | N | 39 |
| 40 | Is this hospital subject to the HAC program reduction adjustment? Enter 'Y' for yes or 'N' for no in column 1, for discharges prior to October 1. Enter 'Y' for yes or 'N' for no in column 2, for discharges on or after October 1. (see instructions) | N | N | 40 |
| 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 | 45 |
| 47 | Is this a new hospital under 42 CFR §412.300 PPS capital? Enter 'Y' for yes or 'N' for no. | N | N | 46 |
| 48 | Is the facility electing full federal capital payment? Enter 'Y' for yes or 'N' for no. | N | N | 47 |
| | | 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 |
| | | NAHE 413.85 Y/N 1 | Worksheet A Line # 2 | Pass-Through Qualification Criteria Code 3 | |
| 60 | Are you claiming nursing and allied health education (NAHE) costs for any program(s) that meet the criteria under 42 CFR 413.85? (see instructions) | N | | | 60 |
| | | Y/N 1 | IME 4 | Direct GME 5 | |
| 61 | Did your hospital receive FTE slots under ACA section 5503? Enter 'Y' for yes or 'N' for no in column 1.(see instructions) | N | | | 61 |
| 61.01 | Enter the average number of unweighted primary care FTEs from the hospital's 3 most recent cost reports ending and submitted before March 23, 2010. (see instructions) | | | | 61.01 |
| 61.02 | Enter the current year total unweighted primary care FTE count (excluding OB/GYN, general surgery FTEs, and primary care FTEs added under section 5503 of ACA). (see instructions) | | | | 61.02 |
| 61.03 | Enter the baseline FTE count for primary care and/or general surgery residents, which is used for determining compliance with the 75% test. (see instructions) | | | | 61.03 |
| 61.04 | Enter the number of unweighted primary care/or surgery allopathic and/or osteopathic FTEs in the current cost reporting period. (see instructions) | | | | 61.04 |
| 61.05 | Enter the difference between the baseline primary and/or general surgery FTEs and the current year's primary care and/or general surgery FTE counts (line 61.04 minus line 61.03). (see instructions) | | | | 61.05 |
| 61.06 | Enter the amount of ACA §5503 award that is being used for cap relief and/or FTEs that are nonprimary care or general surgery. (see instructions) | | | | 61.06 |

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

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

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

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

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

Teaching Hospitals that Claim Residents in Nonprovider Settings

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

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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)) | | |
| 65 | 1 | 2 | 3 | 4 | 5 | | 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)) | | |
| 67 | 1 | 2 | 3 | 4 | 5 | | 67 |

Inpatient Psychiatric Facility PPS

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

Inpatient Rehabilitation Facility PPS

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

Long Term Care Hospital PPS

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

TEFRA Providers

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

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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. | Y | N | 90 |
| 91 | Is this hospital reimbursed for title V and/or XIX through the cost report either in full or in part? Enter 'Y' for yes, or 'N' for no in the applicable column. | N | N | 91 |
| 92 | Are title XIX NF patients occupying title XVIII SNF beds (dual certification)? Enter 'Y' for yes or 'N' for no in the applicable column. | | N | 92 |
| 93 | Does this facility operate an ICF/IID facility for purposes of title V and XIX? Enter 'Y' for yes or 'N' for no in the applicable column. | N | N | 93 |
| 94 | Does title V or title XIX reduce capital cost? Enter 'Y' for yes or 'N' for no in the applicable column. | N | N | 94 |
| 95 | If line 94 is 'Y', enter the reduction percentage in the applicable column. | | | 95 |
| 96 | Does title V or title XIX reduce operating cost? Enter 'Y' for yes or 'N' for no in the applicable column. | N | N | 96 |
| 97 | If line 96 is 'Y', enter the reduction percentage in the applicable column. | | | 97 |
| 98 | Does title V or XIX follow Medicare (title XVIII) for the interns and residents post stepdown adjustments on Wkst. B, Pt. I, col. 25? Enter 'Y' for yes or 'N' for no in column 1 for title V, and in column 2 for title XIX. | N | N | 98 |
| 98.01 | Does title V or XIX follow Medicare (title XVIII) for the reporting of charges on Wkst. C, Pt. I? Enter 'Y' for yes or 'N' for no in column 1 for title V, and in column 2 for title XIX. | N | N | 98.01 |
| 98.02 | Does title V or XIX follow Medicare (title XVIII) for the calculation of observation bed costs on Wkst. D-1, Pt. IV, line 89? Enter 'Y' for yes or 'N' for no in column 1 for title V, and in column 2 for title XIX. | N | N | 98.02 |
| 98.03 | Does title V or XIX follow Medicare (title XVIII) for a critical access hospital (CAH) reimbursed 101% of inpatient services cost? Enter 'Y' for yes or 'N' for no in column 1 for title V, and in column 2 for title XIX. | N | N | 98.03 |
| 98.04 | Does title V or XIX follow Medicare (title XVIII) for a CAH reimbursed 101% of outpatient services cost? Enter 'Y' for yes or 'N' for no in column 1 for title V, and in column 2 for title XIX. | N | N | 98.04 |
| 98.05 | Does title V or XIX follow Medicare (title XVIII) and add back the RCE disallowance on Wkst. C, Pt. I, col. 4? Enter 'Y' for yes or 'N' for no in column 1 for title V, and in column 2 for title XIX. | N | N | 98.05 |
| 98.06 | Does title V or XIX follow Medicare (title XVIII) when cost reimbursed for Wkst. D, Pts. I through IV? Enter 'Y' for yes or 'N' for no in column 1 for title V, and in column 2 for title XIX. | N | N | 98.06 |

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

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

Miscellaneous Cost Reporting Information

| | | | | |
|--------|---|----------|-------------|----------------|
| 115 | Is this an all-inclusive rate provider? Enter 'Y' for yes or 'N' for no in column 1. If column 1 is yes, enter the method used (A, B, or E only) in column 2. If column 2 is 'E', enter in column 3 either '93' percent for short term hospital or '98' percent for long term care (includes psychiatric, rehabilitation and long term hospitals providers) based on the definition in CMS Pub. 15-1, 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 | Paid Losses | Self Insurance |
| | | 169,020 | | |
| 118.02 | Are malpractice premiums and paid losses reported in a cost center other than the Administrative and General cost center? If yes, submit supporting schedule listing cost centers and amounts contained therein. | N | | 118.02 |
| 120 | Is this a SCH or EACH that qualifies for the Outpatient Hold Harmless provision in ACA §3121 and applicable amendments? (see instructions). Enter in column 1 'Y' for yes or 'N' for no. Is this a rural hospital with < 100 beds that qualifies for the Outpatient Hold Harmless provision in ACA §3121 and applicable amendments? (see instructions). Enter in column 2 'Y' for yes or 'N' for no. | N | N | 120 |
| 121 | Did this facility incur and report costs for high cost implantable devices charged to patients? Enter 'Y' for yes or 'N' for no. | Y | | 121 |
| 122 | Does the cost report contain state health care related taxes as defined in §1983(w)(3) of the Act? Enter 'Y' for yes or 'N' for no in column 1. If column 1 is 'Y', enter in column 2 the Worksheet A line number where these taxes are included. | N | | 122 |

Transplant Center Information

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

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| | | | |
|--|---------------------------------------|--|--|
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|--|---------------------------------------|--|--|

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA

**WORKSHEET S-2
PART I**

All Providers

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

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

| | | | | |
|-----|---|------------------------|----------------------------|-----|
| 141 | Name: MERCY HOME OFFICE | Contractor's Name: NGS | Contractor's Number: 00450 | 141 |
| 142 | Street: 1000 MINERAL POINT AVE | P.O. Box: | | 142 |
| 143 | City: JANESVILLE | State: WI | ZIP Code: 53547 | 143 |
| 144 | Are provider based physicians' costs included in Worksheet A? | Y | | 144 |
| 145 | If costs for renal services are claimed on Wkst. A, line 74 are the costs for inpatient services only? Enter 'Y' for yes, or 'N' for no in column 1. If column 1 is no, does the dialysis facility include Medicare utilization for this cost reporting period? Enter 'Y' for yes or 'N' for no in column 2. | N | N | 145 |
| 146 | Has the cost allocation methodology changed from the previously filed cost report? Enter 'Y' for yes and 'N' for no in column 1. (see CMS Pub. 15-2, chapter 40, §4020). If yes, enter the approval date (mm/dd/yyyy) in column 2. | N | | 146 |
| 147 | Was there a change in the statistical basis? Enter 'Y' for yes or 'N' for no. | N | | 147 |
| 148 | Was there a change in the order of allocation? Enter 'Y' for yes or 'N' for no. | N | | 148 |
| 149 | Was there a change to the simplified cost finding method? Enter 'Y' for yes or 'N' for no. | N | | 149 |

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

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

Multicampus

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

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

| | | | | | |
|--------|--|---|----------------|----------------|-----|
| 167 | Is this provider a meaningful user under §1886(n)? Enter 'Y' for yes or 'N' for no. | Y | | 167 | |
| 168 | If this provider is a CAH (line 105 is 'Y') and is a meaningful user (line 167 is 'Y'), enter the reasonable cost incurred for the HIT assets. (see instructions) | | | 168 | |
| 168.01 | If this provider is a CAH and is not a meaningful user, does this provider qualify for a hardship exception under §413.70(a)(6)(ii)? Enter 'Y' for yes or 'N' for no. (see instructions) | | | 168.01 | |
| 169 | If this provider is a meaningful user (line 167 is 'Y') and is not a CAH (line 105 is 'N'), enter the transition factor. (see instructions) | | | 169 | |
| 170 | Enter in columns 1 and 2 the EHR beginning date and ending date for the reporting period respectively (mm/dd/yyyy) | | 10 / 01 / 2017 | 09 / 30 / 2018 | 170 |
| 171 | If line 167 is 'Y', does this provider have any days for individuals enrolled in section 1876 Medicare cost plans reported on Wkst. S-3, Pt. I, line 2, col. 6? Enter 'Y' for yes and 'N' for no in column 1. If column 1 is 'Y', enter the number of section 1876 Medicare days in column 2. (see instructions) | | N | 0 | 171 |

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HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX REIMBURSEMENT QUESTIONNAIRE

**WORKSHEET S-2
PART II**

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

COMPLETED BY ALL HOSPITALS

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

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

| | | Y/N | Y/N | |
|--|--|-----|-----|----|
| Approved Educational Activities | | | | |
| 6 | Column 1: Are costs claimed for nursing school? Column 2: If yes, is the provider the legal operator of the program? | N | | 6 |
| 7 | Are costs claimed for allied health programs? If yes, see instructions. | N | | 7 |
| 8 | Were nursing school and/or allied health programs approved and/or renewed during the cost reporting period? | N | | 8 |
| 9 | Are costs claimed for Interns and Residents in approved GME programs claimed on the current cost report? If yes, see instructions. | N | | 9 |
| 10 | Was an approved Intern and Resident GME program initiated or renewed in the current cost reporting period? If yes, see instructions. | N | | 10 |
| 11 | Are GME costs directly assigned to cost centers other than I & R in an Approved Teaching Program on Worksheet A? If yes, see instructions. | N | | 11 |

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

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

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

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HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX REIMBURSEMENT QUESTIONNAIRE

**WORKSHEET S-2
PART II**

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

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

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

| Interest Expense | | | |
|------------------|---|---|----|
| 28 | Were new loans, mortgage agreements or letters of credit entered into during the cost reporting period? If yes, see instructions. | Y | 28 |
| 29 | Did the provider have a funded depreciation account and/or bond funds (Debt Service Reserve Fund) treated as a funded depreciation account? If yes, see instructions. | N | 29 |
| 30 | Has existing debt been replaced prior to its scheduled maturity with new debt? If yes, see instructions. | Y | 30 |
| 31 | Has debt been recalled before scheduled maturity without issuance of new debt? If yes, see instructions. | N | 31 |

| Purchased Services | | | |
|--------------------|---|---|----|
| 32 | Have changes or new agreements occurred in patient care services furnished through contractual arrangements with suppliers of services? If yes, see instructions. | N | 32 |
| 33 | If line 32 is yes, were the requirements of Sec. 2135.2 applied pertaining to competitive bidding? If no, see instructions. | N | 33 |

| Provider-Based Physicians | | | |
|---------------------------|--|---|----|
| 34 | Are services furnished at the provider facility under an arrangement with provider-based physicians? If yes, see instructions. | Y | 34 |
| 35 | If line 34 is yes, were there new agreements or amended existing agreements with the provider-based physicians during the cost reporting period? If yes, see instructions. | Y | 35 |

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

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

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|--|---------------------------------------|--|--|
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HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA

**WORKSHEET S-3
PART I**

| | Component | Wkst A Line No. | No. of Beds | Bed Days Available | CAH Hours | Inpatient Days / Outpatient Visits / Trips | | | Total All Patients | |
|-------|--|-----------------------|----------------|-----------------------|--------------|--|----------------|--------------|--------------------------|-------|
| | | | | | | Title V | Title XVIII | Title XIX | | |
| | | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | |
| 1 | Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days) (see instructions for col. 2 for the portion of LDP room available beds) | 30 | 10 | 3,650 | 28,296.00 | | 528 | 20 | 1,053 | 1 |
| 2 | HMO and other (see instructions) | | | | | | 38 | 80 | | 2 |
| 3 | HMO IPF Subprovider | | | | | | | | | 3 |
| 4 | HMO IRF Subprovider | | | | | | | | | 4 |
| 5 | Hospital Adults & Peds. Swing Bed SNF | | | | | | | | | 5 |
| 6 | Hospital Adults & Peds. Swing Bed NF | | | | | | | | | 6 |
| 7 | Total Adults & Peds. (exclude observation beds) (see instructions) | | 10 | 3,650 | 28,296.00 | | 528 | 20 | 1,053 | 7 |
| 8 | Intensive Care Unit | 31 | 3 | 1,095 | | | 18 | 1 | 36 | 8 |
| 9 | Coronary Care Unit | 32 | | | | | | | | 9 |
| 10 | Burn Intensive Care Unit | 33 | | | | | | | | 10 |
| 11 | Surgical Intensive Care Unit | 34 | | | | | | | | 11 |
| 12 | Other Special Care (specify) | 35 | | | | | | | | 12 |
| 13 | Nursery | 43 | | | | | | | | 13 |
| 14 | Total (see instructions) | | 13 | 4,745 | 28,296.00 | | 546 | 21 | 1,089 | 14 |
| 15 | CAH Visits | | | | | | | | | 15 |
| 16 | Subprovider - IPF | 40 | | | | | | | | 16 |
| 17 | Subprovider - IRF | 41 | | | | | | | | 17 |
| 18 | Subprovider I | 42 | | | | | | | | 18 |
| 19 | Skilled Nursing Facility | 44 | 13 | 4,576 | | | 1,830 | | 2,300 | 19 |
| 20 | Nursing Facility | 45 | | | | | | | | 20 |
| 21 | Other Long Term Care | 46 | 32 | 11,849 | | | | | 5,505 | 21 |
| 22 | Home Health Agency | 101 | | | | | | | | 22 |
| 23 | ASC (Distinct Part) | 115 | | | | | | | | 23 |
| 24 | Hospice (Distinct Part) | 116 | | | | | | | | 24 |
| 24.10 | Hospice (non-distinct part) | 30 | | | | | | | | 24.10 |
| 25 | CMHC | 99 | | | | | | | | 25 |
| 26 | RHC | 88 | | | | | | | | 26 |
| 27 | Total (sum of lines 14-26) | | 58 | | | | | | | 27 |
| 28 | Observation Bed Days | | | | | | | | 213 | 28 |
| 29 | Ambulance Trips | | | | | | | | | 29 |
| 30 | Employee discount days (see instructions) | | | | | | | | | 30 |
| 31 | Employee discount days-IRF | | | | | | | | | 31 |
| 32 | Labor & delivery (see instructions) | | | | | | | | | 32 |
| 32.01 | Total ancillary labor & delivery room outpatient days (see instructions) | | | | | | | | | 32.01 |
| 33 | LTCH non-covered days | | | | | | | | | 33 |
| 33.01 | LTCH site neutral days and discharges | | | | | | | | | 33.01 |

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|--|---------------------------------------|--|--|
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HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA

**WORKSHEET S-3
PART I**

| | Component | Full Time Equivalents | | | DISCHARGES | | | | |
|-------|--|---------------------------|----------------------|-----------------|------------|-------------|-----------|--------------------|-------|
| | | Total Interns & Residents | Employees On Payroll | Nonpaid Workers | Title V | Title XVIII | Title XIX | Total All Patients | |
| | | 9 | 10 | 11 | 12 | 13 | 14 | 15 | |
| 1 | Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days) (see instructions for col. 2 for the portion of LDP room available beds) | | | | | 212 | 10 | 444 | 1 |
| 2 | HMO and other (see instructions) | | | | | 10 | 29 | | 2 |
| 3 | HMO IPF Subprovider | | | | | | | | 3 |
| 4 | HMO IRF Subprovider | | | | | | | | 4 |
| 5 | Hospital Adults & Peds. Swing Bed SNF | | | | | | | | 5 |
| 6 | Hospital Adults & Peds. Swing Bed NF | | | | | | | | 6 |
| 7 | Total Adults & Peds. (exclude observation beds) (see instructions) | | | | | | | | 7 |
| 8 | Intensive Care Unit | | | | | | | | 8 |
| 9 | Coronary Care Unit | | | | | | | | 9 |
| 10 | Burn Intensive Care Unit | | | | | | | | 10 |
| 11 | Surgical Intensive Care Unit | | | | | | | | 11 |
| 12 | Other Special Care (specify) | | | | | | | | 12 |
| 13 | Nursery | | | | | | | | 13 |
| 14 | Total (see instructions) | | 140.55 | | | 212 | 10 | 444 | 14 |
| 15 | CAH Visits | | | | | | | | 15 |
| 16 | Subprovider - IPF | | | | | | | | 16 |
| 17 | Subprovider - IRF | | | | | | | | 17 |
| 18 | Subprovider I | | | | | | | | 18 |
| 19 | Skilled Nursing Facility | | 14.07 | | | | | | 19 |
| 20 | Nursing Facility | | | | | | | | 20 |
| 21 | Other Long Term Care | | 16.26 | | | | | | 21 |
| 22 | Home Health Agency | | | | | | | | 22 |
| 23 | ASC (Distinct Part) | | | | | | | | 23 |
| 24 | Hospice (Distinct Part) | | | | | | | | 24 |
| 24.10 | Hospice (non-distinct part) | | | | | | | | 24.10 |
| 25 | CMHC | | | | | | | | 25 |
| 26 | RHC | | | | | | | | 26 |
| 27 | Total (sum of lines 14-26) | | 170.88 | | | | | | 27 |
| 32.01 | Total ancillary labor & delivery room outpatient days (see instructions) | | | | | | | | 32.01 |
| 33 | LTCH non-covered days | | | | | | | | 33 |
| 33.01 | LTCH site neutral days and discharges | | | | | | | | 33.01 |

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PROSPECTIVE PAYMENT FOR SNF STATISTICAL DATA

WORKSHEET S-7

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

| | Group | SNF Days | Swing Bed SNF Days | Total (sum of col. 2 + 3) | |
|----|-------|----------|--------------------|---------------------------|----|
| | 1 | 2 | 3 | 4 | |
| 3 | RUX | | | | 3 |
| 4 | RUL | | | | 4 |
| 5 | RVX | | | | 5 |
| 6 | RVL | | | | 6 |
| 7 | RHX | | | | 7 |
| 8 | RHL | | | | 8 |
| 9 | RMX | | | | 9 |
| 10 | RML | | | | 10 |
| 11 | RLX | | | | 11 |
| 12 | RUC | | | | 12 |
| 13 | RUB | 11 | | 11 | 13 |
| 14 | RUA | 42 | | 42 | 14 |
| 15 | RVC | 140 | | 140 | 15 |
| 16 | RVB | 578 | | 578 | 16 |
| 17 | RVA | 370 | | 370 | 17 |
| 18 | RHC | 122 | | 122 | 18 |
| 19 | RHB | 109 | | 109 | 19 |
| 20 | RHA | 169 | | 169 | 20 |
| 21 | RMC | 120 | | 120 | 21 |
| 22 | RMB | 58 | | 58 | 22 |
| 23 | RMA | 46 | | 46 | 23 |
| 24 | RLB | | | | 24 |
| 25 | RLA | | | | 25 |
| 26 | ES3 | | | | 26 |
| 27 | ES2 | | | | 27 |
| 28 | ES1 | | | | 28 |
| 29 | HE2 | | | | 29 |
| 30 | HE1 | | | | 30 |
| 31 | HD2 | | | | 31 |
| 32 | HD1 | 1 | | 1 | 32 |
| 33 | HC2 | | | | 33 |
| 34 | HC1 | | | | 34 |
| 35 | HB2 | | | | 35 |
| 36 | HB1 | | | | 36 |
| 37 | LE2 | | | | 37 |
| 38 | LE1 | | | | 38 |
| 39 | LD2 | | | | 39 |
| 40 | LD1 | | | | 40 |
| 41 | LC2 | | | | 41 |
| 42 | LC1 | | | | 42 |
| 43 | LB2 | | | | 43 |
| 44 | LB1 | | | | 44 |
| 45 | CE2 | | | | 45 |
| 46 | CE1 | | | | 46 |
| 47 | CD2 | 4 | | 4 | 47 |
| 48 | CD1 | 8 | | 8 | 48 |
| 49 | CC2 | | | | 49 |
| 50 | CC1 | 3 | | 3 | 50 |
| 51 | CB2 | | | | 51 |
| 52 | CB1 | 18 | | 18 | 52 |
| 53 | CA2 | | | | 53 |
| 54 | CA1 | 19 | | 19 | 54 |
| 55 | SE3 | | | | 55 |
| 56 | SE2 | | | | 56 |
| 57 | SE1 | | | | 57 |
| 58 | SSC | | | | 58 |
| 59 | SSB | | | | 59 |
| 60 | SSA | | | | 60 |
| 61 | IB2 | | | | 61 |
| 62 | IB1 | | | | 62 |
| 63 | IA1 | | | | 63 |
| 64 | IA2 | | | | 64 |
| 65 | BB2 | | | | 65 |
| 66 | BB1 | | | | 66 |
| 67 | BA2 | | | | 67 |
| 68 | BA1 | | | | 68 |
| 69 | PE2 | | | | 69 |
| 70 | PE1 | | | | 70 |
| 71 | PD2 | | | | 71 |

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| | | | |
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PROSPECTIVE PAYMENT FOR SNF STATISTICAL DATA

WORKSHEET S-7

| | Group | SNF Days | Swing Bed SNF Days | Total (sum of col. 2 + 3) | |
|-----|-------|----------|--------------------|---------------------------|-----|
| | 1 | 2 | 3 | 4 | |
| 72 | PD1 | | | | 72 |
| 73 | PC2 | | | | 73 |
| 74 | PC1 | 2 | | 2 | 74 |
| 75 | PB2 | | | | 75 |
| 76 | PB1 | 8 | | 8 | 76 |
| 77 | PA2 | | | | 77 |
| 78 | PA1 | 1 | | 1 | 78 |
| 199 | AAA | 1 | | 1 | 199 |
| 200 | TOTAL | 1,830 | | 1,830 | 200 |

SNF SERVICES

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

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

| | | Expenses | Percentage | Associated with Direct Patient Care and Related Expenses? | |
|-----|---|----------|------------|---|-----|
| | | 1 | 2 | 3 | |
| 202 | Staffing | | | | 202 |
| 203 | Recruitment | | | | 203 |
| 204 | Retention of employees | | | | 204 |
| 205 | Training | | | | 205 |
| 206 | Other (specify) | | | | 206 |
| 207 | Total SNF Revenue (Worksheet G-2, Part I, line 7, column 3) | 806,669 | | | 207 |

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HOSPITAL UNCOMPENSATED AND INDIGENT CARE DATA

WORKSHEET S-10

Uncompensated and indigent care cost computation

| | | | | |
|---|--|--|----------|---|
| 1 | Cost to charge ratio (Worksheet C, Part I, line 202, column 3 divided by line 202, column 8) | | 0.347899 | 1 |
|---|--|--|----------|---|

Medicaid (see instructions for each line)

| | | | | |
|---|---|--|------------|---|
| 2 | Net revenue from Medicaid | | 2,764,014 | 2 |
| 3 | Did you receive DSH or supplemental payments from Medicaid? | | Y | 3 |
| 4 | If line 3 is yes, does line 2 include all DSH and/or supplemental payments from Medicaid? | | N | 4 |
| 5 | If line 4 is no, enter DSH and/or supplemental payments from Medicaid | | 1,180,406 | 5 |
| 6 | Medicaid charges | | 11,372,266 | 6 |
| 7 | Medicaid cost (line 1 times line 6) | | 3,956,400 | 7 |
| 8 | Difference between net revenue and costs for Medicaid program (line 7 minus the sum of lines 2 and 5). If line 7 is less than the sum of lines 2 and 5, then enter zero. | | 11,980 | 8 |

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

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

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

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

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

| | | | | |
|----|--|--|--------|----|
| 17 | Private grants, donations, or endowment income restricted to fundng charity care | | | 17 |
| 18 | Government grants, appropriations of transfers for support of hospital operations | | 21,146 | 18 |
| 19 | Total unreimbursed cost for Medicaid, SCHIP and state and local indigent care programs (sum of lines 8, 12 and 16) | | 11,980 | 19 |

Uncompensated care (see instructions for each line)

| | | Uninsured patients | Insured patients | TOTAL (col. 1 + col. 2) | |
|----|---|--------------------|------------------|-------------------------|----|
| | | 1 | 2 | 3 | |
| 20 | Charity care charges and uninsured discounts for the entire facility (see instructions) | 18,394 | 40,208 | 58,602 | 20 |
| 21 | Cost of patients approved for charity care and uninsured discounts (see instructions) | 6,399 | 40,208 | 46,607 | 21 |
| 22 | Payments received from patients for amounts previously written off as charity care | 328 | 129 | 457 | 22 |
| 23 | Cost of charity care (line 21 minus line 22) | 6,071 | 40,079 | 46,150 | 23 |

| | | | | |
|-------|---|--|-----------|-------|
| 24 | Does the amount in line 20, column 2 include charges for patient days beyond a length of stay limit imposed on patients covered by Medicaid or other indigent care program? | | N | 24 |
| 25 | If line 24 is yes, charges for patient days beyond the indigent care program's length of stay limit | | | 25 |
| 26 | Total bad debt expense for the entire hospital complex (see instructions) | | 1,918,851 | 26 |
| 27 | Medicare reimbursable bad debts for the entire hospital complex (see instructions) | | 139,125 | 27 |
| 27.01 | Medicare allowable bad debts for the entire hospital complex (see instructions) | | 214,038 | 27.01 |
| 28 | Non-Medicare and non-reimbursable Medicare bad debt expense (see instructions) | | 1,704,813 | 28 |
| 29 | Cost of non-Medicare and non-reimbursable Medicare bad debt expense (line 1 times line 28) | | 668,016 | 29 |
| 30 | Cost of uncompensated care (line 23, column 3 plus line 29) | | 714,166 | 30 |
| 31 | Total unreimbursed and uncompensated care cost (line 19 plus line 30) | | 726,146 | 31 |

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RECLASSIFICATION AND ADJUSTMENT OF TRIAL BALANCE OF EXPENSES

WORKSHEET A

| | | COST CENTER DESCRIPTIONS | SALARIES | OTHER | TOTAL (col. 1 + col. 2) | RECLASSI- FICATIONS | RECLASSI- FIED TRIAL BALANCE (col. 3 ± col. 4) | ADJUST- MENTS | NET EXPENSES FOR ALLOC- ATION (col. 5 ± col. 6) | |
|-------|-------|---|-----------|------------|-------------------------------|------------------------|--|------------------|--|-------|
| | | | 1 | 2 | 3 | 4 | 5 | 6 | 7 | |
| | | GENERAL SERVICE COST CENTERS | | | | | | | | |
| 1 | 00100 | Cap Rel Costs-Bldg & Fixt | | | | 1,094,169 | 1,094,169 | -291,538 | 802,631 | 1 |
| 2 | 00200 | Cap Rel Costs-Mvble Equip | | 1,979,788 | 1,979,788 | -1,094,169 | 885,619 | -268,185 | 617,434 | 2 |
| 3 | 00300 | Other Cap Rel Costs | | | | | | | -0- | 3 |
| 4 | 00400 | Employee Benefits Department | | 1,790,869 | 1,790,869 | | 1,790,869 | 195,941 | 1,986,810 | 4 |
| 5 | 00500 | Administrative & General | 849,632 | 1,828,459 | 2,678,091 | -441,910 | 2,236,181 | 1,429,462 | 3,665,643 | 5 |
| 6 | 00600 | Maintenance & Repairs | | | | | | | | 6 |
| 7 | 00700 | Operation of Plant | | 726,332 | 726,332 | | 726,332 | -11,406 | 714,926 | 7 |
| 8 | 00800 | Laundry & Linen Service | | 6,926 | 6,926 | | 6,926 | | 6,926 | 8 |
| 9 | 00900 | Housekeeping | 210,854 | 81,499 | 292,353 | | 292,353 | | 292,353 | 9 |
| 10 | 01000 | Dietary | 433,131 | 200,271 | 633,402 | | 633,402 | -93,659 | 539,743 | 10 |
| 11 | 01100 | Cafeteria | | | | | | | | 11 |
| 12 | 01200 | Maintenance of Personnel | | | | | | | | 12 |
| 13 | 01300 | Nursing Administration | 721,102 | 82,820 | 803,922 | 157,836 | 961,758 | | 961,758 | 13 |
| 14 | 01400 | Central Services & Supply | | | | | | | | 14 |
| 15 | 01500 | Pharmacy | | | | | | | | 15 |
| 16 | 01600 | Medical Records & Library | 161,893 | 16,496 | 178,389 | 112,263 | 290,652 | 78,630 | 369,282 | 16 |
| 17 | 01700 | Social Service | | | | | | | | 17 |
| 19 | 01900 | Nonphysician Anesthetists | | | | | | | | 19 |
| 20 | 02000 | Nursing School | | | | | | | | 20 |
| 21 | 02100 | I&R Services-Salary & Fringes Apprvd | | | | | | | | 21 |
| 22 | 02200 | I&R Services-Other Prgm Costs Apprvd | | | | | | | | 22 |
| 23 | 02300 | Paramed Ed Prgm-(specify) | | | | | | | | 23 |
| | | INPATIENT ROUTINE SERVICE COST CENTERS | | | | | | | | |
| 30 | 03000 | Adults & Pediatrics | 797,716 | 162,670 | 960,386 | -15,154 | 945,232 | 3,141 | 948,373 | 30 |
| 31 | 03100 | Intensive Care Unit | 115,767 | 29,418 | 145,185 | -432 | 144,753 | | 144,753 | 31 |
| 44 | 04400 | Skilled Nursing Facility | | | | 1,161,032 | 1,161,032 | -4,477 | 1,156,555 | 44 |
| 46 | 04600 | Other Long Term Care | 1,652,083 | 513,676 | 2,165,759 | -1,743,676 | 422,083 | -48,647 | 373,436 | 46 |
| | | ANCILLARY SERVICE COST CENTERS | | | | | | | | |
| 50 | 05000 | Operating Room | 675,913 | 1,593,254 | 2,269,167 | -833,379 | 1,435,788 | -119 | 1,435,669 | 50 |
| 51 | 05100 | Recovery Room | 546,401 | 137,417 | 683,818 | | 683,818 | | 683,818 | 51 |
| 53 | 05300 | Anesthesiology | 94,971 | 1,419,310 | 1,514,281 | | 1,514,281 | -1,261,237 | 253,044 | 53 |
| 54 | 05400 | Radiology-Diagnostic | 685,727 | 526,425 | 1,212,152 | -22,669 | 1,189,483 | | 1,189,483 | 54 |
| 60 | 06000 | Laboratory | 513,634 | 473,678 | 987,312 | 39,625 | 1,026,937 | -16,320 | 1,010,617 | 60 |
| 60.01 | 06001 | BLOOD LABORATORY | | | | | | | | 60.01 |
| 62.30 | 06250 | BLOOD CLOTTING FOR HEMOPHILIACS | | | | | | | | 62.30 |
| 65 | 06500 | Respiratory Therapy | 170,159 | 83,295 | 253,454 | -715 | 252,739 | | 252,739 | 65 |
| 66 | 06600 | Physical Therapy | 197,723 | 18,125 | 215,848 | 262,386 | 478,234 | | 478,234 | 66 |
| 67 | 06700 | Occupational Therapy | | | | 267,035 | 267,035 | | 267,035 | 67 |
| 68 | 06800 | Speech Pathology | | | | 22,233 | 22,233 | | 22,233 | 68 |
| 71 | 07100 | Medical Supplies Charged to Patients | 65,148 | 8,609 | 73,757 | 605,710 | 679,467 | | 679,467 | 71 |
| 72 | 07200 | Impl. Dev. Charged to Patients | | | | 396,195 | 396,195 | | 396,195 | 72 |
| 73 | 07300 | Drugs Charged to Patients | 209,259 | 728,874 | 938,133 | 63,143 | 1,001,276 | | 1,001,276 | 73 |
| 76.97 | 07697 | CARDIAC REHABILITATION | 38,928 | 5,528 | 44,456 | 16,602 | 61,058 | | 61,058 | 76.97 |
| 76.98 | 07698 | HYPERBARIC OXYGEN THERAPY | | | | | | | | 76.98 |
| 76.99 | 07699 | LITHOTRIPSY | | | | | | | | 76.99 |
| | | OUTPATIENT SERVICE COST CENTERS | | | | | | | | |
| 91 | 09100 | Emergency | 918,179 | 2,151,746 | 3,069,925 | -46,125 | 3,023,800 | -139,127 | 2,884,673 | 91 |
| 92 | 09200 | Observation Beds (Non-Distinct Part) | | | | | | | | 92 |
| | | OTHER REIMBURSABLE COST CENTERS | | | | | | | | |
| 99.10 | 09910 | CORF | | | | | | | | 99.10 |
| | | SPECIAL PURPOSE COST CENTERS | | | | | | | | |
| 118 | | SUBTOTALS (sum of lines 1-117) | 9,058,220 | 14,565,485 | 23,623,705 | | 23,623,705 | -427,541 | 23,196,164 | 118 |
| | | NONREIMBURSABLE COST CENTERS | | | | | | | | |
| 192 | 19200 | Physicians' Private Offices | | | | | | | | 192 |
| 200 | | TOTAL (sum of lines 118-199) | 9,058,220 | 14,565,485 | 23,623,705 | | 23,623,705 | -427,541 | 23,196,164 | 200 |

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RECLASSIFICATIONS

WORKSHEET A-6

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

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

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RECLASSIFICATIONS

WORKSHEET A-6

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

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

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RECONCILIATION OF CAPITAL COST CENTERS

**WORKSHEET A-7
PARTS I, II & III**

PART I - ANALYSIS OF CHANGES IN CAPITAL ASSETS BALANCES

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

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

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

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

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

PART III - RECONCILIATION OF CAPITAL COST CENTERS

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

| | Description | SUMMARY OF CAPITAL | | | | | | | 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 | 1,094,169 | | -291,538 | | | | 802,631 | 1 | |
| 2 | Cap Rel Costs-Mvble Equip | 617,434 | | | | | | 617,434 | 2 | |
| 3 | Total (sum of lines 1-2) | 1,711,603 | | -291,538 | | | | 1,420,065 | 3 | |

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

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ADJUSTMENTS TO EXPENSES

WORKSHEET A-8

| | DESCRIPTION(1) | BASIS/ CODE (2) | AMOUNT | EXPENSE CLASSIFICATION ON WORKSHEET A TO/FROM WHICH THE AMOUNT IS TO BE ADJUSTED | | | Wkst. A-7 Ref. |
|----|---|-----------------------|------------|--|-------|----|----------------------|
| | | | | COST CENTER | LINE# | | |
| | | 1 | 2 | 3 | 4 | 5 | |
| 1 | Investment income-buildings & fixtures (chapter 2) | | | Cap Rel Costs-Bldg & Fixt | 1 | | 1 |
| 2 | Investment income-movable equipment (chapter 2) | | | Cap Rel Costs-Mvble Equip | 2 | | 2 |
| 3 | Investment income-other (chapter 2) | | | | | | 3 |
| 4 | Trade, quantity, and time discounts (chapter 8) | | | | | | 4 |
| 5 | Refunds and rebates of expenses (chapter 8) | | | | | | 5 |
| 6 | Rental of provider space by suppliers (chapter 8) | | | | | | 6 |
| 7 | Telephone services (pay stations excl) (chapter 21) | | | | | | 7 |
| 8 | Television and radio service (chapter 21) | A | -4,293 | Operation of Plant | 7 | | 8 |
| 9 | Parking lot (chapter 21) | | | | | | 9 |
| 10 | Provider-based physician adjustment | Wkst A-8-2 | -1,743,758 | | | | 10 |
| 11 | Sale of scrap, waste, etc. (chapter 23) | | | | | | 11 |
| 12 | Related organization transactions (chapter 10) | Wkst A-8-1 | 2,539,436 | | | | 12 |
| 13 | Laundry and linen service | | | | | | 13 |
| 14 | Cafeteria - employees and guests | B | -93,659 | Dietary | 10 | | 14 |
| 15 | Rental of quarters to employees & others | | | | | | 15 |
| 16 | Sale of medical and surgical supplies to other than patients | | | | | | 16 |
| 17 | Sale of drugs to other than patients | | | | | | 17 |
| 18 | Sale of medical records and abstracts | B | -60 | Medical Records & Library | 16 | | 18 |
| 19 | Nursing and allied health education (tuition, fees, books, etc.) | | | | | | 19 |
| 20 | Vending machines | | | | | | 20 |
| 21 | Income from imposition of interest, finance or penalty charges (chapter 21) | | | | | | 21 |
| 22 | Interest exp on Medicare overpayments & borrowings to repay Medicare overpayments | | | | | | 22 |
| 23 | Adj for respiratory therapy costs in excess of limitation (chapter 14) | Wkst A-8-3 | | Respiratory Therapy | 65 | | 23 |
| 24 | Adj for physical therapy costs in excess of limitation (chapter 14) | Wkst A-8-3 | | Physical Therapy | 66 | | 24 |
| 25 | Util review-physicians' compensation (chapter 21) | | | Utilization Review-SNF | 114 | | 25 |
| 26 | Depreciation--buildings & fixtures | | | Cap Rel Costs-Bldg & Fixt | 1 | | 26 |
| 27 | Depreciation--movable equipment | | | Cap Rel Costs-Mvble Equip | 2 | | 27 |
| 28 | Non-physician anesthetist | | | Nonphysician Anesthetists | 19 | | 28 |
| 29 | Physicians' assistant | | | | | | 29 |
| 30 | Adj for occupational therapy costs in excess of limitation (chapter 14) | Wkst A-8-3 | | Occupational Therapy | 67 | | 30 |
| 31 | Adj for speech pathology costs in excess of limitation (chapter 14) | Wkst A-8-3 | | Speech Pathology | 68 | | 31 |
| 32 | CAH HIT Adj for Depreciation | A | -210,136 | Cap Rel Costs-Mvble Equip | 2 | 9 | 32 |
| 33 | OTHER OPERATING REVENUE | B | -1,489 | Administrative & General | 5 | | 33 |
| 34 | ILLINOIS UNALLOWABLE REAL ESTAT | A | -7,788 | Operation of Plant | 7 | | 34 |
| 35 | LOBBYING EXPENSE | A | -11,972 | Administrative & General | 5 | | 35 |
| 36 | | | | | | | 36 |
| 37 | HOSPITAL TAX | A | -542,759 | Administrative & General | 5 | | 37 |
| 38 | | | | | | | 38 |
| 39 | CASH DISCOUNTS | B | -401 | Administrative & General | 5 | | 39 |
| 40 | HOME OFFICE INTEREST EXPENSE | A | -291,538 | Cap Rel Costs-Bldg & Fixt | 1 | 11 | 40 |
| 41 | | | | | | | 41 |
| 42 | SNF TAX | A | -7,260 | Skilled Nursing Facility | 44 | | 42 |
| 43 | CARE CENTER TAX | A | -51,728 | Other Long Term Care | 46 | | 43 |
| 44 | OTHER OPERATING | B | -136 | Other Long Term Care | 46 | | 44 |
| 45 | | | | | | | 45 |
| 46 | | | | | | | 46 |
| 47 | | | | | | | 47 |
| 48 | | | | | | | 48 |
| 49 | | | | | | | 49 |
| 50 | TOTAL (sum of lines 1 thru 49) (Transfer to worksheet A, column 6, line 200) | | -427,541 | | | | 50 |

- (1) Description - all chapter references in this column pertain to CMS Pub. 15-1
- (2) Basis for adjustment (see instructions)
 - A. Costs - if cost, including applicable overhead, can be determined
 - B. Amount Received - if cost cannot be determined
- (3) Additional adjustments may be made on lines 33 thru 49 and subscripts thereof.

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

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

WORKSHEET A-8-1

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

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

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

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

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

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

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

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

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

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PROVIDER-BASED PHYSICIANS ADJUSTMENTS

WORKSHEET A-8-2

| | Wkst A Line # | Cost Center/ Physician Identifier | Total Remun- eration | Professional Component | Provider Component | RCE Amount | Physician/ Provider Component Hours | Unadjusted RCE Limit | 5 Percent of Unadjusted RCE Limit | |
|-----|------------------|---|----------------------------|---------------------------|-----------------------|---------------|--|-------------------------|--|-----|
| | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | |
| 1 | 50 | Operating Room AGGREGATE-OPERA | 43,639 | 119 | 43,520 | | | | | 1 |
| 2 | 60 | Laboratory AGGREGATE-LABOR | 16,320 | 16,320 | | | | | | 2 |
| 3 | 53 | Anesthesiology AGGREGATE-ANEST | 1,406,665 | 1,406,665 | | | | | | 3 |
| 4 | 91 | Emergency AGGREGATE-EMERG | 1,352,790 | 320,654 | 1,032,136 | | | | | 4 |
| 5 | | | | | | | | | | 5 |
| 6 | | | | | | | | | | 6 |
| 7 | | | | | | | | | | 7 |
| 8 | | | | | | | | | | 8 |
| 9 | | | | | | | | | | 9 |
| 10 | | | | | | | | | | 10 |
| 11 | | | | | | | | | | 11 |
| 12 | | | | | | | | | | 12 |
| 13 | | | | | | | | | | 13 |
| 14 | | | | | | | | | | 14 |
| 15 | | | | | | | | | | 15 |
| 16 | | | | | | | | | | 16 |
| 17 | | | | | | | | | | 17 |
| 18 | | | | | | | | | | 18 |
| 19 | | | | | | | | | | 19 |
| 20 | | | | | | | | | | 20 |
| 200 | | TOTAL | 2,819,414 | 1,743,758 | 1,075,656 | | | | | 200 |

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PROVIDER-BASED PHYSICIANS ADJUSTMENTS

WORKSHEET A-8-2

| | Wkst A Line # | Cost Center/ Physician Identifier | Cost of Memberships & Continuing Education | Provider Component Share of col. 12 | Physician Cost of Malpractice Insurance | Provider Component Share of col. 14 | Adjusted RCE Limit | RCE Disallowance | Adjustment | |
|-----|------------------|---|---|--|--|--|-----------------------|---------------------|------------|-----|
| | 10 | 11 | 12 | 13 | 14 | 15 | 16 | 17 | 18 | |
| 1 | 50 | Operating Room AGGREGATE-OPERA | | | | | | | 119 | 1 |
| 2 | 60 | Laboratory AGGREGATE-LABOR | | | | | | | 16,320 | 2 |
| 3 | 53 | Anesthesiology AGGREGATE-ANEST | | | | | | | 1,406,665 | 3 |
| 4 | 91 | Emergency AGGREGATE-EMERG | | | | | | | 320,654 | 4 |
| 5 | | | | | | | | | | 5 |
| 6 | | | | | | | | | | 6 |
| 7 | | | | | | | | | | 7 |
| 8 | | | | | | | | | | 8 |
| 9 | | | | | | | | | | 9 |
| 10 | | | | | | | | | | 10 |
| 11 | | | | | | | | | | 11 |
| 12 | | | | | | | | | | 12 |
| 13 | | | | | | | | | | 13 |
| 14 | | | | | | | | | | 14 |
| 15 | | | | | | | | | | 15 |
| 16 | | | | | | | | | | 16 |
| 17 | | | | | | | | | | 17 |
| 18 | | | | | | | | | | 18 |
| 19 | | | | | | | | | | 19 |
| 20 | | | | | | | | | | 20 |
| 200 | | TOTAL | | | | | | | 1,743,758 | 200 |

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COST ALLOCATION - GENERAL SERVICE COSTS

**WORKSHEET B
PART I**

| | COST CENTER DESCRIPTIONS | NET EXP FOR COST ALLOCATION (from Wkst A, col.7) | CAP BLDGS & FIXTURES | CAP MOVABLE EQUIPMENT | EMPLOYEE BENEFITS DEPARTMENT | SUBTOTAL (cols.0-4) | ADMINISTRATIVE & GENERAL | |
|-------|--|--|----------------------|-----------------------|------------------------------|---------------------|--------------------------|-------|
| | | 0 | 1 | 2 | 4 | 4A | 5 | |
| | GENERAL SERVICE COST CENTERS | | | | | | | |
| 1 | Cap Rel Costs-Bldg & Fixt | 802,631 | 802,631 | | | | | 1 |
| 2 | Cap Rel Costs-Mvble Equip | 617,434 | | 617,434 | | | | 2 |
| 4 | Employee Benefits Department | 1,986,810 | | | 1,986,810 | | | 4 |
| 5 | Administrative & General | 3,665,643 | 96,240 | 6,035 | 405,152 | 4,173,070 | 4,173,070 | 5 |
| 6 | Maintenance & Repairs | | | | | | | 6 |
| 7 | Operation of Plant | 714,926 | 159,634 | 97,901 | | 972,461 | 213,328 | 7 |
| 8 | Laundry & Linen Service | 6,926 | 9,264 | 1,093 | | 17,283 | 3,791 | 8 |
| 9 | Housekeeping | 292,353 | 3,649 | 1,014 | 35,221 | 332,237 | 72,882 | 9 |
| 10 | Dietary | 539,743 | 24,694 | 14,631 | 72,351 | 651,419 | 142,901 | 10 |
| 11 | Cafeteria | | 13,274 | | | 13,274 | 2,912 | 11 |
| 12 | Maintenance of Personnel | | | | | | | 12 |
| 13 | Nursing Administration | 961,758 | 4,452 | 1,754 | 144,708 | 1,112,672 | 244,086 | 13 |
| 14 | Central Services & Supply | | | | | | | 14 |
| 15 | Pharmacy | | | | | | | 15 |
| 16 | Medical Records & Library | 369,282 | 17,094 | | 44,294 | 430,670 | 94,476 | 16 |
| 17 | Social Service | | | | | | | 17 |
| 19 | Nonphysician Anesthetists | | | | | | | 19 |
| 20 | Nursing School | | | | | | | 20 |
| 21 | I&R Services-Salary & Fringes Apprvd | | | | | | | 21 |
| 22 | I&R Services-Other Prgm Costs Apprvd | | | | | | | 22 |
| 23 | Paramed Ed Prgm-(specify) | | | | | | | 23 |
| | INPATIENT ROUTINE SERV COST CENTERS | | | | | | | |
| 30 | Adults & Pediatrics | 948,373 | 66,913 | 11,255 | 133,251 | 1,159,792 | 254,422 | 30 |
| 31 | Intensive Care Unit | 144,753 | 18,428 | 529 | 19,338 | 183,048 | 40,155 | 31 |
| 44 | Skilled Nursing Facility | 1,156,555 | 47,854 | 5,344 | 147,941 | 1,357,694 | 297,836 | 44 |
| 46 | Other Long Term Care | 373,436 | 82,203 | 12,646 | 60,092 | 528,377 | 115,910 | 46 |
| | ANCILLARY SERVICE COST CENTERS | | | | | | | |
| 50 | Operating Room | 1,435,669 | 78,564 | 201,415 | 112,887 | 1,828,535 | 401,124 | 50 |
| 51 | Recovery Room | 683,818 | 3,208 | 5,212 | 91,271 | 783,509 | 171,878 | 51 |
| 53 | Anesthesiology | 253,044 | | 8,139 | | 261,183 | 57,295 | 53 |
| 54 | Radiology-Diagnostic | 1,189,483 | 22,909 | 187,871 | 117,100 | 1,517,363 | 332,862 | 54 |
| 60 | Laboratory | 1,010,617 | 15,310 | 9,777 | 91,411 | 1,127,115 | 247,254 | 60 |
| 60.01 | BLOOD LABORATORY | | | | | | | 60.01 |
| 62.30 | BLOOD CLOTTING FOR HEMOPHILIACS | | | | | | | 62.30 |
| 65 | Respiratory Therapy | 252,739 | 12,934 | 8,281 | 28,515 | 302,469 | 66,352 | 65 |
| 66 | Physical Therapy | 478,234 | 36,204 | 3,470 | 64,825 | 582,733 | 127,834 | 66 |
| 67 | Occupational Therapy | 267,035 | | | 33,210 | 300,245 | 65,864 | 67 |
| 68 | Speech Pathology | 22,233 | | 171 | 2,768 | 25,172 | 5,522 | 68 |
| 71 | Medical Supplies Charged to Patients | 679,467 | | 20,691 | 18,485 | 718,643 | 157,648 | 71 |
| 72 | Impl. Dev. Charged to Patients | 396,195 | | | | 396,195 | 86,913 | 72 |
| 73 | Drugs Charged to Patients | 1,001,276 | 5,414 | 2,117 | 43,098 | 1,051,905 | 230,755 | 73 |
| 76.97 | CARDIAC REHABILITATION | 61,058 | 5,013 | 8,648 | 9,054 | 83,773 | 18,377 | 76.97 |
| 76.98 | HYPERBARIC OXYGEN THERAPY | | | | | | | 76.98 |
| 76.99 | LITHOTRIPSY | | | | | | | 76.99 |
| | OUTPATIENT SERVICE COST CENTERS | | | | | | | |
| 91 | Emergency | 2,884,673 | 14,568 | 9,440 | 311,838 | 3,220,519 | 706,476 | 91 |
| 92 | Observation Beds (Non-Distinct Part) | | | | | | | 92 |
| | OTHER REIMBURSABLE COST CENTERS | | | | | | | |
| 99.10 | CORF | | | | | | | 99.10 |
| | SPECIAL PURPOSE COST CENTERS | | | | | | | |
| 118 | SUBTOTALS (sum of lines 1-117) | 23,196,164 | 737,823 | 617,434 | 1,986,810 | 23,131,356 | 4,158,853 | 118 |
| | NONREIMBURSABLE COST CENTERS | | | | | | | |
| 192 | Physicians' Private Offices | | 64,808 | | | 64,808 | 14,217 | 192 |
| 200 | Cross Foot Adjustments | | | | | | | 200 |
| 201 | Negative Cost Centers | | | | | | | 201 |
| 202 | TOTAL (sum of lines 118-201) | 23,196,164 | 802,631 | 617,434 | 1,986,810 | 23,196,164 | 4,173,070 | 202 |

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

**WORKSHEET B
PART I**

| | COST CENTER DESCRIPTIONS | OPERATION OF PLANT | LAUNDRY & LINEN SERVICE | HOUSE-KEEPING | DIETARY | CAFETERIA | NURSING ADMINISTRATION | |
|-------|--|--------------------|-------------------------|---------------|---------|-----------|------------------------|-------|
| | | 7 | 8 | 9 | 10 | 11 | 13 | |
| | GENERAL SERVICE COST CENTERS | | | | | | | |
| 1 | Cap Rel Costs-Bldg & Fixt | | | | | | | 1 |
| 2 | Cap Rel Costs-Mvble Equip | | | | | | | 2 |
| 4 | Employee Benefits Department | | | | | | | 4 |
| 5 | Administrative & General | | | | | | | 5 |
| 6 | Maintenance & Repairs | | | | | | | 6 |
| 7 | Operation of Plant | 1,185,789 | | | | | | 7 |
| 8 | Laundry & Linen Service | 20,091 | 41,165 | | | | | 8 |
| 9 | Housekeeping | 7,915 | | 413,034 | | | | 9 |
| 10 | Dietary | 53,556 | | 19,106 | 866,982 | | | 10 |
| 11 | Cafeteria | 28,789 | | 10,270 | 192,391 | 247,636 | | 11 |
| 12 | Maintenance of Personnel | | | | | | | 12 |
| 13 | Nursing Administration | 9,654 | | 3,444 | | 16,907 | 1,386,763 | 13 |
| 14 | Central Services & Supply | | | | | | | 14 |
| 15 | Pharmacy | | | | | | | 15 |
| 16 | Medical Records & Library | 37,074 | | 13,226 | | 7,616 | | 16 |
| 17 | Social Service | | | | | | | 17 |
| 19 | Nonphysician Anesthetists | | | | | | | 19 |
| 20 | Nursing School | | | | | | | 20 |
| 21 | I&R Services-Salary & Fringes Apprvd | | | | | | | 21 |
| 22 | I&R Services-Other Prgm Costs Apprvd | | | | | | | 22 |
| 23 | Paramed Ed Prgm-(specify) | | | | | | | 23 |
| | INPATIENT ROUTINE SERV COST CENTERS | | | | | | | |
| 30 | Adults & Pediatrics | 145,120 | 5,472 | 51,771 | 55,648 | 22,803 | 275,257 | 30 |
| 31 | Intensive Care Unit | 39,966 | 197 | 14,258 | | 2,524 | 25,523 | 31 |
| 44 | Skilled Nursing Facility | 103,784 | 8,599 | 37,025 | 285,412 | 31,312 | 145,316 | 44 |
| 46 | Other Long Term Care | 178,279 | 9,937 | 63,598 | 329,801 | 36,200 | 167,914 | 46 |
| | ANCILLARY SERVICE COST CENTERS | | | | | | | |
| 50 | Operating Room | 170,386 | 7,907 | 60,785 | | 18,046 | 208,336 | 50 |
| 51 | Recovery Room | 6,958 | 640 | 2,482 | | 16,013 | 205,410 | 51 |
| 53 | Anesthesiology | | | | | 10,542 | 35,006 | 53 |
| 54 | Radiology-Diagnostic | 49,685 | 2,829 | 17,725 | | 18,671 | | 54 |
| 60 | Laboratory | 33,203 | | 11,845 | | 17,510 | | 60 |
| 60.01 | BLOOD LABORATORY | | | | | | | 60.01 |
| 62.30 | BLOOD CLOTTING FOR HEMOPHILIACS | | | | | | | 62.30 |
| 65 | Respiratory Therapy | 28,050 | | 10,007 | | 5,025 | | 65 |
| 66 | Physical Therapy | 78,518 | 438 | 28,011 | | 6,343 | | 66 |
| 67 | Occupational Therapy | | | | | | | 67 |
| 68 | Speech Pathology | | | | | | | 68 |
| 71 | Medical Supplies Charged to Patients | | | | | 3,372 | | 71 |
| 72 | Impl. Dev. Charged to Patients | | | | | | | 72 |
| 73 | Drugs Charged to Patients | 11,742 | | 4,189 | | 4,467 | | 73 |
| 76.97 | CARDIAC REHABILITATION | 10,872 | 390 | 3,879 | | 2,256 | | 76.97 |
| 76.98 | HYPERBARIC OXYGEN THERAPY | | | | | | | 76.98 |
| 76.99 | LITHOTRIPSY | | | | | | | 76.99 |
| | OUTPATIENT SERVICE COST CENTERS | | | | | | | |
| 91 | Emergency | 31,594 | 4,644 | 11,271 | 3,730 | 28,029 | 324,001 | 91 |
| 92 | Observation Beds (Non-Distinct Part) | | | | | | | 92 |
| | OTHER REIMBURSABLE COST CENTERS | | | | | | | |
| 99.10 | CORF | | | | | | | 99.10 |
| | SPECIAL PURPOSE COST CENTERS | | | | | | | |
| 118 | SUBTOTALS (sum of lines 1-117) | 1,045,236 | 41,053 | 362,892 | 866,982 | 247,636 | 1,386,763 | 118 |
| | NONREIMBURSABLE COST CENTERS | | | | | | | |
| 192 | Physicians' Private Offices | 140,553 | 112 | 50,142 | | | | 192 |
| 200 | Cross Foot Adjustments | | | | | | | 200 |
| 201 | Negative Cost Centers | | | | | | | 201 |
| 202 | TOTAL (sum of lines 118-201) | 1,185,789 | 41,165 | 413,034 | 866,982 | 247,636 | 1,386,763 | 202 |

KPMG LLP Compu-Max 2552-10

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

COST ALLOCATION - GENERAL SERVICE COSTS

**WORKSHEET B
PART I**

| | COST CENTER DESCRIPTIONS | MEDICAL RECORDS & LIBRARY | SUBTOTAL | I&R COST & POST STEP-DOWN ADJS | TOTAL | | |
|-------|--|---------------------------|------------|--------------------------------|------------|--|-------|
| | | 16 | 24 | 25 | 26 | | |
| | GENERAL SERVICE COST CENTERS | | | | | | |
| 1 | Cap Rel Costs-Bldg & Fixt | | | | | | 1 |
| 2 | Cap Rel Costs-Mvble Equip | | | | | | 2 |
| 4 | Employee Benefits Department | | | | | | 4 |
| 5 | Administrative & General | | | | | | 5 |
| 6 | Maintenance & Repairs | | | | | | 6 |
| 7 | Operation of Plant | | | | | | 7 |
| 8 | Laundry & Linen Service | | | | | | 8 |
| 9 | Housekeeping | | | | | | 9 |
| 10 | Dietary | | | | | | 10 |
| 11 | Cafeteria | | | | | | 11 |
| 12 | Maintenance of Personnel | | | | | | 12 |
| 13 | Nursing Administration | | | | | | 13 |
| 14 | Central Services & Supply | | | | | | 14 |
| 15 | Pharmacy | | | | | | 15 |
| 16 | Medical Records & Library | 583,062 | | | | | 16 |
| 17 | Social Service | | | | | | 17 |
| 19 | Nonphysician Anesthetists | | | | | | 19 |
| 20 | Nursing School | | | | | | 20 |
| 21 | I&R Services-Salary & Fringes Apprvd | | | | | | 21 |
| 22 | I&R Services-Other Prgm Costs Apprvd | | | | | | 22 |
| 23 | Paramed Ed Prgm-(specify) | | | | | | 23 |
| | INPATIENT ROUTINE SERV COST CENTERS | | | | | | |
| 30 | Adults & Pediatrics | 26,848 | 1,997,133 | | 1,997,133 | | 30 |
| 31 | Intensive Care Unit | 1,666 | 307,337 | | 307,337 | | 31 |
| 44 | Skilled Nursing Facility | | 2,266,978 | | 2,266,978 | | 44 |
| 46 | Other Long Term Care | | 1,430,016 | | 1,430,016 | | 46 |
| | ANCILLARY SERVICE COST CENTERS | | | | | | |
| 50 | Operating Room | 163,494 | 2,858,613 | | 2,858,613 | | 50 |
| 51 | Recovery Room | | 1,186,890 | | 1,186,890 | | 51 |
| 53 | Anesthesiology | | 364,026 | | 364,026 | | 53 |
| 54 | Radiology-Diagnostic | 329,026 | 2,268,161 | | 2,268,161 | | 54 |
| 60 | Laboratory | | 1,436,927 | | 1,436,927 | | 60 |
| 60.01 | BLOOD LABORATORY | | | | | | 60.01 |
| 62.30 | BLOOD CLOTTING FOR HEMOPHILIACS | | | | | | 62.30 |
| 65 | Respiratory Therapy | | 411,903 | | 411,903 | | 65 |
| 66 | Physical Therapy | 8,888 | 832,765 | | 832,765 | | 66 |
| 67 | Occupational Therapy | | 366,109 | | 366,109 | | 67 |
| 68 | Speech Pathology | | 30,694 | | 30,694 | | 68 |
| 71 | Medical Supplies Charged to Patients | | 879,663 | | 879,663 | | 71 |
| 72 | Impl. Dev. Charged to Patients | | 483,108 | | 483,108 | | 72 |
| 73 | Drugs Charged to Patients | | 1,303,058 | | 1,303,058 | | 73 |
| 76.97 | CARDIAC REHABILITATION | 17,405 | 136,952 | | 136,952 | | 76.97 |
| 76.98 | HYPERBARIC OXYGEN THERAPY | | | | | | 76.98 |
| 76.99 | LITHOTRIPSY | | | | | | 76.99 |
| | OUTPATIENT SERVICE COST CENTERS | | | | | | |
| 91 | Emergency | 35,735 | 4,365,999 | | 4,365,999 | | 91 |
| 92 | Observation Beds (Non-Distinct Part) | | | | | | 92 |
| | OTHER REIMBURSABLE COST CENTERS | | | | | | |
| 99.10 | CORF | | | | | | 99.10 |
| | SPECIAL PURPOSE COST CENTERS | | | | | | |
| 118 | SUBTOTALS (sum of lines 1-117) | 583,062 | 22,926,332 | | 22,926,332 | | 118 |
| | NONREIMBURSABLE COST CENTERS | | | | | | |
| 192 | Physicians' Private Offices | | 269,832 | | 269,832 | | 192 |
| 200 | Cross Foot Adjustments | | | | | | 200 |
| 201 | Negative Cost Centers | | | | | | 201 |
| 202 | TOTAL (sum of lines 118-201) | 583,062 | 23,196,164 | | 23,196,164 | | 202 |

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

ALLOCATION OF CAPITAL-RELATED COSTS

**WORKSHEET B
PART II**

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

KPMG LLP Compu-Max 2552-10

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

ALLOCATION OF CAPITAL-RELATED COSTS

**WORKSHEET B
PART II**

| | COST CENTER DESCRIPTIONS | OPERATION OF PLANT | LAUNDRY & LINEN SERVICE | HOUSE-KEEPING | DIETARY | CAFETERIA | NURSING ADMINISTRATION | |
|-------|--|--------------------|-------------------------|---------------|---------|-----------|------------------------|-------|
| | | 7 | 8 | 9 | 10 | 11 | 13 | |
| | GENERAL SERVICE COST CENTERS | | | | | | | |
| 1 | Cap Rel Costs-Bldg & Fixt | | | | | | | 1 |
| 2 | Cap Rel Costs-Mvble Equip | | | | | | | 2 |
| 4 | Employee Benefits Department | | | | | | | 4 |
| 5 | Administrative & General | | | | | | | 5 |
| 6 | Maintenance & Repairs | | | | | | | 6 |
| 7 | Operation of Plant | 304,261 | | | | | | 7 |
| 8 | Laundry & Linen Service | 5,155 | 15,745 | | | | | 8 |
| 9 | Housekeeping | 2,031 | | 13,457 | | | | 9 |
| 10 | Dietary | 13,742 | | 622 | 64,466 | | | 10 |
| 11 | Cafeteria | 7,387 | | 335 | 14,306 | 35,481 | | 11 |
| 12 | Maintenance of Personnel | | | | | | | 12 |
| 13 | Nursing Administration | 2,477 | | 112 | | 2,422 | 26,736 | 13 |
| 14 | Central Services & Supply | | | | | | | 14 |
| 15 | Pharmacy | | | | | | | 15 |
| 16 | Medical Records & Library | 9,513 | | 431 | | 1,091 | | 16 |
| 17 | Social Service | | | | | | | 17 |
| 19 | Nonphysician Anesthetists | | | | | | | 19 |
| 20 | Nursing School | | | | | | | 20 |
| 21 | I&R Services-Salary & Fringes Apprvd | | | | | | | 21 |
| 22 | I&R Services-Other Prgm Costs Apprvd | | | | | | | 22 |
| 23 | Paramed Ed Prgm-(specify) | | | | | | | 23 |
| | INPATIENT ROUTINE SERV COST CENTERS | | | | | | | |
| 30 | Adults & Pediatrics | 37,236 | 2,093 | 1,687 | 4,138 | 3,267 | 5,307 | 30 |
| 31 | Intensive Care Unit | 10,255 | 75 | 465 | | 362 | 492 | 31 |
| 44 | Skilled Nursing Facility | 26,630 | 3,289 | 1,206 | 21,222 | 4,486 | 2,802 | 44 |
| 46 | Other Long Term Care | 45,743 | 3,802 | 2,073 | 24,523 | 5,188 | 3,237 | 46 |
| | ANCILLARY SERVICE COST CENTERS | | | | | | | |
| 50 | Operating Room | 43,719 | 3,024 | 1,980 | | 2,586 | 4,017 | 50 |
| 51 | Recovery Room | 1,785 | 245 | 81 | | 2,294 | 3,960 | 51 |
| 53 | Anesthesiology | | | | | 1,510 | 675 | 53 |
| 54 | Radiology-Diagnostic | 12,749 | 1,082 | 577 | | 2,675 | | 54 |
| 60 | Laboratory | 8,520 | | 386 | | 2,509 | | 60 |
| 60.01 | BLOOD LABORATORY | | | | | | | 60.01 |
| 62.30 | BLOOD CLOTTING FOR HEMOPHILIACS | | | | | | | 62.30 |
| 65 | Respiratory Therapy | 7,197 | | 326 | | 720 | | 65 |
| 66 | Physical Therapy | 20,147 | 167 | 913 | | 909 | | 66 |
| 67 | Occupational Therapy | | | | | | | 67 |
| 68 | Speech Pathology | | | | | | | 68 |
| 71 | Medical Supplies Charged to Patients | | | | | 483 | | 71 |
| 72 | Impl. Dev. Charged to Patients | | | | | | | 72 |
| 73 | Drugs Charged to Patients | 3,013 | | 136 | | 640 | | 73 |
| 76.97 | CARDIAC REHABILITATION | 2,790 | 149 | 126 | | 323 | | 76.97 |
| 76.98 | HYPERBARIC OXYGEN THERAPY | | | | | | | 76.98 |
| 76.99 | LITHOTRIPSY | | | | | | | 76.99 |
| | OUTPATIENT SERVICE COST CENTERS | | | | | | | |
| 91 | Emergency | 8,107 | 1,776 | 367 | 277 | 4,016 | 6,246 | 91 |
| 92 | Observation Beds (Non-Distinct Part) | | | | | | | 92 |
| | OTHER REIMBURSABLE COST CENTERS | | | | | | | |
| 99.10 | CORF | | | | | | | 99.10 |
| | SPECIAL PURPOSE COST CENTERS | | | | | | | |
| 118 | SUBTOTALS (sum of lines 1-117) | 268,196 | 15,702 | 11,823 | 64,466 | 35,481 | 26,736 | 118 |
| | NONREIMBURSABLE COST CENTERS | | | | | | | |
| 192 | Physicians' Private Offices | 36,065 | 43 | 1,634 | | | | 192 |
| 200 | Cross Foot Adjustments | | | | | | | 200 |
| 201 | Negative Cost Centers | | | | | | | 201 |
| 202 | TOTAL (sum of lines 118-201) | 304,261 | 15,745 | 13,457 | 64,466 | 35,481 | 26,736 | 202 |

KPMG LLP Compu-Max 2552-10

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

**WORKSHEET B
PART II**

| | COST CENTER DESCRIPTIONS | MEDICAL RECORDS & LIBRARY | SUBTOTAL | I&R COST & POST STEP-DOWN ADJS | TOTAL | | |
|-------|--|---------------------------|-----------|--------------------------------|-----------|--|-------|
| | | 16 | 24 | 25 | 26 | | |
| | GENERAL SERVICE COST CENTERS | | | | | | |
| 1 | Cap Rel Costs-Bldg & Fixt | | | | | | 1 |
| 2 | Cap Rel Costs-Mvble Equip | | | | | | 2 |
| 4 | Employee Benefits Department | | | | | | 4 |
| 5 | Administrative & General | | | | | | 5 |
| 6 | Maintenance & Repairs | | | | | | 6 |
| 7 | Operation of Plant | | | | | | 7 |
| 8 | Laundry & Linen Service | | | | | | 8 |
| 9 | Housekeeping | | | | | | 9 |
| 10 | Dietary | | | | | | 10 |
| 11 | Cafeteria | | | | | | 11 |
| 12 | Maintenance of Personnel | | | | | | 12 |
| 13 | Nursing Administration | | | | | | 13 |
| 14 | Central Services & Supply | | | | | | 14 |
| 15 | Pharmacy | | | | | | 15 |
| 16 | Medical Records & Library | 35,012 | | | | | 16 |
| 17 | Social Service | | | | | | 17 |
| 19 | Nonphysician Anesthetists | | | | | | 19 |
| 20 | Nursing School | | | | | | 20 |
| 21 | I&R Services-Salary & Fringes Apprvd | | | | | | 21 |
| 22 | I&R Services-Other Prgm Costs Apprvd | | | | | | 22 |
| 23 | Paramed Ed Prgm-(specify) | | | | | | 23 |
| | INPATIENT ROUTINE SERV COST CENTERS | | | | | | |
| 30 | Adults & Pediatrics | 1,612 | 153,150 | | 153,150 | | 30 |
| 31 | Intensive Care Unit | 100 | 34,331 | | 34,331 | | 31 |
| 44 | Skilled Nursing Facility | | 146,335 | | 146,335 | | 44 |
| 46 | Other Long Term Care | | 204,062 | | 204,062 | | 46 |
| | ANCILLARY SERVICE COST CENTERS | | | | | | |
| 50 | Operating Room | 9,818 | 401,858 | | 401,858 | | 50 |
| 51 | Recovery Room | | 28,183 | | 28,183 | | 51 |
| 53 | Anesthesiology | | 13,840 | | 13,840 | | 53 |
| 54 | Radiology-Diagnostic | 19,757 | 277,530 | | 277,530 | | 54 |
| 60 | Laboratory | | 58,458 | | 58,458 | | 60 |
| 60.01 | BLOOD LABORATORY | | | | | | 60.01 |
| 62.30 | BLOOD CLOTTING FOR HEMOPHILIACS | | | | | | 62.30 |
| 65 | Respiratory Therapy | | 39,176 | | 39,176 | | 65 |
| 66 | Physical Therapy | 534 | 71,357 | | 71,357 | | 66 |
| 67 | Occupational Therapy | | 4,060 | | 4,060 | | 67 |
| 68 | Speech Pathology | | 511 | | 511 | | 68 |
| 71 | Medical Supplies Charged to Patients | | 30,858 | | 30,858 | | 71 |
| 72 | Impl. Dev. Charged to Patients | | 5,334 | | 5,334 | | 72 |
| 73 | Drugs Charged to Patients | | 84,208 | | 84,208 | | 73 |
| 76.97 | CARDIAC REHABILITATION | 1,045 | 19,371 | | 19,371 | | 76.97 |
| 76.98 | HYPERBARIC OXYGEN THERAPY | | | | | | 76.98 |
| 76.99 | LITHOTRIPSY | | | | | | 76.99 |
| | OUTPATIENT SERVICE COST CENTERS | | | | | | |
| 91 | Emergency | 2,146 | 93,057 | | 93,057 | | 91 |
| 92 | Observation Beds (Non-Distinct Part) | | | | | | 92 |
| | OTHER REIMBURSABLE COST CENTERS | | | | | | |
| 99.10 | CORF | | | | | | 99.10 |
| | SPECIAL PURPOSE COST CENTERS | | | | | | |
| 118 | SUBTOTALS (sum of lines 1-117) | 35,012 | 1,665,679 | | 1,665,679 | | 118 |
| | NONREIMBURSABLE COST CENTERS | | | | | | |
| 192 | Physicians' Private Offices | | 103,422 | | 103,422 | | 192 |
| 200 | Cross Foot Adjustments | | | | | | 200 |
| 201 | Negative Cost Centers | | | | | | 201 |
| 202 | TOTAL (sum of lines 118-201) | 35,012 | 1,769,101 | | 1,769,101 | | 202 |

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

WORKSHEET B-1

| | COST CENTER DESCRIPTIONS | CAP BLDGS & FIXTURES SQUARE FEET | CAP MOVABLE EQUIPMENT DOLLAR VALUE | EMPLOYEE BENEFITS DEPARTMENT GROSS SALARIES | RECONCILIATION | ADMINISTRATIVE & GENERAL ACCUM COST | OPERATION OF PLANT SQUARE FEET | |
|-------|--|----------------------------------|------------------------------------|---|----------------|-------------------------------------|--------------------------------|-------|
| | | 1 | 2 | 4 | 5A | 5 | 7 | |
| | GENERAL SERVICE COST CENTERS | | | | | | | |
| 1 | Cap Rel Costs-Bldg & Fixt | 80,055 | | | | | | 1 |
| 2 | Cap Rel Costs-Mvble Equip | | 673,279 | | | | | 2 |
| 4 | Employee Benefits Department | | | 11,894,112 | | | | 4 |
| 5 | Administrative & General | 9,599 | 6,581 | 2,425,423 | -4,173,070 | 19,023,094 | | 5 |
| 6 | Maintenance & Repairs | | | | | | | 6 |
| 7 | Operation of Plant | 15,922 | 106,756 | | | 972,461 | 54,534 | 7 |
| 8 | Laundry & Linen Service | 924 | 1,192 | | | 17,283 | 924 | 8 |
| 9 | Housekeeping | 364 | 1,106 | 210,854 | | 332,237 | 364 | 9 |
| 10 | Dietary | 2,463 | 15,954 | 433,131 | | 651,419 | 2,463 | 10 |
| 11 | Cafeteria | 1,324 | | | | 13,274 | 1,324 | 11 |
| 12 | Maintenance of Personnel | | | | | | | 12 |
| 13 | Nursing Administration | 444 | 1,913 | 866,300 | | 1,112,672 | 444 | 13 |
| 14 | Central Services & Supply | | | | | | | 14 |
| 15 | Pharmacy | | | | | | | 15 |
| 16 | Medical Records & Library | 1,705 | | 265,167 | | 430,670 | 1,705 | 16 |
| 17 | Social Service | | | | | | | 17 |
| 19 | Nonphysician Anesthetists | | | | | | | 19 |
| 20 | Nursing School | | | | | | | 20 |
| 21 | I&R Services-Salary & Fringes Apprvd | | | | | | | 21 |
| 22 | I&R Services-Other Prgm Costs Apprvd | | | | | | | 22 |
| 23 | Paramed Ed Prgm-(specify) | | | | | | | 23 |
| | INPATIENT ROUTINE SERV COST CENTERS | | | | | | | |
| 30 | Adults & Pediatrics | 6,674 | 12,273 | 797,716 | | 1,159,792 | 6,674 | 30 |
| 31 | Intensive Care Unit | 1,838 | 577 | 115,767 | | 183,048 | 1,838 | 31 |
| 44 | Skilled Nursing Facility | 4,773 | 5,827 | 885,658 | | 1,357,694 | 4,773 | 44 |
| 46 | Other Long Term Care | 8,199 | 13,790 | 359,747 | | 528,377 | 8,199 | 46 |
| | ANCILLARY SERVICE COST CENTERS | | | | | | | |
| 50 | Operating Room | 7,836 | 219,632 | 675,803 | | 1,828,535 | 7,836 | 50 |
| 51 | Recovery Room | 320 | 5,683 | 546,401 | | 783,509 | 320 | 51 |
| 53 | Anesthesiology | | 8,875 | | | 261,183 | | 53 |
| 54 | Radiology-Diagnostic | 2,285 | 204,863 | 701,024 | | 1,517,363 | 2,285 | 54 |
| 60 | Laboratory | 1,527 | 10,661 | 547,238 | | 1,127,115 | 1,527 | 60 |
| 60.01 | BLOOD LABORATORY | | | | | | | 60.01 |
| 62.30 | BLOOD CLOTTING FOR HEMOPHILIACS | | | | | | | 62.30 |
| 65 | Respiratory Therapy | 1,290 | 9,030 | 170,709 | | 302,469 | 1,290 | 65 |
| 66 | Physical Therapy | 3,611 | 3,784 | 388,079 | | 582,733 | 3,611 | 66 |
| 67 | Occupational Therapy | | | 198,814 | | 300,245 | | 67 |
| 68 | Speech Pathology | | 187 | 16,570 | | 25,172 | | 68 |
| 71 | Medical Supplies Charged to Patients | | 22,562 | 110,664 | | 718,643 | | 71 |
| 72 | Impl. Dev. Charged to Patients | | | | | 396,195 | | 72 |
| 73 | Drugs Charged to Patients | 540 | 2,309 | 258,011 | | 1,051,905 | 540 | 73 |
| 76.97 | CARDIAC REHABILITATION | 500 | 9,430 | 54,202 | | 83,773 | 500 | 76.97 |
| 76.98 | HYPERBARIC OXYGEN THERAPY | | | | | | | 76.98 |
| 76.99 | LITHOTRIPSY | | | | | | | 76.99 |
| | OUTPATIENT SERVICE COST CENTERS | | | | | | | |
| 91 | Emergency | 1,453 | 10,294 | 1,866,834 | | 3,220,519 | 1,453 | 91 |
| 92 | Observation Beds (Non-Distinct Part) | | | | | | | 92 |
| | OTHER REIMBURSABLE COST CENTERS | | | | | | | |
| 99.10 | CORF | | | | | | | 99.10 |
| | SPECIAL PURPOSE COST CENTERS | | | | | | | |
| 118 | SUBTOTALS (sum of lines 1-117) | 73,591 | 673,279 | 11,894,112 | -4,173,070 | 18,958,286 | 48,070 | 118 |
| | NONREIMBURSABLE COST CENTERS | | | | | | | |
| 192 | Physicians' Private Offices | 6,464 | | | | 64,808 | 6,464 | 192 |
| 200 | Cross foot adjustments | | | | | | | 200 |
| 201 | Negative cost centers | | | | | | | 201 |
| 202 | Cost to be allocated (Per Wkst. B, Part I) | 802,631 | 617,434 | 1,986,810 | | 4,173,070 | 1,185,789 | 202 |
| 203 | Unit Cost Multiplier (Wkst. B, Part I) | 10.025995 | 0.917055 | 0.167041 | | 0.219369 | 21.744031 | 203 |
| 204 | Cost to be allocated (Per Wkst. B, Part II) | | | 1,061 | | 256,088 | 304,261 | 204 |
| 205 | Unit Cost Multiplier (Wkst. B, Part II) | | | 0.000089 | | 0.013462 | 5.579290 | 205 |
| 206 | NAHE adjustment amount to be allocated (per Wkst. B-2) | | | | | | | 206 |
| 207 | NAHE Unit Cost Multiplier (Wkst. D, Parts III and IV) | | | | | | | 207 |

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COST ALLOCATION - STATISTICAL BASIS

WORKSHEET B-1

| | COST CENTER DESCRIPTIONS | LAUNDRY & LINEN SERVICE POUNDS OF LAUNDR | HOUSE-KEEPING SQUARE FEET | DIETARY MEALS SERVED | CAFETERIA FULL TIME EQUIVALE | NURSING ADMINIS-TRATION DIRECT NRSING HR | MEDICAL RECORDS & LIBRARY TIME SPENT | |
|-------|--|---|------------------------------|-------------------------|---------------------------------|---|---|-------|
| | | 8 | 9 | 10 | 11 | 13 | 16 | |
| | GENERAL SERVICE COST CENTERS | | | | | | | |
| 1 | Cap Rel Costs-Bldg & Fixt | | | | | | | 1 |
| 2 | Cap Rel Costs-Mvble Equip | | | | | | | 2 |
| 4 | Employee Benefits Department | | | | | | | 4 |
| 5 | Administrative & General | | | | | | | 5 |
| 6 | Maintenance & Repairs | | | | | | | 6 |
| 7 | Operation of Plant | | | | | | | 7 |
| 8 | Laundry & Linen Service | 134,346 | | | | | | 8 |
| 9 | Housekeeping | | 53,246 | | | | | 9 |
| 10 | Dietary | | 2,463 | 50,665 | | | | 10 |
| 11 | Cafeteria | | 1,324 | 11,243 | 11,088 | | | 11 |
| 12 | Maintenance of Personnel | | | | | | | 12 |
| 13 | Nursing Administration | | 444 | | 757 | 66,830 | | 13 |
| 14 | Central Services & Supply | | | | | | | 14 |
| 15 | Pharmacy | | | | | | | 15 |
| 16 | Medical Records & Library | | 1,705 | | 341 | | 3,149 | 16 |
| 17 | Social Service | | | | | | | 17 |
| 19 | Nonphysician Anesthetists | | | | | | | 19 |
| 20 | Nursing School | | | | | | | 20 |
| 21 | I&R Services-Salary & Fringes Apprvd | | | | | | | 21 |
| 22 | I&R Services-Other Prgm Costs Apprvd | | | | | | | 22 |
| 23 | Paramed Ed Prgm-(specify) | | | | | | | 23 |
| | INPATIENT ROUTINE SERV COST CENTERS | | | | | | | |
| 30 | Adults & Pediatrics | 17,859 | 6,674 | 3,252 | 1,021 | 13,265 | 145 | 30 |
| 31 | Intensive Care Unit | 642 | 1,838 | | 113 | 1,230 | 9 | 31 |
| 44 | Skilled Nursing Facility | 28,064 | 4,773 | 16,679 | 1,402 | 7,003 | | 44 |
| 46 | Other Long Term Care | 32,430 | 8,199 | 19,273 | 1,621 | 8,092 | | 46 |
| | ANCILLARY SERVICE COST CENTERS | | | | | | | |
| 50 | Operating Room | 25,804 | 7,836 | | 808 | 10,040 | 883 | 50 |
| 51 | Recovery Room | 2,088 | 320 | | 717 | 9,899 | | 51 |
| 53 | Anesthesiology | | | | 472 | 1,687 | | 53 |
| 54 | Radiology-Diagnostic | 9,233 | 2,285 | | 836 | | 1,777 | 54 |
| 60 | Laboratory | | 1,527 | | 784 | | | 60 |
| 60.01 | BLOOD LABORATORY | | | | | | | 60.01 |
| 62.30 | BLOOD CLOTTING FOR HEMOPHILIACS | | | | | | | 62.30 |
| 65 | Respiratory Therapy | | 1,290 | | 225 | | | 65 |
| 66 | Physical Therapy | 1,429 | 3,611 | | 284 | | 48 | 66 |
| 67 | Occupational Therapy | | | | | | | 67 |
| 68 | Speech Pathology | | | | | | | 68 |
| 71 | Medical Supplies Charged to Patients | | | | 151 | | | 71 |
| 72 | Impl. Dev. Charged to Patients | | | | | | | 72 |
| 73 | Drugs Charged to Patients | | 540 | | 200 | | | 73 |
| 76.97 | CARDIAC REHABILITATION | 1,274 | 500 | | 101 | | 94 | 76.97 |
| 76.98 | HYPERBARIC OXYGEN THERAPY | | | | | | | 76.98 |
| 76.99 | LITHOTRIPSY | | | | | | | 76.99 |
| | OUTPATIENT SERVICE COST CENTERS | | | | | | | |
| 91 | Emergency | 15,157 | 1,453 | 218 | 1,255 | 15,614 | 193 | 91 |
| 92 | Observation Beds (Non-Distinct Part) | | | | | | | 92 |
| | OTHER REIMBURSABLE COST CENTERS | | | | | | | |
| 99.10 | CORF | | | | | | | 99.10 |
| | SPECIAL PURPOSE COST CENTERS | | | | | | | |
| 118 | SUBTOTALS (sum of lines 1-117) | 133,980 | 46,782 | 50,665 | 11,088 | 66,830 | 3,149 | 118 |
| | NONREIMBURSABLE COST CENTERS | | | | | | | |
| 192 | Physicians' Private Offices | 366 | 6,464 | | | | | 192 |
| 200 | Cross foot adjustments | | | | | | | 200 |
| 201 | Negative cost centers | | | | | | | 201 |
| 202 | Cost to be allocated (Per Wkst. B, Part I) | 41,165 | 413,034 | 866,982 | 247,636 | 1,386,763 | 583,062 | 202 |
| 203 | Unit Cost Multiplier (Wkst. B, Part I) | 0.306410 | 7.757090 | 17.112050 | 22.333694 | 20.750606 | 185.157828 | 203 |
| 204 | Cost to be allocated (Per Wkst. B, Part II) | 15,745 | 13,457 | 64,466 | 35,481 | 26,736 | 35,012 | 204 |
| 205 | Unit Cost Multiplier (Wkst. B, Part II) | 0.117197 | 0.252733 | 1.272397 | 3.199946 | 0.400060 | 11.118450 | 205 |
| 206 | NAHE adjustment amount to be allocated (per Wkst. B-2) | | | | | | | 206 |
| 207 | NAHE Unit Cost Multiplier (Wkst. D, Parts III and IV) | | | | | | | 207 |

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COST ALLOCATION - STATISTICAL BASIS

WORKSHEET B-1

| | | | | | | | | |
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| | COST CENTER DESCRIPTIONS | | | | | | | |
|--|--------------------------|--|--|--|--|--|--|--|

| | | | | | | | | |
|-------|--|--|--|--|--|--|--|-------|
| | GENERAL SERVICE COST CENTERS | | | | | | | |
| 1 | Cap Rel Costs-Bldg & Fixt | | | | | | | 1 |
| 2 | Cap Rel Costs-Mvble Equip | | | | | | | 2 |
| 4 | Employee Benefits Department | | | | | | | 4 |
| 5 | Administrative & General | | | | | | | 5 |
| 6 | Maintenance & Repairs | | | | | | | 6 |
| 7 | Operation of Plant | | | | | | | 7 |
| 8 | Laundry & Linen Service | | | | | | | 8 |
| 9 | Housekeeping | | | | | | | 9 |
| 10 | Dietary | | | | | | | 10 |
| 11 | Cafeteria | | | | | | | 11 |
| 12 | Maintenance of Personnel | | | | | | | 12 |
| 13 | Nursing Administration | | | | | | | 13 |
| 14 | Central Services & Supply | | | | | | | 14 |
| 15 | Pharmacy | | | | | | | 15 |
| 16 | Medical Records & Library | | | | | | | 16 |
| 17 | Social Service | | | | | | | 17 |
| 19 | Nonphysician Anesthetists | | | | | | | 19 |
| 20 | Nursing School | | | | | | | 20 |
| 21 | I&R Services-Salary & Fringes Apprvd | | | | | | | 21 |
| 22 | I&R Services-Other Prgm Costs Apprvd | | | | | | | 22 |
| 23 | Paramed Ed Prgm-(specify) | | | | | | | 23 |
| | INPATIENT ROUTINE SERV COST CENTERS | | | | | | | |
| 30 | Adults & Pediatrics | | | | | | | 30 |
| 31 | Intensive Care Unit | | | | | | | 31 |
| 44 | Skilled Nursing Facility | | | | | | | 44 |
| 46 | Other Long Term Care | | | | | | | 46 |
| | ANCILLARY SERVICE COST CENTERS | | | | | | | |
| 50 | Operating Room | | | | | | | 50 |
| 51 | Recovery Room | | | | | | | 51 |
| 53 | Anesthesiology | | | | | | | 53 |
| 54 | Radiology-Diagnostic | | | | | | | 54 |
| 60 | Laboratory | | | | | | | 60 |
| 60.01 | BLOOD LABORATORY | | | | | | | 60.01 |
| 62.30 | BLOOD CLOTTING FOR HEMOPHILIACS | | | | | | | 62.30 |
| 65 | Respiratory Therapy | | | | | | | 65 |
| 66 | Physical Therapy | | | | | | | 66 |
| 67 | Occupational Therapy | | | | | | | 67 |
| 68 | Speech Pathology | | | | | | | 68 |
| 71 | Medical Supplies Charged to Patients | | | | | | | 71 |
| 72 | Impl. Dev. Charged to Patients | | | | | | | 72 |
| 73 | Drugs Charged to Patients | | | | | | | 73 |
| 76.97 | CARDIAC REHABILITATION | | | | | | | 76.97 |
| 76.98 | HYPERBARIC OXYGEN THERAPY | | | | | | | 76.98 |
| 76.99 | LITHOTRIPSY | | | | | | | 76.99 |
| | OUTPATIENT SERVICE COST CENTERS | | | | | | | |
| 91 | Emergency | | | | | | | 91 |
| 92 | Observation Beds (Non-Distinct Part) | | | | | | | 92 |
| | OTHER REIMBURSABLE COST CENTERS | | | | | | | |
| 99.10 | CORF | | | | | | | 99.10 |
| | SPECIAL PURPOSE COST CENTERS | | | | | | | |
| 118 | SUBTOTALS (sum of lines 1-117) | | | | | | | 118 |
| | NONREIMBURSABLE COST CENTERS | | | | | | | |
| 192 | Physicians' Private Offices | | | | | | | 192 |
| 200 | Cross foot adjustments | | | | | | | 200 |
| 201 | Negative cost centers | | | | | | | 201 |
| 202 | Cost to be allocated (Per Wkst. B, Part I) | | | | | | | 202 |
| 203 | Unit Cost Multiplier (Wkst. B, Part I) | | | | | | | 203 |
| 204 | Cost to be allocated (Per Wkst. B, Part II) | | | | | | | 204 |
| 205 | Unit Cost Multiplier (Wkst. B, Part II) | | | | | | | 205 |
| 206 | NAHE adjustment amount to be allocated (per Wkst. B-2) | | | | | | | 206 |
| 207 | NAHE Unit Cost Multiplier (Wkst. D, Parts III and IV) | | | | | | | 207 |

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POST STEPDOWN ADJUSTMENTS

WORKSHEET B-2

| | | WORKSHEET | | |
|-------------|--|-----------|----------|--------|
| DESCRIPTION | | CODE | LINE NO. | AMOUNT |
| 1 | | 2 | 3 | 4 |

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

**WORKSHEET C
PART I**

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

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

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

COMPUTATION OF RATIO OF COST TO CHARGES - TITLE XIX (NOT AN OFFICIAL FORM CMS-2552-10 WORKSHEET)

**WORKSHEET C
PART I**

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

KPMG LLP Compu-Max 2552-10

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

COMPUTATION OF RATIO OF COST TO CHARGES - TITLE XIX (NOT AN OFFICIAL FORM CMS-2552-10 WORKSHEET)

**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 | | | | |
| | INPATIENT ROUTINE SERVICE COST CENTERS | | | | | | | |
| 30 | Adults & Pediatrics | | | | | | | 30 |
| 31 | Intensive Care Unit | | | | | | | 31 |
| 44 | Skilled Nursing Facility | | | | | | | 44 |
| 46 | Other Long Term Care | | | | | | | 46 |
| | ANCILLARY SERVICE COST CENTERS | | | | | | | |
| 50 | Operating Room | | | | | | | 50 |
| 51 | Recovery Room | | | | | | | 51 |
| 53 | Anesthesiology | | | | | | | 53 |
| 54 | Radiology-Diagnostic | | | | | | | 54 |
| 60 | Laboratory | | | | | | | 60 |
| 60.01 | BLOOD LABORATORY | | | | | | | 60.01 |
| 62.30 | BLOOD CLOTTING FOR HEMOPHILIACS | | | | | | | 62.30 |
| 65 | Respiratory Therapy | | | | | | | 65 |
| 66 | Physical Therapy | | | | | | | 66 |
| 67 | Occupational Therapy | | | | | | | 67 |
| 68 | Speech Pathology | | | | | | | 68 |
| 71 | Medical Supplies Charged to Patients | | | | | | | 71 |
| 72 | Impl. Dev. Charged to Patients | | | | | | | 72 |
| 73 | Drugs Charged to Patients | | | | | | | 73 |
| 76.97 | CARDIAC REHABILITATION | | | | | | | 76.97 |
| 76.98 | HYPERBARIC OXYGEN THERAPY | | | | | | | 76.98 |
| 76.99 | LITHOTRIPSY | | | | | | | 76.99 |
| | OUTPATIENT SERVICE COST CENTERS | | | | | | | |
| 91 | Emergency | | | | | | | 91 |
| 92 | Observation Beds (Non-Distinct Part) | | | | | | | 92 |
| | OTHER REIMBURSABLE COST CENTERS | | | | | | | |
| 99.10 | CORF | | | | | | | 99.10 |
| 200 | Subtotal (sum of lines 30 thru 199) | | | | | | | 200 |
| 201 | Less Observation Beds | | | | | | | 201 |
| 202 | Total (line 200 minus line 201) | | | | | | | 202 |

KPMG LLP Compu-Max 2552-10

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

CALCULATION OF OUTPATIENT SERVICE COST TO CHARGE RATIOS NET OF REDUCTIONS FOR MEDICAID ONLY

**WORKSHEET C
PART II**

[] Title V

[XX] Title XIX

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

KPMG LLP Compu-Max 2552-10

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

CALCULATION OF OUTPATIENT SERVICE COST TO CHARGE RATIOS NET OF REDUCTIONS FOR MEDICAID ONLY

**WORKSHEET C
PART II**

[] Title V

[XX] Title XIX

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

KPMG LLP Compu-Max 2552-10

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

APPORTIONMENT OF MEDICAL AND OTHER HEALTH SERVICE COSTS

COMPONENT CCN: 14-1335

WORKSHEET D
PART V

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

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

(A) Worksheet A line numbers

KPMG LLP Compu-Max 2552-10

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

**APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE
OTHER PASS THROUGH COSTS**

COMPONENT CCN: 14-6014

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

(A) Worksheet A line numbers

KPMG LLP Compu-Max 2552-10

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

**APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE
OTHER PASS THROUGH COSTS**

COMPONENT CCN: 14-6014

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

(A) Worksheet A line numbers

KPMG LLP Compu-Max 2552-10

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

APPORTIONMENT OF MEDICAL AND OTHER HEALTH SERVICE COSTS

COMPONENT CCN: 14-6014

WORKSHEET D
PART V

Check [] Title V - O/P [] Hospital [] SUB (Other) [] Swing Bed SNF
 Applicable [XX] Title XVIII, Part B [] IPF [XX] 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 | |
| | ANCILLARY SERVICE COST CENTERS | | | | | | | | |
| 50 | Operating Room | 0.158081 | | | | | | | 50 |
| 51 | Recovery Room | 0.313074 | | | | | | | 51 |
| 53 | Anesthesiology | 3.893826 | | | | | | | 53 |
| 54 | Radiology-Diagnostic | 0.196745 | | | | | | | 54 |
| 60 | Laboratory | 0.424798 | | | | | | | 60 |
| 60.01 | BLOOD LABORATORY | | | | | | | | 60.01 |
| 62.30 | BLOOD CLOTTING FOR HEMOPHILIACS | | | | | | | | 62.30 |
| 65 | Respiratory Therapy | 0.247017 | | | | | | | 65 |
| 66 | Physical Therapy | 0.457928 | | | | | | | 66 |
| 67 | Occupational Therapy | 0.809238 | | | | | | | 67 |
| 68 | Speech Pathology | 0.821068 | | | | | | | 68 |
| 71 | Medical Supplies Charged to Pat | 0.156423 | | | | | | | 71 |
| 72 | Impl. Dev. Charged to Patients | 0.265372 | | | | | | | 72 |
| 73 | Drugs Charged to Patients | 0.194145 | | | 325 | | | 63 | 73 |
| 76.97 | CARDIAC REHABILITATION | 0.564404 | | | | | | | 76.97 |
| 76.98 | HYPERBARIC OXYGEN THERAPY | | | | | | | | 76.98 |
| 76.99 | LITHOTRIPSY | | | | | | | | 76.99 |
| | OUTPATIENT SERVICE COST CENTERS | | | | | | | | |
| 91 | Emergency | 0.887156 | | | | | | | 91 |
| 92 | Observation Beds (Non-Distinct | 0.781261 | | | | | | | 92 |
| | OTHER REIMBURSABLE COST CENTERS | | | | | | | | |
| 200 | Subtotal (see instructions) | | | | 325 | | | 63 | 200 |
| 201 | Less PBP Clinic Lab. Services-Program Only Charges | | | | | | | | 201 |
| 202 | Net Charges (line 200 - line 201) | | | | 325 | | | 63 | 202 |

(A) Worksheet A line numbers

KPMG LLP Compu-Max 2552-10

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

APPORTIONMENT OF INPATIENT ROUTINE SERVICE CAPITAL COSTS

**WORKSHEET D
PART I**

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

| (A) | Cost Center Description | Capital Related Cost (from Wkst. B, Part II, (col. 26)) | Swing Bed Adjustment | Reduced Capital Related Cost (col. 1 minus col. 2) | Total Patient Days | Per Diem (col. 3 ÷ col. 4) | Inpatient Program Days | Inpatient Program Capital Cost (col. 5 x col. 6) | |
|-----|---|---|----------------------|--|--------------------|----------------------------|------------------------|--|-----|
| | | 1 | 2 | 3 | 4 | 5 | 6 | 7 | |
| | INPATIENT ROUTINE SERVICE COST CENTERS | | | | | | | | |
| 30 | Adults & Pediatrics General Routine Care) | 153,150 | | 153,150 | 1,266 | 120.97 | 20 | 2,419 | 30 |
| 31 | Intensive Care Unit | 34,331 | | 34,331 | 36 | 953.64 | 1 | 954 | 31 |
| 32 | Coronary Care Unit | | | | | | | | 32 |
| 33 | Burn Intensive Care Unit | | | | | | | | 33 |
| 34 | Surgical Intensive Care Unit | | | | | | | | 34 |
| 35 | Other Special Care (specify) | | | | | | | | 35 |
| 40 | Subprovider - IPF | | | | | | | | 40 |
| 41 | Subprovider - IRF | | | | | | | | 41 |
| 42 | Subprovider I | | | | | | | | 42 |
| 43 | Nursery | | | | | | | | 43 |
| 44 | Skilled Nursing Facility | 146,335 | | 146,335 | 2,300 | 63.62 | | | 44 |
| 45 | Nursing Facility | | | | | | | | 45 |
| 200 | Total (lines 30-199) | 333,816 | | 333,816 | 3,602 | | 21 | 3,373 | 200 |

(A) Worksheet A line numbers

KPMG LLP Compu-Max 2552-10

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

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS

COMPONENT CCN: 14-1335

**WORKSHEET D
PART II**

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

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

(A) Worksheet A line numbers

KPMG LLP Compu-Max 2552-10

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

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

(A) Worksheet A line numbers

KPMG LLP Compu-Max 2552-10

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

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 | |
| | INPATIENT ROUTINE SERVICE COST CENTERS | | | | | |
| 30 | Adults & Pediatrics (General Routine Care) | 1,266 | | 20 | | 30 |
| 31 | Intensive Care Unit | 36 | | 1 | | 31 |
| 32 | Coronary Care Unit | | | | | 32 |
| 33 | Burn Intensive Care Unit | | | | | 33 |
| 34 | Surgical Intensive Care Unit | | | | | 34 |
| 35 | Other Special Care (specify) | | | | | 35 |
| 40 | Subprovider - IPF | | | | | 40 |
| 41 | Subprovider - IRF | | | | | 41 |
| 42 | Subprovider I | | | | | 42 |
| 43 | Nursery | | | | | 43 |
| 44 | Skilled Nursing Facility | 2,300 | | | | 44 |
| 45 | Nursing Facility | | | | | 45 |
| 200 | Total (lines 30-199) | 3,602 | | 21 | | 200 |

(A) Worksheet A line numbers

KPMG LLP Compu-Max 2552-10

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

**APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE
OTHER PASS THROUGH COSTS**

COMPONENT CCN: 14-1335

**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

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

(A) Worksheet A line numbers

KPMG LLP Compu-Max 2552-10

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

**APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE
OTHER PASS THROUGH COSTS**

COMPONENT CCN: 14-1335

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

(A) Worksheet A line numbers

KPMG LLP Compu-Max 2552-10

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

APPORTIONMENT OF MEDICAL AND OTHER HEALTH SERVICE COSTS

COMPONENT CCN: 14-1335

WORKSHEET D
PART V

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

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

(A) Worksheet A line numbers

KPMG LLP Compu-Max 2552-10

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

COMPUTATION OF INPATIENT OPERATING COST

COMPONENT CCN: 14-1335

WORKSHEET D-1
PART I

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

PART I - ALL PROVIDER COMPONENTS

INPATIENT DAYS

| | | | |
|----|---|-------|----|
| 1 | Inpatient days (including private room days and swing-bed days, excluding newborn) | 1,266 | 1 |
| 2 | Inpatient days (including private room days, excluding swing-bed and newborn days) | 1,266 | 2 |
| 3 | Private room days (excluding swing-bed private room days). If you have only private room days, do not complete this line. | | 3 |
| 4 | Semi-private room days (excluding swing-bed private room days) | 1,053 | 4 |
| 5 | Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost reporting period | | 5 |
| 6 | Total swing-bed SNF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line) | | 6 |
| 7 | Total swing-bed NF type inpatient days (including private room days) through December 31 of the cost reporting period | | 7 |
| 8 | Total swing-bed NF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line) | | 8 |
| 9 | Total inpatient days including private room days applicable to the Program (excluding swing-bed and newborn days) | 528 | 9 |
| 10 | Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) through December 31 of the cost reporting period (see instructions) | | 10 |
| 11 | Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line) | | 11 |
| 12 | Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) through December 31 of the cost reporting period | | 12 |
| 13 | Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line) | | 13 |
| 14 | Medically necessary private room days applicable to the program (excluding swing-bed days) | | 14 |
| 15 | Total nursery days (title V or XIX only) | | 15 |
| 16 | Nursery days (title V or XIX only) | | 16 |

SWING-BED ADJUSTMENT

| | | | |
|----|--|-----------|----|
| 17 | Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost reporting period | | 17 |
| 18 | Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period | | 18 |
| 19 | Medicaid rate for swing-bed NF services applicable to services through December 31 of the cost reporting period | | 19 |
| 20 | Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period | | 20 |
| 21 | Total general inpatient routine service cost (see instructions) | 1,997,133 | 21 |
| 22 | Swing-bed cost applicable to SNF type services through December 31 of the cost reporting period (line 5 x line 17) | | 22 |
| 23 | Swing-bed cost applicable to SNF type services after December 31 of the cost reporting period (line 6 x line 18) | | 23 |
| 24 | Swing-bed cost applicable to NF type services through December 31 of the cost reporting period (line 7 x line 19) | | 24 |
| 25 | Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8 x line 20) | | 25 |
| 26 | Total swing-bed cost (see instructions) | | 26 |
| 27 | General inpatient routine service cost net of swing-bed cost (line 21 minus line 26) | 1,997,133 | 27 |

PRIVATE ROOM DIFFERENTIAL ADJUSTMENT

| | | | |
|----|---|-----------|----|
| 28 | General inpatient routine service charges (excluding swing-bed and observation bed charges) | | 28 |
| 29 | Private room charges (excluding swing-bed charges) | | 29 |
| 30 | Semi-private room charges (excluding swing-bed charges) | | 30 |
| 31 | General inpatient routine service cost/charge ratio (line 27 ÷ line 28) | | 31 |
| 32 | Average private room per diem charge (line 29 ÷ line 3) | | 32 |
| 33 | Average semi-private room per diem charge (line 30 ÷ line 4) | | 33 |
| 34 | Average per diem private room charge differential (line 32 minus line 33) (see instructions) | | 34 |
| 35 | Average per diem private room cost differential (line 34 x line 31) | | 35 |
| 36 | Private room cost differential adjustment (line 3 x line 35) | | 36 |
| 37 | General inpatient routine service cost net of swing-bed cost and private room cost differential (line 27 minus line 36) | 1,997,133 | 37 |

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

COMPUTATION OF INPATIENT OPERATING COST

COMPONENT CCN: 14-1335

WORKSHEET D-1
PART II

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

PART II - HOSPITALS AND SUBPROVIDERS ONLY

PROGRAM INPATIENT OPERATING COST BEFORE PASS-THROUGH COST ADJUSTMENTS

| | | | | | | | |
|----|---|----------------------|----------------------|------------------------------------|--------------|--------------------------------|----|
| 38 | Adjusted general inpatient routine service cost per diem (see instructions) | | | | | 1,577.51 | 38 |
| 39 | Program general inpatient routine service cost (line 9 x line 38) | | | | | 832,925 | 39 |
| 40 | Medically necessary private room cost applicable to the Program (line 14 x line 35) | | | | | | 40 |
| 41 | Total Program general inpatient routine service cost (line 39 + line 40) | | | | | 832,925 | 41 |
| | | Total Inpatient Cost | Total Inpatient Days | Average Per Diem (col. 1 ÷ col. 2) | Program Days | Program Cost (col. 3 x col. 4) | |
| | | 1 | 2 | 3 | 4 | 5 | |
| 42 | Nursery (Titles V and XIX only) | | | | | | 42 |
| | Intensive Care Type Inpatient Hospital Units | | | | | | |
| 43 | Intensive Care Unit | 307,337 | 36 | 8,537.14 | 18 | 153,669 | 43 |
| 44 | Coronary Care Unit | | | | | | 44 |
| 45 | Burn Intensive Care Unit | | | | | | 45 |
| 46 | Surgical Intensive Care Unit | | | | | | 46 |
| 47 | Other Special Care (specify) | | | | | | 47 |
| | | | | | | 1 | |
| 48 | Program inpatient ancillary service cost (Wkst. D-3, col. 3, line 200) | | | | | 566,676 | 48 |
| 49 | Total program inpatient costs (sum of lines 41 through 48)(see instructions) | | | | | 1,553,270 | 49 |

PASS THROUGH COST ADJUSTMENTS

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

TARGET AMOUNT AND LIMIT COMPUTATION

| | | | | | | | |
|----|--|--|--|--|--|--|----|
| 54 | Program discharges | | | | | | 54 |
| 55 | Target amount per discharge | | | | | | 55 |
| 56 | Target amount (line 54 x line 55) | | | | | | 56 |
| 57 | Difference between adjusted inpatient operating cost and target amount (line 56 minus line 53) | | | | | | 57 |
| 58 | Bonus payment (see instructions) | | | | | | 58 |
| 59 | Lesser of line 53 ÷ line 54 or line 55 from the cost reporting period ending 1996, updated and compounded by the market basket. | | | | | | 59 |
| 60 | Lesser of line 53 ÷ line 54 or line 55 from prior year cost report, updated by the market basket. | | | | | | 60 |
| 61 | If line 53 ÷ 54 is less than the lower of lines 55, 59 or 60 enter the lesser of 50% of the amount by which operating costs (line 53) are less than expected costs (line 54 x 60), or 1% of the target amount (line 56), otherwise enter zero (see instructions) | | | | | | 61 |
| 62 | Relief payment (see instructions) | | | | | | 62 |
| 63 | Allowable Inpatient cost plus incentive payment (see instructions) | | | | | | 63 |

PROGRAM INPATIENT ROUTINE SWING BED COST

| | | | | | | | |
|----|---|--|--|--|--|--|----|
| 64 | Medicare swing-bed SNF inpatient routine costs through December 31 of the cost reporting period (See instructions) (title XVIII only) | | | | | | 64 |
| 65 | Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (See instructions) (title XVIII only) | | | | | | 65 |
| 66 | Total Medicare swing-bed SNF inpatient routine costs (title XVIII only. For CAH, see instructions) | | | | | | 66 |
| 67 | Title V or XIX swing-bed NF inpatient routine costs through December 31 of the cost reporting period (line 12 x line 19) | | | | | | 67 |
| 68 | Title V or XIX swing-bed NF inpatient routine costs after December 31 of the cost reporting period (line 13 x line 20) | | | | | | 68 |
| 69 | Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68) | | | | | | 69 |

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

COMPUTATION OF INPATIENT OPERATING COST

COMPONENT CCN: 14-1335

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) | | | | | 213 | 87 |
| 88 | Adjusted general inpatient routine cost per diem (line 27 ÷ line 2) | | | | | 1,577.51 | 88 |
| 89 | Observation bed cost (line 87 x line 88) (see instructions) | | | | | 336,010 | 89 |
| | | Cost | Routine Cost (from line 21) | col. 1÷col. 2 | Total Observation Bed Cost (from line 89) | Observation Bed Pass Through Cost col. 3 x col. 4 (see instructions) | |
| | | 1 | 2 | 3 | 4 | 5 | |
| 90 | Capital-related cost | 153,150 | 1,997,133 | 0.076685 | 336,010 | 25,767 | 90 |
| 91 | Nursing School | | | | | | 91 |
| 92 | Allied Health | | | | | | 92 |
| 93 | Other Medical Education | | | | | | 93 |

KPMG LLP Compu-Max 2552-10

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

COMPUTATION OF INPATIENT OPERATING COST

COMPONENT CCN: 14-6014

WORKSHEET D-1
PART I

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

PART I - ALL PROVIDER COMPONENTS

INPATIENT DAYS

| | | | |
|----|---|-------|----|
| 1 | Inpatient days (including private room days and swing-bed days, excluding newborn) | 2,300 | 1 |
| 2 | Inpatient days (including private room days, excluding swing-bed and newborn days) | 2,300 | 2 |
| 3 | Private room days (excluding swing-bed private room days). If you have only private room days, do not complete this line. | | 3 |
| 4 | Semi-private room days (excluding swing-bed private room days) | 2,300 | 4 |
| 5 | Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost reporting period | | 5 |
| 6 | Total swing-bed SNF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line) | | 6 |
| 7 | Total swing-bed NF type inpatient days (including private room days) through December 31 of the cost reporting period | | 7 |
| 8 | Total swing-bed NF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line) | | 8 |
| 9 | Total inpatient days including private room days applicable to the Program (excluding swing-bed and newborn days) | 1,830 | 9 |
| 10 | Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) through December 31 of the cost reporting period (see instructions) | | 10 |
| 11 | Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line) | | 11 |
| 12 | Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) through December 31 of the cost reporting period | | 12 |
| 13 | Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line) | | 13 |
| 14 | Medically necessary private room days applicable to the program (excluding swing-bed days) | | 14 |
| 15 | Total nursery days (title V or XIX only) | | 15 |
| 16 | Nursery days (title V or XIX only) | | 16 |

SWING-BED ADJUSTMENT

| | | | |
|----|--|-----------|----|
| 17 | Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost reporting period | | 17 |
| 18 | Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period | | 18 |
| 19 | Medicaid rate for swing-bed NF services applicable to services through December 31 of the cost reporting period | | 19 |
| 20 | Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period | | 20 |
| 21 | Total general inpatient routine service cost (see instructions) | 2,266,978 | 21 |
| 22 | Swing-bed cost applicable to SNF type services through December 31 of the cost reporting period (line 5 x line 17) | | 22 |
| 23 | Swing-bed cost applicable to SNF type services after December 31 of the cost reporting period (line 6 x line 18) | | 23 |
| 24 | Swing-bed cost applicable to NF type services through December 31 of the cost reporting period (line 7 x line 19) | | 24 |
| 25 | Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8 x line 20) | | 25 |
| 26 | Total swing-bed cost (see instructions) | | 26 |
| 27 | General inpatient routine service cost net of swing-bed cost (line 21 minus line 26) | 2,266,978 | 27 |

PRIVATE ROOM DIFFERENTIAL ADJUSTMENT

| | | | |
|----|---|-----------|----|
| 28 | General inpatient routine service charges (excluding swing-bed and observation bed charges) | | 28 |
| 29 | Private room charges (excluding swing-bed charges) | | 29 |
| 30 | Semi-private room charges (excluding swing-bed charges) | | 30 |
| 31 | General inpatient routine service cost/charge ratio (line 27 ÷ line 28) | | 31 |
| 32 | Average private room per diem charge (line 29 ÷ line 3) | | 32 |
| 33 | Average semi-private room per diem charge (line 30 ÷ line 4) | | 33 |
| 34 | Average per diem private room charge differential (line 32 minus line 33) (see instructions) | | 34 |
| 35 | Average per diem private room cost differential (line 34 x line 31) | | 35 |
| 36 | Private room cost differential adjustment (line 3 x line 35) | | 36 |
| 37 | General inpatient routine service cost net of swing-bed cost and private room cost differential (line 27 minus line 36) | 2,266,978 | 37 |

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| | | | |
|--|---------------------------------------|--|--|
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|--|---------------------------------------|--|--|

COMPUTATION OF INPATIENT OPERATING COST

COMPONENT CCN: 14-6014

WORKSHEET D-1
PARTS III & IV

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

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

| | | | |
|----|--|-----------|----|
| 70 | Skilled nursing facility/other nursing facility/ICF/IID routine service cost (line 37) | 2,266,978 | 70 |
| 71 | Adjusted general inpatient routine service cost per diem (line 70 ÷ line 2) | 985.64 | 71 |
| 72 | Program routine service cost (line 9 x line 71) | 1,803,721 | 72 |
| 73 | Medically necessary private room cost applicable to Program (line 14 x line 35) | | 73 |
| 74 | Total Program general inpatient routine service costs (line 72 + line 73) | 1,803,721 | 74 |
| 75 | Capital-related cost allocated to inpatient routine service costs (from Worksheet B, Part II, column 26) | | 75 |
| 76 | Per diem capital-related costs (line 75 ÷ line 2) | | 76 |
| 77 | Program capital-related costs (line 9 x line 76) | | 77 |
| 78 | Inpatient routine service cost (line 74 minus line 77) | | 78 |
| 79 | Aggregate charges to beneficiaries for excess costs (from provider records) | | 79 |
| 80 | Total Program routine service costs for comparison to the cost limitation (line 78 minus line 79) | | 80 |
| 81 | Inpatient routine service cost per diem limitation | | 81 |
| 82 | Inpatient routine service cost limitation (line 9 x line 81) | | 82 |
| 83 | Reasonable inpatient routine service costs (see instructions) | 1,803,721 | 83 |
| 84 | Program inpatient ancillary services (see instructions) | 539,490 | 84 |
| 85 | Utilization review - physician compensation (see instructions) | | 85 |
| 86 | Total Program inpatient operating costs (sum of lines 83 through 85) | 2,343,211 | 86 |

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

COMPUTATION OF INPATIENT OPERATING COST

COMPONENT CCN: 14-1335

WORKSHEET D-1
PART I

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

PART I - ALL PROVIDER COMPONENTS

INPATIENT DAYS

| | | | |
|----|---|-------|----|
| 1 | Inpatient days (including private room days and swing-bed days, excluding newborn) | 1,266 | 1 |
| 2 | Inpatient days (including private room days, excluding swing-bed and newborn days) | 1,266 | 2 |
| 3 | Private room days (excluding swing-bed private room days). If you have only private room days, do not complete this line. | | 3 |
| 4 | Semi-private room days (excluding swing-bed private room days) | 1,053 | 4 |
| 5 | Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost reporting period | | 5 |
| 6 | Total swing-bed SNF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line) | | 6 |
| 7 | Total swing-bed NF type inpatient days (including private room days) through December 31 of the cost reporting period | | 7 |
| 8 | Total swing-bed NF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line) | | 8 |
| 9 | Total inpatient days including private room days applicable to the Program (excluding swing-bed and newborn days) | 20 | 9 |
| 10 | Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) through December 31 of the cost reporting period (see instructions) | | 10 |
| 11 | Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line) | | 11 |
| 12 | Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) through December 31 of the cost reporting period | | 12 |
| 13 | Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line) | | 13 |
| 14 | Medically necessary private room days applicable to the program (excluding swing-bed days) | | 14 |
| 15 | Total nursery days (title V or XIX only) | | 15 |
| 16 | Nursery days (title V or XIX only) | | 16 |

SWING-BED ADJUSTMENT

| | | | |
|----|--|-----------|----|
| 17 | Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost reporting period | | 17 |
| 18 | Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period | | 18 |
| 19 | Medicaid rate for swing-bed NF services applicable to services through December 31 of the cost reporting period | | 19 |
| 20 | Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period | | 20 |
| 21 | Total general inpatient routine service cost (see instructions) | 1,997,133 | 21 |
| 22 | Swing-bed cost applicable to SNF type services through December 31 of the cost reporting period (line 5 x line 17) | | 22 |
| 23 | Swing-bed cost applicable to SNF type services after December 31 of the cost reporting period (line 6 x line 18) | | 23 |
| 24 | Swing-bed cost applicable to NF type services through December 31 of the cost reporting period (line 7 x line 19) | | 24 |
| 25 | Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8 x line 20) | | 25 |
| 26 | Total swing-bed cost (see instructions) | | 26 |
| 27 | General inpatient routine service cost net of swing-bed cost (line 21 minus line 26) | 1,997,133 | 27 |

PRIVATE ROOM DIFFERENTIAL ADJUSTMENT

| | | | |
|----|---|-----------|----|
| 28 | General inpatient routine service charges (excluding swing-bed and observation bed charges) | | 28 |
| 29 | Private room charges (excluding swing-bed charges) | | 29 |
| 30 | Semi-private room charges (excluding swing-bed charges) | | 30 |
| 31 | General inpatient routine service cost/charge ratio (line 27 ÷ line 28) | | 31 |
| 32 | Average private room per diem charge (line 29 ÷ line 3) | | 32 |
| 33 | Average semi-private room per diem charge (line 30 ÷ line 4) | | 33 |
| 34 | Average per diem private room charge differential (line 32 minus line 33) (see instructions) | | 34 |
| 35 | Average per diem private room cost differential (line 34 x line 31) | | 35 |
| 36 | Private room cost differential adjustment (line 3 x line 35) | | 36 |
| 37 | General inpatient routine service cost net of swing-bed cost and private room cost differential (line 27 minus line 36) | 1,997,133 | 37 |

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

COMPUTATION OF INPATIENT OPERATING COST

COMPONENT CCN: 14-1335

WORKSHEET D-1
PART II

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

PART II - HOSPITALS AND SUBPROVIDERS ONLY

PROGRAM INPATIENT OPERATING COST BEFORE PASS-THROUGH COST ADJUSTMENTS

| | | | | | | | |
|----|---|----------------------|----------------------|------------------------------------|--------------|--------------------------------|----|
| 38 | Adjusted general inpatient routine service cost per diem (see instructions) | | | | | 1,577.51 | 38 |
| 39 | Program general inpatient routine service cost (line 9 x line 38) | | | | | 31,550 | 39 |
| 40 | Medically necessary private room cost applicable to the Program (line 14 x line 35) | | | | | | 40 |
| 41 | Total Program general inpatient routine service cost (line 39 + line 40) | | | | | 31,550 | 41 |
| | | Total Inpatient Cost | Total Inpatient Days | Average Per Diem (col. 1 ÷ col. 2) | Program Days | Program Cost (col. 3 x col. 4) | |
| | | 1 | 2 | 3 | 4 | 5 | |
| 42 | Nursery (Titles V and XIX only) | | | | | | 42 |
| | Intensive Care Type Inpatient Hospital Units | | | | | | |
| 43 | Intensive Care Unit | 307,337 | 36 | 8,537.14 | 1 | 8,537 | 43 |
| 44 | Coronary Care Unit | | | | | | 44 |
| 45 | Burn Intensive Care Unit | | | | | | 45 |
| 46 | Surgical Intensive Care Unit | | | | | | 46 |
| 47 | Other Special Care (specify) | | | | | | 47 |

| | | | | | | | |
|----|--|--|--|--|--|--------|----|
| 48 | Program inpatient ancillary service cost (Wkst. D-3, col. 3, line 200) | | | | | | 48 |
| 49 | Total program inpatient costs (sum of lines 41 through 48)(see instructions) | | | | | 40,087 | 49 |

PASS THROUGH COST ADJUSTMENTS

| | | | | | | | |
|----|--|--|--|--|--|-------|----|
| 50 | Pass through costs applicable to Program inpatient routine services (from Wkst. D, sum of Parts I and III) | | | | | 3,373 | 50 |
| 51 | Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV) | | | | | | 51 |
| 52 | Total Program excludable cost (sum of lines 50 and 51) | | | | | 3,373 | 52 |
| 53 | Total Program inpatient operating cost excluding capital related, nonphysician anesthetist and medical education costs (line 49 minus line 52) | | | | | | 53 |

TARGET AMOUNT AND LIMIT COMPUTATION

| | | | | | | | |
|----|--|--|--|--|--|--|----|
| 54 | Program discharges | | | | | | 54 |
| 55 | Target amount per discharge | | | | | | 55 |
| 56 | Target amount (line 54 x line 55) | | | | | | 56 |
| 57 | Difference between adjusted inpatient operating cost and target amount (line 56 minus line 53) | | | | | | 57 |
| 58 | Bonus payment (see instructions) | | | | | | 58 |
| 59 | Lesser of line 53 ÷ line 54 or line 55 from the cost reporting period ending 1996, updated and compounded by the market basket. | | | | | | 59 |
| 60 | Lesser of line 53 ÷ line 54 or line 55 from prior year cost report, updated by the market basket. | | | | | | 60 |
| 61 | If line 53 ÷ 54 is less than the lower of lines 55, 59 or 60 enter the lesser of 50% of the amount by which operating costs (line 53) are less than expected costs (line 54 x 60), or 1% of the target amount (line 56), otherwise enter zero (see instructions) | | | | | | 61 |
| 62 | Relief payment (see instructions) | | | | | | 62 |
| 63 | Allowable Inpatient cost plus incentive payment (see instructions) | | | | | | 63 |

PROGRAM INPATIENT ROUTINE SWING BED COST

| | | | | | | | |
|----|---|--|--|--|--|--|----|
| 64 | Medicare swing-bed SNF inpatient routine costs through December 31 of the cost reporting period (See instructions) (title XVIII only) | | | | | | 64 |
| 65 | Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (See instructions) (title XVIII only) | | | | | | 65 |
| 66 | Total Medicare swing-bed SNF inpatient routine costs (title XVIII only. For CAH, see instructions) | | | | | | 66 |
| 67 | Title V or XIX swing-bed NF inpatient routine costs through December 31 of the cost reporting period (line 12 x line 19) | | | | | | 67 |
| 68 | Title V or XIX swing-bed NF inpatient routine costs after December 31 of the cost reporting period (line 13 x line 20) | | | | | | 68 |
| 69 | Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68) | | | | | | 69 |

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

COMPUTATION OF INPATIENT OPERATING COST

COMPONENT CCN: 14-1335

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) | | | | | 213 | 87 |
| 88 | Adjusted general inpatient routine cost per diem (line 27 ÷ line 2) | | | | | 1,577.51 | 88 |
| 89 | Observation bed cost (line 87 x line 88) (see instructions) | | | | | 336,010 | 89 |
| | | Cost | Routine Cost (from line 21) | col. 1÷col. 2 | Total Observation Bed Cost (from line 89) | Observation Bed Pass Through Cost col. 3 x col. 4 (see instructions) | |
| | | 1 | 2 | 3 | 4 | 5 | |
| 90 | Capital-related cost | 153,150 | 1,997,133 | 0.076685 | 336,010 | 25,767 | 90 |
| 91 | Nursing School | | | | | | 91 |
| 92 | Allied Health | | | | | | 92 |
| 93 | Other Medical Education | | | | | | 93 |

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

COMPONENT CCN: 14-1335

WORKSHEET D-3

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

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

(A) Worksheet A line numbers

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

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT

COMPONENT CCN: 14-6014

WORKSHEET D-3

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

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

(A) Worksheet A line numbers

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

CALCULATION OF REIMBURSEMENT SETTLEMENT

COMPONENT CCN: 14-1335

**WORKSHEET E
PART B**

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

PART B - MEDICAL AND OTHER HEALTH SERVICES

| | | 1 | 1.01 | 1.02 | |
|-------|---|-----------|------|------|-------|
| 1 | Medical and other services (see instructions) | 5,138,520 | | | 1 |
| 2 | Medical and other services reimbursed under OPPTS (see instructions) | | | | 2 |
| 3 | OPPS payments | | | | 3 |
| 4 | Outlier payment (see instructions) | | | | 4 |
| 4.01 | Outlier reconciliation amount (see instructions) | | | | 4.01 |
| 5 | Enter the hospital specific payment to cost ratio (see instructions) | | | | 5 |
| 6 | Line 2 times line 5 | | | | 6 |
| 7 | Sum of lines 3, 4, and 4.01, divided by line 6 | | | | 7 |
| 8 | Transitional corridor payment (see instructions) | | | | 8 |
| 9 | Ancillary service other pass through costs from Wkst. D, Pt. IV, col. 13, line 200 | | | | 9 |
| 10 | Organ acquisition | | | | 10 |
| 11 | Total cost (sum of lines 1 and 10) (see instructions) | 5,138,520 | | | 11 |
| | COMPUTATION OF LESSER OF COST OR CHARGES | | | | |
| | REASONABLE CHARGES | | | | |
| 12 | Ancillary service charges | | | | 12 |
| 13 | Organ acquisition charges (from Wkst. D-4, Part III, col. 4, line 69) | | | | 13 |
| 14 | Total reasonable charges (sum of lines 12 and 13) | | | | 14 |
| | CUSTOMARY CHARGES | | | | |
| 15 | Aggregate amount actually collected from patients liable for payment for services on a charge basis | | | | 15 |
| 16 | Amounts that would have been realized from patients liable for payment for services on a charge basis had such payment been made in accordance with 42 CFR §413.13(e) | | | | 16 |
| 17 | Ratio of line 15 to line 16 (not to exceed 1.000000) | | | | 17 |
| 18 | Total customary charges (see instructions) | | | | 18 |
| 19 | Excess of customary charges over reasonable cost (complete only if line 18 exceeds line 11 (see instructions) | | | | 19 |
| 20 | Excess of reasonable cost over customary charges (complete only if line 11 exceeds line 18 (see instructions) | | | | 20 |
| 21 | Lesser of cost or charges (see instructions) | 5,189,905 | | | 21 |
| 22 | Interns and residents (see instructions) | | | | 22 |
| 23 | Cost of physicians' services in a teaching hospital (see instructions) | | | | 23 |
| 24 | Total prospective payment (sum of lines 3, 4, 4.01, 8 and 9) | | | | 24 |
| | COMPUTATION OF REIMBURSEMENT SETTLEMENT | | | | |
| 25 | Deductibles and coinsurance (see instructions) | 20,445 | | | 25 |
| 26 | Deductibles and coinsurance relating to amount on line 24 (see instructions) | 3,047,191 | | | 26 |
| 27 | Subtotal [(lines 21 and 24 minus the sum of lines 25 and 26) plus the sum of lines 22 and 23] (see instructions) | 2,122,269 | | | 27 |
| 28 | Direct graduate medical education payments (from Wkst. E-4, line 50) | | | | 28 |
| 29 | ESRD direct medical education costs (from Wkst. E-4, line 36) | | | | 29 |
| 30 | Subtotal (sum of lines 27 through 29) | 2,122,269 | | | 30 |
| 31 | Primary payer payments | 601 | | | 31 |
| 32 | Subtotal (line 30 minus line 31) | 2,121,668 | | | 32 |
| | ALLOWABLE BAD DEBTS (EXCLUDE BAD DEBTS FOR PROFESSIONAL SERVICES) | | | | |
| 33 | Composite rate ESRD (from Wkst. I-5, line 11) | | | | 33 |
| 34 | Allowable bad debts (see instructions) | 204,057 | | | 34 |
| 35 | Adjusted reimbursable bad debts (see instructions) | 132,637 | | | 35 |
| 36 | Allowable bad debts for dual eligible beneficiaries (see instructions) | 161,744 | | | 36 |
| 37 | Subtotal (see instructions) | 2,254,305 | | | 37 |
| 38 | MSP-LCC reconciliation amount from PS&R | | | | 38 |
| 39 | Other adjustments (specify) (see instructions) | | | | 39 |
| 39.50 | Pioneer ACO demonstration payment adjustment (see instructions) | | | | 39.50 |
| 40 | Subtotal (see instructions) | 2,254,305 | | | 40 |
| 40.01 | Sequestration adjustment (see instructions) | 45,086 | | | 40.01 |
| 40.02 | Demonstration payment adjustment amount after sequestration | | | | 40.02 |
| 41 | Interim payments | 2,416,978 | | | 41 |
| 42 | Tentative settlement (for contractors use only) | | | | 42 |
| 43 | Balance due provider/program (see instructions) | -207,759 | | | 43 |
| 44 | Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2 | | | | 44 |

TO BE COMPLETED BY CONTRACTOR

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

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

CALCULATION OF REIMBURSEMENT SETTLEMENT

COMPONENT CCN: 14-6014

**WORKSHEET E
PART B**

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

PART B - MEDICAL AND OTHER HEALTH SERVICES

| | | 1 | 1.01 | 1.02 | |
|-------|---|----------|------|------|-------|
| 1 | Medical and other services (see instructions) | 63 | | | 1 |
| 2 | Medical and other services reimbursed under OPPS (see instructions) | | | | 2 |
| 3 | OPPS payments | | | | 3 |
| 4 | Outlier payment (see instructions) | | | | 4 |
| 4.01 | Outlier reconciliation amount (see instructions) | | | | 4.01 |
| 5 | Enter the hospital specific payment to cost ratio (see instructions) | | | | 5 |
| 6 | Line 2 times line 5 | | | | 6 |
| 7 | Sum of lines 3, 4, and 4.01, divided by line 6 | | | | 7 |
| 8 | Transitional corridor payment (see instructions) | | | | 8 |
| 9 | Ancillary service other pass through costs from Wkst. D, Pt. IV, col. 13, line 200 | | | | 9 |
| 10 | Organ acquisition | | | | 10 |
| 11 | Total cost (sum of lines 1 and 10) (see instructions) | 63 | | | 11 |
| | COMPUTATION OF LESSER OF COST OR CHARGES | | | | |
| | REASONABLE CHARGES | | | | |
| 12 | Ancillary service charges | 325 | | | 12 |
| 13 | Organ acquisition charges (from Wkst. D-4, Part III, col. 4, line 69) | | | | 13 |
| 14 | Total reasonable charges (sum of lines 12 and 13) | 325 | | | 14 |
| | CUSTOMARY CHARGES | | | | |
| 15 | Aggregate amount actually collected from patients liable for payment for services on a charge basis | | | | 15 |
| 16 | Amounts that would have been realized from patients liable for payment for services on a charge basis had such payment been made in accordance with 42 CFR §413.13(e) | | | | 16 |
| 17 | Ratio of line 15 to line 16 (not to exceed 1.000000) | 1.000000 | | | 17 |
| 18 | Total customary charges (see instructions) | 325 | | | 18 |
| 19 | Excess of customary charges over reasonable cost (complete only if line 18 exceeds line 11 (see instructions)) | 262 | | | 19 |
| 20 | Excess of reasonable cost over customary charges (complete only if line 11 exceeds line 18 (see instructions)) | | | | 20 |
| 21 | Lesser of cost or charges (see instructions) | 63 | | | 21 |
| 22 | Interns and residents (see instructions) | | | | 22 |
| 23 | Cost of physicians' services in a teaching hospital (see instructions) | | | | 23 |
| 24 | Total prospective payment (sum of lines 3, 4, 4.01, 8 and 9) | | | | 24 |
| | COMPUTATION OF REIMBURSEMENT SETTLEMENT | | | | |
| 25 | Deductibles and coinsurance (see instructions) | | | | 25 |
| 26 | Deductibles and coinsurance relating to amount on line 24 (see instructions) | | | | 26 |
| 27 | Subtotal [(lines 21 and 24 minus the sum of lines 25 and 26) plus the sum of lines 22 and 23] (see instructions) | 63 | | | 27 |
| 28 | Direct graduate medical education payments (from Wkst. E-4, line 50) | | | | 28 |
| 29 | ESRD direct medical education costs (from Wkst. E-4, line 36) | | | | 29 |
| 30 | Subtotal (sum of lines 27 through 29) | 63 | | | 30 |
| 31 | Primary payer payments | | | | 31 |
| 32 | Subtotal (line 30 minus line 31) | 63 | | | 32 |
| | ALLOWABLE BAD DEBTS (EXCLUDE BAD DEBTS FOR PROFESSIONAL SERVICES) | | | | |
| 33 | Composite rate ESRD (from Wkst. I-5, line 11) | | | | 33 |
| 34 | Allowable bad debts (see instructions) | | | | 34 |
| 35 | Adjusted reimbursable bad debts (see instructions) | | | | 35 |
| 36 | Allowable bad debts for dual eligible beneficiaries (see instructions) | | | | 36 |
| 37 | Subtotal (see instructions) | 63 | | | 37 |
| 38 | MSP-LCC reconciliation amount from PS&R | | | | 38 |
| 39 | Other adjustments (specify) (see instructions) | | | | 39 |
| 39.50 | Pioneer ACO demonstration payment adjustment (see instructions) | | | | 39.50 |
| 40 | Subtotal (see instructions) | 63 | | | 40 |
| 40.01 | Sequestration adjustment (see instructions) | 1 | | | 40.01 |
| 40.02 | Demonstration payment adjustment amount after sequestration | | | | 40.02 |
| 41 | Interim payments | 318 | | | 41 |
| 42 | Tentative settlement (for contractors use only) | | | | 42 |
| 43 | Balance due provider/program (see instructions) | -256 | | | 43 |
| 44 | Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2 | | | | 44 |

TO BE COMPLETED BY CONTRACTOR

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

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

ANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED

COMPONENT CCN: 14-1335

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 | | 1,338,730 | | 2,165,445 | 1 |
| 2 | Interim payments payable on individual bills, either submitted or to be submitted to the intermediary for services rendered in the cost reporting period. If none, write 'NONE' or enter a zero | | | | | 2 |
| 3 | List separately each retroactive lump sum adjustment amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each payment. If none, write 'NONE' or enter a zero. (1) | | | | | |
| | | .01 | 01/11/2018 | 01/11/2018 | 165,304 | 3.01 |
| | | .02 | 06/13/2018 | 06/13/2018 | 86,229 | 3.02 |
| | Program | .03 | | | | 3.03 |
| | to | .04 | | | | 3.04 |
| | Provider | .05 | | | | 3.05 |
| | | .06 | | | | 3.06 |
| | | .07 | | | | 3.07 |
| | | .08 | | | | 3.08 |
| | | .09 | | | | 3.09 |
| | | .10 | | | | 3.10 |
| | | .50 | | | | 3.50 |
| | | .51 | | | | 3.51 |
| | Provider | .52 | | | | 3.52 |
| | to | .53 | | | | 3.53 |
| | Program | .54 | | | | 3.54 |
| | | .55 | | | | 3.55 |
| | | .56 | | | | 3.56 |
| | | .57 | | | | 3.57 |
| | | .58 | | | | 3.58 |
| | | .59 | | | | 3.59 |
| | Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98) | .99 | 33,913 | | 251,533 | 3.99 |
| 4 | Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Wkst. E or Wkst. E-3, line and column as appropriate) | | 1,372,643 | | 2,416,978 | 4 |
| TO BE COMPLETED BY CONTRACTOR | | | | | | |
| 5 | List separately each tentative settlement payment after desk review. Also show date of each payment. If none, write 'NONE' or enter a zero. (1) | | | | | |
| | | .01 | | | | 5.01 |
| | | .02 | | | | 5.02 |
| | Program | .03 | | | | 5.03 |
| | to | .04 | | | | 5.04 |
| | Provider | .05 | | | | 5.05 |
| | | .06 | | | | 5.06 |
| | | .07 | | | | 5.07 |
| | | .08 | | | | 5.08 |
| | | .09 | | | | 5.09 |
| | | .10 | | | | 5.10 |
| | | .50 | | | | 5.50 |
| | | .51 | | | | 5.51 |
| | Provider | .52 | | | | 5.52 |
| | to | .53 | | | | 5.53 |
| | Program | .54 | | | | 5.54 |
| | | .55 | | | | 5.55 |
| | | .56 | | | | 5.56 |
| | | .57 | | | | 5.57 |
| | | .58 | | | | 5.58 |
| | | .59 | | | | 5.59 |
| | Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98) | .99 | | | | 5.99 |
| 6 | Determined net settlement amount (balance due) based on the cost report (1) | .01 | 4,323 | | | 6.01 |
| | | .02 | | | -207,759 | 6.02 |
| 7 | Total Medicare program liability (see instructions) | | 1,376,966 | | 2,209,219 | 7 |
| 8 | Name of Contractor | | Contractor Number | | NPR Date (Month/Day/Year) | 8 |

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

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

ANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED

COMPONENT CCN: 14-6014

WORKSHEET E-1
PART I

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

| | 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 | | 665,989 | | 318 |
| 2 | Interim payments payable on individual bills, either submitted or to be submitted to the intermediary for services rendered in the cost reporting period. If none, write 'NONE' or enter a zero | | | | |
| 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 to | .03 | | | 3.03 |
| | Provider | .04 | | | 3.04 |
| | | .05 | | | 3.05 |
| | | .06 | | | 3.06 |
| | | .07 | | | 3.07 |
| | | .08 | | | 3.08 |
| | | .09 | | | 3.09 |
| | | .10 | | | 3.10 |
| | | .50 | | | 3.50 |
| | | .51 | | | 3.51 |
| | Provider to | .52 | | | 3.52 |
| | Program | .53 | | | 3.53 |
| | | .54 | | | 3.54 |
| | | .55 | | | 3.55 |
| | | .56 | | | 3.56 |
| | | .57 | | | 3.57 |
| | | .58 | | | 3.58 |
| | | .59 | | | 3.59 |
| | Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98) | .99 | | | 3.99 |
| 4 | Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Wkst. E or Wkst. E-3, line and column as appropriate) | | 665,989 | | 318 |
| TO BE COMPLETED BY CONTRACTOR | | | | | |
| 5 | List separately each tentative settlement payment 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 to | .03 | | | 5.03 |
| | Provider | .04 | | | 5.04 |
| | | .05 | | | 5.05 |
| | | .06 | | | 5.06 |
| | | .07 | | | 5.07 |
| | | .08 | | | 5.08 |
| | | .09 | | | 5.09 |
| | | .10 | | | 5.10 |
| | | .50 | | | 5.50 |
| | | .51 | | | 5.51 |
| | Provider to | .52 | | | 5.52 |
| | Program | .53 | | | 5.53 |
| | | .54 | | | 5.54 |
| | | .55 | | | 5.55 |
| | | .56 | | | 5.56 |
| | | .57 | | | 5.57 |
| | | .58 | | | 5.58 |
| | | .59 | | | 5.59 |
| | Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98) | .99 | | | 5.99 |
| 6 | Determined net settlement amount (balance due) based on the cost report (1) | .01 | | | 6.01 |
| | | .02 | | | 6.02 |
| 7 | Total Medicare program liability (see instructions) | | 665,988 | | 62 |
| 8 | Name of Contractor | Contractor Number | | NPR Date (Month/Day/Year) | |

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

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

**WORKSHEET E-3
PART V**

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

| | | | |
|-------|---|-----------|-------|
| 1 | Inpatient services | 1,553,270 | 1 |
| 2 | Nursing an dallied health managed care payment (see instructions) | | 2 |
| 3 | Organ acquisition | | 3 |
| 4 | Subtotal (sum of lines 1-3) | 1,553,270 | 4 |
| 5 | Primary payer payments | | 5 |
| 6 | Total cost (see instructions) | 1,568,803 | 6 |
| | COMPUTATION OF LESSER OF COST OR CHARGES | | |
| | REASONABLE CHARGES | | |
| 7 | Routine service charges | | 7 |
| 8 | Ancillary service charges | | 8 |
| 9 | Organ acquisition charges, net of revenue | | 9 |
| 10 | Total reasonable charges | | 10 |
| | CUSTOMARY CHARGES | | |
| 11 | Aggregate amount actually collected from patients liable for payment for services on a charge basis | | 11 |
| 12 | Amounts that would have been realized from patients liable for payment for services on a charge basis had such payment been made in accordance with 42 CFR §413.13(e) | | 12 |
| 13 | Ratio of line 11 to line 12 (not to exceed 1.000000) | 0.000000 | 13 |
| 14 | Total customary charges (see instructions) | | 14 |
| 15 | Excess of customary charges over reasonable cost (complete only if line 14 exceeds line 6) (see instructions) | | 15 |
| 16 | Excess of reasonable cost over customary charges (complete only if line 6 exceeds line 14) (see instructions) | | 16 |
| 17 | Cost of physicians' services in a teaching hospital (see instructions) | | 17 |
| | COMPUTATION OF REIMBURSEMENT SETTLEMENT | | |
| 18 | Direct graduate medical education payments | | 18 |
| 19 | Cost of covered services (sum of lines 6 and 17) | 1,568,803 | 19 |
| 20 | Deductibles (exclude professional component) | 170,224 | 20 |
| 21 | Excess reasonable cost (from line 16) | | 21 |
| 22 | Subtotal (line 19 minus the sum of lines 20 and 21) | 1,398,579 | 22 |
| 23 | Coinsurance | | 23 |
| 24 | Subtotal (line 22 minus line 23) | 1,398,579 | 24 |
| 25 | Allowable bad debts (exclude bad debts for professional services) (see instructions) | 9,981 | 25 |
| 26 | Adjusted reimbursable bad debts (see instructions) | 6,488 | 26 |
| 27 | Allowable bad debts for dual eligible beneficiaries (see instructions) | | 27 |
| 28 | Subtotal (sum of lines 24 and 26) | 1,405,067 | 28 |
| 29 | Other adjustments (specify) (see instructions) | | 29 |
| 29.50 | Pioneer ACO demonstration payment adjustment (see instructions) | | 29.50 |
| 30 | Subtotal (see instructions) | 1,405,067 | 30 |
| 30.01 | Sequestration adjustment (see instructions) | 28,101 | 30.01 |
| 30.02 | Demonstration payment adjustment amount after sequestration | | 30.02 |
| 31 | Interim payments | 1,372,643 | 31 |
| 32 | Tentative settlement (for contractor use only) | | 32 |
| 33 | Balance due provider/program (line 30 minus lines 30.01, 30.02, 31 and 32) | 4,323 | 33 |
| 34 | Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2 | | 34 |

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

CALCULATION OF REIMBURSEMENT SETTLEMENT

**WORKSHEET E-3
PART VI**

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

| PROSPECTIVE PAYMENT AMOUNT (see instructions) | | | |
|--|--|---------|-------|
| 1 | Resource Utilization Group (RUGS) payment | 803,901 | 1 |
| 2 | Routine service other pass through costs | | 2 |
| 3 | Ancillary service other pass through costs | | 3 |
| 4 | Subtotal (sum of lines 1-3) | 803,901 | 4 |
| COMPUTATION OF NET COST OF COVERED SERVICES | | | |
| 5 | Medical and other services. Do not use this line. (see instructions) | | 5 |
| 6 | Deductibles | | 6 |
| 7 | Coinsurance | 124,321 | 7 |
| 8 | Allowable bad debts (see instructions) | | 8 |
| 9 | Reimbursable bad debts for dual eligible beneficiaries (see instructions) | | 9 |
| 10 | Adjusted reimbursable bad debts (see instructions) | | 10 |
| 11 | Utilization review | | 11 |
| 12 | Subtotal (sum of lines 4 and 5, minus lines 6 and 7, plus lines 10 and 11) (see instructions) | 679,580 | 12 |
| 13 | Inpatient primary payer payments | | 13 |
| 14 | Other adjustments (specify) (see instructions) | | 14 |
| 14.50 | Pioneer ACO demonstration payment adjustment (see instructions) | | 14.50 |
| 15 | Subtotal (see instructions) | 679,580 | 15 |
| 15.01 | Sequestration adjustment (see instructions) | 13,592 | 15.01 |
| 15.02 | Demonstration payment adjustment amount after sequestration | | 15.02 |
| 16 | Interim payments | 665,989 | 16 |
| 17 | Tentative settlement (for contractor use only) | | 17 |
| 18 | Balance due provider/program (line 15 minus lines 15.01, 15.02, 16 and 17) | -1 | 18 |
| 19 | Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2 | | 19 |

KPMG LLP Compu-Max 2552-10

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

CALCULATION OF REIMBURSEMENT SETTLEMENT

COMPONENT CCN: 14-1335

WORKSHEET E-3
PART VII

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

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

| | INPATIENT TITLE V OR TITLE XIX | OUTPAT- IENT TITLE V OR TITLE XIX | |
|--|---|---|----|
| COMPUTATION OF NET COST OF COVERED SERVICES | | | |
| 1 | Inpatient hospital/SNF/NF services | 40,087 | 1 |
| 2 | Medical and other services | | 2 |
| 3 | Organ acquisition (certified transplant centers only) | | 3 |
| 4 | Subtotal (sum of lines 1, 2 and 3) | 40,087 | 4 |
| 5 | Inpatient primary payer payments | | 5 |
| 6 | Outpatient primary payer payments | | 6 |
| 7 | Subtotal (line 4 less sum of lines 5 and 6) | 40,087 | 7 |
| COMPUTATION OF LESSER OF COST OR CHARGES | | | |
| REASONABLE CHARGES | | | |
| 8 | Routine service charges | | 8 |
| 9 | Ancillary service charges | | 9 |
| 10 | Organ acquisition charges, net of revenue | | 10 |
| 11 | Incentive from target amount computation | | 11 |
| 12 | Total reasonable charges (sum of lines 8-11) | | 12 |
| CUSTOMARY CHARGES | | | |
| 13 | Amount actually collected from patients liable for payment for services on a cahрге basis | | 13 |
| 14 | Amounts that would have been realized from patients liable for payment for services on a charge basis had such payment been made in accordance with 42 CFR §413.13(c) | | 14 |
| 15 | Ratio of line 13 to line 14 (not to exceed 1.000000) | 1.000000 | 15 |
| 16 | Total customary charges (see instructions) | | 16 |
| 17 | Excess of customary charges over reasonable cost (complete only if line 16 exceeds line 4) (see instructions) | | 17 |
| 18 | Excess of reasonable cost over customary charges (complete only if line 4 exceeds line 16) (see instructions) | | 18 |
| 19 | Interns and residents (see instructions) | | 19 |
| 20 | Cost of physicians' services in a teaching hospital (see instructions) | | 20 |
| 21 | Cost of covered services (lesser of line 4 or line 16) | 40,087 | 21 |
| PROSPECTIVE PAYMENT AMOUNT | | | |
| 22 | Other than outlier payments | | 22 |
| 23 | Outlier payments | | 23 |
| 24 | Program capital payments | | 24 |
| 25 | Capital exception payments (see instructions) | | 25 |
| 26 | Routine and ancillary service other pass through costs | | 26 |
| 27 | Subtotal (sum of lines 22 through 26) | | 27 |
| 28 | Customary charges (Titles V or XIX PPS covered services only) | | 28 |
| 29 | Titles V or XIX (sum of lines 21 and 27) | 40,087 | 29 |
| COMPUTATION OF REIMBURSEMENT SETTLEMENT | | | |
| 30 | Excess of reasonable cost (from line 18) | | 30 |
| 31 | Subtotal (sum of lines 19 and 20, plus 29 minus lines 5 and 6) | 40,087 | 31 |
| 32 | Deductibles | | 32 |
| 33 | Coinsurance | | 33 |
| 34 | Allowable bad debts (see instructions) | | 34 |
| 35 | Utilization review | | 35 |
| 36 | Subtotal (sum of lines 31, 34 and 35 minus the sum of lines 32 and 33) | 40,087 | 36 |
| 37 | OTHER ADJUSTMENTS (SPECIFY) (see instructions) | -40,087 | 37 |
| 38 | Subtotal (line 36 ± line 37) | | 38 |
| 39 | Direct graduate medical education payments (from Wkst. E-4) | | 39 |
| 40 | Total amount payable to the provider (sum of lines 38 and 39) | | 40 |
| 41 | Interim payments | | 41 |
| 42 | Balance due provider/program (line 40 minus line 41) | | 42 |
| 43 | Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2 | | 43 |

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BALANCE SHEET

WORKSHEET G

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

| | | General Fund | Specific Purpose Fund | Endowment Fund | Plant Fund | |
|--|--|--------------|-----------------------|----------------|------------|----|
| Assets (Omit Cents) | | 1 | 2 | 3 | 4 | |
| CURRENT ASSETS | | | | | | |
| 1 | Cash on hand and in banks | 1,553,272 | | | | 1 |
| 2 | Temporary investments | | | | | 2 |
| 3 | Notes receivable | | | | | 3 |
| 4 | Accounts receivable | 18,918,497 | | | | 4 |
| 5 | Other receivables | 353,884 | | | | 5 |
| 6 | Allowances for uncollectible notes and accounts receivable | -13,241,616 | | | | 6 |
| 7 | Inventory | 993,227 | | | | 7 |
| 8 | Prepaid expenses | 48,817 | | | | 8 |
| 9 | Other current assets | | | | | 9 |
| 10 | Due from other funds | | | | | 10 |
| 11 | Total current assets (sum of lines 1-10) | 8,626,081 | | | | 11 |
| FIXED ASSETS | | | | | | |
| 12 | Land | 222,604 | | | | 12 |
| 13 | Land improvements | 835,359 | | | | 13 |
| 14 | Accumulated depreciation | -635,074 | | | | 14 |
| 15 | Buildings | 20,974,244 | | | | 15 |
| 16 | Accumulated depreciation | -14,918,944 | | | | 16 |
| 17 | Leasehold improvements | | | | | 17 |
| 18 | Accumulated depreciation | | | | | 18 |
| 19 | Fixed equipment | | | | | 19 |
| 20 | Accumulated depreciation | | | | | 20 |
| 21 | Automobiles and trucks | | | | | 21 |
| 22 | Accumulated depreciation | | | | | 22 |
| 23 | Major movable equipment | 15,633,979 | | | | 23 |
| 24 | Accumulated depreciation | -13,016,581 | | | | 24 |
| 25 | Minor equipment depreciable | | | | | 25 |
| 26 | Accumulated depreciation | | | | | 26 |
| 27 | HIT designated assets | | | | | 27 |
| 28 | Accumulated depreciation | | | | | 28 |
| 29 | Minor equipment-nondepreciable | | | | | 29 |
| 30 | Total fixed assets (sum of lines 12-29) | 9,095,587 | | | | 30 |
| OTHER ASSETS | | | | | | |
| 31 | Investments | | | | | 31 |
| 32 | Deposits on leases | | | | | 32 |
| 33 | Due from owners/officers | | | | | 33 |
| 34 | Other assets | 423 | | | | 34 |
| 35 | Total other assets (sum of lines 31-34) | 423 | | | | 35 |
| 36 | Total assets (sum of lines 11, 30 and 35) | 17,722,091 | | | | 36 |
| Liabilities and Fund Balances (Omit Cents) | | | | | | |
| | | 1 | 2 | 3 | 4 | |
| CURRENT LIABILITIES | | | | | | |
| 37 | Accounts payable | 271,450 | | | | 37 |
| 38 | Salaries, wages and fees payable | 888,377 | | | | 38 |
| 39 | Payroll taxes payable | | | | | 39 |
| 40 | Notes and loans payable (short term) | -51,900 | | | | 40 |
| 41 | Deferred income | | | | | 41 |
| 42 | Accelerated payments | | | | | 42 |
| 43 | Due to other funds | 1,367,239 | | | | 43 |
| 44 | Other current liabilities | 212,318 | | | | 44 |
| 45 | Total current liabilities (sum of lines 37 thru 44) | 2,687,484 | | | | 45 |
| LONG TERM LIABILITIES | | | | | | |
| 46 | Mortgage payable | | | | | 46 |
| 47 | Notes payable | | | | | 47 |
| 48 | Unsecured loans | | | | | 48 |
| 49 | Other long term liabilities | 7,241,524 | | | | 49 |
| 50 | Total long term liabilities (sum of lines 46 thru 49) | 7,241,524 | | | | 50 |
| 51 | Total liabilities (sum of lines 45 and 50) | 9,929,008 | | | | 51 |
| CAPITAL ACCOUNTS | | | | | | |
| 52 | General fund balance | 7,793,083 | | | | 52 |
| 53 | Specific purpose fund | | | | | 53 |
| 54 | Donor created - endowment fund balance - restricted | | | | | 54 |
| 55 | Donor created - endowment fund balance - unrestricted | | | | | 55 |
| 56 | Governing body created - endowment fund balance | | | | | 56 |
| 57 | Plant fund balance - invested in plant | | | | | 57 |
| 58 | Plant fund balance - reserve for plant improvement, replacement, and expansion | | | | | 58 |
| 59 | Total fund balances (sum of lines 52 thru 58) | 7,793,083 | | | | 59 |
| 60 | Total liabilities and fund balances (sum of lines 51 and 59) | 17,722,091 | | | | 60 |

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STATEMENT OF CHANGES IN FUND BALANCES

WORKSHEET G-1

| | | GENERAL FUND | | SPECIFIC PURPOSE FUND | |
|----|---|--------------|-----------|-----------------------|----|
| | | 1 | 2 | 3 | 4 |
| 1 | Fund balances at beginning of period | | 4,046,219 | | 1 |
| 2 | Net income (loss) (from Worksheet G-3, line 29) | | 3,746,863 | | 2 |
| 3 | Total (sum of line 1 and line 2) | | 7,793,082 | | 3 |
| 4 | Additions (credit adjustments) (specify) | 1 | | | 4 |
| 5 | | | | | 5 |
| 6 | | | | | 6 |
| 7 | | | | | 7 |
| 8 | | | | | 8 |
| 9 | | | | | 9 |
| 10 | Total additions (sum of lines 4-9) | | 1 | | 10 |
| 11 | Subtotal (line 3 plus line 10) | | 7,793,083 | | 11 |
| 12 | Deductions (debit adjustments) (specify) | | | | 12 |
| 13 | | | | | 13 |
| 14 | | | | | 14 |
| 15 | | | | | 15 |
| 16 | | | | | 16 |
| 17 | | | | | 17 |
| 18 | Total deductions (sum of lines 12-17) | | | | 18 |
| 19 | Fund balance at end of period per balance sheet (line 11 minus line 18) | | 7,793,083 | | 19 |

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

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

**WORKSHEET G-2
PARTS I & II**

PART I - PATIENT REVENUES

| | REVENUE CENTER | INPATIENT | OUTPATIENT | TOTAL | |
|-------|--|------------|------------|------------|-------|
| | | 1 | 2 | 3 | |
| | GENERAL INPATIENT ROUTINE CARE SERVICES | | | | |
| 1 | Hospital | 3,194,723 | | 3,194,723 | 1 |
| 2 | Subprovider IPF | | | | 2 |
| 3 | Subprovider IRF | | | | 3 |
| 5 | Swing Bed - SNF | | | | 5 |
| 6 | Swing Bed - NF | | | | 6 |
| 7 | Skilled nursing facility | 806,669 | | 806,669 | 7 |
| 8 | Nursing facility | | | | 8 |
| 9 | Other long term care | 932,163 | | 932,163 | 9 |
| 10 | Total general inpatient care services (sum of lines 1-9) | 4,933,555 | | 4,933,555 | 10 |
| | INTENSIVE CARE TYPE INPATIENT HOSPITAL SERVICES | | | | |
| 11 | Intensive Care Unit | 234,158 | | 234,158 | 11 |
| 12 | Coronary Care Unit | | | | 12 |
| 13 | Burn Intensive Care Unit | | | | 13 |
| 14 | Surgical Intensive Care Unit | | | | 14 |
| 15 | Other Special Care (specify) | | | | 15 |
| 16 | Total intensive care type inpatient hospital services (sum of lines 11-15) | 234,158 | | 234,158 | 16 |
| 17 | Total inpatient routine care services (sum of lines 10 and 16) | 5,167,713 | | 5,167,713 | 17 |
| 18 | Ancillary services | 7,730,283 | 48,328,712 | 56,058,995 | 18 |
| 19 | Outpatient services | | 5,051,181 | 5,051,181 | 19 |
| 20 | Rural Health Clinic (RHC) | | | | 20 |
| 21 | Federally Qualified Health Center (FQHC) | | | | 21 |
| 22 | Home health agency | | | | 22 |
| 23 | Ambulance | | | | 23 |
| 25 | ASC | | | | 25 |
| 26 | Hospice | | | | 26 |
| 27 | Other (specify) | | | | 27 |
| 27.01 | PROFESSIONAL FEES | | 3,552,942 | 3,552,942 | 27.01 |
| 28 | Total patient revenues (sum of lines 17-27) (transfer column 3 to Worksheet G-3, line 1) | 12,897,996 | 56,932,835 | 69,830,831 | 28 |

PART II - OPERATING EXPENSES

| | | 1 | 2 | |
|----|---|-----------|------------|----|
| 29 | Operating expenses (per Worksheet A, column 3, line 200) | | 23,623,705 | 29 |
| 30 | Add (specify) | | | 30 |
| 31 | | 2,106,286 | | 31 |
| 32 | | | | 32 |
| 33 | | | | 33 |
| 34 | | | | 34 |
| 35 | | | | 35 |
| 36 | Total additions (sum of lines 30-35) | | 2,106,286 | 36 |
| 37 | Deduct (specify) | | | 37 |
| 38 | | | | 38 |
| 39 | | | | 39 |
| 40 | | | | 40 |
| 41 | | | | 41 |
| 42 | Total deductions (sum of lines 37-41) | | | 42 |
| 43 | Total operating expenses (sum of lines 29 and 36 minus line 42) (transfer to Worksheet G-3, line 4) | | 25,729,991 | 43 |

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STATEMENT OF REVENUES AND EXPENSES

WORKSHEET G-3

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

OTHER INCOME

| | | | |
|----|---|-----------|----|
| 6 | Contributions, donations, bequests, etc. | | 6 |
| 7 | Income from investments | 21,313 | 7 |
| 8 | Revenues from telephone and other miscellaneous communication services | | 8 |
| 9 | Revenue from television and radio service | | 9 |
| 10 | Purchase discounts | | 10 |
| 11 | Rebates and refunds of expenses | | 11 |
| 12 | Parking lot receipts | | 12 |
| 13 | Revenue from laundry and linen service | | 13 |
| 14 | Revenue from meals sold to employees and guests | 93,953 | 14 |
| 15 | Revenue from rental of living quarters | | 15 |
| 16 | Revenue from sale of medical and surgical supplies to other than patients | | 16 |
| 17 | Revenue from sale of drugs to other than patients | | 17 |
| 18 | Revenue from sale of medical records and abstracts | | 18 |
| 19 | Tuition (fees, sale of textbooks, uniforms, etc.) | | 19 |
| 20 | Revenue from gifts, flowers, coffee shops and canteen | | 20 |
| 21 | Rental of vending machines | | 21 |
| 22 | Rental of hospital space | | 22 |
| 23 | Governmental appropriations | | 23 |
| 24 | Other (OTHER OPERATING REVENUE) | 1,793 | 24 |
| 25 | Total other income (sum of lines 6-24) | 117,059 | 25 |
| 26 | Total (line 5 plus line 25) | 3,760,113 | 26 |
| 27 | Other expenses (GRANT) | 13,250 | 27 |
| 28 | Total other expenses (sum of line 27 and subscripts) | 13,250 | 28 |
| 29 | Net income (or loss) for the period (line 26 minus line 28) | 3,746,863 | 29 |

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ALLOCATION OF ALLOWABLE COSTS FOR EXTRAORDINARY CIRCUMSTANCES

**WORKSHEET L-1
PART I**

| | COST CENTER DESCRIPTIONS | EXTRAORDI- NARY CAP- REL COSTS | SUBTOTAL (cols.0-4) | SUBTOTAL | I&R COST & POST STEP- DOWN ADJS | TOTAL | |
|-------|---|--------------------------------------|------------------------|----------|---------------------------------------|-------|-------|
| | | 0 | 2A | 24 | 25 | 26 | |
| | GENERAL SERVICE COST CENTERS | | | | | | |
| 1 | Cap Rel Costs-Bldg & Fixt | | | | | | 1 |
| 2 | Cap Rel Costs-Mvble Equip | | | | | | 2 |
| 4 | Employee Benefits Department | | | | | | 4 |
| 5 | Administrative & General | | | | | | 5 |
| 6 | Maintenance & Repairs | | | | | | 6 |
| 7 | Operation of Plant | | | | | | 7 |
| 8 | Laundry & Linen Service | | | | | | 8 |
| 9 | Housekeeping | | | | | | 9 |
| 10 | Dietary | | | | | | 10 |
| 11 | Cafeteria | | | | | | 11 |
| 12 | Maintenance of Personnel | | | | | | 12 |
| 13 | Nursing Administration | | | | | | 13 |
| 14 | Central Services & Supply | | | | | | 14 |
| 15 | Pharmacy | | | | | | 15 |
| 16 | Medical Records & Library | | | | | | 16 |
| 17 | Social Service | | | | | | 17 |
| 19 | Nonphysician Anesthetists | | | | | | 19 |
| 20 | Nursing School | | | | | | 20 |
| 21 | I&R Services-Salary & Fringes Apprvd | | | | | | 21 |
| 22 | I&R Services-Other Prgm Costs Apprvd | | | | | | 22 |
| 23 | Paramed Ed Prgm-(specify) | | | | | | 23 |
| | INPATIENT ROUTINE SERVICE COST CENTERS | | | | | | |
| 30 | Adults & Pediatrics | | | | | | 30 |
| 31 | Intensive Care Unit | | | | | | 31 |
| 44 | Skilled Nursing Facility | | | | | | 44 |
| 46 | Other Long Term Care | | | | | | 46 |
| | ANCILLARY SERVICE COST CENTERS | | | | | | |
| 50 | Operating Room | | | | | | 50 |
| 51 | Recovery Room | | | | | | 51 |
| 53 | Anesthesiology | | | | | | 53 |
| 54 | Radiology-Diagnostic | | | | | | 54 |
| 60 | Laboratory | | | | | | 60 |
| 60.01 | BLOOD LABORATORY | | | | | | 60.01 |
| 62.30 | BLOOD CLOTTING FOR HEMOPHILIACS | | | | | | 62.30 |
| 65 | Respiratory Therapy | | | | | | 65 |
| 66 | Physical Therapy | | | | | | 66 |
| 67 | Occupational Therapy | | | | | | 67 |
| 68 | Speech Pathology | | | | | | 68 |
| 71 | Medical Supplies Charged to Patients | | | | | | 71 |
| 72 | Impl. Dev. Charged to Patients | | | | | | 72 |
| 73 | Drugs Charged to Patients | | | | | | 73 |
| 76.97 | CARDIAC REHABILITATION | | | | | | 76.97 |
| 76.98 | HYPERBARIC OXYGEN THERAPY | | | | | | 76.98 |
| 76.99 | LITHOTRIPSY | | | | | | 76.99 |
| | OUTPATIENT SERVICE COST CENTERS | | | | | | |
| 91 | Emergency | | | | | | 91 |
| 92 | Observation Beds (Non-Distinct Part) | | | | | | 92 |
| | OTHER REIMBURSABLE COST CENTERS | | | | | | |
| 99.10 | CORF | | | | | | 99.10 |
| | SPECIAL PURPOSE COST CENTERS | | | | | | |
| 118 | SUBTOTALS (sum of lines 1-117) | | | | | | 118 |
| | NONREIMBURSABLE COST CENTERS | | | | | | |
| 192 | Physicians' Private Offices | | | | | | 192 |
| 200 | Cross Foot Adjustments | | | | | | 200 |
| 201 | Negative Cost Centers | | | | | | 201 |
| 202 | TOTAL (sum of lines 118-201) | | | | | | 202 |