Heal th Financia	al Systems	HUNTINGTON MEMORIA	AL HOSPITAL	In Lieu	of Form CMS-25	552-10
	required by law (42 USC 1395g;				FORM APPROVED	
payments made :	since the beginning of the cost	reporting period being	deemed overpayments (42	2 USC 1395g).	OMB NO. 0938-00 EXPIRES 05-31-2	
HOSPITAL AND HORD HORD HORD HORD HORD HORD HORD HOR	OSPITAL HEALTH CARE COMPLEX COS SUMMARY	T REPORT CERTIFICATION	Provider CCN: 15-0091	Period: From 01/01/2016 To 12/31/2016	Worksheet S Parts I-III Date/Time Prepa 5/22/2017 9:23	ared: am
PART I - COST	REPORT STATUS					
Provi der	1. [ X ] Electronically filed co			Date: 5/22/20	17 Time: 9:	23 am
use only	2. [ ] Manually submitted cost	•				
	3. [ 0 ] If this is an amended r 4. [ F ] Medicare Utilization. E			esubmitted this co	ost report	
Contractor use only	<ol> <li>As Submitted</li> <li>Settled without Audit 8.</li> </ol>	Date Received: Contractor No. [ N ]Initial Report fo [ N ]Final Report for	11.( or this Provider CCN 12.			
PART II - CERT	I FI CATI ON		· · · · · ·			
ADMI NI STRATI VE PROVI DED OR PRO	ION OR FALSIFICATION OF ANY INF ACTION, FINE AND/OR IMPRISONME OCURED THROUGH THE PAYMENT DIRE ACTION, FINES AND/OR IMPRISONM	NT UNDER FEDERAL LAW. CTLY OR INDIRECTLY OF A	FURTHERMORE, IF SERVICES	S IDENTIFIED IN TH	IS REPORT WERE	

## 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 (15-0091) for the cost reporting period beginning 01/01/2016 and ending 12/31/2016 and to the best of my knowledge and belief, this report and statement are true, correct, complete and prepared from the books and records of the provider in accordance with applicable instructions, except as noted. I further certify that I am familiar with the laws and regulations regarding the provision of health care services, and that the services identified in this cost report were provided in compliance with such laws and regulations.

(Si gned)

Officer or Administrator of Provider(s)

Title

υa	te	

			Title	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	33, 702	39, 946	0	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	33, 702	39, 946	0	0	200. 00

The above amounts represent "due to" or "due from" the applicable program for the element of the above complex indicated. According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The 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-MEDI CARE.

							From 01/0			eet S-2	
									Date/Ti 5/19/20		
	1.00		2. 00		3.00			4.00	10/11/2	517 7.1	
~	Hospital and Hospital Health Care Com										1
0 0	Street: 2001 STULTS ROAD City: HUNTINGTON	PO Box: State:		in Code	: 46750	Cour	nty: HUNTIN	GTON			1.
		Component N		CCN	CBSA	Provi de			nent Syst	em (P,	
			N	umber	Number	Туре	Certifie		T, 0, or		4
	-	1.00		2.00	3.00	4.00	5.00	V 6. 0		XI X 8.00	-
	Hospital and Hospital-Based Component			2.00	5.00	4.00		0.0	0   7.00	0.00	
0		UNTI NGTON MEMOR	REAL 1	50091	99915	1	07/01/19	66 N	Р	Р	3
0	Subprovider - IPF	IOSPI TAL									4
0	Subprovider - IRF										5
0	Subprovider - (Other)										6
0	Swing Beds - SNF										7.
0 0	Swing Beds - NF Hospital-Based SNF										8.
00	Hospi tal -Based NF										10
00	Hospi tal -Based OLTC										11.
00	Hospi tal -Based HHA										12
00 00	Separately Certified ASC Hospital-Based Hospice										13
00	Hospital - Based Health Clinic - RHC										15
00	Hospital-Based Health Clinic - FQHC										16
00 00	Hospital-Based (CMHC) I										17
	Renal Dialysis Other										18
	,						Fre	om:	Тс	):	
							1.		2.		
	Cost Reporting Period (mm/dd/yyyy) Type of Control (see instructions)						01/01	/2016 2	12/31	/2016	20
00	Inpatient PPS Information						·	-			21.
00	Does this facility qualify and is it							/	N	I	22
	share hospital adjustment, in accorda										
	for yes or "N" for no. Is this facili amendment hospital?) In column 2, ent				2. 106(C	) (2) (РІ СК	le				
01	Did this hospital receive interim unc				s cost	reporting	1	J	N	I	22
	period? Enter in column 1, "Y" for ye										
	reporting period occurring prior to O for no for the portion of the cost re										
	(see instructions)	por tring period	occurring c			LODEI I.					
02	Is this a newly merged hospital that				1 2			1	N	1	22
	determined at cost report settlement? or "N" for no, for the portion of the										
	in column 2, "Y" for yes or "N" for n										
	or after October 1.	o, ioi the point			opor trin	9 poi ou					
03	Did this hospital receive a geographi							1	N	1	22.
	of the OMB standards for delineating : in column 1, "Y" for yes or "N" for n						r				
	prior to October 1. Enter in column 2						he				
	cost reporting period occurring on or	after October	1. (see ins	structi	ons) Do	es this					
	hospital contain at least 100 but not 42 CFR 412.105)? Enter in column 3, ""			ounted	in acco	rdance wi	th				
00	Which method is used to determine Med			l/or 25	bel ow?	In colum	n	3	3 N	I	23.
	1, enter 1 if date of admission, 2 if	<b>J</b> .			5						
	method of identifying the days in this used in the prior cost reporting peri-										
	lased in the piror cost reporting perio		In-State	In-St		Out-of	Out-of	Medi c	aid 0	ther	
			Medi cai d	Medio	aid	State	State	HMO d		di cai d	
			paid days			edi cai d	Medicaid		0	days	
				unpa day		aid days	el i gi bl e unpai d				
			1.00	2.0		3.00	4.00	5.0	0 0	5.00	
00	If this provider is an IPPS hospital,		91	1	620	0	0		730	0	24
	in-state Medicaid paid days in column Medicaid eligible unpaid days in colu										
	out-of-state Medicaid paid days in colu										
	out-of-state Medicaid eligible unpaid		1								
	4, Medicaid HMO paid and eligible but	unpaid days in									
00	column 5, and other Medicaid days in If this provider is an LPE, optor the		0		0	0	0		0		25
00	If this provider is an IRF, enter the Medicaid paid days in column 1, the i			1		0	0				20
	Medicaid eligible unpaid days in colu	mn 2,									
				1							
	out-of-state Medicaid days in column	S, Out-of-State	·			1					
	Medicaid eligible unpaid days in column HMO paid and eligible but unpaid days	mn 4, Medicaid									

HOSPI T	Financial Systems HUNTINGTO AL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DA		RIAL HOSPITAL Provider CC	N: 15-0091 P	eri od:		u of For Workshe		
				F	rom 01/01/ o 12/31/		Part I		
							5/19/20	<u>)17 9:1</u>	
					Urban/Rur 1.00		Date of 2.0		-
26.00	Enter your standard geographic classification (not wa			inning of the		2	2.0		26.00
27.00	cost reporting period. Enter "1" for urban or "2" for Enter your standard geographic classification (not wa reporting period. Enter in column 1, "1" for urban or	ge) sta "2" fo	atus at the end or rural. If ap			1	10/01/	/2016	27.00
35.00	enter the effective date of the geographic reclassifi If this is a sole community hospital (SCH), enter the effect in the cost reporting period.			H status in		C			35.00
					Begi nni 1. 00		Endi 2. (		-
6.00	Enter applicable beginning and ending dates of SCH st	atus. S	Subscript line	36 for number	1.00		2.0		36.00
7.00	of periods in excess of one and enter subsequent date If this is a Medicare dependent hospital (MDH), enter is in effect in the cost reporting period.		umber of period	s MDH status		C			37.00
7. 01	Is this hospital a former MDH that is eligible for th accordance with FY 2016 OPPS final rule? Enter "Y" fo instructions)				N				37.01
8. 00	If line 37 is 1, enter the beginning and ending dates greater than 1, subscript this line for the number of enter subsequent dates.								38.00
	Jones Subsequent dutes.				Y/N		Y/		-
9,00	Does this facility qualify for the inpatient hospital	pavmer	nt adjustment f	or low volume	1.00 Y		2.0 Y		39.00
	hospitals in accordance with 42 CFR §412.101(b)(2)(ii or "N" for no. Does the facility meet the mileage req CFR 412.101(b)(2)(ii)? Enter in column 2 "Y" for yes	)? Ente uiremer or "N"	er in column 1 nts in accordan for no. (see i	"Y" for yes ce with 42 nstructions)					
0.00	Is this hospital subject to the HAC program reduction "N" for no in column 1, for discharges prior to Octob no in column 2, for discharges on or after October 1.	er 1. E	Enter "Y" for y		N		N		40.00
						V 1.00	XVIII 2.00	XIX 3.00	
5. 00	Prospective Payment System (PPS)-Capital Does this facility qualify and receive Capital paymen with 42 CFR Section §412.320? (see instructions)	t for a	di sproporti onat	e share in acc	cordance	N	N	N	45.00
6. 00	Is this facility eligible for additional payment exce pursuant to 42 CFR §412.348(f)? If yes, complete Wkst Pt. III.					N	N	N	46.00
	Is this a new hospital under 42 CFR §412.300 PPS capi Is the facility electing full federal capital payment Teaching Hospitals					N N	N N	N N	47.00 48.00
6.00	Is this a hospital involved in training residents in	approve	ed GME programs	? Enter "Y" 1	for yes	N			56.00
7.00	or "N" for no. If line 56 is yes, is this the first cost reporting p GME programs trained at this facility? Enter "Y" for is "Y" did residents start training in the first mont for yes or "N" for no in column 2. If column 2 is "Y	yes or h of th ", comp	r "N" for no in his cost report plete Worksheet	column 1. lf ing period? [	column 1 Enter "Y"	N			57.00
8. 00	"N", complete Wkst. D, Parts III & IV and D-2, Pt. II If line 56 is yes, did this facility elect cost reimb defined in CMS Pub. 15-1, chapter 21, §2148? If yes,	ursemer	nt for physicia	ns' services a	as	N			58.00
	Are costs claimed on line 100 of Worksheet A? If yes	, compl	lete Wkst. D-2,			N			59.00
0.00	Are you claiming nursing school and/or allied health provider-operated criteria under §413.85? Enter "Y"				ctions)	N			60.00
		Y/N	IME	Direct GME	IME		Di rect	GME	
		1.00	2.00	3.00	4.00	)	5.0	)0	-
1.00	Did your hospital receive FTE slots under ACA	N				0.00			61.00
1. 01	section 5503? Enter "Y" for yes or "N" for no in column 1. (see instructions) Enter the average number of unweighted primary care FTEs from the hospital's 3 most recent cost reports		0.00	0.00	Ď				61.01
1 02	instructions) Enter the current year total unweighted primary care		0.00	0.00					61.02
1. 02	FTE count (excluding OB/GYN, general surgery FTEs, and primary care FTEs added under section 5503 of ACA). (see instructions)		0.00	0.00					01.0.
1. 03	Enter the base line FTE count for primary care and/or general surgery residents, which is used for determining compliance with the 75% test. (see		0. 00	0.00					61. 03
1. 04	instructions) Enter the number of unweighted primary care/or surgery allopathic and/or osteopathic FTEs in the		0.00	0.00	b				61. 04
51. 05	current cost reporting period. (see instructions). Enter the difference between the baseline primary and/or general surgery FTEs and the current year's primary care and/or general surgery FTE counts (line		0.00	0.00					61. 05

ealth Financial Sys DSPITAL AND HOSPIT		LEX IDENTIFICATION DA		RIAL HOSPITAL Provider CC		eri od:	Worksheet S-2	2552-
					Fr Tc	com 01/01/2016 12/31/2016	Part I Date/Time Pre 5/19/2017 9:1	
			Y/N	IME	Direct GME	IME	Direct GME	
-			1.00	2.00	3.00	4.00	5.00	
used for cap	ount of ACA §5503 aw relief and/or FTEs ral surgery. (see in	that are nonprimary		0.00	0.00			61.
u			Pro	ogram Name	Program Code	Unweighted IME FTE Count	Unweighted Direct GME FTE Count	
				1.00	2.00	3.00	4, 00	-
specialty, if for each new column 1, the program code,	any, and the numbe program. (see instreprogram name, ente enter in column 3, punt and enter in co	uctions) Enter in r in column 2, the the IME FTE				0. 00	0.00	61.
1.20 Of the FTEs i program speci residents for instructions) enter in colu 3, the IME FT	n line 61.05, speci alty, if any, and t each expanded prog Enter in column 1, umn 2, the program c	he number of FTE ram. (see the program name, ode, enter in column and enter in column				0.00	0.00	61.
							1.00	-
		Ith Resources and Se						
		s that your hospital funding (see instruc		d in this cost	reporting peri	od for which	0.00	62.
2.01 Enter the num during in thi	nber of FTE resident <u>s cost reporting p</u> e	s that rotated from a riod of HRSA THC prog sidents in Nonprovide	a Teachi gram. (s	<u>see instruction</u>		your hospital	0.00	62.
3.00 Has your faci	lity trained reside	nts in nonprovider se umn 1. If yes, comple	ettings	during this co	instructions)		N	63.
					Unweighted FTEs Nonprovider Site	Unweighted FTEs in Hospital	Ratio (col. 1/ (col. 1 + col. 2))	
C 11 5504					1.00	2.00	3.00	
		r FTE Residents in No uly 1, 2009 and befor			inis base year	is your cost r	eporiting	
4.00 Enter in colu in the base y resident FTEs settings. Er resident FTEs	umn 1, if line 63 is year period, the num s attributable to ro nter in column 2 the s that trained in yo	yes, or your facilit ber of unweighted nor tations occurring in number of unweighted ur hospital. Enter ir 1 + column 2)). (see	ty trair -primar all nor non-pr columr	ned residents ry care nprovider rimary care n 3 the ratio	0.00	0.00		
		Program Name	Pro	ogram Code	Unweighted FTEs Nonprovider Site	Unweighted FTEs in Hospital	Ratio (col. 3/ (col. 3 + col. 4))	
		1.00		2.00	3.00	4.00	5.00	
is yes, or yo trained resic year period, associated wi FTEs for each program in wh residents. Er the program c col umn 3, the unweighted pr residents att rotations occ non-provider col umn 4, the	dents in the base the program name th primary care n primary care nich you trained ther in column 2, code, enter in a number of rimary care FTE tributable to curring in all settings. Enter in				0. 00	0.00	0. 000000	65.

Health Financial Systems		HUNTINGTON MEMORIA	AL HOSPITAL			eu of Form CMS-2	
HOSPITAL AND HOSPITAL HEALTH	CARE COMPLEX IDENTIFIC	CATION DATA	Provider CCN		eriod: rom 01/01/2016 o 12/31/2016		pared:
				Unweighted FTEs Nonprovider Site	Unweighted FTEs in Hospital	Ratio (col. 1/ (col. 1 + col. 2))	
Section 5504 of the ACA	A Current Year FTF Res	idents in Nonprov	ider Settings	1.00 Effective fo	2.00 2.00	3.00	
66.00 Enter in column 1 the r FTEs attributable to rc Enter in column 2 the r FTEs that trained in yo	July 1, 2010 number of unweighted n otations occurring in number of unweighted n our hospital. Enter in	on-primary care ro all nonprovider so on-primary care ro column 3 the rati	esi dent etti ngs. esi dent o of	0.00			66. 00
(column 1 divided by (c	Program	· · · · · · · · · · · · · · · · · · ·	ram Code	Unweighted FTEs Nonprovider	Unweighted FTEs in Hospital	Ratio (col. 3/ (col. 3 + col. 4))	
	1.00		2.00	Si te	4.00	E 00	
67.00 Enter in column 1, the name associated with ear your primary care progr which you trained resic Enter in column 2, the code. Enter in column 3 number of unweighted pr care FTE residents attr to rotations occurring non-provider settings. column 4, the number of unweighted primary care resident FTEs that trai your hospital. Enter in 5, the ratio of (column divided by (column 3 + 4)). (see instructions)	ich of rams in lents. program B, the iimary ributable in all Enter in red in n column 1 3 column		2.00	3.00 0.00	4.00	5.00	67.00
					1.0	0 2.00 3.00	
Inpatient Psychiatric F 70.00 Is this facility an Inp Enter "Y" for yes or "N 71.00 If line 70 yes: Column recent cost report file 42 CFR 412.424(d)(1)(ii program in accordance w Column 3: If column 2 i (see instructions)	patient Psychiatric Fa "for no. 1: Did the facility h ed on or before Novemb i)(c)) Column 2: Did <i>i</i> ith 42 CFR 412.424 (d s Y, indicate which p	ave an approved G er 15, 2004? Ento this facility trai )(1)(iii)(D)? Ento	/E teaching pi er "Y" for yes n residents i er "Y" for yes	rogram in the s or "N" for r in a new teach s or "N" for r	most no. (see ni ng no.	0	70. 00 71. 00
75.00 Is this facility an Inp		Facility (IRF), (	or does it com	ntain an IRF	N		75.00
<ul> <li>subprovider? Enter "Y"</li> <li>76.00 If line 75 yes: Column recent cost reporting p no. Column 2: Did this CFR 412.424 (d)(1)(iii) indicate which program</li> </ul>	for yes and "N" for 1: Did the facility h period ending on or be facility train reside (D)? Enter "Y" for ye	no. ave an approved G fore November 15, nts in a new teacl s or "N" for no. (	ME teaching pu 2004? Enter ' hing program i Column 3: If (	rogram in the "Y" for yes or in accordance column 2 is Y,	most "N" for with 42	0	76.00
						1.00	
Long Term Care Hospital 80.00 Is this a long term car 81.00 Is this a LTCH co-locat "Y" for yes and "N" for TEFRA Providers	e hospital (LTCH)? E ed within another hos				period? Enter	N N	80. 00 81. 00
85.00 Is this a new hospital 86.00 Did this facility estab §413.40(f)(1)(ii)? Ent	lish a new Other subp	rovider (excluded				N	85. 00 86. 00
87.00 Is this hospital a "sub for yes or "N" for no.			tion 1886(d)(	1)(B)(iv)(II)?	'Enter "Y"	Ν	87.00
					V 1.00	XI X 2.00	
Title V and XIX Service							
90.00 Does this facility have yes or "N" for no in th		npatient hospital	serví ces? En	ter "Y" for	N	Y	90.00
91.00 Is this hospital reimbu full or in part? Enter				either in	N	N	91.00
92.00 Are title XIX NF patier	nts occupying title XV	III SNF beds (dual	certi fi cati d	on)? (see		Ν	92.00
93.00 instructions) Enter "Y" Does this facility oper "Y" for yes or "N" for	ate an ICF/IID facili no in the applicable	ty for purposes of column.	fitle V and		Ν	Ν	93. 00
94.00 Does title V or XIX rec applicable column.	luce capital cost? Ent	er "Y" for yes, ai	nd "N" for no	in the	N	N	94.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA	RIAL HOSPITAL				of Form CM	
	Provider C	CN: 15-0091	Period: From 01/01/2 To 12/31/2	2016 Pa 2016 Da	orksheet S art I ate/Time P /19/2017 9	Prepared:
			V		XI X	
95.00 If line 94 is "Y", enter the reduction percentage in the app	olicable colum	<u>ــــــــــــــــــــــــــــــــــــ</u>	1.00		2.00	95.00
96.00 Does title V or XIX reduce operating cost? Enter "Y" for yes applicable column.	s or "N" for n	o in the	N		N	96.00
97.00 If line 96 is "Y", enter the reduction percentage in the app Rural Providers	olicable colum	1.	0.00		0.00	97.00
105.00 Does this hospital qualify as a critical access hospital (C/ 106.00 If this facility qualifies as a CAH, has it elected the all- for outpatient services? (see instructions)		nod of paymen	t			105. 00 106. 00
107.00 If this facility qualifies as a CAH, is it eligible for cost training programs? Enter "Y" for yes or "N" for no in column yes, the GME elimination is not made on Wkst. B, Pt. I, col. reimbursed. If yes complete Wkst. D-2, Pt. II.	n 1. (see inst 25 and the p	ructions) lf rogram is cos				107.00
108.00 Is this a rural hospital qualifying for an exception to the CFR Section §412.113(c). Enter "Y" for yes or "N" for no.	CRNA fee sche	dule? See 42	N			108.00
	Physi cal 1.00	Occupationa 2.00	I Speech 3.00	n F	Respirator 4.00	У
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 Hospita the current cost reporting period? Enter "Y" for yes or "N"		on project (4	10A Demo)for		N	110.00
			-	1.00	2.00 3.0	00
Miscellaneous Cost Reporting Information 115.00 Is this an all-inclusive rate provider? Enter "Y" for yes or is yes, enter the method used (A, B, or E only) in column 2. 3 either "93" percent for short term hospital or "98" percer psychiatric, rehabilitation and long term hospitals provider	If column 2 int for long te	s "E", enter rm care (incl	in column udes	N	0	115.00
Pub. 15-1, chapter 22, §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			"N" for	N Y		116. 00 117. 00
no. 118.00 Is the mal practice insurance a claims-made or occurrence pol	icy? Enter 1	f the policy	is	1		118.00
claim-made. Enter 2 if the policy is occurrence.		Premiums	Losses	; [	Insurance	
		1.00	2.00		3.00	
118.01 List amounts of malpractice premiums and paid losses:		58,8				
				0		137 118. 01
			1.00	0		137 118. 01
118.02 Are malpractice premiums and paid losses reported in a cost Administrative and General? If yes, submit supporting scheo and amounts contained therein.				0	125, 1	118. 02
<ul> <li>Administrative and General? If yes, submit supporting schedand amounts contained therein.</li> <li>119.00 DO NOT USE THIS LINE</li> <li>120.00 Is this a SCH or EACH that qualifies for the Outpatient Hold §3121 and applicable amendments? (see instructions) Enter in "N" for no. Is this a rural hospital with &lt; 100 beds that que Hold Harmless provision in ACA §3121 and applicable amendment</li> </ul>	dule listing c d Harmless pro n column 1, "Y ualifies for t	ost centers vision in ACA ' for yes or ne Outpatient	1.00 N	0	125, 1	
<ul> <li>Administrative and General? If yes, submit supporting schedand amounts contained therein.</li> <li>119.00 DO NOT USE THIS LINE</li> <li>120.00 Is this a SCH or EACH that qualifies for the Outpatient Hold §3121 and applicable amendments? (see instructions) Enter in "N" for no. Is this a rural hospital with &lt; 100 beds that qualified Harmless provision in ACA §3121 and applicable amendment Enter in column 2, "Y" for yes or "N" for no.</li> <li>121.00 Did this facility incur and report costs for high cost implation of the statement of the</li></ul>	dule listing co d Harmless pro n column 1, "Y ualifies for ti nts? (see inst	ost centers vision in ACA ' for yes or ne Outpatient ructions)	1.00 N	0	125, 1 2. 00	118.02
<ul> <li>Administrative and General? If yes, submit supporting schedand amounts contained therein.</li> <li>119.00 D0 NOT USE THIS LINE</li> <li>120.00 Is this a SCH or EACH that qualifies for the Outpatient Hold §3121 and applicable amendments? (see instructions) Enter in "N" for no. Is this a rural hospital with &lt; 100 beds that que Hold Harmless provision in ACA §3121 and applicable amendmer Enter in column 2, "Y" for yes or "N" for no.</li> <li>121.00 Did this facility incur and report costs for high cost implation patients? Enter "Y" for yes or "N" for no.</li> <li>122.00 Does the cost report contain state heal th or similar taxes? for no in column 1. If column 1 is "Y", enter in column 2 the cost of the cost of</li></ul>	dule listing co d Harmless provin column 1, "Y ualifies for th nts? (see inst antable device: Enter "Y" for	ost centers vision in ACA ' for yes or ne Outpatient ructions) s charged to yes or "N"	1.00 N	0	125, 1 2. 00	118. 02 119. 00 120. 00
<ul> <li>Administrative and General? If yes, submit supporting schedand amounts contained therein.</li> <li>119.00 DO NOT USE THIS LINE</li> <li>120.00 Is this a SCH or EACH that qualifies for the Outpatient Hold §3121 and applicable amendments? (see instructions) Enter in "N" for no. Is this a rural hospital with &lt; 100 beds that que Hold Harmless provision in ACA §3121 and applicable amendment Enter in column 2, "Y" for yes or "N" for no.</li> <li>121.00 Did this facility incur and report costs for high cost implation patients? Enter "Y" for yes or "N" for no.</li> <li>122.00 Does the cost report contain state heal th or similar taxes? for no in column 1. If column 1 is "Y", enter in column 2 th where these taxes are included. Transplant Center Information</li> </ul>	dule listing co d Harmless provin n column 1, "Y ualifies for ti nts? (see instr antable device: Enter "Y" for ne Worksheet A	vision in ACA ' for yes or ne Outpatient ructions) s charged to yes or "N" line number	1.00 N N Y N	0	125, 1 2. 00	118. 02 119. 00 120. 00 121. 00 122. 00
Administrative and General? If yes, submit supporting sched and amounts contained therein. 119.00 DO NOT USE THIS LINE 120.00 Is this a SCH or EACH that qualifies for the Outpatient Hold §3121 and applicable amendments? (see instructions) Enter in "N" for no. Is this a rural hospital with < 100 beds that qu Hold Harmless provision in ACA §3121 and applicable amendmen Enter in column 2, "Y" for yes or "N" for no. 121.00 Did this facility incur and report costs for high cost impla patients? Enter "Y" for yes or "N" for no. 122.00 Does the cost report contain state health or similar taxes? for no in column 1. If column 1 is "Y", enter in column 2 th where these taxes are included. Transplant Center Information 125.00 Does this facility operate a transplant center? Enter "Y" for yes, enter certification date(s) (mm/dd/yyyy) below.	dule listing of d Harmless pro- n column 1, "Y ualifies for th nts? (see inst antable device: Enter "Y" for ne Worksheet A por yes and "N"	vision in ACA ' for yes or ne Outpatient ructions) s charged to yes or "N" line number	1.00 N N Y N	0	125, 1 2. 00	118. 02 119. 00 120. 00 121. 00 122. 00 125. 00
<ul> <li>Administrative and General? If yes, submit supporting schedand amounts contained therein.</li> <li>119.00 D0 NOT USE THIS LINE</li> <li>120.00 Is this a SCH or EACH that qualifies for the Outpatient Hold §3121 and applicable amendments? (see instructions) Enter in "N" for no. Is this a rural hospital with &lt; 100 beds that que Hold Harmless provision in ACA §3121 and applicable amendment Enter in column 2, "Y" for yes or "N" for no.</li> <li>121.00 Did this facility incur and report costs for high cost implation patients? Enter "Y" for yes or "N" for no.</li> <li>122.00 Does the cost report contain state heal th or similar taxes? for no in column 1. If column 1 is "Y", enter in column 2 th where these taxes are included.</li> <li>Transplant Center Information</li> <li>125.00 Does this facility operate a transplant center? Enter "Y" for yes, enter certification date(s) (mm/dd/yyyy) below.</li> <li>126.00 If this is a Medicare certified kidney transplant center, enter in column 1 and termination date, if applicable, in column 2</li> </ul>	dule listing co d Harmless pro- n column 1, "Y ualifies for th nts? (see inst- antable device: Enter "Y" for ne Worksheet A or yes and "N" nter the certi- 2.	vision in ACA ' for yes or he Outpatient ructions) s charged to yes or "N" line number for no. If fication date	1.00 N N Y N		125, 1 2. 00	118. 02 119. 00 120. 00 121. 00 122. 00 125. 00 126. 00
<ul> <li>Administrative and General? If yes, submit supporting sched and amounts contained therein.</li> <li>119.00 D0 NOT USE THIS LINE</li> <li>120.00 Is this a SCH or EACH that qualifies for the Outpatient Hold §3121 and applicable amendments? (see instructions) Enter in "N" for no. Is this a rural hospital with &lt; 100 beds that qu Hold Harmless provision in ACA §3121 and applicable amendmen Enter in column 2, "Y" for yes or "N" for no.</li> <li>121.00 Did this facility incur and report costs for high cost impla patients? Enter "Y" for yes or "N" for no.</li> <li>122.00 Does the cost report contain state health or similar taxes? for no in column 1. If column 1 is "Y", enter in column 2 th where these taxes are included. Transplant Center Information</li> <li>125.00 Does this facility operate a transplant center? Enter "Y" for yes, enter certification date(s) (mm/dd/yyyy) below.</li> <li>126.00 If this is a Medicare certified kidney transplant center, enter</li> </ul>	dule listing control of the dumn 1, "Y ualifies for the devices antable devices Enter "Y" for the Worksheet A bor yes and "N" ther the certifies the the certifies 2.	vision in ACA ' for yes or ne Outpatient ructions) s charged to yes or "N" line number for no. If fication date cation date	1.00 N N Y N		125, 1 2. 00	118. 02 119. 00 120. 00 121. 00 122. 00 125. 00
<ul> <li>Administrative and General? If yes, submit supporting sched and amounts contained therein.</li> <li>119.00 DO NOT USE THIS LINE</li> <li>120.00 Is this a SCH or EACH that qualifies for the Outpatient Hold §3121 and applicable amendments? (see instructions) Enter in "N" for no. Is this a rural hospital with &lt; 100 beds that qu Hold Harmless provision in ACA §3121 and applicable amendment Enter in column 2, "Y" for yes or "N" for no.</li> <li>121.00 Did this facility incur and report costs for high cost implation patients? Enter "Y" for yes or "N" for no.</li> <li>122.00 Does the cost report contain state heal th or similar taxes? for no in column 1. If column 1 is "Y", enter in column 2 th where these taxes are included. Transplant Center Information</li> <li>125.00 Does this facility operate a transplant center? Enter "Y" for yes, enter certification date(s) (mm/dd/yyyy) below.</li> <li>126.00 If this is a Medicare certified kidney transplant center, ent in column 1 and termination date, if applicable, in column 2</li> </ul>	dule listing of d Harmless pro- n column 1, "Y ualifies for th nts? (see inst- antable device: Enter "Y" for ne Worksheet A por yes and "N" nter the certif 2. ter the certif 2.	vision in ACA ' for yes or ne Outpatient ructions) s charged to yes or "N" line number for no. If fication date cation date	- 1.00 N N Y N N		125, 1 2. 00	118. 02 119. 00 120. 00 121. 00 122. 00 125. 00 126. 00 127. 00
Administrative and General? If yes, submit supporting sched and amounts contained therein. 119.00 D0 NOT USE THIS LINE 120.00 Is this a SCH or EACH that qualifies for the Outpatient Hold §3121 and applicable amendments? (see instructions) Enter in "N" for no. Is this a rural hospital with < 100 beds that qu Hold Harmless provision in ACA §3121 and applicable amendmer Enter in column 2, "Y" for yes or "N" for no. 121.00 Did this facility incur and report costs for high cost impla patients? Enter "Y" for yes or "N" for no. 122.00 Does the cost report contain state heal th or similar taxes? for no in column 1. If column 1 is "Y", enter in column 2 th where these taxes are included. Transplant Center Information 125.00 Does this facility operate a transplant center? Enter "Y" for yes, enter certification date(s) (mm/dd/yyyy) below. 126.00 If this is a Medicare certified kidney transplant center, en in column 1 and termination date, if applicable, in column 2 128.00 If this is a Medicare certified heart transplant center, en in column 1 and termination date, if applicable, in column 2 128.00 If this is a Medicare certified heart transplant center, en in column 1 and termination date, if applicable, in column 2 128.00 If this is a Medicare certified heart transplant center, en in column 1 and termination date, if applicable, in column 2	dule listing control of the dumentation of the devices of the devi	vision in ACA ' for yes or ne Outpatient ructions) s charged to yes or "N" line number for no. If fication date cation date cation date i	- 1.00 N N Y N N		125, 1 2. 00	118. 02 119. 00 120. 00 121. 00 122. 00 125. 00 126. 00 127. 00 128. 00
Administrative and General? If yes, submit supporting sched and amounts contained therein. 119.00 D0 NOT USE THIS LINE 120.00 Is this a SCH or EACH that qualifies for the Outpatient Hold §3121 and applicable amendments? (see instructions) Enter in "N" for no. Is this a rural hospital with < 100 beds that qu Hold Harmless provision in ACA §3121 and applicable amendmen Enter in column 2, "Y" for yes or "N" for no. 121.00 Did this facility incur and report costs for high cost implation patients? Enter "Y" for yes or "N" for no. 122.00 Does the cost report contain state heal th or similar taxes? for no in column 1. If column 1 is "Y", enter in column 2 th where these taxes are included. Transplant Center Information 125.00 Does this facility operate a transplant center? Enter "Y" for yes, enter certification date(s) (mm/dd/yyyy) below. 126.00 If this is a Medicare certified kidney transplant center, ent in column 1 and termination date, if applicable, in column 2 127.00 If this is a Medicare certified liver transplant center, ent in column 1 and termination date, if applicable, in column 2 128.00 If this is a Medicare certified liver transplant center, ent in column 1 and termination date, if applicable, in column 2 129.00 If this is a Medicare certified liver transplant center, ent in column 1 and termination date, if applicable, in column 2 129.00 If this is a Medicare certified liver transplant center, ent in column 1 and termination date, if applicable, in column 2 129.00 If this is a Medicare certified liver transplant center, ent column 1 and termination date, if applicable, in column 2	dule listing of d Harmless pro- n column 1, "Y ualifies for th nts? (see inst antable device: Enter "Y" for ne Worksheet A bor yes and "N" nter the certific ter the certific enter the certific enter the certific	vision in ACA ' for yes or ne Outpatient ructions) s charged to yes or "N" line number for no. If fication date cation date cation date i tification	- 1.00 N N Y N N		125, 1 2. 00	118. 02 119. 00 120. 00 121. 00 122. 00 125. 00 126. 00 127. 00 128. 00 129. 00

	HUNTINGTON MEM	Provi der CCN	I: 15-0091	Peri od:	eu of Form CMS Worksheet S	
				From 01/01/2016 To 12/31/2016	Part I Date/Time Pi 5/19/2017 9:	repared: :13 am
				1.00	2.00	_
33.00 If this is a Medicare certified ot	her transplant center, er	nter the certific	cation date	1.00	2.00	133.00
in column 1 and termination date, i						
4.00 If this is an organ procurement org and termination date, if applicable All Providers		the OPO number in	n column 1			134.00
40.00 Are there any related organization chapter 10? Enter "Y" for yes or "I	N" for no in column 1. It	f yes, and home o	office costs	Y	15H032	140. 00
are claimed, enter in column 2 the 1.00		r. (see instructi 00	ons)	3.00		_
If this facility is part of a chai			gh 143 the r		of the	
home office and enter the home off 1.00 Name: PARKVIEW HEALTH SYSTEM, INC	. Contractor's Name: W	<u>contractor numbe</u> /ISCONSIN PHYSICI / SERVICE	r. ANS <mark>Contract</mark>	or's Number: 0810	01	141.00
2.00Street: 10501 CORPORATE DRIVE		600				142.00
3.00 City: FORT WAYNE		N	Zip Code	: 4689	95-5600	143.00
					1.00	_
14.00 Are provider based physicians' cos	ts included in Worksheet	A?			1.00 Y	144.00
,						
15.00 If costs for renal services are cla	aimad on What A Line 7	1 and the	for	1.00 N	2.00 N	145.00
5.00    Costs for renal services are cla inpatient services only? Enter "Y" no, does the dialysis facility incl period? Enter "Y" for yes or "N"	for yes or "N" for no in Lude Medicare utilization	n column 1. If co	olumn 1 is	N	N	145. 0
6.00 Has the cost allocation methodolog Enter "Y" for yes or "N" for no in yes, enter the approval date (mm/de	y changed from the previo column 1. (See CMS Pub.			N		146. 0
					1.00	
7.00 Was there a change in the statistic 8.00 Was there a change in the order of					N	147.00
9.00 Was there a change to the simplific				no.	N	148.00
	<u> </u>	Part A	Part B	Title V	Title XIX	
Does this facility contain a provi	den that much fice for a	1.00	2.00	3.00	4.00	
or charges? Enter "Y" for yes or "						
55.00Hospi tal	· · · · · ·	N	N	N	N	155.00
6 00 Subprovidor I DE		N	N	N	N	156.00
		N	NI	N		
57.00 Subprovider - IRF		Ν	Ν	N	Ν	157.00
i7.00 Subprovi der – IRF i8.00 SUBPROVI DER		N	N	N		157. 00 158. 00
57.00 Subprovider - IRF 58.00 SUBPROVIDER 59.00 SNF 50.00 HOME HEALTH AGENCY			N N	N N	N N N	157.00 158.00 159.00 160.00
57.00 Subprovider - IRF 58.00 SUBPROVIDER 59.00 SNF 50.00 HOME HEALTH AGENCY		N	Ν	N	N	157.00 158.00 159.00 160.00
57.00 Subprovi der – IRF 58.00 SUBPROVI DER 59.00 SNF 50.00 HOME HEALTH AGENCY 51.00 CMHC		N	N N	N N	N N N	157.00 158.00 159.00 160.00
57.00 Subprovider - IRF 58.00 SUBPROVIDER 59.00 SNF 50.00 HOME HEALTH AGENCY 51.00 CMHC Multicampus	mpus hospital that has or	N N	N N N	N N N	N N N	150.00 157.00 158.00 159.00 160.00 161.00
57.00 Subprovider - IRF 58.00 SUBPROVIDER 59.00 SNF 50.00 HOME HEALTH AGENCY 50.00 CMHC Multicampus 55.00 Is this hospital part of a Multican	Name	N N N ne or more campus County	N N Ses in diffe	rent CBSAs?	N N N 1.00 FTE/Campus	157.00 158.00 159.00 160.00 161.00 165.00
7.00 Subprovider - IRF 8.00 SUBPROVIDER 9.00 SNF 0.00 HOME HEALTH AGENCY 1.00 CMHC <u>Multicampus</u> 5.00 Is this hospital part of a Multicar Enter "Y" for yes or "N" for no.	· · ·	N N ne or more campus	N N Ses in diffe	N N Prent CBSAs?	N N N 1.00 FTE/Campus 5.00	157.00 158.00 159.00 160.00 161.00 165.00
57.00 Subprovider - IRF 58.00 SUBPROVIDER 59.00 SNF 50.00 HOME HEALTH AGENCY 51.00 CMHC Multicampus 55.00 Is this hospital part of a Multican Enter "Y" for yes or "N" for no. 56.00 If line 165 is yes, for each campus enter the name in column 0, county in column 1, state in	Name	N N N ne or more campus County	N N Ses in diffe	rent CBSAs?	N N N 1.00 FTE/Campus 5.00	157.00 158.00 159.00 160.00 161.00 165.00
7.00 Subprovider - IRF 8.00 SUBPROVIDER 9.00 SNF 0.00 HOME HEALTH AGENCY 1.00 CMHC 5.00 Is this hospital part of a Multican Enter "Y" for yes or "N" for no. 6.00 If line 165 is yes, for each campus enter the name in column	Name	N N N ne or more campus County	N N Ses in diffe	rent CBSAs?	N N N 1.00 FTE/Campus 5.00	157.00 158.00 159.00 160.00 161.00 165.00
57.00 Subprovider - IRF 18.00 SUBPROVIDER 19.00 SNF 10.00 HOME HEALTH AGENCY 1.00 CMHC Multicampus 55.00 Is this hospital part of a Multicar Enter "Y" for yes or "N" for no. 16.00 If line 165 is yes, for each campus enter the name in column 0, county in column 1, state in column 2, zip code in column 3, CBSA in column 4, FTE/Campus in	Name	N N N ne or more campus County	N N Ses in diffe	rent CBSAs?	N N N 1.00 FTE/Campus 5.00	157.00 158.00 159.00 160.00 161.00 165.00
<ul> <li>if. 00 Subprovider - IRF</li> <li>if. 00 SUBPROVIDER</li> <li>if. 00 SNF</li> <li>if. 00 OHOME HEALTH AGENCY</li> <li>if. 00 CMHC</li> </ul> Multicampus 55. 00 Is this hospital part of a Multicate Enter "Y" for yes or "N" for no. 66. 00 If line 165 is yes, for each campus enter the name in column 0, county in column 1, state in column 2, zip code in column 3, CBSA in column 4, FTE/Campus in column 5 (see instructions) Health Information Technology (HIT	Name 0 ) incentive in the Ameri	N N N ne or more campus <u>County</u> 1.00	N N Ses in diffe State Zi 2.00 Reinvestmer	Prent CBSAs?	N N N 1.00 FTE/Campus 5.00 0.0	157.00 158.00 159.00 160.00 161.00 165.00 00 166.00
<ul> <li>b5.00 Is this hospital part of a Multical Enter "Y" for yes or "N" for no.</li> <li>b6.00 If line 165 is yes, for each campus enter the name in column 0, county in column 1, state in column 2, zip code in column 3, CBSA in column 4, FTE/Campus in column 5 (see instructions)</li> <li>Heal th Information Technology (HIT 57.00 Is this provider a meaningful user 58.00 If this provider is a CAH (line 105)</li> </ul>	Name 0 0 ) incentive in the Ameri under §1886(n)? Enter ' 5 is "Y") and is a meaning	N N N ne or more campus <u>County</u> 1.00 can Recovery and "Y" for yes or "N ngful user (line	N N ses in diffe State Zi 2.00 Reinvestmer	rrent CBSAs? p Code CBSA 3. 00 4. 00	N N N 1.00 FTE/Campus 5.00 0.1	157.00 158.00 159.00 160.00 161.00 165.00
<ul> <li>if 00 Subprovider - IRF</li> <li>if 00 SUBPROVIDER</li> <li>if 00 SNF</li> <li>if 00 ONF</li> <li>if 00 OHOME HEALTH AGENCY</li> <li>if 00 CMHC</li> <li>if 1 00 CMHC</li> <li>if 1 in 165 is yes, for each campus enter the name in column 0, county in column 1, state in column 2, zip code in column 3, CBSA in column 4, FTE/Campus in column 5 (see instructions)</li> <li>if Heal th Information Technology (HIT 57.00 Is this provider a meaningful user)</li> </ul>	Name 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	N N N ne or more campus <u>County</u> 1.00 <u>can Recovery and</u> "Y" for yes or "N ngful user (line ons) es this provider	N N Sees in diffe State Zi 2.00 Reinvestmer J" for no. 167 is "Y") qualify for	N N N rrent CBSAs? p Code CBSA 3.00 4.00 nt Act , enter the r a hardship	N N N 1.00 FTE/Campus 5.00 0.0	157. 0 158. 0 159. 0 160. 0 161. 0 165. 0 165. 0 00 166. 0 166. 0

Health Financial Systems HUNT	INGTON MEMORIAL HOSPITAL	In Lie	u of Form CMS-:	2552-10
HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATIO		eriod: rom 01/01/2016	Worksheet S-2 Part I	
		Begi nni ng	Endi ng	
		1.00	2.00	
170.00 Enter in columns 1 and 2 the EHR beginning date a period respectively (mm/dd/yyyy)	01/01/2016	12/31/2016	170.00	
				1
		1.00	2.00	
171.00 If line 167 is "Y", does this provider have any of section 1876 Medicare cost plans reported on Wkst "Y" for yes and "N" for no in column 1. If column 1876 Medicare days in column 2. (see instructions	t. S-3, Pt. I, line 2, col. 6? Enter n 1 is yes, enter the number of section	N	O	171.00

IOSPI I	AL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE	Provider C	CN: 15-0091	Period: From 01/01/2016 To 12/31/2016	5/19/2017 9:	epared:
				Y/N	Date	
	General Instruction: Enter Y for all YES responses. Enter N	for all NO re	sponses. Ente	1.00 er all dates in t	2.00 he	
	mm/dd/yyyy format. COMPLETED BY ALL HOSPITALS					_
00	Provider Organization and Operation Has the provider changed ownership immediately prior to the	haginning of	the east	N		1 1 00
. 00	reporting period? If yes, enter the date of the change in c	olumn 2. (see	instructions)			1.00
			Y/N	Date	V/I	
2.00	Has the provider terminated participation in the Medicare P	rogram2 lf	1.00 N	2.00	3.00	2.00
	yes, enter in column 2 the date of termination and in colum voluntary or "I" for involuntary.	n 3, "V" for				
8.00	Is the provider involved in business transactions, including contracts, with individuals or entities (e.g., chain home of or medical supply companies) that are related to the provid officers, medical staff, management personnel, or members of of directors through ownership, control, or family and othe relationships? (see instructions)	ffices, drug er or its f the board	N			3. 00
			Y/N	Туре	Date	
	Financial Data and Reports		1.00	2.00	3.00	
. 00	Column 1: Were the financial statements prepared by a Cert Accountant? Column 2: If yes, enter "A" for Audited, "C" for or "R" for Reviewed. Submit complete copy or enter date ava column 3. (see instructions) If no, see instructions.	or Compiled,	Y	A	04/23/2016	4.00
6. 00	Are the cost report total expenses and total revenues diffe those on the filed financial statements? If yes, submit rec		Ν			5.00
				Y/N 1.00	Legal Oper. 2.00	
	Approved Educational Activities			1.00	2.00	
o. 00 7. 00	Column 1: Are costs claimed for nursing school? Column 2: the legal operator of the program? Are costs claimed for Allied Health Programs? If "Y" see in:	5	ne provider is	S N N		6.00
. 00 8. 00	Were nursing school and/or allied health programs approved a cost reporting period? If yes, see instructions.		l during the	N		7.00
. 00	Are costs claimed for Interns and Residents in an approved program in the current cost report? If yes, see instruction		al education	Ν		9.00
0. 00	Was an approved Intern and Resident GME program initiated o cost reporting period? If yes, see instructions.		he current	Ν		10.00
1.00	Are GME cost directly assigned to cost centers other than I Teaching Program on Worksheet A? If yes, see instructions.	& R in an App	proved	N	N/ (N)	11.00
					Y/N 1.00	
	Bad Debts Is the provider seeking reimbursement for bad debts? If yes	see instruct	ions		Y	12.00
	If line 12 is yes, did the provider's bad debt collection p period? If yes, submit copy.			ost reporting	N	13.0
	If line 12 is yes, were patient deductibles and/or co-payme Bed Complement				N	14.0
5.00	Did total beds available change from the prior cost reporti	Par	t A	Par		15.00
	-	Y/N 1.00	Date 2.00	Y/N 3.00	Date 4.00	_
	PS&R Data	1.00	2.00	3.00	4.00	
6. 00	Was the cost report prepared using the PS&R Report only? If either column 1 or 3 is yes, enter the paid-through date of the PS&R Report used in columns 2 and 4 .(see instructions)	Ν		N		16.00
7.00	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	Y	05/01/2017	Y	05/01/2017	17.0
8. 00	in columns 2 and 4. (see instructions) If line 16 or 17 is yes, were adjustments made to PS&R Report data for additional claims that have been billed but are not included on the PS&R Report used to file this	Υ		Y		18. 0
9. 00	cost report? If yes, see instructions. If line 16 or 17 is yes, were adjustments made to PS&R Report data for corrections of other PS&R Report	Ν		Ν		19.00

Health Financial Sy	ystems
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## HUNTINGTON MEMORIAL HOSPITAL

In Lieu of Form CMS-2552-10

	AL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE		CCN: 15-0091	Peri od:	Worksheet S-	
				From 01/01/2016 To 12/31/2016		
		Desci	ription	Y/N	Y/N	
20.00	If line 16 or 17 is yes, were adjustments made to PS&R		0	1.00 N	3.00 N	20.00
20.00	Report data for Other? Describe the other adjustments:			IN	IN	20.00
		Y/N	Date	Y/N	Date	
		1.00	2.00	3.00	4.00	
21.00	Was the cost report prepared only using the provider's records? If yes, see instructions.	N		Ν		21.00
		1	1			
	COMPLETED BY COST REIMBURSED AND TEFRA HOSPITALS ONLY (EXC				1.00	
	Completed by cost retailed and terra hospitals oner (exc	LET CHILDRENS	HUSFITALS)			
22.00	Have assets been relifed for Medicare purposes? If yes, se	e instructions				22.00
23.00	Have changes occurred in the Medicare depreciation expense	e due to apprai	sals made dur	ing the cost		23.00
24.00	reporting period? If yes, see instructions. Were new leases and/or amendments to existing leases enter	od into during	this cost ro	porting poriod?		24.00
24.00	If yes, see instructions	ed filto dulling	this cost re	porting periou?		24.00
25.00	Have there been new capitalized leases entered into during	g the cost repo	orting period?	lf yes, see		25.00
26. 00	instructions. Were assets subject to Sec. 2314 of DEFRA acquired during t	the cost report	ing period? I	f vas saa		26.00
20.00	instructions.		ing period: i	1 yes, see		20.00
27.00	Has the provider's capitalization policy changed during th	ne cost reporti	ng period? If	yes, submit		27.00
	copy. Interest Expense				L	
28.00	Were new Loans, mortgage agreements or letters of credit e	entered into du	ring the cost	reporting		28.00
~ ~ ~	period? If yes, see instructions.			5 1)		00.00
29.00	Did the provider have a funded depreciation account and/or treated as a funded depreciation account? If yes, see inst		ebt Service R	eserve Fund)		29.00
30.00	Has existing debt been replaced prior to its scheduled mat		debt? If yes	, see		30.00
21 00	instructions.	couches of now	dab+2 lf yoo			21 00
31.00	Has debt been recalled before scheduled maturity without i instructions.	ssuance of new	debt? IT yes	, see		31.00
	Purchased Services					
32.00	Have changes or new agreements occurred in patient care se		ed through co	ntractual		32.00
33.00	arrangements with suppliers of services? If yes, see instr If line 32 is yes, were the requirements of Sec. 2135.2 ap		na to competi	tive biddina? If		33.00
	no, see instructions.			g		
	Provi der-Based Physi ci ans					
34.00	Are services furnished at the provider facility under an a If yes, see instructions.	arrangement wit	n provider-ba	sed physicians?		34.00
35.00	If line 34 is yes, were there new agreements or amended ex	kisting agreeme	ents with the	provi der-based		35.00
	physicians during the cost reporting period? If yes, see i	nstructions.		N/ (1)		
				Y/N 1.00	Date 2.00	-
	Home Office Costs				2100	
	Were home office costs claimed on the cost report?			Y		36.00
37.00	If line 36 is yes, has a home office cost statement been p If yes, see instructions.	prepared by the	home office?	Y		37.00
38.00	If line 36 is yes, was the fiscal year end of the home of	fice different	from that of	N		38.00
~~ ~~	the provider? If yes, enter in column 2 the fiscal year er					
39.00	If line 36 is yes, did the provider render services to oth see instructions.	ner chain compo	nents? If yes	, N		39.00
40.00	If line 36 is yes, did the provider render services to the	e home office?	lf yes, see	Ν		40.00
	instructions.		-			_
		1	. 00	2	00	_
	Cost Report Preparer Contact Information					_
41.00	Enter the first name, last name and the title/position	ERI C		NI CKESON		41.00
	held by the cost report preparer in columns 1, 2, and 3, respectively.					
42.00	Enter the employer/company name of the cost report	PARKVI EW HEAL	RKVIEW HEALTH SYSTEM, INC.			42.00
40.00	preparer.		,			40.00
43.00	Enter the telephone number and email address of the cost report preparer in columns 1 and 2, respectively.	(260) 373-840	O	ERI C. NI CKESON@	PARKVLEW. COM	43.00
	$r$ spart property in containing random $Z_r$ respectively.	I		1		11

Heal th	Financial Systems HUNTINGTON ME	MORIAL HOSPITAL	In Lie	u of Form CMS-	2552-10
H0SPI T	AL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE	Provider CCN: 15-0091	Peri od:	Worksheet S-2	
			From 01/01/2016 To 12/31/2016		pared: <u>3 am</u>
		3.00			
	Cost Report Preparer Contact Information				
41.00	Enter the first name, last name and the title/position	DI RECTOR, REI MBURSEMENT			41.00
	held by the cost report preparer in columns 1, 2, and 3,				
	respecti vel y.				
42.00	Enter the employer/company name of the cost report				42.00
	preparer.				
43.00	Enter the telephone number and email address of the cost				43.00
	report preparer in columns 1 and 2, respectively.				

	J	UNTINGTON MEMOR		15 0004		u of Form CMS-2	
HOSPII	AL AND HOSPITAL HEALTH CARE COMPLEX STATISTIC	AL DATA	Provider CC	:N: 15-0091	Period: From 01/01/2016 To 12/31/2016	Date/Time Pre	pared:
						5/19/2017 9:1 I/P Days / 0/P	
						Visits / Trips	
	Component	Worksheet A	No. of Beds	Bed Days	CAH Hours	Title V	
	Component	Line Number	Not of bodo	Avai I abl e	or an initial of		
		1.00	2.00	3.00	4.00	5.00	
1.00	Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2	30. 00	36	13, 1	76 0.00	0	1.00
	for the portion of LDP room available beds)						
2.00	HMO and other (see instructions)						2.00
3.00	HMO IPF Subprovider						3.00
4.00	HMO I RF Subprovi der						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 beds) (see instructions)		36	13, 1	76 0.00	0	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	43.00				0	13.00
14.00	Total (see instructions)		36	13, 1	76 0.00		14.00
15.00	CAH visits					0	15.00
16.00	SUBPROVIDER - IPF						16.00
17.00	SUBPROVIDER - IRF						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. ) HOSPICE						23.00 24.00
24.00 24.10		30, 00					24.00
24.10	HOSPICE (non-distinct part) CMHC - CMHC	30.00					24.10
26.00	RURAL HEALTH CLINIC						25.00
26.25	FEDERALLY QUALIFIED HEALTH CENTER	89.00				0	26.00
20.25	Total (sum of lines 14-26)	07.00	36			0	26.25
27.00	Observation Bed Days		30			0	27.00
29.00	Ambul ance Trips					0	29.00
30.00	Employee discount days (see instruction)						30.00
31.00	Employee discount days (see first detroit)						31.00
32.00	Labor & delivery days (see instructions)		0		0		32.00
32.00	Total ancillary labor & delivery room		0		č		32.00
52.01	outpatient days (see instructions)						
22.00	LTCH non-covered days						33.00

IOSPI 1	Financial Systems H AL AND HOSPITAL HEALTH CARE COMPLEX STATISTIC/		Provider CC		Period: From 01/01/2016 Fo 12/31/2016	u of Form CMS-: Worksheet S-3 Part I Date/Time Pre 5/19/2017 9:1	pared:
		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	
. 00	Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days) (see instructions for col. 2	1, 633	51	4, 33		10.00	1.00
2.00	for the portion of LDP room available beds) HMO and other (see instructions)	881	1, 305				2.00
3.00	HMO I PF Subprovi der	0	0				3.00
1.00	HMO IRF Subprovider	0	0				4.00
5.00	Hospital Adults & Peds. Swing Bed SNF	0	0		D		5.00
o. 00	Hospital Adults & Peds. Swing Bed NF		0		D		6.00
7.00 8.00	Total Adults and Peds. (exclude observation beds) (see instructions)	1, 633	51	4, 33	5		7.00 8.00
9.00 9.00	I NTENSI VE CARE UNI T CORONARY CARE UNI T						9.00
0.00	BURN INTENSIVE CARE UNIT						10.00
1.00	SURGI CAL I NTENSI VE CARE UNI T						11.00
2.00	OTHER SPECIAL CARE (SPECIFY)						12.00
3.00	NURSERY		35	74	3		13.00
4.00	Total (see instructions)	1, 633	86		-	215.00	
5.00	CAH visits	0	0		)	210100	15.00
6.00	SUBPROVIDER - IPF				-		16.00
7.00	SUBPROVIDER - IRF						17.00
8.00	SUBPROVI DER						18.00
9.00	SKILLED NURSING FACILITY						19.00
20.00	NURSING FACILITY						20.00
21.00	OTHER LONG TERM CARE						21.00
2.00	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		D		24.10
25.00	CMHC - CMHC						25.00
26.00	RURAL HEALTH CLINIC						26.00
26. 25	FEDERALLY QUALIFIED HEALTH CENTER	0	0		0.00	0.00	
27.00	Total (sum of lines 14-26)				0.00	215.00	
28.00	Observation Bed Days	1 5 1 0	272	1, 19	1		28.00
29.00	Ambulance Trips	1, 519		_			29.00
30.00	Employee discount days (see instruction)			9			30.00
31.00	Employee discount days - IRF						31.00
32.00	Labor & delivery days (see instructions)	0	50	-			32.00
32.01	Total ancillary labor & delivery room						32.01
	outpatient days (see instructions) LTCH non-covered days	0					33.00

HOSPI T	AL AND HOSPITAL HEALTH CARE COMPLEX STATISTIC.	AL DATA	Provider C	CN: 15-0091	Period: From 01/01/2016 To 12/31/2016	Worksheet S-3 Part I Date/Time Prep 5/19/2017 9:13	
		Full Time Equivalents		Di s	charges		
	Component	Nonpai d Workers	Title V	Title XVIII	Title XIX	Total All Patients	
		11.00	12.00	13.00	14.00	15.00	
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)		0		27 516	1, 606	1.00
2.00 3.00	HMO and other (see instructions) HMO IPF Subprovider			2	87 0 0		2.00
4.00 5.00 6.00 7.00	HMO IRF Subprovider Hospital Adults & Peds. Swing Bed SNF Hospital Adults & Peds. Swing Bed NF Total Adults and Peds. (exclude observation beds) (see instructions)				0		4.00 5.00 6.00 7.00
8.00 9.00 10.00 11.00	INTENSIVE CARE UNIT CORONARY CARE UNIT BURN INTENSIVE CARE UNIT SUBCLOCAL INTENSIVE CARE UNIT						8.00 9.00 10.00 11.00
12. 00 13. 00	SURGI CAL INTENSIVE CARE UNIT OTHER SPECIAL CARE (SPECIFY) NURSERY						12. 00 13. 00
14.00 15.00 16.00 17.00 18.00	Total (see instructions) CAH visits SUBPROVIDER - IPF SUBPROVIDER - IRF SUBPROVIDER	0.00	0	5.	27 516	1, 606	14.00 15.00 16.00 17.00 18.00
19.00 20.00 21.00 22.00 23.00	SKILLED NURSING FACILITY NURSING FACILITY OTHER LONG TERM CARE HOME HEALTH AGENCY AMBULATORY SURGICAL CENTER (D.P.)						19. 0 20. 0 21. 0 22. 0 23. 0
24.00 24.10 25.00 26.00	HOSPICE HOSPICE (non-distinct part) CMHC - CMHC RURAL HEALTH CLINIC	0.00					24. 0 24. 1 25. 0 26. 0
<ol> <li>26. 25</li> <li>27. 00</li> <li>28. 00</li> <li>29. 00</li> <li>30. 00</li> </ol>	FEDERALLY QUALIFIED HEALTH CENTER Total (sum of lines 14-26) Observation Bed Days Ambulance Trips Employee discount days (see instruction)	0.00 0.00					26. 2 27. 0 28. 0 29. 0 30. 0
31. 00 32. 00 32. 01	Employee discount days - IRF Labor & delivery days (see instructions) Total ancillary labor & delivery room outpatient days (see instructions)						31. 0 32. 0 32. 0

PL I.	AL WAGE INDEX INFORMATION			Provider C	F	Period: From 01/01/2016 To 12/31/2016		pare
		Worksheet A Line Number	Reported	Reclassificati on of Salaries (from Worksheet A-6)	Adj usted Sal ari es (col . 2 ± col . 3)		Average Hourly Wage (col. 4 ÷ col. 5)	
		1.00	2.00	3.00	4.00	5.00	6.00	
	PART II - WAGE DATA SALARIES							-
0	Total salaries (see	200.00	14, 178, 804	3, 297, 706	17, 476, 510	588, 008. 00	29.72	1.
~	instructions)		0	0		0.00	0.00	2
0	Non-physician anesthetist Part A		0	0	C	0.00	0.00	2.
0	Non-physician anesthetist Part		0	0	C	0.00	0.00	3.
0	B Physician-Part A -		24, 000	0	24, 000	191.00	125. 65	4
1	Administrative Physicians – Part A – Teaching		0	0	l c	0.00	0.00	4
0	Physician and Non		0					
_	Physician-Part B							
0	Non-physician-Part B for hospital-based RHC and FQHC		0	0	C	0.00	0.00	6
0	services Interns & residents (in an	21.00	0	0	C	0.00	0.00	7
1	approved program) Contracted interns and residents (in an approved		0	0	С	0.00	0. 00	7
0	programs) Home office and/or related organization personnel		3, 303, 681	0	3, 303, 681	108, 586. 00	30. 42	8
0	SNF	44.00	0	0	C	0.00		
00	Excluded area salaries (see instructions)		1, 787, 995	298, 600	2, 086, 595	84, 995. 00	24. 55	10
	OTHER WAGES & RELATED COSTS							
00	Contract Labor: Direct Patient		0	0	C	0.00	0.00	11
00	Care Contract Labor: Top Level management and other		0	0	С	0.00	0. 00	12
	management and administrative services							
00	Contract Labor: Physician-Part A - Administrative		0	-	_			
00	Home office and/or related orgainzation salaries and wage-related costs		3, 303, 681	0	3, 303, 681	108, 586. 00	30. 42	. 14
01	Home office salaries		0	0	c	0.00	0.00	14
02	Related organization salaries		0	-	C	0.00		
00	Home office: Physician Part A - Administrative		0	0	C	0.00	0.00	15
00	Home office and Contract Physicians Part A - Teaching		0	0	C	0.00	0.00	16
	WAGE-RELATED COSTS				1	1	I	
00	Wage-related costs (core) (see instructions)		3, 592, 415	0	3, 592, 415			17
00	Wage-related costs (other)		0	0	C			18
00	(see instructions) Excluded areas		(10,00)	0	(10.00/			19
00 00	Non-physician anesthetist Part		619, 886 0	0	619, 886 C			20
00	A Non-physician anesthetist Part		0	0	 	)		21
00	B Physician Part A -		0	-	 	)		22
01	Administrative Physician Part A - Teaching		0	0	   0			22
00	Physician Part B		0	0	c			23
	Wage-related costs (RHC/FQHC)		0	0	0			24
00	Interns & residents (in an approved program)		0	0	C			25
50 51	Home office wage-related Related orgainzation		942, 547 0	0	942, 547 C			25 25
	wage-related Home office: Physician Part A		0	0	   C	)		25
	- Administrative - wage-related							
53	Home office & Contract Physicians Part A - Teaching - wage-related		0	0	C			25
	OVERHEAD COSTS - DIRECT SALARIE				L		·	1
	Employee Benefits Department	4.00	1, 348, 924	-1, 348, 924	0 5, 308, 256	0.00	0.00	26

Heal th	Financial Systems	Н	UNTINGTON MEMO	RIAL HOSPITAL		In Lie	u of Form CMS-2	2552-10
HOSPI T	AL WAGE INDEX INFORMATION			Provider CC	F	Period: From 01/01/2016 Fo 12/31/2016	Date/Time Pre 5/19/2017 9:1	<u>3 am</u>
		Worksheet A		Recl assi fi cati			Average Hourly	
		Line Number	Reported	on of Salaries			Wage (col. 4 ÷	
				(from	$(col.2 \pm col.$	Salaries in	col. 5)	
				Worksheet A-6)	3)	col. 4		
		1.00	2.00	3.00	4.00	5.00	6.00	
28.00	Administrative & General under contract (see inst.)		0	0	(	0.00	0.00	28.00
29.00	Maintenance & Repairs	6.00	0	0	(	0.00	0.00	29.00
30.00	Operation of Plant	7.00	310, 502	39, 415	349, 917	7 13, 550. 00	25.82	30.00
31.00	Laundry & Linen Service	8.00	0	29, 633	29, 633	3 2, 257. 00	13. 13	31.00
32.00	Housekeepi ng	9.00	299, 038	8, 338	307, 376	5 20, 308. 00	15. 14	32.00
33.00	Housekeeping under contract (see instructions)		0	0	(	0.00	0.00	33.00
34.00	Dietary	10.00	362, 460	-290, 961	71, 499	6, 106. 00	11. 71	34.00
35.00	Dietary under contract (see instructions)		0	0	(	0.00	0.00	35.00
36.00	Cafeteri a	11.00	0	213, 772	213, 772	2 16, 075. 00	13. 30	36.00
37.00	Maintenance of Personnel	12.00	0	0	(	0.00	0.00	37.00
38.00	Nursing Administration	13.00	186, 433	23, 673	210, 106	5, 207. 00	40.35	38.00
39.00	Central Services and Supply	14.00	0	0	(	0.00	0.00	39.00
40.00	Pharmacy	15.00	543, 828	0	543, 828	10, 378. 00	52.40	40.00
41.00	Medi cal Records & Medi cal Records Li brary	16.00	0	0	(	0.00		41.00
42.00	Soci al Servi ce	17.00	0	0	(	0.00	0.00	42.00
43.00	Other General Service	18.00	0	0	(	0.00	0.00	43.00

Heal th	Financial Systems	H	UNTINGTON MEMO	RIAL HOSPITAL		In Lie	eu of Form CMS-2	2552-10
HOSPI	FAL WAGE INDEX INFORMATION			Provider CC		Period: From 01/01/2016 To 12/31/2016		pared:
		Worksheet A		Recl assi fi cati			Average Hourly	
		Line Number	Reported	on of Salaries			Wage (col. 4 ÷	
				(from	(col.2 ± col.		col. 5)	
				Worksheet A-6)		col. 4		
		1.00	2.00	3.00	4.00	5.00	6.00	
	PART III - HOSPITAL WAGE INDEX	SUMMARY				-1		
1.00	Net salaries (see		10, 875, 123	3, 297, 706	14, 172, 82	9 479, 422. 00	29.56	1.00
	instructions)							
2.00	Excluded area salaries (see instructions)		1, 787, 995	298, 600	2, 086, 59	5 84, 995.00	24.55	2.00
3.00	Subtotal salaries (line 1		9, 087, 128	2, 999, 106	12, 086, 23	4 394, 427. 00	30. 64	3.00
	minus line 2)							
4.00	Subtotal other wages & related costs (see inst.)		3, 303, 681	0	3, 303, 68	1 108, 586.00	30. 42	4.00
5.00	Subtotal wage-related costs (see inst.)		4, 534, 962	0	4, 534, 96	2 0.00	37. 52	5.00
6.00	Total (sum of lines 3 thru 5)		16, 925, 771	2, 999, 106	19, 924, 87	7 503, 013. 00	39.61	6.00
7.00	Total overhead cost (see instructions)		5, 038, 077			7 226, 507.00	31.06	7.00

Heal th	Financial Systems HUNTINGTON MEMORI	AL HOSPI TAL	In Lie	u of Form CMS-2	2552-10
HOSPI T	AL WAGE RELATED COSTS	Provider CCN: 15-0091	Period: From 01/01/2016 To 12/31/2016	Worksheet S-3 Part IV Date/Time Pre 5/19/2017 9:13	pared:
				Amount Reported	
				1,00	
	PART IV - WAGE RELATED COSTS				
	Part A - Core List				
	RETI REMENT COST				
1.00	401K Employer Contributions			0	1.00
2.00	Tax Sheltered Annuity (TSA) Employer Contribution			227, 148	2.00
3.00	Nonqualified Defined Benefit Plan Cost (see instructions)			563, 220	3.00
4.00	Qualified Defined Benefit Plan Cost (see instructions)			0	4.00
	PLAN ADMINISTRATIVE COSTS (Paid to External Organization)				
5.00	401K/TSA Plan Administration fees			0	5.00
6.00	Legal/Accounting/Management Fees-Pension Plan			0	6.00
7.00	Employee Managed Care Program Administration Fees			52, 645	7.00
	HEALTH AND INSURANCE COST				
8.00	Health Insurance (Purchased or Self Funded)			2, 279, 685	8.00
8.01	Health Insurance (Self Funded without a Third Party Administr			0	8.01
8.02	Health Insurance (Self Funded with a Third Party Administrate	or)		0	8. 02
8.03	Health Insurance (Purchased)			0	8.03
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)			22, 303	
	Accident Insurance (If employee is owner or beneficiary)			0	
13.00	Disability Insurance (If employee is owner or beneficiary)			60, 154	
	Long-Term Care Insurance (If employee is owner or beneficiary	4)		0	14.00
15.00	'Workers' Compensation Insurance			16, 488	
16.00	Retirement Health Care Cost (Only current year, not the extra	aordinary accrual require	ed by FASB 106.	0	16.00
	Non cumulative portion) TAXES				
17 00	FICA-Employers Portion Only			917, 644	17.00
	Medicare Taxes - Employers Portion Only			917, 644	17.00
	Unemployment Insurance			0	19.00
	State or Federal Unemployment Taxes			0	20.00
20.00	OTHER			0	20.00
21 00	Executive Deferred Compensation (Other Than Retirement Cost F	Penarted on lines 1 throu	igh 1 above (see	37, 426	21.00
21.00	instructions))	reported on times i through	igit 4 above. (see	57, 420	21.00
22 00	Day Care Cost and Allowances			0	22.00
	Tui ti on Rei mbursement			32, 902	
	Total Wage Related cost (Sum of lines 1 -23)			4, 209, 615	
	Part B - Other than Core Related Cost				
25.00	OTHER WAGE RELATED COSTS (SPECIFY)			0	25.00

Heal th Financi	al Systems	HUNTINGTON MEMORIA	AL HOSPI TAL	In Lie	eu of Form CMS-2	2552-10
HOSPI TAL CONT	RACT LABOR AND BENEFIT COST		Provider CCN: 15-0091	Peri od:	Worksheet S-3	
				From 01/01/2016		
				To 12/31/2016	Date/Time Pre 5/19/2017 9:13	
	Cost Center Description			Contract Labor		
				1.00	2.00	
PART V	- Contract Labor and Benefit Cost					
Hospi ta	al and Hospital-Based Component Iden	iti fi cati on:				
1.00 Total	facility's contract labor and benefi	t cost		0	4, 209, 615	1.00
2.00 Hospita	al			0	4, 209, 615	2.00
3.00 Subprov	vider – IPF					3.00
4.00 Subprov	vider – IRF					4.00
5.00 Subprov	vider – (Other)			0	0	5.00
6.00 Swing I	Beds - SNF			0	0	6.00
7.00 Swing I	Beds - NF			0	0	7.00
8.00 Hospita	al-Based SNF					8.00
9.00 Hospita	al-Based NF					9.00
10.00 Hospi ta	al-Based OLTC					10.00
11.00 Hospi ta	al-Based HHA					11.00
12.00 Separa	tely Certified ASC					12.00
13.00 Hospi ta	al-Based Hospice					13.00
14.00 Hospita	al-Based Health Clinic RHC					14.00
15.00 Hospi ta	al-Based Health Clinic FQHC					15.00
16.00 Hospi ta	al-Based-CMHC					16.00
17.00 Renal I	Di al ysi s					17.00
18.00 Other				0	0	18.00

Heal th	Financial Systems	HUNTINGTON MEMORIA	L HOSPITAL		In Lie	eu of Form CMS-:	2552-10
HOSPI T	AL UNCOMPENSATED AND INDIGENT CARE DATA		Provider CC	CN: 15-0091	Peri od:	Worksheet S-1	0
					From 01/01/2016 To 12/31/2016	Date/Time Pre	nared
						5/19/2017 9:1	
						1.00	
	Uncompensated and indigent care cost compu-	tation				1.00	
1.00	Cost to charge ratio (Worksheet C, Part I		vided by Li	ne 202 colum	n 8)	0.213345	1.00
	Medicaid (see instructions for each line)		trada by tr	10 202 001 411	,	01210010	
2.00	Net revenue from Medicaid					1, 613, 212	2.00
3.00	Did you receive DSH or supplemental paymen	ts from Medicaid?				Y	3.00
4.00	If line 3 is "yes", does line 2 include al		al payments	from Medicai	d?	N	4.00
5.00	If line 4 is "no", then enter DSH or supply					1, 085, 839	5.00
6.00	Medi cai d charges	1 3				15, 919, 851	6.00
7.00	Medicaid cost (line 1 times line 6)					3, 396, 421	7.00
8.00	Difference between net revenue and costs f	or Medicaid program	(line 7 min	us sum of li	nes 2 and 5; if	697, 370	8.00
	< zero then enter zero)						
	Children's Health Insurance Program (CHIP)	(see instructions f	or each lin	e)		-	
9.00	Net revenue from stand-alone CHIP					1, 826	
10.00	Stand-al one CHIP charges					6, 159	
11.00	Stand-alone CHIP cost (line 1 times line 1					1, 314	
12.00	Difference between net revenue and costs f	or stand-alone CHIP	(line 11 mi	nus line 9;	f < zero then	0	12.00
	enter zero) Other state or local government indigent ca	no program (and inc	tructions f	an aaah lina'	N		
13.00	Net revenue from state or local indigent ca					2, 550, 014	12 00
14.00	Charges for patients covered under state of					18, 832, 202	
14.00	10)	i i local i nui gent cai		Not The udeu	TH THES U U	10, 032, 202	14.00
15.00	State or local indigent care program cost	(line 1 times line 1	4)			4,017,756	15.00
16.00	Difference between net revenue and costs for			program (li	ne 15 minus line		
	13; if < zero then enter zero)		<u>j</u>	1 3 4		, , .	
	Uncompensated care (see instructions for ea						
	Private grants, donations, or endowment in		5	5		0	
18.00	Government grants, appropriations or trans					0	
19.00	Total unreimbursed cost for Medicaid , CHI	P and state and loca	al indigent	care program	s (sum of lines	2, 165, 112	19.00
	8, 12 and 16)			Uni nsured	Insured	Tatal (asl 1	
				patients	patients	Total (col. 1 + col. 2)	
				1.00	2.00	3.00	
20.00	Charity care charges for the entire facili	ty (see instructions	5)	1, 521, 3			20.00
	Cost of patients approved for charity care			324, 5			
22.00	Partial payment by patients approved for c		-	, -	0 451		
23.00	Cost of charity care (line 21 minus line 2	2)		324, 5	78 209, 802	534, 380	23.00
	1					1.00	
24.00	Does the amount in line 20 column 2 includ			nd a length	of stay limit		24.00
05 00	imposed on patients covered by Medicaid or						05 00
	If line 24 is "yes," charges for patient Total bad debt expense for the entire hosp				in of stay limit	0 5, 743, 885	
26.00							
27.00 28.00	Medicare bad debts for the entire hospital Non-Medicare and non-reimbursable Medicare			c line 27)		57, 916	
28.00 29.00	Cost of non-Medicare and non-reimbursable Medicare				- 20 <b>)</b>	5, 685, 969	
29.00 30.00	Cost of uncompensated care (line 23 column		wense (inne		= 20)	1, 213, 073 1, 747, 453	
	Total unreimbursed and uncompensated care		ine 30)			3, 912, 565	
51.00	rotar an crimbar sea and ancompensated care	cost (rine is plus i	110 00)			1 3, 7, 2, 303	1 31.00

RECLAS	Financial Systems SIFICATION AND ADJUSTMENTS OF TRIAL BALANCE C	HUNTINGTON MEMORI DF EXPENSES	Provider CC		eriod: rom 01/01/2016	u of Form CMS-2 Worksheet A	
				T		Date/Time Pre 5/19/2017 9:13	
	Cost Center Description	Sal ari es	Other	Total (col. 1 + col. 2)	Reclassificati ons (See A-6)	Reclassified Trial Balance (col. 3 +- col. 4)	
	CENEDAL SEDVICE COST CENTEDS	1.00	2.00	3.00	4.00	5.00	
1.00	GENERAL SERVICE COST CENTERS 00100 CAP REL COSTS-BLDG & FIXT		1, 379, 435	1, 379, 435	28, 825	1, 408, 260	1.00
2.00	00200 CAP REL COSTS-MVBLE EQUIP		877, 459	877, 459		913, 606	2.00
3.00	00300 OTHER CAP REL COSTS	1 240 024	0	0	0	0	3.00
4.00 5.00	00400 EMPLOYEE BENEFITS DEPARTMENT 00500 ADMINISTRATIVE & GENERAL	1, 348, 924 1, 986, 892	4, 456, 533 12, 326, 755	5, 805, 457 14, 313, 647	-1, 348, 924 -40, 180	4, 456, 533 14, 273, 467	4.00
5.00	00600 MAI NTENANCE & REPAI RS	0	0	0	0	0	6.00
7.00	00700 OPERATION OF PLANT	310, 502	930, 204	1, 240, 706	39, 415	1, 280, 121	7.00
3.00 9.00	00800 LAUNDRY & LINEN SERVICE 00900 HOUSEKEEPING	299, 038	147, 401 85, 041	147, 401 384, 079	29, 633 8, 338	177, 034 392, 417	8.00 9.00
	01000 DI ETARY	362, 460	385, 035	747, 495			
11.00	01100 CAFETERI A	0	6, 072	6, 072	412, 539	418, 611	1
	01200 MAINTENANCE OF PERSONNEL	0	0	0	0	0	12.00
	01300 NURSI NG ADMI NI STRATI ON 01400 CENTRAL SERVI CES & SUPPLY	186, 433	6, 932	193, 365	23, 673 0	217, 038 0	13.00
	01500 PHARMACY	543, 828	747, 679	1, 291, 507	0	1, 291, 507	15.00
16.00	01600 MEDICAL RECORDS & LIBRARY	0	0	0	0	0	16.00
	01700 SOCIAL SERVICE	0	0	0	0	0	17.00
	01900 NONPHYSICIAN ANESTHETISTS 02000 NURSING SCHOOL	0	0	0	0	0	19.00
21.00	02100 I &R SERVICES-SALARY & FRINGES APPRV	0	0	0	0	0	20.00
22.00	02200 I&R SERVICES-OTHER PRGM COSTS APPRV	0	0	0	0	0	22.00
23.00	02300 PARAMED ED PRGM-(SPECIFY)	0	0	0	0	0	23.00
30.00	INPATIENT ROUTINE SERVICE COST CENTERS 03000 ADULTS & PEDIATRICS	3, 043, 465	340, 672	2 204 127	-358, 445	2 025 402	30.00
	04300 NURSERY	3, 043, 465	340, 872	3, 384, 137 0			•
	ANCILLARY SERVICE COST CENTERS	· · · · ·	<u> </u>			1111270	
	05000 OPERATING ROOM	840, 472	477, 045	1, 317, 517	107, 838		
2.00 3.00	05200 DELI VERY ROOM & LABOR ROOM 05300 ANESTHESI OLOGY	0	0 550, 901	0 550, 901	600, 726 0	600, 726 550, 901	52.00 53.00
53.00 54.00	05400 RADI OLOGY-DI AGNOSTI C	844, 145	545, 180	1, 389, 325	103, 316	1, 492, 641	54.00
	06000 LABORATORY	0	2, 117, 798	2, 117, 798	-145	2, 117, 653	
2.30	06250 BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0	0	0	62.30
5.00 6.00	06500 RESPI RATORY THERAPY 06600 PHYSI CAL THERAPY	586, 593 1, 005, 979	105, 888 73, 742	692, 481 1, 079, 721	74, 485 -186, 354	766, 966 893, 367	65.00 66.00
50.00 57.00	06700 OCCUPATI ONAL THERAPY	1,003,979	/3, /42	1, 079, 721	236, 793		
8.00	06800 SPEECH PATHOLOGY	0	Ō	0	75, 827	75, 827	
	06900 ELECTROCARDI OLOGY	0	0	0	0	0	
71.00 72.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT 07200 IMPL. DEV. CHARGED TO PATIENTS	0	1, 562, 754	1, 562, 754	-834, 831 834, 749	727, 923 834, 749	
	07300 DRUGS CHARGED TO PATIENTS	0	2, 137, 700	2, 137, 700			
	07697 CARDI AC REHABI LI TATI ON	0	0	0	0	0	76.97
	07698 HYPERBARI C OXYGEN THERAPY	8, 789	1, 868	10, 657	0	10, 657	
6.99	07699 LI THOTRI PSY OUTPATI ENT SERVI CE COST CENTERS	0	0	0	0	0	76.99
91.00	09100 EMERGENCY	1, 023, 289	203, 140	1, 226, 429	123, 751	1, 350, 180	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART						92.00
	OTHER REIMBURSABLE COST CENTERS	4 747 050	100.107		212.055	0.100.001	
95.00	09500 AMBULANCE SERVICES SPECIAL PURPOSE COST CENTERS	1, 717, 259	198, 487	1, 915, 746	218, 055	2, 133, 801	95.00
113.00	11300 I NTEREST EXPENSE		6, 164	6, 164	-6, 164	0	113.00
118.00	SUBTOTALS (SUM OF LINES 1-117)	14, 108, 068	29, 669, 885				
	NONREI MBURSABLE COST CENTERS					0	1100.00
	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN 19200 PHYSICIANS' PRIVATE OFFICES	0 66, 045	0 21, 328	0 87, 373	0 8, 386		190.00
	07950 OCC HEALTH	0	0	0,0,0,0	0,000		194.00
94.01	07951 PAIN CLINIC	0	0	0	0	0	194.01
	07952 OCC HEALTH	0	-12, 335	-12, 335			194.02
	07953 FOUNDATIO 07954 KIDS CAMPUS	29	80, 001	80, 030 0	0	80, 030 0	194. 03 194. 04
/ . 04	07955 COMMUNITY & VOLUNTEER SERVICES	4, 662	426, 488	431, 150	0	431, 150	•
94.05		.,	0	0	0		194.06
	07956 HUNTINGTON COLLEGE NURSE	I U	U U	0		0	
94. 06 94. 07	07957 MISC CATERING	0	0	0	141, 927	141, 927	194.07
94.06 94.07 94.08		0	0 0 66, 741		141, 927 0 0	141, 927 66, 741	194. 07

CLAS	Financial Systems SIFICATION AND ADJUSTMENTS OF TRIAL BALANCE (	HUNTINGTON MEMOR DF EXPENSES	Provider CCN: 15-009	1 Period:	<u>of Form CMS-2552</u> Worksheet A
				From 01/01/2016 To 12/31/2016	Date/Time Prepare 5/19/2017 9:13 am
	Cost Center Description	Adjustments	Net Expenses		<u>37 177 2017 9. 13 alli</u>
			or Allocation		
	CENEDAL SEDVICE COST CENTEDS	6.00	7.00		
00	GENERAL SERVICE COST CENTERS 00100 CAP REL COSTS-BLDG & FIXT	-1, 201, 490	206, 770		1.
00	00200 CAP REL COSTS-MVBLE EQUIP	-206, 011	707, 595		2.
00	00300 OTHER CAP REL COSTS	200,011	0		3.
00	00400 EMPLOYEE BENEFITS DEPARTMENT	-2, 634, 385	1, 822, 148		4.
00	00500 ADMI NI STRATI VE & GENERAL	-2, 761, 169	11, 512, 298		5.
00	00600 MAI NTENANCE & REPAI RS	0	0		6.
00	00700 OPERATION OF PLANT	-10, 979	1, 269, 142		7.
00	00800 LAUNDRY & LINEN SERVICE	0	177, 034		8.
0C	00900 HOUSEKEEPI NG	0	392, 417		9.
	01000 DI ETARY	-12, 330	180, 699		10.
	01100 CAFETERI A	-218, 236	200, 375		11.
	01200 MAINTENANCE OF PERSONNEL	0	0		12.
	01300 NURSING ADMINISTRATION	-11, 567	205, 471		13.
	01400 CENTRAL SERVICES & SUPPLY	0	0		14.
	01500 PHARMACY	-724, 467	567, 040		15
	01600 MEDICAL RECORDS & LIBRARY	0	0		16
	01700 SOCIAL SERVICE	0	0		17
	01900 NONPHYSI CLAN ANESTHETI STS	0	0		19
	02000 NURSING SCHOOL 02100 I &R SERVICES-SALARY & FRINGES APPRV	0	0		20
	02200 I &R SERVICES-SALART & FRINGES APPRV	0	o		22
	02300 PARAMED ED PRGM-(SPECIFY)	0	o		23
00	INPATIENT ROUTINE SERVICE COST CENTERS	0	0		23
00	03000 ADULTS & PEDIATRICS	-102, 399	2, 923, 293		30
	04300 NURSERY	0	144, 276		43
	ANCILLARY SERVICE COST CENTERS	· · · ·			
00	05000 OPERATI NG ROOM	-540, 414	884, 941		50
00	05200 DELIVERY ROOM & LABOR ROOM	0	600, 726		52
	05300 ANESTHESI OLOGY	0	550, 901		53
	05400 RADI OLOGY-DI AGNOSTI C	0	1, 492, 641		54
	06000 LABORATORY	0	2, 117, 653		60
	06250 BLOOD CLOTTING FOR HEMOPHILIACS	0	0		62
	06500 RESPI RATORY THERAPY	-25, 772	741, 194		65
	06600 PHYSI CAL THERAPY	-3, 065	890, 302		66
	06700 OCCUPATIONAL THERAPY	0	236, 793		67
	06800 SPEECH PATHOLOGY	0	75, 827		68
	06900 ELECTROCARDI OLOGY 07100 MEDI CAL SUPPLI ES CHARGED TO PATI ENT	0	0 727, 923		69
	07200 IMPL. DEV. CHARGED TO PATIENT	0	834, 749		71
	07300 DRUGS CHARGED TO PATIENTS	0	2, 206, 175		72
	07697 CARDIAC REHABILITATION	0	2,200,175		73
	07698 HYPERBARI C OXYGEN THERAPY	0	10, 657		76
	07699 LI THOTRI PSY	0	0		76
	OUTPATIENT SERVICE COST CENTERS	1 01	5		
00	09100 EMERGENCY	-38, 862	1, 311, 318		91
	09200 OBSERVATION BEDS (NON-DISTINCT PART				92
	OTHER REIMBURSABLE COST CENTERS	· · ·			
00	09500 AMBULANCE SERVI CES	-15, 950	2, 117, 851		95
	SPECIAL PURPOSE COST CENTERS	· · ·			
	11300 INTEREST EXPENSE	0	0		113
3. 00		-8, 507, 096	35, 108, 209		118
	NONREI MBURSABLE COST CENTERS				
	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0		190
	19200 PHYSI CLANS' PRI VATE OFFI CES	0	95, 759		192
	07950 OCC HEALTH	0	0		194
	07951 PAIN CLINIC	0	0		194
	07952 OCC HEALTH	0	0		194
	07953 FOUNDATIO	0	80, 030		194
	07954 KIDS CAMPUS	0	0		194
	07955 COMMUNITY & VOLUNTEER SERVICES	0	431, 150		194
	07956 HUNTINGTON COLLEGE NURSE	0	0		194
	07957 MISC CATERING	0	141, 927		194
	07958 AUTI SM CENTER	0	66, 741		194.
	07959 HUNTI NGTON BUA		o		194.

	Financial Systems		JNTI NGTON MEMOR	Provider CCN: 15-0091	Peri od:	u of Form CMS-2552 Worksheet A-6
, (55					From 01/01/2016	
					To 12/31/2016	Date/Time Prepare 5/19/2017 9:13 ar
		Increases				
	Cost Center	Line #	Sal ary	Other		
	2.00	3.00	4.00	5.00		
	A - CAFETERIA AND CATERING					
		11.00	213, 772	198, 767		1
00	MISC_CATERING	1 <u>94.</u> 07	7 <u>2, 1</u> 59 285, 931	6 <u>9, 768</u> 268, 535		2
	B - INTEREST		205, 951	208, 555		
	CAP REL COSTS-MVBLE EQUIP	2.00	0	6, 164		1
	TOTALS		0	6, 164		
	F - INSURANCE	•		·		
	CAP REL COSTS-BLDG & FIXT	1.00	0	28, 825		1
00	CAP REL COSTS-MVBLE EQUIP	2.00	0	2 <u>9, 9</u> 83		2
	0		0	58, 808		
	G - LAUNDRY					
00	LAUNDRY & LINEN SERVICE		29, 633	<u>O</u>		1
	U   H - HOME OFFICE SALARY		29, 633	U		
	ADMI NI STRATI VE & GENERAL	5.00	3, 303, 681	0		1
	0		3, 303, 681	O		
	I - PTO		0,000,001	5		
	ADMI NI STRATI VE & GENERAL	5.00	18, 628	0		1
00	OPERATION OF PLANT	7.00	39, 415	0		2
00	HOUSEKEEPI NG	9.00	37, 971	0		3
00	NURSING ADMINISTRATION	13.00	23, 673	0		4
	ADULTS & PEDIATRICS	30.00	386, 557	0		5
	OPERATING ROOM	50.00	107, 838	0		6
	RADI OLOGY-DI AGNOSTI C	54.00	107, 188	0		7
	RESPI RATORY THERAPY	65.00	74, 485	0		8
	PHYSICAL THERAPY	66.00	127, 738	0		9
	DRUGS CHARGED TO PATIENTS EMERGENCY	73.00 91.00	69, 054 129, 936	0 0		10
	AMBULANCE SERVICES	95.00	218, 055	0		12
	PHYSICIANS' PRIVATE OFFICES	192.00	8, 386			13
	0		1, 348, 924	0_ 0		
1	J - SALARY					
00	ADMI NI STRATI VE & GENERAL	5.00	0	945		1
00	DI ETARY		0	<u>5, 0</u> 30		2
	0		0	5, 975		
	K - OCC HEALTH	101.00		10.005		
	OCC HEALTH	194.02	0	12, 335		1
00 00		0.00 0.00	0	0		2
00		0.00	0	0 0		5
00		0.00	0			
00		0.00	0	0		7
	o — — — — — —			12, 335		'
	L - IMPLANTS					
	IMPL. DEV. CHARGED TO	72.00	0	834, 749		1
	PATI ENTS	↓				
	0		0	834, 749		
	M - OB	10.05	400 445	45 444		
		43.00	129, 110	15, 166		1
00	DELIVERY ROOM & LABOR ROOM	<u>52.00</u>	537, 578	$ \frac{63, 148}{78, 214}$		2
	0 – THERAPY		666, 688	78, 314		
	OCCUPATIONAL THERAPY	67.00	217, 465	19, 328		1
	SPEECH PATHOLOGY	68.00	69, 638	6, 189		2
			287, 103	25, 517		
	Grand Total: Increases		5, 921, 960	1, 290, 397		500

		Provider (	CN: 15-0091	Period:	Worksheet A-6
				From 01/01/2016 To 12/31/2016	Date/Time Prepar
Docroasos					5/19/2017 9:13 a
	Salary	Other	Wkst. A-7 Ref		
7.00	8.00	9.00	10.00	-	
10.00	285, 931	268, 535			1
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	285, 931	268, 535	L		
112 00		<u> </u>	1	1	1
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5.00	0	58, 808	1	2	1
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91.00	0	6, 185		0	
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	0	12, 335	<u> </u>		
71.00	0	834, 749		0	
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	J	034, 749			
30 00	666 688	78 314		0	
	0	, 0, 314			
	666.688	78.314		7	
66.00	287, 103	25, 517		0	1
00100					
0.00	0 			0	2
	$\begin{array}{c} 10.00\\ 0.00\\ 0.00\\ \hline \\ 113.00\\ \hline \\ 5.00\\ \hline \\ \\ \\ \\ \\ \\ \\ \\ \\ \\ \\ \\ \\ \\ \\ \\ \\ $	Li ne #         Sal ary           7.00         8.00           10.00         285,931	Decreases         Other           10.00         285,931         268,535           0.00         0         0           113.00         0         6,164           0         0         6,164           0         0         0           113.00         0         5,808           0         0         5,808           0         0         5,808           0         29,633         0           29,00         29,633         0           29,633         0         3,303,681           1         0         3,303,681           4.00         1,348,924         0           0.00         0         0           0.00         0         0           0.00         0         0           0.00         0         0           0.00         0         0           0.00         0         0           0.00         0         0           0.00         0         0           0.00         0         0           0.00         0         0           0.00         0         0           0	Line #         Sal ary         Other         Wkst. A-7 Ref           7.00         8.00         9.00         10.00           10.00         285, 931         268, 535	$\begin{array}{ c c c c c c c c c c c c c c c c c c c$

Heal th	Financial Systems	UNTINGTON MEMO	RIAL HOSPITAL			In Lie	u of Form CMS-2	2552-10
	ILIATION OF CAPITAL COSTS CENTERS		Provider CO		Fro To	riod: om 01/01/2016	Worksheet A-7 Part I	
				Acquisition:	s			
		Begi nni ng Bal ances	Purchases	Donati on		Total	Disposals and Retirements	
		1.00	2.00	3.00		4.00	5.00	
	PART I - ANALYSIS OF CHANGES IN CAPITAL ASSE	BALANCES						
1.00	Land	0	0	I	0	0	0	1.00
2.00	Land Improvements	465, 871	79, 015		0	79, 015	13, 245	2.00
3.00	Buildings and Fixtures	1, 927, 095	389, 629		0	389, 629		3.00
4.00	Building Improvements	32, 500	35, 419		0	35, 419	0	4.00
5.00	Fixed Equipment	1, 250, 412	130, 055		0	130, 055	0	5.00
6.00	Movable Equipment	10, 802, 524	1, 831, 283		0	1, 831, 283	494, 114	6.00
7.00	HIT designated Assets	2, 742, 800	34, 310		0	34, 310	0	7.00
8.00	Subtotal (sum of lines 1-7)	17, 221, 202	2, 499, 711		0	2, 499, 711	507, 359	8.00
9.00	Reconciling Items	2, 586, 017	-108, 733		0	-108, 733	0	9.00
10.00	Total (line 8 minus line 9)	14, 635, 185	2, 608, 444		0	2, 608, 444	507, 359	10.00
		Ending Balance	Fully					
		Ũ	Depreci ated					
			Assets					
		6.00	7.00					
	PART I - ANALYSIS OF CHANGES IN CAPITAL ASSE	BALANCES		_				
1.00	Land	0	0					1.00
2.00	Land Improvements	531, 641	128, 649					2.00
3.00	Buildings and Fixtures	2, 316, 724	341, 690					3.00
4.00	Building Improvements	67, 919	0					4.00
5.00	Fixed Equipment	1, 380, 467	539, 055					5.00
6.00	Movable Equipment	12, 139, 693	7, 110, 290					6.00
7.00	HIT designated Assets	2, 777, 110	0					7.00
8.00	Subtotal (sum of lines 1-7)	19, 213, 554	8, 119, 684					8.00
9.00	Reconciling Items	2, 477, 284	0					9.00
10.00	Total (line 8 minus line 9)	16, 736, 270	8, 119, 684					10.00

Heal th	Financial Systems	HUNTINGTON MEMORIAL HOSPITAL			In Lieu of Form CMS-2552-10		
RECON	CILIATION OF CAPITAL COSTS CENTERS		Provider CC	CN: 15-0091	Peri od:	Worksheet A-7	
					From 01/01/2016 To 12/31/2016		narad
					10 12/31/2010	Date/Time Pre 5/19/2017 9:1	3 am
			SU	IMMARY OF CAP	TAL		
	Cost Center Description	Depreciation	Lease	Interest	Insurance (see		
						instructions)	
		9.00	10.00	11.00	12.00	13.00	
	PART II - RECONCILIATION OF AMOUNTS FROM WOR						
1.00	CAP REL COSTS-BLDG & FIXT	145, 702			0 0	0	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	767, 174			0 0	3, 852	•
3.00	Total (sum of lines 1-2)	912, 876	1, 333, 555		0 0	3, 852	3.00
		SUMMARY 0	F CAPITAL				
	Cost Center Description		Total (1) (sum				
		Capi tal -Rel ate					
		d Costs (see	through 14)				
		instructions)					
		14.00	15.00				
	PART II - RECONCILIATION OF AMOUNTS FROM WOR						
1.00	CAP REL COSTS-BLDG & FIXT	1, 625		1			1.00
2.00	CAP REL COSTS-MVBLE EQUIP	4, 986					2.00
3.00	Total (sum of lines 1-2)	6, 611	2, 256, 894				3.00

Health Financial Systems	HUNTINGTON MEMO	RIAL HOSPITAL		In Lie	u of Form CMS-2	552-10
RECONCILIATION OF CAPITAL COSTS CENTERS		Provider C	F	Period: From 01/01/2016 To 12/31/2016		oared: 3 am
	COMI	PUTATION OF RAT	FI OS	ALLOCATION OF	OTHER CAPITAL	
Cost Center Description	Gross Assets	Capi tal i zed Leases	Gross Assets for Ratio (col. 1 - col. 2)		Insurance	
	1.00	2.00	3.00	4.00	5.00	
PART III - RECONCILIATION OF CAPITAL COSTS C 1.00 CAP REL COSTS-BLDG & FIXT 2.00 CAP REL COSTS-MVBLE EQUIP	4, 296, 752 12, 139, 693		4, 296, 752 11, 921, 076		0	1.00 2.00
3.00 Total (sum of lines 1-2)	16, 436, 445				0	3.00
	ALLOCA	TION OF OTHER (		SUMMARY O	F CAPITAL	
Cost Center Description	Taxes	Other Capital-Relate d Costs	Total (sum of cols.5 through 7)	Depreciation	Lease	
	6.00	7.00	8.00	9.00	10.00	
PART III - RECONCILIATION OF CAPITAL COSTS C	ENTERS			174 000		
1.00 CAP REL COSTS-BLDG & FIXT 2.00 CAP REL COSTS-MVBLE EQUIP 3.00 Total (sum of lines 1-2)	0			) 176, 320 567, 327 743, 647	0 101, 447 101, 447	1.00 2.00 3.00
		SI	JMMARY OF CAPI		101, 447	3.00
Cost Center Description		Insurance (see instructions)		Other Capital-Relate d Costs (see instructions)	Total (2) (sum of cols. 9 through 14)	
	11.00	12.00	13.00	14.00	15.00	
PART III - RECONCILIATION OF CAPITAL COSTS C			-			
1.00 CAP REL COSTS-BLDG & FIXT 2.00 CAP REL COSTS-MVBLE EQUIP	0	29, 983	3, 852		707, 595	1.00 2.00
3.00  Total (sum of lines 1-2)	0	58, 808	3, 852	6, 611	914, 365	3.00

Systems	HUNTI NGTON	MEMORI AL

## ΗΟ ΣΡΙ ΤΔΙ

CC           00         Ir           00         Ir           00         Tr           1.00         Sa           5.00         Re           5.00         Sa	Cost Center Description nvestment income - CAP REL OSTS-BLDG & FIXT (chapter 2) nvestment income - CAP REL OSTS-MVBLE EQUIP (chapter 2) nvestment income - other chapter 2) rade, quantity, and time i scounts (chapter 8) lefunds and rebates of expenses (chapter 8) tental of provider space by uppliers (chapter 8) elephone services (pay tations excluded) (chapter 1)	Basi s/Code (2) 1.00 B		Expense Classification on To/From Which the Amount is Cost Center 3.00 CAP REL COSTS-BLDG & FIXT CAP REL COSTS-MVBLE EQUIP	to be Adjusted	5/19/2017 9:13 Wkst. A-7 Ref. 5.00 0	3 am
CC           00         Ir           00         Ir           00         Tr           1.00         Sa           5.00         Re           5.00         Sa	nvestment income - CAP REL OSTS-BLDG & FIXT (chapter 2) nvestment income - CAP REL OSTS-MVBLE EQUIP (chapter 2) nvestment income - other chapter 2) rade, quantity, and time liscounts (chapter 8) lefunds and rebates of expenses (chapter 8) tental of provider space by uppliers (chapter 8) elephone services (pay tations excluded) (chapter	1.00	2.00 0 -6,164	To/From Which the Amount is Cost Center 3.00 CAP REL COSTS-BLDG & FIXT CAP REL COSTS-MVBLE EQUIP	to be Adjusted Line # 1 4.00 1.00	Wkst. A-7 Ref. 5.00 0	
CC           00         Ir           00         Ir           00         Tr           1.00         Sa           5.00         Re           5.00         Sa	nvestment income - CAP REL OSTS-BLDG & FIXT (chapter 2) nvestment income - CAP REL OSTS-MVBLE EQUIP (chapter 2) nvestment income - other chapter 2) rade, quantity, and time liscounts (chapter 8) lefunds and rebates of expenses (chapter 8) tental of provider space by uppliers (chapter 8) elephone services (pay tations excluded) (chapter	1.00	2.00 0 -6,164	To/From Which the Amount is Cost Center 3.00 CAP REL COSTS-BLDG & FIXT CAP REL COSTS-MVBLE EQUIP	to be Adjusted Line # 1 4.00 1.00	5.00 0	1
CC           00         Ir           00         Ir           00         Tr           1.00         Sa           5.00         Re           5.00         Sa	nvestment income - CAP REL OSTS-BLDG & FIXT (chapter 2) nvestment income - CAP REL OSTS-MVBLE EQUIP (chapter 2) nvestment income - other chapter 2) rade, quantity, and time liscounts (chapter 8) lefunds and rebates of expenses (chapter 8) tental of provider space by uppliers (chapter 8) elephone services (pay tations excluded) (chapter	1.00	2.00 0 -6,164	3.00 CAP REL COSTS-BLDG & FIXT CAP REL COSTS-MVBLE EQUIP	4.00	5.00 0	1
CC           00         Ir           00         Ir           00         Tr           1.00         Sa           5.00         Re           5.00         Sa	nvestment income - CAP REL OSTS-BLDG & FIXT (chapter 2) nvestment income - CAP REL OSTS-MVBLE EQUIP (chapter 2) nvestment income - other chapter 2) rade, quantity, and time liscounts (chapter 8) lefunds and rebates of expenses (chapter 8) tental of provider space by uppliers (chapter 8) elephone services (pay tations excluded) (chapter	1.00	2.00 0 -6,164	3.00 CAP REL COSTS-BLDG & FIXT CAP REL COSTS-MVBLE EQUIP	4.00	5.00 0	1
CC           00         Ir           00         Ir           00         Tr           1.00         Sa           5.00         Re           5.00         Sa	nvestment income - CAP REL OSTS-BLDG & FIXT (chapter 2) nvestment income - CAP REL OSTS-MVBLE EQUIP (chapter 2) nvestment income - other chapter 2) rade, quantity, and time liscounts (chapter 8) lefunds and rebates of expenses (chapter 8) tental of provider space by uppliers (chapter 8) elephone services (pay tations excluded) (chapter	1.00	2.00 0 -6,164	3.00 CAP REL COSTS-BLDG & FIXT CAP REL COSTS-MVBLE EQUIP	4.00	5.00 0	1
CC           00         Ir           00         Ir           00         Tr           1.00         Sa           5.00         Re           5.00         Sa	nvestment income - CAP REL OSTS-BLDG & FIXT (chapter 2) nvestment income - CAP REL OSTS-MVBLE EQUIP (chapter 2) nvestment income - other chapter 2) rade, quantity, and time liscounts (chapter 8) lefunds and rebates of expenses (chapter 8) tental of provider space by uppliers (chapter 8) elephone services (pay tations excluded) (chapter	1.00	2.00 0 -6,164	3.00 CAP REL COSTS-BLDG & FIXT CAP REL COSTS-MVBLE EQUIP	4.00	5.00 0	1
CC           00         Ir           00         Ir           00         Tr           1.00         Sa           5.00         Re           5.00         Sa	OSTS-BLDG & FIXT (chapter 2) nvestment income - CAP REL OSTS-MVBLE EQUIP (chapter 2) nvestment income - other chapter 2) rade, quantity, and time liscounts (chapter 8) defunds and rebates of expenses (chapter 8) tental of provider space by uppliers (chapter 8) elephone services (pay tations excluded) (chapter	В	-6, 164	CAP REL COSTS-MVBLE EQUIP			1
00         Ir           00         Ir           00         Ir           00         Tr           00         Re           00         Re           00         Re           00         Re           00         Te           1.00         Sa           2.00         Re           3.00         La           4.00         Ca           5.00         Re           5.00         Sa	nvestment income - CAP REL OSTS-MVBLE EQUIP (chapter 2) nvestment income - other chapter 2) rrade, quantity, and time iscounts (chapter 8) defunds and rebates of expenses (chapter 8) ental of provider space by uppliers (chapter 8) elephone services (pay tations excluded) (chapter	В			2.00	i	1 .
00         Ir           00         Tr           00         Re           00         Re           00         Re           00         Re           00         Te           1.00         Sa           2.00         Re           4.00         Ca           5.00         Re           5.00         Sa           5.00         Sa           5.00         Sa           7.00         Sa	nvestment income - other chapter 2) rade, quantity, and time iscounts (chapter 8) tefunds and rebates of xpenses (chapter 8) tental of provider space by uppliers (chapter 8) telephone services (pay tations excluded) (chapter		0			11	2
(c 00 Tr di 00 Re 00 Re 10 Tr 10 Tr 1	chapter 2) rade, quantity, and time iscounts (chapter 8) lefunds and rebates of xpenses (chapter 8) lental of provider space by uppliers (chapter 8) elephone services (pay tations excluded) (chapter		0		0.00		
00 Tr di 00 Re ey 00 Re ey 00 Re ey 12 00 Te 12 00 Te (c 00 Pa 00 Pa 00 Pa 1.00 Sa 5.00 Re 1.00 Sa 5.00 Sa 5.00 Sa 1.00 Sa	rade, quantity, and time liscounts (chapter 8) lefunds and rebates of xpenses (chapter 8) lental of provider space by uppliers (chapter 8) elephone services (pay tations excluded) (chapter		0		0.00	0	) 3
00         Re           00         Re           00         Re           00         Te           1.00         Sa           5.00         Re           5.00         Re           5.00         Sa	efunds and rebates of expenses (chapter 8) ental of provider space by uppliers (chapter 8) elephone services (pay tations excluded) (chapter				0.00	0	4
ex 00 Re SL 00 Te 21 00 Te (0 00 Pa 00 Pa	xpenses (chapter 8) ental of provider space by uppliers (chapter 8) elephone services (pay tations excluded) (chapter		0		0.00	0	) 5
00 Te s1 21 00 Te (c (c (c 00 Pa 0.00 Pr ac 1.00 Sa 5.00 Re ar 5.00 Re ar 5.00 Sa 5.00 Sa	uppliers (chapter 8) elephone services (pay tations excluded) (chapter					-	
00 Te st 21 00 Te (c 00 Pa 20.00 Pr ac 1.00 Sa 4.00 Ca 5.00 Re ar 5.00 Sa 5.00 Sa 5.00 Sa 5.00 Sa	elephone services (pay tations excluded) (chapter		0		0.00	0	6
21 00 Te (c (c 00 Pa 2.00 Pr 1.00 Sa (c 2.00 Re tr 3.00 La 5.00 Re ar 5.00 Sa 5.00 Sa 5.00 Sa		А	-1, 582	ADMI NI STRATI VE & GENERAL	5.00	О	7
00 Te (00 Pa ). 00 Pr at. 00 Sa (02. 00 Re tr 3. 00 La 1. 00 Ca 5. 00 Re ar 5. 00 Sa Su Su Su Su Su Su Su Su Su Su Su Su Su							
00 Pa 0.00 Pr ac 1.00 Sa (c 2.00 Re 4.00 Ca 5.00 Re ar 5.00 Sa 5.00 Sa 5.00 Sa	elevision and radio service	А	-435	OPERATION OF PLANT	7.00	О	) 8
D. 00 Pr ac 1. 00 Sa (Q 2. 00 Re tr 3. 00 La 4. 00 Ca 5. 00 Sa 5. 00 Sa 5. 00 Sa	chapter 21)		0		0.00		
ac           1.00         Sa           2.00         Re           4.00         Ca           5.00         La           6.00         Sa           5.00         Sa           5.00         Sa           5.00         Sa           7.00         Sa	arking lot (chapter 21) Provider-based physician	A-8-2	0 -573, 153		0.00	0	
(0 2.00 Re 1 tr 3.00 La 4.00 Ca 5.00 Re 5.00 Sa 5.00 Sa 5.00 Sa 5.00 Sa	djustment				0.00		
2.00 Re 3.00 La 4.00 Ca 5.00 Re ar 5.00 Sa 5.00 Sa 7.00 Sa	ale of scrap, waste, etc. chapter 23)		0		0.00	0	11
8.00 La 1.00 Ca 5.00 Re 5.00 Sa 5.00 Sa 5.00 Sa 7.00 Sa	elated organization	A-8-1	-2, 784, 328			0	12
4. 00 Ca 5. 00 Re ar 5. 00 Sa 5. 00 Sa 7. 00 Sa	ransactions (chapter 10) aundry and linen service		0		0.00	0	) 13
0. 00 Sa su 2. 00 Sa	afeteria-employees and guests	А	-38, 086	CAFETERI A	11.00	0	
5.00 Sa su 2.00 Sa	ental of quarters to employee		0		0.00	0	15
su pa 7.00 Sa	nd others ale of medical and surgical		0		0.00	0	10
7.00 Sa	upplies to other than						
	atients ale of drugs to other than		0		0.00	0	17
	atients		0			Ŭ	
	ale of medical records and bstracts		0		0.00	0	18
. 00 NL	lursing school (tuition, fees,		0		0.00	0	19
	ooks, etc.) 'ending machines	А	E 020	DI ETARY	10.00	0	
	ncome from imposition of	A	-5, 030 0	DIETARY	0.00	0	
	nterest, finance or penalty						
	harges (chapter 21) nterest expense on Medicare		0		0.00	0	22
0\	verpayments and borrowings to						
	epay Medicare overpayments djustment for respiratory	A-8-3	0	RESPI RATORY THERAPY	65.00		23
th	herapy costs in excess of	X 8 8	0		00.00		
1	imitation (chapter 14)	A-8-3	0	PHYSICAL THERAPY	66.00		24
	djustment for physical herapy costs in excess of	A-0-3	0	IN JIONE INENAFI	00.00		2
11	imitation (chapter 14)		-	*** Coct Conton D-1-+	114 00		0
	tilization review - hysicians' compensation		0	*** Cost Center Deleted ***	114.00		25
(0	chapter 21)				1.00		
	epreciation - CAP REL OSTS-BLDG & FIXT		0	CAP REL COSTS-BLDG & FIXT	1.00	0	26
7.00 De	epreciation - CAP REL		0	CAP REL COSTS-MVBLE EQUIP	2.00	0	27
	OSTS-MVBLE EQUIP Ion-physician Anesthetist		0	NONPHYSI CI AN ANESTHETI STS	19.00		28
	hysicians' assistant		0		0.00	0	
). 00 Ac	djustment for occupational	A-8-3	0	OCCUPATI ONAL THERAPY	67.00		30
	herapy costs in excess of imitation (chapter 14)						
). 99 Ho	lospice (non-distinct) (see		0	ADULTS & PEDIATRICS	30.00		30
	nstructions) djustment for speech	A-8-3	Ω	SPEECH PATHOLOGY	68.00		31
pa	athology costs in excess of		0		00.00		
	imitation (chapter 14) AH HIT Adjustment for		0		0.00	0	) 32
			0		0.00	0	32
3.00 AE 3.01 TE	epreciation and Interest	А	-2,000			1	

Heal th	Financial Systems	н	UNTINGTON MEMO	RIAL HOSPITAL	In Lie	eu of Form CMS-2	2552-10
	MENTS TO EXPENSES			Provider CCN: 15-0091	Peri od:	Worksheet A-8	
					From 01/01/2016		
					To 12/31/2016	Date/Time Pre 5/19/2017 9:1	
				Expense Classification of	n Worksheet A	3/19/2017 9.1	
				To/From Which the Amount is			
	Cost Center Description	Basis/Code (2)	Amount	Cost Center		Wkst. A-7 Ref.	
		1.00	2.00	3.00	4.00	5.00	
33.02	VENDI NG	A		EMPLOYEE BENEFITS DEPARTMEN			
33.03	VENDI NG	A		OPERATION OF PLANT	7.00	0	
33.04	RENT	A		CAP REL COSTS-BLDG & FIXT	1.00		
33.05	RENT	A		CAP REL COSTS-BLDG & FIXT	1.00		
33.06	RENT	A		CAP REL COSTS-BLDG & FIXT	1.00		33.06
33.07	PHARMACY EMPLOYEE PURCHASES	В		PHARMACY	15.00		
33.08	PHYSICIAN RECRUITMENT	A		ADMI NI STRATI VE & GENERAL	5.00	0	
33.09	RENT	A		CAP REL COSTS-BLDG & FIXT	1.00	10	
33. 10	SELF INSURANCE	A		EMPLOYEE BENEFITS DEPARTMEN			
33. 11	GUEST MEALS	A		CAFETERI A	11.00	0	
33. 12	OTHER OPERATING REVENUE	A		EMERGENCY	91.00		
33. 13	LOBBY DUES	A		ADMI NI STRATI VE & GENERAL	5.00		
33.14	LIQUOR	A		ADMI NI STRATI VE & GENERAL	5.00		
33. 15	OTHER OPERATING REVENUE	В		NURSING ADMINISTRATION	13.00		
33. 16	CONSULTING PT REVENUE	В		PHYSICAL THERAPY	66.00		33.16
33. 18	OTHER OPERATING REVENUE	В		ADMI NI STRATI VE & GENERAL	5.00		33. 18
33.19	OTHER OPERATING REVENUE	В		DI ETARY	10.00		33.19
33. 20	OTHER OPERATING REVENUE	В		CAFETERIA	11.00		33.20
33. 21	OTHER OPERATING REVENUE	В		PHARMACY	15.00		
33. 24	OTHER OPERATING REVENUE	В		RESPI RATORY THERAPY	65.00		
33.25	OTHER OPERATING REVENUE	В		PHYSICAL THERAPY	66.00		33.25
33. 27	OTHER OPERATING REVENUE	В		AMBULANCE SERVICES	95.00		33.27
33.29	TELEMETRY	A		ADULTS & PEDIATRICS	30.00		
33.30	OTHER OPERATING REVENUE	В		ADULTS & PEDIATRICS	30.00		33.30
33.31	OTHER OPERATING REVENUE	В		OPERATION OF PLANT	7.00		33.31
34.00	DEPRECIATION	A		CAP REL COSTS-BLDG & FIXT	1.00		
35.00	DEPRECIATION	A		CAP REL COSTS-MVBLE EQUIP	2.00		35.00
37.00	PHYS ADMIN SALARIES	A		ADMI NI STRATI VE & GENERAL	5.00	0	37.00
50.00	TOTAL (sum of lines 1 thru 49)		-8, 507, 096				50.00
	(Transfer to Worksheet A,						
(1) 5	column 6, line 200.)						

(1) Description - all chapter references in this column pertain to CMS Pub. 15-1.
(2) Basis for adjustment (see instructions).
A. Costs - if cost, including applicable overhead, can be determined.
B. Amount Received - if cost cannot be determined.
(3) Additional adjustments may be made on lines 33 thru 49 and subscripts thereof.
Note: See instructions for column 5 referencing to Worksheet A-7.

Heal th	Financial Systems	HUNTI NGTON MEM	IORI AL HOSPI TAL	eu of Form CMS-	2552-10	
	ENT OF COSTS OF SERVICES FROM	RELATED ORGANIZATIONS AND HOM	ME Provider CCN: 15-0091	Period:	Worksheet A-8	3-1
OFFICE	COSTS			From 01/01/2016 To 12/31/2016		
	Line No.	Cost Center	Expense Items	Amount of	Amount	
				Allowable Cost	Included in	
					Wks. A, column	
					5	
	1.00	2.00	3.00	4.00	5.00	
	A. COSTS I NCURRED AND ADJUSTMENTS REQUIRED AS A RESULT OF TRANSACTIONS WITH RELATED ORGANIZATIONS OR CLAIMED					
	HOME OFFICE COSTS:					
1.00	5.00	ADMINISTRATIVE & GENERAL	HOME OFFICE ALLOCATIONS	8, 304, 806	6, 981, 000	1.00
2.00	5.00	ADMINISTRATIVE & GENERAL	PPG_SUBSI DY	0	4, 108, 134	2.00
3.00	0.00			0	0	3.00
4.00	0.00			0	0	4.00
5.00	TOTALS (sum of lines 1-4).			8, 304, 806	11, 089, 134	5.00
	Transfer column 6, line 5 to					
	Worksheet A-8, column 2,					
	line 12.					

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

na	5 1101	been posted to worksheet A,				FOI this part.	
					Related Organization(s) and/	or Home Office	
		Symbol (1)	Nama	Democratore of	Nama	Democrateria of	<u> </u>
		Symbol (1)	Name	Percentage of	Name	Percentage of	
				Ownershi p		Ownershi p	
		1.00	2.00	3.00	4.00	5.00	
		B INTERPRIATIONSHIP TO REL	TED OPCANIZATION(S) AND/OP I	OME DEELCE			

B. INTERRELATIONSHIP TO RELATED ORGANIZATION(S) AND/OR HOME OFFICE: The Secretary, by virtue of the authority granted under section 1814(b)(1) of the Social Security Act, requires that you furnish the information requested under Part B of this worksheet.

This information is used by the Centers for Medicare and Medicaid Services and its intermediaries/contractors in determining that the costs applicable to services, facilities, and supplies furnished by organizations related to you by common ownership or control represent reasonable costs as determined under section 1861 of the Social Security Act. If you do not provide all or any part of the 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	0.00	7.00
8.00		0.00	0.00	8.00
9.00		0.00	0.00	9.00
10.00		0.00	0.00	10.00
100.00	G. Other (financial or			100.00
	non-financial) specify:		1	1

(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.

Health Financial Systems	HUNTINGTON MEMORIAL HOSPITAL	In Lie	u of Form CMS-2552-10
STATEMENT OF COSTS OF SERVICES OFFICE COSTS	FROM RELATED ORGANIZATIONS AND HOME Provider CCN:	From 01/01/2016	Worksheet A-8-1 Date/Time Prepared: 5/19/2017 9:13 am

					5/19/2017 9:	3 800
	Net	Wkst. A-7 Ref.				
	Adjustments					
	(col. 4 minus					
	col. 5)*					
	6.00	7.00				
	A. COSTS INCUR	RED AND ADJUST	MENTS REQUIRED AS A RESULT OF TRAM	SACTIONS WITH RELATED C	RGANIZATIONS OR CLAIMED	
	HOME OFFICE CO	STS:				
1.00	1, 323, 806	0				1.00
2.00	-4, 108, 134	0				2.00
3.00	0	0				3.00
4.00	0	0				4.00
5.00	-2, 784, 328					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.

nu.	3 1101	been posted to norkaneet A,		
		Rel ated Organi zati on(s)		
		and/or Home Office		
		Type of Business		
		51		
		6, 00	1	
		B. INTERRELATIONSHIP TO RELA	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.

rerinbu		· · · · · · · · · · · · · · · · · · ·
6.00	HOME OFFICE	6.00
7.00		7.00
8.00		8.00
9.00		9.00
10. 00 100. 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.

Heal th	Financial Syste	ems	HUNTI NGTON MEM	ORIAL HOSPITAL		In Lie	eu of Form CMS-	2552-10
PROVI DE	R BASED PHYSIC	I AN ADJUSTMENT		Provider (		Period: From 01/01/2016 To 12/31/2016		epared:
	Wkst. A Line #	Cost Center/Physician Identifier	Total Remuneration	Professional Component	Provider Component	RCE Amount	Physician/Prov ider Component Hours	
	1.00	2.00	3.00	4.00	5.00	6.00	7.00	
1.00		OPERATING ROOM	562, 397	538, 397	24,000	239, 400	191	1.00
2.00		RESPI RATORY THERAPY	2, 739			0	0	2.00
3.00		EMERGENCY	15,000	15, 000	C	0	, s	
4.00		AMBULANCE SERVICES	15,000	15, 000	C	0 0	0	4.00
5.00	0.00		0	0	C	0	0	5.00
6.00	0.00		0	0	C	0	0	6.00
7.00	0.00		0	0	C	0	0	7.00
8.00	0.00		0	0	C	0 0	0	8.00
9.00	0.00		0	0	C	0	0	9.00
10.00	0.00		0	0	C	0	0	10.00
200.00			595, 136		24,000	)	191	200.00
	Wkst. A Line #		Unadjusted RCE		Cost of	Provi der	Physician Cost	
		l denti fi er	Limit	Unadjusted RCE		Component	of Malpractice	
				Limit	Conti nui ng	Share of col.	Insurance	
	4.00	0.00		0.00	Educati on	12	44.00	
1 00	1.00	2.00	8.00	9.00	12.00	13.00	14.00	1.00
1.00		OPERATING ROOM	21, 983	1, 099	-	-	0	
2.00		RESPI RATORY THERAPY	0	0			0	
3.00			0	0	-	~	0	
4.00		AMBULANCE SERVICES	0	-			-	
5.00 6.00	0.00 0.00		0	0			0	
6.00 7.00	0.00		0					
7.00 8.00	0.00		0				0	7.00 8.00
8.00 9.00	0.00		0	0			0	
9.00 10.00	0.00		0	0		-		
200.00	0.00		21, 983	1, 099		,	, s	200.00
	Wkst. A Line #	Cost Center/Physician	Provi der	Adjusted RCE	RCE	Adjustment	0	200.00
	WKSL A LINE #	I denti fi er	Component	Limit	Di sal I owance	Aujustment		
		rdentriter	Share of col.		Disarrowance			
			14					
	1.00	2.00	15.00	16.00	17.00	18.00		
1.00		OPERATI NG ROOM	0		2,017	540, 414		1.00
2.00	65.00	RESPI RATORY THERAPY	0	0				2.00
3.00	91.00	EMERGENCY	0	0	C			3.00
4.00	95.00	AMBULANCE SERVICES	0	0	C			4.00
5.00	0.00		0	0	C	0		5.00
6.00	0.00		0	0	C	0 0		6.00
7.00	0.00		0	0	C	0 0		7.00
8.00	0.00		0	0	C	0		8.00
9.00	0.00		0	0	C	0		9.00
10.00	0.00		0	0	C	0 0		10.00
200.00			0	21, 983	2, 017	573, 153		200.00
-	<u>.</u>	1						

COST A	Financial Systems LLOCATION - GENERAL SERVICE COSTS	HUNTINGTON MEMO	Provi der CC	F	Period: From 01/01/2016 To 12/31/2016	u of Form CMS-: Worksheet B Part I Date/Time Pre 5/19/2017 9:1	pared:
			CAPI TAL REL	ATED COSTS		371772017 7.1	
	Cost Center Description	Net Expenses for Cost Allocation (from Wkst A col. 7)	BLDG & FIXT	MVBLE EQUIP	EMPLOYEE BENEFI TS DEPARTMENT	Subtotal	
		0	1.00	2.00	4.00	4A	
1 00	GENERAL SERVICE COST CENTERS	204 770	20( 770				1 1 00
1.00 2.00	00100 CAP REL COSTS-BLDG & FLXT 00200 CAP REL COSTS-MVBLE EQUI P	206, 770 707, 595	206, 770	707, 595			1.00
2.00 4.00	00400 EMPLOYEE BENEFITS DEPARTMENT	1, 822, 148	234				4.00
5.00	00500 ADMI NI STRATI VE & GENERAL	11, 512, 298	13, 618			12, 090, 089	5.00
6.00	00600 MAINTENANCE & REPAIRS	0	0	C	0 0	0	6.00
7.00	00700 OPERATION OF PLANT	1, 269, 142	54, 384	24, 332		1, 384, 346	
8.00	00800 LAUNDRY & LINEN SERVICE	177,034	1, 115		-,	181, 239	•
9.00	00900 HOUSEKEEPING	392, 417	908			425, 377	9.00
10. 00 11. 00	01000 DI ETARY 01100 CAFETERI A	180, 699 200, 375	8, 673 1, 968			198, 470 224, 634	10.00
12.00	01200 MAINTENANCE OF PERSONNEL	200, 373	1, 700			224,004	12.00
13.00	01300 NURSI NG ADMI NI STRATI ON	205, 471	0		-	227, 380	•
14.00	01400 CENTRAL SERVICES & SUPPLY	0	3, 378		0 0	3, 378	14.00
	01500 PHARMACY	567,040	2, 048			686, 538	1
16.00	01600 MEDICAL RECORDS & LIBRARY	0	1, 131		-	1, 131	•
17.00 19.00	01700 SOCIAL SERVICE 01900 NONPHYSICIAN ANESTHETISTS	0	0			0	17.00
20.00	02000 NURSI NG SCHOOL	0	0			0	20.00
21.00	02100 I &R SERVICES-SALARY & FRINGES APPRV	0	0		) O	0	21.00
22.00	02200 I &R SERVICES-OTHER PRGM COSTS APPRV	0	0	C	0 0	0	22.00
23.00	02300 PARAMED ED PRGM-(SPECIFY)	0	0	C	0 0	0	23.00
	INPATIENT ROUTINE SERVICE COST CENTERS						
	03000 ADULTS & PEDI ATRI CS	2, 923, 293				3, 341, 950	
43.00	04300 NURSERY ANCI LLARY SERVI CE COST CENTERS	144, 276	181		13, 463	157, 920	43.00
50.00	05000 OPERATING ROOM	884, 941	16, 992	107, 852	98, 886	1, 108, 671	50.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	600, 726	0			656, 782	52.00
53.00	05300 ANESTHESI OLOGY	550, 901	0	C	0	550, 901	53.00
54.00	05400 RADI OLOGY-DI AGNOSTI C	1, 492, 641	21, 297	193, 253	99, 201	1, 806, 392	
60.00	06000 LABORATORY	2, 117, 653	3, 227	0	-	2, 120, 880	•
62.30 65.00	06250 BLOOD CLOTTING FOR HEMOPHILIACS 06500 RESPIRATORY THERAPY	741, 194	0 2, 386		, i	0 844, 074	62.30 65.00
66. 00	106600 PHYSI CAL THERAPY	890, 302	2, 380 14, 758			1, 001, 014	
67.00	06700 OCCUPATI ONAL THERAPY	236, 793	0			259, 469	
68.00	06800 SPEECH PATHOLOGY	75, 827	0	0	7, 262	83, 089	68.00
69.00	06900 ELECTROCARDI OLOGY	0	0	C	0 0	0	69.00
	07100 MEDI CAL SUPPLIES CHARGED TO PATIENT	727, 923			-	727, 923	
	07200 I MPL. DEV. CHARGED TO PATI ENTS 07300 DRUGS CHARGED TO PATI ENTS	834, 749				834, 749	
76.97	07697 CARDIAC REHABILITATION	2, 206, 175	0			2, 213, 376 0	
76.98	07698 HYPERBARI C OXYGEN THERAPY	10, 657	0		-	11, 573	
76.99	07699 LI THOTRI PSY	0	0	C	0 0	0	76.99
	OUTPATIENT SERVICE COST CENTERS						
	09100 EMERGENCY	1, 311, 318	9, 078	28, 803	3 120, 254	1, 469, 453	•
92.00	09200 OBSERVATI ON BEDS (NON-DI STI NCT PART OTHER REI MBURSABLE COST CENTERS					0	92.00
95.00	09500 AMBULANCE SERVICES	2, 117, 851	6, 296	154, 308	3 201, 807	2, 480, 262	95.00
. 5. 50	SPECIAL PURPOSE COST CENTERS	2, 117, 001	0,270	104,000	201,007	2, 100, 202	
113.00	11300 INTEREST EXPENSE						113.00
118.00		35, 108, 209	206, 281	706, 709	1, 806, 608	35, 091, 060	118.00
100.00	NONREI MBURSABLE COST CENTERS			-			100.00
	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN 19200 PHYSICIANS' PRIVATE OFFICES	95, 759	0			0 104, 406	190.00
	07950 OCC HEALTH	95,759	489				192.00
	07951 PALN CLINIC	0	0		o o		194.00
	07952 OCC HEALTH	0	0	C	0 0	0	194.02
	07953 FOUNDATI 0	80, 030	0	( C	3		194. 03
	07954 KI DS CAMPUS	0	0		0		194.04
	07955 COMMUNITY & VOLUNTEER SERVICES	431, 150	0		486	431, 636	194.05 194.06
	07956 HUNTI NGTON COLLEGE NURSE 07957 MISC CATERI NG	141, 927	0		7, 524	0 149, 451	•
	07958 AUTI SM CENTER	66, 741	0		0		194.07
	07959 HUNTI NGTON BUA	0	0		o o		194.09
						0	200.00
200.00							
200.00 201.00 202.00		35, 923, 816	0 206, 770	707, 595	0 5 1, 822, 382		201.00

Heal th	Financial Systems	HUNTI NGTON MEMOR	IAL HOSPITAL		In Lie	u of Form CMS-	2552-10
COST A	LLOCATION - GENERAL SERVICE COSTS		Provider CC	F	Period: From 01/01/2016 To 12/31/2016	Worksheet B Part I Date/Time Pre 5/19/2017 9:1	pared: 3 am
	Cost Center Description	ADMI NI STRATI VE M & GENERAL 5.00	AI NTENANCE & REPAI RS 6.00	OPERATION OF PLANT 7.00	LAUNDRY & LINEN SERVICE 8.00	HOUSEKEEPI NG 9.00	
	GENERAL SERVICE COST CENTERS						
1.00	00100 CAP REL COSTS-BLDG & FIXT						1.00
2.00 4.00	00200 CAP REL COSTS-MVBLE EQUIP 00400 EMPLOYEE BENEFITS DEPARTMENT						2.00 4.00
4.00 5.00	00500 ADMINI STRATI VE & GENERAL	12, 090, 089					5.00
6.00	00600 MAI NTENANCE & REPAI RS	0	0				6.00
7.00	00700 OPERATION OF PLANT	702, 234	0	2, 086, 580			7.00
8.00	00800 LAUNDRY & LINEN SERVICE	91, 937	0	16, 797			8.00
9.00	00900 HOUSEKEEPING	215, 780	0	13, 673		654, 873	
10.00 11.00	01000 DI ETARY 01100 CAFETERI A	100, 677 113, 950	0	130, 638 29, 642		41, 608 9, 441	10.00
12.00	01200 MAINTENANCE OF PERSONNEL	0	0	2 7, 042		<sup>2</sup> , 441 0	12.00
13.00	01300 NURSING ADMINISTRATION	115, 343	0	(		0	13.00
14.00	01400 CENTRAL SERVICES & SUPPLY	1, 714	0	50, 872	1, 132	16, 203	14.00
15.00	01500 PHARMACY	348, 259	0	30, 844		9, 824	15.00
16.00	01600 MEDICAL RECORDS & LIBRARY 01700 SOCIAL SERVICE	574	0	17,037		5, 426	•
17.00 19.00	01900 NONPHYSICIAN ANESTHETISTS	0	0	(	-	0	17.00
20.00	02000 NURSI NG SCHOOL	0	0	(	0	0	20.00
21.00	02100 I & R SERVICES-SALARY & FRINGES APPRV	0	0	(	0	0	21.00
22.00	02200 I &R SERVICES-OTHER PRGM COSTS APPRV	0	0	(	0	0	22.00
23.00	02300 PARAMED ED PRGM-(SPECIFY)	0	0	(	0 0	0	23.00
30.00	I NPATI ENT ROUTI NE SERVI CE COST CENTERS 03000 ADULTS & PEDI ATRI CS	1, 695, 266	0	671, 884	88, 036	213, 995	30.00
43.00	04300 NURSERY	80, 108	0	2, 724		868	
	ANCILLARY SERVICE COST CENTERS						
50.00	05000 OPERATING ROOM	562, 393	0	255, 936		81, 516	•
52.00 53.00	05200 DELIVERY ROOM & LABOR ROOM 05300 ANESTHESI OLOGY	333, 164	0	(		0	52.00 53.00
53.00	05400 RADI OLOGY – DI AGNOSTI C	279, 454 916, 325	0	320, 774	, v	102, 167	
60.00	06000 LABORATORY	1, 075, 855	0	48, 602		15, 480	
62.30	06250 BLOOD CLOTTING FOR HEMOPHILIACS	0	0	(	0	0	62.30
65.00	06500 RESPI RATORY THERAPY	428, 172	0	35, 944		11, 448	
66.00 67.00	06600 PHYSI CAL THERAPY 06700 OCCUPATI ONAL THERAPY	507, 782	0	222, 288		70, 799 0	66.00 67.00
68.00	06800 SPEECH PATHOLOGY	131, 620 42, 148	0	(		0	68.00
69.00	06900 ELECTROCARDI OLOGY	0	0	(	0	0	69.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	369, 252	0	(	0	0	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	423, 441	0	(	0	0	72.00
73.00 76.97	07300 DRUGS CHARGED TO PATIENTS	1, 122, 775	0	(	0	0	73.00
76.97	07697 CARDI AC REHABI LI TATI ON 07698 HYPERBARI C OXYGEN THERAPY	0 5, 871	0	(		0	76. 97 76. 98
76.99	07699 LI THOTRI PSY	0	0	(	0	0	
	OUTPATIENT SERVICE COST CENTERS						
91.00 92.00	09100 EMERGENCY	745, 406	0	136, 727	85, 598	43, 548	91.00 92.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART OTHER REIMBURSABLE COST CENTERS						92.00
95.00	09500 AMBULANCE SERVICES	1, 258, 158	0	94, 828	3, 929	30, 203	95.00
	SPECIAL PURPOSE COST CENTERS						
	11300 INTEREST EXPENSE	11 (17 (50	2	0.070.044	000.0(1	(50.50)	113.00
118.00	SUBTOTALS         (SUM OF LINES 1-117)           NONREI MBURSABLE         COST CENTERS	11, 667, 658	0	2, 079, 210	283, 361	652, 526	118.00
190.00	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	(	o	0	190.00
	19200 PHYSICIANS' PRIVATE OFFICES	52, 962	0	(	6, 612		192.00
	07950 OCC HEALTH	248	0	7, 370			194.00
	07951 PAIN CLINIC	0	0	(	0		194.01
	07952 OCC HEALTH 07953 FOUNDATI 0	40, 598	0	(			194. 02 194. 03
	07954 KIDS CAMPUS	-0, 378	0	(	0		194.03
	07955 COMMUNITY & VOLUNTEER SERVICES	218, 955	0	(	0		194.05
	07956 HUNTI NGTON COLLEGE NURSE	0	0	(	0		194.06
	07957 MISC CATERING	75, 812	0	(	0		194.07
	07958 AUTI SM CENTER 07959 HUNTI NGTON BUA	33, 856	0	(			194. 08 194. 09
200.00			0	C	, 0	0	200.00
201.00	Negative Cost Centers	0	0	(	0		201.00
202.00	TOTAL (sum lines 118-201)	12, 090, 089	0	2, 086, 580	289, 973	654, 873	202.00

	Financial Systems	HUNTI NGTON MEMOR			-		u of Form CMS-	2552-10
COST A	LLOCATION - GENERAL SERVICE COSTS		Provider C	CN: 15-0091		eriod: com 01/01/2016 0 12/31/2016	Worksheet B Part I Date/Time Pre 5/19/2017 9:1	pared: 3 am
	Cost Center Description	DI ETARY	CAFETERI A	MAI NTENANCE PERSONNEL		NURSI NG ADMI NI STRATI ON	CENTRAL	
		10.00	11.00	12.00		13.00	14.00	
1.00	GENERAL SERVICE COST CENTERS 00100 CAP REL COSTS-BLDG & FIXT							1.00
$\begin{array}{c} 2.\ 00\\ 4.\ 00\\ 5.\ 00\\ 6.\ 00\\ 7.\ 00\\ 8.\ 00\\ 9.\ 00\\ 10.\ 00\\ 11.\ 00\\ 12.\ 00\\ 13.\ 00\\ 14.\ 00\\ 15.\ 00\\ 16.\ 00\\ 17.\ 00\\ \end{array}$	00100 CAP REL COSTS-MVBLE EQUI P 00400 EMPLOYEE BENEFI TS DEPARTMENT 00500 ADMI NI STRATI VE & GENERAL 00600 MAI NTENANCE & REPAI RS 00700 OPERATI ON OF PLANT 00800 LAUNDRY & LI NEN SERVI CE 00900 HOUSEKEEPI NG 01000 DI ETARY 01100 CAFETERI A 01200 MAI NTENANCE OF PERSONNEL 01300 NURSI NG ADMI NI STRATI ON 01400 CENTRAL SERVI CES & SUPPLY 01500 PHARMACY 01600 MEDI CAL RECORDS & LI BRARY 01700 SOCI AL SERVI CE	471, 393 0 0 0 0 0 0 0 0 0 0	377, 667 0 5, 215 0 10, 395 0 0 0		0 0 0 0 0 0	347, 938 0 0 0 0 0	73, 299 878 0 0	$\begin{array}{c} 2.\ 00\\ 4.\ 00\\ 5.\ 00\\ 6.\ 00\\ 7.\ 00\\ 8.\ 00\\ 9.\ 00\\ 10.\ 00\\ 11.\ 00\\ 12.\ 00\\ 13.\ 00\\ 14.\ 00\\ 15.\ 00\\ 16.\ 00\\ 17.\ 00\\ \end{array}$
	02000 NURSI NG SCHOOL	0	0		0	0	0	1
21. 00 22. 00	02100 I &R SERVICES-SALARY & FRINGES APPRV 02200 I &R SERVICES-OTHER PRGM COSTS APPRV 02300 PARAMED ED PRGM-(SPECIFY)	0	0		0 0 0	0 0 0	0	21.00 22.00
	I NPATI ENT ROUTI NE SERVI CE COST CENTERS 03000 ADULTS & PEDI ATRI CS 04300 NURSERY	471, 393	96, 661 4, 268		0 0	177, 912 7, 855	5, 670 0	1
F0 00	ANCI LLARY SERVICE COST CENTERS		20.005		0	E4 04E	0.010	1 50 00
	05000 OPERATING ROOM 05200 DELIVERY ROOM & LABOR ROOM	0	30, 885 17, 768		0 0	56, 845 32, 702	9, 212 0	1
	05300 ANESTHESI OLOGY	0	0		0	02,702	0	1
	05400 RADI OLOGY-DI AGNOSTI C	0	31, 622		0	0	1, 698	
	06000 LABORATORY	0	0		0	0	27	60.00
	06250 BLOOD CLOTTING FOR HEMOPHILIACS 06500 RESPIRATORY THERAPY	0	0 23, 216		0	0	0 2, 430	
	06600 PHYSI CAL THERAPY	0	23, 210		0	0	835	1
	06700 OCCUPATI ONAL THERAPY	0	7, 144		0	0	0	67.00
	06800 SPEECH PATHOLOGY	0	2, 288		0	0	0	
	06900 ELECTROCARDIOLOGY 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0	0		0 0	0	0 41, 869	
	07200 IMPL. DEV. CHARGED TO PATIENTS	0	0		0	0	41,809	1
	07300 DRUGS CHARGED TO PATIENTS	0	0		0	0	2, 025	1
	07697 CARDI AC REHABI LI TATI ON	0	0		0	0	0	1
	07698 HYPERBARI C OXYGEN THERAPY	0	0		0	0	50	
70.99	07699 LI THOTRI PSY OUTPATI ENT SERVI CE COST CENTERS	0	0		0	0	0	76.99
91.00	09100 EMERGENCY	0	39, 457		0	72, 624	3, 575	91.00
	09200 OBSERVATION BEDS (NON-DISTINCT PART							92.00
	OTHER REIMBURSABLE COST CENTERS 09500 AMBULANCE SERVICES	0	73, 866		0	0	1 772	95.00
	SPECIAL PURPOSE COST CENTERS	<u> </u>	73,000	1		0	4,772	75.00
113. 00 118. 00	11300 INTEREST EXPENSE SUBTOTALS (SUM OF LINES 1-117)	471, 393	366, 402		0	347, 938	73, 041	113. 00 118. 00
	NONREIMBURSABLE COST CENTERS 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0		0	0	0	190.00
	19200 PHYSI CI ANS' PRI VATE OFFI CES	0	3, 546		0	0		192.00
194.00	07950 OCC HEALTH	0	0		0	0	0	194.00
	07951 PALN CLINIC	0	0		0	0		194.01
	07952 OCC HEALTH 07953 FOUNDATI 0	0	0 2, 083		0	0		194. 02 194. 03
	07954 KIDS CAMPUS	0	2,003		0	0		194.03
194.05	07955 COMMUNITY & VOLUNTEER SERVICES	0	201		0	0	27	194.05
	07956 HUNTI NGTON COLLEGE NURSE	0	0		0	0		194.06
	07957 MISC CATERING 07958 AUTISM CENTER	0	5, 435		0 0	0		194. 07 194. 08
	07959 HUNTI NGTON BUA	0	0		0	0		194.08
200.00	Cross Foot Adjustments		0			Ŭ		200.00
201.00	Negative Cost Centers	0	0		0	0		201.00
202.00	TOTAL (sum lines 118-201)	471, 393	377, 667	I	0	347, 938	/3, 299	202.00

	Financial Systems LLOCATION - GENERAL SERVICE COSTS	HUNTINGTON MEMOR	Provider CO	CN: 15-0091	Peri od:	u of Form CMS- Worksheet B	-2002-10
					From 01/01/2016 To 12/31/2016	Part I	epared:
	Cost Center Description	PHARMACY	MEDI CAL RECORDS & LI BRARY	SOCIAL SERVIC	E NONPHYSI CI AN ANESTHETI STS	NURSI NG SCHOOL	-
		15.00	16.00	17.00	19.00	20.00	
1.00	GENERAL SERVICE COST CENTERS 00100 CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200 CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400 EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00 6.00	00500 ADMINISTRATIVE & GENERAL 00600 MAINTENANCE & REPAIRS						5.00
7.00	00700 OPERATI ON OF PLANT						7.00
8.00	00800 LAUNDRY & LINEN SERVICE						8.00
9.00	00900 HOUSEKEEPI NG						9.00
10. 00 11. 00	01000 DI ETARY 01100 CAFETERI A						10.00
12.00	01200 MAINTENANCE OF PERSONNEL						12.00
13.00	01300 NURSI NG ADMI NI STRATI ON						13.00
	01400 CENTRAL SERVICES & SUPPLY	4 004 700					14.00
15.00 16.00	01500 PHARMACY 01600 MEDICAL RECORDS & LIBRARY	1, 086, 738 0	24, 168				15.00
17.00	01700 SOCIAL SERVICE	0	24, 100		0		17.00
	01900 NONPHYSICIAN ANESTHETISTS	0	0		0 0		19.00
20.00	02000 NURSI NG SCHOOL	0	0		0	(	20.00
21.00 22.00	02100 I & R SERVI CES-SALARY & FRI NGES APPRV 02200 I & R SERVI CES-OTHER PRGM COSTS APPRV	0	0		0		21.00
	02300 PARAMED ED PRGM-(SPECIFY)	0	0		0		22.00
201.00	INPATIENT ROUTINE SERVICE COST CENTERS						- 20100
30.00	03000 ADULTS & PEDIATRICS	0	1, 344		0 0	(	
43.00	04300 NURSERY ANCI LLARY SERVI CE COST CENTERS	0	136		0 0	(	43.00
50.00	05000 OPERATI NG ROOM	0	3, 241		0 0	(	50.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0	579		0 0		52.00
53.00	05300 ANESTHESI OLOGY	0	526		0 0	(	
54.00 60.00	05400 RADI OLOGY-DI AGNOSTI C 06000 LABORATORY	0	5, 050 2, 510		0 0 0 0		
62.30	06250 BLOOD CLOTTING FOR HEMOPHILIACS	0	2, 510		0 0	(	
65.00	06500 RESPI RATORY THERAPY	0	831		0 0	(	
66.00	06600 PHYSI CAL THERAPY	0	628		0 0	(	
67.00 68.00	06700 OCCUPATIONAL THERAPY 06800 SPEECH PATHOLOGY	0	178 56		0 0 0 0		
69.00	06900 ELECTROCARDI OLOGY	0	146		0 0		
	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0	1, 647		0 0	(	
	07200 IMPL. DEV. CHARGED TO PATIENTS	0	925		0 0	(	
73.00 76.97	07300 DRUGS CHARGED TO PATIENTS 07697 CARDIAC REHABILITATION	1, 086, 738 0	2, 107 0		0 0 0 0		
	07698 HYPERBARI C OXYGEN THERAPY	0	35		0 0		76.98
76.99	07699 LI THOTRI PSY	0	0		0 0	(	76.99
01 00	OUTPATIENT SERVICE COST CENTERS	0	2 052		0 0		91.00
	09200 OBSERVATION BEDS (NON-DISTINCT PART	0	3, 053		0 0		92.00
	OTHER REIMBURSABLE COST CENTERS						
95.00	09500 AMBULANCE SERVICES	0	1, 176		0 0	(	95.00
113 00	SPECIAL PURPOSE COST CENTERS 11300 INTEREST EXPENSE						113.00
118.00		1, 086, 738	24, 168		0 0	(	118.00
	NONREI MBURSABLE COST CENTERS	· · · ·					
	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0		0 0		190.00
	19200 PHYSI CLANS' PRI VATE OFFI CES 07950 OCC HEALTH	0	0		0 0 0 0		) 192.00 ) 194.00
	07951 PAIN CLINIC	0	0		0 0		194.00
194.02	07952 OCC HEALTH	0	0		0 0	(	194. 02
	07953 FOUNDATI 0	0	0		0 0		194.03
	07954 KIDS CAMPUS 07955 COMMUNITY & VOLUNTEER SERVICES	0	0				) 194. 04 ) 194. 05
	07956 HUNTI NGTON COLLEGE NURSE	0	0		o o		194.05
	07957 MI SC CATERI NG	0	0		0 0	C	194. 07
	07958 AUTI SM CENTER	0	0		0 0	(	194. 08
194.08							
194.08 194.09	07959 HUNTI NGTON BUA	0	0		0 0		194.09
194.08	07959 HUNTINGTON BUA Cross Foot Adjustments	0	0		0 0 0 0	(	) 194. 09 ) 200. 00 ) 201. 00

Health Financial Systems COST ALLOCATION - GENERAL SERVICE COSTS	HUNTI NGTON MEMO	RIAL HOSPITAL Provider CC	CN: 15-0091	In Lie Period: From 01/01/2016	u of Form CMS-: Worksheet B Part I	2552-10
				To 12/31/2016	Date/Time Pre	
	INTERNS &	RESIDENTS			5/19/2017 9:1	
Cost Center Description	SERVI CES-SALAR	SERVICES_OTHER	PARAMED ED	Subtotal	Intern &	
	Y & FRI NGES APPRV	PRGM COSTS APPRV	PRGM		Resi dents Cost & Post Stepdown Adjustments	
	21.00	22.00	23.00	24.00	25.00	
GENERAL SERVICE COST CENTERS						1 1 00
1.00       00100       CAP       REL       COSTS-BLDG & FIXT         2.00       00200       CAP       REL       COSTS-MVBLE       EQUIP         4.00       00400       EMPLOYEE       BENEFITS       DEPARTMENT         5.00       00500       ADMINISTRATIVE       & GENERAL         6.00       00600       MAINTENANCE       & REPAIRS         7.00       00700       OPERATION OF       PLANT         8.00       00800       LAUNDRY       & LINEN       SERVICE         9.00       00900       HOUSEKEEPING       0       0         10.00       01100       CAFETERIA       1       2.00       01200       MAINTENANCE OF       PERSONNEL         13.00       01400       CENTRAL       SERVICES       & SUPPLY         15.00       01500       PHARMACY       1       0       01600       MEDICAL       RECORDS       & LI BRARY         17.00       01700       SOCIAL       SERVICE       9.00       01900       NONPHYSI CI AN ANESTHETI STS         20.00       02000       NURSI NG SCHOOL       21.00       02000       NURSI NG SCHOOL       21.00       02100       I& SERVICES <td>0</td> <td></td> <td></td> <td></td> <td></td> <td><math display="block">\begin{array}{c} 1. \ 00\\ 2. \ 00\\ 4. \ 00\\ 5. \ 00\\ 6. \ 00\\ 7. \ 00\\ 8. \ 00\\ 9. \ 00\\ 10. \ 00\\ 11. \ 00\\ 12. \ 00\\ 12. \ 00\\ 13. \ 00\\ 14. \ 00\\ 15. \ 00\\ 14. \ 00\\ 15. \ 00\\ 16. \ 00\\ 17. \ 00\\ 20. \ 00\\ 20. \ 00\\ 21. \ 00\\ \end{array}</math></td>	0					$\begin{array}{c} 1. \ 00\\ 2. \ 00\\ 4. \ 00\\ 5. \ 00\\ 6. \ 00\\ 7. \ 00\\ 8. \ 00\\ 9. \ 00\\ 10. \ 00\\ 11. \ 00\\ 12. \ 00\\ 12. \ 00\\ 13. \ 00\\ 14. \ 00\\ 15. \ 00\\ 14. \ 00\\ 15. \ 00\\ 16. \ 00\\ 17. \ 00\\ 20. \ 00\\ 20. \ 00\\ 21. \ 00\\ \end{array}$
22. 00 02200 I &R SERVICES-OTHER PRGM COSTS APPRV	0	о				22.00
23.00 02300 PARAMED ED PRGM-(SPECIFY)				0		23.00
I NPATI ENT ROUTI NE SERVI CE COST CENTERS           30. 00         03000         ADULTS & PEDI ATRI CS	0	0		0 6, 764, 111	0	30.00
43. 00 04300 NURSERY	0	0		0 258, 648		
ANCI LLARY SERVI CE COST CENTERS						
50.00 05000 OPERATING ROOM	0	0		0 2, 155, 279 0 1, 060, 852	0	50.00
52. 00 05200 DELIVERY ROOM & LABOR ROOM 53. 00 05300 ANESTHESI OLOGY	0	0		0 1, 060, 852 0 830, 881	0	52.00 53.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	0	Ö		0 3, 200, 182	0	54.00
60. 00 06000 LABORATORY	0	0		0 3, 263, 354	0	60.00
62. 30 06250 BLOOD CLOTTING FOR HEMOPHILIACS	0	0		0 0	0	62.30
65. 00 06500 RESPI RATORY THERAPY 66. 00 06600 PHYSI CAL THERAPY	0	0		0 1, 363, 378 0 1, 826, 963		65.00 66.00
67. 00 06700 OCCUPATI ONAL THERAPY	0	0		0 1, 020, 903	0	67.00
68.00 06800 SPEECH PATHOLOGY	0	0		0 127, 581	0	68.00
69. 00 06900 ELECTROCARDI OLOGY	0	0		0 146	0	69.00
71. 00 07100 MEDI CAL SUPPLIES CHARGED TO PATI ENT	0	0		0 1, 140, 691	0	71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS 73.00 07300 DRUGS CHARGED TO PATIENTS	0	0		0 1, 259, 115 0 4, 427, 021	0	
76. 97 07697 CARDI AC REHABI LI TATI ON	0	0		0 0	0	•
76. 98 07698 HYPERBARI C OXYGEN THERAPY	0	0		0 17, 529		76. 98
76. 99 07699 LI THOTRI PSY	0	0		0 0	0	76.99
0UTPATI ENT SERVICE COST CENTERS 91. 00 09100 EMERGENCY	0	0		0 2, 599, 441	0	91.00
92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART		J.		2,0,,,,,,,	0	92.00
OTHER REIMBURSABLE COST CENTERS	1					
95. 00 09500 AMBULANCE SERVI CES SPECI AL PURPOSE COST CENTERS	0	0		0 3, 947, 194	0	95.00
113. 00 11300 INTEREST EXPENSE						113.00
118.00 SUBTOTALS (SUM OF LINES 1-117)	0	0		0 34, 640, 777	0	118.00
NONREI MBURSABLE COST CENTERS	11				1	
190. 00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN 192. 00 19200 PHYSICIANS' PRIVATE OFFICES	0	0		0 0 0 167 757		190.00 192.00
192. 00 19200 PHYSICIANS PRIVATE OFFICES	0	0		0 167, 757 0 10, 454		192.00
194. 01 07951 PALN CLINIC	0	0		0 0		194.01
194.0207952 OCC HEALTH	0	О		0 0	0	194. 02
194. 03 07953 FOUNDATI 0	0	0		0 122, 714		194.03
194.04 07954 KIDS CAMPUS 194.05 07955 COMMUNITY & VOLUNTEER SERVICES		0		0 0 0 650, 819		194. 04 194. 05
194. 06 07956 HUNTI NGTON COLLEGE NURSE	0	0		0 0		194.05
194. 07 07957 MI SC CATERI NG	0	О		0 230, 698		194.07
194. 08 07958 AUTI SM CENTER	0	0		0 100, 597		194.08
194.09 07959 HUNTINGTON BUA 200.00 Cross Foot Adjustments	0	0				194. 09 200. 00
201.00 Negative Cost Centers	0	0		0 0		201.00
202.00 TOTAL (sum lines 118-201)	0	0		0 35, 923, 816		202.00

USI ALLO	CATION - GENERAL SERVICE COSTS		Provider CCN: 15-0091	Period: From 01/01/2016	Worksheet B Part I	
		1		To 12/31/2016	Date/Time Pre 5/19/2017 9:1	
	Cost Center Description	Total 26.00				
GEN	ERAL SERVICE COST CENTERS	20100				
	00 CAP REL COSTS-BLDG & FIXT					1.
	00 CAP REL COSTS-MVBLE EQUIP					2.
	OO EMPLOYEE BENEFITS DEPARTMENT					4.
	00 ADMINI STRATI VE & GENERAL					5.
	00 MAINTENANCE & REPAIRS					6.
	OO OPERATION OF PLANT					7.
	00 LAUNDRY & LINEN SERVICE 00 HOUSEKEEPING					8. 9.
	00 DI ETARY					10.
	00 CAFETERIA					111.
	00 MAINTENANCE OF PERSONNEL					12.
	OO NURSI NG ADMI NI STRATI ON					13.
	00 CENTRAL SERVICES & SUPPLY					14.
	OO PHARMACY					15.
6.00 016	00 MEDICAL RECORDS & LIBRARY					16.
7.00 017	OO SOCIAL SERVICE					17.
	00 NONPHYSICIAN ANESTHETISTS					19.
	00 NURSI NG SCHOOL					20.
	00 I &R SERVICES-SALARY & FRINGES APPRV					21.
	00 I &R SERVICES-OTHER PRGM COSTS APPRV					22.
	00 PARAMED ED PRGM- (SPECIFY)					23.
	ATLENT ROUTINE SERVICE COST CENTERS	/ 7/4 111				1
	00 ADULTS & PEDI ATRI CS	6, 764, 111 258, 648				30.
	00 NURSERY I LLARY SERVICE COST CENTERS	208, 048				43.
	OO OPERATI NG ROOM	2, 155, 279				50.
	OO DELIVERY ROOM & LABOR ROOM	1, 060, 852				52.
	00 ANESTHESI OLOGY	830, 881				53.
	00 RADI OLOGY-DI AGNOSTI C	3, 200, 182				54.
	OO LABORATORY	3, 263, 354				60.
	50 BLOOD CLOTTING FOR HEMOPHILIACS	0				62.
5.00 065	00 RESPI RATORY THERAPY	1, 363, 378				65.
5. 00 066	00 PHYSI CAL THERAPY	1, 826, 963				66.
7.00 067	00 OCCUPATI ONAL THERAPY	398, 411				67.
	OO SPEECH PATHOLOGY	127, 581				68.
	00 ELECTROCARDI OLOGY	146				69.
	00 MEDI CAL SUPPLIES CHARGED TO PATIENT	1, 140, 691				71.
	00 IMPL. DEV. CHARGED TO PATIENTS	1, 259, 115				72.
	OO DRUGS CHARGED TO PATIENTS	4, 427, 021				73.
	97 CARDI AC REHABI LI TATI ON 98 HYPERBARI C OXYGEN THERAPY	17, 529				76.
	99 LI THOTRI PSY	0				76.
	PATIENT SERVICE COST CENTERS	0				1 / 0
	00 EMERGENCY	2, 599, 441				91
	OO OBSERVATION BEDS (NON-DISTINCT PART	_, ,				92
	ER REIMBURSABLE COST CENTERS					
5.00 095	00 AMBULANCE SERVI CES	3, 947, 194				95
	CLAL PURPOSE COST CENTERS					
	00 INTEREST EXPENSE					113.
8.00	SUBTOTALS (SUM OF LINES 1-117)	34, 640, 777				118.
	REIMBURSABLE COST CENTERS	1				
	OO GIFT, FLOWER, COFFEE SHOP & CANTEEN	0				190
	00 PHYSI CLANS' PRI VATE OFFI CES	167, 757				192
	50 OCC HEALTH 51 PAIN CLINIC	10, 454				194 194
	51 PAIN CLINIC 52 OCC HEALTH	0				194
	52 OCC HEALTH 53 FOUNDATI O	122, 714				194
	53 FOUNDATTO 54 KIDS CAMPUS	122, / 14				194
	55 COMMUNITY & VOLUNTEER SERVICES	650, 819				194
	56 HUNTINGTON COLLEGE NURSE	0.00, 019				194
	57 MI SC CATERI NG	230, 698				194
	58 AUTI SM CENTER	100, 597				194
	59 HUNTI NGTON BUA	0				194
00.00	Cross Foot Adjustments	0				200.
01.00	Negative Cost Centers	0				201
02.00	TOTAL (sum lines 118-201)	35, 923, 816				202

	Financial Systems TION OF CAPITAL RELATED COSTS		RIAL HOSPITAL Provider CC		Period: From 01/01/2016 To 12/31/2016	u of Form CMS-: Worksheet B Part II Date/Time Pre	pared:
			CAPI TAL REL	ATED COSTS		5/19/2017 9:1	3 am
	Cost Center Description	Di rectl y Assi gned New Capi tal Rel ated Costs	BLDG & FIXT	MVBLE EQUIP	Subtotal	EMPLOYEE BENEFI TS DEPARTMENT	
		0	1.00	2.00	2A	4.00	
1.00	GENERAL SERVICE COST CENTERS 00100 CAP REL COSTS-BLDG & FIXT						1.00
2.00 4.00 5.00 6.00	00200 CAP REL COSTS-MVBLE EQUI P 00400 EMPLOYEE BENEFI TS DEPARTMENT 00500 ADMI NI STRATI VE & GENERAL 00600 MAI NTENANCE & REPAI RS	0 1, 974, 536 0	234 13, 618 0	10, 64	0 234 7 1, 998, 801 0 0	234 75 0	2.00 4.00 5.00 6.00
7.00 8.00	00700 OPERATION OF PLANT	0	54, 384	24, 33		5 0	7.00
8.00 9.00	00800 LAUNDRY & LI NEN SERVI CE 00900 HOUSEKEEPI NG	0	1, 115 908		0 1, 115 0 908	4	8.00 9.00
10.00	01000 DI ETARY	0	8, 673	1, 64	2 10, 315	1	10.00
11.00 12.00	01100 CAFETERIA 01200 MAINTENANCE OF PERSONNEL	0	1, 968 0		0 1,968 0 0	3	11.00
12.00	01300 NURSI NG ADMI NI STRATI ON	0	0			3	12.00
14.00	01400 CENTRAL SERVICES & SUPPLY	0	3, 378		3, 378	0	14.00
15.00 16.00	01500 PHARMACY 01600 MEDICAL RECORDS & LIBRARY	0	2, 048 1, 131	60, 74	2 62, 790 0 1, 131	7	15.00
17.00	01700 SOCIAL SERVICE	0	1, 131		0 0	0	17.00
19.00	01900 NONPHYSICIAN ANESTHETISTS	0	0	(	o c	0	19.00
20.00 21.00	02000 NURSING SCHOOL 02100 I & SERVICES-SALARY & FRINGES APPRV	0	0	(		0	20.00
21.00	02200 I &R SERVICES-OTHER PRGM COSTS APPRV	0	0	(		0	21.00
23.00	02300 PARAMED ED PRGM-(SPECIFY)	0	0	(	o c	0	23.00
30.00	I NPATI ENT ROUTI NE SERVI CE COST CENTERS 03000 ADULTS & PEDI ATRI CS	0	44, 609	85, 89	9 130, 508	36	30.00
43.00	04300 NURSERY	0	181		130, 300	2	43.00
50.00	ANCI LLARY SERVICE COST CENTERS		4 ( . 000	407.05	104.044		50.00
50.00 52.00	05000 OPERATING ROOM 05200 DELIVERY ROOM & LABOR ROOM	0	16, 992 0	107, 85:	2 124, 844 0 0	12 7	50.00 52.00
53.00	05300 ANESTHESI OLOGY	0	0	(	0 0	0	53.00
54.00	05400 RADI OLOGY-DI AGNOSTI C	0	21, 297	193, 25		12	
60.00 62.30	06000 LABORATORY 06250 BLOOD CLOTTING FOR HEMOPHILIACS	0	3, 227 0		0 3, 227 0 0	0	60.00 62.30
65.00	06500 RESPI RATORY THERAPY	0	2, 386	31, 559	9 33, 945	9	65.00
66.00 67.00	06600 PHYSI CAL THERAPY 06700 OCCUPATI ONAL THERAPY	0	14, 758	7,67	2 22, 430	11	66.00 67.00
68.00	06800 SPEECH PATHOLOGY	0	0	(		1	68.00
69.00	06900 ELECTROCARDI OLOGY	0	0	(	o c	0	69.00
71.00 72.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT 07200 IMPL. DEV. CHARGED TO PATIENTS	0	0	(		0	71.00
	07300 DRUGS CHARGED TO PATIENTS	0	0			1	•
76.97	07697 CARDI AC REHABI LI TATI ON	0	0		0 0	0	•
76. 98 76. 99	07698 HYPERBARI C OXYGEN THERAPY 07699 LI THOTRI PSY	0	0			0	
	OUTPATIENT SERVICE COST CENTERS	1 9	٩			~	
91.00 92.00	09100 EMERGENCY 09200 OBSERVATION BEDS (NON-DISTINCT PART	0	9, 078	28, 80	3 37, 881 0	15	91.00 92.00
72.00	OTHER REIMBURSABLE COST CENTERS				V		72.00
95.00	09500 AMBULANCE SERVICES	0	6, 296	154, 30	8 160, 604	25	95.00
113 00	SPECIAL PURPOSE COST CENTERS						113.00
118.00	SUBTOTALS (SUM OF LINES 1-117)	1, 974, 536	206, 281	706, 70	9 2, 887, 526	232	118.00
100.00	NONREIMBURSABLE COST CENTERS	0	0			0	190.00
	19000 GFFT, FLOWER, COFFEE SHOP & CANTEEN 19200 PHYSI CLANS' PRI VATE OFFI CES	0	0 0	88	0 0 6 886		190.00
	07950 OCC HEALTH	0	489	(	0 489		194.00
	O7951 PAIN CLINIC 207952 OCC HEALTH	0	0	(			194. 01 194. 02
194.03	07953 FOUNDATI 0	0	0				194.02
	07954 KIDS CAMPUS	0	0	(	0 0		194.04
	07955 COMMUNITY & VOLUNTEER SERVICES 07956 HUNTINGTON COLLEGE NURSE	0	0				194.05 194.06
194.07	07957 MISC CATERING	0	0	(		1	194. 07
	07958 AUTI SM CENTER	0	0	(	0 0		194.08
194 ()9	07959 HUNTINGTON BUA Cross Foot Adjustments	0	0	(		0	194.09 200.00
200. 00 201. 00 202. 00	Negative Cost Centers	1, 974, 536	0 206, 770	, 707, 59	0 0 5 2, 888, 901		201. 00 202. 00

Health Financial Systems	HUNTI NGTON MEMOR	AL HOSPITAL		In Lie	u of Form CMS-:	2552-10
ALLOCATION OF CAPITAL RELATED COSTS		Provider CC		eriod: rom 01/01/2016 o 12/31/2016	Worksheet B Part II Date/Time Pre 5/19/2017 9:1	pared: 3 am
Cost Center Description	ADMI NI STRATI VE	MAINTENANCE &	OPERATION OF	LAUNDRY &	HOUSEKEEPI NG	
	& GENERAL	REPAI RS	PLANT	LINEN SERVICE		
	5.00	6.00	7.00	8.00	9.00	
GENERAL SERVICE COST CENTERS 1. 00 00100 CAP REL COSTS-BLDG & FIXT						1.00
2.00 00200 CAP REL COSTS-BLDG & FIXT						2.00
4.00 00400 EMPLOYEE BENEFITS DEPARTMENT						4.00
5. 00 00500 ADMI NI STRATI VE & GENERAL	1, 998, 876					5.00
6.00 00600 MAINTENANCE & REPAIRS	0	0				6.00
7.00 00700 OPERATION OF PLANT	116, 102	0	194, 823			7.00
8.00 00800 LAUNDRY & LINEN SERVICE	15, 200	0	1, 568			8.00
9.00 00900 HOUSEKEEPI NG	35, 676	0	1, 277		37, 868	9.00
10. 00 01000 DI ETARY	16, 645	0	12, 198		2,406	
11.00 01100 CAFETERIA 12.00 01200 MAINTENANCE OF PERSONNEL	18, 840	0	2, 768 0		546 0	11.00 12.00
13. 00 01300 NURSI NG ADMI NI STRATI ON	19,070	0	0	0	0	12.00
14. 00 01400 CENTRAL SERVICES & SUPPLY	283	0	4, 750	-	937	14.00
15. 00 01500 PHARMACY	57, 579	0	2, 880		568	15.00
16.00 01600 MEDICAL RECORDS & LIBRARY	95	0	1, 591	0	314	16.00
17.00 01700 SOCIAL SERVICE	0	0	0	0	0	17.00
19.00 01900 NONPHYSICIAN ANESTHETISTS	0	0	0	0	0	19.00
20. 00 02000 NURSI NG SCHOOL	0	0	0	0	0	20.00
21.00 02100 I &R SERVICES-SALARY & FRINGES APPRV 22.00 02200 I &R SERVICES-OTHER PRGM COSTS APPRV	0	0	0	0	0	21.00
22.00 02200 I&R SERVICES-OTHER PRGM COSTS APPRV 23.00 02300 PARAMED ED PRGM-(SPECIFY)	0	0	-	-	0	22.00 23.00
INPATIENT ROUTINE SERVICE COST CENTERS	<u> </u>		0	<u> </u>	0	23.00
30. 00 03000 ADULTS & PEDI ATRI CS	280, 273	0	62, 732	5, 428	12, 374	30.00
43. 00 04300 NURSERY	13, 244	0	254	294	50	43.00
ANCI LLARY SERVI CE COST CENTERS						
50.00 05000 OPERATING ROOM	92, 982	0		2, 873	4, 714	50.00
52. 00 05200 DELIVERY ROOM & LABOR ROOM 53. 00 05300 ANESTHESI OLOGY	55, 083 46, 203	0	0	1, 225 0	0	52.00 53.00
54. 00  05400  RADI OLOGY - DI AGNOSTI C	151, 498	0	29, 951	996	5, 908	54.00
60. 00 06000 LABORATORY	177, 874	0	4, 538		895	60.00
62. 30 06250 BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0	0	0	62.30
65. 00 06500 RESPI RATORY THERAPY	70, 791	0	3, 356	1, 065	662	65.00
66.00 06600 PHYSI CAL THERAPY	83, 953	0	20, 755		4, 094	66.00
67.00 06700 OCCUPATIONAL THERAPY	21, 761	0	0		0	67.00
68. 00 06800 SPEECH PATHOLOGY 69. 00 06900 ELECTROCARDI OLOGY	6, 969	0	0	0	0	68.00 69.00
71. 00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	61, 049	0	0	0	0	71.00
72. 00 07200 IMPL. DEV. CHARGED TO PATIENTS	70,009	0	0	0	0	72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	185, 631	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 OXYGEN THERAPY	971	0	0	0	0	76. 98
76. 99 07699 LI THOTRI PSY	0	0	0	0	0	76.99
0UTPATIENT SERVICE COST CENTERS 91. 00 09100 EMERGENCY	123, 240	0	12, 766	5, 279	2, 518	91.00
92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART	123, 240	0	12,700	5,219	2, 310	91.00
OTHER REIMBURSABLE COST CENTERS						72.00
95.00 09500 AMBULANCE SERVICES	208, 015	0	8, 854	242	1, 746	95.00
SPECIAL PURPOSE COST CENTERS	1 1			1		
113.00 11300 INTEREST EXPENSE		_				113.00
118.00 SUBTOTALS (SUM OF LINES 1-117)	1, 929, 036	0	194, 135	17, 475	37, 732	118.00
NONREI MBURSABLE COST CENTERS 190. 00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
192. 00 19200 PHYSI CLANS' PRI VATE OFFICES	8, 756	0				192.00
194. 00 07950 OCC HEALTH	41	0				194.00
194. 01 07951 PAIN CLINIC	0	0				194.01
194.02079520CC HEALTH	0	0	0	0		194. 02
194. 03 07953 FOUNDATI 0	6, 712	0	0	0		194.03
194. 04 07954 KIDS CAMPUS	0	0	0	0		194.04
194.05 07955 COMMUNI TY & VOLUNTEER SERVICES 194.06 07956 HUNTINGTON COLLEGE NURSE	36, 200	0	0			194. 05 194. 06
194. 07 07957 MI SC CATERING	12, 534	0	0	0		194.06
194. 08 07958 AUTI SM CENTER	5, 597	0	0	0		194.08
194. 09 07959 HUNTI NGTON BUA	0	0	0	Ő		194.09
200.00 Cross Foot Adjustments						200. 00
201.00 Negative Cost Centers	0	0		0		201.00
202.00   TOTAL (sum lines 118-201)	1, 998, 876	0	194, 823	17, 883	37, 868	202.00

Health Financial Systems	HUNTI NGTON MEMOR	REAL HOSPETAL		In Lie	u of Form CMS-:	2552-10
ALLOCATION OF CAPITAL RELATED COSTS		Provider CO		Period: From 01/01/2016 To 12/31/2016	Worksheet B Part II Date/Time Pre 5/19/2017 9:1	pared: 3 am
Cost Center Description	DI ETARY	CAFETERI A	MAINTENANCE O PERSONNEL	F NURSI NG ADMI NI STRATI ON	CENTRAL SERVI CES & SUPPLY	
GENERAL SERVICE COST CENTERS	10.00	11.00	12.00	13.00	14.00	
1.00 00100 CAP REL COSTS-BLDG & FIXT						1.00
2.00         00200         CAP REL COSTS-MVBLE EQUIP           4.00         00400         EMPLOYEE BENEFITS DEPARTMENT           5.00         00500         ADMI NI STRATI VE & GENERAL           6.00         00600         MAI NTENANCE & REPAIRS           7.00         00700         OPERATI ON OF PLANT           8.00         00800         LAUNDRY & LI NEN SERVI CE           9.00         00900         HOUSEKEEPI NG           10.00         01000         DI ETARY           11.00         01100         CAFETERI A           12.00         01200         MAI NTENANCE OF PERSONNEL           13.00         01300         NURSI NG ADMI NI STRATI ON           14.00         01400         CENTRAL SERVI CES & SUPPLY           15.00         01500         PHARMACY           16.00         01600         MEDI CAL RECORDS & LI BRARY           17.00         01700         SOCI AL SERVI CE           19.00         01900         NONPHYSI CI AN ANESTHETI STS           20.00         02000         NURSI NG SCHOOL	41, 565 0 0 0 0 0 0 0 0 0 0 0 0	24, 125 0 333 0 664 0 0 0 0 0		0 0 19, 406 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	9, 418 113 0 0 0 0 0	$\begin{array}{c} 2.\ 00\\ 4.\ 00\\ 5.\ 00\\ 6.\ 00\\ 7.\ 00\\ 8.\ 00\\ 9.\ 00\\ 10.\ 00\\ 11.\ 00\\ 12.\ 00\\ 13.\ 00\\ 14.\ 00\\ 15.\ 00\\ 16.\ 00\\ 17.\ 00\\ 19.\ 00\\ 20.\ 00\\ \end{array}$
21.00 02100 I &R SERVICES-SALARY & FRINGES APPRV 22.00 02200 I &R SERVICES-OTHER PRGM COSTS APPRV	0	0		0 0 0 0	0	
23.00 02300 PARAMED ED PRGM-(SPECIFY)	0	0		0 0	0	•
INPATIENT ROUTINE SERVICE COST CENTERS	· · · · · · · · · · · · · · · · · · ·					
30. 00 03000 ADULTS & PEDIATRICS 43. 00 04300 NURSERY	41, 565 0	6, 175 273		0 9, 923 0 438	728 0	
ANCI LLARY SERVI CE COST CENTERS						
50. 00 05000 OPERATING ROOM	0	1, 973		0 3, 170	1, 184	•
52. 00 05200 DELIVERY ROOM & LABOR ROOM 53. 00 05300 ANESTHESI OLOGY	0	1, 135 0		0 1,824 0 0	0	
54. 00 05400 RADI OLOGY-DI AGNOSTI C	0	2, 020		0 0	218	
60. 00 06000 LABORATORY	0	0		0 0	3	1
62. 30 06250 BLOOD CLOTTING FOR HEMOPHILIACS 65. 00 06500 RESPIRATORY THERAPY	0	0 1, 483		0 0 0 0	0 312	
66. 00 06600 PHYSI CAL THERAPY	0	1, 403		0 0	107	
67.00 06700 OCCUPATI ONAL THERAPY	0	456		0 0	0	
68. 00 06800 SPEECH PATHOLOGY 69. 00 06900 ELECTROCARDI OLOGY	0	146 0		0 0 0 0	0	
69.00 06900 ELECTROCARDIOLOGY 71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0	0		0 0	5, 382	
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0	0		0 0	0	1
73. 00 07300 DRUGS CHARGED TO PATIENTS	0	0		0 0	260	•
76. 97 07697 CARDI AC REHABI LI TATI ON 76. 98 07698 HYPERBARI C OXYGEN THERAPY	0	0		0 0 0 0	0	
76. 99 07699 LI THOTRI PSY	0	0		0 0	0	
0UTPATI ENT SERVICE COST CENTERS 91.00 09100 EMERGENCY	0	2 5 2 1		0 4, 051	459	91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART	0	2, 521		0 4, 051	409	91.00
OTHER REIMBURSABLE COST CENTERS						
95. 00 09500 AMBULANCE SERVICES SPECIAL PURPOSE COST CENTERS	0	4, 718		0 0	613	95.00
113.00 11300 INTEREST EXPENSE						113.00
118.00 SUBTOTALS (SUM OF LINES 1-117) NONRELIMBURSABLE COST CENTERS	41, 565	23, 406		0 19, 406		118.00
190. 00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN 192. 00 19200 PHYSICIANS' PRIVATE OFFICES	0	0 226		0 0 0 0		190. 00 192. 00
194.0007950 OCC HEALTH	0	0		0 0		194.00
194. 01 07951 PALN CLINIC	0	0		0 0		194. 01
194. 02 07952  0CC HEALTH 194. 03 07953  FOUNDATI 0	0	0 133		0 0 0 0		194. 02 194. 03
194. 04 07954 KLDS_CAMPUS	0	0		0 0		194.03
194. 05 07955 COMMUNI TY & VOLUNTEER SERVICES	0	13		0 0	3	194.05
194. 06 07956 HUNTI NGTON COLLEGE NURSE	0	0		0 0		194. 06 194. 07
194. 07 07957 MISC CATERING 194. 08 07958 AUTISM CENTER	0	347 0		0 0 0 0		194. 07 194. 08
194. 09 07959 HUNTI NGTON BUA	Ő	0		0 0		194.09
200.00 Cross Foot Adjustments		~			_	200.00
201.00Negative Cost Centers202.00TOTAL (sum lines 118-201)	41, 565	0 24, 125		0 0 0 19, 406		201. 00 202. 00
	11,000	21,120	I	1, 100	,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,	

	Financial Systems ATION OF CAPITAL RELATED COSTS	HUNTI NGTON MEMOR	Provider CC	N: 15-0091	In Lie Period:	u of Form CMS- Worksheet B	2552-10
ALLOOP	THOR OF CALLINE RELATED COSTS			N. 13-0071	From 01/01/2016 To 12/31/2016	Part II	
	Cost Center Description	PHARMACY	MEDI CAL RECORDS & LI BRARY	SOCIAL SERVIC	E NONPHYSI CI AN ANESTHETI STS	NURSI NG SCHOOL	-
		15.00	16.00	17.00	19.00	20.00	
1.00	GENERAL SERVICE COST CENTERS 00100 CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200 CAP REL COSTS-BEDG & TTXT						2.00
4.00	00400 EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500 ADMINI STRATI VE & GENERAL						5.00
6.00	00600 MAI NTENANCE & REPAI RS						6.00
7.00	00700 OPERATION OF PLANT						7.00
8.00	00800 LAUNDRY & LINEN SERVICE						8.00
9.00 10.00	00900 HOUSEKEEPI NG 01000 DI ETARY						9.00
11.00	01100 CAFETERIA						11.00
12.00	01200 MAINTENANCE OF PERSONNEL						12.00
13.00	01300 NURSI NG ADMI NI STRATI ON						13.00
14.00	01400 CENTRAL SERVICES & SUPPLY						14.00
15.00	01500 PHARMACY	124, 601	0 101				15.00
16.00 17.00	01600 MEDI CAL RECORDS & LI BRARY 01700 SOCI AL SERVI CE	0	3, 131 0		0		16.00
19.00	01900 NONPHYSICIAN ANESTHETISTS	0	0		0 0		19.00
20.00	02000 NURSI NG SCHOOL	0	0		0	0	
21.00	02100 I &R SERVICES-SALARY & FRINGES APPRV	0	0		0		21.00
22.00	02200 I &R SERVICES-OTHER PRGM COSTS APPRV	0	0		0		22.00
23.00	02300 PARAMED ED PRGM-(SPECIFY)	0	0		0		23.00
30. 00	I NPATI ENT ROUTI NE SERVI CE COST CENTERS 03000 ADULTS & PEDI ATRI CS	0	171		0		30.00
43.00	04300 NURSERY	0	17		0		43.00
10.00	ANCI LLARY SERVI CE COST CENTERS	0			0		10.00
50.00	05000 OPERATING ROOM	0	413		0		50.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0	74		0		52.00
53.00	05300 ANESTHESI OLOGY	0	67		0		53.00
54.00	05400 RADI OLOGY-DI AGNOSTI C	0	694		0		54.00
60.00 62.30	06000 LABORATORY 06250 BLOOD CLOTTING FOR HEMOPHILIACS	0	320 0		0		60.00 62.30
65.00	06500 RESPIRATORY THERAPY	0	106		0		65.00
66.00	06600 PHYSI CAL THERAPY	0	80		0		66.00
67.00	06700 OCCUPATI ONAL THERAPY	0	23		0		67.00
68.00	06800 SPEECH PATHOLOGY	0	7		0		68.00
69.00	06900 ELECTROCARDI OLOGY	0	19		0		69.00
71.00 72.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT 07200 IMPL. DEV. CHARGED TO PATIENTS	0	210 118		0		71.00
73.00	07300 DRUGS CHARGED TO PATIENTS	124, 601	269		0		73.00
76.97	07697 CARDI AC REHABI LI TATI ON	0	0		0		76.97
76. 98	07698 HYPERBARI C OXYGEN THERAPY	0	4		0		76. 98
76.99	07699 LI THOTRI PSY	0	0		0		76.99
01 00	OUTPATIENT SERVICE COST CENTERS						0.1 0.0
91.00 92.00	09100 EMERGENCY 09200 OBSERVATI ON BEDS (NON-DI STI NCT PART	0	389		0		91.00 92.00
92.00	OTHER REIMBURSABLE COST CENTERS						92.00
95.00	09500 AMBULANCE SERVICES	0	150		0		95.00
	SPECIAL PURPOSE COST CENTERS						
	11300 INTEREST EXPENSE						113.00
118.00		124, 601	3, 131		0 0	0	118.00
100.00	NONREIMBURSABLE COST CENTERS 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN		0		0		100.00
	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0		0		190.00 192.00
	07950 OCC HEALTH	0	0		0		194.00
	07951 PAIN CLINIC	0	0		0		194.01
	207952 OCC HEALTH	0	0		0		194. 02
		0	0		0		194.03
	107954 KIDS CAMPUS	0	0		0		194.04
	07955 COMMUNI TY & VOLUNTEER SERVI CES 07956 HUNTI NGTON COLLEGE NURSE	0	0		0		194.05 194.06
	07958 HUNTINGTON COLLEGE NORSE	0	0		0		194.06
	307958 AUTI SM CENTER	0	0		0		194.08
	07959 HUNTI NGTON BUA	0	0		0		194.09
194.09							
200.00					0		200.00
	Negative Cost Centers	0 124, 601	0 3, 131		0 0 0 0	0	200.00

	Financial Systems TION OF CAPITAL RELATED COSTS	HUNTINGTON MEMO	Provi der CC		Period: From 01/01/2016	u of Form CMS-: Worksheet B Part II	
					To 12/31/2016		pared: 3 am
		INTERNS &	RESI DENTS				
	Cost Center Description	SERVI CES-SALAR Y & FRI NGES APPRV	SERVI CES-OTHER PRGM COSTS APPRV	PARAMED ED PRGM	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	
		21.00	22.00	23.00	24.00	25.00	
	GENERAL SERVICE COST CENTERS						1 1 00
$\begin{array}{c} 11. \ 00\\ 12. \ 00\\ 13. \ 00\\ 14. \ 00\\ 15. \ 00\\ 16. \ 00\\ 17. \ 00\\ 19. \ 00\\ 20. \ 00\\ 21. \ 00 \end{array}$	00100 CAP REL COSTS-BLDG & FIXT 00200 CAP REL COSTS-WUBLE EQUIP 00400 EMPLOYEE BENEFITS DEPARTMENT 00500 ADMINISTRATIVE & GENERAL 00600 MAINTENANCE & REPAIRS 00700 OPERATION OF PLANT 00800 LAUNDRY & LINEN SERVICE 00900 HOUSEKEEPING 01000 DI ETARY 01100 CAFETERIA 01200 MAINTENANCE OF PERSONNEL 01300 NURSING ADMINISTRATION 01400 CENTRAL SERVICES & SUPPLY 01500 PHARMACY 01600 MEDICAL RECORDS & LIBRARY 01700 SOCIAL SERVICE 01900 NURSING SCHOOL 02100 I& SERVICES-SALARY & FRINGES APPRV 02200 I & SERVICES-OTHER PRGM COSTS APPRV	0	0				1.00 2.00 4.00 5.00 6.00 9.00 10.00 11.00 12.00 13.00 14.00 15.00 14.00 15.00 14.00 17.00 20.00 21.00 22.00
23.00	02300 PARAMED ED PRGM-(SPECIFY)				D		23.00
30.00	INPATIENT ROUTINE SERVICE COST CENTERS 03000 ADULTS & PEDIATRICS				549, 913	0	30.00
	04300 NURSERY				14, 753	0	43.00
	ANCI LLARY SERVI CE COST CENTERS				05/ 0/0		
	05000 OPERATING ROOM 05200 DELIVERY ROOM & LABOR ROOM				256, 062	0	50.00 52.00
	05300 ANESTHESI OLOGY				59, 348 46, 270	0	52.00
	05400 RADI OLOGY-DI AGNOSTI C				405, 847	0	54.00
	06000 LABORATORY				186, 857	0	60.00
62.30	06250 BLOOD CLOTTING FOR HEMOPHILIACS				0	0	62.30
65.00	06500 RESPI RATORY THERAPY				111, 729	0	65.00
66.00	06600 PHYSI CAL THERAPY				132, 939	0	66.00
67.00	06700 OCCUPATI ONAL THERAPY				22, 243	0	67.00
	06800 SPEECH PATHOLOGY				7, 123	0	68.00
	06900 ELECTROCARDI OLOGY				19	0	69.00
	07100 MEDICAL SUPPLIES CHARGED TO PATIENT				66, 641	0	
	07200 I MPL. DEV. CHARGED TO PATIENTS				70, 127	0	
	07300 DRUGS CHARGED TO PATIENTS 07697 CARDIAC REHABILITATION				310, 762	0	73.00
	07698 HYPERBARI C OXYGEN THERAPY				981	0	76.97
	07699 LI THOTRI PSY				0	0	
	OUTPATIENT SERVICE COST CENTERS		I				
91.00	09100 EMERGENCY				189, 119	0	91.00
	09200 OBSERVATION BEDS (NON-DISTINCT PART					0	92.00
	OTHER REIMBURSABLE COST CENTERS				-		
95.00	09500 AMBULANCE SERVICES				384, 967	0	95.00
112 00	SPECIAL PURPOSE COST CENTERS						112 00
113.00	11300 INTEREST EXPENSE SUBTOTALS (SUM OF LINES 1-117)	0	о		2, 815, 700	0	113.00 118.00
110.00	NONREI MBURSABLE COST CENTERS	0	0		2, 815, 700	0	110.00
190 00	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN				0	0	190.00
	19200 PHYSI CLANS' PRI VATE OFFI CES				10, 307		192.00
	07950 OCC HEALTH				1, 354		194.00
	07951 PAIN CLINIC				0	0	194.01
194.02	07952 OCC HEALTH				0	0	194. 02
	07953 FOUNDATI 0				6, 845		194.03
	07954 KIDS CAMPUS				0		194.04
	07955 COMMUNITY & VOLUNTEER SERVICES				36, 216		194.05
	07956 HUNTI NGTON COLLEGE NURSE				10,000		194.06
	07957 MISC CATERING 07958 AUTISM CENTER				12, 882 5, 597		194.07 194.08
	07959 HUNTINGTON BUA				5, 597		194.08
	Cross Foot Adjustments	0	()I	(	) 1		200.00
200.00 201.00		0	0	(			200.00 201.00

ALLOCAT	ION OF CAPITAL RELATED COSTS		Provider CCN: 15-0091	Period: From 01/01/2016	Worksheet B Part II
				To 12/31/2016	Date/Time Prepare 5/19/2017 9:13 am
	Cost Center Description	Total 26.00			
	GENERAL SERVICE COST CENTERS				
1	00100 CAP REL COSTS-BLDG & FIXT				1.
1	00200 CAP REL COSTS-MVBLE EQUIP				2.
	00400 EMPLOYEE BENEFITS DEPARTMENT				4.
1	00500 ADMINI STRATI VE & GENERAL				5.
	00600 MAINTENANCE & REPAIRS				6.
1	00700 OPERATION OF PLANT				7.
	00800 LAUNDRY & LI NEN SERVI CE 00900 HOUSEKEEPI NG				8.
	01000 DI ETARY				9.
	01100 CAFETERI A				11.
	01200 MAINTENANCE OF PERSONNEL				12.
1	01300 NURSI NG ADMI NI STRATI ON				13.
	01400 CENTRAL SERVICES & SUPPLY				13.
	01500 PHARMACY				15.
	01600 MEDICAL RECORDS & LIBRARY				16.
	01700 SOCIAL SERVICE				17.
	01900 NONPHYSICIAN ANESTHETISTS				19.
	02000 NURSI NG SCHOOL				20.
	02100 I &R SERVICES-SALARY & FRINGES APPRV				20.
	02200 I &R SERVICES-OTHER PRGM COSTS APPRV				22.
	02300 PARAMED ED PRGM-(SPECIFY)				23.
-	INPATIENT ROUTINE SERVICE COST CENTERS	L			20.
	03000 ADULTS & PEDIATRICS	549, 913			30.
1	04300 NURSERY	14, 753			43.
	ANCI LLARY SERVICE COST CENTERS	11,700			
	05000 OPERATING ROOM	256, 062			50.
	05200 DELIVERY ROOM & LABOR ROOM	59, 348			52.
1	05300 ANESTHESI OLOGY	46, 270			53.
	05400 RADI OLOGY-DI AGNOSTI C	405, 847			54.
1	06000 LABORATORY	186, 857			60.
	06250 BLOOD CLOTTING FOR HEMOPHILIACS	0			62.
	06500 RESPI RATORY THERAPY	111, 729			65.
1	06600 PHYSI CAL THERAPY	132, 939			66.
7.00	06700 OCCUPATI ONAL THERAPY	22, 243			67.
8.00	06800 SPEECH PATHOLOGY	7, 123			68.
9.00	06900 ELECTROCARDI OLOGY	19			69.
1.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	66, 641			71.
2.00	07200 IMPL. DEV. CHARGED TO PATIENTS	70, 127			72.
3.00	07300 DRUGS CHARGED TO PATIENTS	310, 762			73.
	07697 CARDI AC REHABI LI TATI ON	0			76.
6. 98	07698 HYPERBARI C OXYGEN THERAPY	981			76.
	07699 LI THOTRI PSY	0			76.
	OUTPATIENT SERVICE COST CENTERS				
	09100 EMERGENCY	189, 119			91.
	09200 OBSERVATION BEDS (NON-DISTINCT PART				92.
	OTHER REIMBURSABLE COST CENTERS	001 01-			
	09500 AMBULANCE SERVICES	384, 967			95.
	SPECIAL PURPOSE COST CENTERS				
	11300 INTEREST EXPENSE	2 015 700			113.
18.00	SUBTOTALS (SUM OF LINES 1-117)	2, 815, 700			118.
	VONREIMBURSABLE COST CENTERS				100
	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN 19200 PHYSICIANS' PRIVATE OFFICES	0			190.
	07950 OCC HEALTH	10, 307			192. 194.
	07950 OCC HEALTH 07951 PAIN CLINIC	1,354			194.
	07951 PAIN CLINIC 07952 OCC HEALTH	0			194.
	07952 000 HEALTH 07953 FOUNDATI 0				194.
	07953 FOUNDATTO 07954 KIDS CAMPUS	6, 845			194.
	07954 KIDS CAMPUS 07955 COMMUNITY & VOLUNTEER SERVICES	26 214			194.
		36, 216			
	07956 HUNTI NGTON COLLEGE NURSE	-			194.
	07957 MI SC CATERING	12,882			194.
	07958 AUTI SM CENTER	5, 597			194.
	07959 HUNTINGTON BUA	0			194.
00.00	Cross Foot Adjustments	0			200.
01.00 02.00	Negative Cost Centers	0			201.
00 DO	TOTAL (sum lines 118-201)	2, 888, 901			202.

	Financial Systems LLOCATION - STATISTICAL BASIS	HUNTI NGTON MEMO	DRIAL HOSPITAL		eriod:	u of Form CMS- Worksheet B-1	
					rom 01/01/2016 o 12/31/2016		
	· · · · · · · · · · · · · · · · · · ·	CAPI TAL RE	LATED COSTS			5/19/2017 9:1	
	Cost Center Description	BLDG & FIXT (SQUARE FEET)	MVBLE EQUIP (DOLLAR VALUE)	EMPLOYEE BENEFITS DEPARTMENT (GROSS SALARIES)	Reconciliation	ADMI NI STRATI VE & GENERAL (ACCUM COST)	
		1.00	2.00	4.00	5A	5.00	
1.00	GENERAL SERVICE COST CENTERS 00100 CAP REL COSTS-BLDG & FIXT	11/ / 00					1.00
2.00 4.00 5.00 6.00	00200 CAP REL COSTS-MVBLE EQUIP 00400 EMPLOYEE BENEFITS DEPARTMENT 00500 ADMINISTRATIVE & GENERAL 00600 MAINTENANCE & REPAIRS	116, 622 132 7, 681 0	767, 040 0 11, 541 0	17, 476, 510 5, 308, 256 0	-12, 090, 089 0	0	2.00 4.00 5.00 6.00
7.00 8.00 9.00 10.00 11.00	00700 OPERATION OF PLANT 00800 LAUNDRY & LINEN SERVICE 00900 HOUSEKEEPING 01000 DIETARY 01100 CAFETERIA	30, 673 629 512 4, 892 1, 110	0 0 1, 780	29, 633 307, 376	0 0 0		8.00 9.00 10.00 11.00
12.00 13.00 14.00 15.00 16.00 17.00	01200 MAI NTENANCE OF PERSONNEL 01300 NURSI NG ADMI NI STRATI ON 01400 CENTRAL SERVI CES & SUPPLY 01500 PHARMACY 01600 MEDI CAL RECORDS & LI BRARY 01700 SOCI AL SERVI CE	0 0 1,905 1,155 638	0 65, 845 0	0 210, 106 0 543, 828 0	0	0 227, 380 3, 378 686, 538 1, 131 0	13.00 14.00 15.00 16.00
19.00 20.00 21.00 22.00 23.00	01900 NONPHYSI CI AN ANESTHETI STS 02000 NURSI NG SCHOOL 02100 I &R SERVI CES-SALARY & FRI NGES APPRV 02200 I &R SERVI CES-OTHER PRGM COSTS APPRV 02300 PARAMED ED PRGM-(SPECI FY)				0 0 0 0	0 0 0 0	19.00 20.00 21.00 22.00
30.00 43.00	I NPATI ENT ROUTI NE SERVI CE COST CENTERS 03000 ADULTS & PEDI ATRI CS 04300 NURSERY	25, 160 102					
50.00 52.00	ANCI LLARY SERVICE COST CENTERS 05000 OPERATI NG ROOM 05200 DELIVERY ROOM & LABOR ROOM	9, 584		948, 310 537, 578	0	656, 782	52.00
53.00 54.00 60.00 62.30	05300 ANESTHESI OLOGY 05400 RADI OLOGY-DI AGNOSTI C 06000 LABORATORY 06250 BLOOD CLOTTI NG FOR HEMOPHI LI ACS	12, 012 1, 820	0	951, 333 0	0 0 0 0	550, 901 1, 806, 392 2, 120, 880 0	54.00 60.00
65. 00 66. 00 67. 00 68. 00 69. 00	06500 RESPI RATORY THERAPY 06600 PHYSI CAL THERAPY 06700 OCCUPATI ONAL THERAPY 06800 SPEECH PATHOLOGY 06900 ELECTROCARDI OLOGY	1, 346 8, 324 0 0			0 0 0	844, 074 1, 001, 014 259, 469	65.00 66.00 67.00 68.00
71.00 72.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT 07200 IMPL. DEV. CHARGED TO PATIENTS 07300 DRUGS CHARGED TO PATIENTS 07697 CARDIAC REHABILITATION		0	0 0 69, 054	0	727, 923 834, 749 2, 213, 376	71.00 72.00 73.00
76. 97 76. 98 76. 99	07698 HYPERBARI C OXYGEN THERAPY 07699 LI THOTRI PSY		0	8, 789 0		11, 573	76. 98
91. 00 92. 00	OUTPATIENT SERVICE COST CENTERS 09100 EMERGENCY 09200 OBSERVATION BEDS (NON-DISTINCT PART	5, 120	31, 223	1, 153, 225	0	1, 469, 453	91.00 92.00
95.00	OTHER REIMBURSABLE COST CENTERS 09500 AMBULANCE SERVICES SPECIAL PURPOSE COST CENTERS	3, 551	167, 271	1, 935, 314	0	2, 480, 262	95.00
113.00 118.00	11300 I NTEREST EXPENSE	116, 346	766, 080	17, 325, 229	-12, 090, 089	23, 000, 971	113. 00 118. 00
192.00 194.00	19900 GIFT, FLOWER, COFFEE SHOP & CANTEEN 19200 PHYSI CIANS' PRIVATE OFFICES 07950 OCC HEALTH 07951 PAIN CLINIC	0 0 276	960	0 74, 431 0	0 0 0 0	104, 406 489	190. 00 192. 00 194. 00 194. 01
194.02 194.03 194.04	07952 OCC HEALTH 07953 FOUNDATI 0 07954 KI DS CAMPUS			0 0 29 0	0 0 0	0 80, 033 0	194. 02 194. 03 194. 04
194.06 194.07	07955 COMMUNITY & VOLUNTEER SERVICES 07956 HUNTINGTON COLLEGE NURSE 07957 MISC CATERING 07958 AUTISM CENTER			4, 662 0 72, 159 0	0	0 149, 451	194.06
	07959 HUNTINGTON BUA Cross Foot Adjustments Negative Cost Centers	206, 770	0 707, 595	0	0		194. 09 200. 00 201. 00
202.00	Part I)	1. 772993				0. 507268	

Health Financial Systems	HUNTI NGTON MEMO	RIAL HOSPITAL		In Lieu of Form CMS-2552-10			
COST ALLOCATION - STATISTICAL BASIS		Provider CO		Period: From 01/01/2016	Worksheet B-1		
				To 12/31/2016			
	CAPI TAL REL	ATED COSTS					
Cost Center Description	BLDG & FIXT (SQUARE FEET)	MVBLE EQUIP (DOLLAR VALUE)	EMPLOYEE BENEFI TS DEPARTMENT (GROSS SALARI ES)	Reconci l i ati on	ADMI NI STRATI VE & GENERAL (ACCUM COST)		
	1.00	2.00	4.00	5A	5.00		
204.00 Cost to be allocated (per Wkst. B, Part II)			23	4	1, 998, 876	204.00	
205.00 Unit cost multiplier (Wkst. B, Part			0. 00001	3	0. 083868	205.00	

COST AL	Financial Systems LOCATION - STATISTICAL BASIS		Provider C		eriod: rom 01/01/2016	Worksheet B-1	
				Т	0 12/31/2016	Date/Time Pre 5/19/2017 9:1	
	Cost Center Description	MAI NTENANCE & REPAI RS (SQUARE FEET)	OPERATION OF PLANT (SQUARE FEET)	LAUNDRY & LI NEN SERVI CE (POUNDS OF	HOUSEKEEPI NG (SQUARE FEET)	DIETARY	
		6.00	7.00	LAUNDRY) 8.00	9.00	10.00	
	GENERAL SERVICE COST CENTERS						1 1 0
2.00 4.00 5.00 5.00	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	0	78, 136				1. 0 2. 0 4. 0 5. 0 6. 0 7. 0
. 00	00800 LAUNDRY & LI NEN SERVI CE 00900 HOUSEKEEPI NG 01000 DI ETARY	0	629 512 4, 892	38	76, 995	27, 536	8. 0 9. 0 10. 0
	01100 CAFETERIA	0	1, 110		1, 110	27, 330	
1	01200 MAINTENANCE OF PERSONNEL	0	0	-	-	0	
	01300 NURSI NG ADMI NI STRATI ON 01400 CENTRAL SERVI CES & SUPPLY	0	0 1, 905	0 1, 003	-	0	
	01500 PHARMACY	0	1, 155			0	
	01600 MEDI CAL RECORDS & LI BRARY	0	638			0	16.0
	01700 SOCIAL SERVICE	0	0	0	0	0	17.0
	01900 NONPHYSICIAN ANESTHETISTS 02000 NURSING SCHOOL	0		0	0	0	19.0
	02100 I&R SERVICES-SALARY & FRINGES APPRV	0	0	0	0	0	
	02200 I &R SERVICES-OTHER PRGM COSTS APPRV	0	0	0	0	0	
	02300 PARAMED ED PRGM-(SPECIFY)	0	0	0	0	0	23.0
	INPATIENT ROUTINE SERVICE COST CENTERS 03000 ADULTS & PEDIATRICS	0	25, 160	78, 026	25, 160	27, 536	30. (
	04300 NURSERY	0				27, 330	1
	ANCILLARY SERVICE COST CENTERS			1			
1	05000 OPERATING ROOM	0		41, 283		0	
1	05200 DELI VERY ROOM & LABOR ROOM 05300 ANESTHESI OLOGY	0	0	17, 599 0	0	0	
	05400 RADI OLOGY-DI AGNOSTI C	0	12, 012	-	12, 012	0	
	06000 LABORATORY	0	1, 820			0	
1	06250 BLOOD CLOTTING FOR HEMOPHILIACS 06500 RESPIRATORY THERAPY	0	0	-	-	0	62.3
	06600 PHYSI CAL THERAPY	0	1, 346 8, 324		1, 346 8, 324	0	66.0
	06700 OCCUPATI ONAL THERAPY	0	0	0	0	0	67.
	06800 SPEECH PATHOLOGY	0	0	0	0	0	
	06900 ELECTROCARDI OLOGY 07100 MEDI CAL SUPPLI ES CHARGED TO PATI ENT	0			0	0	
1	07200 IMPL. DEV. CHARGED TO PATIENTS	0	0	Ő	0	0	
	07300 DRUGS CHARGED TO PATIENTS	0	0	0	0	0	
	07697 CARDI AC REHABI LI TATI ON 07698 HYPERBARI C OXYGEN THERAPY	0	0	0	0	0 0	
	07699 LI THOTRI PSY	0		0	0	0	
	OUTPATIENT SERVICE COST CENTERS	-			· · · ·		
	09100 EMERGENCY	0	5, 120	75, 864	5, 120	0	
	09200 OBSERVATION BEDS (NON-DISTINCT PART OTHER REIMBURSABLE COST CENTERS						92.
	09500 AMBULANCE SERVICES	0	3, 551	3, 482	3, 551	0	95.
	SPECIAL PURPOSE COST CENTERS			1			
13. 00 18. 00	11300 INTEREST EXPENSE SUBTOTALS (SUM OF LINES 1-117)	0	77 040	251 120	76 710	27, 536	113. 118
	NONREIMBURSABLE COST CENTERS	0	77, 860	251, 139	76, 719	27, 530	1110.
90.00	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0		0	0		190. (
	19200 PHYSI CLANS' PRI VATE OFFI CES	0		5, 860			192.
	07950 OCC HEALTH 07951 PAIN CLINIC	0	276		276 0		194. ( 194. (
	07952 OCC HEALTH	0	0	0	0		194.
94.03	07953 FOUNDATI 0	0	0	0	0	0	194. (
	07954 KIDS CAMPUS	0	0	0	0		194. (
1	07955 COMMUNITY & VOLUNTEER SERVICES 07956 HUNTINGTON COLLEGE NURSE				0		194. ( 194. (
	07957 MI SC CATERI NG	0	0	0	0		194. (
94.08	07958 AUTI SM CENTER	0	0	0	0	0	194.
	07959 HUNTINGTON BUA	0	0	0	0	0	194.
00.00 01.00	Cross Foot Adjustments Negative Cost Centers						200. 201.
00.00 02.00	Cost to be allocated (per Wkst. B,	0	2, 086, 580	289, 973	654, 873	471, 393	
	Part I)						
03.00 04.00	Unit cost multiplier (Wkst. B, Part I) Cost to be allocated (per Wkst. B,	0. 000000				17. 119153 41, 565	
	TUST TO DE ALLUCATED (DEL WKSL, B.	0	194, 823	1 17,003	J/, 808	41.005	1204.

Health Financial Systems	HUNTI NGTON MEMO	RIAL HOSPITAL		In Lieu of Form CMS-2552-10		
COST ALLOCATION - STATISTICAL BASIS		Provi der C		Period: From 01/01/2016	Worksheet B-1	
				o 12/31/2016		
Cost Center Description	MAINTENANCE &	OPERATION OF	LAUNDRY &	HOUSEKEEPI NG	DI ETARY	
	REPAI RS	PLANT	LINEN SERVICE	(SQUARE FEET)	(MEALS SERVED)	
	(SQUARE FEET)	(SQUARE FEET)	(POUNDS OF			
			LAUNDRY)			
	6.00	7.00	8.00	9.00	10.00	
205.00 Unit cost multiplier (Wkst. B, Part	0. 000000	2. 493383	0. 069584	0. 491824	1. 509479	205.00
		1	1	1		

	ATION - STATISTICAL BASIS		FIOVICE			eriod: com 01/01/2016 0 12/31/2016	Worksheet B-1 Date/Time Pre	
	Cast Contor Description	CAFETERI A	MAI NTENANCE	OF	NURSING	CENTRAL	5/19/2017 9:1 PHARMACY	3 am
	Cost Center Description	(HOURS OF SERVICE)	PERSONNEL (NUMBER HOUSED)	_ /	ADMI NI STRATI ON	SERVICES & SUPPLY (COSTED	(COSTED REQUIS.)	
			HOUSED)		HRS)	REQUIS.)		
CENE		11.00	12.00		13.00	14.00	15.00	
	RAL SERVICE COST CENTERS							1.
	O CAP REL COSTS-MVBLE EQUI P							2.
	0 EMPLOYEE BENEFITS DEPARTMENT 0 ADMINISTRATIVE & GENERAL							4. 5.
	O MAINTENANCE & REPAIRS							6.
	O OPERATION OF PLANT							7.
	O LAUNDRY & LINEN SERVICE							8.
	O HOUSEKEEPI NG							9.
	O DI ETARY O CAFETERI A	377, 061						10. 11.
	O MAINTENANCE OF PERSONNEL	0		o				12.
	O NURSI NG ADMI NI STRATI ON	5, 207		0	188, 736			13.
	0 CENTRAL SERVICES & SUPPLY	0		0	0	2, 735, 871		14.
	O PHARMACY	10, 378		0	0	32, 767	100	
	0 MEDICAL RECORDS & LIBRARY 0 SOCIAL SERVICE	0		0	0	0	0	16. 17.
	O NONPHYSI CI AN ANESTHETI STS	0		0	0	0	0	19
	O NURSING SCHOOL	0		0	0	0	0	20.
	0 I&R SERVICES-SALARY & FRINGES APPRV	0		0	0	0	0	21
	O I &R SERVICES-OTHER PRGM COSTS APPRV	0		0	0	0	0	22
	O PARAMED ED PRGM-(SPECIFY) TIENT ROUTINE SERVICE COST CENTERS	0		0	0	0	0	23
	0 ADULTS & PEDIATRICS	96, 507		0	96, 507	211, 612	0	30
1	0 NURSERY	4, 261		0	4, 261	0	0	43
	LLARY SERVICE COST CENTERS							
	O OPERATING ROOM O DELIVERY ROOM & LABOR ROOM	30, 835 17, 739		0	30, 835 17, 739	343, 841 0	0 0	50 52
	O ANESTHESI OLOGY	17, 739		0	17, 739	0	0	52
	0 RADI OLOGY-DI AGNOSTI C	31, 571		0	0	63, 370	0	54
. 00 0600	0 LABORATORY	0		0	0	1, 002	0	60
1	O BLOOD CLOTTING FOR HEMOPHILIACS	0		0	0	0	0	62
	0 RESPI RATORY THERAPY 0 PHYSI CAL THERAPY	23, 179 23, 579		0	0	90, 716	0	65 66
	0 OCCUPATIONAL THERAPY	7, 133		0	0	31, 167 0	0	67
	O SPEECH PATHOLOGY	2, 284		0	0	0	0	68
	0 ELECTROCARDI OLOGY	0		0	0	0	0	69
	O MEDICAL SUPPLIES CHARGED TO PATIENT	0		0	0	1, 562, 754	0	71
	0 I MPL. DEV. CHARGED TO PATIENTS 0 DRUGS CHARGED TO PATIENTS	0		0	0	75 590	0 100	72
	7 CARDI AC REHABI LI TATI ON	0		0	0	75, 589		76
	8 HYPERBARI C OXYGEN THERAPY	0		0	0	1, 868	0	
	9 LI THOTRI PSY	0		0	0	0	0	76
	ATLENT SERVICE COST CENTERS							
	O EMERGENCY O OBSERVATION BEDS (NON-DISTINCT PART	39, 394		0	39, 394	133, 434	0	91 92
	R REIMBURSABLE COST CENTERS							1 12
	0 AMBULANCE SERVI CES	73, 747		0	0	178, 118	0	95
	I AL PURPOSE COST CENTERS							1110
8.00	O INTEREST EXPENSE SUBTOTALS (SUM OF LINES 1-117)	365, 814		0	188, 736	2, 726, 238	100	113 118
	EIMBURSABLE COST CENTERS	0007011			100,700	2,720,200	100	1.10
	O GIFT, FLOWER, COFFEE SHOP & CANTEEN	0		0	0	0		190
	O PHYSI CLANS' PRI VATE OFFI CES	3, 540		0	0	8, 618		192
	O OCC HEALTH 1 PAIN CLINIC	0		0	0	0		194 194
	2 OCC HEALTH	0		0	0	0		194
4. 03 0795	3 FOUNDATI 0	2, 080		0	0	0	0	194
	4 KIDS CAMPUS	0		0	0	0		194
	5 COMMUNITY & VOLUNTEER SERVICES	201		0	0	1, 015		194
	6 HUNTI NGTON COLLEGE NURSE 7 MI SC CATERI NG	0 5, 426		0	0	0		194 194
	8 AUTI SM CENTER	5, 420		0	0	0		194
	9 HUNTI NGTON BUA	0		0	0	o		194
0.00	Cross Foot Adjustments							200
1.00	Negative Cost Centers				o		a aas =: :	201
2.00	Cost to be allocated (per Wkst. B,	377, 667		0	347, 938	73, 299	1, 086, 738	202
3.00	Part I) Unit cost multiplier (Wkst. B, Part I)	1. 001607	0.000	000	1.843517	0 026792	10, 867. 380000	203
4.00	Cost to be allocated (per Wkst. B,	24, 125	0.000	0	1. 843517	9, 418	124, 601	
4.001		, 0		~1		.,	,	1.2

Health Financial Systems	HUNTINGTON MEMO	ORIAL HOSPITAL		In Lie	u of Form CMS-2	2552-10
COST ALLOCATION - STATISTICAL BASIS		Provider C		Period:	Worksheet B-1	
				rom 01/01/2016 o 12/31/2016	Date/Time Pre	
	_				5/19/2017 9:1	<u>3 am</u>
Cost Center Description	CAFETERI A	MAINTENANCE OF	NURSI NG	CENTRAL	PHARMACY	
	(HOURS OF	PERSONNEL	ADMI NI STRATI ON	SERVICES &	(COSTED	
	SERVICE)	(NUMBER		SUPPLY	REQUIS.)	
		HOUSED)	(DIRECT NRSING	G (COSTED	,	
			HRS)	REQUIS.)		
	11.00	12.00	13.00	14.00	15.00	
205.00 Unit cost multiplier (Wkst. B, Part	0. 063982	0. 000000	0. 102821	0.003442	1, 246. 010000	205.00

COST AL	Financial Systems LOCATION - STATISTICAL BASIS	IUNTI NGTON MEMO	Provider C		Period:	u of Form CMS-2 Worksheet B-1	2002-10
				F	rom 01/01/2016 0 12/31/2016		nared
				!	12/31/2010	5/19/2017 9:1	
						I NTERNS & RESI DENTS	
	Cost Center Description	MEDI CAL	SOCI AL SERVI CE	NONPHYSI CI AN	NURSING SCHOOL		
		RECORDS &	(	ANESTHETI STS	(	Y & FRINGES	
		LI BRARY (GROSS	(TIME SPENT)	(ASSIGNED TIME)	(ASSI GNED TI ME)	APPRV (ASSI GNED	
		REVENUE)		TTWL)	TTWL)	TI ME)	
		16.00	17.00	19.00	20.00	21.00	
	GENERAL SERVICE COST CENTERS						1 1 00
	DO100 CAP REL COSTS-BLDG & FIXT DO200 CAP REL COSTS-MVBLE EQUIP						1.00 2.00
	DO400 EMPLOYEE BENEFITS DEPARTMENT						4.00
	DO500 ADMI NI STRATI VE & GENERAL						5.00
	DO600 MAINTENANCE & REPAIRS						6.00
	DO700 OPERATION OF PLANT						7.00
1	DO800 LAUNDRY & LINEN SERVICE DO900 HOUSEKEEPING						8.00 9.00
	D1000 DI ETARY						10.00
	D1100 CAFETERI A						11.00
	D1200 MAINTENANCE OF PERSONNEL						12.00
	D1300 NURSI NG ADMI NI STRATI ON						13.00
	01400 CENTRAL SERVI CES & SUPPLY 01500 PHARMACY						14.00 15.00
	01600 MEDICAL RECORDS & LIBRARY	162, 369, 521					16.00
	01700 SOCI AL SERVICE	02,007,021					17.00
19.00	01900 NONPHYSI CI AN ANESTHETI STS	C	0	C			19.00
	D2000 NURSING SCHOOL	0	0		0	_	20.00
	D2100 I &R SERVICES-SALARY & FRINGES APPRV	0	0			0	21.00
	D2200 I&R SERVICES-OTHER PRGM COSTS APPRV D2300 PARAMED ED PRGM-(SPECIFY)	0	-				22.00 23.00
	NPATIENT ROUTINE SERVICE COST CENTERS		0				23.00
	D3000 ADULTS & PEDI ATRI CS	9, 022, 964		C		0	30.00
	D4300 NURSERY	910, 329	0	C	0	0	43.00
	ANCI LLARY SERVI CE COST CENTERS	21, 748, 743	0	C	0	0	50.00
	D5200 DELIVERY ROOM & LABOR ROOM	3, 884, 031		C	-	0	52.00
	D5300 ANESTHESI OLOGY	3, 531, 192		C	-	0	53.00
	D5400 RADI OLOGY-DI AGNOSTI C	34, 061, 645		C	0 0	0	54.00
	06000 LABORATORY	16, 842, 513		C	0	0	60.00
	06250 BLOOD CLOTTING FOR HEMOPHILIACS 06500 RESPIRATORY THERAPY	0 5, 578, 080	-			0	62.30 65.00
	D6600 PHYSI CAL THERAPY	4, 212, 614		C	0	0	66.00
67.00	D6700 OCCUPATI ONAL THERAPY	1, 197, 366		C	0	0	67.00
	D6800 SPEECH PATHOLOGY	377, 097		C	0	0	68.00
		981,907		C	0	0	69.00
	07100 MEDICAL SUPPLIES CHARGED TO PATIENT 07200 IMPL. DEV. CHARGED TO PATIENTS	11, 054, 476 6, 208, 274		C		0	
	D7300 DRUGS CHARGED TO PATIENTS	14, 143, 133		0		0	1 2.00
	07697 CARDI AC REHABI LI TATI ON	0		C	0	0	
	07698 HYPERBARI C OXYGEN THERAPY	232, 789	0	C	0 0	0	
	07699 LI THOTRI PSY DUTPATI ENT SERVI CE COST CENTERS	0	0	C	0 0	0	76.99
	DOTPATTENT SERVICE COST CENTERS	20, 493, 059	0	C	0	0	91.00
	09200 OBSERVATION BEDS (NON-DISTINCT PART		_	-		-	92.00
	OTHER REIMBURSABLE COST CENTERS		-		-		
	09500 AMBULANCE SERVICES SPECIAL PURPOSE COST CENTERS	7, 889, 309	0	C	0 0	0	95.00
	11300 INTEREST EXPENSE						113.00
118.00	SUBTOTALS (SUM OF LINES 1-117)	162, 369, 521	0	C	0	0	118.00
	NONREI MBURSABLE COST CENTERS						
190 00	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	C	0		190.00
			0	C	0	0	192. 00 194. 00
192.00	19200 PHYSI CLANS' PRI VATE OFFI CES	0				0	194.00
192.00 194.00	D7950 OCC HEALTH	0	0		0		194 01
192.00 194.00 194.01	07950 OCC HEALTH 07951 PAIN CLINIC	0 0 0	0 0 0	0 0		0	
192.00 194.00 194.01 194.02	D7950 OCC HEALTH		0 0 0 0			0 0	194. 02
192.00 194.00 194.01 194.02 194.03 194.03	07950 OCC HEALTH 07951 PAIN CLINIC 07952 OCC HEALTH 07953 FOUNDATIO 07954 KIDS CAMPUS		0 0 0 0			0 0 0 0	194. 02 194. 03 194. 04
192.00 194.00 194.01 194.02 194.03 194.03 194.04 194.05	07950 OCC HEALTH 07951 PAIN CLINIC 07952 OCC HEALTH 07953 FOUNDATIO 07954 KIDS CAMPUS 07955 COMMUNITY & VOLUNTEER SERVICES					0 0 0 0 0	194. 02 194. 03 194. 04 194. 05
192.00 194.00 194.01 194.02 194.03 194.03 194.04 194.05 194.06	07950 OCC HEALTH 07951 PAIN CLINIC 07952 OCC HEALTH 07953 FOUNDATIO 07954 KIDS CAMPUS 07955 COMMUNITY & VOLUNTEER SERVICES 07956 HUNTINGTON COLLEGE NURSE					0 0 0 0 0 0 0	194. 02 194. 03 194. 04 194. 05 194. 06
192.00 194.01 194.01 194.02 194.03 194.04 194.05 194.06 194.06	07950 OCC HEALTH 07951 PAIN CLINIC 07952 OCC HEALTH 07953 FOUNDATIO 07954 KIDS CAMPUS 07955 COMMUNITY & VOLUNTEER SERVICES 07955 COMMUNITY & VOLUNTEER SERVICES 07956 HUNTINGTON COLLEGE NURSE 07957 MISC CATERING					0 0 0 0 0 0 0 0	194.02 194.03 194.04 194.05 194.06 194.07
192.00 194.01 194.02 194.02 194.03 194.04 194.05 194.06 194.06 194.07 194.08	07950 OCC HEALTH 07951 PAIN CLINIC 07952 OCC HEALTH 07953 FOUNDATIO 07954 KIDS CAMPUS 07955 COMMUNITY & VOLUNTEER SERVICES 07956 HUNTINGTON COLLEGE NURSE					0 0 0 0 0 0 0 0 0 0 0	194. 01 194. 02 194. 03 194. 04 194. 05 194. 06 194. 07 194. 08 194. 09
192.00 194.00 194.01 194.02 194.03 194.04 194.05 194.06 194.07 194.08 194.09 200.00	07950 OCC HEALTH 07951 PAIN CLINIC 07952 OCC HEALTH 07953 FOUNDATIO 07954 KIDS CAMPUS 07955 COMMUNITY & VOLUNTEER SERVICES 07955 HUNTINGTON COLLEGE NURSE 07958 AUTISM CENTER 07959 HUNTINGTON BUA 07058 Foot Adjustments					0 0 0 0 0 0 0 0 0 0 0	194. 02 194. 03 194. 04 194. 05 194. 06 194. 07 194. 08 194. 09 200. 00
192.00 194.01 194.02 194.02 194.03 194.03 194.04 194.05 194.07 194.07 194.08 194.09 200.00 201.00	07950 OCC HEALTH 07951 PAIN CLINIC 07952 OCC HEALTH 07953 FOUNDATIO 07954 KIDS CAMPUS 07955 COMMUNITY & VOLUNTEER SERVICES 07956 HUNTINGTON COLLEGE NURSE 07957 MISC CATERING 07958 AUTISM CENTER 07959 HUNTINGTON BUA Cross Foot Adjustments Negative Cost Centers					0 0 0 0 0 0 0 0 0 0	194. 02 194. 03 194. 04 194. 05 194. 06 194. 07 194. 08 194. 09 200. 00 201. 00
192.00 194.00 194.01 194.02 194.03 194.04 194.05 194.06 194.07 194.08 194.09 200.00	07950 OCC HEALTH 07951 PAIN CLINIC 07952 OCC HEALTH 07953 FOUNDATIO 07954 KIDS CAMPUS 07955 COMMUNITY & VOLUNTEER SERVICES 07955 HUNTINGTON COLLEGE NURSE 07958 AUTISM CENTER 07959 HUNTINGTON BUA 07058 Foot Adjustments	24, 168				0 0 0 0 0 0 0 0 0 0	194. 02 194. 03 194. 04 194. 05 194. 06 194. 07 194. 08 194. 09 200. 00

Health Financial Systems H	UNTINGTON MEMO	RIAL HOSPITAL		In Lieu of Form CMS-2552-10			
COST ALLOCATION - STATISTICAL BASIS		Provider CO		Period: From 01/01/2016	Worksheet B-1		
				o 12/31/2016		pared: 3 am	
					INTERNS &		
					RESI DENTS		
Cost Center Description	MEDI CAL	SOCIAL SERVICE	NONPHYSI CI AN	NURSING SCHOOL			
	RECORDS &		ANESTHETI STS		Y & FRINGES		
	LI BRARY	(TIME SPENT)	(ASSI GNED	(ASSI GNED	APPRV		
	(GROSS		TIME)	TIME)	(ASSI GNED		
	REVENUE)		, í		TIME)		
	16.00	17.00	19.00	20.00	21.00		
204.00 Cost to be allocated (per Wkst. B,	3, 131	0	(	0 0	0	204.00	
Part II)							
205.00 Unit cost multiplier (Wkst. B, Part	0.000019	0. 000000	0.00000	0. 000000	0.000000	205.00	

Cost Center Description  Cost Centers  Cost Center Description  Cost Centers  Cost Center Description  Cost Centers  Cost	VTERNS & ESI DENTS I CES-OTHER GM COSTS APPRV 22.00 22.00 C C C C C C C C C C C C C C C C C C	PRGM (ASSI GNED TI ME) 23.00 0 0 0 0 0 0 0		From 01/01/20 To 12/31/20	
Cost Center Description         R           GENERAL SERVICE COST CENTERS         (           1.00         00100 CAP REL COSTS-BLDG & FIXT         (           2.00         00200 CAP REL COSTS-MVBLE EQUIP         (           4.00         00400 EMPLOYEE BENEFITS DEPARTMENT         (           5.00         00500 ADMINISTRATIVE & GENERAL         (           5.00         00500 ADMINISTRATIVE & GENERAL         (           5.00         00500 ADMINISTRATIVE & GENERAL         (           6.00         00600 (ALUNDRY & LINEN SERVICE         (           7.00         00700 (DERATY)         (           8.00         00300 (AUNTENANCE OF PERSONNEL         (           11.00         01100 CAFETERIA         (           12.00         01300 (NURSI NG ADMINISTRATION         (           14.00         01400 CENTRAL SERVICES & SUPPLY         (           15.00         01600 (MEDICAL RECORDS & LIBRARY         (           17.00         01700 SOCIAL SERVICE         SUPLY           15.00         01600 (AUSING SCHOOL         (           21.00         02000 NURSING SCHOOL         (           22.00         02200 NURSING SCHOOL         (           21.00         02300 PARAMED ED PRGM-(SPECIFY)         (<	ESI DENTS I CES-OTHER GM COSTS APPRV SSI GNED TI ME) 22. 00 C C C C C C C C C C C C C C C C C C	PRGM (ASSI GNED TI ME) 23.00 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0			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 15. 00 14. 00 15. 00 14. 00 17. 00 20. 00 21. 00 22. 00 23. 00 30. 00 43. 00 50. 00 52. 00 54. 00 66. 00 0 62. 30
1.00         00100         CAP REL COSTS-BLDG & FIXT           2.00         00200         CAP REL COSTS-MVBLE EQUIP           4.00         00400         EMPLOYEE BENEFITS DEPARTMENT           5.00         00500         ADMI NI STRATI VE & GENERAL           5.00         00500         ADMI NI STRATI VE & GENERAL           5.00         00500         DEPATI ON OF PLANT           3.00         00800         LAUNDRY & LI NEN SERVICE           9.00         00900         HOUSEKEEPI NG           10.00         01100         CAFETERI A           12.00         01200         MAI NTENANCE OF PERSONNEL           13.00         01300         NURSI NG ADMI NI STRATI ON           14.00         1400         CETERI A           12.00         01400         ENTAL SERVICES           15.00         01500         PHARMACY           16.00         01600         MEDI CAL SERVICE           17.00         01700         NORTAL SERVI CE           10.00         01900         NURSI NG SCHOOL           21.00         02100         I & SERVI CES-SALARY & FRI NGES APPRV           22.00         02200         I & SERVI CES-OTHER PRGM COSTS APPRV           22.00         02200         I & SERVI CE					$\begin{array}{c} 2. \ 00\\ 4. \ 00\\ 5. \ 00\\ 6. \ 00\\ 7. \ 00\\ 8. \ 00\\ 9. \ 00\\ 10. \ 00\\ 11. \ 00\\ 12. \ 00\\ 13. \ 00\\ 13. \ 00\\ 13. \ 00\\ 14. \ 00\\ 15. \ 00\\ 15. \ 00\\ 15. \ 00\\ 22. \ 00\\ 21. \ 00\\ 22. \ 00\\ 23. \ 00\\ 23. \ 00\\ 50. \ 00\\ 52. \ 00\\ 53. \ 00\\ 54. \ 00\\ 60. \ 00\\ 62. \ 30\\ \end{array}$
.00         00100         CAP REL COSTS-BLDG & FIXT           .00         00200         CAP REL COSTS-MVBLE EQUIP           .00         00400         EMPLOVEE BENEFITS DEPARMENT           .00         00500         ADMI NI STRATI VE & GENERAL           .00         00600         MAI NTENANCE & REPAIRS           .00         00600         DEPATION OF PLANT           .00         00800         LAUNDRY & LINEN SERVICE           .00         00900         HOUSEKEEPING           .00         01200         MAI NTENANCE OF PERSONNEL           .00         01300         NURSI NG ADMINI STRATI ON           .00         01400         CENTRAL SERVICES & SUPPLY           5.00         01500         PHARMACY           6.00         01600         MEDI CAL RECORDS & LIBRARY           7.00         01700         SOCI AL SERVICE           9.00         01900         NURSI NG SCHOOL           21.00         02200         NRS SERVI CES-SALARY & FRI NGES APPRV           22.00         02200         NRS SERVI CES-OTHER PRGM COSTS APPRV           23.00         02300         PARAMED ED PRGM-CSPECI FY)           1NPATI ENT ROUTI NG SCONT CENTERS         10000           30.00         03000					$\begin{array}{c} 2. \ 00\\ 4. \ 00\\ 5. \ 00\\ 6. \ 00\\ 7. \ 00\\ 8. \ 00\\ 9. \ 00\\ 10. \ 00\\ 11. \ 00\\ 12. \ 00\\ 13. \ 00\\ 13. \ 00\\ 13. \ 00\\ 14. \ 00\\ 15. \ 00\\ 15. \ 00\\ 15. \ 00\\ 22. \ 00\\ 23. \ 00\\ 23. \ 00\\ 23. \ 00\\ 50. \ 00\\ 50. \ 00\\ 53. \ 00\\ 54. \ 00\\ 60. \ 00\\ 62. \ 30\\ \end{array}$
4.00         00400         EMPLOYEE BENEFITS DEPARTMENT           5.00         00500         ADMI NI STRATI VE & GENERAL           5.00         00600         MAI NTENANCE & REPAI RS           7.00         00700         OPERATI ON OF PLANT           3.00         00800         LAUNDRY & LI NEN SERVI CE           9.00         00900         HOUSEKEEPI NG           10.00         01100         CAFETERI A           12.00         01300         NURSI NG ADMI NI STRATI ON           14.00         01400         CENTRAL SERVI CES & SUPPLY           15.00         01500         PHARMACY           16.00         01600         MEDI CAL RECORDS & LI BRARY           17.00         01700         SOCI AL SERVI CE           10.00         2000         NURSI NG SCHOOL           21.00         02100         IAR SERVI CES-SALARY & FRI NGES APPRV           22.00         02200         IAR SERVI CES-SALARY & FRI NGES APPRV           23.00         03000         ADULTS & PEDI ATRI CS           30.00         03000         ADULTS & PEDI ATRI CS           30.00         03000         ADULTS & PEDI ATRI CS           30.00         05000         OPERATI NG ROOM           31.00         05300					$\begin{array}{c} 4. \ 00\\ 5. \ 00\\ 6. \ 00\\ 7. \ 00\\ 8. \ 00\\ 9. \ 00\\ 10. \ 00\\ 11. \ 00\\ 12. \ 00\\ 13. \ 00\\ 14. \ 00\\ 13. \ 00\\ 14. \ 00\\ 15. \ 00\\ 16. \ 00\\ 20. \ 00\\ 21. \ 00\\ 22. \ 00\\ 22. \ 00\\ 23. \ 00\\ 30. \ 00\\ 43. \ 00\\ 55. \ 00\\ 55. \ 00\\ 54. \ 00\\ 54. \ 00\\ 62. \ 30\\ \end{array}$
21.00       02100       1&R SERVI CES-SALARY & FRI NGES APPRV         22.00       02200       1&R SERVI CES-OTHER PRGM COSTS APPRV         23.00       02200       PARAMED ED PRGM-(SPECI FY)         INPATI ENT ROUTI NE SERVI CE COST CENTERS         00.00       03000       ADULTS & PEDI ATRI CS         04300       NURSERY         ANCI LLARY SERVI CE COST CENTERS         00.00       05000         05000       DELI VERY ROOM & LABOR ROOM         052.00       05200         05200       DELI VERY ROOM & LABOR ROOM         053.00       05300         05000       OERATI NG ROOM         052.00       06400         05400       RADI OLOGY-DI AGNOSTI C         00       06600         064500       RESPI RATORY THERAPY         05.00       06500         06400       PHYSI CAL THERAPY         05.00       06600         06400       PHYSI CAL THERAPY         06.00       06600         06400       PHYSI CAL THERAPY         06.00       06600         07100       MEDI CAL SUPPLI ES CHARGED TO PATI ENTS         23.00       07300       DRUGS CHARGED TO PATI ENTS         24.00       07					21. 0 22. 0 23. 0 30. 0 43. 0 50. 0 52. 0 53. 0 54. 0 60. 0 62. 3
30.00         03000         ADULTS & PEDIATRICS           31.00         04300         NURSERY           ANCILLARY SERVICE COST CENTERS         04300           50.00         05000         OPERATING ROOM           52.00         05200         DELIVERY ROOM & LABOR ROOM           52.00         05200         DELIVERY ROOM & LABOR ROOM           53.00         05300         ANESTHESI OLOGY           54.00         05400         RADI OLOGY-DI AGNOSTI C           50.00         06000         LABORATORY           52.30         06250         BLODD CLOTTING FOR HEMOPHILIACS           55.00         06500         RESPI RATORY THERAPY           56.00         06600         PHYSI CAL THERAPY           56.00         06600         SPECH PATHOLOGY           59.00         06400         ELECTROCARDI OLOGY           59.00         06400         ELECTROCARDI OLOGY           50.00         07200         IMPL. DEV. CHARGED TO PATI ENTS           73.00         ORUGS CHARGED TO PATI ENTS         73.00           73.00         ORUGS CHARGED TO PATI ENTS         74.99           76.97         CARDI AC REHABI LI TATI ON         76.98           76.97         OT691 LAR ERGENCY         75.00					43.00 50.00 52.00 53.00 54.00 60.00 62.30
ANCILLARY SERVICE COST CENTERS           60.00         05000         OPERATING ROOM           62.00         05200         DELIVERY ROOM & LABOR ROOM           63.00         05300         ANESTHESI OLOGY           64.00         05400         RADIOLOGY-DIAGNOSTI C           00.00         06000         LABORATORY           92.30         06250         BLOOD CLOTTING FOR HEMOPHILIACS           95.00         06400         RADIOLOGY-DIAGNOSTI C           00.00         06400         RESPI RATORY THERAPY           96.00         06400         PHYSI CAL THERAPY           97.00         06700         OCCUPATI ONAL THERAPY           98.00         066000         PEECH PATHOLOGY           99.00         06900         ELECTROCARDI OLOGY           99.00         06900         ELECTROCARDI OLOGY           90.00         06900         ELECTROCARDI OLOGY           90.00         06900         ELECTROCARDI OLOGY           90.00         06900         ELECTROCARDI OLOGY           90.00         06900         ELECTROCARDI OLOGY           91.00         OT100         MEDI CAL SUPPLI ES CHARGED TO PATI ENTS           73.00         DRUGS CHARGED TO PATI ENTS         76.97		0 0 0 0 0 0 0			50.00 52.00 53.00 54.00 60.00 62.30
60.00         05000         OPERATI NG ROOM           62.00         05200         DELI VERY ROOM & LABOR ROOM           63.00         05300         ANESTHESI OLOGY           64.00         05400         RADI OLOGY-DI AGNOSTI C           60.00         LABORATORY         06250           62.30         06250         BLODD CLOTTI NG FOR HEMOPHI LI ACS           65.00         06500         RESPI RATORY THERAPY           66.00         06600         PHYSI CAL THERAPY           77.00         06700         OCUPATI ONAL THERAPY           78.00         06900         ELECTROCARDI OLOGY           71.00         06700         OCUPATI ONAL THERAPY           78.00         06900         ELECTROCARDI OLOGY           71.00         06700         DCLUPATI ONAL THERAPY           72.00         06700         DCLUPATI ONAL THERAPY           73.00         07100         MEDI CAL SUPPLI ES CHARGED TO PATI ENTS           73.00         07300         DRUGS CHARGED TO PATI ENTS           74.00         07697         CARDI AC REHABI LI TATI ON           76.97         OR698         HYPERBARI C OXYGEN THERAPY           70.00         09100         EMERGENCY           9000         09500		0 0 0 0 0			52.00 53.00 54.00 60.00 62.30
53.00       05300       ANESTHESI OLOGY         54.00       05400       RADI OLOGY-DI AGNOSTI C         50.00       06000       LABORATORY         52.30       06250       BLOOD CLOTTI NG FOR HEMOPHI LI ACS         55.00       06500       RESPI RATORY THERAPY         56.00       06600       PHYSI CAL THERAPY         57.00       06700       OCCUPATI ONAL THERAPY         57.00       06700       OCCUPATI ONAL THERAPY         58.00       06800       SPEECH PATHOLOGY         59.00       06900       ELECTROCARDI OLOGY         57.00       07100       MEDI CAL SUPPLI ES CHARGED TO PATI ENT         72.00       07200       IMPL.       DEV. CHARGED TO PATI ENTS         73.00       07300       DRUGS CHARGED TO PATI ENTS       76.97         76.97       CARDI AC REHABI LI TATI ON       76.98       07698         76.99       07697       CARDI AC REHABI LI TATI ON       76.99         76.99       07699       LI THOTRI PSY       0017101         00       O9100       EMERGENCY       70         72.00       09200       OBSERVATI ON BEDS (NON-DI STI NCT PART       71.90         011800       11300       I 1300       I 1300       I N		0 0 0			53.00 54.00 60.00 62.30
44.00       05400       RADI OLOGY - DI AGNOSTI C         60.00       LABORATORY         22.30       06250       BLOOD CLOTTI NG FOR HEMOPHI LI ACS         55.00       06500       RESPI RATORY THERAPY         66.00       06400       PHYSI CAL THERAPY         7.00       06700       OCCUPATI ONAL THERAPY         88.00       06800       SPEECH PATHOLOGY         99.00       06900       ELECTROCARDI OLOGY         99.00       06900       ELECTROCARDI OLOGY         11.00       07100       MEDI CAL SUPPLI ES CHARGED TO PATI ENT         12.00       07200       IMPL. DEV. CHARGED TO PATI ENTS         13.00       07697       CARDI AC REHABI LI TATI ON         14.99       07698       HYPERBARI C OXYGEN THERAPY         15.00       09100       EMERGENCY         10.00       OP1001       EMERGENCY         12.00       09200       OBSERVATI ON BEDS (NON-DI STI NCT PART         0THER REI MBURSABLE COST CENTERS       13.00         11.300       INTEREST EXPENSE         13.000       INTEREST EXPENSE         18.000       SUBTOTALS (SUM OF LI NES 1-117)         NONREI MBURSABLE COST CENTERS         190.00       GI FT, FLOWER, COFFEE SHOP & CANTEEN <td></td> <td>0 0 0</td> <td></td> <td></td> <td>54.0 60.0 62.3</td>		0 0 0			54.0 60.0 62.3
2.30       06250       BLOOD CLOTTING FOR HEMOPHILIACS         5.00       06500       RESPIRATORY THERAPY         6.00       06600       PHYSICAL THERAPY         7.00       06600       PHYSICAL THERAPY         8.00       06600       PHYSICAL THERAPY         8.00       06600       SPEECH PATHOLOGY         9.00       06900       ELECTROCARDIOLOGY         1.00       07100       MEDICAL SUPPLIES CHARGED TO PATIENT         2.00       07200       IMPL. DEV. CHARGED TO PATIENTS         3.00       07300       DRUGS CHARGED TO PATIENTS         6.97       07697       CARDIAC REHABILITATION         6.98       07698       HYPERBARIC OXYGEN THERAPY         6.99       07699       LI THOTRI PSY         OUTPATIENT SERVICE COST CENTERS       09100         9000       OBSERVATION BEDS (NON-DI STINCT PART         OTHER REI MBURSABLE COST CENTERS       5         5.00       09500       AMBULANCE SERVICES         SPECIAL PURPOSE COST CENTERS       11300         13.00       INTEREST EXPENSE         18.00       SUBTOTALS (SUM OF LINES 1-117)         NONREI MBURSABLE COST CENTERS       90.00         19000       GIFT, FLOWER, COFFEE SHOP & CANTEEN		0			62.3
5.00       06500       RESPI RATORY THERAPY         6.00       06600       PHYSI CAL THERAPY         7.00       06700       0CCUPATI ONAL THERAPY         8.00       06800       SPEECH PATHOLOGY         9.00       06900       ELECTROCARDI OLOGY         1.00       07100       MEDI CAL SUPPLI ES CHARGED TO PATI ENT         2.00       07200       IMPL.       DEV. CHARGED TO PATI ENTS         3.00       07300       DRUGS CHARGED TO PATI ENTS         6.97       07697       CARDI AC REHABI LI TATI ON         6.98       07698       HYPERBARI C OXYGEN THERAPY         6.99       07699       LI THOTRI PSY         0UTPATI ENT SERVI CE COST CENTERS       09100         1.00       09200       OBSERVATI ON BEDS (NON-DI STI NCT PART         0THER REI MBURSABLE COST CENTERS       5.00       09500         13.00       11300       I NTEREST EXPENSE         13.00       11300       INTEREST EXPENSE         13.00       11300       SUBTOTALS (SUM OF LI NES 1-117)         NONREI MBURSABLE COST CENTERS       90.00         19000       GI FT, FLOWER, COFFEE SHOP & CANTEEN         92.00       19200       PHYSI CI ANS' PRI VATE OFFI CES		-	1		
6.00       06600       PHYSI CAL THERAPY         7.00       06700       OCCUPATI ONAL THERAPY         8.00       06800       SPEECH PATHOLOGY         9.00       06900       ELECTROCARDI OLOGY         1.00       07100       MEDI CAL SUPPLI ES CHARGED TO PATI ENT         2.00       07200       IMPL.       DEV. CHARGED TO PATI ENTS         3.00       07300       DRUGS CHARGED TO PATI ENTS         6.97       07697       CARDI AC REHABI LI TATI ON         6.98       07698       HYPERBARI C OXYGEN THERAPY         6.99       07699       LI THOTRI PSY         OUTPATI ENT SERVI CE COST CENTERS       0         1.00       09200       DBSERVATI ON BEDS (NON-DI STI NCT PART         OTHER REI MBURSABLE COST CENTERS       5         5.00       09500       AMBULANCE SERVI CES         SPECI AL PURPOSE COST CENTERS       13.00         13.00       1NTEREST EXPENSE         13.00       SUBTOTALS (SUM OF LI NES 1-117)         NONREI MBURSABLE COST CENTERS         90.00       19000         GI FT, FLOWER, COFFEE SHOP & CANTEEN         92.00       19200         92.00       19200					00.0
8. 00         06800         SPEECH PATHOLOGY           9. 00         06900         ELECTROCARDI OLOGY           1. 00         07100         MEDI CAL         SUPPLI ES           2. 00         07200         IMPL.         DEV.         CHARGED TO PATI ENT           2. 00         07200         IMPL.         DEV.         CHARGED TO PATI ENTS           3. 00         07300         DRUGS CHARGED TO PATI ENTS         6           6. 97         07697         CARDI AC         REHABI LI TATI ON           6. 98         07698         HYPERBARI C OXYGEN THERAPY           0.90         07699         LI THOTRI PSY           0UTPATI ENT SERVICE COST CENTERS         09100           0.9100         BEDS (NON-DI STI NCT PART           0THER REI MBURSABLE COST CENTERS         5.00           09500         AMBULANCE SERVICES           SPECI AL PURPOSE COST CENTERS         13.00           13.00         INTEREST EXPENSE           18. 00         SUBTOTALS (SUM OF LI NES 1-117)           NONREI MBURSABLE COST CENTERS           90. 00         19000           90.00         19000           91.00         19000           92.00         19200           91.920         <		0			66.0
9.00         06900         ELECTROCARDI OLOGY           1.00         07100         MEDI CAL SUPPLI ES CHARGED TO PATI ENT           2.00         07200         IMPL. DEV. CHARGED TO PATI ENTS           3.00         07300         DRUGS CHARGED TO PATI ENTS           6.97         07697         CARDI AC REHABI LI TATI ON           6.98         07698         HYPERBARI C OXYGEN THERAPY           6.99         07699         LI THOTRI PSY           0UTPATI ENT SERVI CE COST CENTERS         09100           1.00         O9100         EMERGENCY           2.00         09200         OBSERVATI ON BEDS (NON-DI STI NCT PART           0THER REI MBURSABLE COST CENTERS         07500           5.00         09500         AMBULANCE SERVI CES           SPECI AL PURPOSE COST CENTERS         13.00           11.300         I NTEREST EXPENSE           18.00         SUBTOTALS (SUM OF LI NES 1-117)           NONREI MBURSABLE COST CENTERS           90.00         19000           90.00         19000           92.00         19200           92.00         19200		0			67.0
1. 00       07100       MEDI CAL SUPPLIES CHARGED TO PATIENT         2. 00       07200       IMPL. DEV. CHARGED TO PATIENTS         3. 00       07300       DRUGS CHARGED TO PATIENTS         6. 97       07697       CARDIAC REHABILITATION         6. 98       07698       HYPERBARI C OXYGEN THERAPY         6. 99       017PATIENT SERVICE COST CENTERS         1. 00       09100       EMERGENCY         2. 00       09200       OBSERVATION BEDS (NON-DISTINCT PART         0THER REI MBURSABLE COST CENTERS       09500         5. 00       09500       AMBULANCE SERVICES         SPECIAL PURPOSE COST CENTERS       11300         11300       INTEREST EXPENSE         18. 00       SUBTOTALS (SUM OF LINES 1-117)         NONREI MBURSABLE COST CENTERS         90. 00       19000         GIFT, FLOWER, COFFEE SHOP & CANTEEN         92. 00       19200         92. 00       PHYSICIANS' PRIVATE OFFICES					68.0
2. 00         07200         IMPL. DEV. CHARGED TO PATIENTS           3. 00         07300         DRUGS CHARGED TO PATIENTS           5. 97         07697         CARDIAC REHABILITATION           5. 97         07697         CARDIAC REHABILITATION           5. 98         07698         HYPERBARI C OXYGEN THERAPY           6. 99         07699         LI THOTRI PSY           OUTPATIENT SERVICE COST CENTERS         09100           DMERGENCY         09200           2. 00         09200           OBSERVATION BEDS (NON-DI STINCT PART           OTHER REI MBURSABLE COST CENTERS           5. 00         09500           OMBULANCE SERVICES           SPECIAL PURPOSE COST CENTERS           13. 00         11300           SUBTOTALS (SUM OF LINES 1-117)           NONREI MBURSABLE COST CENTERS           20. 00         19000           GIFT, FLOWER, COFFEE SHOP & CANTEEN           20. 00         19200           PHYSICI ANS' PRIVATE OFFICES	C	0			69.0
6. 97       07697       CARDI AC REHABI LI TATI ON         6. 98       07698       HYPERBARI C OXYGEN THERAPY         6. 99       07699       LI THOTRI PSY         OUTPATI ENT SERVICE COST CENTERS       0         1. 00       09100       EMERGENCY         2. 00       09200       0BSERVATI ON BEDS (NON-DI STI NCT PART         OTHER       REI MBURSABLE COST CENTERS         5. 00       09500       AMBULANCE SERVICES         SPECI AL PURPOSE COST CENTERS       11300         11.300       INTEREST EXPENSE         18. 00       SUBTOTALS (SUM OF LI NES 1-117)         NONREI MBURSABLE COST CENTERS         90. 00       19000         GI FT, FLOWER, COFFEE SHOP & CANTEEN         92. 00       19200         PHYSI CI ANS' PRI VATE OFFICES	r	0	•		72.0
6. 98       07698       HYPERBARI C OXYGEN THERAPY         6. 99       07699       LI THOTRI PSY         OUTPATI ENT SERVICE COST CENTERS         1. 00       09100       EMERGENCY         2. 00       09200       OBSERVATI ON BEDS (NON-DI STI NCT PART         OTHER REI MBURSABLE COST CENTERS       07500         5. 00       09500       AMBULANCE SERVICES         SPECI AL PURPOSE COST CENTERS       13.00         11.300       INTEREST EXPENSE         18. 00       SUBTOTALS (SUM OF LI NES 1-117)         NONREI MBURSABLE COST CENTERS         90. 00       19000         GI FT, FLOWER, COFFEE SHOP & CANTEEN         92. 00       19200         PHYSI CI ANS' PRI VATE OFFICES	0	0			73.0
6. 99       07699       LI THOTRI PSY         OUTPATI ENT SERVICE COST CENTERS         1. 00       09100       EMERGENCY         2. 00       09200       OBSERVATI ON BEDS (NON-DI STINCT PART         OTHER REI MBURSABLE COST CENTERS       09500         OP500       AMBULANCE SERVICES         SPECIAL PURPOSE COST CENTERS         13. 00       INTEREST EXPENSE         18. 00       SUBTOTALS (SUM OF LINES 1-117)         NONREI MBURSABLE COST CENTERS         90. 00       GIFT, FLOWER, COFFEE SHOP & CANTEEN         92. 00       19200         PHYSICI ANS' PRIVATE OFFICES	C	0	1		76.9
1. 00       09100       EMERGENCY         2. 00       09200       OBSERVATI ON BEDS (NON-DI STINCT PART         OTHER REI MBURSABLE COST CENTERS         5. 00       09500       AMBULANCE SERVI CES         SPECIAL PURPOSE COST CENTERS         13. 00       INTEREST EXPENSE         18. 00       SUBTOTALS (SUM OF LINES 1-117)         NONREI MBURSABLE COST CENTERS         90. 00       GIFT, FLOWER, COFFEE SHOP & CANTEEN         92. 00       19200       PHYSI CLANS' PRI VATE OFFICES	C	0			 76.9
2. 00       09200       OBSERVATI ON BEDS (NON-DI STINCT PART         OTHER REI MBURSABLE COST CENTERS         5. 00       09500       AMBULANCE SERVI CES         SPECI AL PURPOSE COST CENTERS         13. 00       1NTEREST EXPENSE         18. 00       SUBTOTALS (SUM OF LINES 1-117)         NONREI MBURSABLE COST CENTERS         90. 00       19000         GI FT, FLOWER, COFFEE SHOP & CANTEEN         92. 00       19200         PHYSI CI ANS' PRI VATE OFFICES		0			1 01 0
OTHER       REI MBURSABLE       COST       CENTERS         95.00       AMBULANCE       SERVI CES         SPECIAL       PURPOSE       COST       CENTERS         13.00       11300       INTEREST       EXPENSE         18.00       SUBTOTALS       (SUM OF LINES 1-117)         NONREI       MBURSABLE       COST       CENTERS         90.00       19000       GI FT.       FLOWER,       COFFEE       SHOP & CANTEEN         92.00       19200       PHYSI CI ANS'       PRI VATE       OFFI CES       DESCRIPTION	C	0			91.0
SPECIAL PURPOSE COST CENTERS         13.00       11300         INTEREST EXPENSE         18.00       SUBTOTALS (SUM OF LINES 1-117)         NONREI MBURSABLE COST CENTERS         90.00       GI FT, FLOWER, COFFEE SHOP & CANTEEN         92.00       19200         PHYSI CI ANS' PRI VATE OFFICES					
13. 00       11300       I NTEREST EXPENSE         18. 00       SUBTOTALS (SUM OF LINES 1-117)         NONREI MBURSABLE COST CENTERS         90. 00       19000       GI FT, FLOWER, COFFEE SHOP & CANTEEN         92. 00       19200       PHYSI CI ANS' PRI VATE OFFI CES	C	0	)		95.0
18. 00       SUBTOTALS (SUM OF LINES 1-117)         NONREI MBURSABLE COST CENTERS         90. 00       19000         GI FT, FLOWER, COFFEE SHOP & CANTEEN         92. 00       19200         PHYSI CI ANS' PRI VATE OFFICES					113. C
NONREI MBURSABLE         COST         CENTERS           90. 00         19000         GI FT,         FLOWER,         COFFEE         SHOP & CANTEEN           92. 00         19200         PHYSI CI ANS'         PRI VATE         OFFI CES	C	0			118.0
92. 00 19200 PHYSI CLANS' PRI VATE OFFI CES	-				
	C		1		190. 0
94. 00 07950 OCC HEALTH	C	0			192. C
94. 01 07951 PALN CLINIC	0	0			194.0
94. 02 07952 OCC HEALTH	C	0			194. 0
94. 03 07953 FOUNDATI 0	C	0			194.0
94. 04 07954 KIDS CAMPUS 94. 05 07955 COMMUNI TY & VOLUNTEER SERVICES	C				194. C
94. 06 07956 HUNTI NGTON COLLEGE NURSE	0	0			194. 0
94. 07 07957 MI SC CATERI NG	C	0			194. (
94. 08 07958 AUTI SM CENTER	C	0	1		194.0
94.09 07959 HUNTINGTON BUA 00.00 Cross Foot Adjustments		Ű			
200.00     Cross Foot Adjustments       201.00     Negative Cost Centers	C	0			194.0
202.00 Cost to be allocated (per Wkst. B,	C	0			194. 0 200. 0
Part I) 203.00 Unit cost multiplier (Wkst. B, Part I)	c	0			194.0

Health Financial Systems	HUNTINGTON MEMOR	RIAL HOSPITAL		In Lieu of Form CMS-2552-10			
COST ALLOCATION - STATISTICAL BASIS		Provider CO	CN: 15-0091	Peri od:	Worksheet B-1		
				From 01/01/2016 To 12/31/2016	Date/Time Pre 5/19/2017 9:1		
	INTERNS &						
	RESI DENTS						
Cost Center Description	SERVI CES-OTHER	PARAMED ED					
	PRGM COSTS	PRGM					
	APPRV	(ASSI GNED					
	(ASSI GNED	TIME)					
	TIME)						
	22.00	23.00					
204.00 Cost to be allocated (per Wkst. B,	0	0	1			204.00	
Part II)							
205.00 Unit cost multiplier (Wkst. B, Part	0. 000000	0.000000				205.00	

Health Financial Systems	HUNTI NGTON MEMO	RIAL HOSPITAL		In Lie	u of Form CMS-	2552-10
COMPUTATION OF RATIO OF COSTS TO CHARGES		Provider C		Period: From 01/01/2016 To 12/31/2016	5/19/2017 9:1	pared: 3 am
		Title	XVIII	Hospi tal	PPS	
				Costs		
Cost Center Description	Total Cost (from Wkst. B, Part I, col. 26)	,	Total Costs	RCE Di sal I owance	Total Costs	
	1.00	2.00	3.00	4.00	5.00	
INPATIENT ROUTINE SERVICE COST CENTERS				1		
30. 00 03000 ADULTS & PEDI ATRI CS	6, 764, 111		6, 764, 11		6, 764, 111	
43. 00 04300 NURSERY	258, 648		258, 64	8 0	258, 648	43.00
ANCI LLARY SERVICE COST CENTERS	1	1		1		
50.00 05000 OPERATING ROOM	2, 155, 279		2, 155, 27		2, 157, 296	1
52.00 05200 DELIVERY ROOM & LABOR ROOM	1, 060, 852		1, 060, 85		1, 060, 852	
53. 00 05300 ANESTHESI OLOGY	830, 881		830, 88		830, 881	
54.00 05400 RADI OLOGY-DI AGNOSTI C	3, 200, 182		3, 200, 18		3, 200, 182	
60. 00 06000 LABORATORY	3, 263, 354		3, 263, 35	4 0	3, 263, 354	
62.30 06250 BLOOD CLOTTING FOR HEMOPHILIACS	0			0 0	0	
65. 00 06500 RESPI RATORY THERAPY	1, 363, 378		.,		1, 363, 378	1
66. 00 06600 PHYSI CAL THERAPY	1, 826, 963		1, 826, 96		1, 826, 963	1
67.00 06700 OCCUPATI ONAL THERAPY	398, 411		398, 41		398, 411	
68.00 06800 SPEECH PATHOLOGY	127, 581		127, 58		127, 581	
69. 00 06900 ELECTROCARDI OLOGY	146		14		146	
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	1, 140, 691		1, 140, 69		1, 140, 691	
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	1, 259, 115		1, 259, 11	5 0	1, 259, 115	72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	4, 427, 021		4, 427, 02	1 0	4, 427, 021	
76. 97 07697 CARDI AC REHABI LI TATI ON	0			0 0	0	
76. 98 07698 HYPERBARI C OXYGEN THERAPY	17, 529		17, 52	9 0	17, 529	76.98
76. 99 07699 LI THOTRI PSY	0			0 0	0	76.99
OUTPATIENT SERVICE COST CENTERS			-			
91. 00 09100 EMERGENCY	2, 599, 441		2, 599, 44	1 0	2, 599, 441	91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART	1, 457, 582		1, 457, 58	2	1, 457, 582	92.00
OTHER REIMBURSABLE COST CENTERS						
95. 00 09500 AMBULANCE SERVICES	3, 947, 194		3, 947, 19	4 0	3, 947, 194	95.00
SPECIAL PURPOSE COST CENTERS						
113.00 11300 INTEREST EXPENSE						113.00
200.00 Subtotal (see instructions)	36, 098, 359	0	36, 098, 35	9 2, 017		
201.00 Less Observation Beds	1, 457, 582		1, 457, 58		1, 457, 582	
202.00 Total (see instructions)	34, 640, 777	0	34, 640, 77	7 2, 017	34, 642, 794	202.00

Heal th	Financial Systems	HUNTINGTON MEMOR	RIAL HOSPITAL		In Lie	u of Form CMS-	2552-10
COMPUT	ATION OF RATIO OF COSTS TO CHARGES		Provider C		Period: From 01/01/2016 To 12/31/2016	Date/Time Pre 5/19/2017 9:1	pared: 3 am
				XVIII	Hospi tal	PPS	
	Cost Center Description	I npati ent	<u>Charges</u> Outpati ent	Total (col. + col. 7)	6 Cost or Other Ratio	TEFRA I npati ent Rati o	
		6.00	7.00	8.00	9.00	10.00	
	INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000 ADULTS & PEDIATRICS	7, 456, 512		7, 456, 51			30.00
43.00	04300 NURSERY	910, 329		910, 32	9		43.00
	ANCI LLARY SERVICE COST CENTERS	-					
50.00	05000 OPERATI NG ROOM	6, 220, 194	15, 528, 549				
52.00	05200 DELIVERY ROOM & LABOR ROOM	3, 884, 031	0	0,001,00		0. 000000	
53.00	05300 ANESTHESI OLOGY	703, 888	2, 827, 304			0. 000000	
54.00	05400 RADI OLOGY-DI AGNOSTI C	3, 222, 014	30, 839, 631			0. 000000	
60.00	06000 LABORATORY	2, 989, 066	13, 853, 447	16, 842, 51		0. 000000	
62.30	06250 BLOOD CLOTTING FOR HEMOPHILIACS	0	0		0 0. 000000	0. 000000	
65.00	06500 RESPI RATORY THERAPY	1, 294, 679	4, 283, 401			0. 000000	
66.00	06600 PHYSI CAL THERAPY	555, 703	3, 656, 911			0. 000000	
67.00	06700 OCCUPATI ONAL THERAPY	93, 481	1, 103, 885			0. 000000	
68.00	06800 SPEECH PATHOLOGY	24, 055	353, 042			0. 000000	
69.00	06900 ELECTROCARDI OLOGY	685, 038	296, 869			0. 000000	
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	2, 413, 122	8, 641, 354			0. 000000	
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	5, 058, 524	1, 149, 750			0. 000000	•
73.00	07300 DRUGS CHARGED TO PATIENTS	4, 789, 243	9, 353, 890	14, 143, 13	3 0. 313016	0.00000	
76.97	07697 CARDI AC REHABI LI TATI ON	0	0		0 0.000000	0.00000	
76. 98	07698 HYPERBARI C OXYGEN THERAPY	119, 730	113, 059	232, 78			
76.99	07699 LI THOTRI PSY	0	0		0 0.000000	0.00000	76.99
	OUTPATIENT SERVICE COST CENTERS						
91.00	09100 EMERGENCY	2, 402, 958	18, 090, 101				
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART	0	1, 566, 452	1, 566, 45	2 0. 930499	0.00000	92.00
	OTHER REIMBURSABLE COST CENTERS						
95.00	09500 AMBULANCE SERVICES	0	7, 889, 309	7, 889, 30	9 0. 500322	0.00000	95.00
	SPECIAL PURPOSE COST CENTERS			1	-		
	11300 INTEREST EXPENSE						113.00
200.00		42, 822, 567	119, 546, 954	162, 369, 52	1		200. 00
201.00							201.00
202.00	Total (see instructions)	42, 822, 567	119, 546, 954	162, 369, 52	1		202.00

Health Financial Systems	HUNTI NGTON MEMOR	AL HOSPITAL	In Lie	u of Form CMS-	2552-10
COMPUTATION OF RATIO OF COSTS TO CHARGES		Provi der CCN: 15-0091	Period: From 01/01/2016 To 12/31/2016	Worksheet C Part I Date/Time Pre 5/19/2017 9:1	pared: 3 am
		Title XVIII	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
ANCI LLARY SERVICE COST CENTERS					
50. 00 05000 OPERATI NG ROOM	0. 099192				50.00
52.00 05200 DELIVERY ROOM & LABOR ROOM	0. 273132				52.00
53. 00 05300 ANESTHESI OLOGY	0. 235298				53.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	0. 093953				54.00
60. 00 06000 LABORATORY	0. 193757				60.00
62. 30 06250 BLOOD CLOTTING FOR HEMOPHILIACS	0. 000000				62.30
65. 00 06500 RESPI RATORY THERAPY	0. 244417				65.00
66.00 06600 PHYSI CAL THERAPY	0. 433689				66.00
67.00 06700 OCCUPATIONAL THERAPY	0. 332740				67.00
68.00 06800 SPEECH PATHOLOGY	0. 338324				68.00
69. 00 06900 ELECTROCARDI OLOGY	0.000149				69.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0. 103188				71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0. 202812				72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	0. 313016				73.00
76. 97 07697 CARDI AC REHABI LI TATI ON	0. 000000				76.97
76. 98 07698 HYPERBARI C OXYGEN THERAPY	0. 075300				76.98
76. 99 07699 LI THOTRI PSY	0. 000000				76.99
OUTPATIENT SERVICE COST CENTERS					
91.00 09100 EMERGENCY	0. 126845				<b>91. 0</b>
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART	0. 930499				92.00
OTHER REIMBURSABLE COST CENTERS					
95.00 09500 AMBULANCE SERVICES	0. 500322				95. OC
SPECIAL PURPOSE COST CENTERS					1
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 Fina	ancial Systems	HUNTI NGTON MEMO	RIAL HOSPITAL		In Lie	u of Form CMS-	2552-10
COMPUTATI O	N OF RATIO OF COSTS TO CHARGES		Provider C		Period: From 01/01/2016 To 12/31/2016		epared: 13 am
			Titl	e XIX	Hospi tal	PPS	
					Costs		
	Cost Center Description	Total Cost (from Wkst. B, Part I, col. 26)	<u>,</u>	Total Costs	RCE Di sal I owance	Total Costs	
		1.00	2.00	3.00	4.00	5.00	
	ATIENT ROUTINE SERVICE COST CENTERS	1		1			
	DO ADULTS & PEDIATRICS	6, 764, 111		6, 764, 11			
43.00 0430		258, 648		258, 64	8 0	258, 648	43.00
	LLARY SERVICE COST CENTERS	1	1		-		
	DO OPERATING ROOM	2, 155, 279		2, 155, 27		2, 157, 296	
	DO DELIVERY ROOM & LABOR ROOM	1, 060, 852		1, 060, 85		.,	
	DO ANESTHESI OLOGY	830, 881		830, 88		830, 881	
	DO RADI OLOGY-DI AGNOSTI C	3, 200, 182		3, 200, 18		3, 200, 182	
	DO LABORATORY	3, 263, 354		3, 263, 35	4 0	3, 263, 354	
	50 BLOOD CLOTTING FOR HEMOPHILIACS	0			0 0	0	
65.00 0650	DO RESPI RATORY THERAPY	1, 363, 378	0	1, 363, 37	8 0	1, 363, 378	65.00
66.00 0660	DO PHYSI CAL THERAPY	1, 826, 963	0	1, 826, 96	3 0	1, 826, 963	66.00
67.00 0670	DO OCCUPATIONAL THERAPY	398, 411	0	398, 41	1 0	398, 411	67.00
68.00 0680	DO SPEECH PATHOLOGY	127, 581	0	127, 58	1 0	127, 581	68.00
69.00 0690	DO ELECTROCARDI OLOGY	146		14	6 0	146	69.00
71.00 0710	DO MEDICAL SUPPLIES CHARGED TO PATIENT	1, 140, 691		1, 140, 69	1 0	1, 140, 691	71.00
72.00 0720	DO IMPL. DEV. CHARGED TO PATIENTS	1, 259, 115		1, 259, 11	5 0	1, 259, 115	72.00
73.00 0730	DO DRUGS CHARGED TO PATIENTS	4, 427, 021		4, 427, 02	1 0	4, 427, 021	
76.97 076	97 CARDI AC REHABI LI TATI ON	0			0 0	C	76.97
76.98 076	98 HYPERBARI C OXYGEN THERAPY	17, 529		17, 52	9 0	17, 529	76.98
76.99 076	99 LI THOTRI PSY	0			0 0	C	76.99
OUTF	PATIENT SERVICE COST CENTERS						1
	DO EMERGENCY	2, 599, 441		2, 599, 44	1 0	2, 599, 441	91.00
92.00 0920	OO OBSERVATION BEDS (NON-DISTINCT PART	1, 457, 582		1, 457, 58	2	1, 457, 582	92.00
	ER REIMBURSABLE COST CENTERS		1				
	DO AMBULANCE SERVICES	3, 947, 194		3, 947, 19	4 0	3, 947, 194	95.00
	CLAL PURPOSE COST CENTERS		1				
	DO INTEREST EXPENSE						1113.00
200.00	Subtotal (see instructions)	36, 098, 359	0	36, 098, 35	9 2,017	36, 100, 376	
201.00	Less Observation Beds	1, 457, 582		1, 457, 58		1, 457, 582	
202.00	Total (see instructions)	34, 640, 777					
1		1 1 1					

Heal th Fi	nancial Systems	HUNTI NGTON MEMOR	RIAL HOSPITAL		In Lie	u of Form CMS-	2552-10
COMPUTATI	ON OF RATIO OF COSTS TO CHARGES		Provider C		Period: From 01/01/2016 To 12/31/2016	Date/Time Pre 5/19/2017 9:1	
		-	Titl	e XIX	Hospi tal	PPS	
			Charges				
	Cost Center Description	I npati ent	Outpati ent	Total (col. + col. 7)	6 Cost or Other Ratio	TEFRA I npati ent Rati o	
		6.00	7.00	8.00	9.00	10.00	
IN	PATIENT ROUTINE SERVICE COST CENTERS			•			
30.00 03	000 ADULTS & PEDIATRICS	7, 456, 512		7, 456, 51	2		30.00
43.00 04	300 NURSERY	910, 329		910, 32	9		43.00
ANG	CILLARY SERVICE COST CENTERS						1
	000 OPERATI NG ROOM	6, 220, 194	15, 528, 549	21, 748, 74	3 0.099099	0.00000	50.00
52.00 05	200 DELIVERY ROOM & LABOR ROOM	3, 884, 031	0	3, 884, 03	0. 273132	0.00000	52.00
53.00 05	300 ANESTHESI OLOGY	703, 888	2, 827, 304	3, 531, 19	0. 235298	0.00000	53.00
54.00 05	400 RADI OLOGY-DI AGNOSTI C	3, 222, 014	30, 839, 631	34, 061, 64	5 0.093953	0.00000	54.00
60.00 06	000 LABORATORY	2, 989, 066	13, 853, 447	16, 842, 51	3 0. 193757	0. 000000	60.00
62.30 06	250 BLOOD CLOTTING FOR HEMOPHILIACS	0	0		0 0.000000	0. 000000	62.30
65.00 06	500 RESPI RATORY THERAPY	1, 294, 679	4, 283, 401	5, 578, 08	0. 244417	0. 000000	65.00
66.00 06	600 PHYSI CAL THERAPY	555, 703	3, 656, 911	4, 212, 61	4 0.433689	0. 000000	66.00
67.00 06	700 OCCUPATI ONAL THERAPY	93, 481	1, 103, 885	1, 197, 36	0. 332740	0. 000000	67.00
68.00 06	800 SPEECH PATHOLOGY	24, 055	353, 042	377, 09	0. 338324	0. 000000	68.00
69.00 06	900 ELECTROCARDI OLOGY	685, 038	296, 869			0. 000000	69.00
	100 MEDICAL SUPPLIES CHARGED TO PATIENT	2, 413, 122	8, 641, 354			0. 000000	71.00
72.00 07	200 IMPL. DEV. CHARGED TO PATIENTS	5,058,524	1, 149, 750		0. 202812	0. 000000	72.00
73.00 07	300 DRUGS CHARGED TO PATIENTS	4, 789, 243	9, 353, 890			0.00000	1
	697 CARDI AC REHABI LI TATI ON	0	0		0 0.000000	0.00000	
	698 HYPERBARI C OXYGEN THERAPY	119, 730	113, 059	232, 78		0.00000	
	699 LI THOTRI PSY	0	0		0 0.000000	0.00000	
	TPATIENT SERVICE COST CENTERS						
	100 EMERGENCY	2, 402, 958	18, 090, 101	20, 493, 05	0. 126845	0.00000	91.00
	200 OBSERVATION BEDS (NON-DISTINCT PART	0	1, 566, 452			0.00000	
	HER REIMBURSABLE COST CENTERS						
	500 AMBULANCE SERVICES	0	7, 889, 309	7, 889, 30	0. 500322	0.00000	95.00
	ECIAL PURPOSE COST CENTERS			,,			
	300 INTEREST EXPENSE						113.00
200.00	Subtotal (see instructions)	42, 822, 567	119, 546, 954	162, 369, 52	21		200.00
201.00	Less Observation Beds	.2, 322, 007	,,,				201.00
202.00	Total (see instructions)	42, 822, 567	119, 546, 954	162, 369, 52	21		202.00

Health Financial Systems	HUNTINGTON MEMORI	AL HOSPI TAL	In Lie	u of Form CMS-2552-10
COMPUTATION OF RATIO OF COSTS TO CHARGES		Provider CCN: 15-0091	Period: From 01/01/2016 To 12/31/2016	Worksheet C Part I Date/Time Prepared: 5/19/2017 9:13 am
		Title XIX	Hospi tal	PPS
Cost Center Description	PPS Inpatient			
	Ratio			
	11.00			
INPATIENT ROUTINE SERVICE COST CENTERS				
30. 00 03000 ADULTS & PEDIATRICS				30.00
43.00 04300 NURSERY				43.00
ANCILLARY SERVICE COST CENTERS				
50.00 05000 OPERATI NG ROOM	0. 099192			50.00
52.00 05200 DELIVERY ROOM & LABOR ROOM	0. 273132			52.00
53. 00 05300 ANESTHESI OLOGY	0. 235298			53.00
54.00 05400 RADI OLOGY-DI AGNOSTI C	0. 093953			54.00
60.00 06000 LABORATORY	0. 193757			60.00
62.30 06250 BLOOD CLOTTING FOR HEMOPHILIACS	0. 000000			62.30
65. 00 06500 RESPI RATORY THERAPY	0. 244417			65.00
66. 00 06600 PHYSI CAL THERAPY	0. 433689			66.00
67.00 06700 OCCUPATI ONAL THERAPY	0. 332740			67.00
68.00 06800 SPEECH PATHOLOGY	0. 338324			68.00
69. 00 06900 ELECTROCARDI OLOGY	0.000149			69.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0. 103188			71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0. 202812			72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	0. 313016			73.00
76. 97 07697 CARDI AC REHABI LI TATI ON	0. 000000			76.97
76. 98 07698 HYPERBARI C OXYGEN THERAPY	0. 075300			76.98
76. 99 07699 LI THOTRI PSY	0. 000000			76.99
OUTPATIENT SERVICE COST CENTERS	<b>I</b> I			
91. 00 09100 EMERGENCY	0. 126845			91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART	0. 930499			92.00
OTHER REIMBURSABLE COST CENTERS	<b>i</b>			
95. 00 09500 AMBULANCE SERVICES	0. 500322			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
	1 I			

Health Financial Systems	HUNTI NGTON MEMO	RIAL HOSPITAL		In Lie	u of Form CMS-:	2552-10
CALCULATION OF OUTPATIENT SERVICE COST TO CHARGE R REDUCTIONS FOR MEDICAID ONLY	ATIOS NET OF	Provider C		Period: From 01/01/2016 To 12/31/2016	5/19/2017 9:1	pared: 3 am
		Titl	e XIX	Hospi tal	PPS	
Cost Center Description	Total Cost	Capital Cost			Operating Cost	
	(Wkst. B, Part	(Wkst. B, Part	Net of Capita	I Reduction	Reduction	
	I, col. 26)	II col. 26)	Cost (col. 1	-	Amount	
			col. 2)			
	1.00	2.00	3.00	4.00	5.00	
ANCI LLARY SERVI CE COST CENTERS						
50.00 05000 OPERATING ROOM	2, 155, 279	256, 062	1, 899, 21	7 0	0	50.00
52.00 05200 DELIVERY ROOM & LABOR ROOM	1, 060, 852	59, 348	1, 001, 50	04 0	0	52.00
53. 00 05300 ANESTHESI OLOGY	830, 881	46, 270	784, 61	1 0	0	53.00
54.00 05400 RADI OLOGY-DI AGNOSTI C	3, 200, 182	405, 847	2, 794, 33	35 0	0	54.00
60. 00 06000 LABORATORY	3, 263, 354	186, 857	3, 076, 49	97 0	0	60.00
62.30 06250 BLOOD CLOTTING FOR HEMOPHILIACS	0	0		0 0	0	62.30
65. 00 06500 RESPI RATORY THERAPY	1, 363, 378	111, 729	1, 251, 64	19 0	0	65.00
66. 00 06600 PHYSI CAL THERAPY	1, 826, 963	132, 939	1, 694, 02	24 0	0	66.00
67.00 06700 OCCUPATI ONAL THERAPY	398, 411	22, 243	376, 16	0 8	0	67.00
68.00 06800 SPEECH PATHOLOGY	127, 581	7, 123	120, 45	0 8	0	68.00
69.00 06900 ELECTROCARDI OLOGY	146	19	12	27 0	0	69.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	1, 140, 691	66, 641	1, 074, 05	0 0	0	71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	1, 259, 115	70, 127	1, 188, 98	0 88	0	72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	4, 427, 021	310, 762	4, 116, 25	59 O	0	73.00
76. 97 07697 CARDI AC REHABI LI TATI ON	0	C		0 0	0	76.97
76. 98 07698 HYPERBARI C OXYGEN THERAPY	17, 529	981	16, 54	8 0	0	76.98
76. 99 07699 LI THOTRI PSY	0			0 0	0	76.99
OUTPATIENT SERVICE COST CENTERS		·	•			1
91.00 09100 EMERGENCY	2, 599, 441	189, 119	2, 410, 32	22 0	0	91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART	1, 457, 582	118, 500	1, 339, 08	32 0	0	92.00
OTHER REIMBURSABLE COST CENTERS						1
95. 00 09500 AMBULANCE SERVICES	3, 947, 194	384, 967	3, 562, 22	27 0	0	95.00
SPECIAL PURPOSE COST CENTERS						1
113.00 11300 INTEREST EXPENSE						113.00
200.00 Subtotal (sum of lines 50 thru 199)	29, 075, 600	2, 369, 534	26, 706, 06	0 0	0	200.00
201.00 Less Observation Beds	1, 457, 582					201.00
202.00 Total (line 200 minus line 201)	27, 618, 018					202.00
•						

Health Financial Systems	HUNTI NGTON MEMOR	I AL HOSPI TAL		In Lie	u of Form CMS-255	2-10
CALCULATION OF OUTPATIENT SERVICE COST TO CHARGE REDUCTIONS FOR MEDICAID ONLY	RATIOS NET OF	Provider C	CN: 15-0091	Period: From 01/01/2016 To 12/31/2016	Worksheet C Part II Date/Time Prepar 5/19/2017 9:13 a	
		Ti tl	e XIX	Hospi tal	PPS	
Cost Center Description		Total Charges				
		(Worksheet C,				
	Operating CostP	art I, column	Ratio (col.	6		
	Reduction	8)	/ col. 7)			
	6.00	7.00	8.00			
ANCILLARY SERVICE COST CENTERS						
50.00 05000 OPERATI NG ROOM	2, 155, 279	21, 748, 743	0.0990	99		0.00
52.00 05200 DELIVERY ROOM & LABOR ROOM	1, 060, 852	3, 884, 031	0. 27313	32	52	2.00
53. 00 05300 ANESTHESI OLOGY	830, 881	3, 531, 192	0. 23529	98	53	3.00
54.00 05400 RADI OLOGY-DI AGNOSTI C	3, 200, 182	34, 061, 645	0. 09395	53	54	4.00
60. 00 06000 LABORATORY	3, 263, 354	16, 842, 513	0. 1937	57	60	0. 00
62.30 06250 BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0.0000	00	62	2.30
65. 00 06500 RESPI RATORY THERAPY	1, 363, 378	5, 578, 080	0. 2444	17	6	5.00
66. 00 06600 PHYSI CAL THERAPY	1, 826, 963	4, 212, 614	0. 43368	39	60	6.00
67.00 06700 OCCUPATI ONAL THERAPY	398, 411	1, 197, 366	0. 33274	40	6	7.00
68.00 06800 SPEECH PATHOLOGY	127, 581	377, 097	0. 33832	24	68	8.00
69.00 06900 ELECTROCARDI OLOGY	146	981, 907	0.00014	19	60	9.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	1, 140, 691	11, 054, 476	0. 10318	38	7	1.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	1, 259, 115	6, 208, 274	0. 2028	12	7:	2.00
73.00 07300 DRUGS CHARGED TO PATIENTS	4, 427, 021	14, 143, 133	0. 3130	16	7:	3.00
76. 97 07697 CARDI AC REHABI LI TATI ON	0	0		00	70	6. 97
76. 98 07698 HYPERBARI C OXYGEN THERAPY	17, 529	232, 789	0.07530	00	70	6. 98
76. 99 07699 LI THOTRI PSY	0	0	0.0000	00	70	6.99
OUTPATIENT SERVICE COST CENTERS	· · ·					
91. 00 09100 EMERGENCY	2, 599, 441	20, 493, 059	0. 12684	15	9'	1.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART	1, 457, 582	1, 566, 452			9	2.00
OTHER REIMBURSABLE COST CENTERS	, ,					
95. 00 09500 AMBULANCE SERVICES	3, 947, 194	7, 889, 309	0.50032	22	9!	5.00
SPECIAL PURPOSE COST CENTERS		.,				
113. 00 11300 I NTEREST EXPENSE					11:	3.00
200.00 Subtotal (sum of lines 50 thru 199)	29, 075, 600	154, 002, 680				0.00
201.00 Less Observation Beds	1, 457, 582	0				1.00
202.00 Total (line 200 minus line 201)	27, 618, 018	154, 002, 680				2.00

Health Financial Systems	HUNTINGTON MEMORIAL HOSPITAL			In Lie	u of Form CMS-	2552-10
APPORTIONMENT OF INPATIENT ROUTINE SERVICE CAPITAL	COSTS	Provider C		Peri od:	Worksheet D	
				From 01/01/2016 To 12/31/2016		narod
				10 12/31/2010	5/19/2017 9:1	3 am
		Title	e XVIII	Hospi tal	PPS	
Cost Center Description	Capi tal	Swing Bed	Reduced		Per Diem (col.	
	Related Cost	Adjustment	Capi tal	Days	3 / col. 4)	
	(from Wkst. B,		Related Cost			
	Part II, col.		(col. 1 - col			
	26)		2)			
	1.00	2.00	3.00	4.00	5.00	
INPATIENT ROUTINE SERVICE COST CENTERS	1	r	1	-	r	
30.00 ADULTS & PEDIATRICS	549, 913		549, 91			•
43.00 NURSERY	14, 753		14, 75	53 748	19. 72	•
200.00 Total (lines 30-199)	564, 666		564, 66	6, 275		200.00
Cost Center Description	Inpati ent	Inpatient				
	Program days	Program				
		Capital Cost				
		(col. 5 x col.				
		6)	1			
	6.00	7.00				
INPATIENT ROUTINE SERVICE COST CENTERS						
30. 00 ADULTS & PEDIATRICS	1,633	162, 484	+			30.00
43.00 NURSERY	0	0				43.00
200.00 Total (lines 30-199)	1, 633	162, 484	.			200.00

Health Financial Systems	HUNTINGTON MEMO	RIAL HOSPITAL		In Lie	eu of Form CMS-:	2552-10
APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPIT.	AL COSTS	Provider C		Period: From 01/01/2016 To 12/31/2016	Date/Time Pre 5/19/2017 9:1	pared: 3 am
		Title	XVIII	Hospi tal	PPS	
Cost Center Description	Capi tal	Total Charges	Ratio of Cos	t Inpatient	Capital Costs	
	Related Cost	(from Wkst. C,	to Charges	Program	(column 3 x	
	(from Wkst. B,	Part I, col.	(col. 1 ÷ col	. Charges	column 4)	
	Part II, col.	8)	2)			
	26)					
	1.00	2.00	3.00	4.00	5.00	
ANCILLARY SERVICE COST CENTERS						
50. 00 05000 OPERATI NG ROOM	256, 062	21, 748, 743	0. 01177	4 1, 738, 470	20, 469	50.00
52.00 05200 DELIVERY ROOM & LABOR ROOM	59, 348	3, 884, 031	0. 01528	0 0	0	52.00
53. 00 05300 ANESTHESI OLOGY	46, 270	3, 531, 192	0. 01310	03 0	0	53.00
54.00 05400 RADI OLOGY-DI AGNOSTI C	405, 847	34, 061, 645	0. 01191	5 1, 273, 204	15, 170	54.00
60. 00 06000 LABORATORY	186, 857	16, 842, 513	0. 01109	1, 124, 640	12, 477	60.00
62.30 06250 BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0.00000	0 0	0	62.30
65. 00 06500 RESPI RATORY THERAPY	111, 729	5, 578, 080	0. 02003	581, 765	11, 653	65.00
66. 00 06600 PHYSI CAL THERAPY	132, 939	4, 212, 614	0. 03155	291, 675		66.00
67.00 06700 OCCUPATIONAL THERAPY	22, 243	1, 197, 366	0. 01857			67.00
68.00 06800 SPEECH PATHOLOGY	7, 123					68,00
69. 00 06900 ELECTROCARDI OLOGY	19				6	69.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	66, 641				3, 470	
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	70, 127					
73.00 07300 DRUGS CHARGED TO PATIENTS	310, 762					
76. 97 07697 CARDI AC REHABI LI TATI ON	0				0	76.97
76. 98 07698 HYPERBARI C OXYGEN THERAPY	981	232, 789			0	76.98
76. 99 07699 LI THOTRI PSY	0				-	76.99
OUTPATIENT SERVICE COST CENTERS			0.00000	.0	<u> </u>	/0. //
91. 00 09100 EMERGENCY	189, 119	20, 493, 059	0.00922	1, 025, 012	9, 459	91.00
92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART	118, 500					92.00
OTHER REIMBURSABLE COST CENTERS	110,000	1,000,402	0.0700-	0		12.00
95. 00 09500 AMBULANCE SERVICES						95.00
200.00 Total (lines 50-199)	1, 984, 567	146, 113, 371		10, 543, 311	141, 427	
	1, 704, 307	170, 113, 371	I	10, 545, 511	171,427	1200.00

Health Financial Systems	HUNTINGTON MEMORIAL HOSPITAL In Lieu o						2552-10
APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER P	ASS THROUGH COS	TS	Provider CO		Period: From 01/01/2016 To 12/31/2016		pared: 3 am
i				XVIII	Hospi tal	PPS	
Cost Center Description	Nursing School	ALLI	ed Health	All Other	Swi ng-Bed	Total Costs	
			Cost	Medi cal	Adjustment	(sum of cols.	
				Education Cos	t 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 & PEDIATRICS	0	)	0	1	0 0	0	30.00
43. 00 04300 NURSERY	0		0		0	0	43.00
200.00 Total (lines 30-199)	0		0		0	0	200.00
Cost Center Description	Total Patient	Per	Diem (col.	Inpatient	Inpati ent		
	Days	5 -	+ col. 6)	Program Days	Program		
					Pass-Through		
					Cost (col. 7 x		
					col. 8)		
	6.00		7.00	8.00	9.00	1	
INPATIENT ROUTINE SERVICE COST CENTERS							
30. 00 03000 ADULTS & PEDIATRICS	5, 527	'	0.00	1, 63	3 C		30.00
43.00 04300 NURSERY	748	3	0.00		0 0		43.00
200.00 Total (lines 30-199)	6, 275	5		1, 63	3 C		200. 00

Health Financial Systems	HUNTI NGTON MEMOR	REAL HOSPETAL		In Lie	u of Form CMS-2	2552-10
APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SE THROUGH COSTS	ERVICE OTHER PASS			Period: From 01/01/2016 To 12/31/2016	5/19/2017 9:1	pared: 3 am
		Title	e XVIII	Hospi tal	PPS	
Cost Center Description	Non Physician	Nursing School	Allied Healt	h All Other	Total Cost	
	Anesthetist	-		Medi cal	(sum of col 1	
	Cost			Education Cost	through col.	
					4)	
	1.00	2.00	3.00	4.00	5.00	
ANCI LLARY SERVI CE COST CENTERS						
50. 00 05000 OPERATI NG ROOM	0	0	1	0 0	0	50.00
52.00 05200 DELIVERY ROOM & LABOR ROOM	0	0		0 0	0	52.00
53. 00 05300 ANESTHESI OLOGY	0	0		0 0	0	53.00
54.00 05400 RADI OLOGY-DI AGNOSTI C	0	0		0 0	0	54.00
60. 00 06000 LABORATORY	0	0		0 0	0	60.00
62.30 06250 BLOOD CLOTTING FOR HEMOPHILIACS	0	0		0 0	0	62.30
65. 00 06500 RESPI RATORY THERAPY	0	0		0 0	0	65.00
66. 00 06600 PHYSI CAL THERAPY	0	0		0 0	0	66.00
67.00 06700 OCCUPATI ONAL THERAPY	0	0		0 0	0	67.00
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 I MPL. 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 OXYGEN THERAPY	0	0		0 0	0	76.98
76. 99 07699 LI THOTRI PSY	0	0		0 0	0	76.99
OUTPATIENT SERVICE COST CENTERS	-1 -1		1		-	
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	-1 -1				-	
95. 00 09500 AMBULANCE SERVICES						95.00
200.00 Total (lines 50-199)	0	0		0 0	0	200.00
	1			-		

Heal th	Financial Systems	HUNTINGTON MEMO	RIAL HOSPITAL		In Lie	u of Form CMS-2	2552-10
APPORT	IONMENT OF INPATIENT/OUTPATIENT ANCILLARY SER	VICE OTHER PASS	S Provider C		Peri od:	Worksheet D	
THROUG	GH COSTS				From 01/01/2016	Part IV	
					To 12/31/2016	Date/Time Pre 5/19/2017 9:1	
				XVIII	Hospital PPS		
	Cost Center Description	Total	Total Charges			Inpati ent	
			(from Wkst. C,		Ratio of Cost		
		Cost (sum of				Charges	
		col. 2, 3 and	8)	7)	(col. 6 ÷ col.		
		4)			7)		
		6.00	7.00	8.00	9.00	10.00	
	ANCI LLARY SERVICE COST CENTERS	1		1	1		
50.00	05000 OPERATING ROOM	0	21, 748, 743			1, 738, 470	
52.00	05200 DELIVERY ROOM & LABOR ROOM	0	3, 884, 031			0	52.00
53.00	05300 ANESTHESI OLOGY	0	3, 531, 192	0.00000	0 0. 000000	0	53.00
54.00	05400 RADI OLOGY-DI AGNOSTI C	0	34, 061, 645			1, 273, 204	54.00
60.00	06000 LABORATORY	0	16, 842, 513	0.00000	0.000000	1, 124, 640	60.00
62.30	06250 BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0.00000	0.000000	0	62.30
65.00	06500 RESPI RATORY THERAPY	0	5, 578, 080	0.00000	0.000000	581, 765	65.00
66.00	06600 PHYSI CAL THERAPY	0	4, 212, 614	0. 00000	0.000000	291, 675	66.00
67.00	06700 OCCUPATI ONAL THERAPY	0	1, 197, 366	0. 00000	0.000000	48, 637	67.00
68.00	06800 SPEECH PATHOLOGY	0	377, 097	0. 00000	0.000000	12, 391	68.00
69.00	06900 ELECTROCARDI OLOGY	0	981, 907	0. 00000	0.000000	329, 511	69.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0	11, 054, 476	0. 00000	0.000000	575, 610	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0	6, 208, 274	0. 00000	0.000000	1, 822, 183	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0	14, 143, 133	0. 00000	0. 000000	1, 720, 213	73.00
76.97	07697 CARDI AC REHABI LI TATI ON	0	0		0. 000000	0	1
76. 98	07698 HYPERBARI C OXYGEN THERAPY	0	232, 789	0. 00000	0. 000000	0	76.98
76.99	07699 LI THOTRI PSY	0	0	1	0. 000000	0	76.99
	OUTPATIENT SERVICE COST CENTERS						1
91.00	09100 EMERGENCY	0	20, 493, 059	0.00000	0 0.00000	1, 025, 012	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART	0	1, 566, 452	0. 00000	0. 000000	0	92.00
	OTHER REIMBURSABLE COST CENTERS						1
95.00	09500 AMBULANCE SERVICES						95.00
200.00		0	146, 113, 371			10, 543, 311	200.00

Health Financial Systems	HUNTI NGTON MEMOR	REAL HOSPETAL		In Lie	u of Form CMS-	2552-10
APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SEF THROUGH COSTS	RVICE OTHER PASS			Period: From 01/01/2016 To 12/31/2016	Date/Time Pre 5/19/2017 9:1	
		Title	XVIII	Hospi tal	PPS	
Cost Center Description	I npati ent	Outpati ent	Outpati ent			
	Program	Program	Program			
	Pass-Through	Charges	Pass-Through			
	Costs (col. 8		Costs (col.	9		
	x col. 10)		x col. 12)			
	11.00	12.00	13.00			
ANCI LLARY SERVI CE COST CENTERS						
50.00 05000 OPERATI NG ROOM	0	3, 352, 756		0		50.00
52.00 05200 DELIVERY ROOM & LABOR ROOM	0	0		0		52.00
53. 00 05300 ANESTHESI OLOGY	0	0		0		53.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	0	6, 747, 456		0		54.00
60. 00 06000 LABORATORY	0	298, 830		0		60.00
62.30 06250 BLOOD CLOTTING FOR HEMOPHILIACS	0	0		0		62.30
65. 00 06500 RESPI RATORY THERAPY	0	795, 982		0		65.00
66. 00 06600 PHYSI CAL THERAPY	0	0		0		66.00
67.00 06700 OCCUPATI ONAL THERAPY	0	0		0		67.00
68.00 06800 SPEECH PATHOLOGY	0	0		0		68.00
69. 00 06900 ELECTROCARDI OLOGY	0	119, 067		0		69.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0	429, 384		0		71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0	120, 003		0		72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	0	192, 722		0		73.00
76. 97 07697 CARDI AC REHABI LI TATI ON	0	0		0		76.97
76. 98 07698 HYPERBARI C OXYGEN THERAPY	0	921		0		76.98
76. 99 07699 LI THOTRI PSY	0	0		0		76.99
OUTPATIENT SERVICE COST CENTERS	· · ·					
91.00 09100 EMERGENCY	0	3, 348, 687		0		7 91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART	0	812, 988		0		92.00
OTHER REIMBURSABLE COST CENTERS						
95. 00 09500 AMBULANCE SERVICES						95.00
200.00 Total (lines 50-199)	0	16, 218, 796		0		200.00
•						

Health Financ	cial Systems	HUNTINGTON MEMO	RIAL HOSPITAL		In Lie	u of Form CMS-	2552-10
APPORTI ONMEN	T OF MEDICAL, OTHER HEALTH SERVICES AND	VACCINE COST	Provider CO		Period: From 01/01/2016 To 12/31/2016		
			Title	XVIII	Hospi tal	PPS	
				Charges		Costs	
	Cost Center Description	Cost to Charge	PPS Reimbursed	Cost	Cost	PPS Services	
		Ratio From	Services (see	Reimbursed	Reimbursed	(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	
	ARY SERVICE COST CENTERS	1					
	OPERATING ROOM	0. 099099			0 0	332, 255	
	DELIVERY ROOM & LABOR ROOM	0. 273132			0 0	0	
	ANESTHESI OLOGY	0. 235298			0 0	0	
	RADI OLOGY-DI AGNOSTI C	0. 093953			0 0	633, 944	
	LABORATORY	0. 193757	298, 830		0 0	57, 900	
	BLOOD CLOTTING FOR HEMOPHILIACS	0. 000000			0 0	0	
	RESPI RATORY THERAPY	0. 244417			0 0	194, 552	
66.00 06600	PHYSI CAL THERAPY	0. 433689	0		0 0	0	66.00
67.00 06700	OCCUPATIONAL THERAPY	0. 332740	0		0 0	0	67.00
68.00 06800	SPEECH PATHOLOGY	0. 338324	0		0 0	0	68.00
69.00 06900	ELECTROCARDI OLOGY	0.000149	119, 067		0 0	18	69.00
71.00 07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0. 103188	429, 384		0 0	44, 307	71.00
72.00 07200	IMPL. DEV. CHARGED TO PATIENTS	0. 202812	120, 003		0 0	24, 338	72.00
73.00 07300	DRUGS CHARGED TO PATIENTS	0. 313016	192, 722		0 0	60, 325	73.00
76.97 07697	CARDI AC REHABI LI TATI ON	0. 000000	0		0 0	0	76.97
76.98 07698	HYPERBARIC OXYGEN THERAPY	0.075300	921		0 0	69	76.98
76.99 07699	LI THOTRI PSY	0. 000000	0		0 0	0	76.99
OUTPAT	TIENT SERVICE COST CENTERS						
91.00 09100	EMERGENCY	0. 126845	3, 348, 687		0 0	424, 764	91.00
92.00 09200	OBSERVATION BEDS (NON-DISTINCT PART	0. 930499	812, 988	1	0 0	756, 485	92.00
OTHER	REIMBURSABLE COST CENTERS						1
95.00 09500	AMBULANCE SERVICES	0. 500322			0		95.00
200.00	Subtotal (see instructions)		16, 218, 796		0 0	2, 528, 957	200.00
201.00	Less PBP Clinic Lab. Services-Program				0 0		201.00
	Only Charges						
202.00	Net Charges (line 200 +/- line 201)		16, 218, 796		0 0	2, 528, 957	202.00

Health Financial Systems HUNTINGTON MEMORIAL HOSPITAL In Lieu of Form CMS-2552-1								
APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND	VACCINE COST	Provider C	CN: 15-0091	Period: From 01/01/2016 To 12/31/2016	Worksheet D Part V Date/Time Pre 5/19/2017 9:1			
		Title	XVIII	Hospi tal	PPS			
	Cos							
Cost Center Description	Cost	Cost						
	Reimbursed	Reimbursed						
	Servi ces	Services Not						
	Subject To	Subject To						
		Ded. & Coins.						
	(see inst.)	(see inst.)	-					
	6.00	7.00						
ANCI LLARY SERVI CE COST CENTERS		-	1			1		
50. 00 05000 OPERATI NG ROOM	0	0	•			50.00		
52.00 05200 DELIVERY ROOM & LABOR ROOM	0	C				52.00		
53. 00 05300 ANESTHESI OLOGY	0	C				53.00		
54. 00 05400 RADI OLOGY-DI AGNOSTI C	0	C				54.00		
60. 00 06000 LABORATORY	0	C				60.00		
62.30 06250 BLOOD CLOTTING FOR HEMOPHILIACS	0	C				62.30		
65. 00 06500 RESPI RATORY THERAPY	0	C				65.00		
66. 00 06600 PHYSI CAL THERAPY	0	C				66.00		
67.00 06700 OCCUPATI ONAL THERAPY	0	C				67.00		
68.00 06800 SPEECH PATHOLOGY	0	0				68.00		
69. 00 06900 ELECTROCARDI OLOGY	0	0				69.00		
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0	0				71.00		
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0	0				72.00		
73.00 07300 DRUGS CHARGED TO PATIENTS	0	0				73.00		
76. 97 07697 CARDI AC REHABI LI TATI ON	0	C				76.97		
76. 98 07698 HYPERBARI C OXYGEN THERAPY	0	C				76. 98		
76. 99 07699 LI THOTRI PSY	0	C				76.99		
OUTPATIENT SERVICE COST CENTERS								
91. 00 09100 EMERGENCY	0	C				91.00		
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART	0	C				92.00		
OTHER REIMBURSABLE COST CENTERS								
95. 00 09500 AMBULANCE SERVI CES	0					95.00		
200.00 Subtotal (see instructions)	0	C				200.00		
201.00 Less PBP Clinic Lab. Services-Program	0					201.00		
Only Charges								
202.00 Net Charges (line 200 +/- line 201)	0	C				202.00		

Health Financial Systems					eu of Form CMS-	2552-10
APPORTIONMENT OF INPATIENT ROUTINE SERVICE CAPITAL	COSTS	Provider C	CN: 15-0091	Period: From 01/01/2016	Worksheet D Part I	
				To 12/31/2016	Date/Time Pre 5/19/2017 9:1	pared: 3 am
		Titl	e 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 - co	l.		
	26)		2)			
	1.00	2.00	3.00	4.00	5.00	
INPATIENT ROUTINE SERVICE COST CENTERS						
30. 00 ADULTS & PEDIATRICS	549, 913	C	549, 9	13 5, 527	99.50	30.00
43.00 NURSERY	14, 753		14, 7	53 748	19.72	43.00
200.00 Total (lines 30-199)	564,666		564, 6	66 6, 275		200.00
Cost Center Description	I npati ent	I npati ent				
	Program days	Program				
		Capital Cost				
		(col. 5 x col.				
		6)				
	6.00	7.00				
INPATIENT ROUTINE SERVICE COST CENTERS						
30. 00 ADULTS & PEDIATRICS	51	5, 075	j			30.00
43.00 NURSERY	35	690				43.00
200.00 Total (lines 30-199)	86	5, 765	5			200. 00

Health Financial Systems	HUNTINGTON MEMO	RIAL HOSPITAL		In Lie	u of Form CMS-2	2552-10
APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITA	L COSTS		Provider CCN: 15-0091		Date/Time Pre 5/19/2017 9:1	pared: 3 am
		Titl	e XIX	Hospi tal	PPS	
Cost Center Description	Capi tal	Total Charges	Ratio of Cos	t Inpatient	Capital Costs	
	Related Cost	(from Wkst. C,		Program	(column 3 x	
	(from Wkst. B,			. Charges	column 4)	
	Part II, col.	8)	2)			
	26)					
	1.00	2.00	3.00	4.00	5.00	
ANCILLARY SERVICE COST CENTERS						
50.00 05000 OPERATING ROOM	256, 062	21, 748, 743	0. 01177	4 2, 410, 739	28, 384	50.00
52.00 05200 DELIVERY ROOM & LABOR ROOM	59, 348	3, 884, 031	0. 01528	0 0	0	52.00
53. 00 05300 ANESTHESI OLOGY	46, 270	3, 531, 192	0. 01310	3 0	0	53.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	405, 847	34, 061, 645	0. 01191	5 360, 061	4, 290	54.00
60. 00 06000 LABORATORY	186, 857	16, 842, 513	0. 01109	4 528, 870	5, 867	60.00
62.30 06250 BLOOD CLOTTING FOR HEMOPHILIACS	0		0. 00000	0 0	0	62.30
65. 00 06500 RESPI RATORY THERAPY	111, 729	5, 578, 080	0. 02003	0 178, 189	3, 569	65.00
66. 00 06600 PHYSI CAL THERAPY	132, 939	4, 212, 614	0. 03155	7 23, 349	737	66.00
67.00 06700 OCCUPATI ONAL THERAPY	22, 243	1, 197, 366	0. 01857	7 3, 575	66	67.00
68.00 06800 SPEECH PATHOLOGY	7, 123	377, 097	0. 01888	9 1, 224	23	68.00
69.00 06900 ELECTROCARDI OLOGY	19	981, 907	0. 00001	9 0	0	69.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	66, 641	11, 054, 476	0. 00602	.8 241, 373	1, 455	71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	70, 127	6, 208, 274	0. 01129	6 295, 710	3, 340	72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	310, 762					73.00
76. 97 07697 CARDI AC REHABI LI TATI ON	0		0.00000		0	76.97
76. 98 07698 HYPERBARI C OXYGEN THERAPY	981	232, 789			0	76.98
76. 99 07699 LI THOTRI PSY	0			0 0	0	76.99
OUTPATIENT SERVICE COST CENTERS		-		-		
91. 00 09100 EMERGENCY	189, 119	20, 493, 059	0.00922	8 319,070	2, 944	91.00
92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART	118, 500					92.00
OTHER REIMBURSABLE COST CENTERS	110,000	., 000, 102				
95. 00 09500 AMBULANCE SERVICES						95.00
200.00 Total (lines 50-199)	1, 984, 567	146, 113, 371		5, 194, 426	68, 962	

ealth Financial Systems HUNTINGTON MEMORIAL HOSPITAL In Lieu o						eu of Form CMS-	2552-10
APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER P	ASS THROUGH COS	TS I		CN: 15-0091	Period: From 01/01/2016 To 12/31/2016	Date/Time Pre 5/19/2017 9:1	pared: 3 am
i				e XIX	Hospi tal	PPS	
Cost Center Description	Nursing School	ALLI	ed Health	All Other	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 & PEDIATRICS	0	)	0	)	0 0	0	30.00
43. 00 04300 NURSERY	0		0		0	0	43.00
200.00 Total (lines 30-199)	0		0	)	0	0	200.00
Cost Center Description	Total Patient	Per	Diem (col.	I npati ent	I npati ent		
	Days	5 ÷	- col. 6)	Program Days	s Program		
					Pass-Through		
					Cost (col. 7 x		
					col. 8)		
	6.00		7.00	8.00	9.00		
INPATIENT ROUTINE SERVICE COST CENTERS	·						
30. 00 03000 ADULTS & PEDIATRICS	5, 527	/	0.00	) į	51 C		30.00
43.00 04300 NURSERY	748	3	0.00		35 C		43.00
200.00 Total (lines 30-199)	6, 275	5		8	36 C		200. 00

Health Financial Systems	HUNTI NGTON MEMOR	RIAL HOSPITAL		In Lie	u of Form CMS-2	2552-10
APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SER THROUGH COSTS	RVICE OTHER PASS			Period: From 01/01/2016 To 12/31/2016	Date/Time Pre 5/19/2017 9:1	pared: 3 am
		Ti tl	e XIX	Hospi tal	PPS	
Cost Center Description	Non Physician	Nursing School	Allied Healt	h All Other	Total Cost	
	Anesthetist	-		Medi cal	(sum of col 1	
	Cost			Education Cost	through col.	
					4)	
	1.00	2.00	3.00	4.00	5.00	
ANCI LLARY SERVI CE COST CENTERS			_			
50.00 05000 OPERATING ROOM	0	0		0 0	0	50.00
52.00 05200 DELIVERY ROOM & LABOR ROOM	0	0		0 0	0	52.00
53.00 05300 ANESTHESI OLOGY	0	0		0 0	0	53.00
54.00 05400 RADI OLOGY-DI AGNOSTI C	0	0	1	0 0	0	54.00
60. 00 06000 LABORATORY	0	0	1	0 0	0	60.00
62.30 06250 BLOOD CLOTTING FOR HEMOPHILIACS	0	0		0 0	0	62.30
65. 00 06500 RESPI RATORY THERAPY	0	0		0 0	0	65.00
66. 00 06600 PHYSI CAL THERAPY	0	0		0 0	0	66.00
67.00 06700 OCCUPATI ONAL THERAPY	0	0		0 0	0	67.00
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 OXYGEN THERAPY	0	0		0 0	0	76. 98
76. 99 07699 LI THOTRI PSY	0	0		0 0	0	76.99
OUTPATIENT SERVICE COST CENTERS	· · · ·		1			
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 09500 AMBULANCE SERVICES						95.00
200.00 Total (lines 50-199)	0	0		0 0	0	200.00
	'			1		•

Heal th	Financial Systems	HUNTINGTON MEMO	RIAL HOSPITAL		In Lie	u of Form CMS-2	2552-10
APPORT	IONMENT OF INPATIENT/OUTPATIENT ANCILLARY SER	VICE OTHER PASS	S Provider C		Peri od:	Worksheet D	
THROUG	GH COSTS				From 01/01/2016	Part IV	
					To 12/31/2016	Date/Time Pre 5/19/2017 9:1	
			Titl	e XIX	Hospi tal	PPS	
	Cost Center Description	Total	Total Charges			Inpati ent	
			(from Wkst. C,		Ratio of Cost	Program	
		Cost (sum of				Charges	
		col. 2, 3 and	8)	7)	(col. 6 ÷ col.		
		4)			7)		
		6.00	7.00	8.00	9.00	10.00	
	ANCI LLARY SERVICE COST CENTERS	1	-	1	-1		
50.00	05000 OPERATING ROOM	0	21, 748, 743			2, 410, 739	
52.00	05200 DELIVERY ROOM & LABOR ROOM	0	3, 884, 031			0	52.00
53.00	05300 ANESTHESI OLOGY	0	3, 531, 192	0.00000	0.000000	0	53.00
54.00	05400 RADI OLOGY-DI AGNOSTI C	0	34, 061, 645	0.00000	0.000000	360, 061	54.00
60.00	06000 LABORATORY	0	16, 842, 513	0. 00000	0.000000	528, 870	60.00
62.30	06250 BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0. 00000	0.000000	0	62.30
65.00	06500 RESPI RATORY THERAPY	0	5, 578, 080	0. 00000	0.000000	178, 189	65.00
66.00	06600 PHYSI CAL THERAPY	0	4, 212, 614	0. 00000	0.000000	23, 349	66.00
67.00	06700 OCCUPATI ONAL THERAPY	0	1, 197, 366	0. 00000	0. 000000	3, 575	67.00
68.00	06800 SPEECH PATHOLOGY	0	377,097	0. 00000	0. 000000	1, 224	68.00
69.00	06900 ELECTROCARDI OLOGY	0	981, 907	0. 00000	0. 000000	0	69.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0	11, 054, 476	0. 00000	0. 000000	241, 373	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0	6, 208, 274	0. 00000	0. 000000	295, 710	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0	14, 143, 133	0. 00000	0.00000	832, 266	73.00
76.97	07697 CARDI AC REHABI LI TATI ON	0	0	0.00000		0	76.97
76.98	07698 HYPERBARI C OXYGEN THERAPY	0	232, 789			0	76.98
76.99	07699 LI THOTRI PSY	0	0			0	76.99
	OUTPATIENT SERVICE COST CENTERS			0100000	0,00000		10177
91.00	09100 EMERGENCY	0	20, 493, 059	0,00000	0 0.00000	319, 070	91.00
	09200 OBSERVATION BEDS (NON-DISTINCT PART	0					92.00
00	OTHER REIMBURSABLE COST CENTERS		.,000,102		51 000000		
95.00	09500 AMBULANCE SERVICES						95.00
200.00		0	146, 113, 371			5, 194, 426	
			1	I	1	2, 17 1, 120	

Health Financial Systems HUNTINGTON MEMORIAL HOSPITAL In Lieu of						2552-10
APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS			CN: 15-0091	Period: From 01/01/2016 To 12/31/2016	Date/Time Pre 5/19/2017 9:1	
			e XIX	Hospi tal	PPS	
Cost Center Description	I npati ent	Outpati ent	Outpatient			
	Program	Program	Program			
	Pass-Through	Charges	Pass-Throug			
	Costs (col. 8		Costs (col.	9		
	x col. 10)		x col. 12)			
	11.00	12.00	13.00			
ANCI LLARY SERVI CE COST CENTERS						
50.00 05000 OPERATING ROOM	0	0		0		50.00
52.00 05200 DELIVERY ROOM & LABOR ROOM	0	0		0		52.00
53. 00 05300 ANESTHESI OLOGY	0	0		0		53.00
54.00 05400 RADI OLOGY-DI AGNOSTI C	0	0		0		54.00
60. 00 06000 LABORATORY	0	0		0		60.00
62.30 06250 BLOOD CLOTTING FOR HEMOPHILIACS	0	0	1	0		62.30
65. 00 06500 RESPI RATORY THERAPY	0	0		0		65.00
66. 00 06600 PHYSI CAL THERAPY	0	0		0		66.00
67.00 06700 OCCUPATI ONAL THERAPY	0	0		0		67.00
68.00 06800 SPEECH PATHOLOGY	0	0		0		68.00
69.00 06900 ELECTROCARDI OLOGY	0	0		0		69.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0	0		0		71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0	0		0		72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	0	0		0		73.00
76. 97 07697 CARDI AC REHABI LI TATI ON	0	0		0		76, 97
76. 98 07698 HYPERBARI C OXYGEN THERAPY	0	0		0		76, 98
76. 99 07699 LI THOTRI PSY	0	0		0		76, 99
OUTPATIENT SERVICE COST CENTERS				-		
91. 00 09100 EMERGENCY	0	0		0		91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART	0	0		0		92.00
OTHER REIMBURSABLE COST CENTERS	· · · · · ·		1			
95. 00 09500 AMBULANCE SERVICES						95.00
200.00 Total (lines 50-199)	0	0		0		200.00
		0	1	- 1		

Health Financial Systems	HUNTI NGTON MEMO	RIAL HOSPITAL		In Lie	u of Form CMS-:	2552-10
APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND	O VACCINE COST	Provider C	CN: 15-0091	Period: From 01/01/2016 To 12/31/2016		pared: 3 am
		Titl	e XIX	Hospi tal	PPS	
			Charges		Costs	
Cost Center Description	Cost to Charge			Cost	PPS Services	
		Services (see	Reimbursed	Reimbursed	(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	
ANCI LLARY SERVI CE COST CENTERS						
50. 00 05000 OPERATI NG ROOM	0. 099099	0	7, 145, 52	21 0	0	
52.00 05200 DELIVERY ROOM & LABOR ROOM	0. 273132	0		0 0	0	
53. 00 05300 ANESTHESI OLOGY	0. 235298	0		0 0	0	53.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	0. 093953	0	5, 894, 09		0	54.00
60. 00 06000 LABORATORY	0. 193757	0	2, 825, 16	5 0	0	60.00
62.30 06250 BLOOD CLOTTING FOR HEMOPHILIACS	0. 000000	0		0 0	0	62.30
65. 00 06500 RESPI RATORY THERAPY	0. 244417	0	475, 99	95 0	0	65.00
66. 00 06600 PHYSI CAL THERAPY	0. 433689	0	784, 10	02 0	0	66.00
67.00 06700 OCCUPATI ONAL THERAPY	0. 332740	0	398, 9	72 0	0	67.00
68.00 06800 SPEECH PATHOLOGY	0. 338324	0	177, 13	32 0	0	68.00
69. 00 06900 ELECTROCARDI OLOGY	0. 000149	0		0 0	0	69.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0. 103188	0	609, 02	22 0	0	71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0. 202812	0	206, 80	06 0	0	72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	0. 313016	0	1, 286, 15	56 0	0	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	0.075300	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. 126845	0	5, 752, 52	26 0	0	91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART	0. 930499	0	36, 03	39 0	0	92.00
OTHER REIMBURSABLE COST CENTERS					• •	1
95. 00 09500 AMBULANCE SERVICES	0. 500322	0	1, 255, 44	11		95.00
200.00 Subtotal (see instructions)		0	26, 846, 90	68 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	26, 846, 96	0 8	0	202.00

Health Financial Systems	HUNTINGTON MEMO	RIAL HOSPITAL		In Lie	u of Form CMS-:	2552-10
APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND	VACCINE COST	Provider C		Peri od: From 01/01/2016 To 12/31/2016	Worksheet D Part V Date/Time Pre 5/19/2017 9:1	pared: 3 am
		Titl	e XIX	Hospi tal	PPS	
	Cos	sts				
Cost Center Description	Cost	Cost				
	Reimbursed	Reimbursed				
	Servi ces	Services Not				
	Subject To	Subject To				
		Ded. & Coins.				
	(see inst.)	(see inst.)	-			
	6.00	7.00				
ANCI LLARY SERVI CE COST CENTERS						
50.00 05000 OPERATING ROOM	708, 114		•			50.00
52.00 05200 DELIVERY ROOM & LABOR ROOM	0	0				52.00
53. 00 05300 ANESTHESI OLOGY	0	0				53.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	553, 768					54.00
60. 00 06000 LABORATORY	547, 395	0				60.00
62.30 06250 BLOOD CLOTTING FOR HEMOPHILIACS	0	0				62.30
65. 00 06500 RESPI RATORY THERAPY	116, 341	0				65.00
66. 00 06600 PHYSI CAL THERAPY	340, 056	0				66.00
67.00 06700 OCCUPATI ONAL THERAPY	132, 754	0				67.00
68.00 06800 SPEECH PATHOLOGY	59, 928	0				68.00
69. 00 06900 ELECTROCARDI OLOGY	0	0				69.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	62, 844	C				71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	41, 943					72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	402, 587	0				73.00
76. 97 07697 CARDI AC REHABI LI TATI ON	0	0				76.97
76. 98 07698 HYPERBARI C OXYGEN THERAPY	0	0				76.98
76. 99 07699 LI THOTRI PSY	0	0				76.99
OUTPATIENT SERVICE COST CENTERS		•				1
91.00 09100 EMERGENCY	729, 679	0	1			91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART	33, 534	0				92.00
OTHER REIMBURSABLE COST CENTERS						]
95. 00 09500 AMBULANCE SERVICES	628, 125					95.00
200.00 Subtotal (see instructions)	4, 357, 068	0				200.00
201.00 Less PBP Clinic Lab. Services-Program	0					201.00
Only Charges						
202.00 Net Charges (line 200 +/- line 201)	4, 357, 068	o				202.00

MPUT	ATION OF INPATIENT OPERATING COST Provider CCN: 15-0091	Period: From 01/01/2016 To 12/31/2016	5/19/2017 9:1	parec
	Cost Center Description	Hospi tal	PPS	
	PART I - ALL PROVIDER COMPONENTS		1.00	
	I NPATI ENT DAYS			
00	Inpatient days (including private room days and swing-bed days, excluding newborn) Inpatient days (including private room days, excluding swing-bed and newborn days)		5, 527	
00	Private room days (excluding swing-bed and observation bed days). If you have only p	orivate room days,	5, 527 0	
	do not complete this line.			
00 00	Semi-private room days (excluding swing-bed and observation bed days) Total swing-bed SNF type inpatient days (including private room days) through Decemb	per 31 of the cost	4, 336 0	
00	reporting period		Ū	0.
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) Total swing-bed NF type inpatient days (including private room days) through December	er 31 of the cost	0	7.
00	reporting period		Ū	
00	Total swing-bed NF type inpatient days (including private room days) after December	31 of the cost	0	8.
00	reporting period (if calendar year, enter 0 on this line) Total inpatient days including private room days applicable to the Program (excluding	ng swing-bed and	1, 633	9.
	newborn days)	0 0	.,	
. 00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private through December 31 of the cost reporting period (see instructions)	room days)	0	10.
. 00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private	room days) after	0	11.
	December 31 of the cost reporting period (if calendar year, enter 0 on this line)	5 .	_	
. 00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including priva through December 31 of the cost reporting period	ate room days)	0	12.
. 00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including priva	ate room days)	0	13.
~~	after December 31 of the cost reporting period (if calendar year, enter 0 on this li			
	Medically necessary private room days applicable to the Program (excluding swing-bed Total nursery days (title V or XIX only)	days)	0	
	Nursery days (title V or XIX only)		0	
~~	SWING BED ADJUSTMENT	6.11	0.00	1 4 7
. 00	Medicare rate for swing-bed SNF services applicable to services through December 31 reporting period	of the cost	0.00	17.
.00	Medicare rate for swing-bed SNF services applicable to services after December 31 of	f the cost	0.00	18.
00	reporting period Medicaid rate for swing-bed NF services applicable to services through December 31 of	of the cost	0.00	19.
	reporting period			
. 00	Medicaid rate for swing-bed NF services applicable to services after December 31 of reporting period	the cost	0.00	20
00	Total general inpatient routine service cost (see instructions)		6, 764, 111	21
00	Swing-bed cost applicable to SNF type services through December 31 of the cost report	ting period (line	0	22
. 00	5 x line 17) Swing-bed cost applicable to SNF type services after December 31 of the cost reporti	ng period (line 6	0	23
	x line 18)	• • •		
. 00	Swing-bed cost applicable to NF type services through December 31 of the cost report $7 \times 1$ (ine 19)	ting period (line	0	24
. 00	Swing-bed cost applicable to NF type services after December 31 of the cost reportin	ng period (line 8	0	25.
. 00	x line 20) Total swing-bed cost (see instructions)		0	26.
	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)	)	6, 764, 111	
	PRIVATE ROOM DIFFERENTIAL ADJUSTMENT			
	General inpatient routine service charges (excluding swing-bed and observation bed of Private room charges (excluding swing-bed charges)	charges)	0	28
	Semi -private room charges (excluding swing bed charges)		0	
	General inpatient routine service cost/charge ratio (line 27 ÷ line 28)		0. 000000	
	Average private room per diem charge (line 29 ÷ line 3)		0.00	
	Average semi-private room per diem charge (line 30 ÷ line 4)		0.00	
	Average per diem private room charge differential (line 32 minus line 33) (see instru	ictions)	0.00	
	Average per diem private room cost differential (line 34 x line 31) Private room cost differential adjustment (line 3 x line 35)		0. 00 0	
	General inpatient routine service cost net of swing-bed cost and private room cost of	differential (line	6, 764, 111	
	27 minus Line 36)			1
	PART II - HOSPITAL AND SUBPROVIDERS ONLY PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS			-
	Adjusted general inpatient routine service cost per diem (see instructions)		1, 223. 83	38
	Program general inpatient routine service cost (line 9 x line 38)		1, 998, 514	
	Medically necessary private room cost applicable to the Program (line 14 x line 35)		0	40
. 00	Total Program general inpatient routine service cost (line 39 + line 40)		1, 998, 514	41

Heal th	Financial Systems	HUNTINGTON MEMO	RIAL HOSPITAL		In Lie	u of Form CMS-2	2552-10
COMPUT	ATION OF INPATIENT OPERATING COST		Provi der C		Period: From 01/01/2016	Worksheet D-1	
					To 12/31/2016		pared:
						5/19/2017 9:1	<u>3 am</u>
	Cost Conton Description	Total		XVIII	Hospi tal	PPS	
	Cost Center Description	Total	Total Inpatient Days	Average Per	Program Days	Program Cost (col. 3 x col.	
				col . 2)		4)	
		1.00	2.00	3.00	4.00	5.00	
42.00	NURSERY (title V & XIX only)	0	C	0.0	0 0	0	42.00
43.00	Intensive Care Type Inpatient Hospital Units INTENSIVE CARE UNIT			1			43.00
	CORONARY CARE UNIT						44.00
	BURN INTENSIVE CARE UNIT						45.00
	SURGICAL INTENSIVE CARE UNIT						46.00
47.00	OTHER SPECIAL CARE (SPECIFY)						47.00
	Cost Center Description					1.00	
48.00	Program inpatient ancillary service cost (Wk	st. D-3, col. 3	3, line 200)			1, 896, 512	48.00
	Total Program inpatient costs (sum of lines			ons)		3, 895, 026	49.00
	PASS THROUGH COST ADJUSTMENTS						
50.00	Pass through costs applicable to Program inp	patient routine	services (from	n Wkst. D, sum	of Parts I and	162, 484	50.00
51.00	<pre>III) Pass through costs applicable to Program inp and IV)</pre>	oatient ancillar	ry services (fr	rom Wkst. D, s	um of Parts II	141, 427	51.00
52.00	Total Program excludable cost (sum of lines	50 and 51)				303, 911	52.00
	Total Program inpatient operating cost exclu		ated, non-phy	sician anesth	etist, and	3, 591, 115	
	medical education costs (line 49 minus line	52)					
F 4 00	TARGET AMOUNT AND LIMIT COMPUTATION						
	Program discharges Target amount per discharge					0.00	54.00 55.00
	Target amount (line 54 x line 55)					0.00	56.00
	Difference between adjusted inpatient operat	ing cost and ta	arget amount (I	ine 56 minus	line 53)	0	57.00
	Bonus payment (see instructions)					0	58.00
59.00	Lesser of lines 53/54 or 55 from the cost remarket basket	mpounded by the	0.00	59.00			
60.00	Lesser of lines 53/54 or 55 from prior year	cost report, up	dated by the m	narket basket		0.00	60.00
	If line 53/54 is less than the lower of line				the amount by	0	61.00
	which operating costs (line 53) are less that		s (lines 54 x	60), or 1% of	the target		
62.00	amount (line 56), otherwise enter zero (see	instructions)				0	62.00
	Relief payment (see instructions) Allowable Inpatient cost plus incentive paym	nent (see instru	uctions)				
	PROGRAM INPATIENT ROUTINE SWING BED COST	(	,			-	
64.00	Medicare swing-bed SNF inpatient routine cos	sts through Dece	ember 31 of the	e cost reporti	ng period (See	0	64.00
65.00	instructions)(title XVIII only) Medicare swing-bed SNF inpatient routine cos	ts after Decemb	ver 31 of the c	rost reporting	neriod (See	0	65.00
	instructions)(title XVIII only)						00.00
66.00	Total Medicare swing-bed SNF inpatient routi	ne costs (line	64 plus line 6	5)(title XVII	l only). For	0	66.00
67.00	CAH (see instructions) Title V or XIX swing-bed NF inpatient routir	o costs through	Docombor 21 c	of the cost re	porting poriod	0	67.00
07.00	(line 12 x line 19)	le costs through	i December 31 c	of the cost re	boi tring period	0	07.00
68.00	Title V or XIX swing-bed NF inpatient routir	ne costs after D	ecember 31 of	the cost repo	rting period	0	68.00
69.00	(line 13 x line 20)	routino costa (	lino 67 i lino	× 40)		0	69.00
09.00	Total title V or XIX swing-bed NF inpatient PART III - SKILLED NURSING FACILITY, OTHER N					0	09.00
70.00	Skilled nursing facility/other nursing facil						70.00
	Adjusted general inpatient routine service of		ine 70 ÷ line	2)			71.00
	Program routine service cost (line 9 x line	,		no 25)			72.00
73.00 74.00	Medically necessary private room cost applic Total Program general inpatient routine serv						73.00 74.00
	Capital -related cost allocated to inpatient	•			art II, column		75.00
	26, line 45)						
	Per diem capital-related costs (line 75 ÷ li						76.00
77.00 78.00	Program capital-related costs (line 9 x line Inpatient routine service cost (line 74 minu	· · · · ·					77.00 78.00
79.00	Aggregate charges to beneficiaries for exces		orovi der record	ls)			79.00
80.00	Total Program routine service costs for comp	parison to the o	ost limitation	n (line 78 min	us line 79)		80.00
	Inpatient routine service cost per diem limi						81.00
	Inpatient routine service cost limitation (I		· .				82.00 83.00
	Reasonable inpatient routine service costs ( Program inpatient ancillary services (see in	•	13)				83.00
	Utilization review - physician compensation		ons)				85.00
	Total Program inpatient operating costs (sum	n of lines 83 th					86.00
07 00	PART IV - COMPUTATION OF OBSERVATION BED PAS					1 101	87.00
	Total observation bed days (see instructions Adjusted general inpatient routine cost per		line 2)			1, 191 1, 223. 83	
	Observation bed cost (line 87 x line 88) (se					1, 457, 582	

Health Financial Systems	HUNTI NGTON MEMO	RIAL HOSPITAL		In Lieu of Form CMS-2552-1			
COMPUTATION OF INPATIENT OPERATING COST	Provider CC	Provider CCN: 15-0091 Period:					
				From 01/01/2016 To 12/31/2016			
		Title	XVIII	Hospi tal	PPS		
Cost Center Description	Cost	Routine Cost	column 1 ÷	Total	Observation		
		(from line 21)	column 2	Observati on	Bed Pass		
				Bed Cost (from	Through Cost		
				line 89)	(col. 3 x col.		
					4) (see		
					instructions)		
	1.00	2.00	3.00	4.00	5.00		
COMPUTATION OF OBSERVATION BED PASS THROUGH (	COST						
90.00 Capital-related cost	549, 913	6, 764, 111	0. 08129	9 1, 457, 582	118, 500	90.00	
91.00 Nursing School cost	0	6, 764, 111	0.00000	0 1, 457, 582	0	91.00	
92.00 Allied health cost	0	6, 764, 111	0.00000	0 1, 457, 582	0	92.00	
93.00 All other Medical Education	0	6, 764, 111	0.00000	0 1, 457, 582	0	93.00	

OMPUT	ATION OF INPATIENT OPERATING COST	Provider CCN: 15-0091	Period: From 01/01/2016 To 12/31/2016	Worksheet D-1 Date/Time Pre 5/19/2017 9:13	pared
		Title XIX	Hospi tal	PPS	
	Cost Center Description		-	1.00	
	PART I - ALL PROVIDER COMPONENTS			1.00	
	I NPATI ENT DAYS				
00	Inpatient days (including private room days and swing-bed day Inpatient days (including private room days, excluding swing-			5, 527 5, 527	1.0
00	Private room days (excluding swing-bed and observation bed da		rivate room davs.	5, 527	3.0
00	do not complete this line.			0	
00	Semi-private room days (excluding swing-bed and observation b			4, 336	4.0
00	Total swing-bed SNF type inpatient days (including private ro	oom days) through Decembe	er 31 of the cost	0	5.0
00	reporting period Total swing-bed SNF type inpatient days (including private ro	oom days) after December	31 of the cost	0	6. (
	reporting period (if calendar year, enter 0 on this line)			-	
00	Total swing-bed NF type inpatient days (including private roo	om days) through December	r 31 of the cost	0	7.0
00	reporting period Total swing-bed NF type inpatient days (including private roo	am dave) after December (	21 of the cost	0	8.0
00	reporting period (if calendar year, enter 0 on this line)	Sill days) al tel December .	SI UI LINE CUST	0	0.0
00	Total inpatient days including private room days applicable t	to the Program (excluding	g swing-bed and	51	9.1
	newborn days)				
0. 00	Swing-bed SNF type inpatient days applicable to title XVIII of through December 31 of the cost reporting period (see instruct		room days)	0	10.0
1.00	Swing-bed SNF type inpatient days applicable to title XVIII of		room davs) after	0	11.
	December 31 of the cost reporting period (if calendar year, e	enter 0 on this line)	5 ,		
2.00	Swing-bed NF type inpatient days applicable to titles V or XI	IX only (including priva <sup>.</sup>	te room days)	0	12.
3. 00	through December 31 of the cost reporting period Swing-bed NF type inpatient days applicable to titles V or XI	IX only (including prive	te room dave)	0	13.
5.00	after December 31 of the cost reporting period (if calendary			0	13.
4.00	Medically necessary private room days applicable to the Progr	ram (excluding swing-bed	days)	0	14.
5.00	Total nursery days (title V or XIX only)				15.
5.00	Nursery days (title V or XIX only) SWING BED ADJUSTMENT			35	16.
7.00	Medicare rate for swing-bed SNF services applicable to service	ces through December 31 (	of the cost	0.00	17.
	reporting period	0			
3.00	Medicare rate for swing-bed SNF services applicable to servic reporting period	ces after December 31 of	the cost	0.00	18.
9. 00	Medicaid rate for swing-bed NF services applicable to service	es through December 31 of	f the cost	0.00	19.
D. 00	reporting period Medicaid rate for swing-bed NF services applicable to service	es after December 31 of :	the cost	0.00	20.
5. 00	reporting period			0.00	20.
1.00	Total general inpatient routine service cost (see instruction	·		6, 764, 111	21.
2.00	Swing-bed cost applicable to SNF type services through Decemb	ber 31 of the cost repor	ting period (line	0	22.
3. 00	5 x line 17) Swing-bed cost applicable to SNF type services after December	r 31 of the cost reportio	na period (line 6	0	23.
5.00	x line 18)		ig period (inite o	0	20.
4.00	Swing-bed cost applicable to NF type services through December	er 31 of the cost reporti	ng period (line	0	24.
5.00	7 x line 19) Swing-bed cost applicable to NF type services after December	31 of the cost reporting	n period (line 8	0	25.
5.00	x line 20)			0	20.
5.00	Total swing-bed cost (see instructions)			0	26.
7.00	General inpatient routine service cost net of swing-bed cost	(line 21 minus line 26)		6, 764, 111	27.
3. 00	PRIVATE ROOM DIFFERENTIAL ADJUSTMENT General inpatient routine service charges (excluding swing-be	ed and observation bed cl	narges)	0	28.
7.00 7.00	Private room charges (excluding swing-bed charges)			0	29.
D. 00	Semi -private room charges (excluding swing-bed charges)			0	30.
1.00	General inpatient routine service cost/charge ratio (line 27	÷line 28)		0.00000	
2.00	Average private room per diem charge (line 29 ÷ line 3)			0.00	
3.00 4.00	Average semi-private room per diem charge (line 30 ÷ line 4) Average per diem private room charge differential (line 32 mi	inus line 33)(see instru	ctions)	0.00 0.00	
5.00	Average per diem private room cost differential (line 34 x li			0.00	
5.00	Private room cost differential adjustment (line 3 x line 35)			0	36.
7.00	General inpatient routine service cost net of swing-bed cost	and private room cost di	fferential (line	6, 764, 111	37.
	27 minus line 36) PART II - HOSPITAL AND SUBPROVIDERS ONLY				1
	PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJ	JUSTMENTS			
3. 00	Adjusted general inpatient routine service cost per diem (see	-		1, 223. 83	
				() 115	1 20
5.00 9.00 0.00	Program general inpatient routine service cost (line 9 x line Medically necessary private room cost applicable to the Progr	-		62, 415 0	39. 40.

JMPUI	TATION OF INPATIENT OPERATING COST		Provider C	CN: 15-0091	Period:	Worksheet D-1	1	
					From 01/01/2016 To 12/31/2016	Date/Time Pre		
			Titl	e XIX	Hospi tal	5/19/2017 9:1 PPS	<u>13 am</u>	
	Cost Center Description	Total	Total	Average Per	Program Days	Program Cost		
		Inpatient Cost	npatient Days	Diem (col. 1 col. 2)	÷	(col. 3 x col. 4)		
		1.00	2.00	3.00	4.00	5.00		
. 00		258, 648	748	345.	79 35	12, 103	3 42	
. 00	Intensive Care Type Inpatient Hospital Units INTENSIVE CARE UNIT						43	
. 00	CORONARY CARE UNI T						44	
. 00	BURN INTENSIVE CARE UNIT						45	
	SURGICAL INTENSIVE CARE UNIT						46	
. 00	OTHER SPECIAL CARE (SPECIFY) Cost Center Description						47	
	· · · · · · · · · · · · · · · · · · ·					1.00		
. 00	Program inpatient ancillary service cost (W			``		816, 575		
. 00	Total Program inpatient costs (sum of lines PASS THROUGH COST ADJUSTMENTS	41 through 48)(s	see instructio	ns)		891, 093	3 49	
. 00		patient routine s	ervices (from	Wkst. D, su	n of Parts I and	5, 765	5 50	
. 00	Pass through costs applicable to Program inp and IV)	batient ancillary	services (fr	om Wkst. D,	sum of Parts II	68, 962	2 51	
. 00	Total Program excludable cost (sum of lines	50 and 51)				74, 727	52	
8. 00	Total Program inpatient operating cost exclu	uding capital rel	ated, non-phy	sician anest	netist, and	816, 366		
	medical education costs (line 49 minus line	52)						
. 00	TARGET AMOUNT AND LIMIT COMPUTATION Program discharges					C	54	
. 00	Target amount per discharge					0.00		
. 00	Target amount (line 54 x line 55)					C		
. 00	Difference between adjusted inpatient operat Bonus payment (see instructions)							
. 00 . 00								
	market basket	-p						
. 00	Lesser of lines 53/54 or 55 from prior year					0.00		
. 00	If line 53/54 is less than the lower of line which operating costs (line 53) are less that					C	) 61	
	amount (line 56), otherwise enter zero (see			00), 01 1% 0	i the turget			
2.00	1 5 (					C		
. 00	Allowable Inpatient cost plus incentive payr PROGRAM INPATIENT ROUTINE SWING BED COST	nent (see Instruc	ctions)			C	) 63	
. 00		sts through Decem	ber 31 of the	cost report	ng period (See	C	64	
	instructions)(title XVIII only)							
. 00	Medicare swing-bed SNF inpatient routine cos instructions)(title XVIII only)	sts after Decembe	er 31 of the c	ost reportin	g period (See	C	65	
. 00	Total Medicare swing-bed SNF inpatient routi	ne costs (line 6	4 plus line 6	5)(title XVI	ll only). For	C	66	
	CAH (see instructions)				•			
. 00	Title V or XIX swing-bed NF inpatient routir (line 12 x line 19)	ne costs through	December 31 c	f the cost r	eporting period	C	67	
. 00	Title V or XIX swing-bed NF inpatient routin	ne costs after De	cember 31 of	the cost rep	orting period	c	68	
	(line 13 x line 20)				3 1			
. 00	Total title V or XIX swing-bed NF inpatient					C	) 69	
. 00	PART III - SKILLED NURSING FACILITY, OTHER N Skilled nursing facility/other nursing facil				)		70	
. 00	Adjusted general inpatient routine service of	2			, ,		71	
. 00	5			25)			72	
. 00 . 00	Medically necessary private room cost applic Total Program general inpatient routine serv	0	•	ne 35)			73	
. 00	Capital -related cost allocated to inpatient			orksheet B,	Part II, column		75	
	26, line 45)							
. 00	Per diem capital -related costs (line 75 ÷ li						76	
. 00	Program capital-related costs (line 9 x line Inpatient routine service cost (line 74 minu						77	
00	Aggregate charges to beneficiaries for excess		ovider record	s)			79	
00	Total Program routine service costs for comp		ost limitation	(line 78 mi	nus line 79)		80	
. 00	Inpatient routine service cost per diem limi						81	
. 00	Inpatient routine service cost limitation (I Reasonable inpatient routine service costs	,					82	
. 00	Program inpatient ancillary services (see in	•					84	
. 00	1 5 1						85	
. 00	Total Program inpatient operating costs (sur PART IV - COMPUTATION OF OBSERVATION BED PAS		rough 85)				86	
. 00	Total observation bed days (see instructions					1, 191	87	
3.00	Adjusted general inpatient routine cost per	diem (line 27 ÷	line 2)			1, 223. 83	88   88	
	Observation bed cost (line 87 x line 88) (se					1, 457, 582		

Health Financial Systems	HUNTINGTON MEMO	RIAL HOSPITAL		In Lieu of Form CMS-2552-10			
COMPUTATION OF INPATIENT OPERATING COST		Provider CC		Period:	Worksheet D-1		
				From 01/01/2016 To 12/31/2016		pared: 3 am	
		Titl	e XIX	Hospi tal	PPS		
Cost Center Description	Cost	Routine Cost	column 1 ÷	Total	Observati on		
		(from line 21)	column 2	Observati on	Bed Pass		
				Bed Cost (from	Through Cost		
				line 89)	(col. 3 x col.		
					4) (see		
					instructions)		
	1.00	2.00	3.00	4.00	5.00		
COMPUTATION OF OBSERVATION BED PASS THROUGH (	COST						
90.00 Capital-related cost	549, 913	6, 764, 111	0. 08129	9 1, 457, 582	118, 500	90.00	
91.00 Nursing School cost	0	6, 764, 111	0.00000	0 1, 457, 582	0	91.00	
92.00 Allied health cost	0	6, 764, 111	0.00000	0 1, 457, 582	0	92.00	
93.00 All other Medical Education	0	6, 764, 111	0. 00000	0 1, 457, 582	0	93.00	

Health Financial Systems	HUNTINGTON MEMORIAL HOSPITAL		In Lie	eu of Form CMS-	2552-10
INPATIENT ANCILLARY SERVICE COST APPORTIONMENT	Provider C	CN: 15-0091	Peri od:	Worksheet D-3	;
			From 01/01/2016		norod.
			To 12/31/2016	Date/Time Pre 5/19/2017 9:1	
	Title	XVIII	Hospi tal	PPS	
Cost Center Description		Ratio of Cos	t Inpatient	I npati ent	
		To Charges		Program Costs	
			Charges	(col. 1 x col.	
				2)	
		1.00	2.00	3.00	_
I NPATI ENT ROUTI NE SERVI CE COST CENTERS			0 704 770		1 00 00
30. 00 03000 ADULTS & PEDI ATRI CS			2, 796, 773		30.00
43. 00 04300 NURSERY					43.00
ANCI LLARY SERVI CE COST CENTERS 50. 00 05000 OPERATI NG ROOM		0.0991	92 1, 738, 470	172, 442	50.00
52.00 05200 DELIVERY ROOM & LABOR ROOM		0. 0991		172, 442   0	
53. 00 05300 ANESTHESI OLOGY		0. 2731			
54. 00 05400 RADI OLOGY-DI AGNOSTI C		0. 0939		e e e e e e e e e e e e e e e e e e e	
60. 00 06000 LABORATORY		0. 1937			
62. 30 06250 BLOOD CLOTTING FOR HEMOPHILIACS		0. 00000			
65. 00 06500 RESPIRATORY THERAPY		0. 2444			
66. 00 06600 PHYSI CAL THERAPY		0. 4336			
67. 00 06700 OCCUPATI ONAL THERAPY		0. 3327			67.00
68.00 06800 SPEECH PATHOLOGY		0. 3383		4, 192	
69.00 06900 ELECTROCARDI OLOGY		0.0001		49	
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT		0. 1031		59, 396	71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS		0. 2028	1, 822, 183	369, 561	72.00
73.00 07300 DRUGS CHARGED TO PATIENTS		0. 3130	1, 720, 213	538, 454	73.00
76. 97 07697 CARDI AC REHABI LI TATI ON		0.0000	0 0	0	76.97
76. 98 07698 HYPERBARI C OXYGEN THERAPY		0.0753		0	1 / 0/ /0
76. 99 07699 LI THOTRI PSY		0.0000	0 00	0	76.99
OUTPATIENT SERVICE COST CENTERS					
91. 00 09100 EMERGENCY		0. 1268		130, 018	
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART		0. 9304	99 0	0	92.00
OTHER REIMBURSABLE COST CENTERS					_
95. 00 09500 AMBULANCE SERVICES					95.00
200.00 Total (sum of lines 50-94 and 96-98)			10, 543, 311	1, 896, 512	
201.00 Less PBP Clinic Laboratory Services-			0		201.00
202.00 Net Charges (line 200 minus line 201	)	l	10, 543, 311	l	202.00

Health Financial Systems	HUNTINGTON MEMORIAL HOSPITAL		In Lie	u of Form CMS-	2552-10
INPATIENT ANCILLARY SERVICE COST APPORTIONMENT	Provider C	CN: 15-0091	Peri od:	Worksheet D-3	;
			From 01/01/2016	Data /Tima Dra	norod.
			To 12/31/2016	Date/Time Pre 5/19/2017 9:1	
	Titl	e XIX	Hospi tal	PPS	
Cost Center Description		Ratio of Cos	t Inpatient	I npati ent	
		To Charges	Program	Program Costs	
			Charges	(col. 1 x col.	
				2)	
		1.00	2.00	3.00	
I NPATI ENT ROUTI NE SERVI CE COST CENTERS			0.0(4.447		0.00
30. 00 03000 ADULTS & PEDI ATRI CS			2, 264, 447		30.00
43. 00 04300 NURSERY			418, 532		43.00
ANCI LLARY SERVI CE COST CENTERS 50. 00 05000 OPERATI NG ROOM		0. 0991	2, 410, 739	239, 126	50.00
52.00 05200 DELIVERY ROOM & LABOR ROOM		0. 2731		239, 120	
53. 00 05300 ANESTHESI OLOGY		0. 2731			
54. 00 05400 RADI OLOGY-DI AGNOSTI C		0. 2352		33, 829	•
60. 00 06000 LABORATORY		0. 1937		102, 472	
62. 30 06250 BLOOD CLOTTING FOR HEMOPHILIACS		0. 0000		02,472	
65. 00 06500 RESPIRATORY THERAPY		0. 2444			
66. 00 06600 PHYSI CAL THERAPY		0. 4336			•
67. 00 06700 OCCUPATI ONAL THERAPY		0. 3327			67.00
68.00 06800 SPEECH PATHOLOGY		0. 3383		414	•
69.00 06900 ELECTROCARDI OLOGY		0.0001		0	
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT		0. 1031	38 241, 373	24, 907	71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS		0. 2028	12 295, 710	59, 974	72.00
73.00 07300 DRUGS CHARGED TO PATIENTS		0. 3130	16 832, 266	260, 513	73.00
76. 97 07697 CARDIAC REHABILITATION		0.0000	0 0	0	76.97
76. 98 07698 HYPERBARI C OXYGEN THERAPY		0.0753		0	1 1 0 1 7 0
76. 99 07699 LI THOTRI PSY		0.0000	0 00	0	76.99
OUTPATIENT SERVICE COST CENTERS					
91. 00 09100 EMERGENCY		0. 1268			91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART		0. 9304	99 0	0	92.00
OTHER REIMBURSABLE COST CENTERS		1	-	L	
95. 00 09500 AMBULANCE SERVICES					95.00
200.00 Total (sum of lines 50-94 and 96-98)			5, 194, 426	816, 575	
201.00 Less PBP Clinic Laboratory Services-I			0		201.00
202.00 Net Charges (line 200 minus line 201)	)	I	5, 194, 426		202.00

CALCUL		er CCN: 15-0091	Period: From 01/01/2016 To 12/31/2016	Date/Time Prep 5/19/2017 9:13	pared:
		itle XVIII	Hospi tal Before GEO Reclass 1.00	PPS On/After GEO Reclass 1.01	
1 00	PART A - INPATIENT HOSPITAL SERVICES UNDER IPPS		0	0	1 00
1. 00 1. 01	DRG Amounts Other than Outlier Payments DRG amounts other than outlier payments for discharges occurring prio (see instructions)	r to October 1	2, 103, 567	0	
1. 02	DRG amounts other than outlier payments for discharges occurring on o (see instructions)	r after October	1 0	801, 401	1. 02
1.03	DRG for federal specific operating payment for Model 4 BPCI for disch prior to October 1 (see instructions)	arges occurring	0	0	1. 03
1.04	DRG for federal specific operating payment for Model 4 BPCI for disch on or after October 1 (see instructions)	arges occurring	0	0	1. 04
2.00	Outlier payments for discharges. (see instructions)		1, 104	7, 470	
2. 01 2. 02	Outlier reconciliation amount Outlier payment for discharges for Model 4 BPCI (see instructions)		0	0 0	
3.00 4.00	Managed Care Simulated Payments Bed days available divided by number of days in the cost reporting pe	riad (soo	0 32. 75	0	3.00 4.00
4.00	instructions)		52.75		4.00
5.00	Indirect Medical Education Adjustment FTE count for allopathic and osteopathic programs for the most recent	cost reporting	0.00		5.00
6.00	period ending on or before 12/31/1996. (see instructions) FTE count for allopathic and osteopathic programs which meet the crit		0.00		6.00
7.00	add-on to the cap for new programs in accordance with 42 CFR 413.79(e MMA Section 422 reduction amount to the IME cap as specified under 42	)	0.00		7.00
7.01	\$412.105(f)(1)(iv)(B)(1) ACA Section 5503 reduction amount to the IME cap as specified under 4		0.00		7.01
	(1) (1) (1) (1) (1) (1) (1) (1) (1) (1) (1)				,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,
8.00	Adjustment (increase or decrease) to the FTE count for allopathic and programs for affiliated programs in accordance with 42 CFR 413.75(b),	osteopathi c	0.00		8. 00
8. 01	413.79(c)(2)(iv), 64 FR 26340 (May 12, 1998), and 67 FR 50069 (August The amount of increase if the hospital was awarded FTE cap slots unde		f 0.00		8. 01
8. 02	the ACA. If the cost report straddles July 1, 2011, see instructions. The amount of increase if the hospital was awarded FTE cap slots from	a closed	0.00		8. 02
9.00	teaching hospital under section 5506 of ACA. (see instructions) Sum of lines 5 plus 6 minus lines (7 and 7.01) plus/minus lines (8, 8	,01 and 8,02)	0.00		9.00
10. 00	(see instructions) FTE count for allopathic and osteopathic programs in the current year records	from your	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 September 30, 1997, otherwise enter zero.	on or after	0.00		14.00
15.00	Sum of lines 12 through 14 divided by 3.		0.00		15.00
16.00	Adjustment for residents in initial years of the program Adjustment for residents displaced by program or hospital closure		0. 00 0. 00		16.00 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 21.00	Prior year resident to bed ratio (see instructions) Enter the lesser of lines 19 or 20 (see instructions)		0. 000000 0. 000000		20.00 21.00
22.00	IME payment adjustment (see instructions)		0.000000	0	
22. 01	IME payment adjustment - Managed Care (see instructions)		0	0	22.01
23.00	Indirect Medical Education Adjustment for the Add-on for Section 422 Number of additional allopathic and osteopathic IME FTE resident cap		0.00		23.00
24.00	Sec. 412.105 (f)(1)(iv)(C ). 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 lower of 24 (see instructions)	line 23 or line			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	0	27.00
28. 00 28. 01	IME add-on adjustment amount (see instructions) IME add-on adjustment amount - Managed Care (see instructions)		0	0	28.00 28.01
29.00	Total IME payment ( sum of lines 22 and 28)		0	0	
29. 01	Total IME payment - Managed Care (sum of lines 22.01 and 28.01) Disproportionate Share Adjustment		0	0	
30. 00	Percentage of SSI recipient patient days to Medicare Part A patient d instructions)	ays (see	2.73		30.00
31.00	Percentage of Medicaid patient days (see instructions)		27.42		31.00
32.00	Sum of lines 30 and 31 Allowable disproportionate share percentage (see instructions)		30.15	12 00	32.00 33.00
33.00	Disproportionate share adjustment (see instructions)		12.00 63,107	12.00	33.00

	Systems HUNTINGTON MEMORI EIMBURSEMENT SETTLEMENT	Provider CCN: 15-0091	Peri od:	u of Form CMS-2 Worksheet E	
			From 01/01/2016 To 12/31/2016		
		Title XVIII	Hospi tal	PPS	
			Prior to 10/1		
Uncompany	tod Cara Adjustment		1.00	2.00	
	nted Care Adjustment pompensated care amount (see instructions)		6, 406, 145, 534	5, 977, 483, 147	35.
	(see instructions)		0. 000051203		
	uncompensated care payment (If line 34 is zero, en	ter zero on this line)	328, 014		
(see inst					
	share of the hospital uncompensated care payment am		245, 562		
	ompensated care (sum of columns 1 and 2 on line 35.		320, 265		36
	payment for high percentage of ESRD beneficiary di		gh 46) 0		1 40
	care discharges on Worksheet S-3, Part I excluding 683, 684 and 685 (see instructions)	discharges for MS-DRGS	0		40
052, 002,			Before GEO	On/After GEO	
			Recl ass	Recl ass	
			1.00	1. 01	
	D Medicare discharges excluding MS-DRGs 652, 682,	683, 684 an 685. (see	0	0	41
instruction 01 Total ESR	ons) ) Medicare covered and paid discharges excluding MS	-DPGs 652 692 692 694	0	0	41
	see instructions)	-DRGS 052, 062, 065, 064	0	0	41
	ne 41 by line 40 (if less than 10%, you do not qual	ify for adjustment)	0.00		42
	care ESRD inpatient days excluding MS-DRGs 652, 6				43
instructi	·				
	average length of stay to one week (line 43 divided	by line 41 divided by 7	0. 000000		44
days) .00 Average w	eekly cost for dialysis treatments (see instruction		0.00	0.00	45
	tional payment (line 45 times line 44 times line 4		0.00	0.00	40
	(see instructions)	1.01)	2, 488, 043	832, 913	
	specific payments (to be completed by SCH and MDH,	small rural hospitals	0	0	
only. (see	instructions)	· · · · · · · · · · · · · · · · · · ·			
				Amount 1.00	
. 00 Total pay	ment for inpatient operating costs (see instruction	c)		1.00	
				3 320 956	1 4 9
		-		3, 320, 956 234, 643	
.00 Payment f	payment for inpatient program capital (from Wkst. L, Pt. I a payment for inpatient program capital (Wkst. L, Pt	nd Pt. II, as applicable)		3, 320, 956 234, 643 0	50
.00 Payment fo .00 Exception	or inpatient program capital (from Wkst. L, Pt. I a	nd Pt. II, as applicable) . III, see instructions)		234, 643	50 51
00 Payment fo 00 Exception 00 Direct gra 00 Nursing au	pr inpatient program capital (from Wkst. L, Pt. I a payment for inpatient program capital (Wkst. L, Pt aduate medical education payment (from Wkst. E-4, I nd Allied Health Managed Care payment	nd Pt. II, as applicable) . III, see instructions)		234, 643 0 0 0	50 51 52 53
.00 Payment fo .00 Exception .00 Direct gra .00 Nursing an .00 Special ad	or inpatient program capital (from Wkst. L, Pt. I a payment for inpatient program capital (Wkst. L, Pt aduate medical education payment (from Wkst. E-4, I nd Allied Health Managed Care payment dd-on payments for new technologies	nd Pt. II, as applicable) . III, see instructions)		234, 643 0 0 0 0 0	50 51 52 53 54
00 Payment fo 00 Exception 00 Direct gra 00 Nursing a 00 Special a 01 Islet iso	or inpatient program capital (from Wkst. L, Pt. I a payment for inpatient program capital (Wkst. L, Pt aduate medical education payment (from Wkst. E-4, I nd Allied Health Managed Care payment dd-on payments for new technologies ation add-on payment	nd Pt. II, as applicable) . III, see instructions) ine 49 see instructions).		234, 643 0 0 0 0 0 0 0	50 51 52 53 54 54
.00Payment fr.00Exception.00Direct gra.00Nursing al.00Special al.01Islet iso.00Net organ	pr inpatient program capital (from Wkst. L, Pt. I a payment for inpatient program capital (Wkst. L, Pt aduate medical education payment (from Wkst. E-4, I nd Allied Health Managed Care payment dd-on payments for new technologies ation add-on payment acquisition cost (Wkst. D-4 Pt. III, col. 1, line	nd Pt. II, as applicable) . III, see instructions) ine 49 see instructions). 69)		234, 643 0 0 0 0 0 0 0 0	50 51 52 53 54 54 54 55
.00Payment fi.00Exception.00Direct gr00Nursing at.00Special at.01Islet iso.00Net organ.00Cost of pl	pr inpatient program capital (from Wkst. L, Pt. I a payment for inpatient program capital (Wkst. L, Pt aduate medical education payment (from Wkst. E-4, I nd Allied Health Managed Care payment dd-on payments for new technologies ation add-on payment acquisition cost (Wkst. D-4 Pt. III, col. 1, line nysicians' services in a teaching hospital (see int	nd Pt. II, as applicable) . III, see instructions) ine 49 see instructions). 69) ructions)	hrough 35).	234, 643 0 0 0 0 0 0 0	50 51 52 53 54 54 55 56
.00Payment fi.00Exception.00Direct grader.00Nursing and.00Special and.01Islet iso.00Net organ.00Cost of pl.00Routine s.00Ancillary	br inpatient program capital (from Wkst. L, Pt. I a payment for inpatient program capital (Wkst. L, Pt aduate medical education payment (from Wkst. E-4, I ad Allied Health Managed Care payment dd-on payments for new technologies ation add-on payment acquisition cost (Wkst. D-4 Pt. III, col. 1, line acquisition cost (Wkst. D-4 Pt. III, col. 1, line acquisition services in a teaching hospital (see int ervice other pass through costs (from Wkst. D, Pt. service other pass through costs from Wkst. D, Pt.	nd Pt. II, as applicable) . III, see instructions) ine 49 see instructions). 69) ructions) III, column 9, lines 30 ti	hrough 35).	234, 643 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	50 51 52 54 54 54 56 57 58
.00Payment fi.00Exception.00Direct gra.00Nursing at.00Special at.01Islet iso.00Net organ.00Cost of pl.00Routine s.00Ancillary.00Total (sur	pr inpatient program capital (from Wkst. L, Pt. I a payment for inpatient program capital (Wkst. L, Pt aduate medical education payment (from Wkst. E-4, I ad Allied Health Managed Care payment dd-on payments for new technologies ation add-on payment acquisition cost (Wkst. D-4 Pt. III, col. 1, line hysicians' services in a teaching hospital (see int ervice other pass through costs (from Wkst. D, Pt. service other pass through costs from Wkst. D, Pt. n of amounts on lines 49 through 58)	nd Pt. II, as applicable) . III, see instructions) ine 49 see instructions). 69) ructions) III, column 9, lines 30 ti	hrough 35).	234, 643 0 0 0 0 0 0 0 0 0 0 0 0	50 51 52 52 52 54 52 52 52 52 52 52 52 52 52 52
.00Payment fi.00Exception.00Direct gra.00Nursing at.00Special at.01Islet iso.00Net organ.00Cost of pl.00Routine st.00Ancillary.00Total (su.00Primary pl	br inpatient program capital (from Wkst. L, Pt. I a payment for inpatient program capital (Wkst. L, Pt aduate medical education payment (from Wkst. E-4, I ad Allied Health Managed Care payment dd-on payments for new technologies ation add-on payment acquisition cost (Wkst. D-4 Pt. III, col. 1, line hysicians' services in a teaching hospital (see int ervice other pass through costs (from Wkst. D, Pt. service other pass through costs from Wkst. D, Pt. n of amounts on lines 49 through 58) ayer payments	nd Pt. II, as applicable) . III, see instructions) ine 49 see instructions). 69) ructions) III, column 9, lines 30 ti IV, col. 11 line 200)	hrough 35).	234, 643 0 0 0 0 0 0 0 0 0 3, 555, 599 0	50 51 52 52 54 54 54 55 56 57 58 59 60
.00Payment fr.00Exception.00Direct gr.00Nursing at.00Special at.01Islet iso.00Net organ.00Cost of pl.00Routine st.00Ancillary.00Primary p00Total (sum.00Total among	br inpatient program capital (from Wkst. L, Pt. I a payment for inpatient program capital (Wkst. L, Pt aduate medical education payment (from Wkst. E-4, I dd Allied Health Managed Care payment dd-on payments for new technologies ation add-on payment acquisition cost (Wkst. D-4 Pt. III, col. 1, line hysicians' services in a teaching hospital (see int ervice other pass through costs (from Wkst. D, Pt. service other pass through costs from Wkst. D, Pt. n of amounts on lines 49 through 58) ayer payments unt payable for program beneficiaries (line 59 minu:	nd Pt. II, as applicable) . III, see instructions) ine 49 see instructions). 69) ructions) III, column 9, lines 30 ti IV, col. 11 line 200)	hrough 35).	234, 643 0 0 0 0 0 0 0 3, 555, 599 3, 555, 599	50 51 52 53 54 54 54 54 54 56 57 58 57 58 59 60 61
.00Payment fi.00Exception.00Direct gr00Nursing al.00Special ac.01Islet iso.00Net organ.00Cost of pl.00Routine sc.00Ancillary.00Total (su.00Primary pc.00Total aco.00Deductible	br inpatient program capital (from Wkst. L, Pt. I a payment for inpatient program capital (Wkst. L, Pt aduate medical education payment (from Wkst. E-4, I dd Allied Health Managed Care payment dd-on payments for new technologies ation add-on payment acquisition cost (Wkst. D-4 Pt. III, col. 1, line hysicians' services in a teaching hospital (see int ervice other pass through costs (from Wkst. D, Pt. service other pass through costs from Wkst. D, Pt. n of amounts on lines 49 through 58) ayer payments unt payable for program beneficiaries (line 59 minu- es billed to program beneficiaries	nd Pt. II, as applicable) . III, see instructions) ine 49 see instructions). 69) ructions) III, column 9, lines 30 ti IV, col. 11 line 200)	hrough 35).	234, 643 0 0 0 0 0 0 0 3, 555, 599 0 3, 555, 599 473, 145	50 51 52 53 54 54 54 54 54 54 55 56 57 57 58 59 60 61 62
.00Payment fr.00Exception.00Direct gr.00Nursing at.00Special at.01Islet iso.00Net organ.00Cost of pl.00Routine st.00Ancillary.00Total (su.00Primary pt.00Deductible.00Deductible	br inpatient program capital (from Wkst. L, Pt. I a payment for inpatient program capital (Wkst. L, Pt aduate medical education payment (from Wkst. E-4, I dd lied Health Managed Care payment dd-on payments for new technologies ation add-on payment acquisition cost (Wkst. D-4 Pt. III, col. 1, line mysicians' services in a teaching hospital (see int ervice other pass through costs (from Wkst. D, Pt. service other pass through costs from Wkst. D, Pt. n of amounts on lines 49 through 58) ayer payments unt payable for program beneficiaries (line 59 minu- es billed to program beneficiaries	nd Pt. II, as applicable) . III, see instructions) ine 49 see instructions). 69) ructions) III, column 9, lines 30 ti IV, col. 11 line 200)	hrough 35).	234, 643 0 0 0 0 0 0 0 3, 555, 599 3, 555, 599 473, 145 7, 589	50 51 52 53 54 54 54 54 54 54 54 54 57 58 57 58 59 60 61 62 63
.00Payment fi.00Exception.00Direct grade.00Nursing and.00Special and.01Islet iso.00Net organ.00Cost of pl.00Routine set.00Ancillary.00Total (sur.00Primary pr.00Deductible.00Cost nur.00Cost nur.00Cost nur.00Cost nur.00Allowable	br inpatient program capital (from Wkst. L, Pt. I a payment for inpatient program capital (Wkst. L, Pt aduate medical education payment (from Wkst. E-4, I ad Allied Health Managed Care payment dd-on payments for new technologies ation add-on payment acquisition cost (Wkst. D-4 Pt. III, col. 1, line mysicians' services in a teaching hospital (see int ervice other pass through costs (from Wkst. D, Pt. service other pass through costs from Wkst. D, Pt. service other pass through costs from Wkst. D, Pt. nof amounts on lines 49 through 58) ayer payments unt payable for program beneficiaries (line 59 minu- es billed to program beneficiaries bad debts (see instructions)	nd Pt. II, as applicable) . III, see instructions) ine 49 see instructions). 69) ructions) III, column 9, lines 30 ti IV, col. 11 line 200)	hrough 35).	234, 643 0 0 0 0 0 0 3, 555, 599 3, 555, 599 473, 145 7, 589 26, 381	500 511 522 533 544 555 566 577 588 599 600 611 622 633 644
.00Payment fi.00Exception.00Direct grader.00Nursing and.00Special and.01Islet iso.00Net organ.00Cost of pl.00Routine sc.00Ancillary.00Total (su.00Primary pr.00Deductible.00Coinsurann.00Allowable.00Allowable	br inpatient program capital (from Wkst. L, Pt. I a payment for inpatient program capital (Wkst. L, Pt aduate medical education payment (from Wkst. E-4, I dd lied Health Managed Care payment dd-on payments for new technologies ation add-on payment acquisition cost (Wkst. D-4 Pt. III, col. 1, line mysicians' services in a teaching hospital (see int ervice other pass through costs (from Wkst. D, Pt. service other pass through costs from Wkst. D, Pt. n of amounts on lines 49 through 58) ayer payments unt payable for program beneficiaries (line 59 minu- es billed to program beneficiaries	nd Pt. II, as applicable) . III, see instructions) ine 49 see instructions). 69) ructions) III, column 9, lines 30 tl IV, col. 11 line 200) s line 60)	hrough 35).	234, 643 0 0 0 0 0 0 0 3, 555, 599 3, 555, 599 473, 145 7, 589	500 511 522 533 544 555 560 577 588 599 600 611 622 633 644 655
.00Payment fi.00Exception.00Direct gr00Nursing al.00Special ac.01Islet iso.00Net organ.00Cost of pl.00Routine s00Ancillary.00Primary p00Total amon.00Deductible.00Allowable.00Allowable.00Allowable.00Allowable.00Subtotal	br inpatient program capital (from Wkst. L, Pt. I a payment for inpatient program capital (Wkst. L, Pt aduate medical education payment (from Wkst. E-4, I dd Allied Health Managed Care payment dd-on payments for new technologies ation add-on payment acquisition cost (Wkst. D-4 Pt. III, col. 1, line hysicians' services in a teaching hospital (see int ervice other pass through costs (from Wkst. D, Pt. service other pass through costs from Wkst. D, Pt. no f amounts on lines 49 through 58) ayer payments unt payable for program beneficiaries (line 59 minu- es billed to program beneficiaries bad debts (see instructions) reimbursable bad debts (see instructions) bad debts for dual eligible beneficiaries (see ins (line 61 plus line 65 minus lines 62 and 63)	nd Pt. II, as applicable) . III, see instructions) ine 49 see instructions). 69) ructions) III, column 9, lines 30 th IV, col. 11 line 200) s line 60)		234, 643 0 0 0 0 0 0 0 3, 555, 599 0 3, 555, 599 473, 145 7, 589 26, 381 17, 148	500 511 522 533 544 556 577 588 599 600 611 622 633 644 655 666
.00Payment fi.00Exception.00Direct gr00Nursing al.00Special ac.01Islet iso.00Net organ.00Cost of pl.00Routine s00Ancillary.00Total (sur.00Total aco.00Deductible.00Coinsurant.00Allowable.00Allowable.00Subtotal.00Subtotal	br inpatient program capital (from Wkst. L, Pt. I a payment for inpatient program capital (Wkst. L, Pt aduate medical education payment (from Wkst. E-4, I dd Allied Health Managed Care payment dd-on payments for new technologies ation add-on payment acquisition cost (Wkst. D-4 Pt. III, col. 1, line hysicians' services in a teaching hospital (see int ervice other pass through costs (from Wkst. D, Pt. service other pass through costs from Wkst. D, Pt. n of amounts on lines 49 through 58) ayer payments unt payable for program beneficiaries (line 59 minu- es billed to program beneficiaries bald debts (see instructions) reimbursable bad debts (see instructions) bad debts for dual eligible beneficiaries (see ins (line 61 plus line 65 minus lines 62 and 63) eceived from manufacturers for replaced devices for	nd Pt. II, as applicable) . III, see instructions) ine 49 see instructions). 69) ructions) III, column 9, lines 30 th IV, col. 11 line 200) s line 60) tructions) applicable to MS-DRGs (se	ee instructions)	234, 643 0 0 0 0 0 0 3, 555, 599 473, 145 7, 589 26, 381 17, 148 26, 381 3, 092, 013 0	500 51 52 53 54 55 56 57 58 59 600 61 62 63 64 65 66 66 67 68
.00Payment fi.00Exception.00Direct gr00Nursing al.00Special ar.01Islet iso.00Net organ.00Cost of pl.00Routine sr.00Ancillary.00Total (su.00Primary pr.00Deductible.00Coinsurant.00Allowable.00Allowable.00Allowable.00Credits r.00Curler pr.00Outlier pr	br inpatient program capital (from Wkst. L, Pt. I a payment for inpatient program capital (Wkst. L, Pt aduate medical education payment (from Wkst. E-4, I dd allied Health Managed Care payment dd-on payments for new technologies ation add-on payment acquisition cost (Wkst. D-4 Pt. III, col. 1, line mysicians' services in a teaching hospital (see int ervice other pass through costs (from Wkst. D, Pt. service other pass through costs from Wkst. D, Pt. n of amounts on lines 49 through 58) ayer payments unt payable for program beneficiaries (line 59 minutes billed to program beneficiaries ce billed to program beneficiaries bad debts (see instructions) reimbursable bad debts (see instructions) bad debts for dual eligible beneficiaries (see ins (line 61 plus line 65 minus lines 62 and 63) eceived from manufacturers for replaced devices for ayments reconciliation (sum of lines 93, 95 and 96)	nd Pt. II, as applicable) . III, see instructions) ine 49 see instructions). 69) ructions) III, column 9, lines 30 th IV, col. 11 line 200) s line 60) tructions) applicable to MS-DRGs (se	ee instructions)	234, 643 0 0 0 0 0 0 0 3, 555, 599 473, 145 7, 589 26, 381 17, 148 26, 381 3, 092, 013 0 0	500 51 52 53 54 55 56 57 58 59 600 61 62 63 64 65 66 66 67 68 69
.00Payment fi.00Exception.00Direct grain.00Nursing ai.00Special ai.01Islet iso.00Net organ.00Cost of pi.00Routine si.00Ancillary.00Total (su.00Primary pi.00Coinsurant.00Deductible.00Allowable.00Allowable.00Subtotal.00Outlier pi.00Outlier pi.00Outlier pi	br inpatient program capital (from Wkst. L, Pt. I a payment for inpatient program capital (Wkst. L, Pt aduate medical education payment (from Wkst. E-4, I dd lied Health Managed Care payment dd-on payments for new technologies ation add-on payment acquisition cost (Wkst. D-4 Pt. III, col. 1, line mysicians' services in a teaching hospital (see int ervice other pass through costs (from Wkst. D, Pt. service other pass through costs from Wkst. D, Pt. nof amounts on lines 49 through 58) ayer payments unt payable for program beneficiaries (line 59 minu- es billed to program beneficiaries bad debts (see instructions) reimbursable bad debts (see instructions) bad debts for dual eligible beneficiaries (see ins (line 61 plus line 65 minus lines 62 and 63) eceived from manufacturers for replaced devices for ayments reconciliation (sum of lines 93, 95 and 96) JSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	nd Pt. II, as applicable) . III, see instructions) ine 49 see instructions). 69) ructions) III, column 9, lines 30 th IV, col. 11 line 200) s line 60) tructions) applicable to MS-DRGs (se	ee instructions)	234, 643 0 0 0 0 0 0 0 3, 555, 599 473, 145 7, 589 26, 381 17, 148 26, 381 3, 092, 013 0 0 0 0 0	500 51 52 53 54 55 56 57 58 57 58 59 600 61 62 63 64 65 66 67 68 69 700
.00Payment fr.00Exception.00Direct gra.00Nursing at.00Special at.01Islet iso.00Net organ.00Cost of pl.00Routine st.00Ancillary.00Total (su.00Primary pt.00Coinsurant.00Coinsurant.00Adjusted t.00Allowable.00Subtotal.00Credits re.00Ottler pt.00Ottler ADJ.00Ottler ADJ.00Ottler ADJ.00RURAL DEM	br inpatient program capital (from Wkst. L, Pt. I a payment for inpatient program capital (Wkst. L, Pt aduate medical education payment (from Wkst. E-4, I aduate medical education payment (from Wkst. E-4, I acquisition cost (Wkst. D-4 Pt. III, col. 1, line ( mysicians' services in a teaching hospital (see int ervice other pass through costs (from Wkst. D, Pt. service other pass through costs from Wkst. D, Pt. n of amounts on lines 49 through 58) ayer payments unt payable for program beneficiaries (line 59 minu- es billed to program beneficiaries bad debts (see instructions) reimbursable bad debts (see instructions) bad debts for dual eligible beneficiaries (see ins (line 61 plus line 65 minus lines 62 and 63) eceived from manufacturers for replaced devices for ayments reconciliation (sum of lines 93, 95 and 96) DSTMENTS (SEE INSTRUCTIONS) (SPECIFY) DNSTRATION PROJECT	nd Pt. II, as applicable) . III, see instructions) ine 49 see instructions). 69) ructions) III, column 9, lines 30 th IV, col. 11 line 200) s line 60) tructions) applicable to MS-DRGs (se	ee instructions)	234, 643 0 0 0 0 0 0 3, 555, 599 473, 145 7, 589 26, 381 17, 148 26, 381 3, 092, 013 0 0 0 0 0	500 51 52 53 54 55 56 57 58 59 600 61 62 63 64 65 66 66 67 68 69 700 700
.00Payment fi.00Exception.00Direct gr00Nursing al.00Special ac.01Islet iso.00Net organ.00Cost of pl.00Routine sr.00Ancillary.00Primary pr.00Total (suu).00Primary pr.00Coinsurant.00Allowable.00Allowable.00Subtotal.00Credits r.00Outlier pr.00OUTHER ADJI.00SUBTOTAL DEMIN.00SCH or MDI	br inpatient program capital (from Wkst. L, Pt. I a payment for inpatient program capital (Wkst. L, Pt aduate medical education payment (from Wkst. E-4, I dd Allied Health Managed Care payment dd-on payments for new technologies ation add-on payment acquisition cost (Wkst. D-4 Pt. III, col. 1, line hysicians' services in a teaching hospital (see int ervice other pass through costs (from Wkst. D, Pt. service other pass through costs (from Wkst. D, Pt. no of amounts on lines 49 through 58) ayer payments unt payable for program beneficiaries (line 59 minu es billed to program beneficiaries bad debts (see instructions) eimbursable bad debts (see instructions) bad debts for dual eligible beneficiaries (see ins (line 61 plus line 65 minus lines 62 and 63) eceived from manufacturers for replaced devices for ayments (SEE INSTRUCTIONS) (SPECIFY) DNSTRATION PROJECT i volume decrease adjustment	nd Pt. II, as applicable) . III, see instructions) ine 49 see instructions). 69) ructions) III, column 9, lines 30 th IV, col. 11 line 200) s line 60) tructions) applicable to MS-DRGs (see instructions)	ee instructions)	234, 643 0 0 0 0 0 0 0 3, 555, 599 473, 145 7, 589 26, 381 17, 148 26, 381 3, 092, 013 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	500 51 52 53 54 55 56 57 58 59 600 61 62 63 64 65 66 67 68 69 700 700 700 700
.00Payment fr.00Exception.00Direct gr:.00Nursing al.00Special ac.01Islet iso.00Net organ.00Cost of pl.00Routine s:.00Ancillary.00Primary p00Total (sur.00Primary p00Coinsurant.00Adjusted i.00Allowable.00Subtotal.00Credits ra.00OUTHER ADJI.00SURAL DEMN.88SCH or MDI.89Pioneer Ad	br inpatient program capital (from Wkst. L, Pt. I a payment for inpatient program capital (Wkst. L, Pt aduate medical education payment (from Wkst. E-4, I dd Allied Health Managed Care payment dd-on payments for new technologies ation add-on payment acquisition cost (Wkst. D-4 Pt. III, col. 1, line hysicians' services in a teaching hospital (see int ervice other pass through costs (from Wkst. D, Pt. service other pass through costs (from Wkst. D, Pt. no f amounts on lines 49 through 58) ayer payments unt payable for program beneficiaries (line 59 minu- es billed to program beneficiaries bad debts (see instructions) reimbursable bad debts (see instructions) bad debts for dual eligible beneficiaries (see ins (line 61 plus line 65 minus lines 62 and 63) eceived from manufacturers for replaced devices for ayments reconciliation (sum of lines 93, 95 and 96) JSTMENTS (SEE INSTRUCTIONS) (SPECIFY) DNSTRATION PROJECT I volume decrease adjustment 20 demonstration payment adjustment amount (see ins	nd Pt. II, as applicable) . III, see instructions) ine 49 see instructions). 69) ructions) III, column 9, lines 30 th IV, col. 11 line 200) s line 60) tructions) applicable to MS-DRGs (see instructions)	ee instructions)	234, 643 0 0 0 0 0 0 3, 555, 599 473, 145 7, 589 26, 381 17, 148 26, 381 3, 092, 013 0 0 0 0 0	500 51 52 53 54 55 56 57 58 59 600 61 62 63 64 65 66 67 68 69 700 700 700 700 700
.00Payment fr.00Exception.00Direct gr.00Nursing al.00Special ac.01Islet iso.00Net organ.00Cost of pl.00Routine sc.00Routine sc.00Ancillary.00Total (su.00Primary pc.00Total amoi.00Deductible.00Allowable.00Allowable.00Subtotal.00Outlier pc.00Outlier pc.00Outlier pc.00Outlier pc.00Outlier pc.00Allowable.00Subtotal.00RURAL DEME.00HSP bonus	br inpatient program capital (from Wkst. L, Pt. I a payment for inpatient program capital (Wkst. L, Pt aduate medical education payment (from Wkst. E-4, I dd Allied Health Managed Care payment dd-on payments for new technologies ation add-on payment acquisition cost (Wkst. D-4 Pt. III, col. 1, line hysicians' services in a teaching hospital (see int ervice other pass through costs (from Wkst. D, Pt. service other pass through costs (from Wkst. D, Pt. no of amounts on lines 49 through 58) ayer payments unt payable for program beneficiaries (line 59 minu es billed to program beneficiaries bad debts (see instructions) eimbursable bad debts (see instructions) bad debts for dual eligible beneficiaries (see ins (line 61 plus line 65 minus lines 62 and 63) eceived from manufacturers for replaced devices for ayments (SEE INSTRUCTIONS) (SPECIFY) DNSTRATION PROJECT i volume decrease adjustment	nd Pt. II, as applicable) . III, see instructions) ine 49 see instructions). 69) ructions) III, column 9, lines 30 th IV, col. 11 line 200) s line 60) tructions) applicable to MS-DRGs (see instructions)	ee instructions)	234, 643 0 0 0 0 0 0 0 3, 555, 599 473, 145 7, 589 26, 381 17, 148 26, 381 17, 148 26, 381 3, 092, 013 0 0 0 0 0 0 0 0	500 511 522 533 544 554 557 588 559 600 611 622 633 644 656 667 670 700 700 700 700 700
<ul> <li>00 Payment fri</li> <li>00 Exception</li> <li>00 Direct gr:</li> <li>00 Nursing al</li> <li>00 Special ad</li> <li>01 Islet iso</li> <li>00 Net organ</li> <li>00 Cost of pl</li> <li>00 Routine sc</li> <li>00 Ancillary</li> <li>00 Total (su</li> <li>00 Primary pr</li> <li>00 Total addition</li> <li>00 Deductible</li> <li>00 Adjusted</li> <li>00 Allowable</li> <li>00 Outlier pr</li> <li>00 Augusted Ploneer Addition</li> <li>89 Ploneer Addition</li> <li>90 HSP bonus</li> </ul>	br inpatient program capital (from Wkst. L, Pt. I a payment for inpatient program capital (Wkst. L, Pt aduate medical education payment (from Wkst. E-4, I dd Allied Health Managed Care payment dd-on payments for new technologies ation add-on payment acquisition cost (Wkst. D-4 Pt. III, col. 1, line hysicians' services in a teaching hospital (see int ervice other pass through costs (from Wkst. D, Pt. service other pass through costs from Wkst. D, Pt. n of amounts on lines 49 through 58) ayer payments unt payable for program beneficiaries (line 59 minu- es billed to program beneficiaries bald debts (see instructions) reimbursable bad debts (see instructions) bad debts for dual eligible beneficiaries (see ins (line 61 plus line 65 minus lines 62 and 63) eceived from manufacturers for replaced devices for ayments reconciliation (sum of lines 93, 95 and 96) JSTMENTS (SEE INSTRUCTIONS) (SPECIFY) DNSTRATION PROJECT 4 volume decrease adjustment 20 demonstration payment adjustment amount (see instructions)	nd Pt. II, as applicable) . III, see instructions) ine 49 see instructions). 69) ructions) III, column 9, lines 30 th IV, col. 11 line 200) s line 60) tructions) applicable to MS-DRGs (see instructions)	ee instructions)	234, 643 0 0 0 0 0 0 0 3, 555, 599 473, 145 7, 589 26, 381 17, 148 26, 381 3, 092, 013 3, 092, 013 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	500 511 522 533 544 555 566 577 588 599 600 611 622 633 644 655 667 670 700 700 700 700 700 700 700
<ul> <li>D. 00 Payment fri</li> <li>D. 00 Exception</li> <li>Con Direct gra</li> <li>D. 00 Special are</li> <li>D. 01 Islet iso</li> <li>D. 01 Islet iso</li> <li>D. 00 Routine se</li> <li>D. 00 Routine se</li> <li>D. 00 Ancillary</li> <li>D. 00 Total among</li> <li>D. 00 Primary payment</li> <li>D. 00 Primary payment</li> <li>D. 00 Primary payment</li> <li>D. 01 Total among</li> <li>D. 00 Adjusted iso</li> <li>D. 00 Allowable</li> <li>D. 00 Allowable</li> <li>D. 00 Ottler payment</li> <li>D. 00 Ottler payment</li> <li>D. 01 Allowable</li> <li>D. 02 Ottler payment</li> <li>D. 03 Credits rn</li> <li>D. 04 Ottler payment</li> <li>D. 05 RURAL DEMI</li> <li>D. 88 SCH or MDI</li> <li>D. 90 HSP bonus</li> <li>D. 91 HSP bonus</li> <li>D. 92 Bundled MI</li> </ul>	br inpatient program capital (from Wkst. L, Pt. I a payment for inpatient program capital (Wkst. L, Pt aduate medical education payment (from Wkst. E-4, I dd allied Health Managed Care payment dd-on payments for new technologies ation add-on payment acquisition cost (Wkst. D-4 Pt. III, col. 1, line hysicians' services in a teaching hospital (see int ervice other pass through costs (from Wkst. D, Pt. service other pass through costs from Wkst. D, Pt. n of amounts on lines 49 through 58) ayer payments unt payable for program beneficiaries (line 59 minutes billed to program beneficiaries bad debts (see instructions) reimbursable bad debts (see instructions) bad debts for dual eligible beneficiaries (see ins (line 61 plus line 65 minus lines 62 and 63) eceived from manufacturers for replaced devices for ayments reconciliation (sum of lines 93, 95 and 96) USTRATION PROJECT 4 volume decrease adjustment 20 demonstration payment amount (see instructions) payment HVBP adjustment amount (see instructions)	nd Pt. II, as applicable) . III, see instructions) ine 49 see instructions). 69) ructions) III, column 9, lines 30 th IV, col. 11 line 200) s line 60) tructions) applicable to MS-DRGs (see instructions)	ee instructions)	$\begin{array}{c} 234, 643\\ 0\\ 0\\ 0\\ 0\\ 0\\ 0\\ 0\\ 0\\ 0\\ 0\\ 0\\ 0\\ 0\\$	500 511522 533544 54555665577588599600 6116226666667668669700 700700700700700700700700700700700700

	Financial Systems HUNTINGTON MEMORIA ATION OF REIMBURSEMENT SETTLEMENT	AL HOSPITAL Provider CO	CN 15 0001	Period:	u of Form CMS-2	2552-10
CALCUL	ATION OF REIMBURSEMENT SETTLEMENT	Provider Co	UN: 15-0091	From 01/01/2016	Worksheet E Part A	
				To 12/31/2016	Date/Time Pre 5/19/2017 9:13	pared: 3 am
		Title XVIII		Hospi tal	PPS	_
			FF۱	(уууу)	Amount	
				0	1.00	
70. 96	Low volume adjustment for federal fiscal year (yyyy) (Enter in the corresponding federal year for the period prior to 10/1)	n column O		2016	329, 094	70. 96
70. 97	Low volume adjustment for federal fiscal year (yyyy) (Enter in the corresponding federal year for the period ending on or af			2017	129, 118	70. 97
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 lines 6	69 & 70)			3, 589, 303	71.00
71.01	Sequestration adjustment (see instructions)	,			71, 786	
72.00	Interim payments				3, 483, 815	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, 72,	and 73)			33, 702	74.00
75.00	Protested amounts (nonallowable cost report items) in accordan	nce with			183, 255	75.00
	CMS Pub. 15-2, chapter 1, §115.2					
	TO BE COMPLETED BY CONTRACTOR (lines 90 through 96)		1			
90.00	Operating outlier amount from Wkst. E, Pt. A, line 2 (see ins	tructions)			0	
91.00	Capital outlier from Wkst. L, Pt. I, line 2				0	91. OC
92.00	Operating outlier reconciliation adjustment amount (see instru				0	92.00
	Capital outlier reconciliation adjustment amount (see instruc				0	93.00
94.00		uctions)			0.00	
95.00	Time value of money for operating expenses (see instructions)	、			0	95.00
96.00	Time value of money for capital related expenses (see instruc	tions)		Prior to 10/1	$\frac{0}{0\pi/4}$	96.00
				1.00	2.00	
	HSP Bonus Payment Amount			1.00	2.00	
100 00	HSP bonus amount (see instructions)			0	0	100. 00
100.00	HVBP Adjustment for HSP Bonus Payment			V	0	100.00
101 00	HVBP adjustment factor (see instructions)			1.0142869700	1.0176257790	101 00
	HVBP adjustment amount for HSP bonus payment (see instructions	5)		0		102.00
	HRR Adjustment for HSP Bonus Payment	- /		0	0	
103.00	HRR adjustment factor (see instructions)			0. 9989	1.0000	103.00
	HRR adjustment amount for HSP bonus payment (see instructions)	<b>`</b>		0		104.00

	Financial Systems LUME CALCULATION EXHIBIT 4		HUNTI NGTON MEMOF	Provider C	F	Period: From 01/01/2016 To 12/31/2016		t 4 pare
			Amounts (from	Pre/Post	XVIII Period Prior	Hospi tal Peri od	PPS Total (Col 2	
		line 0	E, Part A) 1.00	Entitlement 2.00	to 10/01 3.00	0n/After 10/01 4.00	through 4) 5.00	
00	DRG amounts other than outlier	1.00	0	0			0	1.
01	payments DRG amounts other than outlier payments for discharges	1.01	2, 103, 567	0	2, 103, 567	7	2, 103, 567	1.
02	occurring prior to October 1 DRG amounts other than outlier payments for discharges occurring on or after October	1. 02	801, 401	0		801, 401	801, 401	1.
03	1 DRG for Federal specific operating payment for Model 4 BPCl occurring prior to	1. 03	0	0	С		0	1
04	October 1 DRG for Federal specific operating payment for Model 4 BPCI occurring on or after	1.04	0	0		0	0	1
00	October 1 Outlier payments for discharges (see instructions)	2.00	8, 574	0	1, 103	3 7, 471	8, 574	2
D1	Outlier payments for	2.02	0	0	c	0 0	0	2
00	discharges for Model 4 BPCI Operating outlier reconciliation	2. 01	0	0	c	0	0	3
00	Managed care simulated payments	3.00	0	0	С	0	0	4
0	Indirect Medical Education Adju Amount from Worksheet E, Part A, line 21 (see instructions)	21.00	0. 000000	0. 000000	0. 000000	0.000000		5
0	IME payment adjustment (see	22.00	0	0	C	0 0	0	6
1	instructions) IME payment adjustment for managed care (see instructions)	22.01	0	0	С	0 0	0	ė
	Indirect Medical Education Adju							
00	IME payment adjustment factor (see instructions)	27.00	0. 000000	0.00000	0.00000	0. 000000		7
00	IME adjustment (see	28.00	0	0	C	0 0	0	8
1	instructions) IME payment adjustment add on for managed care (see	28.01	0	0	С	0 0	0	8
0	instructions) Total IME payment (sum of lines 6 and 8)	29.00	0	0	С	0 0	0	9
)1	Total IME payment for managed care (sum of lines 6.01 and 8.01)	29.01	0	0	C	0 0	0	ç
00	Disproportionate Share Adjustme			0.1053	0.10			
00	Allowable disproportionate share percentage (see instructions)	33.00	0. 1200	0. 1200	0. 1200	0. 1200		10
00	Disproportionate share adjustment (see instructions)	34.00	87, 149	0			87, 149	
01	Uncompensated care payments Additional payment for high per	36.00 centage of ESF	320, 265 320, 265 320, 265	0 li scharges	245, 562	2 74, 703	320, 265	
00	Total ESRD additional payment	46.00	0	0	C	0 0	0	12
00 00	(see instructions) Subtotal (see instructions) Hospital specific payments	47.00 48.00	3, 320, 956 0	0	2, 413, 339 C	907, 617 0 0	3, 320, 956 0	
00	(completed by SCH and MDH, small rural hospitals only.) (see instructions) Total payment for inpatient operating costs (see	49.00	3, 320, 956	0	2, 413, 339	907, 617	3, 320, 956	15
00	instructions) Payment for inpatient program	50.00	234, 643	0	167, 788	66, 855	234, 643	16
00	capital Special add-on payments for new technologies	54.00	о	0	с	0 0	0	17
01 02	Net organ aquisition cost Credits received from manufacturers for replaced	68.00	0	0	c	0 0	0	17 17
00	devices for applicable MS-DRGs Capital outlier reconciliation adjustment amount (see instructions)	93.00	0	0	С	0	0	18

Heal th	Financial Systems	ł	UNTI NGTON MEMO	RIAL HOSPITAL		In Lie	u of Form CMS-:	2552-10
LOW VO	LUME CALCULATION EXHIBIT 4			Provider C		Period: From 01/01/2016 Fo 12/31/2016		pared:
				Title	e XVIII	Hospi tal	PPS	
		W/S E, Part A	Amounts (from	Pre/Post	Period Prior	Period	Total (Col 2	
		line	E, Part A)	Entitlement	to 10/01	0n/After 10/01	through 4)	
		0	1.00	2.00	3.00	4.00	5.00	
19.00	SUBTOTAL			0	2, 581, 12	7 974, 472	3, 555, 599	19.00
		W/S L, line	(Amounts from L)					
		0	1.00	2.00	3.00	4.00	5.00	
20.00	Capital DRG other than outlier	1.00	231, 632	0	165, 53	4 66, 098	231, 632	20.00
	Model 4 BPCI Capital DRG other than outlier	1.01	0	0			0	
21.00	Capital DRG outlier payments	2.00	3, 011	0	2, 25	4 757	3, 011	21.00
21.01	Model 4 BPCI Capital DRG	2.01	0	0		0 0	0	1
	outlier payments					-	-	-
22.00	Indirect medical education percentage (see instructions)	5.00	0. 0000	0.0000	0.000	0. 0000		22.00
23.00	Indirect medical education adjustment (see instructions)	6.00	0	0		0 0	0	23.00
24.00	Al lowable disproportionate share percentage (see instructions)	10.00	0. 0000	0.0000	0.000	0.0000		24.00
25.00	Disproportionate share	11.00	0	0		0 0	0	25.00
	adjustment (see instructions)					-	-	
26.00	Total prospective capital	12.00	234, 643	0	167, 78	66, 855	234, 643	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. 12750	0. 132500		27.00
28.00	Low volume adjustment	70.96			329, 09	1	329, 094	28.00
	(transfer amount to Wkst. E, Pt. A, line)							
29.00	Low volume adjustment (transfer amount to Wkst. E, Pt. A, line)	70. 97				129, 118	129, 118	29.00
100.00	Transfer low volume adjustments to Wkst. E, Pt. A.		Y					100. 00

HOSPI T	Financial Systems H AL ACQUIRED CONDITION (HAC) REDUCTION CALCULA	HUNTINGTON MEMO TION EXHIBIT 5	Provider CO		Period: From 01/01/2016	w of Form CMS-2 Worksheet E Part A Exhibi	
					To 12/31/2016		pared:
			Title	XVIII	Hospi tal	PPS	
		Wkst. E, Pt. A, line	Amt. from Wkst. E, Pt. A)	Period to 10/01	Period on after 10/01	Total (cols. 2 and 3)	
		0	1.00	2.00	3.00	4.00	
1.00	DRG amounts other than outlier payments	1.00					1.00
1.01	DRG amounts other than outlier payments for discharges occurring prior to October 1	1.01	2, 103, 567	2, 201, 60		2, 201, 607	1.01
1.02	DRG amounts other than outlier payments for discharges occurring on or after October 1	1.02	801, 401		838, 752		1.02
1.03	DRG for Federal specific operating payment for Model 4 BPCI occurring prior to October 1	1.03	0		0	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	0	1. 04
2.00	Outlier payments for discharges (see instructions)	2.00	8, 574		0 0	0	2.00
2.01	Outlier payments for discharges for Model 4 BPCI	2.02	0		0 0	0	2. 01
3.00 4.00	Operating outlier reconciliation Managed care simulated payments	2. 01 3. 00	0		0 0 0 0	0	3.00 4.00
	Indirect Medical Education Adjustment						
5.00	Amount from Worksheet E, Part A, line 21 (see instructions)	21.00	0. 000000	0. 00000	0 0.000000		5.00
6.00 6.01	IME payment adjustment (see instructions) IME payment adjustment for managed care (see instructions)	22. 00 22. 01	0		0 0 0 0	0	6. 00 6. 01
	Indirect Medical Education Adjustment for the						
7.00	IME payment adjustment factor (see instructions)	27.00	0. 000000	0.00000	0 0.000000		7.00
8. 00 8. 01	IME adjustment (see instructions) IME payment adjustment add on for managed care (see instructions)	28.00 28.01	0		0 0 0 0	0	8. 00 8. 01
9.00	Total IME payment (sum of lines 6 and 8)	29.00	0		0 0	0	9.00
9.01	Total IME payment for managed care (sum of lines 6.01 and 8.01)	29. 01	0		0 0	0	9. 01
10.00	Disproportionate Share Adjustment	22.00	0 1000	0.100	0 0 1000		10.00
	Allowable disproportionate share percentage (see instructions)	33.00	0. 1200	0. 120			10.00
11.00	Disproportionate share adjustment (see instructions)	34.00	87, 149	61, 98			
	Uncompensated care payments Additional payment for high percentage of ESF		320, 265 di scharges	245, 56			
12.00	Total ESRD additional payment (see instructions)	46.00	0		0 0	0	12.00
	Subtotal (see instructions) Hospital specific payments (completed by SCH and MDH, small rural hospitals only.) (see	47.00 48.00	3, 320, 956 0		8 938, 618 0 0		13.00 14.00
15. 00	instructions) Total payment for inpatient operating costs (see instructions)	49.00	3, 320, 956	2, 382, 33	8 938, 618	3, 320, 956	15.00
16.00 17.00	Payment for inpatient program capital Special add-on payments for new technologies	50.00 54.00	234, 643 0	172, 91	3 61, 730 0 0	234, 643 0	17.00
17. 01 17. 02	Net organ acquisition cost Credits received from manufacturers for replaced dowices for applicable MS_DPCs	68.00	0		0 0	0	17.01 17.02
18.00	replaced devices for applicable MS-DRGs Capital outlier reconciliation adjustment amount (see instructions)	93.00	0		0 0	0	18.00

		UNTINGTON MEMO		N 15 0001		eu of Form CMS-	2552-10
HUSPII	AL ACQUIRED CONDITION (HAC) REDUCTION CALCULA	IION EXHIBIT 5	Provider CO	JN: 15-0091	Period: From 01/01/2016 To 12/31/2016	Worksheet E Part A Exhibi Date/Time Pre 5/19/2017 9:1	pared:
			Title	XVIII	Hospi tal	PPS	_
		Wkst. L, line	(Amt. from Wkst. L)				
		0	1.00	2.00	3.00	4.00	
20.00	Capital DRG other than outlier	1.00	231, 632	170, 65	60, 973	231, 632	20.00
20. 01	Model 4 BPCI Capital DRG other than outlier	1.01	0		0 0	0	20.01
21.00	Capital DRG outlier payments	2.00	3, 011	2, 25	54 757	3, 011	21.00
21.01	Model 4 BPCI Capital DRG outlier payments	2.01	0		0 0	0	21.01
22.00	Indirect medical education percentage (see instructions)	5.00	0.0000	0.000	0.0000		22.00
23.00	Indirect medical education adjustment (see instructions)	6.00	0		0 0	0	23.00
24.00	Allowable disproportionate share percentage (see instructions)	10.00	0.0000	0.000	0.0000		24.00
25.00	Disproportionate share adjustment (see instructions)	11.00	0		0 0	0	25.00
26. 00	Total prospective capital payments (see instructions)	12.00	234, 643	172, 91	61, 730	234, 643	26.00
		Wkst. E, Pt. A, line	(Amt. from Wkst. E, Pt. A)				
		0	1.00	2.00	3.00	4.00	
27.00							27.00
28.00	Low volume adjustment prior to October 1	70.96	329, 094	329, 09	94	329, 094	28.00
29.00	Low volume adjustment on or after October 1	70.97	129, 118		129, 118	129, 118	29.00
30.00	HVBP payment adjustment (see instructions)	70. 93	41, 238	28, 05	53 13, 185	41, 238	30.00
30. 01	HVBP payment adjustment for HSP bonus payment (see instructions)	70. 90	0		0 0	0	30. 01
31. 00 31. 01	HRR adjustment (see instructions) HRR adjustment for HSP bonus payment (see instructions)	70. 94 70. 91	-2, 160 0	-2, 16	50 0 0 0	-2, 160 0	•
	· · · · · · · · · · · · · · · · · · ·					(Amt. to Wkst. E, Pt. A)	
		0	1.00	2.00	3.00	4.00	
32.00	HAC Reduction Program adjustment (see instructions)	70. 99			0 0	0	32.00
100.00	Transfer HAC Reduction Program adjustment to Wkst. E, Pt. A.		N				100. 00

	Financial Systems         HUNTINGTON MEMORIAL HOSPITAL         In Lie           ATION OF REIMBURSEMENT SETTLEMENT         Provider CCN: 15-0091         Period: From 01/01/2016	u of Form CMS-2 Worksheet E Part B	2552-10
	To 12/31/2016	Date/Time Prep 5/19/2017 9:13	
	Title XVIII Hospital	PPS	
		1.00	
1.00	PART B - MEDICAL AND OTHER HEALTH SERVICES Medical and other services (see instructions)	0	1.00
2.00	Medical and other services reimbursed under OPPS (see instructions)	2, 528, 957	2.00
3.00	PPS payments	2, 428, 237	3.00
4.00 5.00	Outlier payment (see instructions) Enter the hospital specific payment to cost ratio (see instructions)	3, 834 0. 859	4.00 5.00
6.00	Line 2 times line 5	2, 172, 374	
7.00	Sum of line 3 plus line 4 divided by line 6	0.00	
8.00 9.00	Transitional corridor payment (see instructions) Ancillary service other pass through costs from Wkst. D, Pt. IV, col. 13, line 200	0	
10.00	Organ acqui si ti ons	0	10.00
11.00	Total cost (sum of lines 1 and 10) (see instructions)	0	11.00
	COMPUTATION OF LESSER OF COST OR CHARGES Reasonable charges		
12.00	Anci I l'ary servi ce charges	0	12.00
	Organ acquisition charges (from Wkst. D-4, Pt. III, col. 4, line 69)	0	
14.00	Total reasonable charges (sum of lines 12 and 13) Customary charges	0	14.00
15.00	Aggregate amount actually collected from patients liable for payment for services on a charge basis	0	15.00
	Amounts that would have been realized from patients liable for payment for services on a chargebasis	0	16.00
17 00	had such payment been made in accordance with 42 CFR §413.13(e) Ratio of line 15 to line 16 (not to exceed 1.000000)	0,000000	17 00
	Total customary charges (see instructions)	0. 000000 0	18.00
19.00	Excess of customary charges over reasonable cost (complete only if line 18 exceeds line 11) (see	0	
20.00	instructions)	0	20.00
20.00	Excess of reasonable cost over customary charges (complete only if line 11 exceeds line 18) (see instructions)	0	20.00
	Lesser of cost or charges (line 11 minus line 20) (for CAH see instructions)	0	
	Interns and residents (see instructions) Cost of physicians' services in a teaching hospital (see instructions)	0	22.00 23.00
23.00	Total prospective payment (sum of lines 3, 4, 8 and 9)	2, 432, 071	
	COMPUTATION OF REIMBÜRSEMENT SETTLEMENT		
	Deductibles and coinsurance (for CAH, see instructions)	0 539, 586	
	Deductibles and Coinsurance relating to amount on line 24 (for CAH, see instructions) Subtotal [(lines 21 and 24 minus the sum of lines 25 and 26) plus the sum of lines 22 and 23] (see	1, 892, 485	
	instructions)		
	Direct graduate medical education payments (from Wkst. E-4, line 50) ESRD direct medical education costs (from Wkst. E-4, line 36)	0	
	Subtotal (sum of lines 27 through 29)	1, 892, 485	
31.00	Primary payer payments	878	31.00
32.00	Subtotal (line 30 minus line 31)	1, 891, 607	32.00
33.00	ALLOWABLE BAD DEBTS (EXCLUDE BAD DEBTS FOR PROFESSIONAL SERVICES) Composite rate ESRD (from Wkst. 1-5, line 11)	0	33.00
34.00	Allowable bad debts (see instructions)	62, 720	
	Adjusted reimbursable bad debts (see instructions)	40, 768	
	Allowable bad debts for dual eligible beneficiaries (see instructions) Subtotal (see instructions)	62, 720 1, 932, 375	
	MSP-LCC reconciliation amount from PS&R	0	38.00
	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	0	39.00
	Pioneer ACO demonstration payment adjustment (see instructions) Partial or full credits received from manufacturers for replaced devices (see instructions)	0	39.50 39.98
	RECOVERY OF ACCELERATED DEPRECIATION	0	39.99
	Subtotal (see instructions)	1, 932, 375	
40.01 41.00	Sequestration adjustment (see instructions) Interim payments	38, 648 1, 853, 781	
	Tentative settlement (for contractors use only)	1, 033, 701	
43.00	Balance due provider/program (see instructions)	39, 946	
44.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2	0	44.00
	TO BE COMPLETED BY CONTRACTOR		
	Original outlier amount (see instructions)	0	
	Outlier reconciliation adjustment amount (see instructions) The rate used to calculate the Time Value of Money	0 0.00	91.00 92.00
	Time Value of Money (see instructions)	0	93.00
	Total (sum of lines 91 and 93)		94.00

IALY:	SIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED	Provider CC	CN: 15-0091	Period: From 01/01/2016 To 12/31/2016		
		Title	XVIII	Hospi tal	PPS	
		I npati en	t Part A	Par	t B	
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount	
		1.00	2.00	3.00	4.00	
00 00	Total interim payments paid to provider Interim payments payable on individual bills, either submitted or to be submitted to the contractor for services rendered in the cost reporting period. If none, write "NONE" or enter a zero List separately each retroactive lump sum adjustment		3, 483, 8′	15 0	1, 853, 781 0	1. 0 2. 0 3. 0
	amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1) Program to Provider					0.0
01	ADJUSTMENTS TO PROVIDER			0	0	3. C
02				0	0	3. C
03				0	0	3. ( 3. (
04 05				0	0	3. 3.
00	Provider to Program					0.
50	ADJUSTMENTS TO PROGRAM			0	0	3.
51				0	0	3.
52 53				0	0	3. 3.
53 54				0	0	3. 3.
99	Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98)			0	0	3.
00	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Wkst. E or Wkst. E-3, line and column as appropriate)		3, 483, 81	15	1, 853, 781	4.
00	TO BE COMPLETED BY CONTRACTOR 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					0.
01	TENTATI VE TO PROVI DER			0	0	5.
02				0	0	5.
03				0	0	5.
50	Provider to Program TENTATIVE TO PROGRAM			0	0	5.
50 51	I ENTATIVE TO PROGRAM			0	0	5. 5.
52				0	0	5.
99	Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98)			0	0	5.
00	Determined net settlement amount (balance due) based on the cost report. (1) SETTLEMENT TO PROVIDER			22	20.044	6.
01 02	SETTLEMENT TO PROVIDER SETTLEMENT TO PROGRAM		33, 70	0	39, 946 0	6. 6.
)2 )0	Total Medicare program liability (see instructions)		3, 517, 51	-	1, 893, 727	0. 7.
-	,			Contractor Number	NPR Date (Mo/Day/Yr)	
	Name of Contractor	(	)	1.00	2.00	8.

Heal th	Financial Systems HUNTINGTON MEMOR	I AL HOSPI TAL	In Lie	u of Form CMS-2	2552-10	
CALCUL	CALCULATION OF REIMBURSEMENT SETTLEMENT FOR HIT Provider CCN: 15-0091 Period: From 01/01/2016 To 12/31/2016					
		Title XVIII	Hospi tal	PPS		
				1.00		
	TO BE COMPLETED BY CONTRACTOR FOR NONSTANDARD COST REPORTS					
	HEALTH INFORMATION TECHNOLOGY DATA COLLECTION AND CALCULATIO			1, 606	1.00	
1.00						
2.00	.00 Medicare days from Wkst. S-3, Pt. I, col. 6 sum of lines 1, 8-12					
3.00	Medicare HMO days from Wkst. S-3, Pt. I, col. 6. line 2			881	3.00	
4.00	Total inpatient days from S-3, Pt. I col. 8 sum of lines 1,	8-12		4, 336	4.00	
5.00	Total hospital charges from Wkst C, Pt. I, col. 8 line 200			162, 369, 521	5.00	
6.00	Total hospital charity care charges from Wkst. S-10, col. 3	line 20		2, 506, 881	6.00	
7.00	CAH only - The reasonable cost incurred for the purchase of line 168	certified HIT technology	Wkst. S-2, Pt. I	0	7.00	
8.00	Calculation of the HIT incentive payment (see instructions)			0	8.00	
9.00	Sequestration adjustment amount (see instructions)			0	9.00	
10.00	Calculation of the HIT incentive payment after sequestration	(see instructions)		0	10.00	
	INPATIENT HOSPITAL SERVICES UNDER THE IPPS & CAH					
30.00	Initial/interim HIT payment adjustment (see instructions)			0	30.00	
31.00	Other Adjustment (specify)			0	31.00	
32.00	Balance due provider (line 8 (or line 10) minus line 30 and	line 31) (see instruction	is)	0	32.00	

	Systems HUNTINGTON MEMO f you are nonproprietary and do not maintain	Provider C		eriod: rom 01/01/2016	u of Form CMS-2 Worksheet G	
ind-type accour ily)	iting records, complete the General Fund column		T			
		General Fund	Speci fi c	Endowment Fund	5/19/2017 9:1 Plant Fund	<u>3 a</u>
		1.00	Purpose Fund	2.00	4.00	_
CURRENT A	SSETS	1.00	2.00	3.00	4.00	-
	and in banks	2, 580	0	0	0	) 1
	investments	0	0	0	0	
00 Notes rec		0	0	0	0	
	recei vabl e	18, 947, 927	0	0	0	
	s for uncollectible notes and accounts receivable	116, 692 12, 417, 925-	0	0	0	
00 Inventory		272, 824	0	0	0	
00 Prepaid e		-2, 840, 532	0	0	0	
00 Other cur	rent assets	0	0	0	0	
	other funds	0	0	0	0	
	rent assets (sum of lines 1-10)	4, 081, 566	0	0	0	11
FI XED ASS	EIS	0		ol	0	1 1
.00 Land .00 Land impr	ovements	531, 642	0	0	0	
	ed depreciation	-279, 599	-	0	0	
00 Buildings		2, 316, 724	0	0	0	
5	ed depreciation	-1, 112, 475	0	0	0	
. 00 Leasehol c	improvements	32, 500	0	0	0	1
	ed depreciation	-30, 062	0	0	0	1
. 00 Fixed equ	•	588, 704	0	0	0	
	ed depreciation	-495, 462	0	0	0	
	es and trucks	1, 028, 900		0	0	
	ed depreciation able equipment	-626, 183 10, 819, 322	0	0	0	
	ed depreciation	-8, 722, 751	0	0	0	
	ipment depreciable	1, 083, 234	0	0	0	
	ed depreciation	-595, 626	0	Ő	0	
	nated Assets	0	0	0	0	2
. 00 Accumul at	ed depreciation	0	0	0	0	2
	ipment-nondepreciable	0	0	0	0	
	ed assets (sum of lines 12-29)	4, 538, 868	0	0	0	30
. 00 Investmer		22 (02 7(0	0	0	0	1 2
.00  Investmer .00  Deposits		33, 692, 768	0	0	0	
	owners/officers		0	0	0	
.00 Other ass		623, 513	0	0	0	
.00 Total oth	er assets (sum of lines 31-34)	34, 316, 281	0	0	0	35
.00 Total ass	ets (sum of lines 11, 30, and 35)	42, 936, 715	0	0	0	36
	I ABI LI TI ES					
. 00 Accounts		1, 244, 730		0	0	
	wages, and fees payable	817, 312	0	0	0	
	axes payable Ioans payable (short term)	0 41, 012	0	0	0	
. 00 Deferred		41,012	0	0	0	
	ed payments	0	Ŭ	0	0	42
.00 Due to ot		0	0	0	0	
.00 Other cur	rent liabilities	-67, 477	0	0	0	44
	rent liabilities (sum of lines 37 thru 44)	2, 035, 577	0	0	0	4!
	LIABILITIES	L	1			4
.00 Mortgage		0	0	0	0	
.00 Notes pay .00 Unsecured		153, 700	0	0	0	
	g term liabilities	42, 267	0	0	0	
	g term liabilities (sum of lines 46 thru 49)	195, 967	0	0	0	
	bilities (sum of lines 45 and 50)	2, 231, 544		0	0	
CAPI TAL A						1
	und bal ance	40, 705, 171				5
	purpose fund		0			5
	ated - endowment fund balance - restricted			0		5
	ated - endowment fund balance - unrestricted			0		5
	body created - endowment fund balance			0	^	50
	d balance – invested in plant d balance – reserve for plant improvement,				0	
	nt, and expansion				0	3
	d balances (sum of lines 52 thru 58)	40, 705, 171	0	0	0	59
	bilities and fund balances (sum of lines 51 and	42, 936, 715	-	0	0	-
	•			-	-	1

Heal th	Financial Systems	HUNTI NGTON MEMOR	IAL HOSPITAL		In Lie	eu of Form CMS-2	2552-10
	IENT OF CHANGES IN FUND BALANCES		Provider CC	CN: 15-0091	Period: From 01/01/2016 To 12/31/2016		
		General	Fund	Speci al	Purpose Fund	Endowment Fund	
			0.00	0.00	1.00	5.00	
1.00	Fund balances at beginning of period	1.00	2.00	3.00	4.00	5.00	1.00
2.00 3.00 4.00 5.00	Net income (loss) (from Wkst. G-3, line 29) Total (sum of line 1 and line 2) Additions (credit adjustments) (specify)	0	15, 624, 415 56, 274, 009		0		2.00 3.00 4.00 5.00
6.00 7.00 8.00 9.00		0			0 0 0 0	000000000000000000000000000000000000000	6. 00 7. 00 8. 00 9. 00
10.00 11.00 12.00 13.00 14.00	Total additions (sum of line 4-9) Subtotal (line 3 plus line 10) ASSET TRANSFERS	15, 568, 838 0 0	0 56, 274, 009		0 0 0	0 0 0	10. 00 11. 00 12. 00 13. 00 14. 00
15.00 16.00 17.00 18.00 19.00	Total deductions (sum of lines 12-17) Fund balance at end of period per balance	0 0 0	15, 568, 838 40, 705, 171			0 0 0	15. 00 16. 00 17. 00 18. 00 19. 00
	sheet (line 11 minus line 18)	Endowment Fund	PI ant	Fund			
		6.00	7.00	8.00			
1.00 2.00 3.00 4.00 5.00 6.00	Fund balances at beginning of period Net income (loss) (from Wkst. G-3, line 29) Total (sum of line 1 and line 2) Additions (credit adjustments) (specify)	0	0 0 0	8.00	0		1.00 2.00 3.00 4.00 5.00 6.00
7.00 8.00 9.00 10.00 11.00 12.00 13.00 14.00 15.00	Total additions (sum of line 4-9) Subtotal (line 3 plus line 10) ASSET TRANSFERS	0 0	0 0 0 0 0 0 0 0		0 0		7.00 8.00 9.00 10.00 11.00 12.00 13.00 14.00 15.00
16. 00 17. 00 18. 00 19. 00	Total deductions (sum of lines 12–17) Fund balance at end of period per balance sheet (line 11 minus line 18)	0 0	0 0		0 0		16. 00 17. 00 18. 00 19. 00

STATEN	IENT OF PATIENT REVENUES AND OPERATING EXPENSES	Provider CCN		Period: From 01/01/2016 To 12/31/2016	Worksheet G-2 Parts I & II Date/Time Pre	
				10 12/31/2010	5/19/2017 9:1	3 am
	Cost Center Description		Inpatient	Outpati ent	Total	
			1.00	2.00	3.00	
	PART I - PATIENT REVENUES					-
1 00	General Inpatient Routine Services		7 507 0/	-	7 507 0/5	1 1 00
1.00	Hospi tal		7, 587, 26	5	7, 587, 265	1.00
2.00	SUBPROVIDER - IPF					2.00
3.00 4.00	SUBPROVI DER – I RF SUBPROVI DER					3.00
4.00 5.00	Swing bed - SNF			0	0	
6.00	Swing bed - NF			0	0	
7.00	SKILLED NURSING FACILITY			0	0	7.00
8.00	NURSI NG FACILITY					8.00
9.00	OTHER LONG TERM CARE					9.00
10.00	Total general inpatient care services (sum of lines 1-9)		7, 587, 26	5	7, 587, 265	
	Intensive Care Type Inpatient Hospital Services		.,		.,	
11.00	INTENSIVE CARE UNIT					11.00
12.00	CORONARY CARE UNI T					12.00
13.00	BURN INTENSIVE CARE UNIT					13.00
14.00	SURGICAL INTENSIVE CARE UNIT					14.00
15.00	OTHER SPECIAL CARE (SPECIFY)					15.00
16.00	Total intensive care type inpatient hospital services (sum of	lines		0	0	16.00
	11-15)					
17.00	Total inpatient routine care services (sum of lines 10 and 16	)	7, 587, 26		7, 587, 265	
18.00	Ancillary services		35, 882, 33		35, 882, 334	
19.00	Outpatient services			0 119, 616, 337	119, 616, 337	
20.00	RURAL HEALTH CLINIC			0 0	0	
21.00	FEDERALLY QUALIFIED HEALTH CENTER			0 0	0	
22.00	HOME HEALTH AGENCY			0 7, 917, 288	7 017 200	22.00
23.00 24.00	AMBULANCE SERVICES CMHC			0 7, 917, 288	7, 917, 288	23.00
24.00						24.00
26.00	AMBULATORY SURGI CAL CENTER (D. P.) HOSPI CE					26.00
27.00	OTHER (SPECIFY)			0	0	
28.00	Total patient revenues (sum of lines 17-27)(transfer column 3	to Wkst	43, 469, 59	9 127, 533, 625	171, 003, 224	
20.00	G-3, line 1)	to wikst.	40,407,07	127, 000, 020	171,000,224	20.00
	PART II - OPERATING EXPENSES	I				
29.00	Operating expenses (per Wkst. A, column 3, line 200)			44, 430, 912		29.00
30.00	PROVISION FOR BAD DEBT		5, 743, 88	15		30.00
31.00				0		31.00
32.00				0		32.00
33.00				0		33.00
34.00				0		34.00
35.00				0		35.00
36.00	Total additions (sum of lines 30-35)			5, 743, 885		36.00
37.00	DEDUCT (SPECIFY)			0		37.00
38.00				0		38.00
39.00				0		39.00
40.00				0		40.00
41.00				0		41.00
42.00	Total deductions (sum of lines 37-41)			0		42.00
43.00	Total operating expenses (sum of lines 29 and 36 minus line 4	2)(transfer		50, 174, 797		43.00

Heal th	Financial Systems	HUNTI NGTON MEMORI	AL HOSPI TAL	In Lie	u of Form CMS-2	2552-10
STATE	IENT OF REVENUES AND EXPENSES		Provider CCN: 15-0091	Peri od:	Worksheet G-3	
				From 01/01/2016 To 12/31/2016	Date/Time Pre	arod
				10 12/31/2010	5/19/2017 9:1	
	1				1.00	
1.00	Total patient revenues (from Wkst. G				171, 003, 224	1.00
2.00	Less contractual allowances and disc		its		109, 109, 894	2.00
3.00	Net patient revenues (line 1 minus l				61, 893, 330	3.00
4.00	Less total operating expenses (from		43)		50, 174, 797	
5.00	Net income from service to patients	(line 3 minus line 4)			11, 718, 533	5.00
	OTHER INCOME			1		
6.00	Contributions, donations, bequests,	etc			0	6.00
7.00	Income from investments				2, 269, 943	
8.00	Revenues from telephone and other mi		servi ces		0	8.00
9.00	Revenue from television and radio se	ervi ce			0	9.00
10.00	Purchase di scounts				0	10.00
11.00	Rebates and refunds of expenses				0	11.00
12.00	Parking lot receipts				0	12.00
13.00	Revenue from Laundry and Linen servi				0	13.00
14.00	Revenue from meals sold to employees	and guests			157, 322	14.00
15.00	Revenue from rental of living quarte	ers			0	15.00
16.00	Revenue from sale of medical and sur	gical supplies to other t	han patients		0	16.00
17.00	Revenue from sale of drugs to other	than patients			0	17.00
18.00	Revenue from sale of medical records	and abstracts			0	18.00
19.00	Tuition (fees, sale of textbooks, ur	niforms, etc.)			0	19.00
20.00	Revenue from gifts, flowers, coffee	shops, and canteen			0	20.00
21.00	Rental of vending machines				0	21.00
22.00	Rental of hospital space				0	22.00
23.00	Governmental appropriations				0	23.00
24.00	OTHER (SPECIFY)				0	24.00
24.01	GAIN/(LOSS) ON SALE OF CAPITAL ASSET	-			8, 564	24.01
24.02	EMS_SUBSI DY				352, 080	24.02
24.03	OTHER OPERATING REVENUE				1, 117, 973	24.03
25.00	Total other income (sum of lines 6-2	24)			3, 905, 882	25.00
26.00	Total (line 5 plus line 25)				15, 624, 415	26.00
27.00	OTHER EXPENSES (SPECI FY)				0	27.00
28.00	Total other expenses (sum of line 27	′and subscripts)			0	28.00
29.00	Net income (or loss) for the period	(line 26 minus line 28)			15, 624, 415	29.00

Heal th	i Financial Systems	HUNTI NGTON MEMORIA	In Lie	2552-10			
CALCULATION OF CAPITAL PAYMENT			Provider CCN: 15-0091		Worksheet L Parts I-III Date/Time Pre 5/19/2017 9:1		
			Title XVIII	Hospi tal	PPS		
				-	1.00		
	PART I - FULLY PROSPECTIVE METHOD				1.00		
	CAPITAL FEDERAL AMOUNT						
1.00	Capital DRG other than outlier				231, 632	1.00	
1.01	Model 4 BPCI Capital DRG other than outlier				0	1.01	
2.00	Capital DRG outlier payments			3, 011	2.00		
2.01	Model 4 BPCI Capital DRG outlier pa	yments			0	2. 01	
3.00	Total inpatient days divided by num	per of days in the cost rep	porting period (see inst	tructions)	12.32	3.00	
4.00	Number of interns & residents (see	nstructions)			0.00	4.00	
5.00	Indirect medical education percenta	ge (see instructions)			0.00	5.00	
6.00	Indirect medical education adjustment (multiply line 5 by the sum of lines 1 and 1.01, columns 1 and 1.01) (see instructions)				0	6.00	
7.00	Percentage of SSI recipient patient 30) (see instructions)	days to Medicare Part A pa	atient days (Worksheet E	E, part A line	0.00	7.00	
8.00	Percentage of Medicaid patient days	to total days (see instruc	ctions)		0.00	8.00	
9.00	Sum of lines 7 and 8				0.00	9.00	
10. 00	Allowable disproportionate share pe	<pre>centage (see instructions)</pre>	)		0.00	10.00	
	Disproportionate share adjustment (				0	11.00	
40.00		· · · · · ·				40.00	

234, 643 12.00

		1.00	
	PART II - PAYMENT UNDER REASONABLE COST		
1.00	Program inpatient routine capital cost (see instructions)	0	1.00
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	1.00
2.00	Program inpatient capital costs for extraordinary circumstances (see instructions)	0	2.00
3.00	Net program inpatient capital costs (line 1 minus line 2)	0	3.00
4.00	Applicable exception percentage (see instructions)	0.00	4.00
5.00	Capital cost for comparison to payments (line 3 x line 4)	0	5.00
6.00	Percentage adjustment for extraordinary circumstances (see instructions)	0.00	6.00
7.00	Adjustment to capital minimum payment level for extraordinary circumstances (line 2 x line 6)	0	7.00
8.00	Capital minimum payment level (line 5 plus line 7)	0	8.00
9.00	Current year capital payments (from Part I, line 12, as applicable)	0	9.00
10.00	Current year comparison of capital minimum payment level to capital payments (line 8 less line 9)	0	10.00
11.00	Carryover of accumulated capital minimum payment level over capital payment (from prior year Worksheet L, Part III, line 14)	0	11.00
12.00	Net comparison of capital minimum payment level to capital payments (line 10 plus line 11)	0	12.00
13.00	Current year exception payment (if line 12 is positive, enter the amount on this line)	0	13.00

14.00 Carryover of accumulated capital minimum payment level over capital payment for the following period 0 14.00 14.00 Current your of accumulated capital minimum payment reversion capital payment (if line 12 is negative, enter the amount on this line)
15.00 Current year allowable operating and capital payment (see instructions)
16.00 Current year operating and capital costs (see instructions)
17.00 Current year exception offset amount (see instructions) 0 15.00 0 16.00 0 17.00

12.00 Total prospective capital payments (see instructions)