Heal th Financi	al Syst	tems	HUNTINGTON MEMORIAL	_ HOSPI TAL			In Lie	u of Form	CMS-	2552-10
This report is	requi	red by law (42 USC 1395	g; 42 CFR 413.20(b)). Fail	ure to report ca	n resul	t in all	interim	FORM APP	ROVED)
payments made	si nce	the beginning of the co	st reporting period being	deemed overpayme	nts (42	USC 1395	ig).	OMB NO.	0938-	0050
HOSPITAL AND H	10SPI TA	L HEALTH CARE COMPLEX C	OST REPORT CERTIFICATION	Provi der CCN: 1	50091	Peri od:		Workshee		
AND SETTLEMENT	SUMMA	RY						Parts I-		
						To 12/	31/2015	Date/Tim		
								10/28/20	16 10):36 am
PART I - COST	REPORT	STATUS								
Provi der	1. [X] Electronically filed	cost report			Date:	10/28/2	016 Tin	ne: 10	0:36 am
use only	2. [] Manually submitted co	st report							
	3. [0 4. [F] If this is an amended Medicare Utilization.	report enter the number of Enter "F" for full or "L"	of times the prov for low.	vider re	esubmitted	d this c	ost report		
Contractor use only	(1) (2) (3)	Cost Report Status As Submitted Settled without Audit Settled with Audit Reopened		this Provider (his Provider CCN	11. C CCN 12. [ne 5, co			

PART II - CERTIFICATION

(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 OFFICER OR ADMINISTRATOR OF PROVIDER(S)

I HEREBY CERTIFY that I have read the above certification statement and that I have examined the accompanying electronically filed or manually submitted cost report and the Balance Sheet and Statement of Revenue and Expenses prepared by HUNTINGTON MEMORIAL HOSPITAL (150091) for the cost reporting period beginning 01/01/2015 and ending 12/31/2015 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.

(Si gned)	Officer or Administrator of Provider(s)
Title	
Date	

			Title	XVIII			
	Cost Center Description	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	86, 790	47, 906	24, 141	0	1. 00
2.00	Subprovider - IPF	0	0	0		0	2. 00
3.00	Subprovider - IRF	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
200.0	0 Total	0	86, 790	47, 906	24, 141	0	200.00
Tho a	hove amounts represent "due to" or "due from"	the applicable	program for th	o alamont of t	ho abovo compl	ov indicated	

The above amounts represent "due to" or "due from" the applicable program for the element of the above complex indicated. According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0938-0050. The time required to complete and review the information collection is estimated 673 hours per response, including the time to review instructions, search existing resources, gather the data needed, and complete and review the information collection. If you have any comments concerning the accuracy of the time estimate(s) or suggestions for improving 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.

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA Provi der CCN: 150091 Peri od: Worksheet S-2 From 01/01/2015 Part I Date/Time Prepared: 12/31/2015 10/28/2016 10:35 am 3.00 4.00 Hospital and Hospital Health Care Complex Address: Street: 2001 STULTS ROAD 1.00 PO Box: 1.00 2.00 City: HUNTINGTON State: IN Zip Code: 46750 County: HUNTINGTON 2.00 Component Name CCN CBSA Provi der Date Payment System (P, T, O, or N)

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 HUNTINGTON MEMORIAL 150091 23060 1 07/01/1966 Ν 3.00 HOSPI TAI Subprovider - IPF 4.00 4 00 5.00 Subprovider - IRF 5.00 6.00 Subprovider - (Other) 6.00 Swing Beds - SNF 7.00 7 00 8.00 Swing Beds - NF 8.00 9.00 Hospi tal -Based SNF 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 13.00 Separately Certified ASC 13.00 Hospi tal -Based Hospi ce 14.00 14.00 Hospital-Based Health Clinic - RHC 15.00 15 00 Hospital -Based Health Clinic - FQHC 16.00 17.00 Hospital-Based (CMHC) I 17.00 Renal Dialysis 18.00 18.00 19.00 Other 19.00 From: 1. 00 2.00 20.00 Cost Reporting Period (mm/dd/yyyy) 01/01/2015 12/31/2015 20.00 21.00 Type of Control (see instructions) 21.00 2 Inpatient PPS Information Does this facility qualify and is it currently receiving payments for disproportionate 22.00 γ N 22.00 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 uncompensated care payments for this cost reporting Ν Ν 22.01 period? Enter in column 1, "Y" for yes or "N" for no for the portion of the cost reporting period occurring prior to October 1. Enter in column 2, "Y" for yes or "N" for no for the portion of the cost reporting period occurring on or after October 1. (see instructions) 22.02 Is this a newly merged hospital that requires final uncompensated care payments to be Ν 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 "Y" for yes or "N" for no, for the portion of the cost reporting period on in column 2. or after October 1 22.03 Did this hospital receive a geographic reclassification from urban to rural as a result Ν Ν 22 03 of the OMB standards for delineating statistical areas adopted by CMS in FY2015? Enter in column 1, "Y" for yes or "N" for no for the portion of the cost reporting period prior to October 1. Enter in column 2, "Y" for yes or "N" for no for the portion of the cost reporting period occurring on or after October 1. (see instructions) Does this hospital contain at least 100 but not more than 499 beds (as counted in accordance with 42 CFR 412.105)? Enter in column 3, "Y" for yes or "N" for no. Which method is used to determine Medicaid days on lines 24 and/or 25 below? In column 23.00 3 Ν 23 00 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 enter "Y" "N" fo<u>r no</u>. used in the prior cost reporting period? In column 2 for yes or In-State Out-of Medi cai d 0ther In-State Out-of Medi cai d Medi cai d State State HMO days Medi cai d paid days el i gi bl e Medi cai d Medi cai d days paid days unpai d el i gi bl e days unpai d 1.00 2.00 3. 00 4.00 5.00 6.00 783 24.00 If this provider is an IPPS hospital, enter the 254 538 24. 00 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.

	Financial Systems HUNTINGTO AL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DA		RIAL HOSPITAL Provider	CCN: 150091	Peri	od:		Workshe		2552-10
					From To	01/01/20 12/31/20	15	Part I Date/Ti		
					Ur	ban/Rural		10/28/2 Date of		
26. 00	Enter your standard geographic classification (not wa	ae) st	atus at the bed	i nni na of	the	1. 00	2	2. (00	26. 00
	cost reporting period. Enter "1" for urban or "2" for Enter your standard geographic classification (not wa reporting period. Enter in column 1, "1" for urban or enter the effective date of the geographic reclassifi	rural ge) st "2" f	atus at the enc or rural. If ap	of the co			2	10/01	/2013	27. 00
35. 00	If this is a sole community hospital (SCH), enter the effect in the cost reporting period.			H status i	n		0			35. 00
					E	Begi nni ng: 1. 00		Endi 2. (
36. 00	Enter applicable beginning and ending dates of SCH st		Subscript line	36 for num	ber	1.00		2. (36. 00
37. 00	of periods in excess of one and enter subsequent date If this is a Medicare dependent hospital (MDH), enter is in effect in the cost reporting period.		umber of period	ls MDH stat	us		0			37. 00
37. 01	Is this hospital a former MDH that is eligible for th accordance with FY 2016 OPPS final rule? Enter "Y" fo					N				37. 01
38. 00	instructions) 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.									38. 00
						Y/N 1. 00		Y/ 2. (
39. 00	Does this facility qualify for the inpatient hospital					Υ Υ		Υ Υ		39. 00
40. 00	hospitals in accordance with 42 CFR §412.101(b)(2)(ii or "N" for no. Does the facility meet the mileage req CFR 412.101(b)(2)(ii)? Enter in column 2 "Y" for yes Is this hospital subject to the HAC program reduction "N" for no in column 1, for discharges prior to Octob no in column 2, for discharges on or after October 1.	ui reme or "N" adjus er 1.	nts in accordar for no. (see i tment? Enter "Y Enter "Y" for y	nce with 42 nstruction " for yes	s) or	N		N		40. 00
	The three distinct 2, Tell discharges on or arter detector.	(300	r no tr do tr ono,			1	V . 00	XVI I I	XI X 3. 00	
	Prospective Payment System (PPS)-Capital									
45. 00	Does this facility qualify and receive Capital paymen with 42 CFR Section §412.320? (see instructions)	t for	di sproporti onat	e share in	accord	lance	N	N	N	45. 00
46. 00	Is this facility eligible for additional payment exce pursuant to 42 CFR §412.348(f)? If yes, complete Wkst Pt. III.					ough	N	N	N	46. 00
	Is this a new hospital under 42 CFR §412.300 PPS capils the facility electing full federal capital payment Teaching Hospitals						N N	N N	N N	47. 00 48. 00
56. 00	Is this a hospital involved in training residents in	approv	ed GME programs	? Enter "	Y" for	yes	N			56. 00
57. 00	or "N" for no. If line 56 is yes, is this the first cost reporting p GME programs trained at this facility? Enter "Y" for is "Y" did residents start training in the first mont for yes or "N" for no in column 2. If column 2 is "Y "N", complete Wkst. D, Parts III & IV and D-2, Pt. II	yes o h of t	r "N" for no ir his cost report plete Worksheet	column 1. ing period	lf col ? Ent∈	umn 1 er "Y"	N			57. 00
58. 00	If line 56 is yes, did this facility elect cost reimb defined in CMS Pub. 15-1, chapter 21, §2148? If yes,	urseme	nt for physicia	ıns' servic	es as		N			58. 00
	Are costs claimed on line 100 of Worksheet A? If yes	, comp	lete Wkst. D-2,		41		N			59.00
60. 00	Are you claiming nursing school and/or allied health provider-operated criteria under §413.85? Enter "Y"					ons)	N			60.00
		Y/N	IME	Direct G	ME	IME		Di rec	t GME	
61 00	Did your hospital receive FTE slots under ACA	1. 00 N	2. 00	3. 00		4.00	. 00	5. (61.00
	section 5503? Enter "Y" for yes or "N" for no in column 1. (see instructions)	IN				U	. 00		0.00	01.00
61. 01	Enter the average number of unweighted primary care FTEs from the hospital's 3 most recent cost reports ending and submitted before March 23, 2010. (see		0.00		0.00					61. 01
61. 02	instructions) Enter the current year total unweighted primary care FTE count (excluding OB/GYN, general surgery FTEs, and primary care FTEs added under section 5503 of		0.00		0.00					61. 02
61. 03	ACA). (see instructions) Enter the base line FTE count for primary care and/or general surgery residents, which is used for determining compliance with the 75% test. (see		0.00		0.00					61. 03
	instructions) Enter the number of unweighted primary care/or surgery allopathic and/or osteopathic FTEs in the		0.00		0. 00					61. 04
	current cost reporting period (see instructions). Enter the difference between the baseline primary and/or general surgery FTEs and the current year's primary care and/or general surgery FTE counts (line 61.04 minus line 61.03). (see instructions)		0.00		0. 00					61. 05

	ancial Systems ND HOSPITAL HEALTH CARE COMPL			Provi der	CCN: 150091	Peri od:	u of Form CMS-2 Worksheet S-2	
HOSI I IAE A	IND HOST THE HEALTH SAME SOME	LEX TRENTITION DA		T T OV T GET		From 01/01/2015 To 12/31/2015	Part I Date/Time Pre 10/28/2016 10	pared:
			Y/N	IME	Direct GME	IME	Direct GME	
			1. 00	2. 00	3. 00	4. 00	5. 00	
used	er the amount of ACA §5503 aw d for cap relief and/or FTEs e or general surgery. (see in:	that are nonprimary		0.00	0.0	00		61.0
1		,	Pro	gram Name	Program Code		Unweighted Direct GME FTE Count	
				1. 00	2. 00	3. 00	4.00	
spec for col u prog unwe	the FTEs in line 61.05, speci- cialty, if any, and the number each new program. (see instrumn 1, the program name, enter gram code, enter in column 3, eighted count and enter in column unweighted count.	r of FTE residents uctions) Enter in r in column 2, the the IME FTE				0.00	0.00	61. 10
61. 20 Of 1 prog resi i nst ente 3, 1	the FTEs in line 61.05, speci- gram specialty, if any, and the dents for each expanded prog- tructions) Enter in column 1, er in column 2, the program of the IME FTE unweighted count is direct GME FTE unweighted count	ne number of FTE ram. (see the program name, ode, enter in column and enter in column				0. 00	0.00	61. 20
							1.00	
	<u>Provisions Affecting the Hea</u> er the number of FTE resident:					iod for which	0.00	62.00
62. 01 Ente	r hospital received HRSA PCRE er the number of FTE resident: ing in this cost reporting pe	s that rotated from a	Teachi			your hospital	0.00	62. 0 ⁻
Tead	ching Hospitals that Claim Re your facility trained reside	sidents in Nonprovide	er Setti	ngs		period? Enter	l N	63. 00
	for yes or "N" for no in col				instructions)	<u>. </u>	= ()	
					Unwei ghted FTEs Nonprovi der Si te	Unweighted FTEs in Hospital	Ratio (col. 1/ (col. 1 + col. 2))	
					1. 00	2.00	3.00	
	tion 5504 of the ACA Base Yea od that begins on or after J				his base year	r is your cost r	reporting	
64.00 Ente in t resi sett	that begins on or are so er in column 1, if line 63 is the base year period, the num dent FTEs attributable to ro tings. Enter in column 2 the dent FTEs that trained in you	yes, or your facilit oer of unweighted nor tations occurring in number of unweighted	y traino n-primary all nonp I non-pri	ed residents y care provider mary care	O. C	0.00	0. 000000	64.00
	(column 1 divided by (column	1 + column 2)). (see	instruc	tions)				
		Program Name	Pro	gram Code	Unwei ghted FTEs Nonprovi der Si te	FTEs in	Ratio (col. 3/ (col. 3 + col. 4))	
/F 00 F :		1.00		2.00	3. 00	4.00	5.00	/F 5:
is year asso resi the column resi rota non-column column column column column resi your	er in column 1, if line 63 yes, or your facility ined residents in the base r period, the program name ociated with primary care s for each primary care gram in which you trained idents. Enter in column 2, program code, enter in umn 3, the number of eighted primary care FTE idents attributable to ations occurring in all provider settings. Enter in umn 4, the number of eighted primary care ident FTEs that trained in thospital. Enter in column the ratio of (column 3 ided by (column 3 + column				O. C	0.00	0. 000000	. 65. U

Health Financial Systems HUNTINGTON MEMOR				eu of Form CMS	
HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA	Provi der	Fi	eriod: rom 01/01/2015		
		To		10/28/2016	
			V 1. 00	XI X 2. 00	
95.00 If line 94 is "Y", enter the reduction percentage in the appl 96.00 Does title V or XIX reduce operating cost? Enter "Y" for yes applicable column.			0. 00 N	0. 00 N	95. 00 96. 00
97.00 If line 96 is "Y", enter the reduction percentage in the appl Rural Providers	icable column	า.	0. 00	0.00	97. 00
105.00 Does this hospital qualify as a critical access hospital (CAI 106.00) If this facility qualifies as a CAH, has it elected the all-i	*	nod of payment	N		105. 00 106. 00
for outpatient services? (see instructions) 107.00 f this facility qualifies as a CAH, is it eligible for cost training programs? Enter "Y" for yes or "N" for no in column yes, the GME elimination is not made on Wkst. B, Pt. I, col. reimbursed. If yes complete Wkst. D-2, Pt. II.	1. (see instr	ructions) If			107. 00
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.			N		108. 00
	Physi cal 1.00	Occupational 2.00	Speech 3.00	Respiratory 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				109. 00
				1.00	
110.00 Did this hospital participate in the Rural Community Hospital the current cost reporting period? Enter "Y" for yes or "N" 1		on project (410	OA Demo)for	N	110. 00
			1. 0	00 2.00 3.00	0
Miscellaneous Cost Reporting Information 115.00[s this an all-inclusive rate provider? Enter "Y" for yes or	"N" for no ir	n column 1 lf	column 1 N	0	115. 00
is yes, enter the method used (A, B, or E only) in column 2. 3 either "93" percent for short term hospital or "98" percent psychiatric, rehabilitation and long term hospitals providers Pub. 15-1, chapter 22, §2208. 1.	If column 2 i t for long ter	is "E", enter i rm care (includ	n column les		113.00
116.00 s this facility classified as a referral center? Enter "Y" 1117.00 s this facility legally-required to carry malpractice insura	-		N" for Y		116. 00 117. 00
no. 118.00 Is the malpractice insurance a claims-made or occurrence policlaim-made. Enter 2 if the policy is occurrence.	cy? Enter 1 i	f the policy i	s 1		118. 00
jordin made. Enter 2 11 the portey 13 decarrence.		Premi ums	Losses	Insurance	
		1. 00	2.00	3.00	
118.01 List amounts of malpractice premiums and paid losses:		91, 141		0 18, 7	39 118. 01
118.02 Are mal practice premiums and paid losses reported in a cost of Administrative and General? If yes, submit supporting scheduland amounts contained therein.			1. 00 N	2.00	118. 02
119.00 DO NOT USE THIS LINE 120.00 Is this a SCH or EACH that qualifies for the Outpatient Hold §3121 and applicable amendments? (see instructions) Enter in "N" for no. Is this a rural hospital with < 100 beds that qua	column 1, "Y"	' for yes or	N	Y	119. 00 120. 00
Hold Harmless provision in ACA §3121 and applicable amendment Enter in column 2, "Y" for yes or "N" for no.	ts? (see instr	ructi ons)			
121.00 Did this facility incur and report costs for high cost implar patients? Enter "Y" for yes or "N" for no.	ntable devices	s charged to	Υ		121. 00
122.00 Does the cost report contain state health or similar taxes? For no in column 1. If column 1 is "Y", enter in column 2 the			N		122. 00
where these taxes are included. Transplant Center Information					
125.00 Does this facility operate a transplant center? Enter "Y" for yes, enter certification date(s) (mm/dd/yyyy) below.	r yes and "N"	for no. If	N		125. 00
126.00 If this is a Medicare certified kidney transplant center, en in column 1 and termination date, if applicable, in column 2.		fication date			126. 00
127.00 If this is a Medicare certified heart transplant center, ento in column 1 and termination date, if applicable, in column 2.	er the certifi	cation date			127. 00
128.00 If this is a Medicare certified liver transplant center, enter	er the certifi	cation date			128. 00
in column 1 and termination date, if applicable, in column 2. 129.00 f this is a Medicare certified lung transplant center, enter		cation date in			129. 00
column 1 and termination date, if applicable, in column 2. 130.00 If this is a Medicare certified pancreas transplant center, e		ti fi cati on			130. 00
date in column 1 and termination date, if applicable, in column 131.00 of this is a Medicare certified intestinal transplant center,		erti fi cati on			131. 00
date in column 1 and termination date, if applicable, in column 132.00 If this is a Medicare certified islet transplant center, ento in column 1 and termination date, if applicable, in column 2.	er the certifi	cation date			132. 00
pro corumn i and termination date, if applicable, in corumn 2.			I	I	I

Health Financial Systems HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX	HUNTINGTON MEM		CCN: 150091			u of Form CMS Worksheet S- Part I Date/Time Pr 10/28/2016	-2 repared:
					1. 00	2. 00	_
133.00 If this is a Medicare certified oth			cation date	Э			133. 00
in column 1 and termination date, i 34.00 If this is an organ procurement organd termination date, if applicable	anization (OPO), enter		n column 1				134. 00
All Providers	, TH COLUMN 2.						
40.00 Are there any related organization chapter 10? Enter "Y" for yes or "N are claimed, enter in column 2 the	" for no in column 1. I	f yes, and home	office cos	ts	Υ	15H032	140. 0
1.00		00	LT OHS)		3. 00		
If this facility is part of a chain			ugh 143 the	name and		of the	
home office and enter the home offi 41.00 Name: PARKVIEW HEALTH SYSTEM, INC.	Contractor's Name: W			ctor's Nu	ımber: 0810	1	141. 0
42.00 Street: 10501 CORPORATE DRIVE		600					142. 0
43.00 City: FORT WAYNE	State: I	N	Zi p Coo	de:	4689	5-5600	143. 0
						1.00	_
44.00 Are provider based physicians' cost	s included in Worksheet	Α?				1. 00 Y	144. 00
The copin of province business project or allowed to	THO GOOD THE HOLICON	711					
					1. 00	2. 00	
45.00 f costs for renal services are cla inpatient services only? Enter "Y" no, does the dialysis facility incl period? Enter "Y" for yes or "N" for	for yes or "N" for no i ude Medicare utilization	n column 1. If o	column 1 is		N		145. 00
46.00 Has the cost allocation methodology Enter "Y" for yes or "N" for no in yes, enter the approval date (mm/dd	changed from the previo			f	N		146. 0
						1.00	
47.00 Was there a change in the statistic	al hasis? Enter "V" for	ves or "N" for	no			1. 00 N	147. 0
48.00 Was there a change in the order of						N	148. 0
49.00 Was there a change to the simplifie	d cost finding method? I					N	149. 0
		Part A 1.00	Part B	T	itle V	Title XIX	4
Does this facility contain a provid	er that qualifies for a		2.00 n the appli	cation o	3.00 f the Lowe	4.00	
or charges? Enter "Y" for yes or "N							
55. 00 Hospi tal		N	N		N	N	155. 0
56.00 Subprovider - IPF 57.00 Subprovider - IRF		N N	N N		N N	N N	156. 0 157. 0
58. OO SUBPROVI DER		IN	l IN		IV	Į IN	158. 0
59. 00 SNF		N	N		N	N	159. 0
60.00 HOME HEALTH AGENCY		N	N		N	N	160. 0
61. 00 CMHC			N N		N	N	161. 0
						1.00	\dashv
Multicampus							
65.00 Is this hospital part of a Multicam Enter "Y" for yes or "N" for no.	pus hospital that has o	ne or more campu	uses in dif	ferent CE	BSAs?	N	165. 00
Effect 1 for yes of N for no.	Name	County	State	Zip Code	CBSA	FTE/Campus	
	0	1. 00	2. 00	3. 00	4. 00	5. 00	
66.00 If line 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	00 166. O
						4.22	
Health Information Technology (HIT)	incentive in the Ameri	can Recovery an	d Rainvactm	ent Act		1.00	
67.00 Is this provider a meaningful user 68.00 If this provider is a CAH (line 105	under §1886(n)? Enter ' is "Y") and is a meaniu	"Y" for yes or ' ngful user (line	'N" for no.		the	Y	167. 00 0168. 00
reasonable cost incurred for the HI 68.01 If this provider is a CAH and is no exception under §413.70(a)(6)(ii)?	t a meaningful user, do	es this provide			dshi p		168. 0
69.00 If this provider is a meaningful us transition factor. (see instruction		d is not a CAH	(line 105 i	s "N"), €	enter the	0.	25 169. 0

Health Financial Systems	HUNTINGTON MEMORIAL	HOSPI TAL	In Lie	u of Form CMS-	2552-10			
HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX ID	ENTIFICATION DATA	Provi der CCN: 150091	Peri od:	Worksheet S-2				
			From 01/01/2015					
			To 12/31/2015	Date/Time Pre 10/28/2016 10	pared: :35 am_			
	Begi nni ng							
			1. 00	2.00				
170.00 Enter in columns 1 and 2 the EHR beging period respectively (mm/dd/yyyy)	12/31/2015	170. 00						
				1.00				
171.00 If line 167 is "Y", does this provider Medicare cost plans reported on Wkst. (see instructions)				N	171. 00			

	Financial Systems HUNTINGTON MEMO AL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE		CCN: 150091		u of Form CMS-	
				Peri od: From 01/01/2015 To 12/31/2015	Worksheet S-2 Part II Date/Time Pre 10/28/2016 10	pared:
				Y/N	Date	
				1. 00	2. 00	
	General Instruction: Enter Y for all YES responses. Enter Nmm/dd/yyyy format. COMPLETED BY ALL HOSPITALS Description of County and	l for all NO re	sponses. Ente	er all dates in t	the	
1.00	Provider Organization and Operation Has the provider changed ownership immediately prior to the	e beginning of	the cost	N		1.00
	reporting period? If yes, enter the date of the change in o		instructions)			
			Y/N	Date	V/I	
2.00	Has the provider terminated participation in the Medicare F	Program2 If	1. 00 N	2. 00	3. 00	2. 00
	yes, enter in column 2 the date of termination and in colum voluntary or "I" for involuntary.					
3.00	Is the provider involved in business transactions, includir contracts, with individuals or entities (e.g., chain home or medical supply companies) that are related to the provide officers, medical staff, management personnel, or members of directors through ownership, control, or family and other relationships? (see instructions)	offices, drug der or its of the board	N			3.00
	relationships: (see Thati detrons)		Y/N	Туре	Date	
			1.00	2.00	3. 00	
4 00	Financial Data and Reports	tified Dublic	Υ	Δ	04/22/2014	4.00
4. 00	Column 1: Were the financial statements prepared by a Cert Accountant? Column 2: If yes, enter "A" for Audited, "C" for "R" for Reviewed. Submit complete copy or enter date avacolumn 3. (see instructions) If no, see instructions.	for Compiled,	Ť	A	04/23/2016	4.00
5.00	Are the cost report total expenses and total revenues diffe		N			5. 00
	those on the filed financial statements? If yes, submit rec	conciliation.		Y/N	Legal Oper.	
				1.00	2. 00	
	Approved Educational Activities					
6. 00	Column 1: Are costs claimed for nursing school? Column 2: the legal operator of the program?		e provider is			6. 00
7. 00 8. 00	Are costs claimed for Allied Health Programs? If "Y" see in Were nursing school and/or allied health programs approved cost reporting period? If yes, see instructions.	and/or renewed	G	N N		7. 00
9. 00	Are costs claimed for Interns and Residents in an approved program in the current cost report? If yes, see instruction		ai education	N		9. 00
10. 00	Was an approved Intern and Resident GME program initiated cost reporting period? If yes, see instructions.	or renewed in t	he current	N		10.00
11. 00	Are GME cost directly assigned to cost centers other than I Teaching Program on Worksheet A? If yes, see instructions.	& R in an App	roved	N		11. 00
					Y/N 1. 00	
	Bad Debts					
12. 00 13. 00	Is the provider seeking reimbursement for bad debts? If yes If line 12 is yes, did the provider's bad debt collection period? If yes, submit copy.			ost reporting	Y N	12. 00 13. 00
14. 00	If line 12 is yes, were patient deductibles and/or co-payme Bed Complement	ents waived? If	yes, see ins	structi ons.	N	14. 00
15. 00	Did total beds available change from the prior cost reporti		yes, see inst t A		N t B	15. 00
		Y/N	Date	Y/N	Date	
	DS&D Data	1.00	2.00	3. 00	4. 00	
16. 00	PS&R Data Was the cost report prepared using the PS&R Report only? If either column 1 or 3 is yes, enter the paid-through date of the PS&R Report used in columns 2 and 4 (see	N		N		16. 00
17. 00	<pre>instructions) Was the cost report prepared using the PS&R Report for totals and the provider's records for allocation? If either column 1 or 3 is yes, enter the paid-through date</pre>	Y	03/16/2016	Y	03/16/2016	17. 00
18. 00	in columns 2 and 4. (see instructions) If line 16 or 17 is yes, were adjustments made to PS&R Report data for additional claims that have been billed but are not included on the PS&R Report used to file this	Y		Y		18. 00
19. 00	cost report? If yes, see instructions. If line 16 or 17 is yes, were adjustments made to PS&R Report data for corrections of other PS&R Report information? If yes, see instructions.	N		N		19. 00

HOSPI T	Financial Systems HUNTINGTON MEMO FAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE		CCN: 150091	Peri od: From 01/01/2015 To 12/31/2015	w of Form CMS Worksheet S- Part II Date/Time Pr 10/28/2016 1	·2 repared:		
		Descri	pti on	Y/N	Y/N	0. 33 diii		
)	1. 00	3. 00			
20. 00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for Other? Describe the other adjustments:			N	N	20. 00		
		Y/N	Date	Y/N	Date			
21. 00	Was the cost report prepared only using the provider's	1.00 N	2. 00	3. 00 N	4. 00	21. 00		
21.00	records? If yes, see instructions.	IV		14		21.00		
					1. 00			
	COMPLETED BY COST REIMBURSED AND TEFRA HOSPITALS ONLY (EXCE Capital Related Cost	PT CHILDRENS H	OSPI TALS)					
22. 00	Have assets been relifed for Medicare purposes? If yes, see	instructions				22. 00		
23. 00	Have changes occurred in the Medicare depreciation expense reporting period? If yes, see instructions.		als made dur	ing the cost		23. 00		
24. 00	Were new leases and/or amendments to existing leases entere If yes, see instructions	ed into during	this cost re	eporting period?		24. 00		
25. 00	Have there been new capitalized leases entered into during instructions.	•	.			25. 00		
26. 00	Were assets subject to Sec. 2314 of DEFRA acquired during thinstructions.	ne cost reporti	ng period? I	f yes, see		26. 00		
27. 00	Has the provider's capitalization policy changed during the copy.	cost reportin	g period? If	fyes, submit		27. 00		
28. 00	Interest Expense Were new loans, mortgage agreements or letters of credit en	ntered into dur	ing the cost	reporting		28. 00		
29. 00	period? If yes, see instructions. Did the provider have a funded depreciation account and/or		bt Service F	Reserve Fund)		29. 00		
30. 00	treated as a funded depreciation account? If yes, see instr Has existing debt been replaced prior to its scheduled matu	ructions Irity with new	debt? If yes	s, see		30. 00		
31. 00	<pre>instructions. Has debt been recalled before scheduled maturity without is instructions.</pre>	ssuance of new	debt? If yes	s, see		31. 00		
32. 00	Purchased Services Have changes or new agreements occurred in patient care ser	vices furnishe	d through co	ontractual		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 no, see instructions.	ıcti ons.	•			33. 00		
0.4.00	Provi der-Based Physi ci ans							
34. 00	If yes, see instructions.	o .	•	. ,		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		ts with the			35. 00		
				Y/N 1. 00	2. 00			
36 00	Home Office Costs Were home office costs claimed on the cost report?			Υ		36.00		
	If line 36 is yes, has a home office cost statement been pr	repared by the	home office?			36.00		
38. 00	If yes, see instructions. If line 36 is yes, was the fiscal year end of the home off the provider? If yes, enter in column 2 the fiscal year end			- N		38. 00		
39. 00				s, N		39. 00		
40. 00	If line 36 is yes, did the provider render services to the instructions.	home office?	If yes, see	N		40. 00		
		1	00	2.	00			
	Cost Report Preparer Contact Information							
41. 00	held by the cost report preparer in columns 1, 2, and 3,	ERI C		NI CKESON		41. 00		
	respectively.							
42. 00		PARKVIEW HEALT	PARKVIEW HEALTH SYSTEM, INC. (260) 373-8406 ERIC. NICKESON@PARKVIEW. COM					

Heal th	Financial Systems	HUNTI NGTON ME	MORI AL	HOSPI TAL			In Lieu	u of Form CMS-	2552-10
HOSPI T	AL AND HOSPITAL HEALTH CARE REIMBURSEMENT	QUESTI ONNAI RE		Provi der CC	CN: 150091	Peri	od: 01/01/2015	Worksheet S-2 Part II	
						To			nared·
								10/28/2016 10	: 35 am
				3. 00)				
	Cost Report Preparer Contact Information								
41.00	Enter the first name, last name and the t	itle/position	DI REC	CTOR, REIMBU	RSEMENT				41.00
	held by the cost report preparer in colum	ns 1, 2, and 3,							
	respecti vel y.								
42.00	Enter the employer/company name of the co	st report							42.00
	preparer.								
43.00	Enter the telephone number and email addr	ress of the cost							43.00
	report preparer in columns 1 and 2, respe	ecti vel y.							
	report preparer in columns 1 and 2, respe	ecti vel y.							

| Peri od: | Worksheet S-3 | From 01/01/2015 | Part | To 12/31/2015 | Date/Time Prepared: Health Financial Systems HUNTINGTO HUSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA Provi der CCN: 150091

						To	12/31/2015	Date/Time Pre 10/28/2016 10	
								1/P Days / 0/P	
								Visits / Trips	
	Component	Worksheet A Line Number	No.	of Beds	Bed Days Available		CAH Hours	Title V	
		1. 00		2. 00	3.00		4. 00	5. 00	
1.00	Hospital Adults & Peds. (columns 5, 6, 7 and	30. 00		36	13, 14	0	0.00	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 4. 00	HMO IPF Subprovider								3. 00 4. 00
5. 00	HMO IRF Subprovider Hospital Adults & Peds. Swing Bed SNF							0	
6.00	Hospital Adults & Peds. Swing Bed SNI							0	
7. 00	Total Adults and Peds. (exclude observation			36	13, 14	0	0.00	0	
7.00	beds) (see instructions)			00]		0.00	· ·	/
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	43. 00						0	
14.00	Total (see instructions)			36	13, 14	O	0. 00	0	
15. 00 16. 00	CAH visits SUBPROVIDER - IPF							0	15. 00 16. 00
17. 00	SUBPROVIDER - IPF								17. 00
18. 00	SUBPROVI DER								18.00
19. 00	SKILLED NURSING FACILITY								19. 00
20.00	NURSING FACILITY								20.00
21.00	OTHER LONG TERM CARE								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)	30. 00							24. 10
25. 00 26. 00	CMHC								25. 00 26. 00
26. 00	FEDERALLY QUALIFIED HEALTH CENTER								26. 00
27. 00	Total (sum of lines 14-26)			36					27. 00
28. 00	Observation Bed Days			30				0	
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)			0		0			32. 00
32. 01	Total ancillary labor & delivery room								32. 01
	outpatient days (see instructions)								
33. 00	LTCH non-covered days						l		33. 00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA

Provi der CCN: 150091 | Peri od: | From 01/01/2015 |

d: Worksheet S-3 01/01/2015 Part I 12/31/2015 Date/Time Prepared:

10/28/2016 10:35 am Full Time Equivalents I/P Days / O/P Visits / Trips Title XVIII Component Title XIX Total All Total Interns Employees On Pati ents & Residents Payrol I 7.00 10.00 6.00 8.00 9.00 1.00 Hospital Adults & Peds. (columns 5, 6, 7 and 1, 424 176 4. 491 1.00 8 exclude Swing Bed, Observation Bed and Hospice days) (see instructions for col. 2 for the portion of LDP room available beds) 1, 275 2 00 HMO and other (see instructions) 1, 148 2 00 3.00 HMO IPF Subprovider 3.00 HMO IRF Subprovider 4.00 0 4.00 5.00 Hospital Adults & Peds. Swing Bed SNF 0 0 5.00 Hospital Adults & Peds. Swing Bed NF 6.00 C 0 6.00 7.00 Total Adults and Peds. (exclude observation 1, 424 176 4, 491 7.00 beds) (see instructions) INTENSIVE CARE UNIT 8.00 8.00 CORONARY CARE UNIT 9.00 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 725 13.00 14.00 Total (see instructions) 1, 424 247 5, 216 0.00 205.00 14.00 CAH visits 15.00 15.00 SUBPROVIDER - IPF 16.00 16.00 SUBPROVIDER - IRF 17.00 17.00 18.00 SUBPROVI DER 18.00 19.00 SKILLED NURSING FACILITY 19.00 20 00 NURSING FACILITY 20 00 21.00 OTHER LONG TERM CARE 21.00 22.00 HOME HEALTH AGENCY 22.00 23.00 AMBULATORY SURGICAL CENTER (D. P.) 23.00 HOSPI CE 24 00 24 00 24. 10 HOSPICE (non-distinct part) 0 0 0 24. 10 25. 00 CMHC - CMHC 25.00 26.00 RURAL HEALTH CLINIC 26, 00 FEDERALLY QUALIFIED HEALTH CENTER 26. 25 26.25 27.00 Total (sum of lines 14-26) 0.00 205.00 27.00 28.00 Observation Bed Days 234 1,053 28.00 29.00 29.00 Ambul ance Trips 1, 233 30.00 Employee discount days (see instruction) 102 30.00 31.00 Employee discount days - IRF 31.00 32.00 Labor & delivery days (see instructions) 53 89 32.00 0 Total ancillary labor & delivery room 32.01 0 32.01 outpatient days (see instructions) 33.00 LTCH non-covered days 0 33.00

Health Financial Systems HUNTINGTO HUSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA Provi der CCN: 150091

					0 12/31/2013	10/28/2016 10:	
		Full Time	<u> </u>	Di sch	arges		
		Equi val ents			,		
	Component	Nonpai d	Title V	Title XVIII	Title XIX	Total All	
		Workers				Pati ents	
		11. 00	12.00	13. 00	14.00	15. 00	
1.00	Hospital Adults & Peds. (columns 5, 6, 7 and		0	470	537	1, 607	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)			373			2. 00
3.00	HMO IPF Subprovider				0		3.00
4.00	HMO IRF Subprovider				0		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	470	537	1, 607	14.00
15. 00	CAH visits						15.00
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						19.00
20.00	NURSING FACILITY						20.00
21. 00	OTHER LONG TERM CARE						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)						24. 10
25. 00	CMHC - CMHC						25.00
26. 00	RURAL HEALTH CLINIC						26.00
26. 25	FEDERALLY QUALIFIED HEALTH CENTER						26. 25
27. 00	Total (sum of lines 14-26)	0. 00					27.00
28. 00	Observation Bed Days						28.00
29. 00	Ambul ance Tri ps						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
	outpatient days (see instructions)						
33. 00	LTCH non-covered days						33. 00

| Peri od: | Worksheet S-3 | From 01/01/2015 | Part II | To 12/31/2015 | Date/Time Prepared: Provider CCN: 150091

					Т	o 12/31/2015	Date/Time Pre 10/28/2016 10	
		Worksheet A	Amount	Reclassi fi cati	Adj usted	Pai d Hours	Average Hourly	
		Line Number	Reported	on of Salaries (from	Sal ari es (col. 2 ± col.	Related to Salaries in	Wage (col. 4 ÷ col. 5)	
				Worksheet A-6)	3)	col. 4	ŕ	
	PART II - WAGE DATA	1. 00	2. 00	3. 00	4.00	5. 00	6. 00	
	SALARI ES							1
1.00	Total salaries (see	200. 00	13, 332, 706	3, 516, 096	16, 848, 802	566, 292. 00	29. 75	1.00
2.00	instructions) Non-physician anesthetist Part		0	О	C	0.00	0.00	2. 00
3. 00	A Non-physician anesthetist Part		0	0	C	0.00	0. 00	3.00
4. 00	B Physician-Part A -		24, 000	0	24, 000	199. 00	120. 60	4.00
4. 01	Administrative Physicians - Part A - Teaching		0	0	C	0.00	0.00	4. 01
5.00	Physician-Part B		0	0	C	0.00	•	
6. 00 7. 00	Non-physician-Part B Interns & residents (in an	21. 00	0	0	0	0. 00 0. 00	•	
7. 01	approved program) Contracted interns and		O	0	C	0. 00	0.00	7. 01
	residents (in an approved programs)							
8.00	Home office personnel		4, 424, 639	0	4, 424, 639			
9. 00 10. 00	SNF Excluded area salaries (see	44. 00	0 1, 492, 729	0 245, 828	1, 738, 557	0. 00 78, 606. 00		
	instructions)		., ., ., .,	2.10, 020	.,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,	70,000.00		10.00
11. 00	OTHER WAGES & RELATED COSTS Contract labor: Direct Patient		0	0	1 0	0.00	0.00	11.00
	Care		, and a second			0.00		
12. 00	Contract labor: Top level management and other		0	0	C	0.00	0.00	12. 00
	management and administrative							
13. 00	services Contract Labor: Physician-Part		0	0	С	0.00	0. 00	13. 00
14. 00	A - Administrative Home office salaries &		4, 424, 639	0	4, 424, 639	116, 724. 00	37. 91	14. 00
15. 00	wage-related costs Home office: Physician Part A		0	0	c	0.00	0.00	15.00
16. 00	- Administrative Home office and Contract		0	0	0	0.00	0.00	16. 00
	Physicians Part A - Teaching WAGE-RELATED COSTS							
17. 00	Wage-related costs (core) (see instructions)		4, 474, 907	0	4, 474, 907			17. 00
18. 00	Wage-related costs (other)		0	0	С			18. 00
19. 00	(see instructions) Excluded areas		668, 785	0	668, 785			19.00
20. 00	Non-physician anesthetist Part		0	0	c			20. 00
21. 00	Non-physician anesthetist Part		0	0	С			21. 00
22. 00	Physician Part A - Administrative		0	0	С			22. 00
22. 01	Physician Part A - Teaching		0	О	C			22. 01
23. 00	Physician Part B		0	_	C			23. 00
24. 00 25. 00	Wage-related costs (RHC/FQHC)		0	0	C			24. 00 25. 00
	approved program)		-					
26. 00	OVERHEAD COSTS - DIRECT SALARIE Employee Benefits Department	4. 00	1, 310, 130	-1, 310, 130	С	0.00	0.00	26. 00
27. 00	Administrative & General	5. 00	2, 008, 501			158, 526. 00	35. 02	27. 00
28. 00	Administrative & General under contract (see inst.)		0	0	C	0.00	0.00	28. 00
29. 00	Maintenance & Repairs	6. 00	0	0	C	0.00	0.00	29. 00
30.00	Operation of Plant	7. 00	294, 525					
31.00	Laundry & Linen Service	8. 00	201 214	32, 347				
32. 00 33. 00	Housekeepi ng under contract	9. 00	281, 214 0	5, 381 0	286, 595 C	23, 257. 00 0. 00	1	
34. 00	(see instructions) Dietary	10. 00	353, 141	-287, 815	65, 326	5, 854. 00	11. 16	34.00
35. 00	Di etary under contract (see instructions)		0	0	C	0.00	1	
36. 00	Cafeteri a	11. 00	0	229, 178	229, 178		1	1
37. 00	Maintenance of Personnel	12. 00	174 500	00 445	107.040	0.00		
38. 00 39. 00	Nursing Administration Central Services and Supply	13. 00 14. 00	174, 528 0	23, 415 0	197, 943	4, 987. 00 0. 00	1	38.00
40. 00		15. 00	534, 626	768	535, 394		1	40.00

Health Financial Systems	Н	IUNTI NGTON MEM	ORIAL HOSPITAL		In Lie	eu of Form CMS-2	2552-10
HOSPITAL WAGE INDEX INFORMATION			Provi der	CCN: 150091	Peri od:	Worksheet S-3	
					From 01/01/2015		
					To 12/31/2015		pared:
						10/28/2016 10	
	Worksheet A	Amount	Recl assi fi cati	Adj usted	Pai d Hours	Average Hourly	
	Line Number	Reported	on of Salaries	Sal ari es	Related to	Wage (col. 4 ÷	
			(from	(col.2 ± col.	Sal ari es in	col . 5)	
			Worksheet A-6)	3)	col. 4		
	1.00	2.00	3. 00	4.00	5. 00	6. 00	
41.00 Medical Records & Medical	16. 00	(O C)	0.00	0. 00	41. 00
Records Library							
42.00 Social Service	17. 00	(o c		0.00	0. 00	42.00
43.00 Other General Service	18. 00	(o c)	0.00	0. 00	43. 00

HOSPITAL WAGE INDEX INFORMATION Worksheet S-3 Part III Date/Time Prepared: Provider CCN: 150091 Peri od: From 01/01/2015 To 12/31/2015 10/28/2016 10:35 am Average Hourly Worksheet A Amount Recl assi fi cati Adj usted Pai d Hours Line Number Reported on of Salaries Sal ari es Related to Wage (col. 4 (col.2 ± col. col. 5) Salaries in (from Works<u>heet A-6)</u> 3) col. 4 1.00 5.00 6.00 2.00 3.00 4.00 PART III - HOSPITAL WAGE INDEX SUMMARY 1.00 Net salaries (see 8, 908, 067 3, 516, 096 12, 424, 163 449, 568. 00 1.00 27.64 instructions) 2.00 1, 492, 729 245, 828 1, 738, 557 78, 606. 00 22. 12 2.00 Excluded area salaries (see instructions) 3.00 Subtotal salaries (line 1 7, 415, 338 3, 270, 268 10, 685, 606 370, 962. 00 28.81 3.00 minus line 2)

4, 424, 639

4, 474, 907

19, 585, 152

7, 232, 510

Ω

3, 270, 268

2, 275, 845

116, 724. 00

487, 686. 00

235, 675. 00

0.00

37.91

41.88

40. 16

30. 69

4.00

5.00

6.00

7.00

4, 424, 639

4, 474, 907

16, 314, 884

4, 956, 665

4.00

5.00

6.00

7.00

Subtotal other wages & related

Subtotal wage-related costs

Total overhead cost (see

Total (sum of lines 3 thru 5)

costs (see inst.)

(see inst.)

instructions)

Health Financial Systems	HUNTINGTON MEMORIAL HOSPITAL	In Lieu of Form CMS-2552-10
HOSPITAL WAGE RELATED COSTS	Provi der CCN: 150091	Period: Worksheet S-3 From 01/01/2015 Part IV
		To 12/31/2015 Date/Time Prepared:

	To 12/31/2015	Date/Time Prep 10/28/2016 10:	
		Amount	
		Reported	
		1.00	
	PART IV - WAGE RELATED COSTS		
	Part A - Core List		
	RETI REMENT COST		
1.00	401K Employer Contributions	0	1. 00
2.00	Tax Sheltered Annuity (TSA) Employer Contribution	327, 571	2.00
3.00	Nonqualified Defined Benefit Plan Cost (see instructions)	312, 516	3. 00
4.00	Qualified Defined Benefit Plan Cost (see instructions)	0	4. 00
	PLAN ADMINISTRATIVE COSTS (Paid to External Organization)		
5.00	401K/TSA Plan Administration fees	0	5. 00
6.00	Legal /Accounting/Management Fees-Pension Plan	0	6. 00
7.00	Employee Managed Care Program Administration Fees	52, 689	7. 00
	HEALTH AND INSURANCE COST		
8.00	Health Insurance (Purchased or Self Funded)	2, 995, 829	8. 00
9.00	Prescription Drug Plan	0	9. 00
10.00	Dental, Hearing and Vision Plan	0	10.00
11. 00	Life Insurance (If employee is owner or beneficiary)	26, 049	11.00
12.00	Accident Insurance (If employee is owner or beneficiary)	0	12.00
13.00	Disability Insurance (If employee is owner or beneficiary)	65, 144	13.00
14.00	Long-Term Care Insurance (If employee is owner or beneficiary)	0	14.00
15.00	'Workers' Compensation Insurance	28, 855	15.00
16.00	Retirement Health Care Cost (Only current year, not the extraordinary accrual required by FASB 106.	0	16.00
	Non cumulative portion)		
	TAXES		
17.00	FICA-Employers Portion Only	1, 257, 876	17.00
18.00	Medicare Taxes - Employers Portion Only	0	18.00
19.00	Unempl oyment Insurance	0	19.00
20.00	State or Federal Unemployment Taxes	0	20.00
	OTHER		
21.00	Executive Deferred Compensation (Other Than Retirement Cost Reported on lines 1 through 4 above. (see	47, 001	21.00
	instructions))		
	Day Care Cost and Allowances	0	22. 00
	Tuition Reimbursement	30, 162	
24.00	Total Wage Related cost (Sum of lines 1 -23)	5, 143, 692	24. 00
	Part B - Other than Core Related Cost		
25.00	OTHER WAGE RELATED COSTS (SPECIFY)	0	25. 00

Health Financial Systems	HUNTINGTON MEMORIAL HOSPITAL	In Lie	u of Form CMS-2	2552-10
HOSPITAL CONTRACT LABOR AND BENEFIT COST		Peri od:	Worksheet S-3	
		From 01/01/2015 To 12/31/2015	Date/Time Prep	nared.
		12, 01, 2010	10/28/2016 10:	35 am
Cost Center Description		Contract Labor	Benefit Cost	
		1. 00	2. 00	
PART V - Contract Labor and Benefit Cost				
Hospital and Hospital-Based Component Identi	fication:			

	Cost Center Description	Contract Labor	Benefit Cost	
		1. 00	2. 00	
	PART V - Contract Labor and Benefit Cost			
	Hospital and Hospital-Based Component Identification:			
1.00	Total facility's contract labor and benefit cost	0	0	1. 00
2.00	Hospi tal	0	0	2. 00
3.00	Subprovi der - I PF			3. 00
4.00	Subprovi der - I RF			4.00
5.00	Subprovi der - (Other)	0	0	5. 00
6.00	Swing Beds - SNF	0	0	6. 00
7.00	Swing Beds - NF	0	0	7. 00
8.00	Hospi tal -Based SNF			8. 00
9.00	Hospi tal -Based NF			9. 00
10.00	Hospi tal -Based OLTC			10.00
11.00	Hospi tal -Based HHA			11. 00
12.00	Separately Certified ASC			12. 00
13.00	Hospi tal -Based Hospi ce			13. 00
14.00	Hospital-Based Health Clinic RHC			14. 00
15.00	Hospital-Based Health Clinic FQHC			15. 00
16.00	Hospi tal -Based-CMHC			16. 00
17. 00	Renal Di al ysi s			17. 00
18. 00	Other	0	0	18. 00

Health Financial Systems	HUNTINGTON MEMORIAL HOSPITAL		In Lie	u of Form CMS-2	2552-10
HOSPITAL UNCOMPENSATED AND INDIGENT CARE DATA	Provi der	CCN: 150091	Peri od:	Worksheet S-10	<u>)</u>
			From 01/01/2015 To 12/31/2015	Date/Time Prep 10/28/2016 10:	
				1. 00	
Uncompensated and indigent care cost computa					
1.00 Cost to charge ratio (Worksheet C, Part I Ii	ine 202 column 3 divided by I	ine 202 column	1 8)	0. 232849	1. 00
Medicaid (see instructions for each line)				4 500 000	
2.00 Net revenue from Medicaid	6			1, 502, 332	2.00
3.00 Did you receive DSH or supplemental payments		£ N!!!	10	Y	3. 00
4.00 If line 3 is "yes", does line 2 include all 5.00 If line 4 is "no", then enter DSH or suppler			1?	N 3, 885, 308	4. 00 5. 00
6.00 Medicaid charges	neritar payments from Medicard			27, 772, 924	6. 00
7.00 Medicald cost (line 1 times line 6)				6, 466, 898	7. 00
8.00 Difference between net revenue and costs for	r Medicaid program (line 7 mi	nus sum of lir	nes 2 and 5 if	1, 079, 258	8. 00
< zero then enter zero)	meareara pregram (Tries 7 mi		.00 2 4.14 0, 1.	., 0, ,, 200	0.00
State Children's Health Insurance Program (S	SCHIP) (see instructions for	each line)			
9.00 Net revenue from stand-alone SCHIP				13, 381	9. 00
10.00 Stand-alone SCHIP charges				113, 067	10.00
11.00 Stand-alone SCHIP cost (line 1 times line 10				26, 328	
12.00 Difference between net revenue and costs for	r stand-alone SCHIP (line 11	minus line 9;	if < zero then	12, 947	12. 00
enter zero)		6 1 1 1 1			
Other state or local government indigent car				1 100 154	12 00
13.00 Net revenue from state or local indigent cal 14.00 Charges for patients covered under state or				1, 102, 156 9, 548, 691	
10)	rocai indigent care program	(Not Theradea	III IIIles 6 01	9, 340, 091	14.00
15.00 State or local indigent care program cost (line 1 times line 14)			2, 223, 403	15. 00
16.00 Difference between net revenue and costs for		e program (lir	ne 15 minus line	1, 121, 247	
13; if < zero then enter zero)	<u> </u>	1 3 (
Uncompensated care (see instructions for each					
17.00 Private grants, donations, or endowment inco					17. 00
18.00 Government grants, appropriations or transfe		•		0	18. 00
19.00 Total unreimbursed cost for Medicaid, SCHII 8, 12 and 16)	P and state and local indigen	t care program	ns (sum of lines	2, 213, 452	19. 00
		Uni nsured	Insured	Total (col. 1	
		patients	pati ents	+ col . 2)	
20 00 Total initial obligation of nationts approx	ad for charity care (at full	1.00	2. 00	3.00	20.00
20.00 Total initial obligation of patients approve charges excluding non-reimbursable cost centered.		1, 939, 87	765, 722	2, 705, 594	20. 00
21.00 Cost of initial obligation of patients appro			77 178, 298	629, 995	21. 00
times line 20)	even ren enan ty eare (trine t	101,01	170,270	027,770	211.00
22.00 Partial payment by patients approved for cha	arity care	22	3, 698	3, 919	22. 00
23.00 Cost of charity care (line 21 minus line 22))	451, 47	76 174, 600	626, 076	23. 00
				1. 00	
24.00 Does the amount in line 20 column 2 include	charges for nationt days bey	ond a Length o	of stay limit	N N	24. 00
		ona a rengtir c	71 Stay IIIII t	1,4	24.00
imposed on patients covered by Medicaid or o				l	
imposed on patients covered by Medicaid or of 25.00 If line 24 is "yes," charges for patient dates	other indigent care program?	rogram's Lengt	h of stay limit	0	25. 00
	other indigent care program? ays beyond an indigent care p		h of stay limit	0 7, 340, 468	
25.00 If line 24 is "yes," charges for patient da	other indigent care program? ays beyond an indigent care p tal complex (see instructions		th of stay limit	-	26. 00
25.00 If line 24 is "yes," charges for patient da 26.00 Total bad debt expense for the entire hospi	other indigent care program? ays beyond an indigent care p tal complex (see instructions complex (see instructions))	th of stay limit	7, 340, 468	26. 00 27. 00
25.00 If line 24 is "yes," charges for patient do 26.00 Total bad debt expense for the entire hospital 27.00 Medicare bad debts for the entire hospital 28.00 Non-Medicare and non-reimbursable Medicare la 29.00 Cost of non-Medicare and non-reimbursable Medicare	other indigent care program? ays beyond an indigent care p tal complex (see instructions complex (see instructions) bad debt expense (line 26 min edicare bad debt expense (lin	us line 27)	•	7, 340, 468 68, 601 7, 271, 867 1, 693, 247	26. 00 27. 00 28. 00 29. 00
25.00 If line 24 is "yes," charges for patient do 26.00 Total bad debt expense for the entire hospital 27.00 Medicare bad debts for the entire hospital 28.00 Non-Medicare and non-reimbursable Medicare I	other indigent care program? ays beyond an indigent care p tal complex (see instructions complex (see instructions) bad debt expense (line 26 min edicare bad debt expense (lin 3 plus line 29)	us line 27)	•	7, 340, 468 68, 601 7, 271, 867	26. 00 27. 00 28. 00 29. 00 30. 00

Heal th	Financial Systems	HUNTINGTON MEMORI	AL HOSPITAL		In Lie	u of Form CMS-2	2552-10
	SIFICATION AND ADJUSTMENTS OF TRIAL BALANCE (OF EXPENSES	Provi der	CCN: 150091 F	Peri od:	Worksheet A	
					From 01/01/2015 To 12/31/2015	Date/Time Pre	nared·
					12/31/2013	10/28/2016 10	: 35 am
	Cost Center Description	Sal ari es	Other		Recl assi fi cati	Recl assi fi ed	
				+ col . 2)	ons (See A-6)	Trial Balance	
						(col. 3 +-	
		1.00	2.00	2.00	4.00	col . 4) 5.00	
	GENERAL SERVICE COST CENTERS	1.00	2. 00	3. 00	4. 00	5.00	
1.00	00100 CAP REL COSTS-BLDG & FIXT		814, 062	814, 062	-655, 078	158, 984	1.00
2. 00	00200 CAP REL COSTS-MVBLE EQUIP		011,002	(11,002	802, 086		1
3.00	00300 OTHER CAP REL COSTS		0		0	0	1
4.00	00400 EMPLOYEE BENEFITS DEPARTMENT	1, 310, 130	3, 980, 752	5, 290, 882	-1, 310, 130	3, 980, 752	4. 00
5.00	00500 ADMINISTRATIVE & GENERAL	2, 008, 501	12, 515, 599	14, 524, 100	-130, 493	14, 393, 607	5. 00
6.00	00600 MAI NTENANCE & REPAI RS	0	0	(0	0	
7.00	00700 OPERATION OF PLANT	294, 525	832, 355			1, 166, 047	1
8.00	00800 LAUNDRY & LINEN SERVICE	201 214	145, 077			177, 424	1
9. 00 10. 00	00900 HOUSEKEEPI NG 01000 DI ETARY	281, 214 353, 141	121, 771 306, 849			408, 366 164, 990	
11. 00	01100 CAFETERI A	353, 141	6, 336			410, 440	1
12. 00	01200 MAINTENANCE OF PERSONNEL	0	0, 000	0,000	0	110, 110	12. 00
13.00	01300 NURSI NG ADMI NI STRATI ON	174, 528	7, 557	182, 085	23, 415	205, 500	
14.00	01400 CENTRAL SERVICES & SUPPLY	0	0	(o	0	14. 00
15. 00	01500 PHARMACY	534, 626	988, 210	1, 522, 83 <i>6</i>	-11, 435	1, 511, 401	15. 00
16. 00	01600 MEDICAL RECORDS & LIBRARY	0	0	(0	0	16. 00
17. 00	01700 SOCIAL SERVICE	0	0	(0	0	17. 00
19. 00	01900 NONPHYSICIAN ANESTHETISTS	0	0	(0	0	19.00
20. 00 21. 00	02000 NURSING SCHOOL 02100 I&R SERVICES-SALARY & FRINGES APPRV	0	0			1 0	20.00
22. 00	02200 I &R SERVI CES-OTHER PRGM COSTS APPRV		0			1 0	22.00
23. 00	02300 PARAMED ED PRGM-(SPECIFY)	0	0			0	1
23.00	I NPATI ENT ROUTI NE SERVI CE COST CENTERS				91 91		25.00
30.00	03000 ADULTS & PEDIATRICS	2, 842, 050	311, 877	3, 153, 927	-350, 516	2, 803, 411	30.00
43.00	04300 NURSERY	0	0	(39, 403	39, 403	43.00
	ANCILLARY SERVICE COST CENTERS						
50.00	05000 OPERATING ROOM	818, 013	445, 961	1, 263, 974		1, 348, 607	
52. 00 53. 00	05200 DELIVERY ROOM & LABOR ROOM 05300 ANESTHESI OLOGY	0	737, 309	1	0,0,,,,	690, 974 737, 309	
54. 00	05400 RADI OLOGY-DI AGNOSTI C	799, 536	487, 013			1, 380, 946	
60. 00	06000 LABORATORY	777, 330	1, 857, 961			1, 857, 729	1
62. 30	06250 BLOOD CLOTTING FOR HEMOPHILIACS	o	0	(0	0	1
65.00	06500 RESPI RATORY THERAPY	553, 103	118, 818	671, 921	72, 725	744, 646	65. 00
66. 00	06600 PHYSI CAL THERAPY	898, 333	78, 811	977, 144		798, 616	66. 00
67. 00	06700 OCCUPATI ONAL THERAPY	0	0	(196, 710		1
68. 00	06800 SPEECH PATHOLOGY	0	0 504	(79, 014	79, 014	•
69. 00 71. 00	06900 ELECTROCARDI OLOGY 07100 MEDI CAL SUPPLI ES CHARGED TO PATI ENT	0	8, 594 1, 456, 915			8, 594 691, 795	
71.00	07200 I MPL. DEV. CHARGED TO PATIENTS		1, 430, 913	1, 430, 913	764, 734		1
73. 00	07300 DRUGS CHARGED TO PATIENTS	0	1, 679, 481	1, 679, 481			1
76. 97	07697 CARDI AC REHABI LI TATI ON	0	0	1,077,101	0	0	1
76. 98	07698 HYPERBARI C OXYGEN THERAPY	0	0	(o	0	1
76. 99	07699 LI THOTRI PSY	0	0	(0	0	76. 99
	OUTPATIENT SERVICE COST CENTERS						4
91. 00		972, 277	180, 618	1, 152, 895	106, 536	1, 259, 431	
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART OTHER REIMBURSABLE COST CENTERS						92.00
95. 00	09500 AMBULANCE SERVICES	1, 390, 932	215, 068	1, 606, 000	179, 434	1, 785, 434	95. 00
	SPECIAL PURPOSE COST CENTERS	.,	,	.,,		1, 100, 101	1
	11300 I NTEREST EXPENSE		-1, 953				113. 00
118.00		13, 230, 909	27, 295, 041	40, 525, 950	-213, 246	40, 312, 704	118. 00
100.00	NONREI MBURSABLE COST CENTERS						100.00
	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN 19200 PHYSICIANS' PRIVATE OFFICES	59, 077	259, 669	318, 746	7, 500	326, 246	190.00
	07950 OCC HEALTH	34,077	237, 007 O	310, 740	7, 300		194. 00
	07951 PAIN CLINIC	0	0		o o		194. 01
	07952 OCC HEALTH	0	-49, 599	-49, 599	49, 599		194. 02
194.03	07953 FOUNDATI 0	0	86, 900	86, 900	o	86, 900	194. 03
	07954 KIDS CAMPUS	0	0	(o o		194. 04
	07955 COMMUNITY & VOLUNTEER SERVICES	42, 720	422, 311	465, 031	-1, 350		
	07956 HUNTI NGTON COLLEGE NURSE	0	0)	0 - 0		194. 06
	07957 MISC CATERING 07958 AUTISM CENTER	0	0	(194. 07 194. 08
	07958 AUTISM CENTER 07959 HUNTI NGTON BUA		0		66, 741		194. 08
200.00		13, 332, 706	28, 014, 322	41, 347, 028			
			,				

Peri od: From 01/01/2015 To 12/31/2015 Date/Ti me Prepared: 10/28/2016 10:35 am

			10/28/2016 10:	35 am
Cost Center Description	Adjustments	Net Expenses		
	(See A-8) 6.00	For Allocation 7.00		
GENERAL SERVICE COST CENTERS	6.00	7.00		
1. 00 O0100 CAP REL COSTS-BLDG & FIXT	55, 771	214, 755		1. 00
2.00 O0200 CAP REL COSTS-MVBLE EQUIP	-57, 153	744, 933		2. 00
3. 00 00300 OTHER CAP REL COSTS	0	0		3. 00
4.00 00400 EMPLOYEE BENEFITS DEPARTMENT	-1, 757, 666	2, 223, 086		4. 00
5.00 00500 ADMINISTRATIVE & GENERAL	-2, 025, 663	12, 367, 944		5. 00
6.00 00600 MAINTENANCE & REPAIRS	o	0		6.00
7.00 00700 OPERATION OF PLANT	-1, 323	1, 164, 724		7. 00
8.00 00800 LAUNDRY & LINEN SERVICE	0	177, 424		8.00
9. 00 00900 HOUSEKEEPI NG	0	408, 366		9. 00
10. 00 01000 DI ETARY	-16, 199	148, 791		10.00
11. 00 01100 CAFETERI A	-215, 465	194, 975		11. 00
12. 00 01200 MAI NTENANCE OF PERSONNEL	0	0		12.00
13. 00 01300 NURSI NG ADMI NI STRATI ON	0	205, 500		13.00
14. 00 01400 CENTRAL SERVI CES & SUPPLY	1 204 074	214 425		14.00
15. 00 01500 PHARMACY 16. 00 01600 MEDICAL RECORDS & LIBRARY	-1, 296, 976	214, 425		15. 00 16. 00
17. 00 01700 SOCIAL SERVICE		0		17. 00
19. 00 01900 NONPHYSI CLAN ANESTHETI STS	0	0		19. 00
20. 00 02000 NURSI NG SCHOOL		0		20. 00
21. 00 02100 1 &R SERVI CES-SALARY & FRI NGES APPRV	o	0		21. 00
22. 00 02200 I &R SERVICES-OTHER PRGM COSTS APPRV	o	o		22. 00
23. 00 02300 PARAMED ED PRGM-(SPECIFY)	o	0		23. 00
INPATIENT ROUTINE SERVICE COST CENTERS	-1	- '		
30. 00 03000 ADULTS & PEDI ATRI CS	28, 152	2, 831, 563		30.00
43. 00 04300 NURSERY	0	39, 403		43.00
ANCILLARY SERVICE COST CENTERS				
50.00 05000 OPERATING ROOM	-675, 873	672, 734		50.00
52.00 05200 DELIVERY ROOM & LABOR ROOM	0	690, 974		52. 00
53. 00 05300 ANESTHESI OLOGY	0	737, 309		53.00
54. 00 05400 RADI OLOGY - DI AGNOSTI C	0	1, 380, 946		54.00
60. 00 06000 LABORATORY	0	1, 857, 729 0		60.00
62. 30 06250 BLOOD CLOTTING FOR HEMOPHILIACS 65. 00 06500 RESPIRATORY THERAPY	-60, 120	684, 526		62. 30 65. 00
66. 00 06600 PHYSI CAL THERAPY	-15, 236	783, 380		66. 00
67. 00 06700 OCCUPATI ONAL THERAPY	-13, 230	196, 710		67. 00
68. 00 06800 SPEECH PATHOLOGY	o	79, 014		68. 00
69. 00 06900 ELECTROCARDI OLOGY	0	8, 594		69. 00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	o	691, 795		71. 00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	o	764, 734		72. 00
73.00 07300 DRUGS CHARGED TO PATIENTS	o	1, 747, 707		73.00
76. 97 07697 CARDIAC REHABILITATION	o	0		76. 97
76. 98 07698 HYPERBARI C OXYGEN THERAPY	O	0		76. 98
76. 99 07699 LI THOTRI PSY	0	0		76. 99
OUTPATIENT SERVICE COST CENTERS				
91. 00 09100 EMERGENCY	-15, 000	1, 244, 431		91. 00
92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART				92. 00
OTHER REIMBURSABLE COST CENTERS	00.000	4 7/4 /04		05.00
95. 00 09500 AMBULANCE SERVICES	-23, 830	1, 761, 604		95. 00
SPECIAL PURPOSE COST CENTERS 113. 00 11300 INTEREST EXPENSE	1, 953	0		113. 00
118.00 SUBTOTALS (SUM OF LINES 1-117)	-6, 074, 628			113.00
NONREIMBURSABLE COST CENTERS	-0,074,020	34, 230, 070		116.00
190. 00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	O	0		190. 00
192. 00 19200 PHYSI CLANS' PRI VATE OFFI CES	-244, 153	82, 093		192. 00
194. 00 07950 OCC HEALTH	0	02,070		194. 00
194. 01 07951 PAIN CLINIC		o		194. 01
194. 02 07952 OCC HEALTH	O	0		194. 02
194. 03 07953 FOUNDATI 0	0	86, 900		194. 03
194.04 07954 KIDS CAMPUS	0	0	ŀ	194. 04
194.05 07955 COMMUNITY & VOLUNTEER SERVICES	0	463, 681		194. 05
194.06 07956 HUNTI NGTON COLLEGE NURSE	0	0		194. 06
194. 07 07957 MISC CATERING	0	90, 756		194. 07
194. 08 07958 AUTI SM CENTER	0	66, 741		194. 08
194. 09 07959 HUNTI NGTON BUA	0	0		194. 09
200.00 TOTAL (SUM OF LINES 118-199)	-6, 318, 781	35, 028, 247	į	200. 00

Peri od: From 01/01/2015 To 12/31/2015 Date/Ti me Prepared:

					0/28/2016 10:35 am
		Increases			
	Cost Center	Li ne #	Sal ary	Other 5.00	
	2. 00 A - CAFETERIA AND CATERING	3. 00	4. 00	5. 00	
1.00	CAFETERI A	11. 00	229, 178	174, 926	1.00
2.00	MISC CATERING	1 <u>94.</u> 07	5 <u>1, 2</u> 94	<u>39, 4</u> 62	2. 00
	0		280, 472	214, 388	
4 00	D - DEPRECIATION	0.00	ما	(05, 005	1.00
1. 00	CAP REL COSTS-MVBLE EQUIP		0	68 <u>5, 2</u> 35 685, 235	1. 00
	E - BUILDING AND EQUIPMENT		<u>U</u>	000, 200	
1. 00	CAP REL COSTS-MVBLE EQUIP	2.00	0	90, 707	1. 00
2.00	AUTISM CENTER	194. 08	0	66, 741	2. 00
3.00		0.00	0	О	3. 00
5.00		0.00	0	0	5. 00
6.00		0.00	0	0	6.00
7. 00 8. 00		0. 00 0. 00	0	0	7. 00 8. 00
9. 00		0.00	0	0	9.00
10. 00		0.00	0	Ö	10.00
12. 00		0.00	Ö	Ö	12. 00
13.00		0.00	0	О	13. 00
14.00		0.00	0	0	14. 00
15. 00			0	0	15. 00
	0 F - I NSURANCE		0	157, 448	
1.00	CAP REL COSTS-BLDG & FIXT	1.00	0	30, 157	1.00
2. 00	CAP REL COSTS-MVBLE EQUIP	2. 00	o	26, 144	2.00
	0			56, 301	
	G - LAUNDRY				
1. 00	LAUNDRY & LINEN SERVICE		32, 347	0	1.00
	H - HOME OFFICE SALARY		32, 347	0	
1.00	ADMI NI STRATI VE & GENERAL	5. 00	3, 524, 581	0	1.00
1.00	0		3, 524, 581	— — <u> </u>	1.00
	I - PTO	I	0, 02 1, 00 1		
1.00	ADMINISTRATIVE & GENERAL	5. 00	19, 748	0	1. 00
2.00	OPERATION OF PLANT	7. 00	39, 514	О	2. 00
3.00	HOUSEKEEPI NG	9. 00	37, 728	O	3.00
4.00	NURSI NG ADMI NI STRATI ON	13.00	23, 415	0	4.00
5. 00 6. 00	ADULTS & PEDIATRICS OPERATING ROOM	30. 00 50. 00	381, 288 109, 745	0	5. 00 6. 00
7. 00	RADI OLOGY-DI AGNOSTI C	54.00	107, 266	0	7. 00
8. 00	RESPIRATORY THERAPY	65. 00	74, 204	Ö	8. 00
9.00	PHYSI CAL THERAPY	66.00	120, 521	o	9. 00
10.00	DRUGS CHARGED TO PATIENTS	73. 00	70, 958	О	10.00
11.00	EMERGENCY	91. 00	130, 441	О	11. 00
12.00	AMBULANCE SERVICES	95.00	186, 608	0	12. 00
13.00	PHYSICIANS' PRIVATE OFFICES	192.00	7, 926	0	13.00
14. 00	PHARMACY			$$ $$ $\frac{0}{0}$	14. 00
	J - SALARY		1, 310, 130	U	
1.00	ADMINISTRATIVE & GENERAL	5. 00	0	1, 142	1. 00
2. 00	DI ETARY	10.00	0	7, 343	2. 00
	0			8, 485	
1 00	K - OCC HEALTH	404.60	-	40.500	4 22
1. 00 2. 00	OCC HEALTH	194. 02 0. 00	0	49, 599 0	1. 00 2. 00
2. 00 3. 00		0.00	0	0	3.00
4. 00		0.00	0	ő	4. 00
5. 00		0.00	o	ő	5. 00
6.00		0.00	0	0	6. 00
7. 00		0.00	•	0	7. 00
	U L LMDLANTS		0	49, 599	
1. 00	L - IMPLANTS IMPL. DEV. CHARGED TO	72.00	ol	764, 734	1.00
1.00	PATI ENTS	72.00	U	704, 734	1.00
	0	+		764, 734	
	M - OB				
1.00	NURSERY	43.00	35, 569	3, 834	1. 00
2.00	DELI VERY ROOM & LABOR ROOM	52.00	623, 739	6 <u>7, 2</u> 35	2. 00
	0 0 - THERAPY		659, 308	71, 069	
1. 00	O - THERAPY OCCUPATIONAL THERAPY	67.00	180, 844	15, 866	1.00
2. 00	SPEECH PATHOLOGY	68. 00	72, 642	6, 372	2. 00
	TOTALS		253, 486	22, 238	
500.00	Grand Total: Increases		6, 060, 324	2, 029, 497	500. 00
-	<u>'</u>	•			· · · · · · · · · · · · · · · · · · ·

RECLASSI FI CATIONS

Provi der CCN: 150091

Peri od: Worksheet A-6 From 01/01/2015

Date/Time Prepared:

12/31/2015

10/28/2016 10:35 am Decreases Cost Center Sal ary 0ther Wkst. A-7 Ref. Line # 6.00 7.00 8.00 9.00 10.00 - CAFETERIA AND CATERING 1.00 1.00 DI ETARY 10.00 280, 472 214, 388 0 0 2.00 0.00 2.00 280, 472 214, 388 D - DEPRECIATION 1.00 1.00 CAP REL COSTS-BLDG & FIXT 685, 235 9 1.00 0 685, 235 E - BUILDING AND EQUIPMENT 1.00 ADMINISTRATIVE & GENERAL 5.00 0 93, 940 10 1.00 OPERATION OF PLANT 0 2.00 7.00 347 0 2.00 3 00 DI FTARY 10.00 0 0 3 00 140 PHARMACY 5.00 15.00 0 12, 203 0 5.00 6.00 ADULTS & PEDIATRICS 30.00 o 1, 427 0 6.00 7.00 OPERATING ROOM 50.00 0 20, 410 0 7.00 RADI OLOGY-DI AGNOSTI C 0 0 8 00 54 00 8 00 117 0 9.00 RESPIRATORY THERAPY 65.00 0 1, 479 9.00 10.00 PHYSICAL THERAPY 66.00 o 17, 023 0 10.00 12.00 EMERGENCY 91.00 0 1, 412 0 12.00 0 7, 174 AMBULANCE SERVICES 95.00 0 13.00 13.00 14.00 PHYSICIANS' PRIVATE OFFICES 192.00 0 426 0 14.00 COMMUNITY & VOLUNTEER 194.05 15.00 1, 350 15.00 SERVI CES 0 157, 448 F - INSURANCE 5.00 1.00 ADMINISTRATIVE & GENERAL 0 56, 301 9 1.00 2.00 0.00 2.00 ō 56, 301 - LAUNDRY HOUSEKEEPI NG 1.00 9.00 32, 347 0 1.00 32, 347 H - HOME OFFICE SALARY 1.00 ADMINISTRATIVE & GENERAL 5.00 3, 524, 581 0 1.00 ō 3, 524, 581 I - PTO 1.00 EMPLOYEE BENEFITS DEPARTMENT 4.00 1, 310, 130 0 0 1.00 2.00 0.00 0 0 2.00 3.00 0.00 0 0 0 3.00 0 0 0 4.00 0.00 4.00 5.00 0.00 0 0 0 5.00 0 6.00 0.00 0 0 6.00 7 00 0 00 0 O 0 7 00 0 8.00 0.00 0 0 8.00 9.00 0.00 0 0 9.00 10.00 0.00 0 0 0 10.00 0 0 0 00 0 11 00 11 00 12.00 0.00 0 0 0 12.00 13.00 0.00 0 13.00 14.00 0.00 0 14.00 0 1, 310, 130 0 SALARY ADMINISTRATIVE & GENERAL 5.00 0 1.00 1, 142 1.00 DI ETARY <u>7, 3</u>43 2.00 0 10.00 2.00 0 8, 485 0 K - OCC HEALTH 1.00 RADI OLOGY-DI AGNOSTI C 54.00 12, 752 0 1.00 LABORATORY 60.00 0 2.00 232 0 2.00 3.00 PHYSICAL THERAPY 66.00 0 6, 302 0 3.00 4.00 4.00 MEDICAL SUPPLIES CHARGED TO 71.00 0 386 0 PATI ENT 5.00 DRUGS CHARGED TO PATIENTS 73.00 ol 0 5.00 2.732 91.00 6.00 EMERGENCY 0 22, 493 0 6.00 7.00 OPERATING ROOM 50.00 4, 702 0 7.00 ō 49, 599 - IMPLANTS 1.00 MEDICAL SUPPLIES CHARGED TO 71.00 0 764, 734 0 1.00 PATI ENT ō 764, 734 M - OB 1.00 ADULTS & PEDIATRICS 30.00 659.308 71,069 0 1.00 2.00 0 2.00 0.00 659, 308 71, 069

Н	leal th f	Financial Systems		HUNTI NGTON MEM	ORI AL	HOSPI TAL		In Lie	u of Form CMS-	2552-10
RECLASSI FI CATI ONS					Provi der	CCN: 150091	Peri od: From 01/01/2015	Worksheet A-6		
									Date/Time Pre	
			Decreases							
		Cost Center	Li ne #	Sal ary	0	ther	Wkst. A-7 Ref			
		6. 00	7. 00	8. 00	(9. 00	10. 00			

		Decreases				
	Cost Center	Li ne #	Sal ary	Other	Wkst. A-7 Ref.	
	6. 00	7. 00	8. 00	9. 00	10. 00	
	O - THERAPY					
1.00	PHYSI CAL THERAPY	66.00	253, 486	22, 238	3	1.00
2.00		0.00	0	C) (2.00
	TOTALS		253, 486	22, 238	3	
500.00	Grand Total: Decreases		2, 544, 228	5, 545, 593	3	500.00
	•					

				T	o 12/31/2015	Date/Time Pre 10/28/2016 10	
			·	Acqui si ti ons			
		Begi nni ng	Purchases	Donati on	Total	Di sposal s and	
		Bal ances				Retirements	
		1.00	2. 00	3. 00	4. 00	5. 00	
	PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET	T BALANCES					
1.00	Land	0	0	0	0	0	1. 00
2.00	Land Improvements	465, 871	0	0	0	0	2. 00
3.00	Buildings and Fixtures	1, 641, 580	285, 515	0	285, 515	0	3. 00
4.00	Building Improvements	32, 500	0	0	0	0	4. 00
5.00	Fi xed Equipment	1, 249, 874	538	0	538	0	5. 00
6.00	Movable Equipment	10, 565, 636	238, 188	0	238, 188	1, 300	6. 00
7.00	HIT designated Assets	2, 539, 169	203, 630	0	203, 630	0	7. 00
8.00	Subtotal (sum of lines 1-7)	16, 494, 630	727, 871	0	727, 871	1, 300	8. 00
9.00	Reconciling Items	2, 353, 119	232, 897	0	232, 897	0	9. 00
10. 00	Total (line 8 minus line 9)	14, 141, 511	494, 974	0	494, 974	1, 300	10.00
		Endi ng Bal ance	Fully				
			Depreci ated				
			Assets				
		6.00	7. 00				
	PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET	T BALANCES					
1.00	Land	0	0				1. 00
2.00	Land Improvements	465, 871	128, 649				2. 00
3.00	Buildings and Fixtures	1, 927, 095	138, 882				3. 00
4.00	Building Improvements	32, 500	0				4. 00
5.00	Fixed Equipment	1, 250, 412	530, 253				5. 00
6.00	Movable Equipment	10, 802, 524	7, 003, 581				6. 00
7.00	HIT designated Assets	2, 742, 799	0				7. 00
8.00	Subtotal (sum of lines 1-7)	17, 221, 201	7, 801, 365				8. 00
9.00	Reconciling Items	2, 586, 016	0				9. 00
10.00	Total (line 8 minus line 9)	14, 635, 185	7, 801, 365				10. 00

Heal th	Financial Systems	HUNTI NGTON MEMO	RIAL HOSPITAL		In Lie	u of Form CMS-2	2552-10
RECONC	CILIATION OF CAPITAL COSTS CENTERS		Provi der	CCN: 150091	Peri od: From 01/01/2015 To 12/31/2015		pared:
			SL	JMMARY OF CAP	I TAL	107 207 2010 10	00 4
	Cost Center Description	Depreciation	Lease	Interest	Insurance (see instructions)		
		9.00	10.00	11. 00	12.00	13.00	
	PART II - RECONCILIATION OF AMOUNTS FROM WOR	KSHEET A, COLUM	N 2, LINES 1 a	nd 2			
1.00	CAP REL COSTS-BLDG & FIXT	814, 062	0		0 0	0	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	0		0 0	0	2. 00
3.00	Total (sum of lines 1-2)	814, 062	0		0 0	0	3. 00
		SUMMARY O	F CAPITAL				
	Cost Center Description	Other	Total (1) (sum				
	·	Capi tal -Relate	of cols. 9				
		d Costs (see	through 14)				
		instructions)					
		14.00	15. 00				
	PART II - RECONCILIATION OF AMOUNTS FROM WOR	KSHEET A, COLUM	N 2, LINES 1 a	nd 2			
1.00	CAP REL COSTS-BLDG & FIXT	0	814, 062				1. 00
2.00	CAP REL COSTS-MVBLE EQUIP	0	0				2.00
0 00	T 1 1 (C1' 4 0)	1	044040	1			

0 0 0

814, 062

1. 00 2. 00 3. 00

1.00 CAP REL COSTS-BLDG & FLX1
2.00 CAP REL COSTS-MVBLE EQUIP
3.00 Total (sum of lines 1-2)

Heal th	Financial Systems	HUNTINGTON MEMO	ORIAL HOSPITAL		In Lie	eu of Form CMS-2	2552-10
RECON	CILIATION OF CAPITAL COSTS CENTERS		Provi der		Period: From 01/01/2015 To 12/31/2015		pared:
		COM	PUTATION OF RAT	TI OS	ALLOCATION OF	OTHER CAPITAL	
	Cost Center Description	Gross Assets		Gross Assets for Ratio (col. 1 - col 2)		Insurance	
	DART III DECONOLILIATION OF CARLTAL COCTO	1. 00	2.00	3. 00	4. 00	5. 00	
1. 00	PART III - RECONCILIATION OF CAPITAL COSTS CENTERS O CAP REL COSTS-BLDG & FIXT 3, 675, 878 0 3, 675, 878 0. 260400					0	1. 00
2. 00	CAP REL COSTS-BLDG & FIXT	10, 802, 524	l .				
3. 00	Total (sum of lines 1-2)	14, 478, 402					
0.00	Total (Sail of Tries 12)		TION OF OTHER (F CAPITAL	0.00
		Taxes					
	Cost Center Description		0ther	Total (sum of	Depreciation	Lease	
			Capi tal -Relate d Costs	cols. 5 through 7)			
		6. 00	7.00	8. 00	9. 00	10.00	
	PART III - RECONCILIATION OF CAPITAL COSTS C	ENTERS					
1.00	CAP REL COSTS-BLDG & FLXT	0	0		214, 755	0	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	0		0 654, 226		2. 00
3.00	Total (sum of lines 1-2)	0	0		868, 981	90, 707	3. 00
			Sl	JMMARY OF CAPI	TAL		
	Cost Center Description	Interest	Insurance (see	Taxes (see	0ther	Total (2) (sum	
			instructions)	instructions)	Capi tal -Rel ate		
					d Costs (see	through 14)	
		11 00	12.00	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		0 (214, 755	1.00
2.00	CAP REL COSTS-BEDG & TTXT		_		0 0	744, 933	
3.00	Total (sum of lines 1-2)				0		ı
2.00	1 (: :	1	1	1	-1	, ,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,	

| Period: | Worksheet A-8 | From 01/01/2015 | To 12/31/2015 | Date/Time Prepared: Health Financial Systems
ADJUSTMENTS TO EXPENSES Provider CCN: 150091

					o 12/31/2015	Date/Time Prep 10/28/2016 10:	
				Expense Classification on To/From Which the Amount is			. 33 alli
					-		
	Cost Center Description	Basi s/Code (2)	Amount	Cost Center	Li ne #	Wkst. A-7 Ref.	
1.00	Investment income - CAP REL	1.00	2.00	3.00 CAP REL COSTS-BLDG & FIXT	4. 00	5. 00 0	1. 00
	COSTS-BLDG & FIXT (chapter 2) Investment income - CAP REL						
2. 00	COSTS-MVBLE EQUIP (chapter 2)		U	CAP REL COSTS-MVBLE EQUIP	2.00		2. 00
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	o	4. 00
5.00	Refunds and rebates of		0		0.00	О	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	A	-2 007	ADMINISTRATIVE & GENERAL	5. 00	0	7. 00
7.00	stations excluded) (chapter 21)	^	2,007	Nomina Stratifica di Generale	0.00	Ŭ	7.00
8. 00	Television and radio service (chapter 21)	A	-493	OPERATION OF PLANT	7. 00	0	
9. 00 10. 00	Parking Lot (chapter 21) Provider-based physician	A-8-2	-704, 720		0.00	0 0	9. 00 10. 00
11. 00	adj ustment		0		0.00		
	Sale of scrap, waste, etc. (chapter 23)		-		0.00		
12. 00	Related organization transactions (chapter 10)	A-8-1	-1, 106, 281			0	12. 00
13. 00 14. 00	Laundry and linen service Cafeteria-employees and guests	А	-39, 671	CAFETERI A	0. 00 11. 00		13. 00 14. 00
15. 00	Rental of quarters to employee		0		0. 00		15. 00
16. 00	and others Sale of medical and surgical supplies to other than		0		0.00	0	16. 00
17. 00	patients 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 school (tuition, fees,		0		0.00	0	19. 00
20. 00	books, etc.) Vending machines	А	-7, 343	DI ETARY	10.00	0	20. 00
21. 00	Income from imposition of interest, finance or penalty charges (chapter 21)		0		0.00	0	21. 00
22. 00	Interest expense on Medicare overpayments and borrowings to		0		0. 00	0	22. 00
23. 00	repay Medicare overpayments Adjustment for respiratory therapy costs in excess of	A-8-3	0	RESPIRATORY THERAPY	65.00		23. 00
24. 00	limitation (chapter 14) Adjustment for physical	A-8-3	0	PHYSI CAL THERAPY	66. 00		24. 00
	therapy costs in excess of limitation (chapter 14)						
25. 00	Utilization review - physicians' compensation		0	*** Cost Center Deleted ***	114. 00		25. 00
26. 00	(chapter 21) Depreciation - CAP REL		0	CAP REL COSTS-BLDG & FIXT	1.00	0	26. 00
27. 00	COSTS-BLDG & FLXT Depreciation - CAP REL		0	CAP REL COSTS-MVBLE EQUIP	2. 00	0	27. 00
28. 00	COSTS-MVBLE EQUIP Non-physician Anesthetist		0	NONPHYSICIAN ANESTHETISTS	19. 00		28. 00
29. 00 30. 00	Physicians' assistant Adjustment for occupational	A-8-3	0	OCCUPATIONAL THERAPY	0. 00 67. 00		29. 00 30. 00
	therapy costs in excess of limitation (chapter 14)						
30. 99	Hospice (non-distinct) (see instructions)		0	ADULTS & PEDIATRICS	30.00		30. 99
31. 00	Adjustment for speech pathology costs in excess of	A-8-3	0	SPEECH PATHOLOGY	68. 00		31. 00
32. 00	limitation (chapter 14)		0		0.00	0	32. 00
33. 00	Depreciation and Interest OTHER ADJUSTMENTS (SPECIFY)		0		0.00	0	33. 00
30.00	(3)				0.00	l	55. 66

12/31/2015 Date/Time Prepared: 10/28/2016 10:35 am Expense Classification on Worksheet A To/From Which the Amount is to be Adjusted Cost Center Description Basis/Code (2) Amount Cost Center Line # Wkst. A-7 Ref. 1.00 2.00 3.00 4. 00 5.00 33. 01 TELEPHONE SERVICES -341 EMPLOYEE BENEFITS DEPARTMENT 33. 01 4.00 Α -2, 192 EMPLOYEE BENEFITS DEPARTMENT 33.02 VENDING Α 4.00 0 33.02 33. 03 VENDI NG Α -830 OPERATION OF PLANT 7.00 33.03 33.04 RENT -964, 968 ADMI NI STRATI VE & GENERAL 5.00 33.04 Α 33. 05 -18, 187 RESPIRATORY THERAPY -244, 153 PHYSICIANS' PRIVATE OFFICES RFNT 65.00 ol 33 05 Α 33.06 RENT Α 192.00 33.06 33. 07 PHARMACY EMPLOYEE PURCHASES В -712, 644 PHARMACY 15.00 33.07 33.08 PHYSICIAN RECRUITMENT -25.000 ADMINISTRATIVE & GENERAL 5.00 ol 33.08 Α SELF INSURANCE -1, 755, 133 EMPLOYEE BENEFITS DEPARTMENT 33.10 Α 4.00 33.10 33. 11 **GUEST MEALS** Α -23, 415 CAFETERI A 11.00 33.11 CONSULTING PT 33. 12 В -365 PHYSI CAL THERAPY 66.00 33.12 LOBBY DUES -3, 411 ADMINI STRATI VE & GENERAL 33 13 33 13 5 00 Α 33.14 LI QUOR Α -1, 559 ADMI NI STRATI VE & GENERAL 5.00 0 33.14 33. 18 OTHER OPERATING REVENUE В -8, 881 ADMINISTRATIVE & GENERAL 5.00 33. 18 -8, 856 DI ETARY OTHER OPERATING REVENUE 10.00 33.19 33.19 В OTHER OPERATING REVENUE -152, 379 CAFETERI A -584, 332 PHARMACY 33. 20 11.00 0 В 33.20 33. 21 OTHER OPERATING REVENUE В 15.00 0 33. 21 OTHER OPERATING REVENUE -35, 459 RESPIRATORY THERAPY 65.00 33. 24 33. 24 В OTHER OPERATING REVENUE В -14, 871 PHYSI CAL THERAPY 66.00 o 33. 25 33, 25 -8, 830 AMBULANCE SERVICES 33.27 OTHER OPERATING REVENUE 95.00 В 33.27 33. 29 **TELEMETRY** 29, 163 ADULTS & PEDIATRICS 30.00 33. 29 Α OTHER OPERATING REVENUE В -1, 011 ADULTS & PEDIATRICS 33.30 33. 30 30.00 OTHER OPERATING REVENUE -7, 627 OPERATING ROOM 33. 31 В 50.00 0 33. 31 DEPRECIATION 55, 771 CAP REL COSTS-BLDG & FIXT 34.00 Α 1.00 34 00 35.00 DEPRECIATION Α -57, 153 CAP REL COSTS-MVBLE EQUIP 2.00 35.00 1, 953 I NTEREST EXPENSE 36.00 INTEREST EXPENSE 113.00 36.00 Α 37.00 PHYS ADMIN SALARIES 86, 444 ADMINI STRATI VE & GENERAL 5.00 37.00 Α 50.00 TOTAL (sum of lines 1 thru 49) -6. 318. 781 50.00 (Transfer to Worksheet A, column 6, line 200.)

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

⁽²⁾ Basis for adjustment (see instructions)

A. Costs - if cost, including applicable overhead, can be determined.

B. Amount Received - if cost cannot be determined.

⁽³⁾ Additional adjustments may be made on lines 33 thru 49 and subscripts thereof.

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

Heal th	Financial Systems	HUNTI NGTON MEM	HUNTINGTON MEMORIAL HOSPITAL				
	ENT OF COSTS OF SERVICES FROM	RELATED ORGANIZATIONS AND HOM		Peri od:	Worksheet A-8	3-1	
OFFICE	COSTS			From 01/01/2015 To 12/31/2015			
	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		
	A. COSTS INCURRED AND ADJUSTM	MENTS REQUIRED AS A RESULT OF	TRANSACTIONS WITH RELATED OF	RGANIZATIONS OR	CLAI MED		
	HOME OFFICE COSTS:						
1.00	5. 00	ADMINISTRATIVE & GENERAL	HOME OFFICE ALLOCATIONS	9, 008, 499	7, 620, 000	1.00	
2.00	5. 00	ADMINISTRATIVE & GENERAL	PPG SUBSIDY	0	2, 494, 780	2.00	
3.00	0.00			0	0	3.00	
4.00	0. 00			0	0	4.00	
5.00	TOTALS (sum of lines 1-4).			9, 008, 499	10, 114, 780	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.

 as her seen peered to not keneer hij our amine I dilayer by the amount all ourself and be that our amin I of the parti							
			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 PARKVIEW HEALTH SYSTEM, INC. 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:

Transfer column 6, line 5 to Worksheet A-8, column 2,

line 12.

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

Heal th	Financial Syste	ems		HU	INTI NGTON	MEMORI AL	HOSPI TAL			In Lie	u of Form CMS-	2552-10
STATEME OFFICE	NT OF COSTS OF	SERVICES FROM	RELATED	ORGANI ZA	TIONS AND	HOME	Provi der	CCN:	150091	Peri od: From 01/01/2015	Worksheet A-8	3-1
OTTTOL	00313									To 12/31/2015	Date/Time Pro 10/28/2016 10	epared: D: 35 am
	Net	Wkst. A-7 Ref.										
	Adjustments											
	(col. 4 minus											
	col. 5)*											
	6. 00	7. 00										
	A. COSTS INCUR	RED AND ADJUST	MENTS RE	QUI RED AS	A RESULT	OF TRANS	ACTIONS WI	ITH R	ELATED C	RGANIZATIONS OR	CLAI MED	
	HOME OFFICE CO	STS:										
1.00	1, 388, 499	C										1. 00
2.00	-2, 494, 780	l c										2. 00
3.00	0											3. 00
4.00	0											4. 00
5 00	1 106 201	1	1									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.

1103 1101	been posted to worksheet A,	cordinate and or 2, the amount arrowable should be that cated the cordinate of this part.	
	Related Organization(s)		
	and/or Home Office		
	Type of Business		
	31		
	6. 00		
	B. INTERRELATIONSHIP TO RELAT	TED ORGANIZATION(S) AND/OR HOME OFFICE:	

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

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

	HOME OFFICE	6. 00
7.00		7. 00
8.00		8. 00
8. 00 9. 00		9. 00
10.00		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 organization.
- E. Individual is director, officer, administrator, or key person of provider and related organization.
- F. Director, officer, administrator, or key person of related organization or relative of such person has financial interest in provider.

					'	12/31/2013	10/28/2016 10	
	Wkst. A Line #	Cost Center/Physician	Total	Professi onal	Provi der	RCE Amount	Physi ci an/Prov	
		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	50. 00	OPERATING ROOM	691, 150	667, 150	24, 000	239, 400	199	1. 00
2.00	65. 00	RESPI RATORY THERAPY	6, 474	6, 474	0	0	0	2. 00
3.00	91. 00	EMERGENCY	15, 000	15, 000	0	0	0	3. 00
4.00	95. 00	AMBULANCE SERVICES	15, 000	15, 000	0	0	0	4. 00
5.00	0.00		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	0	8. 00
9.00	0.00		0	0	0	0	0	9. 00
10.00	0.00		0	0	0	0	0	10.00
200.00			727, 624	703, 624	24, 000		199	200.00
	Wkst. A Line #	Cost Center/Physician	Unadjusted RCE		Cost of	Provi der	Physician Cost	
		I denti fi er	Limit	Unadjusted RCE	Memberships &	Component	of Mal practice	
				Limit	Continuing	Share of col.	Insurance	
					Educati on	12		
	1. 00	2.00	8.00	9. 00	12. 00	13.00	14. 00	
1.00		OPERATING ROOM	22, 904	1, 145	0	0	0	1. 00
2.00	65. 00	RESPI RATORY THERAPY	0	0	0	0	0	2. 00
3.00		EMERGENCY	0	0	0	0	0	3. 00
4.00		AMBULANCE SERVICES	0	0	0	0	0	
5.00	0. 00		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	0	8. 00
9.00	0. 00		0	0	0	0	0	9. 00
10.00	0. 00		0	0	0	0	0	10. 00
200.00			22, 904			0	0	200. 00
	Wkst. A Line #	1	Provi der	Adjusted RCE	RCE	Adjustment		
		I denti fi er	Component	Limit	Di sal I owance			
			Share of col.					
	4.00	0.00	14	1/ 00	47.00	10.00		
1 00	1. 00	2.00	15. 00	16. 00	17. 00	18. 00		4.00
1.00		OPERATING ROOM	0			668, 246		1.00
2.00		RESPIRATORY THERAPY	0	0	0	6, 474		2.00
3.00		EMERGENCY	0	0	0	15, 000		3. 00
4.00		AMBULANCE SERVICES	0	0	0	15, 000		4. 00
5.00	0. 00		0	0	0	0		5. 00
6.00	0. 00		0	0	0	0		6. 00
7.00	0. 00		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		10.00
200. 00		l	0	22, 904	1, 096	704, 720	l	200. 00

Health Financial Systems HUNTINGTON MEMORIAL HOSPITAL In Lieu of Form CMS-2552-10 COST ALLOCATION - GENERAL SERVICE COSTS Provider CCN: 150091 Peri od: Worksheet B From 01/01/2015 Part I Date/Time Prepared: 12/31/2015 10/28/2016 10:35 am CAPITAL RELATED COSTS Cost Center Description Net Expenses BLDG & FIXT MVBLE EQUIP **EMPLOYEE** Subtotal for Cost **BENEFLTS** DEPARTMENT Allocation (from Wkst A col. 7) 1.00 2.00 4. 00 4A GENERAL SERVICE COST CENTERS 1 00 00100 CAP REL COSTS-BLDG & FLXT 214, 755 214, 755 1 00 2.00 00200 CAP REL COSTS-MVBLE EQUIP 744, 933 744, 933 2.00 4.00 00400 EMPLOYEE BENEFITS DEPARTMENT 2, 223, 086 2, 223, 329 4.00 243 00500 ADMINISTRATIVE & GENERAL 13, 133, 710 5 00 12, 367, 944 19,037 5 00 14, 144 732, 585 6.00 00600 MAINTENANCE & REPAIRS 6.00 7.00 00700 OPERATION OF PLANT 1, 164, 724 56, 484 30, 976 44, 079 1, 296, 263 7.00 8.00 00800 LAUNDRY & LINEN SERVICE 177, 424 1, 158 4, 268 182, 850 8.00 C 00900 HOUSEKEEPI NG 9 00 408, 366 943 37, 819 447, 128 0 9 00 10.00 01000 DI ETARY 148, 791 9,008 4, 261 8, 620 170,680 10.00 01100 CAFETERI A 194, 975 11.00 2.044 C 30, 242 227, 261 11.00 01200 MAINTENANCE OF PERSONNEL 12.00 12.00 0 n 01300 NURSING ADMINISTRATION 231, 620 13.00 205.500 O 26, 120 13.00 14.00 01400 CENTRAL SERVICES & SUPPLY 3, 508 3, 508 14.00 0 01500 PHARMACY 15.00 214, 425 2, 127 94, 721 70,650 381, 923 15.00 01600 MEDICAL RECORDS & LIBRARY 1, 175 1, 175 16,00 0 0 0 16,00 17 00 01700 SOCIAL SERVICE 0 0 0 Ω 17.00 19.00 01900 NONPHYSICIAN ANESTHETISTS 0 0 0 19.00 0 20.00 02000 NURSING SCHOOL 0 0 0 0 0 20.00 02100 I &R SERVICES-SALARY & FRINGES APPRV 0 21.00 0 0 21.00 0 0 02200 I&R SERVICES-OTHER PRGM COSTS APPRV O 22.00 0 r 0 0 22.00 02300 PARAMED ED PRGM-(SPECIFY) 23.00 0 23.00 INPATIENT ROUTINE SERVICE COST CENTERS 30 00 03000 ADULTS & PEDIATRICS 3, 335, 719 30.00 2.831.563 46, 331 119, 481 338.344 04300 NURSERY 43.00 39, 403 188 4,694 44, 285 43.00 ANCILLARY SERVICE COST CENTERS 50.00 05000 OPERATING ROOM 672, 734 17, 649 0 122, 425 812, 808 50.00 05200 DELIVERY ROOM & LABOR ROOM 690, 974 52.00 0 82, 307 773, 281 52.00 05300 ANESTHESI OLOGY 737, 309 53.00 737, 309 53.00 54.00 05400 RADI OLOGY-DI AGNOSTI C 1, 380, 946 22, 120 221, 178 119, 660 1, 743, 904 54.00 06000 LABORATORY 60.00 1,857,729 3, 351 \cap 1, 861, 080 60.00 06250 BLOOD CLOTTING FOR HEMOPHILIACS 62.30 0 62.30 06500 RESPIRATORY THERAPY 2, 479 65.00 684, 526 39, 354 82, 778 809, 137 65.00 06600 PHYSI CAL THERAPY 100, 996 912, 817 66.00 783.380 15, 328 13.113 66.00 06700 OCCUPATIONAL THERAPY 23, 864 196, 710 67.00 0 220, 574 67.00 68.00 06800 SPEECH PATHOLOGY 79,014 C 0 9,586 88,600 68.00 69.00 06900 ELECTROCARDI OLOGY 8, 594 0 8, 594 69.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT 691, 795 0 691, 795 71 00 Ω O 71 00 07200 IMPL. DEV. CHARGED TO PATIENTS 72.00 764, 734 C 0 764, 734 72.00 73.00 07300 DRUGS CHARGED TO PATIENTS 1, 747, 707 0 9, 363 1, 757, 070 73.00 07697 CARDIAC REHABILITATION 76. 97 0 0 76.97 0 0 0 07698 HYPERBARI C OXYGEN THERAPY 0 76. 98 76 98 0 Ω 0 0 76. 99 07699 LI THOTRI PSY 0 0 76.99 OUTPATIENT SERVICE COST CENTERS 91.00 09100 EMERGENCY 1. 244. 431 9. 428 40, 762 145, 512 1, 440, 133 91.00 09200 OBSERVATION BEDS (NON-DISTINCT PART 92.00 0 92.00 OTHER REIMBURSABLE COST CENTERS 09500 AMBULANCE SERVICES 95.00 1, 761, 604 6, 539 156, 286 208, 169 2, 132, 598 95.00 SPECIAL PURPOSE COST CENTERS 113.00 11300 INTEREST EXPENSE 113.00 118.00 SUBTOTALS (SUM OF LINES 1-117) 34, 238, 076 214, 247 739, 169 2, 202, 081 34, 210, 556 118. 00 NONREI MBURSABLE COST CENTERS 190.00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN 0 190.00 192.00 19200 PHYSICIANS' PRIVATE OFFICES 82,093 5,764 8, 842 96, 699 192. 00 194.00 07950 OCC HEALTH 508 194. 00 0 508 0 194. 01 07951 PAIN CLINIC 0 194. 01 0 0 0 194. 02 07952 OCC HEALTH 0 01194.02 C 0 194. 03 07953 FOUNDATI 0 86, 900 0 0 0 86, 900 194. 03 194. 04 07954 KIDS CAMPUS 0 194.04 194. 05 07955 COMMUNITY & VOLUNTEER SERVICES 0 0 469, 318 194. 05 463, 681 5, 637 194.06 07956 HUNTI NGTON COLLEGE NURSE 0 C 0 194, 06 194.07 07957 MISC CATERING 90, 756 97, 525 194. 07 6, 769 194.08 07958 AUTISM CENTER 66, 741 Ω 0 0 66, 741 194. 08 194. 09 07959 HUNTI NGTON BUA 0 194, 09 0 0 200.00 Cross Foot Adjustments 0 200. 00 201.00 Negative Cost Centers 0 201, 00 202.00 TOTAL (sum lines 118-201) 35, 028, 247 214, 755 744, 933 2, 223, 329 35, 028, 247 202. 00

				1	0 12/31/2015	10/28/2016 10	
	Cost Center Description	ADMI NI STRATI VE	MAINTENANCE &	OPERATION OF	LAUNDRY &	HOUSEKEEPI NG	00 (
		& GENERAL	REPAI RS	PLANT	LINEN SERVICE		
	CENEDAL CEDVICE COCT CENTEDS	5. 00	6. 00	7. 00	8. 00	9. 00	
1. 00	GENERAL SERVICE COST CENTERS 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	13, 133, 710					5. 00
6.00	00600 MAINTENANCE & REPAIRS	0	0				6. 00
7.00	00700 OPERATION OF PLANT	777, 579	0	2, 073, 842			7. 00
8.00	00800 LAUNDRY & LINEN SERVICE	109, 685		16, 695		l	8. 00
9.00	00900 HOUSEKEEPI NG	268, 215		13, 589	2, 053		9. 00
10.00	01000 DI ETARY	102, 384		129, 841	0	46, 444	10.00
11.00	01100 CAFETERI A	136, 325		29, 461	0	10, 538	11.00
12. 00 13. 00	01200 MAI NTENANCE OF PERSONNEL 01300 NURSI NG ADMI NI STRATI ON	138, 940	0	0	0	0	12. 00 13. 00
14. 00	01400 CENTRAL SERVICES & SUPPLY	2, 104		50, 561	3, 278		14.00
15. 00	01500 PHARMACY	229, 101		30, 655		10, 965	15. 00
16. 00	01600 MEDICAL RECORDS & LIBRARY	705	Ö	16, 933		6, 057	16. 00
17. 00	01700 SOCIAL SERVICE	0	l .	0	0	0	17. 00
19.00	01900 NONPHYSICIAN ANESTHETISTS	0	0	0	0	0	19. 00
20.00	02000 NURSI NG SCHOOL	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 SERVI CES-OTHER PRGM COSTS APPRV	0	0	0	0	0	22. 00
23. 00	O2300 PARAMED ED PRGM-(SPECIFY)	0	0	0	0	0	23. 00
30. 00	INPATIENT ROUTINE SERVICE COST CENTERS 03000 ADULTS & PEDIATRICS	2, 000, 978	0	667, 784	92, 072	238, 869	30.00
43. 00	04300 NURSERY	26, 565		1	3, 150		43. 00
10. 00	ANCILLARY SERVICE COST CENTERS	20,000		2,707	0, 100	700	10.00
50.00	05000 OPERATING ROOM	487, 573	0	254, 373	54, 140	90, 990	50.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	463, 862	0	0	22, 745	0	52. 00
53.00	05300 ANESTHESI OLOGY	442, 284	0	0	0	0	53. 00
54. 00	05400 RADI OLOGY-DI AGNOSTI C	1, 046, 102	0	318, 816		114, 041	54. 00
60.00	06000 LABORATORY	1, 116, 391	0	48, 305	0	17, 279	60.00
62. 30	06250 BLOOD CLOTTING FOR HEMOPHILIACS	405 271	0	0	20.4/1	12 770	62. 30
65. 00 66. 00	06500 RESPI RATORY THERAPY 06600 PHYSI CAL THERAPY	485, 371 547, 564	0	35, 725 220, 931	20, 461	12, 779 79, 027	65. 00 66. 00
67. 00	06700 OCCUPATIONAL THERAPY	132, 314		220, 731	0	74,027	67.00
68. 00	06800 SPEECH PATHOLOGY	53, 148	0	0	0	Ö	68. 00
69. 00	06900 ELECTROCARDI OLOGY	5, 155		ō	0	0	69. 00
71. 00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	414, 982	0	0	0	0	71. 00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	458, 735	0	0	0	0	72. 00
73. 00	07300 DRUGS CHARGED TO PATIENTS	1, 054, 000	0	0	0	0	73. 00
76. 97	07697 CARDI AC REHABI LI TATI ON	0	0	0	0	0	76. 97
76. 98 76. 99	07698 HYPERBARI C OXYGEN THERAPY 07699 LI THOTRI PSY	0	0	0	0	0	76. 98
70. 99	OUTPATIENT SERVICE COST CENTERS] 0	0	0	0	0	76. 99
91. 00	09100 EMERGENCY	863, 881	0	135, 892	77, 822	48, 609	91.00
92. 00	09200 OBSERVATION BEDS (NON-DISTINCT PART	330,331		100,072	7.7,022	10,007	92.00
	OTHER REIMBURSABLE COST CENTERS				l.		
95.00	09500 AMBULANCE SERVICES	1, 279, 265	0	94, 249	5, 659	33, 713	95. 00
	SPECIAL PURPOSE COST CENTERS		1				
	11300 INTEREST EXPENSE		_				113. 00
118. 00		12, 643, 208	0	2, 066, 517	305, 687	728, 365	1118. 00
100 00	NONREIMBURSABLE COST CENTERS 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	T 0		1	Ι ο	0	190. 00
	19200 PHYSI CLANS' PRI VATE OFFICES	58, 006			3, 543	•	192.00
	07950 OCC HEALTH	305	l .	7, 325			194. 00
	07951 PAIN CLINIC	0	l .	0	0		194. 01
	07952 OCC HEALTH	0	0	0	0	0	194. 02
194. 03	B 07953 FOUNDATI 0	52, 128	0	0	0	0	194. 03
	1 07954 KIDS CAMPUS	0	0	0	0		194. 04
	07955 COMMUNITY & VOLUNTEER SERVICES	281, 526	0	0	0	l .	194. 05
	07956 HUNTI NGTON COLLEGE NURSE	0	0	0	0	l .	194. 06
	7 07957 MI SC CATERI NG	58, 502		0	0	l	194. 07
	3 07958 AUTI SM CENTER 9 07959 HUNTI NGTON BUA	40, 035			0		194. 08 194. 09
200.00				1		l	200.00
201.00		0	0	0	n	n	200.00
202.00		13, 133, 710			309, 230	l e	
				•			

				To 12/31/2015	Date/Time Pre 10/28/2016 10	
Cost Center Description	DI ETARY	CAFETERI A	MAINTENANCE O	F NURSI NG	CENTRAL	. 33 aiii
			PERSONNEL	ADMI NI STRATI ON	SERVICES &	
					SUPPLY	
OFNEDAL CEDIM OF COCT OFNEDO	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 OO200 CAP REL COSTS-BLDG & FIXT						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 OO700 OPERATION OF PLANT						7. 00
8. 00 00800 LAUNDRY & LINEN SERVICE						8.00
9. 00 00900 EXCHANDE A ETINEN SERVICE						9. 00
10. 00 01000 DI ETARY	449, 349					10.00
11. 00 01100 CAFETERI A	447, 347	403, 585				11. 00
12. 00 01200 MAI NTENANCE OF PERSONNEL	o o	100, 000		0		12.00
13. 00 01300 NURSI NG ADMI NI STRATI ON	0	5, 818		0 376, 378		13. 00
14. 00 01400 CENTRAL SERVI CES & SUPPLY	o o	0, 010		0 0,0,0,0	77, 537	14. 00
15. 00 01500 PHARMACY	0	12, 130			938	15. 00
16. 00 01600 MEDI CAL RECORDS & LI BRARY	0	12, 100			0	16. 00
17. 00 01700 SOCIAL SERVICE	0	0			0	17. 00
19. 00 01900 NONPHYSI CLAN ANESTHETI STS	0	0			0	19. 00
20. 00 02000 NURSI NG SCHOOL	0	0			0	20. 00
21. 00 02100 L&R SERVI CES-SALARY & FRINGES APPRV	0	0			0	21. 00
22. 00 02200 L&R SERVICES-OTHER PRGM COSTS APPRV	0	0			0	22. 00
23. 00 02300 PARAMED ED PRGM-(SPECIFY)	0	0			0	23. 00
INPATIENT ROUTINE SERVICE COST CENTERS	-1	-	I.	-1		
30. 00 03000 ADULTS & PEDIATRICS	449, 349	95, 118		0 180, 691	6, 185	30.00
43. 00 04300 NURSERY	0	1, 350		0 2, 564	0	43. 00
ANCI LLARY SERVI CE COST CENTERS	-1	,		, , , , , , , , , , , , , , , , , , , ,		
50. 00 05000 OPERATING ROOM	0	34, 971		0 66, 434	9, 265	50.00
52.00 05200 DELIVERY ROOM & LABOR ROOM	0	23, 669		0 44, 964	0	52.00
53. 00 05300 ANESTHESI OLOGY	0	0		0 0	0	53.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	0	35, 463		o o	1, 972	54.00
60. 00 06000 LABORATORY	0	0		0 0	22	60.00
62.30 06250 BLOOD CLOTTING FOR HEMOPHILIACS	0	0		o o	0	62. 30
65. 00 06500 RESPI RATORY THERAPY	0	26, 404		0 0	2, 752	65. 00
66. 00 06600 PHYSI CAL THERAPY	0	33, 944		o o	851	66. 00
67. 00 06700 OCCUPATI ONAL THERAPY	0	0		o o	0	67. 00
68.00 06800 SPEECH PATHOLOGY	0	0		o o	0	68. 00
69. 00 06900 ELECTROCARDI OLOGY	0	0		o o	0	69. 00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0	0		0 0	47, 171	71. 00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0	0		0 0	0	72. 00
73.00 07300 DRUGS CHARGED TO PATIENTS	0	0		0 0	1, 097	73. 00
76. 97 07697 CARDIAC REHABILITATION	0	0		0 0	0	76. 97
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						
91. 00 09100 EMERGENCY	0	43, 020		0 81, 725	3, 852	91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART						92. 00
OTHER REIMBURSABLE COST CENTERS						
95. 00 09500 AMBULANCE SERVICES	0	78, 461		0 0	3, 104	95. 00
SPECIAL PURPOSE COST CENTERS						
113. 00 11300 I NTEREST EXPENSE						113. 00
118.00 SUBTOTALS (SUM OF LINES 1-117)	449, 349	390, 348		0 376, 378	77, 209	118. 00
NONREI MBURSABLE COST CENTERS						
190.00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0		0 0		190. 00
192.00 19200 PHYSI CLANS' PRI VATE OFFI CES	0	3, 917		0 0	310	192. 00
194. 00 07950 OCC HEALTH	0	0		0 0		194. 00
194. 01 07951 PAIN CLINIC	0	0		0 0		194. 01
194. 02 07952 OCC HEALTH	0	0		0 0	0	194. 02
194. 03 07953 FOUNDATI 0	0	2, 426		0 0	0	194. 03
194. 04 07954 KIDS CAMPUS	0	0		0 0		194. 04
194.05 07955 COMMUNITY & VOLUNTEER SERVICES	0	2, 362		이		194. 05
194.06 07956 HUNTI NGTON COLLEGE NURSE	0	0		이		194. 06
194. 07 07957 MISC CATERING	0	4, 532		이		194. 07
194.08 07958 AUTISM CENTER	0	0		이		194. 08
194. 09 07959 HUNTI NGTON BUA	0	0		이	0	194. 09
200.00 Cross Foot Adjustments						200. 00
201.00 Negative Cost Centers	0	0		0 0		201. 00
202.00 TOTAL (sum lines 118-201)	449, 349	403, 585		0 376, 378	77, 537	202. 00

Provider CCN: 150091

| Period: | Worksheet B | From 01/01/2015 | Part | To | 12/31/2015 | Date/Time Prepared: | 10/28/2016 10:35 am

					10/28/2016 10	
Cost Center Description	PHARMACY		SOCIAL SERVICE		NURSING SCHOOL	
		RECORDS & LI BRARY		ANESTHETI STS		
	15. 00	16. 00	17. 00	19. 00	20.00	
GENERAL SERVICE COST CENTERS						
1.00 O0100 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 O0700 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 MAI NTENANCE OF PERSONNEL						12.00
13. 00 01300 NURSI NG ADMI NI STRATI ON						13.00
14. 00 01400 CENTRAL SERVICES & SUPPLY	//5 710					14. 00
15. 00 01500 PHARMACY	665, 712	24 070				15. 00
16. 00 01600 MEDI CAL RECORDS & LI BRARY 17. 00 01700 SOCI AL SERVI CE	0	24, 870				16.00
17. 00 01700 SOCI AL SERVI CE 19. 00 01900 NONPHYSI CI AN ANESTHETI STS	0	0	0	0		17. 00 19. 00
20. 00 02000 NURSI NG SCHOOL		0		0	0	1
21. 00 02100 1 &R SERVICES-SALARY & FRINGES APPRV		0			ĺ	21.00
22. 00 02200 &R SERVI CES-OTHER PRGM COSTS APPRV		0				22. 00
23. 00 02300 PARAMED ED PRGM- (SPECIFY)		0				23. 00
INPATIENT ROUTINE SERVICE COST CENTERS	9	J				20.00
30. 00 03000 ADULTS & PEDIATRICS	0	1, 471	0	0	0	30.00
43. 00 04300 NURSERY	l ol	161	Ö			1
ANCILLARY SERVICE COST CENTERS	· · · · · · · · · · · · · · · · · · ·					
50. 00 05000 OPERATING ROOM	0	3, 310	0	0	0	50.00
52.00 05200 DELIVERY ROOM & LABOR ROOM	o	592	0	0	0	52. 00
53. 00 05300 ANESTHESI OLOGY	0	511	0	0	0	53.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	o	5, 434	0	0	0	54.00
60. 00 06000 LABORATORY	o	2, 559	0	0	0	60.00
62.30 06250 BLOOD CLOTTING FOR HEMOPHILIACS	o	0	0	0	0	62. 30
65. 00 06500 RESPI RATORY THERAPY	o	875	0	0	0	65. 00
66. 00 06600 PHYSI CAL THERAPY	0	590	0	0	0	66. 00
67. 00 06700 OCCUPATI ONAL THERAPY	0	161	0	0	0	67. 00
68.00 06800 SPEECH PATHOLOGY	0	64	0	0	0	
69. 00 06900 ELECTROCARDI OLOGY	0	142	0	0	0	
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0	1, 677	0	0	0	
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	665, 712	911	0	0	0	
73.00 07300 DRUGS CHARGED TO PATIENTS	0	2, 257	0	0	0	
76. 97 07697 CARDI AC REHABI LI TATI ON	0	0	0	0	0	1
76. 98 07698 HYPERBARI C OXYGEN THERAPY	0	0	0	0	0	
76. 99 07699 LI THOTRI PSY	0	0	0	0	0	76. 99
OUTPATIENT SERVICE COST CENTERS		2.047				01 00
91. 00 09100 EMERGENCY 92. 00 09200 0BSERVATION BEDS (NON-DISTINCT PART	0	3, 047	0	0	0	
92. 00 09200 0BSERVATION BEDS (NON-DISTINCT PART OTHER REIMBURSABLE COST CENTERS						92. 00
95. 00 O9500 AMBULANCE SERVI CES	0	1, 108	0	0	0	95. 00
SPECIAL PURPOSE COST CENTERS	<u> </u>	1, 100		0		75.00
113. 00 11300 NTEREST EXPENSE						113. 00
118.00 SUBTOTALS (SUM OF LINES 1-117)	665, 712	24, 870	0	0	1 0	118. 00
NONREI MBURSABLE COST CENTERS	000,712	21,070			, and the second	1110.00
190.00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	O	0	0	0	0	190. 00
192. 00 19200 PHYSI CLANS' PRI VATE OFFI CES	o	0	0	0		192. 00
194. 00 07950 OCC HEALTH	o	0	0	0	ĺ	194. 00
194. 01 07951 PAIN CLINIC	o	0	0	0	0	194. 01
194. 02 07952 OCC HEALTH	o	0	0	0	ĺ	194. 02
194. 03 07953 FOUNDATI 0	O	0	0	0	0	194. 03
194.04 07954 KIDS CAMPUS	o	0	0	0	0	194. 04
194. 05 07955 COMMUNITY & VOLUNTEER SERVICES	0	0	0	0		194. 05
194.06 07956 HUNTI NGTON COLLEGE NURSE	0	0	0	0		194. 06
194. 07 07957 MISC CATERING	0	0	0	0		194. 07
194.08 07958 AUTISM CENTER	0	0	0	0		194. 08
194. 09 07959 HUNTI NGTON BUA	0	0	0	0		194. 09
200.00 Cross Foot Adjustments				0		200. 00
201.00 Negative Cost Centers	0	0	0			201. 00
202.00 TOTAL (sum lines 118-201)	665, 712	24, 870	0	0	0	202. 00

Health Financial Systems HUNTINGTON MEMORIAL HOSPITAL In Lieu of Form CMS-2552-10 COST ALLOCATION - GENERAL SERVICE COSTS Provi der CCN: 150091 Peri od: Worksheet B From 01/01/2015 Part I Date/Time Prepared: 12/31/2015 10/28/2016 10:35 am INTERNS & RESIDENTS Cost Center Description SERVI CES-SALAR SERVI CES-OTHER PARAMED ED Subtotal Intern & Y & FRINGES PRGM COSTS Residents Cost PRGM **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 & FLXT 1 00 2.00 00200 CAP REL COSTS-MVBLE EQUIP 2 00 4.00 00400 EMPLOYEE BENEFITS DEPARTMENT 4.00 00500 ADMINISTRATIVE & GENERAL 5 00 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 00900 HOUSEKEEPI NG 9 00 9 00 10.00 01000 DI ETARY 10.00 01100 CAFETERI A 11.00 11.00 01200 MAINTENANCE OF PERSONNEL 12.00 12.00 01300 NURSING ADMINISTRATION 13.00 13.00 14.00 01400 CENTRAL SERVICES & SUPPLY 14.00 01500 PHARMACY 15.00 15.00 01600 MEDICAL RECORDS & LIBRARY 16.00 16,00 17 00 01700 SOCIAL SERVICE 17 00 19.00 01900 NONPHYSICIAN ANESTHETISTS 19.00 20.00 02000 NURSING SCHOOL 20.00 02100 I &R SERVICES-SALARY & FRINGES APPRV 21.00 0 21.00 02200 I&R SERVICES-OTHER PRGM COSTS APPRV 22.00 C 22.00 02300 PARAMED ED PRGM-(SPECIFY) 23.00 23.00 INPATIENT ROUTINE SERVICE COST CENTERS 30 00 03000 ADULTS & PEDIATRICS 30.00 0 0 0 7,068,236 0 04300 NURSERY 0 43.00 0 C 81, 750 0 43.00 ANCILLARY SERVICE COST CENTERS 50.00 05000 OPERATING ROOM 0 0 0 1, 813, 864 0 50.00 05200 DELIVERY ROOM & LABOR ROOM 0 0 52.00 0 1, 329, 113 0 52.00 05300 ANESTHESI OLOGY 0 1, 180, 104 53.00 53.00 000000000000 0 0 54.00 05400 RADI OLOGY-DI AGNOSTI C 0 3, 290, 039 0 54.00 0 06000 LABORATORY 0 60.00 3, 045, 636 Λ 60.00 06250 BLOOD CLOTTING FOR HEMOPHILIACS 62. 30 0 0 62.30 06500 RESPIRATORY THERAPY 0 1, 393, 504 65.00 0 0 65.00 06600 PHYSI CAL THERAPY 0 1, 795, 724 66.00 66.00 06700 OCCUPATIONAL THERAPY 0 0 353, 049 67.00 0 67.00 68.00 06800 SPEECH PATHOLOGY 0 0 141, 812 0 68.00 69.00 06900 ELECTROCARDI OLOGY 13, 891 69.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT 0 0 71 00 1 155 625 0 71 00 07200 IMPL. DEV. CHARGED TO PATIENTS 0 72.00 0 1, 890, 092 0 72.00 73.00 07300 DRUGS CHARGED TO PATIENTS 0 2, 814, 424 0 73.00 07697 CARDIAC REHABILITATION 0 0 76. 97 0 0 76.97 0 07698 HYPERBARI C OXYGEN THERAPY 0 76. 98 76 98 Ω 0 0 76. 99 07699 LI THOTRI PSY 0 0 0 76.99 OUTPATIENT SERVICE COST CENTERS 91.00 09100 EMERGENCY 0 0 0 2. 697. 981 0 91.00 09200 OBSERVATION BEDS (NON-DISTINCT PART 92.00 Ω 92.00 OTHER REIMBURSABLE COST CENTERS 09500 AMBULANCE SERVICES 0 95.00 95.00 0 0 3, 628, 157 0 SPECIAL PURPOSE COST CENTERS 113.00 11300 INTEREST EXPENSE 113.00 118.00 SUBTOTALS (SUM OF LINES 1-117) 0 0 33, 693, 001 0 118.00 0 NONREI MBURSABLE COST CENTERS 190.00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN 0 190.00 0 Ω 0 0 192.00 19200 PHYSICIANS' PRIVATE OFFICES 0 162, 475 0 192.00 000000000000000 194.00 07950 OCC HEALTH 0 0 194.00 0 10, 758 194. 01 07951 PAIN CLINIC 0 194. 01 0 0 194. 02 07952 OCC HEALTH 0 0 194.02 0 194. 03 07953 FOUNDATI 0 0 0 141, 454 0 194. 03 194. 04 07954 KIDS CAMPUS 0 194. 04 194. 05 07955 COMMUNITY & VOLUNTEER SERVICES 0 0 0 194. 05 753, 224 194.06 07956 HUNTI NGTON COLLEGE NURSE 0 0 194.06 0 194.07 07957 MISC CATERING 160, 559 0 194. 07 194.08 07958 AUTISM CENTER 0 0 106, 776 0 194. 08 194. 09 07959 HUNTI NGTON BUA 0 0 194, 09 0 0 200.00 Cross Foot Adjustments 0 0 0 200. 00 201.00 Negative Cost Centers 0 0 0 201.00 TOTAL (sum lines 118-201) 35, 028, 247 0 202.00 202.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 150091 Pc

Peri od: Worksheet B From 01/01/2015 Part I To 12/31/2015 Date/Time Prepared:

10/28/2016 10:35 am 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 4.00 00400 EMPLOYEE BENEFITS DEPARTMENT 4.00 00500 ADMINISTRATIVE & GENERAL 5.00 5 00 6.00 00600 MAINTENANCE & REPAIRS 6.00 00700 OPERATION OF PLANT 7.00 7.00 00800 LAUNDRY & LINEN SERVICE 8.00 8.00 00900 HOUSEKEEPI NG 9.00 9.00 10.00 01000 DI ETARY 10.00 01100 CAFETERI A 11.00 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 01700 SOCIAL SERVICE 17.00 17.00 19.00 01900 NONPHYSICIAN ANESTHETISTS 19.00 20.00 02000 NURSING SCHOOL 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 7, 068, 236 30.00 04300 NURSERY 81, 750 43.00 43.00 ANCILLARY SERVICE COST CENTERS 50.00 05000 OPERATING ROOM 1 813 864 50.00 52.00 05200 DELIVERY ROOM & LABOR ROOM 1, 329, 113 52.00 05300 ANESTHESI OLOGY 1, 180, 104 53.00 53.00 05400 RADI OLOGY-DI AGNOSTI C 3, 290, 039 54.00 54.00 60.00 06000 LABORATORY 3, 045, 636 60 00 62.30 06250 BLOOD CLOTTING FOR HEMOPHILIACS 62.30 65 00 06500 RESPIRATORY THERAPY 1, 393, 504 65.00 1, 795, 724 06600 PHYSI CAL THERAPY 66.00 66.00 06700 OCCUPATIONAL THERAPY 67.00 353,049 67 00 68.00 06800 SPEECH PATHOLOGY 141, 812 68.00 06900 ELECTROCARDI OLOGY 69.00 13, 891 69.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT 71.00 1, 155, 625 71.00 72.00 07200 I MPL. DEV. CHARGED TO PATIENTS 1, 890, 092 72.00 73.00 07300 DRUGS CHARGED TO PATIENTS 2, 814, 424 73.00 07697 CARDIAC REHABILITATION 76. 97 0 76. 97 07698 HYPERBARI C OXYGEN THERAPY 76. 98 0 76. 98 07699 LI THOTRI PSY 76.99 0 76.99 OUTPATIENT SERVICE COST CENTERS 91.00 09100 EMERGENCY 2, 697, 981 91.00 09200 OBSERVATION BEDS (NON-DISTINCT PART 92.00 92.00 OTHER REIMBURSABLE COST CENTERS 95.00 09500 AMBULANCE SERVICES 3, 628, 157 95.00 SPECIAL PURPOSE COST CENTERS 113.00 11300 INTEREST EXPENSE 113.00 118.00 SUBTOTALS (SUM OF LINES 1-117) 33, 693, 001 118.00 NONREI MBURSABLE COST CENTERS 190.00 190.00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN 192.00 19200 PHYSICIANS' PRIVATE OFFICES 162, 475 192.00 194.00 07950 OCC HEALTH 10, 758 194.00 194. 01 07951 PAIN CLINIC 194. 01 O 194. 02 07952 OCC HEALTH 0 194.02 194. 03 07953 FOUNDATI 0 194. 03 141, 454 194.04 07954 KIDS CAMPUS 194.04 194. 05 07955 COMMUNITY & VOLUNTEER SERVICES 194 05 753, 224 194.06 07956 HUNTI NGTON COLLEGE NURSE 194.06 194. 07 07957 MISC CATERING 194. 07 160, 559 194.08 07958 AUTISM CENTER 194. 08 106, 776 194.09 07959 HUNTI NGTON BUA 194 09 0 200.00 Cross Foot Adjustments 0 200.00 201.00 Negative Cost Centers 201.00 202.00 TOTAL (sum lines 118-201) 35, 028, 247 202.00

| Peri od: | Worksheet B | From 01/01/2015 | Part | I | To 12/31/2015 | Date/Time Prepared: | 12/31/2015 | Date/Time Prep Health Financial Systems
ALLOCATION OF CAPITAL RELATED COSTS Provider CCN: 150091

					То	12/31/2015	Date/Time Pre 10/28/2016 10	
				CAPI TAL REI	LATED COSTS		1072072010 10	33 dili
		Cook Cooks Doors at the	D:+1	DIDC & FLVT	M/DLE FOLLD	C	EMDL OVEE	
		Cost Center Description	Directly Assigned New	BLDG & FIXT	MVBLE EQUIP	Subtotal	EMPLOYEE BENEFITS	
			Capi tal				DEPARTMENT	
			Related Costs	1.00	0.00			
	GENER	AL SERVICE COST CENTERS	0	1. 00	2.00	2A	4. 00	
1.00		CAP REL COSTS-BLDG & FIXT						1. 00
2.00		CAP REL COSTS-MVBLE EQUIP						2.00
4.00		EMPLOYEE BENEFITS DEPARTMENT	0	243		243	243	4. 00
5.00		ADMINISTRATIVE & GENERAL	2, 264, 702	14, 144		2, 297, 883	84	5. 00
6. 00 7. 00		MAINTENANCE & REPAIRS OPERATION OF PLANT	0	0 56, 484		87, 460	0 5	6. 00 7. 00
8. 00		LAUNDRY & LINEN SERVICE	0	1, 158		1, 158	0	8. 00
9.00	00900	HOUSEKEEPI NG	0	943		943	4	9. 00
10.00	1	DI ETARY	0	9, 008		13, 269	1	10.00
11. 00 12. 00	1	CAFETERIA	0	2, 044 0	1	2, 044 0	3	11. 00 12. 00
13. 00	1	MAINTENANCE OF PERSONNEL NURSING ADMINISTRATION	0	0	_	0	3	13. 00
14. 00	1	CENTRAL SERVICES & SUPPLY	0	3, 508	-	3, 508	0	14. 00
15. 00		PHARMACY	0	2, 127	94, 721	96, 848	7	15.00
16. 00	1	MEDICAL RECORDS & LIBRARY	0	1, 175	0	1, 175	0	16. 00
17. 00 19. 00	1	SOCIAL SERVICE	0	0	0	0	0	17. 00
20. 00	1	NONPHYSICIAN ANESTHETISTS NURSING SCHOOL	0	0		0	0	19. 00 20. 00
21. 00	1	I&R SERVICES-SALARY & FRINGES APPRV	0	0	Ö	o	0	21. 00
22. 00		I&R SERVICES-OTHER PRGM COSTS APPRV	0	0	0	0	0	22.00
23. 00		PARAMED ED PRGM-(SPECIFY)	0	0	0	0	0	23. 00
20.00		ADULTS & PEDIATRICS	0	44 221	119, 481	145 013	24	30. 00
30. 00 43. 00	1	NURSERY	0	46, 331 188		165, 812 188	36 0	43. 00
10.00		LARY SERVICE COST CENTERS	<u> </u>	100	<u> </u>			10.00
50.00		OPERATING ROOM	0	17, 649	0	17, 649	13	50.00
52. 00		DELIVERY ROOM & LABOR ROOM	0	0		0	9	52.00
53. 00 54. 00	1	ANESTHESI OLOGY RADI OLOGY-DI AGNOSTI C	0	0 22, 120	-	0 243, 298	0 13	53. 00 54. 00
60.00		LABORATORY	0	3, 351		3, 351	0	60.00
62. 30		BLOOD CLOTTING FOR HEMOPHILIACS	0	0		0	0	62. 30
65. 00	1	RESPI RATORY THERAPY	0	2, 479	39, 354	41, 833	9	65. 00
66. 00	1	PHYSI CAL THERAPY	0	15, 328	13, 113	28, 441	11	66. 00
67. 00 68. 00	1	OCCUPATIONAL THERAPY SPEECH PATHOLOGY	0	0	0	0	3	67. 00 68. 00
69. 00	1	ELECTROCARDI OLOGY	0	0		o	0	69. 00
71. 00		MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	Ö	ō	0	71. 00
72. 00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00		DRUGS CHARGED TO PATIENTS	0	0	0	0	1	73.00
76. 97 76. 98		CARDIAC REHABILITATION HYPERBARIC OXYGEN THERAPY	0	0	0	0	0	76. 97 76. 98
76. 99		LI THOTRI PSY	0	0		o	0	76. 99
		TIENT SERVICE COST CENTERS				1		
91.00		EMERGENCY	0	9, 428	40, 762	50, 190	15	
92. 00		OBSERVATION BEDS (NON-DISTINCT PART REIMBURSABLE COST CENTERS				0		92. 00
95. 00		AMBULANCE SERVICES	0	6, 539	156, 286	162, 825	22	95. 00
70.00		AL PURPOSE COST CENTERS		0,007	100/200	1027 020		70.00
		INTEREST EXPENSE						113. 00
118. 00		SUBTOTALS (SUM OF LINES 1-117)	2, 264, 702	214, 247	739, 169	3, 218, 118	240	118. 00
100 00		MBURSABLE COST CENTERS GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	O	ol	0	190. 00
		PHYSICIANS' PRIVATE OFFICES	0	0		5, 764		190.00
		OCC HEALTH	0	508		508		194. 00
		PAIN CLINIC	0	0	0	o		194. 01
		OCC HEALTH	0	0	0	0		194. 02
	1	FOUNDATIO KIDS CAMPUS	0	0	0	O		194. 03 194. 04
		COMMUNITY & VOLUNTEER SERVICES		0		0		194. 04 194. 05
		HUNTI NGTON COLLEGE NURSE	O	Ö	l o	Ö		194. 06
194. 07	07957	MISC CATERING	0	0	0	o		194. 07
		AUTI SM CENTER	0	0	0	0		194. 08
194. 09 200. 00		HUNTINGTON BUA Cross Foot Adjustments	O	0	0	0	0	194. 09 200. 00
200.00	1	Negative Cost Centers		0	0	ol	0	200.00
202.00		TOTAL (sum lines 118-201)	2, 264, 702	214, 755	744, 933	3, 224, 390		202. 00

Health Financial Systems
ALLOCATION OF CAPITAL RELATED COSTS

Provi der CCN: 150091 Peri od: From 01/01/2

	0/28/2016 10: 35 am 0USEKEEPI NG 9. 00
5. 00 6. 00 7. 00 8. 00 GENERAL SERVICE COST CENTERS	
GENERAL SERVI CE COST CENTERS	
	1.00
2. 00 00200 CAP REL COSTS-MVBLE EQUI P	2. 00
4. OO OO4OO EMPLOYEE BENEFITS DEPARTMENT	4. 00
5. 00 00500 ADMINI STRATI VE & GENERAL 2, 297, 967	5. 00
6. 00 00600 MAI NTENANCE & REPAI RS 0 0	6. 00
7. 00 00700 OPERATI ON OF PLANT 136, 051 0 223, 516	7. 00
8. 00 00800 LAUNDRY & LI NEN SERVI CE 19, 191 0 1, 799 22, 148	8. 00
9. 00 00900 HOUSEKEEPI NG 46, 929 0 1, 465 147	49, 488 9. 00
10. 00 01000 DI ETARY	3, 144 10. 00
11. 00 01100 CAFETERI A 23, 852 0 3, 175 0 3	713 11. 00
12. 00 01200 MAI NTENANCE OF PERSONNEL 0 0 0 0 0 13. 00 01300 NURSI NG ADMI NI STRATI ON 24, 310 0 0 0	0 12.00 0 13.00
14. 00 01400 CENTRAL SERVI CES & SUPPLY 368 0 5, 449 235	1, 224 14. 00
15. 00 01500 PHARMACY 40, 085 0 3, 304 0	742 15. 00
16. 00 01600 MEDI CAL RECORDS & LI BRARY 123 0 1, 825 0	410 16.00
17. 00 01700 SOCIAL SERVICE 0 0 0	0 17.00
19.00 01900 NONPHYSICIAN ANESTHETISTS 0 0 0 0	0 19.00
20. 00 02000 NURSI NG SCH00L 0 0 0 0	0 20.00
21.00 02100 1&R SERVI CES-SALARY & FRINGES APPRV 0 0 0 0	0 21.00
22. 00 02200 1&R SERVI CES-0THER PRGM COSTS APPRV 0 0 0 0	0 22.00
23. 00 02300 PARAMED ED PRGM-(SPECIFY) 0 0 0 0	0 23.00
INPATIENT ROUTINE SERVICE COST CENTERS 350, 107 0 71, 973 6, 594	16, 173 30. 00
43. 00 04300 NURSERY	66 43.00
ANCI LLARY SERVI CE COST CENTERS	00 43.00
50. 00 05000 OPERATI NG ROOM 85, 309 0 27, 416 3, 878	6, 160 50. 00
52.00 05200 DELIVERY ROOM & LABOR ROOM 81,160 0 0 1,629	0 52.00
53. 00 05300 ANESTHESI OLOGY 77, 385 0 0 0	0 53.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C 183, 033 0 34, 362 1, 741	7, 721 54. 00
60. 00 06000 LABORATORY 195, 332 0 5, 206 0	1, 170 60. 00
62. 30 06250 BLOOD CLOTTING FOR HEMOPHILIACS 0 0 0 0 0 0 0 0 0	0 62.30
65. 00 06500 RESPI RATORY THERAPY 84, 924 0 3, 850 1, 465	865 65.00
66. 00 06600 PHYSI CAL THERAPY 95, 806 0 23, 812 0 67. 00 06700 0CCUPATI ONAL THERAPY 23, 151 0 0 0	5, 350 66. 00 0 67. 00
68. 00 06800 SPEECH PATHOLOGY 9, 299 0 0 0	0 68.00
69. 00 06900 ELECTROCARDI OLOGY 902 0 0	0 69.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT 72,608 0 0	0 71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS 80,263 0 0	0 72.00
73.00 07300 DRUGS CHARGED TO PATIENTS 184,415 0 0 0	0 73.00
76.97 07697 CARDIAC REHABILITATION 0 0 0 0	0 76. 9
76. 98 07698 HYPERBARI C OXYGEN THERAPY 0 0 0 0	0 76. 98
76. 99 07.699 LI THOTRI PSY 0 0 0 0	0 76. 99
0UTPATI ENT SERVI CE COST CENTERS 91. 00 09100 EMERGENCY 151. 151 0 14. 646 5. 574	2 201 01 0
91. 00 09100 EMERGENCY 151, 151 0 14, 646 5, 574 92. 00 09200 OBSERVATI ON BEDS (NON-DI STI NCT PART	3, 291 91. 00 92. 00
OTHER REIMBURSABLE COST CENTERS	92.00
95. 00 09500 AMBULANCE SERVI CES 223, 829 0 10, 158 405	2, 282 95. 00
SPECIAL PURPOSE COST CENTERS	
113. 00 11300 I NTEREST EXPENSE	113. 00
118. 00 SUBTOTALS (SUM OF LINES 1-117) 2, 212, 145 0 222, 726 21, 894	49, 311 118. 00
NONREI MBURSABLE COST CENTERS	
190. OO 1900OO GIFT, FLOWER, COFFEE SHOP & CANTEEN O O O	0 190. 00
192. 00 19200 PHYSI CI ANS' PRI VATE OFFI CES 10, 149 0 0 254	0 192. 00
194. 00 07950 OCC HEALTH 53 0 790 0 194. 01 07951 PAIN CLINIC 0 0 0	177 194. 00 0 194. 0
194. 01 07931 PATN CETNIC 0 0 0 0	0 194. 0
194. 03 07953 FOUNDATIO 9, 121 0 0	0 194. 0
194. 04 07954 KI DS CAMPUS 0 0 0	0 194. 0
194. 05 07955 COMMUNI TY & VOLUNTEER SERVI CES 49, 258 0 0 0	0 194. 0
194.06 07956 HUNTI NGTON COLLEGE NURSE 0 0 0	0 194. 0
194. 07 07957 MISC CATERING 10, 236 0 0	0 194. 0
194. 08 07958 AUTI SM CENTER 7, 005 0 0	0 194. 08
194. 09 07959 HUNTI NGTON BUA 0 0 0	0 194. 0
200.00 Cross Foot Adjustments	200. 00
201.00 Negative Cost Centers 0 0 0 0 0 0 0 0 0	0 201. 00 49, 488 202. 00
202.00 TOTAL (sum lines 118-201) 2,297,967 0 223,516 22,148	47, 488 ZUZ. U

Provider CCN: 150091

| In Lieu of Form CMS-2552-10 | Period: | Worksheet B | From 01/01/2015 | Part II | To 12/31/2015 | Date/Time Prepared: | 10/28/2016 10:35 am

					10/28/2016 10	35 am
Cost Center Description	DI ETARY	CAFETERI A	MAINTENANCE OF PERSONNEL	NURSI NG ADMI NI STRATI ON	CENTRAL SERVICES &	
					SUPPLY	
GENERAL SERVI CE COST CENTERS	10.00	11. 00	12. 00	13. 00	14. 00	
1.00 O0100 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						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	48, 322					10.00
11. 00 01100 CAFETERI A	0	29, 787				11. 00
12. 00 01200 MAINTENANCE OF PERSONNEL	o	27,707				12. 00
13. 00 01300 NURSING ADMINISTRATION	0	429		24, 742		13. 00
14. 00 01400 CENTRAL SERVICES & SUPPLY	o	,	1	0	10, 784	1
15. 00 01500 PHARMACY	o	895			130	1
16. 00 01600 MEDICAL RECORDS & LIBRARY	o	0,0			0	16. 00
17. 00 01700 SOCIAL SERVICE	o	0			0	17. 00
19. 00 01900 NONPHYSI CI AN ANESTHETI STS	o	0			0	19.00
20. 00 02000 NURSI NG SCHOOL	o	0			0	20.00
21. 00 02100 &R SERVI CES-SALARY & FRINGES APPRV	o	0			0	21.00
22. 00 02200 I &R SERVI CES-OTHER PRGM COSTS APPRV	o	0			0	22. 00
23. 00 02300 PARAMED ED PRGM- (SPECIFY)	o	0			0	23. 00
INPATIENT ROUTINE SERVICE COST CENTERS	<u> </u>			۷		20.00
30. 00 03000 ADULTS & PEDI ATRI CS	48, 322	7, 022		11, 878	860	30.00
43. 00 04300 NURSERY	0	100		169	0	43. 00
ANCI LLARY SERVI CE COST CENTERS	<u> </u>	100		5 107		10.00
50. 00 05000 OPERATING ROOM	0	2, 581		4, 367	1, 288	50.00
52.00 05200 DELIVERY ROOM & LABOR ROOM	o	1, 747		2, 956	0	52. 00
53. 00 05300 ANESTHESI OLOGY	o	., , .,		0 2,700	0	53. 00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	o	2, 617			274	
60. 00 06000 LABORATORY	o	2, 017			3	60.00
62. 30 06250 BLOOD CLOTTING FOR HEMOPHILIACS	o	0			0	62. 30
65. 00 06500 RESPIRATORY THERAPY		1, 949			383	
66. 00 06600 PHYSI CAL THERAPY		2, 505			118	1
67. 00 06700 OCCUPATI ONAL THERAPY		2, 303 N			0	67.00
68. 00 06800 SPEECH PATHOLOGY		0			0	68. 00
69. 00 06900 ELECTROCARDI OLOGY		0			0	69.00
71. 00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT		0			6, 562	1
72. 00 07200 IMPL. DEV. CHARGED TO PATIENTS		0			0, 302	72.00
73. 00 07300 DRUGS CHARGED TO PATIENTS		0			153	1
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 LITHOTRI PSY	0	0			0	76. 99
OUTPATIENT SERVICE COST CENTERS	<u> </u>		1	<u> </u>	U	70. 77
91. 00 09100 EMERGENCY	ol	3, 175	1	5, 372	536	91.00
92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART	٥	3, 173	·	3, 372	330	92.00
OTHER REIMBURSABLE COST CENTERS						72.00
95. 00 09500 AMBULANCE SERVI CES	0	5, 791		ol ol	432	95. 00
SPECIAL PURPOSE COST CENTERS	<u> </u>	5, 171	<u> </u>	<u> </u>	432	75.00
113. 00 11300 I NTEREST EXPENSE						113. 00
118.00 SUBTOTALS (SUM OF LINES 1-117)	48, 322	28, 811		24, 742	10 730	118. 00
NONREI MBURSABLE COST CENTERS	40, 322	20, 011	<u> </u>	24, 742	10, 737	110.00
190. 00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	ol	0		ol lo	0	190. 00
192. 00 19200 PHYSI CI ANS' PRI VATE OFFI CES	0	289				192.00
194. 00 07950 OCC HEALTH	0	209				194. 00
	0	_				194. 00
194. 01 07951 PALN CLINIC	0	0	•			194. 01
194. 02 07952 OCC HEALTH	0	170		1		194. 02
194. 03 07953 FOUNDATI 0	0	179				194. 03
194. 04 07954 KLDS CAMPUS	0	174				
194. 05 07955 COMMUNITY & VOLUNTEER SERVICES	0	174				194. 05
194. 06 07956 HUNTI NGTON COLLEGE NURSE	0	0				194. 06 194. 07
194. 07 07957 MI SC CATERI NG	0	334				
194. 08 07958 AUTI SM CENTER	O	0		1		194. 08 194. 09
194.09 07959 HUNTINGTON BUA	Ч	0	1		Ü	200.00
200.00 Cross Foot Adjustments		^		ر ا	_	200.00
201.00 Negative Cost Centers	40 222	0 70 707		0 24 742		
202.00 TOTAL (sum lines 118-201)	48, 322	29, 787	1	24, 742	10, 784	202. 00

Provi der CCN: 150091

| In Lieu of Form CMS-2552-10 | Period: | Worksheet B | From 01/01/2015 | Part II | To 12/31/2015 | Date/Time Prepared: | 10/28/2016 10: 35 am | CT | NONDING CALAB | NUMBER CALAB | CT | NONDING CALAB | NUMBER CALAB |

	Cost Center Description	PHARMACY	MEDI CAL	SOCIAL SERVICE		10/28/2016 10 NURSING SCHOOL	
			RECORDS & LI BRARY		ANESTHETI STS		
	location of the control of the contr	15. 00	16. 00	17. 00	19. 00	20. 00	
1. 00	GENERAL SERVICE COST CENTERS OO100 CAP REL COSTS-BLDG & FIXT			I		I	1. 00
2. 00	00200 CAP REL COSTS-BLDG & TTXT			•			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 11. 00	01000 DI ETARY 01100 CAFETERI A						10. 00 11. 00
	01200 MAI NTENANCE OF PERSONNEL						12.00
	01300 NURSI NG ADMI NI STRATI ON						13. 00
	01400 CENTRAL SERVICES & SUPPLY						14. 00
15.00	01500 PHARMACY	142, 011					15. 00
	01600 MEDICAL RECORDS & LIBRARY	0	3, 533				16. 00
	01700 SOCIAL SERVICE	0	0	0			17. 00
	01900 NONPHYSI CLAN ANESTHETI STS	0	0	0	0	0	19.00
	02000 NURSING SCHOOL 02100 I&R SERVICES-SALARY & FRINGES APPRV		0	0		0	20. 00 21. 00
	02200 I &R SERVICES-OTHER PRGM COSTS APPRV		0	Ö			22. 00
	02300 PARAMED ED PRGM-(SPECIFY)	o	0				23. 00
	INPATIENT ROUTINE SERVICE COST CENTERS]
	03000 ADULTS & PEDI ATRI CS	0	205	1			30. 00
43.00	04300 NURSERY	0	23	0			43. 00
50. 00	ANCILLARY SERVICE COST CENTERS 05000 OPERATING ROOM	O	4/.2	0		1	FO 00
52. 00	05200 DELIVERY ROOM & LABOR ROOM	0	462 83	1			50. 00 52. 00
	05300 ANESTHESI OLOGY		71				53.00
	05400 RADI OLOGY-DI AGNOSTI C	O	821	l .			54.00
60.00	06000 LABORATORY	o	357	0			60.00
62. 30	06250 BLOOD CLOTTING FOR HEMOPHILIACS	0	0				62. 30
65.00	06500 RESPIRATORY THERAPY	0	122	1			65. 00
66.00	06600 PHYSI CAL THERAPY	0	82	1			66.00
67. 00 68. 00	06700 OCCUPATIONAL THERAPY 06800 SPEECH PATHOLOGY		22 9	1			67. 00 68. 00
69. 00	06900 ELECTROCARDI OLOGY		20				69. 00
	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	o	234	1			71. 00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	142, 011	127	0			72. 00
	07300 DRUGS CHARGED TO PATIENTS	0	315	i			73. 00
	07697 CARDI AC REHABI LI TATI ON	0	0	•			76. 97
	07698 HYPERBARI C OXYGEN THERAPY 07699 LI THOTRI PSY	0	0			-	76. 98 76. 99
70. 77	OUTPATIENT SERVICE COST CENTERS	<u> </u>		· · · · · · · ·		1	70.77
	09100 EMERGENCY	0	425	0			91. 00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART						92. 00
	OTHER REIMBURSABLE COST CENTERS				T	1	
95. 00	09500 AMBULANCE SERVI CES	0	155	0			95. 00
112 00	SPECIAL PURPOSE COST CENTERS 11300 INTEREST EXPENSE			I		I	113. 00
118. 00		142, 011	3, 533	О	0	0	118. 00
110.00	NONREI MBURSABLE COST CENTERS	142,011	5, 333			,	1110.00
190.00	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0			190. 00
192.00	19200 PHYSICIANS' PRIVATE OFFICES	0	0	0			192. 00
	07950 OCC HEALTH	0	0				194. 00
	07951 PAIN CLINIC	0	0	1			194. 01
	07952 OCC HEALTH 07953 FOUNDATI 0	0	0	0			194. 02 194. 03
	07954 KIDS CAMPUS		0	0			194. 03
	07955 COMMUNITY & VOLUNTEER SERVICES		0	Ö			194. 05
	07956 HUNTI NGTON COLLEGE NURSE	o	0	Ö			194. 06
	07957 MISC CATERING	0	0	0			194. 07
	07958 AUTISM CENTER	0	0	0			194. 08
	07959 HUNTI NGTON BUA	0	0	0			194. 09
200.00	1 1		_	_	0		200.00
201. 00 202. 00	1 1 9	142, 011	3, 533	0	0		201. 00 202. 00
202.00	1 1.57/12 (Sam 111105 110 201)	142,011	3, 333		1		1-02.00

	ON OF CAPITAL RELATED COSTS	HUNTINGTON MEMO		CCN: 150091	Peri od:	Worksheet B	2332-10
ALLUCATI	ON OF CAPITAL RELATED COSTS		Provi der		From 01/01/2015 To 12/31/2015	Part II	pared:
		INTERNS &	RESI DENTS			10,20,2010 10	. JJ aiii
	Cost Center Description		SERVI CES-OTHER		Subtotal	Intern &	
		Y & FRINGES APPRV	PRGM COSTS APPRV	PRGM		Residents Cost & Post	
		APPRV	APPRV			Stepdown	
						Adjustments	
		21.00	22.00	23. 00	24.00	25. 00	
	ENERAL SERVICE COST CENTERS						
	0100 CAP REL COSTS-BLDG & FLXT						1.00
	0200 CAP REL COSTS-MVBLE EQUIP						2.00
1	0400 EMPLOYEE BENEFITS DEPARTMENT						4.00
1	0500 ADMINISTRATIVE & GENERAL						5.00
1	0600 MAINTENANCE & REPAIRS 0700 OPERATION OF PLANT						6. 00 7. 00
1	0800 LAUNDRY & LINEN SERVICE						8.00
1	0900 HOUSEKEEPI NG						9. 00
	1000 DI ETARY						10.00
	1100 CAFETERI A						11.00
12. 00 01	1200 MAINTENANCE OF PERSONNEL						12.00
	1300 NURSING ADMINISTRATION						13.00
	1400 CENTRAL SERVICES & SUPPLY						14.00
1	1500 PHARMACY						15. 00
	1600 MEDICAL RECORDS & LIBRARY						16.00
	1700 SOCIAL SERVICE						17.00
	1900 NONPHYSICIAN ANESTHETISTS 2000 NURSING SCHOOL						19.00
	2100 &R SERVICES-SALARY & FRINGES APPRV	0					20.00
	2200 I &R SERVICES-OTHER PRGM COSTS APPRV		΄]				22. 00
	2300 PARAMED ED PRGM-(SPECIFY)			1	o		23. 00
	NPATIENT ROUTINE SERVICE COST CENTERS				<u> </u>		20.00
30.00 03	3000 ADULTS & PEDIATRICS				678, 982	0	30.00
	4300 NURSERY				5, 712	0	43.00
	NCILLARY SERVICE COST CENTERS						
	5000 OPERATING ROOM				149, 123		1
	5200 DELIVERY ROOM & LABOR ROOM				87, 584		
	5300 ANESTHESI OLOGY 5400 RADI OLOGY-DI AGNOSTI C				77, 456 473, 880		
	6000 LABORATORY				205, 419		1
1	6250 BLOOD CLOTTING FOR HEMOPHILIACS				203, 419	0	
1	6500 RESPIRATORY THERAPY				135, 400	-	1
1	6600 PHYSI CAL THERAPY				156, 125		1
	6700 OCCUPATIONAL THERAPY				23, 176		1
68. 00 06	6800 SPEECH PATHOLOGY				9, 309	0	68.00
	6900 ELECTROCARDI OLOGY				922	0	
1	7100 MEDICAL SUPPLIES CHARGED TO PATIENT				79, 404		
1	7200 I MPL. DEV. CHARGED TO PATIENTS				222, 401	0	
. 1	7300 DRUGS CHARGED TO PATIENTS				184, 884		
	7697 CARDIAC REHABILITATION 7698 HYPERBARIC OXYGEN THERAPY				0	0	
	7699 LI THOTRI PSY				0		
	JTPATIENT SERVICE COST CENTERS						1
91.00 09	9100 EMERGENCY				234, 375	0	91.00
	9200 OBSERVATION BEDS (NON-DISTINCT PART					0	92. 00
	THER REIMBURSABLE COST CENTERS						
	9500 AMBULANCE SERVI CES				405, 899	0	95. 00
	PECIAL PURPOSE COST CENTERS 1300 NTEREST EXPENSE			T		I	112 00
118.00	SUBTOTALS (SUM OF LINES 1-117)	0			0 3, 130, 051	0	113. 00 118. 00
_	ONREI MBURSABLE COST CENTERS		,	1	0 3, 130, 031	0	1118.00
_	9000 GIFT, FLOWER, COFFEE SHOP & CANTEEN				0	0	190. 00
	9200 PHYSICIANS' PRIVATE OFFICES				16, 500		192. 00
194. 00 07	7950 OCC HEALTH				1, 528		194. 00
	7951 PAIN CLINIC				0	0	194. 01
	7952 OCC HEALTH				0		194. 02
	7953 FOUNDATIO				9, 300		194. 03
	7954 KIDS CAMPUS				0		194. 04
	7955 COMMUNITY & VOLUNTEER SERVICES				49, 435		194. 05
	7956 HUNTI NGTON COLLEGE NURSE				10.571		194. 06
	7957 MISC CATERING 7958 AUTISM CENTER				10, 571	l .	194. 07 194. 08
	7958 AUTISM CENTER 7959 HUNTINGTON BUA				7, 005	l .	194. 08
200. 00	Cross Foot Adjustments	0	ر ا				200. 00
201.00	Negative Cost Centers		1		0 0		201. 00
202. 00	TOTAL (sum lines 118-201)	0			0 3, 224, 390		202. 00

Health Financial Systems
ALLOCATION OF CAPITAL RELATED COSTS Provi der CCN: 150091

			10 12/31/2015 Date/lime Pr	
	Cost Center Description	Total		
OFN	EDAL CERVILOE COCT CENTERS	26. 00		
	ERAL SERVICE COST CENTERS OO CAP REL COSTS-BLDG & FLXT			1.00
1	COO CAP REL COSTS-BLDG & FIXT			2.00
1	OO EMPLOYEE BENEFITS DEPARTMENT			4. 00
4	OO ADMINISTRATIVE & GENERAL			5. 00
1	000 MAI NTENANCE & REPAI RS			6. 00
1	OO OPERATION OF PLANT			7. 00
8.00 008	OO LAUNDRY & LINEN SERVICE			8. 00
	HOUSEKEEPI NG			9. 00
1	000 DI ETARY			10. 00
1	00 CAFETERI A			11. 00
1	MAINTENANCE OF PERSONNEL			12.00
	NURSI NG ADMI NI STRATI ON			13.00
1	OO CENTRAL SERVICES & SUPPLY OO PHARMACY			14. 00 15. 00
1	00 MEDICAL RECORDS & LIBRARY			16.00
1	OO SOCIAL SERVICE			17. 00
1	NONPHYSICIAN ANESTHETISTS			19. 00
1	000 NURSI NG SCHOOL			20. 00
21. 00 021	00 I&R SERVICES-SALARY & FRINGES APPRV			21. 00
22. 00 022	00 I&R SERVICES-OTHER PRGM COSTS APPRV			22. 00
	OO PARAMED ED PRGM-(SPECIFY)			23. 00
	ATIENT ROUTINE SERVICE COST CENTERS			
1	000 ADULTS & PEDI ATRI CS	678, 982		30.00
	:OO NURSERY :ILLARY SERVICE COST CENTERS	5, 712		43. 00
	OOO OPERATING ROOM	149, 123		50.00
1	OD DELIVERY ROOM & LABOR ROOM	87, 584		52.00
	OO ANESTHESI OLOGY	77, 456		53. 00
	OO RADI OLOGY-DI AGNOSTI C	473, 880		54.00
60.00 060	000 LABORATORY	205, 419		60. 00
62. 30 062	50 BLOOD CLOTTING FOR HEMOPHILIACS	0		62. 30
1	RESPI RATORY THERAPY	135, 400		65. 00
1	000 PHYSI CAL THERAPY	156, 125		66. 00
1	OO OCCUPATIONAL THERAPY	23, 176		67.00
1	SOO SPEECH PATHOLOGY	9, 309 922		68. 00 69. 00
	OO ELECTROCARDIOLOGY OO MEDICAL SUPPLIES CHARGED TO PATIENT	79, 404		71.00
	ON IMPL. DEV. CHARGED TO PATIENTS	222, 401		72.00
1	OO DRUGS CHARGED TO PATIENTS	184, 884		73. 00
1	97 CARDIAC REHABILITATION	0		76. 97
76. 98 076	98 HYPERBARIC OXYGEN THERAPY	0		76. 98
	99 LI THOTRI PSY	0		76. 99
	PATIENT SERVICE COST CENTERS			
	OO EMERGENCY	234, 375		91.00
	200 OBSERVATION BEDS (NON-DISTINCT PART ER REIMBURSABLE COST CENTERS			92. 00
	OO AMBULANCE SERVICES	405, 899		95. 00
	CLAL PURPOSE COST CENTERS	100,077		70.00
	00 INTEREST EXPENSE			113. 00
118. 00	SUBTOTALS (SUM OF LINES 1-117)	3, 130, 051		118. 00
	REIMBURSABLE COST CENTERS			
	000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0		190. 00
	PHYSICIANS' PRIVATE OFFICES	16, 500		192. 00
	050 OCC HEALTH	1, 528		194. 00
	PAIN CLINIC	0		194. 01
	952 OCC HEALTH 953 FOUNDATIO	9, 300		194. 02 194. 03
	1954 KIDS CAMPUS	9, 300		194. 03
	955 COMMUNITY & VOLUNTEER SERVICES	49, 435		194. 04
	956 HUNTI NGTON COLLEGE NURSE	0		194. 06
	757 MISC CATERING	10, 571		194. 07
	58 AUTISM CENTER	7, 005		194. 08
	959 HUNTI NGTON BUA	0		194. 09
200.00	Cross Foot Adjustments	0		200. 00
201.00	Negative Cost Centers	0		201.00
202.00	TOTAL (sum lines 118-201)	3, 224, 390		202. 00

		•	HUNIINGION MEMO		2011 450004 5		U OT FORM CMS	
COST A	LLOCA	TION - STATISTICAL BASIS		Provi der		Period: From 01/01/2015	Worksheet B-1	
						To 12/31/2015		
			1				10/28/2016 10	:35 am
			CAPITAL REI	_ATED COSTS				
		Cost Contor Doscription	BLDG & FLXT	MVBLE EQUIP	EMPLOYEE	Reconciliation	ADMI NII CTDATI VE	
		Cost Center Description	(SQUARE FEET)	(DOLLAR VALUE)		Reconciliation	& GENERAL	
			(SQUARE TEET)	(DOLLAR VALUE)	DEPARTMENT		(ACCUM COST)	
					(GROSS		(/100011)	
					SALARI ES)			
			1.00	2.00	4.00	5A	5. 00	
		AL SERVICE COST CENTERS						
1.00	1	CAP REL COSTS-BLDG & FIXT	116, 622	l				1.00
2.00	1	CAP REL COSTS-MVBLE EQUI P		587, 106	1			2. 00
4.00		EMPLOYEE BENEFITS DEPARTMENT	132	l e	16, 848, 802		04 004 507	4.00
5.00	1	ADMINISTRATIVE & GENERAL	7, 681	15, 004	5, 551, 688	-13, 133, 710	21, 894, 537	
6. 00 7. 00		MAINTENANCE & REPAIRS OPERATION OF PLANT	30, 673	24, 413	334, 039		0 1, 296, 263	
8. 00		LAUNDRY & LINEN SERVICE	629	1	32, 347		182, 850	1
9. 00		HOUSEKEEPI NG	512	l e	286, 595		447, 128	1
10. 00		DI ETARY	4, 892	l e	1		170, 680	1
11. 00	01100	CAFETERI A	1, 110	1	229, 178		227, 261	1
12.00	01200	MAINTENANCE OF PERSONNEL	0	0) (o	0	12.00
13.00		NURSING ADMINISTRATION	0	0	197, 943	0	231, 620	
14. 00		CENTRAL SERVICES & SUPPLY	1, 905	ł)	0	3, 508	
15. 00	1	PHARMACY	1, 155	74, 653	535, 394		381, 923	
16.00		MEDICAL RECORDS & LIBRARY	638	0			1, 175	1
17. 00 19. 00	1	SOCIAL SERVICE	0			-	0	
20. 00		NONPHYSICIAN ANESTHETISTS NURSING SCHOOL	0				0	1
21. 00		I &R SERVI CES-SALARY & FRINGES APPRV	0				0	1
22. 00		I&R SERVICES-OTHER PRGM COSTS APPRV	0	ĺ		ol öl	0	1
23. 00		PARAMED ED PRGM-(SPECIFY)	Ö			-	0	•
		IENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	25, 160	94, 167	2, 564, 030	0	3, 335, 719	30.00
43.00		NURSERY	102	0	35, 569	0	44, 285	43. 00
		LARY SERVICE COST CENTERS						1
50. 00	1	OPERATING ROOM	9, 584	0	927, 758		812, 808	1
52.00		DELIVERY ROOM & LABOR ROOM	0	0	623, 739		773, 281	1
53.00		ANESTHESI OLOGY	12.012	174 217	007 007	-	737, 309	1
54. 00 60. 00		RADI OLOGY-DI AGNOSTI C LABORATORY	12, 012 1, 820	174, 317	906, 802		1, 743, 904 1, 861, 080	1
62. 30	1	BLOOD CLOTTING FOR HEMOPHILIACS	1, 820				1, 661, 060	1
65. 00		RESPIRATORY THERAPY	1, 346	31, 016	627, 307		809, 137	1
66. 00		PHYSI CAL THERAPY	8, 324	10, 335	1		912, 817	
67. 00		OCCUPATIONAL THERAPY	0	0	180, 844		220, 574	1
68. 00	06800	SPEECH PATHOLOGY	0	o	72, 642		88, 600	68. 00
69. 00		ELECTROCARDI OLOGY	0	0) (0	8, 594	
71. 00		MEDICAL SUPPLIES CHARGED TO PATIENT	0	0		0	691, 795	1
72. 00		IMPL. DEV. CHARGED TO PATIENTS	0	0)	0	764, 734	
	1	DRUGS CHARGED TO PATIENTS	0	1	70, 958		1, 757, 070	1
		CARDIAC REHABILITATION HYPERBARIC OXYGEN THERAPY	0	ł			0	1
	1	LI THOTRI PSY	0				0	
70. 77		TIENT SERVICE COST CENTERS			′1	71 9		70. 77
91. 00		EMERGENCY	5, 120	32, 126	1, 102, 718	3 0	1, 440, 133	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
		REIMBURSABLE COST CENTERS						
95. 00		AMBULANCE SERVICES	3, 551	123, 174	1, 577, 540	0	2, 132, 598	95. 00
		AL PURPOSE COST CENTERS	1			1		
		INTEREST EXPENSE	11/ 24/	F02 F/2	1/ /07 70	12 122 710	21 07/ 04/	113.00
118. 00		SUBTOTALS (SUM OF LINES 1-117) IMBURSABLE COST CENTERS	116, 346	582, 563	16, 687, 785	-13, 133, 710	21, 076, 846]118.00
100.00		GIFT, FLOWER, COFFEE SHOP & CANTEEN	0			ol	0	190. 00
		PHYSICIANS' PRIVATE OFFICES	0	1	67, 003			190.00
		OCC HEALTH	276	4, 343	07,000			194. 00
194. 01	07951	PAIN CLINIC	0			ol ol		194. 01
		OCC HEALTH	0	Ö		ol ol		194. 02
194.03	07953	FOUNDATI O	0	0		o	86, 900	194. 03
194. 04	07954	KIDS CAMPUS	0	0) (0	0	194. 04
		COMMUNITY & VOLUNTEER SERVICES	0	0	42, 720	이	469, 318	
		HUNTI NGTON COLLEGE NURSE	0	0)	0		194. 06
		MI SC CATERI NG	0	0	51, 294	0		194. 07
		AUTI SM CENTER	0		(194. 08
194. 09 200. 00		HUNTINGTON BUA Cross Foot Adjustments	0			ا ا	0	194. 09 200. 00
200.00	1	Negative Cost Centers						200.00
201.00		Cost to be allocated (per Wkst. B,	214, 755	744, 933	2, 223, 329	, 	13, 133, 710	1
_52.00		Part I)	211,733	, , , , , , , , , ,	2,220,32		.5, 155, 710	
203.00		Unit cost multiplier (Wkst. B, Part I)	1. 841462	1. 268822	0. 131958	3	0. 599862	203. 00
						·		

Heal th Financi	al Systems	HUNTINGTON MEMO	RIAL HOSPITAL		In Lie	eu of Form CMS-2	2552-10
COST ALLOCATIO	ON - STATISTICAL BASIS		Provi der		Peri od:	Worksheet B-1	
					From 01/01/2015 Fo 12/31/2015		pared: :35 am
		CAPITAL REL	_ATED COSTS				
C	ost Center Description	BLDG & FLXT (SQUARE FEET)	MVBLE EQUIP (DOLLAR VALUE)	EMPLOYEE BENEFITS DEPARTMENT (GROSS SALARIES)	Reconciliation	ADMINISTRATIVE & GENERAL (ACCUM COST)	
		1.00	2. 00	4. 00	5A	5. 00	
204. 00 C	ost to be allocated (per Wkst. B,			24	3	2, 297, 967	204. 00
	art II) nit cost multiplier (Wkst. B, Part I)			0. 00001	4	0. 104956	205. 00

Provider CCN: 150091

| Peri od: | From 01/01/2015 | To 12/31/2015 | Date/Ti me Prepared:

				Τ	o 12/31/2015	Date/Time Pre 10/28/2016 10	
	Cost Center Description	MAINTENANCE & REPAIRS (SQUARE FEET)	OPERATION OF PLANT (SQUARE FEET)	LAUNDRY & LI NEN SERVI CE (POUNDS OF	HOUSEKEEPI NG (SQUARE FEET)	DI ETARY (MEALS SERVED)	
		6. 00	7. 00	LAUNDRY) 8. 00	9. 00	10. 00	
	GENERAL SERVICE COST CENTERS		ı				1.00
1. 00 2. 00 4. 00 5. 00 6. 00	00100 CAP REL COSTS-BLDG & FIXT 00200 CAP REL COSTS-MVBLE EQUIP 00400 EMPLOYEE BENEFITS DEPARTMENT 00500 ADMINISTRATIVE & GENERAL 00600 MAINTENANCE & REPAIRS	0	70.10/				1. 00 2. 00 4. 00 5. 00 6. 00
7. 00 8. 00 9. 00 10. 00 11. 00 12. 00	OO700 OPERATION OF PLANT OO800 LAUNDRY & LINEN SERVICE OO900 HOUSEKEEPING O1000 DIETARY O1100 CAFETERIA O1200 MAINTENANCE OF PERSONNEL	000000000000000000000000000000000000000	78, 136 629 512 4, 892 1, 110	251, 698 1, 671 (25, 077 0 0	12. 00
13. 00 14. 00 15. 00 16. 00 17. 00	01300 NURSI NG ADMI NI STRATI ON 01400 CENTRAL SERVI CES & SUPPLY 01500 PHARMACY 01600 MEDI CAL RECORDS & LI BRARY 01700 SOCI AL SERVI CE	000000000000000000000000000000000000000	0 1, 905 1, 155 638	2, 668	0 3 1, 905 1, 155 0 638	0 0 0 0	14. 00 15. 00 16. 00 17. 00
19. 00 20. 00 21. 00 22. 00 23. 00	01900 NONPHYSICIAN ANESTHETISTS 02000 NURSING SCHOOL 02100 I &R SERVICES-SALARY & FRINGES APPRV 02200 I &R SERVICES-OTHER PRGM COSTS APPRV 02300 PARAMED ED PRGM-(SPECIFY) INPATIENT ROUTINE SERVICE COST CENTERS	000000000000000000000000000000000000000		1		0 0 0 0	
30. 00 43. 00	03000 ADULTS & PEDI ATRI CS 04300 NURSERY ANCI LLARY SERVI CE COST CENTERS	0				25, 077 0	30. 00 43. 00
50. 00 52. 00 53. 00	ANCIOLARY SERVICE COST CENTERS O5200 OPERATING ROOM O5200 DELIVERY ROOM & LABOR ROOM O5300 ANESTHESIOLOGY	0			0	0	52. 00
54. 00 60. 00 62. 30	05400 RADI OLOGY-DI AGNOSTI C 06000 LABORATORY 06250 BLOOD CLOTTI NG FOR HEMOPHI LI ACS	0	12, 012 1, 820 0) (0 0 0	1
65. 00 66. 00 67. 00	06500 RESPI RATORY THERAPY 06600 PHYSI CAL THERAPY 06700 OCCUPATI ONAL THERAPY	0 0	1, 346 8, 324 0		1, 346 8, 324 0 0	0 0 0	65. 00 66. 00 67. 00
68. 00 69. 00 71. 00	06800 SPEECH PATHOLOGY 06900 ELECTROCARDI OLOGY 07100 MEDI CAL SUPPLI ES CHARGED TO PATI ENT	0	0 0		0 0	0 0	68. 00 69. 00 71. 00
72. 00 73. 00 76. 97 76. 98	O7200 IMPL. DEV. CHARGED TO PATIENTS O7300 DRUGS CHARGED TO PATIENTS O7697 CARDIAC REHABILITATION O7698 HYPERBARIC OXYGEN THERAPY	0	0		0 0	0 0	72. 00 73. 00 76. 97 76. 98
76. 99	07699 LI THOTRI PSY OUTPATI ENT SERVI CE COST CENTERS	0	0		0 0	0	1
91. 00 92. 00		0	5, 120	63, 343	5, 120	0	91. 00 92. 00
95. 00	09500 AMBULANCE SERVICES SPECIAL PURPOSE COST CENTERS	0	3, 551	4, 606	3, 551	0	95. 00
113. 00 118. 00	11300 INTEREST EXPENSE	0	77, 860	248, 814	76, 719	25, 077	113. 00 118. 00
192. 00 194. 00	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN 19200 PHYSICIANS' PRIVATE OFFICES 07950 OCC HEALTH 07951 PAIN CLINIC	0 0	0 276	2, 884	0 0 0 276	0	190. 00 192. 00 194. 00 194. 01
194. 02 194. 03 194. 04	07952 OCC HEALTH 07953 FOUNDATIO 07954 KIDS CAMPUS	0	1			0 0 0	194. 02 194. 03 194. 04
194. 06 194. 07 194. 08 194. 09 200. 00		000000000000000000000000000000000000000	0 0 0		0 0 0	0 0 0	194. 05 194. 06 194. 07 194. 08 194. 09 200. 00
201. 00 202. 00		O	2, 073, 842	309, 230	730, 985	449, 349	201. 00 202. 00
203. 00 204. 00	Unit cost multiplier (Wkst. B, Part I)	0. 000000 0	26. 541441 223, 516				203. 00 204. 00

Health Financial Systems	HUNTI NGTON MEMO	ORIAL HOSPITAL		In Lie	eu of Form CMS-	2552-10
COST ALLOCATION - STATISTICAL BASIS		Provi der		eri od:	Worksheet B-1	
				rom 01/01/2015 o 12/31/2015	Date/Time Pre 10/28/2016 10	
Cost Center Description	MAINTENANCE &	OPERATION OF	LAUNDRY &	HOUSEKEEPI NG	DI ETARY	
	REPAI RS	PLANT	LINEN SERVICE	(SQUARE FEET)	(MEALS SERVED)	
	(SQUARE FEET)	(SQUARE FEET)	(POUNDS OF			
			LAUNDRY)			
	6.00	7. 00	8. 00	9. 00	10.00	
205.00 Unit cost multiplier (Wkst. B, Part	0. 000000	2. 860602	0. 087994	0. 642743	1. 926945	205. 00

	ALLOCATION - STATISTICAL BASIS	HONTINGTON WEMO		CCN: 150091 F	eri od:	Worksheet B-1	
				T T	rom 01/01/2015 o 12/31/2015	Date/Time Pre	epared: 0:35 am
	Cost Center Description	CAFETERI A (HOURS OF SERVI CE)	MAINTENANCE OF PERSONNEL (NUMBER HOUSED)	NURSING ADMINISTRATION (DIRECT NRSING HRS)	SUPPLY	PHARMACY (COSTED REQUIS.)	
		11.00	12.00	13. 00	14.00	15.00	
4 00	GENERAL SERVI CE COST CENTERS				1		4 00
16. 00 17. 00 19. 00 20. 00 21. 00 22. 00	I I	345, 963 0 4, 987 0 10, 398 0 0 0 0		169, 839 0 C 0 C 0 C 0 C 0 C 0 C 0 C 0 C 0 C	2, 394, 739	100 0 0 0 0 0 0	16. 00 17. 00 19. 00 20. 00 21. 00 22. 00
		81, 536 1, 157	0			0	
72. 00	05000 OPERATING ROOM 05200 DELIVERY ROOM & LABOR ROOM 05300 ANESTHESI OLOGY 05400 RADI OLOGY-DI AGNOSTI C 06000 LABORATORY 06250 BLOOD CLOTTING FOR HEMOPHILIACS 06500 RESPIRATORY THERAPY 06600 PHYSI CAL THERAPY 06700 OCCUPATIONAL THERAPY 06800 SPEECH PATHOLOGY 06900 ELECTROCARDIOLOGY 07100 MEDICAL SUPPLIES CHARGED TO PATIENT 07200 IMPL. DEV. CHARGED TO PATIENTS 07300 DRUGS CHARGED TO PATIENTS 07697 CARDIAC REHABILITATION 07698 HYPERBARIC OXYGEN THERAPY	29, 978 20, 290 0 30, 400 0 22, 634 29, 098 0 0 0	000000000000000000000000000000000000000	29, 978 20, 290 0 0 0 0 0 0 0 0 0 0 0 0 0	0 0 60, 892 680	0 0 0 0 0 0 0 0 0 0 0 0	52. 00 53. 00 54. 00 60. 00 62. 30 65. 00 67. 00 68. 00 71. 00 72. 00 73. 00 76. 97
	07699 LI THOTRI PSY	0	O		o	1	76. 99
91. 00 92. 00	09200 OBSERVATION BEDS (NON-DISTINCT PART	36, 878	O	36, 878	118, 956	0	91. 00 92. 00
95. 00	OTHER REI MBURSABLE COST CENTERS O9500 AMBULANCE SERVI CES CDECLAR DUPPOSE COST CENTERS	67, 259	0	0	95, 878	0	95. 00
113. 00 118. 00	SPECIAL PURPOSE COST CENTERS 11300 I NTEREST EXPENSE SUBTOTALS (SUM OF LINES 1-117) NONREI MBURSABLE COST CENTERS	334, 615	O	169, 839	2, 384, 634	100	113. 00 118. 00
192.00 194.01 194.02 194.03 194.04 194.05 194.06 194.07	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN 19200 PHYSI CIANS' PRIVATE OFFICES 07950 OCC HEALTH 07951 PAIN CLINIC 07952 OCC HEALTH 07953 FOUNDATIO 07954 KIDS CAMPUS 07955 COMMUNITY & VOLUNTEER SERVICES 07956 HUNTINGTON COLLEGE NURSE 07957 MISC CATERING	3, 358 0 0 0 2, 080 0 2, 025 0 3, 885 0 0	0 0		9, 562 0 0	0 0 0 0 0 0 0	190. 00 192. 00 194. 00 194. 01 194. 02 194. 03 194. 04 194. 05 194. 06 194. 07 194. 08 194. 09
200. 00 201. 00 202. 00	Cross Foot Adjustments Negative Cost Centers	403, 585	O	376, 378	77, 537	665, 712	200. 00 201. 00
203. 00 204. 00	Part I) Unit cost multiplier (Wkst. B, Part I)	1. 166555 29, 787	0. 000000		0. 032378	6, 657. 120000 142, 011	203. 00

Health Financial Systems	HUNTINGTON MEMO	ORIAL HOSPITAL		In Lie	u of Form CMS-2	2552-10
COST ALLOCATION - STATISTICAL BASIS		Provi der		Peri od:	Worksheet B-1	
				From 01/01/2015 To 12/31/2015	Date/Time Pre	narod:
				10 12/31/2013	10/28/2016 10:	35 am
Cost Center Description	CAFETERI A	MAINTENANCE OF	NURSI NG	CENTRAL	PHARMACY	
	(HOURS OF	PERSONNEL	ADMI NI STRATI O	N SERVICES &	(COSTED	
	SERVI CE)	(NUMBER		SUPPLY	REQUIS.)	
		HOUSED)	(DIRECT NRSIN	G (COSTED		
			HRS)	REQUIS.)		
	11. 00	12.00	13.00	14. 00	15. 00	
205.00 Unit cost multiplier (Wkst. B, Part	0. 086099	0. 000000	0. 14567	9 0. 004503	1, 420. 110000	205. 00
11)						

Heal th	Fi nan	cial Systems	HUNTINGTON MEMO	RIAL	HOSPI TAL		In Lie	u of Form CMS-	2552-	10
COST A	LLOCA	TION - STATISTICAL BASIS			Provi der		Peri od:	Worksheet B-1		
							From 01/01/2015 To 12/31/2015			
								10/28/2016 10 INTERNS &	: 35_a	<u>ım</u>
								RESI DENTS		
		Cost Center Description	MEDI CAL	SOCI A	L SERVICE	NONPHYSICI AN	NURSING SCHOOL	SERVI CES-SALAR		
			RECORDS &	,		ANESTHETI STS		Y & FRINGES		
			LI BRARY (GROSS	(IIM	E SPENT)	(ASSIGNED TIME)	(ASSI GNED TIME)	APPRV (ASSI GNED		
			REVENUE)			I IIWE)	I I WE	TIME)		
			16. 00	-	17. 00	19. 00	20.00	21.00		
4 00		AL SERVICE COST CENTERS				1		ı		
1. 00 2. 00	1	CAP REL COSTS-BLDG & FIXT CAP REL COSTS-MVBLE EQUIP							1. (2. (
4.00		EMPLOYEE BENEFITS DEPARTMENT							4. (
5. 00	1	ADMINISTRATIVE & GENERAL							5. (
6.00		MAINTENANCE & REPAIRS							6. (
7.00		OPERATION OF PLANT							7. (
8.00		LAUNDRY & LINEN SERVICE							8. (
9. 00 10. 00		HOUSEKEEPI NG DI ETARY							9. (10. (
11. 00	1	CAFETERIA							11. (
12.00		MAINTENANCE OF PERSONNEL							12. (00
		NURSING ADMINISTRATION							13. (00
		CENTRAL SERVICES & SUPPLY							14. (
15. 00 16. 00	1	PHARMACY MEDICAL RECORDS & LIBRARY	144 400 021						15. (
17. 00		SOCIAL SERVICE	144, 698, 821		C				16. (17. (
		NONPHYSICIAN ANESTHETISTS	0		C		0		19. (
20. 00	1	NURSI NG SCHOOL	0		C		0		20. (
		I&R SERVICES-SALARY & FRINGES APPRV	0		C			0		
22. 00		I &R SERVICES-OTHER PRGM COSTS APPRV	0		C				22. (
23. 00		PARAMED ED PRGM-(SPECIFY) I ENT ROUTINE SERVICE COST CENTERS	0		C	1			23. (JU
30. 00		ADULTS & PEDIATRICS	8, 553, 500		C		0 0	0	30. (00
		NURSERY	937, 714		C		0 0			
		LARY SERVICE COST CENTERS	10.04/.044			1		_		
50. 00 52. 00	1	OPERATING ROOM DELIVERY ROOM & LABOR ROOM	19, 246, 811 3, 439, 242		C	1	0 0	•		
53. 00		ANESTHESI OLOGY	2, 968, 311			1	0 0	0	53. (
54. 00		RADI OLOGY-DI AGNOSTI C	31, 697, 748		C		0 0	Ö	54. (
60.00	06000	LABORATORY	14, 878, 000		C		0	0	60. (00
62. 30		BLOOD CLOTTING FOR HEMOPHILIACS	0		C	1	0	0		
65. 00 66. 00		RESPI RATORY THERAPY PHYSI CAL THERAPY	5, 088, 144 3, 427, 929			1	0 0	0	65.0	
67. 00		OCCUPATIONAL THERAPY	935, 134		0	l .	0 0	0	67. (
		SPEECH PATHOLOGY	373, 089		C	1	o o	ő	68. (
69. 00		ELECTROCARDI OLOGY	827, 256		C		0	0	69. (00
	1	MEDICAL SUPPLIES CHARGED TO PATIENT	9, 748, 643		C		0	0	71. (
		IMPL. DEV. CHARGED TO PATIENTS DRUGS CHARGED TO PATIENTS	5, 298, 973		C	1	0 0	l	72. (73. (
	1	CARDIAC REHABILITATION	13, 119, 841			1	0 0	0		
		HYPERBARI C OXYGEN THERAPY	Ö		C	l .	o o	ő		
76. 99		LI THOTRI PSY	0		C		0 0	0	76. 9	99
04 00		TIENT SERVICE COST CENTERS	47.744.040	г		ı			0.1	00
		EMERGENCY OBSERVATION BEDS (NON-DISTINCT PART	17, 714, 949		C		0	0	91. (92. (
72.00		REI MBURSABLE COST CENTERS				I .			/	50
95. 00		AMBULANCE SERVI CES	6, 443, 537		C		0 0	0	95. (00
112 00		AL PURPOSE COST CENTERS INTEREST EXPENSE				I			 113. ($\cap \cap$
118.00		SUBTOTALS (SUM OF LINES 1-117)	144, 698, 821		C		0	0	1118. (
		IMBURSABLE COST CENTERS					-			
		GIFT, FLOWER, COFFEE SHOP & CANTEEN	0		C	1	0		190. (
		PHYSICIANS' PRIVATE OFFICES	0		C	1	0		192. (
		OCC HEALTH PAIN CLINIC	0			1	0 0		194. (194. (
	1	OCC HEALTH	0		0	1	0 0		194. (
		FOUNDATI O	0		C	1	0 0	l	194. (
		KIDS CAMPUS	0		C	1	0		194. (
		COMMUNITY & VOLUNTEER SERVICES	0		C	1	0	l e	194. (
		HUNTINGTON COLLEGE NURSE MISC CATERING	0		(0 0	l e	194. (194. (
		AUTISM CENTER	0		C		0 0		194. (
		HUNTI NGTON BUA	0		C		0 0		194. (
200.00		Cross Foot Adjustments							200. (
201.00		Negative Cost Centers	04.070		_			_	201. (
202.00	,	Cost to be allocated (per Wkst. B, Part I)	24, 870		C		0		202. (JU
203.00		Unit cost multiplier (Wkst. B, Part I)	0. 000172		0. 000000	0. 00000	0. 000000	0. 000000	203. (00
										—

Health Financial Systems	HUNTINGTON MEMO	ORI AL	HOSPI TAL		In Lie	eu of Form CMS-	2552-10
COST ALLOCATION - STATISTICAL BASIS			Provi der		Peri od:	Worksheet B-1	
					From 01/01/2015 To 12/31/2015		
						INTERNS &	
						RESI DENTS	
Cost Center Description	MEDI CAL	SOCI A	L SERVICE	NONPHYSICI AN	NURSING SCHOOL	SERVI CES-SALAR	
	RECORDS &			ANESTHETI STS		Y & FRINGES	
	LI BRARY	(TIM	E SPENT)	(ASSI GNED	(ASSI GNED	APPRV	
	(GROSS			TIME)	TIME)	(ASSI GNED	
	REVENUE)			, i	,	TIME)	
	16. 00		17. 00	19. 00	20.00	21.00	
204.00 Cost to be allocated (per Wkst. B,	3, 533	3	0		0 0	0	204. 00
Part II)							
205.00 Unit cost multiplier (Wkst. B, Part	0. 000024	1	0.000000	0.00000	0.00000	0.000000	205.00

In Lieu of Form CMS-2552-10 Health Financial Systems HUNTINGTON MEMORIAL HOSPITAL COST ALLOCATION - STATISTICAL BASIS Provider CCN: 150091 Peri od: Worksheet B-1 From 01/01/2015 12/31/2015 Date/Time Prepared: 10/28/2016 10:35 am INTERNS & **RESI DENTS** Cost Center Description SERVI CES-OTHER PARAMED ED PRGM COSTS PRGM (ASSI GNED **APPRV** (ASSI GNED TIME) TIME) 23.00 22.00 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 00500 ADMINISTRATIVE & GENERAL 5 00 5 00 6.00 00600 MAINTENANCE & REPAIRS 6.00 7.00 00700 OPERATION OF PLANT 7.00 00800 LAUNDRY & LINEN SERVICE 8.00 8.00 00900 HOUSEKEEPI NG 9 00 9 00 10.00 01000 DI ETARY 10.00 01100 CAFETERI A 11.00 11.00 01200 MAINTENANCE OF PERSONNEL 12.00 12.00 13.00 01300 NURSING ADMINISTRATION 13.00 14.00 01400 CENTRAL SERVICES & SUPPLY 14.00 01500 PHARMACY 15.00 15.00 01600 MEDICAL RECORDS & LIBRARY 16.00 16, 00 17 00 01700 SOCIAL SERVICE 17 00 19.00 01900 NONPHYSICIAN ANESTHETISTS 19.00 20.00 02000 NURSING SCHOOL 20.00 02100 I &R SERVICES-SALARY & FRINGES APPRV 21.00 21.00 02200 I&R SERVICES-OTHER PRGM COSTS APPRV 22.00 22.00 02300 PARAMED ED PRGM-(SPECIFY) 0 23.00 INPATIENT ROUTINE SERVICE COST CENTERS 30 00 03000 ADULTS & PEDIATRICS 30.00 0 0 04300 NURSERY 43.00 Ω 43.00 ANCILLARY SERVICE COST CENTERS 50.00 05000 OPERATING ROOM 0 0 50.00 05200 DELIVERY ROOM & LABOR ROOM 0 52.00 0 52.00 53.00 05300 ANESTHESI OLOGY 000000000000000 0 53.00 0 54.00 05400 RADI OLOGY-DI AGNOSTI C 54.00 06000 LABORATORY 60.00 0 60.00 06250 BLOOD CLOTTING FOR HEMOPHILIACS 62.30 0 62.30 06500 RESPIRATORY THERAPY 0 65.00 65.00 06600 PHYSI CAL THERAPY 0 66.00 66.00 06700 OCCUPATI ONAL THERAPY 67.00 0 67.00 68.00 06800 SPEECH PATHOLOGY 0 68.00 69.00 06900 ELECTROCARDI OLOGY 0 69.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT 0 71 00 71 00 07200 I MPL. DEV. CHARGED TO PATIENTS 72.00 0 72.00 73.00 07300 DRUGS CHARGED TO PATIENTS 0 73.00 07697 CARDIAC REHABILITATION 76. 97 0 76.97 07698 HYPERBARI C OXYGEN THERAPY 76 98 76 98 0 76.99 07699 LI THOTRI PSY 0 76.99 OUTPATIENT SERVICE COST CENTERS 91.00 09100 EMERGENCY 0 0 91.00 09200 OBSERVATION BEDS (NON-DISTINCT PART 92.00 92.00 OTHER REIMBURSABLE COST CENTERS 09500 AMBULANCE SERVICES 0 0 95.00 SPECIAL PURPOSE COST CENTERS 113.00 11300 INTEREST EXPENSE 113.00 118.00 SUBTOTALS (SUM OF LINES 1-117) 0 118.00 NONREI MBURSABLE COST CENTERS 190.00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN 0 190.00 0 192.00 19200 PHYSICIANS' PRIVATE OFFICES 00000000 0 192.00 194.00 07950 OCC HEALTH 0 194.00 194. 01 07951 PAIN CLINIC 0 194. 01 194. 02 07952 OCC HEALTH 194. 02 0 194. 03 07953 FOUNDATI 0 0 194.03 194. 04 194. 04 07954 KIDS CAMPUS 194. 05 07955 COMMUNITY & VOLUNTEER SERVICES 0 194. 05 194.06 07956 HUNTI NGTON COLLEGE NURSE 0 194.06 194.07 07957 MISC CATERING 194.07 194.08 07958 AUTISM CENTER 0 0 194. 08 194. 09 07959 HUNTI NGTON BUA 0 0 194. 09 200.00 Cross Foot Adjustments 200. 00

0.000000

0.000000

201.00

202. 00

203.00

Negative Cost Centers

Part I)

Cost to be allocated (per Wkst. B,

Unit cost multiplier (Wkst. B, Part I)

201.00

202.00

203.00

Health Financial Systems	HUNTI NGTON MEMOI	RIAL HOSPITAL		In Lie	u of Form CMS-	2552-10
COST ALLOCATION - STATISTICAL BASIS		Provi der	CCN: 150091	Peri od: From 01/01/2015	Worksheet B-1	
				To 12/31/2015	Date/Time Pre 10/28/2016 10	pared: : 35_am_
	INTERNS &					
	RESI DENTS					
Cost Center Description	SERVI CES-OTHER	PARAMED ED				
	PRGM COSTS	PRGM				
	APPRV	(ASSI GNED				
	(ASSI GNED	TIME)				
	TIME)	ŕ				
	22. 00	23. 00				
204.00 Cost to be allocated (per Wkst. B,	0	0				204.00
Part II)						
205.00 Unit cost multiplier (Wkst. B, Part	0. 000000	0.000000				205. 00

Health Financial Systems	HUNTINGTON MEMORIAL HOSPITAL	In Lie	u of Form CMS-2552-10
COMPUTATION OF RATIO OF COSTS TO CHARGES	Provi der CCN: 150091	From 01/01/2015	Worksheet C Part I Date/Time Prepared:

					Го 12/31/2015	Date/Time Pre 10/28/2016 10	
			Ti tl	e XVIII	Hospi tal	PPS	
					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)					
	LANDATI ENT. DOUTLAND OFFICE OF CONT. OFFITEDO	1. 00	2. 00	3. 00	4. 00	5. 00	
20.00	INPATIENT ROUTINE SERVICE COST CENTERS	7.0/0.00/		7.0/0.00		7.0/0.00/	00.00
30.00	03000 ADULTS & PEDIATRICS	7, 068, 236		7, 068, 23		7, 068, 236	1
43. 00	04300 NURSERY ANCI LLARY SERVI CE COST CENTERS	81, 750		81, 75) 0	81, 750	43. 00
50. 00	05000 OPERATING ROOM	1, 813, 864		1, 813, 86	1, 096	1, 814, 960	50.00
52. 00	05200 DELIVERY ROOM & LABOR ROOM	1, 329, 113		1, 329, 11		1, 329, 113	1
53. 00	05300 ANESTHESI OLOGY	1, 180, 104		1, 180, 10		1, 180, 104	•
54. 00	05400 RADI OLOGY-DI AGNOSTI C	3, 290, 039		3, 290, 03		3, 290, 039	1
60.00	06000 LABORATORY	3, 045, 636		3, 045, 63		3, 045, 636	
62. 30	06250 BLOOD CLOTTING FOR HEMOPHILIACS	0,043,030		3, 043, 03		0, 043, 030	62. 30
65. 00	06500 RESPIRATORY THERAPY	1, 393, 504	0	1, 393, 50	1 0	1, 393, 504	1
66. 00	06600 PHYSI CAL THERAPY	1, 795, 724	0	1, 795, 72		1, 795, 724	
67. 00	06700 OCCUPATI ONAL THERAPY	353, 049	0	353, 04	1	353, 049	1
68. 00	06800 SPEECH PATHOLOGY	141, 812		141, 81	1	141, 812	1
69. 00	06900 ELECTROCARDI OLOGY	13, 891	_	13, 89		13, 891	1
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	1, 155, 625		1, 155, 62	5 0	1, 155, 625	71. 00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	1, 890, 092		1, 890, 09		1, 890, 092	
73.00	07300 DRUGS CHARGED TO PATIENTS	2, 814, 424		2, 814, 42	4 0	2, 814, 424	73. 00
76. 97	07697 CARDI AC REHABI LI TATI ON	0			o	0	76. 97
76. 98	07698 HYPERBARI C OXYGEN THERAPY	0			o o	0	76. 98
76. 99	07699 LI THOTRI PSY	0			0	0	76. 99
	OUTPATIENT SERVICE COST CENTERS						
91.00	09100 EMERGENCY	2, 697, 981		2, 697, 98		2, 697, 981	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART	1, 342, 501		1, 342, 50	1	1, 342, 501	92.00
	OTHER REIMBURSABLE COST CENTERS						
95. 00	09500 AMBULANCE SERVICES	3, 628, 157		3, 628, 15	7 0	3, 628, 157	95. 00
	SPECIAL PURPOSE COST CENTERS						
	11300 INTEREST EXPENSE						113. 00
200.00	, , , , ,	35, 035, 502	0			35, 036, 598	
201.00		1, 342, 501	_	1, 342, 50		1, 342, 501	
202.00	Total (see instructions)	33, 693, 001	0	33, 693, 00	1 1, 096	33, 694, 097	J202. 00

Health Financial Systems	HUNTINGTON MEMORIAL HOSPITAL	In Lieu of Form CMS-2552-10
COMPUTATION OF RATIO OF COSTS TO CHARGES	Provi der CCN: 1500	91

				0 12/31/2015	Date/lime Pre 10/28/2016 10	pared: :35 am
		Ti tl	e XVIII	Hospi tal	PPS	
		Charges				
Cost Center Description	I npati ent	Outpati ent	Total (col. 6	Cost or Other	TEFRA	
·	·	·	+ col. 7)	Ratio	I npati ent	
					Rati o	
	6.00	7. 00	8. 00	9. 00	10.00	
INPATIENT ROUTINE SERVICE COST CENTERS						
30. 00 03000 ADULTS & PEDI ATRI CS	7, 209, 434		7, 209, 434			30. 00
43. 00 04300 NURSERY	937, 714		937, 714			43.00
ANCILLARY SERVICE COST CENTERS						
50. 00 05000 OPERATING ROOM	6, 144, 868	13, 101, 943	19, 246, 811	0. 094242	0.000000	50.00
52.00 05200 DELIVERY ROOM & LABOR ROOM	3, 439, 242	0	3, 439, 242	0. 386455	0.000000	52.00
53. 00 05300 ANESTHESI OLOGY	683, 420	2, 284, 891	2, 968, 311	0. 397568	0.000000	53.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	3, 248, 338	28, 449, 410	31, 697, 748	0. 103794	0.000000	54.00
60. 00 06000 LABORATORY	2, 773, 384	12, 104, 616	14, 878, 000	0. 204707	0.000000	60.00
62.30 06250 BLOOD CLOTTING FOR HEMOPHILIACS	o	0	C	0.000000	0.000000	62. 30
65. 00 06500 RESPIRATORY THERAPY	1, 373, 450	3, 714, 694	5, 088, 144	0. 273873	0.000000	65.00
66. 00 06600 PHYSI CAL THERAPY	549, 561	2, 878, 368	3, 427, 929	0. 523851	0.000000	66. 00
67. 00 06700 OCCUPATI ONAL THERAPY	49, 274	885, 860	935, 134	0. 377538	0.000000	67.00
68. 00 06800 SPEECH PATHOLOGY	16, 349	356, 740	373, 089	0. 380102	0.000000	68. 00
69. 00 06900 ELECTROCARDI OLOGY	616, 184	211, 072	827, 256	0. 016792	0.000000	69.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	2, 511, 563	7, 237, 080	9, 748, 643	0. 118542	0.000000	71. 00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	4, 165, 632	1, 133, 341	5, 298, 973	0. 356690	0.000000	72. 00
73.00 07300 DRUGS CHARGED TO PATIENTS	4, 680, 319	8, 439, 522	13, 119, 841	0. 214517	0.000000	73. 00
76. 97 07697 CARDIAC REHABILITATION	o	0	C	0.000000	0.000000	76. 97
76. 98 07698 HYPERBARI C OXYGEN THERAPY	o	0	C	0. 000000	0.000000	76. 98
76. 99 07699 LI THOTRI PSY	o	0	C	0. 000000	0.000000	76. 99
OUTPATIENT SERVICE COST CENTERS	<u>'</u>					1
91. 00 09100 EMERGENCY	2, 114, 121	15, 600, 828	17, 714, 949	0. 152300	0.000000	91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART	o	1, 344, 066	1, 344, 066	0. 998836	0.000000	92.00
OTHER REIMBURSABLE COST CENTERS	'					1
95. 00 09500 AMBULANCE SERVI CES	0	6, 443, 537	6, 443, 537	0. 563069	0.000000	95. 00
SPECIAL PURPOSE COST CENTERS	'					1
113. 00 11300 I NTEREST EXPENSE						113. 00
200.00 Subtotal (see instructions)	40, 512, 853	104, 185, 968	144, 698, 821			200.00
201.00 Less Observation Beds						201.00
202.00 Total (see instructions)	40, 512, 853	104, 185, 968	144, 698, 821			202. 00
			,			

Health Financial Systems	HUNTINGTON MEMORIAL HOSPITAL	In Lie	eu of Form CMS-2552-10
COMPUTATION OF RATIO OF COSTS TO CHARGES	Provi der CCN: 15009'	From 01/01/2015	Worksheet C Part I Date/Time Prepared: 10/28/2016 10:35 am

			12, 01, 2010	10/28/2016 10: 35 am
		Title XVIII	Hospi tal	PPS
Cost Center Description	PPS Inpatient			
	Ratio			
	11. 00			
INPATIENT ROUTINE SERVICE COST CENTERS				
30. 00 03000 ADULTS & PEDIATRICS				30.00
43. 00 04300 NURSERY				43. 00
ANCILLARY SERVICE COST CENTERS				
50. 00 05000 OPERATI NG ROOM	0. 094299			50.00
52.00 05200 DELIVERY ROOM & LABOR ROOM	0. 386455			52. 00
53. 00 05300 ANESTHESI OLOGY	0. 397568			53.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	0. 103794			54.00
60. 00 06000 LAB0RAT0RY	0. 204707			60.00
62.30 06250 BLOOD CLOTTING FOR HEMOPHILIACS	0. 000000			62. 30
65. 00 06500 RESPIRATORY THERAPY	0. 273873			65. 00
66. 00 06600 PHYSI CAL THERAPY	0. 523851			66. 00
67. 00 06700 OCCUPATI ONAL THERAPY	0. 377538			67. 00
68.00 06800 SPEECH PATHOLOGY	0. 380102			68. 00
69. 00 06900 ELECTROCARDI OLOGY	0. 016792			69. 00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0. 118542			71. 00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0. 356690			72. 00
73.00 07300 DRUGS CHARGED TO PATIENTS	0. 214517			73. 00
76. 97 07697 CARDIAC REHABILITATION	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. 152300			91. 00
92.00 O9200 OBSERVATION BEDS (NON-DISTINCT PART	0. 998836			92. 00
OTHER REIMBURSABLE COST CENTERS				
95. 00 09500 AMBULANCE SERVICES	0. 563069			95. 00
SPECIAL PURPOSE COST CENTERS				
113. 00 11300 I NTEREST EXPENSE				113. 00
200.00 Subtotal (see instructions)				200. 00
201.00 Less Observation Beds				201. 00
202.00 Total (see instructions)				202. 00

Health Financial Systems	HUNTINGTON MEMORIAL	HOSPI TAL		In Lie	u of Form CMS-2	2552-10
COMPUTATION OF RATIO OF COSTS TO CHARGES		Provi der	CCN: 150091	From 01/01/2015	Worksheet C Part I Date/Time Pre 10/28/2016 10	
		Ti t	le XIX	Hospi tal	PPS	
				Costs		

					10 12/31/2013	10/28/2016 10	:35 am
			Ti t	le XIX	Hospi tal	PPS	
					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	
	TIENT ROUTINE SERVICE COST CENTERS	_					
	O ADULTS & PEDIATRICS	7, 068, 236		7, 068, 23		7, 068, 236	
43. 00 0430		81, 750		81, 75	0	81, 750	43. 00
	LLARY SERVICE COST CENTERS						
	O OPERATING ROOM	1, 813, 864		1, 813, 86		1, 814, 960	
	O DELIVERY ROOM & LABOR ROOM	1, 329, 113		1, 329, 11	3 0	1, 329, 113	
	O ANESTHESI OLOGY	1, 180, 104		1, 180, 10		1, 180, 104	
	O RADI OLOGY-DI AGNOSTI C	3, 290, 039		3, 290, 03	9 0	3, 290, 039	54.00
	O LABORATORY	3, 045, 636		3, 045, 63	6 0	3, 045, 636	60. 00
	O BLOOD CLOTTING FOR HEMOPHILIACS	0			0	0	62. 30
65. 00 0650	O RESPI RATORY THERAPY	1, 393, 504	0	1, 393, 50	4 0	1, 393, 504	65. 00
66.00 0660	O PHYSI CAL THERAPY	1, 795, 724	0	1, 795, 72	4 0	1, 795, 724	66. 00
67. 00 0670	O OCCUPATI ONAL THERAPY	353, 049	0	353, 04	9 0	353, 049	67. 00
68. 00 0680	O SPEECH PATHOLOGY	141, 812	0	141, 81	2 0	141, 812	68. 00
69. 00 0690	O ELECTROCARDI OLOGY	13, 891		13, 89	1 0	13, 891	69. 00
71.00 0710	O MEDICAL SUPPLIES CHARGED TO PATIENT	1, 155, 625		1, 155, 62	5 0	1, 155, 625	71. 00
72.00 0720	O IMPL. DEV. CHARGED TO PATIENTS	1, 890, 092		1, 890, 09	2 0	1, 890, 092	72. 00
73.00 0730	O DRUGS CHARGED TO PATIENTS	2, 814, 424		2, 814, 42	4 0	2, 814, 424	73. 00
76. 97 0769	7 CARDIAC REHABILITATION	0			0	0	76. 97
76. 98 0769	8 HYPERBARIC OXYGEN THERAPY	0			0	0	76. 98
76. 99 0769	9 LI THOTRI PSY	0			0	0	76. 99
OUTP	ATIENT SERVICE COST CENTERS						
91. 00 0910	O EMERGENCY	2, 697, 981		2, 697, 98	1 0	2, 697, 981	91. 00
92. 00 0920	O OBSERVATION BEDS (NON-DISTINCT PART	1, 342, 501		1, 342, 50	1	1, 342, 501	92.00
OTHE	R REIMBURSABLE COST CENTERS						
95. 00 0950	O AMBULANCE SERVICES	3, 628, 157		3, 628, 15	7 0	3, 628, 157	95. 00
SPEC	IAL PURPOSE COST CENTERS						
113. 00 1130	O I NTEREST EXPENSE						113. 00
200. 00	Subtotal (see instructions)	35, 035, 502	0	35, 035, 50	2 1, 096	35, 036, 598	200. 00
201. 00	Less Observation Beds	1, 342, 501		1, 342, 50	1	1, 342, 501	201.00
202. 00	Total (see instructions)	33, 693, 001	[c	33, 693, 00	1, 096	33, 694, 097	202. 00

Health Financial Systems	HUNTINGTON MEMORIAL HOSPITAL	In Lie	u of Form CMS-2552-10
COMPUTATION OF RATIO OF COSTS TO CHARGES	Provi der CCN: 150091	Peri od: From 01/01/2015 To 12/31/2015	Worksheet C Part I Date/Time Prepared: 10/28/2016 10:35 am

				1	o 12/31/2015	Date/Time Pre 10/28/2016 10	
			Ti t	le XIX	Hospi tal	PPS	
			Charges				
	Cost Center Description	I npati ent	Outpati ent		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 & PEDI ATRI CS	7, 209, 434		7, 209, 434			30. 00
43.00	04300 NURSERY	937, 714		937, 714	l I		43. 00
	ANCILLARY SERVICE COST CENTERS						
50.00	05000 OPERATING ROOM	6, 144, 868	13, 101, 943			0. 000000	
52.00	05200 DELIVERY ROOM & LABOR ROOM	3, 439, 242	0	-,,		0. 000000	
53.00	05300 ANESTHESI OLOGY	683, 420	2, 284, 891	2, 968, 311		0.000000	
54.00	05400 RADI OLOGY-DI AGNOSTI C	3, 248, 338	28, 449, 410			0.000000	
60.00	06000 LABORATORY	2, 773, 384	12, 104, 616	14, 878, 000		0.000000	
62. 30	06250 BLOOD CLOTTING FOR HEMOPHILIACS	0	0		0.000000	0.000000	
65.00	06500 RESPI RATORY THERAPY	1, 373, 450	3, 714, 694	5, 088, 144		0.000000	
66.00	06600 PHYSI CAL THERAPY	549, 561	2, 878, 368		0. 523851	0.000000	
67.00	06700 OCCUPATI ONAL THERAPY	49, 274	885, 860	935, 134	0. 377538	0.000000	67. 00
68.00	06800 SPEECH PATHOLOGY	16, 349	356, 740	373, 089	0. 380102	0.000000	68. 00
69.00	06900 ELECTROCARDI OLOGY	616, 184	211, 072	827, 256	0. 016792	0.000000	69. 00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	2, 511, 563	7, 237, 080	9, 748, 643	0. 118542	0.000000	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	4, 165, 632	1, 133, 341	5, 298, 973	0. 356690	0.000000	72. 00
73.00	07300 DRUGS CHARGED TO PATIENTS	4, 680, 319	8, 439, 522	13, 119, 84 ²	0. 214517	0.000000	73. 00
76. 97	07697 CARDI AC REHABI LI TATI ON	0	0	(0. 000000	0.000000	76. 97
76. 98	07698 HYPERBARI C OXYGEN THERAPY	o	0	(0. 000000	0.000000	76. 98
76. 99	07699 LI THOTRI PSY	o	0	(0. 000000	0.000000	76. 99
	OUTPATIENT SERVICE COST CENTERS						
91.00	09100 EMERGENCY	2, 114, 121	15, 600, 828	17, 714, 949	0. 152300	0.000000	91. 00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART	0	1, 344, 066	1, 344, 066	0. 998836	0.000000	92.00
	OTHER REIMBURSABLE COST CENTERS						
95.00	09500 AMBULANCE SERVICES	0	6, 443, 537	6, 443, 537	0. 563069	0.000000	95. 00
	SPECIAL PURPOSE COST CENTERS	'			'		
113.00	11300 NTEREST EXPENSE						113. 00
200.00	Subtotal (see instructions)	40, 512, 853	104, 185, 968	144, 698, 82°			200. 00
201.00	,						201. 00
202.00	1	40, 512, 853	104, 185, 968	144, 698, 82°			202. 00
				•			

Health Financial Systems	HUNTINGTON MEMORIAL HOSPITAL	In Lie	eu of Form CMS-2552-10
COMPUTATION OF RATIO OF COSTS TO CHARGES	Provi der CCN: 1500	From 01/01/2015	Worksheet C Part I Date/Time Prepared: 10/28/2016 10:35 am

				10/28/2016 10:35 am
		Title XIX	Hospi tal	PPS
Cost Center Description	PPS Inpatient			
	Ratio			
	11.00			
INPATIENT ROUTINE SERVICE COST CENTERS				
30. 00 03000 ADULTS & PEDI ATRI CS				30.00
43. 00 04300 NURSERY				43. 00
ANCILLARY SERVICE COST CENTERS				
50.00 05000 OPERATI NG ROOM	0. 094299			50.00
52.00 05200 DELIVERY ROOM & LABOR ROOM	0. 386455			52. 00
53. 00 05300 ANESTHESI OLOGY	0. 397568			53. 00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	0. 103794			54.00
60. 00 06000 LABORATORY	0. 204707			60. 00
62.30 06250 BLOOD CLOTTING FOR HEMOPHILIACS	0. 000000			62. 30
65. 00 06500 RESPI RATORY THERAPY	0. 273873			65. 00
66. 00 06600 PHYSI CAL THERAPY	0. 523851			66.00
67. 00 06700 OCCUPATI ONAL THERAPY	0. 377538			67. 00
68.00 06800 SPEECH PATHOLOGY	0. 380102			68. 00
69. 00 06900 ELECTROCARDI OLOGY	0. 016792			69. 00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0. 118542			71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0. 356690			72. 00
73.00 07300 DRUGS CHARGED TO PATIENTS	0. 214517			73. 00
76. 97 07697 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. 152300			91. 00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART	0. 998836			92. 00
OTHER REIMBURSABLE COST CENTERS				
95. 00 09500 AMBULANCE SERVICES	0. 563069			95. 00
SPECIAL PURPOSE COST CENTERS				
113. 00 11300 I NTEREST EXPENSE				113. 00
200.00 Subtotal (see instructions)				200. 00
201.00 Less Observation Beds				201. 00
202.00 Total (see instructions)				202. 00

Health Financial Systems			HUNTINGTON MEMOR	I AL HOSPI TAL	In Lie	u of Form CMS-2552-10
CALCULATION OF OUTPATIENT	SERVICE COST	TO CHARGE	RATIOS NET OF	Provider CCN: 15009		Worksheet C
DEDUCTIONS FOR MEDICALD OF	NIL XZ				Erom 01/01/2015	Dart II

From 01/01/2015 Part II To 12/31/2015 Date/Ti me Prepared: REDUCTIONS FOR MEDICALD ONLY

						10/28/2016 10	35 am
			Ti t	le XIX	Hospi tal	PPS	
	Cost Center Description	Total Cost		Operating Cos		Operating Cost	
		(Wkst. B, Part	(Wkst. B, Part	Net of Capita	I Reduction	Reduction	
		I, col. 26)	II col. 26)	Cost (col. 1	-	Amount	
				col . 2)			
		1.00	2. 00	3.00	4. 00	5. 00	
AN	ICILLARY SERVICE COST CENTERS						
50.00 05	5000 OPERATING ROOM	1, 813, 864	149, 123	1, 664, 74	1 0	0	50.00
52. 00 05	5200 DELIVERY ROOM & LABOR ROOM	1, 329, 113	87, 584	1, 241, 52	9 0	0	52.00
53.00 05	5300 ANESTHESI OLOGY	1, 180, 104	77, 456	1, 102, 64	8 0	0	53.00
54.00 05	5400 RADI OLOGY-DI AGNOSTI C	3, 290, 039	473, 880	2, 816, 15	9 0	0	54.00
60.00 06	6000 LABORATORY	3, 045, 636	205, 419	2, 840, 21	7 0	0	60.00
62. 30 06	5250 BLOOD CLOTTING FOR HEMOPHILIACS	0	0)	0	0	62. 30
65. 00 06	5500 RESPIRATORY THERAPY	1, 393, 504	135, 400	1, 258, 10	4 0	0	65.00
66. 00 06	6600 PHYSI CAL THERAPY	1, 795, 724	156, 125	1, 639, 59	9 0	0	66. 00
67. 00 06	5700 OCCUPATIONAL THERAPY	353, 049	23, 176	329, 87	3 0	0	67. 00
68. 00 06	SPEECH PATHOLOGY	141, 812	9, 309	132, 50	3 0	0	68. 00
69. 00 06	5900 ELECTROCARDI OLOGY	13, 891	922	12, 96	9 0	0	69. 00
71. 00 07	7100 MEDICAL SUPPLIES CHARGED TO PATIENT	1, 155, 625	79, 404	1, 076, 22	1 0	0	71. 00
72. 00 07	7200 IMPL. DEV. CHARGED TO PATIENTS	1, 890, 092	222, 401	1, 667, 69	1 0	0	72.00
73. 00 07	7300 DRUGS CHARGED TO PATIENTS	2, 814, 424	184, 884	2, 629, 54	o o	0	73.00
76. 97 07	7697 CARDIAC REHABILITATION	0	O		o o	0	76. 97
76. 98 07	7698 HYPERBARIC OXYGEN THERAPY	0	Ö	1	o o	0	76. 98
76. 99 07	7699 LI THOTRI PSY	0	Ö	1	o o	0	76. 99
OU	JTPATIENT SERVICE COST CENTERS				<u> </u>		
91.00 09	P100 EMERGENCY	2, 697, 981	234, 375	2, 463, 60	6 0	0	91.00
92. 00 09	9200 OBSERVATION BEDS (NON-DISTINCT PART	1, 342, 501	128, 962	1, 213, 53	9 0	0	92.00
ОТ	THER REIMBURSABLE COST CENTERS						
95. 00 09	9500 AMBULANCE SERVICES	3, 628, 157	405, 899	3, 222, 25	8 0	0	95. 00
SP	PECIAL PURPOSE COST CENTERS						
113.00 11	1300 INTEREST EXPENSE						113. 00
200.00	Subtotal (sum of lines 50 thru 199)	27, 885, 516	2, 574, 319	25, 311, 19	7 0	0	200. 00
201.00	Less Observation Beds	1, 342, 501			9 0	0	201. 00
202. 00	Total (line 200 minus line 201)	26, 543, 015	2, 445, 357	24, 097, 65	8 0	0	202. 00

Health Financial Systems	HUNTINGTON MEMORIAL	HOSPI TAL	In Lie	u of Form CMS-2552-10
CALCULATION OF OUTPATIENT SERVICE COST	TO CHARGE RATIOS NET OF	Provider CCN: 150091	From 01/01/2015	Worksheet C Part II Date/Time Prepared:

						10/28/2016 1	0:35 am
			Ti t	le XIX	Hospi tal	PPS	
	Cost Center Description	Cost Net of	Total Charges				
		Capital and		Cost to Charge			
		Operating Cost	Part I, column	Ratio (col. 6			
		Reducti on	8)	/ col. 7)			
		6.00	7. 00	8.00			
	ANCILLARY SERVICE COST CENTERS						
50.00	05000 OPERATING ROOM	1, 813, 864	19, 246, 811	0. 094242			50.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	1, 329, 113	3, 439, 242	0. 386455			52. 00
53.00	05300 ANESTHESI OLOGY	1, 180, 104	2, 968, 311	0. 397568			53. 00
54.00	05400 RADI OLOGY-DI AGNOSTI C	3, 290, 039	31, 697, 748	0. 103794			54.00
60.00	06000 LABORATORY	3, 045, 636	14, 878, 000	0. 204707			60.00
62. 30	06250 BLOOD CLOTTING FOR HEMOPHILIACS	0	C	0.000000			62. 30
65.00	06500 RESPI RATORY THERAPY	1, 393, 504	5, 088, 144	0. 273873			65. 00
66.00	06600 PHYSI CAL THERAPY	1, 795, 724	3, 427, 929	0. 523851			66. 00
67.00	06700 OCCUPATI ONAL THERAPY	353, 049	935, 134	0. 377538			67. 00
68. 00	06800 SPEECH PATHOLOGY	141, 812	373, 089	0. 380102			68. 00
69.00	06900 ELECTROCARDI OLOGY	13, 891	827, 256	0. 016792			69. 00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	1, 155, 625	9, 748, 643	0. 118542			71. 00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	1, 890, 092	5, 298, 973	0. 356690			72. 00
73.00	07300 DRUGS CHARGED TO PATIENTS	2, 814, 424	13, 119, 841	0. 214517			73. 00
76. 97	07697 CARDI AC REHABI LI TATI ON	0	C	0. 000000			76. 97
76. 98	07698 HYPERBARI C OXYGEN THERAPY	0	C	0.000000			76. 98
76. 99	07699 LI THOTRI PSY	0	C	0.000000			76. 99
	OUTPATIENT SERVICE COST CENTERS						
91.00	09100 EMERGENCY	2, 697, 981	17, 714, 949	0. 152300			91. 00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART	1, 342, 501	1, 344, 066	0. 998836			92.00
	OTHER REIMBURSABLE COST CENTERS			•			
95.00	09500 AMBULANCE SERVICES	3, 628, 157	6, 443, 537	0. 563069			95. 00
	SPECIAL PURPOSE COST CENTERS						
113.00	11300 INTEREST EXPENSE						113. 00
200.00	Subtotal (sum of lines 50 thru 199)	27, 885, 516	136, 551, 673	В			200. 00
201.00	Less Observation Beds	1, 342, 501	C				201.00
202.00	Total (line 200 minus line 201)	26, 543, 015	136, 551, 673	3			202. 00

Health Financial Systems	HUNTINGTON MEMO	RI AL	HOSPI TAL		In Lieu of Form CMS-2552-10			
APPORTIONMENT OF INPATIENT ROUTINE SERVICE CAPITAL	SERVICE CAPITAL COSTS				Peri od:	Worksheet D		
					From 01/01/2015			
					To 12/31/2015	Date/Time Pre 10/28/2016 10	pared: ·35 am	
			Ti tl	e XVIII	Hospi tal	PPS		
Cost Center Description	Capi tal	Sw	ing Bed	Reduced	Total Patient	Per Diem (col.		
	Related Cost	Adj	justment	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 & PEDI ATRI CS	678, 982		C	678, 98	2 5, 544	122. 47	30.00	
43. 00 NURSERY	5, 712			5, 71	2 725	7. 88	43.00	
200.00 Total (lines 30-199)	684, 694			684, 69	4 6, 269		200. 00	
Cost Center Description	I npati ent	In	pati ent					
	Program days	P	rogram					
		Capi	ital Cost					
		(col.	. 5 x col.					
			6)					
	6. 00		7.00					
INPATIENT ROUTINE SERVICE COST CENTERS								
30. 00 ADULTS & PEDIATRICS	1, 424		174, 397				30. 00	
43. 00 NURSERY	0		C)			43.00	
200.00 Total (lines 30-199)	1, 424		174, 397	·			200. 00	

Health Financial Systems	HUNTINGTON MEMO	RIAL	HOSPI TAL		In Lie	u of Form CMS-2	2552-10
APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPIT	AL COSTS		Provi der	CCN: 150091	Peri od:	Worksheet D	
					From 01/01/2015		
					To 12/31/2015	Date/Time Pre	
						10/28/2016 10	35 am
			Ti tl	e XVIII	Hospi tal	PPS	
Cost Center Description	Capi tal	Tota	l Charges	Ratio of Cos	t Inpatient	Capital Costs	
	Related Cost	(fron	n 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)			

					10/28/2016 10	35 am_
			e XVIII	Hospi tal	PPS	
Cost Center Description	Capi tal	Total Charges	Ratio of Cost	I npati ent	Capital Costs	
		(from Wkst. C,		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 OPERATI NG ROOM	149, 123		1	1, 252, 305	9, 703	50.00
52.00 05200 DELIVERY ROOM & LABOR ROOM	87, 584	3, 439, 242	0. 025466	0	0	52.00
53. 00 05300 ANESTHESI OLOGY	77, 456	2, 968, 311	0. 026094	0	0	53.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	473, 880	31, 697, 748	0. 014950	1, 196, 416	17, 886	54.00
60. 00 06000 LABORATORY	205, 419	14, 878, 000	0. 013807	940, 991	12, 992	60.00
62.30 06250 BLOOD CLOTTING FOR HEMOPHILIACS	0	C	0.000000	0	0	62.30
65. 00 06500 RESPIRATORY THERAPY	135, 400	5, 088, 144	0. 026611	534, 595	14, 226	65.00
66. 00 06600 PHYSI CAL THERAPY	156, 125	3, 427, 929	0. 045545	248, 955	11, 339	66.00
67. 00 06700 OCCUPATI ONAL THERAPY	23, 176	935, 134	0. 024784	21, 360	529	67.00
68. 00 06800 SPEECH PATHOLOGY	9, 309	373, 089	0. 024951	9, 297	232	68.00
69. 00 06900 ELECTROCARDI OLOGY	922	827, 256	0. 001115	0	0	69.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	79, 404	9, 748, 643	0. 008145	442, 569	3, 605	71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	222, 401	5, 298, 973	0. 041971	1, 414, 048	59, 349	72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	184, 884	13, 119, 841	0. 014092	1, 368, 220	19, 281	73.00
76. 97 07697 CARDI AC REHABI LI TATI ON	0	C	0.000000	0	0	76. 97
76. 98 07698 HYPERBARI C OXYGEN THERAPY	0	l	0.000000	o	0	76. 98
76. 99 07699 LI THOTRI PSY	0		0. 000000	0	0	76. 99
OUTPATIENT SERVICE COST CENTERS	<u>'</u>	<u> </u>		'		
91. 00 09100 EMERGENCY	234, 375	17, 714, 949	0. 013230	846, 276	11, 196	91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART	128, 962	1, 344, 066	0. 095949	0	0	92.00
OTHER REIMBURSABLE COST CENTERS	•	· · · · · · · · · · · · · · · · · · ·		'		
95. 00 09500 AMBULANCE SERVI CES						95.00
200.00 Total (lines 50-199)	2, 168, 420	130, 108, 136	,	8, 275, 032	160, 338	200. 00

Health Financial Systems	HUNTI NGTON MEMO	RIAL HOSPITAL		In Li€	eu of Form CMS-	2552-10
APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER P	ASS THROUGH COS	TS Provi der		Period: From 01/01/2015	Worksheet D Part III	
				To 12/31/2015		pared:
					10/28/2016 10	
	_		e XVIII	Hospi tal	PPS	
Cost Center Description	Nursing School			Swi ng-Bed	Total Costs	
		Cost	Medi cal	Adjustment	(sum of cols.	
			Education Cos		1 through 3,	
					minus col. 4)	
	1. 00	2.00	3. 00	4. 00	5. 00	
INPATIENT ROUTINE SERVICE COST CENTERS						
30. 00 03000 ADULTS & PEDI ATRI CS	0	C)	0	0	30.00
43. 00 04300 NURSERY	0	C		0	0	43.00
200.00 Total (lines 30-199)	0	C)	0	0	200. 00
Cost Center Description	Total Patient	Per Diem (col.	I npati ent	I npati ent		
	Days	5 ÷ col. 6)	Program Days	Program		
				Pass-Through		
				Cost (col. 7 x		
				col . 8)		
	6. 00	7.00	8. 00	9. 00		
INPATIENT ROUTINE SERVICE COST CENTERS						
30. 00 03000 ADULTS & PEDIATRICS	5, 544	0.00	1, 42	4 0)	30.00
43. 00 04300 NURSERY	725	0.00)	0		43.00
200.00 Total (lines 30-199)	6, 269		1, 42	4 0		200.00

Heal th	Financial Systems	HUNTI NGTON MEMOR	RIAL HOSPITAL		In Lie	eu of Form CMS-2	2552-10
APPORT	IONMENT OF INPATIENT/OUTPATIENT ANCILLARY SEI H COSTS	RVICE OTHER PASS	Provi der		Period: From 01/01/2015 Fo 12/31/2015		
				e XVIII	Hospi tal	PPS	
	Cost Center Description	Non Physician N Anesthetist Cost	Nursing School	Allied Health	All Other Medical Education Cost	Total Cost (sum of col 1 through col. 4)	
		1.00	2. 00	3. 00	4. 00	5. 00	
	ANCILLARY SERVICE COST CENTERS						
50.00	05000 OPERATING ROOM	0	0	(0	0	50. 00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0	0	(0	0	52. 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
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	0	0	(0	0	66. 00
67.00	06700 OCCUPATI ONAL THERAPY	0	0	(0	0	67.00
68. 00	06800 SPEECH PATHOLOGY	0	0	(0	0	68. 00
69.00	06900 ELECTROCARDI OLOGY	0	0	(0	0	69.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	(0	0	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0	0	(0	0	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0	0	(0	0	73. 00
76 07	07607 CADDIAC DEHADILITATION	1 0	0	l ,	ما م	۸ ا	76 07

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0 76. 97

0 76. 98

0 76. 99

0 91.00

0 92.00

76. 97

76. 99

91.00

200.00

07697 CARDIAC REHABILITATION

OUTPATIENT SERVICE COST CENTERS

Total (lines 50-199)

92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART OTHER REIMBURSABLE COST CENTERS

76. 98 07698 HYPERBARI C OXYGEN THERAPY

07699 LI THOTRI PSY

95. 00 09500 AMBULANCE SERVICES

09100 EMERGENCY

		HUNTINGTON MEMO		2011 452224		u of Form CMS-2	2552-10
	IONMENT OF INPATIENT/OUTPATIENT ANCILLARY SEF	RVICE OTHER PAS	S Provi der		Period: From 01/01/2015	Worksheet D Part IV	
THROUG	H COSTS				To 12/31/2015	Date/Time Pre	nared:
					10 12/01/2010	10/28/2016 10	
			Ti tl	e XVIII	Hospi tal	PPS	
	Cost Center Description	Total	Total Charges			I npati ent	
		Outpati ent	(from Wkst. C,	to Charges	Ratio of Cost	Program	
		Cost (sum of		(col. 5 ÷ col		Charges	
		col . 2, 3 and	8)	7)	(col. 6 ÷ col.		
		4)			7)		
		6. 00	7. 00	8. 00	9. 00	10. 00	
	ANCILLARY SERVICE COST CENTERS	_	,				
50.00	05000 OPERATING ROOM	0	19, 246, 811	1		1, 252, 305	50.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0	3, 439, 242	l .		0	52. 00
53.00	05300 ANESTHESI OLOGY	0	2, 968, 311	1		0	53. 00
54.00	05400 RADI OLOGY-DI AGNOSTI C	0	31, 697, 748	1		1, 196, 416	54. 00
60.00	06000 LABORATORY	0	14, 878, 000	1		940, 991	
62. 30	06250 BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0.00000	0. 000000	0	62. 30
65.00	06500 RESPI RATORY THERAPY	0	5, 088, 144			534, 595	65. 00
66.00	06600 PHYSI CAL THERAPY	0	3, 427, 929	0.00000	0. 000000	248, 955	66. 00
67.00	06700 OCCUPATI ONAL THERAPY	0	935, 134	0.00000	0. 000000	21, 360	67. 00
68.00	06800 SPEECH PATHOLOGY	0	373, 089	0.00000	0. 000000	9, 297	68. 00
69.00	06900 ELECTROCARDI OLOGY	0	827, 256	0.00000	0. 000000	0	69. 00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0	9, 748, 643	0.00000	0. 000000	442, 569	71. 00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0	5, 298, 973	0.00000	0. 000000	1, 414, 048	72. 00
73.00	07300 DRUGS CHARGED TO PATIENTS	0	13, 119, 841	0.00000	0. 000000	1, 368, 220	73. 00
76. 97	07697 CARDI AC REHABI LI TATI ON	0	0	0.00000	0. 000000	0	76. 97
76. 98	07698 HYPERBARI C OXYGEN THERAPY	0	0	0.00000	0. 000000	0	76. 98
76. 99	07699 LI THOTRI PSY	0	0	0.00000	0. 000000	0	76. 99
	OUTPATIENT SERVICE COST CENTERS	•					
91 00	09100 EMERGENCY	0	17 714 949	0.00000	0 000000	846, 276	91.00

0

17, 714, 949

130, 108, 136

1, 344, 066

0. 000000 0. 000000 0. 000000 0. 000000

846, 276

8, 275, 032 200. 00

91.00

0 92.00

95.00

91.00 09100 EMERGENCY 92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART OTHER REIMBURSABLE COST CENTERS

95. 00 | 09500 | AMBULANCE SERVICES | Total (lines 50-199)

Health Financial Systems		HUNTI	NGTON	MEMORI AL	HOSPI TAL			In Lieu	of Form CMS-2552-10
APPORTIONMENT OF INPATIENT/OUTPATIENT THROUGH COSTS	ANCI LLARY	SERVI CE	OTHER	PASS	Provi der	CCN:	150091	01/01/2015 12/31/2015	Worksheet D Part IV Date/Time Prepared:

					10/28/2016 10): 35 am_
		Ti tl	e XVIII	Hospi tal	PPS	
Cost Center Description	I npati ent	Outpati ent	Outpati ent			
	Program	Program	Program			
	Pass-Through	Charges	Pass-Through			
	Costs (col. 8		Costs (col. 9			
	x col. 10)		x col. 12)			
	11.00	12. 00	13. 00			
ANCILLARY SERVICE COST CENTERS						
50. 00 05000 OPERATI NG ROOM	0	3, 078, 535	0			50.00
52.00 05200 DELIVERY ROOM & LABOR ROOM	0	0	0			52. 00
53. 00 05300 ANESTHESI OLOGY	0	0	0			53.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	0	6, 483, 709	0			54.00
60. 00 06000 LABORATORY	0	432, 136	0			60.00
62.30 06250 BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0			62. 30
65. 00 06500 RESPIRATORY THERAPY	0	645, 229	0			65.00
66. 00 06600 PHYSI CAL THERAPY	0	0	0			66.00
67. 00 06700 OCCUPATI ONAL THERAPY	0	0	0			67.00
68. 00 06800 SPEECH PATHOLOGY	0	0	0			68. 00
69. 00 06900 ELECTROCARDI OLOGY	0	0	0			69. 00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0	358, 924	. 0			71. 00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0	147, 738	0			72. 00
73.00 07300 DRUGS CHARGED TO PATIENTS	o	1, 737, 347	0			73.00
76. 97 07697 CARDI AC REHABI LI TATI ON	o	0	0			76. 97
76. 98 07698 HYPERBARI C OXYGEN THERAPY	o	0	0			76. 98
76. 99 07699 LI THOTRI PSY	ol	0	0			76. 99
OUTPATIENT SERVICE COST CENTERS	,					
91. 00 09100 EMERGENCY	0	2, 937, 146	0			91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART	o	613, 520	0			92.00
OTHER REIMBURSABLE COST CENTERS	'	·				1
95. 00 09500 AMBULANCE SERVI CES						95. 00
200.00 Total (lines 50-199)	o	16, 434, 284	. 0			200. 00

Health Financial Systems	HUNTI NGTON MEMORI AL	HOSPI TAL	In Lie	u of Form CMS-2552-10
APPORTIONMENT OF MEDICAL,	OTHER HEALTH SERVICES AND VACCINE COST	Provider CCN: 150091	Peri od:	Worksheet D

From 01/01/2015 | Part V To 12/31/2015 | Date/Time Prepared: 10/28/2016 10:35 am Title XVIII Hospi tal PPS Charges Costs Cost to Charge PPS Reimbursed Cost Center Description Cost Cost PPS Services Ratio From Services (see Rei mbursed Rei mbursed (see inst.) Worksheet C, inst.) Servi ces Services Not Part I, col. 9 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 0.094242 3, 078, 535 290, 127 50.00 0 52.00 05200 DELIVERY ROOM & LABOR ROOM 0. 386455 0 52.00 05300 ANESTHESI OLOGY 0. 397568 0 53 00 53 00 0 0 0 54.00 05400 RADI OLOGY-DI AGNOSTI C 0.103794 6, 483, 709 672, 970 54.00 60.00 06000 LABORATORY 0. 204707 432, 136 0 0 88, 461 60.00 0 62.30 06250 BLOOD CLOTTING FOR HEMOPHILIACS 0.000000 0 0 0 0 0 62 30 0 06500 RESPIRATORY THERAPY 65.00 0.273873 645, 229 176, 711 65.00 66.00 06600 PHYSI CAL THERAPY 0.523851 66.00 06700 OCCUPATIONAL THERAPY 0 67.00 0. 377538 0 67.00 0 06800 SPEECH PATHOLOGY 0.380102 0 68 00 68 00 Ω 0 69.00 06900 ELECTROCARDI OLOGY 0.016792 Ω 69.00 71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT 0.118542 358, 924 0 0 0 0 42, 548 71.00 147, 738 72.00 07200 IMPL. DEV. CHARGED TO PATIENTS 0.356690 0 52, 697 72.00 0 07300 DRUGS CHARGED TO PATIENTS 73 00 0.214517 1, 737, 347 372, 690 73.00 76.97 07697 CARDIAC REHABILITATION 0.000000 0 0 76.97 76. 98 07698 HYPERBARI C OXYGEN THERAPY 0.000000 0 76. 98 76. 99 07699 LI THOTRI PSY 0.000000 0 76. 99 0 OUTPATIENT SERVICE COST CENTERS 91.00 09100 EMERGENCY 0. 152300 2, 937, 146 0 0 447, 327 91.00 09200 OBSERVATION BEDS (NON-DISTINCT PART 0 0 92.00 92.00 0.998836 613, 520 612, 806 OTHER REIMBURSABLE COST CENTERS 95 00 09500 AMBULANCE SERVICES 0.563069 0 95 00 200.00 Subtotal (see instructions) 16, 434, 284 0 0 2, 756, 337 200.00 Less PBP Clinic Lab. Services-Program 0 o 201.00 201. 00 Only Charges 0 0 202.00 Net Charges (line 200 +/- line 201) 2, 756, 337 202. 00 16, 434, 284

Health Financial Systems		HUNTINGTON MEMORIAL	HOSPI TAL	In Lie	u of Form CMS-2552-10
APPORTIONMENT OF MEDICAL,	OTHER HEALTH SERVICES	AND VACCINE COST	Provider CCN: 150091	From 01/01/2015	Worksheet D Part V Date/Time Prepared:

				10 12/31/2015	Date/IIme Pre 10/28/2016 10	
		Ti tl	e XVIII	Hospi tal	PPS	
	Cos	sts				
Cost Center Description	Cost	Cost				
	Rei mbursed	Reimbursed				
	Servi ces	Services Not				
	Subject To	Subject To				
	Ded. & Coins.	Ded. & Coins.				
	(see inst.)	(see inst.)				
ANOUL ARY OFRWAR COOK OFFITERS	6. 00	7.00				
ANCILLARY SERVICE COST CENTERS						
50. 00 05000 OPERATING ROOM	0	C				50.00
52. 00 05200 DELI VERY ROOM & LABOR ROOM	0					52.00
53. 00 05300 ANESTHESI OLOGY	0	(53. 00
54. 00 05400 RADI OLOGY - DI AGNOSTI C	0	(54.00
60. 00 06000 LABORATORY	0	(1			60.00
62. 30 06250 BLOOD CLOTTING FOR HEMOPHILIACS	0	(1			62. 30
65. 00 06500 RESPI RATORY THERAPY	0	(1			65. 00
66. 00 06600 PHYSI CAL THERAPY	0	(1			66. 00
67. 00 06700 OCCUPATI ONAL THERAPY	0	(1			67. 00
68. 00 06800 SPEECH PATHOLOGY	0	(1			68. 00
69. 00 06900 ELECTROCARDI OLOGY	0	(1			69. 00
71. 00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0	(71.00
72. 00 07200 IMPL. DEV. CHARGED TO PATIENTS	0					72. 00
73. 00 07300 DRUGS CHARGED TO PATIENTS	0					73.00
76. 97 O7697 CARDI AC REHABI LI TATI ON	0					76. 97
76. 98 O7698 HYPERBARI C OXYGEN THERAPY	0					76. 98
76. 99 07699 LI THOTRI PSY	0		1			76. 99
91.00 OUTPATIENT SERVICE COST CENTERS 91.00 O9100 EMERGENCY						91. 00
	0	l	1			91.00
92. 00 O9200 OBSERVATION BEDS (NON-DISTINCT PART OTHER REIMBURSABLE COST CENTERS	0		1			92.00
95. 00 09500 AMBULANCE SERVICES	0		Ι			95. 00
200.00 Subtotal (see instructions)		(J			200.00
201.00 Less PBP Clinic Lab. Services-Program			Ί			200.00
Only Charges						201.00
202.00 Net Charges (line 200 +/- line 201)	0		,			202. 00
202. 30	1	1	Т			1202.00

Health Financial Systems	HUNTINGTON MEMORIAL HOSPITAL In Lieu of Form CMS-2					2552-10	
APPORTIONMENT OF INPATIENT ROUTINE SERVICE CAPITAL	COSTS		Provi der		Peri od:	Worksheet D	
					From 01/01/2015		
					To 12/31/2015	Date/Time Pre 10/28/2016 10	parea: ·35 am
			Ti t	le XIX	Hospi tal	PPS	. 55 am
Cost Center Description	Capi tal	Sw	ing Bed	Reduced		Per Diem (col.	
'	Related Cost		justment	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 & PEDI ATRI CS	678, 982		C	678, 98	2 5, 544	122. 47	30. 00
43. 00 NURSERY	5, 712			5, 71	2 725	7. 88	43.00
200.00 Total (lines 30-199)	684, 694			684, 69	4 6, 269		200. 00
Cost Center Description	I npati ent	۱n	pati ent				
	Program days	P	rogram				
		Capi	ital Cost				
		(col.	. 5 x col.				
			6)				
	6. 00		7. 00				
INPATIENT ROUTINE SERVICE COST CENTERS	_						
30. 00 ADULTS & PEDIATRICS	176		21, 555				30. 00
43. 00 NURSERY	71	1	559	1			43. 00
200.00 Total (lines 30-199)	247		22, 114				200. 00

Health Financial System	ie.	HUNTI NGTON MEM	ODI AI	UUSDI TVI		In Lie	u of Form CMS-:	2552 10
	ENT ANCILLARY SERVICE CA		OKTAL		CCN: 150091	Peri od:	Worksheet D	2552-10
						From 01/01/2015 To 12/31/2015	Part II Date/Time Pre 10/28/2016 10	
				Ti t	le XIX	Hospi tal	PPS	
Cost Center	r Description	Capi tal	Tota	l Charges	Ratio of Cos	t Inpatient	Capital Costs	
		Related Cost	(fron	n Wkst. C,	to Charges	Program	(column 3 x	
		(from Wkst. B,			1	. Charges	column 4)	
Cost Center	r Description	Related Cost	(from	l Charges n Wkst. C,	Ratio of Cos to Charges	t Inpatient Program	Capital Costs (column 3 x	

					10 12/01/2010	10/28/2016 10	: 35 am
				Title XIX	Hospi tal	PPS	
	Cost Center Description	Capi tal	Total Charg	es Ratio of Cos	t Inpatient	Capital Costs	
		Related Cost				(column 3 x	
		(from Wkst. B,		I. (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						
	05000 OPERATING ROOM	149, 123				20, 384	
	05200 DELIVERY ROOM & LABOR ROOM	87, 584				0	52. 00
	05300 ANESTHESI OLOGY	77, 456				0	53. 00
	05400 RADI OLOGY-DI AGNOSTI C	473, 880		•	·		
	06000 LABORATORY	205, 419	14, 878,		·	6, 841	
	06250 BLOOD CLOTTING FOR HEMOPHILIACS	0		0. 00000		0	
	06500 RESPI RATORY THERAPY	135, 400					
	06600 PHYSI CAL THERAPY	156, 125	3, 427,		·	1	
	06700 OCCUPATI ONAL THERAPY	23, 176			·		67. 00
	06800 SPEECH PATHOLOGY	9, 309				9	68. 00
	06900 ELECTROCARDI OLOGY	922	827,			0	69. 00
	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	79, 404	9, 748,		·		
	07200 IMPL. DEV. CHARGED TO PATIENTS	222, 401	5, 298,	973 0. 04197	71 137, 471	5, 770	72. 00
	07300 DRUGS CHARGED TO PATIENTS	184, 884	13, 119,	841 0. 01409	92 904, 803	12, 750	73. 00
	07697 CARDIAC REHABILITATION	0		0.00000	00	0	76. 97
76. 98	07698 HYPERBARIC OXYGEN THERAPY	0		0.00000	00 0	0	76. 98
	07699 LI THOTRI PSY	0		0.00000	00 0	0	76. 99
	OUTPAȚIENT SERVICE COST CENTERS						
	09100 EMERGENCY	234, 375	17, 714,			3, 395	
	09200 OBSERVATION BEDS (NON-DISTINCT PART	128, 962	1, 344,	066 0. 09594	19 C	0	92. 00
	OTHER REIMBURSABLE COST CENTERS						
	09500 AMBULANCE SERVICES						95. 00
200.00	Total (lines 50-199)	2, 168, 420	130, 108,	136	5, 297, 617	64, 412	200. 00

Health Financial Systems	HUNTINGTON MEMO	ORIAL HOSPITAL		In Li€	eu of Form CMS-2	2552-10
APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER	PASS THROUGH COS	TS Provi der		Peri od:	Worksheet D	
				From 01/01/2015 To 12/31/2015		narod:
				10 12/31/2013	10/28/2016 10	: 35 am
		_ Ti ·	tle XIX	Hospi tal	PPS	
Cost Center Description	Nursing School			Swi ng-Bed	Total Costs	
		Cost	Medi cal	Adjustment	(sum of cols.	
			Education Cos		1 through 3,	
					minus col. 4)	
	1. 00	2. 00	3. 00	4. 00	5. 00	
INPATIENT ROUTINE SERVICE COST CENTERS						
30. 00 03000 ADULTS & PEDI ATRI CS	C))	0	0	
43. 00 04300 NURSERY	C))	0	0	
200.00 Total (lines 30-199)	C)	D	0	0	200. 00
Cost Center Description		Per Diem (col.		I npati ent		
	Days	5 ÷ col. 6)	Program Days			
				Pass-Through		
				Cost (col. 7 x		
				col . 8)		
	6. 00	7. 00	8. 00	9. 00		
INPATIENT ROUTINE SERVICE COST CENTERS						
30. 00 03000 ADULTS & PEDIATRICS	5, 544	0.00	0 17	6 0	4	30. 00
43. 00 04300 NURSERY	725	0.00	0 7	1 0	4	43. 00
200.00 Total (lines 30-199)	6, 269	1	24	7 0		200. 00

Heal th	Financial Systems	HUNTINGTON MEMO	RIAL HOSPITAL		In lie	u of Form CMS-2	2552-10
APPOR1	TIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SER SH COSTS		S Provi der	F	Period: From 01/01/2015 To 12/31/2015	Worksheet D Part IV	pared:
			Ti t	le XIX	Hospi tal	PPS	
	Cost Center Description	Non Physician Anesthetist Cost	Nursing School	Allied Health	All Other Medical Education Cost	Total Cost (sum of col 1 through col.	
						4)	
		1. 00	2. 00	3. 00	4. 00	5. 00	
	ANCILLARY SERVICE COST CENTERS						
50.00	05000 OPERATI NG ROOM	0	0) (0	0	00.00
52. 00	05200 DELIVERY ROOM & LABOR ROOM	0	0) (0	0	52. 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
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	0	0) (0	0	66. 00
67. 00	06700 OCCUPATI ONAL THERAPY	0	0) (0	0	67. 00
68. 00	06800 SPEECH PATHOLOGY	0	0) (0	0	68. 00
69.00	06900 ELECTROCARDI OLOGY	0	Ö		0	0	69. 00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0	Ö		0	0	71. 00
72. 00	07200 IMPL. DEV. CHARGED TO PATIENTS	0	d		0	0	72. 00
73.00	07300 DRUGS CHARGED TO PATIENTS	0	o		0	0	73. 00
76. 97	07697 CARDI AC REHABI LI TATI ON	0	o		0	0	76. 97
76. 98	07698 HYPERBARI C OXYGEN THERAPY	0	O		0	0	76. 98
76. 99	07699 LI THOTRI PSY	0	0		0	0	76. 99

0

0

0

0

0

0

0

0

95.00

0 200. 00

0 91.00

0 92.00

OUTPATIENT SERVICE COST CENTERS

Total (lines 50-199)

92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART OTHER REIMBURSABLE COST CENTERS

95. 00 09500 AMBULANCE SERVICES

09100 EMERGENCY

91.00

200.00

Heal th	Financial Systems	HUNTINGTON MEMO	NTIDONH INIDI		Inlie	u of Form CMS-2	2552_10
APPORT	TONMENT OF INPATIENT/OUTPATIENT ANCILLARY SEF H COSTS				Period: From 01/01/2015 To 12/31/2015	Worksheet D Part IV Date/Time Pre	pared:
			Ti	tle XIX	Hospi tal	10/28/2016 10 PPS	: 35 am
	Cost Center Description	Total		Ratio of Cost		Inpati ent	
	2001 201101 20001 pt on		(from Wkst. C		Ratio of Cost	Program	
		Cost (sum of		(col. 5 ÷ col		Charges	
		col. 2, 3 and	·	7)	(col. 6 ÷ col.		
		4)	ĺ	_	7)		
		6. 00	7. 00	8. 00	9. 00	10.00	
	ANCILLARY SERVICE COST CENTERS			•			
50.00	05000 OPERATING ROOM	0	19, 246, 81	0.00000	0. 000000	2, 630, 932	50.00
	05200 DELIVERY ROOM & LABOR ROOM	0	3, 439, 24	0.00000		0	52. 00
53.00	05300 ANESTHESI OLOGY	0	2, 968, 31	0.00000	0. 000000	0	53. 00
54.00	05400 RADI OLOGY-DI AGNOSTI C	0	31, 697, 74	0. 00000	0. 000000	370, 959	54. 00
60.00	06000 LABORATORY	0	14, 878, 00	0. 00000	0. 000000	495, 508	60.00
62. 30	06250 BLOOD CLOTTING FOR HEMOPHILIACS	0		0. 00000	0. 000000	0	62. 30
65.00	06500 RESPI RATORY THERAPY	0	5, 088, 14	0.00000	0. 000000	261, 425	65. 00
66.00	06600 PHYSI CAL THERAPY	0	3, 427, 92	0.00000	0. 000000	20, 555	66. 00
67.00	06700 OCCUPATI ONAL THERAPY	0	935, 13	0.00000	0. 000000	2, 461	67. 00
68. 00	06800 SPEECH PATHOLOGY	0	373, 08	0.00000	0. 000000	357	68. 00
69.00	06900 ELECTROCARDI OLOGY	0	827, 25	0. 00000	0. 000000	0	69. 00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0	9, 748, 64	0. 00000	0. 000000	216, 501	71. 00
	07200 IMPL. DEV. CHARGED TO PATIENTS	0	5, 298, 97	0. 00000	0. 000000	137, 471	72. 00
73.00	07300 DRUGS CHARGED TO PATIENTS	0	13, 119, 84	0. 00000	0. 000000	904, 803	73. 00
76. 97	07697 CARDI AC REHABI LI TATI ON	0	(0. 00000	0. 000000	0	76. 97
76. 98	07698 HYPERBARI C OXYGEN THERAPY	0		0. 00000	0. 000000	0	76. 98
76. 99	07699 LI THOTRI PSY	0		0.00000	0. 000000	0	76. 99
	OUTPATIENT SERVICE COST CENTERS						
91.00	09100 EMERGENCY	0	17, 714, 94	0.00000	0.000000	256, 645	91.00

0

0. 000000 0. 000000

17, 714, 949 1, 344, 066

130, 108, 136

0. 000000 0. 000000

91.00 92.00 0

95.00

256, 645

5, 297, 617 200. 00

95. 00 | 09500 | AMBULANCE SERVICES | Total (lines 50-199)

Health Financial Systems	HUNTINGTON MEMORIAL	HOSPI TAL	In Lie	u of Form CMS-2552-10
APPORTIONMENT OF INPATIENT/OUTPATIENT THROUGH COSTS	ANCILLARY SERVICE OTHER PASS	Provider CCN: 150091	Peri od: From 01/01/2015 To 12/31/2015	Worksheet D Part IV Date/Time Prepared: 10/28/2016 10:35 am

					10/28/2016 10	<u>): 35 am</u>
			le XIX	Hospi tal	PPS	
Cost Center Description	Inpati ent	Outpati ent	Outpati ent			
	Program	Program	Program			
	Pass-Through	Charges	Pass-Through			
	Costs (col. 8		Costs (col. 9	9		
	x col. 10)		x col. 12)			
	11.00	12. 00	13. 00			
ANCILLARY SERVICE COST CENTERS						
50. 00 05000 OPERATI NG ROOM	0	0)	0		50.00
52.00 05200 DELIVERY ROOM & LABOR ROOM	0	0		0		52. 00
53. 00 05300 ANESTHESI OLOGY	0	0)	0		53. 00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	0	0)	0		54. 00
60. 00 06000 LABORATORY	0	0)	0		60.00
62.30 06250 BLOOD CLOTTING FOR HEMOPHILIACS	0	0)	0		62. 30
65. 00 06500 RESPI RATORY THERAPY	0	0)	0		65. 00
66. 00 06600 PHYSI CAL THERAPY	0	0		0		66. 00
67. 00 06700 OCCUPATI ONAL THERAPY	0	0		0		67. 00
68. 00 06800 SPEECH PATHOLOGY	0	0		0		68. 00
69. 00 06900 ELECTROCARDI OLOGY	0	0		O		69. 00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0	0		O		71. 00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0	0		o		72. 00
73.00 07300 DRUGS CHARGED TO PATIENTS	O	0		o		73. 00
76. 97 07697 CARDIAC REHABILITATION	O	0		o		76. 97
76. 98 07698 HYPERBARI C OXYGEN THERAPY	o	0		o		76. 98
76. 99 07699 LI THOTRI PSY	O	0		o		76. 99
OUTPATIENT SERVICE COST CENTERS						
91. 00 09100 EMERGENCY	0	0)	0		91. 00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART	o	O		o		92.00
OTHER REIMBURSABLE COST CENTERS						
95. 00 09500 AMBULANCE SERVICES						95. 00
200.00 Total (lines 50-199)	o	0		o		200. 00
			•	•		•

Health Financial Systems	HUNTINGTON MEMORIAL	HOSPI TAL		In Lieu of Form CMS-2552-10
APPORTIONMENT OF MEDICAL.	OTHER HEALTH SERVICES AND VACCINE COST	Provi der CCN: 150091	Peri od:	Worksheet D

near th Fir	nanci ai systems	HUNTINGTON WEWL	RIAL HUSPITAL		III LIE	u or Form CMS-2	2552-10
APPORTI ON	MENT OF MEDICAL, OTHER HEALTH SERVICES AND	VACCINE COST	Provi der		Peri od:	Worksheet D	
					From 01/01/2015		
					To 12/31/2015		pared:
			T: +	le XIX	Hospi tal	10/28/2016 10 PPS	: 35 am
			111		ноѕрі таі	Costs	
	Coat Contan Decement on	Coot to Change	PPS Reimbursed	Charges Cost	Cost	PPS Services	
	Cost Center Description						
			Services (see		Rei mbursed	(see inst.)	
		Worksheet C,	inst.)	Servi ces	Services Not		
		Part I, col. 9		Subject To	Subject To		
				Ded. & Coins			
				(see inst.)	(see inst.)		
		1. 00	2. 00	3. 00	4. 00	5. 00	
	CILLARY SERVICE COST CENTERS						
	OOO OPERATING ROOM	0. 094242		4, 364, 94	13 0	0	00.00
	200 DELIVERY ROOM & LABOR ROOM	0. 386455		1	0	0	
53.00 053	300 ANESTHESI OLOGY	0. 397568	0		0	0	53.00
54.00 054	400 RADI OLOGY-DI AGNOSTI C	0. 103794	0	4, 890, 32	23 0	0	54.00
60.00 060	DOO LABORATORY	0. 204707	0	2, 241, 99	0	0	60.00
62. 30 062	250 BLOOD CLOTTING FOR HEMOPHILIACS	0. 000000	l o		0 0	0	62, 30
65.00 065	500 RESPIRATORY THERAPY	0. 273873		375, 35	59 0	0	65.00
1	600 PHYSI CAL THERAPY	0. 523851	0	525, 54		0	66.00
	700 OCCUPATI ONAL THERAPY	0. 377538	1	295, 54		0	
	BOO SPEECH PATHOLOGY	0. 380102		177, 44		0	
	900 ELECTROCARDI OLOGY	0. 016792		177,	0 0	ĺ	
	100 MEDICAL SUPPLIES CHARGED TO PATIENT	0. 118542		316, 40	٥	0	1
	200 IMPL. DEV. CHARGED TO PATIENTS	0. 356690		179, 86		0	1
						ľ	73. 00
	BOO DRUGS CHARGED TO PATIENTS	0. 214517		995, 06	0	0	
4	697 CARDI AC REHABI LI TATI ON	0. 000000		1	0	0	1 . 0
4	698 HYPERBARI C OXYGEN THERAPY	0. 000000		1	0	0	
	699 LI THOTRI PSY	0. 000000	0		0 0	0	76. 99
	TPATIENT SERVICE COST CENTERS		T	,			
	100 EMERGENCY	0. 152300		.,			
92.00 092	200 OBSERVATION BEDS (NON-DISTINCT PART	0. 998836	0	274, 72	20 0	0	92. 00
	HER REI MBURSABLE COST CENTERS						
95.00 095	500 AMBULANCE SERVICES	0. 563069	0	844, 03	80		95. 00
200.00	Subtotal (see instructions)		0	19, 937, 06	0 0	0	200.00
201.00	Less PBP Clinic Lab. Services-Program				0 0		201. 00
	Only Charges						
202.00	Net Charges (line 200 +/- line 201)		0	19, 937, 06	0 0	0	202. 00
'		1	'		1		

Health Financial Systems	HUNTI NGTON MEMORI AL	HOSPI TAL	In Lie	ı of Form CMS-2552-10
APPORTI ONMENT OF MEDICAL,	OTHER HEALTH SERVICES AND VACCINE COST	Provi der CCN: 150091	Peri od: From 01/01/2015	Worksheet D Part V

To 12/31/2015 Part V

Date/Time Prepared:

				1.0	10/28/2016 10): 35 am
		Ti t	le XIX	Hospi tal	PPS	
	Cos	sts				
Cost Center Description	Cost	Cost				
	Rei mbursed	Rei mbursed				
	Servi ces	Services Not				
	Subject To	Subject To				
		Ded. & Coins.				
	(see inst.)	(see inst.)				
	6. 00	7. 00				
ANCILLARY SERVICE COST CENTERS						
50. 00 05000 OPERATING ROOM	411, 361	0				50. 00
52.00 05200 DELIVERY ROOM & LABOR ROOM	0	0				52. 00
53. 00 05300 ANESTHESI OLOGY	0	0				53. 00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	507, 586	0				54.00
60. 00 06000 LABORATORY	458, 951	0				60.00
62.30 06250 BLOOD CLOTTING FOR HEMOPHILIACS	0	0				62. 30
65. 00 06500 RESPIRATORY THERAPY	102, 801	0				65. 00
66. 00 06600 PHYSI CAL THERAPY	275, 309	0				66. 00
67. 00 06700 OCCUPATI ONAL THERAPY	111, 581	0				67. 00
68. 00 06800 SPEECH PATHOLOGY	67, 448	0				68. 00
69. 00 06900 ELECTROCARDI OLOGY	0	0				69. 00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	37, 507	0				71. 00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	64, 155	0				72. 00
73.00 07300 DRUGS CHARGED TO PATIENTS	213, 459	0				73. 00
76. 97 07697 CARDIAC REHABILITATION	0	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	678, 621	0				91. 00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART	274, 400	0				92.00
OTHER REIMBURSABLE COST CENTERS						1
95. 00 09500 AMBULANCE SERVICES	475, 247					95. 00
200.00 Subtotal (see instructions)	3, 678, 426	0				200. 00
201.00 Less PBP Clinic Lab. Services-Program	0					201. 00
Only Charges						
202.00 Net Charges (line 200 +/- line 201)	3, 678, 426	0				202. 00
		**************************************	•			•

Health Financial Systems	HUNTINGTON MEMORIAL	HOSPI TAL	In Lie	u of Form CMS-2	2552-10
COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 150091	Peri od: From 01/01/2015	Worksheet D-1	
			To 12/31/2015	Date/Time Pre 10/28/2016 10	pared: :35 am
		Title XVIII	Hospi tal	PPS	
Cost Center Description					
				1. 00	
PART I - ALL PROVIDER COMPONENTS					

		Title XVIII	Hospi tal	PPS	
	Cost Center Description		-	1. 00	
	PART I - ALL PROVIDER COMPONENTS			1.00	
	I NPATI ENT DAYS				
1.00	Inpatient days (including private room days and swing-bed days,			5, 544	1.00
2. 00 3. 00	Inpatient days (including private room days, excluding swing-be Private room days (excluding swing-bed and observation bed days		vate room days	5, 544 0	2. 00 3. 00
3.00	do not complete this line.). It you have only pri	vate room days,	O	3.00
4.00	Semi-private room days (excluding swing-bed and observation bed	days)		4, 491	4.00
5.00	Total swing-bed SNF type inpatient days (including private room	days) through December	31 of the cost	0	5. 00
4 00	reporting period	daya) aftan Dagamban (01 of the cost	0	
6. 00	Total swing-bed SNF type inpatient days (including private room reporting period (if calendar year, enter 0 on this line)	days) after becember s	si di the cost	0	6. 00
7.00	Total swing-bed NF type inpatient days (including private room	days) through December	31 of the cost	0	7. 00
	reporting period				
8. 00	Total swing-bed NF type inpatient days (including private room reporting period (if calendar year, enter 0 on this line)	days) after December 31	of the cost	0	8. 00
9. 00	Total inpatient days including private room days applicable to	the Program (excluding	swing-hed and	1, 424	9. 00
7. 00	newborn days)	the rrogram (exercaring	Swifing bed did	1, 121	7. 00
10.00	Swing-bed SNF type inpatient days applicable to title XVIII onl		oom days)	0	10.00
11. 00	through December 31 of the cost reporting period (see instructi Swing-bed SNF type inpatient days applicable to title XVIII onl		nom daya) aftan	0	11. 00
11.00	December 31 of the cost reporting period (if calendar year, ent		Joil days) arter	U	11.00
12.00	Swing-bed NF type inpatient days applicable to titles V or XIX		e room days)	0	12.00
	through December 31 of the cost reporting period			_	
13. 00	Swing-bed NF type inpatient days applicable to titles V or XIX after December 31 of the cost reporting period (if calendar yea			0	13. 00
14. 00	Medically necessary private room days applicable to the Program			0	14. 00
15. 00	Total nursery days (title V or XIX only)	(0	15.00
16. 00	Nursery days (title V or XIX only)			0	16. 00
17 00	SWING BED ADJUSTMENT	through Docombon 21 of	f the cost	0.00	17 00
17. 00	Medicare rate for swing-bed SNF services applicable to services reporting period	through becember 31 of	the cost	0. 00	17. 00
18.00	Medicare rate for swing-bed SNF services applicable to services	after December 31 of 1	the cost	0.00	18. 00
40.00	reporting period				40.00
19. 00	Medicaid rate for swing-bed NF services applicable to services reporting period	through December 31 of	the cost	0. 00	19. 00
20.00	Medicaid rate for swing-bed NF services applicable to services	after December 31 of th	ne cost	0.00	20.00
	reporting period				
21. 00 22. 00	Total general inpatient routine service cost (see instructions) Swing-bed cost applicable to SNF type services through December		ng poriod (line	7, 068, 236 0	21. 00 22. 00
22.00	5 x line 17)	31 of the cost reporti	ng perrod (Trie	O	22.00
23. 00	Swing-bed cost applicable to SNF type services after December 3	1 of the cost reporting	g period (line 6	0	23.00
24.00	x line 18)	24 -6 +6++!-		0	24.00
24. 00	Swing-bed cost applicable to NF type services through December 7 x line 19)	3) of the cost reportin	ng period (iine	0	24. 00
25. 00	Swing-bed cost applicable to NF type services after December 31	of the cost reporting	period (line 8	0	25. 00
	x line 20)			_	
26. 00 27. 00	Total swing-bed cost (see instructions) General inpatient routine service cost net of swing-bed cost (I	ino 21 minus lino 26)		0 7, 068, 236	26. 00 27. 00
27.00	PRIVATE ROOM DIFFERENTIAL ADJUSTMENT	The 21 millus Title 20)		7, 000, 230	27.00
28. 00	General inpatient routine service charges (excluding swing-bed	and observation bed cha	arges)	0	28. 00
29. 00	Private room charges (excluding swing-bed charges)			0	29. 00
30.00	Semi-private room charges (excluding swing-bed charges)	00)		0	30.00
31. 00	General inpatient routine service cost/charge ratio (line 27 ÷	line 28)		0.000000	31.00
32.00	Average private room per diem charge (line 29 ÷ line 3)			0.00	32.00
33. 00	Average semi-private room per diem charge (line 30 ÷ line 4)	a line 22) (acc instruct	ti ana)	0.00	33.00
34.00	Average per diem private room charge differential (line 32 minu		11 0(15)	0.00	34.00
35. 00 36. 00	Average per diem private room cost differential (line 34 x line Private room cost differential adjustment (line 3 x line 35)	31)		0.00	35. 00 36. 00
37. 00	General inpatient routine service cost net of swing-bed cost an	d private room cost dit	ferential (line	7, 068, 236	37. 00
37.00	27 minus line 36)	a private room cost uri	Torontial (Title	7, 000, 230	37.00
	PART II - HOSPITAL AND SUBPROVIDERS ONLY		,		
	PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUS				
38. 00	Adjusted general inpatient routine service cost per diem (see i	,		1, 274. 93	38. 00
39. 00 40. 00	Program general inpatient routine service cost (line 9 x line 3 Medically necessary private room cost applicable to the Program		}	1, 815, 500 0	39. 00 40. 00
	Total Program general inpatient routine service cost (line 39 +	` ,		1, 815, 500	
	, J. J		ı	, ,	

		HUNTI NGTON MEMOI				eu of Form CMS-2	
COMPUT	ATION OF INPATIENT OPERATING COST		Provi der	CCN: 150091	Peri od: From 01/01/2015		
					To 12/31/2015	Date/Time Pre 10/28/2016 10	
				le XVIII	Hospi tal	PPS	
	Cost Center Description	Total Inpatient Cost	Total Innatient Dav	Average Per		Program Cost (col. 3 x col.	
		impatrent cost	тпраттепт вау	col . 2)		4)	
42.00	MUDCEDY (+: +Lo V & VIV only)	1.00	2. 00	3.00	4.00	5. 00	42.00
42.00	NURSERY (title V & XIX only) Intensive Care Type Inpatient Hospital Units	<u> 0</u>		0. 0.	00 C	0	42.00
43. 00	INTENSIVE CARE UNIT						43. 00
44. 00	CORONARY CARE UNIT						44. 00
45. 00 46. 00	BURN INTENSIVE CARE UNIT SURGICAL INTENSIVE CARE UNIT						45. 00 46. 00
	OTHER SPECIAL CARE (SPECIFY)						47. 00
	Cost Center Description					1.00	
48. 00	Program inpatient ancillary service cost (Wk	st. D-3, col. 3	. line 200)			1. 00 1, 702, 557	48. 00
	Total Program inpatient costs (sum of lines			ons)		3, 518, 057	
EO 00	PASS THROUGH COST ADJUSTMENTS Pass through costs applicable to Program inp	nationt routing	convices (fre	m Wkst D su	m of Dorte L and	174, 397	50.00
50. 00	Pass through costs applicable to Program The	batient routine	services (110	III WKSt. D, Sui	ii oi Parts i and	174, 397	50.00
51. 00	Pass through costs applicable to Program inp	oatient ancillar	y services (f	rom Wkst. D, s	sum of Parts II	160, 338	51. 00
52. 00	and IV) Total Program excludable cost (sum of lines	50 and 51)				334, 735	52.00
53. 00	Total Program inpatient operating cost exclu	uding capital re	lated, non-ph	ysician anestl	netist, and	3, 183, 322	
	medical education costs (line 49 minus line	52)					
54. 00	TARGET AMOUNT AND LIMIT COMPUTATION Program discharges					0	54.00
	Target amount per discharge					0.00	55. 00
56. 00 57. 00	,	ting coot and to	mast smount (lina E/ minua	line E2)	0 0	
58. 00	Difference between adjusted inpatient operations payment (see instructions)	iring cost and ta	rget allibuit (Title 56 IIITlus	111le 55)	0	
59. 00	Lesser of lines 53/54 or 55 from the cost re	eporting period	endi ng 1996,	updated and co	ompounded by the	0.00	
60. 00	market basket Lesser of lines 53/54 or 55 from prior year	cost report un	dated by the	markat haskat		0.00	60.00
61. 00	If line 53/54 is less than the lower of line				the amount by	0.00	
	which operating costs (line 53) are less that		s (lines 54 x	60), or 1% of	f the target		
62. 00	amount (line 56), otherwise enter zero (see Relief payment (see instructions)	instructions)				0	62. 00
	Allowable Inpatient cost plus incentive paym	ment (see instru	ctions)			0	63.00
PROGRAM INPATIENT ROUTINE SWING BED COST 64.00 Medicare swing-bed SNF inpatient routine costs through December 31 of the cost reporting period (See						T 0	64. 00
64. 00	instructions) (title XVIII only)	sts till ough bece	iliber 31 01 tri	e cost reporti	ng perrou (see		04.00
65. 00	Medicare swing-bed SNF inpatient routine cos	sts after Decemb	er 31 of the	cost reportin	g period (See	0	65. 00
66. 00	instructions)(title XVIII only) Total Medicare swing-bed SNF inpatient routi	ne costs (line	64 plus line	65)(title XVII	I only). For	0	66. 00
	CAH (see instructions)						
67. 00	Title V or XIX swing-bed NF inpatient routing (line 12 x line 19)	ne costs through	December 31	of the cost re	eporting period	0	67. 00
68. 00	Title V or XIX swing-bed NF inpatient routin	ne costs after D	ecember 31 of	the cost repo	orting period	0	68. 00
(0.00	(line 13 x line 20)		l: /7 l:-	- (0)			40.00
69.00	Total title V or XIX swing-bed NF inpatient PART III - SKILLED NURSING FACILITY, OTHER N					0	69. 00
70. 00	Skilled nursing facility/other nursing facil	ity/ICF/IID rou	tine service	cost (line 37))		70. 00
71. 00 72. 00	Adjusted general inpatient routine service of Program routine service cost (line 9 x line		ine 70 ÷ line	2)			71. 00 72. 00
73. 00	Medically necessary private room cost applic		(line 14 x l	ine 35)			73.00
74. 00	Total Program general inpatient routine serv	•		•			74.00
75. 00	Capital-related cost allocated to inpatient 26, line 45)	routine service	costs (from	worksheet B, l	Part II, column		75. 00
76. 00	Per diem capital-related costs (line 75 ÷ li	,					76. 00
77. 00	Program capital -related costs (line 9 x line	,					77. 00
78. 00 79. 00	Inpatient routine service cost (line 74 minu Aggregate charges to beneficiaries for exces		rovi der recor	ds)			78. 00 79. 00
80.00	Total Program routine service costs for comp	parison to the c			nus line 79)		80.00
81. 00 82. 00	Inpatient routine service cost per diem limi Inpatient routine service cost limitation (I)				81. 00 82. 00
83. 00	Reasonable inpatient routine service costs (* .				83. 00
84. 00	Program inpatient ancillary services (see in	nstructions)					84. 00
85. 00 86. 00	Utilization review - physician compensation Total Program inpatient operating costs (sum						85. 00 86. 00
00.00	PART IV - COMPUTATION OF OBSERVATION BED PAS						00.00
87.00	Total observation bed days (see instructions	5)	11 0			1, 053	
88. 00 89. 00	Adjusted general inpatient routine cost per Observation bed cost (line 87 x line 88) (se	•	iine 2)			1, 274. 93 1, 342, 501	
57.00	1222. 121. 31. 300 3001 (11110 07 X 11110 00) (30					1 ., 012, 301	, 57. 50

Health Financial Systems	HUNTI NGTON MEMO	ORIAL HOSPITAL		In Lie	u of Form CMS-2	2552-10
COMPUTATION OF INPATIENT OPERATING COST		Provi der		Peri od:	Worksheet D-1	
				From 01/01/2015 To 12/31/2015	Date/Time Pre 10/28/2016 10	
		Ti tl	e XVIII	Hospi tal	PPS	
Cost Center Description	Cost	Routine Cost	column 1 ÷	Total	Observati on	
		(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	678, 982	7, 068, 236	0. 09606	1 1, 342, 501	128, 962	90.00
91.00 Nursing School cost	0	7, 068, 236	0.00000	0 1, 342, 501	0	91.00
92.00 Allied health cost	0	7, 068, 236	0.00000	0 1, 342, 501	0	92.00
93.00 All other Medical Education	0	7, 068, 236	0.00000	0 1, 342, 501	0	93. 00

Heal th	Financial Systems	HUNTINGTON MEMORIAL	HOSPI TAL	In Lie	u of Form CMS-:	2552-10
COMPUT	ATION OF INPATIENT OPERATING COST		Provider CCN: 150091	Peri od:	Worksheet D-1	
				From 01/01/2015 To 12/31/2015	Date/Time Pre 10/28/2016 10	
			Title XIX	Hospi tal	PPS	
	Cost Center Description					
					1. 00	
	PART I - ALL PROVIDER COMPONENTS					
	I NPATI ENT DAYS					
1.00	Inpatient days (including private room day	rs and swing-bed days,	excluding newborn)		5, 544	1.00
2.00	2.00 Inpatient days (including private room days, excluding swing-bed and newborn days) 5,544					
3. 00	Private room days (excluding swing-bed and do not complete this line.	observation bed days). If you have only pr	ivate room days,	0	3. 00

	Cost Center Description		
	DADT I ALL DOUVEDED COMPONENTS	1. 00	
	PART I - ALL PROVIDER COMPONENTS INPATIENT DAYS		
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)	5, 544	1. 00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)	5, 544	2. 00
3.00	Private room days (excluding swing-bed and observation bed days). If you have only private room days,	0	3. 00
4. 00	do not complete this line. Semi-private room days (excluding swing-bed and observation bed days)	4, 491	4. 00
5.00	Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost	4, 491	5. 00
	reporting period		
6.00	Total swing-bed SNF type inpatient days (including private room days) after December 31 of the cost	0	6. 00
7. 00	reporting period (if calendar year, enter 0 on this line) Total swing-bed NF type inpatient days (including private room days) through December 31 of the cost	0	7. 00
7.00	reporting period	١	7.00
8.00	Total swing-bed NF type inpatient days (including private room days) after December 31 of the cost	0	8. 00
	reporting period (if calendar year, enter 0 on this line)		
9. 00	Total inpatient days including private room days applicable to the Program (excluding swing-bed and	176	9. 00
10. 00	newborn days) Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days)	0	10. 00
10.00	through December 31 of the cost reporting period (see instructions)	Ĭ	10.00
11. 00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) after	0	11. 00
40.00	December 31 of the cost reporting period (if calendar year, enter 0 on this line)		10.00
12. 00	Swing-bed NF type inpatient days applicable to titles V or XLX only (including private room days) through December 31 of the cost reporting period	0	12. 00
13. 00	Swing-bed NF type inpatient days applicable to titles V or XLX only (including private room days)	0	13. 00
	after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		
14.00	Medically necessary private room days applicable to the Program (excluding swing-bed days)	0	14. 00
15.00	Total nursery days (title V or XIX only)	725	15.00
16. 00	Nursery days (title V or XIX only) SWING BED ADJUSTMENT	71	16. 00
17. 00	Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost	0.00	17. 00
	reporting period		
18. 00	Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost	0. 00	18. 00
19. 00	reporting period Medicaid rate for swing-bed NF services applicable to services through December 31 of the cost	0. 00	19. 00
19.00	reporting period	0.00	19.00
20. 00	Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost	0.00	20. 00
	reporting period		
21. 00	Total general inpatient routine service cost (see instructions)	7, 068, 236 0	21. 00
22. 00	Swing-bed cost applicable to SNF type services through December 31 of the cost reporting period (line 5×1) x line 17)	١	22. 00
23. 00	Swing-bed cost applicable to SNF type services after December 31 of the cost reporting period (line 6	0	23. 00
	x line 18)		
24. 00	Swing-bed cost applicable to NF type services through December 31 of the cost reporting period (line	0	24. 00
25. 00	7 x line 19) Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8	0	25. 00
20.00	x line 20)	Ĭ	20.00
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)	7, 068, 236	27. 00
28. 00	PRIVATE ROOM DIFFERENTIAL ADJUSTMENT General inpatient routine service charges (excluding swing-bed and observation bed charges)	0	28. 00
29. 00		0	29. 00
30. 00	Semi -pri vate room charges (excluding swing-bed charges)	Ö	30. 00
31.00	General inpatient routine service cost/charge ratio (line 27 ÷ line 28)	0. 000000	31. 00
32. 00	Average private room per diem charge (line 29 ÷ line 3)	0.00	32. 00
33. 00 34. 00	Average semi-private room per diem charge (line 30 ÷ line 4) Average per diem private room charge differential (line 32 minus line 33)(see instructions)	0. 00 0. 00	33. 00 34. 00
35. 00	Average per diem private room cost differential (line 34 x line 31)	0.00	35. 00
36. 00	Private room cost differential adjustment (line 3 x line 35)	0.00	36. 00
37. 00	General inpatient routine service cost net of swing-bed cost and private room cost differential (line	7, 068, 236	37. 00
	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)	1, 274. 93	38. 00
39. 00	Program general inpatient routine service cost (line 9 x line 38)	224, 388	39. 00
40.00	Medically necessary private room cost applicable to the Program (line 14 x line 35)	0	40.00
41. 00	Total Program general inpatient routine service cost (line 39 + line 40)	224, 388	41. 00

18.00	reporting period	0.00	18.00
19. 00	Medicaid rate for swing-bed NF services applicable to services through December 31 of the cost	0.00	19. 00
20. 00	reporting period Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost	0.00	20. 00
20.00	reporting period	0.00	20.00
21. 00	Total general inpatient routine service cost (see instructions)	7, 068, 236	21. 00
	Swing-bed cost applicable to SNF type services through December 31 of the cost reporting period (line		
	5 x line 17)		
23. 00	Swing-bed cost applicable to SNF type services after December 31 of the cost reporting period (line 6 x line 18)	0	23. 00
24. 00	Swing-bed cost applicable to NF type services through December 31 of the cost reporting period (line	0	24.00
	7 x line 19)		
25. 00	Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8	0	25. 00
26. 00	x line 20) Total swing-bed cost (see instructions)		26. 00
	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)	7, 068, 236	
27.00	PRIVATE ROOM DIFFERENTIAL ADJUSTMENT	7,000,230	27.00
28. 00	General inpatient routine service charges (excluding swing-bed and observation bed charges)	0	28. 00
	Pri vate room charges (excluding swing-bed charges)	0	29.00
30.00	Semi -pri vate room charges (excluding swing-bed charges)	0	30.00
	General inpatient routine service cost/charge ratio (line 27 ÷ line 28)	0.000000	
32.00	Average private room per diem charge (line 29 ÷ line 3)	0.00	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
	Private room cost differential adjustment (line 3 x line 35)		36.00
37. 00	General inpatient routine service cost net of swing-bed cost and private room cost differential (line	7, 068, 236	37. 00
	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)	1, 274. 93	38 00
	Program general inpatient routine service cost (line 9 x line 38)	224, 388	
	Medically necessary private room cost applicable to the Program (line 14 x line 35)		40.00
	Total Program general inpatient routine service cost (line 39 + line 40)	224, 388	41.00
		,	

MPUT	Financial Systems I ATION OF INPATIENT OPERATING COST	HUNTI NGTON MEMOR		r CCN: 150091	Peri od: From 01/01/2015	w of Form CMS-2 Worksheet D-1	
					To 12/31/2015	Date/Time Pre 10/28/2016 10	
				itle XIX	Hospi tal	PPS	
	Cost Center Description	Total Inpatient Cost		col . 2)	1 ÷	Program Cost (col. 3 x col. 4)	
	NUDCEDY (+: +1 - V 0 VIV1)	1.00	2.00	3.00	4. 00	5. 00	42.0
. 00	NURSERY (title V & XIX only) Intensive Care Type Inpatient Hospital Units	81, 750		25 112.	76 71	8, 006	42.0
. 00	INTENSIVE CARE UNIT						43.0
. 00	CORONARY CARE UNIT						44.0
. 00	BURN INTENSIVE CARE UNIT						45.0
	SURGICAL INTENSIVE CARE UNIT OTHER SPECIAL CARE (SPECIFY)						46. 0 47. 0
. 00	Cost Center Description						47.0
	,					1. 00	
. 00	Program inpatient ancillary service cost (Wk			:>		779, 343	
. 00	Total Program inpatient costs (sum of lines PASS THROUGH COST ADJUSTMENTS	41 through 48)(see Instruct	ions)		1, 011, 737	49. (
. 00	Pass through costs applicable to Program inp	atient routine	services (fr	om Wkst. D, su	um of Parts I and	22, 114	50.0
. 00	Pass through costs applicable to Program inpland IV)	atient ancillar	y services (rrom Wkst. D,	sum of Parts II	64, 412	51.0
. 00	Total Program excludable cost (sum of lines	50 and 51)				86, 526	52. (
. 00	Total Program inpatient operating cost exclu		lated, non-p	hysician anest	thetist, and	925, 211	1
	medical education costs (line 49 minus line	52)					
. 00	TARGET AMOUNT AND LIMIT COMPUTATION Program discharges					0	54.
. 00	Target amount per discharge					0.00	
. 00	Target amount (line 54 x line 55)					0	
. 00	Difference between adjusted inpatient operat	ing cost and ta	rget amount	(line 56 minus	s line 53)	0	57.
. 00	Bonus payment (see instructions) Lesser of lines 53/54 or 55 from the cost re	porting period	endina 1006	undated and o	compounded by the	0 0. 00	
. 00	market basket	portring perrou	ending 1770,	upuateu anu c	compounded by the	0.00	37.
. 00	Lesser of lines 53/54 or 55 from prior year					0.00	
. 00	If line 53/54 is less than the lower of line					0	61.
	which operating costs (line 53) are less tha amount (line 56), otherwise enter zero (see		S (TITIES 54	x 60), OF 1% (or the target		
. 00	1	,				0	62. (
. 00	Allowable Inpatient cost plus incentive paym	ent (see instru	ctions)			0	63. (
. 00	PROGRAM INPATIENT ROUTINE SWING BED COST Medicare swing-bed SNF inpatient routine cos	ts through Dece	mher 31 of t	he cost renort	ting period (See	0	64. (
. 00	instructions)(title XVIII only)	to thi ough becci	imper or or t	ne cost report	ing period (occ		01. (
. 00	Medicare swing-bed SNF inpatient routine cos	ts after Decemb	er 31 of the	cost reportir	ng period (See	0	65. (
. 00	<pre>instructions)(title XVIII only) Total Medicare swing-bed SNF inpatient routi</pre>	ne costs (line	64 nlus lina	65)(+i+le YVI	II only) For	0	66. (
. 00	CAH (see instructions)	ne costs (Title	04 prus rrne	05)(11116 XVI	rr only). To	U	00.
. 00	Title V or XIX swing-bed NF inpatient routing	e costs through	December 31	of the cost r	reporting period	0	67. (
	(line 12 x line 19) Title V or XIX swing-bed NF inpatient routin	t. ofter D	ocombon 21 o	f the cost war	anting paried	0	/ 0 /
. 00	(line 13 x line 20)	e costs after D	ecember 31 0	i the cost rep	orting period	0	68. (
. 00	Total title V or XIX swing-bed NF inpatient	routine costs (line 67 + li	ne 68)		0	69. (
	PART III - SKILLED NURSING FACILITY, OTHER NU				->		
. 00	Skilled nursing facility/other nursing facil Adjusted general inpatient routine service c	,		•	/)		70. 71.
. 00	Program routine service cost (line 9 x line		THE 70 + THI	C 2)			72.
. 00	Medically necessary private room cost application		(line 14 x	line 35)			73.
. 00	Total Program general inpatient routine serv	•		•	5		74.
. 00	Capital-related cost allocated to inpatient 26, line 45)	routine service	costs (from	Worksheet B,	Part II, column		75.
. 00	Per diem capital-related costs (line 75 ÷ li	ne 2)					76.
. 00	Program capital-related costs (line 9 x line						77.
. 00	Inpatient routine service cost (line 74 minu		rovi don no	rdc)			78. 79.
. 00	Aggregate charges to beneficiaries for exces Total Program routine service costs for comp.				nus line 79)		80.
. 00	Inpatient routine service cost per diem limi			(1.1.0 / 0 1111	,		81.
. 00	Inpatient routine service cost limitation (•				82.
. 00	Reasonable inpatient routine service costs (s)				83.
. 00	Program inpatient ancillary services (see in Utilization review - physician compensation		ns)				84. 85.
	Total Program inpatient operating costs (sum						86.
	PART IV - COMPUTATION OF OBSERVATION BED PASS	S THROUGH COST					
		1				1, 053	. 07
. 00	Total observation bed days (see instructions Adjusted general inpatient routine cost per	•	line 2)			1, 274. 93	1

Health Financial Systems	HUNTI NGTON MEMO	ORIAL HOSPITAL		In Lie	u of Form CMS-2	2552-10
COMPUTATION OF INPATIENT OPERATING COST		Provi der		Peri od:	Worksheet D-1	
				From 01/01/2015 To 12/31/2015	Date/Time Pre 10/28/2016 10	
		Ti t	le XIX	Hospi tal	PPS	
Cost Center Description	Cost	Routine Cost	column 1 ÷	Total	Observati on	
		(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	678, 982	7, 068, 236	0. 09606	1 1, 342, 501	128, 962	90.00
91.00 Nursing School cost	0	7, 068, 236	0.00000	0 1, 342, 501	0	91.00
92.00 Allied health cost	0	7, 068, 236	0.00000	0 1, 342, 501	0	92.00
93.00 All other Medical Education	0	7, 068, 236	0.00000	0 1, 342, 501	0	93.00

Heal th	Financial Systems HUNTINGTON MEMORIAL	HUSDI TVI		In lie	u of Form CMS-	2552_10
	ENT ANCILLARY SERVICE COST APPORTIONMENT		CCN: 150091	Peri od:	Worksheet D-3	
				From 01/01/2015	D 1 (T' D	
				To 12/31/2015	Date/Time Pre 10/28/2016 10	
		Ti tl	e XVIII	Hospi tal	PPS	. 00 am
	Cost Center Description		Ratio of Cos		I npati ent	
			To Charges	Program	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			2, 682, 916		30.00
	04300 NURSERY			_,,		43. 00
	ANCILLARY SERVICE COST CENTERS					1
50.00	05000 OPERATI NG ROOM		0. 0942		118, 091	
52.00	05200 DELIVERY ROOM & LABOR ROOM		0. 3864		0	
53.00	05300 ANESTHESI OLOGY		0. 3975		0	53. 00
54.00	05400 RADI OLOGY-DI AGNOSTI C		0. 1037		124, 181	
60.00	06000 LABORATORY		0. 2047		192, 627	60.00
62. 30	06250 BLOOD CLOTTING FOR HEMOPHILIACS		0.0000	00	0	62. 30
65.00	06500 RESPI RATORY THERAPY		0. 2738	73 534, 595	146, 411	65. 00
66. 00	06600 PHYSI CAL THERAPY		0. 5238		130, 415	66. 00
67. 00	06700 OCCUPATI ONAL THERAPY		0. 3775		8, 064	67. 00
68. 00	06800 SPEECH PATHOLOGY		0. 3801		3, 534	
69. 00	06900 ELECTROCARDI OLOGY		0. 0167	92 0	0	69. 00
71. 00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT		0. 1185	42 442, 569	52, 463	
	07200 I MPL. DEV. CHARGED TO PATIENTS		0. 3566	90 1, 414, 048	504, 377	72. 00
	07300 DRUGS CHARGED TO PATIENTS		0. 2145		293, 506	
76. 97	07697 CARDI AC REHABI LI TATI ON		0.0000		0	
76. 98	07698 HYPERBARI C OXYGEN THERAPY		0.0000		0	76. 98
76. 99	07699 LI THOTRI PSY		0.0000	00	0	76. 99
	OUTPATIENT SERVICE COST CENTERS					
	09100 EMERGENCY		0. 1523		128, 888	1
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART		0. 9988	36 0	0	92. 00
	OTHER REIMBURSABLE COST CENTERS					
	09500 AMBULANCE SERVICES					95. 00
200.00				8, 275, 032	1, 702, 557	
201.00		(line 61)		0		201. 00
202.00	Net Charges (line 200 minus line 201)		1	8, 275, 032		202. 00

INPATI	ENT ANCILLARY SERVICE COST APPORTIONMENT	Provi der	CCN: 150091	Peri od:	Worksheet D-3	
				From 01/01/2015 To 12/31/2015	Date/Time Pre 10/28/2016 10	
		Ti t	le XIX	Hospi tal	PPS	
	Cost Center Description		Ratio of Cos To Charges	Program	Inpatient Program Costs (col. 1 x col. 2)	
			1.00	2. 00	3. 00	
	INPATIENT ROUTINE SERVICE COST CENTERS					
30. 00	03000 ADULTS & PEDI ATRI CS			2, 336, 343		30.00
43.00	04300 NURSERY			488, 441		43.00
	ANCI LLARY SERVI CE COST CENTERS					
50.00	05000 OPERATI NG ROOM		0. 0942		248, 094	
52. 00	05200 DELIVERY ROOM & LABOR ROOM		0. 3864		0	
53. 00	05300 ANESTHESI OLOGY		0. 3975		0	
54. 00	05400 RADI OLOGY-DI AGNOSTI C		0. 1037			
60. 00	06000 LABORATORY		0. 20470		101, 434	
62. 30	06250 BLOOD CLOTTING FOR HEMOPHILIACS		0.00000		0	
65. 00	06500 RESPI RATORY THERAPY		0. 2738		71, 597	
66. 00	06600 PHYSI CAL THERAPY		0. 5238		10, 768	
57. 00	06700 OCCUPATI ONAL THERAPY		0. 3775		929	
58. 00	06800 SPEECH PATHOLOGY		0. 38010		136	
59. 00	06900 ELECTROCARDI OLOGY		0. 01679		0	69.00
71. 00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT		0. 1185		25, 664	
72. 00	07200 IMPL. DEV. CHARGED TO PATIENTS		0. 3566		49, 035	
	07300 DRUGS CHARGED TO PATIENTS		0. 2145		194, 096	
76. 97	07697 CARDI AC REHABI LI TATI ON		0.00000		0	1
76. 98	07698 HYPERBARI C OXYGEN THERAPY		0.00000		0	76. 98
76. 99	07699 LI THOTRI PSY		0.0000	00 0	0	76. 99
	OUTPATIENT SERVICE COST CENTERS					1
	09100 EMERGENCY		0. 15230		39, 087	
92. 00	09200 OBSERVATION BEDS (NON-DISTINCT PART		0. 9988	36 0	0	92.00
	OTHER REIMBURSABLE COST CENTERS		1			4
	09500 AMBULANCE SERVICES					95.00
200. 00				5, 297, 617	779, 343	
201. 00		(line 61)		0		201.00
202.00	Net Charges (line 200 minus line 201)			5, 297, 617		202.00

Health Financial Systems	HUNTINGTON MEMORIAL HOSPITAL	In Lie	u of Form CMS-2552-10
CALCULATION OF REIMBURSEMENT SETTLEMENT	Provi der CCN: 150091	Peri od: From 01/01/2015 To 12/31/2015	Worksheet E Part A Date/Time Prepared: 10/28/2016 10:35 am
	T' 11 \0.0111		DDC

		Title XVIII	Hospi tal	10/28/2016 10: PPS	35 am
				1. 00	
	PART A - INPATIENT HOSPITAL SERVICES UNDER IPPS			1.00	
1.00	DRG Amounts Other than Outlier Payments			0	1.00
1. 01	DRG amounts other than outlier payments for discharges occurring instructions)	1, 961, 068	1. 01		
1. 02	DRG amounts other than outlier payments for discharges occurring instructions)	on or after October 1	l (see	676, 133	1. 02
1. 03	DRG for federal specific operating payment for Model 4 BPCI for 1 (see instructions)	discharges occurring p	orior to October	0	1. 03
1. 04	DRG for federal specific operating payment for Model 4 BPCI for	discharges occurring o	on or after	0	1. 04
2.00	October 1 (see instructions) Outlier payments for discharges. (see instructions)			2, 055	2. 00
2. 01 2. 02	Outlier reconciliation amount Outlier payment for discharges for Model 4 BPCI (see instruction	5)		0	2. 01 2. 02
3.00	Managed Care Simulated Payments	3)		0	3. 00
4. 00	Bed days available divided by number of days in the cost reporti Indirect Medical Education Adjustment	ng period (see instruc	ctions)	33. 12	4. 00
5. 00	FTE count for allopathic and osteopathic programs for the most r or before 12/31/1996. (see instructions)	ecent cost reporting p	period ending on	0.00	5. 00
6. 00	FTE count for allopathic and osteopathic programs which meet the for new programs in accordance with 42 CFR 413.79(e)	criteria for an add-d	on to the cap	0. 00	6. 00
7.00	MMA Section 422 reduction amount to the IME cap as specified und	er 42 CFR §412.105(f)	(1) (i v) (B) (1)	0. 00	7. 00
7. 01	ACA Section 5503 reduction amount to the IME cap as specified un If the cost report straddles July 1, 2011 then see instructions.			0. 00	7. 01
8. 00	Adjustment (increase or decrease) to the FTE count for allopathi affiliated programs in accordance with 42 CFR 413.75(b), 413.79(1998), and 67 FR 50069 (August 1, 2002).			0. 00	8. 00
8. 01	The amount of increase if the hospital was awarded FTE cap slots under section 5503 of the ACA. If				8. 01
8. 02	the cost report straddles July 1, 2011, see instructions. The amount of increase if the hospital was awarded FTE cap slots from a closed teaching hospital under section 5506 of ACA. (see instructions)				8. 02
9. 00	Sum of lines 5 plus 6 minus lines (7 and 7.01) plus/minus lines	(8, 8,01 and 8,02) (s	see	0. 00	9. 00
10.00	instructions) FTE count for allopathic and osteopathic programs in the current	year from your record	ds	0.00	10.00
11. 00 12. 00	FTE count for residents in dental and podiatric programs. Current year allowable FTE (see instructions)				11. 00 12. 00
13. 00	Total allowable FTE count for the prior year.			0.00	13. 00
14. 00	Total allowable FTE count for the penultimate year if that year otherwise enter zero.	ended on or after Sept	tember 30, 1997,	0. 00	
15. 00	Sum of lines 12 through 14 divided by 3.			0.00	15. 00
16. 00	Adjustment for residents in initial years of the program				16. 00
17. 00	Adjustment for residents displaced by program or hospital closur	е		0.00	17. 00
18. 00	Adjusted rolling average FTE count				18. 00
19. 00	Current year resident to bed ratio (line 18 divided by line 4).			0. 000000	
20. 00	Prior year resident to bed ratio (see instructions) Enter the lesser of lines 19 or 20 (see instructions)			0. 000000 0. 000000	20. 00 21. 00
21. 00 22. 00	IME payment adjustment (see instructions)			0.000000	22. 00
22. 01	IME payment adjustment (see Fristructions)			Ö	22. 01
	Indirect Medical Education Adjustment for the Add-on for Section	422 of the MMA		_	
23. 00	Number of additional allopathic and osteopathic IME FTE resident $(f)(1)(iv)(C)$.	cap slots under 42 Se	ec. 412.105	0. 00	23. 00
24.00	IME FTE Resident Count Over Cap (see instructions)			0.00	24. 00
25. 00	If the amount on line 24 is greater than -O-, then enter the low	er of line 23 or line	24 (see	0.00	25. 00
0/ 00	instructions)			0.000000	07.00
26. 00	Resident to bed ratio (divide line 25 by line 4)			0. 000000	26. 00
27. 00 28. 00	IME payments adjustment factor. (see instructions)			0. 000000 0	27. 00
28. 00	IME add-on adjustment amount (see instructions) IME add-on adjustment amount - Managed Care (see instructions)			0	28. 00 28. 01
29. 00	Total IME payment (sum of lines 22 and 28)			0	29. 00
29. 01	Total IME payment - Managed Care (sum of lines 22.01 and 28.01) Disproportionate Share Adjustment			0	29. 01
30. 00	Percentage of SSI recipient patient days to Medicare Part A pati	ent days (see instruct	tions)	3. 51	30. 00
31. 00	Percentage of Medicaid patient days (see instructions)	44,0 (000 111011 401		29. 13	
32. 00	Sum of lines 30 and 31			32. 64	32. 00
33. 00	Allowable disproportionate share percentage (see instructions)			12. 00	33. 00
34.00	Disproportionate share adjustment (see instructions)			79, 116	34.00

Hool th	Financial Systems WINTINGTON MEMORIAL	HOSDI TAI	In Lie	u of Form CMS (DEE2 10
	Financial Systems HUNTINGTON MEMORIAL ATION OF REIMBURSEMENT SETTLEMENT	Provi der CCN: 150091	Period: From 01/01/2015 To 12/31/2015	w of Form CMS-2 Worksheet E Part A Date/Time Pre 10/28/2016 10	pared:
		Title XVIII	Hospi tal	PPS	
			1.00	0n/After 10/1 2.00	
	Uncompensated Care Adjustment		1.00	2.00	
35. 00	Total uncompensated care amount (see instructions)		7, 647, 644, 885		35. 00
35. 01	Factor 3 (see instructions)		0. 000051392	0. 000051203	1
35. 02	Hospital uncompensated care payment (If line 34 is zero, enter (see instructions)	zero on this line)	393, 028	328, 014	35. 02
35. 03		nt (see instructions)	293, 963	82, 452	35. 03
	Total uncompensated care (sum of columns 1 and 2 on line 35.03)		376, 415		36. 00
	Additional payment for high percentage of ESRD beneficiary disc				
40. 00	Total Medicare discharges on Worksheet S-3, Part I excluding di	scharges for MS-DRGs	0		40. 00
41. 00	652, 682, 683, 684 and 685 (see instructions) Total ESRD Medicare discharges excluding MS-DRGs 652, 682, 683 instructions)	3, 684 an 685. (see	0		41. 00
41. 01	1	RGs 652, 682, 683, 684	0		41. 01
42.00	Divide line 41 by line 40 (if less than 10%, you do not qualify	for adjustment)	0.00		42. 00
43. 00	Total Medicare ESRD inpatient days excluding MS-DRGs 652, 682, instructions)	683, 684 an 685. (see	0		43. 00
44. 00	Ratio of average length of stay to one week (line 43 divided by days)	/line 41 divided by 7	0.000000		44.00
45. 00 46. 00	Average weekly cost for dialysis treatments (see instructions) Total additional payment (line 45 times line 44 times line 41.0	11)	0.00		45. 00 46. 00
47. 00	, , ,)1)	3, 094, 787		47. 00
48. 00	Hospital specific payments (to be completed by SCH and MDH, sma	all rural hospitals	0		48. 00
	only. (see instructions)	•			
				Amount 1.00	
49. 00	Total payment for inpatient operating costs (see instructions)			3, 094, 787	49. 00
50. 00	Payment for inpatient program capital (from Wkst. L, Pt. I and	Pt. II, as applicable)		209, 835	1
51. 00	Exception payment for inpatient program capital (Wkst. L, Pt. I			0	51. 00
52. 00	Direct graduate medical education payment (from Wkst. E-4, line	e 49 see instructions).		0	52.00
53. 00 54. 00	Nursing and Allied Health Managed Care payment Special add-on payments for new technologies			0 0	53. 00 54. 00
55. 00	Net organ acquisition cost (Wkst. D-4 Pt. III, col. 1, line 69)			0	55.00
56. 00	Cost of physicians' services in a teaching hospital (see intruc			0	56. 00
57. 00	Routine service other pass through costs (from Wkst. D, Pt. III		hrough 35).	0	57. 00
58. 00	Ancillary service other pass through costs from Wkst. D, Pt. I	/, col. 11 line 200)		0	58. 00
59. 00 60. 00	Total (sum of amounts on lines 49 through 58) Primary payer payments			3, 304, 622 4, 110	
61. 00	Total amount payable for program beneficiaries (line 59 minus l	ine 60)		3, 300, 512	1
62. 00	Deductibles billed to program beneficiaries			422, 946	•
63.00	Coinsurance billed to program beneficiaries			0	63. 00
64. 00	Allowable bad debts (see instructions)			30, 329	1
65. 00		uati ana)		19, 714	1
66. 00 67. 00	Allowable bad debts for dual eligible beneficiaries (see instru Subtotal (line 61 plus line 65 minus lines 62 and 63)	ictions)		22, 934 2, 897, 280	1
68. 00	Credits received from manufacturers for replaced devices for ap	oplicable to MS-DRGs (s	ee instructions)	2,077,200	68. 00
69. 00	Outlier payments reconciliation (sum of lines 93, 95 and 96). (F		,	0	1
70. 00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)			0	70. 00
70. 50	RURAL DEMONSTRATION PROJECT			0	70. 50
70. 88 70. 89	SCH or MDH volume decrease adjustment Pioneer ACO demonstration payment adjustment amount (see instru	uctions)		0	70. 88 70. 89
70. 90	HSP bonus payment HVBP adjustment amount (see instructions)	,		0	70. 90
70. 91	HSP bonus payment HRR adjustment amount (see instructions)			0	70. 91
70. 92	,			0	70. 92
70. 93	HVBP payment adjustment amount (see instructions)			23, 901	70. 93
	HRR adjustment amount (see instructions) Recovery of accelerated depreciation			-7, 216 0	70. 94 70. 95
, 5. ,5	photos y or according appropriation			٥	, 70. 70

	Financial Systems HUNTINGTON MEMORIAL				u of Form CMS-2	2332-10
CALCUL	ATION OF REIMBURSEMENT SETTLEMENT	Provi der	CCN: 150091	Peri od: From 01/01/2015	Worksheet E Part A	
				To 12/31/2015		nared:
				10 12/31/2013	10/28/2016 10	
		Ti tl	e XVIII	Hospi tal	PPS	
			FFY	(yyyy)	Amount	
				0	1. 00	
70. 96	Low volume adjustment for federal fiscal year (yyyy) (Enter in	column 0		2015	279, 522	70. 96
	the corresponding federal year for the period prior to 10/1)					
70. 97	Low volume adjustment for federal fiscal year (yyyy) (Enter in	column 0		2016	106, 545	70. 97
	the corresponding federal year for the period ending on or afte	r 10/1)				
70. 98	Low Volume Payment-3				0	
70. 99	HAC adjustment amount (see instructions)				0	70. 99
71.00	Amount due provider (line 67 minus lines 68 plus/minus lines 69	& 70)			3, 300, 032	71. 00
71. 01	Sequestration adjustment (see instructions)				66, 001	71. 01
72.00	Interim payments				3, 147, 241	72. 00
	Tentative settlement (for contractor use only)				0	73. 00
74.00	Balance due provider (Program) (line 71 minus lines 71.01, 72,	and 73)			86, 790	74. 00
75.00	Protested amounts (nonallowable cost report items) in accordance	e with			210, 220	75. 00
	CMS Pub. 15-2, chapter 1, §115.2					
	TO BE COMPLETED BY CONTRACTOR (Lines 90 through 96)					
90.00	Operating outlier amount from Wkst. E, Pt. A, line 2 (see instr	ucti ons)			0	
91. 00	Capital outlier from Wkst. L, Pt. I, line 2				0	, , , , 00
92.00	Operating outlier reconciliation adjustment amount (see instruc				0	92. 00
93.00	Capital outlier reconciliation adjustment amount (see instructi				0	93. 00
	The rate used to calculate the time value of money (see instruc	ti ons)			0. 00	
	Time value of money for operating expenses (see instructions)				0	95. 00
96. 00	Time value of money for capital related expenses (see instructi	ons)			0	96. 00
				Prior to 10/1		
				1. 00	2. 00	
	HSP Bonus Payment Amount					
100.00	HSP bonus amount (see instructions)			0	0	100. 00
	HVBP Adjustment for HSP Bonus Payment			1		
	HVBP adjustment factor (see instructions)			1. 0016715778	1. 0084637595	
102.00	HVBP adjustment amount for HSP bonus payment (see instructions)			0	0	102. 00
	HRR Adjustment for HSP Bonus Payment					
	HRR adjustment factor (see instructions)			0. 9967	0. 9989	
104 00	HRR adjustment amount for HSP bonus payment (see instructions)			l Ol	0	104.00

Peri od: Worksheet E
From 01/01/2015 Part A Exhi bit 4
To 12/31/2015 Date/Time Prepared: 10/28/2016 10: 35 am Provi der CCN: 150091

Section Sect					Ti +I	e XVIII	Hospi tal	10/28/2016 10 PPS	:35 am
1.00 106 sexuals other than suffice 1.00 1.00 0.			W/S E, Part A	Amounts (from					
1.00 DRC amounts other than outlier 1.00 0 0 0 0 0 0 0 0 0									
1,00 Disc amounts other than out eq 1,01 1,941,068 0 1,941,068 1,941,068 1,01	1.00	DRG amounts other than outlier			2.00	3.00	4.00		1. 00
Sympeths For discharges									
1.00 Discurring prior to 0-Clober 1 0.00 0.	1. 01		1. 01	1, 961, 068	0	1, 961, 068		1, 961, 068	1.01
December December		occurring prior to October 1							
1.03	1. 02		1. 02	676, 133	0		676, 133	676, 133	1. 02
Operating payment for Model 4 BRCL occurring prior to Cotober 1 Cotober									
Operating payment for Model 4 BRCL occurring prior to Cotober 1 Cotober	4 00	1	4.00						4 00
BPC Occurring prior to	1.03	operating payment for Model 4	1.03	U	0		1	0	1.03
1.04 1.08 for Federal Specific operating payment for Model 4 1.04 0 0 0 0 0 0 0 0 0		BPCI occurring prior to							
operating payment for Model 4	1 04		1 04		0			0	1 04
October 1	1.04		1.04		0			0	1.04
2.00		BPCI occurring on or after							
discharges (see Instructions) 2.00 0 0 0 0 0 0 0 0 0	2 00		2 00	2 055	0	77	1 978	2 055	2 00
discharges for Model 4 BPCI 2.01 0 0 0 0 0 0 0 3.00		discharges (see instructions)		2,000		, ,	1,770	2,000	
3.00 Operating outlier 2.01 0 0 0 0 0 0 0 0 0	2. 01		2. 02	0	0	C	0	0	2. 01
Managed care simulated 3.00 0 0 0 0 0 0 0 0 0	3.00		2. 01	0	0	c	o	0	3. 00
payments		reconciliation		_	_	_		_	
Indirect Medical Education Adjustment	4.00		3.00	O	0	(0	4.00
A. Iline 21 (see instructions) 6. 00 Mip payment adjustment for 22.00 0 0 0 0 0 0 0 0 0		Indirect Medical Education Adju							
MITE payment adjustment (see 22.00 0 0 0 0 0 0 0 0 0	5.00	•	21. 00	0. 000000	0. 000000	0. 000000	0.000000		5. 00
Instructions	6. 00		22. 00	0	0	C	o	0	6. 00
managed care (see				_	_	_		_	
Instructions	6. 01		22. 01	0	0	C	0	0	6. 01
1.00 IME payment adjustment factor 27.00 0.0000000 0.0000000 0.0000000 0.0000000 0.00000000		instructions)							
See Instructions	7 00						0.000000		7 00
Instructions Second	7.00		27.00	0.000000	0.00000	0.000000	0.00000		7.00
Section Sect	8.00	IME adjustment (see	28. 00	0	0	C	O	0	8. 00
For managed care (see instructions) 9.00 Total IME payment (sum of Ilnes 6 and 8) 9.01 Total IME payment (sum of Ilnes 6 and 8) 9.01 Total IME payment for managed care (sum of Ilnes 6 and 8) 9.01 Total IME payment for managed care (sum of Ilnes 6 and 8) 9.01 1.00 1.00 1.00 0	8 01		28 01	0	0	,	0	0	8 01
9.00 Total IME payment (sum of lines 6 and 8) 0 0 0 0 0 0 0 0 0	0.01	for managed care (see	20.01	J	0			0	0.01
1	0.00		20.00		0			0	0.00
Care (sum of lines 6.01 and 8.01) Disproportionate Share Adjustment Disproportionate Share Adjustment Disproportionate Share Adjustment Disproportionate Share percentage (see Instructions) Disproportionate share adjustment (see instructions) Disproportionate Share Disproportionate Sha	9.00		29.00		0			0	9.00
8.01 Disproportionate Share Adjustment	9. 01		29. 01	O	0	C	o	0	9. 01
Disproportionate Share Adjustment 33.00 0.1200									
Share percentage (see instructions) 11.00 10 10 10 10 10 10		Disproportionate Share Adjustme							
11.00 Disproportionate share 34.00 79,116 0 58,832 20,284 79,116 11.00 30 34.00 376,415 0 293,963 82,452 376,415 11.01 200 2	10. 00		33. 00	0. 1200	0. 1200	0. 1200	0. 1200		10.00
11. 01									
11. 01 Uncompensated care payments 36. 00 376, 415 0 293, 963 82, 452 376, 415 11. 01 Additional payment for high percentage of ESRD beneficiary discharges 12. 00 Total ESRD additional payment (see instructions) 46. 00 0 0 0 0 0 0 0 13. 00 Subtotal (see instructions) 47. 00 3, 094, 787 0 2, 313, 940 780, 847 3, 094, 787 13. 00 14. 00 Hospital specific payments (completed by SCH and MDH, small rural hospitals only.) (see instructions) 15. 00 Total payment for inpatient operating costs (see instructions) 16. 00 Payment for inpatient program 50. 00 209, 835 0 155, 034 54, 801 209, 835 16. 00 17. 00 Special add-on payments for 54. 00 0 0 0 0 0 0 17. 00 17. 01 Total rogan aquisition cost 55. 00 0 0 0 0 0 0 0 17. 01 Credits received from 68. 00 0 0 0 0 0 0 0 17. 02 18. 00 Capital outlier reconciliation 93. 00 0 0 0 0 0 0 0 0 0	11. 00		34.00	79, 116	0	58, 832	20, 284	79, 116	11. 00
Additional payment for high percentage of ESRD beneficiary discharges	11. 01	, ,	36.00	376, 415	0	293. 963	82. 452	376, 415	11. 01
13.00 Subtotal (see instructions) 47.00 3,094,787 0 2,313,940 780,847 3,094,787 13.00 14.00 Hospital specific payments (completed by SCH and MDH, small rural hospitals only.) (see instructions) 15.00 Total payment for inpatient operating costs (see instructions) 16.00 Payment for inpatient program capital 17.00 Special add-on payments for new technologies 17.01 Net organ aquisition cost 17.02 Credits received from manufacturers for replaced devices for applicable MS-DRGs 18.00 Capital outlier reconciliation 93.00 0 0 0 0 0 0 0 0 0		Additional payment for high per	centage of ESF		di scharges	.,	,		
13.00 Subtotal (see instructions) 47.00 3,094,787 0 2,313,940 780,847 3,094,787 13.00 14.00 Hospital specific payments (completed by SCH and MDH, small rural hospitals only.) (see instructions) 48.00 0 0 0 0 0 14.00 15.00 Total payment for inpatient operating costs (see instructions) 49.00 3,094,787 0 2,313,940 780,847 3,094,787 15.00 16.00 Payment for inpatient program capital 50.00 209,835 0 155,034 54,801 209,835 16.00 17.01 Special add-on payments for new technologies 54.00 0 0 0 0 0 0 17.00 17.02 Credits received from anufacturers for replaced devices for applicable MS-DRGs Capital outlier reconciliation adjustment amount (see 93.00 0 0 0 0 0 0 0 0 18.00	12. 00		46. 00	0	0	C	0	0	12.00
(completed by SCH and MDH, small rural hospitals only.) (see instructions) 15.00 Total payment for inpatient operating costs (see instructions) 49.00 3,094,787 0 2,313,940 780,847 3,094,787 15.00 16.00 Payment for inpatient program capital 50.00 209,835 0 155,034 54,801 209,835 16.00 17.00 Special add-on payments for new technologies 54.00 0 0 0 0 0 0 17.00 17.01 Net organ aquisition cost 55.00 0 0 0 0 0 0 17.01 17.02 Credits received from devices for applicable MS-DRGs 68.00 0 0 0 0 0 0 0 0 0 17.02 0 <t< td=""><td>13. 00</td><td></td><td>47. 00</td><td>3, 094, 787</td><td>0</td><td>2, 313, 940</td><td>780, 847</td><td>3, 094, 787</td><td>13. 00</td></t<>	13. 00		47. 00	3, 094, 787	0	2, 313, 940	780, 847	3, 094, 787	13. 00
Small rural hospitals only.) (see instructions) 15.00 Total payment for inpatient 49.00 3,094,787 0 2,313,940 780,847 3,094,787 15.00 15.00 209,835 0 155,034 54,801 209,835 16.00 209,835 16.00 209,835 20	14. 00		48. 00	0	0	C	0	0	14. 00
15.00 (see instructions) 49.00 (see instructions) 15.00 (perating costs (see instructions) 49.00 (see instructions) 16.00 (payment for inpatient program instructions) 50.00 (see instructions) 16.00 (payment for inpatient program capital) 50.00 (see instructions) 17.00 (payment for inpatient program capital) 50.00 (see instructions) 17.00 (payment for inpatient program capital) 50.00 (see instructions) 17.01 (payment for inpatient program capital) 50.00 (see instructions) 17.01 (payment for inpatient program capital) 50.00 (see instructions) 18.01 (payment for inpatient program capital) 50.00 (see instructions) 18.02 (payment for inpatient program capital) 50.00 (see instructions) 18.00 (payment for inpatient program capital) 50.00 (see instructions) 18.00 (payment for inpatient program capital) 50.00 (see instructions) 18.00 (payment for inpatient program capital) 50.00 (see instructions) 18.00 (payment for inpatient program capital) 50.00 (see instructions) 18.00 (payment for inpatient program capital) 50.00 (see instructions) 18.00 (payment for inpatient program capital) 50.00 (see instructions) 17.01 (payment for inpatient program capital) 50.00 (see instructions) 17.01 (payment for inpatient program capital) 50.00 (see instructions) 17.00 (payment for inpatient progr									
16.00 Payment for inpatient program 50.00 209,835 0 155,034 54,801 209,835 16.00 17.00 Special add-on payments for consist of the program 54.00 0 0 0 0 0 0 17.01 Net organ aquisition cost 55.00 0 0 0 0 0 0 0 17.02 Credits received from 68.00 0 0 0 0 0 0 17.02 manufacturers for replaced devices for applicable MS-DRGs 18.00 Capital outlier reconciliation 93.00 0 0 0 0 0 0 18.00 18.00 adjustment amount (see		(see instructions)							
16.00 Payment for inpatient program 50.00 209,835 0 155,034 54,801 209,835 16.00 17.00 Special add-on payments for new technologies 17.01 Net organ aquisition cost 55.00 0 0 0 0 0 0 17.01 17.02 Credits received from 68.00 0 0 0 0 0 0 17.02 18.00 Capital outlier reconciliation 93.00 0 0 0 0 0 0 18.00 18.00 Capital outlier amount (see	15. 00		49. 00	3, 094, 787	0	2, 313, 940	780, 847	3, 094, 787	15. 00
Capital Capi									
17. 00 Special add-on payments for new technologies 54.00 0 0 0 0 0 0 17.00 17. 01 Net organ aquisition cost 55.00 0 0 0 0 0 0 0 17.01 17. 02 Credits received from manufacturers for replaced devices for applicable MS-DRGs 68.00 0 0 0 0 0 0 0 17.02 18. 00 Capital outlier reconciliation adjustment amount (see 93.00 0 0 0 0 0 0 0 0 18.00	16. 00		50. 00	209, 835	0	155, 034	54, 801	209, 835	16. 00
new technologies	17. 00		54.00	0	0		o	0	17.00
17. 02 Credits received from 68. 00 0 0 0 0 0 17. 02 manufacturers for replaced devices for applicable MS-DRGs Capital outlier reconciliation adjustment amount (see		new technologies							
manufacturers for replaced devices for applicable MS-DRGs 18.00 Capital outlier reconciliation adjustment amount (see				٥	0		1	0	
devices for applicable MS-DRGs 18.00 Capital outlier reconciliation adjustment amount (see	17.02		00.00		0				17.02
adjustment amount (see	40.05	devices for applicable MS-DRGs		_	_	_	_	_	10.00
	18.00		93.00	0	0	ſ	'	0	18.00

Part A Exhibit 4
Date/Time Prepared: 12/31/2015 10/28/2016 10:35 am Title XVIII Hospi tal W/S E, Part A Amounts (from Pre/Post Period Prior Total (Col 2 Peri od to 10/01 Part A) On/After 10/01 line E, Entitlement through 4) 0 1 00 2 00 3 00 4.00 5 00 2, 468, 974 19.00 SUBTOTAL 835, 648 3, 304, 622 19. 00 W/S L, line (Amounts from L) 2.00 3.00 4.00 5.00 0 1.00 20.00 Capital DRG other than outlier 155, 034 54, 801 209, 835 20 00 1 00 209.835 20.01 Model 4 BPCI Capital DRG other 1.01 20.01 than outlier 21.00 Capital DRG outlier payments 2.00 0 0 0 21.00 Model 4 BPCI Capital DRG 0 0 ol 21.01 C 21.01 2.01 outlier payments 22.00 Indirect medical education 5.00 0.0000 0.0000 0.0000 0.0000 22.00 percentage (see instructions) Indirect medical education 23.00 23.00 6.00 0 adjustment (see instructions) Allowable disproportionate 0.0000 0.0000 24.00 10 00 0.0000 0.0000 24.00 share percentage (see instructions) 25.00 Di sproporti onate share 11.00 0 0 25.00 adjustment (see instructions) 26.00 Total prospective capital 12.00 209, 835 155, 034 54, 801 209, 835 26.00 payments (see instructions) W/S E, Part A (Amounts to E, line Part A) 2.00 1.00 3.00 4.00 5.00 27.00 Low volume adjustment factor 0. 113214 0. 127500 27. 00 Low volume adjustment 70.96 279, 522 279, 522 28.00 28.00 (transfer amount to Wkst. E, Pt. A, line) Low volume adjustment 70.97 106, 545 106, 545 29.00 (transfer amount to Wkst. E, Pt. A. line) 100.00 Transfer low volume 100.00 adjustments to Wkst. E, Pt. A.

Health Financial Systems	HUNTINGTON MEMORIAL HO	OSPI TAL		In Lieu	u of Form CMS-2552-10
CALCULATION OF REIMBURSEMENT SETTLEMENT	P	Provider CCN:	150091	Peri od: From 01/01/2015 To 12/31/2015	Worksheet E Part B Date/Time Prepared: 10/28/2016 10:35 am
		T: 11 \0			200

			10 12/31/2015	10/28/2016 10:	
		Title XVIII	Hospi tal	PPS	. 33 alli
		TI LIE XVIII	поѕрі таі	PP3	
			-	1 00	
	DART R MEDICAL AND OTHER HEALTH CERVICES			1. 00	
1 00	PART B - MEDICAL AND OTHER HEALTH SERVICES			0	1 00
1.00	Medical and other services (see instructions)				1.00
2.00	Medical and other services reimbursed under OPPS (see instructi	ons)		2, 756, 337	2.00
3.00	PPS payments			2, 529, 927	3. 00
4.00	Outlier payment (see instructions)			9, 617	4. 00
5.00	Enter the hospital specific payment to cost ratio (see instruct	i ons)		0. 859	
6.00	Line 2 times line 5			2, 367, 693	•
7. 00	Sum of line 3 plus line 4 divided by line 6			0. 00	
8.00	Transitional corridor payment (see instructions)			0	8. 00
9.00	Ancillary service other pass through costs from Wkst. D, Pt. IV	, col. 13, line 200		0	9. 00
10.00	Organ acqui si ti ons			0	10.00
11.00	Total cost (sum of lines 1 and 10) (see instructions)			0	11. 00
	COMPUTATION OF LESSER OF COST OR CHARGES				
	Reasonabl e charges				
12.00	Ancillary service charges			0	12.00
13.00	Organ acquisition charges (from Wkst. D-4, Pt. III, col. 4, lin	e 69)		0	13.00
14.00	Total reasonable charges (sum of lines 12 and 13)	•		0	14.00
	Customary charges		1		
15. 00	Aggregate amount actually collected from patients liable for pa	vment 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 chargebasi's	١	10.00
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)			0.000000	
19. 00	Excess of customary charges over reasonable cost (complete only	if line 19 exceeds lin	0 11) (600	0	
19.00	instructions)	II Tille to exceeds till	s 11) (See	U	19.00
20. 00		if line 11 exceeds lin	0 10) (000	0	20. 00
20.00	Excess of reasonable cost over customary charges (complete only instructions)	II Tille II exceeds IIII	s 10) (See	U	20.00
21. 00	Lesser of cost or charges (line 11 minus line 20) (for CAH see	instructions)		0	21. 00
	, ,	THSTI uctions)		-	
22. 00	Interns and residents (see instructions)	-+!>		0	22. 00
23. 00	Cost of physicians' services in a teaching hospital (see instru	ctions)		0 500 544	23. 00
24. 00	Total prospective payment (sum of lines 3, 4, 8 and 9)			2, 539, 544	24. 00
	COMPUTATION OF REIMBURSEMENT SETTLEMENT			504 500	
25. 00	Deductibles and coinsurance (for CAH, see instructions)			581, 539	
26. 00	Deductibles and Coinsurance relating to amount on line 24 (for			0	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, 958, 005	27. 00
	instructions)	==>			
28. 00	Direct graduate medical education payments (from Wkst. E-4, lin	e 50)		0	28. 00
29. 00	ESRD direct medical education costs (from Wkst. E-4, line 36)			0	29. 00
30. 00	Subtotal (sum of lines 27 through 29)			1, 958, 005	•
31. 00	Primary payer payments			1, 277	
32. 00	Subtotal (line 30 minus line 31)			1, 956, 728	32. 00
	ALLOWABLE BAD DEBTS (EXCLUDE BAD DEBTS FOR PROFESSIONAL SERVICE	\$)			
33. 00	Composite rate ESRD (from Wkst. I-5, line 11)			0	
34. 00	Allowable bad debts (see instructions)			75, 210	•
35. 00	Adjusted reimbursable bad debts (see instructions)			48, 887	35. 00
36.00	Allowable bad debts for dual eligible beneficiaries (see instru	ctions)		68, 647	36. 00
37.00	Subtotal (see instructions)			2, 005, 615	37.00
38.00	MSP-LCC reconciliation amount from PS&R			0	38. 00
39.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)			0	39. 00
39. 50	Pioneer ACO demonstration payment adjustment (see instructions)			0	39. 50
39. 98	Partial or full credits received from manufacturers for replace	d devices (see instruct	i ons)	0	39. 98
39. 99	RECOVERY OF ACCELERATED DEPRECIATION	•	, i	0	39. 99
40. 00	Subtotal (see instructions)			2, 005, 615	
40. 01	Sequestration adjustment (see instructions)			40, 112	
41. 00				1, 917, 597	
42. 00				0	
43. 00				47, 906	•
44. 00				47, 700	1
44.00	§115. 2	e with two rub. 15-2, t	lapter I,	U	44.00
	TO BE COMPLETED BY CONTRACTOR				
90. 00	Original outlier amount (see instructions)			0	90. 00
	Outlier reconciliation adjustment amount (see instructions)			0	
91.00	, , , , , , , , , , , , , , , , , , , ,				
	The rate used to calculate the Time Value of Money				92.00
93. 00	Time Value of Money (see instructions)			0	
94.00	Total (sum of lines 91 and 93)			0	94. 00

| Peri od: | Worksheet E-1 | From 01/01/2015 | Part | To 12/31/2015 | Date/Time Prepared: | 10/28/2016 10: 35 am Health Financial Systems HUNTI
ANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED Provi der CCN: 150091

					10/28/2016 10:	35 am
			e XVIII	Hospi tal	PPS	
		Inpatier	t Part A	Par	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		3, 147, 241		1, 917, 597	1.00
2.00	Interim payments payable on individual bills, either		C)	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
3.00	amount based on subsequent revision of the interim rate					3.00
	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		C)	0	3. 01
3.02			C)	0	3. 02
3.03			C)	o	3. 03
3.04			C)	0	3.04
3.05			C		0	3.05
	Provider to Program					
3.50	ADJUSTMENTS TO PROGRAM		C		0	3. 50
3. 51			C		0	3. 51
3. 52			C		0	3. 52
3. 53			C		0	3. 53
3.54			C		0	3. 54
3. 99	Subtotal (sum of lines 3.01-3.49 minus sum of lines		C		0	3. 99
4. 00	3.50-3.98) Total interim payments (sum of lines 1, 2, and 3.99)		3, 147, 241		1, 917, 597	4. 00
4.00	(transfer to Wkst. E or Wkst. E-3, line and column as		3, 147, 241		1, 917, 397	4.00
	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					
5. 01	TENTATI VE TO PROVI DER		C		0	5. 01
5. 02			C		0	5. 02
5. 03			C		0	5. 03
F F0	Provi der to Program					F F0
5. 50	TENTATI VE TO PROGRAM		C		0	5. 50
5. 51 5. 52						5. 51 5. 52
5. 52 5. 99	Subtotal (sum of lines 5.01-5.49 minus sum of lines					5. 52
5. 77	5. 50-5. 98)				ا	3. 77
6. 00	Determined net settlement amount (balance due) based on					6. 00
5. 55	the cost report. (1)					0. 00
6. 01	SETTLEMENT TO PROVIDER		86, 790)	47, 906	6. 01
6. 02	SETTLEMENT TO PROGRAM		l c)	0	6. 02
7.00	Total Medicare program liability (see instructions)		3, 234, 031		1, 965, 503	7. 00
				Contractor	NPR Date	
				Number	(Mo/Day/Yr)	
)	1. 00	2. 00	
8.00	Name of Contractor					8. 00

Heal th	Financial Systems HUNTINGTON MEMORIA	L HOSPI TAL	In Lie	u of Form CMS-2	2552-10
	ATION OF REIMBURSEMENT SETTLEMENT FOR HIT	Provi der CCN: 150091	Peri od: From 01/01/2015 To 12/31/2015		
		Title XVIII	Hospi tal	PPS	
				1. 00	
	TO BE COMPLETED BY CONTRACTOR FOR NONSTANDARD COST REPORTS				
	HEALTH INFORMATION TECHNOLOGY DATA COLLECTION AND CALCULATION			1, 607	1. 00
1.00	9				
2.00	00 Medicare days from Wkst. S-3, Pt. I, col. 6 sum of lines 1, 8-12				
3.00	.00 Medicare HMO days from Wkst. S-3, Pt. I, col. 6. line 2				
4.00	Total inpatient days from S-3, Pt. I col. 8 sum of lines 1, 8-	12		4, 491	4. 00
5.00	Total hospital charges from Wkst C, Pt. I, col. 8 line 200			144, 698, 821	5. 00
6.00	Total hospital charity care charges from Wkst. S-10, col. 3 li			2, 705, 594	6. 00
7. 00	CAH only - The reasonable cost incurred for the purchase of ce line 168	rtified HIT technology	Wkst. S-2, Pt. I	0	7. 00
8.00	Calculation of the HIT incentive payment (see instructions)			305, 165	8. 00
9.00	Sequestration adjustment amount (see instructions)		6, 103	9. 00	
10.00	Calculation of the HIT incentive payment after sequestration (299, 062	10.00	
	INPATIENT HOSPITAL SERVICES UNDER THE IPPS & CAH				
30.00	Initial/interim HIT payment adjustment (see instructions)			274, 921	30.00
31.00	Other Adjustment (specify)			0	31.00
22 00	00 Palance due provider (Line 9 (or Line 10) minus Line 30 and Line 31) (see instructions)				

32.00 Balance due provider (line 8 (or line 10) minus line 30 and line 31) (see instructions)

274, 921 30. 00 0 31. 00 24, 141 32. 00

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

				10 12/31/2015	10/28/2016 10	pared: :35 am
		General Fund	Speci fi c	Endowment Fund		, 55 diii
		1.00	Purpose Fund 2.00	3.00	4. 00	
	CURRENT ASSETS	1.00	2.00	3.00	4.00	
1.00	Cash on hand in banks	2, 550)	0	0	
2.00	Temporary investments	0	1	0	0	
3.00	Notes receivable	14 224 144	1	0	0	
4. 00 5. 00	Accounts recei vabl e Other recei vabl e	16, 324, 146 218, 561			0	
6. 00	Allowances for uncollectible notes and accounts receivable	-10, 472, 035			0	
7. 00	Inventory	208, 223		o o	0	
8.00	Prepai d expenses	1, 391, 349		o	0	
9.00	Other current assets	0		0	0	
10.00	Due from other funds	0	1	0	0	
11. 00	Total current assets (sum of lines 1-10) FIXED ASSETS	7, 672, 794	.[(0	0	11. 00
12. 00	Land	1		ol	0	12. 00
13. 00	Land improvements	465, 871		ol ol	0	
14.00	Accumul ated depreciation	-259, 799	•	o	0	
15. 00	Bui I di ngs	1, 927, 095	5	0	0	
16. 00	Accumulated depreciation	-999, 486		0	0	
17. 00	Leasehold improvements	32, 500	1	0	0	
18. 00 19. 00	Accumulated depreciation Fixed equipment	-28, 437 510, 214	1	1 1	0	
20. 00	Accumulated depreciation	-491, 323		1 4	0	
21. 00	Automobiles and trucks	660, 453	1	ol ol	0	
22. 00	Accumul ated depreciation	-579, 972	1	o	0	22. 00
23. 00	Major movable equipment	9, 707, 084		0	0	
24. 00	Accumulated depreciation	-8, 180, 105		0	0	
25. 00	Mi nor equi pment depreci abl e	1, 175, 184		1 1	0	
26. 00 27. 00	Accumulated depreciation HIT designated Assets	-778, 677		1 1	0	
28. 00	Accumulated depreciation				0	
29. 00	Mi nor equi pment-nondepreci abl e	156, 783		ol ol	0	
30.00	Total fixed assets (sum of lines 12-29)	3, 317, 385		0	0	30.00
	OTHER ASSETS					
31. 00 32. 00	Investments	31, 421, 235	1	0	0	
32.00	Deposits on leases Due from owners/officers			1	0	
34. 00	Other assets	33, 799	1		0	
35. 00	Total other assets (sum of lines 31-34)	31, 455, 034	•	ol ol	0	
36.00	Total assets (sum of lines 11, 30, and 35)	42, 445, 213	1	0	0	36. 00
	CURRENT LIABILITIES					
37. 00	Accounts payable	740, 985	1	0	0	
38. 00 39. 00	Salaries, wages, and fees payable Payroll taxes payable	713, 193		0	0	
40. 00	Notes and Loans payable (short term)	69, 828			0	
41. 00	Deferred income	07, 020			0	
42.00	Accel erated payments	0				42.00
43.00	Due to other funds	0)	0	0	
44. 00		201, 641		0	0	
45. 00		1, 725, 647	1(0	0	45. 00
46. 00	LONG TERM LIABILITIES Mortgage payable	Ι ο			0	46. 00
47. 00	Notes payable	36, 175			0	
48. 00	Unsecured Loans	00,170		ol ol	0	1
49.00	Other long term liabilities	33, 797	,	o	0	49. 00
50.00	Total long term liabilities (sum of lines 46 thru 49)	69, 972	2	0	0	
51. 00	Total liabilities (sum of lines 45 and 50)	1, 795, 619) (0	0	51. 00
F2 00	CAPI TAL ACCOUNTS	10 (40 504				F2 00
52. 00 53. 00	General fund balance Specific purpose fund	40, 649, 594				52. 00 53. 00
54. 00	Donor created - endowment fund balance - restricted		1	1		54.00
55. 00	Donor created - endowment fund balance - unrestricted			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	40 / 40 504] ,		0	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	40, 649, 594 42, 445, 213	1)))	0	
55.00	[59]	12, 770, 213]	1		55. 66
	1 * 7	I	1	1		1

Provi der CCN: 150091

Peri od: Worksheet G-1 From 01/01/2015 To 12/31/2015 Date/Time Prepared:

					To 12/31/2015	Date/Time Prep 10/28/2016 10	pared:
		General	Fund	Speci al	Purpose Fund	Endowment Fund	. 33 alli
		1.00	2. 00	3.00	4. 00	5. 00	
1.00	Fund balances at beginning of period		40, 578, 818		C		1. 00
2.00	Net income (loss) (from Wkst. G-3, line 29)		12, 570, 308				2.00
3. 00 4. 00	Total (sum of line 1 and line 2) Additions (credit adjustments) (specify)	0	53, 149, 126			0	3. 00 4. 00
4. 00 5. 00	Additions (credit adjustments) (specify)				0	0	5. 00
6. 00					0		6. 00
7. 00		l ol			o	0	7. 00
8.00		o			0	0	8. 00
9.00		0			0	0	9. 00
10. 00	Total additions (sum of line 4-9)		0		C)	10.00
11. 00	Subtotal (line 3 plus line 10)		53, 149, 126		C		11.00
12. 00 13. 00	Deductions (debit adjustments) (specify) ASSET TRANSFERS	12, 499, 532			0	0	12. 00 13. 00
14. 00	ASSET TRANSFERS	12, 499, 532			0	0	14.00
15. 00					0		15. 00
16. 00		o			0	0	16. 00
17. 00		o			0	0	17. 00
18. 00	Total deductions (sum of lines 12-17)		12, 499, 532	•	C		18. 00
19. 00	Fund balance at end of period per balance		40, 649, 594		C		19. 00
	sheet (line 11 minus line 18)	Endowment Fund	PI ant	Fund			
		6.00	7. 00	8. 00			
1.00	Fund balances at beginning of period	0			0		1.00
2. 00 3. 00	Net income (loss) (from Wkst. G-3, line 29) Total (sum of line 1 and line 2)	0			0		2. 00 3. 00
4. 00	Additions (credit adjustments) (specify)	٩	0		O O		4.00
5. 00	(Speerry)		0				5.00
6.00			0				6. 00
7.00			0				7. 00
8.00			0				8. 00
9.00	T		0				9. 00
10. 00 11. 00	Total additions (sum of line 4-9) Subtotal (line 3 plus line 10)	0			0		10. 00 11. 00
12. 00	Deductions (debit adjustments) (specify)	٩	0		O .		12.00
13. 00	ASSET TRANSFERS		0				13. 00
14. 00			0				14. 00
15.00			0				15. 00
16. 00			0				16. 00
17. 00			0				17.00
18.00	Total deductions (sum of lines 12-17)	0			0		18.00
19. 00	Fund balance at end of period per balance sheet (line 11 minus line 18)	0			0		19. 00
	price (Trie II milius Trie 10)	1	l	ı	l .	l	ı

Health Financial Systems HU STATEMENT OF PATIENT REVENUES AND OPERATING EXPENSES Provi der CCN: 150091

			10 12/31/2013	10/28/2016 10:	
	Cost Center Description	Inpatient	Outpati ent	Total	00 0
	3331 331131 23331 pt 31	1. 00	2. 00	3. 00	
	PART I - PATIENT REVENUES	1.00	2.00	0.00	
	General Inpatient Routine Services				
1.00	Hospi tal	7, 410, 01	0	7, 410, 010	1.00
2.00	SUBPROVI DER - I PF	, , , , , ,		, ,	2.00
3.00	SUBPROVI DER - I RF				3. 00
4.00	SUBPROVI DER				4.00
5. 00	Swing bed - SNF		ol	0	5. 00
6.00	Swing bed - NF		0	0	
7. 00	SKILLED NURSING FACILITY		1	· ·	7. 00
8.00	NURSING FACILITY				8. 00
9. 00	OTHER LONG TERM CARE				9. 00
10.00	Total general inpatient care services (sum of lines 1-9)	7, 410, 01		7, 410, 010	
	Intensive Care Type Inpatient Hospital Services	77 110701	<u> </u>	77 1107 010	
11. 00	INTENSIVE CARE UNIT				11. 00
12. 00	CORONARY CARE UNIT				12.00
13. 00	BURN INTENSIVE CARE UNIT				13. 00
14. 00	SURGI CAL INTENSI VE CARE UNI T				14. 00
15. 00	OTHER SPECIAL CARE (SPECIFY)				15. 00
16. 00	Total intensive care type inpatient hospital services (sum of lines		o	0	
	11-15)		1	· ·	
17. 00	Total inpatient routine care services (sum of lines 10 and 16)	7, 410, 01	ol	7, 410, 010	17. 00
18. 00	Ancillary services	33, 850, 55		33, 850, 556	
19. 00	Outpati ent servi ces		0 103, 495, 080	103, 495, 080	
20. 00	RURAL HEALTH CLINIC		0 0	0	20. 00
21. 00	FEDERALLY QUALIFIED HEALTH CENTER	•		0	21. 00
22. 00	HOME HEALTH AGENCY		Ĭ Ĭ	o ,	22. 00
23. 00	AMBULANCE SERVICES		0 6, 473, 588	6, 473, 588	
24. 00	CMHC		0, 170, 000	0, 170, 000	24. 00
25. 00	AMBULATORY SURGICAL CENTER (D. P.)				25. 00
26. 00	HOSPI CE				26. 00
27. 00	OTHER (SPECIFY)		ol ol	0	27. 00
28. 00	Total patient revenues (sum of lines 17-27)(transfer column 3 to Wkst	t. 41, 260, 56	6 109, 968, 668	151, 229, 234	
	G-3, line 1)	,	101,111,111	,,	
	PART II - OPERATING EXPENSES		1		
29. 00	Operating expenses (per Wkst. A, column 3, line 200)		41, 347, 028		29. 00
30.00	PROVISION FOR BAD DEBT	7, 340, 46	8		30. 00
31.00			ol		31. 00
32.00			ol		32.00
33.00			ol		33. 00
34.00			o I		34.00
35. 00			o I		35. 00
36. 00	Total additions (sum of lines 30-35)		7, 340, 468		36. 00
37. 00	DEDUCT (SPECIFY)		0		37. 00
38. 00			0		38. 00
39. 00			ol l		39. 00
40. 00			0		40. 00
41. 00			ol l		41. 00
42. 00	Total deductions (sum of lines 37-41)		0		42.00
43. 00	Total operating expenses (sum of lines 29 and 36 minus line 42)(trans	sfer	48, 687, 496		43. 00
	to Wkst. G-3, line 4)				

	Financial Systems HUNTINGTON MEMORIAL ENT OF REVENUES AND EXPENSES	Provi der CCN: 150091	Peri od:	Worksheet G-3	
01711211	ENT OF NEVEROLO 7810 ENTERIOLO		From 01/01/2015		
			To 12/31/2015	Date/Time Pre	
				10/28/2016 10	: 35 am
			-	1. 00	
1.00	Total patient revenues (from Wkst. G-2, Part I, column 3, line	28)		151, 229, 234	1.00
2.00	Less contractual allowances and discounts on patients' accounts			90, 952, 095	
3.00	Net patient revenues (line 1 minus line 2)			60, 277, 139	3.00
4. 00	Less total operating expenses (from Wkst. G-2, Part II, line 43)		48, 687, 496	4. 00
5. 00	Net income from service to patients (line 3 minus line 4)	,		11, 589, 643	
	OTHER I NCOME		l.	,	
6.00	Contributions, donations, bequests, etc			0	6. 00
7.00	Income from investments			-1, 159, 298	7. 00
8.00	Revenues from telephone and other miscellaneous communication s	ervi ces		0	8. 00
9.00	Revenue from television and radio service			0	9. 00
10.00	Purchase di scounts			0	10.00
11.00	Rebates and refunds of expenses			0	11. 00
12.00	Parking lot receipts			0	12. 00
13.00	Revenue from Laundry and Linen service			0	13.00
14.00	Revenue from meals sold to employees and guests			152, 379	14.00
15.00	Revenue from rental of living quarters			0	15. 00
16.00	Revenue from sale of medical and surgical supplies to other tha	n patients		0	16. 00
17.00	Revenue from sale of drugs to other than patients			0	17. 00
18.00	Revenue from sale of medical records and abstracts			0	18. 00
19. 00	Tuition (fees, sale of textbooks, uniforms, etc.)			0	19. 00
20.00	Revenue from gifts, flowers, coffee shops, and canteen			0	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 (SPECIFY)			0	24. 00
24. 01	GAIN/LOSS ON SALE OF CAPITAL ASSETS			0	24. 01
24. 02	EMS SUBSI DY			250, 000	24. 02
24. 03	OTHER REVENUE			1, 737, 584	24. 03
25. 00	Total other income (sum of lines 6-24)			980, 665	
26.00				12, 570, 308	
	OTHER EXPENSES (SPECIFY)			0	27. 00
	Total other expenses (sum of line 27 and subscripts)			0	28. 00
29. 00	Net income (or loss) for the period (line 26 minus line 28)			12, 570, 308	29. 00

Heal th	Financial Systems HUNTINGTON MEMORIAL	- HOSPI TAL	In Lie	u of Form CMS-2	2552-10
	ATION OF CAPITAL PAYMENT	Provider CCN: 150091	Peri od: From 01/01/2015 To 12/31/2015	Worksheet L Parts I-III Date/Time Pre 10/28/2016 10	pared:
		Title XVIII	Hospi tal	PPS	
				1. 00	
	PART I - FULLY PROSPECTIVE METHOD			-	
1. 00	CAPITAL FEDERAL AMOUNT Capital DRG other than outlier			209, 835	1.00
1. 00	Model 4 BPCI Capital DRG other than outlier			204, 833	
2. 00	Capital DRG outlier payments			0	
2. 01	Model 4 BPCI Capital DRG outlier payments			0	
3.00	Total inpatient days divided by number of days in the cost repo	orting period (see inst	ructions)	12. 83	
4.00	Number of interns & residents (see instructions)	3 1	ĺ	0.00	4. 00
5.00	Indirect medical education percentage (see instructions)			0.00	5. 00
6.00	Indirect medical education adjustment (multiply line 5 by the s	sum of lines 1 and 1.01	, columns 1 and	0	6. 00
	1.01) (see instructions)				
7. 00	Percentage of SSI recipient patient days to Medicare Part A pat	tient days (Worksheet E	, part A line	0. 00	7. 00
0.00	30) (see instructions) Percentage of Medicaid patient days to total days (see instruct	ti ana)		0. 00	8.00
8. 00 9. 00	Sum of lines 7 and 8	LI OIIS)		0.00	
10. 00	Allowable disproportionate share percentage (see instructions)				10.00
11. 00	Disproportionate share adjustment (see instructions)			0.00	
12. 00	, , , , , , , , , , , , , , , , , , , ,	209, 835			
				,	
	PART II - PAYMENT UNDER REASONABLE COST			1. 00	
1. 00	Program inpatient routine capital cost (see instructions)			0	1.00
2.00	Program inpatient ancillary capital cost (see instructions)			0	
3.00	Total inpatient program capital cost (line 1 plus line 2)			0	
4.00	Capital cost payment factor (see instructions)			0	4. 00
5.00	Total inpatient program capital cost (line 3 x line 4)			0	5. 00
				1.00	
	PART III - COMPUTATION OF EXCEPTION PAYMENTS			1. 00	
1.00	Program inpatient capital costs (see instructions)			0	1. 00
2.00	Program inpatient capital costs for extraordinary circumstances	s (see instructions)		0	2. 00
3.00	Net program inpatient capital costs (line 1 minus line 2)			0	3. 00
4.00	Applicable exception percentage (see instructions)			0.00	
5.00	Capital cost for comparison to payments (line 3 x line 4)			0	
6.00	Percentage adjustment for extraordinary circumstances (see inst			0. 00	
7.00	Adjustment to capital minimum payment level for extraordinary of	circumstances (line 2 x	: line 6)	0	
8.00	Capital minimum payment level (line 5 plus line 7)			0	
9. 00 10. 00	Current year capital payments (from Part I, line 12, as application Current year comparison of capital minimum payment level to capital minimum payment level minimum		loog line ()	0	
11. 00	Carryover of accumulated capital minimum payment level over cap			0	
11.00	Worksheet L, Part III, line 14)	ortar payment (from pri	oi yeai	ا ا	11.00
12.00	Net comparison of capital minimum payment level to capital paym	ments (line 10 plus lin	ie 11)	0	12. 00
13.00	Current year exception payment (if line 12 is positive, enter t	the amount on this line	e)	0	13. 00
14.00	Carryover of accumulated capital minimum payment level over cap	0	14. 00		
	(if line 12 is negative, enter the amount on this line)				
15.00	Current year allowable operating and capital payment (see instr	ructions)		0	
16.00				0	
17.00	Current year exception offset amount (see instructions)		l	0	17. 00