Heal th Financi	al Syst	tems	HUNTINGTON MEMORIAL	_ HOSPI TAL			In Lie	u of Form	CMS-25	552-10
This report is	requi	red by law (42 USC 1395	g; 42 CFR 413.20(b)). Fail	ure to report o	can resul	t in all	interim	FORM APP	ROVED	
payments made	si nce	the beginning of the co	st reporting period being	deemed overpaym	nents (42	USC 1395	g).	OMB NO.	0938-0	050
HOSPITAL AND H	IOSPI TA	L HEALTH CARE COMPLEX C	OST REPORT CERTIFICATION	Provi der CCN:	150091	Peri od:		Workshee		
AND SETTLEMENT	SUMMA	RY				From 01/				
						To 12/	31/2014	Date/Tim		
								5/22/201	5 11:30	<u>υ am</u>
PART I - COST	REPORT	STATUS								
Provi der	1. [X] Electronically filed	cost report			Date:	5/22/20	15 Ti	me: 11:	30 am
use only	2. [] Manually submitted co	st report							
	3. [0 4. [F] If this is an amended] Medicare Utilization.	report enter the number o Enter "F" for full or "L"	of times the profor low.	ovi der re	esubmitted	l this co	ost repor	t	
Contractor use only	(1) (2) (3)]Cost Report Status As Submitted Settled without Audit Settled with Audit Reopened		this Provider his Provider C	11. C CCN 12. [ne 5, cc			

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 01/01/2014 and ending 12/31/2014 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)				
	Offi cer	or	Admi ni strator	of Provider(s)
Title				
Date				

			Ti tle XVIII				
	Cost Center Description	Title V	Part A	Part B	HIT	Title XIX	
		1. 00	2.00	3. 00	4. 00	5. 00	
	PART III - SETTLEMENT SUMMARY						
1.00	Hospi tal	0	13, 737	28, 078	-35, 833	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
200.00	Total	0	13, 737	28, 078	-35, 833	0	200. 00

The above amounts represent "due to" or "due from" the applicable program for the element of the above complex indicated. According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The 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 01/01/2014 Part I Date/Time Prepared: 12/31/2014 5/22/2015 11:28 am 3.00 4.00 Hospital and Hospital Health Care Complex Address: Street: 2001 STULTS ROAD 1.00 PO Box: 1.00 State: IN 2.00 City: HUNTINGTON 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: 2.00 1.00 20.00 Cost Reporting Period (mm/dd/yyyy) 01/01/2014 12/31/2014 20.00 21.00 Type of Control (see instructions) 21.00 Inpatient PPS Information Does this facility qualify and is it currently receiving payments for disproportionate 22.00 N 22.00 Υ 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 §412.06(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 N 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 95 24.00 If this provider is an IPPS hospital, enter the 331 904 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.

0.00

0.00

61.06

61.06 Enter the amount of ACA §5503 award that is being

used for cap relief and/or FTEs that are nonprimary care or general surgery. (see instructions)

trained residents in the base year period, the program name associated with primary care FTEs for each primary care program in which you trained residents. Enter in column 2, the program code, enter in column 3, the number of unweighted primary care FTE residents attributable to rotations occurring in all non-provider settings. Enter in column 4, the number of unweighted primary care resident FTEs that trained in your hospital. Enter in column 5, the ratio of (column 3 divided by (column 3 + column 4)). (see instructions)

Health Financial Systems HUNTINGTON MEMORIAL HOSPITAL In Lieu of Form CMS-2552-10 HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA Provider CCN: 150091 Peri od: Worksheet S-2 From 01/01/2014 Part I Date/Time Prepared: 12/31/2014 5/22/2015 11: 28 am Unwei ghted Unwei ghted Ratio (col. (col. 1 + col FTEs FTEs in Nonprovi der Hospi tal 2)) Si te 1.00 2.00 3.00 Section 5504 of the ACA Current Year FTE Residents in Nonprovider Settings--Effective for cost reporting periods beginning on or after July 1, 2010 0. 00 66.00 Enter in column 1 the number of unweighted non-primary care resident 0.00 0.000000 66.00 FTEs attributable to rotations occurring in all nonprovider settings. Enter in column 2 the number of unweighted non-primary care resident FTEs that trained in your hospital. Enter in column 3 the ratio of (column 1 divided by (column 1 + column 2)). (see instructions) Program Name Program Code Unwei ghted Unwei ghted Ratio (col. 3/ FTEs FTEs in (col. 3 + col Nonprovi der Hospi tal 4)) Si te 1.00 2 00 3. 00 4. 00 5 00 67.00 Enter in column 1, the program 0. 00 0.00 0.000000 67.00 name associated with each of your primary care programs in which you trained residents. Enter in column 2, the program code. Enter in column 3, the number of unweighted primary care FTE residents attributable to rotations occurring in all non-provider settings. Enter in column 4, the number of unweighted primary care resident FTEs that trained in your hospital. Enter in column 5, the ratio of (column 3 divided by (column 3 + column 4)) (see instructions) 1.00 2.00 3.00 Inpatient Psychiatric Facility PPS 70.00 Is this facility an Inpatient Psychiatric Facility (IPF), or does it contain an IPF subprovider? N 70.00 Enter "Y" for yes or "N" for no. If line 70 yes: Column 1: Did the facility have an approved GME teaching program in the most 71.00 0 71.00 recent cost report filed on or before November 15, 2004? Enter "Y" for yes or "N" for no. (see 42 CFR 412.424(d)(1)(iii)(c)) Column 2: Did this facility train residents in a new teaching program in accordance with 42 CFR 412.424 (d)(1)(iii)(D)? Enter "Y" for yes or "N" for no. Column 3: If column 2 is Y, enter 1, 2, or 3, in column 3. (see instructions) If this cost reporting period covers the beginning of the fourth year, enter 4 in column 3, or if the fifth or subsequent academic years of the new teaching program in existence, enter 5. (see instructions) For cost reporting periods beginning on or after October 1, 2012, if this cost reporting period covers the beginning of the sixth or any subsequent academic year of the new teaching program in existence, enter 6 in column 3. (see instructions) Inpatient Rehabilitation Facility PPS 75.00 Is this facility an Inpatient Rehabilitation Facility (IRF), or does it contain an IRF Ν 75.00 subprovider? Enter "Y" for yes and "N" for no. If line 75 yes: Column 1: Did the facility have an approved GME teaching program in the most 0 76.00 recent cost reporting period ending on or before November 15, 2004? Enter "Y" for yes or "N" for no. Column 2: Did this facility train residents in a new teaching program in accordance with 42 CFR 412.424 (d)(1)(iii)(D)? Enter "Y" for yes or "N" for no. Column 3: If column 2 is Y, enter 1, 2, or 3, in column 3. (see instructions) If this cost reporting period covers the beginning of the fourth year, enter 4 in column 3, or if the fifth or subsequent academic years of the new teaching program in existence, enter 5. (see instructions) For cost reporting periods beginning on or after October 1, 2012, if this cost reporting period covers the beginning of the sixth or any subsequent academic year of the new teaching program in existence, enter 6 in column 3. (see instructions) 1.00 Long Term Care Hospital PPS 80.00 Is this a long term care hospital (LTCH)? Enter "Y" for yes and "N" for no. 80.00 N 81.00 | Is this a LTCH co-located within another hospital for part or all of the cost reporting period? Enter N 81.00 Y" for yes and "N" for no. TEFRA Providers 85.00 Is this a new hospital under 42 CFR Section §413.40(f)(1)(i) TEFRA? Enter "Y" for yes or "N" for no. 86.00 Did this facility establish a new Other subprovider (excluded unit) under 42 CFR Section N 85.00 86.00 §413.40(f)(1)(ii)? Enter "Y" for yes and "N" for no.

Health Financial Systems HUNTINGTON MEMO HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA			In Li Period: From 01/01/201 To 12/31/201		-2 repared:	
Title V and XIX Services			1.00	2.00		
90.00 Does this facility have title V and/or XIX inpatient hospitally yes or "N" for no in the applicable column. 91.00 Is this hospital reimbursed for title V and/or XIX through			N N	Y	90.00	
full or in part? Enter "Y" for yes or "N" for no in the app	licable column.					
92.00 Are title XIX NF patients occupying title XVIII SNF beds (di instructions) Enter "Y" for yes or "N" for no in the applications		on)? (see		N	92. 00	
93.00 Does this facility operate an ICF/MR facility for purposes ("Y" for yes or "N" for no in the applicable column.	of title V and	XIX? Enter	N	N	93. 00	
94.00 Does title V or XIX reduce capital cost? Enter "Y" for yes, applicable column.	and "N" for no	o in the	N	N	94. 00	
95.00 Filine 94 is "Y", enter the reduction percentage in the app 96.00 Does title V or XIX reduce operating cost? Enter "Y" for year			O. 0	00 O. 0	95. 00 96. 00	
applicable column. 97.00 If line 96 is "Y", enter the reduction percentage in the applicable applicable column.	plicable column	٦.	0. (00 0. 0	97. 00	
Rural Providers 105.00 Does this hospital qualify as a Critical Access Hospital (CA	AH)?		N		105. 00	
106.00 of this facility qualifies as a CAH, has it elected the all for outpatient services? (see instructions)	-inclusive meth	nod of payment			106. 00	
107.00 Column 1: If this facility qualifies as a CAH, is it eligil for I &R training programs? Enter "Y" for yes or "N" for no instructions) If yes, the GME elimination would not be on WI the program would be cost reimbursed. If yes complete Wkst. this facility is a CAH, do I&Rs in an approved medical educations can be considered as a complete with the constructions. 108.00 Is this a rural hospital qualifying for an exception to the	o in column 1. kst. B, Pt. I, D-2, Pt. II. (ation program † "N" for no in ((see col. 25 and Column 2: If train in the column 2. (see	e N		107. 00	
CFR Section §412.113(c). Enter "Y" for yes or "N" for no.				Dooni rotory		
	Physi cal 1.00	Occupati onal 2.00	Speech 3.00	Respi ratory 4.00		
109.00 If this hospital qualifies as a CAH or a cost provider, are therapy services provided by outside supplier? Enter "Y" for yes or "N" for no for each therapy.	N				109. 00	
				1.00		
110.00 Did this hospital participate in the Rural Community Hospitathe current cost reporting period? Enter "Y" for yes or "N"		on project (41	IOA Demo)for	N	110. 00	
			1.	00 2.00 3.00)	
Miscellaneous Cost Reporting Information 115.00 Is this an all-inclusive rate provider? Enter "Y" for yes on is yes, enter the method used (A, B, or E only) in column 2 a either "93" percent for short term hospital or "98" percent psychiatric, rehabilitation and long term hospitals provided Pub. 15-1, §2208.1. 116.00 Is this facility classified as a referral center? Enter "Y" 117.00 Is this facility legally-required to carry malpractice insur	. If column 2 int for long tents, based on the for yes or "N"	s "E", enter rm care (inclu ne definition ' for no.	in column udes in CMS	N O	115. 00 116. 00 117. 00	
no. 118.00 s the malpractice insurance a claims-made or occurrence pol	licy? Enter 1 i	f the policy	is	1	118. 00	
claim-made. Enter 2 if the policy is occurrence.		Premi ums	Losses	Insurance		
440.04		1.00	2.00	3.00	10110 01	
118.01 List amounts of malpractice premiums and paid losses:		46, 68	36	0 20, 7	10 118. 01	
118.02 Are malpractice premiums and paid losses reported in a cost	center other	than the	1. 00 N	2.00	118. 02	
Administrative and General? If yes, submit supporting scher and amounts contained therein. 119.00 DO NOT USE THIS LINE					119. 00	
§3121 and applicable amendments? (see instructions) Enter in "N" for no. Is this a rural hospital with < 100 beds that qu	120.00 Is this a SCH or EACH that qualifies for the Outpatient Hold Harmless provision in ACA §3121 and applicable amendments? (see instructions) Enter in column 1, "Y" for yes or "N" for no. Is this a rural hospital with < 100 beds that qualifies for the Outpatient Hold Harmless provision in ACA §3121 and applicable amendments? (see instructions)					
121.00 Did this facility incur and report costs for high cost implements? Enter "Y" for yes or "N" for no. Transplant Center Information	antable devices	s charged to	Y		121. 00	
125.00 Does this facility operate a transplant center? Enter "Y" for	or yes and "N"	for no. If	N		125. 00	
yes, enter certification date(s) (mm/dd/yyyy) below. 126.00 f this is a Medicare certified kidney transplant center, en	nter the certii	fication date			126. 00	
in column 1 and termination date, if applicable, in column 1 127.00 f this is a Medicare certified heart transplant center, en	2.				127. 00	
in column 1 and termination date, if applicable, in column 3						

Health Financial Systems	HUNTI NGTON MEM	ORIAL HOSPITAL			In Lie	u of Form CMS	-2552-10
HOSPITAL AND HOSPITAL HEALTH CARE COMPLE	X IDENTIFICATION DATA	Provi der (CCN: 15009		1/01/2014	Worksheet S- Part I	2
					2/31/2014	Date/Time Pr	
						5/22/2015 11	: 28 am
100 001 0 111 1 11 11 11 11 11					1. 00	2.00	100.00
128.00 If this is a Medicare certified li in column 1 and termination date,			cation da	ite			128. 00
129.00 If this is a Medicare certified Lu	ng transplant center, en		ation dat	e in			129. 00
column 1 and termination date, if 130.00 of this is a Medicare certified pa		, enter the cert	ification	1			130. 00
date in column 1 and termination of 131.00 lf this is a Medicare certified in			rti fi cati	on			131. 00
date in column 1 and termination o	ate, if applicable, in c	olumn 2.					
132.00 If this is a Medicare certified is in column 1 and termination date,			cation da	ite			132. 00
133.00 If this is a Medicare certified of	her transplant center, e	nter the certifi	cation da	ite			133. 00
in column 1 and termination date, 134.00 If this is an organ procurement or			n column	1			134. 00
and termination date, if applicabl				<u> </u>			
All Providers 140.00 Are there any related organization	or home office costs as	defined in CMS	Pub 15-1		Υ	15H032	140. 00
chapter 10? Enter "Y" for yes or "	N" for no in column 1. I	f yes, and home	office co				1.10.00
are claimed, enter in column 2 the		<u>r. (see instruct</u> 00	i ons)		3. 00		
If this facility is part of a chai	n organization, enter on	lines 141 throu		ne name and		of the	
home office and enter the home off 141.00 Name: PARKVIEW HEALTH SYSTEM, INC				actor's Nu	mhar: 0810)1	141. 00
	S	ERVI CE	ANSICOTET	actor 3 Na	iliber. oore	, ,	
142.00 Street: 10501 CORPORATE DRIVE 143.00 City: FORT WAYNE		6600 N	Zip C	ode.	4689	95-5600	142. 00 143. 00
Tio. color ty.	otate. 1	11	Z, p 0	ouc.	1007		110.00
144.00 Are provider based physicians' cos	ts included in Workshoot	Λ2				1. 00 Y	144. 00
145.00 If costs for renal services are cl			osts for	i npati ent	servi ces	N N	145. 00
only? Enter "Y" for yes or "N" for	no.						
					1. 00	2.00	
146.00 Has the cost allocation methodolog Enter "Y" for yes or "N" for no ir				tor	N		146. 00
the approval date (mm/dd/yyyy) in		15-2, 9 4020) 1	i yes, ei	itei			
147.00 Was there a change in the statisti 148.00 Was there a change in the order of					N N		147. 00 148. 00
149.00 Was there a change to the simplifi				for	N		149. 00
no.		Part A	Part	D T	itle V	Title XIX	
		1.00	2. 00		3.00	4.00	
Does this facility contain a provi							
or charges? Enter "Y" for yes or '	N FOR NO FOR Each compo	N N	and Part N	B. (See 42	N 9413	N N	155. 00
156.00 Subprovi der - IPF		N N	N		N	N	156. 00
157.00 Subprovi der - I RF 158.00 SUBPROVI DER		N	N		N	N	157. 00 158. 00
159. 00 SNF		N	N		N	N	159. 00
160.00 HOME HEALTH AGENCY 161.00 CMHC		N	N N		N N	N N	160. 00 161. 00
TOT. OOJCIWITE			IN		IV	14	101.00
Multicampus						1. 00	
Multicampus 165.00 s this hospital part of a Multica	mpus hospital that has o	ne or more campu	ses in di	fferent CB	SAs?	N	165. 00
Enter "Y" for yes or "N" for no.	Nome	County	Ctata	7: n Codo	CDCA	FTF /Compute	
	Name O	County 1.00	State 2.00	Zi p Code 3.00	4. 00	FTE/Campus 5.00	-
166.00 If line 165 is yes, for each						0.0	00 166. 00
campus enter the name in column O, county in column 1, state in							
column 2, zip code in column 3,							
CBSA in column 4, FTE/Campus in column 5 (see instructions)							
1001 41111 0 (000 111011 4011 0110)	,				1		
Health Information Technology (HI) incentive in the Ameri	can Recovery and	l Reinvest	ment Act		1. 00	
167.00 Is this provider a meaningful user	under Section §1886(n)?	Enter "Y" for	yes or "N	l" for no.		Y	167. 00
168.00 If this provider is a CAH (line 10 reasonable cost incurred for the H			167 is "	Y"), enter	the		0168. 00
169.00 If this provider is a meaningful ι	ser (line 167 is "Y") and		line 105	is "N"), e	nter the	0. 5	50169.00
transition factor. (see instruction	ns)						1

HUNTINGTON MEMORIAL	HOSPI TAL	In Lie	u of Form CMS-	2552-10	
TIFICATION DATA	Provi der CCN: 150091				
		10 12/31/2014			
			t'	28 am	
		Begi nni ng	Endi ng		
		1. 00	2.00		
170.00 Enter in columns 1 and 2 the EHR beginning date and ending date for the reporting period respectively (mm/dd/yyyy)				170. 00	
			1.00		
171.00 If line 167 is "Y", does this provider have any days for individuals enrolled in section 1876 Medicare cost plans reported on Wkst. S-3, Pt. I, line 2, col. 6? Enter "Y" for yes and "N" for no. (see instructions)					
	ng date and ending date	ng date and ending date for the reporting ave any days for individuals enrolled in secti	Provider CCN: 150091 Period: From 01/01/2014 To 12/31/2014 Beginning 1.00 ng date and ending date for the reporting 10/01/2013 ave any days for individuals enrolled in section 1876	Provider CCN: 150091	

		HUNTINGTON MEMORIAL HOSPITAL			eu of Form CMS-	
HOSPI T	AL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUE	STI ONNAI RE Provi der	F	eriod: rom 01/01/2014 o 12/31/2014	Date/Time Pre	pared:
				Y/N	5/22/2015 11: Date	Zo alli
	General Instruction: Enter Y for all YES resp	nences Enter N for all NO re	onences Enter	1.00	2. 00	
	mm/dd/yyyy format.	oonses. Enter N for all NO re	esponses. Enter	all dates in	tne	
	COMPLETED BY ALL HOSPITALS Provider Organization and Operation					
1. 00	Has the provider changed ownership immediatel	ly prior to the beginning of	the cost	N		1.00
	reporting period? If yes, enter the date of		instructions)	D-+-	\/ /I	
			Y/N 1.00	Date 2.00	V/I 3. 00	
2. 00	Has the provider terminated participation in		N			2. 00
	yes, enter in column 2 the date of termination voluntary or "I" for involuntary.	on and in column 3, v for				
3.00	Is the provider involved in business transaction contracts, with individuals or entities (e.g. or medical supply companies) that are related officers, medical staff, management personnel of directors through ownership, control, or the relationships? (see instructions)	., chain home offices, drug d to the provider or its I, or members of the board	N			3. 00
			Y/N	Туре	Date	
	Financial Data and Reports		1. 00	2. 00	3. 00	
4.00	Column 1: Were the financial statements prey Accountant? Column 2: If yes, enter "A" for or "R" for Reviewed. Submit complete copy or column 3. (see instructions) If no, see instru	Audited, "C" for Compiled, enter date available in	Y	А	04/24/2013	4. 00
5.00	Are the cost report total expenses and total	revenues different from	N			5. 00
	those on the filed financial statements? If	yes, submit reconciliation.		Y/N	Legal Oper.	
				1. 00	2. 00	
6. 00	Approved Educational Activities Column 1: Are costs claimed for nursing scho	nol?Column 2: If wes is th	ne provider is	N		6. 00
	the legal operator of the program?		ie provider 13			
7. 00 8. 00	Are costs claimed for Allied Health Programs' Were nursing school and/or allied health programs'		during the	N N		7. 00 8. 00
	cost reporting period? If yes, see instruction	ons.	Ü			
9. 00	Are costs claimed for Intern-Resident program yes, see instructions.	ms claimed on the current cos	st report? If	N		9. 00
10.00	Was an Intern-Resident program been initiated	d or renewed in the current c	cost reporting	N		10.00
11. 00	period? If yes, see instructions. Are GME cost directly assigned to cost center	rs other than I & R in an App	proved	N		11. 00
	Teaching Program on Worksheet A? If yes, see				V (A)	
					Y/N 1.00	
12.00	Bad Debts	d debt-2 16				10.00
	Is the provider seeking reimbursement for bad If line 12 is yes, did the provider's bad del			t reporting	Y N	12. 00 13. 00
14. 00	period? If yes, submit copy. If line 12 is yes, were patient deductibles a Bed Complement	and/or co-payments waived? If	yes, see inst	ructi ons.	N	14. 00
15. 00	Did total beds available change from the price	or cost reporting period? If	yes, see instr	uctions.	N	15. 00
		Description	Par Y/N	t A Date	Part B Y/N	
		Description 0	1.00	2. 00	3. 00	
14 00	PS&R Data Was the cost report prepared using the PS&R		N		l N	16. 00
16. 00	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		IN IN	16.00
17. 00	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 in columns		Y	04/30/2013	Y	17. 00
18. 00	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		Y		Y	18. 00
19. 00	included on the PS&R Report used to file this cost report? If yes, see instructions. If line 16 or 17 is yes, were adjustments made to PS&R Report data for corrections of other PS&R Report information? If yes, see		N		N	19. 00
20. 00	instructions. 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

						5/22/2015 11:	: 28 am
				Pai	rt A	Part B	
		Descr	i pti on	Y/N	Date	Y/N	
			0	1. 00	2. 00	3. 00	
21.00	Was the cost report prepared only using the			N		N	21. 00
	provider's records? If yes, see						
	i nstructi ons.						
						1. 00	
	COMPLETED BY COST REIMBURSED AND TEFRA HOSPIT	TALS ONLY (EXCE	PT CHILDRENS H	OSPI TALS)			
	Capital Related Cost						
22. 00	Have assets been relifed for Medicare purpose	es? If ves. see	e instructions				22.00
23. 00	Have changes occurred in the Medicare depreci			als made durin	na the cost		23. 00
20.00	reporting period? If yes, see instructions.	ration expense	ade to apprais	ars made adrir	ig the cost		20.00
24. 00	Were new leases and/or amendments to existing	n Leases entere	ed into durina	this cost rend	orting period?		24. 00
21.00	If yes, see instructions	g reases enterv	sa riito dairiig	tin a coat repo	or tring period.		2 1. 00
25. 00	Have there been new capitalized leases entere	od into durina	the cost repor	ting ported2 I	f voc coo		25. 00
25.00	instructions.	ed Titto dulling	the cost repor	ting perrous i	i yes, see		25.00
26. 00	Were assets subject to Sec. 2314 of DEFRA acqu	uirod during +	an cost roporti	na noriod2 lf	V06 600		26. 00
20.00		urred durring ti	ie cost reporti	ng perrou? II	yes, see		20.00
27 00	instructions.						27.00
27. 00	Has the provider's capitalization policy char	ngea auring the	e cost reportin	ig period? if y	yes, submit		27. 00
	copy.						
	Interest Expense						
28. 00	Were new Loans, mortgage agreements or Letter	rs of credit er	ntered into dur	ing the cost r	reporting		28. 00
	period? If yes, see instructions.						
29. 00	Did the provider have a funded depreciation a			bt Service Res	serve Fund)		29. 00
	treated as a funded depreciation account? If						
30.00	Has existing debt been replaced prior to its	scheduled matu	urity with new	debt? If yes,	see		30.00
	i nstructi ons.						
31.00	Has debt been recalled before scheduled matur	rity without is	ssuance of new	debt? If yes,	see		31.00
	i nstructi ons.						
	Purchased Services						
32.00	Have changes or new agreements occurred in pa	atient care sei	rvices furnishe	d through conf	tractual		32.00
	arrangements with suppliers of services? If	yes, see instru	uctions.				
33.00	If line 32 is yes, were the requirements of	Sec. 2135.2 app	olied pertainin	g to competiti	ve bidding? If		33.00
	no, see instructions.		·		Ü		
	Provi der-Based Physi ci ans						
34.00	Are services furnished at the provider facili	itv under an a	rangement with	provi der-base	ed physicians?		34.00
	If yes, see instructions.			p			
35.00	If line 34 is yes, were there new agreements	or amended exi	sting agreemen	its with the ni	rovi der-based		35. 00
	physicians during the cost reporting period?						
	phrysreruns during the cost reporting perrou.	11 yes, see 11	istructions.		Y/N	Date	
					1, 00	2.00	
	Home Office Costs				1.00	2.00	
36. 00	Were home office costs claimed on the cost re	enort2			Y		36.00
			congrad by the	homo offico?	Y		37.00
37. 00	If line 36 is yes, has a home office cost sta	arement been bi	epared by the	nome office?	Y		37.00
00.00	If yes, see instructions.	6 11 1 6	c. 1. cc 1	6 11 1 6			00.00
38. 00	If line 36 is yes , was the fiscal year end o				N		38.00
	the provider? If yes, enter in column 2 the						
39. 00	If line 36 is yes, did the provider render se	ervices to othe	er chain compon	ients? If yes,	N		39.00
	see instructions.						
40. 00	If line 36 is yes, did the provider render so	ervices to the	home office?	lf yes, see	N		40.00
	i nstructi ons.						
			1.	00	2.	. 00	
	Cost Report Preparer Contact Information						_
41.00	Enter the first name, last name and the title	e/position	ERI C		NI CKESON		41.00
	held by the cost report preparer in columns	1, 2, and 3,					
	respecti vel y.						
42.00	Enter the employer/company name of the cost i	report	PARKVIEW HEALT	H SYSTEM, INC.			42.00
	preparer.		[1
43.00	Enter the telephone number and email address	of the cost	(260) 373-8406		ERI C. NI CKESON@	PARKVI EW. COM	43.00
			1 '		1		11

report preparer in columns 1 and 2, respectively.

				To 12/31/2014	Date/Time Prepared: 5/22/2015 11:28 am
		Part B			0, 22, 2010 111 Eg diii
		Date			
		4. 00			
	PS&R Data				
16. 00	Was the cost report prepared using the PS&R				16. 00
	Report only? If either column 1 or 3 is yes,				
	enter the paid-through date of the PS&R				
	Report used in columns 2 and 4 (see				
	instructions)				
17. 00		04/30/2013			17. 00
	Report for totals and the provider's records				
	for allocation? If either column 1 or 3 is yes, enter the paid-through date in columns				
	2 and 4. (see instructions)				
18. 00	1 '				18. 00
10.00	made to PS&R Report data for additional				10.00
	claims that have been billed but are not				
	included on the PS&R Report used to file				
	this cost report? If yes, see instructions.				
19.00	If line 16 or 17 is yes, were adjustments				19. 00
	made to PS&R Report data for corrections of				
	other PS&R Report information? If yes, see				
	instructions.				
20. 00					20. 00
	made to PS&R Report data for Other? Describe				
21 00	the other adjustments:				21.00
21. 00	Was the cost report prepared only using the provider's records? If yes, see				21. 00
	instructions.				
	THIS CLUCK TONIS.		_		
			3.00		
	Cost Report Preparer Contact Information				
41.00	Enter the first name, last name and the title	e/position	DIRECTOR, REIMBURSEMENT		41. 00
	held by the cost report preparer in columns 1	, 2, and 3,			
	respecti vel y.				
42. 00	Enter the employer/company name of the cost r	eport			42. 00
40.0-	preparer.	6.11			
43. 00					43. 00
	report preparer in columns 1 and 2, respective	reiy.	l		l

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

						Fo 12/31/2014	Date/Time Pre 5/22/2015 11:	
							I/P Days / 0/P	
							Visits / Trips	
	Component	Worksheet A Line Number	No. o	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				1. 00
	8 exclude Swing Bed, Observation Bed and				·			
	Hospice days) (see instructions for col. 2							
2. 00	for the portion of LDP room available beds) HMO and other (see instructions)							2.00
3. 00	HMO IPF Subprovider							3.00
4. 00	HMO IRF Subprovider							4. 00
5.00	Hospital Adults & Peds. Swing Bed SNF						0	5. 00
6.00	Hospital Adults & Peds. Swing Bed NF						0	6. 00
7. 00	Total Adults and Peds. (exclude observation			36	13, 140	0.00	0	7. 00
8. 00	beds) (see instructions) 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	13. 00
14.00	Total (see instructions)			36	13, 140	0.00	l	14.00
15. 00 16. 00	CAH visits SUBPROVIDER - IPF						0	15. 00 16. 00
17. 00	SUBPROVIDER - 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 24. 00	AMBULATORY SURGICAL CENTER (D. P.) HOSPICE							23. 00 24. 00
24. 10	HOSPICE (non-distinct part)	30. 00						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)			36				27. 00
28. 00 29. 00	Observation Bed Days Ambulance Trips						0	28. 00 29. 00
30.00	Employee discount days (see instruction)							30.00
31. 00	Employee discount days - IRF							31. 00
32.00	Labor & delivery days (see instructions)			0				32.00
32. 01	Total ancillary labor & delivery room							32. 01
00.00	outpatient days (see instructions)							00.00
33.00	LTCH non-covered days				l		l	33. 00

Provider CCN: 150091

| Peri od: | Worksheet S-3 | From 01/01/2014 | Part I | To 12/31/2014 | Date/Time Prepared: | 5/22/2015 11: 28 am

						5/22/2015 11:	28 am_
		I/P Days	/ O/P Visits	/ Trips	Full Time E	Equi val ents	
	Component	Title XVIII	Title XIX	Total All Patients	Total Interns & Residents	Employees On Payroll	
		6. 00	7. 00	8. 00	9. 00	10.00	
1. 00	Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days) (see instructions for col. 2 for the portion of LDP room available beds)	1, 770	265	5, 307			1. 00
2.00	HMO and other (see instructions)	1, 487	1, 004				2. 00
3.00	HMO IPF Subprovider	o	0				3. 00
4.00	HMO IRF Subprovider	ol	0				4.00
5.00	Hospital Adults & Peds. Swing Bed SNF	o	0	Ö)		5. 00
6.00	Hospital Adults & Peds. Swing Bed NF		0	C)		6.00
7. 00	Total Adults and Peds. (exclude observation beds) (see instructions)	1, 770	265	5, 307	,		7. 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	SURGI CAL INTENSI VE CARE UNI T						11. 00
12. 00	OTHER SPECIAL CARE (SPECIFY)						12. 00
13. 00	NURSERY		66	710			13. 00
14. 00	Total (see instructions)	1, 770	331	6, 017	0.00	207. 00	
15. 00	CAH visits	0	0	C)		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)	0	0	C			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	207.00	
28. 00	Observation Bed Days		214	1, 164			28. 00
29. 00	Ambul ance Trips	1, 191					29. 00
30.00	Employee discount days (see instruction)			55			30. 00
31.00	Employee discount days - IRF			C)		31.00
32.00	Labor & delivery days (see instructions)	o	49	73			32. 00
32. 01	Total ancillary labor & delivery room			C			32. 01
	outpatient days (see instructions)						
33. 00	LTCH non-covered days	O					33. 00

| Peri od: | Worksheet S-3 | From 01/01/2014 | Part | To 12/31/2014 | Date/Time Prepared: Provi der CCN: 150091

					To	12/31/2014	Date/Time Prep 5/22/2015 11:2	
		Full Time Equivalents	<u>'</u>		Di sch	arges		
	Component	Nonpai d	Title V		Title XVIII	Title XIX	Total All	
		Workers 11.00	12.00	-	12.00	14.00	Pati ents 15.00	
1. 00	Hospital Adults & Peds. (columns 5, 6, 7 and	11.00	12. 00	0	13. 00 518	14. 00	15.00	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, 737	
2. 00 3. 00	HMO and other (see instructions) HMO IPF Subprovider			- 1	409	0		2. 00 3. 00
4. 00	HMO IRF Subprovider			- 1				4. 00
5.00	Hospital Adults & Peds. Swing Bed SNF			1				5. 00
6. 00	Hospital Adults & Peds. Swing Bed NF			ı				6. 00
7. 00	Total Adults and Peds. (exclude observation beds) (see instructions)							7. 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				540	450	4 700	13.00
14.00	Total (see instructions)	0. 00		0	518	459	1, 739	14.00
15. 00	CAH visits			ŀ				15. 00
16.00	SUBPROVIDER - IPF			- 1				16.00
17. 00 18. 00	SUBPROVI DER			ł				17. 00 18. 00
19. 00	SKILLED NURSING FACILITY			1				19. 00
20. 00	NURSING FACILITY			ł				20. 00
21. 00	OTHER LONG TERM CARE			ı				21. 00
22. 00	HOME HEALTH AGENCY			ı				22. 00
23. 00	AMBULATORY SURGICAL CENTER (D. P.)			ı				23. 00
24. 00	HOSPI CE			1				24.00
24. 10	HOSPICE (non-distinct part)			- 1				24. 10
25.00	CMHC - CMHC							25.00
26. 00	RURAL HEALTH CLINIC							26.00
26. 25	FEDERALLY QUALIFIED HEALTH CENTER							26. 25
	Total (sum of lines 14-26)	0. 00						27. 00
28. 00	Observation Bed Days							28. 00
29. 00								29. 00
30.00	Employee discount days (see instruction)							30.00
31.00	, , ,			ŀ				31. 00
32.00	Labor & delivery days (see instructions) Total ancillary labor & delivery room			-				32. 00 32. 01
32. 01	outpatient days (see instructions)							32. UT
33. 00	LTCH non-covered days							33. 00
		•			'	'	'	

| Peri od: | Worksheet S-3 | From 01/01/2014 | Part II | To 12/31/2014 | Date/Time Prepared: | To 12/31/2014 Provider CCN: 150091

					To	12/31/2014	Date/Time Pre 5/22/2015 11:	
		Worksheet A	Amount	Reclassi fi cati	Adj usted	Paid 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	COI . 3)	
		1.00	2. 00	3.00	4. 00	5. 00	6. 00	
	PART II - WAGE DATA SALARIES							1
1.00	Total salaries (see	200. 00	12, 822, 486	3, 381, 565	16, 204, 051	600, 512. 00	26. 98	1.00
2 00	instructions)		0			0.00	0.00	2 00
2. 00	Non-physician anesthetist Part		U	0	U	0. 00	0.00	2. 00
3.00	Non-physician anesthetist Part		0	0	0	0.00	0.00	3. 00
4. 00	B Physician-Part A -		38, 230	0	38, 230	143. 00	267. 34	4.00
1. 00	Admi ni strati ve		30, 200		30, 200	110.00	207.01	1.00
4. 01	Physicians - Part A - Teaching		0		0	0. 00 0. 00		
5. 00 6. 00	Physician-Part B Non-physician-Part B		0	_	0	0.00		
7. 00	Interns & residents (in an	21. 00	0	0	0	0.00	l .	
7. 01	approved program) Contracted interns and		0	0		0. 00	0.00	7. 01
7.01	resi dents (in an approved		O			0.00	0.00	7.01
8. 00	programs) Home office personnel		4 200 042		4 200 042	125, 155. 00	24.25	8. 00
9. 00	SNF	44. 00	4, 298, 863 0	0	4, 298, 863 0	0.00		
10.00	Excluded area salaries (see		1, 423, 220	244, 943	1, 668, 163	72, 827. 00	22. 91	10.00
	instructions) OTHER WAGES & RELATED COSTS							1
11. 00	Contract labor: Direct Patient		0	0	0	0.00	0.00	11. 00
12.00	Care		0			0.00	0.00	12. 00
12. 00	Contract labor: Top level management and other		U			0.00	0.00	12.00
	management and administrative							
13. 00	services Contract Labor: Physician-Part		0	0	0	0.00	0.00	13. 00
10.00	A - Administrative		_					10.00
14. 00	Home office salaries & wage-related costs		4, 298, 863	0	4, 298, 863	125, 155. 00	34. 35	14. 00
15. 00	Home office: Physician Part A		0	О	0	0.00	0.00	15. 00
47.00	- Administrative					0.00		4, 00
16. 00	Home office and Contract Physicians Part A - Teaching		0	0	0	0.00	0. 00	16. 00
	WAGE-RELATED COSTS			ı			ı	1
17. 00	Wage-related costs (core) (see instructions)		4, 436, 175	0	4, 436, 175			17. 00
18. 00	Wage-related costs (other)		0	0	0			18. 00
19. 00	(see instructions) Excluded areas		661, 011		661, 011			19. 00
20.00	Non-physician anesthetist Part		001, 011	0	001,011			20.00
04.00	A							04.00
21. 00	Non-physician anesthetist Part B		U	0	0			21. 00
22. 00	Physician Part A -		38, 230	0	38, 230			22. 00
22. 01	Administrative Physician Part A - Teaching		0	0	0			22. 01
23. 00	Physician Part B		0	Ö	0			23. 00
24. 00	Wage-related costs (RHC/FQHC)		0	_	0			24. 00
25. 00	Interns & residents (in an approved program)		U					25. 00
0/ 00	OVERHEAD COSTS - DIRECT SALARIE		4 07/ 044	4 07/ 044		0.00		
26. 00 27. 00	Employee Benefits Department Administrative & General	4. 00 5. 00	1, 276, 241 1, 812, 534			0. 00 171, 198. 00		
28. 00	Administrative & General under	0.00	0,012,001	0, 112, 332	0, 223, 333	0.00		•
20.00	contract (see inst.)	(00	0			0.00	0.00	20.00
29. 00 30. 00	Maintenance & Repairs Operation of Plant	6. 00 7. 00	282, 165	37, 833	319, 998	0. 00 12, 382. 00		
31.00	Laundry & Linen Service	8. 00	0	29, 279	29, 279	2, 783. 00	10. 52	31.00
32. 00 33. 00	Housekeeping under contract	9. 00	282, 764	8, 634	291, 398	25, 056. 00 0. 00	l .	•
33.00	(see instructions)		O			0.00	0.00	33.00
34.00	Di etary	10. 00	366, 206	-288, 902	77, 304	6, 630. 00		
35. 00	Di etary under contract (see instructions)		0	0	0	0.00	0. 00	35. 00
36. 00	Cafeteri a	11. 00	0	224, 041	224, 041	14, 019. 00		
37. 00 38. 00	Maintenance of Personnel Nursing Administration	12. 00 13. 00	0 159, 031	0 21, 323	0 180, 354	0. 00 5, 487. 00		
39.00	Central Services and Supply	14. 00	139, 031	21, 323	160, 354	5, 487. 00 0. 00		
40. 00	Pharmacy	15. 00	508, 534	О .	508, 534	10, 758. 00		40. 00

Health Financial Systems	Н	IUNTI NGTON MEM	ORIAL HOSPITAL		In Li€	eu of Form CMS-2	2552-10
HOSPITAL WAGE INDEX INFORMATION			Provi der		Peri od:	Worksheet S-3	
					From 01/01/2014		
					To 12/31/2014	Date/Time Pre 5/22/2015 11:	
	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.	Salaries 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 Records Library	16. 00	(0		0.00	0. 00	41. 00
42.00 Social Service	17. 00	(0		0.00	0.00	42.00
43.00 Other General Service	18. 00	(0		0.00	0.00	43. 00

					''	0 12/31/2014	5/22/2015 11: 2	
		Worksheet A	Amount	Reclassi 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.	Salaries in	col . 5)	
				Worksheet A-6)	3)	col. 4		
		1. 00	2.00	3. 00	4. 00	5. 00	6.00	
	PART III - HOSPITAL WAGE INDEX	SUMMARY						
1.00	Net salaries (see		8, 523, 623	3, 381, 565	11, 905, 188	475, 357. 00	25. 04	1.00
	instructions)							
2.00	Excluded area salaries (see		1, 423, 220	244, 943	1, 668, 163	72, 827. 00	22. 91	2. 00
	instructions)							
3.00	Subtotal salaries (line 1		7, 100, 403	3, 136, 622	10, 237, 025	402, 530. 00	25. 43	3.00
	minus line 2)							
4.00	Subtotal other wages & related		4, 298, 863	0	4, 298, 863	125, 155. 00	34. 35	4. 00
	costs (see inst.)							
5.00	Subtotal wage-related costs		4, 474, 405	0	4, 474, 405	0.00	43. 71	5. 00
	(see inst.)							
6.00	Total (sum of lines 3 thru 5)		15, 873, 671	3, 136, 622	19, 010, 293	527, 685. 00	36. 03	6. 00
7.00	Total overhead cost (see		4, 687, 475	2, 168, 519	6, 855, 994	248, 313. 00	27. 61	7. 00
	instructions)							

Health Financial Systems	HUNTINGTON MEMORIAL HOSPITAL	In Lieu of Form CMS-2552-10
HOSPITAL WAGE RELATED COSTS	Provi der CCN: 150091	Peri od: Worksheet S-3 From 01/01/2014 Part IV
		To 12/31/2014 Date/Time Prepared

PART I V - WAGE RELATED COSTS 1.00 1.0		To 12/31/2014	Date/Time Pre 5/22/2015 11:	
PART IV - WAGE RELATED COSTS Part A - Core List			Amount	
PART IV - WAGE RELATED COSTS Part A - Core List RETIREMENT COST 401K Employer Contributions 306, 721 2.00 7				
Part A - Core List RETIREMENT COST			1. 00	
RETIREMENT COST		PART IV - WAGE RELATED COSTS		
1.00				
2.00				
3.00 Nonqualified Defined Benefit Plan Cost (see instructions) 2.00 0.0			- 1	
A.00				
PLAM ADMINISTRATIVE COSTS (Paid to External Organization) 401K/TSA Plan Administration fees 0 0 6.00 1			547, 258	3. 00
5.00 401K/TSA PI an Administration fees 0 5.00 6.00 Legal Accounting/Management Fees-Pension PI an 0 6.00 7.00 Employee Managed Care Program Administration Fees 52,799 8.00 Heal th Insurance (Purchased or Self Funded) 1,560,335 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) 24,511 11.00 12.00 Accident Insurance (If employee is owner or beneficiary) 51,610 13.00 13.00 Disability Insurance (If employee is owner or beneficiary) 51,610 13.00 14.00 Long-Term Care Insurance (If employee is owner or beneficiary) 0 14.00 15.00 Workers' Compensation Insurance 82,681 15.00 16.00 Retirement Health Care Cost (Only current year, not the extraordinary accrual required by FASB 106. 0 16.00 17.00 FICA-Employers Portion Only 1,163,259 17.00 18.00 Medicare Taxes - Employers Portion Only 0 14.00 19.00 State or Federal Unemployment Taxes </td <td>4.00</td> <td></td> <td>0</td> <td>4. 00</td>	4.00		0	4. 00
Legal / Accounting / Management Fees-Pension Plan				
The column Table			-	
HEALTH AND INSURANCE COST			•	
Heal th Insurance (Purchased or Self Funded) 1,560,335 9.00 Prescription Drug Plan 0 9.00 1.00	7. 00		52, 799	7. 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) 24, 511 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) 51, 610 13. 00 14. 00 Long-Term Care Insurance (If employee is owner or beneficiary) 0 14. 00 15. 00 'Workers' Compensation Insurance 82, 681 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) 1, 163, 259 17. 00 18. 00 Medicare Taxes - Employers Portion Only 1, 163, 259 17. 00 19. 00 Unemployment Insurance 0 19. 00 20. 00 State or Federal Unemployment Taxes 0 20. 00 0THER 21. 00 Executive Deferred Compensation (Other Than Retirement Cost Reported on Lines 1 through 4 above. (see 27, 962 21. 00 22. 00 Day Care Cost and Allowances 30, 585 </td <td></td> <td></td> <td></td> <td></td>				
10.00 Dental, Hearing and Vision Plan 0 10.00 11.00 Life Insurance (If employee is owner or beneficiary) 24,511 11.00 12.00 Accident Insurance (If employee is owner or beneficiary) 12.00 13.00 Disability Insurance (If employee is owner or beneficiary) 51,610 13.00 Long-Term Care Insurance (If employee is owner or beneficiary) 0 14.00 Long-Term Care Insurance (If employee is owner or beneficiary) 0 15.00 Workers' Compensation Insurance 82,681 15.00 Retirement Health Care Cost (Only current year, not the extraordinary accrual required by FASB 106. 0 10.00 Non cumulative portion 10.00 17.00 FICA-Employers Portion Only 1,163,259 18.00 Medicare Taxes - Employers Portion Only 0 19.00 Unemployment Insurance 0 19.00 Unemployment Insurance 0 20.00 OTHER 21.00 21.00 Executive Deferred Compensation (Other Than Retirement Cost Reported on Lines 1 through 4 above. (see instructions)) 22.00 23.00 Tuition Relimbursement 30,585 23.00 Tuition Relimbursement 30,585 24.00 Part B - Other than Core Related Cost 30,847,721 24.00 Part B - Other than Core Related Cost 30,847,721 24.00 Part B - Other than Core Related Cost 30,847,721 30,000 24.00 Part B - Other than Core Related Cost 30,000 24.00 Part B - Other than Core Related Cost 30,000 24.00 Part B - Other than Core Related Cost 30,000 24.00 Part B - Other than Core Related Cost 30,000 24.00 Part B - Other than Core Related Cost 30,000 25.00 Part B - Other than Core Related Cost 30,000 26.00 Part B - Other than Core Related Cost 30,000 27.00 Part B - Other than Core Related Cost 30,000 28.00 Part B - Other than Core Related Cost 30,000 29.00 Part B - Other than Core Related Cost 30,000 29.00 Part B - Other than Core Related Cost 30,000 29.00 Part B - Other than Core Part Part Part Part Part Part Part Part			1, 560, 335	
11.00			0	
12.00 Accident Insurance (If employee is owner or beneficiary) 12.00 13.00 15.00 15.00 11.00 15.00 15.00 17.00 1			•	
13.00 Disability Insurance (If employee is owner or beneficiary) 14.00 Long-Term Care Insurance (If employee is owner or beneficiary) 15.00 'Workers' Compensation Insurance 16.00 Retirement Health Care Cost (Only current year, not the extraordinary accrual required by FASB 106. Non cumulative portion) TAXES 17.00 FICA-Employers Portion Only 18.00 Medicare Taxes - Employers Portion Only 19.00 Unemployment Insurance 20.00 State or Federal Unemployment Taxes 21.00 Executive Deferred Compensation (Other Than Retirement Cost Reported on Lines 1 through 4 above. (see instructions)) 22.00 Day Care Cost and Allowances 23.00 Titition Reimbursement 24.00 Part B - Other than Core Related Cost			24, 511	
14.00 Long-Term Care Insurance (If employee is owner or beneficiary) 15.00 'Workers' Compensation Insurance Retirement Heal th Care Cost (Only current year, not the extraordinary accrual required by FASB 106. Non cumulative portion) TAXES 17.00 FICA-Employers Portion Only Medicare Taxes - Employers Portion Only Unemployment Insurance State or Federal Unemployment Taxes 21.00 Executive Deferred Compensation (Other Than Retirement Cost Reported on Lines 1 through 4 above. (see instructions)) 22.00 Day Care Cost and Allowances Tuition Reimbursement 30, 585 23.00 Total Wage Related cost (Sum of Lines 1 -23) Part B - Other than Core Related Cost			-	
15.00 'Workers' Compensation Insurance Retirement Heal th Care Cost (Only current year, not the extraordinary accrual required by FASB 106. Non cumulative portion) TAXES 17.00 FICA-Employers Portion Only 18.00 Medicare Taxes - Employers Portion Only 19.00 Unemployment Insurance 20.00 State or Federal Unemployment Taxes 17.00 Executive Deferred Compensation (Other Than Retirement Cost Reported on Lines 1 through 4 above. (see 27, 962 21.00 instructions)) 22.00 Day Care Cost and Allowances 23.00 Tuition Reimbursement 24.00 Total Wage Related cost (Sum of Lines 1 -23) Part B - Other than Core Related Cost			51, 610	
Retirement Health Care Cost (Only current year, not the extraordinary accrual required by FASB 106. Non cumulative portion) TAXES 17. 00 FICA-Employers Portion Only 18. 00 Medicare Taxes - Employers Portion Only 19. 00 Unemployment Insurance 20. 00 State or Federal Unemployment Taxes 10. 00 Executive Deferred Compensation (Other Than Retirement Cost Reported on Lines 1 through 4 above. (see instructions)) 22. 00 Day Care Cost and Allowances 30. 585 23. 00 Total Wage Related cost (Sum of Lines 1 -23) Part B - Other than Core Related Cost			-	
Non cumulative portion TAXES 17.00 FICA-Employers Portion Only 1,163,259 17.00 18.00 Medicare Taxes - Employers Portion Only 0 18.00 19.00 Unemployment Insurance 0 19.00 20.00			82, 681	
TAXES FI CA-Employers Portion Only 1, 163, 259 17. 00	16. 00		0	16. 00
17. 00 FI CA-Employers Portion Only 1, 163, 259 17. 00 18. 00 Medicare Taxes - Employers Portion Only 0 18. 00 19. 00				
18.00 Medicare Taxes - Employers Portion Only 19.00 Unemployment Insurance State or Federal Unemployment Taxes OTHER 21.00 Executive Deferred Compensation (Other Than Retirement Cost Reported on Lines 1 through 4 above. (see instructions)) 22.00 Day Care Cost and Allowances Tuition Reimbursement 24.00 Total Wage Related cost (Sum of Lines 1 -23) Part B - Other than Core Related Cost 18.00 19.00 20.00 21.00 22.00 23.00 24.00 24.00		·		
19.00 Unemployment Insurance 0 19.00 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 instructions)) 22.00 Day Care Cost and Allowances 0 22.00 Tuition Reimbursement 30,585 23.00 Tuition Reimbursement 30,585 23.00 Total Wage Related cost (Sum of Lines 1 -23) 3,847,721 24.00 Part B - Other than Core Related Cost				
20.00 State or Federal Unemployment Taxes 0 OTHER 21.00 Executive Deferred Compensation (Other Than Retirement Cost Reported on Lines 1 through 4 above. (see instructions)) 22.00 Day Care Cost and Allowances 0 23.00 Tuition Reimbursement 30,585 23.00 24.00 Total Wage Related cost (Sum of Lines 1 -23) 3,847,721 Part B - Other than Core Related Cost			-	
OTHER 21. 00 Executive Deferred Compensation (Other Than Retirement Cost Reported on Lines 1 through 4 above. (see 27, 962 instructions)) 22. 00 Day Care Cost and Allowances 23. 00 Tuition Reimbursement 24. 00 Total Wage Related cost (Sum of Lines 1 -23) Part B - Other than Core Related Cost			-	
21. 00 Executive Deferred Compensation (Other Than Retirement Cost Reported on Lines 1 through 4 above. (see instructions)) 22. 00 Day Care Cost and Allowances Tuition Reimbursement 30, 585 23. 00 Total Wage Related cost (Sum of Lines 1 -23) Part B - Other than Core Related Cost	20. 00		0	20. 00
instructions)) 22.00 Day Care Cost and Allowances Tuition Reimbursement 30,585 24.00 Total Wage Related cost (Sum of lines 1 -23) Part B - Other than Core Related Cost 22.00 23.00 24.00				
22. 00 Day Care Cost and Allowances 0 22. 00 23. 00 Tuition Reimbursement 30, 585 23. 00 24. 00 Total Wage Related cost (Sum of lines 1 -23) 3, 847, 721 24. 00 Part B - Other than Core Related Cost 22. 00 24. 00	21. 00		27, 962	21. 00
23.00 Tui ti on Reimbursement 30,585 23.00 24.00 Total Wage Related cost (Sum of lines 1 -23) 24.00 Part B - Other than Core Related Cost (20.00 24.00			_	
24.00 Total Wage Related cost (Sum of lines 1 -23) Part B - Other than Core Related Cost 24.00				
Part B - Other than Core Related Cost				
	24. 00		3, 847, 721	24.00
25. UU UTHER WAGE RELATED COSTS (SPECIFY) 0 25. 00	05.00			05.00
	25. 00	UTHER WAGE RELATED COSTS (SPECIFY)	0	25.00

Health Financial Systems	HUNTINGTON MEMORIAL HOSPITAL	In Lieu	of Form CMS-2552-10
HOSPITAL CONTRACT LABOR AND BENEFIT COST	Provi der CCN: 150091	From 01/01/2014 To 12/31/2014	Worksheet S-3 Part V Date/Time Prepared:

			0 12/31/2014	5/22/2015 11: 2	
	Cost Center Description	· · · · · · · · · · · · · · · · · · ·	Contract Labor		
			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 - IPF				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

Heal th	Financial Systems HUNTINGTON MEMORIAL H	HOSPI TAI		In lie	u of Form CMS-2	2552-10
			CCN: 150091	Peri od:	Worksheet S-10	
				From 01/01/2014		
				To 12/31/2014	Date/Time Prep 5/22/2015 11:3	
			'	'	0, 22, 2010 111	20 4
					1. 00	
	Uncompensated and indigent care cost computation			2)	0.00/000	
1. 00	Cost to charge ratio (Worksheet C, Part I line 202 column 3 divided caid (see instructions for each line)	ded by II	ne 202 column	1 8)	0. 236983	1. 00
2. 00	Net revenue from Medicaid				2, 094, 988	2. 00
3.00	Did you receive DSH or supplemental payments from Medicaid?				2, 094, 900 Y	3. 00
4. 00	If line 3 is "yes", does line 2 include all DSH or supplemental	navments	from Medicaio	12	N N	4. 00
5. 00	If line 4 is "no", then enter DSH or supplemental payments from				3, 501, 637	5. 00
6.00	Medi cai d charges				22, 105, 186	6. 00
7.00	Medicaid cost (line 1 times line 6)				5, 238, 553	7.00
8.00	Difference between net revenue and costs for Medicaid program (I	ine 7 min	us sum of lir	nes 2 and 5; if	0	8.00
	< zero then enter zero)					
	State Children's Health Insurance Program (SCHIP) (see instruction	ons for e	ach line)			
9.00	Net revenue from stand-alone SCHIP				26, 105	9. 00
10.00	Stand-alone SCHIP charges				3, 355 795	
11. 00 12. 00	Stand-alone SCHIP cost (line 1 times line 10) Difference between net revenue and costs for stand-alone SCHIP (lino 11 m	inus lino O	if a zoro thon	795	11. 00 12. 00
12.00	lenter zero)	iiie ii iii	THUS TITLE 9,	II < Zei O tileli	U	12.00
	Other state or local government indigent care program (see instru	uctions f	or each line)			
13.00	Net revenue from state or local indigent care program (Not included)				346, 252	13.00
14.00	Charges for patients covered under state or local indigent care	program (Not included	in lines 6 or	2, 389, 622	14.00
	10)					
15. 00	State or local indigent care program cost (line 1 times line 14)				566, 300	
16. 00	Difference between net revenue and costs for state or local indi	gent care	program (lir	ne 15 minus line	220, 048	16. 00
	13; if < zero then enter zero) Uncompensated care (see instructions for each line)					
17. 00	Private grants, donations, or endowment income restricted to fundament	ding char	ity care		0	17. 00
18. 00	Government grants, appropriations or transfers for support of hos				Ö	18. 00
19. 00	Total unreimbursed cost for Medicaid , SCHIP and state and local			ns (sum of lines	220, 048	19. 00
	8, 12 and 16)					
			Uni nsured	Insured	Total (col. 1	
			patients	pati ents	+ col . 2)	
20. 00	Total initial obligation of patients approved for charity care (at full	1. 00 1, 923, 83	2. 00 34 663, 636	3. 00 2, 587, 470	20.00
20.00	charges excluding non-reimbursable cost centers) for the entire		1, 723, 00	003, 030	2, 367, 470	20.00
21. 00	Cost of initial obligation of patients approved for charity care		455, 91	157, 270	613, 186	21. 00
	times line 20)	`			·	
22. 00	Partial payment by patients approved for charity care		8, 11	5, 388	13, 501	22.00
23. 00	Cost of charity care (line 21 minus line 22)		447, 80	151, 882	599, 685	23. 00
					1. 00	
24. 00	Does the amount in line 20 column 2 include charges for patient	davs bevo	nd a Length o	of stav limit	1.00 N	24. 00
	imposed on patients covered by Medicaid or other indigent care p					
25.00	If line 24 is "yes," charges for patient days beyond an indigen	t care pr	ogram's Lengt	h of stay limit	0	25.00
26. 00	Total bad debt expense for the entire hospital complex (see inst				7, 228, 705	
27. 00	Medicare bad debts for the entire hospital complex (see instruct	,			30, 531	27. 00
28. 00	Non-Medicare and non-reimbursable Medicare bad debt expense (line		,		7, 198, 174	
29. 00	Cost of non-Medicare and non-reimbursable Medicare bad debt expe	nse (line	1 times line	28)	1, 705, 845	
30.00	Cost of uncompensated care (line 23 column 3 plus line 29)	. 20)			2, 305, 530	
31.00	Total unreimbursed and uncompensated care cost (line 19 plus line	e 30)			2, 525, 578	31.00

Heal th	Financial Systems	HUNTINGTON MEMORIA	L HOSPITAL		In Lie	u of Form CMS-	2552-10
RECLAS	SSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE	OF EXPENSES	Provi der		Peri od:	Worksheet A	
					From 01/01/2014 To 12/31/2014	Date/Time Pre	pared·
					10 12/31/2014	5/22/2015 11:	
	Cost Center Description	Sal ari es	0ther	Total (col. 1	Recl assi fi cati	Recl assi fi ed	
				+ col . 2)	ons (See A-6)	Trial Balance	
				,		(col. 3 +-	
						col. 4)	
		1. 00	2. 00	3.00	4. 00	5. 00	
	GENERAL SERVICE COST CENTERS						
1.00	00100 CAP REL COSTS-BLDG & FLXT		948, 876	948, 87	6 -791, 861	157, 015	1. 00
2.00	00200 CAP REL COSTS-MVBLE EQUIP		C		0 1, 064, 946	1, 064, 946	2. 00
3.00	00300 OTHER CAP REL COSTS		C		0	0	3. 00
4.00	00400 EMPLOYEE BENEFITS DEPARTMENT	1, 276, 241	4, 029, 173		4 -1, 276, 241	4, 029, 173	4. 00
5.00	00500 ADMINISTRATIVE & GENERAL	1, 812, 534	12, 072, 548	13, 885, 08	2 -62, 372	13, 822, 710	5. 00
6.00	00600 MAINTENANCE & REPAIRS	0	C		0	0	6. 00
7.00	00700 OPERATION OF PLANT	282, 165	823, 083			1, 142, 737	
8.00	00800 LAUNDRY & LINEN SERVICE	0	159, 815			189, 094	
9.00	00900 HOUSEKEEPI NG	282, 764	102, 035	384, 79	9 8, 634	393, 433	9. 00
10.00	01000 DI ETARY	366, 206	296, 428	662, 63	4 -471, 616	191, 018	10.00
11. 00	01100 CAFETERI A	0	5, 962	5, 96	2 371, 064	377, 026	
12.00	01200 MAI NTENANCE OF PERSONNEL	0	C		0	0	12. 00
13. 00	01300 NURSING ADMINISTRATION	159, 031	2, 448	161, 47	9 21, 297	182, 776	13. 00
14. 00	01400 CENTRAL SERVICES & SUPPLY	0	C		0	0	14.00
15. 00	01500 PHARMACY	508, 534	1, 038, 428	1, 546, 96	2 -472	1, 546, 490	15. 00
16. 00	01600 MEDICAL RECORDS & LIBRARY	0	C		0	0	16. 00
17. 00	01700 SOCIAL SERVICE	0	C		0	0	17.00
19. 00	01900 NONPHYSICIAN ANESTHETISTS	0	C		0	0	19. 00
20. 00	02000 NURSI NG SCHOOL	0	C		0	0	20.00
21. 00	02100 I &R SERVICES-SALARY & FRINGES APPRV	0	C		0	0	21. 00
22. 00	02200 I&R SERVICES-OTHER PRGM COSTS APPRV	0	C		0	0	22. 00
23.00	02300 PARAMED ED PRGM-(SPECIFY)	0	C		0 0	0	23. 00
	INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000 ADULTS & PEDI ATRI CS	2, 757, 256	276, 416	3, 033, 67	2 -306, 929	2, 726, 743	30.00
43.00	04300 NURSERY	0	C		0 27, 696	27, 696	43. 00
	ANCILLARY SERVICE COST CENTERS						
50. 00	05000 OPERATI NG ROOM	814, 621	489, 469	1, 304, 09		1, 335, 624	
52. 00	05200 DELIVERY ROOM & LABOR ROOM	0	C		0 648, 082	648, 082	
53. 00	05300 ANESTHESI OLOGY	0	913, 802			913, 802	
54. 00	05400 RADI OLOGY-DI AGNOSTI C	795, 245	475, 582	1		1, 332, 058	
60.00	06000 LABORATORY	0	2, 074, 244	2, 074, 24	4 -1, 648	2, 072, 596	
62. 30	06250 BLOOD CLOTTING FOR HEMOPHILIACS	0	C		0	0	62. 30
65. 00	06500 RESPI RATORY THERAPY	574, 795	106, 145			755, 771	
66. 00	06600 PHYSI CAL THERAPY	843, 475	76, 631	920, 10	6 85, 086	1, 005, 192	
68. 00	06800 SPEECH PATHOLOGY	0	C		0	0	
69. 00	06900 ELECTROCARDI OLOGY	이	C		0	0	69. 00
71. 00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0	1, 570, 845	1, 570, 84		755, 435	
72. 00	07200 I MPL. DEV. CHARGED TO PATI ENTS	0)	0 814, 226	814, 226	
73. 00	07300 DRUGS CHARGED TO PATIENTS	0	1, 451, 047	1, 451, 04	7 59, 043	1, 510, 090	1
76. 97	07697 CARDI AC REHABI LI TATI ON	0	C)	0	0	76. 97
	07698 HYPERBARI C OXYGEN THERAPY	0	C)	0	0	
76. 99	07699 LI THOTRI PSY	0)	0 0	0	76. 99
04 00	OUTPATIENT SERVICE COST CENTERS	204 200	474 077	1 4 404 07	(0.005	4 4 4 0 7 4	04 00
	09100 EMERGENCY	926, 399	174, 977	1, 101, 37	62, 895	1, 164, 271	
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART						92.00
05.00	OTHER REIMBURSABLE COST CENTERS	1 010 007	045 006	4 500 00	1/0 045	4 700 440	05 00
95.00	09500 AMBULANCE SERVICES	1, 318, 007	215, 090	1, 533, 09	7 169, 315	1, 702, 412	95.00
112 0	SPECIAL PURPOSE COST CENTERS		10.055	10.05	10.055	0	112 00
	11300 INTEREST EXPENSE	10 717 070	10, 255				113. 00
118.00		12, 717, 273	27, 313, 299	40, 030, 57	2 -170, 156	39, 860, 416	1118.00
100.00	NONREIMBURSABLE COST CENTERS 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN			1		0	100 00
190.00	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN 19200 PHYSICIANS' PRIVATE OFFICES	61, 384	264, 944	326, 32	0 7 725	334, 053	190.00
	07950 OCC HEALTH	61, 384	204, 944	320, 32	8 7, 725		
	O7950 OCC HEALTH				0		194. 00 194. 01
	207952 OCC HEALTH		-128, 858	-128, 85	8 128, 858		194. 01
	07953 FOUNDATIO						194. 02
	107953 FOUNDATTO		85, 478	1	0 0		194. 03
	07954 KTDS CAMPUS 07955 COMMUNITY & VOLUNTEER SERVICES	43, 829	274, 756	1	-	318, 585	
	07956 HUNTI NGTON COLLEGE NURSE	43,027	Z14, 130	310, 30			194. 05
	707957 MISC CATERING	0		ál .	0 100, 312	100, 312	
	07957 MISC CATERING BO7958 AUTISM CENTER	0	12, 000	12, 00		-54, 739	
	PO7959 HUNTI NGTON BUA	0	12,000	12,00	0 -00, 739		194. 09
200.00		12, 822, 486	27, 821, 619	40, 644, 10			
_00.00	1.0 (30 01 ETHES 110 177)		, 021, 017	10, 544, 10	-, 0	.5,5,7,105	1=55.00

Provi der CCN: 150091

Peri od: From 01/01/2014 To 12/31/2014 | WorkSneet... Date/Time Prepared: 5/22/2015 11: 28 am

			5/22/2015 11: 28	am_
Cost Center Description	Adjustments	Net Expenses		
	(See A-8)	For Allocation		
OFNEDAL CEDIMOR COCT OFNITEDO	6. 00	7.00		
GENERAL SERVICE COST CENTERS	070 700	105 744		4 00
1. 00 00100 CAP REL COSTS-BLDG & FIXT	278, 729	l		1.00
2. 00 00200 CAP REL COSTS-MVBLE EQUIP	646, 965	I I		2. 00
3. 00 00300 OTHER CAP REL COSTS	0			3. 00
4. 00 00400 EMPLOYEE BENEFITS DEPARTMENT	-1, 251, 660			4. 00
5. 00 00500 ADMINISTRATIVE & GENERAL	-3, 114, 508			5. 00
6.00 00600 MAINTENANCE & REPAIRS	0	0		6. 00
7.00 O0700 OPERATION OF PLANT	-3, 037			7. 00
8.00 00800 LAUNDRY & LINEN SERVICE	0	189, 094		8.00
9. 00 00900 HOUSEKEEPI NG	0	393, 433		9.00
10. 00 01000 DI ETARY	-21, 139	169, 879		10.00
11. 00 01100 CAFETERI A	-199, 543	177, 483		11. 00
12. 00 01200 MAI NTENANCE OF PERSONNEL	0	o		12. 00
13. 00 01300 NURSING ADMINISTRATION	0	182, 776		13. 00
14.00 01400 CENTRAL SERVICES & SUPPLY	0	0		14. 00
15. 00 01500 PHARMACY	-2, 058, 588	-512, 098		15. 00
16. 00 01600 MEDI CAL RECORDS & LI BRARY	2,000,000	0.2,070		16. 00
17. 00 01700 SOCI AL SERVI CE	Ö			17. 00
19. 00 01900 NONPHYSICIAN ANESTHETISTS	0			19. 00
20. 00 02000 NURSI NG SCHOOL				20. 00
	0			21. 00
+ I	0	0		
22. 00 02200 1 &R SERVI CES-OTHER PRGM COSTS APPRV	0	0		22. 00
23. 00 02300 PARAMED ED PRGM-(SPECIFY)	0	0		23. 00
I NPATI ENT ROUTI NE SERVI CE COST CENTERS				
30. 00 03000 ADULTS & PEDI ATRI CS	22, 320			30. 00
43. 00 04300 NURSERY	0	27, 696		43. 00
ANCILLARY SERVICE COST CENTERS		,		
50.00 05000 OPERATING ROOM	-899, 330	l		50. 00
52.00 05200 DELIVERY ROOM & LABOR ROOM	0			52. 00
53. 00 05300 ANESTHESI OLOGY	0	913, 802		53. 00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	-10, 783	1, 321, 275		54. 00
60. 00 06000 LABORATORY	-114	2, 072, 482		60.00
62.30 06250 BLOOD CLOTTING FOR HEMOPHILIACS	0	o		62. 30
65. 00 06500 RESPIRATORY THERAPY	-49, 480	706, 291		65. 00
66. 00 06600 PHYSI CAL THERAPY	-1, 154, 182			66. 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	755, 435		71. 00
72. 00 07200 IMPL. DEV. CHARGED TO PATIENTS		814, 226		71.00
73. 00 07300 DRUGS CHARGED TO PATIENTS	0	1, 510, 090		73. 00
· · · · · · · · · · · · · · · · · · ·		l ' '		
76. 97 O7697 CARDI AC REHABI LI TATI ON	1			76. 97
76. 98 07698 HYPERBARI C OXYGEN THERAPY	0			76. 98
76. 99 07699 LI THOTRI PSY	0	0		76. 99
OUTPATIENT SERVICE COST CENTERS				
91. 00 09100 EMERGENCY	-15, 220	1, 149, 051		91. 00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART				92. 00
OTHER REIMBURSABLE COST CENTERS				
95. 00 09500 AMBULANCE SERVICES	-24, 880	1, 677, 532		95. 00
SPECIAL PURPOSE COST CENTERS				
113. 00 11300 I NTEREST EXPENSE	0	0	1	13.00
118.00 SUBTOTALS (SUM OF LINES 1-117)	-7, 854, 450	32, 005, 966	1	18. 00
NONREI MBURSABLE COST CENTERS				
190. 00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	1	90. 00
192. 00 19200 PHYSI CLANS' PRI VATE OFFI CES	-239, 365	94, 688		92.00
194. 00 07950 OCC HEALTH	0	0		94. 00
194. 01 07951 PALN CLINIC	0			94. 01
194. 02 07952 OCC HEALTH				94. 02
194. 03 07953 FOUNDATI 0		05 170		94. 03
194. 04 07954 KLDS CAMPUS		85, 478		94. 03 94. 04
	E0 202	374 970		
194. 05 07955 COMMUNITY & VOLUNTEER SERVICES	58, 293	376, 878		94. 05
194. 06 07956 HUNTI NGTON COLLEGE NURSE	0	10000		94. 06
194. 07 07957 MI SC CATERING	0	100, 312		94. 07
194. 08 07958 AUTI SM CENTER	0	-54, 739		94. 08
194. 09 07959 HUNTI NGTON BUA	0	0		94. 09
200.00 TOTAL (SUM OF LINES 118-199)	-8, 035, 522	32, 608, 583	2	00. 00

Health Financial Systems RECLASSIFICATIONS Provider CCN: 150091 Peri od: Worksheet A-6 From 01/01/2014 To 12/31/2014 Date/Time Prepared:

					To 12/31/2014 Date/Time Pi 5/22/2015 1	
		Increases			, 0, 22, 20.0	1
	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	224, 041	147, 023		1.00
2.00	MISC_CATERING	1 <u>94.</u> 07	<u>59, 9</u> 96	40, 316		2. 00
	0		284, 037	187, 339		_
1 00	B - INTEREST	2 00	al	10.055		1 00
1. 00	CAP REL COSTS-MVBLE EQUIP		0	1 <u>0, 2</u> 55 10, 255		1. 00
	D - DEPRECIATION		<u> </u>	10, 233		=
1.00	CAP REL COSTS-MVBLE EQUIP	2.00	0	820, 187		1. 00
13. 00		0.00	0	0		13. 00
	0		0	820, 187		\exists
1. 00	E - BUILDING AND EQUIPMENT CAP REL COSTS-MVBLE EQUIP	2. 00	0	203, 517		1.00
2.00	CAF REL COSTS-WVBEL EQUIF	0.00	o	203, 517		2. 00
3. 00		0.00	O	Ō		3. 00
4.00		0. 00	О	0		4. 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	ő	ő		9. 00
10.00		0.00	O	0		10.00
11. 00		0. 00	О	0		11. 00
12.00		0. 00	0	0		12. 00
13.00		0.00	0	0		13. 00
14. 00				<u>0</u> 203, 517		14. 00
	F - I NSURANCE		<u> </u>	203, 317		_
1.00	CAP REL COSTS-BLDG & FIXT	1.00	0	28, 326		1. 00
2.00	CAP REL COSTS-MVBLE EQUIP	2. 00	0	30, 987		2. 00
22. 00		0.00	0	0		22. 00
	O G - LAUNDRY		0	59, 313		_
1.00	LAUNDRY & LINEN SERVICE	8.00	29, 279	0		1.00
	0		29, 279	0		
	H - HOME OFFICE SALARY					
1. 00	ADMI NI STRATI VE & GENERAL	5.00	3, 388, 248	0		1. 00
	0 I - PTO		3, 388, 248	0		\dashv
1.00	ADMINISTRATIVE & GENERAL	5.00	26, 122	0		1.00
2.00	OPERATION OF PLANT	7. 00	37, 833	Ö		2. 00
3.00	HOUSEKEEPI NG	9. 00	37, 913	0		3. 00
4.00	NURSI NG ADMI NI STRATI ON	13. 00	21, 323	0		4. 00
5.00	ADULTS & PEDIATRICS OPERATING ROOM	30. 00 50. 00	369, 693 109, 225	0		5. 00
6. 00 7. 00	RADI OLOGY-DI AGNOSTI C	54.00	109, 225	0		6. 00 7. 00
8. 00	RESPIRATORY THERAPY	65. 00	77, 069	Ö		8. 00
9.00	PHYSI CAL THERAPY	66.00	113, 093	0		9. 00
10.00	DRUGS CHARGED TO PATIENTS	73. 00	68, 184	0		10. 00
11.00	EMERGENCY	91.00	124, 212	0		11. 00
12. 00 13. 00	AMBULANCE SERVICES PHYSICIANS' PRIVATE OFFICES	95. 00 192. 00	176, 719 8, 228	0		12. 00 13. 00
13.00	0	192.00	1, 276, 241	<u>o</u>		13.00
	J - SALARY		1,2,0,211	<u> </u>		
1.00	ADMINISTRATIVE & GENERAL	5. 00	0	1, 818		1. 00
2.00	DI ETARY	10. 00		4, 865		2. 00
	O CC HEALTH		0	6, 683		_
1. 00	K - OCC HEALTH OCC HEALTH	194. 02	ol	128, 858		1.00
2.00	OGG TIERETTI	0.00	o	0		2. 00
3. 00		0.00	O	Ō		3. 00
4.00		0. 00	0	0		4. 00
5.00		0.00	0	0		5. 00
6. 00			0	0 128, 858		6. 00
	U _ IMPLANTS		U	120,000		
1.00	I MPL. DEV. CHARGED TO	72.00	0	814, 226		1. 00
	PATI ENTS					
	0		0	814, 226		_
1 00	M - OB	42.00	25 1/0	2 524		1 00
1. 00 2. 00	NURSERY DELIVERY ROOM & LABOR ROOM	43. 00 52. 00	25, 160 588, 737	2, 536 59, 345		1. 00 2. 00
2.00	0		613, 897	61, 881		2.00
500.00	Grand Total: Increases		5, 591, 702	2, 292, 259		500.00

RECLASSI FI CATIONS

Provider CCN: 150091

Peri od: Worksheet A-6 From 01/01/2014 To 12/31/2014 Date/Ti me Prepared:

5/22/2015 11:28 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 10.00 284, 037 187, 339 0 1.00 2.00 0.00 0 2.00 284, 037 187, 339 B - INTEREST 1.00 INTEREST EXPENSE 113.00 10, 255 1.00 0 11 10, 255 D - DEPRECIATION 1.00 CAP REL COSTS-BLDG & FIXT 1.00 0 820, 187 9 1.00 0. 00 0 13.00 9 13.00 820, 187 - BUILDING AND EQUIPMENT 1.00 ADMINISTRATIVE & GENERAL 5.00 0 29, 181 10 1.00 2.00 OPERATION OF PLANT 7.00 0 0 344 2.00 0 DI FTARY 10.00 3 00 240 0 3 00 NURSING ADMINISTRATION 4.00 13.00 0 26 0 4.00 5.00 PHARMACY 15.00 o 472 0 5.00 ADULTS & PEDIATRICS 6.00 30.00 0 844 0 6.00 Ol 0 50.00 OPERATING ROOM 7 00 77.691 7.00 8.00 RADI OLOGY-DI AGNOSTI C 54.00 0 405 0 8.00 RESPIRATORY THERAPY 9.00 65.00 2, 238 9.00 0 0 PHYSICAL THERAPY 66.00 16, 107 10.00 10.00 11.00 AUTISM CENTER 194.08 0 66, 739 0 11.00 EMERGENCY 91.00 0 1, 323 0 12.00 12.00 13.00 AMBULANCE SERVICES 95.00 0 10 7, 404 13.00 14.00 PHYSICIANS' PRIVATE OFFICES 192.00 503 0 14.00 203, 517 - INSURANCE 0 1.00 ADMINISTRATIVE & GENERAL 5.00 59, 313 12 1.00 2 00 0 00 0 12 2 00 22.00 0.00 12 22.00 59, 313 G - LAUNDRY 29, 279 1.00 HOUSEKEEPI NG 9.00 0 0 1.00 29, 279 H - HOME OFFICE SALARY ADMINISTRATIVE & GENERAL 3, 388, 248 1.00 5.00 0 1.00 3, 388, 248 - PT0 1.00 EMPLOYEE BENEFITS DEPARTMENT 4.00 1, 276, 241 0 1.00 2.00 0 0.00 0 2.00 3.00 0.00 0 0 0 3.00 0 4.00 0.00 0 4.00 ol 0 5.00 0.00 0 5.00 0 6.00 0.00 0 6.00 7.00 0.00 o 0 7.00 8.00 0.00 0 0 8.00 0 0 9.00 0.00 9.00 10.00 0.00 0 0 10.00 11.00 0.00 0 0 0 11.00 12 00 0 00 O 0 12 00 13.00 0.00 0 13.00 1, 276, 241 0 J - SALARY 1.00 ADMINISTRATIVE & GENERAL 0 5 00 n 1 00 1 818 2.00 DI ETARY 10.00 4,865 0 0 2.00 6,683 K - OCC HEALTH 44, 991 1 00 RADI OLOGY-DI AGNOSTI C 54.00 0 1.00 2.00 LABORATORY 60.00 0 1, 648 0 2.00 3.00 PHYSICAL THERAPY 0 11, 900 0 66.00 3.00 MEDICAL SUPPLIES CHARGED TO 0 0 4.00 71.00 1, 184 4.00 PATI ENT DRUGS CHARGED TO PATIENTS 5.00 73.00 9, 141 0 5.00 59, 994 6.00 EMERGENCY 91.00 0 6.00 ō 128, 858 - IMPLANTS 1.00 MEDICAL SUPPLIES CHARGED TO 71.00 0 814, 226 0 1.00 PATI ENT 814, 226 M - OB 1.00 ADULTS & PEDIATRICS 30 00 613, 897 61,881 0 1.00 0.00 2.00 0 2.00 613, 897 61, 881

Health Financial Systems HUNTINGTON MEMORIAL HOSPITAL In Lieu of Form CMS-2552-10
RECLASSIFICATIONS Provider CCN: 150091 Period: From 01/01/2014 To 12/31/2014 Date/Time Prepared: 5/22/2015 11: 28 am

						5/22/2015 11	:28 am
		Decreases					
	Cost Center	Li ne #	Sal ary	0ther	Wkst. A-7 Ref		
	6. 00	7. 00	8. 00	9. 00	10.00		
500.00	Grand Total: Decreases		2, 210, 137	5, 673, 824			500.00

Provi der CCN: 150091

					To 12/31/2014		pared:
				Acqui si ti ons	;	07 227 2010 11.	20 4111
		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	1. 00
2.00	Land Improvements	465, 871	0		0	0	2. 00
3.00	Buildings and Fixtures	1, 641, 580	0		0	0	3. 00
4.00	Building Improvements	32, 500	0		0	0	4. 00
5.00	Fi xed Equi pment	1, 232, 059	17, 815		0 17, 815	0	5. 00
6.00	Movable Equipment	10, 286, 655	402, 526		0 402, 526	123, 545	
7.00	HIT designated Assets	2, 214, 717	324, 452		0 324, 452	0	7. 00
8.00	Subtotal (sum of lines 1-7)	15, 873, 382	744, 793		0 744, 793	123, 545	
9.00	Reconciling Items	2, 113, 486	239, 650		0 239, 650		9. 00
10.00	Total (line 8 minus line 9)	13, 759, 896	505, 143		0 505, 143	123, 545	10. 00
		Endi ng Bal ance	Fully				
			Depreci ated				
			Assets				
		6.00	7. 00				
4 00	PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET	T BALANCES					
1.00	Land	0	0				1.00
2.00	Land Improvements	465, 871	149, 458				2. 00
3.00	Buildings and Fixtures	1, 641, 580	222, 375				3. 00
4.00	Building Improvements	32, 500	0				4. 00
5.00	Fi xed Equipment	1, 249, 874	763, 422				5. 00
6.00	Movable Equipment	10, 565, 636	12, 003, 509				6. 00
7. 00	HIT designated Assets	2, 539, 169	0				7. 00
8.00	Subtotal (sum of lines 1-7)	16, 494, 630	13, 138, 764				8. 00
9.00	Reconciling Items	2, 353, 136	0				9. 00
10. 00	Total (line 8 minus line 9)	14, 141, 494	13, 138, 764				10. 00

Heal th	Financial Systems	HUNTINGTON MEMORIAL HOSPITAL			In Lieu of Form CMS-2552-1			
RECONO	CILIATION OF CAPITAL COSTS CENTERS		Provi der	CCN: 150091	Peri od:	Worksheet A-7		
					From 01/01/2014			
					To 12/31/2014	Date/Time Prep 5/22/2015 11:2	pared:	
			SI SI	JMMARY OF CAP	I TAI	3/22/2013 11.	20 4111	
			30	JIVIIVIAKT OF CAF	TIAL			
	Cost Center Description	Depreciation	Lease	Interest	Insurance (see	Taxes (see		
					instructions)	instructions)		
		9. 00	10.00	11. 00	12.00	13. 00		
	PART II - RECONCILIATION OF AMOUNTS FROM WORK	SHEET A, COLUM	N 2, LINES 1 a	nd 2				
1.00	CAP REL COSTS-BLDG & FIXT	948, 876	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)	948, 876	0		0 0	0	3. 00	
		SUMMARY 0	F CAPITAL					
	Cost Center Description		Total (1) (sum					
		Capi tal -Relate						
		d Costs (see	through 14)					
		instructions)						
		14. 00	15. 00					
	PART II - RECONCILIATION OF AMOUNTS FROM WORK	KSHEET A, COLUM	N 2, LINES 1 a	nd 2				
1.00	CAP REL COSTS-BLDG & FIXT	0	948, 876				1.00	
2.00	CAP REL COSTS-MVBLE EQUIP	0	0				2.00	
	1		0.40 07/	I				

0 0 0

948, 876

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	RIAL HOSPITAL		In Lie	eu of Form CMS-2	2552-10
RECONG	CILIATION OF CAPITAL COSTS CENTERS		Provi der	1	Period: From 01/01/2014 Fo 12/31/2014	Date/Time Pre	pared:
		СОМІ	PUTATION OF RAT	TI 0S	ALLOCATION OF	5/22/2015 11: 0THER CAPITAL	28 am
	Cost Center Description	Gross Assets	Capi tal i zed Leases	Gross Assets for Ratio (col. 1 - col.	Ratio (see instructions)	Insurance	
		1.00	2.00	3. 00	4. 00	5. 00	
	PART III - RECONCILIATION OF CAPITAL COSTS CI	ENTERS	<u> </u>		•		
1.00	CAP REL COSTS-BLDG & FLXT	3, 389, 825	0	3, 389, 82	0. 249374	0	1. 00
2.00	CAP REL COSTS-MVBLE EQUIP	10, 565, 636	362, 132			l ol	2.00
3.00	Total (sum of lines 1-2)	13, 955, 461					3. 00
		ALLOCATION OF OTHER CAPITAL				F CAPITAL	
	Cost Center Description	Taxes	Other Capi tal -Relate	Total (sum of cols. 5	Depreciation	Lease	
			d Costs	through 7)			
		6, 00	7.00	8.00	9. 00	10.00	
	PART III - RECONCILIATION OF CAPITAL COSTS CI	ENTERS					
1.00	CAP REL COSTS-BLDG & FLXT	0	0	(407, 418	0	1. 00
2.00	CAP REL COSTS-MVBLE EQUIP	0	0		1, 467, 152		2. 00
3.00	Total (sum of lines 1-2)	0	0		1, 874, 570		3. 00
			SL	JMMARY OF CAPI			
	Cost Center Description	Interest	Insurance (see			Total (2) (sum	
			Instructions)	nstructions)	Capi tal -Rel ate d Costs (see	of cols. 9 through 14)	
					instructions)		
		11.00	12.00	13.00	14.00	15. 00	
	PART III - RECONCILIATION OF CAPITAL COSTS CI	ENTERS					
1.00	CAP REL COSTS-BLDG & FLXT	0	28, 326	(0	435, 744	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	10, 255	30, 987		0	1, 711, 911	2.00
3.00	Total (sum of lines 1-2)	10, 255	59, 313		0	2, 147, 655	3.00

Peri od: Worksheet A-8 From 01/01/2014 Date/Time Prepared: 5/23/2015 11:28 am Provider CCN: 150091

				T	0 12/31/2014	Date/Time Prep 5/22/2015 11:2	
				Expense Classification on To/From Which the Amount is		3/22/2013 11.2	o aiii
				10/11 oill will cit the Allouit 13	to be haj usted		
	Cost Center Description	Basis/Code (2)	Amount	Cost Center		Wkst. A-7 Ref.	
1. 00	Investment income - CAP REL	1. 00	2.00	3.00 CAP REL COSTS-BLDG & FIXT	4. 00 1. 00	5. 00	1. 0
	COSTS-BLDG & FLXT (chapter 2)						
2. 00	Investment income - CAP REL COSTS-MVBLE EQUIP (chapter 2)		0	CAP REL COSTS-MVBLE EQUIP	2. 00	0	2. 0
3. 00	Investment income - other (chapter 2)		0		0. 00	0	3. 0
4. 00	Trade, quantity, and time		0		0. 00	О	4. 0
5. 00	discounts (chapter 8) Refunds and rebates of		0		0. 00	0	5. 0
	expenses (chapter 8)		-				
6. 00	Rental of provider space by suppliers (chapter 8)		0		0. 00	0	6. 0
7. 00	Telephone services (pay stations excluded) (chapter	A	-3, 748	ADMINISTRATIVE & GENERAL	5. 00	0	7. 0
8. 00	21) Tel evi si on and radio service (chapter 21)	A	-2, 188	OPERATION OF PLANT	7. 00	0	8. 0
9. 00 10. 00	Parking Lot (chapter 21) Provider-based physician	A-8-2	-935, 767		0. 00	0	9. 00 10. 00
	adjustment	N-U-2					
11. 00	Sale of scrap, waste, etc. (chapter 23)		0		0. 00	0	11. 0
12.00	Related organization transactions (chapter 10)	A-8-1	-2, 105, 189		0.00		12. 0
13. 00 14. 00	Laundry and linen service Cafeteria-employees and guests	A	-39, 803	CAFETERI A	0. 00 11. 00		13. 00 14. 00
15. 00	Rental of quarters to employee		0		0. 00	0	15. 0
16. 00	and others Sale of medical and surgical supplies to other than		0		0. 00	0	16. 0
17. 00	patients Sale of drugs to other than patients		0		0. 00	0	17. 0
18. 00	Sale of medical records and		0		0. 00	О	18. 0
19. 00	abstracts Nursing school (tuition, fees,		0		0. 00	o	19. 0
	books, etc.)		4.0/5	DIETARY			
20. 00 21. 00	Vending machines Income from imposition of interest, finance or penalty	A	-4, 865 0	DI ETARY	10. 00 0. 00		20. 00 21. 00
22. 00	charges (chapter 21) Interest expense on Medicare overpayments and borrowings to		0		0. 00	0	22. 0
23. 00	repay Medicare overpayments Adjustment for respiratory therapy costs in excess of	A-8-3	0	RESPIRATORY THERAPY	65. 00		23. 0
24. 00	limitation (chapter 14) Adjustment for physical therapy costs in excess of	A-8-3	0	PHYSICAL THERAPY	66. 00		24. 0
25. 00	limitation (chapter 14) Utilization review - physicians' compensation		0	*** Cost Center Deleted ***	114. 00		25. 0
26. 00	(chapter 21) Depreciation - CAP REL COSTS-BLDG & FIXT		0	CAP REL COSTS-BLDG & FIXT	1. 00	0	26. 0
27. 00			0	CAP REL COSTS-MVBLE EQUIP	2. 00	0	27. 0
28. 00	Non-physician Anesthetist		0	NONPHYSICIAN ANESTHETISTS	19. 00		28. 0
29. 00 30. 00	Physicians' assistant Adjustment for occupational therapy costs in excess of	A-8-3	0	*** Cost Center Deleted ***	0. 00 67. 00	0	29. 00 30. 00
30. 99	Hospice (non-distinct) (see		0	ADULTS & PEDIATRICS	30. 00		30. 9
31. 00	instructions) Adjustment for speech pathology costs in excess of	A-8-3	0	SPEECH PATHOLOGY	68. 00		31. 0
32. 00	limitation (chapter 14) CAH HIT Adjustment for		0		0. 00	0	32. 0
33. 00	Depreciation and Interest OTHER ADJUSTMENTS (SPECIFY)		Ω		0. 00	0	33. 0
	(3)		O		3.30	7	23.0

						5/22/2015 11: 3	28 am
				Expense Classification on	Worksheet A		
				To/From Which the Amount is	to be Adjusted		
					-		
	Cost Center Description	Basis/Code (2)	Amount	Cost Center	Li ne #	Wkst. A-7 Ref.	
	•	1.00	2. 00	3.00	4. 00	5. 00	
33. 01	TELEPHONE SERVICES	Α	-597	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	33. 01
33. 02	VENDI NG	A	-1, 597	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	33. 02
33. 03	VENDI NG	A	· ·	OPERATION OF PLANT	7. 00	0	33. 03
33. 04	RENT	A		ADMINISTRATIVE & GENERAL	5. 00	0	33. 04
33. 05	RENT	A	· ·	RESPIRATORY THERAPY	65. 00	0	33. 05
33. 06	RENT	A	· ·	PHYSICIANS' PRIVATE OFFICES	192.00	o O	33. 06
33. 07	PHARMACY EMPLOYEE PURCHASES	B	· ·	PHARMACY	15. 00	0	33. 07
33. 08	PHYSICIAN RECRUITMENT	A	· ·	ADMINISTRATIVE & GENERAL	5. 00	0	33. 08
33. 09	INTEREST EXPENSE OFFSET	B		CAP REL COSTS-MVBLE EQUIP	2.00	0	33. 09
33. 10	SELF INSURANCE	A		EMPLOYEE BENEFITS DEPARTMENT	4. 00	7	33. 10
33. 10	GUEST MEALS	A		CAFETERIA	11. 00	0	33. 10
33. 11	CONSULTING PT	B B		PHYSI CAL THERAPY		0	33. 11
				1	66.00	0	
33. 13	LOBBY DUES	A	· ·	ADMINISTRATIVE & GENERAL	5. 00	0	33. 13
33. 14	LI QUOR	A	· ·	ADMINISTRATIVE & GENERAL	5. 00	0	33. 14
33. 18	OTHER OPERATING REVENUE	В	· ·	ADMINISTRATIVE & GENERAL	5. 00	0	33. 18
33. 19	OTHER OPERATING REVENUE	В		DI ETARY	10. 00	0	33. 19
33. 20	OTHER OPERATING REVENUE	В		CAFETERI A	11. 00	0	33. 20
33. 21	OTHER OPERATING REVENUE	В	-2, 004, 790	1	15. 00	0	33. 21
33. 22	OTHER OPERATING REVENUE	В		RADI OLOGY-DI AGNOSTI C	54.00	0	33. 22
33. 23	OTHER OPERATING REVENUE	В		LABORATORY	60.00	0	33. 23
33. 24	OTHER OPERATING REVENUE	В	-25, 213	RESPIRATORY THERAPY	65.00	0	33. 24
33. 25	OTHER OPERATING REVENUE	В	-4, 762	PHYSI CAL THERAPY	66.00	0	33. 25
33. 26	OTHER OPERATING REVENUE	В	-220	EMERGENCY	91.00	0	33. 26
33. 27	OTHER OPERATING REVENUE	В	-9, 880	AMBULANCE SERVICES	95.00	0	33. 27
33. 28	OTHER OPERATING REVENUE	В	58, 293	COMMUNITY & VOLUNTEER	194. 05	0	33. 28
				SERVI CES			
33. 29	TELEMETRY	A	22, 320	ADULTS & PEDIATRICS	30.00	0	33. 29
34.00	DEPRECI ATI ON	A	278, 729	CAP REL COSTS-BLDG & FIXT	1.00	9	34. 00
35. 00	DEPRECIATION	A	· ·	CAP REL COSTS-MVBLE EQUIP	2. 00	9	35. 00
50.00	TOTAL (sum of lines 1 thru 49)		-8, 035, 522	1			50.00
	(Transfer to Worksheet A,		-, ,				
	column 6, line 200.)						
(1) Do	scription - all chapter referen	ocas in this cal	umn nertain to	CMS Dub 15_1			

- (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.

* 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.

PPG SUBSIDY

2, 172, 647

10, 194, 647

0

0

0

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8, 089, 458

2.00

3.00

4.00

5.00

 zoon pootou to normonout m	cor anni s r aria, or 2, tric anoar	it aironabro on	cara be inarcated in corami.	or time 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:

5. OO ADMINISTRATIVE & GENERAL

0.00

0.00

TOTALS (sum of lines 1-4).

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

- 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.

2.00

3.00

4.00

5.00

line 12.

Heal th	Financial Syste	ems		H	UNTI NGTON	MEMORI AL	HOSPI TAL			In Lie	eu of Form Cl	MS-2552-10
STATEME OFFICE	INT OF COSTS OF	SERVICES FROM	RELATED	ORGANI ZA	ATIONS AND	HOME	Provi der	CCN:	150091	Peri od: From 01/01/2014	Worksheet	A-8-1
011102										To 12/31/2014	Date/Ti me 5/22/2015	Prepared: 11:28 am
	Net	Wkst. A-7 Ref.										
	Adjustments											
	(col. 4 minus											
	col. 5)*											
	6. 00	7. 00										
	A. COSTS INCUR	RED AND ADJUST	MENTS REC	QUI RED AS	A RESULT	OF TRANS	ACTIONS W	ITH F	RELATED C	RGANI ZATI ONS OR	CLAI MED	
	HOME OFFICE CO	STS:										
1.00	67, 458	C										1. 00
2.00	-2, 172, 647	C										2. 00
3.00	0	l c										3. 00
4.00	0											4. 00
5 00	_2 105 190	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.

Provider CCN: 150091

					'	10 12/31/2014	5/22/2015 11:	
	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		OPERATING ROOM	913, 101	874, 871	38, 230	200, 300	143	1. 00
2.00	65. 00	RESPI RATORY THERAPY	6, 437	6, 437	0	200, 300	0	2. 00
3.00	91. 00	EMERGENCY	15, 000	15, 000	0	200, 300	0	3. 00
4.00	95. 00	AMBULANCE SERVICES	15, 000	15, 000	0	200, 300	0	4. 00
5.00	0.00		0	C	0	0	0	5. 00
6.00	0.00		0	C	0	0	0	6. 00
7. 00	0. 00		0	C	0	0	0	7. 00
8.00	0. 00		0	C	0	0	0	8. 00
9. 00	0. 00		0	C	0	0	0	9. 00
10.00	0. 00		0	C	0	0	0	10.00
200.00			949, 538	911, 308	38, 230		143	200.00
	Wkst. A Line #	Cost Center/Physician	Unadjusted RCE		Cost of		Physician Cost	
		ldenti fi er	Limit	Unadjusted RCE	Memberships &		of Malpractice	
				Limit	Conti nui ng	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	13, 771	689		0	0	
2.00		RESPIRATORY THERAPY	0	C	0	0	0	
3. 00		EMERGENCY	0		0	0	0	1
4. 00		AMBULANCE SERVICES	0		0	0	0	
5. 00	0. 00		0		0	0	0	
6. 00	0. 00		0		0	0	0	0.00
7. 00	0. 00		0		0	0	0	
8. 00	0. 00		0		0	0	0	0.00
9. 00	0. 00		0		0	0	0	
10.00	0. 00		0	0	0	0	0	1
200.00	1111 1 A 1 ' //	0 1 0 1 /DI : :	13, 771			0	0	200. 00
	Wkst. A Line #	Cost Center/Physician	Provi der	Adjusted RCE	RCE	Adjustment		
		l denti fi er	Component Share of col.	Limit	Di sal I owance			
			Share of col.					
	1. 00	2.00	15. 00	16. 00	17. 00	18. 00		
1. 00		OPERATI NG ROOM	13.00			899, 330		1. 00
2. 00		RESPI RATORY THERAPY	0	1		6, 437		2. 00
3. 00		EMERGENCY	0	1	_	15, 000		3. 00
4. 00		AMBULANCE SERVICES				15, 000		4. 00
5. 00	0.00	TIMBOLTHOE SERVI SES	0		o o	10,000		5. 00
6. 00	0.00					0		6. 00
7. 00	0.00		1 0		n n	l o		7. 00
8. 00	0.00) n		8.00
9. 00	0.00		0		n n	l o		9. 00
10. 00	0.00		Ö		n n	l o		10.00
200.00]		l ő	•	24, 459	935, 767		200.00
	ı !		1	/			ı	

| Peri od: | Worksheet B | From 01/01/2014 | Part | To 12/31/2014 | Date/Time Prepared: | To 12/31/2014 | Da Health Financial Systems
COST ALLOCATION - GENERAL SERVICE COSTS HUNTINGTON MEMORIAL HOSPITAL Provi der CCN: 150091

					To	12/31/2014	Date/Time Pre 5/22/2015 11:	
				CAPI TAL REI	ATED COSTS		3/22/2013 11.	20 aiii
			_					
		Cost Center Description	Net Expenses	BLDG & FIXT	MVBLE EQUIP	EMPLOYEE	Subtotal	
			for Cost Allocation			BENEFITS DEPARTMENT		
			(from Wkst A			DEI AKTIMENT		
			col . 7)					
	OENED	AL CERVILOR COCT CENTERS	0	1. 00	2. 00	4. 00	4A	
1. 00		AL SERVICE COST CENTERS CAP REL COSTS-BLDG & FIXT	435, 744	435, 744				1. 00
2.00	1	CAP REL COSTS-BUBG & TTXT	1, 711, 911	435, 744	1, 711, 911			2. 00
4.00	1	EMPLOYEE BENEFITS DEPARTMENT	2, 777, 513	493		2, 778, 006		4. 00
5.00	00500	ADMINISTRATIVE & GENERAL	10, 708, 202	28, 699	38, 867	895, 784	11, 671, 552	5. 00
6.00		MAINTENANCE & REPAIRS	0	0	0	0	0	6. 00
7.00	1	OPERATION OF PLANT	1, 139, 700	114, 608		54, 860	1, 361, 542	7. 00
8. 00 9. 00		LAUNDRY & LINEN SERVICE HOUSEKEEPING	189, 094 393, 433	2, 350 1, 913		5, 020 49, 957	196, 464 445, 303	8. 00 9. 00
10. 00		DI ETARY	169, 879			13, 253	212, 220	
11. 00		CAFETERI A	177, 483			38, 409	220, 039	
12. 00	1	MAINTENANCE OF PERSONNEL	0	0		0	0	12. 00
13.00		NURSING ADMINISTRATION CENTRAL SERVICES & SUPPLY	182, 776		-	30, 920	213, 696	13.00
14. 00 15. 00		PHARMACY	-512, 098	7, 118 4, 316		87, 183	7, 118 -238, 572	14. 00 15. 00
16. 00		MEDICAL RECORDS & LIBRARY	0 0	2, 384		07, 103	2, 384	16. 00
17. 00	1	SOCIAL SERVICE	0	0		o	0	17. 00
19. 00	1	NONPHYSICIAN ANESTHETISTS	0	0	0	0	0	19. 00
20.00		NURSING SCHOOL	0	0	0	0	0	20.00
21. 00 22. 00		I&R SERVICES-SALARY & FRINGES APPRV I&R SERVICES-OTHER PRGM COSTS APPRV	0	0	0	0	0	21. 00 22. 00
23. 00	1	PARAMED ED PRGM-(SPECIFY)	o o	0		ő	0	23. 00
		IENT ROUTINE SERVICE COST CENTERS						
30.00		ADULTS & PEDIATRICS	2, 749, 063			430, 835	3, 506, 297	30. 00
43. 00		NURSERY	27, 696	381	0	4, 313	32, 390	43. 00
50. 00		LARY SERVICE COST CENTERS OPERATING ROOM	436, 294	35, 809	170, 629	158, 383	801, 115	50. 00
52. 00	1	DELIVERY ROOM & LABOR ROOM	648, 082	0		100, 932	749, 014	52. 00
53.00	05300	ANESTHESI OLOGY	913, 802	0	0	0	913, 802	53. 00
54.00		RADI OLOGY-DI AGNOSTI C	1, 321, 275			154, 616	2, 032, 755	
60.00	1	LABORATORY	2, 072, 482	6, 800		0	2, 079, 282	60.00
62. 30 65. 00		BLOOD CLOTTING FOR HEMOPHILIACS RESPIRATORY THERAPY	706, 291	0 5, 029		111, 755	0 893, 059	62. 30 65. 00
66. 00		PHYSI CAL THERAPY	-148, 990			163, 993	71, 683	66. 00
68. 00		SPEECH PATHOLOGY	0	0		o	0	68. 00
69. 00	1	ELECTROCARDI OLOGY	0	0	0	0	0	69. 00
71. 00 72. 00		MEDICAL SUPPLIES CHARGED TO PATIENT IMPL. DEV. CHARGED TO PATIENTS	755, 435		0	0	755, 435	
72.00	1	DRUGS CHARGED TO PATIENTS	814, 226 1, 510, 090		0	11, 689	814, 226 1, 521, 779	72. 00 73. 00
76. 97		CARDI AC REHABI LI TATI ON	0	0	o o	0	0	76. 97
76. 98	07698	HYPERBARI C OXYGEN THERAPY	0	0	0	o	0	76. 98
76. 99		LI THOTRI PSY	0	0	0	0	0	76. 99
91. 00		TIENT SERVICE COST CENTERS EMERGENCY	1, 149, 051	19, 130	70, 586	180, 116	1, 418, 883	91. 00
92. 00		OBSERVATION BEDS (NON-DISTINCT PART	1, 147, 031	17, 130	70, 300	100, 110	1, 410, 003	
	OTHER	REIMBURSABLE COST CENTERS						
95. 00		AMBULANCE SERVI CES	1, 677, 532	13, 268	326, 839	256, 254	2, 273, 893	95. 00
112 00		AL PURPOSE COST CENTERS INTEREST EXPENSE						113. 00
118.00		SUBTOTALS (SUM OF LINES 1-117)	32, 005, 966	434, 713	1, 692, 069	2, 748, 272	31, 955, 359	
		IMBURSABLE COST CENTERS	02/000/700	101,710	1,072,007	2/ / 10/ 2 / 2	01,700,007	
	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0		0	0	190. 00
		PHYSICIANS' PRIVATE OFFICES	94, 688	0	19, 842	11, 934	126, 464	
		OCC HEALTH PAIN CLINIC	0	1, 031	0	0		194. 00 194. 01
	1	OCC HEALTH	0	0	0	o		194. 01
		FOUNDATI O	85, 478	0	Ō	ō	85, 478	
		KIDS CAMPUS	0	0	0	o		194. 04
	1	COMMUNITY & VOLUNTEER SERVICES	376, 878	0	0	7, 514	384, 392	
		HUNTINGTON COLLEGE NURSE MISC CATERING	0 100, 312	0	0	0 10, 286	0 110, 598	194. 06 194. 07
		AUTISM CENTER	-54, 739	0	0	10, 280	-54, 739	
		HUNTI NGTON BUA	0	0		o	0	194. 09
200.00		Cross Foot Adjustments				ļ		200. 00
201.00	1	Negative Cost Centers	22 400 502	0	1 711 011	2 779 004	0 32, 608, 583	201. 00
202.00	'I	TOTAL (sum lines 118-201)	32, 608, 583	435, 744	1, 711, 911	2, 778, 006	32, 000, 383	202.00

Provider CCN: 150091

				1	0 12/31/2014	Date/Time Pre 5/22/2015 11:	
	Cost Center Description	ADMI NI STRATI VE		OPERATION OF	LAUNDRY &	HOUSEKEEPI NG	
		& GENERAL	REPAI RS	PLANT	LINEN SERVICE	0.00	
	GENERAL SERVICE COST CENTERS	5. 00	6. 00	7. 00	8. 00	9. 00	
1.00	00100 CAP REL COSTS-BLDG & FLXT			I			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	11, 671, 552					5. 00
6.00	00600 MAINTENANCE & REPAIRS	0	0				6. 00
7.00	00700 OPERATION OF PLANT	748, 519		2, 110, 061			7. 00
8. 00	00800 LAUNDRY & LINEN SERVICE	108, 008		16, 986			8. 00
9.00	00900 HOUSEKEEPI NG	244, 809		13, 827		711, 833	1
10.00	01000 DI ETARY	116, 670		132, 108		45, 227	1
11. 00	01100 CAFETERI A	120, 968	0	29, 976 0		10, 262 0	1
12. 00 13. 00	01200 MAI NTENANCE OF PERSONNEL 01300 NURSI NG ADMI NI STRATI ON	117, 481			0	0	
14. 00		3, 913		51, 444	4, 890		
15. 00	01500 PHARMACY	0,719		31, 191		10, 678	1
16. 00	01600 MEDICAL RECORDS & LIBRARY	1, 311	0	17, 229		5, 898	1
17. 00	01700 SOCI AL SERVI CE	0	Ö	0	0	0	1
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		0	0	0	0	0	
23. 00	. ,	0	0	0	0	0	23. 00
20.00	NPATIENT ROUTINE SERVICE COST CENTERS 03000 ADULTS & PEDIATRICS	1 007 /17	1 0	(70.445	114 200	222 (10	20.00
30. 00 43. 00		1, 927, 617 17, 807			•	232, 610 943	1
43.00	ANCI LLARY SERVI CE COST CENTERS	17,607		2,755	2,044	943	43.00
50. 00	05000 OPERATING ROOM	440, 419	0	258, 816	42, 624	88, 606	50.00
52. 00	1	411, 776		1		0	1
53.00	05300 ANESTHESI OLOGY	502, 370	0	0	0	0	1
54.00	05400 RADI OLOGY-DI AGNOSTI C	1, 117, 523		324, 384	25, 590	111, 053	54. 00
60.00	06000 LABORATORY	1, 143, 102	0	49, 149	0	16, 826	60.00
62. 30	06250 BLOOD CLOTTING FOR HEMOPHILIACS	0	1	0	0	0	
65. 00	06500 RESPI RATORY THERAPY	490, 966		36, 349		12, 444	1
66. 00	06600 PHYSI CAL THERAPY	39, 408	0	224, 789	0	76, 957	1
68. 00	1	0	0	0	0	0	1
69. 00	06900 ELECTROCARDI OLOGY	415 204	0	0	0	0	
71. 00 72. 00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT 07200 IMPL. DEV. CHARGED TO PATIENTS	415, 306 447, 627			0	0	
73. 00		836, 610			0	0	
76. 97	07697 CARDI AC REHABI LI TATI ON	030,010			0	0	
76. 98	07698 HYPERBARI C OXYGEN THERAPY	o o	1	Ö	0	Ö	1
76. 99	07699 LI THOTRI PSY	0	0	0	0	0	
	OUTPATIENT SERVICE COST CENTERS						
91. 00		780, 042	0	138, 265	82, 850	47, 335	
92. 00							92. 00
05.00	OTHER REIMBURSABLE COST CENTERS	4 050 004	1	I 05 005		20.000	05.00
95. 00	09500 AMBULANCE SERVI CES SPECI AL PURPOSE COST CENTERS	1, 250, 091	0	95, 895	6, 551	32, 830	95. 00
113 0	11300 INTEREST EXPENSE			1			113. 00
118. 00		11, 282, 343	0	2, 102, 608	316, 040	709, 281	
	NONREI MBURSABLE COST CENTERS	11/202/010		27 1027 000	0.070.10	7077201	1
190.00	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190. 00
	19200 PHYSI CLANS' PRI VATE OFFICES	69, 525	0	0	5, 418	0	192. 00
194.00	07950 OCC HEALTH	567		7, 453	0	2, 552	194. 00
	1 07951 PAIN CLINIC	0	0	0	0		194. 01
	2 07952 OCC HEALTH	0		0	0		194. 02
	3 07953 FOUNDATI 0	46, 992	0	0	0		194. 03
	4 07954 KIDS CAMPUS	0	0	0	0		194. 04
	5 07955 COMMUNITY & VOLUNTEER SERVICES	211, 323	0	0	0		194. 05
	6 07956 HUNTINGTON COLLEGE NURSE 7 07957 MISC CATERING	40.000			0		194. 06 194. 07
	BO7958 AUTISM CENTER	60, 802					194. 07
	907959 HUNTINGTON BUA				0		194. 08
200. 00	1						200.00
201.00		0	0	0	0	О	201.00
202.00		11, 671, 552	0	2, 110, 061	321, 458		202. 00

COST ALLOCATION - GENERAL SERVICE COSTS

Provi der CCN: 150091

Period: Worksheet B From 01/01/2014 Part I To 12/31/2014 Date/Time Prepared:

5/22/2015 11:28 am Cost Center Description DI ETARY CAFETERI A MAINTENANCE OF NURSI NG CENTRAL ADMI NI STRATI ON SERVICES & **PERSONNEL SUPPLY** 10.00 11.00 12.00 13.00 14.00 GENERAL SERVICE COST CENTERS 1.00 00100 CAP REL COSTS-BLDG & FIXT 1.00 00200 CAP REL COSTS-MVBLE EQUIP 2.00 2.00 4.00 00400 EMPLOYEE BENEFITS DEPARTMENT 4.00 5.00 00500 ADMINISTRATIVE & GENERAL 5.00 00600 MAINTENANCE & REPAIRS 6.00 6.00 7.00 00700 OPERATION OF PLANT 7.00 00800 LAUNDRY & LINEN SERVICE 8.00 8 00 9.00 00900 HOUSEKEEPI NG 9.00 10.00 01000 DI ETARY 506, 225 10.00 01100 CAFETERI A 11.00 381, 245 11.00 01200 MAINTENANCE OF PERSONNEL 12.00 0 12.00 13.00 01300 NURSING ADMINISTRATION 0 5,746 336, 923 13.00 14.00 01400 CENTRAL SERVICES & SUPPLY 84, 977 14.00 01500 PHARMACY 0 15.00 0 0 1, 330 15.00 11, 266 01600 MEDICAL RECORDS & LIBRARY 16.00 0 Ω 16.00 17.00 01700 SOCIAL SERVICE 0 17.00 0 0 01900 NONPHYSICIAN ANESTHETISTS 0 0 0 0 0 19.00 19.00 0 02000 NURSING SCHOOL 20 00 C Ω 20.00 21.00 02100 I&R SERVICES-SALARY & FRINGES APPRV 0 0 21.00 02200 | &R SERVICES-OTHER PRGM COSTS APPRV 0 0 22.00 0 0 22.00 02300 PARAMED ED PRGM-(SPECIFY) 23.00 23.00 0 0 INPATIENT ROUTINE SERVICE COST CENTERS 30.00 03000 ADULTS & PEDIATRICS 506, 225 94, 336 0 167, 487 6, 182 30.00 04300 NURSERY 43.00 907 0 1, 610 0 43.00 0 ANCILLARY SERVICE COST CENTERS 50.00 05000 OPERATING ROOM 33, 816 0 60,038 9,597 50.00 05200 DELIVERY ROOM & LABOR ROOM 0 0 37, 696 52.00 21, 232 0 52.00 0 53.00 05300 ANESTHESI OLOGY 0 0 53.00 0 05400 RADI OLOGY-DI AGNOSTI C 0 54.00 33, 088 0 1,860 54.00 0 60.00 06000 LABORATORY 0 60.00 06250 BLOOD CLOTTING FOR HEMOPHILIACS 0 62.30 00000000 0 0 62.30 26, 506 65 00 06500 RESPIRATORY THERAPY 0 2 378 65 00 0 06600 PHYSI CAL THERAPY 66.00 29,600 933 66.00 06800 SPEECH PATHOLOGY 0 0 68.00 68.00 C 0 0 69.00 06900 ELECTROCARDI OLOGY 0 69.00 0 07100 MEDICAL SUPPLIES CHARGED TO PATIENT 0 53, 550 71 00 Ω 71 00 0 72.00 07200 IMPL. DEV. CHARGED TO PATIENTS C 0 0 72.00 07300 DRUGS CHARGED TO PATIENTS 73.00 1.241 73.00 0 76.97 07697 CARDIAC REHABILITATION 0 0 0 0 76.97 07698 HYPERBARI C OXYGEN THERAPY 0 76. 98 76.98 0 0 76. 99 07699 LI THOTRI PSY 0 76.99 0 OUTPATIENT SERVICE COST CENTERS 91.00 70, 092 3, 817 91.00 09100 EMERGENCY 0 39, 478 0 09200 OBSERVATION BEDS (NON-DISTINCT PART 92.00 92.00 OTHER REIMBURSABLE COST CENTERS 95.00 09500 AMBULANCE SERVICES 0 71, 820 0 0 95.00 SPECIAL PURPOSE COST CENTERS 113.00 11300 INTEREST EXPENSE 113.00 SUBTOTALS (SUM OF LINES 1-117) 506, 225 367, 795 0 336, 923 80, 891 118. 00 118.00 NONREI MBURSABLE COST CENTERS 3, 635 190. 00 190.00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN 0 0 192. 00 19200 PHYSICIANS' PRIVATE OFFICES 0 3, 750 0 451 192. 00 194.00 07950 OCC HEALTH 0 0 0 0 194.00 0 0 194. 01 07951 PAIN CLINIC 0 194. 01 0 C 0 0 194. 02 194. 02 07952 OCC HEALTH 194. 03 07953 FOUNDATIO 0 0 0 0 0 0 0 0 194. 03 2, 245 194. 04 07954 KIDS CAMPUS 0 194. 04 194. 05 07955 COMMUNITY & VOLUNTEER SERVICES 0 194, 05 2, 386 0 194.06 07956 HUNTI NGTON COLLEGE NURSE 0 0 194. 06 194.07 07957 MISC CATERING 0 5,069 0 0 194. 07 0 0 194.08 07958 AUTISM CENTER 0 0 194. 08 194. 09 07959 HUNTI NGTON BUA 0 0 0 0 194.09 C 200.00 Cross Foot Adjustments 200.00 201.00 Negative Cost Centers 0 0 201.00 TOTAL (sum lines 118-201) 202.00 506, 225 381, 245 0 336, 923 84, 977 202, 00

Provi der CCN: 150091

| Period: | Worksheet B | From 01/01/2014 | Part I | Date/Time Prepared: | 5/22/2015 | 11: 28 am

				'		5/22/2015 11:	28 am
	Cost Center Description	PHARMACY	RECORDS &	SOCIAL SERVICE	NONPHYSI CI AN ANESTHETI STS	NURSING SCHOOL	
		15. 00	16. 00	17. 00	19. 00	20.00	
	GENERAL SERVICE COST CENTERS	13.00	10.00	17.00	17.00	20.00	
1. 00 2. 00 4. 00 5. 00 6. 00 7. 00 8. 00 9. 00 11. 00 12. 00 13. 00 14. 00	00100 CAP REL COSTS-BLDG & FIXT 00200 CAP REL COSTS-MVBLE EQUIP 00400 EMPLOYEE BENEFITS DEPARTMENT 00500 ADMINISTRATIVE & GENERAL 00600 MAINTENANCE & REPAIRS 00700 OPERATION OF PLANT 00800 LAUNDRY & LINEN SERVICE 00900 HOUSEKEEPING 01000 DIETARY 01100 CAFETERIA 01200 MAINTENANCE OF PERSONNEL 01300 NURSING ADMINISTRATION 01400 CENTRAL SERVICES & SUPPLY 01500 PHARMACY	-184, 107					1. 00 2. 00 4. 00 5. 00 6. 00 7. 00 8. 00 9. 00 10. 00 11. 00 12. 00 13. 00 14. 00
16. 00 17. 00	01600 MEDI CAL RECORDS & LI BRARY 01700 SOCI AL SERVI CE	0	26, 822				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	0 0 0 0 0	0 0 0 0 0	0 0 0	0 0 0 0	0 0 0 0	17. 00 19. 00 20. 00 21. 00 22. 00 23. 00
30. 00 43. 00	03000 ADULTS & PEDIATRICS	0	1, 754 155				30. 00 43. 00
43.00	ANCILLARY SERVICE COST CENTERS	<u> </u>	133				43.00
50. 00 52. 00 53. 00 54. 00 60. 00 62. 30	05000 OPERATING ROOM 05200 DELIVERY ROOM & LABOR ROOM 05300 ANESTHESI OLOGY 05400 RADI OLOGY-DI AGNOSTI C 06000 LABORATORY 06250 BLOOD CLOTTING FOR HEMOPHILIACS	0 0 0	3, 596 588 461 6, 067 2, 624		0	0 0 0 0 0 0 0 0 0	50. 00 52. 00 53. 00 54. 00 60. 00 62. 30
65. 00 66. 00 68. 00 69. 00	06500 RESPI RATORY THERAPY 06600 PHYSI CAL THERAPY 06800 SPEECH PATHOLOGY 06900 ELECTROCARDI OLOGY	0 0 0 0	967 619 3 121	0	0 0 0	0 0 0 0	65. 00 66. 00 68. 00 69. 00
71. 00 72. 00 73. 00 76. 97 76. 98 76. 99	07200 IMPL. DEV. CHARGED TO PATIENTS 07300 DRUGS CHARGED TO PATIENTS 07697 CARDIAC REHABILITATION 07698 HYPERBARIC OXYGEN THERAPY	0 0 0	1, 879 1, 080 2, 532 0 0	0	0	0 0 0 0 0 0 0 0 0	71. 00 72. 00 73. 00 76. 97 76. 98 76. 99
70. 77	OUTPATIENT SERVICE COST CENTERS	<u> </u>	0				70.77
91. 00 92. 00	09200 OBSERVATION BEDS (NON-DISTINCT PART	0	3, 177	0	0	0	91. 00 92. 00
95. 00	OTHER REIMBURSABLE COST CENTERS 09500 AMBULANCE SERVICES	0	1, 199	0	0	0	95. 00
	SPECIAL PURPOSE COST CENTERS 11300 INTEREST EXPENSE						113. 00
118.00	NONREI MBURSABLE COST CENTERS	0	26, 822		-		118. 00
192.00	D 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN D 19200 PHYSICIANS' PRIVATE OFFICES D 07950 OCC HEALTH	0 0	0	0 0	0	0	190. 00 192. 00 194. 00
194. 01	1 07951 PAIN CLINIC	0	0	O	0	0	194. 01
	2 07952 0CC	0	0	0	_		194. 02 194. 03
194. 04	4 07954 KIDS CAMPUS	0	0	0	0	0	194. 04
	5 07955 COMMUNITY & VOLUNTEER SERVICES 6 07956 HUNTINGTON COLLEGE NURSE	0	0	0	0		194. 05 194. 06
194. 07	7 07957 MISC CATERING	o o	0	Ö	Ö	0	194. 07
	B 07958 AUTI SM CENTER 9 07959 HUNTI NGTON BUA	0	0	0	0		194. 08 194. 09
200. 00			0		0	0	200. 00
201.00 202.00		-184, 107 -184, 107	0 26, 822	0			201. 00 202. 00
						-	-

In Lieu of Form CMS-2552-10
Worksheet B
01/2014 Part I
01/2014 Date/Time Prepared:
05/22/2015 11: 28 am Health Financial Systems
COST ALLOCATION - GENERAL SERVICE COSTS HUNTINGTON MEMORIAL HOSPITAL Provi der CCN: 150091 Peri od: From 01/01/2014 To 12/31/2014 INTERNS & RESIDENTS

APPRV APPRV	Intern & Jesi dents Cost & Post Stepdown Adjustments 25.00	
GENERAL SERVICE COST CENTERS		_
1.00	1. 00 2. 00 4. 00	0
5. 00 00500 ADMI NI STRATI VE & GENERAL 6. 00 00600 MAI NTENANCE & REPAI RS	5. 0	0
7. 00 00700 OPERATION OF PLANT 8. 00 00800 LAUNDRY & LI NEN SERVI CE	7. 0	0
9. 00 00900 HOUSEKEEPI NG 10. 00 01000 DI ETARY	9.00	0
11. 00 01100 DIETARY	11. 0	
12. 00 01200 MAI NTENANCE OF PERSONNEL	12. 0	
13. 00 01300 NURSI NG ADMI NI STRATI ON 14. 00 01400 CENTRAL SERVI CES & SUPPLY	13.00	
15. 00 01500 PHARMACY	15. 0	
16. 00 01600 MEDI CAL RECORDS & LI BRARY	16. 0	0
17. 00 01700 SOCI AL SERVI CE	17. 0	
19. 00 01900 NONPHYSI CI AN ANESTHETI STS 20. 00 02000 NURSI NG SCHOOL	19. 00	
21. 00 02100 1 &R SERVI CES-SALARY & FRI NGES APPRV 0	21. 0	
22. 00 02200 1 &R SERVI CES-OTHER PRGM COSTS APPRV 0 0 0	22. 0	
23. 00 02300 PARAMED ED PRGM-(SPECIFY) 0 0 0 0 1 1 1 1 1 1	23. 0	J
30. 00 03000 ADULTS & PEDI ATRI CS 0 0 7, 236, 252	0 30.0	0
43. 00 04300 NURSERY 0 0 58, 611	0 43.0	O
ANCI LLARY SERVI CE COST CENTERS	0 50.00	Ω
52. 00 05200 DELI VERY ROOM & LABOR ROOM 0 0 1, 235, 060	0 52.0	
53. 00 05300 ANESTHESI OLOGY 0 0 1, 416, 633	0 53.0	
54. 00 05400 RADI 0LOGY-DI AGNOSTI C	0 54. 0 0 60. 0	
62. 30 06250 BLOOD CLOTTING FOR HEMOPHILIACS 0 0 0 0	0 62.3	
65. 00 06500 RESPI RATORY THERAPY 0 0 1, 477, 213	0 65.0	
66. 00 06600 PHYSI CAL THERAPY	0 66. 0 0 68. 0	
69. 00 06900 ELECTROCARDI OLOGY 0 0 121	0 69.0	
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT 0 0 1, 226, 170	0 71.0	
72. 00 07200 IMPL. DEV. CHARGED TO PATIENTS 0 0 0 1, 262, 933 73. 00 07300 DRUGS CHARGED TO PATIENTS 0 0 0 2, 362, 162	0 72.00 0 73.00	
73. 00 07300 DRUGS CHARGED TO PATIENTS 0 0 0 2, 362, 162 76. 97 07697 CARDI AC REHABILITATION 0 0 0 0	0 76. 9	
76. 98 07698 HYPERBARI C 0XYGEN THERAPY 0 0 0 0	0 76. 9	
76. 99 07699 LI THOTRI PSY 0 0 0 0	0 76. 9	9
OUTPATI ENT SERVI CE COST CENTERS 91.00 09100 EMERGENCY 0 0 0 2,583,939	0 91.0	0
92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART	0 92.0	
OTHER REI MBURSABLE COST CENTERS 95. 00 09500 AMBULANCE SERVI CES 0 0 0 3, 732, 279	0 95.0	^
SPECIAL PURPOSE COST CENTERS	0 95.0	J
113. 00 11300 I NTEREST EXPENSE	113. 0	
118. 00 SUBTOTALS (SUM OF LINES 1-117) 0 0 31, 717, 298	0 118. 0	O
NONREI MBURSABLE COST CENTERS 190. 00 19000 GI FT, FLOWER, COFFEE SHOP & CANTEEN 0 0 3,635	0 190. 0	0
192. 00 19200 PHYSI CI ANS' PRI VATE OFFI CES 0 0 205, 608	0 192. 0	
194. 00 07950 OCC HEALTH 0 0 11, 603	0 194. 0	
194. 01 07951 PAIN CLINIC 0 0 0 0 194. 02 07952 OCC HEALTH 0 0 0 0	0 194. 0 0 194. 0	
194. 03 07953 FOUNDATI 0 0 0 134, 715	0 194. 0	
194. 04 07954 KI DS CAMPUS 0 0 0	0 194. 0	
194. 05 07955 COMMUNI TY & VOLUNTEER SERVICES 0 0 598, 101 194. 06 07956 HUNTI NGTON COLLEGE NURSE 0 0 0 0	0 194. 0 0 194. 0	
194. 00 0 7950 HONTT NGTON COLLEGE NORSE 0 0 0 176, 469	0 194. 0	7
194. 08 07958 AUTISM CENTER 0 0 -54, 739	0 194. 0	8
194.09 07959 HUNTI NGTON BUA 0 0 0 200.00 Cross Foot Adjustments 0 0 0	0 194. 0 0 200. 0	
201.00 Cross Foot Adjustments	0 201. 0	
202.00 TOTAL (sum lines 118-201) 0 0 32,608,583	0 202. 0	

| Peri od: | Worksheet B | From 01/01/2014 | Part | To 12/31/2014 | Date/Time Prepared: | To 12/31/2014 | Da Health Financial Systems
COST ALLOCATION - GENERAL SERVICE COSTS Provi der CCN: 150091

			5/22/2015 11	
	Cost Center Description	Total	372272013 11	. 20 am
		26. 00		
-	GENERAL SERVICE COST CENTERS			
1	00100 CAP REL COSTS-BLDG & FIXT			1. 00
1	00200 CAP REL COSTS-MVBLE EQUIP			2. 00
1	00400 EMPLOYEE BENEFITS DEPARTMENT			4. 00
1	00500 ADMINISTRATIVE & GENERAL			5. 00
1	00600 MAI NTENANCE & REPAI RS			6.00
1	00700 OPERATION OF PLANT			7. 00 8. 00
	DO800 LAUNDRY & LINEN SERVICE DO900 HOUSEKEEPING			9.00
1	01000 DI ETARY			10.00
1	01100 CAFETERI A			11. 00
1	01200 MAINTENANCE OF PERSONNEL			12. 00
1	01300 NURSI NG ADMI NI STRATI ON			13. 00
1	01400 CENTRAL SERVICES & SUPPLY			14. 00
1	01500 PHARMACY			15. 00
1	01600 MEDICAL RECORDS & LIBRARY			16. 00
1	01700 SOCIAL SERVICE			17. 00
19.00	01900 NONPHYSICIAN ANESTHETISTS			19. 00
20.00	D2000 NURSING SCHOOL			20. 00
21.00	02100 I&R SERVICES-SALARY & FRINGES APPRV			21. 00
22. 00	02200 I&R SERVICES-OTHER PRGM COSTS APPRV			22. 00
23. 00	D2300 PARAMED ED PRGM-(SPECIFY)			23. 00
	NPATIENT ROUTINE SERVICE COST CENTERS			
30.00	D3000 ADULTS & PEDIATRICS	7, 236, 252		30.00
	04300 NURSERY	58, 611		43. 00
	ANCILLARY SERVICE COST CENTERS			
1	05000 OPERATING ROOM	1, 738, 627		50. 00
	D5200 DELIVERY ROOM & LABOR ROOM	1, 235, 060		52. 00
	D5300 ANESTHESI OLOGY	1, 416, 633		53. 00
1	05400 RADI OLOGY-DI AGNOSTI C	3, 652, 320		54.00
1	06000 LABORATORY	3, 290, 986		60.00
	06250 BLOOD CLOTTING FOR HEMOPHILIACS	0		62. 30
1	06500 RESPI RATORY THERAPY	1, 477, 213		65. 00
1	06600 PHYSI CAL THERAPY 06800 SPEECH PATHOLOGY	443, 989		66. 00 68. 00
1	06900 ELECTROCARDI OLOGY	121		69.00
1	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	1, 226, 170		71.00
1	07200 IMPL. DEV. CHARGED TO PATIENTS	1, 262, 933		72.00
1	07300 DRUGS CHARGED TO PATIENTS	2, 362, 162		73. 00
1	07697 CARDI AC REHABI LI TATI ON	0		76. 97
1	07698 HYPERBARI C OXYGEN THERAPY	0		76. 98
1	07699 LI THOTRI PSY	O		76. 99
C	DUTPATIENT SERVICE COST CENTERS			
91.00	09100 EMERGENCY	2, 583, 939		91. 00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART			92. 00
	OTHER REIMBURSABLE COST CENTERS			
_	09500 AMBULANCE SERVICES	3, 732, 279		95. 00
	SPECIAL PURPOSE COST CENTERS			
	11300 INTEREST EXPENSE			113. 00
118. 00	SUBTOTALS (SUM OF LINES 1-117)	31, 717, 298		118. 00
	NONREI MBURSABLE COST CENTERS			
	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	3, 635		190. 00
1	19200 PHYSI CLANS' PRI VATE OFFI CES	205, 608		192. 00
	07950 OCC HEALTH	11, 603		194. 00
	07951 PAIN CLINIC	0		194. 01
	07952 OCC HEALTH	124 715		194. 02
	07953 FOUNDATIO 07954 KIDS CAMPUS	134, 715		194. 03 194. 04
	07955 COMMUNITY & VOLUNTEER SERVICES	598, 101		194. 04
1	07956 HUNTI NGTON COLLEGE NURSE	070, 101		194. 05
	07956 HUNTINGTON COLLEGE NURSE	176, 469		194. 06
	07957 MISC CATERING	-54, 739		194. 07
1	07959 HUNTI NGTON BUA	-54, 739		194. 06
200. 00	Cross Foot Adjustments			200. 00
201.00	Negative Cost Centers	-184, 107		201.00
202.00	TOTAL (sum lines 118-201)	32, 608, 583		202. 00
		,		,

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

				To	12/31/2014	Date/Time Pre	
			CAPI TAL REI	LATED COSTS		5/22/2015 11:	20 4111
		D: 11	DI DO A FLYT	MVDLE FOULD		EMDL OVEE	
	Cost Center Description	Directly Assigned New	BLDG & FIXT	MVBLE EQUIP	Subtotal	EMPLOYEE BENEFITS	
		Capi tal				DEPARTMENT	
		Related Costs	1.00	2.22			
	GENERAL SERVICE COST CENTERS	0	1. 00	2.00	2A	4. 00	
	00100 CAP REL COSTS-BLDG & FLXT						1.00
	00200 CAP REL COSTS-MVBLE EQUIP						2. 00
	00400 EMPLOYEE BENEFITS DEPARTMENT	0	493		493	493	4.00
	00500 ADMINISTRATIVE & GENERAL 00600 MAINTENANCE & REPAIRS	2, 013, 291	28, 699 0		2, 080, 857	162 0	5. 00 6. 00
	00700 OPERATION OF PLANT	0	114, 608		166, 982	10	•
	00800 LAUNDRY & LINEN SERVICE	0	2, 350		2, 350	1	8. 00
	00900 HOUSEKEEPI NG	0	1, 913	1	1, 913	9	9.00
	01000 DI ETARY 01100 CAFETERI A	0	18, 278 4, 147		29, 088 4, 147	2	10. 00 11. 00
	01200 MAINTENANCE OF PERSONNEL	0	0	1	0	0	12.00
	01300 NURSING ADMINISTRATION	0	0		o	5	13. 00
	01400 CENTRAL SERVICES & SUPPLY	0	7, 118	1	7, 118	0	14.00
	01500 PHARMACY 01600 MEDICAL RECORDS & LIBRARY	0	4, 316 2, 384		186, 343 2, 384	15 0	15. 00 16. 00
	01700 SOCIAL SERVICE	Ö	0	1	2, 33 1	0	17. 00
	01900 NONPHYSICIAN ANESTHETISTS	0	0	0	o	0	19. 00
	02000 NURSING SCHOOL	0	0	0	0	0	20.00
	D2100 &R SERVICES-SALARY & FRINGES APPRV D2200 &R SERVICES-OTHER PRGM COSTS APPRV	0) 0	0	0	0	21. 00 22. 00
	02300 PARAMED ED PRGM-(SPECIFY)	0	0	ő	o	0	23. 00
	NPATIENT ROUTINE SERVICE COST CENTERS						
	03000 ADULTS & PEDIATRICS 04300 NURSERY	0		232, 392	326, 399 381	75 1	30. 00 43. 00
	NCILLARY SERVICE COST CENTERS	U	381	<u> </u>	301]	<u></u>	43.00
	D5000 OPERATING ROOM	0	35, 809	170, 629	206, 438	28	50. 00
	D5200 DELIVERY ROOM & LABOR ROOM	0	0	0	0	18	ł
	D5300 ANESTHESI OLOGY D5400 RADI OLOGY-DI AGNOSTI C	0	0 44, 881	511, 983	0 556, 864	0 27	53. 00 54. 00
	06000 LABORATORY	0	6, 800		6, 800	0	60.00
62. 30 C	06250 BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0	o	0	62. 30
	06500 RESPI RATORY THERAPY	0	5, 029		75, 013	20	1
	06600 PHYSI CAL_THERAPY 06800 SPEECH_PATHOLOGY	0	31, 102 0	1	56, 680 0	29 0	66. 00 68. 00
	06900 ELECTROCARDI OLOGY	0	Ö		o	0	69.00
	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	o	0	71. 00
	07200 IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
	07300 DRUGS CHARGED TO PATIENTS 07697 CARDIAC REHABILITATION	0	0	0	0	2	73. 00 76. 97
	07698 HYPERBARI C OXYGEN THERAPY	0	0	0	o	0	76. 98
_	07699 LI THOTRI PSY	0	0	0	o	0	76. 99
	DUTPATIENT SERVICE COST CENTERS D9100 EMERGENCY		10 120	70 50/	00.71/	32	01 00
91. 00 C	09200 OBSERVATION BEDS (NON-DISTINCT PART	0	19, 130	70, 586	89, 716 0	32	91. 00 92. 00
	OTHER REIMBURSABLE COST CENTERS			<u> </u>	<u>~</u>		72.00
	09500 AMBULANCE SERVI CES	0	13, 268	326, 839	340, 107	45	95. 00
	SPECIAL PURPOSE COST CENTERS						113. 00
118. 00	SUBTOTALS (SUM OF LINES 1-117)	2, 013, 291	434, 713	1, 692, 069	4, 140, 073	488	118. 00
	IONREI MBURSABLE COST CENTERS	=/ = / =	,	., ., ., .,	.,		
	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0		0		190. 00
	19200 PHYSICIANS' PRIVATE OFFICES 07950 OCC HEALTH	0	0 1, 031		19, 842 1, 031		192. 00 194. 00
	07951 PAIN CLINIC	0	1,031	0	1, 031		194. 00
194. 02 C	07952 OCC HEALTH	0	0	O	ō	0	194. 02
	07953 FOUNDATIO	0	0	0	0		194. 03
	07954 KIDS CAMPUS 07955 COMMUNITY & VOLUNTEER SERVICES	0	0	0	0		194. 04 194. 05
	07956 HUNTINGTON COLLEGE NURSE	0	0		0		194. 05
194. 07 C	07957 MISC CATERING	0	O	0	ō	2	194. 07
	07958 AUTI SM CENTER	0	0	0	O		194. 08
194. 09 C 200. 00	07959 HUNTINGTON BUA Cross Foot Adjustments	0	0	0	0	0	194. 09 200. 00
200.00	Negative Cost Centers		О	o	ol	0	200.00
202. 00	TOTAL (sum lines 118-201)	2, 013, 291	435, 744	1, 711, 911	4, 160, 946	493	202. 00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 150091

Period: Worksheet B From 01/01/2014 Part II To 12/31/2014 Date/Time Prepared:

5/22/2015 11:28 am Cost Center Description ADMINISTRATIVE MAINTENANCE & OPERATION OF LAUNDRY & HOUSEKEEPI NG & GENERAL REPAI RS **PLANT** LINEN SERVICE 7.00 9.00 5.00 6.00 8.00 GENERAL SERVICE COST CENTERS 1.00 1.00 00100 CAP REL COSTS-BLDG & FLXT 00200 CAP REL COSTS-MVBLE EQUIP 2.00 2.00 00400 EMPLOYEE BENEFITS DEPARTMENT 4.00 4.00 00500 ADMINISTRATIVE & GENERAL 5 00 2, 081, 019 5 00 6.00 00600 MAINTENANCE & REPAIRS 6.00 00700 OPERATION OF PLANT 300, 452 7.00 133, 460 7.00 8.00 00800 LAUNDRY & LINEN SERVICE 19.258 0 2, 419 24, 028 8.00 00900 HOUSEKEEPI NG 1.969 48, 130 9.00 43.649 0 590 9 00 10.00 01000 DI ETARY 20, 802 18,811 3,058 10.00 11.00 01100 CAFETERI A 21, 568 4, 268 0 694 11.00 01200 MAINTENANCE OF PERSONNEL 12.00 12 00 0 C0 0 13.00 01300 NURSING ADMINISTRATION 20, 947 0 13.00 14.00 01400 CENTRAL SERVICES & SUPPLY 698 7, 325 366 1, 191 14.00 01500 PHARMACY 15.00 4.441 0 15.00 0 722 01600 MEDICAL RECORDS & LIBRARY 16.00 234 0 2.453 399 16.00 17.00 01700 SOCIAL SERVICE 0 0 C 0 0 17.00 01900 NONPHYSICIAN ANESTHETISTS 0 0 19 00 0 0 19.00 0 02000 NURSING SCHOOL 20.00 0 0 0 20.00 0 02100 I&R SERVICES-SALARY & FRINGES APPRV 0 21.00 0 Ω 0 0 21.00 02200 I&R SERVICES-OTHER PRGM COSTS APPRV 22.00 0 22.00 02300 PARAMED ED PRGM-(SPECIFY) 23.00 23.00 INPATIENT ROUTINE SERVICE COST CENTERS 30.00 03000 ADULTS & PEDIATRICS 343, 691 0 96, 747 8.542 15, 726 30.00 43.00 04300 NURSERY 3, 175 0 392 153 64 43.00 ANCILLARY SERVICE COST CENTERS 05000 OPERATING ROOM 5, 991 50.00 78.526 36, 853 3.186 50.00 52.00 05200 DELIVERY ROOM & LABOR ROOM 73, 419 0 1, 103 0 52.00 05300 ANESTHESI OLOGY 89, 572 53.00 0 53.00 54.00 05400 RADI OLOGY-DI AGNOSTI C 199, 253 0 46, 189 1. 913 7.509 54.00 06000 LABORATORY 0 6, 998 60.00 203, 813 1, 138 60.00 0 62.30 06250 BLOOD CLOTTING FOR HEMOPHILIACS 0 62.30 06500 RESPIRATORY THERAPY 65.00 87, 539 5, 176 1,087 841 65.00 66 00 06600 PHYSI CAL THERAPY 7.026 32,008 5 203 66 00 0 06800 SPEECH PATHOLOGY 68.00 0 C 0 0 68.00 06900 ELECTROCARDI OLOGY 0 0 0 69.00 69.00 0 71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT 74.048 0 0 71.00 0 07200 IMPL. DEV. CHARGED TO PATIENTS 0 0 72.00 79,811 0 0 72.00 149, 166 73.00 07300 DRUGS CHARGED TO PATIENTS 0 0 0 0 73.00 07697 CARDIAC REHABILITATION 0 76. 97 0 0 76.97 76 98 07698 HYPERBARI C OXYGEN THERAPY C 0 0 76. 98 0 0 07699 LI THOTRI PSY 76.99 C 0 76.99 OUTPATIENT SERVICE COST CENTERS 91.00 09100 EMERGENCY 139,080 0 19, 688 6, 193 3, 201 91.00 09200 OBSERVATION BEDS (NON-DISTINCT PART 92.00 92.00 OTHER REIMBURSABLE COST CENTERS 95.00 09500 AMBULANCE SERVICES 222, 889 0 13, 654 490 2, 220 95.00 SPECIAL PURPOSE COST CENTERS 113. 00 11300 INTEREST EXPENSE 113 00 299, 391 47, 957 118. 00 118.00 SUBTOTALS (SUM OF LINES 1-117) 2,011,624 0 23, 623 NONREIMBURSABLE COST CENTERS 190.00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN 192.00 19200 PHYSICIANS' PRIVATE OFFICES 0 0 190. 00 C 12.396 Ω 0 405 0 192 00 194.00 07950 OCC HEALTH 101 173 194. 00 1,061 194. 01 07951 PAIN CLINIC 0 0 0 0 194. 01 C 194. 02 07952 OCC HEALTH 0 194. 02 0 0 0 0 0 194. 03 194. 03 07953 FOUNDATI 0 8.379 Ω 0 0 194. 04 07954 KIDS CAMPUS 0 0 194. 04 0 0 194. 05 07955 COMMUNITY & VOLUNTEER SERVICES 0 0 194. 05 37.678 194.06 07956 HUNTI NGTON COLLEGE NURSE 0 194, 06 0 0 0 194. 07 07957 MISC CATERING 10,841 C 0 0 194. 07 194.08 07958 AUTISM CENTER 0 0 0 194. 08 194. 09 07959 HUNTI NGTON BUA 0 194. 09 0 0 0 0 200.00 Cross Foot Adjustments 200. 00 201.00 Negative Cost Centers 0 201.00 202.00 TOTAL (sum lines 118-201) 2, 081, 019 300, 452 24, 028 48, 130 202. 00

ALLOCATION OF CAPITAL RELATED COSTS

Provi der CCN: 150091

Period: Worksheet B From 01/01/2014 Part II To 12/31/2014 Date/Time Prepared:

5/22/2015 11:28 am Cost Center Description DI ETARY CAFETERI A MAINTENANCE OF NURSI NG CENTRAL ADMI NI STRATI ON SERVICES & **PERSONNEL SUPPLY** 10.00 11.00 12.00 13.00 14.00 GENERAL SERVICE COST CENTERS 1.00 00100 CAP REL COSTS-BLDG & FIXT 1.00 00200 CAP REL COSTS-MVBLE EQUIP 2.00 2.00 4.00 00400 EMPLOYEE BENEFITS DEPARTMENT 4.00 5.00 00500 ADMINISTRATIVE & GENERAL 5.00 00600 MAINTENANCE & REPAIRS 6.00 6.00 7.00 00700 OPERATION OF PLANT 7.00 00800 LAUNDRY & LINEN SERVICE 8.00 8 00 9.00 00900 HOUSEKEEPI NG 9.00 10.00 01000 DI ETARY 71, 761 10.00 01100 CAFETERI A 11.00 30, 684 11.00 0 01200 MAINTENANCE OF PERSONNEL 12.00 0 12.00 13.00 01300 NURSING ADMINISTRATION 0 462 21, 414 13.00 14.00 01400 CENTRAL SERVICES & SUPPLY 0 16, 698 14.00 01500 PHARMACY 00000 0 15.00 907 0 261 15.00 01600 MEDICAL RECORDS & LIBRARY 0 16.00 C 0 0 16.00 17.00 01700 SOCIAL SERVICE 17.00 0 01900 NONPHYSICIAN ANESTHETISTS 0 0 19.00 0 0 19.00 02000 NURSING SCHOOL 0 20.00 20 00 C Ω 21.00 02100 I&R SERVICES-SALARY & FRINGES APPRV C 0 0 21.00 02200 | &R SERVICES-OTHER PRGM COSTS APPRV 0 0 0 22.00 0 22.00 02300 PARAMED ED PRGM-(SPECIFY) 0 23.00 23.00 0 INPATIENT ROUTINE SERVICE COST CENTERS 30.00 03000 ADULTS & PEDIATRICS 71, 761 7, 593 0 10, 645 1, 215 30.00 04300 NURSERY 0 43.00 73 102 0 43.00 0 ANCILLARY SERVICE COST CENTERS 50.00 05000 OPERATING ROOM 2,722 0 3,816 1,886 50.00 05200 DELIVERY ROOM & LABOR ROOM 0 1, 709 0 2, 396 52.00 52.00 0 0 53.00 05300 ANESTHESI OLOGY 0 0 0 53.00 05400 RADI OLOGY-DI AGNOSTI C 0 54.00 2, 663 0 365 54.00 0 60.00 06000 LABORATORY 0 0 60.00 06250 BLOOD CLOTTING FOR HEMOPHILIACS 0 62.30 00000000 0 0 62.30 06500 RESPIRATORY THERAPY 0 65 00 2.133 467 65 00 0 06600 PHYSI CAL THERAPY 66.00 2, 382 183 66.00 06800 SPEECH PATHOLOGY 0 0 68.00 68.00 0 0 69.00 06900 ELECTROCARDI OLOGY 0 0 69.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT 0 10, 524 71 00 Ω 71 00 07200 IMPL. DEV. CHARGED TO PATIENTS 0 72.00 C 0 0 72.00 07300 DRUGS CHARGED TO PATIENTS 0 244 73.00 73.00 0 76.97 07697 CARDIAC REHABILITATION 0 0 0 0 76.97 07698 HYPERBARI C OXYGEN THERAPY 76. 98 0 76. 98 0 C 0 07699 LI THOTRI PSY 76. 99 0 76.99 OUTPATIENT SERVICE COST CENTERS 91.00 4, 455 750 91.00 09100 EMERGENCY 0 3. 177 0 09200 OBSERVATION BEDS (NON-DISTINCT PART 92.00 92.00 OTHER REIMBURSABLE COST CENTERS 95.00 09500 AMBULANCE SERVICES 0 5, 780 0 0 95.00 SPECIAL PURPOSE COST CENTERS 113.00 11300 INTEREST EXPENSE 113.00 SUBTOTALS (SUM OF LINES 1-117) 71, 761 29, 601 0 21, 414 15, 895 118. 00 118.00 NONREI MBURSABLE COST CENTERS 190.00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN 714 190. 00 0 0 0 192.00 19200 PHYSICIANS' PRIVATE OFFICES 302 0 89 192. 00 194.00 07950 OCC HEALTH 0 C 0 0 0 194.00 194. 01 07951 PAIN CLINIC 0 0 00000 0 194. 01 C 0 194. 02 194. 02 07952 OCC HEALTH 194. 03 07953 FOUNDATIO 0 0 0 0 0 194. 03 181 194. 04 07954 KIDS CAMPUS 0 0 194. 04 194. 05 07955 COMMUNITY & VOLUNTEER SERVICES 0 0 194, 05 192 194.06 07956 HUNTI NGTON COLLEGE NURSE 0 0 194. 06 194.07 07957 MISC CATERING 0 408 0 0 0 194. 07 0 0 0 194.08 07958 AUTISM CENTER 0 194. 08 C 194. 09 07959 HUNTI NGTON BUA 0 0 0 0 194.09 C 200.00 Cross Foot Adjustments 200.00 201.00 Negative Cost Centers 0 0 201.00 TOTAL (sum lines 118-201) 202.00 71.761 30, 684 0 21.414 16, 698 202. 00

ALLOCATION OF CAPITAL RELATED COSTS

Provi der CCN: 150091

Period: Worksheet B From 01/01/2014 Part II To 12/31/2014 Date/Time Prepared:

5/22/2015 11:28 am Cost Center Description **PHARMACY** MEDI CAL SOCIAL SERVICE NONPHYSICIAN NURSING SCHOOL RECORDS & **ANESTHETISTS** LI BRARY 15. 00 17.00 19. 00 20.00 16,00 GENERAL SERVICE COST CENTERS 1.00 00100 CAP REL COSTS-BLDG & FIXT 1.00 00200 CAP REL COSTS-MVBLE EQUIP 2.00 2.00 4.00 00400 EMPLOYEE BENEFITS DEPARTMENT 4.00 5.00 00500 ADMINISTRATIVE & GENERAL 5.00 00600 MAINTENANCE & REPAIRS 6.00 6.00 7.00 00700 OPERATION OF PLANT 7.00 00800 LAUNDRY & LINEN SERVICE 8.00 8 00 9.00 00900 HOUSEKEEPI NG 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 15.00 192,689 15.00 01600 MEDICAL RECORDS & LIBRARY 16.00 5, 470 16.00 17.00 01700 SOCIAL SERVICE 17.00 0 01900 NONPHYSICIAN ANESTHETISTS 19.00 0 0 0 0 19.00 02000 NURSING SCHOOL 0 Λ 20.00 20 00 C 21.00 02100 I&R SERVICES-SALARY & FRINGES APPRV C 21.00 02200 I&R SERVICES-OTHER PRGM COSTS APPRV 0 0 22.00 22.00 02300 PARAMED ED PRGM-(SPECIFY) 0 23.00 23.00 INPATIENT ROUTINE SERVICE COST CENTERS 30.00 03000 ADULTS & PEDIATRICS 0 360 0 30.00 04300 NURSERY 0 43.00 0 32 43.00 ANCILLARY SERVICE COST CENTERS 50.00 05000 OPERATING ROOM 0 737 0 50.00 05200 DELIVERY ROOM & LABOR ROOM 0 121 0 52.00 52.00 0 53.00 05300 ANESTHESI OLOGY 0000000000000 94 53.00 05400 RADI OLOGY-DI AGNOSTI C 0 54.00 1, 215 54.00 60.00 06000 LABORATORY 538 60.00 06250 BLOOD CLOTTING FOR HEMOPHILIACS 0 62.30 62.30 06500 RESPIRATORY THERAPY 65 00 198 0 65 00 06600 PHYSI CAL THERAPY 66.00 127 66.00 0 68.00 06800 SPEECH PATHOLOGY 68.00 0 69.00 06900 ELECTROCARDI OLOGY 25 69.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT 0 71 00 385 71 00 07200 IMPL. DEV. CHARGED TO PATIENTS 0 72.00 221 72.00 07300 DRUGS CHARGED TO PATIENTS 0 73.00 73.00 76.97 07697 CARDIAC REHABILITATION C 0 76.97 07698 HYPERBARI C OXYGEN THERAPY 0 76. 98 76. 98 Ω 07699 LI THOTRI PSY 76. 99 0 76.99 OUTPATIENT SERVICE COST CENTERS 91.00 0 91.00 09100 EMERGENCY О 651 09200 OBSERVATION BEDS (NON-DISTINCT PART 92.00 92.00 OTHER REIMBURSABLE COST CENTERS 95.00 09500 AMBULANCE SERVICES 0 246 0 95.00 SPECIAL PURPOSE COST CENTERS 113.00 11300 INTEREST EXPENSE 113 00 SUBTOTALS (SUM OF LINES 1-117) 5, 470 0 0 118.00 118.00 0 NONREI MBURSABLE COST CENTERS 190.00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN 0 0 190.00 0 192.00 19200 PHYSICIANS' PRIVATE OFFICES C 192.00 194.00 07950 OCC HEALTH 0 0 194.00 0000000 194. 01 07951 PAIN CLINIC 0 194. 01 0 194. 02 07952 OCC HEALTH 0 194 02 194. 03 07953 FOUNDATI 0 0 0 194.03 194.04 07954 KIDS CAMPUS 0 194.04 194. 05 07955 COMMUNITY & VOLUNTEER SERVICES 0 0 194.05 194.06 07956 HUNTI NGTON COLLEGE NURSE 0 C 194.06 194.07 07957 MISC CATERING 194. 07 0 0 194.08 07958 AUTISM CENTER 194. 08 0 194. 09 07959 HUNTI NGTON BUA 0 0 194 09 200.00 Cross Foot Adjustments 0 200. 00 0 Negative Cost Centers 0 201.00 201.00 192, 689 0 TOTAL (sum lines 118-201) 202.00 192, 689 5.470 0 0 202, 00

	OF CAPITAL RELATED COSTS	TIONTINGTON WEW		CCN: 150091 F	Peri od:	Worksheet B	2002 10
				F	From 01/01/2014 Fo 12/31/2014	Part II	narodi
				'	10 12/31/2014	5/22/2015 11:	28 am
		INTERNS &	RESI DENTS				
	Cook Cooker Donordation	CEDVI CEC CALAD	CEDVI CEC OTHE	DADAMED ED	C		
	Cost Center Description	SERVICES-SALAR Y & FRINGES	PRGM COSTS	PARAMED ED PRGM	Subtotal	Intern & Residents Cost	
		APPRV	APPRV	1 Kom		& Post	
						Stepdown	
		21.00	22.00	22.00	24.00	Adjustments	
CENED	AL SERVICE COST CENTERS	21. 00	22. 00	23. 00	24. 00	25. 00	
	CAP REL COSTS-BLDG & FIXT						1.00
	CAP REL COSTS-MVBLE EQUIP						2. 00
4.00 00400	EMPLOYEE BENEFITS DEPARTMENT						4. 00
	ADMINISTRATIVE & GENERAL						5. 00
	MAINTENANCE & REPAIRS						6.00
	OPERATION OF PLANT LAUNDRY & LINEN SERVICE						7. 00 8. 00
	HOUSEKEEPI NG						9. 00
10.00 01000	DIETARY						10. 00
	CAFETERIA						11. 00
	MAINTENANCE OF PERSONNEL						12.00
	NURSING ADMINISTRATION CENTRAL SERVICES & SUPPLY						13. 00 14. 00
	PHARMACY						15. 00
	MEDICAL RECORDS & LIBRARY						16. 00
	SOCIAL SERVICE						17. 00
	NONPHYSI CI AN ANESTHETI STS						19. 00
	NURSING SCHOOL I&R SERVICES-SALARY & FRINGES APPRV	0					20.00
	I &R SERVICES-SALART & FRINGES APPRV						22.00
	PARAMED ED PRGM-(SPECIFY)						23. 00
	TENT ROUTINE SERVICE COST CENTERS]
	ADULTS & PEDIATRICS				882, 754		1
	NURSERY				4, 373	0	43. 00
	LARY SERVICE COST CENTERS OPERATING ROOM			1	340, 183	0	50.00
	DELIVERY ROOM & LABOR ROOM				78, 766	1	1
	ANESTHESI OLOGY				89, 666	l e	
	RADI OLOGY-DI AGNOSTI C				815, 998		1
	LABORATORY				219, 287	0	
	BLOOD CLOTTING FOR HEMOPHILIACS RESPIRATORY THERAPY				172, 474	0	1
	PHYSI CAL THERAPY				103, 638		
	SPEECH PATHOLOGY				1	Ö	1
69. 00 06900	ELECTROCARDI OLOGY				25	0	69. 00
	MEDICAL SUPPLIES CHARGED TO PATIENT				84, 957	0	1
	IMPL. DEV. CHARGED TO PATIENTS				80, 032	0	
	DRUGS CHARGED TO PATIENTS CARDIAC REHABILITATION				149, 931	0	
	HYPERBARI C OXYGEN THERAPY				0	ő	
	LI THOTRI PSY				0		
	TIENT SERVICE COST CENTERS		1				
	EMERGENCY				266, 943	0	1
	OBSERVATION BEDS (NON-DISTINCT PART REIMBURSABLE COST CENTERS					0	92. 00
	AMBULANCE SERVICES				585, 431	0	95. 00
	AL PURPOSE COST CENTERS				·		
	INTEREST EXPENSE						113. 00
118. 00	SUBTOTALS (SUM OF LINES 1-117)	0	<u> </u>		3, 874, 459	0	118. 00
	IMBURSABLE COST CENTERS GIFT, FLOWER, COFFEE SHOP & CANTEEN			1	714	0	190. 00
	PHYSICIANS' PRIVATE OFFICES				33, 036		192.00
194. 00 07950					2, 366	l e	194. 00
	PAIN CLINIC				0		194. 01
194. 02 07952	•				0	l	194. 02
194. 03 07953					8, 560		194. 03
	KIDS CAMPUS				27 071		194. 04 194. 05
	COMMUNITY & VOLUNTEER SERVICES HUNTINGTON COLLEGE NURSE				37, 871	l	194. 05
	MISC CATERING				11, 251		194. 07
	AUTI SM CENTER				0	0	194. 08
	HUNTI NGTON BUA				0		194. 09
200.00	Cross Foot Adjustments	0		1	0		200.00
201. 00 202. 00	Negative Cost Centers TOTAL (sum lines 118-201)	0	l .		192, 689 4, 160, 946		201. 00 202. 00
202.00	TOTAL (Suil TITIES TID-201)	1	1	۱ (٠, ١٥٥, ٦٩٥	1	1202.00

| Peri od: | Worksheet B | From 01/01/2014 | Part | I | To 12/31/2014 | Date/Time Prepared: | To 12/31/2014 Health Financial Systems
ALLOCATION OF CAPITAL RELATED COSTS Provi der CCN: 150091

	Cost Center Description	Total		
	1	26. 00		
1 00	GENERAL SERVICE COST CENTERS			1 00
1. 00 2. 00	00100 CAP REL COSTS-BLDG & FIXT 00200 CAP REL COSTS-MVBLE EQUIP			1. 00 2. 00
4.00	00400 EMPLOYEE BENEFITS DEPARTMENT			4. 00
5. 00	00500 ADMINISTRATIVE & GENERAL			5. 00
6. 00	00600 MAI NTENANCE & REPAI RS			6. 00
7.00	00700 OPERATION OF PLANT			7. 00
8.00	00800 LAUNDRY & LINEN SERVICE			8. 00
9.00	00900 HOUSEKEEPI NG			9. 00
10.00	01000 DI ETARY			10. 00
11.00	01100 CAFETERIA			11.00
12.00	01200 MAI NTENANCE OF PERSONNEL			12.00
14. 00	01300 NURSING ADMINISTRATION 01400 CENTRAL SERVICES & SUPPLY			13. 00 14. 00
	01500 PHARMACY			15. 00
	01600 MEDI CAL RECORDS & LI BRARY			16. 00
17. 00				17. 00
	01900 NONPHYSICIAN ANESTHETISTS			19. 00
20.00	02000 NURSI NG SCHOOL			20. 00
21. 00	02100 I&R SERVICES-SALARY & FRINGES APPRV			21. 00
22. 00	02200 I &R SERVICES-OTHER PRGM COSTS APPRV			22. 00
23. 00	,			23. 00
20.00	I NPATI ENT ROUTI NE SERVI CE COST CENTERS	000 754		1 20 00
43. 00	03000 ADULTS & PEDI ATRI CS 04300 NURSERY	882, 754		30. 00 43. 00
43.00	ANCI LLARY SERVI CE COST CENTERS	4, 373		43.00
50. 00	05000 OPERATING ROOM	340, 183		50.00
52. 00		78, 766		52. 00
53. 00		89, 666		53. 00
54.00	05400 RADI OLOGY-DI AGNOSTI C	815, 998		54.00
60.00	06000 LABORATORY	219, 287		60. 00
62. 30	06250 BLOOD CLOTTING FOR HEMOPHILIACS	0		62. 30
65. 00	06500 RESPI RATORY THERAPY	172, 474		65. 00
66.00	1	103, 638		66. 00
68. 00 69. 00	06800 SPEECH PATHOLOGY	1 25		68. 00 69. 00
71. 00	1	84, 957		71.00
	07200 IMPL. DEV. CHARGED TO PATIENTS	80, 032		72.00
73. 00		149, 931		73. 00
76. 97	07697 CARDI AC REHABI LI TATI ON	0		76. 97
76. 98	07698 HYPERBARI C OXYGEN THERAPY	0		76. 98
76. 99	07699 LI THOTRI PSY	0		76. 99
	OUTPATIENT SERVICE COST CENTERS			
91.00		266, 943		91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART			92. 00
95 00	OTHER REIMBURSABLE COST CENTERS O9500 AMBULANCE SERVICES	585, 431		95. 00
73.00	SPECIAL PURPOSE COST CENTERS	305, 431		75.00
113 00	11300 I NTEREST EXPENSE			113. 00
118. 00		3, 874, 459		118. 00
	NONREI MBURSABLE COST CENTERS			
190.00	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	714		190. 00
	19200 PHYSICIANS' PRIVATE OFFICES	33, 036		192. 00
	07950 OCC HEALTH	2, 366		194. 00
	07951 PAIN CLINIC	0		194. 01
	2 07952 OCC HEALTH	0		194. 02
	3 07953 FOUNDATIO 1 07954 KIDS CAMPUS	8, 560		194. 03 194. 04
	5 07955 COMMUNITY & VOLUNTEER SERVICES	37, 871		194. 04
	07956 HUNTINGTON COLLEGE NURSE	37,671		194. 05
	7 07957 MISC CATERING	11, 251		194. 07
	307958 AUTISM CENTER	1 0		194. 08
	07755 HUNTI NGTON BUA			194. 09
200.00		0		200. 00
201.00		192, 689		201. 00
202.00	TOTAL (sum lines 118-201)	4, 160, 946		202. 00

Provi der CCN: 150091

					Т	o 12/31/2014	Date/Time Pre 5/22/2015 11:	
			CAPITAL REI	LATED COSTS			, 0, 22, 2010 111	
		Cost Center Description	BLDG & FLXT	MVBLE EQUIP	EMPLOYEE	Reconciliation	ADMI NI STRATI VE	
		osst somes. Boson ptron		(DOLLAR VALUE)	BENEFITS	neconor i rati ci	& GENERAL	
					DEPARTMENT (GROSS		(ACCUM COST)	
					SALARI ES)			
			1.00	2. 00	4. 00	5A	5. 00	
1.00		AL SERVICE COST CENTERS CAP REL COSTS-BLDG & FIXT	116, 622		Ι			1. 00
2.00		CAP REL COSTS-MVBLE EQUIP	110,022	1, 612, 467				2. 00
4.00	1	EMPLOYEE BENEFITS DEPARTMENT	132	0	, ,			4. 00
5.00	1	ADMINISTRATIVE & GENERAL	7, 681	36, 609	5, 225, 086	-11, 671, 552	1	5. 00
6. 00 7. 00		MAINTENANCE & REPAIRS OPERATION OF PLANT	30, 673	49, 332	319, 998	0	0 1, 361, 542	6. 00 7. 00
8. 00	1	LAUNDRY & LINEN SERVICE	629				196, 464	8. 00
9.00		HOUSEKEEPI NG	512				445, 303	•
10. 00 11. 00	1	DI ETARY CAFETERI A	4, 892 1, 110				212, 220 220, 039	•
12. 00		MAINTENANCE OF PERSONNEL	0	i .	1		0	12. 00
13. 00	1	NURSING ADMINISTRATION	0	0			213, 696	
14. 00 15. 00		CENTRAL SERVICES & SUPPLY PHARMACY	1, 905 1, 155	l .	1	0 238, 572	7, 118 0	14. 00 15. 00
16. 00	1	MEDICAL RECORDS & LIBRARY	638		000, 554	238, 372	2, 384	
17. 00	01700	SOCIAL SERVICE	0	0	0	0	0	17. 00
19.00	1	NONPHYSI CLAN ANESTHETI STS	0	0	0	0	0	19. 00
20. 00 21. 00		NURSING SCHOOL I&R SERVICES-SALARY & FRINGES APPRV	0	0		0	0	20. 00 21. 00
22. 00		I &R SERVI CES-OTHER PRGM COSTS APPRV	0	Ö	Ö	0	Ö	22. 00
23. 00		PARAMED ED PRGM-(SPECIFY)	0	0	0	0	0	23. 00
30. 00		I ENT ROUTINE SERVICE COST CENTERS ADULTS & PEDIATRICS	25, 160	218, 892	2, 513, 052	0	3, 506, 297	30. 00
43. 00		NURSERY	102	· ·				
F0 00		LARY SERVICE COST CENTERS	0.504	4/0 747	000.044		004 445	F0 00
50. 00 52. 00	1	OPERATING ROOM DELIVERY ROOM & LABOR ROOM	9, 584	160, 717 0			801, 115 749, 014	
53. 00		ANESTHESI OLOGY	Ö	Ö			913, 802	1
54. 00		RADI OLOGY-DI AGNOSTI C	12, 012		1		2, 032, 755	•
60. 00 62. 30	1	LABORATORY BLOOD CLOTTING FOR HEMOPHILIACS	1, 820	0		0	2, 079, 282	60. 00 62. 30
65. 00		RESPIRATORY THERAPY	1, 346	_	1	0	893, 059	65. 00
66. 00	1	PHYSI CAL THERAPY	8, 324	24, 092	956, 568	0	71, 683	66. 00
68. 00 69. 00		SPEECH PATHOLOGY ELECTROCARDI OLOGY	0	0	0	0	0	68. 00 69. 00
71. 00	1	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	755, 435	
72. 00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	_	814, 226	72. 00
73. 00 76. 97		DRUGS CHARGED TO PATIENTS CARDIAC REHABILITATION	0	0	68, 184	0	1, 521, 779 0	73. 00 76. 97
76. 97 76. 98	1	HYPERBARIC OXYGEN THERAPY		0		0		76. 97 76. 98
76. 99	07699	LI THOTRI PSY	0	0	0	0	0	76. 99
91. 00		TIENT SERVICE COST CENTERS EMERGENCY	5, 120	66, 486	1, 050, 611	0	1, 418, 883	91. 00
92. 00		OBSERVATION BEDS (NON-DISTINCT PART	5, 120	00, 480	1, 030, 011	0	1, 410, 663	92.00
		REIMBURSABLE COST CENTERS		1				
95. 00		AL PURPOSE COST CENTERS	3, 551	307, 853	1, 494, 726	0	2, 273, 893	95. 00
113.00		INTEREST EXPENSE						113. 00
118.00		SUBTOTALS (SUM OF LINES 1-117)	116, 346	1, 593, 778	16, 030, 614	-11, 432, 980	20, 522, 379	118. 00
190 00		IMBURSABLE COST CENTERS GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190. 00
		PHYSI CLANS' PRI VATE OFFI CES	0				126, 464	
		OCC HEALTH	276			0	1	194. 00
		PAIN CLINIC OCC HEALTH	0	0	0	0		194. 01 194. 02
		FOUNDATIO		0	0	0	85, 478	
		KIDS CAMPUS	0	0	1	0	0	194. 04
		COMMUNITY & VOLUNTEER SERVICES	0	0	43, 829	0	384, 392	•
		HUNTINGTON COLLEGE NURSE MISC CATERING	0	0	59, 996	0	110, 598	194. 06 194. 07
		AUTI SM CENTER	0	Ö	0,7,7,0	54, 739	l	194. 08
		HUNTI NGTON BUA	0	0	0	0	0	194. 09
200. 00 201. 00	1	Cross Foot Adjustments Negative Cost Centers						200. 00 201. 00
202.00		Cost to be allocated (per Wkst. B,	435, 744	1, 711, 911	2, 778, 006		11, 671, 552	
202 00		Part I)			0 171400		0 540750	202 00
203.00	'1	Unit cost multiplier (Wkst. B, Part I)	3. 736379	1. 061672	0. 171439	I	0. 549758	₁ 203. UU

Health Financial Syste	ms l	HUNTINGTON MEMO	RIAL HOSPITAL		In Lie	eu of Form CMS-2	2552-10
COST ALLOCATION - STAT	ISTICAL BASIS		Provi der		Peri od:	Worksheet B-1	
					From 01/01/2014 To 12/31/2014		pared: 28 am
		CAPITAL REL	_ATED COSTS				
Cost Cente	er 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	
	e allocated (per Wkst. B,			493	3	2, 081, 019	204. 00
205.00 Part II) Unit cost	multiplier (Wkst. B, Part			0. 000030		0. 098021	205. 00

| Period: | Worksheet B-1 | From 01/01/2014 | To 12/31/2014 | Date/Time Prepared: Health Financial Systems
COST ALLOCATION - STATISTICAL BASIS Provi der CCN: 150091

						0 12/31/2014	Date/Time Pre 5/22/2015 11:	
		Cost Center Description	MAINTENANCE &		LAUNDRY &	HOUSEKEEPI NG	DI ETARY	20 alli
			REPAIRS (SQUARE FEET)	PLANT (SQUARE FEET)	LINEN SERVICE (POUNDS OF	(SQUARE FEET)	(MEALS SERVED)	
			(SQUARE TEET)	(SQUARE TEET)	LAUNDRY)			
	CENED	AL CEDVICE COST CENTEDS	6. 00	7. 00	8. 00	9. 00	10.00	
1. 00		AL SERVICE COST CENTERS CAP REL COSTS-BLDG & FIXT						1. 00
2.00	1	CAP REL COSTS-MVBLE EQUIP						2. 00
4.00		EMPLOYEE BENEFITS DEPARTMENT						4. 00
5. 00 6. 00	1	ADMINISTRATIVE & GENERAL MAINTENANCE & REPAIRS	0		•			5. 00 6. 00
7. 00	1	OPERATION OF PLANT	0	78, 136				7. 00
8.00	00800	LAUNDRY & LINEN SERVICE	0	629	255, 723			8. 00
9.00		HOUSEKEEPI NG	0	512	1		l e	9. 00
10. 00 11. 00		DI ETARY CAFETERI A	0	4, 892 1, 110			l	10. 00 11. 00
12. 00	1	MAINTENANCE OF PERSONNEL	Ö	0	i	0	ő	12. 00
13.00	1	NURSING ADMINISTRATION	0	0	1	0	0	13.00
14. 00 15. 00		CENTRAL SERVICES & SUPPLY PHARMACY	0	1, 905 1, 155	1	1, 905 1, 155	0	14. 00 15. 00
16. 00	1	MEDICAL RECORDS & LIBRARY	0	638	I	638		16. 00
17. 00	01700	SOCIAL SERVICE	0	0	1	0	0	17. 00
19.00		NONPHYSI CI AN ANESTHETI STS	0	0	0	0	0	19. 00
20. 00 21. 00		NURSING SCHOOL I&R SERVICES-SALARY & FRINGES APPRV	0		0	0	0	20. 00 21. 00
22. 00		I &R SERVI CES-OTHER PRGM COSTS APPRV	0	Ö	Ö	0	ő	22. 00
23. 00		PARAMED ED PRGM-(SPECIFY)	0	0	0	0	0	23. 00
30. 00		I ENT ROUTINE SERVICE COST CENTERS ADULTS & PEDIATRICS	0	25, 160	90, 926	25, 160	27, 492	30. 00
43. 00	1	NURSERY	0		1	· ·	27, 472	43. 00
F0 00		LARY SERVICE COST CENTERS		0.504	1 00 000	0.504		F0 00
50. 00 52. 00	1	OPERATING ROOM DELIVERY ROOM & LABOR ROOM	0	9, 584 0	1		0	50. 00 52. 00
53. 00		ANESTHESI OLOGY	0	Ö	1	0	ő	53. 00
54. 00		RADI OLOGY-DI AGNOSTI C	0	12, 012			0	54. 00
60. 00 62. 30	1	LABORATORY BLOOD CLOTTING FOR HEMOPHILIACS	0	1, 820		1, 820 0	0	60. 00 62. 30
65. 00	1	RESPIRATORY THERAPY	0	1, 346	_	l -	1	65. 00
66. 00	06600	PHYSI CAL THERAPY	0	8, 324	1		0	66. 00
68. 00	1	SPEECH PATHOLOGY	0	0		0	0	68. 00
69. 00 71. 00		ELECTROCARDIOLOGY MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	0	69. 00 71. 00
72. 00		IMPL. DEV. CHARGED TO PATIENTS	0	Ö	Ö	0	ő	72.00
73. 00		DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73. 00
76. 97 76. 98		CARDI AC REHABI LI TATI ON HYPERBARI C OXYGEN THERAPY	0		0	0	0	76. 97 76. 98
76. 99		LI THOTRI PSY	0			0	0	76. 99
		TIENT SERVICE COST CENTERS	_					
91. 00 92. 00	1	EMERGENCY OBSERVATION BEDS (NON-DISTINCT PART	0	5, 120	65, 908	5, 120	0	91. 00 92. 00
	OTHER	REIMBURSABLE COST CENTERS						72.00
95. 00		AMBULANCE SERVICES	0	3, 551	5, 211	3, 551	0	95. 00
113 00		AL PURPOSE COST CENTERS INTEREST EXPENSE						113. 00
118. 00	1	SUBTOTALS (SUM OF LINES 1-117)	0	77, 860	251, 413	76, 719	27, 492	118. 00
400.00		I MBURSABLE COST CENTERS			1			
		GIFT, FLOWER, COFFEE SHOP & CANTEEN PHYSICIANS' PRIVATE OFFICES	0		1			190. 00 192. 00
194.00	07950	OCC HEALTH	0	276				194. 00
194. 01	07951	PAIN CLINIC	0	0	0	0	0	194. 01
		OCC HEALTH	0	0		0	l e	194. 02
		FOUNDATIO KIDS CAMPUS	0	0	0	0	l e	194. 03 194. 04
		COMMUNITY & VOLUNTEER SERVICES	0	Ö	Ö	0	l e	194. 05
		HUNTI NGTON COLLEGE NURSE	0	0	0	0		194. 06
		MISC CATERING AUTISM CENTER	0	0	0	0		194. 07 194. 08
		HUNTI NGTON BUA	0		0	0	•	194. 09
200.00		Cross Foot Adjustments						200. 00
201.00	1	Negative Cost Centers		2 110 0/1	224 450	711 000	FO/ 22F	201. 00
202.00	ľ	Cost to be allocated (per Wkst. B, Part I)	0	2, 110, 061	321, 458	711, 833	506, 225	202.00
203.00	1	Unit cost multiplier (Wkst. B, Part I)	0. 000000	27. 004978	1. 257055		l e	•
204.00)	Cost to be allocated (per Wkst. B,	0	300, 452	24, 028	48, 130	71, 761	204. 00
205.00		Part II) Unit cost multiplier (Wkst. B, Part	0. 000000	3. 845244	0. 093961	0. 625106	2. 610250	205. 00
		[11)						

	LLOCATION - STATISTICAL BASIS	HUNTINGTON MEMO		CCN: 150091 F	eriod:	Worksheet B-1	
CUST A	LLUCATION - STATISTICAL BASIS	_	Provider	F	From 01/01/2014 o 12/31/2014		pared:
	Cost Center Description	CAFETERI A (HOURS OF SERVI CE)	MAI NTENANCE OF PERSONNEL (NUMBER HOUSED)	NURSING ADMINISTRATION (DIRECT NRSING HRS)	SUPPLY	PHARMACY (COSTED REQUIS.)	
		11.00	12.00	13. 00	14.00	15. 00	
	GENERAL SERVI CE COST CENTERS		Г	T	T T		
1. 00 2. 00 4. 00 5. 00 6. 00 7. 00 8. 00 9. 00 10. 00	00100 CAP REL COSTS-BLDG & FIXT 00200 CAP REL COSTS-MVBLE EQUIP 00400 EMPLOYEE BENEFITS DEPARTMENT 00500 ADMINISTRATIVE & GENERAL 00600 MAINTENANCE & REPAIRS 00700 OPERATION OF PLANT 00800 LAUNDRY & LINEN SERVICE 00900 HOUSEKEEPING 01000 DIETARY	244 041					1. 00 2. 00 4. 00 5. 00 6. 00 7. 00 8. 00 9. 00
11. 00 12. 00	01100 CAFETERI A 01200 MAI NTENANCE OF PERSONNEL	364, 041	0				11. 00 12. 00
13. 00	01300 NURSI NG ADMI NI STRATI ON	5, 487		181, 205	5	l	13. 00
14. 00	01400 CENTRAL SERVICES & SUPPLY	0	0			I	14.00
15. 00	01500 PHARMACY	10, 758	0	(39, 029	0	
16. 00 17. 00	01600 MEDICAL RECORDS & LIBRARY 01700 SOCIAL SERVICE	0	0			0	16. 00 17. 00
19. 00	01900 NONPHYSICIAN ANESTHETISTS	0	0			0	19.00
	02000 NURSI NG SCHOOL	0	0	C	o	0	
21. 00	02100 I &R SERVI CES-SALARY & FRI NGES APPRV	0	0	(0	0	
22. 00 23. 00	02200 I &R SERVI CES-OTHER PRGM COSTS APPRV 02300 PARAMED ED PRGM-(SPECIFY)	0	0			0	
20.00	INPATIENT ROUTINE SERVICE COST CENTERS				,		20.00
30. 00	03000 ADULTS & PEDIATRICS	90, 078	ł	1		0	
43. 00	04300 NURSERY ANCI LLARY SERVI CE COST CENTERS	866	0	866	0	0	43.00
50. 00	05000 OPERATING ROOM	32, 290	0	32, 290	281, 526	0	50.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	20, 274	0	20, 274		0	52.00
53.00	05300 ANESTHESI OLOGY	0	0	(0	
54. 00 60. 00	05400 RADI OLOGY-DI AGNOSTI C 06000 LABORATORY	31, 595	0			0	
62. 30	06250 BLOOD CLOTTING FOR HEMOPHILIACS	0	Ö		Ó	0	62. 30
65. 00	06500 RESPI RATORY THERAPY	25, 310	0	C	69, 772	0	65. 00
66. 00	06600 PHYSI CAL THERAPY	28, 264	0	(27, 368	0	66.00
68. 00 69. 00	06800 SPEECH PATHOLOGY 06900 ELECTROCARDI OLOGY					0	
71. 00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0	Ö	d	1, 570, 845	0	71. 00
72. 00	07200 I MPL. DEV. CHARGED TO PATIENTS	0	0	(0	0	72.00
73. 00 76. 97	07300 DRUGS CHARGED TO PATIENTS 07697 CARDIAC REHABILITATION	0	0		36, 418	0	73. 00 76. 97
76. 98	07698 HYPERBARI C OXYGEN THERAPY	0	Ö		o o	0	
76. 99	07699 LI THOTRI PSY	0	0	(0	0	76. 99
01 00	OUTPATIENT SERVICE COST CENTERS	27 (07		27.40	111 004		01.00
	O9100 EMERGENCY O9200 OBSERVATION BEDS (NON-DISTINCT PART OTHER REIMBURSABLE COST CENTERS	37, 697	0	37, 697	111, 984	0	91. 00 92. 00
95. 00	09500 AMBULANCE SERVI CES	68, 579	0	(0	0	95.00
113 00	SPECIAL PURPOSE COST CENTERS 11300 INTEREST EXPENSE] 113. 00
118.00		351, 198	О	181, 205	2, 372, 915	0	118. 00
	NONREI MBURSABLE COST CENTERS			I			
	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN 19200 PHYSICIANS' PRIVATE OFFICES	3, 581	0		1		190. 00 192. 00
	07950 OCC HEALTH	3, 361					194. 00
194. 01	07951 PAIN CLINIC	0	0	C	o	0	194. 01
	07952 OCC HEALTH	0	0	(0		194. 02
	07953 FOUNDATIO 07954 KIDS CAMPUS	2, 144	0				194. 03 194. 04
	07955 COMMUNITY & VOLUNTEER SERVICES	2, 278	Ö		o o		194. 05
	07956 HUNTI NGTON COLLEGE NURSE	0	0	C	o		194. 06
	07957 MISC CATERING 07958 AUTISM CENTER	4, 840	0				194. 07 194. 08
	07959 HUNTI NGTON BUA						194. 00
200.00	Cross Foot Adjustments					ı	200.00
201.00	Negative Cost Centers						201.00
202.00	Cost to be allocated (per Wkst. B, Part I)	381, 245	0	336, 923	84, 977	-184, 107	202.00
203.00		1. 047258	0. 000000	1. 859347	0. 034089	0. 000000	203. 00
204.00	Cost to be allocated (per Wkst. B,	30, 684		21, 414			
	Part II)			I		i	

Health Financial Systems	HUNTI NGTON MEMO	ORIAL HOSPITAL		In Lie	u of Form CMS-2	2552-10
COST ALLOCATION - STATISTICAL BASIS		Provi der		Peri od:	Worksheet B-1	
				From 01/01/2014	D-+- /T: D	
				To 12/31/2014	Date/Time Pre 5/22/2015 11:	
Cost Center Description	CAFETERI A	MAINTENANCE OF	NURSI NG	CENTRAL	PHARMACY	
	(HOURS OF	PERSONNEL	ADMI NI STRATI OI	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. 084287	0. 000000	0. 11817	0. 006699	0.000000	205. 00
1)						

Health Financial Systems
COST ALLOCATION - STATISTICAL BASIS HUNTINGTON MEMORIAL HOSPITAL In Lieu of Form CMS-2552-10 Provi der CCN: 150091 Peri od: From 01/01/2014 To 12/31/2014 Worksheet B-1 Date/Time Prepared: 5/22/2015 11:28 am INTERNS &

					RESI DENTS	
Cost Center Description		SOCIAL SERVICE		NURSING SCHOOL		
	RECORDS & LI BRARY	(TIME SPENT)	ANESTHETI STS (ASSI GNED	(ASSI GNED	Y & FRINGES APPRV	
	(GROSS	(TIME SI EIVI)	TIME)	TIME)	(ASSI GNED	
	REVENUE)	17.00	10.00	20.00	TIME)	
GENERAL SERVICE COST CENTERS	16. 00	17. 00	19. 00	20.00	21. 00	
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 7.00 00700 OPERATION OF PLANT						6. 00 7. 00
8.00 00800 LAUNDRY & LINEN SERVICE						8. 00
9. 00 00900 HOUSEKEEPI NG						9. 00
10. 00 01000 DI ETARY						10. 00
11. 00 01100 CAFETERI A						11. 00
12. 00 01200 MAI NTENANCE OF PERSONNEL						12.00
13. 00 01300 NURSI NG ADMINI STRATI ON 14. 00 01400 CENTRAL SERVI CES & SUPPLY						13. 00 14. 00
15. 00 01500 PHARMACY						15. 00
16. 00 01600 MEDICAL RECORDS & LIBRARY	133, 837, 806					16. 00
17. 00 01700 SOCIAL SERVICE	0	0				17. 00
19. 00 01900 NONPHYSICIAN ANESTHETISTS	0	0	0			19. 00
20. 00 02000 NURSI NG SCHOOL	0	0		0	_	20. 00
21.00 02100 1 &R SERVICES-SALARY & FRINGES APPRV 22.00 02200 1 &R SERVICES-OTHER PRGM COSTS APPRV	0	0			0	21. 00
23. 00 02300 PARAMED ED PRGM-(SPECIFY)	0	0				22. 00 23. 00
I NPATI ENT ROUTI NE SERVI CE COST CENTERS	0					23.00
30. 00 03000 ADULTS & PEDI ATRI CS	8, 768, 876	0		0	0	30. 00
43. 00 04300 NURSERY	772, 753	0		0	0	43. 00
ANCI LLARY SERVI CE COST CENTERS 50. 00 05000 0PERATI NG ROOM	17 000 417	0	0	O	0	E0 00
52. 00 05000 DELI VERY ROOM & LABOR ROOM	17, 980, 617 2, 939, 618			l .	0	50. 00 52. 00
53. 00 05300 ANESTHESI OLOGY	2, 304, 116	0		l !	0	53. 00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	30, 069, 102	0	0	0	0	54.00
60. 00 06000 LABORATORY	13, 118, 861	0	0	0	0	60.00
62. 30 06250 BLOOD CLOTTING FOR HEMOPHILIACS	0	0	1	- 1	0	62. 30
65. 00 06500 RESPI RATORY THERAPY 66. 00 06600 PHYSI CAL THERAPY	4, 834, 514	0	0	· ·	0	65. 00
66. 00 06600 PHYSI CAL THERAPY 68. 00 06800 SPEECH PATHOLOGY	3, 097, 379 14, 110) 0	0	0	0	66. 00 68. 00
69. 00 06900 ELECTROCARDI OLOGY	603, 314	Ö	Ö	o	Ö	69. 00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	9, 396, 928	0	0	0	0	71. 00
72. 00 07200 I MPL. DEV. CHARGED TO PATIENTS	5, 397, 632	0	0	- 1	0	72. 00
73. 00 07300 DRUGS CHARGED TO PATIENTS	12, 661, 468	0	0	- 1	0	73.00
76. 97 07697 CARDI AC REHABI LI TATI ON 76. 98 07698 HYPERBARI C OXYGEN THERAPY	0	0	0	· ·	0	76. 97 76. 98
76. 99 07699 LI THOTRI PSY	o o	0		· ·	0	76. 99
OUTPATIENT SERVICE COST CENTERS			T			
91. 00 09100 EMERGENCY	15, 883, 132	0	0	0	0	91.00
92.00 OBSERVATION BEDS (NON-DISTINCT PART OTHER REIMBURSABLE COST CENTERS						92. 00
95. 00 09500 AMBULANCE SERVI CES	5, 995, 386	0	0	0	0	95. 00
SPECIAL PURPOSE COST CENTERS	, , , , , ,					
113. 00 11300 I NTEREST EXPENSE						113. 00
118. 00 SUBTOTALS (SUM OF LINES 1-117)	133, 837, 806	0	0	0	0	118. 00
NONREI MBURSABLE COST CENTERS 190. 00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	O	0	190. 00
192. 00 19200 PHYSI CLANS' PRI VATE OFFICES	0	0		l I		192. 00
194. 00 07950 OCC HEALTH	0	0		l !		194. 00
194.01 07951 PAIN CLINIC	0	0	0	0		194. 01
194. 02 07952 OCC HEALTH	0	0		l !		194. 02
194. 03 07953 FOUNDATIO	0	0	0	· ·		194. 03
194.04 07954 KIDS CAMPUS 194.05 07955 COMMUNITY & VOLUNTEER SERVICES	0	0	0	· ·		194. 04 194. 05
194. 06 07956 HUNTI NGTON COLLEGE NURSE	0	Ö	ĺ	- 1		194. 06
194. 07 07957 MI SC CATERI NG	Ö	Ö	Ö	- 1		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						200. 00
201.00 Negative Cost Centers 202.00 Cost to be allocated (per Wkst. B,	26, 822	0	0	o		201. 00 202. 00
Part I)	20, 022				٥	202.00
203.00 Unit cost multiplier (Wkst. B, Part I)	0. 000200	0. 000000	0. 000000	0. 000000	0. 000000	203. 00

				u of Form CMS-2	2332-10
	Provi der			Worksheet B-1	
				I NTERNS & RESI DENTS	
EDICAL SOC CORDS &	OCIAL SERVICE			SERVICES-SALAR Y & FRINGES	
,	(TIME SPENT)	(ASSI GNED	(ASSI GNED	APPRV	
GROSS		TIME)	TIME)	,	
16. 00	17. 00	19. 00	20.00	21. 00	
5, 470	0	(0	0	204. 00
0. 000041	0. 000000	0. 000000	0. 000000	0. 000000	205. 00
	BRARY (GROSS VENUE) 6.00 5,470	DI CAL SOCI AL SERVI CE ORDS & (TI ME SPENT) GROSS WENUE) 6.00 17.00 0	DI CAL SOCI AL SERVI CE NONPHYSI CI AN ANESTHETI STS (ASSI GNED TI ME) VENUE) 6.00 17.00 19.00	From 01/01/2014	From 01/01/2014 Date/Time Pre 5/22/2015 11: INTERNS & RESI DENTS INTERNS & RESI DENTS SERVI CE S-SALAR Y & FRI NGES BRARY (TIME SPENT) (ASSI GNED TIME) TIME) TIME) TIME) CASSI GNED TIME

COST ALLOCATION - STATISTICAL BASIS Provider CCN: 150091 Peri od: Worksheet B-1 From 01/01/2014 12/31/2014 Date/Time Prepared: 5/22/2015 11:28 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 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 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 0 43.00 ANCILLARY SERVICE COST CENTERS 50.00 05000 OPERATING ROOM 0 0 50.00 0 05200 DELIVERY ROOM & LABOR ROOM 52.00 0 52.00 05300 ANESTHESI OLOGY 53.00 000000000000 0 53.00 54.00 05400 RADI OLOGY-DI AGNOSTI C 0 54.00 06000 LABORATORY 0 60.00 60.00 62.30 06250 BLOOD CLOTTING FOR HEMOPHILIACS 0 62.30 06500 RESPIRATORY THERAPY 0 65.00 65.00 06600 PHYSI CAL THERAPY 0 66.00 66.00 06800 SPEECH PATHOLOGY 0 68.00 68.00 69.00 06900 ELECTROCARDI OLOGY 0 69.00 71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT 0 71.00 07200 IMPL. DEV. CHARGED TO PATIENTS 0 72 00 72 00 07300 DRUGS CHARGED TO PATIENTS 73.00 0 73.00 76. 97 07697 CARDIAC REHABILITATION 0 76. 97 07698 HYPERBARI C OXYGEN THERAPY 0 76. 98 0 76.98 07699 LI THOTRI PSY 76. 99 76. 99 0 0 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 95.00 0 0 95.00 SPECIAL PURPOSE COST CENTERS 113. 00 11300 | INTEREST EXPENSE 113.00 SUBTOTALS (SUM OF LINES 1-117) 0 0 118, 00 118.00 NONREI MBURSABLE COST CENTERS 190.00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN 0 0 190.00 192. 00 19200 PHYSICIANS' PRIVATE OFFICES 00000000 0 192 00 194.00 07950 OCC HEALTH 0 194.00 194. 01 194. 01 07951 PAIN CLINIC 0 194. 02 07952 OCC HEALTH 194. 02 0 194. 03 07953 FOUNDATI 0 194. 03 0 194. 04 07954 KIDS CAMPUS 0 194.04 194. 05 07955 COMMUNITY & VOLUNTEER SERVICES 194.05 194.06 07956 HUNTI NGTON COLLEGE NURSE 0 194.06 194. 07 07957 MISC CATERING 0 194. 07 194.08 07958 AUTISM CENTER 0 194.08 0 194.09 07959 HUNTI NGTON BUA Ω 194. 09 200.00 Cross Foot Adjustments 200. 00 201.00 Negative Cost Centers 201.00 202.00 Cost to be allocated (per Wkst. B, 202.00 Part I) 203 00 Unit cost multiplier (Wkst. B, Part I) 0.000000 0.000000 203.00

Health Financial Systems	HUNTINGTON MEMOR	RIAL HOSPITAL		In Lieu of Form CMS-2552-10		
COST ALLOCATION - STATISTICAL BASIS		Provi der	CCN: 150091	Peri od: From 01/01/2014 To 12/31/2014	Worksheet B-1 Date/Time Pre 5/22/2015 11:	pared:
Cost Center Description	I NTERNS & RESI DENTS SERVI CES-OTHER PRGM COSTS APPRV (ASSI GNED TI ME) 22.00	PARAMED ED PRGM (ASSI GNED TI ME)			072272010	ZO diii
204.00 Cost to be allocated (per Wkst. B,	0	0				204. 00
205.00 Part II) Unit cost multiplier (Wkst. B, Part II)	0. 000000	0. 000000				205. 00

Health Financial Systems	HUNTINGTON MEMO	ORI AL	HOSPI TAL		In Lie	u of Form CMS-2	2552-10
COMPUTATION OF RATIO OF COSTS TO CHARGES			Provi der	CCN: 150091	Peri od: From 01/01/2014 To 12/31/2014	Worksheet C Part I Date/Time Pre 5/22/2015 11:	
			Ti tl	e XVIII	Hospi tal	PPS	
					Costs		
Cost Center Description	Total Cost (from Wkst. B,		apy Limit Adj.	Total Costs	RCE Di sal I owance	Total Costs	

			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)					
		1.00	2. 00	3. 00	4. 00	5. 00	
	INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000 ADULTS & PEDIATRICS	7, 236, 252		7, 236, 252		7, 236, 252	
43. 00	04300 NURSERY	58, 611		58, 611	0	58, 611	43. 00
	ANCILLARY SERVICE COST CENTERS						
50.00	05000 OPERATI NG ROOM	1, 738, 627		1, 738, 627		1, 763, 086	
52.00	05200 DELIVERY ROOM & LABOR ROOM	1, 235, 060		1, 235, 060		1, 235, 060	
53.00	05300 ANESTHESI OLOGY	1, 416, 633		1, 416, 633	l .	1, 416, 633	
54.00	05400 RADI OLOGY-DI AGNOSTI C	3, 652, 320		3, 652, 320		3, 652, 320	
60.00	06000 LABORATORY	3, 290, 986		3, 290, 986	0	3, 290, 986	
62. 30	06250 BLOOD CLOTTING FOR HEMOPHILIACS	0		0	0	0	62. 30
65.00	06500 RESPI RATORY THERAPY	1, 477, 213	0	1, 477, 213	0	1, 477, 213	
66.00	06600 PHYSI CAL THERAPY	443, 989	0	443, 989	0	443, 989	
68. 00	06800 SPEECH PATHOLOGY	3	0	3	0	3	68. 00
69. 00	06900 ELECTROCARDI OLOGY	121		121	0	121	69. 00
71. 00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	1, 226, 170		1, 226, 170	0	1, 226, 170	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	1, 262, 933		1, 262, 933	0	1, 262, 933	72. 00
73.00	07300 DRUGS CHARGED TO PATIENTS	2, 362, 162		2, 362, 162	0	2, 362, 162	73. 00
76. 97	07697 CARDIAC REHABILITATION	0		0	0	0	76. 97
76. 98	07698 HYPERBARI C OXYGEN THERAPY	0		0	0	0	76. 98
76. 99	07699 LI THOTRI PSY	0		0	0	0	76. 99
	OUTPATIENT SERVICE COST CENTERS						
91.00	09100 EMERGENCY	2, 583, 939		2, 583, 939	0	2, 583, 939	91. 00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART	1, 301, 655		1, 301, 655		1, 301, 655	92. 00
	OTHER REIMBURSABLE COST CENTERS						1
95.00	09500 AMBULANCE SERVI CES	3, 732, 279		3, 732, 279	0	3, 732, 279	95. 00
	SPECIAL PURPOSE COST CENTERS						1
113.00	11300 INTEREST EXPENSE						113. 00
200.00	Subtotal (see instructions)	33, 018, 953	0	33, 018, 953	24, 459	33, 043, 412	200.00
201.00	Less Observation Beds	1, 301, 655		1, 301, 655		1, 301, 655	201.00
202.00	Total (see instructions)	31, 717, 298	0	31, 717, 298	24, 459	31, 741, 757	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	From 01/01/2014	Worksheet C Part I Date/Time Prepared: 5/22/2015 11:28 am
	Title XVIII	Hosni tal	PPS

Cost Center Description				'	0 12/31/2014	5/22/2015 11:	рагец. 28 am
Inpatient			Ti tl	e XVIII	Hospi tal	PPS	
INPATI ENT ROUTI NE SERVI CE COST CENTERS			Charges				
INPATI ENT ROUTI NE SERVI CE COST CENTERS 30.00 7.00 8.00 9.00 10.	Cost Center Description	I npati ent	Outpati ent	Total (col. 6	Cost or Other	TEFRA	
NPATI ENT ROUTI NE SERVI CE COST CENTERS 7, 480, 287 7, 480, 287 772, 753 772, 753 43. 00 04300 NURSERY 772, 753				+ col. 7)	Ratio		
INPATI ENT ROUTINE SERVICE COST CENTERS 30.00							
30. 00		6.00	7. 00	8. 00	9. 00	10. 00	
43.00							
ANCILLARY SERVICE COST CENTERS		1 1			1		
50.00		772, 753		772, 753			43. 00
52. 00 05200 DELI VERY ROOM & LABOR ROOM 2, 939, 618 0 2, 939, 618 0 420143 0 0000000 52. 00 53. 00 05300 ANESTHESI DLOGY 599, 385 1, 704, 731 2, 304, 116 0 614827 0 0000000 54. 00 60.		1			1		
53.00 05300 ANESTHESI OLOGY 599, 385 1, 704, 731 2, 304, 116 0. 614827 0. 000000 53.00 54.00 65400 RADI OLOGY-DI AGNOSTI C 3, 376, 034 26, 693, 068 30, 069, 102 0. 121464 0. 000000 54.00 60.00 CABORATORY 2, 581, 909 10, 536, 952 13, 118, 861 0. 250859 0. 000000 60. 00 0. 000000 62. 30 65. 00 65.00							
54. 00 05400 RADI OLOGY - DI AGNOSTI C 3, 376, 034 26, 693, 068 30, 069, 102 0. 121464 0. 000000 54. 00 60. 00			-				
60. 00 06000 LABORATORY 2,581,909 10,536,952 13,118,861 0.250859 0.000000 60.0							1
62. 30							
65. 00		2, 581, 909					
66. 00 06600 PHYSI CAL THERAPY 547, 050 2, 550, 329 3, 097, 379 0. 143343 0. 000000 66. 00 68. 00 06800 SPEECH PATHOLOGY 14, 110 0 14, 110 0.000213 0. 000000 68. 00 06900 ELECTROCARDI OLOGY 492, 502 110, 812 603, 314 0. 000201 0. 000000 69. 00 071. 00 07100 MEDI CAL SUPPLIES CHARGED TO PATI ENT 2, 111, 628 7, 285, 300 9, 396, 928 0. 130486 0. 000000 71. 00 0720 IMPL. DEV. CHARGED TO PATI ENTS 4, 124, 977 1, 272, 655 5, 397, 632 0. 233979 0. 000000 72. 00 07300 DRUGS CHARGED TO PATI ENTS 4, 762, 366 7, 899, 102 12, 661, 468 0. 186563 0. 000000 73. 00 07300 DRUGS CHARGED TO PATI ENTS 4, 762, 366 7, 899, 102 12, 661, 468 0. 186563 0. 000000 73. 00 0. 000000 0. 000000 0. 000000 74. 90 0. 000000 0. 000000 0. 000000 74. 90 0. 000000 0. 000000 0. 000000 74. 90 0. 000000 0. 000000 0. 000000 74. 90 0. 000000 0. 000000 0. 000000 74. 90 0. 000000 0. 000000 0. 000000 74. 90 0. 000000 0. 000000 0. 000000 0. 000000		0	-				
68. 00							
69. 00							
71. 00			•				
72. 00							1
73. 00 07300 DRUGS CHARGED TO PATIENTS 4, 762, 366 7, 899, 102 12, 661, 468 0. 186563 0. 000000 73. 00 76. 97 76. 97 76. 98 07698 HYPERBARI C OXYGEN THERAPY 0 0 0 0. 0000000 0. 0000000 0. 0000000 0. 00000000							1
76. 97 O7697 CARDI AC REHABI LITATI ON O O O O O O O O O		1 1			1		1
76. 98 07698 HYPERBARI C OXYGEN THERAPY 0 0 0 0 0 0 0 0 0		4, 762, 366	7, 899, 102	12, 661, 468			
76. 99 O7699 LI THOTRI PSY O O O O O 0.000000 O.000000 76. 99 OUTPATI ENT SERVI CE COST CENTERS 91. 00 O9100 EMERGENCY O9200 OBSERVATI ON BEDS (NON-DI STI NCT PART O 1, 288, 589 1, 288, 589 1. 010140 0.000000 92. 00 OTHER REI MBURSABLE COST CENTERS 95. 00 O9500 AMBULANCE SERVI CES O.000000 O9500 AMBULANCE SERVI CES O.000000 O9500 OFTE CONTERS 113. 00 O9500 OFTE CONTERS 113. 00 O9500 OFTE CONTERS SPECIAL PURPOSE COST CENTERS 200. 00 Subtotal (see instructions) O9500 OFTE OFTE ON		0	0	C			1
91. 00		0	0	C			1
91. 00		0	0	C	0. 000000	0.000000	76. 99
92. 00					1		
95. 00 OTHER REIMBURSABLE COST CENTERS 95. 00 O9500 AMBULANCE SERVICES 1, 137 5, 994, 249 5, 995, 386 0. 622525 0. 000000 95. 00 SPECIAL PURPOSE COST CENTERS 113. 00 11300 INTEREST EXPENSE 113. 00 Subtotal (see instructions) 39, 006, 589 94, 831, 217 133, 837, 806 200. 00 Less Observation Beds 201. 00		1					
95. 00 09500 AMBULANCE SERVICES 1, 137 5, 994, 249 5, 995, 386 0. 622525 0. 000000 95. 00 SPECIAL PURPOSE COST CENTERS 113. 00 11300 INTEREST EXPENSE 113. 00 Subtotal (see instructions) 39, 006, 589 94, 831, 217 133, 837, 806 200. 00 Less Observation Beds 201. 00		0	1, 288, 589	1, 288, 589	1. 010140	0. 000000	92. 00
SPECIAL PURPOSE COST CENTERS 113.00 11300 INTEREST EXPENSE 200.00 Subtotal (see instructions) 39,006,589 94,831,217 133,837,806 200.00 201.00 Less Observation Beds 201.00					1		
113.00		1, 137	5, 994, 249	5, 995, 386	0. 622525	0. 000000	95. 00
200.00 Subtotal (see instructions) 39,006,589 94,831,217 133,837,806 200.00 201.00 Less Observation Beds 200.00							
201.00 Less Observation Beds 201.00							1
		39, 006, 589	94, 831, 217	133, 837, 806			
202.00 Total (see instructions) 39,006,589 94,831,217 133,837,806 202.00							
	202.00 Total (see instructions)	39, 006, 589	94, 831, 217	133, 837, 806			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: 15009	From 01/01/2014	Worksheet C Part I Date/Time Prepared: 5/22/2015 11:28 am

NPATI ENT ROUTI NE SERVICE COST CENTERS 11.00					5/22/2015 11:28 am
Ratio 11.00			Title XVIII	Hospi tal	PPS
INPATI ENT ROUTI NE SERVICE COST CENTERS 30. 00 03000 ADULTS & PEDI ATRICS 30. 00 04300 NURSERY 43. 00 04300 NURSERY 43. 00 04300 NURSERY 43. 00 04300 NURSERY 55. 00 05000 OPERATI NG ROOM 0. 420143 52. 00 05200 DELI VERY ROOM & LABOR ROOM 0. 420143 52. 00 05300 ANESTHESI OLOGY 0. 614827 53. 00 05300 ANESTHESI OLOGY 0. 614827 53. 00 05300 ANESTHESI OLOGY 0. 121464 54. 00 06400 RADIOLOGY-DI AGNOSTI C 0. 121464 54. 00 06400 LABORATORY 0. 250859 60. 00 06. 00 06000 LABORATORY 0. 250859 60. 00 06. 00 06000 LABORATORY 0. 250859 60. 00 06.	Cost Center Description	PPS Inpatient			
INPATI ENT ROUTI NE SERVI CE COST CENTERS 30. 00 03000 AULTS & PEDI ATRI CS 30. 00 34. 00 04300 NURSERY 43. 00 AUGUST & PEDI ATRI CS 34. 00 AUGUST & AUGUST & 34. 00 AUGUST & AUGUST & 34. 00 AUGUST & AUGUST & 34. 00 A					
30. 00 03000 ADULTS & PEDIATRICS 30. 00 43. 00 Ad300 NURSERY 43. 00 ARCILLARY SERVICE COST CENTERS		11.00			
43. 00 0.4300 NURSERY					
ANCILLARY SERVICE COST CENTERS					
50. 00 05000 OPERATING ROOM 0. 098055 50. 00 52.00 05200 DELI VERY ROOM & LABOR ROOM 0. 420143 52. 00 05200 DELI VERY ROOM & LABOR ROOM 0. 420143 52. 00 05300 ANESTHESI OLOGY 0. 514827 53. 00 05400 RADI OLOGY-DI AGNOSTI C 0. 121464 54. 00 06. 00 06000 LABORATORY 0. 250859 66. 00 06250 BLOOD CLOTTING FOR HEMOPHILIACS 0. 000000 622. 30 06500 ROSPI RATORY THERAPY 0. 305556 65. 00 06600 PHYSI CAL THERAPY 0. 143343 66. 00 06600 PHYSI CAL THERAPY 0. 143343 66. 00 06600 PHYSI CAL THERAPY 0. 000213 68. 00 06900 ELECTROCARDI OLOGY 0. 000213 68. 00 06900 ELECTROCARDI OLOGY 0. 000201 69. 00 07100 MEDI CAL SUPPLIES CHARGED TO PATI ENT 0. 130486 71. 00 77.00 07200 IMPL DEV. CHARGED TO PATI ENTS 0. 233979 72. 00 07300 DRUGS CHARGED TO PATI ENTS 0. 186563 73. 00 76. 97 07697 CARDI AC REHABI LI TATI ON 0. 000000 76. 98 76. 99 07699 LI THOTRI PSY 0. 000000 76. 98 76. 99 07699 LI THOTRI PSY 0. 0000000 76. 98 76. 99 00179ATI ENT SERVI CE COST CENTERS 91. 00 09100 EMERGENCY 0. 0000000 07100 07100 EMERGENCY 0. 0000000 0710					43. 00
52. 00 05200 DELI VERY ROOM & LABOR ROOM 0. 420143 0. 614827 53. 00 53. 00 05300 AMESTHESI DLOCY 0. 614827 53. 00 05400 RADI OLOGY-DI AGNOSTI C 0. 121464 54. 00 06000 LABORATORY 0. 250859 60. 00 06000 LABORATORY 0. 250859 60. 00 06250 BLOOD CLOTTING FOR HEMOPHILIACS 0. 000000 62. 30 06250 BLOOD CLOTTING FOR HEMOPHILIACS 0. 0000000 66. 00 06500 RESPI RATORY THERAPY 0. 305556 65. 00 06600 PHYSI CAL THERAPY 0. 143343 06. 00 06800 SPECCH PATHOLOGY 0. 000213 0. 00021 0. 00021 0. 00021 0. 00021 0. 00021 0. 00021 0. 00021 0. 00021 0. 00021 0. 00021 0. 00021 0. 00021 0. 00021 0. 00021 0. 000200 0. 000201 0. 000201 0. 000200 0. 000201 0. 000200 0. 0					
53. 00 05300 ANESTHESI OLOGY 0. 614827 53. 00 54. 00 05400 RADI OLOGY -DI AGNOSTI C 0. 121464 54. 00 60. 00 06000 LABORATORY 0. 250859 66. 00 62. 30 06250 BLOOD CLOTTI NG FOR HEMOPHI LI ACS 0. 0000000 62. 30 65. 00 06500 RESPI RATORY THERAPY 0. 305556 65. 00 66. 00 06600 PHYSI CAL THERAPY 0. 143343 66. 00 68. 00 06800 SPEECH PATHOLOGY 0. 000213 68. 00 69. 00 06900 ELECTROCARDI OLOGY 0. 000201 69. 00 71. 00 07100 MEDI CAL SUPPLI ES CHARGED TO PATI ENT 0. 130486 71. 00 72. 00 07200 IMPL. DEV. CHARGED TO PATI ENTS 0. 233979 72. 00 73. 00 07300 DRUGS CHARGED TO PATI ENTS 0. 186563 73. 00 76. 97 7697 CARDI AC REHABI LITATI ON 0. 000000 76. 97 76. 99 07699 LI THOTRI PSY 0. 000000 76. 99 91. 00 09100 EMERGENCY 0. 162684 91. 00 92. 00 09200 OBSERVATI ON BEDS (NON-DI STI NCT PART D. 0.01400 92. 00 90500 AMBULANCE SERVI CES S. 0.0					
54. 00 05400 RADI OLOGY-DI AGNOSTI C 0. 121464 54. 00 60. 00 06000 LABORATORY 0. 250859 60. 00 62. 30 06250 BLOOD CLOTTING FOR HEMOPHILI ACS 0. 000000 62. 30 65. 00 06500 RESPI RATORY THERAPY 0. 305556 65. 00 66. 00 06600 PHYSI CAL THERAPY 0. 143343 66. 00 68. 00 06800 SPEECH PATHOLOGY 0. 000213 68. 00 69. 00 06900 ELECTROCARDI OLOGY 0. 000201 69. 00 71. 00 07100 MEDI CAL SUPPLIES CHARGED TO PATI ENT 0. 130486 71. 00 72. 00 07200 I MPL. DEV. CHARGED TO PATI ENTS 0. 233979 72. 00 73. 00 07300 DRUGS CHARGED TO PATI ENTS 0. 186563 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. 98 92. 00 09200 DESERVATI ON BEDS (NON-DI STI NCT PART DI 1. 010140 92. 00 95. 00 09500 ABBULANCE SERVI CES 0. 622525 95. 00 09500 ABBULANCE SERVI CE		0. 420143			
60. 00 06000 LABORATORY 0. 250859 60. 00 662. 30 06250 BLOOD CLOTTING FOR HEMOPHILIACS 0. 0000000 62. 30 06250 BLOOD CLOTTING FOR HEMOPHILIACS 0. 0000000 65. 00 06500 RESPIRATORY THERAPY 0. 305556 65. 00 06600 PHYSI CAL THERAPY 0. 143343 66. 00 06600 PHYSI CAL THERAPY 0. 143343 66. 00 06800 SPEECH PATHOLOGY 0. 000213 68. 00 06900 ELECTROCARDI OLOGY 0. 000201 69. 00 07100 MEDI CAL SUPPLIES CHARGED TO PATIENT 0. 130486 71. 00 07100 MEDI CAL SUPPLIES CHARGED TO PATIENT 0. 130486 71. 00 07200 IMPL. DEV. CHARGED TO PATIENTS 0. 233979 72. 00 07300 DRUGS CHARGED TO PATIENTS 0. 186563 73. 00 07300 DRUGS CHARGED TO PATIENTS 0. 186563 73. 00 07699 CARDI AC REHABILITATION 0. 000000 76. 97 07697 CARDI AC REHABILITATION 0. 000000 76. 98 07699 LITHOTRI PSY 0. 000000 76. 98 07699 LITHOTRI PSY 0. 000000 76. 99 000000 76. 99 000000 76. 99 000000 76. 99 0000000 76. 99 0000000 76. 99 0000000 76. 99 0000000 76. 99 0000000 76. 99 0000000 76. 99 0000000 76. 99 0000000000 76. 99 0000000000000000000000000000000000		0. 614827			
62. 30	54. 00 05400 RADI OLOGY-DI AGNOSTI C	0. 121464			54.00
65. 00	60. 00 06000 LABORATORY	0. 250859			60. 00
66. 00	62.30 06250 BLOOD CLOTTING FOR HEMOPHILIACS	0. 000000			62. 30
68. 00	65. 00 06500 RESPIRATORY THERAPY	0. 305556			65. 00
69. 00 06900 Carried Supplies Charged To Patient Carried Supplies	66. 00 06600 PHYSI CAL THERAPY	0. 143343			66. 00
71. 00	68. 00 06800 SPEECH PATHOLOGY	0. 000213			68. 00
72. 00	69. 00 06900 ELECTROCARDI OLOGY	0. 000201			69. 00
73. 00 07300 DRUGS CHARGED TO PATIENTS 0. 186563 73. 00 76. 97 07697 CARDI AC REHABILITATION 0. 000000 76. 97 76. 98 07698 HYPERBARI C OXYGEN THERAPY 0. 000000 76. 98 76. 99 OTOPP LITHOTRIPSY 0. 000000 76. 99 0UTPATIENT SERVICE COST CENTERS 91. 00 09100 EMERGENCY 0. 162684 91. 00 0010 OTHER REIMBURSABLE COST CENTERS 95. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART 1. 010140 92. 00 0THER REIMBURSABLE COST CENTERS 95. 01 09500 AMBULANCE SERVICES 0. 622525 95. 00 SPECIAL PURPOSE COST CENTERS 113. 00 11300 INTEREST EXPENSE 113. 00 200. 00 Subtotal (see instructions) 200. 00 201. 00 Less Observation Beds	71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0. 130486			71. 00
76. 97 76. 97 76. 98 76. 98 76. 99 07699 HYPERBARI C OXYGEN THERAPY 0. 000000 76. 98 76. 99 00TPATIENT SERVICE COST CENTERS 91. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART 1.010140) 0THER REIMBURSABLE COST CENTERS 95. 00 09500 AMBULANCE SERVICES SPECIAL PURPOSE COST CENTERS 113. 00 11300 INTEREST EXPENSE 200. 00 201. 00 Less Observation Beds 76. 97 76. 98 0. 000000 76. 98 0. 000000 76. 99 0. 000000 76. 99 0. 000000 76. 99 0. 000000 76. 99 0. 000000 76. 99 0. 000000 76. 99 0. 000000 76. 99 0. 000000 76. 99 0. 000000 76. 99 0. 0000000 76. 99 0. 0000000 76. 99 0. 0000000 76. 99 0. 0000000 76. 99 0. 0000000 76. 99 0. 0000000 76. 99 0. 0000000 76. 99 0. 0000000 76. 99 0. 0000000 76. 99 0. 0000000000 76. 99 0. 00000000000 76. 99 0. 000000000000000 76. 99 0. 00000000000000000000000000000000	72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0. 233979			72. 00
76. 98 76. 99 76. 99 76. 99 76. 99 0000000 0000000 0000000 00000000 000000	73.00 07300 DRUGS CHARGED TO PATIENTS	0. 186563			73. 00
76. 99 O7699 LI THOTRI PSY O. 000000 76. 99 OUTPATI ENT SERVI CE COST CENTERS 91. 00 09100 EMERGENCY O. 162684 92. 00 09200 OBSERVATI ON BEDS (NON-DI STI NCT PART 1. 010140 92. 00 OTHER REI MBURSABLE COST CENTERS 95. 00 O9500 AMBULANCE SERVI CES O. 622525 95. 00 SPECI AL PURPOSE COST CENTERS 113. 00 11300 INTEREST EXPENSE 113. 00 200. 00 Subtotal (see instructions) 200. 00 201. 00 Less Observation Beds 201. 00	76. 97 07697 CARDI AC REHABI LI TATI ON	0. 000000			76. 97
OUTPATIENT SERVICE COST CENTERS 91.00 09100 EMERGENCY 0.162684 91.00 09200 OBSERVATION BEDS (NON-DISTINCT PART 1.010140 92.00 OTHER REIMBURSABLE COST CENTERS 09500 AMBULANCE SERVICES 0.622525 95.00 SPECIAL PURPOSE COST CENTERS 113.00 11300 INTEREST EXPENSE 113.00 200.00 Subtotal (see instructions) 200.00 201.00 Less Observation Beds 201.00	76. 98 07698 HYPERBARI C OXYGEN THERAPY	0. 000000			76. 98
91. 00	76. 99 07699 LI THOTRI PSY	0. 000000			76. 99
92. 00 09200 OBSERVATI ON BEDS (NON-DISTINCT PART 1. 010140 92. 00 OTHER REIMBURSABLE COST CENTERS 95. 00 SPECIAL PURPOSE COST CENTERS 95. 00 11300 INTEREST EXPENSE 113. 00 200. 00 Subtotal (see instructions) 200. 00 Less Observation Beds 201. 00 201. 00 Control of the	OUTPATIENT SERVICE COST CENTERS				
OTHER REI MBURSABLE COST CENTERS 95.00 95.00 AMBULANCE SERVI CES 0.622525 95.00 SPECIAL PURPOSE COST CENTERS 113.00 11300 INTEREST EXPENSE 113.00 200.00 Subtotal (see instructions) 200.00 201.00 Less Observation Beds 201.00	91. 00 09100 EMERGENCY	0. 162684			91. 00
95. 00 09500 AMBULANCE SERVICES 0. 622525 95. 00 SPECIAL PURPOSE COST CENTERS 113. 00 11300 1NTEREST EXPENSE 200. 00 Subtotal (see instructions) 200. 00 201. 00 Less Observation Beds 201. 00	92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART	1. 010140			92. 00
SPECIAL PURPOSE COST CENTERS 113.00 11300 INTEREST EXPENSE 200.00 Subtotal (see instructions) 200.00 201.00 Less Observation Beds 201.00	OTHER REIMBURSABLE COST CENTERS				
113. 00	95. 00 09500 AMBULANCE SERVICES	0. 622525			95. 00
200. 00 Subtotal (see instructions) 200. 00 201. 00 Less Observation Beds 201. 00	SPECIAL PURPOSE COST CENTERS				
201.00 Less Observation Beds 201.00	113. 00 11300 I NTEREST EXPENSE				113. 00
	200.00 Subtotal (see instructions)				200. 00
202. 00 Total (see instructions) 202. 00	201.00 Less Observation Beds				201. 00
	202.00 Total (see instructions)				202. 00

Health Financial Systems	HUNTI NGTON MEMO	ORIAL I	HOSPI TAL		In Lie	u of Form CMS-2	2552-10
COMPUTATION OF RATIO OF COSTS TO CHARGES			Provi der		Period: From 01/01/2014 To 12/31/2014	Worksheet C Part I Date/Time Pre 5/22/2015 11:	pared: 28 am
			Ti t	le XIX	Hospi tal	PPS	
					Costs		
Cost Center Description	Total Cost		npy Limit	Total Costs		Total Costs	
	(from Wkst. B, Part I, col. 26)	,	Adj.		Di sal I owance		
	1.00		2. 00	3.00	4. 00	5. 00	

				ie xix	HOSPITAI	PP5	
					Costs		
	Cost Center Description	Total Cost	Therapy Limit	Total Costs	RCE	Total Costs	
		(from Wkst. B,	Adj .		Di sal I owance		
		Part I, col.					
		26)					
		1.00	2. 00	3. 00	4. 00	5. 00	
	INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000 ADULTS & PEDIATRICS	7, 236, 252		7, 236, 252	0	7, 236, 252	30. 00
43.00	04300 NURSERY	58, 611		58, 611	0	58, 611	43.00
	ANCILLARY SERVICE COST CENTERS						
50.00	05000 OPERATING ROOM	1, 738, 627		1, 738, 627	24, 459	1, 763, 086	50.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	1, 235, 060		1, 235, 060	o	1, 235, 060	52.00
53.00	05300 ANESTHESI OLOGY	1, 416, 633		1, 416, 633	o	1, 416, 633	53. 00
54.00	05400 RADI OLOGY-DI AGNOSTI C	3, 652, 320		3, 652, 320	o	3, 652, 320	
60.00	06000 LABORATORY	3, 290, 986		3, 290, 986	o	3, 290, 986	60.00
62. 30	06250 BLOOD CLOTTING FOR HEMOPHILIACS	0		0	o	0	62. 30
65.00	06500 RESPIRATORY THERAPY	1, 477, 213	0	1, 477, 213	o	1, 477, 213	65. 00
66.00	06600 PHYSI CAL THERAPY	443, 989		443, 989		443, 989	
68. 00	06800 SPEECH PATHOLOGY	3	0	3	o	3	68. 00
69. 00	06900 ELECTROCARDI OLOGY	121		121	o	121	69. 00
71. 00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	1, 226, 170		1, 226, 170	o	1, 226, 170	71. 00
72. 00	07200 IMPL. DEV. CHARGED TO PATIENTS	1, 262, 933		1, 262, 933	o	1, 262, 933	
73. 00	07300 DRUGS CHARGED TO PATIENTS	2, 362, 162		2, 362, 162	o	2, 362, 162	
76. 97	07697 CARDI AC REHABI LI TATI ON	0		0	o	0	76. 97
	07698 HYPERBARI C OXYGEN THERAPY	0		0	ol	0	76. 98
	07699 LI THOTRI PSY	0		0	ol	0	76. 99
	OUTPATIENT SERVICE COST CENTERS				- 1		
91. 00	09100 EMERGENCY	2, 583, 939		2, 583, 939	0	2, 583, 939	91.00
	09200 OBSERVATION BEDS (NON-DISTINCT PART	1, 301, 655		1, 301, 655		1, 301, 655	
72.00	OTHER REIMBURSABLE COST CENTERS	1,001,000		1,001,000		1,001,000	72.00
95 00	09500 AMBULANCE SERVI CES	3, 732, 279		3, 732, 279	ol	3, 732, 279	95. 00
70.00	SPECIAL PURPOSE COST CENTERS	0,702,277		0,702,277	<u> </u>	0, 102, 217	70.00
113 00	11300 I NTEREST EXPENSE						113. 00
200.00	1 1	33, 018, 953	0	33, 018, 953	24, 459	33, 043, 412	
201.00	,	1, 301, 655		1, 301, 655		1, 301, 655	
202.00		31, 717, 298				31, 741, 757	
202.00	Total (See Histi detions)	31,717,270	1	1 31,717,270	27,437	51, 771, 757	1202.00

Health Financial Systems	H	HUNTI NGTON MEM	ORI AL	HOSPI TAL		In Lie	u of Form CMS-2	2552-10
COMPUTATION OF RATIO OF COSTS TO	CHARGES			F		Period: From 01/01/2014 To 12/31/2014	Worksheet C Part I Date/Time Pre 5/22/2015 11:	pared: 28 am
				Ti t	le XIX	Hospi tal	PPS	
·		Charges						
Cost Center Descrip	ti on	I npati ent	0u1	tpati ent		Cost or Other	TEFRA	
					+ col. 7)	Ratio	Inpati ent	
							Ratio	

		Title XIX Hospital PPS				PPS	
			Charges				
	Cost Center Description	I npati ent	Outpati ent	Total (col. 6	Cost or Other	TEFRA	
				+ col. 7)	Ratio	I npati ent	
						Ratio	
		6. 00	7. 00	8. 00	9. 00	10.00	
	INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000 ADULTS & PEDIATRICS	7, 480, 287		7, 480, 287			30. 00
43.00	04300 NURSERY	772, 753		772, 753			43.00
	ANCILLARY SERVICE COST CENTERS						
50.00	05000 OPERATING ROOM	5, 491, 682	12, 488, 935	17, 980, 617	0. 096695	0.000000	50.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	2, 939, 618	0	2, 939, 618	0. 420143	0.000000	52.00
53.00	05300 ANESTHESI OLOGY	599, 385	1, 704, 731	2, 304, 116	0. 614827	0.000000	53.00
54.00	05400 RADI OLOGY-DI AGNOSTI C	3, 376, 034	26, 693, 068	30, 069, 102	0. 121464	0.000000	54.00
60.00	06000 LABORATORY	2, 581, 909	10, 536, 952	13, 118, 861	0. 250859	0.000000	60.00
62. 30	06250 BLOOD CLOTTING FOR HEMOPHILIACS	O	0	0	0.000000	0.000000	62. 30
65.00	06500 RESPI RATORY THERAPY	1, 614, 041	3, 220, 473	4, 834, 514	0. 305556	0.000000	65. 00
66.00	06600 PHYSI CAL THERAPY	547, 050	2, 550, 329	3, 097, 379	0. 143343	0.000000	66. 00
68.00	06800 SPEECH PATHOLOGY	14, 110	0	14, 110	0. 000213	0.000000	68. 00
69.00	06900 ELECTROCARDI OLOGY	492, 502	110, 812	603, 314	0. 000201	0.000000	69.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	2, 111, 628	7, 285, 300	9, 396, 928	0. 130486	0.000000	71. 00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	4, 124, 977	1, 272, 655	5, 397, 632	0. 233979	0.000000	72. 00
73.00	07300 DRUGS CHARGED TO PATIENTS	4, 762, 366	7, 899, 102	12, 661, 468	0. 186563	0.000000	73. 00
76. 97	07697 CARDIAC REHABILITATION	O	0	0	0.000000	0.000000	76. 97
76. 98	07698 HYPERBARI C OXYGEN THERAPY	O	0	0	0.000000	0.000000	76. 98
76. 99	07699 LI THOTRI PSY	0	0	0	0.000000	0.000000	76. 99
	OUTPATIENT SERVICE COST CENTERS						
91.00	09100 EMERGENCY	2, 097, 110	13, 786, 022	15, 883, 132	0. 162684	0.000000	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART	0	1, 288, 589	1, 288, 589	1. 010140	0.000000	92.00
	OTHER REIMBURSABLE COST CENTERS						
95.00	09500 AMBULANCE SERVICES	1, 137	5, 994, 249	5, 995, 386	0. 622525	0.000000	95. 00
	SPECIAL PURPOSE COST CENTERS						
113.00	11300 INTEREST EXPENSE						113. 00
200.00	Subtotal (see instructions)	39, 006, 589	94, 831, 217	133, 837, 806			200. 00
201.00	Less Observation Beds						201. 00
202.00	Total (see instructions)	39, 006, 589	94, 831, 217	133, 837, 806			202. 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 Period: Worksheet C From 01/01/2014 Part I To 12/31/2014 Date/Time Prepared: 5/22/2015 11:28 am

				5/22/2015 11:28 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 OPERATING ROOM	0. 098055			50.00
52.00 05200 DELIVERY ROOM & LABOR ROOM	0. 420143			52. 00
53. 00 05300 ANESTHESI OLOGY	0. 614827			53.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	0. 121464			54.00
60. 00 06000 LABORATORY	0. 250859			60.00
62.30 06250 BLOOD CLOTTING FOR HEMOPHILIACS	0. 000000			62. 30
65. 00 06500 RESPIRATORY THERAPY	0. 305556			65. 00
66. 00 06600 PHYSI CAL THERAPY	0. 143343			66. 00
68. 00 06800 SPEECH PATHOLOGY	0. 000213			68. 00
69. 00 06900 ELECTROCARDI OLOGY	0. 000201			69. 00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0. 130486			71. 00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0. 233979			72. 00
73.00 07300 DRUGS CHARGED TO PATIENTS	0. 186563			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. 162684			91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART	1. 010140			92. 00
OTHER REIMBURSABLE COST CENTERS				
95. 00 09500 AMBULANCE SERVICES	0. 622525			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	PI TAL	In Lieu	of Form CMS-2552-10
CALCULATION OF OUTPATIENT SERVICE COST TO CH	IARGE RATIOS NET OF Provi			Worksheet C
REDUCTIONS FOR MEDICALD ONLY			From 01/01/2014	Part II

KEDUCT	TONS FOR MEDICALD UNET			j	To 12/31/2014	Date/Time Pre 5/22/2015 11:	
			Ti t	le XIX	Hospi tal	PPS	
	Cost Center Description	Total Cost	Capital Cost	Operating Cost	Capi tal	Operating Cost	
		(Wkst. B, Part				Reduction	
		I, col. 26)	II col. 26)	Cost (col. 1 -	-	Amount	
				col . 2)			
		1.00	2. 00	3. 00	4. 00	5. 00	
	ANCILLARY SERVICE COST CENTERS					1	
	05000 OPERATING ROOM	1, 738, 627	· ·	1		0	
	05200 DELIVERY ROOM & LABOR ROOM	1, 235, 060				0	52. 00
	05300 ANESTHESI OLOGY	1, 416, 633	· ·			0	53. 00
	05400 RADI OLOGY-DI AGNOSTI C	3, 652, 320		1		0	54. 00
	06000 LABORATORY	3, 290, 986	219, 287	3, 071, 699	9 0	0	60.00
	06250 BLOOD CLOTTING FOR HEMOPHILIACS	0	C	ή	0	0	62. 30
	06500 RESPI RATORY THERAPY	1, 477, 213			9 0	0	65. 00
	06600 PHYSI CAL THERAPY	443, 989	103, 638	340, 351	0	0	66. 00
	06800 SPEECH PATHOLOGY	3	1	2	2 0	0	68. 00
	06900 ELECTROCARDI OLOGY	121	25		1	0	69. 00
71. 00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	1, 226, 170	84, 957	1, 141, 213	3 0	0	71. 00
	07200 IMPL. DEV. CHARGED TO PATIENTS	1, 262, 933	80, 032	1, 182, 901	0	0	72. 00
	07300 DRUGS CHARGED TO PATIENTS	2, 362, 162	149, 931	2, 212, 231	0	0	73. 00
76. 97	07697 CARDIAC REHABILITATION	0	C) (0	0	76. 97
76. 98	07698 HYPERBARIC OXYGEN THERAPY	0	C) (0	0	76. 98
	07699 LI THOTRI PSY	0	C) (0	0	76. 99
	OUTPATIENT SERVICE COST CENTERS						
	09100 EMERGENCY	2, 583, 939				0	91. 00
	09200 OBSERVATION BEDS (NON-DISTINCT PART	1, 301, 655	158, 790	1, 142, 865	5 0	0	92. 00
	OTHER REIMBURSABLE COST CENTERS						
95.00	09500 AMBULANCE SERVICES	3, 732, 279	585, 431	3, 146, 848	3 0	0	95. 00
	SPECIAL PURPOSE COST CENTERS						
113.00	11300 INTEREST EXPENSE						113. 00
200.00		25, 724, 090	3, 146, 122	22, 577, 968	3 0	0	200. 00
201.00	Less Observation Beds	1, 301, 655	158, 790	1, 142, 865	5 0	0	201. 00
202.00	Total (line 200 minus line 201)	24, 422, 435	2, 987, 332	21, 435, 103	3 0	0	202. 00

Health Financial Systems	HUNTINGTON MEMORIAL	HOSPI TAL	In Lie	u of Form CMS-2552-10
CALCULATION OF OUTPATIENT SERVICE COST REDUCTIONS FOR MEDICALD ONLY	TO CHARGE RATIOS NET OF	Provider CCN: 150091	From 01/01/2014	Worksheet C Part II Date/Time Prepared:

						5/22/2015 11	28 am
				le XIX	Hospi tal	PPS	
	Cost Center Description	Cost Net of					
		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						
	O5000 OPERATI NG ROOM	1, 738, 627					50. 00
52.00	05200 DELIVERY ROOM & LABOR ROOM	1, 235, 060	2, 939, 618	0. 420143	3		52.00
	05300 ANESTHESI OLOGY	1, 416, 633	2, 304, 116	0. 614827	7		53.00
54.00	05400 RADI OLOGY-DI AGNOSTI C	3, 652, 320	30, 069, 102	0. 121464	1		54.00
60.00	06000 LABORATORY	3, 290, 986	13, 118, 861	0. 250859	9		60. 00
62.30	06250 BLOOD CLOTTING FOR HEMOPHILIACS	0	C	0.000000			62. 30
65.00	06500 RESPI RATORY THERAPY	1, 477, 213	4, 834, 514	0. 305556	5		65. 00
66.00	06600 PHYSI CAL THERAPY	443, 989	3, 097, 379	0. 143343	3		66. 00
68. 00	06800 SPEECH PATHOLOGY	3	14, 110	0. 000213	3		68. 00
69.00	06900 ELECTROCARDI OLOGY	121	603, 314	0. 000201	I		69. 00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	1, 226, 170	9, 396, 928	0. 130486	5		71. 00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	1, 262, 933	5, 397, 632	0. 233979	9		72. 00
73.00	07300 DRUGS CHARGED TO PATIENTS	2, 362, 162	12, 661, 468	0. 186563	3		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, 583, 939	15, 883, 132	0. 162684	1		91. 00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART	1, 301, 655	1, 288, 589	1. 010140			92. 00
	OTHER REIMBURSABLE COST CENTERS						
95.00	09500 AMBULANCE SERVICES	3, 732, 279	5, 995, 386	0. 622525	5		95. 00
	SPECIAL PURPOSE COST CENTERS						
113.00	11300 I NTEREST EXPENSE						113. 00
200.00	Subtotal (sum of lines 50 thru 199)	25, 724, 090	125, 584, 766				200. 00
201.00	Less Observation Beds	1, 301, 655	C				201. 00
202.00	Total (line 200 minus line 201)	24, 422, 435	125, 584, 766				202. 00

Health Financial Systems	HUNTINGTON MEMO	RIAL HOSPITAL		In Lie	u of Form CMS-2	2552-10
APPORTIONMENT OF INPATIENT ROUTINE SERVICE CAPITAL	COSTS	Provi der		Peri od:	Worksheet D	
				From 01/01/2014		
				To 12/31/2014	Date/Time Pre 5/22/2015 11:	
		Ti tl	e XVIII	Hospi tal	PPS	20 alli
Cost Center Description	Capi tal	Swing Bed	Reduced	Total Patient		
	Related Cost	Adjustment	Capi tal	Days	3 / col. 4)	
	(from Wkst. B,		Related Cost		,	
	Part II, col.		(col . 1 - col			
	26)		2)			
	1.00	2. 00	3.00	4. 00	5. 00	
INPATIENT ROUTINE SERVICE COST CENTERS						
30. 00 ADULTS & PEDI ATRI CS	882, 754	C	882, 75	4 6, 471	136. 42	30. 00
43. 00 NURSERY	4, 373		4, 37	3 710	6. 16	43. 00
200.00 Total (lines 30-199)	887, 127		887, 12	7, 181		200. 00
Cost Center Description	I npati ent	I npati ent				
	Program days	Program				
		Capital Cost				
		(col. 5 x col.				
		6)				
	6. 00	7. 00				
INPATIENT ROUTINE SERVICE COST CENTERS						
30. 00 ADULTS & PEDI ATRI CS	1, 770	241, 463	3			30. 00
43. 00 NURSERY	0	C)			43. 00
200.00 Total (lines 30-199)	1,770	241, 463	3			200. 00

Health Financial Customs	HUNTINGTON MEMO	NDIAL HOCDITAL		l m l i a	eu of Form CMS-2	DEED 10
Health Financial Systems I APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITA		Provi der		Period: From 01/01/2014 To 12/31/2014	Worksheet D Part II Date/Time Pre 5/22/2015 11:	pared:
			e XVIII	Hospi tal	PPS	
Cost Center Description	Capi tal	Total Charges			Capital Costs	
		(from Wkst. C,		Program	(column 3 x	
	(from Wkst. B,	Part I, 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	340, 183	,				
52.00 05200 DELIVERY ROOM & LABOR ROOM	78, 766		1		_	
53. 00 05300 ANESTHESI OLOGY	89, 666		1		0	
54. 00 05400 RADI OLOGY-DI AGNOSTI C	815, 998					
60. 00 06000 LABORATORY	219, 287					
62.30 06250 BLOOD CLOTTING FOR HEMOPHILIACS	0		0.00000		_	
65. 00 06500 RESPIRATORY THERAPY	172, 474		1	· ·		
66. 00 06600 PHYSI CAL THERAPY	103, 638				7, 797	
68.00 06800 SPEECH PATHOLOGY	1	14, 110			_	
69. 00 06900 ELECTROCARDI OLOGY	25				_	69. 00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	84, 957			· ·		
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	80, 032					
73.00 07300 DRUGS CHARGED TO PATIENTS	149, 931	12, 661, 468	l .		18, 018	
76. 97 07697 CARDI AC REHABI LI TATI ON	0	0	0.00000		0	
76. 98 07698 HYPERBARI C OXYGEN THERAPY	0	0	0.00000		0	76. 98
76. 99 07699 LI THOTRI PSY	0	0	0.00000	0 0	0	76. 99
OUTPAȚI ENT SERVI CE COST CENTERS						
91. 00 09100 EMERGENCY	266, 943				14, 721	
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART	158, 790	1, 288, 589	0. 12322	8 0	0	92.00
OTHER REIMBURSABLE COST CENTERS						
95. 00 09500 AMBULANCE SERVICES						95. 00
200.00 Total (lines 50-199)	2, 560, 691	119, 589, 380		8, 322, 097	161, 557	200. 00

Health Financial Systems	HUNTI NGTON MEMO	ORI AL	HOSPI TAL		In Li€	eu of Form CMS-2	2552-10
APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER	PASS THROUGH COS	TS	Provi der	CCN: 150091	Peri od:	Worksheet D	
					From 01/01/2014		
					To 12/31/2014	Date/Time Pre 5/22/2015 11:	pared: 28 am
-			Ti tl	e XVIII	Hospi tal	PPS	20 4111
Cost Center Description	Nursing School	Alli			Swi ng-Bed	Total Costs	
· ·			Cost	Medi cal	Adjustment	(sum of cols.	
				Education Cos	st Amount (see	1 through 3,	
					instructions)	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		C)	0	0	30.00
43. 00 04300 NURSERY	C		C)	0	0	43. 00
200.00 Total (lines 30-199)	C		C)	0	0	200. 00
Cost Center Description	Total Patient	Per	Diem (col.	I npati ent	Inpati ent		
	Days	5 ÷	- col . 6)	Program Days			
					Pass-Through		
					Cost (col. 7 x		
					col . 8)		
	6. 00		7. 00	8. 00	9. 00		
I NPATI ENT ROUTI NE SERVI CE COST CENTERS							
30. 00 03000 ADULTS & PEDI ATRI CS	6, 471		0. 00	1	70 0		30. 00
43. 00 04300 NURSERY	710	1	0. 00		0		43. 00
200.00 Total (lines 30-199)	7, 181			1, 7	70 0		200. 00

Heal th Financial Systems	50. 00
Non Physician Anesthetist Cost Nursing School Allied Health All Other Medical Education Cost Sum of col 1 Sum of c	
Anesthetist Cost	
ANCI LLARY SERVI CE COST CENTERS	
50. 00 05000 OPERATI NG ROOM 0 <td></td>	
52. 00 05200 DELI VERY ROOM & LABOR ROOM 0	
54. 00 05400 RADI OLOGY-DI AGNOSTI C 0	52.00
60. 00 06000 LABORATORY	53.00
62. 30 06250 BLOOD CLOTTING FOR HEMOPHILIACS 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	54.00
65. 00 06500 RESPIRATORY THERAPY 0 0 0 0	60.00
	62. 30
	65.00
66. 00 06600 PHYSI CAL THERAPY 0 0 0 0 0	66.00
68. 00 06800 SPEECH PATHOLOGY 0 0 0 0 0	68. 00
69. 00 06900 ELECTROCARDI OLOGY 0 0 0 0 0	69. 00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT 0 0 0 0 0	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 0	73.00
76. 97 07697 CARDI AC REHABI LI TATI ON 0 0 0 0 0	76. 97
76. 98 07698 HYPERBARI C 0XYGEN THERAPY 0 0 0 0 0	76. 98
76. 99 07699 LI THOTRI PSY 0 0 0 0 0 0	76. 99
OUTPATIENT SERVICE COST CENTERS	
91. 00 09100 EMERGENCY 0 0 0 0 0	91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART 0 0 0 0 0	92.00
OTHER REIMBURSABLE COST CENTERS	
95. 00 O9500 AMBULANCE SERVICES	95.00
200.00 Total (lines 50-199) 0 0 0 0	00.00

Health Financial Systems APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SE THROUGH COSTS	HUNTINGTON MEMORVICE OTHER PAS	S Provi der		Period: From 01/01/2014 To 12/31/2014	u of Form CMS-2 Worksheet D Part IV Date/Time Pre 5/22/2015 11:	pared:
			e XVIII	Hospi tal	PPS	
Cost Center Description	Total	Total Charges			Inpati ent	
	Outpati ent	(from Wkst. C,		Ratio of Cost		
	Cost (sum of		(col . 5 ÷ col		Charges	
	col. 2, 3 and	8)	7)	(col. 6 ÷ col.		
	4) 6, 00	7. 00	8. 00	7) 9. 00	10.00	
ANCILLARY SERVICE COST CENTERS	6.00	7.00	8.00	9.00	10.00	
50. 00 05000 OPERATING ROOM	1 0	17, 980, 617	0.00000	0. 000000	1, 257, 908	50.00
52. 00 05200 DELIVERY ROOM & LABOR ROOM			1		1, 237, 700	1
53. 00 05300 ANESTHESI OLOGY		2, 304, 116			0	
54. 00 05400 RADI OLOGY-DI AGNOSTI C		30, 069, 102			1, 417, 485	
60. 00 06000 LABORATORY		13, 118, 861	1		929, 532	
62. 30 06250 BLOOD CLOTTING FOR HEMOPHILIACS		0	1		0	
65. 00 06500 RESPIRATORY THERAPY	0	4, 834, 514	1		678, 571	65. 00
66. 00 06600 PHYSI CAL THERAPY		3, 097, 379			233, 030	
68, 00 06800 SPEECH PATHOLOGY	0	14, 110	1		0	
69. 00 06900 ELECTROCARDI OLOGY	0	603, 314	1		0	69.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0	9, 396, 928	1	0. 000000	322, 861	71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0	5, 397, 632	0.00000	0. 000000	1, 085, 285	72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	0	12, 661, 468	0. 00000	0. 000000	1, 521, 564	73.00
76. 97 07697 CARDI AC REHABI LI TATI ON	0	0	0. 00000	0. 000000	0	
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	•			•		1
91. 00 09100 EMERGENCY	0	15, 883, 132	0.00000	0. 000000	875, 861	91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART	0	1, 288, 589	0.00000	0. 000000	0	92.00
OTHER REIMBURSABLE COST CENTERS						
95. 00 09500 AMBULANCE SERVICES						95. 00
200.00 Total (lines 50-199)	0	119, 589, 380)		8, 322, 097	200.00

Health Financial Systems	HUNTI NGTON MEMORI AL	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 01/01/2014 To 12/31/2014	Worksheet D Part IV Date/Time Prepared:

					5/22/2015 11:	28 am_
			e XVIII	Hospi tal	PPS	
Cost Center Description Inpa	tient Ou	ıtpati ent	Outpati ent			
		Program	Program			
		Charges	Pass-Through			
	(col. 8		Costs (col. 9			
	. 10)		x col. 12)			
	. 00	12. 00	13. 00			
ANCILLARY SERVICE COST CENTERS						
50. 00 05000 OPERATI NG ROOM	0	2, 881, 565	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	5, 884, 790	0			54. 00
60. 00 06000 LABORATORY	0	356, 278	0			60.00
62.30 06250 BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0			62. 30
65. 00 06500 RESPI RATORY THERAPY	0	552, 564	0			65. 00
66. 00 06600 PHYSI CAL THERAPY	0	0	0			66. 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	473, 814	0			71. 00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0	213, 072	0			72. 00
73.00 07300 DRUGS CHARGED TO PATIENTS	0	1, 443, 075	0			73.00
76. 97 O7697 CARDI AC REHABI LI TATI ON	0	0	0			76. 97
76. 98 07698 HYPERBARI C OXYGEN THERAPY	О	0	0			76. 98
76. 99 07699 LI THOTRI PSY	О	0	0			76. 99
OUTPATIENT SERVICE COST CENTERS						1
91. 00 09100 EMERGENCY	0	2, 445, 104	0			91. 00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART	o	544, 997	0			92.00
OTHER REIMBURSABLE COST CENTERS						1
95. 00 09500 AMBULANCE SERVICES				-	-	95. 00
200.00 Total (lines 50-199)	o	14, 795, 259	0			200. 00

Health Financial Systems	HUNTINGTON MEMORIAL	HOSPI TAL	In Lie	u of Form CMS-2552-10
APPORTI ONMENT OF MEDICAL,	OTHER HEALTH SERVICES AND VACCINE COST	Provider CCN: 150091	Peri od:	Worksheet D

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND	VACCINE COST	Provi der		Period: From 01/01/2014 To 12/31/2014	Worksheet D Part V Date/Time Pre 5/22/2015 11:	
		Ti tl	e XVIII	Hospi tal	PPS	
			Charges		Costs	
Cost Center Description	Cost to Charge	PPS Reimbursed	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.			
			(see inst.)	(see inst.)		
	1.00	2. 00	3. 00	4. 00	5. 00	
ANCILLARY SERVICE COST CENTERS						
50.00 05000 OPERATING ROOM	0. 096695			0 0	278, 633	
52.00 05200 DELIVERY ROOM & LABOR ROOM	0. 420143	0	1	0 0	0	52. 00
53. 00 05300 ANESTHESI OLOGY	0. 614827	0)	0	0	53. 00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	0. 121464	5, 884, 790		0 0	714, 790	
60. 00 06000 LABORATORY	0. 250859			0	89, 376	
62.30 06250 BLOOD CLOTTING FOR HEMOPHILIACS	0. 000000		1	0	0	62. 30
65. 00 06500 RESPI RATORY THERAPY	0. 305556			0	168, 839	
66. 00 06600 PHYSI CAL THERAPY	0. 143343	0	1	0	0	66. 00
68.00 06800 SPEECH PATHOLOGY	0. 000213	0	1	0	0	68. 00
69. 00 06900 ELECTROCARDI OLOGY	0. 000201	0	1	0	0	69. 00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0. 130486			0	61, 826	
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0. 233979	213, 072		0	49, 854	72. 00
73.00 07300 DRUGS CHARGED TO PATIENTS	0. 186563	1, 443, 075		0 0	269, 224	73. 00
76. 97 07697 CARDI AC REHABI LI TATI ON	0. 000000	0)	0 0	0	76. 97
76. 98 07698 HYPERBARI C OXYGEN THERAPY	0. 000000	0)	0 0	0	76. 98
76. 99 07699 LI THOTRI PSY	0. 000000	0		0 0	0	76. 99
OUTPATIENT SERVICE COST CENTERS						
91. 00 09100 EMERGENCY	0. 162684	2, 445, 104		0 0	397, 779	91. 00
92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART	1. 010140	544, 997		0	550, 523	92. 00
OTHER REIMBURSABLE COST CENTERS						
95. 00 09500 AMBULANCE SERVICES	0. 622525			0		95. 00
200.00 Subtotal (see instructions)		14, 795, 259	1	0 0	2, 580, 844	200. 00
201.00 Less PBP Clinic Lab. Services-Program				0 0		201. 00
Only Charges						
202.00 Net Charges (line 200 +/- line 201)		14, 795, 259	1	0 0	2, 580, 844	202. 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		Worksheet D
			From 01/01/2014	
			T- 10/01/001/	D-+- /T! D

					To 12/31/2014	Date/Time Pro	epared: :28 am
			7	Title XVIII	Hospi tal	PPS	
		Costs					
	Cost Center Description	Cost	Cost				
		Rei mbursed	Reimburse				
		Servi ces	Services N				
		Subject To	Subject T				
		Ded. & Coins.	Ded. & Coi				
		(see inst.) 6.00	(see inst 7.00	.)			
	ANCILLARY SERVICE COST CENTERS	0.00	7.00				
	05000 OPERATING ROOM			0			50.00
	05200 DELIVERY ROOM & LABOR ROOM			0			52.00
	05300 ANESTHESI OLOGY			o			53. 00
	05400 RADI OLOGY-DI AGNOSTI C	0		ol			54. 00
60.00	06000 LABORATORY	0		o			60.00
62. 30	06250 BLOOD CLOTTING FOR HEMOPHILIACS	0		o			62. 30
65.00	06500 RESPI RATORY THERAPY	0		o			65. 00
66.00	06600 PHYSI CAL THERAPY	0		o			66. 00
68.00	06800 SPEECH PATHOLOGY	0		o			68. 00
69.00	06900 ELECTROCARDI OLOGY	0		0			69. 00
	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0	1	0			71. 00
	07200 IMPL. DEV. CHARGED TO PATIENTS	0	1	0			72. 00
	07300 DRUGS CHARGED TO PATIENTS	0	1	0			73. 00
	07697 CARDIAC REHABILITATION	0		0			76. 97
	07698 HYPERBARI C OXYGEN THERAPY	0		0			76. 98
76. 99	07699 LI THOTRI PSY	0		0			76. 99
	OUTPATIENT SERVICE COST CENTERS		1				
	09100 EMERGENCY	0	l .	0			91.00
	09200 OBSERVATION BEDS (NON-DISTINCT PART	0		0			92. 00
	OTHER REIMBURSABLE COST CENTERS 09500 AMBULANCE SERVICES	1	ı				95. 00
200.00				0			200.00
200.00	, , , , , , , , , , , , , , , , , , , ,			٧			200.00
201.00	Only Charges		1				201.00
202.00		0		o			202. 00

Health Financial Systems	HUNTINGTON MEMO	RIAL HOSPITAL		In Lie	eu of Form CMS-	2552-10
APPORTIONMENT OF INPATIENT ROUTINE SERVICE CAPITAL	COSTS	Provi der	CCN: 150091	Peri od:	Worksheet D	
				From 01/01/2014 To 12/31/2014		narod:
				10 12/31/2014	5/22/2015 11:	
		Ti	tle XIX	Hospi tal	PPS	
Cost Center Description	Capi tal	Swing Bed	Reduced	Total Patient	Per Diem (col.	
	Related Cost	Adjustment	Capi tal	Days	3 / col . 4)	
	(from Wkst. B,		Related Cos			
	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	882, 754		0 882, 75	6, 471	136. 42	30. 00
43. 00 NURSERY	4, 373		4, 3	73 710	6. 16	43.00
200.00 Total (lines 30-199)	887, 127		887, 12	7, 181		200. 00
Cost Center Description	I npati ent	I npati ent				
	Program days	Program				
		Capital Cost				
		(col. 5 x col				
		6)				
	6.00	7. 00				
INPATIENT ROUTINE SERVICE COST CENTERS					<u> </u>	
30. 00 ADULTS & PEDI ATRI CS	265	36, 15	1			30.00
43. 00 NURSERY	66	40	7			43.00
200.00 Total (lines 30-199)	331	36, 55	8			200. 00

Health Financial Systems	HUNTINGTON MEMO	ORIAL HOSPITAL		In Li∈	eu of Form CMS-2	2552-10
APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITA		CCN: 150091	Peri od:	Worksheet D		
				From 01/01/2014	Part II	
				To 12/31/2014	Date/Time Pre	pared:
		T: 4	.1 - VIV	11: +-1	5/22/2015 11:	28 am
Cook Cooks Doors at a	0		le XIX	Hospi tal	PPS	
Cost Center Description	Capi tal	Total Charges (from Wkst. C,	ta Charges		Capital Costs	
	(from Wkst. B,	Part I, col.		Program . Charges	(column 3 x column 4)	
	Part II, col.	8)	2)	. Charges	COTUIIIT 4)	
	26)	0)	2)			
	1.00	2.00	3.00	4. 00	5. 00	
ANCI LLARY SERVI CE COST CENTERS	1.00	2.00	3.00	4.00	3.00	
50. 00 05000 OPERATING ROOM	340, 183	17, 980, 617	0. 01891	9 1, 779, 168	33, 660	50.00
52. 00 05200 DELIVERY ROOM & LABOR ROOM	78, 766				0	1
53. 00 05300 ANESTHESI OLOGY	89, 666				0	1
54. 00 05400 RADI OLOGY-DI AGNOSTI C	815, 998				7, 099	
60. 00 06000 LABORATORY	219, 287		•			
62.30 06250 BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0. 00000	0	0	62. 30
65. 00 06500 RESPIRATORY THERAPY	172, 474	4, 834, 514	0. 03567	6 213, 221	7, 607	65.00
66. 00 06600 PHYSI CAL THERAPY	103, 638	3, 097, 379	0. 03346	0 21, 971	735	66. 00
68. 00 06800 SPEECH PATHOLOGY	1	14, 110	0. 00007	1 0	0	68. 00
69. 00 06900 ELECTROCARDI OLOGY	25	603, 314	0. 00004	1 161, 230	7	69. 00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	84, 957	9, 396, 928	0. 00904	1 115, 937	1, 048	71. 00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	80, 032	5, 397, 632	0. 01482	731, 713	10, 849	72. 00
73.00 07300 DRUGS CHARGED TO PATIENTS	149, 931	12, 661, 468	0. 01184	.2 0	0	73. 00
76. 97 07697 CARDI AC REHABI LI TATI ON	0	0	0. 00000	0 0	0	76. 97
76. 98 07698 HYPERBARI C OXYGEN THERAPY	0	0	0.00000	0 0	0	76. 98
76. 99 07699 LI THOTRI PSY	0	0	0.00000	0 0	0	76. 99
OUTPATIENT SERVICE COST CENTERS						
91. 00 09100 EMERGENCY	266, 943			189, 623	3, 187	91. 00
92.00 O9200 OBSERVATION BEDS (NON-DISTINCT PART	158, 790	1, 288, 589	0. 12322	.8	0	92. 00
OTHER REIMBURSABLE COST CENTERS						
95. 00 09500 AMBULANCE SERVICES						95. 00
200.00 Total (lines 50-199)	2, 560, 691	119, 589, 380)	3, 831, 082	70, 153	200. 00

Health Financial Systems	HUNTI NGTON 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 01/01/2014		
				To 12/31/2014	Date/Time Pre 5/22/2015 11:	
		Ti ·	tle XIX	Hospi tal	PPS	20 alli
Cost Center Description	Nursing School			Swi ng-Bed	Total Costs	
cost center bescription	Nul Sirily Scribbi	Cost	Medi cal	Adjustment	(sum of cols.	
		COST				
			Education Cos		1 through 3,	
	1.00	0.00			minus col. 4)	
	1. 00	2.00	3. 00	4. 00	5. 00	
INPATIENT ROUTINE SERVICE COST CENTERS						1
30. 00 03000 ADULTS & PEDIATRICS	C))	0	0	30.00
43. 00 04300 NURSERY	C) ()	0	0	43.00
200.00 Total (lines 30-199)	C			0	0	200.00
Cost Center Description	Total Patient	Per Diem (col.	Inpati ent	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					I.	
30. 00 03000 ADULTS & PEDIATRICS	6, 471	0.00	26	5 0		30.00
43. 00 04300 NURSERY	710	l .	l .	6 0		43. 00
200.00 Total (lines 30-199)	7, 181	l .	33			200. 00
200.00 Total (TITIES 30-199)	1, 101	1	1 33	1	1	1200.00

Health Financial Systems	HUNTINGTON MEMO	ORIAL HOSPITAL		In Lie	eu of Form CMS-2	2552-10
APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SEF THROUGH COSTS		S Provi der		Period: From 01/01/2014 To 12/31/2014	Worksheet D Part IV Date/Time Pre 5/22/2015 11:	pared:
			le XIX	Hospi tal	PPS	
Cost Center Description		Nursing School	Allied Healt		Total Cost	
	Anesthetist			Medi cal	(sum of col 1	
	Cost			Education Cost		
					4)	4
	1. 00	2.00	3. 00	4. 00	5. 00	
ANCI LLARY SERVI CE COST CENTERS	_	1			_	4
50. 00 05000 OPERATING ROOM	0		2	0	0	
52. 00 05200 DELI VERY ROOM & LABOR ROOM	0	0)	0	0	
53. 00 05300 ANESTHESI OLOGY	0	0)	0	0	
54. 00 05400 RADI OLOGY-DI AGNOSTI C	0	0)	0	0	
60. 00 06000 LABORATORY	0	0)	0	0	
62. 30 06250 BLOOD CLOTTING FOR HEMOPHILIACS	0	0)	0	0	
65. 00 06500 RESPI RATORY THERAPY	0	0)	0	0	
66. 00 06600 PHYSI CAL THERAPY	0	0)	0	0	
68. 00 06800 SPEECH PATHOLOGY	0	0)	0	0	
69. 00 06900 ELECTROCARDI OLOGY	0	0)	0	0	
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0	0)	0	0	
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0	0)	0	0	1 - 1 - 0 - 0
73.00 07300 DRUGS CHARGED TO PATIENTS	0	0)	0	0	
76. 97 07697 CARDI AC REHABI LI TATI ON	0	0)	0	0	1
76. 98 07698 HYPERBARI C OXYGEN THERAPY	0	0)	0	0	1
76. 99 07699 LI THOTRI PSY	0	0)	0 0	0	76. 99
OUTPATIENT SERVICE COST CENTERS	_					
91. 00 09100 EMERGENCY	0	0)	0	0	
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART	0	0		0 0	0	92. 00
OTHER REIMBURSABLE COST CENTERS						
95. 00 09500 AMBULANCE SERVICES						95. 00
200.00 Total (lines 50-199)	0	o c)	0	0	200. 00

Health Financial Systems APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SE THROUGH COSTS	ERVICE OTHER PAS	S Provi der		Peri od: From 01/01/2014 To 12/31/2014	Date/Time Pre	
		Ti +	tle XIX	Hospi tal	5/22/2015 11: PPS	28 am
Cost Center Description	Total		Ratio of Cos		Inpati ent	
oost conton boson per on	Outpati ent	(from Wkst. C,		Ratio of Cost		
	Cost (sum of		(col. 5 ÷ col		Charges	
	col. 2, 3 and		7)	(col . 6 ÷ col .	3	
	4)	,	ĺ	7)		
	6. 00	7.00	8.00	9. 00	10.00	
ANCILLARY SERVICE COST CENTERS				-		
50. 00 05000 OPERATING ROOM	0	17, 980, 617	0.00000	0. 000000	1, 779, 168	50.00
52.00 05200 DELIVERY ROOM & LABOR ROOM	0	2, 939, 618	0. 00000	0. 000000	0	52.00
53. 00 05300 ANESTHESI OLOGY	0	2, 304, 116	0.00000	0. 000000	0	53.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	0	30, 069, 102	0.00000	0. 000000	261, 589	54.00
60. 00 06000 LABORATORY	0	13, 118, 861	0.00000	0. 000000	356, 630	60.00
62.30 06250 BLOOD CLOTTING FOR HEMOPHILIACS	0	C	0.00000	0. 000000	0	62. 30
65.00 06500 RESPIRATORY THERAPY	0	4, 834, 514	0.00000	0. 000000	213, 221	65.00
66. 00 06600 PHYSI CAL THERAPY	0	3, 097, 379	0.00000	0. 000000	21, 971	66. 00
68.00 06800 SPEECH PATHOLOGY	0	14, 110	0.00000	0. 000000	0	68. 00
59. 00 06900 ELECTROCARDI OLOGY	0	603, 314	0.00000	0. 000000	161, 230	69.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0	9, 396, 928	0.00000	0. 000000	115, 937	71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0	5, 397, 632	0.00000	0. 000000	731, 713	72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	0	12, 661, 468	0.00000	0. 000000	0	73.00
76. 97 07697 CARDIAC REHABILITATION	0	C	0.00000	0. 000000	0	76. 97
76. 98 07698 HYPERBARIC OXYGEN THERAPY	0	C	0.00000	0. 000000	0	76. 98
76. 99 07699 LI THOTRI PSY	0	C	0.00000	0. 000000	0	76. 99
OUTPATIENT SERVICE COST CENTERS						
91. 00 09100 EMERGENCY	0					
92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART	0	1, 288, 589	0.00000	0. 000000	0	92.00
OTHER REIMBURSABLE COST CENTERS						
95. 00 09500 AMBULANCE SERVICES						95.00
200.00 Total (lines 50-199)	0	119, 589, 380)		3, 831, 082	200.00

Health Financial Systems		HUNTI N	IGTON I	MEMORI AL	HOSPI TAL			In Lieu	u of Form (CMS-2552-10
APPORTIONMENT OF INPATIENT/OUTPATIENT THROUGH COSTS	ANCI LLARY	SERVI CE (OTHER	PASS	Provi der	CCN:	150091	01/01/2014 12/31/2014		Prepared:

							12, 01, 2011	5/22/2015 11	
				Ti t	le XIX		Hospi tal	PPS	
C	Cost Center Description	I npati ent	Outp	oati ent	Outpati ent				
		Program	Pr	ogram	Program				
		Pass-Through	Ch	arges	Pass-Through				
		Costs (col. 8			Costs (col.	9			
		x col. 10)			x col. 12)				
		11. 00	1	2. 00	13. 00				
	ARY SERVICE COST CENTERS								
	PERATING ROOM	0		0		0			50. 00
	DELIVERY ROOM & LABOR ROOM	0		0		0			52. 00
	ANESTHESI OLOGY	0		0		0			53. 00
	RADI OLOGY-DI AGNOSTI C	0		0		0			54. 00
	ABORATORY	0		0		0			60. 00
	BLOOD CLOTTING FOR HEMOPHILIACS	0		0		0			62. 30
65. 00 06500 R	RESPI RATORY THERAPY	0		0		0			65. 00
	PHYSI CAL THERAPY	0		0		0			66. 00
68. 00 06800 S	SPEECH PATHOLOGY	0		0		0			68. 00
	ELECTROCARDI OLOGY	0		0		0			69. 00
71.00 07100 N	MEDICAL SUPPLIES CHARGED TO PATIENT	0		0		0			71. 00
	MPL. DEV. CHARGED TO PATIENTS	0		0		0			72. 00
73.00 07300 0	DRUGS CHARGED TO PATLENTS	0		0		0			73. 00
76. 97 07697 C	CARDIAC REHABILITATION	0		0		0			76. 97
76. 98 07698 H	HYPERBARI C OXYGEN THERAPY	0		0		0			76. 98
76. 99 07699 L	LI THOTRI PSY	0		0		0			76. 99
OUTPATI	ENT SERVICE COST CENTERS								
91. 00 09100 E	MERGENCY	0		0		0			91. 00
92.00 09200 0	DBSERVATION BEDS (NON-DISTINCT PART	0		0		0			92. 00
OTHER F	REIMBURSABLE COST CENTERS								
95. 00 09500 A	MBULANCE SERVICES								95. 00
200. 00 T	otal (lines 50-199)	0		0		0			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

Health Fina	incial Systems	HUNIINGION MEMO	REAL HOSPITAL		In Lie	eu of Form CMS-:	2552-10
APPORTI ONME	ENT OF MEDICAL, OTHER HEALTH SERVICES AND	VACCINE COST	Provi der	CCN: 150091	Peri od:	Worksheet D	
					From 01/01/2014		
					To 12/31/2014		
			T: +	Lo VIV	Hooni tol	5/22/2015 11: PPS	28 am_
				le XIX	Hospi tal		
	Cook Cooker Doored at least	0+ +- 0	DDC D-!	Charges	C+	Costs	
	Cost Center Description	Cost to Charge			Cost	PPS Services	
			Services (see	Rei mbursed	Rei mbursed	(see inst.)	
		Worksheet C,	inst.)	Servi ces	Services Not		
		Part I, col. 9		Subject To Ded. & Coins	Subject To		
		1.00	2.00	(see inst.) 3.00	(see inst.) 4.00	5. 00	
ANCI	LLARY SERVICE COST CENTERS	1.00	2.00	3.00	4.00	5.00	
	O OPERATING ROOM	0. 096695	1 0	2 70/ 2/	98	0	50.00
				3, 706, 29	98	0	50.00
	O DELIVERY ROOM & LABOR ROOM	0. 420143	0		0	ľ	
	O ANESTHESI OLOGY	0. 614827	0	4 040 5	0	0	53.00
	O RADI OLOGY-DI AGNOSTI C	0. 121464	0	4, 242, 59		0	54.00
	O LABORATORY	0. 250859		1, 624, 6		0	60.00
	O BLOOD CLOTTING FOR HEMOPHILIACS	0. 000000			0 0	0	62. 30
	O RESPI RATORY THERAPY	0. 305556		272, 70		0	65. 00
	O PHYSI CAL THERAPY	0. 143343		848, 20	05 0	0	66. 00
	O SPEECH PATHOLOGY	0. 000213	0		0	0	68. 00
	O ELECTROCARDI OLOGY	0. 000201	0		0	0	69. 00
	O MEDICAL SUPPLIES CHARGED TO PATIENT	0. 130486		300, 16		0	71. 00
	O IMPL. DEV. CHARGED TO PATIENTS	0. 233979	0	157, 10		0	72. 00
	O DRUGS CHARGED TO PATIENTS	0. 186563	0	925, 80	07 0	0	73. 00
	7 CARDIAC REHABILITATION	0. 000000			0	0	76. 97
76. 98 0769	8 HYPERBARIC OXYGEN THERAPY	0. 000000	0		0	0	76. 98
76. 99 0769	9 LI THOTRI PSY	0. 000000	0		0 0	0	76. 99
	ATIENT SERVICE COST CENTERS						
91.00 0910	O EMERGENCY	0. 162684	0	3, 606, 24	13 0	0	91. 00
92.00 0920	O OBSERVATION BEDS (NON-DISTINCT PART	1. 010140	0		0 0	0	92.00
OTHE	R REIMBURSABLE COST CENTERS						
95. 00 0950	O AMBULANCE SERVICES	0. 622525	0	728, 03	31		95. 00
200.00	Subtotal (see instructions)		0	16, 411, 7	73 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	16, 411, 7	73 0	0	202. 00
	, , , , , , , , , , , , , , , , , , , ,	•	•	•	•	•	•

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	Period: From 01/01/2014	

					To 12/31/2014		
			Ti t	le XIX	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.)				
	ANGLEL ARV. OFRIVERS COOT OFFITTERS	6. 00	7.00				
	ANCILLARY SERVICE COST CENTERS	250,000					
	05000 OPERATING ROOM	358, 380					50.00
	05200 DELIVERY ROOM & LABOR ROOM	0					52.00
	05300 ANESTHESI OLOGY	515 222					53.00
	05400 RADI OLOGY - DI AGNOSTI C	515, 323	l .				54.00
	06000 LABORATORY	407, 548					60.00
	06250 BLOOD CLOTTING FOR HEMOPHILIACS	02 220					62. 30
	06500 RESPIRATORY THERAPY	83, 328	l e				65. 00 66. 00
	06600 PHYSI CAL THERAPY 06800 SPEECH PATHOLOGY	121, 584					68.00
	06900 ELECTROCARDI OLOGY	0					69.00
	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	20 1/0					71.00
1	07200 IMPL. DEV. CHARGED TO PATIENTS	39, 168 36, 760	l				71.00
	07300 DRUGS CHARGED TO PATTENTS	172, 721					73.00
	07697 CARDI AC REHABI LI TATI ON	1/2, /21					76. 97
	07698 HYPERBARI C OXYGEN THERAPY	0					76. 98
	07699 LI THOTRI PSY	0					76. 99
	OUTPATIENT SERVICE COST CENTERS			′			70. 77
	09100 EMERGENCY	586, 678	C)			91. 00
	09200 OBSERVATION BEDS (NON-DISTINCT PART	000,070	ł	1			92. 00
	OTHER REIMBURSABLE COST CENTERS			1			72.00
	09500 AMBULANCE SERVICES	453, 217					95. 00
200.00		2, 774, 707	l c				200. 00
201.00	Less PBP Clinic Lab. Services-Program	0					201.00
	Only Charges						
202.00	Net Charges (line 200 +/- line 201)	2, 774, 707	C				202. 00

Health Financial Systems	HUNTINGTON MEMORIAL	HOSPI TAL		In Lie	u of Form CMS-2552-10
COMPUTATION OF INPATIENT OPERATING COST		Provi der CCN	: 150091	Peri od: From 01/01/2014	Worksheet D-1
					Date/Time Prepared: 5/22/2015 11:28 am
		Title X\	/111	Hospi tal	PPS

		T; +1 o V/// 1 l	Hooni tol	5/22/2015 11:	28 am
	Cost Center Description	Title XVIII	Hospi tal	PPS	
				1. 00	
	PART I - ALL PROVIDER COMPONENTS				
1. 00	INPATIENT DAYS Inpatient days (including private room days and swing-bed days,	excluding newborn)		6, 471	1.00
2.00	Inpatient days (including private room days, excluding swing-be			6, 471	2.00
3.00	Private room days (excluding swing-bed and observation bed days). If you have only pr	ivate room days,	0	3. 00
	do not complete this line.			5 007	
4. 00 5. 00	Semi-private room days (excluding swing-bed and observation bed Total swing-bed SNF type inpatient days (including private room		r 21 of the cost	5, 307 0	4. 00 5. 00
5.00	reporting period	days) trii dugir beceiibe	i si di the cost	U	3.00
6.00	Total swing-bed SNF type inpatient days (including private room	days) after December	31 of the cost	0	6. 00
	reporting period (if calendar year, enter 0 on this line)			_	
7. 00	Total swing-bed NF type inpatient days (including private room reporting period	days) through December	31 of the cost	0	7. 00
8. 00	Total swing-bed NF type inpatient days (including private room	davs) after December 3	1 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	1, 770	9. 00
10. 00	newborn days) Swing-bed SNF type inpatient days applicable to title XVIII onl	v (including privato r	oom days)	0	10. 00
10.00	through December 31 of the cost reporting period (see instructi		oon days)	U	10.00
11. 00	Swing-bed SNF type inpatient days applicable to title XVIII onl		oom days) after	0	11. 00
40.00	December 31 of the cost reporting period (if calendar year, ent				40.00
12. 00	Swing-bed NF type inpatient days applicable to titles V or XIX through December 31 of the cost reporting period	only (including privat	e room days)	0	12. 00
13. 00	Swing-bed NF type inpatient days applicable to titles V or XIX	only (including privat	e room days)	0	13. 00
	after December 31 of the cost reporting period (if calendar yea	r, enter O on this lin	e)		
14.00	Medically necessary private room days applicable to the Program	(excluding swing-bed	days)	0	14.00
15. 00 16. 00	Total nursery days (title V or XIX only) Nursery days (title V or XIX only)			0	15. 00 16. 00
10.00	SWING BED ADJUSTMENT			0	10.00
17. 00	Medicare rate for swing-bed SNF services applicable to services	through December 31 o	f the cost	0. 00	17. 00
10 00	reporting period	often December 21 of	+ha aaa+	0.00	10.00
18. 00	Medicare rate for swing-bed SNF services applicable to services reporting period	arter becember 31 or	the cost	0. 00	18. 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 t	he cost	0.00	20. 00
21. 00	reporting period Total general inpatient routine service cost (see instructions)			7, 236, 252	21. 00
22. 00	Swing-bed cost applicable to SNF type services through December	31 of the cost report	ing period (line	0	22. 00
	5 x line 17)				
23. 00	Swing-bed cost applicable to SNF type services after December 3 x line 18)	1 of the cost reportin	g period (line 6	0	23. 00
24. 00	Swing-bed cost applicable to NF type services through December	31 of the cost reporti	na period (line	0	24. 00
	7 x line 19)	·			
25. 00	Swing-bed cost applicable to NF type services after December 31 x line 20)	of the cost reporting	period (line 8	0	25. 00
26. 00	Total swing-bed cost (see instructions)			0	26. 00
27. 00	General inpatient routine service cost net of swing-bed cost (I	ine 21 minus line 26)		7, 236, 252	27. 00
00.00	PRIVATE ROOM DIFFERENTIAL ADJUSTMENT		`		00.00
28. 00 29. 00	General inpatient routine service charges (excluding swing-bed Private room charges (excluding swing-bed charges)	and observation bed cn	arges)	0	28. 00 29. 00
30.00	Semi -private 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	Average semi-private room per diem charge (line 30 ÷ line 4)	- 1: 22) (:+	±:>	0.00	33.00
34. 00 35. 00	Average per diem private room charge differential (line 32 minu Average per diem private room cost differential (line 34 x line		tions)	0. 00 0. 00	34. 00 35. 00
36. 00	Private room cost differential adjustment (line 3 x line 35)	31)		0.00	36.00
37. 00	General inpatient routine service cost net of swing-bed cost an	d private room cost di	fferential (line	7, 236, 252	37. 00
	27 minus line 36)				
	PART II - HOSPITAL AND SUBPROVIDERS ONLY PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUS	TMENTS			
38. 00	Adjusted general inpatient routine service cost per diem (see i			1, 118. 26	38. 00
39. 00	Program general inpatient routine service cost (line 9 x line 3	•		1, 979, 320	39. 00
40.00	Medically necessary private room cost applicable to the Program			0	40.00
41.00	Total Program general inpatient routine service cost (line 39 +	iine 40)	l	1, 979, 320	41.00

Tetrensive Care Type Inpatient Hospital Units Author Comment Care Type Inpatient Hospital Units		<u> </u>	HUNTI NGTON MEMO				eu of Form CMS-2	
To 123/12016 District	COMPUT	ATION OF INPATIENT OPERATING COST		Provi der	CCN: 150091			
Cost Center Description							Date/Time Pre	
Impution Cost Inpution Cost Inpution Cost Cost 3 x col				Ti t	le XVIII	Hospi tal		20 ан
1.00		Cost Center Description						
1.00			Inpatient Cost	Inpatient Day		÷		
Theresive Care Type Inpatient Hospital Units			1.00	2. 00		4. 00		
13.00 INTERSIVE CARE UNIT	42. 00				0. (00 0	0	42. 00
44.00 COROMARY CARE UNIT 45.00 BIRNENTIFIES IVE CARE UNIT 45.00 BIRNENTIFIES IVE CARE UNIT 46.00 SIRGICAL INTENSIVE CARE UNIT 47.00 DIRE SECTION 47.00 DIRE SEC	43 00		; 				1	43.00
44.00 SIRRIGIAN INTERSIVE CARF UNIT 4.00 OTHER SPECIAL CARE (SPECIAY)	44. 00							44. 00
17.00	45. 00							45. 00
Cost Center Description 1.00 1.00 1.00 1.491, 802 48.00 1 Total Program inpatient ancillary service cost (Wst. D-3, col. 3, line 200) 1.491, 802 48.00 1 Total Program inpatient costs (sum of lines 41 through 48) (see instructions) 2.471, 182 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.	46. 00							46.00
48. 00 Program inpatient ancillary service cost (Wast. D-3, col. 3, line 200) 1,491,862 48, 00 Program inpatient costs (sum of lines 41 through 48) (see instructions) 1,491,862 48, 20, 20, 20, 20, 20, 20, 20, 20, 20, 20	47. 00							47. 00
49.00 Total Program inpatient costs (sum of lines 41 through 48)(see instructions) 70.00 Pass through costs applicable to Program inpatient routine services (from West. D., sum of Parts I and 241, 463 to 111) through costs applicable to Program inpatient ancillarly services (from West. D., sum of Parts II 161, 557 51, 161) through costs applicable to Program inpatient ancillarly services (from West. D., sum of Parts II 161, 557 51, 161) through costs applicable to Program inpatient ancillarly services (from West. D., sum of Parts II 161, 557 51, 161) through costs applicable to Program inpatient ancillarly services (from West. D., sum of Parts II 161, 557 51, 161) through costs (sum of lines 50 and 51) to 161 Program excludable cost (sum of lines 50 and 51) to 161 Program excludable cost (sum of lines 51) through costs (line 49 almus line 52) through costs (line 54 x line 55) to 16 arget amount (line 54 x line 55) to 16 arget amount (line 54 x line 55) to 16 arget amount (see instructions) to 50 to 16 arget amount (see instructions) to 50 to 16 arget (line 53) are 51 from the cost reporting period ending 1996, updated and compounded by the market basket to 20 to 16 arget (line 53) are 51 from the cost report, updated by the market basket to 20 to 16 arget (line 53) are 16 arget (line 54 x line 64) arget (line 54 x line		oust defiter bescription					1. 00	
ASS THROUGH COST ADJUSTNEMINS 50 00 Plass through costs applicable to Program inpatient routine services (from Wast. D. sum of Parts I and 241,463 50 1) 51 00 Plass through costs applicable to Program inpatient ancillary services (from Wast. D. sum of Parts II and 197 1) 52 00 Plass through costs applicable to Program inpatient ancillary services (from Wast. D. sum of Parts II and 197 1) 53 00 Plass through costs applicable to Program inpatient ancillary services (from Wast. D. sum of Parts II and 197 1) 54 00 Plass through costs applicable to Program inpatient ancillary services (from Wast. D. sum of Parts II and 197 1) 55 00 Plarges through costs (sum of lines 50 and 51) 56 00 Plass through costs applicable to Program inpatient ancillary services (from Wast. D. sum of Parts II and 197 1) 56 00 Plass through costs (sum of lines 50 and 51) 57 00 Program addischarges 58 00 Plarges amount (line 54 x line 55) 58 00 Plarges amount (line 54 x line 55) 58 00 Elesser of lines 30 for 55 from the cost reporting period ending 1996, updated and compounded by the Description of lines 53 for 55 from the cost reporting period ending 1996, updated and compounded by the Description of lines 53 for 55 from the cost reporting period ending 1996, updated and compounded by the Description of lines 53 for 55 from the cost reporting period ending 1996, updated and compounded by the Description of lines 53 for 55 from the cost reporting period ending 1996, updated and compounded by the Description of lines 53 for 55 from the cost reporting 1996, updated and compounded by the Description of lines 53 for 55 from the cost reporting 1996, updated and compounded by the Description of lines 53 for 55 from the cost reporting 1996, updated and compounded by the Description of lines 53 for 55 from the cost reporting 1996, updated 1996, up	48. 00	, ,			_			
9 Ass through costs applicable to Program inpatient routine services (from Wkst. D. sum of Parts I and III) 10 Pass through costs applicable to Program inpatient ancillary services (from Wkst. D. sum of Parts II 161,557 51 and IV) 10 Total Program excludable cost (sum of lines 50 and 51) 10 Total Program excludable cost (sum of lines 50 and 51) 10 Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and 3,068,162 33 30 Total Program discharges 0.00 Forgar discharges 0.00 Program discharges 0.00 Program discharges 0.00 S5. 50 Total English and IIII COMPUIATION 0.00 Program discharges 0.00 S5. 50 Total English and IIII COMPUIATION 0.00 Program discharges 0.00 S5. 50 Total English and IIII STATE COMPUIATION 0.00 Program discharges 0.00 S5. 50 Total English and IIII STATE COMPUIATION 0.00 Program discharges 0.00 S5. 50 Total English and IIII STATE COMPUIATION 0.00 Program discharges 0.00 S5. 50 Total English and IIII STATE COMPUIATION 0.00 Program discharges 0.00 S5. 50 Total English and IIII STATE COMPUIATION 0.00 Program discharges 0.00 S5. 50 Total English and IIII STATE COMPUIATION 0.00 Program discharges 0.00 S5. 50 Total English and IIII STATE COMPUIATION 0.00 Program discharges 0.00 S5. 50 Total English Computer (see instructions) 0.00 Program (se	49. 00		41 through 48)(see instructi	ons)		3, 471, 182	49. 00
111 111	50 00		patient routine	services (fro	m Wkst D sur	n of Parts I and	241 463	50.00
	00.00		atront routino	00.7.000 (00.00
10 Total Program excludable cost (sum of lines 50 and 51) 10 Total Program inpatient operating cost excluding capit al related, non-physician anesthetist, and medical education costs (line 49 minus line 52) 11 ARRET ARROWINT AND LIMIT COMPUTATION 12 ARROWINT AND LIMIT COMPUTATION 13 ARROWING AND LIMIT COMPUTATION 14 September 20 Costs (line 49 minus line 52) 15 Costs amount per discharges 10 Costs amount (line 54 x line 55) 10 Costs amount (line 54 x line 55) 10 Costs amount per discharge (line 54 x line 55) 10 Costs amount (line 55 x line 55) 10 Costs amount (line 56 x line 51 x line 55) 10 Costs amount (line 55 x line 55 x	51. 00	, , , , , , , , , , , , , , , , , , , ,	oatient ancillar	y services (f	rom Wkst. D,	sum of Parts II	161, 557	51.00
Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)	52 00	1	50 and 51)				403 020	52. 00
medical education costs (line 4º minus line 52)	53. 00			lated, non-ph	ysician anestl	netist, and		
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71. 00 Adjusted general inpatient routine service cost per diem (line 70 ÷ line 2) 72. 00 Program routine service cost (line 9 x line 71) 73. 00 Medically necessary private room cost applicable to Program (line 14 x line 35) 74. 00 Total Program general inpatient routine service costs (line 72 + line 73) 75. 00 Capital-related cost allocated to inpatient routine service costs (from Worksheet B, Part II, column 26, line 45) 76. 00 Per diem capital-related costs (line 75 ÷ line 2) 77. 00 Program capital-related costs (line 9 x line 76) 77. 00 Aggregate charges to beneficiaries for excess costs (from provider records) 78. 00 Total Program routine service cost per diem limitation 81. 00 Inpatient routine service cost per diem limitation 82. 00 Inpatient routine service cost limitation (line 9 x line 81) 83. 00 Reasonable inpatient routine service costs (see instructions) 84. 00 Program inpatient ancillary services (see instructions) 85. 00 Utilization review - physician compensation (see instructions) 86. 00 Total Program inpatient operating costs (sum of lines 83 through 85) PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST 71. Total observation bed days (see instructions) 87. 1, 164 87. 118. 26 88.	70 00			•			I	70.00
73. 00 Medically necessary private room cost applicable to Program (line 14 x line 35) 74. 00 Total Program general inpatient routine service costs (line 72 + line 73) 75. 00 Capital -related cost allocated to inpatient routine service costs (from Worksheet B, Part II, column 26, line 45) 76. 00 Per diem capital -related costs (line 75 ÷ line 2) 77. 00 Program capital -related costs (line 9 x line 76) 78. 00 Inpatient routine service cost (line 74 minus line 77) 79. 00 Aggregate charges to beneficiaries for excess costs (from provider records) 79. 00 Total Program routine service costs for comparison to the cost limitation (line 78 minus line 79) 80. 00 Inpatient routine service cost per diem limitation 81. 00 Inpatient routine service cost limitation (line 9 x line 81) 82. 00 Reasonable inpatient routine service costs (see instructions) 83. 00 Reasonable inpatient ancillary services (see instructions) 84. 00 Program inpatient ancillary services (see instructions) 85. 00 Utilization review - physician compensation (see instructions) 86. 00 Total Program inpatient operating costs (sum of lines 83 through 85) PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST 87. 00 Total observation bed days (see instructions) 88. 00 Adjusted general inpatient routine cost per diem (line 27 ÷ line 2) 1, 118. 26 88.	71. 00	, , , , , , , , , , , , , , , , , , , ,	-					71.00
Total Program general inpatient routine service costs (line 72 + line 73) Capital -related cost allocated to inpatient routine service costs (from Worksheet B, Part II, column 26, line 45) Per diem capital -related costs (line 75 ÷ line 2) Program capital -related costs (line 9 x line 76) Inpatient routine service cost (line 74 minus line 77) Aggregate charges to beneficiaries for excess costs (from provider records) Total Program routine service costs for comparison to the cost limitation (line 78 minus line 79) Reasonable inpatient routine service cost limitation Inpatient routine service cost limitation (line 9 x line 81) Reasonable inpatient routine service costs (see instructions) Reasonable inpatient ancillary services (see instructions) Willization review - physician compensation (see instructions) Total Program inpatient operating costs (sum of lines 83 through 85) PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST Total observation bed days (see instructions) Adjusted general inpatient routine cost per diem (line 27 ÷ line 2) 1, 118. 26 88.	72. 00				ŕ			72. 00
75. 00 Capital-related cost allocated to inpatient routine service costs (from Worksheet B, Part II, column 26, line 45) 76. 00 Per diem capital-related costs (line 75 ÷ line 2) 77. 00 Program capital-related costs (line 9 x line 76) 78. 00 Inpatient routine service cost (line 74 minus line 77) 79. 00 Aggregate charges to beneficiaries for excess costs (from provider records) 79. 01 Total Program routine service costs for comparison to the cost limitation (line 78 minus line 79) 80. 01 Inpatient routine service cost per diem limitation 81. 02 Inpatient routine service cost limitation (line 9 x line 81) 82. 00 Inpatient routine service cost (see instructions) 83. 00 Reasonable inpatient routine service costs (see instructions) 84. 00 Program inpatient ancillary services (see instructions) 85. 00 Utilization review - physician compensation (see instructions) 86. 00 Total Program inpatient operating costs (sum of lines 83 through 85) 87. 00 PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST 87. 00 Adjusted general inpatient routine cost per diem (line 27 ÷ line 2) 88. 00 Adjusted general inpatient routine cost per diem (line 27 ÷ line 2) 88. 88.	73.00							73.00
26, line 45) 76.00 Per diem capital-related costs (line 75 ÷ line 2) 77.00 Program capital-related costs (line 9 x line 76) 78.00 Inpatient routine service cost (line 74 minus line 77) 79.00 Aggregate charges to beneficiaries for excess costs (from provider records) 79.01 Inpatient routine service costs for comparison to the cost limitation (line 78 minus line 79) 81.00 Inpatient routine service cost per diem limitation 82.00 Inpatient routine service cost limitation (line 9 x line 81) 83.00 Reasonable inpatient routine service costs (see instructions) 84.00 Program inpatient ancillary services (see instructions) 85.00 Utilization review - physician compensation (see instructions) 70.01 Total Program inpatient operating costs (sum of lines 83 through 85) 86.00 PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST 76.01 Total observation bed days (see instructions) 77.02 Total observation bed days (see instructions) 78.00 Adjusted general inpatient routine cost per diem (line 27 ÷ line 2) 78.01 Total observation bed days (see instructions) 79.02 Total observation bed days (see instructions) 79.03 Total observation bed days (see instructions) 79.04 Total observation bed days (see instructions) 79.05 Total observation bed days (see instructions) 79.06 Total observation bed days (see instructions) 79.07 Total observation bed days (see instructions) 79.08 Total observation bed days (see instructions)		, ,	•		,	Part II column		74. 00 75. 00
77. 00 Program capital-related costs (line 9 x line 76) 78. 00 Inpatient routine service cost (line 74 minus line 77) 79. 00 Aggregate charges to beneficiaries for excess costs (from provider records) 80. 00 Total Program routine service costs for comparison to the cost limitation (line 78 minus line 79) 81. 00 Inpatient routine service cost per diem limitation 82. 00 Inpatient routine service cost limitation (line 9 x line 81) 83. 00 Reasonable inpatient routine service costs (see instructions) 84. 00 Program inpatient ancillary services (see instructions) 85. 00 Utilization review - physician compensation (see instructions) 86. 00 Total Program inpatient operating costs (sum of lines 83 through 85) PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST Total observation bed days (see instructions) 87. 00 Adjusted general inpatient routine cost per diem (line 27 ÷ line 2) 78. 07. 07. 07. 07. 07. 07. 07. 07. 07. 07	. 5. 50	·	551 11 66					5.55
78. 00 Inpatient routine service cost (line 74 minus line 77) 79. 00 Aggregate charges to beneficiaries for excess costs (from provider records) 79. 01 Total Program routine service costs for comparison to the cost limitation (line 78 minus line 79) 80. 01 Inpatient routine service costs for comparison to the cost limitation (line 78 minus line 79) 81. 00 Inpatient routine service cost per diem limitation 82. 00 Inpatient routine service cost limitation (line 9 x line 81) 83. 00 Reasonable inpatient routine service costs (see instructions) 84. 00 Program inpatient ancillary services (see instructions) 85. 00 Utilization review - physician compensation (see instructions) 86. 00 Total Program inpatient operating costs (sum of lines 83 through 85) PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST Total observation bed days (see instructions) 87. 00 Adjusted general inpatient routine cost per diem (line 27 ÷ line 2) 88. 88.	76. 00	1	. *					76.00
79. 00 Aggregate charges to beneficiaries for excess costs (from provider records) 80. 00 Total Program routine service costs for comparison to the cost limitation (line 78 minus line 79) 81. 00 Inpatient routine service cost per diem limitation 82. 00 Inpatient routine service cost limitation (line 9 x line 81) 83. 00 Reasonable inpatient routine service costs (see instructions) 84. 00 Program inpatient ancillary services (see instructions) 85. 00 Utilization review - physician compensation (see instructions) 86. 00 Total Program inpatient operating costs (sum of lines 83 through 85) 87. 00 Total Observation bed days (see instructions) 87. 00 Adjusted general inpatient routine cost per diem (line 27 ÷ line 2) 88. 80.		,						77. 00 78. 00
80. 00 Total Program routine service costs for comparison to the cost limitation (line 78 minus line 79) 81. 00 Inpatient routine service cost per diem limitation 82. 00 Inpatient routine service cost limitation (line 9 x line 81) 83. 00 Reasonable inpatient routine service costs (see instructions) 84. 00 Program inpatient ancillary services (see instructions) 85. 00 Utilization review - physician compensation (see instructions) 86. 00 Total Program inpatient operating costs (sum of lines 83 through 85) 86. 00 PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST 87. 00 Adjusted general inpatient routine cost per diem (line 27 ÷ line 2) 88. 80. Adjusted general inpatient routine cost per diem (line 27 ÷ line 2) 89. 00 Adjusted general inpatient routine cost per diem (line 27 ÷ line 2) 80. 00 Inpatient routine 79 minus line 79 81. 00 81. 0	79. 00	1 .		rovi der recor	ds)			79.00
82. 00 Inpatient routine service cost limitation (line 9 x line 81) 83. 00 Reasonable inpatient routine service costs (see instructions) 84. 00 Program inpatient ancillary services (see instructions) 85. 00 Utilization review - physician compensation (see instructions) 86. 00 Total Program inpatient operating costs (sum of lines 83 through 85) 86. 00 PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST 87. 00 Robervation bed days (see instructions) 88. 00 Adjusted general inpatient routine cost per diem (line 27 ÷ line 2) 89. 00 Robervation bed days (see instructions) 80 Robervation bed days (see instructions) 80 Robervation bed days (see instructions) 81. 118. 26 Robervation bed days (see instructions) 82. 22 Robervation bed days (see instructions) 82. 23 Robervation bed days (see instructions) 84. 40 Robervation bed days (see instructions) 85. 86. 86. 86. 86. 86. 87 Robervation bed days (see instructions) 87. 00 Robervation bed days (see instructions) 88. 00 Robervation bed days (see instructions) 89. 00 Robervation bed days (see instructions)		Total Program routine service costs for comp	parison to the c			nus line 79)		80. 00
83. 00 Reasonable inpatient routine service costs (see instructions) 84. 00 Program inpatient ancillary services (see instructions) 85. 00 Utilization review - physician compensation (see instructions) 86. 00 Total Program inpatient operating costs (sum of lines 83 through 85) PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST 87. 00 Adjusted general inpatient routine cost per diem (line 27 ÷ line 2) 88. 00 Adjusted general inpatient routine cost per diem (line 27 ÷ line 2) 88. 00 Reasonable inpatient routine service costs (see instructions) 84. 88.	81.00	1 .)				81. 00 82. 00
84. 00 Program inpatient ancillary services (see instructions) 85. 00 Utilization review - physician compensation (see instructions) 86. 00 PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST 87. 00 Total observation bed days (see instructions) 88. 00 Adjusted general inpatient routine cost per diem (line 27 ÷ line 2) 89. 00 Representation of the content of the conte	82.00	1 .		* .				82.00
86. 00 Total Program inpatient operating costs (sum of lines 83 through 85) PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST Total observation bed days (see instructions) 87. 00 Adjusted general inpatient routine cost per diem (line 27 ÷ line 2) 1, 118. 26 88.	84. 00	1	•	-,				84. 00
PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST Total observation bed days (see instructions) 1, 164 87. 88. 00 Adjusted general inpatient routine cost per diem (line 27 ÷ line 2) 1, 118. 26 88.	85. 00							85.00
87.00 Total observation bed days (see instructions) 1,164 87. 88.00 Adjusted general inpatient routine cost per diem (line 27 ÷ line 2) 1,118.26 88.	86. 00			rough 85)				86. 00
88.00 Adjusted general inpatient routine cost per diem (line 27 ÷ line 2) 1,118.26 88.	87. 00						1, 164	87. 00
89.00 Observation bed cost (line 87 x line 88) (see instructions) 1,301,655 89.	88. 00	Adjusted general inpatient routine cost per	diem (line 27 ÷	line 2)			1, 118. 26	88. 00
	89. 00	Ubservation bed cost (line 87 x line 88) (se	ee instructions)				1, 301, 655	89. 00

Health Financial Systems	HUNTINGTON 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 01/01/2014 To 12/31/2014	Date/Time Pre 5/22/2015 11:	
		Ti tl	e XVIII	Hospi tal	PPS	
Cost Center Description	Cost	Routine Cost	column 1 ÷	Total	Observati on	
		(from line 27)	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	H COST					
90.00 Capi tal -related cost	882, 754	7, 236, 252	0. 12199	1 1, 301, 655	158, 790	90.00
91.00 Nursing School cost	0	7, 236, 252	0.00000	0 1, 301, 655	0	91.00
92.00 Allied health cost	0	7, 236, 252	0.00000	0 1, 301, 655	0	92.00
93.00 All other Medical Education	0	7, 236, 252	0.00000	0 1, 301, 655	0	93. 00

Health Financial Systems	HUNTINGTON MEMORIAL HOSPI	PLTAL	In Lieu	ı of Form CMS-2	552-10
COMPUTATION OF INPATIENT OPERATING COST	Prov	vider CCN: 150091	From 01/01/2014	Worksheet D-1	
				Date/Time Prep 5/22/2015 11:2	
		Title XIX	Hospi tal	PPS	
Cost Center Description					

		Title XIX	Hospi tal	5/22/2015 11:: PPS	28 am_
	Cost Center Description	TITLE XIX	nospi tai	113	
	·			1. 00	
	PART I - ALL PROVIDER COMPONENTS				
1. 00	INPATIENT DAYS Inpatient days (including private room days and swing-bed days,	excluding newhorn)		6, 471	1. 00
2.00	Inpatient days (including private room days, excluding swing-be			6, 471	2. 00
3. 00	Private room days (excluding swing-bed and observation bed days		vate room days,	0	3. 00
	do not complete this line.	3 .	3		
4.00	Semi-private room days (excluding swing-bed and observation bed			5, 307	4. 00
5.00	Total swing-bed SNF type inpatient days (including private room	days) through December	r 31 of the cost	0	5. 00
6. 00	reporting period Total swing-bed SNF type inpatient days (including private room	days) after December (31 of the cost	0	6. 00
0.00	reporting period (if calendar year, enter 0 on this line)	days) at tel becember .	of the cost	0	0.00
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	days) after December 3°	1 of the cost	0	8. 00
9. 00	reporting period (if calendar year, enter 0 on this line) Total inpatient days including private room days applicable to	the Drogram (eveluding	cwing had and	265	9. 00
9.00	newborn days)	the Program (excluding	Swifig-bed and	200	9.00
10. 00	Swing-bed SNF type inpatient days applicable to title XVIII only	y (including private ro	oom days)	0	10. 00
	through December 31 of the cost reporting period (see instruction	ons)	,		
11. 00	Swing-bed SNF type inpatient days applicable to title XVIII only		oom days) after	0	11. 00
12 00	December 31 of the cost reporting period (if calendar year, ent		a maam daysa)	0	12 00
12. 00	Swing-bed NF type inpatient days applicable to titles V or XIX through December 31 of the cost reporting period	only (flictually private	e room days)	0	12. 00
13. 00	Swing-bed NF type inpatient days applicable to titles V or XIX	only (including private	e room days)	0	13. 00
	after December 31 of the cost reporting period (if calendar yea				
14. 00	Medically necessary private room days applicable to the Program	(excluding swing-bed	days)	0	
15.00	Total nursery days (title V or XIX only)			710	
16. 00	Nursery days (title V or XIX only) SWING BED ADJUSTMENT			66	16. 00
17. 00	Medicare rate for swing-bed SNF services applicable to services	through December 31 of	f the cost	0.00	17. 00
	reporting period	3			
18. 00	Medicare rate for swing-bed SNF services applicable to services	after December 31 of	the cost	0.00	18. 00
10.00	reporting period	through Docombon 21 of	the cost	0.00	10.00
19. 00	Medicaid rate for swing-bed NF services applicable to services reporting period	till ought beceiliber 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	Total general inpatient routine service cost (see instructions)	21 of the cost reports	ing ported (Line	7, 236, 252	
22. 00	Swing-bed cost applicable to SNF type services through December 5×1 ine 17)	31 of the cost reporti	ing period (iine	0	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
	x line 18)				
24. 00	Swing-bed cost applicable to NF type services through December 17 x line 19)	31 of the cost reporti	ng period (line	0	24. 00
25. 00	X Time 19) Swing-bed cost applicable to NF type services after December 31	of the cost reporting	neriod (line 8	0	25. 00
20.00	x line 20)	or the cost reporting	perred (Trie 6	o o	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 (I	ine 21 minus line 26)		7, 236, 252	27. 00
20 00	PRIVATE ROOM DIFFERENTIAL ADJUSTMENT General inpatient routine service charges (excluding swing-bed	and observation had che	arace)	0	28. 00
29. 00	Private room charges (excluding swing-bed charges)	and observation bed cha	ai ges)	0	
30. 00	Semi-private room charges (excluding swing-bed charges)			0	30. 00
31.00	General inpatient routine service cost/charge ratio (line 27 ÷	line 28)		0. 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)			0. 00	
34. 00	Average per diem private room charge differential (line 32 minu	, ,	tions)	0.00	
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 0	35. 00 36. 00
36.00	General inpatient routine service cost net of swing-bed cost an	d private room cost di	fferential (line	7, 236, 252	37. 00
37.00	27 minus line 36)			., 200, 202	000
	PART II - HOSPITAL AND SUBPROVIDERS ONLY				
	PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUST				
38. 00	Adjusted general inpatient routine service cost per diem (see i	-		1, 118. 26	
39. 00 40. 00	Program general inpatient routine service cost (line 9 x line 3	•		296, 339 0	39. 00 40. 00
	Medically necessary private room cost applicable to the Program Total Program general inpatient routine service cost (line 39 +			296, 339	
	1	,		2,0,007	

COMPUT	Financial Systems F ATION OF INPATIENT OPERATING COST	HUNTI NGTON MEMO		CCN: 150091	Peri od:	worksheet D-1	
					From 01/01/2014 To 12/31/2014	Date/Time Pre	
			Ti	tle XIX	Hospi tal	5/22/2015 11:: PPS	20 alli
	Cost Center Description	Total Inpatient Cost	Total Inpatient Day 2.00	Average Pe rs Di em (col. 1 col. 2) 3.00		Program Cost (col. 3 x col. 4) 5.00	
42. 00	NURSERY (title V & XIX only)	58, 611	2.00				42.00
	Intensive Care Type Inpatient Hospital Units	33, 31.					1
43. 00	INTENSIVE CARE UNIT						43.00
44. 00 45. 00	CORONARY CARE UNIT BURN INTENSIVE CARE UNIT						44. 00 45. 00
	SURGICAL INTENSIVE CARE UNIT						46.00
	OTHER SPECIAL CARE (SPECIFY)						47.00
	Cost Center Description					4.00	
48. 00	Program inpatient ancillary service cost (Wk:	st D_3 col 3	line 200)			1. 00 581, 208	48. 00
49. 00	, ,			ons)		882, 995	•
	PASS THROUGH COST ADJUSTMENTS	<u> </u>		•			1
50. 00	Pass through costs applicable to Program inpa	atient routine	services (fro	om Wkst. D, su	m of Parts I and	36, 558	50.00
51. 00		ationt ancillar	v sarvicas (f	From Wkst D	sum of Darts II	70, 153	51.00
31.00	and IV)	atrent ancirrar	y services (i	TOIL WKSt. D,	Sum Of Tarts II	70, 133	31.00
52. 00	Total Program excludable cost (sum of lines!					106, 711	
53. 00	Total Program inpatient operating cost exclude medical education costs (line 49 minus line !		lated, non-ph	nysician anest	hetist, and	776, 284	53. 0
	TARGET AMOUNT AND LIMIT COMPUTATION	02)					
54. 00						0	54.0
55. 00							55. 0
56. 00 57. 00	Target amount (line 54 x line 55) Difference between adjusted inpatient operati	ng cost and ta	raot amount /	lino 56 minus	· Lino 52)	0 0	
58. 00	1	ng cost and ta	rget amount (Title 50 IIITlus	111le 55)		
59. 00	Lesser of lines 53/54 or 55 from the cost rep	porting period	endi ng 1996,	updated and o	compounded by the		59. 0
,	market basket						
60. 00 61. 00	Lesser of lines 53/54 or 55 from prior year of line 53/54 is less than the lower of lines					0.00	1
31.00	which operating costs (line 53) are less than					٥	01.0
	amount (line 56), otherwise enter zero (see i		`	, .	3	0	62. 00
62.00							
53.00	Allowable Inpatient cost plus incentive payme PROGRAM INPATIENT ROUTINE SWING BED COST	ent (see mstru	Ctrons)			0	63.00
64. 00	Medicare swing-bed SNF inpatient routine cos	ts through Dece	mber 31 of th	ne cost report	ing period (See	0	64.00
	instructions)(title XVIII only)		04 6 11				
65. 00	Medicare swing-bed SNF inpatient routine cosinstructions)(title XVIII only)	ts after Decemb	er 31 of the	cost reportir	ig period (See	0	65.00
66. 00	Total Medicare swing-bed SNF inpatient routing	ne costs (line	64 plus line	65)(title XVI	II only). For	0	66.00
	CAH (see instructions)						
67. 00	Title V or XIX swing-bed NF inpatient routine (line 12 x line 19)	e costs through	December 31	of the cost r	eporting period	0	67.00
68. 00	Title V or XIX swing-bed NF inpatient routine	e costs after D	ecember 31 of	the cost rep	orting period	0	68.00
	(line 13 x line 20)				0 1		
69. 00	Total title V or XIX swing-bed NF inpatient IPART III - SKILLED NURSING FACILITY, OTHER NU					0	69.00
70. 00	Skilled nursing facility/other nursing facility		•				70.00
71. 00	Adjusted general inpatient routine service co	•		,			71.00
72. 00	,	,					72. 0
73. 00 74. 00	Medically necessary private room cost application of the cost application of t	9	•	,			73.00
75. 00	Capital -related cost allocated to inpatient				Part II, column		75.00
	26, line 45)		`		•		
76. 00	Per diem capital -related costs (line 75 ÷ lin						76.0
77. 00 78. 00	Program capital-related costs (line 9 x line Inpatient routine service cost (line 74 minus						77. 0
79. 00	Aggregate charges to beneficiaries for excess		rovi der recor	ds)			79. 0
30.00	Total Program routine service costs for compa		ost limitatio	on (line 78 mi	nus line 79)		80.0
31. 00 32. 00	Inpatient routine service cost per diem limi)				81.0
32. 00 33. 00	Inpatient routine service cost limitation (li Reasonable inpatient routine service costs (•				83.0
34. 00	Program inpatient ancillary services (see ins		•				84. 0
	Utilization review - physician compensation						85. 0
86. 00	Total Program inpatient operating costs (sum PART IV - COMPUTATION OF OBSERVATION BED PASS		rough 85)				86. 0
87. 00	Total observation bed days (see instructions)					1, 164	87. 0
	Adjusted general inpatient routine cost per of		line 2)			1, 118. 26	•
88. 00	Observation bed cost (line 87 x line 88) (see					1, 301, 655	

Health Financial Systems	HUNTINGTON MEMO	RIAL HOSP	TAL		In Lie	u of Form CMS-2	2552-10
COMPUTATION OF INPATIENT OPERATING COST		Prov	i der		Peri od:	Worksheet D-1	
					From 01/01/2014 To 12/31/2014	Date/Time Prep 5/22/2015 11:	
			Ti t!	le XIX	Hospi tal	PPS	
Cost Center Description	Cost	Routi ne		column 1 ÷	Total	Observation	
		(from lin	27)	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	882, 754	7, 23	5, 252	0. 12199	1 1, 301, 655	158, 790	90.00
91.00 Nursing School cost	0	7, 23	5, 252	0.00000	0 1, 301, 655	0	91.00
92.00 Allied health cost	0	7, 23	5, 252	0.00000	0 1, 301, 655	0	92.00
93.00 All other Medical Education	0	7, 23	5, 252	0. 00000	0 1, 301, 655	0	93. 00

	Financial Systems HUNTINGTON MEMORIAL ENT ANCILLARY SERVICE COST APPORTIONMENT		CCN: 150091	Period:	eu of Form CMS- Worksheet D-3	
INFAII	ENT ANGILLARI SERVICE COST AFFORTIONWENT	FIOVIGE	CCN. 150091	From 01/01/2014		
				To 12/31/2014		
		T: ±1	- \/\/	11: 4-1	5/22/2015 11:	28 am_
	Cost Center Description	1111	e XVIII Ratio of Cos	Hospi tal	PPS Inpati ent	
	cost center bescription		To Charges	Program	Program Costs	
			10 charges	Charges	(col. 1 x col.	
				orial ges	2)	
			1.00	2. 00	3. 00	
	INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000 ADULTS & PEDIATRICS			2, 851, 980		30. 00
43.00	04300 NURSERY					43. 00
	ANCI LLARY SERVI CE COST CENTERS					
50.00	05000 OPERATING ROOM		0. 0980			
52.00	05200 DELIVERY ROOM & LABOR ROOM		0. 4201		1	
53. 00	05300 ANESTHESI OLOGY		0. 6148		0	
54.00	05400 RADI OLOGY-DI AGNOSTI C		0. 1214			
60.00	06000 LABORATORY		0. 2508	· ·		
62. 30	06250 BLOOD CLOTTING FOR HEMOPHILIACS		0.0000		1	
65.00	06500 RESPIRATORY THERAPY		0. 3055	· ·	207, 341	65.00
66.00	06600 PHYSI CAL THERAPY 06800 SPEECH PATHOLOGY		0. 1433			1
68. 00 69. 00	06900 ELECTROCARDI OLOGY		0. 0002 0. 0002		0	
71. 00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT		0. 0002			
71.00	07200 IMPL. DEV. CHARGED TO PATIENTS		0. 2339			
73. 00	07300 DRUGS CHARGED TO PATIENTS		0. 1865	· · ·		
76. 97	07697 CARDI AC REHABI LI TATI ON		0. 0000		203, 000	
	07698 HYPERBARI C OXYGEN THERAPY		0. 0000		l o	1
	07699 LI THOTRI PSY		0.0000			1
	OUTPATIENT SERVICE COST CENTERS					
91.00	09100 EMERGENCY		0. 1626	875, 861	142, 489	91. 00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART		1. 0101			
	OTHER REIMBURSABLE COST CENTERS					
95.00	09500 AMBULANCE SERVI CES					95. 00
200.00				8, 322, 097	1, 491, 862	
201.00		(line 61)		0		201. 00
202.00	Net Charges (line 200 minus line 201)		[8, 322, 097	l	202. 00

I NPATI ENT	ANCILLARY SERVICE COST APPORTIONMENT	Provi der	CCN: 150091	Peri od: From 01/01/2014	Worksheet D-3	
				To 12/31/2014	Date/Time Pre 5/22/2015 11:	
		Ti t	le XIX	Hospi tal	PPS	
	Cost Center Description		Ratio of Cos		Inpati ent	
			To Charges	Program	Program Costs	
				Charges	(col. 1 x col.	
			1.00	2.00	2) 3. 00	
LND	PATIENT ROUTINE SERVICE COST CENTERS		1.00	2.00	3.00	
	DOO ADULTS & PEDIATRICS			1, 676, 321		30.00
	BOO NURSERY			412, 876		43.00
	CILLARY SERVICE COST CENTERS		1	112,010		10.00
	OOO OPERATING ROOM		0. 0980	55 1, 779, 168	174, 456	50.00
52. 00 052	200 DELIVERY ROOM & LABOR ROOM		0. 4201		0	52.00
	BOO ANESTHESI OLOGY		0. 61482	27 0	0	53.00
54. 00 054	100 RADI OLOGY-DI AGNOSTI C		0. 1214	64 261, 589	31, 774	54.00
60. 00 060	DOO LABORATORY		0. 2508!	59 356, 630	89, 464	60.00
62. 30 062	250 BLOOD CLOTTING FOR HEMOPHILIACS		0.0000	00	0	62. 30
	500 RESPI RATORY THERAPY		0. 3055!		65, 151	65.00
	500 PHYSI CAL THERAPY		0. 1433		3, 149	
	SPEECH PATHOLOGY		0. 0002		0	68. 00
	POO ELECTROCARDI OLOGY		0. 00020		32	69.00
	100 MEDICAL SUPPLIES CHARGED TO PATIENT		0. 13048	•	15, 128	
	200 IMPL. DEV. CHARGED TO PATIENTS		0. 2339		171, 205	
	BOO DRUGS CHARGED TO PATIENTS		0. 1865		0	
	597 CARDI AC REHABI LI TATI ON		0. 00000		0	76. 97
	998 HYPERBARI C OXYGEN THERAPY		0.00000		0	76. 98
	999 LI THOTRI PSY PATI ENT SERVI CE COST CENTERS		0.0000	00 0	0	76. 99
	IOO EMERGENCY		0. 1626	189, 623	30, 849	91.00
	200 OBSERVATION BEDS (NON-DISTINCT PART		1. 01014			
	IER REIMBURSABLE COST CENTERS		1.01014	+0 0	0	92.00
	500 AMBULANCE SERVICES					95.00
200.00	Total (sum of lines 50-94 and 96-98)			3, 831, 082	581, 208	
201.00	Less PBP Clinic Laboratory Services-Program only charges	(Line 61)		0, 331, 302		201. 00
202.00	Net Charges (line 200 minus line 201)	(.1110 01)		3, 831, 082		202. 00

CALCUL	ATION OF REIMBURSEMENT SETTLEMENT	Provi der	CCN: 150091	Peri od: From 01/01/2014 To 12/31/2014	Worksheet E Part A Date/Time Pre 5/22/2015 11:	
		Ti tl	e XVIII	Hospi tal	PPS	
			0	1. 00	2. 00	
1 00	PART A - INPATIENT HOSPITAL SERVICES UNDER IPPS			0		1 00
1. 00 1. 01	DRG Amounts Other than Outlier Payments DRG amounts other than outlier payments for discharges occurrin	g prior		2, 063, 643		1. 00 1. 01
1. 02	to October 1 (see instructions) DRG amounts other than outlier payments for discharges occurrin	g on or		722, 789		1. 02
1.03	after October 1 (see instructions) DRG for federal specific operating payment for Model 4 BPCI for			0		1. 03
1.04	discharges occurring prior to October 1 (see instructions) DRG for federal specific operating payment for Model 4 BPCI for			0		1. 04
2. 00	discharges occurring on or after October 1 (see instructions) Outlier payments for discharges. (see instructions)			8, 514		2. 00
2. 01	Outlier reconciliation amount			0		2. 01
2.02	Outlier payment for discharges for Model 4 BPCI (see instructio	ns)		0		2. 02
3. 00 4. 00	Managed Care Simulated Payments Bed days available divided by number of days in the cost report	i na	-	32. 81		3. 00 4. 00
4.00	peri od (see i nstructi ons)			32.01		4.00
5. 00	Indirect Medical Education Adjustment FTE count for allopathic and osteopathic programs for the most	recent		0.00		5.00
6. 00	cost reporting period ending on or before 12/31/1996. (see instr FTE count for allopathic and osteopathic programs which meet th	uctions)		0.00		6. 00
0.00	criteria for an add-on to the cap for new programs in accordanc			0.00		0.00
7. 00	CFR 413.79(e) MMA Section 422 reduction amount to the IME cap as specified un	der 42		0.00		7. 00
7. 01	CFR $\S412.105(f)(1)(iv)(B)(1)$ ACA Section 5503 reduction amount to the IME cap as specified u	nder 42		0.00		7. 01
	CFR $\S412.105(f)(1)(iv)(B)(2)$ If the cost report straddles July then see instructions.	1, 2011				
8. 00	Adjustment (increase or decrease) to the FTE count for allopath osteopathic programs for affiliated programs in accordance with			0.00		8. 00
	413.75(b), 413.79(c)(2)(iv), 64 FR 26340 (May 12, 1998), and 67 (August 1, 2002).					
8. 01	The amount of increase if the hospital was awarded FTE cap slot			0.00		8. 01
	section 5503 of the ACA. If the cost report straddles July 1, 2 instructions.					
8. 02	The amount of increase if the hospital was awarded FTE cap slot closed teaching hospital under section 5506 of ACA. (see instru			0.00		8. 02
9. 00	Sum of lines 5 plus 6 minus lines (7 and 7.01) plus/minus lines and 8,02) (see instructions)	(8, 8, 01		0.00		9. 00
10. 00	FTE count for allopathic and osteopathic programs in the curren from your records	t year		0.00		10.00
11.00	FTE count for residents in dental and podiatric programs.			0.00		11.00
12. 00 13. 00	Current year allowable FTE (see instructions) Total allowable FTE count for the prior year.		-	0. 00 0. 00		12. 00 13. 00
14. 00	Total allowable FTE count for the penultimate year if that year	ended on		0.00		14. 00
15 00	or after September 30, 1997, otherwise enter zero.			0.00		15 00
15. 00 16. 00	Sum of lines 12 through 14 divided by 3. Adjustment for residents in initial years of the program			0. 00 0. 00		15. 00 16. 00
17. 00	Adjusment for residents displaced by program or hospital closur	e		0.00		17. 00
18. 00	Adjusted rolling average FTE count			0.00		18. 00
19. 00	Current year resident to bed ratio (line 18 divided by line 4).			0. 000000		19. 00
20.00	Prior year resident to bed ratio (see instructions)			0. 000000		20.00
21. 00	Enter the lesser of lines 19 or 20 (see instructions)			0.000000		21.00
22. 00 22. 01	IME payment adjustment (see instructions)			0		22. 00 22. 01
	IME payment adjustment - Managed Care (see instructions) Indirect Medical Education Adjustment for the Add-on for Section		the MMA			
23. 00	Number of additional allopathic and osteopathic IME FTE residen slots under 42 Sec. 412.105 (f)(1)(iv)(C).	t cap		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 -0-, then enter the lo line 23 or line 24 (see instructions)	wer of		0.00		25. 00
26. 00	Resident to bed ratio (divide line 25 by line 4)			0. 000000		26. 00
27. 00	IME payments adjustment factor. (see instructions)			0. 000000		27. 00
28. 00	IME add-on adjustment amount (see instructions)			0		28. 00
28. 01	IME add-on adjustment amount - Managed Care (see instructions)			0		28. 01
29. 00 29. 01	Total IME payment (sum of lines 22 and 28) Total IME payment - Managed Care (sum of lines 22.01 and 28.01)			0		29. 00 29. 01
30. 00	Disproportionate Share Adjustment Percentage of SSI recipient patient days to Medicare Part A pat	i ent days		3. 51		30.00
	(see instructions)	,				
31.00	Percentage of Medicaid patient days (see instructions)			22. 52		31.00
32.00	Sum of lines 30 and 31		1	26. 03		32.00
33. 00 34. 00	Allowable disproportionate share percentage (see instructions) Disproportionate share adjustment (see instructions)			10. 69 74, 468		33. 00 34. 00
5 1. 00	15. 5p. 5po. tronato sharo daj detimorit (300 metrati detrone)		1	1 77, 400	I	1 0 1. 00

ONLOGE	ATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 150091	Period: From 01/01/2014 To 12/31/2014	Worksheet E Part A Date/Time Pre 5/22/2015 11:	epared:
		Title XVIII	Hospi tal	PPS	20 4111
			Prior to	On/After	
			October 1	October 1	
		0	1. 00	2.00	
	Uncompensated Care Adjustment				
35.00	Total uncompensated care amount (see instructions)		9, 046, 380, 143	7, 647, 644, 885	35.00
35. 01	Factor 3 (see instructions)		0. 000049959	0.000051392	
35. 02	Hospital uncompensated care payment (If line 34 is zero,		451, 948	393, 028	1
00.02	enter zero on this line) (see instructions)		101, 710	070, 020	00.02
35. 03	Pro rata share of the hospital uncompensated care payment		338, 032	99, 065	35. 03
33. 03	amount (see instructions)		330, 032	77, 003	35.00
27 00			427 007		2/ 00
36. 00	Total uncompensated care (sum of columns 1 and 2 on line		437, 097		36.00
	35.03)	(1)	1 (1)		-
	Additional payment for high percentage of ESRD beneficiary di	scharges (lines 40 throug			٠
40. 00	Total Medicare discharges on Worksheet S-3, Part I		0		40.00
	excluding discharges for MS-DRGs 652, 682, 683, 684 and				
	685 (see instructions)				
41. 00	Total ESRD Medicare discharges excluding MS-DRGs 652,		0		41.00
	682, 683, 684 an 685. (see instructions)				
41. 01	Total ESRD Medicare covered and paid discharges excluding		0		41. 01
	MS-DRGs 652, 682, 683, 684 an 685. (see instructions)				
42.00	Divide line 41 by line 40 (if less than 10%, you do not		0.00		42.00
	qualify for adjustment)				
43.00	Total Medicare ESRD inpatient days excluding MS-DRGs 652,		ol		43.00
	682, 683, 684 an 685. (see instructions)				1
44.00	Ratio of average length of stay to one week (line 43		0. 000000		44.00
50	divided by line 41 divided by 7 days)		3. 300000		1
45. 00	Average weekly cost for dialysis treatments (see		0.00		45. 00
45.00	instructions)		0.00		1 45.00
46. 00	Total additional payment (line 45 times line 44 times line		0		46.00
40.00	41.01)		U U		40.00
47.00			2 20/ 511		17.00
47. 00	Subtotal (see instructions)		3, 306, 511		47. 00
48. 00	Hospital specific payments (to be completed by SCH and		0		48. 00
	MDH, small rural hospitals only. (see instructions)		0.007.544		
49. 00	Total payment for inpatient operating costs (see		3, 306, 511		49.00
	instructions)				
50. 00	Payment for inpatient program capital (from Wkst. L, Pt. I		225, 907		50.00
	and Pt. II, as applicable)				
51. 00			0		51.00
	Pt. III, see instructions)				
52.00	Direct graduate medical education payment (from Wkst. E-4,		0		52. 00
	line 49 see instructions).				
53.00	Nursing and Allied Health Managed Care payment		0		53.00
54.00	Special add-on payments for new technologies		0		54.00
55.00	Net organ acquisition cost (Wkst. D-4 Pt. III, col. 1,		0		55. 00
	line 69)				
56.00	Cost of physicians' services in a teaching hospital (see		0		56.00
	intructions)				
57.00	Routine service other pass through costs (from Wkst. D,		0		57. 00
	Pt. III, column 9, lines 30 through 35).				
58. 00	Ancillary service other pass through costs from Wkst. D,		o		58.00
	Pt. IV, col. 11 line 200)				
59. 00	Total (sum of amounts on lines 49 through 58)		3, 532, 418		59.00
60.00	Primary payer payments		6, 521		60.00
61. 00	Total amount payable for program beneficiaries (line 59		3, 525, 897		61. 00
51.00	minus line 60)		3, 323, 097] 31.00
62. 00	Deductibles billed to program beneficiaries		457, 986		62.00
63. 00					
	Coinsurance billed to program beneficiaries		1, 853		63.00
64.00	Allowable bad debts (see instructions)		1, 109		64.00
65.00	Adjusted reimbursable bad debts (see instructions)		721		65.00
66. 00	Allowable bad debts for dual eligible beneficiaries (see		-9, 397		66. 00
	instructions)				1.
67. 00	Subtotal (line 61 plus line 65 minus lines 62 and 63)		3, 066, 779		67. 00
68.00	Credits received from manufacturers for replaced devices		0		68. 00
	for applicable to MS-DRGs (see instructions)				1
69. 00	Outlier payments reconciliation (sum of lines 93, 95 and		0		69. 00
	96).(For SCH see instructions)				
70.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)		0		70.00
70. 50	RURAL DEMONSTRATION PROJECT		0		70. 50
70. 89	Pioneer ACO demonstration payment adjustment amount (see		0		70. 89
	instructions)				
70. 90	HSP bonus payment HVBP adjustment amount (see		o		70. 90
	instructions)		i i		/
70. 91	HSP bonus payment HRR adjustment amount (see instructions)		n		70. 91
70. 92	Bundled Model 1 discount amount (see instructions)		l o		70. 92
	HVBP payment adjustment amount (see instructions)		8, 011		70. 93
/() 4 3	payorre day astimorre amount (300 mistractions)				70. 94
70. 93 70. 94	HRR adjustment amount (see instructions)				
70. 94	HRR adjustment amount (see instructions) Recovery of accelerated depreciation		-2, 348 0		70. 95

Health Financial Systems	HUNTI NGTON	MEMORI AL	HOSPI TAL		In Lie	u of Form CMS-2	2552-10
CALCULATION OF REIMBURSEMENT SETTLEMENT			Provi der		Peri od: From 01/01/2014 To 12/31/2014	Worksheet E Part A Date/Time Pre 5/22/2015 11:	pared: 28 am
			Ti tl e	e XVIII	Hospi tal	PPS	
					Prior to	On/After	
					October 1	October 1	
			0)	1. 00	2. 00	
70.96 Low volume adjustment for federal fiscal ye (Enter in column 0 the corresponding federal period prior to 10/1)		the		201	4 310, 875		70. 96
70.97 Low volume adjustment for federal fiscal ye (Enter in column 0 the corresponding federa		the		201	5 101, 744		70. 97

			Prior to October 1	On/After October 1	
		0	1. 00	2. 00	
70. 96	Low volume adjustment for federal fiscal year (yyyy)	2014			70. 96
	(Enter in column 0 the corresponding federal year for the				
	period prior to 10/1)				
70. 97	Low volume adjustment for federal fiscal year (yyyy)	2015	101, 744		70. 97
	(Enter in column 0 the corresponding federal year for the				
	period ending on or after 10/1)				
70. 98	Low Volume Payment-3		0		70. 98
70. 99	HAC adjustment amount (see instructions)		0		70. 99
71.00	Amount due provider (line 67 minus lines 68 plus/minus		3, 485, 061		71. 00
	lines 69 & 70)				
71. 01	Sequestration adjustment (see instructions)		69, 701		71. 01
72.00	Interim payments		3, 401, 623		72. 00
73. 00	Tentative settlement (for contractor use only)		0		73. 00
74.00	Balance due provider (Program) (line 71 minus lines 71.01,		13, 737		74. 00
	72, and 73)				
75. 00	Protested amounts (nonallowable cost report items) in		0		75. 00
	accordance with CMS Pub. 15-2, chapter 1, §115.2				
	TO BE COMPLETED BY CONTRACTOR (lines 90 through 96)	I	_		
90. 00	Operating outlier amount from Wkst. E, Pt. A, line 2 (see		0		90. 00
01 00	instructions)				01.00
91.00	Capital outlier from Wkst. L, Pt. I, line 2		0		91.00
92. 00	Operating outlier reconciliation adjustment amount (see instructions)		0		92. 00
93. 00	Capital outlier reconciliation adjustment amount (see		0		93. 00
93.00	linstructions)		0		93.00
94. 00	The rate used to calculate the time value of money (see		0.00		94.00
74.00	instructions)		0.00		74.00
95. 00	Time value of money for operating expenses (see		0		95. 00
75. 00	instructions)				75.00
96. 00	Time value of money for capital related expenses (see		0		96. 00
70.00	instructions)				70.00
	,		Prior to 10/1	On/After 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				
101.00	HVBP adjustment factor (see instructions)		0	0	101. 00
102.00	HVBP adjustment amount for HSP bonus payment (see instructi	ons)	0	0	102.00
	HRR Adjustment for HSP Bonus Payment				1
103.00	HRR adjustment factor (see instructions)		0.0000	0.0000	103. 00
	HRR adjustment amount for HSP bonus payment (see instruction	ons)	0	0	104. 00
			•	•	•

| Period: | Worksheet E | From 01/01/2014 | Part A Exhibit 4 | Date/Time Prepared: | 5/22/2015 | 11: 28 am Health Financial Systems

LOW VOLUME CALCULATION EXHIBIT 4 Provider CCN: 150091

					0 12/31/2014	5/22/2015 11: 28 am		
		W/C E Dowt A	Amounto (from		e XVIII	Hospi tal	PPS	
		line	Amounts (from E, Part A)	Pre/Post Entitlement	Period Prior to 10/01	Peri od On/After 10/01	Total (Col 2 through 4)	
		0	1.00	2.00	3.00	4. 00	5. 00	
1.00	DRG amounts other than outlier	1. 00	0	0	C	0	0	1. 00
1. 01	payments DRG amounts other than outlier payments for discharges	1. 01	2, 063, 643	0	2, 063, 643	0	2, 063, 643	1. 01
1. 02	occurring prior to October 1 DRG amounts other than outlier payments for discharges	1. 02	722, 789	0	C	722, 789	722, 789	1. 02
1. 03	occurring on or after October 1 DRG for Federal specific	1. 03	0	0	ſ	0	0	1. 03
1.03	operating payment for Model 4 BPCI occurring prior to October 1	1.03	o o	0	C		0	1.03
1. 04	DRG for Federal specific operating payment for Model 4 BPCI occurring on or after October 1	1. 04	0	0	C	0	0	1. 04
2. 00	Outlier payments for discharges (see instructions)	2. 00	8, 514	0	8, 514	0	8, 514	2. 00
2. 01	Outlier payments for discharges for Model 4 BPCI	2. 02	О	0	C	0	0	2. 01
3.00	Operating outlier	2. 01	О	0	C	0	0	3. 00
4. 00	reconciliation Managed care simulated payments	3. 00	0	0	C	0	0	4. 00
F 00	Indirect Medical Education Adju	ustment 21.00	0.000000	0.000000	0. 000000	0.000000		F 00
5. 00	Amount from Worksheet E, Part A, line 21 (see instructions)	21.00	0. 000000	0. 000000	0.000000	0. 000000		5. 00
6. 00	IME payment adjustment (see instructions)	22. 00	0	0	С	0	0	6. 00
6. 01	IME payment adjustment for managed care (see instructions)	22. 01	0	0	C	0	0	6. 01
	Indirect Medical Education Adju	ustment for the	Add-on for Se	ction 422 of t	he MMA			
7. 00	IME payment adjustment factor (see instructions)	27. 00	0. 000000	0. 000000	0. 000000	0. 000000		7. 00
8.00	IME adjustment (see	28. 00	О	0	C	0	0	8. 00
8. 01	<pre>Instructions) IME payment adjustment add on for managed care (see Instructions)</pre>	28. 01	O	0	C	О	0	8. 01
9. 00	Total IME payment (sum of	29. 00	О	0	C	0	0	9. 00
9. 01	lines 6 and 8) Total IME payment for managed care (sum of lines 6.01 and 8.01)	29. 01	0	0	C	О	0	9. 01
	Di sproporti onate Share Adjustmo	ent						
10. 00	Allowable disproportionate share percentage (see instructions)	33. 00	0. 1069	0. 1069	0. 1069	0. 1069		10. 00
11. 00	Di sproporti onate share	34. 00	74, 468	0	55, 151	19, 317	74, 468	11. 00
11. 01	adjustment (see instructions) Uncompensated care payments	36.00	437, 097	0	338, 032	99, 065	437, 097	11. 01
12. 00	Additional payment for high per Total ESRD additional payment	centage of ESF 46.00	אט beneficiary (הו	di scharges 0	C		0	12. 00
	(see instructions)		2 20/ 544					
13. 00 14. 00	Subtotal (see instructions) Hospital specific payments (completed by SCH and MDH, small rural hospitals only.)	47. 00 48. 00	3, 306, 511	0	2, 465, 340 C	841, 171 0	3, 306, 511 0	13. 00 14. 00
15. 00	(see instructions) Total payment for inpatient operating costs (see	49. 00	3, 306, 511	0	2, 465, 340	841, 171	3, 306, 511	15. 00
16. 00	instructions) Payment for inpatient program capital	50. 00	225, 907	0	168, 387	57, 520	225, 907	16. 00
17. 00	Special add-on payments for	54. 00	0	0	C	0	0	17. 00
17. 01	new technologies Net organ aquisition cost	55. 00	0	0	С	0	0	17. 01
17. 02	Capital received from manufacturers for replaced devices for applicable MS-DRGs	68. 00	0	0	C	0	0	17. 02
18. 00	Capital outlier reconciliation adjustment amount (see instructions)	93. 00	0	0	C	O	0	18. 00

						rom 01/01/2014	Part A Exhibi	
						To 12/31/2014	Date/Time Pre	
				T: +1	e XVIII	Hospi tal	5/22/2015 11: PPS	28 am
		W/C E D+ A	A	Pre/Post				
			Amounts (from		Period Prior	Peri od	Total (Col 2	
		line	E, Part A)	Entitlement	to 10/01	On/After 10/01	through 4)	
10.00	CURTOTAL	0	1.00	2.00	3.00	4.00	5. 00	10.00
19.00	SUBTOTAL	W/C 1 1:	(1)	С	2, 633, 727	898, 691	3, 532, 418	19.00
		W/S L, line	(Amounts from					
			L)	0.00		4.00		
	I	0	1.00	2.00	3. 00	4. 00	5. 00	
20. 00	Capital DRG other than outlier		221, 176	C	163, 656	57, 520	221, 176	
20. 01	Model 4 BPCI Capital DRG other	1. 01	0	C	(0	0	20. 01
	than outlier							
21. 00	Capital DRG outlier payments	2. 00	4, 731	C	4, 73	0	4, 731	
21. 01	Model 4 BPCI Capital DRG	2. 01	0	C	(0	0	21. 01
	outlier payments							
22. 00	Indirect medical education	5. 00	0. 0000	0.0000	0.0000	0.0000		22. 00
	percentage (see instructions)							
23. 00	Indirect medical education	6. 00	0	C	(0	0	23. 00
	adjustment (see instructions)							
24.00	Allowable disproportionate	10.00	0. 0000	0.0000	0.0000	0.0000		24. 00
	share percentage (see							
	instructions)							
25.00	Di sproporti onate share	11.00	0	C	(0	0	25. 00
	adjustment (see instructions)							
26.00	Total prospective capital	12.00	225, 907	C	168, 387	57, 520	225, 907	26. 00
	payments (see instructions)							
		W/S E, Part A	(Amounts to E,					
		line	Part A)					
		0	1.00	2. 00	3.00	4. 00	5. 00	
27. 00	Low volume adjustment factor				0. 118036	0. 113214		27. 00
28. 00	Low volume adjustment	70. 96			310, 875	5	310, 875	28. 00
	(transfer amount to Wkst. E,						·	
	Pt. A. line)							
29. 00	Low volume adjustment	70. 97				101, 744	101, 744	29. 00
	(transfer amount to Wkst. E,							
	Pt. A, line)							
100.00	Transfer low volume		Υ					100.00
	adjustments to Wkst. E, Pt. A.							
		•	'	1	•		1	

Health Financial Systems	HUNTINGTON MEMORIAL HO	OSPI TAL		In Lie	u of Form CMS-2552-10
CALCULATION OF REIMBURSEMENT SETTLEMENT	P	Provi der	CCN: 150091	Peri od: From 01/01/2014 To 12/31/2014	Worksheet E Part B Date/Time Prepared: 5/22/2015 11:28 am

			10 12/31/2014	5/22/2015 11:	
		Title XVIII	Hospi tal	PPS	20 aiii
			noopi tui		
				1. 00	
	PART B - MEDICAL AND OTHER HEALTH SERVICES				
1.00	Medical and other services (see instructions)			0	1. 00
2.00	Medical and other services reimbursed under OPPS (see instruction	ons)		2, 580, 844	2. 00
3. 00	PPS payments			2, 346, 165	3. 00
4.00	Outlier payment (see instructions)			0	4. 00
5. 00 6. 00	Enter the hospital specific payment to cost ratio (see instruct Line 2 times line 5	ions)		0. 859 2, 216, 945	5. 00 6. 00
7. 00	Sum of line 3 plus line 4 divided by line 6			0.00	
8. 00	Transitional corridor payment (see instructions)			0.00	
9. 00	Ancillary service other pass through costs from Wkst. D, Pt. IV	. col. 13. Line 200		0	
	Organ acquisitions	, 661. 16, 111.6 266		0	10.00
11. 00	Total cost (sum of lines 1 and 10) (see instructions)			0	
	COMPUTATION OF LESSER OF COST OR CHARGES				
	Reasonable charges				
	Ancillary service charges				12. 00
	Organ acquisition charges (from Wkst. D-4, Pt. III, line 69, co	I. 4)		0	
	Total reasonable charges (sum of lines 12 and 13)			0	14. 00
15. 00	Customary charges Aggregate amount actually collected from patients liable for pa	yment 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)	payment for services o	ir a chargebasi's	· ·	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	18. 00
19. 00	Excess of customary charges over reasonable cost (complete only	if line 18 exceeds li	ne 11) (see	0	19. 00
	instructions)			_	
20. 00	Excess of reasonable cost over customary charges (complete only	if line 11 exceeds li	ne 18) (see	0	20. 00
21. 00	instructions) Lesser of cost or charges (line 11 minus line 20) (for CAH see	instructions)		0	21. 00
	Interns and residents (see instructions)	instructions)		0	22. 00
	Cost of physicians' services in a teaching hospital (see instru	ctions)		0	23. 00
24. 00	Total prospective payment (sum of lines 3, 4, 8 and 9)			2, 346, 165	
	COMPUTATION OF REIMBURSEMENT SETTLEMENT		<u>'</u>	· · ·	
25. 00	Deductibles and coinsurance (for CAH, see instructions)			526, 022	
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} (for	1, 820, 143	27. 00
28. 00	CAH, see instructions) Direct graduate medical education payments (from Wkst. E-4, lin	o 50)		0	28. 00
29. 00	ESRD direct medical education costs (from Wkst. E-4, line 36)	c 30)		0	29. 00
30. 00	Subtotal (sum of lines 27 through 29)			1, 820, 143	
	Pri mary payer payments			1, 092	
	Subtotal (line 30 minus line 31)			1, 819, 051	32. 00
	ALLOWABLE BAD DEBTS (EXCLUDE BAD DEBTS FOR PROFESSIONAL SERVICE:	S)			
	Composite rate ESRD (from Wkst. I-5, line 11)			0	
	Allowable bad debts (see instructions)			45, 862	
	Adjusted reimbursable bad debts (see instructions)	-+:>		29, 810	
	Allowable bad debts for dual eligible beneficiaries (see instru	CTI ONS)		33, 641	
	Subtotal (see instructions) MSP-LCC reconciliation amount from PS&R			1, 848, 861 0	
	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)			0	
39. 50	Pioneer ACO demonstration payment adjustment (see instructions)			0	
39. 98	Partial or full credits received from manufacturers for replace	d devices (see instruc	tions)	0	39. 98
39. 99	RECOVERY OF ACCELERATED DEPRECIATION	`	,	0	39. 99
40.00	Subtotal (see instructions)			1, 848, 861	40. 00
40. 01	Sequestration adjustment (see instructions)			36, 977	
41.00	Interim payments			1, 783, 806	
	Tentative settlement (for contractors use only)			0	42.00
43. 00	Balance due provider/program (see instructions)	0110 D 45 0		28, 078	
44. 00	Protested amounts (nonallowable cost report items) in accordanc §115.2	e with CMS Pub. 15-2,	cnapter I,	0	44. 00
	TO BE COMPLETED BY CONTRACTOR				
	Original outlier amount (see instructions)			0	90. 00
	Outlier reconciliation adjustment amount (see instructions)			0	
	The rate used to calculate the Time Value of Money			0.00	
93.00	Time Value of Money (see instructions)			0	93. 00
	Total (sum of lines 91 and 93)				94.00

Health Financial Systems HUNTII

ANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED Peri od: Worksheet E-1
From 01/01/2014 Part I
To 12/31/2014 Date/Ti me Prepared: 5/22/2015 11: 28 am Provi der CCN: 150091

			20/11/1		5/22/2015 11: 2	28 am_
			e XVIII	Hospi tal	PPS	
		Inpatien	t Part A		⁻t B	
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount	
		1. 00	2.00	3. 00	4. 00	
1.00	Total interim payments paid to provider		3, 401, 623		1, 783, 806	1. 00
2.00	Interim payments payable on individual bills, either		()	0	2. 00
	submitted or to be submitted to the contractor for					
	services rendered in the cost reporting period. If none,					
3. 00	write "NONE" or enter a zero 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		()	0	3. 01
3.02			()	0	3. 02
3.03			(0	3. 03
3.04			(0	3. 04
3.05			()	0	3. 05
	Provider to Program				_	
3.50	ADJUSTMENTS TO PROGRAM		(0	3. 50
3. 51 3. 52			(3. 51 3. 52
3. 52 3. 53			(3. 52 3. 53
3. 53 3. 54			(3. 53
3. 99	Subtotal (sum of lines 3.01-3.49 minus sum of lines		(3. 99
J. 77	3. 50-3. 98)			,		3. 77
4.00	Total interim payments (sum of lines 1, 2, and 3.99)		3, 401, 623	3	1, 783, 806	4.00
	(transfer to Wkst. E or Wkst. E-3, line and column as					
	appropri ate)					
	TO BE COMPLETED BY CONTRACTOR					
5.00	List separately each tentative settlement payment after					5. 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		(\	1 0	5. 01
5. 01	TENTATIVE TO PROVIDER		(5. 02
5. 03			(5. 03
0.00	Provider to Program			4		0.00
5.50	TENTATI VE TO PROGRAM		()	0	5. 50
5. 51			()	0	5. 51
5.52			(0	5. 52
5. 99	Subtotal (sum of lines 5.01-5.49 minus sum of lines		()	0	5. 99
	5. 50-5. 98)					
6.00	Determined net settlement amount (balance due) based on					6. 00
. 01	the cost report. (1)		40 70	,	20.070	/ 01
6. 01	SETTLEMENT TO PROVIDER		13, 737		28, 078	6. 01
6. 02	SETTLEMENT TO PROGRAM) 41E 240		1 011 004	6. 02
7. 00	Total Medicare program liability (see instructions)		3, 415, 360	Contractor	1,811,884 NPR Date	7. 00
				Number	(Mo/Day/Yr)	
		()	1. 00	2.00	
8. 00	Name of Contractor					8. 00
	,			•	. '	

Hool +h	Financial Systems	HIINTI NCTON MEMODI AI	HOCDI TAI	Inlia	u of Form CMS-2	DEE2 10
	Health Financial Systems HUNTINGTON MEMORIAL HOSPITAL In Lieu CALCULATION OF REIMBURSEMENT SETTLEMENT FOR HIT Provider CCN: 150091 From 01/01/2014 To 12/31/2014					
			Title XVIII	Hospi tal	PPS	
					1. 00	
	TO BE COMPLETED BY CONTRACTOR FOR NON STANDA					
	HEALTH INFORMATION TECHNOLOGY DATA COLLECTION					
1. 00	Total hospital discharges as defined in AAR.	-	•	14	1, 739	1. 00
2.00	Medicare days from Wkst. S-3, Pt. I, col. 6		2		1, 770	2. 00
3.00	Medicare HMO days from Wkst. S-3, Pt. I, co	I. 6. line 2			1, 487	3. 00
4.00	Total inpatient days from S-3, Pt. I col. 8	sum of lines 1, 8-1	2		5, 307	4. 00
5.00	Total hospital charges from Wkst C, Pt. I,	col. 8 line 200			133, 837, 806	5. 00
6.00	Total hospital charity care charges from Wk	st. S-10, col. 3 lin	e 20		2, 587, 470	6.00
7. 00						7. 00
8.00	Calculation of the HIT incentive payment (s	ee instructions)			662, 722	8.00
9.00	Sequestration adjustment amount (see instru	ctions)			13, 254	9. 00
10.00						10.00
	INPATIENT HOSPITAL SERVICES UNDER PPS & CAH		,			
30.00	Initial/interim HIT payment adjustment (see	instructions)			685, 301	30. 00
	Other Adjustment (specify)	•			0	31. 00
	22. 00 Palance due provider (line 9 (or line 10) minus line 20 and line 21) (coe instructions)					

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

-35, 833 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)

				0 12/31/2014	Date/IIme Pre 5/22/2015 11:	
		General Fund	Speci fi c	Endowment Fund	Plant Fund	20 am
			Purpose Fund			
	CHIDDENT ASSETS	1.00	2. 00	3. 00	4. 00	
1.00	CURRENT ASSETS Cash on hand in banks	2, 550) 0	0	1.00
2. 00	Temporary investments	0	1		0	2. 00
3.00	Notes recei vabl e	0	d	0	0	3. 00
4.00	Accounts receivable	16, 143, 377	C	0	0	4. 00
5.00	Other recei vable	187, 257	l .	0	0	
6.00	Allowances for uncollectible notes and accounts receivable	-9, 725, 350	l .	<u> </u>	0	6.00
7. 00 8. 00	Inventory Prepaid expenses	183, 329 -537, 310	l .		0	7. 00 8. 00
9. 00	Other current assets	-557, 510		<u> </u>	0	9.00
10. 00	Due from other funds	Ö	i c		0	10.00
11. 00	Total current assets (sum of lines 1-10)	6, 253, 853	C	0	0	11. 00
	FIXED ASSETS					
12.00	Land	0			0	
13. 00 14. 00	Land improvements	465, 871	1		0	13. 00 14. 00
15. 00	Accumulated depreciation Buildings	-226, 365 1, 641, 580	1		0	15. 00
16. 00	Accumulated depreciation	-905, 718	1		0	16. 00
17. 00	Leasehold improvements	32, 500	1	0	0	17. 00
18. 00	Accumul ated depreciation	-26, 812	C	0	0	18. 00
19. 00	Fi xed equipment	510, 214	1	0	0	19. 00
20.00	Accumulated depreciation	-482, 709	i	0	0	20.00
21. 00 22. 00	Automobiles and trucks Accumulated depreciation	660, 453 -517, 307	l .		0	21. 00 22. 00
23. 00	Major movable equipment	9, 470, 196	1		0	23. 00
24. 00	Accumulated depreciation	-7, 686, 000	l .		0	24. 00
25. 00	Mi nor equi pment depreci abl e	1, 174, 647		0	0	25. 00
26. 00	Accumulated depreciation	-654, 792	C	0	0	26. 00
27. 00	HIT designated Assets	0	C C		0	27. 00
28. 00	Accumulated depreciation	10/ 050	C	_	0	28. 00
29. 00 30. 00	Minor equipment-nondepreciable Total fixed assets (sum of lines 12-29)	186, 050 3, 641, 808	l .		0	
30.00	OTHER ASSETS	3, 041, 808	1)	0	30.00
31.00	Investments	32, 580, 865	C	0	0	31. 00
32.00	Deposits on Leases	0	c	0	0	32. 00
33. 00	Due from owners/officers	0	C	0	0	33. 00
34. 00	Other assets	45, 340	1	0	0	34. 00
35. 00	Total other assets (sum of lines 31-34)	32, 626, 205	1		0	35.00
36. 00	Total assets (sum of lines 11, 30, and 35) CURRENT LIABILITIES	42, 521, 866	C) 0	0	36. 00
37. 00	Accounts payable	729, 188	C	0	0	37. 00
38. 00	Salaries, wages, and fees payable	690, 253	1		0	
39. 00	Payroll taxes payable	0	C	0	0	39. 00
40.00	Notes and Loans payable (short term)	68, 661	C	0	0	40. 00
41.00	Deferred income	0	C	0	0	41.00
42. 00 43. 00	Accel erated payments Due to other funds	0	C		0	42. 00 43. 00
	Other current liabilities	303, 616		-	0	
45. 00	Total current liabilities (sum of lines 37 thru 44)	1, 791, 718		,	0	
	LONG TERM LIABILITIES					
46. 00	Mortgage payable	0	C		0	1
47. 00	Notes payable	106, 003	C	0	0	
48. 00	Unsecured Loans	45 224		0	0	ł
49. 00 50. 00	Other long term liabilities Total long term liabilities (sum of lines 46 thru 49	45, 326 151, 329	l .		0	ı
51. 00	Total liabilites (sum of lines 45 and 50)	1, 943, 047	l .		0	ł
01.00	CAPI TAL ACCOUNTS	1,7,10,017		<u>, </u>		0 00
52.00	General fund balance	40, 578, 819				52. 00
53.00	Specific purpose fund		(c)		53. 00
54. 00	Donor created - endowment fund balance - restricted			0		54.00
55. 00	Donor created - endowment fund balance - unrestricted			0		55.00
56. 00 57. 00	Governing body created - endowment fund balance Plant fund balance - invested in plant				0	56. 00 57. 00
58. 00	Plant fund balance - reserve for plant improvement,				0	1
	replacement, and expansion				9	
59. 00	Total fund balances (sum of lines 52 thru 58)	40, 578, 819	i	0	0	59. 00
60. 00	Total liabilities and fund balances (sum of lines 51 and	42, 521, 866	· C	0	0	60. 00
	[59]	I	I	1		I

| Period: | Worksheet G-1 | To | 12/31/2014 | From 01/01/2014 | To | 12/31/2014 | To Health Financial Systems
STATEMENT OF CHANGES IN FUND BALANCES Provi der CCN: 150091

					To	o 12/31/2014	Date/Time Pre 5/22/2015 11:	pared: 28 am
		General	l Fund	Speci al	Pu	rpose Fund	Endowment Fund	
		1.00	2. 00	3.00		4. 00	5. 00	
1.00	Fund balances at beginning of period		40, 490, 859			0		1.00
2. 00 3. 00	Net income (loss) (from Wkst. G-3, line 29) Total (sum of line 1 and line 2)		15, 811, 106 56, 301, 965	1		0		2. 00 3. 00
4. 00	Additions (credit adjustments) (specify)	0	30, 301, 703		0	_	0	1
5.00	, , , , , , , , , , , , , , , , , , ,	o			0		0	1
6.00		0			0		0	
7.00		0			0		0	
8. 00 9. 00		0			0			
10. 00	Total additions (sum of line 4-9)		0		O	0	· -	10.00
11. 00	Subtotal (line 3 plus line 10)		56, 301, 965			0		11. 00
12. 00	Deductions (debit adjustments) (specify)	0			0		0	
13.00	ASSET TRANSFERS	15, 723, 146			0		0	
14. 00 15. 00		0			0		0	
16. 00					0			
17. 00		o			0		0	17. 00
18. 00	Total deductions (sum of lines 12-17)		15, 723, 146	1		0		18. 00
19. 00	Fund balance at end of period per balance sheet (line 11 minus line 18)		40, 578, 819			0		19. 00
	Islieet (Title 11 IIII lius Title 10)	Endowment Fund	PI ant	Fund				
1.00		6.00	7. 00	8. 00				1.00
1. 00 2. 00	Fund balances at beginning of period Net income (loss) (from Wkst. G-3, line 29)	0			0			1. 00 2. 00
3. 00	Total (sum of line 1 and line 2)	o			0			3.00
4.00	Additions (credit adjustments) (specify)		0					4. 00
5.00			0					5. 00
6. 00 7. 00			0					6. 00 7. 00
8. 00			0					8. 00
9.00			0					9. 00
10.00	Total additions (sum of line 4-9)	0			0			10.00
11. 00 12. 00	Subtotal (line 3 plus line 10) Deductions (debit adjustments) (specify)	0	0		0			11. 00 12. 00
13. 00	ASSET TRANSFERS		0					13. 00
14.00			0					14. 00
15. 00			0					15. 00
16. 00 17. 00			0					16. 00 17. 00
18.00	Total deductions (sum of lines 12-17)	0	U	1	0			18.00
19. 00	Fund balance at end of period per balance sheet (line 11 minus line 18)	o			0			19. 00

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

Cost Center Description				10 12/31/2014	5/22/2015 11:	
PART I - PATTENT REVENUES 1.00 2.00 3.00		Cost Center Description	Inpati ent	Outpati ent		20 4
Central Inpatient Routine Services 1.00						
1.00		PART I - PATIENT REVENUES	·	<u> </u>		
2.00 SUBPROVIDER - IPF		General Inpatient Routine Services				
SUBROVIDER - IRF	1.00	Hospi tal	7, 575, 08	35	7, 575, 085	1. 00
4.00 SUBPROVIDER	2.00	SUBPROVI DER - I PF				2.00
5.00 Swing bed - NF	3.00	SUBPROVI DER - I RF				3. 00
SWING BORD - NF NO SWING BORD - NF NF NF NF NF NF NF NF	4.00	SUBPROVI DER				4.00
3.00 SKILLED NURSING FACILITY	5.00	Swing bed - SNF		0	0	5.00
8.00 NURSING FACILITY	6.00			0	0	6. 00
9.00 10.00 11.00 10.00 11.00 1	7.00	SKILLED NURSING FACILITY				7. 00
10.00						
Intensive Care Type Inpatient Hospital Services	9.00	OTHER LONG TERM CARE				9. 00
11.00	10.00		7, 575, 08	85	7, 575, 085	10.00
12.00 CORONARY CARE UNIT 12.00 13.00 BURN INTENSIVE CARE UNIT 14.00 13.00 13.00 0THER SPECIAL CARE (SPECIFY) 15.00 0THER SPECIAL CARE (SPECIFY) 15.00 15.00 11-15) 17.00 17.01 Inpatient routine care services (sum of lines 10 and 16) 7,575,085 7,575,085 17.00 18.00 Ancillary services 31,907,563 0 31,907,563 18.00 19.00						
13. 00 BURN INTENSIVE CARE UNIT 13. 00 14. 00 15. 00 16. 00 16. 00 17. 575, 085 15. 00 16. 00 17. 575, 085 17. 575, 085 17. 575, 085 17. 00 17.						
14. 00 SURGICAL INTENSIVE CARE UNIT 14. 00 14. 00 15. 00 16. 00						
15. 00 OTHER SPECIAL CARE (SPECIFY) Total intensive care type inpatient hospital services (sum of lines 10 and 16) T. 50 Total intensive care type inpatient hospital services (sum of lines 10 and 16) T. 575, 085 T. 575, 085 T. 7. 508 T. 7.						
16.00 Total intensive care type inpatient hospital services (sum of lines 10 and 16) 11-15) 17.00 17.01 inpatient routine care services (sum of lines 10 and 16) 7,575,085 31,907,563						
11-15 Total inpatient routine care services (sum of lines 10 and 16) Total inpatient routine care services (sum of lines 10 and 16) Total inpatient routine care services (sum of lines 10 and 16) Total inpatient routine care services (sum of lines 10 and 16) Total inpatient routine care services (sum of lines 17-27) and 16 Total inpatient routine care services (sum of lines 10 and 16) Total inpatient routine care services (sum of lines 20 and 16) Total inpatient routine care services (sum of lines 20 and 16) Total inpatient routine care services (sum of lines 20 and 16) Total inpatient routine care services (sum of lines 20 and 16) Total inpatient routine care services (sum of lines 20 and 16) Total inpatient routine care services (sum of lines 20 and 16) Total inpatient routine care services (sum of lines 10 and 16) Total inpatient routine care services (sum of lines 10 and 16) Total inpatient routine care services (sum of lines 10 and 16) Total inpatient routine care services (sum of lines 10 and 16) Total inpatient routine care services (sum of lines 20 and 17. 00 and 17. 00 and 18. 00 and 19. 00 an		, ,				
17. 00	16. 00	, , , , , , , , , , , , , , , , , , , ,	es	0	0	16. 00
18. 00 Ancillary services 31, 907, 563 0 31, 907, 563 18. 00 19. 00 0 0 0 0 0 0 0 0 0				_		
19.00						
20. 00 RURÂL HEALTH CLINIC 0 0 0 0 0 0 20.00 21. 00 FEDERALLY QUALIFIED HEALTH CENTER 0 0 0 0 0 21.00 22. 00 HOME HEALTH AGENCY 22.00 23. 00 AMBULANCE SERVICES 0 0 6,021,207 24. 00 CMHC 25. 00 25. 00 AMBULATORY SURGICAL CENTER (D.P.) 26. 00 27. 00 HOSPICE 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0			31, 907, 56			
21. 00 FEDERALLY QUALIFIED HEALTH CENTER 0 0 0 21. 00 22. 00 HOME HEALTH AGENCY 22. 00 HOME HEALTH AGENCY 22. 00 HOME HEALTH AGENCY 23. 00 24. 00 25. 00 26. 00 0 0 0 0 0 0 0 0 0						
22. 00 HOME HEALTH AGENCY AMBULANCE SERVICES 0 6, 021, 207 6, 021, 207 24, 00 24, 00 25, 00 AMBULATORY SURGICAL CENTER (D.P.) 6, 001, 207 26, 00 HOSPICE 0 27, 00 OTHER (SPECIFY) 0 0 OTHER (SPECIFY) 0 OTHER (SPECIFY) 39, 482, 648 100, 718, 107 140, 200, 755 28, 00 27, 00 OTHER (SPECIFY) 39, 40, 644, 105 39, 482, 648 100, 718, 107 140, 200, 755 28, 00 27, 00 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0				-		
23. 00				0	0	
24. 00 25. 00 25. 00 26. 00 100					/ 004 007	
25. 00				6, 021, 207	6, 021, 207	
26. 00 HOSPICE 0 0 0 27. 00 0 27. 00 0 0 27. 00 0 0 27. 00 0 0 0 0 0 0 0 0 0						
27. 00 OTHER (SPECIFY) 28. 00 Total patient revenues (sum of lines 17-27) (transfer column 3 to Wkst. 39, 482, 648 100, 718, 107 140, 200, 755 28. 00 PART II - OPERATING EXPENSES 29. 00 Operating expenses (per Wkst. A, column 3, line 200) PROVISION FOR BAD DEBT 7, 228, 705 30. 00 31. 00 32. 00 33. 00 34. 00 35. 00 36. 00 37. 00 38. 00 37. 00 38. 00 39. 00 40. 00 41. 00 41. 00 42. 00 Total deductions (sum of lines 37-41) Total operating expenses (sum of lines 29 and 36 minus line 42) (transfer 40, 644, 105 7, 228, 705 30, 40, 644, 105 7, 228, 705 30, 00 31. 00 32. 00 33. 00 34. 00 35. 00 36. 00 37. 00 38. 00 39. 00 40. 00 41. 00 41. 00 43. 00 Total deductions (sum of lines 37-41) Total operating expenses (sum of lines 29 and 36 minus line 42) (transfer						
28.00 Total patient revenues (sum of lines 17-27) (transfer column 3 to Wkst. 39, 482, 648 100, 718, 107 140, 200, 755 6.3, line 1) PART II - OPERATING EXPENSES Operating expenses (per Wkst. A, column 3, line 200) PROVISION FOR BAD DEBT 7, 228, 705 0 30.00 31.00 32.00 33.00 34.00 35.00 36.00 Total additions (sum of lines 30-35) DEDUCT (SPECIFY) DEDUCT (SPECIFY) 0 39.00 40.00 41.00 42.00 Total deductions (sum of lines 37-41) Total operating expenses (sum of lines 29 and 36 minus line 42) (transfer 47, 872, 810) 28.00 40, 644, 105 7 4					0	
G-3, line 1) PART II - OPERATING EXPENSES 29. 00 30. 00 31. 00 31. 00 32. 00 33. 00 34. 00 35. 00 36. 00 37. 00 DEDUCT (SPECIFY) Total deductions (sum of lines 37-41) 43. 00 Total operating expenses (per Wkst. A, column 3, line 200) 7, 228, 705 40, 644, 105 29. 00 31. 00 31. 00 32. 00 31. 00 32. 00 33. 00 34. 00 35. 00 36. 00 37. 00 DEDUCT (SPECIFY) 0 37. 00 38. 00 39. 00 40. 00 41. 00 42. 00 Total deductions (sum of lines 37-41) Total operating expenses (sum of lines 29 and 36 minus line 42) (transfer) 7, 228, 705 0 0 37. 00 38. 00 39. 00 40. 00 41. 00 42. 00 Total operating expenses (sum of lines 29 and 36 minus line 42) (transfer) 47, 872, 810			Wkc+ 20 492 4	0 100 710 107	-	
PART II - OPERATING EXPENSES Operating expenses (per Wkst. A, column 3, line 200) PROVISION FOR BAD DEBT 7, 228, 705 30. 00 31. 00 32. 00 33. 00 34. 00 35. 00 36. 00 Total additions (sum of lines 30-35) DEDUCT (SPECIFY) 0 37. 00 38. 00 39. 00 40. 00 41. 00 41. 00 42. 00 Total operating expenses (sum of lines 29 and 36 minus line 42) (transfer) 40, 644, 105 40, 644, 105 40, 644, 105 40, 644, 105 40, 644, 105 40, 644, 105 40, 644, 105 40, 644, 105 40, 644, 105 40, 644, 105 40, 644, 105 40, 644, 105 30. 00 31. 00 31. 00 32. 00 33. 00 34. 00 35. 00 37. 00 36. 00 37. 00 38. 00 39. 00 40. 00 41. 00 42. 00 Total deductions (sum of lines 37-41) 43. 00 Total operating expenses (sum of lines 29 and 36 minus line 42) (transfer) 47, 872, 810 43. 00	26.00		WKSt. 39, 462, 62	100, 716, 107	140, 200, 755	26.00
29. 00 30. 00 30. 00 31. 00 31. 00 32. 00 33. 00 34. 00 35. 00 36. 00 37. 00 38. 00 39. 00 39. 00 40, 644, 105 30. 00 31. 00 32. 00 33. 00 34. 00 35. 00 36. 00 37. 00 38. 00 39. 00 40. 00 41. 00 42. 00 Total deductions (sum of lines 37-41) Total operating expenses (per Wkst. A, column 3, line 200) 7, 228, 705 30. 00 31. 00 32. 00 33. 00 34. 00 35. 00 36. 00 37. 00 38. 00 39. 00 40. 00 41. 00 42. 00 Total deductions (sum of lines 37-41) Total operating expenses (sum of lines 29 and 36 minus line 42)(transfer 40, 644, 105 7, 228, 705 30. 00 31. 00 32. 00 33. 00 34. 00 35. 00 37. 00 38. 00 39. 00 40. 00 41. 00 42. 00 43. 00 47, 872, 810						
30. 00	29 00			40 644 105		29 00
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40.00 41.00 42.00 Total deductions (sum of lines 37-41) 43.00 Total operating expenses (sum of lines 29 and 36 minus line 42)(transfer 47,872,810 43.00				0		
41.00 42.00 Total deductions (sum of lines 37-41) 43.00 Total operating expenses (sum of lines 29 and 36 minus line 42)(transfer 47,872,810 43.00				0		
42.00 Total deductions (sum of lines 37-41) 43.00 Total operating expenses (sum of lines 29 and 36 minus line 42)(transfer 47, 872, 810 43.00				0		
43.00 Total operating expenses (sum of lines 29 and 36 minus line 42)(transfer 47,872,810 43.00		Total deductions (sum of lines 37-41)		0		42.00
to Wkst. G-3, line 4)			ransfer	47, 872, 810		
		to Wkst. G-3, line 4)				

	Financial Systems HUNTINGTON MEMORIA ENT OF REVENUES AND EXPENSES	Provi der CCN: 150091	Peri od:	u of Form CMS-2 Worksheet G-3	
			From 01/01/2014 To 12/31/2014		pared:
				1. 00	
1. 00	Total patient revenues (from Wkst. G-2, Part I, column 3, line			140, 200, 755	
2.00	Less contractual allowances and discounts on patients' accoun	ts		81, 046, 136	
3.00	Net patient revenues (line 1 minus line 2)			59, 154, 619	
4.00	Less total operating expenses (from Wkst. G-2, Part II, line	43)		47, 872, 810	
5.00	Net income from service to patients (line 3 minus line 4)			11, 281, 809	5. 00
	OTHER INCOME				
6.00	Contributions, donations, bequests, etc			0	6. 00
7.00	Income from investments			941, 331	
8.00	Revenues from telephone and other miscellaneous communication	servi ces		0	
9.00	Revenue from television and radio service			0	
10.00	Purchase di scounts			0	
11. 00	Rebates and refunds of expenses			0	
12.00	Parking lot receipts			0	1 00
	Revenue from Laundry and Linen service			0	13. 00
	Revenue from meals sold to employees and guests			138, 958	
15. 00	Revenue from rental of living quarters			0	
16. 00		han patients		0	
	Revenue from sale of drugs to other than patients			0	
	Revenue from sale of medical records and abstracts			0	
19. 00	Tuition (fees, sale of textbooks, uniforms, etc.)			0	
20.00	Revenue from gifts, flowers, coffee shops, and canteen			0	
	Rental of vending machines			0	
22. 00	Rental of hospital space			0	
23.00	Governmental appropriations			0	23. 00
24. 00	OTHER (SPECIFY)			0	24. 00
24. 01	GAIN/(LOSS) ON SALE OF CAPITAL ASSET			0	
24. 02	EMS SUBSIDY			250, 000	24. 02
24. 03	OTHER REVENUE			3, 199, 008	24. 03
25.00	Total other income (sum of lines 6-24)			4, 529, 297	25. 00
26.00	Total (line 5 plus line 25)			15, 811, 106	26. 00
27.00	OTHER EXPENSES (SPECIFY)			0	27. 00
28.00	Total other expenses (sum of line 27 and subscripts)			0	28. 00

28.00 Total other expenses (sum of line 27 and subscripts)
29.00 Net income (or loss) for the period (line 26 minus line 28)

15, 811, 106 29. 00

0 28. 00

Hoal th	Financial Systems HUNTINGTON MEMORIAL	HOSDI TAI	Inlie	u of Form CMS-2	2552_10
	ATION OF CAPITAL PAYMENT	Provi der CCN: 150091	Period: From 01/01/2014 To 12/31/2014	Worksheet L Parts I-III Date/Time Pre 5/22/2015 11:	pared:
		Title XVIII	Hospi tal	PPS	
	DART I FILLY PROCEETIVE METHOD			1. 00	
	PART I - FULLY PROSPECTIVE METHOD CAPITAL FEDERAL AMOUNT				
1.00	Capital DRG other than outlier			221, 176	1. 00
1. 01	Model 4 BPCI Capital DRG other than outlier			221, 170	1. 01
2. 00	Capital DRG outlier payments			4, 731	2.00
2. 01	Model 4 BPCI Capital DRG outlier payments			0	2. 01
3.00	Total inpatient days divided by number of days in the cost repo	orting period (see inst	ructions)	14. 89	3. 00
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)	0	6. 00
7. 00	Percentage of SSI recipient patient days to Medicare Part A pat 30) (see instructions)	ient days (Worksheet E	, part A line	0.00	7. 00
8.00	Percentage of Medicaid patient days to total days (see instruct	i ons)		0.00	8. 00
9.00	Sum of lines 7 and 8			0.00	9. 00
10.00	Allowable disproportionate share percentage (see instructions)			0.00	10. 00
11. 00	Disproportionate share adjustment (line 10 times the sum of lin			0	
12. 00	Total prospective capital payments (sum of lines 1, 1.01, 2, 2.	01, 6 and 11)		225, 907	12. 00
				1. 00	
	PART II - PAYMENT UNDER REASONABLE COST				
1.00	Program inpatient routine capital cost (see instructions)			0	
2.00	Program inpatient ancillary capital cost (see instructions)			0	2. 00
3.00	Total inpatient program capital cost (line 1 plus line 2)			0	3. 00
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	Program inpatient capital costs (see instructions)			0	
2.00	Program inpatient capital costs for extraordinary circumstances	s (see instructions)		0	
3. 00	Net program inpatient capital costs (line 1 minus line 2)			0	
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 8. 00	Adjustment to capital minimum payment level for extraordinary of	circumstances (line 2 x	Tine 6)	0	
9.00	Capital minimum payment level (line 5 plus line 7)	ره امر		0	9.00
10. 00	Current year capital payments (from Part I, line 12, as applica Current year comparison of capital minimum payment level to cap		loce line ()	0	
11. 00	Carryover of accumulated capital minimum payment level over cap			0	
11.00	Worksheet L, Part III, line 14)	ortar payment (110m pri	or year	O	11.00
12. 00					12. 00
13. 00	Current year exception payment (if line 12 is positive, enter t	0			
14. 00	Carryover of accumulated capital minimum payment level over cap (if line 12 is negative, enter the amount on this line)			0	14. 00
15. 00	Current year allowable operating and capital payment (see instr	ructions)		0	15. 00
	Current year operating and capital costs (see instructions)	· - · · - /		0	
	Current year exception offset amount (see instructions)				17. 00
			'		•