## PART II - CERTIFICATION

(3)

(4) Reopened (5) Amended

Settled with Audit

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 01/01/2018 and ending 12/31/2018 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.

[ X ]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.

> JEANNE WICKENS (Si gned) Officer or Administrator of Provider(s)

CF0/SVP

Title

(Dated when report is electronically signed.) Date

number of times reopened = 0-9.

Title XVIII Title V Part B Cost Center Description Part A HIT Title XIX 1.00 2.00 3.00 4.00 5.00 PART III - SETTLEMENT SUMMARY 1.00 0 -17, 853 70, 766 0 Hospi tal 1.00 0 Subprovi der - IPF 2 00 2 00 C 0 3.00 Subprovider - IRF 0 C 0 0 3.00 Swing bed - SNF 0 0 0 5.00 5.00 0 Swina bed - NF 6 00 0 0 6.00 200.00 Total -17, 853 0 200. 00 70, 766

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. 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.

Health Financial Systems HUNTINGTON MEMORIAL HOSPITAL In Lieu of Form CMS-2552-10 HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA Provider CCN: 15-0091 Peri od: Worksheet S-2 From 01/01/2018 Part I 12/31/2018 Date/Time Prepared: 5/28/2019 10:58 am 3.00 4.00 Hospital and Hospital Health Care Complex Address: Street: 2001 STULTS ROAD 1.00 PO Box: 1.00 State: IN 2.00 City: HUNTINGTON Zip Code: 46750 County: HUNTINGTON 2.00 Component Name CCN CBSA Provi der Date Payment System (P, T, 0, or N)

/ XVIII XIX Certi fi ed Number Number Type 1.00 2.00 3.00 4.00 5.00 6.00 | 7.00 | 8.00 Hospital and Hospital-Based Component Identification: 3.00 HUNTINGTON MEMORIAL 150091 99915 07/01/1966 N 3.00 HOSPI TAI Subprovi der - IPF 4.00 4 00 5.00 Subprovider - IRF 5.00 Subprovi der - (Other) 6.00 6.00 Swing Beds - SNF 7 00 7 00 Swing Beds - NF 8.00 8.00 9.00 Hospi tal -Based SNF 9.00 Hospi tal -Based NF 10.00 10.00 11.00 Hospi tal -Based OLTC 11.00 12.00 Hospi tal -Based HHA 12.00 Separately Certified ASC 13.00 13.00 14.00 Hospi tal -Based Hospi ce 14.00 Hospital-Based Health Clinic - RHC 15 00 15 00 16.00 Hospital-Based Health Clinic - FQHC 16.00 17.00 Hospital -Based (CMHC) I 17.00 18.00 Renal Dialysis 18.00 19.00 Other 19.00 From: 1. 00 2.00 20.00 Cost Reporting Period (mm/dd/yyyy) 01/01/2018 12/31/2018 20.00 21.00 Type of Control (see instructions) 21.00 2 1. 00 2. 00 3.00 Inpatient PPS Information 22.00 Does this facility qualify and is it currently receiving payments for Υ N 22.00 disproportionate share hospital adjustment, in accordance with 42 CFR §412.106? In column 1, enter "Y" for yes or "N" for no. Is this facility subject to 42 CFR Section §412.106(c)(2)(Pickle amendment hospital?) In column 2, enter "Y" for yes or "N" for no. Did this hospital receive interim uncompensated care payments for this 22.01 Ν Ν 22.01 cost reporting period? Enter in column 1, "Y" for yes or "N" for no for the portion of the cost reporting period occurring prior to October 1.

Enter in column 2, "Y" for yes or "N" for no for the portion of the cost reporting period occurring on or after October 1. (see instructions)

Is this a newly merged hospital that requires final uncompensated care payments to be determined at cost report settlement? (see instructions) 22.02 22.02 N N Enter in column 1, "Y" for yes or "N" for no, for the portion of the cost reporting period prior to October 1. Enter in column 2, "Y" for yes or "N" for no, for the portion of the cost reporting period on or after October 1. 22.03 Did this hospital receive a geographic reclassification from urban to 22.03 N Ν N rural as a result of the OMB standards for delineating statistical areas adopted by CMS in FY2015? Enter in column 1, "Y" for yes or "N" for no for the portion of the cost reporting period prior to October 1. Enter in column 2, "Y" for yes or "N" for no for the portion of the cost reporting period occurring on or after October 1. (see instructions) Does this hospital contain at least 100 but not more than 499 beds (as counted in accordance with 42 CFR 412.105)? Enter in column 3, "Y" for yes or "N" for no. Which method is used to determine Medicaid days on lines 24 and/or 25 Ν 23.00 below? In column 1, enter 1 if date of admission, 2 if census days, or 3 if date of discharge. Is the method of identifying the days in this cost reporting period different from the method used in the prior cost

						1
n-State	In-State	Out-of	Out-of	Medi cai d	d Other	
Medi cai d	Medi cai d	State	State	HMO days	Medicaid	
aid days	eligible	Medi cai d	Medi cai d		days	
	unpai d	paid days	el i gi bl e			
	days		unpai d			
1.00	2. 00	3. 00	4. 00	5. 00	6.00	
113	490	0	6	82	29 0	24.00
	id days	eligible unpaid days  1.00 2.00	eligible Medicaid paid days days 1.00 2.00 3.00	id days eligible unpaid days days 1.00 2.00 3.00 Medicaid Medicaid eligible unpaid	id days eligible unpaid days eligible unpaid days 1.00 2.00 3.00 4.00 5.00	id days eligible unpaid days eligible unpaid days 2.00 3.00 4.00 5.00 6.00

	Financial Systems HUNTINGTO AL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DA	ON MEMORIAL	Provider CC	N: 15-0091	Peri		IN LI			CMS-2 et S-2	
					From To	01/0	1/2018	Par Dat 5/2	t I e/Tir 28/201	ne Prej 19 10:	pared
		In-State Medicaid paid days	In-State Medicaid eligible unpaid days	Out-of State Medicaid paid days	Out- Sta Medic eligi unpa	te caid ble aid	Medic HMO c	lays	Medi da	her cai d nys	
. 00	If this provider is an IRF, enter the in-state	1.00	2.00	3.00	4. C	00	5. C	00	6.	00	25.
	Medicaid paid days in column 1, the in-state Medicaid paid days in column 1, the in-state Medicaid eligible unpaid days in column 2, out-of-state Medicaid days in column 3, out-of-state Medicaid eligible unpaid days in column 4, Medicaid HMO paid and eligible but unpaid days in column 5.	0	0	U		-ban/R				0	25.
					UI	1. C		Dat	2.00		
. 00	Enter your standard geographic classification (not was cost reporting period. Enter "1" for urban or "2" for Enter your standard geographic classification (not was reporting period. Enter in column 1, "1" for urban or enter the effective date of the geographic reclassifilf this is a sole community hospital (SCH), enter the	rural. age) status r"2" for r cation in	at the end ural. If ap column 2.	of the cos	st			2 2 10 0	)/01/:	2016	26. 27. 35.
	effect in the cost reporting period.				F	Begi nr	ni na:		Endi n	a:	
				21.5		1. 0			2. 00		
00	Enter applicable beginning and ending dates of SCH stop of periods in excess of one and enter subsequent date		cript line	36 for numb	er						36
00	If this is a Medicare dependent hospital (MDH), enter		r of period	ls MDH statu	ıs			o			37
01	is in effect in the cost reporting period.  Is this hospital a former MDH that is eligible for the accordance with FY 2016 OPPS final rule? Enter "Y" for instructions)										37
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
						Υ/			Y/N		
	Does this facility qualify for the inpatient hospital hospitals in accordance with 42 CFR §412.101(b)(2)(i)1 "Y" for yes or "N" for no. Does the facility meet taccordance with 42 CFR 412.101(b)(2)(i), (ii), or (ii) or "N" for no. (see instructions)	), (ii), or the mileage	(iii)? Ent	er in colum nts in	ın	1. C Y			2. 00 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.	oer 1. Ente	r "Y" for y			N			Y		40
							1.0		. 00	XIX	
	Prospective Payment System (PPS)-Capital						1.0	10   2	. 00	3. 00	
	Does this facility qualify and receive Capital paymer with 42 CFR Section §412.320? (see instructions) Is this facility eligible for additional payment exce	·	•			dance	N		N N	N N	45 46
	pursuant to 42 CFR §412.348(f)? If yes, complete Wkst Pt. III.	t. L, Pt. I	II and Wkst	. L-1, Pt.	I thro	ough					
	Is this a new hospital under 42 CFR §412.300(b) PPS of the facility electing full federal capital payment Teaching Hospitals					10.	N N		N N	N N	47 48
00	Is this a hospital involved in training residents in or "N" for no.	approved G	ME programs	? Enter "Y	" for	yes	N				56
00	of N 101 NO.  If line 56 is yes, is this the first cost reporting proceed from trained at this facility? Enter "Y" for is "Y" did residents start training in the first month for yes or "N" for no in column 2. If column 2 is "No.	yes or "N th of this	" for no in cost report	n column 1. ing period?	lf col ≀ Ent∈	umn 1 er "Y"					57
	"N", complete Wkst. D, Parts III & IV and D-2, Pt. II If line 56 is yes, did this facility elect cost reimb defined in CMS Pub. 15-1, chapter 21, §2148? If yes,	, if applicursement for complete W	cable. or physicia kst. D-5.	ıns' service		-	N				58
	Are costs claimed on line 100 of Worksheet A? If yes	s, complete	Wkst. D-2,	NAHE 413.8	85 W	lorksh Li ne		Pas	ss-Thi	ough	59
				Y/N						n Code	
				1. 00		2. (				n Code	

			I AL HOSPI TAL			eu of Form CMS-2	
HOSPI T	AL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DA	TΑ	Provi der 0	CCN: 15-0091	Peri od: From 01/01/2018 To 12/31/2018	Date/Time Pre	pared:
		Y/N	IME	Direct GME	IME	5/28/2019 10: Direct GME	58 alli
		1. 00	2. 00	3. 00	4.00	5. 00	
	Did your hospital receive FTE slots under ACA section 5503? Enter "Y" for yes or "N" for no in column 1. (see instructions)	N			0.00	0.00	61.00
61.01	Enter the average number of unweighted primary care FTEs from the hospital's 3 most recent cost reports ending and submitted before March 23, 2010. (see instructions)						61. 01
61. 02	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. 02
61. 03	ACA). (see instructions) Enter the base line FTE count for primary care and/or general surgery residents, which is used for determining compliance with the 75% test. (see						61. 03
61. 04	instructions) Enter the number of unweighted primary care/or surgery allopathic and/or osteopathic FTEs in the current cost reporting period.(see instructions).						61. 04
61. 05	Enter the difference between the baseline primary and/or general surgery FTEs and the current year's primary care and/or general surgery FTE counts (line						61. 05
61. 06	61.04 minus line 61.03). (see instructions) Enter the amount of ACA §5503 award that is being used for cap relief and/or FTEs that are nonprimary care or general surgery. (see instructions)						61. 06
		Pro	ogram Name	Program Code	e Unweighted IME FTE Count	Unweighted Direct GME FTE Count	
61 10	Of the FTEs in line 61.05, specify each new program		1.00	2. 00	3.00	4.00	61. 10
01.10	for each new program. (see instructions) Enter in column 1, the program name. Enter in column 2, the program code. Enter in column 3, the IME FTE unweighted count. Enter in column 4, the direct GME FTE unweighted count.				0.00	0.00	01. 10
61. 20	Of the FTEs in line 61.05, specify each expanded program specialty, if any, and the number of FTE residents for each expanded program. (see instructions) Enter in column 1, the program name. Enter in column 2, the program code. Enter in column 3, the IME FTE unweighted count. Enter in column 4, the direct GME FTE unweighted count.				O. OC	0.00	61. 20
						1. 00	
62 00	ACA Provisions Affecting the Health Resources and Ser Enter the number of FTE residents that your hospital				riod for which	0.00	62.00
	your hospital received HRSA PCRE funding (see instruc Enter the number of FTE residents that rotated from a during in this cost reporting period of HRSA THC prog	tions) Teachi ram. (s	ng Health Cer ee instructio	nter (THC) int			62. 01
63. 00	Teaching Hospitals that Claim Residents in Nonprovide Has your facility trained residents in nonprovider se "Y" for yes or "N" for no in column 1. If yes, comple	ttings	during this o			N	63. 00
			_ 0 ough	Unwei ghted FTEs	Unwei ghted	Ratio (col. 1/ (col. 1 + col.	
				Nonprovi der Si te	FTEs in Hospital	2))	

	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 Base Year FTE Residents in Nonprovider Settings1	This base year	is your cost r	eporti ng	
period that begins on or after July 1, 2009 and before June 30, 2010.				
64.00 Enter in column 1, if line 63 is yes, or your facility trained residents	0.00	0.00	0. 000000	64.00
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				1
of (column 1 divided by (column 1 + column 2)). (see instructions)				

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA Provider CCN: 15-0091 Peri od: Worksheet S-2 From 01/01/2018 Part I Date/Time Prepared: 12/31/2018 5/28/2019 10:58 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)

Health Financial Syst	ems HUNTINGTON MEMOR	IAL HOSPITAL		In Lie	u of Form CMS	5-2552-10
HOSPITAL AND HOSPITAL	_ HEALTH CARE COMPLEX IDENTIFICATION DATA	Provi der CCN: 15-	F	Period: From 01/01/2018 To 12/31/2018	Worksheet S- Part I Date/Time Pr 5/28/2019 10	repared:
					1. 00	
	term care hospital (LTCH)? Enter "Y" for yes				N	80.00
81.00 Is this a LTCH "Y" for yes an	co-located within another hospital for part of d "N" for no.	r all of the cost r	eporti ng	period? Enter	N	81. 00
TEFRA Provider 85.00 Is this a new	s hospital under 42 CFR Section §413.40(f)(1)(i)	TEFRA? Enter "Y"	for yes	or "N" for no.	N	85. 00
86.00 Did this facil	ity establish a new Other subprovider (excluder ii)? Enter "Y" for yes and "N" for no.					86. 00
87.00 Is this hospit	al an extended neoplastic disease care hospita vi)? Enter "Y" for yes or "N" for no.	l classified under	secti on		N	87. 00
	., ,			V 1. 00	XI X 2. 00	
Title V and XI	X Servi ces			1.00	2.00	
	lity have title V and/or XLX inpatient hospita	l services? Enter "	Y" for	N	Y	90.00
91.00 Is this hospit	no in the applicable column. al reimbursed for title V and/or XIX through tl		er in	N	N	91. 00
	t? Enter "Y" for yes or "N" for no in the appl NF patients occupying title XVIII SNF beds (dua		(see		N	92. 00
i nstructi ons)	Enter "Y" for yes or "N" for no in the applical	ble column.	•	N		93. 00
"Y" for yes or	lity operate an ICF/IID facility for purposes ("N" for no in the applicable column.				N	
94.00 Does title V o applicable col	r XIX reduce capital cost? Enter "Y" for yes, a umn.	and "N" for no in t	he	N	N	94. 00
	"Y", enter the reduction percentage in the app r XIX reduce operating cost? Enter "Y" for yes		he	0. 00 N	0. 00 N	95. 00 96. 00
applicable col	umn.			0.00	0.00	97. 00
98.00 Does title V o	"Y", enter the reduction percentage in the app r XIX follow Medicare (title XVIII) for the in	terns and residents		0.00 N	Y	98. 00
	tments on Wkst. B, Pt. I, col. 25? Enter "Y" foitle V, and in column 2 for title XIX.	or yes or "N" for n	io in			
	r XIX follow Medicare (title XVIII) for the re r "Y" for yes or "N" for no in column 1 for ti			N	Y	98. 01
title XIX.	r XIX follow Medicare (title XVIII) for the ca			N	Y	98. 02
bed costs on W	kst. D-1, Pt. IV, line 89? Enter "Y" for yes o			IN .	'	90.02
	nd in column 2 for title XIX. r XIX follow Medicare (title XVIII) for a crit	ical access hospita	ıl (CAH)	N	N	98. 03
	% of inpatient services cost? Enter "Y" for ye: nd in column 2 for title XIX.	s or "N" for no in	column 1			
98.04 Does title V o	r XIX follow Medicare (title XVIII) for a CAH vices cost? Enter "Y" for yes or "N" for no in		. V. and	N	N	98. 04
in column 2 fo	r title XIX.				.,	00.05
	r XIX follow Medicare (title XVIII) and add ba , col. 4? Enter "Y" for yes or "N" for no in c			N	Y	98. 05
column 2 for t 98.06 Does title V o	itle XIX. r XIX follow Medicare (title XVIII) when cost :	reimbursed for Wkst	. D,	N	Υ	98. 06
Pts. I through column 2 for t	IV? Enter "Y" for yes or "N" for no in column itle XIX	1 for title V, and	lin			
Rural Provider	S					
	ital qualify as a CAH? ty qualifies as a CAH, has it elected the all-	inclusive method of	pavment	N		105. 00 106. 00
for outpatient	services? (see instructions)		1 3			
training progr	ty qualifies as a CAH, is it eligible for cost ams? Enter "Y" for yes or "N" for no in column	1. (see instruction	ns) If			107. 00
P   .	limination is not made on Wkst. B, Pt. I, col. yes complete Wkst. D-2, Pt. II.	25 and the program	is cost			
108.00 Is this a rura	I hospital qualifying for an exception to the	CRNA fee schedule?	See 42	N		108. 00
UFK Section §4	12.113(c). Enter "Y" for yes or "N" for no.	Physi cal Occu	ıpati onal	Speech	Respi ratory	/
100 001 f +b; a bas=: +	al qualifies as a CAH on a cost provider	1.00 N	2.00	3. 00	4. 00	100.00
therapy servic	al qualifies as a CAH or a cost provider, are es provided by outside supplier? Enter "Y"	IN				109. 00
for yes or "N"	for no for each therapy.					

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.

1.00

N

110. 00

OSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA	Provider CCN: 15-0091	Peri od:	Worksheet S	S-2552- -2
SOUTH AND THOU THE TELL TO STATE SOUTH EET, TO ELL TO ELL TO STATE SOUTH EET, TO ELL T		From 01/01/2018 To 12/31/2018	8 Part I	repared
·				
11.00   If this facility qualifies as a CAH, did it participate in the Health Integration Project (FCHIP) demonstration for this cost in "Y" for yes or "N" for no in column 1. If the response to column integration prong of the FCHIP demo in which this CAH is particible. Enter all that apply: "A" for Ambulance services; "B" for additing for tele-health services.	reporting period? Enter n 1 is Y, enter the ipating in column 2.	1.00 N	2.00	111.
		1. (	00 2.00 3.0	0
Miscellaneous Cost Reporting Information  15.00 Is this an all-inclusive rate provider? Enter "Y" for yes or "N" is yes, enter the method used (A, B, or E only) in column 2. If 3 either "93" percent for short term hospital or "98" percent for psychiatric, rehabilitation and long term hospitals providers) Pub. 15-1, chapter 22, §2208.1.	column 2 is "E", enter or long term care (incl based on the definition	r in column udes n in CMS		
16.00 s this facility classified as a referral center? Enter "Y" for 17.00 s this facility legally-required to carry malpractice insurance no.		r"N" for Y		116. 117.
18.00 Is the malpractice insurance a claims-made or occurrence policy claim-made. Enter 2 if the policy is occurrence.	? Enter 1 if the policy	yis 1		118.
ordini mado. Error E ri vilo porroy re coodirionos.	Premi ums	Losses	Insurance	
	1.00	2.00	3.00	
18.01 List amounts of malpractice premiums and paid losses:	91, 8	317	0 43, 1	56 118.
		1. 00	2.00	
18.02 Are malpractice premiums and paid losses reported in a cost center Administrative and General? If yes, submit supporting schedule and amounts contained therein.  19.00 DO NOT USE THIS LINE 20.00 Is this a SCH or EACH that qualifies for the Outpatient Hold Hai §3121 and applicable amendments? (see instructions) Enter in column "N" for no. Is this a rural hospital with < 100 beds that qualified Hold Harmless provision in ACA §3121 and applicable amendments?	Insting cost centers  rmless provision in AC/ lumn 1, "Y" for yes or fies for the Outpatient		N	118.  119.  120.
Enter in column 2, "Y" for yes or "N" for no. 21.00 Did this facility incur and report costs for high cost implantal	ble devices charged to	Υ		121.
patients? Enter "Y" for yes or "N" for no. 22.00 Does the cost report contain healthcare related taxes as defined Act?Enter "Y" for yes or "N" for no in column 1. If column 1 is the Worksheet A line number where these taxes are included.				122.
Transplant Center Information  25.00 Does this facility operate a transplant center? Enter "Y" for year	es and "N" for no. If	N		125.
yes, enter certification date(s) (mm/dd/yyyy) below.  6.00  f this is a Medicare certified kidney transplant center, enter	the certification date	e		126.
in column 1 and termination date, if applicable, in column 2.  7.00 If this is a Medicare certified heart transplant center, enter in column 1 and termination date, if applicable, in column 2.	the certification date			127.
8.00 If this is a Medicare certified liver transplant center, enter in column 1 and termination date, if applicable, in column 2.				128.
9.00 If this is a Medicare certified lung transplant center, enter the column 1 and termination date, if applicable, in column 2. 0.00 If this is a Medicare certified pancreas transplant center, enter		n		129. 130.
date in column 1 and termination date, if applicable, in column 1.00 f this is a Medicare certified intestinal transplant center, e	2.			131.
date in column 1 and termination date, if applicable, in column 2.00  f this is a Medicare certified islet transplant center, enter				132.
in column 1 and termination date, if applicable, in column 2. 3.00 If this is a Medicare certified other transplant center, enter in column 1 and termination date, if applicable, in column 2.	the certification date			133.
34.00 If this is an organ procurement organization (OPO), enter the OF and termination date, if applicable, in column 2.	PO number in column 1			134.
All Providers 0.00 Are there any related organization or home office costs as define	ned in CMS Pub 15-1	Y	15H032	140.
is some a thore any related brightnizhtron or Holle Office Costs as ucili	III OMO I UD. IJ-I,	5	1011002	1,40.

	Name	County	State	Zip Code	CBSA	FTE/Campus	
	0	1. 00	2. 00	3.00	4. 00	5. 00	
166.00 If line 165 is yes, for each campus enter the name in column 0, county in column 1, state in column 2, zip code in column 3, CBSA in column 4, FTE/Campus in column 5 (see instructions)						0.00	166. 00
corumn 5 (see mistructrons)	1						
						1.00	1
Health Information Technology (HI	T) incentive in the A	merican Recovery and	Rei nves	tment Act			
167.00 Is this provider a meaningful use		Υ	167. 00				
168.00 If this provider is a CAH (line 1 reasonable cost incurred for the	the	(	168. 00				
168.01 If this provider is a CAH and is exception under §413.70(a)(6)(ii)		168. 01					
169.00 If this provider is a meaningful transition factor. (see instructi	user (line 167 is "Y")				enter the	9. 9	9169. 00
transfers (see thetrastr				Be	gi nni ng	Endi ng	
					1. 00	2.00	1
170.00 Enter in columns 1 and 2 the EHR period respectively (mm/dd/yyyy)	beginning date and en	ding date for the rep	orting	10/	/01/2017	09/30/2018	170. 00
					1. 00	2.00	
71.00 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)							171. 00
prove mean early days sortain 2.	222			1		ı	1

	Financial Systems HUNTINGTON MEMO		ON 45 005:		u of Form CMS-	
HOSPI T	AL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE	Provi der C	CN: 15-0091	Peri od: From 01/01/2018 To 12/31/2018	Worksheet S-2 Part II Date/Time Pre 5/28/2019 10:	epared:
		<u> </u>		Y/N	Date	
				1. 00	2. 00	
	General Instruction: Enter Y for all YES responses. Enter Nmm/dd/yyyy format. COMPLETED BY ALL HOSPITALS	l for all NO re	esponses. Ente	er all dates in t	he	
1. 00	Provider Organization and Operation Has the provider changed ownership immediately prior to the	e heainning of	the cost	N		1.00
1.00	reporting period? If yes, enter the date of the change in o					1.00
			Y/N	Date	V/I	
	I		1.00	2. 00	3. 00	
2.00	Has the provider terminated participation in the Medicare F yes, enter in column 2 the date of termination and in colum voluntary or "I" for involuntary.	mn 3, "V" for	N			2. 00
3.00	Is the provider involved in business transactions, includir contracts, with individuals or entities (e.g., chain home or medical supply companies) that are related to the provide officers, medical staff, management personnel, or members of directors through ownership, control, or family and other relationships? (see instructions)	N			3.00	
			Y/N	Type	Date	
			1.00	2. 00	3. 00	
4 00	Financial Data and Reports		l v			4 00
4. 00	Column 1: Were the financial statements prepared by a Cert Accountant? Column 2: If yes, enter "A" for Audited, "C" for "R" for Reviewed. Submit complete copy or enter date avacolumn 3. (see instructions) If no, see instructions. Are the cost report total expenses and total revenues differences.	for Compiled, ailable in	Y	A		4.00
5.00	those on the filed financial statements? If yes, submit rec		l IN			5. 00
	Those on the fired financial Statements. If you, Submit Fee	sonor ratron.		Y/N	Legal Oper.	
				1. 00	2. 00	
	Approved Educational Activities	1.6	. , .			
6. 00	Column 1: Are costs claimed for nursing school? Column 2: the legal operator of the program?	ir yes, is th	ie provider is	S N		6. 00
7.00	Are costs claimed for Allied Health Programs? If "Y" see in	nstructions.		N		7. 00
8. 00	Were nursing school and/or allied health programs approved cost reporting period? If yes, see instructions.	and/or renewed	J	N		8. 00
9. 00	Are costs claimed for Interns and Residents in an approved program in the current cost report? If yes, see instruction		cal education	N		9. 00
10. 00	Was an approved Intern and Resident GME program initiated 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	proved	N	Y/N	11. 00
					1. 00	
	Bad Debts					
12. 00 13. 00	Is the provider seeking reimbursement for bad debts? If yes If line 12 is yes, did the provider's bad debt collection period? If yes, submit copy.			ost reporting	Y N	12. 00 13. 00
14. 00	If line 12 is yes, were patient deductibles and/or co-payme Bed Complement	ents waived? If	yes, see ins	structi ons.	N	14. 00
15. 00	Did total beds available change from the prior cost reporti				t B	15. 00
		Y/N	t A Date	Y/N	Date	
		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	N		N		16. 00
47.00	date of the PS&R Report used in columns 2 and 4 (see instructions)	, v	05 (04 (0040		05 (04 (004 0	47.00
17. 00	Was the cost report prepared using the PS&R Report for totals and the provider's records for allocation? If either column 1 or 3 is yes, enter the paid-through date in columns 2 and 4. (see instructions)	Y	05/01/2018	Y	05/01/2018	17. 00
18. 00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for additional claims that have been billed but are not included on the PS&R Report used to file this	Y		Y		18. 00
19. 00	cost report? If yes, see instructions. If line 16 or 17 is yes, were adjustments made to PS&R Report data for corrections of other PS&R Report	N		N		19. 00

.551 1 1	Financial Systems HUNTINGTON MEMON FAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE	Provi der CCN	l: 15-0091	Peri od:	u of Form CMS Worksheet S-			
				From 01/01/2018 To 12/31/2018	Part II Date/Time Pr			
		Descri p	nti on	Y/N	5/28/2019 10 Y/N	): 58 am		
		0		1. 00	3. 00			
20. 00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for Other? Describe the other adjustments:			N	N	20.00		
	report data for other: bescribe 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)					
2 00	Capital Related Cost Have assets been relifed for Medicare purposes? If yes, see	instructions				22. 0		
2. 00 3. 00	Have changes occurred in the Medicare depreciation expense reporting period? If yes, see instructions.		ls made dur	ing the cost		23. 0		
4. 00	Were new leases and/or amendments to existing leases entered if yes, see instructions	ed into during t	his cost re	porting period?		24. 0		
5. 00	Have there been new capitalized leases entered into during instructions.	the cost report	ing period?	If yes, see		25. 0		
26. 00	Were assets subject to Sec. 2314 of DEFRA acquired during the instructions.	ne cost reportin	g period? I	f yes, see		26. 0		
7. 00	Has the provider's capitalization policy changed during the copy.	cost reporting	period? If	yes, submit		27. 0		
8. 00	Interest Expense Were new Loans, mortgage agreements or Letters of credit en	ntered into duri	ng the cost	reporting		28. 0		
9. 00	period? If yes, see instructions.  00 Did the provider have a funded depreciation account and/or bond funds (Debt Service Reserve Fund)							
0. 00	treated as a funded depreciation account? If yes, see instructions ON Has existing debt been replaced prior to its scheduled maturity with new debt? If yes, see							
1. 00	instructions.  Has debt been recalled before scheduled maturity without is instructions.	suance of new d	ebt? If yes	, see		31.0		
2. 00	Purchased Services Have changes or new agreements occurred in patient care ser	vi ces furni shed	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	ıcti ons.				33. 0		
	no, see instructions. Provider-Based Physicians							
4. 00	Are services furnished at the provider facility under an ar If yes, see instructions.	rangement with p	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:		s with the	provi der-based		35. 0		
	The second of th			Y/N	Date			
	Home Office Costs			1. 00	2. 00			
36. 00	Were home office costs claimed on the cost report?			Υ		36. 0		
	If line 36 is yes, has a home office cost statement been pro	epared by the h	ome office?			37. 0		
8. 00	If yes, see instructions. If line 36 is yes, was the fiscal year end of the home off the provider? If yes, enter in column 2 the fiscal year end			N		38. 0		
0 00				, N		39. C		
7. 00	If line 36 is yes, did the provider render services to the instructions.	home office? I	f yes, see	N		40. 0		
		1 0	Ω	2	00			
		1.00	0	2.	00			
11. 00	Cost Report Preparer Contact Information Enter the first name, last name and the title/position held by the cost report preparer in columns 1, 2, and 3,	1. 00 ERI C	0	NI CKESON	00	41.0		
10. 00	Cost Report Preparer Contact Information  Enter the first name, last name and the title/position held by the cost report preparer in columns 1, 2, and 3, respectively.			NI CKESON	00	41.0		

Health Financial Systems HUNTINGTON MEN				I TAL		In Lieu	u of Form CN	IS-25	552-10
HOSPI 1	ΓAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QU	UESTI ONNAI RE	Provi	der CCN: 15-0091	Peri		Worksheet S	S-2	·
					To	n 01/01/2018 12/31/2018			
				3. 00					
	Cost Report Preparer Contact Information								
41.00	Enter the first name, last name and the tit	tle/position	DI RECTOR,	REIMBURSEMENT					41.00
	held by the cost report preparer in columns	s 1, 2, and 3,							
	respecti vel y.								
42.00	Enter the employer/company name of the cost	t report							42.00
	preparer.								
43.00	Enter the telephone number and email address	ss of the cost							43.00
	report preparer in columns 1 and 2, respect	ti vel y.							

| Period: | Worksheet S-3 | From 01/01/2018 | Part | To 12/31/2018 | Date/Time Prepared: 
 Heal th Financial
 Systems
 HUNTINGTO

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

				Τ	o 12/31/2018	Date/Time Prep 5/28/2019 10:	
						1/P Days / 0/P	36 alli
						Visits / Trips	
	Component	Worksheet A	No. of Beds	Bed Days	CAH Hours	Title V	
	Compensite	Line Number	No. or beas	Avai I abl e	oran nodi s	11 110 1	
		1. 00	2. 00	3.00	4. 00	5. 00	
1.00	Hospital Adults & Peds. (columns 5, 6, 7 and	30, 00	36			0	1, 00
	8 exclude Swing Bed, Observation Bed and	22.22				_	
	Hospice days) (see instructions for col. 2						
	for the portion of LDP room available beds)						
2.00	HMO and other (see instructions)						2. 00
3.00	HMO IPF Subprovider						3.00
4.00	HMO IRF Subprovider						4. 00
5.00	Hospital Adults & Peds. Swing Bed SNF					0	5. 00
6.00	Hospital Adults & Peds. Swing Bed NF					0	6. 00
7.00	Total Adults and Peds. (exclude observation		36	13, 140	0.00	0	7. 00
	beds) (see instructions)						
8.00	INTENSIVE CARE UNIT						8. 00
9. 00	CORONARY CARE UNIT						9. 00
10. 00	BURN INTENSIVE CARE UNIT						10. 00
11. 00	SURGICAL INTENSIVE CARE UNIT						11. 00
12. 00	OTHER SPECIAL CARE (SPECIFY)						12. 00
13. 00	NURSERY	43. 00				0	13. 00
14. 00	Total (see instructions)		36	13, 140	0.00	0	14. 00
15. 00	CAH visits					0	15. 00
16. 00	SUBPROVIDER - I PF						16. 00
17. 00	SUBPROVIDER - IRF						17. 00
18.00	SUBPROVI DER						18. 00
19. 00	SKILLED NURSING FACILITY						19. 00
20.00	NURSING FACILITY						20. 00
21. 00	OTHER LONG TERM CARE						21. 00
22. 00	HOME HEALTH AGENCY						22. 00 23. 00
23. 00 24. 00	AMBULATORY SURGICAL CENTER (D. P. ) HOSPICE						23.00
24. 00		30. 00					24. 00
25. 00	HOSPICE (non-distinct part) CMHC - CMHC	30.00					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)	07.00	36			U	27. 00
28. 00	Observation Bed Days		30			0	28. 00
29. 00	Ambul ance Tri ps					O	29. 00
30.00	Employee discount days (see instruction)						30.00
31. 00	Employee discount days (see Fristraction)						31. 00
32. 00	Labor & delivery days (see instructions)		0		)		32. 00
32. 01	Total ancillary labor & delivery room		O				32. 01
JE. 31	outpatient days (see instructions)						
33.00	LTCH non-covered days						33. 00
	LTCH site neutral days and discharges						33. 01

Peri od: Worksheet S-3 From 01/01/2018 Part I To 12/31/2018 Date/Time Prepared: 5/38/2019 10:58 am

						5/28/2019 10:	58 am
		I/P Days	s / O/P Visits	/ Trips	Full Time	Equi val ents	
	Component	Title XVIII	Title XIX	Total All Patients	Total Interns & Residents	Employees On Payroll	
		6. 00	7. 00	8.00	9. 00	10.00	
1. 00	Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days) (see instructions for col. 2 for the portion of LDP room available beds)	1, 359	79	4, 351			1. 00
2.00	HMO and other (see instructions)	1, 184	1, 265				2.00
3.00	HMO I PF Subprovi der	0	0				3. 00
4.00	HMO IRF Subprovider	o	0				4. 00
5.00	Hospital Adults & Peds. Swing Bed SNF	o	0	l c	)		5. 00
6.00	Hospital Adults & Peds. Swing Bed NF		0		)		6.00
7. 00	Total Adults and Peds. (exclude observation beds) (see instructions)	1, 359	79	4, 351			7. 00
8.00	INTENSIVE CARE UNIT						8. 00
9.00	CORONARY CARE UNIT						9. 00
10.00	BURN INTENSIVE CARE UNIT						10.00
11. 00	SURGICAL INTENSIVE CARE UNIT						11. 00
12.00	OTHER SPECIAL CARE (SPECIFY)						12. 00
13.00	NURSERY		27	718	1		13. 00
14.00	Total (see instructions)	1, 359	106	5, 069	0.00	220.00	14.00
15.00	CAH visits	o	0	l	)		15. 00
16.00	SUBPROVIDER - IPF						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)			44			24. 10
25.00	CMHC - CMHC						25. 00
26.00	RURAL HEALTH CLINIC						26. 00
26. 25	FEDERALLY QUALIFIED HEALTH CENTER	O	0	l	0.00	0.00	26. 25
27. 00	Total (sum of lines 14-26)				0.00	220.00	27. 00
28. 00	Observation Bed Days		208	1, 647	,		28. 00
29. 00	Ambul ance Trips	1, 793		·			29. 00
30.00	Employee discount days (see instruction)	1		66			30. 00
31. 00	Employee discount days - IRF						31. 00
32. 00	Labor & delivery days (see instructions)	0	67	116			32. 00
32. 01	Total ancillary labor & delivery room		0,				32. 01
	outpatient days (see instructions)			]			
33. 00	1 ' ' ' ' ' ' ' ' ' ' ' ' ' ' ' ' ' ' '	0					33. 00
	LTCH site neutral days and discharges	0					33. 01
	,	1		'	1	•	

| Period: | Worksheet S-3 | From 01/01/2018 | Part | To 12/31/2018 | Date/Time Prepared: Provider CCN: 15-0091

					To	12/31/2018	Date/Time Prep 5/28/2019 10:	
		Full Time Equivalents			Di sch	arges	0, 20, 20, 7	
	Component	Nonpai d	Title V	П	Title XVIII	Title XIX	Total All	
		Workers					Pati ents	
		11. 00	12. 00		13. 00	14. 00	15. 00	
1. 00	Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days) (see instructions for col. 2 for the portion of LDP room available beds)			0	504	33	1, 853	1. 00
2. 00 3. 00	HMO and other (see instructions) HMO IPF Subprovider				423	367 0 0		2. 00 3. 00
4. 00 5. 00	HMO IRF Subprovider Hospital Adults & Peds. Swing Bed SNF					U		4. 00 5. 00
6. 00 7. 00	Hospital Adults & Peds. Swing Bed NF Total Adults and Peds. (exclude observation beds) (see instructions)							6. 00 7. 00
8.00	INTENSIVE CARE UNIT							8. 00
9.00	CORONARY CARE UNIT							9. 00
10.00	BURN INTENSIVE CARE UNIT							10.00
11. 00 12. 00	SURGICAL INTENSIVE CARE UNIT OTHER SPECIAL CARE (SPECIFY)							11. 00 12. 00
13. 00	NURSERY			ł				13. 00
14. 00	Total (see instructions)	0.00		0	504	33	1, 853	14. 00
15. 00	CAH visits						.,	15. 00
16.00	SUBPROVI DER - I PF			ı				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								21. 00
22. 00	HOME HEALTH AGENCY							22. 00
23. 00	AMBULATORY SURGICAL CENTER (D. P. )							23. 00
24. 00	HOSPI CE			-				24. 00
24. 10	HOSPICE (non-distinct part)							24. 10
25. 00 26. 00	CMHC - CMHC			- 1				25. 00 26. 00
26. 25	RURAL HEALTH CLINIC FEDERALLY QUALIFIED HEALTH CENTER	0. 00		- 1				26. 25
27. 00	Total (sum of lines 14-26)	0.00		ı				27. 00
28. 00	Observation Bed Days	0.00						28. 00
29. 00	Ambul ance Tri ps			ı				29. 00
30. 00	Employee discount days (see instruction)							30.00
31. 00	Employee discount days - IRF							31. 00
32. 00	Labor & delivery days (see instructions)							32. 00
32. 01	Total ancillary labor & delivery room							32. 01
	outpatient days (see instructions)							
33. 00	LTCH non-covered days				0			33. 00
33. 01	LTCH site neutral days and discharges				0			33. 01

Health Financial Systems
HOSPITAL WAGE INDEX INFORMATION Provi der CCN: 15-0091

					To	nom 01/01/2018 n 12/31/2018	Date/Time Pre	pared:
		Wkst. A Line	Amount	Recl assi fi cati	Adj usted	Pai d Hours	5/28/2019 10: Average Hourly	58 am
		Number	Reported	on of Salaries	Sal ari es	Related to	Wage (col. 4 ÷	
				(from Wkst. A-6)	(col.2 ± col. 3)	Salaries in col. 4	col . 5)	
		1. 00	2.00	3. 00	4.00	5. 00	6. 00	
	PART II - WAGE DATA							
1. 00	SALARIES Total salaries (see	200. 00	15, 055, 192	3, 800, 176	18, 855, 368	593, 944. 00	31. 75	1. 00
	instructions)							
2. 00	Non-physician anesthetist Part		0	0	0	0. 00	0. 00	2. 00
3.00	Non-physician anesthetist Part		0	О	0	0.00	0. 00	3. 00
4. 00	B Physician-Part A -		24, 000	0	24, 000	106. 00	226. 42	4. 00
4.00	Administrative		24, 000	ĺ	24, 000	100.00	220. 42	4.00
4. 01	Physicians - Part A - Teaching		0	0	0	0.00		4. 01
5. 00	Physician and Non Physician-Part B		0	0	0	0. 00	0.00	5. 00
6.00	Non-physician-Part B for		0	0	0	0.00	0. 00	6. 00
	hospital-based RHC and FQHC services							
7. 00	Interns & residents (in an	21. 00	0	О	0	0.00	0. 00	7. 00
7. 01	approved program) Contracted interns and		0	0	0	0. 00	0. 00	7. 01
7.01	residents (in an approved		O	9		0.00	0.00	7.01
0.00	programs)		2 000 17/		2 000 17/	115 022 00	22.01	0.00
8. 00	Home office and/or related organization personnel		3, 800, 176	0	3, 800, 176	115, 832. 00	32. 81	8. 00
9. 00	SNF	44. 00	0	0	0	0.00		
10. 00	Excluded area salaries (see instructions)		2, 589, 704	344, 362	2, 934, 066	76, 435. 00	38. 39	10. 00
	OTHER WAGES & RELATED COSTS							
11. 00	Contract Labor: Direct Patient Care		0	0	0	0.00	0. 00	11. 00
12. 00	Contract Labor: Top Level		0	О	0	0.00	0. 00	12. 00
	management and other							
	management and administrative services							
13.00	Contract Labor: Physician-Part		0	0	0	0.00	0. 00	13.00
14. 00	A - Administrative Home office and/or related		0	0	0	0. 00	0.00	14. 00
00	organization salaries and		· ·			0.00	0.00	00
14. 01	wage-related costs Home office salaries		3, 800, 176	0	3, 800, 176	115, 832. 00	32 81	14. 01
14. 02	Related organization salaries		0,000,170	ő	0,000,170	0.00	1	
15. 00	Home office: Physician Part A - Administrative		0	0	0	0. 00	0. 00	15. 00
16. 00	Home office and Contract		0	О	0	0.00	0. 00	16. 00
	Physicians Part A - Teaching							
17. 00	WAGE-RELATED COSTS Wage-related costs (core) (see		4, 235, 464	0	4, 235, 464			17. 00
	instructions)		.,,					
18. 00	Wage-related costs (other) (see instructions)		0	0	0			18. 00
19. 00	Excluded areas		1, 008, 826	О	1, 008, 826			19. 00
20. 00	Non-physician anesthetist Part		0	0	0			20. 00
21. 00	Non-physician anesthetist Part		0	О	o			21. 00
22. 00	B Physician Part A -		0	_				22. 00
	Admi ni strati ve		O					
22. 01	Physician Part A - Teaching		0	0	0			22. 01
23. 00 24. 00	Physician Part B Wage-related costs (RHC/FQHC)		0		0			23. 00 24. 00
25. 00	Interns & residents (in an		0	0	0			25. 00
25. 50	approved program) Home office wage-related		2, 089, 778	0	2, 089, 778			25. 50
	(core)							
25. 51	Related organization wage-related (core)		0	0	0			25. 51
25. 52	Home office: Physician Part A		0	0	О			25. 52
	- Administrative - wage-related (core)							
25. 53	Home office & Contract		0	О	0			25. 53
	Physicians Part A - Teaching -							
	wage-related (core)  OVERHEAD COSTS - DIRECT SALARIE	S .						
26.00	Employee Benefits Department	4. 00	1, 474, 544			0.00		
27. 00	Administrative & General	5. 00	1, 466, 767	3, 818, 384	5, 285, 151	133, 479. 00	J 39. 60	27. 00

HOSPITAL WAGE INDEX INFORMATION

36.00

37.00

38.00

39.00

40.00

41.00

42.00

Cafeteri a

Pharmacy

Records Library Social Service

43.00 Other General Service

Maintenance of Personnel

Central Services and Supply

Medical Records & Medical

Nursing Administration

Provi der CCN: 15-0091

258, 644

32, 689

35

C

0

Peri od: Worksheet S-3 From 01/01/2018 Part II To 12/31/2018 Date/Time Prepared:

12, 168. 00

6, 511. 00

10, 209. 00

0.00

0.00

0.00

0.00

0.00

258, 644

305, 824

532, 637

0

0

0

21. 26

0.00

46. 97

0.00

0.00

52. 17

36.00

37.00

38.00

39.00

40.00

41.00

0. 00 42. 00 0. 00 43. 00

12/31/2018 5/28/2019 10:58 am Wkst. A Line Amount Recl assi fi cati Adj usted Pai d Hours Average Hourly Number Reported on of Salaries Sal ari es Related to Wage (col. 4 col . 5) (from Wkst. (col. 2 ± col. Salaries in col. 4 A-6)3) 1.00 2.00 4.00 6.00 5.00 3.00 28.00 Administrative & General under 0.00 0.00 28.00 contract (see inst.) 29.00 Maintenance & Repairs 6.00 0.00 29.00 0.00 Operation of Plant 30.00 7.00 304, 288 36, 418 340, 706 13, 296. 00 25. 62 30.00 31.00 8.00 24, 742 Laundry & Linen Service 24, 742 1, 740. 00 14. 22 31.00 32.00 Housekeepi ng 9.00 216, 740 7, 603 224, 343 15, 228. 00 14. 73 32.00 33.00 Housekeeping under contract 0.00 0.00 33.00 (see instructions) 34.00 10.00 12, 822. 00 5. 85 34.00 368, 019 -293, 065 74, 954 Di etary 35.00 Di etary under contract (see 0.00 0.00 35.00 instructions)

273, 135

532, 602

0

0

0

11.00

12.00

13.00

14.00

15.00

16.00

17.00

18.00

| Peri od: | Worksheet S-3 | From 01/01/2018 | Part III | To 12/31/2018 | Date/Time Prepared: | To 12/31/201 Provider CCN: 15-0091

					'	0 12/01/2010	5/28/2019 10:	
		Worksheet A	Amount	Reclassi fi cati	Adj usted	Pai d Hours	Average Hourly	
		Line Number	Reported	on of Salaries	Sal ari es	Related to	Wage (col. 4 ÷	
				(from	(col.2 ± col.	Salaries in	col. 5)	
				Worksheet A-6)	3)	col. 4		
		1. 00	2. 00	3. 00	4. 00	5. 00	6. 00	
	PART III - HOSPITAL WAGE INDEX	SUMMARY						
1.00	Net salaries (see		11, 255, 016	3, 800, 176	15, 055, 192	478, 112. 00	31. 49	1.00
	instructions)							
2.00	Excluded area salaries (see		2, 589, 704	344, 362	2, 934, 066	76, 435. 00	38. 39	2.00
	instructions)							
3.00	Subtotal salaries (line 1		8, 665, 312	3, 455, 814	12, 121, 126	401, 677. 00	30. 18	3.00
	minus line 2)							
4.00	Subtotal other wages & related		3, 800, 176	0	3, 800, 176	115, 832. 00	32. 81	4. 00
	costs (see inst.)							
5.00	Subtotal wage-related costs		6, 325, 242	0	6, 325, 242	0.00	52. 18	5.00
	(see inst.)							
6.00	Total (sum of lines 3 thru 5)		18, 790, 730	3, 455, 814	22, 246, 544	517, 509. 00	42. 99	6. 00
7.00	Total overhead cost (see		4, 636, 095	2, 410, 906	7, 047, 001	205, 453. 00	34. 30	7.00
	instructions)							

Health Financial Systems	HUNTINGTON MEMORIAL HOSPITAL	In Lie	u of Form CMS-2552-10
HOSPITAL WAGE RELATED COSTS	Provi der CCN: 15-0091	From 01/01/2018	Worksheet S-3 Part IV Date/Time Prepared:

	To 12/31/2018	Date/Time Pre 5/28/2019 10:	
		Amount	
		Reported	
		1.00	
	PART IV - WAGE RELATED COSTS		
	Part A - Core List		
	RETI REMENT COST		
1.00	401K Employer Contributions	0	1. 00
2.00	Tax Sheltered Annuity (TSA) Employer Contribution	241, 098	2. 00
3.00	Nonqualified Defined Benefit Plan Cost (see instructions)	1, 183, 213	3. 00
4.00	Qualified Defined Benefit Plan Cost (see instructions)	0	4.00
	PLAN ADMINISTRATIVE COSTS (Paid to External Organization)		
5.00	401K/TSA Plan Administration fees	0	5. 00
6.00	Legal /Accounting/Management Fees-Pension Plan	2, 164	6. 00
7.00	Employee Managed Care Program Administration Fees	33, 919	7. 00
	HEALTH AND INSURANCE COST		
8.00	Health Insurance (Purchased or Self Funded)	0	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)	2, 648, 128	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, 014	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)	61, 216	13. 00
14.00	Long-Term Care Insurance (If employee is owner or beneficiary)	0	14. 00
15.00	'Workers' Compensation Insurance	14, 760	15. 00
16.00	Retirement Health Care Cost (Only current year, not the extraordinary accrual required by FASB 106.	0	16. 00
	Non cumulative portion)		
	TAXES		
17.00		936, 819	17. 00
18.00	Medicare Taxes - Employers Portion Only	0	18. 00
19.00	Unempl oyment Insurance	0	19. 00
20.00	State or Federal Unemployment Taxes	0	20. 00
	OTHER		
21.00	Executive Deferred Compensation (Other Than Retirement Cost Reported on lines 1 through 4 above. (see	60, 215	21. 00
	instructions))		
22. 00	Day Care Cost and Allowances	0	22. 00
23.00	Tuition Reimbursement	35, 745	23. 00
24.00	Total Wage Related cost (Sum of lines 1 -23)	5, 244, 291	24. 00
	Part B - Other than Core Related Cost		
25.00	OTHER WAGE RELATED COSTS (SPECIFY)	0	25. 00

Health Financial Systems	HUNTINGTON MEMORIAL HOSPITAL	In Lie	u of Form CMS-2552-10
HOSPITAL CONTRACT LABOR AND BENEFIT COST	Provi der CCN: 15-0091	Peri od: From 01/01/2018 To 12/31/2018	Worksheet S-3 Part V Date/Time Prepared: 5/28/2019 10:58 am
Cost Contor Description		Contract Labor	Popofit Cost

			5/28/2019 10:	58 am
	Cost Center Description	Contract Labor	Benefit Cost	
		1. 00	2. 00	
	PART V - Contract Labor and Benefit Cost			
	Hospital and Hospital-Based Component Identification:			
1.00	Total facility's contract labor and benefit cost	0	5, 244, 291	1.00
2.00	Hospi tal	0	5, 244, 291	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	Swi ng Beds - SNF	0	0	6. 00
7.00	Swing Beds - NF	0	0	7. 00
8.00	Hospi tal -Based SNF			8. 00
9.00	Hospi tal -Based NF			9. 00
10.00	Hospi tal -Based OLTC			10.00
11.00	Hospi tal -Based HHA			11.00
12.00	Separately Certified ASC			12.00
13.00	Hospi tal -Based Hospi ce			13.00
14.00	Hospital-Based Health Clinic RHC			14.00
15.00	Hospital-Based Health Clinic FQHC			15.00
16.00	Hospi tal -Based-CMHC			16.00
17. 00	Renal Dialysis			17. 00
18. 00	Other	0	0	18. 00

	TAL UNCOMPENSATED AND INDIGENT CARE DATA Provide	r CCN: 15-0091	Peri od:	Worksheet S-1	0
			From 01/01/2018 To 12/31/2018		no no d
	<u> </u>		To 12/31/2018	Date/Time Pre 5/28/2019 10:	
				1. 00	
	Uncompensated and indigent care cost computation				
. 00	Cost to charge ratio (Worksheet C, Part I line 202 column 3 divided by	/line 202 colu	mn 8)	0. 202423	1. C
. 00	Medicaid (see instructions for each line)  Net revenue from Medicaid			2, 265, 183	2.0
. 00	Did you receive DSH or supplemental payments from Medicaid?			2, 203, 103 Y	3.0
. 00	If line 3 is yes, does line 2 include all DSH and/or supplemental pays	ments from Medi	cai d?	Ϋ́	4. C
. 00	If line 4 is no, then enter DSH and/or supplemental payments from Med	cai d		0	
. 00	Medicaid charges			16, 378, 072	
. 00	Medicaid cost (line 1 times line 6)	. 61		3, 315, 298	
8. 00	Difference between net revenue and costs for Medicaid program (line 7 < zero then enter zero)	minus sum of i	ines 2 and 5; if	1, 050, 115	8.0
	Children's Health Insurance Program (CHIP) (see instructions for each	line)			
. 00	Net revenue from stand-alone CHIP	,		21, 472	9.0
0. 00				98, 979	
1.00	Stand-alone CHIP cost (line 1 times line 10)			20, 036	
2. 00	Difference between net revenue and costs for stand-alone CHIP (line 1 enter zero)	I minus line 9;	if < zero then	0	12. C
	Other state or local government indigent care program (see instruction	ns for each line	e)		
3. 00				2, 838, 577	13.0
4. 00	Charges for patients covered under state or local indigent care progra	am (Not include	d in lines 6 or	21, 225, 449	14. (
F 00	10)			4 00/ 540	45.0
5. 00 6. 00		caro program (I	ino 15 minus lino	4, 296, 519 1, 457, 942	
0. 00	13; if < zero then enter zero)	care program (i	THE 15 IIITHUS TITLE	1, 437, 742	10.0
	Grants, donations and total unreimbursed cost for Medicaid, CHIP and sinstructions for each line)	state/local ind	gent care program	ms (see	
7. 00	·	charity care		0	17.0
8. 00		•		0	18. C
9. 00	,	ent care progra	ms (sum of lines	2 500 057	1
	18 12 and 16)	int care progra		2, 500, 057	19. 0
	8, 12 and 16)	Uni nsured	l Insured	Z, 508, 037	1
	[8, 12 and 16)	Uni nsured pati ents	pati ents	Total (col. 1 + col. 2)	1
		Uni nsured		Total (col. 1	1
0.00	Uncompensated Care (see instructions for each line)	Uni nsured pati ents	pati ents 2.00	Total (col. 1 + col. 2) 3.00	19. 0
0. 00		Uni nsured pati ents	pati ents 2.00	Total (col. 1 + col. 2) 3.00	19.0
	Uncompensated Care (see instructions for each line) Charity care charges and uninsured discounts for the entire facility (see instructions) Cost of patients approved for charity care and uninsured discounts (see	Uni nsured pati ents 1.00	pati ents 2. 00 747 668, 987	Total (col. 1 + col. 2) 3.00	20.0
1. 00	Uncompensated Care (see instructions for each line) Charity care charges and uninsured discounts for the entire facility (see instructions) Cost of patients approved for charity care and uninsured discounts (sinstructions)	Uni nsured pati ents 1.00  2,878, ee 582,	pati ents 2.00  747 668, 987  725 668, 987	Total (col. 1 + col. 2) 3.00 3,547,734 1,251,712	20. C
1. 00	Uncompensated Care (see instructions for each line) Charity care charges and uninsured discounts for the entire facility (see instructions) Cost of patients approved for charity care and uninsured discounts (sinstructions) Payments received from patients for amounts previously written off as	Uni nsured pati ents 1.00  2,878, ee 582,	pati ents 2. 00 747 668, 987	Total (col. 1 + col. 2) 3.00 3,547,734 1,251,712	20. 0
1. 00 2. 00	Uncompensated Care (see instructions for each line) Charity care charges and uninsured discounts for the entire facility (see instructions) Cost of patients approved for charity care and uninsured discounts (sinstructions) Payments received from patients for amounts previously written off as charity care	Uni nsured pati ents 1.00  2,878, ee 582,	pati ents 2. 00  747 668, 987 725 668, 987 6, 441	Total (col. 1 + col. 2) 3.00 3,547,734 1,251,712 7,318	20. 0 21. 0 22. 0
1. 00 2. 00	Uncompensated Care (see instructions for each line) Charity care charges and uninsured discounts for the entire facility (see instructions) Cost of patients approved for charity care and uninsured discounts (sinstructions) Payments received from patients for amounts previously written off as charity care	Uni nsurece pati ents 1.00  2,878, ee 582,	pati ents 2. 00  747 668, 987 725 668, 987 6, 441	Total (col. 1 + col. 2) 3.00 3,547,734 1,251,712 7,318 1,244,394	20. 0 21. 0 22. 0
1. 00 2. 00 3. 00	Uncompensated Care (see instructions for each line) Charity care charges and uninsured discounts for the entire facility (see instructions) Cost of patients approved for charity care and uninsured discounts (sinstructions) Payments received from patients for amounts previously written off as charity care Cost of charity care (line 21 minus line 22)	Uni nsured pati ents 1.00  2,878, ee 582, 581,	pati ents 2.00  747 668, 987  725 668, 987  877 6, 441  848 662, 546	Total (col. 1 + col. 2) 3.00 3,547,734 1,251,712 7,318 1,244,394	20. 0 21. 0 22. 0 23. 0
1. 00 2. 00 3. 00 4. 00	Uncompensated Care (see instructions for each line) Charity care charges and uninsured discounts for the entire facility (see instructions) Cost of patients approved for charity care and uninsured discounts (sinstructions) Payments received from patients for amounts previously written off as charity care Cost of charity care (line 21 minus line 22)  Does the amount on line 20 column 2, include charges for patient days imposed on patients covered by Medicaid or other indigent care program	Uni nsurece pati ents 1.00  2,878, 28 582, 581, beyond a Lengt	pati ents 2.00  747 668, 987  725 668, 987  877 6, 441  848 662, 546	Total (col. 1 + col. 2) 3.00 3,547,734 1,251,712 7,318 1,244,394 1.00 N	20. C 21. C 22. C 23. C
1. 00 2. 00 3. 00 4. 00	Uncompensated Care (see instructions for each line) Charity care charges and uninsured discounts for the entire facility (see instructions) Cost of patients approved for charity care and uninsured discounts (sinstructions) Payments received from patients for amounts previously written off as charity care Cost of charity care (line 21 minus line 22)  Does the amount on line 20 column 2, include charges for patient days imposed on patients covered by Medicaid or other indigent care program	Uni nsurece pati ents 1.00  2,878, 28 582, 581, beyond a Lengt	pati ents 2.00  747 668, 987  725 668, 987  877 6, 441  848 662, 546	Total (col. 1 + col. 2) 3.00 3,547,734 1,251,712 7,318 1,244,394	20. C 21. C 22. C 23. C
1. 00 2. 00 3. 00 4. 00 5. 00	Uncompensated Care (see instructions for each line)  Charity care charges and uninsured discounts for the entire facility (see instructions)  Cost of patients approved for charity care and uninsured discounts (sinstructions)  Payments received from patients for amounts previously written off as charity care  Cost of charity care (line 21 minus line 22)  Does the amount on line 20 column 2, include charges for patient days imposed on patients covered by Medicaid or other indigent care program of the patient of the charges for patient days beyond the indigent care program of the patient days beyond the indigent care program of the patient days beyond the indigent care program of the patient days beyond the indigent care program of the patient days beyond the indigent care program of the patient days beyond the indigent care program of the patient days beyond the indigent care program of the patient days beyond the indigent care program of the patient days beyond the indigent care program of the patient days beyond the indigent care program of the patient days beyond the indigent care program of the patient days beyond the indigent care program of the patients of the	Uni nsured pati ents 1.00  2,878, 2,878, 582, 581, beyond a lengt n? gent care progra	pati ents 2.00  747 668, 987  725 668, 987  877 6, 441  848 662, 546	Total (col. 1 + col. 2) 3.00 3,547,734 1,251,712 7,318 1,244,394 1.00 N	20. C 21. C 22. C 23. C 24. C 25. C
21. 00 22. 00 33. 00 44. 00 25. 00 26. 00 27. 00	Uncompensated Care (see instructions for each line) Charity care charges and uninsured discounts for the entire facility (see instructions) Cost of patients approved for charity care and uninsured discounts (sinstructions) Payments received from patients for amounts previously written off as charity care Cost of charity care (line 21 minus line 22)  Does the amount on line 20 column 2, include charges for patient days imposed on patients covered by Medicaid or other indigent care progral If line 24 is yes, enter the charges for patient days beyond the indistay limit Total bad debt expense for the entire hospital complex (see instruction Medicare reimbursable bad debts for the entire hospital complex (see	Uni nsured pati ents 1.00  2,878, ee 582,  581,  beyond a lengt in gent care programs ons) instructions)	pati ents 2.00  747 668, 987  725 668, 987  877 6, 441  848 662, 546	Total (col. 1 + col. 2) 3.00 3,547,734 1,251,712 7,318 1,244,394 1.00 N 0 7,027,411 95,727	20. 0 21. 0 22. 0 23. 0 24. 0 25. 0 26. 0 27. 0
21. 00 22. 00 23. 00 24. 00 25. 00 27. 00 27. 01	Uncompensated Care (see instructions for each line)  Charity care charges and uninsured discounts for the entire facility (see instructions)  Cost of patients approved for charity care and uninsured discounts (sinstructions)  Payments received from patients for amounts previously written off as charity care  Cost of charity care (line 21 minus line 22)  Does the amount on line 20 column 2, include charges for patient days imposed on patients covered by Medicaid or other indigent care progral If line 24 is yes, enter the charges for patient days beyond the indistance of the indicate of the entire hospital complex (see instruction Medicare reimbursable bad debts for the entire hospital complex (see Medicare allowable bad debts for the entire hospital complex (see instruction medicare allowable bad debts for the entire hospital complex (see instructions)	Uni nsured pati ents 1.00  2,878, ee 582,  581,  beyond a lengt in gent care programs ons) instructions)	pati ents 2.00  747 668, 987  725 668, 987  877 6, 441  848 662, 546	Total (col. 1 + col. 2) 3.00 3,547,734 1,251,712 7,318 1,244,394 1.00 N 0 7,027,411 95,727 147,271	20. 0 21. 0 22. 0 23. 0 24. 0 25. 0 26. 0 27. 0 27. 0
21. 00 22. 00 23. 00 24. 00 25. 00 27. 00 27. 01 28. 00	Uncompensated Care (see instructions for each line)  Charity care charges and uninsured discounts for the entire facility (see instructions)  Cost of patients approved for charity care and uninsured discounts (sinstructions)  Payments received from patients for amounts previously written off as charity care  Cost of charity care (line 21 minus line 22)  Does the amount on line 20 column 2, include charges for patient days imposed on patients covered by Medicaid or other indigent care prograf If line 24 is yes, enter the charges for patient days beyond the indistaly limit  Total bad debt expense for the entire hospital complex (see instructions)  Medicare allowable bad debts for the entire hospital complex (see instructions)	Uni nsured patients 1.00  2,878, 2,878, 582, 581, beyond a length of the program ons) nstructions) cructions)	patients 2.00  747 668,987  725 668,987  877 6,441  848 662,546  h of stay limit  am's length of	Total (col. 1 + col. 2) 3. 00 3, 547, 734 1, 251, 712 7, 318 1, 244, 394 1. 00 N 0 7, 027, 411 95, 727 147, 271 6, 880, 140	20. 0 21. 0 22. 0 23. 0 24. 0 25. 0 26. 0 27. 0 28. 0
22. 00 22. 00 22. 00 23. 00 24. 00 25. 00 27. 00 27. 01 28. 00 30. 00	Uncompensated Care (see instructions for each line)  Charity care charges and uninsured discounts for the entire facility (see instructions)  Cost of patients approved for charity care and uninsured discounts (sinstructions)  Payments received from patients for amounts previously written off as charity care  Cost of charity care (line 21 minus line 22)  Does the amount on line 20 column 2, include charges for patient days imposed on patients covered by Medicaid or other indigent care prograif line 24 is yes, enter the charges for patient days beyond the indistay limit  Total bad debt expense for the entire hospital complex (see instructions) (see instructions)  Medicare reimbursable bad debts for the entire hospital complex (see instructions)  Cost of non-Medicare and non-reimbursable Medicare bad debt expense (see	Uni nsured patients 1.00  2,878, 2,878, 582, 581, beyond a length of the program ons) nstructions) cructions)	patients 2.00  747 668,987  725 668,987  877 6,441  848 662,546  h of stay limit  am's length of	Total (col. 1 + col. 2) 3.00 3,547,734 1,251,712 7,318 1,244,394 1.00 N 0 7,027,411 95,727 147,271	20. 0 21. 0 22. 0 23. 0 25. 0 26. 0 27. 0 28. 0 29. 0

Health Financial Systems	HUNTI NGTON MEMOR	IAL HOSPITAL		In Lie	u of Form CMS-2	2552-10
RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALA	NCE OF EXPENSES	Provi der Co		Period: From 01/01/2018	Worksheet A	
				o 12/31/2018	Date/Time Pre	
Cost Conton Decement on	Colonico	Othon	Tatal (asl 1	Dool agai fi agti	5/28/2019 10:	58 am
Cost Center Description	Sal ari es	Other	+ col . 2)	Reclassifications (See A-6)	Reclassified Trial Balance	
				(000 // 0)	(col . 3 +-	
					col . 4)	
OFNEDAL CERVILOE COCT OFNEEDO	1.00	2. 00	3. 00	4. 00	5. 00	
GENERAL SERVICE COST CENTERS  1. 00   00100   CAP REL COSTS-BLDG & FIXT		1, 476, 415	1, 476, 415	37, 676	1, 514, 091	1.00
2. 00   00200 CAP REL COSTS MVBLE EQUIP		856, 068			889, 126	2. 00
3.00 00300 OTHER CAP REL COSTS		0	. (		0	3. 00
4.00 00400 EMPLOYEE BENEFITS DEPARTMENT	1, 474, 544	4, 892, 203			4, 892, 203	4. 00
5.00   00500   ADMINISTRATIVE & GENERAL 6.00   00600   MAINTENANCE & REPAIRS	1, 466, 767	18, 192, 608	19, 659, 375		19, 612, 434 0	5. 00 6. 00
7. 00   00700   OPERATION OF PLANT	304, 288	814, 825	1	ή "Ι	1, 155, 531	7. 00
8. 00 00800 LAUNDRY & LINEN SERVICE	0	163, 755			188, 497	8.00
9. 00   00900   HOUSEKEEPI NG	216, 740	172, 732			397, 075	9. 00
10. 00   01000   DI ETARY	368, 019	420, 208			179, 671	
11. 00   01100   CAFETERI A 12. 00   01200   MAI NTENANCE OF PERSONNEL	0	6, 148	6, 148	537, 071	543, 219 0	11. 00 12. 00
13. 00 01300 NURSING ADMINISTRATION	273, 135	7, 107	280, 242	32, 689	312, 931	1
14.00 01400 CENTRAL SERVICES & SUPPLY	0	0	(	0	0	14. 00
15. 00 01500 PHARMACY	532, 602	727, 656	1, 260, 258	35	1, 260, 293	
16. 00 01600 MEDI CAL RECORDS & LI BRARY	0	0	(		0	16.00
17. 00   01700   SOCIAL SERVICE 19. 00   01900   NONPHYSICIAN ANESTHETISTS		0			0	17. 00 19. 00
20. 00   02000   NURSI NG SCHOOL	Ö	0		ol ol	0	20.00
21.00 02100 I &R SERVICES-SALARY & FRINGES APPR	ev o	0	(	o	0	21. 00
22.00 02200 I &R SERVI CES-OTHER PRGM COSTS APPR	1	0	(	0	0	22. 00
23. 00 02300 PARAMED ED PRGM-(SPECIFY)	0	0		) 0	0	23. 00
I NPATI ENT ROUTI NE SERVI CE COST CENTERS  30. 00   03000   ADULTS & PEDI ATRI CS	2, 973, 429	643, 838	3, 617, 267	-515, 544	3, 101, 723	30.00
43. 00   04300   NURSERY	0	0			183, 288	43. 00
ANCILLARY SERVICE COST CENTERS						
50. 00 05000 OPERATING ROOM	967, 109	462, 142	1, 429, 251	115, 746	1, 544, 997	50.00
50. 01   05001   OPERATING ROOM 52. 00   05200   DELIVERY ROOM & LABOR ROOM	0	0	(	731, 495	0 731, 495	50. 01 52. 00
53. 00   05300   ANESTHESI OLOGY		982, 146	982, 146		982, 146	
54. 00 05400 RADI OLOGY-DI AGNOSTI C	934, 174	570, 136			1, 616, 114	
60. 00   06000   LABORATORY	0	2, 351, 278	2, 351, 278	0	2, 351, 278	
62. 30 06250 BLOOD CLOTTING FOR HEMOPHILIACS	(04, 001	122 220	010 201	ή "Ι	000 410	62. 30
65. 00   06500   RESPI RATORY   THERAPY 66. 00   06600   PHYSI CAL   THERAPY	686, 081 1, 070, 755	132, 220 68, 002			900, 419 943, 736	
67. 00 06700 OCCUPATI ONAL THERAPY	0	00,002	1, 100, 707	258, 425	258, 425	
68.00 06800 SPEECH PATHOLOGY	0	38, 046	38, 046	69, 294	107, 340	68. 00
69. 00 06900 ELECTROCARDI OLOGY	0	0	(70.00)	0	0	69.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIEN 72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0 0	1, 672, 821	1, 672, 821	-859, 030 859, 030	813, 791 859, 030	1
73. 00 07300 DRUGS CHARGED TO PATIENTS		1, 958, 236	1, 958, 236		2, 021, 944	1
76. 97 07697 CARDIAC REHABILITATION	o	0	(	0	0	
76. 98 07698 HYPERBARI C OXYGEN THERAPY	17, 139	14, 509	31, 648	0	31, 648	
76. 99 07699 LITHOTRI PSY OUTPATI ENT SERVI CE COST CENTERS	0	0		)  0	0	76. 99
90. 00 09000 CLINIC	82, 493	5, 970	88, 463	B O	88, 463	90.00
91. 00 09100 EMERGENCY	1, 098, 213	320, 081			1, 557, 889	
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PAR	PT					92. 00
OTHER REIMBURSABLE COST CENTERS	2 514 211	274 250	2 000 5/4	200 00/	2 100 4/7	05.00
95. 00 O9500 AMBULANCE SERVICES SPECIAL PURPOSE COST CENTERS	2, 514, 211	374, 350	2, 888, 561	300, 906	3, 189, 467	95.00
113. 00 11300   INTEREST EXPENSE		5, 585	5, 585	-5, 585	0	113. 00
118.00 SUBTOTALS (SUM OF LINES 1 through	117) 14, 979, 699	37, 329, 085			52, 228, 264	
NONREI MBURSABLE COST CENTERS				ı al		
190. 00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEE 192. 00 19200 PHYSI CLANS' PRI VATE OFFI CES	N 0 75, 493	0 16, 209	91, 702	9, 035	0 100, 737	190.00
194. 00 07950  OCC HEALTH	75, 473	10, 209	91, 702			194. 00
194. 01 07951 PAIN CLINIC	O	0	d	-		194. 01
194. 02 07952 OCC HEALTH	0	11	11			194. 02
194. 03 07953 FOUNDATI 0	0	80, 001	80, 001	0	· ·	194. 03
194. 04 07954 KIDS CAMPUS 194. 05 07955 COMMUNITY & VOLUNTEER SERVICES	0	0 350, 861	350, 861	0	0 350, 861	194. 04
194.06 07956 HUNTI NGTON COLLEGE NURSE	0	330, 881	330, 86			194. 05
194. 07 07957 MI SC CATERI NG	0	-434	-434	71, 485	71, 051	194. 07
194. 08 07958 AUTISM CENTER	0	50, 056			50, 056	
194.09 07959 HUNTINGTON BUA 200.00  TOTAL (SUM OF LINES 118 through 19	0 09) 15, 055, 192	27 925 700	52, 880, 981	0	0 52, 880, 981	194. 09
200.00   TOTAL (SUM OF LINES 118 through 19	10,000,192	37, 825, 789	J JZ, 08U, 98	ų ų	JZ, 00U, 781	1200.00

Peri od: Worksheet A From 01/01/2018 Date/Time Prepared: 5/28/2019 10:58 am

Count   Counter   Presert pitton   Agi   Insteads   Service   Counter   Co					5/28/2019 10:	
		Cost Center Description				
CEMERAL SERVICE COST CENTERS   1 0 0 0000 CAP REL COSTS APPRILE EQUIP   -131 863   757, 273   2 0 0 0 0000 CAP REL COSTS APPRILE EQUIP   -131 863   757, 273   2 0 0 0 0 0000 CAP REL COSTS APPRILE EQUIP   -131 863   757, 273   2 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0						
2.00   0.0200   CAP REL DOSTS-MYBLE EQUIP   -131 863   757, 273   0   3.0   0.030   0.0030   0.005   0	GE	ENERAL SERVICE COST CENTERS	0.00	71.00		
3.00   00000   DITHE CAR PRIL COSTS   4.00   0.00		•				1
4.00   0.0400   IMPLICIVE REPRETED PERATRIMITY   -3,517,4277   1,374,776   5.00   0.0500 ADM INSTRATIVE & GENERAL   -5,681,104   14,013,300   5.0   0.0500   0.0500   MINISTRATIVE & GENERAL   -5,681,104   14,013,300   5.0   0.0500   0.0500   MINISTRATIVE & 10,000   1,145,488   1.0   0.00   0.000   0.00000   0.0000   0.0000   0.0000   0.0000   0.0000   0.0000   0.00000   0.00000   0.00000   0.00000   0.00000   0.00000000					1	
0.0000   0.0000   DAMIN INTRATIVE & CENTERAL   -5, 591, 104   14, 031, 330   0			_	_		
0.000   0.000   0.000   0.000   0.000   0.000   0.000   0.000   0.000   0.000   0.000   0.000   0.00000   0.0000   0.0000   0.0000   0.0000   0.0000   0.0000   0.00000   0.0000   0.0000   0.0000   0.0000   0.0000   0.0000   0.00000   0.0000   0.0000   0.0000   0.0000   0.0000   0.0000   0.00000   0.0000   0.00000   0.00000   0.00000   0.00000   0.00000   0.000000   0.00000000						
8.00   00800   AUNDRY & LINEN SERVICE   0   188,497   9,00   00900   001000   DIFTARY   7,300   737,075   9,00   10.00   DIFTARY   7,300   737,075   11.00   DIFTARY   7,300   172,371   11.00   DIFTARY   7,300   172,371   11.00   DIFTARY   7,300   DIFTARY   7			0	0		6. 00
9.00   0900  MUSISKEPTPING		•				
10.00   01000   DETARY			_			
11.00   1100   CAFETERIA			_		l e e e e e e e e e e e e e e e e e e e	1
12.00   10200   MAINTENANCE OF PERSONNEL   0   0   12.00   13.00   130.00		•			l control of the cont	1
14.00   01400 (ENTRAL SERVICES & SUPPLY   0   0   11.00   16.00   16.00   16.00   16.00   16.00   16.00   16.00   16.00   16.00   16.00   16.00   16.00   16.00   16.00   16.00   16.00   17		•				1
15.00     1500   PHARMARCY			-11, 567	301, 364		
16.00   16500   MEDICAL RECORDS & LIBRARY   0   0   17.00   170.			742 122	510.1/1		
17.00   01700   SOCIAL SERVICE   0   0   0   17.00   19.00   19.00   20.00	1	•			l e e e e e e e e e e e e e e e e e e e	1
19.00   01900   NONPHYSIC ICAN AMESTHERISTS   0   0   0   22.00   20.00   20.00   0210.00   MIRSING SCHOOL   0   0   0   0   0   22.00   22.00   22.00   MIRSING SCHOOL   187 SERVI CES-SALARY & FRINGES APPRV   0   0   0   0   22.00   22.00   22.00   187 SERVI CES-SALARY & FRINGES APPRV   0   0   0   0   22.0		•		Ö		
21 00			0	0		
22.00				0		
23. 00   02300   PARAMIDE DE PROM. (SPECIFY)   0   0   0   0   0   0   0   0   0				0		
INPATIENT ROUTINE SERVICE COST CENTERS   30,00					l e e e e e e e e e e e e e e e e e e e	
30.00   03000   ADULTS & PEDLATRIC CS   -95, 868   3,005, 855   30,00   30,00   40,00   43,00   430,					·	25.00
ANCILLARY SERVICE COST CENTERS   50.00   50.			-95, 868	3, 005, 855	5	30.00
50.00   0500			0	183, 288	3	43. 00
SO. 01   OS.001   O			067 000	577 117	,1	50.00
S2.00   0520					1	1
54.00   05400  RADIOLOGY-DIAGNOSTIC   0   1,616,114   54.00   0.00   06000   LABORATORY   0   2,351,278   60.00   062.30   06250   BLOOD CLOTTING FOR HEMOPHILIACS   0   0   0   0.00   06000   LABORATORY   0   2,351,278   06.00   06500   06500   PHYSI CAL THERAPY   -2,900   940,836   065.00   06600   PHYSI CAL THERAPY   -2,900   940,836   066.00   06600   PHYSI CAL THERAPY   0   258,425   07.00			_	731, 495		
60.00   06.000   LABORATORY   0   2,351,278   0   0.00   0.23   06.250   BLODD CLOTTING FOR HEMOPHILIACS   0   0   0.62   30   06.500   07.500		•	0			1
62.30   06.250   BLODD CLOTTING FOR HEMOPHILIACS   0   0   62.30   65.00   06.500   RESPIRATORY THERAPY   -23.033   877.386   66.5 00   66.00   06.600   PHYSI CAL THERAPY   -2.900   940,836   66.00   67.00   06.700   06.700   06.700   06.700   06.700   06.700   06.700   68.00   06.800   SPECH PATHOLOGY   0   107.340   68. 00   69.00   06.900   ELECTROCARDI OLOGY   0   0   0   69.00   06.900   ELECTROCARDI OLOGY   0   0   0   71.00   07.00   07.00   07.00   07.00   07.00   72.00   07.200   IMPL DEV. CHARGED TO PATIENTS   0   859,030   72. 00   73.00   07.300   DRUGS CHARGED TO PATIENTS   0   859,030   72. 00   76.97   07.697   07.697   07.697   07.697   07.697   07.697   07.697   07.697   07.697   07.697   07.697   07.697   07.697   07.697   07.698   07.698   HYPERBARIS COXYGEN THERAPY   0   31,648   76.98   76.99   07.699   LITHOTRI PSY   0   0   31,648   76.99   76.90   07.00   09.00   06.80   07.697   07.6			_			1
65.00   06500   RSPI RATORY THERAPY   -23, 033   877, 386   66.00		•	_			1
66. 00   06600   PHYSI CAL THERAPY   -2, 900   940, 836   66. 00   06700   OCCUPATI ONAL THERAPY   0   258, 425   67. 00   680. 00   06800   SPEECH PATHOLOGY   0   0   0   0   68. 00   06900   SPEECH PATHOLOGY   0   0   0   0   69. 00   07100   MEDI CAL SUPPLIES CHARGED TO PATI ENT   0   813, 791   71. 00   07200   MEDI CAL SUPPLIES CHARGED TO PATI ENTS   0   859, 030   72. 00   07300   07300   DRUGS CHARGED TO PATI ENTS   0   859, 030   72. 00   07300   DRUGS CHARGED TO PATI ENTS   0   859, 030   72. 00   07300   DRUGS CHARGED TO PATI ENTS   0   2, 021, 944   73. 00   07697   CARDI ACR REHABI LI TATI ON   0   0   0   0   0   0   0   0   0			ı	-		
68. 00 66800 SPEECH PATHOLOGY 0 107, 340 68. 00 699. 00 66900 ELECTROCARDIOLOGY 0 0 0 71. 00 07100 IMEDICAL SUPPLIES CHARGED TO PATIENT 0 813, 791 71. 00 72. 00 07200 IMPL. DEV. CHARGED TO PATIENTS 0 859, 030 72. 00 73. 00 07300 DRUGS CHARGED TO PATIENTS 0 2, 021, 944 73. 00 74. 97 07697 CARDIAC REHABILITATION 0 0 76. 97 76. 98 07698 HYPERBARIC OXYGEN THERAPY 0 31, 648 76. 99 76. 99 07699 LITHOTRIPSY 0 0 0 90. 00 09000 CLINIC 0 88, 463 90. 00 91. 00 09000 CLINIC 0 0 88, 463 90. 00 92. 00 09000 CLINIC 0 0 88, 463 91. 00 92. 00 09000 CLINIC 0 0 88, 463 91. 00 92. 00 09000 CLINIC 0 0 88, 463 91. 00 93. 00 09000 CLINIC 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	66. 00 06	6600 PHYSI CAL THERAPY				66. 00
69. 00   06900   LELCTROCARDI OLOGY   0 0 0   0   0   0   0   0   0   0			_			1
71. 00   07100   MEDICAL SUPPLIES CHARGED TO PATIENTS   0   813, 791     71. 00   72. 00   772. 00   772. 00   772. 00   772. 00   772. 00   773. 00   773. 00   773. 00   773. 00   773. 00   773. 00   773. 00   773. 00   773. 00   773. 00   773. 00   773. 00   773. 00   773. 00   773. 00   774. 775. 775. 775. 775. 775. 775. 775.	1	·	0	107, 340		
72. 00   07200   MPL DEV. CHARGED TO PATIENTS   0   859,030   73. 00   73. 00   07300   DRUGS CHARGED TO PATIENTS   0   2,021,944   73. 00   76. 97   76. 99   07697   CARDI AC REHABILITATION   0   0   0   76. 97   76. 99   07697   CARDI AC REHABILITATION   0   0   31,648   76. 98   76. 99   07699   LITHORIP PSY   0   0   0   0   0   0   0   0   0			0	813 791		
76. 97 76. 97 76. 98 76. 98 76. 98 76. 98 76. 99 76. 98 76. 99 76. 90 76		•	o o			
76. 98   07699   HYPERBARIC 0XYGEN THERAPY   0   31, 648   0   76. 99   07699   LI THOTRI PSY   0   0   0   0   0   0   0   0   0			0	2, 021, 944		
76. 99 OUTPATT IENT SERVICE COST CENTERS  90. 00 O9000 CLI IN IC				0		
OUTPATIENT SERVICE COST CENTERS   90.00   9000  CLINIC   0   88, 463   90.00   91.00   9000  CLINIC   91.00   92.00	1				1	
90. 00   09000   CLI NI C   0   088, 463   90. 00   91. 00   9900   09100   EMERGENCY   -27, 500   1,530, 389   91. 00   92. 00   09200   09SERVATI ON BEDS (NON-DI STI NCT PART   92. 00   00   09500   AMBULANCE SERVI CES   -13, 291   3, 176, 176   95. 00   SPECI AL PURPOSE COST CENTERS   95. 00   113. 00   11300   INTEREST EXPENSE   0   0   0   113. 00   118. 00   SUBTOTALS (SUM OF LI NES 1 through 117)   -12, 599, 709   39, 628, 555   118. 00   19000   GI FT, FLOWER, COFFEE SHOP & CANTEEN   0   0   0   190. 00   192. 00   19200   PHYSI CI ANS' PRI VATE OFFI CES   0   100, 737   192. 00   194. 00			0	0	<u>/ </u>	70.99
92. 00 09200   OBSERVATI ON BEDS (NON-DI STI NCT PART   92. 00 07162 REI MBURSABLE COST CENTERS  95. 00 09500   AMBULANCE SERVI CES   -13, 291   3, 176, 176   95. 00 SPECI AL PURPOSE COST CENTERS  113. 00   11300   INTEREST EXPENSE   0   0   113. 00 118. 00   SUBTOTALS (SUM OF LINES 1 through 117)   -12, 599, 709   39, 628, 555   118. 00 NONREI MBURSABLE COST CENTERS  190. 00   19000   GI FT, FLOWER, COFFEE SHOP & CANTEEN   0   100, 737   192. 00 192. 00   19200 PHYSI CI ANS' PRI VATE OFFI CES   0   100, 737   192. 00 194. 00   07950   OCC HEALTH   0   0   0   194. 00 194. 01   07951   PAIN CLINIC   0   0   194. 01 194. 02   07952   OCC HEALTH   0   11   194. 02 194. 03   07953   FOUNDATI O   -117   79, 884   194. 03 194. 04   07954   KI DS CAMPUS   0   0   194. 03 194. 06   07955   COMMUNI TY & VOLUNTEER SERVI CES   0   350, 861   194. 05 194. 06   07955   HUNTI NGTON COLLEGE NURSE   0   0   194. 06 194. 07   07957   MI SC CATERING   0   71, 051   194. 06 194. 09   07959   HUNTI NGTON BUA   0   0   194. 08	90.00	9000 CLI NI C				90.00
OTHER REIMBURSABLE COST CENTERS   O9500  AMBULANCE SERVI CES   -13, 291   3, 176, 176   95.00			-27, 500	1, 530, 389		
95. 00   09500   AMBULANCE SERVICES   -13, 291   3, 176, 176   95. 00     SPECIAL PURPOSE COST CENTERS   0 0   113. 00     118. 00   SUBTOTALS (SUM OF LINES 1 through 117)   -12, 599, 709   39, 628, 555   118. 00     NONREI MBURSABLE COST CENTERS   0 0 0   190. 00     192. 00   19200   PHYSI CI ANS' PRI VATE OFFICES   0 0   100, 737   192. 00     194. 00   07950   OCC HEALTH   0 0   0   194. 00     194. 01   07951   PAIN CLINIC   0 0   0   194. 01     194. 02   07952   OCC HEALTH   0 0   11   194. 01     194. 03   07953   FOUNDATI 0   -117   79, 884   194. 03     194. 04   07954   KI DS CAMPUS   0 0   194. 04     194. 05   07955   COMMUNI TY & VOLUNTEER SERVICES   0   350, 861   194. 05     194. 06   07956   HUNTI NGTON COLLEGE NURSE   0   71, 051   194. 05     194. 08   07958   AUTI SM CENTER   0   50, 056   194. 08     194. 09   07959   HUNTI NGTON BUA   0   0   194. 09     194. 09   07959   HUNTI NGTON BUA						92.00
SPECIAL PURPOSE COST CENTERS   113.00   1NTEREST EXPENSE   SUBTOTALS (SUM OF LINES 1 through 117)   -12,599,709   39,628,555   118.00   118.00   NONREI MBURSABLE COST CENTERS   118.00   190.00   GIFT, FLOWER, COFFEE SHOP & CANTEEN   0   0   0   190.00   192.00			-13, 291	3, 176, 176		95. 00
118. 00   SUBTOTALS (SUM OF LINES 1 through 117)   -12, 599, 709   39, 628, 555   118. 00   NONREI MBURSABLE COST CENTERS   190. 00   1900   GI FT, FLOWER, COFFEE SHOP & CANTEEN   0   0   190. 0						
NONRE   MBURSABLE   COST   CENTERS   190. 00   19000   GIFT, FLOWER, COFFEE SHOP & CANTEEN   0   0   0   190. 00   192. 00   192. 00   192. 00   192. 00   192. 00   192. 00   192. 00   192. 00   192. 00   192. 00   192. 00   194. 00   194. 00   194. 00   194. 00   194. 01   194. 02   194. 07   194. 07   194. 08   194. 08   194. 08   194. 08   194. 09						
190. 00 1900   GIFT, FLOWER, COFFEE SHOP & CANTEEN 192. 00 192. 00 1920   PHYSI CI ANS' PRI VATE OFFI CES 0   100, 737 192. 00 194. 00 1950   OCC HEALTH 0   O   O   194. 01 194. 02 194. 02 194. 03 1952   OCC HEALTH 0   O   O   194. 01 194. 03 1953   FOUNDATI O   194. 04 1954   OT 9755   COMMUNI TY & VOLUNTEER SERVI CES   194. 05   OT955   COMMUNI TY & VOLUNTEER SERVI CES   194. 06   OT956   HUNTI NGTON COLLEGE NURSE   194. 07 194. 08 1950   O   1950   O   1960   O   1970   O   19			-12, 599, 709	39, 628, 555		1118.00
192. 00			0	0		190. 00
194. 01 07951 PAIN CLINIC 0 0 194. 01 194. 02 194. 02 07952 OCC HEALTH 0 11 194. 02 194. 03 07953 FOUNDATI 0 11 194. 03 194. 04 07954 KI DS CAMPUS 0 0 0 194. 04 194. 05 07955 COMMUNI TY & VOLUNTEER SERVICES 0 350, 861 194. 05 194. 06 07956 HUNTI NGTON COLLEGE NURSE 0 0 194. 06 194. 07 07957 MI SC CATERI NG 0 71, 051 194. 06 194. 07 07958 AUTI SM CENTER 0 50, 056 194. 08 194. 09 07959 HUNTI NGTON BUA 0 0 194. 09				-		
194. 02 07952 OCC HEALTH 0 11 194. 02 194. 03 07953 FOUNDATI 0 -117 79, 884 194. 04 194. 05 1955 COMMUNI TY & VOLUNTEER SERVI CES 0 350, 861 194. 06 07956 HUNTI NGTON COLLEGE NURSE 0 71, 051 194. 06 1950 OT955 AUTISM CENTER 0 50, 056 194. 07 1950 OT959 HUNTI NGTON BUA 0 194. 09 07959 HUNTI NGTON BUA			_			
194. 03 07953 FOUNDATI 0 -117 79, 884 194. 04 194. 04 194. 05 194. 05 07955 COMMUNI TY & VOLUNTEER SERVI CES 0 350, 861 194. 06 1956 HUNTI NGTON COLLEGE NURSE 0 0 194. 06 194. 07 07957 MI SC CATERI NG 0 71, 051 194. 08 07958 AUTI SM CENTER 0 50, 056 194. 09 07959 HUNTI NGTON BUA 194. 09 07959 HUNTI NGTON BUA			_	-		
194. 04 07954 KI DS CAMPUS 194. 05 07955 COMMUNI TY & VOLUNTEER SERVI CES 194. 06 07956 HUNTI NGTON COLLEGE NURSE 194. 07 07957 MI SC CATERI NG 194. 08 07958 AUTI SM CENTER 194. 09 07959 HUNTI NGTON BUA 194. 09 07959 O 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0						
194. 05   07955   COMMUNI TY & VOLUNTEER SERVI CES   0   350, 861   194. 05   194. 06   194. 06   194. 07   194. 08   194. 07   194. 08   194. 09		•		77,004		
194. 07 07957 MISC CATERING 0 71, 051 194. 07 194. 08 07958 AUTI SM CENTER 0 50, 056 194. 09 07959 HUNTI NGTON BUA 0 0 0 194. 09			-	350, 861		
194. 08 07958 AUTI SM CENTER 0 50, 056 194. 09 07959 HUNTI NGTON BUA 09 0 0 194. 09			0	0		194. 06
194. 09 07959 HUNTI NGTON BUA 0 0 194. 09			0		i de la companya del companya de la companya de la companya del companya de la co	
			0			
[200.00]		•	_	_		
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Peri od: From 01/01/2018 To 12/31/2018 Date/Ti me Prepared:

						5/28/2019 10:58 am
		Increases				
	Cost Center	Li ne #	Sal ary	Other		
	2. 00	3. 00	4.00	5. 00		
	A - CAFETERIA AND CATERING					
1.00	CAFETERI A	11. 00	258, 644	278, 427		1. 00
2.00	MISC CATERING	194. 07	34, 421	37, 064		2.00
	0		293, 065	315, 491		
	B - INTEREST		270,000	0.07.77		
1. 00	CAP REL COSTS-MVBLE EQUIP	2.00	0	5, 585		1. 00
1.00	0		— — <del> </del>	5, 585		1.00
	F - I NSURANCE		<u> </u>	3, 303		
1. 00	CAP REL COSTS-BLDG & FIXT	1.00	O	37, 676		1.00
2.00	CAP REL COSTS-MVBLE EQUIP	2.00	o	27, 473		2.00
2.00	O KEE COSTS-WVBLE EQUIP		— — <del>0</del>	65, 149		2.00
	G - LAUNDRY		U	05, 147		
1.00	LAUNDRY & LINEN SERVICE	8. 00	24, 742	0		1.00
1.00	LAUNDRY & LINEN SERVICE			0		1.00
	U HOME OFFICE CALADY		24, 742	U		
1 00	H - HOME OFFICE SALARY	F 00	2 000 17/	0		1.00
1. 00	ADMI NI STRATI VE & GENERAL	5.00	3, 800, 176	0		1.00
	0		3, 800, 176	U		
	I - PTO	5 00	10.000			4.00
1. 00	ADMINISTRATIVE & GENERAL	5. 00	18, 208	0		1. 00
2.00	OPERATION OF PLANT	7. 00	36, 418	0		2. 00
3. 00	HOUSEKEEPI NG	9. 00	32, 345	0		3. 00
4.00	NURSING ADMINISTRATION	13. 00	32, 689	0		4. 00
5.00	ADULTS & PEDIATRICS	30. 00	399, 239	0		5. 00
6.00	OPERATING ROOM	50.00	115, 746	0		6. 00
7.00	RADI OLOGY-DI AGNOSTI C	54. 00	111, 804	0		7. 00
8.00	RESPIRATORY THERAPY	65. 00	82, 118	0		8. 00
9.00	PHYSI CAL THERAPY	66. 00	132, 698	0		9. 00
10.00	DRUGS CHARGED TO PATIENTS	73. 00	63, 708	0		10.00
11. 00	PHARMACY	15. 00	35	0		11.00
13.00	EMERGENCY	91.00	139, 595	0		13.00
14.00	AMBULANCE SERVICES	95.00	300, 906	0		14. 00
15.00	PHYSICIANS' PRIVATE OFFICES	192.00	9, 035	0		15. 00
	0		1, 474, 544	0		
	L - IMPLANTS					
1.00	IMPL. DEV. CHARGED TO	72. 00	0	859, 030		1.00
	PATI ENTS					
	0		0	859, 030		
	M - OB					
1.00	NURSERY	43.00	140, 621	42, 667		1. 00
2.00	DELIVERY ROOM & LABOR ROOM	52.00	561, 213	170, 282		2. 00
	0 — — — — —		701, 834	212, 949		
	0 - THERAPY	· ·				
1.00	OCCUPATI ONAL THERAPY	67.00	242, 993	15, 432		1. 00
2.00	SPEECH PATHOLOGY	68. 00	65, 156	4, 138		2.00
	0	— <u> </u>	308, 149	19, 570		2.00
500 00	Grand Total: Increases		6, 602, 510	1, 477, 774		500. 00
555.50	12. 2 10 (0 1110) 00303		5, 552, 510	., .,,,,,		1 333. 00

Peri od: Worksheet A-6 From 01/01/2018 To 12/31/2018 Date/Time Prepared:

Solution
1.00
1. 00
1.00   DI ETARY   10.00   293,065   315,491   0   0   0   0   0   0   0   0   0
2.00
1.00   NTEREST   SPENSE   113.00   0   5,585   11   1.00
1.00
1.00   NTEREST EXPENSE   113.00   0   5,585   11
The color of the
Tool   ADMINISTRATIVE & GENERAL   Soo   O   O   O   12   O   O   O   O   O   O   O   O   O
1. 00   ADMINISTRATIVE & GENERAL   5. 00   0   65, 149   12   2. 00   0   0   12   2. 00   0   0   0   0   12   2. 00   0   0   0   0   0   0   0   0   0
2.00
1.00   H - HOME OFFI CE SALARY
1.00   HOUSEKEEPING
1.00   HOUSEKEEPING
1.00   H - HOME OFFICE SALARY
H - HOME OFFICE SALARY
1.00   ADMINISTRATIVE & GENERAL   5.00   0 3,800,176   0
1.00
1 - PTO
1. 00 EMPLOYEE BENEFITS DEPARTMENT
2.00     0.00     0     0     0     0     3.00       3.00     0.00     0     0     0     0     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
3. 00     0. 00     0     0     0     0     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
4.00     0.00     0     0     0     4.00       5.00     0.00     0     0     0     5.00       6.00     0.00     0     0     0     6.00       7.00     0.00     0     0     0     0       8.00     0.00     0     0     0     0       9.00     0.00     0     0     0     0       10.00     0.00     0     0     0     0
5.00     0.00     0     0     0     0     5.00       6.00     0.00     0     0     0     0     6.00       7.00     0.00     0     0     0     0     7.00       8.00     0.00     0     0     0     0     8.00       9.00     0.00     0     0     0     0     9.00       10.00     0.00     0     0     0     10.00
6.00 7.00 8.00 9.00 10.00 0.00
7. 00 8. 00 0. 00 0 0 0 0 8. 00 9. 00 0 0 10. 00 9. 00 10.
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
9. 00 10. 00 0. 00 0 0 0 0 9. 00 10. 00
10.00 0.00 0 0 0 10.00
11. 00 13. 00 0. 00 0 0 0 13. 00
13.00
15. 00
L - IMPLANTS
1. 00 MEDI CAL SUPPLI ES CHARGED TO 71. 00 0 859, 030 0 1. 00
PATIENT
0 859,030
M - 0B
1. 00 ADULTS & PEDIATRICS 30. 00 701, 834 212, 949 0 1. 00
2.00
0 701, 834 212, 949
O - THERAPY
1.00 PHYSICAL THERAPY 66.00 308, 149 19, 570 0 1.00
2.00
0 308, 149 19, 570
500.00 Grand Total: Decreases 2,802,334 5,277,950 500.00

				To	12/31/2018	Date/Time Prep 5/28/2019 10:	
				Acqui si ti ons		072072017 10.	JO UIII
		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	T BALANCES					
1.00	Land	0	0	0	0	0	1.00
2.00	Land Improvements	556, 529	0	0	0	0	2. 00
3.00	Buildings and Fixtures	2, 311, 528	58, 980	0	58, 980	0	3. 00
4.00	Building Improvements	32, 500	0	0	0	0	4. 00
5.00	Fixed Equipment	1, 380, 863	403, 000	0	403, 000	0	5. 00
6.00	Movable Equipment	12, 120, 346	1, 353, 789	0	1, 353, 789	1, 241, 941	6. 00
7.00	HIT designated Assets	3, 015, 676	24, 113	0	24, 113	0	7. 00
8.00	Subtotal (sum of lines 1-7)	19, 417, 442	1, 839, 882	0	1, 839, 882	1, 241, 941	8. 00
9.00	Reconciling Items	1, 834, 401	-5, 331, 348	0	-5, 331, 348	0	9. 00
10.00	Total (line 8 minus line 9)	17, 583, 041	7, 171, 230	0	7, 171, 230	1, 241, 941	10.00
		Endi ng Bal ance	Fully				
			Depreci ated				
			Assets				
		6.00	7. 00				
	PART I - ANALYSIS OF CHANGES IN CAPITAL ASSE	T BALANCES					
1.00	Land	0	0				1. 00
2.00	Land Improvements	556, 529	156, 244				2. 00
3.00	Buildings and Fixtures	2, 370, 508	621, 193				3. 00
4.00	Building Improvements	32, 500	0				4. 00
5.00	Fixed Equipment	1, 783, 863	467, 265				5. 00
6.00	Movable Equipment	12, 232, 194	7, 426, 143				6. 00
7.00	HIT designated Assets	3, 039, 789	0				7. 00
8.00	Subtotal (sum of lines 1-7)	20, 015, 383	8, 670, 845				8. 00
9.00	Reconciling Items	-3, 496, 947	0				9. 00
10. 00	Total (line 8 minus line 9)	23, 512, 330	8, 670, 845				10. 00

Heal t	h Financial Systems	HUNTINGTON MEMORIAL HOSPITAL			In Lieu of Form CMS-2552-1			
	ICILIATION OF CAPITAL COSTS CENTERS	TIONT WOTON MEMO	Provi der Co		Peri od: From 01/01/2018	Worksheet A-7 Part II		
					To 12/31/2018	Date/Time Prep 5/28/2019 10:	pared: 58 am	
			Sl	JMMARY OF CAP	I TAL			
	Cost Center Description	Depreciation	Lease	Interest	Insurance (see instructions)	Taxes (see instructions)		
		9. 00	10.00	11.00	12.00	13. 00		
	PART II - RECONCILIATION OF AMOUNTS FROM WOR	KSHEET A, COLUM	IN 2, LINES 1 a	ind 2				
1.00	CAP REL COSTS-BLDG & FIXT	148, 825	1, 326, 777	'	0 0	0	1.00	
2.00	CAP REL COSTS-MVBLE EQUIP	774, 327	71, 610		0 0	6, 642	2. 00	
3.00	Total (sum of lines 1-2)	923, 152	1, 398, 387		0 0	6, 642	3. 00	
		SUMMARY O	F CAPITAL					
	Cost Center Description	Other	Total (1) (sum					
		Capi tal -Rel ate	of cols. 9					
		d Costs (see	through 14)					
		instructions)						
		14. 00	15. 00					
	PART II - RECONCILIATION OF AMOUNTS FROM WOR	KSHEET A, COLUM	N 2, LINES 1 a	ind 2				
1.00	CAP REL COSTS-BLDG & FLXT	813	1, 476, 415	5		ļ	1. 00	
2.00	CAP REL COSTS-MVBLE EQUIP	3, 489		•		ļ	2. 00	

813 3, 489 4, 302

1, 476, 415 856, 068 2, 332, 483

1. 00 2. 00 3. 00

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

Health Financial Systems	HUNTINGTON MEMO	ORIAL HOSPITAL		In Lieu of Form CMS-2552-10			
RECONCILIATION OF CAPITAL COSTS CENTERS		Provi der C		Period: From 01/01/2018	Worksheet A-7 Part III		
				To 12/31/2018	Date/Time Pre		
	COM	COMPUTATION OF RATIOS			5/28/2019 10: 0THER CAPITAL	58 am	
	COIVI	I OTATION OF ICA	1103	ALLOCATION OF			
Cost Center Description	Gross Assets	Capi tal i zed	Gross Assets	Ratio (see	Insurance		
		Leases	for Ratio (col. 1 - col	instructions)			
			2)	•			
	1. 00	2.00	3.00	4. 00	5. 00		
PART III - RECONCILIATION OF CAPITAL COSTS		1	1				
1.00 CAP REL COSTS-BLDG & FLXT	4, 743, 399	<b>1</b>	.,		0	1. 00	
2. 00 CAP REL COSTS-MVBLE EQUIP	12, 232, 194					2. 00	
3.00 Total (sum of lines 1-2)	16, 975, 593				0	3. 00	
	ALLOCATION OF OTHER CAPITAL SUMMARY OF CAPITAL						
Cost Center Description	Taxes	Other	Total (sum of	Depreciation	Lease		
		Capi tal -Rel ate					
		d Costs	through 7)	0.00	10.00		
DADT III DECONCILIATION OF CARLTAL COCTO	6. 00	7. 00	8. 00	9. 00	10. 00		
PART III - RECONCILIATION OF CAPITAL COSTS  1.00 CAP REL COSTS-BLDG & FLXT	LENIERS	0		189 249	42 722	1 00	
	_	1		107, 217		1.00	
2.00 CAP REL COSTS-MVBLE EQUIP	C	_		0 648, 059		2.00	
3.00 Total (sum of lines 1-2)	C	1	IMMADY OF CARL	837, 308	115, 333	3. 00	
		St	JMMARY OF CAPI	IAL			
Cost Center Description	Interest	Insurance (see	Taxes (see	0ther	Total (2) (sum		
		instructions)	instructions)	Capi tal -Rel ate			
				d Costs (see	through 14)		
				instructions)			
	11. 00	12. 00	13. 00	14. 00	15. 00		
PART III - RECONCILIATION OF CAPITAL COSTS							
1.00 CAP REL COSTS-BLDG & FLXT	C		1	813	271, 461	1. 00	
2. 00 CAP REL COSTS-MVBLE EQUIP	C			· ·		2. 00	
3.00  Total (sum of lines 1-2)	C	65, 149	6, 64	2 4, 302	1, 028, 734	3. 00	

Provider CCN: 15-0091 Peri od: Worksheet A-8 From 01/01/2018 To 12/31/2018 Date/Time Prepared:

					Γο 12/31/2018	Date/Time Prep 5/28/2019 10:5	
				Expense Classification or	Worksheet A	372072017 10.	oo aiii
				To/From Which the Amount is			
	Cost Center Description		Amount	Cost Center	Li ne #	Wkst. A-7 Ref.	
1 00		1.00	2.00	3.00	4. 00	5. 00	4 00
1. 00	Investment income - CAP REL COSTS-BLDG & FIXT (chapter 2)		0	CAP REL COSTS-BLDG & FIXT	1.00	0	1. 00
2. 00	Investment income - CAP REL	В	-5, 585	CAP REL COSTS-MVBLE EQUIP	2.00	11	2. 00
	COSTS-MVBLE EQUIP (chapter 2)						
3.00	Investment income - other		0		0.00	0	3. 00
4. 00	(chapter 2) Trade, quantity, and time		0		0.00	0	4. 00
4.00	di scounts (chapter 8)		0		0.00	Ĭ	4.00
5.00	Refunds and rebates of		0		0.00	0	5.00
, 00	expenses (chapter 8)		•		0.00		
6. 00	Rental of provider space by suppliers (chapter 8)		0		0.00	0	6. 00
7. 00	Tel ephone servi ces (pay	A	-1, 181	ADMINISTRATIVE & GENERAL	5. 00	0	7. 00
	stations excluded) (chapter						
	21)		0.40	000000000000000000000000000000000000000	7.00		
8. 00	Television and radio service (chapter 21)	A	-248	OPERATION OF PLANT	7.00	0	8. 00
9. 00	Parking Lot (chapter 21)		0		0.00	o	9. 00
10.00	Provi der-based physician	A-8-2	-1, 007, 721			o	10.00
	adjustment						
11. 00	Sale of scrap, waste, etc. (chapter 23)		0		0.00	0	11. 00
12. 00	Related organization	A-8-1	-3, 945, 544			o	12. 00
	transactions (chapter 10)						
13.00	Laundry and linen service		0		0.00	0	13.00
14.00	Cafeteria-employees and guests		-45, 196	CAFETERI A	11.00	0	14.00
15. 00	Rental of quarters to employee and others		U		0.00	0	15. 00
16. 00	Sale of medical and surgical		0		0.00	o	16.00
	supplies to other than						
17 00	patients		0		0.00	0	17 00
17. 00	Sale of drugs to other than patients		U		0.00	٥	17. 00
18. 00	Sale of medical records and		0		0.00	О	18. 00
	abstracts						
19. 00	Nursing and allied health		0		0.00	0	19. 00
	education (tuition, fees, books, etc.)						
20.00	Vendi ng machi nes		0	DI ETARY	10.00	0	20.00
21. 00	Income from imposition of		0		0.00	0	21. 00
	interest, finance or penalty charges (chapter 21)						
22. 00	Interest expense on Medicare		0		0.00	o	22. 00
22.00	overpayments and borrowings to		0		0.00	Ĭ	22.00
	repay Medicare overpayments						
23. 00	Adjustment for respiratory	A-8-3	0	RESPI RATORY THERAPY	65.00		23. 00
	therapy costs in excess of limitation (chapter 14)						
24. 00	Adjustment for physical	A-8-3	0	PHYSI CAL THERAPY	66.00		24. 00
	therapy costs in excess of						
2F 00	limitation (chapter 14)		^	*** Cost Conton Doloted ***	114 00		25 00
25. 00	Utilization review - physicians' compensation		0	*** Cost Center Deleted ***	114. 00		25. 00
	(chapter 21)						
26. 00	Depreciation - CAP REL		0	CAP REL COSTS-BLDG & FIXT	1.00	o	26.00
27 00	COSTS-BLDG & FLXT		^	CAD DEL COSTS MUDIE FOURD	2.00		27 00
27. 00	Depreciation - CAP REL COSTS-MVBLE EQUIP		0	CAP REL COSTS-MVBLE EQUIP	2. 00	0	27. 00
28. 00	Non-physician Anesthetist		0	NONPHYSICIAN ANESTHETISTS	19.00		28. 00
29. 00	Physicians' assistant		0		0.00	o	29. 00
30. 00	Adjustment for occupational	A-8-3	0	OCCUPATI ONAL THERAPY	67. 00		30. 00
	therapy costs in excess of limitation (chapter 14)						
30. 99	Hospice (non-distinct) (see		0	ADULTS & PEDIATRICS	30.00		30. 99
	instructions)						
31. 00	Adjustment for speech	A-8-3	0	SPEECH PATHOLOGY	68. 00		31. 00
	pathology costs in excess of limitation (chapter 14)						
32. 00	CAH HIT Adjustment for		0		0.00	0	32. 00
	Depreciation and Interest					[	
33. 00	OFFSET FOUNDATION SALARIES	Α	-117	FOUNDATI O	194. 03	0	33. 00

					o 12/31/2018	Date/Time Prep 5/28/2019 10:	pared: 58 am
				Expense Classification on	Worksheet A	0,20,201,	- Cann
				To/From Which the Amount is			
	Cost Center Description	Basis/Code (2)	Amount	Cost Center	Line #	Wkst. A-7 Ref.	
		1.00	2.00	3. 00	4. 00	5. 00	
33. 01	TELEPHONE SERVICES	A		EMPLOYEE BENEFITS DEPARTMENT	4. 00	0	33. 01
33. 03	HAF FEE ADJUSTMENT	A		ADMINISTRATIVE & GENERAL	5. 00	0	33. 03
33. 04	RENT	A		CAP REL COSTS-BLDG & FIXT	1.00	10	
33. 05	RENT	A		CAP REL COSTS-BLDG & FIXT	1.00	10	
33. 06	RENT	A		CAP REL COSTS-BLDG & FIXT	1. 00	10	
33. 07	PHARMACY EMPLOYEE PURCHASES	В		PHARMACY	15. 00	0	
33. 08	PHYSICIAN RECRUITMENT	A	·	ADMINISTRATIVE & GENERAL	5. 00	0	33. 08
33. 09	RENT	A		CAP REL COSTS-BLDG & FIXT	1. 00	10	
33. 10	SELF INSURANCE	A		EMPLOYEE BENEFITS DEPARTMENT	4. 00	0	33. 10
33. 11	GUEST MEALS	A		CAFETERI A	11. 00	0	33. 11
33. 13	LOBBY DUES	A		ADMINISTRATIVE & GENERAL	5. 00	0	33. 13
33. 14	LI QUOR	A	·	ADMINISTRATIVE & GENERAL	5. 00	0	33. 14
33. 15	OTHER OPERATING REVENUE	В		NURSING ADMINISTRATION	13. 00	0	33. 15
33. 18	OTHER OPERATING REVENUE	В		ADMINISTRATIVE & GENERAL	5. 00	0	33. 18
33. 19	OTHER OPERATING REVENUE	В	·	DI ETARY	10. 00	0	33. 19
33. 20	OTHER OPERATING REVENUE	В		CAFETERI A	11. 00	0	33. 20
33. 21	OTHER OPERATING REVENUE	В		PHARMACY	15. 00	0	33. 21
33. 24	OTHER OPERATING REVENUE	В	·	RESPI RATORY THERAPY	65. 00	0	33. 24
33. 25	OTHER OPERATING REVENUE	В	·	PHYSI CAL THERAPY	66. 00	0	33. 25
33. 27	OTHER OPERATING REVENUE	В		AMBULANCE SERVICES	95. 00	0	33. 27
33. 29	TELEMETRY	A	·	ADULTS & PEDIATRICS	30.00	0	33. 29
33. 30	OTHER OPERATING REVENUE	В	·	ADULTS & PEDIATRICS	30. 00	0	33. 30
33. 31	OTHER OPERATING REVENUE	В		OPERATION OF PLANT	7. 00	0	33. 31
34.00	DEPRECI ATI ON	A		CAP REL COSTS-BLDG & FIXT	1. 00	9	34. 00
35. 00	DEPRECI ATI ON	A	·	CAP REL COSTS-MVBLE EQUIP	2. 00	9	35. 00
37. 00	PHYS ADMIN SALARIES	A	·	ADMINISTRATIVE & GENERAL	5. 00	0	37. 00
50. 00	TOTAL (sum of lines 1 thru 49)		-12, 599, 826				50. 00
	(Transfer to Worksheet A,						
	column 6, line 200.)						

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

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

B. Amount Received - if cost cannot be determined.

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

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

\* 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.

NONALLOWABLE INTEREST EXPENS

0

11, 394, 916

608, 567

15, 340, 460

3.00

4.00

5.00

 p	or amore and an end of the party						
			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 PARKVI EW HEALTH SYSTEM, INC. 100.00	6. 00
7.00		0.00	7. 00
8.00		0.00	8. 00
9.00		0.00	9. 00
10.00		0.00	10.00
100.00	G. Other (financial or		100.00
	non-financial) specify:		

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

5. 00 ADMINISTRATIVE & GENERAL

0.00

TOTALS (sum of lines 1-4).

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

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

3.00

4.00

5.00

line 12.

Heal th	Financial Syste	ems	HUI	NTINGTON MEMORIA	AL HOSPITAL		In Lieu	of Form CMS-	2552-10
		SERVICES FROM	RELATED ORGANIZAT	TONS AND HOME	Provider CCN:	15-0091	Peri od:	Worksheet A-8	3-1
OFFICE	COSTS						From 01/01/2018 To 12/31/2018	Date/Time Pro	anarad.
							10 12/31/2010	5/28/2019 10:	
	Net	Wkst. A-7 Ref.							
	Adjustments								
	(col. 4 minus								
	col. 5)*								
	6. 00	7. 00							
	A. COSTS INCUR	RED AND ADJUST	MENTS REQUIRED AS	A RESULT OF TRA	NSACTIONS WITH	I RELATED O	RGANIZATIONS OR (	CLAIMED	
	HOME OFFICE CO								
1.00	2, 976, 916	C							1.00
2.00	-6, 313, 893	C	)						2. 00
3.00	-608, 567	C	)						3. 00
4.00	0	C							4. 00
5.00	-3, 945, 544								5. 00
* The	amounts on line	es 1-4 (and sub	bscripts as approp	riate) are trans	sferred in deta	ail to Work	ksheet A, column	6, lines as	

\* 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.

nas not	been posted to worksheet A,	cordinate and the amount arrowable should be murcated in cordinate and this part.	
	Related Organization(s)		
	and/or Home Office		
	Type of Business		
	6. 00		
	B. INTERRELATIONSHIP TO RELA	FED ORGANIZATION(S) AND/OR HOME OFFICE:	

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

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

	HOME OFFICE	6. 00
7.00		7. 00
8.00		8. 00
9.00		9. 00
10.00		10. 00
9. 00 10. 00 100. 00		100.00

- (1) Use the following symbols to indicate interrelationship to related organizations:
- A. Individual has financial interest (stockholder, partner, etc.) in both related organization and in provider.
- B. Corporation, partnership, or other organization has financial interest in provider.
- $\hbox{\it C. Provider has financial interest in corporation, partnership, or other organization.}\\$
- 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.

| Peri od: | Worksheet A-8-2 | From 01/01/2018 | To 12/31/2018 | Date/Time Prepared: Provider CCN: 15-0091

						7	To 12/31/2018	B Date/Time Pre 5/28/2019 10:	
	Wkst. A Line #	Cost	Center/Physician	Total	Professi onal	Provi der	RCE Amount	Physi ci an/Prov	
			I denti fi er	Remuneration	Component	Component		ider Component	
					·	·		Hours	
	1. 00		2. 00	3. 00	4. 00	5. 00	6. 00	7. 00	
1.00	50. 00 DF	R. A		980, 080		24, 000	239, 400	106	1. 00
2.00	91. 00 DF			27, 500	27, 500	0	0	0	2. 00
3.00	95. 00 DF	R. C		12, 341	12, 341	0	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				1, 019, 921				106	200.00
	Wkst. A Line #	Cost		Unadjusted RCE		Cost of		Physician Cost	
			ldenti fi er	Limit		Memberships &		of Malpractice	
					Limit	Conti nui ng	Share of col.	Insurance	
						Educati on	12		
4 00	1. 00		2. 00	8.00	9.00	12. 00	13. 00	14. 00	1 00
1.00	50. 00 DF			12, 200		_			1.00
2.00	91. 00 DF			0			0		
3.00	95. 00 DF	₹. C		0	-	_	0	0	3. 00
4.00	0.00			0	0	0	0	0	
5.00	0.00			0	0	0	0	0	5. 00
6.00	0.00			0	0	0	0	0	
7.00	0.00			0	0	0	0	0	7. 00
8.00	0.00			0	0	0	0	0	
9.00	0.00			0	0	0	0	0	9. 00
10.00	0. 00			0	0	1	0	-	10.00
200.00	WI+ A I : //	01	C	12, 200 Provi der		RCE	0	0	200. 00
	Wkst. A Line #	Cost	Center/Physician		Adjusted RCE Limit	Di sal I owance	Adjustment		
			Identi fi er	Component 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 DF	R. A		0	12, 200	11, 800	967, 880		1. 00
2.00	91. 00 DF	R. B		0	0	0	27, 500		2. 00
3.00	95. 00 DF			0	0	0	12, 341		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	12, 200	11, 800	1, 007, 721		200.00
				-	•	•			•

Health Financial Systems HUNTINGTON MEMORIAL HOSPITAL In Lieu of Form CMS-2552-10 COST ALLOCATION - GENERAL SERVICE COSTS Provider CCN: 15-0091 Peri od: Worksheet B From 01/01/2018 Part I Date/Time Prepared: 12/31/2018 5/28/2019 10:58 am CAPITAL RELATED COSTS Cost Center Description Net Expenses BLDG & FIXT MVBLE EQUIP **EMPLOYEE** Subtotal for Cost **BENEFITS** DEPARTMENT All ocation (from Wkst A col. 7) 1.00 2.00 4. 00 4A GENERAL SERVICE COST CENTERS 1 00 271, 461 00100 CAP REL COSTS-BLDG & FLXT 271, 461 1 00 2.00 00200 CAP REL COSTS-MVBLE EQUIP 757, 273 757, 273 2.00 4.00 00400 EMPLOYEE BENEFITS DEPARTMENT 1, 374, 776 1, 375, 081 4.00 305 00500 ADMINISTRATIVE & GENERAL 5 00 14, 031, 330 17, 750 3, 517 385, 434 14, 438, 031 5 00 6.00 00600 MAINTENANCE & REPAIRS 6.00 7.00 00700 OPERATION OF PLANT 1, 145, 488 70, 879 21, 936 24, 847 1, 263, 150 7.00 8.00 00800 LAUNDRY & LINEN SERVICE 188, 497 1, 454 1,804 191, 755 8.00 C 00900 HOUSEKEEPI NG 397, 075 9 00 414, 619 9 00 1, 183 0 16, 361 10.00 01000 DI ETARY 172, 371 11, 305 1, 469 5, 466 190, 611 10.00 01100 CAFETERI A 11.00 318, 038 2, 565 C 18,862 339, 465 11.00 01200 MAINTENANCE OF PERSONNEL 12.00 12.00 0 0 01300 NURSING ADMINISTRATION 301, 364 22, 303 323, 667 13.00 O 13.00 14.00 01400 CENTRAL SERVICES & SUPPLY 4, 402 4, 402 14.00 C 01500 PHARMACY 15.00 518, 161 2,669 59, 485 38, 844 619, 159 15.00 01600 MEDICAL RECORDS & LIBRARY 1, 474 1, 474 16,00 0 0 16,00 17 00 01700 SOCIAL SERVICE 0 C 0 0 Ω 17.00 19.00 01900 NONPHYSICIAN ANESTHETISTS 0 0 0 19.00 0 20.00 02000 NURSING SCHOOL 0 C 0 0 O 20.00 02100 I &R SERVICES-SALARY & FRINGES APPRV 0 21.00 0 0 21.00 0 0 02200 I&R SERVICES-OTHER PRGM COSTS APPRV 0 O 22.00 r 0 0 22.00 02300 PARAMED ED PRGM-(SPECIFY) 23.00 0 23.00 INPATIENT ROUTINE SERVICE COST CENTERS 30 00 03000 ADULTS & PEDIATRICS 3, 357, 451 30.00 3,005,855 58, 141 98,676 194.779 04300 NURSERY 43.00 183, 288 236 10, 255 193, 779 43.00 ANCILLARY SERVICE COST CENTERS 50.00 05000 OPERATING ROOM 577, 117 22, 147 119, 701 78, 970 797, 935 50.00 05001 OPERATING ROOM 50.01 C 0 Ω 50.01 05200 DELIVERY ROOM & LABOR ROOM 731, 495 52.00 0 40.928 772.423 52.00 53.00 05300 ANESTHESI OLOGY 982, 146 C 982, 146 53.00 05400 RADI OLOGY-DI AGNOSTI C 27, 758 1, 891, 058 54 00 1,616,114 170, 905 76, 281 54 00 60.00 06000 LABORATORY 2, 351, 278 4, 206 2, 355, 484 60.00 06250 BLOOD CLOTTING FOR HEMOPHILIACS 62.30 0 62.30 06500 RESPIRATORY THERAPY 877, 386 5, 075 33, 601 972, 085 65.00 56.023 65.00 06600 PHYSI CAL THERAPY 65, 293 940, 836 1, 048, 954 66.00 19, 236 23, 589 66.00 67.00 06700 OCCUPATI ONAL THERAPY 258, 425 C 17, 721 276, 146 67.00 68.00 06800 SPEECH PATHOLOGY 107, 340 0 4, 752 112, 092 68.00 69 00 06900 ELECTROCARDI OLOGY 0 Ω 0 69 00 0 |07100|MEDICAL SUPPLIES CHARGED TO PATIENT 71.00 813, 791 C 0 0 813, 791 71.00 72.00 07200 IMPL. DEV. CHARGED TO PATIENTS 859, 030 0 859, 030 72.00 73.00 07300 DRUGS CHARGED TO PATIENTS 2, 021, 944 0 0 2, 026, 590 73.00 4,646 07697 CARDIAC REHABILITATION 76 97 O 76 97 Ω 0 76. 98 07698 HYPERBARIC OXYGEN THERAPY 31,648 0 1, 250 32, 898 76.98 07699 LI THOTRI PSY 76.99 0 0 76.99 OUTPATIENT SERVICE COST CENTERS 90 00 09000 CLI NI C 88 463 6,016 94, 479 90 00 91.00 09100 EMERGENCY 1,530,389 11, 832 17, 792 90, 271 1, 650, 284 91.00 09200 OBSERVATION BEDS (NON-DISTINCT PART 92.00 92.00 OTHER REIMBURSABLE COST CENTERS 09500 AMBULANCE SERVICES 3, 176, 176 205, 752 205, 301 3, 595, 435 95.00 8.206 95.00 SPECIAL PURPOSE COST CENTERS 113.00 11300 INTEREST EXPENSE 113 00 SUBTOTALS (SUM OF LINES 1 through 117) 39, 628, 555 270, 823 756, 423 1, 366, 407 39, 618, 393 118. 00 118.00 NONREI MBURSABLE COST CENTERS 190.00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN 0 190. 00 192. 00 19200 PHYSI CLANS' PRI VATE OFFI CES 107, 751 192. 00 100.737 C 850 6, 164 194.00 07950 OCC HEALTH 638 194.00 638 0 194. 01 07951 PAIN CLINIC 0 0 0 194. 01 0 194. 02 07952 OCC HEALTH 11 194. 02 11 0 0 0 194. 03 07953 FOUNDATI 0 0 79, 884 194. 03 79,884 0 194. 04 07954 KIDS CAMPUS 0 C 0 0 194. 04 350, 861 194. 05 194. 05 07955 COMMUNITY & VOLUNTEER SERVICES 0 350, 861 194.06 07956 HUNTI NGTON COLLEGE NURSE 0 0 0 194. 06 194. 07 07957 MISC CATERING 2, 510 71.051 C 0 73, 561 194. 07 194.08 07958 AUTISM CENTER 50,056 0 50, 056 194. 08 194.09 07959 HUNTI NGTON BUA 0 0 0 194. 09 200.00 Cross Foot Adjustments 0 200.00

40, 281, 155

271, 461

757, 273

1, 375, 081

0 201, 00

40, 281, 155 202. 00

Negative Cost Centers

TOTAL (sum lines 118 through 201)

201 00

202.00

In Lieu of Form CMS-2552-10

Period: Worksheet B
From 01/01/2018 Part I
To 12/31/2018 Date/Time Prepared: 5/28/2019 10:58 am

					0 12/31/2016	5/28/2019 10:	
	Cost Center Description	ADMI NI STRATI VE		OPERATION OF	LAUNDRY &	HOUSEKEEPI NG	
		<u> </u>	REPAI RS 6. 00	PLANT 7. 00	LINEN SERVICE 8.00	9. 00	
	GENERAL SERVICE COST CENTERS	3.00	0.00	7.00	0.00	7.00	
1.00	00100 CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200 CAP REL COSTS-MVBLE EQUIP						2. 00
4.00	00400 EMPLOYEE BENEFITS DEPARTMENT						4. 00
5.00	00500 ADMINISTRATIVE & GENERAL	14, 438, 031					5. 00
6. 00 7. 00	00600 MAINTENANCE & REPAIRS 00700 OPERATION OF PLANT	705, 697	0	1, 968, 847			6. 00 7. 00
8. 00	00800 LAUNDRY & LINEN SERVICE	107, 130		15, 679			8.00
9. 00	00900 HOUSEKEEPI NG	231, 639		12, 762		659, 020	1
10.00	01000 DI ETARY	106, 491	0	121, 941	0	41, 415	1
11.00	01100  CAFETERI A	189, 652	0	27, 668	0	9, 397	11. 00
12.00	01200 MAINTENANCE OF PERSONNEL	0		0	0	0	
13.00	01300 NURSI NG ADMI NI STRATI ON	180, 826		0	0	0	
14. 00	01400 CENTRAL SERVICES & SUPPLY	2, 459		47, 485		16, 127	
15. 00 16. 00	01500 PHARMACY 01600 MEDICAL RECORDS & LIBRARY	345, 912 823		28, 790 15, 903		9, 778 5, 401	1
17. 00	01700 SOCIAL SERVICE	023		15, 703	0	0, 401	1
19. 00	01900 NONPHYSI CI AN ANESTHETI STS	0		0	0	Ö	1
20.00	02000 NURSI NG SCHOOL	0	0	Ö	0	0	1
21.00	02100 I&R SERVICES-SALARY & FRINGES APPRV	0	0	0	0	0	21. 00
22. 00	02200 I &R SERVICES-OTHER PRGM COSTS APPRV	0	0	0	0	0	
23. 00	02300 PARAMED ED PRGM-(SPECIFY)	0	0	0	0	0	23. 00
20.00	I NPATI ENT ROUTI NE SERVI CE COST CENTERS 03000 ADULTS & PEDI ATRI CS	1, 875, 741	T 0	627, 152	02 215	212, 999	20.00
30. 00 43. 00	04300 NURSERY	1, 875, 741		1		212, 999	1
43.00	ANCILLARY SERVICE COST CENTERS	100, 200		2, 545	4, 033	004	43.00
50.00	05000 OPERATI NG ROOM	445, 790	0	238, 896	45, 954	81, 136	50.00
50. 01	05001   OPERATI NG ROOM	0	0	0	0	0	50. 01
52.00	05200 DELIVERY ROOM & LABOR ROOM	431, 537	0	0	18, 499	0	
53. 00	05300 ANESTHESI OLOGY	548, 705	l e	0	0	0	53. 00
54. 00	05400 RADI OLOGY-DI AGNOSTI C 06000 LABORATORY	1, 056, 496		299, 417			1
60. 00 62. 30	06250 BLOOD CLOTTING FOR HEMOPHILIACS	1, 315, 962	0	45, 366 0	0	15, 408 0	1
65. 00	06500 RESPIRATORY THERAPY	543, 084		54, 739	22, 195		1
66. 00	06600 PHYSI CAL THERAPY	586, 030	Ö	207, 488		70, 469	1
67.00	06700 OCCUPATI ONAL THERAPY	154, 277	0	0	0	0	67. 00
68. 00	06800 SPEECH PATHOLOGY	62, 624	0	0	0	0	68. 00
69. 00	06900 ELECTROCARDI OLOGY	0	1	0	0	0	
71. 00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	454, 649		0	0	0	
72. 00 73. 00	07200 IMPL. DEV. CHARGED TO PATIENTS 07300 DRUGS CHARGED TO PATIENTS	479, 923		0	0	0   0	
76. 97	07500 DRUGS CHARGED TO PATTENTS	1, 132, 215		0	0	0	
76. 98	07698 HYPERBARI C OXYGEN THERAPY	18, 379	1	0	0	Ö	1
76. 99	07699 LI THOTRI PSY	0		Ō	0	Ō	1
	OUTPATIENT SERVICE COST CENTERS						
90.00	09000 CLI NI C	52, 784			_		
91.00	09100 EMERGENCY	921, 981	0	127, 624	78, 009	43, 345	
92. 00	09200 OBSERVATION BEDS (NON-DISTINCT PART OTHER REIMBURSABLE COST CENTERS						92.00
95 00	09500 AMBULANCE SERVICES	2, 008, 694	Ιο	88, 514	6, 469	30, 062	95. 00
	SPECIAL PURPOSE COST CENTERS			29,5	27		1
113.00	11300 I NTEREST EXPENSE						113. 00
118. 00		14, 067, 760	0	1, 961, 967	307, 112	656, 683	118. 00
400.00	NONREI MBURSABLE COST CENTERS		1	1 0			100.00
	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN 19200 PHYSICIANS' PRIVATE OFFICES	60, 198		_	7, 452		190. 00 192. 00
	07950 OCC HEALTH	356		6, 880			194. 00
	07951 PALN CLINIC	0		0,000	0		194. 01
	07952 OCC HEALTH	6	0	Ō	0		194. 02
194. 03	07953 FOUNDATIO	44, 630	0	0	0	0	194. 03
	07954 KIDS CAMPUS	0	0	0	0		194. 04
	07955 COMMUNITY & VOLUNTEER SERVICES	196, 019	0	0	0		194. 05
	07956 HUNTI NGTON COLLEGE NURSE	0	0	0	0		194. 06
	7 07957 MISC CATERING	41, 097		0	0		194. 07 194. 08
	307958 AUTI SM CENTER 07959 HUNTI NGTON BUA	27, 965		0	0		194. 08 194. 09
200.00			١				200.00
201.00		0	0	О	o	О	201. 00
202.00		14, 438, 031	0	1, 968, 847	314, 564		

				10 12/31/2018	5/28/2019 10:	
Cost Center Description	DI ETARY	CAFETERI A	MAINTENANCE O	F NURSI NG	CENTRAL	
·			PERSONNEL	ADMI NI STRATI ON	SERVICES &	
	10.00	11.00	10.00	10.00	SUPPLY	
CENEDAL CEDIM OF COCT CENTEDS	10. 00	11. 00	12. 00	13. 00	14. 00	
GENERAL SERVICE COST CENTERS  1. 00 00100 CAP REL COSTS-BLDG & FLXT						1. 00
2.00   00200 CAP REL COSTS-MVBLE EQUIP						2. 00
4. 00   00400 EMPLOYEE BENEFITS DEPARTMENT						4. 00
5. 00 00500 ADMINISTRATIVE & GENERAL						5. 00
6. 00 00600 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	460, 458					10. 00
11. 00   01100   CAFETERI A	o	566, 182				11. 00
12.00 01200 MAINTENANCE OF PERSONNEL	o	0		0		12.00
13.00 01300 NURSING ADMINISTRATION	o	9, 097		0 513, 590		13.00
14.00 01400 CENTRAL SERVICES & SUPPLY	0	0		0 0	71, 100	14.00
15. 00   01500   PHARMACY	0	14, 264		0 0	839	15. 00
16.00 01600 MEDICAL RECORDS & LIBRARY	0	0		0 0	0	16. 00
17. 00   01700   SOCIAL SERVICE	0	0		0 0	0	17. 00
19. 00 01900 NONPHYSICIAN ANESTHETISTS	0	0		0 0	0	19. 00
20. 00   02000   NURSI NG SCHOOL	0	0		0 0	0	20. 00
21.00   02100   1 &R SERVI CES-SALARY & FRINGES APPRV	0	0		0 0	0	21. 00
22.00   02200   1 &R SERVI CES-OTHER PRGM COSTS APPRV	0	0		0 0	0	22. 00
23. 00 O2300 PARAMED ED PRGM-(SPECIFY)	0	0		0 0	0	23. 00
I NPATI ENT ROUTI NE SERVI CE COST CENTERS						
30. 00   03000   ADULTS & PEDI ATRI CS	460, 458	182, 232		0 305, 280	4, 999	30.00
43. 00   04300   NURSERY	0	5, 761		0 9, 651	0	43. 00
ANCILLARY SERVICE COST CENTERS	ما	41 ((0		0 (0.701	7 242	FO 00
50. 00 05000 OPERATI NG ROOM	0	41, 660		0 69, 791	7, 343	50.00
50. 01   05001   0PERATI NG ROOM	0	22,002		0 0	0	50. 01
52. 00 05200 DELIVERY ROOM & LABOR ROOM	U O	22, 992		0 38, 516	0	52.00
53. 00 05300 ANESTHESI OLOGY	U O	44 001		0 0	1 017	53.00
54. 00   05400   RADI OLOGY-DI AGNOSTI C 60. 00   06000   LABORATORY	O O	44, 891		0 0	1, 817	54. 00 60. 00
62. 30   06250   BLOOD CLOTTING FOR HEMOPHILIACS	0	0		0	29 0	62. 30
65. 00 06500 RESPIRATORY THERAPY	0	36, 529			2, 801	65. 00
66. 00   06600   PHYSI CAL THERAPY	0	34, 203			941	66. 00
67. 00   06700   OCCUPATI ONAL THERAPY	0	10, 898			0	67. 00
68. 00 06800 SPEECH PATHOLOGY		2, 922			0	68. 00
69. 00   06900   ELECTROCARDI OLOGY		2, 722			0	69. 00
71. 00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	ol	0			41, 733	71. 00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	ol	0		ol ol	0	72. 00
73.00 07300 DRUGS CHARGED TO PATIENTS	ol	0		ol ol	1, 295	73. 00
76. 97   07697 CARDI AC REHABI LI TATI ON	o	0		o o	0	76. 97
76. 98 07698 HYPERBARI C OXYGEN THERAPY	o	0		o o	139	76. 98
76. 99 07699 LI THOTRI PSY	О	0		o o	0	76. 99
OUTPATIENT SERVICE COST CENTERS	<u> </u>					
90. 00 09000 CLI NI C	0	0		0 0	0	90.00
91. 00 09100 EMERGENCY	o	53, 934		0 90, 352	4, 066	91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART						92.00
OTHER REIMBURSABLE COST CENTERS						
95. 00 09500 AMBULANCE SERVICES	0	95, 268		0 0	5, 015	95. 00
SPECIAL PURPOSE COST CENTERS						
113. 00 11300 I NTEREST EXPENSE						113. 00
118.00 SUBTOTALS (SUM OF LINES 1 through 117)	460, 458	554, 651		0 513, 590	71, 017	118. 00
NONREI MBURSABLE COST CENTERS						
190.00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0		0 0		190. 00
192.00 19200 PHYSI CLANS' PRI VATE OFFI CES	0	5, 291		0 0		192. 00
194. 00 07950 OCC HEALTH	0	0		0 0		194. 00
194. 01 07951 PAIN CLINIC	0	0		0 0		194. 01
194. 02 07952 OCC HEALTH	0	0		0		194. 02
194. 03 07953 FOUNDATI 0	0	3, 978		0		194. 03
194. 04 07954 KIDS CAMPUS	0	0		0		194. 04
194. 05 07955 COMMUNITY & VOLUNTEER SERVICES	0	0				194. 05
194. 06 07956 HUNTI NGTON COLLEGE NURSE	O	2 2/2				194. 06
194. 07 07957 MISC CATERING 194. 08 07958 AUTISM CENTER	ol	2, 262				194. 07
194. 08 07958 AUTI SM CENTER 194. 09 07959 HUNTI NGTON BUA	ol	0				194. 08 194. 09
200.00 Cross Foot Adjustments	Y	U		٦ °	0	200. 00
201.00   Negative Cost Centers		0			0	200.00
202.00 TOTAL (sum lines 118 through 201)	460, 458	566, 182		0 513, 590		
202.00   101AL (30111 11163 110 till 00gil 201)	400, 430	300, 102	I	o <sub>1</sub> 313, 370	71, 100	202.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 15-0091

Peri od: Worksheet B From 01/01/2018 Part I To 12/31/2018 Date/Time Prepared:

5/28/2019 10:58 am Cost Center Description **PHARMACY** MEDI CAL SOCIAL SERVICE NONPHYSICIAN NURSING SCHOOL RECORDS & **ANESTHETISTS** LI BRARY 15. 00 17.00 19. 00 20.00 16,00 GENERAL SERVICE COST CENTERS 1.00 00100 CAP REL COSTS-BLDG & FIXT 1.00 00200 CAP REL COSTS-MVBLE EQUIP 2.00 2.00 4.00 00400 EMPLOYEE BENEFITS DEPARTMENT 4.00 5.00 00500 ADMINISTRATIVE & GENERAL 5.00 00600 MAINTENANCE & REPAIRS 6.00 6.00 7.00 00700 OPERATION OF PLANT 7.00 00800 LAUNDRY & LINEN SERVICE 8.00 8 00 9.00 00900 HOUSEKEEPI NG 9.00 10.00 01000 DI ETARY 10 00 01100 CAFETERI A 11.00 11.00 01200 MAINTENANCE OF PERSONNEL 12.00 12.00 13.00 01300 NURSING ADMINISTRATION 13.00 14.00 01400 CENTRAL SERVICES & SUPPLY 14.00 01500 PHARMACY 1,018,742 15.00 15.00 01600 MEDICAL RECORDS & LIBRARY 16.00 23, 601 16.00 17.00 01700 SOCIAL SERVICE 0 17.00 0 19.00 01900 NONPHYSICIAN ANESTHETISTS 0 0 19.00 02000 NURSING SCHOOL 0 0 Λ 20.00 20 00 C 21.00 02100 I&R SERVICES-SALARY & FRINGES APPRV 0 C 21.00 02200 | &R SERVICES-OTHER PRGM COSTS APPRV 0 0 22.00 22.00 02300 PARAMED ED PRGM-(SPECIFY) 23.00 23.00 0 INPATIENT ROUTINE SERVICE COST CENTERS 30.00 03000 ADULTS & PEDIATRICS 72, 481 1, 608 0 0 0 30.00 04300 NURSERY 0 43.00 135 0 0 43.00 ANCILLARY SERVICE COST CENTERS 50.00 05000 OPERATING ROOM 106, 471 2,681 0 0 0 50.00 05001 OPERATING ROOM 0 0 0 50.01 50.01 0 52.00 05200 DELIVERY ROOM & LABOR ROOM 0 554 0 0 0 0 0 0 0 0 0 0 0 0 0 52.00 05300 ANESTHESI OLOGY 0 53.00 Ω 415 0 53.00 0 54.00 05400 RADI OLOGY-DI AGNOSTI C 26, 343 4, 424 0 54.00 06000 LABORATORY 0 60.00 427 2, 658 0 60.00 62 30 06250 BLOOD CLOTTING FOR HEMOPHILIACS 0 0 62 30 0 06500 RESPIRATORY THERAPY 65.00 40,615 885 0 65.00 06600 PHYSI CAL THERAPY 0 0 66.00 13.651 582 66.00 06700 OCCUPATIONAL THERAPY 67.00 190 0 0 67.00 06800 SPEECH PATHOLOGY 0 68 00 0 68 00 44 0 0 69.00 06900 ELECTROCARDI OLOGY 137 0 69.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT 605, 079 71.00 1, 343 0 71.00 72.00 07200 IMPL. DEV. CHARGED TO PATIENTS 717 0 0 72.00 07300 DRUGS CHARGED TO PATIENTS 0 73 00 18, 780 2.109 0 73 00 0 76. 97 07697 CARDIAC REHABILITATION 0 76.97 07698 HYPERBARIC OXYGEN THERAPY 76.98 2,015 27 0 0 0 76. 98 07699 LI THOTRI PSY 76.99 0 0 0 76.99 0 OUTPATIENT SERVICE COST CENTERS 90.00 09000 CLI NI C 92 0 0 0 90.00 91.00 09100 EMERGENCY 58, 955 3, 232 0 0 0 91.00 09200 OBSERVATION BEDS (NON-DISTINCT PART 92.00 92.00 OTHER REIMBURSABLE COST CENTERS 09500 AMBULANCE SERVICES 72, 718 1, 768 0 0 95.00 0 SPECIAL PURPOSE COST CENTERS 113.00 11300 INTEREST EXPENSE 113.00 SUBTOTALS (SUM OF LINES 1 through 117) 118.00 1,017,535 23, 601 0 0 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 1.131 0 0 192, 00 194.00 07950 OCC HEALTH 0 0 194.00 0 0 0 0 0 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 C 0 194. 03 194. 04 07954 KIDS CAMPUS 0 194. 04 76 0 0 194. 05 07955 COMMUNITY & VOLUNTEER SERVICES 0 0 0 194. 05 194.06 07956 HUNTI NGTON COLLEGE NURSE 0 0 194, 06 C 194. 07 07957 MISC CATERING 0 194. 07 194.08 07958 AUTISM CENTER 0 0 194. 08 0 0 194. 09 07959 HUNTI NGTON BUA 0 0 194.09 0 200.00 Cross Foot Adjustments 200.00 201.00 Negative Cost Centers 0 0 201.00 202.00 TOTAL (sum lines 118 through 201) 1,018,742 23, 601 0 202.00

| In Lieu of Form CMS-2552-10 | Peri od: | Worksheet B | From 01/01/2018 | Part | | To 12/31/2018 | Date/Time Prepared: | To 12/31/2018 | Date/Tim Health Financial Systems
COST ALLOCATION - GENERAL SERVICE COSTS Provider CCN: 15-0091

Control Center Description						lo	12/31/2018	Date/lime Pre 5/28/2019 10:	
V S. PHINGES   PROM COSTS   PROM   Residents Cost   PROM   Residents Cost   Promise			INTERNS &	RESI DENTS				072072017 10.	OG GIII
Variety   Proceedings   Process		Coot Contan Decement on	CEDVI CEC CALAD	CEDVICES OTHER	DADAMED ED		Cub+o+ol	l ntonn 0	
APPROV   A		Cost Center Description				3	Subtotai		
					I Kow				
DEMONITOR SERVICE COST CENTERS   21.00   22.00   23.00   24.00   25.00									
Control   Cont			21.00	22.00	22.00		24 00		
1.00   20100  CAP REL COSIS-HUBE STITY		GENERAL SERVICE COST CENTERS	21.00	22.00	23.00		24.00	25.00	
4.00   00000   DEPLOYEE BEREFITS DEPARTMENT									1.00
5.00	1	· ·							2. 00
0.00   0.000   MAINTENANCE & REPAIR S   0.000   0.00	1	I							1
7.00   0.0700   DOPERATION OF PLANT	1								1
8.00	1	· ·							1
10.00   01000   DETARY	1	· ·							1
11.00   01100   CAFTERIA	1	· · · · · · · · · · · · · · · · · · ·							
12.00   10200   MA NITAMACE OF PERSONNEL   12.00   13.00   1	1	· · · · · · · · · · · · · · · · · · ·							
13.00   1300   NURSING ADMINISTRATION     14.00   1400   1400   1400   1400   1400   1400   1400   1400   1400   1400   1400   1400   1500   1500   1500   1500   1600	1	· ·							
15.00   1500   PHARMARY	1	· · · · · · · · · · · · · · · · · · ·							
10.00   01.00   NEDI CAL, RECORDS & LI SHRARY     17.00   170.00	1	· · · · · · · · · · · · · · · · · · ·							1
17.00   1700   01700   00900   000000	1	· ·							1
19.00   0.900   NOMPHYSICI AN AMESTHET ISTS   20.00	1	· · · · · · · · · · · · · · · · · · ·							1
20.00	1								1
22 0.0	20. 00	02000 NURSING SCHOOL							20. 00
	1	· ·	0	_					1
IMPATI ENT ROUTINE SERVICE COST CENTERS   0 0 0 0, 7,193,616 0 30.00   33.00 0, 3000 ADULTS & PEDIA TRICS   0 0 0 0, 325,628 0 43.00   33.00 ADULTS & PEDIA TRICS   0 0 0 0, 325,628 0 43.00   ANCILLARY SERVICE COST CENTERS   0 0 0 0 0, 325,628 0 0, 43.00   ANCILLARY SERVICE COST CENTERS   0 0 0 0 0, 0 0 0, 0 0, 0 0, 0 0, 0 0	1			0		0			1
30.00   30000   ADULTS & PEDI ATRICS   0   0   0   7,193,616   0   30.00						U			23.00
MOLILLARY SERVICE COST CENTERS			0	0		0	7, 193, 616	0	30.00
50.00   05000   OPERATI NG ROOM	<u> </u>		0	0		0	325, 628	0	43. 00
50.00			1	1 0			1 027 657	l 0	50.00
52.00   05200   DELIVERY ROOM & LABOR ROOM   0   0   1, 284, 521   0   5.00	- 1			1					1
54. 00   05400   RADIO CLORY-DI AGNOSTIC   0 0 0 3.463, 646   0 54. 00	1	· ·	0	1		-	1, 284, 521		1
60.00   06000   LABORATORY   0	1	I	0	0		-			1
62.30   06250   BLOOD CLOTTING FOR HEMOPHILIACS   0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	1		0	0		-		l	1
65.00   06500   RESPIRATORY THERAPY   0   0   0   1, 691, 524   0   65.00	1	· ·		0		-			1
67.00   06700   06700   06700   06700   06800   06800   06800   06800   06800   06800   06800   06800   06800   06800   06800   06800   06800   06800   06800   06900   06800   06800   0690	1	· · · · · · · · · · · · · · · · · · ·	0	1	•	-	_	1	1
68. 00   06800   DEECH PATHOLOGY   0   0   0   177, 682   0   68. 00	66. 00	06600 PHYSI CAL THERAPY	0	0		0	1, 962, 318	0	66. 00
69-00   06900   CLECTROCARDIOLOGY   0   0   0   137   0   69-00	1		0	0		-			
71. 00   07100   MEDICAL SUPPLIES CHARGED TO PATIENT   0   0   0   1,916,595   0   71. 00   72. 00   07200   IMPL. DEV. CHARGED TO PATIENTS   0   0   0   1,339,670   0   72. 00   73. 00   07300   DRUGS CHARGED TO PATIENTS   0   0   0   0   3,180,999   0   73. 00   76. 97   07697   07697   07697   07697   07697   07697   07697   07697   07697   07697   07698   MERCANGED TO PATIENTS   0   0   0   0   0   0   0   0   0	1	· ·	0	0		-		1	
172.00   07200   IMPL. DEV. CHARGED TO PATIENTS   0   0   0   1,339,670   0   72.00	1	· · · · · · · · · · · · · · · · · · ·				-			ı
76. 97 07697 (CARDI AC REHABILLITATION 0 0 0 0 0 0 76. 99 76. 98 07698 HYPERBARIC OXYGEN THERAPY 0 0 0 0 53, 458 0 76. 99 07699 LITHOTRI PSY 0 0 0 0 53, 458 0 76. 99 0000 (CLINIC 0 0 0 147, 355 0 90. 00 91. 00 09100 EMERGENCY 0 0 0 0 147, 355 0 90. 00 92. 00 09200 (DSSERVATI ON BEDS (NON-DISTINCT PART 0 92. 00 07690 LITHOTRI PSY 0 0 0 0 0 147, 355 0 90. 00 92. 00 09200 (DSSERVATI ON BEDS (NON-DISTINCT PART 0 92. 00 07690 AMBULANCE SERVI CES  0 92. 00 07690 AMBULANCE SERVI CES  0 0 0 0 55, 903, 943 0 95. 00 118. 00 11300 INTEREST EXPENSE  113. 00 118. 00 SUBTOTALS (SUM OF LINES 1 through 117) 0 0 0 0 39, 218, 632 0 118. 00 190. 00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN 0 0 0 181, 901 0 192. 00 194. 00 17900 (GFT, FLOWER, COFFEE SHOP & CANTEEN 0 0 0 181, 901 0 192. 00 194. 00 17950 (CCHEALTH 0 0 0 0 10, 211 0 194. 00 194. 01 07951 (PAIN THE CLINIC 0 0 0 0 10, 211 0 194. 01 194. 01 07951 (PAIN THE CLINIC 0 0 0 0 128, 492 0 194. 01 194. 02 07952 (CCHEALTH 0 0 0 0 128, 492 0 194. 02 194. 03 07953 (FOUNDATI O 0 0 0 184, 901 0 194. 02 194. 04 07954 (KIDS CAMPUS 0 0 0 0 186, 961 0 194. 03 194. 04 07955 (CMMUNITY & VOLUNTEER SERVI CES 0 0 0 0 186, 961 0 194. 04 194. 05 07955 (CMMUNITY & VOLUNTEER SERVI CES 0 0 0 0 0 166, 961 0 194. 05 194. 08 07956 (HUNTI NGTON BUA 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	1	· · · · · · · · · · · · · · · · · · ·	0	0		0		i e	1
76. 98 07698   IMPERBARI C OXYGEN THERAPY 0 0 0 0 53,458 0 76. 98 076. 99 076.			0	0		-		i e	
76. 99   07699   LITHOTRI PSY   0   0   0   0   0   0   0   76. 99     001971   LITHOTRI PSY   0   0   0   0   0   0   0   0   0			0				-	l e	1
OUTPAT I ENT SERVI CE COST CENTERS   OUTPAT I ENT SERVI CE SERVI CES   OUTPAT I						-			
91. 00   09100   EMERGENCY   0   0   0   0   3, 031, 782   0   91. 00   92. 00   09200   OBSERVATI ON BEDS (NON-DISTINCT PART   0   92. 00   0   0   0   5, 903, 943   0   95. 00   09500   AMBULANCE SERVICES   0   0   0   0   5, 903, 943   0   95. 00   0   0   0   0   0   0   0   0   0			-	_				· · · · · ·	
92. 00   09200   0BSERVATION BEDS (NON-DISTINCT PART   0   92. 00   0THER REI MBURSABLE COST CENTERS   0   0   0   0   5, 903, 943   0   95. 00   0   0   5, 903, 943   0   95. 00   0   0   0   5, 903, 943   0   95. 00   0   0   0   0   0   0   0   0   0			1	•				l	
OTHER REI MBURSABLE COST CENTERS   O O O O O O O O O O O O O O O O O O			0	0		0	3, 031, 782		
95. 00				L	l			0	72.00
113.00   11300   INTEREST EXPENSE			0	0		0	5, 903, 943	0	95. 00
118.00   SUBTOTALS (SUM OF LINES 1 through 117)   0   0   0   39, 218, 632   0   118.00									
NONRE   MBURSABLE COST CENTERS   NO. 0   19000   GI FT, FLOWER, COFFEE SHOP & CANTEEN   NO. 0   19000   O   O   O   O   O   O   O   O   O						0	20 210 422	_	
190. 00	-		0			U	39, 218, 632	0	] 118.00
194. 00 07950 OCC HEALTH 0 0 0 0 10, 211 0 194. 00 194. 01 07951 PAI N CLI NI C 0 0 0 0 0 0 194. 01 194. 02 07952 OCC HEALTH 0 0 0 0 0 177 0 194. 02 194. 03 07953 FOUNDATI O 0 0 0 128, 492 0 194. 02 194. 04 07954 KI DS CAMPUS 0 0 0 0 0 128, 492 0 194. 04 194. 05 07955 COMMUNI TY & VOLUNTEER SERVI CES 0 0 0 0 0 194. 06 194. 07 07957 MI SC CATERI NG 0 0 0 116, 920 0 194. 07 194. 08 07958 AUTI SM CENTER 0 0 0 0 0 116, 920 0 194. 08 194. 09 07959 HUNTI NGTON BUA 0 0 0 0 0 0 0 194. 08 194. 09 07959 HUNTI NGTON BUA 0 0 0 0 0 0 0 0 194. 08 194. 09 07959 HUNTI NGTON BUA 0 0 0 0 0 0 0 0 0 0 0 194. 08 194. 09 07959 HUNTI NGTON BUA 0 0 0 0 0 0 0 0 0 0 0 194. 08 194. 09 07959 HUNTI NGTON BUA 0 0 0 0 0 0 0 0 0 0 0 0 0 194. 08 194. 09 07959 HUNTI NGTON BUA 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	190.00	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0		0	0	0	190. 00
194. 01 07951 PAIN CLINIC 0 0 0 0 0 194. 01 194. 02 194. 02 07952 OCC HEALTH 0 0 0 0 17 0 194. 02 194. 03 07953 FOUNDATI 0 0 0 0 0 128, 492 0 194. 03 194. 04 07954 KI DS CAMPUS 0 0 0 0 0 0 0 128, 492 0 194. 04 194. 05 07955 COMMUNI TY & VOLUNTEER SERVI CES 0 0 0 0 546, 961 0 194. 05 194. 06 07956 HUNTI NGTON COLLEGE NURSE 0 0 0 0 116, 920 0 194. 07 194. 08 07958 AUTI SM CENTER 0 0 0 0 116, 920 0 194. 07 194. 08 07959 HUNTI NGTON BUA 0 0 0 0 0 0 0 0 0 0 0 0 194. 09 200. 00 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	192. 00	19200 PHYSICIANS' PRIVATE OFFICES	0	0		-			
194. 02 07952 OCC HEALTH 0 0 0 0 17 0 194. 02 194. 03 07953 FOUNDATI 0 0 0 0 0 128, 492 0 194. 03 194. 04 07954 KI DS CAMPUS 0 0 0 0 0 0 194. 04 194. 05 07955 COMMUNI TY & VOLUNTEER SERVI CES 0 0 0 546, 961 0 194. 05 194. 06 07956 HUNTI NGTON COLLEGE NURSE 0 0 0 0 116, 920 0 194. 06 194. 07 07957 MI SC CATERI NG 0 0 0 116, 920 0 194. 07 194. 08 07958 AUTI SM CENTER 0 0 0 0 0 78, 021 0 194. 08 194. 09 07959 HUNTI NGTON BUA 0 0 0 0 0 0 0 0 194. 09 200. 00 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0			0	0		-			
194. 03 07953   FOUNDATI 0       0       0       0       128, 492   0       194. 03         194. 04 07954   KI DS CAMPUS       0       0       0       0       0       194. 04         194. 05 07955   COMMUNI TY & VOLUNTEER SERVI CES       0       0       0       546, 961   0       0 194. 05         194. 07 07957   HUNTI NGTON COLLEGE NURSE       0       0       0       0       0       0 194. 06         194. 08 07958   AUTI SM CENTER       0       0       0       0       116, 920   0       0 194. 07         194. 09 07959   HUNTI NGTON BUA       0       0       0       0       0       0       194. 09         200. 00   Cross Foot Adj ustments       0 <t< td=""><td></td><td></td><td></td><td>0</td><td></td><td>-</td><td></td><td></td><td></td></t<>				0		-			
194. 04 07954 KI DS CAMPUS  194. 05 07955 COMMUNI TY & VOLUNTEER SERVI CES  194. 06 07956 HUNTI NGTON COLLEGE NURSE  0 0 0 546, 961  0 194. 06  194. 07 07957 MI SC CATERI NG  0 0 0 116, 920  194. 08 07958 AUTI SM CENTER  0 0 0 0 78, 021  194. 09 07959 HUNTI NGTON BUA  200. 00 Cross Foot Adj ustments  0 0 0 0 0 0 0 0 194. 08  0 0 0 0 0 0 194. 08  0 0 0 0 0 0 0 194. 08  0 0 0 0 0 0 0 194. 08  0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0				0		-			
194. 06 07956 HUNTI NGTON COLLEGE NURSE 0 0 0 0 0 194. 06 194. 07 07957 MI SC CATERI NG 0 0 0 116, 920 0 194. 07 194. 08 07958 AUTI SM CENTER 0 0 0 0 78, 021 0 194. 08 194. 09 07959 HUNTI NGTON BUA 0 0 0 0 0 0 194. 09 200. 00 Cross Foot Adjustments 0 0 0 0 0 0 0 200. 00 201. 00 Negative Cost Centers 0 0 0 0 0 0 0 0 201. 00			0	0		0	0		
194. 07     07957     MI SC CATERING     0     0     116, 920     0     194. 07       194. 08     07958     AUTI SM CENTER     0     0     0     78, 021     0     194. 08       194. 09     07959     HUNTI NGTON BUA     0     0     0     0     0     194. 09       200. 00     Cross Foot Adjustments     0     0     0     0     0     0     200. 00       201. 00     Negati ve Cost Centers     0     0     0     0     0     0     201. 00			0	0		0	546, 961		
194. 08 07958 AUTI SM CENTER     0     0     0     78, 021     0 194. 08       194. 09 07959 HUNTI NGTON BUA     0     0     0     0     0 194. 09       200. 00 Cross Foot Adjustments     0     0     0     0     0     0     0     0     0     200. 00       201. 00 Negative Cost Centers     0     0     0     0     0     0     0     0     201. 00						0	0 116 020		
194. 09 07959 HUNTI NGTON BUA     0     0     0     0 194. 09       200. 00 Cross Foot Adjustments     0     0     0     0     0     0     0     200. 00       201. 00 Negative Cost Centers     0			0	0		-			
201.00   Negative Cost Centers   0   0   0   0   201.00	194. 09	07959 HUNTI NGTON BUA	0	0		-		0	194. 09
			0	0			0		
202. 00    TOTAL (30    TTHES TTO THE OUGH 2017)   0  0  40, 201, 133  0 202. 00			0	1			0 4∩ 281 155		
		1 Total (Sam Filles Flo through 201)			l .	91	,0,201,100	<u> </u>	1202.00

Peri od: Worksheet B From 01/01/2018 Part I To 12/31/2018 Date/Ti me Prepared: 5/28/2019 10:58 am Provider CCN: 15-0091

			5/28/2019 10	
	Cost Center Description	Total		
	ENEDAL CEDVICE COCT CENTEDS	26. 00		
	ENERAL SERVICE COST CENTERS 0100 CAP REL COSTS-BLDG & FLXT			1.00
1	10200 CAP REL COSTS-MVBLE EQUIP			2. 00
1	0400 EMPLOYEE BENEFITS DEPARTMENT			4. 00
1	0500 ADMINISTRATIVE & GENERAL			5. 00
1	0600 MAI NTENANCE & REPAI RS			6. 00
1	0700 OPERATION OF PLANT			7. 00
8.00	0800 LAUNDRY & LINEN SERVICE	i		8. 00
9.00	0900 HOUSEKEEPI NG			9. 00
	1000 DI ETARY			10. 00
1	1100 CAFETERI A			11. 00
1	1200 MAINTENANCE OF PERSONNEL			12. 00
	1300 NURSING ADMINISTRATION			13. 00
	1400 CENTRAL SERVICES & SUPPLY			14. 00
	1500 PHARMACY			15. 00
	11600 MEDICAL RECORDS & LIBRARY			16. 00
	17700 SOCIAL SERVICE			17. 00 19. 00
	11900 NONPHYSICIAN ANESTHETISTS 12000 NURSING SCHOOL			20.00
	12100 I &R SERVI CES-SALARY & FRI NGES APPRV			21. 00
	12200 I &R SERVICES-OTHER PRGM COSTS APPRV			22. 00
	2300 PARAMED ED PRGM-(SPECIFY)			23. 00
	NPATIENT ROUTINE SERVICE COST CENTERS			7 25.00
_	3000 ADULTS & PEDI ATRI CS	7, 193, 616		30.00
	4300 NURSERY	325, 628		43. 00
	NCILLARY SERVICE COST CENTERS	223, 223		10.00
	5000 OPERATING ROOM	1, 837, 657		50.00
50. 01 0	5001 OPERATING ROOM	0		50. 01
52.00	5200 DELIVERY ROOM & LABOR ROOM	1, 284, 521		52. 00
53.00	5300 ANESTHESI OLOGY	1, 531, 266		53. 00
54.00 0	5400 RADI OLOGY-DI AGNOSTI C	3, 463, 646		54. 00
60.00	6000 LABORATORY	3, 735, 334		60. 00
	6250 BLOOD CLOTTING FOR HEMOPHILIACS	0		62. 30
1	6500 RESPI RATORY THERAPY	1, 691, 524		65. 00
1	6600 PHYSI CAL THERAPY	1, 962, 318		66. 00
1	6700 OCCUPATI ONAL THERAPY	441, 511		67. 00
	6800 SPEECH PATHOLOGY	177, 682		68. 00
	6900 ELECTROCARDI OLOGY	137		69. 00
1	17100 MEDICAL SUPPLIES CHARGED TO PATIENT 17200 IMPL. DEV. CHARGED TO PATIENTS	1, 916, 595 1, 339, 670		71. 00 72. 00
	17300 DRUGS CHARGED TO PATIENTS	3, 180, 989		73. 00
	7360 DROGS CHARGED TO TATTENTS	3, 100, 707		76. 97
	17698 HYPERBARI C OXYGEN THERAPY	53, 458		76. 98
1	17699 LI THOTRI PSY	0		76. 99
_	UTPATIENT SERVICE COST CENTERS			
90.00	9000 CLI NI C	147, 355		90.00
91.00	9100 EMERGENCY	3, 031, 782		91. 00
	9200 OBSERVATION BEDS (NON-DISTINCT PART			92. 00
_	THER REIMBURSABLE COST CENTERS			
	9500 AMBULANCE SERVI CES	5, 903, 943		95. 00
	PECIAL PURPOSE COST CENTERS			
1	1300 I NTEREST EXPENSE	20 210 422		113. 00
118. 00	SUBTOTALS (SUM OF LINES 1 through 117)   ONREIMBURSABLE COST CENTERS	39, 218, 632		118. 00
_	9000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0		190. 00
	9200 PHYSI CI ANS' PRI VATE OFFI CES	181, 901		192. 00
	7250 OCC HEALTH	10, 211		194. 00
	77951 PAIN CLINIC	0		194. 01
1	7755 TATA GETATO	17		194. 02
	17953 FOUNDATI 0	128, 492		194. 03
	17954 KIDS CAMPUS	0		194. 04
	17955 COMMUNITY & VOLUNTEER SERVICES	546, 961		194. 05
	17956 HUNTI NGTON COLLEGE NURSE	0		194. 06
	7957 MISC CATERING	116, 920		194. 07
	7958 AUTISM CENTER	78, 021		194. 08
	7959 HUNTI NGTON BUA	0		194. 09
200.00	Cross Foot Adjustments	0		200. 00
201.00	Negative Cost Centers	0		201. 00
202. 00	TOTAL (sum lines 118 through 201)	40, 281, 155		202. 00

| Peri od: | Worksheet B | From 01/01/2018 | Part | I | To | 12/31/2018 | Date/Time Prepared: Health Financial Systems
ALLOCATION OF CAPITAL RELATED COSTS Provider CCN: 15-0091

			T	12/31/2018		
		CAPITAL RELATED COSTS			5/28/2019 10:	38 alli
Cost Center Description	Directly Assigned New Capital	BLDG & FIXT	MVBLE EQUIP	Subtotal	EMPLOYEE BENEFITS DEPARTMENT	
	Related Costs					
OFNEDAL CERVILOR COCT CENTERS	0	1. 00	2. 00	2A	4. 00	
GENERAL SERVICE COST CENTERS  1.00 O0100 CAP REL COSTS-BLDG & FLXT						1. 00
2. 00   00200 CAP REL COSTS-MVBLE EQUIP						2. 00
4.00 00400 EMPLOYEE BENEFITS DEPARTMENT	0	305	0	305	305	4. 00
5. 00 00500 ADMINISTRATIVE & GENERAL	2, 350, 017	17, 750	3, 517	2, 371, 284	89	5. 00
6. 00 00600 MAI NTENANCE & REPAI RS	0	0	0	0	0	6. 00
7. 00 00700 OPERATION OF PLANT	0	70, 879		92, 815	5 0	7. 00
8.00   00800   LAUNDRY & LI NEN SERVI CE 9.00   00900   HOUSEKEEPI NG	0	1, 454 1, 183		1, 454 1, 183	4	8. 00 9. 00
10. 00   01000 DI ETARY	0	11, 305			1	10. 00
11. 00   01100   CAFETERI A	0	2, 565		2, 565	4	11. 00
12.00 01200 MAINTENANCE OF PERSONNEL	0	0	0	0	0	12. 00
13. 00 01300 NURSI NG ADMI NI STRATI ON	0	0	0	0	5	13.00
14. 00   01400   CENTRAL SERVI CES & SUPPLY 15. 00   01500   PHARMACY	0	4, 402 2, 669		4, 402 62, 154	0	14. 00 15. 00
16. 00 01600 MEDI CAL RECORDS & LI BRARY	0	1, 474		1, 474	0	16. 00
17. 00 01700 SOCI AL SERVI CE	0	0	Ö	0	0	17. 00
19.00 01900 NONPHYSICIAN ANESTHETISTS	0	0	0	0	0	19. 00
20. 00   02000   NURSI NG SCH00L	0	0	0	0	0	20. 00
21. 00   02100   1 &R SERVI CES-SALARY & FRINGES APPRV	0	0	0	0	0	21. 00
22.00   02200   L&R SERVICES-OTHER PRGM COSTS APPRV 23.00   02300   PARAMED ED PRGM-(SPECIFY)	0	0	0	0	0	22. 00 23. 00
INPATIENT ROUTINE SERVICE COST CENTERS	U	0	0	U		23.00
30. 00 03000 ADULTS & PEDIATRICS	0	58, 141	98, 676	156, 817	43	30. 00
43. 00 04300 NURSERY	0	236	0	236	2	43.00
ANCILLARY SERVICE COST CENTERS	1 0	00.447	140 704	4.44 0.40	47	F0 00
50. 00   05000   0PERATI NG ROOM 50. 01   05001   0PERATI NG ROOM	0	22, 147	119, 701	141, 848	17 0	50. 00 50. 01
52. 00 05200 DELIVERY ROOM & LABOR ROOM	0	0	0	0	9	52. 00
53. 00   05300   ANESTHESI OLOGY	0	0	ő	0	0	53. 00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	0	27, 758	170, 905	198, 663	17	54.00
60. 00   06000   LABORATORY	0	4, 206	0	4, 206	0	60.00
62. 30   06250   BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0	0	0	62. 30
65. 00   06500   RESPI RATORY THERAPY 66. 00   06600   PHYSI CAL THERAPY	0	5, 075 19, 236		38, 676 42, 825	12 14	65. 00 66. 00
67. 00 06700 OCCUPATI ONAL THERAPY	0	17, 230	25, 507	42, 023	4	67. 00
68. 00 06800 SPEECH PATHOLOGY	0	0	0	0	1	68. 00
69. 00 06900 ELECTROCARDI OLOGY	0	0	0	0	0	69. 00
71. 00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	0	71. 00
72.00 O7200 IMPL. DEV. CHARGED TO PATIENTS 73.00 O7300 DRUGS CHARGED TO PATIENTS	0	0	0	0	0	72.00
73. 00   07300   DRUGS CHARGED TO PATIENTS 76. 97   07697   CARDIAC REHABILITATION	0	0	0	0	0	73. 00 76. 97
76. 98 07698 HYPERBARI C OXYGEN THERAPY	0	0	0	0	0	76. 77
76. 99 07699 LI THOTRI PSY	0	0	0	0	0	76. 99
OUTPATIENT SERVICE COST CENTERS	1		1	ام		
90. 00   09000   CLI NI C 91. 00   09100   EMERGENCY	0	0 11, 832	0 17, 792	0 29, 624	1 20	90. 00 91. 00
92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART		11,032	17, 792	29, 024	20	92.00
OTHER REIMBURSABLE COST CENTERS				<u> </u>		72.00
95. 00 09500 AMBULANCE SERVICES	0	8, 206	205, 752	213, 958	45	95. 00
SPECIAL PURPOSE COST CENTERS	T		T			
113.00 11300 INTEREST EXPENSE 118.00  SUBTOTALS (SUM OF LINES 1 through 117)	2, 350, 017	270, 823	756, 423	3, 377, 263	202	113. 00 118. 00
NONREI MBURSABLE COST CENTERS	2, 350, 017	270, 623	750, 423	3, 377, 203	303	116.00
190. 00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190. 00
192.00 19200 PHYSICIANS' PRIVATE OFFICES	0	0	850	850		192. 00
194. 00 07950 OCC HEALTH	0	638	0	638		194. 00
194. 01 07951 PAIN CLINIC	0	0	0	0		194. 01 194. 02
194. 02 07952 0CC HEALTH 194. 03 07953 FOUNDATIO	0	0	0	0		194. 02 194. 03
194. 04 07954 KIDS CAMPUS	0	0	0	0		194. 04
194.05 07955 COMMUNITY & VOLUNTEER SERVICES	0	0	0	0	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 194. 09 07959  HUNTI NGTON BUA	0	0	0	0		194. 08 194. 09
200.00 Cross Foot Adjustments		0		ol	O	200. 00
201.00 Negative Cost Centers		0	0	O		201. 00
202.00 TOTAL (sum lines 118 through 201)	2, 350, 017	271, 461	757, 273	3, 378, 751	305	202. 00

Health Financial Systems
ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 15-0091

In Lieu of Form CMS-2552-10

Period: Worksheet B
From 01/01/2018 Part II
To 12/31/2018 Date/Time Prepared: 5/28/2019 10:58 am

					0 12/31/2016	5/28/2019 10:	
	Cost Center Description	ADMI NI STRATI VE		OPERATION OF	LAUNDRY &	HOUSEKEEPI NG	
		<u> </u>	REPAI RS 6. 00	PLANT 7. 00	LINEN SERVICE 8.00	9. 00	
	GENERAL SERVICE COST CENTERS	3.00	0.00	7.00	0.00	7. 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	2, 371, 373					5. 00
6. 00 7. 00	00600 MAI NTENANCE & REPAIRS 00700 OPERATION OF PLANT	115, 907	0	208, 727			6. 00 7. 00
8. 00	00800 LAUNDRY & LINEN SERVICE	17, 595	1 0	1, 662			8.00
9. 00	00900 HOUSEKEEPI NG	38, 045	l e	1, 353		40, 585	9. 00
10.00	01000 DI ETARY	17, 490	l e	12, 928		2, 550	1
11. 00	01100 CAFETERI A	31, 149	0	2, 933	0	579	11. 00
12.00	01200 MAINTENANCE OF PERSONNEL	0	0	0	0	0	12. 00
13. 00	01300 NURSING ADMINISTRATION	29, 700	0	0	0	0	13. 00
14. 00	01400 CENTRAL SERVICES & SUPPLY	404	0	5, 034	41	993	14.00
15. 00 16. 00	01500 PHARMACY 01600 MEDICAL RECORDS & LIBRARY	56, 814 135	0	3, 052 1, 686	0	602 333	15. 00 16. 00
17. 00	01700 SOCIAL SERVICE	0	1 0	1,080	0	0	17. 00
19. 00	01900 NONPHYSICIAN ANESTHETISTS	0	0	0	0	0	19.00
20.00	02000 NURSI NG SCHOOL	0	o	0	0	0	20. 00
21.00	02100 I&R SERVICES-SALARY & FRINGES APPRV	0	0	0	0	0	21. 00
22. 00	02200 I&R SERVICES-OTHER PRGM COSTS APPRV	0	0	0	0	0	22. 00
23. 00	02300 PARAMED ED PRGM-(SPECIFY)	0	0	0	0	0	23. 00
20.00	I NPATI ENT ROUTI NE SERVI CE COST CENTERS	200,000		66, 487	( 127	10 117	20.00
30. 00 43. 00	03000 ADULTS & PEDI ATRI CS 04300 NURSERY	308, 080 17, 781	0		6, 137 305	13, 117 53	30. 00 43. 00
43.00	ANCILLARY SERVICE COST CENTERS	17,701		270	303	33	1 43.00
50.00	05000 OPERATING ROOM	73, 219	0	25, 327	3, 026	4, 997	50.00
50. 01	05001 OPERATING ROOM	0	0	0	0	0	50. 01
52.00	05200 DELIVERY ROOM & LABOR ROOM	70, 878	0	0	1, 218	0	52.00
53. 00	05300 ANESTHESI OLOGY	90, 122	0	0	0	0	53. 00
54. 00	05400 RADI OLOGY - DI AGNOSTI C	173, 523	0	31, 743		6, 263	
60. 00 62. 30	06000 LABORATORY 06250 BLOOD CLOTTING FOR HEMOPHILIACS	216, 139	0	4, 809 0	0	949 0	60. 00 62. 30
65. 00	06500 RESPIRATORY THERAPY	89, 199	0	5, 803	1, 461	1, 145	1
66. 00	06600 PHYSI CAL THERAPY	96, 252	Ö	21, 997	0	4, 340	
67.00	06700 OCCUPATI ONAL THERAPY	25, 339	0	0	0	0	67. 00
68. 00	06800 SPEECH PATHOLOGY	10, 286	0	0	0	0	68. 00
69. 00	06900 ELECTROCARDI OLOGY	0	0	0	0	0	69. 00
71. 00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	74, 673	0	0	0	0	71.00
72. 00 73. 00	07200 IMPL. DEV. CHARGED TO PATIENTS 07300 DRUGS CHARGED TO PATIENTS	78, 825 185, 960	0	0	0	0	72. 00 73. 00
76. 97	07697 CARDI AC REHABI LI TATI ON	165, 960		0	0	0	76. 97
76. 98	07698 HYPERBARI C OXYGEN THERAPY	3, 019	0	0	0	0	76. 98
76. 99	07699 LI THOTRI PSY	0	Ō	Ō	0	0	76. 99
	OUTPATIENT SERVICE COST CENTERS						
90.00	09000 CLI NI C	8, 669	ŀ		_	0	90.00
91.00	09100 EMERGENCY	151, 430	0	13, 530	5, 136	2, 669	
92. 00	09200 OBSERVATION BEDS (NON-DISTINCT PART OTHER REIMBURSABLE COST CENTERS						92.00
95 00	09500 AMBULANCE SERVICES	329, 925	0	9, 384	426	1, 851	95. 00
	SPECIAL PURPOSE COST CENTERS	9=111=9	-	.,,,,,	.=-,	.,, .,,	
113.00	11300 I NTEREST EXPENSE						113. 00
118. 00		2, 310, 558	0	207, 998	20, 220	40, 441	118. 00
100.00	NONREI MBURSABLE COST CENTERS				٥	0	100.00
	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN 19200 PHYSICIANS' PRIVATE OFFICES	0 007	0		1		190. 00 192. 00
	07950 OCC HEALTH	9, 887 59					194. 00
	107951 PAIN CLINIC	0	0	727	l .		194. 00
	207952 OCC HEALTH	1	Ö	Ö	-		194. 02
	3 07953 FOUNDATI 0	7, 330	0	0	0	0	194. 03
194. 04	1 07954 KIDS CAMPUS	0	0	0	0		194. 04
	07955 COMMUNITY & VOLUNTEER SERVICES	32, 195	0	0	0		194. 05
	07956 HUNTI NGTON COLLEGE NURSE	0	0	0	0		194. 06
	7 07957 MI SC CATERI NG	6, 750		0	0		194. 07
	3 07958  AUTI SM CENTER  07959  HUNTI NGTON BUA	4, 593			0		194. 08 194. 09
200.00			١			0	200.00
201.00		0	0	0	ol	0	201. 00
202.00		2, 371, 373	Ö	208, 727	20, 711		202. 00
					·		

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 15-0091

Period: Worksheet B From 01/01/2018 Part II To 12/31/2018 Date/Time Prepared:

5/28/2019 10:58 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 45,743 10 00 01100 CAFETERI A 11.00 37, 230 11.00 0 01200 MAINTENANCE OF PERSONNEL 12.00 0 12.00 13.00 01300 NURSING ADMINISTRATION 0 598 30, 303 13.00 14.00 01400 CENTRAL SERVICES & SUPPLY 0 10,874 14.00 01500 PHARMACY 0 0 15.00 938 0 128 15.00 01600 MEDICAL RECORDS & LIBRARY 0 16.00 C 0 0 16.00 17.00 01700 SOCIAL SERVICE 0 0 0 0 17.00 0 01900 NONPHYSICIAN ANESTHETISTS 0 0 19.00 0 0 19.00 02000 NURSING SCHOOL 0 20 00 C 0 20.00  $\mathbf{c}$ 21.00 02100 I&R SERVICES-SALARY & FRINGES APPRV 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 45, 743 11, 983 0 18, 012 764 30.00 04300 NURSERY 0 43.00 379 569 0 43.00 0 ANCILLARY SERVICE COST CENTERS 50.00 05000 OPERATING ROOM 2, 739 0 4, 118 1, 123 50.00 05001 OPERATING ROOM 0 0 0 50.01 50.01 0 52.00 05200 DELIVERY ROOM & LABOR ROOM 0 1, 512 2, 273 0 52.00 05300 ANESTHESI OLOGY 0 53.00 0 Λ 53.00 0 54.00 05400 RADI OLOGY-DI AGNOSTI C 2, 952 0 278 54.00 06000 LABORATORY 0 60.00 000000000000 0 5 60.00 0 62 30 06250 BLOOD CLOTTING FOR HEMOPHILIACS 0 0 62 30 0 06500 RESPIRATORY THERAPY 65.00 2, 402 428 65.00 06600 PHYSI CAL THERAPY 2, 249 0 144 66.00 0 0 0 66.00 06700 OCCUPATIONAL THERAPY 67.00 717 0 0 67.00 06800 SPEECH PATHOLOGY 0 68 00 68 00 192 0 69.00 06900 ELECTROCARDI OLOGY C 0 0 69.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT 0 6, 383 71.00 71.00 0 72.00 07200 IMPL. DEV. CHARGED TO PATIENTS 0 0 0 72.00 07300 DRUGS CHARGED TO PATIENTS 0 198 73 00 Ω 73.00 0 76. 97 07697 CARDIAC REHABILITATION 0 0 76.97 76.98 07698 HYPERBARI C OXYGEN THERAPY 0 0 0 21 76.98 07699 LI THOTRI PSY 76. 99 76.99 0 0 0 OUTPATIENT SERVICE COST CENTERS 90.00 09000 CLI NI C 0 0 0 90.00 91.00 09100 EMERGENCY 3, 546 0 5, 331 622 91.00 09200 OBSERVATION BEDS (NON-DISTINCT PART 92.00 92.00 OTHER REIMBURSABLE COST CENTERS 09500 AMBULANCE SERVICES 0 767 95.00 0 6, 264 0 SPECIAL PURPOSE COST CENTERS 113.00 11300 I NTEREST EXPENSE 113.00 SUBTOTALS (SUM OF LINES 1 through 117) 118.00 45, 743 36, 471 0 30, 303 10, 861 118. 00 NONREI MBURSABLE COST CENTERS 190.00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN 0 190. 00 0 192.00 19200 PHYSICIANS' PRIVATE OFFICES 0 0 348 0 12 192.00 194.00 07950 OCC HEALTH 0 0 0 0 194.00 194. 01 07951 PAIN CLINIC 0 0 194. 01 0 0 0 0 0 0 0 Ω 0 194. 02 07952 OCC HEALTH 0 0 194, 02 194. 03 07953 FOUNDATI 0 0 262 0 194. 03 0 194. 04 07954 KIDS CAMPUS 0 194. 04 0 194. 05 07955 COMMUNITY & VOLUNTEER SERVICES 0 0 1 194. 05 194.06|07956|HUNTINGTON COLLEGE NURSE 0 0 194, 06 C 0 0 194. 07 07957 MISC CATERING 149 0 194. 07 194.08 07958 AUTISM CENTER 0 0 0 0 194. 08 0 ol 194. 09 07959 HUNTI NGTON BUA C 0 0 194.09 200.00 Cross Foot Adjustments 200.00 201.00 Negative Cost Centers 0 0 201.00 202.00 TOTAL (sum lines 118 through 201) 45, 743 37, 230 30, 303 10, 874 202. 00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 15-0091

Peri od: Worksheet B From 01/01/2018 Part II To 12/31/2018 Date/Time Prepared:

5/28/2019 10:58 am Cost Center Description **PHARMACY** MEDI CAL SOCIAL SERVICE NONPHYSICIAN NURSING SCHOOL RECORDS & **ANESTHETISTS** LI BRARY 15. 00 17.00 19. 00 20.00 16,00 GENERAL SERVICE COST CENTERS 1.00 00100 CAP REL COSTS-BLDG & FIXT 1.00 00200 CAP REL COSTS-MVBLE EQUIP 2.00 2.00 4.00 00400 EMPLOYEE BENEFITS DEPARTMENT 4.00 5.00 00500 ADMINISTRATIVE & GENERAL 5.00 00600 MAINTENANCE & REPAIRS 6.00 6.00 7.00 00700 OPERATION OF PLANT 7.00 00800 LAUNDRY & LINEN SERVICE 8.00 8 00 9.00 00900 HOUSEKEEPI NG 9.00 10.00 01000 DI ETARY 10.00 01100 CAFETERI A 11.00 11.00 01200 MAINTENANCE OF PERSONNEL 12.00 12.00 13.00 01300 NURSING ADMINISTRATION 13.00 14.00 01400 CENTRAL SERVICES & SUPPLY 14.00 01500 PHARMACY 15.00 123, 697 15.00 01600 MEDICAL RECORDS & LIBRARY 16.00 3,628 16.00 17.00 01700 SOCIAL SERVICE 0 17.00 01900 NONPHYSICIAN ANESTHETISTS 0 19.00 0 0 19.00 02000 NURSING SCHOOL 0 0 Λ 20.00 20 00 C 21.00 02100 I&R SERVICES-SALARY & FRINGES APPRV 0 C 21.00 02200 | &R SERVICES-OTHER PRGM COSTS APPRV 0 0 22.00 22.00 02300 PARAMED ED PRGM-(SPECIFY) 0 23.00 23.00 INPATIENT ROUTINE SERVICE COST CENTERS 30.00 03000 ADULTS & PEDIATRICS 8,801 250 0 30.00 04300 NURSERY 0 43.00 21 43.00 ANCILLARY SERVICE COST CENTERS 50.00 05000 OPERATING ROOM 12, 928 418 0 50.00 05001 OPERATING ROOM 0 50.01 50.01 0 52.00 05200 DELIVERY ROOM & LABOR ROOM 0 86 52.00 05300 ANESTHESI OLOGY 0 53.00 0 65 53.00 3, 199 54.00 05400 RADI OLOGY-DI AGNOSTI C 642 54.00 06000 LABORATORY 0 60.00 52 414 60.00 62 30 06250 BLOOD CLOTTING FOR HEMOPHILIACS 0 62 30 0 06500 RESPIRATORY THERAPY 65.00 4, 932 138 65.00 06600 PHYSI CAL THERAPY 91 0 66.00 66.00 1.657 06700 OCCUPATIONAL THERAPY 0 67.00 30 67.00 0 06800 SPEECH PATHOLOGY 68 00 0 68 00 0 69.00 06900 ELECTROCARDI OLOGY 0 21 69.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT 209 71.00 73, 468 71.00 72.00 07200 IMPL. DEV. CHARGED TO PATIENTS 112 0 72.00 07300 DRUGS CHARGED TO PATIENTS 0 73 00 2, 280 328 73 00 0 76. 97 07697 CARDIAC REHABILITATION 76.97 76.98 07698 HYPERBARI C OXYGEN THERAPY 245 0 76. 98 07699 LI THOTRI PSY 76.99 0 0 76.99 0 OUTPATIENT SERVICE COST CENTERS 90.00 09000 CLI NI C 14 0 90.00 91.00 09100 EMERGENCY 7, 159 503 0 91.00 09200 OBSERVATION BEDS (NON-DISTINCT PART 92.00 92.00 OTHER REIMBURSABLE COST CENTERS 09500 AMBULANCE SERVICES 8,830 275 0 95.00 SPECIAL PURPOSE COST CENTERS 113.00 11300 I NTEREST EXPENSE 113.00 SUBTOTALS (SUM OF LINES 1 through 117) 118.00 123, 551 3,628 0 0 118.00 NONREI MBURSABLE COST CENTERS 190. 00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN 190.00 0 192.00 19200 PHYSICIANS' PRIVATE OFFICES 0 137 C 192. 00 194.00 07950 OCC HEALTH 0 194.00 0 0 194. 01 07951 PAIN CLINIC 0 0 0 194. 01 194. 02 07952 OCC HEALTH 0 0 0 9 0 0 0 0 194.02 194. 03 07953 FOUNDATIO C 194. 03 194. 04 07954 KIDS CAMPUS 194. 04 0 194. 05 07955 COMMUNITY & VOLUNTEER SERVICES 0 194. 05 194.06|07956|HUNTINGTON COLLEGE NURSE 0 194. 06 C 0 194. 07 07957 MISC CATERING 194.07 194.08 07958 AUTISM CENTER 0 0 194. 08 0 0 194. 09 07959 HUNTI NGTON BUA 0 194. 09 200.00 Cross Foot Adjustments 0 200.00 201.00 Negative Cost Centers 0 0 0 201.00 202.00 TOTAL (sum lines 118 through 201) 123, 697 3,628 0 202.00

| Peri od: | Worksheet B | From 01/01/2018 | Part | I | To 12/31/2018 | Date/Time Prepared: | To 12/31/2018 Health Financial Systems
ALLOCATION OF CAPITAL RELATED COSTS Provider CCN: 15-0091

				Т	o 12/31/2018	Date/Time Pre 5/28/2019 10:	
		INTERNS &	RESI DENTS			3/28/2014 10.	Jo alli
	Cost Center Description		SERVI CES-OTHER		Subtotal	Intern &	
		Y & FRINGES APPRV	PRGM COSTS	PRGM		Residents Cost & Post	
		APPRV	APPRV			Stepdown	
						Adjustments	
		21.00	22. 00	23. 00	24. 00	25. 00	
	GENERAL SERVICE COST CENTERS						1 00
1	00100 CAP REL COSTS-BLDG & FIXT 00200 CAP REL COSTS-MVBLE EQUIP						1. 00 2. 00
1	00400 EMPLOYEE BENEFITS DEPARTMENT						4.00
1	00500 ADMINISTRATIVE & GENERAL						5. 00
6.00	00600 MAINTENANCE & REPAIRS						6. 00
1	00700 OPERATION OF PLANT						7. 00
	00800 LAUNDRY & LINEN SERVICE						8.00
1	00900  HOUSEKEEPI NG 01000  DI ETARY						9. 00 10. 00
1	01100 CAFETERI A						11.00
1	01200 MAINTENANCE OF PERSONNEL						12. 00
13. 00	01300 NURSING ADMINISTRATION						13. 00
1	01400 CENTRAL SERVICES & SUPPLY						14. 00
1	01500 PHARMACY						15. 00 16. 00
1	01600 MEDICAL RECORDS & LIBRARY 01700 SOCIAL SERVICE						17. 00
1	01900 NONPHYSICIAN ANESTHETISTS						19. 00
1	02000 NURSI NG SCHOOL						20. 00
1	02100 I &R SERVICES-SALARY & FRINGES APPRV	0					21. 00
1	02200 I &R SERVI CES-OTHER PRGM COSTS APPRV		0	•			22. 00
23. 00	02300 PARAMED ED PRGM-(SPECIFY) INPATIENT ROUTINE SERVICE COST CENTERS			0			23. 00
30. 00	03000 ADULTS & PEDIATRICS				636, 234	. 0	30.00
	04300 NURSERY				19, 616	1	1
	ANCILLARY SERVICE COST CENTERS					_	
	05000 OPERATING ROOM				269, 760	1	
1	05001 OPERATING ROOM 05200 DELIVERY ROOM & LABOR ROOM				75, 976	0	50. 01 52. 00
1	05300 ANESTHESI OLOGY				90, 187	1	53. 00
54.00	05400 RADI OLOGY-DI AGNOSTI C				419, 750	0	54. 00
1	06000 LABORATORY				226, 574	1	60.00
1	06250 BLOOD CLOTTING FOR HEMOPHILIACS				144 104	_	62. 30
1	06500 RESPI RATORY THERAPY 06600 PHYSI CAL THERAPY				144, 196 169, 569	1	65. 00 66. 00
1	06700 OCCUPATI ONAL THERAPY				26, 090	l e	67. 00
68. 00	06800 SPEECH PATHOLOGY				10, 486	0	68. 00
1	06900 ELECTROCARDI OLOGY				21	1	69. 00
1	07100 MEDICAL SUPPLIES CHARGED TO PATIENT				154, 733	l e	71.00
	07200 IMPL. DEV. CHARGED TO PATIENTS 07300 DRUGS CHARGED TO PATIENTS				78, 937 188, 767	1	72. 00 73. 00
	07697 CARDI AC REHABI LI TATI ON				C	1	76. 97
76. 98	07698 HYPERBARI C OXYGEN THERAPY				3, 289		
	07699 LI THOTRI PSY				C	0	76. 99
	OUTPATIENT SERVICE COST CENTERS 09000 CLINIC		Ι		8, 684	. 0	90.00
	09100 EMERGENCY				219, 570	1	1
92. 00	09200 OBSERVATION BEDS (NON-DISTINCT PART				·	0	92. 00
	OTHER REIMBURSABLE COST CENTERS						
	09500 AMBULANCE SERVICES				571, 725	0	95. 00
	SPECIAL PURPOSE COST CENTERS 11300   INTEREST EXPENSE						113. 00
118. 00	l e e e e e e e e e e e e e e e e e e e	0	0	0	3, 314, 164		118. 00
	NONREI MBURSABLE COST CENTERS						
	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN				C		190. 00
	19200 PHYSI CLANS' PRI VATE OFFI CES				11, 726		192.00
	07950 OCC HEALTH 07951 PALN CLINIC				1, 570		194. 00 194. 01
	07952 OCC HEALTH				1		194. 02
	07953 FOUNDATI 0				7, 592	•	194. 03
	07954 KI DS CAMPUS				C	1	194. 04
	07955 COMMUNITY & VOLUNTEER SERVICES				32, 205		194. 05
	07956 HUNTI NGTON COLLEGE NURSE 07957 MI SC CATERI NG				4 000		194. 06 194. 07
	07957 MISC CATERING 07958 AUTISM CENTER				6, 900 4, 593		194. 07
	07959 HUNTI NGTON BUA				4, 373		194. 09
200.00	Cross Foot Adjustments	0	0	0	d	0	200. 00
201.00		0	0				201. 00
202. 00	TOTAL (sum lines 118 through 201)	0	0	0	3, 378, 751	1 0	202. 00

| In Lieu of Form CMS-2552-10 | Peri od: | Worksheet B | From 01/01/2018 | Part II | To 12/31/2018 | Date/Time Prepared: | From 01/2014 | Prepared: | Health Financial Systems
ALLOCATION OF CAPITAL RELATED COSTS Provider CCN: 15-0091

				10   12/31/2018   Date/lime Pre   5/28/2019 10:	
		Cost Center Description	Total		
	OFNED	AL CERVILOE COCT CENTERS	26. 00		
1. 00		AL SERVICE COST CENTERS  CAP REL COSTS-BLDG & FIXT			1.00
2.00	1	CAP REL COSTS-BLBG & TTAT			2.00
4.00	1	EMPLOYEE BENEFITS DEPARTMENT			4. 00
5.00	1	ADMINISTRATIVE & GENERAL			5. 00
6.00	00600	MAINTENANCE & REPAIRS			6. 00
7.00		OPERATION OF PLANT			7. 00
8.00	1	LAUNDRY & LINEN SERVICE			8. 00
9.00		HOUSEKEEPI NG			9.00
10. 00 11. 00		DI ETARY CAFETERI A			10. 00 11. 00
12. 00	1	MAINTENANCE OF PERSONNEL			12.00
13. 00	1	NURSI NG ADMI NI STRATI ON			13. 00
14. 00	1	CENTRAL SERVICES & SUPPLY			14. 00
15.00	01500	PHARMACY			15. 00
16. 00	1	MEDICAL RECORDS & LIBRARY			16. 00
17. 00	1	SOCIAL SERVICE			17. 00
19.00	1	NONPHYSI CLAN ANESTHETI STS			19. 00
20. 00 21. 00		NURSING SCHOOL I&R SERVICES-SALARY & FRINGES APPRV			20. 00 21. 00
22. 00	1	I &R SERVI CES-OTHER PRGM COSTS APPRV			22. 00
23. 00		PARAMED ED PRGM-(SPECIFY)			23. 00
	I NPAT	IENT ROUTINE SERVICE COST CENTERS	<u>'</u>		
30.00	03000	ADULTS & PEDIATRICS	636, 234		30. 00
43. 00		NURSERY	19, 616		43. 00
FO 00		LARY SERVICE COST CENTERS OPERATING ROOM	2/0.7/0		F0 00
50. 00 50. 01		OPERATING ROOM OPERATING ROOM	269, 760 0		50. 00 50. 01
52. 00	1	DELIVERY ROOM & LABOR ROOM	75, 976		52. 00
53. 00		ANESTHESI OLOGY	90, 187		53. 00
54.00	05400	RADI OLOGY-DI AGNOSTI C	419, 750		54.00
60.00		LABORATORY	226, 574		60.00
62. 30		BLOOD CLOTTING FOR HEMOPHILIACS	0		62. 30
65. 00	1	RESPI RATORY THERAPY	144, 196		65. 00
66. 00 67. 00	1	PHYSI CAL THERAPY OCCUPATI ONAL THERAPY	169, 569 26, 090		66. 00 67. 00
68. 00	1	SPEECH PATHOLOGY	10, 486		68.00
69. 00	1	ELECTROCARDI OLOGY	21		69. 00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	154, 733		71. 00
72. 00	1	IMPL. DEV. CHARGED TO PATIENTS	78, 937		72. 00
73. 00		DRUGS CHARGED TO PATIENTS	188, 767		73. 00
76. 97		CARDI AC REHABI LI TATI ON	0		76. 97
76. 98 76. 99	1	HYPERBARI C OXYGEN THERAPY LI THOTRI PSY	3, 289 0		76. 98 76. 99
70. 77		TIENT SERVICE COST CENTERS	<u> </u>		70.77
90.00		CLINIC	8, 684		90.00
91. 00		EMERGENCY	219, 570		91. 00
92. 00		OBSERVATION BEDS (NON-DISTINCT PART			92. 00
05 00		REIMBURSABLE COST CENTERS	E71 70E		05 00
95.00		AMBULANCE SERVICES AL PURPOSE COST CENTERS	571, 725		95. 00
113.00		INTEREST EXPENSE			113. 00
118.00	1	SUBTOTALS (SUM OF LINES 1 through 117)	3, 314, 164		118. 00
		IMBURSABLE COST CENTERS			
		GIFT, FLOWER, COFFEE SHOP & CANTEEN	0		190. 00
	1	PHYSICIANS' PRIVATE OFFICES	11, 726		192. 00
	1	OCC HEALTH PAIN CLINIC	1, 570 0		194. 00 194. 01
		OCC HEALTH	1		194. 02
		FOUNDATIO	7, 592		194. 03
	1	KI DS CAMPUS	0		194. 04
		COMMUNITY & VOLUNTEER SERVICES	32, 205		194. 05
	1	HUNTI NGTON COLLEGE NURSE	0		194. 06
		MI SC CATERI NG	6, 900		194. 07
		AUTISM CENTER HUNTINGTON BUA	4, 593 0		194. 08 194. 09
200.00		Cross Foot Adjustments	0		200. 00
201.00	1	Negative Cost Centers	o		201. 00
202.00	1	TOTAL (sum lines 118 through 201)	3, 378, 751		202. 00

COST ALLOCATION - STATISTICAL BASIS Provider CCN: 15-0091 Peri od: Worksheet B-1 From 01/01/2018 12/31/2018 Date/Time Prepared: 5/28/2019 10:58 am CAPITAL RELATED COSTS BLDG & FIXT MVBLE EQUIP **EMPLOYEE** Reconciliation ADMINISTRATIVE Cost Center Description (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 117 472 1 00 2.00 00200 CAP REL COSTS-MVBLE EQUIP 724, 209 2 00 4.00 00400 EMPLOYEE BENEFITS DEPARTMENT 18, 855, 368 4.00 132 00500 ADMINISTRATIVE & GENERAL 5 00 3, 363 5, 285, 151 -14, 438, 031 25, 843, 124 7,681 5 00 6.00 00600 MAINTENANCE & REPAIRS 6.00 7.00 00700 OPERATION OF PLANT 30, 673 20, 978 340, 706 1, 263, 150 7.00 00800 LAUNDRY & LINEN SERVICE 24, 742 191, 755 8.00 8.00 629 0 00900 HOUSEKEEPI NG 9 00 224 343 414, 619 512 9 00 10.00 01000 DI ETARY 4,892 1, 405 74, 954 190, 611 10.00 01100 CAFETERI A o 11.00 1.110 258, 644 339, 465 11.00 0 01200 MAINTENANCE OF PERSONNEL 12.00 12.00 0 01300 NURSING ADMINISTRATION 305, 824 323, 667 13.00 C 13 00 14.00 01400 CENTRAL SERVICES & SUPPLY 1,905 0 4, 402 14.00 01500 PHARMACY 1, 155 15.00 56,888 532, 637 619, 159 15.00 0 01600 MEDICAL RECORDS & LIBRARY 1, 474 16,00 638 C C 16,00 17 00 01700 SOCIAL SERVICE 0 C 0 Ω 17 00 01900 NONPHYSICIAN ANESTHETISTS 0 0 19.00 19.00 0 0 20.00 02000 NURSING SCHOOL 0 C 0 O 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 23.00 INPATIENT ROUTINE SERVICE COST CENTERS 30 00 03000 ADULTS & PEDIATRICS 3, 357, 451 30.00 25, 160 94, 368 2, 670, 834 0 04300 NURSERY 43.00 102 140, 621 193, 779 43.00 ANCILLARY SERVICE COST CENTERS 50.00 05000 OPERATING ROOM 9, 584 114, 475 1, 082, 855 0 797, 935 50.00 05001 OPERATING ROOM 0 50.01 0 Ω 50.01 05200 DELIVERY ROOM & LABOR ROOM 52.00 0 561, 213 772.423 52.00 53.00 05300 ANESTHESI OLOGY 0 982, 146 53.00 1, 891, 058 05400 RADI OLOGY-DI AGNOSTI C 12.012 54 00 163, 443 1,045,978 54 00 60.00 06000 LABORATORY 1,820 2, 355, 484 60.00 06250 BLOOD CLOTTING FOR HEMOPHILIACS 62.30 0 0 0 0 62.30 06500 RESPIRATORY THERAPY 2, 196 32, 134 768, 199 972, 085 65.00 65.00 06600 PHYSI CAL THERAPY 895, 304 1, 048, 954 66.00 8, 324 22, 559 66.00 67.00 06700 OCCUPATI ONAL THERAPY 242, 993 276, 146 67.00 68.00 06800 SPEECH PATHOLOGY 0 65, 156 0 0 0 112, 092 68.00 0 06900 ELECTROCARDI OLOGY 69 00 C 0 69 00 0 |07100|MEDICAL SUPPLIES CHARGED TO PATIENT 0 71.00 C 0 813, 791 71.00 72.00 07200 IMPL. DEV. CHARGED TO PATIENTS 0 859, 030 72.00 73.00 07300 DRUGS CHARGED TO PATIENTS 0 0 63, 708 2,026,590 73.00 07697 CARDIAC REHABILITATION 76 97 76 97 C0 76. 98 07698 HYPERBARIC OXYGEN THERAPY 0 17, 139 0 32, 898 76.98 07699 LI THOTRI PSY 76.99 76.99 OUTPATIENT SERVICE COST CENTERS 90 00 82, 493 09000 CLI NI C 0 94, 479 90 00 91.00 09100 EMERGENCY 5, 120 17, 015 1, 237, 808 1, 650, 284 91.00 09200 OBSERVATION BEDS (NON-DISTINCT PART 92.00 92.00 OTHER REIMBURSABLE COST CENTERS 09500 AMBULANCE SERVICES 3, 551 196, 768 2, 815, 117 0 3, 595, 435 95.00 95.00 SPECIAL PURPOSE COST CENTERS 113 00 11300 INTEREST EXPENSE 113 00 SUBTOTALS (SUM OF LINES 1 through 117) 117, 196 723, 396 18, 736, 419 -14, 438, 031 25, 180, 362 118. 00 118.00 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 107, 751 192. 00 0 813 84. 528

Heal th Finar	ncial Systems	HUNTINGTON MEMO	RIAL HOSPITAL		In Lieu of Form CMS-2552-10			
COST ALLOCA	TION - STATISTICAL BASIS		Provi der Co		Peri od:	Worksheet B-1		
					From 01/01/2018 Fo 12/31/2018			
		CAPITAL REI	LATED COSTS					
	Cost Center Description	BLDG & FIXT (SQUARE FEET)	MVBLE EQUIP (DOLLAR VALUE)	DEPARTMENT (GROSS	Reconciliation	ADMINISTRATIVE & GENERAL (ACCUM. COST)		
		1.00	2.00	SALARI ES) 4. 00	5A	5. 00		
202.00	Cost to be allocated (per Wkst. B,	271, 461				14, 438, 031	202 00	
202.00	Part I)	271, 401	131,213	1, 375, 00	1	14, 436, 031	202.00	
203. 00	Unit cost multiplier (Wkst. B, Part I)	2. 310857	1. 045655	0. 07292	3	0. 558680	203. 00	
204. 00	Cost to be allocated (per Wkst. B, Part II)			30	5	2, 371, 373	204. 00	
205. 00	Unit cost multiplier (Wkst. B, Part			0. 00001	5	0. 091760	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 HUNTINGT
COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 15-0091

Peri od: Worksheet B-1 From 01/01/2018 To 12/31/2018 Date/Time Prepared:

					0 12/31/2018	5/28/2019 10:	
	Cost Center Description	MAI NTENANCE & REPAI RS	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPING (SQUARE FEET)	DIETARY (MEALS SERVED)	
		(SQUARE FEET)	(SQUARE FEET)	(POUNDS OF	(SQUARE TEET)	(WEAES SERVED)	
				LAUNDRY)			
	GENERAL SERVICE COST CENTERS	6. 00	7. 00	8.00	9. 00	10. 00	
1. 00	00100 CAP REL COSTS-BLDG & FIXT						1.00
2. 00	00200 CAP REL COSTS-MVBLE EQUIP						2. 00
4.00	00400 EMPLOYEE BENEFITS DEPARTMENT						4. 00
5.00	00500 ADMINISTRATIVE & GENERAL						5. 00
6.00	00600 MAI NTENANCE & REPAI RS	0	70.00/				6.00
7. 00 8. 00	00700 OPERATION OF PLANT 00800 LAUNDRY & LINEN SERVICE	0	78, 986 629	1			7. 00 8. 00
9. 00	00900 HOUSEKEEPING		512		77, 845		9. 00
10. 00	01000 DI ETARY		4, 892	1	4, 892	27, 875	
11. 00	01100 CAFETERI A	0	1, 110	0	1, 110	0	11. 00
12.00	01200 MAINTENANCE OF PERSONNEL	0	0	0	0	0	12. 00
13.00	01300 NURSI NG ADMI NI STRATI ON	0	0	0	1 005	0	13.00
14. 00 15. 00	01400 CENTRAL SERVI CES & SUPPLY 01500 PHARMACY	0	1, 905 1, 155		1, 905 1, 155	0	14. 00 15. 00
16. 00	01600 MEDICAL RECORDS & LIBRARY				638	0	16. 00
17. 00	01700 SOCIAL SERVICE		0	o o	0	0	17. 00
19. 00	01900 NONPHYSICIAN ANESTHETISTS	0	0	0	0	0	19. 00
20. 00	02000 NURSI NG SCHOOL	0	0	0	0	0	20. 00
21. 00	02100 I &R SERVI CES-SALARY & FRI NGES APPRV	0	0	0	0	0	21. 00
22. 00 23. 00	02200   1&R SERVICES-OTHER PRGM COSTS APPRV 02300   PARAMED ED PRGM-(SPECIFY)		0		0	0	22. 00 23. 00
23.00	INPATIENT ROUTINE SERVICE COST CENTERS		0	η <u></u>	<u> </u>	U	23.00
30. 00	03000 ADULTS & PEDIATRICS	0	25, 160	76, 157	25, 160	27, 875	30.00
43.00	04300 NURSERY	0			102	0	43. 00
	ANCI LLARY SERVI CE COST CENTERS						
50.00	05000 OPERATING ROOM	0	9, 584	37, 545	9, 584	0	50.00
50. 01 52. 00	05001 OPERATING ROOM	0	0	0	0	0	50. 01 52. 00
52.00	05200 DELIVERY ROOM & LABOR ROOM 05300 ANESTHESIOLOGY		0	15, 114	0	0	53.00
54. 00	05400 RADI OLOGY-DI AGNOSTI C		12, 012	30, 645	12, 012	0	54.00
60.00	06000 LABORATORY	0	1, 820		1, 820	0	60.00
62. 30	06250 BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0	0	0	62. 30
65. 00	06500 RESPI RATORY THERAPY	0	_,			0	65. 00
66.00	06600 PHYSI CAL THERAPY	0	8, 324	0	8, 324	0	66.00
67. 00 68. 00	06700 OCCUPATI ONAL THERAPY 06800 SPEECH PATHOLOGY	0	0		0	0	67. 00 68. 00
69. 00	06900 ELECTROCARDI OLOGY		0		0	0	69.00
71. 00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	Ö	0	0	71. 00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72. 00
73. 00	07300 DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73. 00
76. 97	07697 CARDI AC REHABI LI TATI ON	0	0	0	0	0	76. 97
76. 98 76. 99	07698 HYPERBARI C OXYGEN THERAPY 07699 LI THOTRI PSY	0			0	0	76. 98 76. 99
70. 77	OUTPATIENT SERVICE COST CENTERS		0	η <u></u> Ο	l o	U	70. 77
90. 00		0	0	0	0	0	90.00
91.00	09100 EMERGENCY	0	5, 120	63, 734	5, 120	0	91. 00
92. 00	09200 OBSERVATION BEDS (NON-DISTINCT PART						92. 00
05.00	OTHER REIMBURSABLE COST CENTERS		0.554	F 00F	0 554	0	05.00
95. 00	09500 AMBULANCE SERVICES SPECIAL PURPOSE COST CENTERS	0	3, 551	5, 285	3, 551	0	95. 00
113 00	11300 INTEREST EXPENSE						113. 00
118. 00		0	78, 710	250, 912	77, 569	27, 875	118. 00
	NONREI MBURSABLE COST CENTERS				,	, , , , ,	
	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0			-		190. 00
	19200 PHYSICIANS' PRIVATE OFFICES	0	l .	6, 088			192. 00
	07950 OCC HEALTH	0		0	276		194. 00
	07951  PALN CLINIC   07952  0CC HEALTH	0	_		0		194. 01 194. 02
	3 07953 FOUNDATI 0		0		0		194. 02
	107954 KIDS CAMPUS	0	0	Ö	0		194. 04
194. 05	07955 COMMUNITY & VOLUNTEER SERVICES	0	0	0	o	0	194. 05
	07956 HUNTI NGTON COLLEGE NURSE	0	0	0	0		194. 06
	7 07957 MI SC CATERI NG	0	0	0	0		194. 07
	3 07958  AUTI SM CENTER 9 07959  HUNTI NGTON BUA				0		194. 08 194. 09
200.00				7		0	200.00
200.00							201.00
202. 00		0	1, 968, 847	314, 564	659, 020	460, 458	
	Part I)						
203.00	Unit cost multiplier (Wkst. B, Part I)	0. 000000	24. 926531	1. 223984	8. 465797	16. 518673	203. 00

Health Fina	ancial Systems	HUNTINGTON MEMORIAL HOSPITAL			In Lieu of Form CMS-2552-10			
COST ALLOC	ATION - STATISTICAL BASIS		Provi der Co		eriod: rom 01/01/2018	Worksheet B-1		
				T	o 12/31/2018	Date/Time Pre 5/28/2019 10:		
	Cost Center Description	MAINTENANCE &	OPERATION OF	LAUNDRY &	HOUSEKEEPI NG	DI ETARY		
		REPAI RS	PLANT	LINEN SERVICE	(SQUARE FEET)	(MEALS SERVED)		
		(SQUARE FEET)	(SQUARE FEET)	(POUNDS OF				
				LAUNDRY)				
		6.00	7. 00	8. 00	9. 00	10.00		
204. 00	Cost to be allocated (per Wkst. B, Part II)	0	208, 727	20, 711	40, 585	45, 743	204. 00	
205. 00	Unit cost multiplier (Wkst. B, Part	0. 000000	2. 642582	0. 080588	0. 521357	1. 641004	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	

-		HUNTINGTON MEMO			45 0004 D		U OT FORM CMS-	
COST A	LLOCATION - STATISTICAL BASIS		Provi der	CCN:		eriod: rom 01/01/2018 o 12/31/2018	Worksheet B-1 Date/Time Pre 5/28/2019 10:	pared:
	Cost Center Description	CAFETERI A (HOURS OF SERVI CE)	MAI NTENANCE PERSONNEL (NUMBER HOUSED)	AD	NURSI NG DMI NI STRATI ON DI RECT NRSI NG	CENTRAL SERVI CES & SUPPLY (COSTED REQUI S. )	PHARMACY (COSTED REQUIS.)	JO alli
		11.00	12. 00		HRS) 13. 00	14. 00	15. 00	
	GENERAL SERVICE COST CENTERS							
11. 00 12. 00 13. 00 14. 00 15. 00 16. 00 17. 00 19. 00 20. 00 21. 00 22. 00	00100 CAP REL COSTS-BLDG & FIXT 00200 CAP REL COSTS-WBLE EQUIP 00400 EMPLOYEE BENEFITS DEPARTMENT 00500 ADMINISTRATIVE & GENERAL 00600 MAINTENANCE & REPAIRS 00700 OPERATION OF PLANT 00800 LAUNDRY & LINEN SERVICE 00900 HOUSEKEEPING 01000 DIETARY 01100 CAFETERIA 01200 MAINTENANCE OF PERSONNEL 01300 NURSING ADMINISTRATION 01400 CENTRAL SERVICES & SUPPLY 01500 PHARMACY 01600 MEDICAL RECORDS & LIBRARY 01700 SOCIAL SERVICE 01900 NONPHYSICIAN ANESTHETISTS 02000 NURSING SCHOOL 02100 I &R SERVICES-SALARY & FRINGES APPRV 02200 I &R SERVICES-OTHER PRGM COSTS APPRV 02300 PARAMED ED PRGM-(SPECIFY) INPATIENT ROUTINE SERVICE COST CENTERS	405, 214 0 6, 511 0 10, 209 0 0 0 0		0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	219, 416 0 0 0 0 0 0 0 0	2, 850, 056 33, 612 0 0 0 0 0 0	2, 816, 445 0 0 0 0 0 0	16. 00 17. 00 19. 00 20. 00 21. 00 22. 00
	03000 ADULTS & PEDI ATRI CS 04300 NURSERY	130, 422 4, 123		0	130, 422 4, 123	200, 383 0	200, 383 0	1
50. 00 50. 01	ANCILLARY SERVICE COST CENTERS 05000 OPERATING ROOM 05001 OPERATING ROOM	29, 816		0	29, 816 0	294, 354	294, 354 0	50. 00 50. 01
52. 00	05200 DELIVERY ROOM & LABOR ROOM	16, 455		o	16, 455	ol ol	0	52. 00
53.00	05300 ANESTHESI OLOGY	0		0	0	o	0	53. 00
54.00	05400 RADI OLOGY-DI AGNOSTI C	32, 128		0	0	72, 829	72, 829	
60. 00 62. 30	06000   LABORATORY   06250   BLOOD   CLOTTING   FOR   HEMOPHILIACS	0		0	0	1, 181	1, 181 0	1
65. 00	06500 RESPIRATORY THERAPY	26, 144		0	0	112, 285	112, 285	
	06600 PHYSI CAL THERAPY	24, 479		o	o	37, 739	37, 739	
	06700 OCCUPATI ONAL THERAPY	7, 800		0	0	0	0	1
	06800 SPEECH PATHOLOGY	2, 091		0	0	o	0	
	06900 ELECTROCARDI OLOGY	0		0	0	0	0	69. 00
	07100 MEDI CAL SUPPLI ES CHARGED TO PATI ENT	0		0	0	1, 672, 821	1, 672, 821	
	07200 IMPL. DEV. CHARGED TO PATIENTS	0		0	0	0 E1 020	0 E1 030	
	07300 DRUGS CHARGED TO PATIENTS 07697 CARDIAC REHABILITATION	0		0	0	51, 920 0	51, 920 0	1
	07698 HYPERBARI C OXYGEN THERAPY	0		0	0	5, 569		76. 98
	07699 LI THOTRI PSY	0		0	Ō	0	0	
	OUTPATIENT SERVICE COST CENTERS							
	09000 CLI NI C	0		0	0	0	0	90.00
	09100 EMERGENCY 09200 OBSERVATION BEDS (NON-DISTINCT PART	38, 600		0	38, 600	162, 990	162, 990	91. 00 92. 00
92.00	OTHER REIMBURSABLE COST CENTERS					l		72.00
95.00	09500 AMBULANCE SERVICES	68, 183		0	0	201, 038	201, 038	95. 00
	SPECIAL PURPOSE COST CENTERS							
113. 00 118. 00	11300 INTEREST EXPENSE SUBTOTALS (SUM OF LINES 1 through 117) NONREIMBURSABLE COST CENTERS	396, 961		0	219, 416	2, 846, 721	2, 813, 110	113. 00 118. 00
	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0		0	0	0	0	190. 00
	19200 PHYSICIANS' PRIVATE OFFICES	3, 787		0	0	3, 126		192. 00
	07950 OCC HEALTH	0		0	0	0		194. 00
	07951 PAIN CLINIC 07952 OCC HEALTH	0		0	0	0		194. 01 194. 02
	07953 FOUNDATI 0	2, 847		0	0	0		194. 02
	07954 KIDS CAMPUS	0		o	Ö	Ö	0	194. 04
	07955 COMMUNITY & VOLUNTEER SERVICES	0		0	0	209		194. 05
	07956 HUNTI NGTON COLLEGE NURSE	0		0	0	0		194. 06
	07957 MISC CATERING	1, 619		0	0	0		194. 07
	07958 AUTISM CENTER 07959 HUNTINGTON BUA			0	0	0		194. 08 194. 09
200.00				~	J	٩	O	200.00
201.00	1 1							201.00
202. 00	Cost to be allocated (per Wkst. B,	566, 182		O	513, 590	71, 100	1, 018, 742	202. 00
203. 00	Part I)   Unit cost multiplier (Wkst. B, Part I)	1. 397242	0. 0000	000	2. 340714	0. 024947	0. 361712	203 00
200.00	joint cost martipitor (most. b, rait i)	1. 377242	0.0000		2. 540714	0. 024747	0. 301712	

Heal th Fin	ancial Systems I	HUNTI NGTON MEMO	ORIAL HOSPITAL		In Lieu of Form CMS-2552-10			
COST ALLO	CATION - STATISTICAL BASIS	Provi der CCN: 15-0091			Peri od:	Worksheet B-1		
					From 01/01/2018 To 12/31/2018	Date/Time Pre 5/28/2019 10:		
	Cost Center Description	CAFETERI A	MAINTENANCE OF		CENTRAL	PHARMACY		
		(HOURS OF	PERSONNEL	ADMI NI STRATI O	N SERVICES &	(COSTED		
		SERVICE)	(NUMBER		SUPPLY	REQUIS.)		
			HOUSED)	(DIRECT NRSIN	G (COSTED			
				HRS)	REQUIS.)			
		11.00	12.00	13.00	14.00	15. 00		
204. 00	Cost to be allocated (per Wkst. B, Part II)	37, 230	0	30, 30	3 10, 874	123, 697	204. 00	
205. 00	Unit cost multiplier (Wkst. B, Part	0. 091877	0. 000000	0. 13810	0. 003815	0. 043920	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
COST ALLOCATION - STATISTICAL BASIS Provider CCN: 15-0091 

						'	o 12/31/2018	Date/lime Pre 5/28/2019 10:	
								I NTERNS & RESI DENTS	
		Cost Center Description	MEDI CAL	SOCI A	L SERVICE	NONPHYSICIAN	NURSI NG SCHOOL		
		osst sontsi beserrption	RECORDS &	000.71	_ 02 02	ANESTHETI STS		Y & FRINGES	
			LI BRARY	(TIM	E SPENT)	(ASSI GNED	(ASSI GNED	APPRV	
			(GROSS REVE			TIME)	TIME)	(ASSI GNED	
			NUE) 16. 00		17. 00	19. 00	20.00	TI ME) 21. 00	
		AL SERVICE COST CENTERS							
1.00	1	CAP REL COSTS-BLDG & FIXT							1. 00
2. 00 4. 00	1	CAP REL COSTS-MVBLE EQUIP EMPLOYEE BENEFITS DEPARTMENT							2. 00 4. 00
5.00	1	ADMINISTRATIVE & GENERAL				•			5. 00
6. 00	1	MAINTENANCE & REPAIRS				•			6. 00
7.00	00700	OPERATION OF PLANT							7. 00
8. 00	1	LAUNDRY & LINEN SERVICE							8. 00
9. 00 10. 00	1	HOUSEKEEPI NG DI ETARY				•			9. 00 10. 00
11. 00		CAFETERI A				•			11. 00
12. 00	1	MAINTENANCE OF PERSONNEL							12. 00
13. 00		NURSING ADMINISTRATION							13. 00
14.00	1	CENTRAL SERVICES & SUPPLY							14.00
15. 00 16. 00		PHARMACY MEDICAL RECORDS & LIBRARY	193, 746, 382			•			15. 00 16. 00
17. 00	1	SOCIAL SERVICE	193, 740, 362		0				17. 00
19. 00		NONPHYSICIAN ANESTHETISTS	0		0		)		19. 00
20.00	02000	NURSI NG SCHOOL	0		0		0		20. 00
21. 00	1	I &R SERVICES-SALARY & FRINGES APPRV	0		0			0	21. 00
22. 00	1	I &R SERVICES-OTHER PRGM COSTS APPRV	0		0				22. 00
23. 00		PARAMED ED PRGM-(SPECIFY) IENT ROUTINE SERVICE COST CENTERS	0						23. 00
30. 00		ADULTS & PEDIATRICS	13, 179, 158		0	(	0	0	30. 00
43.00	04300	NURSERY	1, 109, 979		0				43. 00
		LARY SERVICE COST CENTERS	01 071 150			1			
50.00	1	OPERATING ROOM	21, 974, 152		0			0	50.00
50. 01 52. 00	1	OPERATING ROOM DELIVERY ROOM & LABOR ROOM	4, 538, 142		0			0	50. 01 52. 00
53. 00	1	ANESTHESI OLOGY	3, 403, 187		0		Ö	Ö	53. 00
54.00	1	RADI OLOGY-DI AGNOSTI C	36, 557, 143		0	C	0	0	54. 00
60.00	1	LABORATORY	21, 783, 044		0	1	0	0	60.00
62. 30	1	BLOOD CLOTTING FOR HEMOPHILIACS	7 251 151		0			0	62. 30
65. 00 66. 00		RESPI RATORY THERAPY PHYSI CAL THERAPY	7, 251, 151 4, 773, 422		0	1	_	0	65. 00 66. 00
67. 00	1	OCCUPATI ONAL THERAPY	1, 560, 149		0	1	Ö	Ö	67. 00
68. 00	06800	SPEECH PATHOLOGY	361, 323		0	) c	0	0	68. 00
69. 00	1	ELECTROCARDI OLOGY	1, 121, 431	ŀ	0	C	0	0	69. 00
71. 00 72. 00	1	MEDICAL SUPPLIES CHARGED TO PATIENT IMPL. DEV. CHARGED TO PATIENTS	11, 010, 504		0		0	0	71. 00 72. 00
73. 00		DRUGS CHARGED TO PATTENTS	5, 874, 532 17, 288, 485		0			0	73. 00
		CARDI AC REHABI LI TATI ON	0		0	d	Ö	Ö	76. 97
		HYPERBARIC OXYGEN THERAPY	224, 458		0	1	_	_	
76. 99		LI THOTRI PSY	0		0	(	0	0	76. 99
90. 00		TIENT SERVICE COST CENTERS CLINIC	753, 774		0		0	0	90. 00
91. 00		EMERGENCY	26, 493, 850		0	1			
92.00		OBSERVATION BEDS (NON-DISTINCT PART							92. 00
05.00		REI MBURSABLE COST CENTERS	4.4.400.400	г		ı			05.00
95. 00		AMBULANCE SERVICES AL PURPOSE COST CENTERS	14, 488, 498		0	(	0	0	95. 00
113.00		INTEREST EXPENSE							113. 00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	193, 746, 382		0	C	0	0	118. 00
		MBURSABLE COST CENTERS							
		GIFT, FLOWER, COFFEE SHOP & CANTEEN	0		0	1			190.00
		PHYSICIANS' PRIVATE OFFICES OCC HEALTH	0		0		0		192. 00 194. 00
		PAIN CLINIC	0		0				194. 00
		OCC HEALTH	0		0	d	0		194. 02
		FOUNDATI O	0		0	C	0		194. 03
		KIDS CAMPUS	0		0		0		194. 04
		COMMUNITY & VOLUNTEER SERVICES HUNTINGTON COLLEGE NURSE	0		0		0		194. 05 194. 06
		MISC CATERING	0		0		0		194. 00
		AUTI SM CENTER	0		0	i c	o	0	194. 08
		HUNTI NGTON BUA	0		0	(	0	0	194. 09
200.00		Cross Foot Adjustments							200. 00 201. 00
201.00	1	Negative Cost Centers		l		ſ	1	I	ZU1. UU

Heal tl	Financial Systems F	HUNTINGTON MEMO	ORIAL HOSPITAL		In Lie	eu of Form CMS-:	2552-10
COST	ALLOCATION - STATISTICAL BASIS		Provi der Co		Period: From 01/01/2018	Worksheet B-1	
					o 12/31/2018		
						INTERNS &	
	Cost Center Description	MEDI CAL RECORDS &	SOCI AL SERVI CE	NONPHYSI CI AN ANESTHETI STS	NURSING SCHOOL	RESI DENTS SERVI CES-SALAR Y & FRI NGES	
		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	
202.0	, and the second	23, 601	0	(	0	0	202. 00
	Part I)						
203.0	Unit cost multiplier (Wkst. B, Part I)	0. 000122	0. 000000	0. 000000	0. 000000	0.000000	203. 00
204. 0	Cost to be allocated (per Wkst. B, Part II)	3, 628	0	(	0	0	204. 00
205. 0	Unit cost multiplier (Wkst. B, Part	0. 000019	0. 000000	0. 000000	0. 000000	0. 000000	205. 00
206. 0	NAHE adjustment amount to be allocated (per Wkst. B-2)				0		206. 00
207. 0	1 "				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

Provider CCN: 15-0091 From 01/01/2018 12/31/2018 Date/Time Prepared: 5/28/2019 10:58 am INTERNS & **RESI DENTS** Cost Center Description SERVI CES-OTHER PARAMED ED PRGM COSTS PRGM (ASSI GNED **APPRV** (ASSI GNED TIME) TIME) 23.00 22.00 GENERAL SERVICE COST CENTERS 1 00 00100 CAP REL COSTS-BLDG & FLXT 1 00 2.00 00200 CAP REL COSTS-MVBLE EQUIP 2.00 4.00 00400 EMPLOYEE BENEFITS DEPARTMENT 4.00 00500 ADMINISTRATIVE & GENERAL 5 00 5 00 6.00 00600 MAINTENANCE & REPAIRS 6.00 7.00 00700 OPERATION OF PLANT 7.00 8.00 00800 LAUNDRY & LINEN SERVICE 8.00 00900 HOUSEKEEPI NG 9 00 9 00 10.00 01000 DI ETARY 10.00 01100 CAFETERI A 11.00 11.00 01200 MAINTENANCE OF PERSONNEL 12.00 12.00 13.00 01300 NURSING ADMINISTRATION 13.00 14.00 01400 CENTRAL SERVICES & SUPPLY 14.00 01500 PHARMACY 15.00 15.00 01600 MEDICAL RECORDS & LIBRARY 16.00 16, 00 17 00 01700 SOCIAL SERVICE 17 00 19.00 01900 NONPHYSICIAN ANESTHETISTS 19.00 20.00 02000 NURSING SCHOOL 20.00 02100 I &R SERVICES-SALARY & FRINGES APPRV 21.00 21.00 02200 I&R SERVICES-OTHER PRGM COSTS APPRV 22.00 22.00 02300 PARAMED ED PRGM-(SPECIFY) 0 23.00 INPATIENT ROUTINE SERVICE COST CENTERS 30 00 03000 ADULTS & PEDIATRICS 30.00 0 0 04300 NURSERY 43.00 0 43.00 ANCILLARY SERVICE COST CENTERS 50.00 05000 OPERATING ROOM 0 0 50.00 0 05001 OPERATING ROOM 50.01 0 50.01 05200 DELIVERY ROOM & LABOR ROOM 52.00 0000000000000000 0 52.00 0 53.00 05300 ANESTHESI OLOGY 53.00 54 00 05400 RADI OLOGY-DI AGNOSTI C 0 54 00 60.00 06000 LABORATORY 0 60.00 06250 BLOOD CLOTTING FOR HEMOPHILIACS 0 62.30 62.30 06500 RESPIRATORY THERAPY 0 65.00 65.00 06600 PHYSI CAL THERAPY 0 66.00 66.00 67.00 06700 OCCUPATIONAL THERAPY 0 67.00 68.00 06800 SPEECH PATHOLOGY 0 68.00 06900 ELECTROCARDI OLOGY 0 69 00 69 00 |07100|MEDICAL SUPPLIES CHARGED TO PATIENT 71.00 0 71.00 72.00 07200 IMPL. DEV. CHARGED TO PATIENTS 0 72.00 73.00 07300 DRUGS CHARGED TO PATIENTS 0 73.00 07697 CARDIAC REHABILITATION 76 97 76 97 0 76. 98 07698 HYPERBARIC OXYGEN THERAPY 0 76.98 07699 LI THOTRI PSY 0 76. 99 76.99 0 OUTPATIENT SERVICE COST CENTERS 90 00 09000 CLI NI C 0 0 90 00 91.00 09100 EMERGENCY 0 0 91.00 09200 OBSERVATION BEDS (NON-DISTINCT PART 92.00 92.00 OTHER REIMBURSABLE COST CENTERS 09500 AMBULANCE SERVICES 95.00 0 0 95.00 SPECIAL PURPOSE COST CENTERS 113.00 11300 INTEREST EXPENSE 113 00 SUBTOTALS (SUM OF LINES 1 through 117) 0 0 118.00 118.00 NONREI MBURSABLE COST CENTERS 190.00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN 190.00 0 192.00 19200 PHYSICIANS' PRIVATE OFFICES 192. 00 0000000000 0 194.00 07950 OCC HEALTH 194. 00 0 194. 01 07951 PAIN CLINIC 0 194.01 194. 02 07952 OCC HEALTH 0 194.02 194. 03 07953 FOUNDATI 0 0 194. 03 194. 04 07954 KIDS CAMPUS 0 194.04 194. 05 07955 COMMUNITY & VOLUNTEER SERVICES 194.05 194.06 07956 HUNTI NGTON COLLEGE NURSE 0 194.06 194. 07 07957 MISC CATERING 0 194. 07 194.08 07958 AUTISM CENTER 0 194.08 194.09 07959 HUNTI NGTON BUA 194.09 200.00 Cross Foot Adjustments 200.00 201.00 201.00 Negative Cost Centers

Health Fina	ncial Systems	HUNTI NGTON MEMOI	RIAL HOSPITAL		In Lie	u of Form CMS-2552-10
COST ALLOCA	ATION - STATISTICAL BASIS		Provi der CO	CN: 15-0091	Peri od:	Worksheet B-1
					From 01/01/2018 To 12/31/2018	Date/Time Prepared: 5/28/2019 10:58 am
	Cost Center Description	I NTERNS & RESI DENTS SERVI CES-OTHER	PARAMED ED			
		PRGM COSTS	PRGM			
		APPRV	(ASSI GNED			
		(ASSI GNED	TIME)			
		TI ME) 22. 00	23. 00			
202. 00	Cost to be allocated (per Wkst. B,	22.00	25.00			202.00
202.00	Part I)		· ·			202.00
203. 00	Unit cost multiplier (Wkst. B, Part I)	0. 000000	0. 000000			203. 00
204. 00	Cost to be allocated (per Wkst. B,	0	0			204. 00
	Part II)					
205. 00	Unit cost multiplier (Wkst. B, Part	0. 000000	0. 000000			205. 00
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

Heal th	Financial Systems	HUNTINGTON MEMO	RIAL HOSPITAL		In Lie	eu of Form CMS-2	2552-10
COMPUT	ATION OF RATIO OF COSTS TO CHARGES		Provi der C		Period: From 01/01/2018 To 12/31/2018		
			Titl∈	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						
30.00	03000 ADULTS & PEDIATRICS	7, 193, 616		7, 193, 61	6 0	7, 193, 616	30.00
43.00	04300 NURSERY	325, 628		325, 62	8 0	325, 628	43. 00
	ANCILLARY SERVICE COST CENTERS						
	05000 OPERATING ROOM	1, 837, 657		1, 837, 65	7 11, 800	1, 849, 457	
50. 01	05001  OPERATI NG ROOM	0			0	0	50. 01
52.00	05200 DELIVERY ROOM & LABOR ROOM	1, 284, 521		1, 284, 52	1 0	1, 284, 521	52. 00
53.00	05300 ANESTHESI OLOGY	1, 531, 266		1, 531, 26	6 0	1, 531, 266	53.00
54.00	05400 RADI OLOGY-DI AGNOSTI C	3, 463, 646		3, 463, 64	6 0	3, 463, 646	54. 00
60.00	06000 LABORATORY	3, 735, 334		3, 735, 33	4 0	3, 735, 334	60.00
62. 30	06250 BLOOD CLOTTING FOR HEMOPHILIACS	0			0 0	0	62. 30
65.00	06500 RESPI RATORY THERAPY	1, 691, 524	0	1, 691, 52	4 0	1, 691, 524	65.00
66.00	06600 PHYSI CAL THERAPY	1, 962, 318	0	1, 962, 31	8 0	1, 962, 318	66. 00
67. 00	06700 OCCUPATI ONAL THERAPY	441, 511	0	441, 51	1 0	441, 511	67. 00
68. 00	06800 SPEECH PATHOLOGY	177, 682	0	177, 68	2 0	177, 682	68. 00
69. 00	06900 ELECTROCARDI OLOGY	137		13	7 0	137	69. 00
71. 00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	1, 916, 595		1, 916, 59	5 0	1, 916, 595	71. 00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	1, 339, 670		1, 339, 67	0	1, 339, 670	72. 00
73. 00	07300 DRUGS CHARGED TO PATIENTS	3, 180, 989		3, 180, 98	9 0	3, 180, 989	73. 00
76. 97	07697 CARDI AC REHABI LI TATI ON	0			0	0	76. 97
76. 98	07698 HYPERBARI C OXYGEN THERAPY	53, 458		53, 45	8 0	53, 458	76. 98
7/ 00	OZ COOL LITHOTEL DOV		I	1	ما م		7/ 00

147, 355

3, 031, 782

1, 975, 313

5, 903, 943

41, 193, 945 1, 975, 313

39, 218, 632

147, 355

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5, 903, 943

41, 193, 945

1, 975, 313

39, 218, 632

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5, 903, 943 95. 00

41, 205, 745 200. 00 1, 975, 313 201. 00

39, 230, 432 202. 00

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113.00

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3, 031, 782

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11, 800

76. 99

92.00

200.00

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202.00

07699 LI THOTRI PSY

95. 00 09500 AMBULANCE SERVICES

113.00 11300 I NTEREST EXPENSE

90. 00 09000 CLI NI C

91. 00 09100 EMERGENCY

OUTPATIENT SERVICE COST CENTERS

SPECIAL PURPOSE COST CENTERS

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

Subtotal (see instructions)

Less Observation Beds

Total (see instructions)

Haal th	Financial Systems	HUNTI NGTON MEMOR	IATIDONH IAIG		Inlia	u of Form CMS-2	2552_10
	TATION OF RATIO OF COSTS TO CHARGES	HONTINGTON WILMON	Provi der Co		Peri od: From 01/01/2018	Worksheet C	pared:
			Title	XVIII	Hospi tal	PPS	
			Charges				
	Cost Center Description	I npati ent	Outpati ent	Total (col.	6 Cost or Other	TEFRA	
		·		+ col. 7)	Ratio	I npati ent	
						Ratio	
		6.00	7.00	8. 00	9. 00	10.00	
	INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000 ADULTS & PEDIATRICS	7, 933, 200		7, 933, 20	00		30.00
43.00	04300 NURSERY	1, 109, 979		1, 109, 97	'9		43.00
	ANCILLARY SERVICE COST CENTERS						l
50.00	05000 OPERATING ROOM	6, 893, 049	15, 081, 103	21, 974, 15	0. 083628	0.000000	50.00
50. 01	05001 OPERATING ROOM	0	0		0. 000000	0.000000	50. 01
	1 1	1		1			1

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	Period: From 01/01/2018 To 12/31/2018	Worksheet C Part I Date/Time Prepared: 5/28/2019 10:58 am

Cost Center Description				1.5	5/28/2019 10:58 am
NPATI ENT ROUTI NE SERVICE COST CENTERS   11.00			Title XVIII	Hospi tal	PPS
INPATI ENT ROUTI NE SERVICE COST CENTERS   30.00	Cost Center Description	PPS Inpatient			
NPATIENT ROUTINE SERVICE COST CENTERS   30.00					
30. 00   03000   ADULTS & PEDIATRICS		11. 00			
43.00					
ANCILLARY SERVICE COST CENTERS   50.00					
50. 00   05000   0PERATI NG ROOM   0. 084165   50. 00   05001   0PERATI NG ROOM   0. 000000   0. 000000   50. 01   05001   0PERATI NG ROOM   0. 000000   0. 000000   52. 00   05200   DELI VERY ROOM & LABOR ROOM   0. 283050   52. 00   05300   ANESTHESI OLOGY   0. 449951   53. 00   05400   RADI OLOGY-DI AGNOSTI C   0. 094746   0. 00   06000   LABORATORY   0. 171479   60. 00   06000   LABORATORY   0. 171479   60. 00   06000   LABORATORY   0. 171479   60. 00   06000   CLOTTI NG FOR HEMOPHI LI ACS   0. 000000   0. 000000   0. 000000   0. 000000   0. 000000   0. 000000   0. 000000   0. 000000   0. 000000   0. 000000   0. 0000000   0. 0000000   0. 0000000   0. 0000000   0. 0000000   0. 0000000   0. 0000000   0. 0000000   0. 0000000   0. 0000000   0. 0000000   0. 0000000   0. 0000000   0. 0000000   0. 00000000					43. 00
50. 01   05001   OPERATI NG ROOM   0.0000000   0.283050   0.5000   0.0000000   0.5000   0.0000000   0.0000000   0.0000000   0.00000000					
52. 00     05200     DELI VERY ROOM & LABOR ROOM     0. 283050       53. 00     05300     AMESTHESI OLOGY     0. 449951       54. 00     05400     RADI OLOGY-DI AGNOSTI C     0. 094746       60. 00     06000     LABORATORY     0. 171479       62. 30     06250     BLOD CLOTTING FOR HEMOPHILIACS     0. 0000000       65. 00     06500     RESPI RATORY THERAPY     0. 233277       66. 00     06600     PHYSI CAL THERAPY     0. 411093       67. 00     06700     OCCUPATI ONAL THERAPY     0. 282993       68. 00     06800     SPEECH PATHOLOGY     0. 491754       68. 00     06900     SPEECH PATHOLOGY     0. 491754       69. 00     06900     ELECTROCARDI OLOGY     0. 174070       71. 00     07100     MEDI CAL SUPPLIES CHARGED TO PATIENT     0. 174070       72. 00     07200     IMPL. DEV. CHARGED TO PATIENTS     0. 228047       73. 00     07300     DRUGS CHARGED TO PATIENTS     0. 183995       76. 97     7697     CARDA C REHABI LITATI ON     0. 000000       76. 99     70497     CARDA C REHABI LITATI ON     0. 000000       76. 99     70599     LI THOTRI PSY     0. 000000       77. 00     09000     CLINIC C OST CENTERS       99. 00     09000 <td></td> <td></td> <td></td> <td></td> <td></td>					
53.00   05300   ANESTHESI OLOGY   0.449951   53.00   54.00   05400   RADI OLOGY-DI AGNOSTI C   0.094746   54.00   60.00   06000   LABORATORY   0.171479   60.00   62.30   06250   BLOOD CLOTTING FOR HEMOPHILIACS   0.000000   62.30   65.00   06500   RESPIRATORY   THERAPY   0.233277   65.00   66.00   06600   PKISCAL THERAPY   0.411093   66.00   67.00   06700   OCCUPATI ONAL THERAPY   0.282993   67.00   68.00   06800   SPECCH PATHOLOGY   0.491754   68.00   69.00   06900   ELECTROCARDI OLOGY   0.401754   68.00   71.00   07100   MEDI CAL SUPPLIES CHARGED TO PATI ENTS   0.228047   71.00   72.00   07200   IMPL. DEV. CHARGED TO PATI ENTS   0.228047   72.00   73.00   07300   DRUGS CHARGED TO PATI ENTS   0.288047   72.00   76.97   76.98   O7697   CARDI AC REHABILITATI ON   0.000000   76.97   76.99   O7698   HYPERBARI C OXYGEN THERAPY   0.238165   75.98   76.99   O7699   LITORI PSY   0.000000   76.99   76.99   OUTPATI ENT SERVI CE COST CENTERS    90.00   09000   CLINIC   0.195490   91.00   91.00   09000   CLINIC   0.195490   91.00   92.00   O9000   ONBERNATI ON BEDS (NON-DI STI NCT PART   0.376540   92.00   07HER REI MBURSABLE COST CENTERS   95.00   07HER REI MBURSABLE CO					
54. 00       05400 RADI OLOGY-DI AGNOSTI C       0.094746         60. 00       06000 LABORATORY       0.171479         62. 30       06250 BLOOD CLOTTING FOR HEMOPHILIACS       0.000000         65. 00       06500 RESPI RATORY THERAPY       0.233277         66. 00       06600 PHYSI CAL THERAPY       0.411093         67. 00       06700 OCCUPATI ONAL THERAPY       0.282993         68. 00       06800 SPEECH PATHOLOGY       0.491754         69. 00       06900 ELECTROCARDI OLOGY       0.00122         71. 00       07100 MEDI CAL SUPPLIES CHARGED TO PATI ENT       0.174070         72. 00       07200 IMPL. DEV. CHARGED TO PATI ENTS       0.228047         73. 00       07300 DRUGS CHARGED TO PATI ENTS       0.183995         6. 97       07697 CARDI AC REHABI LI TATI ON       0.000000         76. 98       07698 HYPERBARI C OXYGEN THERAPY       0.238165         76. 99       07699 LI THOTRI PSY       0.000000         00100 UPLATI ENT SERVI CE COST CENTERS         90. 00       09000 CLI NI C       0.195490         90. 00       09000 CLI NI C       0.376540         90. 00       09000 CLI NI C       0.376540         90. 00       09000 CLI NIC C       0.376540         95. 00       09500 AM					
60. 00   06000   LABORATORY   0. 171479   60. 00   62. 30   06250   BLOOD CLOTTING FOR HEMOPHILIACS   0. 000000   62. 30   65. 00   06500   RESPI RATORY THERAPY   0. 233277   65. 00   66. 00   06600   PHYSI CAL THERAPY   0. 411093   66. 00   67. 00   06600   OCCUPATI ONAL THERAPY   0. 282993   67. 00   68. 00   06800   SPEECH PATHOLOGY   0. 491754   68. 00   69. 00   06900   ELECTROCARDI OLOGY   0. 000122   69. 00   71. 00   07100   MEDI CAL SUPPLIES CHARGED TO PATI ENT   0. 174070   71. 00   72. 00   07200   IMPL. DEV. CHARGED TO PATI ENTS   0. 228047   72. 00   73. 00   07300   DRUGS CHARGED TO PATI ENTS   0. 228047   73. 00   76. 97   07697   CARDIA CREHABI LI TATI ON   0. 000000   76. 97   76. 98   07697   CARDIA CREHABI COXYGEN THERAPY   0. 238165   76. 97   76. 99   07699   LITHOTRI PSY   0. 000000   76. 99   00   09000   CLI NI C   0. 195490   0. 000000   79. 00   09100   EMERGENCY   0. 114433   99. 00   91. 00   09100   EMERGENCY   0. 114433   99. 00   92. 00   09200   OBSERVATI ON BEDS (NON-DI STI NCT PART   0. 376540   92. 00   071ECR REI MBURSABLE COST CENTERS   95. 00   075ECI AL PURPOSE COST CENTERS   113. 00   075ECI					
62. 30 06250 BLOOD CLOTTING FOR HEMOPHILIACS 0.000000 65.00 RESPIRATORY THERAPY 0.233277 65.00 66.00 06600 PHYSI CAL THERAPY 0.411093 66.00 66.00 6600 PHYSI CAL THERAPY 0.411093 66.00 66					
65. 00					
66. 00					
67. 00 06700 OCCUPATIONAL THERAPY 0. 282993 67. 00 68. 00 06800 SPECCH PATHOLOGY 0. 491754 68. 00 69. 00 06900 ELECTROCARDIOLOGY 0. 001052 69. 00 71. 00 07100 MEDI CAL SUPPLIES CHARGED TO PATIENT 0. 174070 71. 00 72. 00 07200 IMPL. DEV. CHARGED TO PATIENTS 0. 228047 72. 00 73. 00 07300 DRUGS CHARGED TO PATIENTS 0. 183995 73. 00 76. 97 07697 CARDIAC REHABILITATION 0. 0000000 76. 99 076. 98 07698 HYPERBARIC OXYGEN THERAPY 0. 238165 76. 99 07699 UITHOTRI PSY 0. 0000000 76. 99 0017PATIENT SERVICE COST CENTERS  90. 00 09000 CLI NI C 0. 195490 91. 00 91. 00 09100 EMERGENCY 0. 114433 91. 00 92. 00 07400 DSSERVATION BEDS (NON-DISTINCT PART 0. 376540 91. 00 071ER REI MBURSABLE COST CENTERS  95. 00 07500 AMBULANCE SERVICES 0. 407492 95. 00 071ER REI MBURSABLE COST CENTERS  113. 00 11300 INTEREST EXPENSE 113. 00 200. 00 Subtotal (see instructions) 200. 00 201. 00 Less Observation Beds	65. 00 06500 RESPIRATORY THERAPY	0. 233277			65. 00
68. 00	66. 00 06600 PHYSI CAL THERAPY	0. 411093			66. 00
69. 00   06900   ELECTROCARDI OLOGY   0.000122   69. 00   71. 00   07100   MEDI CAL SUPPLIES CHARGED TO PATI ENT   0.174070   72. 00   07200   IMPL. DEV. CHARGED TO PATI ENTS   0.228047   72. 00   07300   DRUGS CHARGED TO PATI ENTS   0.183995   73. 00   07697   CARDI AC REHABI LI TATI ON   0.000000   76. 97   07697   CARDI AC REHABI LI TATI ON   0.000000   76. 98   07698   HYPERBARI C OXYGEN THERAPY   0.238165   76. 98   07699   LI THOTRI PSY   0.000000   000000	67. 00 06700 OCCUPATI ONAL THERAPY	0. 282993			67. 00
71. 00	68.00 06800 SPEECH PATHOLOGY	0. 491754			68. 00
72. 00	69. 00   06900   ELECTROCARDI OLOGY	0. 000122			69. 00
73. 00 73. 00 76. 97 76. 97 76. 98 76. 98 76. 99 78. 99 76	71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0. 174070			71.00
76. 97 76. 97 76. 98 76. 98 76. 99 07699 HYPERBARI C OXYGEN THERAPY 0. 238165 76. 99 00UTPATIENT SERVICE COST CENTERS  90. 00 91. 00 991.00 991.00 114433 92. 00 07690 ABBULANCE SERVICES  95. 00 07500 ABBULANCE SERVICES  95. 00 SPECIAL PURPOSE COST CENTERS  113. 00 11300 INTEREST EXPENSE 200. 00 201. 00 Subtotal (see instructions) 201. 00 201. 00 Less Observation Beds  76. 97 76. 97 76. 98 76. 98 76. 98 76. 99 0. 0000000 76. 99 0. 0000000 76. 99 0. 00000000 76. 99 0. 00000000 76. 99 0. 00000000 76. 99 0. 000000000000 76. 99 0. 00000000000 76. 99 0. 00000000000000000000000000000000	72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0. 228047			72. 00
76. 98 76. 99 07699 LI THOTRI PSY 0. 0000000  90. 00 001PATI ENT SERVI CE COST CENTERS  90. 00 91. 00 91. 00 91. 00 92. 00 001 DEMERGENCY 0. 09200 OBSERVATI ON BEDS (NON-DI STI NCT PART 0. 376540) 07HER REI MBURSABLE COST CENTERS  95. 00 09500 AMBULANCE SERVI CES 09500 AMBULANCE SERVI CES SPECIAL PURPOSE COST CENTERS  113. 00 11300 INTEREST EXPENSE 200. 00 201. 00 Less Observati on Beds  76. 98 76. 99 76.	73.00 07300 DRUGS CHARGED TO PATIENTS	0. 183995			73. 00
76. 99   07699   LI THOTRI PSY   0.000000   76. 99   0UTPATI ENT SERVI CE COST CENTERS   90. 00   09000   CLI NI C   0.195490   91. 00   09100   EMERGENCY   0.114433   91. 00   09200   OBSERVATI ON BEDS (NON-DI STI NCT PART   0.376540   92. 00   OTHER REI MBURSABLE COST CENTERS   95. 00   OP500   AMBULANCE SERVI CES   0.407492   95. 00   OP500   AMBULANCE SERVI CES   0.407492   95. 00   OTHER REI MBURSABLE COST CENTERS   113. 00   11300   INTEREST EXPENSE   113. 00   200. 00   Subtotal (see instructions)   200. 00   201. 00   Less Observation Beds   201. 00	76. 97   07697 CARDIAC REHABILITATION	0. 000000			76. 97
OUTPATI ENT SERVI CE COST CENTERS   90. 00   09000   CLI NI C   0. 195490   90. 00   91. 00   09100   EMERGENCY   0. 114433   91. 00   92. 00   09200   OBSERVATI ON BEDS (NON-DI STI NCT PART   0. 376540   92. 00   OTHER REI MBURSABLE COST CENTERS   95. 00   O9500   AMBULANCE SERVI CES   0. 407492   95. 00   SPECI AL PURPOSE COST CENTERS   113. 00   11300   INTEREST EXPENSE   113. 00   200. 00   Subtotal (see instructions)   200. 00   201. 00   Less Observation Beds   201. 00	76. 98 07698 HYPERBARI C OXYGEN THERAPY	0. 238165			76. 98
90. 00   09000   CLI NI C   0. 195490   90. 00   91. 00   09100   EMERGENCY   0. 114433   91. 00   92. 00   09200   OBSERVATI ON BEDS (NON-DI STI NCT PART   0. 376540   92. 00   OTHER REI MBURSABLE COST CENTERS   95. 00   SPECI AL PURPOSE COST CENTERS   95. 00   SPECI AL PURPOSE COST CENTERS   113. 00   11300   INTEREST EXPENSE   113. 00   200. 00   Subtotal (see instructions)   200. 00   201. 00   Less Observation Beds   201. 00		0. 000000			76. 99
91. 00   09100   EMERGENCY   0. 114433   91. 00   09200   OBSERVATION BEDS (NON-DISTINCT PART   0. 376540   92. 00   071HER REIMBURSABLE COST CENTERS   09500   AMBULANCE SERVICES   0. 407492   95. 00   SPECIAL PURPOSE COST CENTERS   113. 00   11300   INTEREST EXPENSE   113. 00   200. 00   Subtotal (see instructions)   200. 00   201. 00   Less Observation Beds   201. 00					
92. 00   09200   0BSERVATI ON BEDS (NON-DISTINCT PART   0. 376540   92. 00   0THER REIMBURSABLE COST CENTERS   95. 00   09500   AMBULANCE SERVI CES   0. 407492   95. 00   SPECIAL PURPOSE COST CENTERS   113. 00   1NTEREST EXPENSE   113. 00   200. 00   Subtotal (see instructions)   200. 00   201. 00   Less Observation Beds   201. 00		0. 195490			
OTHER REIMBURSABLE COST CENTERS   95.00	91. 00  09100 EMERGENCY				
95. 00   09500   AMBULANCE SERVICES   0. 407492   95. 00   SPECIAL PURPOSE COST CENTERS   113. 00   11300   INTEREST EXPENSE   113. 00   200. 00   Subtotal (see instructions)   200. 00   201. 00   Less Observation Beds   201. 00		0. 376540			92. 00
SPECIAL PURPOSE COST CENTERS   113.00   11300   INTEREST EXPENSE   200.00   Subtotal (see instructions)   200.00   201.00   Less Observation Beds   201.00					
113. 00	95. 00 09500 AMBULANCE SERVICES	0. 407492			95. 00
200.00       Subtotal (see instructions)       200.00         201.00       Less Observation Beds       201.00					
201.00 Less Observation Beds 201.00	113. 00 11300 I NTEREST EXPENSE				113. 00
202. 00   Total (see instructions)   202. 00					
	202.00 Total (see instructions)				202. 00

Heal th	Financial Systems	HUNTINGTON MEMO	RIAL HOSPITAL		In Lie	u of Form CMS-2	2552-10
COMPUT	ATION OF RATIO OF COSTS TO CHARGES		Provi der Co		Peri od:	Worksheet C	
					From 01/01/2018 Fo 12/31/2018		nanad.
					To 12/31/2018	Date/Time Pre 5/28/2019 10:	pareu: 58 am
			Ti tl	e XIX	Hospi tal	PPS	00 4
					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	
	I NPATI ENT ROUTI NE SERVI CE COST CENTERS	7 100 (1)	ı	7 400 (4)		7 400 (4)	
	03000 ADULTS & PEDI ATRI CS	7, 193, 616		7, 193, 616		7, 193, 616	
43.00	04300 NURSERY	325, 628		325, 628	3 0	325, 628	43. 00
50. 00	ANCI LLARY SERVI CE COST CENTERS    O5000   OPERATI NG ROOM	1 027 / 57		1 027 / 5	11 000	1 040 457	FO 00
	05000 OPERATING ROOM	1, 837, 657 0		1, 837, 657	11, 800	1, 849, 457 0	50. 00 50. 01
	05200 DELIVERY ROOM & LABOR ROOM	1, 284, 521		1, 284, 52	0	1, 284, 521	
	05300 ANESTHESI OLOGY	1, 531, 266		1, 531, 266		1, 531, 266	
	05400 RADI OLOGY-DI AGNOSTI C	3, 463, 646		3, 463, 646		3, 463, 646	
	06000 LABORATORY	3, 735, 334		3, 735, 334		3, 735, 334	
	06250 BLOOD CLOTTING FOR HEMOPHILIACS	0, 733, 334		3, 733, 33-		0, 755, 554	
65. 00	06500 RESPIRATORY THERAPY	1, 691, 524	0	1, 691, 524	1 0	1, 691, 524	
66. 00	06600 PHYSI CAL THERAPY	1, 962, 318		1, 962, 318		1, 962, 318	
	06700 OCCUPATI ONAL THERAPY	441, 511	l e	441, 51		441, 511	
	06800 SPEECH PATHOLOGY	177, 682		177, 682		177, 682	
69.00	06900 ELECTROCARDI OLOGY	137		137	7 0	137	69.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	1, 916, 595		1, 916, 595	5 0	1, 916, 595	71. 00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	1, 339, 670		1, 339, 670	0	1, 339, 670	72. 00
73.00	07300 DRUGS CHARGED TO PATIENTS	3, 180, 989		3, 180, 989	9 0	3, 180, 989	73. 00
76. 97	07697 CARDIAC REHABILITATION	0		(	0	0	76. 97
76. 98	07698 HYPERBARI C OXYGEN THERAPY	53, 458		53, 458	0	53, 458	76. 98

147, 355

3, 031, 782

1, 975, 313

5, 903, 943

41, 193, 945

1, 975, 313

39, 218, 632

OUTPATIENT SERVICE COST CENTERS

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

Subtotal (see instructions)

Less Observation Beds

Total (see instructions)

09500 AMBULANCE SERVICES

SPECIAL PURPOSE COST CENTERS

07699 LI THOTRI PSY

113. 00 11300 | INTEREST EXPENSE

09000 CLI NI C 91. 00 09100 EMERGENCY

76. 99

90.00

92.00

95.00

200.00

201.00

202.00

147, 355

3, 031, 782

1, 975, 313

5, 903, 943

41, 193, 945

1, 975, 313

39, 218, 632

0

0

0

0

11, 800

11, 800

147, 355

3, 031, 782

1, 975, 313

5, 903, 943

41, 205, 745 200. 00

1, 975, 313 201. 00

39, 230, 432 202. 00

76. 99 0

90.00

91.00

92.00

95.00

113.00

Health Financial Systems	HUNTI NGTON MEMOR	RIAL HOSPITAL		In Lie	u of Form CMS-2	2552-10
COMPUTATION OF RATIO OF COSTS TO CHARGES		Provi der Co		Period: From 01/01/2018 To 12/31/2018	Worksheet C Part I Date/Time Prep 5/28/2019 10:5	
		Ti tl	e XIX	Hospi tal	PPS	
Cost Center Description	I npati ent	Charges Outpati ent	Total (col. 6 + col. 7)	Cost or Other Ratio	TEFRA Inpati ent Rati o	
	6.00	7. 00	8. 00	9. 00	10.00	
INPATIENT ROUTINE SERVICE COST CENTERS						
30. 00 03000 ADULTS & PEDIATRICS	7, 933, 200		7, 933, 20	0		30.00
43. 00   04300 NURSERY	1, 109, 979		1, 109, 97	9		43.00
ANCILLARY SERVICE COST CENTERS	·					l
50. 00 05000 OPERATING ROOM	6, 893, 049	15, 081, 103	21, 974, 15	2 0. 083628	0.000000	50.00
50. 01   05001   OPERATI NG ROOM	0	0		0. 000000	0.000000	50. 01
52.00 05200 DELLVERY ROOM & LABOR ROOM	4, 537, 618	524	4, 538, 14	2 0. 283050	0. 000000	52.00

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 01/01/2018 To 12/31/2018	Worksheet C Part I Date/Time Prepared: 5/28/2019 10:58 am
	T: +1 o VIV	Hooni tol	DDC

Cost Center Description					5/28/2019 10:58 am
NPATI ENT ROUTI NE SERVICE COST CENTERS   11.00			Title XIX	Hospi tal	PPS
IMPATI ENT ROUTI NE SERVICE COST CENTERS   30.00	Cost Center Description				
INPATIENT ROUTINE SERVICE COST CENTERS   33.0.00					
30. 00		11. 00			
43.00					
ANCI LLARY SERVICE COST CENTERS   50.00					
50.00   050000   05000   05000   05000   05000   05000   05000   05000   05000   05000   05000   05000   05000   05000   05000   05000   050000   050000   050000   050000   050000   050000   0500000   0500000   0500000   0500000   05000000   0500000   05000000   05000000   05000000   05000000   05000000   05000000   05000000   05000000   05000000   05000000   05000000   050000000   050000000   050000000   050000000   0500000000					43.00
50. 01   05001   0FERATI NG ROOM   0.000000   052000   052000   052000   052000   052000   052000   052000					
52. 00   05200   DELIVERY ROOM & LABOR ROOM   0. 283050   0. 449951   53. 00   05300   ANESTHESI OLOGY   0. 449951   53. 00   05400   RADI OLOGY-DI AGNOSTI C   0. 094746   54. 00   06400   LABORATORY   0. 171479   60. 00   06500   LABORATORY   0. 233277   65. 00   06500   RESPI RATORY THERAPY   0. 233277   65. 00   06500   RESPI RATORY THERAPY   0. 233277   66. 00   06600   PHYSI CAL THERAPY   0. 411093   66. 00   06600   PHYSI CAL THERAPY   0. 282993   66. 00   06800   SPECH PATHOLOGY   0. 491754   68. 00   06800   SPECH PATHOLOGY   0. 491754   68. 00   06800   SPECH PATHOLOGY   0. 491754   68. 00   07100   MEDI CAL SUPPLIES CHARGED TO PATI ENT   0. 174070   71. 00   07200   IMPL. DEV. CHARGED TO PATI ENT   0. 174070   71. 00   07300   DRUGS CHARGED TO PATI ENTS   0. 228047   72. 00   73. 00   07300   DRUGS CHARGED TO PATI ENTS   0. 183995   73. 00   07698   HYPERBARI C OXYGEN THERAPY   0. 233165   76. 99   07699   LI THOTRI PSY   0. 0000000   0. 0000000   0. 0000000   0. 0000000   0. 00000000					
53.00   05300   ANESTHESI OLOCY   0.449951   53.00   54.00   05400   RADI OLOGY-DI AGNOSTI C   0.094746   54.00   0.0000   LABORATORY   0.171479   60.00   62.30   62.50   60.00   CABORATORY   0.233277   65.00   65.00   06500   RESPI RATORY THERAPY   0.233277   65.00   06500   RESPI RATORY THERAPY   0.411093   66.00   67.00   06700   0CCUPATI ONAL THERAPY   0.282993   67.00   68.00   06800   SPECH PATHOLOGY   0.411093   68.00   06800   SPECH PATHOLOGY   0.491754   68.00   06900   ELECTROCARDI OLOGY   0.000122   69.00   06900   ELECTROCARDI OLOGY   0.7100   MEDI CAL SUPPLIES CHARGED TO PATI ENTS   0.228047   71.00   72.00   07200   IMPL. DEV. CHARGED TO PATI ENTS   0.288047   72.00   73.00   07300   DRUGS CHARGED TO PATI ENTS   0.183995   73.00   76.97   76.98   07697   CARDI AC REHABI LITATI ON   0.000000   76.97   76.98   07699   LITATIRI PSY   0.238165   76.98   0.00012   76.99   0.00012   76.99   0.00012   76.99   0.00012   76.99   0.00012   76.99   0.00012   76.99   0.00012   76.90   0.00010   0.00000   0.00000   0.00000   0.00000   0.00000   0.00000   0.00000   0.00000   0.00000   0.00000   0.00000   0.00000   0.00000   0.000000   0.00000   0.00000   0.00000   0.00000   0.00000   0.00000   0.000000   0.000000   0.000000   0.000000   0.000000   0.000000   0.000000   0.000000   0.000000   0.000000   0.000000   0.000000   0.000000   0.000000   0.000000   0.000000   0.000000   0.000000   0.0000000   0.00000000					
54. 00					
60. 00   06000   LABORATORY   0. 171479   60. 00   62. 30   06250   BLOOD CLOTTING FOR HEMOPHILIACS   0. 0000000   62. 30   66. 00   66.00   RESPIRATORY THERAPY   0. 233277   65. 00   66. 00   66.00   PHYSI CAL THERAPY   0. 411093   66. 00   67. 00   06600   PHYSI CAL THERAPY   0. 282993   67. 00   68. 00   06800   SPEECH PATHOLOGY   0. 491754   68. 00   68. 00   06900   ELECTROCARDI OLOGY   0. 000122   68. 00   06900   ELECTROCARDI OLOGY   0. 000122   69. 00   07100   MEDI CAL SUPPLIES CHARGED TO PATIENT   0. 174070   71. 00   72. 00   07200   IMPL. DEV. CHARGED TO PATIENTS   0. 228047   73. 00   07300   DRUGS CHARGED TO PATIENTS   0. 283047   73. 00   07300   DRUGS CHARGED TO PATIENTS   0. 283047   73. 00   07300   DRUGS CHARGED TO PATIENTS   0. 283047   73. 00   074091   CARDIA CREHABILITATION   0. 000000   76. 97   76.98   77698   HYPERBARIC OXYGEN THERAPY   0. 238165   76. 99   07699   LIHOTRI PSY   0. 000000   76. 97   07699   CLINIC C   0. 195490   0. 000000   09100   EMERGENCY   0. 114433   91. 00   09200   0BSERVATI ON BEDS (NON-DI STI NCT PART   0. 376540   09200   09500   AMBURANCE SERVI CES   0. 407492   95. 00   09200   DRIBURISABLE COST CENTERS   95. 00   09200   Subrovali (see instructions)   200. 00   00000   00000   000000   0000000   000000					
62. 30	54. 00   05400   RADI OLOGY-DI AGNOSTI C				
65. 00   06500   RESPIRATORY THERAPY   0. 233277   65. 00   66. 00   06600   PHYSI CAL THERAPY   0. 411093   66. 00   66. 00   66. 00   67. 00   67. 00   67. 00   67. 00   68. 00   68. 00   68. 00   68. 00   68. 00   68. 00   68. 00   68. 00   68. 00   68. 00   68. 00   68. 00   68. 00   68. 00   69. 00   ELECTROCARDI OLOGY   0. 000122   69. 00   69. 0	60. 00   06000   LABORATORY	0. 171479			60.00
66. 00   06600   PHYSI CAL THERAPY   0. 411093   66. 00   6700   0CCUPATI ONAL THERAPY   0. 282993   67. 00   68. 00   06800   SPEECH PATHOLOGY   0. 491754   68. 00   69. 00   6900   ELECTROCARDI OLOGY   0. 000122   69. 00   71. 00   07100   MEDI CAL SUPPLIES CHARGED TO PATI ENT   0. 174070   71. 00   72. 00   07200   IMPL. DEV. CHARGED TO PATI ENTS   0. 228047   72. 00   73. 00   07300   DRUGS CHARGED TO PATI ENTS   0. 183995   73. 00   76. 97   07697   CARDI AC REHABI LI TATI ON   0. 000000   76. 97   76. 98   07698   HYPERBARI C OXYGEN THERAPY   0. 238165   76. 98   76. 99   000000   1. INTEREST EXPENSE   0. 0. 195490   90. 00   09100   EMERGENCY   0. 114433   91. 00   91. 00   09200   OBSERVATI ON BEDS (NON-DI STI NCT PART   0. 376540   92. 00   09200   OBSERVATI ON BEDS (NON-DI STI NCT PART   0. 376540   95. 00   09200   OBSERVATI ON BEDS (STEVICES   0. 407492   95. 00   09200   OBSERVATI ON BEDS (STEVICES   0. 407492   95. 00   09200   OSSERVATI ON BEDS (STEVICES   0. 407492   95. 00   09200   OSSERVATI ON BEDS (STEVICES   0. 407492   95. 00   09200   OSSERVATI ON BEDS (STEVICES   0. 407492   95. 00   09200   OSSERVATI ON BEDS (STEVICES   0. 407492   95. 00   09200   OSSERVATI ON BEDS (STEVICES   0. 407492   95. 00   09200   OSSERVATI ON BEDS (STEVICES   0. 407492   95. 00   09200   OSSERVATI ON BEDS (STEVICES   0. 407492   95. 00   09200   OSSERVATI ON BEDS (STEVICES   0. 407492   95. 00   09200   OSSERVATI ON BEDS (STEVICES   0. 407492   95. 00   09200   OSSERVATI ON BEDS (STEVICES   0. 407492   95. 00   09200   OSSERVATI ON BEDS (STEVICES   0. 407492   95. 00   09200   0	62.30 06250 BLOOD CLOTTING FOR HEMOPHILIACS	0. 000000			62. 30
67. 00	65. 00 06500 RESPIRATORY THERAPY	0. 233277			65. 00
68. 00	66. 00   06600 PHYSI CAL THERAPY	0. 411093			66. 00
69.00 06900 ELECTROCARDIOLOGY 0.000122 69.00 71.00 07100 MEDI CAL SUPPLIES CHARGED TO PATI ENT 0.174070 71.00 72.00 07200 IMPL. DEV. CHARGED TO PATI ENTS 0.228047 72.00 7300 DRUGS CHARGED TO PATI ENTS 0.183995 73.00 7300 DRUGS CHARGED TO PATI ENTS 0.183995 73.00 76.97 07697 CARDIAC REHABI LI TATI ON 0.000000 76.99 07699 LI THOTRI PSY 0.000000 76.99 000 09000 CLI NI C 0.000000 76.99 000 09000 CLI NI C 0.000000 76.99 09000 CLI NI C 0.000000 09100 EMERGENCY 0.114433 91.00 092.00 09200 OBSERVATI ON BEDS (NON-DI STI NCT PART 0.376540 92.00 07600 AMBULANCE SERVI CES 0.000000 NOTHER REI MBURSABLE COST CENTERS 0.0000000 NOTHER REI MBURSABLE COST CENTERS 0.0000000 NOTHER REI MBURSABLE COST CENTERS 0.00000000 NOTHER REI MBURSABLE COST CENTERS 0.00000000000000000000000000000000000	67. 00 06700 OCCUPATI ONAL THERAPY	0. 282993			67. 00
71. 00	68. 00 06800 SPEECH PATHOLOGY	0. 491754			68. 00
72. 00	69. 00 06900 ELECTROCARDI OLOGY	0. 000122			69. 00
73. 00 76. 97 76. 97 76. 98 76. 98 76. 99 07699 LI THORIPSY 0. 000000 91. 00 91. 00 92. 00 92. 00 07500 BERGENCY 07500 BERGENC	71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0. 174070			71. 00
76. 97	72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0. 228047			72. 00
76. 98   07698   HYPERBARI C 0XYGEN THERAPY   0. 238165   76. 99   07699   LI THOTRI PSY   0. 000000   76. 99   000000   000000   000000   000000   000000	73.00 07300 DRUGS CHARGED TO PATIENTS	0. 183995			73. 00
76. 99 07699 LI THOTRI PSY 0. 000000 76. 99  OUTPATI ENT SERVI CE COST CENTERS  90. 00 09000 CLI NI C 0. 195490 91. 00  91. 00 09100 EMERGENCY 0. 114433 91. 00  OP2. 00 09200 OBSERVATI ON BEDS (NON-DI STI NCT PART 0. 376540 92. 00  OTHER REI MBURSABLE COST CENTERS  95. 00 09500 AMBULANCE SERVI CES 0. 407492 95. 00  SPECIAL PURPOSE COST CENTERS  113. 00 11300 INTEREST EXPENSE 113. 00  200. 00  201. 00 Less Observati on Beds 201. 00	76. 97 07697 CARDIAC REHABILITATION	0. 000000			76. 97
OUTPATIENT SERVICE COST CENTERS   O. 195490   O. 195490   O. 195490   O. 195490   O. 114433   O. 114	76. 98 07698 HYPERBARI C OXYGEN THERAPY	0. 238165			76. 98
90. 00 91. 00 91. 00 91. 00 92. 00 09100 EMERGENCY 09200 OBSERVATION BEDS (NON-DISTINCT PART 0. 376540) 92. 00 07HER REIMBURSABLE COST CENTERS 95. 00 09500 AMBULANCE SERVICES 113. 00 11300 INTEREST EXPENSE 200. 00 201. 00 Less Observation Beds 90. 00 0. 195490 0. 114433 91. 00 92. 00 92. 00 92. 00 92. 00 95. 00	76. 99 07699 LI THOTRI PSY	0. 000000			76. 99
91. 00   09100   EMERGENCY   0. 114433   91. 00   09200   OBSERVATI ON BEDS (NON-DI STI NCT PART   0. 376540   92. 00   OTHER REI MBURSABLE COST CENTERS   09500   AMBULANCE SERVI CES   0. 407492   95. 00   SPECIAL PURPOSE COST CENTERS   113. 00   11300   INTEREST EXPENSE   200. 00   Subtotal (see instructions)   200. 00   201. 00   Less Observation Beds   201. 00	OUTPATIENT SERVICE COST CENTERS				
92. 00 09200 0BSERVATI ON BEDS (NON-DI STI NCT PART 0. 376540 92. 00 OTHER REI MBURSABLE COST CENTERS 95. 00 SPECIAL PURPOSE COST CENTERS 95. 00 SPECIAL PURPOSE COST CENTERS 95. 00 SUbtotal (see instructions) 200. 00 Less Observation Beds 92. 00 201. 00	90. 00 09000 CLI NI C	0. 195490			90.00
0THER REIMBURSABLE COST CENTERS  95. 00  95. 00  SPECIAL PURPOSE COST CENTERS  113. 00  11300 INTEREST EXPENSE  200. 00  Subtotal (see instructions)  Less Observation Beds  201. 00	91. 00   09100   EMERGENCY	0. 114433			91. 00
95. 00   09500   AMBULANCE SERVICES   0. 407492   95. 00   SPECIAL PURPOSE COST CENTERS   113. 00   11300   INTEREST EXPENSE   200. 00   Subtotal (see instructions)   200. 00   201. 00   Less Observation Beds   201. 00	92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART	0. 376540			92. 00
SPECIAL PURPOSE COST CENTERS   113.00   11300   INTEREST EXPENSE   200.00   Subtotal (see instructions)   200.00   Less Observation Beds   201.00	OTHER REIMBURSABLE COST CENTERS				
113.00	95. 00 09500 AMBULANCE SERVICES	0. 407492			95. 00
200.00         Subtotal (see instructions)         200.00           201.00         Less Observation Beds         201.00	SPECIAL PURPOSE COST CENTERS				
201.00 Less Observation Beds 201.00	113. 00 11300   I NTEREST EXPENSE		·		113. 00
	200.00 Subtotal (see instructions)				200. 00
202.00   Total (see instructions)   202.00	201.00 Less Observation Beds				
	202.00 Total (see instructions)				202. 00

Health Financial Systems	HUNTI NGTON MEMORI A	AL HOSPITAL	In Lieu	u of Form CMS-2552-10
CALCULATION OF OUTPATIENT SERVICE (	COST TO CHARGE RATIOS NET OF	Provider CCN: 15-0091		Worksheet C
REDUCTIONS FOR MEDICALD ONLY			From 01/01/2018	Part II

REDUCTIONS FOR MEDICATE CHE			To	12/31/2018	Date/Time Pre 5/28/2019 10:	
		Ti tl	e XIX	Hospi tal	PPS	
Cost Center Description	Total Cost	Capital Cost	Operating Cost	Capi tal	Operating Cost	
	(Wkst. B, Part	(Wkst. B, Part	Net of Capital	Reduction	Reducti on	
	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   05000   OPERATI NG ROOM	1, 837, 657	269, 760	1, 567, 897	0	0	1 00.00
50. 01   05001   OPERATI NG ROOM	0	0	1	0	0	
52.00   05200   DELIVERY ROOM & LABOR ROOM	1, 284, 521	75, 976	1, 208, 545	0	0	52. 00
53. 00   05300   ANESTHESI OLOGY	1, 531, 266	90, 187	1, 441, 079	0	0	53. 00
54. 00   05400   RADI OLOGY-DI AGNOSTI C	3, 463, 646	419, 750	3, 043, 896	0	0	54.00
60. 00   06000   LABORATORY	3, 735, 334	226, 574	3, 508, 760	0	0	60.00
62.30 06250 BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0	0	0	62. 30
65. 00 06500 RESPIRATORY THERAPY	1, 691, 524	144, 196	1, 547, 328	0	0	65. 00
66. 00 06600 PHYSI CAL THERAPY	1, 962, 318	169, 569	1, 792, 749	0	0	66.00
67. 00 06700 OCCUPATI ONAL THERAPY	441, 511	26, 090	415, 421	0	0	67.00
68. 00 06800 SPEECH PATHOLOGY	177, 682	10, 486	167, 196	0	0	68. 00
69. 00 06900 ELECTROCARDI OLOGY	137	21	116	0	0	69. 00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	1, 916, 595	154, 733	1, 761, 862	0	0	71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	1, 339, 670	78, 937	1, 260, 733	0	0	72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	3, 180, 989	188, 767	2, 992, 222	0	0	73. 00
76. 97   07697   CARDIAC REHABILITATION	O	0	0	0	0	76. 97
76. 98 07698 HYPERBARI C OXYGEN THERAPY	53, 458	3, 289	50, 169	0	0	76. 98
76. 99   07699   LI THOTRI PSY	0	0	0	0	0	76. 99
OUTPATIENT SERVICE COST CENTERS						
90. 00 09000 CLI NI C	147, 355	8, 684	138, 671	0	0	90. 00
91. 00   09100   EMERGENCY	3, 031, 782	219, 570	2, 812, 212	0	0	91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART	1, 975, 313	174, 705	1, 800, 608	0	0	92.00
OTHER REIMBURSABLE COST CENTERS						
95. 00 09500 AMBULANCE SERVICES	5, 903, 943	571, 725	5, 332, 218	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)	33, 674, 701	2, 833, 019	30, 841, 682	0	0	200. 00
201.00 Less Observation Beds	1, 975, 313	174, 705	1, 800, 608	0	0	201.00
202.00 Total (line 200 minus line 201)	31, 699, 388	2, 658, 314	29, 041, 074	0	0	202. 00
			•			

Н	ealth Financial Systems	ancial Systems HUNTINGTON MEMORIAL HOSPI				of Form CMS-2552-10
	CALCULATION OF OUTPATIENT SERVICE REDUCTIONS FOR MEDICALD ONLY	COST TO CHARGE RA	RATIOS NET OF	Provi der CCN: 15-0091	From 01/01/2018	Worksheet C Part II Date/Time Prepared:

						5/28/2019 10:58 am
				e XIX	Hospi tal	PPS
	Cost Center Description	Cost Net of	Total Charges			
		Capital and	(Worksheet C,			
		Operating Cost			6	
		Reduction	8)	/ col. 7)		
		6. 00	7. 00	8. 00		
	ANCILLARY SERVICE COST CENTERS					
50.00	05000  OPERATI NG ROOM	1, 837, 657	21, 974, 152			50.00
50. 01	05001  OPERATI NG ROOM	0	0	0.0000		50. 01
52.00	05200 DELIVERY ROOM & LABOR ROOM	1, 284, 521	4, 538, 142			52. 00
53.00	05300 ANESTHESI OLOGY	1, 531, 266	3, 403, 187	0. 4499	51	53. 00
54.00	05400  RADI OLOGY-DI AGNOSTI C	3, 463, 646	36, 557, 143			54. 00
60.00	06000 LABORATORY	3, 735, 334	21, 783, 044	0. 1714	19	60.00
62. 30	06250 BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0.00000	00	62. 30
65.00	06500 RESPI RATORY THERAPY	1, 691, 524	7, 251, 151	0. 2332	77	65. 00
66.00	06600 PHYSI CAL THERAPY	1, 962, 318	4, 773, 422	0. 4110	93	66.00
67.00	06700 OCCUPATI ONAL THERAPY	441, 511	1, 560, 149	0. 2829	93	67. 00
68.00	06800 SPEECH PATHOLOGY	177, 682	361, 323	0. 4917	54	68. 00
69.00	06900 ELECTROCARDI OLOGY	137	1, 121, 431	0. 00012	22	69. 00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	1, 916, 595	11, 010, 504	0. 1740	70	71. 00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	1, 339, 670	5, 874, 532	0. 22804	17	72. 00
73.00	07300 DRUGS CHARGED TO PATIENTS	3, 180, 989	17, 288, 485	0. 18399	95	73. 00
76. 97	07697 CARDI AC REHABI LI TATI ON	0	0	0.00000	00	76. 97
76. 98	07698 HYPERBARI C OXYGEN THERAPY	53, 458	224, 458	0. 2381	5	76. 98
76. 99	07699 LI THOTRI PSY	0	0	0. 00000	00	76. 99
	OUTPATIENT SERVICE COST CENTERS			•	_	
90.00	09000 CLI NI C	147, 355	753, 774	0. 19549	90	90.00
91.00	09100 EMERGENCY	3, 031, 782	26, 493, 850	0. 11443	33	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART	1, 975, 313	5, 245, 958	0. 37654	10	92. 00
	OTHER REIMBURSABLE COST CENTERS			•		
95.00	09500 AMBULANCE SERVI CES	5, 903, 943	14, 488, 498	0. 40749	92	95. 00
	SPECIAL PURPOSE COST CENTERS			•		
113.00	11300   NTEREST EXPENSE					113. 00
200.00		33, 674, 701	184, 703, 203			200. 00
201.00		1, 975, 313				201. 00
202.00		31, 699, 388				202. 00
	1 1 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2			•		1 /=

Health Financial Systems	HUNTI NGTON MEMO	RIAL HOSPITAL		In Lieu of Form CMS-2552-10			
APPORTIONMENT OF INPATIENT ROUTINE SERVICE CAPITAL	COSTS	Provi der C		Peri od:	Worksheet D		
				From 01/01/2018			
				To 12/31/2018	Date/Time Pre 5/28/2019 10:		
		Title	xVIII	Hospi tal	972072019 10. PPS	oo alii	
Cost Center Description	Capi tal	Swing Bed	Reduced		Per Diem (col.		
	Related Cost	Adjustment	Capi tal	Days	3 / col . 4)		
	(from Wkst. B,	.,	Related Cost		,		
	Part II, col.		(col . 1 - col				
	26)		2)				
	1. 00	2. 00	3. 00	4. 00	5. 00		
INPATIENT ROUTINE SERVICE COST CENTERS							
30. 00 ADULTS & PEDIATRICS	636, 234	0	636, 23	5, 998	106. 07	30. 00	
43. 00 NURSERY	19, 616		19, 61	6 718	27. 32	43.00	
200.00 Total (lines 30 through 199)	655, 850		655, 85	6, 716		200. 00	
Cost Center Description	I npati ent	I npati ent					
	Program days	Program					
		Capital Cost					
		(col. 5 x col.					
		6)					
	6. 00	7. 00					
INPATIENT ROUTINE SERVICE COST CENTERS							
30. 00 ADULTS & PEDI ATRI CS	1, 359	144, 149	1			30. 00	
43. 00 NURSERY	0	0				43.00	
200.00 Total (lines 30 through 199)	1, 359	144, 149	1			200. 00	

Heal th	Financial Systems	HUNTI NGTON MEMO	RIAL HOSPITAL		In Lie	eu of Form CMS-2	2552-10
APPORT	TONMENT OF INPATIENT ANCILLARY SERVICE CAPI	TAL COSTS	Provi der Co		Period: From 01/01/2018 To 12/31/2018		
			Title	: XVIII	Hospi tal	PPS	
	Cost Center Description	(from Wkst. B, Part II, col.	Total Charges (from Wkst. C, Part I, col. 8)	to Charges	Program	Capital Costs (column 3 x column 4)	
		26)					
	ANOLULARY OFRICAS COOT OFFITTED	1.00	2.00	3. 00	4. 00	5. 00	
	ANCILLARY SERVICE COST CENTERS	0.0.7.0	04 074 450			1 45 /45	
50. 00	05000 OPERATING ROOM	269, 760	21, 974, 152	1		15, 615	1
50. 01	05001 OPERATING ROOM	0	0	0.00000		0	50. 01
52. 00	05200 DELIVERY ROOM & LABOR ROOM	75, 976		1		0	52. 00
53. 00	05300 ANESTHESI OLOGY	90, 187		1		0	53.00
54.00	05400  RADI OLOGY-DI AGNOSTI C	419, 750	36, 557, 143	0. 01148	1, 337, 607	15, 358	54. 00
60.00	06000 LABORATORY	226, 574	21, 783, 044	0. 01040	1, 286, 117	13, 377	60.00
62. 30	06250 BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0.00000	0 0	0	62. 30
65.00	06500 RESPIRATORY THERAPY	144, 196	7, 251, 151	0. 01988	553, 226	11, 001	65. 00
66.00	06600 PHYSI CAL THERAPY	169, 569	4, 773, 422	0. 03552	24 203, 722	7, 237	66. 00
67. 00	06700 OCCUPATI ONAL THERAPY	26, 090				1	1
68. 00	06800 SPEECH PATHOLOGY	10, 486					1
	06900 ELECTROCARDI OLOGY	21				l .	69 00

154, 733

78, 937

3, 289

8,684

219, 570

174, 705

2, 261, 294

188, 767

11, 010, 504

5, 874, 532

17, 288, 485

224, 458

753, 774

26, 493, 850

170, 214, 705

5, 245, 958

513, 810

0

0

1, 266, 435

1, 528, 601

1, 229, 004

9, 629, 551

7, 221

17, 017

16, 691

0 76. 97

0 76. 98

0

115, 415 200. 00

10, 186

71.00

72.00

73.00

0 76. 99

90.00

91.00

0 92.00

95.00

0.014053

0.013437

0.010919

0.000000

0.014653

0.000000

0.011521

0.008288

0.033303

71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT

73.00 07300 DRUGS CHARGED TO PATIENTS

07699 LI THOTRI PSY

95. 00 09500 AMBULANCE SERVICES

09000 CLI NI C

91. 00 09100 EMERGENCY

76. 97

76. 98

76. 99

90.00

92.00

200.00

07697 CARDIAC REHABILITATION

07698 HYPERBARI C OXYGEN THERAPY

OUTPATIENT SERVICE COST CENTERS

07200 I MPL. DEV. CHARGED TO PATIENTS

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

Total (lines 50 through 199)

Health Financial Systems	HUNTI NGTON MEMO	RIAL HOSPITAL		In Lie	eu of Form CMS-:	2552-10
APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER F	ASS THROUGH COST	rs Provider Co		Period: From 01/01/2018 To 12/31/2018		
		Title	: XVIII	Hospi tal	PPS	
Cost Center Description	Post-Stepdown Adjustments	Ü	Post-Stepdowi Adjustments		All Other Medical Education Cost	
	1A	1. 00	2A	2. 00	3. 00	
I NPATI ENT ROUTI NE SERVI CE COST CENTERS						
30. 00 03000 ADULTS & PEDIATRICS	0	0		0	0	
43. 00   04300   NURSERY	0	0		0	0	1 .0.00
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						1
30. 00   03000   ADULTS & PEDI ATRI CS	0	0	5, 99			
43. 00   04300   NURSERY		0	71			
200.00 Total (lines 30 through 199)		0	6, 71	6	1, 359	200. 00
Cost Center Description	I npati ent					
	Program					
	Pass-Through					
	Cost (col. 7 x					
	col . 8)					
LANDATI ENT. DOUTLING OFFICE OF COOT OFFITEDO	9. 00					
INPATIENT ROUTINE SERVICE COST CENTERS						
30. 00   03000   ADULTS & PEDI ATRI CS	0					30.00
43. 00 04300 NURSERY	0					43. 00
200.00   Total (lines 30 through 199)	0					200. 00

Health Financial Systems	HUNTINGTON MEMORIAL HOSPITAL					In Lieu of Form CMS-2552-10		
APPORTIONMENT OF INPATIENT/OUTPATIENT THROUGH COSTS	ANCI LLARY	SERVI CE OTHER	PASS	Provi der C	CN: 15-0091	From 01/01/2018	Worksheet D Part IV Date/Time Prepared	

				'	0 12/31/2010	5/28/2019 10:	58 am
			Title	xVIII	Hospi tal	PPS	
	Cost Center Description	Non Physician	Nursing School	Nursing School	Allied Health	Allied Health	
		Anestheti st	Post-Stepdown		Post-Stepdown		
		Cost	Adjustments		Adjustments		
		1. 00	2A	2.00	3A	3. 00	
	ANCILLARY SERVICE COST CENTERS						
	05000 OPERATING ROOM	0	0	(	0	0	50.00
50. 01	05001 OPERATI NG ROOM	0	0	) C	0	0	50. 01
52.00	05200 DELIVERY ROOM & LABOR ROOM	0	0	) C	0	0	52. 00
	05300 ANESTHESI OLOGY	0	0	) C	0	0	53.00
54.00	05400  RADI OLOGY-DI AGNOSTI C	0	0	C	0	0	54. 00
	06000 LABORATORY	0	0	) c	0	0	60.00
	06250 BLOOD CLOTTING FOR HEMOPHILIACS	0	0	) c	0	0	62. 30
65.00	06500 RESPI RATORY THERAPY	0	0	) c	0	0	65. 00
66. 00	06600 PHYSI CAL THERAPY	0	0	) c	0	0	66. 00
67. 00	06700 OCCUPATI ONAL THERAPY	0	0	) c	0	0	67. 00
68. 00	06800 SPEECH PATHOLOGY	0	0	) c	0	0	68. 00
69.00	06900 ELECTROCARDI OLOGY	0	0	C	0	0	69. 00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	C	0	0	71. 00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0	0	) c	0	0	72. 00
73.00	07300 DRUGS CHARGED TO PATIENTS	0	0	C	0	0	73. 00
76. 97	07697 CARDI AC REHABI LI TATI ON	0	0	) c	0	0	76. 97
76. 98	07698 HYPERBARI C OXYGEN THERAPY	0	0	) c	0	0	76. 98
76. 99	07699 LI THOTRI PSY	0	0	) c	0	0	76. 99
	OUTPATIENT SERVICE COST CENTERS						
90.00	09000 CLI NI C	0	0	C	0	0	90.00
91.00	09100 EMERGENCY	0	0	ıl c	0	0	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART	0		c		0	92.00
	OTHER REIMBURSABLE COST CENTERS						
95.00	09500 AMBULANCE SERVICES						95. 00
200.00	Total (lines 50 through 199)	0	0	(	0	0	200. 00

Health Financial Systems	AL HOSPITAL	In Lieu of Form CMS-2552-10		
APPORTIONMENT OF INPATIENT/OUTPATIENT THROUGH COSTS	ANCILLARY SERVICE OTHER PASS	Provider CCN: 15-0091		Worksheet D Part IV Date/Time Prepared: 5/28/2019 10:58 am
		Title XVIII	Hospi tal	PPS

THROUGH COSTS				o 12/31/2018	Date/Time Pre	pared:
		Title	e XVIII	Hospi tal	5/28/2019 10: PPS	58 am_
Cost Center Description	All Other	Total Cost	Total		Ratio of Cost	
coot conton bood i pti cii	Medi cal	(sum of cols.	Outpati ent	(from Wkst. C,		
	Education Cost		Cost (sum of		(col. 5 ÷ col.	
		4)	col s. 2, 3,	8)	7)	
		ŕ	and 4)		,	
	4. 00	5. 00	6. 00	7. 00	8. 00	
ANCILLARY SERVICE COST CENTERS						
50. 00   05000 OPERATING ROOM	0	0	(	21, 974, 152	0.000000	50.00
50. 01   05001   OPERATI NG ROOM	0	0	(	0	0.000000	50. 01
52.00   05200   DELIVERY ROOM & LABOR ROOM	0	0	(	4, 538, 142	0.000000	52. 00
53. 00   05300   ANESTHESI OLOGY	0	0	(	3, 403, 187	0.000000	53. 00
54. 00   05400   RADI OLOGY-DI AGNOSTI C	0	0	(	36, 557, 143	0.000000	54. 00
60. 00   06000   LABORATORY	0	0	(	21, 783, 044	0.000000	60.00
62.30 06250 BLOOD CLOTTING FOR HEMOPHILIACS	0	0	(	0	0.000000	62. 30
65. 00 06500 RESPIRATORY THERAPY	0	0	(	7, 251, 151	0.000000	65.00
66. 00 06600 PHYSI CAL THERAPY	0	0	(	4, 773, 422	0.000000	66. 00
67. 00 06700 OCCUPATI ONAL THERAPY	0	0	(	1, 560, 149	0.000000	67. 00
68. 00 06800 SPEECH PATHOLOGY	0	0	(	361, 323	0.000000	68. 00
69. 00 06900 ELECTROCARDI OLOGY	0	0	(	1, 121, 431	0.000000	69. 00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	(	11, 010, 504	0.000000	71. 00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0	0	(	5, 874, 532	0.000000	72. 00
73.00 07300 DRUGS CHARGED TO PATIENTS	0	0	(	17, 288, 485	0.000000	73. 00
76. 97 07697 CARDIAC REHABILITATION	0	0	(	0	0.000000	76. 97
76. 98 07698 HYPERBARI C OXYGEN THERAPY	0	0	(	224, 458	0.000000	76. 98
76. 99 07699 LI THOTRI PSY	0	0	(	0	0.000000	76. 99
OUTPATIENT SERVICE COST CENTERS						
90. 00   09000   CLI NI C	0	0	(	753, 774	0.000000	90. 00
91. 00   09100   EMERGENCY	0	0	(	26, 493, 850	0.000000	91. 00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART	0	0	(	5, 245, 958	0.000000	92. 00
OTHER REIMBURSABLE COST CENTERS						
95. 00 09500 AMBULANCE SERVICES						95. 00
200.00   Total (lines 50 through 199)	0	0	(	170, 214, 705		200. 00

		HUNTI NGTON MEMOR	_	15 0001		eu of Form CMS-2	2552-10
	TIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SEF	RVICE OTHER PASS	Provi der CO		Period: From 01/01/2018	Worksheet D Part IV	
THROUG	SH COSTS				To 12/31/2018		pared:
						5/28/2019 10:	58 am
				XVIII	Hospi tal	PPS	
	Cost Center Description	Outpati ent	Inpati ent	I npati ent	Outpati ent	Outpati ent	
		Ratio of Cost	Program	Program	Program	Program	
		to Charges	Charges	Pass-Through		Pass-Through	
		(col. 6 ÷ col.		Costs (col. 8	3	Costs (col. 9	
		7)		x col. 10)		x col. 12)	
	T	9. 00	10. 00	11. 00	12. 00	13. 00	
	ANCI LLARY SERVI CE COST CENTERS						
50.00	05000 OPERATI NG ROOM	0. 000000	1, 271, 954		0 3, 856, 080		50.00
50. 01	05001   OPERATI NG ROOM	0. 000000	0		0	0	50. 01
52.00	05200 DELIVERY ROOM & LABOR ROOM	0. 000000	0		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, 337, 607		0 6, 734, 045	0	54.00
60.00	06000 LABORATORY	0. 000000	1, 286, 117		0 1, 645, 781	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	553, 226		0 1, 024, 993	0	65. 00
66.00	06600 PHYSI CAL THERAPY	0. 000000	203, 722		0 0	0	66. 00
67.00	06700 OCCUPATI ONAL THERAPY	0. 000000	74, 504		0 0	0	67. 00
68.00	06800 SPEECH PATHOLOGY	0. 000000	15, 813		0 0	0	68. 00
69.00	06900 ELECTROCARDI OLOGY	0. 000000	348, 758		0 493, 098	0	69. 00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0. 000000	513, 810		0 509, 834	0	71. 00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0. 000000	1, 266, 435		0 500, 970	0	72. 00
73.00	07300 DRUGS CHARGED TO PATIENTS	0. 000000	1, 528, 601		0 4, 288, 244	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		o o	0	76. 98
76. 99	07699 LI THOTRI PSY	0. 000000	0		0 0	0	76. 99
	OUTPATIENT SERVICE COST CENTERS						
90.00	09000 CLI NI C	0. 000000	0		0 0	0	90. 00
91.00	09100 EMERGENCY	0. 000000	1, 229, 004		0 3, 556, 834	0	91.00
02 00	00200 OBSEDVATION BEDS (NON DISTINCT DADT	0.000000	0	I	1 102 007	1 ^	02.00

0. 000000 0. 000000 0. 000000

9, 629, 551

0 0

0

3, 556, 834 1, 192, 887

23, 802, 766

0 200. 00

0 92.00 95.00

92. 00 | 09200 | 09200 | 09200 | 09200 | 09200 | 09200 | 09200 | 09200 | 09200 | 09200 | 09200 | 09200 | 09200 | 09200 | 09200 | 09200 | 09200 | 09200 | 09200 | 09200 | 09200 | 09200 | 09200 | 09200 | 09200 | 09200 | 09200 | 09200 | 09200 | 09200 | 09200 | 09200 | 09200 | 09200 | 09200 | 09200 | 09200 | 09200 | 09200 | 09200 | 09200 | 09200 | 09200 | 09200 | 09200 | 09200 | 09200 | 09200 | 09200 | 09200 | 09200 | 09200 | 09200 | 09200 | 09200 | 09200 | 09200 | 09200 | 09200 | 09200 | 09200 | 09200 | 09200 | 09200 | 09200 | 09200 | 09200 | 09200 | 09200 | 09200 | 09200 | 09200 | 09200 | 09200 | 09200 | 09200 | 09200 | 09200 | 09200 | 09200 | 09200 | 09200 | 09200 | 09200 | 09200 | 09200 | 09200 | 09200 | 09200 | 09200 | 09200 | 09200 | 09200 | 09200 | 09200 | 09200 | 09200 | 09200 | 09200 | 09200 | 09200 | 09200 | 09200 | 09200 | 09200 | 09200 | 09200 | 09200 | 09200 | 09200 | 09200 | 09200 | 09200 | 09200 | 09200 | 09200 | 09200 | 09200 | 09200 | 09200 | 09200 | 09200 | 09200 | 09200 | 09200 | 09200 | 09200 | 09200 | 09200 | 09200 | 09200 | 09200 | 09200 | 09200 | 09200 | 09200 | 09200 | 09200 | 09200 | 09200 | 09200 | 09200 | 09200 | 09200 | 09200 | 09200 | 09200 | 09200 | 09200 | 09200 | 09200 | 09200 | 09200 | 09200 | 09200 | 09200 | 09200 | 09200 | 09200 | 09200 | 09200 | 09200 | 09200 | 09200 | 09200 | 09200 | 09200 | 09200 | 09200 | 09200 | 09200 | 09200 | 09200 | 09200 | 09200 | 09200 | 09200 | 09200 | 09200 | 09200 | 09200 | 09200 | 09200 | 09200 | 09200 | 09200 | 09200 | 09200 | 09200 | 09200 | 09200 | 09200 | 09200 | 09200 | 09200 | 09200 | 09200 | 09200 | 09200 | 09200 | 09200 | 09200 | 09200 | 09200 | 09200 | 09200 | 09200 | 09200 | 09200 | 09200 | 09200 | 09200 | 09200 | 09200 | 09200 | 09200 | 09200 | 09200 | 09200 | 09200 | 09200 | 09200 | 09200 | 09200 | 09200 | 09200 | 09200 | 09200 | 09200 | 09200 | 09200 | 09200 | 09200 | 09200 | 09200 | 09200 | 09200 | 09200 | 09200 | 09200 | 09200 | 09200 | 09200 | 09200 | 09200 | 09200 | 09200 | 09200 | 09200 | 09200 | 09200 | 09200 | 09200 | 09200 | 09200

Health Financial Systems	HUNTI NGTON MEMOR	NGTON MEMORIAL HOSPITAL			In Lieu of Form CMS-2552-10		
APPORTIONMENT OF MEDICAL, OTHER HEALTH SERV	ICES AND VACCINE COST	Provi der CC	Provi der CCN: 15-0091 Pe Fr To		Worksheet D Part V Date/Time Pre 5/28/2019 10:		
		Title	XVIII	Hospi tal	PPS		
·			Charges		Costs		
Cost Center Description	Cost to Charge	PS Reimbursed	Cost	Cost	PPS Services		
	Ratio From S	Services (see	Rei mbursed	Rei mbursed	(see inst.)		
	Worksheet C,	inst.)	Servi ces	Services Not			
	Part I, col. 9		Subject To	Subject To			
			Ded. & Coins.	Ded. & Coins.			

			Charges			Costs	
	Cost Center Description	Cost to Charge	PPS Reimbursed	Cost	Cost	PPS Services	
			Services (see	Rei mbursed	Rei mbursed	(see inst.)	
		Worksheet C,	inst.)	Servi ces	Services Not		
		Part I, col. 9		Subject To	Subject To		
				Ded. & Coins.	Ded. & Coins.		
				(see inst.)	(see inst.)		
		1.00	2. 00	3. 00	4. 00	5. 00	
	ANCILLARY SERVICE COST CENTERS						
į	50.00 05000 OPERATING ROOM	0. 083628	3, 856, 080	0	0	322, 476	50. 00
į	50. 01   05001   OPERATI NG ROOM	0. 000000	0	0	0	0	50. 01
į	52.00 05200 DELIVERY ROOM & LABOR ROOM	0. 283050	0	0	0	0	52. 00
į	53. 00   05300   ANESTHESI OLOGY	0. 449951	0	0	0	0	53. 00
į	54. 00   05400   RADI OLOGY-DI AGNOSTI C	0. 094746	6, 734, 045	0	0	638, 024	54.00
	60. 00 06000 LABORATORY	0. 171479	1, 645, 781	1 0	0	282, 217	60.00
	62.30 06250 BLOOD CLOTTING FOR HEMOPHILIAC			l 0	0	l ol	62. 30
	65. 00 06500 RESPIRATORY THERAPY	0. 233277	1, 024, 993	0	0	239, 107	65. 00
	66. 00   06600 PHYSI CAL THERAPY	0. 411093		0	0	0	66.00
	67. 00 06700 OCCUPATI ONAL THERAPY	0. 282993	0	0	0	0	67. 00
	68. 00 06800 SPEECH PATHOLOGY	0. 491754		0	0	0	68. 00
	69. 00 06900 ELECTROCARDI OLOGY	0. 000122	493, 098	0	0	60	69. 00
	71.00 07100 MEDICAL SUPPLIES CHARGED TO PA				0	88, 747	71. 00
	72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0. 228047		•	0	114, 245	72.00
	73. 00 07300 DRUGS CHARGED TO PATIENTS	0. 183995		•	0	789, 015	73. 00
	76. 97 07697 CARDI AC REHABI LI TATI ON	0. 000000		0	0	0	76. 97
	76. 98 07698 HYPERBARI C OXYGEN THERAPY	0. 238165		Ö	0	0	76. 98
	76. 99 07699 LI THOTRI PSY	0. 000000				0	76. 99
	OUTPATIENT SERVICE COST CENTERS	,		-		_	
	90. 00 09000 CLI NI C	0. 195490	0	0	0	0	90.00
	91. 00   09100   EMERGENCY	0. 114433		•		407, 019	91. 00
	92.00 09200 OBSERVATION BEDS (NON-DISTINCT	1				449, 170	92. 00
	OTHER REIMBURSABLE COST CENTERS		17 1727007			1177 170	72.00
	95. 00 09500 AMBULANCE SERVICES	0. 407492		0			95. 00
	200.00 Subtotal (see instructions)	0. 107 172	23, 802, 766			3, 330, 080	
	201.00 Less PBP Clinic Lab. Services-	Program	20,002,700		0		201. 00
•	Only Charges			Ĭ			
	202.00 Net Charges (line 200 - line 2	01)	23, 802, 766	0	0	3, 330, 080	202 00
	202.00	0.7	25,002,700		١	2, 300, 000	

alth Financial Systems	HUNTI NGTON MEMO	Health Financial Systems HUNTINGTON MEMORIAL HOSPITAL In Lieu of Form CP						
· · · · · · · · · · · · · · · · · · ·		Provi der CC	CN: 15-0091	Peri od: From 01/01/2018 To 12/31/2018	Worksheet D Part V Date/Time Pre 5/28/2019 10:	pared: 58 am		
		Title	XVIII	Hospi tal	PPS			
	Cos	sts						
Cost Center Description	Cost Reimbursed Services Subject To Ded. & Coins. (see inst.) 6.00	Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.) 7.00						

	Cost Center Description	Cost	Cost		
		Rei mbursed	Reimbursed		
		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		1		4
	05000 OPERATING ROOM	0	0	1	50. 00
	05001 OPERATING ROOM	0	0	1	50. 01
	05200 DELIVERY ROOM & LABOR ROOM	0	0	1	52. 00
	05300 ANESTHESI OLOGY	0	0	1	53. 00
	05400 RADI OLOGY-DI AGNOSTI C	0	0	1	54. 00
	06000 LABORATORY	0	0	)	60.00
	06250 BLOOD CLOTTING FOR HEMOPHILIACS	0	0	)	62. 30
	06500 RESPI RATORY THERAPY	0	0	)	65. 00
	06600 PHYSI CAL THERAPY	0	0	)	66. 00
	06700 OCCUPATI ONAL THERAPY	0	0	)	67. 00
	06800 SPEECH PATHOLOGY	0	0	)	68. 00
69. 00	06900 ELECTROCARDI OLOGY	0	0		69. 00
	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0	0		71. 00
	07200 IMPL. DEV. CHARGED TO PATIENTS	0	0		72. 00
73. 00	07300 DRUGS CHARGED TO PATIENTS	0	0		73.00
	07697 CARDIAC REHABILITATION	0	0		76. 97
	07698 HYPERBARIC OXYGEN THERAPY	0	0		76. 98
76. 99	07699 LI THOTRI PSY	0	0	)	76. 99
	OUTPATIENT SERVICE COST CENTERS				
	09000 CLI NI C	0	0		90.00
91.00	09100 EMERGENCY	0	0		91. 00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART	0	0	)	92. 00
	OTHER REIMBURSABLE COST CENTERS				
95.00	09500 AMBULANCE SERVI CES	0			95. 00
200.00	Subtotal (see instructions)	0	0	)	200. 00
201.00	Less PBP Clinic Lab. Services-Program	0			201. 00
	Only Charges				
202.00	Net Charges (line 200 - line 201)	0	0	ı	202. 00

Health Financial Systems	HUNTINGTON MEMO	u of Form CMS-2	2552-10			
APPORTIONMENT OF INPATIENT ROUTINE SERVICE CAPITAL	COSTS	Provi der C	Provi der CCN: 15-0091		Worksheet D	
				From 01/01/2018		
				To 12/31/2018	Date/Time Pre 5/28/2019 10:	
		Ti +I	e XIX	Hospi tal	972072019 10. PPS	30 alli
Cost Center Description	Capi tal	Swing Bed	Reduced		Per Diem (col.	
cost center bescription					,	
	Related Cost	Adjustment	Capi tal	Days	3 / col . 4)	
	(from Wkst. B,		Related Cost			
	Part II, col.		(col . 1 - col			
	26)		2)			
	1. 00	2. 00	3. 00	4. 00	5. 00	
INPATIENT ROUTINE SERVICE COST CENTERS						
30. 00 ADULTS & PEDI ATRI CS	636, 234	0	636, 23	5, 998	106. 07	30.00
43. 00 NURSERY	19, 616		19, 61	6 718	27. 32	43.00
200.00 Total (lines 30 through 199)	655, 850		655, 85	0 6, 716		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	1			
INPATIENT ROUTINE SERVICE COST CENTERS						
30. 00 ADULTS & PEDI ATRI CS	79	8, 380				30. 00
43. 00 NURSERY	27	738	8			43.00
200.00 Total (lines 30 through 199)	106	9, 118	3			200. 00

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS  Provider CCN: 15-0091 Period: From 01/01/2018 To 12/31/2018 Part II Date/Time Prepared: 5/28/2019 10: 58 am Provider CCN: 15-0091 Part II Date/Time Prepared: 5/28/2019 10: 58 am Provider CCN: 15-0091 Part II Date/Time Prepared: 5/28/2019 10: 58 am Provider CCN: 15-0091 Part II Date/Time Prepared: 5/28/2019 10: 58 am Provider CCN: 15-0091 Part II Date/Time Prepared: 5/28/2019 10: 58 am Provider CCN: 15-0091 Part II Date/Time Prepared: 5/28/2019 10: 58 am Provider CCN: 15-0091 Part II Date/Time Prepared: 5/28/2019 10: 58 am Provider CCN: 15-0091 Part II Date/Time Prepared: 5/28/2019 10: 58 am Provider CCN: 15-0091 Part II Date/Time Prepared: 5/28/2019 10: 58 am Provider CCN: 15-0091 Part II Date/Time Prepared: 5/28/2019 10: 58 am Provider CCN: 15-0091 Part II Date/Time Prepared: 5/28/2019 10: 58 am Provider CCN: 15-0091 Part II Date/Time Prepared: 5/28/2019 10: 58 am Provider CCN: 15-0091 Part II Date/Time Prepared: 5/28/2019 10: 58 am Provider CCN: 15-0091 Part II Date/Time Prepared: 5/28/2019 10: 58 am Provider CCN: 15-0091 Part II Date/Time Prepared: 5/28/2019 10: 58 am Provider CCN: 15-0091 Part II Date/Time Prepared: 5/28/2019 10: 58 am Provider CCN: 15-0091 Part II Date/Time Prepared: 5/28/2019 10: 58 am Provider CCN: 15-0091 Part II Date/Time Prepared: 5/28/2019 10: 58 am Provider CCN: 15-0091 Part II Date/Time Prepared: 5/28/2019 10: 58 am Provider CCN: 15-0091 Part II Date/Time Prepared: 5/28/2019 10: 58 am Provider CCN: 15-0091 Part II Date/Time Prepared: 5/28/2019 10: 58 am Provider CCN: 15-0091 Part II Date/Time Prepared: 5/28/2019 10: 58 am Provider CCN: 15-0091 Part II Date/Time Prepared: 5/28/2019 10: 58 am Provider CCN: 15-0091 Part II Date/Time Prepared: 5/28/2019 10: 58 am Provider CCN: 15-0091 Part II Date/Time Prepared: 5/28/2019 10: 58 am Provider CCN: 16 a	Cost Center Description  Capital Related Cost (from Wkst. B, Part II, col. 26)  Capital Related Cost (from Wkst. B) Part II, col. 26  Part II Date/Time Prepare 5/28/2019 10:58 a  Part II Date/Time Prep	leal th Financial	Systems	HUNTINGTON ME	MORI A	L HOSPITAL		In Lie	u of Form CMS-2	2552-10
Cost Center Description  Capital Related Cost (from Wkst. C, to Charges (column 3 x (from Wkst. B, Part II, col. 26)  Capital Total Charges Ratio of Cost to Charges (column 3 x (column 4) 2)  Capital Related Cost (from Wkst. C, Part I, col. 8)  Capital Charges Ratio of Cost to Charges (column 4)  Part II, col. 8)  Capital Charges Program (column 4)  Capital Costs (from Wkst. C, Part I, col. 8)  Capital Charges Program (column 4)	Cost Center Description  Capital Related Cost (from Wkst. C, from Wkst. C, Part II, col. 26)  Capital Related Cost (from Wkst. B, Part II, col. 26)  Capital Total Charges Ratio of Cost to Charges (column 3 x column 4)  Part II, col. 8)  Capital Related Cost (from Wkst. C, Part I, col. Col. 1 ÷ col. Charges column 4)  Capital Costs (column 3 x column 4)  Capital Costs (from Wkst. C, Part I, col. S)  Column 3 x column 4)	APPORTIONMENT OF	INPATIENT ANCILLARY SERVICE	CAPITAL COSTS		Provi der Co		From 01/01/2018	Part II Date/Time Pre	oared: 58 am
Related Cost (from Wkst. C, to Charges (column 3 x (from Wkst. B, Part I, col. (col. 1 ÷ col. Charges column 4)  Part II, col. 8) 2)	Related Cost (from Wkst. C, to Charges (from Wkst. B, Part I, col. Part II, col. 8)   2)   Charges (column 4)   26)   1.00   2.00   3.00   4.00   5.00					Ti tl	e XIX	Hospi tal	PPS	
	ANCILLARY SERVICE COST CENTERS	Cost	Center Description	Related Cos (from Wkst. Part II, col 26)	t (fr B, Pa	rom Wkst. C, art I, col. 8)	to Charges (col. 1 ÷ col 2)	Program . Charges	(column 3 x column 4)	

			CAIA	nospi tai		
Cost Center Description	Capi tal		Ratio of Cost	Inpati ent	Capital Costs	
		(from Wkst. C,	to Charges	Program	(column 3 x	
	(from Wkst. B,	Part I, col.	(col. 1 ÷ col.	Charges	column 4)	
	Part II, col.	8)	2)			
	26)					
	1.00	2. 00	3.00	4. 00	5. 00	
ANCILLARY SERVICE COST CENTERS						
50. 00   05000 OPERATING ROOM	269, 760	21, 974, 152	0. 012276	266, 229	3, 268	50.00
50. 01   05001   OPERATING ROOM	0	0	0.000000	0	0	50. 01
52.00   05200   DELIVERY ROOM & LABOR ROOM	75, 976	4, 538, 142	0. 016742	86, 977	1, 456	52.00
53. 00   05300   ANESTHESI OLOGY	90, 187	3, 403, 187	0. 026501	0	0	53.00
54. 00   05400   RADI OLOGY-DI AGNOSTI C	419, 750	36, 557, 143	0. 011482	50, 941	585	54.00
60. 00   06000   LABORATORY	226, 574	21, 783, 044	0. 010401	69, 942	727	60.00
62.30 06250 BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0.000000	0	0	62. 30
65. 00 06500 RESPIRATORY THERAPY	144, 196	7, 251, 151	0. 019886	17, 268	343	65. 00
66. 00   06600 PHYSI CAL THERAPY	169, 569	4, 773, 422	0. 035524	196	7	66. 00
67. 00 06700 OCCUPATI ONAL THERAPY	26, 090	1, 560, 149	0. 016723	0	0	67. 00
68. 00 06800 SPEECH PATHOLOGY	10, 486	361, 323	0. 029021	259	8	68. 00
69. 00 06900 ELECTROCARDI OLOGY	21	1, 121, 431	0.000019	11, 234	0	69. 00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	154, 733	11, 010, 504	0. 014053	20, 991	295	71. 00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	78, 937	5, 874, 532	0. 013437	0	0	72. 00
73.00 07300 DRUGS CHARGED TO PATIENTS	188, 767	17, 288, 485	0. 010919	95, 982	1, 048	73. 00
76. 97 07697 CARDI AC REHABI LI TATI ON	0	0	0.000000	0	0	76. 97
76. 98 07698 HYPERBARI C OXYGEN THERAPY	3, 289	224, 458	0. 014653	0	0	76. 98
76. 99 07699 LI THOTRI PSY	0	0	0.000000	0	0	76. 99
OUTPATIENT SERVICE COST CENTERS						
90. 00 09000 CLI NI C	8, 684	753, 774	0. 011521	0	0	90. 00
91. 00 09100 EMERGENCY	219, 570	26, 493, 850	0. 008288	39, 959	331	91. 00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART	174, 705	5, 245, 958	0. 033303	0	0	92.00
OTHER REIMBURSABLE COST CENTERS	<u> </u>					
95. 00 09500 AMBULANCE SERVI CES						95. 00
200.00 Total (lines 50 through 199)	2, 261, 294	170, 214, 705		659, 978	8, 068	200. 00
3	1					'

Health Financial Systems	HUNTINGTON MEMO	RIAL HOSPITAL		In Lie	eu of Form CMS-2	2552-10
APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER P	ASS THROUGH COST	rs Provider Co		Period: From 01/01/2018 To 12/31/2018		pared: 58 am
			e XIX	Hospi tal	PPS	
Cost Center Description	Post-Stepdown Adjustments		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, 99			
43. 00   04300   NURSERY		0	71			43. 00
200. 00   Total (lines 30 through 199)		0	6, 71	6	106	200. 00
Cost Center Description	I npati ent					
	Program					
	Pass-Through					
	Cost (col. 7 x					
	col . 8)					
INPATIENT ROUTINE SERVICE COST CENTERS	9. 00					
						20.00
30. 00   03000   ADULTS & PEDI ATRI CS 43. 00   04300   NURSERY	0					30. 00 43. 00
						200. 00
200.00   Total (lines 30 through 199)	0					1200.00

Health Financial Systems	HUN	NTINGTON MEMORIA	AL HOSPITAL	In Lie	u of Form CMS-2552-10
APPORTIONMENT OF INPATIENT/OUTPATIENT THROUGH COSTS	ANCILLARY SERVI	CE OTHER PASS	Provider CCN: 15-0091	Peri od: From 01/01/2018 To 12/31/2018	Worksheet D Part IV Date/Time Prepared:

				10 12/31/2018	5/28/2019 10:	
			e XIX	Hospi tal	PPS	
Cost Center Description	Non Physician	Nursing School	Nursing Schoo	Allied Health	Allied Health	
	Anestheti st	Post-Stepdown		Post-Stepdown		
	Cost	Adjustments		Adjustments		
	1. 00	2A	2.00	3A	3. 00	
ANCILLARY SERVICE COST CENTERS						
50.00   05000   OPERATING ROOM	0	0	)	0	0	00.00
50. 01   05001   OPERATING ROOM	0	) 0	)	0	0	50. 01
52.00   05200   DELIVERY ROOM & LABOR ROOM	0	0	)	0	0	52. 00
53. 00   05300   ANESTHESI OLOGY	0	0	)	0	0	53. 00
54. 00   05400   RADI OLOGY-DI AGNOSTI C	0	0	)	0	0	54.00
60. 00   06000   LABORATORY	0	0	)	0	0	60.00
62.30   06250   BLOOD CLOTTING FOR HEMOPHILIACS	0	0	)	0	0	62. 30
65. 00   06500   RESPI RATORY THERAPY	0	0	)	0	0	65. 00
66. 00   06600 PHYSI CAL THERAPY	0	0	)	0	0	66. 00
67. 00  06700 OCCUPATI ONAL THERAPY	0	0	)	0	0	67. 00
68. 00   06800   SPEECH PATHOLOGY	0	0	)	0	0	68. 00
69. 00   06900   ELECTROCARDI OLOGY	0	0	)	0	0	69. 00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	)	0	0	71. 00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0	0	)	0	0	72. 00
73.00 07300 DRUGS CHARGED TO PATIENTS	0	0		0	0	73. 00
76. 97   07697   CARDI AC   REHABI LI TATI ON	0	0		0	0	76. 97
76. 98 07698 HYPERBARI C OXYGEN THERAPY	0	0	)	0	0	76. 98
76. 99 07699 LI THOTRI PSY	0	0	)	0	0	76. 99
OUTPATIENT SERVICE COST CENTERS						
90. 00  09000  CLI NI C	0	0	)	0	0	90.00
91. 00  09100 EMERGENCY	0	0	)	0	0	91. 00
92.00 O9200 OBSERVATION BEDS (NON-DISTINCT PART	0	)		0	0	92. 00
OTHER REIMBURSABLE COST CENTERS						
95. 00 09500 AMBULANCE SERVICES						95. 00
200.00   Total (lines 50 through 199)	0	) 0	)	0	0	200. 00

Health Financial Systems	HUNTI NGTON MEMORI	AL HOSPITAL	In Lie	u of Form CMS-2552-10
APPORTIONMENT OF INPATIENT/OUTPATIENT THROUGH COSTS	ANCILLARY SERVICE OTHER PASS	Provider CCN: 15-0091	Peri od: From 01/01/2018 To 12/31/2018	Worksheet D Part IV Date/Time Prepared:

THROUG	H COSTS				To 12/31/2018		pared: 58 am
				e XIX	Hospi tal	PPS	
	Cost Center Description	All Other	Total Cost	Total		Ratio of Cost	
		Medi cal	(sum of cols.	Outpati ent	(from Wkst. C,		
		Education Cost	1, 2, 3, and	Cost (sum of		(col. 5 ÷ col.	
			4)	col s. 2, 3,	8)	7)	
		4.00	5. 00	and 4) 6.00	7. 00	8. 00	
	ANCILLARY SERVICE COST CENTERS	4.00	5.00	0.00	7.00	8.00	
50.00	05000 OPERATING ROOM	0	0	1 (	21, 974, 152	0.000000	50.00
	05001 OPERATING ROOM	0	0		0 21,771,102	0.000000	
	05200 DELIVERY ROOM & LABOR ROOM	0	0		4, 538, 142		
	05300 ANESTHESI OLOGY	0	0		3, 403, 187	•	
	05400 RADI OLOGY-DI AGNOSTI C	0	0		36, 557, 143	•	
	06000 LABORATORY	0	0		21, 783, 044	•	
62. 30	06250 BLOOD CLOTTING FOR HEMOPHILIACS	0	0	) (	0 0	0.000000	62. 30
65.00	06500 RESPIRATORY THERAPY	0	0	) (	7, 251, 151	0.000000	65. 00
66.00	06600 PHYSI CAL THERAPY	0	0	) (	4, 773, 422	0.000000	66. 00
67.00	06700 OCCUPATI ONAL THERAPY	0	0	) (	1, 560, 149	0.000000	67. 00
68.00	06800 SPEECH PATHOLOGY	0	0		361, 323	0.000000	68. 00
69.00	06900 ELECTROCARDI OLOGY	0	0	) (	1, 121, 431	0.000000	69. 00
71. 00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0	0		11, 010, 504	0.000000	71. 00
72.00	07200 I MPL. DEV. CHARGED TO PATIENTS	0	0	) (	5, 874, 532	0.000000	72. 00
	07300 DRUGS CHARGED TO PATIENTS	0	0	) (	17, 288, 485	0.000000	73. 00
	07697 CARDI AC REHABI LI TATI ON	0	0	) (	0 0	0.000000	
	07698 HYPERBARI C OXYGEN THERAPY	0	0	) (	224, 458		
76. 99	07699 LI THOTRI PSY	0	0	) (	0 0	0.000000	76. 99
	OUTPATIENT SERVICE COST CENTERS						
	09000 CLI NI C	0	0	•	753, 774	l e	
	09100 EMERGENCY	0	0		26, 493, 850		
92. 00	09200 OBSERVATION BEDS (NON-DISTINCT PART	0	0	(	5, 245, 958	0.000000	92.00
05.00	OTHER REIMBURSABLE COST CENTERS						05.00
	09500 AMBULANCE SERVICES			] ,	170 214 705		95. 00
200.00	Total (lines 50 through 199)	0	0	ή (	170, 214, 705	i	200. 00

Health Financial Systems	HUNTI NGTON MEMOR				eu of Form CMS-	2552-10
APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SE THROUGH COSTS	RVICE OTHER PASS	Provi der Co		Period: From 01/01/2018 To 12/31/2018		pared: 58 am
		Ti tl	e XIX	Hospi tal	PPS	
Cost Center Description	Outpatient Ratio of Cost to Charges (col. 6 ÷ col.	Inpatient Program Charges	Inpatient Program Pass-Through Costs (col. 8		Outpatient Program Pass-Through 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	266, 229	(	0	0	
50. 01   05001 OPERATING ROOM	0. 000000	0	1	0	0	50. 01
52.00   05200   DELIVERY ROOM & LABOR ROOM	0. 000000	86, 977		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	50, 941	1	0	0	54. 00
60. 00   06000   LABORATORY	0. 000000	69, 942		0	0	60.00
62. 30 06250 BLOOD CLOTTING FOR HEMOPHILIACS	0. 000000	0		0	0	62. 30
65. 00 06500 RESPIRATORY THERAPY	0. 000000	17, 268		0	0	65. 00
66. 00 06600 PHYSI CAL THERAPY	0. 000000	196	(	0	0	66. 00
67. 00 06700 OCCUPATIONAL THERAPY	0. 000000	0	1	0	0	67. 00
68. 00 06800 SPEECH PATHOLOGY	0. 000000	259		0	0	68. 00
69. 00 06900 ELECTROCARDI OLOGY	0. 000000	11, 234		0	0	69. 00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0. 000000	20, 991		0	0	71. 00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0. 000000	0	1	0	0	72. 00
73.00 07300 DRUGS CHARGED TO PATIENTS	0. 000000	95, 982		0	0	73. 00
76. 97 07697 CARDIAC REHABILITATION	0. 000000	0	(	0	0	76. 97
76. 98 07698 HYPERBARI C OXYGEN THERAPY	0. 000000	0	(	0	0	76. 98
76. 99 07699 LI THOTRI PSY	0. 000000	0	(	0	0	76. 99
OUTPATIENT SERVICE COST CENTERS						
00 00 000000 CLINIC	0 000000	0		n 0	Λ.	0000

0. 000000 0. 000000

0. 000000

39, 959

659, 978

0 0 0

0

0 0 0

0

0 90.00

0 91.00

0 92.00 95.00

0 200. 00

90.00

09000 CLI NI C

92. 00 | 09200 | 0BSERVATION BEDS (NON-DISTINCT PART OTHER REIMBURSABLE COST CENTERS | 09500 | AMBULANCE SERVICES | Total (lines 50 through 199)

91. 00 09100 EMERGENCY

Health Financial Systems		HUNTINGTON MEMORIA	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 01/01/2018	Worksheet D
					Nate/Time Prepared:

					rom 01/01/2018 o 12/31/2018	Date/Time Pre	
			Ti +1	e XIX	Hospi tal	5/28/2019 10: PPS	58 am_
			11 (1	Charges	HOSPI tai	Costs	
	Cost Center Description	Cost to Charge	DDS Daimhursad		Cost	PPS Services	
	cost center bescription		Servi ces (see	Rei mbursed	Rei mbursed	(see inst.)	
		Worksheet C,	inst.)	Servi ces	Services Not	(300 11131.)	
		Part I, col. 9		Subject To	Subject To		
				Ded. & Coins.	Ded. & Coins.		
				(see inst.)	(see inst.)		
		1.00	2.00	3.00	4. 00	5. 00	
	ANCILLARY SERVICE COST CENTERS						
50.00	05000 OPERATING ROOM	0. 083628	0	(	163, 219	0	50.00
50. 01	05001 OPERATING ROOM	0. 000000	0	C	0	0	50. 01
52.00	05200 DELIVERY ROOM & LABOR ROOM	0. 283050	0	C	0	0	52.00
53.00	05300 ANESTHESI OLOGY	0. 449951	0	C	0	0	53.00
54.00	05400 RADI OLOGY-DI AGNOSTI C	0. 094746	0	(	364, 671	0	54.00
60.00	06000 LABORATORY	0. 171479	0	(	207, 581	0	60.00
62. 30	06250 BLOOD CLOTTING FOR HEMOPHILIACS	0. 000000	0	(	0	0	62. 30
65.00	06500 RESPI RATORY THERAPY	0. 233277	0	(	55, 309	0	65. 00
66.00	06600 PHYSI CAL THERAPY	0. 411093	0	(	86, 683	0	66. 00
67.00	06700 OCCUPATI ONAL THERAPY	0. 282993	0	(	70, 934	0	67. 00
68. 00	06800 SPEECH PATHOLOGY	0. 491754	0		9, 504	0	68. 00
69.00	06900 ELECTROCARDI OLOGY	0. 000122	0		4, 519	0	69. 00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0. 174070	0	(	13, 603	0	71. 00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0. 228047	0	C	3, 233	0	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0. 183995	0	C	236, 732	0	73.00
76. 97	07697 CARDIAC REHABILITATION	0. 000000	0	C	0	0	76. 97
76. 98	07698 HYPERBARI C OXYGEN THERAPY	0. 238165	0	C	0	0	76. 98
76. 99	07699 LI THOTRI PSY	0. 000000	0	C	0	0	76. 99
	OUTPATIENT SERVICE COST CENTERS						
	09000 CLI NI C	0. 195490	0	C	0	0	90.00
91.00	09100 EMERGENCY	0. 114433	0	C	334, 785	0	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART	0. 376540	0	C	58, 542	0	92. 00
	OTHER REIMBURSABLE COST CENTERS						
95.00	09500 AMBULANCE SERVICES	0. 407492	0	C	)		95. 00
200.00	Subtotal (see instructions)		0	C	1, 609, 315	0	200. 00
201.00	Less PBP Clinic Lab. Services-Program			(	0	I	201. 00
	Only Charges					I	
202.00	Net Charges (line 200 - line 201)		0	(	1, 609, 315	0	202. 00

Health Financial Systems	HUNTINGTON MEMOF	RIAL HOSPITAL		In Lie	u of Form CMS-2	2552-10
APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND	VACCINE COST	Provider CO	CN: 15-0091	Peri od: From 01/01/2018 To 12/31/2018	Worksheet D Part V Date/Time Pre 5/28/2019 10:	pared: 58 am
		Ti tl	e XIX	Hospi tal	PPS	
	Cos	ts				
Cost Center Description	Cost Reimbursed	Cost Reimbursed				

			Titl	e XIX	Hospi tal	PPS	
		Cos	sts				
	Cost Center Description	Cost	Cost				
		Rei mbursed	Reimbursed				
		Servi ces	Services Not				
		Subject To	Subject To				
		Ded. & Coins.	Ded. & Coins.				
		(see inst.)	(see inst.)				
		6.00	7. 00				
	ANCILLARY SERVICE COST CENTERS						
	05000 OPERATING ROOM	0	13, 650			5	50. 00
50. 01	05001 OPERATING ROOM	0	0			5	50. 01
52.00	D5200 DELIVERY ROOM & LABOR ROOM	0	0			5	52. 00
53.00	D5300 ANESTHESI OLOGY	0	0			5	53. 00
54.00	05400 RADI OLOGY-DI AGNOSTI C	0	34, 551			5	54. 00
60.00	06000 LABORATORY	0	35, 596			6	60. 00
62. 30	06250 BLOOD CLOTTING FOR HEMOPHILIACS	0	0	1		6	62. 30
65.00	06500 RESPI RATORY THERAPY	0	12, 902			6	65. 00
	06600 PHYSI CAL THERAPY	0	35, 635			1 6	66. 00
	06700 OCCUPATI ONAL THERAPY	0	20, 074				67. 00
	06800 SPEECH PATHOLOGY	0	4, 674				68. 00
	06900 ELECTROCARDI OLOGY	0	1				69. 00
	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0	2, 368				71. 00
	07200 IMPL. DEV. CHARGED TO PATIENTS	0	737				72. 00
	07300 DRUGS CHARGED TO PATIENTS	0	43, 558				73. 00
	07697 CARDI AC REHABI LI TATI ON	0	0	i			76. 97
	07698 HYPERBARI C OXYGEN THERAPY	0	o o				76. 98
	07699 LI THOTRI PSY	0					76. 99
	OUTPATIENT SERVICE COST CENTERS					,	, 0. , ,
	09000 CLI NI C	0	0				90. 00
	D9100 EMERGENCY	0					91. 00
	09200 OBSERVATION BEDS (NON-DISTINCT PART	0					92. 00
	OTHER REIMBURSABLE COST CENTERS		22,043	l			72.00
	09500 AMBULANCE SERVI CES	1 0				c	95. 00
200.00	Subtotal (see instructions)		264, 099				00.00
201. 00	Less PBP Clinic Lab. Services-Program		204, 077				01. 00
201.00	Only Charges					20	51.00
202. 00	Net Charges (line 200 - line 201)	0	264, 099			20	02. 00
202.00	1.100 S.Idi 905 (11110 200 11110 201)	1	201,077	I		120	52.00

Health Financial Systems	HUNTINGTON MEMORIAL HOSPITAL	In Lie	u of Form CMS-2552-10
COMPUTATION OF INPATIENT OPERATING COST	Provi der CCN: 15-00	Peri od: From 01/01/2018	Worksheet D-1
		To 12/31/2018	Date/Time Prepared: 5/28/2019 10:58 am
	Title XVIII	Hospi tal	PPS

				5/28/2019 10:	58 am
		Title XVIII	Hospi tal	PPS	
	Cost Center Description			1. 00	
	PART I - ALL PROVIDER COMPONENTS			1.00	
	INPATIENT DAYS				1
1.00	Inpatient days (including private room days and swing-bed days	s, excluding newborn)		5, 998	1.00
2.00	Inpatient days (including private room days, excluding swing-			5, 998	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
	do not complete this line.				
4.00	Semi-private room days (excluding swing-bed and observation be			4, 351	4.00
5. 00	Total swing-bed SNF type inpatient days (including private roo	om days) through Decembe	r 31 of the cost	01	5. 00
6. 00	reporting period Total swing-bed SNF type inpatient days (including private roo	om days) after December	21 of the cost	0	6. 00
0.00	reporting period (if calendar year, enter 0 on this line)	olii days) ai tei beceilibei	of the cost	ا ا	0.00
7.00	Total swing-bed NF type inpatient days (including private room	m davs) through December	31 of the cost	0	7. 00
	reporting period				
8.00	Total swing-bed NF type inpatient days (including private room	m days) after December 3	1 of the cost	0	8. 00
	reporting period (if calendar year, enter 0 on this line)				
9. 00	Total inpatient days including private room days applicable to	the Program (excluding	swing-bed and	1, 359	9. 00
10. 00	newborn days) Swing-bed SNF type inpatient days applicable to title XVIII or	aly (including private r	nom dave)	o	10. 00
10.00	through December 31 of the cost reporting period (see instruct		Join days)	ا	10.00
11.00	Swing-bed SNF type inpatient days applicable to title XVIII or		oom days) after	0	11. 00
	December 31 of the cost reporting period (if calendar year, er	nter O on this line)	,		
12.00	Swing-bed NF type inpatient days applicable to titles V or XI)	Konly (including privat	e room days)	0	12. 00
12.00	through December 31 of the cost reporting period	/	d)		12.00
13. 00	Swing-bed NF type inpatient days applicable to titles V or XI) 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)	am (exertaining swring bea	udy5)	0	
16. 00	Nursery days (title V or XIX only)			Ō	
	SWING BED ADJUSTMENT				
17.00	Medicare rate for swing-bed SNF services applicable to service	es through December 31 o	f the cost	0.00	17. 00
10.00	reporting period	CI D I 01 C		0.00	10.00
18. 00	Medicare rate for swing-bed SNF services applicable to service reporting period	es after December 31 of	the cost	0. 00	18. 00
19. 00	Medicald rate for swing-bed NF services applicable to services	s through December 31 of	the cost	0.00	19. 00
17.00	reporting period	o tili odgir becelliber o'r o'r	the cost	J. 00	17.00
20.00	Medicaid 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, 193, 616	
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 (iine	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	- 1	
24.00	Swing-bed cost applicable to NF type services through December	31 of the cost reporti	ng period (line	0	24. 00
	7 x line 19)			· _ !	
25. 00	Swing-bed cost applicable to NF type services after December 3	31 of the cost reporting	period (line 8	0	25. 00
26. 00	x line 20) 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, 193, 616	
	PRIVATE ROOM DIFFERENTIAL ADJUSTMENT	<u>(                                    </u>		.,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,	
28.00	General inpatient routine service charges (excluding swing-bed	d and observation bed ch	arges)	0	28. 00
29. 00	Private room charges (excluding swing-bed charges)			0	29. 00
30.00	Semi-private room charges (excluding swing-bed charges)			0	
31.00	General inpatient routine service cost/charge ratio (line 27	: line 28)		0. 000000	
32.00	Average private room per diem charge (line 29 ÷ line 3)			0.00	
33. 00 34. 00	Average semi-private room per diem charge (line 30 ÷ line 4) Average per diem private room charge differential (line 32 mir	nus line 33)(see instruc	tions)	0. 00 0. 00	1
35. 00	Average per diem private room cost differential (line 34 x line		1 0113)	0.00	
36. 00	Private room cost differential adjustment (line 3 x line 35)	/		0.00	1
37. 00	General inpatient routine service cost net of swing-bed cost a	and private room cost di	fferential (line	7, 193, 616	
	27 minus line 36)		<u> </u>		]
	PART II - HOSPITAL AND SUBPROVIDERS ONLY				1
20.00	PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJU			4 400 5	1 20 2-
38. 00	Adjusted general inpatient routine service cost per diem (see Program general inpatient routine service cost (line 9 x line			1, 199. 34	
39. 00 40. 00		*		1, 629, 903 0	
	Total Program general inpatient routine service cost (line 39	•		1, 629, 903	
55	1	,	ı	., 52,, 700	, 50

	Financial Systems FATION OF INPATIENT OPERATING COST	HUNTI NGTON MEMOF		CCN: 15-0091	Peri od:	worksheet D-1	
CONIFU	ATTOM OF THE ATTENT OF ENATITING COST		Trovider C	ON. 13-0071	From 01/01/2018		
					To 12/31/2018	Date/Time Pre 5/28/2019 10:	pared: 58 am
	Cook Control Documents on	T-+-1	_	e XVIII	Hospi tal	PPS	
	Cost Center Description	Total Inpatient Cost	Total	Average Per		Program Cost (col. 3 x col.	
		impatront oosti	- ipatront bay	col . 2)		4)	
10.00	Thursday, (11.11 M. a. M.)	1.00	2. 00	3. 00	4. 00	5. 00	10.00
42.00	NURSERY (title V & XIX only) Intensive Care Type Inpatient Hospital Uni	0	(	0. (	00 0	0	42. 00
43. 00							43. 00
44.00	CORONARY CARE UNIT						44. 00
45.00							45. 00
46.00	SURGICAL INTENSIVE CARE UNIT OTHER SPECIAL CARE (SPECIFY)						46. 00 47. 00
47.00	Cost Center Description						47.00
				_		1. 00	
48. 00	Program inpatient ancillary service cost (		,	>		1, 496, 176	1
49.00	Total Program inpatient costs (sum of line: PASS THROUGH COST ADJUSTMENTS	s 41 through 48)(s	see instruction	ons)		3, 126, 079	49. 00
50.00	Pass through costs applicable to Program in	npatient routine s	servi ces (fro	m Wkst. D, sur	n of Parts I and	144, 149	50.00
					6.5		
51. 00	Pass through costs applicable to Program i and IV)	npatient ancillar	y services (fi	rom Wkst. D, s	sum of Parts II	115, 415	51. 00
52. 00	Total Program excludable cost (sum of line	s 50 and 51)				259, 564	52. 00
53.00	Total Program inpatient operating cost exc	luding capital rel	ated, non-phy	ysician anesth	netist, and	2, 866, 515	
	medical education costs (line 49 minus line	e 52)					
54 00	TARGET AMOUNT AND LIMIT COMPUTATION Program discharges					0	54.00
	Target amount per discharge					0.00	
56. 00	,					0	
57. 00 58. 00	1	ating cost and tai	rget amount (	line 56 minus	line 53)	0	
59.00	Bonus payment (see instructions) Lesser of lines 53/54 or 55 from the cost	reporting period (	endi na 1996. i	updated and co	ompounded by the	0.00	
	market basket		g,				
60.00	Lesser of lines 53/54 or 55 from prior yea				*b b	0.00	
61. 00	If line 53/54 is less than the lower of liwhich operating costs (line 53) are less t					0	61.00
	amount (line 56), otherwise enter zero (se		s (Tries or x	00), 01 1% 01	the target		
	Relief payment (see instructions)					0	
63. 00	Allowable Inpatient cost plus incentive par PROGRAM INPATIENT ROUTINE SWING BED COST	yment (see instru	ctions)			0	63. 00
64. 00		osts through Decer	mber 31 of the	e cost reporti	ng period (See	0	64. 00
	instructions)(title XVIII only)					_	
65. 00	Medicare swing-bed SNF inpatient routine constructions)(title XVIII only)	osts after Decembe	er 31 of the (	cost reportino	g period (See	0	65. 00
66. 00	Total Medicare swing-bed SNF inpatient rou	tine costs (line o	64 plus line (	65)(title XVII	I only). For	0	66. 00
	CAH (see instructions)						
67. 00	Title V or XIX swing-bed NF inpatient rout (line 12 x line 19)	ine costs through	December 31	of the cost re	eporting period	0	67. 00
68. 00	Title V or XIX swing-bed NF inpatient rout	ine costs after De	ecember 31 of	the cost repo	orting period	0	68. 00
	(line 13 x line 20)			·	3 1		
69. 00	Total title V or XIX swing-bed NF inpatien					0	69. 00
70. 00	PART III - SKILLED NURSING FACILITY, OTHER Skilled nursing facility/other nursing fac				<u> </u>		70. 00
71. 00	Adjusted general inpatient routine service	•					71. 00
72. 00							72. 00
73. 00 74. 00	Medically necessary private room cost appl Total Program general inpatient routine se						73.00
75. 00	3 3 1				Part II, column		75. 00
	26, line 45)		•		·		
76. 00	Per diem capital related costs (line 75 ÷	,					76.00
77. 00 78. 00	Program capital-related costs (line 9 x li Inpatient routine service cost (line 74 mi	,					77. 00 78. 00
79. 00	1 '		rovi der recor	ds)			79.00
	Total Program routine service costs for co	•	ost limitatio	n (line 78 mir	nus line 79)		80.00
81. 00 82. 00	Inpatient routine service cost per diem li		<b>\</b>				81. 00 82. 00
82.00	Inpatient routine service cost limitation Reasonable inpatient routine service costs	·					82.00
84. 00	Program inpatient ancillary services (see	•	•				84. 00
85.00	1 3 1						85. 00
86. 00	Total Program inpatient operating costs (SPART IV - COMPUTATION OF OBSERVATION BED PART IV - COMPUTATION BED		rough 85)				86. 00
87. 00	Total observation bed days (see instruction					1, 647	87. 00
		•	line 2)			1, 199. 34	
88. 00	Observation bed cost (line 87 x line 88) (	•	. ,			1, 975, 313	

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		Period: From 01/01/2018	Worksheet D-1	
				To 12/31/2018	Date/Time Prep 5/28/2019 10:	oared: 58 am
		Title	XVIII	Hospi tal	PPS	
Cost Center Description	Cost	Routine Cost	column 1 ÷	Total	Observati on	
		(from line 21)	column 2	Observati on	Bed Pass	
				Bed Cost (from	Through Cost	
				line 89)	(col. 3 x col.	
					4) (see	
					instructions)	
	1.00	2.00	3. 00	4. 00	5. 00	
COMPUTATION OF OBSERVATION BED PASS THROUGH	COST					
90.00 Capital -related cost	636, 234	7, 193, 616	0. 08844	4 1, 975, 313	174, 705	90.00
91.00 Nursing School cost	0	7, 193, 616	0.00000	1, 975, 313	0	91.00
92.00 Allied health cost	0	7, 193, 616	0.00000	1, 975, 313	0	92.00
93.00 All other Medical Education	0	7, 193, 616	0.00000	1, 975, 313	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 01/01/2018	Worksheet D-1	
			Date/Time Pre 5/28/2019 10:	
	Title XIX	Hospi tal	PPS	
Cook Cooker December 1				

		Title XIX	Hospi tal	572872019 10: PPS	36 aiii
	Cost Center Description			1. 00	
	PART I - ALL PROVIDER COMPONENTS			1. 00	
4 00	I NPATI ENT DAYS			F 000	4 00
1. 00 2. 00	Inpatient days (including private room days and swing-bed days Inpatient days (including private room days, excluding swing-b			5, 998 5, 998	1. 00 2. 00
3. 00	Private room days (excluding swing-bed and observation bed days). If you have only private room days,				
	do not complete this line.		, ,		
4. 00 5. 00	Semi-private room days (excluding swing-bed and observation be Total swing-bed SNF type inpatient days (including private roo		21 of the cost	4, 351 0	4. 00 5. 00
5.00	reporting period	ili days) trii ougri beceiliber	31 Of the Cost	U	3.00
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) Total swing-bed NF type inpatient days (including private room	days) through Docombor	21 of the cost	0	7. 00
7.00	reporting period	days) through becember	31 Of the Cost	U	7.00
8.00	Total swing-bed NF type inpatient days (including private room	days) after December 31	of the cost	0	8. 00
0.00	reporting period (if calendar year, enter 0 on this line)	the Discourse Court will be		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 on	ly (including private ro	oom days)	0	10.00
44.00	through December 31 of the cost reporting period (see instruct				44 00
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) arter	0	11. 00
12.00	Swing-bed NF type inpatient days applicable to titles V or XIX		e room days)	0	12. 00
40.00	through December 31 of the cost reporting period				40.00
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)			718	
16. 00	Nursery days (title V or XIX only)			27	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	G			
18. 00	Medicare rate for swing-bed SNF services applicable to service	s 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	till dagit bedember of or	the cost	0.00	
20. 00	Medicaid rate for swing-bed NF services applicable to services reporting period	after December 31 of th	ne cost	0. 00	20. 00
21. 00	Total general inpatient routine service cost (see instructions	)		7, 193, 616	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) Swing-bed cost applicable to SNF type services after December	21 of the cost reporting	noried (line 4	0	23. 00
23.00	x line 18)	31 of the cost reporting	perrou (Trile 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	1 of the cost reporting	period (line 8	0	25. 00
20.00	x line 20)	To the east reporting		, and the second	20.00
26. 00	Total swing-bed cost (see instructions)	li 21 li 2()		7 102 (1(	26. 00
27. 00	General inpatient routine service cost net of swing-bed cost ( PRIVATE ROOM DIFFERENTIAL ADJUSTMENT	line 21 minus line 26)		7, 193, 616	27.00
28. 00	General inpatient routine service charges (excluding swing-bed	and observation bed cha	rges)	0	28. 00
29. 00	Private room charges (excluding swing-bed charges)			0	29. 00
30.00	Semi -private room charges (excluding swing-bed charges)	1: 20)		0	30.00
31. 00 32. 00	General inpatient routine service cost/charge ratio (line 27 ÷ Average private room per diem charge (line 29 ÷ line 3)	line 28)		0. 000000 0. 00	31. 00 32. 00
33. 00	Average semi-private room per diem charge (line 30 ÷ line 4)			0.00	33. 00
34. 00	Average per diem private room charge differential (line 32 min	us line 33)(see instruct	i ons)	0.00	34. 00
35.00	Average per diem private room cost differential (line 34 x lin		<i>,</i>	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	nd private room cost dif	ferential (line	7, 193, 616	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	i nstructi ons)		1, 199. 34	38. 00
39.00	Program general inpatient routine service cost (line 9 x line			94, 748	39.00
40. 00 41 00	Medically necessary private room cost applicable to the Progra Total Program general inpatient routine service cost (line 39	,		0 94, 748	40. 00 41. 00
11.00	1.0ta ogram gonerar impatront routine service cost (inte si		ı	74, 740	1 00

	Financial Systems FATION OF INPATIENT OPERATING COST	HUNTI NGTON MEMO		- CCN: 15-0091	In Lie	u of Form CMS-2 Worksheet D-1	
CONICUI	ALION OF THE ATTEM OF LATING COST		1 i ovi del	OON. 10-0091	From 01/01/2018		
					To 12/31/2018	Date/Time Pre 5/28/2019 10:	
			_	tle XIX	Hospi tal	PPS	
	Cost Center Description	Total Inpatient Cost	Total Innatient Dav	Average Per		Program Cost (col. 3 x col.	
		impatront oost	The trent baj	col . 2)	·	4)	
	T	1. 00	2. 00	3.00	4. 00	5. 00	
42.00	NURSERY (title V & XIX only) Intensive Care Type Inpatient Hospital Unit	325, 628		18 453.	52 27	12, 245	42.00
43. 00		.3					43.00
44. 00	CORONARY CARE UNIT						44. 00
45.00	BURN INTENSIVE CARE UNIT						45.00
46.00	SURGICAL INTENSIVE CARE UNIT OTHER SPECIAL CARE (SPECIFY)						46. 00 47. 00
47.00	Cost Center Description						47.00
	To the state of th					1. 00	
48. 00	Program inpatient ancillary service cost (			anal		93, 970	
49.00	Total Program inpatient costs (sum of lines PASS THROUGH COST ADJUSTMENTS	s 41 through 48)(	see Instructi	ons)		200, 963	49. 00
50.00	Pass through costs applicable to Program in	npatient routine	services (fr	om Wkst. D, su	m of Parts I and	9, 118	50.00
						0.040	-4 00
51. 00	Pass through costs applicable to Program ir and IV)	npatient ancillar	y services (	from Wkst. D,	sum of Parts II	8, 068	51.00
52. 00	Total Program excludable cost (sum of lines	s 50 and 51)				17, 186	52.00
53.00	Total Program inpatient operating cost excl	uding capital re	lated, non-pl	nysician anest	hetist, and	183, 777	
	medical education costs (line 49 minus line	52)					
54 00	TARGET AMOUNT AND LIMIT COMPUTATION Program discharges					0	54. 00
	Target amount per discharge						55.00
56.00	,						56. 00
57. 00	,	ating cost and ta	rget amount	(line 56 minus	line 53)	0	
58. 00 59. 00	Bonus payment (see instructions) Lesser of lines 53/54 or 55 from the cost r	reporting period	endi na 1996	undated and c	ompounded by the	0 00	58. 00 59. 00
07.00	market basket	opor tring por rou	onaring 1770,	apaaroa ana o	ompounded by the	0.00	07.00
60.00	Lesser of lines 53/54 or 55 from prior year						60.00
61. 00	If line 53/54 is less than the lower of lir which operating costs (line 53) are less the					0	61.00
	amount (line 56), otherwise enter zero (see		3 (111163 54 .	x 00), 01 1% 0	i the target		
	Relief payment (see instructions)					0	
63. 00	Allowable Inpatient cost plus incentive pay PROGRAM INPATIENT ROUTINE SWING BED COST	ment (see instru	ctions)			0	63.00
64. 00		osts through Dece	mber 31 of t	ne cost report	ing period (See	0	64. 00
	instructions)(title XVIII only)	Ü		·			
65. 00	Medicare swing-bed SNF inpatient routine co	osts after Decemb	er 31 of the	cost reportin	g period (See	0	65. 00
66. 00	instructions)(title XVIII only) Total Medicare swing-bed SNF inpatient rout	tine costs (line	64 plus line	65)(title XVI	II only). For	0	66. 00
	CAH (see instructions)				3,		
67. 00	Title V or XIX swing-bed NF inpatient routi	ne costs through	December 31	of the cost r	eporting period	0	67. 00
68 00	(line 12 x line 19) Title V or XIX swing-bed NF inpatient routi	ne costs after D	ecember 31 o	f the cost rep	orting period	0	68. 00
00.00	(line 13 x line 20)				or tring portion		00.00
69. 00	Total title V or XIX swing-bed NF inpatient					0	69. 00
70. 00	PART III - SKILLED NURSING FACILITY, OTHER Skilled nursing facility/other nursing faci				)		70.00
71.00	Adjusted general inpatient routine service				)		71.00
72.00	Program routine service cost (line 9 x line	9 71)					72. 00
73.00	Medically necessary private room cost appli						73.00
74. 00 75. 00	Total Program general inpatient routine ser Capital-related cost allocated to inpatient	•		*	Part II column		74. 00 75. 00
73.00	26, line 45)	routine service	COSTS (TIOIII	worksneet b,	rait II, corumii		75.00
76. 00	Per diem capital-related costs (line 75 ÷ l						76. 00
77. 00 78. 00	Program capital -related costs (line 9 x lin						77. 00 78. 00
79. 00	Inpatient routine service cost (line 74 mir Aggregate charges to beneficiaries for exce		rovi der reco	rds)			79.00
	Total Program routine service costs for com				nus line 79)		80.00
81.00	Inpatient routine service cost per diem lim						81.00
82. 00 83. 00	Inpatient routine service cost limitation (Reasonable inpatient routine service costs	•	* .				82. 00 83. 00
84. 00	Program inpatient ancillary services (see i	•	3)				84.00
85. 00	Utilization review - physician compensation	n (see instructio					85. 00
86. 00	Total Program inpatient operating costs (su	um of lines 83 th					86. 00
07 00	PART IV - COMPUTATION OF OBSERVATION BED PA					1 4 4 7	07 00
87. 00	Total observation bed days (see instruction	•	line 2)			1, 647 1, 199. 34	
88. 00	Adjusted general inpatient routine cost per	urem (True 27 -	Tine 2)			1, 199, 34	1 00. 00

Health Financial Systems	HUNTINGTON 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 01/01/2018 To 12/31/2018		
		Ti tl	e XIX	Hospi tal	PPS	
Cost Center Description	Cost	Routine Cost	column 1 ÷	Total	Observati on	
		(from line 21)	column 2	Observati on	Bed Pass	
				Bed Cost (from	Through Cost	
				line 89)	(col. 3 x col.	
					4) (see	
					instructions)	
	1.00	2.00	3. 00	4. 00	5. 00	
COMPUTATION OF OBSERVATION BED PASS THROUGH	COST					
90.00 Capital -related cost	636, 234	7, 193, 616	0. 08844	4 1, 975, 313	174, 705	90.00
91.00 Nursing School cost	0	7, 193, 616	0. 00000	1, 975, 313	0	91.00
92.00 Allied health cost	0	7, 193, 616	0.00000	1, 975, 313	0	92.00
93.00 All other Medical Education	0	7, 193, 616	0.00000	1, 975, 313	0	93.00

NPATIENT A	ANCILLARY SERVICE COST APPORTIONMENT	Provi der C	CN: 15-0091	Peri od:	Worksheet D-3	}
				From 01/01/2018 To 12/31/2018	Date/Time Pre	pared
		Ti +l c	e XVIII	Hospi tal	5/28/2019 10: PPS	58 an
	Cost Center Description	11 11	Ratio of Cos		Inpati ent	
	COST CONTENT DESCRIPTION		To Charges		Program Costs	
			l ro onar goo	Charges	(col . 1 x col .	
				J 9	2)	
			1.00	2. 00	3.00	
I NPA	TIENT ROUTINE SERVICE COST CENTERS					
	O ADULTS & PEDIATRICS			2, 469, 765		30.0
	0 NURSERY					43.0
	LLARY SERVICE COST CENTERS					
	O OPERATING ROOM		0. 0841		107, 054	
	1 OPERATING ROOM		0.0000		0	1
	O DELIVERY ROOM & LABOR ROOM		0. 2830		0	
	0 ANESTHESI OLOGY		0. 4499		0	1
	O RADI OLOGY-DI AGNOSTI C		0. 0947			
	0 LABORATORY		0. 1714		220, 542	
	O BLOOD CLOTTING FOR HEMOPHILIACS		0.0000		_	
	O RESPI RATORY THERAPY		0. 2332			
	O PHYSI CAL THERAPY		0. 4110			
	O OCCUPATI ONAL THERAPY		0. 2829			
	O SPEECH PATHOLOGY		0. 4917			
	0 ELECTROCARDI OLOGY		0. 0001			
	O MEDICAL SUPPLIES CHARGED TO PATIENT		0. 1740			
	O I MPL. DEV. CHARGED TO PATI ENTS		0. 2280			
	O DRUGS CHARGED TO PATIENTS		0. 1839			
	7 CARDI AC REHABI LI TATI ON		0.0000		_	
	8 HYPERBARI C OXYGEN THERAPY		0. 2381		_	1
	9 LI THOTRI PSY		0.0000	00 0	0	76.
	ATIENT SERVICE COST CENTERS		0.1054	00		90.
	O EMERGENCY		0. 1954		_	
			0. 1144			
	O OBSERVATION BEDS (NON-DISTINCT PART R REIMBURSABLE COST CENTERS		0. 3765	40 <u>C</u>	0	92.
	O AMBULANCE SERVICES					95.
3. 00  0950 30. 00	Total (sum of lines 50 through 94 and 96 through 98)			9, 629, 551	1, 496, 176	
00.00	Less PBP Clinic Laboratory Services-Program only charges	(line 61)		9, 629, 551		200.
02.00	Net charges (line 200 minus line 201)	(TITIE OI)		9, 629, 551		201.

Health Financial Systems INPATIENT ANCILLARY SERVICE COST APPORTIONMENT	HUNTINGTON MEMORIAL HOSPITAL  Provider C	CN 15 0001	In Lie Period:	u of Form CMS- Worksheet D-3	
INPATIENT ANCILLARY SERVICE COST APPORTIONMENT	Provider C		From 01/01/2018	worksneet D-3	1
			To 12/31/2018	Date/Time Pre	pared:
				5/28/2019 10:	58 am
	Ti tl	e XIX	Hospi tal	PPS	
Cost Center Description		Ratio of Cos		Inpati ent	
		To Charges	Program	Program Costs	
			Charges	(col. 1 x col.	
		1.00	2. 00	2) 3. 00	
INPATIENT ROUTINE SERVICE COST CENTERS		1.00	2.00	3.00	
30. 00 03000 ADULTS & PEDIATRICS			148, 125		30.00
43. 00   04300   NURSERY			33, 994		43. 00
ANCI LLARY SERVI CE COST CENTERS			33, 774		43.00
50. 00 05000 OPERATING ROOM		0. 08416	55 266, 229	22, 407	50.00
50. 01   05001   OPERATING ROOM		0.00000		0	1
52. 00 05200 DELIVERY ROOM & LABOR ROOM		0. 28305		24, 619	
53. 00 05300 ANESTHESI OLOGY		0. 44995		21,017	1
54. 00 05400 RADI OLOGY-DI AGNOSTI C		0. 09474		4, 826	
60. 00   06000   LABORATORY		0. 17147		11, 994	
62. 30 06250 BLOOD CLOTTING FOR HEMOPHILIACS		0.00000		0	
65. 00 06500 RESPIRATORY THERAPY		0. 23327	17, 268	4, 028	65. 00
66. 00 06600 PHYSI CAL THERAPY		0. 41109	196	81	66. 00
67. 00 06700 OCCUPATI ONAL THERAPY		0. 28299	93 0	0	67. 00
68.00 06800 SPEECH PATHOLOGY		0. 49175	54 259	127	68. 00
69. 00 06900 ELECTROCARDI OLOGY		0.00012	22 11, 234	1	69. 00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT		0. 17407		3, 654	71. 00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS		0. 22804		0	
73.00 07300 DRUGS CHARGED TO PATIENTS		0. 18399		17, 660	
76. 97 07697 CARDIAC REHABILITATION		0.00000		0	1
76. 98 07698 HYPERBARI C OXYGEN THERAPY		0. 23816		0	
76. 99 07699 LI THOTRI PSY		0.00000	00 0	0	76. 99
OUTPATIENT SERVICE COST CENTERS					
90. 00 09000 CLI NI C		0. 19549		0	
91. 00   09100   EMERGENCY		0. 11443		4, 573	
92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART		0. 37654	10 0	0	92. 00
OTHER REIMBURSABLE COST CENTERS					05.00
95. 00 09500 AMBULANCE SERVICES	0/ through 00)		/E0 070	02 070	95. 00
200.00 Total (sum of lines 50 through 94 and Less PBP Clinic Laboratory Services-P			659, 978	93, 970	200. 00 201. 00
201.00 Less PBP Clinic Laboratory Services-P 202.00 Net charges (line 200 minus line 201)	rogram only charges (Tine 61)		450.070		201.00
202. 00      Net charges (Title 200 IIII hus Title 201)		I	659, 978	l	1202.00

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 01/01/2018 To 12/31/2018	Worksheet E Part A Date/Time Prepared: 5/28/2019 10:58 am

	Title XVIII Hospital	5/28/2019 10: 5 PPS	58 am_
		1.00	
	PART A - INPATIENT HOSPITAL SERVICES UNDER IPPS	1.00	
1.00	DRG Amounts Other than Outlier Payments	0	1. 00
1. 01	DRG amounts other than outlier payments for discharges occurring prior to October 1 (see instructions)	2, 278, 214	1. 01
1. 02	DRG amounts other than outlier payments for discharges occurring on or after October 1 (see instructions)	574, 855	1. 02
1.03	DRG for federal specific operating payment for Model 4 BPCI for discharges occurring prior to October 1 (see instructions)	0	1. 03
1.04	DRG for federal specific operating payment for Model 4 BPCI for discharges occurring on or after	0	1. 04
2. 00	October 1 (see instructions) Outlier payments for discharges. (see instructions)	18, 758	2. 00
2. 01 2. 02	Outlier reconciliation amount Outlier payment for discharges for Model 4 BPCI (see instructions)	0	2. 01 2. 02
2. 02 3. 00	Managed Care Simulated Payments	3, 164, 939	3. 00
4. 00	Bed days available divided by number of days in the cost reporting period (see instructions)	31. 37	4. 00
00	Indirect Medical Education Adjustment	01107	00
5.00	FTE count for allopathic and osteopathic programs for the most recent cost reporting period ending on or before 12/31/1996. (see instructions)	0.00	5. 00
6. 00	FTE count for allopathic and osteopathic programs that meet the criteria for an add-on to the cap for new programs in accordance with 42 CFR 413.79(e)	0.00	6. 00
7. 00	MMA Section 422 reduction amount to the IME cap as specified under 42 CFR §412.105(f)(1)(iv)(B)(1)	0.00	7. 00
7. 01	ACA § 5503 reduction amount to the IME cap as specified under 42 CFR §412.105(f)(1)(iv)(B)(2) If the cost report straddles July 1, 2011 then see instructions.	0. 00	7. 01
8. 00	Adjustment (increase or decrease) to the FTE count for allopathic and osteopathic programs for affiliated programs in accordance with 42 CFR 413.75(b), 413.79(c)(2)(iv), 64 FR 26340 (May 12,	0. 00	8. 00
8. 01	1998), and 67 FR 50069 (August 1, 2002). The amount of increase if the hospital was awarded FTE cap slots under § 5503 of the ACA. If the cost	0.00	8. 01
8. 02	report straddles July 1, 2011, see instructions.  The amount of increase if the hospital was awarded FTE cap slots from a closed teaching hospital	0.00	8. 02
9. 00	lunder § 5506 of ACA. (see instructions) Sum of lines 5 plus 6 minus lines (7 and 7.01) plus/minus lines (8, 8,01 and 8,02) (see	0.00	9. 00
10. 00	instructions) FTE count for allopathic and osteopathic programs in the current year from your records	0.00	10. 00
11. 00	FTE count for residents in dental and podiatric programs.	0.00	11. 00
12.00	Current year allowable FTE (see instructions)		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 September 30, 1997, otherwise enter zero.	0.00	14. 00
15. 00	Sum of lines 12 through 14 divided by 3.	0.00	15. 00
16. 00	Adjustment for residents in initial years of the program		16. 00
17.00	Adjustment for residents displaced by program or hospital closure	0.00	17.00
18. 00	Adjusted rolling average FTE count	1	18. 00
19. 00	Current year resident to bed ratio (line 18 divided by line 4).	1	
20.00	Prior year resident to bed ratio (see instructions)	0.000000	
21. 00 22. 00	Enter the lesser of lines 19 or 20 (see instructions)  IME payment adjustment (see instructions)	0.000000	21. 00 22. 00
22. 00	IME payment adjustment - Managed Care (see instructions)	0	22. 00
22.01	Indirect Medical Education Adjustment for the Add-on for § 422 of the MMA		22.01
23. 00	Number of additional allopathic and osteopathic IME FTE resident cap slots under 42 CFR 412.105 $(f)(1)(iv)(C)$ .	0.00	23. 00
24. 00	IME FTE Resident Count Over Cap (see instructions)	0.00	24. 00
25. 00	If the amount on line 24 is greater than -0-, then enter the lower of line 23 or line 24 (see instructions)	0.00	
26. 00	Resident to bed ratio (divide line 25 by line 4)	0. 000000	26. 00
27. 00	IME payments adjustment factor. (see instructions)	0.000000	27.00
28. 00	IME add-on adjustment amount (see instructions)	0	28. 00
28. 01	IME add-on adjustment amount - Managed Care (see instructions)	0	28. 01
29. 00	Total IME payment ( sum of lines 22 and 28)	0	29. 00
29. 01	Total IME payment - Managed Care (sum of lines 22.01 and 28.01) Disproportionate Share Adjustment	0	29. 01
30.00	Percentage of SSI recipient patient days to Medicare Part A patient days (see instructions)	2. 40	30.00
31.00	Percentage of Medicaid patient days (see instructions)	27. 39	31.00
32.00	Sum of lines 30 and 31	29. 79	32.00
33.00	Allowable disproportionate share percentage (see instructions)	12.00	33.00
34.00	Disproportionate share adjustment (see instructions)	85, 593	34.00

ALCUL	ATION OF REIMBURSEMENT SETTLEMENT	Provi der CCN: 15-0091	Peri od: From 01/01/2018 To 12/31/2018		
		Title XVIII	Hospi tal	PPS	
			1.00	On/After 10/1 2.00	
	Uncompensated Care Adjustment		1.00	2.00	
5. 00	Total uncompensated care amount (see instructions)			8, 272, 872, 447	
5. 01	Factor 3 (see instructions)	on zono on this line) (se	0. 000062342		
5. 02	Hospital uncompensated care payment (If line 34 is zero, ent instructions)	er zero on this line) (se	e 421, 849	640, 742	35.0
5. 03	Pro rata share of the hospital uncompensated care payment am	ount (see instructions)	315, 520	161, 502	35.0
6. 00	Total uncompensated care (sum of columns 1 and 2 on line 35.		477, 022		36.0
0. 00	Additional payment for high percentage of ESRD beneficiary d Total Medicare discharges on Worksheet S-3, Part I excluding		911 46)		40.0
	652, 682, 683, 684 and 685 (see instructions)				
1. 00	Total ESRD Medicare discharges excluding MS-DRGs 652, 682, instructions)	683, 684 an 685. (see	0		41.0
1. 01	Total ESRD Medicare covered and paid discharges excluding MS	-DRGs 652, 682, 683, 684			41.0
	an 685. (see instructions)				
2.00	Divide line 41 by line 40 (if less than 10%, you do not qual Total Medicare ESRD inpatient days excluding MS-DRGs 652, 6		0.00	1	42.0
3. 00	ווסנמו שפעוכמופ באט וווף מנופות days excluding שא-טאסs 652, 6 linstructions)	82, 083, 084 an 085. (See	0		43.0
4. 00	Ratio of average length of stay to one week (line 43 divided	by line 41 divided by 7	0. 000000		44.0
5. 00	days) Average weekly cost for dialysis treatments (see instruction	5)	0.00		45.0
6. 00	Total additional payment (line 45 times line 44 times line 4		0.00		46. 0
7. 00	Subtotal (see instructions)	,	3, 434, 442		47. 0
8. 00	Hospital specific payments (to be completed by SCH and MDH,	small rural hospitals	0		48. (
	only. (see instructions)			Amount	
				1. 00	
9. 00	Total payment for inpatient operating costs (see instruction			3, 434, 442	
0. 00	Payment for inpatient program capital (from Wkst. L, Pt. I a Exception payment for inpatient program capital (Wkst. L, Pt			231, 179 0	1
2. 00	Direct graduate medical education payment (from Wkst. E-4, I				1
3. 00	Nursing and Allied Health Managed Care payment	,		0	53. (
4. 00	Special add-on payments for new technologies			0	54. (
4. 01 5. 00	Islet isolation add-on payment	40)		0	54. ( 55. (
6. 00	Net organ acquisition cost (Wkst. D-4 Pt. III, col. 1, line Cost of physicians' services in a teaching hospital (see int				56.
7. 00	Routine service other pass through costs (from Wkst. D, Pt.	•	hrough 35).	Ō	57.
8. 00	Ancillary service other pass through costs from Wkst. D, Pt.	IV, col. 11 line 200)		0	58.
9.00	Total (sum of amounts on lines 49 through 58)			3, 665, 621	1
0.00	Primary payer payments Total amount payable for program beneficiaries (line 59 minu	s line 60)		8, 682 3, 656, 939	1
2. 00	Deductibles billed to program beneficiaries	3 11110 00)		492, 615	
3. 00				0	1
4. 00	1			42, 524	
5. 00	, ,			27, 641	1
6.00	Allowable bad debts for dual eligible beneficiaries (see ins	tructions)		19, 554	1
7. 00 8. 00	Subtotal (line 61 plus line 65 minus lines 62 and 63) Credits received from manufacturers for replaced devices for	annlicable to MS_DRCs (s	ee instructions)	3, 191, 965 0	
9. 00	Outlier payments reconciliation (sum of lines 93, 95 and 96)			Ö	69.
0.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)		,	0	70.
0. 50	Rural Community Hospital Demonstration Project (§410A Demons		instructions)	0	70.
0. 87	Demonstration payment adjustment amount before sequestration			0	70.
0. 88 0. 89	SCH or MDH volume decrease adjustment (contractor use only)	tructions)		0	70. 70.
	Pioneer ACO demonstration payment adjustment amount (see ins HSP bonus payment HVBP adjustment amount (see instructions)	ti deti diis)		0	1
	HSP bonus payment HRR adjustment amount (see instructions)			Ö	1
0. 90 0. 91	This bonds payment that adjustment amount (see this true trons)				1
0. 90	Bundled Model 1 discount amount (see instructions)			0	70.
0. 90 0. 91	, , , , , , , , , , , , , , , , , , , ,			0 32, 017 -2, 185	70.

Health Financial Systems	HUNTINGTON MEMORIAL HOSPITAL		In Lie	u of Form CMS-2	2552-10
CALCULATION OF REIMBURSEMENT SETTLEMENT	Provider Co	CN: 15-0091	Peri od: From 01/01/2018 To 12/31/2018	Worksheet E Part A Date/Time Pre 5/28/2019 10:	
	Title	XVIII	Hospi tal	PPS	
		FFY	(уууу)	Amount	

				To 12/31/2018	Date/Time Pre	pared:
		Title	e XVIII	Hospi tal	5/28/2019 10: PPS	58 am_
		11116		(yyyy)	Amount	
				0	1. 00	
70. 96	Low volume adjustment for federal fiscal year (yyyy) (Enter in	n column 0		018	432, 423	70. 96
	the corresponding federal year for the period prior to 10/1)					
70. 97	Low volume adjustment for federal fiscal year (yyyy) (Enter in	n column O	20	019	117, 007	70. 97
	the corresponding federal year for the period ending on or aff					
70. 98	Low Volume Payment-3				0	70. 98
70. 99	HAC adjustment amount (see instructions)				8, 845	
71. 00	Amount due provider (line 67 minus lines 68 plus/minus lines 6	69 & 70)			3, 762, 382	
71. 01	Sequestration adjustment (see instructions)				75, 248	
71. 02	Demonstration payment adjustment amount after sequestration				0	71. 02
72. 00	Interim payments				3, 704, 987	
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	2, 72, and			-17, 853	74. 00
75 00	[73]				00 070	75 00
75. 00	Protested amounts (nonallowable cost report items) in accordan	nce with			80, 878	75. 00
	CMS Pub. 15-2, chapter 1, §115.2  TO BE COMPLETED BY CONTRACTOR (lines 90 through 96)					
90. 00	Operating outlier amount from Wkst. E, Pt. A, line 2, or sum of	of 2 02			0	90. 00
90.00	plus 2.04 (see instructions)	01 2.03			U	90.00
91. 00	Capital outlier from Wkst. L, Pt. I, line 2				0	91. 00
92. 00	Operating outlier reconciliation adjustment amount (see instru	uctions)			0	92. 00
93. 00	Capital outlier reconciliation adjustment amount (see instruction)				0	93. 00
94. 00	The rate used to calculate the time value of money (see instru				0.00	
95. 00	Time value of money for operating expenses (see instructions)	uc (1 0113)			0.00	95. 00
96. 00	Time value of money for capital related expenses (see instructions)	tions)			0	96. 00
70.00	Time varies or money for each tell refuted expenses (see first de	tr ons)		Prior to 10/1		70.00
				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			T		
	HVBP adjustment factor (see instructions)	,		1. 0123297327	1. 0068310850	
102.00	HVBP adjustment amount for HSP bonus payment (see instructions	S)		] 0	0	102. 00
100.00	HRR Adjustment for HSP Bonus Payment			0.0000	0.0000	100.00
	HRR adjustment factor (see instructions)			0.0000	0.0000	
104.00	HRR adjustment amount for HSP bonus payment (see instructions)			0	0	104. 00
200 00	Rural Community Hospital Demonstration Project (§410A Demonstr					200 00
200.00	Is this the first year of the current 5-year demonstration per Century Cures Act? Enter "Y" for yes or "N" for no.	i i od under t	ille 21St			200. 00
	Cost Reimbursement					
201 00	Medicare inpatient service costs (from Wkst. D-1, Pt. II, line	a 49)				201. 00
	Medicare discharges (see instructions)	, ,				202. 00
	Case-mix adjustment factor (see instructions)					203. 00
	Computation of Demonstration Target Amount Limitation (N/A in	first year	of the current	5-year demonst	rati on	
	peri od)	,		,		
204.00	Medicare target amount					204. 00
205.00	Case-mix adjusted target amount (line 203 times line 204)					205. 00
						206. 00
206.00	Medicare inpatient routine cost cap (line 202 times line 205)					200.00
206.00						200.00
207.00	Medicare inpatient routine cost cap (line 202 times line 205) Adjustment to Medicare Part A Inpatient Reimbursement Program reimbursement under the §410A Demonstration (see insti					207. 00
207. 00 208. 00	Medicare inpatient routine cost cap (line 202 times line 205) Adjustment to Medicare Part A Inpatient Reimbursement Program reimbursement under the §410A Demonstration (see insti- Medicare Part A inpatient service costs (from Wkst. E, Pt. A,					207. 00 208. 00
207. 00 208. 00 209. 00	Medicare inpatient routine cost cap (line 202 times line 205) Adjustment to Medicare Part A Inpatient Reimbursement Program reimbursement under the §410A Demonstration (see institute Medicare Part A inpatient service costs (from Wkst. E, Pt. A, Adjustment to Medicare IPPS payments (see instructions)					207. 00 208. 00 209. 00
207. 00 208. 00 209. 00 210. 00	Medicare inpatient routine cost cap (line 202 times line 205) Adjustment to Medicare Part A Inpatient Reimbursement Program reimbursement under the §410A Demonstration (see institute Medicare Part A inpatient service costs (from Wkst. E, Pt. A, Adjustment to Medicare IPPS payments (see instructions) Reserved for future use					207. 00 208. 00 209. 00 210. 00
207. 00 208. 00 209. 00 210. 00	Medicare inpatient routine cost cap (line 202 times line 205) Adjustment to Medicare Part A Inpatient Reimbursement Program reimbursement under the \$410A Demonstration (see instructions) Medicare Part A inpatient service costs (from Wkst. E, Pt. A, Adjustment to Medicare IPPS payments (see instructions) Reserved for future use Total adjustment to Medicare IPPS payments (see instructions)					207. 00 208. 00 209. 00
207. 00 208. 00 209. 00 210. 00 211. 00	Medicare inpatient routine cost cap (line 202 times line 205) Adjustment to Medicare Part A Inpatient Reimbursement Program reimbursement under the \$410A Demonstration (see instructions) Medicare Part A inpatient service costs (from Wkst. E, Pt. A, Adjustment to Medicare IPPS payments (see instructions) Reserved for future use Total adjustment to Medicare IPPS payments (see instructions) Comparision of PPS versus Cost Reimbursement	line 59)				207. 00 208. 00 209. 00 210. 00 211. 00
207. 00 208. 00 209. 00 210. 00 211. 00	Medicare inpatient routine cost cap (line 202 times line 205) Adjustment to Medicare Part A Inpatient Reimbursement Program reimbursement under the §410A Demonstration (see instructions) Medicare Part A inpatient service costs (from Wkst. E, Pt. A, Adjustment to Medicare IPPS payments (see instructions) Reserved for future use Total adjustment to Medicare IPPS payments (see instructions) Comparision of PPS versus Cost Reimbursement Total adjustment to Medicare Part A IPPS payments (from line 2	line 59)				207. 00 208. 00 209. 00 210. 00 211. 00
207. 00 208. 00 209. 00 210. 00 211. 00 212. 00 213. 00	Medicare inpatient routine cost cap (line 202 times line 205) Adjustment to Medicare Part A Inpatient Reimbursement Program reimbursement under the §410A Demonstration (see instructions) Medicare Part A inpatient service costs (from Wkst. E, Pt. A, Adjustment to Medicare IPPS payments (see instructions) Reserved for future use Total adjustment to Medicare IPPS payments (see instructions) Comparision of PPS versus Cost Reimbursement Total adjustment to Medicare Part A IPPS payments (from line 2 Low-volume adjustment (see instructions)	line 59) 211)				207. 00 208. 00 209. 00 210. 00 211. 00 212. 00 213. 00
207. 00 208. 00 209. 00 210. 00 211. 00 212. 00 213. 00	Medicare inpatient routine cost cap (line 202 times line 205) Adjustment to Medicare Part A Inpatient Reimbursement Program reimbursement under the §410A Demonstration (see instructions) Medicare Part A inpatient service costs (from Wkst. E, Pt. A, Adjustment to Medicare IPPS payments (see instructions) Reserved for future use Total adjustment to Medicare IPPS payments (see instructions) Comparision of PPS versus Cost Reimbursement Total adjustment to Medicare Part A IPPS payments (from line 2	line 59) 211)	nbursement)			207. 00 208. 00 209. 00 210. 00 211. 00

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 01/01/2018 To 12/31/2018	Worksheet E Part B Date/Time Prepared: 5/28/2019 10:58 am

			10 12/01/2010	5/28/2019 10:	
		Title XVIII	Hospi tal	PPS	
				1. 00	
	PART B - MEDICAL AND OTHER HEALTH SERVICES				
1.00	Medical and other services (see instructions)			0	
2.00	Medical and other services reimbursed under OPPS (see instructions)	tions)		3, 330, 080	
3.00	OPPS payments			3, 066, 252	
4.00	Outlier payment (see instructions)			4, 112	4.00
4. 01	Outlier reconciliation amount (see instructions)	ations)		0 0. 859	4. 01
5. 00 6. 00	Enter the hospital specific payment to cost ratio (see instruction 2 times line 5	etrons)		2, 860, 539	5. 00 6. 00
7. 00	Sum of lines 3, 4, and 4.01, divided by line 6			2, 860, 539 0. 00	
8.00	Transitional corridor payment (see instructions)			0.00	
9. 00	Ancillary service other pass through costs from Wkst. D, Pt. I	V col 13 line 200		0	9. 00
10. 00	Organ acquisitions	v, cor. 13, 11110 200		0	10.00
11. 00	Total cost (sum of lines 1 and 10) (see instructions)			0	
	COMPUTATION OF LESSER OF COST OR CHARGES				
	Reasonable charges				
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	13.00
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 patients	payment for services on a	a charge basis	0	15. 00
16.00	Amounts that would have been realized from patients liable for	r payment for services o	n a chargebasis	0	16. 00
	had such payment been made in accordance with 42 CFR §413.13(e	e)			
17. 00	Ratio of line 15 to line 16 (not to exceed 1.000000)			0. 000000	
18. 00	Total customary charges (see instructions)	1011 10	44) (	0	
19. 00	Excess of customary charges over reasonable cost (complete onl	y if line 18 exceeds li	ne 11) (see	0	19. 00
20.00	instructions)	: 6   ! 11     ! !	10) (		20.00
20. 00	Excess of reasonable cost over customary charges (complete onlinstructions)	y II II ne II exceeds III	16 18) (See	0	20. 00
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	23. 00
24. 00	Total prospective payment (sum of lines 3, 4, 4.01, 8 and 9)	,		3, 070, 364	
	COMPUTATION OF REIMBURSEMENT SETTLEMENT			.,	
25.00	Deductibles and coinsurance amounts (for CAH, see instructions	s)		620, 597	25. 00
26.00	Deductibles and Coinsurance amounts relating to amount on line	e 24 (for CAH, see instr	uctions)	0	26. 00
27. 00	Subtotal [(lines 21 and 24 minus the sum of lines 25 and 26) p	olus the sum of lines 22	and 23] (see	2, 449, 767	27. 00
	instructions)				
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, 449, 767	
31.00	Primary payer payments			929	
32. 00	Subtotal (line 30 minus line 31) ALLOWABLE BAD DEBTS (EXCLUDE BAD DEBTS FOR PROFESSIONAL SERVICE)	re)		2, 448, 838	32. 00
33. 00	Composite rate ESRD (from Wkst. I-5, line 11)	,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,		0	33. 00
34. 00	Allowable bad debts (see instructions)			104, 747	
35. 00	Adjusted reimbursable bad debts (see instructions)			68, 086	
36. 00	Allowable bad debts for dual eligible beneficiaries (see instr	ructions)		88, 243	
37. 00	Subtotal (see instructions)	,		2, 516, 924	
38. 00	MSP-LCC reconciliation amount from PS&R			0	
39.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)			0	39. 00
39. 50	Pioneer ACO demonstration payment adjustment (see instructions	s)			39. 50
39. 97	Demonstration payment adjustment amount before sequestration			0	39. 97
39. 98	Partial or full credits received from manufacturers for replace	ced devices (see instruc	tions)	0	39. 98
39. 99	RECOVERY OF ACCELERATED DEPRECIATION			0	39. 99
40.00	Subtotal (see instructions)			2, 516, 924	
40. 01	Sequestration adjustment (see instructions)			50, 338	
40. 02	Demonstration payment adjustment amount after sequestration			0	40. 02
41.00	Interim payments			2, 395, 820	
42.00	Tentative settlement (for contractors use only)			0	42.00
43.00	Balance due provider/program (see instructions)	and with CMC Dub. 1E 3	abantan 1	70, 766	
44. 00	Protested amounts (nonallowable cost report items) in accordar §115.2	ice with CMS Pub. 15-2, (	Jiiapter" I,	0	44. 00
	TO BE COMPLETED BY CONTRACTOR				
90. 00	Original outlier amount (see instructions)			0	90. 00
91. 00	Outlier reconciliation adjustment amount (see instructions)			0	91.00
92. 00	The rate used to calculate the Time Value of Money			0.00	
93. 00	Time Value of Money (see instructions)			0	
	Total (sum of lines 91 and 93)				94. 00
			'		

Health Financial Systems HUNTI
ANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED Provider CCN: 15-0091

					5/28/2019 10: 5	58 am
		Title	XVIII	Hospi tal	PPS	
		Inpatien	t Part A	Par	rt B	
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount	
		1. 00		3. 00	4.00	
1.00	Total interim payments paid to provider			37	2, 395, 820	1. 00
2.00	Interim payments payable on individual bills, either			0	l ol	2.00
	submitted or to be submitted to the contractor for					
	services rendered in the cost reporting period. If none,					
	write "NONE" or enter a zero					
3.00	List separately each retroactive lump sum adjustment					3.00
	amount based on subsequent revision of the interim rate					
	for the cost reporting period. Also show date of each					
	payment. If none, write "NONE" or enter a zero. (1)					
	Program to Provider					
3. 01	ADJUSTMENTS TO PROVIDER					
3. 02				-		
3. 03						
3.04				*		
3. 05	Describer to Describe			<u>O</u>	0	3. 05
3. 50	Provider to Program ADJUSTMENTS TO PROGRAM					2 50
3. 50	ADJUSTIMENTS TO PROGRAM					
3. 52				-	1 - 1	
3. 53				-		
3. 54				-		
3. 99	Subtotal (sum of lines 3.01-3.49 minus sum of lines				- 1	
0. ,,	3. 50-3. 98)					0. ,,
4.00	Total interim payments (sum of lines 1, 2, and 3.99)		3, 704, 98	37	2, 395, 820	4.00
	(transfer to Wkst. E or Wkst. E-3, line and column as					
	appropri ate)					
	TO BE COMPLETED BY CONTRACTOR					
5.00	List separately each tentative settlement payment after					5. 00
	desk review. Also show date of each payment. If none,					
	write "NONE" or enter a zero. (1)					
5. 01	Program to Provider TENTATIVE TO PROVIDER		I			E 01
5. 01	TENTATIVE TO PROVIDER					
5. 02				-	1 - 1	
5.05	Provider to Program			<u> </u>	0	5. 05
5. 50	TENTATI VE TO PROGRAM			0	0	5, 50
5. 51				*	l ol	5. 51
5. 52				0	0	5. 52
5. 99	Subtotal (sum of lines 5.01-5.49 minus sum of lines			0	0	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			-		
6. 02	SETTLEMENT TO PROGRAM		,	-	0	
7. 00	Total Medicare program liability (see instructions)	Inpatient Part A				
		,	1			
8. 00	Name of Contractor		J	1.00	2.00	8. 00
0.00	Name of Softfactor			1	1	0.00

Heal th	Financial Systems HUNTINGTON MEMORIA	AL HOSPITAL	In Lie	u of Form CMS-	2552-10
CALCUL	ATION OF REIMBURSEMENT SETTLEMENT FOR HIT	Provider CCN: 15-0091	Peri od: From 01/01/2018 To 12/31/2018		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				
1.00	Total hospital discharges as defined in AARA §4102 from Wkst.	S-3, Pt. I col. 15 line	e 14		1. 00
2.00	Medicare days 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	-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 l	ine 20			6. 00
7. 00	CAH only - The reasonable cost incurred for the purchase of cline 168	ertified 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
22 00	Polones due provider (line 0 (er line 10) minus line 20 and l	ina 21) (aaa imatmustian	20)		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)

Provider CCN: 15-0091 Period: From 01/0

Period: Worksheet G From 01/01/2018 To 12/31/2018 Date/Time Prepared: 5/28/2019 10:58 am

oni y)					5/28/2019 10:	58 am
		General Fund		Endowment Fund	Plant Fund	
		1.00	Purpose Fund 2.00	3. 00	4. 00	
	CURRENT ASSETS					
1.00	Cash on hand in banks	2, 676		0	0	
2.00	Temporary investments	0	0	0	0	2.00
3. 00 4. 00	Notes recei vabl e Accounts recei vabl e	22, 365, 676		0	0	
5. 00	Other recei vable	1, 826, 461		o	0	
6.00	Allowances for uncollectible notes and accounts receivable	-14, 418, 307	1	0	0	1
7.00	Inventory	411, 303	1	0	0	1
8.00	Prepaid expenses	33, 077	1	0	0	1
9. 00 10. 00	Other current assets Due from other funds	0 -14, 267, 224	1	0	0	
11. 00	Total current assets (sum of lines 1-10)	-4, 046, 338	1	_	0	1
11.00	FIXED ASSETS	1,040,330		<u> </u>	0	11.00
12.00	Land	0	0	0	0	12. 00
13.00	Land improvements	556, 529	1	0	0	
14. 00	Accumulated depreciation	-354, 671	1	0	0	1
15. 00 16. 00	Buildings Accumulated depreciation	2, 370, 508 -1, 325, 810	1	0	0	
17. 00	Leasehold improvements	32, 500	1	0	0	17. 00
18. 00	Accumulated depreciation	-32, 500	1	ő	Ö	1
19. 00	Fi xed equipment	589, 100	0	0	0	19. 00
20. 00	Accumulated depreciation	-508, 311	1	0	0	
21. 00	Automobiles and trucks	1, 376, 077	1	0	0	
22. 00 23. 00	Accumulated depreciation Major movable equipment	-802, 154 10, 587, 649	1	0	0	
24. 00	Accumulated depreciation	-8, 551, 486	1	0	0	24. 00
25. 00	Mi nor equi pment depreci abl e	1, 464, 154		ő	Ö	25. 00
26.00	Accumulated depreciation	-796, 431	1	0	0	26. 00
27. 00	HIT designated Assets	0	_	0	0	
28. 00	Accumulated depreciation	0	0	0	0	
29. 00 30. 00	Minor equipment-nondepreciable Total fixed assets (sum of lines 12-29)	7, 024, 107 11, 629, 261	l .	0	0	
30.00	OTHER ASSETS	11,029,201	1 0	l o	0	30.00
31.00	Investments	36, 377, 785	0	0	0	31. 00
32.00	Deposits on Leases	0	0	0	0	32. 00
33. 00	Due from owners/officers	0	0	0	0	1
34. 00	Other assets	301, 113	1	0	0	
35. 00 36. 00	Total other assets (sum of lines 31-34) Total assets (sum of lines 11, 30, and 35)	36, 678, 898 44, 261, 821	1	0	0	
30.00	CURRENT LIABILITIES	44, 201, 021		<u> </u>	0	30.00
37.00	Accounts payable	1, 901, 576	0	0	0	37. 00
38. 00	Salaries, wages, and fees payable	830, 393	0	0	0	
39. 00	Payroll taxes payable	0	0	0	0	1
40. 00 41. 00	Notes and Loans payable (short term) Deferred income	44, 564	0	0	0	40. 00 41. 00
42. 00	Accel erated payments			O O	0	42.00
43. 00	Due to other funds	0	O	0	0	
44.00	Other current liabilities	32, 370	0	0	0	44. 00
45. 00	Total current liabilities (sum of lines 37 thru 44)	2, 808, 903	0	0	0	45. 00
47 00	LONG TERM LIABILITIES	1 0	1 0	٥	0	47 00
46. 00 47. 00	Mortgage payable Notes payable	66, 385	0	0	0	
48. 00	Unsecured Loans	00, 303	Ö	0	0	1
49. 00	Other long term liabilities	55, 113		0	0	1
50.00	Total long term liabilities (sum of lines 46 thru 49)	121, 498		0	0	
51. 00	Total liabilities (sum of lines 45 and 50)	2, 930, 401	0	0	0	51. 00
E2 00	CAPITAL ACCOUNTS  General fund balance	41, 331, 420				E2 00
52. 00 53. 00	Specific purpose fund	41, 331, 420	o			52. 00 53. 00
54. 00	Donor created - endowment fund balance - restricted			0		54. 00
55. 00	Donor created - endowment fund balance - unrestricted			o		55. 00
56. 00	Governing body created - endowment fund balance			0		56. 00
57. 00	Plant fund balance - invested in plant				0	1
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, 331, 420	0	0	0	59. 00
60.00	Total liabilities and fund balances (sum of lines 51 and	44, 261, 821	1	0	0	60.00
	[59]					

Provider CCN: 15-0091

					То	12/31/2018	Date/Time Prep 5/28/2019 10:5	
		General	Fund	Speci al	Pur	pose Fund	Endowment Fund	30 diii
		1.00		2 22			5.00	
1 00	[F.m.] balance at basins as a second	1.00	2.00	3. 00		4. 00	5. 00	1 00
1. 00 2. 00	Fund balances at beginning of period Net income (loss) (from Wkst. G-3, line 29)		41, 289, 000 11, 308, 684			0		1. 00 2. 00
3.00	Total (sum of line 1 and line 2)		52, 597, 684			0		3. 00
4. 00	Additions (credit adjustments) (specify)	0	32, 377, 004		0	O	0	4. 00
5. 00	NONALLOWABLE HOME OFFICE INTEREST	608, 567			0		ő	5. 00
6.00	FOUNDATION TRANSFERS	19, 169			0		o	6. 00
7.00		0			0		0	7. 00
8.00		0			0		0	8.00
9.00		0			0		0	9. 00
10.00	Total additions (sum of line 4-9)		627, 736			0		10.00
11. 00	Subtotal (line 3 plus line 10)		53, 225, 420			0		11.00
12. 00	Deductions (debit adjustments) (specify)	0			0		0	12.00
13. 00	TRANSFERS TO PARKVIEW HEALTH SYSTEM	11, 894, 000			0		0	13. 00
14.00		0			0		0	14.00
15.00		0			0		0	15. 00 16. 00
16. 00 17. 00					0		0	17. 00
18. 00	Total deductions (sum of lines 12-17)		11, 894, 000		U	0	١	18. 00
19. 00	Fund balance at end of period per balance		41, 331, 420			0		19. 00
	sheet (line 11 minus line 18)		,,			_		
		Endowment Fund	PI ant	Fund				
4 00		6.00	7. 00	8. 00				1.00
1.00	Fund balances at beginning of period	0			0			1. 00 2. 00
2. 00 3. 00	Net income (loss) (from Wkst. G-3, line 29) Total (sum of line 1 and line 2)				0			2. 00 3. 00
4.00	Additions (credit adjustments) (specify)		0		U			4. 00
5.00	NONALLOWABLE HOME OFFICE INTEREST		0					5. 00
6.00	FOUNDATION TRANSFERS		0					6. 00
7. 00			0					7. 00
8.00			0					8.00
9.00			0					9.00
10.00	Total additions (sum of line 4-9)	0			0			10.00
11. 00	Subtotal (line 3 plus line 10)	0			0			11.00
12. 00	Deductions (debit adjustments) (specify)		0					12.00
13. 00	TRANSFERS TO PARKVIEW HEALTH SYSTEM		0					13.00
14.00			0					14.00
15. 00 16. 00			0					15. 00 16. 00
17. 00		1	0					17. 00
18.00	Total deductions (sum of lines 12-17)		U		0			17. 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

		T	o 12/31/2018	Date/Time Prep 5/28/2019 10:	
	Cost Center Description	Inpati ent	Outpati ent	Total	
	'	1.00	2.00	3. 00	
	PART I - PATIENT REVENUES				
	General Inpatient Routine Services				
1.00	Hospi tal	8, 019, 409		8, 019, 409	1. 00
2.00	SUBPROVI DER - I PF				2. 00
3.00	SUBPROVI DER - I RF				3. 00
4.00	SUBPROVI DER				4. 00
5.00	Swing bed - SNF	0		0	5. 00
6.00	Swing bed - NF	0		0	6. 00
7. 00	SKILLED NURSING FACILITY				7. 00
8.00	NURSI NG FACILITY				8. 00
9.00	OTHER LONG TERM CARE	0.010.100		0.040.400	9. 00
10. 00	Total general inpatient care services (sum of lines 1-9)	8, 019, 409		8, 019, 409	10. 00
44.00	Intensive Care Type Inpatient Hospital Services				44 00
11.00	INTENSIVE CARE UNIT				11.00
12. 00 13. 00	CORONARY CARE UNIT BURN INTENSIVE CARE UNIT				12. 00 13. 00
14. 00					14. 00
15. 00	SURGICAL INTENSIVE CARE UNIT OTHER SPECIAL CARE (SPECIFY)				15. 00
16. 00	Total intensive care type inpatient hospital services (sum of lines			0	16. 00
10.00	11-15)			U	16.00
17. 00	Total inpatient routine care services (sum of lines 10 and 16)	8, 019, 409		8, 019, 409	17. 00
18. 00	Ancillary services	38, 076, 120		38, 076, 120	18. 00
19. 00	Outpatient services	30, 070, 120		128, 408, 135	19. 00
20. 00	RURAL HEALTH CLINIC			0	20.00
21. 00	FEDERALLY QUALIFIED HEALTH CENTER		-	0	21. 00
22. 00	HOME HEALTH AGENCY			J.	22. 00
23. 00	AMBULANCE SERVICES		14, 573, 677	14, 573, 677	23. 00
24. 00	CMHC		,	,	24. 00
25. 00	AMBULATORY SURGICAL CENTER (D. P. )				25. 00
26.00	HOSPI CE				26. 00
27.00	OTHER (SPECIFY)		0	0	27. 00
28.00	Total patient revenues (sum of lines 17-27)(transfer column 3 to Wkst.	46, 095, 529	142, 981, 812	189, 077, 341	28. 00
	G-3, line 1)				
	PART II - OPERATING EXPENSES				
29. 00	Operating expenses (per Wkst. A, column 3, line 200)		52, 880, 981		29. 00
30.00	ADD (SPECIFY)	0			30.00
31. 00	HOME OFFICE INTEREST EXPENSE	608, 567			31. 00
32.00		C			32. 00
33. 00		C			33. 00
34. 00		0			34.00
35. 00	T	C			35.00
36.00	Total additions (sum of lines 30-35)		608, 567		36. 00
37. 00	DEDUCT (SPECIFY)	0			37. 00
38. 00		0			38. 00
39. 00					39. 00
40.00		0			40.00
41. 00 42. 00	Total deductions (sum of lines 37-41)				41. 00 42. 00
42.00	Total operating expenses (sum of lines 29 and 36 minus line 42)(transfer		53, 489, 548		42.00
43.00	to Wkst. G-3, line 4)		33, 407, 346		73.00

	Financial Systems HUNTINGTO MENT OF REVENUES AND EXPENSES	ON MEMORIAL HOSPITAL  Provider CCN: 15-0091	Peri od:	u of Form CMS-2 Worksheet G-3	
317(12)	ENT OF REVENUES AND ENTEROES	17607467 660. 16 6677	From 01/01/2018 To 12/31/2018		pared:
	·				
				1.00	
1.00	Total patient revenues (from Wkst. G-2, Part I, colum			189, 077, 341	
2.00	Less contractual allowances and discounts on patients	s' accounts		125, 128, 829	
3.00	Net patient revenues (line 1 minus line 2)			63, 948, 512	
4.00	Less total operating expenses (from Wkst. G-2, Part I			53, 489, 548	
5.00	Net income from service to patients (line 3 minus lir	ne 4)		10, 458, 964	5.00
	OTHER INCOME				
6.00	Contributions, donations, bequests, etc			0	6. 00
7.00	Income from investments			-901, 749	
8.00	Revenues from telephone and other miscellaneous commu	unication services		0	
9.00	Revenue from television and radio service			0	
10.00	Purchase di scounts			0	
11. 00				0	
12.00				0	1
	Revenue from Laundry and Linen service			0	13. 00
14.00	Revenue from meals sold to employees and guests			162, 601	
15. 00				0	
16. 00		o other than patients		0	
	Revenue from sale of drugs to other than patients			0	
	Revenue from sale of medical records and abstracts			0	
19. 00	Tuition (fees, sale of textbooks, uniforms, etc.)			0	
20.00		en		0	1 -0.00
	Rental of vending machines			0	1 00
22. 00	Rental of hospital space			0	
23.00	Governmental appropriations			0	23. 00
24.00	OTHER (SPECIFY)			0	24. 00
24. 01	GAIN/(LOSS) ON SALE OF CAPITAL ASSET			-10, 183	24. 01
24. 02	EMS SUBSIDY			556, 440	24. 02
24. 03	OTHER OPERATING REVENUE			1, 042, 611	24. 03
25.00	Total other income (sum of lines 6-24)			849, 720	25. 00
26.00	Total (line 5 plus line 25)			11, 308, 684	26. 00
27. 00	OTHER EXPENSES (SPECIFY)			0	27. 00
28.00	Total other expenses (sum of line 27 and subscripts)			0	28.00

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

11, 308, 684 29. 00

0 28. 00

ALCUL	ATION OF CAPITAL PAYMENT	Provider CCN: 15-0091	Period: From 01/01/2018 To 12/31/2018	Worksheet L Parts I-III Date/Time Pre 5/28/2019 10:	
		Title XVIII	Hospi tal	PPS	30 ai
				1. 00	
	PART I - FULLY PROSPECTIVE METHOD				
	CAPITAL FEDERAL AMOUNT				
00	Capital DRG other than outlier			229, 344	1.
01	Model 4 BPCI Capital DRG other than outlier			0	
00	Capital DRG outlier payments			1, 835	
01	Model 4 BPCI Capital DRG outlier payments			0	I
00	Total inpatient days divided by number of days in the cost	reporting period (see ins	tructi ons)	12. 42	
00	Number of interns & residents (see instructions)			0.00	
. 00	Indirect medical education percentage (see instructions)	£   ; 1 1 0:	1! 1!	0.00	
00	Indirect medical education adjustment (multiply line 5 by t 1.01) (see instructions)			0	
00	Percentage of SSI recipient patient days to Medicare Part A 30) (see instructions)	,	E, part A line	0. 00	
00	Percentage of Medicaid patient days to total days (see inst	ructions)		0. 00	
00	Sum of lines 7 and 8			0. 00	
0.00	Allowable disproportionate share percentage (see instruction	ons)		0.00	
. 00	Disproportionate share adjustment (see instructions)			0	1
2. 00	Total prospective capital payments (see instructions)			231, 179	12.
				1. 00	
	PART II - PAYMENT UNDER REASONABLE COST			1.00	
00	Program inpatient routine capital cost (see instructions)			0	1.
00	Program inpatient ancillary capital cost (see instructions)			0	2.
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				
00	Program inpatient capital costs (see instructions)			0	
00	Program inpatient capital costs for extraordinary circumsta	nces (see instructions)		0	
00	Net program inpatient capital costs (line 1 minus line 2)			0	
00	Applicable exception percentage (see instructions)			0. 00	
00	Capital cost for comparison to payments (line 3 x line 4)			0	
00	Percentage adjustment for extraordinary circumstances (see	,		0.00	
00	Adjustment to capital minimum payment level for extraordina	ary circumstances (line 2 :	x line 6)	0	
00 00	Capital minimum payment level (line 5 plus line 7)	uli aabla)		0	
. 00	Current year capital payments (from Part I, line 12, as app Current year comparison of capital minimum payment level to		Loss Lino (1)	0	
. 00	Carryover of accumulated capital minimum payment level over			0	1
00	Worksheet L, Part III, line 14)   Net comparison of capital minimum payment level to capital	paymonts (line 10 plus li	20 11)	0	12.
. 00	Current year exception payment (if line 12 is positive, ent			0	
$\cap$	Carryover of accumulated capital minimum payment level over		′	0	
		capital payment for the	iorrowing period	U	14
	(if line 12 is possible onter the amount on this line)				
1. 00	(if line 12 is negative, enter the amount on this line)	nstructions)		<u> </u>	15
3. 00 4. 00 5. 00 6. 00	Current year allowable operating and capital payment (see i			0	