## PART II - CERTIFICATION

(4) Reopened (5) Amended

MISREPRESENTATION OR FALSIFICATION OF ANY INFORMATION CONTAINED IN THIS COST REPORT MAY BE PUNISHABLE BY CRIMINAL, CIVIL AND ADMINISTRATIVE ACTION, FINE AND/OR IMPRISONMENT UNDER FEDERAL LAW. FURTHERMORE, IF SERVICES IDENTIFIED IN THIS REPORT WERE PROVIDED OR PROCURED THROUGH THE PAYMENT DIRECTLY OR INDIRECTLY OF A KICKBACK OR WERE OTHERWISE ILLEGAL, CRIMINAL, CIVIL AND ADMINISTRATIVE ACTION, FINES AND/OR IMPRISONMENT MAY RESULT.

CERTIFICATION BY CHIEF FINANCIAL OFFICER OR ADMINISTRATOR OF PROVIDER(S)

I HEREBY CERTIFY that I have read the above certification statement and that I have examined the accompanying electronically filed or manually submitted cost report and the Balance Sheet and Statement of Revenue and Expenses prepared by HUNTINGTON MEMORIAL HOSPITAL (15-0091) for the cost reporting period beginning 01/01/2017 and ending 12/31/2017 and to the best of my knowledge and belief, this report and statement are true, correct, complete and prepared from the books and records of the provider in accordance with applicable instructions, except as noted. I further certify that I am familiar with the laws and regulations regarding the provision of health care services, and that the services identified in this cost report were provided in compliance with such laws and regulations.

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

(Si gned)	
	Officer or Administrator of Provider(s)
	` '
Ti tl	е
Date	

			Title XVIII				
	Cost Center Description	Title V	Part A	Part B	HI T	Title XIX	
		1.00	2. 00	3. 00	4. 00	5. 00	
	PART III - SETTLEMENT SUMMARY						
1.00	Hospi tal	0	-53, 043	59, 812	0	0	1. 00
2.00	Subprovi der - IPF	0	0	0		0	2. 00
3.00	Subprovi der - 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	-53, 043	59, 812	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-MEDICARE.

	acca in the pire cost repetiting period. In ceramit	-/ 011601 1	,					
		In-State	In-State	Out-of	Out-of	Medi cai d	0ther	
		Medi cai d	Medi cai d	State	State	HMO days	Medi cai d	
		paid days	eligible	Medi cai d	Medi cai d		days	
			unpai d	paid days	eligible			
			days		unpai d			
		1.00	2. 00	3. 00	4. 00	5. 00	6.00	
24. 00	If this provider is an IPPS hospital, enter the	118	608	0	5	828	0	24. 00
	in-state Medicaid paid days in column 1, in-state							
	Medicaid eligible unpaid days in column 2,							
	out-of-state Medicaid paid days in column 3,							
	out-of-state Medicaid eligible unpaid days in column							
	4, Medicaid HMO paid and eligible but unpaid days in							
	column 5, and other Medicaid days in column 6.							
25.00	If this provider is an IRF, enter the in-state	0	0	О (	l o	0		25. 00
	Medicaid paid days in column 1, the in-state							
	Medicaid eligible unpaid days in column 2,							
	out-of-state Medicaid days in column 3, out-of-state							
	Medicaid eligible unpaid days in column 4, Medicaid							
	HMO paid and eligible but unpaid days in column 5.							
	, . ,	1		1	1	1	1	'

	Financial Systems HUNTINGTO AL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DA		Provider CC	N: 15_0091	Peri od:	ı Lie	u of For Workshe		
,5111	AL AND HOSTITAL HEALTH SAIL SOME ELA TELINITION DA	174	Trovider ee	13 0071	From 01/01/ To 12/31/		Part I Date/Ti 5/30/20	me Pre	pared:
					Urban/Rur 1.00	al S		Geogr	
7. 00	Enter your standard geographic classification (not wa cost reporting period. Enter "1" for urban or "2" for Enter your standard geographic classification (not wa reporting period. Enter in column 1, "1" for urban or enter the effective date of the geographic reclassifi	rural. ge) sta "2" fo	atus at the enc or rural. If ap	of the cost	е	2	10/01/		26. 0 27. 0
5. 00	If this is a sole community hospital (SCH), enter the effect in the cost reporting period.			CH status in		0			35. C
					Begi nni r 1. 00	ng:	Endi 2. 0		
	Enter applicable beginning and ending dates of SCH st of periods in excess of one and enter subsequent date If this is a Medicare dependent hospital (MDH), enter	S.	•		r	0			36. 0 37. 0
	is in effect in the cost reporting period. Is this hospital a former MDH that is eligible for th accordance with FY 2016 OPPS final rule? Enter "Y" fo instructions)				N				37. (
3. 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. (			
					Y/N 1. 00		Y/ 2.0		
	.00 Does this facility qualify for the inpatient hospital payment adjustment for low volume hospitals in accordance with 42 CFR §412.101(b)(2)(i) or (ii)? Enter in column 1 "Y" for yes or "N" for no. Does the facility meet the mileage requirements in accordance with 42 CFR 412.101(b)(2)(i) or (ii)? Enter in column 2 "Y" for yes or "N" for no. (see instructions)						Y		39. (
	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		40. (
						1. 00	XVIII 0 2.00	XI X 3. 00	
	Prospective Payment System (PPS)-Capital								
5. 00	Does this facility qualify and receive Capital paymen with 42 CFR Section §412.320? (see instructions) Is this facility eligible for additional payment exce pursuant to 42 CFR §412.348(f)? If yes, complete Wkst	ption f	or extraordina	nry circumsta	nces	N N	N N	N N	45. (
. 00	Pt. III.  00 Is this a new hospital under 42 CFR §412.300(b) PPS capital? Enter "Y for yes or "N" for the facility electing full federal capital payment? Enter "Y" for yes or "N" for no.  Teaching Hospitals						N N	N N	47. 48.
	Is this a hospital involved in training residents in	approve	ed GME programs	? Enter "Y"	for yes	N			56.
'. 00	or "N" for no.  If line 56 is yes, is this the first cost reporting p  GME programs trained at this facility? Enter "Y" for  is "Y" did residents start training in the first mont  for yes or "N" for no in column 2. If column 2 is "Y  "N", complete Wkst. D, Parts III & IV and D-2, Pt. II	yes or h of th ", comp	"N" for no ir nis cost report blete Worksheet	column 1. I ing period?	f column 1 Enter "Y"	N			57.
	If line 56 is yes, did this facility elect cost reimb defined in CMS Pub. 15-1, chapter 21, §2148? If yes, Are costs claimed on line 100 of Worksheet A? If yes	complet	e Wkst. D-5.		as	N N			58. 59.
r. 00	Are costs crammed on time too of morksheet A: Tr yes	, compr	ete wkst. D-2,	NAHE 413.85 Y/N	Workshee Line #	t A	Pass-Th Qualifi Criterio	cation	
				1. 00	2.00		3.0	00	
	Are you claiming nursing and allied health education any programs that meet the criteria under §413.85? (			N					60.
	and programs that most the oritional under 3413.00?	Y/N	IME	Direct GME			Di rect		
	Did your hospital receive FTE slots under ACA section 5503? Enter "Y" for yes or "N" for no in	1. 00 N	2. 00	3. 00	4. 00	0. 00	5. C	0.00	61.
. 01	column 1. (see instructions) Enter the average number of unweighted primary care FTEs from the hospital's 3 most recent cost reports ending and submitted before March 23, 2010. (see								61.
. 02	instructions) Enter the current year total unweighted primary care FTE count (excluding OB/GYN, general surgery FTEs, and primary care FTEs added under section 5503 of								61.
. 03	ACA). (see instructions) Enter the base line FTE count for primary care and/or general surgery residents, which is used for determining compliance with the 75% test. (see								61.

HOSPI TAL /	nancial Systems AND HOSPITAL HEALTH CARE COMPL	EX IDENTIFICATION DA	TA	Provi der C		Period: From 01/01/2017 To 12/31/2017	u of Form CMS-2 Worksheet S-2 Part I Date/Time Pre 5/30/2018 9:2	pared:
			Y/N	IME	Direct GME	I ME	Direct GME	
			1. 00	2. 00	3. 00	4.00	5. 00	
sur cur 61. 05 Ent and pri	ter the number of unweighted progery allopathic and/or osteoprent cost reporting period. (ster the difference between the d/or general surgery FTEs and imary care and/or general surg	athic FTEs in the ee instructions). baseline primary the current year's ery FTE counts (line						61. 04
61.06 Ent use	.04 minus line 61.03). (see in ter the amount of ACA §5503 aw ed for cap relief and/or FTEs re or general surgery. (see in	ard that is being that are nonprimary						61. 06
·			Pro	gram Name	Program Code		Unweighted Direct GME FTE Count	
				1. 00	2. 00	3.00	4.00	/ / / / /
spe for col pro unw	the FTEs in line 61.05, speciecialty, if any, and the number each new program. (see instrumn 1, the program name. Enteogram code. Enter in column 3, weighted count. Enter in colum E unweighted count.	of FTE residents uctions) Enter in in column 2, the the IME FTE				0.00	0.00	61. 10
61. 20 Of pro res i ns Ent 3,	the FTEs in line 61.05, speciogram specialty, if any, and to sidents for each expanded progostructions) Enter in column 1, ter in column 2, the program count IME FTE unweighted count.	ne number of FTE ram. (see the program name. ode. Enter in column Enter in column 4,				0.00	0.00	61. 20
							1.00	
62. 00 Ent	A Provisions Affecting the Hea ter the number of FTE resident ur hospital received HRSA PCRE	s that your hospital	trai ned			riod for which	0.00	62. 00
62.01 Ent dur	ter the number of FTE resident ring in this cost reporting pe	s that rotated from a riod of HRSA THC prog	Teachi ram. (s	<u>ee instructio</u>		o your hospital	0.00	62. 01
63.00 Has	aching Hospitals that Claim Res your facility trained reside	nts in nonprovider se	ttings	during this c			N	63. 00
Ι Υ	" for yes or "N" for no in col	umn I. IT yes, comple	ete iine	s 64 through	Unwei ghted FTEs Nonprovi der Si te	Unweighted FTEs in	Ratio (col. 1/ (col. 1 + col. 2))	
					1. 00	2.00	3.00	
	ction 5504 of the ACA Base Yea				This base yea	r is your cost r	reporting	
64.00 Ent in res set res	neriod that begins on or after July 1, 2009 and before June 30, 2010. Inter in column 1, if line 63 is yes, or your facility trained residents 0.00 0.00 In the base year period, the number of unweighted non-primary care resident FTEs attributable to rotations occurring in all nonprovider settings. Enter in column 2 the number of unweighted non-primary care resident FTEs that trained in your hospital. Enter in column 3 the ratio of (column 1 divided by (column 1 + column 2)). (see instructions)					0. 000000	64. 00	
		Program Name	Pro	gram Code	Unwei ghted FTEs Nonprovi der Si te	FTEs in	Ratio (col. 3/ (col. 3 + col. 4))	
		1. 00		2. 00	3. 00	4.00	5.00	1

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA Provider CCN: 15-0091 Peri od: Worksheet S-2 From 01/01/2017 Part I Date/Time Prepared: 12/31/2017 5/30/2018 9:25 am Program Code Unwei ghted Unwei ghted Program Name Ratio (col. (col. 3 + col FTEs FTEs in Nonprovi der Hospi tal 4)) Si te 1.00 2.00 3.00 4.00 5.00 65.00 Enter in column 1, if line 63 is yes, or your facility 0. 00 0. 00 0.000000 65.00 trained residents in the base year period, the program name associated with primary care FTEs for each primary care program in which you trained residents. Enter in column 2, the program code. Enter in column 3, the number of unweighted primary care FTE residents attributable to rotations occurring in all non-provider settings. Enter in column 4, the number of unweighted primary care resident FTEs that trained in your hospital. Enter in column 5, the ratio of (column 3 divided by (column 3 + column 4)). (see instructions) Unwei ghted Unwei ghted Ratio (col. 1/ FTEs FTEs in (col. 1 + col Nonprovi der Hospi tal 2)) Si te 1.00 2.00 3.00 Section 5504 of the ACA Current Year FTE Residents in Nonprovider Settings--Effective for cost reporting periods beginning on or after July 1, 2010 Enter in column 1 the number of unweighted non-primary care resident 0.00 0. 00 0.000000 66.00 FTEs attributable to rotations occurring in all nonprovider settings. Enter in column 2 the number of unweighted non-primary care resident FTEs that trained in your hospital. Enter in column 3 the ratio of (column 1 divided by (column 1 + column 2)). (see instructions) Program Name Unwei ghted Ratio (col. 3/ Program Code Unwei ahted FTES FTEs in (col. 3 + col Nonprovi der Hospi tal 4)) Si te 1.00 2.00 3. 00 4.00 5.00 67.00 Enter in column 1, the program 0.000000 67.00 0.00 0.00 name associated with each of your primary care programs in which you trained residents. Enter in column 2, the program code. Enter in column 3, the number of unweighted primary care FTE residents attributable to rotations occurring in all non-provider settings. Enter in column 4, the number of unweighted primary care resident FTEs that trained in your hospital. Enter in column 5, the ratio of (column 3 divided by (column 3 + column 4)) (see instructions) 1.00 2.00 3.00 Inpatient Psychiatric Facility PPS Is this facility an Inpatient Psychiatric Facility (IPF), or does it contain an IPF subprovider? 70.00 Enter "Y" for yes or "N" for no. 71.00 If line 70 is yes: Column 1: Did the facility have an approved GME teaching program in the most O 71.00 recent cost report filed on or before November 15, 2004? Enter "Y" for yes or "N" for no. (see 42 CFR 412.424(d)(1)(iii)(c)) Column 2: Did this facility train residents in a new teaching program in accordance with 42 CFR 412.424 (d)(1)(iii)(D)? Enter "Y" for yes or "N" for no. Column 3: If column 2 is Y, indicate which program year began during this cost reporting period. (see instructions) Inpatient Rehabilitation Facility PPS 75.00 Is this facility an Inpatient Rehabilitation Facility (IRF), or does it contain an IRF N 75.00 subprovider? Enter "Y" for yes and "N" for no. If line 75 is yes: Column 1: Did the facility have an approved GME teaching program in the most 76.00 recent cost reporting period ending on or before November 15, 2004? Enter "Y" for yes or "N" for no. Column 2: Did this facility train residents in a new teaching program in accordance with 42 CFR 412.424 (d)(1)(iii)(D)? Enter "Y" for yes or "N" for no. Column 3: If column 2 is Y, indicate which program year began during this cost reporting period. (see instructions)

HOSFI	AL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA	Provider CO	CN: 15-0091	Peri od: From 01/01/2017 To 12/31/2017	Worksheet S-2 Part I Date/Time Pre 5/30/2018 9:2	epared:
					1.00	+
80. 00 81. 00	Long Term Care Hospital PPS Is this a long term care hospital (LTCH)? Enter "Y" for yes Is this a LTCH co-located within another hospital for part o "Y" for yes and "N" for no.			ng period? Enter	N N	80. 00 81. 00
85. 00 86. 00	TEFRA Providers Is this a new hospital under 42 CFR Section §413.40(f)(1)(i) Did this facility establish a new Other subprovider (excluder §413.40(f)(1)(ii)? Enter "Y" for yes and "N" for no.				N	85. 00 86. 00
87. 00	Is this hospital an extended neoplastic disease care hospital 1886(d)(1)(B)(vi)? Enter "Y" for yes or "N" for no.	l classified (	ınder sectic	n	N	87. 00
	Tiood(a) (1) (b) (vi): Einter 1 Toll yes of N Toll ito.			V 1.00	XI X 2. 00	
	Title V and XIX Services					
90. 00	Does this facility have title V and/or XIX inpatient hospital yes or "N" for no in the applicable column.	l services? Ei	nter "Y" for	N	Y	90.00
91. 00	Is this hospital reimbursed for title V and/or XIX through the full or in part? Enter "Y" for yes or "N" for no in the appl			N	N	91.00
92. 00	Are title XIX NF patients occupying title XVIII SNF beds (dual)	al certificati			N	92. 00
93. 00	instructions) Enter "Y" for yes or "N" for no in the applical Does this facility operate an ICF/IID facility for purposes	N	N	93.00		
94. 00	"Y" for yes or "N" for no in the applicable column.  Does title V or XIX reduce capital cost? Enter "Y" for yes,	N	N	94.00		
95. 00	applicable column.  If line 94 is "Y", enter the reduction percentage in the app	0. 00	0.00	95. 00		
96. 00	.00 Does title V or XIX reduce operating cost? Enter "Y" for yes or "N" for no in the				N N	96. 00
97. 00 98. 00						97. 00 98. 00
98. 01	column 1 for title V, and in column 2 for title XIX.					98. 01
98. 02	title XIX.  Does title V or XIX follow Medicare (title XVIII) for the ca bed costs on Wkst. D-1, Pt. IV, line 89? Enter "Y" for yes o			Y	Y	98. 02
98. 03	for title V, and in column 2 for title XIX. Does title V or XIX follow Medicare (title XVIII) for a crit- reimbursed 101% of inpatient services cost? Enter "Y" for ye: for title V, and in column 2 for title XIX.				N	98. 03
98. 04	Does title V or XIX follow Medicare (title XVIII) for a CAH outpatient services cost? Enter "Y" for yes or "N" for no in in column 2 for title XIX.			N N	N	98. 04
98. 05	Does title V or XIX follow Medicare (title XVIII) and add bawkst. C, Pt. I, col. 4? Enter "Y" for yes or "N" for no in column 2 for title XIX.				Y	98. 05
98. 06	Does title V or XIX follow Medicare (title XVIII) when cost Pts. I through IV? Enter "Y" for yes or "N" for no in column column 2 for title XIX.			Y	Y	98. 06
105.00	Rural Providers  Does this hospital qualify as a CAH?			N		105.00
106. 00	If this facility qualifies as a CAH, has it elected the all- for outpatient services? (see instructions)	inclusive meth	nod of payme	nt		106. 00
107.00 If this facility qualifies as a CAH, is it eligible for cost reimbursement for L&R training programs? Enter "Y" for yes or "N" for no in column 1. (see instructions) If yes, the GME elimination is not made on Wkst. B, Pt. I, col. 25 and the program is cost						107. 00
08. 00	reimbursed. If yes complete Wkst. D-2, Pt. II. 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	dul e? See 4	2 N		108. 00
	101 yes of 1 101 ild.	Physi cal	Occupation		Respiratory	
100.00	If this hospital qualifies as a CAH or a cost provider, are	1.00 N	2.00	3.00	4.00	109.00

110.00 Did this hospital participate in the Rural Community Hospital Demonstration project (§410A Demonstration) for the current cost reporting period? Enter "Y" for yes or "N" for no. If yes, complete Worksheet E, Part A, lines 200 through 218, and Worksheet E-2, lines 200 through 215, as applicable.

OSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA	Provi der CCN: 15-0091	Peri od: From 01/01/ To 12/31/		Worksheet Part I Date/Time 5/30/2018	Prepared:
		1. 00		2.00	
11.00 If this facility qualifies as a CAH, did it participate in the Health Integration Project (FCHIP) demonstration for this community of the response to column 1. If the response to column the response to column the response of the FCHIP demo in which this CAH is participated all that apply: "A" for Ambulance services; "B" for additional for tele-health services.	st reporting period? Enter Lumn 1 is Y, enter the ticipating in column 2.	N		2.00	111.00
			1. 00	2.00 3	. 00
Miscellaneous Cost Reporting Information  15.00 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" percent psychiatric, rehabilitation and long term hospitals providers Pub. 15-1, chapter 22, §2208.1.  16.00 Is this facility classified as a referral center? Enter "Y" in the content of	If column 2 is "E", enter t for long term care (incl s) based on the definition	in column udes	N N		0 115.00
17.00 ls this facility legally-required to carry malpractice insurance.	ance? Enter "Y" for yes o		Υ		117. 00
18.00 Is the malpractice insurance a claims-made or occurrence policlaim-made. Enter 2 if the policy is occurrence.	icy? Enter 1 if the policy	/ is	1		118. 00
	Premi ums	Losses	5	Insurand	ce
	1. 00	2.00		3. 00	
18.01 List amounts of malpractice premiums and paid losses:	77,2	271 3	3, 147	47	7, 760 118. 0
		1. 00		2. 00	
18.02 Are malpractice premiums and paid losses reported in a cost of Administrative and General? If yes, submit supporting scheduland amounts contained therein.  19.00 DO NOT USE THIS LINE 20.00 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 qualifies.	ule listing cost centers  Harmless provision in AC/ column 1, "Y" for yes or			Υ	118. 0 119. 0 120. 0
Hold Harmless provision in ACA §3121 and applicable amendmen Enter in column 2, "Y" for yes or "N" for no.	ts? (see instructions)	Y			121. 0
21.00 Did this facility incur and report costs for high cost implan patients? Enter "Y" for yes or "N" for no.	· ·				
22.00 Does the cost report contain healthcare related taxes as defi Act?Enter "Y" for yes or "N" for no in column 1. If column 1 the Worksheet A line number where these taxes are included.					122. 0
<u>Transplant Center Information</u> 25.00 Does this facility operate a transplant center? Enter "Y" for	r yes and "N" for no. If	N			125. C
yes, enter certification date(s) (mm/dd/yyyy) below. 26.00 f this is a Medicare certified kidney transplant center, enin column 1 and termination date, if applicable, in column 2.		e			126. 0
27.00  f this is a Medicare certified heart transplant center, ento  in column 1 and termination date, if applicable, in column 2.	er the certification date				127. 0
28.00  f this is a Medicare certified liver transplant center, ento in column 1 and termination date, if applicable, in column 2. 29.00  f this is a Medicare certified lung transplant center, enter		n			128. 0
column 1 and termination date, if applicable, in column 2. 30.00 f this is a Medicare certified pancreas transplant center, o	enter the certification				130. 0
date in column 1 and termination date, if applicable, in column 31.00 of this is a Medicare certified intestinal transplant center, date in column 1 and termination date, if applicable, in column 2 and termination date, if applicable	, enter the certification				131. 0
32.00 If this is a Medicare certified islet transplant center, ento in column 1 and termination date, if applicable, in column 2.	er the certification date				132. 0
33.00 If this is a Medicare certified other transplant center, ento in column 1 and termination date, if applicable, in column 2.	er the certification date				133. 0
34.00  If this is an organ procurement organization (0P0), enter the and termination date, if applicable, in column 2.	e UPO number in column 1				134. 0
All Providers					

		1.00	
Health Information Technology (HIT) incentive in the American Recovery and Reinvestmen	Act		
167.00 s this provider a meaningful user under §1886(n)? Enter "Y" for yes or "N" for no.		Υ	167. 00
168.00 If this provider is a CAH (line 105 is "Y") and is a meaningful user (line 167 is "Y"),	enter the	,	0168.00
reasonable cost incurred for the HIT assets (see instructions)			
168.01 If this provider is a CAH and is not a meaningful user, does this provider qualify for	a hardshi p		168. 01
exception under §413.70(a)(6)(ii)? Enter "Y" for yes or "N" for no. (see instructions)			
169.00 If this provider is a meaningful user (line 167 is "Y") and is not a CAH (line 105 is "	N"), enter the	9. 9	9169. 00
transition factor. (see instructions)			
	Begi nni ng	Endi ng	_
	1. 00	2.00	
170.00 Enter in columns 1 and 2 the EHR beginning date and ending date for the reporting period respectively (mm/dd/yyyy)	10/01/2016	09/30/2017	170. 00
	1. 00	2.00	
171.00 If line 167 is "Y", does this provider have any days for individuals enrolled in section 1876 Medicare cost plans reported on Wkst. S-3, Pt. I, line 2, col. 6? Enter "Y" for yes and "N" for no in column 1. If column 1 is yes, enter the number of section 1876 Medicare days in column 2. (see instructions)	N		0 171. 00

	Financial Systems HUNTINGTON MEMOR AL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE	RIAL HOSPITAL  Provider C	CN: 15_0001	Period:	u of Form CMS- Worksheet S-2		
1103F1 1	AL AND HOSPITAL HEALTH CARE REIMBORSEMENT QUESTIONNAIRE	Provider C	UN. 13-0041	From 01/01/2017 To 12/31/2017	Part II Date/Time Pre 5/30/2018 9:2	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 Provider Organization and Operation					-	
1.00	Has the provider changed ownership immediately prior to the			N		1. 00	
	reporting period? If yes, enter the date of the change in c	olumn 2. (see	instructions) Y/N	Date	V/I		
			1.00	2. 00	3. 00		
2.00	Has the provider terminated participation in the Medicare P yes, enter in column 2 the date of termination and in colum voluntary or "I" for involuntary.	J	N			2. 00	
3.00	Is the provider involved in business transactions, includin contracts, with individuals or entities (e.g., chain home o or medical supply companies) that are related to the provid officers, medical staff, management personnel, or members o of directors through ownership, control, or family and othe relationships? (see instructions)	ffices, drug er or its f the board	N			3. 00	
	Trefutivitality. (366 That detroils)		Y/N	Туре	Date		
	Financial Data and Reports		1. 00	2. 00	3. 00		
4.00	Column 1: Were the financial statements prepared by a Cert Accountant? Column 2: If yes, enter "A" for Audited, "C" for "R" for Reviewed. Submit complete copy or enter date ava column 3. (see instructions) If no, see instructions.	or Compiled, ilable in	Y	A		4.00	
5. 00	Are the cost report total expenses and total revenues diffe those on the filed financial statements? If yes, submit rec		N			5. 00	
				Y/N 1. 00	Legal Oper. 2.00		
	Approved Educational Activities			1.00	2.00		
6.00	the legal operator of the program?						
7. 00 8. 00	Are costs claimed for Allied Health Programs? If "Y" see in Were nursing school and/or allied health programs approved cost reporting period? If yes, see instructions.	N N		7. 00 8. 00			
9. 00	Are costs claimed for Interns and Residents in an approved program in the current cost report? If yes, see instruction		al education	N		9. 00	
10. 00	Was an approved Intern and Resident GME program initiated o cost reporting period? If yes, see instructions.		he current	N		10.00	
11. 00	Are GME cost directly assigned to cost centers other than I Teaching Program on Worksheet A? If yes, see instructions.	& R in an App	roved	N		11. 00	
					Y/N 1. 00		
	Bad Debts				1.00		
	Is the provider seeking reimbursement for bad debts? If yes If line 12 is yes, did the provider's bad debt collection p period? If yes, submit copy.			ost reporting	Y N	12. 00 13. 00	
14. 00	1,	nts waived? If	yes, see ins	structi ons.	N	14. 00	
15. 00	Did total beds available change from the prior cost reporti		yes, see inst t A	ructions. Par	+ R	15. 00	
		Y/N	Date	Y/N	Date		
	DC*D Doto	1.00	2. 00	3. 00	4. 00		
16. 00	PS&R Data Was the cost report prepared using the PS&R Report only? If either column 1 or 3 is yes, enter the paid-through date of the PS&R Report used in columns 2 and 4 .(see	N		N		16. 00	
17. 00	instructions) Was the cost report prepared using the PS&R Report for totals and the provider's records for allocation? If either column 1 or 3 is yes, enter the paid-through date	Υ	05/01/2018	Y	05/01/2018	17. 00	
18. 00	in columns 2 and 4. (see instructions)  If line 16 or 17 is yes, were adjustments made to PS&R  Report data for additional claims that have been billed but are not included on the PS&R Report used to file this	Υ		Υ		18. 00	
19. 00	cost report? If yes, see instructions.  If line 16 or 17 is yes, were adjustments made to PS&R Report data for corrections of other PS&R Report information? If yes, see instructions.	N		N		19. 00	

10SPI T	Financial Systems HUNTINGTON MEMORAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE	Provi der CC	N: 15-0091	Peri od: From 01/01/2017	worksheet S-		
					Part II Date/Time Pr		
		Descri	nti on	Y/N	5/30/2018 9: Y/N	25 am	
		0		1. 00	3. 00		
20. 00	If line 16 or 17 is yes, were adjustments made to PS&R	-		N	N	20.00	
	Report data for Other? Describe the other adjustments:	Y/N	Date	Y/N	Date		
		1.00	2.00	3. 00	4. 00		
21. 00	Was the cost report prepared only using the provider's records? If yes, see instructions.	N		N		21. 0	
					1. 00		
	COMPLETED BY COST REIMBURSED AND TEFRA HOSPITALS ONLY (EXCE	PT CHILDRENS HO	SPI TALS)				
0 00	Capital Related Cost					22.0	
2. 00 3. 00							
4. 00	Were new leases and/or amendments to existing leases entere lif yes, see instructions	d into during t	this cost re	porting period?		24.0	
5. 00	Have there been new capitalized leases entered into during instructions.	the cost report	ting period?	If yes, see		25. 0	
26. 00	Were assets subject to Sec. 2314 of DEFRA acquired during th instructions.	e cost reportir	ng period? I	f yes, see		26. 0	
27. 00	Has the provider's capitalization policy changed during the copy.	cost reportino	g period? If	yes, submit		27. 0	
8. 00							
9. 00							
0. 00							
1. 00	<pre>instructions. Has debt been recalled before scheduled maturity without is instructions.</pre>	suance of new o	debt? If yes	, see		31.0	
2. 00	Purchased Services Have changes or new agreements occurred in patient care ser		d through co	ntractual		32.0	
3. 00	arrangements with suppliers of services? If yes, see instru If line 32 is yes, were the requirements of Sec. 2135.2 app no, see instructions.		g to competi	tive bidding? If		33. C	
	Provi der-Based Physi ci ans						
4. 00	Are services furnished at the provider facility under an ar If yes, see instructions.	rangement with	provi der-ba	sed physicians?		34.0	
5. 00	If line 34 is yes, were there new agreements or amended exiphysicians during the cost reporting period? If yes, see in		ts with the	provi der-based		35. 0	
	physicians during the cost reporting period: 11 yes, see th	istructions.		Y/N	Date		
	U 066: C			1. 00	2. 00		
16 NO	Home Office Costs Were home office costs claimed on the cost report?			Y		36.0	
	If line 36 is yes, has a home office cost statement been pr If yes, see instructions.	epared by the h	nome office?			37. 0	
8. 00	If line 36 is yes, was the fiscal year end of the home off the provider? If yes, enter in column 2 the fiscal year end			N		38. C	
9. 00	If line 36 is yes, did the provider render services to othe see instructions.			, N		39.0	
0. 00	If line 36 is yes, did the provider render services to the instructions.	home office? I	f yes, see	N		40.0	
		1. (	00	2.	00		
	Cost Report Preparer Contact Information						
	cost report reparer contact rinormation			NI CKESON		41.0	
1. 00	Enter the first name, last name and the title/position held by the cost report preparer in columns 1, 2, and 3,	ERI C		in skeden			
1. 00	Enter the first name, last name and the title/position held by the cost report preparer in columns 1, 2, and 3, respectively.	ERIC PARKVIEW HEALTH	I SYSTEM, INC			42.0	

Heal th	Financial Systems HUNTINGTON MEM	ORIAL HOSPIT	AL	In Lieu of Form CMS-2552-10				
HOSPI T	AL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE	Provi dei	r CCN: 15-0091	Period: From 01/01/2017 To 12/31/2017		pared:		
			3.00	_				
	Cost Report Preparer Contact Information							
41. 00	Enter the first name, last name and the title/position held by the cost report preparer in columns 1, 2, and 3, respectively.	DI RECTOR, R	EI MBURSEMENT			41. 00		
42.00	Enter the employer/company name of the cost report					42. 00		
43. 00	preparer. Enter the telephone number and email address of the cost report preparer in columns 1 and 2, respectively.					43. 00		

| Period: | Worksheet S-3 | From 01/01/2017 | Part | To 12/31/2017 | Date/Time Prepared: 
 Heal th Financial
 Systems
 HUNTINGTO

 HOSPITAL
 AND
 HOSPITAL
 HEALTH CARE COMPLEX
 STATISTICAL
 DATA
 Provider CCN: 15-0091

					То	12/31/2017	Date/Time Prep 5/30/2018 9: 2	
							I/P Days / 0/P	<u> </u>
							Visits / Trips	
	Component	Worksheet A	No. of Beds	Bed Days		CAH Hours	Title V	
		Line Number		Avai I abl	9			
		1. 00	2.00	3.00		4. 00	5. 00	
1.00	Hospital Adults & Peds. (columns 5, 6, 7 and	30. 00	3	13,	140	0.00	0	1.00
	8 exclude Swing Bed, Observation Bed and							
	Hospice days) (see instructions for col. 2							
	for the portion of LDP room available beds)							
2.00	HMO and other (see instructions)							2. 00
3. 00	HMO I PF Subprovi der							3. 00
4.00	HMO IRF Subprovider						_	4. 00
5.00	Hospital Adults & Peds. Swing Bed SNF						0	5. 00
6.00	Hospital Adults & Peds. Swing Bed NF		_				0	6. 00
7. 00	Total Adults and Peds. (exclude observation		3	13,	140	0. 00	0	7. 00
8. 00	beds) (see instructions) INTENSIVE CARE UNIT							8. 00
9. 00	CORONARY CARE UNIT							9. 00
10.00	BURN INTENSIVE CARE UNIT							9. 00 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)	45.00		13,	140	0. 00	0	14. 00
15. 00	CAH visits			13,	140	0.00	0	15. 00
16. 00	SUBPROVI DER - I PF						O	16. 00
17. 00	SUBPROVI DER – I RF							17. 00
18. 00	SUBPROVI DER							18. 00
19. 00	SKILLED NURSING FACILITY							19. 00
20. 00	NURSING FACILITY							20. 00
21. 00	OTHER LONG TERM CARE							21. 00
22. 00	HOME HEALTH AGENCY							22.00
23.00	AMBULATORY SURGICAL CENTER (D. P.)							23.00
24.00	HOSPI CE							24.00
24. 10	HOSPICE (non-distinct part)	30. 00						24. 10
25.00	CMHC - CMHC							25.00
26.00	RURAL HEALTH CLINIC							26.00
26. 25	FEDERALLY QUALIFIED HEALTH CENTER	89. 00					0	26. 25
27. 00	Total (sum of lines 14-26)		3	36				27.00
28. 00	Observation Bed Days						0	28.00
29. 00	Ambul ance Tri ps							29. 00
30.00	Employee discount days (see instruction)							30.00
31. 00	Employee discount days - IRF							31. 00
32. 00	Labor & delivery days (see instructions)			0	0			32.00
32. 01	Total ancillary labor & delivery room							32. 01
00.05	outpatient days (see instructions)							00.00
33. 00	LTCH non-covered days							33. 00
33. 01	LTCH site neutral days and discharges			1				33. 01

 
 Heal th Financial
 Systems
 HUNTINGTO

 HOSPITAL
 AND
 HOSPITAL
 HEALTH CARE COMPLEX
 STATISTICAL
 DATA
 Provider CCN: 15-0091

| Peri od: | Worksheet S-3 | From 01/01/2017 | Part | To 12/31/2017 | Date/Time Prepared: | Part | P

				1	0 12/31/2017	5/30/2018 9:2	
		I/P Days	/ O/P Visits	/ Trips	Full Time I	Equi val ents	- Cam
	Component	Title XVIII	Title XIX	Total All Patients	Total Interns & Residents	Employees On Payroll	
		6.00	7. 00	8. 00	9. 00	10.00	
1.00	Hospital Adults & Peds. (columns 5, 6, 7 and	1, 571	79	4, 534			1. 00
	8 exclude Swing Bed, Observation Bed and						
	Hospice days) (see instructions for col. 2						
2. 00	for the portion of LDP room available beds) HMO and other (see instructions)	1, 356	1, 385				2.00
3.00	HMO IPF Subprovider	1, 330	1, 363				3.00
4. 00	HMO IRF Subprovider		0				4.00
5. 00	Hospital Adults & Peds. Swing Bed SNF	l ol	o	0			5. 00
6. 00	Hospital Adults & Peds. Swing Bed NF		o	0			6. 00
7.00	Total Adults and Peds. (exclude observation	1, 571	79	4, 534			7. 00
	beds) (see instructions)						
8. 00	INTENSIVE CARE UNIT						8. 00
9.00	CORONARY CARE UNIT						9.00
10.00	BURN INTENSIVE CARE UNIT						10.00
11. 00 12. 00	SURGICAL INTENSIVE CARE UNIT OTHER SPECIAL CARE (SPECIFY)						11. 00 12. 00
13. 00	NURSERY		35	731			13.00
14. 00	Total (see instructions)	1, 571	114	5, 265		221.00	
15. 00	CAH visits	1,0,1	o	0, 200	0.00	221.00	15. 00
16. 00	SUBPROVIDER - I PF						16. 00
17. 00	SUBPROVI DER - I RF						17. 00
18.00	SUBPROVI DER						18. 00
19. 00	SKILLED NURSING FACILITY						19. 00
20. 00	NURSING FACILITY						20. 00
21. 00	OTHER LONG TERM CARE						21. 00
22. 00	HOME HEALTH AGENCY						22. 00
23. 00 24. 00	AMBULATORY SURGICAL CENTER (D. P. ) HOSPICE						23. 00 24. 00
24. 00	HOSPICE (non-distinct part)	0	0	0			24. 00
25. 00	CMHC - CMHC	o o	U	0			25. 00
26. 00	RURAL HEALTH CLINIC						26. 00
26. 25	FEDERALLY QUALIFIED HEALTH CENTER	o	o	0	0.00	0.00	
27. 00	Total (sum of lines 14-26)				0.00	221.00	27. 00
28.00	Observation Bed Days		277	1, 209			28. 00
29. 00	Ambul ance Tri ps	1, 993					29. 00
30. 00	Employee discount days (see instruction)			90			30. 00
31. 00	Employee discount days - IRF			0			31. 00
32. 00	Labor & delivery days (see instructions)	0	60	97			32.00
32. 01	Total ancillary labor & delivery room			0			32. 01
33. 00	outpatient days (see instructions) LTCH non-covered days	0					33.00
	LTCH site neutral days and discharges	0					33. 00
55.51	1 = 1 = 1 = 1 = 1 = 1 = 1 = 1 = 1 = 1 =	١			I .	I	1 30.01

| Period: | Worksheet S-3 | From 01/01/2017 | Part | To 12/31/2017 | Date/Time Prepared: Provider CCN: 15-0091

					To	12/31/2017	Date/Time Pre 5/30/2018 9: 2	
		Full Time Equivalents	<u>'</u>		Di scha	arges		
	Component	Nonpai d	Title V		Title XVIII	Title XIX	Total All	
		Workers 11.00	12. 00	$\dashv$	13. 00	14. 00	Pati ents 15.00	
1. 00	Hospital Adults & Peds. (columns 5, 6, 7 and	11.00	12.00	0	533	14.00	1, 801	1. 00
1.00	8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2 for the portion of LDP room available beds)					27	1,001	1. 00
2.00	HMO and other (see instructions)				445	0		2. 00
3.00	HMO IPF Subprovider					0		3. 00
4.00	HMO I RF Subprovi der			1		0		4. 00
5.00	Hospital Adults & Peds. Swing Bed SNF			1				5. 00
6.00	Hospital Adults & Peds. Swing Bed NF			ł				6. 00
7. 00	Total Adults and Peds. (exclude observation							7. 00
8. 00	beds) (see instructions)   INTENSIVE CARE UNIT			ł				8. 00
9. 00	CORONARY CARE UNIT			ł				9. 00
10.00	BURN INTENSIVE CARE UNIT			l				10. 00
11. 00	SURGICAL INTENSIVE CARE UNIT			l				11. 00
12. 00	OTHER SPECIAL CARE (SPECIFY)			İ				12. 00
13.00	NURSERY			ĺ				13. 00
14.00	Total (see instructions)	0.00		0	533	29	1, 801	14. 00
15.00	CAH visits			l				15. 00
16.00	SUBPROVI DER - I PF							16.00
17.00	SUBPROVI DER - I RF							17. 00
18. 00	SUBPROVI DER			1				18. 00
19. 00	SKILLED NURSING FACILITY			1				19. 00
20. 00	NURSING FACILITY							20. 00
21. 00	OTHER LONG TERM CARE			l				21. 00
22. 00	HOME HEALTH AGENCY			l				22. 00
23. 00	AMBULATORY SURGICAL CENTER (D. P. )			1				23. 00
24. 00 24. 10	HOSPICE HOSPICE (non-distinct part)			ł				24. 00 24. 10
25. 00	CMHC - CMHC			ł				25. 00
26. 00	RURAL HEALTH CLINIC			ł				26. 00
26. 25	FEDERALLY QUALIFIED HEALTH CENTER	0. 00		l				26. 25
27. 00	Total (sum of lines 14-26)	0. 00		l				27. 00
28. 00	Observation Bed Days	0.00		İ				28. 00
29. 00	Ambul ance Tri ps			İ				29. 00
30.00	Employee discount days (see instruction)			İ				30.00
31.00	Employee discount days - IRF			- 1				31. 00
32.00	Labor & delivery days (see instructions)							32. 00
32. 01	Total ancillary labor & delivery room							32. 01
	outpatient days (see instructions)			-				
	LTCH non-covered days				0			33. 00
33. 01	LTCH site neutral days and discharges				0			33. 01

| Peri od: | Worksheet S-3 | From 01/01/2017 | Part II | To 12/31/2017 | Date/Time Prepared: | Part II | Part II | Part II | Part II | Part II | Part II | Part II | Part II | Part II | Part II | Part II | Part II | Part II | Part II | Part II | Part II | Part II | Part II | Part II | Part II | Part II | Part II | Part II | Part II | Part II | Part II | Part II | Part II | Part II | Part II | Part II | Part II | Part II | Part II | Part II | Part II | Part II | Part II | Part II | Part II | Part II | Part II | Part II | Part II | Part II | Part II | Part II | Part II | Part II | Part II | Part II | Part II | Part II | Part II | Part II | Part II | Part II | Part II | Part II | Part II | Part II | Part II | Part II | Part II | Part II | Part II | Part II | Part II | Part II | Part II | Part II | Part II | Part II | Part II | Part II | Part II | Part II | Part II | Part II | Part II | Part II | Part II | Part II | Part II | Part II | Part II | Part II | Part II | Part II | Part II | Part II | Part II | Part II | Part II | Part II | Part II | Part II | Part II | Part II | Part II | Part II | Part II | Part II | Part II | Part II | Part II | Part II | Part II | Part II | Part II | Part II | Part II | Part II | Part II | Part II | Part II | Part II | Part II | Part II | Part II | Part II | Part II | Part II | Part II | Part II | Part II | Part II | Part II | Part II | Part II | Part II | Part II | Part II | Part II | Part II | Part II | Part II | Part II | Part II | Part II | Part II | Part II | Part II | Part II | Part II | Part II | Part II | Part II | Part II | Part II | Part II | Part II | Part II | Part II | Part II | Part II | Part II | Part II | Part II | Part II | Part II | Part II | Part II | Part II | Part II | Part II | Part II | Part II | Part II | Part II | Part II | Part II | Part II | Part II | Part II | Part II | Part II | Part II | Part II | Part II | Part II | Part II | Part II | Part II | Part II | Part II | Part II | Part II | Part II | Part II | Part II | Part II | Part II | Part II | Part II | P

Number   Reported   on of Salaries   Salaries   (from Wkst.   A-6)   3)   Co		0. 00 0. 00 137. 93	1.00
A-6)   3)   C0	07, 099. 00 0. 00 0. 00 174. 00 0. 00	6. 00 30. 33 0. 00 0. 00 137. 93	2. 00
PART II - WAGE DATA   SALARIES	07, 099. 00 0. 00 0. 00 174. 00 0. 00	30. 33 0. 00 0. 00 137. 93	2. 00
SALARIES   Total salaries (see   200.00   14,531,150   3,882,957   18,414,107   60	0. 00 0. 00 174. 00 0. 00	0. 00 0. 00 137. 93	2. 00
instructions) 2.00   Non-physician anesthetist Part	0. 00 0. 00 174. 00 0. 00	0. 00 0. 00 137. 93	2. 00
2. 00       Non-physician anesthetist Part A       0       0       0         3. 00       Non-physician anesthetist Part B       0       0       0         4. 00       Physician-Part A -       24,000       0       24,000	0. 00 174. 00 0. 00	0. 00 137. 93	
B 4.00 Physician-Part A - 24,000 0 24,000	174. 00 0. 00	137. 93	3. 00
	0. 00		
Administrative			4. 00
4.01       Physicians - Part A - Teaching       0       0       0         5.00       Physician and Non       0       0       0			
Physician-Part B 6.00 Non-physician-Part B for 0 0 0 0 hospital-based RHC and FQHC	0. 00	0. 00	6. 00
services 7.00 Interns & residents (in an 21.00 0 0	0. 00	0. 00	7. 00
approved program) 7.01 Contracted interns and residents (in an approved 0	0.00	0. 00	7. 01
programs) 8.00 Home office and/or related 3,888,887 0 3,888,887 12 organization personnel	25, 587. 00	30. 97	8. 00
9.00 SNF ' 44.00 O O O	0. 00 84, 995. 00		
instructions) OTHER WAGES & RELATED COSTS	.,		
11.00 Contract labor: Direct Patient 0 0 0 0 Care	0. 00	0. 00	11. 00
12.00 Contract labor: Top level 0 0 0 0 management and other	0. 00	0. 00	12. 00
management and administrative services			
13.00 Contract Labor: Physician-Part 0 0 0	0. 00	0. 00	13. 00
14.00 Home office and/or related organization salaries and wage-related costs	0.00	0. 00	14. 00
	25, 587. 00 0. 00		14. 01 14. 02
15.00 Home office: Physician Part A	0.00		15. 00
16.00 Home office and Contract 0 0 0 Physicians Part A - Teaching	0. 00	0. 00	16. 00
WAGE-RELATED COSTS           17. 00 Wage-rel ated costs (core) (see         4, 016, 565         0         4, 016, 565			17. 00
instructions) 18.00 Wage-related costs (other) 0 0			18. 00
(see instructions) 19.00 Excluded areas 917,743 0 917,743			19. 00
20.00 Non-physician anesthetist Part 0 0 0			20. 00
21.00 Non-physician anesthetist Part 0 0 0			21. 00
22.00 Physician Part A - 0 0 0 0 Administrative			22. 00
22.01 Physician Part A - Teaching 0 0			22. 01
23. 00   Physician Part B			23. 00 24. 00
25. 00 Interns & residents (in an approved program)			25. 00
25. 50 Home office wage-related 1, 609, 733 0 1, 609, 733 (core)			25. 50
25. 51 Related organization 0 0 0 0 0 0 wage-related (core)			25. 51
wage-related (COFe) 25.52 Home office: Physician Part A			25. 52
wage-related (core) 25.53 Home office & Contract 0 0 0			25. 53
Physicians Part A - Teaching - wage-related (core)  OVERHEAD COSTS - DIRECT SALARIES			
26.00 Employee Benefits Department 4.00 1,294,447 -1,294,447 0	0.00		26. 00
27. 00   Admi ni strati ve & General     5. 00   1,619,561   3,905,223   5,524,784   15	3, 321. 00	36. 03	27. 00

| In Lieu of Form CMS-2552-10 | Peri od: | Worksheet S-3 | From 01/01/2017 | Part II | To 12/31/2017 | Date/Time Prepared: | From CMS-2552-10 | Part II | Part II | Part II | Part II | Part II | Part II | Part II | Part II | Part II | Part II | Part II | Part II | Part II | Part II | Part II | Part II | Part II | Part II | Part II | Part II | Part II | Part II | Part II | Part II | Part II | Part II | Part II | Part II | Part II | Part II | Part II | Part II | Part II | Part II | Part II | Part II | Part II | Part II | Part II | Part II | Part II | Part II | Part II | Part II | Part II | Part II | Part II | Part II | Part II | Part II | Part II | Part II | Part II | Part II | Part II | Part II | Part II | Part II | Part II | Part II | Part II | Part II | Part II | Part II | Part II | Part II | Part II | Part II | Part II | Part II | Part II | Part II | Part II | Part II | Part II | Part II | Part II | Part II | Part II | Part II | Part II | Part II | Part II | Part II | Part II | Part II | Part II | Part II | Part II | Part II | Part II | Part II | Part II | Part II | Part II | Part II | Part II | Part II | Part II | Part II | Part II | Part II | Part II | Part II | Part II | Part II | Part II | Part II | Part II | Part II | Part II | Part II | Part II | Part II | Part II | Part II | Part II | Part II | Part II | Part II | Part II | Part II | Part II | Part II | Part II | Part II | Part II | Part II | Part II | Part II | Part II | Part II | Part II | Part II | Part II | Part II | Part II | Part II | Part II | Part II | Part II | Part II | Part II | Part II | Part II | Part II | Part II | Part II | Part II | Part II | Part II | Part II | Part II | Part II | Part II | Part II | Part II | Part II | Part II | Part II | Part II | Part II | Part II | Part II | Part II | Part II | Part II | Part II | Part II | Part II | Part II | Part II | Part II | Part II | Part II | Part II | Part II | Part II | Part II | Part II | Part II | Part II | Part II | Part II | Part II | Part II | Part II | Part II | Part II | Part II | Pa

							5/30/2018 9: 2	5 am
		Wkst. A Line	Amount	Reclassi fi cati		Paid Hours	Average Hourly	
		Number	Reported	on of Salaries	Sal ari es	Related to	Wage (col. 4 ÷	
				(from Wkst.	(col.2 ± col.	Salaries in	col. 5)	
				A-6)	3)	col. 4		
		1. 00	2. 00	3. 00	4. 00	5. 00	6. 00	
28. 00	Administrative & General under		0	0	0	0.00	0.00	28. 00
	contract (see inst.)							
29. 00	Maintenance & Repairs	6. 00		0	0	0.00		29. 00
30.00	Operation of Plant	7. 00	•			·		30. 00
31. 00	Laundry & Linen Service	8. 00		24, 115	24, 115	1, 780. 00	13. 55	31. 00
32.00	Housekeepi ng	9. 00	208, 217	5, 300	213, 517	16, 023. 00	13. 33	32.00
33.00	Housekeeping under contract		0	0	0	0.00	0.00	33.00
	(see instructions)							
34.00	1	10. 00	353, 187	-277, 330	75, 857	13, 207. 00		34.00
35.00	Di etary under contract (see		0	0	0	0.00	0.00	35. 00
	instructions)							
36.00	Cafeteri a	11. 00	0	224, 344	224, 344	10, 997. 00	20. 40	36.00
37.00	Maintenance of Personnel	12. 00	0	0	0	0.00	0.00	37.00
38.00	Nursing Administration	13. 00	216, 457	23, 390	239, 847	5, 329. 00	45. 01	38. 00
39.00	Central Services and Supply	14. 00	0	0	0	0.00	0.00	39. 00
40.00	Pharmacy	15. 00	501, 215	0	501, 215	9, 633. 00	52. 03	40.00
41.00	Medical Records & Medical	16. 00	0	0	0	0.00	0.00	41.00
	Records Library							
42.00	Social Service	17. 00	0	0	0	0.00	0.00	42.00
43.00	Other General Service	18. 00	0	0	0	0.00	0.00	43.00

| Peri od: | Worksheet S-3 | From 01/01/2017 | Part III | To 12/31/2017 | Date/Time Prepared:

					''	0 12/31/201/	5/30/2018 9: 2	
		Worksheet A	Amount	Recl assi fi cati	Adj usted	Pai d Hours	Average Hourly	
		Line Number	Reported	on of Salaries	Sal ari es	Related to	Wage (col. 4 ÷	
				(from	(col.2 ± col.	Salaries in	col. 5)	
				Worksheet A-6)	3)	col. 4		
		1. 00	2. 00	3. 00	4. 00	5. 00	6. 00	
	PART III - HOSPITAL WAGE INDEX	SUMMARY						
1.00	Net salaries (see		10, 642, 263	3, 882, 957	14, 525, 220	481, 512. 00	30. 17	1.00
	instructions)							
2.00	Excluded area salaries (see		2, 492, 367	316, 842	2, 809, 209	84, 995. 00	33. 05	2.00
	instructions)							
3.00	Subtotal salaries (line 1		8, 149, 896	3, 566, 115	11, 716, 011	396, 517. 00	29. 55	3.00
	minus line 2)							
4.00	Subtotal other wages & related		3, 888, 887	0	3, 888, 887	125, 587. 00	30. 97	4.00
	costs (see inst.)							
5.00	Subtotal wage-related costs		5, 626, 298	0	5, 626, 298	0.00	48. 02	5.00
	(see inst.)							
6.00	Total (sum of lines 3 thru 5)		17, 665, 081	3, 566, 115	21, 231, 196	522, 104. 00	40. 66	6.00
7.00	Total overhead cost (see		4, 470, 108	2, 640, 481	7, 110, 589	222, 843. 00	31. 91	7.00
	instructions)							

Health Financial Systems	HUNTINGTON MEMORIAL HOSPITAL	In Lieu of Form CMS-2552-10		
HOSPITAL WAGE RELATED COSTS	Provi der CCN: 15-0091	Peri od: Worksheet S-3		
		From 01/01/2017   Part IV		

	To 12/31/2017	Date/Time Prep 5/30/2018 9: 2!	
		Amount	
		Reported	
		1. 00	
-	PART IV - WAGE RELATED COSTS		
	Part A - Core List		1
	RETI REMENT COST		1
1.00	401K Employer Contributions	0	1.00
2.00	Tax Sheltered Annuity (TSA) Employer Contribution	259, 783	2.00
3.00	Nonqualified Defined Benefit Plan Cost (see instructions)	636, 136	3.00
4.00	Qualified Defined Benefit Plan Cost (see instructions)	0	4. 00
	PLAN ADMINISTRATIVE COSTS (Paid to External Organization)		1
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	43, 937	7. 00
	HEALTH AND INSURANCE COST		
8.00	Health Insurance (Purchased or Self Funded)	2, 729, 815	8. 00
8. 01	Health Insurance (Self Funded without a Third Party Administrator)	0	8. 01
8. 02	Health Insurance (Self Funded with a Third Party Administrator)	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)	27, 223	11. 00
12.00	Accident Insurance (If employee is owner or beneficiary)	0	12.00
13.00	Disability Insurance (If employee is owner or beneficiary)	73, 809	13.00
14.00	Long-Term Care Insurance (If employee is owner or beneficiary)	0	14.00
15.00	'Workers' Compensation Insurance	22, 153	15. 00
16.00	Retirement Health Care Cost (Only current year, not the extraordinary accrual required by FASB 106.	0	16. 00
	Non cumul ative portion)		
	TAXES		
	FICA-Employers Portion Only	1, 050, 745	17. 00
	Medicare Taxes - Employers Portion Only	0	
	Unempl oyment Insurance	0	19. 00
20.00	State or Federal Unemployment Taxes	0	20. 00
	OTHER		
21. 00	Executive Deferred Compensation (Other Than Retirement Cost Reported on lines 1 through 4 above. (see	42, 994	21. 00
	instructions))	_	
	Day Care Cost and Allowances	0	22. 00
	Tuition Reimbursement	43, 481	
24. 00	Total Wage Related cost (Sum of Lines 1 -23)	4, 930, 076	24. 00
	Part B - Other than Core Related Cost		
25.00	OTHER WAGE RELATED COSTS (SPECIFY)	0	25. 00

Health Financial Systems	HUNTINGTON MEMORIAL HOSPITAL	In Lie	eu of Form CMS-2552-10
HOSPITAL CONTRACT LABOR AND BENEFIT COST	Provi der CCN: 15-0091	Peri od: From 01/01/2017 To 12/31/2017	Worksheet S-3 Part V Date/Time Prepared: 5/30/2018 9:25 am
Cost Center Description		Contract Labor	Benefit Cost

		0 12/31/2017	5/30/2018 9: 2	
	Cost Center Description	Contract Labor		
		1. 00	2. 00	
	PART V - Contract Labor and Benefit Cost			
	Hospital and Hospital-Based Component Identification:			
1.00	Total facility's contract labor and benefit cost	0	4, 930, 076	1.00
2.00	Hospi tal	0	4, 930, 076	2.00
3.00	Subprovi der - I PF			3.00
4.00	Subprovi der - I RF			4.00
5. 00	Subprovi der - (Other)	0	0	5.00
6. 00	Swing Beds - SNF	0	0	6. 00
7. 00	Swing Beds - NF	0	0	7. 00
8. 00	Hospi tal -Based SNF			8. 00
9. 00	Hospi tal -Based NF			9. 00
10. 00	Hospi tal -Based OLTC			10.00
11. 00	Hospi tal -Based HHA			11. 00
12.00	Separately Certified ASC			12.00
13. 00	Hospi tal -Based Hospi ce			13.00
14. 00	Hospital-Based Health Clinic RHC			14.00
15. 00	Hospital-Based Health Clinic FQHC			15.00
	Hospi tal -Based-CMHC			16.00
17. 00	Renal Di al ysi s			17.00
18. 00	Other	0	0	18. 00

	Financial Systems HUNTINGTON MEMORIAL HOSTAL UNCOMPENSATED AND INDIGENT CARE DATA Prov	opital vider CCN: 15-0091	Peri od:	u of Form CMS-2 Worksheet S-10	
10321 1	AL UNCOMPENSATED AND THOUGHT CARE DATA PLOY	rider CCN. 15-0091	From 01/01/2017 To 12/31/2017		
		Date/Time Prep 5/30/2018 9:2	pared: 5 am		
				1. 00	
	Uncompensated and indigent care cost computation				
. 00	Cost to charge ratio (Worksheet C, Part I line 202 column 3 divided Medicaid (see instructions for each line)	d by line 202 colum	n 8)	0. 209956	1.0
2. 00	Net revenue from Medicaid			2, 368, 088	2.0
3. 00	Did you receive DSH or supplemental payments from Medicaid?			γ	3.0
1.00	If line 3 is yes, does line 2 include all DSH and/or supplemental p	payments from Medic	ai d?	N	4. C
5. 00	If line 4 is no, then enter DSH and/or supplemental payments from N	Medi cai d		554, 696	
. 00	Medicaid charges			18, 440, 368	
7. 00 3. 00	Medicaid cost (line 1 times line 6) Difference between net revenue and costs for Medicaid program (line	a 7 minus sum of li	nes 2 and 5: if	3, 871, 666 948, 882	•
3. 00	<pre>&lt; zero then enter zero)</pre>	e / IIII IIus suiii oi Ti	nes 2 and 5, 11	740, 002	0.0
	Children's Health Insurance Program (CHIP) (see instructions for ea	ach line)			1
9. 00	Net revenue from stand-alone CHIP			35, 403	
0.00	Stand-alone CHIP charges			99, 281	1
11. 00 12. 00	Stand-alone CHIP cost (line 1 times line 10) Difference between net revenue and costs for stand-alone CHIP (line	a 11 minus lina O	if / zero then	20, 845 0	1
12.00	enter zero)	e ii iiiiilius iiile 7,	ii < zero tileli	O	12.0
	Other state or local government indigent care program (see instruct	tions for each line	)		
3. 00	Net revenue from state or local indigent care program (Not included			2, 861, 356	
4. 00	Charges for patients covered under state or local indigent care pro	ogram (Not included	in lines 6 or	20, 868, 141	14.0
5. 00	10)   State or local indigent care program cost (line 1 times line 14)			4, 381, 391	15. C
6. 00	Difference between net revenue and costs for state or local indiger	nt care program (li	ne 15 minus line	1, 520, 035	•
	13; if < zero then enter zero)				
	Grants, donations and total unreimbursed cost for Medicaid, CHIP ar instructions for each line)	nd state/local indi	gent care program	ns (see	
7. 00		ng charity care		0	17.0
18. 00	Government grants, appropriations or transfers for support of hospi			0	
19. 00	Total unreimbursed cost for Medicaid , CHIP and state and local inc 8, 12 and 16)	digent care program	is (sum of lines	2, 468, 917	19.0
	[0, 12 and 10)	Uni nsured	Insured	Total (col. 1	
		patients	pati ents	+ col . 2)	
		1.00	2. 00	3. 00	
20. 00	Uncompensated Care (see instructions for each line) Charity care charges and uninsured discounts for the entire facility	ty 2, 598, 5	1, 319, 153	3, 917, 729	20 C
.0. 00	(see instructions)	2,370,3	1,517,155	3, 717, 727	20.0
21. 00	Cost of patients approved for charity care and uninsured discounts	(see 545, 5	1, 319, 153	1, 864, 740	21.0
	instructions)				
22. 00	Payments received from patients for amounts previously written off charity care	as 2, 4	4, 513	6, 916	22.0
23. 00		543, 1	84 1, 314, 640	1, 857, 824	23.0
				1. 00	
24. 00	Does the amount on line 20 column 2, include charges for patient dainposed on patients covered by Medicaid or other indigent care produced by Medicaid or other produced b		of stay limit		24.0
25. 00	If line 24 is yes, enter the charges for patient days beyond the instay limit		m's length of	0	25. 0
6. 00	Total bad debt expense for the entire hospital complex (see instruc	ctions)		6, 482, 693	26.0
7. 00	Medicare reimbursable bad debts for the entire hospital complex (see			74, 665	1
27. 01	Medicare allowable bad debts for the entire hospital complex (see i			114, 870	
	Non-Medicare bad debt expense (see instructions)			6, 367, 823	
	1				
28. 00	Cost of non-Medicare and non-reimbursable Medicare bad debt expense	e (see instructions	)	1, 377, 168	1
29. 00 30. 00	Cost of non-Medicare and non-reimbursable Medicare bad debt expense Cost of uncompensated care (line 23 column 3 plus line 29)  Total unreimbursed and uncompensated care cost (line 19 plus line 3		)	1, 377, 168 3, 234, 992 5, 703, 909	30.0

Heal th	Financial Systems	HUNTINGTON MEMOR	I AL HOSPI TAL		In Lie	eu of Form CMS-	2552-10
RECLAS	SSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE	OF EXPENSES	Provi der C		Peri od:	Worksheet A	
					From 01/01/2017 To 12/31/2017		pared:
						5/30/2018 9: 2	
	Cost Center Description	Sal ari es	0ther		Reclassificati	Reclassi fied	
				+ col . 2)	ons (See A-6)	Trial Balance	
						(col. 3 +- col. 4)	
		1.00	2. 00	3.00	4. 00	5. 00	
	GENERAL SERVICE COST CENTERS	1.00	2.00	3.00	4.00	3.00	
1.00	00100 CAP REL COSTS-BLDG & FIXT		1, 472, 132	1, 472, 13	2 38, 062	1, 510, 194	1.00
2.00	00200 CAP REL COSTS-MVBLE EQUIP		914, 216	1			1
3.00	00300 OTHER CAP REL COSTS		0		0 0	0	3. 00
4.00	00400 EMPLOYEE BENEFITS DEPARTMENT	1, 294, 447	4, 721, 145	1			1
5. 00	00500 ADMI NI STRATI VE & GENERAL	1, 619, 561	16, 983, 952	18, 603, 51	3 -44, 395		
6.00	00600 MAI NTENANCE & REPAI RS	0	050 (54	1 100 /7	0	0	
7. 00 8. 00	OO7OO  OPERATION OF PLANT   OO8OO  LAUNDRY & LINEN SERVICE	277, 024	852, 654	l .			1
9. 00	00900 HOUSEKEEPING	208, 217	138, 650 179, 385				1
10. 00	01000 DI ETARY	353, 187	397, 714	1			
11. 00	01100 CAFETERI A	0	4, 041	1			
12.00	01200 MAI NTENANCE OF PERSONNEL	O	0		0 0	0	12. 00
13.00	01300 NURSING ADMINISTRATION	216, 457	4, 283	220, 74	0 23, 390	244, 130	13. 00
14.00	01400 CENTRAL SERVICES & SUPPLY	0	0		0 0	0	14. 00
15. 00	01500 PHARMACY	501, 215	742, 476	1, 243, 69	1 0	1, 243, 691	•
16. 00	01600 MEDI CAL RECORDS & LI BRARY	0	0		0	0	
17. 00	01700 SOCIAL SERVICE	0	0		0	0	
19. 00 20. 00	01900 NONPHYSICIAN ANESTHETISTS 02000 NURSING SCHOOL		0		0		19. 00 20. 00
21. 00	02100 I &R SERVI CES-SALARY & FRI NGES APPRV		0		0 0		21. 00
22. 00	02200 I &R SERVICES-OTHER PRGM COSTS APPRV		0		0 0	1 0	22. 00
23. 00	02300 PARAMED ED PRGM-(SPECIFY)	0	0		0 0	0	1
	INPATIENT ROUTINE SERVICE COST CENTERS	-1	-		-		1
30.00	03000 ADULTS & PEDIATRICS	3, 057, 407	694, 423	3, 751, 83	0 -545, 787	3, 206, 043	30. 00
43.00	04300 NURSERY	0	0	)	0 169, 697	169, 697	43. 00
	ANCILLARY SERVICE COST CENTERS	0/5 /44	504.000		107.070	1 557 000	
50. 00 52. 00	O5000   OPERATING ROOM   O5200   DELIVERY ROOM & LABOR ROOM	865, 611	584, 399	1, 450, 01	0 107, 370 0 742, 309		1
53. 00	05300 ANESTHESI OLOGY		666, 016	666, 01		666, 016	
54. 00	05400 RADI OLOGY-DI AGNOSTI C	920, 577	561, 069	1			
60.00	06000 LABORATORY	0	2, 168, 532	1			1
62. 30	06250 BLOOD CLOTTING FOR HEMOPHILIACS	0	0		0 0	0	62. 30
65.00	06500 RESPI RATORY THERAPY	642, 358	111, 593				1
66. 00	06600 PHYSI CAL THERAPY	1, 020, 498	60, 310	1, 080, 80			1
67. 00	06700 OCCUPATIONAL THERAPY	1 000	0	1 00	0 245, 597		1
68. 00 69. 00	06800 SPEECH PATHOLOGY 06900 ELECTROCARDI OLOGY	1, 099	0	1, 09	9 70, 751	71, 850	68. 00 69. 00
71. 00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT		1, 750, 368	1, 750, 36	8 -981, 481	768, 887	
72. 00	07200 I MPL. DEV. CHARGED TO PATIENTS	0	1, 700, 000	1, 700, 00	0 981, 399		1
73.00	07300 DRUGS CHARGED TO PATIENTS	456	2, 006, 222	2, 006, 67			1
	07697 CARDI AC REHABI LI TATI ON	0	0		0 0	0	76. 97
	07698 HYPERBARI C OXYGEN THERAPY	8, 698	1, 832				76. 98
76. 99	07699 LI THOTRI PSY	0	0	)	0 0	<u> </u>	76. 99
01 00	OUTPATIENT SERVICE COST CENTERS	1 051 071	2/7 0/7	1 210 01	0 110 017	1, 432, 834	01 00
	O9100   EMERGENCY   O9200   OBSERVATION   BEDS   (NON-DISTINCT   PART	1, 051, 971	267, 947	1, 319, 91	8 112, 916	1, 432, 834	91. 00 92. 00
72.00	OTHER REIMBURSABLE COST CENTERS						72.00
95.00	09500 AMBULANCE SERVICES	2, 421, 017	463, 726	2, 884, 74	3 261, 138	3, 145, 881	95. 00
	SPECIAL PURPOSE COST CENTERS						
	11300 I NTEREST EXPENSE		7, 324				113. 00
118.00		14, 459, 800	35, 754, 409	50, 214, 20	9 -116, 754	50, 097, 455	1118. 00
100 00	NONREIMBURSABLE COST CENTERS 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN			1	0 0		190. 00
	19200 PHYSI CI ANS' PRI VATE OFFI CES	71, 350	23, 342	94, 69			
	07950 OCC HEALTH	0	0		0 0		194. 00
194. 01	07951 PAIN CLINIC	0	0		0 0	0	194. 01
	07952 OCC HEALTH	0	1, 716	1, 71	6 12, 336		194. 02
	07953 FOUNDATI 0	0	80, 000				194. 03
	07954 KIDS CAMPUS	0	0		0		194. 04
	07955 COMMUNITY & VOLUNTEER SERVICES	0	380, 760			380, 760	
	07956 HUNTI NGTON COLLEGE NURSE 07957 MISC CATERI NG		0	()	0 0 96, 712		194. 06 194. 07
	07957 MISC CATERING 07958 AUTISM CENTER		69, 936	69, 93		69 036	194. 07
	07959 HUNTI NGTON BUA		07, 730	07, 73	0 0		194. 09
200.00	· ·	14, 531, 150	36, 310, 163	50, 841, 31			
		'					

Peri od: From 01/01/2017 To 12/31/2017 Date/Ti me Prepared: 5/30/2018 9:25 am

			5/30/2018 9: 2	<u>5 am</u>
Cost Center Description	Adjustments	Net Expenses		
		For Allocation		
	6. 00	7.00		
GENERAL SERVICE COST CENTERS				
1.00 O0100 CAP REL COSTS-BLDG & FIXT	-1, 269, 667	240, 527		1. 00
2.00   00200   CAP REL COSTS-MVBLE EQUIP	-88, 131	857, 020		2. 00
3.00 00300 OTHER CAP REL COSTS	0	o		3. 00
4.00 00400 EMPLOYEE BENEFITS DEPARTMENT	-3, 557, 225	1, 163, 920		4. 00
5.00 00500 ADMINISTRATIVE & GENERAL	-5, 255, 710	13, 303, 408		5. 00
6.00 00600 MAINTENANCE & REPAIRS	0	0		6. 00
7. 00 00700 OPERATION OF PLANT	-11, 005	1, 148, 559		7. 00
8. 00 00800 LAUNDRY & LINEN SERVICE	0	162, 765		8. 00
9. 00   00900   HOUSEKEEPI NG	0	392, 902		9. 00
	- 1			
10. 00 01000 DI ETARY	-12, 288	185, 809		10.00
11. 00 01100 CAFETERI A	-217, 937	242, 196		11. 00
12.00 01200 MAINTENANCE OF PERSONNEL	0	0		12. 00
13. 00   01300   NURSI NG ADMI NI STRATI ON	-11, 567	232, 563		13. 00
14.00   01400   CENTRAL SERVICES & SUPPLY	0	0		14. 00
15. 00   01500   PHARMACY	-704, 702	538, 989		15. 00
16. 00 01600 MEDICAL RECORDS & LIBRARY	0	ol		16. 00
17. 00 01700 SOCI AL SERVI CE	o	0		17. 00
19.00 01900 NONPHYSICIAN ANESTHETISTS	o	0		19.00
20. 00   02000   NURSI NG SCHOOL	0	0		20. 00
21. 00   02100   &R SERVI CES-SALARY & FRINGES APPRV	o	0		21. 00
22. 00   02200   1 &R SERVI CES-OTHER PRGM COSTS APPRV	0	0		22. 00
23. 00 02300 PARAMED ED PRGM-(SPECIFY)	0	0		23. 00
I NPATI ENT ROUTI NE SERVI CE COST CENTERS				
30. 00   03000   ADULTS & PEDI ATRI CS	-99, 181	3, 106, 862		30.00
43. 00 04300 NURSERY	0	169, 697		43. 00
ANCILLARY SERVICE COST CENTERS				
50.00   05000   OPERATING ROOM	-663, 303	894, 077		50.00
52.00   05200   DELIVERY ROOM & LABOR ROOM	0	742, 309		52. 00
53. 00   05300   ANESTHESI OLOGY	0	666, 016		53.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	o	1, 577, 087		54.00
60. 00   06000   LABORATORY	o	2, 168, 387		60.00
62.30 06250 BLOOD CLOTTING FOR HEMOPHILIACS	0	0		62. 30
65. 00 06500 RESPIRATORY THERAPY	-23, 033	800, 216		65. 00
66. 00 06600 PHYSI CAL THERAPY	-2, 900	870, 299		66. 00
67. 00 06700 OCCUPATI ONAL THERAPY	-2, 700	245, 597		67. 00
	- 1			
68. 00 06800 SPEECH PATHOLOGY	0	71, 850		68. 00
69. 00 06900 ELECTROCARDI OLOGY	0	0		69. 00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0	768, 887		71. 00
72.00 07200 I MPL. DEV. CHARGED TO PATIENTS	0	981, 399		72. 00
73.00 07300 DRUGS CHARGED TO PATIENTS	0	2, 060, 220		73. 00
76. 97   07697   CARDI AC   REHABI LI TATI ON	0	0		76. 97
76. 98 07698 HYPERBARI C OXYGEN THERAPY	0	10, 530		76. 98
76. 99 07699 LI THOTRI PSY	o	o		76. 99
OUTPATIENT SERVICE COST CENTERS		·		
91. 00 09100 EMERGENCY	-13, 750	1, 419, 084		91. 00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART	10,700	.,,,		92.00
OTHER REIMBURSABLE COST CENTERS				72.00
95. 00 09500 AMBULANCE SERVI CES	7 11/	2 152 005		95. 00
	7, 114	3, 152, 995		95.00
SPECIAL PURPOSE COST CENTERS	0			440 00
113. 00 11300 INTEREST EXPENSE	0	0		113. 00
118.00 SUBTOTALS (SUM OF LINES 1 through 117)	-11, 923, 285	38, 174, 170		118. 00
NONREI MBURSABLE COST CENTERS				
190.00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0		190. 00
192. 00 19200 PHYSI CLANS' PRI VATE OFFI CES	0	102, 398		192. 00
194. 00 07950 OCC HEALTH	0	0		194. 00
194. 01 07951 PAIN CLINIC	0	ol		194. 01
194. 02 07952 OCC HEALTH	0	14, 052		194. 02
194. 03 07953 FOUNDATI 0	n	80, 000		194. 03
194. 04 07954 KIDS CAMPUS	o	00,000		194. 04
194. 05 07955 COMMUNI TY & VOLUNTEER SERVICES	0	380, 760		194. 05
194. 06 07956 HUNTI NGTON COLLEGE NURSE	0	380, 760		194. 05
	٥	-1		
194. 07 07957 MI SC CATERI NG	Ō	96, 712		194. 07
194. 08 07958 AUTI SM CENTER	0	69, 936		194. 08
194. 09 07959 HUNTI NGTON BUA	0	0		194. 09
200.00   TOTAL (SUM OF LINES 118 through 199)	-11, 923, 285	38, 918, 028		200. 00

Peri od: Worksheet A-6
From 01/01/2017
To 12/31/2017 Date/Time Prepared: 5/30/2018 9: 25 am

					10 12/31/201/	5/30/2018 9: 25	
		Increases					
	Cost Center	Li ne #	Sal ary	0ther			
	2. 00	3. 00	4. 00	5. 00			
	A - CAFETERIA AND CATERING						
1.00	CAFETERI A	11. 00	224, 344	231, 748			1.00
2.00	MISC CATERING	194. 07	47, 998	48, 714			2.00
	TOTALS		272, 342	280, 462			
	B - INTEREST						
1.00	CAP REL COSTS-MVBLE EQUIP	2.00	0	7, 324			1.00
	TOTALS			7, 324			
	F - INSURANCE						
1.00	CAP REL COSTS-BLDG & FIXT	1.00	0	38, 062			1. 00
2.00	CAP REL COSTS-MVBLE EQUIP	2.00	o	23, 611			2.00
	TOTALS			61, 673			
	G - LAUNDRY	,					
1.00	LAUNDRY & LINEN SERVICE	8. 00	24, 115	0			1. 00
	TOTALS		24, 115				
	H - HOME OFFICE SALARY			-1			
1.00	ADMINISTRATIVE & GENERAL	5. 00	3, 888, 887	0			1. 00
	TOTALS	— — <del></del> +	3, 888, 887	<del>_</del> _			
	I - PTO		27 2227 22.1				
1.00	ADMINISTRATIVE & GENERAL	5. 00	17, 278	0			1. 00
2.00	OPERATION OF PLANT	7. 00	29, 886	O			2. 00
3. 00	HOUSEKEEPI NG	9. 00	29, 415	0			3. 00
4. 00	NURSING ADMINISTRATION	13. 00	23, 390	0			4. 00
5. 00	ADULTS & PEDIATRICS	30.00	366, 219	0			5. 00
6. 00	OPERATING ROOM	50.00	107, 370	o o			6. 00
7. 00	RADI OLOGY-DI AGNOSTI C	54.00	99, 313	0			7. 00
8. 00	RESPIRATORY THERAPY	65. 00	69, 298	0			8. 00
9. 00	PHYSI CAL THERAPY	66.00	110, 211	0			9. 00
10. 00	DRUGS CHARGED TO PATIENTS	73. 00	54, 121	0			10.00
13. 00	EMERGENCY	91.00	119, 102	0			13. 00
14. 00	AMBULANCE SERVICES	95. 00	261, 138	0			14. 00
15. 00	PHYSICIANS' PRIVATE OFFICES	192. 00	7, 706	0			15. 00
13.00	TOTALS	192.00		0			13.00
	J - SALARY		1, 294, 447	U			
1. 00	ADMI NI STRATI VE & GENERAL	5.00	0	942			1. 00
2. 00	DI ETARY	10. 00	0	4, 988			2. 00
2.00	TOTALS						2.00
			υĮ	5, 930			
1 00	K - OCC HEALTH	104.00	ما	12 22/			1 00
1.00	OCC HEALTH	194. 02	0	12, 336			1.00
2.00		0.00	0	0			2.00
3.00		0.00	0	0			3. 00
4.00		0.00	0	0			4. 00
5.00		0.00	0	0			5. 00
6.00							6. 00
	TOTALS		0	12, 336			
	L - IMPLANTS	70.00	ما	224 222			
1.00	I MPL. DEV. CHARGED TO	72.00	0	981, 399			1. 00
	PATI ENTS	+					
	TOTALS		0	981, 399			
	M - OB	1	40				
1.00	NURSERY	43.00	124, 802	44, 895			1. 00
2.00	DELIVERY ROOM & LABOR ROOM	52.00	<u>545, 9</u> 24	19 <u>6, 3</u> 85			2. 00
	TOTALS		670, 726	241, 280			
	O - THERAPY	,					
1.00	OCCUPATI ONAL THERAPY	67. 00	231, 892	13, 705			1. 00
2.00	SPEECH PATHOLOGY	68.00	66, 803	<u>3, 948</u>			2. 00
	TOTALS		298, 695	17, 653			
500.00	Grand Total: Increases		6, 449, 212	1, 608, 057		Ĺ	500. 00

					10	5/30/2018 9	
		Decreases					
	Cost Center	Li ne #	Sal ary	0ther	Wkst. A-7 Ref.		
	6. 00	7. 00	8. 00	9. 00	10.00		
	A - CAFETERIA AND CATERING						
1.00	DI ETARY	10.00	272, 342	280, 462			1. 00
2.00		0.00	0		0		2. 00
	TOTALS		272, 342	280, 462	!		_
4 00	B - INTEREST	440.00	ما	7.004	4.4		4 00
1. 00	INTEREST EXPENSE	113.00	0				1. 00
	TOTALS   F - INSURANCE		U	7, 324	1		
1 00	ADMINISTRATIVE & GENERAL	5. 00	ol	(1 (7)	10		1 00
1. 00 2. 00	ADMINISTRATIVE & GENERAL	0.00	0	61, 673	12 12		1. 00 2. 00
2.00	TOTALS			61, 673			2.00
	G - LAUNDRY		U	01, 0/3	1		_
1. 00	HOUSEKEEPI NG	9. 00	24 115		0		1.00
1.00	TOTALS	— — <del>9.</del> 00	2 <u>4, 1</u> 15 24, 115		<del>                                     </del>		1.00
	H - HOME OFFICE SALARY		24, 113		'		
1.00	ADMI NI STRATI VE & GENERAL	5. 00	0	3, 888, 887	0		1.00
1.00	TOTALS	— — <del>-3.00</del>		3, 888, 887			1.00
	I - PTO	L	<u> </u>	3, 000, 007			
1.00	EMPLOYEE BENEFITS DEPARTMENT	4.00	1, 294, 447	C	0		1.00
2.00	LIMI LOTEE BENEFIT TO BET ANTIMENT	0.00	1, 2,74, 447	Ö	l l		2. 00
3. 00		0.00	0	C	l l		3. 00
4. 00		0.00	Ö	O			4. 00
5. 00		0.00	0	0	0		5. 00
6. 00		0.00	Ö	Ö	٦		6. 00
7. 00		0.00	Ö	Ö	0		7. 00
8. 00		0.00	Ö	Ö	0		8. 00
9. 00		0.00	o	Ö	0		9. 00
10.00		0.00	o	C	0		10.00
13. 00		0.00	o	C	0		13. 00
14. 00		0.00	o	C	1		14. 00
15. 00		0.00	o	C			15. 00
	TOTALS	+	1, 294, 447				
	J - SALARY	<u> </u>			·		
1.00	ADMINISTRATIVE & GENERAL	5. 00	942	C	0		1. 00
2.00	DI ETARY	10.00	4, 988	C	0		2. 00
	TOTALS	T	5, 930	0			
	K - OCC HEALTH						
1.00	RADI OLOGY-DI AGNOSTI C	54.00	0	3, 872	0		1. 00
2.00	LABORATORY	60.00	0	145	0		2. 00
3.00	PHYSI CAL THERAPY	66. 00	0	1, 472	0		3. 00
4.00	DRUGS CHARGED TO PATIENTS	73. 00	0	579	0		4. 00
5.00	EMERGENCY	91. 00	0	6, 186			5. 00
6.00	MEDICAL SUPPLIES CHARGED TO	71. 00	0	82	0		6. 00
	PATI ENT	+					
	TOTALS		0	12, 336			
	L - IMPLANTS		_1				
1. 00	MEDICAL SUPPLIES CHARGED TO	71. 00	0	981, 399	0		1. 00
	PATI ENT	+					
	TOTALS		0	981, 399			
1 00	M - OB	20.00	/70 70/	0.44 000			1 00
1.00	ADULTS & PEDIATRICS	30.00	670, 726	241, 280			1. 00
2.00		0.00			0		2. 00
	TOTALS  0 - THERAPY		670, 726	241, 280	'I		
1 00	PHYSICAL THERAPY	44 00	298, 695	17 / 50			1 00
1. 00 2. 00	PRISICAL INEKAPY	66. 00 0. 00	298, 095	17, 653	0		1. 00 2. 00
2.00	TOTALS		00 298, 695	17, 653			2.00
500 00	Grand Total: Decreases		2, 566, 255	5, 491, 014			500. 00
500.00	prana rotar. Decreases		2, 500, 255	5, 471, 014	1		1 300.00

				1	To 12/31/2017	Date/Time Prep 5/30/2018 9: 2	
	·			Acqui si ti ons			
		Begi nni ng	Purchases	Donati on	Total	Disposals and	
		Bal ances				Retirements	
		1.00	2. 00	3.00	4. 00	5. 00	
	PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET	Γ BALANCES			_		
1.00	Land	0	0	(	0	0	1. 00
2.00	Land Improvements	531, 642	31, 167	(	31, 167		2. 00
3.00	Buildings and Fixtures	2, 316, 724	0	(	0	5, 196	3. 00
4.00	Building Improvements	32, 500	0	(	0	0	4. 00
5.00	Fixed Equipment	1, 380, 467	3, 895	(	3, 895	3, 500	5. 00
6.00	Movable Equipment	12, 139, 693	262, 153	(	262, 153	281, 500	6. 00
7.00	HIT designated Assets	2, 777, 110	238, 566	(	238, 566	0	7. 00
8.00	Subtotal (sum of lines 1-7)	19, 178, 136	535, 781	(	535, 781	296, 476	8. 00
9.00	Reconciling Items	2, 441, 864	-1, 083, 672	C	-1, 083, 672	0	9. 00
10.00	Total (line 8 minus line 9)	16, 736, 272	1, 619, 453	C	1, 619, 453	296, 476	10.00
		Endi ng Bal ance	Fully				
			Depreci ated				
			Assets				
		6.00	7. 00				
	PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET	F BALANCES					
1.00	Land	0	0				1. 00
2.00	Land Improvements	556, 529	123, 744				2. 00
3.00	Buildings and Fixtures	2, 311, 528	432, 484				3. 00
4.00	Building Improvements	32, 500	0				4. 00
5.00	Fixed Equipment	1, 380, 862	541, 739				5. 00
6.00	Movable Equipment	12, 120, 346	7, 290, 628				6. 00
7.00	HIT designated Assets	3, 015, 676	0				7. 00
8.00	Subtotal (sum of lines 1-7)	19, 417, 441	8, 388, 595				8. 00
9.00	Reconciling Items	1, 358, 192	0				9. 00
10. 00	Total (line 8 minus line 9)	18, 059, 249	8, 388, 595				10. 00

Heal th	n Financial Systems	HUNTINGTON MEMO	RIAL HOSPITAL		In Lieu of Form CMS-2552-10			
RECON	CILIATION OF CAPITAL COSTS CENTERS		Provi der Co		Peri od:	Worksheet A-7		
					From 01/01/2017 To 12/31/2017		nared·	
						5/30/2018 9: 2		
			Sl	JMMARY OF CAPI	TAL			
	Cost Center Description	Depreciation	Lease	Interest	Insurance (see			
					instructions)	instructions)		
		9.00	10.00	11.00	12. 00	13. 00		
	PART II - RECONCILIATION OF AMOUNTS FROM WORK	· · · · · · · · · · · · · · · · · · ·						
1.00	CAP REL COSTS-BLDG & FIXT	151, 059		1	0	0	1.00	
2.00	CAP REL COSTS-MVBLE EQUIP	883, 743		1	0	4, 204	1	
3. 00	Total (sum of lines 1-2)	1, 034, 802			0 0	4, 204	3. 00	
		SUMMARY 0						
	Cost Center Description		Total (1) (sum					
		Capi tal -Relate	of cols. 9					
		d Costs (see	through 14)					
		instructions)						
		14. 00	15. 00					
	PART II - RECONCILIATION OF AMOUNTS FROM WORK	KSHEET A, COLUM	N 2, LINES 1 a	nd 2				
1.00	CAP REL COSTS-BLDG & FLXT	1, 625	1, 472, 132	!			1. 00	
2.00	CAP REL COSTS-MVBLE EQUIP	5, 178	914, 216	,			2. 00	
3.00	Total (sum of lines 1-2)	6, 803	2, 386, 348	1			3. 00	

Heal th	Financial Systems	HUNTINGTON MEMO	ORIAL HOSPITAL		In Lie	eu of Form CMS-2	2552-10
RECON	CILIATION OF CAPITAL COSTS CENTERS		Provider Co	1	Period: From 01/01/2017 To 12/31/2017	Worksheet A-7 Part III Date/Time Pre 5/30/2018 9:2	pared:
		COM	PUTATION OF RAT	TI OS	ALLOCATION OF	OTHER CAPITAL	
	Cost Center Description	Gross Assets	Capi tal i zed	Gross Assets		Insurance	
			Leases	for Ratio	instructions)		
				(col . 1 - col . 2)	•		
		1.00	2.00	3. 00	4. 00	5. 00	
	PART III - RECONCILIATION OF CAPITAL COSTS CI						
1.00	CAP REL COSTS-BLDG & FIXT	4, 281, 419				0	
2.00	CAP REL COSTS-MVBLE EQUIP	12, 120, 346					2. 00
3.00	Total (sum of lines 1-2)	16, 401, 765					3. 00
		ALLOCA	TION OF OTHER (	CAPITAL	SUMMARY C	F CAPITAL	
	Cost Center Description	Taxes	Other	Total (sum of	Depreciation	Lease	
			Capi tal -Relate				
			d Costs	through 7)			
	DART III DECONCILIATION OF CARLTAL COCTO OF	6. 00	7. 00	8. 00	9. 00	10.00	
1. 00	PART III - RECONCILIATION OF CAPITAL COSTS CI	ENTERS	0	1 ,	157, 118	43, 722	1. 00
2.00	CAP REL COSTS-BLDG & FIXI	0		)	802, 936		2.00
3.00	Total (sum of lines 1-2)				960, 054		3. 00
3.00	Total (Sum of Titles 1 2)		SI	JMMARY OF CAPI		04, 013	3.00
	Cost Center Description	Interest	Insurance (see	Taxes (see	Other	Total (2) (sum	
			instructions)	instructions)	Capi tal -Relate		
					d Costs (see	through 14)	
		11 00	12.00	12.00	instructions)	15.00	
	PART III - RECONCILIATION OF CAPITAL COSTS CI	11.00 ENTERS	12. 00	13. 00	14. 00	15. 00	
1. 00	CAP REL COSTS-BLDG & FIXT	ENTERS 0	38, 062		1, 625	240, 527	1. 00
2. 00	CAP REL COSTS-MVBLE EQUIP	0			· ·		
3.00	Total (sum of lines 1-2)	0					

Expense Classification on Norscheet A   Formal Price   Formal Pr						o 12/31/2017	Date/Time Prep 5/30/2018 9:25	
Lost Center Description							07 007 20 10 7. 20	J dill
1.00					To/From Which the Amount is	to be Adjusted		
1.00								
1.00								
1.00						1		
		Cost Center Description						
DOSTS-BULG A FIXT (chapter 2)   B	1. 00	Investment income - CAP REL	1.00					1. 00
0.0075-MRSLE EQUIP (chapter 2)   0.00   0.00   0.3 a.0   0.00		COSTS-BLDG & FLXT (chapter 2)						
Investment   Income - other     0   0   0   0   0   0   0   0   0	2.00		В	-7, 324	CAP REL COSTS-MVBLE EQUIP	2. 00	11	2. 00
Chapter 2)	3 00			0		0.00	0	3 00
discounts (chapter 8)	3.00			O		0.00	Ĭ	3. 00
Refunds and rehates of expenses (chapter 8)	4.00			0		0.00	O	4. 00
Expenses (Chapter 8)   Chopter 8   Chapter	E 00			0		0.00		E 00
Sentral of provider space by   0   0.00   0.6.00   0.6.00   0.00   0.6.00   0	5.00			O		0.00		5.00
Telephone services (pay stations excluded) (chapter 2)	6.00	Rental of provider space by		0		0.00	o	6. 00
Stations excluded) (Chépter 21)   210	7.00			0.40	ADMINISTRATIVE & CENEDAL	F 00		7.00
8. 00   Television and radio service   A	7.00		A	-942	ADMINISTRATIVE & GENERAL	5.00	۷	7.00
Chapter 21)								
9.00   Parking lot (chapter 21)   A - 8 - 2   -668, Web   0   10.00	8.00	II.	Α	-423	OPERATION OF PLANT	7. 00	0	8. 00
10.00   Provider-based physician   Al-8-2   -668,999   and gustment   11.00   Sale of Scrap, waste, etc.   0   0.00   0.00   0.11.00	0.00			0		0.00		0 00
adjustment (chapter 23)			A-8-2	-668. 989		0.00	-	
Chapter 23)   Chapter 23)   Chapter 23)   Chapter 24)		adjustment						
12.00   Related organization   characations (chapter 10)   characations (chapter 1)   chapter 1)   characations (chapter 1)   chapter 1)   characations (chapter 1)   characations (c	11. 00			0		0.00	0	11. 00
transactions (chapter 10) 14.00 14.00 14.00 15.00 16.0	12 00		Δ-8-1	-5 287 955			0	12 00
14. 00   Caffeteria - employees and guests   A   -38, 867/AFETERIA   11. 00   0   14. 00	12.00		7.01	0,201,700			Ĭ	12.00
15.00   Rental of quarters to employee   0   0.00   0   15.00   0   16.00   0   0   16.00   0   0   0   0   0   0   0   0   0				0			_	
and others				-38, 867	CAFETERI A		_	
16.00   Sale of medical and surgical supplies to other than patients   0   0.00   0.	13.00			U		0.00	٥	15.00
patients	16. 00	Sale of medical and surgical		0		0.00	0	16.00
17.00   Sale of drugs to other than patients   0   0.00								
patients	17 00			0		0.00	0	17 00
abstracts	17.00			O		0.00	Ĭ	17.00
19.00   Nursing and allied health education (tuition, fees, books, etc.)   20.00   Vending machines   A	18. 00	II.		0		0.00	0	18. 00
education (tuition, fees, books, etc.)   20.00   Vending machines   A	19 00	1		0		0.00	0	19 00
20.00   Vending machines   A   -4,988 DIETARY   10.00   0   20.00	17.00			O		0.00	Ĭ	17.00
21.00								
Interest, finance or penal ty charges (chapter 21)   22.00   Interest expense on Medicare overpayments and borrowings to repay Medicare overpayments   23.00   Adjustment for respiratory therapy costs in excess of limitation (chapter 14)   24.00   Adjustment for physical hardward provided   A-8-3   A-8-3   ORESPIRATORY THERAPY   A-8-3   OPHYSICAL THERAPY   A-8-3			Α	-4, 988	DI ETARY		-	
Charges (chapter 21)   Charges (chapter 21)   Charges (chapter 21)   Charges (chapter 21)   Charges (chapter 21)   Charges (chapter 21)   Charges (chapter 21)   Charges (chapter 21)   Charges (chapter 21)   Charges (chapter 21)   Charges (chapter 21)   Chapter 14)   Chapter 17)   Chapter 19)   Chapter 19)   Chapter 21)	21.00			U		0.00	٥	21.00
overpayments and borrowings to repay Medicare overpayments Adjustment for respiratory therapy costs in excess of limitation (chapter 14)  24.00 Adjustment for physical (chapter 14)  25.00 Utilization review - physicians' compensation (chapter 21)  26.00 Depreciation - CAP REL (COSTS-BLDG & FIXT (C		charges (chapter 21)						
Page   Medicare overpayments   A-8-3   ORESPIRATORY THERAPY   65.00   23.00	22. 00			0		0.00	0	22. 00
23. 00 Adjustment for respiratory therapy costs in excess of limitation (chapter 14) 24. 00 Adjustment for physical threapy costs in excess of limitation (chapter 14) 25. 00 Utilization review - physicians' compensation (chapter 21) 26. 00 Depreciation - CAP REL COSTS-BLDG & FIXT 27. 00 Depreciation - CAP REL COSTS-BLDG & FIXT 27. 00 Depreciation - CAP REL COSTS-MVBLE EQUIP 28. 00 Non-physicians' assistant 29. 00 Physicians' assistant 30. 00 Adjustment for occupational therapy costs in excess of limitation (chapter 14) 30. 99 Hospice (non-distinct) (see instructions) 31. 00 Adjustment for speech pathology costs in excess of limitation (chapter 14) 32. 00 CAH RIT Adjustment for Depreciation and Interest  A-8-3  ORSPIRATORY THERAPY 65. 00  PHYSICAL THERAPY 66. 00  24. 00  CAP REL COSTS-BLDG & FIXT  1. 00  0 CAP REL COSTS-BLDG & FIXT 1. 00  0 CAP REL COSTS-BLDG & FIXT 1. 00  0 CAP REL COSTS-MVBLE EQUIP 2. 00  0 CAP REL COSTS-MVBLE EQUIP 2. 00  0 CAP REL COSTS-MVBLE EQUIP 2. 00  0 CAP REL COSTS-MVBLE EQUIP 2. 00  0 CAP REL COSTS-MVBLE EQUIP 2. 00  0 CAP REL COSTS-MVBLE EQUIP 2. 00  0 CAP REL COSTS-MVBLE EQUIP 2. 00  0 CAP REL COSTS-MVBLE EQUIP 2. 00  0 CAP REL COSTS-MVBLE EQUIP 2. 00  0 CAP REL COSTS-MVBLE EQUIP 2. 00  0 CAP REL COSTS-MVBLE EQUIP 2. 00  0 CAP REL COSTS-MVBLE EQUIP 2. 00  0 CAP REL COSTS-MVBLE EQUIP 2. 00  0 CAP REL COSTS-MVBLE EQUIP 2. 00  0 CAP REL COSTS-MVBLE EQUIP 2. 00  0 CAP REL COSTS-MVBLE EQUIP 2. 00  0 ADULTS & PEDIATRICS 30. 00  30.			'					
1 imitation (chapter 14)	23. 00		A-8-3	0	RESPIRATORY THERAPY	65.00		23. 00
24.00 Adjustment for physical therapy costs in excess of limitation (chapter 14) 25.00 Utilization review - physicians' compensation (chapter 21) 26.00 Depreciation - CAP REL COSTS-BLDG & FIXT								
therapy costs in excess of limitation (chapter 14)  25.00 Utilization review - physicians' compensation (chapter 21)  26.00 Depreciation - CAP REL COSTS-BLDG & FIXT  27.00 Depreciation - CAP REL COSTS-BLDG & FIXT  27.00 Depreciation - CAP REL COSTS-BLDG & FIXT  28.00 Non-physician Anesthetist  29.00 Physicians' assistant  29.00 Adjustment for occupational therapy costs in excess of limitation (chapter 14)  30.99 Hospice (non-distinct) (see instructions)  31.00 Adjustment for speech pathology costs in excess of limitation (chapter 14)  32.00 CAP REL COSTS-BLDG & FIXT  0 CAP REL COSTS-MVBLE EQUIP  0 CAP REL COSTS-MVBLE EQUIP  2 0 0 CAP REL COSTS-MVBLE EQUIP  3 0 0 CAP REL COSTS-MVBLE EQUIP  3 0 0 CAP REL COSTS-MVBLE EQUIP  3 0 0 CAP REL COSTS-MVBLE EQUIP  3 0 0 CAP REL COSTS-MVBLE EQUIP  4 0 CAP REL COSTS-MVBLE EQUIP  5 0 0 CAP REL COSTS-MVBLE EQUIP  5 0 0 CAP REL COSTS-MVBLE EQUIP  5 0 0 CAP REL COSTS-MVBLE EQUIP  5 0 0 CAP REL COSTS-MVBLE EQUI	24 00		Δ_8-3	0	PHYSICAL THERADY	66 00		24 00
limitation (chapter 14)	24.00		N-0-3	U	HISTORE HIERAFT	00.00		Z4. UU
physicians' compensation (chapter 21)  26.00 Depreciation - CAP REL COSTS-BLDG & FIXT		limitation (chapter 14)	]					
Chapter 21)   Depreciation - CAP REL   OCAP REL COSTS-BLDG & FIXT   1.00   0 26.00	25. 00			0	*** Cost Center Deleted ***	114. 00		25. 00
26. 00 Depreciation - CAP REL COSTS-BLDG & FIXT 1.00 0 26. 00 CAP REL COSTS-BLDG & FIXT 1.00 0 26. 00 CAP REL COSTS-BLDG & FIXT 1.00 0 26. 00 CAP REL COSTS-BLDG & FIXT 1.00 0 27. 00 CAP REL COSTS-MVBLE EQUIP 2.00 0 CAP COSTS-MVBL								
27. 00 Depreciation - CAP REL COSTS-MVBLE EQUIP 28. 00 Non-physician Anesthetist 29. 00 Physicians' assistant 30. 00 Adjustment for occupational therapy costs in excess of limitation (chapter 14) 30. 99 Hospice (non-distinct) (see instructions) 31. 00 Adjustment for speech pathology costs in excess of limitation (chapter 14) 32. 00 CAP REL COSTS-MVBLE EQUIP 2. 00 ONONPHYSICIAN ANESTHETISTS 19. 00 28. 00 29. 00 0 00 00 00 0 29. 00 0 00 00 0 00 00 0 00 00 0 00 00 0 00 0	26. 00	Depreciation - CAP REL		0	CAP REL COSTS-BLDG & FIXT	1.00	o	26. 00
28. 00   Non-physician Anesthetist   ONONPHYSICIAN ANESTHETISTS   19. 00   28. 00   29. 00   Physicians' assistant   O   OCCUPATIONAL THERAPY   67. 00   30. 00   30. 00   Adjustment for occupational therapy costs in excess of limitation (chapter 14)   1. 00   0.00   0.00   30. 99   Hospice (non-distinct) (see instructions)   A-8-3   OSPEECH PATHOLOGY   Compathology costs in excess of limitation (chapter 14)   0.00   0.00   0.00   31. 00   Adjustment for speech   A-8-3   OSPEECH PATHOLOGY   Compathology costs in excess of limitation (chapter 14)   0.00   0.00   0.00   0.00   32. 00   CAH HIT Adjustment for   O   O. 00   O. 00   0.00   Depreciation and Interest   ONONPHYSICIAN ANESTHETISTS   19. 00   28. 00   28. 00   O   29. 00   0.00   0.00   29. 00   O   O   O   O   O   29. 00   O   O   O   O   29. 00   O   O   O   29. 00   O   O   O   29. 00   O   O   29. 00   O   O   29. 00   O   O   29. 00   O   O   29. 00   O	07.00			=	CAR DEL COCTO MURI E SOUI E	0.55	_	07.66
28.00 Non-physician Anesthetist 29.00 Physicians' assistant 30.00 Adjustment for occupational therapy costs in excess of limitation (chapter 14) 30.99 Hospice (non-distinct) (see instructions) 31.00 Adjustment for speech pathology costs in excess of limitation (chapter 14) 32.00 CAH HIT Adjustment for Depreciation and Interest  ONONPHYSICIAN ANESTHETISTS 19.00 0 29.00 30.00 0 29.00 30.00 30.00 30.00 30.00 30.00 30.99 0 ABULTS & PEDIATRICS 30.00 31.00 0 ONONPHYSICIAN ANESTHETISTS 19.00 0 29.00 0 30.00 0 30.00 0 30.00 0 30.00	27.00			0	CAP KEL CUSIS-MVBLE EQUIP	2.00		27.00
29. 00 Physicians' assistant 30. 00 Adjustment for occupational therapy costs in excess of limitation (chapter 14) Hospice (non-distinct) (see instructions)  31. 00 Adjustment for speech pathology costs in excess of limitation (chapter 14)  32. 00 CAH HIT Adjustment for Depreciation and Interest	28. 00			0	NONPHYSICIAN ANESTHETISTS	19. 00		28. 00
therapy costs in excess of limitation (chapter 14) 30. 99 Hospice (non-distinct) (see instructions) 31. 00 Adjustment for speech pathology costs in excess of limitation (chapter 14) 32. 00 CAH HIT Adjustment for Depreciation and Interest  OADULTS & PEDIATRICS 30. 00 30. 99 31. 00 32. 00 30. 00 30. 99 31. 00 32. 00				0				
I i mi tati on (chapter 14)  30. 99   Hospice (non-distinct) (see instructions)  31. 00   Adjustment for speech pathology costs in excess of limitation (chapter 14)  32. 00   CAH HIT Adjustment for Depreciation and Interest	30. 00		A-8-3	0	OCCUPATIONAL THERAPY	67.00		30. 00
30. 99 Hospice (non-distinct) (see instructions) 31. 00 Adjustment for speech pathology costs in excess of limitation (chapter 14) 32. 00 CAH HIT Adjustment for Depreciation and Interest								
31.00 Adjustment for speech pathology costs in excess of limitation (chapter 14) 32.00 CAH HIT Adjustment for Depreciation and Interest	30. 99	Hospice (non-distinct) (see		0	ADULTS & PEDIATRICS	30.00		30. 99
pathology costs in excess of limitation (chapter 14)  32.00 CAH HIT Adjustment for 0 0.00 0 32.00 Depreciation and Interest	04.05			_	CDEFOUL DATUGLOSS			04.00
limitation (chapter 14) 32.00 CAH HIT Adjustment for 0 0.00 0 32.00 Depreciation and Interest	31.00		A-8-3	0	SPEECH PATHULUGY	68.00		31.00
32.00 CAH HIT Adjustment for 0 0.00 0 32.00 Depreciation and Interest								
	32. 00	CAH HIT Adjustment for		0		0.00	0	32. 00
2, 000   DEVENTION   3.00   0   35.00	33 00		Δ	2 000	ADMINISTRATIVE & CENEDAL	5 00	0	33 UU
		INDVENTION NO	1 0 1	2,000	PROMINIOTIVE & OLIVERAL	3.00	ı <u> </u>	

				T	o 12/31/2017	Date/Time Prep 5/30/2018 9: 2	pared: 5 am
				Expense Classification on	Worksheet A	0,00,2010 ,12	<u> </u>
				To/From Which the Amount is			
	Cost Center Description	Basis/Code (2)	Amount	Cost Center	Li ne #	Wkst. A-7 Ref.	
		1.00	2.00	3. 00	4. 00	5. 00	
33. 01	TELEPHONE SERVICES	A	-262	EMPLOYEE BENEFITS DEPARTMENT	4. 00	0	33. 01
33. 02	VENDI NG	A	-1, 620	EMPLOYEE BENEFITS DEPARTMENT	4. 00	0	33. 02
33. 03	VENDI NG	A	-787	OPERATION OF PLANT	7. 00	0	33. 03
33. 04	RENT	A	-985, 876	CAP REL COSTS-BLDG & FIXT	1. 00	10	33. 04
33. 05	RENT	A	-17, 561	CAP REL COSTS-BLDG & FIXT	1. 00	10	33. 05
33.06	RENT	A	-257, 889	CAP REL COSTS-BLDG & FIXT	1. 00	10	33. 06
33. 07	PHARMACY EMPLOYEE PURCHASES	В	-657, 351	PHARMACY	15. 00	0	33. 07
33. 08	PHYSICIAN RECRUITMENT	A	-25, 000	ADMINISTRATIVE & GENERAL	5. 00	0	33. 08
33.09	RENT	A	-14, 400	CAP REL COSTS-BLDG & FIXT	1. 00	10	33. 09
33. 10	SELF INSURANCE	A	-3, 555, 343	EMPLOYEE BENEFITS DEPARTMENT	4. 00	0	33. 10
33. 11	GUEST MEALS	A	-21, 748	CAFETERI A	11. 00	0	33. 11
33. 13	LOBBY DUES	A	-3, 764	ADMINISTRATIVE & GENERAL	5. 00	0	33. 13
33. 14	LI QUOR	A	-1, 305	ADMINISTRATIVE & GENERAL	5. 00	0	33. 14
33. 15	OTHER OPERATING REVENUE	В	-11, 567	NURSING ADMINISTRATION	13. 00	0	33. 15
33. 18	OTHER OPERATING REVENUE	В	-51, 332	ADMINISTRATIVE & GENERAL	5. 00	0	33. 18
33. 19	OTHER OPERATING REVENUE	В	-7, 300	DI ETARY	10.00	0	33. 19
33. 20	OTHER OPERATING REVENUE	В	-157, 322	CAFETERI A	11. 00	0	33. 20
33. 21	OTHER OPERATING REVENUE	В	-47, 351	PHARMACY	15. 00	0	33. 21
33. 24	OTHER OPERATING REVENUE	В	-23, 033	RESPI RATORY THERAPY	65.00	0	33. 24
33. 25	OTHER OPERATING REVENUE	В	-2, 900	PHYSICAL THERAPY	66.00	0	33. 25
33. 27	OTHER OPERATING REVENUE	В	-950	AMBULANCE SERVICES	95. 00	0	33. 27
33. 29	TELEMETRY	A	29, 761	ADULTS & PEDIATRICS	30.00	0	33. 29
33. 30	OTHER OPERATING REVENUE	В	-128, 942	ADULTS & PEDIATRICS	30.00	0	33. 30
33. 31	OTHER OPERATING REVENUE	В	-9, 795	OPERATION OF PLANT	7. 00	0	33. 31
34.00	DEPRECIATION	A	6, 059	CAP REL COSTS-BLDG & FIXT	1. 00	9	34.00
35.00	DEPRECIATION	A	-80, 807	CAP REL COSTS-MVBLE EQUIP	2. 00	9	35. 00
37.00	PHYS ADMIN SALARIES	A	112, 588	ADMINISTRATIVE & GENERAL	5. 00	0	37. 00
50.00	TOTAL (sum of lines 1 thru 49)		-11, 923, 285				50.00
	(Transfer to Worksheet A,						
	column 6, line 200.)	1					1

(1) Description - all chapter references in this column pertain to CMS Pub. 15-1. (2) Basis for adjustment (see instructions).

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

B. Amount Received - if cost cannot be determined.

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

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

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

 The seen posted to heritariot in condition and the seen posted to heritariot and the seen posted to heritariot and the partition											
			Related Organization(s) and/	or Home Office							
Symbol (1)	Name	Percentage of	Name	Percentage of							
		Ownershi p		Ownershi p							
1. 00	2. 00	3. 00	4. 00	5. 00							
B. INTERRELATIONSHIP TO RELAT	TED ORGANIZATION(S) AND/OR HO	ME OFFICE:									

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

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

6.00	В	0.00 PARKVIEW HEALTH SYSTEM, INC. 100.0	6.00
7.00		0.00	7.00
8.00		0.00	8.00
9.00		0.00	9.00
10.00		0.00	10.00
100.00	G. Other (financial or		100.00
	non-financial) specify:		

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

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

line 12.

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

Heal th	Health Financial Systems			HUNTINGTON MEMORIAL HOSPITAL						In Lieu of Form CMS-2552-10					
STATEME OFFICE		SERVICES FROM	RELATE	D ORGANIZ	ATI ONS	AND HO	OME	Provi der	CCN:	15-0091	Period: From 01/	n1/2017	Worksheet	A-8-	1
UFFICE												31/2017	Date/Ti me 5/30/2018		
	Net	Wkst. A-7 Ref.													
	Adjustments														
	(col. 4 minus														
	col. 5)*														
	6. 00	7. 00													
	A. COSTS INCUR	RED AND ADJUST	MENTS F	REQUIRED A	AS A RE	SULT 0	F TRAI	NSACTI ONS	WITH	I RELATED	ORGANI ZATI	ONS OR (	CLAI MED		
	HOME OFFICE CO	STS:													
1.00	1, 966, 226	0													1.00
2.00	-7, 254, 181	0													2.00
3.00	0	0													3.00
4.00	0	0													4.00
5.00	-5, 287, 955														5. 00
* The	amounts on line	es 1-4 (and sub	scri pt	s as appr	opri at	e) are	trans	sferred in	det	ail to Wor	ksheet A.	col umn	6. lines a	S	

\* 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.

	boon poored to non noned 7.1	cordinate i dilator 21 the amount directable chours to the cordinate of the parti-	
	Related Organization(s)		
	and/or Home Office		
	Type of Business		
	31		
	6. 00		
	B. INTERRELATIONSHIP TO RELA	TED ORGANIZATION(S) AND/OR HOME OFFICE:	
TI 0		10.00	

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	HOME OFFICE		6. 00
7.00			7.00
8.00			8.00
9.00			9.00
10.00			10.00
7. 00 8. 00 9. 00 10. 00 100. 00		1	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.

						To 12/31/2017	Date/Time Pro 5/30/2018 9:2	
	Wkst. A Line #	Cost Center/Physician	Total	Professi onal	Provi der	RCE Amount	Physi ci an/Prov	
		l denti fi er	Remuneration	Component	Component		ider Component	
				·	•		Hours	
	1. 00	2. 00	3.00	4. 00	5. 00	6. 00	7. 00	
1.00		OPERATING ROOM	664, 294			11, 844		
2.00	91. 00	EMERGENCY	13, 750	13, 75	i0 C	0	0	2. 00
3.00		AMBULANCE SERVICES	-8, 064	-8, 06	04 C	0	0	3. 00
4.00	0. 00		0		0 0	0	0	4. 00
5.00	0. 00		0		0 0	0	0	5. 00
6.00	0. 00		0		0 0	0	0	6. 00
7.00	0.00		0		0 0	0	0	7. 00
8.00	0. 00		0		0 0	0	0	8. 00
9.00	0.00		0		0 0	0	0	9. 00
10.00	0.00		0		0 0	0	0	10.00
200.00			669, 980	645, 98	24, 000		174	200.00
	Wkst. A Line #	Cost Center/Physician	Unadjusted RCE	5 Percent of	Cost of	Provi der	Physician Cost	
		l denti fi er	Limit		E Memberships &	Component	of Malpractice	
				Limit	Conti nui ng	Share of col.	Insurance	
					Educati on	12		
1.00	1.00	2.00	8.00	9. 00	12. 00	13.00	14.00	4 00
1.00		OPERATING ROOM	991		50			
2.00		EMERGENCY	0		0			
3.00		AMBULANCE SERVICES	0		0	0	0	
4.00	0.00		0		0	0	0	
5.00	0.00		0			0	0	0.00
6.00	0. 00 0. 00		0			0	0	
7.00			0			0	0	7. 00
8. 00	0. 00 0. 00		0			0	0	0.00
9.00			0			0	0	7.00
10.00	0. 00		0 991	_	0 0	_	0	
200.00	Wkst. A Line #	Cost Center/Physician	Provi der	Adjusted RCE	RCE	Adjustment	0	200.00
	WKSt. A LITTE #	I denti fi er	Component	Limit	Di sal I owance	Aujustillerit		
		ruenti i ei	Share of col.	LIIIII	Di Sai i Owance			
			14					
	1. 00	2.00	15. 00	16. 00	17. 00	18. 00		
1. 00	50. 00	OPERATING ROOM	0	99	23, 009	663, 303		1. 00
2.00		EMERGENCY	0		0 0	13, 750		2. 00
3.00	95. 00	AMBULANCE SERVICES	0		0 0	-8, 064		3. 00
4.00	0. 00		0		0 0	0		4. 00
5.00	0. 00		0		0 0	0		5. 00
6.00	0. 00		0		0 0	0		6.00
7.00	0.00		0		0 0	0		7. 00
8.00	0.00		0		0 0	0		8. 00
9.00	0.00		0		0 0	0		9. 00
10.00	0. 00		0		0 0	0		10.00
200.00			0	99	23, 009	668, 989		200. 00
	·							

| Period: | Worksheet B | From 01/01/2017 | Part | To 12/31/2017 | Date/Time Prepared: Health Financial Systems
COST ALLOCATION - GENERAL SERVICE COSTS Provider CCN: 15-0091

						o 12/31/2017	Date/Time Pre	
			CAPI TAL REI	LATED COSTS		5/30/2018 9: 2	5 am	
Cook Contan December of			Nat Francisco			EMDL OVEE	Cultatatat	
		Cost Center Description	Net Expenses for Cost	BLDG & FIXT	MVBLE EQUIP	EMPLOYEE BENEFITS	Subtotal	
			Allocation			DEPARTMENT		
			(from Wkst A col. 7)					
			0	1.00	2.00	4. 00	4A	
4 00		AL SERVICE COST CENTERS	0.40 507	040 507				1.00
1. 00 2. 00	1	CAP REL COSTS-BLDG & FIXT CAP REL COSTS-MVBLE EQUIP	240, 527 857, 020	240, 527	857, 020			1. 00 2. 00
4.00		EMPLOYEE BENEFITS DEPARTMENT	1, 163, 920	272				4. 00
5.00	1	ADMINISTRATIVE & GENERAL	13, 303, 408	15, 842			13, 675, 338	1
6. 00 7. 00		MAINTENANCE & REPAIRS OPERATION OF PLANT	0 1, 148, 559	0 63, 261	1	0 19, 404	0 1, 258, 790	
8.00		LAUNDRY & LINEN SERVICE	162, 765	1, 297		1, 525	165, 587	8. 00
9.00		HOUSEKEEPI NG	392, 902	1, 056	•		407, 457	9.00
10. 00 11. 00	1	DI ETARY CAFETERI A	185, 809 242, 196	10, 090 2, 289			202, 306 258, 669	1
12. 00	01200	MAINTENANCE OF PERSONNEL	0	0	1		0	1
13. 00 14. 00		NURSING ADMINISTRATION CENTRAL SERVICES & SUPPLY	232, 563	0 3, 929			247, 727	
15. 00		PHARMACY	538, 989	2, 382	•		3, 929 632, 642	
16. 00	1	MEDICAL RECORDS & LIBRARY	o	1, 316	0	0	1, 316	16. 00
17. 00 19. 00	1	SOCIAL SERVICE NONPHYSICIAN ANESTHETISTS	0	0	0	0	0	17. 00 19. 00
20. 00		NURSING SCHOOL	0	0	0	0	0	20.00
21. 00	02100	I&R SERVICES-SALARY & FRINGES APPRV	o	0	0	0	0	
22. 00 23. 00		I&R SERVICES-OTHER PRGM COSTS APPRV PARAMED ED PRGM-(SPECIFY)	0	0	-	_	0	
23.00		IENT ROUTINE SERVICE COST CENTERS	<u> </u>	0	0	١	0	23.00
30. 00		ADULTS & PEDIATRICS	3, 106, 862				3, 434, 241	30. 00
43. 00		NURSERY LARY SERVICE COST CENTERS	169, 697	210	0	7, 890	177, 797	43.00
50.00		OPERATING ROOM	894, 077	19, 767	120, 830	61, 515	1, 096, 189	50. 00
52.00		DELIVERY ROOM & LABOR ROOM	742, 309	0			776, 824	1
53. 00 54. 00	1	ANESTHESI OLOGY RADI OLOGY-DI AGNOSTI C	666, 016 1, 577, 087	0 24, 774	1	0 64, 481	666, 016 1, 935, 719	1
60.00		LABORATORY	2, 168, 387	3, 754			2, 172, 141	
62. 30		BLOOD CLOTTING FOR HEMOPHILIACS	0	0	1	0	0	62. 30
65. 00 66. 00		RESPI RATORY THERAPY PHYSI CAL THERAPY	800, 216 870, 299	2, 776 17, 168			871, 321 947, 955	65. 00 66. 00
67. 00	06700	OCCUPATIONAL THERAPY	245, 597	0	1	14, 661	260, 258	
68. 00 69. 00		SPEECH PATHOLOGY ELECTROCARDI OLOGY	71, 850 0	0	0	4, 293	76, 143 0	1
71. 00		MEDICAL SUPPLIES CHARGED TO PATIENT	768, 887	0	0	0	768, 887	
72. 00	07200	IMPL. DEV. CHARGED TO PATIENTS	981, 399	0	0	0	981, 399	72. 00
73. 00 76. 97		DRUGS CHARGED TO PATIENTS CARDIAC REHABILITATION	2, 060, 220	0	0	3, 451	2, 063, 671 0	73. 00 76. 97
76. 98		HYPERBARI C OXYGEN THERAPY	10, 530			550	11, 080	1
76. 99		LI THOTRI PSY	0	0	0	0	0	76. 99
91. 00		TIENT SERVICE COST CENTERS  EMERGENCY	1, 419, 084	10, 560	23, 208	74, 039	1, 526, 891	91.00
92. 00		OBSERVATION BEDS (NON-DISTINCT PART	1, 117, 001	10, 000	20, 200	71,007	0	
05.00		REI MBURSABLE COST CENTERS	2 152 005	7 224	214 707	1/0 574	2 544 (70	05.00
95. 00		AMBULANCE SERVICES AL PURPOSE COST CENTERS	3, 152, 995	7, 324	214, 786	169, 574	3, 544, 679	95. 00
	11300	INTEREST EXPENSE						113. 00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)   MBURSABLE COST CENTERS	38, 174, 170	239, 958	856, 424	1, 156, 159	38, 164, 972	118. 00
190. 00		GIFT, FLOWER, COFFEE SHOP & CANTEEN	O	0	0	O	0	190. 00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	102, 398	0	596	4, 998	107, 992	192. 00
		OCC HEALTH PAIN CLINIC	0	569 0	1	0		194. 00 194. 01
		OCC HEALTH	14, 052	0		0		194. 01
		FOUNDATI O	80, 000	0	0	0		194. 03
		KIDS CAMPUS COMMUNITY & VOLUNTEER SERVICES	0 380, 760	0	0	0	0 380, 760	194. 04 194. 05
		HUNTI NGTON COLLEGE NURSE	0	0	Ö	Ö		194. 06
		MI SC CATERI NG	96, 712	0	0	3, 035		194. 07
		AUTISM CENTER HUNTINGTON BUA	69, 936 0	0		0		194. 08 194. 09
200.00		Cross Foot Adjustments			<b> </b>		0	200. 00
201.00		Negative Cost Centers	20 010 000	0	0.57 000	0		201.00
202.00	<b>'</b>	TOTAL (sum lines 118 through 201)	38, 918, 028	240, 527	857, 020	1, 164, 192	38, 918, 028	1202. UU

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 15-0091

Peri od: Worksheet B From 01/01/2017 Part I To 12/31/2017 Date/Time Prepared:

5/30/2018 9:25 am Cost Center Description ADMINISTRATIVE MAINTENANCE & OPERATION OF LAUNDRY & HOUSEKEEPI NG & GENERAL REPAI RS **PLANT** LINEN SERVICE 9.00 5.00 6.00 7.00 8.00 GENERAL SERVICE COST CENTERS 1.00 00100 CAP REL COSTS-BLDG & FLXT 1.00 00200 CAP REL COSTS-MVBLE EQUIP 2.00 2.00 00400 EMPLOYEE BENEFITS DEPARTMENT 4.00 4.00 00500 ADMINISTRATIVE & GENERAL 5 00 13, 675, 338 5 00 6.00 00600 MAINTENANCE & REPAIRS 6.00 00700 OPERATION OF PLANT 681, 955 1, 940, 745 7.00 7.00 8.00 00800 LAUNDRY & LINEN SERVICE 89, 707 0 15, 623 270, 917 8.00 00900 HOUSEKEEPI NG 12, 717 640, 915 9.00 220, 741 9 00 10.00 01000 DI ETARY 109,600 121, 508 40, 722 10.00 11.00 01100 CAFETERI A 140, 135 27, 570 0 9, 240 11.00 01200 MAINTENANCE OF PERSONNEL 12.00 0 12 00 Ω C 0 13.00 01300 NURSING ADMINISTRATION 134, 207 13.00 C 0 14.00 01400 CENTRAL SERVICES & SUPPLY 2, 129 47, 316 0 15, 857 14.00 0 01500 PHARMACY 342, 736 15.00 28, 688 9.614 15.00 01600 MEDICAL RECORDS & LIBRARY 16.00 713 0 15.847 5, 311 16.00 0 17.00 01700 SOCIAL SERVICE 0 C 0 17.00 01900 NONPHYSICIAN ANESTHETISTS 0 19 00 0 0 19.00 0 02000 NURSING SCHOOL 0 20.00 0 0 20.00 0 02100 I&R SERVICES-SALARY & FRINGES APPRV 0 21.00 0 Ω 0 0 21 00 02200 I&R SERVICES-OTHER PRGM COSTS APPRV 0 22.00 C 0 22.00 02300 PARAMED ED PRGM-(SPECIFY) 23.00 23.00 INPATIENT ROUTINE SERVICE COST CENTERS 30.00 03000 ADULTS & PEDIATRICS 1,860,514 0 624, 925 76.899 209, 436 30.00 43.00 04300 NURSERY 96, 322 0 2,533 4,083 849 43.00 ANCILLARY SERVICE COST CENTERS 50.00 05000 OPERATING ROOM 593.865 238, 048 43 952 79,778 50.00 52.00 05200 DELIVERY ROOM & LABOR ROOM 420,848 C 17,865 52.00 C 0 05300 ANESTHESI OLOGY 53.00 360, 817 53.00 0 05400 RADI OLOGY-DI AGNOSTI C 0 298. 355 99, 989 54.00 1,048,684 30, 400 54.00 06000 LABORATORY 60.00 1, 176, 766 C 45, 205 15, 150 60.00 62.30 06250 BLOOD CLOTTING FOR HEMOPHILIACS 0 62.30 06500 RESPIRATORY THERAPY 65.00 472,042 33, 432 17, 612 11, 204 65.00 66 00 06600 PHYSI CAL THERAPY 513 558 Ω 206, 752 69, 290 66 00 06700 OCCUPATIONAL THERAPY 67.00 140, 996 0 C 0 0 67.00 06800 SPEECH PATHOLOGY 41, 251 0 0 68.00 0 68.00 0 69.00 06900 ELECTROCARDI OLOGY 0 69.00 0 07100 MEDICAL SUPPLIES CHARGED TO PATIENT 0 71.00 416, 548 0 0 71.00 72.00 07200 IMPL. DEV. CHARGED TO PATIENTS 531,677 0 0 0 0 72.00 07300 DRUGS CHARGED TO PATIENTS o 73.00 1, 118, 002 0 0 0 73.00 76 97 07697 CARDIAC REHABILITATION Ω 0 0 76 97 0 07698 HYPERBARIC OXYGEN THERAPY 76.98 6,003 C 0 0 0 76.98 07699 LI THOTRI PSY 76. 99 76.99 0 OUTPATIENT SERVICE COST CENTERS 91 00 91 00 827, 199 127, 171 68 884 42.619 09100 EMERGENCY 09200 OBSERVATION BEDS (NON-DISTINCT PART 92.00 92.00 OTHER REIMBURSABLE COST CENTERS 09500 AMBULANCE SERVICES 0 29, 559 95.00 1, 920, 353 88. 200 5. 615 95.00 SPECIAL PURPOSE COST CENTERS 113. 00 11300 | INTEREST EXPENSE 113.00 SUBTOTALS (SUM OF LINES 1 through 117) 13, 267, 368 1, 933, 890 265, 310 118.00 0 638, 618 118. 00 NONREIMBURSABLE COST CENTERS 190. 00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN 0 0 190 00 192.00 19200 PHYSICIANS' PRIVATE OFFICES 58, 505 5, 607 0 192.00 194.00 07950 OCC HEALTH 308 6,855 2, 297 194. 00 0 194. 01 07951 PAIN CLINIC 0 194, 01 0 0 C 0 0 194. 02 194. 02 07952 OCC HEALTH 7 613 Ω 0 0 194. 03 07953 FOUNDATIO 0 0 0 194. 03 43, 340 0 194. 04 07954 KIDS CAMPUS 0 0 194. 04 194. 05 07955 COMMUNITY & VOLUNTEER SERVICES 206, 278 0 0 0 194, 05 0 194.06 07956 HUNTI NGTON COLLEGE NURSE C 0 0 194.06 194. 07 07957 MISC CATERING 54, 038 0 0 0 194. 07 194.08 07958 AUTISM CENTER 0 194. 08 37,888 0 0 0 194. 09 07959 HUNTI NGTON BUA C 0 0 194. 09 0 200.00 Cross Foot Adjustments 200.00 201.00 Negative Cost Centers 0 0 201.00 TOTAL (sum lines 118 through 201) 13, 675, 338 1. 940. 745 270. 917 640, 915 202. 00 202.00 0

				0 12/31/201/	Date/IIme Pre   5/30/2018 9:2	
Cost Center Description	DI ETARY	CAFETERI A	MAINTENANCE OF	NURSI NG	CENTRAL	<u> </u>
			PERSONNEL	ADMI NI STRATI ON	SERVICES &	
	10.00	11. 00	12. 00	13. 00	SUPPLY 14. 00	
GENERAL SERVICE COST CENTERS	10.00	11.00	12.00	13.00	14.00	
1. 00 00100 CAP REL COSTS-BLDG & FLXT						1. 00
2.00 00200 CAP REL COSTS-MVBLE EQUIP						2. 00
4.00 00400 EMPLOYEE BENEFITS DEPARTMENT						4. 00
5.00 00500 ADMINISTRATIVE & GENERAL						5. 00
6.00 00600 MAINTENANCE & REPAIRS						6. 00
7. 00 00700 OPERATION OF PLANT						7. 00
8.00   00800   LAUNDRY & LI NEN SERVI CE 9.00   00900   HOUSEKEEPI NG						8. 00 9. 00
10. 00   01000 DI ETARY	474, 136					10.00
11. 00 01100 CAFETERI A	474, 130	435, 614				11. 00
12.00 01200 MAINTENANCE OF PERSONNEL	o	0	d			12.00
13.00 01300 NURSING ADMINISTRATION	o	5, 815	(	387, 749		13. 00
14.00 01400 CENTRAL SERVICES & SUPPLY	0	0	C	0	69, 231	14. 00
15. 00   01500   PHARMACY	0	10, 512	C	0	791	15. 00
16. 00 01600 MEDI CAL RECORDS & LI BRARY	0	0			0	16.00
17. 00 O1700 SOCIAL SERVICE 19. 00 O1900 NONPHYSICIAN ANESTHETISTS	0	0			0	17.00
19. 00   01900   NONPHYSI CLAN ANESTHETI STS 20. 00   02000   NURSI NG SCHOOL	0	0			0	19. 00 20. 00
21. 00   02100   &R SERVICES-SALARY & FRINGES APPRV		0			0	21. 00
22. 00 02200 I &R SERVI CES-OTHER PRGM COSTS APPRV	l ől	0		ol ol	0	22. 00
23.00 02300 PARAMED ED PRGM-(SPECIFY)	o	0	C	o	0	23. 00
INPATIENT ROUTINE SERVICE COST CENTERS						
30. 00   03000   ADULTS & PEDI ATRI CS	474, 136	141, 848			4, 728	30. 00
43. 00 04300 NURSERY	0	4, 195	(	6, 893	0	43. 00
ANCILLARY SERVICE COST CENTERS		22 211		F4 F70	7 51/	FO 00
50.00   05000   OPERATING ROOM 52.00   05200   DELIVERY ROOM & LABOR ROOM	0	33, 211 18, 350			7, 516 0	50. 00 52. 00
53. 00   05300   ANESTHESI OLOGY		16, 330			0	53. 00
54. 00   05400   RADI OLOGY - DI AGNOSTI C	o o	35, 853	`	1 1	1, 666	54. 00
60. 00   06000   LABORATORY	o	0	1	-	29	60.00
62.30 06250 BLOOD CLOTTING FOR HEMOPHILIACS	o	0	C	o	0	62. 30
65. 00 06500 RESPI RATORY THERAPY	0	27, 304	C	0	2, 213	65. 00
66. 00   06600   PHYSI CAL THERAPY	0	25, 348	1	0	585	66. 00
67. 00 06700 OCCUPATI ONAL THERAPY	0	8, 144	•		0	67.00
68. 00   06800   SPEECH   PATHOLOGY   69. 00   06900   ELECTROCARDI OLOGY	0	2, 346			0	68. 00 69. 00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT		0			41, 516	71.00
72. 00 07200 IMPL. DEV. CHARGED TO PATIENTS	o o	0		ol ol	11, 310	72.00
73. 00 07300 DRUGS CHARGED TO PATIENTS	ol	0		ol ol	2, 256	73. 00
76. 97 07697 CARDIAC REHABILITATION	o	0	C	o	0	76. 97
76. 98 07698 HYPERBARI C OXYGEN THERAPY	0	0	C	0	43	76. 98
76. 99 07699 LI THOTRI PSY	0	0	(	0	0	76. 99
OUTPATIENT SERVICE COST CENTERS		20 207	Ι ,	(2.004	2 (44	04 00
91. 00   09100   EMERGENCY 92. 00   09200   OBSERVATI ON BEDS (NON-DI STINCT PART	0	38, 337	C	63, 004	3, 644	91. 00 92. 00
OTHER REIMBURSABLE COST CENTERS						92.00
95. 00 09500 AMBULANCE SERVI CES	0	75, 331		ol	4, 169	95. 00
SPECIAL PURPOSE COST CENTERS	<u> </u>	, 0, 00.		,	1, 10,	70.00
113. 00 11300 I NTEREST EXPENSE						113. 00
118.00 SUBTOTALS (SUM OF LINES 1 through 117)	474, 136	426, 594	(	387, 749	69, 156	118. 00
NONREI MBURSABLE COST CENTERS			_			
190. 00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0				190. 00
192. 00 19200 PHYSI CI ANS' PRI VATE OFFI CES	0	4, 139		-		192.00
194. 00 07950 0CC HEALTH 194. 01 07951 PAIN CLINIC	0	0				194. 00 194. 01
194. 02 07952 OCC HEALTH	0	0		-		194. 01
194. 03 07953 FOUNDATI 0	o o	2, 313	1	ol ol		194. 03
194. 04 07954 KI DS CAMPUS	o	0	d	ol ol		194. 04
194. 05 07955 COMMUNITY & VOLUNTEER SERVICES	o	0	d	ol ol		194. 05
194. 06 07956 HUNTI NGTON COLLEGE NURSE	o	0	(	o		194. 06
194. 07 07957 MI SC CATERI NG	0	2, 568	0	) 0		194. 07
194. 08 07958 AUTI SM CENTER	0	0	(	이		194. 08
194. 09 07959 HUNTI NGTON BUA	0	0	C	이	0	194. 09
200.00 Cross Foot Adjustments 201.00 Negative Cost Centers		^		ا ا	^	200. 00 201. 00
202.00 TOTAL (sum lines 118 through 201)	474, 136	435, 614				
202.00   10 me (50m 171105 110 till ough 201)	1 174, 130	755, 014	1	307, 747	07, 231	1202.00

In Lieu of Form CMS-2552-10

Period: Worksheet B
From 01/01/2017 Part I
To 12/31/2017 Date/Time Prepared: 5/30/2018 9:25 am

			'	0 12/31/2017	5/30/2018 9: 2	
Cost Center Description	PHARMACY		SOCIAL SERVICE		NURSING SCHOOL	
		RECORDS & LI BRARY		ANESTHETI STS		
	15. 00	16. 00	17. 00	19. 00	20. 00	
GENERAL SERVICE COST CENTERS						
1.00 O0100 CAP REL COSTS-BLDG & FIXT						1. 00
2.00 O0200 CAP REL COSTS-MVBLE EQUIP						2. 00
4.00   00400   EMPLOYEE BENEFITS DEPARTMENT						4. 00
5. 00   00500   ADMINISTRATIVE & GENERAL						5. 00
6.00 00600 MAINTENANCE & REPAIRS						6. 00
7. 00   00700   OPERATION OF PLANT						7. 00
8. 00   00800 LAUNDRY & LINEN SERVICE						8. 00
9. 00   00900   HOUSEKEEPI NG						9.00
10. 00   01000   DI ETARY						10.00
11. 00   01100   CAFETERI A 12. 00   01200   MAI NTENANCE OF PERSONNEL						11.00
13. 00   01300 NURSING ADMINISTRATION						12. 00 13. 00
14. 00 01400 CENTRAL SERVICES & SUPPLY						14.00
15. 00   01500   PHARMACY	1, 024, 983					15. 00
16. 00 01600 MEDI CAL RECORDS & LI BRARY	1, 024, 705	23, 187				16.00
17. 00 01700 SOCIAL SERVICE	0	20, 107				17. 00
19. 00 01900 NONPHYSI CLAN ANESTHETI STS	0	0		0		19.00
20. 00   02000   NURSI NG   SCHOOL	o	0	l d	_	0	1
21.00 02100 I &R SERVICES-SALARY & FRINGES APPRV	o	0	l d			21. 00
22.00 02200 I &R SERVICES-OTHER PRGM COSTS APPRV	O	0	C			22. 00
23.00 02300 PARAMED ED PRGM-(SPECIFY)	О	0	C			23. 00
INPATIENT ROUTINE SERVICE COST CENTERS						
30. 00 03000 ADULTS & PEDIATRICS	0	1, 276	C	0		
43. 00 04300 NURSERY	0	117	C	0	0	43. 00
ANCILLARY SERVICE COST CENTERS				1		
50. 00   05000   OPERATI NG ROOM	0	2, 919		_		1
52. 00 05200 DELIVERY ROOM & LABOR ROOM	0	524		0	-	1
53. 00 05300 ANESTHESI OLOGY	0	473		0	0	
54. 00   05400   RADI OLOGY-DI AGNOSTI C 60. 00   06000   LABORATORY	0	4, 755 2, 322		0	0	
62. 30   06250   BLOOD CLOTTING FOR HEMOPHILIACS	0	2, 322		0	0	
65. 00 06500 RESPIRATORY THERAPY	0	841		0	0	1
66. 00   06600 PHYSI CAL THERAPY	0	594		0	0	1
67. 00 06700 OCCUPATI ONAL THERAPY	0	184		0	0	
68. 00 06800 SPEECH PATHOLOGY	Ö	49	•	0	Ö	1
69. 00 06900 ELECTROCARDI OLOGY	o	152	•	0	l o	
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	O	1, 613		0	0	1
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	О	883		0	0	72. 00
73.00 07300 DRUGS CHARGED TO PATIENTS	1, 024, 983	1, 971		0	0	73. 00
76. 97 07697 CARDIAC REHABILITATION	o	0	C	0	0	76. 97
76. 98 07698 HYPERBARI C OXYGEN THERAPY	0	30	C	0		1
76. 99 07699 LI THOTRI PSY	0	0	C	0	0	76. 99
OUTPATIENT SERVICE COST CENTERS			T	_		4
91. 00   09100   EMERGENCY	0	3, 010	C	0	0	
92. 00 09200 OBSERVATI ON BEDS (NON-DI STI NCT PART						92. 00
OTHER REIMBURSABLE COST CENTERS  95. 00 09500 AMBULANCE SERVICES	0	1, 474	С	0	0	95. 00
SPECIAL PURPOSE COST CENTERS	<u> </u>	1,474		0	0	75.00
113. 00 11300 I NTEREST EXPENSE						113. 00
118.00 SUBTOTALS (SUM OF LINES 1 through 117)	1, 024, 983	23, 187		0	0	118. 00
NONREI MBURSABLE COST CENTERS	., == ., . ==		-			1
190.00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	C	0	0	190. 00
192.00 19200 PHYSICIANS' PRIVATE OFFICES	0	0	C	0	0	192. 00
194. 00 07950 OCC HEALTH	О	0	C	0	0	194. 00
194. 01 07951 PAIN CLINIC	O	0	C	0	0	194. 01
194. 02 07952 OCC HEALTH	0	0	C	0	0	194. 02
194. 03 07953 FOUNDATI 0	0	0	C	0		194. 03
194. 04 07954 KIDS CAMPUS	0	0	C	0		194. 04
194. 05 07955 COMMUNITY & VOLUNTEER SERVICES	0	0	C	0		194. 05
194. 06 07956 HUNTI NGTON COLLEGE NURSE	0	0	0	0		194. 06
194. 07 07957 MI SC CATERI NG	0	0	0	0		194. 07
194. 08 07958 AUTI SM CENTER	0	0	9	0		194. 08
194. 09 07959 HUNTI NGTON BUA	O	0	0	0		194. 09
200.00   Cross Foot Adjustments 201.00   Negative Cost Centers		^		0		200. 00 201. 00
202.00 TOTAL (sum lines 118 through 201)	1, 024, 983	23, 187		0		201.00
	., 321, 733	25, 107	1		,	,_02.00

Health Financial Systems
COST ALLOCATION - GENERAL SERVICE COSTS Provider CCN: 15-0091

						То	12/31/2017	Date/Time Prep 5/30/2018 9: 2	
			INTERNS &	RESI DENTS				3/30/2018 9.2	J alli
		Coat Contar Decement on	CEDVI CEC CALAD	CEDVI CEC OTHER	DADAMED ED		Cubtatal	lntorn 0	
		Cost Center Description	SERVICES-SALAR Y & FRINGES	PRGM COSTS	PARAMED ED PRGM		Subtotal	Intern & Residents Cost	
			APPRV	APPRV				& Post	
								Stepdown Adjustments	
			21. 00	22. 00	23. 00		24. 00	25. 00	
		AL SERVICE COST CENTERS							
1. 00 2. 00	1	CAP REL COSTS-BLDG & FIXT CAP REL COSTS-MVBLE EQUIP							1. 00 2. 00
4.00	1	EMPLOYEE BENEFITS DEPARTMENT							4. 00
5.00	1	ADMINISTRATIVE & GENERAL							5. 00
6.00	1	MAINTENANCE & REPAIRS							6.00
7. 00 8. 00	1	OPERATION OF PLANT LAUNDRY & LINEN SERVICE							7. 00 8. 00
9. 00	1	HOUSEKEEPI NG							9. 00
10.00		DIETARY							10.00
11. 00 12. 00	1	CAFETERIA MAINTENANCE OF PERSONNEL							11. 00 12. 00
13. 00	1	NURSI NG ADMINISTRATION							13. 00
14. 00		CENTRAL SERVICES & SUPPLY							14. 00
15. 00 16. 00	1	PHARMACY MEDICAL RECORDS & LIBRARY							15. 00 16. 00
17. 00	1	SOCIAL SERVICE							17. 00
19. 00	1	NONPHYSICIAN ANESTHETISTS							19. 00
20. 00 21. 00		NURSING SCHOOL I&R SERVICES-SALARY & FRINGES APPRV							20.00
21.00	1	I &R SERVICES-SALART & FRINGES APPRV	0	0					21. 00 22. 00
23. 00	02300	PARAMED ED PRGM-(SPECIFY)				0			23. 00
20.00		I ENT ROUTINE SERVICE COST CENTERS	T 0	0			7 041 120	0	20.00
30. 00 43. 00		ADULTS & PEDI ATRI CS NURSERY	0	_		0	7, 061, 120 292, 789	0	
		LARY SERVICE COST CENTERS		-					
50.00	1	OPERATI NG ROOM	0	0		0	2, 150, 057	0	50.00
52. 00 53. 00	1	DELIVERY ROOM & LABOR ROOM ANESTHESIOLOGY	0	0		0	1, 264, 567 1, 027, 306	0	52. 00 53. 00
54. 00	1	RADI OLOGY-DI AGNOSTI C	0	0		0	3, 455, 421	0	54. 00
60.00	1	LABORATORY	0	0	•	0	3, 411, 613	0	60. 00
62. 30 65. 00	1	BLOOD CLOTTING FOR HEMOPHILIACS RESPIRATORY THERAPY	0	0		0	0 1, 435, 969	0	62. 30 65. 00
66. 00	1	PHYSI CAL THERAPY	0	0	•	0	1, 764, 082	0	66. 00
67. 00	1	OCCUPATIONAL THERAPY	0	0		0	409, 582	0	67. 00
68.00		SPEECH PATHOLOGY ELECTROCARDI OLOGY	0	0		0	119, 789	0	68. 00
69. 00 71. 00	1	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0		0	152 1, 228, 564	0	69. 00 71. 00
72. 00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0		0	1, 513, 959	0	72. 00
73.00	1	DRUGS CHARGED TO PATIENTS	0	0		0	4, 210, 883	0	73. 00
76. 97 76. 98		CARDIAC REHABILITATION HYPERBARIC OXYGEN THERAPY	0	0   0		0	0 17, 156	0	76. 97 76. 98
76. 99	07699	LI THOTRI PSY	0	0		0	0	0	
04 00		TIENT SERVICE COST CENTERS		0	Γ		0 700 750		04 00
91. 00 92. 00		EMERGENCY OBSERVATION BEDS (NON-DISTINCT PART	0	0		0	2, 700, 759	0	
72.00		REI MBURSABLE COST CENTERS						0	72.00
95. 00		AMBULANCE SERVICES	0	0		0	5, 669, 380	0	95. 00
113 00		AL PURPOSE COST CENTERS INTEREST EXPENSE							113. 00
118.00	1	SUBTOTALS (SUM OF LINES 1 through 117)	0	0		0	37, 733, 148		118. 00
		MBURSABLE COST CENTERS							
		GIFT, FLOWER, COFFEE SHOP & CANTEEN PHYSICIANS' PRIVATE OFFICES	0	0		0	0 176, 318		190. 00 192. 00
	1	OCC HEALTH	0	0		0	10, 029		194. 00
194. 01	07951	PAIN CLINIC	0	0		0	0	0	194. 01
		OCC HEALTH	0	0		0	21, 665		194. 02
		FOUNDATIO KIDS CAMPUS		0		0	125, 653 0		194. 03 194. 04
194. 05	07955	COMMUNITY & VOLUNTEER SERVICES	0	0		0	587, 038	0	194. 05
		HUNTINGTON COLLEGE NURSE	0	0		0	15/ 252		194. 06
		MISC CATERING AUTISM CENTER	0	)		0	156, 353 107, 824		194. 07 194. 08
194. 09	07959	HUNTI NGTON BUA	0	0		0	0	0	194. 09
200.00	1	Cross Foot Adjustments	0	0		0	0		200.00
201. 00 202. 00		Negative Cost Centers TOTAL (sum lines 118 through 201)	0	0		0	0 38, 918, 028		201. 00 202. 00
	1		,		'	1	, ,, ===0		

Provider CCN: 15-0091 

	Cost Center Description	Total		
CF	THERAL CERVICE COCT CENTERS	26. 00		
	ENERAL SERVICE COST CENTERS D100 CAP REL COSTS-BLDG & FIXT			1.00
	D200 CAP REL COSTS-MVBLE EQUIP			2.00
	0400 EMPLOYEE BENEFITS DEPARTMENT			4. 00
5.00 00	D500 ADMINISTRATIVE & GENERAL			5. 00
6.00 00	D600 MAINTENANCE & REPAIRS			6. 00
	0700 OPERATION OF PLANT			7. 00
	D800 LAUNDRY & LINEN SERVICE			8. 00
	0900 HOUSEKEEPI NG 1000 DI ETARY			9. 00 10. 00
1	1100 CAFETERI A			11.00
1	1200 MAINTENANCE OF PERSONNEL			12.00
1	1300 NURSING ADMINISTRATION			13.00
14. 00 01	1400 CENTRAL SERVICES & SUPPLY			14. 00
	1500 PHARMACY			15. 00
	1600 MEDICAL RECORDS & LIBRARY			16. 00
	1700 SOCIAL SERVICE			17. 00 19. 00
	1900 NONPHYSICIAN ANESTHETISTS 2000 NURSING SCHOOL			20.00
	2100 I &R SERVI CES-SALARY & FRINGES APPRV			21.00
	2200 I &R SERVICES-OTHER PRGM COSTS APPRV			22. 00
23. 00 02	2300 PARAMED ED PRGM-(SPECIFY)			23. 00
	NPATIENT ROUTINE SERVICE COST CENTERS			
	BOOO ADULTS & PEDIATRICS	7, 061, 120		30. 00
	4300 NURSERY	292, 789		43. 00
	NCILLARY SERVICE COST CENTERS 5000 OPERATING ROOM	2, 150, 057		50.00
	5200 DELIVERY ROOM & LABOR ROOM	1, 264, 567		52.00
	5300 ANESTHESI OLOGY	1, 027, 306		53. 00
	5400 RADI OLOGY-DI AGNOSTI C	3, 455, 421		54.00
60.00 06	6000 LABORATORY	3, 411, 613		60.00
1	8250 BLOOD CLOTTING FOR HEMOPHILIACS	0		62. 30
- 1	5500 RESPIRATORY THERAPY	1, 435, 969		65. 00
- 1	6600 PHYSI CAL THERAPY	1, 764, 082		66. 00 67. 00
1	5700 OCCUPATIONAL THERAPY 5800 SPEECH PATHOLOGY	409, 582 119, 789		68.00
1	5900 ELECTROCARDI OLOGY	152		69. 00
	7100 MEDICAL SUPPLIES CHARGED TO PATIENT	1, 228, 564		71. 00
72.00 07	7200 IMPL. DEV. CHARGED TO PATIENTS	1, 513, 959		72. 00
	7300 DRUGS CHARGED TO PATIENTS	4, 210, 883		73. 00
	7697 CARDI AC REHABI LI TATI ON	17.15(		76. 97
	7698 HYPERBARI C OXYGEN THERAPY 7699 LI THOTRI PSY	17, 156 0		76. 98 76. 99
<del>-</del>	JTPATIENT SERVICE COST CENTERS	<u> </u>		70. 99
	9100 EMERGENCY	2, 700, 759		91.00
92.00 09	9200 OBSERVATION BEDS (NON-DISTINCT PART			92. 00
	THER REIMBURSABLE COST CENTERS			
	9500 AMBULANCE SERVI CES	5, 669, 380		95. 00
	PECIAL PURPOSE COST CENTERS			112 00
113.00	SUBTOTALS (SUM OF LINES 1 through 117)	37, 733, 148		113. 00 118. 00
	ONREIMBURSABLE COST CENTERS	37, 733, 140		118.00
	9000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0		190. 00
	P200 PHYSICIANS' PRIVATE OFFICES	176, 318		192. 00
	7950 OCC HEALTH	10, 029		194. 00
	7951 PAIN CLINIC	0		194. 01
	7952 OCC HEALTH	21, 665		194. 02
	7953 FOUNDATIO 7954 KIDS CAMPUS	125, 653		194. 03 194. 04
	7954 KIDS CAMPUS 7955 COMMUNITY & VOLUNTEER SERVICES	587, 038		194. 04
	7956 HUNTI NGTON COLLEGE NURSE	0.00		194. 05
	7957 MI SC CATERI NG	156, 353		194. 07
194. 08 07	7958 AUTISM CENTER	107, 824		194. 08
	7959 HUNTI NGTON BUA	o		194. 09
200.00	Cross Foot Adjustments	0		200.00
201.00	Negative Cost Centers	30 010 030		201. 00
202.00	TOTAL (sum lines 118 through 201)	38, 918, 028		202. 00

| Peri od: | Worksheet B | From 01/01/2017 | Part II | To 12/31/2017 | Date/Time Prepared: | Part II | Prepared: | Part II | Prepared: | Part II | Prepared: | Part II | Prepared: | Part II | Prepared: | Part II | Prepared: | Part II | Prepared: | Part II | Prepared: | Part II | Part II | Prepared: | Part II | Prepared: | Part II | Part II | Part II | Part II | Part II | Part II | Part II | Part II | Part II | Part II | Part II | Part II | Part II | Part II | Part II | Part II | Part II | Part II | Part II | Part II | Part II | Part II | Part II | Part II | Part II | Part II | Part II | Part II | Part II | Part II | Part II | Part II | Part II | Part II | Part II | Part II | Part II | Part II | Part II | Part II | Part II | Part II | Part II | Part II | Part II | Part II | Part II | Part II | Part II | Part II | Part II | Part II | Part II | Part II | Part II | Part II | Part II | Part II | Part II | Part II | Part II | Part II | Part II | Part II | Part II | Part II | Part II | Part II | Part II | Part II | Part II | Part II | Part II | Part II | Part II | Part II | Part II | Part II | Part II | Part II | Part II | Part II | Part II | Part II | Part II | Part II | Part II | Part II | Part II | Part II | Part II | Part II | Part II | Part II | Part II | Part II | Part II | Part II | Part II | Part II | Part II | Part II | Part II | Part II | Part II | Part II | Part II | Part II | Part II | Part II | Part II | Part II | Part II | Part II | Part II | Part II | Part II | Part II | Part II | Part II | Part II | Part II | Part II | Part II | Part II | Part II | Part II | Part II | Part II | Part II | Part II | Part II | Part II | Part II | Part II | Part II | Part II | Part II | Part II | Part II | Part II | Part II | Part II | Part II | Part II | Part II | Part II | Part II | Part II | Part II | Part II | Part II | Part II | Part II | Part II | Part II | Part II | Part II | Part II | Part II | Part II | Part II | Part II | Part II | Part II | Part II | Part II | Part II | Part II | Part II | Part II | Part II | Par Health Financial Systems
ALLOCATION OF CAPITAL RELATED COSTS Provider CCN: 15-0091

					То	12/31/2017	Date/Time Prep 5/30/2018 9: 2	
				CAPI TAL REI	LATED COSTS		37 307 2010 7. 2	J dill
		Coat Contar Decement on	Dimontly	DIDC 0 FLVT	M/DLE FOLLD	Cubtatal	EMDL OVEE	
		Cost Center Description	Directly Assigned New	BLDG & FIXT	MVBLE EQUIP	Subtotal	EMPLOYEE BENEFITS	
			Capi tal				DEPARTMENT	
			Related Costs 0	1.00	2.00	2A	4. 00	
	GENER	AL SERVICE COST CENTERS	0	1.00	2.00	ZA	4.00	
1.00		CAP REL COSTS-BLDG & FIXT						1. 00
2.00		CAP REL COSTS-MVBLE EQUIP		070		070	070	2. 00
4. 00 5. 00		EMPLOYEE BENEFITS DEPARTMENT ADMINISTRATIVE & GENERAL	0 1, 967, 287	272 15, 842		272 1, 989, 929	272 79	4. 00 5. 00
6. 00		MAINTENANCE & REPAIRS	1, 707, 207	13, 042		0	0	6. 00
7.00		OPERATION OF PLANT	0	63, 261	27, 566	90, 827	5	7. 00
8.00		LAUNDRY & LINEN SERVICE	0	1, 297		1, 297	0	8. 00
9. 00 10. 00		HOUSEKEEPI NG DI ETARY	0	1, 056 10, 090		1, 056 11, 701	3	9. 00 10. 00
11. 00	1	CAFETERI A	0	2, 289		2, 289	3	10.00
12. 00	1	MAINTENANCE OF PERSONNEL	0	0	1	0	0	12. 00
13.00	1	NURSING ADMINISTRATION	0	0	-	0	4	13. 00
14. 00 15. 00		CENTRAL SERVICES & SUPPLY PHARMACY	0	3, 929	i i	3, 929	0	14. 00 15. 00
16. 00		MEDICAL RECORDS & LIBRARY	0	2, 382 1, 316		61, 965 1, 316	8	16. 00
17. 00		SOCIAL SERVICE	0	0	Ö	0	0	17. 00
19. 00	1	NONPHYSICIAN ANESTHETISTS	0	0	0	O	0	19. 00
20. 00 21. 00	1	NURSING SCHOOL	0	0	0	0	0	20. 00 21. 00
21.00		I&R SERVICES-SALARY & FRINGES APPRV I&R SERVICES-OTHER PRGM COSTS APPRV	0	0	0	ol Ol	0	22. 00
23. 00		PARAMED ED PRGM-(SPECIFY)	Ö	0	-	Ö	0	23. 00
		ENT ROUTINE SERVICE COST CENTERS						
30. 00 43. 00		ADULTS & PEDI ATRI CS	0	51, 891		153, 332	41	30.00
43.00		NURSERY LARY SERVICE COST CENTERS	<u> </u>	210	0	210		43. 00
50.00		OPERATI NG ROOM	0	19, 767	120, 830	140, 597	15	50. 00
52. 00		DELIVERY ROOM & LABOR ROOM	0	0		o	8	52. 00
53.00	1	ANESTHESI OLOGY	0	24.774	-	0	0	53.00
54. 00 60. 00		RADI OLOGY-DI AGNOSTI C LABORATORY	0	24, 774 3, 754		294, 151 3, 754	15 0	54. 00 60. 00
62. 30		BLOOD CLOTTING FOR HEMOPHILIACS	o o	0, 731		0, 731	0	62. 30
65. 00	1	RESPI RATORY THERAPY	0	2, 776		26, 112	11	65. 00
66.00	1	PHYSI CAL THERAPY	0	17, 168	7, 886	25, 054	12	66. 00
67. 00 68. 00	1	OCCUPATIONAL THERAPY SPEECH PATHOLOGY	0	0	0	0	3	67. 00 68. 00
69. 00	06900	ELECTROCARDI OLOGY	0	0	ō	ō	0	69. 00
71. 00		MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	0	71. 00
72. 00 73. 00	1	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73. 00 76. 97		DRUGS CHARGED TO PATIENTS CARDIAC REHABILITATION	0	0	0	0	0	73. 00 76. 97
76. 98		HYPERBARI C OXYGEN THERAPY	Ö	0	Ö	Ö	0	76. 98
76. 99		LI THOTRI PSY	0	0	0	0	0	76. 99
91. 00		TIENT SERVICE COST CENTERS  EMERGENCY	0	10 540	22 200	22 740	18	91. 00
91.00		OBSERVATION BEDS (NON-DISTINCT PART		10, 560	23, 208	33, 768 0	10	91.00
		REI MBURSABLE COST CENTERS				- 1		
95. 00		AMBULANCE SERVICES	0	7, 324	214, 786	222, 110	40	95. 00
113 00		AL PURPOSE COST CENTERS INTEREST EXPENSE						113. 00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	1, 967, 287	239, 958	856, 424	3, 063, 669		118. 00
		MBURSABLE COST CENTERS						
		GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0		0		190. 00
		PHYSICIANS' PRIVATE OFFICES OCC HEALTH	0	0 569		596 569		192. 00 194. 00
		PAIN CLINIC	O	0		o		194. 01
		OCC HEALTH	0	0	0	0		194. 02
		FOUNDATIO KIDS CAMPUS	0	0	0	0		194. 03 194. 04
		COMMUNITY & VOLUNTEER SERVICES		0		0		194. 04 194. 05
		HUNTI NGTON COLLEGE NURSE	l ő	0		o		194. 06
		MISC CATERING	0	0	0	o		194. 07
		AUTISM CENTER	0	0	0	0		194. 08
200.00		HUNTINGTON BUA Cross Foot Adjustments		Ü	"	O O		194. 09 200. 00
201.00		Negative Cost Centers		0	О	ō	0	201. 00
202.00		TOTAL (sum lines 118 through 201)	1, 967, 287	240, 527	857, 020	3, 064, 834	272	202. 00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 15-0091

Period: Worksheet B From 01/01/2017 Part II To 12/31/2017 Date/Time Prepared:

5/30/2018 9:25 am Cost Center Description ADMINISTRATIVE MAINTENANCE & OPERATION OF LAUNDRY & HOUSEKEEPI NG & GENERAL REPAI RS **PLANT** LINEN SERVICE 9.00 5.00 6.00 7.00 8.00 GENERAL SERVICE COST CENTERS 1.00 00100 CAP REL COSTS-BLDG & FLXT 1.00 00200 CAP REL COSTS-MVBLE EQUIP 2.00 2.00 00400 EMPLOYEE BENEFITS DEPARTMENT 4.00 4.00 00500 ADMINISTRATIVE & GENERAL 1, 990, 008 5 00 5 00 6.00 00600 MAINTENANCE & REPAIRS 6.00 00700 OPERATION OF PLANT 99, 237 190, 069 7.00 7.00 8.00 00800 LAUNDRY & LINEN SERVICE 13, 054 0 1,530 15, 881 8.00 00900 HOUSEKEEPI NG 9.00 32, 122 0 1. 245 34, 426 9 00 10.00 01000 DI ETARY 15, 949 11, 900 2, 187 10.00 11.00 01100 CAFETERI A 20, 392 2,700 0 496 11.00 0 01200 MAINTENANCE OF PERSONNEL Ω 12 00 12 00 0 C 0 13.00 01300 NURSING ADMINISTRATION 19,530 0 0 0 13.00 14.00 01400 CENTRAL SERVICES & SUPPLY 310 4,634 0 852 14.00 01500 PHARMACY 15.00 49.874 2.810 516 15.00 01600 MEDICAL RECORDS & LIBRARY 16.00 104 0 1.552 285 16.00 17.00 01700 SOCIAL SERVICE 0 0 C 0 0 17.00 01900 NONPHYSICIAN ANESTHETISTS 0 19 00 0 0 19.00 02000 NURSING SCHOOL 0 20.00 0 0 20.00 0 02100 I&R SERVICES-SALARY & FRINGES APPRV 0 21.00 0 0 0 0 21.00 02200 I&R SERVICES-OTHER PRGM COSTS APPRV 0 0 22.00 C 0 22.00 02300 PARAMED ED PRGM-(SPECIFY) 23.00 0 23.00 INPATIENT ROUTINE SERVICE COST CENTERS 30.00 03000 ADULTS & PEDIATRICS 270, 738 0 61, 204 4,509 11, 250 30.00 43.00 04300 NURSERY 14,017 0 248 239 46 43.00 ANCILLARY SERVICE COST CENTERS 05000 OPERATING ROOM 50.00 86.418 23, 313 2.576 4, 285 50.00 52.00 05200 DELIVERY ROOM & LABOR ROOM 61, 241 C 1,047 0 52.00 C 05300 ANESTHESI OLOGY 52, 505 53.00 C 0 53.00 05400 RADI OLOGY-DI AGNOSTI C 152, 602 0 29, 220 5.371 54.00 1.782 54.00 06000 LABORATORY 60.00 171, 241 0 4, 427 814 60.00 62.30 06250 BLOOD CLOTTING FOR HEMOPHILIACS 0 62.30 06500 RESPIRATORY THERAPY 65.00 68, 691 0 3, 274 1,032 602 65.00 66 00 06600 PHYSI CAL THERAPY 74 732 Ω 20, 248 3, 722 66 00 0 06700 OCCUPATIONAL THERAPY 67.00 20, 517 0 0 0 0 67.00 06800 SPEECH PATHOLOGY 6,003 0 0 68.00 68.00 0 0 69.00 06900 ELECTROCARDI OLOGY 0 0 69.00 0 07100 MEDICAL SUPPLIES CHARGED TO PATIENT 0 0 71.00 60,615 0 71.00 72.00 07200 IMPL. DEV. CHARGED TO PATIENTS 77, 369 0 0 0 0 72.00 07300 DRUGS CHARGED TO PATIENTS o 73.00 162, 690 0 0 0 73.00 76 97 07697 CARDIAC REHABILITATION Ω 0 0 76 97 0 0 07698 HYPERBARIC OXYGEN THERAPY 76.98 873 C 0 0 0 76.98 07699 LI THOTRI PSY 76. 99 76.99 0 OUTPATIENT SERVICE COST CENTERS 91 00 4 038 2, 289 91 00 09100 EMERGENCY 120, 372 12, 455 09200 OBSERVATION BEDS (NON-DISTINCT PART 92.00 92.00 OTHER REIMBURSABLE COST CENTERS 09500 AMBULANCE SERVICES 0 329 1, 588 95.00 279.444 8, 638 95.00 SPECIAL PURPOSE COST CENTERS 113. 00 11300 | INTEREST EXPENSE 113.00 SUBTOTALS (SUM OF LINES 1 through 117) 1, 930, 640 189, 398 15, 552 118.00 0 34, 303 118. 00 NONREIMBURSABLE COST CENTERS 190. 00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN Ô 0 0 190 00 192.00 19200 PHYSICIANS' PRIVATE OFFICES 8, 514 0 329 0 192.00 194.00 07950 OCC HEALTH 45 0 671 0 123 194. 00 194. 01 07951 PAIN CLINIC 0 194. 01 0 0 0 C 0 194. 02 194. 02 07952 OCC HEALTH 1.108 Ω 0 0 194. 03 07953 FOUNDATIO 6, 307 0 0 0 194. 03 0 0 0 194. 04 07954 KIDS CAMPUS 0 0 194. 04 194. 05 07955 COMMUNITY & VOLUNTEER SERVICES 30.017 0 0 0 194, 05 194.06 07956 HUNTI NGTON COLLEGE NURSE C 0 0 194.06 194.07 07957 MISC CATERING 7,864 0 0 0 194. 07 194.08 07958 AUTISM CENTER 0 0 194. 08 0 0 5, 513 194. 09 07959 HUNTI NGTON BUA C 0 0 0 194. 09 0 200.00 Cross Foot Adjustments 200.00 201.00 Negative Cost Centers 0 0 201.00 TOTAL (sum lines 118 through 201) 1.990.008 190, 069 15.881 34, 426 202. 00 202.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 15-0091

Peri od: Worksheet B From 01/01/2017 Part II To 12/31/2017 Date/Time Prepared:

5/30/2018 9:25 am Cost Center Description DI ETARY CAFETERI A MAINTENANCE OF NURSI NG CENTRAL ADMI NI STRATI ON SERVICES & **PERSONNEL SUPPLY** 10.00 11.00 12.00 13.00 14.00 GENERAL SERVICE COST CENTERS 1.00 00100 CAP REL COSTS-BLDG & FIXT 1.00 00200 CAP REL COSTS-MVBLE EQUIP 2.00 2.00 4.00 00400 EMPLOYEE BENEFITS DEPARTMENT 4.00 5.00 00500 ADMINISTRATIVE & GENERAL 5.00 00600 MAINTENANCE & REPAIRS 6.00 6.00 7.00 00700 OPERATION OF PLANT 7.00 00800 LAUNDRY & LINEN SERVICE 8.00 8 00 9.00 00900 HOUSEKEEPI NG 9.00 10.00 01000 DI ETARY 41,738 10.00 01100 CAFETERI A 11.00 25, 880 11.00 0 01200 MAINTENANCE OF PERSONNEL 12.00 0 12.00 13.00 01300 NURSING ADMINISTRATION 0 345 19,879 13.00 14.00 01400 CENTRAL SERVICES & SUPPLY 0 9, 725 14.00 01500 PHARMACY 0 0 15.00 0 111 15.00 624 01600 MEDICAL RECORDS & LIBRARY 0 16.00 C 0 0 16.00 17.00 01700 SOCIAL SERVICE 0 0 0 0 17.00 0 0 19.00 01900 NONPHYSICIAN ANESTHETISTS 0 0 0 19.00 0 02000 NURSING SCHOOL 20 00 C 0 20.00 21.00 02100 I&R SERVICES-SALARY & FRINGES APPRV C 0 0 21.00 02200 | &R SERVICES-OTHER PRGM COSTS APPRV 0 0 0 22.00 0 22.00 02300 PARAMED ED PRGM-(SPECIFY) 23.00 23.00 0 0 INPATIENT ROUTINE SERVICE COST CENTERS 30.00 03000 ADULTS & PEDIATRICS 41, 738 8, 429 0 11, 952 664 30.00 04300 NURSERY 43.00 249 0 353 0 43.00 0 ANCILLARY SERVICE COST CENTERS 50.00 05000 OPERATING ROOM 1,973 0 2,798 1,056 50.00 05200 DELIVERY ROOM & LABOR ROOM 0 1, 090 0 1, 546 52.00 52.00 0 0 53.00 05300 ANESTHESI OLOGY 0 0 53.00 0 05400 RADI OLOGY-DI AGNOSTI C 0 54.00 2, 130 0 234 54.00 0 60.00 06000 LABORATORY 0 60.00 06250 BLOOD CLOTTING FOR HEMOPHILIACS 0 62.30 00000000 0 0 62.30 65 00 06500 RESPIRATORY THERAPY 1 622 0 311 65 00 0 06600 PHYSI CAL THERAPY 66.00 1,506 82 66.00 06700 OCCUPATIONAL THERAPY 484 0 0 0 67.00 67.00 0 68.00 06800 SPEECH PATHOLOGY 139 0 0 68.00 06900 ELECTROCARDI OLOGY 0 69 00 69 00 C 0 07100 MEDICAL SUPPLIES CHARGED TO PATIENT 0 71.00 C 0 5,831 71.00 07200 IMPL. DEV. CHARGED TO PATIENTS 0 72.00 0 72.00 0 0 73.00 07300 DRUGS CHARGED TO PATIENTS 0 0 317 73.00 76. 97 07697 CARDIAC REHABILITATION 0 76. 97 Ω 0 76. 98 07698 HYPERBARIC OXYGEN THERAPY 0 0 0 76.98 76.99 07699 LI THOTRI PSY 0 0 76.99 OUTPATIENT SERVICE COST CENTERS 91.00 09100 EMERGENCY 0 2.278 0 3.230 512 91 00 09200 OBSERVATION BEDS (NON-DISTINCT PART 92.00 92.00 OTHER REIMBURSABLE COST CENTERS 09500 AMBULANCE SERVICES
SPECIAL PURPOSE COST CENTERS 4, 475 95.00 95.00 0 0 0 586 113. 00 11300 | INTEREST EXPENSE 113.00 SUBTOTALS (SUM OF LINES 1 through 117)
NONREIMBURSABLE COST CENTERS 9, 714 118. 00 118.00 41, 738 25, 344 0 19, 879 190. 00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN 0 0 190. 00 192.00 19200 PHYSICIANS' PRIVATE OFFICES 0 246 0 0 11 192. 00 194.00 07950 OCC HEALTH 0 0 0 194.00 0 C ő 0 194. 01 194. 01 07951 PAIN CLINIC r 194. 02 07952 OCC HEALTH 0 0 194. 02 0 0 0 C 0 0 0 0 0 194. 03 07953 FOUNDATI 0 137 0 0 194. 03 194. 04 07954 KIDS CAMPUS 0 194, 04 C 0 194. 05 07955 COMMUNITY & VOLUNTEER SERVICES C 0 0 194. 05 194.06 07956 HUNTI NGTON COLLEGE NURSE 0 0 0 194.06 0 194.07 07957 MISC CATERING 0 0 194. 07 153 0 194.08 07958 AUTISM CENTER 0 0 194, 08 C 0 194. 09 07959 HUNTI NGTON BUA 0 C 0 0 194. 09 200. 00 200.00 Cross Foot Adjustments 201.00 Negative Cost Centers 0 0 0 0 201.00 0 19, 879 9, 725 202. 00 202.00 TOTAL (sum lines 118 through 201) 41,738 25, 880

Health Financial Systems
ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 15-0091

In Lieu of Form CMS-2552-10

Period: Worksheet B
From 01/01/2017 Part II
To 12/31/2017 Date/Time Prepared: 5/30/2018 9:25 am

			'	0 12/31/2017	5/30/2018 9: 2	
Cost Center Description	PHARMACY		SOCIAL SERVICE		NURSING SCHOOL	
		RECORDS & LI BRARY		ANESTHETI STS		
	15. 00	16. 00	17. 00	19. 00	20.00	
GENERAL SERVICE COST CENTERS						
1.00 O0100 CAP REL COSTS-BLDG & FLXT						1. 00
2.00 O0200 CAP REL COSTS-MVBLE EQUIP						2. 00
4.00   00400   EMPLOYEE BENEFITS DEPARTMENT						4. 00
5.00 00500 ADMINISTRATIVE & GENERAL						5. 00
6.00   00600 MAI NTENANCE & REPAI RS						6. 00
7. 00 00700 OPERATION OF PLANT						7. 00
8. 00   00800 LAUNDRY & LINEN SERVICE						8. 00
9. 00   00900   HOUSEKEEPI NG						9.00
10. 00   01000   DI ETARY						10.00
11. 00   01100   CAFETERI A						11.00
12. 00   01200   MAI NTENANCE OF PERSONNEL 13. 00   01300   NURSI NG ADMI NI STRATI ON						12.00
13. 00   01300   NURSI NG ADMI NI STRATI ON 14. 00   01400   CENTRAL   SERVI CES & SUPPLY						13. 00 14. 00
15. 00   01500   PHARMACY	115, 908					15. 00
16. 00   01600   MEDI CAL RECORDS & LI BRARY	115, 406	3, 257				16.00
17. 00 01700 SOCI AL SERVI CE	0	3, 237 N	0			17. 00
19. 00 01900 NONPHYSICIAN ANESTHETISTS		0		0		19.00
20. 00   02000   NURSI NG SCHOOL		0			0	20.00
21. 00   02100   &R SERVI CES-SALARY & FRINGES APPRV	o	0			Ĭ	21. 00
22. 00   02200   L&R SERVICES-OTHER PRGM COSTS APPRV	o	0	Ö			22. 00
23.00 02300 PARAMED ED PRGM-(SPECIFY)	ol	0				23. 00
INPATIENT ROUTINE SERVICE COST CENTERS	-1	-		L	L	
30. 00 03000 ADULTS & PEDI ATRI CS	0	178	0			30.00
43. 00   04300 NURSERY	O	16				43.00
ANCILLARY SERVICE COST CENTERS						
50.00   05000   OPERATING ROOM	0	407	0			50. 00
52.00   05200   DELIVERY ROOM & LABOR ROOM	0	73	0			52. 00
53. 00   05300   ANESTHESI OLOGY	0	66	0			53. 00
54. 00   05400   RADI OLOGY-DI AGNOSTI C	0	686	0			54.00
60. 00   06000   LABORATORY	0	324	0			60.00
62.30 06250 BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0			62. 30
65. 00 06500 RESPI RATORY THERAPY	0	117	0			65. 00
66. 00   06600   PHYSI CAL THERAPY	0	83				66. 00
67. 00 06700 OCCUPATI ONAL THERAPY	0	26	0			67. 00
68. 00   06800   SPEECH PATHOLOGY	0	7	0			68. 00
69. 00   06900   ELECTROCARDI OLOGY	0	21	0			69.00
71. 00 07100 MEDI CAL SUPPLI ES CHARGED TO PATI ENT	0	225	0			71.00
72. 00 07200 IMPL. DEV. CHARGED TO PATIENTS	115 000	123	0			72.00
73. 00   07300   DRUGS CHARGED TO PATIENTS 76. 97   07697   CARDI AC REHABI LI TATI ON	115, 908 0	275 0	1 0			73. 00 76. 97
76. 98 07698 HYPERBARI C OXYGEN THERAPY	ol ol	4				76. 98
76. 99   07699 LI THOTRI PSY	o	0				76. 99
OUTPATIENT SERVICE COST CENTERS	<u> </u>					70. 77
91. 00 09100 EMERGENCY	0	420	0			91.00
92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART	٩	.20				92. 00
OTHER REIMBURSABLE COST CENTERS	<u> </u>					
95. 00 09500 AMBULANCE SERVICES	0	206	0			95. 00
SPECIAL PURPOSE COST CENTERS						
113. 00 11300 I NTEREST EXPENSE						113. 00
118.00 SUBTOTALS (SUM OF LINES 1 through 117)	115, 908	3, 257	0	0	0	118. 00
NONREI MBURSABLE COST CENTERS						
190.00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0			190. 00
192.00 19200 PHYSI CLANS' PRI VATE OFFI CES	0	0	0			192. 00
194. 00 07950 OCC HEALTH	0	0	0			194. 00
194. 01 07951 PALN CLINIC	0	0	0			194. 01
194. 02 07952 OCC HEALTH	0	0	0			194. 02
194. 03 07953 FOUNDATI 0	0	0	0			194. 03
194. 04 07954 KIDS CAMPUS	0	0	0			194. 04
194. 05 07955 COMMUNITY & VOLUNTEER SERVICES	0	0	0			194. 05
194. 06 07956 HUNTI NGTON COLLEGE NURSE	0	0	0			194. 06
194. 07 07957 MI SC CATERI NG	0	0	0			194. 07
194. 08 07958 AUTI SM CENTER	0	0	0			194. 08
194.09 07959 HUNTI NGTON BUA	o	0	0	_	_	194. 09 200. 00
200.00 Cross Foot Adjustments 201.00 Negative Cost Centers		^	0			200.00
202.00 TOTAL (sum lines 118 through 201)	115, 908	3, 257		0		201.00
	. 10, 700	5, 257		,		,_02. 00

| In Lieu of Form CMS-2552-10 | Peri od: | Worksheet B | From 01/01/2017 | Part II | To 12/31/2017 | Date/Time Prepared: | From 0.0017 | Prepared: | Prepared: | Prepared: | Prepared: | Prepared: | Prepared: | Prepared: | Prepared: | Prepared: | Prepared: | Prepared: | Prepared: | Prepared: | Prepared: | Prepared: | Prepared: | Prepared: | Prepared: | Prepared: | Prepared: | Prepared: | Prepared: | Prepared: | Prepared: | Prepared: | Prepared: | Prepared: | Prepared: | Prepared: | Prepared: | Prepared: | Prepared: | Prepared: | Prepared: | Prepared: | Prepared: | Prepared: | Prepared: | Prepared: | Prepared: | Prepared: | Prepared: | Prepared: | Prepared: | Prepared: | Prepared: | Prepared: | Prepared: | Prepared: | Prepared: | Prepared: | Prepared: | Prepared: | Prepared: | Prepared: | Prepared: | Prepared: | Prepared: | Prepared: | Prepared: | Prepared: | Prepared: | Prepared: | Prepared: | Prepared: | Prepared: | Prepared: | Prepared: | Prepared: | Prepared: | Prepared: | Prepared: | Prepared: | Prepared: | Prepared: | Prepared: | Prepared: | Prepared: | Prepared: | Prepared: | Prepared: | Prepared: | Prepared: | Prepared: | Prepared: | Prepared: | Prepared: | Prepared: | Prepared: | Prepared: | Prepared: | Prepared: | Prepared: | Prepared: | Prepared: | Prepared: | Prepared: | Prepared: | Prepared: | Prepared: | Prepared: | Prepared: | Prepared: | Prepared: | Prepared: | Prepared: | Prepared: | Prepared: | Prepared: | Prepared: | Prepared: | Prepared: | Prepared: | Prepared: | Prepared: | Prepared: | Prepared: | Prepared: | Prepared: | Prepared: | Prepared: | Prepared: | Prepared: | Prepared: | Prepared: | Prepared: | Prepared: | Prepared: | Prepared: | Prepared: | Prepared: | Prepared: | Prepared: | Prepared: | Prepared: | Prepared: | Prepared: | Prepared: | Prepared: | Prepared: | Prepared: | Prepared: | Prepared: | Prepared: | Prepared: | Prepared: | Prepared: | Prepared: | Prepared: | Prepared: | Prepared: | Prepared: | Prepared: | Prepared: | Prepared: | Prepared: | Prepared: | Prepared: | Prepared: | P Health Financial Systems
ALLOCATION OF CAPITAL RELATED COSTS Provider CCN: 15-0091

						To 12/31/2017	Date/lime Prep   5/30/2018 9:29	
			INTERNS &	RESI DENTS			07 007 2010 7.2	J diii
		Cost Center Description		SERVI CES-OTHER		Subtotal	Intern &	
			Y & FRINGES APPRV	PRGM COSTS APPRV	PRGM		Residents Cost	
			APPRV	APPKV			& Post Stepdown	
							Adjustments	
			21.00	22.00	23. 00	24.00	25. 00	
		AL SERVICE COST CENTERS						
1. 00	1	CAP REL COSTS-BLDG & FIXT						1. 00
2.00	1	CAP REL COSTS-MVBLE EQUIP						2.00
4. 00 5. 00		EMPLOYEE BENEFITS DEPARTMENT ADMINISTRATIVE & GENERAL						4.00
6.00	1	MAINTENANCE & REPAIRS						5. 00 6. 00
7. 00	1	OPERATION OF PLANT						7. 00
8. 00	1	LAUNDRY & LINEN SERVICE						8. 00
9.00	00900	HOUSEKEEPI NG						9. 00
10.00		DI ETARY						10. 00
11. 00	1	CAFETERI A						11. 00
12.00	1	MAINTENANCE OF PERSONNEL						12.00
13. 00 14. 00	1	NURSI NG ADMI NI STRATI ON CENTRAL SERVI CES & SUPPLY						13. 00 14. 00
15. 00	1	PHARMACY						15. 00
16. 00	1	MEDICAL RECORDS & LIBRARY						16. 00
17. 00	1	SOCIAL SERVICE						17. 00
19.00	01900	NONPHYSICIAN ANESTHETISTS						19. 00
20.00		NURSI NG SCHOOL						20.00
21. 00	1	I &R SERVI CES-SALARY & FRI NGES APPRV	0	_				21. 00
22. 00	1	I&R SERVICES-OTHER PRGM COSTS APPRV		0				22. 00
23. 00		PARAMED ED PRGM-(SPECIFY)				0		23. 00
30. 00		ADULTS & PEDIATRICS				564, 035	0	30. 00
43. 00		NURSERY				15, 380		43. 00
		_ARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM				263, 438	0	50.00
52.00	1	DELIVERY ROOM & LABOR ROOM				65, 005	0	52.00
53. 00	1	ANESTHESI OLOGY				52, 571	0	53. 00
54.00	1	RADI OLOGY-DI AGNOSTI C				486, 191	0	54. 00
60. 00 62. 30	1	LABORATORY BLOOD CLOTTING FOR HEMOPHILIACS				180, 564	0	60. 00 62. 30
65. 00	1	RESPIRATORY THERAPY				101, 772	0	65. 00
66. 00	1	PHYSI CAL THERAPY				125, 439	o o	66. 00
67.00	1	OCCUPATIONAL THERAPY				21, 030	0	67. 00
68.00	06800	SPEECH PATHOLOGY				6, 150	0	68. 00
69. 00	1	ELECTROCARDI OLOGY				21	0	69. 00
71. 00	1	MEDICAL SUPPLIES CHARGED TO PATIENT				66, 671	0	71. 00
72.00		IMPL. DEV. CHARGED TO PATIENTS DRUGS CHARGED TO PATIENTS				77, 492	0	72.00
73. 00 76. 97	1	CARDI AC REHABILITATION				279, 191		73. 00 76. 97
		HYPERBARI C OXYGEN THERAPY				883	Ö	76. 98
	1	LI THOTRI PSY				0		76. 99
	OUTPA <sup>*</sup>	TIENT SERVICE COST CENTERS						
91. 00		EMERGENCY				179, 380		
92. 00		OBSERVATION BEDS (NON-DISTINCT PART					0	92. 00
95. 00		REI MBURSABLE COST CENTERS AMBULANCE SERVI CES				517, 416	0	95. 00
93.00		AL PURPOSE COST CENTERS				317, 410	0	93.00
113.00		INTEREST EXPENSE						113. 00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	0	0		0 3, 002, 629	0	118. 00
		MBURSABLE COST CENTERS						
		GIFT, FLOWER, COFFEE SHOP & CANTEEN				0		190. 00
		PHYSICIANS' PRIVATE OFFICES				9, 697		192. 00
		OCC HEALTH PAIN CLINIC				1, 408		194. 00
	1	OCC HEALTH				1, 108	1	194. 01 194. 02
		FOUNDATIO				6, 444		194. 02
		KIDS CAMPUS				0	Ö	194. 04
		COMMUNITY & VOLUNTEER SERVICES				30, 017		194. 05
		HUNTINGTON COLLEGE NURSE				0		194. 06
		MI SC CATERI NG				8, 018		194. 07
		AUTI SM CENTER				5, 513		194. 08
194. 09 200. 00		HUNTINGTON BUA	_			0		194. 09 200. 00
200.00		Cross Foot Adjustments Negative Cost Centers	0	0		0 0		200. 00
202.00		TOTAL (sum lines 118 through 201)	0	0		0 3, 064, 834		201.00
	•	· · · · · · · · · · · · · · · · · · ·			•			•

| In Lieu of Form CMS-2552-10 | Peri od: | Worksheet B | From 01/01/2017 | Part II | To 12/31/2017 | Date/Time Prepared: | From 0.0017 | Prepared: | Prepared: | Prepared: | Prepared: | Prepared: | Prepared: | Prepared: | Prepared: | Prepared: | Prepared: | Prepared: | Prepared: | Prepared: | Prepared: | Prepared: | Prepared: | Prepared: | Prepared: | Prepared: | Prepared: | Prepared: | Prepared: | Prepared: | Prepared: | Prepared: | Prepared: | Prepared: | Prepared: | Prepared: | Prepared: | Prepared: | Prepared: | Prepared: | Prepared: | Prepared: | Prepared: | Prepared: | Prepared: | Prepared: | Prepared: | Prepared: | Prepared: | Prepared: | Prepared: | Prepared: | Prepared: | Prepared: | Prepared: | Prepared: | Prepared: | Prepared: | Prepared: | Prepared: | Prepared: | Prepared: | Prepared: | Prepared: | Prepared: | Prepared: | Prepared: | Prepared: | Prepared: | Prepared: | Prepared: | Prepared: | Prepared: | Prepared: | Prepared: | Prepared: | Prepared: | Prepared: | Prepared: | Prepared: | Prepared: | Prepared: | Prepared: | Prepared: | Prepared: | Prepared: | Prepared: | Prepared: | Prepared: | Prepared: | Prepared: | Prepared: | Prepared: | Prepared: | Prepared: | Prepared: | Prepared: | Prepared: | Prepared: | Prepared: | Prepared: | Prepared: | Prepared: | Prepared: | Prepared: | Prepared: | Prepared: | Prepared: | Prepared: | Prepared: | Prepared: | Prepared: | Prepared: | Prepared: | Prepared: | Prepared: | Prepared: | Prepared: | Prepared: | Prepared: | Prepared: | Prepared: | Prepared: | Prepared: | Prepared: | Prepared: | Prepared: | Prepared: | Prepared: | Prepared: | Prepared: | Prepared: | Prepared: | Prepared: | Prepared: | Prepared: | Prepared: | Prepared: | Prepared: | Prepared: | Prepared: | Prepared: | Prepared: | Prepared: | Prepared: | Prepared: | Prepared: | Prepared: | Prepared: | Prepared: | Prepared: | Prepared: | Prepared: | Prepared: | Prepared: | Prepared: | Prepared: | Prepared: | Prepared: | Prepared: | Prepared: | Prepared: | Prepared: | Prepared: | Prepared: | Prepared: | P Provider CCN: 15-0091

			10 12/31/201/ Date/lime Pre 5/30/2018 9: 2	
	Cost Center Description	Total	070072010 7.2	T din
		26. 00		
	GENERAL SERVICE COST CENTERS			1 00
	DO100 CAP REL COSTS-BLDG & FLXT DO200 CAP REL COSTS-MVBLE EQUIP			1.00
	00400 EMPLOYEE BENEFITS DEPARTMENT			4. 00
	00500 ADMINISTRATIVE & GENERAL			5. 00
1	00600 MAINTENANCE & REPAIRS			6.00
1	00700 OPERATION OF PLANT			7. 00
	00800 LAUNDRY & LINEN SERVICE			8. 00
9.00	00900 HOUSEKEEPI NG			9. 00
	D1000 DI ETARY			10. 00
1	D1100 CAFETERI A			11. 00
1	D1200 MAI NTENANCE OF PERSONNEL			12. 00
4	01300 NURSI NG ADMI NI STRATI ON			13.00
	01400 CENTRAL SERVICES & SUPPLY 01500 PHARMACY			14. 00 15. 00
	01600 MEDICAL RECORDS & LIBRARY			16. 00
	01700 SOCIAL SERVICE			17. 00
	01900 NONPHYSICIAN ANESTHETISTS			19. 00
	02000 NURSI NG SCHOOL			20.00
21.00	02100 I&R SERVICES-SALARY & FRINGES APPRV			21. 00
22. 00	02200 I&R SERVICES-OTHER PRGM COSTS APPRV			22. 00
-	02300 PARAMED ED PRGM-(SPECIFY)			23. 00
_	NPATIENT ROUTINE SERVICE COST CENTERS			
	03000 ADULTS & PEDI ATRI CS	564, 035		30.00
	04300 NURSERY	15, 380		43. 00
	ANCILLARY SERVICE COST CENTERS D5000 OPERATING ROOM	263, 438		50.00
	D5200 DELIVERY ROOM & LABOR ROOM	65, 005		52. 00
	05300 ANESTHESI OLOGY	52, 571		53. 00
	D5400 RADI OLOGY-DI AGNOSTI C	486, 191		54. 00
60.00	06000 LABORATORY	180, 564		60.00
62. 30	D6250 BLOOD CLOTTING FOR HEMOPHILIACS	0		62. 30
	06500 RESPI RATORY THERAPY	101, 772		65. 00
1	06600 PHYSI CAL THERAPY	125, 439		66. 00
	06700 OCCUPATI ONAL THERAPY	21, 030		67. 00
	06800 SPEECH PATHOLOGY 06900 ELECTROCARDI OLOGY	6, 150 21		68. 00 69. 00
	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	66, 671		71. 00
	07200 IMPL. DEV. CHARGED TO PATIENTS	77, 492		72.00
1	07300 DRUGS CHARGED TO PATIENTS	279, 191		73. 00
76. 97	07697 CARDIAC REHABILITATION	0		76. 97
	07698 HYPERBARI C OXYGEN THERAPY	883		76. 98
_	07699 LITHOTRIPSY	0		76. 99
_	DUTPATIENT SERVICE COST CENTERS	170 200		01 00
	09100 EMERGENCY 09200 OBSERVATION BEDS (NON-DISTINCT PART	179, 380		91.00
	OTHER REIMBURSABLE COST CENTERS			72.00
_	09500 AMBULANCE SERVI CES	517, 416		95. 00
	SPECIAL PURPOSE COST CENTERS			
	11300 I NTEREST EXPENSE			113. 00
118. 00	SUBTOTALS (SUM OF LINES 1 through 117)	3, 002, 629		118. 00
	NONREI MBURSABLE COST CENTERS			
	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0 (07		190.00
	19200 PHYSICIANS' PRIVATE OFFICES	9, 697		192. 00
	07950 OCC HEALTH 07951 PAIN CLINIC	1, 408 0		194. 00 194. 01
	07952 OCC HEALTH	1, 108		194. 01
	07953 FOUNDATI 0	6, 444		194. 03
	07954 KI DS CAMPUS	0		194. 04
	07955 COMMUNITY & VOLUNTEER SERVICES	30, 017		194. 05
	07956 HUNTI NGTON COLLEGE NURSE	0		194. 06
	07957 MISC CATERING	8, 018		194. 07
	07958 AUTISM CENTER	5, 513		194. 08
	07959 HUNTI NGTON BUA	0		194. 09
200. 00 201. 00	Cross Foot Adjustments	0		200. 00 201. 00
201.00	Negative Cost Centers TOTAL (sum lines 118 through 201)	3, 064, 834		201.00
202.00	1.517.E (Sam Titles Tie through 201)	5, 554, 554		1-02.00

COST ALLOCATION - STATISTICAL BASIS Provider CCN: 15-0091 Peri od: Worksheet B-1 From 01/01/2017 12/31/2017 Date/Time Prepared: 5/30/2018 9:25 am CAPITAL RELATED COSTS Cost Center Description BLDG & FIXT MVBLE EQUIP **EMPLOYEE** Reconciliation ADMINISTRATIVE (SQUARE FEET) (DOLLAR VALUE) BENEFITS & GENERAL (ACCUM. COST) DEPARTMENT (GROSS SALARI ES) 1.00 2.00 5A 5. 00 4.00 GENERAL SERVICE COST CENTERS 1 00 00100 CAP REL COSTS-BLDG & FLXT 1 00 116,622 2.00 00200 CAP REL COSTS-MVBLE EQUIP 884, 037 2.00 4.00 00400 EMPLOYEE BENEFITS DEPARTMENT 18, 414, 107 4.00 132 00500 ADMINISTRATIVE & GENERAL 5 00 7,014 5, 524, 784 -13, 675, 338 25, 242, 690 5 00 7,681 6.00 00600 MAINTENANCE & REPAIRS 6.00 7.00 00700 OPERATION OF PLANT 30, 673 28, 435 306, 910 1, 258, 790 7.00 8.00 00800 LAUNDRY & LINEN SERVICE 24, 115 0 165, 587 8.00 629 00900 HOUSEKEEPI NG 213 517 407, 457 9 00 9 00 512 10.00 01000 DI ETARY 4,892 1,662 75, 857 202, 306 10.00 01100 CAFETERI A 0 11.00 1.110 224, 344 258, 669 11.00 0 01200 MAINTENANCE OF PERSONNEL 12.00 12.00 0 0 247, 727 01300 NURSING ADMINISTRATION 13.00 0 Ω 239, 847 13.00 14.00 01400 CENTRAL SERVICES & SUPPLY 1,905 0 3, 929 14.00 01500 PHARMACY 1, 155 15.00 61, 461 501, 215 632, 642 15.00 0 01600 MEDICAL RECORDS & LIBRARY 1, 316 638 16,00 C 0 16,00 17 00 01700 SOCIAL SERVICE 0 C 0 Ω 17.00 19.00 01900 NONPHYSICIAN ANESTHETISTS 0 0 19.00 0 0 20.00 02000 NURSING SCHOOL 0 Ω 0 0 20.00 02100 I &R SERVICES-SALARY & FRINGES APPRV 21.00 0 0 21.00 0 0 02200 I&R SERVICES-OTHER PRGM COSTS APPRV O 0 22.00 0 r 0 22.00 02300 PARAMED ED PRGM-(SPECIFY) 23.00 0 23.00 INPATIENT ROUTINE SERVICE COST CENTERS 30 00 03000 ADULTS & PEDIATRICS 2, 752, 900 3, 434, 241 30.00 25, 160 104, 639 0 04300 NURSERY 43.00 102 124, 802 177, 797 43.00 ANCILLARY SERVICE COST CENTERS 50.00 05000 OPERATING ROOM 9, 584 124, 639 972, 981 0 1, 096, 189 50.00 05200 DELIVERY ROOM & LABOR ROOM 0 52.00 0 545, 924 776, 824 52.00 05300 ANESTHESI OLOGY 0 53.00 666, 016 53.00 54.00 05400 RADI OLOGY-DI AGNOSTI C 12,012 277, 868 1, 019, 890 0 1, 935, 719 54.00 06000 LABORATORY 60.00 1,820  $\cap$ 2, 172, 141 60.00 06250 BLOOD CLOTTING FOR HEMOPHILIACS 62.30 Ω 62.30 06500 RESPIRATORY THERAPY 65.00 1, 346 24, 072 711, 656 0 0 0 871, 321 65.00 06600 PHYSI CAL THERAPY 947, 955 66.00 8.324 8, 135 832.014 66.00 06700 OCCUPATIONAL THERAPY 260, 258 67.00 C 231, 892 67.00 68.00 06800 SPEECH PATHOLOGY 0 C 67, 902 76, 143 68.00 69.00 06900 ELECTROCARDI OLOGY 0 0 0 0 69.00 0 768, 887 07100 MEDICAL SUPPLIES CHARGED TO PATIENT 71 00 C 0 71 00 07200 IMPL. DEV. CHARGED TO PATIENTS 72.00 C  $\cap$ 981, 399 72.00 73.00 07300 DRUGS CHARGED TO PATIENTS 0 54, 577 2, 063, 671 73.00 07697 CARDIAC REHABILITATION 0 0 76. 97 0 76.97 0 07698 HYPERBARI C OXYGEN THERAPY 0 0 76 98 76 98 8,698 11,080 Ω 76.99 07699 LI THOTRI PSY 0 76.99 OUTPATIENT SERVICE COST CENTERS 91.00 09100 EMERGENCY 5. 120 23, 940 1. 171. 073 1, 526, 891 91.00 09200 OBSERVATION BEDS (NON-DISTINCT PART 92.00 92.00 OTHER REIMBURSABLE COST CENTERS 09500 AMBULANCE SERVICES 95.00 3, 551 221, 557 2, 682, 155 0 3, 544, 679 95.00 SPECIAL PURPOSE COST CENTERS 113.00 11300 INTEREST EXPENSE 113.00 118.00 SUBTOTALS (SUM OF LINES 1 through 117) 116, 346 883, 422 18, 287, 053 -13, 675, 338 24, 489, 634 118. 00 NONREI MBURSABLE COST CENTERS 190.00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN 0 190. 00 0 192.00 19200 PHYSICIANS' PRIVATE OFFICES 0 615 79,056 0 107, 992 192. 00 569 194. 00 194.00 07950 OCC HEALTH 0 276 0 194. 01 07951 PAIN CLINIC 0 0 194. 01 0 0 0 0 194. 02 07952 OCC HEALTH 14, 052 194. 02 0 C 0 194. 03 07953 FOUNDATI 0 0 0 0 80, 000 194. 03 194. 04 07954 KIDS CAMPUS 0 0 0 194.04 0 0 194. 05 07955 COMMUNITY & VOLUNTEER SERVICES 0 380, 760 194. 05 0 194.06 07956 HUNTI NGTON COLLEGE NURSE C 0 0 194, 06 194.07 07957 MISC CATERING 0 47, 998 99, 747 194. 07 0 194.08 07958 AUTISM CENTER C 69, 936 194. 08 194. 09 07959 HUNTI NGTON BUA 0 0 194, 09 200.00 Cross Foot Adjustments 200. 00 201.00 Negative Cost Centers 201.00 Cost to be allocated (per Wkst. B, 13, 675, 338 202. 00 202.00 240, 527 857,020 1, 164, 192 Part I) 0. 541754 203. 00 203.00 Unit cost multiplier (Wkst. B, Part I) 2.062450 0.969439 0.063223

Health Financial Systems		HUNTINGTON MEMORIAL HOSPITAL			In Lieu of Form CMS-2552-10			
COST ALLOCA	TION - STATISTICAL BASIS				Peri od:	Worksheet B-1		
					From 01/01/2017 To 12/31/2017			
		CAPITAL REI	_ATED COSTS					
	Cost Center Description	BLDG & FIXT (SQUARE FEET)	MVBLE EQUIP (DOLLAR VALUE)	EMPLOYEE BENEFITS DEPARTMENT	Reconci I i ati on	ADMINISTRATIVE & GENERAL (ACCUM. COST)		
				(GROSS SALARI ES)		, ,		
		1. 00	2.00	4. 00	5A	5. 00		
204. 00	Cost to be allocated (per Wkst. B, Part II)			27.	2	1, 990, 008	204. 00	
205. 00	Unit cost multiplier (Wkst. B, Part			0. 00001	5	0. 078835	205. 00	
206. 00	NAHE adjustment amount to be allocated (per Wkst. B-2)						206. 00	
207. 00	NAHE unit cost multiplier (Wkst. D, Parts III and IV)						207. 00	

Provider CCN: 15-0091

				'	0 12/31/201/	Date/lime Pre 5/30/2018 9:2	
	Cost Center Description	MAINTENANCE & REPAIRS (SQUARE FEET)	OPERATION OF PLANT (SQUARE FEET)	LAUNDRY & LINEN SERVICE (POUNDS OF LAUNDRY)	HOUSEKEEPING (SQUARE FEET)	DIETARY (MEALS SERVED)	
		6. 00	7. 00	8. 00	9. 00	10. 00	
	GENERAL SERVICE COST CENTERS						
1. 00 2. 00 4. 00 5. 00	00100 CAP REL COSTS-BLDG & FIXT 00200 CAP REL COSTS-MVBLE EQUIP 00400 EMPLOYEE BENEFITS DEPARTMENT 00500 ADMINISTRATIVE & GENERAL						1. 00 2. 00 4. 00 5. 00
6. 00 7. 00 8. 00 9. 00 10. 00	00600 MAINTENANCE & REPAIRS 00700 OPERATION OF PLANT 00800 LAUNDRY & LINEN SERVICE 00900 HOUSEKEEPING 01000 DI ETARY	0 0	78, 136 629 512 4, 892	256, 999 0	76, 995 4, 892	29, 923	6. 00 7. 00 8. 00 9. 00 10. 00
11. 00 12. 00 13. 00 14. 00	01100 CAFETERIA 01200 MAI NTENANCE OF PERSONNEL 01300 NURSI NG ADMI NI STRATI ON 01400 CENTRAL SERVI CES & SUPPLY	0 0	1, 110 0 0 1, 905	0 0 0	1, 110 0	0 0	11. 00 12. 00 13. 00
15. 00 16. 00 17. 00 19. 00	01500 PHARMACY 01600 MEDICAL RECORDS & LIBRARY 01700 SOCIAL SERVICE 01900 NONPHYSICIAN ANESTHETISTS	0 0 0 0	1, 155 638 0 0		1, 155 638 0 0	0 0 0 0	16. 00 17. 00
20. 00 21. 00 22. 00 23. 00	02000 NURSING SCHOOL 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 0 0 0	0 0 0 0	0 0 0 0	21. 00 22. 00
30. 00 43. 00	INPATLENT ROUTINE SERVICE COST CENTERS   03000   ADULTS & PEDLATRICS   04300   NURSERY	0	25, 160 102			29, 923 0	1
50. 00 52. 00	ANCILLARY SERVICE COST CENTERS  05000 OPERATING ROOM  05200 DELIVERY ROOM & LABOR ROOM	0	9, 584 0	41, 694 16, 947		0	
53. 00 54. 00 60. 00	05300 ANESTHESI OLOGY 05400 RADI OLOGY-DI AGNOSTI C 06000 LABORATORY	0	0 12, 012 1, 820		0 12, 012 1, 820	0 0 0	54.00
62. 30 65. 00 66. 00	06250 BLOOD CLOTTING FOR HEMOPHILIACS 06500 RESPIRATORY THERAPY 06600 PHYSICAL THERAPY	0	0 1, 346 8, 324	0	0 1, 346 8, 324	0	62. 30 65. 00
67. 00 68. 00 69. 00	06700 OCCUPATIONAL THERAPY 06800 SPEECH PATHOLOGY 06900 ELECTROCARDIOLOGY	0 0	0, 324	0 0	0, 324	0 0 0	67. 00 68. 00
71. 00 72. 00 73. 00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT 07200 IMPL. DEV. CHARGED TO PATIENTS 07300 DRUGS CHARGED TO PATIENTS	0 0 0	0 0 0	0 0	0 0	0 0	72. 00 73. 00
76. 97 76. 98 76. 99	07697 CARDI AC REHABI LITATION 07698 HYPERBARI C OXYGEN THERAPY 07699 LITHOTRI PSY 0UTPATI ENT SERVI CE COST CENTERS	0 0	0	0	0 0	0 0 0	76. 98
	09100 EMERGENCY 09200 OBSERVATION BEDS (NON-DISTINCT PART OTHER REIMBURSABLE COST CENTERS	0	5, 120	65, 345	5, 120	0	91. 00 92. 00
95. 00	09500 AMBULANCE SERVICES SPECIAL PURPOSE COST CENTERS	0	3, 551	5, 327	3, 551	0	
118. 00	NONREI MBURSABLE COST CENTERS	0	77, 860	251, 680	76, 719		113. 00 118. 00
192. 00 194. 00	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN 19200 PHYSICIANS' PRIVATE OFFICES 07950 OCC HEALTH 07951 PAIN CLINIC	0 0 0	0 0 276 0	0 5, 319 0 0	0 0 276	0	190. 00 192. 00 194. 00 194. 01
194. 02 194. 03	07952 OCC HEALTH 07953 FOUNDATIO 07954 KIDS CAMPUS	0 0	0	0 0	0	0	194. 02 194. 03 194. 04
194. 06 194. 07 194. 08	07955 COMMUNITY & VOLUNTEER SERVICES 07956 HUNTINGTON COLLEGE NURSE 07957 MISC CATERING 07958 AUTISM CENTER	0 0 0	0 0 0 0	0 0 0	0 0 0 0	0 0 0	194. 05 194. 06 194. 07 194. 08
194. 09 200. 00 201. 00 202. 00	Negative Cost Centers	0	0 1, 940, 745	0 270, 917	640, 915	0 474, 136	200. 00 201. 00
203. 00 204. 00	Part I) Unit cost multiplier (Wkst. B, Part I)	0. 000000 0	24. 838039	1. 054156		15. 845203	

Heal th Finar	ncial Systems	HUNTINGTON MEMO	RIAL HOSPITAL		In Lie	eu of Form CMS-2	2552-10
COST ALLOCATION - STATISTICAL BASIS					Period: From 01/01/2017	Worksheet B-1	
					o 12/31/2017	Date/Time Pre 5/30/2018 9:2	
	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. 432541	0. 061794	0. 447120	1. 394847	205. 00
206. 00	NAHE adjustment amount to be allocated (per Wkst. B-2)						206. 00
207. 00	NAHE unit cost multiplier (Wkst. D, Parts III and IV)						207. 00

	LLOCATION - STATISTICAL BASIS	IONTTINOTON WEWO	Provi der C	CN: 15-0091 Pe	eri od:	Worksheet B-1	
				Fi To	com 01/01/2017 o 12/31/2017	Date/Time Pre 5/30/2018 9:2	pared: 5 am
	Cost Center Description	CAFETERIA M (HOURS OF SERVICE)	MAINTENANCE OF PERSONNEL (NUMBER HOUSED)	NURSING ADMINISTRATION (DIRECT NRSING	CENTRAL SERVI CES & SUPPLY (COSTED	PHARMACY (COSTED REQUIS.)	
		11.00	12. 00	HRS) 13. 00	REQUIS.)	15.00	
	GENERAL SERVICE COST CENTERS	11.00	12.00	13.00	14. 00	15. 00	
14. 00 15. 00 16. 00 17. 00 19. 00	GENERAL SERVICE COST CENTERS  00100 CAP REL COSTS-BLDG & FIXT  00200 CAP REL COSTS-MVBLE EQUIP  00400 EMPLOYEE BENEFITS DEPARTMENT  00500 ADMINISTRATIVE & GENERAL  00600 MAINTENANCE & REPAIRS  00700 OPERATION OF PLANT  00800 LAUNDRY & LINEN SERVICE  00900 HOUSEKEEPING  01100 CAFETERIA  01200 MAINTENANCE OF PERSONNEL  01300 NURSING ADMINISTRATION  01400 CENTRAL SERVICES & SUPPLY  01500 PHARMACY  01600 MEDICAL RECORDS & LIBRARY  01700 SOCIAL SERVICE  01900 NONPHYSICIAN ANESTHETISTS  02000 NURSING SCHOOL  02100 I&R SERVICES-SALARY & FRINGES APPRV	399, 203 0 5, 329 0 9, 633 0 0 0	0 0 0 0 0 0	216, 221 0 0 0 0 0	2, 919, 000 33, 371 0 0 0 0	100 0 0 0 0	16. 00 17. 00 19. 00 20. 00
22. 00	02200 I&R SERVICES-OTHER PRGM COSTS APPRV	0	0	0	0	0	
23. 00	02300 PARAMED ED PRGM-(SPECIFY) INPATIENT ROUTINE SERVICE COST CENTERS	0	0	0	0	0	23. 00
30. 00	03000 ADULTS & PEDIATRICS	129, 993	0	129, 993	199, 369	0	30.00
43.00	04300 NURSERY	3, 844	0	3, 844	0	0	43. 00
50. 00	ANCI LLARY SERVI CE COST CENTERS  05000 OPERATI NG ROOM	30, 435	0	30, 435	316, 907	0	50. 00
52. 00	05200 DELIVERY ROOM & LABOR ROOM	16, 816	0	16, 816	310, 907	0	
53. 00	05300 ANESTHESI OLOGY	0	0	0	0	0	
54.00	05400 RADI OLOGY-DI AGNOSTI C	32, 856	0	0	70, 234	0	
60. 00 62. 30	06000 LABORATORY 06250 BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0	1, 227	0	
65. 00	06500 RESPIRATORY THERAPY	25, 022	0	0	93, 315	0	
66. 00	06600 PHYSI CAL THERAPY	23, 229	0	Ö	24, 646	-	
67. 00	06700 OCCUPATIONAL THERAPY	7, 463	0	0	0	0	
68. 00	06800 SPEECH PATHOLOGY	2, 150	0	0	0	0	
69. 00 71. 00	06900 ELECTROCARDIOLOGY 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	1, 750, 368		
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0	0	Ö	0	Ō	
	07300 DRUGS CHARGED TO PATIENTS	0	0	0	95, 140	100	
76. 97	07697 CARDI AC REHABI LI TATI ON	0	0	0	0	0	
	07698 HYPERBARI C OXYGEN THERAPY	0	0	0	1, 832	0	
70. 77	07699 LITHOTRIPSY OUTPATIENT SERVICE COST CENTERS	0	0	0	0	0	70. 99
91.00	09100 EMERGENCY	35, 133	0	35, 133	153, 631	0	91.00
	09200 OBSERVATION BEDS (NON-DISTINCT PART						92.00
	OTHER REIMBURSABLE COST CENTERS  09500 AMBULANCE SERVICES	69, 034	0	0	175, 799	0	95. 00
75. 00	SPECIAL PURPOSE COST CENTERS	07,034			175, 777		75.00
	11300 I NTEREST EXPENSE						113. 00
118.00	NONREI MBURSABLE COST CENTERS	390, 937	0	- 1	2, 915, 839		118. 00 190. 00
	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN 19200 PHYSICIANS' PRIVATE OFFICES	0 3, 793	0	1	3, 161		190.00
	07950 OCC HEALTH	0	0	o	0, 101		194. 00
	07951 PAIN CLINIC	0	0	0	0		194. 01
	07952 OCC HEALTH	0	0	0	0		194. 02
	07953 FOUNDATIO 07954 KIDS CAMPUS	2, 120	0	0	0		194. 03 194. 04
	07955 COMMUNITY & VOLUNTEER SERVICES	0	0	o	0		194. 05
194. 06	07956 HUNTI NGTON COLLEGE NURSE	0	0	0	0		194. 06
	07957 MI SC CATERI NG	2, 353	0	0	0		194. 07
	07958 AUTISM CENTER 07959 HUNTINGTON BUA	0	0	0	0		194. 08 194. 09
200.00		۱	0		Ü		200. 00
201.00	,						201. 00
202. 00	Cost to be allocated (per Wkst. B, Part I)	435, 614	0	387, 749		1, 024, 983	202. 00
203. 00 204. 00		1. 091209 25, 880	0. 000000 0	1. 793299 19, 879		10, 249. 830000 115, 908	

Heal th Finar	ncial Systems	HUNTINGTON MEMO	RIAL HOSPITAL		In Lieu of Form CMS-2552-10			
COST ALLOCA	TION - STATISTICAL BASIS				Peri od:	Worksheet B-1		
					From 01/01/2017 To 12/31/2017	Date/Time Pre 5/30/2018 9:2		
	Cost Center Description		MAINTENANCE OF		CENTRAL	PHARMACY		
		(HOURS OF	PERSONNEL	ADMI NI STRATI O	N SERVICES &	(COSTED		
		SERVI CE)	(NUMBER		SUPPLY	REQUIS.)		
			HOUSED)	(DIRECT NRSIN	G (COSTED			
				HRS)	REQUIS.)			
		11. 00	12.00	13.00	14. 00	15. 00		
205. 00	Unit cost multiplier (Wkst. B, Part	0. 064829	0. 000000	0. 09193	0. 003332	1, 159. 080000	205. 00	
206. 00	NAHE adjustment amount to be allocated (per Wkst. B-2)						206. 00	
207. 00	NAHE unit cost multiplier (Wkst. D, Parts III and IV)						207. 00	

Health Financial Systems HUNTINGTON MEMORIAL HOSPITAL In Lieu of Form CMS-2552-10 COST ALLOCATION - STATISTICAL BASIS Provider CCN: 15-0091 Peri od: Worksheet B-1 From 01/01/2017 12/31/2017 Date/Time Prepared: 5/30/2018 9:25 am INTERNS & **RESI DENTS** Cost Center Description MEDI CAL SOCIAL SERVICE NONPHYSI CI AN NURSING SCHOOL SERVICES-SALAR Y & FRINGES RECORDS & **ANESTHETISTS** (ASSI GNED (ASSI GNED LI BRARY (TIME SPENT) **APPRV** (GROSS REVE TIME) TIME) (ASSI GNED NUE) TIME) 17. 00 19.00 20.00 16, 00 21.00 GENERAL SERVICE COST CENTERS 1 00 00100 CAP REL COSTS-BLDG & FLXT 1 00 2.00 00200 CAP REL COSTS-MVBLE EQUIP 2 00 4.00 00400 EMPLOYEE BENEFITS DEPARTMENT 4.00 00500 ADMINISTRATIVE & GENERAL 5 00 5 00 6.00 00600 MAINTENANCE & REPAIRS 6.00 7.00 00700 OPERATION OF PLANT 7.00 8.00 00800 LAUNDRY & LINEN SERVICE 8.00 00900 HOUSEKEEPI NG 9 00 9 00 10.00 01000 DI ETARY 10.00 01100 CAFETERI A 11.00 11.00 01200 MAINTENANCE OF PERSONNEL 12.00 12.00 01300 NURSING ADMINISTRATION 13.00 13.00 14.00 01400 CENTRAL SERVICES & SUPPLY 14.00 01500 PHARMACY 15.00 15.00 01600 MEDICAL RECORDS & LIBRARY 16.00 179, 719, 659 16,00 17 00 01700 SOCIAL SERVICE 17 00 19.00 01900 NONPHYSICIAN ANESTHETISTS 19.00 0 0 20.00 02000 NURSING SCHOOL 0 0 20.00 02100 I &R SERVICES-SALARY & FRINGES APPRV 21.00 0 0 0 21.00 02200 I&R SERVICES-OTHER PRGM COSTS APPRV 22.00 0 C 22.00 02300 PARAMED ED PRGM-(SPECIFY) 23.00 0 23.00 INPATIENT ROUTINE SERVICE COST CENTERS 30.00 03000 ADULTS & PEDIATRICS 9, 889, 914 30.00 0 0 0 0 04300 NURSERY 0 43.00 908, 264 0 0 0 43.00 ANCILLARY SERVICE COST CENTERS 50.00 05000 OPERATING ROOM 22, 628, 254 0 0 0 0 50.00 05200 DELIVERY ROOM & LABOR ROOM 0 0 52.00 4,060,330 0 0 52.00 05300 ANESTHESI OLOGY 0 53.00 53.00 3, 663, 305 0 0 0 0 0 0 0 0 0 0 0 0 54.00 05400 RADI OLOGY-DI AGNOSTI C 36, 851, 313 0 0 54.00 06000 LABORATORY 17, 998, 878 0 0 60.00 0 60.00 06250 BLOOD CLOTTING FOR HEMOPHILIACS 0 62. 30 0 0 62.30 06500 RESPIRATORY THERAPY 6, 517, 564 0 65.00 0 65.00 06600 PHYSI CAL THERAPY 4, 601, 216 0 66.00 0 66.00 06700 OCCUPATI ONAL THERAPY 0 0 67.00 1, 423, 168 0 67.00 68.00 06800 SPEECH PATHOLOGY 379,086 0 0 68.00 69.00 06900 ELECTROCARDI OLOGY 1, 178, 801 0 69.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT 0 71 00 12 505 911 Ω 0 71 00 07200 IMPL. DEV. CHARGED TO PATIENTS 0 72.00 6,844,739 C 0 72.00 73.00 07300 DRUGS CHARGED TO PATIENTS 15, 280, 436 0 0 0 73.00 07697 CARDIAC REHABILITATION 0 0 76. 97 0 0 76.97 07698 HYPERBARIC OXYGEN THERAPY 0 76. 98 76 98 232, 742 Ω 0 76. 99 07699 LI THOTRI PSY 0 0 0 76.99 OUTPATIENT SERVICE COST CENTERS 91.00 09100 EMERGENCY 23, 330, 308 0 0 0 0 91.00 09200 OBSERVATION BEDS (NON-DISTINCT PART 92.00 92.00 OTHER REIMBURSABLE COST CENTERS 09500 AMBULANCE SERVICES 11, 425, 430 0 0 0 0 95.00 SPECIAL PURPOSE COST CENTERS 113.00 113.00 11300 INTEREST EXPENSE 118.00 SUBTOTALS (SUM OF LINES 1 through 117) 179, 719, 659 0 0 0 118.00 0 NONREI MBURSABLE COST CENTERS 190. 00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN 0 190 00 0 0 0 192.00 19200 PHYSICIANS' PRIVATE OFFICES 0 0 0 0 192.00 194.00 07950 OCC HEALTH 0 0 0 194.00 0 0 0 0 0 0 0 194. 01 07951 PAIN CLINIC 0 194. 01 0 0 194. 02 07952 OCC HEALTH 0 0 194, 02 0 0 194. 03 07953 FOUNDATI 0 0 0 0 194. 03 194. 04 07954 KIDS CAMPUS 0 194. 04 0 194. 05 07955 COMMUNITY & VOLUNTEER SERVICES 0 0 194. 05 0 194.06 07956 HUNTI NGTON COLLEGE NURSE 0 0 194.06 C o 194.07 07957 MISC CATERING 0 0 194. 07 194.08 07958 AUTISM CENTER 0 0 0 0 0 194. 08 194. 09 07959 HUNTI NGTON BUA 0 194, 09 0 0 200.00 Cross Foot Adjustments 200. 00 201.00 Negative Cost Centers 201.00 Cost to be allocated (per Wkst. B, 0 202.00 202.00 23, 187 Part I)

0.000129

0.000000

0.000000

0.000000

0.000000 203.00

Unit cost multiplier (Wkst. B, Part I)

203.00

Health Financial Systems		HUNTINGTON MEMORIAL HOSPITAL			In Lieu of Form CMS-2552-10			
COST ALLOCA	TION - STATISTICAL BASIS				Peri od:	Worksheet B-1		
					From 01/01/2017 Fo 12/31/2017	Date/Time Pre 5/30/2018 9:2		
						I NTERNS & RESI DENTS		
	Cost Center Description		SOCIAL SERVICE		NURSING SCHOOL			
		RECORDS &		ANESTHETI STS		Y & FRINGES		
		LI BRARY	(TIME SPENT)	(ASSI GNED	(ASSI GNED	APPRV		
		(GROSS REVE		TIME)	TIME)	(ASSI GNED		
		NUE)				TIME)		
		16. 00	17. 00	19. 00	20.00	21. 00		
204. 00	Cost to be allocated (per Wkst. B, Part II)	3, 257	0	(	0	0	204. 00	
205. 00	Unit cost multiplier (Wkst. B, Part	0. 000018	0. 000000	0.00000	0.000000	0.000000	205. 00	
206. 00	NAHE adjustment amount to be allocated (per Wkst. B-2)				0		206. 00	
207. 00	NAHE unit cost multiplier (Wkst. D, Parts III and IV)				0. 000000		207. 00	

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

COST ALLOCATION - STATISTICAL BASIS Provider CCN: 15-0091 Period: Worksheet B-1

From 01/01/2017 12/31/2017 Date/Time Prepared: 5/30/2018 9:25 am INTERNS & **RESI DENTS** Cost Center Description SERVI CES-OTHER PARAMED ED PRGM COSTS **PRGM** (ASSI GNED **APPRV** (ASSI GNED TIME) TIME) 23.00 22.00 GENERAL SERVICE COST CENTERS 1 00 00100 CAP REL COSTS-BLDG & FLXT 1 00 2.00 00200 CAP REL COSTS-MVBLE EQUIP 2 00 4.00 00400 EMPLOYEE BENEFITS DEPARTMENT 4.00 00500 ADMINISTRATIVE & GENERAL 5 00 5 00 6.00 00600 MAINTENANCE & REPAIRS 6.00 7.00 00700 OPERATION OF PLANT 7.00 00800 LAUNDRY & LINEN SERVICE 8.00 8.00 00900 HOUSEKEEPI NG 9 00 9 00 10.00 01000 DI ETARY 10.00 01100 CAFETERI A 11.00 11.00 01200 MAINTENANCE OF PERSONNEL 12.00 12.00 13.00 01300 NURSING ADMINISTRATION 13.00 14.00 01400 CENTRAL SERVICES & SUPPLY 14.00 01500 PHARMACY 15.00 15.00 01600 MEDICAL RECORDS & LIBRARY 16.00 16, 00 17 00 01700 SOCIAL SERVICE 17 00 19.00 01900 NONPHYSICIAN ANESTHETISTS 19.00 20.00 02000 NURSING SCHOOL 20.00 02100 I &R SERVICES-SALARY & FRINGES APPRV 21.00 21.00 02200 I&R SERVICES-OTHER PRGM COSTS APPRV 22.00 0 22.00 02300 PARAMED ED PRGM-(SPECIFY) 0 23.00 INPATIENT ROUTINE SERVICE COST CENTERS 30 00 03000 ADULTS & PEDIATRICS 30.00 0 0 04300 NURSERY 43.00 Ω 43.00 ANCILLARY SERVICE COST CENTERS 50.00 05000 OPERATING ROOM 0 0 50.00 05200 DELIVERY ROOM & LABOR ROOM 0 52.00 0 52.00 53.00 05300 ANESTHESI OLOGY 000000000000000 0 53.00 0 54.00 05400 RADI OLOGY-DI AGNOSTI C 54.00 06000 LABORATORY 60.00 0 60.00 06250 BLOOD CLOTTING FOR HEMOPHILIACS 62.30 0 62.30 06500 RESPIRATORY THERAPY 0 65.00 65.00 06600 PHYSI CAL THERAPY 0 66.00 66.00 06700 OCCUPATI ONAL THERAPY 67.00 0 67.00 68.00 06800 SPEECH PATHOLOGY 0 68.00 69.00 06900 ELECTROCARDI OLOGY 0 69.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT 0 71 00 71 00 07200 I MPL. DEV. CHARGED TO PATIENTS 72.00 0 72.00 73.00 07300 DRUGS CHARGED TO PATIENTS 0 73.00 07697 CARDIAC REHABILITATION 76. 97 0 76.97 07698 HYPERBARI C OXYGEN THERAPY 76 98 76 98 0 76.99 07699 LI THOTRI PSY 0 76.99 OUTPATIENT SERVICE COST CENTERS 91.00 09100 EMERGENCY 0 0 91.00 09200 OBSERVATION BEDS (NON-DISTINCT PART 92.00 92.00 OTHER REIMBURSABLE COST CENTERS 09500 AMBULANCE SERVICES 0 0 95.00 SPECIAL PURPOSE COST CENTERS 113.00 11300 INTEREST EXPENSE 113.00 118.00 SUBTOTALS (SUM OF LINES 1 through 117) 0 118.00 NONREI MBURSABLE COST CENTERS 190.00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN 0 190.00 0 192.00 19200 PHYSICIANS' PRIVATE OFFICES 0 192.00 00000000 194.00 07950 OCC HEALTH 0 194.00 194. 01 07951 PAIN CLINIC 0 194. 01 194. 02 07952 OCC HEALTH 194. 02 0 194. 03 07953 FOUNDATI 0 0 194.03 194. 04 194. 04 07954 KIDS CAMPUS 194. 05 07955 COMMUNITY & VOLUNTEER SERVICES 0 194. 05 194.06 07956 HUNTI NGTON COLLEGE NURSE 0 194.06 194.07 07957 MISC CATERING 194.07 194.08 07958 AUTISM CENTER 0 0 194. 08 194. 09 07959 HUNTI NGTON BUA 0 0 194. 09 200.00 Cross Foot Adjustments 200. 00 201.00 Negative Cost Centers 201.00 Cost to be allocated (per Wkst. B, 202.00 202. 00 Part I) 203.00 Unit cost multiplier (Wkst. B, Part I) 0.000000 0.000000 203.00

Health Financial Systems	HUNTI NGTON MEMOI	RIAL HOSPITAL		In Lie	u of Form C	MS-2552-10
COST ALLOCATION - STATISTICAL BASIS		Provider CO	CN: 15-0091	Peri od: From 01/01/2017 To 12/31/2017	Worksheet Date/Time 5/30/2018	Prepared:
Cost Center Description	I NTERNS & RESI DENTS SERVI CES-OTHER PRGM COSTS APPRV (ASSI GNED TI ME) 22. 00	PARAMED ED PRGM (ASSI GNED TI ME)				
204.00   Cost to be allocated (per Wkst. B, Part II)	0	0				204. 00
205.00 Unit cost multiplier (Wkst. B, Part	0. 000000	0. 000000				205. 00
206.00 NAHE adjustment amount to be allocated (per Wkst. B-2)		0				206. 00
207.00 NAHE unit cost multiplier (Wkst. D, Parts III and IV)		0. 000000				207. 00

ealth Financial Systems OMPUTATION OF RATIO OF COSTS TO CHARGES	HUNTINGTON MEMO	Provi der Co		Period: From 01/01/2017 To 12/31/2017	u of Form CMS-2 Worksheet C Part I Date/Time Pre 5/30/2018 9:2	pared
		Title	XVIII	Hospi tal	PPS	
				Costs		
Cost Center Description	Total Cost (from Wkst. B, Part I, col. 26)	Therapy Limit Adj.	Total Costs	RCE Di sal I owance	Total Costs	
	1.00	2.00	3. 00	4. 00	5. 00	
INPATIENT ROUTINE SERVICE COST CENTERS						
0.00  03000 ADULTS & PEDIATRICS	7, 061, 120		7, 061, 12		7, 061, 120	30.0
3. 00 04300 NURSERY	292, 789		292, 78	9 0	292, 789	43. (
ANCILLARY SERVICE COST CENTERS						
0.00   05000   OPERATING ROOM	2, 150, 057		2, 150, 05		2, 173, 066	
2.00   05200   DELIVERY ROOM & LABOR ROOM	1, 264, 567	,	1, 264, 56	7 0	1, 264, 567	52.
3. 00   05300   ANESTHESI OLOGY	1, 027, 306		1, 027, 30	6 0	1, 027, 306	53.
4. 00   05400   RADI OLOGY-DI AGNOSTI C	3, 455, 421		3, 455, 42	1 0	3, 455, 421	54.
D. 00   06000   LABORATORY	3, 411, 613	3	3, 411, 61	3 0	3, 411, 613	60.
2.30 06250 BLOOD CLOTTING FOR HEMOPHILIACS	C			0 0	0	62.
5. 00 06500 RESPI RATORY THERAPY	1, 435, 969	0	1, 435, 96	9 0	1, 435, 969	65.
5. 00 06600 PHYSI CAL THERAPY	1, 764, 082	2 0	1, 764, 08	2 0	1, 764, 082	66.
7. 00 06700 OCCUPATIONAL THERAPY	409, 582	2 0	409, 58	2 0	409, 582	67.
3. 00 06800 SPEECH PATHOLOGY	119, 789	0	119, 78	9 0	119, 789	68.
P. 00 06900 ELECTROCARDI OLOGY	152		15	2 0	152	69.
.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	1, 228, 564		1, 228, 56	4 o	1, 228, 564	71.
2.00 07200 IMPL. DEV. CHARGED TO PATIENTS	1, 513, 959		1, 513, 95	9 0	1, 513, 959	72.
3.00 07300 DRUGS CHARGED TO PATIENTS	4, 210, 883	3	4, 210, 88	3 0	4, 210, 883	73.
5. 97 07697 CARDI AC REHABI LI TATI ON				ol ol	0	76.
5. 98 07698 HYPERBARI C OXYGEN THERAPY	17, 156		17, 15	6 0	17, 156	
5. 99 07699 LI THOTRI PSY	, ,	<b> </b>		ol ol	0	1
OUTPATIENT SERVICE COST CENTERS				-1		1
09100 EMERGENCY	2, 700, 759		2, 700, 75	9 0	2, 700, 759	91.
2. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART	1, 486, 490		1, 486, 49		1, 486, 490	
OTHER REIMBURSABLE COST CENTERS	.,,	1	., .55, 17	-1	.,, 170	1
5. 00 09500 AMBULANCE SERVICES	5, 669, 380		5, 669, 38	ol ol	5, 669, 380	95.
SPECIAL PURPOSE COST CENTERS	3,557,666		5,557,00	-1 9	2, 22,, 000	1
3. 00 11300 I NTEREST EXPENSE						113

39, 219, 638

1, 486, 490 37, 733, 148

39, 219, 638

1, 486, 490 37, 733, 148

113. 00 39, 242, 647 200. 00 1, 486, 490 201. 00 37, 756, 157 202. 00

23, 009

23, 009

113. 00 11300 | INTEREST EXPENSE

Subtotal (see instructions)

Less Observation Beds Total (see instructions)

200.00

201.00 202.00

Health Financial Systems H	IUNTI NGTON MEMOR	RIAL HOSPITAL		In Lie	u of Form CMS-2	2552-10
COMPUTATION OF RATIO OF COSTS TO CHARGES		Provider Co		From 01/01/2017	Worksheet C Part I Date/Time Prep 5/30/2018 9:29	
		Title	: XVIII	Hospi tal	PPS	
		Charges				
Cost Center Description	I npati ent	Outpati ent	Total (col.	6 Cost or Other Ratio	TEFRA Inpatient	

						07 007 2010 7. 2	o um
				XVIII	Hospi tal	PPS	
	Cost Center Description	I npati ent	Charges Outpatient	Total (col. 6 + col. 7)	Cost or Other Ratio	TEFRA Inpatient Ratio	
		6.00	7. 00	8. 00	9. 00	10.00	
	INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000 ADULTS & PEDIATRICS	8, 238, 415		8, 238, 41	5		30. 00
43.00	04300 NURSERY	908, 264		908, 26	4		43.00
	ANCILLARY SERVICE COST CENTERS						
50.00	05000 OPERATI NG ROOM	7, 266, 684	15, 361, 570	22, 628, 25	4 0. 095016	0.000000	50. 00
52.00	05200 DELIVERY ROOM & LABOR ROOM	4, 060, 330	0	4, 060, 33	0. 311444	0.000000	52. 00
53.00	05300 ANESTHESI OLOGY	830, 105	2, 833, 200	3, 663, 30	0. 280431	0.000000	53.00
54.00	05400 RADI OLOGY-DI AGNOSTI C	3, 823, 332	33, 027, 981	36, 851, 31	0. 093767	0.000000	54. 00
60.00	06000 LABORATORY	3, 313, 206	14, 685, 672	17, 998, 87	0. 189546	0.000000	60.00
62. 30	06250 BLOOD CLOTTING FOR HEMOPHILIACS	o	0		0.00000	0.000000	62. 30
65.00	06500 RESPIRATORY THERAPY	1, 515, 355	5, 002, 209	6, 517, 56	4 0. 220323	0.000000	65.00
66.00	06600 PHYSI CAL THERAPY	563, 760	4, 037, 456	4, 601, 21	6 0. 383395	0.000000	66.00
67.00	06700 OCCUPATI ONAL THERAPY	168, 360	1, 254, 808	1, 423, 16	0. 287796	0.000000	67. 00
68.00	06800 SPEECH PATHOLOGY	19, 133	359, 953	379, 08	6 0. 315994	0.000000	68. 00
69.00	06900 ELECTROCARDI OLOGY	601, 117	577, 684	1, 178, 80	0. 000129	0.000000	69. 00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	3, 212, 497	9, 293, 414	12, 505, 91	0. 098239	0.000000	71. 00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	5, 234, 880	1, 609, 859	6, 844, 73	9 0. 221186	0.000000	72. 00
73.00	07300 DRUGS CHARGED TO PATIENTS	4, 865, 037	10, 415, 399	15, 280, 43	6 0. 275573	0.000000	73. 00
76. 97	07697 CARDI AC REHABI LI TATI ON	0	0		0. 000000	0.000000	76. 97
76. 98	07698 HYPERBARI C OXYGEN THERAPY	92, 225	140, 517	232, 74	0. 073713	0.000000	76. 98
76. 99	07699 LI THOTRI PSY	0	0		0. 000000	0.000000	76. 99
	OUTPATIENT SERVICE COST CENTERS				_		
91.00	09100 EMERGENCY	3, 074, 143	20, 256, 165	23, 330, 30	0. 115762	0.000000	91. 00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART	0	1, 651, 499	1, 651, 49	9 0. 900085	0.000000	92. 00
	OTHER REIMBURSABLE COST CENTERS						
95.00	09500 AMBULANCE SERVICES	0	11, 425, 430	11, 425, 43	0. 496207	0.000000	95. 00
	SPECIAL PURPOSE COST CENTERS						
	11300 I NTEREST EXPENSE		·				113. 00
200.00		47, 786, 843	131, 932, 816	179, 719, 65	9		200. 00
201.00	Less Observation Beds						201. 00
202.00	Total (see instructions)	47, 786, 843	131, 932, 816	179, 719, 65	9		202. 00

Health Financial Systems	HUNTINGTON MEMORIAL HOSPITAL	In Lieu	u of Form CMS-2552-10
COMPUTATION OF RATIO OF COSTS TO CHARGES	Provi der CCN: 15-0091	From 01/01/2017 To 12/31/2017	Worksheet C Part I Date/Time Prepared: 5/30/2018 9:25 am

					5/30/2018 9: 25	5 am
			Title XVIII	Hospi tal	PPS	
	Cost Center Description	PPS Inpatient				
		Ratio				
		11. 00				
	INPATIENT ROUTINE SERVICE COST CENTERS					
30. 00	03000 ADULTS & PEDIATRICS					30. 00
43.00						43. 00
	ANCILLARY SERVICE COST CENTERS					
50.00	05000 OPERATING ROOM	0. 096033				50. 00
52. 00	05200 DELIVERY ROOM & LABOR ROOM	0. 311444				52. 00
53.00	05300 ANESTHESI OLOGY	0. 280431				53.00
54.00		0. 093767				54.00
60.00	06000 LABORATORY	0. 189546				60.00
62. 30		0. 000000				62. 30
65.00	06500 RESPI RATORY THERAPY	0. 220323				65. 00
66.00	06600 PHYSI CAL THERAPY	0. 383395				66. 00
67. 00	06700 OCCUPATI ONAL THERAPY	0. 287796				67. 00
68. 00		0. 315994				68. 00
	06900 ELECTROCARDI OLOGY	0. 000129				69. 00
	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0. 098239				71. 00
72. 00		0. 221186				72. 00
73.00	· ·	0. 275573				73. 00
	07697 CARDI AC REHABI LI TATI ON	0. 000000				76. 97
	07698 HYPERBARI C OXYGEN THERAPY	0. 073713				76. 98
76. 99	07699 LI THOTRI PSY	0. 000000				76. 99
	OUTPATIENT SERVICE COST CENTERS					
	09100 EMERGENCY	0. 115762				91. 00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART	0. 900085				92. 00
	OTHER REIMBURSABLE COST CENTERS					
95.00	09500 AMBULANCE SERVICES	0. 496207				95. 00
	SPECIAL PURPOSE COST CENTERS					
	11300 I NTEREST EXPENSE					113. 00
200.00						200. 00
201.00						201. 00
202.00	Total (see instructions)				l	202. 00

Health Financial Systems	HUNTI NGTON MEMO	RIAL HOSPITAL		In Lie	u of Form CMS-2	2552-10
COMPUTATION OF RATIO OF COSTS TO CHARGES		Provider CC		Period: From 01/01/2017 To 12/31/2017	Worksheet C Part I Date/Time Prep 5/30/2018 9:29	pared:
		Ti tl	e XIX	Hospi tal	PPS	
				Costs		
Cost Center Description	Total Cost (from Wkst. B, Part I, col. 26)	Therapy Limit Adj.	Total Costs	RCE Di sal I owance	Total Costs	
	1. 00	2.00	3. 00	4. 00	5. 00	
INPATIENT ROUTINE SERVICE COST CENTERS						

					Costs		
	Cost Center Description	Total Cost	Therapy Limit	Total Costs	RCE	Total Costs	
		(from Wkst. B,	Adj .		Di sal I owance		
		Part I, col.					
		26)					
		1. 00	2.00	3.00	4. 00	5. 00	
	INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000 ADULTS & PEDIATRICS	7, 061, 120		7, 061, 120	0	7, 061, 120	30. 00
43.00	04300 NURSERY	292, 789		292, 789	0	292, 789	43. 00
	ANCILLARY SERVICE COST CENTERS						
50.00	05000 OPERATING ROOM	2, 150, 057		2, 150, 057	23, 009	2, 173, 066	50.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	1, 264, 567		1, 264, 567	0	1, 264, 567	52.00
53.00	05300 ANESTHESI OLOGY	1, 027, 306		1, 027, 306	0	1, 027, 306	53.00
54.00	05400 RADI OLOGY-DI AGNOSTI C	3, 455, 421		3, 455, 421	0	3, 455, 421	54. 00
60.00	06000 LABORATORY	3, 411, 613		3, 411, 613	0	3, 411, 613	60.00
62. 30	06250 BLOOD CLOTTING FOR HEMOPHILIACS	0		0	0	0	62. 30
65.00	06500 RESPIRATORY THERAPY	1, 435, 969	0	1, 435, 969	0	1, 435, 969	65.00
66.00	06600 PHYSI CAL THERAPY	1, 764, 082	0	1, 764, 082	0	1, 764, 082	66.00
67.00	06700 OCCUPATI ONAL THERAPY	409, 582	0	409, 582	o	409, 582	67.00
68. 00	06800 SPEECH PATHOLOGY	119, 789	0	119, 789	0	119, 789	68. 00
69. 00	06900 ELECTROCARDI OLOGY	152		152	o	152	69. 00
71. 00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	1, 228, 564		1, 228, 564	0	1, 228, 564	71. 00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	1, 513, 959		1, 513, 959	o	1, 513, 959	72. 00
73.00	07300 DRUGS CHARGED TO PATIENTS	4, 210, 883		4, 210, 883	o	4, 210, 883	73. 00
76. 97	07697 CARDIAC REHABILITATION	0		0	o	0	76. 97
76. 98	07698 HYPERBARI C OXYGEN THERAPY	17, 156		17, 156	o	17, 156	76. 98
76. 99	07699 LI THOTRI PSY	0		0	o	0	76. 99
	OUTPATIENT SERVICE COST CENTERS						
91.00	09100 EMERGENCY	2, 700, 759		2, 700, 759	0	2, 700, 759	91. 00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART	1, 486, 490		1, 486, 490		1, 486, 490	92. 00
	OTHER REIMBURSABLE COST CENTERS						1
95.00	09500 AMBULANCE SERVICES	5, 669, 380		5, 669, 380	0	5, 669, 380	95. 00
	SPECIAL PURPOSE COST CENTERS	<u>'</u>					1
113.00	11300 INTEREST EXPENSE						113. 00
200.00	Subtotal (see instructions)	39, 219, 638	0	39, 219, 638	23, 009	39, 242, 647	200.00
201.00	Less Observation Beds	1, 486, 490		1, 486, 490		1, 486, 490	201.00
202.00	Total (see instructions)	37, 733, 148	0	37, 733, 148	23, 009	37, 756, 157	202. 00
			'				•

Health Financial Systems	HUNTINGTON MEMO	RIAL HOSPITAL		In Lie	u of Form CMS-2	2552-10
COMPUTATION OF RATIO OF COSTS TO CHARGES		Provi der C	CN: 15-0091	Peri od: From 01/01/2017 To 12/31/2017	Worksheet C Part I Date/Time Pre 5/30/2018 9:2	
		Ti tl	le XIX	Hospi tal	PPS	
		Charges				
Cost Center Description	I npati ent	Outpati ent	Total (col.	6 Cost or Other	TEFRA	

	5/30/2018 9: 2t	5 am
Title XIX Hospital	PPS	
Charges		
Cost Center Description   Inpatient   Outpatient   Total (col. 6   Cost or Other	TEFRA	
+ col. 7) Ratio	Inpati ent	
	Ratio	
6.00 7.00 8.00 9.00	10.00	
INPATIENT ROUTINE SERVICE COST CENTERS		
30. 00 03000 ADULTS & PEDI ATRI CS 8, 238, 415 8, 238, 415		30. 00
43. 00   04300   NURSERY   908, 264   908, 264		43.00
ANCI LLARY SERVI CE COST CENTERS		
50. 00   05000   OPERATI NG ROOM 7, 266, 684 15, 361, 570 22, 628, 254 0. 095016	0. 000000	50. 00
52. 00   05200   DELI VERY ROOM & LABOR ROOM 4, 060, 330 0 4, 060, 330 0. 311444	0. 000000	52.00
53. 00   05300   ANESTHESI OLOGY   830, 105   2, 833, 200   3, 663, 305   0. 280431	0.000000	53.00
54. 00   05400   RADI OLOGY-DI AGNOSTI C 3, 823, 332 33, 027, 981 36, 851, 313 0. 093767	0. 000000	54.00
60. 00   06000   LABORATORY 3, 313, 206 14, 685, 672 17, 998, 878 0. 189546	0. 000000	60.00
62. 30   06250   BLOOD CLOTTING FOR HEMOPHILIACS   0   0   0   0.000000	0. 000000	62. 30
65. 00   06500   RESPI RATORY THERAPY 1, 515, 355 5, 002, 209 6, 517, 564 0. 220323	0. 000000	65. 00
66. 00   06600   PHYSI CAL THERAPY 563, 760 4, 037, 456 4, 601, 216 0. 383395	0. 000000	66. 00
67. 00   06700   OCCUPATI ONAL THERAPY 168, 360 1, 254, 808 1, 423, 168 0. 287796	0. 000000	67.00
68. 00   06800   SPEECH PATHOLOGY   19, 133   359, 953   379, 086   0. 315994	0. 000000	68. 00
69. 00   06900   ELECTROCARDI OLOGY   601, 117   577, 684   1, 178, 801   0. 000129	0. 000000	69. 00
71. 00   07100   MEDICAL SUPPLIES CHARGED TO PATIENT   3, 212, 497   9, 293, 414   12, 505, 911   0. 098239	0. 000000	71. 00
72.00 07200 MPL. DEV. CHARGED TO PATIENTS 5, 234, 880 1, 609, 859 6, 844, 739 0. 221186	0. 000000	72. 00
73. 00   07300   DRUGS CHARGED TO PATIENTS 4, 865, 037 10, 415, 399 15, 280, 436 0. 275573	0. 000000	73. 00
76. 97   07697   CARDI AC REHABI LI TATI ON 0 0 0 0.000000	0. 000000	76. 97
76. 98   07698   HYPERBARI C 0XYGEN THERAPY 92, 225 140, 517 232, 742 0. 073713	0. 000000	76. 98
76. 99 07699 LI THOTRI PSY 0 0 0.000000	0. 000000	76. 99
OUTPATIENT SERVICE COST CENTERS		
91. 00   09100   EMERGENCY   3, 074, 143   20, 256, 165   23, 330, 308   0. 115762	0. 000000	91.00
92.00   09200   OBSERVATI ON BEDS (NON-DISTINCT PART   0 1,651,499 1,651,499 0.900085	0. 000000	92.00
OTHER REI MBURSABLE COST CENTERS		
95. 00   09500   AMBULANCE SERVI CES   0   11, 425, 430   11, 425, 430   0. 496207	0. 000000	95. 00
SPECIAL PURPOSE COST CENTERS		
113. 00 11300 I NTEREST EXPENSE		113. 00
200.00 Subtotal (see instructions) 47,786,843 131,932,816 179,719,659		200. 00
201.00 Less Observation Beds		201. 00
202.00 Total (see instructions) 47,786,843 131,932,816 179,719,659		202. 00

Health Financial Systems	HUNTINGTON MEMORIAL HOSPITAL	In Lie	u of Form CMS-2552-10
COMPUTATION OF RATIO OF COSTS TO CHARGES	Provi der CCN: 15-0091	Peri od: From 01/01/2017 To 12/31/2017	Worksheet C Part I Date/Time Prepared: 5/30/2018 9:25 am

Cost Center Description PPS Inpatient Title XIX Hospital PPS	5
Cost Contor Description DDS Innation	
cost center bescription [FF3 inpatrent]	
Rati o	
INPATIENT ROUTINE SERVICE COST CENTERS	
30. 00   03000   ADULTS & PEDI ATRI CS	30. 00
43. 00 <u>04300</u> <u>NURSERY</u>	43. 00
ANCILLARY SERVICE COST CENTERS	
50. 00   05000   OPERATI NG ROOM   0. 096033	50. 00
52. 00   05200   DELIVERY ROOM & LABOR ROOM   0. 311444	52. 00
53. 00   05300   ANESTHESI OLOGY 0. 280431	53. 00
54. 00   05400   RADI OLOGY-DI AGNOSTI C   0. 093767	54.00
60. 00   06000   LABORATORY 0. 189546	60.00
62.30   06250   BLOOD CLOTTING FOR HEMOPHILIACS   0.000000	62. 30
65. 00   06500   RESPI RATORY THERAPY 0. 220323	65. 00
66. 00   06600   PHYSI CAL THERAPY 0. 383395	66. 00
67. 00   06700   0CCUPATI ONAL THERAPY 0. 287796	67. 00
68. 00   06800   SPEECH   PATHOLOGY   0. 315994	68. 00
69. 00   06900   ELECTROCARDI OLOGY 0. 000129	69. 00
71.00   07100   MEDICAL SUPPLIES CHARGED TO PATIENT   0.098239	71. 00
72. 00   07200   I MPL. DEV. CHARGED TO PATIENTS 0. 221186	72. 00
73. 00   07300   DRUGS CHARGED TO PATIENTS   0. 275573	73. 00
76. 97   07697   CARDI AC REHABI LI TATI ON 0. 000000	76. 97
76. 98   07698   HYPERBARI C OXYGEN THERAPY 0. 073713	76. 98
76. 99   07699   LI THOTRI PSY   0. 000000	76. 99
OUTPATIENT SERVICE COST CENTERS	
91. 00   09100   EMERGENCY 0. 115762	91. 00
92. 00   <u>09200</u>   <u>0BSERVATI ON BEDS (NON-DI STI NCT PART</u>   0. 900085	92. 00
OTHER REIMBURSABLE COST CENTERS	
95. 00   09500   AMBULANCE   SERVI CES   0. 496207	95. 00
SPECIAL PURPOSE COST CENTERS	
113. 00 11300 I NTEREST EXPENSE	113. 00
200.00 Subtotal (see instructions)	200. 00
201.00 Less Observation Beds	201. 00
202.00   Total (see instructions)	202. 00

Health Financial Systems	stems HUNTINGTON MEMORIAL HOSPITAL			u of Form CMS-2552-10
CALCULATION OF OUTPATIENT SERVICE C	OST TO CHARGE RATIOS NET OF	Provider CCN: 15-0091		Worksheet C
REDUCTIONS FOR MEDICALD ONLY			From 01/01/2017	

				To	12/31/2017	Date/Time Pre 5/30/2018 9:2	
			Ti tl	e XIX	Hospi tal	PPS	<u> </u>
	Cost Center Description	Total Cost	Capital Cost	Operating Cost		Operating Cost	
	·	(Wkst. B, Part			Reducti on	Reduction	
		I, col. 26)	II col. 26)	Cost (col. 1 -		Amount	
				col . 2)			
		1.00	2. 00	3.00	4. 00	5. 00	
	ANCILLARY SERVICE COST CENTERS						
50.00	O5000  OPERATI NG ROOM	2, 150, 057	263, 438	1, 886, 619	0	0	50. 00
52.00	05200 DELIVERY ROOM & LABOR ROOM	1, 264, 567	65, 005		0	0	52. 00
53.00	05300 ANESTHESI OLOGY	1, 027, 306	52, 571	974, 735	0	0	53.00
54.00	05400  RADI OLOGY-DI AGNOSTI C	3, 455, 421	486, 191	2, 969, 230	0	0	54. 00
60.00	06000 LABORATORY	3, 411, 613	180, 564	3, 231, 049	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, 435, 969	101, 772	1, 334, 197	0	0	65. 00
66.00	06600 PHYSI CAL THERAPY	1, 764, 082	125, 439	1, 638, 643	0	0	66. 00
67.00	06700 OCCUPATI ONAL THERAPY	409, 582	21, 030	388, 552	0	0	67. 00
68.00	06800 SPEECH PATHOLOGY	119, 789	6, 150	113, 639	0	0	68. 00
69. 00	06900 ELECTROCARDI OLOGY	152	21	131	0	0	69. 00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	1, 228, 564	66, 671	1, 161, 893	0	0	71. 00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	1, 513, 959	77, 492	1, 436, 467	0	0	72. 00
73.00	07300 DRUGS CHARGED TO PATIENTS	4, 210, 883	279, 191	3, 931, 692	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	17, 156	883	16, 273	0	0	76. 98
76. 99	07699 LI THOTRI PSY	0	0	0	0	0	76. 99
	OUTPATIENT SERVICE COST CENTERS						
91.00	09100 EMERGENCY	2, 700, 759	179, 380	2, 521, 379	0	0	91. 00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART	1, 486, 490	118, 739	1, 367, 751	0	0	92. 00
	OTHER REIMBURSABLE COST CENTERS						
95.00	09500 AMBULANCE SERVICES	5, 669, 380	517, 416	5, 151, 964	0	0	95. 00
	SPECIAL PURPOSE COST CENTERS						
113.00	11300 I NTEREST EXPENSE						113. 00
200.00	Subtotal (sum of lines 50 thru 199)	31, 865, 729	2, 541, 953	29, 323, 776	0	0	200. 00
201.00	Less Observation Beds	1, 486, 490	118, 739	1, 367, 751	0	0	201. 00
202.00	Total (line 200 minus line 201)	30, 379, 239	2, 423, 214	27, 956, 025	0	0	202. 00

Health Financial Systems	HUNTI NGTON MEMORI A	L HOSPITAL	In Lieu of Form CMS-2552-10		
CALCULATION OF OUTPATIENT SERVING REDUCTIONS FOR MEDICALD ONLY	CE COST TO CHARGE RATIOS NET OF	Provider CCN: 15-0091	From 01/01/2017	Worksheet C Part II Date/Time Prepared:	

						5/30/2018 9:	25 am
			Ti tl	e XIX	Hospi tal	PPS	
Cost (	Center Description		Total Charges				
		Capital and	(Worksheet C,	Cost to Charge			
		Operating Cost	Part I, column	Ratio (col. 6			
		Reduction	8)	/ col . 7)			
		6. 00	7. 00	8. 00			
	ERVICE COST CENTERS						
50. 00   05000   OPERAT	TING ROOM	2, 150, 057	22, 628, 254	0. 095016			50. 00
	ERY ROOM & LABOR ROOM	1, 264, 567	4, 060, 330	0. 311444			52. 00
53. 00   05300   ANESTH	HESI OLOGY	1, 027, 306	3, 663, 305	0. 280431			53. 00
54. 00   05400   RADI OL	LOGY-DI AGNOSTI C	3, 455, 421	36, 851, 313	0. 093767	'		54.00
60. 00   06000   LABORA	ATORY	3, 411, 613	17, 998, 878	0. 189546			60. 00
62. 30   06250 BL00D	CLOTTING FOR HEMOPHILIACS	0	0	0.000000			62. 30
65. 00 06500 RESPI F	RATORY THERAPY	1, 435, 969	6, 517, 564	0. 220323	3		65.00
66. 00 06600 PHYSI 0	CAL THERAPY	1, 764, 082	4, 601, 216	0. 383395	5		66. 00
67. 00 06700 OCCUPA	ATIONAL THERAPY	409, 582	1, 423, 168	0. 287796			67. 00
68. 00 06800 SPEECH	H PATHOLOGY	119, 789	379, 086	0. 315994			68. 00
69. 00 06900 ELECTF	ROCARDI OLOGY	152	1, 178, 801	0. 000129			69. 00
71. 00 07100 MEDI CA	AL SUPPLIES CHARGED TO PATIENT	1, 228, 564	12, 505, 911	0. 098239			71. 00
72.00 07200 I MPL.	DEV. CHARGED TO PATIENTS	1, 513, 959	6, 844, 739	0. 221186			72. 00
73. 00 07300 DRUGS	CHARGED TO PATIENTS	4, 210, 883	15, 280, 436	0. 275573	3		73. 00
76. 97 07697 CARDI A	AC REHABILITATION	0	0	0.000000			76. 97
76. 98 07698 HYPERE	BARIC OXYGEN THERAPY	17, 156	232, 742	0. 073713	3		76. 98
76. 99 07699 LI THOT	TRI PSY	0	0	0.000000			76. 99
OUTPATIENT S	SERVICE COST CENTERS						
91. 00 09100 EMERGE	ENCY	2, 700, 759	23, 330, 308	0. 115762	2		91. 00
92. 00 09200 OBSER\	VATION BEDS (NON-DISTINCT PART	1, 486, 490	1, 651, 499	0. 900085	5		92. 00
OTHER REIMBU	URSABLE COST CENTERS						
95. 00 09500 AMBULA	ANCE SERVICES	5, 669, 380	11, 425, 430	0. 496207	'		95. 00
SPECIAL PURP	POSE COST CENTERS						
113. 00 11300 I NTERE	EST EXPENSE						113. 00
200. 00 Subtot	tal (sum of lines 50 thru 199)	31, 865, 729	170, 572, 980				200.00
201.00 Less 0	Observation Beds	1, 486, 490	0				201. 00
202. 00 Total	(line 200 minus line 201)	30, 379, 239	170, 572, 980				202. 00

Health Financial Systems	HUNTINGTON MEMO	RIAL HOSPITAL		In Lie	In Lieu of Form CMS-2552-10		
APPORTIONMENT OF INPATIENT ROUTINE SERVICE CAPITAL	COSTS	Provi der C		Peri od:	Worksheet D		
				From 01/01/2017 To 12/31/2017		namad.	
				10 12/31/2017	Date/Time Pre 5/30/2018 9:2		
		Title	xVIII	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 Cost				
	Part II, col.		(col. 1 - col				
	26)		2)				
	1. 00	2. 00	3.00	4. 00	5. 00		
INPATIENT ROUTINE SERVICE COST CENTERS							
30. 00 ADULTS & PEDIATRICS	564, 035	0	564, 03	5, 743	98. 21	30.00	
43. 00 NURSERY	15, 380		15, 38	0 731	21. 04	43.00	
200.00 Total (lines 30 through 199)	579, 415		579, 41	5 6, 474		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	1, 571	154, 288				30.00	
43. 00 NURSERY	0	0	)			43.00	
200.00 Total (lines 30 through 199)	1, 571	154, 288				200.00	

Heal th	Financial Systems	HUNTINGTON MEMO	ORIAL HOSPITAL		In Lie	u of Form CMS-2	2552-10
	TIONMENT OF INPATIENT ANCILLARY SERVICE CAPITA	AL COSTS	Provi der C		Period: From 01/01/2017 To 12/31/2017	Worksheet D Part II Date/Time Pre 5/30/2018 9:2	
			Titl∈	XVIII	Hospi tal	PPS	
	Cost Center Description	Capital Related Cost (from Wkst. B,	Total Charges (from Wkst. C, Part I, col.	to Charges (col. 1 ÷ col	Program	Capital Costs (column 3 x column 4)	
		Part II, col. 26)	8)	2)			
		1.00	2.00	3.00	4. 00	5. 00	
	ANCILLARY SERVICE COST CENTERS						
50.00	05000 OPERATING ROOM	263, 438	22, 628, 254	0. 01164	1, 937, 594	22, 557	50.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	65, 005	4, 060, 330	0. 01601	0 1, 264	20	52.00
53.00	05300 ANESTHESI OLOGY	52, 571	3, 663, 305	0. 01435	51 0	0	53.00
54.00	05400 RADI OLOGY-DI AGNOSTI C	486, 191	36, 851, 313	0. 01319	1, 440, 168	19, 000	54.00
60.00	06000 LABORATORY	180, 564	17, 998, 878	0. 01003	1, 149, 025	11, 527	60.00
62. 30	06250 BLOOD CLOTTING FOR HEMOPHILIACS	0	O	0.00000	00	0	62. 30
65.00	06500 RESPI RATORY THERAPY	101, 772				9, 368	65.00
66.00	06600 PHYSI CAL THERAPY	125, 439	4, 601, 216	0. 02726	247, 323	6, 743	66. 00
	06700 OCCUPATI ONAL THERAPY	21, 030					
	06800 SPEECH PATHOLOGY	6, 150	379, 086	0. 01622	12, 002	195	68. 00
69. 00	06900 ELECTROCARDI OLOGY	21	1, 178, 801	0. 00001	8 407, 813	7	69. 00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	66, 671	12, 505, 911	0.00533	691, 152	3, 685	71. 00
72.00	07200 I MPL. DEV. CHARGED TO PATIENTS	77, 492	6, 844, 739	0. 01132	1, 755, 405	19, 873	72. 00
73.00	07300 DRUGS CHARGED TO PATIENTS	279, 191	15, 280, 436	0. 01827	1, 484, 421	27, 122	73.00
76. 97	07697 CARDIAC REHABILITATION	0	0	0.00000	0 0	0	76. 97
76. 98	07698 HYPERBARI C OXYGEN THERAPY	883	232, 742	0.00379	04	0	76. 98
76. 99	07699 LI THOTRI PSY	0	0	0.00000	0 0	0	76. 99
	OUTPATIENT SERVICE COST CENTERS						
91.00	09100 EMERGENCY	179, 380	23, 330, 308	0. 00768	1, 134, 255	8, 721	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART	118, 739	1, 651, 499	0. 07189	0 8	0	92.00
	OTHER REIMBURSABLE COST CENTERS						
95 00	109500 AMBULANCE SERVICES		I	[	1		95 00

2, 024, 537

159, 147, 550

10, 929, 812

129, 844 200. 00

95.00

95. 00 | 09500 | AMBULANCE SERVICES 200. 00 | Total (Lines 50 through 199)

Health Financial Systems	HUNTINGTON MEMO	RIAL HOSPITAL		In Lie	eu of Form CMS-2	2552-10
APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER F	ASS THROUGH COST	rs Provider CO		Period: From 01/01/2017 To 12/31/2017		pared: 5 am
			XVIII	Hospi tal	PPS	
Cost Center Description	Post-Stepdown Adjustments	<u> </u>	Post-Stepdowr Adjustments		All Other Medical Education Cost	
	1A	1. 00	2A	2. 00	3. 00	
INPATIENT ROUTINE SERVICE COST CENTERS						
30. 00   03000   ADULTS & PEDI ATRI CS	0	0		0	0	
43. 00   04300   NURSERY	0	0		0	0	
200.00 Total (lines 30 through 199)	0	0		0 0		200. 00
Cost Center Description	Swi ng-Bed	Total Costs		Per Diem (col.	Inpati ent	
	Adjustment	(sum of cols.	Days	5 ÷ col. 6)	Program Days	
	Amount (see	1 through 3,				
		minus col. 4)				
	4. 00	5. 00	6. 00	7. 00	8. 00	
INPATIENT ROUTINE SERVICE COST CENTERS	_	_				
30. 00   03000   ADULTS & PEDI ATRI CS	0	0	5, 74			
43. 00   04300   NURSERY		0	73			
200.00   Total (lines 30 through 199)		0	6, 47	4	1, 571	200. 00
Cost Center Description	I npati ent					
	Program					
	Pass-Through					
	Cost (col. 7 x					
	col. 8) 9.00					
INPATIENT ROUTINE SERVICE COST CENTERS	9.00					
30. 00 03000 ADULTS & PEDIATRICS						30.00
43. 00   03000   ADDLIS & PEDIATRICS	0					43. 00
200.00 Total (lines 30 through 199)	0					200. 00
200.00   Total (Tries 30 tillough 199)	1					1200.00

Health Financial Systems	ealth Financial Systems HUNTINGTON MEMORI		In Lie	u of Form CMS-2552-10
APPORTIONMENT OF INPATIENT/OUTPATIENT THROUGH COSTS	ANCILLARY SERVICE OTHER PASS	Provi der CCN: 15-0091	Peri od: From 01/01/2017 To 12/31/2017	Worksheet D Part IV Date/Time Prepared:

						5/30/2018 9:2	5 am
				XVIII	Hospi tal	PPS	
	Cost Center Description	Non Physician	Nursing School	Nursing School	Allied Health	Allied Health	
		Anesthetist	Post-Stepdown		Post-Stepdown		
		Cost	Adjustments		Adjustments		
		1.00	2A	2.00	3A	3. 00	
	ANCILLARY SERVICE COST CENTERS						
50.00	05000 OPERATI NG ROOM	0	0	(	0	0	50.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0	0	(	0	0	52.00
53.00	05300 ANESTHESI OLOGY	0	0	(	0	0	53.00
54.00	05400 RADI OLOGY-DI AGNOSTI C	0	0	(	o	0	54.00
60.00	06000 LABORATORY	0	0		o	0	60.00
62. 30	06250 BLOOD CLOTTING FOR HEMOPHILIACS	0	0		o	0	62. 30
65. 00	06500 RESPI RATORY THERAPY	0	0		o	0	65. 00
66.00	06600 PHYSI CAL THERAPY	0	l o	(	o	0	66.00
67.00	06700 OCCUPATI ONAL THERAPY	0	l o	(	o	0	67. 00
68. 00	06800 SPEECH PATHOLOGY	0	0		o	0	68. 00
69. 00	06900 ELECTROCARDI OLOGY	0	0		o	0	69.00
71. 00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0	0		o	0	71. 00
	07200 IMPL. DEV. CHARGED TO PATIENTS	0	0		0	0	72. 00
	07300 DRUGS CHARGED TO PATIENTS	0	0		0	0	73. 00
	07697 CARDI AC REHABI LI TATI ON	0	0		0	0	76. 97
	07698 HYPERBARI C OXYGEN THERAPY	0	0		0	0	76. 98
	07699 LI THOTRI PSY	0	0		0	0	76. 99
70.77	OUTPATIENT SERVICE COST CENTERS				,		70.77
91. 00	09100 EMERGENCY	0	0	(	0	0	91. 00
	09200 OBSERVATION BEDS (NON-DISTINCT PART	0	Ĭ			0	92.00
72.00	OTHER REIMBURSABLE COST CENTERS				4	<u> </u>	72.00
95. 00	09500 AMBULANCE SERVI CES						95.00
200.00		0	1			0	200. 00
200.00	1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1	1	1	1	٦ ٧	1	1-00.00

Health Financial Systems	HUNTI NGTON MEMOR	RLAL HOSPITAL		In Lie	u of Form CMS-2	2552-10
APPORTIONMENT OF INPATIENT/OUTPATIENT ANCITHROUGH COSTS	LLARY SERVICE OTHER PASS	Provider Co		Period: From 01/01/2017 To 12/31/2017	Worksheet D Part IV Date/Time Prep 5/30/2018 9:29	pared:
		Title	: XVIII	Hospi tal	PPS	
Cost Center Description	All Other Medical	Total Cost (sum of col 1	Total Outpati ent	Total Charges (from Wkst. C,	Ratio of Cost to Charges	
	Education Cost	through col.	Cost (sum of		(col. 5 ÷ col.	
		4)	col. 2, 3 and		7)	
			4)			
	4. 00	5.00	6.00	7. 00	8. 00	
ANCILLARY SERVICE COST CENTERS						

	Cost Center Description	All Other	Total Cost	Total	Total Charges	Ratio of Cost	
		Medi cal	(sum of col 1		(from Wkst. C,		
		Education Cost	through col.	Cost (sum of		(col. 5 ÷ col.	
			4)	col. 2, 3 and	8)	7)	
				4)			
		4. 00	5. 00	6. 00	7. 00	8. 00	
	ANCI LLARY SERVI CE COST CENTERS			,	ı		
50. (		0	0	0	22, 628, 254		1
52. (	00  05200 DELIVERY ROOM & LABOR ROOM	0	0	0	4, 060, 330	0.000000	52.00
53. (	00 05300 ANESTHESI OLOGY	0	0	0	3, 663, 305	0.000000	53. 00
54. (	00 05400 RADI OLOGY-DI AGNOSTI C	0	0	0	36, 851, 313	0.000000	54. 00
60. (	00  06000  LABORATORY	0	0	0	17, 998, 878	0.000000	60.00
62. 3	06250 BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0	0	0.000000	62. 30
65. (	00 06500 RESPIRATORY THERAPY	0	0	0	6, 517, 564	0.000000	65. 00
66. (	00 06600 PHYSI CAL THERAPY	0	0	0	4, 601, 216	0.000000	66. 00
67. (	00 06700 OCCUPATIONAL THERAPY	0	0	0	1, 423, 168	0.000000	67. 00
68. (	00 06800 SPEECH PATHOLOGY	0	0	0	379, 086	0.000000	68. 00
69. (	00 06900 ELECTROCARDI OLOGY	0	0	0	1, 178, 801	0.000000	69. 00
71. (	00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	12, 505, 911	0.000000	71. 00
72. (	00 07200 IMPL. DEV. CHARGED TO PATIENTS	0	0	0	6, 844, 739	0.000000	72. 00
73. (	00 07300 DRUGS CHARGED TO PATIENTS	0	0	0	15, 280, 436	0. 000000	73. 00
76.	07 07697 CARDIAC REHABILITATION	0	0	0	0	0. 000000	76, 97
76.	07698 HYPERBARIC OXYGEN THERAPY	0	0	0	232, 742		1
76.	9 07699 LI THOTRI PSY	0	0	0	0	0.000000	76, 99
	OUTPATIENT SERVICE COST CENTERS			_	_		
91. (		0	0	0	23, 330, 308	0.000000	91. 00
92. (		0	0	0	1, 651, 499	1	1
	OTHER REIMBURSABLE COST CENTERS		-	_	., ., ., ., ., ., ., ., ., ., ., ., ., .		
95. (	00 09500 AMBULANCE SERVI CES						95. 00
200.		0	ი	0	159, 147, 550		200.00
_00.	(	1	ľ		, , , 000		

Health Financial Systems	HUNTI NGTON MEMOR				eu of Form CMS-:	2552-10
APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SE	RVICE OTHER PASS	Provi der Co		Period: From 01/01/2017	Worksheet D	
THROUGH COSTS				To 12/31/2017		nared:
				12, 01, 201,	5/30/2018 9: 2	5 am
		Title	XVIII	Hospi tal	PPS	
Cost Center Description	Outpati ent	Inpati ent	Inpati ent	Outpati ent	Outpati ent	
	Ratio of Cost	Program	Program	Program	Program	
	to Charges	Charges	Pass-Through		Pass-Through	
	(col. 6 ÷ col.		Costs (col. 8	3	Costs (col. 9	
	7)		x col. 10)		x col. 12)	
	9. 00	10.00	11. 00	12. 00	13. 00	
ANCILLARY SERVICE COST CENTERS					,	
50.00   05000   OPERATING ROOM	0. 000000	1, 937, 594	•	0 4, 009, 607	0	00.00
52.00  05200   DELIVERY ROOM & LABOR ROOM	0. 000000	1, 264		0	0	52. 00
53. 00   05300   ANESTHESI OLOGY	0. 000000	0		0	0	53. 00
54. 00   05400   RADI OLOGY-DI AGNOSTI C	0. 000000	1, 440, 168		0 7, 597, 871	0	54. 00
60. 00  06000  LABORATORY	0. 000000	1, 149, 025		0 311, 110	0	60.00
62.30 06250 BLOOD CLOTTING FOR HEMOPHILIACS	0. 000000	0		0 0	0	62. 30
65. 00 06500 RESPIRATORY THERAPY	0. 000000	599, 957		0 881, 681	0	65. 00
66. 00  06600 PHYSI CAL THERAPY	0. 000000	247, 323		0 0	0	66. 00
67. 00 06700 OCCUPATI ONAL THERAPY	0. 000000	69, 433		0 0	0	67. 00
68. 00 06800 SPEECH PATHOLOGY	0. 000000	12, 002		0 0	0	68. 00
69. 00 06900 ELECTROCARDI OLOGY	0. 000000	407, 813		0 400, 478	0	69. 00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0. 000000	691, 152		0 522, 944	0	71. 00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0. 000000	1, 755, 405		0 155, 283	0	72. 00
73.00 07300 DRUGS CHARGED TO PATIENTS	0. 000000	1, 484, 421		0 3, 334, 437	0	73.00
76. 97 07697 CARDIAC REHABILITATION	0. 000000	0		0 0	0	76. 97
76. 98 07698 HYPERBARI C OXYGEN THERAPY	0. 000000	0		0 0	0	76. 98
76. 99 07699 LI THOTRI PSY	0. 000000	0		0 0	0	76. 99
OUTPATIENT SERVICE COST CENTERS						
01 00 00100 EMERCENCY	0.000000	1 12/ 255		0 2 450 010	0	01 00

0. 000000

0. 000000

1, 134, 255

10, 929, 812

3, 458, 019 1, 255, 438

21, 926, 868

0 91.00

0 92.00

95. 00 0 200. 00

0

0

95. 00 | 09500 | AMBULANCE SERVICES 200. 00 | Total (Lines 50 through 199)

Health Financial Systems	HUNTINGTON MEMORIA	In Lieu	of Form CMS-2552-10	
APPORTI ONMENT OF MEDICAL,	OTHER HEALTH SERVICES AND VACCINE COST	Provider CCN: 15-0091	Peri od: From 01/01/2017	Worksheet D Part V

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST		Provider Co	Provider CCN: 15-0091		Part V Date/Time Prepared:		
						5/30/2018 9: 2	5 am
	,		Title	XVIII	Hospi tal	PPS	
				Charges	_	Costs	
	Cost Center Description	Cost to Charge	PPS Reimbursed	Cost	Cost	PPS Services	
		Ratio From	Servi ces (see	Rei mbursed	Rei mbursed	(see inst.)	
		Worksheet C,	inst.)	Servi ces	Services Not		
		Part I, col. 9		Subject To	Subject To		
				Ded. & Coins.			
		1.00	0.00	(see inst.)	(see inst.)		
	ANOLILIABLE OFFICE OFFICE	1.00	2. 00	3. 00	4. 00	5. 00	
	ANCILLARY SERVICE COST CENTERS				_		
	05000 OPERATING ROOM	0. 095016			0	380, 977	
	05200 DELIVERY ROOM & LABOR ROOM	0. 311444	-		0	0	
	05300 ANESTHESI OLOGY	0. 280431	-		0	0	53. 00
	05400 RADI OLOGY-DI AGNOSTI C	0. 093767			0	712, 430	
	06000 LABORATORY	0. 189546			0	58, 970	1
	06250 BLOOD CLOTTING FOR HEMOPHILIACS	0. 000000			0	0	62. 30
	06500 RESPI RATORY THERAPY	0. 220323			0	194, 255	1
	06600 PHYSI CAL THERAPY	0. 383395			0	0	
	06700 OCCUPATI ONAL THERAPY	0. 287796	0		0	0	67. 00
68. 00	06800 SPEECH PATHOLOGY	0. 315994	0		0	0	68. 00
69.00	06900 ELECTROCARDI OLOGY	0. 000129	400, 478		0	52	69. 00
71. 00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0. 098239	522, 944		0	51, 373	71. 00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0. 221186	155, 283		0	34, 346	72. 00
73.00	07300 DRUGS CHARGED TO PATIENTS	0. 275573	3, 334, 437		0	918, 881	73. 00
76. 97	07697 CARDIAC REHABILITATION	0. 000000	0		0	0	76. 97
76. 98	07698 HYPERBARI C OXYGEN THERAPY	0. 073713	0		0	0	76. 98
76. 99	07699 LI THOTRI PSY	0. 000000	0		0	0	76. 99
	OUTPATIENT SERVICE COST CENTERS	*			*		1
91.00	09100 EMERGENCY	0. 115762	3, 458, 019		0 0	400, 307	91. 00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART	0. 900085	1, 255, 438		0 0	1, 130, 001	92.00
	OTHER REIMBURSABLE COST CENTERS	<u>'</u>		•	<u>'</u>		1
95.00	09500 AMBULANCE SERVICES	0. 496207			0		95. 00
200.00			21, 926, 868		0	3, 881, 592	200.00
201.00			, ,		0 0		201. 00
	Only Charges						
202.00			21, 926, 868	1	0	3, 881, 592	202. 00

Health Financial Systems	HUNTINGTON MEMO	ORIAL HOSPITAL		In Lie	u of Form CMS-2	2552-10
APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES			CN: 15-0091	Peri od: From 01/01/2017 To 12/31/2017	Worksheet D Part V Date/Time Prepared: 5/30/2018 9:25 am	
		Title	XVIII	Hospi tal	PPS	
	Co	sts				
Cost Center Description	Cost Reimbursed Services Subject To	Cost Reimbursed Services Not Subject To				

	Co	sts		
Cost Center Description	Cost	Cost		
	Rei mbursed	Rei mbursed		
	Servi ces	Servi ces Not		
	Subject To	Subject To		
	Ded. & Coins.	Ded. & Coins.		
	(see inst.)	(see inst.)		
	6.00	7.00		
ANCILLARY SERVICE COST CENTERS				
50.00 05000 OPERATING ROOM	C	0		50. 00
52.00 05200 DELIVERY ROOM & LABOR ROOM	C	0		52.00
53. 00   05300   ANESTHESI OLOGY		ol o		53.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	C	ol o	)	54. 00
60. 00   06000   LABORATORY		ol o		60.00
62.30 06250 BLOOD CLOTTING FOR HEMOPHILIACS		ol o		62. 30
65. 00 06500 RESPIRATORY THERAPY		ol o		65. 00
66. 00 06600 PHYSI CAL THERAPY		ol o		66.00
67. 00 06700 OCCUPATI ONAL THERAPY		ol o		67. 00
68. 00 06800 SPEECH PATHOLOGY		ol o		68. 00
69. 00 06900 ELECTROCARDI OLOGY				69.00
71. 00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT				71. 00
72. 00 07200 IMPL. DEV. CHARGED TO PATIENTS				72. 00
73. 00 07300 DRUGS CHARGED TO PATIENTS				73. 00
76. 97 07697 CARDIAC REHABILITATION		ol o		76. 97
76. 98 07698 HYPERBARI C OXYGEN THERAPY		ol o		76, 98
76. 99 07699 LI THOTRI PSY		ol o		76, 99
OUTPATIENT SERVICE COST CENTERS				
91. 00 09100 EMERGENCY	C	0		91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART		ol o		92.00
OTHER REIMBURSABLE COST CENTERS	•			
95. 00 09500 AMBULANCE SERVICES	C			95. 00
200.00 Subtotal (see instructions)		ol o	)	200. 00
201.00 Less PBP Clinic Lab. Services-Program				201. 00
Only Charges				
202.00   Net Charges (line 200 - line 201)	c	o	)	202. 00

Health Financial Systems	HUNTINGTON MEMORIAL HOSPITAL			In Lieu of Form CMS-2552-10			
APPORTIONMENT OF INPATIENT ROUTINE SERVICE CAPITAL	. COSTS Provi d			Peri od:	Worksheet D		
				From 01/01/2017 To 12/31/2017		narod:	
				10 12/31/2017	5/30/2018 9: 2		
		Ti tI	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 Cost				
	Part II, col.		(col. 1 - col				
	26)		2)				
	1. 00	2. 00	3.00	4. 00	5. 00		
INPATIENT ROUTINE SERVICE COST CENTERS							
30. 00 ADULTS & PEDIATRICS	564, 035	0	564, 03	5, 743	98. 21	30. 00	
43. 00 NURSERY	15, 380		15, 38	0 731	21.04	43.00	
200.00 Total (lines 30 through 199)	579, 415		579, 41	5 6, 474		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	79	7, 759				30. 00	
43. 00 NURSERY	35	736				43. 00	
200.00 Total (lines 30 through 199)	114	8, 495				200. 00	

Health Financial Systems	HUNTI NGTON MEMO			In Lie	u of Form CMS-2	<u> 2552-10</u>
APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAP	TAL COSTS	Provi der C	Provider CCN: 15-0091		Worksheet D	
				From 01/01/2017 To 12/31/2017	Part II Date/Time Pre	nared:
				10 12/31/2017	5/30/2018 9: 2	5 am
		Ti tl	e XIX	Hospi tal	PPS	
Cost Center Description	Capi tal	Total Charges			Capital Costs	
	Related Cost	(from Wkst. C,		Program	(column 3 x	
	(from Wkst. B,	Part I, col.	(col. 1 ÷ col	. Charges	column 4)	
	Part II, col.	8)	2)			
	26)					
	1.00	2.00	3. 00	4. 00	5. 00	
ANCILLARY SERVICE COST CENTERS						
50.00   05000   OPERATING ROOM	263, 438	22, 628, 254			7, 840	
52.00   05200   DELIVERY ROOM & LABOR ROOM	65, 005	4, 060, 330	0. 01601	0 264, 082	4, 228	52. 00
53. 00   05300   ANESTHESI OLOGY	52, 571	3, 663, 305	0. 01435	164, 775	2, 365	53. 00
54. 00   05400   RADI OLOGY-DI AGNOSTI C	486, 191	36, 851, 313	0. 01319	113, 916	1, 503	54.00
60. 00   06000   LABORATORY	180, 564	17, 998, 878	0. 01003	136, 456	1, 369	60.00
62. 30 06250 BLOOD CLOTTING FOR HEMOPHILIACS	C	C	0.00000	0 0	0	62. 30
65. 00 06500 RESPIRATORY THERAPY	101, 772	6, 517, 564	0. 01561	5 34, 909	545	65.00
66. 00 06600 PHYSI CAL THERAPY	125, 439	4, 601, 216	0. 02726	11, 199	305	66.00
67. 00 06700 OCCUPATI ONAL THERAPY	21, 030	1, 423, 168	0. 01477	7 304	4	67.00
68. 00 06800 SPEECH PATHOLOGY	6, 150	379, 086	0. 01622	23 0	0	68. 00
69. 00 06900 ELECTROCARDI OLOGY	21	1, 178, 801	0. 00001	8 1, 422	0	69.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	66, 671	12, 505, 911	0.00533	187, 154	998	71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	77, 492			190, 105	2, 152	72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	279, 191	15, 280, 436	0. 01827	1 229, 787	4, 198	73.00
76. 97 07697 CARDI AC REHABI LI TATI ON		1 ' '	0.00000		0	76. 97
76. 98 07698 HYPERBARI C OXYGEN THERAPY	883	232, 742	•		0	76. 98
76. 99   07699 LI THOTRI PSY		1	0.00000		0	76. 99
OUTPATIENT SERVICE COST CENTERS			3. 23000		0	1 ,
91. 00 09100 EMERGENCY	179, 380	23, 330, 308	0. 00768	77, 976	600	91.00
92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART	118, 739		•		0	92.00
OTHER REIMBURSABLE COST CENTERS		., ., , . , , , , , , , , , , , , ,	2.27.07		0	1
95. 00 09500 AMBULANCE SERVI CES						95.00

2, 024, 537

159, 147, 550

2, 085, 492

26, 107 200. 00

95.00

95. 00 | 09500 | AMBULANCE SERVICES 200. 00 | Total (Lines 50 through 199)

Health Financial Systems	HUNTI NGTON MEMO	RIAL HOSPITAL		In Lie	u of Form CMS-:	2552-10
APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER P.	ASS THROUGH COST			Period: From 01/01/2017 To 12/31/2017	Worksheet D Part III Date/Time Pre 5/30/2018 9:2	pared: 5 am
			e XIX	Hospi tal	PPS	
Cost Center Description	Nursing School Post-Stepdown Adjustments	Nursing School	Allied Health Post-Stepdown Adjustments		All Other Medical Education Cost	
	1A	1.00	2A	2. 00	3. 00	
INPATIENT ROUTINE SERVICE COST CENTERS						
30. 00   03000   ADULTS & PEDI ATRI CS 43. 00   04300   NURSERY	0	0		0 0 0	0	30. 00 43. 00
200.00 Total (lines 30 through 199)	0	0		0 0	0	200.00
Cost Center Description	Swing-Bed Adjustment Amount (see instructions)	Total Costs (sum of cols. 1 through 3, minus col. 4)	Total Patien Days	Per Diem (col. 5 ÷ col. 6)	Inpatient Program Days	
	4.00	5.00	6.00	7. 00	8. 00	
INPATIENT ROUTINE SERVICE COST CENTERS						
30. 00   03000   ADULTS & PEDIATRICS 43. 00   04300   NURSERY 200. 00   Total (lines 30 through 199)	0	0	5, 74 73 6, 47	0.00		
Cost Center Description	Inpatient Program Pass-Through Cost (col. 7 x col. 8) 9.00					
I NPATI ENT ROUTI NE SERVI CE COST CENTERS						
30.00   03000   ADULTS & PEDIATRICS 43.00   04300   NURSERY 200.00   Total (lines 30 through 199)	0 0					30. 00 43. 00 200. 00

Health Financial Systems	HUNTINGTON MEMORIA	AL HOSPITAL	In Lie	u of Form CMS-2552-10
APPORTIONMENT OF INPATIENT/OUTPATIENT THROUGH COSTS	ANCILLARY SERVICE OTHER PASS	Provi der CCN: 15-0091	Peri od: From 01/01/2017 To 12/31/2017	Worksheet D Part IV Date/Time Prepared:

						5/30/2018 9: 2	5 am
				e XIX	Hospi tal	PPS	
	Cost Center Description		Nursing School	Nursing School		Allied Health	
		Anesthetist	Post-Stepdown		Post-Stepdown		
		Cost	Adjustments		Adjustments		
		1.00	2A	2. 00	3A	3. 00	
	ANCILLARY SERVICE COST CENTERS						
50.00	05000 OPERATI NG ROOM	0	0	(	0	0	50.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0	0	(	0	0	52. 00
53.00	05300 ANESTHESI OLOGY	0	0	(	0	0	53. 00
54.00	05400  RADI OLOGY-DI AGNOSTI C	0	0	(	0	0	54.00
60.00	06000 LABORATORY	0	0	(	0	0	60.00
62. 30	06250 BLOOD CLOTTING FOR HEMOPHILIACS	0	0	(	0	0	62. 30
65.00	06500 RESPI RATORY THERAPY	0	0	(	0	0	65. 00
66.00	06600 PHYSI CAL THERAPY	0	0	(	0	0	66. 00
67. 00	06700 OCCUPATI ONAL THERAPY	0	0	(	ol ol	0	67. 00
68. 00	06800 SPEECH PATHOLOGY	0	0	(	ol ol	0	68. 00
69. 00	06900 ELECTROCARDI OLOGY	0	0	(	ol ol	0	69. 00
71. 00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0	0		ol ol	0	71. 00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0	0		ol ol	0	72. 00
73.00	07300 DRUGS CHARGED TO PATIENTS	0	0		ol ol	0	73. 00
76. 97	07697 CARDI AC REHABI LI TATI ON	0	0		ol ol	0	76. 97
76. 98	07698 HYPERBARI C OXYGEN THERAPY	0	0		ol ol	0	76. 98
76. 99	07699 LI THOTRI PSY	0	0		ol ol	0	76. 99
	OUTPATIENT SERVICE COST CENTERS		•		<u>'</u>		
91. 00	09100 EMERGENCY	0	0		0	0	91. 00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART	0				0	92. 00
	OTHER REIMBURSABLE COST CENTERS						
95. 00	09500 AMBULANCE SERVICES						95. 00
200.00	1	0	0		ol ol	0	200. 00
		1	1	'	٠,	ŭ	1===:00

Health Financial Systems	HUNTI NGTON MEMOR	RIAL HOSPITAL		In Lie	u of Form CMS-2	2552-10
APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLATHROUGH COSTS	ARY SERVICE OTHER PASS	Provi der CC		Period: From 01/01/2017 To 12/31/2017	Worksheet D Part IV Date/Time Pre 5/30/2018 9:2	
		Ti tl	e XIX	Hospi tal	PPS	_
Cost Center Description		Total Cost (sum of col 1	Total Outpatient	(from Wkst. C,		
	Education Cost	through col. 4)	Cost (sum of col. 2, 3 and	· ·	(col. 5 ÷ col. 7)	

					5/30/2018 9:2	o alli
		Ti tl	e XIX	Hospi tal	PPS	
Cost Center Description	All Other	Total Cost	Total	Total Charges	Ratio of Cost	
	Medi cal	(sum of col 1	Outpati ent	(from Wkst. C,	to Charges	
	Education Cost	through col.	Cost (sum of	Part I, col.	(col. 5 ÷ col.	
		4)	col. 2, 3 and	8)	7)	
			4)			
	4.00	5. 00	6. 00	7. 00	8. 00	
ANCILLARY SERVICE COST CENTERS						
50.00   05000   OPERATING ROOM	0	0	C	22, 628, 254		50.00
52.00   05200   DELIVERY ROOM & LABOR ROOM	0	0	C	4, 060, 330	0.000000	52. 00
53. 00   05300   ANESTHESI OLOGY	0	0	C	3, 663, 305		
54. 00   05400   RADI OLOGY-DI AGNOSTI C	0	0	C	36, 851, 313		54. 00
60. 00   06000   LABORATORY	0	0	C	17, 998, 878	0.000000	60.00
62.30 06250 BLOOD CLOTTING FOR HEMOPHILIACS	0	0	C	0	0.000000	62. 30
65. 00 06500 RESPIRATORY THERAPY	0	0	C	6, 517, 564	0.000000	65. 00
66. 00 06600 PHYSI CAL THERAPY	0	0	C	4, 601, 216	0.000000	66. 00
67. 00 06700 OCCUPATI ONAL THERAPY	0	0	C	1, 423, 168	0.000000	67. 00
68.00 06800 SPEECH PATHOLOGY	0	0	C	379, 086	0.000000	68. 00
69. 00 06900 ELECTROCARDI OLOGY	0	0	C	1, 178, 801	0.000000	69. 00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	C	12, 505, 911	0.000000	71. 00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0	0	C	6, 844, 739	0.000000	72. 00
73.00 07300 DRUGS CHARGED TO PATIENTS	0	0	C	15, 280, 436	0.000000	73. 00
76. 97 07697 CARDIAC REHABILITATION	0	0	C	0	0.000000	76. 97
76. 98 07698 HYPERBARI C OXYGEN THERAPY	0	0	C	232, 742	0.000000	76. 98
76. 99 07699 LI THOTRI PSY	0	0	C	0	0.000000	76. 99
OUTPATIENT SERVICE COST CENTERS						
91. 00 09100 EMERGENCY	0	0	C	23, 330, 308	0.000000	91. 00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART	0	0	C	1, 651, 499	0.000000	92.00
OTHER REIMBURSABLE COST CENTERS						
95. 00 09500 AMBULANCE SERVICES						95. 00
200.00 Total (lines 50 through 199)	0	0	C	159, 147, 550		200. 00
	•	•			•	•

Heal th	Financial Systems	HUNTI NGTON MEMOR	IAL HOSPITAL		In Lie	eu of Form CMS-2	2552-10
APPORT	TIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SEI SH COSTS	RVICE OTHER PASS	Provi der CC		Period: From 01/01/2017 To 12/31/2017	Worksheet D Part IV Date/Time Pre 5/30/2018 9:2	
				e XIX	Hospi tal	PPS	
	Cost Center Description	Outpatient Ratio of Cost to Charges (col. 6 ÷ col. 7)	Inpatient Program Charges	Inpatient Program Pass-Through Costs (col. 8 x col. 10)		Outpatient Program Pass-Through Costs (col. 9 x col. 12)	
		9. 00	10.00	11.00	12.00	13.00	
	ANCILLARY SERVICE COST CENTERS	<u>.                                      </u>			*		
50.00	05000 OPERATING ROOM	0. 000000	673, 407		0 0	0	50.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0. 000000	264, 082		0 0	0	52. 00
53.00	05300 ANESTHESI OLOGY	0. 000000	164, 775		0	0	
54.00	05400 RADI OLOGY-DI AGNOSTI C	0. 000000	113, 916		0	0	54. 00
60.00	06000 LABORATORY	0. 000000	136, 456		0 0	0	60.00
62. 30	06250 BLOOD CLOTTING FOR HEMOPHILIACS	0. 000000	0		0	0	62. 30
65.00	06500 RESPI RATORY THERAPY	0. 000000	34, 909		0	0	65. 00
66. 00	06600 PHYSI CAL THERAPY	0. 000000	11, 199		0	0	66. 00
67. 00	06700 OCCUPATI ONAL THERAPY	0. 000000	304		0	0	67. 00
68. 00	06800 SPEECH PATHOLOGY	0. 000000	0		0	0	68. 00
69. 00	06900 ELECTROCARDI OLOGY	0. 000000	1, 422		0 0	0	
71. 00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0. 000000	187, 154		0	0	
72. 00	07200 I MPL. DEV. CHARGED TO PATIENTS	0. 000000	190, 105		0	0	72. 00
73.00	07300 DRUGS CHARGED TO PATIENTS	0. 000000	229, 787		0 0	0	73. 00
76. 97	07697 CARDIAC REHABILITATION	0. 000000	0		0 0	0	76. 97
76. 98	07698 HYPERBARI C OXYGEN THERAPY	0. 000000	0		0 0	0	76. 98
76. 99	07699 LI THOTRI PSY	0. 000000	0		0 0	0	76. 99
	OUTPATIENT SERVICE COST CENTERS						
91.00	09100 EMERGENCY	0. 000000	77, 976		0 0	0	91. 00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART	0. 000000	0		0 0	0	92. 00
	OTHER REIMBURSABLE COST CENTERS						
95.00	09500 AMBULANCE SERVICES						95. 00

2, 085, 492

0

0

95. 00 0 200. 00

95. 00 | 09500 | AMBULANCE SERVICES 200. 00 | Total (Lines 50 through 199)

Health Financial Systems	HUNTINGTON MEMORIA	L HOSPITAL		In Lieu of Form CMS-2552-10
APPORTIONMENT OF MEDICAL.	OTHER HEALTH SERVICES AND VACCINE COST	Provider CCN: 15-0091	Peri od:	Worksheet D

Heal th	Financial Systems	HUNIINGION MEMO	RIAL HOSPITAL		In Lie	eu of Form CMS-2	2552-10
APPORT	IONMENT OF MEDICAL, OTHER HEALTH SERVICES AND	VACCINE COST	Provi der Co	CN: 15-0091	Peri od:	Worksheet D	
					From 01/01/2017		
					To 12/31/2017		
			T: +1	e XIX	Hospi tal	5/30/2018 9: 2 PPS	o alli
			11 (1	Charges	поѕрі таі	Costs	
	Cost Center Description	Cost to Charge	DDC Doimburged		Cost	PPS Services	
	cost center bescription	Ratio From	Services (see	Rei mbursed	Rei mbursed	(see inst.)	
		Worksheet C,	inst.)	Servi ces	Services Not	(See Hist.)	
		Part I, col. 9		Subject To	Subject To		
		Tart 1, Cor. 7		Ded. & Coins.			
				(see inst.)	(see inst.)		
		1. 00	2.00	3.00	4. 00	5. 00	
	ANCILLARY SERVICE COST CENTERS	1.00	2.00	3.00	4.00	3.00	
	05000 OPERATING ROOM	0. 095016		924, 07	3 0	0	50.00
	05200 DELIVERY ROOM & LABOR ROOM	0. 311444		724,07	0	٥	52.00
	05300 ANESTHESI OLOGY	0. 280431			0	1	53.00
	05400 RADI OLOGY-DI AGNOSTI C	0. 280431		1, 299, 05	6	0	
	06000 LABORATORY	0. 093767	0			0	1
	06250 BLOOD CLOTTING FOR HEMOPHILIACS	0. 189340	l .	033, 70	0	0	1
	06500 RESPIRATORY THERAPY	0. 220323		100.00	0	0	65. 00
				108, 89		0	
	06600 PHYSI CAL THERAPY	0. 383395		225, 12		0	66.00
	06700 OCCUPATI ONAL THERAPY	0. 287796	l e	143, 84		0	67. 00
	06800 SPEECH PATHOLOGY	0. 315994		45, 30		0	68. 00
	06900 ELECTROCARDI OLOGY	0. 000129	l e	1, 87		0	69.00
	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0. 098239		170, 53		0	
	07200 IMPL. DEV. CHARGED TO PATIENTS	0. 221186		33, 86		0	72. 00
	07300 DRUGS CHARGED TO PATIENTS	0. 275573	l e	278, 24	1 0	0	73. 00
	07697 CARDI AC REHABI LI TATI ON	0. 000000			0	0	76. 97
	07698 HYPERBARI C OXYGEN THERAPY	0. 073713	l e		0	0	76. 98
76. 99	07699 LI THOTRI PSY	0. 000000	0		0 0	0	76. 99
	OUTPATIENT SERVICE COST CENTERS		Г	T .	T		
	09100 EMERGENCY	0. 115762					
	09200 OBSERVATION BEDS (NON-DISTINCT PART	0. 900085	0	219, 56	4 0	0	92. 00
	OTHER REIMBURSABLE COST CENTERS				1		
	09500 AMBULANCE SERVICES	0. 496207	0	,			95. 00
200. 00			0	6, 052, 28	1 0	0	200. 00
201. 00					0		201. 00
	Only Charges						
202.00	Net Charges (line 200 - line 201)		0	6, 052, 28	1 0	0	202. 00

Health Financial Systems	HUNTI NGTON MEMORI A	AL HOSPITAL	In Lie	u of Form CMS-2552-10
APPORTIONMENT OF MEDICAL,	OTHER HEALTH SERVICES AND VACCINE COST	Provider CCN: 15-0091	Peri od: From 01/01/2017	Worksheet D
				Date/Time Prepared:

				To 12/31/2017	Date/Time Pro	epared: 25 am
		Ti tl	e XIX	Hospi tal	PPS	
	Cos	sts				
Cost Center Description	Cost	Cost				
	Rei mbursed	Rei mbursed				
	Servi ces	Servi ces Not				
	Subject To	Subject To				
	Ded. & Coins.	Ded. & Coins.				
	(see inst.)	(see inst.)				
	6. 00	7. 00				
ANCI LLARY SERVI CE COST CENTERS	T	_	1			
50. 00   05000   OPERATI NG ROOM	87, 802		ł			50.00
52.00   05200   DELI VERY ROOM & LABOR ROOM	0	0				52. 00
53. 00   05300   ANESTHESI OLOGY	0	0				53. 00
54. 00   05400   RADI OLOGY-DI AGNOSTI C	121, 809					54.00
60. 00   06000   LABORATORY	120, 116	0				60. 00
62. 30 06250 BLOOD CLOTTING FOR HEMOPHILIACS	0	0				62. 30
65. 00 06500 RESPI RATORY THERAPY	23, 991					65. 00
66. 00   06600   PHYSI CAL THERAPY	86, 310					66. 00
67. 00 06700 OCCUPATI ONAL THERAPY	41, 397					67. 00
68. 00   06800   SPEECH PATHOLOGY	14, 316	0				68. 00
69. 00 06900 ELECTROCARDI OLOGY	0	0				69. 00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	16, 753					71. 00
72. 00 07200 I MPL. DEV. CHARGED TO PATIENTS	7, 490					72. 00
73. 00 07300 DRUGS CHARGED TO PATIENTS	76, 676	0				73. 00
76. 97 O7697 CARDI AC REHABI LI TATI ON	0	0				76. 97
76. 98 07698 HYPERBARI C OXYGEN THERAPY	0	0	1			76. 98
76. 99 07699 LI THOTRI PSY	0	0				76. 99
OUTPATIENT SERVICE COST CENTERS	155 704	1 0	I			01 00
91. 00 09100 EMERGENCY	155, 794		1			91.00
92. 00 09200 OBSERVATI ON BEDS (NON-DI STI NCT PART	197, 626	0				92. 00
95. 00 OTHER REI MBURSABLE COST CENTERS 95. 00 O9500 AMBULANCE SERVI CES	308, 838	I	I			95. 00
						200.00
,	1, 258, 918	0				
201.00 Less PBP Clinic Lab. Services-Program Only Charges						201. 00
202.00 Net Charges (line 200 - line 201)	1, 258, 918	0				202. 00
202.00	1,250,910	ı	T			1202.00

Health Financial Systems	HUNTINGTON MEMORIAL HOSPITAL	In Lie	u of Form CMS-2552-10
COMPUTATION OF INPATIENT OPERATING COST	Provi der CCN: 15-0091	Peri od: From 01/01/2017 To 12/31/2017	Worksheet D-1 Date/Time Prepared: 5/30/2018 9:25 am
	Title XVIII	Hospi tal	PPS

		T: +1 o V/// / /	Hooni tol	5/30/2018 9: 2	5 am
	Cost Center Description	Title XVIII	Hospi tal	PPS	
	·			1. 00	
	PART I - ALL PROVIDER COMPONENTS				
1. 00	INPATIENT DAYS Inpatient days (including private room days and swing-bed days	s excluding newborn)		5, 743	1.00
2. 00	Inpatient days (including private room days, excluding swing-			5, 743	2.00
3.00	Private room days (excluding swing-bed and observation bed day	ys). If you have only pr	ivate room days,	0	3. 00
4 00	do not complete this line.			4 504	4 00
4. 00 5. 00	Semi-private room days (excluding swing-bed and observation be Total swing-bed SNF type inpatient days (including private roo		r 21 of the cost	4, 534 0	4. 00 5. 00
5.00	reporting period	on days) through becembe	i si di the cost	U	3.00
6.00	Total swing-bed SNF type inpatient days (including private roo	om days) after December	31 of the cost	0	6. 00
	reporting period (if calendar year, enter 0 on this line)				
7. 00	Total swing-bed NF type inpatient days (including private roor	n days) through December	31 of the cost	0	7. 00
8. 00	reporting period Total swing-bed NF type inpatient days (including private roor	n days) after December 3	1 of the cost	0	8. 00
0.00	reporting period (if calendar year, enter 0 on this line)	adys) arter becomber o	i or the cost	· ·	0.00
9.00	Total inpatient days including private room days applicable to	the Program (excluding	swing-bed and	1, 571	9. 00
40.00	newborn days)				40.00
10. 00	Swing-bed SNF type inpatient days applicable to title XVIII or through December 31 of the cost reporting period (see instruc-		oom days)	0	10. 00
11. 00	Swing-bed SNF type inpatient days applicable to title XVIII or		oom davs) after	0	11. 00
	December 31 of the cost reporting period (if calendar year, en	nter O on this line)	,		
12. 00	Swing-bed NF type inpatient days applicable to titles V or XI)	( only (including privat	e room days)	0	12. 00
13. 00	through December 31 of the cost reporting period Swing-bed NF type inpatient days applicable to titles V or XI)	/ only (including privat	o room days)	0	13. 00
13.00	after December 31 of the cost reporting period (if calendar ve			U	13.00
14.00	Medically necessary private room days applicable to the Progra			0	14. 00
15. 00	Total nursery days (title V or XIX only)			0	15. 00
16. 00	Nursery days (title V or XIX only)			0	16. 00
17. 00	SWING BED ADJUSTMENT  Medicare rate for swing-bed SNF services applicable to service	es through December 31 o	f the cost	0.00	17. 00
17.00	reporting period	23 thi dagii becember 31 0	the cost	0.00	17.00
18.00	Medicare rate for swing-bed SNF services applicable to service	es after December 31 of	the cost	0.00	18. 00
	reporting period				
19. 00	Medicaid rate for swing-bed NF services applicable to services reporting period	s through December 31 of	the cost	0.00	19. 00
20. 00	Medicald rate for swing-bed NF services applicable to services	s after December 31 of t	he cost	0.00	20. 00
	reporting period				
21. 00	Total general inpatient routine service cost (see instructions			7, 061, 120	21.00
22. 00	Swing-bed cost applicable to SNF type services through December $5 \times 1$ ine 17)	er 31 of the cost report	ing period (line	0	22. 00
23. 00	Swing-bed cost applicable to SNF type services after December	31 of the cost reporting	a period (line 6	0	23. 00
	x line 18)		9		
24. 00	Swing-bed cost applicable to NF type services through December	31 of the cost reporti	ng period (line	0	24. 00
25. 00	7 x line 19) Swing-bed cost applicable to NF type services after December (	21 of the cost reporting	poriod (line 0	0	25. 00
25.00	x line 20)	of the cost reporting	perrou (Trile 8	O	25.00
26.00	Total swing-bed cost (see instructions)			0	26. 00
27. 00	General inpatient routine service cost net of swing-bed cost	(line 21 minus line 26)		7, 061, 120	27. 00
20.00	PRIVATE ROOM DIFFERENTIAL ADJUSTMENT	l and abacquetion had ab	02200)	0	20.00
28. 00 29. 00	General inpatient routine service charges (excluding swing-bed Private room charges (excluding swing-bed charges)	a and observation bed ch	arges)	0	28. 00 29. 00
30.00	Semi -private room charges (excluding swing-bed charges)			0	30.00
31.00	General inpatient routine service cost/charge ratio (line 27	: line 28)		0. 000000	31.00
32. 00	Average private room per diem charge (line 29 ÷ line 3)			0.00	32. 00
33. 00	Average semi-private room per diem charge (line 30 ÷ line 4)	aug line 22) (ees instrue	+: ana)	0.00	33.00
34. 00 35. 00	Average per diem private room charge differential (line 32 min Average per diem private room cost differential (line 34 x lin		tions)	0. 00 0. 00	34. 00 35. 00
36. 00	Private room cost differential adjustment (line 3 x line 35)	10 01)		0.00	36.00
37. 00	General inpatient routine service cost net of swing-bed cost a	and private room cost di	fferential (line	7, 061, 120	37. 00
	27 minus line 36)				
	PART II - HOSPITAL AND SUBPROVIDERS ONLY PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJU	ISTMENTS			
38. 00	Adjusted general inpatient routine service cost per diem (see			1, 229. 52	38. 00
39. 00	Program general inpatient routine service cost (line 9 x line	*		1, 931, 576	39. 00
40.00	Medically necessary private room cost applicable to the Progra			0	40. 00
41. 00	Total Program general inpatient routine service cost (line 39	+ line 40)		1, 931, 576	41.00

	Financial Systems FATION OF INPATIENT OPERATING COST	HUNTI NGTON MEMOR		CN: 15-0091	In Lie	u of Form CMS- Worksheet D-1	
COMITO	ATTON OF THEATTENT OF ENATING COST		l l ovi dei c	CN. 13-0071	From 01/01/2017		
					To 12/31/2017	Date/Time Pre 5/30/2018 9:2	pared: 5 am
				e XVIII	Hospi tal	PPS	
	Cost Center Description	Total Inpatient Costl	Total	Average Per		Program Cost (col. 3 x col.	
		Impatrent costi	iipati eiit bays	col. 2)	<del>-</del>	4)	
		1.00	2. 00	3. 00	4. 00	5. 00	
42. 00	NURSERY (title V & XIX only)	0	(	0.	00 0	0	42. 00
43. 00	Intensive Care Type Inpatient Hospital Unit	:S		1			43. 00
44. 00	CORONARY CARE UNIT						44. 00
45. 00	BURN INTENSIVE CARE UNIT						45. 00
46.00							46. 00
47.00	OTHER SPECIAL CARE (SPECIFY)  Cost Center Description						47. 00
	cost center bescription					1. 00	
48. 00	Program inpatient ancillary service cost (	Wkst. D-3, col. 3,	line 200)			1, 786, 674	48. 00
49. 00	Total Program inpatient costs (sum of lines	s 41 through 48)(s	see instructio	ons)		3, 718, 250	49. 00
50. 00	PASS THROUGH COST ADJUSTMENTS Pass through costs applicable to Program in	anationt routing s	convices (from	m Wkst D su	m of Darte L and	154, 288	50.00
30. 00		ipatrent routine s	services (IIO	II WKSt. D, Su	II OI FAILS I AIIU	154, 200	30.00
51. 00	Pass through costs applicable to Program in	npatient ancillary	y services (fr	rom Wkst. D,	sum of Parts II	129, 844	51.00
E0 00	and IV)	5 EO and E4)				204 422	E0.00
52. 00 53. 00	Total Program excludable cost (sum of line: Total Program inpatient operating cost excl		ated_non-phy	vsician anest	hetist and	284, 132 3, 434, 118	1
33. 00	medical education costs (line 49 minus line		atea, non-pny	ysi ci aii allest	neti st, and	3, 434, 110	33.00
	TARGET AMOUNT AND LIMIT COMPUTATION	,					
	Program di scharges					0	
56.00	Target amount per discharge Target amount (line 54 x line 55)						55. 00 56. 00
57. 00	,	ating cost and tar	get amount (I	ine 56 minus	line 53)	0	
58.00	Bonus payment (see instructions)	· ·			ŕ	0	58. 00
59. 00	Lesser of lines 53/54 or 55 from the cost i	reporting period e	endi ng 1996, ເ	updated and c	ompounded by the	0. 00	59. 00
60. 00	market basket Lesser of lines 53/54 or 55 from prior year	cost report und	dated by the r	market basket		0.00	60.00
61.00	1					0	
	which operating costs (line 53) are less the		s (lines 54 x	60), or 1% o	f the target		
62 00	amount (line 56), otherwise enter zero (see Relief payment (see instructions)	e instructions)				0	62.00
	Allowable Inpatient cost plus incentive par	ment (see instruc	ctions)			0	
	PROGRAM INPATIENT ROUTINE SWING BED COST	,	,				
64. 00		osts through Decem	mber 31 of the	e cost report	ing period (See	0	64. 00
65. 00	<pre>instructions)(title XVIII only) Medicare swing-bed SNF inpatient routine co</pre>	osts after Decembe	er 31 of the d	cost reportin	n period (See	0	65. 00
	instructions)(title XVIII only)				9 1 (	_	
66. 00	Total Medicare swing-bed SNF inpatient rou	tine costs (line 6	64 plus line 6	65)(title XVI	II only). For	0	66. 00
67. 00	CAH (see instructions) Title V or XIX swing-bed NF inpatient routi	ne costs through	December 31 (	of the cost r	enorting period	0	67.00
07.00	(line 12 x line 19)	ne costs through	December 31 (	or the cost is	eportring perrod		07.00
68. 00	Title V or XIX swing-bed NF inpatient routi	ne costs after De	ecember 31 of	the cost rep	orting period	0	68. 00
40.00	(line 13 x line 20) Total title V or XIX swing-bed NF inpatien	t routing costs (	ino 47 : lino	. 40)		0	69.00
69.00	PART III - SKILLED NURSING FACILITY, OTHER	•				0	1 69.00
70. 00	Skilled nursing facility/other nursing faci				)		70. 00
71.00	Adjusted general inpatient routine service		ne 70 ÷ line	2)			71.00
72. 00 73. 00	Program routine service cost (line 9 x line Medically necessary private room cost appli		(lino 14 v li	no 25)			72. 00 73. 00
74.00	Total Program general inpatient routine ser						74.00
75. 00	Capital -related cost allocated to inpatien	•			Part II, column		75. 00
	26, line 45)	>					
76. 00 77. 00	Per diem capital-related costs (line 75 ÷ l Program capital-related costs (line 9 x lin						76. 00 77. 00
78. 00	,	,					78.00
79. 00	Aggregate charges to beneficiaries for exce	ess costs (from pr					79. 00
	Total Program routine service costs for con	•	ost limitation	n (line 78 mi	nus line 79)		80.00
81. 00 82. 00	Inpatient routine service cost per diem lin Inpatient routine service cost limitation		1				81. 00 82. 00
83. 00	Reasonable inpatient routine service costs	•					83. 00
84. 00	Program inpatient ancillary services (see i		•				84. 00
85.00	Utilization review - physician compensation						85. 00
86. 00	Total Program inpatient operating costs (SEPART IV - COMPUTATION OF OBSERVATION BED PA		ough 85)				86. 00
87. 00	Total observation bed days (see instruction					1, 209	87. 00
	, ·	•	Line 2)			1, 229. 52	
88. 00	Observation bed cost (line 87 x line 88) (s	·	11116 2)			1, 227. 32	00.00

Health Financial Systems	HUNTINGTON MEMO	RIAL HOSPITAL		In Lie	eu of Form CMS-2	2552-10
COMPUTATION OF INPATIENT OPERATING COST		Provi der CC		Peri od:	Worksheet D-1	
				From 01/01/2017 Fo 12/31/2017	Date/Time Pre 5/30/2018 9:2	
		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	564, 035	7, 061, 120	0. 07987	9 1, 486, 490	118, 739	90.00
91.00 Nursing School cost	0	7, 061, 120	0.00000	1, 486, 490	0	91.00
92.00 Allied health cost	0	7, 061, 120	0.00000	1, 486, 490	0	92.00
93.00 All other Medical Education	0	7, 061, 120	0.00000	1, 486, 490	0	93. 00

Health Financial Systems	HUNTINGTON MEMORIAL HOSPITAL	In Lie	u of Form CMS-	2552-10
COMPUTATION OF INPATIENT OPERATING COST	Provider CCN: 15-0091	Peri od: From 01/01/2017	Worksheet D-1	
			Date/Time Pre 5/30/2018 9:2	
	Title XIX	Hospi tal	PPS	
Cook Cooker December 1				

		Title XIX	Hospi tal	PPS	<u> </u>
	Cost Center Description			1. 00	
	PART I - ALL PROVIDER COMPONENTS			1.00	
	I NPATI ENT DAYS				
1. 00 2. 00	Inpatient days (including private room days and swing-bed days Inpatient days (including private room days, excluding swing-b			5, 743 5, 743	1. 00 2. 00
3. 00	Private room days (excluding swing-bed and observation bed day		vate room days.	0, 743	3.00
	do not complete this line.	-,· , , p			
4.00	Semi-private room days (excluding swing-bed and observation be		04 6 11	4, 534	4.00
5. 00	Total swing-bed SNF type inpatient days (including private roc reporting period	om days) through December	31 of the cost	0	5. 00
6.00	Total swing-bed SNF type inpatient days (including private roo	m days) after December 3	31 of the cost	0	6. 00
7.00	reporting period (if calendar year, enter 0 on this line)		21 -6	0	7.00
7. 00	Total swing-bed NF type inpatient days (including private room reporting period	r days) through becember	31 Of the Cost	0	7. 00
8.00	Total swing-bed NF type inpatient days (including private room	days) after December 3°	of the cost	0	8. 00
0.00	reporting period (if calendar year, enter 0 on this line)			70	0.00
9. 00	Total inpatient days including private room days applicable to newborn days)	the Program (excluding	swing-bed and	79	9. 00
10.00	Swing-bed SNF type inpatient days applicable to title XVIII or	ly (including private ro	oom days)	0	10.00
	through December 31 of the cost reporting period (see instruct			_	
11. 00	Swing-bed SNF type inpatient days applicable to title XVIII or December 31 of the cost reporting period (if calendar year, er		oom days) after	0	11. 00
12. 00	Swing-bed NF type inpatient days applicable to titles V or XIX		e room days)	0	12. 00
	through December 31 of the cost reporting period			_	
13. 00	Swing-bed NF type inpatient days applicable to titles V or XIX after December 31 of the cost reporting period (if calendar ye			0	13. 00
14. 00	Medically necessary private room days applicable to the Progra			0	14. 00
15. 00	Total nursery days (title V or XIX only)			731	
16. 00	Nursery days (title V or XIX only)			35	16. 00
17. 00	SWING BED ADJUSTMENT  Medicare rate for swing-bed SNF services applicable to service	s through December 31 of	the cost	0.00	17. 00
	reporting period	3			
18. 00	Medicare rate for swing-bed SNF services applicable to service	es after December 31 of t	the cost	0. 00	18. 00
19. 00	reporting period Medicaid rate for swing-bed NF services applicable to services	: through December 31 of	the cost	0.00	19. 00
17.00	reporting period	through becember of or	1110 0031	0.00	
20. 00	Medicaid rate for swing-bed NF services applicable to services	after December 31 of th	ne cost	0. 00	20. 00
21. 00	reporting period Total general inpatient routine service cost (see instructions	(;		7, 061, 120	21. 00
22. 00	Swing-bed cost applicable to SNF type services through Decembe		ng period (line	0	22. 00
23. 00	5 x line 17)	21 of the cost reporting	nomind (line (	0	23. 00
23.00	Swing-bed cost applicable to SNF type services after December x line 18)	31 of the cost reporting	j period (iiile 6	U	23.00
24. 00	Swing-bed cost applicable to NF type services through December	31 of the cost reportir	ng period (line	0	24. 00
25. 00	7 x line 19) Swing-bed cost applicable to NF type services after December 3	11 of the cost reporting	poriod (line 9	0	25. 00
25.00	x line 20)	or or the cost reporting	perrou (Trile 8	O	25.00
26. 00	Total swing-bed cost (see instructions)			0	26. 00
27. 00	General inpatient routine service cost net of swing-bed cost ( PRIVATE ROOM DIFFERENTIAL ADJUSTMENT	line 21 minus line 26)		7, 061, 120	27. 00
28. 00	General inpatient routine service charges (excluding swing-bed	l and observation bed cha	arges)	0	28. 00
29. 00	Private room charges (excluding swing-bed charges)		3.17	0	29. 00
30. 00	Semi-private room charges (excluding swing-bed charges)			0	30. 00
31. 00	General inpatient routine service cost/charge ratio (line 27 ÷	line 28)		0.000000	31.00
32. 00 33. 00	Average private room per diem charge (line 29 ÷ line 3) Average semi-private room per diem charge (line 30 ÷ line 4)			0. 00 0. 00	32. 00 33. 00
34. 00	Average per diem private room charge differential (line 32 mir	us line 33)(see instruct	ions)	0.00	34. 00
35. 00	Average per diem private room cost differential (line 34 x lin		:=/	0.00	35. 00
36. 00	Private room cost differential adjustment (line 3 x line 35)	•		0	36. 00
37. 00	General inpatient routine service cost net of swing-bed cost a	ınd private room cost dif	ferential (line	7, 061, 120	37. 00
	27 minus line 36) PART II - HOSPITAL AND SUBPROVIDERS ONLY				
	PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJU	STMENTS			
38. 00	Adjusted general inpatient routine service cost per diem (see			1, 229. 52	38. 00
39. 00	Program general inpatient routine service cost (line 9 x line			97, 132	39. 00
40.00	Medically necessary private room cost applicable to the Program			07 122	40.00
41.00	Total Program general inpatient routine service cost (line 39	+ ITHE 40)	I	97, 132	41.00

Title XIX   No.   Program   Progra		Financial Systems ATION OF INPATIENT OPERATING COST	HUNTI NGTON MEMO			N: 15-0001	In Li∈ Period:	worksheet D-1	
Cost Center Description    Internal   Noting Pear   Program Byst	COMPUT	ATTON OF INFATTENT OF LIKATING COST		FIOVIGE	i ((		From 01/01/2017		
Cost Center Description							10 12/31/2017		
Inpatient Cost Inpatient Bays Pier (26)   1   1   2   2   3   2   3   4   20   4   20   4   20   4   20   4   20   4   20   4   20   4   20   4   20   4   20   4   20   4   20   4   20   4   20   20					Ti tl			PPS	
1.00		Cost Center Description			าลงร				
Alignorm   Alignorm			Impatront oost	i i i pa ci circ i	Juyu				
Intensive Care Type Inpatient Hospital Units  14. 00   ORONARY CARE UNIT    45. 00   ORONARY CARE UNIT    47. 00   OTHER SPECIAL CARE (SPECIATY)    48. 00   Program inpatient ancillary service cost (West. D-3, col. 3, line 200)    49. 00   OTOTAL Program inpatient ancillary service cost (West. D-3, col. 3, line 200)    49. 00   OTOTAL Program inpatient ancillary service cost (West. D-3, col. 3, line 200)    49. 00   OTOTAL Program inpatient ancillary service cost (West. D-3, col. 3, line 200)    49. 00   OTOTAL Program inpatient costs (sum of lines 41 through 48) (see instructions)    49. 00   OTOTAL Program inpatient costs (sum of lines 41 through 48) (see instructions)    49. 00   OTOTAL Program inpatient costs (sum of lines 50 and 51)    49. 01   OTOTAL Program excludable cost (sum of lines 50 and 51)    49. 02   OTOTAL Program excludable cost (sum of lines 50 and 51)    49. 03   OTOTAL Program inpatient operating cost excluding capital related, non-physician anesthetist, and    49. 10   OTOTAL Program discharges   OTOTAL Program inpatient program inpatient ancillary services (from West. D. sum of Parts III    49. 10   OTOTAL Program excludable cost (sum of lines 50 and 51)    49. 10   OTOTAL Program inpatient operating cost excluding capital related, non-physician anesthetist, and    49. 10   OTOTAL Program discharges   OTOTAL Program inpatient operating cost and target amount (line 56 minus line 53)    49. 10   OTOTAL Program discharges   OTOTAL Program inpatient operating cost and target amount (line 56 minus line 53)    49. 10   OTOTAL Program discharges   OTOTAL Program inpatient operating cost and target amount (line 56 minus line 53)    49. 10   OTOTAL Program discharges   OTOTAL Program inpatient cost submitted lowers   OTOTAL Program (line 53 x line 20)    49. 10   OTOTAL Program (line 54 x line 55)   OTOTAL Program (line 55 x line	10.00	Luiporpy (IIII V a VIV I )			704				10.00
A. 0.0   INTERSIVE CARE UNIT	42.00				/31	400. 5	3  35	14, 019	42.00
8.00 BURN INTENSIVE CARE UNIT 47.00 OTHER SPECIAL CARE (SPECIPY)	43. 00		,						43. 00
4.0 00 SURGICAL INTERSIVE CARE UNIT 7.00 OTHER SPECIAL CARE (SPECIAY) COST Center Description  4.6 00 Program Input ent acceptancy of the Cost Center Description  4.7 0.0 OTHER SPECIAL CARE (SPECIAY)  4.0 00 Program Input ent costs (sous of 11 ness 41 through 48) (see instructions)  4.0 0.0 Program Input ent costs (sous of 11 ness 41 through 48) (see instructions)  4.0 0.0 Program Input ent costs applicable to Program Inpatient routine services (from West. D., sum of Parts II and III)  5.0 0.0 Pass through costs applicable to Program Inpatient ancillary services (from West. D., sum of Parts II and III)  5.0 0.0 Pass through costs applicable to Program Inpatient ancillary services (from West. D., sum of Parts III)  5.0 0.0 Total Program encludable cost (sous of III)  5.0 0.0 Total Program encludable cost (sous of III)  5.0 0.0 Total Program encludable cost (sous of III)  5.0 0.0 Program and IIII (sous III)  5.0 0.0 Program and IIII (sous III)  5.0 0 Program and IIII (sous IIII)  sous IIII)  5.0 0 Program and IIII (sous IIIII)  5.0 0 Program and IIII (sous IIIII (sous IIIII)  5.0 0 Program and IIII (sous IIIII)  5.0 0 Program and IIII (sous IIIII (sous IIIIII)  5.0 0 Program and IIII (sous IIIIII (sous IIIIII)  5.0 0 Program and IIII (sous IIIIII (sous IIIIIII)  5.0 0 Program and IIII (sous IIIIII (sous IIIIIIII)  5.0 0 Program and IIII (sous IIIIII (sous IIIIIIII)  5.0 0 Program and IIII (sous IIIIIIIIIIIIIIIIIIIIIIIIIIIIIIIIIII	44.00	CORONARY CARE UNIT							44. 00
1.00   Other Special Care (Specify)   Other Special Care (Specify)   Other Special Care (Specify)   Other Special Care (Specify)   Other Special Care (Specify)   Other Special Care (Specify)   Other Special Care (Special Car									45. 00
Cost Center Description  1.00  1.00  1.00  371, 326  374, 326  374, 326  375, 327  485, 675  485, 675  485, 675  485, 675  485, 675  485, 675  50. 00  Pass through costs applicable to Program inpatient routine services (from Wkst. D. sum of Parts II and IV)  1.00  Pass through costs applicable to Program inpatient routine services (from Wkst. D. sum of Parts II and IV)  1.00  Pass through costs applicable to Program inpatient ancillary services (from Wkst. D. sum of Parts II and IV)  1.00  Pass through costs applicable to Program inpatient ancillary services (from Wkst. D. sum of Parts II and IV)  1.00  1.01  1.00  Pass through costs applicable to Program inpatient ancillary services (from Wkst. D. sum of Parts II and IV)  1.02  1.03  1.00									46. 00 47. 00
48.00   Program inpatient ancillary service cost (Wist. D-3, col. 3, line 200)   374,525	47.00								47.00
49.00 Total Program Inpatient costs (sum of Flines 41 through 48) (see Instructions) 485.675 4855 THROUGH COST ADJUSTMENTS 50.00 Pass through costs applicable to Program Inpatient routine services (from Wkst. D. sum of Parts I and III) 51.00 Pass through costs applicable to Program inpatient ancillary services (from Wkst. D. sum of Parts III) 52.00 Pass through costs applicable to Program inpatient ancillary services (from Wkst. D. sum of Parts III) 53.00 Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and Motion and costs (line 49 minus Iline 52) 53.00 Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and Motion and cold education costs (line 49 minus Iline 52) 54.00 Program discharges 55.00 Target amount Part discharge 55.00 Difference between adjusted inpatient operating cost and target amount (line 56 minus Iline 53) 50 Difference between adjusted inpatient operating cost and target amount (line 56 minus Iline 53) 50 Difference between adjusted inpatient operating cost and target amount (line 56 minus Iline 53) 50 Difference between adjusted inpatient operating cost and target amount (line 56 minus Iline 53) 50 Difference between adjusted inpatient operating cost and target amount (line 56 minus Iline 53) 50 Difference between adjusted inpatient operating cost and target amount (line 56 minus Iline 53) 60 Difference between adjusted inpatient operating cost and target amount (line 56 minus Iline 53) 61 Committee backet 62 Difference between adjusted inpatient provide cost report updated by the market basket 63 Difference backet 64 Difference between adjusted inpatient provide cost report updated by the market basket 65 Difference between adjusted by an eless than expected costs (line 54 x 60), or 1% of the target amount (line 56), otherwise enter zero (see instructions) 65 Difference between adjusted by an eless than expected costs (line 54 x 60), or 1% of the cost reporting period (See Instructions) 66 Difference betwee									
PASS TIRROUGH COST ADJUSTMENTS  5.0.0 Pass through costs applicable to Program inpatient routine services (from Wkst. D. sum of Parts I and III)  5.1.0 Pass through costs applicable to Program inpatient ancillary services (from Wkst. D. sum of Parts II and III)  5.2.0 Total Program excludable cost (sum of lines 80 and 51)  5.0.0 Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and 451,073  5.0.0 Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and 451,073  5.0.0 Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and 451,073  5.0.0 Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and 451,073  5.0.0 Total Program inpatient operating cost and target amount (line 54 x line 55)  5.0.0 Target amount per discharges  5.0.0 Target amount per discharges  6.0.0 Cost arget amount (line 54 x line 55)  6.0.0 Discharges of lines 53/54 or 55 from the cost reporting period ending 1996, updated and compounded by the market basket  6.0.0 Lesser of lines 53/54 or 55 from prior year cost report, updated by the market basket  6.0.0 Lesser of lines 53/54 or 55 from prior year cost report, updated by the market basket  6.0.0 Lesser of lines 53/54 or 55 from prior year cost report, updated by the market basket  6.0.0 Lesser of lines 53/54 is less than the lower of lines 55, 90 or 60 enter the lesser of 50% of the amount by which operating costs (line 53 are less than expected costs (line 54 x 60), or 1% of the target amount per lines 53/54 or 55 from prior year cost report, updated by the market basket  6.0.0 All combined to the program lines of the cost reporting period (See instructions) (line 50), otherwise enter zero (see instructions)  6.0.0 All combined to the program lines of the cost reporting period (See instructions) (line 50), otherwise enter zero (see instructions)  6.0.0 Medicare swing-bed SMF inpatient routine costs through December 31 of the cost rep		, ,				no)			
50.00 Pass through costs applicable to Program inpatient routine services (from Wkst. D. sum of Parts I and III) 51.00 Pass through costs applicable to Program inpatient ancillary services (from Wkst. D. sum of Parts II 26,107 and IV) 52.00 Total Program excludable cost (sum of lines 50 and 51) 53.00 Total Program excludable cost (sum of lines 50 and 51) 54.00 Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and decided exclusion costs (line 49 minus line 52)  54.10 Program discharges 55.00 Total Program discharge 55.00 Total Program discharge 56.00 Target amount per discharge 57.00 Target amount (line 56) 58.00 Damp spyment (see instructions) 59.00 Lesser of lines 53/54 or 55 from the cost reporting period ending 1996, updated and compounded by the market basket 60.00 Lesser of lines 53/54 or 55 from prior year cost report, updated by the market basket 60.00 Lesser of lines 53/54 or 55 from prior year cost report, updated by the market basket 60.00 Lesser of lines 53/54 or 55 from prior year cost report, updated by the market basket 60.00 Cesser of lines 53/54 or 55 from prior year cost report, updated by the market basket 60.00 In the 53/54 is less than the lower of lines 55, 59 or 60 enter the lesser of 50% of the amount by which operating costs (line 53) are less than expected costs (lines 54 x 60), or 1% of the target amount (line 56), otherwise enter zero (see instructions) 60.00 Allowable Inpatient cost plus incentive payment (see instructions) 61.00 In lines 53/64 is less than the lost reporting period (See Instructions) (line 50 with lines 5	49.00		41 through 48)(	see mstruc	Stro	115)		485, 679	49.00
9 pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and II) 15.20.0 Total Program excludable cost (sum of lines 50 and 51) 15.20.0 Total Program excludable cost (sum of lines 50 and 51) 15.20.0 Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52) 15.20.0 Target amount per discharge	50.00		patient routine	services (1	from	Wkst. D, sum	of Parts I and	8, 495	50.00
and IV)  34,602  Total Program excludable cost (sum of lines 50 and 51)  Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)  TARGET MOUNT AND LIMIT COMPUTATION  TARGET MOUNT AND LIMIT COMPUTATION  54.00 Program discharge  55.00 Target amount per discharge  56.00 Target amount per discharge  57.00 Difference between adjusted inpatient operating cost and target amount (line 56 minus line 53)  58.00 Bonus payment (see instructions)  59.00 Lesser of lines 53/54 or 55 from the cost reporting period ending 1996, updated and compounded by the market basket on	F4 00					W	6.5	0/ 407	F4 00
10   10   10   10   10   10   10   10	51.00	1 9 1	batient ancillar	ry services	(Tr	OM WKST. D, S	um or Parts II	26, 107	51.00
10   Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)   TARGET MOUNTA AND LIMIT COMPUTATION	52. 00	1	50 and 51)					34, 602	52. 00
TARGET ANDURT AND LIMIT COMPUTATION  55.00 Target amount per discharge 55.00 Target amount per discharge 56.00 Target amount per discharge 57.00 Difference between adjusted inpatient operating cost and target amount (line 56 minus line 53) 57.00 Difference between adjusted inpatient operating cost and target amount (line 56 minus line 53) 58.00 Bous payment (see instructions) 59.00 Lesser of lines 53/54 or 55 from the cost reporting period ending 1996, updated and compounded by the market basket 60.00 Lesser of lines 53/54 is 158 from prior year cost report, updated by the market basket 60.00 Lesser of lines 53/54 is less than the lower of lines 55.90 or 60 enter the lesser of 50% of the amount by which operating costs (line 53) are less than expected costs (lines 54 x.60), or 1% of the target amount (line 56), otherwise enter zero (see instructions) 62.00 Relief payment (see instructions) 63.00 Allowable Inpatient cost plus incentive payment (see instructions) 64.00 Medicare swing-bed SNF inpatient routine costs through December 31 of the cost reporting period (See instructions)(title XVIII only) 65.00 Medicare swing-bed SNF inpatient routine costs (line 64 plus line 65) (title XVIII only) 66.00 Total Medicare swing-bed SNF inpatient routine costs (line 64 plus line 65) (title XVIII only) 67.00 Total Medicare swing-bed SNF inpatient routine costs (line 67 + line 68) 68.00 Title Vor XIX swing-bed NF inpatient routine costs (line 67 + line 68) 69.00 Total title V or XIX swing-bed NF inpatient routine costs (line 70 + line 2) 70.00 Skilled nursing facility/other	53.00			elated, non-	-phy	sician anesth	etist, and	451, 077	53. 00
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amount (line 56), otherwise enter zero (see instructions)  62.00 Relief payment (see instructions)  Allowable Inpatient cost plus incentive payment (see instructions)  PROGRAM INPATIENT ROUTINE SWING BED COST  64.00 Medicare swing-bed SNF inpatient routine costs through December 31 of the cost reporting period (See instructions) (title XVIII only)  65.00 Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (See instructions) (title XVIII only)  66.00 Total Medicare swing-bed SNF inpatient routine costs (line 64 plus line 65) (title XVIII only). For CAH (see instructions)  67.00 Title V or XIX swing-bed NF inpatient routine costs through December 31 of the cost reporting period (line 12 x line 19)  68.00 Title V or XIX swing-bed NF inpatient routine costs after December 31 of the cost reporting period (line 13 x line 20)  69.00 Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68)  PART III - SKILLED NURSING FACILITY, OTHER NURSING FACILITY, AND ICF/IID ONLY  70.00 Skilled nursing facility/other nursing facility/ICF/IID routine service cost (line 37)  71.00 Algusted general inpatient routine service cost per diem (line 70 + line 2)  Program routine service cost per diem (line 70 + line 2)  Program general inpatient routine service costs (from Worksheet B, Part II, column 26, line 45)  75.00 Capital -related costs (line 75 + line 2)  76.00 Per diem capital -related costs (line 75 + line 2)  77.00 Program capital -related costs (line 7 x line 2)  78.00 Per diem capital -related costs (line 7 x line 2)  79.00 Program capital -related costs (line 7 x line 2)  79.00 Program capital -related costs (line 7 x line 2)  79.00 Program capital -related costs (line 7 x line 2)  79.00 Program capital -related costs (line 7 x line 2)  79.00 Program capital -related costs (line 9 x line 76)  79.00 Program capital -related costs (line 9 x line 76)  79.00 Program capital -related costs (line 9 x line 81)  79.00 Program routine service cost for comparison to the cost	01.00								01.00
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69.00 Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68) PART III - SKILLED NURSING FACILITY, OTHER NURSING FACILITY, AND ICF/IID ONLY  70.00 Skilled nursing facility/other nursing facility/ICF/IID routine service cost (line 37)  71.00 Adjusted general inpatient routine service cost per diem (line 70 + line 2)  72.00 Program routine service cost (line 9 x line 71)  73.00 Medically necessary private room cost applicable to Program (line 14 x line 35)  74.00 Total Program general inpatient routine service costs (line 72 + line 73)  75.00 Capital-related cost allocated to inpatient routine service costs (from Worksheet B, Part II, column 26, line 45)  76.00 Per diem capital-related costs (line 75 ÷ line 2)  77.00 Program capital-related costs (line 9 x line 76)  78.00 Inpatient routine service cost (line 74 minus line 77)  79.00 Aggregate charges to beneficiaries for excess costs (from provider records)  80.00 Total Program routine service cost per diem limitation  1 Inpatient routine service cost per diem limitation  2.00 Inpatient routine service cost limitation (line 9 x line 81)  82.00 Reasonable inpatient outine service costs (see instructions)  84.00 Program inpatient ancillary services (see instructions)  70 Total Program inpatient operating costs (sum of lines 83 through 85)  PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST	68. 00		ne costs after D	December 31	of	the cost repo	rting period	0	68. 00
PART III - SKILLED NURSING FACILITY, OTHER NURSING FACILITY, AND ICF/IID ONLY  70.00 Skilled nursing facility/other nursing facility/ICF/IID routine service cost (line 37)  71.00 Adjusted general inpatient routine service cost per diem (line 70 ÷ line 2)  72.00 Program routine service cost (line 9 x line 71)  73.00 Medically necessary private room cost applicable to Program (line 14 x line 35)  74.00 Total Program general inpatient routine service costs (line 72 + line 73)  75.00 Capital-related cost allocated to inpatient routine service costs (from Worksheet B, Part II, column 26, line 45)  76.00 Per diem capital-related costs (line 75 ÷ line 2)  77.00 Program capital-related costs (line 74 minus line 77)  78.00 Inpatient routine service cost (line 74 minus line 77)  79.00 Aggregate charges to beneficiaries for excess costs (from provider records)  80.00 Total Program routine service cost per diem limitation  1 Inpatient routine service cost per diem limitation  1 Inpatient routine service cost limitation (line 9 x line 81)  82.00 Reasonable inpatient routine services (see instructions)  84.00 Program inpatient ancillary services (see instructions)  85.00 Utilization review - physician compensation (see instructions)  PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST	40.00		moutine secto (	lino (7 . l		(0)			40.00
70.00 Skilled nursing facility/other nursing facility/ICF/IID routine service cost (line 37) 71.00 Adjusted general inpatient routine service cost per diem (line 70 ÷ line 2) 72.00 Program routine service cost (line 9 x line 71) 73.00 Medically necessary private room cost applicable to Program (line 14 x line 35) 74.00 Total Program general inpatient routine service costs (line 72 + line 73) 75.00 Capital-related cost allocated to inpatient routine service costs (from Worksheet B, Part II, column 26, line 45) 76.00 Per diem capital-related costs (line 75 ÷ line 2) 77.00 Program capital-related costs (line 9 x line 76) 1npatient routine service cost (line 74 minus line 77) 79.00 Aggregate charges to beneficiaries for excess costs (from provider records) 80.00 Total Program routine service cost per diem limitation 1npatient routine service cost per diem limitation 81.00 Reasonable inpatient routine service costs (see instructions) 84.00 Program inpatient ancillary services (see instructions) 85.00 Utilization review - physician compensation (see instructions) 70 Total Program inpatient operating costs (sum of lines 83 through 85) 70 PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST	69.00								69.00
72.00 Program routine service cost (line 9 x line 71) 73.00 Medically necessary private room cost applicable to Program (line 14 x line 35) 74.00 Total Program general inpatient routine service costs (line 72 + line 73) 75.00 Capital-related cost allocated to inpatient routine service costs (from Worksheet B, Part II, column 26, line 45) 76.00 Per diem capital-related costs (line 75 ÷ line 2) 77.00 Program capital-related costs (line 9 x line 76) 78.00 Inpatient routine service cost (line 74 minus line 77) 80.00 Aggregate charges to beneficiaries for excess costs (from provider records) 70.00 Total Program routine service costs for comparison to the cost limitation (line 78 minus line 79) 81.00 Inpatient routine service cost per diem limitation 82.00 Inpatient routine service cost limitation (line 9 x line 81) 83.00 Reasonable inpatient routine services (see instructions) 84.00 Program inpatient ancillary services (see instructions) 85.00 Utilization review - physician compensation (see instructions) 70.01 Total Program inpatient operating costs (sum of lines 83 through 85)  PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST	70. 00								70. 00
73.00 Medically necessary private room cost applicable to Program (line 14 x line 35)  74.00 Total Program general inpatient routine service costs (line 72 + line 73)  75.00 Capital-related cost allocated to inpatient routine service costs (from Worksheet B, Part II, column 26, line 45)  76.00 Per diem capital-related costs (line 75 + line 2)  77.00 Program capital-related costs (line 9 x line 76)  1npatient routine service cost (line 74 minus line 77)  79.00 Aggregate charges to beneficiaries for excess costs (from provider records)  70.00 Total Program routine service costs for comparison to the cost limitation (line 78 minus line 79)  81.00 Inpatient routine service cost per diem limitation  1npatient routine service cost limitation (line 9 x line 81)  82.00 Reasonable inpatient routine services (see instructions)  84.00 Program inpatient ancillary services (see instructions)  85.00 Utilization review - physician compensation (see instructions)  70.00 Total Program inpatient operating costs (sum of lines 83 through 85)  PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST				ine 70 ÷ li	i ne	2)			71.00
Total Program general inpatient routine service costs (line 72 + line 73)  Total Program general inpatient routine service costs (from Worksheet B, Part II, column 26, line 45)  Per diem capital-related costs (line 75 + line 2)  Program capital-related costs (line 9 x line 76)  Inpatient routine service cost (line 74 minus line 77)  Aggregate charges to beneficiaries for excess costs (from provider records)  Total Program routine service costs for comparison to the cost limitation (line 78 minus line 79)  Inpatient routine service cost per diem limitation  Inpatient routine service cost limitation (line 9 x line 81)  Reasonable inpatient routine service costs (see instructions)  Program inpatient ancillary services (see instructions)  Utilization review - physician compensation (see instructions)  Total Program inpatient operating costs (sum of lines 83 through 85)  PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST				ı (line 14 x	v li	ne 35)			72. 00 73. 00
26, line 45)  76.00  77.00  Per diem capital-related costs (line 75 ÷ line 2)  77.00  Rogarm capital-related costs (line 9 x line 76)  Inpatient routine service cost (line 74 minus line 77)  Aggregate charges to beneficiaries for excess costs (from provider records)  Total Program routine service costs for comparison to the cost limitation (line 78 minus line 79)  81.00  Inpatient routine service cost per diem limitation  Inpatient routine service cost limitation (line 9 x line 81)  82.00  Reasonable inpatient routine services (see instructions)  Program inpatient ancillary services (see instructions)  Utilization review - physician compensation (see instructions)  Total Program inpatient operating costs (sum of lines 83 through 85)  PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST						ne 33)			74.00
76.00 Per diem capital-related costs (line 75 ÷ line 2) 77.00 Program capital-related costs (line 9 x line 76) 78.00 Inpatient routine service cost (line 74 minus line 77) 79.00 Aggregate charges to beneficiaries for excess costs (from provider records) 80.00 Total Program routine service costs for comparison to the cost limitation (line 78 minus line 79) 81.00 Inpatient routine service cost per diem limitation 82.00 Inpatient routine service cost limitation (line 9 x line 81) 83.00 Reasonable inpatient routine service costs (see instructions) 84.00 Program inpatient ancillary services (see instructions) 85.00 Utilization review - physician compensation (see instructions) 86.00 PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST	75.00	·	routine service	costs (fro	om Ŵ	orksheet B, P	art II, column		75. 00
77. 00 Program capital-related costs (line 9 x line 76)  78. 00 Inpatient routine service cost (line 74 minus line 77)  Aggregate charges to beneficiaries for excess costs (from provider records)  Total Program routine service costs for comparison to the cost limitation (line 78 minus line 79)  1. 00 Inpatient routine service cost per diem limitation  1. 10 Inpatient routine service cost limitation (line 9 x line 81)  1. 10 Reasonable inpatient routine service costs (see instructions)  1. 11 Program inpatient ancillary services (see instructions)  1. 12 Villization review - physician compensation (see instructions)  1. 12 Villization review - physician compensation (see instructions)  1. 12 Villization review - physician compensation (see instructions)  1. 13 Villization review - physician compensation (see instructions)  1. 14 Program inpatient operating costs (sum of lines 83 through 85)  1. 15 Villization review - physician compensation (see instructions)  1. 15 Villization review - physician compensation (see instructions)  1. 15 Villization review - physician compensation (see instructions)  1. 16 Villization review - physician compensation (see instructions)  1. 17 Villization review - physician compensation (see instructions)  1. 18 Villization review - physician compensation (see instructions)	74 00	1	no 2)						76. 00
78.00 Inpatient routine service cost (line 74 minus line 77) 79.00 Aggregate charges to beneficiaries for excess costs (from provider records) 80.00 Total Program routine service costs for comparison to the cost limitation (line 78 minus line 79) 81.00 Inpatient routine service cost per diem limitation 82.00 Inpatient routine service cost limitation (line 9 x line 81) 83.00 Reasonable inpatient routine service costs (see instructions) 84.00 Program inpatient ancillary services (see instructions) 85.00 Utilization review - physician compensation (see instructions) 86.00 Total Program inpatient operating costs (sum of lines 83 through 85)  PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST		1							77.00
80.00 Total Program routine service costs for comparison to the cost limitation (line 78 minus line 79) 81.00 Inpatient routine service cost per diem limitation 82.00 Inpatient routine service cost limitation (line 9 x line 81) 83.00 Reasonable inpatient routine service costs (see instructions) 84.00 Program inpatient ancillary services (see instructions) 85.00 Utilization review - physician compensation (see instructions) 86.00 Total Program inpatient operating costs (sum of lines 83 through 85)  PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST		,							78. 00
81.00 Inpatient routine service cost per diem limitation 82.00 Inpatient routine service cost limitation (line 9 x line 81) 83.00 Reasonable inpatient routine service costs (see instructions) 84.00 Program inpatient ancillary services (see instructions) 85.00 Utilization review - physician compensation (see instructions) 86.00 Total Program inpatient operating costs (sum of lines 83 through 85) PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST							1: 70)		79.00
82.00 Inpatient routine service cost limitation (line 9 x line 81)  83.00 Reasonable inpatient routine service costs (see instructions)  84.00 Program inpatient ancillary services (see instructions)  85.00 Utilization review - physician compensation (see instructions)  86.00 Total Program inpatient operating costs (sum of lines 83 through 85)  PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST				ost ilmita	ιι on	(iine /8 min	us line /9)		80. 00 81. 00
83.00 Reasonable inpatient routine service costs (see instructions)  84.00 Program inpatient ancillary services (see instructions)  85.00 Utilization review - physician compensation (see instructions)  86.00 Total Program inpatient operating costs (sum of lines 83 through 85)  PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST		1 .		)					82.00
85.00 Utilization review - physician compensation (see instructions) 86.00 Total Program inpatient operating costs (sum of lines 83 through 85) PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST	83.00	Reasonable inpatient routine service costs (	(see instruction	* .					83. 00
86.00 Total Program inpatient operating costs (sum of lines 83 through 85) PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST		, , , , , , , , , , , , , , , , , , , ,		nc)					84.00
PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST									85. 00 86. 00
	55. 50			55911 55)					] 55. 55
		Total observation bed days (see instructions	5)					1, 209	1
		, , , , , , , , , , , , , , , , , , , ,	•					1, 229. 52 1, 486, 490	1

Health Financial Systems	HUNTI NGTON MEMO	RIAL HOSPITAL		In Lie	u of Form CMS-2	2552-10
COMPUTATION OF INPATIENT OPERATING COST		Provi der CC		Peri od:	Worksheet D-1	
				From 01/01/2017 To 12/31/2017	Date/Time Prep 5/30/2018 9: 2	
		Titl	e XIX	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 C	COST					
90.00 Capital -related cost	564, 035	7, 061, 120	0. 07987	9 1, 486, 490	118, 739	90.00
91.00 Nursing School cost	0	7, 061, 120	0.00000	1, 486, 490	0	91.00
92.00 Allied health cost	0	7, 061, 120	0.00000	1, 486, 490	0	92.00
93.00 All other Medical Education	0	7, 061, 120	0.00000	1, 486, 490	0	93. 00

INPATIENT A	ANCILLARY SERVICE COST APPORTIONMENT	Provi der C	CN: 15-0091	Peri od:	Worksheet D-3	
				From 01/01/2017 To 12/31/2017	Date/Time Pre 5/30/2018 9:2	pared: 5 am
		Titl∈	XVIII	Hospi tal	PPS	
	Cost Center Description		Ratio of Cos To Charges	Program	Inpatient Program Costs (col. 1 x col. 2)	
			1.00	2. 00	3. 00	
	TIENT ROUTINE SERVICE COST CENTERS					
	O ADULTS & PEDIATRICS			2, 609, 665		30.00
	0 NURSERY					43.00
	LLARY SERVICE COST CENTERS			[		
	O OPERATI NG ROOM		0. 09603		186, 073	
	O DELIVERY ROOM & LABOR ROOM		0. 31144		394	
	0 ANESTHESI OLOGY		0. 28043		0	
	O RADI OLOGY-DI AGNOSTI C		0. 09376		135, 040	
	O LABORATORY		0. 18954		217, 793	
	O BLOOD CLOTTING FOR HEMOPHILIACS		0.00000		0	
	O RESPIRATORY THERAPY		0. 22032		132, 184	
	O PHYSI CAL THERAPY		0. 38339		94, 822	
	O OCCUPATIONAL THERAPY		0. 28779			
1	O SPEECH PATHOLOGY		0. 31599		3, 793	
	O ELECTROCARDI OLOGY		0.00012			
	O MEDICAL SUPPLIES CHARGED TO PATIENT O IMPL. DEV. CHARGED TO PATIENTS		0. 09823 0. 22118		67, 898 388, 271	
	O DRUGS CHARGED TO PATIENTS					
	7 CARDIAC REHABILITATION		0. 27557		409, 066 0	
	8 HYPERBARI C OXYGEN THERAPY		0. 00000 0. 0737		0	76. 9
	9 LITHOTRIPSY		0.00000		0	
	ATIENT SERVICE COST CENTERS		0.00000	JU U	0	70.9
	O EMERGENCY		0. 11576	62 1, 134, 255	131, 304	91. 0
	O OBSERVATION BEDS (NON-DISTINCT PART		0. 90008			
	R REIMBURSABLE COST CENTERS		0. 70000	55  0		, ,2.0
	O AMBULANCE SERVICES					95. 0
200.00	Total (sum of lines 50 through 94 and 96 through 98)			10, 929, 812	1, 786, 674	
201.00	Less PBP Clinic Laboratory Services-Program only charges	(Line 61)		13, 727, 612	1, 700, 074	201. 0
202.00	Net charges (line 200 minus line 201)	(		10, 929, 812		202. 0

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT	Provi der C	CN: 15-0091	Peri od:	Worksheet D-3	
			From 01/01/2017 To 12/31/2017	Date/Time Pre 5/30/2018 9:2	
	Ti tl	e XIX	Hospi tal	PPS	
Cost Center Description		Ratio of Cos To Charges	Program	Inpatient Program Costs (col. 1 x col. 2)	
		1. 00	2. 00	3. 00	
INPATIENT ROUTINE SERVICE COST CENTERS					
30. 00   03000   ADULTS & PEDI ATRI CS			349, 113		30.00
43. 00 04300 NURSERY			98, 942		43.00
ANCI LLARY SERVI CE COST CENTERS		1	1		
50. 00   05000   OPERATI NG ROOM		0. 09603		64, 669	
52. 00		0. 31144		82, 247	
53. 00   05300   ANESTHESI OLOGY		0. 28043		46, 208	
54. 00   05400   RADI OLOGY - DI AGNOSTI C		0.09376		10, 682	
60. 00   06000   LABORATORY		0. 18954		25, 865	
62. 30 06250 BLOOD CLOTTING FOR HEMOPHILIACS		0.00000		0	
65. 00 06500 RESPIRATORY THERAPY		0. 22032		7, 691	
66. 00   06600   PHYSI CAL THERAPY		0. 38339		4, 294	
67. 00 06700 OCCUPATI ONAL THERAPY		0. 28779		87	
68. 00 06800 SPEECH PATHOLOGY		0. 31599		0	
69. 00 06900 ELECTROCARDI OLOGY		0.00012		10.207	
71.00   O7100   MEDICAL SUPPLIES CHARGED TO PATIENT 72.00   O7200   IMPL. DEV. CHARGED TO PATIENTS		0. 09823 0. 22118		18, 386 42, 049	
73. 00 07300 DRUGS CHARGED TO PATTENTS		0. 22118			
73. 00   07300  DRUGS CHARGED TO PATTENTS  76. 97   07697   CARDI AC REHABI LI TATI ON				63, 323 0	
76. 98   07698   HYPERBARI C OXYGEN THERAPY		0. 00000 0. 0737		0	
		0.0737		0	
76. 99 07699 LITHOTRI PSY OUTPATI ENT SERVI CE COST CENTERS		0.00000	0	U	76. 99
91. 00 O9100 EMERGENCY		0. 11576	52 77, 976	9, 027	91. 00
92. 00   09200   OBSERVATI ON BEDS (NON-DISTINCT PART		0. 90008		9, 027	
OTHER REIMBURSABLE COST CENTERS		0. 70000	)   0	0	72.00
95. 00 09500 AMBULANCE SERVI CES					95. 00
200.00 Total (sum of lines 50 through 94 and 96 through 98)			2, 085, 492	374, 528	
201.00 Less PBP Clinic Laboratory Services-Program only char	nes (line 61)		2, 003, 472	374, 320	201. 00
202.00 Net charges (line 200 minus line 201)	903 (11116 01)	1	2, 085, 492		202. 00

In Lieu of Form CMS-2552-10
Worksheet E
01/2017 Part A
01/2017 Date/Time Prepared:
5/30/2018 9:25 am Peri od: From 01/01/2017 To 12/31/2017

	Ti+Lo VVIII	Hospi tal	5/30/2018 9: 2	5 am
	Title XVIII	Hospi tal Before GEO	PPS On/After GEO	
		Reclass	Reclass	
		1. 00	1. 01	
	PART A - INPATIENT HOSPITAL SERVICES UNDER IPPS			
1.00	DRG Amounts Other than Outlier Payments	0	0	1. 00
1. 01	DRG amounts other than outlier payments for discharges occurring prior to October	r 1 2, 182, 835	0	1. 01
1. 02	(see instructions)	abor 1	944 207	1. 02
1.02	DRG amounts other than outlier payments for discharges occurring on or after Octo (see instructions)	bbei i   0	846, 297	1.02
1. 03	DRG for federal specific operating payment for Model 4 BPCI for discharges occurr	ri na O	o	1. 03
	prior to October 1 (see instructions)		- 1	
1.04	DRG for federal specific operating payment for Model 4 BPCI for discharges occurr	ri ng 0	0	1. 04
	on or after October 1 (see instructions)			
2.00	Outlier payments for discharges. (see instructions)	15, 451		2.00
2. 01	Outlier reconciliation amount	0	0	2. 01
2. 02 3. 00	Outlier payment for discharges for Model 4 BPCI (see instructions) Managed Care Simulated Payments		0	2. 02 3. 00
4. 00	Bed days available divided by number of days in the cost reporting period (see	32. 69	_	4. 00
4.00	instructions)	32.07		4.00
	Indirect Medical Education Adjustment	<u> </u>		
5.00	FTE count for allopathic and osteopathic programs for the most recent cost report	ting 0.00		5. 00
	period ending on or before 12/31/1996. (see instructions)			
6.00	FTE count for allopathic and osteopathic programs which meet the criteria for an	0.00	·	6. 00
7.00	add-on to the cap for new programs in accordance with 42 CFR 413.79(e)	0.00		7.00
7. 00	MMA Section 422 reduction amount to the IME cap as specified under 42 CFR	0.00	1	7. 00
7. 01	\$412.105(f)(1)(iv)(B)(1)  ACA § 5503 reduction amount to the IME cap as specified under 42 CFR	0.00		7. 01
7.01	\[ \frac{\fr	0.00		7.01
	instructions.			
8.00	Adjustment (increase or decrease) to the FTE count for allopathic and osteopathic	0.00	,	8. 00
	programs for affiliated programs in accordance with 42 CFR 413.75(b),			
	413. 79(c)(2)(iv), 64 FR 26340 (May 12, 1998), and 67 FR 50069 (August 1, 2002).			
8. 01	The amount of increase if the hospital was awarded FTE cap slots under § 5503 of	the 0.00	1	8. 01
0.00	ACA. If the cost report straddles July 1, 2011, see instructions.	0.00		0.00
8. 02	The amount of increase if the hospital was awarded FTE cap slots from a closed teaching hospital under § 5506 of ACA. (see instructions)	0.00	1	8. 02
9. 00	Sum of lines 5 plus 6 minus lines (7 and 7.01) plus/minus lines (8, 8,01 and 8,02	2) 0.00		9. 00
7. 00	(see instructions)	0.00		7.00
10.00	FTE count for allopathic and osteopathic programs in the current year from your	0.00	,	10.00
	records			
11. 00	FTE count for residents in dental and podiatric programs.	0.00	•	11. 00
12. 00	Current year allowable FTE (see instructions)	0.00		12.00
13. 00	Total allowable FTE count for the prior year.	0.00		13. 00
14. 00	Total allowable FTE count for the penultimate year if that year ended on or after	0.00	1	14. 00
15 00	September 30, 1997, otherwise enter zero.	0.00	,	15 00
15. 00 16. 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	0.00		17. 00
17. 00 18. 00	Adjustment for residents displaced by program or hospital closure Adjusted rolling average FTE count	0. 00 0. 00		18.00
19. 00	Current year resident to bed ratio (line 18 divided by line 4).	0. 000000		19.00
20. 00	Prior year resident to bed ratio (see instructions)	0. 000000		20.00
21. 00	Enter the lesser of lines 19 or 20 (see instructions)	0. 000000		21. 00
22. 00	IME payment adjustment (see instructions)	0.00000	o	22. 00
22. 01	IME payment adjustment - Managed Care (see instructions)		1	22. 01
22.0.	Indirect Medical Education Adjustment for the Add-on for § 422 of the MMA	,		22.0.
23. 00	Number of additional allopathic and osteopathic IME FTE resident cap slots under	42 0.00		23. 00
	CFR 412.105 (f)(1)(iv)(C).			
24.00	IME FTE Resident Count Over Cap (see instructions)	0.00	1	24. 00
25. 00	If the amount on line 24 is greater than -O-, then enter the lower of line 23 or	line 0.00		25. 00
	24 (see instructions)			
26. 00	Resident to bed ratio (divide line 25 by line 4)	0. 000000		26. 00
27. 00	IME payments adjustment factor. (see instructions)	0. 000000		27. 00
28. 00	IME add-on adjustment amount (see instructions)	0	0	28. 00
28. 01	IME add-on adjustment amount - Managed Care (see instructions)	0	0	28. 01
29. 00 29. 01	Total IME payment ( sum of lines 22 and 28) Total IME payment - Managed Care (sum of lines 22.01 and 28.01)	0	1 "	29. 00 29. 01
∠7. U I	Disproportionate Share Adjustment			_ ∠7. U I
30. 00	Percentage of SSI recipient patient days to Medicare Part A patient days (see	2. 61		30. 00
55. 50	instructions)	2.01		33.30
31. 00	Percentage of Medicaid patient days (see instructions)	28. 60	,	31. 00
32.00	Sum of lines 30 and 31	31. 21		32. 00
33. 00	Allowable disproportionate share percentage (see instructions)	12. 00		33. 00
34.00	Disproportionate share adjustment (see instructions)	65, 485	25, 389	34.00

CALCUL	Financial Systems HUNTINGTON MEMO	RIAL HOSPITAL Provider CCN: 15-0091		eu of Form CMS-2	2552-1
	ATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 15-0091	Period: From 01/01/2017 To 12/31/2017		pared:
		Title XVIII	Hospi tal	PPS	J alli
			Prior to 10/1 1.00	0n/After 10/1 2.00	
35. 00	Uncompensated Care Adjustment Total uncompensated care amount (see instructions)		5 077 512 000	6, 766, 674, 152	35. O
35. 00 35. 01 35. 02	Factor 3 (see instructions)  Hospital uncompensated care payment (If line 34 is zero, en	ter zero on this line) (se	0. 000049582	0. 000062342	35. 0°
35. 03 36. 00	instructions) Pro rata share of the hospital uncompensated care payment a Total uncompensated care (sum of columns 1 and 2 on line 35	,	221, 674 328, 003		35. 03 36. 00
40. 00	Additional payment for high percentage of ESRD beneficiary Total Medicare discharges on Worksheet S-3, Part I excludin	discharges (lines 40 throu			40.00
	652, 682, 683, 684 and 685 (see instructions)		Before GEO	On/After GEO	
			Recl ass	Recl ass	
41. 00	Total ESRD Medicare discharges excluding MS-DRGs 652, 682,	602 604 an 605 (coo	1. 00	1.01	41. 00
+1.00	instructions)	003, 004 dil 003. (See			41.00
41. 01	Total ESRD Medicare covered and paid discharges excluding M an 685. (see instructions)				41. 0
42. 00 43. 00	Divide line 41 by line 40 (if less than 10%, you do not qua Total Medicare ESRD inpatient days excluding MS-DRGs 652, instructions)	, , , , , , , , , , , , , , , , , , ,	0.00	1	42. 00 43. 00
44. 00	Ratio of average length of stay to one week (line 43 divide days)	3	0. 000000		44. 00
15. 00 16. 00	Average weekly cost for dialysis treatments (see instruction Total additional payment (line 45 times line 44 times line		0.00	0.00	45. 0 46. 0
47. 00 48. 00	Subtotal (see instructions) Hospital specific payments (to be completed by SCH and MDH,	,	2, 485, 445 0	981, 427 0	47. 00 48. 00
	only. (see instructions)	<u> </u>		Amount	
				1. 00	
49. 00	Total payment for inpatient operating costs (see instruction			3, 466, 872	1
50. 00 51. 00	Payment for inpatient program capital (from Wkst. L, Pt. I Exception payment for inpatient program capital (Wkst. L, P	and Pt. II, as applicable et III see instructions)		243, 099	50. 00 51. 00
52. 00	Direct graduate medical education payment (from Wkst. E-4,			0	52. 0
3.00	Nursing and Allied Health Managed Care payment			0	53.0
64. 00 64. 01	Special add-on payments for new technologies Islet isolation add-on payment			0 0	54. 0 54. 0
5.00	Net organ acquisition cost (Wkst. D-4 Pt. III, col. 1, line	(69)		0	55.0
6. 00	Cost of physicians' services in a teaching hospital (see in			0	56. 0
7. 00	Routine service other pass through costs (from Wkst. D, Pt.		through 35).	0	57.0
8. 00 9. 00	Ancillary service other pass through costs from Wkst. D, Pt Total (sum of amounts on lines 49 through 58)	. IV, col. 11 line 200)		0 2 700 071	58. 0 59. 0
9. ()()	Primary payer payments			3, 709, 971 18, 150	
	Total amount payable for program beneficiaries (line 59 min	us line 60)		3, 691, 821	
0.00				E14 070	01.0
50. 00 51. 00	Deductibles billed to program beneficiaries			516, 070	l
60. 00 61. 00 62. 00 63. 00	Coinsurance billed to program beneficiaries			15, 125	62. 0 63. 0
60. 00 61. 00 62. 00 63. 00 64. 00	Coinsurance billed to program beneficiaries Allowable bad debts (see instructions)			15, 125 35, 317	62. 0 63. 0 64. 0
00. 00 01. 00 02. 00 03. 00 04. 00 05. 00	Coinsurance billed to program beneficiaries Allowable bad debts (see instructions) Adjusted reimbursable bad debts (see instructions)	structions)		15, 125 35, 317 22, 956	62. 0 63. 0 64. 0 65. 0
00. 00 11. 00 22. 00 33. 00 44. 00 55. 00	Coinsurance billed to program beneficiaries Allowable bad debts (see instructions)	structions)		15, 125 35, 317	62. 0 63. 0 64. 0 65. 0 66. 0
00.00 01.00 02.00 03.00 04.00 05.00 06.00 07.00	Coinsurance billed to program beneficiaries Allowable bad debts (see instructions) Adjusted reimbursable bad debts (see instructions) Allowable bad debts for dual eligible beneficiaries (see in Subtotal (line 61 plus line 65 minus lines 62 and 63) Credits received from manufacturers for replaced devices fo	r applicable to MS-DRGs (s		15, 125 35, 317 22, 956 35, 317 3, 183, 582 0	62. 0 63. 0 64. 0 65. 0 66. 0 67. 0 68. 0
60. 00 61. 00 62. 00 63. 00 64. 00 65. 00 66. 00 67. 00 68. 00 69. 00	Coinsurance billed to program beneficiaries Allowable bad debts (see instructions) Adjusted reimbursable bad debts (see instructions) Allowable bad debts for dual eligible beneficiaries (see in Subtotal (line 61 plus line 65 minus lines 62 and 63) Credits received from manufacturers for replaced devices fo Outlier payments reconciliation (sum of lines 93, 95 and 96	r applicable to MS-DRGs (s		15, 125 35, 317 22, 956 35, 317 3, 183, 582 0	62. 0 63. 0 64. 0 65. 0 66. 0 67. 0 68. 0 69. 0
50. 00 51. 00 52. 00 53. 00 54. 00 55. 00 56. 00 57. 00 58. 00 59. 00	Coinsurance billed to program beneficiaries Allowable bad debts (see instructions) Adjusted reimbursable bad debts (see instructions) Allowable bad debts for dual eligible beneficiaries (see in Subtotal (line 61 plus line 65 minus lines 62 and 63) Credits received from manufacturers for replaced devices fo Outlier payments reconciliation (sum of lines 93, 95 and 96 OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	or applicable to MS-DRGs (s ).(For SCH see instruction	ns)	15, 125 35, 317 22, 956 35, 317 3, 183, 582 0 0	62. 0 63. 0 64. 0 65. 0 66. 0 67. 0 68. 0 69. 0
60. 00 61. 00 62. 00 63. 00 64. 00 65. 00 66. 00 67. 00 68. 00 69. 00 70. 00	Coinsurance billed to program beneficiaries Allowable bad debts (see instructions) Adjusted reimbursable bad debts (see instructions) Allowable bad debts for dual eligible beneficiaries (see in Subtotal (line 61 plus line 65 minus lines 62 and 63) Credits received from manufacturers for replaced devices fo Outlier payments reconciliation (sum of lines 93, 95 and 96	or applicable to MS-DRGs (sol). (For SCH see instructions	ns)	15, 125 35, 317 22, 956 35, 317 3, 183, 582 0	62. 0 63. 0 64. 0 65. 0 66. 0 67. 0 68. 0 70. 0 70. 5
60. 00 61. 00 62. 00 63. 00 64. 00 65. 00 66. 00 67. 00 68. 00 70. 00 70. 50 70. 87	Coinsurance billed to program beneficiaries Allowable bad debts (see instructions) Adjusted reimbursable bad debts (see instructions) Allowable bad debts for dual eligible beneficiaries (see in Subtotal (line 61 plus line 65 minus lines 62 and 63) Credits received from manufacturers for replaced devices fo Outlier payments reconciliation (sum of lines 93, 95 and 96 OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY) Rural Community Hospital Demonstration Project (§410A Demon	or applicable to MS-DRGs (sol). (For SCH see instruction stration) adjustment (see on	ns)	15, 125 35, 317 22, 956 35, 317 3, 183, 582 0 0 0	62. 00 63. 0 64. 0 65. 0 66. 0 67. 0 68. 0 70. 0 70. 5 70. 8
60. 00 61. 00 62. 00 63. 00 64. 00 65. 00 66. 00 67. 00 68. 00 70. 00 70. 50 70. 87 70. 88 70. 89	Coinsurance billed to program beneficiaries Allowable bad debts (see instructions) Adjusted reimbursable bad debts (see instructions) Allowable bad debts for dual eligible beneficiaries (see in Subtotal (line 61 plus line 65 minus lines 62 and 63) Credits received from manufacturers for replaced devices fo Outlier payments reconciliation (sum of lines 93, 95 and 96 OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY) Rural Community Hospital Demonstration Project (§410A Demon Demonstration payment adjustment amount before sequestratio SCH or MDH volume decrease adjustment (contractor use only) Pioneer ACO demonstration payment adjustment amount (see in	or applicable to MS-DRGs (so). (For SCH see instruction stration) adjustment (see in structions)	ns)	15, 125 35, 317 22, 956 35, 317 3, 183, 582 0 0 0 0	62. 00 63. 00 64. 00 65. 00 66. 00 67. 00 68. 00 70. 00 70. 50 70. 8 70. 8
60. 00 61. 00 62. 00 63. 00 64. 00 65. 00 66. 00 67. 00 68. 00 69. 00 70. 50 70. 87 70. 88 70. 89 70. 90	Coinsurance billed to program beneficiaries Allowable bad debts (see instructions) Adjusted reimbursable bad debts (see instructions) Allowable bad debts for dual eligible beneficiaries (see in Subtotal (line 61 plus line 65 minus lines 62 and 63) Credits received from manufacturers for replaced devices fo Outlier payments reconciliation (sum of lines 93, 95 and 96 OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY) Rural Community Hospital Demonstration Project (§410A Demon Demonstration payment adjustment amount before sequestratio SCH or MDH volume decrease adjustment (contractor use only) Pioneer ACO demonstration payment adjustment amount (see in HSP bonus payment HVBP adjustment amount (see instructions)	or applicable to MS-DRGs (so). (For SCH see instruction stration) adjustment (see in structions)	ns)	15, 125 35, 317 22, 956 35, 317 3, 183, 582 0 0 0 0 0	62. 00 63. 00 64. 00 65. 00 66. 00 67. 00 68. 00 70. 00 70. 50 70. 8 70. 8 70. 8
60. 00 61. 00 62. 00 63. 00 64. 00 65. 00 66. 00 67. 00 68. 00 70. 00 70. 50 70. 88 70. 89 70. 91	Coinsurance billed to program beneficiaries Allowable bad debts (see instructions) Adjusted reimbursable bad debts (see instructions) Allowable bad debts for dual eligible beneficiaries (see in subtotal (line 61 plus line 65 minus lines 62 and 63) Credits received from manufacturers for replaced devices fo Outlier payments reconciliation (sum of lines 93, 95 and 96 OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY) Rural Community Hospital Demonstration Project (§410A Demon Demonstration payment adjustment amount before sequestration SCH or MDH volume decrease adjustment (contractor use only) Pioneer ACO demonstration payment adjustment amount (see instructions) HSP bonus payment HVBP adjustment amount (see instructions)	or applicable to MS-DRGs (so). (For SCH see instruction stration) adjustment (see in structions)	ns)	15, 125 35, 317 22, 956 35, 317 3, 183, 582 0 0 0 0 0	62. 00 63. 00 64. 00 65. 00 66. 00 67. 00 68. 00 70. 00 70. 50 70. 8 70. 8 70. 9 70. 9
60. 00 61. 00	Coinsurance billed to program beneficiaries Allowable bad debts (see instructions) Adjusted reimbursable bad debts (see instructions) Allowable bad debts for dual eligible beneficiaries (see in Subtotal (line 61 plus line 65 minus lines 62 and 63) Credits received from manufacturers for replaced devices fo Outlier payments reconciliation (sum of lines 93, 95 and 96 OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY) Rural Community Hospital Demonstration Project (§410A Demon Demonstration payment adjustment amount before sequestratio SCH or MDH volume decrease adjustment (contractor use only) Pioneer ACO demonstration payment adjustment amount (see in HSP bonus payment HVBP adjustment amount (see instructions)	or applicable to MS-DRGs (so). (For SCH see instruction stration) adjustment (see in structions)	ns)	15, 125 35, 317 22, 956 35, 317 3, 183, 582 0 0 0 0 0	62. 0 63. 0 64. 0 65. 0 66. 0 67. 0 68. 0 70. 0 70. 5 70. 8 70. 8 70. 9 70. 9

Health Financial Systems	HUNTINGTON MEMORIAL	HOSPI TAL		In Lie	u of Form CMS-2	2552-10
CALCULATION OF REIMBURSEMENT SETTLEMENT	Pı	Provi der CC	CN: 15-0091	Peri od: From 01/01/2017 To 12/31/2017	Worksheet E Part A Date/Time Pre 5/30/2018 9:2	pared: 5 am
		Title	XVIII	Hospi tal	PPS	
			FFY	(уууу)	Amount	
				0	1. 00	
70.96 Low volume adjustment for federal fiscal y the corresponding federal year for the per		column O		2017	351, 974	70. 96
70.97 Low volume adjustment for federal fiscal y				2018	155, 777	70. 97

	iii (yyyy)	Alliourt	
	0	1. 00	
70.96 Low volume adjustment for federal fiscal year (yyyy) (Enter in column 0 the corresponding federal year for the period prior to 10/1)	2017	351, 974	70. 96
70. 97 Low volume adjustment for federal fiscal year (yyyy) (Enter in column 0 the corresponding federal year for the period ending on or after 10/1)	2018	155, 777	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 69 & 70)		3, 740, 242	71. 00
71.01   Sequestration adjustment (see instructions)		74, 805	1
71.02 Demonstration payment adjustment amount after sequestration		0	71. 02
72.00   Interim payments		3, 718, 480	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, 71.02, 72, and 73)		-53, 043	74. 00
75.00 Protested amounts (nonallowable cost report items) in accordance with		128, 805	75. 00
CMS Pub. 15-2, chapter 1, §115.2		120,000	70.00
TO BE COMPLETED BY CONTRACTOR (lines 90 through 96)			
90.00 Operating outlier amount from Wkst. E, Pt. A, line 2 (see instructions)		0	90.00
91.00 Capital outlier from Wkst. L, Pt. I, line 2			91.00
		0	92.00
3		1	
93.00 Capital outlier reconciliation adjustment amount (see instructions)		0	93. 00
94.00 The rate used to calculate the time value of money (see instructions)		0.00	94.00
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 instructions)		0	96. 00
	Prior to 10/	1 On/After 10/1	
	1. 00	2. 00	
HSP Bonus Payment Amount			
100.00 HSP bonus amount (see instructions)		0 0	100.00
HVBP Adjustment for HSP Bonus Payment	·		
101.00 HVBP adjustment factor (see instructions)	1. 017625779	0 1.0123297327	101.00
102.00 HVBP adjustment amount for HSP bonus payment (see instructions)		ol o	102. 00
HRR Adjustment for HSP Bonus Payment	<u> </u>		
103.00 HRR adjustment factor (see instructions)	1.000	0 1.0000	103 00
104.00 HRR adjustment amount for HSP bonus payment (see instructions)	555		104. 00
Rural Community Hospital Demonstration Project (§410A Demonstration) Adjus	tment	<u> </u>	101.00
200.00 Is this the first year of the current 5-year demonstration period under the			200. 00
Century Cures Act? Enter "Y" for yes or "N" for no.	10 2131		200.00
Cost Reimbursement	<u> </u>		
201.00 Medicare inpatient service costs (from Wkst. D-1, Pt. II, line 49)			201. 00
202.00 Medicare discharges (see instructions)			202. 00
203.00 Case-mix adjustment factor (see instructions)			203. 00
Computation of Demonstration Target Amount Limitation (N/A in first year of	of the current 5 year demon	tration	203.00
period)	The current 5-year demon	stration	
204. 00 Medicare target amount			204. 00
205.00 Case-mix adjusted target amount (line 203 times line 204)			205. 00
206.00 Medicare inpatient routine cost cap (line 202 times line 205)			206. 00
			200.00
Adjustment to Medicare Part A Inpatient Reimbursement			007 00
207.00 Program reimbursement under the §410A Demonstration (see instructions)			207. 00
208.00 Medicare Part A inpatient service costs (from Wkst. E, Pt. A, line 59)			208. 00
209.00 Adjustment to Medicare IPPS payments (see instructions)			209. 00
210.00 Reserved for future use			210. 00
211.00 Total adjustment to Medicare IPPS payments (see instructions)			211. 00
Comparision of PPS versus Cost Reimbursement			
212.00 Total adjustment to Medicare Part A IPPS payments (from line 211)			1212 00
212.00 Total adjustment to medical end the first payments (from fine 211)			212. 00
213.00 Low-volume adjustment (see instructions)			212.00
	oursement)		•
213.00 Low-volume adjustment (see instructions)	oursement)		213. 00

| In Lieu of Form CMS-2552-10 | Period: | Worksheet E | From 01/01/2017 | Part A Exhibit 4 | To 12/31/2017 | Date/Time Prepared: 5/30/2018 9:25 am Health Financial Systems

LOW VOLUME CALCULATION EXHIBIT 4 Provider CCN: 15-0091

A					T: +1 -	WILL I	11: +-1	5/30/2018 9: 2	5 am
1.00   DRG amounts often than outline   1.00   1.00   2.00   3.00   0   0   0   0.00   1.00			W/S F Part A	Amounts (from			Hospi tal Peri od	PPS Total (Col. 2	
1.00   1.00						to 10/01		through 4)	
1.01   1.02   1.02   1.03   1.04   1.05	1.00	Inno.					4. 00		1 00
1.01   Sisk amounts other than outlier   1.01   2.182,835   0   2.182,835   0   2.182,835   1.0   pageworts for discharges progress for discharges pageworts for discharges pageworts for discharges pageworts for discharges pageworts for discharges pageworts for discharges pageworts for discharges pageworts for discharges pageworts for discharges pageworts for discharges pageworts for discharges pagewort for Model 4   SRCI occurring protein to Discourt page for discharges pageworts for discharges pageworts for discharges pageworts for discharges pageworts for discharges pageworts for discharges pageworts for discharges pageworts for discharges pageworts for discharges pageworts for Model 4   SRCI occurring protein to Discourt page for discharges pageworts for Model 4   SRCI occurring pagewort for Model 4   SRCI occurri	1.00		1.00	0	O	0	0	0	1. 00
1.02   386 amounts other than outlier   1.02   386, 277   0   386, 277   346, 277   1.02   2.02   0.03	1. 01	DRG amounts other than outlier payments for discharges	1. 01	2, 182, 835	0	2, 182, 835		2, 182, 835	1. 01
Operating payment for Model 4   BRCI occurring prior to 10   Cotcher   Cot	1. 02	DRG amounts other than outlier payments for discharges	1. 02	846, 297	0		846, 297	846, 297	1. 02
1.04   0	1.03	operating payment for Model 4 BPCI occurring prior to	1. 03	0	0	0		0	1. 03
discharges (see Instructions)   2.00	1.04	DRG for Federal specific operating payment for Model 4 BPCI occurring on or after	1. 04	0	0		0	0	1. 04
2.01   Outlier payments for	2. 00	Outlier payments for	2. 00	18, 863	0	15, 451	3, 412	18, 863	2. 00
3.00   Operating outlier   2.01   O   O   O   O   O   O   O   O   O	2. 01	Outlier payments for	2. 02	0	0	0	0	0	2. 01
A - 00	3. 00	Operating outlier	2. 01	0	0	0	0	0	3. 00
Indirect Medical Education Adjustment   S.00	4. 00	Managed care simulated	3. 00	0	0	0	0	0	4. 00
A, I Ine 21 (see instructions) 6. 01 IME payment adjustment (see 22.00 0 0 0 0 0 0 0 0 0 0 6.00 instructions) 6. 01 IME payment adjustment for 22.01 0 0 0 0 0 0 0 0 0 6.00 instructions) 7. 00 IME payment adjustment for the Add-on for Section 422 of the MMA 7. 00 IME payment adjustment factor (see instructions) 8. 01 IME payment (see 28.00 0 0 0 0 0 0 0 0 0 8.00 instructions) 8. 01 IME payment adjustment add on 28. 01 0 0 0 0 0 0 0 0 0 8. 00 instructions) 8. 01 IME payment adjustment add on 28. 01 0 0 0 0 0 0 0 0 0 0 8. 00 instructions) 8. 01 IME payment (sum of 29.00 0 0 0 0 0 0 0 0 0 0 0 8. 00 instructions) 9. 00 Total IME payment for managed care (see instructions) 9. 01 Total IME payment for managed 29. 01 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0			ustment						
1.00   ME payment adjustment (see   22.00   0   0   0   0   0   0   0   0   0	5.00		21. 00	0. 000000	0. 000000	0. 000000	0. 000000		5. 00
IME payment adjustment for managed care (see instructions)	6.00	IME payment adjustment (see	22. 00	0	0	0	0	0	6. 00
Instructions	6. 01		22. 01	0	0	0	0	0	6. 01
1.00   IME payment adjustment factor   27.00   0.0000000   0.000000   0.0000000   0.00000000		instructions)							
See instructions   See	7 00						0.000000		7 00
Instructions		(see instructions)			0.000000	0. 000000	0.000000	_	
For managed care (see   instructions)	8.00	instructions)	28.00	O	0	0	O	0	8.00
9.00   Total IME payment (sum of lines 6 and 8)   0   0   0   0   0   0   0   0   0	8. 01	for managed care (see	28. 01	0	0	0	0	0	8. 01
9.01 Total IME payment for managed a.01 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	9. 00	Total IME payment (sum of	29. 00	0	0	0	0	0	9. 00
Disproportionate Share Adjustment	9. 01	Total IME payment for managed care (sum of lines 6.01 and	29. 01	О	0	0	О	0	9. 01
10.00			ent						
11.00   Disproportionate share   34.00   90,874   0   65,485   25,389   90,874   11.00   adjustment (see instructions)   34.00   328,003   0   221,673   106,330   328,003   11.00   221,673   106,330   328,003   11.00   221,673   221,6	10.00	Allowable disproportionate		0. 1200	0. 1200	0. 1200	0. 1200		10. 00
11.01									
11.01   Uncompensated care payments   36.00   328,003   0   221,673   106,330   328,003   11.00     Additional payment for high percentage of ESRD beneficiary discharges     12.00   Total ESRD additional payment (see instructions)   46.00   0   0   0   0   0     13.00   Subtotal (see instructions)   47.00   3,466,872   0   2,485,444   981,428   3,466,872   13.00     14.00   Hospital specific payments   48.00   0   0   0   0   0     (completed by SCH and MDH, small rural hospitals only.)   (see instructions)     15.00   Total payment for inpatient   49.00   3,466,872   0   2,485,444   981,428   3,466,872   15.00     15.00   Payment for inpatient program   50.00   243,099   0   170,962   72,137   243,099   16.00     17.00   Special add-on payments for new technologies   17.00     17.01   Net organ aquisition cost   17.00   17.00     17.02   Credits received from   68.00   0   0   0   0   0   0   17.00     manufacturers for replaced   17.00   17.00     18.00   18.00   17.00   17.00   17.00     19.00   19.00   17.00   17.00     19.00   19.00   17.00   17.00     19.00   19.00   17.00   17.00     19.00   19.00   17.00   17.00     19.00   19.00   17.00   17.00     19.00   19.00   17.00   17.00     19.00   19.00   17.00   17.00     19.00   19.00   17.00   17.00     19.00   19.00   19.00   17.00     19.00   19.00   19.00   17.00     19.00   19.00   19.00   19.00     19.00   19.00   19.00     19.00   19.00   19.00   19.00     19.00	11. 00		34.00	90, 874	0	65, 485	25, 389	90, 874	11. 00
12.00 Total ESRD additional payment (see instructions) 13.00 Subtotal (see instructions) 14.00 Hospital specific payments (completed by SCH and MDH, small rural hospitals only.) (see instructions) 15.00 Total payment for inpatient operating costs (see instructions) 16.00 Payment for inpatient program capital (from Wkst. L, Pt. I, if applicable) 17.00 Special add-on payments for new technol ogies 17.01 Net organ aquisition cost 17.02 Credits received from manufacturers for replaced  46.00 0 0 0 2, 485, 444 981, 428 3, 466, 872 13.00 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	11. 01	Uncompensated care payments				221, 673	106, 330	328, 003	11. 01
13.00 Subtotal (see instructions)	12. 00	Total ESRD additional payment				0	0	0	12. 00
(completed by SCH and MDH, small rural hospitals only.) (see instructions)  15.00 Total payment for inpatient 49.00 3,466,872 0 2,485,444 981,428 3,466,872 15.00 operating costs (see instructions)  16.00 Payment for inpatient program capital (from Wkst. L, Pt. I, if applicable)  17.00 Special add-on payments for new technologies  17.01 Net organ aquisition cost  17.02 Credits received from 68.00 0 0 0 0 0 0 0 0 17.00 manufacturers for replaced		Subtotal (see instructions)		3, 466, 872	0	2, 485, 444	981, 428	3, 466, 872	
operating costs (see instructions)  16.00 Payment for inpatient program capital (from Wkst. L, Pt. I, if applicable)  17.00 Special add-on payments for new technologies  17.01 Net organ aquisition cost  17.02 Credits received from manufacturers for replaced  50.00 243,099 0 170,962 72,137 243,099 16.00  0 0 0 0 0 0 0 0 17.00  17.01 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0		(completed by SCH and MDH, small rural hospitals only.) (see instructions)		0	0	0 405 444	0	0	14. 00
capital (from Wkst. L, Pt. I, if applicable)  17.00 Special add-on payments for st.00 0 0 0 0 0 17.00 new technologies  17.01 Net organ aquisition cost 17.02 Credits received from 68.00 0 0 0 0 0 0 17.00 manufacturers for replaced	15.00	operating costs (see instructions)	49.00	3, 466, 8/2	0	2, 485, 444	981, 428	3, 466, 872	15.00
17.00 Special add-on payments for new technologies 17.01 Net organ aquisition cost 17.02 Credits received from 68.00 0 0 0 0 0 17.00 0 0 17.00 0 0 17.00 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	16. 00	capital (from Wkst. L, Pt. I,	50. 00	243, 099	0	170, 962	72, 137	243, 099	16. 00
17. 01 Net organ aquisition cost 17. 02 Credits received from 68. 00 0 0 0 0 17. 02 manufacturers for replaced	17. 00	Special add-on payments for	54. 00	0	0	0	0	0	17. 00
devices for applicable MS-DRGS		Net organ aquisition cost Credits received from		o	0	0	O	0	17. 01 17. 02

	LUME CALCULATION EXHIBIT 4			Provider Co	F	Period: From 01/01/2017 To 12/31/2017		t 4 pared:
					XVIII	Hospi tal	PPS	
			Amounts (from	Pre/Post	Period Prior	Peri od	Total (Col 2	
		line	E, Part A)	Entitlement	to 10/01	On/After 10/01	through 4)	
		0	1.00	2. 00	3. 00	4. 00	5. 00	
	Capital outlier reconciliation adjustment amount (see instructions)	93. 00	0	0	(	,	0	
19. 00	SUBTOTAL			0	2, 656, 406	1, 053, 565	3, 709, 971	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	240, 644	0	168, 924	71, 720	240, 644	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	2, 455	0	2, 038	417	2, 455	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. 0000	0.0000	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. 0000	0. 0000	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	243, 099	0	170, 962	72, 137	243, 099	26. 00
		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. 132500	0. 147857		27. 00
28. 00	Low volume adjustment (transfer amount to Wkst. E,	70. 96			351, 974	1	351, 974	28. 00
29. 00	Pt. A, line) Low volume adjustment (transfer amount to Wkst. E, Pt. A, line)	70. 97				155, 777	155, 777	29. 00
100.00	Transfer low volume adjustments to Wkst. E, Pt. A.		Y					100. 00

				T	o 12/31/2017	Date/Time Prep 5/30/2018 9: 2	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, 182, 835	2, 201, 607		2, 201, 607	1. 01
1. 02	DRG amounts other than outlier payments for discharges occurring on or after October 1	1. 02	846, 297		838, 752	838, 752	1. 02
1. 03	DRG for Federal specific operating payment for Model 4 BPCI occurring prior to October	1. 03	0	0		0	1. 03
1. 04	DRG for Federal specific operating payment for Model 4 BPCI occurring on or after lOctober 1	1. 04	0		0	0	1. 04
2. 00	Outlier payments for discharges (see instructions)	2.00	18, 863	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	Operating outlier reconciliation	2. 01	О	0	0	0	3. 00
4.00	Managed care simulated payments	3. 00	o	0	0	0	4. 00
	Indirect Medical Education Adjustment						
5. 00	Amount from Worksheet E, Part A, line 21 (see instructions)	21. 00	0. 000000	0. 000000	0. 000000		5. 00
6.00	IME payment adjustment (see instructions)	22. 00	o	0	0	0	6. 00
6. 01	IME payment adjustment for managed care (see	22. 01	o	0	0	0	6. 01
	instructions) Indirect Medical Education Adjustment for the	Add-on for Se	ction 422 of th	he MMA			
7. 00	IME payment adjustment factor (see	27. 00	0. 000000	0. 000000	0. 000000		7. 00
0.00	instructions)	20.00		0	0		0.00
8. 00 8. 01	IME adjustment (see instructions) IME payment adjustment add on for managed	28. 00 28. 01	0	0	0	0	8. 00 8. 01
	care (see instructions)			Ī			
9. 00 9. 01	Total IME payment (sum of lines 6 and 8) Total IME payment for managed care (sum of	29. 00 29. 01	0	0	0	0	9. 00 9. 01
7.01	lines 6.01 and 8.01)	29.01	l	U	O	U	7.01
	Di sproporti onate Share Adjustment	<u>I</u>					
10. 00	Allowable disproportionate share percentage	33. 00	0. 1200	0. 1200	0. 1200		10. 00
11. 00	(see instructions) Disproportionate share adjustment (see instructions)	34.00	90, 874	65, 711	25, 163	90, 874	11. 00
11. 01	Uncompensated care payments	36. 00	328, 003	221, 674	106, 329	328, 003	11. 01
40.00	Additional payment for high percentage of ESF						40.00
12. 00	Total ESRD additional payment (see instructions)	46. 00	0	0	0	0	12. 00
13.00	Subtotal (see instructions)	47. 00	3, 466, 872	2, 496, 628	970, 244	3, 466, 872	13. 00
14. 00	Hospital specific payments (completed by SCH and MDH, small rural hospitals only.) (see instructions)	48. 00	0	0	0	0	14. 00
15. 00	Total payment for inpatient operating costs (see instructions)	49. 00	3, 466, 872	2, 496, 628	970, 244	3, 466, 872	15. 00
16. 00	Payment for inpatient program capital (from Wkst. L, Pt. I, if applicable)	50. 00	243, 099	181, 369	61, 730	243, 099	16. 00
17. 00 17. 01	Special add-on payments for new technologies Net organ acquisition cost	54. 00	0	0	0	0	17. 00 17. 01
17. 02	Credits received from manufacturers for replaced devices for applicable MS-DRGs	68. 00	0	0	0	0	
18. 00	Capital outlier reconciliation adjustment amount (see instructions)	93. 00	0	0	0	0	18. 00
19. 00	SUBTOTAL			2, 677, 997	1, 031, 974	3, 709, 971	19. 00

Health Financial Systems	HUNTI NGTON MEMORI A	AL HOSPITAL	In Lie	u of Form CMS-2552-10
HOSPITAL ACQUIRED CONDITION (HAC)	REDUCTION CALCULATION EXHIBIT 5	Provider CCN: 15-0091	Peri od:	Worksheet E

From 01/01/2017 Part A Exhibit 5
To 12/31/2017 Date/Time Prepared: 5/30/2018 9:25 am Title XVIII Hospi tal PPS Wkst. L, line (Amt. from L) Wkst. 2.00 3. 00 4.00 n 1 00 20.00 Capital DRG other than outlier 1.00 240, 644 179, 671 60, 973 240, 644 20.00 20.01 Model 4 BPCI Capital DRG other than outlier 1.01 20.01 Capital DRG outlier payments 1, 698 21.00 2.00 2, 455 757 2, 455 21.00 21.01 Model 4 BPCI Capital DRG outlier payments 2.01 21.01 0 22.00 Indirect medical education percentage (see 5.00 0.0000 0.0000 0.0000 22.00 instructions) 23.00 Indirect medical education adjustment (see 6.00 0 23.00 instructions) 0.0000 0.0000 0.0000 24.00 24 00 Allowable disproportionate share percentage 10 00 (see instructions) 25.00 Disproportionate share adjustment (see 11.00 0 25.00 instructions) Total prospective capital payments (see 12.00 243, 099 181, 369 61, 730 243, 099 26.00 instructions) Wkst. E. Pt. (Amt. from A, line 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 70.96 351, 974 351, 974 351, 974 28.00 29.00 Low volume adjustment on or after October 1 70.97 155, 777 155, 777 155, 777 29.00 HVBP payment adjustment (see instructions) 70. 93 48, 909 13, 185 48, 909 30.00 30.00 35, 724 HVBP payment adjustment for HSP bonus 30.01 70.90 30.01 payment (see instructions) 31.00 HRR adjustment (see instructions) 70.94 C -2, 1602, 160 0 31.00 31.01 HRR adjustment for HSP bonus payment (see 70. 91 0 31.01 instructions) (Amt. to Wkst. Pt. A) 3.00 0 1.00 2.00 4.00 32.00 HAC Reduction Program adjustment (see 70.99 0 32.00 100.00 Transfer HAC Reduction Program adjustment to 100.00 Ν Wkst. E, Pt. A.

Health Financial Systems	HUNTINGTON MEMORIAL HOSPITAL	In Lie	u of Form CMS-2552-10
CALCULATION OF REIMBURSEMENT SETTLEMENT	Provi der CCN: 15-0091	Peri od: From 01/01/2017 To 12/31/2017	Worksheet E Part B Date/Time Prepared:

			12/01/201/	5/30/2018 9: 2	5 am
		Title XVIII	Hospi tal	PPS	
				4.00	
	DART R. MEDICAL AND OTHER HEALTH CERVICES			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 (see instructions)	tions)		3, 881, 592	
3. 00	OPPS payments			2, 967, 801	
4. 00	Outlier payment (see instructions)			9, 307	1
4. 01	Outlier reconciliation amount (see instructions)			0	1
5.00	Enter the hospital specific payment to cost ratio (see instruc	ctions)		0. 859	5.00
6.00	Line 2 times line 5			3, 334, 288	1
7. 00	Sum of lines 3, 4, and 4.01, divided by line 6			89. 29	1
8.00	Transitional corridor payment (see instructions)			0	
9.00	Ancillary service other pass through costs from Wkst. D, Pt. I	V, col. 13, line 200		0	1
10. 00 11. 00	Organ acquisitions  Total cost (sum of Lines 1 and 10) (see instructions)			0	
11.00	Total cost (sum of lines 1 and 10) (see instructions)  COMPUTATION OF LESSER OF COST OR CHARGES			0	11.00
	Reasonable charges				1
12. 00	Ancillary service charges			0	12. 00
13. 00	Organ acquisition charges (from Wkst. D-4, Pt. III, col. 4, Ii	ne 69)		0	1
14.00	Total reasonable charges (sum of lines 12 and 13)	,		0	14. 00
	Customary charges				
15. 00	Aggregate amount actually collected from patients liable for p			0	
16. 00	Amounts that would have been realized from patients liable for		a chargebasis	0	16. 00
17 00	had such payment been made in accordance with 42 CFR §413.13(6	e)		0.000000	17.00
17. 00 18. 00	Ratio of line 15 to line 16 (not to exceed 1.000000) Total customary charges (see instructions)			0. 000000 0	1
19. 00	Excess of customary charges over reasonable cost (complete onl	vifline 18 exceeds lin	e 11) (see	0	1
17.00	instructions)	y IT TITLE TO EXCEEDS ITTL	e 11) (366		17.00
20. 00	Excess of reasonable cost over customary charges (complete onl	y if line 11 exceeds lin	e 18) (see	0	20. 00
	instructions)		, ,		
21. 00	Lesser of cost or charges (see instructions)			0	21. 00
22. 00	Interns and residents (see instructions)			0	
23. 00	Cost of physicians' services in a teaching hospital (see instr	ructions)		0	
24. 00	Total prospective payment (sum of lines 3, 4, 4.01, 8 and 9)			2, 977, 108	24. 00
25 00	COMPUTATION OF REIMBURSEMENT SETTLEMENT  Deductibles and coinsurance (for CAH, see instructions)			0	25. 00
26. 00	Deductibles and Coinsurance relating to amount on line 24 (for	· CAH see instructions)		612, 453	1
27. 00	Subtotal [(lines 21 and 24 minus the sum of lines 25 and 26) p		and 231 (see	2, 364, 655	1
27.00	instructions)	2. 45 1 54 5. 1165 22	ana 20] (000	2,00.,000	27.00
28. 00	Direct graduate medical education payments (from Wkst. E-4, li	ne 50)		0	28. 00
29. 00	ESRD direct medical education costs (from Wkst. E-4, line 36)			0	29. 00
30.00	Subtotal (sum of lines 27 through 29)			2, 364, 655	1
31. 00	1 3 . 3 . 3			64	1
32. 00	Subtotal (line 30 minus line 31) ALLOWABLE BAD DEBTS (EXCLUDE BAD DEBTS FOR PROFESSIONAL SERVICE)	YEC)		2, 364, 591	32. 00
33. 00		LES)		0	33. 00
34. 00	1			79, 553	
35. 00	Adjusted reimbursable bad debts (see instructions)			51, 709	1
36. 00	Allowable bad debts for dual eligible beneficiaries (see instr	ructions)		79, 553	1
37.00		,		2, 416, 300	1
38. 00	MSP-LCC reconciliation amount from PS&R			0	38. 00
39. 00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)			0	39. 00
39. 50	Pioneer ACO demonstration payment adjustment (see instructions	5)			39. 50
39. 97	Demonstration payment adjustment amount before sequestration			0	
39. 98	Partial or full credits received from manufacturers for replace	ced devices (see instruct	i ons)	0	1
39. 99	RECOVERY OF ACCELERATED DEPRECIATION			0	
40. 00 40. 01	Subtotal (see instructions) Sequestration adjustment (see instructions)			2, 416, 300 48, 326	1
40. 01	Demonstration adjustment (see First detrons)  Demonstration payment adjustment amount after sequestration			46, 320	1
41. 00	Interim payments			2, 308, 162	1
42. 00	Tentative settlement (for contractors use only)			0	1
43.00	Balance due provider/program (see instructions)			59, 812	1
44.00	Protested amounts (nonallowable cost report items) in accordan	nce with CMS Pub. 15-2, c	hapter 1,	0	44. 00
	§115. 2				]
00	TO BE COMPLETED BY CONTRACTOR				00.5-
	Original outlier amount (see instructions)			0	1
	Outlier reconciliation adjustment amount (see instructions)			0	1
92.00	The rate used to calculate the Time Value of Money Time Value of Money (see instructions)			0.00	92. 00 93. 00
	Total (sum of lines 91 and 93)				94.00
, +. 00	1.05.6. (Odin of 111105 /1 dild /0)			٠ ٠	, ,, ,,

Health Financial Systems HUNTI
ANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED Peri od: Worksheet E-1
From 01/01/2017 Part I
To 12/31/2017 Date/Time Prepared: 5/30/2018 9:25 am Provider CCN: 15-0091

					5/30/2018 9: 25	o am
			XVIII	Hospi tal	PPS	
		Inpatien	t Part A	Par	-t B	
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount	
		1.00	2.00	3. 00	4.00	
1. 00	Total interim payments paid to provider		3, 718, 48	0	2, 308, 162	1. 00
2.00	Interim payments payable on individual bills, either		-, -, -,	0	0	2. 00
2.00	submitted or to be submitted to the contractor for					2.00
	services rendered in the cost reporting period. If none,					
	write "NONE" or enter a zero					
3.00	List separately each retroactive lump sum adjustment					3. 00
0.00	amount based on subsequent revision of the interim rate					0.00
	for the cost reporting period. Also show date of each					
	payment. If none, write "NONE" or enter a zero. (1)					
	Program to Provider					
3. 01	ADJUSTMENTS TO PROVIDER			0	0	3. 01
3. 02	THE SECTION TO THE STEEL SECTION TO THE SECTION TO THE STEEL SECTION TO THE SECTION TO THE SECTION TO THE SECTION TO THE SECTION TO THE SECTION TO THE SECTION TO THE SECTION TO THE SECTION TO THE SE			Ö	0	3. 02
3. 03				o	0	3. 03
3. 04				0		3. 04
3. 05				0		3. 05
3.03	Provider to Program			<u> </u>	0	3. 03
3. 50	ADJUSTMENTS TO PROGRAM			o	0	3. 50
3. 51	ABSOSTIMENTS TO TROOKAWI			Ö		3. 51
3. 52				0	0	3. 52
3. 53				Ö		3. 53
3. 54				0		3. 54
3. 99	Subtotal (sum of lines 3.01-3.49 minus sum of lines			0		3. 99
3. 77	3. 50-3. 98)			O O		3. 77
4.00	Total interim payments (sum of lines 1, 2, and 3.99)		3, 718, 48	0	2, 308, 162	4. 00
4.00	(transfer to Wkst. E or Wkst. E-3, line and column as		3, 710, 40		2, 300, 102	4.00
	appropriate)					
	TO BE COMPLETED BY CONTRACTOR					
5.00	List separately each tentative settlement payment after					5. 00
0.00	desk review. Also show date of each payment. If none,					0.00
	write "NONE" or enter a zero. (1)					
	Program to Provider					
5. 01	TENTATI VE TO PROVI DER			0	0	5. 01
5. 02				0	o	5. 02
5. 03				0	o	5. 03
	Provider to Program			•		
5.50	TENTATI VE TO PROGRAM			0	0	5. 50
5. 51				0	o	5. 51
5. 52				0	o	5. 52
5. 99	Subtotal (sum of lines 5.01-5.49 minus sum of lines			0	o	5. 99
	5, 50-5, 98)					
6.00	Determined net settlement amount (balance due) based on					6.00
	the cost report. (1)					
6. 01	SETTLEMENT TO PROVIDER			0	59, 812	6. 01
6.02	SETTLEMENT TO PROGRAM		53, 04	3	0	6. 02
7. 00	Total Medicare program liability (see instructions)		3, 665, 43		2, 367, 974	7. 00
				Contractor	NPR Date	
				Number	(Mo/Day/Yr)	
		(	)	1. 00	2.00	
8. 00	Name of Contractor					8. 00
	•			•	. '	

Heal th	Financial Systems HUNTINGTON MEMORI	AL HOSPITAL	In Lie	u of Form CMS-	2552-10
CALCUL	ATION OF REIMBURSEMENT SETTLEMENT FOR HIT	Provider CCN: 15-0091	Peri od: From 01/01/2017 To 12/31/2017		epared:
		Title XVIII	Hospi tal	PPS	
				1. 00	
	TO BE COMPLETED BY CONTRACTOR FOR NONSTANDARD COST REPORTS				4
	HEALTH INFORMATION TECHNOLOGY DATA COLLECTION AND CALCULATION	V			1
1.00 Total hospital discharges as defined in AARA §4102 from Wkst. S-3, Pt. I col. 15 line 14					1.00
2.00 Medicare days from Wkst. S-3, Pt. I, col. 6 sum of lines 1, 8-12				2. 00	
3.00 Medicare HMO days from Wkst. S-3, Pt. I, col. 6. line 2					3. 00
4.00	Total inpatient days from S-3, Pt. I col. 8 sum of lines 1, 8	3-12			4. 00
5.00	Total hospital charges from Wkst C, Pt. I, col. 8 line 200				5. 00
6. 00	Total hospital charity care charges from Wkst. S-10, col. 3 I	ine 20			6. 00
7. 00	CAH only - The reasonable cost incurred for the purchase of line 168 $$	certified HIT technology	Wkst. S-2, Pt. I		7. 00
8. 00	Calculation of the HIT incentive payment (see instructions)				8. 00
9. 00	Sequestration adjustment amount (see instructions)				9.00
10. 00	Calculation of the HIT incentive payment after sequestration	(see instructions)			10.00
	INPATIENT HOSPITAL SERVICES UNDER THE IPPS & CAH				1
30. 00	Initial/interim HIT payment adjustment (see instructions)				30.00
	Other Adjustment (specify)				31.00
	Polones due provider (line 9 (en line 10) minus line 20 and l	ina 21) (aaa inatrustiar	·~)		22 00

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

30. 00 31. 00 32. 00

Health Financial Systems

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

Provi der CCN: 15-0091

Peri od: Worksheet G From 01/01/2017 To 12/31/2017 Date/Time Prepared: 5/30/2018 9: 25 am

—————					5/30/2018 9: 2	5 am
		General Fund		Endowment Fund	Plant Fund	
		1.00	Purpose Fund	2.00	4.00	
	CURRENT ASSETS	1. 00	2.00	3. 00	4. 00	
1.00	Cash on hand in banks	2, 550	0	0	0	1.00
2. 00	Temporary investments	2,330	Ö			2.00
3. 00	Notes receivable	0	Ö	0	Ö	3. 00
4.00	Accounts receivable	24, 646, 437	0	0	0	4. 00
5.00	Other recei vabl e	105, 390	0	0	0	5. 00
6.00	Allowances for uncollectible notes and accounts receivable	-17, 625, 001	0	0	0	6. 00
7.00	Inventory	242, 803	0	0	0	7. 00
8.00	Prepai d expenses	27, 482	1	0	0	8. 00
9. 00	Other current assets	-6, 535, 725		_	0	9. 00
10. 00	Due from other funds	0	0	_	0	10.00
11. 00	Total current assets (sum of lines 1-10)	863, 936	0	0	0	11. 00
12.00	FIXED ASSETS		0	0	0	12 00
12. 00 13. 00	Land improvements	556, 529			0	12. 00 13. 00
14. 00	Accumul ated depreciation	-313, 533	1	_	0	14.00
15. 00	Bui I di ngs	2, 311, 528	1	_	0	15. 00
16. 00	Accumul ated depreciation	-1, 218, 123	1	_	ő	16.00
17. 00	Leasehold improvements	32, 500		_	Ö	17. 00
18. 00	Accumulated depreciation	-31, 687			0	18. 00
19. 00	Fi xed equipment	589, 100	1	0	0	19.00
20.00	Accumulated depreciation	-500, 179	0	0	0	20.00
21.00	Automobiles and trucks	935, 017	0	0	0	21. 00
22. 00	Accumulated depreciation	-678, 889	0	0	0	22. 00
23. 00	Major movable equipment	10, 894, 782	1	0	0	23. 00
24. 00	Accumulated depreciation	-9, 182, 144	1	_	0	24. 00
25. 00	Mi nor equi pment depreci abl e	1, 083, 234	1	_	0	25. 00
26. 00	Accumul ated depreciation	-695, 957	0	0	0	26. 00
27. 00	HIT designated Assets	0	0	0	0	27. 00
28. 00	Accumulated depreciation	1 100 251	0	_	0	28. 00
29. 00 30. 00	Mi nor equi pment-nondepreci abl e	1, 180, 351	1	_		29. 00 30. 00
30.00	Total fixed assets (sum of lines 12-29)  OTHER ASSETS	4, 962, 529	1 0	0	0	30.00
31. 00	Investments	37, 278, 296	0	0	0	31.00
32. 00	Deposits on Leases	0,72,0,2,0	Ö	_		32. 00
33. 00	Due from owners/officers	0	O	0	0	33. 00
34.00	Other assets	290, 139	0	0	0	34.00
35.00	Total other assets (sum of lines 31-34)	37, 568, 435	0	0	0	35. 00
36. 00	Total assets (sum of lines 11, 30, and 35)	43, 394, 900	0	0	0	36. 00
	CURRENT LI ABI LI TI ES					
37. 00	Accounts payable	1, 049, 894	1		-	37. 00
38. 00	Salaries, wages, and fees payable	777, 395	1	_	_	38. 00
39. 00	Payroll taxes payable	0	0	_	0	39. 00
40.00	Notes and Loans payable (short term)	42, 751	0	0	0	40.00
41.00	Deferred income	0	l o	U	0	41.00
42. 00 43. 00	Accel erated payments Due to other funds	0		0	0	42. 00 43. 00
44. 00	Other current liabilities	80, 767		0	0	44.00
45. 00	Total current liabilities (sum of lines 37 thru 44)	1, 950, 807	i	_		45. 00
43.00	LONG TERM LIABILITIES	1, 750, 607	·			1 43.00
46. 00	Mortgage payable	0	0	0	0	46.00
47. 00	Notes payable	110, 949				47. 00
48.00	Unsecured Loans	0	0	0	0	48. 00
49.00	Other long term liabilities	44, 139	0	0	0	49. 00
50.00	Total long term liabilities (sum of lines 46 thru 49)	155, 088	0	0	0	50.00
51.00	Total liabilities (sum of lines 45 and 50)	2, 105, 895	0	0	0	51.00
	CAPITAL ACCOUNTS					
52. 00	General fund balance	41, 289, 005	l .			52. 00
53. 00	Specific purpose fund		0			53. 00
54. 00	Donor created - endowment fund balance - restricted			0		54.00
55. 00	Donor created - endowment fund balance - unrestricted			0		55. 00
56.00	Governing body created - endowment fund balance			0	_	56.00
57.00	Plant fund balance - invested in plant				0	57.00
58. 00	Plant fund balance - reserve for plant improvement, replacement, and expansion				0	58. 00
59. 00	Total fund balances (sum of lines 52 thru 58)	41, 289, 005	0	0	0	59. 00
60. 00	Total liabilities and fund balances (sum of lines 51 and	43, 394, 900	l .	_		60.00
55. 55	[59]	1.5, 5, 1, 700				55.55
		1	•	1	•	'

Provider CCN: 15-0091

					10 12/31/201/	5/30/2018 9:2	
		General	Fund	Speci al	Purpose Fund	Endowment Fund	J Gill
		1.00	2.00	2.00	4.00	F 00	
1. 00	Fund balances at beginning of period	1.00	2. 00 34, 295, 675	3. 00	4. 00	5. 00	1. 00
2.00	Net income (loss) (from Wkst. G-3, line 29)		14, 287, 031				2. 00
3.00	Total (sum of line 1 and line 2)		48, 582, 706				3. 00
4. 00	Additions (credit adjustments) (specify)	0	10, 002, 700		0	0	4. 00
5. 00	(	l ol			0	Ö	5. 00
6.00		o			0	0	6. 00
7.00		O			0	0	7. 00
8.00		o			0	0	8. 00
9.00		O			0	0	9. 00
10.00	Total additions (sum of line 4-9)		0		C		10.00
11.00	Subtotal (line 3 plus line 10)		48, 582, 706		C		11. 00
12.00	ASSET TRANSFERS	7, 293, 701			0	0	12.00
13.00		0			0	0	13.00
14.00		0			0	0	14.00
15.00		0			0	0	15.00
16. 00		0			0	0	16. 00
17. 00		0			0	0	17. 00
18. 00	Total deductions (sum of lines 12-17)		7, 293, 701		C		18. 00
19. 00	Fund balance at end of period per balance		41, 289, 005		C		19. 00
	sheet (line 11 minus line 18)	Endowment Fund	PI ant	Eund			
		Lildowillett Tarid	TTAIT	T UTIU			
		6.00	7. 00	8. 00			
1.00	Fund balances at beginning of period	0			0		1. 00
2.00	Net income (loss) (from Wkst. G-3, line 29)						2.00
3.00	Total (sum of line 1 and line 2)	0			0		3. 00
4.00	Additions (credit adjustments) (specify)		0				4.00
5.00			0				5. 00
6.00			0				6. 00
7.00			0				7. 00
8.00			0				8. 00
9.00	T		0				9. 00
10.00	Total additions (sum of line 4-9)	0			0		10.00
11.00	Subtotal (line 3 plus line 10)	U	0		O		11.00
12.00	ASSET TRANSFERS		0				12. 00 13. 00
13. 00 14. 00			0				14. 00
15. 00			0				15. 00
16. 00			0				16. 00
17. 00			0				17. 00
18. 00	Total deductions (sum of lines 12-17)	0	o l		0		18. 00
19. 00	Fund balance at end of period per balance				0		19. 00
	sheet (line 11 minus line 18)						
		. '		•		'	

Health Financial Systems HU STATEMENT OF PATIENT REVENUES AND OPERATING EXPENSES Provider CCN: 15-0091

			0 12/31/201/	5/30/2018 9:2	
	Cost Center Description	Inpatient	Outpati ent	Total	J dill
		1, 00	2. 00	3. 00	
	PART I - PATIENT REVENUES				
	General Inpatient Routine Services				
1.00	Hospi tal	13, 421, 273	8	13, 421, 273	1. 00
2.00	SUBPROVIDER - I PF				2. 00
3.00	SUBPROVI DER - I RF				3. 00
4. 00	SUBPROVI DER				4. 00
5. 00	Swing bed - SNF			0	5. 00
6.00	Swing bed - NF			0	6. 00
7. 00	SKILLED NURSING FACILITY			_	7. 00
8.00	NURSING FACILITY				8. 00
9. 00	OTHER LONG TERM CARE				9. 00
10.00	Total general inpatient care services (sum of lines 1-9)	13, 421, 273		13, 421, 273	10.00
	Intensive Care Type Inpatient Hospital Services	10/12//2/		10/ 121/270	
11. 00	INTENSIVE CARE UNIT				11. 00
12. 00	CORONARY CARE UNIT				12. 00
13. 00	BURN INTENSIVE CARE UNIT				13. 00
14. 00	SURGI CAL INTENSI VE CARE UNI T				14. 00
15. 00	OTHER SPECIAL CARE (SPECIFY)				15. 00
16. 00	Total intensive care type inpatient hospital services (sum of lines			0	16. 00
	11-15)			_	
17. 00	Total inpatient routine care services (sum of lines 10 and 16)	13, 421, 273		13, 421, 273	17. 00
18. 00	Ancillary services	35, 701, 668		35, 701, 668	18. 00
19. 00	Outpati ent servi ces	(		129, 605, 560	19. 00
20. 00	RURAL HEALTH CLINIC			0	20. 00
21. 00	FEDERALLY QUALIFIED HEALTH CENTER		ol ol	0	21. 00
22. 00	HOME HEALTH AGENCY			Ü	22. 00
23. 00	AMBULANCE SERVICES		11, 477, 487	11, 477, 487	23. 00
24. 00	CMHC			11, 1, 1, 1, 10,	24. 00
25. 00	AMBULATORY SURGICAL CENTER (D. P. )				25. 00
26. 00	HOSPI CE				26. 00
27. 00	OCC HEALTH AND OTHER		1, 407	1, 407	27. 00
28. 00	Total patient revenues (sum of lines 17-27)(transfer column 3 to Wkst.	49, 122, 941		190, 207, 395	28. 00
	G-3, line 1)	, .==,	,	,,	
	PART II - OPERATING EXPENSES	<u>'</u>	<u> </u>		
29.00	Operating expenses (per Wkst. A, column 3, line 200)		50, 841, 313		29. 00
30.00	PROVISION FOR BAD DEBT	6, 482, 693	s		30.00
31.00	HOSPITAL ASSESSMENT FEE	1, 375, 249			31.00
32.00					32.00
33.00					33. 00
34.00					34.00
35.00					35. 00
36.00	Total additions (sum of lines 30-35)		7, 857, 942		36. 00
37.00	DEDUCT (SPECIFY)				37. 00
38. 00	FOUNDATION TRANSFERS	50, 168	3		38. 00
39. 00					39. 00
40.00					40.00
41.00			)		41. 00
42.00	Total deductions (sum of lines 37-41)		50, 168		42.00
43.00	Total operating expenses (sum of lines 29 and 36 minus line 42)(transfe	r	58, 649, 087		43.00
	to Wkst. G-3, line 4)				

	<del></del>	EMORIAL HOSPITAL		u of Form CMS-2	
STATE	ENT OF REVENUES AND EXPENSES	Provider CCN: 15-0091	Peri od: From 01/01/2017	Worksheet G-3	
			To 12/31/2017	Date/Time Pre	pared:
				5/30/2018 9: 2	
				1. 00	
1.00	Total patient revenues (from Wkst. G-2, Part I, column 3			190, 207, 395	
2.00	Less contractual allowances and discounts on patients' a	ccounts		122, 457, 609	
3.00	Net patient revenues (line 1 minus line 2)			67, 749, 786	
4.00	Less total operating expenses (from Wkst. G-2, Part II,			58, 649, 087	
5.00	Net income from service to patients (line 3 minus line 4	)		9, 100, 699	5.00
,	OTHER I NCOME				
6.00	Contributions, donations, bequests, etc			0	6.00
7.00	Income from investments			3, 585, 055	
8.00	Revenues from telephone and other miscellaneous communic	ation services		0	
9.00	Revenue from television and radio service			0	
10.00	Purchase discounts			0	
11.00	Rebates and refunds of expenses			0	
	Parking lot receipts			-	12.00
13.00	Revenue from Laundry and Linen service			0	
	Revenue from meals sold to employees and guests			149, 814	
15.00	Revenue from rental of living quarters			0	
	Revenue from sale of medical and surgical supplies to ot	ner than patients		0	
17.00	Revenue from sale of drugs to other than patients				17.00
	Revenue from sale of medical records and abstracts			0	
	Tuition (fees, sale of textbooks, uniforms, etc.)			0	
20.00	Revenue from gifts, flowers, coffee shops, and canteen			0	
	Rental of vending machines				21.00
22. 00	Rental of hospital space			0	
23. 00	Governmental appropriations			0	
24. 00	OTHER (SPECIFY)			12 027	
24. 01	GAIN/(LOSS) ON SALE OF CAPITAL ASSET			-13, 927	
24. 02	EMS SUBSIDY			535, 607	
	OTHER OPERATING REVENUE			929, 783	
25. 00	Total other income (sum of lines 6-24)			5, 186, 332	
	Total (line 5 plus line 25)			14, 287, 031	
	OTHER EXPENSES (SPECIFY)			0	
	Total other expenses (sum of line 27 and subscripts)	20)		14 207 021	0. 00
29. UÜ	Net income (or loss) for the period (line 26 minus line	28)		14, 287, 031	<sub>1</sub> 29.00

CALCUL	ATION OF CAPITAL PAYMENT	Provi der CCN: 15-0091	Period: From 01/01/2017 To 12/31/2017		pared: 5 am
		Title XVIII	Hospi tal	PPS	
				4 00	
	PART I - FULLY PROSPECTIVE METHOD			1. 00	
	APITAL FEDERAL AMOUNT				1
1.00	Capital DRG other than outlier			240, 644	1.0
1. 01	Model 4 BPCI Capital DRG other than outlier			0	
2. 00	Capital DRG outlier payments			2, 455	
2. 01	Model 4 BPCI Capital DRG outlier payments			0	
3. 00	Total inpatient days divided by number of days in the cost reporting period (see instructions)			12. 93	1
. 00	Number of interns & residents (see instructions)			0.00	
. 00	Indirect medical education percentage (see instructions)			0.00	
. 00	Indirect medical education adjustment (multiply line 5 by	the sum of lines 1 and 1.0	1. columns 1 and	0.00	
	1.01) (see instructions)		.,		
. 00	Percentage of SSI recipient patient days to Medicare Part	A patient days (Worksheet	E, part A line	0.00	7.
	30) (see instructions)	, ,			l
. 00	Percentage of Medicaid patient days to total days (see in	structions)		0.00	8.
. 00	Sum of lines 7 and 8			0.00	9.
0. 00	Allowable disproportionate share percentage (see instruct	ions)		0.00	10.
1.00	Disproportionate share adjustment (see instructions)			0	11.
2. 00	Total prospective capital payments (see instructions)			243, 099	12.
				1. 00	
	PART II - PAYMENT UNDER REASONABLE COST				
. 00	Program inpatient routine capital cost (see instructions)			0	1.
. 00	Program inpatient ancillary capital cost (see instructions	5)		0	
. 00	Total inpatient program capital cost (line 1 plus line 2)	-,		0	3.
. 00	Capital cost payment factor (see instructions)			0	4.
. 00	Total inpatient program capital cost (line 3 x line 4)			0	5.
				1 00	
	PART III - COMPUTATION OF EXCEPTION PAYMENTS			1. 00	
. 00	Program inpatient capital costs (see instructions)			0	1.
. 00	Program inpatient capital costs for extraordinary circums	tances (see instructions)		ĺ	
. 00	Net program inpatient capital costs (line 1 minus line 2)	tanees (see mistractions)		Ö	
. 00	Applicable exception percentage (see instructions)			0.00	
. 00	Capital cost for comparison to payments (line 3 x line 4)			0.00	1
. 00	Percentage adjustment for extraordinary circumstances (see	e instructions)		0.00	
. 00	Adjustment to capital minimum payment level for extraordinates		x line 6)	0.00	
00	Capital minimum payment level (line 5 plus line 7)	, , , , , , , , , , , , , , , , , , ,	/	Ö	
. 00	Current year capital payments (from Part I, line 12, as a	oplicable)		Ö	
0.00	Current year comparison of capital minimum payment level		less line 9)	Ō	
1. 00	Carryover of accumulated capital minimum payment level over			Ō	
	Worksheet L, Part III, line 14)		,		1
2 00		navments (line 10 nlus li		۸ ا	1 12

Net comparison of capital minimum payment level to capital payments (line 10 plus line 11)

Current year exception payment (if line 12 is positive, enter the amount on this line)

Carryover of accumulated capital minimum payment level over capital payment for the following period

(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 12.00

0 13.00

0 15.00

0 16.00 0 17.00

14.00

13.00

14.00