This report is required by law (42 USC 1395g; 42 CFR 413.20(b)). Failure to report can result in all interim FORM APPROVED payments made since the beginning of the cost reporting period being deemed overpayments (42 USC 1395g). OMB NO. 0938-0050 EXPIRES 03-31-2022 HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX COST REPORT CERTIFICATION | Provider CCN: 15-0091 Worksheet S Peri od: From 01/01/2019 Parts I-III AND SETTLEMENT SUMMARY 12/31/2019 Date/Time Prepared: 6/26/2020 11:24 am PART I - COST REPORT STATUS Provi der 1. [X] Electronically prepared cost report Date: 6/26/2020 Time: 11:24 am Manually prepared cost report use only] If this is an amended report enter the number of times the provider resubmitted this cost report] Medicare Utilization. Enter "F" for full or "L" for low. 6. Date Received: 7. Contractor No. Contractor 10. NPR Date:]Cost Report Status (1) As Submitted

7. Contractor No.

(2) Settled without Audit 8. [N] Initial Report for this Provider CCN 12. [0] If line 5, column 1 is 4: Enter (3) Settled with Audit

9. [N] Final Report for this Provider CCN | number of times reopened = 0-9. 11. Contractor's Vendor Code: use only (3) Settled with Audit number of times reopened = 0-9. (4) Reopened

PART II - CERTIFICATION

(5) Amended

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

CERTIFICATION BY 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 01/01/2019 and ending 12/31/2019 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.

(Si gned) JEANNE' WICKENS

Officer or Administrator of Provider(s)

CFO

Title

(Dated when report is electronically signed.)
Date

			Title XVIII				
Cost Center Description		Title V	Part A	Part B	HI T	Title XIX	
		1. 00	2.00	3. 00	4. 00	5. 00	
	PART III - SETTLEMENT SUMMARY						
1.00	Hospi tal	0	-8, 972	39, 336	0	0	1.00
2.00	Subprovider - IPF	0	0	0		0	2.00
3.00	Subprovider - IRF	0	0	0		0	3.00
5.00	Swing Bed - SNF	0	0	0		0	5.00
6.00	Swing Bed - NF	0				0	6.00
200.00	Total	0	-8, 972	39, 336	0	0	200.00

The above amounts represent "due to" or "due from" the applicable program for the element of the above complex indicated. According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0938-0050. The time required to complete and review the information collection is estimated 673 hours per response, including the time to review instructions, search existing resources, gather the data needed, and complete and review the information collection. If you have any comments concerning the accuracy of the time estimate(s) or suggestions for improving the form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Report Clearance Officer, Mail Stop C4-26-05, Baltimore, Maryland 21244-1850. Please do not send applications, claims, payments, medical records or any documents containing sensitive information to the PRA Reports Clearance Office. Please note that any correspondence not pertaining to the information collection burden approved under the associated OMB control number listed on this form will not be reviewed, forwarded, or retained. If you have questions or concerns regarding where to submit your documents, please contact 1-800-MEDICARE.

Health Financial Systems HUNTINGTON MEMORIAL HOSPITAL In Lieu of Form CMS-2552-10 HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA Provi der CCN: 15-0091 Peri od: Worksheet S-2 From 01/01/2019 Part I Date/Time Prepared: 12/31/2019 6/26/2020 11:24 am 3.00 4.00 Hospital and Hospital Health Care Complex Address: Street: 2001 STULTS ROAD 1.00 PO Box: 1.00 State: IN 2.00 City: HUNTINGTON Zip Code: 46750 County: HUNTINGTON 2.00 Component Name CCN CBSA Provi der Date Payment System (P, T, O, or N) 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 3.00 HOSPI TAI Subprovi der - IPF 4.00 4.00 5.00 Subprovi der - IRF 5.00 6.00 Subprovider - (Other) 6.00 Swing Beds - SNF 7 00 7 00 Swing Beds - NF 8.00 8.00 9.00 Hospital-Based SNF 9.00 Hospi tal -Based NF 10.00 10.00 11.00 Hospital -Based OLTC 11.00 12.00 Hospital -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) 01/01/2019 12/31/2019 20.00 21.00 Type of Control (see instructions) 21.00 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. 22.01 Did this hospital receive interim uncompensated care payments for this 22.01 Ν Ν 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) 22.02 Is this a newly merged hospital that requires final uncompensated care Ν Ν 22.02 payments to be determined at cost report settlement? (see instructions) Enter in column 1, "Y" for yes or "N" for no, for the portion of the cost reporting period prior to October 1. Enter in column 2, "Y" for yes or "N" for no, for the portion of the cost reporting period on or after Did this hospital receive a geographic reclassification from urban to 22.03 Ν Ν Ν 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 ves or "N" for no 23.00 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

reporting period? In column 2, enter "Y" for yes or ').					
		In-State	In-State	Out-of	Out-of	Medi cai	d Other	
		Medi cai d	Medi cai d	State	State	HMO day	rs Medicaid	
		pai d days	eligible	Medi cai d	Medi cai d		days	
			unpai d	pai d days	el i gi bl e			
			days		unpai d			
		1.00	2. 00	3. 00	4. 00	5. 00	6. 00	
24.00	If this provider is an IPPS hospital, enter the	87	458	0	4	6	58 0	24.00
	in-state Medicaid paid days in column 1, in-state							
	Medicaid eligible unpaid days in column 2,							
	out-of-state Medicaid paid days in column 3,							
	out-of-state Medicaid eligible unpaid days in column							
	4, Medicaid HMO paid and eligible but unpaid days in							
	column 5, and other Medicaid days in column 6.							

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 01/01/2019 Part I Date/Time Prepared: 12/31/2019 6/26/2020 11:24 am In-State In-State Out-of Out-of Medi cai d 0ther Medi cai d Medi cai d State State HMO days Medi cai d paid days eligible Medi cai d Medi cai d days unpai d pai d days el i gi bl e days unpai d 1.00 2. 00 3. 00 4. 00 5. 00 6. 00 25.00 If this provider is an IRF, enter the in-state 25, 00 \cap 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. Urban/Rural S Date of Geogr 26.00 Enter your standard geographic classification (not wage) status at the beginning of the cost reporting period. Enter "1" for urban or "2" for rural. 26.00 Enter your standard geographic classification (not wage) status at the end of the cost reporting period. Enter in column 1, "1" for urban or "2" for rural. If applicable, 27.00 27.00 enter the effective date of the geographic reclassification in column 2. If this is a sole community hospital (SCH), enter the number of periods SCH status in 35.00 effect in the cost reporting period. Begi nni ng: Endi ng: 1.00 2.00 36.00 Enter applicable beginning and ending dates of SCH status. Subscript line 36 for number 36.00 of periods in excess of one and enter subsequent dates. If this is a Medicare dependent hospital (MDH), enter the number of periods MDH status 37 00 37 00 is in effect in the cost reporting period. Is this hospital a former MDH that is eligible for the MDH transitional payment in 37.01 accordance with FY 2016 OPPS final rule? Enter "Y" for yes or "N" for no. (see instructions) 38 00 If line 37 is 1, enter the beginning and ending dates of MDH status. If line 37 is 38 00 greater than 1, subscript this line for the number of periods in excess of one and enter subsequent dates Y/N Y/N 1.00 2.00 39.00 Does this facility qualify for the inpatient hospital payment adjustment for low volume 39 00 hospitals in accordance with 42 CFR §412.101(b)(2)(i), (ii), or (iii)? Enter in column 1 "Y" for yes or "N" for no. Does the facility meet the mileage requirements in accordance with 42 CFR 412.101(b)(2)(i), (ii), or (iii)? Enter in column 2 "Y" for yes or "N" for no. (see instructions) 40.00 Is this hospital subject to the HAC program reduction adjustment? Enter "Y" for yes or "N" for no in column 1, for discharges prior to October 1. Enter "Y" for yes or "N" for Υ 40 00 Υ no in column 2, for discharges on or after October 1. (see instructions) XVIII 1. 00 2.00 3. 00 Prospective Payment System (PPS)-Capital 45.00 Does this facility qualify and receive Capital payment for disproportionate share in accordance 45.00 Ν Ν Ν with 42 CFR Section §412.320? (see instructions) Is this facility eligible for additional payment exception for extraordinary circumstances Ν Ν Ν 46.00 pursuant to 42 CFR §412.348(f)? If yes, complete Wkst. L, Pt. III and Wkst. L-1, Pt. I through Pt. III. 47.00 | Is this a new hospital under 42 CFR §412.300(b) PPS capital? Enter "Y for yes or "N" for no. Ν Ν 47.00 Ν 48.00 Is the facility electing full federal capital payment? Enter "Y" for yes or "N" for no. N Ν N 48.00 Teaching Hospitals 56.00 Is this a hospital involved in training residents in approved GME programs? Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y", are you impacted by CR 11642 (or subsequent CR), MA N 56.00 GME payment reduction? Enter "Y" for yes or "N" for no in column 2. 57.00 If line 56 is yes, is this the first cost reporting period during which residents in approved Ν 57.00 GME programs trained at this facility? Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y" did residents start training in the first month of this cost reporting period? Enter "Y" for yes or "N" for no in column 2. If column 2 is "Y", complete Worksheet E-4. If column 2 is "N", complete Wkst. D, Parts III & IV and D-2, Pt. II, if applicable. 58.00 If line 56 is yes, did this facility elect cost reimbursement for physicians' services as Ν 58.00 defined in CMS Pub. 15-1, chapter 21, §2148? If yes, complete Wkst. D-5. 59.00 Are costs claimed on line 100 of Worksheet A? If yes, complete Wkst. D-2 59.00 NAHE 413.85 Worksheet A Pass-Through Qualification Y/N Line # Cri teri on Code 1.00 2.00 3.00 60.00 Are you claiming nursing and allied health education (NAHE) costs for Ν 60.00 any programs that meet the criteria under 42 CFR 413.85? (see instructions) Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y", are you impacted by CR 11642 (or subsequent CR) NAHE MA payment adjustement? Enter "Y" for yes or "N" for no in column 2.

		I AL HOSPI TAL			u of Form CMS-2			
OSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DA	TA	Provi der	CCN: 15-0091	Peri od: From 01/01/2019 To 12/31/2019	Date/Time Pre	pared:		
	Y/N	I ME	Direct GME	IME	6/26/2020 11: Direct GME	24 am		
	1.00	2. 00	3.00	4. 00	5. 00	-		
1.00 Did your hospital receive FTE slots under ACA section 5503? Enter "Y" for yes or "N" for no in column 1. (see instructions) 1.01 Enter the average number of unweighted primary care	N			0.00	0.00	61.00		
FTEs from the hospital's 3 most recent cost reports ending and submitted before March 23, 2010. (see instructions)								
1.02 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 ACA). (see instructions)						61. 02		
1.03 Enter the base line FTE count for primary care and/or general surgery residents, which is used for determining compliance with the 75% test. (see instructions)						61. 03		
1.04 Enter the number of unweighted primary care/or surgery allopathic and/or osteopathic FTEs in the						61.04		
current cost reporting period. (see instructions). 1.05 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 61.04 minus line 61.03). (see instructions)						61. 0!		
1.06 Enter the amount of ACA §5503 award that is being used for cap relief and/or FTEs that are nonprimary care or general surgery. (see instructions)	Diag	Name Name	Discourse Cod		University which and	61.00		
	Pro	gram Name	Program Cod	e Unweighted IME FTE Count	Unweighted Direct GME FTE Count			
1.10 Of the FTEs in line 61.05, specify each new program		1. 00	2. 00	3. 00	4.00	61.10		
specialty, if any, and the number of FTE residents 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		
1.20 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.				0.00	0.00	61. 20		
_					1. 00			
ACA Provisions Affecting the Health Resources and Ser 2.00 Enter the number of FTE residents that your hospital	rvices <i>F</i>	Administrati Lin this cos	on (HRSA) st reporting pa	eriod for which	0.00	62.00		
your hospital received HRSA PCRE funding (see instruction 2.01 Enter the number of FTE residents that rotated from a	ti ons) Teachi	ng Health Ce	enter (THC) in			62. 01		
during in this cost reporting period of HRSA THC program. (see instructions) Teaching Hospitals that Claim Residents in Nonprovider Settings 63.00 Has your facility trained residents in nonprovider settings during this cost reporting period? Enter N "Y" for yes or "N" for no in column 1. If yes, complete lines 64 through 67. (see instructions)								
1 TOT YES OF IN TOTAL COLUMN 1. 11 YES, COMPTE	te mil	.s of through	Unweighted		Ratio (col.			

		l IIL3	I ILS III	17 (COL. 1 +	
		Nonprovi der	Hospi tal	col. 2))	
		Si te			
		1. 00	2. 00	3. 00	
	Section 5504 of the ACA Base Year FTE Residents in Nonprovider Settings	This base year	is your cost	reporti 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				
	of (column 1 divided by (column 1 + column 2)). (see instructions)				

IOSPITAL AND HOSPITAL HEALTH CAF	RE COMPLEX IDENTIFICATION D	DATA Provi der (eriod: fom 01/01/2019 o 12/31/2019	Worksheet S-2 Part I Date/Time Pre 6/26/2020 11:	pared:
	Program Name	Program Code	Unwei ghted FTEs Nonprovi der Si te	Unweighted FTEs in Hospital	Ratio (col. 3/ (col. 3 + col. 4))	
	1. 00	2.00	3. 00	4. 00	5. 00	
is yes, or your facility trained residents in the year period, the program associated with primary c FTEs for each primary car program in which you trai residents. Enter in colum the program code. Enter i column 3, the number of unweighted primary care F residents attributable to rotations occurring in al non-provider settings. En column 4, the number of unweighted primary care resident FTEs that traine your hospital. Enter in c 5, the ratio of (column 3 divided by (column 3 + co	base name are e ned n 2, n TE I ter in d in ol umn		0.00	0. 00	0. 000000	3. 0
4)). (see instructions)			University and the selection of	Harris alaka d	D-+: - (I	
			Unwei ghted FTEs Nonprovi der	Unwei ghted FTEs in Hospital	Ratio (col. 1/ (col. 1 + col. 2))	
			Si te 1. 00	2. 00	3. 00	
Section 5504 of the ACA C	urrent Year FTE Residents	in Nonprovider Settir				
beginning on or after Jul						
FTEs attributable to rota Enter in column 2 the num FTEs that trained in your	ber of unweighted non-prima tions occurring in all non, ber of unweighted non-prima hospital. Enter in column umn 1 + column 2)). (see in	provider settings. ary care resident 3 the ratio of	0.00	0. 00	0. 000000	66.00
	Program Name	Program Code	Unwei ghted	Unwei ghted	Ratio (col.	
			FTEs Nonprovi der Si te	FTEs in Hospital	3/ (col. 3 + col. 4))	
	1. 00	2. 00	3. 00	4. 00	5. 00	
pr.00 Enter in column 1, the property name associated with each your primary care program which you trained residen Enter in column 2, the procession care FTE residents attribute to rotations occurring in non-provider settings. En column 4, the number of unweighted primary care resident FTEs that traine your hospital. Enter in cub. 5, the ratio of (column 3 divided by (column 3 + co.)	of sin ts. ogram the ary utable all ter in din olumn		0.00	0. 00	0.000000	37.0
		·				
Inpatient Psychiatric Fac	ility PPS			1.00	2.00 3.00	
0.00 Is this facility an Inpat		(IPF), or does it cor	ntain an IPF sub	provider? N		70.00
Enter "Y" for yes or "N" 1.00 If line 70 is yes: Column recent cost report filed 42 CFR 412.424(d)(1)(iii) program in accordance wit	for no.	an approved GME teach 2004? Enter "Y" for cility train resident i)(D)? Enter "Y" for	ning program in yes or "N" for i ts in a new teac yes or "N" for i	the most no. (see hing no.	0	71.00
(see instructions)		year began darring till				ļ
	Facility PPS		•	N		75. 0

	Provi der 0		Peri od:	Worksheet S-	2
			From 01/01/2019 To 12/31/2019	Part I Date/Time Pr 6/26/2020 11	
	Physi cal 1.00	Occupati ona 2.00	Speech 3. 00	Respi ratory 4.00	
09.00 If this hospital qualifies as a CAH or a cost provider, are therapy services provided by outside supplier? Enter "Y" for yes or "N" for no for each therapy.	N N	2.00	3.00	4.00	109.
				1. 00	-
10.00 Did this hospital participate in the Rural Community Hospital Demonstration) for the current cost reporting period? Enter 'complete Worksheet E, Part A, lines 200 through 218, and Worapplicable.	'Y" for yes o	r "N" for no.	lf yes,	N N	110.
11 0016 this facility mustified as 0011 did it mustified in	.b. F	C	1.00	2. 00	111
11.00 If this facility qualifies as a CAH, did it participate in the Health Integration Project (FCHIP) demonstration for this country for yes or "N" for no in column 1. If the response to cointegration prong of the FCHIP demo in which this CAH is part Enter all that apply: "A" for Ambulance services; "B" for act for tele-health services.	ost reporting olumn 1 is Y, rticipating i	period? Enter enter the n column 2.	- N		111
		1. 00	2.00	3.00	-
2.00 Did this hospital participate in the Pennsylvania Rural Heal demonstration for any portion of the current cost reporting Enter "Y" for yes or "N" for no in column 1. If column 1 is in column 2, the date the hospital began participating in the demonstration. In column 3, enter the date the hospital ceap participation in the demonstration, if applicable.	period? s "Y", enter ne	N N	2.00	3.00	112
Miscellaneous Cost Reporting Information 5.00[s this an all-inclusive rate provider? Enter "Y" for yes or	r "N" for no	N			0115
in column 1. If column 1 is yes, enter the method used (A, E in column 2. If column 2 is "E", enter in column 3 either "G for short term hospital or "98" percent for long term care (psychiatric, rehabilitation and long term hospitals provider the definition in CMS Pub. 15-1, chapter 22, §2208.1.	3, or E only) 93" percent (includes				
6.00 Is this facility classified as a referral center? Enter "Y"	for yes or	N			116
"N" for no. 7.00 s this facility legally-required to carry malpractice insur	canco? Entor	Y			117
"Y" for yes or "N" for no.	ance: Litter	ľ			'''
8.00 Is the malpractice insurance a claims-made or occurrence polif the policy is claim-made. Enter 2 if the policy is occurr			1		118
11 the porrey is craim made. Enter 2 in the porrey is decarr	crice.	Premi ums	Losses	Insurance	
		1. 00	2. 00	3. 00	
3.01 List amounts of malpractice premiums and paid losses:		101, 38			86 118
			1.00	2.00	+
				2.00	118
Administrative and General? If yes, submit supporting schedund amounts contained therein.			N		
Administrative and General? If yes, submit supporting schedand amounts contained therein. 9.00 DO NOT USE THIS LINE 0.00 Is this a SCH or EACH that qualifies for the Outpatient Hold §3121 and applicable amendments? (see instructions) Enter in "N" for no. Is this a rural hospital with < 100 beds that qualifies have a supplicable amendment of the contained by th	dule listing d Harmless pr n column 1, " ualifies for	cost centers ovision in ACA Y" for yes or the Outpatient	A N	N	119
Administrative and General? If yes, submit supporting schedand amounts contained therein. 9.00 DO NOT USE THIS LINE 9.00 Is this a SCH or EACH that qualifies for the Outpatient Hold §3121 and applicable amendments? (see instructions) Enter in "N" for no. Is this a rural hospital with < 100 beds that qualifies provision in ACA §3121 and applicable amendment Enter in column 2, "Y" for yes or "N" for no. 1.00 Did this facility incur and report costs for high cost impla	dule listing d Harmless pr n column 1, " ualifies for nts? (see ins	cost centers ovision in ACA Y" for yes or the Outpatient tructions)	A N	N	120
Administrative and General? If yes, submit supporting sched and amounts contained therein. 2.00D0 NOT USE THIS LINE 2.001s this a SCH or EACH that qualifies for the Outpatient Hold \$3121 and applicable amendments? (see instructions) Enter in "N" for no. Is this a rural hospital with < 100 beds that qualifies provision in ACA \$3121 and applicable amendmententer in column 2, "Y" for yes or "N" for no. 1.00Did this facility incur and report costs for high cost imples patients? Enter "Y" for yes or "N" for no. 2.00Does the cost report contain healthcare related taxes as defact?Enter "Y" for yes or "N" for no in column 1. If column the Worksheet A line number where these taxes are included.	dule listing d Harmless pr n column 1, " ualifies for nts? (see ins antable devic	cost centers ovision in ACA Y" for yes or the Outpatient tructions) es charged to 3(w)(3) of the	A N	N	120
Administrative and General? If yes, submit supporting schedand amounts contained therein. 2.00D0 NOT USE THIS LINE 2.00D1s this a SCH or EACH that qualifies for the Outpatient Hold \$3121 and applicable amendments? (see instructions) Enter in "N" for no. Is this a rural hospital with < 100 beds that qualifies for the Outpatient Hold Hold Harmless provision in ACA \$3121 and applicable amendmer Enter in column 2, "Y" for yes or "N" for no. 1.00Did this facility incur and report costs for high cost implay patients? Enter "Y" for yes or "N" for no. 2.00Does the cost report contain healthcare related taxes as defact?Enter "Y" for yes or "N" for no in column 1. If column the Worksheet A line number where these taxes are included. Transplant Center Information	dule listing d Harmless pr n column 1, " ualifies for nts? (see ins antable devic fined in §190	ovision in ACA Y" for yes or the Outpatient tructions) es charged to 3(w)(3) of the er in column 2	A N	N	120
Administrative and General? If yes, submit supporting schedand amounts contained therein. O OD DO NOT USE THIS LINE Is this a SCH or EACH that qualifies for the Outpatient Hold §3121 and applicable amendments? (see instructions) Enter in "N" for no. Is this a rural hospital with < 100 beds that qualifies provision in ACA §3121 and applicable amendment Enter in column 2, "Y" for yes or "N" for no. OD Did this facility incur and report costs for high cost implay patients? Enter "Y" for yes or "N" for no. OD Does the cost report contain healthcare related taxes as defact? Enter "Y" for yes or "N" for no in column 1. If column the Worksheet A line number where these taxes are included. Transplant Center Information OD Does this facility operate a transplant center? Enter "Y" for yes, enter certification date(s) (mm/dd/yyyy) below.	dule listing d Harmless pr n column 1, " ualifies for nts? (see ins antable devic fined in §190 1 is "Y", ent	ovision in ACA Y" for yes or the Outpatient tructions) es charged to 3(w)(3) of the er in column 2	Y N	N	120
Administrative and General? If yes, submit supporting sched and amounts contained therein. 2.00D0 NOT USE THIS LINE 2.00D1 s this a SCH or EACH that qualifies for the Outpatient Hold \$3121 and applicable amendments? (see instructions) Enter in "N" for no. Is this a rural hospital with < 100 beds that qualifies provision in ACA \$3121 and applicable amendment Enter in column 2, "Y" for yes or "N" for no. 1.00Did this facility incur and report costs for high cost implay patients? Enter "Y" for yes or "N" for no. 2.00Does the cost report contain healthcare related taxes as defact?Enter "Y" for yes or "N" for no in column 1. If column the Worksheet A line number where these taxes are included. Transplant Center Information 5.00Does this facility operate a transplant center? Enter "Y" for yes, enter certification date(s) (mm/dd/yyyy) below. 6.00If this is a Medicare certified kidney transplant center, enter in column 1 and termination date, if applicable, in column 2.	dule listing d Harmless princolumn 1, " ualifies for nts? (see insumantable device fined in §190 lis "Y", enture the cert cert the cert in the cert i	cost centers ovision in ACA Y" for yes or the Outpatient tructions) es charged to 3(w)(3) of the er in column 2 " for no. If ification date	Y N	N	
Administrative and General? If yes, submit supporting sched and amounts contained therein. On ODO NOT USE THIS LINE On ODO NOT USE THIS LINE Is this a SCH or EACH that qualifies for the Outpatient Hold \$3121 and applicable amendments? (see instructions) Enter in "N" for no. Is this a rural hospital with < 100 beds that qualifies for the Outpatient Hold Hold Harmless provision in ACA \$3121 and applicable amendmer Enter in column 2, "Y" for yes or "N" for no. OD Did this facility incur and report costs for high cost implay patients? Enter "Y" for yes or "N" for no. OD Does the cost report contain healthcare related taxes as defact?Enter "Y" for yes or "N" for no in column 1. If column the Worksheet A line number where these taxes are included. Transplant Center Information OD Does this facility operate a transplant center? Enter "Y" for yes, enter certification date(s) (mm/dd/yyyy) below. OD If this is a Medicare certified kidney transplant center, enter in column 1 and termination date, if applicable, in column 2, onlif this is a Medicare certified heart transplant center, enter in column 1 and termination date, if applicable, in column 3, onlif this is a Medicare certified liver transplant center, enter in column 1 and termination date, if applicable, in column 2, onlif this is a Medicare certified liver transplant center, enter in column 1 and termination date, if applicable, in column 2, onlif this is a Medicare certified liver transplant center, enter in column 1 and termination date, if applicable, in column 2, onlif this is a Medicare certified liver transplant center, enter in column 1 and termination date, if applicable, in column 2, onlif this is a Medicare certified liver transplant center, enter in column 1 and termination date, if applicable, in column 2, onlife this is a Medicare certified liver transplant center, enter in column 2, onlife this is a Medicare certified liver transplant center, enter in column 2, onlife this is a Medicare certified liver transplant center.	d Harmless proposed the column 1, "ualifies for the certical strength of the certical strength o	ovision in ACA Y" for yes or the Outpatient tructions) es charged to 3(w)(3) of the er in column 2 " for no. If ification date fication date	Y N	N	120 122 122 128
Administrative and General? If yes, submit supporting sched and amounts contained therein. 9.00 DO NOT USE THIS LINE 0.00 Is this a SCH or EACH that qualifies for the Outpatient Hold §3121 and applicable amendments? (see instructions) Enter in "N" for no. Is this a rural hospital with < 100 beds that qualifies for the Outpatient Hold Hold Harmless provision in ACA §3121 and applicable amendmententer in column 2, "Y" for yes or "N" for no. 1.00 Did this facility incur and report costs for high cost implay patients? Enter "Y" for yes or "N" for no. 2.00 Does the cost report contain healthcare related taxes as defact?Enter "Y" for yes or "N" for no in column 1. If column at the Worksheet A line number where these taxes are included. Transplant Center Information 5.00 Does this facility operate a transplant center? Enter "Y" for yes, enter certification date(s) (mm/dd/yyyy) below. 6.00 If this is a Medicare certified kidney transplant center, entin column 1 and termination date, if applicable, in column 2. 8.00 If this is a Medicare certified liver transplant center, entin column 1 and termination date, if applicable, in column 2. 8.00 If this is a Medicare certified liver transplant center, entin column 1 and termination date, if applicable, in column 2. 8.00 If this is a Medicare certified liver transplant center, entin column 1 and termination date, if applicable, in column 2. 8.00 If this is a Medicare certified liver transplant center, entin column 1 and termination date, if applicable, in column 2.	dule listing d Harmless pr n column 1, " ualifies for nts? (see ins antable devic fined in §190 1 is "Y", ent pr yes and "N nter the cert 2. ter the certi 2. ter the certi 2.	ovision in ACA Y" for yes or the Outpatient tructions) es charged to 3(w)(3) of the er in column 2 " for no. If ification date fication date	A N Y N N N N N N	N	12° 12° 12° 12°
and amounts contained therein. 9.00 DO NOT USE THIS LINE 10.00 Is this a SCH or EACH that qualifies for the Outpatient Hold §3121 and applicable amendments? (see instructions) Enter ir "N" for no. Is this a rural hospital with < 100 beds that que Hold Harmless provision in ACA §3121 and applicable amendmer Enter in column 2, "Y" for yes or "N" for no. 11.00 Did this facility incur and report costs for high cost implation patients? Enter "Y" for yes or "N" for no. 12.00 Does the cost report contain healthcare related taxes as det Act?Enter "Y" for yes or "N" for no in column 1. If column the Worksheet A line number where these taxes are included. Transplant Center Information 15.00 Does this facility operate a transplant center? Enter "Y" for yes, enter certification date(s) (mm/dd/yyyy) below. 16.00 If this is a Medicare certified kidney transplant center, enter in column 1 and termination date, if applicable, in column 2. 17.00 If this is a Medicare certified heart transplant center, enter in column 1 and termination date, if applicable, in column 2. 18.00 If this is a Medicare certified liver transplant center, enters.	dule listing d Harmless princolumn 1, " ualifies for nts? (see instantable device fined in §190 lis "Y", ent nter the certion of the certion of the certion of the certion of the certification of th	cost centers ovision in ACA Y" for yes or the Outpatient tructions) es charged to 3(w)(3) of the er in column 2 " for no. If ification date fication date ication date i	A N Y N N N N N N	N	12° 12° 12° 12° 12° 12°

Health Financial Systems	HUNTI NGTON MEMO		2N. 1E. 000:	David a		u of Form CMS	
HOSPITAL AND HOSPITAL HEALTH CARE COMPLE	EX IDENIIFICATION DATA	Provi der CC	JN: 15-009	From	a: 01/01/2019 12/31/2019	Worksheet S- Part I Date/Time Pr 6/26/2020 11	epared:
							. 24 aiii
32.00 If this is a Medicare certified is in column 1 and termination date,			ication d	ate	1. 00	2.00	132. 0
33.00 Removed and reserved 34.00 If this is an organ procurement o	rganization (OPO), enter		in column	1			133. 00 134. 00
and termination date, if applicab	le, in column 2.						
40.00 Are there any related organization chapter 10? Enter "Y" for yes or are claimed, enter in column 2 the	"N" for no in column 1. I	f yes, and home	office c		Y	15H032	140. 0
1.00 If this facility is part of a cha		00	nugh 142 t	ho namo s	3. 00	of the home	
office and enter the home office	contractor name and contr	actor number.					
41.00 Name: PARKVIEW HEALTH SYSTEM, IN		ISCONSIN PHYSIC ERVICE	I ANS Contr	actor's N	lumber: 0810	11	141.0
42.00 Street: 10501 CORPORATE DRIVE	•	600					142.0
43.00 City: FORT WAYNE	State: I	N	Zip C	ode:	4689	5-5600	143.0
						1.00	1
44.00 Are provider based physicians' co	sts included in Worksheet	A?				Υ	144. 0
					1. 00	2.00	+
45.00 f costs for renal services are c inpatient services only? Enter "Y no, does the dialysis facility in period? Enter "Y" for yes or "N"	" for yes or "N" for no i clude Medicare utilizatio	n column 1. If	column 1				145. 0
46.00 Has the cost allocation methodolog Enter "Y" for yes or "N" for no in yes, enter the approval date (mm/	gy changed from the previ n column 1. (See CMS Pub.				N		146.0
						1. 00	_
47.00 Was there a change in the statist						N	147. C
48.00 Was there a change in the order o 49.00 Was there a change to the simplif				for no		N N	148. C
47.00 was there a change to the shipiri	rea cost irriaring illetinous	Part A	Part		Title V	Title XIX	147.0
Does this facility contain a prov	:	1.00	2.00		3.00	4.00	
or charges? Enter "Y" for yes or							
55. 00 Hospi tal		N	N		N	N	155. (
56.00 Subprovider - IPF 57.00 Subprovider - IRF		N N	N N		N N	N N	156. 0 157. 0
58. 00 SUBPROVI DER		1			14		158. 0
59. 00 SNF		N	N		N	N	159.0
60. 00 HOME HEALTH AGENCY		N	N		N	N	160.0
61. 00 CMHC			l N		N	N	161.0
h						1.00	
Multicampus 65.00 s this hospital part of a Multica	ampus hospital that has o	ne or more camp	uses in d	ifferent	CBSAs?	N	 165. 0
Enter "Y" for yes or "N" for no.	Name	County	State	Zi p Code	CBSA	FTE/Campus	
66.00 f line 165 is yes, for each	0	1. 00	2.00	3. 00	4.00	5. 00 0. 0	0166.0
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)						1.00	
Health Information Technology (HI	T) incentive in the Ameri	can Recovery ar	nd Rei nves	tment Act		1.00	
57.00 Is this provider a meaningful use 58.00 If this provider is a CAH (line 1) reasonable cost incurred for the	r under §1886(n)? Enter O5 is "Y") and is a meani	"Y" for yes or ngful user (lin	"N" for n	٥.		Y	167. (168. (
68.01 If this provider is a CAH and is exception under §413.70(a)(6)(ii)	not a meaningful user, do	es this provide			rdshi p		168.0
69.00 f this provider is a meaningful transition factor. (see instruction		d is not a CAH	(line 105	is "N"),	enter the	9.9	9169. (

Health Financial Systems	HUNTI NGTON MEMORI.	AL HOSPITAL	In Lie	In Lieu of Form CMS-2552-10			
HOSPITAL AND HOSPITAL HEALTH CARE COM	PITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA Provider CCN: 15-0091 Pe						
			From 01/01/2019				
			To 12/31/2019				
				6/26/2020 11:	<u> 24 am</u>		
			Begi nni ng	Endi ng			
			1. 00	2. 00			
170.00 Enter in columns 1 and 2 the Enter in			170. 00				
			1. 00	2. 00			
171.00 If line 167 is "Y", does this p	provider have any days for indi	viduals enrolled in	N	0	171.00		
section 1876 Medicare cost plan							
"Y" for yes and "N" for no in o	on						
1876 Medicare days in column 2.	(see instructions)						

	Financial Systems HUNTINGTON MEMO		ON 15 0001		u of Form CMS-	
OSPI T	AL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE	Provi der C		Period: From 01/01/2019 To 12/31/2019		
					6/26/2020 11	: 24 am
				Y/N	Date	
	Conoral Instruction, Enter V for all VES responses. Enter	N for all NO r	ocnoncoc Ent	1.00	2. 00	_
	General Instruction: Enter Y for all YES responses. Enter mm/dd/yyyy format.	N TOT ALL NO F	esponses. Ente	er arr dates in	trie	
	COMPLETED BY ALL HOSPITALS					_
00	Provider Organization and Operation Has the provider changed ownership immediately prior to th	o hoginning of	the cost	N		1.00
00	reporting period? If yes, enter the date of the change in					1.00
	,		Y/N	Date	V/I	
			1.00	2. 00	3. 00	
00	Has the provider terminated participation in the Medicare yes, enter in column 2 the date of termination and in colu voluntary or "I" for involuntary.		N			2.00
00	Is the provider involved in business transactions, includi contracts, with individuals or entities (e.g., chain home or medical supply companies) that are related to the provi officers, medical staff, management personnel, or members of directors through ownership, control, or family and oth	offices, drug der or its of the board	N			3.00
	relationships? (see instructions)	ei Silliiai				
			Y/N	Туре	Date	
			1.00	2.00	3. 00	
00	Financial Data and Reports Column 1: Were the financial statements prepared by a Cer	tified Dublic	ΙΥ	A	03/25/2020	4.00
00	Accountant? Column 2: If yes, enter "A" for Audited, "C" or "R" for Reviewed. Submit complete copy or enter date av column 3. (see instructions) If no, see instructions.	for Compiled,	1	A	03/23/2020	4.00
00	Are the cost report total expenses and total revenues diff those on the filed financial statements? If yes, submit re		N			5. 00
				Y/N	Legal Oper.	
	Annual Educational Activities			1. 00	2. 00	
00	Approved Educational Activities Column 1: Are costs claimed for nursing school? Column 2: the legal operator of the program?	If yes, is t	he provider is	s N		6.00
00 00	Are costs claimed for Allied Health Programs? If "Y" see i Were nursing school and/or allied health programs approved		d during the	N N		7. 00 8. 00
00	cost reporting period? If yes, see instructions. Are costs claimed for Interns and Residents in an approved program in the current cost report? If yes, see instructio		cal education	N		9.00
. 00	Was an approved Intern and Resident GME program initiated cost reporting period? If yes, see instructions.		the current	N		10.00
. 00	Are GME cost directly assigned to cost centers other than Teaching Program on Worksheet A? If yes, see instructions.	I & R in an Ap	proved	N		11.00
					Y/N	
	D. I. D. I. I.				1. 00	
00	Bad Debts Is the provider seeking reimbursement for bad debts? If ye	s see instruc	ti ons		Y	12.00
	If line 12 is yes, did the provider's bad debt collection period? If yes, submit copy.			ost reporting	Ň	13.00
. 00	If line 12 is yes, were patient deductibles and/or co-paym Bed Complement	ents waived? I	f yes, see in	structions.	N N	14.00
. 00	Did total beds available change from the prior cost report	ing period? If	yes, see ins	tructions.	N	15.00
			t A		t B	
		1. 00	Date	Y/N 3. 00	Date	-
	PS&R Data	1.00	2. 00	3.00	4. 00	
00	Was the cost report prepared using the PS&R Report only? If either column 1 or 3 is yes, enter the paid-through date of the PS&R Report used in columns 2 and 4 (see	N		N		16.00
00	instructions) Was the cost report prepared using the PS&R Report for totals and the provider's records for allocation? If either column 1 or 3 is yes, enter the paid-through date	Y	04/30/2020	Y	04/30/2020	17.00
00	in columns 2 and 4. (see instructions)	Y		Y		18.00
.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

Heal th	Financial Systems HUNTINGTON MEMO	ORIAL HOSPITAL		In Lie	u of Form CMS-	2552-10
HOSPI T	AL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE	Provi der CC	CN: 15-0091	Peri od: From 01/01/2019 To 12/31/2019	Worksheet S-2 Part II Date/Time Pro 6/26/2020 11:	epared:
		Descri	ption	Y/N	Y/N	24 (1111
		C		1.00	3. 00	
20. 00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for Other? Describe the other adjustments:			N	N	20.00
		Y/N 1.00	Date 2.00	Y/N 3.00	Date 4.00	
21. 00	Was the cost report prepared only using the provider's	1.00 N	2.00	3.00 N	4.00	21.00
21.00	records? If yes, see instructions.					21.00
					1. 00	
	COMPLETED BY COST REIMBURSED AND TEFRA HOSPITALS ONLY (EXC Capital Related Cost	CEPT CHILDRENS H	HOSPI TALS)			+
22. 00	Have assets been relifed for Medicare purposes? If yes, se	e instructions				22. 00
23. 00	have dasets been refired in the Medicare depreciation expense reporting period? If yes, see instructions.	ring the cost		23. 00		
24. 00	Were new leases and/or amendments to existing leases enter If yes, see instructions	red into during	this cost re	eporting period?		24. 00
25. 00	Have there been new capitalized leases entered into during instructions.	g the cost repor	rting period?	? If yes, see		25. 00
26. 00	Were assets subject to Sec. 2314 of DEFRA acquired during tinstructions.	the cost reporti	ng period? I	f yes, see		26. 00
27. 00	Has the provider's capitalization policy changed during th copy.	ne cost reportir	ng period? If	f yes, submit		27. 00
28. 00	Interest Expense Were new loans, mortgage agreements or letters of credit e	entered into dur	ing the cost	t reporting		28. 00
29. 00	period? If yes, see instructions. Did the provider have a funded depreciation account and/or		ebt Service F	Reserve Fund)		29. 00
30. 00	treated as a funded depreciation account? If yes, see inst Has existing debt been replaced prior to its scheduled mat		debt? If yes	s, see		30.00
31. 00	<pre>instructions. Has debt been recalled before scheduled maturity without i instructions.</pre>	ssuance of new	debt? If yes	s, see		31.00
32. 00	Purchased Services Have changes or new agreements occurred in patient care se	ervices furnishe	ed through co	ontractual		32.00
	arrangements with suppliers of services? If yes, see instr If line 32 is yes, were the requirements of Sec. 2135.2 ap no, see instructions.	ructions.	-			33. 00
	Provi der-Based Physi ci ans					
34. 00	Are services furnished at the provider facility under an a If yes, see instructions.	arrangement with	n provi der-ba	ased physicians?		34.00
35. 00	If line 34 is yes, were there new agreements or amended ex physicians during the cost reporting period? If yes, see i	kisting agreemer nstructions.	nts with the	provi der-based		35. 00
	, , , , , , , , , , , , , , , , , , ,			Y/N	Date	
				1. 00	2. 00	
24 00	Home Office Costs			\ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \		24 00
	Were home office costs claimed on the cost report? If line 36 is yes, has a home office cost statement been p	prepared by the	home office?	? Y Y		36. 00 37. 00
38. 00	If yes, see instructions. If line 36 is yes, was the fiscal year end of the home of			F N		38.00
39. 00	the provider? If yes, enter in column 2 the fiscal year en Ifline 36 is yes, did the provider render services to oth			s, N		39. 00
40. 00	see instructions. If line 36 is yes, did the provider render services to the instructions.	e home office?	If yes, see	N		40. 00
		1.0	Ω Ω	2.0	00	
	Cost Report Preparer Contact Information	1.,	-	2.1	~~	
41.00	Enter the first name, last name and the title/position held by the cost report preparer in columns 1, 2, and 3,	ERI C		NI CKESON		41.00
42. 00	respectively. Enter the employer/company name of the cost report	PARKVI EW HEALTI	H SYSTEM, IN	C.		42.00
43. 00	preparer. Enter the telephone number and email address of the cost report preparer in columns 1 and 2, respectively.	(260) 373-8406		ERI C. NI CKESON@F	PARKVI EW. COM	43.00

Health Financial Systems HUNTINGTON MEMO				I TAL	In Lieu of Form CMS-2552-1				
HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE							Worksheet S-2		
					To	com 01/01/2019 o 12/31/2019	Date/Time Pre 6/26/2020 11:		
				3. 00					
	Cost Report Preparer Contact Information								
41.00	Enter the first name, last name and the title/position	on	DI RECTOR,	REI MBURSEMENT				41.00	
	held by the cost report preparer in columns 1, 2, and	d 3,							
	respectively.								
42.00	Enter the employer/company name of the cost report							42.00	
	preparer.								
43.00	Enter the telephone number and email address of the d	cost						43.00	
	report preparer in columns 1 and 2, respectively.								

| Period: | Worksheet S-3 | From 01/01/2019 | Part | To 12/31/2019 | Date/Time Prepared: Provi der CCN: 15-0091

						То	12/31/2019	Date/Ti me 6/26/2020		
								1/P Days /		24 alli
								0/P Visits		
								Trips	.	
	Component	Worksheet A	No.	of Beds	Bed Days		CAH Hours	Title V		
	'	Line Number			Avai I abl e					
		1. 00		2. 00	3. 00		4. 00	5. 00		
1. 00	Hospital Adults & Peds. (columns 5, 6, 7 and	30. 00		36	13, 14	10	0. 00		0	1.00
	8 exclude Swing Bed, Observation Bed and									
	Hospice days) (see instructions for col. 2									
0.00	for the portion of LDP room available beds)								ŀ	0.00
2.00	HMO and other (see instructions)								ŀ	2.00
3.00	HMO I PF Subprovi der								ŀ	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			27	10.1		0.00		0	6.00
7. 00	Total Adults and Peds. (exclude observation			36	13, 14	10	0. 00		0	7. 00
9 00	beds) (see instructions)								ŀ	8. 00
8. 00 9. 00	INTENSIVE CARE UNIT								ł	9. 00
10.00	BURN INTENSIVE CARE UNIT								ŀ	10.00
11. 00	SURGICAL INTENSIVE CARE UNIT								ŀ	11. 00
12. 00	OTHER SPECIAL CARE (SPECIFY)								1	12.00
13. 00	NURSERY	43.00							0	13.00
14. 00	Total (see instructions)	43.00		36	13, 14	10	0. 00		0	14. 00
15. 00	CAH visits			30	13, 1	+0	0.00		0	15. 00
16. 00	SUBPROVI DER - I PF								٠	16.00
17. 00	SUBPROVI DER - I RF								ŀ	17. 00
18. 00	SUBPROVI DER									18. 00
19. 00	SKILLED NURSING FACILITY									19. 00
20. 00	NURSING FACILITY								l	20.00
21. 00	OTHER LONG TERM CARE								l	21.00
22. 00	HOME HEALTH AGENCY								ı	22. 00
23. 00	AMBULATORY SURGICAL CENTER (D. P.)									23. 00
24. 00	HOSPICE									24. 00
24. 10	HOSPICE (non-distinct part)	30. 00							l	24. 10
25. 00	CWHC - CWHC								İ	25. 00
26. 00	RURAL HEALTH CLINIC								İ	26. 00
26. 25	FEDERALLY QUALIFIED HEALTH CENTER	89. 00							ol	26. 25
27. 00	Total (sum of lines 14-26)			36						27. 00
28. 00	Observation Bed Days								0	28. 00
29. 00	Ambulance Trips									29.00
30.00	Employee discount days (see instruction)								İ	30.00
31.00	Employee discount days - IRF								ı	31.00
32.00	Labor & delivery days (see instructions)			0		0			l	32.00
32. 01	Total ancillary labor & delivery room								İ	32.01
	outpatient days (see instructions)									
33.00	LTCH non-covered days									33.00
33. 01	LTCH site neutral days and discharges									33. 01

Provi der CCN: 15-0091

Period: Worksheet S-3 From 01/01/2019 Part I To 12/31/2019 Date/Time Prepared: 6/26/2020 11:24 am

		_				6/26/2020 11:	24 am
		I/P Days	/ O/P Visits	/ Tri ps	Full Time E	Equi val ents	
	Component	Title XVIII	Title XIX	Total All	Total Interns	Employees On	
				Pati ents	& Residents	Payrol I	
		6. 00	7. 00	8. 00	9. 00	10.00	
1.00	Hospital Adults & Peds. (columns 5, 6, 7 and	1, 227	67	4, 355			1.00
	8 exclude Swing Bed, Observation Bed and						
	Hospice days) (see instructions for col. 2						
	for the portion of LDP room available beds)						
2.00	HMO and other (see instructions)	1, 369	1, 058				2.00
3.00	HMO IPF Subprovider	0	0				3.00
4.00	HMO IRF Subprovider	o	0				4.00
5.00	Hospital Adults & Peds. Swing Bed SNF	ol	0	0			5.00
6.00	Hospital Adults & Peds. Swing Bed NF		0	0			6.00
7. 00	Total Adults and Peds. (exclude observation	1, 227	67	4, 355			7.00
7.00	beds) (see instructions)	1, 22,	0,1	1,000			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	•						12.00
	OTHER SPECIAL CARE (SPECIFY)		20	(10			1
13.00	NURSERY	1 227	20			2 (04 00	13.00
14.00	Total (see instructions)	1, 227	87	4, 974	0. 00	2, 684. 00	
15.00	CAH visits	0	0	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	AMBULATORY SURGICAL CENTER (D. P.)						23.00
24.00	HOSPI CE						24.00
24. 10	HOSPICE (non-distinct part)			91			24. 10
25.00	CMHC - CMHC						25.00
26.00	RURAL HEALTH CLINIC						26.00
26. 25	FEDERALLY QUALIFIED HEALTH CENTER	ol	0	l o	0.00	0.00	26. 25
27. 00	Total (sum of lines 14-26)		-		0.00	2, 684. 00	
28. 00	Observation Bed Days		234	1, 768		_,	28. 00
29. 00	Ambul ance Trips	1, 793	20.	.,,,			29.00
30.00	Employee discount days (see instruction)	1,770		73			30.00
31. 00	Employee discount days (see Fristraction)			,3			31.00
32. 00	Labor & delivery days (see instructions)	0	62				32.00
	Total ancillary labor & delivery room		02	97			32.00
32. 01	outpatient days (see instructions)			l "			32.01
22 00							22 00
33.00	LTCH non-covered days	0					33.00
33.01	LTCH site neutral days and discharges	0		l			33. 01

Provider CCN: 15-0091

				10) 12/31/2019	Date/IIme Pre 6/26/2020 11:	
		Full Time		Di sch	arges		
		Equi val ents					
	Component	Nonpai d	Title V	Title XVIII	Title XIX	Total All	
		Workers				Pati ents	
		11. 00	12. 00	13. 00	14. 00	15. 00	
1. 00	Hospital Adults & Peds. (columns 5, 6, 7 and		0	453	30	1, 821	1. 00
	8 exclude Swing Bed, Observation Bed and						
	Hospice days) (see instructions for col. 2						
0.00	for the portion of LDP room available beds)			4.4	204		0.00
2.00	HMO and other (see instructions)			464	304		2.00
3.00	HMO I PF Subprovi der				0		3.00
4. 00	HMO I RF Subprovi der				U		4.00
5. 00	Hospital Adults & Peds. Swing Bed SNF						5. 00 6. 00
6. 00 7. 00	Hospital Adults & Peds. Swing Bed NF						7.00
7.00	Total Adults and Peds. (exclude observation						7.00
8. 00	beds) (see instructions) INTENSIVE CARE UNIT						8. 00
9. 00	CORONARY CARE UNIT						9. 00
10.00	BURN INTENSIVE CARE UNIT						10.00
11. 00	SURGICAL INTENSIVE CARE UNIT						11. 00
12. 00	OTHER SPECIAL CARE (SPECIFY)						12.00
13. 00	NURSERY						13.00
14. 00	Total (see instructions)	0.00	0	453	30	1, 821	14. 00
15. 00	CAH visits	0.00	O	455	30	1, 021	15. 00
16. 00	SUBPROVIDER - IPF						16. 00
17. 00	SUBPROVI DER - I RF						17. 00
18. 00	SUBPROVIDER						18.00
19. 00	SKILLED NURSING FACILITY						19. 00
20.00	NURSING FACILITY						20.00
21. 00	OTHER LONG TERM CARE						21. 00
22. 00	HOME HEALTH AGENCY						22. 00
23. 00	AMBULATORY SURGICAL CENTER (D. P.)						23.00
24.00	HOSPI CE						24.00
24. 10	HOSPICE (non-distinct part)						24. 10
25.00	CMHC - CMHC						25.00
26.00	RURAL HEALTH CLINIC						26.00
26. 25	FEDERALLY QUALIFIED HEALTH CENTER	0.00					26. 25
27.00	Total (sum of lines 14-26)	0.00					27.00
28.00	Observation Bed Days						28.00
29. 00	Ambul ance Trips						29.00
30.00	Employee discount days (see instruction)						30.00
31.00	Employee discount days - IRF						31.00
32.00	Labor & delivery days (see instructions)						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

| Period: | Worksheet S-3 | From 01/01/2019 | Part II | To 12/31/2019 | Date/Time Prepared: Health Financial Systems
HOSPITAL WAGE INDEX INFORMATION Provi der CCN: 15-0091

						0 12/31/2019	Date/Time Pre 6/26/2020 11:	
		Wkst. A Line	Amount	Recl assi fi cat	Adj usted	Paid Hours	Average	24 alli
		Number	Reported	ion of Salaries	Sal ari es (col. 2 ± col.	Related to Salaries in	Hourly Wage (col. 4 ÷	
				(from Wkst.	3)	col . 4	col . 5)	
		1. 00	2. 00	A-6) 3. 00	4. 00	5. 00	6. 00	
	PART II - WAGE DATA	1.00	2.00	3.00	4.00	5.00	6.00	
1. 00	SALARIES Total salaries (see	200. 00	16, 347, 199	5, 100, 671	21, 447, 870	614, 371. 67	34. 91	1.00
1.00	instructions)	200.00	10, 347, 177	3, 100, 671	21, 447, 670	014, 371. 07	34. 71	1.00
2. 00	Non-physician anesthetist Part A		0	0	0	0. 00	0. 00	2.00
3.00	Non-physician anesthetist Part		0	О	О	0. 00	0. 00	3.00
4. 00	B Physician-Part A -		24, 000	О	24, 000	106. 00	226. 42	4.00
4 01	Administrative		0	0	0	0.00	0.00	4 01
4. 01 5. 00	Physicians - Part A - Teaching Physician and Non		0		0		0. 00 0. 00	
6. 00	Physician-Part B Non-physician-Part B for		0			0. 00	0. 00	6. 00
0.00	hospi tal -based RHC and FQHC services		O	0		0.00	0.00	0.00
7. 00	Interns & residents (in an	21. 00	0	0	О	0. 00	0. 00	7. 00
7. 01	approved program) Contracted interns and		0	0	О	0. 00	0. 00	7. 01
	residents (in an approved							
8.00	programs) Home office and/or related		5, 100, 671	О	5, 100, 671	130, 526. 47	39. 08	8. 00
9. 00	organization personnel SNF	44. 00	0	0	0	0. 00	0. 00	9. 00
10. 00	Excluded area salaries (see	11.00	2, 633, 599	345, 631	_		40. 63	
	instructions) OTHER WAGES & RELATED COSTS							
11. 00	Contract Labor: Direct Patient		0	0	0	0.00	0. 00	11.00
12. 00	Care Contract Labor: Top Level		0	0	О	0. 00	0. 00	12.00
	management and other							
	management and administrative services							
13. 00	Contract Labor: Physician-Part A - Administrative		0	0	0	0.00	0. 00	13.00
14.00	Home office and/or related		0	0	0	0. 00	0. 00	14.00
	organization salaries and wage-related costs							
14. 01	Home office salaries		5, 100, 671	0				14. 01
14. 02 15. 00	Related organization salaries Home office: Physician Part A		0	0	0	0. 00 0. 00	0. 00 0. 00	ı
1/ 00	- Administrative		0			0.00	0.00	
16. 00	Home office and Contract Physicians Part A - Teaching		0	0	0	0.00	0. 00	16. 00
16. 01	Home office Physicians Part A - Teaching		0	0	0	0.00	0. 00	16. 01
16. 02	Home office contract		0	О	0	0. 00	0. 00	16. 02
	Physicians Part A - Teaching WAGE-RELATED COSTS							
17. 00	Wage-related costs (core) (see		5, 238, 270	0	5, 238, 270			17. 00
18. 00	instructions) Wage-related costs (other)							18. 00
19. 00	(see instructions) Excluded areas		1, 167, 418	0	1, 167, 418			19.00
20. 00	Non-physician anesthetist Part		1, 167, 416	0	1, 167, 416			20.00
21. 00	A Non-physician anesthetist Part		0	0	0			21.00
	В							
22. 00	Physician Part A - Administrative		0	0	0			22.00
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	0			23. 00 24. 00
25. 00	Interns & residents (in an approved program)		0	0	0			25. 00
25. 50	Home office wage-related		1, 561, 252	О	1, 561, 252			25. 50
25. 51	(core) Related organization		0	0	0			25. 51
	wage-related (core)		-	_	_			
25. 52	Home office: Physician Part A - Administrative -		0	0	0			25. 52
	wage-related (core)							

HOSPITAL WAGE INDEX INFORMATION Provider CCN: 15-0091 Peri od: Worksheet S-3 From 01/01/2019 Part II Date/Time Prepared: 12/31/2019 6/26/2020 11:24 am Wkst. A Line Amount Recl assi fi cat Adj usted Paid Hours Average Hourly Wage (col. 4 ÷ col. 5) Number Sal ari es Related to Reported ion of (col. 2 ± col. Sal ari es Salaries in (from Wkst. 3) col. 4 A-6) 1.00 2.00 3.00 4.00 5.00 6.00 25.53 Home office: Physicians Part A 0 25. 53 - Teaching - wage-related (core) OVERHEAD COSTS - DIRECT SALARIES 26.00 Employee Benefits Department 4.00 1, 512, 454 -1, 512, 454 0.00 0. 00 26.00 146, 171. 88 27.00 Administrative & General 5.00 1, 517, 125 5, 136, 514 6, 653, 639 45. 52 27.00 28.00 0.00 28.00 Administrative & General under 0.00 0 contract (see inst.) 29.00 Maintenance & Repairs 6.00 0.00 0.00 29.00 30.00 Operation of Plant 7.00 336, 029 38, 717 374, 746 13, 988. 10 26. 79 30.00 . Laundry & Linen Service 8.00 30, 629 3, 773. 00 8. 12 31.00 31.00 30, 629 32.00 Housekeepi ng 9.00 292, 813 3, 108 295, 921 17, 963. 13 16. 47 32.00 33.00 Housekeeping under contract 0.00 0.00 33.00 (see instructions) 66, 603 34.00 Dietary 10.00 417, 626 -351, 023 5, 791. 23 11. 50 34.00 Dietary under contract (see 35.00 0.00 0.00 35.00 instructions) 36.00 Cafeteri a 11.00 0 308, 830 308, 830 19, 380. 00 15. 94 36.00 0.00 37.00 Maintenance of Personnel 12.00 0.00 37.00 Nursing Administration 49.40 38.00 38.00 13.00 365, 653 42, 130 407, 783 8, 254. 25 39.00 Central Services and Supply 14.00 0.00 0.00 39.00 550, 934 10, 532. 43 40.00 Pharmacy 15.00 0 550, 934 52. 31 40.00 Medical Records & Medical Records Library 41.00 16.00 0 0 O 0.00 0.00 41.00

0

0

0

0

0

0.00

0.00

0.00 42.00

0.00 43.00

17.00

18.00

42.00

Social Service

43.00 Other General Service

Health Financial Systems	HUNTINGTON MEMORIAL HOSPITAL	HUNTINGTON MEMORIAL HOSPITAL		
HOSPITAL WAGE INDEX INFORMATION	Provi der CCN: 15-0091	Peri od:	Worksheet S-3	

позетт	AL WAGE TINDEX TINFORWATTON			Provider C		From 01/01/2019 To 12/31/2019	Part III Date/Time Pre 6/26/2020 11:	
		Worksheet A	Amount	Recl assi fi cat	Adj usted	Paid Hours	Average	
		Line Number	Reported	ion of	Sal ari es	Related to	Hourly Wage	
				Sal ari es	(col.2 ± col	Salaries in	(col. 4 ÷	
				(from	3)	col. 4	col. 5)	
				Worksheet				
				A-6)				
		1. 00	2. 00	3. 00	4. 00	5. 00	6. 00	
	PART III - HOSPITAL WAGE INDEX	SUMMARY						
1.00	Net salaries (see		11, 246, 528	5, 100, 671	16, 347, 19	9 483, 845. 20	33. 79	1.00
	instructions)							
2.00	Excluded area salaries (see		2, 633, 599	345, 631	2, 979, 23	73, 321. 20	40. 63	2.00
	instructions)							
3.00	Subtotal salaries (line 1		8, 612, 929	4, 755, 040	13, 367, 96	9 410, 524. 00	32. 56	3.00
	minus line 2)							
4. 00	Subtotal other wages & related		5, 100, 671	0	5, 100, 67	130, 526. 47	39. 08	4.00
	costs (see inst.)							
5.00	Subtotal wage-related costs		6, 799, 522	0	6, 799, 52	0.00	50. 86	5.00
	(see inst.)							
6. 00	Total (sum of lines 3 thru 5)		20, 513, 122					
7. 00	Total overhead cost (see		4, 992, 634	3, 696, 451	8, 689, 08	225, 854. 02	38. 47	7. 00
	instructions)							

Health Financial Systems	HUNTINGTON MEMORIAL HOSPITAL	In Lieu of Form CMS-2552-10
HOSPITAL WAGE RELATED COSTS	Provi der CCN: 15-0091	Peri od: Worksheet S-3
		From 01/01/2019 Part IV

	To 12/31/2019	Date/Time Pre 6/26/2020 11:	
		Amount	24 (1111
		Reported	
		1. 00	
	PART IV - WAGE RELATED COSTS		
	Part A - Core List		
	RETIREMENT COST		
1.00	401K Employer Contributions	0	1.00
2.00	Tax Sheltered Annuity (TSA) Employer Contribution	334, 502	2.00
3.00	Nonqualified Defined Benefit Plan Cost (see instructions)	1, 159, 324	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	1, 683	6.00
7.00	Employee Managed Care Program Administration Fees	49, 768	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)	3, 326, 886	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)	48, 660	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)	67, 722	
14.00		0	14.00
15. 00		19, 711	
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		1, 300, 957	
18. 00	Medicare Taxes - Employers Portion Only	0	18.00
19. 00	1 1 3 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1	0	19.00
20. 00		0	20.00
	OTHER	07.500	
21. 00		37, 538	21.00
00.00	instructions))		00.00
22. 00		0	22.00
23. 00	Tuition Reimbursement	58, 937	23.00
24. 00		6, 405, 688	24. 00
25 00	Part B - Other than Core Related Cost OTHER WAGE RELATED COSTS (SPECIFY)		25. 00
25.00	TOTHER WAS RELATED 60010 (SPECITI)	ļ	25.00

Health Financial Systems	HUNTINGTON MEMORIAL HOSPITAL	In Lie	u of Form CMS-2552-10
HOSPITAL CONTRACT LABOR AND BENEFIT COST		Peri od: From 01/01/2019 To 12/31/2019	Worksheet S-3 Part V Date/Time Prepared: 6/26/2020 11:24 am
Cost Contor Doscription		Contract	Popofi + Cost

		10	12/31/2019	6/26/2020 11:	
	Cost Center Description		Contract	Benefit Cost	
			Labor		
			1. 00	2.00	
	PART V - Contract Labor and Benefit Cost				
	Hospital and Hospital-Based Component Identification:				
1. 00	Total facility's contract labor and benefit cost		0	6, 405, 688	1.00
2.00	Hospi tal		0	6, 405, 688	2.00
3.00	Subprovi der - I PF				3.00
4. 00	Subprovi der - I RF				4.00
5. 00	Subprovi der - (Other)		0	0	5.00
6. 00	Swing Beds - SNF		0	0	6.00
7. 00	Swing Beds - NF		0	0	7.00
8. 00	Hospi tal -Based SNF				8.00
9. 00	Hospi tal -Based NF				9.00
10.00	Hospi tal -Based OLTC				10.00
	Hospi tal -Based HHA				11.00
12.00	Separately Certified ASC				12.00
13. 00	Hospi tal -Based Hospi ce				13.00
14.00	Hospital-Based Health Clinic RHC				14.00
15. 00	Hospital-Based Health Clinic FQHC				15.00
16.00	Hospi tal -Based-CMHC				16.00
17.00	Renal Di al ysi s				17.00
18. 00	Other		0	0	18.00

	FAL UNCOMPENSATED AND INDIGENT CARE DATA Pr	rovi der CCI	N: 15-0091	Peri od:	Worksheet S-1	0
				From 01/01/2019		
				To 12/31/2019	Date/Time Pre 6/26/2020 11:	
					1. 00	
	Uncompensated and indigent care cost computation				11.00	
00	Cost to charge ratio (Worksheet C, Part I line 202 column 3 divi	ided by li	ne 202 colum	n 8)	0. 219027	1.
	Medicaid (see instructions for each line)					
00	Net revenue from Medicaid				2, 254, 237	2
00	Did you receive DSH or supplemental payments from Medicaid?				Y	3
00	If line 3 is yes, does line 2 include all DSH and/or supplementa			ai d'?	Y 0	4
00 00	If line 4 is no, then enter DSH and/or supplemental payments fro Medicaid charges	on wearcar	u		18, 805, 141	5
00	Medicaid cost (line 1 times line 6)				4, 118, 834	
00	Difference between net revenue and costs for Medicaid program (I	line 7 min	us sum of li	nes 2 and 5: if	1, 864, 597	
	< zero then enter zero)			,	.,,	
	Children's Health Insurance Program (CHIP) (see instructions for	r each line	e)			
00	Net revenue from stand-alone CHIP				15, 791	9
. 00					28, 087	
. 00	Stand-alone CHIP cost (line 1 times line 10)	lina 11 mi	nua lina O.	lf . zono thon	6, 152	
. 00	Difference between net revenue and costs for stand-alone CHIP (I enter zero)	iine ii mii	nus ime 9;	ii < Zero then	0	12
	Other state or local government indigent care program (see instr	ructions fo	or each line)		
. 00	Net revenue from state or local indigent care program (Not inclu				3, 119, 856	13
. 00	Charges for patients covered under state or local indigent care	program (I	Not included	in lines 6 or	23, 696, 292	14
	10)					
. 00	State or local indigent care program cost (line 1 times line 14)				5, 190, 128	ı
. 00	Difference between net revenue and costs for state or local indi	igent care	program (li	ne 15 minus line	2, 070, 272	16
	13; if < zero then enter zero) Grants, donations and total unreimbursed cost for Medicaid, CHIP	2 and state	e/Local indi	gent care progra	l ms (see	
	instructions for each line)	and State	orroddi indi	gent care progre	(300	
. 00	9 .				0	
3. 00						
			care program	is (sum of lines	3, 934, 869	18. 19.
	Total unreimbursed cost for Medicaid , CHIP and state and local 8, 12 and 16)		Uni nsured	Insured	3, 934, 869 Total (col. 1	
			Uni nsured pati ents	Insured patients	Total (col. 1 + col. 2)	
	8, 12 and 16)		Uni nsured	Insured	Total (col. 1	
. 00	8, 12 and 16) Uncompensated Care (see instructions for each line)	i ndi gent	Uni nsured pati ents	I nsured pati ents	Total (col. 1 + col. 2) 3.00	19
. 00	Uncompensated Care (see instructions for each line) Charity care charges and uninsured discounts for the entire faci	i ndi gent	Uni nsured pati ents	I nsured pati ents	Total (col. 1 + col. 2) 3.00	19
0. 00	8, 12 and 16) Uncompensated Care (see instructions for each line)	indigent	Uni nsured pati ents	I nsured pati ents 2.00	Total (col. 1 + col. 2) 3.00 4,623,383	20
0. 00	Uncompensated Care (see instructions for each line) Charity care charges and uninsured discounts for the entire faci (see instructions)	indigent	Uni nsured patients 1.00 3,486,33	I nsured pati ents 2.00	Total (col. 1 + col. 2) 3.00 4,623,383	20
0.00	Uncompensated Care (see instructions for each line) Charity care charges and uninsured discounts for the entire faci (see instructions) Cost of patients approved for charity care and uninsured discouninstructions) Payments received from patients for amounts previously written of	indigent	Uni nsured patients 1.00 3,486,33	Insured patients 2.00 1,137,052 1,137,052	Total (col. 1 + col. 2) 3.00 4,623,383	20.
0. 00	Uncompensated Care (see instructions for each line) Charity care charges and uninsured discounts for the entire faci (see instructions) Cost of patients approved for charity care and uninsured discount instructions) Payments received from patients for amounts previously written of charity care	indigent	Uni nsured pati ents 1.00 3,486,33 763,60	I nsured pati ents 2.00 1,137,052 1,137,052 341 341	Total (col. 1 + col. 2) 3.00 4,623,383 1,900,653 1,689	20. 21. 22.
0.00	Uncompensated Care (see instructions for each line) Charity care charges and uninsured discounts for the entire faci (see instructions) Cost of patients approved for charity care and uninsured discount instructions) Payments received from patients for amounts previously written of charity care	indigent	Uni nsured pati ents 1.00 3,486,33 763,60	I nsured pati ents 2.00 1,137,052 1,137,052 341 341	Total (col. 1 + col. 2) 3.00 4,623,383 1,900,653	20. 21. 22.
. 00	Uncompensated Care (see instructions for each line) Charity care charges and uninsured discounts for the entire faci (see instructions) Cost of patients approved for charity care and uninsured discount instructions) Payments received from patients for amounts previously written of charity care	indigent	Uni nsured pati ents 1.00 3,486,33 763,60	I nsured pati ents 2.00 1,137,052 1,137,052 341 341	Total (col. 1 + col. 2) 3.00 4,623,383 1,900,653 1,689 1,898,964	20 21 22
. 00	Uncompensated Care (see instructions for each line) Charity care charges and uninsured discounts for the entire faci (see instructions) Cost of patients approved for charity care and uninsured discount instructions) Payments received from patients for amounts previously written of charity care Cost of charity care (line 21 minus line 22)	illity nts (see	Uni nsured pati ents 1.00 3, 486, 33 763, 60 1, 36 762, 29	I nsured pati ents 2.00 31 1,137,052 01 1,137,052 48 341 53 1,136,711	Total (col. 1 + col. 2) 3.00 4,623,383 1,900,653 1,689	20 21 22 23
. 00	Uncompensated Care (see instructions for each line) Charity care charges and uninsured discounts for the entire faci (see instructions) Cost of patients approved for charity care and uninsured discount instructions) Payments received from patients for amounts previously written of charity care	ility nts (see	Uni nsured pati ents 1.00 3, 486, 33 763, 60 1, 36 762, 29	I nsured pati ents 2.00 31 1,137,052 01 1,137,052 48 341 53 1,136,711	Total (col. 1 + col. 2) 3.00 4,623,383 1,900,653 1,689 1,898,964	20. 21. 22. 23.
. 00	Uncompensated Care (see instructions for each line) Charity care charges and uninsured discounts for the entire faci (see instructions) Cost of patients approved for charity care and uninsured discount instructions) Payments received from patients for amounts previously written of charity care Cost of charity care (line 21 minus line 22) Does the amount on line 20 column 2, include charges for patient imposed on patients covered by Medicaid or other indigent care particular line 24 is yes, enter the charges for patient days beyond the	indigent ility nts (see off as t days beypprogram?	Uni nsured pati ents 1.00 3, 486, 33 763, 60 1, 34 762, 29 ond a Length	Insured patients 2.00 31 1,137,052 31 1,137,052 341 341 341 1,136,711	Total (col. 1 + col. 2) 3.00 4,623,383 1,900,653 1,689 1,898,964	20 21 22 23
. 00	Uncompensated Care (see instructions for each line) Charity care charges and uninsured discounts for the entire faci (see instructions) Cost of patients approved for charity care and uninsured discount instructions) Payments received from patients for amounts previously written of charity care Cost of charity care (line 21 minus line 22) Does the amount on line 20 column 2, include charges for patient imposed on patients covered by Medicaid or other indigent care plif line 24 is yes, enter the charges for patient days beyond the stay limit	indigent ility nts (see off as t days bey program? e indigent	Uni nsured pati ents 1.00 3, 486, 33 763, 60 1, 34 762, 29 ond a Length	Insured patients 2.00 31 1,137,052 31 1,137,052 341 341 341 1,136,711	Total (col. 1 + col. 2) 3.00 4,623,383 1,900,653 1,689 1,898,964 1.00 N	20 21 22 23 24 25
. 00	Uncompensated Care (see instructions for each line) Charity care charges and uninsured discounts for the entire faci (see instructions) Cost of patients approved for charity care and uninsured discount instructions) Payments received from patients for amounts previously written of charity care Cost of charity care (line 21 minus line 22) Does the amount on line 20 column 2, include charges for patient imposed on patients covered by Medicaid or other indigent care patient line 24 is yes, enter the charges for patient days beyond the stay limit Total bad debt expense for the entire hospital complex (see inst	indigent ility nts (see off as t days beypprogram? e indigent tructions)	Uni nsured pati ents 1.00 3,486,33 763,60 1,34 762,29 ond a Length care progra	Insured patients 2.00 31 1,137,052 31 1,137,052 341 341 341 1,136,711	Total (col. 1 + col. 2) 3.00 4,623,383 1,900,653 1,689 1,898,964 1.00 N	20 21 22 23 24 25 26
0.00 0.00 .00 2.00 3.00	Uncompensated Care (see instructions for each line) Charity care charges and uninsured discounts for the entire faci (see instructions) Cost of patients approved for charity care and uninsured discount instructions) Payments received from patients for amounts previously written of charity care Cost of charity care (line 21 minus line 22) Does the amount on line 20 column 2, include charges for patient imposed on patients covered by Medicaid or other indigent care point line 24 is yes, enter the charges for patient days beyond the stay limit Total bad debt expense for the entire hospital complex (see inst Medicare reimbursable bad debts for the entire hospital complex	indigent ility ints (see off as t days beyprogram? e indigent tructions) (see insti	Uni nsured pati ents 1.00 3, 486, 33 763, 60 1, 34 762, 29 ond a Length care progra	Insured patients 2.00 31 1,137,052 31 1,137,052 341 341 341 1,136,711	Total (col. 1 + col. 2) 3.00 4,623,383 1,900,653 1,689 1,898,964 1.00 N 0 7,118,978 45,468	20. 21. 22. 23. 24. 25. 26. 27.
0. 00 0. 00 0. 00 0. 00 0. 00 0. 00 0. 00 0. 00 0. 00 0. 00	Uncompensated Care (see instructions for each line) Charity care charges and uninsured discounts for the entire faci (see instructions) Cost of patients approved for charity care and uninsured discount instructions) Payments received from patients for amounts previously written of charity care Cost of charity care (line 21 minus line 22) Does the amount on line 20 column 2, include charges for patient imposed on patients covered by Medicaid or other indigent care provided line 24 is yes, enter the charges for patient days beyond the stay limit Total bad debt expense for the entire hospital complex (see inst Medicare reimbursable bad debts for the entire hospital complex (see	indigent ility ints (see off as t days beyprogram? e indigent tructions) (see insti	Uni nsured pati ents 1.00 3, 486, 33 763, 60 1, 34 762, 29 ond a Length care progra	Insured patients 2.00 31 1,137,052 31 1,137,052 341 341 341 1,136,711	Total (col. 1 + col. 2) 3.00 4,623,383 1,900,653 1,689 1,898,964 1.00 N 0 7,118,978 45,468 69,951	20 21 22 23 24 25 26 27 27
0.00 0.00 1.00 2.00 3.00 4.00 5.00 7.01 7.01	Uncompensated Care (see instructions for each line) Charity care charges and uninsured discounts for the entire faci (see instructions) Cost of patients approved for charity care and uninsured discount instructions) Payments received from patients for amounts previously written of charity care Cost of charity care (line 21 minus line 22) Does the amount on line 20 column 2, include charges for patient imposed on patients covered by Medicaid or other indigent care point line 24 is yes, enter the charges for patient days beyond the stay limit Total bad debt expense for the entire hospital complex (see inst Medicare reimbursable bad debts for the entire hospital complex	indigent ility nts (see off as t days beyr program? e indigent tructions) (see instructions)	Uni nsured pati ents 1.00 3,486,33 763,66 1,34 762,29 ond a Length care progra	Insured patients 2.00 1,137,052 1,136,711 of stay limit m's length of	Total (col. 1 + col. 2) 3.00 4,623,383 1,900,653 1,689 1,898,964 1.00 N 0 7,118,978 45,468	20 21 22 23 24 25 26 27 27 28
9. 00 0. 00 1. 00 2. 00 3. 00	Uncompensated Care (see instructions for each line) Charity care charges and uninsured discounts for the entire faci (see instructions) Cost of patients approved for charity care and uninsured discount instructions) Payments received from patients for amounts previously written of charity care Cost of charity care (line 21 minus line 22) Does the amount on line 20 column 2, include charges for patient imposed on patients covered by Medicaid or other indigent care part of line 24 is yes, enter the charges for patient days beyond the stay limit Total bad debt expense for the entire hospital complex (see instantial care reimbursable bad debts for the entire hospital complex (see Medicare allowable bad debt sfor the entire hospital complex (see Non-Medicare bad debt expense (see instructions)	indigent ility nts (see off as t days beyr program? e indigent tructions) (see instructions)	Uni nsured pati ents 1.00 3,486,33 763,66 1,34 762,29 ond a Length care progra	Insured patients 2.00 1,137,052 1,136,711 of stay limit m's length of	Total (col. 1 + col. 2) 3.00 4,623,383 1,900,653 1,689 1,898,964 1.00 N 0 7,118,978 45,468 69,951 7,049,027	20. 21. 22. 23. 24. 25. 26. 27. 27. 28. 29.

Heal th		HUNTINGTON MEMOR	RIAL HOSPITAL		In Lie	u of Form CMS-	2552-10
RECLAS	SSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE (OF EXPENSES	Provi der C		Period: From 01/01/2019	Worksheet A	
					To 12/31/2019	Date/Time Pre	pared:
	Oct 1 Oct 1 con Provided to		0.11	T. I. J. C. J. A	D. J. C. J.	6/26/2020 11:	
	Cost Center Description	Sal ari es	Other	+ col . 2)	Reclassificat ions (See	Reclassified Trial Balance	
				1 (01. 2)	A-6)	(col . 3 +-	
					ŕ	col. 4)	
	OFNEDAL CEDIUSE COCT OFNEDO	1.00	2. 00	3. 00	4. 00	5. 00	
1. 00	GENERAL SERVICE COST CENTERS 00100 CAP REL COSTS-BLDG & FIXT		1, 792, 407	1, 792, 407	7 44, 244	1, 836, 651	1.00
2. 00	00200 CAP REL COSTS-MVBLE EQUIP		1, 123, 773			1, 167, 669	1
3.00	00300 OTHER CAP REL COSTS		0		0	0	1
4. 00	00400 EMPLOYEE BENEFITS DEPARTMENT	1, 512, 454	5, 681, 792			5, 681, 792	
5.00	00500 ADMINISTRATIVE & GENERAL	1, 517, 125	21, 558, 803	23, 075, 928	-47, 494	23, 028, 434	
6. 00 7. 00	00600 MAINTENANCE & REPAIRS 00700 OPERATION OF PLANT	336, 029	971, 980	1, 308, 009	38, 717	0 1, 346, 726	
8. 00	00800 LAUNDRY & LINEN SERVICE	0	147, 890				1
9. 00	00900 HOUSEKEEPI NG	292, 813	138, 336			434, 257	1
10.00	01000 DI ETARY	417, 626	311, 404	729, 030			
11. 00 12. 00	01100 CAFETERI A 01200 MAI NTENANCE OF PERSONNEL		0		540, 367	540, 367 0	1
13. 00	01300 NURSI NG ADMI NI STRATI ON	365, 653	6, 087	371, 740	-	_	1
14.00	01400 CENTRAL SERVICES & SUPPLY	0	0) (0	0	14.00
15.00	01500 PHARMACY	550, 934	142, 135	693, 069	0	693, 069	1
16. 00 17. 00	01600 MEDI CAL RECORDS & LI BRARY 01700 SOCI AL SERVI CE	0	0		0	0	16. 00 17. 00
19. 00	01900 NONPHYSI CI AN ANESTHETI STS		0			0	19.00
20.00	02000 NURSI NG SCHOOL	0	0		0	0	20.00
21. 00	02100 I &R SERVICES-SALARY & FRINGES APPRV	0	0		0	0	21.00
22. 00	02200 I &R SERVICES-OTHER PRGM COSTS APPRV	0	0		0 0	0	22.00
23. 00	02300 PARAMED ED PRGM-(SPECIFY) INPATIENT ROUTINE SERVICE COST CENTERS	l U	0	1	0	0	23. 00
30.00	03000 ADULTS & PEDIATRICS	3, 283, 769	613, 847	3, 897, 616	-342, 474	3, 555, 142	30.00
43.00	04300 NURSERY	0	0) (153, 939	153, 939	43.00
50. 00	ANCILLARY SERVICE COST CENTERS 05000 OPERATING ROOM	1, 044, 255	551, 052	1, 595, 307	129, 500	1, 724, 807	50.00
50. 00	05001 OPERATING ROOM	1,044,255	0 0	1, 373, 30	0 127, 300	1, 724, 007	
52.00	05200 DELIVERY ROOM & LABOR ROOM	0	0) (578, 908	578, 908	
53.00	05300 ANESTHESI OLOGY	0	950, 029			950, 029	1
54. 00 60. 00	05400 RADI OLOGY-DI AGNOSTI C 06000 LABORATORY	1, 016, 337	561, 707 2, 578, 959			1, 695, 144 2, 578, 959	
62. 30	06250 BLOOD CLOTTING FOR HEMOPHILIACS		2, 376, 434	2, 376, 43		2, 376, 737	1
65.00	06500 RESPIRATORY THERAPY	731, 986	112, 405	844, 39	84, 338	928, 729	
66.00	06600 PHYSI CAL THERAPY	1, 246, 060	81, 991	1, 328, 051			1
67. 00 68. 00	06700 OCCUPATI ONAL THERAPY	0	0		268, 734	268, 734	
69.00	06800 SPEECH PATHOLOGY 06900 ELECTROCARDI OLOGY		0		180, 050	180, 050 0	1
71. 00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	l o	1, 710, 509	1, 710, 509	-778, 303	_	
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0	0	(778, 303		
73. 00 76. 97	07300 DRUGS CHARGED TO PATIENTS	0	2, 378, 824	2, 378, 824	63, 477		
	07697 CARDIAC REHABILITATION 07698 HYPERBARIC OXYGEN THERAPY	178, 277	318, 652	496, 929	9 0	496, 929	76. 97 76. 98
	07699 LI THOTRI PSY	0	0) (o o	0	1
	OUTPATIENT SERVICE COST CENTERS				.1 _		
90. 00 91. 00	09000 CLI NI C 09100 EMERGENCY	101, 305 1, 118, 977	8, 339 287, 681				
92.00		1, 110, 777	207, 001	1, 400, 030	130, 233	1, 550, 671	92.00
	OTHER REIMBURSABLE COST CENTERS			,	_]
95.00	09500 AMBULANCE SERVICES	2, 556, 071	405, 341	2, 961, 412	2 294, 505	3, 255, 917	95.00
113 00	SPECIAL PURPOSE COST CENTERS 11300 INTEREST EXPENSE	1	4, 803	4, 803	-4, 803	0	113.00
118.00		16, 269, 671	42, 438, 746				
	NONREI MBURSABLE COST CENTERS						1
	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	77 520	72, 453				190.00
	19200 PHYSICIANS' PRIVATE OFFICES 07950 OCC HEALTH	77, 528 0	11, 889 0	1	8, 933 0 0		192. 00 194. 00
	07951 PALN CLINIC		0		-		194. 01
	07952 OCC HEALTH	0	0) (0		194. 02
	3 O7953 FOUNDATIO	0	205, 133	205, 133		205, 133	
	O7954 KIDS CAMPUS O7955 COMMUNITY & VOLUNTEER SERVICES		364, 962	364, 962	0	0 364, 962	194. 04 194. 05
194. 06	07956 HUNTI NGTON COLLEGE NURSE		0 304, 702) 304, 902			194. 06
194.07	7 07957 MISC CATERING	0	0			73, 848	194. 07
194.08	307958 AUTI SM CENTER	0	0		0		194.08
194. 09	07959 HUNTINGTON BUA TOTAL (SUM OF LINES 118 through 199)	16, 347, 199	43, 093, 183	59, 440, 382	0 0		194.09
_55.50	, , , , , , , , , , , , , , , , , , ,	. 3, 5 . 7, 1 7 7	.5, 5, 5, 100	27, 110, 502			, 5. 00

Provi der CCN: 15-0091

Period: Worksheet A From 01/01/2019 To 12/31/2019 Date/Time Prepared: 6/26/2020 11: 24 am

			/26/2020 11: 24 am
Cost Center Description	Adjustments	Net Expenses	
	(See A-8)	For	
		Allocation	
	6. 00	7. 00	
GENERAL SERVICE COST CENTERS	·		
1.00 O0100 CAP REL COSTS-BLDG & FLXT	173, 187		1.00
2.00 O0200 CAP REL COSTS-MVBLE EQUIP	-73, 667		2. 00
3. 00 00300 OTHER CAP REL COSTS	0	1 -1	3.00
4.00 00400 EMPLOYEE BENEFITS DEPARTMENT	-3, 577, 565		4.00
5. 00 00500 ADMI NI STRATI VE & GENERAL	-6, 132, 733	1	5.00
6. 00 00600 MAI NTENANCE & REPAI RS	0	1	6.00
7. 00 00700 OPERATION OF PLANT	-1, 457	1, 345, 269	7.00
8. 00 00800 LAUNDRY & LINEN SERVICE	0	178, 519	8.00
9. 00 00900 HOUSEKEEPI NG	0	434, 257	9.00
10. 00 01000 DI ETARY	-3, 801	111, 014	10.00
11. 00 01100 CAFETERI A	-242, 671	297, 696	11.00
12.00 O1200 MAINTENANCE OF PERSONNEL 13.00 O1300 NURSING ADMINISTRATION	0	412.070	12.00
	0	413, 870	13.00
14. 00 01400 CENTRAL SERVI CES & SUPPLY 15. 00 01500 PHARMACY	-173, 757	0 519, 312	14. 00 15. 00
16. 00 01600 MEDI CAL RECORDS & LI BRARY	-1/3, /3/	319, 312	16.00
17. 00 01700 SOCIAL SERVICE	0		17. 00
19. 00 01900 NONPHYSICIAN ANESTHETISTS	0		19.00
20. 00 02000 NURSI NG SCHOOL	0		20.00
21. 00 02100 &R SERVICES-SALARY & FRINGES APPRV	0		21.00
22. 00 02200 &R SERVICES-OTHER PRGM COSTS APPRV	0		22. 00
23. 00 02300 PARAMED ED PRGM-(SPECIFY)	o o	1	23. 00
INPATIENT ROUTINE SERVICE COST CENTERS		-1	-3.33
30. 00 03000 ADULTS & PEDIATRICS	-7, 756	3, 547, 386	30.00
43. 00 04300 NURSERY	0		43.00
ANCILLARY SERVICE COST CENTERS	<u>'</u>	· · · ·	
50. 00 05000 OPERATING ROOM	-950, 035	774, 772	50.00
50.01 05001 OPERATING ROOM	0	0	50. 01
52.00 05200 DELIVERY ROOM & LABOR ROOM	0	578, 908	52.00
53. 00 05300 ANESTHESI OLOGY	0	950, 029	53.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	-3, 270	1, 691, 874	54.00
60. 00 06000 LABORATORY	0	2, 578, 959	60.00
62.30 06250 BLOOD CLOTTING FOR HEMOPHILIACS	0	0	62. 30
65. 00 06500 RESPI RATORY THERAPY	-29, 530		65.00
66. 00 06600 PHYSI CAL THERAPY	-13, 455		66.00
67. 00 06700 OCCUPATI ONAL THERAPY	0		67.00
68. 00 06800 SPEECH PATHOLOGY	0		68.00
69. 00 06900 ELECTROCARDI OLOGY	0	0	69.00
71. 00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0		71.00
72. 00 07200 IMPL. DEV. CHARGED TO PATIENTS	0		72.00
73. 00 07300 DRUGS CHARGED TO PATIENTS	0		73.00
76. 97 O7697 CARDI AC REHABI LI TATI ON 76. 98 O7698 HYPERBARI C OXYGEN THERAPY	0	404 020	76. 97
76. 98 07698 HYPERBARI C OXYGEN THERAPY 76. 99 07699 LI THOTRI PSY	0	1	76. 98
OUTPATIENT SERVICE COST CENTERS	0	0	76. 99
90. 00 O9000 CLINIC	0	109, 644	90.00
91. 00 09100 EMERGENCY	-39, 314		91.00
92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART	-37, 314	1,477,377	92.00
OTHER REIMBURSABLE COST CENTERS			72.00
95. 00 09500 AMBULANCE SERVICES	-14, 461	3, 241, 456	95.00
SPECIAL PURPOSE COST CENTERS	,		
113. 00 11300 NTEREST EXPENSE	0	0	113.00
118.00 SUBTOTALS (SUM OF LINES 1 through 117)	-11, 090, 285	47, 535, 351	118.00
NONREI MBURSABLE COST CENTERS		<u> </u>	
190.00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	72, 453	190. 00
192.00 19200 PHYSICIANS' PRIVATE OFFICES	0	98, 350	192.00
194.00 07950 OCC HEALTH	0	0	194. 00
194. 01 07951 PAIN CLINIC	0	0	194. 01
194. 02 07952 OCC HEALTH	0	0	194. 02
194. 03 07953 FOUNDATI 0	0	205, 133	194. 03
194.04 07954 KIDS CAMPUS	0	1	194. 04
194. 05 07955 COMMUNITY & VOLUNTEER SERVICES	0		194. 05
194. 06 07956 HUNTI NGTON COLLEGE NURSE	0	1 -1	194. 06
194. 07 07957 MI SC CATERI NG	0		194. 07
194. 08 07958 AUTI SM CENTER	0	1	194. 08
194. 09 07959 HUNTI NGTON BUA	0	- 1	194. 09
200.00 TOTAL (SUM OF LINES 118 through 199)	-11, 090, 285	48, 350, 097	200.00

Health Financial Systems	HUNTINGTON MEMORIAL HOSPITAL	In Lieu of Form CMS-2552-10		
RECLASSI FI CATI ONS	Provi der CCN: 15-0091	Peri od: Worksheet A-6 From 01/01/2019 To 12/31/2019 Date/Time Prepared:		

					То	12/31/2019	Date/Time P 6/26/2020 1	
		Increases					10/20/2020 1	1. 24 aiii
	Cost Center	Li ne #	Sal ary	Other				
	2. 00	3. 00	4. 00	5. 00				
	A - CAFETERIA & CATERING							
1.00	CAFETERI A	11. 00	308, 830	231, 537				1.00
2.00	MISC_CATERING	194. 07	<u>42, 1</u> 93	<u>31, 6</u> 55				2.00
	TOTALS		351, 023	263, 192				
	B - INTEREST RECLASSIFICATION							
1.00	CAP REL COSTS-MVBLE EQUIP		0	4, 803				1.00
	TOTALS		0	4, 803				
	C - INSURANCE RECLASS							
1.00	CAP REL COSTS-BLDG & FIXT	1. 00	0	44, 244				1.00
2.00	CAP REL COSTS-MVBLE EQUIP		0	39, 093				2. 00
	TOTALS		0	83, 337				
	E - LAUNDRY RECLASS							
1.00	LAUNDRY & LINEN SERVICE	8. 00	30, 629	0				1. 00
	TOTALS		30, 629	0				
	F - HOME OFFICE SALARY RECLAS	S						
1.00	ADMINISTRATIVE & GENERAL	5. 00	5, 100, 671	0				1. 00
	TOTALS		5, 100, 671	0				
	G - PTO & BENEFITS RECLASS							
1.00	ADMINISTRATIVE & GENERAL	5. 00	35, 843	0				1. 00
2.00	OPERATION OF PLANT	7. 00	38, 717	0				2.00
3.00	HOUSEKEEPI NG	9. 00	33, 737	0				3. 00
4.00	NURSING ADMINISTRATION	13. 00	42, 130	0				4.00
5.00	ADULTS & PEDIATRICS	30.00	390, 373	0				5.00
6.00	OPERATING ROOM	50.00	129, 500	0				6.00
7.00	RADI OLOGY-DI AGNOSTI C	54.00	117, 100	0				7. 00
8.00	RESPI RATORY THERAPY	65.00	84, 338	0				8. 00
9.00	PHYSI CAL THERAPY	66.00	143, 568	0				9. 00
10.00	DRUGS CHARGED TO PATIENTS	73.00	63, 477	0				10.00
11.00	EMERGENCY	91.00	130, 233	0				11.00
12.00	AMBULANCE SERVICES	95.00	294, 505	0				12.00
13.00	PHYSICIANS' PRIVATE OFFICES	192. 00	8, 933	0				13.00
	TOTALS		1, 512, 454					
	H - IMPLANTS							
1.00	IMPL. DEV. CHARGED TO	72. 00	0	778, 303				1.00
	PATI ENTS							
	TOTALS		0	778, 303				
	I - OB RECLASS							
1.00	NURSERY	43.00	139, 316	14, 623				1.00
2.00	DELIVERY ROOM & LABOR ROOM	52. 00	52 <u>3, 9</u> 17	54, 991				2.00
	TOTALS		663, 233	69, 614				
	J - THERAPY RECLASS							
1.00	OCCUPATI ONAL THERAPY	67. 00	252, 731	16, 003				1.00
2.00	SPEECH PATHOLOGY	6800	16 <u>9, 3</u> 28	1 <u>0, 7</u> 22				2. 00
	TOTALS		422, 059	26, 725				
500.00	Grand Total: Increases		8, 080, 069	1, 225, 974				500.00
	,	·	•	·				

	From 01/01/2019	
	To 12/31/2019	Date/Time Prepared:
		6/26/2020 11 24 am

					'		6/26/2020 11: 24 am
		Decreases					
	Cost Center	Li ne #	Sal ary	0ther	Wkst. A-7 Ref.		
	6. 00	7.00	8. 00	9. 00	10.00		
	A - CAFETERIA & CATERING						
1. 00	DI ETARY	10. 00	351, 023	263, 192	0		1.00
2. 00		0. 00	0	C	00		2.00
	TOTALS	$ \top$	351, 023	263, 192	2		
	B - INTEREST RECLASSIFICATION						
1. 00	INTEREST EXPENSE	113. 00	0	4, 803	11		1.00
	TOTALS	T		4, 803	3		
	C - INSURANCE RECLASS		•				
1. 00	ADMINISTRATIVE & GENERAL	5. 00	0	83, 337	12		1.00
2. 00		0.00	o	·			2.00
	TOTALS			83, 337			
	E - LAUNDRY RECLASS		- 1				
1.00	HOUSEKEEPING	9. 00	30, 629	C	0		1.00
	TOTALS		30, 629	0	 		
	F - HOME OFFICE SALARY RECLASS		00/02/		<u> </u>		
1. 00	ADMI NI STRATI VE & GENERAL	5. 00	0	5, 100, 671	0		1.00
1.00	TOTALS		 _	5, 100, 671			1.00
	G - PTO & BENEFITS RECLASS		<u> </u>	3, 100, 071	'	L	
1. 00	EMPLOYEE BENEFITS DEPARTMENT	4. 00	1, 512, 454	C	0		1.00
2. 00	LIMI LOTEL BENEFIT TO BETAKTIMENT	0.00	1, 312, 434	C			2.00
3. 00		0.00	0		1		3.00
4. 00		0.00	0				4.00
5. 00		0.00	0	C			5.00
5. 00		0.00	0				6.00
7. 00		0.00	0				7.00
		0.00	U	C			8.00
3. 00			0	C			
9. 00		0. 00	0	C	0		9.00
10.00		0.00	0	C	0		10.00
11.00		0. 00	0	C	7		11.00
12.00		0. 00	0	C	,	•	12. 00
13.00		0.00	0		<u> </u>		13. 00
	TOTALS		1, 512, 454)		
	H - IMPLANTS				.1 _	Ī	
1. 00	MEDICAL SUPPLIES CHARGED TO	71. 00	0	778, 303	0		1.00
	PATI ENT				 		
	TOTALS		0	778, 303	3		
	I - OB RECLASS				T	T	
1.00	ADULTS & PEDIATRICS	30. 00	663, 233	69, 614		1	1.00
2. 00		0.00	0		<u> </u>		2. 00
	TOTALS		663, 233	69, 614	1		
	J - THERAPY RECLASS						
. 00	PHYSI CAL THERAPY	66. 00	422, 059	26, 725			1.00
2. 00		0.00	0	0]	2. 00
	TOTALS		422, 059	26, 725	5		
500.00	Grand Total: Decreases		2, 979, 398	6, 326, 645	5		500.00

				Ť	o 12/31/2019	Date/Time Pre 6/26/2020 11:	
				Acqui si ti ons		07 207 2020 111	
		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 ASSE	T BALANCES					
1.00	Land	0	0	_	0	0	1.00
2.00	Land Improvements	556, 529	55, 265	0	55, 265		2.00
3.00	Buildings and Fixtures	2, 370, 508	6, 892, 707	0	6, 892, 707	0	3.00
4.00	Building Improvements	32, 500	0	0	0	0	4. 00
5.00	Fixed Equipment	1, 783, 863	397, 140		397, 140		5.00
6.00	Movable Equipment	12, 232, 194	1, 217, 029		1, 217, 029		
7. 00	HIT designated Assets	3, 039, 789	123, 346	0	123, 346		7. 00
8.00	Subtotal (sum of lines 1-7)	20, 015, 383	8, 685, 487	0	8, 685, 487		
9.00	Reconciling Items	-3, 496, 947	6, 427, 163		6, 427, 163		9. 00
10.00	Total (line 8 minus line 9)	23, 512, 330	2, 258, 324	0	2, 258, 324	535, 998	10.00
		Endi ng	Fully				
		Bal ance	Depreciated				
		(00	Assets				
	DART I ANALYCIC OF QUANCES IN CARLTAL ACCE	6. 00	7. 00				
1 00	PART I - ANALYSIS OF CHANGES IN CAPITAL ASSE	I BALANCES	0				1 00
1.00	Land	(14 704	0				1.00
2.00	Land Improvements	611, 794	187, 814				2.00
3.00	Buildings and Fixtures	9, 263, 215	721, 854				3.00
4.00	Building Improvements	32, 500	225 102				4.00
5.00	Fi xed Equi pment	2, 181, 003	225, 103				5.00
6. 00 7. 00	Movable Equipment	12, 913, 225	7, 472, 452				6. 00 7. 00
	HIT designated Assets	3, 163, 135	0 407 222				
8. 00 9. 00	Subtotal (sum of lines 1-7) Reconciling Items	28, 164, 872 2, 930, 216	8, 607, 223				8. 00 9. 00
9. 00 10. 00	Total (line 8 minus line 9)		0 407 222				10.00
10.00	Total (Title o IIITius Title 9)	25, 234, 656	8, 607, 223	I			10.00

Heal th	n Financial Systems	HUNTINGTON MEMO	RIAL HOSPITAL		In Lieu of Form CMS-2552-10			
RECON	CILIATION OF CAPITAL COSTS CENTERS		Provi der Co		Peri od:	Worksheet A-7		
					From 01/01/2019 To 12/31/2019		narod:	
					10 12/31/2019	Date/Time Pre 6/26/2020 11:	24 am	
			SU	JMMARY OF CAPI				
	Cost Center Description	Depreciation	Lease	Interest	Insurance	Taxes (see		
					(see	instructions)		
					instructions)			
		9. 00	10. 00	11. 00	12. 00	13. 00		
	PART II - RECONCILIATION OF AMOUNTS FROM WOR					T		
1. 00	CAP REL COSTS-BLDG & FLXT	506, 188			0	0	1.00	
2.00	CAP REL COSTS-MVBLE EQUIP	1, 038, 572	•		0	6, 613		
3.00	Total (sum of lines 1-2)	1, 544, 760			0 0	6, 613	3.00	
		SUMMARY 0	F CAPITAL					
	Cost Center Description	0ther	Total (1)					
		Capi tal -Rel at	(sum of cols.					
		ed Costs (see	9 through 14)					
		instructions)						
		14. 00	15. 00					
	PART II - RECONCILIATION OF AMOUNTS FROM WOR	RKSHEET A, COLUM	MN 2, LINES 1 a	and 2				
1.00	CAP REL COSTS-BLDG & FIXT	0	1, 792, 407				1.00	
2.00	CAP REL COSTS-MVBLE EQUIP	4, 772	1, 123, 773				2.00	
3.00	Total (sum of lines 1-2)	4, 772	2, 916, 180				3.00	

MCRI F32 - 16. 1. 168. 0

Heal th	n Financial Systems	HUNTINGTON MEMO	ORIAL HOSPITAL		In Lie	u of Form CMS-2	2552-10
RECON	CILIATION OF CAPITAL COSTS CENTERS		Provi der Co		Period: From 01/01/2019 To 12/31/2019		pared:
		COMI	PUTATION OF RAT	TI 0S	ALLOCATION OF	OTHER CAPITAL	
	Cost Center Description	Gross Assets	Capi tal i zed	Gross Assets		Insurance	
			Leases	for Ratio	instructions)		
				(col. 1 -			
		1. 00	2.00	col . 2) 3.00	4. 00	5. 00	
	PART III - RECONCILIATION OF CAPITAL COSTS CENTERS						
1. 00	CAP REL COSTS-BLDG & FIXT	12, 088, 511	0	12, 088, 51	1 0. 487772	0	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	12, 913, 225	l .			0	2.00
3.00	Total (sum of lines 1-2)	25, 001, 736			9 1. 000000	0	3.00
	ALLOCATIO			CAPI TAL	SUMMARY C	F CAPITAL	
	Cost Center Description	Taxes	0ther	Total (sum of	Depreciation	Lease	
			Capi tal -Rel at				
			ed Costs	through 7)			
	DART III DECONOLILATION OF CARLTAL COCTO	6. 00	7. 00	8. 00	9. 00	10.00	
1. 00	PART III - RECONCILIATION OF CAPITAL COSTS C	ENTERS			0 1, 971, 889	-6, 295	1. 00
2.00	CAP REL COSTS-BLDG & FIXT	0			0 1, 971, 889		2.00
3.00	Total (sum of lines 1-2)	0	0		0 2, 941, 597		3. 00
0.00	,		SL	JMMARY OF CAPI		37,521	0.00
	Cost Center Description	Interest	Insurance	Taxes (see	Other	Total (2)	
			(see	instructions)	Capi tal -Rel at		
			instructions)		ed Costs (see	9 through 14)	
					instructions)		
	DART III DECONOLILATION OF CARLTAL COCTO	11. 00	12. 00	13. 00	14. 00	15. 00	
1. 00	PART III - RECONCILIATION OF CAPITAL COSTS C	ENTERS	44, 244		0 0	2, 009, 838	1. 00
2.00	CAP REL COSTS-BLDG & FIXT						2.00
3. 00	Total (sum of lines 1-2)						
5.00	10tal (3am 01 111103 1 2)	1	05, 557	0,01	5 4,772	0, 100, 040	5.00

ADJUST	WENTS TO EXPENSES			Provider CCN. 15-0091	From 01/01/2019	WOI KSHEET A-6	
					To 12/31/2019	Date/Time Pre 6/26/2020 11:	
			To	Expense Classification o From Which the Amount is			
				or the fine fine fine fine fine	r to be haj astea		
	Cost Center Description	Basi s/Code	Amount	Cost Center	Li ne #	Wkst. A-7	
		(2) 1. 00	2.00	3. 00	4.00	Ref. 5.00	
1. 00	Investment income - CAP REL	1, 55		AP REL COSTS-BLDG & FIXT	1. 00	0	1.00
2. 00	COSTS-BLDG & FIXT (chapter 2) Investment income - CAP REL	В	-4 803 CA	AP REL COSTS-MVBLE EQUIP	2. 00	11	2.00
	COSTS-MVBLE EQUIP (chapter 2)	D		WEE OOOTS WADEL EGOTT			
3. 00	Investment income - other (chapter 2)		0		0. 00	0	3. 00
4.00	Trade, quantity, and time		0		0.00	0	4. 00
5. 00	discounts (chapter 8) Refunds and rebates of		0		0.00	0	5.00
	expenses (chapter 8)				0.00		,
6. 00	Rental of provider space by suppliers (chapter 8)		0		0.00	O _l	6. 00
7. 00	Tel ephone servi ces (pay	Α	-1, 025 AD	OMINISTRATIVE & GENERAL	5. 00	0	7. 00
	stations excluded) (chapter 21)						
8. 00	Television and radio service	Α	-257 OF	PERATION OF PLANT	7. 00	0	8. 00
9. 00	(chapter 21) Parking Lot (chapter 21)		0		0. 00	0	9. 00
10. 00	Provi der-based physician	A-8-2	-982, 998			0	10.00
11. 00	adjustment Sale of scrap, waste, etc.		o		0. 00	0	11.00
12.00	(chapter 23)	A O 1	4 102 022			0	12.00
12. 00	Related organization transactions (chapter 10)	A-8-1	-6, 183, 922			U _I	12.00
13. 00 14. 00	Laundry and linen service Cafeteria-employees and guests	А	0 -55, 183 C <i>A</i>	AEETEDI A	0. 00 11. 00	0	
15. 00	Rental of quarters to employee		-55, 165 CF	AFEIERIA	0.00	0	1
16. 00	and others Sale of medical and surgical				0. 00	0	16. 00
10.00	supplies to other than				0.00	U _l	16.00
17 00	patients Sale of drugs to other than		0		0. 00		17. 00
17.00	patients				0.00	0	17.00
18. 00	Sale of medical records and abstracts		0		0. 00	0	18. 00
19. 00	Nursing and allied health		0		0. 00	0	19. 00
	education (tuition, fees, books, etc.)						
	Vendi ng machi nes		О		0. 00	0	20.00
21. 00	Income from imposition of interest, finance or penalty		0		0. 00	0	21.00
	charges (chapter 21)						
22. 00	Interest expense on Medicare overpayments and borrowings to		0		0.00	0	22. 00
	repay Medicare overpayments						
23. 00	Adjustment for respiratory therapy costs in excess of	A-8-3	ORE	ESPI RATORY THERAPY	65. 00		23. 00
	limitation (chapter 14)						
24.00	Adjustment for physical therapy costs in excess of	A-8-3	OPF	HYSI CAL THERAPY	66. 00		24.00
05.00	limitation (chapter 14)						
25. 00	Utilization review - physicians' compensation		0 **	Cost Center Deleted ***	114. 00		25. 00
04 00	(chapter 21)			AD DEL COCTO DIDO O FLVT	1 00		0, 00
26. 00	Depreciation - CAP REL COSTS-BLDG & FLXT		OCA	AP REL COSTS-BLDG & FIXT	1. 00	0	26. 00
27. 00	Depreciation - CAP REL		O CA	AP REL COSTS-MVBLE EQUIP	2. 00	0	27. 00
28. 00	COSTS-MVBLE EQUIP Non-physician Anesthetist		ONC	ONPHYSICIAN ANESTHETISTS	19. 00		28. 00
29. 00	Physicians' assistant	A 9 2	0	CCLIDATI ONAL TUEDADV	0.00	0	
30. 00	therapy costs in excess of	A-8-3		CCUPATI ONAL THERAPY	67. 00		30.00
30 00	limitation (chapter 14) Hospice (non-distinct) (see		Olar	DULTS & PEDIATRICS	30. 00		30. 99
JU. 77	instructions)			OCTO & LEDIMINICO	30.00		30. 77
	•		•			'	

Peri od: From 01/01/2019 To 12/31/2019 Date/Time Prepared: 6/26/2020 11: 24 am

					6/26/2020 11:	24 am_
			Expense Classification on	Worksheet A		
			To/From Which the Amount is	to be Adiusted		
Cost Center Description	Basis/Code	Amount	Cost Center	Li ne #	Wkst. A-7	
cost center beserretion	(2)	Amount	COST CONTEN	LITIC #	Ref.	
		0.00	2.00	4.00		
	1. 00	2. 00	3.00	4. 00	5. 00	
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		C		0. 00	0	32.00
Depreciation and Interest			1	0.00	O	32.00
33. 00 OTHER ADJUSTMENTS (SPECIFY)		C)	0. 00	0	33.00
(3)						
33. 01 TELEPHONE SERVICES	A	-333	EMPLOYEE BENEFITS DEPARTMENT	4. 00	0	33. 01
33. 02 RENT EXPENSE OFFSET	l A	-984 267	CAP REL COSTS-BLDG & FIXT	1. 00	10	33. 02
33. 03 RENT EXPENSE OFFSET	A		CAP REL COSTS-BLDG & FIXT	1. 00	10	33. 03
	•					
33.04 RENT EXPENSE OFFSET	A		CAP REL COSTS-BLDG & FIXT	1. 00	10	33. 04
33.05 RENT EXPENSE OFFSET	A	-14, 400	CAP REL COSTS-BLDG & FLXT	1. 00	10	33. 05
33.06 PHARMACY EMPLOYEE RX PURCHASE	S B	-100, 601	PHARMACY	15. 00	0	33.06
33. 07 PHYSICIAN RECRUITMENT	A	-25 000	ADMINISTRATIVE & GENERAL	5. 00	0	33. 07
33. 08 SELF INSURANCE	A		EMPLOYEE BENEFITS DEPARTMENT	4. 00	0	33. 08
	•		l I		· ·	
33.09 GUEST MEAL OFFSET	A		CAFETERI A	11. 00	0	33. 09
33.10 AHA-IHA LOBBYING OFFSET	A	-4, 424	ADMINISTRATIVE & GENERAL	5. 00	0	33. 10
33. 11 LOBBYING OFFSET	A		ADMINISTRATIVE & GENERAL	5. 00	0	33. 11
33. 12 LIQUOR OFFSET	l A		ADMINISTRATIVE & GENERAL	5. 00	0	33. 12
33. 13 OTHER OPERATING REVENUE	В		ADMINISTRATIVE & GENERAL	5. 00	0	33. 13
					_	
33. 14 OTHER OPERATING REVENUE	В		DI ETARY	10. 00	0	33. 14
33.15 OTHER OPERATING REVENUE	В	-178, 135	CAFETERI A	11. 00	0	33. 15
33. 16 OTHER OPERATING REVENUE	В	-73, 156	PHARMACY	15. 00	0	33. 16
33. 17 OTHER OPERATING REVENUE	В	-3 270	RADI OLOGY-DI AGNOSTI C	54.00	0	33. 17
33. 18 OTHER OPERATING REVENUE	В		RESPIRATORY THERAPY	65. 00	0	33. 18
	1				· ·	
33. 19 OTHER OPERATING REVENUE	В		PHYSI CAL THERAPY	66. 00	0	33. 19
33. 20 OTHER OPERATING REVENUE	В	-16, 814	EMERGENCY	91. 00	0	33. 20
33. 21 OTHER OPERATING REVENUE	В	-1, 350	AMBULANCE SERVICES	95.00	0	33. 21
33. 22 OTHER OPERATING REVENUE	В	-43, 932	ADULTS & PEDIATRICS	30. 00	0	33. 22
33. 23 OTHER OPERATING REVENUE	В		OPERATING ROOM	50. 00	0	33. 23
	B				0	33. 24
			OPERATION OF PLANT	7. 00	U	
33. 25 DEPRECIATION	A		CAP REL COSTS-BLDG & FLXT	1. 00	9	33. 25
33. 26 DEPRECIATION	A	-68, 864	CAP REL COSTS-MVBLE EQUIP	2. 00	9	33. 26
33. 27 TELEMETRY COSTS	A	36, 176	ADULTS & PEDIATRICS	30. 00	0	33. 27
33. 28 PHYSI CLAN ADMINISTRATION	A		ADMINISTRATIVE & GENERAL	5. 00	0	33. 28
	_ ^	124, 400	ADMINISTRATIVE & GENERAL	5.00	U	33.20
SALARI ES						
33. 29 OTHER ADJUSTMENTS (SPECIFY)		C)	0. 00	0	33. 29
(3)						
33. 30 OTHER ADJUSTMENTS (SPECIFY)		C		0.00	0	33. 30
(3)						
33. 31 OTHER ADJUSTMENTS (SPECIFY)		C		0. 00	0	33. 31
, ,			ή	0.00	U	ا کی کا
(3)						
33.32 OTHER ADJUSTMENTS (SPECIFY)	1	C)	0. 00	0	33. 32
(3)	1					
50.00 TOTAL (sum of lines 1 thru 49)	-11, 090, 285	<u> </u>	l		50.00
(Transfer to Worksheet A,	1					
·	1					
column 6, line 200.)	1	L				L

⁽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.

			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 RELA	FED ORGANIZATION(S) AND/OR HO	ME OFFICE:			

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

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

6. 00	В	0.00 PARKVIEW HEALTH SYSTEM, INC. 100.0	6.00
7. 00		0.00	7.00
8. 00		0.00	8.00
9. 00		0.00	9.00
10.00		0.00	10.00
100.00	G. Other (financial or		100.00
	non-financial) specify:		

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

Worksheet A-8, column 2,

line 12.

- A. Individual has financial interest (stockholder, partner, etc.) in both related organization and in provider. B. Corporation, partnership, or other organization has financial interest in provider.
- 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
- 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 provi der.

Health Financial Systems			HUNTINGTON MEMORIAL HOSPITAL			In Lieu	u of Form CMS	-2552-10
		SERVICES FROM	RELATED ORGANIZATIONS AND	HOME Provide	CCN: 15-0091	Peri od: From 01/01/2019	Worksheet A-	8-1
OFFICE	COSTS						Date/Time Pr 6/26/2020 11	
	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 TRANSACTION	S WITH RELATED	ORGANI ZATI ONS OR	CLAIMED HOME	
	OFFICE COSTS:							
1.00	2, 257, 255	0						1.00
2.00	-8, 441, 177	0)					2.00
3.00	0	0						3.00
4.00	0	0						4. 00
5.00	-6, 183, 922							5.00
* The	amounts on line	es 1-4 (and sul	bscripts as appropriate) are	e transferred	in detail to Wo	rksheet A. column	6. Lines as	
			se cost and negative amounts					st which
			columns 1 and/or 2, the amo					
	Related Orga	ani zati on(s)						
		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	HOME OFFICE		6.00
7.00			7.00
8.00			8.00
8. 00 9. 00			9.00
10.00			10.00
10. 00 100. 00		1	100.00

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

B. INTERRELATIONSHIP TO RELATED ORGANIZATION(S) AND/OR HOME OFFICE:

Type of Business 6.00

- 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 organi zati on.
- 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

Peri od: Worksheet A-8-2 From 01/01/2019 To 12/31/2019 Date/Time Prepared: Provi der CCN: 15-0091

									То	12/31/2019	Date/Time Pre 6/26/2020 11:	epared:
	Wkst. A Line #		Cost	Center/Physi ci an	Total	Pro	fessi onal	Provi der	Т	RCE Amount	Physi ci an/Prov	
				I denti fi er	Remuneration		mponent	Component			ider Component	
											Hours	
	1.00			2.00	3. 00		4. 00	5. 00		6. 00	7. 00	
1.00	50.00				947, 991		923, 991	24, 00	00	11, 844	106	1.00
2.00	91. 00	DR.	В		22, 500)	22, 500		0	0	0	2.00
3.00	95. 00	DR.	С		13, 111		13, 111		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					983, 602		959, 602		00			200.00
	Wkst. A Line #		Cost	Center/Physi ci an	Unadjusted RCE			Cost of			Physician Cost	
				I denti fi er	Limit			Membershi ps			of Malpractice	
							Limit	Conti nui ng	S	Share of col.	Insurance	
	1 00				0.00			Education	_	12	44.00	
1 00	1.00	DD	^	2. 00	8. 00		9. 00	12. 00		13. 00	14. 00	1 00
1.00	50. 00 91. 00				604	1	30		0	0		1.00
2.00	95.00				0	()	0		0	0		2. 00 3. 00
3. 00 4. 00	0.00		C			()	0		0	0	ı -	4. 00
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			0001	I denti fi er	Component		Limit	Di sal I owance	ا ڊ	riaj ao emorre		
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Health Financial Systems
COST ALLOCATION - GENERAL SERVICE COSTS HUNTINGTON MEMORIAL HOSPITAL In Lieu of Form CMS-2552-10 | Peri od: | Worksheet B | From 01/01/2019 | Part I | To 12/31/2019 | Date/Time Prepared: Provider CCN: 15-0091

CONTROL CENTROL DESCRIPTION						To	12/31/2019	Date/Time Pre 6/26/2020 11:	
COST Center Description					CAPI TAL REI	ATED COSTS		0/20/2020 11.	24 (111)
SEMENAL SERVICE COST CENTERS									
A			Cost Center Description		BLDG & FIXT	MVBLE EQUIP		Subtotal	
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1,000 MACON NURSERY 1,000 1,000 1,000 1,000 1,000 1,000 1,000 1,000 1,000 1,000 1,000 1,000 1,000 1,000 1,000 1,000 1,000 1,000 1,000 1,000 1,000 1,000 1,000 1,000 1,000 1,000 1,000 1,000 1,000 1,000 1,000 1,000 1,000 1,000 1,000 1,000 1,000 1,000 1,000 1,000 1,000 1,000 1,000 1,000 1,000 1,000 1,000 1,000 1,000 1,000 1,000 1,000 1,000 1,000 1,000 1,000 1,000 1,000 1,000 1,000 1,000 1,000 1,000 1,000 1,000 1,000 1,000 1,000 1,000 1,000 1,000 1,000 1,000 1,000 1,000 1,000 1,000 1,000 1,000 1,000 1,000 1,000 1,000 1,000 1,000 1,000 1,000 1,000 1,000 1,000 1,000 1,000 1,000 1,000 1,000 1,000 1,000 1,000 1,000 1,000 1,000 1,000 1,000 1,000 1,000 1,000 1,000 1,000 1,000 1,000 1,000 1,000 1,000 1,000 1,000 1,000 1,000 1,000 1,000 1,000 1,000 1,000 1,000 1,000 1,000 1,000 1,000 1,000 1,000 1,000 1,000 1,000 1,000 1,000 1,000 1,000 1,000 1,000 1,000 1,000 1,000 1,000 1,000 1,000 1,000 1,000 1,000 1,000 1,000 1,000 1,000 1,000 1,000 1,000 1,000 1,000 1,000 1,000 1,000 1,000 1,000 1,000 1,000 1,000 1,000 1,000 1,000 1,000 1,000 1,000 1,000 1,000 1,000 1,000 1,000 1,000 1,000 1,000 1,000 1,000 1,000 1,000 1,000 1,000 1,000 1,000 1,000 1,000 1,000 1,000 1,000 1,000 1,000 1,000 1,000 1,000 1,000 1,000 1,000 1,000 1,000 1,000 1,000 1,000 1,000 1,000 1,000 1,000 1,000 1,000 1,000 1,000 1,000 1,000 1,000 1,000 1,000 1,000 1,000 1,000 1,000 1,000 1,000 1,000 1,000 1,000 1,000 1,000 1,000 1,000 1,000 1,000 1,000 1,000 1,000 1,000 1,000 1,000 1,000 1,000 1,000 1,000 1,000 1,000 1,000 1,000 1,000 1,000 1,000 1,000 1,000 1,000 1,00									
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50.00	43. 00			153, 939	1, 494	0	13, 681	169, 114	43.00
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54. 00 05400 RADIO LOGY-DI AGNOSTIC 1. 691,874 175,954 246,900 111,302 2. 226,030 54. 00 00 00 0 2. 605, 619 60. 00 60. 00 00 0. 2. 605, 619 60. 00 62. 30 6250 80.00 LABORATORY THERAPY 8.99,199 32,255 48,542 80,162 1.060,188 65. 00 65.00 65.00 RESPIRATORY THERAPY 1.,009,380 381,352 34,078 95,014 1.,519,824 66. 00 64. 00 64. 00 64. 00 64. 00 64. 00 64. 00 64. 00 64. 00 64. 00 64. 00 64. 00 64. 00 64. 00 64. 00 64. 00 64. 00 64. 00 64. 00 64. 00 64. 00 64. 00 64. 00 64. 00 64. 00 64. 00 64. 00 64. 00 64. 00 64. 00 64. 00 64. 00 64. 00 64. 00 64. 00 64. 00 64. 00 64. 00 64. 00 64. 00 64. 00 64. 00 64. 00 64. 00 64. 00 64. 00 64. 00 64. 00 64. 00 64. 00 64. 00 64. 00 64. 00 64. 00 64. 00 64. 00 64. 00 64. 00 64. 00 64. 00 64. 00 64. 00 64. 00 64. 00 64. 00 64. 00 64. 00 64. 00 64. 00 64. 00 64. 00 64. 00 64. 00 64. 00 64. 00 64. 00 64. 00 64. 00 64. 00 64. 00 64. 00 64. 00 64. 00 64. 00 64. 00 64. 00 64. 00 64. 00 64. 00 64. 00 64. 00 64. 00 64. 00 64. 00 64. 00 64. 00 64. 00 64. 00 64. 00 64. 00 64. 00 64. 00 64. 00 64. 00 64. 00 64. 00 64. 00 64. 00 64. 00 64. 00 64. 00 64. 00 64. 00 64. 00 64. 00 64. 00 64. 00 64. 00 64. 00 64. 00 64. 00 64. 00 64. 00 64. 00 64. 00 64. 00 64. 00 64. 00 64. 00 64. 00 64. 00 64. 00 64. 00 64. 00 64. 00 64. 00 64. 00 64. 00 64. 00 64. 00 64. 00 64. 00 64. 00 64. 00 64. 00 64. 00 64. 00 64. 00 64. 00 64. 00 64. 00 64. 00 64. 00 64. 00 64. 00 64. 00 64. 00 64. 00 64. 00 64. 00 64. 00 64. 00 64. 00 64. 00 64. 00 64. 00 64. 00 64. 00 64. 00 64. 00 64. 00 64. 00 64. 00 64. 00 64. 00 64. 00 64. 00 64. 00 64. 00 64. 00 64. 00 64. 00 64. 00 64. 00 64. 00							0 1, 1.10		
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65.00 06500 RESPIRATORY THERAPY 899, 199 32, 255 48, 542 80, 162 1, 060, 158 65.00	60.00	06000	LABORATORY	2, 578, 959	26, 660	0	O	2, 605, 619	60.00
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91. 00 09100 EMERGENCY 1, 497, 577 74, 999 25, 703 122, 671 1, 720, 950 91. 00 92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART 0 92. 00 09200 OSSERVATION BEDS (NON-DISTINCT PART 0 92. 00 09500 AMBULANCE SERVICES 3, 241, 456 52, 016 297, 241 279, 924 3, 870, 637 95. 00 0 0 0 0 0 0 0 0 0	00.00			100 (11			0.040	440 500	00.00
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190. 00	118.00			47, 535, 351	2, 005, 795	1, 092, 774	2, 093, 528	47, 517, 447	118. 00
192.00 19200 PHYSI CI ANS' PRI VATE OFFI CES 98, 350 0 1, 228 8, 490 108, 068 192.00 194.00 07950 OCC HEALTH 0 4, 043 0 0 4, 043 194.00 194.01 07951 PAI N CLI NI C 0 0 0 0 0 194.02 07952 OCC HEALTH 0 0 0 0 0 194.03 07953 FOUNDATI O 0 0 0 194.04 07954 KI DS CAMPUS 0 0 0 0 194.05 07955 COMMUNI TY & VOLUNTEER SERVI CES 364, 962 0 0 0 194.06 07956 HUNTI NGTON COLLEGE NURSE 0 0 0 0 194.06 07957 MI SC CATERI NG 73, 848 0 0 4, 143 77, 991 194.07 194.08 07958 AUTI SM CENTER 0 0 0 0 0 194.09 07959 HUNTI NGTON BUA 0 0 0 200.00 Negati ve Cost Centers 0 0 0 0 201.00 Negati ve Cost Centers 0 0 0 200.00 0 0 0 201.00 0 0 0 201.00 0 0 0 201.00 0 0 0 201.00 0 0 0 200.00 0 0 200.00 0 0 201.00 0 0 201.00 0 0 201.00 0 0 201.00 0 0 201.00 0 0 201.00 0 0 201.00 0 0 201.00 0 0 201.00 0 0 201.00 0 0 201.00 0 0 201.00 0 0 201.00 0 0 201.00 0 0 201.00 0 0 201.00 0 0 201.00 0 201.00 0 0 201.00 0 0 201.00 0 201.00 0 201.00 0 201.00 0 201.00 0 201.00 0 201.00 0 201.00 0 201.00 0 201.00 0 201.00 0 201.00 0 201.00 0 201.00 0 201.00 0 201.00 0 201.00 0 201.00 0 201.00 0 201.00 0 201.00 0 201.00 0 201.00 0 201.00 0 201.00 0 201.00 0 201.00 0 201.00 201.00 0 201.00 0 201.00 0 201.00 0 201.00 0 201.00 0 201.00 0 201.00 201.00 0 201.00 201.00 0 201.00 201.00 0 201.00 201.00 201.00 201.00 201.00 201.00 201.00 201.00 201.00 201.00 201.00 201.00 201.00 201.00 201.00 201.00 201.00 201.00 201.00 201.00 201.00 201.00 201.00 201.00 201.00 201.00 201.00 201.00 201.00 201.00 201.00 201.00 201						. 1	. 1		
194. 00 07950 0CC HEALTH							0		
194. 01 07951 PAIN CLINIC 0 0 0 0 0 0 194. 01 194. 02 194. 02 07952 OCC HEALTH 0 0 0 0 0 0 0 194. 02 194. 03 07953 FOUNDATI 0 205, 133 0 0 0 0 0 0 205, 133 194. 03 194. 04 07954 KI DS CAMPUS 0 0 0 0 0 0 0 194. 04 194. 05 07955 COMMUNI TY & VOLUNTEER SERVI CES 364, 962 0 0 0 0 364, 962 194. 05 194. 06 07956 HUNTI NGTON COLLEGE NURSE 0 0 0 0 364, 962 194. 05 194. 07 07957 MI SC CATERI NG 73, 848 0 0 4, 143 77, 991 194. 07 194. 07 07959 AUTI SM CENTER 0 0 0 0 0 0 194. 08 194. 09 07959 HUNTI NGTON BUA 0 0 0 0 0 0 194. 08 194. 09 07959 HUNTI NGTON BUA 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				98, 350			8, 490		
194. 02 07952 OCC HEALTH 0 0 0 0 0 0 194. 02 194. 03 07953 FOUNDATI 0 205, 133 0 0 0 0 0 205, 133 194. 03 194. 04 07954 KI DS CAMPUS 0 0 0 0 0 0 194. 04 194. 05 07955 COMMUNI TY & VOLUNTEER SERVI CES 364, 962 0 0 0 0 364, 962 194. 05 194. 06 07956 HUNTI NGTON COLLEGE NURSE 0 0 0 0 364, 962 194. 05 194. 07 07957 MI SC CATERI NG 73, 848 0 0 4, 143 77, 991 194. 06 194. 08 07958 AUTI SM CENTER 0 0 0 0 0 0 194. 08 194. 09 07959 HUNTI NGTON BUA 0 0 0 0 0 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			U O	·	1
194. 03 07953 FOUNDATI 0 205, 133 0 0 0 205, 133 194. 03 194. 04 07954 KI DS CAMPUS 0 0 0 0 0 0 194. 04 194. 05 07955 COMMUNI TY & VOLUNTEER SERVI CES 364, 962 0 0 0 364, 962 194. 05 194. 06 07956 HUNTI NGTON COLLEGE NURSE 0 0 0 0 364, 962 194. 06 194. 07 07957 MI SC CATERI NG 73, 848 0 0 4, 143 77, 991 194. 07 194. 08 07958 AUTI SM CENTER 0 0 0 0 0 0 194. 07 194. 08 194. 09 07959 HUNTI NGTON BUA 0 0 0 0 0 0 0 194. 09 200. 00 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	0	0		
194. 04 07954 KI DS CAMPUS 0 0 0 0 0 0 194. 04 194. 05 07955 COMMUNI TY & VOLUNTEER SERVI CES 364, 962 0 0 0 0 364, 962 194. 05 194. 06 07956 HUNTI NGTON COLLEGE NURSE 0 0 0 0 0 194. 06 194. 07 07957 MI SC CATERI NG 73, 848 0 0 4, 143 77, 991 194. 07 194. 08 07958 AUTI SM CENTER 0 0 0 0 0 0 194. 09 194. 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 0 201. 00				205 133	0	0	Ö		1
194. 05 07955 COMMUNI TY & VOLUNTEER SERVI CES 364, 962 0 0 0 364, 962 194. 05 194. 06 07956 HUNTI NGTON COLLEGE NURSE 0 0 0 0 0 194. 06 194. 07 07957 MI SC CATERI NG 73, 848 0 0 4, 143 77, 991 194. 07 194. 08 07958 AUTI SM CENTER 0 0 0 0 0 0 194. 08 194. 09 07959 HUNTI NGTON BUA 0 0 0 0 0 194. 09 200. 00 Cross Foot Adjustments 0 Negative Cost Centers 0 0 0 0 0 0 0 0 201. 00				0	Ö	Ö	ō		
194. 06 07956 HUNTI NGTON COLLEGE NURSE				364, 962	0	O	ō		1
194. 08 07958 AUTI SM CENTER 0 0 0 0 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 0 200. 00 0 0 201. 00				0	0	0	0		1
194.09 07959 HUNTINGTON BUA 0 0 0 0 194.09 200.00 Cross Foot Adjustments 0 0 0 0 0 200.00 Negative Cost Centers 0 0 0 0 0 201.00				73, 848		0	4, 143		
200.00 Cross Foot Adjustments 0 200.00 201.00 Negative Cost Centers 0 0 0				0	0	0	0		
201.00 Negative Cost Centers 0 0 0 201.00				0	0	0	0		
		1			_				
202.00 107/12 (30m 11103 110 till 00gil 201) 40, 330, 07/ 2, 007, 030 1, 074, 002 2, 100, 101 40, 330, 07/ 202.00				48 350 007) NUO 820	1 094 002	0 2 106 161		
		1	1.22 (36 1.1.03 110 till dagil 201)	.5,555,577	2,007,000	1,0,4,002	2, 100, 101	.5, 550, 671	

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Peri od: Worksheet B From 01/01/2019 Part I To 12/31/2019 Date/Time Prepared: 6/26/2020 11: 24 am

					6/26/2020 11:	24 am
Cost Center Description		MAINTENANCE &	OPERATION OF	LAUNDRY &	HOUSEKEEPI NG	
	E & GENERAL	REPAI RS	PLANT	LINEN SERVICE	0.00	
GENERAL SERVICE COST CENTERS	5. 00	6.00	7. 00	8. 00	9. 00	
1. 00 O0100 CAP REL COSTS-BLDG & FLXT						1.00
2. 00 00200 CAP REL COSTS-MVBLE EQUIP						2.00
4. 00 00400 EMPLOYEE BENEFITS DEPARTMENT						4.00
5. 00 00500 ADMINISTRATIVE & GENERAL	17, 666, 677					5.00
6.00 00600 MAINTENANCE & REPAIRS	0	0				6.00
7. 00 00700 OPERATION OF PLANT	1, 072, 700	Ö	2, 935, 761			7. 00
8.00 00800 LAUNDRY & LINEN SERVICE	109, 824	o	18, 705	319, 270		8.00
9. 00 00900 HOUSEKEEPI NG	271, 083	0	15, 226		757, 125	9.00
10. 00 01000 DI ETARY	110, 166	0	145, 478	0	37, 957	10.00
11. 00 01100 CAFETERI A	198, 229	0	33, 009	0	8, 613	11.00
12.00 01200 MAINTENANCE OF PERSONNEL	0	0	0	0	0	12.00
13.00 01300 NURSING ADMINISTRATION	261, 351	0	0	0	0	13.00
14.00 01400 CENTRAL SERVICES & SUPPLY	16, 067	0	56, 651	636	14, 781	14.00
15. 00 01500 PHARMACY	389, 377	0	34, 347	0	8, 962	15.00
16.00 01600 MEDICAL RECORDS & LIBRARY	5, 381	0	18, 973	0	4, 950	16.00
17. 00 01700 SOCIAL SERVICE	0	0	0	0	0	17.00
19.00 01900 NONPHYSICIAN ANESTHETISTS	0	0	0	0	0	19.00
20. 00 02000 NURSI NG SCHOOL	0	0	0	0	0	20.00
21.00 02100 I&R SERVICES-SALARY & FRINGES APPRV	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
INPATIENT ROUTINE SERVICE COST CENTERS						1
30. 00 03000 ADULTS & PEDIATRICS	2, 506, 998	0	748, 207	94, 609	195, 217	30.00
43. 00 04300 NURSERY	97, 371	0	3, 033	4, 705	791	43.00
ANCILLARY SERVICE COST CENTERS						
50.00 05000 OPERATING ROOM	692, 857	0	285, 009	46, 642	74, 362	50.00
50. 01 05001 OPERATING ROOM	0	0	0	0	0	50. 01
52.00 05200 DELIVERY ROOM & LABOR ROOM	362, 942	0	0	18, 776	0	52.00
53. 00 05300 ANESTHESI OLOGY	547, 001	0	0	0	0	53.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	1, 281, 688	0	357, 212	38, 070	93, 201	54.00
60. 00 06000 LABORATORY	1, 500, 245	0	54, 123	0	14, 121	60.00
62.30 06250 BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0	0	0	62.30
65. 00 06500 RESPI RATORY THERAPY	610, 410	0	65, 483	22, 527	17, 085	65.00
66. 00 06600 PHYSI CAL THERAPY	875, 074	0	774, 199	0	202, 001	66.00
67. 00 06700 OCCUPATI ONAL THERAPY	169, 019	0	0	0	0	67.00
68. 00 06800 SPEECH PATHOLOGY	113, 242	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	536, 739	0	0	0	0	71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	448, 126	0	0	0	0	72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	1, 409, 800	0	0	0	0	73.00
76. 97 07697 CARDI AC REHABI LI TATI ON	0	0	0	0	0	76. 97
76. 98 07698 HYPERBARI C OXYGEN THERAPY	313, 227	0	60, 041	0	15, 665	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	68, 858	0	0	0	0	90.00
91. 00 09100 EMERGENCY	990, 877	0	152, 258	79, 176	39, 726	91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART						92.00
OTHER REIMBURSABLE COST CENTERS						
95. 00 09500 AMBULANCE SERVICES	2, 228, 608	0	105, 599	6, 566	27, 552	95.00
SPECIAL PURPOSE COST CENTERS						
113. 00 11300 I NTEREST EXPENSE						113. 00
118.00 SUBTOTALS (SUM OF LINES 1 through 117	7) 17, 187, 260	0	2, 927, 553	311, 707	754, 984	118. 00
NONRE MBURSABLE COST CENTERS						
190.00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	41, 716	0	0			190. 00
192.00 19200 PHYSICIANS' PRIVATE OFFICES	62, 223	0	_	.,	0	192. 00
194. 00 07950 0CC HEALTH	2, 328	0	8, 208	0	2, 141	194. 00
194. 01 07951 PALN CLINIC	0	0	0	0	0	194. 01
194. 02 07952 OCC HEALTH	0	0	0	0		194. 02
194. 03 07953 FOUNDATI 0	118, 110	0	0	0		194. 03
194.04 07954 KIDS CAMPUS	0	0	0	0	l e	194. 04
194.05 07955 COMMUNITY & VOLUNTEER SERVICES	210, 135	0	0	0	l e	194. 05
194.06 07956 HUNTINGTON COLLEGE NURSE	0	0	0	0	l	194. 06
194. 07 07957 MISC CATERING	44, 905	0	0	0	l	194. 07
194.08 07958 AUTISM CENTER	0	0	0	0	l	194. 08
194. 09 07959 HUNTI NGTON BUA	0	0	0	0	0	194. 09
200.00 Cross Foot Adjustments					l	200. 00
201.00 Negative Cost Centers	0	0	0	0		201. 00
202.00 TOTAL (sum lines 118 through 201)	17, 666, 677	0	2, 935, 761	319, 270	757, 125	202. 00

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Peri od: Worksheet B From 01/01/2019 Part I To 12/31/2019 Date/Ti me Prepared:

Cost Center Description	DI ETARY	CAFETERI A	MAINTENANCE OF PERSONNEL	NURSI NG ADMI NI STRATI O N	6/26/2020 11: CENTRAL SERVI CES & SUPPLY	
	10. 00	11. 00	12.00	13.00	14. 00	
GENERAL SERVICE COST CENTERS						
1. 00 00100 CAP REL COSTS-BLDG & FIXT 2. 00 00200 CAP REL COSTS-MVBLE EQUIP 4. 00 00400 EMPLOYEE BENEFITS DEPARTMENT 5. 00 00500 ADMINISTRATIVE & GENERAL 6. 00 00600 MAINTENANCE & REPAIRS 7. 00 00700 OPERATION OF PLANT 8. 00 00800 LAUNDRY & LINEN SERVICE 9. 00 00900 HOUSEKEEPING 10. 00 01000 DI ETARY 11. 00 01100 CAFETERIA 12. 00 01200 MAINTENANCE OF PERSONNEL 13. 00 01300 NURSING ADMINISTRATION 14. 00 01400 CENTRAL SERVICES & SUPPLY 15. 00 01500 PHARMACY 16. 00 01600 MEDICAL RECORDS & LIBRARY 17. 00 01700 SOCIAL SERVICE 19. 00 01900 NURSING SCHOOL 21. 00 02000 LAR SERVICES-SALARY & FRINGES APPRV 22. 00 02200 LAR SERVICES-OTHER PRGM COSTS APPRV 23. 00 02300 PARAMED ED PRGM-(SPECIFY)	484, 936 0 0 0 0 0 0 0 0 0 0	584, 134 0 9, 386 0 14, 717 0 0 0 0 0			116, 040 1, 369 0 0 0 0 0 0	1. 00 2. 00 4. 00 5. 00 7. 00 8. 00 9. 00 10. 00 11. 00 12. 00 13. 00 14. 00 15. 00 16. 00 17. 00 20. 00 21. 00 22. 00 23. 00
I NPATI ENT ROUTI NE SERVI CE COST CENTERS 30. 00 03000 ADULTS & PEDI ATRI CS	484, 936	188, 008	(430, 736	8, 159	30.00
43. 00 04300 NURSERY	464, 930	5, 943			0, 139	43.00
ANCILLARY SERVICE COST CENTERS						
50.00 05000 0PERATI NG ROOM 50.01 05001 0PERATI NG ROOM	0	42, 981 0			11, 985 0	50. 00 50. 01
52. 00 05200 DELIVERY ROOM & LABOR ROOM	Ö	23, 721	Č	-	0	52.00
53. 00 05300 ANESTHESI OLOGY	0	0	C	0	0	53.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C 60. 00 06000 LABORATORY	0	46, 314 0			2, 965 48	54. 00 60. 00
62. 30 06250 BLOOD CLOTTING FOR HEMOPHILIACS	o	0			0	62. 30
65. 00 06500 RESPIRATORY THERAPY	O	37, 688	C	o	4, 572	65.00
66. 00 06600 PHYSI CAL THERAPY	0	35, 288	C	-	1, 537	66.00
67. 00 06700 OCCUPATI ONAL THERAPY	0	11, 244		1	0	67.00
68. 00 06800 SPEECH PATHOLOGY 69. 00 06900 ELECTROCARDI OLOGY	0	3, 014 0			0	68. 00 69. 00
71. 00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	o	Ö		ol ol	68, 107	71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0	0	C	o	0	72.00
73. 00 07300 DRUGS CHARGED TO PATIENTS	0	0	C	0	2, 114	73.00
76. 97 O7697 CARDI AC REHABI LI TATI ON	0	0			0	76. 97
76. 98 07698 HYPERBARI C OXYGEN THERAPY 76. 99 07699 LI THOTRI PSY	0	0			227 0	76. 98 76. 99
OUTPATIENT SERVICE COST CENTERS	<u> </u>	<u> </u>		,ı <u> </u>		70.77
90. 00 09000 CLI NI C	0	0	C		0	90.00
91. 00 09100 EMERGENCY	0	55, 644	C	127, 482	6, 636	91.00
92.00 09200 0BSERVATION BEDS (NON-DISTINCT PART OTHER REIMBURSABLE COST CENTERS						92.00
95. 00 09500 AMBULANCE SERVICES	ol	98, 289	C	ol	8, 185	95.00
SPECIAL PURPOSE COST CENTERS	<u> </u>	70, 207		,ı <u> </u>	0, 100	70.00
113. 00 11300 I NTEREST EXPENSE						113. 00
118. 00 SUBTOTALS (SUM OF LINES 1 through 117)	484, 936	572, 237		724, 651	115, 904	118. 00
NONREI MBURSABLE COST CENTERS 190. 00 19000 GI FT, FLOWER, COFFEE SHOP & CANTEEN	ol	O	(ol ol	0	190. 00
192. 00 19200 PHYSI CLANS' PRI VATE OFFICES	0	5, 459		-		190.00
194. 00 07950 OCC HEALTH	o	0, 187	ď	-		194.00
194. 01 07951 PAIN CLINIC	0	0	c	o		194. 01
194. 02 07952 OCC HEALTH	0	0	C	0		194. 02
194. 03 07953 FOUNDATI 0 194. 04 07954 KI DS CAMPUS	0	4, 104		-		194. 03 194. 04
194. 05 07955 COMMUNI TY & VOLUNTEER SERVICES	0	0				194. 04
194. 06 07956 HUNTI NGTON COLLEGE NURSE	o	Ö		ol ol		194. 06
194. 07 07957 MI SC CATERI NG	O	2, 334		o	0	194. 07
194.08 07958 AUTISM CENTER	O	0	C	o o		194. 08
194. 09 07959 HUNTI NGTON BUA	0	0	C	이	0	194. 09
200.00 Cross Foot Adjustments 201.00 Negative Cost Centers	0	0	(0	200. 00 201. 00
202.00 TOTAL (sum lines 118 through 201)	484, 936	584, 134	-	-		
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Peri od: Worksheet B From 01/01/2019 Part I To 12/31/2019 Date/Time Prepared:

					o 12/31/2019	Date/lime Pre 6/26/2020 11:	
	Cost Center Description	PHARMACY	MEDI CAL RECORDS & LI BRARY	SOCI AL SERVI CE	NONPHYSI CI AN ANESTHETI STS	NURSI NG SCHOOL	24 dili
		15. 00	16. 00	17. 00	19. 00	20. 00	
1. 00 2. 00 4. 00 5. 00 6. 00	GENERAL SERVICE COST CENTERS 00100 CAP REL COSTS-BLDG & FIXT 00200 CAP REL COSTS-MVBLE EQUIP 00400 EMPLOYEE BENEFITS DEPARTMENT 00500 ADMINISTRATIVE & GENERAL 00600 MAINTENANCE & REPAIRS						1. 00 2. 00 4. 00 5. 00 6. 00
7. 00 8. 00 9. 00 10. 00 11. 00 12. 00 13. 00 14. 00 15. 00 16. 00 17. 00	00700 OPERATION OF PLANT 00800 LAUNDRY & LINEN SERVICE 00900 HOUSEKEEPING 01000 DI ETARY 01100 CAFETERIA 01200 MAINTENANCE OF PERSONNEL 01300 NURSING ADMINISTRATION 01400 CENTRAL SERVICES & SUPPLY 01500 PHARMACY 01600 MEDICAL RECORDS & LIBRARY 01700 SOCIAL SERVICE 01900 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)	1, 125, 040 0 0 0 0 0 0	38, 650 0 0 0 0 0	000000000000000000000000000000000000000	O	0	7. 00 8. 00 9. 00 10. 00 11. 00 12. 00 13. 00 14. 00 15. 00 16. 00 17. 00 19. 00
20.00	INPATIENT ROUTINE SERVICE COST CENTERS	00.044	0.044				
30. 00 43. 00	03000 ADULTS & PEDI ATRI CS 04300 NURSERY ANCI LLARY SERVI CE COST CENTERS	80, 044	2, 841 193	O O	1	0	
50. 00 50. 01	05000 OPERATING ROOM 05001 OPERATING ROOM	117, 581 0	4, 975 0	0	_	0	
52. 00 53. 00	05200 DELIVERY ROOM & LABOR ROOM	0	738 648	0	-	0	
54. 00	05300 ANESTHESI OLOGY 05400 RADI OLOGY-DI AGNOSTI C	29, 092	6, 585	0	_	0	
60.00	06000 LABORATORY	472	4, 759	0	-	0	
62. 30 65. 00	O6250 BLOOD CLOTTI NG FOR HEMOPHI LI ACS O6500 RESPI RATORY THERAPY	0 44, 853	0 1, 529	0	=	0	
66.00	06600 PHYSI CAL THERAPY	15, 075	998	O	=	0	66. 00
67. 00 68. 00	O6700 OCCUPATI ONAL THERAPY O6800 SPEECH PATHOLOGY	0	349 136	0	-	0	
69. 00	06900 ELECTROCARDI OLOGY		168	0	-	0	1
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	668, 214	1, 032	O	0	0	1
72.00	07200 I MPL. DEV. CHARGED TO PATIENTS	0	770	0	0	0	1
73. 00 76. 97	07300 DRUGS CHARGED TO PATIENTS 07697 CARDIAC REHABILITATION	20, 740	3, 723	0	=	0	
76. 98	07698 HYPERBARI C OXYGEN THERAPY	2, 225	470	O	o	0	
76. 99	07699 LITHOTRIPSY OUTPATIENT SERVICE COST CENTERS	0	0	O	0	0	76. 99
90. 00		O	154	C	ol	0	90.00
	09100 EMERGENCY	65, 107	5, 489	O	o	0	1 / 00
92. 00	09200 OBSERVATION BEDS (NON-DISTINCT PART OTHER REIMBURSABLE COST CENTERS						92.00
95.00	09500 AMBULANCE SERVICES	80, 305	3, 093	C	0	0	95. 00
112 00	SPECIAL PURPOSE COST CENTERS				T T		112 00
113.00	11300 INTEREST EXPENSE SUBTOTALS (SUM OF LINES 1 through 117)	1, 123, 708	38, 650	O	o	C	113. 00 118. 00
	NONREI MBURSABLE COST CENTERS	1, 120, 100	33, 333	<u> </u>	9]
	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0			190.00
	19200 PHYSICIANS' PRIVATE OFFICES 07950 OCC HEALTH	1, 249	0	0	-		192. 00 194. 00
194. 01	07951 PAIN CLINIC	Ö	Ö	0	-	0	194. 01
	07952 OCC HEALTH	0	0	0	0		194. 02
	07953 FOUNDATI 0 07954 KI DS CAMPUS	0	0	0	0		194. 03 194. 04
	07955 COMMUNITY & VOLUNTEER SERVICES	83	ő	0	Ö		194. 05
194.06	07956 HUNTI NGTON COLLEGE NURSE	0	О	O	o	0	194. 06
	O7957 MISC CATERING O7958 AUTISM CENTER	0	0	0	0		194. 07 194. 08
	0/958 AUTISM CENTER 0/07959 HUNTINGTON BUA		0	0			194. 08
200.00			Ĭ	Ö	0	0	200. 00
201.00	Negative Cost Centers	0	0	0	0		201.00
202. 00	TOTAL (sum lines 118 through 201)	1, 125, 040	38, 650	0	0	0	202. 00

Health Financial Systems
COST ALLOCATION - GENERAL SERVICE COSTS | Peri od: | Worksheet B | From 01/01/2019 | Part I | To 12/31/2019 | Date/Time Prepared: Provider CCN: 15-0091

Cost Center Description						To	12/31/2019	Date/Time Pre 6/26/2020 11:	
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194. 02 07952 OCC HEALTH 0 0 0 0 0 0 194. 02 194. 03 07953 FOUNDATI O 0 0 0 0 327, 347 0 194. 03 194. 04 07954 KI DS CAMPUS 0 0 0 0 0 0 0 194. 04 194. 05 07955 COMMUNI TY & VOLUNTEER SERVI CES 0 0 0 0 575, 189 0 194. 05 194. 06 07957 MI SC CATERI NG 0 0 0 125, 230 0 194. 06 194. 08 07958 AUTI SM CENTER 0 0 0 0 0 0 194. 08 194. 08 07958 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 0 0 0 0 0 0 0 0 0 0 0				Ö	0	Ö	0		
194. 04 07954 KIDS CAMPUS 0 0 0 0 0 0 194. 04 194. 05 07955 COMMUNITY & VOLUNTEER SERVICES 0 0 0 0 575, 189 0 194. 05 194. 06 07956 HUNTI NGTON COLLEGE NURSE 0 0 0 0 0 0 194. 06 194. 07 07959 AUTI SM CENTER 0 0 0 0 0 125, 230 0 194. 07 194. 08 07958 AUTI SM CENTER 0 0 0 0 0 0 194. 09 194. 09 194. 09 194. 09 194. 09 194. 09 194. 09 194. 09 194. 09 194. 09 194. 09 194. 09 194. 09 194. 09 194. 09 194. 09 194. 09 194. 09 194. 09 194. 09 194. 09 194. 09 194. 09 194. 09 194. 09 194. 09 194. 09 194. 09 194. 09 194. 09 194. 09 194. 09 194. 09 194. 09 194. 09 194. 09 194. 09 194. 09 194. 09 194. 09 194. 09 194. 09 194. 09 194. 09 194. 09 194. 09 194. 09 194. 09 194. 09 194. 09 194. 09 194. 09 194. 09 194. 09 194. 09 194. 09 194. 09 194. 09 194. 09 194. 09 194. 09 194. 09 194. 09 194. 09 194. 09 194. 09 194. 09 194. 09 194. 09 194. 09 194. 09 194. 09 194. 09 194. 09 194. 09 194. 09 194. 09 194. 09 194. 09 194. 09 194. 09 194. 09 194. 09 194. 09 194. 09 194. 09 194. 09 194. 09 194. 09 194. 09 194. 09 194. 09 194. 09 194. 09 194. 09 194. 09 194. 09 194. 09 194. 09 194. 09 194. 09 194. 09 194. 09 194. 09 194. 09 194. 09 194. 09 194. 09 194. 09 194. 09 194. 09 194. 09 194. 09 194. 09 194. 09 194. 09 194. 09 194. 09 194. 09 194. 09 194. 09 194. 09 194. 09 194. 09 194. 09 194. 09 194. 09 194. 09 194. 09 194. 09 194. 09 194. 09 194. 09 194. 09 194. 09 194. 09 194. 09 194. 09 194. 09 194. 09 194. 09 194. 09 194. 09 194. 09 194. 09 194. 09 194. 09 194. 09 194. 09 194. 09 194. 09 194. 09 194. 09 194. 09 194. 09 194. 09 194. 09 194. 09 194. 09 194. 09 194. 09 194. 09 194. 09 194. 09 194. 09 194. 09 194. 09 194. 09 194. 09 194. 09 194. 09 194. 09 194. 09 194. 09 194. 09 194. 09 194. 09 194. 09 194. 09 194. 09 194. 09 194. 09 194. 09 194. 09 194. 09 194. 09 194. 09 194. 09 194. 09 194. 09 194. 09 194. 09 194. 09 194. 09 194. 09 194. 09 194. 09 194. 09 194. 09 194. 09 194. 09 194. 09 194. 09 194. 09 194. 09 194. 09 194. 09 194. 09 194. 09 194. 09 194. 09 194. 09 194. 09 194. 09 194. 09 194. 09 194. 09 194. 09 194. 09 194. 09 194. 09 1				0	0	0	0	0	194. 02
194. 05 07955 COMMUNI TY & VOLUNTEER SERVI CES 0 0 575, 189 0 194. 05 194. 06 07956 HUNTI NGTON COLLEGE NURSE 0 0 0 0 0 194. 06 194. 07 07957 MI SC CATERI NG 0 0 0 125, 230 0 194. 07 194. 08 07958 AUTI SM CENTER 0 0 0 0 0 194. 08 194. 09 07959 HUNTI NGTON BUA 0 0 0 0 0 194. 08 200. 00 Cross Foot Adj ustments 0 0 0 0 0 0 200. 00 201. 00 Negati ve Cost Centers 0 0 0 0 0 0 0 201. 00				0	0	0	327, 347		
194. 06 07956 HUNTI NGTON COLLEGE NURSE 0 0 0 0 194. 06 194. 07 07957 MI SC CATERI NG 0 0 0 125, 230 0 194. 07 194. 08 07958 AUTI SM CENTER 0 0 0 0 0 0 194. 08 194. 09 07959 HUNTI NGTON BUA 0 0 0 0 0 194. 09 200. 00 Cross Foot Adj ustments 0 0 0 0 0 200. 00 201. 00 Negati ve Cost Centers 0 0 0 0 0 0 0				0	0	0	0		
194.07 07957 MI SC CATERING 0 0 125, 230 0 194.07 194.08 07958 AUTI SM CENTER 0 0 0 0 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 0 201.00				0	0	0	5/5, 189		
194.08 07958 AUTISM CENTER 0 0 0 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 0 200.00 201.00 Negative Cost Centers 0 0 0 0 0 0 0 201.00				0	0	0	125. 230		
200.00 Cross Foot Adjustments 0 0 0 0 200.00 201.00 Negative Cost Centers 0 0 0 0 0 0 201.00				0	0	O	0	0	194. 08
201.00 Negative Cost Centers 0 0 0 0 201.00				0	0	0	o		
				0	0	0	0		
- 1.5.1.12 (Sum 11105 110 till ough 201) 0 0 40, 550, 077 0 202.00						0	0 48 350 007		
		1	1.22 (3a 1.1.65 116 through 201)		, 0	<u>, </u>	.5, 550, 677		

| Peri od: | Worksheet B | From 01/01/2019 | Part | | To | 12/31/2019 | Date/Time Prepared: Provider CCN: 15-0091

			10 12/31/2019 Date/Time Pre 6/26/2020 11:	
Cost Center De	scription	Total	072072020 11.	24 0111
		26. 00	 	
GENERAL SERVICE COST				4
1. 00 00100 CAP REL COSTS- 2. 00 00200 CAP REL COSTS-				1.00
2.00 00200 CAP REL COSTS- 4.00 00400 EMPLOYEE BENEF				2.00 4.00
5. 00 00500 ADMI NI STRATI VE				5.00
6. 00 00600 MAI NTENANCE &				6.00
7. 00 00700 OPERATION OF P				7. 00
8.00 00800 LAUNDRY & LINE	N SERVICE			8.00
9. 00 00900 HOUSEKEEPI NG				9. 00
10. 00 01000 DI ETARY				10.00
11. 00 01100 CAFETERI A	DEDCOMME			11.00
12. 00 01200 MAI NTENANCE OF 13. 00 01300 NURSI NG ADMI NI				12. 00 13. 00
14. 00 01400 CENTRAL SERVI C				14.00
15. 00 01500 PHARMACY	25 & 3011 E1			15.00
16. 00 01600 MEDI CAL RECORD	S & LIBRARY			16.00
17. 00 01700 SOCIAL SERVICE				17. 00
19.00 01900 NONPHYSICIAN A	NESTHETI STS			19. 00
20. 00 02000 NURSI NG SCHOOL				20.00
1 1	ALARY & FRINGES APPRV			21.00
	THER PRGM COSTS APPRV			22.00
23.00 02300 PARAMED ED PRG INPATIENT ROUTINE SE	, ,			23. 00
30. 00 03000 ADULTS & PEDIA		9, 093, 912		30.00
43. 00 04300 NURSERY	TIKI 65	294, 767		43.00
ANCILLARY SERVICE CO	OST CENTERS	271,707		1 .0.00
50. 00 05000 OPERATING ROOM		2, 578, 214		50.00
50. 01 05001 OPERATI NG ROOM		0		50. 01
52. 00 05200 DELI VERY ROOM		1, 090, 878		52.00
53. 00 05300 ANESTHESI OLOGY		1, 497, 678		53.00
54. 00 05400 RADI OLOGY-DI AG	INOSTIC	4, 081, 157		54.00
60. 00 06000 LABORATORY 62. 30 06250 BLOOD CLOTTI NG	EOD HEMODULLIACS	4, 179, 387 0		60. 00 62. 30
65. 00 06500 RESPIRATORY TH		1, 864, 305		65.00
66. 00 06600 PHYSI CAL THERA	18	3, 423, 996		66.00
67. 00 06700 OCCUPATIONAL T		474, 164		67.00
68.00 06800 SPEECH PATHOLO	GY	313, 070		68. 00
69. 00 06900 ELECTROCARDI OL		168		69. 00
1 1	ES CHARGED TO PATIENT	2, 206, 298		71.00
72. 00 07200 MPL. DEV. CHA		1, 227, 199		72.00
73. 00 07300 DRUGS CHARGED 76. 97 07697 CARDI AC REHABI		3, 884, 911 0		73. 00 76. 97
76. 98 07698 HYPERBARI C OXY	-	935, 866		76. 98
76. 99 07699 LI THOTRI PSY	OEN THERM I	755, 666		76. 99
OUTPATIENT SERVICE O	COST CENTERS	-1		1
90. 00 09000 CLI NI C		188, 604		90.00
91.00 09100 EMERGENCY		3, 243, 345		91.00
	DS (NON-DISTINCT PART			92. 00
OTHER REIMBURSABLE C		(400 004		05.00
95. 00 09500 AMBULANCE SERV SPECIAL PURPOSE COST		6, 428, 834		95.00
113. 00 11300 I NTEREST EXPEN				113.00
	I OF LINES 1 through 117)	47, 006, 753		118.00
NONREI MBURSABLE COST		,,		1
190. 00 19000 GIFT, FLOWER,	COFFEE SHOP & CANTEEN	114, 169		190. 00
192. 00 19200 PHYSI CI ANS' PR	IVATE OFFICES	184, 689		192. 00
194. 00 07950 OCC HEALTH		16, 720		194. 00
194. 01 07951 PAIN CLINIC		0		194. 01
194. 02 07952 OCC HEALTH 194. 03 07953 FOUNDATI 0		0 327, 347		194. 02 194. 03
194.0307933 FOUNDATTO 194.04 07954 KIDS CAMPUS		327, 347		194.03
194. 05 07955 COMMUNITY & VO	LUNTEER SFRVICES	575, 189		194. 04
194. 06 07956 HUNTI NGTON COL		0		194.06
194. 07 07957 MI SC CATERING		125, 230		194. 07
194.08 07958 AUTISM CENTER		O		194. 08
194. 09 07959 HUNTI NGTON BUA		o		194. 09
200.00 Cross Foot Adj		0		200.00
201.00 Negative Cost		49 350 007		201. 00 202. 00
202.00 TOTAL (sum lin	es 118 through 201)	48, 350, 097		J2U2. UU

| Peri od: | Worksheet B | From 01/01/2019 | Part | I | To | 12/31/2019 | Date/Time Prepared: Health Financial Systems
ALLOCATION OF CAPITAL RELATED COSTS Provi der CCN: 15-0091

					To	12/31/2019	Date/Time Pre	pared:
				CAPI TAL REI	LATED COSTS		6/26/2020 11:	24 alli
		Cost Center Description	Directly	BLDG & FIXT	MVBLE EQUIP	Subtotal	EMPLOYEE	
			Assigned New Capital				BENEFITS DEPARTMENT	
			Related Costs				DEFARTMENT	
			0	1. 00	2. 00	2A	4. 00	
4 00		AL SERVICE COST CENTERS	T					4 00
1. 00 2. 00		CAP REL COSTS-BLDG & FIXT CAP REL COSTS-MVBLE EQUIP						1. 00 2. 00
4. 00		EMPLOYEE BENEFITS DEPARTMENT	0	1, 934	0	1, 934	1, 934	4.00
5. 00	1	ADMINISTRATIVE & GENERAL	1, 900, 923	112, 513	1	2, 018, 516	600	5. 00
6.00		MAINTENANCE & REPAIRS	0	0		0	0	6.00
7.00	1	OPERATION OF PLANT	0	449, 302		480, 992	34	7.00
8. 00 9. 00	1	LAUNDRY & LINEN SERVICE HOUSEKEEPING	0	9, 214 7, 500	1	9, 214 7, 500	3 27	8. 00 9. 00
10.00	1	DI ETARY	0	71, 659	1	7, 300	6	10.00
11. 00		CAFETERI A	0	16, 260	1	16, 260	28	11.00
12.00	1	MAINTENANCE OF PERSONNEL	0	0	0	o	0	12.00
13.00		NURSI NG ADMI NI STRATI ON	0	0		0	37	13.00
14. 00 15. 00		CENTRAL SERVICES & SUPPLY PHARMACY	0	27, 905 16, 919		27, 905 102, 855	0 50	14. 00 15. 00
16. 00		MEDICAL RECORDS & LIBRARY	0	9, 346	1	9, 346	0	16.00
17. 00		SOCIAL SERVICE	0	0	0	0	0	17. 00
19. 00	1	NONPHYSICIAN ANESTHETISTS	0	0	0	0	0	19. 00
20.00		NURSI NG SCHOOL	0	0	0	0	0	20.00
21. 00 22. 00		I&R SERVICES-SALARY & FRINGES APPRV I&R SERVICES-OTHER PRGM COSTS APPRV	0		0	0	0	21. 00 22. 00
23. 00		PARAMED ED PRGM-(SPECIFY)	0	0		0	0	23. 00
	I NPAT	IENT ROUTINE SERVICE COST CENTERS						
30.00	1	ADULTS & PEDIATRICS	0			511, 103	271	30.00
43. 00		NURSERY	0	1, 494	0	1, 494	13	43. 00
50. 00		LARY SERVICE COST CENTERS OPERATING ROOM	0	140, 389	172, 928	313, 317	106	50. 00
50. 01		OPERATING ROOM	0	0		0	0	50. 00
52.00		DELIVERY ROOM & LABOR ROOM	0	0	0	О	47	52.00
53.00		ANESTHESI OLOGY	0	0	0	0	0	53.00
54.00		RADI OLOGY-DI AGNOSTI C	0	175, 954		422, 854	102	54.00
60. 00 62. 30		LABORATORY BLOOD CLOTTING FOR HEMOPHILIACS	0	26, 660 0	0	26, 660	0	60. 00 62. 30
65. 00		RESPIRATORY THERAPY	0	32, 255	1	80, 797	73	65. 00
66.00	06600	PHYSI CAL THERAPY	0	381, 352	1	415, 430	87	66.00
67. 00		OCCUPATI ONAL THERAPY	0	0	1	0	23	67.00
68.00		SPEECH PATHOLOGY	0	0	0	0	15	68.00
69. 00 71. 00		ELECTROCARDIOLOGY MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	0	69. 00 71. 00
72. 00		IMPL. DEV. CHARGED TO PATIENTS	i o	Ö	ő	o	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	o	6	73.00
76. 97		CARDI AC REHABI LI TATI ON	0	0	0	0	0	76. 97
76. 98 76. 99	1	HYPERBARIC OXYGEN THERAPY	0	29, 575		29, 575	16	
70. 99		LITHOTRIPSY TIENT SERVICE COST CENTERS	0	0	0	0	0	76. 99
90.00		CLINIC	0	0	0	0	9	90.00
91. 00		EMERGENCY	0	74, 999	25, 703	100, 702	112	
92. 00		OBSERVATION BEDS (NON-DISTINCT PART				0		92.00
95 00		REIMBURSABLE COST CENTERS AMBULANCE SERVICES	0	52, 016	297, 241	349, 257	257	95. 00
70.00		AL PURPOSE COST CENTERS	<u> </u>	02,010	277,211	017, 207	207	70.00
	1	INTEREST EXPENSE						113. 00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	1, 900, 923	2, 005, 795	1, 092, 774	4, 999, 492	1, 922	118. 00
100 00		IMBURSABLE COST CENTERS GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0		٥	0	190. 00
		PHYSICIANS' PRIVATE OFFICES	0	0	1	1, 228		190.00
		OCC HEALTH	0	4, 043	0	4, 043		194. 00
		PAIN CLINIC	0	0	0	0		194. 01
	1	OCC HEALTH	0	0	0	0		194. 02
		FOUNDATIO KIDS CAMPUS	0	0	0	0		194. 03 194. 04
		COMMUNITY & VOLUNTEER SERVICES	0	0	0	0		194. 04 194. 05
		HUNTI NGTON COLLEGE NURSE	0	0	o	o	0	194. 06
		MISC CATERING	0	0	0	o		194. 07
		AUTI SM CENTER	0	0	0	0		194. 08
194. 09 200. 00		HUNTINGTON BUA Cross Foot Adjustments	0	0		0	0	194. 09 200. 00
200.00	1	Negative Cost Centers		О	О	ol	0	200.00
202.00	1	TOTAL (sum lines 118 through 201)	1, 900, 923	2, 009, 838	1, 094, 002	5, 004, 763		202. 00
					·	·		

Health Financial Systems
ALLOCATION OF CAPITAL RELATED COSTS

Provi der CCN: 15-0091

In Lieu of Form CMS-2552-10

Period: Worksheet B
From 01/01/2019 Part II
To 12/31/2019 Date/Time Prepared:
6/26/2020 11:24 am

				'		6/26/2020 11:	
	Cost Center Description	ADMI NI STRATI V		OPERATION OF	LAUNDRY &	HOUSEKEEPI NG	
		E & GENERAL 5.00	REPAI RS 6. 00	PLANT 7. 00	LINEN SERVICE 8.00	9. 00	
	GENERAL SERVICE COST CENTERS	5.00	0.00	7.00	8.00	9.00	
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 ADMI NI STRATI VE & GENERAL	2, 019, 116					5.00
6.00	00600 MAINTENANCE & REPAIRS	122 500	0	402 425			6.00
7. 00 8. 00	00700 OPERATION OF PLANT 00800 LAUNDRY & LINEN SERVICE	122, 599 12, 552	0	603, 625 3, 846			7. 00 8. 00
9. 00	00900 HOUSEKEEPI NG	30, 982	0	3, 131	23, 013	41, 640	9.00
10.00	01000 DI ETARY	12, 591	0	29, 912	l ol	2, 088	1
11. 00	01100 CAFETERI A	22, 656	0		o	474	
12.00	01200 MAINTENANCE OF PERSONNEL	0	0	0	o	0	12.00
13.00	01300 NURSI NG ADMI NI STRATI ON	29, 870	0	0	0	0	13.00
14.00	01400 CENTRAL SERVICES & SUPPLY	1, 836	0	,		813	
15.00	01500 PHARMACY	44, 502	0	7, 062	0	493	
16. 00 17. 00	01600 MEDI CAL RECORDS & LI BRARY 01700 SOCI AL SERVI CE	615	0	3, 901 0	0	272 0	16. 00 17. 00
19. 00	01900 NONPHYSI CI AN ANESTHETI STS	0	0	0		0	19.00
20. 00	02000 NURSI NG SCHOOL	o o	0	0	l ől	0	20.00
21.00	02100 I&R SERVICES-SALARY & FRINGES APPRV	0	0	0	o	0	21.00
22.00	02200 I&R SERVICES-OTHER PRGM COSTS APPRV	0	0	0	o	0	22.00
23. 00	02300 PARAMED ED PRGM-(SPECIFY)	0	0	0	0	0	23. 00
	INPATIENT ROUTINE SERVICE COST CENTERS	00/ 54/		150.040	7 500	10.70/	
30. 00 43. 00	03000 ADULTS & PEDI ATRI CS 04300 NURSERY	286, 516	0		7, 592 377	10, 736 44	1
43.00	ANCI LLARY SERVI CE COST CENTERS	11, 129	0	024	377	44	43.00
50.00	05000 OPERATING ROOM	79, 187	0	58, 601	3, 742	4, 090	50.00
50. 01	05001 OPERATING ROOM	0	0		0	0	50. 01
52.00	05200 DELIVERY ROOM & LABOR ROOM	41, 481	0	0	1, 506	0	52.00
53.00	05300 ANESTHESI OLOGY	62, 517	0	0	0	0	53.00
54.00	05400 RADI OLOGY-DI AGNOSTI C	146, 484	0			5, 126	
60.00	06000 LABORATORY	171, 463	0	11, 128	0	777	60.00
62. 30	06250 BLOOD CLOTTING FOR HEMOPHILIACS	0	0	12.444	1 007	0	62.30
65. 00 66. 00	06500 RESPI RATORY THERAPY 06600 PHYSI CAL THERAPY	69, 764 100, 012	0	13, 464 159, 183		940 11, 107	65. 00 66. 00
67. 00	06700 OCCUPATI ONAL THERAPY	19, 317	0			0	67.00
68. 00	06800 SPEECH PATHOLOGY	12, 942	0	0	l ol	0	68.00
69. 00	06900 ELECTROCARDI OLOGY	0	0	Ö	Ö	0	69.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	61, 344	0	0	o	0	71.00
72. 00	07200 I MPL. DEV. CHARGED TO PATIENTS	51, 216	0	0	0	0	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	161, 126	0	0	0	0	73.00
76. 97	07697 CARDI AC REHABI LI TATI ON	0 35, 799	0	10 245	0	0	76. 97
76. 98 76. 99	07698 HYPERBARI C OXYGEN THERAPY 07699 LI THOTRI PSY	35, 799	0		l	862 0	76. 98 76. 99
70. 77	OUTPATIENT SERVICE COST CENTERS	<u> </u>	U		<u> </u>		70.77
90.00	09000 CLINI C	7, 870	0	0	0	0	90.00
91.00	09100 EMERGENCY	113, 247	0	31, 306	6, 352	2, 185	
92. 00							92.00
05.00	OTHER REIMBURSABLE COST CENTERS	254.707	0	01 710	F07	1 515	05 00
95. 00	09500 AMBULANCE SERVI CES SPECI AL PURPOSE COST CENTERS	254, 707	0	21, 712	527	1, 515	95.00
113 00	11300 INTEREST EXPENSE						113. 00
118.00		1, 964, 324	0	601, 937	25, 008	41, 522	118.00
	NONREI MBURSABLE COST CENTERS					, ,	
	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	4, 768	0	0	0	0	190. 00
	19200 PHYSICIANS' PRIVATE OFFICES	7, 111	0				192. 00
	07950 OCC HEALTH	266	0	.,	0		194. 00
	07951 PAIN CLINIC	0	0	0	0		194. 01
194.02	2 07952 OCC HEALTH 3 07953 FOUNDATI 0	13, 499	0	0	0		194. 02 194. 03
	107954 KIDS CAMPUS	13, 499	0	0	0		194.03
	07955 COMMUNITY & VOLUNTEER SERVICES	24, 016	0	1			194. 05
	07956 HUNTI NGTON COLLEGE NURSE	0	0	Ö	l ől		194.06
194. 07	07957 MISC CATERING	5, 132	0	0	o	0	194. 07
	07958 AUTISM CENTER	o	0	0	o		194. 08
	07959 HUNTI NGTON BUA	0	0	0	0	0	194. 09
200.00			_			^	200.00
201. 00 202. 00		0 2, 019, 116	0		0 25, 615		201. 00 202. 00
∠∪∠. ∪(TIVIAL (Sum Times TTO through 201)	2,019,110	U	1 003, 625	ړی کې کا	41, 040	12U2. UU

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 15-0091

Peri od: Worksheet B From 01/01/2019 Part II To 12/31/2019 Date/Time Prepared:

6/26/2020 11:24 am Cost Center Description DI ETARY CAFETERI A MAI NTENANCE NURSI NG CENTRAL ADMI NI STRATI O SERVICES & OF PERSONNEL Ν **SUPPLY** 10. 00 12.00 11 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 00400 EMPLOYEE BENEFITS DEPARTMENT 4 00 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 118, 378 10.00 01100 CAFETERI A 11.00 46, 205 11.00 01200 MAINTENANCE OF PERSONNEL 12.00 0 12.00 13.00 01300 NURSING ADMINISTRATION 0 742 30, 649 13.00 14.00 01400 CENTRAL SERVICES & SUPPLY 0 42, 253 14.00 15.00 01500 PHARMACY 0 0 498 1.164 0 15.00 16.00 01600 MEDICAL RECORDS & LIBRARY 0 0 0 16.00 01700 SOCIAL SERVICE 0 0 17 00 Ω 0 0 17.00 0 01900 NONPHYSICIAN ANESTHETISTS 0 0 0 19.00 19.00 0 0 02000 NURSING SCHOOL 0 20 00 C 0 20.00 02100 I&R SERVICES-SALARY & FRINGES APPRV 0 0 0 21.00 21.00 0 02200 I&R SERVICES-OTHER PRGM COSTS APPRV 0 22.00 0 0 0 22.00 02300 PARAMED ED PRGM-(SPECIFY) 23.00 0 0 23.00 INPATIENT ROUTINE SERVICE COST CENTERS 2, 971 30.00 03000 ADULTS & PEDIATRICS 118, 378 14.873 0 18, 217 30.00 04300 NURSERY 0 576 43.00 470 43.00 0 ANCILLARY SERVICE COST CENTERS 50.00 05000 OPERATING ROOM 0 3,400 0 4, 165 4, 364 50.00 05001 OPERATING ROOM 50.01 0 0 0 50.01 0 0 05200 DELIVERY ROOM & LABOR ROOM 1.876 2. 299 52.00 52.00 0 05300 ANESTHESI OLOGY 0 53.00 0 0 53.00 0 0 54.00 05400 RADI OLOGY-DI AGNOSTI C 3.663 0 1,080 54.00 06000 LABORATORY 0 60.00 0 0 C 0 18 60.00 62 30 06250 BLOOD CLOTTING FOR HEMOPHILIACS 0 0 62 30 0 0 06500 RESPIRATORY THERAPY 0 65.00 2, 981 1,665 65.00 06600 PHYSI CAL THERAPY 0 0 0 0 2, 791 0 0 559 66.00 66.00 06700 OCCUPATI ONAL THERAPY 0 67.00 889 0 67.00 0 ō 06800 SPEECH PATHOLOGY 0 68 00 68 00 238 0 06900 ELECTROCARDI OLOGY 0 0 69.00 C 0 69.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT 0 24, 800 71.00 71.00 72 00 07200 IMPL. DEV. CHARGED TO PATIENTS 0 0 0 0 0 72 00 0 07300 DRUGS CHARGED TO PATIENTS 0 0 73.00 C 770 73.00 76. 97 07697 CARDIAC REHABILITATION 0 0 76.97 0 76. 98 07698 HYPERBARIC OXYGEN THERAPY 0 C 0 ol 83 76.98 07699 LI THOTRI PSY 76.99 76.99 0 0 0 0 0 OUTPATIENT SERVICE COST CENTERS 90.00 09000 CLI NI C 0 0 0 90.00 91.00 09100 EMERGENCY 0 5, 392 91.00 0 4.401 2, 416 09200 OBSERVATION BEDS (NON-DISTINCT PART 92.00 92.00 OTHER REIMBURSABLE COST CENTERS 09500 AMBULANCE SERVICES 0 2, 980 0 7.775 0 95.00 SPECIAL PURPOSE COST CENTERS 113. 00 11300 INTEREST EXPENSE 113 00 SUBTOTALS (SUM OF LINES 1 through 117) 118, 378 45, 263 0 30, 649 42, 204 118. 00 NONREI MBURSABLE COST CENTERS 190.00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN 0 190. 00 0 192. 00 19200 PHYSI CLANS' PRI VATE OFFI CES 0 0 432 0 46 192.00 194.00 07950 OCC HEALTH 0 0 0 0 194.00 C 194. 01 07951 PAIN CLINIC 0 0 0 194.01 0 0 0 0 194. 02 07952 OCC HEALTH 0 0 194, 02 C 194. 03 07953 FOUNDATI 0 0 0 325 0 194.03 0 194.04 194. 04 07954 KIDS CAMPUS 0 0 0 0 194. 05 07955 COMMUNITY & VOLUNTEER SERVICES 0 0 3 194.05 194.06 07956 HUNTI NGTON COLLEGE NURSE 0 01194.06 C 0 194. 07 07957 MISC CATERING 0 185 0 194.07 194. 08 07958 AUTI SM CENTER 0 0 194.08 C 0 0 194. 09 07959 HUNTI NGTON BUA 0 0 0 0 194.09 C 200.00 Cross Foot Adjustments 200.00 Negative Cost Centers 0 201.00 201.00 0 TOTAL (sum lines 118 through 201) 202.00 118.378 46, 205 30, 649 42, 253 202. 00

Health Financial Systems
ALLOCATION OF CAPITAL RELATED COSTS Provider CCN: 15-0091

				To 12/31/2019	Date/Time Pre 6/26/2020 11:	
Cost Center Description	PHARMACY	MEDI CAL RECORDS &	SOCI AL SERVI CE	NONPHYSI CI AN ANESTHETI STS	NURSI NG SCHOOL	24 dill
	15. 00	16. 00	17. 00	19. 00	20. 00	
GENERAL SERVICE COST CENTERS						
1. 00 00100 CAP REL COSTS-BLDG & FIXT 2. 00 00200 CAP REL COSTS-MVBLE EQUIP 4. 00 00400 EMPLOYEE BENEFITS DEPARTMENT 5. 00 00500 ADMINISTRATIVE & GENERAL 6. 00 00600 MAINTENANCE & REPAIRS 7. 00 00700 OPERATION OF PLANT 8. 00 00800 LAUNDRY & LINEN SERVICE 9. 00 00900 HOUSEKEEPING						1. 00 2. 00 4. 00 5. 00 6. 00 7. 00 8. 00 9. 00
10. 00 01000 DI ETARY 11. 00 01100 CAFETERI A 12. 00 01200 MAI NTENANCE OF PERSONNEL 13. 00 01300 NURSI NG ADMI NI STRATI ON 14. 00 01400 CENTRAL SERVI CES & SUPPLY 15. 00 01500 PHARMACY 16. 00 01600 MEDI CAL RECORDS & LI BRARY 17. 00 01700 SOCI AL SERVI CE 19. 00 01900 NONPHYSI CI AN ANESTHETI STS 20. 00 02000 NURSI NG SCHOOL 21. 00 02100 & R SERVI CES-SALARY & FRI NGES APPRV	156, 624 0 0 0 0	14, 134 0 0 0		0 0 0 0	0	10. 00 11. 00 12. 00 13. 00 14. 00 15. 00 16. 00 17. 00 19. 00 20. 00 21. 00
22. 00 02200 1&R SERVICES-OTHER PRGM COSTS APPRV		0		0		22.00
23. 00 02300 PARAMED ED PRGM-(SPECIFY) INPATIENT ROUTINE SERVICE COST CENTERS	0	0		0		23. 00
30. 00 03000 ADULTS & PEDIATRICS	11, 143	1, 042		0		30.00
43.00 O4300 NURSERY ANCILLARY SERVICE COST CENTERS	0	71		0		43.00
50. 00 05000 OPERATING ROOM	16, 369	1, 824		0		50.00
50. 01 05001 0PERATING ROOM 52. 00 05200 DELIVERY ROOM & LABOR ROOM 53. 00 05300 ANESTHESI OLOGY	0 0	0 270 238		0 0 0		50. 01 52. 00 53. 00
54. 00 05400 RADI OLOGY-DI AGNOSTI C 60. 00 06000 LABORATORY 60. 00 06000 DEPON CLOTTI NG FOR UFMORULLI AGS	4, 050 66 0	2, 379 1, 745		0		54. 00 60. 00
62. 30 06250 BLOOD CLOTTING FOR HEMOPHILIACS 65. 00 06500 RESPIRATORY THERAPY	6, 244	0 560		0		62. 30 65. 00
66. 00 06600 PHYSI CAL THERAPY 67. 00 06700 OCCUPATI ONAL THERAPY	2, 099	366 128		0		66. 00 67. 00
68. 00 06800 SPEECH PATHOLOGY	0	50		0		68.00
69. 00 06900 ELECTROCARDI OLOGY	02.024	61		0		69.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT 72.00 07200 MPL. DEV. CHARGED TO PATIENTS	93, 026	378 282		0		71.00
73.00 07300 DRUGS CHARGED TO PATIENTS	2, 887	1, 365		0		73.00
76. 97 O7697 CARDI AC REHABI LI TATI ON 76. 98 O7698 HYPERBARI C OXYGEN THERAPY	0 310	0 172		0		76. 97 76. 98
76. 99 07699 LI THOTRI PSY	0	0		0		76. 99
90. 00 OUTPATIENT SERVICE COST CENTERS 90. 00 O9000 CLINIC	O	56		0		90.00
91.00 09100 EMERGENCY 92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART	9, 064	2, 013		0		91. 00 92. 00
OTHER REIMBURSABLE COST CENTERS 95. 00 09500 AMBULANCE SERVI CES	11, 180	1, 134		0		95.00
SPECIAL PURPOSE COST CENTERS 113. 00 11300 INTEREST EXPENSE						113.00
118.00 SUBTOTALS (SUM OF LINES 1 through 117) NONREI MBURSABLE COST CENTERS	156, 438	14, 134		0 0	0	118. 00
190.00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN 192.00 19200 PHYSICIANS' PRIVATE OFFICES	0 174	0		0		190. 00 192. 00
194. 00 07950 OCC HEALTH	o	Ö		o		194.00
194. 01 07951 PALN CLINIC 194. 02 07952 OCC HEALTH	0	0		0		194. 01 194. 02
194. 03 07953 FOUNDATI 0		0		0		194. 02
194. 04 07954 KI DS CAMPUS	О	0		0		194. 04
194. 05 07955 COMMUNI TY & VOLUNTEER SERVI CES 194. 06 07956 HUNTI NGTON COLLEGE NURSE	12	0		0		194. 05 194. 06
194. 07 07957 MI SC CATERING	0	o		0		194.06
194.08 07958 AUTISM CENTER	O	0		0		194. 08
194.09 07959 HUNTI NGTON BUA 200.00 Cross Foot Adjustments	0	0		0	_	194. 09 200. 00
201.00 Negative Cost Centers	o	О		0 0	0	201.00
202.00 TOTAL (sum lines 118 through 201)	156, 624	14, 134		ol ol	0	202.00

ALLOCATION OF CAPITAL RELATED COSTS Provider CCN: 15-0091 Peri od: Worksheet B From 01/01/2019 Part II Date/Time Prepared: 12/31/2019 6/26/2020 11:24 am INTERNS & RESIDENTS Cost Center Description SERVI CES-SALA | SERVI CES-OTHE PARAMED ED Subtotal Intern & R PRGM COSTS RY & FRINGES PRGM Residents **APPRV APPRV** Cost & Post Stepdown Adjustments 21. 00 22. 00 23.00 24.00 25.00 GENERAL SERVICE COST CENTERS 1.00 00100 CAP REL COSTS-BLDG & FLXT 1.00 00200 CAP REL COSTS-MVBLE EQUIP 2.00 2.00 00400 EMPLOYEE BENEFITS DEPARTMENT 4.00 4.00 00500 ADMINISTRATIVE & GENERAL 5.00 5.00 6.00 00600 MAINTENANCE & REPAIRS 6.00 7.00 00700 OPERATION OF PLANT 7.00 00800 LAUNDRY & LINEN SERVICE 8 00 8 00 00900 HOUSEKEEPI NG 9.00 9.00 10.00 01000 DI ETARY 10.00 11.00 01100 CAFETERI A 11.00 01200 MAINTENANCE OF PERSONNEL 12 00 12 00 13.00 01300 NURSING ADMINISTRATION 13.00 01400 CENTRAL SERVICES & SUPPLY 14.00 14.00 01500 PHARMACY 15.00 15.00 01600 MEDICAL RECORDS & LIBRARY 16.00 16.00 17.00 01700 SOCIAL SERVICE 17.00 01900 NONPHYSICIAN ANESTHETISTS 19.00 19.00 02000 NURSI NG SCHOOL 20 00 20 00 02100 I&R SERVICES-SALARY & FRINGES APPRV 21.00 0 21.00 02200 I&R SERVICES-OTHER PRGM COSTS APPRV 22.00 22.00 23.00 02300 PARAMED ED PRGM-(SPECIFY) 23.00 INPATIENT ROUTINE SERVICE COST CENTERS 30.00 03000 ADULTS & PEDIATRICS 1, 136, 682 0 30.00 14, 798 04300 NURSERY 0 43.00 43.00 ANCILLARY SERVICE COST CENTERS 50.00 05000 OPERATING ROOM 50.00 489, 165 0 50.01 05001 OPERATING ROOM 0 50.01 05200 DELIVERY ROOM & LABOR ROOM 52.00 47 479 52.00 53.00 05300 ANESTHESI OLOGY 62, 755 0 53.00 05400 RADI OLOGY-DI AGNOSTI C 54.00 662, 239 0 54 00 06000 LABORATORY 0 60.00 60.00 211, 857 06250 BLOOD CLOTTING FOR HEMOPHILIACS 62.30 0 62.30 06500 RESPIRATORY THERAPY 178, 295 65.00 65.00 0 06600 PHYSI CAL THERAPY 66.00 691, 634 0 66.00 67.00 06700 OCCUPATI ONAL THERAPY 20, 357 0 67.00 06800 SPEECH PATHOLOGY 68.00 68.00 13, 245 06900 ELECTROCARDI OLOGY 69.00 69.00 61 0 71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT 179, 548 0 71.00 72.00 07200 IMPL. DEV. CHARGED TO PATIENTS 51, 498 0 72.00 07300 DRUGS CHARGED TO PATIENTS 166, 154 0 73.00 73.00 07697 CARDIAC REHABILITATION 76.97 0 76.97 76. 98 07698 HYPERBARIC OXYGEN THERAPY 79, 162 0 76.98 76. 99 07699 LI THOTRI PSY 0 76.99 OUTPATIENT SERVICE COST CENTERS 90.00 09000 CLI NI C 7,935 0 90.00 09100 EMERGENCY 91.00 91.00 277, 190 0 09200 OBSERVATION BEDS (NON-DISTINCT PART 92.00 92.00 0 OTHER REIMBURSABLE COST CENTERS 95.00 09500 AMBULANCE SERVICES 651, 044 0 95.00 SPECIAL PURPOSE COST CENTERS 113. 00 11300 INTEREST EXPENSE 113 00 SUBTOTALS (SUM OF LINES 1 through 117) 0 4, 941, 098 118.00 0 0 118.00 NONREI MBURSABLE COST CENTERS 190.00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN 192.00 19200 PHYSICIANS' PRIVATE OFFICES 0 190.00 4,768 0 192, 00 9,606 194.00 07950 OCC HEALTH 0 194.00 6, 115 194. 01 07951 PAIN CLINIC 0 194. 01 194. 02 07952 OCC HEALTH 0 194. 02 194. 03 07953 FOUNDATI 0 0 194.03 13,824 194. 04 07954 KIDS CAMPUS 0 194.04 194. 05 07955 COMMUNITY & VOLUNTEER SERVICES 0 194.05 24, 031 194.06 07956 HUNTI NGTON COLLEGE NURSE 0 194.06 194. 07 07957 MISC CATERING 5.321 0 194.07 194.08 07958 AUTISM CENTER 0 194.08 194. 09 07959 HUNTI NGTON BUA 0 0 194.09 200.00 0 200.00 Cross Foot Adjustments 0 0 0 201.00 Negative Cost Centers 0 0 0 0 201.00 5, 004, 763

0

0 202.00

TOTAL (sum lines 118 through 201)

| Peri od: | Worksheet B | From 01/01/2019 | Part I I | To 12/31/2019 | Date/Time Prepared: Provider CCN: 15-0091

			10 12/31/2019 Date/lime 6/26/2020	
	Cost Center Description	Total	9, 29, 2929	
	CENEDAL SERVICE COST CENTERS	26. 00		
1. 00	GENERAL SERVICE COST CENTERS O0100 CAP REL COSTS-BLDG & FIXT			1.00
2. 00	00200 CAP REL COSTS-BEDG & TTXT			2.00
4. 00	00400 EMPLOYEE BENEFITS DEPARTMENT			4.00
5. 00	00500 ADMI NI STRATI VE & GENERAL			5. 00
6.00	00600 MAINTENANCE & REPAIRS			6.00
7.00	00700 OPERATION OF PLANT			7. 00
8.00	00800 LAUNDRY & LINEN SERVICE			8. 00
9.00	00900 HOUSEKEEPI NG			9.00
10.00	01000 DI ETARY			10.00
11. 00 12. 00	O1100 CAFETERI A O1200 MAI NTENANCE OF PERSONNEL			11. 00 12. 00
13. 00	01300 NURSI NG ADMI NI STRATI ON			13.00
14. 00	01400 CENTRAL SERVICES & SUPPLY			14. 00
15.00	01500 PHARMACY			15. 00
16.00	01600 MEDICAL RECORDS & LIBRARY			16. 00
17.00	01700 SOCIAL SERVICE			17. 00
19. 00	01900 NONPHYSI CI AN ANESTHETI STS			19. 00
20.00	02000 NURSI NG SCHOOL			20.00
21. 00 22. 00	O2100 L&R SERVICES-SALARY & FRINGES APPRV O2200 L&R SERVICES-OTHER PRGM COSTS APPRV			21. 00 22. 00
23. 00	02300 PARAMED ED PRGM-(SPECIFY)			23. 00
20.00	INPATIENT ROUTINE SERVICE COST CENTERS			
30.00	03000 ADULTS & PEDIATRICS	1, 136, 682		30.00
43.00	04300 NURSERY	14, 798		43.00
	ANCILLARY SERVICE COST CENTERS			
50.00	05000 OPERATING ROOM	489, 165		50.00
50. 01	05001 OPERATING ROOM	0		50. 01
52. 00 53. 00	05200 DELI VERY ROOM & LABOR ROOM 05300 ANESTHESI OLOGY	47, 479 62, 755		52. 00 53. 00
54. 00	05400 RADI OLOGY-DI AGNOSTI C	662, 239		54.00
60.00	06000 LABORATORY	211, 857		60.00
62. 30	06250 BLOOD CLOTTING FOR HEMOPHILIACS	0		62. 30
65.00	06500 RESPIRATORY THERAPY	178, 295		65. 00
66.00	06600 PHYSI CAL THERAPY	691, 634		66.00
67.00	06700 OCCUPATI ONAL THERAPY	20, 357		67.00
68.00	06800 SPEECH PATHOLOGY	13, 245		68.00
69. 00 71. 00	06900 ELECTROCARDI OLOGY 07100 MEDI CAL SUPPLI ES CHARGED TO PATI ENT	61 179, 548		69. 00 71. 00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	51, 498		72.00
73. 00	07300 DRUGS CHARGED TO PATIENTS	166, 154		73.00
76. 97	07697 CARDI AC REHABI LI TATI ON	0		76. 97
76. 98	07698 HYPERBARI C OXYGEN THERAPY	79, 162		76. 98
76. 99	07699 LI THOTRI PSY	0		76. 99
00 00	OUTPATIENT SERVICE COST CENTERS	7 025		00.00
90. 00 91. 00	09000 CLI NI C 09100 EMERGENCY	7, 935 277, 190		90. 00 91. 00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART	277, 190		92.00
72.00	OTHER REIMBURSABLE COST CENTERS			72.00
95.00	09500 AMBULANCE SERVICES	651, 044		95. 00
	SPECIAL PURPOSE COST CENTERS			
	11300 INTEREST EXPENSE			113. 00
118.00	9 /	4, 941, 098		118. 00
100 00	NONREIMBURSABLE COST CENTERS 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	4, 768		190. 00
	19200 PHYSICIANS' PRIVATE OFFICES	9, 606		192.00
	07950 OCC HEALTH	6, 115		194. 00
	07951 PAIN CLINIC	0		194.01
	07952 OCC HEALTH	o		194. 02
	07953 FOUNDATI 0	13, 824		194. 03
	07954 KI DS CAMPUS	0		194.04
	07955 COMMUNITY & VOLUNTEER SERVICES	24, 031		194. 05
	07956 HUNTINGTON COLLEGE NURSE 07957 MISC CATERING	5, 321		194. 06 194. 07
	07957 MISC CATERING 07958 AUTISM CENTER	ی, ع <u>د ا</u>		194.07
	07959 HUNTI NGTON BUA	0		194. 09
200.00		o		200.00
201.00	1 1	o		201. 00
202.00	TOTAL (sum lines 118 through 201)	5, 004, 763		202. 00

From 01/01/2019 12/31/2019 Date/Time Prepared: 6/26/2020 11:24 am CAPITAL RELATED COSTS BLDG & FIXT MVBLE EQUIP **EMPLOYEE** Reconciliatio ADMINISTRATIV Cost Center Description (SQUARE FEET) (DOLLAR BENEFITS F & GENERAL n DEPARTMENT (ACCUM. COST) VALUE) (GROSS SALARI ES) 1. 00 2.00 4.00 5A 5. 00 GENERAL SERVICE COST CENTERS 1.00 00100 CAP REL COSTS-BLDG & FLXT 137, 207 1 00 00200 CAP REL COSTS-MVBLE EQUIP 2.00 724, 209 2.00 00400 EMPLOYEE BENEFITS DEPARTMENT 21, 447, 870 4.00 132 4.00 00500 ADMINISTRATIVE & GENERAL 5.00 7, 681 3, 363 6, 653, 639 -17, 666, 677 30, 683, 420 5.00 6.00 00600 MAINTENANCE & REPAIRS 6.00 7.00 00700 OPERATION OF PLANT 30, 673 20, 978 374.746 0 1,863,061 7.00 00800 LAUNDRY & LINEN SERVICE 0 190, 741 8 00 629 30, 629 8 00 00900 HOUSEKEEPI NG 0 9.00 512 295, 921 470, 816 9.00 10.00 01000 DI ETARY 4, 892 1, 405 66, 603 191, 335 10.00 11.00 01100 CAFETERI A 1, 110 308, 830 0 0 344, 283 11.00 C 01200 MAINTENANCE OF PERSONNEL 12 00 12 00 0 C 0 0 13.00 01300 NURSING ADMINISTRATION 0 C 407, 783 453, 914 13.00 01400 CENTRAL SERVICES & SUPPLY 1, 905 0 27, 905 14.00 14.00 0 01500 PHARMACY 676, 268 15.00 1.155 56.888 550.934 15.00 0 01600 MEDICAL RECORDS & LIBRARY 16.00 638 C 0 9, 346 16.00 17.00 01700 SOCIAL SERVICE 0 0 0 17.00 0 C 01900 NONPHYSICIAN ANESTHETISTS 19.00 0 0 0 19.00 0 0 02000 NURSI NG SCHOOL 0 0 0 20 00 20 00 C 0 02100 I&R SERVICES-SALARY & FRINGES APPRV 0 21.00 0 C 0 0 21.00 02200 I&R SERVICES-OTHER PRGM COSTS APPRV 0 0 22.00 0 22.00 23.00 02300 PARAMED ED PRGM-(SPECIFY) 0 0 0 23.00 INPATIENT ROUTINE SERVICE COST CENTERS 30.00 03000 ADULTS & PEDIATRICS 25, 160 3, 010, 909 0 4, 354, 157 30.00 94, 368 04300 NURSERY 43.00 102 139, 316 169, 114 43.00 ANCILLARY SERVICE COST CENTERS 05000 OPERATING ROOM 50 00 9.584 114, 475 1, 173, 755 0 1, 203, 351 50 00 50.01 05001 OPERATING ROOM 0 50.01 05200 DELIVERY ROOM & LABOR ROOM 0 52.00 0 523, 917 630, 356 52 00 53.00 05300 ANESTHESI OLOGY 0 0 950, 029 53.00 05400 RADI OLOGY-DI AGNOSTI C 54 00 12.012 163, 443 1, 133, 437 2, 226, 030 54 00 06000 LABORATORY 2, 605, 619 60.00 1,820 60.00 62.30 06250 BLOOD CLOTTING FOR HEMOPHILIACS C 0 0 62.30 06500 RESPIRATORY THERAPY 65.00 2, 202 32, 134 816, 324 1,060,158 65.00 66.00 06600 PHYSI CAL THERAPY 26, 034 22, 559 967, 569 1, 519, 824 66.00 67.00 06700 OCCUPATI ONAL THERAPY 252, 731 0 0 293, 552 67.00 06800 SPEECH PATHOLOGY 0 169, 328 68.00 196, 678 68.00 06900 ELECTROCARDI OLOGY 0 69.00 \cap Ω 69 00 71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT 0 0 0 932, 206 71.00 72.00 07200 IMPL. DEV. CHARGED TO PATIENTS 0 0 0 0 778, 303 72.00 07300 DRUGS CHARGED TO PATIENTS 0 73.00 0 63.477 2, 448, 534 73.00 07697 CARDIAC REHABILITATION 76.97 0 C \cap Ω 76.97 76. 98 07698 HYPERBARIC OXYGEN THERAPY 2,019 178, 277 544,011 76.98 76. 99 07699 LI THOTRI PSY 0 76.99 0 OUTPATIENT SERVICE COST CENTERS 90.00 09000 CLI NI C 101, 305 0 119, 592 90.00 09100 EMERGENCY 17, 015 91.00 5, 120 1, 249, 210 1, 720, 950 91.00 09200 OBSERVATION BEDS (NON-DISTINCT PART 92.00 92.00 OTHER REIMBURSABLE COST CENTERS 95.00 09500 AMBULANCE SERVICES 3, 551 196, 768 2, 850, 576 0 3, 870, 637 95.00 SPECIAL PURPOSE COST CENTERS 113. 00 11300 INTEREST EXPENSE 113 00 SUBTOTALS (SUM OF LINES 1 through 117) -17, 666, 677 118.00 136, 931 723, 396 21, 319, 216 29, 850, 770 118. 00 NONREI MBURSABLE COST CENTERS 190.00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN 192.00 19200 PHYSICIANS' PRIVATE OFFICES 72, 453 190. 00 0 C 0 813 0 108, 068 192. 00 86, 461 194.00 07950 OCC HEALTH 276 C 0 4, 043 194. 00 194. 01 07951 PAIN CLINIC 0 194. 01 0 0 0 194. 02 07952 OCC HEALTH 0 0 0 0 0 194. 02 0 194. 03 07953 FOUNDATI 0 0 205, 133 194. 03 0 o 194. 04 07954 KIDS CAMPUS 0 0 0 0 194.04 0 364, 962 194. 05 194. 05 07955 COMMUNITY & VOLUNTEER SERVICES 0 0 194.06 07956 HUNTI NGTON COLLEGE NURSE 0 0 194.06 0 0 194. 07 07957 MISC CATERING 0 42, 193 77, 991 194. 07 194.08 07958 AUTISM CENTER 0 194.08 194. 09 07959 HUNTI NGTON BUA 0 0 194.09 200.00 200.00 Cross Foot Adjustments 201.00 Negative Cost Centers 201.00

Health Fina	ancial Systems	HUNTI NGTON MEMO	RIAL HOSPITAL		In Lieu of Form CMS-2552-10		
COST ALLOC	ATION - STATISTICAL BASIS	Provi der CCN: 15-0091			Peri od:	Worksheet B-1	
					From 01/01/2019 To 12/31/2019		pared: 24 am
		CAPITAL REL	ATED COSTS				
	Cost Center Description	BLDG & FIXT (SQUARE FEET)	MVBLE EQUIP (DOLLAR VALUE)	EMPLOYEE BENEFITS DEPARTMENT (GROSS SALARIES)	Reconciliatio n	ADMINISTRATIV E & GENERAL (ACCUM. COST)	
		1. 00	2.00	4. 00	5A	5. 00	
202. 00	Cost to be allocated (per Wkst. B, Part I)	2, 009, 838	1, 094, 002	2, 106, 16	1	17, 666, 677	202.00
203. 00	Unit cost multiplier (Wkst. B, Part I)	14. 648218	1. 510616	0. 09819	9	0. 575773	203.00
204. 00	Cost to be allocated (per Wkst. B, Part II)			1, 93	4	2, 019, 116	204. 00
205. 00	Unit cost multiplier (Wkst. B, Part			0. 00009	D	0. 065805	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				u of Form CMS-2	
COST A	ALLOCAT	FION - STATISTICAL BASIS		Provi der C		eriod: rom 01/01/2019	Worksheet B-1	
					T	o 12/31/2019	Date/Time Pre 6/26/2020 11:	
		Cost Center Description	MAINTENANCE &	OPERATION OF	LAUNDRY &	HOUSEKEEPI NG	DI ETARY	
			REPAIRS (SQUARE FEET)	PLANT (SQUARE FEET)	LINEN SERVICE (POUNDS OF	(SQUARE FEET)	(MEALS SERVED)	
			(SCOARC TEET)	(SCOMIC TEET)	LAUNDRY)		SERVED)	
	CENED	AL CEDIUSE COCT CENTEDO	6. 00	7. 00	8. 00	9. 00	10. 00	
1. 00		AL SERVICE COST CENTERS CAP REL COSTS-BLDG & FIXT						1.00
2.00		CAP REL COSTS-MVBLE EQUIP						2.00
4.00		EMPLOYEE BENEFITS DEPARTMENT						4.00
5. 00 6. 00		ADMINISTRATIVE & GENERAL MAINTENANCE & REPAIRS	0					5. 00 6. 00
7. 00		OPERATION OF PLANT	Ö	98, 721				7. 00
8. 00	1	LAUNDRY & LINEN SERVICE	0	629				8. 00
9. 00 10. 00	1	HOUSEKEEPI NG DI ETARY	0	512 4, 892	1	, , , , , , , , , , , , , , , , , , , ,	22, 839	9.00
11. 00	1	CAFETERI A	0		1		22, 037	
12.00	1	MAINTENANCE OF PERSONNEL	0	_	1		0	
13. 00 14. 00	1	NURSING ADMINISTRATION CENTRAL SERVICES & SUPPLY	0	0 1, 905	0 512		0	13.00
15. 00		PHARMACY	0	1, 155	l .		0	15.00
16. 00	1	MEDICAL RECORDS & LIBRARY	0	638	1	638	0	16. 00
17. 00 19. 00		SOCIAL SERVICE NONPHYSICIAN ANESTHETISTS	0	0			0	17. 00 19. 00
20. 00	1	NURSING SCHOOL	0	0			0	20.00
21. 00	02100	I&R SERVICES-SALARY & FRINGES APPRV	0	_	O		0	
22. 00		I&R SERVICES-OTHER PRGM COSTS APPRV PARAMED ED PRGM-(SPECIFY)	0		0		0	
23. 00		I ENT ROUTINE SERVICE COST CENTERS	0	0		l O	0	23.00
30.00	03000	ADULTS & PEDIATRICS	0	· ·			22, 839	1
43. 00		NURSERY LARY SERVICE COST CENTERS	0	102	3, 787	102	0	43.00
50.00		OPERATING ROOM	0	9, 584	37, 545	9, 584	0	50.00
50. 01		OPERATING ROOM	0	_	O		0	50. 01
52. 00 53. 00		DELIVERY ROOM & LABOR ROOM ANESTHESIOLOGY	0	0	15, 114	0	0	
54. 00	1	RADI OLOGY-DI AGNOSTI C	0	12, 012	30, 645	12, 012	0	
60.00		LABORATORY	0	1, 820	O	1, 820	0	60.00
62. 30 65. 00		BLOOD CLOTTING FOR HEMOPHILIACS RESPIRATORY THERAPY	0	2, 202	0 18, 133	0 2, 202	0	62. 30 65. 00
66. 00	1	PHYSI CAL THERAPY	0	26, 034	1		0	66.00
67. 00		OCCUPATI ONAL THERAPY	0	0	O		0	
68. 00 69. 00		SPEECH PATHOLOGY ELECTROCARDI OLOGY	0	0	0		0	68. 00 69. 00
71. 00	1	MEDICAL SUPPLIES CHARGED TO PATIENT	0	Ö	Ö		0	
72. 00		IMPL. DEV. CHARGED TO PATIENTS	0	0	O	0	0	
73. 00 76. 97		DRUGS CHARGED TO PATIENTS CARDIAC REHABILITATION	0	0		0	0	73. 00 76. 97
	1	HYPERBARIC OXYGEN THERAPY	0	2, 019	-		0	
76. 99	07699	LI THOTRI PSY	0	0	0	0	0	76. 99
90. 00	001PA	TIENT SERVICE COST CENTERS	0	0		ol	0	90.00
		EMERGENCY	Ö				0	1
92. 00		OBSERVATION BEDS (NON-DISTINCT PART						92.00
95. 00		REIMBURSABLE COST CENTERS AMBULANCE SERVICES	0	3, 551	5, 285	3, 551	0	95.00
	SPECI.	AL PURPOSE COST CENTERS	-	2,22.	5, 25	2, 33.1		
	1	INTEREST EXPENSE		00 445	250.012	07.204	22 020	113.00
118. 00		SUBTOTALS (SUM OF LINES 1 through 117) IMBURSABLE COST CENTERS	0	98, 445	250, 912	97, 304	22, 839]118.00
	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0					190. 00
		PHYSICIANS' PRIVATE OFFICES OCC HEALTH	0					192. 00 194. 00
		PAIN CLINIC		276 0	0			194.00
194. 02	07952	OCC HEALTH	0	0	O	0	0	194. 02
		FOUNDATIO KIDS CAMPUS	0	0	0			194. 03 194. 04
		COMMUNITY & VOLUNTEER SERVICES		0				194. 04
194.06	07956	HUNTINGTON COLLEGE NURSE	0	0	O		0	194. 06
		MISC CATERING AUTISM CENTER	0	0	0	-		194. 07 194. 08
		HUNTINGTON BUA			0		0	194. 08
200.00	o	Cross Foot Adjustments						200.00
201. 00 202. 00	1	Negative Cost Centers Cost to be allocated (per Wkst. B,	0	2, 935, 761	319, 270	757, 125	484, 936	201.00
		Part I)						
203.00)	Unit cost multiplier (Wkst. B, Part I)	0. 000000	29. 737958	1. 242296	7. 759018	21. 232804	203. 00

Health Financial Systems	HUNTI NGTON MEMO	RIAL HOSPITAL		In Lieu of Form CMS-2552-10			
COST ALLOCATION - STATISTICAL BASIS		Provi der C		Peri od:	Worksheet B-1		
				From 01/01/2019 Fo 12/31/2019			
Cost Center Description	MAINTENANCE &	OPERATION OF	LAUNDRY &	HOUSEKEEPI NG	DI ETARY		
	REPAI RS	PLANT	LINEN SERVICE	(SQUARE FEET)	(MEALS		
	(SQUARE FEET)	(SQUARE FEET)	(POUNDS OF		SERVED)		
			LAUNDRY)				
	6. 00	7. 00	8. 00	9. 00	10.00		
204.00 Cost to be allocated (per Wkst. B,	0	603, 625	25, 61	5 41, 640	118, 378	204.00	
Part II)							
205.00 Unit cost multiplier (Wkst. B, Part	0. 000000	6. 114454	0. 09966	9 0. 426727	5. 183152	205.00	
206.00 NAHE adjustment amount to be allocated	t l					206. 00	
(per Wkst. B-2)							
207.00 NAHE unit cost multiplier (Wkst. D,						207.00	
Parts III and IV)							
		•				•	

		HUNTI NGTON MEMO		CN 15 0001 D		u of Form CMS-2	
COST A	LLOCATION - STATISTICAL BASIS		Provi der C		eriod: rom 01/01/2019 o 12/31/2019	Worksheet B-1 Date/Time Pre 6/26/2020 11:	pared:
	Cost Center Description	CAFETERI A (HOURS OF SERVI CE)	MAI NTENANCE OF PERSONNEL (NUMBER	NURSI NG ADMI NI STRATI O N	CENTRAL SERVI CES & SUPPLY	PHARMACY (COSTED REQUIS.)	24 dili
			HOUSED)	(DIRECT NRSING HRS)	(COSTED		
		11. 00	12. 00	13.00	REQUIS.) 14.00	15. 00	
	GENERAL SERVICE COST CENTERS						
1. 00 2. 00 4. 00 5. 00 6. 00 7. 00 8. 00 9. 00 10. 00 11. 00 12. 00 13. 00 14. 00 15. 00 17. 00 19. 00 20. 00	00100 CAP REL COSTS-BLDG & FIXT 00200 CAP REL COSTS-MVBLE EQUIP 00400 EMPLOYEE BENEFITS DEPARTMENT 00500 ADMINISTRATIVE & GENERAL 00600 MAINTENANCE & REPAIRS 00700 OPERATION OF PLANT 00800 LAUNDRY & LINEN SERVICE 00900 HOUSEKEEPING 01000 DIETARY 01100 CAFETERIA 01200 MAINTENANCE OF PERSONNEL 01300 NURSING ADMINISTRATION 01400 CENTRAL SERVICES & SUPPLY 01500 PHARMACY 01600 MEDICAL RECORDS & LIBRARY 01700 SOCIAL SERVICE 01900 NONPHYSICIAN ANESTHETISTS 02000 NURSING SCHOOL	405, 214 0 6, 511 0 10, 209 0 0	0 0 0 0 0 0	219, 416 0 0 0 0 0	2, 850, 056 33, 612 0 0 0	2, 816, 445 0 0 0	16. 00 17. 00 19. 00 20. 00
	02100 &R SERVICES-SALARY & FRINGES APPRV 02200 &R SERVICES-OTHER PRGM COSTS APPRV	0	0	0	0	0	21.00
	02300 PARAMED ED PRGM-(SPECIFY)	0	0	0	0	0	23.00
	INPATIENT ROUTINE SERVICE COST CENTERS						
	03000 ADULTS & PEDIATRICS 04300 NURSERY	130, 422 4, 123	0		200, 383 0	200, 383 0	
50. 00	ANCILLARY SERVICE COST CENTERS 05000 OPERATING ROOM	29, 816	0	29, 816	294, 354	294, 354	50.00
50. 01	05001 OPERATING ROOM	0	0	0	0	0	50. 01
	05200 DELIVERY ROOM & LABOR ROOM	16, 455	0	1	0	0	52.00
	05300 ANESTHESI OLOGY 05400 RADI OLOGY-DI AGNOSTI C	32, 128	0	0	72, 829	0 72, 829	
60.00	06000 LABORATORY	0	0	0	1, 181	1, 181	1
	06250 BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0	0	0	
	06500 RESPI RATORY THERAPY 06600 PHYSI CAL THERAPY	26, 144 24, 479	0	0	112, 285 37, 739	112, 285 37, 739	
	06700 OCCUPATI ONAL THERAPY	7, 800	Ō	Ö	0	0	1
	06800 SPEECH PATHOLOGY	2, 091	0	0	0	0	68.00
	06900 ELECTROCARDIOLOGY 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0 1, 672, 821	0 1, 672, 821	69. 00 71. 00
	07200 IMPL. DEV. CHARGED TO PATIENTS	0	0	Ö	0	0	
	07300 DRUGS CHARGED TO PATIENTS	0	0	0	51, 920		73.00
	07697 CARDIAC REHABILITATION 07698 HYPERBARIC OXYGEN THERAPY	0	0	ı "I	0 5, 569		76. 97 76. 98
76. 99	07699 LI THOTRI PSY	0	0		5, 509	0,570	
	OUTPATIENT SERVICE COST CENTERS						
	09000 CLINIC 09100 EMERGENCY	0 38, 600	0		0 162, 990	0 162, 990	
	09200 OBSERVATION BEDS (NON-DISTINCT PART	38, 600	0	38, 000	102, 990	102, 990	92.00
	OTHER REIMBURSABLE COST CENTERS						
	09500 AMBULANCE SERVICES SPECIAL PURPOSE COST CENTERS	68, 183	0	0	201, 038	201, 038	95.00
	11300 I NTEREST EXPENSE						113.00
118. 00		396, 961	0	219, 416	2, 846, 721	2, 813, 110	118.00
	NONREIMBURSABLE COST CENTERS 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN		0	O	ol	0	190. 00
	19200 PHYSI CLANS' PRI VATE OFFI CES	3, 787	0	-	3, 126		192.00
	07950 OCC HEALTH	0	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
194. 04	07954 KI DS CAMPUS	0	0	0	0	0	194. 04
	07955 COMMUNITY & VOLUNTEER SERVICES 07956 HUNTINGTON COLLEGE NURSE	0	0	0	209		194. 05 194. 06
	07957 MISC CATERING	1, 619	0	0	0		194. 07
194. 08	07958 AUTISM CENTER	0	0	0	0		194. 08
	07959 HUNTI NGTON BUA	0	0	0	O	0	194. 09
200. 00 201. 00	Cross Foot Adjustments Negative Cost Centers						200. 00 201. 00
202.00	Cost to be allocated (per Wkst. B, Part I)	584, 134	0	724, 651	116, 040	1, 125, 040	
203. 00	Unit cost multiplier (Wkst. B, Part I)	1. 441544	0. 000000	3. 302635	0. 040715	0. 399454	203. 00

Heal th Fina	ncial Systems	HUNTINGTON MEMO	RIAL HOSPITAL		In Lieu of Form CMS-2552-10			
COST ALLOCA	TION - STATISTICAL BASIS		Provi der C		Peri od:	Worksheet B-1		
					From 01/01/2019 To 12/31/2019			
	Cost Center Description	CAFETERI A	MAI NTENANCE	NURSI NG	CENTRAL	PHARMACY		
		(HOURS OF	OF PERSONNEL	ADMI NI STRATI (SERVICES &	(COSTED		
		SERVI CE)	(NUMBER	N	SUPPLY	REQUIS.)		
			HOUSED)	(DI RECT	(COSTED			
				NRSING HRS)	REQUIS.)			
		11. 00	12. 00	13.00	14.00	15. 00		
204. 00	Cost to be allocated (per Wkst. B, Part II)	46, 205	0	30, 64	9 42, 253	156, 624	204.00	
205. 00	Unit cost multiplier (Wkst. B, Part	0. 114026	0. 000000	0. 13968	0. 014825	0. 055611	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		ON 45 0004 5		u or form CMS	
COST	NLLOCATION - STATISTICAL BASIS		Provi der C	F	Period: From 01/01/2019		
					o 12/31/2019	Date/Time Pre 6/26/2020 11:	
						INTERNS &	
	Cost Contor Doscription	MEDI CAL	SOCI AL	NONPHYSI CI AN	NURSI NG	RESI DENTS SERVI CES-SALA	
	Cost Center Description	RECORDS &	SERVI CE	ANESTHETI STS	SCH00L	RY & FRINGES	
		LI BRARY	(TIME SPENT)	(ASSI GNED	(ASSI GNED	APPRV	
		(GROSS REVE		TIME)	TIME)	(ASSI GNED	
		NUE)	17.00	10.00	20.00	TI ME)	
	GENERAL SERVICE COST CENTERS	16. 00	17. 00	19. 00	20.00	21. 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 6. 00	OO5OO ADMINISTRATIVE & GENERAL OO6OO MAINTENANCE & REPAIRS						5. 00 6. 00
7. 00	00700 OPERATION OF PLANT						7.00
8. 00	00800 LAUNDRY & LI NEN SERVI CE						8.00
9. 00	00900 HOUSEKEEPI NG						9. 00
10.00	01000 DI ETARY						10.00
11. 00 12. 00	O1100 CAFETERI A O1200 MAI NTENANCE OF PERSONNEL						11.00
13. 00	01300 NURSI NG ADMI NI STRATI ON						13.00
14.00	01400 CENTRAL SERVICES & SUPPLY						14.00
15.00	01500 PHARMACY						15. 00
16.00	01600 MEDICAL RECORDS & LIBRARY	214, 616, 429	0				16.00
17.00	01700 SOCIAL SERVICE 01900 NONPHYSICIAN ANESTHETISTS	0	0	,	,		17. 00 19. 00
20. 00	02000 NURSI NG SCHOOL	0	0		0		20.00
21. 00	02100 I &R SERVICES-SALARY & FRINGES APPRV	0	0			0	1
22. 00	02200 I &R SERVICES-OTHER PRGM COSTS APPRV	0	0				22. 00
23. 00	O2300 PARAMED ED PRGM- (SPECIFY)	0	0				23.00
30. 00	O3000 ADULTS & PEDIATRICS	15, 782, 537	0	С	0	0	30.00
43. 00	04300 NURSERY	1, 074, 564	0				
	ANCILLARY SERVICE COST CENTERS						1
50.00	05000 OPERATING ROOM	27, 637, 007	0			l	
50. 01 52. 00	O5001 OPERATING ROOM O5200 DELIVERY ROOM & LABOR ROOM	0 4, 098, 130	0	1			
53. 00	05300 ANESTHESI OLOGY	3, 599, 291	0			l .	53.00
54. 00	05400 RADI OLOGY-DI AGNOSTI C	36, 499, 479	0	Ċ			54.00
60.00	06000 LABORATORY	26, 438, 766	0	C		0	60.00
62. 30	06250 BLOOD CLOTTING FOR HEMOPHILIACS	0 401 003	0	C			62.30
65. 00 66. 00	06500 RESPI RATORY THERAPY 06600 PHYSI CAL THERAPY	8, 491, 803 5, 542, 815	0	C		0	65. 00 66. 00
67. 00	06700 OCCUPATI ONAL THERAPY	1, 937, 154	0		_	· -	1
68.00	06800 SPEECH PATHOLOGY	755, 491	0	C	0	0	68. 00
69. 00	06900 ELECTROCARDI OLOGY	931, 347	0	C	-	0	69.00
71. 00 72. 00	O7100 MEDICAL SUPPLIES CHARGED TO PATIENT O7200 MPL. DEV. CHARGED TO PATIENTS	5, 730, 698	0	C	_		71.00
	07300 DRUGS CHARGED TO PATIENTS	4, 277, 203 20, 680, 647	0		0		1
	07697 CARDI AC REHABI LI TATI ON	0	0	Ċ	0		1
76. 98	07698 HYPERBARI C OXYGEN THERAPY	2, 613, 035	0	C	0	0	76. 98
76. 99	07699 LI THOTRI PSY	0	0	C	0	0	76. 99
90. 00	OUTPATIENT SERVICE COST CENTERS O9000 CLINIC	853, 342	0		0	0	90.00
	09100 EMERGENCY	30, 492, 461	0				91.00
92.00	1 1	00, 1,2, 101					92.00
	OTHER REIMBURSABLE COST CENTERS						
95. 00	09500 AMBULANCE SERVICES	17, 180, 659	0	C	0	0	95.00
113 00	SPECIAL PURPOSE COST CENTERS 11300 NTEREST EXPENSE						113.00
118. 00		214, 616, 429	0	c	0	0	118.00
	NONREI MBURSABLE COST CENTERS						
	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	C		l .	190. 00
	19200 PHYSICIANS' PRIVATE OFFICES	0	0		-	l	192.00
	07950 0CC HEALTH 07951 PAIN CLINIC	0	0		0	•	194. 00 194. 01
	07952 OCC HEALTH	0	0		0	•	194. 02
	07953 FOUNDATI 0	0	0	C	0	0	194. 03
	07954 KIDS CAMPUS	0	0	C	0	•	194. 04
	07955 COMMUNITY & VOLUNTEER SERVICES	0	0		0	•	194.05
	07956 HUNTI NGTON COLLEGE NURSE 07957 MISC CATERI NG	0	0		0	l	194. 06 194. 07
	07957 MISC CATERING 07958 AUTI SM CENTER	0	0	0	0		194. 07
194. 09	07959 HUNTI NGTON BUA	0	0	c	0	l	194. 09
200.00	1 1						200.00
201.00	Negative Cost Centers			l	1		201.00

Health Fina	ncial Systems H	IUNTI NGTON MEMO	RIAL HOSPITAL		In Lie	u of Form CMS-2	2552-10
COST ALLOCA	TION - STATISTICAL BASIS		Provi der Co		Peri od: From 01/01/2019	Worksheet B-1	
					To 12/31/2019		
						I NTERNS & RESI DENTS	
	Cost Center Description	MEDI CAL RECORDS & LI BRARY	SOCIAL SERVICE (TIME SPENT)	NONPHYSI CI AN ANESTHETI STS (ASSI GNED		SERVI CES-SALA RY & FRI NGES APPRV	
		(GROSS REVE NUE)		TIME)	TIME)	(ASSIGNED TIME)	
		16. 00	17. 00	19. 00	20.00	21. 00	
202. 00	Cost to be allocated (per Wkst. B, Part I)	38, 650	0		0	0	202. 00
203.00	Unit cost multiplier (Wkst. B, Part I)	0. 000180	0. 000000	0.00000	0. 000000	0.000000	203. 00
204. 00	Cost to be allocated (per Wkst. B, Part II)	14, 134	0		0	0	204. 00
205. 00	Unit cost multiplier (Wkst. B, Part	0. 000066	0. 000000	0. 00000	0. 000000	0.000000	205. 00
206. 00	NAHE adjustment amount to be allocated (per Wkst. B-2)				0		206. 00
207. 00	NAHE unit cost multiplier (Wkst. D, Parts III and IV)				0. 000000		207. 00

HUNTINGTON MEMORIAL HOSPITAL In Lieu of Form CMS-2552-10

Health Financial Systems
COST ALLOCATION - STATISTICAL BASIS Provi der CCN: 15-0091

			6/26/2020 11:	
	INTERNS &			
Cost Center Description	RESI DENTS SERVI CES-OTHE	PARAMED ED		
cost center bescription	R PRGM COSTS	PRGM		
	APPRV	(ASSI GNED		
	(ASSI GNED	TIME)		
	TIME)			
GENERAL SERVICE COST CENTERS	22. 00	23. 00		
1. 00 O0100 CAP REL COSTS-BLDG & FLXT				1.00
2. 00 00200 CAP REL COSTS-MVBLE EQUIP				2.00
4.00 00400 EMPLOYEE BENEFITS DEPARTMENT				4.00
5. 00 00500 ADMINI STRATI VE & GENERAL				5. 00
6. 00 00600 MAI NTENANCE & REPAI RS				6.00
7.00 00700 OPERATION OF PLANT 8.00 00800 LAUNDRY & LINEN SERVICE				7.00
8. 00 00800 LAUNDRY & LI NEN SERVI CE 9. 00 00900 HOUSEKEEPI NG				8. 00 9. 00
10. 00 01000 DI ETARY				10.00
11. 00 01100 CAFETERI A				11.00
12.00 01200 MAINTENANCE OF PERSONNEL				12.00
13. 00 01300 NURSI NG ADMI NI STRATI ON				13.00
14. 00 01400 CENTRAL SERVICES & SUPPLY				14.00
15. 00 O1500 PHARMACY 16. 00 O1600 MEDI CAL RECORDS & LI BRARY				15. 00 16. 00
17. 00 01700 SOCI AL SERVI CE				17. 00
19. 00 01900 NONPHYSICIAN ANESTHETISTS				19.00
20. 00 02000 NURSI NG SCHOOL				20.00
21.00 02100 I&R SERVICES-SALARY & FRINGES APPRV				21.00
22. 00 02200 1 &R SERVICES-OTHER PRGM COSTS APPRV	0			22.00
23. 00 O2300 PARAMED ED PRGM-(SPECIFY) I NPATIENT ROUTINE SERVICE COST CENTERS		0		23. 00
30. 00 03000 ADULTS & PEDI ATRI CS	0	0		30.00
43. 00 04300 NURSERY	0	ō		43.00
ANCILLARY SERVICE COST CENTERS				
50. 00 05000 OPERATING ROOM	0	0		50.00
50.01 05001 OPERATING ROOM 52.00 05200 DELIVERY ROOM & LABOR ROOM	0	0		50. 01 52. 00
53. 00 05300 ANESTHESI OLOGY	0	o		53.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	0	o		54.00
60. 00 06000 LABORATORY	0	0		60.00
62. 30 06250 BLOOD CLOTTING FOR HEMOPHILIACS	0	0		62.30
65. 00 06500 RESPI RATORY THERAPY 66. 00 06600 PHYSI CAL THERAPY	0	0		65. 00 66. 00
67. 00 06700 OCCUPATI ONAL THERAPY	0	o		67.00
68.00 06800 SPEECH PATHOLOGY	0	o		68.00
69. 00 06900 ELECTROCARDI OLOGY	0	0		69. 00
71. 00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0	0		71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS 73.00 07300 DRUGS CHARGED TO PATIENTS	0	0		72. 00 73. 00
76. 97 07697 CARDIAC REHABILITATION	0	ol		76. 97
76. 98 07698 HYPERBARI C OXYGEN THERAPY	0	o		76. 98
76. 99 07699 LI THOTRI PSY	0	o		76. 99
OUTPATIENT SERVICE COST CENTERS				
90. 00 09000 CLI NI C 91. 00 09100 EMERGENCY	0	0		90. 00 91. 00
92.00 O9200 OBSERVATION BEDS (NON-DISTINCT PART		U _I		92.00
OTHER REIMBURSABLE COST CENTERS				72.00
95. 00 09500 AMBULANCE SERVICES	0	0		95. 00
SPECIAL PURPOSE COST CENTERS	1			
113.00 11300 INTEREST EXPENSE 118.00 SUBTOTALS (SUM OF LINES 1 through 117)	0	0		113. 00 118. 00
NONREI MBURSABLE COST CENTERS	l o	U]118.00
190. 00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0		190. 00
192.00 19200 PHYSICIANS' PRIVATE OFFICES	0	o		192.00
194.00 07950 OCC HEALTH	0	0		194.00
194. 01 07951 PAIN CLINIC	0	0		194. 01
194. 02 07952 OCC HEALTH 194. 03 07953 FOUNDATI O	0	0		194. 02 194. 03
194. 04 07954 KLDS CAMPUS	0	0		194. 03
194. 05 07955 COMMUNITY & VOLUNTEER SERVICES	l ő	o		194. 05
194.06 07956 HUNTINGTON COLLEGE NURSE	o	o		194. 06
194. 07 07957 MI SC CATERI NG	0	o		194. 07
194. 08 07958 AUTI SM CENTER	0	0		194.08
194.09 07959 HUNTINGTON BUA 200.00 Cross Foot Adjustments		O		194. 09 200. 00
201.00 Negative Cost Centers				200.00
1	'	'	ı	,

Health Fin	ancial Systems F	HUNTINGTON MEMO	RIAL HOSPITAL		In Lieu	of Form CMS-2	2552-10
COST ALLOC	CATION - STATISTICAL BASIS		Provi der C	CN: 15-0091	Peri od:	Worksheet B-1	
					From 01/01/2019 To 12/31/2019	Date/Time Pre 6/26/2020 11:	
	Cook Cooker Doors'at'or	I NTERNS & RESI DENTS	DADAMED ED				
	Cost Center Description	R PRGM COSTS APPRV (ASSI GNED	PARAMED ED PRGM (ASSI GNED TIME)				
		TIME)	22.00				
200 00		22. 00	23. 00				000 00
202. 00	Cost to be allocated (per Wkst. B, Part I)	0	0				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, Part II)	0	0				204. 00
205. 00	Unit cost multiplier (Wkst. B, Part	0. 000000	0. 000000				205. 00
206. 00	NAHE adjustment amount to be allocated (per Wkst. B-2)		0				206. 00
207. 00	NAHE unit cost multiplier (Wkst. D, Parts III and IV)		0. 000000				207. 00

	HUNTINGTON MEMO	RIAL HOSPITAL		In Lie	u of Form CMS-2	2552-10
COMPUTATION OF RATIO OF COSTS TO CHARGES		Provider Co		Period: From 01/01/2019 To 12/31/2019	Worksheet C Part I Date/Time Pre 6/26/2020 11:	pared: 24 am
		Title	XVIII	Hospi tal	PPS	
				Costs		
Cost Center Description	Total Cost (from Wkst. B, Part I, col. 26)	Therapy Limit Adj.	Total Costs	RCE Di sal I owance	Total Costs	
	1. 00	2. 00	3. 00	4. 00	5. 00	
INPATIENT ROUTINE SERVICE COST CENTERS						
30. 00 03000 ADULTS & PEDI ATRI CS	9, 093, 912		9, 093, 91		9, 093, 912	30.00
43. 00 04300 NURSERY	294, 767		294, 76	7 0	294, 767	43.00
ANCILLARY SERVICE COST CENTERS						
50. 00 05000 OPERATING ROOM	2, 578, 214		2, 578, 21	4 23, 396	2, 601, 610	
50. 01 05001 OPERATING ROOM	0			0	0	50. 01
52.00 05200 DELIVERY ROOM & LABOR ROOM	1, 090, 878		1, 090, 87		1, 090, 878	1
53. 00 05300 ANESTHESI OLOGY	1, 497, 678		1, 497, 67		1, 497, 678	
54. 00 05400 RADI OLOGY-DI AGNOSTI C	4, 081, 157		4, 081, 15		4, 081, 157	1
60. 00 06000 LABORATORY	4, 179, 387		4, 179, 38		4, 179, 387	60.00
62.30 06250 BLOOD CLOTTING FOR HEMOPHILIACS	0			0	0	62. 30
65. 00 06500 RESPI RATORY THERAPY	1, 864, 305	0	1, 864, 30		1, 864, 305	65.00
66. 00 06600 PHYSI CAL THERAPY	3, 423, 996	0	3, 423, 99		3, 423, 996	1
67.00 06700 OCCUPATIONAL THERAPY	474, 164	0	474, 16		474, 164	67. 00
68. 00 06800 SPEECH PATHOLOGY	313, 070	0	313, 07		313, 070	
69. 00 06900 ELECTROCARDI OLOGY	168		16		168	
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	2, 206, 298		2, 206, 29		2, 206, 298	
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	1, 227, 199		1, 227, 19		1, 227, 199	
73.00 07300 DRUGS CHARGED TO PATIENTS	3, 884, 911		3, 884, 91		3, 884, 911	
76. 97 07697 CARDI AC REHABI LI TATI ON	0			0	0	76. 97
76.98 07698 HYPERBARIC OXYGEN THERAPY	935, 866		935, 86		935, 866	
76. 99 07699 LI THOTRI PSY	0		(0	0	76. 99
OUTPATIENT SERVICE COST CENTERS						
90. 00 09000 CLINIC	188, 604		188, 60		188, 604	
91. 00 09100 EMERGENCY	3, 243, 345		3, 243, 34	5 0	3, 243, 345	91.00

2, 625, 851

6, 428, 834

49, 632, 604 2, 625, 851

47, 006, 753

2, 625, 851

6, 428, 834

49, 632, 604

2, 625, 851

47, 006, 753

0

2, 625, 851 92.00

6, 428, 834 95.00

49, 656, 000 200. 00 2, 625, 851 201. 00 47, 030, 149 202. 00

113.00

0

23, 396

23, 396

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

Less Observation Beds

Total (see instructions)

Subtotal (see instructions)

95. 00 09500 AMBULANCE SERVICES

200.00

201.00

202.00

SPECIAL PURPOSE COST CENTERS

113. 00 11300 | INTEREST EXPENSE

	HUNTI NGTON MEMOI				u of Form CMS-2	2552-10
COMPUTATION OF RATIO OF COSTS TO CHARGES		Provi der C		Peri od: From 01/01/2019	Worksheet C Part I	
				To 12/31/2019	Date/Time Pre	nared:
					6/26/2020 11:	24 am
			XVIII	Hospi tal	PPS	
		Charges				
Cost Center Description	I npati ent	Outpati ent		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			T	.1		
30. 00 03000 ADULTS & PEDI ATRI CS	9, 864, 402		9, 864, 40			30.00
43. 00 04300 NURSERY	1, 074, 564		1, 074, 56	4		43.00
ANCILLARY SERVICE COST CENTERS			1			
50. 00 05000 OPERATING ROOM	7, 994, 991	19, 642, 016			0. 000000	
50. 01 05001 OPERATI NG ROOM	0	0		0. 000000	0. 000000	
52. 00 05200 DELIVERY ROOM & LABOR ROOM	4, 098, 130	0	4, 098, 13		0. 000000	
53. 00 05300 ANESTHESI OLOGY	640, 276	2, 959, 015			0. 000000	
54. 00 05400 RADI OLOGY-DI AGNOSTI C	3, 878, 153	32, 621, 326			0.000000	
60. 00 06000 LABORATORY	5, 292, 020	21, 146, 746			0. 000000	
62. 30 06250 BLOOD CLOTTING FOR HEMOPHILIACS	0	0		0. 000000	0. 000000	
65. 00 06500 RESPIRATORY THERAPY	1, 697, 261	6, 794, 542			0. 000000	
66. 00 06600 PHYSI CAL THERAPY	562, 729	4, 980, 086			0.000000	
67. 00 06700 OCCUPATI ONAL THERAPY	222, 181	1, 714, 973			0.000000	
68. 00 06800 SPEECH PATHOLOGY	37, 590	717, 901	•		0.000000	
69. 00 06900 ELECTROCARDI OLOGY	581, 015	350, 332			0.000000	
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	1, 461, 396	4, 269, 302			0.000000	
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	1, 690, 686	2, 586, 517			0.000000	
73. 00 07300 DRUGS CHARGED TO PATIENTS	5, 397, 116	15, 283, 531			0.000000	
76. 97 07697 CARDI AC REHABI LI TATI ON	0	0	l .	0. 000000	0.000000	
76. 98 07698 HYPERBARI C OXYGEN THERAPY	87, 597	2, 525, 438	2, 613, 03		0.000000	
76. 99 07699 LI THOTRI PSY	0	0		0. 000000	0.000000	76. 99
OUTPATIENT SERVICE COST CENTERS						
90. 00 09000 CLI NI C	1, 504	851, 838			0.000000	
91. 00 09100 EMERGENCY	4, 098, 089	26, 394, 372			0.000000	
92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART	0	5, 918, 135	5, 918, 13	0. 443696	0.000000	92.00
OTHER REIMBURSABLE COST CENTERS						1
95. 00 09500 AMBULANCE SERVICES	0	17, 180, 659	17, 180, 65	0. 374190	0.000000	95.00
SPECIAL PURPOSE COST CENTERS						1
113. 00 11300 I NTEREST EXPENSE			[1113 00

48, 679, 700

48, 679, 700

165, 936, 729

165, 936, 729

214, 616, 429

214, 616, 429

113. 00 200. 00 201. 00 202. 00

113. 00 11300 INTEREST EXPENSE
200. 00 Subtotal (see instructions)

Less Observation Beds

Total (see instructions)

200.00

Health Financial Systems	HUNTINGTON MEMOR	II AL HOSPI TAL	In Lieu	u of Form CMS-2	2552-10
COMPUTATION OF RATIO OF COSTS TO CHARGES		Provi der CCN: 15-0091	From 01/01/2019	Worksheet C Part I Date/Time Pre 6/26/2020 11::	
		Title XVIII	Hospi tal	PPS	
Cost Center Description	PPS Inpatient				

		Title XVIII	Hospi tal	PPS
Cost Center Description	PPS Inpatient			
	Ratio			
	11. 00			
INPATIENT ROUTINE SERVICE COST CENTERS				
30.00 03000 ADULTS & PEDIATRICS				30.00
43. 00 04300 NURSERY				43.00
ANCILLARY SERVICE COST CENTERS				
50.00 05000 OPERATING ROOM	0. 094135			50.00
50. 01 05001 OPERATI NG ROOM	0. 000000			50.01
52.00 05200 DELIVERY ROOM & LABOR ROOM	0. 266189			52.00
53. 00 05300 ANESTHESI OLOGY	0. 416104			53.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	0. 111814			54.00
60. 00 06000 LABORATORY	0. 158078			60.00
62.30 06250 BLOOD CLOTTING FOR HEMOPHILIACS	0. 000000			62. 30
65. 00 06500 RESPIRATORY THERAPY	0. 219542			65.00
66. 00 06600 PHYSI CAL THERAPY	0. 617736			66.00
67. 00 06700 OCCUPATI ONAL THERAPY	0. 244774			67.00
68. 00 06800 SPEECH PATHOLOGY	0. 414393			68.00
69. 00 06900 ELECTROCARDI OLOGY	0. 000180			69.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0. 384996			71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0. 286916			72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	0. 187852			73.00
76. 97 07697 CARDI AC REHABI LI TATI ON	0. 000000			76. 97
76. 98 07698 HYPERBARI C OXYGEN THERAPY	0. 358153			76. 98
76. 99 07699 LI THOTRI PSY	0. 000000			76. 99
OUTPATIENT SERVICE COST CENTERS				
90. 00 09000 CLINIC	0. 221018			90.00
91. 00 09100 EMERGENCY	0. 106365			91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART	0. 443696			92.00
OTHER REIMBURSABLE COST CENTERS				
95. 00 09500 AMBULANCE SERVICES	0. 374190			95.00
SPECIAL PURPOSE COST CENTERS				
113. 00 11300 I NTEREST EXPENSE				113.00
200.00 Subtotal (see instructions)				200.00
201.00 Less Observation Beds				201.00
202.00 Total (see instructions)				202.00

Health Financial Systems	1	HUNTI NGTON MEMO	RIAL HOSPITAL		In Lie	u of Form CMS-2	2552-10
COMPUTATION OF RATIO OF COST	S TO CHARGES		Provi der C	F	eriod: rom 01/01/2019 o 12/31/2019		pared: 24 am
			Ti tl	e XIX	Hospi tal	PPS	
					Costs		
Cost Center Desc	ri pti on	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 SERV							
30. 00 03000 ADULTS & PEDI ATF	RLCS	9, 093, 912		9, 093, 912	0	9, 093, 912	30.00
43. 00 04300 NURSERY		294, 767		294, 767	0	294, 767	43.00
ANCILLARY SERVICE COST	T CENTERS						
50.00 05000 OPERATING ROOM		2, 578, 214		2, 578, 214	23, 396	2, 601, 610	50.00
50. 01 05001 OPERATING ROOM		0		0	0	0	50. 01
52.00 05200 DELIVERY ROOM &	LABOR ROOM	1, 090, 878		1, 090, 878	0	1, 090, 878	52.00
53. 00 05300 ANESTHESI OLOGY		1, 497, 678		1, 497, 678	0	1, 497, 678	53.00
54. 00 05400 RADI OLOGY-DI AGNO	OSTI C	4, 081, 157		4, 081, 157	0	4, 081, 157	54.00
60. 00 06000 LABORATORY		4, 179, 387		4, 179, 387	0	4, 179, 387	60.00
62. 30 06250 BLOOD CLOTTING F	OR HEMOPHILIACS	0		0	0	0	62. 30
65. 00 06500 RESPIRATORY THEF	RAPY	1, 864, 305	0	1, 864, 305	0	1, 864, 305	65.00
66. 00 06600 PHYSI CAL THERAPY	,	3, 423, 996	0	3, 423, 996	0	3, 423, 996	66.00
67. 00 06700 OCCUPATI ONAL THE	RAPY	474, 164	0	474, 164	0	474, 164	67.00
68.00 06800 SPEECH PATHOLOGY	,	313, 070	0	313, 070	0	313, 070	68.00
69. 00 06900 ELECTROCARDI OLOG	SY	168		168	0	168	69.00
71.00 07100 MEDICAL SUPPLIES	CHARGED TO PATIENT	2, 206, 298		2, 206, 298	0	2, 206, 298	71.00
72.00 07200 IMPL. DEV. CHARG	SED TO PATIENTS	1, 227, 199		1, 227, 199		1, 227, 199	72.00
73.00 07300 DRUGS CHARGED TO	PATIENTS	3, 884, 911		3, 884, 911		3, 884, 911	73.00
76. 97 07697 CARDI AC REHABI LI	TATI ON	O		0	0	0	76. 97
76. 98 07698 HYPERBARI C OXYGE	N THERAPY	935, 866		935, 866	0	935, 866	76. 98
		1 _1			_	_	l -

188, 604

3, 243, 345

2, 625, 851

6, 428, 834

49, 632, 604

2, 625, 851

47, 006, 753

188, 604

3, 243, 345

2, 625, 851

6, 428, 834

49, 632, 604

2, 625, 851

47, 006, 753

0

76. 99

90.00

91.00

92.00

95.00

113.00

188, 604

3, 243, 345

2, 625, 851

6, 428, 834

49, 656, 000 200. 00

47, 030, 149 202. 00

2, 625, 851 201. 00

0

0

23, 396

23, 396

0

07699 LI THOTRI PSY

95. 00 09500 AMBULANCE SERVICES

113. 00 11300 INTEREST EXPENSE

90. 00 09000 CLINIC

91. 00 09100 EMERGENCY

76. 99

92.00

200.00

201.00

202.00

OUTPATIENT SERVICE COST CENTERS

OTHER REIMBURSABLE COST CENTERS

Less Observation Beds

Total (see instructions)

SPECIAL PURPOSE COST CENTERS

09200 OBSERVATION BEDS (NON-DISTINCT PART

Subtotal (see instructions)

Health Financial Systems	HUNTINGTON MEMOI	RLAL HOSPLTAL		In Lie	u of Form CMS-2	2552-10
COMPUTATION OF RATIO OF COSTS TO CHARGES		Provi der Co	F	Period: From 01/01/2019 Fo 12/31/2019	Worksheet C Part I Date/Time Pre 6/26/2020 11:	pared:
			e XIX	Hospi tal	PPS	
		Charges				
Cost Center Description	I npati ent	Outpati ent		Cost or Other	TEFRA	
			+ col. 7)	Ratio	Inpatient	
		7.00		0.00	Ratio	
ANDATI FUT DOUTLING OFFICE OF COST OFFITEDO	6. 00	7. 00	8. 00	9. 00	10. 00	
INPATIENT ROUTINE SERVICE COST CENTERS	0.044.400		0.074.407			00.00
30. 00 03000 ADULTS & PEDIATRICS	9, 864, 402		9, 864, 402	I		30.00
43. 00 04300 NURSERY	1, 074, 564		1, 074, 564	1		43. 00
ANCILLARY SERVICE COST CENTERS 50.00 OPERATING ROOM	7, 994, 991	19, 642, 016	27, 637, 007	0. 093288	0. 000000	50.00
50. 00 05000 OPERATING ROOM 50. 01 05001 OPERATING ROOM		19, 642, 016	27, 637, 00	0.093288	0. 000000	50.00
	4 000 130	0	4 000 120			50.01
52. 00 05200 DELIVERY ROOM & LABOR ROOM 53. 00 05300 ANESTHESIOLOGY	4, 098, 130 640, 276	2, 959, 015	4, 098, 130 3, 599, 29°		0. 000000 0. 000000	52.00
54. 00 05400 RADI OLOGY	3, 878, 153				0. 000000	54.00
60. 00 06000 LABORATORY		32, 621, 326			0. 000000	
62. 30 06250 BLOOD CLOTTING FOR HEMOPHILIACS	5, 292, 020	21, 146, 746	26, 438, 766	0. 000000	0. 000000	62.30
65. 00 06500 RESPIRATORY THERAPY	١	4 704 F42	0 401 001		0. 000000	65.00
	1, 697, 261	6, 794, 542				66.00
	562, 729	4, 980, 086			0. 000000 0. 000000	67.00
	222, 181	1, 714, 973				68.00
	37, 590	717, 901	755, 491		0.000000	69.00
69. 00 06900 ELECTROCARDI OLOGY 71. 00 07100 MEDI CAL SUPPLI ES CHARGED TO PATI ENT	581, 015	350, 332			0.000000	
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT 72.00 07200 MPL. DEV. CHARGED TO PATIENTS	1, 461, 396	4, 269, 302		I I	0. 000000 0. 000000	71. 00 72. 00
	1, 690, 686	2, 586, 517				
73. 00 07300 DRUGS CHARGED TO PATIENTS	5, 397, 116	15, 283, 531	20, 680, 647		0.000000	73.00
76. 97 07697 CARDI AC REHABI LI TATI ON	0	0 505 400	0 (40 00	0.000000	0.000000	76. 97
76. 98 07698 HYPERBARI C OXYGEN THERAPY	87, 597	2, 525, 438	2, 613, 035		0.000000	76. 98
76. 99 07699 LI THOTRI PSY	0	0		0. 000000	0. 000000	76. 99
OUTPATIENT SERVICE COST CENTERS	1 504	051 020	052.24	0 221010	0.000000	00.00
90. 00 09000 CLI NI C	1, 504	851, 838		I	0.000000	
91. 00 09100 EMERGENCY	4, 098, 089	26, 394, 372			0.000000	

48, 679, 700

48, 679, 700

0

5, 918, 135

17, 180, 659

165, 936, 729

165, 936, 729

5, 918, 135

17, 180, 659

214, 616, 429

214, 616, 429

0.000000

0.000000

0. 443696

0. 374190

92.00

95.00

113. 00 200. 00 201. 00 202. 00

92. 00 09200 0BSERVATION BEDS (NON-DISTINCT PART OTHER REIMBURSABLE COST CENTERS

95. 00 09500 AMBULANCE SERVICES
SPECIAL PURPOSE COST CENTERS

Less Observation Beds

Total (see instructions)

113. 00 11300 INTEREST EXPENSE
200. 00 Subtotal (see instructions)

201.00

Health Financial Systems	HUNTINGTON MEMOR	IAL HOSPITAL	In Lie	u of Form CMS-2	2552-10
COMPUTATION OF RATIO OF COSTS TO CHARGES		Provider CCN: 15-0091	Peri od: From 01/01/2019 To 12/31/2019	Worksheet C Part I Date/Time Pre 6/26/2020 11:	
		Title XIX	Hospi tal	PPS	
Cost Center Description	PPS Inpatient Ratio 11.00				
I NPATIENT ROUTINE SERVICE COST CENTER 30.00 03000 ADULTS & PEDIATRICS	RS				30.00

NPATI ENT ROUTI NE SERVI CE COST CENTERS	30. 00 43. 00 50. 00 50. 01 52. 00 53. 00
INPATI ENT ROUTI NE SERVI CE COST CENTERS	43. 00 50. 00 50. 01 52. 00
30. 00	43. 00 50. 00 50. 01 52. 00
43. 00	43. 00 50. 00 50. 01 52. 00
ANCI LLARY SERVI CE COST CENTERS 50. 00 05000 OPERATI NG ROOM 0. 094135 50. 01 05001 OPERATI NG ROOM 0. 000000 52. 00 05200 DELI VERY ROOM & LABOR ROOM 0. 266189 53. 00 05300 ANESTHESI OLOGY 0. 416104 54. 00 05400 RADI OLOGY-DI AGNOSTI C 0. 111814 60. 00 06000 LABORATORY 0. 158078 62. 30 06250 BLOOD CLOTTI NG FOR HEMOPHI LI ACS 0. 000000 65. 00 06500 RESPI RATORY THERAPY 0. 219542 66. 00 06600 PHYSI CAL THERAPY 0. 617736 67. 00 06700 OCCUPATI ONAL THERAPY 0. 244774 68. 00 06800 SPEECH PATHOLOGY 0. 414393 69. 00 06900 ELECTROCARDI OLOGY 0. 000180	50. 00 50. 01 52. 00
50. 00 05000 OPERATI NG ROOM 0. 094135 50. 01 05001 OPERATI NG ROOM 0. 000000 52. 00 05200 DELI VERY ROOM & LABOR ROOM 0. 266189 53. 00 05300 ANESTHESI OLOGY 0. 416104 54. 00 05400 RADI OLOGY-DI AGNOSTI C 0. 111814 60. 00 06000 LABORATORY 0. 158078 62. 30 06250 BLOOD CLOTTI NG FOR HEMOPHI LI ACS 0. 000000 65. 00 06500 RESPI RATORY THERAPY 0. 219542 66. 00 06600 PHYSI CAL THERAPY 0. 617736 67. 00 06700 OCCUPATI ONAL THERAPY 0. 244774 68. 00 06800 SPEECH PATHOLOGY 0. 414393 69. 00 06900 ELECTROCARDI OLOGY 0. 000180	50. 01 52. 00
50. 01 05001 OPERATI NG ROOM 0. 000000 52. 00 05200 DELI VERY ROOM & LABOR ROOM 0. 266189 53. 00 05300 ANESTHESI OLOGY 0. 416104 54. 00 05400 RADI OLOGY-DI AGNOSTI C 0. 111814 60. 00 06000 LABORATORY 0. 158078 62. 30 06250 BLOOD CLOTTI NG FOR HEMOPHI LI ACS 0. 000000 65. 00 06500 RESPI RATORY THERAPY 0. 219542 66. 00 06600 PHYSI CAL THERAPY 0. 617736 67. 00 06700 OCCUPATI ONAL THERAPY 0. 244774 68. 00 06800 SPEECH PATHOLOGY 0. 414393 69. 00 06900 ELECTROCARDI OLOGY 0. 000180	50. 01 52. 00
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62. 30 06250 BLOOD CLOTTI NG FOR HEMOPHI LI ACS	54.00
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69. 00 06900 ELECTROCARDI OLOGY 0. 000180	67.00
	68. 00
71 OO O7100 MEDICAL SUBDILES CHARCED TO DATIENT 0 204006	69. 00
71.00 OTTOO WEDICAL SUFFEILS CHARGED TO FATTENT 0.304770	71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS 0.286916	72.00
73.00 07300 DRUGS CHARGED TO PATIENTS 0.187852	73.00
76. 97 07697 CARDI AC REHABI LI TATI ON 0. 000000	76. 97
76. 98 07698 HYPERBARI C OXYGEN THERAPY 0. 358153	76. 98
76. 99 07699 LI THOTRI PSY 0. 000000	76. 99
OUTPATIENT SERVICE COST CENTERS	
90. 00 09000 CLI NI C 0. 221018	90.00
91. 00 09100 EMERGENCY 0. 106365	91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART 0.443696	92. 00
OTHER REIMBURSABLE COST CENTERS	
95. 00 09500 AMBULANCE SERVI CES 0. 374190	95. 00
SPECIAL PURPOSE COST CENTERS	
113. 00 11300 I NTEREST EXPENSE	113. 00
200.00 Subtotal (see instructions)	200.00
201.00 Less Observation Beds	201.00
202.00 Total (see instructions)	1

Health Financial Systems	HUNTINGTON MEMORIA	AL HOSPITAL	In Lieu	u of Form CMS-2552-10
CALCULATION OF OUTPATIENT SERVICE COST REDUCTIONS FOR MEDICALD ONLY	TO CHARGE RATIOS NET OF	Provider CCN: 15-0091	From 01/01/2019	Worksheet C Part II Date/Time Prepared:

REDUCTIONS FOR MED	TICALD ONE				To 12/31/2019	Date/Time Pre 6/26/2020 11:	
-			Ti tl	e XIX	Hospi tal	PPS	24 alli
Cost C	Center Description	Total Cost	Capital Cost		Capi tal	Operating	
	,	(Wkst. B,	(Wkst. B,	Cost Net of	Reducti on	Cost	
		Part I, col.	Part II col.	Capital Cost		Reducti on	
		26)	26)	(col. 1 -		Amount	
			·	col . 2)			
		1. 00	2. 00	3.00	4. 00	5. 00	
	ERVICE COST CENTERS						
50. 00 05000 OPERAT		2, 578, 214	489, 165	2, 089, 04	9 0	0	00.00
50. 01 05001 OPERAT		0	0		0	0	50. 01
	RY ROOM & LABOR ROOM	1, 090, 878	47, 479		9 0	0	52.00
53. 00 05300 ANESTH		1, 497, 678	62, 755		3 0	0	53.00
	LOGY-DI AGNOSTI C	4, 081, 157	662, 239			0	54.00
60. 00 06000 LABORA		4, 179, 387	211, 857	3, 967, 53	0	0	60.00
	CLOTTING FOR HEMOPHILIACS	0	0		0	0	62. 30
	RATORY THERAPY	1, 864, 305	178, 295			0	65.00
66. 00 06600 PHYSI C		3, 423, 996				0	66. 00
	ATI ONAL THERAPY	474, 164	20, 357			0	67.00
68. 00 06800 SPEECH		313, 070				0	68. 00
69. 00 06900 ELECTR		168	61			0	69.00
	AL SUPPLIES CHARGED TO PATIENT	2, 206, 298	179, 548	2, 026, 75	0	0	71.00
	DEV. CHARGED TO PATIENTS	1, 227, 199	51, 498	1, 175, 70	1 0	0	72.00
	CHARGED TO PATIENTS	3, 884, 911	166, 154	3, 718, 75	7 0	0	73.00
76. 97 07697 CARDI A		0	0		0	0	76. 97
	BARIC OXYGEN THERAPY	935, 866	79, 162	856, 70	4 0	0	76. 98
76. 99 07699 LI THOT		0	0		0	0	76. 99
	SERVICE COST CENTERS						
90.00 09000 CLINIC		188, 604				0	
91. 00 09100 EMERGE		3, 243, 345				0	91.00
	ATION BEDS (NON-DISTINCT PART	2, 625, 851	328, 216	2, 297, 63	5 0	0	92.00
	JRSABLE COST CENTERS						
95. 00 09500 AMBULA		6, 428, 834	651, 044	5, 777, 79	0	0	95.00
	POSE COST CENTERS	, , ,		,			
113. 00 11300 I NTERE							113.00
	al (sum of lines 50 thru 199)	40, 243, 925					200.00
	Observation Beds	2, 625, 851	328, 216				201. 00
202. 00 Total	(line 200 minus line 201)	37, 618, 074	3, 789, 618	33, 828, 45	6 0	0	202. 00

Health Financial Systems HUNTINGTON MEMORIAL HOSPITAL In Lieu of Form CMS-2552-10
CALCULATION OF OUTPATIENT SERVICE COST TO CHARGE RATIOS NET OF REDUCTIONS FOR MEDICALD ONLY Provider CCN: 15-0091 From 01/01/2019 Part II To 12/31/2019 Date/Time Prepared:

Cost Center Description	REDUCTIONS	TON MEDI ON D'ONE!				То	12/31/2019	Date/Time Pr 6/26/2020 11	
Capit tal and Operating Cost Part I, column 8) Cost to Charge Ratio (col. 6 / col. 6 / col. 7)				Ti tl	e XIX		Hospi tal		
Operating Cost Reduction Column 8 Column 8 Column 8 Column 8 Column 8 Column 8 Column 8 Column 8 Column 8 Column 8 Column 8 Column 8 Column 8 Column 8 Column 8 Column 8 Column 8 Column 8 Column 8 Column 8 Column 8 Column 8 Column 8 Column 8 Column 8 Column 8 Column 8 Column 8 Column 8 Column 8 Column 8 Column 8 Column 8 Column 8 Column 8 Column 8 Column 8 Column 8 Column 8 Column 8 Column 8 Column 8 Column 8 Column 8 Column 8 Column 8 Column 8 Column 8 Column 8 Column 8 Column 8 Column 8 Column 8 Column 8 Column 8 Column 8 Column 8 Column 8 Column 8 Column 8 Column 8 Column 8 Column 8 Column 8 Column 8 Column 8 Column 8 Column 8 Column 8 Column 8 Column 8 Column 8 Column 8 Column 8 Column 8 Column 8 Column 8 Column 8 Column 8 Column 8 Column 8 Column 8 Column 8 Column 8 Column 8 Column 8 Column 8 Column 8 Column 8 Column 8 Column 8 Column 8 Column 8 Column 8 Column 8 Column 8 Column 8 Column 8 Column 8 Column 8 Column 8 Column 8 Column 8 Column 8 Column 8 Column 8 Column 8 Column 8 Column 8 Column 8 Column 8 Column 8 Column 8 Column 8 Column 8 Column 8 Column 8 Column 8 Column 8 Column 8 Column 8 Column 8 Column 8 Column 8 Column 8 Column 8 Column 8 Column 8 Column 8 Column 8 Column 8 Column 8 Column 8 Column 8 Column 8 Column 8 Column 8 Column 8 Column 8 Column 8 Column 8 Column 8 Column 8 Column 8 Column 8 Column 8 Column 8 Column 8 Column 8 Column 8 Column 8 Column 8 Column 8 Column 8 Column 8 Column 8 Column 8 Column 8 Column 8 Column 8 Column 8 Column 8 Column 8 Column 8 Column 8 Column 8 Column 8 Column 8 Column 8 Column 8 Column 8 Column 8 Column 8 Column 8 Column 8 Column 8 Column 8 Column 8 Column 8 Column 8 Column 8 Column 8 Column 8		Cost Center Description	Cost Net of	Total Charges	Outpati ent				
Cost Reduction Coil . 7 Coil . 7			Capital and	(Worksheet C,	Cost to				
Reduction Col. 7 Col. 7 Col. 7			Operati ng	Part I,	Charge Ratio	o			
ANCILLARY SERVICE COST CENTERS 50.00 7.00 8.00			Cost	column 8)	(col. 6 /				
ANCI LLARY SERVI CE COST CENTERS Services		Reducti on		col. 7)					
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73. 00	71.00 07100	MEDICAL SUPPLIES CHARGED TO PATIENT	2, 206, 298	5, 730, 698	0. 38499	96			71.00
73. 00	72. 00 07200	O IMPL. DEV. CHARGED TO PATIENTS	1, 227, 199	4, 277, 203	0. 2869	16			72.00
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95. 00 OFFICE ALTO PURPOSE COST CENTERS 113. 00 11300 INTEREST EXPENSE 200. 00 Subtotal (sum of lines 50 thru 199) 40, 243, 925 203, 677, 463 200. 00 201. 00 Less Observation Beds 2, 625, 851 0 201. 00	91.00 09100	O EMERGENCY	3, 243, 345	30, 492, 461	0. 10636	55			91.00
OTHER REIMBURSABLE COST CENTERS 095.00 AMBULANCE SERVICES 6, 428, 834 17, 180, 659 0.374190 95.00 SPECIAL PURPOSE COST CENTERS 113.00 11300 INTEREST EXPENSE 200.00 Subtotal (sum of lines 50 thru 199) 40, 243, 925 203, 677, 463 200.00 201.00 Less Observation Beds 2, 625, 851 0 201.00	92.00 09200	O OBSERVATION BEDS (NON-DISTINCT PART	2, 625, 851	5, 918, 135	0. 44369	96			92.00
SPECIAL PURPOSE COST CENTERS 113.00 11300 INTEREST EXPENSE 200.00 Subtotal (sum of lines 50 thru 199) 40,243,925 203,677,463 200.00 201.00 Less Observation Beds 2,625,851 0 201.00	OTHER	R REIMBURSABLE COST CENTERS							
SPECIAL PURPOSE COST CENTERS 113.00 11300 INTEREST EXPENSE 200.00 Subtotal (sum of lines 50 thru 199) 40,243,925 203,677,463 200.00 201.00 Less Observation Beds 2,625,851 0 201.00	95. 00 09500	O AMBULANCE SERVICES	6, 428, 834	17, 180, 659	0. 37419	90			95. 00
200.00 Subtotal (sum of lines 50 thru 199) 40,243,925 203,677,463 200.00 201.00 Less Observation Beds 2,625,851 0 201.00									
201.00 Less Observation Beds 2,625,851 0 201.00	113. 00 11300	O I NTEREST EXPENSE							113.00
	200. 00	Subtotal (sum of lines 50 thru 199)	40, 243, 925	203, 677, 463					200.00
202.00 Total (line 200 minus line 201) 37,618,074 203,677,463 202.00	201. 00	Less Observation Beds	2, 625, 851	0					201.00
	202. 00	Total (line 200 minus line 201)	37, 618, 074	203, 677, 463					202.00

Health Financial Systems	HUNTINGTON MEMO	RI AL HOSPI TAL		In Lie	u of Form CMS-2	2552-10
APPORTIONMENT OF INPATIENT ROUTINE SERVICE CAPITAL	COSTS	Provi der C		Peri od:	Worksheet D	
				From 01/01/2019		
				To 12/31/2019	Date/Time Pre 6/26/2020 11:	parea:
		Title	: XVIII	Hospi tal	PPS	24 diii
Cost Center Description	Capi tal	Swing Bed	Reduced	Total Patient		
oost conten beschiptron	Related Cost	Adjustment	Capi tal	Days	(col. 3 /	
	(from Wkst.	riaj astilione	Related Cost		col . 4)	
	B, Part II,		(col . 1 -		1	
	col . 26)		col . 2)			
	1. 00	2. 00	3.00	4. 00	5. 00	
INPATIENT ROUTINE SERVICE COST CENTERS			•			
30.00 ADULTS & PEDIATRICS	1, 136, 682	0	1, 136, 68	2 6, 123	185. 64	30.00
43. 00 NURSERY	14, 798		14, 79	8 619	23. 91	43.00
200.00 Total (lines 30 through 199)	1, 151, 480		1, 151, 48	0 6, 742		200.00
Cost Center Description	I npati ent	I npati ent				
	Program days	Program				
		Capital Cost				
		(col. 5 x				
		col. 6)				
	6. 00	7. 00				
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00 ADULTS & PEDIATRICS	1, 227	227, 780			l	30.00
43. 00 NURSERY	0	0	1		ļ	43.00
200.00 Total (lines 30 through 199)	1, 227	227, 780				200. 00

Health Financial Systems	HUNTINGTON MEMORIAL H	HOSPI TAL	In Lieu	of Form CMS-2552-10
APPORTIONMENT OF INPATIENT ANCILLARY	SERVICE CAPITAL COSTS Pr	rovider CCN: 15-0091	Peri od:	Worksheet D

Health Financial Systems	HUNTI NGTON MEMO	RIAL HOSPITAL		In Lie	u of Form CMS-2	2552-10
APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPIT	TAL COSTS	Provider Co		Period: From 01/01/2019 To 12/31/2019	Date/Time Pre 6/26/2020 11:	pared: 24 am
			XVIII	Hospi tal	PPS	
Cost Center Description	Capi tal	Total Charges			Capital Costs	
	Related Cost	(from Wkst.	to Charges	Program	(column 3 x	
	(from Wkst.	C, Part I,	(col. 1 ÷	Charges	column 4)	
	B, Part II,	col. 8)	col. 2)			
	col. 26)					
	1. 00	2.00	3. 00	4. 00	5. 00	
ANCILLARY SERVICE COST CENTERS			,			
50.00 05000 OPERATING ROOM	489, 165	27, 637, 007			26, 015	
50. 01 05001 OPERATING ROOM	0	0	0. 00000		0	50. 01
52.00 05200 DELIVERY ROOM & LABOR ROOM	47, 479	4, 098, 130	•		0	52.00
53. 00 05300 ANESTHESI OLOGY	62, 755	3, 599, 291	•		0	53.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	662, 239	36, 499, 479		· · ·		
60. 00 06000 LABORATORY	211, 857	26, 438, 766			11, 973	
62.30 06250 BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0. 00000		0	62. 30
65. 00 06500 RESPI RATORY THERAPY	178, 295	8, 491, 803				
66. 00 06600 PHYSI CAL THERAPY	691, 634	5, 542, 815				
67. 00 06700 OCCUPATI ONAL THERAPY	20, 357	1, 937, 154				
68. 00 06800 SPEECH PATHOLOGY	13, 245	755, 491		·		
69. 00 06900 ELECTROCARDI OLOGY	61	931, 347		·	15	
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	179, 548	5, 730, 698	0. 03133	1 526, 080	16, 483	
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	51, 498	4, 277, 203	0. 01204	0 691, 574	8, 327	72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	166, 154	20, 680, 647	0.00803	4 1, 453, 769	11, 680	73.00
76. 97 07697 CARDI AC REHABI LI TATI ON	0	0	0.00000		0	76. 97
76. 98 07698 HYPERBARI C OXYGEN THERAPY	79, 162	2, 613, 035			0	76. 98
76. 99 07699 LI THOTRI PSY	0	0	0.00000	0 0	0	76. 99
OUTPATIENT SERVICE COST CENTERS						
90. 00 09000 CLI NI C	7, 935	853, 342	0.00929	9 0	0	
91. 00 09100 EMERGENCY	277, 190	30, 492, 461	0.00909	0 1, 256, 742	11, 424	91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART	328, 216	5, 918, 135	0. 05545	9 0	0	92.00
OTHER REIMBURSABLE COST CENTERS						
95. 00 09500 AMBULANCE SERVICES						95.00
200.00 Total (lines 50 through 199)	3, 466, 790	186, 496, 804		9, 287, 067	146, 693	200.00

Health Financial Systems	HUNTINGTON MEMO	RIAL HOSPITAL		In Lie	u of Form CMS-	2552-10
APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER	PASS THROUGH COS	STS Provider C	1	Period: From 01/01/2019 Fo 12/31/2019	Date/Time Pre 6/26/2020 11:	epared: 24 am
		Title	XVIII	Hospi tal	PPS	
Cost Center Description	Nursi ng School Post-Stepdown Adj ustments		Post-Stepdown Adjustments		All Other Medical Education Cost	
	1A	1.00	2A	2. 00	3. 00	
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00 03000 ADULTS & PEDIATRICS 43.00 04300 NURSERY 200.00 Total (lines 30 through 199)	0 0 0	0		0 0	0	
Cost Center Description	Swing-Bed Adjustment Amount (see instructions)	Total Costs (sum of cols. 1 through 3, minus col. 4)	Total Patient Days	Per Diem (col. 5 ÷ col. 6)	Inpatient Program Days	
	4. 00	5. 00	6.00	7. 00	8. 00	
INPATIENT ROUTINE SERVICE COST CENTERS	<u> </u>					
30.00 03000 ADULTS & PEDIATRICS 43.00 04300 NURSERY 200.00 Total (lines 30 through 199)	0	0	619	0.00	o	
Cost Center Description	Inpatient Program Pass-Through Cost (col. 7 x col. 8) 9.00					
INPATIENT ROUTINE SERVICE COST CENTERS	·	,				
30.00 03000 ADULTS & PEDIATRICS 43.00 04300 NURSERY 200.00 Total (lines 30 through 199)	0 0 0					30. 00 43. 00 200. 00

Health Financial Systems	HUNTINGTON MEMORIAL HOSPITAL	In Lieu of Form CMS-2552-10
APPORTIONMENT OF INPATIENT/OUTPATIENT	ANCILLARY SERVICE OTHER PASS Provider CCN: 15-0091	Peri od: Worksheet D
THROUGH COSTS		From 01/01/2019 Part IV

THROUG	H COSTS				To 12/31/2019		
			Title	: XVIII	Hospi tal	PPS	
	Cost Center Description	Non Physician	Nursi ng	Nursi ng	Allied Health	Allied Health	
		Anesthetist	School	School	Post-Stepdown		
		Cost	Post-Stepdown		Adjustments		
			Adjustments				
		1. 00	2A	2. 00	3A	3. 00	
	ANCILLARY SERVICE COST CENTERS						
50.00	05000 OPERATING ROOM	0	0	1	0	0	50.00
	O5001 OPERATI NG ROOM	0	0	1	0	0	50. 01
52.00	05200 DELIVERY ROOM & LABOR ROOM	0	0	1	0	0	52.00
53.00	05300 ANESTHESI OLOGY	0	0	1	0	0	53.00
54.00	05400 RADI OLOGY-DI AGNOSTI C	0	0	1	0	0	54.00
60.00	06000 LABORATORY	0	0	1	0	0	60.00
62. 30	06250 BLOOD CLOTTING FOR HEMOPHILIACS	0	0	1	0	0	62. 30
65. 00	06500 RESPI RATORY THERAPY	0	0	1	0	0	65.00
66. 00	06600 PHYSI CAL THERAPY	0	0	1	0	0	66. 00
67. 00	06700 OCCUPATI ONAL THERAPY	0	0	1	0	0	67.00
68. 00	06800 SPEECH PATHOLOGY	0	0	1	0	0	68. 00
69. 00	06900 ELECTROCARDI OLOGY	0	0	1	0	0	69. 00
71. 00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	1	0	0	71. 00
72. 00	07200 I MPL. DEV. CHARGED TO PATIENTS	0	0	1	0	0	72.00
	07300 DRUGS CHARGED TO PATIENTS	0	0	1	0	0	73. 00
	07697 CARDI AC REHABI LI TATI ON	0	0	1	0	0	76. 97
	07698 HYPERBARI C OXYGEN THERAPY	0	0	1	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	0	0	1	0	0	70.00
	09100 EMERGENCY	0	0	1	0	0	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART	0		(0	0	92.00
	OTHER REIMBURSABLE COST CENTERS						
	09500 AMBULANCE SERVI CES						95.00
200.00	Total (lines 50 through 199)	0	0	(0 0	0	200. 00

Health Financial Systems	HUNTI NGTON MEMORI A	AL HOSPITAL	In Lieu	u of Form CMS-2552-10
APPORTIONMENT OF INPATIENT/OUTPATIENT	ANCILLARY SERVICE OTHER PASS	Provider CCN: 15-0091	Peri od:	Worksheet D

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SER THROUGH COSTS	VICE OTHER PAS			Period: From 01/01/2019 To 12/31/2019		epared: 24 am
			XVIII	Hospi tal	PPS	
Cost Center Description	All Other	Total Cost	Total		Ratio of Cost	
	Medi cal	(sum of cols.	Outpati ent	(from Wkst.	to Charges	
	Educati on	1, 2, 3, and	Cost (sum of		(col. 5 ÷	
	Cost	4)	col s. 2, 3,	col. 8)	col. 7)	
			and 4)		(see	
					instructions)	
	4. 00	5. 00	6. 00	7. 00	8. 00	
ANCILLARY SERVICE COST CENTERS						
50. 00 05000 OPERATING ROOM	0	0		0 27, 637, 007	0. 000000	
50. 01 05001 OPERATI NG ROOM	0	0		0	0. 000000	
52.00 05200 DELIVERY ROOM & LABOR ROOM	0	0		0 4, 098, 130		
53. 00 05300 ANESTHESI OLOGY	0	0		0 3, 599, 291		
54. 00 05400 RADI OLOGY-DI AGNOSTI C	0	0		0 36, 499, 479		
60. 00 06000 LABORATORY	0	0		0 26, 438, 766		
62. 30 06250 BLOOD CLOTTING FOR HEMOPHILIACS	0	0		0	0. 000000	
65. 00 06500 RESPI RATORY THERAPY	0	0		0 8, 491, 803		
66. 00 06600 PHYSI CAL THERAPY	0	0		0 5, 542, 815		
67. 00 06700 OCCUPATI ONAL THERAPY	0	0		0 1, 937, 154		
68. 00 06800 SPEECH PATHOLOGY	0	0		0 755, 491		
69. 00 06900 ELECTROCARDI OLOGY	0	0		0 931, 347		
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0	0		0 5, 730, 698		
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0	0		0 4, 277, 203		
73.00 07300 DRUGS CHARGED TO PATIENTS	0	0		0 20, 680, 647		
76. 97 O7697 CARDI AC REHABI LI TATI ON	0	0		0	0. 000000	
76. 98 07698 HYPERBARIC OXYGEN THERAPY	0	0		0 2, 613, 035		
76. 99 07699 LI THOTRI PSY	0	0		0 0	0. 000000	76. 99
OUTPATIENT SERVICE COST CENTERS						
90. 00 09000 CLI NI C	0	0		0 853, 342		
91. 00 09100 EMERGENCY	0	0		0 30, 492, 461		
92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART	0	0		0 5, 918, 135	0. 000000	92.00
OTHER REIMBURSABLE COST CENTERS						
95. 00 09500 AMBULANCE SERVICES						95.00
200.00 Total (lines 50 through 199)	0	0		0 186, 496, 804		200.00

Health Financial Systems	HUNTI NGTON MEMORIA	AL HOSPITAL		In Lieu	u of Form CMS-2	2552-10
APPORTIONMENT OF INPATIENT/OUTPATIENT A	ANCILLARY SERVICE OTHER PASS	Provi der CC		Period: From 01/01/2019 To 12/31/2019	Worksheet D Part IV Date/Time Prep 6/26/2020 11:2	
		Title	XVIII	Hospi tal	PPS	
Cost Center Description	Outpatient Ratio of Cost to Charges	Inpatient Program Charges	Inpatient Program Pass-Through	Outpatient Program Charges	Outpatient Program Pass-Through	

					6/26/2020 11:	<u>24 am</u>
			XVIII	Hospi tal	PPS	
Cost Center Description	Outpati ent	I npati ent	I npati ent	Outpati ent	Outpati ent	
	Ratio of Cost	Program	Program	Program	Program	
	to Charges	Charges	Pass-Through	Charges	Pass-Through	
	(col. 6 ÷		Costs (col. 8		Costs (col. 9	
	col. 7)		x col. 10)		x col. 12)	
	9. 00	10. 00	11. 00	12.00	13. 00	
ANCILLARY SERVICE COST CENTERS						
50. 00 05000 OPERATING ROOM	0. 000000	1, 469, 782	0	4, 377, 962	0	50.00
50. 01 05001 OPERATING ROOM	0. 000000	0	0	0	0	50. 01
52.00 05200 DELIVERY ROOM & LABOR ROOM	0. 000000	0	0	0	0	52.00
53. 00 05300 ANESTHESI OLOGY	0. 000000	0	0	0	0	53.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	0. 000000	1, 320, 659	0	7, 090, 754	0	54.00
60. 00 06000 LABORATORY	0. 000000	1, 494, 243	0	482, 039	0	60.00
62.30 06250 BLOOD CLOTTING FOR HEMOPHILIACS	0. 000000	0	0	0	0	62.30
65. 00 06500 RESPIRATORY THERAPY	0. 000000	562, 405	0	1, 105, 968	0	65.00
66. 00 06600 PHYSI CAL THERAPY	0. 000000	192, 119	0	114, 443	0	66.00
67. 00 06700 OCCUPATI ONAL THERAPY	0. 000000	75, 652	0	30, 990	0	67.00
68.00 06800 SPEECH PATHOLOGY	0. 000000	13, 555	0	6, 224	0	68.00
69. 00 06900 ELECTROCARDI OLOGY	0. 000000	230, 487	0	273, 830	0	69. 00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0. 000000	526, 080	0	780, 061	0	71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0. 000000	691, 574	0	406, 435	0	72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	0. 000000	1, 453, 769	0	4, 613, 938	0	73.00
76. 97 07697 CARDI AC REHABI LI TATI ON	0. 000000	0	0	0	0	76. 97
76. 98 07698 HYPERBARI C OXYGEN THERAPY	0. 000000	0	0	0	0	76. 98
76. 99 07699 LI THOTRI PSY	0. 000000	0	0	0	0	76. 99
OUTPATIENT SERVICE COST CENTERS						
90. 00 09000 CLI NI C	0. 000000	0	0	0	0	90.00
91. 00 09100 EMERGENCY	0. 000000	1, 256, 742	0	4, 098, 471	0	91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART	0. 000000	0		1, 626, 364	0	92.00
OTHER REIMBURSABLE COST CENTERS						
95. 00 09500 AMBULANCE SERVICES						95.00
200.00 Total (lines 50 through 199)		9, 287, 067	0	25, 007, 479	0	200. 00
	•					

Health Financial Systems	HUNTI NGTON MEMO	In Lieu of Form CMS-2552-10			
APPORTI ONMENT OF MEDICAL,	OTHER HEALTH SERVICES AND VACCINE COST	Provi der CCN: 15-0091	Peri od: From 01/01/2019 To 12/31/2019	Worksheet D Part V Date/Time Pre 6/26/2020 11::	
		Title XVIII	Hospi tal	PPS	
		Charges		Costs	

					To 12/31/2019	Date/Time Pre 6/26/2020 11:	
			Title	XVIII	Hospi tal	PPS	
				Charges	•	Costs	
	Cost Center Description	Cost to	PPS	Cost	Cost	PPS Services	
		Charge Ratio	Rei mbursed	Reimbursed	Rei mbursed	(see inst.)	
		From	Services (see	Servi ces	Servi ces Not		
		Worksheet C,	inst.)	Subject To	Subj ect To		
		Part I, col.		Ded. & Coins.	Ded. & Coins.		
		9		(see inst.)	(see inst.)		
		1. 00	2. 00	3. 00	4. 00	5. 00	
	LLARY SERVICE COST CENTERS						
	O OPERATING ROOM	0. 093288	4, 377, 962		0	408, 411	50.00
	1 OPERATING ROOM	0. 000000	0		0	0	50. 01
	ODELIVERY ROOM & LABOR ROOM	0. 266189	0		0	0	52.00
	O ANESTHESI OLOGY	0. 416104	0		0	0	53.00
	O RADI OLOGY-DI AGNOSTI C	0. 111814	7, 090, 754		0	792, 846	
	0 LABORATORY	0. 158078	482, 039		0	76, 200	60.00
	O BLOOD CLOTTING FOR HEMOPHILIACS	0. 000000	0		0	0	62. 30
	O RESPI RATORY THERAPY	0. 219542	1, 105, 968	•	0	242, 806	
	O PHYSI CAL THERAPY	0. 617736	114, 443	•	0	70, 696	
	O OCCUPATI ONAL THERAPY	0. 244774	30, 990		0	7, 586	
	O SPEECH PATHOLOGY	0. 414393	6, 224		0	2, 579	
	0 ELECTROCARDI OLOGY	0. 000180	273, 830	•	0	49	
	MEDICAL SUPPLIES CHARGED TO PATIENT	0. 384996	780, 061		0	300, 320	
	O IMPL. DEV. CHARGED TO PATIENTS	0. 286916	406, 435		0	116, 613	
	ODRUGS CHARGED TO PATIENTS	0. 187852	4, 613, 938		0	866, 737	
	7 CARDIAC REHABILITATION	0. 000000	0		0	0	76. 97
	8 HYPERBARIC OXYGEN THERAPY	0. 358153	0		0	0	76. 98
	9 LI THOTRI PSY	0. 000000	0		0 0	0	76. 99
	ATIENT SERVICE COST CENTERS	,					
90.00 0900		0. 221018	0		0	_	
	O EMERGENCY	0. 106365	4, 098, 471		0	435, 934	1
	O OBSERVATION BEDS (NON-DISTINCT PART	0. 443696	1, 626, 364		0 0	721, 611	92.00
	R REIMBURSABLE COST CENTERS				-		
	O AMBULANCE SERVICES	0. 374190		l .	0		95.00
200.00	Subtotal (see instructions)		25, 007, 479		0	4, 042, 388	
201. 00	Less PBP Clinic Lab. Services-Program				0		201. 00
	Only Charges		05 007 :		_		
202. 00	Net Charges (line 200 - line 201)		25, 007, 479	l	0 0	4, 042, 388	202.00

Health Financial Systems	HUNTI NGTON MEMO	ORIAL HOSPITAL		In lie	ı of Form CMS-2	2552-10
APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AN		Provi der C	CN: 15-0091	Peri od: From 01/01/2019	Worksheet D	pared:
		Title	XVIII	Hospi tal	PPS	
	Cos	sts				
Cost Center Description	Cost	Cost				
	Rei mbursed	Rei mbursed				
	Services Subject To	Services Not Subject To				
	, ,	Ded. & Coins.				

Cost Center Description Cost Cost Reimbursed Reimbursed Services Subject To Subject To	
Servi ces Servi ces Not	
Subject To Subject To	
Ded. & Coi ns. Ded. & Coi ns.	
(see inst.)	
6.00 7.00	
ANCILLARY SERVICE COST CENTERS	
50. 00 05000 0PERATI NG ROOM 0 0	50.00
50. 01 05001 0PERATING ROOM 0 0	50. 01
52.00 05200 DELIVERY ROOM & LABOR ROOM 0 0	52.00
53. 00 05300 ANESTHESI OLOGY 0 0	53.00
54. 00 05400 RADI 0LOGY-DI AGNOSTI C 0 0	54.00
60. 00 06000 LABORATORY 0 0	60.00
62.30 06250 BLOOD CLOTTING FOR HEMOPHILIACS 0 0	62. 30
65. 00 06500 RESPI RATORY THERAPY 0 0	65.00
66. 00 06600 PHYSI CAL THERAPY 0 0	66.00
67. 00 06700 0CCUPATI ONAL THERAPY 0 0	67.00
68. 00 06800 SPEECH PATHOLOGY 0 0	68.00
69. 00 06900 ELECTROCARDI OLOGY 0 0	69.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT 0 0	71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS 0 0	72.00
73. 00 07300 DRUGS CHARGED TO PATIENTS 0 0	73.00
76. 97 07697 CARDI AC REHABI LI TATI ON 0 0	76. 97
76. 98 07698 HYPERBARI C OXYGEN THERAPY	76, 98
76. 99 07699 LI THOTRI PSY 0	76. 99
OUTPATIENT SERVICE COST CENTERS	
90. 00 09000 CLI NI C 0 0	90.00
91. 00 09100 EMERGENCY 0 0	91.00
92. 00 09200 0BSERVATION BEDS (NON-DISTINCT PART 0 0	92.00
OTHER REIMBURSABLE COST CENTERS	
95. 00 09500 AMBULANCE SERVICES 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	202. 00

Health Financial Systems	HUNTINGTON MEMORIAL HOSPITAL			In Lieu of Form CMS-2552-10			
APPORTIONMENT OF INPATIENT ROUTINE SERVICE CAPITAL COSTS		Provi der C		Peri od:	Worksheet D		
				From 01/01/2019 To 12/31/2019		narod:	
				10 12/31/2019	6/26/2020 11:		
			e XIX	Hospi tal	PPS		
Cost Center Description	Capi tal	Swing Bed	Reduced	Total Patient	Per Diem		
	Related Cost	Adjustment	Capi tal	Days	(col. 3 /		
	(from Wkst.		Related Cost		col. 4)		
	B, Part II,		(col. 1 -				
	col. 26)		col . 2)				
	1. 00	2. 00	3. 00	4. 00	5. 00		
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00 ADULTS & PEDIATRICS	1, 136, 682		1, 136, 68			1	
43. 00 NURSERY	14, 798		14, 79			43.00	
200.00 Total (lines 30 through 199)	1, 151, 480		1, 151, 48	0 6, 742		200.00	
Cost Center Description	I npati ent	Inpatient					
	Program days	Program					
		Capital Cost					
		(col. 5 x					
		col . 6)					
	6. 00	7. 00					
INPATIENT ROUTINE SERVICE COST CENTERS			1				
30. 00 ADULTS & PEDIATRICS	67	12, 438				30.00	
43. 00 NURSERY	20	478	1			43.00	
200.00 Total (lines 30 through 199)	87	12, 916	·I			200. 00	

Health Financial Systems	HUNTI NGTON MEMORI A	AL HOSPITAL		In Lieu of Form CMS-2552-10
APPORTIONMENT OF INPATIENT ANCILL	ARY SERVICE CAPITAL COSTS	Provider CCN: 15-0091	Peri od:	Worksheet D

Health Financial Systems	HUNTINGTON MEMO	RIAL HOSPITAL		In Lie	u of Form CMS-2	2552-10
APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPIT	AL COSTS	Provi der C		Period: From 01/01/2019 To 12/31/2019	Worksheet D Part II Date/Time Pre 6/26/2020 11:	
		Ti tl	e XIX	Hospi tal	PPS	
Cost Center Description	Capi tal	Total Charges	Ratio of Cos	t Inpatient	Capital Costs	
	Related Cost	(from Wkst.	to Charges	Program	(column 3 x	
	(from Wkst.	C, Part I,	(col. 1 ÷	Charges	column 4)	
	B, Part II,	col. 8)	col . 2)			
	col. 26)					
	1. 00	2. 00	3. 00	4. 00	5. 00	
ANCILLARY SERVICE COST CENTERS						
50.00 05000 OPERATING ROOM	489, 165	27, 637, 007			4, 139	50.00
50. 01 05001 OPERATING ROOM	0		0.0000		0	50. 01
52.00 05200 DELIVERY ROOM & LABOR ROOM	47, 479				903	52.00
53. 00 05300 ANESTHESI OLOGY	62, 755	3, 599, 291			0	53.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	662, 239				1, 099	54.00
60. 00 06000 LABORATORY	211, 857	26, 438, 766	0. 00801	3 100, 615	806	60.00
62.30 06250 BLOOD CLOTTING FOR HEMOPHILIACS	0		0.00000		0	62. 30
65. 00 06500 RESPI RATORY THERAPY	178, 295				423	65.00
66. 00 06600 PHYSI CAL THERAPY	691, 634	5, 542, 815	0. 12478	1, 264	158	66.00
67. 00 06700 OCCUPATI ONAL THERAPY	20, 357	1, 937, 154	0. 01050	9 0	0	67.00
68. 00 06800 SPEECH PATHOLOGY	13, 245	755, 491	0. 01753	2 0	0	68.00
69. 00 06900 ELECTROCARDI OLOGY	61	931, 347	0.00006	5 7, 928	1	69. 00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	179, 548	5, 730, 698	0. 03133	1 23, 071	723	71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	51, 498	4, 277, 203	0. 01204	.0	0	72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	166, 154	20, 680, 647	0.00803	4 89, 384	718	73.00
76. 97 07697 CARDIAC REHABILITATION	0	0	0.00000	0 0	0	76. 97
76. 98 07698 HYPERBARIC OXYGEN THERAPY	79, 162	2, 613, 035	0. 03029	5 0	0	76. 98
76. 99 07699 LI THOTRI PSY	0	0	0. 00000	0 0	0	76. 99
OUTPATIENT SERVICE COST CENTERS						
90. 00 09000 CLI NI C	7, 935	853, 342	0.00929	9 0	0	90.00
91. 00 09100 EMERGENCY	277, 190	30, 492, 461	0.00909	73, 264	666	91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART	328, 216	5, 918, 135	0. 05545	9 0	0	92.00
OTHER REIMBURSABLE COST CENTERS						
95. 00 09500 AMBULANCE SERVICES						95.00
200.00 Total (lines 50 through 199)	3, 466, 790	186, 496, 804		688, 019	9, 636	200. 00

Health Financial Systems	HUNTI NGTON MEMO	RIAL HOSPITAL		In Lie	u of Form CMS-:	2552-10
APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER	PASS THROUGH COS	STS Provider C		Period: From 01/01/2019 To 12/31/2019		pared: 24 am
		Ti tl	e XIX	Hospi tal	PPS	
Cost Center Description	Nursing School Post-Stepdown Adjustments	Nursi ng School	Allied Health Post-Stepdown Adjustments	Allied Health Cost	All Other Medical Education Cost	
	1A	1, 00	2A	2. 00	3. 00	
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	0 0	0	(0 0	0 0 0	
Cost Center Description	Swing-Bed Adjustment Amount (see instructions)	Total Costs (sum of cols. 1 through 3, minus col. 4)	Total Patient Days	Per Diem (col. 5 ÷ col. 6)	Inpatient Program Days	
	4. 00	5.00	6. 00	7. 00	8. 00	
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	0	0	6, 123 619 6, 742	0.00		
Cost Center Description	Inpatient Program Pass-Through Cost (col. 7 x col. 8) 9.00					
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	0 0					30. 00 43. 00 200. 00

Health Financial Systems	HUNTINGTON MEMORI.	AL HOSPITAL	In Lieu	ı of Form CMS-2552-10
APPORTIONMENT OF INPATIENT/OUTPATIEN	T ANCILLARY SERVICE OTHER PASS	Provi der CCN: 15-0091	Peri od:	Worksheet D
TURQUEU COSTS			From 01/01/2019	Part IV

Title XIX	THROUGH COSTS		KVI OL OTTLEK TAC		<u> </u>	From 01/01/2019 Fo 12/31/2019	Date/Time Pre 6/26/2020 11:	
Anesthetist Cost Post-Stepdown Adjustments Post-Stepdown Adjustments Adjustments Adjustments 1.00 2A 2.00 3A 3.00								
ANCILLARY SERVICE COST CENTERS 1.00 2A 2.00 3A 3.00		Cost Center Description					Allied Health	
Adjustments					School			
1.00 2A 2.00 3A 3.00			Cost			Adjustments		
ANCILLARY SERVICE COST CENTERS			1.00		2.00	24	2.00	
50. 00 05000 OPERATI NG ROOM 0 0 0 0 0 0 0 0 0		ANCILLARY SERVICE COST CENTERS	1.00	ZA	2.00	3A	3.00	
50. 01 05001 0PERATING ROOM 0 0 0 0 0 0 0 0 52. 00	EO 00						0	E0 00
52. 00 05200 DELIVERY ROOM & LABOR ROOM 0 0 0 0 0 52. 00)		Ĭ.	
53. 00)		Ĭ.	
S4. 00 05400 RADI OLOGY-DI AGNOSTI C 0 0 0 0 0 0 54. 00 60. 00 60.00 60.00 60.00 60.00 60.00 60.250 60.00 60.250 60.00 60.00 60.00 60.00 60.00 60.00 60.00 60.00 60.00 60.00 60.00 60.00 60.00 60.00 60.00 60.00 60.00 60.00 60.00 60.00 60.00 60.00 60.00 60.00 60.00 60.00 60.00 60.00 60.00 60.00 60.00 60.00 60.00 60.00 60.00 60.00 60.00 60.00 60.00 60.00 60.00 60.00 60.00 60.00 60.00 60.00 60.00 60.00 60.00 60.00 60.00 60.00 60.00 60.00 60.00 60.00 60.00 60.00 60.00 60.00 60.00 60.00 60.00 60.00 60.00 60.00 60.00 60.00 60.00 60.00 60.00 60.00 60.00 60.00 60.00 60.00 60.00 60.00 60.00 60.00 60.00 60.00 60.00 60.00 60.00 60.00 60.00 60.00 60.00 60.00 60.00 60.00 60.00 60.00 60.00 60.00 60.00 60.00 60.00 60.00 60.00 60.00 60.00 60.00 60.00 60.00 60.00 60.00 60.00 60.00 60.00 60.00 60.00 60.00 60.00 60.00 60.00 60.00 60.00 60.00 60.00 60.00 60.00 60.00 60.00 60.00 60.00 60.00 60.00 60.00 60.00 60.00 60.00 60.00 60.00 60.00 60.00 60.00 60.00 60.00 60.00 60.00 60.00 60.00 60.00 60.00 60.00 60.00 60.00 60.00 60.00 60.00 60.00 60.00 60.00 60.00 60.00 60.00 60.00 60.00 60.00 60.00 60.00 60.00 60.00 60.00 60.00 60.00 60.00 60.00 60.00 60.00 60.00 60.00 60.00 60.00 60.00 60.00 60.00 60.00 60.00 60.00 60.00 60.00 60.00 60.00 60.00 60.00 60.00 60.00 60.00 60.00 60.00 60.00 60.00 60.00 60.00 60.00 60.00 60.00 60.00 60.00 60.00 60.00 60.00 60.00 60.00 60.00 60.00 60.00 60.00 60.00 60.00 60.00 60.00 60.00 60.00 60.00 60.00 60.00 60.00 60.00 60.00 60.00 60.00 60.00 60.00 60.00 60.00 60.00 60.00 60.00 60.00 60.00 60.00 60.00 60.00			0)		Ĭ.	
60. 00)	0	0	
62. 30			0				0	
65. 00 06500 RESPIRATORY THERAPY 0 0 0 0 0 0 0 0 0			0				0	
66. 00 06600 PHYSI CAL THERAPY 0 0 0 0 0 0 66. 00 67. 00 06700 0CCUPATI ONAL THERAPY 0 0 0 0 0 0 0 67. 00 68. 00 06800 SPEECH PATHOLOGY 0 0 0 0 0 0 68. 00 69. 00 06900 ELECTROCARDI OLOGY 0 0 0 0 0 0 69. 00 71. 00 07100 MEDI CAL SUPPLIES CHARGED TO PATI ENT 0 0 0 0 0 0 72. 00 07200 IMPL. DEV. CHARGED TO PATI ENTS 0 0 0 0 0 0 73. 00 07300 DRUGS CHARGED TO PATI ENTS 0 0 0 0 0 76. 97 07697 CARDI AC REHABI LI TATI ON 0 0 0 0 0 76. 98 07698 HYPERBARI C OXYGEN THERAPY 0 0 0 0 0 76. 99 007699 LI THOTRI PSY 0 0 0 0 0 76. 99 007699 LI THOTRI PSY 0 0 0 0 76. 99 007690 CLI NI C 0 0 0 76. 90 09200 OSSERVATI ON BEDS (NON-DI STI NCT PART 0 0 0 76. 90 07HER REI MBURSABLE COST CENTERS			0)	0	0	
67. 00 06700 OCCUPATI ONAL THERAPY 0 0 0 0 0 0 0 67. 00 68. 00 06800 SPEECH PATHOLOGY 0 0 0 0 0 0 0 68. 00 69. 00 06900 ELECTROCARDI OLOGY 0 0 0 0 0 0 0 69. 00 71. 00 07100 MEDI CAL SUPPLIES CHARGED TO PATI ENT 0 0 0 0 0 0 0 71. 00 72. 00 07200 I MPL. DEV. CHARGED TO PATI ENTS 0 0 0 0 0 0 0 73. 00 73. 00 07300 DRUGS CHARGED TO PATI ENTS 0 0 0 0 0 0 73. 00 76. 97 07697 CARDI AC REHABI LI TATI ON 0 0 0 0 0 76. 97 76. 98 07698 HYPERBARI C OXYGEN THERAPY 0 0 0 0 0 0 76. 98 76. 99 07699 LI THOTRI PSY 0 0 0 0 0 0 0 76. 99 0UTPATI ENT SERVI CE COST CENTERS 90. 00 09100 EMERGENCY 0 0 0 0 0 0 0 90. 0 91. 00 91. 00 09200 OBSERVATI ON BEDS (NON-DI STI NCT PART 0 0 0 0 0 0 0 0 92. 00 OTHER REI MBURSABLE COST CENTERS		1 1	0)	0	0	
68. 00 06800 SPEECH PATHOLOGY 0 0 0 0 0 0 0 68. 00 69. 00 06900 ELECTROCARDI OLOGY 0 0 0 0 0 0 0 0 69. 00 71. 00 07100 MEDI CAL SUPPLIES CHARGED TO PATI ENT 0 0 0 0 0 0 0 71. 00 72. 00 07200 I MPL. DEV. CHARGED TO PATI ENTS 0 0 0 0 0 0 72. 00 73. 00 07300 DRUGS CHARGED TO PATI ENTS 0 0 0 0 0 0 72. 00 76. 97 07697 CARDI AC REHABI LI TATI ON 0 0 0 0 0 0 76. 97 76. 98 07698 HYPERBARI C OXYGEN THERAPY 0 0 0 0 0 0 0 76. 98 76. 99 07699 LI THOTRI PSY 0 0 0 0 0 0 0 76. 99 0UTPATI ENT SERVI CE COST CENTERS 90. 00 09100 EMERGENCY 0 0 0 0 0 0 0 99. 00 91. 00 09200 OBSERVATI ON BEDS (NON-DI STI NCT PART 0 0 0 0 0 0 0 92. 00 0THER REI MBURSABLE COST CENTERS			0	0)	0	,	
69. 00 06900 ELECTROCARDI OLOGY 0 0 0 0 0 0 0 69. 00 71. 00 07100 MEDI CAL SUPPLIES CHARGED TO PATI ENT 0 0 0 0 0 0 71. 00 72. 00 07200 I MPL. DEV. CHARGED TO PATI ENTS 0 0 0 0 0 0 72. 00 73. 00 07300 DRUGS CHARGED TO PATI ENTS 0 0 0 0 0 0 73. 00 74. 97 07697 CARDI AC REHABI LI TATI ON 0 0 0 0 0 0 73. 00 75. 98 07698 HYPERBARI C OXYGEN THERAPY 0 0 0 0 0 0 0 76. 98 76. 99 07699 LI THOTRI PSY 0 0 0 0 0 0 0 76. 98 76. 99 000 09000 CLI NI C 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0			0	0		0	0	
71. 00			0	0		0	0	
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 0 76. 98 07698 HYPERBARI C OXYGEN THERAPY 0 0 0 0 0 0 76. 99 07699 LI THOTRI PSY 0 0 0 0 0 0 0 0 0			0	l o		0	0	
73. 00 07300 DRUGS CHARGED TO PATIENTS 0 0 0 0 0 73. 00 76. 97 07697 CARDI AC REHABILITATION 0 0 0 0 0 0 76. 98 07698 HYPERBARI C OXYGEN THERAPY 0 0 0 0 0 0 76. 99 07699 LI THOTRI PSY 0 0 0 0 0 90. 00 09000 CLI NI C 0 0 0 0 91. 00 09100 EMERGENCY 0 0 0 0 0 92. 00 09200 OBSERVATI ON BEDS (NON-DI STI NCT PART 0 0 0 00 09500 AMBULANCE SERVI CES 95. 00	72.00	07200 I MPL. DEV. CHARGED TO PATIENTS	0	0		0	0	72.00
76. 98 07698 HYPERBARI C OXYGEN THERAPY 0 0 0 0 0 0 76. 98 76. 99 07699 LI THOTRI PSY 0 0 0 0 0 0 76. 99 OUTPATI ENT SERVI CE COST CENTERS 90. 00 09100 EMERGENCY 0 0 0 0 0 0 99. 00 91. 00 09100 EMERGENCY 0 0 0 0 0 0 991. 00 92. 00 09200 OBSERVATI ON BEDS (NON-DI STI NCT PART 0 0 0 0 0 0 92. 00 OTHER REI MBURSABLE COST CENTERS 95. 00 09500 AMBULANCE SERVI CES		07300 DRUGS CHARGED TO PATIENTS	0	0		0	0	73.00
76. 99 07699 LI THOTRI PSY 0 0 0 0 0 0 76. 99 OUTPATI ENT SERVI CE COST CENTERS 90. 00 09000 CLI NI C 0 0 0 0 0 0 90. 00 91. 00 09100 EMERGENCY 0 0 0 0 0 0 91. 00 92. 00 09200 OBSERVATI ON BEDS (NON-DI STI NCT PART 0 0 0 0 0 0 92. 00 OTHER REI MBURSABLE COST CENTERS 95. 00 09500 AMBULANCE SERVI CES 95. 00	76. 97	07697 CARDI AC REHABI LI TATI ON	0	0		0	0	76. 97
OUTPATIENT SERVICE COST CENTERS 90.00 0 0 0 0 0 0 0 0 0	76. 98	07698 HYPERBARI C OXYGEN THERAPY	0	0		0	0	76. 98
90. 00 09000 CLI NI C 0 0 0 0 0 0 0 0 0	76. 99	07699 LI THOTRI PSY	0	0		0	0	76. 99
91. 00		OUTPATIENT SERVICE COST CENTERS	·					
92. 00 09200 0BSERVATION BEDS (NON-DISTINCT PART 0 0 0 92. 00	90.00	09000 CLI NI C	0	0	(0	0	90.00
OTHER REI MBURSABLE COST CENTERS 95. 00 09500 AMBULANCE SERVI CES 95. 00	91.00	09100 EMERGENCY	0	0	(0	0	91.00
95. 00 09500 AMBULANCE SERVI CES 95. 00	92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART	0		()	0	92.00
200.00 Total (lines 50 through 199) 0 0 0 0 0 0 200.00								
	200.00	Total (lines 50 through 199)	0	0	(0	0	200.00

Health Financial Systems HUNTINGTON MEMORIAL HOSPITAL			In Lieu	of Form CMS-2552-10
APPORTIONMENT OF INPATIENT/OUTPATIENT	ANCI LLARY SERVI CE OTHER PASS PI	rovider CCN: 15-0091	Peri od:	Worksheet D

From 01/01/2019 Part IV
To 12/31/2019 Date/Time Prepared: THROUGH COSTS 6/26/2020 11: 24 am Title XIX Hospi tal All Other Total Cost Total Charges Ratio of Cost Cost Center Description Total to Charges Medi cal (sum of cols. Outpati ent (from Wkst. 1, 2, 3, and 4) C, Part I, Educati on Cost (sum of (col. 5 ÷ Cost col s. 2, 3, col. 8) col. 7) and 4) (see instructions) 7. 00 4. 00 5.00 6.00 8.00 ANCILLARY SERVICE COST CENTERS 50.00 05000 OPERATING ROOM 0 27, 637, 007 0.000000 50.00 05001 OPERATING ROOM 0 0 0.000000 50.01 50.01 0 0 0 0 0 0 0 0 0 0 0 0 0 0 05200 DELIVERY ROOM & LABOR ROOM 0.000000 0 0 4, 098, 130 52.00 52.00 3, 599, 291 53. 00 | 05300 | ANESTHESI OLOGY 0 0 0.000000 53.00 54.00 05400 RADI OLOGY-DI AGNOSTI C 0 36, 499, 479 0.000000 54.00 60.00 06000 LABORATORY 0 26, 438, 766 0.000000 60.00 06250 BLOOD CLOTTING FOR HEMOPHILIACS 0 0.000000 62.30 0 62.30 06500 RESPIRATORY THERAPY 8, 491, 803 65.00 0 0.000000 65.00 66.00 06600 PHYSI CAL THERAPY 5, 542, 815 0.000000 66.00 67.00 06700 OCCUPATIONAL THERAPY 0 1, 937, 154 0.000000 67.00 0 06800 SPEECH PATHOLOGY 0 755, 491 0.000000 68.00 68.00 69.00 06900 ELECTROCARDI OLOGY 931, 347 0.000000 69.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT 5, 730, 698 0.000000 71.00 71.00 07200 IMPL. DEV. CHARGED TO PATIENTS 0 4, 277, 203 0.000000 72 00 72 00 07300 DRUGS CHARGED TO PATIENTS 0 73.00 0 20, 680, 647 0.000000 73.00 76. 97 07697 CARDIAC REHABILITATION 0 0 0.000000 76.97 07698 HYPERBARI C OXYGEN THERAPY 0 0 76.98 0 2, 613, 035 0.000000 76.98 07699 LI THOTRI PSY 0 0 0.000000 76. 99 OUTPATIENT SERVICE COST CENTERS 90.00 09000 CLI NI C 0 0 853, 342 0.000000 90.00 0 0 0.000000 91.00 09100 EMERGENCY 0 30, 492, 461 91.00 <u>5, 918,</u> 135 09200 OBSERVATION BEDS (NON-DISTINCT PART 92.00 0 0 0 0.000000 92.00 OTHER REIMBURSABLE COST CENTERS 95. 00 09500 AMBULANCE SERVICES 95.00

0

0

0

186, 496, 804

200.00

Total (lines 50 through 199)

200.00

Health Financial Systems	HUNTINGTON MEMORIA	AL HOSPITAL	In Lieu	u of Form CMS-2552-10
APPORTIONMENT OF INPATIENT/OUTPATIENT THROUGH COSTS	ANCILLARY SERVICE OTHER PASS	Provider CCN: 15-0091	From 01/01/2019	Worksheet D Part IV Date/Time Prepared: 6/26/2020 11:24 am

THROUGH COSTS				rom 01/01/2019 o 12/31/2019	Date/Time Pre	
					6/26/2020 11:	24 am_
			e XIX	Hospi tal	PPS	
Cost Center Description	Outpati ent	I npati ent	Inpatient	Outpati ent	Outpati ent	
	Ratio of Cost	Program	Program	Program	Program	
	to Charges	Charges	Pass-Through	Charges	Pass-Through	
	(col. 6 ÷		Costs (col. 8		Costs (col. 9	
	col. 7)		x col. 10)		x col. 12)	
	9. 00	10. 00	11. 00	12.00	13. 00	
ANCILLARY SERVICE COST CENTERS			•			
50.00 05000 OPERATI NG ROOM	0. 000000	233, 843	0	0	0	50.00
50. 01 05001 OPERATI NG ROOM	0. 000000	0	0	0	0	50. 01
52.00 05200 DELIVERY ROOM & LABOR ROOM	0. 000000	77, 928	0	0	0	52.00
53. 00 05300 ANESTHESI OLOGY	0. 000000	0	0	0	0	53.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	0. 000000	60, 568	0	0	0	54.00
60. 00 06000 LABORATORY	0. 000000	100, 615	0	0	0	60.00
62.30 06250 BLOOD CLOTTING FOR HEMOPHILIACS	0. 000000	0	0	0	0	62.30
65. 00 06500 RESPIRATORY THERAPY	0. 000000	20, 154	0	0	0	65.00
66. 00 06600 PHYSI CAL THERAPY	0. 000000	1, 264	0	0	0	66.00
67. 00 06700 OCCUPATI ONAL THERAPY	0. 000000	0	0	0	0	67.00
68. 00 06800 SPEECH PATHOLOGY	0. 000000	0	0	0	0	68.00
69. 00 06900 ELECTROCARDI OLOGY	0. 000000	7, 928	0	0	0	69.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0. 000000	23, 071	0	0	0	71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0. 000000	0	0	0	0	72.00
73. 00 07300 DRUGS CHARGED TO PATIENTS	0. 000000	89, 384	0	0	0	73.00
76. 97 07697 CARDI AC REHABI LI TATI ON	0. 000000	0	0	0	0	76. 97
76. 98 07698 HYPERBARIC OXYGEN THERAPY	0. 000000	0	0	0	0	76. 98
76. 99 07699 LI THOTRI PSY	0. 000000	0	0	o	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	73, 264	0	0	0	91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART	0. 000000	0	0	0	0	92.00
OTHER REIMBURSABLE COST CENTERS				1		
95. 00 09500 AMBULANCE SERVICES						95. 00
200.00 Total (lines 50 through 199)		688, 019	0	0	0	200.00
	1	300/01/	١	١	0	

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

From 01/01/2019 Part V 12/31/2019 Date/Time Prepared: 6/26/2020 11:24 am Title XIX Hospi tal PPS Costs Charges PPS PPS Services Cost Center Description Cost to Cost Cost Charge Ratio Rei mbursed Rei mbursed Rei mbursed (see inst.) From Services (see Servi ces Services Not Worksheet C, inst.) Subject To Subject To Ded. & Coins. Part I, col. Ded. & Coins. 9 (see inst.) (see inst.) 1.00 2.00 5.00 3.00 4.00 ANCILLARY SERVICE COST CENTERS 50.00 05000 OPERATING ROOM 388, 941 50.00 0.093288 05001 OPERATING ROOM 50.01 0.000000 0 0 0 0 0 0 0 0 0 0 0 0 0 0 50.01 0 0 05200 DELIVERY ROOM & LABOR ROOM 0 0 52.00 0. 266189 0 52.00 53.00 05300 ANESTHESI OLOGY 0.416104 0 0 53.00 54.00 05400 RADI OLOGY-DI AGNOSTI C 0.111814 0 579, 252 54.00 Ol 60.00 06000 LABORATORY 0.158078 455, 269 0 60.00 06250 BLOOD CLOTTING FOR HEMOPHILIACS 62.30 0.000000 0 0 0 62.30 65.00 06500 RESPIRATORY THERAPY 0. 219542 65.00 66.00 06600 PHYSI CAL THERAPY 0.617736 88, 639 66.00 0 99, 840 06700 OCCUPATI ONAL THERAPY 67.00 0.2447740 67.00 68.00 06800 SPEECH PATHOLOGY 0.414393 33, 481 0 68.00 06900 ELECTROCARDI OLOGY 17, 824 69.00 69.00 0.000180 0 07100 MEDICAL SUPPLIES CHARGED TO PATIENT 71.00 71 00 0.384996 63 220 72.00 07200 IMPL. DEV. CHARGED TO PATIENTS 0. 286916 98, 430 0 72.00 73.00 07300 DRUGS CHARGED TO PATIENTS 0. 187852 524, 700 0 73.00 07697 CARDIAC REHABILITATION 76. 97 0.000000 0 0 0 76.97 76. 98 07698 HYPERBARI C OXYGEN THERAPY 0 0 o 76. 98 0. 358153 Ω 07699 LI THOTRI PSY 76.99 0.000000 C 0 0 0 76.99 OUTPATIENT SERVICE COST CENTERS 90.00 09000 CLI NI C 0. 221018 0 0 0 0 90.00 802, 971 91 00 09100 EMERGENCY 0.106365 0 0 91.00 Ω 09200 OBSERVATION BEDS (NON-DISTINCT PART 92.00 0.443696 263, 047 0 0 92.00 OTHER REIMBURSABLE COST CENTERS 95.00 09500 AMBULANCE SERVICES 0. 374190 443, 059 95.00 Subtotal (see instructions) 3, 858, 673 0 200.00 200.00 Ω 0 201.00 Less PBP Clinic Lab. Services-Program 0 0 201.00 Only Charges 3, 858, 673 0 202.00 202.00 Net Charges (line 200 - line 201)

Health Financial Systems	HUNTI NGTON MEMORI A	AL HOSPITAL	In Lieu	of Form CMS-2552-10
APPORTIONMENT OF MEDICAL,	OTHER HEALTH SERVICES AND VACCINE COST		From 01/01/2019 To 12/31/2019	Worksheet D Part V Date/Time Prepared: 6/26/2020 11: 24 am

				To 12/31/2019	Date/Time Pr 6/26/2020 11	epared: :24 am
		Ti tl	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				
ANCI LLARY SERVI CE COST CENTERS		_				
50.00 05000 OPERATI NG ROOM	36, 284	l				50.00
50. 01 05001 OPERATI NG ROOM	0	0				50. 01
52.00 05200 DELIVERY ROOM & LABOR ROOM	0	0				52.00
53. 00 05300 ANESTHESI OLOGY	0	0				53.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	64, 768		1			54.00
60. 00 06000 LABORATORY	71, 968	ł	ł			60.00
62. 30 06250 BLOOD CLOTTING FOR HEMOPHILIACS	0	0	ł			62. 30
65. 00 06500 RESPIRATORY THERAPY	0	0				65.00
66. 00 06600 PHYSI CAL THERAPY	54, 756	l e				66.00
67. 00 06700 OCCUPATI ONAL THERAPY	24, 438	ł				67.00
68. 00 06800 SPEECH PATHOLOGY	13, 874	0	ł			68.00
69. 00 06900 ELECTROCARDI OLOGY	3	0	ł			69.00
71. 00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	24, 339	ł	ł			71.00
72. 00 07200 IMPL. DEV. CHARGED TO PATIENTS	28, 241	0	ł			72.00
73. 00 07300 DRUGS CHARGED TO PATIENTS	98, 566	l	1			73.00
76. 97 07697 CARDI AC REHABI LI TATI ON	0	0	ł			76. 97
76. 98 07698 HYPERBARI C OXYGEN THERAPY	0	0	•			76. 98
76. 99 07699 LI THOTRI PSY OUTPATIENT SERVICE COST CENTERS	0	0				76. 99
90. 00 09000 CLINIC	1 0		I			90.00
91. 00 09100 EMERGENCY	85, 408		•			91.00
92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART	116, 713	l .				91.00
OTHER REIMBURSABLE COST CENTERS	110,713	0				92.00
95. 00 09500 AMBULANCE SERVICES	165, 788					95.00
200.00 Subtotal (see instructions)	785, 146					200.00
201. 00 Less PBP Clinic Lab. Services-Program	765, 140	0				200.00
Only Charges						201.00
202.00 Net Charges (line 200 - line 201)	785, 146	О				202. 00
202. 00	700, 140	1	I			1202.00

Haddle Standard Control	HUNTI NOTON, MEMORI AL, HOCOL TAL	111	C. F OHC. /	2550 40
Health Financial Systems	HUNTINGTON MEMORIAL HOSPITAL	in Lieu	u of Form CMS-2	2552-10
COMPUTATION OF INPATIENT OPERATING COST	Provi der CCN: 15-0091	Peri od: From 01/01/2019	Worksheet D-1	
		To 12/31/2019	Date/Time Pre 6/26/2020 11:	pared: 24 am
	Title XVIII	Hospi tal	PPS	
Cost Center Description				
			1. 00	
PART I - ALL PROVIDER COMPONENTS				
LNDATI FAIT DAVC				

		Title XVIII	Hospi tal	PPS	
	Cost Center Description		-	1. 00	
	PART I - ALL PROVIDER COMPONENTS			1.00	
	I NPATI ENT DAYS				
1.00	Inpatient days (including private room days and swing-bed day			6, 123	1.00
2. 00 3. 00	Inpatient days (including private room days, excluding swing- Private room days (excluding swing-bed and observation bed days)		ivata room days	6, 123 0	2. 00 3. 00
3.00	do not complete this line.	lys). IT you have only pr	i vate i ooiii days,	Ü	3.00
4.00	Semi-private room days (excluding swing-bed and observation b	ed days)		4, 355	4. 00
5.00	Total swing-bed SNF type inpatient days (including private ro	oom days) through Decembe	r 31 of the cost	0	5.00
,	reporting period				,
6. 00	Total swing-bed SNF type inpatient days (including private reporting period (if calendar year, enter 0 on this line)	oom days) after December	31 OF the COST	0	6. 00
7. 00	Total swing-bed NF type inpatient days (including private roo	om davs) through December	31 of the cost	0	7. 00
	reporting period			_	
8.00	Total swing-bed NF type inpatient days (including private roo	om days) after December 3	1 of the cost	0	8. 00
9. 00	reporting period (if calendar year, enter 0 on this line)	a the Dregree (eveluding	owing had and	1 227	9. 00
9.00	Total inpatient days including private room days applicable t newborn days) (see instructions)	the Program (excruding	Swirig-bed and	1, 227	9.00
10.00	Swing-bed SNF type inpatient days applicable to title XVIII o	only (including private r	oom days)	0	10.00
	through December 31 of the cost reporting period (see instruc				
11. 00	Swing-bed SNF type inpatient days applicable to title XVIII o		oom days) after	0	11. 00
12. 00	December 31 of the cost reporting period (if calendar year, e Swing-bed NF type inpatient days applicable to titles V or XI		e room days)	0	12. 00
12.00	through December 31 of the cost reporting period	x only (mer during private	c room days)	· ·	12.00
13.00	Swing-bed NF type inpatient days applicable to titles V or XI			0	13.00
44.00	after December 31 of the cost reporting period (if calendar y	ear, enter 0 on this lin	e)	0	44.00
14. 00 15. 00	Medically necessary private room days applicable to the Progr Total nursery days (title V or XIX only)	ram (excluding swing-bed	days)	0	14. 00 15. 00
	Nursery days (title V or XIX only)			0	16.00
	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
18. 00	reporting period Medicare rate for swing-bed SNF services applicable to service	eos after December 21 of	the cost	0.00	18. 00
10.00	reporting period	des al tel becember 31 01	the cost	0.00	10.00
19. 00	Medicaid rate for swing-bed NF services applicable to service	es through December 31 of	the cost	0.00	19. 00
	reporting period				
20. 00	Medicaid rate for swing-bed NF services applicable to service reporting period	es after December 31 of t	ne cost	0. 00	20. 00
21. 00		ıs)		9, 093, 912	21.00
22. 00	Swing-bed cost applicable to SNF type services through Decemb	per 31 of the cost report	ing period (line	0	22. 00
22.00	5 x line 17)	21 -6 +1+		0	22.00
23. 00	Swing-bed cost applicable to SNF type services after December x line 18)	31 of the cost reportin	g period (iine 6	0	23. 00
24. 00		er 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 x line 20)	31 of the cost reporting	period (line 8	0	25. 00
26. 00				0	26, 00
27. 00		(line 21 minus line 26)		9, 093, 912	27. 00
	PRIVATE ROOM DIFFERENTIAL ADJUSTMENT				
28. 00	General inpatient routine service charges (excluding swing-be	ed and observation bed ch	arges)	0	
30.00	Private room charges (excluding swing-bed charges) Semi-private room charges (excluding swing-bed charges)			0	29. 00 30. 00
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	Average semi-private room per diem charge (line 30 ÷ line 4)			0.00	
34. 00 35. 00	Average per diem private room charge differential (line 32 mi Average per diem private room cost differential (line 34 x li	, ,	TI ONS)	0. 00 0. 00	
36.00	Private room cost differential adjustment (line 3 x line 35)	ne 31)		0.00	36.00
37. 00	General inpatient routine service cost net of swing-bed cost	and private room cost di	fferential (line	9, 093, 912	37.00
	27 minus line 36)	· 	•		
	PART II - HOSPITAL AND SUBPROVIDERS ONLY	HCTMENTS			
38. 00	PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJ Adjusted general inpatient routine service cost per diem (see			1, 485. 21	38. 00
39. 00	Program general inpatient routine service cost per dreim (see			1, 822, 353	
40.00	Medically necessary private room cost applicable to the Progr	ram (line 14 x line 35)		0	40. 00
41. 00	Total Program general inpatient routine service cost (line 39	9 + line 40)		1, 822, 353	41.00

		(27 militus fille 30)	1	
		PART II - HOSPITAL AND SUBPROVIDERS ONLY		
		PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS		
3	8.00	Adjusted general inpatient routine service cost per diem (see instructions)	1, 485. 21	38.0
3	9.00	Program general inpatient routine service cost (line 9 x line 38)	1, 822, 353	39.0
4	0.00	Medically necessary private room cost applicable to the Program (line 14 x line 35)	0	40.0
4	1.00	Total Program general inpatient routine service cost (line 39 + line 40)	1, 822, 353	41.0

	Financial Systems I	HUNTI NGTON MEMOR		CN: 15-0091	In Lie Period:	u of Form CMS-2 Worksheet D-1	
COIVIPUI	ATTOM OF THEATTENT OF ENATITING COST		i i ovi dei C		From 01/01/2019 From 12/31/2019		
						6/26/2020 11:	24 am
	Cost Center Description	Total	Ti tl e	Average Per	Hospital Program Days	PPS Program Cost	
		I npati ent	I npati ent	Diem (col. 1		(col. 3 x	
		1.00	<u>Days</u> 2. 00	÷ col. 2) 3.00	4.00	col . 4) 5.00	
42.00	NURSERY (title V & XIX only)	0	2. 00				42.00
43. 00	Intensive Care Type Inpatient Hospital Units	; 		I	T		43.00
44. 00	CORONARY CARE UNIT						44. 00
45. 00	BURN I NTENSI VE CARE UNIT						45.00
	SURGICAL INTENSIVE CARE UNIT OTHER SPECIAL CARE (SPECIFY)			1			46. 00 47. 00
171.00	Cost Center Description						177.00
48. 00	Program inpatient ancillary service cost (Wk	est D-3 col 3	line 200)			1. 00 1, 596, 289	48. 00
	Total Program inpatient costs (sum of lines			ons)		3, 418, 642	•
EO 00	PASS THROUGH COST ADJUSTMENTS Pass through costs applicable to Program inp	nationt routing o	convices (fro	m Wks+ D sun	of Dorts L and	227, 780	50.00
50. 00	[111]	battent routine s	services (110	III WKSt. D, Suii	I OI PAILS I AIR	227,760	30.00
51. 00	Pass through costs applicable to Program inp	patient ancillary	/ services (f	rom Wkst. D, s	sum of Parts II	146, 693	51.00
52. 00	and IV) Total Program excludable cost (sum of lines	50 and 51)				374, 473	52.00
53.00	Total Program inpatient operating cost exclu	uding capital rel	ated, non-ph	ysician anesth	etist, and	3, 044, 169	53.00
	medical education costs (line 49 minus line TARGET AMOUNT AND LIMIT COMPUTATION	52)					-
	Program di scharges					0	
55. 00 56. 00	Target amount per discharge Target amount (line 54 x line 55)					0.00	55. 00 56. 00
	Difference between adjusted inpatient operat	ting cost and tar	get amount (line 56 minus	line 53)	ő	1
58.00	Bonus payment (see instructions)					0	
59. 00	Lesser of lines 53/54 or 55 from the cost remarket basket	eporting period e	enaing 1996,	updated and co	ompounded by the	0.00	59.00
60.00	, ,					0.00	1
61.00	If line 53/54 is less than the lower of line which operating costs (line 53) are less that					0	61.00
	amount (line 56), otherwise enter zero (see		(g		
62. 00 63. 00	Relief payment (see instructions) Allowable Inpatient cost plus incentive paym	ment (see instruc	rtions)			0 0	1
	PROGRAM INPATIENT ROUTINE SWING BED COST						
64. 00	Medicare swing-bed SNF inpatient routine cosinstructions)(title XVIII only)	sts through Decem	mber 31 of th	e cost reporti	ng period (See	0	64.00
65.00	Medicare swing-bed SNF inpatient routine cos	sts after Decembe	er 31 of the	cost reportino	period (See	0	65.00
66. 00	<pre>instructions)(title XVIII only) Total Medicare swing-bed SNF inpatient routi</pre>	ne costs (line A	Manlus line	65)(title XVII	Lonly) For	0	66.00
00.00	CAH (see instructions)	ne costs (Trie c	of prus Tric	05)(11110 XVII	1 Om y). 101		00.00
67. 00	Title V or XIX swing-bed NF inpatient routin (line 12 x line 19)	ne costs through	December 31	of the cost re	eporting period	0	67.00
68. 00	Title V or XIX swing-bed NF inpatient routin	ne costs after De	ecember 31 of	the cost repo	orting period	0	68. 00
69. 00	(line 13 x line 20) Total title V or XIX swing-bed NF inpatient	routing costs (ino 67 : lin	0 69)		0	69. 00
69.00	PART III - SKILLED NURSING FACILITY, OTHER N						1 69.00
70.00	Skilled nursing facility/other nursing facil	•		, ,			70.00
71. 00 72. 00	Adjusted general inpatient routine service of Program routine service cost (line 9 x line		ne 70 ÷ 11ne	2)			71.00
73.00	Medically necessary private room cost applic		•				73.00
74. 00 75. 00	Total Program general inpatient routine services capital-related cost allocated to inpatient	,		•	art II. column		74. 00 75. 00
	26, line 45)		(11111				
76. 00 77. 00	Per diem capital-related costs (line 75 ÷ li Program capital-related costs (line 9 x line						76. 00 77. 00
78. 00	Inpatient routine service cost (line 74 minu	us líne 77)					78. 00
79. 00 80. 00	Aggregate charges to beneficiaries for exces Total Program routine service costs for comp	, ,		,	us line 79)		79. 00 80. 00
81.00	Inpatient routine service cost per diem limi	tati on		(11110 /0 11111	11110 17)		81.00
82. 00 83. 00	Inpatient routine service cost limitation (I						82. 00 83. 00
84. 00	Reasonable inpatient routine service costs (Program inpatient ancillary services (see in		2)				84.00
85.00	Utilization review - physician compensation	(see instruction					85.00
86. 00	Total Program inpatient operating costs (sum PART IV - COMPUTATION OF OBSERVATION BED PAS		ougn 85)				86.00
87.00	Total observation bed days (see instructions	5)				1, 768	•
88. 00 89. 00	Adjusted general inpatient routine cost per Observation bed cost (line 87 x line 88) (se	•	line 2)			1, 485. 21 2, 625, 851	
00	(30) (30)					_,,,,	

Health Financial Systems	HUNTI NGTON MEMO	RIAL HOSPITAL		In Lie	u of Form CMS-2	2552-10
COMPUTATION OF INPATIENT OPERATING COST		Provi der CO		Peri od:	Worksheet D-1	
				From 01/01/2019 To 12/31/2019		pared: 24 am_
		Title	XVIII	Hospi tal	PPS	
Cost Center Description	Cost	Routine Cost	column 1 ÷	Total	Observation	
		(from line	column 2	Observation	Bed Pass	
		21)		Bed Cost	Through Cost	
				(from line	(col. 3 x	
				89)	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	1, 136, 682	9, 093, 912	0. 12499	4 2, 625, 851	328, 216	90.00
91.00 Nursing School cost	0	9, 093, 912	0.00000	0 2, 625, 851	0	91.00
92.00 Allied health cost	0	9, 093, 912	0.00000	0 2, 625, 851	0	92.00
93.00 All other Medical Education	0	9, 093, 912	0. 00000	0 2, 625, 851	0	93. 00

Health Financial Systems	HUNTINGTON MEMORIAL HOSPITAL	In Lie	u of Form CMS-2	2552-10
COMPUTATION OF INPATIENT OPERATING COST	Provider CCN: 15-0091	Peri od: From 01/01/2019	Worksheet D-1	
		To 12/31/2019	Date/Time Pre 6/26/2020 11:	pared: 24 am_
	Title XIX	Hospi tal	PPS	
Cost Center Description				
			1. 00	
PART I - ALL PROVIDER COMPONENTS				
I NPATI ENT DAYS				

	Cook Contan Description	PPS	
	Cost Center Description	1. 00	
	PART I - ALL PROVIDER COMPONENTS	11.00	
	INPATIENT DAYS		
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)	6, 123	1.00
2. 00 3. 00	Inpatient days (including private room days, excluding swing-bed and newborn days) Private room days (excluding swing-bed and observation bed days). If you have only private room days,	6, 123 0	2. 00 3. 00
3.00	do not complete this line.	Ü	3.00
4.00	Semi-private room days (excluding swing-bed and observation bed days)	4, 355	4.00
5.00	Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost	0	5. 00
	reporting period	0	/ 00
6. 00	Total swing-bed SNF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	6. 00
7.00	Total swing-bed NF type inpatient days (including private room days) through December 31 of the cost	0	7. 00
	reporting period		
8. 00	Total swing-bed NF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	8. 00
9. 00	Total inpatient days including private room days applicable to the Program (excluding swing-bed and	67	9. 00
	newborn days) (see instructions)		
10. 00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days)	0	10. 00
11. 00	through December 31 of the cost reporting period (see instructions) Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) after	0	11. 00
00	December 31 of the cost reporting period (if calendar year, enter 0 on this line)	Ü	00
12. 00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days)	0	12. 00
13. 00	through December 31 of the cost reporting period Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days)	0	13. 00
13.00	after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	U	13.00
14.00	Medically necessary private room days applicable to the Program (excluding swing-bed days)	0	14.00
15. 00	Total nursery days (title V or XIX only)	619	15.00
16. 00	Nursery days (title V or XIX only) SWING BED ADJUSTMENT	20	16. 00
17. 00	Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost	0. 00	17. 00
	reporting period		
18. 00	Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost	0. 00	18. 00
19. 00	reporting period Medicaid rate for swing-bed NF services applicable to services through December 31 of the cost	0.00	19. 00
17.00	reporting period	0.00	17.00
20.00	Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost	0.00	20.00
21. 00	reporting period Total general inpatient routine service cost (see instructions)	9, 093, 912	21. 00
22. 00	Swing-bed cost applicable to SNF type services through December 31 of the cost reporting period (line		22.00
	5 x line 17)	_	
23. 00	Swing-bed cost applicable to SNF type services after December 31 of the cost reporting period (line 6	0	23. 00
24. 00	x line 18) Swing-bed cost applicable to NF type services through December 31 of the cost reporting period (line	0	24. 00
24.00	7 x line 19)	O	24.00
25.00	Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8	0	25.00
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)	9, 093, 912	27.00
	PRIVATE ROOM DIFFERENTIAL ADJUSTMENT	,	
28. 00	General inpatient routine service charges (excluding swing-bed and observation bed charges)	0	28. 00
29. 00	Private room charges (excluding swing-bed charges)	0	29.00
30. 00 31. 00	Semi-private room charges (excluding swing-bed charges) General inpatient routine service cost/charge ratio (line 27 ÷ line 28)	0. 000000	30. 00 31. 00
32. 00	Average private room per diem charge (line 29 ÷ line 3)	0.00000	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 minus line 33)(see instructions)	0. 00	34.00
35.00	Average per diem private room cost differential (line 34 x line 31)	0.00	35.00
36.00	Private room cost differential adjustment (line 3 x line 35)	0	36.00
37.00	General inpatient routine service cost net of swing-bed cost and private room cost differential (line	9, 093, 912	37. 00
	27 minus line 36) PART II - HOSPITAL AND SUBPROVIDERS ONLY		
	PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS		
38. 00	Adjusted general inpatient routine service cost per diem (see instructions)	1, 485. 21	38. 00
39. 00	Program general inpatient routine service cost (line 9 x line 38)	99, 509	39. 00
40.00	Medically necessary private room cost applicable to the Program (line 14 x line 35)	00 500	40.00
41. 00	Total Program general inpatient routine service cost (line 39 + line 40)	99, 509	41.00

9. 00	Total inpatient days including private room days applicable to the Program (excluding swing-bed and	67	9. 00
10.00	newborn days) (see instructions)	0	40.00
10. 00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days)	0	10.00
11 00	through December 31 of the cost reporting period (see instructions)	0	11 00
11. 00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) after	Ü	11. 00
10.00	December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	10.00
12. 00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days)	0	12.00
12 00	through December 31 of the cost reporting period	0	12 00
13. 00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days)	0	13.00
44.00	after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	44.00
14.00	Medically necessary private room days applicable to the Program (excluding swing-bed days)	0	
15.00	Total nursery days (title V or XIX only)	619	
16. 00	Nursery days (title V or XIX only)	20	16. 00
47.00	SWING BED ADJUSTMENT	0.00	17.00
17. 00	Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost	0. 00	17. 00
10.00	reporting period	0.00	40.00
18. 00	Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost	0. 00	18. 00
10.00	reporting period	0.00	40.00
19. 00	Medicaid rate for swing-bed NF services applicable to services through December 31 of the cost	0. 00	19. 00
00.00	reporting period	0.00	00 00
20. 00	Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost	0. 00	20.00
04 00	reporting period	0 000 010	04 00
21.00	Total general inpatient routine service cost (see instructions)	9, 093, 912	
22. 00	Swing-bed cost applicable to SNF type services through December 31 of the cost reporting period (line	0	22. 00
00.00	5 x line 17)	0	00.00
23. 00	Swing-bed cost applicable to SNF type services after December 31 of the cost reporting period (line 6	0	23. 00
04.00	X line 18)	0	04.00
24. 00	Swing-bed cost applicable to NF type services through December 31 of the cost reporting period (line	0	24.00
05.00	7 x line 19)	0	05 00
25. 00	Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8	0	25. 00
07.00	x line 20)	0	04 00
	Total swing-bed cost (see instructions)	0	0.00
27. 00	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)	9, 093, 912	27. 00
	PRIVATE ROOM DIFFERENTIAL ADJUSTMENT		
28. 00	General inpatient routine service charges (excluding swing-bed and observation bed charges)	0	
29. 00	Pri vate room charges (excluding swing-bed charges)	0	
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	Average semi-private room per diem charge (line 30 ÷ line 4)	0.00	
34.00	Average per diem private room charge differential (line 32 minus line 33)(see instructions)	0. 00	
	Average per diem private room cost differential (line 34 x line 31)	0.00	
36.00	Private room cost differential adjustment (line 3 x line 35)	0	
37.00	General inpatient routine service cost net of swing-bed cost and private room cost differential (line	9, 093, 912	37.00
	27 minus line 36)		
	PART II - HOSPITAL AND SUBPROVIDERS ONLY		
	PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS		
	Adjusted general inpatient routine service cost per diem (see instructions)	1, 485. 21	
	Program general inpatient routine service cost (line 9 x line 38)	99, 509	
	Medically necessary private room cost applicable to the Program (line 14 x line 35)	0	
41. 00	Total Program general inpatient routine service cost (line 39 + line 40)	99, 509	41.00

Heal th	Financial Systems HUNTIN	GTON MEMOR	IAL HOSPITAL		In Lie	u of Form CMS-2	2552-10
	ATION OF INPATIENT OPERATING COST		Provi der CC		Period: From 01/01/2019	Worksheet D-1	
					o 12/31/2019	Date/Time Pre 6/26/2020 11:	
			Title	e XIX	Hospi tal	PPS	24 alli
	·	otal ati ent	Total Inpatient	Average Per Diem (col. 1	Program Days	Program Cost (col. 3 x	
	. (Cost	Days	÷ col . 2)		col . 4)	
42.00	NURSERY (title V & XIX only)	1. 00 294, 767	2. 00 619	3. 00 476. 20	4. 00	5. 00	42.00
42.00	Intensive Care Type Inpatient Hospital Units	274, 707	017	470. 20	, 20	7, 324	42.00
43. 00 44. 00	INTENSIVE CARE UNIT						43. 00 44. 00
	BURN INTENSIVE CARE UNIT						45. 00
46. 00 47. 00	SURGICAL INTENSIVE CARE UNIT OTHER SPECIAL CARE (SPECIFY)						46. 00 47. 00
47.00	Cost Center Description						47.00
48. 00	Program inpatient ancillary service cost (Wkst. D-	-3 col 3	line 200)			1. 00 104, 107	48. 00
	Total Program inpatient costs (sum of lines 41 thr			ons)		213, 140	
50. 00	PASS THROUGH COST ADJUSTMENTS Pass through costs applicable to Program inpatient	routine s	carvicas (from	Wket D sum	of Parts I and	12, 916	50.00
30.00		. routine s	services (11011	i wkst. D, sum	or rarts r and	12, 710	30.00
51. 00	Pass through costs applicable to Program inpatient and IV)	tancillary	y services (fr	om Wkst. D, s	um of Parts II	9, 636	51.00
52.00	Total Program excludable cost (sum of lines 50 and					22, 552	
53. 00	Total Program inpatient operating cost excluding of medical education costs (line 49 minus line 52)	capital rel	ated, non-phy	sician anesth	etist, and	190, 588	53.00
	TARGET AMOUNT AND LIMIT COMPUTATION						
54. 00 55. 00	Program discharges Target amount per discharge					0 0. 00	
56.00	Target amount (line 54 x line 55)					0	56.00
57. 00 58. 00	Difference between adjusted inpatient operating co Bonus payment (see instructions)	ost and tar	rget amount (I	ine 56 minus	line 53)	0	57. 00 58. 00
59. 00	Lesser of lines 53/54 or 55 from the cost reporting	-					
60. 00	market basket Lesser of lines 53/54 or 55 from prior year cost r	report, upo	dated by the m	narket basket		0. 00	60. 00
61. 00	If line 53/54 is less than the lower of lines 55,	59 or 60 e	enter the less	er of 50% of		0	61.00
	which operating costs (line 53) are less than expected costs (lines 54 x 60), or 1% of the target amount (line 56), otherwise enter zero (see instructions)						
62.00 Relief payment (see instructions)							62.00
63.00 Allowable Inpatient cost plus incentive payment (see instructions) PROGRAM INPATIENT ROUTINE SWING BED COST							63.00
64. 00	Medicare swing-bed SNF inpatient routine costs thr instructions)(title XVIII only)	ough Decer	mber 31 of the	cost reporti	ng period (See	0	64.00
65.00	Medicare swing-bed SNF inpatient routine costs aft	ter Decembe	er 31 of the c	ost reporting	period (See	0	65.00
66 00	instructions)(title XVIII only) Total Medicare swing-bed SNF inpatient routine cos	sts (line 6	64 nlus line 6	5)(title XVII	l only) For	0	66. 00
	CAH (see instructions)	•	·		3,		
67. 00	Title V or XIX swing-bed NF inpatient routine cost (line 12 x line 19)	ts through	December 31 c	of the cost re	porting period	0	67. 00
68. 00	Title V or XIX swing-bed NF inpatient routine cost	ts after De	ecember 31 of	the cost repo	rting period	0	68. 00
69. 00	<pre>(line 13 x line 20) Total title V or XIX swing-bed NF inpatient routir</pre>	ne costs (I	ine 67 + line	e 68)		0	69. 00
70.00	PART III - SKILLED NURSING FACILITY, OTHER NURSING	FACILITY,	AND ICF/IID	ONLY			70.00
70. 00 71. 00	Skilled nursing facility/other nursing facility/10 Adjusted general inpatient routine service cost pe			,			70. 00 71. 00
72. 00 73. 00	Program routine service cost (line 9 x line 71) Medically necessary private room cost applicable 1	to Drogram	(lino 14 v li	no 3E)			72. 00 73. 00
74. 00	Total Program general inpatient routine service of						74.00
75. 00	Capital-related cost allocated to inpatient routing 26, line 45)	ne servi ce	costs (from W	lorksheet B, P	art II, column		75. 00
76. 00	Per diem capital-related costs (line 75 ÷ line 2)						76. 00
77. 00 78. 00	Program capital-related costs (line 9 x line 76) Inpatient routine service cost (line 74 minus line	- 77)					77. 00 78. 00
79. 00	Aggregate charges to beneficiaries for excess cost	ts (from pr					79. 00
80. 00 81. 00	Total Program routine service costs for comparisor Inpatient routine service cost per diem limitation		ost limitation	ı (line 78 min	us line 79)		80. 00 81. 00
82.00	Inpatient routine service cost limitation (line 9	x line 81)					82. 00
83. 00 84. 00	Reasonable inpatient routine service costs (see in Program inpatient ancillary services (see instruct		5)				83. 00 84. 00
85.00	Utilization review - physician compensation (see i	nstructi or					85.00
86. 00	Total Program inpatient operating costs (sum of li PART IV - COMPUTATION OF OBSERVATION BED PASS THRO		ough 85)				86. 00
87. 00	Total observation bed days (see instructions)		11 0			1, 768	
88. 00 89. 00	Adjusted general inpatient routine cost per diem (Observation bed cost (line 87 x line 88) (see inst		iine 2)			1, 485. 21 2, 625, 851	88. 00 89. 00
		,					•

Health Financial Systems	HUNTI NGTON MEMO	RIAL HOSPITAL		In Lie	u of Form CMS-2	2552-10
COMPUTATION OF INPATIENT OPERATING COST		Provi der CO		Peri od:	Worksheet D-1	
				From 01/01/2019 To 12/31/2019		
		Ti tl	e XIX	Hospi tal	PPS	
Cost Center Description	Cost	Routine Cost	column 1 ÷	Total	Observation	
		(from line	column 2	Observati on	Bed Pass	
		21)		Bed Cost	Through Cost	
				(from line	(col. 3 x	
				89)	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	1, 136, 682	9, 093, 912	0. 12499	4 2, 625, 851	328, 216	90.00
91.00 Nursing School cost	0	9, 093, 912	0.00000	0 2, 625, 851	0	91.00
92.00 Allied health cost	0	9, 093, 912	0.00000	0 2, 625, 851	0	92.00
93.00 All other Medical Education	0	9, 093, 912	0. 00000	0 2, 625, 851	0	93. 00

NPATIENT AN	NCILLARY SERVICE COST APPORTIONMENT	Provi der C	CN: 15-0091	Peri od: From 01/01/2019 To 12/31/2019	Worksheet D-3 Date/Time Pre 6/26/2020 11:	pared:
		Titl∈	e XVIII	Hospi tal	PPS	
	Cost Center Description		Ratio of Cos		I npati ent	
			To Charges	9	Program Costs	
				Charges	(col. 1 x	
					col. 2)	
			1.00	2. 00	3. 00	
	IENT ROUTINE SERVICE COST CENTERS					
	ADULTS & PEDIATRICS			2, 515, 679	1	30.00
	NURSERY					43.00
	LARY SERVICE COST CENTERS					
	OPERATING ROOM		0. 0941		1	
	OPERATING ROOM		0. 0000		0	
	DELIVERY ROOM & LABOR ROOM		0. 2661		0	
	ANESTHESI OLOGY		0. 4161		0	1
	RADI OLOGY-DI AGNOSTI C		0. 1118			
	LABORATORY		0. 1580			
	BLOOD CLOTTING FOR HEMOPHILIACS		0.0000			
	RESPI RATORY THERAPY		0. 2195			
	PHYSI CAL THERAPY		0. 6177			
	OCCUPATIONAL THERAPY		0. 2447			
	SPEECH PATHOLOGY		0. 4143			
	ELECTROCARDIOLOGY MEDICAL SUPPLIES CHARGED TO PATIENT		0. 0001 0. 3849			
4	IMPL. DEV. CHARGED TO PATTENT		0. 3849	·		
	DRUGS CHARGED TO PATIENTS		0. 2809	·		
	CARDI AC REHABI LI TATI ON		0. 1878			
	HYPERBARIC OXYGEN THERAPY		0. 3581		-	76. 9
	LI THOTRI PSY		0. 0000		1	
	TIENT SERVICE COST CENTERS		0.0000	00 0	0	70.9
90. 00 09000	CLINIC		0. 2210	18 C	0	90.0
	EMERGENCY		0. 1063			
	OBSERVATION BEDS (NON-DISTINCT PART		0. 4436			
	REIMBURSABLE COST CENTERS		0. 4430	,0		1 /2.0
	AMBULANCE SERVICES					95.0
200. 00	Total (sum of lines 50 through 94 and 96 through	98)		9, 287, 067	1, 596, 289	
201. 00	Less PBP Clinic Laboratory Services-Program only			7, 207, 007		201. 0
	Net charges (line 200 minus line 201)	charges (True 01)		9, 287, 067	1	202. 0

	ancial Systems HUNTINGTON MEMORIA ANCILLARY SERVICE COST APPORTIONMENT	Provi der C	CN: 15-0091	Peri od:	u of Form CMS-2 Worksheet D-3	
	WIGHT SERVINGE GOOD THE GIVEN CHIMENT			From 01/01/2019		
				To 12/31/2019		pared:
		Ti +I	e XIX	Hospi tal	6/26/2020 11: PPS	24 am
	Cost Center Description	11 (1	Ratio of Cos		Inpati ent	
	COST CENTER BESCHIPTION		To Charges	Program	Program Costs	
			l o onal goo	Charges	(col. 1 x	
					col . 2)	
			1.00	2. 00	3. 00	
	TIENT ROUTINE SERVICE COST CENTERS					
	O ADULTS & PEDIATRICS			143, 638		30.00
	0 NURSERY			32, 933		43.00
	LLARY SERVICE COST CENTERS					1
	O OPERATING ROOM		0. 0941		22, 013	
	1 OPERATING ROOM		0.0000		0	
	O DELIVERY ROOM & LABOR ROOM		0. 2661		20, 744	
	O ANESTHESI OLOGY		0. 4161		0	
	O RADI OLOGY-DI AGNOSTI C		0. 1118		6, 772	
	O LABORATORY		0. 1580		15, 905	
	O BLOOD CLOTTING FOR HEMOPHILIACS		0.0000		0	62. 30
	O RESPIRATORY THERAPY		0. 2195		4, 425	
	O PHYSI CAL THERAPY		0. 6177		781	66.00
	O OCCUPATI ONAL THERAPY		0. 2447		0	67.0
	O SPEECH PATHOLOGY O ELECTROCARDI OLOGY		0. 4143 0. 0001		0	69.0
	O MEDICAL SUPPLIES CHARGED TO PATIENT		0.0001		1 8, 882	
	O IMPL. DEV. CHARGED TO PATIENTS		0. 3849		8,882	
	O DRUGS CHARGED TO PATIENTS		0. 2809		16, 791	73.00
	7 CARDI AC REHABI LI TATI ON		0. 1878		10, 741	1
	8 HYPERBARI C OXYGEN THERAPY		0. 3581		0	76. 9
	9 LI THOTRI PSY		0.0000		0	
	ATIENT SERVICE COST CENTERS		0.0000	00 0	0	/0. /
	O CLINIC		0. 2210	18 0	0	90.00
	O EMERGENCY		0. 1063		7, 793	
	O OBSERVATION BEDS (NON-DISTINCT PART		0. 4436		0	
	R REIMBURSABLE COST CENTERS		21.100			1
	O AMBULANCE SERVICES					95.0
200. 00	Total (sum of lines 50 through 94 and 96 through 98)			688, 019	104, 107	
201. 00	Less PBP Clinic Laboratory Services-Program only charges	(line 61)		0		201.00
202. 00	Net charges (line 200 minus line 201)			688, 019		202.00

Health Financial Systems	HUNTINGTON MEMORIAL HOSPITAL	In Lieu	u of Form CMS-2552-10
CALCULATION OF REIMBURSEMENT SETTLEMENT	Provi der CCN: 15-0091	Peri od: From 01/01/2019 To 12/31/2019	Worksheet E Part A Date/Time Prepared: 6/26/2020 11:24 am

		T' 11	Here the Land	6/26/2020 11:	24 am
		Title XVIII	Hospi tal	PPS	
				1. 00	
4 00	PART A - INPATIENT HOSPITAL SERVICES UNDER IPPS DRG Amounts Other than Outlier Payments		T	0	4 00
1. 00 1. 01	DRG amounts other than outlier payments for discharges occurring prior to October 1 (see instructions)				1. 00 1. 01
1. 02	DRG amounts other than outlier payments for discharges occurring instructions)	on or after October	1 (see	673, 517	1. 02
1. 03	DRG for federal specific operating payment for Model 4 BPCI for (1) (see instructions)	di scharges occurri ng	prior to October	0	1.03
1. 04	DRG for federal specific operating payment for Model 4 BPCI for (October 1 (see instructions)	di scharges occurri ng	on or after	0	1. 04
2.00	Outlier payments for discharges. (see instructions)			0	2.00
2. 01 2. 02	Outlier reconciliation amount Outlier payment for discharges for Model 4 BPCI (see instructions	(2		0	2. 01 2. 02
2. 03	Outlier payments for discharges occurring prior to October 1 (see	•		0	2.03
2. 04	Outlier payments for discharges occurring on or after October 1			0	2.04
3.00	Managed Care Simulated Payments	,		3, 624, 533	3.00
4.00	Bed days available divided by number of days in the cost reporting	ng period (see instru	ctions)	30. 91	4.00
5. 00	Indirect Medical Education Adjustment FTE count for allopathic and osteopathic programs for the most re	ecent cost reporting	period ending on	0.00	5. 00
	or before 12/31/1996. (see instructions)				
6. 00	FTE count for allopathic and osteopathic programs that meet the new programs in accordance with 42 CFR 413.79(e)			0.00	6.00
7. 00 7. 01	MMA Section 422 reduction amount to the IME cap as specified under ACA § 5503 reduction amount to the IME cap as specified under 42			0. 00 0. 00	7. 00 7. 01
8. 00	cost report straddles July 1, 2011 then see instructions. Adjustment (increase or decrease) to the FTE count for allopathic affiliated programs in accordance with 42 CFR 413.75(b), 413.79(c) and (7.75 F0600) (August 1, 2002)	c and osteopathic pro c)(2)(iv), 64 FR 2634	grams for O (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 report straddles July 1, 2011, see instructions.	under § 5503 of the	ACA. If the cost	0.00	8. 01
8. 02	The amount of increase if the hospital was awarded FTE cap slots under § 5506 of ACA. (see instructions)	from a closed teachi	ng hospital	0. 00	8. 02
9. 00	Sum of lines 5 plus 6 minus lines (7 and 7.01) plus/minus lines instructions)	(8, 8,01 and 8,02) (see	0. 00	9. 00
10.00	FTE count for allopathic and osteopathic programs in the current	year from your recor	ds	0. 00	10.00
11.00	FTE count for residents in dental and podiatric programs.	3		0.00	11.00
12.00	Current year allowable FTE (see instructions)			0.00	12.00
13.00	Total allowable FTE count for the prior year.			0. 00	
14. 00	Total allowable FTE count for the penultimate year if that year	ended on or after Sep	tember 30, 1997,	0. 00	14.00
15 00	otherwise enter zero.			0.00	15 00
15. 00 16. 00	Sum of lines 12 through 14 divided by 3. Adjustment for residents in initial years of the program			0.00	15. 00 16. 00
17. 00	Adjustment for residents displaced by program or hospital closure	Α.			17. 00
18. 00	Adjusted rolling average FTE count			0.00	
19.00	Current year resident to bed ratio (line 18 divided by line 4).			0.000000	
20.00	Prior year resident to bed ratio (see instructions)			0.000000	20.00
21. 00	Enter the lesser of lines 19 or 20 (see instructions)			0.000000	21.00
22. 00	IME payment adjustment (see instructions)			0	22.00
22. 01		6 +h- 1000		0	22. 01
23. 00	Indirect Medical Education Adjustment for the Add-on for § 422 of Number of additional allopathic and osteopathic IME FTE resident		FR 412. 105	0.00	23. 00
24. 00	(f)(1)(iv)(C). IME FTE Resident Count Over Cap (see instructions)			0.00	24.00
25. 00	If the amount on line 24 is greater than -O-, then enter the low instructions)	er of line 23 or line	24 (see	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 patie	ent days (see instruc	tions)	3. 26	30.00
31. 00	Percentage of Medicaid patient days (see instructions)	one days (see mistrate	5113)	23. 46	
32. 00	Sum of lines 30 and 31			26. 72	
33. 00	Allowable disproportionate share percentage (see instructions)			11. 26	
	Disproportionate share adjustment (see instructions)			76, 159	

	Financial Systems HUNTINGTON MEMOR ATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 15-0091	Period:	u of Form CMS-: Worksheet E	∠552-1	
CALCUI	ATTON OF RETWINDORSEMENT SETTLEMENT	110VI del CCN. 13-0071	From 01/01/2019	Part A		
			To 12/31/2019	Date/Time Pre 6/26/2020 11:		
		Title XVIII	Hospi tal	PPS		
			Prior to 10/1 1.00	0n/After 10/1 2.00		
	Uncompensated Care Adjustment		1.00	2.00		
35. 00	Total uncompensated care amount (see instructions)			8, 350, 599, 096		
35. 01 35. 02	,	ter zero on this line) (s	0. 000077451 ee 640, 742	0. 000092584 773, 132	1	
33. 02	instructions)	ter zero on tima rine) (a	040,742	773, 132	33.0.	
35. 03	Pro rata share of the hospital uncompensated care payment an		479, 240		•	
36.00	Total uncompensated care (sum of columns 1 and 2 on line 35. Additional payment for high percentage of ESRD beneficiary of		673, 579 ugh 46)		36.0	
40. 00	Total Medicare discharges on Worksheet S-3, Part I excluding		0		40.0	
11 00	652, 682, 683, 684 and 685 (see instructions)	402 404 on 40E 4000			11 0	
41. 00	Total ESRD Medicare discharges excluding MS-DRGs 652, 682, instructions)	683, 684 an 685. (See	0		41.0	
41. 01	1 3 3	S-DRGs 652, 682, 683, 68	4 0		41.0	
42. 00	an 685. (see instructions) Divide line 41 by line 40 (if less than 10%, you do not qual	lify for adjustment)	0.00		42.0	
43. 00	Total Medicare ESRD inpatient days excluding MS-DRGs 652, 6				43.0	
	instructions)					
44. 00	Ratio of average length of stay to one week (line 43 divided days)	d by line 41 divided by /	0. 000000		44.0	
45. 00	Average weekly cost for dialysis treatments (see instruction		0.00		45.00	
46. 00 47. 00	1	41. 01)	0 3, 455, 202		46.00	
47. 00	Subtotal (see instructions) Hospital specific payments (to be completed by SCH and MDH,	small rural hospitals	3, 455, 202		48.0	
	only. (see instructions)					
				Amount 1.00		
49. 00	Total payment for inpatient operating costs (see instruction	ns)		3, 455, 202	49.0	
50.00	Payment for inpatient program capital (from Wkst. L, Pt. I a)	216, 330	•	
51. 00 52. 00	Exception payment for inpatient program capital (Wkst. L, PDirect graduate medical education payment (from Wkst. E-4, I			0		
53. 00	Nursing and Allied Health Managed Care payment	Title 47 See Thistractions,	•	0	1	
54. 00	Special add-on payments for new technologies			0		
54. 01 55. 00	Islet isolation add-on payment Net organ acquisition cost (Wkst. D-4 Pt. III, col. 1, line	69)		0	1	
56. 00	Cost of physicians' services in a teaching hospital (see in			0	1	
57. 00	Routine service other pass through costs (from Wkst. D, Pt.		through 35).	0		
58. 00 59. 00	Ancillary service other pass through costs from Wkst. D, Pt. Total (sum of amounts on lines 49 through 58)	. IV, col. 11 line 200)		0 3, 671, 532		
60.00	Primary payer payments			14, 873	1	
61.00	Total amount payable for program beneficiaries (line 59 minu	us line 60)		3, 656, 659	1	
62. 00 63. 00	Deductibles billed to program beneficiaries Coinsurance billed to program beneficiaries			492, 237 0	1	
	Allowable bad debts (see instructions)			28, 018		
65.00	Adjusted reimbursable bad debts (see instructions)			18, 212	1	
66. 00 67. 00	Allowable bad debts for dual eligible beneficiaries (see ins Subtotal (line 61 plus line 65 minus lines 62 and 63)	structi ons)		9, 770 3, 182, 634	1	
68. 00	Credits received from manufacturers for replaced devices for	r applicable to MS-DRGs (see instructions)		1	
59. 00	Outlier payments reconciliation (sum of lines 93, 95 and 96)).(For SCH see instructio	ns)	0	1	
70. 00 70. 50	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY) Rural Community Hospital Demonstration Project (§410A Demons	etration) adjustment (see	instructions)	0		
70. 50 70. 87	Demonstration payment adjustment amount before sequestration	, ,	matructi ona)	0	1	
10.01	SCH or MDH volume decrease adjustment (contractor use only)			0	1	
70. 88	Pioneer ACO demonstration payment adjustment amount (see ins	structions)		0	70.8	
70. 88 70. 89				0	1	
70. 88 70. 89 70. 90	HSP bonus payment HVBP adjustment amount (see instructions) HSP bonus payment HRR adjustment amount (see instructions)	91 HSP bonus payment HRR adjustment amount (see instructions)				
70. 88 70. 89 70. 90 70. 91 70. 92				0	•	
70. 88 70. 89 70. 90 70. 91	HSP bonus payment HRR adjustment amount (see instructions)				70. 9 70. 9	

Heal th	Financial Systems HUNTINGTON MEMO	ORIAL HOSPITAL		Inlie	u of Form CMS-2	2552-10
	ATION OF REIMBURSEMENT SETTLEMENT		CN: 15-0091	Peri od:	Worksheet E	2002 10
				From 01/01/2019	Part A	
				To 12/31/2019	Date/Time Pre 6/26/2020 11:	epared: 24 am
		Title	: XVIII	Hospi tal	PPS	
			FFY	(yyyy)	Amount	
				0	1. 00	
70. 96	Low volume adjustment for federal fiscal year (yyyy) (Enterthe corresponding federal year for the period prior to 10/		2	2019	416, 738	70. 96
70. 97	Low volume adjustment for federal fiscal year (yyyy) (Enter the corresponding federal year for the period ending on or	er in column 0	2	2020	133, 334	70. 97
70. 98	Low Volume Payment-3	ditter 10/1)			0	70. 98
70. 99	HAC adjustment amount (see instructions)				42, 224	
71.00	Amount due provider (line 67 minus lines 68 plus/minus lin	nes 69 & 70)			3, 706, 996	
71. 01	Sequestration adjustment (see instructions)	,			74, 140	71. 01
71. 02	Demonstration payment adjustment amount after sequestration	on			0	71. 02
71.03	Sequestration adjustment-PARHM pass-throughs					71.03
	Interim payments				3, 641, 828	
	Interim payments-PARHM					72. 01
73. 00	1				0	
73. 01	Tentative settlement-PARHM (for contractor use only)					73. 01
74. 00	Balance due provider/program (line 71 minus lines 71.01, 773)	71.02, 72, and			-8, 972	74.00
74. 01	Balance due provider/program-PARHM (see instructions)					74. 01
75. 00		ordance with			61, 402	75. 00
	CMS Pub. 15-2, chapter 1, §115.2					
00.00	TO BE COMPLETED BY CONTRACTOR (lines 90 through 96)	6.0.00				
90. 00	Operating outlier amount from Wkst. E, Pt. A, line 2, or s plus 2.04 (see instructions)	sum or 2.03			0	90.00
91.00	Capital outlier from Wkst. L, Pt. I, line 2				0	91.00
92. 00		nstructions)			0	1
93.00	Capital outlier reconciliation adjustment amount (see inst				0	93.00
94.00	The rate used to calculate the time value of money (see in				0.00	94.00
95.00					0	95.00
96.00	Time value of money for capital related expenses (see inst	tructions)			0	96.00
				Prior to 10/1		
	luar a constant and a constant and a constant and a constant and a constant and a constant and a constant and a constant and a constant and a constant and a constant and a constant and a constant and a constant and a constant and a constant and a constant and a constant and a constant and a constant and a constant and a constant and a constant and a constant and a constant and a constant and a constant and a constant and a constant and a constant and a constant and a constant and a constant and a constant and a constant and a constant and a constant and a constant and a constant and a constant and a constant and a constant and a constant and a constant and a constant and a constant and a constant and a constant and a constant and a constant and a constant and a constant and a constant and a constant and a constant and a constant and a constant and a constant and a constant and a constant and a constant and a constant and a constant and a constant and a constant and a constant and a constant and a constant and a constant and a constant and a constant and a constant and a constant and a constant and a constant and a constant and a constant and a constant and a constant and a constant and a constant and a constant and a constant and a constant and a constant and a constant and a constant and a constant and a constant and a constant and a constant and a constant and a constant and a constant and a constant and a constant and a constant and a constant and a constant and a constant and a constant and a constant and a constant and a constant and a constant and a constant and a constant and a constant and a constant and a constant and a constant and a constant and a constant and a constant and a constant and a constant and a constant and a constant and a constant and a constant and a constant and a constant and a constant and a constant and a constant and a constant and a constant and a constant and a constant and a constant and a constant and a constant and a constant and a constant and a constant and a constant and a			1. 00	2. 00	
100.00	HSP Bonus Payment Amount					100.00
100.00	HSP bonus amount (see instructions)			0	0	100.00
101 00	HVBP Adjustment for HSP Bonus Payment HVBP adjustment factor (see instructions)			0. 0000000000	0. 0000000000	101 00
	HVBP adjustment amount for HSP bonus payment (see instruct	tions)		0.000000000		102.00
102.00	HRR Adjustment for HSP Bonus Payment	11 0113)		<u> </u>		102.00
103 00	HRR adjustment factor (see instructions)			0.0000	0.0000	103 00
	HRR adjustment amount for HSP bonus payment (see instructi	ons)		0.0000		104.00
	Rural Community Hospital Demonstration Project (§410A Demo		ustment	<u> </u>		1.000
200.00	Is this the first year of the current 5-year demonstration					200.00
	Century Cures Act? Enter "Y" for yes or "N" for no.	·				
	Cost Reimbursement					
	Medicare inpatient service costs (from Wkst. D-1, Pt. II,	line 49)				201.00
202.00	Medicare discharges (see instructions)					202. 00
203.00	Case-mix adjustment factor (see instructions)					203. 00
	Computation of Demonstration Target Amount Limitation (N/A	in first year	of the curre	nt 5-year demons	tration	
204.00	period) Medicare target amount					204.00
204. UL	AMERICALE LALYEL AMBUTT					12U4.UU

Health Financial Systems	HUNTINGTON MEMORIAL HOSPITAL	In Lieu	u of Form CMS-2552-10
CALCULATION OF REIMBURSEMENT SETTLEMENT	Provi der CCN: 15-0091	Peri od: From 01/01/2019 To 12/31/2019	Worksheet E Part B Date/Time Prepared: 6/26/2020 11:24 am

		Title XVIII	Hospi tal	6/26/2020 11: PPS	24 am_
			1.0001 tai		
	DADT D. MEDICAL AND OTHER HEALTH CERVICES			1. 00	
1. 00	PART B - MEDICAL AND OTHER HEALTH SERVICES Medical and other services (see instructions)			0	1.00
2. 00	Medical and other services (see Fristractions)	ns)		4, 042, 388	
3.00	OPPS payments			3, 565, 052	1
4.00	Outlier payment (see instructions)			18, 263	4.00
4. 01	Outlier reconciliation amount (see instructions)			0	
5.00	Enter the hospital specific payment to cost ratio (see instructi	ons)		0. 859	1
6. 00 7. 00	Line 2 times line 5			3, 472, 411 0. 00	1
8. 00	Sum of lines 3, 4, and 4.01, divided by line 6 Transitional corridor payment (see instructions)			0.00	1
9. 00	Ancillary service other pass through costs from Wkst. D, Pt. IV,	col. 13. line 200		ő	1
10.00	Organ acqui si ti ons	•		0	1
11. 00	Total cost (sum of lines 1 and 10) (see instructions)			0	11.00
	COMPUTATION OF LESSER OF COST OR CHARGES				1
12. 00	Reasonable charges Ancillary service charges			0	12.00
	Organ acquisition charges (from Wkst. D-4, Pt. III, col. 4, line	. 69)		0	
	Total reasonable charges (sum of lines 12 and 13)	<i>37)</i>		0	
	Customary charges]
15.00	Aggregate amount actually collected from patients liable for pay			0	
16. 00	Amounts that would have been realized from patients liable for p	ayment for services of	on a chargebasis	0	16.00
17. 00	had such payment been made in accordance with 42 CFR §413.13(e) Ratio of line 15 to line 16 (not to exceed 1.000000)			0. 000000	17.00
18. 00	Total customary charges (see instructions)			0.000000	
19.00	Excess of customary charges over reasonable cost (complete only	if line 18 exceeds li	ne 11) (see	0	1
	instructions)				
20. 00	Excess of reasonable cost over customary charges (complete only	if line 11 exceeds li	ne 18) (see	0	20.00
21. 00	instructions) Lesser of cost or charges (see instructions)			0	21.00
	Interns and residents (see instructions)			0	1
	Cost of physicians' services in a teaching hospital (see instruc	tions)		0	1
24.00	Total prospective payment (sum of lines 3, 4, 4.01, 8 and 9)	<u> </u>		3, 583, 315	24.00
	COMPUTATION OF REIMBURSEMENT SETTLEMENT				
25.00	Deductibles and coinsurance amounts (for CAH, see instructions)	14 (for CALL occ inctr	ruati ana)	701 774	
26.00	Deductibles and Coinsurance amounts relating to amount on line 2 Subtotal [(lines 21 and 24 minus the sum of lines 25 and 26) plu			701, 776 2, 881, 539	1
27.00	instructions)	3 the sum of filles 22	. and 25] (366	2,001,337	27.00
28.00	Direct graduate medical education payments (from Wkst. E-4, line	50)		0	28. 00
	ESRD direct medical education costs (from Wkst. E-4, line 36)			0	
30.00	Subtotal (sum of lines 27 through 29)			2, 881, 539	1
31.00	Primary payer payments Subtotal (line 30 minus line 31)			334 2, 881, 205	1
32.00	ALLOWABLE BAD DEBTS (EXCLUDE BAD DEBTS FOR PROFESSIONAL SERVICES)		2,001,203	32.00
33.00	Composite rate ESRD (from Wkst. I-5, line 11)			0	33.00
	Allowable bad debts (see instructions)			41, 933	1
	Adjusted reimbursable bad debts (see instructions)	11		27, 256	1
36.00	Allowable bad debts for dual eligible beneficiaries (see instruc Subtotal (see instructions)	tions)		38, 585 2, 908, 461	1
	MSP-LCC reconciliation amount from PS&R			2, 700, 401	
39. 00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)			0	
39. 50	Pioneer ACO demonstration payment adjustment (see instructions)				39. 50
39. 97	Demonstration payment adjustment amount before sequestration			0	
	Partial or full credits received from manufacturers for replaced RECOVERY OF ACCELERATED DEPRECIATION	devices (see instruc	ctions)	0	
39. 99 40. 00	Subtotal (see instructions)			0 2, 908, 461	
40. 01	Sequestration adjustment (see instructions)			58, 169	1
40. 02	Demonstration payment adjustment amount after sequestration			0	1
	Sequestration adjustment-PARHM pass-throughs				40. 03
	Interim payments			2, 810, 956	1
	Interim payments-PARHM			_	41.01
42. 00 42. 01	Tentative settlement (for contractors use only) Tentative settlement-PARHM (for contractor use only)			0	42. 00 42. 01
43. 00	Balance due provider/program (see instructions)			39, 336	1
43. 01	Balance due provider/program-PARHM (see instructions)				43. 01
44.00	Protested amounts (nonallowable cost report items) in accordance	with CMS Pub. 15-2,	chapter 1,	0	44.00
	§115. 2				1
90 00	TO BE COMPLETED BY CONTRACTOR Original outlier amount (see instructions)			0	90.00
	Outlier reconciliation adjustment amount (see instructions)			0	1
	The rate used to calculate the Time Value of Money			0.00	1
93.00	Time Value of Money (see instructions)			0	93.00
94.00	Total (sum of lines 91 and 93)			0	94.00

Health Financial Systems HUNTING ANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED Peri od: Worksheet E-1 From 01/01/2019 Part I To 12/31/2019 Date/Ti me Prepared: 6/26/2020 11:24 am Provider CCN: 15-0091

					6/26/2020 11: 2	24 am
		Title	XVIII	Hospi tal	PPS	
		Inpatien	t Part A	Par	t B	
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount	
		1, 00	2.00	3. 00	4. 00	
1. 00	Total interim payments paid to provider		3, 641, 82	28	2, 810, 956	1.00
2. 00	Interim payments payable on individual bills, either submitted or to be submitted to the contractor for services rendered in the cost reporting period. If none,		3, 3, 1, 32	0	0	2. 00
3.00	write "NONE" or enter a zero List separately each retroactive lump sum adjustment 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)					3.00
	Program to Provider					
3. 01 3. 02 3. 03 3. 04 3. 05	ADJUSTMENTS TO PROVIDER			0 0 0 0	0 0 0	3. 01 3. 02 3. 03 3. 04 3. 05
0.00	Provider to Program			<u> </u>		0.00
3. 50 3. 51 3. 52	ADJUSTMENTS TO PROGRAM			0 0	0 0	3. 50 3. 51 3. 52
3. 53 3. 54				0	0 0	3. 53 3. 54
3. 99	Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98)			0	0	3. 99
4. 00	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Wkst. E or Wkst. E-3, line and column as appropriate) TO BE COMPLETED BY CONTRACTOR		3, 641, 82	28	2, 810, 956	4.00
5. 00	List separately each tentative settlement payment after desk review. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					5. 00
	Program to Provider					
5. 01	TENTATI VE TO PROVI DER			0	0	5. 01
5. 02				0	0	5.02
5. 03				0	0	5.03
	Provider to Program					
5.50	TENTATI VE TO PROGRAM			0	0	5.50
5. 51				0	0	5. 51
5. 52				0	0	5. 52
5. 99	Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98)			0	0	5. 99
6. 00	Determined net settlement amount (balance due) based on the cost report. (1)					6. 00
6. 01	SETTLEMENT TO PROVIDER			0	39, 336	6. 01
6.02	SETTLEMENT TO PROGRAM		8, 97	72	0	6.02
7.00	Total Medicare program liability (see instructions)		3, 632, 85	56	2, 850, 292	7.00
_				Contractor Number	NPR Date (Mo/Day/Yr)	
		()	1. 00	2. 00	
8. 00	Name of Contractor					8.00

Heal th	Financial Systems HUNTINGTON MEMORI	AL HOSPITAL	In Lie	u of Form CMS-	2552-10
CALCUL	CALCULATION OF REIMBURSEMENT SETTLEMENT FOR HIT Provider CCN: 15-0091 Period: From 01/01/2019				
			To 12/31/2019	Date/Time Pre 6/26/2020 11:	
		Title XVIII	Hospi tal	PPS	
				1. 00	
	TO BE COMPLETED BY CONTRACTOR FOR NONSTANDARD COST REPORTS				4
4 00	HEALTH INFORMATION TECHNOLOGY DATA COLLECTION AND CALCULATION				4
1.00	Total hospital discharges as defined in AARA §4102 from Wkst.		e 14		1.00
2.00	Medicare days from Wkst. S-3, Pt. I, col. 6 sum of lines 1, 8	8-12			2.00
3.00	Medicare HMO days from Wkst. S-3, Pt. I, col. 6. line 2	2 12			3.00
4. 00 5. 00	Total inpatient days from S-3, Pt. I col. 8 sum of lines 1, 8	8-12			4. 00 5. 00
6. 00	Total hospital charges from Wkst C, Pt. I, col. 8 line 200 Total hospital charity care charges from Wkst. S-10, col. 3 l	line 20			6.00
7. 00	CAH only - The reasonable cost incurred for the purchase of		What C 2 Dt I		7.00
7.00	line 168	Lei ti i led Hi i tecillology	WKS1. 3-2, Pt. 1		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				
30.00	30.00 Initial/interim HIT payment adjustment (see instructions)				
31.00	Other Adjustment (specify)				31.00
32. 00	Balance due provider (line 8 (or line 10) minus line 30 and l	line 31) (see instructio	ns)		32.00

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

Provi der CCN: 15-0091

Peri od: Worksheet G From 01/01/2019 To 12/31/2019 Date/Time Prepared: 6/26/2020 11: 24 am

J 37		General Fund	Specific	Endowment	6/26/2020 11: Plant Fund	24 am
		1.00	Purpose Fund 2.00	Fund 3. 00	4. 00	
	CURRENT ASSETS					
1.00	Cash on hand in banks	2, 324	1	0	0	1.00
2.00	Temporary investments	0	0	0	0	2.00
3. 00 4. 00	Notes recei vabl e Accounts recei vabl e	23, 710, 836	_	0	0	3. 00 4. 00
5. 00	Other recei vable	1, 437, 289	1	0	0	5.00
6. 00	Allowances for uncollectible notes and accounts receivable		1	ő	0	6.00
7.00	Inventory	538, 815	1	o	0	7.00
8. 00	Prepai d expenses	60, 825	0	0	0	8. 00
9. 00	Other current assets	0	0	0	0	9. 00
10.00	Due from other funds	-7, 008, 059	1	0	0	10.00
11. 00	Total current assets (sum of lines 1-10)	4, 571, 358	0	0	0	11.00
12. 00	FIXED ASSETS Land	1	0	ol	0	12.00
13. 00	Land improvements	625, 461		o	0	13.00
14. 00	Accumulated depreciation	-400, 927	o o	ol	0	14.00
15. 00	Bui I di ngs	9, 260, 360	0	o	0	15.00
16.00	Accumulated depreciation	-1, 783, 316	0	o	0	16.00
17. 00	Leasehold improvements	278, 530	0	0	0	17.00
18. 00	Accumulated depreciation	-195, 115	1	0	0	18.00
19.00	Fixed equipment	343, 428	1	0	0	19.00
20.00	Accumulated depreciation	-269, 893	1	0	0	20.00
21. 00 22. 00	Automobiles and trucks Accumulated depreciation	1, 659, 549 -989, 835		0	0	21. 00 22. 00
23. 00	Major movable equipment	10, 957, 794		0	0	23.00
24. 00	Accumulated depreciation	-8, 785, 677	1	0	0	24.00
25. 00	Minor equipment depreciable	1, 626, 370	1	o	0	25. 00
26.00	Accumulated depreciation	-788, 235	1	o	0	26.00
27.00	HIT designated Assets	0	0	0	0	27.00
28. 00	Accumulated depreciation	0	0	0	0	28. 00
29. 00	Mi nor equi pment-nondepreci abl e	917, 459		0	0	29. 00
30. 00	Total fixed assets (sum of lines 12-29)	12, 455, 953	0	0	0	30.00
21 00	OTHER ASSETS	40.054.472		ol	0	21 00
31. 00 32. 00	Investments Deposits on Leases	40, 854, 472	0	0	0	31. 00 32. 00
33. 00	Due from owners/officers			0	0	33.00
34. 00	Other assets	246, 000	_	ol	0	34.00
35.00	Total other assets (sum of lines 31-34)	41, 100, 472	1	o	0	35.00
36.00	Total assets (sum of lines 11, 30, and 35)	58, 127, 783	0	0	0	36.00
	CURRENT LIABILITIES	1				
37.00	Accounts payable	1, 857, 414	1	0	0	37.00
38.00	Salaries, wages, and fees payable	998, 465	0	0	0	38.00
39. 00 40. 00	Payroll taxes payable Notes and loans payable (short term)	51, 736		U O	0	39. 00 40. 00
41. 00	Deferred income	10	1	0	0	41.00
42. 00	Accel erated payments	0		ĭ	O	42.00
43. 00	Due to other funds	0	o	o	0	43.00
44.00	Other current liabilities	51, 522	0	o	0	44.00
45.00	Total current liabilities (sum of lines 37 thru 44)	2, 959, 147	0	0	0	45. 00
	LONG TERM LIABILITIES					
46. 00	Mortgage payable	0	0	0	0	46. 00
47. 00	Notes payable	36, 568	1	0	0	47.00
48. 00	Unsecured Loans Other Long torm LightLities	0	0	0	0	48.00
49. 00 50. 00	Other long term liabilities Total long term liabilities (sum of lines 46 thru 49)	36, 568		0	0	49. 00 50. 00
51. 00	Total liabilities (sum of lines 45 and 50)	2, 995, 715	1	o	0	51.00
01.00	CAPITAL ACCOUNTS	2,770,710	<u> </u>	<u></u>		01.00
52.00	General fund balance	55, 132, 068				52.00
53.00	Specific purpose fund		0			53.00
54.00	Donor created - endowment fund balance - restricted			0		54.00
55. 00	Donor created - endowment fund balance - unrestricted	ļ		0		55.00
56. 00	Governing body created - endowment fund balance			0	_	56.00
57.00	Plant fund balance - invested in plant				0	57.00
58. 00	Plant fund balance - reserve for plant improvement, replacement, and expansion				0	58. 00
59. 00	Total fund balances (sum of lines 52 thru 58)	55, 132, 068	0	0	0	59.00
60.00	Total liabilities and fund balances (sum of lines 51 and	58, 127, 783	1	ő	0	60.00
	59)			٦		

Health Financial Systems
STATEMENT OF CHANGES IN FUND BALANCES Peri od: From 01/01/2019 Provi der CCN: 15-0091 Worksheet G-1

					To 12/31/2019		pared: 24 am_
		General	Fund	Special I	Purpose Fund	Endowment Fund	
		1. 00	2. 00	3. 00	4. 00	5. 00	
1. 00 2. 00 3. 00 4. 00 5. 00 6. 00 7. 00 8. 00 9. 00	Fund balances at beginning of period Net income (loss) (from Wkst. G-3, line 29) Total (sum of line 1 and line 2) Additions (credit adjustments) (specify) TRANSFERS	0 1, 864, 230 0 0 0	41, 331, 420 13, 128, 763 54, 460, 183		0 0 0 0 0 0 0		1. 00 2. 00 3. 00 4. 00 5. 00 6. 00 7. 00 8. 00 9. 00
10. 00 11. 00 12. 00 13. 00 14. 00 15. 00 16. 00 17. 00 18. 00 19. 00	Total additions (sum of line 4-9) Subtotal (line 3 plus line 10) ASSET TRANSFERS DEDUCTIONS ROUNDING Total deductions (sum of lines 12-17) Fund balance at end of period per balance sheet (line 11 minus line 18)	22, 474 1, 169, 868 3 0 0 0	1, 864, 230 56, 324, 413 1, 192, 345 55, 132, 068		0 0 0 0 0 0 0 0	0 0 0 0 0	10. 00 11. 00 12. 00 13. 00 14. 00 15. 00 16. 00 17. 00 18. 00 19. 00
		Endowment Fund	PI ant	Fund			
		6. 00	7. 00	8. 00			
1. 00 2. 00 3. 00 4. 00 5. 00 6. 00 7. 00 8. 00 9. 00	Fund balances at beginning of period Net income (loss) (from Wkst. G-3, line 29) Total (sum of line 1 and line 2) Additions (credit adjustments) (specify) TRANSFERS	0	0 0 0 0		0		1. 00 2. 00 3. 00 4. 00 5. 00 6. 00 7. 00 8. 00 9. 00
10. 00 11. 00 12. 00 13. 00 14. 00 15. 00 16. 00 17. 00	Total additions (sum of line 4-9) Subtotal (line 3 plus line 10) ASSET TRANSFERS DEDUCTIONS ROUNDING	0	0 0 0 0 0		0 0		10. 00 11. 00 12. 00 13. 00 14. 00 15. 00 16. 00 17. 00
18. 00 19. 00	Total deductions (sum of lines 12-17) Fund balance at end of period per balance sheet (line 11 minus line 18)	0			0		18. 00 19. 00

| Peri od: | Worksheet G-2 | From 01/01/2019 | Parts | & II | To 12/31/2019 | Date/Time Prepared: Health Financial Systems HUNSTATEMENT OF PATIENT REVENUES AND OPERATING EXPENSES Provider CCN: 15-0091

			To 12/31/2019	Date/Time Pre 6/26/2020 11:	
	Cost Center Description	I npati ent	Outpati ent	Total	21 4111
		1.00	2. 00	3. 00	
	PART I - PATIENT REVENUES				
	General Inpatient Routine Services				
1.00	Hospi tal	8, 601, 77	8	8, 601, 778	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		o	0	5.00
6.00	Swing bed - NF		0	0	6.00
7. 00	SKILLED NURSING FACILITY				7. 00
8. 00	NURSING FACILITY				8.00
9. 00	OTHER LONG TERM CARE				9. 00
10.00	Total general inpatient care services (sum of lines 1-9)	8, 601, 77	8	8, 601, 778	10.00
	Intensive Care Type Inpatient Hospital Services	0,001,77	<u> </u>	0,001,770	10.00
11. 00	INTENSIVE CARE UNIT				11.00
12. 00	CORONARY CARE UNIT				12.00
13. 00	BURN INTENSIVE CARE UNIT				13.00
14. 00	SURGI CAL I NTENSI VE CARE UNI T				14.00
15. 00	OTHER SPECIAL CARE (SPECIFY)				15.00
16. 00	Total intensive care type inpatient hospital services (sum of lines		0	0	16. 00
10.00	11-15)			O	10.00
17. 00	Total inpatient routine care services (sum of lines 10 and 16)	8, 601, 77	8	8, 601, 778	17. 00
18. 00	Ancillary services	40, 177, 05		40, 177, 053	18.00
19. 00	Outpati ent servi ces		0 154, 887, 185	154, 887, 185	
20.00	RURAL HEALTH CLINIC	•	0 134, 007, 103	0	20.00
21. 00	FEDERALLY QUALIFIED HEALTH CENTER		0 0	0	21.00
22. 00	HOME HEALTH AGENCY			U	22.00
23. 00	AMBULANCE SERVICES		0 17, 245, 741	17, 245, 741	23. 00
24. 00	CMHC		17, 243, 741	17, 245, 741	24.00
25. 00	AMBULATORY SURGICAL CENTER (D. P.)				25.00
26. 00	HOSPICE				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.	48, 778, 83	1 172, 132, 926	220, 911, 757	28.00
20.00	G-3, line 1)	40, 770, 03	1 1/2, 132, 920	220, 911, 737	26.00
	PART II - OPERATING EXPENSES				
29. 00	Operating expenses (per Wkst. A, column 3, line 200)		59, 440, 382		29. 00
30.00	PROVI SI ON FOR B/D	6, 987, 92			30.00
31. 00	HOME OFFICE INTEREST EXPENSE	654, 35			31.00
32. 00	HOWE OFFICE INTEREST EXIENSE		0		32.00
33. 00			o l		33.00
34. 00			0		34.00
35. 00			o l		35.00
36. 00	Total additions (sum of lines 30-35)		7, 642, 276		36.00
37. 00	DEDUCT (SPECIFY)		0 7, 642, 276		37.00
38.00	DEDUCT (SPECIFY)		0		38.00
			0		
39. 00 40. 00					39.00
		1	0		40. 00 41. 00
41.00	Total deductions (our of lines 27 41)	1	0		
42. 00 43. 00	Total deductions (sum of lines 37-41)	or	47 000 450		42.00
43.00	Total operating expenses (sum of lines 29 and 36 minus line 42)(transf	ei	67, 082, 658		43. 00
	to Wkst. G-3, line 4)	I	1		

	Financial Systems HUNTINGTON MI MENT OF REVENUES AND EXPENSES	Provider CCN: 15-0091	Peri od:	u of Form CMS-2 Worksheet G-3	
STATE	IENT OF KEVENUES AND EXPENSES	Provider CCN: 15-0091	From 01/01/2019	worksneet G-3	
			To 12/31/2019		
	<u> </u>			6/26/2020 11:	24 am
	T			1.00	4 00
1.00	Total patient revenues (from Wkst. G-2, Part I, column 3			220, 911, 757	1.00
2.00	Less contractual allowances and discounts on patients' a	accounts		146, 464, 297	
3.00	Net patient revenues (line 1 minus line 2)			74, 447, 460	
4.00	Less total operating expenses (from Wkst. G-2, Part II,			67, 082, 658	
5.00	Net income from service to patients (line 3 minus line 4 OTHER INCOME	l)		7, 364, 802	5. 00
6. 00	Contributions, donations, bequests, etc			0	6.00
7. 00	Income from investments			4, 523, 013	
8. 00	Revenues from telephone and other miscellaneous communic	ention convices		4, 523, 013	
9. 00	Revenue from television and radio service	ation services		0	
10.00	Purchase di scounts			0	
11. 00	Rebates and refunds of expenses			0	
12. 00	Parking lot receipts			0	12.00
	Revenue from Laundry and Linen service			0	13.00
14. 00	Revenue from meals sold to employees and guests			181, 936	
15. 00	Revenue from rental of living quarters			101, 930	
	Revenue from sale of medical and surgical supplies to of	har than nationts		0	
	Revenue from sale of drugs to other than patients	mer than patrents		- 1	17.00
	Revenue from sale of medical records and abstracts			-	18.00
	Tuition (fees, sale of textbooks, uniforms, etc.)				19.00
20.00	Revenue from gifts, flowers, coffee shops, and canteen			0	
21. 00	Rental of vending machines			0	
22. 00	Rental of hospital space			0	22.00
23. 00				-	
24. 00	Governmental appropriations EMS SUBSLDY			0 467, 397	
	OTHER OPERATING REVENUE			591, 615	
	Total other income (sum of lines 6-24)			5, 763, 961	
	Total (line 5 plus line 25)			13, 128, 763	
				0	27. 00 28. 00
	Total other expenses (sum of line 27 and subscripts)	20)		0	
29.00	Net income (or loss) for the period (line 26 minus line	28)	I	13, 128, 763	29.00

llool +b	Financial Systems	AL HOCDITAL	la li o	u of Form CMC (DEE2 10
	Financial Systems HUNTINGTON MEMORI ATION OF CAPITAL PAYMENT	Provi der CCN: 15-0091	Period: From 01/01/2019 To 12/31/2019	Date/Time Pre	pared:
		Title XVIII	Hospi tal	6/26/2020 11: PPS	24 am
	· · · · · · · · · · · · · · · · · · ·	THE AVIII	nospi tai	113	
				1. 00	
	PART I - FULLY PROSPECTIVE METHOD				
	CAPITAL FEDERAL AMOUNT				
1. 00	Capital DRG other than outlier			214, 495	
1. 01	Model 4 BPCI Capital DRG other than outlier			0	1. 01
2.00	Capital DRG outlier payments			1, 835	
2. 01	Model 4 BPCI Capital DRG outlier payments			0	2.01
3.00	Total inpatient days divided by number of days in the cost r	eporting period (see ins	tructions)	12. 40	
4.00	Number of interns & residents (see instructions)			0.00	1
5.00	Indirect medical education percentage (see instructions)	1 1 0	1! 1!	0.00	1
6. 00	Indirect medical education adjustment (multiply line 5 by th 1.01)(see instructions)	le sum of lines I and I.O	i, corumns i and	0	6.00
7. 00	Percentage of SSI recipient patient days to Medicare Part A	nationt days (Workshoot)	F nart Aline	0.00	7.00
7.00	30) (see instructions)	patrent days (worksheet	L, part A Title	0.00	7.00
8. 00	Percentage of Medicaid patient days to total days (see instr	ructions)		0.00	8.00
9. 00	Sum of lines 7 and 8	401.01.0)		0.00	
10.00	Allowable disproportionate share percentage (see instruction	s)		0.00	
11. 00	Disproportionate share adjustment (see instructions)	/		0	1
12.00	Total prospective capital payments (see instructions)			216, 330	12.00
	PART II - PAYMENT UNDER REASONABLE COST			1. 00	
1. 00	Program inpatient routine capital cost (see instructions)			0	1.00
2. 00	Program inpatient ancillary capital cost (see instructions)			Ö	
3.00	Total inpatient program capital cost (line 1 plus line 2)			0	
4. 00	Capital cost payment factor (see instructions)			0	4.00
5. 00	Total inpatient program capital cost (line 3 x line 4)			0	5.00
	DADT III COMPUTATION OF EVERTION DAVMENTS			1. 00	
1. 00	PART III - COMPUTATION OF EXCEPTION PAYMENTS Program inpatient capital costs (see instructions)			0	1.00
2. 00	Program inpatient capital costs (see instructions) Program inpatient capital costs for extraordinary circumstan	ucos (soo instructions)		0	2.00
3. 00	Net program inpatient capital costs for extraordinary circumstant Net program inpatient capital costs (line 1 minus line 2)	ices (see Histructions)		0	
4. 00	Applicable exception percentage (see instructions)			0.00	
5. 00	Capital cost for comparison to payments (line 3 x line 4)			0.00	5.00
6. 00	Percentage adjustment for extraordinary circumstances (see i	nstructions)		0.00	
7. 00	Adjustment to capital minimum payment level for extraordinar		x line 6)	0.00	
8. 00	Capital minimum payment level (line 5 plus line 7)	, o oaotaooo (Ö	
9. 00	Current year capital payments (from Part I, line 12, as appl	i cabl e)		0	1
10.00	Current year comparison of capital minimum payment level to		less line 9)	0	10.00
11. 00	Carryover of accumulated capital minimum payment level over Worksheet L, Part III, line 14)			0	11.00
12. 00	Net comparison of capital minimum payment level to capital p	ayments (line 10 plus li	ne 11)	0	12.00
13. 00	Current year exception payment (if line 12 is positive, ente			0	13.00
14. 00	Carryover of accumulated capital minimum payment level over		,	0	
	(if line 12 is negative, enter the amount on this line)		3 1		
15.00	Current year allowable operating and capital payment (see in	structions)		0	15.00
16. 00	Current year operating and capital costs (see instructions)			0	
17.00	Current year exception offset amount (see instructions)			0	17.00