This report is required by law (42 USC 1395g; 42 CFR 413.20(b)). Failure to report can result in all interim FORM APPROVED payments made since the beginning of the cost reporting period being deemed overpayments (42 USC 1395g). OMB NO. 0938-0050 EXPI RES 09-30-2025 HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX COST REPORT CERTIFICATION | Provider CCN: 14-1335 Period: Worksheet S From 07/01/2022 Parts I-III AND SETTLEMENT SUMMARY 06/30/2023 Date/Time Prepared: 11/28/2023 5:06 pm PART I - COST REPORT STATUS Provi der 1. [X] Electronically prepared cost report Date: 11/28/2023 Time: 5:06 pm] Manually prepared cost report use only] If this is an amended report enter the number of times the provider resubmitted this cost report] Medicare Utilization. Enter "F" for full, "L" for low, or "N" for no. 6. Date Received: 7. Contractor No. 10. NPR Date: Contractor]Cost Report Status 11. Contractor's Vendor Code: (1) As Submitted use only (2) Settled without Audit 8. [N] Initial Report for this Provider CCN 12. [0] If line 5, column 1 is 4: Enter (3) Settled with Audit 9. [N] Final Report for this Provider CCN | number of times reopened = 0-9.

number of times reopened = 0-9.

PART II - CERTIFICATION BY A CHIEF FINANCIAL OFFICER OR ADMINISTRATOR OR PROVIDER(S)

(3) Settled with Audit

(4) Reopened (5) Amended

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 submitted cost report and the Balance Sheet and Statement of Revenue and Expenses prepared by HARVARD MEMORIAL HOSPITAL (14-1335) for the cost reporting period beginning 07/01/2022 and ending 06/30/2023 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.

	SIGNATURE OF CHIEF FINA	NCIAL OFFICER OR ADMINISTRATOR	CHECKBOX		
		1	2	SI GNATURE STATEMENT	
1	Todo	d Anderson	Y	I have read and agree with the above certification statement. I certify that I intend my electronic signature on this certification be the legally binding equivalent of my original signature.	1
2	Signatory Printed Name	Todd Anderson			2
3	Signatory Title	CF0			3
4	Date	(Dated when report is electronica			4

			Title	XVIII			
		Title V	Part A	Part B	HI T	Title XIX	
		1. 00	2.00	3. 00	4. 00	5. 00	
	PART III - SETTLEMENT SUMMARY						
1.00	HOSPI TAL	0	307, 612	633, 227	0	0	1.00
2.00	SUBPROVI DER - I PF	0	0	0		0	2.00
3.00	SUBPROVI DER - I RF	0	0	0		0	3.00
5.00	SWING BED - SNF	0	0	0		0	5.00
6.00	SWING BED - NF	0				0	6.00
7.00	SKILLED NURSING FACILITY	0	0	0		0	7. 00
200.00	TOTAL	0	307, 612	633, 227	0	0	200.00

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 number for this information collection is OMB 0938-0050 and the number for the Supplement to Form CMS 2552-10, Worksheet N95, is OMB 0938-1425. The time required to complete and review the information collection is estimated 675 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 the 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.

In Lieu of Form CMS-2552-10 HARVARD MEMORIAL HOSPITAL Health Financial Systems HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA Provider CCN: 14-1335 Peri od: Worksheet S-2 From 07/01/2022 Part I Date/Time Prepared: 06/30/2023 11/28/2023 5:06 pm 3.00 4.00 Hospital and Hospital Health Care Complex Address: Street: 901 GRANT STREET 1.00 PO Box: 1.00 County: MC HENRY 2.00 City: HARVARD State: IL Zi p Code: 60033-2.00 Component Name CCN CBSA Provi der Date Payment System (P, T, O, or N)
V XVIII XIX Certi fi ed Number Number Type 1.00 2.00 3.00 4.00 5.00 6.00 | 7.00 | 8.00 Hospital and Hospital-Based Component Identification: 3.00 Hospi tal HARVARD MEMORIAL 141335 16984 01/01/2004 N 0 3.00 HOSPI TAL Subprovi der - IPF 4.00 4.00 5.00 Subprovi der - IRF 5.00 6.00 Subprovider - (Other) 6.00 Swing Beds - SNF 7 00 7 00 Swing Beds - NF 8.00 8.00 9.00 Hospi tal -Based SNF CARE CENTER 146014 99914 01/01/2002 Ρ Ν 9.00 Hospi tal -Based NF 10.00 10.00 11.00 Hospi tal -Based OLTC 11.00 12.00 Hospi tal -Based HHA 12.00 Separately Certified ASC 13.00 13.00 Hospi tal -Based Hospi ce 14.00 14.00 Hospital -Based Health Clinic - RHC 15.00 15 00 16.00 Hospital -Based Health Clinic - FQHC 16.00 Hospital -Based (CMHC) I 17.00 17.00 17. 10 Hospi tal -Based (CORF) I 17.10 18.00 Renal Dialysis 18.00 19.00 Other 19.00 From: To: 1.00 2.00 20.00 Cost Reporting Period (mm/dd/yyyy) 07/01/2022 06/30/2023 20.00 21.00 Type of Control (see instructions) 21.00 2 1. 00 3. 00 2.00 Inpatient PPS Information Does this facility qualify and is it currently receiving payments for 22.00 Ν N 22.00 disproportionate share hospital adjustment, 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 Section §412.106(c)(2)(Pickle amendment hospital?) In column 2, enter "Y" for yes or "N" for no. Did this hospital receive interim UCPs, including supplemental UCPs, for this cost reporting period? Enter in column 1, "Y" for yes or "N" for no N Ν 22 01 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) 22.02 Is this a newly merged hospital that requires a final UCP to be N Ν 22.02 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. 22.03 Did this hospital receive a geographic reclassification from urban to N 22 03 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

22.04

23.00

3

Ν

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

rural as a result of the revised OMB delineations for statistical areas adopted by CMS in FY 2021? 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

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.

22.04 Did this hospital receive a geographic reclassification from urban to

yes or "N" for no.

yes or "N" for no.

In Lieu of Form CMS-2552-10 HARVARD MEMORIAL HOSPITAL Health Financial Systems HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA Provider CCN: 14-1335 Worksheet S-2 Peri od: From 07/01/2022 Part I Date/Time Prepared: 06/30/2023 11/28/2023 5:06 pm In-State In-State Out-of Out-of Medi cai d 0ther Medi cai d Medi cai d State State HMO days Medi cai d el i gi bl e Medi cai d paid days Medi cai d days pai d days el i gi bl e unpai d days unpai d 1.00 2. 00 3. 00 4. 00 5. 00 6. 00 24.00 If this provider is an IPPS hospital, enter the 0 24.00 \cap 0 n 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. 25.00 If this provider is an IRF, enter the in-state 0 0 0 0 0 25.00 Medicaid paid days in column 1, the 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. Urban/Rural S Date of Geogr 1.00 2.00 26.00 Enter your standard geographic classification (not wage) status at the beginning of the 26 00 cost reporting period. Enter "1" for urban or "2" for rural 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, 27.00 27.00 enter the effective date of the geographic reclassification in column 2 35.00 If this is a sole community hospital (SCH), enter the number of periods SCH status in 0 35.00 effect in the cost reporting period. Begi nni ng: Endi ng: 1.00 2.00 36.00 Enter applicable beginning and ending dates of SCH status. Subscript line 36 for number 36.00 of periods in excess of one and enter subsequent dates. If this is a Medicare dependent hospital (MDH), enter the number of periods MDH status 0 37.00 is in effect in the cost reporting period. Is this hospital a former MDH that is eligible for the MDH transitional payment in 37.01 accordance with FY 2016 OPPS final rule? Enter "Y" for yes or "N" for no. (see instructions) 38.00 38.00 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 Y/N Y/N 2.00 1.00 39.00 Does this facility qualify for the inpatient hospital payment adjustment for low volume Ν 39.00 N hospitals in accordance with 42 CFR §412.101(b)(2)(i), (ii), or (iii)? 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), (ii), or (iii)? Enter in column 2 "Y" for yes or "N" for no. (see instructions) 40.00 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 40.00 Ν N no in column 2, for discharges on or after October 1. (see instructions) XVIII XIX 1.00 2.00 3.00 Prospective Payment System (PPS)-Capital Does this facility qualify and receive Capital payment for disproportionate share in accordance Ν Ν Ν 45.00 with 42 CFR Section §412.320? (see instructions) 46.00 Is this facility eligible for additional payment exception for extraordinary circumstances Ν Ν Ν 46.00 pursuant to 42 CFR §412.348(f)? If yes, complete Wkst. L, Pt. III and Wkst. L-1, Pt. I through Pt. III. 47.00 Is this a new hospital under 42 CFR §412.300(b) PPS capital? Enter "Y for yes or "N" for no. Ν Ν Ν 47.00 48.00 Is the facility electing full federal capital payment? Enter "Y" for yes or "N" for no. N Ν 48.00 Ν Teaching Hospitals Is this a hospital involved in training residents in approved GME programs? For cost reporting periods beginning prior to December 27, 2020, enter "Y" for yes or "N" for no in column 1. For 56.00 Ν 56.00 cost reporting periods beginning on or after December 27, 2020, under 42 CFR 413.78(b)(2), see the instructions. For column 2, if the response to column 1 is "Y", or if this hospital was involved in training residents in approved GME programs in the prior year or penultimate year, and are you are impacted by CR 11642 (or applicable CRs) MA direct GME payment reduction? Enter "Y" for yes; otherwise, enter "N" for no in column 2. 57.00 For cost reporting periods beginning prior to December 27, 2020, if line 56, column 1, is yes, 57.00 is this the first cost reporting period during which residents in approved GME programs trained at this facility? Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y", did residents start training in the first month of this cost reporting period? Enter "Y" for yes or 'N" for no in column 2. If column 2 is "Y", complete Worksheet E-4. If column 2 is "N" complete Wkst. D, Parts III & IV and D-2, Pt. II, if applicable. For cost reporting periods

beginning on or after December 27, 2020, under 42 CFR 413.77(e)(1)(iv) and (v), regardless of which month(s) of the cost report the residents were on duty, if the response to line 56 is "Y" for yes, enter "Y" for yes in column 1, do not complete column 2, and complete Worksheet E-4.

HARVARD MEMORIAL HOSPITAL In Lieu of Form CMS-2552-10 Health Financial Systems HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA Provider CCN: 14-1335 Peri od: Worksheet S-2 From 07/01/2022 Part I Date/Time Prepared: 06/30/2023 11/28/2023 5: 06 pm | XVIII | XIX 2.00 3.00 1. 00 58.00 If line 56 is yes, did this facility elect cost reimbursement for physicians' services as defined in CMS Pub. 15-1, chapter 21, §2148? If yes, complete Wkst. D-5. Ν 58.00 Are costs claimed on line 100 of Worksheet A? If yes, complete Wkst. D-2 59.00 NAHE 413.85 Worksheet A Pass-Through Y/N Line # Qual i fi cati on Criterion Code 1.00 2.00 3.00 60.00 Are you claiming nursing and allied health education (NAHE) costs for 60 00 N any programs that meet the criteria under 42 CFR 413.85? (see instructions) Enter "Y" for yes or "N" for no in column 1. is "Y", are you impacted by CR 11642 (or subsequent CR) NAHE MA payment adjustment? Enter "Y" for yes or "N" for no in column 2. IME Direct GME IME Direct GME 1. 00 2.00 3. 00 4.00 5. 00 0. 00 61.00 Did your hospital receive FTE slots under ACA 0.00 61.00 section 5503? Enter "Y" for yes or "N" for no in column 1. (see instructions) 61.01 Enter the average number of unweighted primary care 61.01 FTEs from the hospital's 3 most recent cost reports ending and submitted before March 23, 2010. (see instructions) 61.02 Enter the current year total unweighted primary care 61 02 FTE count (excluding OB/GYN, general surgery FTEs, and primary care FTEs added under section 5503 of ACA). (see instructions) 61.03 Enter the base line FTE count for primary care 61.03 and/or general surgery residents, which is used for determining compliance with the 75% test. (see instructions) 61.04 Enter the number of unweighted primary care/or 61.04 surgery allopathic and/or osteopathic FTEs in the current cost reporting period. (see instructions). 61.05 Enter the difference between the baseline primary 61 05 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) 61.06 Enter the amount of ACA §5503 award that is being 61.06 used for cap relief and/or FTEs that are nonprimary care or general surgery. (see instructions) Program Code Unweighted IME Unweighted Program Name Direct GME FTE FTE Count Count 2 00 1 00 3 00 4 00 61.10 Of the FTEs in line 61.05, specify each new program 0. 00 0.00 61.10 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. 61.20 Of the FTEs in line 61.05, specify each expanded 0.00 61.20 0.00 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, the direct GME FTE unweighted count. 1.00 ACA Provisions Affecting the Health Resources and Services Administration (HRSA) 62.00 Enter the number of FTE residents that your hospital trained in this cost reporting period for which 0.00 62.00 your hospital received HRSA PCRE funding (see instructions) Enter the number of FTE residents that rotated from a Teaching Health Center (THC) into your hospital 0.00 62.01 62.01 during in this cost reporting period of HRSA THC program. (see instructions) Teaching Hospitals that Claim Residents in Nonprovider Settings Has your facility trained residents in nonprovider settings during this cost reporting period? Enter "Y" for yes or "N" for no in column 1. If yes, complete lines 64 through 67. (see instructions) 63.00

Health Financial Systems	HARVARD	MEMORIAL HOSPITAL		In lie	u of Form CMS-2	2552-10
HOSPITAL AND HOSPITAL HEALTH CARE COMP				eriod: com 07/01/2022	Worksheet S-2 Part I Date/Time Pre 11/28/2023 5:0	pared:
			Unweighted FTEs	Unweighted FTEs in	Ratio (col. 1/ (col. 1 + col.	
			Nonprovi der Si te	Hospi tal	2))	
			1.00	2.00	3. 00	
Section 5504 of the ACA Base Yea			This base year	is your cost	reporting	
period that begins on or after of the following seriod that begins on or after of the following seriod the first seriod the following seriod that the following seriod seriod that the following seriod that the following seriod seri	0.00	0.00	0.000000	64.00		
	Program Name	Program Code	Unwei ghted	Unwei ghted	Ratio (col. 3/	
			FTEs	FTEs in	(col. 3 + col.	
			Nonprovi der Si te	Hospi tal	4))	
	1.00	2. 00	3. 00	4. 00	5. 00	
65.00 Enter in column 1, if line 63 is yes, or your facility trained residents in the base year period, the program name associated with primary care FTEs for each primary care program in which you trained residents. 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)	., 55		Unwei ghted FTEs Nonprovi der Si te	Unwei ghted FTEs in Hospi tal	0.000000 Ratio (col. 1/ (col. 1 + col. 2))	65. 00
Section 5504 of the ACA Current	Year FTE Residents in	n Nonprovider Setting	1.00 sEffective fo	2.00 or cost report	3. 00 i ng	
periods beginning on or after Ju	ıl y 1, 2010					44 00
66.00 Enter in column 1 the number of FTEs attributable to rotations of Enter in column 2 the number of FTEs that trained in your hospit (column 1 divided by (column 1 divided by (column 1 divided by (column 1 divided by	occurring in all nonpount unweighted non-priman al. Enter in column 3	rovider settings. ry care resident 3 the ratio of	0.00	0.00	0. 000000	oo. UU
	Program Name	Program Code	Unwei ghted FTEs Nonprovi der Si te	Unweighted FTEs in Hospital	Ratio (col. 3/ (col. 3 + col. 4))	
67 00 Enter in column 1 the program	1. 00	2. 00	3.00	4. 00	5. 00 0. 000000	67.00
67.00 Enter in column 1, the program name associated with each of your primary care programs in which you trained residents. 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)			0.00	0.00	, J. 000000	67.00

	Financial Systems HARVARD MEMORIAL AL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA	Provi der CC	N: 14-1335	Period: From 07/01/ To 06/30/	2022	of Form Worksheet Part I Date/Time 11/28/202	t S-2 e Prep	pared:
						1. 00		
	Direct GME in Accordance with the FY 2023 IPPS Final Rule, 87 For a cost reporting period beginning prior to October 1, 2022 MAC to apply the new DGME formula in accordance with the FY 20 (August 10, 2022)?	did you ol	otain permis	sion from yo		N		68. 00
					1. 00	2.00 3	3. 00	
70 00	Inpatient Psychiatric Facility PPS Is this facility an Inpatient Psychiatric Facility (IPF), or o	loes it conta	ain an IPE s	ubprovi der?	N			70.00
	Enter "Y" for yes or "N" for no. If line 70 is yes: Column 1: Did the facility have an approved recent cost report filed on or before November 15, 2004? Enter 42 CFR 412. 424(d)(1)(iii)(c)) Column 2: Did this facility traist program in accordance with 42 CFR 412. 424 (d)(1)(iii)(D)? Enter Column 3: If column 2 is Y, indicate which program year began (see instructions) Inpatient Rehabilitation Facility PPS	I GME teachin r "Y" for ye n residents r "Y" for ye	ng program i es or "N" fo in a new te es or "N" fo	n the most r no. (see aching r no.			0	71. 00
75. 00	Is this facility an Inpatient Rehabilitation Facility (IRF), o	or does it co	ontain an IR	F	N			75. 00
76. 00	subprovider? Enter "Y" for yes and "N" for no. If line 75 is yes: Column 1: Did the facility have an approved recent cost reporting period ending on or before November 15, no. Column 2: Did this facility train residents in a new teach CFR 412.424 (d)(1)(iii)(0)? Enter "Y" for yes or "N" for no. (indicate which program year began during this cost reporting program of the cost reporting program of the cost reporting program year began during the cost reporting year began during the year began during the cost year year began during the year began during the year began during the year began during the year year year year year year year yea	2004? Enter ing program column 3: If	"Y" for yes in accordan column 2 is	or "N" for ce with 42 Y,			0	76. 00
						1. 00		
	Long Term Care Hospital PPS Is this a long term care hospital (LTCH)? Enter "Y" for yes a ls this a LTCH co-located within another hospital for part or "Y" for yes and "N" for no.			ng period? E	nter	N N		80. 00 81. 00
86. 00	TEFRA Providers Is this a new hospital under 42 CFR Section §413.40(f)(1)(i) 1 Did this facility establish a new Other subprovider (excluded §413.40(f)(1)(ii)? Enter "Y" for yes and "N" for no.				no.	N		85. 00 86. 00
	Is this hospital an extended neoplastic disease care hospital 1886(d)(1)(B)(vi)? Enter "Y" for yes or "N" for no.	classified u	under sectio	n		N		87. 00
	1000(d)(1)(D)(V1). Enter 1 101 yes of 10 101 no.			Approved Permane Adjustme (Y/N) 1.00	ent ent	Number Approve Permane Adjustme	ed ent	
	Column 1: Is this hospital approved for a permanent adjustment amount per discharge? Enter "Y" for yes or "N" for no. If yes, 89. (see instructions)					2.00	0	88. 00
	Column 2: Enter the number of approved permanent adjustments.		Wkst Alir	ne Effective	Date	Approve	ed he	
			No.			Permane Adjustme Amount F Dischar	nt ent Per	
89. 00	Column 1: If line 88, column 1 is Y, enter the Worksheet A lir	e number	1. 00	2.00		3. 00	0	89. 00
	on which the per discharge permanent adjustment approval was become 2: Enter the effective date (i.e., the cost reporting peginning date) for the permanent adjustment to the TEFRA targuer discharge.	pased. period pet amount						
	Column 3: Enter the amount of the approved permanent adjustmer TEFRA target amount per discharge.	it to the						
				V 1. 00		XI X 2. 00		
90. 00	Title V and XIX Services Does this facility have title V and/or XIX inpatient hospital	servi ces? Er	nter "Y" for	N		N		90.00
91. 00	yes or "N" for no in the applicable column. Is this hospital reimbursed for title V and/or XIX through the	cost repor	t either in	N		Υ		91. 00
	full or in part? Enter "Y" for yes or "N" for no in the applic Are title XIX NF patients occupying title XVIII SNF beds (dual	certi fi cati				N		92. 00
93. 00	instructions) Enter "Y" for yes or "N" for no in the applicabl Does this facility operate an ICF/IID facility for purposes of "Y" for yes or "N" for no in the applicable column.		d XIX? Enter	N		N		93. 00
94. 00	Does title V or XIX reduce capital cost? Enter "Y" for yes, ar applicable column.	nd "N" for no	o in the	N		N		94. 00
	If line 94 is "Y", enter the reduction percentage in the appli Does title V or XIX reduce operating cost? Enter "Y" for yes capplicable column.			0. 00 N		0. 00 N		95. 00 96. 00
	If line 96 is "Y", enter the reduction percentage in the appli			0.00	ŀ	0. 00		97. 00

Health Financial Systems HARVARD MEMORI	AL HOSPITAL		In lie	u of Form CMS.	-2552-10
HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA	Provi der C		Period: From 07/01/2022	Worksheet S- Part I	2
		7	To 06/30/2023	Date/Time Pr 11/28/2023 5	
			V	XI X	
98.00 Does title V or XIX follow Medicare (title XVIII) for the in	nterns and res	sidents post	1. 00 N	2. 00 N	98. 00
stepdown adjustments on Wkst. B, Pt. I, col. 25? Enter "Y" column 1 for title V, and in column 2 for title XIX.	for yes or "N"	for no in			
98.01 Does title V or XIX follow Medicare (title XVIII) for the ro C, Pt. I? Enter "Y" for yes or "N" for no in column 1 for ti title XIX.	eporting of ch itle V, and ir	narges on Wkst. n column 2 for	N	N	98. 01
98.02 Does title V or XIX follow Medicare (title XVIII) for the cabed costs on Wkst. D-1, Pt. IV, line 89? Enter "Y" for yes a 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 cri- reimbursed 101% of inpatient services cost? Enter "Y" for ye for title V, and in column 2 for title XIX.			N N	N	98. 03
98.04 Does title V or XIX follow Medicare (title XVIII) for a CAH outpatient services cost? Enter "Y" for yes or "N" for no in in column 2 for title XIX.	N	N	98. 04		
98.05 Does title V or XIX follow Medicare (title XVIII) and add by Wkst. C, Pt. I, col. 4? Enter "Y" for yes or "N" for no in a column 2 for title XIX.		N N	N	98. 05	
98.06 Does title V or XIX follow Medicare (title XVIII) when cost Pts. I through IV? Enter "Y" for yes or "N" for no in column			N	N	98. 06
column 2 for title XIX. Rural Providers					
105.00 Does this hospital qualify as a CAH? 106.00 of this facility qualifies as a CAH, has it elected the all	inclusivo mot	had of navmon	Y		105. 00 106. 00
for outpatient services? (see instructions)		. 3			
107.00 Column 1: If line 105 is Y, is this facility eligible for contraining programs? Enter "Y" for yes or "N" for no in column Column 2: If column 1 is Y and line 70 or line 75 is Y, do approved medical education program in the CAH's excluded II	n 1. (see ins you train I&F PF and/or IRF	structions) Rs in an	N		107. 00
Enter "Y" for yes or "N" for no in column 2. (see instruction 108.00 is this a rural hospital qualifying for an exception to the CFR Section §412.113(c). Enter "Y" for yes or "N" for no.		edul e? See 42	N		108. 00
	Physi cal 1. 00	Occupati onal 2.00	Speech 3.00	Respi ratory 4.00	
109.00 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 no for each therapy.		N N	N N	N N	109. 00
Tot yes of it for no for each therapy.					
110.00 Did this hospital participate in the Rural Community Hospital Demonstration) for the current cost reporting period? Enter complete Worksheet E, Part A, lines 200 through 218, and Worapplicable.	"Y" for yes or	"N" for no. I	f yes,	1. 00 N	110.00
			1. 00	2. 00	+
111.00 If this facility qualifies as a CAH, did it participate in Health Integration Project (FCHIP) demonstration for this compart of the response to compart of the FCHIP demonstration prong of the FCHIP demonstration that apply: "A" for Ambulance services; "B" for action for tele-health services.	ost reporting olumn 1 is Y, rticipating ir	period? Enter enter the column 2.	N		111.00
		1.00	2.00	3. 00	_
112.00 Did this hospital participate in the Pennsylvania Rural Heal (PARHM) demonstration for any portion of the current cost reperiod? Enter "Y" for yes or "N" for no in column 1. If conter "Y", enter in column 2, the date the hospital began participation. In column 3, enter the date the hospital comparticipation in the demonstration, if applicable.	eporting olumn 1 is pating in the	N			112. 00
Miscellaneous Cost Reporting Information	r "N" for	l N			0115 00
115.00 s this an all-inclusive rate provider? Enter "Y" for yes of in column 1. If column 1 is yes, enter the method used (A, I in column 2. If column 2 is "E", enter in column 3 either "for short term hospital or "98" percent for long term care psychiatric, rehabilitation and long term hospitals provided the definition in CMS Pub. 15-1, chapter 22, §2208.1.	B, or E only) 93" percent (includes	N			0 115.00
116.00 Is this facility classified as a referral center? Enter "Y" "N" for no.	for yes or	N			116. 00
117.00 s this facility legally-required to carry malpractice insu "Y" for yes or "N" for no.	rance? Enter	Y			117. 00
118.00 s the malpractice insurance a claims-made or occurrence polif the policy is claim-made. Enter 2 if the policy is occurrence.			2		118. 00

##SPRITAL AND MOSPITAL HEALTH CASE COMPLEX IDENTIFICATION DATA Private	Health Financial Systems HARVARD MEMORIAL	HOSPI TAL		In Lie	u of Form CN	IS-2552-10
118. Oil List Januarits of metiprocitice premiums and paid losses: 10.0 2.00 3.00 0.018.01				Peri od:	Worksheet :	
118. 01 List amounts of neignactice preeliums and paid losses. 1.00 2.00 3.00 0116.01 118. 02 Are malpractice preeliums and paid losses reported in a cust center other than the Administrative and General? If yes, submit supporting secular listing cost centers and amounts contained therein. 120. 001 siths a Solf or EACH that qualifies for the Outpatient Hold Harmiless provision in ACA N 112. 00 131. 001 siths a Solf or EACH that qualifies for the Outpatient Hold Harmiless provision in ACA N 112. 00 132. 001 siths a Solf or EACH that qualifies for the Outpatient Hold Harmiless provision in ACA N 112. 00 133. 123 and applicable amondments? Osco instructions) Enter in column 1, "Y" for yes or "N" for no. 112. 00 133. 124 and applicable amondments? Osco instructions) Enter in column 1, "Y" for yes or "N" for no. 112. 00 134. 135. 136 and "N" for no. 114 in a "Use Dest Nata qualifies for the Outpatient Enter in column 2, "Y" for yes or "N" for no. 114 in a "Use Dest Nata qualifies for the Outpatient Enter in column 2, "Y" for yes or "N" for no. 114 in a "Use Dest Nata qualifies for the Outpatient Enter in Column 2, "Y" for yes or "N" for no. 114 in a "Use Dest Nata qualifies for the Outpatient Enter in Column 2, "Y" for yes or "N" for no. 115 in a "Use Dest Nata qualifies for the Outpatient Enter in Column 2, "Y" for yes or "N" for no. 114 in a "Use Dest Nata qualifies for the Outpatient Enter in Column 2, "Y" for yes or "N" for no. 114 in a "Use Dest Nata qualifies for "N" for no. 114 in a "Use Dest Nata qualifies for "N" for no. 114 in a "Use Dest Nata qualifies for "N" for no. 114 in a "Use Dest Nata qualifies for "N" for no. 114 in a "Use Dest Nata qualifies for "N" for no. 114 in a "Use Dest Nata qualifies for "N" for no. 114 in a "Use Dest Nata qualifies for "N" for no. 114 in a "Use Dest Nata qualifies for "N" for no. 114 in a "Use Dest Nata qualifies for "N" for no. 114 in a "Use Dest Nata qualifies for "N" for no. 114 in a "Use Dest Nata qualifies for "N" for no. 114 in a "Use Dest Nata qualifies for					Date/Time I	
118 O' Li st amounts of mail practice preal uns and paid i losses: 740, 368 0 0 0,118 01 118 O' Ri st all practice primitizes and paid i losses reported in a cest center of the riban the 1,00 2,00 118 01 119 OOD NOT LIST THIS LIST I Types, submit supporting schedule listing cast centers and amounts contained therein. 119 OOD NOT LIST THIS LIST I THE THIS LIST I TYPES, submit supporting schedule listing cast centers and amounts contained therein. 119 OOD NOT LIST THIS LIST I THE THIS LIST I THE OTHER CONTROL I THIS CONTROL			Premi ums	Losses		
18. Oliver all practice presiums and paid i losses: reported in a cost center other than the Abin instrative and General? If yes, submit supporting schedule listing cost centers in a manual scortained therein. 19. Cool Not Total Ist List. 19. Cool Not Total Ist.			T T CIIII CIIII	203303	Trisur unoc	
18. Oliver all practice presiums and paid i losses: reported in a cost center other than the Abin instrative and General? If yes, submit supporting schedule listing cost centers in a manual scortained therein. 19. Cool Not Total Ist List. 19. Cool Not Total Ist.						
118. 02 Are mall practice; greatures and gail of losses reported in a cost center other than the N 1.00 2.00 118. 02 And mall factor to and Security 2 if yes, submit supporting schedule listing cost center's and associated therein. 119. 000 NOT USE THIS LINE 119. 000 NOT USE THIS LINE 110. 000 NOT USE THIS						
18 02 Administrative and General? If I yes, submit supporting schedule its listing cost centers and amounts contained therein. 19 00 paid amounts contained therein. 110 00 paid amounts contained therein. 111 00 paid amounts contained therein. 112 00 paid amounts contained there are feel and taxes as defined in \$1903(w)(3) of the Actifity amounts are paid to the facility amounts are paid to the paid amounts. 112 00 paid the facility amounts are paid to the paid amounts. 112 00 paid the facility amounts are paid to the paid amounts. 113 00 paid the facility amounts are paid to the paid amounts are paid to the paid amounts. 114 00 paid the facility amounts are paid to the paid amounts. 115 00 paid the facility amounts are paid to the paid	118.01 List amounts of malpractice premiums and paid losses:		720, 3	68 0		0 118. 01
Administrative and General? If yes, submit supporting schedule listing cost centers and amounts contained therein. 119.000 NoT USE THIS LINE 120.001 is this a SOA or FACH that qualifies for the durpstiant ited isoanless provision in ACA No No. No. No. No. No. No. No. No. No.				1.00	2. 00	
and amounts contained therein. 10 colo Not ISE THIS LIME 10 colo Sizizi and applicable amendments? (see instructions) Enter in column 1, "Y for yes or Not				N		118. 02
120.00 is this a SQLI or FACII that qualifies for the Outpatient hold Harmless provision in ACA SISTIA and applicable amendments? (see instructions) Enter in column 1, "Ye for yes or "Y' for no. Is this a rural hospital with <a "\text{"="" "y"="" (if="" (m<="" (middly)="" (see="" 1="" 1,="" 100="" 121.00="" 122.00="" 125.00="" 13="" 2,="" 2.="" 53121="" <="" \text{="" a="" aca="" accounting="" amendments?="" an="" and="" applicable="" applicable)="" applicable,="" are="" beds="" bit="" bookbeeping,="" bost="" cbsa="" cbsa?="" charged="" class="" coct="" column="" consoliting="" date(s)="" date,="" devices="" e.g.,="" enter="" expensess.="" facility="" finter="" fooling="" for="" fraction="" from="" harmless="" high="" hold="" hospital="" href="https://doi.org/10.1001/j.com/1</td><td>j</td><td>ire risting co</td><td>ost centers</td><td></td><td></td><td></td></tr><tr><td>\$\frac{\text{s121}}{\text{s127}}\$ and applicable amendments? (see Instructions) Enter in column 1, " if="" implantable="" in="" included.="" instructions)="" is="" its="" located="" loggl,="" main="" management="" medical="" no.="" norsheet="" number="" objects="" of="" operate="" or="" organization?="" organizations="" outpatient="" outside="" payroli,="" professional="" proparation,="" provision="" purchase="" purchased="" qualifies="" rural="" services="" services,="" subproviders="" tax="" taxes="" td="" termination="" that="" the="" these="" this="" tile="" to="" toggl,="" unrelated="" where="" with="" y="" y"="" yes="" yes.}="" }=""><td></td><td>Harmlace prov</td><td>vision in AC</td><td>N N</td><td>N</td><td></td>		Harmlace prov	vision in AC	N N	N	
Bold Harmless provision in AGA \$3121 and applicable amendments? (See instructions)				- IV	IN	120.00
Einter In column 2. "Y" for yes or "N" for no. 121.000 laths facility incur and report costs for high cost implantable devices charged to patients? Enter "Y" for yes or "N" for no. 122.000 lates the cost report contain heal theare related taxes as defined in \$1903(w)(3) of the Activate Port for the Column 1 for On In column 1 for Column 1 is "Y", enter in column 2 123.000 lather facility and/or its subproviders (if applicable) purchase professional services, e.g., legal, accounting, tax preparation, bookkeeping, payroll, and/or services, e.g., legal, accounting, tax preparation, bookkeeping, payroll, and/or professional services, expenses, for services purchased from unrelated organization? In column 1, enter "Y" for yes or "N" for no. 125.000 lates this facility operate a Modicare-certified to 16587 in column 2, enter "Y" for yes or "N" for no. 126.000 lates this facility operate a Modicare-certified transplant center? Enter "Y" for yes or "N" for no. 127.000 lates this facility operate a Modicare-certified this with the certification date in column 1 and termination date. If applicable, in column 2, enter "Y" for yes or "N" for no. 127.000 lates this is a Medicare-certified tide they transplant program, enter the certification date in column 1 and termination date. If applicable, in column 2. 128.001 if this is a Medicare-certified liver transplant program, enter the certification date in column 1 and termination date, if applicable, in column 2. 129.001 fithis is a Medicare-certified liver transplant program, enter the certification date in column 1 and termination date, if applicable, in column 2. 129.001 fithis is a Medicare-certified liver transplant program, enter the certification date in column 1 and termination date, if applicable, in column 2. 129.001 fithis is a Medicare-certified late, if applicable, in column 2. 120.001 fithis is a Medicare-certified late, if applicable, in column 2. 120.001 fithis is a Medicare-certified late in the modified late in column 3 in column 1 in terminatio				t		
patients? Enter "Y" for yes or "N" for no. 120.00Des the known from the content patient there re lated taxes as defined in \$1903(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. 123.00Uid the facility and/or its subproviders (If applicable) purchase professional services, e.g., legal, accounting lax preparation, bookkeeping, payroll, and/or memory professional services expenses, i.e., were the major professional services expenses, i.e., greater than 50% of total professional services expenses, for services purchased from unrelated organizations incated in a CRSA outside of the main hospital CRSA? In column 2, enter "Y" for yes or "N" for no. 125.00Dess this facility operate a Medicare-certified transplant center? Enter "Y" for yes or and "N" for no. If yes, enter certification date(s) (mm/dd/yyyy) below. 126.001T this is a Medicare-certified theat transplant program, enter the certification date in column 1 and termination date, if applicable, in column 2. 127.001 fish is a Medicare-certified theat transplant program, enter the certification date in column 1 and termination date, if applicable, in column 2. 128.001T this is a Medicare-certified lung transplant program, enter the certification date in column 1 and termination date, if applicable, in column 2. 129.001 fish is is a Medicare-certified lung transplant program, enter the certification date in column 1 and termination date, if applicable, in column 2. 130.001T this is a Medicare-certified payer and program, enter the certification date in column 1 and termination date, if applicable, in column 2. 131.001 fish is is a Medicare-certified payer and program, enter the certification date in column 1 and termination date, if applicable, in column 2. 131.001 fish is is a Medicare-certified payer and program, enter the certification date in column 1 and termination date, if applicable, in column 2. 132.001 fish is is a host care-certified		.s: (see msti	ructions)			
122.00 boses the cost report contain heal theare related taxes as defined in \$1903(w)(3) of the Act?Pather Y" for yes or "N" for no in column 1. If column 1 is "Y", enter in column 2 the Worksheet A I in enumber where these taxes are included. 123.00 is directly and/or Its subproviders (if applicable) purchase professional services, e.g., legal, accounting, tax preparation, bookkeeping, payroll, and/or providers (if applicable) purchase professional services, e.g., legal, accounting, tax preparation, bookkeeping, payroll, and/or provides in the services, from an unrelated organization? In column 1, enter "Y" for yes or "N" for no. The services of the majority of the expenses, i.e., greater than 50% of total professional services expenses, for services pararchased from unrelated organizations located in a CBSA outside of the main hospital CBSA? In column 2, enter "Y" for yes or "N" for no. 125.000 and "N" for no. If yes, enter certification date(s) (em/dd/yyyy) below. 126.001 f this is a Medicare-certification date(s) (em/dd/yyyy) below. 127.001 f this is a Medicare-certification date(s) (em/dd/yyyy) below. 128.001 f this is a Medicare-certification date if applicable, in column 2. 129.001 this is a determination date, if applicable, in column 2. 129.002 this is a medicare-certification date if applicable, in column 2. 120.003 f this is a selection date if applicable, in column 2. 120.004 f this is a medicare-certification date, if applicable, in column 2. 120.005 f this is a medicare-certification date, if applicable, in column 2. 120.006 f this is a medicare-certification date, if applicable, in column 2. 120.007 f this is a Medicare-certification date, if applicable, in column 2. 120.008 f this is a medicare-certification date, if applicable, in column 2. 120.009 f this is a medicare-certification date, if applicable, in column 2. 121.000 f this is a medicare-certification date, if applicable, in column 2. 122.001 f this is a hodicare-certification date, if applicable, in column 2. 123.000 f		ntable devices	s charged to	Y		121. 00
the Worksheet A Line number where these taxes are included. 123.00 Did the facility and/or its subproviders (if applicable) purchase professional services, e.g., legal, accounting, tax preparation, bookkeeping, payroll, and/or management/consulting services, from an unrelated organization? In column 1, enter "Y" for yes or "N" for no.		ned in §1903	(w)(3) of the	e N		122. 00
123.00 lot the facility and/or its subproviders (if applicable) purchase professional services, e.g., legal, accounting, tax preparation, bookkeeping, payroll, and/or management/consulting services, from an unrelated organization? In column 1, enter "Y" for yes or "N" for no. If column 1 is "Y", were the majority of the expenses, i. e., greater than 50% of total professional services expenses, for services purchased from unrelated organizations located in a CBSA outside of the main hospital CBSA? In column 2, enter "Y" for yes or "N" for no. Sertified Transplant Center Information 125.00 Does this facility operate a Medicare-certified transplant center? Enter "Y" for yes or "N" for no. 126.00 If this is a Medicare-certified kidney transplant program, enter the certification date in column 1 and termination date, if applicable, in column 2. 127.00 If this is a Medicare-certified kidney transplant program, enter the certification date in column 1 and termination date, if applicable, in column 2. 128.00 If this is a Medicare-certified liver transplant program, enter the certification date in column 1 and termination date, if applicable, in column 2. 129.00 If this is a Medicare-certified lung transplant program, enter the certification date in column 1 and termination date. If applicable, in column 2. 130.00 If this is a Medicare-certified lung transplant program, enter the certification date in column 1 and termination date. If applicable, in column 2. 131.00 If this is a Medicare-certified intestinal transplant program, enter the certification date in column 1 and termination date. If applicable, in column 2. 132.00 Proposed and reserved in date, if applicable, in column 2. 133.00 Proposed and reserved in date, if applicable, in column 2. 141. Providers 142.00 If this is a hospital-based organ procurement organization (OPO), enter the OPO number in column 1 and termination date, if applicable, in column 2. 143.00 If this is a hospital-based organ procurement organization (OPO), enter the OPO number		is "Y", enter	r in column 2	2		
management/consulting services, from an unrelated organization? In column 1, enter "Y" for yes or "N" for no. If column 1 is "Y", were the majority of the expenses, i.e., greater than 50% of total professional services expenses, for services purchased from unrelated organizations located in a CBSA outside of the main hospital CBSA? In column 2, enter "Y" for yes or "N" for no. 125.00 Dose this facility operate a Medicare-certification date(s) (mm/dd/yyyy) below. 126.00 The form of it yes, enter certification date(s) (mm/dd/yyyy) below. 127.00 If this is a Medicare-certification date(s) (mm/dd/yyyy) below. 127.00 If this is a Medicare-certification date(s) (mm/dd/yyyy) below. 128.00 If this is a Medicare-certification date in column 1 and termination date, if applicable, in column 2. 129.00 If this is a Medicare-certification date in column 2. 129.00 If this is a Medicare-certification date in column 2. 129.00 If this is a Medicare-certification date in column 3 and termination date, if applicable, in column 2. 129.00 If this is a Medicare-certification date in column 1 and termination date, if applicable, in column 2. 129.00 If this is a Medicare-certification date, if applicable, in column 2. 130.00 If this is a Medicare-certification date, if applicable, in column 2. 131.00 If this is a Medicare-certifical internal date, if applicable, in column 2. 132.00 If this is a Medicare-certifical internal date, if applicable, in column 2. 133.00 If this is a Medicare-certifical internal date, if applicable, in column 2. 134.00 If this is a Medicare-certifical internal date, if applicable, in column 2. 135.00 If this is a Medicare-certifical internal date, if applicable, in column 2. 136.00 If this is a heat derivation date, if applicable, in column 2. 137.00 If this is a heat derivation date, if applicable, in column 2. 138.00 If this is a heat derivation date, if applicable, in column 2. 139.00 If this is a heat derivation date, if applicable, in column 3. 140.00 Are there any related organizati		chase professi	i onal			123. 00
For Yes or "N" for no. If column 1 is "Y", were the majority of the expenses, i. e., greater than 50% of total professional services expenses. For services purchased from unrelated organizations located in a DBSA outside of the main hospital CBSA? In column 2, enter "Y" for yes or "N" for no.						
professional services expenses, for services purchased from unrelated organizations ocated in a CBSA outside of the main hospital CBSA? In column 2, enter "Y" for yes or "N" for no. Certified Transplant Center Information 125.00 Does this facility operate a Medicare-certified transplant center? Enter "Y" for yes and "N" for no. If yes, enter certification date(s) (unwodd/yyyy) below. 126.00 If this is a Medicare-certified kidney transplant program, enter the certification date in column 1 and termination date, if applicable, in column 2. 127.00 If this is a Medicare-certified heart transplant program, enter the certification date in column 1 and termination date, if applicable, in column 2. 128.00 If this is a Medicare-certified liver transplant program, enter the certification date in column 1 and termination date, if applicable, in column 2. 129.00 If this is a Medicare-certified liver transplant program, enter the certification date in column 1 and termination date, if applicable, in column 2. 130.00 If this is a Medicare-certified pancreas transplant program, enter the certification date in column 1 and termination date, if applicable, in column 2. 131.00 If this is a Medicare-certified intestinal transplant program, enter the certification date in column 1 and termination date, if applicable, in column 2. 132.00 If this is a Medicare-certified is transplant program, enter the certification date in column 1 and termination date, If applicable, in column 2. 133.00 If this is a Medicare-certified is transplant program, enter the certification date in column 1 and termination date, If applicable, in column 2. 134.00 If this is a hospital-based organ procurement organization (0P0), enter the 0P0 number in a column 1 and termination date, If applicable, in column 2. 134.00 If this is a hospital-based organ procurement organization (0P0), enter the 0P0 number in column 1 and termination date, If applicable, in column 2. 135.00 If column 1 and termination date, If applicable, in column 2. 136.00 If th		on? In corumn	i, enter y			
located in a CBSA outside of the main hospital CBSA? In column 2, enter "Y" for yes or "N" for no.						
Certified Transplant Center Information 125.00 2				-		
125. 00 Does this Facility operate a Medicare-certified transplant center? Enter "Y" for yes and "N" for no. If yes, enter certification date(s) (mm/dd/yyyy) below. 126. 00 If this is a Medicare-certified kidney transplant program, enter the certification date in column 1 and termination date, if applicable, in column 2. 127. 00 If this is a Medicare-certified heart transplant program, enter the certification date in column 1 and termination date, if applicable, in column 2. 128. 00 If this is a Medicare-certified liver transplant program, enter the certification date in column 1 and termination date, if applicable, in column 2. 129. 00 If this is a Medicare-certified liver transplant program, enter the certification date in column 1 and termination date, if applicable, in column 2. 130. 00 If this is a Medicare-certified pancreas transplant program, enter the certification date in column 1 and termination date, if applicable, in column 2. 130. 00 If this is a Medicare-certified intestinal transplant program, enter the certification date in column 1 and termination date, if applicable, in column 2. 131. 00 If this is a Medicare-certified intestinal transplant program, enter the certification date in column 1 and termination date, if applicable, in column 2. 132. 00 If this is a Medicare-certified islet transplant program, enter the certification date in column 1 and termination date, if applicable, in column 2. 133. 00 Removed and reserved 134. 00 If this is a hospital-based organ procurement organization (OPO), enter the OPO number in column 1 and termination date, if applicable, in column 2. 140. 00 Are there any related organization or home office costs as defined in CMS Pub. 15-1, Y HB0764 140. 00 Are there any related organization or home office costs and defined in CMS Pub. 15-1, All Providers 141. 00 Name: MERCY HOME OFFICE Contractor name and contractor number. 141. 00 Name: MERCY HOME OFFICE Contractor name and contractor number. 142. 00 Street: 100 MINERAL POINT AVE PO Box: William of t			•			
126. 00 f this is a Medicare-certified kidney transplant program, enter the certification date 126. 00	125.00 Does this facility operate a Medicare-certified transplant ce	enter? Enter '	"Y" for yes	N		125. 00
in column 1 and termination date, if applicable, in column 2. 127. 00 If this is a Medicare-certified heart transplant program, enter the certification date in column 1 and termination date, if applicable, in column 2. 128. 00 If this is a Medicare-certified liver transplant program, enter the certification date in column 1 and termination date, if applicable, in column 2. 129. 00 If this is a Medicare-certified liver transplant program, enter the certification date in column 1 and termination date, if applicable, in column 2. 130. 00 If this is a Medicare-certified loads, if applicable, in column 2. 131. 00 If this is a Medicare-certified intestinal transplant program, enter the certification date in column 1 and termination date, if applicable, in column 2. 132. 00 If this is a Medicare-certified intestinal transplant program, enter the certification date in column 1 and termination date, if applicable, in column 2. 132. 00 If this is a Medicare-certified intestinal transplant program, enter the certification date in column 1 and termination date, if applicable, in column 2. 133. 00 If this is a Medicare-certified islet transplant program, enter the certification date in column 1 and termination date, if applicable, in column 2. 133. 00 Removed and reserved 134. 00 If this is a hospital-based organ procurement organization (OPO), enter the OPO number in column 1 and termination date, if applicable, in column 2. 140. 00 Are there any related organization or home office costs as defined in CMS Pub. 15-1, Applicable in column 2. 141. 00 Name in column 2 the home office costs as defined in CMS Pub. 15-1, Applicable in column 2. 142. 00 Street: 1000 MINERAL POINT AVE Po Box: 143. 00 If this facility is part of a chain organization, enter on lines 141 through 143 the name and address of the home office and enter the home office contractor name and contractor number. 144. 00 Are provider based physicians' costs included in Worksheet A? 145. 00 If costs for renal services are claimed on Wkst. A, line			ification dat	to		124 00
in column 1 and termination date, if applicable, in column 2. 128. 00 If this is a Medicare-certified liver transpl and program, enter the certification date in column 1 and termination date, if applicable, in column 2. 129. 00 If this is a Medicare-certified lung transplant program, enter the certification date in column 1 and termination date, if applicable, in column 2. 130. 00 If this is a Medicare-certified pancreas transplant program, enter the certification date in column 1 and termination date, if applicable, in column 2. 131. 00 If this is a Medicare-certified intestinal transplant program, enter the certification date in column 1 and termination date, if applicable, in column 2. 132. 00 If this is a Medicare-certified pancreas transplant program, enter the certification date in column 1 and termination date, if applicable, in column 2. 133. 00 If this is a Medicare-certified lister transplant program, enter the certification date in column 1 and termination date, if applicable, in column 2. 133. 00 Removed and reserved 134. 00 If this is a hospital-based organ procurement organization (0P0), enter the 0P0 number in column 1 and termination date, if applicable, in column 2. 141. Providers 140. 00 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) 141. 00 Name: MERCY HOME OFFICE Contractor name and contractor number. 141. 00 Name: MERCY HOME OFFICE Contractor's Name: MSS Contractor's Number: 0450 142. 00 Street: 1000 MINERAL POINT AVE PO Box: State: WI Zip Code: 53547 143. 00 143. 00 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 1. Ecolumn 1 is			ilication dat	le		126.00
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						146. 00
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Health Financial Systems	HARVARD MEN	MORIAL HOSPITAL			In Lie	u of Form CMS	-2552-10
HOSPITAL AND HOSPITAL HEALTH CARE COMPLE	X IDENTIFICATION DATA	Provi der CC			od: 07/01/2022 06/30/2023		epared:
						1. 00	
147.00Was there a change in the statist	ical basis? Enter "Y" f	or ves or "N" for	no.			1.00 N	147. 00
148.00 Was there a change in the order o						N	148. 00
149.00 Was there a change to the simplif	ied cost finding method	l? Enter "Y" for y	es or "N"	for no.		N	149. 00
		Part A	Part (3	Title V	Title XIX	
December 6 and 1 a		1.00	2.00		3.00	4. 00	
Does this facility contain a prov costs or charges? Enter "Y" for y §413.13)		ach component for	Part A and		(See 42 Cl	FR	
155. 00 Hospi tal		Υ	Y		N	N	155. 00
156.00 Subprovi der - IPF		N	N		N	N	156. 00
157. 00 Subprovi der - I RF		N	N		N	N	157. 00
158. 00 SUBPROVI DER 159. 00 SNF		N	l N		N	N	158. 00 159. 00
160.00HOME HEALTH AGENCY		N	N N		N	N N	160.00
161. 00 CMHC		IV.	l N		N	N	161.00
161. 10 CORF			l N		N	N N	161. 10
Multicampus						1. 00	
165.00 s this hospital part of a Multic Enter "Y" for yes or "N" for no.	ampus hospital that has	one or more camp	uses in di	fferent	CBSAs?	N	165. 00
	Name	County	State	Zi p Code	e CBSA	FTE/Campus	
	0	1. 00	2. 00	3. 00	4. 00	5. 00	
166.00 ffline 165 is yes, for each campus enter the name in column 0, county in column 1, state in column 2, zip code in column 3, CBSA in column 4, FTE/Campus in column 5 (see instructions)						0.0	166. 00
						1.00	
Health Information Technology (HI	T) incentive in the Ame	rican Pecovery an	nd Painvast	ment Act		1. 00	
167.00 Is this provider a meaningful use					L .	Y	167. 00
168.00 If this provider is a CAH (line 1	05 is "Y") and is a mea	ningful user (lin			er the		168. 00
reasonable cost incurred for the 168.01 If this provider is a CAH and is			r qualify	for a ha	ırdshi p	N	168. 01
exception under §413.70(a)(6)(ii)					•		
169.00 If this provider is a meaningful transition factor. (see instructions		and is not a CAH	(line 105	is "N"),	enter the	9. 9	99169. 00
				Е	Begi nni ng	Endi ng	
170.00 Enter in columns 1 and 2 the EHR	noginning data and ondi	ng data for the r	oporting		1. 00	2. 00	170. 00
peri od respecti vel y (mm/dd/yyyy)	Degrining date and endi	ing date for the r	epoi triig				170.00
					1. 00	2. 00	-
171.00 If line 167 is "Y", does this pro section 1876 Medicare cost plans "Y" for yes and "N" for no in col 1876 Medicare days in column 2. (reported on Wkst. S-3, umn 1. If column 1 is y	Pt. I, line 2, co	I. 6? Ente		N		0 171. 00

HARVARD MEMORIAL HOSPITAL In Lieu of Form CMS-2552-10 Health Financial Systems HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE Provider CCN: 14-1335 Worksheet S-2 From 07/01/2022 Part II Date/Time Prepared: 06/30/2023 11/28/2023 5:06 pm Y/N Date 1.00 2.00 PART II - HOSPITAL AND HOSPITAL HEATHCARE COMPLEX REIMBURSEMENT QUESTIONNAIRE General Instruction: Enter Y for all YES responses. Enter N for all NO responses. Enter all dates in the mm/dd/yyyy format. COMPLETED BY ALL HOSPITALS Provider Organization and Operation 1.00 Has the provider changed ownership immediately prior to the beginning of the cost N 1.00 reporting period? If yes, enter the date of the change in column 2. (see instructions) Date V/I 1.00 2.00 3.00 2.00 Has the provider terminated participation in the Medicare Program? If N 2 00 yes, enter in column 2 the date of termination and in column $\hat{\textbf{3}},$ "V" for voluntary or "I" for involuntary. 3.00 Is the provider involved in business transactions, including management 3.00 contracts, with individuals or entitles (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/N Date Type 1 00 2 00 3 00 Financial Data and Reports Column 1: Were the financial statements prepared by a Certified Public Accountant? Column 2: If yes, enter "A" for Audited, "C" for Compiled, 4.00 Υ 4.00 Α or "R" for Reviewed. Submit complete copy or enter date available in column 3. (see instructions) If no, see instructions. Are the cost report total expenses and total revenues different from 5.00 Ν 5.00 those on the filed financial statements? If yes, submit reconciliation Y/N Legal Oper 1 00 2 00 Approved Educational Activities 6.00 Column 1: Are costs claimed for a nursing program? Column 2: If yes, is the provider 6.00 Ν the legal operator of the program? Are costs claimed for Allied Health Programs? If "Y" see instructions. 7.00 7.00 N Were nursing programs and/or allied health programs approved and/or renewed during the 8.00 N 8.00 cost reporting period? If yes, see instructions. Are costs claimed for Interns and Residents in an approved graduate medical education Ν 9.00 program in the current cost report? If yes, see instructions.

Was an approved Intern and Resident GME program initiated or renewed in the current Ν 10.00 10.00 cost reporting period? If yes, see instructions. 11.00 Are GME cost directly assigned to cost centers other than I & R in an Approved N 11.00 Teaching Program on Worksheet A? If yes, see instructions Y/N 1.00 Bad Debts 12.00 Is the provider seeking reimbursement for bad debts? If yes, see instructions. Υ 12.00 13.00 If line 12 is yes, did the provider's bad debt collection policy change during this cost reporting Ν 13.00 period? If yes, submit copy. If line 12 is yes, were patient deductibles and/or coinsurance amounts waived? If yes, see Ν 14 00 instructions. Bed Complement 15.00 Did total beds available change from the prior cost reporting period? If yes, see instructions Ν 15.00 Part B Part A Y/N Date Y/N Date 1.00 2.00 3.00 4.00 PS&R Data Was the cost report prepared using the PS&R Report only? 16.00 Ν N 16.00 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) Was the cost report prepared using the PS&R Report for totals and the provider's records for allocation? If 09/29/2023 09/29/2023 17.00 Υ 17.00 either column 1 or 3 is yes, enter the paid-through date in columns 2 and 4. (see instructions) 18 00 If line 16 or 17 is yes, were adjustments made to PS&R Ν Ν 18.00 Report data for additional claims that have been billed but are not included on the PS&R Report used to file this cost report? If yes, see instructions. If line 16 or 17 is yes, were adjustments made to PS&R 19.00 Ν Ν 19.00 Report data for corrections of other PS&R Report information? If yes, see instructions.

Heal th	Financial Systems HARVARD MEMORI	IAL HOSPITAL		In Lie	u of Form CM:	S-2552-10		
HOSPI T	AL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE	Provi der C	CN: 14-1335	Peri od: From 07/01/2022 To 06/30/2023	Worksheet S Part II Date/Time P 11/28/2023	repared:		
			i pti on	Y/N	Y/N			
20. 00	If line 1/ on 17 is yes were adjustments made to DCOD		0	1. 00 N	3. 00 N	20. 00		
20.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for Other? Describe the other adjustments:			IN	IN	20.00		
		Y/N	Date	Y/N	Date			
		1.00	2. 00	3. 00	4. 00			
21. 00	Was the cost report prepared only using the provider's records? If yes, see instructions.	N		N		21. 00		
					1. 00			
	COMPLETED BY COST REIMBURSED AND TEFRA HOSPITALS ONLY (EXCE	EPT CHILDRENS	HOSPI TALS)		1.00			
	Capital Related Cost							
22. 00	Have assets been relifed for Medicare purposes? If yes, see				N	22. 00		
23. 00	Have changes occurred in the Medicare depreciation expense	due to apprais	sals made dur	ing the cost	N	23. 00		
24. 00	reporting period? If yes, see instructions. Were new leases and/or amendments to existing leases entered if yes, see instructions	ed into during	this cost re	eporting period?	N	24. 00		
25. 00	Have there been new capitalized leases entered into during instructions.	the cost repo	rting period?	'If yes, see	N	25. 00		
26. 00	Were assets subject to Sec. 2314 of DEFRA acquired during thinstructions.	he cost report	ing period? I	f yes, see	N	26. 00		
27. 00	Has the provider's capitalization policy changed during the copy.	e cost reporti	ng period? If	yes, submit	N	27. 00		
28. 00	<u>Interest Expense</u> Were new Loans, mortgage agreements or Letters of credit en	ntered into du	ring the cost	reporting	Y	28. 00		
29. 00	period? If yes, see instructions. Did the provider have a funded depreciation account and/or bond funds (Debt Service Reserve Fund)							
30.00	treated as a funded depreciation account? If yes, see inst Has existing debt been replaced prior to its scheduled matu	Υ	30. 00					
31. 00	instructions. Has debt been recalled before scheduled maturity without issuance of new debt? If yes, see instructions.							
32. 00	Purchased Services Have changes or new agreements occurred in patient care ser		ed through co	ntractual	N	32.00		
33. 00	arrangements with suppliers of services? If yes, see instru If line 32 is yes, were the requirements of Sec. 2135.2 app		ng to competi	tive bidding? If	N	33. 00		
	no, see instructions. Provider-Based Physicians							
	Were services furnished at the provider facility under an a lf yes, see instructions.	Ü	·	. ,	Y	34.00		
35. 00	If line 34 is yes, were there new agreements or amended exi physicians during the cost reporting period? If yes, see in		nts with the		Y	35. 00		
				Y/N 1.00	2. 00			
	Home Office Costs			1.00	2.00			
36.00	Were home office costs claimed on the cost report?			Υ		36.00		
37. 00	If line 36 is yes, has a home office cost statement been pulf yes, see instructions.	repared by the	home office?	Υ		37. 00		
38. 00	If line 36 is yes, was the fiscal year end of the home of the provider? If yes, enter in column 2 the fiscal year end			N		38. 00		
39. 00	If line 36 is yes, did the provider render services to othe see instructions.	er chain compo	nents? If yes	s, Y		39. 00		
40. 00	If line 36 is yes, did the provider render services to the instructions.	home office?	If yes, see	Y		40. 00		
		1.	00	2.	00			
44 05	Cost Report Preparer Contact Information	Taxas /	CEAODI OT		46.00			
41. 00	held by the cost report preparer in columns 1, 2, and 3,	AMY	SEACRI ST		41.00			
42.00	respectively. Enter the employer/company name of the cost report preparer.	MERCY				42. 00		
43. 00	· · ·	8159715010		ASEACRI ST@MHEM	AI L. ORG	43. 00		

Heal th	Financial Systems HARVA	ARD MEMORI.	AL HOSPI TAL			In Lieu	u of Form CMS-	2552-10
HOSPI T	AL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTION	NAI RE	Provi der	CCN: 14-1335	Peri Fror To	m 07/01/2022	Worksheet S-2 Part II Date/Time Pre 11/28/2023 5:	pared:
				3. 00				
	Cost Report Preparer Contact Information							
41.00	Enter the first name, last name and the title/posi	tion [DI RECTOR OF	REIMBURSEMENT				41.00
	held by the cost report preparer in columns 1, 2,	and 3,						
	respecti vel y.							
42.00	Enter the employer/company name of the cost report	t I						42.00
	preparer.							
43.00	Enter the telephone number and email address of th	ne cost						43.00
	report preparer in columns 1 and 2, respectively.							

Period: Worksheet S-3 From 07/01/2022 Part I To 06/30/2023 Date/Time Prepared: Provi der CCN: 14-1335

					-	To 06/30/2023	Date/Time Prep 11/28/2023 5:0	
							I/P Days / 0/P	оо ріп
							Visits / Trips	
	Component	Worksheet A	No	. of Beds	Bed Days	CAH/REH Hours	Title V	
	·	Li ne No.			Avai I abl e			
		1.00		2. 00	3. 00	4. 00	5. 00	
	PART I - STATISTICAL DATA							
1.00	Hospital Adults & Peds. (columns 5, 6, 7 and	30. 00		10	3, 650	14, 383. 00	0	1. 00
	8 exclude Swing Bed, Observation Bed and							
	Hospice days) (see instructions for col. 2							
	for the portion of LDP room available beds)							
2.00	HMO and other (see instructions)							2.00
3.00	HMO IPF Subprovider							3.00
4.00	HMO IRF Subprovider						0	4. 00 5. 00
5. 00 6. 00	Hospital Adults & Peds. Swing Bed SNF Hospital Adults & Peds. Swing Bed NF						0	6. 00
7. 00	Total Adults and Peds. (exclude observation			10	3, 650	14, 383. 00	0	7. 00
7.00	beds) (see instructions)			10	3, 000	14, 363. 00	U	7.00
8. 00	INTENSIVE CARE UNIT	31. 00		3	1, 09!	0.00	0	8. 00
9. 00	CORONARY CARE UNIT	31.00		3	1,0%	0.00	J	9. 00
10.00	BURN INTENSIVE CARE UNIT							10.00
11. 00	SURGICAL INTENSIVE CARE UNIT							11. 00
12.00	OTHER SPECIAL CARE (SPECIFY)							12. 00
13. 00	NURSERY							13. 00
14.00	Total (see instructions)			13	4, 745	14, 383. 00	0	14.00
15.00	CAH visits				1		0	15. 00
15. 10	REH hours and visits							15. 10
16.00	SUBPROVI DER - I PF							16.00
17.00	SUBPROVI DER - I RF							17.00
18.00	SUBPROVI DER							18. 00
19. 00	SKILLED NURSING FACILITY	44. 00		16	5, 840		0	19. 00
20.00	NURSING FACILITY							20.00
21.00	OTHER LONG TERM CARE	46. 00		29	10, 58			21. 00
22.00	HOME HEALTH AGENCY							22. 00
23.00	AMBULATORY SURGICAL CENTER (D. P.)							23. 00
24. 00	HOSPICE	20.00						24. 00 24. 10
24. 10 25. 00	HOSPICE (non-distinct part) CMHC - CMHC	30. 00						24. 10 25. 00
25. 00	CMHC - CORF	99. 10					0	25. 00
26. 00	RURAL HEALTH CLINIC	77. 10					O	26. 00
26. 25	FEDERALLY QUALIFIED HEALTH CENTER	89. 00					0	
27. 00	Total (sum of lines 14-26)	07.00		58			O	27. 00
28. 00	Observation Bed Days			00			0	28. 00
29. 00	Ambul ance Trips						_	29. 00
30.00	Employee discount days (see instruction)							30. 00
31.00	Employee discount days - IRF							31. 00
32.00	Labor & delivery days (see instructions)			0	(32.00
32.01	Total ancillary labor & delivery room							32. 01
	outpatient days (see instructions)							
33.00	LTCH non-covered days							33.00
33. 01	LTCH site neutral days and discharges			_				33. 01
34.00	Temporary Expansion COVID-19 PHE Acute Care	30. 00		0	'I ()	0	34. 00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA

Provider CCN: 14-1335 Period: From 07/01/2

Peri od: Worksheet S-3
From 07/01/2022 Part I
To 06/30/2023 Date/Time Prepared: 11/28/2023 5:06 pm

		L/D Days	/ O/P Vi si ts	/ Trins	Full Time E	06 pm	
		17P Days	/ U/P VISITS	/ 111ps	ruii iiille t	equi vai erres	
	Component	Title XVIII	Title XIX	Total All Patients	Total Interns & Residents	Employees On Payroll	
		6.00	7. 00	8. 00	9. 00	10.00	
	PART I - STATISTICAL DATA						
1.00	Hospital Adults & Peds. (columns 5, 6, 7 and	273	15	585	5		1.00
	8 exclude Swing Bed, Observation Bed and						
	Hospice days)(see instructions for col. 2						
	for the portion of LDP room available beds)						
2. 00	HMO and other (see instructions)	0	27				2. 00
3.00	HMO IPF Subprovider	0	0				3.00
4.00	HMO I RF Subprovi der	0	0				4.00
5.00	Hospital Adults & Peds. Swing Bed SNF	0	0	C			5.00
6.00	Hospital Adults & Peds. Swing Bed NF	272	0	C			6.00
7. 00	Total Adults and Peds. (exclude observation	273	15	585)		7. 00
8. 00	beds) (see instructions) INTENSIVE CARE UNIT	7	o	21			8. 00
9. 00	CORONARY CARE UNIT	'	ď	21			9.00
10.00	BURN INTENSIVE CARE UNIT						10.00
11. 00	SURGICAL INTENSIVE CARE UNIT						11. 00
12.00	OTHER SPECIAL CARE (SPECIFY)						12.00
13.00	NURSERY						13.00
14. 00	Total (see instructions)	280	15	606	0. 00	157. 12	14. 00
15. 00	CAH visits	0	o	C)		15. 00
15. 10	REH hours and visits						15. 10
16.00	SUBPROVI DER - I PF						16.00
17.00	SUBPROVI DER - I RF						17. 00
18.00	SUBPROVI DER						18. 00
19.00	SKILLED NURSING FACILITY	767	0	2, 088	0.00	4. 84	19. 00
20.00	NURSING FACILITY						20.00
21.00	OTHER LONG TERM CARE			3, 666	0. 00	8. 49	21. 00
22.00	HOME HEALTH AGENCY						22. 00
23.00	AMBULATORY SURGICAL CENTER (D. P.)						23. 00
24.00	HOSPI CE						24. 00
24. 10	HOSPICE (non-distinct part)			C)		24. 10
25. 00	CMHC - CMHC	_	_	_			25. 00
25. 10	CMHC - CORF	0	0	C	0. 00	0. 00	25. 10
26.00	RURAL HEALTH CLINIC				0.00	0.00	26. 00
26. 25	FEDERALLY QUALIFIED HEALTH CENTER	0	0	C		0.00	26. 25
27. 00	Total (sum of lines 14-26)		4	27/	0. 00	170. 45	27. 00
28.00	Observation Bed Days Ambulance Trips	o	4	276)		28. 00 29. 00
29. 00 30. 00	Employee discount days (see instruction)	٩		C			30.00
31.00	Employee discount days (see Histruction)						31.00
32. 00	Labor & delivery days (see instructions)	0	0				32.00
32. 00	Total ancillary labor & delivery room	٩	ď				32. 00
JZ. U1	outpatient days (see instructions)						32.01
33. 00	LTCH non-covered days	0					33. 00
33. 01	LTCH site neutral days and discharges	o o	İ				33. 01
	Temporary Expansi on COVI D-19 PHE Acute Care	Ö	o	C			34. 00
					•	•	•

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA

| Period: | Worksheet S-3 | From 07/01/2022 | Part | To 06/30/2023 | Date/Time Prepared:

					00/30/2023	11/28/2023 5:0	
		Full Time Equivalents		Di sch	arges		•
	Component	Nonpai d Workers	Title V	Title XVIII	Title XIX	Total All Patients	
		11. 00	12.00	13.00	14.00	15. 00	
	PART I - STATISTICAL DATA						
1. 00	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)		0	93	5	212	1. 00
2.00	HMO and other (see instructions)			l o	o		2. 00
3.00	HMO IPF Subprovider				o		3. 00
4.00	HMO IRF Subprovider				o		4.00
5.00	Hospital Adults & Peds. Swing Bed SNF						5. 00
6.00	Hospital Adults & Peds. Swing Bed NF						6. 00
7. 00	Total Adults and Peds. (exclude observation						7. 00
	beds) (see instructions)						
8.00	INTENSIVE CARE UNIT						8. 00
9.00	CORONARY CARE UNIT						9. 00
10.00	BURN INTENSIVE CARE UNIT						10.00
11.00	SURGICAL INTENSIVE CARE UNIT						11.00
12.00	OTHER SPECIAL CARE (SPECIFY)						12.00
13.00	NURSERY						13.00
14.00	Total (see instructions)	0.00	0	93	5	212	14.00
15.00	CAH visits						15.00
15. 10	REH hours and visits						15. 10
16.00	SUBPROVI DER - I PF						16.00
17.00	SUBPROVI DER - I RF						17.00
18.00	SUBPROVI DER						18.00
19.00	SKILLED NURSING FACILITY	0.00					19.00
20.00	NURSING FACILITY						20.00
21.00	OTHER LONG TERM CARE	0.00				136	
22.00	HOME HEALTH AGENCY						22. 00
23. 00	AMBULATORY SURGICAL CENTER (D. P.)						23. 00
24.00	HOSPI CE						24. 00
24. 10	HOSPICE (non-distinct part)						24. 10
25.00	CMHC - CMHC						25. 00
25. 10	CMHC - CORF	0. 00					25. 10
26.00	RURAL HEALTH CLINIC						26. 00
26. 25	FEDERALLY QUALIFIED HEALTH CENTER	0.00					26. 25
27.00	Total (sum of lines 14-26)	0.00					27. 00
28.00	Observation Bed Days						28. 00
29.00	Ambulance Trips						29. 00
30.00	Employee discount days (see instruction)						30.00
31.00	Employee discount days - IRF						31.00
32.00	Labor & delivery days (see instructions)						32.00
32. 01	Total ancillary labor & delivery room						32. 01
22 00	outpatient days (see instructions)						33. 00
	LTCH non-covered days LTCH site neutral days and discharges			0			33. 00
	Temporary Expansion COVID-19 PHE Acute Care			١			34. 00
34.00	Transporter y Expansion Covid-19 The Acute Care	ı I		ı	I		34.00

	Financial Systems HARVARD MEMORIAL HO		1225		u of Form CMS-2	
10SPI	TAL UNCOMPENSATED AND INDIGENT CARE DATA	rovider CCN: 14-		Period: From 07/01/2022	Worksheet S-1	U
				To 06/30/2023	Date/Time Pre 11/28/2023 5:	pared: 06 pm
					1. 00	
	Uncompensated and indigent care cost computation					
. 00	Cost to charge ratio (Worksheet C, Part I line 202 column 3 divi	ded by line 20	2 column	8)	0. 339320	1.0
	Medicaid (see instructions for each line)					1
2. 00	Net revenue from Medicaid				2, 623, 236	
. 00	Did you receive DSH or supplemental payments from Medicaid?			0	Y	3.0
. 00	If line 3 is yes, does line 2 include all DSH and/or supplementa		т меагса	11 0 ?	N 1 FE1 0F2	4. (
. 00	If line 4 is no, then enter DSH and/or supplemental payments from Medicaid charges	medical d			1, 551, 852 13, 198, 570	
. 00	Medicaid cost (line 1 times line 6)	4, 478, 539	1			
. 00	Difference between net revenue and costs for Medicaid program (I	es 2 and 5: if	303, 451	1		
	<pre>< zero then enter zero)</pre>				222, 121	
	Children's Health Insurance Program (CHIP) (see instructions for	each line)				1
. 00	Net revenue from stand-alone CHIP				0	
0.00	,				0	
1.00	Stand-alone CHIP cost (line 1 times line 10)			6	0	11. (
2. 00	Difference between net revenue and costs for stand-alone CHIP (I enter zero)	ine ii minus i	ine 9; i	r < zero then	0	12. (
	Other state or local government indigent care program (see instr	ructions for ea	ch line)			
3. 00	Net revenue from state or local indigent care program (Not inclu				0	13.
4. 00	Charges for patients covered under state or local indigent care				0	
	10)	1 3 4 (44				
5. 00	State or local indigent care program cost (line 1 times line 14)				0	15.
6. 00	Difference between net revenue and costs for state or local indi 13; if < zero then enter zero)	gent care prog	ram (lin	e 15 minus line	0	16.
	Grants, donations and total unreimbursed cost for Medicaid, CHIF instructions for each line)	and state/loc	al indig	ent care progra	ms (see	
7 00	Private grants, donations, or endowment income restricted to fur	nding charity c	are		0	17. (
	Government grants, appropriations or transfers for support of ho				14, 938	1
9. 00	Total unreimbursed cost for Medicaid , CHIP and state and local			(sum of lines	303, 451	19. (
	8, 12 and 16)	Uni	nsured	Insured	Total (col. 1	
			tients	patients	+ col . 2)	
			1. 00	2. 00	3. 00	
	Uncompensated Care (see instructions for each line)					
0.00	Charity care charges and uninsured discounts for the entire faci (see instructions)	lity	809, 18	3 192, 367	1, 001, 550	20. (
1. 00	Cost of patients approved for charity care and uninsured discour	nts (see	274, 57	2 192, 367	466, 939	21.
	instructions)				,	
2. 00	Payments received from patients for amounts previously written of	off as	(0 0	0	22.
	charity care					
3. 00	Cost of charity care (line 21 minus line 22)		274, 57	2 192, 367	466, 939	23.
					1 00	
4. 00	Does the amount on line 20 column 2, include charges for patient	days heyond a	Length	of stay limit	1. 00 N	24. (
+. 00	imposed on patients covered by Medicaid or other indigent care p		rengtii	or stay iriii t	IV	24. (
5. 00	If line 24 is yes, enter the charges for patient days beyond the	0	program	's length of	0	25.
5. 00	stay limit Total bad debt expense for the entire hospital complex (see inst	tructions)			2, 540, 845	26.
7. 00	Medicare reimbursable bad debts for the entire hospital complex		ons)		320, 415	1
7. 01	Medicare allowable bad debts for the entire hospital complex (se	•			492, 947	1
	Non-Medicare bad debt expense (see instructions)		•		2, 047, 898	1
						1
8.00	Cost of non-Medicare and non-reimbursable Medicare bad debt expe	ense (see instr	uctions)		867, 425	29. (
28. 00 29. 00 30. 00		ense (see instr	uctions)		867, 425 1, 334, 364	

Hoal th	Financial Systems	HARVARD MEMORIA	I LICOUL I		Inlio	u of Form CMS-2	2552 10
	SSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF		Provi der C	F	reriod: from 07/01/2022 o 06/30/2023	Worksheet A Date/Time Pre	pared:
	Cost Center Description	Sal ari es	Other	Total (col. 1 + col. 2)	Reclassificati ons (See A-6)	11/28/2023 5: Reclassified Trial Balance (col. 3 +-	06 pm
		1.00	2. 00	3.00	4. 00	col . 4) 5.00	
	GENERAL SERVICE COST CENTERS						
1.00	00100 CAP REL COSTS-BLDG & FLXT		0	C	1, 091, 043	1, 091, 043	1.00
2.00	00200 CAP REL COSTS-MVBLE EQUIP		1, 872, 592	1, 872, 592	-1, 091, 043	781, 549	2.00
3.00	00300 OTHER CAP REL COSTS		0	0	0	0	3.00
4.00	00400 EMPLOYEE BENEFITS DEPARTMENT	0	1, 613, 925	1, 613, 925	0	1, 613, 925	4.00
5.00	00500 ADMINISTRATIVE & GENERAL	1, 003, 762	2, 363, 338	3, 367, 100	-537, 227	2, 829, 873	5.00
6.00	00600 MAINTENANCE & REPAIRS	0	0	0	0	0	6. 00
7.00	00700 OPERATION OF PLANT	0	669, 504	669, 504	-31, 996	637, 508	7.00
8.00	00800 LAUNDRY & LI NEN SERVI CE	0	86, 325			86, 325	1
9.00	00900 HOUSEKEEPI NG	190, 104	284, 247			474, 351	9. 00
10.00	01000 DI ETARY	504, 866	192, 113	696, 979	0	696, 979	1
11. 00	01100 CAFETERI A	0	0	0	0	0	1
12.00	01200 MAINTENANCE OF PERSONNEL	0	0	0		0	
13.00	01300 NURSING ADMINISTRATION	1, 119, 399	98, 676	1, 218, 075	152, 556	1, 370, 631	1
14.00	01400 CENTRAL SERVICES & SUPPLY	0	0	0	0	0	14.00
	01500 PHARMACY	0	0	0	9	0	
16.00	01600 MEDI CAL RECORDS & LI BRARY	139, 118	10, 506	149, 624	0	149, 624	1
	01700 SOCI AL SERVI CE	0	0	0	0	0	
19.00	01900 NONPHYSI CI AN ANESTHETI STS	0	0	0	0	0	
20.00	02000 NURSI NG PROGRAM	0	0	0	0	0	
21.00	02100 I &R SERVI CES-SALARY & FRI NGES APPRV	0	0	0	0	0	
22.00	02200 I &R SERVICES-OTHER PRGM COSTS APPRV	0	0		0	0	22. 00
23. 00	02300 PARAMED ED PRGM-(SPECIFY)	0	0	0	U	0	23. 00
30.00	I NPATI ENT ROUTI NE SERVI CE COST CENTERS 03000 ADULTS & PEDI ATRI CS	972, 982	166, 255	1, 139, 237	-17, 668	1, 121, 569	30.00
31.00	03100 INTENSIVE CARE UNIT	154, 402	63, 266			217, 668	1
44. 00	04400 SKILLED NURSING FACILITY	134, 402	03, 200			487, 192	
	04600 OTHER LONG TERM CARE	1, 574, 409	455, 618	1		798, 155	
10.00	ANCILLARY SERVICE COST CENTERS	1, 0, 1, 10,	1007010	2,000,02.	1/201/072	7707100	10.00
50.00	05000 OPERATI NG ROOM	1, 176, 348	1, 818, 540	2, 994, 888	-1, 165, 167	1, 829, 721	50.00
51.00	05100 RECOVERY ROOM	998, 373	186, 827			1, 185, 200	1
53.00	05300 ANESTHESI OLOGY	8, 265	1, 771, 555			1, 779, 820	
54.00	05400 RADI OLOGY-DI AGNOSTI C	828, 564	166, 982			982, 820	1
60.00	06000 LABORATORY	627, 812	171, 323			951, 688	1
60.01	06001 BLOOD LABORATORY	0	0			0	1
62.30	06250 BLOOD CLOTTING FOR HEMOPHILIACS	O	0	0	0	0	62. 30
65.00	06500 RESPIRATORY THERAPY	15, 691	22, 455	38, 146	3, 569	41, 715	65.00
66.00	06600 PHYSI CAL THERAPY	185, 983	18, 853	204, 836		491, 075	66.00
	06700 OCCUPATI ONAL THERAPY	0	0	O	0.2,2	312, 211	
68.00	06800 SPEECH PATHOLOGY	0	0	0	24, 496	24, 496	68. 00
	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	54, 884	18, 926	73, 810			1
	07200 IMPL. DEV. CHARGED TO PATIENTS	0	0	0	,	455, 867	1
	07300 DRUGS CHARGED TO PATIENTS	216, 932	717, 989				1
	07697 CARDI AC REHABI LI TATI ON	5, 810	12, 683			44, 614	
	07698 HYPERBARI C OXYGEN THERAPY	0	0	•		0	
76. 99	07699 LI THOTRI PSY	0	0	0	0	0	76. 99
04.05	OUTPATIENT SERVICE COST CENTERS	4 400 505	0.054.5:5	1 4 255 211	1 22 ==:1	4 004 0:=	04 55
	09100 EMERGENCY	1, 100, 599	2, 954, 562	4, 055, 161	-33, 796	4, 021, 365	
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART						92.00
00 10	OTHER REIMBURSABLE COST CENTERS	٥		1 0			00 10
99. 10	O9910 CORF SPECIAL PURPOSE COST CENTERS	0	0	0	0	0	99. 10
118. 00		10, 878, 303	15, 737, 060	26, 615, 363	0	26, 615, 363	118 00
110.00	NONREI MBURSABLE COST CENTERS	10, 070, 303	13, 737, 000	20,010,303	·I U	20, 010, 303	1. 10. 00
192 00	19200 PHYSICIANS PRIVATE OFFICES	0	0		0	0	192. 00
200.00	1 1	10, 878, 303	15, 737, 060				
	, , , , , , , , , , , , , , , , , , ,	.,	., .,,.,,	, ,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,	, ,	., ,	

Health Financial Systems	HARVARD MEMOR	I AL HOSPI TAL		In Lieu	of Form CMS-2552-10
RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE O		Provi der CC	N: 14-1335	Peri od:	Worksheet A
				From 07/01/2022	Data (T)
				To 06/30/2023	Date/Time Prepared: 11/28/2023 5:06 pm
Cost Center Description	Adjustments	Net Expenses		<u> </u>	1172072023 3.00 piii
oost center beserretten	(See A-8)	For Allocation			
	6.00	7. 00			
GENERAL SERVICE COST CENTERS					
1. 00 O0100 CAP REL COSTS-BLDG & FLXT	C	1, 091, 043			1.00
2.00 00200 CAP REL COSTS-MVBLE EQUIP	-3, 641	1			2. 00
3.00 00300 OTHER CAP REL COSTS	C	o			3. 00
4.00 00400 EMPLOYEE BENEFITS DEPARTMENT	95, 903	1, 709, 828			4.00
5. 00 00500 ADMINISTRATIVE & GENERAL	1, 620, 526	1 1			5. 00
6. 00 00600 MAINTENANCE & REPAIRS	0	0			6. 00
7.00 00700 OPERATION OF PLANT	689, 300	1, 326, 808			7. 00
8.00 00800 LAUNDRY & LINEN SERVICE	0				8.00
9. 00 00900 HOUSEKEEPI NG					9.00
10. 00 01000 DI ETARY	-115, 540	1			10.00
11. 00 01100 CAFETERI A	1.0,010	0			11. 00
12. 00 01200 MAINTENANCE OF PERSONNEL					12. 00
13. 00 01300 NURSI NG ADMI NI STRATI ON	18, 138				13. 00
14. 00 01400 CENTRAL SERVICES & SUPPLY	10, 100	1			14. 00
15. 00 01500 PHARMACY					15. 00
16. 00 01600 MEDI CAL RECORDS & LI BRARY	20, 348	1			16. 00
17. 00 01700 SOCI AL SERVI CE	20, 010	1			17. 00
19. 00 01900 NONPHYSI CLAN ANESTHETI STS		1			19.00
20. 00 02000 NURSI NG PROGRAM					20.00
21. 00 02100 &R SERVICES-SALARY & FRINGES APPRV					21. 00
22. 00 02200 1&R SERVICES-OTHER PRGM COSTS APPRV					22.00
23. 00 02300 PARAMED ED PRGM- (SPECIFY)		1			23. 00
I NPATI ENT ROUTI NE SERVI CE COST CENTERS		0			23.00
30. 00 03000 ADULTS & PEDIATRICS	С	1 121 560			30.00
31. 00 03100 NTENSI VE CARE UNI T		1 1			31.00
		,			
44.00 04400 SKILLED NURSING FACILITY	6, 000	1			44.00
46.00 O4600 OTHER LONG TERM CARE		798, 155			46. 00
ANCILLARY SERVICE COST CENTERS 50.00 OPERATING ROOM	C	1, 829, 721			50.00
51. 00 05100 RECOVERY ROOM					51.00
53. 00 05300 ANESTHESI OLOGY	-1, 706, 171	1			53.00
54. 00 05400 RADI OLOGY - DI AGNOSTI C	-1, 700, 171	982, 820			54.00
60. 00 06000 LABORATORY		1			60.00
60. 01 06000 LABORATORY		951,000			60.00
62. 30 06250 BLOOD CLOTTING FOR HEMOPHILIACS					62. 30
65. 00 06500 RESPIRATORY THERAPY					65.00
66. 00 06600 PHYSI CAL THERAPY		41, 715			66.00
67. 00 06700 OCCUPATI ONAL THERAPY		491, 075			67.00
68. 00 06800 SPEECH PATHOLOGY					
	-	= ", " " "			68.00
71. 00 07100 MEDI CAL SUPPLI ES CHARGED TO PATI ENT	103, 853	1			71.00
72.00 O7200 IMPL. DEV. CHARGED TO PATIENTS 73.00 O7300 DRUGS CHARGED TO PATIENTS	40, 181				72. 00 73. 00
	130, 613	1			
76. 97 O7697 CARDI AC REHABI LI TATI ON	C				76. 97
76. 98 07698 HYPERBARI C OXYGEN THERAPY	C				76. 98
76. 99 07699 LI THOTRI PSY	C	0			76. 99
OUTPATIENT SERVICE COST CENTERS	F0/ 240	2 425 025			01.00
91. 00 09100 EMERGENCY	-596, 340	3, 425, 025			91.00
92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART					92. 00
OTHER REIMBURSABLE COST CENTERS		.1			
99. 10 09910 CORF	C	0			99. 10
SPECIAL PURPOSE COST CENTERS					
118. 00 SUBTOTALS (SUM OF LINES 1 through 117)	303, 170	26, 918, 533			118. 00
NONREI MBURSABLE COST CENTERS					
192. 00 19200 PHYSI CLANS PRI VATE OFFI CES	C	1			192. 00
200.00 TOTAL (SUM OF LINES 118 through 199)	303, 170	26, 918, 533			200. 00

Peri od: Worksheet A-6 From 07/01/2022 To 06/30/2023 Date/Ti me Prepared: 11/28/2023 5:06 pm

						11/28/2023 5:06 pt	m_
		Increases					
	Cost Center	Li ne #	Sal ary	0ther			
	2.00	3.00	4. 00	5. 00			
	A - SNF/LONG TERM CARE EXP RE		274 247	445 005			
1. 00	SKI LLED NURSI NG FACI LI TY	4400	371, 267	11 <u>5, 9</u> 25		1.	00
	TOTALS		371, 267	115, 925			
	B - IMPLANTABLE DEVICES		-1				
1. 00	I MPL. DEV. CHARGED TO	72. 00	0	455, 867		1.	00
	PATIENTS	+		<u></u>			
	TOTALS		0	455, 867			
4 00	C - MANAGER/DIRECTOR RECLASS	40.00	440.047	10.010			00
1.00	NURSI NG ADMI NI STRATI ON	13. 00	142, 316	10, 240		•	00
2.00	OTHER LONG TERM CARE	46. 00	183, 556	13, 207		•	00
3.00	OPERATING ROOM	50. 00	21, 034	0		•	00
4.00	LABORATORY	60.00	116, 026	8, 348		•	00
5.00	RESPIRATORY THERAPY	65. 00	3, 961	303		•	00
6.00	CARDI AC REHABI LI TATI ON	76. 97	24, 368	1, 753			00
7. 00	EMERGENCY	91.00	12, 115	0		7.	00
	TOTALS		503, 376	33, 851			
	D - INTERCOMPANY TRANSACTIONS						
1.00	EMPLOYEE BENEFITS DEPARTMENT	4. 00	58, 293	0			00
2.00	ADMINISTRATIVE & GENERAL	5. 00	407, 731	0		•	00
3.00	OPERATION OF PLANT	7. 00	165, 240	0		•	00
4.00	INTENSIVE CARE UNIT	31. 00	3, 249	0		•	00
5.00	OTHER LONG TERM CARE	46. 00	3, 083	0			00
6. 00	OPERATING ROOM	50. 00	0	8, 435			00
7. 00	RECOVERY ROOM	51. 00	337	0			00
8.00	RADI OLOGY-DI AGNOSTI C	54. 00	9, 293	0			00
9.00	RESPI RATORY THERAPY	65. 00	4, 589	0			00
10.00	DRUGS CHARGED TO PATIENTS	73. 00	86, 419	0		10.	
11. 00	CARDIAC REHABILITATION	<u>76.</u> 97	<u>9, 8</u> 76	0		11.	00
	TOTALS		748, 110	8, 435			
	E - SNF AND LTC RECLASS						
1. 00	RADI OLOGY-DI AGNOSTI C	54. 00	7, 981	2, 492			00
2. 00	LABORATORY	60. 00	21, 474	6, 705			00
3. 00	RESPI RATORY THERAPY	65. 00	598	187			00
4.00	PHYSI CAL THERAPY	66. 00	218, 169	68, 122		•	00
5. 00	OCCUPATI ONAL THERAPY	67. 00	237, 922	74, 289		•	00
6. 00	SPEECH PATHOLOGY	68. 00	18, 667	5, 829			00
7. 00	MEDICAL SUPPLIES CHARGED TO	71. 00	59, 943	18, 717		7.	00
	PATI ENT						
8. 00	DRUGS CHARGED TO PATIENTS	7300	15 <u>2, 6</u> 76	<u>47, 6</u> 72		8.	00
	TOTALS		717, 430	224, 013			
	F - DEPRECIATION	1					
1. 00	CAP REL COSTS-BLDG & FIXT	1. 00	0	1, 091, 043			00
2.00		0.00		0		2.	00
	TOTALS		0	1, 091, 043			
	G - LOCUM SALARY RECLASS			. 1			
1. 00	ANESTHESI OLOGY	53. 00	1, 455, 225	0			00
2. 00	EMERGENCY	91.00	<u>1, 712, 015</u>	0		2.	00
	TOTALS		3, 167, 240	0			
	H - MEDICAL SUPPLIES CHARGED						
1. 00	MEDICAL SUPPLIES CHARGED TO	71. 00	0	850, 640		1.	00
	PATI ENT						
2.00		0. 00	0	0		•	00
3.00		0. 00	0	0			00
4.00		0. 00	0	0			00
5. 00		0. 00	0	0			00
6.00		0.00	•	0		6.	00
	TOTALS		0	850, 640			
	I - BIOMEDICAL						
1. 00	OPERATING ROOM	50. 00	0	6, 930		•	00
2.00	RADI OLOGY-DI AGNOSTI C	54. 00	•	2 <u>5, 0</u> 66		2.	00
	TOTALS		0	31, 996			
500. 00	Grand Total: Increases		5, 507, 423	2, 811, 770		500.	00

						11/28/2023 5	o:06 p
		Decreases					
	Cost Center	Li ne #	Sal ary		Wkst. A-7 Ref.		
	6. 00	7. 00	8. 00	9. 00	10. 00		
	A - SNF/LONG TERM CARE EXP RE	CLASS					
00	OTHER LONG TERM CARE	4600	37 <u>1, 2</u> 67	11 <u>5, 9</u> 25	0		1.
	TOTALS		371, 267	115, 925			
	B - IMPLANTABLE DEVICES						
00	OPERATING ROOM	50. 00	0	455, 867	0		1.
	TOTALS	T		455, 867			
	C - MANAGER/DIRECTOR RECLASS	•		,	•		
00	ADMINISTRATIVE & GENERAL	5. 00	503, 376	33, 851	0		7 1.
00		0. 00	0	0	O		2.
0		0. 00	ol	0	0		3.
0		0. 00	o	0	0		4.
0		0. 00	ol	0	0		5
0		0. 00	o l	0	0		6.
0		0. 00	o o	0	o		7
0	TOTALS — — — —	<u> </u>	503, 376	33, 851			'
	D - INTERCOMPANY TRANSACTIONS	<u> </u>	303, 370	33, 031			-
0	EMPLOYEE BENEFITS DEPARTMENT	4. 00	0	58, 293	0		1.
0	ADMINISTRATIVE & GENERAL	5. 00	0		0		2
			O O	407, 731	0		
0 0	OPERATION OF PLANT INTENSIVE CARE UNIT	7. 00 31. 00	O	165, 240 3, 249	0		3
		1	U		0		4
0	OTHER LONG TERM CARE	46. 00	0 405	3, 083	0		5
0	OPERATING ROOM	50. 00	8, 435	0	0		6
0	RECOVERY ROOM	51. 00	0	337	0		7
0	RADI OLOGY-DI AGNOSTI C	54. 00	0	9, 293	0		8
0	RESPI RATORY THERAPY	65. 00	0	4, 589	0		9
00	DRUGS CHARGED TO PATIENTS	73. 00	0	86, 419	0		10
00	CARDIAC REHABILITATION	<u>76.</u> 97	•	<u>9, 8</u> 76	0		11
	TOTALS		8, 435	748, 110			
	E - SNF AND LTC RECLASS						
0	OTHER LONG TERM CARE	46. 00	717, 430	224, 013	0		1.
0		0. 00	0	0	0		2
0		0. 00	0	0	0		3
0		0. 00	0	0	0		4
0		0. 00	0	0	0		5
0		0. 00	0	0	0		6
0		0. 00	0	0	0		7
0		0. 00	0	0	0		8
	TOTALS						
		l	717, 430	224, 013			
	F - DEPRECIATION		717, 430	224, 013			
0	F - DEPRECIATION CAP REL COSTS-MVBLE EQUIP	2. 00	717, 430	224, 013 1, 091, 043	9		1
		2. 00 0. 00			9 9		- 1
			0				- 1
	CAP REL COSTS-MVBLE EQUIP TOTALS		0	1, 091, 043			- 1
)	CAP REL COSTS-MVBLE EQUIP TOTALS G - LOCUM SALARY RECLASS	0.00	0 0	1, 091, 043 0 1, 091, 043	9		2
0	CAP REL COSTS-MVBLE EQUIP TOTALS G - LOCUM SALARY RECLASS ANESTHESI OLOGY	53. 00	0 0	1, 091, 043 0 1, 091, 043 1, 455, 225	9		2
0	CAP REL COSTS-MVBLE EQUIP TOTALS G - LOCUM SALARY RECLASS ANESTHESI OLOGY EMERGENCY	0.00	0 0	1, 091, 043 0 1, 091, 043 1, 455, 225 1, 712, 015	9		2
0	CAP REL COSTS-MVBLE EQUIP TOTALS G - LOCUM SALARY RECLASS ANESTHESI OLOGY EMERGENCY TOTALS	53. 00 91. 00	0 0	1, 091, 043 0 1, 091, 043 1, 455, 225	9		2
0	CAP REL COSTS-MVBLE EQUIP TOTALS G - LOCUM SALARY RECLASS ANESTHESI OLOGY EMERGENCY TOTALS H - MEDI CAL SUPPLIES CHARGED	53. 00 91. 00	0 0 0	1, 091, 043 0 1, 091, 043 1, 455, 225 1, 712, 015 3, 167, 240	0 0		1 2
0	CAP REL COSTS-MVBLE EQUIP TOTALS G - LOCUM SALARY RECLASS ANESTHESI OLOGY EMERGENCY TOTALS H - MEDI CAL SUPPLIES CHARGED ADULTS & PEDI ATRI CS	53. 00 91. 00 TO PATIENT 30. 00	0 0 0 0 0	1, 091, 043 0 1, 091, 043 1, 455, 225 1, 712, 015 3, 167, 240 17, 668	0 0		1 2
	CAP REL COSTS-MVBLE EQUIP TOTALS G - LOCUM SALARY RECLASS ANESTHESI OLOGY EMERGENCY TOTALS H - MEDI CAL SUPPLIES CHARGED ADULTS & PEDI ATRI CS OPERATI NG ROOM	53. 00 91. 00 TO PATIENT 30. 00 50. 00	0 0 0 0 0 0	1, 091, 043 0 1, 091, 043 1, 455, 225 1, 712, 015 3, 167, 240 17, 668 737, 264	0 0		1 2
	CAP REL COSTS-MVBLE EQUIP TOTALS G - LOCUM SALARY RECLASS ANESTHESI OLOGY EMERGENCY TOTALS H - MEDI CAL SUPPLIES CHARGED ADULTS & PEDI ATRI CS OPERATI NG ROOM RADI OLOGY-DI AGNOSTI C	53. 00 91. 00 TO PATI ENT 30. 00 50. 00 54. 00	0 0 0 0 0 0 0	1, 091, 043 0 1, 091, 043 1, 455, 225 1, 712, 015 3, 167, 240 17, 668 737, 264 48, 265	0 0		1 2 1 2 1 2 3
	CAP REL COSTS-MVBLE EQUIP TOTALS G - LOCUM SALARY RECLASS ANESTHESI OLOGY EMERGENCY TOTALS H - MEDI CAL SUPPLIES CHARGED ADULTS & PEDI ATRI CS OPERATI NG ROOM RADI OLOGY-DI AGNOSTI C RESPI RATORY THERAPY	53. 00 91. 00 TO PATIENT 30. 00 50. 00 54. 00 65. 00	0 0 0 0 0 0	1, 091, 043 0 1, 091, 043 1, 455, 225 1, 712, 015 3, 167, 240 17, 668 737, 264 48, 265 1, 480	0 0 0		1 2 1 2 3 4
	CAP REL COSTS-MVBLE EQUIP TOTALS G - LOCUM SALARY RECLASS ANESTHESI OLOGY EMERGENCY TOTALS H - MEDICAL SUPPLIES CHARGED ADULTS & PEDIATRICS OPERATING ROOM RADIOLOGY-DIAGNOSTIC RESPIRATORY THERAPY PHYSICAL THERAPY	53. 00 91. 00 TO PATI ENT 30. 00 50. 00 54. 00 65. 00 66. 00	0 0 0 0 0 0 0	1, 091, 043 0 1, 091, 043 1, 455, 225 1, 712, 015 3, 167, 240 17, 668 737, 264 48, 265 1, 480 52	0 0 0 0 0 0 0		1 2 1 2 3 4 5
	CAP REL COSTS-MVBLE EQUIP TOTALS G - LOCUM SALARY RECLASS ANESTHESI OLOGY EMERGENCY TOTALS H - MEDICAL SUPPLIES CHARGED ADULTS & PEDIATRICS OPERATING ROOM RADIOLOGY-DIAGNOSTIC RESPIRATORY THERAPY PHYSI CAL THERAPY EMERGENCY	53. 00 91. 00 TO PATIENT 30. 00 50. 00 54. 00 65. 00	0 0 0 0 0 0	1, 091, 043 0 1, 091, 043 1, 455, 225 1, 712, 015 3, 167, 240 17, 668 737, 264 48, 265 1, 480 52 45, 911	0 0 0		1 2 1 2 3 4 5
	CAP REL COSTS-MVBLE EQUIP TOTALS G - LOCUM SALARY RECLASS ANESTHESI OLOGY EMERGENCY TOTALS H - MEDI CAL SUPPLIES CHARGED ADULTS & PEDI ATRI CS OPERATI NG ROOM RADI OLOGY-DI AGNOSTI C RESPI RATORY THERAPY PHYSI CAL THERAPY EMERGENCY TOTALS	53. 00 91. 00 TO PATI ENT 30. 00 50. 00 54. 00 65. 00 66. 00	0 0 0 0 0 0	1, 091, 043 0 1, 091, 043 1, 455, 225 1, 712, 015 3, 167, 240 17, 668 737, 264 48, 265 1, 480 52	0 0 0 0 0 0 0		1 2 1 2 3 4 5
0)	CAP REL COSTS-MVBLE EQUIP TOTALS G - LOCUM SALARY RECLASS ANESTHESI OLOGY EMERGENCY TOTALS H - MEDI CAL SUPPLIES CHARGED ADULTS & PEDI ATRI CS OPERATI NG ROOM RADI OLOGY-DI AGNOSTI C RESPI RATORY THERAPY PHYSI CAL THERAPY EMERGENCY TOTALS I - BI OMEDI CAL	53. 00 91. 00 TO PATIENT 30. 00 50. 00 54. 00 65. 00 66. 00 91. 00	0 0 0 0 0 0 0 0 0 0 0	1, 091, 043 0 1, 091, 043 1, 455, 225 1, 712, 015 3, 167, 240 17, 668 737, 264 48, 265 1, 480 52 45, 911 850, 640	0 0 0 0 0 0 0		1 1 2 3 4 5 6
	CAP REL COSTS-MVBLE EQUIP TOTALS G - LOCUM SALARY RECLASS ANESTHESI OLOGY EMERGENCY TOTALS H - MEDI CAL SUPPLIES CHARGED ADULTS & PEDI ATRI CS OPERATI NG ROOM RADI OLOGY-DI AGNOSTI C RESPI RATORY THERAPY PHYSI CAL THERAPY EMERGENCY TOTALS	53. 00 91. 00 TO PATIENT 30. 00 50. 00 54. 00 65. 00 66. 00 91. 00	0 0 0 0 0 0	1, 091, 043 0 1, 091, 043 1, 455, 225 1, 712, 015 3, 167, 240 17, 668 737, 264 48, 265 1, 480 52 45, 911 850, 640 31, 996	0 0 0 0 0 0 0 0		1 2 1 2 3 4 5 6 6 1 1
000000000000000000000000000000000000000	CAP REL COSTS-MVBLE EQUIP TOTALS G - LOCUM SALARY RECLASS ANESTHESI OLOGY EMERGENCY TOTALS H - MEDI CAL SUPPLIES CHARGED ADULTS & PEDI ATRI CS OPERATI NG ROOM RADI OLOGY-DI AGNOSTI C RESPI RATORY THERAPY PHYSI CAL THERAPY EMERGENCY TOTALS I - BI OMEDI CAL	53. 00 91. 00 TO PATIENT 30. 00 50. 00 54. 00 65. 00 66. 00 91. 00	0 0 0 0 0 0 0 0 0 0 0	1, 091, 043 0 1, 091, 043 1, 455, 225 1, 712, 015 3, 167, 240 17, 668 737, 264 48, 265 1, 480 52 45, 911 850, 640	0 0 0 0 0 0 0		1. 2. 1. 2. 3. 4. 5. 6. 1. 2.

				1	To 06/30/2023	Date/Time Pre 11/28/2023 5:	pared: 06 pm
	·			Acqui si ti ons		1172072020 0.	DO PIII
		Beginning	Purchases	Donati on	Total	Disposals and	
		Bal ances				Retirements	
		1.00	2. 00	3. 00	4. 00	5. 00	
	PART I - ANALYSIS OF CHANGES IN CAPITAL ASSE						
1.00	Land	222, 604	0	(0	0	1. 00
2.00	Land Improvements	883, 085	6, 480	(6, 480	0	2. 00
3.00	Buildings and Fixtures	0	0	(0	0	3. 00
4.00	Building Improvements	22, 895, 287	45, 537	(45, 537	0	4. 00
5. 00	Fi xed Equi pment	0	0	(0	0	5.00
6.00	Movable Equipment	19, 433, 152	432, 909	(432, 909	0	6. 00
7. 00	HIT designated Assets	0	0	(0	0	7. 00
8.00	Subtotal (sum of lines 1-7)	43, 434, 128	484, 926	(484, 926	0	8. 00
9.00	Reconciling Items	0	0	(0	0	9. 00
10.00	Total (line 8 minus line 9)	43, 434, 128	484, 926	(484, 926	0	10.00
		Endi ng Bal ance	Fully				
			Depreci ated				
			Assets				
	DART I ANALYSIS OF SUMMED IN SARITAL ASSE	6.00	7. 00				
	PART I - ANALYSIS OF CHANGES IN CAPITAL ASSE						
1.00	Land	222, 604	0				1.00
2.00	Land Improvements	889, 565	0				2.00
3.00	Buildings and Fixtures	0 040 004	0				3.00
4.00	Building Improvements	22, 940, 824	0				4.00
5.00	Fixed Equipment	10.0(/.0/1	0				5.00
6.00	Movable Equipment	19, 866, 061	0				6.00
7.00	HIT designated Assets	42 010 054	0				7.00
8. 00 9. 00	Subtotal (sum of lines 1-7)	43, 919, 054	0				8. 00 9. 00
	Reconciling Items	42 010 054	0				
10.00	Total (line 8 minus line 9)	43, 919, 054	0	l			10.00

Health Financial Systems	HARVARD MEMORIA	AL HOSPITAL		In Lie	u of Form CMS-2	2552-10
RECONCILIATION OF CAPITAL COSTS CENTERS		Provi der CC		Period: From 07/01/2022 To 06/30/2023		pared:
		SU	JMMARY OF CAPI	TAL	11/26/2023 5.	оо рііі
Cost Center Description	Depreci ati on	Lease	Interest	Insurance (see instructions)		
	9.00	10.00	11. 00	12.00	13. 00	
PART II - RECONCILIATION OF AMOUNTS FRO	OM WORKSHEET A, COLUMN	N 2, LINES 1 a	and 2			
1.00 CAP REL COSTS-BLDG & FIXT	0	0	(0	0	1.00
2.00 CAP REL COSTS-MVBLE EQUIP	1, 606, 369	0	266, 223	3 0	0	2.00
3.00 Total (sum of lines 1-2)	1, 606, 369	0	266, 223	0	0	3.00
	SUMMARY OF	CAPI TAL				
Cost Center Description	Other To	otal (1) (sum				
	Capi tal -Rel ate	of cols. 9				
		through 14)				
	instructions)	,				
	14. 00	15. 00				
PART II - RECONCILIATION OF AMOUNTS FRO	OM WORKSHEET A, COLUMN	V 2, LINES 1 a	and 2			
1. 00 CAP REL COSTS-BLDG & FLXT	0	0				1.00
2.00 CAP REL COSTS-MVBLE EQUIP	lo	1, 872, 592				2.00
3.00 Total (sum of lines 1-2)	o	1, 872, 592				3. 00

Health Financial Systems	HARVARD MEMOR	I AL HOSPI TAL		In Lie	u of Form CMS-2	<u> 2552-10</u>
RECONCILIATION OF CAPITAL COSTS CENTERS		Provi der C		Period: From 07/01/2022 To 06/30/2023		pared:
	COM	PUTATION OF RA	TIOS	ALLOCATION OF		,
Cost Center Description	Gross Assets	Capi tal i zed Leases	Gross Assets for Ratio	Ratio (see instructions)	Insurance	
		Leases	(col. 1 - col.			
	1.00	2.00	3.00	4. 00	5. 00	
PART III - RECONCILIATION OF CAPITAL COSTS C	ENTERS					
1.00 CAP REL COSTS-BLDG & FIXT	24, 052, 992	0	24, 052, 99	0. 547666	0	1.00
2. 00 CAP REL COSTS-MVBLE EQUIP	19, 866, 062		19, 866, 06		0	2.00
3.00 Total (sum of lines 1-2)	43, 919, 054		43, 919, 05		0	3. 00
	ALLOCA	TION OF OTHER (CAPI TAL	SUMMARY 0	F CAPITAL	
Cost Center Description	Taxes	0ther	Total (sum of	Depreciation	Lease	
		Capi tal -Rel ate				
		d Costs	through 7)			
DADT III DECONOLILATION OF CARLTH COOTS	6.00	7.00	8. 00	9. 00	10. 00	
PART III - RECONCILIATION OF CAPITAL COSTS C		J		4 004 040	0	4 00
1. 00 CAP REL COSTS-BLDG & FIXT	0	l ~		0 1, 091, 043		1.00
2. 00 CAP REL COSTS-MVBLE EQUIP	0	l ~	1	515, 326		2.00
3.00 Total (sum of lines 1-2)	0	·	JMMARY OF CAPI	1, 606, 369	0	3. 00
Cost Center Description	Interest	Insurance (see			Total (2) (sum	
		instructions)	instructions)	Capi tal -Rel ate		
				d Costs (see	through 14)	
	11.00	10.00	12.00	instructions)	15.00	
PART III - RECONCILIATION OF CAPITAL COSTS C	11.00	12.00	13.00	14. 00	15. 00	
1.00 CAP REL COSTS-BLDG & FIXT	ENTERS 0	0	1 (0 0	1, 091, 043	1.00
2. 00 CAP REL COSTS-BUBB & TTXT	262, 582		l .	0 0	777, 908	2.00
3.00 Total (sum of lines 1-2)	262, 582	•	l .	0 0		
5. 55 . 5 tal (5 tall 6) 1 11165 2)	202, 002	.1	1	9	1,000,701	0.00

				To	06/30/2023	Date/Time Prep 11/28/2023 5:0	
				Expense Classification on		11/20/2023 5.	Jo pili
				To/From Which the Amount is	to be Adjusted		
	Cost Center Description	Basis/Code (2) 1.00	Amount 2.00	Cost Center 3.00	Li ne # 4.00	Wkst. A-7 Ref. 5.00	
1. 00	Investment income - CAP REL	1.00		CAP REL COSTS-BLDG & FLXT	1.00	5.00	1. 00
2. 00	COSTS-BLDG & FIXT (chapter 2) Investment income - CAP REL	A	-3 641	CAP REL COSTS-MVBLE EQUIP	2. 00	11	2. 00
	COSTS-MVBLE EQUIP (chapter 2)						
3. 00	Investment income - other (chapter 2)		0		0. 00	0	3. 00
4. 00	Trade, quantity, and time discounts (chapter 8)		0		0. 00	0	4. 00
5. 00	Refunds and rebates of		0		0. 00	0	5. 00
6. 00	expenses (chapter 8) Rental of provider space by		0		0. 00	0	6. 00
7. 00	suppliers (chapter 8) Telephone services (pay		0		0. 00	0	7. 00
7.00	stations excluded) (chapter		0		0.00	Ŭ	7.00
8. 00	21) Tellevision and radio service (chapter 21)	A	-3, 069	OPERATION OF PLANT	7. 00	0	8. 00
9.00	Parking Lot (chapter 21)		0		0. 00	0	9. 00
10. 00	Provider-based physician adjustment	A-8-2	-2, 486, 329			0	10. 00
11. 00	Sale of scrap, waste, etc. (chapter 23)		0		0. 00	0	11. 00
12.00	Related organization	A-8-1	3, 805, 056			О	12. 00
13. 00	transactions (chapter 10) Laundry and Linen service		0		0. 00	o	13. 00
14. 00 15. 00	Cafeteria-employees and guests Rental of quarters to employee		-115, 540	DI ETARY	10. 00 0. 00	0	14. 00 15. 00
	and others		0				
16. 00	Sale of medical and surgical supplies to other than patients		0		0. 00	0	16. 00
17. 00	Sale of drugs to other than		0		0. 00	0	17. 00
18. 00	patients Sale of medical records and		0		0. 00	0	18. 00
19. 00	abstracts Nursing and allied health		0		0. 00	0	19. 00
	education (tuition, fees, books, etc.)						
20. 00 21. 00	Vending machines Income from imposition of		0		0. 00 0. 00	0	20. 00 21. 00
21.00	interest, finance or penalty		0		0.00	Ŭ	21.00
22. 00	charges (chapter 21) Interest expense on Medicare		0		0. 00	0	22. 00
	overpayments and borrowings to repay Medicare overpayments						
23. 00	Adjustment for respiratory therapy costs in excess of	A-8-3	0	RESPI RATORY THERAPY	65. 00		23. 00
24.00	limitation (chapter 14)	4.0.2	0	DUVCI CAL THEDADY	// 00		24.00
24. 00	Adjustment for physical therapy costs in excess of	A-8-3	Ü	PHYSI CAL THERAPY	66. 00		24. 00
25. 00	limitation (chapter 14) Utilization review -		0	*** Cost Center Deleted ***	114. 00		25. 00
	physicians' compensation						
26. 00	(chapter 21) Depreciation - CAP REL		0	CAP REL COSTS-BLDG & FLXT	1. 00	0	26. 00
27. 00	COSTS-BLDG & FIXT Depreciation - CAP REL		0	CAP REL COSTS-MVBLE EQUIP	2. 00	0	27. 00
	COSTS-MVBLE EQUIP						
28. 00 29. 00	Non-physician Anesthetist Physicians' assistant		0	NONPHYSICIAN ANESTHETISTS	19. 00 0. 00	0	28. 00 29. 00
30. 00	Adjustment for occupational therapy costs in excess of	A-8-3	0	OCCUPATI ONAL THERAPY	67. 00		30. 00
30. 99	limitation (chapter 14) Hospice (non-distinct) (see		0	ADULTS & PEDIATRICS	30. 00		30. 99
31. 00	instructions) Adjustment for speech	A-8-3	^	SPEECH PATHOLOGY	68. 00		31. 00
51.00	pathology costs in excess of	N-0-3	U	S. LEGIT I ATHOLOGY	00.00		31.00
32.00	limitation (chapter 14) CAH HIT Adjustment for		0		0. 00	0	32. 00
33.00	Depreciation and Interest OTHER OPERATING REVENUE	В	0	ADMINISTRATIVE & GENERAL	5. 00		33. 00
	<u> </u>						

Heal th	Financial Systems		HARVARD MEMOR	IAL HOSPITAL	In Lieu of Form CMS-2552-10			
ADJUST	MENTS TO EXPENSES				Peri od:	Worksheet A-8		
					From 07/01/2022 Fo 06/30/2023			
				Expense Classification on	Worksheet A			
				To/From Which the Amount is	to be Adjusted			
	Cost Center Description	Basis/Code (2)	Amount	Cost Center	Li ne #	Wkst. A-7 Ref.		
		1.00	2. 00	3. 00	4.00	5. 00		
33.01	OTHER OPERATING REVENUE	В	0	OPERATING ROOM	50.00	0	33. 01	
33.02	OTHER OPERATING REVENUE	В	-1, 193	DRUGS CHARGED TO PATIENTS	73. 00	0	33. 02	
34.00	ILLINOIS UNALLOWABLE REAL	Α	-8, 802	OPERATION OF PLANT	7. 00	0	34.00	
	ESTAT							
35.00	LOBBYING EXPENSE	Α	-1, 502	ADMINISTRATIVE & GENERAL	5. 00	0	35.00	
37.00	HOSPITAL TAX	Α	-881, 709	ADMINISTRATIVE & GENERAL	5. 00	0	37.00	
39.00	CASH DI SCOUNTS	В	-101	ADMINISTRATIVE & GENERAL	5. 00	0	39.00	
42.00	SNF TAX	Α	0	SKILLED NURSING FACILITY	44.00	0	42.00	
43.00	CARE CENTER TAX	A	0	OTHER LONG TERM CARE	46. 00	0	43.00	
50.00	TOTAL (sum of lines 1 thru 49)		303, 170				50.00	

column 6, line 200.) (1) Description - all chapter references in this column pertain to CMS Pub. 15-1.

(Transfer to Worksheet A,

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

⁽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.

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

From 07/01/2022 To 06/30/2023 Date/Time Prepared:

				10 00/30/2023	11/28/2023 5:	
	Li ne No.	Cost Center	Expense Items	Amount of	Amount	•
			·	Allowable Cost	Included in	
					Wks. A, column	
					5	
	1. 00	2. 00	3. 00	4. 00	5. 00	
		MENTS REQUIRED AS A RESULT OF	TRANSACTIONS WITH RELATED OF	RGANIZATIONS OR	: CLAIMED	
	HOME OFFICE COSTS:			1		
1. 00			HOME OFFICE EMPLOYEE BENEFIT			1. 00
2.00			HOME OFFICE ADMIN & GENERAL	3, 378, 915		2. 00
3.00			HOME OFFICE OPERATION OF PLA			3. 00
3. 01			HOME OFFICE MEDICAL SUPPLIES			3. 01
3. 02		IMPL. DEV. CHARGED TO PATIEN		40, 181		3. 02
3.07	73.00	DRUGS CHARGED TO PATIENTS	HOME OFFICE DRUGS	131, 806	0	3. 07
3. 10	16.00	MEDICAL RECORDS & LIBRARY	HOME OFFICE MEDICAL RECORDS	20, 348	0	3. 10
3. 11	13.00	NURSING ADMINISTRATION	HOME OFFICE NURSING ADMIN	175, 985	0	3. 11
3. 12	0.00			0	0	3. 12
3. 14	44.00	SKILLED NURSING FACILITY	MED DIRECTOR DIRECT ALLOC	6, 000	0	3. 14
3. 16	53.00	ANESTHESI OLOGY	PHYSICIAN BENEFITS	25, 971	0	3. 16
3. 17	0.00			0	0	3. 17
4.00	0.00			0	0	4.00
5.00	TOTALS (sum of lines 1-4).			4, 743, 749	938, 693	5.00
	Transfer column 6, line 5 to					
	Worksheet A-8, column 2,					
	line 12.					

The amounts on lines 1-4 (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 has not been posted to Worksheet A, columns 1 and/or 2, the amount allowable should be indicated in column 4 of this part.

			Related Organization(s) and/	or Home Office	
Symbol (1)	Name	Percentage of	Name	Percentage of	
		Ownershi p		Ownershi p	
1. 00	2. 00	3. 00	4. 00	5. 00	
B. INTERRELATIONSHIP TO RELAT	TED ORGANIZATION(S) AND/OR HO	ME 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 request information, the cost report is considered incomplete and not acceptable for purposes of claiming reimbursement under title XVIII.

6. 00	В	0.00 MERCY HOME OFFI 100.00	6. 00
7.00		0.00	7. 00
8. 00		0.00	8. 00
9. 00		0.00	9. 00
10.00		0.00	10.00
100.00	G. Other (financial or		100.00
	non-financial) specify:		

- (1) Use the following symbols to indicate 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.
- 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 organi zati on.
- 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 provi der.

3.07

3.10

3.11

3.12

3.14

3.16

3.17

4.00

5.00

The amounts on lines 1-4 (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 has not been posted to Worksheet A, columns 1 and/or 2, the amount allowable should be indicated in column 4 of this part

Related Organization(s)			-	
and/or Home Office				
Type of Business				
6. 00				
B. INTERRELATIONSHIP TO RELA	TED ORGANIZATION(S)	AND/OR HOME OFFICE:		i

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 request information, the cost report is considered incomplete and not acceptable for purposes of claiming reimbursement under title XVIII.

6. 00	HEALTH SYSTEM	6.00
7. 00 8. 00 9. 00 10. 00		7.00
8.00		8.00
9.00		9.00
10.00		10.00
100.00		100.00

- (1) Use the following symbols to indicate 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 organi zati on.
- E. Individual is director, officer, administrator, or key person of provider and related organization.
- Director, officer, administrator, or key person of related organization or relative of such person has financial interest in provi der

3.07

3.10

3. 11

3.12

3.14

3.16

3.17

4.00

5.00

131, 806

175, 985

20, 348

6,000

0

25, 971

3, 805, 056

0

0

0

9

0

0

0

Peri od: Worksheet A-8-2 From 07/01/2022 To 06/30/2023 Date/Time Prepared: Provi der CCN: 14-1335

					1	To 06/30/2023	Date/Time Pre	epared:
	Wkst. A Line #	Cost Center/Physician	Total	Professi onal	Provi der	RCE Amount	Physi ci an/Prov	оо рііі
		I denti fi er	Remuneration	Component	Component		ider Component	
				'	· ·		Hours	
	1. 00	2. 00	3. 00	4. 00	5. 00	6. 00	7. 00	
1.00	13.00	AGGREGATE-NURSI NG	157, 847	157, 847	0	0	0	1. 00
		ADMINISTRATION						
2.00		AGGREGATE-OPERATING ROOM	43, 392		43, 392	0	_	2. 00
3.00		AGGREGATE-ANESTHESI OLOGY	1, 732, 142	1, 732, 142	0	0	_	3.00
4.00	54.00	AGGREGATE-RADI OLOGY-DI AGNOST	0	0	0	0	0	4.00
		I C				_	_	
5. 00		AGGREGATE-EMERGENCY	2, 458, 335	596, 340	1, 861, 995	0	1	5.00
6. 00	0.00		0	0	0	0		6.00
7. 00	0.00		0	0	0	0	0	7.00
8. 00	0.00		0	0	0	0	0	8. 00 9. 00
9. 00	0. 00 0. 00		0	0	0	0	0	
10. 00 200. 00	0.00		4, 391, 716	2 404 220	1, 905, 387	U	0	10. 00 200. 00
200.00	Wkst. A Line #	Cost Center/Physician	Unadjusted RCE		Cost of	Provi der	Physician Cost	200.00
	WKSt. A LITTE #	I denti fi er	Limit	Unadjusted RCE		Component	of Malpractice	
		ruentiffei	Limit	Li mi t	Continuing	Share of col.	Insurance	
				Limit	Education	12	Trisui ance	
	1. 00	2.00	8. 00	9. 00	12. 00	13. 00	14. 00	
1. 00		AGGREGATE-NURSI NG	0.00	0		0		1. 00
		ADMI NI STRATI ON	_	_	_	_		
2.00	50.00	AGGREGATE-OPERATING ROOM	0	0	0	0	O	2.00
3.00	53.00	AGGREGATE-ANESTHESI OLOGY	0	0	0	0	o	3.00
4.00	54.00	AGGREGATE-RADI OLOGY-DI AGNOST	0	0	0	0	o	4.00
		I C						
5.00	91.00	AGGREGATE-EMERGENCY	0	0	0	0	0	5.00
6. 00	0.00		0	0	0	0	0	6. 00
7.00	0.00		0	0	0	0	0	7. 00
8. 00	0.00		0	0	_	0	0	8. 00
9. 00	0.00		0	0	_	0	0	9. 00
10.00	0.00		0	0	0	0	l "I	10.00
200.00			0	0	0	0	0	200.00
	Wkst. A Line #		Provi der	Adjusted RCE	RCE	Adjustment		
		I denti fi er	Component	Limit	Di sal I owance			
			Share of col.					
	1. 00	2.00	14 15. 00	16. 00	17. 00	18. 00	-	
1. 00		AGGREGATE-NURSI NG	15.00	10.00		157, 847		1. 00
1.00	13.00	ADMI NI STRATI ON	٥	0	0	137,047		1.00
2.00	50.00	AGGREGATE-OPERATING ROOM	0	0	0	0		2.00
3. 00	•	AGGREGATE - ANESTHESI OLOGY	١	0	_	1, 732, 142		3.00
4. 00	•	AGGREGATE-RADI OLOGY-DI AGNOST	١	0	_	1,,02,112		4. 00
1. 00	01.00	I C				Ĭ		1. 00
5. 00	91.00	AGGREGATE-EMERGENCY	l 0	0	0	596, 340		5. 00
6. 00	0.00		l o	Ö	_	0	1	6. 00
7. 00	0.00		l 0	0		Ö		7. 00
8.00	0.00		0	0	0	0		8.00
9.00	0.00		0	0	0	0		9. 00
10.00	0.00		0	0	0	0		10.00
200. 00	[0	0	0	2, 486, 329		200.00

Period: Worksheet B From 07/01/2022 Part I To 06/30/2023 Date/Time Prepared:

			T		06/30/2023	Date/Time Pre	pared:	
				CAPITAL REI	_ATED COSTS		11/28/2023 5:0	06 pm
	(Cost Center Description	Net Expenses	BLDG & FIXT	MVBLE EQUIP	EMPLOYEE	Subtotal	
			for Cost Allocation			BENEFITS DEPARTMENT		
			(from Wkst A			DEFARTMENT		
			col. 7)					
	1		0	1. 00	2.00	4. 00	4A	
1 00		L SERVICE COST CENTERS	1 001 043	1 001 042				1 00
1. 00 2. 00	1 1	CAP REL COSTS-BLDG & FIXT CAP REL COSTS-MVBLE EQUIP	1, 091, 043 777, 908	1, 091, 043	777, 908			1. 00 2. 00
4. 00		EMPLOYEE BENEFITS DEPARTMENT	1, 709, 828	0		1, 709, 828		4. 00
5.00		ADMINISTRATIVE & GENERAL	4, 450, 399	130, 822	6, 432	324, 718	4, 912, 371	5. 00
6.00		MAINTENANCE & REPAIRS	0	0	0	0	0	6. 00
7.00	1 1	OPERATION OF PLANT	1, 326, 808	216, 997	54, 997	0	1, 598, 802	7.00
8. 00 9. 00	1 1	LAUNDRY & LINEN SERVICE HOUSEKEEPING	86, 325 474, 351	12, 593 4, 961	912 985	0 23, 263	99, 830 503, 560	8. 00 9. 00
10.00		DI ETARY	581, 439	33, 567	14, 443	61, 780	691, 229	10.00
11. 00	1 1	CAFETERI A	0	18, 044		0	18, 044	11. 00
12.00		MAINTENANCE OF PERSONNEL	o	0	0	0	0	12.00
13.00		NURSING ADMINISTRATION	1, 388, 769	6, 051	56, 066	135, 080	1, 585, 966	13.00
14.00	1 1	CENTRAL SERVICES & SUPPLY	0	0	0	0	0	14.00
15. 00 16. 00	1 1	PHARMACY MEDICAL RECORDS & LIBRARY	169, 972	23, 237	0	17, 024	0 210, 233	15. 00 16. 00
17. 00		SOCIAL SERVICE	0	23, 237	Ö	17, 024	210, 233	17. 00
19.00	1 1	NONPHYSICIAN ANESTHETISTS	ō	0	Ō	Ō	0	19. 00
20.00	1 1	NURSING PROGRAM	0	0	0	0	0	20. 00
21.00		I&R SERVICES-SALARY & FRINGES APPRV	0	0	0	0	0	21. 00
22. 00		I&R SERVICES-OTHER PRGM COSTS APPRV	0	0	0	O O	0	22. 00
23. 00		PARAMED ED PRGM-(SPECIFY) ENT ROUTINE SERVICE COST CENTERS	U	0	0	U _I	0	23. 00
30.00		ADULTS & PEDIATRICS	1, 121, 569	90, 958	57, 607	119, 064	1, 389, 198	30. 00
31.00	1 1	INTENSIVE CARE UNIT	217, 668	25, 049		18, 894	262, 754	31.00
44.00		SKILLED NURSING FACILITY	493, 192	65, 050		45, 432	608, 511	44. 00
46. 00		OTHER LONG TERM CARE	798, 155	111, 741	8, 493	81, 898	1, 000, 287	46. 00
50. 00		ARY SERVICE COST CENTERS OPERATING ROOM	1, 829, 721	109, 111	338, 742	145, 491	2, 423, 065	50. 00
51.00		RECOVERY ROOM	1, 185, 200	4, 361	5, 628	122, 171	1, 317, 360	51.00
53.00		ANESTHESI OLOGY	73, 649	0	414	0	74, 063	53. 00
54.00	05400 F	RADI OLOGY-DI AGNOSTI C	982, 820	28, 825	157, 892	102, 368	1, 271, 905	54.00
60.00	1 1	LABORATORY	951, 688	20, 811	5, 660	93, 651	1, 071, 810	
60. 01		BLOOD LABORATORY	0	0	0	0	0	60. 01
62. 30 65. 00		BLOOD CLOTTING FOR HEMOPHILIACS RESPIRATORY THERAPY	41, 715	0 17, 581	9, 628	2, 478	0 71, 402	62. 30 65. 00
66.00		PHYSI CAL THERAPY	491, 075	49, 213	3, 079	49, 456	592, 823	66. 00
67.00	1 1	OCCUPATI ONAL THERAPY	312, 211	0	3, 100	29, 115	344, 426	
68.00	1 1	SPEECH PATHOLOGY	24, 496	0	243	2, 284	27, 023	
71.00	1 1	MEDICAL SUPPLIES CHARGED TO PATIENT	1, 106, 963	0	3, 995	14, 051	1, 125, 009	
72.00		IMPL. DEV. CHARGED TO PATIENTS	496, 048	7 250	1 000	45 220	496, 048	
73. 00 76. 97	1	DRUGS CHARGED TO PATIENTS CARDIAC REHABILITATION	1, 265, 882	7, 359 6, 914		45, 229	1, 320, 459	
76. 98		HYPERBARI C OXYGEN THERAPY	44, 614 0	6, 814 0	9, 297 0	3, 693 0	64, 418 0	
76. 99		LI THOTRI PSY	o	0		Ö	Ö	
		IENT SERVICE COST CENTERS						
91.00		EMERGENCY	3, 425, 025	19, 802	32, 326	272, 688	3, 749, 841	91.00
92.00		OBSERVATION BEDS (NON-DISTINCT PART					0	92. 00
99. 10		REIMBURSABLE COST CENTERS	O	0	0	0	0	99. 10
77. 10		L PURPOSE COST CENTERS	<u> </u>		<u> </u>	<u> </u>	Ü	77. 10
118. 00		SUBTOTALS (SUM OF LINES 1 through 117)	26, 918, 533	1, 002, 947	777, 908	1, 709, 828	26, 830, 437	118. 00
		MBURSABLE COST CENTERS						
		PHYSICIANS PRIVATE OFFICES	0	88, 096	0	0	88, 096	
200. 00 201. 00		Cross Foot Adjustments Negative Cost Centers		0		0		200. 00 201. 00
201.00		TOTAL (sum lines 118 through 201)	26, 918, 533	-	777, 908	1, 709, 828	26, 918, 533	
00	1	(a. a. a	.,	, ,	,	, ,		

COST ALLOCATION - GENERAL SERVICE COSTS

Provi der CCN: 14-1335

Peri od: Worksheet B From 07/01/2022 Part I To 06/30/2023 Date/Time Prepared: 11/28/2023 5:06 pm

						11/28/2023 5:	06 pm
	Cost Center Description	ADMI NI STRATI VE	MAINTENANCE &	OPERATION OF	LAUNDRY &	HOUSEKEEPI NG	
		& GENERAL	REPAI RS	PLANT	LINEN SERVICE		
		5. 00	6. 00	7. 00	8. 00	9. 00	
	GENERAL SERVICE COST CENTERS						
1.00	00100 CAP REL COSTS-BLDG & FLXT						1. 00
2.00	00200 CAP REL COSTS-MVBLE EQUIP						2. 00
4. 00	00400 EMPLOYEE BENEFITS DEPARTMENT						4. 00
5. 00	00500 ADMI NI STRATI VE & GENERAL	4, 912, 371					5. 00
6.00	00600 MAINTENANCE & REPAIRS	0	C)			6. 00
7.00	00700 OPERATION OF PLANT	356, 896	C	1, 955, 698			7. 00
8.00	00800 LAUNDRY & LINEN SERVICE	22, 285	C	33, 136	155, 251		8. 00
9.00	00900 HOUSEKEEPI NG	112, 408	C	13, 054	22, 552	651, 574	9. 00
10.00	01000 DI ETARY	154, 301	C	88, 328	0	30, 140	10.00
11.00	01100 CAFETERI A	4, 028	C	47, 481	0	16, 202	11. 00
12.00	01200 MAINTENANCE OF PERSONNEL	o	C	0	0	0	12.00
13.00	01300 NURSI NG ADMI NI STRATI ON	354, 030	C	15, 923	0	5, 433	13.00
14.00	01400 CENTRAL SERVICES & SUPPLY	o	C	0	0	0	14. 00
15.00	01500 PHARMACY	l ol	C	0	0	0	15. 00
16.00	01600 MEDI CAL RECORDS & LIBRARY	46, 930	C	61, 145	o	20, 864	1
17. 00	01700 SOCIAL SERVICE	l ol	C		0	0	17. 00
	01900 NONPHYSI CI AN ANESTHETI STS	l ol	C	ol o	0	0	ı
	02000 NURSI NG PROGRAM	l ol	C		0	0	20.00
	02100 I &R SERVICES-SALARY & FRINGES APPRV	l ol	C		0	0	21. 00
	02200 I &R SERVICES-OTHER PRGM COSTS APPRV	l ol	C	ol o	0	Ō	ı
	02300 PARAMED ED PRGM-(SPECIFY)		C	1	0	o o	23. 00
20.00	INPATIENT ROUTINE SERVICE COST CENTERS	9		,ı	<u> </u>		20.00
30.00	03000 ADULTS & PEDIATRICS	310, 107	C	239, 343	20, 412	81, 670	30.00
	03100 NTENSI VE CARE UNI T	58, 654	C		47	22, 492	1
44. 00	04400 SKILLED NURSING FACILITY	135, 836	C		l .		44. 00
46. 00	04600 OTHER LONG TERM CARE	223, 291	C			· ·	1
40.00	ANCI LLARY SERVI CE COST CENTERS	225, 271		274,034	10, 020	100, 332	10.00
50.00	05000 OPERATING ROOM	540, 894	C	287, 111	29, 350	97, 970	50.00
51.00	05100 RECOVERY ROOM	294, 070	C		7, 337	3, 916	
53.00	05300 ANESTHESI OLOGY	16, 533	C	1	0	0, 7.0	53. 00
54.00	05400 RADI OLOGY-DI AGNOSTI C	283, 924	C	1		25, 881	1
60.00	06000 LABORATORY	239, 257	C	1	554	18, 686	1
60. 01	06001 BLOOD LABORATORY	0	C	1,	0	0	60. 01
62. 30	06250 BLOOD CLOTTING FOR HEMOPHILIACS		C	1	0	0	62. 30
65. 00	06500 RESPIRATORY THERAPY	15, 939	C	1	7, 720	-	1
66. 00	06600 PHYSI CAL THERAPY	132, 334	C	1		44, 188	1
67. 00	06700 OCCUPATI ONAL THERAPY	76, 885	C	1	6, 139	0	1
68. 00	06800 SPEECH PATHOLOGY	6, 032	C		481	0	1
71. 00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	251, 132	C		1, 547	0	71.00
	07200 IMPL. DEV. CHARGED TO PATIENTS	110, 731			1, 547	0	72.00
	07300 DRUGS CHARGED TO PATIENTS	294, 762	C	19, 365	3, 940	6, 608	1
	07697 CARDI AC REHABI LI TATI ON	14, 380	C	1	3, 940	6, 119	
76. 97 76. 98	07698 HYPERBARI C OXYGEN THERAPY	14, 360	C		0	0, 119	1
76. 98 76. 99		0	C		0		
76. 99	07699 LI THOTRI PSY	l U)l U	U	0	76. 99
01 00	OUTPATIENT SERVICE COST CENTERS	007.047		F0 107	14 (50	17 700	01 00
	09100 EMERGENCY	837, 067	C	52, 107	14, 650	17, 780	1
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART						92.00
00.40	OTHER REIMBURSABLE COST CENTERS	1 0					
99. 10	09910 CORF	0	C) 0	0	0	99. 10
	SPECIAL PURPOSE COST CENTERS						
118. 00		4, 892, 706	C	1, 723, 886	155, 251	572, 474	1118.00
46	NONREI MBURSABLE COST CENTERS						
	19200 PHYSI CI ANS PRI VATE OFFI CES	19, 665	C	231, 812	0	79, 100	
200.00							200. 00
201.00		0	C	1	0		201. 00
202. 00	TOTAL (sum lines 118 through 201)	4, 912, 371	C	1, 955, 698	155, 251	651, 574	J202. 00

COST ALLOCATION - GENERAL SERVICE COSTS

Provi der CCN: 14-1335

Period: Worksheet B From 07/01/2022 Part I To 06/30/2023 Date/Time Prepared: 11/28/2023 5:06 pm

						11/28/2023 5:	06 pm
	Cost Center Description	DI ETARY	CAFETERI A	MAINTENANCE OF	NURSI NG	CENTRAL	
				PERSONNEL	ADMI NI STRATI ON	SERVICES &	
						SUPPLY	
		10. 00	11. 00	12.00	13. 00	14. 00	
	GENERAL SERVICE COST CENTERS						
1.00	00100 CAP REL COSTS-BLDG & FLXT						1.00
2.00	00200 CAP REL COSTS-MVBLE EQUIP						2. 00
4.00	00400 EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500 ADMINISTRATIVE & GENERAL						5. 00
6.00	00600 MAINTENANCE & REPAIRS						6. 00
7.00	00700 OPERATION OF PLANT						7. 00
8.00	00800 LAUNDRY & LINEN SERVICE						8. 00
9.00	00900 HOUSEKEEPI NG						9. 00
10.00	01000 DI ETARY	963, 998					10.00
11.00	01100 CAFETERI A	301, 000	386, 755				11.00
12.00	01200 MAINTENANCE OF PERSONNEL	O	0		ı		12.00
13.00	01300 NURSING ADMINISTRATION	ol	33, 975		1, 995, 327		13.00
14. 00	01400 CENTRAL SERVICES & SUPPLY	ام	0	1	0	0	14. 00
15. 00	01500 PHARMACY	o o	0		i o	ő	15. 00
16. 00	01600 MEDICAL RECORDS & LIBRARY	o o	8, 137		i o	ő	16.00
17. 00	01700 SOCI AL SERVI CE		0, 137	1		Ö	17. 00
19. 00	01900 NONPHYSI CLAN ANESTHETI STS		0			Ö	19.00
20. 00	02000 NURSI NG PROGRAM		0		0	0	20.00
21. 00	02100 I &R SERVI CES-SALARY & FRI NGES APPRV		0			0	21.00
22. 00	02200 I &R SERVI CES-OTHER PRGM COSTS APPRV		0			0	22.00
23. 00	02300 PARAMED ED PRGM-(SPECIFY)		0			0	23.00
23.00	I NPATI ENT ROUTI NE SERVI CE COST CENTERS	UU			0	0	23.00
30. 00	03000 ADULTS & PEDIATRICS	39, 813	37, 831		392, 510	0	30.00
31. 00	03100 INTENSIVE CARE UNIT	37, 613	4, 628		1	0	31.00
44. 00	04400 SKILLED NURSING FACILITY	131, 798	18, 665				44.00
46. 00	04600 OTHER LONG TERM CARE	231, 414	32, 741		1	0	46.00
40.00	ANCI LLARY SERVICE COST CENTERS	231,414	32, 741		144, 740	0	40.00
50. 00	05000 OPERATING ROOM	147	55, 415		306, 410	0	50.00
51. 00	05100 RECOVERY ROOM	147	39, 335	•		0	51.00
53. 00	05300 ANESTHESI OLOGY		694			0	53.00
54. 00	05400 RADI OLOGY-DI AGNOSTI C	2, 832	32, 316	•	_	0	54.00
60.00	06000 LABORATORY	7, 632	33, 820				60.00
60. 00	06001 BLOOD LABORATORY	7,032	33, 620	1		0	60.00
62. 30	06250 BLOOD CLOTTING FOR HEMOPHILIACS		0	1	_	0	62. 30
65. 00	06500 RESPIRATORY THERAPY	221	733		_		65.00
66. 00	06600 PHYSI CAL THERAPY	i i				0	1
		77, 457	19, 667		,	-	66.00
67.00	06700 OCCUPATI ONAL THERAPY	84, 463	11, 955				67.00
68.00	06800 SPEECH PATHOLOGY	6, 620	926		.,	0	68.00
71.00	07100 MEDI CAL SUPPLI ES CHARGED TO PATI ENT	21, 277	7, 327				71.00
72.00	07200 I MPL. DEV. CHARGED TO PATIENTS	54 010	0	1	_	0	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	54, 212	11, 916		,	0	73.00
76. 97	07697 CARDI AC REHABI LI TATI ON	0	1, 003				76. 97
76. 98	07698 HYPERBARI C OXYGEN THERAPY	0	0				76. 98
76. 99	07699 LI THOTRI PSY	0	0	0	0	0	76. 99
	OUTPATIENT SERVICE COST CENTERS			_		_	
	09100 EMERGENCY	5, 112	35, 671	0	466, 908	0	
92. 00	09200 OBSERVATION BEDS (NON-DISTINCT PART						92.00
	OTHER REIMBURSABLE COST CENTERS	.1					
99. 10	09910 CORF	0	0	C	0	0	99. 10
	SPECIAL PURPOSE COST CENTERS						
118. 00	9 /	963, 998	386, 755	0	1, 995, 327	0	118. 00
	NONREI MBURSABLE COST CENTERS						
	19200 PHYSICIANS PRIVATE OFFICES	0	0	0	0		192. 00
200.00							200. 00
201.00		0	0	1			201. 00
202. 00	TOTAL (sum lines 118 through 201)	963, 998	386, 755	0	1, 995, 327	0	202. 00

COST ALLOCATION - GENERAL SERVICE COSTS

Provi der CCN: 14-1335

Peri od: Worksheet B From 07/01/2022 To 06/30/2023 Date/Time Prepared: 11/28/2023 5:06 pm

				''	0 00/30/2023	11/28/2023 5:	
	Cost Center Description	PHARMACY	MEDI CAL	SOCIAL SERVICE	NONPHYSI CI AN	NURSI NG	
	·		RECORDS &		ANESTHETI STS	PROGRAM	
			LI BRARY				
		15. 00	16. 00	17. 00	19. 00	20. 00	
	GENERAL SERVICE COST CENTERS			1		1	4
1.00	00100 CAP REL COSTS-BLDG & FLXT						1.00
2.00	00200 CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400 EMPLOYEE BENEFITS DEPARTMENT						4.00
5. 00 6. 00	00500 ADMI NI STRATI VE & GENERAL						5.00
7. 00	00600 MAINTENANCE & REPAIRS 00700 OPERATION OF PLANT						6. 00 7. 00
8. 00	00800 LAUNDRY & LINEN SERVICE						8.00
9. 00	00900 HOUSEKEEPI NG						9.00
10. 00	01000 DI ETARY						10.00
11. 00	01100 CAFETERI A						11.00
12. 00	01200 MAINTENANCE OF PERSONNEL						12.00
13. 00	01300 NURSI NG ADMI NI STRATI ON						13.00
14. 00	01400 CENTRAL SERVICES & SUPPLY						14. 00
15. 00	01500 PHARMACY	o					15. 00
16. 00	01600 MEDI CAL RECORDS & LI BRARY	ol	347, 309				16. 00
17. 00	01700 SOCI AL SERVI CE	ol	0	0			17. 00
19. 00	01900 NONPHYSI CI AN ANESTHETI STS	ol	0	0	0		19.00
20. 00	02000 NURSI NG PROGRAM	ol	0	0		l	1
21.00	02100 I&R SERVICES-SALARY & FRINGES APPRV	ol	0	o o			21.00
22. 00	02200 I&R SERVICES-OTHER PRGM COSTS APPRV	o	0	Ó			22. 00
23. 00	02300 PARAMED ED PRGM-(SPECIFY)	o	0	Ó			23. 00
	INPATIENT ROUTINE SERVICE COST CENTERS	<u> </u>					
30.00	03000 ADULTS & PEDIATRICS	0	15, 848	0	0	C	30.00
31.00	03100 INTENSIVE CARE UNIT	0	674	0	0	0	31.00
44.00	04400 SKILLED NURSING FACILITY	0	0	1		0	44.00
46.00	04600 OTHER LONG TERM CARE	0	0	0	0	0	46. 00
	ANCILLARY SERVICE COST CENTERS			1			
50.00	05000 OPERATI NG ROOM	0	226, 258	i		l	1
51.00	05100 RECOVERY ROOM	0	0	1		0	
53.00	05300 ANESTHESI OLOGY	0	- U	0	_	0	
54.00	05400 RADI OLOGY-DI AGNOSTI C	U O	56, 648	i	_	0	
60.00	06000 LABORATORY	U O	0		_		
60. 01 62. 30	06001 BLOOD LABORATORY	O O	0	0	_		
65. 00	06250 BLOOD CLOTTING FOR HEMOPHILIACS	O O	0	0	_		1
66.00	06500 RESPI RATORY THERAPY 06600 PHYSI CAL THERAPY	O O	7, 081		0		1
67. 00	06700 OCCUPATI ONAL THERAPY	0	7,081	0	0		1
68. 00	06800 SPEECH PATHOLOGY	0	0	0			1
71. 00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	_		1
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0	0		0		1
73. 00	07300 DRUGS CHARGED TO PATIENTS		0	Ö	0	ĺ	1
76. 97	07697 CARDI AC REHABI LI TATI ON		0	0	_		1
76. 98	07698 HYPERBARI C OXYGEN THERAPY	Ö	0	Ö	_	ĺ	1
76. 99	07699 LI THOTRI PSY	Ö	0	Ö			1
, 0. , ,	OUTPATIENT SERVICE COST CENTERS	<u> </u>					10.77
91.00	09100 EMERGENCY	0	40, 800	0	0	C	91.00
	09200 OBSERVATION BEDS (NON-DISTINCT PART						92.00
	OTHER REIMBURSABLE COST CENTERS						
99. 10	09910 CORF	0	0	0	0	C	99. 10
	SPECIAL PURPOSE COST CENTERS				+		1
118. 00		0	347, 309	0	0	0	118. 00
400.55	NONREI MBURSABLE COST CENTERS	_1	_		=		1400 00
	19200 PHYSI CI ANS PRI VATE OFFI CES	0	0	0	_		192.00
200.00	1 1		^] _	0		200.00
201. 00		0	247 200	0			201. 00 202. 00
202. 00	TIVIAL (Sum TINES TIV UNIOUGH 201)	Ŋ	347, 309	1 0	1	ı	1202.00

Period: Worksheet B From 07/01/2022 Part I To 06/30/2023 Date/Time Prepared:

					To 06/30/20	23 Date/Time Pre 11/28/2023 5:	
		INTERNS &	RESI DENTS			11/20/2023 3.	UO PIII
		TIVIERIUS &	RESIDENTS				
	Cost Center Description	SERVI CES-SALAR	SERVI CES-OTHER	PARAMED ED	Subtotal	Intern &	
		Y & FRINGES	PRGM COSTS	PRGM		Residents Cost	
		APPRV	APPRV			& Post	
						Stepdown	
						Adjustments	
		21. 00	22. 00	23. 00	24.00	25. 00	
	GENERAL SERVICE COST CENTERS						
1. 00	00100 CAP REL COSTS-BLDG & FIXT						1. 00
2.00	00200 CAP REL COSTS-MVBLE EQUIP						2. 00
4. 00	00400 EMPLOYEE BENEFITS DEPARTMENT						4. 00
5. 00	00500 ADMI NI STRATI VE & GENERAL						5. 00
6. 00	00600 MAINTENANCE & REPAIRS						6.00
7. 00	00700 OPERATION OF PLANT						7.00
8. 00 9. 00	00800 LAUNDRY & LI NEN SERVI CE						8.00
10.00	00900 HOUSEKEEPI NG 01000 DI ETARY						9.00
11. 00	01100 CAFETERI A						11.00
12. 00	01200 MAINTENANCE OF PERSONNEL						12.00
13. 00	01300 NURSING ADMINISTRATION						13.00
14. 00	01400 CENTRAL SERVICES & SUPPLY						14.00
15. 00	01500 PHARMACY						15. 00
16. 00	01600 MEDI CAL RECORDS & LI BRARY						16.00
17. 00	01700 SOCI AL SERVI CE						17. 00
19.00	01900 NONPHYSI CI AN ANESTHETI STS						19.00
20.00	02000 NURSI NG PROGRAM						20.00
21.00	02100 I&R SERVICES-SALARY & FRINGES APPRV	0					21.00
22.00	02200 I&R SERVICES-OTHER PRGM COSTS APPRV		0				22. 00
23.00	02300 PARAMED ED PRGM-(SPECIFY)				0		23. 00
	INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000 ADULTS & PEDIATRICS	0	0		0 2, 526, 7	l l	1
31. 00	03100 I NTENSI VE CARE UNI T	0	0		0 443, 1		
44.00	04400 SKILLED NURSING FACILITY	0	0		0 1, 216, 4	l l	1
46. 00	04600 OTHER LONG TERM CARE	0	0		0 2,043,6	67 0	46. 00
E0 00	ANCILLARY SERVICE COST CENTERS 05000 OPERATING ROOM	0	0		0 3, 966, 6	20 0	FO 00
50. 00 51. 00	05100 RECOVERY ROOM	0			0 3, 966, 6 0 2, 060, 9		
53. 00	05300 ANESTHESI OLOGY	0	0		0 2,000, 7	l l	
54. 00	05400 RADI OLOGY-DI AGNOSTI C	0	0		0 1, 786, 7	l l	
60.00	06000 LABORATORY	0	0		0 1, 431, 2	1	
60. 01	06001 BLOOD LABORATORY	0	0		0 .,, 2	ol o	1
62. 30	06250 BLOOD CLOTTING FOR HEMOPHILIACS	0	Ö		o	ol o	1
65.00	06500 RESPIRATORY THERAPY	0	0		0 158, 2	02 0	1
66.00	06600 PHYSI CAL THERAPY	0	0		0 1,057,2	l l	66.00
67.00	06700 OCCUPATI ONAL THERAPY	0	0		0 576, 6	93 0	67. 00
68.00	06800 SPEECH PATHOLOGY	0	0		0 45, 2	14 0	68. 00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0	0		0 1, 419, 6	02 0	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0	0		0 606, 7	79 0	72. 00
	07300 DRUGS CHARGED TO PATIENTS	0	0		0 1, 745, 1	i i	
	07697 CARDI AC REHABI LI TATI ON	0	0		0 104, 0		1
	07698 HYPERBARI C OXYGEN THERAPY	0	l e	l .	0	0 0	
76. 99	07699 LI THOTRI PSY	0	0		0	0 0	76. 99
01 00	OUTPATIENT SERVICE COST CENTERS			I	0 5 210 0	2/	01 00
	09100 EMERGENCY	0	0		0 5, 219, 9	l e	
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART OTHER REIMBURSABLE COST CENTERS					0	92.00
00 10	09910 CORF	0	О		0	0 0	99. 10
77. 10	SPECIAL PURPOSE COST CENTERS	0	0		<u> </u>	0 0	77. 10
118. 00		0	0		0 26, 499, 8	60 0	118. 00
	NONREI MBURSABLE COST CENTERS		·		5, 20, 477, 0	0	1
192. 00	19200 PHYSI CI ANS PRI VATE OFFI CES	0	0		0 418, 6	73 0	192. 00
200.00		0	l		0		200.00
201.00		0	0		0	0 0	201.00
202. 00	TOTAL (sum lines 118 through 201)	0	0		0 26, 918, 5	33 0	202. 00

Heal th FinancialSystemsHARVARD MEMORIALHOSPITALIn Lieu of Form CMS-2552-10COST ALLOCATION- GENERAL SERVICE COSTSProvider CCN: 14-1335Period: From 07/01/2022Worksheet B From 07/01/2022

Date/Time Prepared:

06/30/2023

11/28/2023 5:06 pm Cost Center Description Total 26. 00 GENERAL SERVICE COST CENTERS 1 00 00100 CAP REL COSTS-BLDG & FIXT 1 00 2.00 00200 CAP REL COSTS-MVBLE EQUIP 2.00 00400 EMPLOYEE BENEFITS DEPARTMENT 4.00 4.00 00500 ADMINISTRATIVE & GENERAL 5.00 5 00 6.00 00600 MAINTENANCE & REPAIRS 6.00 00700 OPERATION OF PLANT 7.00 7.00 8.00 00800 LAUNDRY & LINEN SERVICE 8.00 00900 HOUSEKEEPI NG 9.00 9 00 10.00 01000 DI ETARY 10.00 11.00 01100 CAFETERI A 11.00 12 00 01200 MAINTENANCE OF PERSONNEL 12 00 01300 NURSING ADMINISTRATION 13.00 13.00 14.00 01400 CENTRAL SERVICES & SUPPLY 14.00 15.00 01500 PHARMACY 15.00 01600 MEDICAL RECORDS & LIBRARY 16 00 16 00 17. 00 | 01700 | SOCIAL SERVICE 17.00 19.00 01900 NONPHYSICIAN ANESTHETISTS 19.00 02000 NURSI NG PROGRAM 20 00 20 00 02100 I&R SERVICES-SALARY & FRINGES APPRV 21.00 21.00 22.00 02200 I&R SERVICES-OTHER PRGM COSTS APPRV 22.00 02300 PARAMED ED PRGM-(SPECIFY) 23.00 23.00 INPATIENT ROUTINE SERVICE COST CENTERS 30.00 03000 ADULTS & PEDIATRICS 2, 526, 732 30.00 03100 INTENSIVE CARE UNIT 31.00 443, 197 31.00 44.00 04400 SKILLED NURSING FACILITY 1, 216, 406 44.00 04600 OTHER LONG TERM CARE 46.00 2, 043, 667 46.00 ANCILLARY SERVICE COST CENTERS 3, 966, 620 50.00 05000 OPERATING ROOM 50.00 05100 RECOVERY ROOM 2, 060, 957 51.00 51.00 53 00 05300 ANESTHESLOLOGY 91, 290 53 00 54.00 05400 RADI OLOGY-DI AGNOSTI C 1, 786, 750 54.00 60.00 06000 LABORATORY 1, 431, 289 60.00 06001 BLOOD LABORATORY 60.01 60.01 0 06250 BLOOD CLOTTING FOR HEMOPHILIACS 62.30 0 62.30 06500 RESPIRATORY THERAPY 158, 202 65.00 65.00 66.00 06600 PHYSI CAL THERAPY 1, 057, 294 66.00 06700 OCCUPATI ONAL THERAPY 67.00 67.00 576, 693 68.00 06800 SPEECH PATHOLOGY 45, 214 68.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT 71.00 1, 419, 602 71.00 72.00 07200 IMPL. DEV. CHARGED TO PATIENTS 606, 779 72.00 07300 DRUGS CHARGED TO PATIENTS 73.00 1, 745, 175 73.00 76.97 07697 CARDIAC REHABILITATION 104, 057 76.97 76. 98 07698 HYPERBARI C OXYGEN THERAPY 76.98 07699 LI THOTRI PSY 76. 99 76. 99 OUTPATIENT SERVICE COST CENTERS 91.00 91.00 09100 EMERGENCY 5, 219, 936 09200 OBSERVATION BEDS (NON-DISTINCT PART 92.00 92.00 OTHER REIMBURSABLE COST CENTERS 99.10 09910 CORF 0 99.10 SPECIAL PURPOSE COST CENTERS SUBTOTALS (SUM OF LINES 1 through 117) 118 00 26, 499, 860 118 00 NONREI MBURSABLE COST CENTERS 192. 00 19200 PHYSICIANS PRIVATE OFFICES 418, 673 192.00 200.00 Cross Foot Adjustments 200.00 201.00 201.00 Negative Cost Centers 202.00 TOTAL (sum lines 118 through 201) 26, 918, 533 202.00

Period: Worksheet B From 07/01/2022 Part II To 06/30/2023 Date/Time Prepared:

				То	06/30/2023	Date/Time Prep 11/28/2023 5:0	oared:
	,		CAPI TAL REI	LATED COSTS		11/20/2023 5.	JO PIII
			07.11.77.12.77.22.	21125 00010			
	Cost Center Description	Directly	BLDG & FIXT	MVBLE EQUIP	Subtotal	EMPLOYEE	
	·	Assigned New				BENEFI TS	
		Capi tal				DEPARTMENT	
		Related Costs					
		0	1. 00	2.00	2A	4. 00	
	IERAL SERVI CE COST CENTERS						4 00
	OO CAP REL COSTS-BLDG & FLXT						1.00
	200 CAP REL COSTS-MVBLE EQUIP		0			0	2.00
	OO EMPLOYEE BENEFITS DEPARTMENT OO ADMINISTRATIVE & GENERAL	142, 595	120 922	_	270 940	0	4. 00 5. 00
	000 MAINTENANCE & REPAIRS	142, 393	130, 822	6, 432	279, 849	0	6. 00
	700 OPERATION OF PLANT	27, 439	216, 997	54, 997	299, 433	0	7. 00
	300 LAUNDRY & LINEN SERVICE	27, 437	12, 593		13, 505	o o	8. 00
	POO HOUSEKEEPI NG	0	4, 961	985	5, 946	0	9. 00
1	000 DI ETARY	399	33, 567		48, 409	0	10.00
	00 CAFETERI A	0	18, 044		18, 044	0	11.00
12.00 012	MAINTENANCE OF PERSONNEL	0	0	O	o	0	12.00
13.00 013	NURSING ADMINISTRATION	0	6, 051	56, 066	62, 117	0	13.00
	OO CENTRAL SERVICES & SUPPLY	0	0	0	0	0	14.00
	OO PHARMACY	0	0	0	0	0	15.00
	MEDICAL RECORDS & LIBRARY	0	23, 237	0	23, 237	0	16.00
	OO SOCIAL SERVICE	0	0	0	0	0	17. 00
	200 NONPHYSI CI AN ANESTHETI STS	0	0	0	0	0	19. 00
	NURSI NG PROGRAM	0	0	0	0	0	20.00
	00 I &R SERVICES-SALARY & FRINGES APPRV	0	0	0	0	0	21.00
	200 I&R SERVICES-OTHER PRGM COSTS APPRV	0	0	0	0	0	22. 00
	BOO PARAMED ED PRGM-(SPECIFY) PATIENT ROUTINE SERVICE COST CENTERS	U U	0	0	U	0	23. 00
	000 ADULTS & PEDIATRICS	6, 062	90, 958	57, 607	154, 627	0	30. 00
	00 INTENSIVE CARE UNIT	0,002	25, 049		26, 192	0	31. 00
	OO SKILLED NURSING FACILITY	1, 508	65, 050		71, 395	o o	44. 00
1	OOO OTHER LONG TERM CARE	11, 048	111, 741	8, 493	131, 282	0	46. 00
	ILLARY SERVICE COST CENTERS		,		,	-	
	000 OPERATING ROOM	17, 232	109, 111	338, 742	465, 085	0	50.00
51.00 051	00 RECOVERY ROOM	1, 126	4, 361	5, 628	11, 115	0	51.00
	300 ANESTHESI OLOGY	488	0	414	902	0	53.00
	100 RADI OLOGY-DI AGNOSTI C	243	28, 825		186, 960	0	54.00
	000 LABORATORY	1, 615	20, 811	5, 660	28, 086	0	60.00
1	001 BLOOD LABORATORY	0	0	0	0	0	60. 01
1	250 BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0	0	0	62. 30
	000 RESPI RATORY THERAPY	2	17, 581	9, 628	27, 211	0	65.00
	500 PHYSI CAL THERAPY 700 OCCUPATI ONAL THERAPY	909	49, 213		53, 201	0	66. 00 67. 00
	SOO SPEECH PATHOLOGY	967 76	0	3, 100 243	4, 067 319	0	68.00
	00 MEDICAL SUPPLIES CHARGED TO PATIENT	244	0	3, 995	4, 239	0	71. 00
	200 IMPL. DEV. CHARGED TO PATIENTS	0	0	3, 773	4, 237	0	71.00
	OO DRUGS CHARGED TO PATIENTS	0	7, 359	_	9, 348	0	73.00
	97 CARDI AC REHABI LI TATI ON	0	6, 814		16, 111	0	76. 97
	98 HYPERBARI C OXYGEN THERAPY	O	0		0	0	76. 98
	99 LI THOTRI PSY	0	0	0	o	0	
OUT	PATIENT SERVICE COST CENTERS						
91.00 091	OO EMERGENCY	2, 025	19, 802	32, 326	54, 153	0	91.00
	200 OBSERVATION BEDS (NON-DISTINCT PART				0		92.00
	IER REI MBURSABLE COST CENTERS	,		,	-		
99. 10 099		0	0	0	0	0	99. 10
	CIAL PURPOSE COST CENTERS	040 0==1	4 000 0:=		4 004 0==1		440.00
118. 00	SUBTOTALS (SUM OF LINES 1 through 117)	213, 978	1, 002, 947	777, 908	1, 994, 833	0	118. 00
	IREI MBURSABLE COST CENTERS		00.007		00.004		102.00
200. 00	200 PHYSICIANS PRIVATE OFFICES Cross Foot Adjustments	0	88, 096	0	88, 096 0		192. 00 200. 00
200.00	Negative Cost Centers		0	0	0	_	200.00
201.00	TOTAL (sum lines 118 through 201)	213, 978	-		2, 082, 929	0	201.00
202.00	1.5 (Sam 111165 116 till bagil 201)	215, 770	1, 0 / 1, 043	1 777, 700	2,002,727	١	_52.00

Provi der CCN: 14-1335

Peri od: Worksheet B From 07/01/2022 Part II To 06/30/2023 Date/Time Prepared: 11/28/2023 5:06 pm

				'	0 00/30/2023	11/28/2023 5:	
	Cost Center Description	ADMI NI STRATI VE	MAINTENANCE &	OPERATION OF	LAUNDRY &	HOUSEKEEPI NG	
	•	& GENERAL	REPAI RS	PLANT	LINEN SERVICE		
		5. 00	6. 00	7. 00	8. 00	9. 00	
	GENERAL SERVICE COST CENTERS						
1.00	00100 CAP REL COSTS-BLDG & FLXT						1.00
2.00	00200 CAP REL COSTS-MVBLE EQUIP						2.00
4. 00	00400 EMPLOYEE BENEFITS DEPARTMENT						4. 00
5. 00	00500 ADMINISTRATIVE & GENERAL	279, 849					5. 00
6. 00	00600 MAINTENANCE & REPAIRS	277,047	0				6.00
7. 00	00700 OPERATION OF PLANT	20, 332	0	319, 765			7. 00
8. 00	00800 LAUNDRY & LINEN SERVICE	1	0				8.00
		1, 270	-	5, 418		17 417	•
9.00	00900 HOUSEKEEPI NG	6, 404	0	2, 134	,	17, 417	9.00
10.00	01000 DI ETARY	8, 790	0	14, 442	0	806	10.00
11.00	01100 CAFETERI A	229	0	7, 763	0	433	1
12.00	01200 MAINTENANCE OF PERSONNEL	0	0	0	0	0	12.00
13.00	01300 NURSING ADMINISTRATION	20, 169	0	2, 603	0	145	1
14. 00	01400 CENTRAL SERVICES & SUPPLY	0	0	0	0	0	14. 00
	01500 PHARMACY	0	0	0	0	0	15. 00
16. 00	01600 MEDI CAL RECORDS & LI BRARY	2, 674	0	9, 997	0	558	16. 00
17.00	01700 SOCI AL SERVI CE	0	0	0	0	0	17. 00
19.00	01900 NONPHYSICIAN ANESTHETISTS	0	0	0	0	0	19. 00
20.00	02000 NURSING PROGRAM	0	0	0	0	0	20.00
21.00	02100 I&R SERVICES-SALARY & FRINGES APPRV	0	0	0	0	0	21.00
22.00	02200 I&R SERVICES-OTHER PRGM COSTS APPRV	0	0	0	0	0	22. 00
23.00	02300 PARAMED ED PRGM-(SPECIFY)	o	0	0	0	0	23. 00
	INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000 ADULTS & PEDIATRICS	17, 666	0	39, 134	2, 655	2, 183	30.00
31.00	03100 INTENSIVE CARE UNIT	3, 341	0	10, 777	6	601	31.00
44.00	04400 SKILLED NURSING FACILITY	7, 738	0	27, 987	1, 246	1, 561	44. 00
46. 00	04600 OTHER LONG TERM CARE	12, 721	0	48, 078		2, 682	46. 00
	ANCILLARY SERVICE COST CENTERS	.=, .=.		.5, 5.5	_,	_,	
50.00	05000 OPERATI NG ROOM	30, 814	0	46, 944	3, 818	2, 619	50.00
51.00	05100 RECOVERY ROOM	16, 753	0	1, 876	954	105	1
53.00	05300 ANESTHESI OLOGY	942	0	0.7070	0	0	53.00
54.00	05400 RADI OLOGY-DI AGNOSTI C	16, 175	0	12, 401	1, 073	692	54.00
60.00	06000 LABORATORY	13, 630	0	8, 954	72	499	60.00
60. 01	06001 BLOOD LABORATORY	0	0	0, 751	0	0	60. 01
62. 30	06250 BLOOD CLOTTING FOR HEMOPHILIACS		0	0	0	0	62. 30
65. 00	06500 RESPIRATORY THERAPY	908	0	7, 564	1, 004	422	65. 00
66. 00	06600 PHYSI CAL THERAPY	7, 539	0	21, 173	755	1, 181	66.00
67.00	06700 OCCUPATI ONAL THERAPY	4, 380	0	21, 173	798	0	67.00
68. 00	06800 SPEECH PATHOLOGY	344	0	0		0	68.00
		1	0	0	63	· .	ı
71.00	07100 MEDI CAL SUPPLI ES CHARGED TO PATI ENT	14, 307	0	0	201	0	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	6, 308	0	0	0	0	72.00
	07300 DRUGS CHARGED TO PATIENTS	16, 792	0	3, 166	512	177	73.00
76. 97	07697 CARDI AC REHABI LI TATI ON	819	0	2, 932	9	164	1
76. 98	07698 HYPERBARI C OXYGEN THERAPY	0	0	0	0	0	76. 98
76. 99	07699 LI THOTRI PSY	0	0	0	0	0	76. 99
	OUTPATIENT SERVICE COST CENTERS						
	09100 EMERGENCY	47, 684	0	8, 520	1, 906	475	1
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART						92. 00
	OTHER REIMBURSABLE COST CENTERS						
99. 10	09910 CORF	0	0	0	0	0	99. 10
	SPECIAL PURPOSE COST CENTERS						
118.00	SUBTOTALS (SUM OF LINES 1 through 117)	278, 729	0	281, 863	20, 193	15, 303	118. 00
	NONREI MBURSABLE COST CENTERS						
192.00	19200 PHYSICIANS PRIVATE OFFICES	1, 120	0	37, 902	0	2, 114	192. 00
200.00	Cross Foot Adjustments						200. 00
201.00		o	0	0	0	0	201. 00
202. 00		279, 849	0	319, 765	20, 193	17, 417	202.00
		· ·					

Health Financial Systems
ALLOCATION OF CAPITAL RELATED COSTS Period: Worksheet B From 07/01/2022 Part II To 06/30/2023 Date/Time Prepared: Provi der CCN: 14-1335

				1	o 06/30/2023	Date/Time Pre 11/28/2023 5:	
	Cost Center Description	DI ETARY	CAFETERI A	MAINTENANCE OF	NURSI NG	CENTRAL	OO piii
	3001 3011101 30001 Pt 1 011	5.2.7	0,11 2 1211171		ADMI NI STRATI ON		
						SUPPLY	
		10. 00	11. 00	12.00	13.00	14. 00	
	GENERAL SERVICE COST CENTERS						
1. 00	00100 CAP REL COSTS-BLDG & FLXT						1.00
2. 00	00200 CAP REL COSTS-MVBLE EQUIP						2. 00
4. 00	00400 EMPLOYEE BENEFITS DEPARTMENT						4. 00
5. 00	00500 ADMI NI STRATI VE & GENERAL						5. 00
6. 00	00600 MAI NTENANCE & REPAI RS						6.00
7. 00	00700 OPERATION OF PLANT						7.00
8. 00	00800 LAUNDRY & LINEN SERVICE						8.00
9.00	00900 HOUSEKEEPI NG	70 447					9.00
10.00	01000 DI ETARY	72, 447	40,000				10.00
11.00	01100 CAFETERI A	22, 620	49, 089				11.00
12.00	01200 MAI NTENANCE OF PERSONNEL	0	4 212	0			12.00
13.00	01300 NURSING ADMINISTRATION	0	4, 312	1			13.00
14.00	01400 CENTRAL SERVICES & SUPPLY	0	0	0	0	0	1
15. 00 16. 00	01500 PHARMACY 01600 MEDICAL RECORDS & LIBRARY	0	1, 033	_	=	0	
17. 00	01700 SOCIAL SERVICE	0	1, 033		_	0	1
17.00	01900 NONPHYSI CI AN ANESTHETI STS	0	0	0	=	0	1
20. 00	02000 NURSI NG PROGRAM	0	0	0		0	20.00
21.00	02100 I & SERVICES-SALARY & FRINGES APPRV	0	0		٥	0	21.00
22. 00	02200 I &R SERVICES-OTHER PRGM COSTS APPRV	0	0	0	Ö	0	
23. 00	02300 PARAMED ED PRGM-(SPECIFY)	0	0	0	_	0	
20.00	INPATIENT ROUTINE SERVICE COST CENTERS	<u> </u>			<u> </u>	Ü	20.00
30. 00	03000 ADULTS & PEDIATRICS	2, 992	4, 802	0	17, 576	0	30.00
31. 00	03100 I NTENSI VE CARE UNI T	-,	587		,	0	
44. 00	04400 SKILLED NURSING FACILITY	9, 905	2, 369	•		0	1
46.00	04600 OTHER LONG TERM CARE	17, 391	4, 156	1		0	1
	ANCILLARY SERVICE COST CENTERS	· .	·		·		
50.00	05000 OPERATING ROOM	11	7, 034	0	13, 720	0	50.00
51.00	05100 RECOVERY ROOM	0	4, 993	0	17, 350	0	51.00
53.00	05300 ANESTHESI OLOGY	0	88	0		0	53.00
54.00	05400 RADI OLOGY-DI AGNOSTI C	213	4, 102		,	0	
60.00	06000 LABORATORY	574	4, 293	0	214	0	
60. 01	06001 BLOOD LABORATORY	0	0		_	0	60. 01
62. 30	06250 BLOOD CLOTTING FOR HEMOPHILIACS	0	0	1	0	0	62. 30
65.00	06500 RESPI RATORY THERAPY	17	93	•	6	0	65.00
66.00	06600 PHYSI CAL THERAPY	5, 821	2, 496		_,	0	66.00
67.00	06700 OCCUPATI ONAL THERAPY	6, 348	1, 517	1	2, 365	0	
68. 00	06800 SPEECH PATHOLOGY	498	117			0	
71.00	07100 MEDI CAL SUPPLI ES CHARGED TO PATI ENT	1, 599	930			0	
72.00	07200 I MPL. DEV. CHARGED TO PATIENTS	4 074	1 513	_		0	
73.00	07300 DRUGS CHARGED TO PATIENTS	4, 074	1, 512		,	0	
76. 97	07697 CARDI AC REHABI LI TATI ON 07698 HYPERBARI C OXYGEN THERAPY	0	127	0	_	0	
76. 98 76. 99		0	0			0	
70. 99	07699 LI THOTRI PSY OUTPATI ENT SERVI CE COST CENTERS	U		0	<u> </u>	0	76. 99
91 00	09100 EMERGENCY	384	4, 528	0	20, 908	0	91. 00
	09200 OBSERVATION BEDS (NON-DISTINCT PART	304	4, 520		20, 700		92.00
72.00	OTHER REIMBURSABLE COST CENTERS						72.00
99. 10	09910 CORF	0	0	0	0	0	99. 10
	SPECIAL PURPOSE COST CENTERS	<u> </u>					
118.00	SUBTOTALS (SUM OF LINES 1 through 117)	72, 447	49, 089	0	89, 346	0	118. 00
	NONREI MBURSABLE COST CENTERS						
	19200 PHYSICIANS PRIVATE OFFICES	0	0	0	0		192. 00
200. 00							200.00
201.00		0	0				201.00
202. 00	TOTAL (sum lines 118 through 201)	72, 447	49, 089	0	89, 346	0	202. 00

Period: Worksheet B From 07/01/2022 Part II To 06/30/2023 Date/Time Prepared: Provi der CCN: 14-1335

				Т	o 06/30/2023	Date/Time Pro 11/28/2023 5:	
	Cost Center Description	PHARMACY	MEDI CAL	SOCIAL SERVICE	NONPHYSI CI AN	NURSI NG	. 00 piii
			RECORDS &		ANESTHETI STS	PROGRAM	
			LI BRARY				
		15. 00	16. 00	17. 00	19. 00	20.00	
	GENERAL SERVICE COST CENTERS						
1. 00	00100 CAP REL COSTS-BLDG & FLXT						1.00
2. 00	00200 CAP REL COSTS-MVBLE EQUIP						2. 00
4. 00	OO4OO EMPLOYEE BENEFITS DEPARTMENT						4.00
5. 00	00500 ADMINI STRATI VE & GENERAL						5.00
6. 00	00600 MAI NTENANCE & REPAI RS						6. 00
7. 00	00700 OPERATION OF PLANT						7.00
8. 00	00800 LAUNDRY & LINEN SERVICE						8. 00
9. 00	00900 HOUSEKEEPI NG						9.00
10.00	01000 DI ETARY						10.00
11.00	01100 CAFETERI A						11.00
12.00	01200 MAINTENANCE OF PERSONNEL						12.00
13.00	01300 NURSI NG ADMI NI STRATI ON						13.00
14.00	01400 CENTRAL SERVI CES & SUPPLY						14.00
	01500 PHARMACY	0	27 400				15.00
16.00	01600 MEDI CAL RECORDS & LI BRARY	0	37, 499				16.00
17.00	01700 SOCI AL SERVI CE	0	0	0			17. 00
	01900 NONPHYSI CI AN ANESTHETI STS	0	0	0	0	l ,	19.00
20.00	02000 NURSI NG PROGRAM	0	0	0			20.00
21.00	02100 I &R SERVI CES-SALARY & FRI NGES APPRV	0	0	0			21.00
22.00	02200 I &R SERVI CES-OTHER PRGM COSTS APPRV	0	0	0			22. 00
23. 00	02300 PARAMED ED PRGM-(SPECIFY)	U	0				23. 00
30. 00	INPATIENT ROUTINE SERVICE COST CENTERS 03000 ADULTS & PEDIATRICS	0	1, 711	0			30.00
31. 00	03100 INTENSIVE CARE UNIT	0	73				31.00
44. 00	04400 SKILLED NURSING FACILITY	0	73	1			44.00
	04600 OTHER LONG TERM CARE	0	0	1			46.00
40.00	ANCI LLARY SERVICE COST CENTERS	<u> </u>					1 40.00
50. 00	05000 OPERATI NG ROOM	0	24, 429	0			50.00
51. 00	05100 RECOVERY ROOM	0	21, 127	0			51.00
53. 00	05300 ANESTHESI OLOGY	0	0	0			53.00
54.00	05400 RADI OLOGY-DI AGNOSTI C	0	6, 116	0			54.00
60.00	06000 LABORATORY	0	0, 0	0			60.00
60. 01	06001 BLOOD LABORATORY	0	0	0			60. 01
62. 30	06250 BLOOD CLOTTING FOR HEMOPHILIACS	o	0	l o			62. 30
65.00	06500 RESPIRATORY THERAPY	0	0	0			65.00
66.00	06600 PHYSI CAL THERAPY	0	765	0			66. 00
67.00	06700 OCCUPATI ONAL THERAPY	0	0	0			67.00
68.00	06800 SPEECH PATHOLOGY	o	0	0			68. 00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0			71. 00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0	0	0			72. 00
73.00	07300 DRUGS CHARGED TO PATIENTS	0	0	0			73. 00
76. 97	07697 CARDI AC REHABI LI TATI ON	0	0	0			76. 97
76. 98	07698 HYPERBARI C OXYGEN THERAPY	0	0	0			76. 98
76. 99	07699 LI THOTRI PSY	0	0	0			76. 99
	OUTPATIENT SERVICE COST CENTERS						
	09100 EMERGENCY	0	4, 405	0			91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART						92. 00
	OTHER REIMBURSABLE COST CENTERS						
99. 10	09910 CORF	0	0	0			99. 10
	SPECIAL PURPOSE COST CENTERS	.1					
118. 00		0	37, 499	0	0		118. 00
40-	NONREI MBURSABLE COST CENTERS	.1					1.00
	19200 PHYSICIANS PRIVATE OFFICES	0	0	0			192. 00
200.00		_]	=	_	0		200.00
201. 00		0	07.400	0			201.00
202. 00	TOTAL (sum lines 118 through 201)	0	37, 499	0	0	1	202.00

ALLOCATION OF CAPITAL RELATED COSTS	Provi der CCN: 14-1335	Peri od:	Worksheet B
		From 07/01/2022	Part II
		To 06/30/2023	Date/Time Prepared:
			11/20/2022 E. 04 pm

					To 06/30/		ate/Time Prep 1/28/2023 5:(
		INTERNS &	RESI DENTS				1/20/2023 5.	JO DIII
	Cost Center Description		SERVI CES-OTHER		Subtota	I	Intern &	
		Y & FRINGES	PRGM COSTS	PRGM		Res	idents Cost	
		APPRV	APPRV				& Post Stepdown	
							djustments	
		21. 00	22. 00	23. 00	24. 00		25. 00	
	GENERAL SERVICE COST CENTERS							
1.00	00100 CAP REL COSTS-BLDG & FLXT							1.00
2. 00	00200 CAP REL COSTS-MVBLE EQUIP							2. 00
4. 00	00400 EMPLOYEE BENEFITS DEPARTMENT							4.00
5. 00 6. 00	00500 ADMINISTRATIVE & GENERAL 00600 MAINTENANCE & REPAIRS							5. 00
7. 00	00700 OPERATION OF PLANT							6. 00 7. 00
8. 00	00800 LAUNDRY & LINEN SERVICE							8. 00
9. 00	00900 HOUSEKEEPI NG							9. 00
10.00	01000 DI ETARY							10.00
11.00	01100 CAFETERI A							11.00
12.00	01200 MAINTENANCE OF PERSONNEL							12.00
13.00	01300 NURSI NG ADMI NI STRATI ON							13.00
14.00	01400 CENTRAL SERVICES & SUPPLY							14.00
15.00	01500 PHARMACY							15.00
16. 00 17. 00	01600 MEDI CAL RECORDS & LI BRARY 01700 SOCI AL SERVI CE							16. 00 17. 00
19.00	01900 NONPHYSICIAN ANESTHETISTS							17.00
20. 00	02000 NURSI NG PROGRAM							20. 00
21.00	02100 I &R SERVICES-SALARY & FRINGES APPRV	0						21. 00
22. 00	02200 I &R SERVICES-OTHER PRGM COSTS APPRV]	0					22. 00
23.00	02300 PARAMED ED PRGM-(SPECIFY)	•			0			23.00
	INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000 ADULTS & PEDI ATRI CS					3, 346	0	30.00
31.00	03100 I NTENSI VE CARE UNI T					2, 832	0	31.00
44. 00 46. 00	04400 SKILLED NURSING FACILITY					5, 892	0	44. 00 46. 00
46.00	04600 OTHER LONG TERM CARE ANCILLARY SERVICE COST CENTERS				222	1, 979	0	46.00
50.00	05000 OPERATI NG ROOM				594	, 474	0	50. 00
51.00	05100 RECOVERY ROOM					3, 146	O	51.00
53.00	05300 ANESTHESI OLOGY				1	, 932	0	53.00
54.00	05400 RADI OLOGY-DI AGNOSTI C				229	, 037	0	54.00
60.00	06000 LABORATORY				56	, 322	0	60.00
60. 01	06001 BLOOD LABORATORY					0	0	60. 01
62. 30 65. 00	06250 BLOOD CLOTTI NG FOR HEMOPHI LI ACS 06500 RESPI RATORY THERAPY				27	0 7, 225	0	62. 30 65. 00
66.00	06600 PHYSI CAL THERAPY					, 223	0	66. 00
67. 00	06700 OCCUPATI ONAL THERAPY					, 475	ő	67. 00
68. 00	06800 SPEECH PATHOLOGY					, 526	ő	68. 00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT					, 872	o	71. 00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS				6	, 308	o	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS					', 100	0	73.00
	07697 CARDI AC REHABI LI TATI ON				20), 168	0	76. 97
	07698 HYPERBARI C OXYGEN THERAPY					0		76. 98
76. 99	07699 LI THOTRI PSY OUTPATI ENT SERVI CE COST CENTERS					0	0	76. 99
91 00	09100 EMERGENCY				143	2, 963	0	91. 00
	09200 OBSERVATION BEDS (NON-DISTINCT PART				172	., 703		92.00
72.00	OTHER REIMBURSABLE COST CENTERS	<u> </u>					Ŭ.	72.00
99. 10	09910 CORF					0	0	99. 10
	SPECIAL PURPOSE COST CENTERS							
118. 00		0	0		0 1, 953	3, 697	0	118. 00
102.00	NONREI MBURSABLE COST CENTERS				100	222		102 00
200.00	19200 PHYSICIANS PRIVATE OFFICES Cross Foot Adjustments	0	0		0	0, 232 0		192. 00 200. 00
200.00			0		0	0		200.00
202. 00		0			0 2,082	2, 929		202. 00
50	('	,		_,,	* * *1	۹۱	

Peri od: Worksheet B From 07/01/2022 Part II To 06/30/2023 Date/Time Prepared: 11/28/2023 5:06 pm

			11/28/2023	5:06 pm
	Cost Center Description	Total		
		26. 00		
	GENERAL SERVICE COST CENTERS			
1.00	00100 CAP REL COSTS-BLDG & FLXT			1.00
2.00	00200 CAP REL COSTS-MVBLE EQUIP			2.00
4.00	00400 EMPLOYEE BENEFITS DEPARTMENT			4.00
5. 00	00500 ADMINISTRATIVE & GENERAL			5. 00
6. 00	00600 MAI NTENANCE & REPAI RS			6.00
7. 00	00700 OPERATION OF PLANT			7.00
8. 00	00800 LAUNDRY & LINEN SERVICE			8. 00
9. 00	00900 HOUSEKEEPI NG			9. 00
10.00	01000 DI ETARY			10.00
11.00	01100 CAFETERI A			11.00
12.00	01200 MAINTENANCE OF PERSONNEL			12.00
				•
13.00	01300 NURSI NG ADMI NI STRATI ON			13.00
14.00	01400 CENTRAL SERVICES & SUPPLY			14. 00
15.00	01500 PHARMACY			15. 00
16.00	01600 MEDICAL RECORDS & LIBRARY			16. 00
17. 00	01700 SOCI AL SERVI CE			17. 00
19.00	01900 NONPHYSICIAN ANESTHETISTS			19. 00
20.00	02000 NURSING PROGRAM			20.00
21.00	02100 I&R SERVICES-SALARY & FRINGES APPRV			21.00
22.00	02200 I&R SERVICES-OTHER PRGM COSTS APPRV			22. 00
23.00	02300 PARAMED ED PRGM-(SPECIFY)			23.00
	INPATIENT ROUTINE SERVICE COST CENTERS			
30.00	03000 ADULTS & PEDIATRICS	243, 346		30.00
31.00	03100 I NTENSI VE CARE UNI T	42, 832		31.00
44.00	04400 SKILLED NURSING FACILITY	125, 892		44. 00
46. 00	04600 OTHER LONG TERM CARE	224, 979		46.00
40.00	ANCILLARY SERVICE COST CENTERS	224, 717		40.00
50.00	05000 OPERATING ROOM	594, 474		50.00
51.00	05100 RECOVERY ROOM	53, 146		51.00
53.00	05300 ANESTHESI OLOGY	1, 932		53.00
54.00	05400 RADI OLOGY-DI AGNOSTI C	229, 037		54.00
60.00	06000 LABORATORY	56, 322		60.00
60. 01	06001 BLOOD LABORATORY	0		60. 01
62. 30	06250 BLOOD CLOTTING FOR HEMOPHILIACS	0		62. 30
65.00	06500 RESPI RATORY THERAPY	37, 225		65. 00
66.00	06600 PHYSI CAL THERAPY	95, 100		66. 00
67.00	06700 OCCUPATI ONAL THERAPY	19, 475		67. 00
68.00	06800 SPEECH PATHOLOGY	1, 526		68. 00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	21, 872		71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	6, 308		72. 00
73.00	07300 DRUGS CHARGED TO PATIENTS	37, 100		73.00
76. 97	07697 CARDI AC REHABI LI TATI ON	20, 168		76. 97
76. 98	07698 HYPERBARI C OXYGEN THERAPY	0		76. 98
76. 99	07699 LI THOTRI PSY	o		76. 99
, 0. , ,	OUTPATIENT SERVICE COST CENTERS	0		- / 0. //
91.00	09100 EMERGENCY	142, 963		91, 00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART	142, 703		92.00
72.00	OTHER REIMBURSABLE COST CENTERS			72.00
99. 10	09910 CORF	0		99. 10
99. 10		U U		79. 10
110 00	SPECIAL PURPOSE COST CENTERS	1 050 (07		110 00
118. 00	3 7	1, 953, 697		118. 00
40-	NONREI MBURSABLE COST CENTERS			100
	19200 PHYSICIANS PRIVATE OFFICES	129, 232		192. 00
200.00		0		200. 00
201. 00		0		201. 00
202. 00	TOTAL (sum lines 118 through 201)	2, 082, 929		202. 00

				o 06/30/2023		
	CAPITAL REI	L LATED COSTS			11/28/2023 5:	06 pm
01.01	DI DO A FLYT	MANDLE FOLLID	EMBLOVEE	D	ADMINI CEDATINE	
Cost Center Description	BLDG & FIXT (SQUARE FEET)	MVBLE EQUIP (DOLLAR VALUE)	EMPLOYEE BENEFITS	Reconciliation	ADMINISTRATIVE & GENERAL	
	,		DEPARTMENT		(ACCUM. COST)	
			(GROSS SALARI ES)			
	1.00	2.00	4.00	5A	5. 00	
GENERAL SERVICE COST CENTERS	00.055	1				1 00
1. 00 00100 CAP REL COSTS-BLDG & FIXT 2. 00 00200 CAP REL COSTS-MVBLE EQUIP	80, 055	750, 838				1. 00 2. 00
4. 00 00400 EMPLOYEE BENEFITS DEPARTMENT	0	0	13, 972, 653	3		4.00
5. 00 00500 ADMI NI STRATI VE & GENERAL	9, 599	6, 208	2, 653, 608	-4, 912, 371	22, 006, 162	5.00
6. 00 00600 MAINTENANCE & REPAIRS 7. 00 00700 OPERATION OF PLANT	0 15, 922	53, 083	(0 1, 598, 802	6. 00 7. 00
8.00 00800 LAUNDRY & LINEN SERVICE	924	880	C	Ö	99, 830	8. 00
9. 00 00900 HOUSEKEEPI NG	364	951	190, 104		503, 560	9.00
10. 00 01000 DI ETARY 11. 00 01100 CAFETERI A	2, 463 1, 324	13, 940	504, 866		691, 229 18, 044	10. 00 11. 00
12.00 01200 MAINTENANCE OF PERSONNEL	0	o	C	Ö	0	12. 00
13. 00 01300 NURSI NG ADMI NI STRATI ON	444	54, 115	1, 103, 868		1, 585, 966	13.00
14. 00 01400 CENTRAL SERVICES & SUPPLY 15. 00 01500 PHARMACY	0		(0 0	14. 00 15. 00
16.00 01600 MEDICAL RECORDS & LIBRARY	1, 705	o	139, 118	0	210, 233	16. 00
17. 00 01700 SOCI AL SERVI CE	0	· -	C	0	0	17.00
19.00 01900 NONPHYSI CLAN ANESTHETISTS 20.00 02000 NURSI NG PROGRAM	0	0	(0	19. 00 20. 00
21.00 02100 I&R SERVICES-SALARY & FRINGES APPRV	0	o	C	Ö	0	21. 00
22. 00 02200 L&R SERVICES-OTHER PRGM COSTS APPRV	0	0	C	0	0	22.00
23. 00 02300 PARAMED ED PRGM-(SPECIFY) INPATIENT ROUTINE SERVICE COST CENTERS	0	0	C	0	0	23. 00
30. 00 03000 ADULTS & PEDI ATRI CS	6, 674	55, 602	972, 982	2 0	1, 389, 198	30.00
31. 00 03100 I NTENSI VE CARE UNI T	1, 838		154, 402		,	31.00
44.00 04400 SKILLED NURSING FACILITY 46.00 04600 OTHER LONG TERM CARE	4, 773 8, 199		371, 267 669, 268			44. 00 46. 00
ANCI LLARY SERVI CE COST CENTERS	0, 177	0, 177	007, 200	,	1,000,207	10.00
50. 00 05000 OPERATI NG ROOM	8, 006		1, 188, 947		_,,	50.00
51. 00 05100 RECOVERY ROOM 53. 00 05300 ANESTHESI OLOGY	320 0	5, 432 400	998, 373 (1, 317, 360 74, 063	51. 00 53. 00
54. 00 05400 RADI OLOGY - DI AGNOSTI C	2, 115		836, 545	-	1, 271, 905	54.00
60. 00 06000 LABORATORY	1, 527	5, 463	765, 312		1, 071, 810	•
60. 01 06001 BLOOD LABORATORY 62. 30 06250 BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0		0	60. 01 62. 30
65. 00 06500 RESPI RATORY THERAPY	1, 290	9, 293	20, 250	o o	71, 402	65.00
66. 00 06600 PHYSI CAL THERAPY	3, 611	2, 972	404, 152		592, 823	66.00
67. 00 06700 0CCUPATI ONAL THERAPY 68. 00 06800 SPEECH PATHOLOGY	0	2, 992 235	237, 922 18, 667		344, 426 27, 023	67. 00 68. 00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0	3, 856	114, 827		1, 125, 009	71.00
72. 00 07200 IMPL. DEV. CHARGED TO PATIENTS	0		0 (0)	0	496, 048	
73. 00 07300 DRUGS CHARGED TO PATLENTS 76. 97 07697 CARDLAC REHABILLITATION	540 500		369, 608 30, 178		.,,	76. 97
76. 98 07698 HYPERBARI C OXYGEN THERAPY	0		00, 170		l .	76. 98
76. 99 07699 LI THOTRI PSY	0	0	C	0	0	76. 99
OUTPATIENT SERVICE COST CENTERS 91. 00 09100 EMERGENCY	1, 453	31, 201	2, 228, 389) 0	3, 749, 841	91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART	,	,				92.00
OTHER REIMBURSABLE COST CENTERS 99. 10 O9910 CORF	0			0		00 10
99. 10 09910 CORF SPECI AL PURPOSE COST CENTERS	0	0		0	0	99. 10
118.00 SUBTOTALS (SUM OF LINES 1 through 117)	73, 591	750, 838	13, 972, 653	-4, 912, 371	21, 918, 066	118. 00
NONREI MBURSABLE COST CENTERS 192. 00 19200 PHYSI CI ANS PRI VATE OFFI CES	6, 464	O	C	0	400.00	192. 00
200.00 Cross Foot Adjustments	0, 404			,	88,090	200.00
201.00 Negative Cost Centers						201. 00
202.00 Cost to be allocated (per Wkst. B, Part I)	1, 091, 043	777, 908	1, 709, 828	3	4, 912, 371	202. 00
203.00 Unit cost multiplier (Wkst. B, Part I)	13. 628668	1. 036053	0. 122370		0. 223227	203. 00
204.00 Cost to be allocated (per Wkst. B,			C		279, 849	204. 00
Part II) 205.00 Unit cost multiplier (Wkst. B, Part			0. 000000		0. 012717	205 00
II)			0.000000		0.012/1/	200.00
206.00 NAHE adjustment amount to be allocated						206. 00
(per Wkst. B-2) 207.00 NAHE unit cost multiplier (Wkst. D,						207. 00
Parts III and IV)						

Provi der CCN: 14-1335

Peri od: From 07/01/2022 To 06/30/2023 Date/Ti me Prepared:

				'	0 00/30/2023	11/28/2023 5:	
	Cost Center Description	MAINTENANCE & REPAIRS	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPING (SQUARE FEET)	DI ETARY	
		(SQUARE FEET)	(SQUARE FEET)	(POUNDS OF	(SQUARE TELT)	(WLALS SLRVLD)	
			7.00	LAUNDR)	2.22	10.00	
	GENERAL SERVICE COST CENTERS	6. 00	7. 00	8. 00	9. 00	10. 00	
1. 00	00100 CAP REL COSTS-BLDG & FIXT						1.00
2. 00	00200 CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400 EMPLOYEE BENEFITS DEPARTMENT						4. 00
5.00	00500 ADMINISTRATIVE & GENERAL						5. 00
6.00	00600 MAI NTENANCE & REPAI RS	0	o.				6.00
7.00	00700 OPERATION OF PLANT	0	54, 534 924				7.00
8. 00 9. 00	00800 LAUNDRY & LI NEN SERVI CE 00900 HOUSEKEEPI NG	0	364	151, 285 21, 976	l .		8. 00 9. 00
10.00	01000 DI ETARY	0	2, 463	0	2, 463	52, 421	10.00
11.00	01100 CAFETERI A	0	1, 324	0		16, 368	11.00
12.00	01200 MAINTENANCE OF PERSONNEL	0	0	0	o	0	12.00
13.00	01300 NURSING ADMINISTRATION	0	444	0	444	0	13.00
14.00	01400 CENTRAL SERVICES & SUPPLY	0	0	0	0	0	14.00
15. 00 16. 00	01500 PHARMACY 01600 MEDI CAL RECORDS & LI BRARY	0	1, 705	0	1, 705	0	15. 00 16. 00
17. 00	01700 SOCIAL SERVICE	0	1, 703	0	1, 703	0	17.00
19. 00	01900 NONPHYSI CI AN ANESTHETI STS	0	Ö	Ö	o	0	19.00
20.00	02000 NURSING PROGRAM	0	0	0	o	0	20. 00
21. 00	02100 I &R SERVICES-SALARY & FRINGES APPRV	0	0	0	0	0	21.00
22. 00	02200 I &R SERVI CES-OTHER PRGM COSTS APPRV	0	0	0	0	0	22. 00
23. 00	02300 PARAMED ED PRGM-(SPECIFY)	0	0	0	0	0	23. 00
30.00	INPATIENT ROUTINE SERVICE COST CENTERS 03000 ADULTS & PEDIATRICS	0	6, 674	19, 891	6, 674	2, 165	30.00
31.00	03100 INTENSIVE CARE UNIT	0			l ' '	2, 103	31.00
44. 00	04400 SKILLED NURSING FACILITY	0		9, 335		7, 167	44.00
46.00	04600 OTHER LONG TERM CARE	0	8, 199	16, 390	8, 199	12, 584	46. 00
	ANCILLARY SERVICE COST CENTERS	1					
50.00	05000 OPERATI NG ROOM	0	8, 006	28, 600	l	8	50.00
51. 00 53. 00	05100 RECOVERY ROOM 05300 ANESTHESI OLOGY	0	320	7, 150 0	320	0	51. 00 53. 00
54.00	05400 RADI OLOGY-DI AGNOSTI C	0	2, 115	8, 041	2, 115	154	54.00
60.00	06000 LABORATORY	0	1, 527	540	l	415	60.00
60. 01	06001 BLOOD LABORATORY	0	0	0	o	0	60. 01
62. 30	06250 BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0	0	0	62. 30
65.00	06500 RESPI RATORY THERAPY	0	1, 290			12	65.00
66. 00 67. 00	06600 PHYSI CAL THERAPY 06700 OCCUPATI ONAL THERAPY	0	3, 611	5, 655 5, 982	3, 611	4, 212 4, 593	66. 00 67. 00
68.00	06800 SPEECH PATHOLOGY	0	0	3, 962		360	68.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0	Ö	1, 507	o	1, 157	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0	0	0	o	0	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0	540		l .	2, 948	73. 00
76. 97	07697 CARDI AC REHABI LI TATI ON	0	500		500	0	76. 97
76. 98	07698 HYPERBARI C OXYGEN THERAPY	0	0	0	0	0	76. 98
76. 99	07699 LI THOTRI PSY OUTPATI ENT SERVI CE COST CENTERS	0		0	l o	U	76. 99
91.00	09100 EMERGENCY	0	1, 453	14, 276	1, 453	278	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART		,,,,,,,	,	.,		92.00
	OTHER REIMBURSABLE COST CENTERS						
99. 10	09910 CORF	0	0	0	0	0	99. 10
440.0	SPECIAL PURPOSE COST CENTERS	1 0	40.070	154 005	44 700	FO 404	1440 00
118. 00	SUBTOTALS (SUM OF LINES 1 through 117) NONREIMBURSABLE COST CENTERS	0	48, 070	151, 285	46, 782	52, 421	1118.00
192 0	19200 PHYSI CLANS PRI VATE OFFI CES	Ο	6, 464	0	6, 464	0	192. 00
200. 00		0	0, 404		0, 404	O	200.00
201. 00	1 1						201. 00
202. 00	Cost to be allocated (per Wkst. B,	0	1, 955, 698	155, 251	651, 574	963, 998	202. 00
	Part I)						
203. 00		0. 000000		1. 026215	l .	18. 389539	
204. 00		0	319, 765	20, 193	17, 417	72, 447	204.00
205. 00	Part II) Unit cost multiplier (Wkst. B, Part	0. 000000	5. 863590	0. 133477	0. 327104	1. 382022	205 00
200.00		5. 000000	3. 003390	0. 133477	0. 327 104	1. 302022	200.00
206. 00	1 1 /						206. 00
	(per Wkst. B-2)						
207. 0							207. 00
	Parts III and IV)	I	I	I	ı I		I

COST A	ALLOCATION - STATISTICAL BASIS		Provi der C	Į.	Period: From 07/01/2022 To 06/30/2023		epared:
	Cost Center Description	CAFETERI A	MAINTENANCE OF	NURSI NG	CENTRAL	11/28/2023 5: PHARMACY	06 pm
	cost center bescription	(FULL TIME		ADMI NI STRATI ON		(COSTED	
		EQUI VALE)	(FULL TIME	(DI RECT NRS	SUPPLY	REQUIS.)	
			EQUI VALE)	ING HR)	(COSTED		
		11 00	12.00	12.00	REQUIS.)	15.00	
	GENERAL SERVICE COST CENTERS	11. 00	12. 00	13. 00	14. 00	15. 00	
1. 00	00100 CAP REL COSTS-BLDG & FLXT						1.00
2. 00	00200 CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400 EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500 ADMI NI STRATI VE & GENERAL						5. 00
6. 00	00600 MAINTENANCE & REPAIRS						6.00
7. 00 8. 00	00700 OPERATION OF PLANT 00800 LAUNDRY & LINEN SERVICE						7. 00 8. 00
9. 00	00900 HOUSEKEEPI NG						9.00
10.00	01000 DI ETARY						10.00
11.00	01100 CAFETERI A	10, 029					11. 00
12.00	01200 MAINTENANCE OF PERSONNEL	0	0				12.00
13.00	01300 NURSING ADMINISTRATION	881	0	71, 957			13.00
14. 00 15. 00	01400 CENTRAL SERVICES & SUPPLY 01500 PHARMACY	0) 0			0	14. 00 15. 00
16. 00	01600 MEDI CAL RECORDS & LI BRARY	211	0		0		1
17. 00	01700 SOCI AL SERVI CE	0	Ō		0	Ō	
19.00	01900 NONPHYSICIAN ANESTHETISTS	0	0		0	0	19. 00
20.00	02000 NURSING PROGRAM	0	0	(0	0	
21.00	02100 I &R SERVI CES-SALARY & FRI NGES APPRV	0	0		0	0	1
22. 00 23. 00	02200 I &R SERVI CES-OTHER PRGM COSTS APPRV	0	0 0	-	0	0	
23.00	02300 PARAMED ED PRGM-(SPECIFY) INPATIENT ROUTINE SERVICE COST CENTERS	0	0) 0		23.00
30.00	03000 ADULTS & PEDIATRICS	981	0	14, 155	0	0	30.00
31.00	03100 INTENSIVE CARE UNIT	120	0			0	31.00
44.00	04400 SKILLED NURSING FACILITY	484	0	1			1
46. 00	04600 OTHER LONG TERM CARE	849	0	5, 220) 0	0	46. 00
50. 00	ANCILLARY SERVICE COST CENTERS 05000 OPERATING ROOM	1, 437	0	11, 050) 0	0	50.00
51.00	05100 RECOVERY ROOM	1, 437	0				1
53.00	05300 ANESTHESI OLOGY	18	0	1		1	
54.00	05400 RADI OLOGY-DI AGNOSTI C	838	0	1, 051	0	0	
60.00	06000 LABORATORY	877	0	172	0	0	
60. 01	06001 BLOOD LABORATORY	0	0		0	0	
62. 30 65. 00	06250 BLOOD CLOTTING FOR HEMOPHILIACS 06500 RESPIRATORY THERAPY	0	0	(0	0	
66.00	06600 PHYSI CAL THERAPY	510	0	1, 747	0		1
67. 00	06700 OCCUPATI ONAL THERAPY	310	Ö			Ö	
68.00	06800 SPEECH PATHOLOGY	24	0	149	0	0	68. 00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	190	0	480	0	0	
72.00	07200 I MPL. DEV. CHARGED TO PATIENTS	0	0	1 22	0	0	
73. 00	07300 DRUGS CHARGED TO PATIENTS 07697 CARDIAC REHABILITATION	309 26	0	1, 223		0	
	07698 HYPERBARI C OXYGEN THERAPY	0	0	1	<u> </u>		
76. 99	07699 LI THOTRI PSY	0	0		-	l e	
	OUTPATIENT SERVICE COST CENTERS						
91.00	09100 EMERGENCY	925	0	16, 838	0	0	
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART						92.00
99. 10	OTHER REIMBURSABLE COST CENTERS 09910 CORF	0	0		0	0	99. 10
77. 10	SPECIAL PURPOSE COST CENTERS	0	0) 0		77. 10
118. 00		10, 029	0	71, 957	0	0	118. 00
	NONREI MBURSABLE COST CENTERS						
	19200 PHYSICIANS PRIVATE OFFICES	0	0	(0	0	192. 00
200.00							200.00
201. 00 202. 00		386, 755	0	1, 995, 327	,		201. 00 202. 00
202.00	Part I)	300, 733	0	1, 775, 327	0	١	202.00
203. 00	,	38. 563665	0. 000000	27. 729436	0. 000000	0. 000000	203. 00
204. 00		49, 089	0	89, 346			204.00
	Part II)						
205. 00		4. 894705	0. 000000	1. 241658	0. 000000	0. 000000	205. 00
206. 00	NAHE adjustment amount to be allocated						206. 00
200. U	(per Wkst. B-2)						200.00
207. 00	NAHE unit cost multiplier (Wkst. D,						207. 00
	Parts III and IV)						1

Health Financial Systems
COST ALLOCATION - STATISTICAL BASIS Provi der CCN: 14-1335

				l C	06/30/2023	Date/lime Pre 11/28/2023 5:	
						INTERNS &	<u> Бо</u>
	Cost Center Description	MEDI CAL	COCIAI SEDVICE	NONDHYSLCLAN	MIDCINC	RESI DENTS SERVI CES-SALAR	
	Cost Center Description	RECORDS &	SOCIAL SERVICE	ANESTHETISTS	NURSI NG PROGRAM	Y & FRINGES	
		LI BRARY	(TIME SPENT)	(ASSI GNED	(ASSI GNED	APPRV	
		(TIME SPENT)		TIME)	TIME)	(ASSI GNED	
		1/ 00	17.00	10.00	20.00	TIME)	
	GENERAL SERVICE COST CENTERS	16. 00	17. 00	19. 00	20. 00	21. 00	
	00100 CAP REL COSTS-BLDG & FLXT						1.00
	00200 CAP REL COSTS-MVBLE EQUIP						2. 00
	00400 EMPLOYEE BENEFITS DEPARTMENT						4. 00
	00500 ADMINISTRATIVE & GENERAL 00600 MAINTENANCE & REPAIRS						5.00
	00700 OPERATION OF PLANT						6. 00 7. 00
	00800 LAUNDRY & LINEN SERVICE						8. 00
	00900 HOUSEKEEPI NG						9. 00
	01000 DI ETARY						10.00
	01100 CAFETERIA 01200 MAINTENANCE OF PERSONNEL						11. 00 12. 00
	01300 NURSING ADMINISTRATION						13.00
	01400 CENTRAL SERVICES & SUPPLY						14.00
	01500 PHARMACY						15. 00
	01600 MEDICAL RECORDS & LIBRARY	1, 030					16.00
	01700 SOCI AL SERVI CE 01900 NONPHYSI CI AN ANESTHETI STS	0	0	0			17. 00 19. 00
	02000 NURSI NG PROGRAM	0	Ö		0		20.00
	02100 I&R SERVICES-SALARY & FRINGES APPRV	0	0			0	21.00
	02200 I&R SERVICES-OTHER PRGM COSTS APPRV	0	0				22. 00
	02300 PARAMED ED PRGM-(SPECIFY) INPATIENT ROUTINE SERVICE COST CENTERS	0	0				23. 00
	03000 ADULTS & PEDIATRICS	47	0	O	0	0	30.00
	03100 NTENSI VE CARE UNI T	2	Ö		Ö	0	1
	04400 SKILLED NURSING FACILITY	0	0		0	0	1
	04600 OTHER LONG TERM CARE	0	0	0	0	0	46. 00
	ANCILLARY SERVICE COST CENTERS 05000 OPERATING ROOM	671	0	O	0	0	50.00
	05100 RECOVERY ROOM	0	1		Ö	0	
53.00	05300 ANESTHESI OLOGY	0	0	0	0	0	53.00
	05400 RADI OLOGY-DI AGNOSTI C	168	l	0	0	0	
	06000 LABORATORY 06001 BLOOD LABORATORY	0	0	1	0	0	
	06250 BLOOD CLOTTING FOR HEMOPHILIACS	0		1	0	0	1
	06500 RESPIRATORY THERAPY	0	o	0	0	0	65.00
	06600 PHYSI CAL THERAPY	21	0	0	0	0	66.00
	06700 OCCUPATI ONAL THERAPY	0	0	0	0	0	
	06800 SPEECH PATHOLOGY 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	0	1
	07200 IMPL. DEV. CHARGED TO PATIENTS	0	Ö	Ö	Ö	0	
	07300 DRUGS CHARGED TO PATIENTS	0	0		0	0	
	07697 CARDI AC REHABI LI TATI ON	0	0	0	0	0	1 . 0 . , ,
	07698 HYPERBARI C OXYGEN THERAPY 07699 LI THOTRI PSY	0	0	T .	0	0	1
	OUTPATIENT SERVICE COST CENTERS	<u> </u>		<u> </u>		<u> </u>	70.77
	09100 EMERGENCY	121	0	0	0	0	
	09200 OBSERVATION BEDS (NON-DISTINCT PART						92.00
	OTHER REIMBURSABLE COST CENTERS 09910 CORF	0	0	O	0	0	99. 10
	SPECIAL PURPOSE COST CENTERS	0		0	<u> </u>	0	77.10
118. 00	SUBTOTALS (SUM OF LINES 1 through 117)	1, 030	0	0	0	0	118. 00
	NONREI MBURSABLE COST CENTERS						
192. 00 200. 00	19200 PHYSICIANS PRIVATE OFFICES Cross Foot Adjustments	0	0	0	0	0	192. 00 200. 00
200.00	Negative Cost Centers						200.00
202. 00	Cost to be allocated (per Wkst. B,	347, 309	0	0	0	0	202.00
	Part I)						
203. 00	Unit cost multiplier (Wkst. B, Part I)	337. 193204	l	0. 000000	0. 000000		
204. 00	Cost to be allocated (per Wkst. B, Part II)	37, 499	0	0	0	0	204. 00
205. 00	Unit cost multiplier (Wkst. B, Part	36. 406796	0. 000000	0. 000000	0. 000000	0. 000000	205. 00
	11)						
206. 00	NAHE adjustment amount to be allocated				0		206. 00
207. 00	(per Wkst. B-2) NAHE unit cost multiplier (Wkst. D,				0. 000000		207. 00
237.00	Parts III and IV)				5. 555556		
'	,			,	·		

Heal th Financial Systems HARVARD MEMORIAL HOSPITAL In Lieu of Form CMS-2552-10 COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 14-1335 | Period: From 07/01/2022 To 06/30/2023 | Date/Time Prepared:

				To 06/30/2023	Date/Time Prepared: 11/28/2023 5:06 pm	
	INTERNS &		<u>'</u>		, , , <u>, , , , , , , , , , , , , , , , </u>	
Cost Center Description	RESI DENTS SERVI CES-OTHER	PARAMED ED				
cost center bescription	PRGM COSTS	PRGM				
	APPRV	(ASSI GNED				
	(ASSI GNED TIME)	TIME)				
	22. 00	23. 00				
GENERAL SERVICE COST CENTERS						_
1.00 00100 CAP REL COSTS-BLDG & FIXT 2.00 00200 CAP REL COSTS-MVBLE EQUIP					1.0	
4. 00 00400 EMPLOYEE BENEFITS DEPARTMENT					4.0	
5. 00 00500 ADMI NI STRATI VE & GENERAL					5. 0	
6. 00 00600 MAINTENANCE & REPAIRS					6. 0	
7.00 00700 OPERATION OF PLANT 8.00 00800 LAUNDRY & LINEN SERVICE					7.0	
9. 00 00900 HOUSEKEEPI NG					9.0	
10. 00 01000 DI ETARY					10. 0	Ю
11. 00 01100 CAFETERI A					11.0	
12.00 O1200 MAINTENANCE OF PERSONNEL 13.00 O1300 NURSING ADMINISTRATION					12. 0	
14. 00 01400 CENTRAL SERVICES & SUPPLY					14. 0	
15. 00 01500 PHARMACY					15. 0	
16. 00 01600 MEDI CAL RECORDS & LI BRARY					16.0	
17. 00 01700 SOCI AL SERVI CE 19. 00 01900 NONPHYSI CI AN ANESTHETI STS					17. 0	
20. 00 02000 NURSI NG PROGRAM					20. 0	
21.00 02100 I &R SERVICES-SALARY & FRINGES APPRV					21. 0	Ю
22. 00 02200 L&R SERVICES-OTHER PRGM COSTS APPRV	0				22. 0	
23. 00 O2300 PARAMED ED PRGM-(SPECIFY) I NPATIENT ROUTINE SERVICE COST CENTERS		0			23. 0	Ю
30. 00 03000 ADULTS & PEDIATRICS	0	0			30.0	00
31.00 03100 INTENSIVE CARE UNIT	0	O			31. 0	
44.00 04400 SKILLED NURSING FACILITY	0	0			44.0	
46.00 O4600 OTHER LONG TERM CARE ANCILLARY SERVICE COST CENTERS	0	0			46. 0	Ю
50. 00 05000 OPERATING ROOM	0	0			50.0	0
51. 00 05100 RECOVERY ROOM	0	0			51. 0	
53. 00 05300 ANESTHESI OLOGY 54. 00 05400 RADI OLOGY - DI AGNOSTI C	0	0			53. 0 54. 0	
60. 00 06000 LABORATORY	Ö	O			60. 0	
60. 01 06001 BLOOD LABORATORY	0	0			60. 0	
62. 30 06250 BLOOD CLOTTING FOR HEMOPHILIACS	0	0			62. 3	
65. 00 06500 RESPI RATORY THERAPY 66. 00 06600 PHYSI CAL THERAPY	0	0			65. 0 66. 0	
67. 00 06700 OCCUPATI ONAL THERAPY	O	Ö			67. 0	
68.00 06800 SPEECH PATHOLOGY	0	0			68. 0	
71.00 O7100 MEDICAL SUPPLIES CHARGED TO PATIENT 72.00 O7200 IMPL. DEV. CHARGED TO PATIENTS	0	0			71. 0	
73. 00 07300 DRUGS CHARGED TO PATIENTS	0	0			73. 0	
76. 97 07697 CARDIAC REHABILITATION	0	О			76. 9	
76. 98 07698 HYPERBARI C OXYGEN THERAPY	0	0			76. 9	
76. 99 O7699 LI THOTRI PSY OUTPATI ENT SERVI CE COST CENTERS	0	0			76. 9	19
91. 00 09100 EMERGENCY	0	0			91. 0	00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART					92. 0	00
OTHER REIMBURSABLE COST CENTERS 99. 10 09910 CORF		0			99. 1	
SPECIAL PURPOSE COST CENTERS	0	U _I			99. 1	U
118.00 SUBTOTALS (SUM OF LINES 1 through 11	7) 0	0			118. 0	00
NONREI MBURSABLE COST CENTERS		٥			100.0	
192.00 19200 PHYSICIANS PRIVATE OFFICES 200.00 Cross Foot Adjustments	0	0			192. 0 200. 0	
201.00 Negative Cost Centers					201. 0	
202.00 Cost to be allocated (per Wkst. B,	0	0			202. 0	00
Part I)	0,000000	0.000000			202.0	١0
203.00 Unit cost multiplier (Wkst. B, Part Cost to be allocated (per Wkst. B,	0.000000	0. 000000			203. 0 204. 0	
Part II)					20.1.0	
205.00 Unit cost multiplier (Wkst. B, Part	0. 000000	0. 000000			205. 0	10
206.00 NAHE adjustment amount to be allocat	ed	0			206. 0)()
(per Wkst. B-2)					200.0	J
207.00 NAHE unit cost multiplier (Wkst. D,		0. 000000			207. 0	00
Parts III and IV)	1 1	l			1	

Health Financial Systems	HARVARD MEMOR	I AL HOSPI TAL		In Lie	u of Form CMS-2	2552-10
COMPUTATION OF RATIO OF COSTS TO CHARGES		Provider CO		Period: From 07/01/2022 To 06/30/2023		pared: 06 pm
		Title	XVIII	Hospi tal	Cost	
				Costs		
Cost Center Description	Total Cost (from Wkst. B, Part I, col. 26)	,		Di sal I owance	Total Costs	
				4 00		

		litle	XVIII	Hospi tal	Cost	
				Costs		
Cost Center Description	Total Cost	Therapy Limit	Total Costs	RCE	Total Costs	
	(from Wkst. B,	Adj .		Di sal I owance		
	Part I, col.					
	26)					
	1.00	2.00	3.00	4.00	5. 00	
INPATIENT ROUTINE SERVICE COST CENTERS						
30. 00 03000 ADULTS & PEDIATRICS	2, 526, 732		2, 526, 732	0	2, 526, 732	30.00
31.00 03100 INTENSIVE CARE UNIT	443, 197		443, 197	o	443, 197	
44.00 04400 SKILLED NURSING FACILITY	1, 216, 406		1, 216, 406	o	1, 216, 406	44.00
46.00 O4600 OTHER LONG TERM CARE	2, 043, 667		2, 043, 667	o	2, 043, 667	46. 00
ANCILLARY SERVICE COST CENTERS						1
50. 00 05000 OPERATING ROOM	3, 966, 620		3, 966, 620	0	3, 966, 620	50.00
51.00 05100 RECOVERY ROOM	2, 060, 957		2, 060, 957	o	2, 060, 957	51.00
53. 00 05300 ANESTHESI OLOGY	91, 290		91, 290	o	91, 290	53.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	1, 786, 750		1, 786, 750	ol	1, 786, 750	54.00
60. 00 06000 LABORATORY	1, 431, 289		1, 431, 289	o	1, 431, 289	
60. 01 06001 BLOOD LABORATORY	0		0	o	0	60. 01
62.30 06250 BLOOD CLOTTING FOR HEMOPHILIACS	0		0	ol	0	62. 30
65. 00 06500 RESPIRATORY THERAPY	158, 202	0	158, 202	o	158, 202	65.00
66. 00 06600 PHYSI CAL THERAPY	1, 057, 294	0	1, 057, 294	ol	1, 057, 294	66.00
67. 00 06700 OCCUPATI ONAL THERAPY	576, 693	0	576, 693	ol	576, 693	67.00
68.00 06800 SPEECH PATHOLOGY	45, 214	0	45, 214	ol	45, 214	68. 00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	1, 419, 602		1, 419, 602	ol	1, 419, 602	71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	606, 779		606, 779	ol	606, 779	
73.00 07300 DRUGS CHARGED TO PATIENTS	1, 745, 175		1, 745, 175	ol	1, 745, 175	73.00
76. 97 07697 CARDI AC REHABI LI TATI ON	104, 057		104, 057	ol	104, 057	76. 97
76. 98 07698 HYPERBARI C OXYGEN THERAPY	0		0	ol	0	76. 98
76. 99 07699 LI THOTRI PSY	0		0	ol	0	76. 99
OUTPATIENT SERVICE COST CENTERS	•	•				1
91. 00 09100 EMERGENCY	5, 219, 936		5, 219, 936	0	5, 219, 936	91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART	809, 963		809, 963		809, 963	92.00
OTHER REIMBURSABLE COST CENTERS		<u>'</u>				1
99. 10 09910 CORF	0		0		0	99. 10
200.00 Subtotal (see instructions)	27, 309, 823	0	27, 309, 823	o	27, 309, 823	200.00
201.00 Less Observation Beds	809, 963		809, 963	آ	809, 963	
202.00 Total (see instructions)	26, 499, 860			ol	·	
		'		٩١	,, 000	, ,_, ,,

Health Financial Systems	HARVARD MEMORI	AL HOSPITAL		In Lie	u of Form CMS-:	2552-10
COMPUTATION OF RATIO OF COSTS TO CHARGES		Provi der 0		Period: From 07/01/2022 To 06/30/2023	Worksheet C Part I Date/Time Pre 11/28/2023 5:	epared: 06 pm
		Title	e XVIII	Hospi tal	Cost	
		Charges				
Cost Center Description	Inpati ent	Outpati ent	Total (col.	6 Cost or Other	TEFRA	
			+ col . 7)	Ratio	I npati ent	
					Ratio	
	6. 00	7. 00	8. 00	9. 00	10.00	
INPATIENT ROUTINE SERVICE COST CENTERS						
30. 00 03000 ADULTS & PEDIATRICS	2, 549, 219		2, 549, 21	9		30. 00

			Charges				
	Cost Center Description	Inpati ent	Outpati ent	Total (col. 6	Cost or Other	TEFRA	
	·	·	·	+ col. 7)	Rati o	I npati ent	
						Rati o	
		6.00	7. 00	8. 00	9. 00	10.00	
	INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000 ADULTS & PEDIATRICS	2, 549, 219		2, 549, 219			30.00
31.00	03100 INTENSIVE CARE UNIT	164, 703		164, 703			31.00
44.00	04400 SKILLED NURSING FACILITY	495, 597		495, 597			44.00
46.00	04600 OTHER LONG TERM CARE	867, 493		867, 493			46. 00
	ANCILLARY SERVICE COST CENTERS						
	05000 OPERATI NG ROOM	2, 784, 330	20, 867, 638	23, 651, 968		0. 000000	50.00
51.00	05100 RECOVERY ROOM	159, 572	5, 253, 899	5, 413, 471	0. 380709	0. 000000	51.00
53.00	05300 ANESTHESI OLOGY	0	14, 758	14, 758	6. 185798	0. 000000	53.00
54.00	05400 RADI OLOGY-DI AGNOSTI C	646, 468	14, 028, 453	14, 674, 921	0. 121755	0. 000000	54.00
60.00	06000 LABORATORY	388, 084	3, 524, 571	3, 912, 655	0. 365810	0. 000000	60.00
60. 01	06001 BLOOD LABORATORY	0	0	0	0. 000000	0.000000	60. 01
62.30	06250 BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0	0. 000000	0.000000	62. 30
65.00	06500 RESPIRATORY THERAPY	21, 525	63, 449	84, 974	1. 861769	0.000000	65.00
66.00	06600 PHYSI CAL THERAPY	456, 934	1, 309, 370	1, 766, 304	0. 598591	0.000000	66.00
67.00	06700 OCCUPATI ONAL THERAPY	317, 597	0	317, 597	1. 815801	0.000000	67.00
68.00	06800 SPEECH PATHOLOGY	24, 918	0	24, 918	1. 814512	0.000000	68. 00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	642, 866	4, 830, 096	5, 472, 962	0. 259385	0.000000	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	664, 055	1, 453, 432	2, 117, 487	0. 286556	0.000000	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	1, 075, 849	5, 870, 188	6, 946, 037	0. 251248	0. 000000	73.00
76. 97	07697 CARDI AC REHABI LI TATI ON	0	250, 230	250, 230	0. 415845	0.000000	76. 97
76. 98	07698 HYPERBARI C OXYGEN THERAPY	0	0	0	0. 000000	0.000000	76. 98
76. 99	07699 LI THOTRI PSY	0	0	0	0. 000000	0. 000000	76. 99
	OUTPATIENT SERVICE COST CENTERS						
91.00	09100 EMERGENCY	214, 528	8, 388, 654	8, 603, 182	0. 606745	0. 000000	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART	23, 355	745, 086	768, 441	1. 054034	0.000000	92.00
	OTHER REIMBURSABLE COST CENTERS						
99. 10	09910 CORF	0	0	0			99. 10
200.00	Subtotal (see instructions)	11, 497, 093	66, 599, 824	78, 096, 917			200.00
201.00							201.00
202. 00	Total (see instructions)	11, 497, 093	66, 599, 824	78, 096, 917			202. 00

Health Financial Systems	HARVARD MEMORIA	L HOSPI TAL	In Lie	u of Form CMS-	2552-10
COMPUTATION OF RATIO OF COSTS TO CHARGES		Provider CCN: 14-1335	Peri od: From 07/01/2022 To 06/30/2023	Date/Time Pre	epared: 06 pm
		Title XVIII	Hospi tal	Cost	<u> </u>
Cost Center Description	PPS Inpatient				
	Ratio				
	11. 00			Part I Date/Time Pre 11/28/2023 5:	
INPATIENT ROUTINE SERVICE COST CENTERS					
30. 00 03000 ADULTS & PEDIATRICS					30.00
31.00 03100 INTENSIVE CARE UNIT					31.00
44.00 04400 SKILLED NURSING FACILITY					44.00

Health Financial Systems	HARVARD MEMORIAL HOSPITAL	In Lie	u of Form CMS-2552-10
COMPUTATION OF RATIO OF COSTS TO CHARGES		Peri od: From 07/01/2022 To 06/30/2023	Date/Time Prepared:
	Ti +l o YI Y	Hospi tal	11/28/2023 5:06 pm

			'	0 06/30/2023	11/28/2023 5:	06 pm
		Ti tl	e XIX	Hospi tal	Cost	
				Costs		
Cost Center Description	Total Cost	Therapy Limit	Total Costs	RCE	Total Costs	
	(from Wkst. B,	Adj .		Di sal I owance		
	Part I, col.					
	26)					
	1. 00	2. 00	3. 00	4. 00	5. 00	
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00 03000 ADULTS & PEDIATRICS	2, 526, 732		2, 526, 732	0	0	30.00
31.00 03100 INTENSIVE CARE UNIT	443, 197		443, 197	0	0	31.00
44.00 04400 SKILLED NURSING FACILITY	1, 216, 406		1, 216, 406	0	0	44.00
46.00 O4600 OTHER LONG TERM CARE	2, 043, 667		2, 043, 667	0	0	46. 00
ANCILLARY SERVICE COST CENTERS						
50.00 05000 OPERATING ROOM	3, 966, 620		3, 966, 620	0	0	50.00
51.00 05100 RECOVERY ROOM	2, 060, 957		2, 060, 957	0	0	51.00
53. 00 05300 ANESTHESI OLOGY	91, 290		91, 290	0	0	53.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	1, 786, 750		1, 786, 750	0	0	54.00
60. 00 06000 LABORATORY	1, 431, 289		1, 431, 289	0	0	60.00
60. 01 06001 BLOOD LABORATORY	0		0	0	0	60. 01
62.30 06250 BLOOD CLOTTING FOR HEMOPHILIACS	0		0	0	0	62. 30
65.00 06500 RESPIRATORY THERAPY	158, 202	0	158, 202	0	0	65.00
66.00 06600 PHYSI CAL THERAPY	1, 057, 294	0	1, 057, 294	0	0	66.00
67.00 06700 OCCUPATI ONAL THERAPY	576, 693	0	576, 693	0	0	67.00
68.00 06800 SPEECH PATHOLOGY	45, 214	0	45, 214	0	0	68. 00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	1, 419, 602		1, 419, 602	0	0	71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	606, 779		606, 779	0	0	72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	1, 745, 175		1, 745, 175	0	0	73.00
76. 97 07697 CARDI AC REHABI LI TATI ON	104, 057		104, 057	0	0	76. 97
76.98 07698 HYPERBARIC OXYGEN THERAPY	0		0	0	0	76. 98
76. 99 07699 LI THOTRI PSY	0		0	0	0	76. 99
OUTPATIENT SERVICE COST CENTERS]
91. 00 09100 EMERGENCY	5, 219, 936		5, 219, 936	0	0	91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART	809, 963		809, 963		0	92.00
OTHER REIMBURSABLE COST CENTERS						
99. 10 09910 CORF	0		O		0	99. 10
200.00 Subtotal (see instructions)	27, 309, 823	0	27, 309, 823	0	0	200. 00
201.00 Less Observation Beds	809, 963		809, 963		0	201.00
202.00 Total (see instructions)	26, 499, 860	0	26, 499, 860	0	0	202. 00

Health Financial Systems	HARVARD MEMORI		ON 44 4005		u of Form CMS-	<u> 2552-10</u>
COMPUTATION OF RATIO OF COSTS TO CHARGES		Provi der C	CN: 14-1335	Period: From 07/01/2022	Worksheet C Part I	
				To 06/30/2023		enared:
					11/28/2023 5:	
		Ti tl	e XIX	Hospi tal	Cost	
		Charges				
Cost Center Description	I npati ent	Outpati ent		6 Cost or Other	TEFRA	
			+ col . 7)	Ratio	I npati ent	
					Ratio	
	6.00	7. 00	8. 00	9. 00	10.00	
INPATIENT ROUTINE SERVICE COST CENTERS						
30. 00 03000 ADULTS & PEDIATRICS	0			0		30.00
31.00 03100 INTENSIVE CARE UNIT	0			0		31.00
44.00 04400 SKILLED NURSING FACILITY	0			0		44.00
46.00 O4600 OTHER LONG TERM CARE	0			0		46. 00
ANCILLARY SERVICE COST CENTERS						
50. 00 05000 OPERATING ROOM	0	(1	0.000000	0. 000000	
51. 00 05100 RECOVERY ROOM	0	(0.000000	0. 000000	
53. 00 05300 ANESTHESI OLOGY	0	(0. 000000	0. 000000	
54. 00 05400 RADI OLOGY-DI AGNOSTI C	0	(0. 000000	0. 000000	
60. 00 06000 LABORATORY	0	(0. 000000	0. 000000	
60. 01 06001 BLOOD LABORATORY	0	(0. 000000	0. 000000	
62.30 06250 BLOOD CLOTTING FOR HEMOPHILIACS	0	(0. 000000	0. 000000	
65. 00 06500 RESPIRATORY THERAPY	0	(0. 000000	0. 000000	
66. 00 06600 PHYSI CAL THERAPY	0	(0. 000000	0. 000000	
67. 00 06700 OCCUPATI ONAL THERAPY	0	(0. 000000	0. 000000	
68. 00 06800 SPEECH PATHOLOGY	0	(0. 000000	0. 000000	
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0	(0. 000000	0. 000000	
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0	(0. 000000	0. 000000	
73.00 07300 DRUGS CHARGED TO PATIENTS	0	(0. 000000	0. 000000	
76. 97 07697 CARDI AC REHABI LI TATI ON	0	(0. 000000	0. 000000	
76. 98 07698 HYPERBARI C OXYGEN THERAPY	0	(0. 000000	0. 000000	
76. 99 07699 LI THOTRI PSY	0	(0. 000000	0. 000000	76. 99
OUTPATIENT SERVICE COST CENTERS						1
91. 00 09100 EMERGENCY	0	(0. 000000	0. 000000	
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART	0	()	0. 000000	0. 000000	92.00
OTHER REIMBURSABLE COST CENTERS						
99. 10 09910 CORF	0	(0		99. 10
200.00 Subtotal (see instructions)	0	(0		200.00
201.00 Less Observation Beds						201.00

99. 10 200. 00 201. 00 202. 00

Less Observation Beds Total (see instructions)

201.00 202. 00

Health Financial Systems	HARVARD MEMORIAL	HOSPI TAL	In Lieu	of Form CMS-	<u> 2552-10</u>
COMPUTATION OF RATIO OF COSTS TO CHARGES		Provider CCN: 14-1335	Peri od:	Worksheet C	
			From 07/01/2022 To 06/30/2023	Part I Date/Time Pre	narod:
			10 00/30/2023	11/28/2023 5:	
		Title XIX	Hospi tal	Cost	00 p
Cost Center Description	PPS Inpatient				
'	Ratio				
	11. 00				
INPATIENT ROUTINE SERVICE COST CENTERS					
30. 00 03000 ADULTS & PEDIATRICS					30.00
31.00 03100 INTENSIVE CARE UNIT					31.00
44.00 04400 SKILLED NURSING FACILITY					44.00
46.00 O4600 OTHER LONG TERM CARE					46.00
ANCILLARY SERVICE COST CENTERS					
50. 00 05000 OPERATI NG ROOM	0. 000000				50.00
51.00 05100 RECOVERY ROOM	0. 000000				51.00
53. 00 05300 ANESTHESI OLOGY	0. 000000				53.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	0. 000000				54.00
60. 00 06000 LABORATORY	0. 000000				60.00
60. 01 06001 BL00D LABORATORY	0. 000000				60. 01
62.30 06250 BLOOD CLOTTING FOR HEMOPHILIACS	0. 000000				62. 30
65. 00 06500 RESPIRATORY THERAPY	0. 000000				65.00
66. 00 06600 PHYSI CAL THERAPY	0. 000000				66.00
67. 00 06700 OCCUPATI ONAL THERAPY	0. 000000				67.00
68. 00 06800 SPEECH PATHOLOGY	0. 000000				68.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0. 000000				71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0. 000000				72. 00
73.00 07300 DRUGS CHARGED TO PATIENTS	0. 000000				73.00
76. 97 O7697 CARDI AC REHABI LI TATI ON	0. 000000				76. 97
76. 98 07698 HYPERBARI C OXYGEN THERAPY	0. 000000				76. 98
76. 99 07699 LI THOTRI PSY	0. 000000				76. 99
OUTPATIENT SERVICE COST CENTERS					
91. 00 09100 EMERGENCY	0. 000000				91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART	0. 000000				92.00
OTHER REIMBURSABLE COST CENTERS					
99. 10 09910 CORF					99. 10
200.00 Subtotal (see instructions)					200.00

99. 10 200. 00 201. 00 202. 00

200. 00 201. 00 202. 00

Subtotal (see instructions) Less Observation Beds Total (see instructions)

Health Financial Systems	HARVARD MEMOR				u of Form CMS-2	<u> 2552-10</u>
APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPI	TAL COSTS	Provi der C		Peri od:	Worksheet D	
				From 07/01/2022 To 06/30/2023	Part II Date/Time Pre	narod:
				10 00/30/2023	11/28/2023 5:	
		Ti tl e	XVIII	Hospi tal	Cost	
Cost Center Description	Capi tal	Total Charges	Ratio of Cos	t Inpatient	Capital Costs	
·	Related Cost	(from Wkst. C,	to Charges	Program	(column 3 x	
	(from Wkst. B,	Part I, col.	(col. 1 ÷ col	. Charges	column 4)	
	Part II, col.	8)	2)			
	26)					
	1. 00	2.00	3. 00	4. 00	5. 00	
ANCILLARY SERVICE COST CENTERS						
50.00 05000 OPERATING ROOM	594, 474					1
51.00 05100 RECOVERY ROOM	53, 146		1		505	
53. 00 05300 ANESTHESI OLOGY	1, 932				0	
54. 00 05400 RADI OLOGY-DI AGNOSTI C	229, 037	14, 674, 921	0. 01560	132, 404		54.00
60. 00 06000 LABORATORY	56, 322	3, 912, 655			2, 272	60.00
60. 01 06001 BL00D LABORATORY	0	0	0. 00000		0	60. 01
62.30 06250 BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0. 00000	00	0	62. 30
65. 00 06500 RESPIRATORY THERAPY	37, 225	84, 974	0. 43807	75 8, 623	3, 778	65. 00
66. 00 06600 PHYSI CAL THERAPY	95, 100	1, 766, 304	0. 05384	1 84, 245	4, 536	66. 00
67. 00 06700 OCCUPATI ONAL THERAPY	19, 475	317, 597	0. 06132	.0	0	67. 00
68. 00 06800 SPEECH PATHOLOGY	1, 526	24, 918	0. 06124	1 0	0	68. 00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	21, 872	5, 472, 962	0.00399	145, 162	580	71. 00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	6, 308	2, 117, 487	0. 00297	79 292, 068	870	72. 00
73.00 07300 DRUGS CHARGED TO PATIENTS	37, 100	6, 946, 037	0. 00534	361, 075	1, 929	73. 00
76. 97 07697 CARDI AC REHABI LI TATI ON	20, 168	250, 230	0. 08059	0 8	0	76. 97
76. 98 07698 HYPERBARIC OXYGEN THERAPY	0	0	0. 00000	0 0	0	76. 98
76. 99 07699 LI THOTRI PSY	0	0	0. 00000	0 0	0	76. 99
OUTPATIENT SERVICE COST CENTERS						
91. 00 09100 EMERGENCY	142, 963	8, 603, 182	0. 01661	7 423	7	91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART	78, 007				0	92. 00
200.00 Total (lines 50 through 199)	1, 394, 655	74, 019, 905	1	2, 139, 394	39, 319	200. 00

Health Financial Systems	HARVARD MEMORIAL	HOSPI TAL	In Lieu	u of Form CMS-2552-10
APPORTIONMENT OF INPATIENT/OUTPATIENT THROUGH COSTS	ANCI LLARY SERVI CE OTHER PASS	Provi der CCN: 14-1335	Period: From 07/01/2022 To 06/30/2023	Worksheet D Part IV Date/Time Prepared:

					10 06/30/2023	Date/Time Pre 11/28/2023 5:	
			Title	e XVIII	Hospi tal	Cost	оо рііі
	Cost Center Description	Non Physician		Nursi ng	Allied Health		
	·	Anesthetist	Program	Program	Post-Stepdown		
		Cost	Post-Stepdown		Adjustments		
			Adjustments				
	I	1.00	2A	2. 00	3A	3. 00	
	ANCILLARY SERVICE COST CENTERS			1			
50.00	05000 OPERATI NG ROOM	0	0	(0	0	50.00
51.00	05100 RECOVERY ROOM	0	0		0	0	51.00
53.00	05300 ANESTHESI OLOGY	0	0	(0	0	53.00
54.00	05400 RADI OLOGY-DI AGNOSTI C	0	0		0	0	54.00
60.00	06000 LABORATORY	0	0		0	0	60.00
60. 01	06001 BLOOD LABORATORY	0	0		0	0	60. 01
62. 30	06250 BLOOD CLOTTING FOR HEMOPHILIACS	0	0		0	0	62.30
65.00	06500 RESPI RATORY THERAPY	0	0		0	0	65.00
66.00	06600 PHYSI CAL THERAPY 06700 OCCUPATI ONAL THERAPY	0	0		0	0	66.00
67. 00 68. 00	106800 SPEECH PATHOLOGY	0	0			0	67. 00 68. 00
71.00	107100 MEDI CAL SUPPLI ES CHARGED TO PATI ENT	0	0		0	0	71.00
	107200 I MPL. DEV. CHARGED TO PATIENTS	0	0			0	72.00
	07300 DRUGS CHARGED TO PATIENTS		0			0	73.00
	07697 CARDIAC REHABILITATION	0	0		0	0	76. 97
	07698 HYPERBARI C OXYGEN THERAPY	0	0		0	0	76. 98
	07699 LI THOTRI PSY	0	١		0	0	76. 99
70. 77	OUTPATIENT SERVICE COST CENTERS		·	1	5 0		70.77
91.00	09100 EMERGENCY	0	0	(0	0	91.00
	09200 OBSERVATION BEDS (NON-DISTINCT PART	0]			l ő	92.00
200. 00		0	0		0	0	200. 00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVITHROUGH COSTS Cost Center Description Cost Center Description ANCILLARY SERVICE COST CENTERS 50. 00 05000 OPERATING ROOM 051. 00 05100 RECOVERY ROOM 053. 00 05300 ANESTHESIOLOGY 54. 00 05400 RADIOLOGY-DIAGNOSTIC	All Other Medical	Title Total Cost (sum of cols. 1, 2, 3, and 4)		Period: From 07/01/2022 Fo 06/30/2023 Hospital Total Charges (from Wkst. C, Part I, col.	Date/Time Prep 11/28/2023 5:0 Cost Ratio of Cost to Charges	
ANCILLARY SERVICE COST CENTERS 50. 00 05000 OPERATING ROOM 51. 00 05100 RECOVERY ROOM 53. 00 05300 ANESTHESIOLOGY	Medical ducation Cost	Total Cost (sum of cols. 1, 2, 3, and 4)	Total Outpatient Cost (sum of cols. 2, 3,	Total Charges (from Wkst. C, Part I, col.	Ratio of Cost to Charges	
ANCILLARY SERVICE COST CENTERS 50. 00 05000 OPERATING ROOM 51. 00 05100 RECOVERY ROOM 53. 00 05300 ANESTHESIOLOGY	Medical ducation Cost	(sum of cols. 1, 2, 3, and 4)	Outpatient Cost (sum of cols. 2, 3,	(from Wkst. C, Part I, col.	to Charges	
ANCILLARY SERVICE COST CENTERS 50. 00	ducation Cost	1, 2, 3, and 4)	Cost (sum of cols. 2, 3,	Part I, col.		
ANCILLARY SERVICE COST CENTERS 50. 00		4)	col s. 2, 3,		'(col E . col	
50. 00 05000 0PERATI NG ROOM 51. 00 05100 RECOVERY ROOM 53. 00 05300 ANESTHESI OLOGY	4. 00	ŕ		8)		
50. 00 05000 0PERATI NG ROOM 51. 00 05100 RECOVERY ROOM 53. 00 05300 ANESTHESI OLOGY	4. 00	5.00	and 4)	,	7)	
50. 00 05000 0PERATI NG ROOM 51. 00 05100 RECOVERY ROOM 53. 00 05300 ANESTHESI OLOGY	4.00	F 00			(see	
50. 00 05000 0PERATI NG ROOM 51. 00 05100 RECOVERY ROOM 53. 00 05300 ANESTHESI OLOGY	4. 00				instructions)	
50. 00 05000 0PERATI NG ROOM 51. 00 05100 RECOVERY ROOM 53. 00 05300 ANESTHESI OLOGY		5. 00	6. 00	7. 00	8. 00	
51. 00 05100 RECOVERY ROOM 53. 00 05300 ANESTHESI OLOGY				_		
53. 00 05300 ANESTHESI OLOGY	0	0	(20,00.,,00		
	0	0	(-,,	0. 000000	
54. 00 05400 RADI OLOGY-DI AGNOSTI C	0	0	(14, 758		
	0	0	(14, 674, 921	0. 000000	
60. 00 06000 LABORATORY	0	0	(3, 912, 655	0. 000000	60.00
60. 01 06001 BLOOD LABORATORY	0	0	(0	0. 000000	60. 01
62.30 06250 BLOOD CLOTTING FOR HEMOPHILIACS	0	0	(0	0. 000000	62. 30
65. 00 06500 RESPIRATORY THERAPY	0	0	(84, 974	0. 000000	65.00
66. 00 06600 PHYSI CAL THERAPY	0	0	(1, 766, 304	0. 000000	66.00
67. 00 06700 OCCUPATI ONAL THERAPY	0	0	(317, 597	0. 000000	67.00
68.00 06800 SPEECH PATHOLOGY	0	0	(24, 918	0. 000000	68. 00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	(5, 472, 962	0. 000000	71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0	0	(2, 117, 487	0. 000000	72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	o	0	(6, 946, 037	0. 000000	73.00
76. 97 07697 CARDI AC REHABI LI TATI ON	О	0	(250, 230		76. 97
76. 98 07698 HYPERBARI C OXYGEN THERAPY	o	0	(0	0. 000000	76. 98
76. 99 07699 LI THOTRI PSY	o	0	(0	0. 000000	76. 99
OUTPATIENT SERVICE COST CENTERS	- 1					
91. 00 09100 EMERGENCY	0	0	(8, 603, 182	0. 000000	91.00
92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART	Ö	0	(0. 000000	
200.00 Total (lines 50 through 199)	ol	0	(

Health Financial Systems	HARVARD MEMORIA	AL HOSPITAL		In Lie	eu of Form CMS-2	2552-10
APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SE THROUGH COSTS		Provi der CO		Period: From 07/01/2022 To 06/30/2023	Worksheet D Part IV	epared:
			XVIII	Hospi tal	Cost	
Cost Center Description	Outpati ent	I npati ent	I npati ent	Outpati ent	Outpati ent	
	Ratio of Cost	Program	Program	Program	Program	
	to Charges	Charges	Pass-Through		Pass-Through	
	(col. 6 ÷ col.		Costs (col.	8	Costs (col. 9	
	7)		x col. 10)		x col. 12)	
	9. 00	10.00	11. 00	12. 00	13. 00	
ANCILLARY SERVICE COST CENTERS						
50.00 05000 OPERATING ROOM	0. 000000	906, 163		0 0	0	
51.00 05100 RECOVERY ROOM	0. 000000	51, 395		0 0	0	
53. 00 05300 ANESTHESI OLOGY	0. 000000	0		0 0	0	
54. 00 05400 RADI OLOGY-DI AGNOSTI C	0. 000000	132, 404		0 0	0	
60. 00 06000 LABORATORY	0. 000000	157, 836		0 0	0	
60. 01 06001 BLOOD LABORATORY	0. 000000	0		0 0	0	60. 01
62.30 06250 BLOOD CLOTTING FOR HEMOPHILIACS	0. 000000	0		0 0	0	62. 30
65. 00 06500 RESPIRATORY THERAPY	0. 000000	8, 623		0 0	0	65.00
66. 00 06600 PHYSI CAL THERAPY	0.000000	84, 245		0 0	0	66.00
67. 00 06700 OCCUPATI ONAL THERAPY	0.000000	0		0 0	0	67.00
68.00 06800 SPEECH PATHOLOGY	0. 000000	0		0 0	0	68. 00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0. 000000	145, 162		0 0	0	71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0. 000000	292, 068		0 0	0	72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	0. 000000	361, 075		0 0	0	73.00
76. 97 07697 CARDIAC REHABILITATION	0.000000	0		0 0	0	76. 97
76. 98 07698 HYPERBARI C OXYGEN THERAPY	0. 000000	0		0 0	0	76. 98
76. 99 07699 LI THOTRI PSY	0. 000000	0		o c	0	76. 99
OUTPATIENT SERVICE COST CENTERS				•		
91. 00 09100 EMERGENCY	0. 000000	423		0 0	0	91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART	0. 000000	0		0 0	0	92.00
200.00 Total (lines 50 through 199)		2, 139, 394		0 0	0	200. 00

Health Financial Systems	HARVARD MEMORIAL	HOSPI TAL	In Lieu	u of Form CMS-2552-10
APPORTIONMENT OF MEDICAL,	OTHER HEALTH SERVICES AND VACCINE COST	Provi der CCN: 14-1335	Peri od:	Worksheet D

From 07/01/2022 Part V To 06/30/2023 Date/Time Prepared: 11/28/2023 5:06 pm Title XVIII Hospi tal Cost Costs Charges Cost to Charge PPS Reimbursed PPS Services Cost Center Description Cost Cost Ratio From Services (see Rei mbursed Rei mbursed (see inst.) Worksheet C, inst.) Servi ces Services Not Part I, col. Subject To Subject To Ded. & Coins. Ded. & Coins. (see inst.) (see inst.) 1.00 2.00 5.00 3.00 4.00 ANCILLARY SERVICE COST CENTERS 50.00 05000 OPERATING ROOM 4, 936, 358 50.00 0. 167708 0 0 0 0 0 0 0 0 0 51.00 05100 RECOVERY ROOM 0.380709 1, 348, 322 51.00 53.00 05300 ANESTHESI OLOGY 6. 185798 53.00 6, 220 0 54.00 05400 RADI OLOGY-DI AGNOSTI C 0. 121755 0 4, 040, 670 0 54.00 60.00 06000 LABORATORY 0. 365810 1, 356, 463 0 60.00 60.01 06001 BLOOD LABORATORY 0.000000 60.01 Ω Λ 06250 BLOOD CLOTTING FOR HEMOPHILIACS 62.30 0.000000 0 0 62.30 65.00 06500 RESPIRATORY THERAPY 1. 861769 13, 078 65.00 297, 063 06600 PHYSI CAL THERAPY 0.598591 66.00 66.00 06700 OCCUPATI ONAL THERAPY 1.815801 67.00 0 0 67.00 68.00 06800 SPEECH PATHOLOGY 1.814512 0 68.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT 0. 259385 0 71.00 71.00 1,060,832 0 07200 IMPL. DEV. CHARGED TO PATIENTS 0 417, 519 72.00 72 00 0 286556 73.00 07300 DRUGS CHARGED TO PATIENTS 0. 251248 0 2, 283, 111 3, 043 0 73.00 76. 97 07697 CARDIAC REHABILITATION 0. 415845 0 177, 091 0 76. 97 07698 HYPERBARI C OXYGEN THERAPY 76. 98 76.98 0.000000 0 0 0 07699 LI THOTRI PSY 0.000000 76. 99 76.99 O 0 Ω OUTPATIENT SERVICE COST CENTERS 91.00 09100 EMERGENCY 0.606745 1, 622, 102 0 91.00 92.00 92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART 1.054034 0 329, 177 0 200.00 Subtotal (see instructions) Ω 17, 888, 006 3, 043 0 200. 00 201.00 Less PBP Clinic Lab. Services-Program 201.00 Only Charges 202.00 Net Charges (line 200 - line 201) 0 202.00 17, 888, 006 3, 043

Health Financial Systems			HARVARD	MEMORI AL	HOSPI TAL		In Lie	u of Form CMS-2552-10	
APPORTI ONMENT OF MEDI CAL,	OTHER HEALTH	SERVI CES ANI	D VACCINE	COST	Provi der	CCN: 14-1335	Peri od: From 07/01/2022 To 06/30/2023	Worksheet D Part V Date/Time Prepared:	

				To 06/30/2023	Date/Time Pre	
		Title	XVIII	Hospi tal	Cost	
	Cos	sts				
Cost Center Description	Cost	Cost				
	Rei mbursed	Rei mbursed				
	Servi ces	Services Not				
	Subject To	Subject To				
	Ded. & Coins.	Ded. & Coins.				
	(see inst.)	(see inst.)				
	6. 00	7. 00				
ANCILLARY SERVICE COST CENTERS	_					
50.00 05000 OPERATING ROOM	827, 867	0				50.00
51.00 05100 RECOVERY ROOM	513, 318	0				51.00
53. 00 05300 ANESTHESI OLOGY	38, 476	0				53.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	491, 972	0				54.00
60. 00 06000 LABORATORY	496, 208	0				60.00
60. 01 06001 BLOOD LABORATORY	0	0				60. 01
62.30 06250 BLOOD CLOTTING FOR HEMOPHILIACS	0	0				62. 30
65. 00 06500 RESPIRATORY THERAPY	24, 348	0				65.00
66. 00 06600 PHYSI CAL THERAPY	177, 819	0				66.00
67. 00 06700 OCCUPATI ONAL THERAPY	0	0				67.00
68.00 06800 SPEECH PATHOLOGY	0	0				68. 00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	275, 164	0				71. 00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	119, 643	0				72. 00
73.00 07300 DRUGS CHARGED TO PATIENTS	573, 627	765				73. 00
76. 97 07697 CARDIAC REHABILITATION	73, 642	0				76. 97
76. 98 07698 HYPERBARI C OXYGEN THERAPY	0	0				76. 98
76. 99 07699 LI THOTRI PSY	0	0				76. 99
OUTPATIENT SERVICE COST CENTERS						
91. 00 09100 EMERGENCY	984, 202	0				91. 00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART	346, 964	0				92.00
200.00 Subtotal (see instructions)	4, 943, 250	765				200.00
201.00 Less PBP Clinic Lab. Services-Program	0					201.00
Only Charges						
202.00 Net Charges (line 200 - line 201)	4, 943, 250	765				202.00
	•	=				•

Health Financial Systems	HARVARD MEMORI	AL HOSPI TAL		In Lie	u of Form CMS-2	<u> 2552-10</u>
APPORTIONMENT OF INPATIENT ROUTINE SERVICE CAPITAL	COSTS	Provi der Co		Period: From 07/01/2022 To 06/30/2023		nared:
				10 00/ 30/ 2023	11/28/2023 5:	06 pm
		Ti tl	e XIX	Hospi tal	Cost	
Cost Center Description	Capi tal	Swing Bed	Reduced		Per Diem (col.	
	Related Cost	Adjustment	Capi tal	Days	3 / col. 4)	
	(from Wkst. B,		Related Cost			
	Part II, col.		(col. 1 - col			
	26)		2)			
	1.00	2. 00	3. 00	4. 00	5. 00	
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00 ADULTS & PEDIATRICS	243, 346	0	243, 34	6 861	282. 63	30.00
31.00 INTENSIVE CARE UNIT	42, 832		42, 83	2	2, 039. 62	31.00
44.00 SKILLED NURSING FACILITY	125, 892		125, 89	2, 088	60. 29	44.00
200.00 Total (lines 30 through 199)	412, 070		412, 07	0 2, 970		200.00
Cost Center Description	I npati ent	I npati ent				
	Program days	Program				
		Capital Cost				
		(col. 5 x col.				
		6)				
	6. 00	7. 00				
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00 ADULTS & PEDIATRICS	15	4, 239				30.00
31.00 INTENSIVE CARE UNIT	0	0				31.00
44.00 SKILLED NURSING FACILITY	0	0				44.00
200.00 Total (lines 30 through 199)	15	4, 239				200. 00

Health Financial Systems	HARVARD MEMOR	IAI HOODITAI		ln lio	u of Form CMS-2	neen 10
APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITA		Provi der Co		Period: From 07/01/2022 To 06/30/2023	Worksheet D Part II	pared:
			e XIX	Hospi tal	Cost	
Cost Center Description	Capi tal	Total Charges			Capital Costs	
		(from Wkst. C,		Program	(column 3 x	
	(from Wkst. B,			. Charges	column 4)	
	Part II, col.	8)	2)			
	26)					
	1.00	2. 00	3. 00	4. 00	5. 00	
ANCILLARY SERVICE COST CENTERS						
50.00 05000 OPERATING ROOM	594, 474	l .	0. 00000		0	
51.00 05100 RECOVERY ROOM	53, 146		0. 00000		0	
53. 00 05300 ANESTHESI OLOGY	1, 932		0. 00000		0	
54. 00 05400 RADI OLOGY-DI AGNOSTI C	229, 037		0. 00000		0	
60. 00 06000 LABORATORY	56, 322	0	0. 00000		0	60.00
60. 01 06001 BL00D LABORATORY	0	0	0. 00000	0	0	60. 01
62.30 06250 BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0. 00000		0	62. 30
65. 00 06500 RESPI RATORY THERAPY	37, 225	0	0. 00000	0	0	65.00
66. 00 06600 PHYSI CAL THERAPY	95, 100	0	0. 00000	0	0	66.00
67. 00 06700 OCCUPATI ONAL THERAPY	19, 475	0	0. 00000	0 0	0	67.00
68.00 06800 SPEECH PATHOLOGY	1, 526	0	0. 00000	0 0	0	68. 00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	21, 872	0	0. 00000	0 0	0	71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	6, 308	0	0. 00000	0 0	0	72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	37, 100	0	0. 00000	0 0	0	73. 00
76. 97 07697 CARDI AC REHABI LI TATI ON	20, 168	0	0.00000	0 0	0	76. 97
76. 98 07698 HYPERBARI C OXYGEN THERAPY	0	0	0. 00000	0	0	76. 98
76. 99 07699 LI THOTRI PSY	0	0	0. 00000	0	0	76. 99
OUTPATIENT SERVICE COST CENTERS						
91. 00 09100 EMERGENCY	142, 963	0	0.00000	0 0	0	91. 00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART	78, 007	0	0. 00000	0	0	92.00
200.00 Total (lines 50 through 199)	1, 394, 655	0		0	0	200. 00

Health Financial Systems	HARVARD MEMORI	AL HOSPITAL		In Lie	u of Form CMS-2	2552-10
APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER F	PASS THROUGH COS	TS Provider C		Period: From 07/01/2022 To 06/30/2023		
	_	Ti tl	e XIX	Hospi tal	Cost	
Cost Center Description	Nursi ng	Nursi ng	Allied Health	Allied Health	All Other	
	Program	Program	Post-Stepdowr	Cost	Medi cal	
	Post-Stepdown	•	Adjustments		Education Cost	
	Adjustments					
	1A	1. 00	2A	2. 00	3. 00	
INPATIENT ROUTINE SERVICE COST CENTERS						
30. 00 03000 ADULTS & PEDIATRICS	0	0	(0 0	0	30.00
31.00 03100 INTENSIVE CARE UNIT	0	0		0	0	31.00
44.00 04400 SKILLED NURSING FACILITY	0	0		0		44.00
200.00 Total (lines 30 through 199)	0	0		0	0	200.00
Cost Center Description	Swi ng-Bed	Total Costs	Total Patient	Per Diem (col.	I npati ent	
·	Adjustment	(sum of cols.	Days	5 ÷ col . 6)	Program Days	
	Amount (see	1 through 3,				
	instructions)	minus col. 4)				
	4.00	5. 00	6.00	7. 00	8. 00	
INPATIENT ROUTINE SERVICE COST CENTERS						
30. 00 03000 ADULTS & PEDIATRICS	0	0	86	1 0.00	15	30.00
31.00 03100 INTENSIVE CARE UNIT		0	2	0.00	0	31.00
44.00 04400 SKILLED NURSING FACILITY		0	2, 08	0.00	0	44. 00
200.00 Total (lines 30 through 199)		0	2, 97	0	15	200. 00
Cost Center Description	Inpatient		•	•		
	Program					
	Pass-Through					
	Cost (col. 7 x					
	col . 8)					
	9. 00					
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00 03000 ADULTS & PEDIATRICS	0					30.00
31.00 03100 INTENSIVE CARE UNIT	0					31.00
44.00 04400 SKILLED NURSING FACILITY	0					44.00
200.00 Total (lines 30 through 199)	0					200. 00

Health Financial Systems	HARVARD MEMORIAL	HOSPI TAL	In Lieu	u of Form CMS-2552-10
APPORTIONMENT OF INPATIENT/OUTPATIENTHROUGH COSTS	ANCILLARY SERVICE OTHER PASS	Provider CCN: 14-1335	Peri od: From 07/01/2022 To 06/30/2023	Worksheet D Part IV Date/Time Prepared:

					10 00/30/2023	11/28/2023 5:	
			Ti tl	e XIX	Hospi tal	Cost	
	Cost Center Description	Non Physi ci an	Nursi ng	Nursi ng	Allied Health	Allied Health	
		Anesthetist	Program	Program	Post-Stepdown		
		Cost	Post-Stepdown		Adjustments		
			Adjustments				
		1. 00	2A	2. 00	3A	3. 00	
	ANCILLARY SERVICE COST CENTERS						
	05000 OPERATING ROOM	0	0	1	0	0	50.00
	05100 RECOVERY ROOM	0	0		0	0	51.00
	05300 ANESTHESI OLOGY	0	0		0	0	53. 00
54.00	05400 RADI OLOGY-DI AGNOSTI C	0	0	1	0	0	54. 00
	06000 LABORATORY	0	0	1	0	0	60.00
	06001 BLOOD LABORATORY	0	0	1	0	0	60. 01
	06250 BLOOD CLOTTING FOR HEMOPHILIACS	0	0	1	0	0	62. 30
	06500 RESPI RATORY THERAPY	0	0	1	0	0	65. 00
	06600 PHYSI CAL THERAPY	0	0	1	0	0	66. 00
	06700 OCCUPATI ONAL THERAPY	0	0	1	0	0	67. 00
	06800 SPEECH PATHOLOGY	0	0	1	0	0	68. 00
	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	1	0	0	71. 00
	07200 IMPL. DEV. CHARGED TO PATIENTS	0	0	1	0	0	72. 00
	07300 DRUGS CHARGED TO PATIENTS	0	0		0	0	73. 00
	07697 CARDI AC REHABI LI TATI ON	0	0		0	0	76. 97
	07698 HYPERBARIC OXYGEN THERAPY	0	0		0	0	76. 98
76. 99	07699 LI THOTRI PSY	0	0		0 0	0	76. 99
	OUTPATIENT SERVICE COST CENTERS		T .	T	. T		
	09100 EMERGENCY	0	0	1	0	0	91.00
	09200 OBSERVATION BEDS (NON-DISTINCT PART	0	1		0	0	92.00
200. 00	Total (lines 50 through 199)	0	0	1	0 0	0	200.00

Health Financial Systems	HARVARD MEMORI	AL HOSPITAL		In Lie	u of Form CMS-2	2552-10
APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SE THROUGH COSTS	RVICE OTHER PAS			Period: From 07/01/2022 To 06/30/2023		
			e XIX	Hospi tal	Cost	
Cost Center Description	All Other	Total Cost	Total	Total Charges		
	Medi cal	(sum of cols.	Outpati ent	(from Wkst. C,		
	Education Cost	1, 2, 3, and	Cost (sum of		(col. 5 ÷ col.	
		4)	col s. 2, 3,	8)	7)	
			and 4)		(see	
					instructions)	
	4. 00	5. 00	6. 00	7. 00	8. 00	
ANCI LLARY SERVI CE COST CENTERS	1		T	.1		
50. 00 05000 OPERATI NG ROOM	0	0		0	0. 000000	
51. 00 05100 RECOVERY ROOM	0	0		0	0. 000000	
53. 00 05300 ANESTHESI OLOGY	0	0		0	0. 000000	
54. 00 05400 RADI OLOGY-DI AGNOSTI C	0	0		0	0. 000000	
60. 00 06000 LABORATORY	0	0		0	0. 000000	
60. 01 06001 BL00D LABORATORY	0	0		0	0. 000000	
62.30 06250 BLOOD CLOTTING FOR HEMOPHILIACS	0	0		0	0. 000000	
65. 00 06500 RESPI RATORY THERAPY	0	0		0	0. 000000	65. 00
66. 00 06600 PHYSI CAL THERAPY	0	0		0	0. 000000	66. 00
67. 00 06700 OCCUPATI ONAL THERAPY	0	0		0	0. 000000	
68. 00 06800 SPEECH PATHOLOGY	0	0		0	0. 000000	
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0	0		0	0. 000000	71. 00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0	0		0	0. 000000	72. 00
73.00 07300 DRUGS CHARGED TO PATIENTS	0	0		0 0	0. 000000	73.00
76. 97 07697 CARDI AC REHABI LI TATI ON	0	0		0 0	0. 000000	76. 97
76. 98 07698 HYPERBARI C OXYGEN THERAPY	0	0		0 0	0. 000000	76. 98
76. 99 07699 LI THOTRI PSY	0	0		0 0	0. 000000	76. 99
OUTPATIENT SERVICE COST CENTERS						
91. 00 09100 EMERGENCY	0	0		0 0	0. 000000	91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART	0	0		0 0	0. 000000	92.00
200.00 Total (lines 50 through 199)	1	Ι	I	0 0	l l	200. 00

Health Financial Systems	HARVARD MEMORIA	AL HOSPITAL		In Lie	u of Form CMS-2	2552-10
APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY S THROUGH COSTS		Provi der CO		Period: From 07/01/2022 To 06/30/2023	Worksheet D Part IV	pared:
			e XIX	Hospi tal	Cost	
Cost Center Description	Outpati ent	I npati ent	I npati ent	Outpati ent	Outpati ent	
	Ratio of Cost	Program	Program	Program	Program	
	to Charges	Charges	Pass-Through		Pass-Through	
	(col. 6 ÷ col.		Costs (col.	8	Costs (col. 9	
	7)		x col. 10)		x col. 12)	
	9. 00	10. 00	11. 00	12.00	13. 00	
ANCILLARY SERVICE COST CENTERS						
50.00 05000 OPERATING ROOM	0. 000000	0		0	0	
51.00 05100 RECOVERY ROOM	0. 000000	0		0	0	51.00
53. 00 05300 ANESTHESI OLOGY	0. 000000	0		0	0	53.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	0. 000000	0		0	0	
60. 00 06000 LABORATORY	0. 000000	0		0	0	
60. 01 06001 BLOOD LABORATORY	0. 000000	0		0	0	
62.30 06250 BLOOD CLOTTING FOR HEMOPHILIACS	0. 000000	0		0	0	62. 30
65. 00 06500 RESPIRATORY THERAPY	0. 000000	0		0	0	65.00
66. 00 06600 PHYSI CAL THERAPY	0. 000000	0		0	0	66.00
67. 00 06700 OCCUPATI ONAL THERAPY	0. 000000	0		0	0	67.00
68.00 06800 SPEECH PATHOLOGY	0. 000000	0		0	0	
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0. 000000	0		0	0	
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0. 000000	0		0	0	
73.00 07300 DRUGS CHARGED TO PATIENTS	0. 000000	0		0	0	70.00
76. 97 O7697 CARDIAC REHABILITATION	0. 000000	0		0	0	76. 97
76.98 07698 HYPERBARIC OXYGEN THERAPY	0. 000000	0		0	0	76. 98
76. 99 07699 LI THOTRI PSY	0. 000000	0		0 0	0	76. 99
OUTPATIENT SERVICE COST CENTERS						
91. 00 09100 EMERGENCY	0. 000000	0		0	0	
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART	0. 000000	0		0	0	
200.00 Total (lines 50 through 199)		0		0 0	0	200. 00

	Financial Systems	HARVARD MEMORIAL			u of Form CMS-2	
COMPUT	ATION OF INPATIENT OPERATING COST		Provi der CCN: 14-1335	Peri od: From 07/01/2022	Worksheet D-1	
				To 06/30/2023		pared:
			Title XVIII	Hospi tal	11/28/2023 5: Cost	06 pm
	Cost Center Description		TI CIC XVIII	nospi tai	0031	
	·				1. 00	
	PART I - ALL PROVIDER COMPONENTS INPATIENT DAYS					+
1. 00	Inpatient days (including private room day	s and swing-bed days	s excluding newborn)		861	1.00
2. 00	Inpatient days (including private room day				861	•
3.00	Private room days (excluding swing-bed and			rivate room days,	0	3.00
	do not complete this line.					
4.00	Semi-private room days (excluding swing-be				585	
5. 00	Total swing-bed SNF type inpatient days (i	ncluding private roo	om days) through Decemb	er 31 of the cost	0	5.00
6. 00	reporting period Total swing-bed SNF type inpatient days (i	ncluding private ro	om days) after December	31 of the cost	0	6.00
0.00	reporting period (if calendar year, enter		om days) arter becember	or the cost	O	0.00
7.00	Total swing-bed NF type inpatient days (in		m days) through Decembe	r 31 of the cost	0	7.00
	reporting period	• .				
8. 00	Total swing-bed NF type inpatient days (in		m days) after December	31 of the cost	0	8.00
9. 00	reporting period (if calendar year, enter Total inpatient days including private roo		the Drogram (eveludin	a cwina bod and	273	9.00
9.00	newborn days) (see instructions)	ili days appircable to	o the Program (excruding	y swifig-bed and	2/3	9.00
10.00	Swing-bed SNF type inpatient days applicab	le to title XVIII or	nlv (includina private	room davs)	0	10.00
	through December 31 of the cost reporting					
11.00	Swing-bed SNF type inpatient days applicab			room days) after	0	11.00
	December 31 of the cost reporting period (40.00
12.00	Swing-bed NF type inpatient days applicabl through December 31 of the cost reporting		t only (including priva	te room days)	0	12. 00
13.00	Swing-bed NF type inpatient days applicable		X only (including priva	te room days)	0	13.00
.0.00	after December 31 of the cost reporting pe				ŭ	
14.00	Medically necessary private room days appl				0	14.00
15.00	Total nursery days (title V or XIX only)				0	
16. 00	Nursery days (title V or XIX only)				0	16. 00
17. 00	SWING BED ADJUSTMENT Medicare rate for swing-bed SNF services a	nnlicable to convice	os through Docombor 21	of the cost] 17. 00
17.00	reporting period	ppircable to service	es till odgil becelliber 31	of the cost		17.00
18. 00	Medicare rate for swing-bed SNF services a	pplicable to service	es after December 31 of	the cost		18.00
	reporting period					
19.00	Medicaid rate for swing-bed NF services ap	plicable to services	s through December 31 o	f the cost	0. 00	19.00
20.00	reporting period	-1:	£t Db 21 -£		0.00	20.00
20. 00	Medicaid rate for swing-bed NF services apreporting period	pilcable to services	s after December 31 of	tne cost	0. 00	20.00
21. 00	Total general inpatient routine service co	st (see instructions	5)		2, 526, 732	21.00
22. 00	Swing-bed cost applicable to SNF type serv	•	,	ting period (line		1
	5 x line 17)	•	·			
23. 00	Swing-bed cost applicable to SNF type serv	ices after December	31 of the cost reporti	ng period (line 6	0	23. 00
24.00	x line 18)	aca +braugh Dagamba	s 21 of the cost reserve	ing ported (line	0	24 00
24. 00	Swing-bed cost applicable to NF type servi 7 x line 19)	ces trii ougri beceiibei	31 of the cost report	ing period (inte	0	24.00
25. 00	Swing-bed cost applicable to NF type servi	ces after December :	31 of the cost reportin	g period (line 8	0	25. 00
	x line 20)					
26.00	Total swing-bed cost (see instructions)				0	
27. 00	General inpatient routine service cost net	of swing-bed cost	(line 21 minus line 26)		2, 526, 732	27. 00
20 00	PRI VATE ROOM DI FFERENTI AL ADJUSTMENT	(oveluding ewing be-	d and observation had a	harace)	0	20 00
28. 00 29. 00	General inpatient routine service charges Private room charges (excluding swing-bed		a and observation bed C	nai yes)	0	
30.00	Semi-private room charges (excluding swing-bed				0	1
	,					1

Impatriant days (including private room days, and sell-g-had days, excluding newborn) 861		PART I - ALL PROVIDER COMPONENTS		
Impatient days (Including private room days, excluding swing-bed and newborn days) 20 3.00 Private room days, (sectuding swing-bed and observation bed days). If you have end by private room days. 3.00 4.00 3.00 4.00 3.00 4.00 3.00 3.00 4.00 3.00	1 00	INPATIENT DAYS	0/1	1 00
Private room days (excluding swing-bed and observation bod days). If you have only private room days. 0 3.00				
do not complete this line. 1.00 Semi-private room days (excluding swing-bed and observation bod days) 1.01 Total swing-bod SRF type inpatient days (including private room days) after December 31 of the cost reporting period (if culendar year, enter 0 on this line) 1.02 Total swing-bod SRF type inpatient days (including private room days) after December 31 of the cost reporting period (if culendar year, enter 0 on this line) 1.02 Total swing-bod SRF type inpatient days (including private room days) through December 31 of the cost reporting period (if culendar year, enter 0 on this line) 1.03 Total swing-bod SRF type inpatient days (including private room days) after December 31 of the cost reporting period (if culendar year, enter 0 on this line) 1.04 Total impatient days including private room days spell cable to the Program (excluding swing-bed and nesborn days) (see instructions) 1.05 Swing-bed SRF type inpatient days applicable to this line) 1.06 Swing-bed SRF type inpatient days applicable to the SRF type inpatient days applicable to sRF type inpatient days applicable to sRF type inpatient days applicable to sRF type sRF type inpatient days appli				
Semi-private room days (excluding swing-bed and observation bed days) 586 4.00	3.00		U	3.00
5.00 Total swing-bed SNF type inpatient days (including private room days) after December 31 of the cost of Corporting period (including private room days) after December 31 of the cost reporting period (including private room days) through December 31 of the cost reporting period (including private room days) after December 31 of the cost reporting period (including private room days) after December 31 of the cost reporting period (including private room days) after December 31 of the cost reporting period (including private room days) after December 31 of the cost reporting period (including private room days) after December 31 of the cost reporting period (including private room days) after December 31 of the cost reporting period (including private room days) after December 31 of the cost reporting period (including private room days) after December 31 of the cost reporting period (including private room days) after December 31 of the cost reporting period (including private room days) after December 31 of the cost reporting period (including private room days) after December 31 of the cost reporting period (including private room days) after December 31 of the cost reporting period (including private room days) after December 31 of the cost reporting period (including private room days) after December 31 of the cost reporting period (including private room days) after December 31 of the cost reporting period (including private room days) after December 31 of the cost reporting period (including private room days) after December 31 of the cost reporting period (including private room days) after December 31 of the cost reporting period (including private room days) after December 31 of the cost reporting period (including private room days) after December 31 of the cost reporting period (including private room days) after December 31 of the cost reporting period (including private room days) after December 31 of the cost reporting period (including private room days) after December 31 of the cost reporting	4 00		595	4 00
reporting period (if calendar year, enter 0 on this line) 7. 00 Total soling-bed SNF type inpatient days (including private room days) after December 31 of the cost of reporting period (if calendar year, enter 0 on this line) 8. 00 Total inpatient days (including private room days) after December 31 of the cost or reporting period (if calendar year, enter 0 on this line) 9. 00 Total inpatient days including private room days apricable to the Program (excluding swing-bed and newtorm days) (see instructions) 10. 00 Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) after December 31 of the cost of through December 31 of the cost reporting period (if calendar year, enter 0 on this line) 11. 00 Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) after through December 31 of the cost reporting period (if calendar year) 12. 00 Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) after through December 31 of the cost reporting period (if calendar year, enter 0 on this line) 13. 00 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) 14. 00 Medically incessary private room days applicable to the Program (excluding swing-bed days) 15. 00 Interest of the swing-bed SNF services applicable to services through December 31 of the cost reporting period (if calendar year, enter 0 on this line) 16. 00 Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost reporting period (including private room days) 18. 00 Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost reporting period (line of the cost applicable to SNF type services after December 31 of the cost reporting period (l				
7.00 Total swing-bed SNF type inpatient days (including private room days) after December 31 of the cost proprior of (including private room days) through December 31 of the cost proprior of the cos	5.00		U	3.00
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PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS 38.00 Adjusted general inpatient routine service cost per diem (see instructions) 39.00 Program general inpatient routine service cost (line 9 x line 38) 40.00 Medically necessary private room cost applicable to the Program (line 14 x line 35) 2, 934.65 38.00 801, 159 39.00 40.00				
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40.00 Medically necessary private room cost applicable to the Program (line 14 x line 35) 0 40.00				
41.00 Total Frogram general impatient fouttine service cost (Title 39 + Title 40)				
	41.00	Total Trogram general Tipatrent Toutine Service Cost (Tine 37 + Tine 40)	001, 159	41.00

	From 07/01/2022 To 06/30/2023	Worksheet D-1 Date/Time Pre 11/28/2023 5:	pared
	Cost Center Description Total Total Average Per Program Days Inpatient Cost Inpatient Days Diem (col. 1 ÷ col. 2) Title XVIII Hospital Total Total Average Per Cool. 2	Cost Program Cost (col. 3 x col. 4)	
10.00	1.00 2.00 3.00 4.00	5. 00	40.6
12.00	NURSERY (title V & XIX only) Intensive Care Type Inpatient Hospital Units		42.0
13.00 14.00 15.00		147, 732	43. C 44. C 45. C 46. C
	OTHER SPECIAL CARE (SPECIFY)		47. 0
	Cost Center Description	1. 00	
18. 00	Program inpatient ancillary service cost (Wkst. D-3, col. 3, line 200)	524, 202	48.0
18. 01 19. 00	Program inpatient cellular therapy acquisition cost (Worksheet D-6, Part III, line 10, column 1) Total Program inpatient costs (sum of lines 41 through 48.01)(see instructions) PASS THROUGH COST ADJUSTMENTS	0 1, 473, 093	
0.00	Pass through costs applicable to Program inpatient routine services (from Wkst. D, sum of Parts I and	0	50. C
51. 00		0	51.0
2. 00 3. 00	Total Program excludable cost (sum of lines 50 and 51) Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)	0	
	TARGET AMOUNT AND LIMIT COMPUTATION		
54. 00 55. 00	Program discharges Target amount per discharge	0 00	54. C
5. 01	Permanent adjustment amount per discharge		55.0
5. 02	1 3 1	0. 00	
5.00	1 9 ,	0	
3. 00	Difference between adjusted inpatient operating cost and target amount (line 56 minus line 53) Bonus payment (see instructions)	0	
9. 00	Trended costs (lesser of line 53 ÷ line 54, or line 55 from the cost reporting period ending 1996,	0.00	
2 00	updated and compounded by the market basket)	0.00	(0)
0.00	market basket) Continuous improvement bonus payment (if line 53 ÷ line 54 is less than the lowest of lines 55 plus	0. 00	
	55.01, or line 59, or line 60, enter the lesser of 50% of the amount by which operating costs (line 53) are less than expected costs (lines 54 x 60), or 1 % of the target amount (line 56), otherwise enter zero. (see instructions)		
2.00	1		62. 63.
3.00	Allowable Inpatient cost plus incentive payment (see instructions) PROGRAM INPATIENT ROUTINE SWING BED COST	0	63.
1. 00	Medicare swing-bed SNF inpatient routine costs through December 31 of the cost reporting period (See	0	64.
5. 00	<pre>instructions)(title XVIII only) Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (See instructions)(title XVIII only)</pre>	0	65.
6. 00	Total Medicare swing-bed SNF inpatient routine costs (line 64 plus line 65)(title XVIII only); for	0	66.
7. 00	CAH, see instructions Title V or XIX swing-bed NF inpatient routine costs through December 31 of the cost reporting period (line 12 x line 19)	0	67.
3. 00	Title V or XIX swing-bed NF inpatient routine costs after December 31 of the cost reporting period (line 13 x line 20)	0	68.
9. 00	Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68)	0	69.
0. 00 1. 00	PART III - SKILLED NURSING FACILITY, OTHER NURSING FACILITY, AND ICF/IID ONLY Skilled nursing facility/other nursing facility/ICF/IID routine service cost (line 37) Adjusted general inpatient routine service cost per diem (line 70 ÷ line 2)		70. (71. (
2. 00	Program routine service cost (line 9 x line 71)		72.
. 00	Medically necessary private room cost applicable to Program (line 14 x line 35)		73.
. 00	Total Program general inpatient routine service costs (line 72 + line 73) Capital-related cost allocated to inpatient routine service costs (from Worksheet B, Part II, column		74. 75.
00	26, line 45)		٦,
. 00	Per diem capital-related costs (line 75 ÷ line 2) Program capital-related costs (line 9 x line 76)		76. 77.
. 00	, ,		78.
. 00	Aggregate charges to beneficiaries for excess costs (from provider records)		79.
. 00	, , ,		80.
. 00	Inpatient routine service cost per diem limitation Inpatient routine service cost limitation (line 9 x line 81)		81. 82.
3. 00	Reasonable inpatient routine service costs (see instructions)		83.
1. 00	Program inpatient ancillary services (see instructions)		84.
5. 00			85.
	Total Program inpatient operating costs (sum of lines 83 through 85)		86.
5. 00	PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST		

Health Financial Systems	Financial Systems HARVARD MEMORIAL HOSPITAL In Lieu			eu of Form CMS-2552-10		
COMPUTATION OF INPATIENT OPERATING COST	Provi der CCN: 14-1335			Peri od:	Worksheet D-1	
		Title	XVIII	Hospi tal	Cost	
Cost Center Description						
					1.00	
89.00 Observation bed cost (line 87 x line 88) (see instructions)						89.00
Cost Center Description	Cost	Routine Cost	column 1 ÷	Total	Observation	
		(from line 21)	column 2	Observati on	Bed Pass	
				Bed Cost (from	Through Cost	
				line 89)	(col. 3 x col.	
					4) (see	
					instructions)	
	1.00	2.00	3.00	4. 00	5. 00	
COMPUTATION OF OBSERVATION BED PASS THROUGH (COST					
90.00 Capital -related cost	243, 346	2, 526, 732	0. 09630	9 809, 963	78, 007	90.00
91.00 Nursing Program cost	0	2, 526, 732	0.00000	0 809, 963	0	91.00
92.00 Allied health cost	0	2, 526, 732	0.00000	0 809, 963	0	92.00
93.00 All other Medical Education	0	2, 526, 732	0. 00000	0 809, 963	ol	93.00

Health Financial Systems	HARVARD MEMORIAL HOSPITAL	In Lie	u of Form CMS-2552-10
COMPUTATION OF INPATIENT OPERATING COST	Provi der CCN: 14-1335	Period: From 07/01/2022	Worksheet D-1
	Component CCN: 14-6014		
	Title XVIII	Skilled Nursing	PPS
		Facility	

ALL FlowUpber Description ALL FlowUpber DOWNDENTS 1.00 AND Implation Labys, (including private room days, excluding newborn) 1.00 Implation Caves 1.00 Implation tays, (including private room days, excluding asing-bad and newborn days) 2.088 2.00 2.00 Private room days, (coulding swing-bad and observation bed days). If you have only private room days 2.00 Private room days (coulding swing-bad and observation bed days). If you have only private room days 3.00 and complete this line. 3.00 Intell saing-bad SM type inpatient days, (including private room days) through Becember 31 of the cost proporting period 3.00 Intell saing-bad SM type inpatient days, (including private room days) after December 31 of the cost reporting period 4.00 Intell saing-bad SM type inpatient days, (including private room days) through December 31 of the cost reporting period (including private room days) through December 31 of the cost reporting period (including private room days) through December 31 of the cost reporting period (including private room days) through December 31 of the cost reporting period (including private room days) through December 31 of the cost reporting period (including private room days) through December 31 of the cost reporting period (including private room days) applicable to the private room days and period (including private room days) applicable and period (including private room da			litle XVIII	Facility	PPS	
New York		Cost Center Description		-		
MARTIERT DAYS		DART I _ ALL PROVIDER COMPONENTS			1. 00	
1.00 Inpatient days (including private room days and swing-bed days, excluding newborn) 2.088 2.00 Inpatient days (including private room days, excluding swing-bed and newborn days) 2.088 2.00 2.0						
Private room days (excluding swing-bed and observation bed days). If you have only private room days. 0 3.00	1.00		s, excluding newborn)		2, 088	1. 00
do not complete this line. 4. 00 Selectivitate room days (sectual ing swing-bed and observation bed days) 7. 00 Total swing-bed SNF type inpatient days (including private room days) after December 31 of the cost of the cost swing-bed SNF type inpatient days (including private room days) after December 31 of the cost of the cost reporting period (if callendar year, enter 0 on this line) 7. 00 Total swing-bed SNF type inpatient days (including private room days) after December 31 of the cost of the cost reporting period (if callendar year, enter 0 on this line) 8. 00 Total swing-bed SNF type inpatient days (including private room days) after December 31 of the cost of the cost reporting period (if callendar year, enter 0 on this line) 9. 00 Total swing-bed SNF type inpatient days (including private room days) after December 31 of the cost reporting period (if callendar year, enter 0 on this line) 10. 01 Sking-bed SNF type inpatient days applicable to the Program (excluding swing-bed and head of the cost reporting period (if callendar year, enter 0 on this line) 10. 02 Sking-bed SNF type inpatient days applicable to the Program (excluding private room days) after December 31 of the cost reporting period (if callendar year, enter 0 on this line) 10. 02 SNI and bed NF type inpatient days applicable to thitle XVIII only (including private room days) after December 31 of the cost reporting period (if callendar year, enter 0 on this line) 10. 02 SNI and bed NF type inpatient days applicable to thitle SVIII only (including private room days) 10. 03 SNI and bed NF type inpatient days applicable to the Program (excluding swing-bed and patient days applicable to thitle XVIII only (including private room days) 10. 01 SNI and bed NF type inpatient days applicable to the program (excluding private room days) 10. 02 SNI and bed NF type inpatient days applicable to thitle XVIII only (including private room days) 10. 02 SNI and bed NF type inpatient days applicable to this XVIII only (including private room days) 1			<i>3 /</i>			
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Total swing-bed SNF type inpatient days (including private room days) after December 31 of the cost reporting period (including private room days) after December 31 of the cost room in part of the cost reporting period (if cal ender year, enter 0 on this Line) rotal swing-bed SNF type inpatient days (including private room days) through December 31 of the cost roporting period (if cal ender year, enter 0 on this Line) rotal swing-bed SNF type inpatient days (including private room days) after December 31 of the cost reporting period (if cal ender year, enter 0 on this Line) roporting period (if cal ender year, enter 0 on	4 00	•	ad days)		2 000	4 00
reporting period (if calendar year, enter 0 on this line) 7.00 7				er 31 of the cost	· ·	
reporting period (if calendar year, enter 0 on this line) 7.00 Total saling-bed MF type inpatient days (including private room days) through December 31 of the cost on the cost of the c	0.00		om daye, till odgi. becomb	0. 0. 0 000.	Ü	0.00
Total swing-bed NF type inpatient days (including private room days) through December 31 of the cost reporting period 10	6.00		om days) after December	31 of the cost	0	6. 00
reporting period Total inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line) Total inpatient days including private room days applicable to the Program (excluding swing-bed and 767 9.00 sing-bed SW type inpatient day applicable to title XVIII only (including private room days) Swing-bed SW type inpatient days applicable to title XVIII only (including private room days) after 0 incompleted on the cost reporting period (see instructions) Swing-bed SW type inpatient days applicable to title XVIII only (including private room days) after 0 incomplete in						
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x line 20) 26.00 Total swing-bed cost (see instructions) Ceneral inpatient routine service cost net of swing-bed cost (line 21 minus line 26) PRI VATE ROOM DIFFERENTIAL ADJUSTMENT 28.00 General inpatient routine service charges (excluding swing-bed and observation bed charges) Pri vate room charges (excluding swing-bed charges) Semi-pri vate room charges (excluding swing-bed charges) Ceneral inpatient routine service cost/charge ratio (line 27 ÷ line 28) Average pri vate room per diem charge (line 29 ÷ line 3) Average semi-pri vate room per diem charge (line 30 ÷ line 4) Average per diem pri vate room cost differential (line 34 x line 31) Average per diem pri vate room cost differential (line 34 x line 31) Pri vate room cost differential adjustment (line 3 x line 35) General inpatient routine service cost net of swing-bed cost and private room cost differential (line 1, 216, 406) PART II - HOSPITAL AND SUBPROVIDERS ONLY PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS 38.00 Adjusted general inpatient routine service cost (line 9 x line 38) Medically necessary private room cost applicable to the Program (line 14 x line 35) D 26.00 Coneral inpatient routine service cost applicable to the Program (line 14 x line 35) D 26.00 Coneral inpatient routine service cost applicable to the Program (line 14 x line 35) Adout the coneral inpatient routine service cost (line 9 x line 38) Modically necessary private room cost applicable to the Program (line 14 x line 35)	21.00		. Or or the cost reports	ing period (ine	G	21.00
26.00 General inpatient routine service cost net of swing-bed cost (line 21 minus line 26) 27.00 General inpatient routine service cost net of swing-bed cost (line 21 minus line 26) 28.00 General inpatient routine service charges (excluding swing-bed and observation bed charges) 29.00 Private room charges (excluding swing-bed charges) 30.00 Semi-private room charges (excluding swing-bed charges) 30.00 Semi-private room charges (excluding swing-bed charges) 30.00 General inpatient routine service cost/charge ratio (line 27 ÷ line 28) 30.00 Average private room per diem charge (line 29 ÷ line 3) 30.00 Average semi-private room per diem charge (line 30 ÷ line 4) 30.00 Average per diem private room cost differential (line 32 minus line 33)(see instructions) 30.00 Average per diem private room cost differential (line 34 x line 31) 30.00 Average per diem private room cost differential (line 34 x line 31) 30.00 General inpatient routine service cost net of swing-bed cost and private room cost differential (line 1, 216, 406) 30.00 Program inpatient routine service cost per diem (see instructions) 30.00 Adjusted general inpatient routine service cost per diem (see instructions) 30.00 Program general inpatient routine service cost (line 9 x line 38) 30.00 Medically necessary private room cost applicable to the Program (line 14 x line 35) 30.00 Medically necessary private room cost applicable to the Program (line 14 x line 35)	25.00		31 of the cost reporting	g period (line 8	0	25. 00
27. 00 General inpatient routine service cost net of swing-bed cost (line 21 minus line 26) 1, 216, 406 PRIVATE ROOM DIFFERENTIAL ADJUSTMENT 28. 00 General inpatient routine service charges (excluding swing-bed and observation bed charges) 0 29. 00 Private room charges (excluding swing-bed charges) 0 29. 00 30. 00 Semi-private room charges (excluding swing-bed charges) 0 30. 00 31. 00 General inpatient routine service cost/charge ratio (line 27 + line 28) 0. 0000000 32. 00 Average private room per diem charge (line 29 + line 3) 0. 00 33. 00 Average semi-private room per diem charge (line 30 + line 4) 0. 00 34. 00 Average per diem private room charge differential (line 32 minus line 33) (see instructions) 0. 00 35. 00 Average per diem private room cost differential (line 34 x line 31) 0. 00 35. 00 Average per diem private room cost differential (line 34 x line 31) 0. 00 35. 00 Average per diem private room cost differential (line 3 x line 35) 0 36. 00 37. 00 Office of the private room cost differential adjustment (line 3 x line 35) 0 36. 00 37. 00 PRAT II - HOSPITAL AND SUBPROVIDERS ONLY PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS 38. 00 39. 00 Program general inpatient routine service cost (line 9 x line 38) 39. 00 40. 00 Medically necessary private room cost applicable to the Program (line 14 x line 35) 40. 00	27 00				0	27 00
PRI VATE ROOM DIFFERENTIAL ADJUSTMENT 28.00 General inpatient routine service charges (excluding swing-bed and observation bed charges) 9.00 Pri vate room charges (excluding swing-bed charges) 30.00 Semi-pri vate room charges (excluding swing-bed charges) 31.00 General inpatient routine service cost/charge ratio (line 27 + line 28) 32.00 Average pri vate room per diem charge (line 29 + line 3) 32.00 Average semi-pri vate room per diem charge (line 30 + line 4) 32.00 Average per diem pri vate room charge differential (line 32 minus line 33) (see instructions) 33.00 Average per diem pri vate room cost differential (line 34 x line 31) 35.00 Pri vate room cost differential adjustment (line 3 x line 35) 37.00 General inpatient routine service cost net of swing-bed cost and private room cost differential (line 1, 216, 406) 37.00 PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS 38.00 Adjusted general inpatient routine service cost (line 9 x line 38) 9.00 Medically necessary private room cost applicable to the Program (line 14 x line 35) 40.00 Medically necessary private room cost applicable to the Program (line 14 x line 35)		, ,	(line 21 minus line 26)		-	
28.00 General inpatient routine service charges (excluding swing-bed and observation bed charges) 29.00 Private room charges (excluding swing-bed charges) 30.00 Semi-private room charges (excluding swing-bed charges) 30.00 Semi-private room charges (excluding swing-bed charges) 30.00 General inpatient routine service cost/charge ratio (line 27 ÷ line 28) 30.00 Average private room per diem charge (line 29 ÷ line 3) 30.00 Average semi-private room per diem charge (line 30 ÷ line 4) 30.00 Average per diem private room charge differential (line 32 minus line 33)(see instructions) 30.00 Average per diem private room cost differential (line 34 x line 31) 30.00 Average per diem private room cost differential (line 34 x line 31) 30.00 Average per diem private room cost differential (line 34 x line 31) 30.00 Average per diem private room cost differential (line 34 x line 31) 30.00 Average per diem private room cost differential (line 34 x line 35) 30.00 Average per diem private room cost differential (line 37 x line 36) 30.00 Average per diem private room cost differential (line 30 x line 30) 30.00 Average per diem private room cost differential (line 30 x line 30) 30.00 Average per diem private room cost differential (line 30 x line 30) 30.00 Average per diem private room cost differential (line 30 x line 31) 30.00 Average per diem private room cost differential (line 30 x line 31) 30.00 Average per diem private room cost differential (line 30 x line 31) 30.00 Average per diem private room cost differential (line 30 x line 31) 30.00 Average per diem private room cost differential (line 30 x line 31) 30.00 Average per diem private room cost differential (line 30 x line 31) 30.00 Average per diem private room cost differential (line 30 x line 31) 30.00 Average per diem private room cost differential (line 30 x line 31) 30.00 Average per diem private room cost differential (line 30 x line 31) 30.00 Average per diem private room cost differential (line 30 x line 31) 30.00 Average per diem privat	27.00		(Tric 21 iii lid3 Tric 20)		1, 210, 400	27.00
29.00 Private room charges (excluding swing-bed charges) 30.00 Semi-private room per diem service (line 29 + line 39 30.00 Average private room per diem charge (line 29 + line 30 + line 4) 30.00 Average per diem private room charge differential (line 32 minus line 33)(see instructions) 31.00 Average per diem private room cost differential (line 34 x line 31) 32.00 Average per diem private room cost differential (line 3 x line 35) 33.00 Average per diem private room cost differential (line 3 x line 35) 34.00 Private room cost differential adjustment (line 3 x line 35) 35.00 General inpatient routine service cost net of swing-bed cost and private room cost differential (line 1, 216, 406) 37.00 PART II - HOSPITAL AND SUBPROVIDERS ONLY PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS 38.00 Adjusted general inpatient routine service cost (line 9 x line 38) 40.00 Medically necessary private room cost applicable to the Program (line 14 x line 35) 40.00	28.00		d and observation bed cl	harges)	0	28. 00
31.00 General inpatient routine service cost/charge ratio (line 27 ÷ line 28) 32.00 Average private room per diem charge (line 29 ÷ line 3) 32.00 Average semi-private room per diem charge (line 30 ÷ line 4) 32.00 Average semi-private room per diem charge (line 30 ÷ line 4) 32.00 Average per diem private room charge differential (line 32 minus line 33) (see instructions) 32.00 Average per diem private room cost differential (line 34 x line 31) 33.00 Average per diem private room cost differential (line 3 x line 31) 34.00 Private room cost differential adjustment (line 3 x line 35) 35.00 General inpatient routine service cost net of swing-bed cost and private room cost differential (line 1, 216, 406 and 27 minus line 36) PART II - HOSPITAL AND SUBPROVIDERS ONLY PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS Adjusted general inpatient routine service cost per diem (see instructions) Program general inpatient routine service cost (line 9 x line 38) 40.00 Medically necessary private room cost applicable to the Program (line 14 x line 35) 40.00					-	29. 00
32.00 Average private room per diem charge (line 29 + line 3) 32.00 Average semi-private room per diem charge (line 30 + line 4) 33.00 Average per diem private room charge differential (line 32 minus line 33) (see instructions) 34.00 Average per diem private room cost differential (line 34 x line 31) 35.00 Average per diem private room cost differential (line 34 x line 31) 36.00 Private room cost differential adjustment (line 3 x line 35) 37.00 General inpatient routine service cost net of swing-bed cost and private room cost differential (line 1, 216, 406) 27 minus line 36) PART II - HOSPITAL AND SUBPROVIDERS ONLY PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS Adjusted general inpatient routine service cost (line 9 x line 38) 40.00 Medically necessary private room cost applicable to the Program (line 14 x line 35) 40.00						
33.00 Average semi-private room per diem charge (line 30 ÷ line 4) 34.00 Average per diem private room charge differential (line 32 minus line 33)(see instructions) 35.00 Average per diem private room cost differential (line 34 x line 31) 36.00 Private room cost differential adjustment (line 3 x line 35) 37.00 General inpatient routine service cost net of swing-bed cost and private room cost differential (line 1, 216, 406) PART II - HOSPITAL AND SUBPROVIDERS ONLY PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS Adjusted general inpatient routine service cost (line 9 x line 38) Program general inpatient routine service cost (line 9 x line 38) Medically necessary private room cost applicable to the Program (line 14 x line 35) 0.00 33.00 0.00 34.00 0.00 35.00 0.00 35.00 0.00 36.00		, ,	÷ line 28)			
34.00 Average per diem private room charge differential (line 32 minus line 33) (see instructions) 34.00 Average per diem private room cost differential (line 34 x line 31) 35.00 Average per diem private room cost differential (line 34 x line 31) 36.00 Private room cost differential adjustment (line 3 x line 35) 37.00 General inpatient routine service cost net of swing-bed cost and private room cost differential (line 1, 216, 406) 27 minus line 36) PART II - HOSPITAL AND SUBPROVIDERS ONLY PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS 38.00 Adjusted general inpatient routine service cost per diem (see instructions) Program general inpatient routine service cost (line 9 x line 38) 40.00 Medically necessary private room cost applicable to the Program (line 14 x line 35) 40.00		, , , , , , , , , , , , , , , , , , , ,				
35.00 Average per diem private room cost differential (line 34 x line 31) 36.00 Private room cost differential adjustment (line 3 x line 35) 37.00 General inpatient routine service cost net of swing-bed cost and private room cost differential (line 1, 216, 406) PART II - HOSPITAL AND SUBPROVIDERS ONLY PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS 38.00 Adjusted general inpatient routine service cost per diem (see instructions) Program general inpatient routine service cost (line 9 x line 38) 40.00 Medically necessary private room cost applicable to the Program (line 14 x line 35) 37.00 37.00 38.00 39.00		, , , , , , , , , , , , , , , , , , , ,	nus line 33)(see instru	ctions)		
37.00 General inpatient routine service cost net of swing-bed cost and private room cost differential (line 27 minus line 36) PART II - HOSPITAL AND SUBPROVIDERS ONLY PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS 38.00 Adjusted general inpatient routine service cost per diem (see instructions) Program general inpatient routine service cost (line 9 x line 38) 40.00 Medically necessary private room cost applicable to the Program (line 14 x line 35) 37.00 Available 1, 216, 406 Available 1, 216, 406 Available 2, 37.00 Available 3, 37.00 Available 2, 37.00 Available 3, 37.00 Available 2, 37.00 Available 3, 37.0		, , , , , , , , , , , , , , , , , , , ,	, ,	<i>'</i>		
27 minus line 36) PART II - HOSPITAL AND SUBPROVIDERS ONLY PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS 38.00 Adjusted general inpatient routine service cost per diem (see instructions) 39.00 Program general inpatient routine service cost (line 9 x line 38) 40.00 Medically necessary private room cost applicable to the Program (line 14 x line 35) 40.00		, , , , , , , , , , , , , , , , , , , ,			-	
PART II - HOSPITAL AND SUBPROVIDERS ONLY PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS 38.00 Adjusted general inpatient routine service cost per diem (see instructions) 38.00 Program general inpatient routine service cost (line 9 x line 38) 40.00 Medically necessary private room cost applicable to the Program (line 14 x line 35) 40.00	37. 00		and private room cost d	ifferential (line	1, 216, 406	37. 00
PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS 38.00 Adjusted general inpatient routine service cost per diem (see instructions) 38.00 Program general inpatient routine service cost (line 9 x line 38) 40.00 Medically necessary private room cost applicable to the Program (line 14 x line 35) 40.00		,				
38.00Adjusted general inpatient routine service cost per diem (see instructions)38.0039.00Program general inpatient routine service cost (line 9 x line 38)39.0040.00Medically necessary private room cost applicable to the Program (line 14 x line 35)40.00			USTMENTS			
39.00 Program general inpatient routine service cost (line 9 x line 38) 40.00 Medically necessary private room cost applicable to the Program (line 14 x line 35) 39.00 40.00	38. 00					38. 00
	39.00	Program general inpatient routine service cost (line 9 x line	38)			39. 00
41.00 Iotal Program general inpatient routine service cost (line 39 + line 40) 41.00						
	41.00	liotal Program general inpatient routine service cost (line 39	+ IIne 40)			41.00

	inancial Systems	HARVARD MEMORIA		N 14 1005		u of Form CMS-	
COMPUTAT	TION OF INPATIENT OPERATING COST		Provi der CC	CN: 14-1335	Period: From 07/01/2022	Worksheet D-1	l
			Component C	CCN: 14-6014	To 06/30/2023	Date/Time Pre 11/28/2023 5:	
			Title	XVIII	Skilled Nursing	PPS	оо ріі
	Cook Cooks Decoration	T-+-1	T-+-1	A	Facility	D C+	
	Cost Center Description	Total Inpatient Costlr	Total npatient Davsl	Average Per Diem (col. 1		Program Cost (col. 3 x col.	
		·		col . 2)		4)	
2 00 NI	IDCEDY (+; +l o V e VIV only)	1.00	2. 00	3. 00	4. 00	5. 00	42.0
	URSERY (title V & XIX only) ntensive Care Type Inpatient Hospital Uni	ts					42.0
	NTENSIVE CARE UNIT						43.0
	ORONARY CARE UNIT						44. (
	URN INTENSIVE CARE UNIT URGICAL INTENSIVE CARE UNIT						45. (
	THER SPECIAL CARE (SPECIFY)						47.
	Cost Center Description		'				
0.00	regree inputiont ancillary convice cost (Wks+ D 2 asl 2	Line 200)			1. 00	40
	rogram inpatient ancillary service cost (rogram inpatient cellular therapy acquisi			III. line 10). column 1)		48.
	otal Program inpatient costs (sum of line				, oo. a		49.
	ASS THROUGH COST ADJUSTMENTS						
	ass through costs applicable to Program i II)	npatient routine s	ervices (from	Wkst. D, su	um of Parts I and		50.
- 1	ass through costs applicable to Program i	npatient ancillary	services (fr	om Wkst. D,	sum of Parts II		51.
- 1	nd IV)						
	otal Program excludable cost (sum of line otal Program inpatient operating cost exc		atod non nhv	eician ancet	thatist and		52. (
	edical education costs (line 49 minus lin		ateu, non-pny	SICIAII AIRSI	inetist, and		33.
TA	ARGET AMOUNT AND LIMIT COMPUTATION	,					
1	rogram discharges						54.
	arget amount per discharge ermanent adjustment amount per discharge						55. 55.
	djustment amount per discharge (contracto	r use only)					55.
5. 00 Ta	arget amount (line 54 x sum of lines 55,	55. 01, and 55. 02)					56.
- 1	ifference between adjusted inpatient oper	ating cost and tar	get amount (I	ine 56 minus	s line 53)		57.
	onus payment (see instructions) rended costs (lesser of line 53 ÷ line 54	. or line 55 from	the cost repo	rtina period	d endina 1996.		58. 59.
u	pdated and compounded by the market baske	t)	•	0.			
	xpected costs (lesser of line 53 ÷ line 5	4, or line 55 from	prior year c	ost report,	updated by the		60.
1	arket basket) ontinuous improvement bonus payment (if L	ine 53 ÷ line 54 i	s less than t	he lowest of	lines 55 plus		61.
5	5.01, or line 59, or line 60, enter the L	esser of 50% of th	e amount by w	hich operati	ng costs (line		
	are less than expected costs (lines 54 nter zero. (see instructions)	x 60), or 1 % of	the target am	ount (line 5	66), otherwise		
	elief payment (see instructions)						62.
3.00 A	llowable Inpatient cost plus incentive pa	yment (see instruc	tions)				63.
	ROGRAM INPATIENT ROUTINE SWING BED COST ledicare swing-bed SNF inpatient routine c	osts through Docom	har 21 of the	cost roport	ting paried (Saa		64.
	nstructions)(title XVIII only)	osts till odgir becell	bei 31 of the	cost report	ing period (see		04.
5.00 M	edicare swing-bed SNF inpatient routine c	osts after Decembe	r 31 of the c	ost reportir	ng period (See		65.
	nstructions)(title XVIII only)	tino costo (lino 6	4 plus lino 4	E) (+; + \ \ \/!	II only): for		44
	otal Medicare swing-bed SNF inpatient rou AH, see instructions	tille costs (Tille o	4 prus rine o	s)(title xvi	ii oniy), ioi		66.
1	itle V or XIX swing-bed NF inpatient rout	ine costs through	December 31 o	f the cost r	reporting period		67.
1 7	line 12 x line 19)	ino costo often De	combon 21 of	the cost s-	orting ported		40
	itle V or XIX swing-bed NF inpatient rout line 13 x line 20)	rue costs after De	celliber 31 OF	the cost rep	or tring period		68.
	otal title V or XIX swing-bed NF inpatien						69.
	ART III - SKILLED NURSING FACILITY, OTHER killed nursing facility/other nursing fac				7)	1, 216, 406	70.
	djusted general inpatient routine service					582. 57	1
2. 00 P	rogram routine service cost (line 9 x lin	e 71)		•		446, 831	
1	edically necessary private room cost appl	•	•			0	1
1	otal Program general inpatient routine se apital-related cost allocated to inpatien	•			Part II column	446, 831 0	1
	6, line 45)	t routine service		or Koneet B,	rare rr, corumn		70.
1	er diem capital-related costs (line 75 ÷						76.
- 1	rogram capital-related costs (line 9 x li npatient routine service cost (line 74 mi) 0	1
1	ggregate charges to beneficiaries for exc		ovi der record	s)		0	1
D. 00 T	otal Program routine service costs for co	mparison to the co		•	nus line 79)	0	80.
1	npatient routine service cost per diem li					0.00	1
1	npatient routine service cost limitation easonable inpatient routine service costs	,				0 446, 831	
1	rogram inpatient ancillary services (see	•	,			691, 213	
5. 00 U	tilization review - physician compensatio	n (see instruction	*			0	85.
6. 00 To	otal Program inpatient operating costs (s ART IV - COMPUTATION OF OBSERVATION BED P.		ough 85)			1, 138, 044	86.
		ACC THRUINGH LINET					

Health Financial Systems	HARVARD MEMORIA	AL_HOSPITAL		In Lie	u of Form CMS-2	2552-10
COMPUTATION OF INPATIENT OPERATING COST		Provi der CC		Peri od:	Worksheet D-1	
		Component (CCN: 14-6014	From 07/01/2022 To 06/30/2023		
		Title	: XVIII	Skilled Nursing	PPS	
				Facility		
Cost Center Description						
					1. 00	
88.00 Adjusted general inpatient routine cost per	diem (line 27 ÷	line 2)			0.00	88. 00
89.00 Observation bed cost (line 87 x line 88) (se	e instructions)				0	89. 00
Cost Center Description	Cost	Routine Cost	column 1 ÷	Total	Observation	
		from line 21)	column 2	Observati on	Bed Pass	
				Bed Cost (from	Through Cost	
					(col. 3 x col.	
				,	4) (see	
					instructions)	
	1.00	2.00	3.00	4. 00	5. 00	
COMPUTATION OF OBSERVATION BED PASS THROUGH	COST					
90.00 Capital -related cost	0	0	0. 00000	0 0	0	90. 00
91.00 Nursing Program cost	o	0	0. 00000	0	0	91.00
92.00 Allied health cost		0	0. 00000		o	92.00
93.00 All other Medical Education	0	0	0. 00000		0	93.00

COMPUT	ATION OF INPATIENT OPERATING COST					2552-10
	ATTON OF INPATTENT OPERATING COST		Provi der CCN: 14-1335	Peri od:	Worksheet D-1	
				From 07/01/2022 To 06/30/2023		
			Title XIX	Hospi tal	11/28/2023 5: Cost	06 pm
	Cost Center Description		II tie xix	поѕрі таі	COST	
	<u> </u>				1. 00	
	PART I - ALL PROVIDER COMPONENTS					
1. 00	INPATIENT DAYS Inpatient days (including private room days	and swing-bed day	rs. excluding newborn)		861	1.00
2. 00	Inpatient days (including private room days,		861	2. 00		
3. 00	Private room days (excluding swing-bed and o	rivate room days,	0	3. 00		
4. 00	do not complete this line. Semi-private room days (excluding swing-bed		585	4. 00		
5. 00	Total swing-bed SNF type inpatient days (inc			er 31 of the cost	0	5. 00
	reporting period				_	
6. 00	Total swing-bed SNF type inpatient days (increporting period (if calendar year, enter 0		om days) after December	31 of the cost	0	6. 00
7. 00	Total swing-bed NF type inpatient days (incl		m days) through Decembe	r 31 of the cost	0	7. 00
0.00	reporting period	Programme and the second	- L -) - Cl D L	04 - 6 11 1	0	0.00
8. 00	Total swing-bed NF type inpatient days (incl reporting period (if calendar year, enter 0		m days) after December	31 of the cost	0	8. 00
9. 00	Total inpatient days including private room		o the Program (excludin	g swing-bed and	15	9. 00
40.00	newborn days) (see instructions)		40.00			
10. 00	Swing-bed SNF type inpatient days applicable through December 31 of the cost reporting pe	0	10. 00			
11. 00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) after					11. 00
40.00	December 31 of the cost reporting period (if	0	40.00			
12. 00	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. 00
13.00	Swing-bed NF type inpatient days applicable		0	13. 00		
14.00	after December 31 of the cost reporting peri				0	14.00
14. 00 15. 00	Medically necessary private room days applic Total nursery days (title V or XIX only)	able to the Progr	alli (exci udi ng Swi ng-bed	uays)	0	14. 00 15. 00
16.00	Nursery days (title V or XIX only)				0	16. 00
17.00	SWI NG BED ADJUSTMENT	1::-	thursday December 21	-6 +1		17.00
17. 00	Medicare rate for swing-bed SNF services appreporting period	officable to servic	es through December 31	or the cost		17. 00
18. 00	Medicare rate for swing-bed SNF services app	licable to servic	es after December 31 of	the cost		18. 00
10.00	reporting period		- +h	£ +1+	0.00	10.00
19. 00	Medicaid rate for swing-bed NF services appl reporting period	reable to service	s through December 31 o	r the cost	0.00	19. 00
20.00	Medicaid rate for swing-bed NF services appl	icable to service	s after December 31 of	the cost	0.00	20. 00
21. 00	reporting period Total general inpatient routine service cost	(coo instruction	c)		2, 526, 732	21.00
22. 00	Swing-bed cost applicable to SNF type service			ting period (line	2, 520, 732	22.00
	5 x line 17)	Ü	·			
23. 00	3	es after December	31 of the cost reporti	ng period (line 6	0	23. 00
24. 00	x line 18) Swing-bed cost applicable to NF type service	s through Decembe	r 31 of the cost report	ing period (line	0	24. 00
	7 x line 19)	-	·			
25. 00	Swing-bed cost applicable to NF type service x line 20)	g period (line 8	0	25. 00		
26. 00	Total swing-bed cost (see instructions)				0	26. 00
27. 00	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26) 2,526,732					
28. 00	PRIVATE ROOM DIFFERENTIAL ADJUSTMENT General inpatient routine service charges (e	veluding swing bo	d and observation had a	harges)	0	28. 00
28.00	Private room charges (excluding swing-bed ch		u anu observation bed c	nai yes <i>)</i>	0	29.00
30.00	Semi-private room charges (excluding swing-b	ed charges)			0	30. 00
31.00	General inpatient routine service cost/charg Average private room per diem charge (line 2	•	÷ line 28)		0. 000000 0. 00	31.00

	ION OF INPATIENT OPERATING COST		Provi der CC		Period: From 07/01/2022 To 06/30/2023	Worksheet D-1 Date/Time Preprint 11/28/2023 5:0	epared
				e XIX	Hospi tal	Cost	
	Cost Center Description	Total Inpatient Costl	Total npatient Davsl	Average Per Diem (col. 1	Program Days	Program Cost (col. 3 x col.	
				col. 2)		4)	
2 00 NII	IDCEDY (+; +l - V o VIVl ·)	1.00	2. 00	3. 00	4. 00	5. 00	12
2.00 NL	JRSERY (title V & XIX only) Itensive Care Type Inpatient Hospital Units	1					42.
	NTENSIVE CARE UNIT	443, 197	21	21, 104. 6	2 0	0	43.
	DRONARY CARE UNIT						44.
	JRN INTENSIVE CARE UNIT						45.
- 1	JRGICAL INTENSIVE CARE UNIT THER SPECIAL CARE (SPECIFY)						46. 47.
7.00 [0]	Cost Center Description						77.
						1. 00	10
	rogram inpatient ancillary service cost (W rogram inpatient cellular therapy acquisit			III line 10	column 1)	0	
	otal Program inpatient costs (sum of lines				cordiiii 1)	44, 020	
	SS THROUGH COST ADJUSTMENTS						
	ass through costs applicable to Program in	oatient routine s	services (from	Wkst. D, sum	of Parts I and	0	50.
1	l) ass through costs applicable to Program in	natient ancillary	services (fr	om Wkst D s	sum of Parts II	o	51.
	nd IV)	5a tr 5.71 a.15. 1 . a. j	(oot. 5, c	01 141 15 11		"
4	otal Program excludable cost (sum of lines					0	1
	otal Program inpatient operating cost excluded in the education costs (line 49 minus line		ated, non-phy	sician anestr	etist, and	0	53.
	RGET AMOUNT AND LIMIT COMPUTATION	32)					i
	rogram discharges					0	
	arget amount per discharge					0.00	
	ermanent adjustment amount per discharge djustment amount per discharge (contractor	use only)				0. 00 0. 00	
	arget amount (line 54 x sum of lines 55, 5)					0.00	
1	Difference between adjusted inpatient operating cost and target amount (line 56 minus line 53)						
	onus payment (see instructions)	on line EE from	the east rand	nting paried	anding 1004	0	
	rended costs (lesser of line 53 ÷ line 54, odated and compounded by the market basket		the cost repo	rting period	ending 1996,	0.00	59.
	0 Expected costs (lesser of line 53 ÷ line 54, or line 55 from prior year cost report, updated by the						
	arket basket)	50	_	h-	liana EE alaa		/1
	ontinuous improvement bonus payment (if li 5.01, or line 59, or line 60, enter the le					0	61.
	3) are less than expected costs (lines 54)		,		•		
	nter zero. (see instructions)					_	
1	elief payment (see instructions) Iowable Inpatient cost plus incentive paym	mont (soo instruc	stions)			0	62. 63.
_	OGRAM INPATIENT ROUTINE SWING BED COST	ilent (see mistruc	, (1 0113)				03.
I. 00 Me	edicare swing-bed SNF inpatient routine co	sts through Decem	ber 31 of the	cost reporti	ng period (See	0	64.
	nstructions)(title XVIII only) edicare swing-bed SNF inpatient routine co	sts after Decembe	or 21 of the c	act raparting	noried (See		65.
I	nstructions)(title XVIII only)	sts after beceilibe	er 31 or the C	ost reporting	, perrou (see	ا	05.
5. 00 To	otal Medicare swing-bed SNF inpatient rout	ne costs (line 6	4 plus line 6	5)(title XVII	I only); for	0	66.
	AH, see instructions tle V or XIX swing-bed NF inpatient routio	ne costs through	December 21 -	f the cost ~	anorting pariod	0	67.
	ine 12 x line 19)	le costs through	December 31 0	Title Cost Te	portring perrou	ا	07.
3. 00 Ti	tle V or XIX swing-bed NF inpatient routi	ne costs after De	ecember 31 of	the cost repo	orting period	o	68.
1 -	ine 13 x line 20)	routing costs (ino 47 : lino	40)			40
	otal title V or XIX swing-bed NF inpatient .RT III – SKILLED NURSING FACILITY, OTHER N					0	69.
). 00 Sk	killed nursing facility/other nursing faci	ity/ICF/IID rout	ine service c	ost (line 37)			70.
1	djusted general inpatient routine service		ne 70 ÷ line	2)			71.
- 1	rogram routine service cost (line 9 x line edically necessary private room cost applio	,	(line 14 v li	ne 35)			72.
- 1	otal Program general inpatient routine ser						74
	apital-related cost allocated to inpatient	routine service	costs (from W	orksheet B, F	art II, column		75.
1	5, line 45) or diem capital-related costs (line 75 ÷ 15	ne 2)					76.
	er diem capital-related costs (line 75 ÷ li rogram capital-related costs (line 9 x lino						77
1	npatient routine service cost (line 74 min						78
1 `	ggregate charges to beneficiaries for exce	, ,		•	==:		79
	otal Program routine service costs for com npatient routine service cost per diem lim		st IImitation	(line 78 min	us line 79)		80
1	npatient routine service cost per diem iim npatient routine service cost limitation (82
1	easonable inpatient routine service costs						83
	rogram inpatient ancillary services (see i						84
	tilization review – physician compensation otal Program inpatient operating costs (su						85
, 00 117	star riogram impatrent operating costs (sui	UL LITICS 03 LIII	ough 00)				1 00.
	RT IV - COMPUTATION OF OBSERVATION BED PAS	SS THROUGH COST				The second secon	1

Health Financial Systems	HARVARD MEMORI	I AL HOSPI TAL		In Lie	u of Form CMS-2	2552-10
COMPUTATION OF INPATIENT OPERATING COST		Provi der CC		Peri od:	Worksheet D-1	
				From 07/01/2022 To 06/30/2023		pared: 06 pm_
		Ti tl	e XIX	Hospi tal	Cost	
Cost Center Description						
					1.00	
89.00 Observation bed cost (line 87 x line 88) (see instructions)					809, 963	89. 00
Cost Center Description	Cost	Routine Cost	column 1 ÷	Total	Observation	
		(from line 21)	column 2	Observati on	Bed Pass	
				Bed Cost (from	Through Cost	
				line 89)	(col. 3 x col.	
					4) (see	
					instructions)	
	1. 00	2.00	3. 00	4. 00	5. 00	
COMPUTATION OF OBSERVATION BED PASS THROUGH (COST					
90.00 Capital -related cost	243, 346	2, 526, 732	0. 09630	9 809, 963	78, 007	90.00
91.00 Nursing Program cost	0	2, 526, 732	0. 00000	809, 963	0	91.00
92.00 Allied health cost	0	2, 526, 732	0. 00000	809, 963	0	92.00
93.00 All other Medical Education	0	2, 526, 732	0. 00000	809, 963	0	93. 00

INDATIONS ANCHIADY CONTROL COCT ADDODELOWATERS	Dec :	CCN: 14-1335	Peri od:	Worksheet D-3	
INPATIENT ANCILLARY SERVICE COST APPORTIONMENT	Provi der		Period: From 07/01/2022	Worksheet D-3	i
			To 06/30/2023	Date/Time Pre	pared:
				11/28/2023 5:	06 pm
	Ti tl	e XVIII	Hospi tal	Cost	
Cost Center Description		Ratio of Cos		Inpati ent	
		To Charges		Program Costs	
			Charges	(col. 1 x col.	
		1.00	2.00	2) 3. 00	
INPATIENT ROUTINE SERVICE COST CENTERS		1.00	2.00	3.00	
30. 00 03000 ADULTS & PEDIATRICS		1	895, 878		30.00
31. 00 03100 NTENSI VE CARE UNI T			52, 960		31.00
ANCILLARY SERVICE COST CENTERS		1	02,700		01.00
50. 00 05000 OPERATING ROOM		0. 16770	906, 163	151, 971	50.00
51. 00 05100 RECOVERY ROOM		0. 38070		19, 567	1
53. 00 05300 ANESTHESI OLOGY		6. 18579		0	1
54. 00 05400 RADI OLOGY-DI AGNOSTI C		0. 12175	132, 404	16, 121	54.00
60. 00 06000 LABORATORY		0. 36581	157, 836	57, 738	60.00
60. 01 06001 BLOOD LABORATORY		0. 00000	00	0	60. 01
62.30 06250 BLOOD CLOTTING FOR HEMOPHILIACS		0. 00000	00	0	62. 30
65. 00 06500 RESPIRATORY THERAPY		1. 86176			
66. 00 06600 PHYSI CAL THERAPY		0. 59859		50, 428	
67. 00 06700 OCCUPATI ONAL THERAPY		1. 81580		0	
68. 00 06800 SPEECH PATHOLOGY		1. 81451		0	
71. 00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT		0. 25938			
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS		0. 28655			
73. 00 07300 DRUGS CHARGED TO PATIENTS		0. 25124		90, 719	
76. 97 O7697 CARDI AC REHABI LI TATI ON		0. 41584		0	
76. 98 O7698 HYPERBARI C OXYGEN THERAPY		0.00000		0	1 , 0 , , 0
76. 99 07699 LI THOTRI PSY		0. 00000	0	0	76. 99
OUTPATIENT SERVICE COST CENTERS 91. 00 09100 EMERGENCY		0. 60674	15 423	257	91.00
92.00 O9200 OBSERVATION BEDS (NON-DISTINCT PART		1. 05403		257	
200.00 Total (sum of lines 50 through 94 and	96 through 98)	1. 05403	2, 139, 394	524, 202	
201.00 Less PBP Clinic Laboratory Services-Pi			Z, 137, 374		201.00
201.00 LE33 DE OFFIE LADOLATORY 3ELVECS-FI	ogram only charges (TITE OT)	1	1		1201.00

Health Financial Systems	HARVARD MEMORIAL	HOSPI TAL		In Lie	u of Form CMS-2	2552-10
INPATIENT ANCILLARY SERVICE COST APPORTIONMENT		Provi der Co	CN: 14-1335	Peri od:	Worksheet D-3	
				From 07/01/2022	5 . (7) 5	
		Component	CCN: 14-6014	To 06/30/2023	Date/Time Pre 11/28/2023 5:	pared:
		Title	· XVIII	Skilled Nursing	PPS	oo piii
		11 11 0	, ,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,	Facility	110	
Cost Center Description			Ratio of Cos		I npati ent	
			To Charges	Program	Program Costs	
				Charges	(col. 1 x col.	
				· ·	2)	
			1.00	2. 00	3. 00	
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00 03000 ADULTS & PEDIATRICS						30.00
31.00 03100 INTENSIVE CARE UNIT						31.00
ANCILLARY SERVICE COST CENTERS						
50.00 05000 OPERATING ROOM			0. 16770		0	
51.00 05100 RECOVERY ROOM			0. 38070		0	51.00
53. 00 05300 ANESTHESI OLOGY			6. 1857		0	53.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C			0. 1217!		944	54.00
60. 00 06000 LABORATORY			0. 3658		6, 310	
60. 01 06001 BL00D LABORATORY			0.00000	00	0	60. 01
62.30 06250 BLOOD CLOTTING FOR HEMOPHILIACS			0.00000		0	62. 30
65. 00 06500 RESPI RATORY THERAPY			1. 8617		4, 478	65.00
66. 00 06600 PHYSI CAL THERAPY			0. 5985		136, 503	
67. 00 06700 OCCUPATI ONAL THERAPY			1. 81580		466, 038	
68.00 06800 SPEECH PATHOLOGY			1. 8145	12 18, 906	34, 305	68. 00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT			0. 2593		2, 581	71. 00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS			0. 2865!		50	72.00
73.00 07300 DRUGS CHARGED TO PATIENTS			0. 2512	· ·	40, 001	73.00
76. 97 O7697 CARDI AC REHABI LI TATI ON			0. 4158		0	76. 97
76. 98 07698 HYPERBARI C OXYGEN THERAPY			0. 00000		0	76. 98
76. 99 07699 LI THOTRI PSY			0. 00000	00	0	76. 99
OUTPATIENT SERVICE COST CENTERS						
91. 00 09100 EMERGENCY			0. 6067		3	91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART			1. 0540		0	92.00
200.00 Total (sum of lines 50 through 94 and				700, 350		1
201.00 Less PBP Clinic Laboratory Services-Pr	rogram only charges	(line 61)		0		201. 00
202.00 Net charges (line 200 minus line 201)			l	700, 350		202. 00

Health Financial Systems	HARVARD MEMORIAL HOSPITAL	In Lie	u of Form CMS-2552-10
CALCULATION OF REIMBURSEMENT SETTLEMENT	Provi der CCN: 14-1335	Peri od: From 07/01/2022 To 06/30/2023	Worksheet E Part B Date/Time Prepared: 11/28/2023 5:06 pm

			10 00/30/2023	11/28/2023 5:	
		Title XVIII	Hospi tal	Cost	
				1. 00	
4 00	PART B - MEDICAL AND OTHER HEALTH SERVICES				
1.00	Medical and other services (see instructions)	>		4, 944, 015	1.00
2. 00 3. 00	Medical and other services reimbursed under OPPS (see instructi OPPS or REH payments	ons)		0 4, 650, 893	2. 00 3. 00
4. 00	Outlier payment (see instructions)			4, 650, 693	4.00
4. 01	Outlier reconciliation amount (see instructions)			0	4. 01
5. 00	Enter the hospital specific payment to cost ratio (see instruct	tions)		0. 000	5. 00
6. 00	Line 2 times line 5	,		0	ı
7.00	Sum of lines 3, 4, and 4.01, divided by line 6			0.00	1
8.00	Transitional corridor payment (see instructions)			0	8. 00
9.00	Ancillary service other pass through costs from Wkst. D, Pt. I\	/, col. 13, line 200		0	9. 00
10.00	Organ acquisitions			0	10.00
11. 00	Total cost (sum of lines 1 and 10) (see instructions)			4, 944, 015	11. 00
	COMPUTATION OF LESSER OF COST OR CHARGES				
10.00	Reasonable charges			0	10.00
	Ancillary service charges Organ acquisition charges (from Wkst. D-4, Pt. III, col. 4, lir	20 (0)		0	
	Total reasonable charges (sum of lines 12 and 13)	ne 69)		0	
14.00	Customary charges			0	14.00
15. 00	Aggregate amount actually collected from patients liable for pa	avment for services on	a charge basis	0	15.00
16. 00	Amounts that would have been realized from patients liable for			0	16. 00
10.00	had such payment been made in accordance with 42 CFR §413.13(e)		a ona gozaoi o	Ü	
17.00	Ratio of line 15 to line 16 (not to exceed 1.000000)			0. 000000	17. 00
18.00	Total customary charges (see instructions)			0	18. 00
19.00	Excess of customary charges over reasonable cost (complete only	y if line 18 exceeds li	ne 11) (see	0	19. 00
	instructions)		> _ (_	
20. 00	Excess of reasonable cost over customary charges (complete only	y if line 11 exceeds li	ne 18) (see	0	20. 00
21 00	instructions)			4 002 4EE	21 00
	Lesser of cost or charges (see instructions) Interns and residents (see instructions)			4, 993, 455 0	ı
	Cost of physicians' services in a teaching hospital (see instru	ictions)		0	23. 00
	Total prospective payment (sum of lines 3, 4, 4.01, 8 and 9)	actions)		4, 650, 893	1
21.00	COMPUTATION OF REIMBURSEMENT SETTLEMENT			1,000,070	21.00
25.00	Deductibles and coinsurance amounts (for CAH, see instructions))		25, 015	25. 00
26.00	Deductibles and Coinsurance amounts relating to amount on line	24 (for CAH, see instr	uctions)	3, 135, 395	26. 00
27.00	Subtotal [(lines 21 and 24 minus the sum of lines 25 and 26) pl	us the sum of lines 22	and 23] (see	1, 833, 045	27. 00
	instructions)				
	Direct graduate medical education payments (from Wkst. E-4, lir	ne 50)		0	28. 00
	REH facility payment amount				28. 50
	ESRD direct medical education costs (from Wkst. E-4, line 36)			0	
	Subtotal (sum of lines 27, 28, 28.50 and 29)			1, 833, 045	1
	Primary payer payments			646 1, 832, 399	•
32.00	Subtotal (line 30 minus line 31) ALLOWABLE BAD DEBTS (EXCLUDE BAD DEBTS FOR PROFESSIONAL SERVICE	59)		1, 032, 399	32.00
33 00	Composite rate ESRD (from Wkst. I-5, line 11)	-5)		0	33. 00
	Allowable bad debts (see instructions)			468, 391	1
	Adjusted reimbursable bad debts (see instructions)			304, 454	
	Allowable bad debts for dual eligible beneficiaries (see instru	uctions)		211, 651	1
37.00	Subtotal (see instructions)	•		2, 136, 853	1
38.00	MSP-LCC reconciliation amount from PS&R			0	38. 00
39.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)			0	39. 00
	Pioneer ACO demonstration payment adjustment (see instructions))			39. 50
39. 75	N95 respirator payment adjustment amount (see instructions)			0	
	Demonstration payment adjustment amount before sequestration			0	
39. 98	Partial or full credits received from manufacturers for replace	ed devices (see instruc	tions)	0	
	RECOVERY OF ACCELERATED DEPRECIATION			0	39. 99
	Subtotal (see instructions)			2, 136, 853	•
40. 01	Sequestration adjustment (see instructions)			42, 737	1
	Demonstration payment adjustment amount after sequestration Sequestration adjustment-PARHM pass-throughs			0	40. 02
	Interim payments			1, 460, 889	1
	Interim payments-PARHM			1, 400, 007	41. 01
	Tentative settlement (for contractors use only)			0	1
42. 01	Tentative settlement-PARHM (for contractor use only)				42. 01
43.00	Balance due provider/program (see instructions)			633, 227	1
43.01	Balance due provider/program-PARHM (see instructions)				43. 01
44.00	Protested amounts (nonallowable cost report items) in accordance	ce with CMS Pub. 15-2,	chapter 1,	0	44. 00
	§115. 2				
00.00	TO BE COMPLETED BY CONTRACTOR			_	00.00
	Original outlier amount (see instructions)			0	
	Outlier reconciliation adjustment amount (see instructions)			0 0. 00	
	The rate used to calculate the Time Value of Money Time Value of Money (see instructions)			0.00	1
	Total (sum of lines 91 and 93)			0	ı
	1 - 1 - 1 - 1 - 1 - 1 - 1 - 1 - 1 - 1 -				

Health Financial Systems	HARVARD MEMORIAL	HOSPI TAL	In Lieu	of Form CMS	-2552-10
CALCULATION OF REIMBURSEMENT SETTLEMENT		Provi der CCN: 14-1335	Peri od: From 07/01/2022 To 06/30/2023		
		Title XVIII	Hospi tal	Cost	
				1. 00	
MEDICARE PART B ANCILLARY COSTS					
200.00 Part B Combined Billed Days					0 200. 00

			'	0 06/30/2023	Date/lime Prep 11/28/2023 5:0	
		Title	XVIII	Hospi tal	Cost	50 р
		I npati en	t Part A	Par	rt B	
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount	
		1.00	2.00	3. 00	4. 00	
1. 00	Total interim payments paid to provider		963, 539)	1, 460, 702	1.00
2. 00	Interim payments payable on individual bills, either		()	0	2.00
	submitted or to be submitted to the contractor for					
	services rendered in the cost reporting period. If none, write "NONE" or enter a zero					
3. 00	List separately each retroactive lump sum adjustment					3.00
0.00	amount based on subsequent revision of the interim rate					0.00
	for the cost reporting period. Also show date of each					
	payment. If none, write "NONE" or enter a zero. (1)					
0.01	Program to Provider	00 (04 (0000	74 74	07 (00 (0000	107	0.00
3. 01	ADJUSTMENTS TO PROVIDER	02/21/2023 06/22/2023	71, 76 <i>6</i> 22, 455		187	3. 0° 3. 0°
3. 02		00/22/2023	22, 450			3. 02
3. 04						3. 04
3. 05			Ċ		0	3. 05
	Provider to Program					
3. 50	ADJUSTMENTS TO PROGRAM		(0	3. 50
3. 51					0	3. 5 ²
3. 52 3. 53						3. 52
3. 54						3. 54
3. 99	Subtotal (sum of lines 3.01-3.49 minus sum of lines		94, 221		187	3. 99
	3. 50-3. 98)					
4.00	Total interim payments (sum of lines 1, 2, and 3.99)		1, 057, 760)	1, 460, 889	4.00
	(transfer to Wkst. E or Wkst. E-3, line and column as					
	appropriate) TO BE COMPLETED BY CONTRACTOR					
5. 00	List separately each tentative settlement payment after					5. 00
	desk review. Also show date of each payment. If none,					
	write "NONE" or enter a zero. (1)					
	Program to Provider	1			_	
5. 01 5. 02	TENTATI VE TO PROVI DER		(0 0	5. 0° 5. 0°
5. 02						5. 02
5. 05	Provider to Program	l		<u> </u>		5. 00
5. 50	TENTATI VE TO PROGRAM		()	0	5. 50
5. 51			(0	5. 51
5. 52			(0	5. 52
5. 99	Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98)		(ין	0	5. 99
6. 00	Determined net settlement amount (balance due) based on					6. 00
5. 50	the cost report. (1)					5. 00
6. 01	SETTLEMENT TO PROVIDER		307, 612	2	633, 227	6.01
6. 02	SETTLEMENT TO PROGRAM		(0	6. 02
7. 00	Total Medicare program liability (see instructions)		1, 365, 372		2, 094, 116	7.00
				Contractor	NPR Date	
)	Number 1.00	(Mo/Day/Yr) 2.00	
8. 00	Name of Contractor	NATI ONAL GOVER	<u></u>		2.00	8. 00
		INC.				٥. ٥٠

Health Financial Systems HARVARD MEMORIAL HOSPITAL In Lieu of Form CMS-2552-10

ANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED Provider CCN: 14-1335 Component CCN: 14-6014 Part I Date/Time Prepared: 11/28/2023 5:06 pm

Title XVIII Skilled Nursing

PPS

				Facility		
		I npati en	it Part A		t B	
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount	
		1.00	2.00	3. 00	4. 00	
1. 00	Total interim payments paid to provider		406, 833		0	1.0
2. 00	Interim payments payable on individual bills, either		0		0	2. 0
	submitted or to be submitted to the contractor for					
	services rendered in the cost reporting period. If none,					
0.00	write "NONE" or enter a zero					
3. 00	List separately each retroactive lump sum adjustment amount based on subsequent revision of the interim rate					3.0
	for the cost reporting period. Also show date of each					
	payment. If none, write "NONE" or enter a zero. (1)					
	Program to Provider					
3. 01	ADJUSTMENTS TO PROVIDER		0		0	3.0
3. 02			0		0	
3. 03			0		0	3.0
3. 04			0		0	3.0
3. 05			0		0	3.0
	Provider to Program					
3. 50	ADJUSTMENTS TO PROGRAM		0		0	
3. 51			0		0	
3. 52			0		0 0	
3. 53 3. 54			0		0	
3. 99			0		0	
J. 77	3. 50-3. 98)					3. 7
4. 00	Total interim payments (sum of lines 1, 2, and 3.99)		406, 833		0	4.0
	(transfer to Wkst. E or Wkst. E-3, line and column as					
	appropri ate)					
	TO BE COMPLETED BY CONTRACTOR					
5. 00	List separately each tentative settlement payment after					5.0
	desk review. Also show date of each payment. If none,					
	write "NONE" or enter a zero. (1) Program to Provider					1
5. 01	TENTATI VE TO PROVI DER		0		0	5.0
5. 02	TENTATI VE TO TROVIDER		0		0	
5. 03			0		0	
	Provider to Program	L				1 0.0
5. 50	TENTATI VE TO PROGRAM		0		0	5.5
5. 51			0		0	5.5
5. 52			0		0	5.5
5. 99	Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98)		0		0	5. 9
. 00	Determined net settlement amount (balance due) based on					6.0
	the cost report. (1)					
5. 01	SETTLEMENT TO PROVIDER		0		0	
6. 02	SETTLEMENT TO PROGRAM		0		0	
7. 00	Total Medicare program liability (see instructions)		406, 833		0	7.0
				Contractor	NPR Date	
)	Number 1.00	(Mo/Day/Yr) 2.00	
	No. 10 Control of the		NMENT SERVICES		2.00	8.0
8. 00	Name of Contractor					

Heal th	Financial Systems HARVARD MEMORIAL	HOSPI TAL	In Lie	u of Form CMS-	2552-10
CALCUL	ATION OF REIMBURSEMENT SETTLEMENT FOR HIT	Provi der CCN: 14-1335	Peri od: From 07/01/2022	Worksheet E-1 Part II	
				Date/Time Pro 11/28/2023 5:	
		Title XVIII	Hospi tal	Cost	
				1. 00	
	TO BE COMPLETED BY CONTRACTOR FOR NONSTANDARD COST REPORTS				_
	HEALTH INFORMATION TECHNOLOGY DATA COLLECTION AND CALCULATION				4
1. 00	Total hospital discharges as defined in AARA §4102 from Wkst.	S-3, Pt. I col. 15 line	e 14		1.00
2.00	Medicare days (see instructions)				2. 00
3.00	Medicare HMO days from Wkst. S-3, Pt. I, col. 6. line 2				3. 00
4.00	Total inpatient days (see instructions)				4. 00
5.00	Total hospital charges from Wkst C, Pt. I, col. 8 line 200				5. 00
6.00	Total hospital charity care charges from Wkst. S-10, col. 3 l	ine 20			6.00
7.00	CAH only - The reasonable cost incurred for the purchase of c	certified HIT technology	Wkst. S-2, Pt. I		7. 00
	line 168				
8.00	Calculation of the HIT incentive payment (see instructions)				8. 00
9.00	Sequestration adjustment amount (see instructions)				9. 00
10.00	Calculation of the HIT incentive payment after sequestration	(see instructions)			10.00
	INPATIENT HOSPITAL SERVICES UNDER THE IPPS & CAH				
30.00	Initial/interim HIT payment adjustment (see instructions)				30.00
31.00	Other Adjustment (specify)				31.00
32.00	Balance due provider (line 8 (or line 10) minus line 30 and l	ine 31) (see instruction	ns)		32.00

Health Financial Systems	HARVARD MEMORIAL HOSPITAL	In Lie	u of Form CMS-2552-10
CALCULATION OF REIMBURSEMENT SETTLEMENT	Provi der CCN: 14-1335	From 07/01/2022	Worksheet E-3 Part V Date/Time Prepared: 11/28/2023 5:06 pm
	Title XVIII	Hospi tal	Cost

				11/28/2023 5:	06 pm_
		Title XVIII	Hospi tal	Cost	
	<u> </u>				
				1. 00	
	PART V - CALCULATION OF REIMBURSEMENT SETTLEMENT FOR MEDICARE	PART A SERVICES - COST	REI MBURSEMENT		
1.00	Inpati ent services			1, 473, 093	1.00
2. 00	Nursing and Allied Health Managed Care payment (see instructi	ons)		0	2. 00
3. 00	Organ acquisition			0	3. 00
3. 01	Cellular therapy acquisition cost (see instructions)			0	3. 01
4. 00	Subtotal (sum of lines 1 through 3.01)			1, 473, 093	
5. 00	Pri mary payer payments			0	5. 00
6. 00	Total cost (line 4 less line 5). For CAH (see instructions)			1, 487, 824	
0.00	COMPUTATION OF LESSER OF COST OR CHARGES			1, 107, 021	0.00
	Reasonable charges				
7. 00	Routine service charges			0	7. 00
8. 00	Ancillary service charges			0	8. 00
9. 00	Organ acquisition charges, net of revenue			0	9. 00
10.00	Total reasonable charges			0	
10.00	Customary charges			U	10.00
11. 00	Aggregate amount actually collected from patients liable for	nayment for services on	a chargo basis	0	11. 00
12.00	Amounts that would have been realized from patients liable for			0	
12.00	had such payment been made in accordance with 42 CFR 413.13(e		iii a Cilai ye basi s	U	12.00
13. 00	Ratio of line 11 to line 12 (not to exceed 1.000000)	;)		0. 000000	12 00
14. 00	Total customary charges (see instructions)			0.000000	14. 00
15. 00	Excess of customary charges over reasonable cost (complete on	ly if line 14 exceeds li	no 6) (soo	0	15. 00
13.00	linstructions)	ily II IIIle 14 exceeds II	116 0) (366	U	13.00
16. 00	Excess of reasonable cost over customary charges (complete on	ly if line 6 eyecods lin	0 14) (500	0	16. 00
10.00	linstructions)	ily II IIIle o exceeds IIII	(366	U	10.00
17. 00	Cost of physicians' services in a teaching hospital (see inst	ructions)		0	17. 00
17.00	COMPUTATION OF REIMBURSEMENT SETTLEMENT	i de ti oris)		U	17.00
18. 00	Direct graduate medical education payments (from Worksheet E-	4 Lino 40)		0	18. 00
19.00	Cost of covered services (sum of lines 6, 17 and 18)	4, TITIE 49)		1, 487, 824	
20.00	Deductibles (exclude professional component)			110, 548	
21.00	Excess reasonable cost (from line 16)			110, 546	21. 00
21.00	Subtotal (line 19 minus line 20 and 21)			1, 377, 276	
22.00	Coi nsurance				
24.00				1 277 274	
	Subtotal (line 22 minus line 23)	ass) (see i notrusti ana)		1, 377, 276	
25.00	Allowable bad debts (exclude bad debts for professional servi	ces) (see Instructions)		24, 556	
26.00	Adjusted reimbursable bad debts (see instructions)			15, 961	
27. 00	Allowable bad debts for dual eligible beneficiaries (see inst	ructions)		1, 556	
28.00	Subtotal (sum of lines 24 and 25, or line 26)			1, 393, 237	
29.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)			0	
29. 50	Pioneer ACO demonstration payment adjustment (see instruction	IS)		0	29. 50
29. 98	Recovery of accelerated depreciation.			0	
29. 99	Demonstration payment adjustment amount before sequestration			0	
30.00	Subtotal (see instructions)			1, 393, 237	
30. 01	Sequestration adjustment (see instructions)			27, 865	
30. 02	Demonstration payment adjustment amount after sequestration			0	30. 02
30. 03	Sequestration adjustment-PARHM				30. 03
31.00	Interim payments			1, 057, 760	
31.01	Interim payments-PARHM			_	31. 01
32.00	Tentative settlement (for contractor use only)			0	
32. 01	Tentative settlement-PARHM (for contractor use only)				32. 01
33.00	Balance due provider/program (line 30 minus lines 30.01, 30.0			307, 612	
33. 01	Balance due provider/program-PARHM (lines 2, 3, 18, and 26, m				33. 01
34. 00	Protested amounts (nonallowable cost report items) in accorda	ince with CMS Pub. 15-2,	chapter 1,	0	34. 00
	§115. 2				

Heal th	Financial Systems HARVARD MEMORIAL	HOSPI TAL	In Lie	u of Form CMS-2	<u> 2552-10</u>
CALCUL	ATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 14-1335	Peri od:	Worksheet E-3	
			From 07/01/2022	Part VI	
		Component CCN: 14-6014	To 06/30/2023	Date/Time Pre 11/28/2023 5:	
		Title XVIII	Skilled Nursing	PPS	oo piii
		II the XVIII	Facility	FF3	
			raciiity		
				1. 00	
	PART VI - CALCULATION OF REIMBURSEMENT SETTLEMEMENT - ALL OTH	FR HEALTH SERVICES FOR	TITLE XVIII PART		
	SERVI CES				
	PROSPECTIVE PAYMENT AMOUNT (SEE INSTRUCTIONS)				
1.00	Resource Utilization Group Payment (RUGS)			497, 099	1. 00
2.00	Routine service other pass through costs			0	2. 00
3.00	Ancillary service other pass through costs			0	3.00
4.00	Subtotal (sum of lines 1 through 3)			497, 099	4. 00
	COMPUTATION OF NET COST OF COVERED SERVICES				
5.00	Medical and other services (Do not use this line as vaccine of	osts are included in lir	ne 1 of W/S E,		5.00
	Part B. This line is now shaded.)				
6.00	6.00 Deductible				
7. 00 Coi nsurance					7. 00
8.00 Allowable bad debts (see instructions)					8. 00
9.00	Reimbursable bad debts for dual eligible beneficiaries (see i	nstructions)		0	9. 00
10.00	Adjusted reimbursable bad debts (see instructions)			0	10.00
11. 00				0	11. 00
12.00		0 and 11)(see instruction	ons)	415, 136	
13. 00	Inpatient primary payer payments			0	13. 00
14.00				0	14.00
14. 50		s)		0	
	Recovery of accelerated depreciation.			0	
	Demonstration payment adjustment amount before sequestration			0	14. 99
15.00				415, 136	
	15.01 Sequestration adjustment (see instructions)			8, 303	
15. 02	1			0	15. 02
15. 75	1			0	15. 75
	Interim payments			406, 833	
	Tentative settlement (for contractor use only)	0 15 75 1/ 1 17\		0	17.00
18.00			2	0	18.00
19.00	Protested amounts (nonallowable cost report items) in accorda	nce with CMS 19 Pub. 15-	-2, cnapter I,	0	19. 00
	§115. 2				

Health Financial Systems	HARVARD MEMORIAL HOSPITAL	In Lieu	u of Form CMS-2552-10
CALCULATION OF REIMBURSEMENT SETTLEMENT	Provi der CCN: 14	From 07/01/2022	Worksheet E-3 Part VII Date/Time Prepared: 11/28/2023 5:06 pm
	T1.11	V	0

			06/30/2023	Date/lime Pre 11/28/2023 5:		
	Title XIX Ho		Hospi tal	Cost	оо рііі	
		2 ,2	Inpatient	Outpati ent		
			1.00	2. 00		
	PART VII - CALCULATION OF REIMBURSEMENT - ALL OTHER HEALTH SEF	RVICES FOR TITLES V OR XI	X SERVICES			
	COMPUTATION OF NET COST OF COVERED SERVICES				1	
1.00	Inpatient hospital/SNF/NF services		44, 020		1.00	
2.00	Medical and other services			0	2.00	
3.00	Organ acquisition (certified transplant programs only)		o		3.00	
4.00	Subtotal (sum of lines 1, 2 and 3)		44, 020	0	4.00	
5.00	Inpatient primary payer payments		o		5.00	
6.00	Outpatient primary payer payments			0	6.00	
7.00	Subtotal (line 4 less sum of lines 5 and 6)		44, 020	0	7.00	
	COMPUTATION OF LESSER OF COST OR CHARGES					
	Reasonabl e Charges					
8.00	Routine service charges		0		8.00	
9.00	Ancillary service charges		0	0	9. 00	
10.00	Organ acquisition charges, net of revenue		0		10.00	
11.00	Incentive from target amount computation		0		11. 00	
12.00	Total reasonable charges (sum of lines 8 through 11)		0	0	12. 00	
	CUSTOMARY CHARGES					
13.00	Amount actually collected from patients liable for payment for	r services on a charge	0	0	13. 00	
	basi s					
14. 00	Amounts that would have been realized from patients liable for		0	0	14. 00	
	a charge basis had such payment been made in accordance with	42 CFR §413.13(e)				
15.00	Ratio of line 13 to line 14 (not to exceed 1.000000)		0. 000000	0. 000000		
16.00	Total customary charges (see instructions)		0	0	16.00	
17. 00	Excess of customary charges over reasonable cost (complete onl	ly if line 16 exceeds	0	0	17. 00	
10.00	line 4) (see instructions)	lv if line 4 evecede line	44 020	0	10 00	
18. 00	Excess of reasonable cost over customary charges (complete onl	ry it line 4 exceeds line	44, 020	0	18. 00	
19. 00	16) (see instructions) Interns and Residents (see instructions)		0	0	19. 00	
	Cost of physicians' services in a teaching hospital (see insti	ructions)	0	0		
21. 00	Cost of covered services (enter the lesser of line 4 or line		44, 020	0		
21.00	PROSPECTIVE PAYMENT AMOUNT - Lines 22 through 26 must only be			0	21.00	
22 00	Other than outlier payments	compreted for 113 provid	0	0	22.00	
	Outlier payments		Ö	0		
	Program capital payments		Ö	· ·	24.00	
	Capital exception payments (see instructions)		0		25. 00	
				0	•	
	Subtotal (sum of lines 22 through 26)		o	0		
28. 00	Customary charges (title V or XIX PPS covered services only)		o	0		
29. 00	1		44, 020	0	29. 00	
	COMPUTATION OF REI MBURSEMENT SETTLEMENT					
30.00	Excess of reasonable cost (from line 18)		44, 020	0	30.00	
31.00	Subtotal (sum of lines 19 and 20, plus 29 minus lines 5 and 6)		44, 020	0	31.00	
	Deductibles		0	0	32.00	
33.00	Coi nsurance		0	0	33.00	
34.00	Allowable bad debts (see instructions)		0	0	34.00	
35.00	Utilization review '				35. 00	
36.00	Subtotal (sum of lines 31, 34 and 35 minus sum of lines 32 and 33)			0	36.00	
37.00	PAYMENT			0	37.00	
38.00	Subtotal (line 36 ± line 37)		0	0	38. 00	
39.00	Direct graduate medical education payments (from Wkst. E-4)		0		39. 00	
40.00	Total amount payable to the provider (sum of lines 38 and 39)		0	0		
41.00	Interim payments			0	41.00	
42.00	Balance due provider/program (line 40 minus line 41)	0	0			
43.00	Protested amounts (nonallowable cost report items) in accordan	nce with CMS Pub 15-2,	0	0	43.00	
	chapter 1, §115.2					

Health Financial Systems HARVARD MEMORIAL HOSPITAL In Lieu of Form CMS-2552-10

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

Provider CCN: 14-1335 | Period: From 07/01/

Peri od: From 07/01/2022 To 06/30/2023 Date/Time Prepared: 11/28/2023 5:06 pm

——————————————————————————————————————					11/28/2023 5:	06 pm
		General Fund	Specific Purpose Fund	Endowment Fund	Plant Fund	
		1. 00	2.00	3. 00	4.00	
	CURRENT ASSETS		_	_		
1. 00 2. 00	Cash on hand in banks	4, 867, 253	0	0	0	
3. 00	Temporary investments Notes receivable	0	0		l	
4. 00	Accounts receivable	10, 068, 005	1	_	0	
5. 00	Other recei vabl e	-84, 364		_	Ö	
6.00	Allowances for uncollectible notes and accounts receivable			0	0	
7.00	Inventory	1, 037, 921	1	0	0	
8.00	Prepai d expenses	37, 428	0	0	0	
9.00	Other current assets	0	0	0	0	
10. 00 11. 00	Due from other funds Total current assets (sum of lines 1-10)	7, 373, 282	0	_	0	
11.00	FIXED ASSETS	1, 373, 202		0	0	11.00
12.00	Land	222, 604	. 0	0	0	12. 00
13.00	Land improvements	889, 565		0	0	
14.00	Accumulated depreciation	-783, 553	0	0	0	14. 00
15.00	Bui I di ngs	22, 941, 824	1	0	0	
16.00	Accumulated depreciation	-18, 976, 467	1	0	0	
17.00	Leasehold improvements	0	0	_	0	1
18. 00 19. 00	Accumulated depreciation Fixed equipment		0	_	0	
20.00	Accumulated depreciation			0		
21.00	Automobiles and trucks	0		0	l ő	
22. 00	Accumulated depreciation	0	o	0	0	
23.00	Maj or movable equipment	19, 866, 062	. 0	0	O	
24.00	Accumulated depreciation	-16, 751, 785	0	0	0	
25.00	Mi nor equi pment depreciable	0	0	0	0	
26.00	Accumul ated depreciation	0	0	0	0	
27. 00	HIT designated Assets	0	0	0	0	
28.00	Accumulated depreciation	0	0	_	0	
29. 00 30. 00	Minor equipment-nondepreciable Total fixed assets (sum of lines 12-29)	7, 408, 250	0			
30.00	OTHER ASSETS	7,400,230	,, ,	0		30.00
31.00	Investments	0	0	0	0	31.00
32.00	Deposits on Leases	0	0	0	0	32.00
33.00	Due from owners/officers	0	0	0	0	
34.00	Other assets	32, 045	1	_	0	1
35.00	Total other assets (sum of lines 31-34)	32, 045	1	_	0	
36. 00	Total assets (sum of lines 11, 30, and 35) CURRENT LIABILITIES	14, 813, 577] 0	0	0	36.00
37.00	Accounts payable	391, 874	. 0	0	0	37. 00
38.00	Salaries, wages, and fees payable	905, 015	1	0	l	
39.00	Payrol I taxes payable	0	0	0	0	39. 00
40.00	Notes and Loans payable (short term)	0	0	0	0	
41.00	Deferred income	0	0	0	0	
42.00	Accel erated payments	0				42.00
43.00	Due to other funds Other current liabilities	1, 751, 259		0	0	
44. 00 45. 00	Total current liabilities (sum of lines 37 thru 44)	-19, 652, 504 -16, 604, 356			l	1
45.00	LONG TERM LIABILITIES	- 10, 004, 330	0	0	0	45.00
46.00	Mortgage payable	0	0	0	0	46. 00
47.00	Notes payable	0	0	0	0	47.00
48.00	Unsecured Loans	0	0	0		
49.00	Other long term liabilities	9, 619, 738		_		
50.00	Total long term liabilities (sum of lines 46 thru 49)	9, 619, 738				
51. 00	Total liabilities (sum of lines 45 and 50)	-6, 984, 618	0	0	0	51.00
52. 00	CAPITAL ACCOUNTS General fund balance	21, 798, 195	:			52.00
53.00	Specific purpose fund	21, 770, 173	0			53.00
54.00	Donor created - endowment fund balance - restricted			0		54.00
55. 00	Donor created - endowment fund balance - unrestricted		1	Ö		55.00
56.00	Governing body created - endowment fund balance			0		56.00
57.00	Plant fund balance - invested in plant				0	
58.00	Plant fund balance - reserve for plant improvement,		1		0	58. 00
EO 00	replacement, and expansion	24 700 405		_	_	E0 00
59. 00 60. 00	Total fund balances (sum of lines 52 thru 58) Total liabilities and fund balances (sum of lines 51 and	21, 798, 195 14, 813, 577	1	0	0	
00.00	[59]	14,013,3//			l "	00.00
	1/	1	1	l	I	1

Health Financial Systems
STATEMENT OF CHANGES IN FUND BALANCES HARVARD MEMORIAL HOSPITAL In Lieu of Form CMS-2552-10 Provi der CCN: 14-1335

Period: Worksheet G-1 From 07/01/2022

					To 06/30/2023	Date/Time Pre 11/28/2023 5:	pared: 06 pm
		General	Fund	Speci al	Purpose Fund	Endowment Fund	
		1. 00	2. 00	3. 00	4. 00	5. 00	
1. 00 2. 00 3. 00 4. 00 5. 00 6. 00 7. 00 8. 00 9. 00 10. 00 11. 00 12. 00 13. 00 14. 00 15. 00 16. 00 17. 00	Fund balances at beginning of period Net income (loss) (from Wkst. G-3, line 29) Total (sum of line 1 and line 2) Additions (credit adjustments) (specify) OTHER Total additions (sum of line 4-9) Subtotal (line 3 plus line 10) Deductions (debit adjustments) (specify) OTHER	0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	2, 00 16, 906, 608 3, 926, 061 20, 832, 669 0 20, 832, 669		0 0 0 0 0 0 0 0 0 0 0	0 0 0 0 0	1. 00 2. 00 3. 00 4. 00 5. 00 6. 00 7. 00 8. 00 9. 00 10. 00 11. 00 12. 00 13. 00 14. 00 15. 00 16. 00 17. 00
18. 00 19. 00	Total deductions (sum of lines 12-17) Fund balance at end of period per balance sheet (line 11 minus line 18)		0 20, 832, 669		0		18. 00 19. 00
		Endowment Fund	PI ant	Fund	_		
		6. 00	7. 00	8.00			
1. 00 2. 00 3. 00 4. 00 5. 00 6. 00 7. 00 8. 00 9. 00	Fund balances at beginning of period Net income (loss) (from Wkst. G-3, line 29) Total (sum of line 1 and line 2) Additions (credit adjustments) (specify) OTHER	0	0 0 0 0 0		0		1. 00 2. 00 3. 00 4. 00 5. 00 6. 00 7. 00 8. 00 9. 00
10. 00 11. 00 12. 00 13. 00 14. 00 15. 00 16. 00 17. 00 18. 00 19. 00	Total additions (sum of line 4-9) Subtotal (line 3 plus line 10) Deductions (debit adjustments) (specify) OTHER Total deductions (sum of lines 12-17) Fund balance at end of period per balance	0 0	0 0 0 0 0		0 0 0 0		10. 00 11. 00 12. 00 13. 00 14. 00 15. 00 16. 00 17. 00 18. 00 19. 00
14. 00 15. 00 16. 00 17. 00 18. 00	Total deductions (sum of lines 12-17)	0	0 0 0 0				14. 15. 16. 17.

Provi der CCN: 14-1335

Peri od: Worksheet G-2 From 07/01/2022 Parts I & II To 06/30/2023 Date/Time Prepared:

Cost Center Description				'	0 00/00/2020	11/28/2023 5:	06 pm
PART I - PATIENT REVENUES		Cost Center Description		I npati ent	Outpati ent	Total	
General Inpatient Routine Services 1,962,913 1,9				1. 00	2. 00	3. 00	
1.00 Hospital 1.962,913 1.962,913 1.962,913 1.00 2.00 3.							
SUBPROVIDER FIFE		General Inpatient Routine Services					
3.00 SUBPROVIDER IRF	1.00	Hospi tal		1, 962, 913		1, 962, 913	1.00
4. 00 SUBPROVIDER	2.00						
5.00 Swing bed SNF 0 0 0 5.00 6.00	3.00	SUBPROVI DER - I RF					3.00
Swin	4.00	SUBPROVI DER					4.00
7.00 SKILLED NURSING FACILITY 2, 321, 055 2, 321, 055 7, 00 9.00 OTHER LONG TERM CARE 0 0 9, 00 10.00 Total general Inpatient care services (sum of lines 1-9) 4, 283, 968 4, 283, 968 10, 00 11.00 Intensi ve Care Type Inpatient Hospital Services 162, 215 162, 215 17, 00 12.00 CORONARY CARE UNIT 12, 00 1, 00 13.00 SURGICAL INTENSI VE CARE UNIT 12, 00 1, 00 15.00 OTHER SPECIAL CARE (SPECIFY) 14, 00 15.00 Total intensive care type inpatient hospital services (sum of lines 10, 2, 215 162, 215 16, 00 17.00 Total intensive care type inpatient hospital services (sum of lines 10, 2, 215 162, 215 16, 00 17.00 Total intensive care type inpatient hospital services (sum of lines 10, 2, 215 162, 215 16, 00 17.00 Total intensive care type inpatient hospital services (sum of lines 10, 2, 215 162, 215 16, 00 17.00 Total intensive care type inpatient hospital services (sum of lines 10, 2, 215 162, 215 16, 00 17.00 Total intensive care type inpatient hospital services (sum of lines 10, 2, 215 162, 215 16, 00 17.00 Total intensive care type inpatient hospital services (sum of lines 10, 2, 215 162, 215 16, 00 17.00 Total intensive care type inpatient hospital services (sum of lines 10, 2, 215 216, 385 8, 467, 808 8, 647, 31, 78 8, 00 17.00 Total intensive care type inpatient hospital services (sum of lines 10, 2, 215 216, 385 8, 467, 808 8, 647, 31, 78 8, 00 17.00 Total intensive care type inpatient hospital services (sum of lines 10, 216, 225 216, 385 8, 467, 808 8, 647, 31, 78 8, 00 17.00 Total intensive care type inpatient hospital services (sum of lines 10, 216, 225 216, 385 8, 467, 808 8, 647, 31, 78 8, 00 17.00 Total intensive care type inpatient hospital services (sum of lines 10, 216, 225 216, 385 8, 467, 808 8, 647, 31, 78 8, 00 17.00 Total intensive care type inpatient hospital services (sum of lines 27-41) 22, 23, 23, 23, 23, 23, 23, 23, 23,	5.00	Swing bed - SNF		0		0	5.00
8.00	6.00	Swing bed - NF		0		0	6.00
O	7.00	SKILLED NURSING FACILITY		2, 321, 055		2, 321, 055	7.00
10. 00	8.00	NURSING FACILITY					8.00
Intensive Care Type Inpatient Hospital Services	9.00	OTHER LONG TERM CARE		0		0	9.00
11. 00	10.00			4, 283, 968		4, 283, 968	10.00
11. 00		Intensive Care Type Inpatient Hospital Services					
12.00 CORONARY CARE UNIT	11.00			162, 215		162, 215	11.00
13. 00 BURN INTENSIVE CARE UNIT	12.00	CORONARY CARE UNIT				·	
14. 00 SURGICAL INTENSIVE CARE UNIT	13.00						13.00
15.00	14.00						
16.00							
11-15 Total inpatient routine care services (sum of lines 10 and 16)		1	Lines	162 215		162 215	
17. 00				102,210		.02,2.0	
18. 00 Ancillary services	17.00)	4, 446, 183		4, 446, 183	17. 00
19.00 Outpatient services 216,385 8,467,808 8,684,193 19.00 20.00 RURAL HEALTH CLINIC 0 0 0 0 0 20.00 20.0000 20.000 20.0000 20.0000 20.0000 20.0000 20.0000 20.0000 20.0000 20.0000							
20. 00 RUNAL HEALTH CLINIC							
21.00 FEDERALLY QUALIFIED HEALTH CENTER 0 0 0 0 21.00 22.00 HOME HEALTH AGENCY 22.00 23.00 AMBULANCE SERVICES 23.00 24.00 24.10 25.00 24.00 24.10 25.00 26.00 26.00 27.00							
22. 00 HOME HEALTH AGENCY 23. 00 AMBULANCE SERVICES 23. 00 24. 10 23. 00 24. 10 25. 00 24. 10 25. 00 24. 10 25. 00 24. 10 25. 00 24. 10 25. 00 24. 10 25. 00 26. 00 27.				_	_		
23. 00					Ĭ	O	
24.00 CMHC CORF 0 0 0 0 0 24.10 CORF 0 0 0 0 0 24.10 CORF 0 0 0 0 0 24.10 CORF 0 0 0 0 0 0 24.10 CORF 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0							
24. 10 CORF							
25. 00 26. 00 HOSPICE 27. 00 O THER (SPECIFY) 0 0 0 0 0 27. 00 27. 01 PROFESSI ONAL FEES 0 5, 260, 932 5, 260, 932 5, 260, 932 5, 260, 932 72. 01 28. 00 PART II - OPERATING EXPENSES 0 0 0 0 29. 00 30. 00 31. 00 31. 00 31. 00 32. 00 33. 00 34. 00 35. 00 36. 00 37. 00 38. 00 37. 00 39. 00 40. 00 41. 00 41. 00 42. 00 Total deductions (sum of lines 37-41) Total operating expenses (sum of lines 39 and 36 minus line 42) (transfer 20 (transfer				١		0	
26. 00 HOSPICE				٥		O	
27. 00 OTHER (SPECIFY) 0 5, 260, 932 5, 260, 932 27. 01 PROFESSI ONAL FEES OF Total patient revenues (sum of lines 17-27) (transfer column 3 to Wkst. 10, 789, 493 72, 574, 993 83, 364, 486 28. 00 6-3, line 1) PART II - OPERATING EXPENSES Operating expenses (per Wkst. A, column 3, line 200) 29. 00 30. 00 ADD (SPECIFY) 0 0 30. 00 31. 00 BD 0 31. 00 32. 00 33. 00 34. 00 35. 00 36. 00 36. 00 37. 00 36. 00 37. 00 37. 00 38. 00 39. 00 39. 00 39. 00 40. 00 40. 00 41. 00 42. 00 Total adductions (sum of lines 37-41) Total operating expenses (sum of lines 29 and 36 minus line 42) (transfer column 3 to Wkst. 10, 789, 493 72, 574, 993 83, 364, 486 28. 00 27. 01 27		, ,					
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TO WKST. G-3, line 4)	43.00		2)(transfer		26, 615, 363		43.00
		LO WKSt. G-3, TIME 4)		I	ı l		

Heal th	Financial Systems HARVARD MEMORIAL	. HOSPI TAL	In Lie	u of Form CMS-2	2552-10		
	STATEMENT OF REVENUES AND EXPENSES Provider CCN: 14-1335 Period:						
			From 07/01/2022 To 06/30/2023	Doto/Time Dro	norod.		
			To 06/30/2023	Date/Time Prep 11/28/2023 5:0			
		1172072020 0.	оо рііі				
	1. 00						
1. 00	1.00 Total patient revenues (from Wkst. G-2, Part I, column 3, line 28)						
2.00	Less contractual allowances and discounts on patients' accoun	its		52, 957, 828	2.00		
3.00	Net patient revenues (line 1 minus line 2)			30, 406, 658	3.00		
4.00	Less total operating expenses (from Wkst. G-2, Part II, line	43)		26, 615, 363	4.00		
5.00	Net income from service to patients (line 3 minus line 4)			3, 791, 295	5.00		
	OTHER INCOME						
6.00	Contributions, donations, bequests, etc			0	6.00		
7. 00	Income from investments			0	7. 00		
8.00	Revenues from telephone and other miscellaneous communication	servi ces		0	8. 00 9. 00		
	9.00 Revenue from television and radio service						
	10.00 Purchase discounts						
11. 00	Rebates and refunds of expenses			2, 556	11. 00		
12.00				0	12.00		
	Revenue from Laundry and Linen service			0	13.00		
14.00	1			114, 176			
	Revenue from rental of living quarters			0	15.00		
	Revenue from sale of medical and surgical supplies to other t	han patients		0	16. 00		
	17.00 Revenue from sale of drugs to other than patients				17. 00		
	18.00 Revenue from sale of medical records and abstracts				18. 00		
	19.00 Tuition (fees, sale of textbooks, uniforms, etc.)				19.00		
	20.00 Revenue from gifts, flowers, coffee shops, and canteen				20.00		
21.00	Rental of vending machines			0	21.00		
22.00	Rental of hospital space			0	22. 00		
23. 00	Governmental appropriations			0	23. 00		
24.00	OTHER OPERATING REVENUE			0	24. 00		
24. 50	1 4 4			17, 933			
25.00				134, 766			
26.00				3, 926, 061	26. 00		
27. 00	GRANT			0	27. 00		
	28.00 Total other expenses (sum of line 27 and subscripts)				28. 00		
29.00	Net income (or loss) for the period (line 26 minus line 28)			3, 926, 061	29.00		