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 09-30-2025 HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX COST REPORT CERTIFICATION | Provider CCN: 15-0091 Worksheet S Peri od: From 01/01/2023 Parts I-III AND SETTLEMENT SUMMARY 12/31/2023 Date/Time Prepared: 5/23/2024 4: 22 pm PART I - COST REPORT STATUS Provi der 1. [X] Electronically prepared cost report Date: 5/23/2024 4: 22 pm 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, "L" for low, or "N" for no. [1] Cost Report Status 6. Date Received: 7. Contractor No. (2) Settled without Audit 8. [N] Initial Report for this Provider CCN (3) Settled with Audit 9. [N] Final Report for this Provider CCN (10. NPR Date: 11. Contractor's Vendor Code: 4. (2. [0] If line 5, column 1 is 4: Enter number of times reopened = 0-9. Contractor use only (3) Settled with Audit number of times reopened = 0-9. (4) Reopened

PART II - CERTIFICATION BY A CHIEF FINANCIAL OFFICER OR ADMINISTRATOR OR PROVIDER(S)

(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 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 01/01/2023 and ending 12/31/2023 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.

	SIGNATURE OF CHIEF FINA	NCIAL OFFICER OR ADMINISTRATOR	CHECKBOX	ELECTRONI C	
		1	2	SIGNATURE STATEMENT	
1	Jeanne Wickens		Ţ	I have read and agree with the above certification statement. I certify that I intend my electronic signature on this certification be the legally binding equivalent of my original signature.	1
2	Signatory Printed Name	Jeanne Wickens			2
3	Signatory Title	CF0			3
4	Date	(Dated when report is electronica			4

			Title	XVIII			
		Title V	Part A	Part B	HIT	Title XIX	
		1. 00	2.00	3. 00	4. 00	5. 00	
	PART III - SETTLEMENT SUMMARY						
1.00	HOSPI TAL	0	40, 735	32, 695	0	0	1.00
2.00	SUBPROVIDER - IPF	0	0	0		0	2.00
3.00	SUBPROVI DER - I RF	0	0	0		0	3.00
5.00	SWING BED - SNF	0	O	0		0	5.00
6.00	SWING BED - NF	0				0	6.00
200.00	TOTAL	0	40, 735	32, 695	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 number for this information collection is OMB 0938-0050 and the number for the Supplement to Form CMS 2552-10, Worksheet N95, is OMB 0938-1425. The time required to complete and review the information collection is estimated 675 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.

for the portion of the cost reporting period prior to October 1. Enter in column 2, "Y" for yes or "N" for no for the portion of the cost reporting period occurring on or after October 1. (see instructions) Does this hospital contain at least 100 but not more than 499 beds (as counted in accordance with 42 CFR 412.105)? Enter in column 3, "Y" for yes or "N" for no. 22.04 Did this hospital receive a geographic reclassification from urban to 22 04 rural as a result of the revised OMB delineations for statistical areas adopted by CMS in FY 2021? Enter in column 1, "Y" for yes or "N" for no for the portion of the cost reporting period prior to October 1. Enter in column 2, "Y" for yes or "N" for no for the portion of the cost reporting period occurring on or after October 1. (see instructions) Does this hospital contain at least 100 but not more than 499 beds (as counted in accordance with 42 CFR 412.105)? Enter in column 3, "Y" for yes or "N" for no.

23.00 Which method is used to determine Medicaid days on lines 24 and/or 25 3 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 "N" for no.

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 01/01/2023 Part I Date/Time Prepared: 12/31/2023 5/23/2024 4: 22 pm XVIII XIX 1. 00 2.00 3.00 58.00 | If line 56 is yes, did this facility elect cost reimbursement for physicians' services as defined in CMS Pub. 15-1, chapter 21, §2148? If yes, complete Wkst. D-5. Ν 58.00 Pt. I 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 any programs that meet the criteria under 42 CFR 413.85? (see 60 00 N 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 adjustment? Enter "Y" for yes or "N" for no in column 2. IME Direct GME IME Direct GME 1. 00 2.00 3. 00 4. 00 5.00 61.00 Did your hospital receive FTE slots under ACA 0.00 0.00 61.00 Ν section 5503? Enter "Y" for yes or "N" for no in column 1. (see instructions) 61.01 Enter the average number of unweighted primary care 61.01 FTEs from the hospital's 3 most recent cost reports ending and submitted before March 23, 2010. (see instructions) 61.02 Enter the current year total unweighted primary care 61 02 FTE count (excluding OB/GYN, general surgery FTEs, and primary care FTEs added under section 5503 of ACA). (see instructions) 61.03 Enter the base line FTE count for primary care 61.03 and/or general surgery residents, which is used for determining compliance with the 75% test. (see instructions) Enter the number of unweighted primary care/or 61.04 surgery allopathic and/or osteopathic FTEs in the current cost reporting period. (see instructions). 61.05 Enter the difference between the baseline primary 61.05 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) 61.06 Enter the amount of ACA §5503 award that is being 61.06 used for cap relief and/or FTEs that are nonprimary care or general surgery. (see instructions) Program Name Program Code Unwei ghted Unwei ghted IME FTE Count Direct GME FTE Count 1.00 2.00 3.00 4.00 0.00 61.10 61.10 Of the FTEs in line 61.05, specify each new program 0. 00 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. 61.20 Of the FTEs in line 61.05, specify each expanded 0.00 0.00 61.20 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 1.00 ACA Provisions Affecting the Health Resources and Services Administration (HRSA) 62.00 Enter the number of FTE residents that your hospital trained in this cost reporting period for which 0.00 62.00 your hospital received HRSA PCRE funding (see instructions) Enter the number of FTE residents that rotated from a Teaching Health Center (THC) into your hospital 0.00 62.01 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 63.00

Y" for yes or "N" for no in column 1. If yes, complete lines 64 through 67. (see instructions)

	inancial Systems		ON MEMORIAL HOSPITAL	*CN: 15 0001 D		u of Form CMS-2	
HUSPI IA	L AND HOSPITAL HEALTH CARE COMP	LEA IDENIIFICATION DA	ATA Provider (eriod: rom 01/01/2023 o 12/31/2023	Worksheet S-2 Part I Date/Time Pre 5/23/2024 4:2	pared:
				Unwei ghted FTEs Nonprovi der Si te	Unweighted FTEs in Hospital	Ratio (col. 1/ (col. 1 + col. 2))	
	5504 - C 11 - A0A B V	ETE Davidson I a		1.00	2. 00	3. 00	
	ection 5504 of the ACA Base Yea eriod that begins on or after J			-ınıs base year	r is your cost	reporting	
64.00 E i r s	nter in column 1, if line 63 is n the base year period, the num esident FTEs attributable to ro- ettings. Enter in column 2 the esident FTEs that trained in yo f (column 1 divided by (column	yes, or your facili ber of unweighted no tations occurring in number of unweighte ur hospital. Enter i	ty trained residents n-primary care all nonprovider d non-primary care n column 3 the ratio		0.00	0. 000000	64.00
	(======================================	Program Name	Program Code	Unwei ghted	Unwei ghted	Ratio (col.	
				FTEs	FTEs in	3/ (col. 3 +	
				Nonprovi der Si te	Hospi tal	col. 4))	
		1. 00	2.00	3. 00	4. 00	5. 00	-
65. 00 E	inter in column 1, if line 63	1.00	2.00	0.00			65.00
t yaa F P P P P T t C u r r n c u r y 5 d	s yes, or your facility rained residents in the base ear period, the program name issociated with primary care TEs for each primary care irogram in which you trained residents. Enter in column 2, the program code. Enter in column 3, the number of inweighted primary care FTE residents attributable to otations occurring in all con-provider settings. Enter in column 4, the number of inweighted primary care resident FTEs that trained in rour hospital. Enter in column of, the ratio of (column 3 livided by (column 3 + column of). (see instructions)			Unwei ghted	Unwei ghted	Ratio (col.	
				FTEs Nonprovider Site	FTEs in Hospital	1/ (col. 1 + col. 2))	
- In		V ETE D	- Name - d to Control	1.00	2. 00	3.00	
	ection 5504 of the ACA Current eginning on or after July 1, 20		n Nonprovider Settir	gsETTECTIVE T	or cost report	ing perioas	
	inter in column 1 the number of		ry care resident	0.00	0.00	0. 000000	66.00
	TEs attributable to rotations on inter in column 2 the number of						
	TEs that trained in your hospit						
	column 1 divided by (column 1 +	Program Name	Program Code	Unwei ghted	Unweighted	Ratio (col.	
				FTEs	FTEs in	3/ (col. 3 +	
				Nonprovi der	Hospi tal	col. 4))	
		1 00	2.00	Si te	4.00	E 00	
67. 00 E	inter in column 1, the program	1. 00	2.00	3.00	4. 00	5. 00 0. 000000	67 00
n y w E c c n c t n c u r y 5 d	name associated with each of our primary care programs in which you trained residents. Inter in column 2, the program node. Enter in column 3, the number of unweighted primary nare FTE residents attributable or ortations occurring in all non-provider settings. Enter in nolumn 4, the number of nour hospital. Enter in column four hospital. Enter in column nour hospital. Set in structions nour hospital.						

Health Financial Systems HUNTINGTON MEMORI HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA	AL HOSPITAL Provider CCN: 15-009		eu of Form CMS- Worksheet S-2	
		From 01/01/2023 To 12/31/2023	Part I	pared:
		·	1.00	
Direct GME in Accordance with the FY 2023 IPPS Final Rule, 87 68.00 For a cost reporting period beginning prior to October 1, 202 MAC to apply the new DGME formula in accordance with the FY 2 (August 10, 2022)?	2, did you obtain per	mission from your		68. 00
		1. (00 2.00 3.00	
70.00 Is this facility an Inpatient Psychiatric Facility (IPF), or	does it contain an IP	F subprovider? N		70.00
Enter "Y" for yes or "N" for no. 71.00 If line 70 is yes: Column 1: Did the facility have an approve recent cost report filed on or before November 15, 2004? Ent 42 CFR 412.424(d)(1)(iii)(c)) Column 2: Did this facility tra program in accordance with 42 CFR 412.424 (d)(1)(iii)(D)? Ent Column 3: If column 2 is Y, indicate which program year begar (see instructions) Inpatient Rehabilitation Facility PPS	er "Y" for yes or "N" in residents in a new er "Y" for yes or "N" i during this cost rep	for no. (see teaching for no. orting period.	0	71.00
75.00 Is this facility an Inpatient Rehabilitation Facility (IRF), subprovider? Enter "Y" for yes and "N" for no.	or does it contain an	I RF N		75.00
76.00 If line 75 is yes: Column 1: Did the facility have an approve recent cost reporting period ending on or before November 15, no. Column 2: Did this facility train residents in a new teac CFR 412.424 (d)(1)(iii)(D)? Enter "Y" for yes or "N" for no. indicate which program year began during this cost reporting	2004? Enter "Y" for ching program in accor Column 3: If column 2	yes or "N" for dance with 42 is Y,	0	76.00
, T. O. H. L. L. DDO			1.00	
Long Term Care Hospital PPS 80.00 Is this a long term care hospital (LTCH)? Enter "Y" for yes 81.00 Is this a LTCH co-located within another hospital for part or "Y" for yes and "N" for no.	N N	80. 00 81. 00		
TEFRA Providers 85.00 Is this a new hospital under 42 CFR Section §413.40(f)(1)(i) 86.00 Did this facility establish a new Other subprovider (excluded)	. N	85. 00 86. 00		
\$413.40(f)(1)(ii)? Enter "Y" for yes and "N" for no. 87.00 Is this hospital an extended neoplastic disease care hospital 1886(d)(1)(B)(vi)? Enter "Y" for yes or "N" for no.	classified under sec	ti on	N	87.00
		Approved for Permanent Adjustment (Y/N) 1.00	Number of Approved Permanent Adjustments 2.00	
88.00 Column 1: Is this hospital approved for a permanent adjustmen amount per discharge? Enter "Y" for yes or "N" for no. If yes 89. (see instructions)	, complete col. 2 and	N		88.00
Column 2: Enter the number of approved permanent adjustments.	Wkst. A	Line Effective	Approved	
	No.	Date	Permanent Adjustment Amount Per Discharge	
89.00 Column 1: If line 88, column 1 is Y, enter the Worksheet A li	ne number	0.00	3.00	89.00
on which the per discharge permanent adjustment approval was Column 2: Enter the effective date (i.e., the cost reporting beginning date) for the permanent adjustment to the TEFRA tarper discharge. Column 3: Enter the amount of the approved permanent adjustment TEFRA target amount per discharge.	period get amount			
		V 1.00	XI X 2. 00	
Title V and XIX Services				00.00
 90.00 Does this facility have title V and/or XIX inpatient hospital yes or "N" for no in the applicable column. 91.00 Is this hospital reimbursed for title V and/or XIX through the second content of the second conten			Y	90.00
full or in part? Enter "Y" for yes or "N" for no in the appli 92.00 Are title XIX NF patients occupying title XVIII SNF beds (due	cable column.		N	92.00
instructions) Enter "Y" for yes or "N" for no in the applicate 93.00 Does this facility operate an ICF/IID facility for purposes of	le column.		N	93.00
"Y" for yes or "N" for no in the applicable column.	and "N" for no in the	N	N	94.00
94.00 Does title V or XIX reduce capital cost? Enter "Y" for yes, a		1	1	1
94.00 Does title V or XIX reduce capital cost? Enter "Y" for yes, a applicable column. 95.00 If line 94 is "Y", enter the reduction percentage in the appl 96.00 Does title V or XIX reduce operating cost? Enter "Y" for yes applicable column.		0. 00 N	0. 00 N	95. 00 96. 00

OSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA	10 11 0				-2552	
	Provider (Period: From 01/01/2023 To 12/31/2023	Date/Time Pr	epare	
			V	5/23/2024 4: XI X	22 pn	
			1.00	2.00		
3.00 Does title V or XIX follow Medicare (title XVIII) for the	interns and re	sidents post	N	Y	98.	
stepdown adjustments on Wkst. B, Pt. I, col. 25? Enter "Y	' for yes or "N	" for no in				
column 1 for title V, and in column 2 for title XIX. 3.01 Does title V or XIX follow Medicare (title XVIII) for the C, Pt. I? Enter "Y" for yes or "N" for no in column 1 for				Υ	98.	
title XIX. 3.02 Does title V or XIX follow Medicare (title XVIII) for the bed costs on Wkst. D-1, Pt. IV, line 89? Enter "Y" for ye			N	Y	98.	
for title V, and in column 2 for title XIX. 3.03 Does title V or XIX follow Medicare (title XVIII) for a creimbursed 101% of inpatient services cost? Enter "Y" for for title V, and in column 2 for title XIX.				N	98.	
B. 04 Does title V or XIX follow Medicare (title XVIII) for a Coutpatient services cost? Enter "Y" for yes or "N" for no						
B.05 Does title V or XIX follow Medicare (title XVIII) and add Wkst. C, Pt. I, col. 4? Enter "Y" for yes or "N" for no is column 2 for title XIX.		Y	98			
8.06 Does title V or XIX follow Medicare (title XVIII) when co. Pts. I through IV? Enter "Y" for yes or "N" for no in col. column 2 for title XIX.	N	Y	98			
Rural Providers						
05.00 Does this hospital qualify as a CAH?			N		105	
6.00 If this facility qualifies as a CAH, has it elected the a	I-inclusive me	thod of paymer	t		106	
for outpatient services? (see instructions) 7.00 Column 1: If line 105 is Y, is this facility eligible for	000+ mai mbumaa	mont for LOD			107	
training programs? Enter "Y" for yes or "N" for no in coll Column 2: If column 1 is Y and line 70 or line 75 is Y, approved medical education program in the CAH's excluded	umn 1. (see in do you train I& IPF and/or IRF	structions) Rs in an			107	
Enter "Y" for yes or "N" for no in column 2. (see instru 7.01 If this facility is a REH (line 3, column 4, is "12"), is reimbursement for I&R training programs? Enter "Y" for ye instructions)	it eligible fo				107	
NS.00 s this a rural hospital qualifying for an exception to t (CFR Section §412.113(c). Enter "Y" for yes or "N" for no.	ne CRNA fee sch	edul e? See 42	N		108	
join deetron 3112. Ho(e). Enter 1 Tor year or 11 Tol. Ho.	Physi cal	Occupati onal		Respiratory		
99.00 of this hospital qualifies as a CAH or a cost provider, a therapy services provided by outside supplier? Enter "Y" for yes or "N" for no for each therapy.	1.00 re N	2.00	3. 00	4.00	109	
Tot yes of it for no for each therapy.						
				1.00	-	
0.00 Did this hospital participate in the Rural Community Hosp Demonstration) for the current cost reporting period? Ente	tal Demonstrat	ion project (8		1.00		
complete Worksheet E, Part A, lines 200 through 218, and applicable.	r "Y" for yes o	r "N" for no.	If yes,	N N	110	
complete Worksheet E, Part A, lines 200 through 218, and	r "Y" for yes o	r "N" for no.	If yes, ugh 215, as	N	110	
complete Worksheet E, Part A, lines 200 through 218, and applicable.	r "Y" for yes o Worksheet E-2,	r "N" for no. Lines 200 thro	If yes,			
complete Worksheet E, Part A, lines 200 through 218, and applicable. 1.00 If this facility qualifies as a CAH, did it participate in the Health Integration Project (FCHIP) demonstration for this "Y" for yes or "N" for no in column 1. If the response to integration prong of the FCHIP demo in which this CAH is Enter all that apply: "A" for Ambulance services; "B" for	r "Y" for yes o Worksheet E-2, in the Frontier cost reporting column 1 is Y, participating i	r "N" for no. lines 200 thro Community period? Enter enter the n column 2.	If yes, ugh 215, as 1.00	N		
complete Worksheet E, Part A, lines 200 through 218, and lapplicable. 1.00 If this facility qualifies as a CAH, did it participate in the Health Integration Project (FCHIP) demonstration for this "Y" for yes or "N" for no in column 1. If the response to integration prong of the FCHIP demo in which this CAH is participated.	r "Y" for yes o Worksheet E-2, in the Frontier cost reporting column 1 is Y, participating i	Community period? Enter enter the n column 2. s; and/or "C"	If yes, ugh 215, as	N 2. 00		
complete Worksheet E, Part A, lines 200 through 218, and applicable. 1.00 If this facility qualifies as a CAH, did it participate in Health Integration Project (FCHIP) demonstration for this "Y" for yes or "N" for no in column 1. If the response to integration prong of the FCHIP demo in which this CAH is Enter all that apply: "A" for Ambulance services; "B" for for tele-health services.	r "Y" for yes o Worksheet E-2, In the Frontier cost reporting column 1 is Y, participating i additional bed	Community period? Enter enter the n column 2. s; and/or "C"	If yes, ugh 215, as 1.00	N	111	
complete Worksheet E, Part A, lines 200 through 218, and applicable. 1.00 If this facility qualifies as a CAH, did it participate in Health Integration Project (FCHIP) demonstration for this "Y" for yes or "N" for no in column 1. If the response to integration prong of the FCHIP demo in which this CAH is Enter all that apply: "A" for Ambulance services; "B" for for tele-health services. 2.00 Did this hospital participate in the Pennsylvania Rural H (PARHM) demonstration for any portion of the current cost period? Enter "Y" for yes or "N" for no in column 1. If "Y", enter in column 2, the date the hospital began participate in the date the hospital	r "Y" for yes o Worksheet E-2, In the Frontier cost reporting column 1 is Y, participating i additional bed ealth Model reporting column 1 is cipating in the	Community period? Enter enter the n column 2. s; and/or "C"	If yes, ugh 215, as	N 2. 00	111	
complete Worksheet E, Part A, lines 200 through 218, and applicable. 1.00 If this facility qualifies as a CAH, did it participate in Health Integration Project (FCHIP) demonstration for this "Y" for yes or "N" for no in column 1. If the response to integration prong of the FCHIP demo in which this CAH is Enter all that apply: "A" for Ambulance services; "B" for for tele-health services. 2.00 Did this hospital participate in the Pennsylvania Rural H (PARHM) demonstration for any portion of the current cost period? Enter "Y" for yes or "N" for no in column 1. If "Y", enter in column 2, the date the hospital began participation in the demonstration, if applicable.	r "Y" for yes o Worksheet E-2, In the Frontier cost reporting column 1 is Y, participating i additional bed ealth Model reporting column 1 is cipating in the	Community period? Enter enter the n column 2. s; and/or "C"	If yes, ugh 215, as	N 2. 00	111	
complete Worksheet E, Part A, lines 200 through 218, and applicable. 1.00 If this facility qualifies as a CAH, did it participate in Health Integration Project (FCHIP) demonstration for this "Y" for yes or "N" for no in column 1. If the response to integration prong of the FCHIP demo in which this CAH is Enter all that apply: "A" for Ambulance services; "B" for for tele-health services. 2.00 Did this hospital participate in the Pennsylvania Rural H (PARHM) demonstration for any portion of the current cost period? Enter "Y" for yes or "N" for no in column 1. If "Y", enter in column 2, the date the hospital began participation. In column 3, enter the date the hospital participation in the demonstration, if applicable. Miscellaneous Cost Reporting Information 5.00 Is this an all-inclusive rate provider? Enter "Y" for yes in column 1. If column 1 is yes, enter the method used (A in column 2. If column 2 is "E", enter in column 3 either for short term hospital or "98" percent for long term carpsychiatric, rehabilitation and long term hospitals provided.	r "Y" for yes o Worksheet E-2, In the Frontier cost reporting column 1 is Y, participating i additional bed ealth Model reporting column 1 is cipating in the ceased or "N" for no B, or E only) "93" percent e (includes	Community period? Enter enter the n column 2. s; and/or "C"	If yes, ugh 215, as	2. 00 3. 00	1111	
complete Worksheet E, Part A, lines 200 through 218, and lapplicable. 1.00 If this facility qualifies as a CAH, did it participate in Health Integration Project (FCHIP) demonstration for this "Y" for yes or "N" for no in column 1. If the response to integration prong of the FCHIP demo in which this CAH is Enter all that apply: "A" for Ambulance services; "B" for for tele-health services. 2.00 Did this hospital participate in the Pennsylvania Rural H (PARHM) demonstration for any portion of the current cost period? Enter "Y" for yes or "N" for no in column 1. If "Y", enter in column 2, the date the hospital began participation in the demonstration, if applicable. Miscellaneous Cost Reporting Information 5.00 Is this an all-inclusive rate provider? Enter "Y" for yes in column 1. If column 1 is yes, enter the method used (A in column 2. If column 2 is "E", enter in column 3 either for short term hospital or "98" percent for long term car psychiatric, rehabilitation and long term hospitals provided the definition in CMS Pub. 15-1, chapter 22, §2208.1. 6.00 Is this facility classified as a referral center? Enter ""	n the Frontier cost reporting column 1 is Y, participating i additional bed reporting column 1 is cipating in the ceased or "N" for no B, or E only) "93" percent e (includes ders) based on	Community period? Enter enter the n column 2. s; and/or "C"	If yes, ugh 215, as	2. 00 3. 00	1111	
complete Worksheet E, Part A, lines 200 through 218, and applicable. 11.00 If this facility qualifies as a CAH, did it participate in Health Integration Project (FCHIP) demonstration for this "Y" for yes or "N" for no in column 1. If the response to integration prong of the FCHIP demo in which this CAH is Enter all that apply: "A" for Ambulance services; "B" for for tele-health services. 12.00 Did this hospital participate in the Pennsylvania Rural He (PARHM) demonstration for any portion of the current cost period? Enter "Y" for yes or "N" for no in column 1. If "Y", enter in column 2, the date the hospital began participation. In column 3, enter the date the hospital participation in the demonstration, if applicable. Miscellaneous Cost Reporting Information 15.00 Is this an all-inclusive rate provider? Enter "Y" for yes in column 1. If column 1 is yes, enter the method used (A in column 2. If column 2 is "E", enter in column 3 either for short term hospital or "98" percent for long term car psychiatric, rehabilitation and long term hospitals provided definition in CMS Pub.15-1, chapter 22, §2208.1. 16.00 Is this facility classified as a referral center? Enter ""	r "Y" for yes on Worksheet E-2, In the Frontier cost reporting column 1 is Y, participating in additional bed ealth Model reporting column 1 is cipating in the ceased or "N" for no B, or E only) "93" percent e (includes ders) based on Y" for yes or	Community period? Enter enter the n column 2. s; and/or "C"	If yes, ugh 215, as	2. 00 3. 00	1110	
complete Worksheet E, Part A, lines 200 through 218, and applicable. [1.00] If this facility qualifies as a CAH, did it participate in Health Integration Project (FCHIP) demonstration for this "Y" for yes or "N" for no in column 1. If the response to integration prong of the FCHIP demo in which this CAH is Enter all that apply: "A" for Ambulance services; "B" for for tele-health services. [2.00] Did this hospital participate in the Pennsylvania Rural H (PARHM) demonstration for any portion of the current cost period? Enter "Y" for yes or "N" for no in column 1. If "Y", enter in column 2, the date the hospital began participation in the demonstration, if applicable. Miscellaneous Cost Reporting Information [5.00] Is this an all-inclusive rate provider? Enter "Y" for yes in column 1. If column 1 is yes, enter the method used (A in column 2. If column 2 is "E", enter in column 3 either for short term hospital or "98" percent for long term car psychiatric, rehabilitation and long term hospitals provided the definition in CMS Pub. 15-1, chapter 22, §2208.1.	r "Y" for yes on Worksheet E-2, In the Frontier cost reporting column 1 is Y, participating in additional bed ealth Model reporting column 1 is cipating in the ceased or "N" for no B, or E only) "93" percent e (includes ders) based on Y" for yes or	Community period? Enter enter the n column 2. s; and/or "C"	If yes, ugh 215, as	2. 00 3. 00	1111	

yes, enter the approval date (mm/dd/yyyy) in column 2.

lealth Financial Systems		ORIAL HOSPITAL Provider CCN: 15-0091				u of Form CMS-2552		
HOSPITAL AND HOSPITAL HEALTH CARE COMPLI	EX IDENIIFICATION DATA	Ą	Provider CC	CN: 15-0091		iod: m 01/01/2023 12/31/2023	Worksheet S- Part I Date/Time Pr 5/23/2024 4:	epared:
							1. 00	_
147.00Was there a change in the statist	ical hasis? Enter "Y"	for ves	or "N" for	no			1.00 N	147. 00
148.00 Was there a change in the order o	f allocation? Enter "'	Y" for v	es or "N" fo	or no			N N	148. 0
149.00Was there a change to the simplif					for no).	N	149. 0
3			Part A	Part		Title V	Title XIX	
			1. 00	2. 00		3. 00	4. 00	
Does this facility contain a prov								
or charges? Enter "Y" for yes or	"N" for no for each c	omponent			B. (S∈	-		
55. 00 Hospi tal			N	N		N	N	155. 0
56.00 Subprovi der - IPF			N	N N		N	N	156.0
57.00 Subprovi der - IRF 58.00 SUBPROVI DER			N	N		N	N	157. 0
158. 00 SUBPROVI DER 159. 00 SNF			N	l N		N	N	158. 0 159. 0
160.00 HOME HEALTH AGENCY			N N	l N		N N	N N	160. 0
161. OOCMHC			IV	N N		N	N N	161. 0
OT. GO CIVILIC				I.V		14	14	101.0
							1. 00	
Mul ti campus								
165.00 s this hospital part of a Multic Enter "Y" for yes or "N" for no.	ampus hospital that ha	as one c	or more camp	uses in di	fferen	it CBSAs?	N	165. 0
Enter 1 for yes of N for no.	Name	(County	State	Zi p Cc	ode CBSA	FTE/Campus	
	0		1. 00	2.00	3. 00		5. 00	
66.00 If line 165 is yes, for each							0. 0	00 166. 0
campus enter the name in column								
O, county in column 1, state in								
column 2, zip code in column 3,								
CBSA in column 4, FTE/Campus in column 5 (see instructions)								
cordilli 5 (see Tristructrons)								
							1. 00	
Health Information Technology (HI						\ct		
167.00 s this provider a meaningful use							Y	167. 0
68.00 If this provider is a CAH (line 1				e 167 is '	'Y"), e	enter the		168. 0
reasonable cost incurred for the 168.01 If this provider is a CAH and is				r and i for	for o	hordohi n		168. 0
exception under §413.70(a)(6)(ii)						nai usiii p		100.0
169.00 If this provider is a meaningful) enter the	9 (99169. 0
transition factor. (see instructi		,	, ,,,,,,	(,, 0	, ·	///
	/					Begi nni ng	Endi ng	
						1. 00	2. 00	
170.00 Enter in columns 1 and 2 the EHR period respectively (mm/dd/yyyy)	beginning date and end	ding dat	e for the r	eporti ng				170. 0
perrod respectivery (min/dd/yyyy)								
71 0016 11 - 1/7 1 - 1/4	dalam bassa se de o		d direction of	I I = al		1.00	2. 00	0174 0
171.00 f ine 167 is "Y", does this pro						N		0 171. 0
coction 1074 Modicons coct!	roported or Micot C ?			1 40 Fat	S = 1			
section 1876 Medicare cost plans "Y" for yes and "N" for no in col								

Heal th	Financial Systems HUNTINGTON MEMO	DRIAL HOSPITAL		In lie	u of Form CMS-	2552-10
	AL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE	Provi der C		Peri od:	Worksheet S-2	
				From 01/01/2023 To 12/31/2023		epared:
				V/ /NI	5/23/2024 4: 2	
				Y/N 1.00	2. 00	
	PART II - HOSPITAL AND HOSPITAL HEATHCARE COMPLEX REIMBURS					
	General Instruction: Enter Y for all YES responses. Enter I mm/dd/yyyy format.	N for all NO r	esponses. Ente	er all dates in	the	
	COMPLETED BY ALL HOSPITALS					1
	Provider Organization and Operation				ı	
1. 00	Has the provider changed ownership immediately prior to the reporting period? If yes, enter the date of the change in			N		1.00
	reporting period. It yes, enter the date of the enange in	001 umii 2. (300	Y/N	Date	V/I	
2.00	Use the grand day to select a grant of a termination of the Madi and	D	1.00	2. 00	3. 00	2.00
2. 00	Has the provider terminated participation in the Medicare yes, enter in column 2 the date of termination and in colu		N			2.00
	voluntary or "I" for involuntary.					
3. 00	Is the provider involved in business transactions, includicontracts, with individuals or entities (e.g., chain home)		N			3.00
	or medical supply companies) that are related to the provi					
	officers, medical staff, management personnel, or members	of the board				
	of directors through ownership, control, or family and otherelationships? (see instructions)	er similar				
	relationships: (see instructions)		Y/N	Туре	Date	
			1.00	2. 00	3. 00	
4. 00	Financial Data and Reports Column 1: Were the financial statements prepared by a Cer	tified Public	Υ	A	04/18/2024	4.00
4.00	Accountant? Column 2: If yes, enter "A" for Audited, "C"	for Compiled,	'	A	047 107 2024	4.00
	or "R" for Reviewed. Submit complete copy or enter date av	ailable in				
5. 00	column 3. (see instructions) If no, see instructions. Are the cost report total expenses and total revenues diffe	erent from	l N			5.00
	those on the filed financial statements? If yes, submit re					0.00
				Y/N	Legal Oper.	
	Approved Educational Activities			1. 00	2. 00	
6.00	Column 1: Are costs claimed for a nursing program? Column	2: If yes, i	s the provider	- N		6.00
7. 00	the legal operator of the program?	netrueti one		N		7 00
8. 00	Are costs claimed for Allied Health Programs? If "Y" see i Were nursing programs and/or allied health programs approv		wed during the	N e N		7. 00 8. 00
	cost reporting period? If yes, see instructions.		· ·			
9. 00	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
10.00	Was an approved Intern and Resident GME program initiated		the current	N		10.00
	cost reporting period? If yes, see instructions.					
11. 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
	reaching frogram on worksheet A: IT yes, see first detrons.				Y/N	
					1. 00	
12 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			ost reporting	N N	13.00
44.00	period? If yes, submit copy.					1
14.00	If line 12 is yes, were patient deductibles and/or coinsurinstructions.	ance amounts w	arved? If yes,	see	N	14.00
	Bed Complement					
15. 00	Did total beds available change from the prior cost report		yes, see inst		L N Tt B	15.00
		Y/N	Date	Y/N	Date	
		1.00	2.00	3. 00	4. 00	
14 00	PS&R Data Was the cost report prepared using the PS&R Report only?	N		N	ı	16.00
10.00	If either column 1 or 3 is yes, enter the paid-through	IN IN		IN		16.00
	date of the PS&R Report used in columns 2 and 4 (see					
17. 00	instructions) Was the cost report prepared using the PS&R Report for	Y	04/30/2024	Υ	04/30/2024	17.00
17.00	totals and the provider's records for allocation? If	'	047 307 2024	'	047 307 2024	17.00
	either column 1 or 3 is yes, enter the paid-through date					
18. 00	in columns 2 and 4. (see instructions) If line 16 or 17 is yes, were adjustments made to PS&R	Y		Υ		18.00
. 5. 00	Report data for additional claims that have been billed	·				. 3. 30
	but are not included on the PS&R Report used to file this					
19. 00	cost report? If yes, see instructions. If line 16 or 17 is yes, were adjustments made to PS&R	N		N		19.00
	Report data for corrections of other PS&R Report					
	information? If yes, see instructions.	l	I		I	1

Heal th	Financial Systems HUNTINGTON MEMO	ORIAL HOSPITAL		In Lie	u of Form CMS-:	2552-10
	AL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE	Provi der 0	CCN: 15-0091	Peri od: From 01/01/2023 To 12/31/2023	Worksheet S-2 Part II	epared:
			iption	Y/N	Y/N	
20.00	16.11		0	1.00	3. 00	00.00
20. 00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for Other? Describe the other adjustments:			N	N	20. 00
	report data for other. Beserred the other day astments.	Y/N	Date	Y/N	Date	
		1.00	2.00	3. 00	4. 00	
21. 00	Was the cost report prepared only using the provider's records? If yes, see instructions.	N		N		21. 00
					1. 00	
	COMPLETED BY COST REIMBURSED AND TEFRA HOSPITALS ONLY (EXCE	EPT CHILDRENS	HOSPI TALS)		1.00	
	Capital Related Cost		ĺ			
22. 00	Have assets been relifed for Medicare purposes? If yes, see					22. 00
23. 00	Have changes occurred in the Medicare depreciation expense	due to apprai	sals made du	ing the cost		23. 00
24.00	reporting period? If yes, see instructions.	ad into dunina	. +bio ooo+ m	norting norted?		24.00
24. 00	Were new leases and/or amendments to existing leases entered of the second of the seco	eu into during	inis Cost Fe	sporting period?		24.00
25. 00	Have there been new capitalized leases entered into during	the cost repo	rting period	? If yes, see		25. 00
	instructions.		0 .			
26. 00	Were assets subject to Sec. 2314 of DEFRA acquired during thinstructions.	•	0.			26. 00
27. 00	Has the provider's capitalization policy changed during the	e cost reporti	ng period? It	fyes, submit		27. 00
	copy. Interest Expense					
28. 00	Were new loans, mortgage agreements or letters of credit en period? If yes, see instructions.	t reporting		28. 00		
29. 00	Did the provider have a funded depreciation account and/or	bond funds (D	ebt Service f	Reserve Fund)		29. 00
	treated as a funded depreciation account? If yes, see instr	ructi ons		,		
30.00	Has existing debt been replaced prior to its scheduled matu	urity with new	debt? If yes	s, see		30.00
31. 00	<pre>instructions. Has debt been recalled before scheduled maturity without is instructions.</pre>	ssuance of new	debt? If yes	s, see		31.00
	Purchased Services					-
32.00	Have changes or new agreements occurred in patient care ser	rvi ces furni sh	ed through co	ontractual		32.00
33. 00	arrangements with suppliers of services? If yes, see instru If line 32 is yes, were the requirements of Sec. 2135.2 app		ng to competi	tive bidding? If		33.00
	no, see instructions.					
24 00	Provi der-Based Physi ci ans	orrongoment wi	+h nzavidan l	and abust of another	.	34.00
34. 00	Were services furnished at the provider facility under an a lf yes, see instructions.	arrangement wi	tii provider-i	based physicians:		34.00
35. 00	If line 34 is yes, were there new agreements or amended exiphysicians during the cost reporting period? If yes, see in		ents with the	provi der-based		35. 00
	pringer or allow during the book reporting portion in joe, see in			Y/N	Date	
				1. 00	2. 00	
0/ 05	Home Office Costs					1 0, 05
	Were home office costs claimed on the cost report? If line 36 is yes, has a home office cost statement been processed in the cost statement been processed.	ropared by +ba	homo offica	Y		36.00
37.00	If yes, see instructions.	repared by the	: nome office	? Y		37.00
38. 00	If line 36 is yes , was the fiscal year end of the home off the provider? If yes, enter in column 2 the fiscal year end			- N		38. 00
39. 00	, .			s, N		39.00
40. 00	If line 36 is yes, did the provider render services to the instructions.	home office?	If yes, see	N		40.00
	This is doctroins.					
		1.	. 00	2.	00	
	Cost Report Preparer Contact Information					
41. 00	held by the cost report preparer in columns 1, 2, and 3,	SHANNON		ECENBARGER		41.00
42. 00	, , , , , , , , , , , , , , , , , , , ,	PARKVIEW HEAL	TH SYSTEM, IN	C.		42.00
43. 00	'	260-437-7558		SHANNON. ECENBA	RGER@PARKVI EW.	43.00
	report preparer in columns 1 and 2, respectively.	I		COM	l	II

Heal th	n Financial Systems HU	UNTINGTON MEMOR	RLAL HOSPI	TAL		In Lieu of Form CMS-2552-10			
HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE			Provi d	er CCN: 15-0		eriod: rom 01/01/2023	Worksheet S-2 Part II		
						o 12/31/2023		pared: 2 pm	
				3. 00					
	Cost Report Preparer Contact Information								
41.00	Enter the first name, last name and the title	e/position [OI RECTOR,	REI MBURSEME	ENT			41.00	
	held by the cost report preparer in columns 1	1, 2, and 3,							
	respecti vel y.								
42.00	Enter the employer/company name of the cost r	report						42.00	
	preparer.								
43.00	Enter the telephone number and email address	of the cost						43.00	
	report preparer in columns 1 and 2, respectiv	vel y.							

 Health Financial Systems
 HUNTINGTO

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

						To 12/31/2023	Date/Time Pre 5/23/2024 4:2	
							1/P Days /	Z piii
							0/P Visits /	
							Tri ps	
	Component	Worksheet A	No	o. of Beds	Bed Days	CAH/REH Hours	Title V	
		Li ne No.			Avai I abl e			
		1. 00		2. 00	3. 00	4. 00	5. 00	
4 00	PART I - STATISTICAL DATA	00.00		2.1				
1. 00	Hospital Adults & Peds. (columns 5, 6, 7 and	30. 00		36	13, 14	0.00	0	1. 00
	8 exclude Swing Bed, Observation Bed and							
	Hospice days)(see instructions for col. 2 for the portion of LDP room available beds)							
2. 00	HMO and other (see instructions)		ŀ					2. 00
3. 00	HMO IPF Subprovider		ŀ					3.00
4. 00	HMO IRF Subprovider							4.00
5. 00	Hospital Adults & Peds. Swing Bed SNF		ŀ				0	5.00
6. 00	Hospital Adults & Peds. Swing Bed NF						Ö	6. 00
7. 00	Total Adults and Peds. (exclude observation		İ	36	13, 14	0.00	0	7. 00
	beds) (see instructions)							
8.00	INTENSIVE CARE UNIT							8. 00
9.00	CORONARY CARE UNIT							9. 00
10.00	BURN INTENSIVE CARE UNIT							10.00
11. 00	SURGICAL INTENSIVE CARE UNIT							11. 00
12.00	OTHER SPECIAL CARE (SPECIFY)							12.00
13.00	NURSERY	43. 00					0	13.00
14. 00	Total (see instructions)			36	13, 14	0.00	0	14.00
15. 00	CAH visits						0	15.00
15. 10	REH hours and visits					0. 00	0	15. 10
16.00	SUBPROVIDER - I PF		ŀ					16.00
17. 00 18. 00	SUBPROVIDER - IRF		ŀ					17. 00 18. 00
19. 00	SUBPROVIDER SKILLED NURSING FACILITY		ŀ					19.00
20. 00	NURSING FACILITY							20.00
21. 00	OTHER LONG TERM CARE		ŀ					21.00
22. 00	HOME HEALTH AGENCY							22. 00
23. 00	AMBULATORY SURGICAL CENTER (D. P.)							23. 00
24.00	HOSPI CE							24.00
24. 10	HOSPICE (non-distinct part)	30.00	İ					24. 10
25.00	CMHC - CMHC		ĺ					25. 00
26.00	RURAL HEALTH CLINIC							26.00
26. 25	FEDERALLY QUALIFIED HEALTH CENTER	89. 00					0	26. 25
27. 00	Total (sum of lines 14-26)			36				27. 00
28. 00	Observation Bed Days		ļ				0	28. 00
29. 00	Ambul ance Tri ps							29. 00
30.00	Employee discount days (see instruction)							30.00
31.00	Employee discount days - IRF		ŀ	0				31.00
32. 00	Labor & delivery days (see instructions)		ŀ	0	'	O		32.00
32. 01	Total ancillary labor & delivery room outpatient days (see instructions)							32. 01
33. 00	LTCH non-covered days							33.00
33. 00	LTCH site neutral days and discharges							33.00
	Temporary Expansion COVID-19 PHE Acute Care	30. 00		0		o	0	
5 50	1. Importor of control of the first house out o	33.00	1	٥		-		

Provider CCN: 15-0091

Peri od: Worksheet S-3 From 01/01/2023 Part I To 12/31/2023 Date/Ti me Prepared: 5/23/2024 4:22 pm

						5/23/2024 4: 2	2 pm
	·	I/P Days	/ O/P Visits	/ Tri ps	Full Time I	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	
	PART I - STATISTICAL DATA						
1.00	Hospital Adults & Peds. (columns 5, 6, 7 and	1, 128	78	4, 771			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, 928	1, 307				2.00
3.00	HMO IPF Subprovider	o	0				3.00
4.00	HMO IRF Subprovider	o	O				4.00
5.00	Hospital Adults & Peds. Swing Bed SNF	o	o	0			5.00
6.00	Hospital Adults & Peds. Swing Bed NF		0	0			6.00
7.00	Total Adults and Peds. (exclude observation	1, 128	78	4, 771			7.00
	beds) (see instructions)	·					
8.00	INTENSIVE CARE UNIT						8.00
9.00	CORONARY CARE UNIT						9.00
10.00	BURN INTENSIVE CARE UNIT						10.00
11.00	SURGICAL INTENSIVE CARE UNIT						11.00
12.00	OTHER SPECIAL CARE (SPECIFY)						12.00
13.00	NURSERY		32	735			13.00
14. 00	Total (see instructions)	1, 128	110	5, 506	0.00	224, 21	14.00
15. 00	CAH visits	o	0	0			15.00
15. 10	REH hours and visits	o	0	0			15. 10
16. 00	SUBPROVIDER - IPF	_	-				16.00
17. 00	SUBPROVIDER - I RF						17. 00
18. 00	SUBPROVI DER						18.00
19. 00	SKILLED NURSING FACILITY						19.00
20.00	NURSING FACILITY						20.00
21. 00	OTHER LONG TERM CARE						21.00
22. 00	HOME HEALTH AGENCY						22.00
23. 00	AMBULATORY SURGICAL CENTER (D. P.)						23. 00
24. 00	HOSPI CE						24.00
24. 10	HOSPICE (non-distinct part)			85			24. 10
25. 00	CMHC - CMHC			00			25. 00
26. 00	RURAL HEALTH CLINIC						26.00
26. 25		0	0	0	0.00	0.00	1
27. 00	Total (sum of lines 14-26)	J	Ŭ	· ·	0.00	224. 21	27. 00
28. 00	Observation Bed Days		36	1, 724	0.00	227.21	28.00
29. 00	Ambulance Trips	0	30	1, 727			29.00
30. 00	Employee discount days (see instruction)	١		0			30.00
	Employee discount days (see Thisti detroit)			0			31.00
32. 00	Labor & delivery days (see instructions)	0	73	136			32.00
32. 00	Total ancillary labor & delivery room	٩	7.5	0			32.00
JZ. U1	outpatient days (see instructions)			0			32.01
33 00	LTCH non-covered days	0					33.00
	LTCH site neutral days and discharges						33.00
	Temporary Expansi on COVID-19 PHE Acute Care		0	0			34.00
57.00	Transporting Expansion Covid-17 The Acute Care	ı Y	Ч	0	I	I	1 37.00

Provider CCN: 15-0091

					12/31/2023	5/23/2024 4: 2	
		Full Time Equivalents	·	Di sch	arges		·
	Component	Nonpai d Workers	Title V	Title XVIII	Title XIX	Total All Patients	
		11. 00	12. 00	13.00	14.00	15. 00	
	PART I - STATISTICAL DATA						
1. 00	Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days) (see instructions for col. 2 for the portion of LDP room available beds)		0	396	51	1, 828	1.00
2.00	HMO and other (see instructions)			666	618		2.00
3. 00	HMO IPF Subprovider				o		3.00
4.00	HMO IRF Subprovider				o		4.00
5.00	Hospital Adults & Peds. Swing Bed SNF						5.00
6.00	Hospital Adults & Peds. Swing Bed NF						6.00
7. 00	Total Adults and Peds. (exclude observation beds) (see instructions)						7. 00
8.00	INTENSIVE CARE UNIT						8.00
9.00	CORONARY CARE UNIT						9. 00
10.00	BURN INTENSIVE CARE UNIT						10.00
11.00	SURGICAL INTENSIVE CARE UNIT						11.00
12.00	OTHER SPECIAL CARE (SPECIFY)						12.00
13.00	NURSERY						13.00
14.00	Total (see instructions)	0.00	0	396	51	1, 828	
15. 00	CAH visits						15.00
15. 10	REH hours and visits						15. 10
16.00	SUBPROVIDER - IPF						16. 00
17. 00	SUBPROVIDER - IRF						17. 00
18.00	SUBPROVI DER						18.00
19.00	SKILLED NURSING FACILITY						19.00
20. 00 21. 00	NURSING FACILITY						20. 00 21. 00
21.00	OTHER LONG TERM CARE HOME HEALTH AGENCY						21.00
23. 00	AMBULATORY SURGICAL CENTER (D. P.)						23.00
24. 00	HOSPICE						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
34. 00	Temporary Expansion COVID-19 PHE Acute Care				l		34.00

| Period: | Worksheet S-3 | From 01/01/2023 | Part II | To | 12/31/2023 | Date/Time | Prepared: Health Financial Systems
HOSPITAL WAGE INDEX INFORMATION Provi der CCN: 15-0091

Winter Winter Winter Report to Sal arises							o 12/31/2023		
Salaries Coron Marco Salaries Corol 2 Col 4 Col 5 Col								Average	z piii
NAME 1 NAME DATA SALARIES			Number	Reported					
No. Part 1 - WAGE DATA					(from Wkst.	\ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \		7	
Name			1 00	2 00		4 00	5 00	6.00	
1.00				2. 00	0.00	1	0.00	0.00	
2.00 Non-Physic ian anestheti st Part 0 0 0 0 0 0 0 0 0	1. 00		200.00	19, 422, 790	5, 255, 271	24, 678, 061	614, 809. 12	40. 14	1. 00
3 0 No Physician anesthetist Part 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	2.00	instructions)						0.00	2 00
1.00 Abain is strutive	2.00	A anesthetist Part		U			0.00	0.00	2.00
Administrative 0 0 0 0 0 0 0 0 0	3. 00	Non-physician anesthetist Part		0	0	C	0.00	0. 00	3. 00
Physician and Non	4. 00			0	O	C	0. 00	0. 00	4. 00
Physician-Part B		Physicians - Part A - Teaching		0	0				
hospital -based HIC and FOIIC Services Services Services Interest & residents (in an 21.00 0 0 0 0 0 0 0 0 0	5.00			Ü	0		0.00	0.00	5.00
Interns & residents (in am 21.00 0 0 0 0 0.00 0.00 7.00	6. 00	hospital-based RHC and FQHC		0	0	C	0. 00	0. 00	6. 00
7.01 Contracted interns and provod programs) 8.00 Home office and/or related of the management and administrative service and contract above. Physician Part A - Toaching Home office and Contract Physicians Part A - Toaching Home office and Contract Physicians Part A - Toaching Home office and Service	7. 00		21. 00	0	0	c	0.00	0. 00	7. 00
residents (in an approved programs)	7 01			0			0.00	0.00	7 01
Organization personnel Sexi uded area salaries (see 3,320,025 397,013 3,717,038 119,265,91 31.17 10.00 Excluded area salaries (see 3,320,025 397,013 3,717,038 119,265,91 31.17 10.00 Instructions) OTHER WAGE'S & RELATED COSTS 11.00 Contract I labor: Injected Patient O	7.01	residents (in an approved		O			0.00	0.00	7.01
9.00 SNF 44.00 0 0 0 0 0 0 0 0 0	8. 00	II I		5, 255, 271	0	5, 255, 271	134, 954. 62	38. 94	8. 00
Instructions Ontrace MAGES & RELATED COSTS		SNF	44. 00	0	o				
OTHER WAGES & RELATED COSTS	10. 00	1		3, 320, 025	397, 013	3, 717, 038	119, 265. 91	31. 17	10. 00
Care		OTHER WAGES & RELATED COSTS				1			44.00
management and other management and other management and administrative services	11.00	1		U			0.00	0.00	11.00
management and administrative services	12. 00			0	О	C	0. 00	0. 00	12.00
13.00 Contract Labor: Physician-Part 0 0 0 0 0 0.00 13.00 14.00 Home office and/or related 0 0 0 0 0 0 0.00 14.00 Home office and/or related 0 0 0 0 0 0 0 14.00 organization sal aries and wage-related costs 0 0 0 0 0 0 0 0 14.01 Home office and sal aries 0 0 0 0 0 0 0 0 15.00 Home office and sal aries 0 0 0 0 0 0 0 0 15.00 Home office and contract 0 0 0 0 0 0 0 15.00 Home office and Contract 0 0 0 0 0 0 0 16.01 Home office Physicians Part A - Teaching 0 0 0 0 0 0 0 16.02 Physicians Part A - Teaching 0 0 0 0 0 0 16.03 Home office contract 0 0 0 0 0 0 0 17.00 Wage-related costs (core) (see instructions) 0 0 0 0 0 0 18.00 Wage-related costs (other) (see instructions) 0 0 0 0 0 0 19.00 Excluded areas 1,500,891 0 1,500,891 0 1,500,891 19.00 19.00 Excluded areas 1,500,891 0 1,500,891 19.00 19.00 Physician part A - Teaching 0 0 0 0 19.01 Physician Part A - Teaching 0 0 0 0 19.00 Physician Part A - Teaching 0 0 0 0 19.00 Excluded areas									
14. 00 Home office and/or related or or organization salaries and wage-related costs	13. 00	Contract Labor: Physician-Part		0	0	C	0.00	0. 00	13. 00
14. 01 Home office salaries and wage-related costs 14. 01 Home office salaries 5, 255, 271 0 5, 255, 271 134, 954. 62 38. 94 14. 01 14. 02 Related organization salaries 0 0 0 0 0. 00 0. 00 14. 02 15. 00 0 0 0. 00 0. 00 0. 00 15. 00 0 0. 00 0. 00 0. 00 0. 00 0. 00 15. 00 0. 00 0. 00 0. 00 0. 00 0. 00 0. 00 0. 00 15. 00 0.	14. 00			0	0		0.00	0. 00	14. 00
14. 01 Home office salaries		organization salaries and							
15.00 Home office: Physician Part A 0 0 0 0 0 0 0 0 0	14. 01			5, 255, 271	O	5, 255, 271	134, 954. 62	38. 94	14. 01
- Admini strative Home office and Contract Physicians Part A - Teaching Home office Physicians Part A - Teaching Home office Contract - Teaching Home office Contract - Teaching Home office Contract - Teaching Home office Contract - Teaching WAGE-RELATED COSTS 17. 00 Wage-related costs (core) (see instructions) Sexol uded areas 1,500,891 0,000 Non-physician anesthetist Part A A 1000 Non-physician Part A - Teaching B 22. 00 Physician Part A - Teaching Administrative - Teaching NAGE-RELATED COSTS 17. 00 Instructions) Sexol uded areas 1,500,891 0,000 0,0				0	0				
Physicians Part A - Teaching Home office Physicians Part A Teaching Home office Physicians Part A Teaching Home office contract Description	15.00			U			0.00	0.00	15.00
16. 01 Home office Physicians Part A	16. 00	1		0	0	C	0.00	0. 00	16. 00
16.02 Home office contract	16. 01	Home office Physicians Part A		0	О	c	0. 00	0. 00	16. 01
Physicians Part A - Teaching	16. 02			0	0		0.00	0.00	16. 02
17. 00 Wage-related costs (core) (see instructions) 17. 00 instructions) 18. 00 Wage-related costs (other) (see instructions) 18. 00 Wage-related costs (other) (see instructions) 18. 00 19. 00		Physicians Part A - Teaching		-					
18.00 Wage-related costs (other) (see instructions) 18.00	17. 00			6, 341, 774	0	6, 341, 774			17. 00
19. 00 Excl uded areas 1,500,891 0 1,500,891 20.00	18. 00	Wage-related costs (other)							18. 00
A Non-physician anesthetist Part B		Excluded areas		1, 500, 891	0	1, 500, 891			
B	20. 00	Non-physician anesthetist Part A		0	O	C			20. 00
Administrative 22.01 Physician Part A - Teaching 0 0 0 0 22.01	21. 00	Non-physician anesthetist Part		0	О	C			21. 00
22. 01 Physician Part A - Teaching	22. 00			0	a	C			22. 00
24. 00 Wage-related costs (RHC/FQHC) 0 0 0 0 24. 00 25. 00 Interns & residents (in an approved program) 0 0 0 0 0 25. 00 25. 50 Home office wage-related (core) 2, 659, 921 0 2, 659, 921 25. 50 25. 51 Related organization wage-related (core) 0 0 0 25. 51 25. 52 Home office: Physician Part A - Administrative - 0 0 0 25. 52		Physician Part A - Teaching		0	0	C			
25. 00 Interns & residents (in an approved program) 25. 00 25. 50 Home office wage-related (core) 25. 51 Related organization wage-related (core) Home office: Physician Part A				0					
25. 50 Home office wage-related (core) 25. 51 Related organization wage-related (core) 45. 52 Home office: Physician Part A - Administrative - 25. 52 Home office: Physician Part A - Administrative - 25. 52 Home office: Physician Part A - Administrative - 25. 50 2, 659, 921 25. 50 2		Interns & residents (in an		0	0	C			
25.51 Related organization wage-related (core) 25.52 Home office: Physician Part A	25. 50	Home office wage-related		2, 659, 921	a	2, 659, 921			25. 50
25.52 Home office: Physician Part A 0 0 0 25.52 - Administrative -	25. 51	Related organization		0	0	c			25. 51
- Administrative -	25. 52			Ω	0				25. 52
	02	- Administrative -		Ü					
wage-related (core)		wage-related (core)			l	l	l l		l

HOSPITAL WAGE INDEX INFORMATION Provider CCN: 15-0091 Peri od: Worksheet S-3 From 01/01/2023 Part II Date/Time Prepared: 12/31/2023 5/23/2024 4:22 pm 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 2, 098, 066 -2, 098, 066 0.00 0. 00 26.00 27.00 Administrative & General 5.00 922, 221 5, 342, 125 6, 264, 346 148, 647. 45 42. 14 27.00 28.00 0.00 0.00 28.00 Administrative & General under contract (see inst.) 29.00 Maintenance & Repairs 6.00 0 0.00 0.00 29.00 30.00 Operation of Plant 7.00 420, 286 50, 258 470, 544 13, 147. 75 35. 79 30.00 22. 96 . Laundry & Linen Service 8.00 48, 446 48, 446 2, 110. 00 31.00 31.00 32.00 484, 456 24. 04 Housekeepi ng 9.00 9, 486 493, 942 20, 545. 85 32.00 33.00 Housekeeping under contract 0.00 0.00 33.00 (see instructions) 34.00 Dietary 10.00 611, 565 -235, 524 376, 041 12, 710. 23 29. 59 34.00 Dietary under contract (see 35.00 0.00 0.00 35.00 instructions) 36.00 Cafeteri a 11.00 0 308, 656 308, 656 12, 951. 47 23. 83 36.00 0.00 37.00 Maintenance of Personnel 12.00 0.00 37.00 Nursing Administration 55. 74 38.00 38.00 13.00 328, 341 39, 263 367, 604 6, 595. 00 39.00 Central Services and Supply 14.00 0.00 0.00 39.00 61. 78 40.00 Pharmacy 15.00 632, 997 632, 997 10, 245. 96 40.00 0 Medical Records & Medical Records Library 41.00 16.00 0 0 0.00 0.00 41.00 0

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	PITAL In Lieu of Form CMS-2552-10				
HOSPITAL WAGE INDEX INFORMATION	Provider CCN: 15-0091	Period: Worksheet S-3				

						rom 01/01/2023 o 12/31/2023	Part III Date/Time Pre 5/23/2024 4:2	
		Worksheet A	Amount	Recl assi fi cat	Adj usted	Pai d 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						ı
1.00	Net salaries (see		14, 167, 519	5, 255, 271	19, 422, 790	479, 854. 50	40. 48	1.00
	instructions)							i
2.00	Excluded area salaries (see		3, 320, 025	397, 013	3, 717, 038	119, 265. 91	31. 17	2.00
	instructions)							i
3.00	Subtotal salaries (line 1		10, 847, 494	4, 858, 258	15, 705, 752	360, 588. 59	43. 56	3.00
	minus line 2)							i
4.00	Subtotal other wages & related		5, 255, 271	0	5, 255, 271	134, 954. 62	38. 94	4.00
	costs (see inst.)							i
5.00	Subtotal wage-related costs		9, 001, 695	0	9, 001, 695	0.00	57. 31	5.00
	(see inst.)							ii
6.00	Total (sum of lines 3 thru 5)		25, 104, 460	4, 858, 258	29, 962, 718	495, 543. 21	60. 46	6.00
7.00	Total overhead cost (see		5, 497, 932	3, 464, 644	8, 962, 576	226, 953. 71	39. 49	7.00
	instructions)							

Health Financial Systems	HUNTINGTON MEMORIAL HOSPITAL	In Lieu of Form CMS-255		
HOSPITAL WAGE RELATED COSTS	Provi der CCN: 15-0091	Period: From 01/01/2023	Worksheet S-3 Part IV	

	To 12/31/2023	Date/Time Pre 5/23/2024 4: 2	
		Amount	
		Reported	
		1. 00	
	PART IV - WAGE RELATED COSTS		
	Part A - Core List		
	RETI REMENT COST		
1.00	401K Employer Contributions	0	1.00
2.00	Tax Sheltered Annuity (TSA) Employer Contribution	436, 904	2.00
3.00	Nonqualified Defined Benefit Plan Cost (see instructions)	0	3.00
4.00	Qualified Defined Benefit Plan Cost (see instructions)	1, 355, 069	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	3, 901	6.00
7.00	Employee Managed Care Program Administration Fees	72, 395	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, 163, 883	8. 02
8. 03	Health Insurance (Purchased)	0	8. 03
9.00	Prescription Drug Plan	887, 246	9. 00
10.00		109, 044	
11. 00		20, 775	11.00
12.00		0	12.00
13.00		76, 304	13.00
14.00		0	14.00
15.00		11, 963	15.00
16.00		0	16.00
	Noncumul ati ve porti on)		
	TAXES		
17. 00		1, 642, 878	
18. 00		0	18.00
19. 00		0	19. 00
20. 00		0	20.00
	OTHER		
21. 00		12, 832	21. 00
	instructions))	_	
22. 00		0	22.00
23. 00		49, 472	23. 00
24. 00		7, 842, 666	24.00
25 62	Part B - Other than Core Related Cost		25 00
25.00	OTHER WAGE RELATED COSTS (SPECIFY)		25. 00

Health Financial Systems	HUNTINGTON MEMORIAL HOSPITAL	In Lieu of Form CMS-255			
HOSPITAL CONTRACT LABOR AND BENEFIT COST	Provi der CCN: 15-0091	From 01/01/2023 To 12/31/2023	Worksheet S-3 Part V Date/Time Prepared: 5/23/2024 4:22 pm		

		То	12/31/2023	Date/Time Pre 5/23/2024 4:2	
	Cost Center Description		Contract	Benefit Cost	
		L	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	7, 842, 666	
2. 00	Hospi tal		0	7, 842, 666	
3.00	SUBPROVI DER - I PF				3. 00
4. 00	SUBPROVI DER - I RF				4. 00
5. 00	Subprovi der - (0ther)		0	0	5. 00
6. 00	Swing Beds - SNF		0	0	6.00
7. 00	Swing Beds - NF		0	0	7. 00
8. 00	SKILLED NURSING FACILITY				8. 00
9.00	NURSING FACILITY				9. 00
10. 00	OTHER LONG TERM CARE I				10.00
	Hospi tal -Based HHA				11. 00
	AMBULATORY SURGICAL CENTER (D. P.) I				12.00
	Hospi tal -Based Hospi ce				13.00
14. 00	Hospital-Based Health Clinic RHC				14. 00
15. 00	Hospital-Based Health Clinic FQHC				15. 00
	Hospi tal -Based-CMHC				16.00
	RENAL DIALYSIS I				17. 00
18. 00	Other		O	0	18. 00

Hool +b	Financial Systems HUNTINGTON MEMORIAL	HOSDI TAI		ln lio	u of Form CMS 1	neen 10
	3	Provider C	CN: 15-0091	Peri od: From 01/01/2023 To 12/31/2023		0 pared:
					1. 00	
	PART I - HOSPITAL AND HOSPITAL COMPLEX DATA					
	Uncompensated and Indigent Care Cost-to-Charge Ratio					
1.00	Cost to charge ratio (see instructions)				0. 202744	1.00
	Medicaid (see instructions for each line)					
2.00	Net revenue from Medicaid				3, 137, 492	2.00
3.00	Did you receive DSH or supplemental payments from Medicaid?				Υ	3.00
4.00	If line 3 is yes, does line 2 include all DSH and/or supplement	, ,		ai d?	Υ	4.00
5.00	If line 4 is no, then enter DSH and/or supplemental payments fi	rom Medica	d		0	5.00
6.00	Medi cai d charges				26, 986, 244	
7. 00	Medicaid cost (line 1 times line 6)				5, 471, 299	
8.00	Difference between net revenue and costs for Medicaid program				2, 333, 807	8.00
	Children's Health Insurance Program (CHIP) (see instructions for	or each li	ne)			
9. 00	Net revenue from stand-alone CHIP				28, 803	
10.00	Stand-al one CHIP charges				169, 455	
11.00	Stand-alone CHIP cost (line 1 times line 10)				34, 356	1
12. 00	Difference between net revenue and costs for stand-alone CHIP			`	5, 553	12.00
40.00	Other state or local government indigent care program (see inst				F 044 F07	40.00
13.00	Net revenue from state or local indigent care program (Not incl				5, 841, 587	
14. 00	Charges for patients covered under state or local indigent care	e program	(Not included	in tines 6 or	36, 350, 880	14. 00
15. 00	10) State or local indigent care program cost (line 1 times line 14	4)			7, 369, 923	15. 00
16.00 Difference between net revenue and costs for state or local indigent care program (see instructions)						
10.00	Grants, donations and total unreimbursed cost for Medicaid, CHI				1, 528, 336	10.00
	instructions for each line)	i una sta	ic/ rocar rnai	gent care progre	(300	
17.00	Private grants, donations, or endowment income restricted to fu	undi ng cha	rity care		0	17. 00
18.00	Government grants, appropriations or transfers for support of h	hospital o _l	perations		0	18.00
19.00	Total unreimbursed cost for Medicaid, CHIP and state and local	l indigent	care program	ns (sum of lines	3, 867, 696	19. 00
	8, 12 and 16)					
			Uni nsured	Insured	Total (col. 1	
			pati ents	pati ents	+ col . 2)	
	Uncompensated care cost (see instructions for each line)		1. 00	2. 00	3. 00	
20. 00	Charity care charges and uninsured discounts (see instructions)	`	3, 044, 5	67 1, 501, 021	4, 545, 588	20.00
21. 00	Cost of patients approved for charity care and uninsured discounts		617, 2			
21.00	instructions)	unts (500	017,2	1, 110, 770	2,020,001	21.00
22. 00	Payments received from patients for amounts previously written	off as		0 0	0	22. 00
22.00	charity care	0 40				22.00
23.00	Cost of charity care (see instructions)		617, 2	58 1, 410, 796	2, 028, 064	23. 00
					1. 00	
24. 00	Does the amount on line 20 col. 2, include charges for patient	days beyor	nd a Length o	of stay limit	N	24.00
	imposed on patients covered by Medicaid or other indigent care	program?				
25. 00	If line 24 is yes, enter the charges for patient days beyond the	he indigen	t care progra	m's length of	0	25. 00
	stay limit					
25. 01	Charges for insured patients' liability (see instructions)				113, 170	
26.00	Bad debt amount (see instructions)				3, 293, 843	
27. 00	Medicare reimbursable bad debts (see instructions)				•	27.00
27 ()1	Medicare allowable had debts (see instructions)				91 031	1 27 ()1

91, 031 27. 01

3, 202, 812 28. 00 681, 211 29. 00 2, 709, 275 30. 00

6, 576, 971 31.00

30.00 Cost of uncompensated care (line 23, col. 3, plus line 29)

31.00 Total unreimbursed and uncompensated care cost (line 19 plus line 30)

28.00 Non-Medicare bad debt amount (see instructions)
29.00 Cost of non-Medicare and non-reimbursable Medicare bad debt amounts (see instructions)

27.01 Medicare allowable bad debts (see instructions)

llool +b	Financial Customs	LUCCLITAL		ln lio	u of Form CMC 1	DEE2 10
	Financial Systems HUNTINGTON MEMORIAI FAL UNCOMPENSATED AND INDIGENT CARE DATA	Provider C	CN: 15-0091	Peri od: From 01/01/2023 To 12/31/2023		0 pared:
					1. 00	
	PART II - HOSPITAL DATA				1.00	
	Uncompensated and Indigent Care Cost-to-Charge Ratio					
1.00	Cost to charge ratio (see instructions)				0. 202744	1.00
	Medicaid (see instructions for each line)					
2.00	Net revenue from Medicaid					2. 00
3.00	Did you receive DSH or supplemental payments from Medicaid?					3. 00
4.00	If line 3 is yes, does line 2 include all DSH and/or supplemen			ai d?		4.00
5.00	If line 4 is no, then enter DSH and/or supplemental payments f	rom Medicai	id			5.00
6. 00 7. 00	Medicaid charges Medicaid cost (line 1 times line 6)					6. 00 7. 00
8. 00	Difference between net revenue and costs for Medicaid program	(see instri	uctions)			8.00
0.00	Children's Health Insurance Program (CHIP) (see instructions f					0.00
9. 00	Net revenue from stand-alone CHIP		,			9. 00
10.00	Stand-alone CHIP charges					10.00
11.00	Stand-alone CHIP cost (line 1 times line 10)					11.00
12.00	Difference between net revenue and costs for stand-alone CHIP					12.00
	Other state or local government indigent care program (see ins					
13. 00	Net revenue from state or local indigent care program (Not inc					13.00
14. 00	Charges for patients covered under state or local indigent car	re program	(Not included	lin lines 6 or		14. 00
15. 00	10) State or local indigent care program cost (line 1 times line 1	14)				15. 00
16. 00						
10.00	Grants, donations and total unreimbursed cost for Medicaid, CH				ıms (see	16. 00
	instructions for each line)			3 p3		
17.00	Private grants, donations, or endowment income restricted to f	undi ng chai	ri ty care			17.00
18.00	Government grants, appropriations or transfers for support of					18.00
19. 00	Total unreimbursed cost for Medicaid , CHIP and state and local	al indigent	care program	s (sum of lines		19. 00
	8, 12 and 16)		11.2	1	T. I. I. (I 4	
			Uni nsured pati ents	Insured patients	Total (col. 1 + col. 2)	
			1.00	2.00	3. 00	
	Uncompensated care cost (see instructions for each line)			2.00	3. 00	
20.00	Charity care charges and uninsured discounts (see instructions	5)	3, 044, 50	1, 501, 021	4, 545, 588	20.00
21.00	Cost of patients approved for charity care and uninsured disco	ounts (see	617, 20	1, 410, 796	2, 028, 064	21.00
	instructions)					
22. 00	Payments received from patients for amounts previously writter	n off as		0 0	0	22. 00
	charity care		(47.0			
23.00	Cost of charity care (see instructions)		617, 20	58 1, 410, 796	2, 028, 064	23.00
					1. 00	
24. 00	Does the amount on line 20 col. 2, include charges for patient	days heve	nd a Length o	of stay limit	1. 00 N	24. 00
27.00	imposed on patients covered by Medicaid or other indigent care		ia a religiti c	Stay IIIII t	14	27.00
25. 00	If line 24 is yes, enter the charges for patient days beyond t		t care progra	ım's Lenath of	0	25. 00
	stay limit		₋	- · -··g -·· 3·		
25. 01	Charges for insured patients' liability (see instructions)				113, 170	25. 01
26.00	Bad debt amount (see instructions)				3, 293, 843	
27. 00	Medicare reimbursable bad debts (see instructions)				59, 171	
27 ∩1	Medicare allowable had debts (see instructions)				01 031	1 27 ∩1

91, 031 27. 01

3, 202, 812 28. 00 681, 211 29. 00 2, 709, 275 30. 00 2, 709, 275 31. 00

27.01 Medicare allowable bad debts (see instructions)

28.00 Non-Medicare bad debt amount (see instructions)
29.00 Cost of non-Medicare and non-reimbursable Medicare bad debt amounts (see instructions)
30.00 Cost of uncompensated care (line 23, col. 3, plus line 29)

31.00 Total unreimbursed and uncompensated care cost (line 19 plus line 30)

Heal th	Financial Systems	HUNTI NGTON MEMORI	AL HOSPITAL		In Lie	u of Form CMS-	2552-10
RECLAS	SSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE	OF EXPENSES	Provi der C		Period: From 01/01/2023 To 12/31/2023	Worksheet A Date/Time Pre	
	Cost Center Description	Sal ari es	Other	Total (col. 1 + col. 2)	Reclassificat ions (See A-6)	Reclassified Trial Balance (col. 3 +-	22 pm
		1. 00	2. 00	3. 00	4. 00	col . 4) 5.00	
	GENERAL SERVICE COST CENTERS	11.00	2.00	0.00	11.00	0.00	
1.00	00100 CAP REL COSTS-BLDG & FLXT		1, 805, 093			1, 867, 793	
2. 00	00200 CAP REL COSTS-MVBLE EQUIP		953, 377			1, 003, 729	
3. 00 4. 00	00300 OTHER CAP REL COSTS	2 000 044	6, 260, 320		0	0	
5. 00	00400 EMPLOYEE BENEFITS DEPARTMENT 00500 ADMINISTRATIVE & GENERAL	2, 098, 066 922, 221	26, 712, 405			6, 260, 320 27, 608, 428	
6. 00	00600 MAINTENANCE & REPAIRS	0	20, 712, 409	27,054,020	0 20, 170	0 27, 000, 420	6.00
7. 00	00700 OPERATION OF PLANT	420, 286	809, 862	1, 230, 148	50, 258	1, 280, 406	
8.00	00800 LAUNDRY & LINEN SERVICE	0	149, 667		· ·	198, 113	
9.00	00900 HOUSEKEEPI NG	484, 456	156, 410			650, 352	
10. 00 11. 00	01000 DI ETARY 01100 CAFETERI A	611, 565	331, 175 -456			540, 853 474, 563	
12. 00	01200 MAINTENANCE OF PERSONNEL		-430	-430	0 473,017	0	1
13.00	01300 NURSING ADMINISTRATION	328, 341	13, 746	342, 08	39, 263	381, 350	
14.00	01400 CENTRAL SERVICES & SUPPLY	0	0	(0	0	14.00
15.00	01500 PHARMACY	632, 997	62, 263	695, 260	0	695, 260	1
16. 00 17. 00	01600 MEDICAL RECORDS & LIBRARY 01700 SOCIAL SERVICE	0	0)) 0	16. 00 17. 00
19.00	01900 NONPHYSI CLAN ANESTHETI STS	0	0			0	19.00
20. 00	02000 NURSI NG PROGRAM	o o	0		0	Ö	20.00
21.00	02100 I &R SERVICES-SALARY & FRINGES APPRV	0	0		0	0	21.00
22. 00	02200 I &R SERVI CES-OTHER PRGM COSTS APPRV	0	0	(0 0	0	22. 00
30. 00	INPATIENT ROUTINE SERVICE COST CENTERS 03000 ADULTS & PEDIATRICS	3, 984, 396	598, 143	4, 582, 539	-562, 467	4, 020, 072	30.00
43. 00	04300 NURSERY	0	0 0		221, 706		1
	ANCILLARY SERVICE COST CENTERS						
50.00	05000 OPERATING ROOM	1, 259, 547	735, 595	1, 995, 142	150, 618		
50. 01 52. 00	O5001 OPERATING ROOM O5200 DELIVERY ROOM & LABOR ROOM	0	0		0 850, 695	0 850, 695	
53.00	05300 ANESTHESI OLOGY	0	1, 560, 515	1, 560, 51		1, 560, 515	
54. 00	05400 RADI OLOGY-DI AGNOSTI C	1, 296, 890	786, 425			2, 238, 399	
60.00	06000 LABORATORY	0	3, 216, 128	3, 216, 128	0	3, 216, 128	
62. 30	06250 BLOOD CLOTTING FOR HEMOPHILIACS	0	0	000 400	0 00 (57	0	62.30
65. 00 66. 00	06500 RESPI RATORY THERAPY 06600 PHYSI CAL THERAPY	699, 585 1, 320, 963	222, 818 39, 419			1, 006, 060 1, 021, 858	1
67.00	06700 OCCUPATI ONAL THERAPY	0	0	1, 300, 302	272, 559		1
68. 00	06800 SPEECH PATHOLOGY	0	0		223, 928	223, 928	68.00
69. 00	06900 ELECTROCARDI OLOGY	71, 245	10, 121	•			
71. 00 72. 00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT 07200 IMPL. DEV. CHARGED TO PATIENTS	0	1, 578, 293	1, 578, 293	911, 003 911, 003		
73.00	07300 DRUGS CHARGED TO PATIENTS	0	2, 750, 100	2, 750, 100			
	07697 CARDI AC REHABI LI TATI ON	Ö	0	(0	0	1
	07698 HYPERBARI C OXYGEN THERAPY	325, 415	551, 134	876, 549	38, 914	915, 463	
	07699 LI THOTRI PSY	0	0	(0	0	
77. 00 78. 00	07700 ALLOGENEIC HSCT ACQUISITION 07800 CAR T-CELL IMMUNOTHERAPY	0	0			0	
70.00	OUTPATIENT SERVICE COST CENTERS	<u> </u>			5, 5		70.00
90.00	09000 CLINIC	156, 465	23, 517				
91. 00 92. 00	09100 EMERGENCY 09200 OBSERVATION BEDS (NON-DISTINCT PART	1, 490, 327	481, 496	1, 971, 823	194, 519	2, 166, 342	91.00
92.00	OTHER REIMBURSABLE COST CENTERS						92.00
95.00	09500 AMBULANCE SERVICES	3, 243, 002	864, 288	4, 107, 290	387, 803	4, 495, 093	95.00
102.00	10200 OPIOID TREATMENT PROGRAM	0	0	(0	0	102.00
112 00	SPECIAL PURPOSE COST CENTERS 11300 NTEREST EXPENSE		0	1 ,		0	113.00
118.00		19, 345, 767	50, 671, 854		0 1 -9, 210		
	NONREI MBURSABLE COST CENTERS	, , , , , , , , , , , , , , , , , , , ,		, ,	., ., .,		
	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	22, 126	22, 120	6 0		190.00
) 19100 RESEARCH 19200 PHYSICIANS' PRIVATE OFFICES	76, 126	9, 350	85, 470	0 5 9, 103		191. 00 192. 00
	07950 OCC HEALTH	70, 120	9, 330	05,470	0 7, 103		194.00
	07951 PALN CLINIC	0	0	į (0		194. 01
	07952 OCC HEALTH	0	0	(0		194. 02
	3 O7953 FOUNDATIO	0	14, 154	14, 154			194. 03
	07954 KIDS CAMPUS 07955 COMMUNITY & VOLUNTEER SERVICES	897	55, 828	56, 725	0 5 107		194. 04 194. 05
	07956 HUNTI NGTON COLLEGE NURSE	0	03, 020	30, 72	0		194. 06
194. 07	07957 MISC CATERING	0	0		o o	0	194. 07
	07958 AUTI SM CENTER	0	0		0		194.08
194. 09 200. 00	07959 HUNTINGTON BUA	10 422 700	50 772 212	70 104 104	0 0		194. 09
200. UC	TOTAL (SUM OF LINES 118 through 199)	19, 422, 790	50, 773, 312	70, 196, 102	۷ د	70, 196, 102	₁ ∠00.00

Provi der CCN: 15-0091

Period: Worksheet A From 01/01/2023 To 12/31/2023 Date/Time Prepared: 5/23/2024 4:22 pm

			5/23/2024 4: 2	
Cost Center Description	Adjustments	Net Expenses		
	(See A-8)	For		
		Allocation		
CENEDAL CEDIMAGE COCT CENTEDO	6. 00	7. 00		
GENERAL SERVICE COST CENTERS 1. 00 00100 CAP REL COSTS-BLDG & FLXT	248, 905	2, 116, 698		1.00
2. 00 00200 CAP REL COSTS-MVBLE EQUIP	532, 068	, , , , , ,		2.00
3. 00 00300 OTHER CAP REL COSTS	0 332,000	1, 333, 777		3.00
4. 00 00400 EMPLOYEE BENEFITS DEPARTMENT	-1, 990	· · · · · · · · · · · · · · · · · · ·		4.00
5. 00 00500 ADMINI STRATI VE & GENERAL	-11, 070, 938			5.00
6. 00 00600 MAINTENANCE & REPAIRS	0	0		6.00
7. 00 00700 OPERATION OF PLANT	-2, 659	1, 277, 747		7.00
8.00 00800 LAUNDRY & LINEN SERVICE	0	198, 113		8.00
9. 00 00900 HOUSEKEEPI NG	0	650, 352		9.00
10. 00 01000 DI ETARY	-233, 871	306, 982		10.00
11. 00 01100 CAFETERI A	-84, 351	390, 212		11.00
12.00 01200 MAINTENANCE OF PERSONNEL	0	O		12.00
13.00 01300 NURSING ADMINISTRATION	0	381, 350		13.00
14.00 01400 CENTRAL SERVICES & SUPPLY	0	0		14.00
15. 00 01500 PHARMACY	-64, 258	631, 002		15.00
16.00 01600 MEDICAL RECORDS & LIBRARY	0	0		16.00
17. 00 01700 SOCIAL SERVICE	0	0		17.00
19.00 O1900 NONPHYSICIAN ANESTHETISTS	0	0		19.00
20. 00 02000 NURSI NG PROGRAM	0	0		20.00
21.00 02100 I&R SERVICES-SALARY & FRINGES APPRV	0	0		21.00
22. 00 02200 1 &R SERVI CES-OTHER PRGM COSTS APPRV	0	0		22. 00
INPATIENT ROUTINE SERVICE COST CENTERS		4 000 070		1
30. 00 03000 ADULTS & PEDI ATRI CS 43. 00 04300 NURSERY	0			30.00
43. 00 O4300 NURSERY ANCI LLARY SERVICE COST CENTERS		221, 706		43.00
50. 00 05000 OPERATING ROOM	-1, 560, 515	585, 245		50.00
50. 01 05001 OPERATING ROOM	1, 300, 313	0		50.00
52.00 05200 DELIVERY ROOM & LABOR ROOM	o o	850, 695		52.00
53. 00 05300 ANESTHESI OLOGY	0	1, 560, 515		53.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	0	2, 238, 399		54.00
60. 00 06000 LABORATORY	0	3, 216, 128		60.00
62.30 06250 BLOOD CLOTTING FOR HEMOPHILIACS	0	0		62.30
65. 00 06500 RESPI RATORY THERAPY	0	1, 006, 060		65.00
66. 00 06600 PHYSI CAL THERAPY	0	1, 021, 858		66.00
67. 00 06700 OCCUPATI ONAL THERAPY	0	272, 559		67.00
68.00 06800 SPEECH PATHOLOGY	0	223, 928		68.00
69. 00 06900 ELECTROCARDI OLOGY	0	89, 886		69. 00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0	667, 290		71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0	911, 003		72.00
73. 00 07300 DRUGS CHARGED TO PATIENTS	0	2, 825, 795		73.00
76. 97 07697 CARDI AC REHABI LI TATI ON	0	0		76. 97
76. 98 07698 HYPERBARI C OXYGEN THERAPY	0	915, 463		76. 98
76. 99 O7699 LITHOTRIPSY 77. 00 O7700 ALLOGENEIC HSCT ACQUISITION	0	0		76. 99
77.00 07700 ALLOGENEIC HSCT ACQUISITION 78.00 07800 CAR T-CELL IMMUNOTHERAPY	0	0		77. 00 78. 00
OUTPATIENT SERVICE COST CENTERS	0	U _I		78.00
90. 00 09000 CLINIC	0	198, 692		90.00
91. 00 09100 EMERGENCY	-41, 200			91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART	, ===	_,,		92.00
OTHER REIMBURSABLE COST CENTERS	l .			
95. 00 09500 AMBULANCE SERVICES	-26, 993	4, 468, 100		95.00
102.00 10200 OPIOID TREATMENT PROGRAM	0	0		102.00
SPECIAL PURPOSE COST CENTERS				
113. 00 11300 I NTEREST EXPENSE	0			113.00
118.00 SUBTOTALS (SUM OF LINES 1 through 117)	-12, 305, 802	57, 702, 609		118. 00
NONREI MBURSABLE COST CENTERS		00.404		1400 00
190.00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	22, 126		190.00
191. 00 19100 RESEARCH	0	04 570		191.00
192. 00 19200 PHYSICIANS' PRIVATE OFFICES 194. 00 07950 OCC HEALTH	0	94, 579		192. 00 194. 00
194. 01 07950 OCC HEALTH	0	0		194.00
194. 02 07951 PATN CETNIC				194.01
194. 03 07953 FOUNDATI 0	0	14, 154		194. 02
194. 04 07954 KI DS CAMPUS		14, 134		194.03
194. 05 07955 COMMUNITY & VOLUNTEER SERVICES		56, 832		194.04
194. 06 07956 HUNTI NGTON COLLEGE NURSE		0		194.06
194. 07 07957 MI SC CATERI NG				194. 07
194. 08 07958 AUTI SM CENTER	0	o o		194. 08
194. 09 07959 HUNTI NGTON BUA	0			194. 09
200.00 TOTAL (SUM OF LINES 118 through 199)	-12, 305, 802	57, 890, 300		200.00
,				

Health Financial Systems	HUNTINGTON MEMORIAL HOSPITAL	In Lieu of Form CMS-2552-10
RECLASSI FI CATI ONS	Provi der CCN: 15-0091	Period: Worksheet A-6 From 01/01/2023
		To 12/31/2023 Date/Time Prepared:

					te/Time Prepared: 23/2024 4:22 pm
		Increases			 23/2024 4. 22 pili
	Cost Center	Li ne #	Sal ary	Other	
	2.00	3.00	4. 00	5. 00	
	A - CAFETERIA & CATERING				
1.00	CAFETERI A	<u>11.</u> 00	30 <u>8, 6</u> 56	16 <u>6, 3</u> 63	1.00
	0		308, 656	166, 363	
	B - INTEREST RECLASSIFICATION				
1. 00		000	0	0	1.00
	0			0	
1 00	C - INSURANCE RECLASS	1 00	٥	(2.700	1 00
1. 00 2. 00	CAP REL COSTS BLDG & FLXT	1.00	0	62, 700	1. 00 2. 00
2.00	CAP REL COSTS-MVBLE EQUIP		0	5 <u>0, 3</u> 52 113, 052	2.00
	E - LAUNDRY RECLASS		<u> </u>	113, 032	
1. 00	LAUNDRY & LINEN SERVICE	8. 00	48, 446	0	1.00
1.00	0	— — - 0.00	48, 446	ŏ	1.00
	F - HOME OFFICE SALARY RECLAS	S	10, 110	<u> </u>	
1. 00	ADMINISTRATIVE & GENERAL	5. 00	5, 255, 271	0	1, 00
	0		5, 255, 271	<u> </u>	
	G - PTO & BENEFITS RECLASS			<u>'</u>	
1.00	ADMINISTRATIVE & GENERAL	5. 00	86, 854	0	1.00
2.00	OPERATION OF PLANT	7. 00	50, 258	0	2.00
3.00	HOUSEKEEPI NG	9. 00	57, 932	0	3.00
4.00	DI ETARY	10.00	73, 132	0	4.00
5.00	NURSING ADMINISTRATION	13. 00	39, 263	0	5. 00
6.00	PHARMACY	15. 00	0	0	6.00
7.00	ADULTS & PEDIATRICS	30. 00	509, 934	0	7.00
8. 00	OPERATING ROOM	50. 00	150, 618	0	8. 00
9. 00	RADI OLOGY-DI AGNOSTI C	54.00	155, 084	0	9. 00
10.00	LABORATORY	60.00	0	0	10.00
11.00	RESPIRATORY THERAPY	65.00	83, 657	0	11.00
12.00	PHYSI CAL THERAPY	66.00	157, 963	0	12.00
13. 00 14. 00	DRUGS CHARGED TO PATIENTS	69. 00 73. 00	8, 520 75, 695	0	13. 00 14. 00
15. 00	HYPERBARIC OXYGEN THERAPY	76. 98	75, 695 38, 914	0	15. 00
16. 00	CLI NI C	90.00	18, 710	0	16.00
17. 00	EMERGENCY	91.00	194, 519	0	17. 00
18. 00	AMBULANCE SERVICES	95.00	387, 803	0	18.00
19. 00	PHYSICIANS' PRIVATE OFFICES	192. 00	9, 103	0	19.00
20. 00	COMMUNITY & VOLUNTEER	194. 05	107	Ö	20.00
	SERVI CES				
		- $ +$	2, 098, 066	₀	
	H - IMPLANTS				
1.00	IMPL. DEV. CHARGED TO	72. 00	0	911, 003	1.00
	PATI ENTS	↓			
	0		0	911, 003	
	I - OB RECLASS				
1.00	NURSERY	43.00	191, 919	29, 787	1.00
2. 00	DELIVERY ROOM & LABOR ROOM	52.00	736, 402	114, 293	2.00
	U		928, 321	144, 080	
1. 00	OCCUPATIONAL THERAPY	67. 00	264, 661	7, 898	1.00
2. 00	SPEECH PATHOLOGY	68. 00	217, 439	6, 489	2.00
2.00	0	— — 66. 66	482, 100	$- \frac{0,489}{14,387}$	2.00
500. 00	Grand Total: Increases		9, 120, 860	1, 348, 885	500.00
	1	1	.,0, 000	., = .=, 555	1 000. 00

Health Financial Systems	HUNTINGTON MEMORIAL HOSPITAL	In Lieu of Form CMS-2552-10		
RECLASSI FI CATI ONS	Provi der CCN: 15-0091	Period: Worksheet A-6 From 01/01/2023		
		To 12/31/2023 Date/Time Prepared:		

					Т	o 12/31/2023	Date/Time Prepared: 5/23/2024 4:22 pm
		Decreases					372372024 4. 22 piii
	Cost Center	Li ne #	Sal ary	Other	Wkst. A-7 Ref.		
	6. 00	7. 00	8. 00	9. 00	10.00		
	A - CAFETERIA & CATERING						
1.00	DI ETARY	1000	30 <u>8, 6</u> 56	16 <u>6, 3</u> 63			1.00
	0		308, 656	166, 363			
	B - INTEREST RECLASSIFICATION						
1. 00		0.00		0	0		1.00
	O LNCUDANCE DECLACE		U U	0			
1 00	C - INSURANCE RECLASS ADMINISTRATIVE & GENERAL	5. 00	٥	113, 052	10		1 00
1. 00 2. 00	ADMINISTRATIVE & GENERAL	0. 00	0	113,032			1. 00 2. 00
2.00			0	00 113, 052			2.00
	E - LAUNDRY RECLASS		<u> </u>	113, 032			
1. 00	HOUSEKEEPI NG	9. 00	48, 446	0	0		1.00
00	0	— — // 	48, 446	-			
	F - HOME OFFICE SALARY RECLAS	S	,				
1.00	ADMINISTRATIVE & GENERAL	5. 00	0	5, 255, 271	0		1.00
			0	5, 255, 271			
	G - PTO & BENEFITS RECLASS	<u> </u>					
1.00	EMPLOYEE BENEFITS DEPARTMENT	4. 00	2, 098, 066	0			1.00
2.00		0.00	0	0			2.00
3.00		0. 00	0	0			3.00
4.00		0. 00	0	0	0		4.00
5.00		0. 00	0	0	0		5.00
6.00		0. 00	0	0			6.00
7.00		0. 00	0	0			7.00
8.00		0. 00	0	0	_		8.00
9.00		0. 00	0	0			9.00
10.00		0. 00	0	0			10.00
11.00		0.00	0	0			11.00
12.00		0. 00	0	0			12.00
13.00		0.00	0	0			13.00
14.00		0.00	0	0	0		14.00
15.00		0.00	0	0	0		15.00
16. 00 17. 00		0. 00 0. 00	0	0	0		16. 00 17. 00
17.00		0.00	0	0	0		17.00
19. 00		0.00	0	0			19. 00
20.00		0. 00	0	0	_		20.00
20.00			2, 098, 066	- 0			20.00
	H - IMPLANTS		2/0/0/000				
1.00	MEDICAL SUPPLIES CHARGED TO	71. 00	0	911, 003	0		1.00
	PATI ENT						
				911, 003			
	I - OB RECLASS						
1.00	ADULTS & PEDIATRICS	30. 00	928, 321	144, 080			1.00
2.00		0.00	0	0	0		2.00
	0		928, 321	144, 080			
	J - THERAPY RECLASS						
1. 00	PHYSI CAL THERAPY	66. 00	482, 100	14, 387			1.00
2. 00			0	0			2. 00
	0		482, 100	14, 387			
FUU = UU	Grand Total: Decreases		3, 865, 589	6, 604, 156	1		500.00

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN: 15-0091

Peri od: Worksheet A-7 From 01/01/2023 Part I Date/Time Prepared: 12/31/2023

5/23/2024 4: 22 pm Acqui si ti ons Begi nni ng Disposals and Purchases Donati on Total Bal ances Retirements 2.00 3.00 4.00 5.00 1.00 PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES 1.00 Land 0 1.00 0 645, 981 2.00 Land Improvements 5, 750 5, 750 0 2.00 3.00 10, 173, 038 3.00 Buildings and Fixtures 129, 263 129, 263 0 0 4.00 Building Improvements 32, 500 0 4.00 Fi xed Equi pment 2, 186, 395 0 5.00 343, 136 343, 136 39,889 5.00 0 6.00 Movable Equipment 15, 931, 761 2, 274, 969 2, 274, 969 4, 602, 841 6.00 0 7.00 HIT designated Assets 3, 094, 524 102, 604 102, 604 0 7.00 2, 855, 722 8.00 Subtotal (sum of lines 1-7) 32, 064, 199 2, 855, 722 4, 642, 730 8.00 -2, 984, 461 9.00 Reconciling Items 3, 255, 352 -2, 984, 461 0 0 9.00 5, 840, 183 Total (line 8 minus line 9) 5, 840, 183 4, 642, 730 10.00 28, 808, 847 O 10.00 Endi ng Ful I y Bal ance Depreciated Assets 6. 00 7.00 PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES 1.00 Land 1.00 651, 731 428, 257 2.00 Land Improvements 2.00 3.00 Buildings and Fixtures 10, 302, 301 1, 731, 640 3.00 4.00 Building Improvements 32, 500 4.00 5.00 Fixed Equipment 2, 489, 642 219, 359 5.00 6.00 Movable Equipment 13, 603, 889 6.00 6, 732, 344 3, 197, 128 HIT designated Assets 7.00 7.00 8.00 Subtotal (sum of lines 1-7) 30, 277, 191 9, 111, 600 8.00 Reconciling Items 270, 891 9.00 9.00 10.00 Total (line 8 minus line 9) 30, 006, 300 9, 111, 600 10.00

Heal th	Financial Systems	HUNTINGTON MEMO	RLAL HOSPLTAL		In Lie	u of Form CMS-2	2552-10
	CILIATION OF CAPITAL COSTS CENTERS		Provider CCN: 15-0091		Peri od: From 01/01/2023	Worksheet A-7 Part II	
					To 12/31/2023	Date/Time Pre 5/23/2024 4: 2	
			SL	IMMARY OF CAP	I TAL		
	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			and 2			
1. 00	CAP REL COSTS-BLDG & FIXT	1, 805, 093	0		0	0	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	953, 377			0	0	2.00
3.00	Total (sum of lines 1-2)	2, 758, 470	0		0 0	0	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, 805, 093				1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	953, 377			I	2.00
2 00	T-+-1 (1 ! 1 2)	1	0 750 470				1 0 00

0 0 0

1, 805, 093 953, 377 2, 758, 470

2.00

3.00 Total (sum of lines 1-2)

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 CCN: 15-0091		Peri od:	Worksheet A-7	
					From 01/01/2023 To 12/31/2023		narod:
					10 12/31/2023	5/23/2024 4: 2	
		COMI	PUTATION OF RAT	TI 0S	ALLOCATION OF	OTHER CAPITAL	
	Cost Center Description	Gross Assets	Capi tal i zed	Gross Assets	Ratio (see	Insurance	
	Cost Center Description	GIUSS ASSETS	Leases	for Ratio	instructions)	Trisui ance	
			Leases	(col. 1 -	Thistructions)		
				col . 2)			
		1. 00	2.00	3.00	4. 00	5. 00	
	PART III - RECONCILIATION OF CAPITAL COSTS C						
1. 00	CAP REL COSTS-BLDG & FLXT	13, 476, 175		13, 476, 17			1.00
2.00	CAP REL COSTS-MVBLE EQUIP	16, 801, 017		10,00.,0.			2.00
3. 00	Total (sum of lines 1-2)	30, 277, 192		30, 277, 19			3.00
		ALLOCA	TION OF OTHER (CAPITAL	SUMMARY OF CAPITAL		
	Cost Center Description	Taxes	0ther	Total (sum of	Depreciation	Lease	
			Capi tal -Rel at	cols. 5			
			ed Costs	through 7)			
		6. 00	7. 00	8. 00	9. 00	10.00	
	PART III - RECONCILIATION OF CAPITAL COSTS C	1	1	1			
1.00	CAP REL COSTS-BLDG & FIXT	0	0		0 3, 242, 065		1.00
2. 00 3. 00	CAP REL COSTS-MVBLE EQUIP	0	0		0 1, 484, 179		2.00
3.00	Total (sum of lines 1-2)	0	U 0	L JMMARY OF CAPI	0 4, 726, 244	-1, 188, 067	3. 00
			30	JIVIIVIART OF CAPT	TAL		
	Cost Center Description	Interest	Insurance	Taxes (see	0ther	Total (2)	
			(see	instructions)			
			instructions)		ed Costs (see	9 through 14)	
		11 00	10.00	10.00	instructions)	45.00	
	DART III DECONCILIATION OF CARLTAL COSTS O	11. 00	12. 00	13.00	14. 00	15. 00	
1. 00	PART III - RECONCILIATION OF CAPITAL COSTS C	ENTERS 0	62, 700		0 0	2, 116, 698	1.00
2. 00	CAP REL COSTS-BLDG & FIXT	1, 266		•			2.00
3. 00	Total (sum of lines 1-2)	1, 266		•			
3. 00	10tal (3am 01 111103 1 2)	1, 200	113,032	ı	0	3, 032, 473	3.00

7,05001	INCINIO TO EM ENGES			Trovider osiv. To com	From 01/01/2023 To 12/31/2023	Date/Time Pre 5/23/2024 4:2	pared: 2 pm
			Т	Expense Classification o o/From Which the Amount is			
	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			AP REL COSTS-BLDG & FIXT	1.00	0	1.00
2. 00	COSTS-BLDG & FIXT (chapter 2) Investment income - CAP REL COSTS-MVBLE EQUIP (chapter 2)	В	1, 266 C	AP REL COSTS-MVBLE EQUIP	2. 00	11	2.00
3. 00	Investment income - other (chapter 2)		0		0. 00	0	3. 00
4. 00	Trade, quantity, and time discounts (chapter 8)		0		0.00	0	4. 00
5. 00	Refunds and rebates of expenses (chapter 8)		0		0.00	0	5. 00
6. 00	Rental of provider space by suppliers (chapter 8)		0		0.00	0	
7. 00	Tel ephone services (pay stations excluded) (chapter	A	-6, 173 A	DMINISTRATIVE & GENERAL	5. 00	0	7. 00
8. 00	21) Tel evi si on and radi o servi ce (chapter 21)	А	-2, 6590	PERATION OF PLANT	7. 00	0	8. 00
9. 00 10. 00	Parking Lot (chapter 21) Provider-based physician	A-8-2	0 -1, 622, 848		0.00	0	
11. 00	adjustment Sale of scrap, waste, etc.		0		0. 00	0	11.00
12. 00	(chapter 23) Related organization transactions (chapter 10)	A-8-1	-6, 956, 928			0	12.00
13. 00 14. 00	Laundry and linen service Cafeteria-employees and quests	A	0 -84, 351 C	AFFTERI A	0. 00 11. 00	0	
15. 00	Rental of quarters to employee and others		0	AI ETENIA	0. 00	0	1
16. 00	Sale of medical and surgical supplies to other than patients		0		0. 00	0	16.00
17. 00	Sale of drugs to other than patients		0		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 education (tuition, fees, books, etc.)		0		0. 00	0	19.00
20. 00 21. 00	Vending machines Income from imposition of		0		0. 00 0. 00	0	20. 00 21. 00
	interest, finance or penalty charges (chapter 21)						
22. 00	Interest expense on Medicare overpayments and borrowings to		0		0.00	0	22. 00
23. 00	repay Medicare overpayments Adjustment for respiratory therapy costs in excess of limitation (chapter 14)	A-8-3	OR	ESPI RATORY THERAPY	65. 00		23. 00
24. 00	Adjustment for physical therapy costs in excess of limitation (chapter 14)	A-8-3	0 P	HYSI CAL THERAPY	66. 00		24. 00
25. 00	Utilization review - physicians' compensation (chapter 21)		0 *	** Cost Center Deleted ***	114. 00		25. 00
26. 00	Depreciation - CAP REL COSTS-BLDG & FLXT		ос	AP REL COSTS-BLDG & FIXT	1. 00	0	26. 00
27. 00	Depreciation - CAP REL COSTS-MVBLE EQUIP		ос	AP REL COSTS-MVBLE EQUIP	2. 00	0	27. 00
28. 00 29. 00	Non-physician Anesthetist Physicians' assistant		ON	ONPHYSICIAN ANESTHETISTS	19. 00 0. 00	0	28. 00 29. 00
30. 00	Adjustment for occupational therapy costs in excess of	A-8-3	00	CCUPATI ONAL THERAPY	67. 00	O	30.00
30. 99	limitation (chapter 14) Hospice (non-distinct) (see instructions)		OA	DULTS & PEDIATRICS	30.00		30. 99

From 01/01/2023 | To 12/31/2023 | Date/Time Prepared:

				To	12/31/2023		
				Expense Classification on	Worksheet A	5/23/2024 4: 2	2 pm
				To/From Which the Amount is			
				Topin on the fine famount to	to bo haj aotoa		
	Cost Center Description	Basis/Code	Amount	Cost Center	Li ne #	Wkst. A-7	
	'	(2)				Ref.	
		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		0		0.00	0	32.00
	Depreciation and Interest						
33.00	OTHER ADJUSTMENTS (SPECIFY)		0		0. 00	0	33.00
	(3)						
33. 01	TELEPHONE SERVICES	A	-1, 990	EMPLOYEE BENEFITS DEPARTMENT	4. 00	0	33. 01
33. 02	RENT EXPENSE OFFSET	A		CAP REL COSTS-BLDG & FIXT	1. 00	10	
33. 03	RENT EXPENSE OFFSET	A	-984, 267	CAP REL COSTS-BLDG & FIXT	1. 00	10	33. 03
33.04	RENT EXPENSE OFFSET	A	0	CAP REL COSTS-BLDG & FLXT	1. 00	10	33. 04
33. 05	RENT EXPENSE OFFSET	A	0	CAP REL COSTS-BLDG & FLXT	1. 00	10	33. 05
33.06	PHYSICIAN RECRUITMENT	A	0	ADMINISTRATIVE & GENERAL	5. 00	0	33.06
33. 07	SELF INSURANCE	A	0		0.00	0	33. 07
33. 08	GUEST MEAL OFFSET	A	0	CAFETERI A	11. 00	0	33. 08
33.09	AHA-IHA LOBBYING OFFSET	A	-3, 864	ADMINISTRATIVE & GENERAL	5. 00	0	33. 09
33. 10	LOBBYING OFFSET	A	-2, 033	ADMINISTRATIVE & GENERAL	5. 00	0	33. 10
33. 11	LI QUOR OFFSET	A	0	ADMINISTRATIVE & GENERAL	5. 00	0	33. 11
33. 12	OTHER OPERATING REVENUE	В	0	ADMINISTRATIVE & GENERAL	5. 00	0	33. 12
33. 13	OTHER OPERATING REVENUE	В	-233, 871	DI ETARY	10. 00	0	33. 13
33. 14	OTHER OPERATING REVENUE	В	-64, 258	PHARMACY	15. 00	0	33. 14
33. 15	OTHER OPERATING REVENUE	В	0	ADULTS & PEDIATRICS	30. 00	0	33. 15
33. 16	OTHER OPERATING REVENUE	В	0	OPERATING ROOM	50.00	0	33. 16
33. 17	OTHER OPERATING REVENUE	В	0	RESPI RATORY THERAPY	65. 00	0	33. 17
33. 18	OTHER OPERATING REVENUE	В	0	PHYSI CAL THERAPY	66. 00	0	33. 18
33. 19	OTHER OPERATING REVENUE	В	-1, 200	EMERGENCY	91. 00	0	33. 19
33. 20	OTHER OPERATING REVENUE	В	-4, 660	AMBULANCE SERVICES	95. 00	0	33. 20
33. 21	OTHER OPERATING REVENUE	В	0	DRUGS CHARGED TO PATIENTS	73. 00	0	33. 21
33. 22	OTHER OPERATING REVENUE	В	0	GIFT, FLOWER, COFFEE SHOP &	190. 00	0	33. 22
				CANTEEN			
33. 23	OTHER OPERATING REVENUE	В		PHYSICIANS' PRIVATE OFFICES	192. 00	0	33. 23
33. 24	OTHER OPERATING REVENUE	A	0	FOUNDATI O	194. 03	0	33. 24
33. 25	DEPRECI ATI ON	A		CAP REL COSTS-BLDG & FIXT	1. 00	9	33. 25
33. 26	DEPRECI ATI ON	A	530, 802	CAP REL COSTS-MVBLE EQUIP	2. 00	9	33. 26
33. 27	PHYS ADMIN SALARIES	A	40, 527	ADMINISTRATIVE & GENERAL	5. 00	0	33. 27
33. 28	REMOVE HAF FEES FROM EXPENSE	A	-4, 142, 467	ADMINISTRATIVE & GENERAL	5. 00	0	33. 28
33. 29	REMOVE HAF FEES FROM EXPENSE	A	0	ADMINISTRATIVE & GENERAL	5. 00	0	33. 29
33. 30	OTHER ADJUSTMENTS (SPECIFY)		0		0. 00	0	33. 30
	(3)						
33. 31	OTHER ADJUSTMENTS (SPECIFY)		0		0. 00	0	33. 31
	(3)						
33. 32	OTHER ADJUSTMENTS (SPECIFY)		0		0. 00	0	33. 32
	(3)						
50.00	TOTAL (sum of lines 1 thru 49)		-12, 305, 802				50.00
	(Transfer to Worksheet A,						
	column 6, line 200.)						
(1) D-				- CMC Dub 1F 1			

⁽¹⁾ Description - all chapter references in this column pertain to CMS Pub. 15-1.

⁽²⁾ Basis for adjustment (see instructions).

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

B. Amount Received - if cost cannot be determined.

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

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

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

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

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

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

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

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

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.

Heal th	Financial Syste	ems	HUNTINGTON MEMORIAL HOSPITAL			In Lieu	of Form CMS-	2552-10	
		SERVICES FROM	RELATED ORGANI Z	ATIONS AND HOME	Provi der	CCN: 15-0091	Peri od:	Worksheet A-	8-1
OFFICE	COSTS						From 01/01/2023 To 12/31/2023	Date/Time Pro 5/23/2024 4::	
		Wkst. A-7 Ref.		·					
	Adjustments (col. 4 minus								
	col . 5)*								
	6. 00	7. 00							
		RED AND ADJUST	MENTS REQUIRED A	S A RESULT OF TR	ANSACTI ONS	WITH RELATED	ORGANI ZATI ONS OR	CLAIMED HOME	
	OFFICE COSTS:								
1.00	2, 927, 111	0							1.00
2.00	-9, 400, 204	0							2.00
3.00	-483, 835	0							3.00
4.00	0	0							4.00
5.00	-6, 956, 928								5.00
* The	amounts on line	es 1-4 (and sub	oscripts as appr	opriate) are tran	nsferred i	n detail to Wo	orksheet A, column	6, lines as	
appropr	iate. Positive a	amounts increas	se cost and nega	tive amounts decr	ease cost	. For related o	organization or ho	me office cos	t which
has not	been posted to	o Worksheet A,	columns 1 and/o	r 2, the amount a	allowable	should be indi	cated in column 4	of this part	
	Related Orga	ani zati on(s)							
	and/or Ho	me Office							
	Type of	Busi ness							
		00							

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

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

6.00	HOME OFFICE		6.00						
7.00			7.00						
8.00			8.00						
9.00			9.00						
8. 00 9. 00 10. 00			10.00						
100.00			100.00						

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

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

- 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

Health Financial Systems
PROVIDER BASED PHYSICIAN ADJUSTMENT Provider CCN: 15-0091

						To 12/31/2023		
	Wkst. A Line #		Total	Professi onal	Provi der	RCE Amount	Physi ci an/Prov	
		I denti fi er	Remuneration	Component	Component		ider Component	
	1.00	0.00	2.00	4.00	F 00	(00	Hours	
1 00	1.00	2.00	3. 00	4. 00	5. 00	6. 00	7. 00	1.00
1. 00 2. 00		OPERATING ROOM EMERGENCY	1, 560, 515					
2. 00 3. 00		AMBULANCE SERVICES	40, 000 22, 333		1	1		2.00
4. 00	95.00		22, 333	22, 333	_	1	0	3. 00 4. 00
5. 00	0.00				1		0	5. 00
6. 00	0.00			1 0	1		0	6.00
7. 00	0.00						0	7.00
8. 00	0.00						0	8.00
9. 00	0.00						0	9.00
10.00	0.00						0	10.00
200.00			1, 622, 848	1, 622, 848			0	200.00
200.00	Wkst. A Line #	Cost Center/Physician	Unadjusted RCE		Cost of	Provi der	Physician Cost	
	WKSt. A LITTO #	I denti fi er	Li mi t		Memberships &		of Malpractice	
		T deliter i i e	2, (Li mi t	Continuing	Share of col.	Insurance	
				2	Education	12	11104141100	
	1. 00	2.00	8. 00	9. 00	12. 00	13. 00	14. 00	
1. 00	50.00	OPERATING ROOM	0	C) C	0	0	1.00
2.00	91.00	EMERGENCY	0	0	0	0	0	2. 00
3.00	95. 00	AMBULANCE SERVICES	0	0	0	0	0	3. 00
4.00	0.00		0	0	0	0	0	4.00
5.00	0.00		0	C	0	0	0	5.00
6.00	0.00		0	0	0	0	0	6. 00
7.00	0.00		0	C	0	0	0	7. 00
8.00	0.00		0	0	0	0	0	8. 00
9.00	0.00	4	0	0	0	0	0	9. 00
10.00	0.00		0	0	0	0	0	10. 00
200.00			0	0	0	0	0	200.00
	Wkst. A Line #		Provi der	Adjusted RCE	RCE	Adjustment		
		I denti fi er	Component	Limit	Di sal I owance			
			Share of col.					
	1.00	2.00	14 15. 00	16. 00	17. 00	18. 00		
1. 00		OPERATI NG ROOM	15.00					1. 00
2. 00		EMERGENCY			_	.,,		2.00
3. 00		AMBULANCE SERVICES			_			3. 00
4. 00	0.00	4	1	ĺ	1	0	•	4.00
5. 00	0.00							5.00
6. 00	0.00		1 0	ĺ	1			6. 00
7. 00	0.00		1 0	ĺ		ا ا		7. 00
8. 00	0.00		0			Ö		8. 00
9. 00	0.00		0	Ö		o o		9. 00
10.00	0.00	4	0	O		Ō		10.00
200.00			0	C	0	1, 622, 848		200.00

| Period: | Worksheet B | From 01/01/2023 | Part | To | 12/31/2023 | Date/Time Prepared: Health Financial Systems
COST ALLOCATION - GENERAL SERVICE COSTS Provi der CCN: 15-0091

						o 12/31/2023	Date/Time Pre	pared:
				CAPITAL RELATED COSTS			5/23/2024 4: 2	2 pm
Cost Center Description			Not Evnences	DIDC 0 FLVT	MANDLE FOLLID	EMDLOVEE	Cubtatal	
		cost center bescription	Net Expenses for Cost	BLDG & FIXT	MVBLE EQUIP	EMPLOYEE BENEFITS	Subtotal	
			Allocation			DEPARTMENT		
			(from Wkst A					
			col. 7) 0	1. 00	2.00	4. 00	4A	
		AL SERVICE COST CENTERS			i			
1. 00 2. 00		CAP REL COSTS-BLDG & FIXT CAP REL COSTS-MVBLE EQUIP	2, 116, 698 1, 535, 797	2, 116, 698	1, 535, 797			1. 00 2. 00
4.00		EMPLOYEE BENEFITS DEPARTMENT	6, 258, 330	2, 036				4. 00
5.00	00500	ADMINISTRATIVE & GENERAL	16, 537, 490	118, 495			18, 291, 368	5. 00
6.00		MAINTENANCE & REPAIRS	0	472 104	1	110 240	1 004 204	6.00
7. 00 8. 00		OPERATION OF PLANT LAUNDRY & LINEN SERVICE	1, 277, 747 198, 113	473, 194 9, 704	23, 897	119, 368 12, 290	1, 894, 206 220, 107	7. 00 8. 00
9. 00		HOUSEKEEPI NG	650, 352	7, 899	4, 423		787, 978	9. 00
10.00		DI ETARY	306, 982	75, 469			482, 443	10.00
11. 00 12. 00		CAFETERIA MAINTENANCE OF PERSONNEL	390, 212 0	17, 124 0			485, 636 0	11. 00 12. 00
13. 00		NURSI NG ADMI NI STRATI ON	381, 350	0		-	474, 604	13.00
14. 00		CENTRAL SERVICES & SUPPLY	0	29, 389		- 1	29, 389	14.00
15. 00 16. 00		PHARMACY MEDICAL RECORDS & LIBRARY	631, 002	17, 818 9, 842		160, 579	815, 499 9, 842	15. 00 16. 00
17. 00		SOCIAL SERVICE	o	0,042		0	0, 042	17. 00
19. 00		NONPHYSICIAN ANESTHETISTS	0	0	0	0	0	19. 00
20.00		NURSING PROGRAM	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	i o	0	0	21. 00 22. 00
22.00	I NPAT	IENT ROUTINE SERVICE COST CENTERS	<u> </u>			5		22.00
30.00		ADULTS & PEDIATRICS	4, 020, 072	388, 144			5, 482, 919	30.00
43. 00		NURSERY LARY SERVICE COST CENTERS	221, 706	1, 574	0	48, 686	271, 966	43. 00
50.00	05000	OPERATING ROOM	585, 245	147, 853	171, 559	357, 732	1, 262, 389	50.00
50. 01		OPERATING ROOM	0 0 0 0	0	0	104 011	1 027 504	50. 01
52. 00 53. 00		DELIVERY ROOM & LABOR ROOM ANESTHESIOLOGY	850, 695 1, 560, 515	0		186, 811 0	1, 037, 506 1, 560, 515	52. 00 53. 00
54.00	05400	RADI OLOGY-DI AGNOSTI C	2, 238, 399	185, 310	503, 247	368, 338	3, 295, 294	
60.00	1	LABORATORY	3, 216, 128	28, 077	0		3, 244, 205	60.00
62. 30 65. 00		BLOOD CLOTTING FOR HEMOPHILIACS RESPIRATORY THERAPY	1, 006, 060	0 33, 970	1	0 198, 694	0 1, 376, 586	62. 30 65. 00
66. 00		PHYSI CAL THERAPY	1, 021, 858	401, 628		252, 876	1, 740, 553	66. 00
67.00		OCCUPATIONAL THERAPY	272, 559	0	0	67, 139	339, 698	67.00
68. 00 69. 00	1	SPEECH PATHOLOGY ELECTROCARDI OLOGY	223, 928 89, 886	0		55, 160 20, 235	279, 088 110, 121	68. 00 69. 00
71. 00		MEDICAL SUPPLIES CHARGED TO PATIENT	667, 290	0	Ö	0	667, 290	71.00
72. 00		IMPL. DEV. CHARGED TO PATIENTS	911, 003	0	O	0	911, 003	72.00
73. 00 76. 97		DRUGS CHARGED TO PATIENTS CARDIAC REHABILITATION	2, 825, 795	0	0	19, 202	2, 844, 997 0	73. 00 76. 97
76. 98		HYPERBARIC OXYGEN THERAPY	915, 463	31, 147	7, 183	92, 423	1, 046, 216	
76. 99		LI THOTRI PSY	0	0			0	76. 99
77. 00 78. 00		ALLOGENEIC HSCT ACQUISITION CAR T-CELL IMMUNOTHERAPY	0	0			0	77.00
78.00		TIENT SERVICE COST CENTERS	<u> </u>	0		l O	0	78. 00
90.00	09000	CLINIC	198, 692	0			243, 131	90.00
91. 00 92. 00	1	EMERGENCY OBSERVATION BEDS (NON-DISTINCT PART	2, 125, 142	78, 986	68, 031	427, 413	2, 699, 572 0	91. 00 92. 00
92.00		REIMBURSABLE COST CENTERS					0	92.00
		AMBULANCE SERVICES	4, 468, 100	54, 781			5, 771, 200	
102.00		OPIOID TREATMENT PROGRAM AL PURPOSE COST CENTERS	[0]	0	C	0	0	102. 00
113.00		INTEREST EXPENSE						113. 00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	57, 702, 609	2, 112, 440	1, 534, 643	6, 238, 490	57, 675, 321	118. 00
190 00		IMBURSABLE COST CENTERS GIFT, FLOWER, COFFEE SHOP & CANTEEN	22, 126	0		Ol	22, 126	190 00
191.00	19100	RESEARCH	0	Ö				191. 00
		PHYSICIANS' PRIVATE OFFICES	94, 579	0		21, 621	117, 354	
		OCC HEALTH PAIN CLINIC	0	4, 258 0		0		194. 00 194. 01
		OCC HEALTH	o	0		0		194. 01
194. 03	07953	FOUNDATI O	14, 154	0	0	0	14, 154	194. 03
		KIDS CAMPUS COMMUNITY & VOLUNTEER SERVICES	0 56, 832	0	0	0 255	0 57, 087	194. 04 194. 05
		HUNTINGTON COLLEGE NURSE	0 30, 632	0		235		194. 05 194. 06
194. 07	07957	MISC CATERING	0	0	0	ō	0	194. 07
		AUTISM CENTER HUNTINGTON BUA	0	0				194. 08 194. 09
174. 09	7 U 1 7 D Y	TION I ING I ON DUA	ı U	0	0	1 U	U	174.09

Health Financial Systems		HUNTI NGTON MEMO	RIAL HOSPITAL		In Lieu of Form CMS-2552-10			
COST ALLOCATION - GENERAL SERVICE COSTS			Provi der CCN: 15-0091		Period: From 01/01/2023 To 12/31/2023	Worksheet B Part I Date/Time Prepared: 5/23/2024 4:22 pm		
			CAPITAL RELATED COSTS					
	Cost Center Description	Net Expenses for Cost Allocation (from Wkst A col. 7)	BLDG & FIXT	MVBLE EQUIP	EMPLOYEE BENEFITS DEPARTMENT	Subtotal		
		0	1. 00	2.00	4. 00	4A		
200. 00 201. 00	Cross Foot Adjustments Negative Cost Centers		0		0 0	0	200. 00 201. 00	
202 00	TOTAL (sum Lines 118 through 201)	57 890 300	2 116 698	1 535 79	07 6 260 366	57 890 300	1202 00	

Peri od: Worksheet B From 01/01/2023 Part I To 12/31/2023 Date/Ti me Prepared: 5/23/2024 4: 22 pm

					5/23/2024 4: 2	
Cost Center Description	ADMINISTRATIV E & GENERAL	MAINTENANCE & REPAIRS	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPI NG	
	5. 00	6.00	7. 00	8. 00	9. 00	
GENERAL SERVICE COST CENTERS						
1. 00 O0100 CAP REL COSTS-BLDG & FLXT						1.00
2.00 00200 CAP REL COSTS-MVBLE EQUIP 4.00 00400 EMPLOYEE BENEFITS DEPARTMENT						2. 00 4. 00
5. 00 00500 ADMI NI STRATI VE & GENERAL	18, 291, 368					5.00
6. 00 00600 MAI NTENANCE & REPAI RS	0	0				6.00
7.00 00700 OPERATION OF PLANT	874, 964	0	2, 769, 170			7. 00
8. 00 00800 LAUNDRY & LI NEN SERVI CE	101, 671	0	17, 644		4.44.000	8.00
9. 00 00900 HOUSEKEEPI NG 10. 00 01000 DI ETARY	363, 980		14, 362	0	1, 166, 320	9. 00 10. 00
11. 00 01100 CAFETERI A	222, 848 224, 323	l .	137, 223 31, 136	0	58, 471 13, 267	1
12. 00 01200 MAI NTENANCE OF PERSONNEL	0	l .	0	0	0	12.00
13. 00 01300 NURSI NG ADMI NI STRATI ON	219, 227	Ö	0	0	0	13.00
14.00 01400 CENTRAL SERVICES & SUPPLY	13, 575	l .	53, 436	0	22, 769	14.00
15. 00 01500 PHARMACY	376, 692	l .	32, 398	0	13, 805	15.00
16. 00 01600 MEDI CAL RECORDS & LI BRARY 17. 00 01700 SOCI AL SERVI CE	4, 546	0	17, 896	0	7, 626 0	16. 00 17. 00
19. 00 01900 NONPHYSI CLAN ANESTHETI STS		0] 0 0	0	0	19.00
20. 00 02000 NURSI NG PROGRAM	0	Ö	Ö	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
I NPATI ENT ROUTI NE SERVI CE COST CENTERS	0.500.740	1	705 750	05.000	200 704	1 00 00
30. 00 03000 ADULTS & PEDI ATRI CS 43. 00 04300 NURSERY	2, 532, 648 125, 625			95, 323 6, 326	300, 724 1, 219	30. 00 43. 00
ANCILLARY SERVICE COST CENTERS	125, 625	0	2,001	0, 320	1, 219	43.00
50. 00 05000 OPERATING ROOM	583, 118	0	268, 836	63, 136	114, 552	50.00
50.01 05001 OPERATING ROOM	0	0	0	0	0	50. 01
52.00 05200 DELIVERY ROOM & LABOR ROOM	479, 241	0	0	25, 250	0	52.00
53. 00 05300 ANESTHESI OLOGY	720, 827	0	0	0	0	53.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	1, 522, 149	l .	336, 942	51, 135	143, 573	54.00
60. 00 06000 LABORATORY 62. 30 06250 BLOOD CLOTTI NG FOR HEMOPHI LI ACS	1, 498, 550	0	51, 052	0	21, 753 0	60. 00 62. 30
65. 00 06500 RESPIRATORY THERAPY	635, 867	l o	61, 767	9, 536	26, 319	65.00
66. 00 06600 PHYSI CAL THERAPY	803, 989		730, 266	0	311, 171	66.00
67. 00 06700 OCCUPATI ONAL THERAPY	156, 912	l .	0	0	0	67.00
68. 00 06800 SPEECH PATHOLOGY	128, 915	0	0	0	0	68.00
69. 00 06900 ELECTROCARDI OLOGY 71. 00 07100 MEDI CAL SUPPLI ES CHARGED TO PATI ENT	50, 867	0	0	0	0	69. 00 71. 00
72. 00 07/200 MPL. DEV. CHARGED TO PATIENTS	308, 232 420, 807	0] 0 0	0	0	71.00
73. 00 07300 DRUGS CHARGED TO PATIENTS	1, 314, 150	Ö	Ö	0	0	73.00
76. 97 07697 CARDIAC REHABILITATION	0	0	0	0	0	76. 97
76. 98 07698 HYPERBARIC OXYGEN THERAPY	483, 264	0	56, 634	0	24, 132	76. 98
76. 99 07699 LI THOTRI PSY	0	0	0	0	0	76. 99
77.00 07700 ALLOGENEIC HSCT ACQUISITION 78.00 07800 CAR T-CELL MMUNOTHERAPY	0 0		0	0	0	77. 00 78. 00
OUTPATIENT SERVICE COST CENTERS		0	0	U	0	76.00
90. 00 09000 CLINIC	112, 306	0	0	582	0	90.00
91. 00 09100 EMERGENCY	1, 246, 975		143, 618	84, 186	61, 197	91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART						92.00
OTHER REIMBURSABLE COST CENTERS	0 //5 700	1	00.407	2.040	40.440	05.00
95. 00 09500 AMBULANCE SERVICES 102. 00 10200 OPIOID TREATMENT PROGRAM	2, 665, 798		99, 607	3, 948	42, 443	95. 00 102. 00
SPECIAL PURPOSE COST CENTERS		0	0	U	0	102.00
113. 00 11300 NTEREST EXPENSE						113.00
118.00 SUBTOTALS (SUM OF LINES 1 through 117)	18, 192, 066	0	2, 761, 428	339, 422	1, 163, 021	118.00
NONREI MBURSABLE COST CENTERS	1	1	_	_		
190. 00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	10, 220	l .	0	0		190.00
191. 00 19100 RESEARCH 192. 00 19200 PHYSI CI ANS' PRI VATE OFFI CES	54, 208	0	0	0		191. 00 192. 00
194. 00 07950 OCC HEALTH	1, 967	l .	7, 742	0		194.00
194. 01 07951 PAIN CLINIC	0	l .	0	0		194. 01
194. 02 07952 OCC HEALTH	0	0	0	0	0	194. 02
194. 03 07953 FOUNDATI 0	6, 538	0	0	0		194. 03
194. 04 07954 KI DS CAMPUS	0 0 0 0 0	0	0	0		194.04
194. 05 07955 COMMUNITY & VOLUNTEER SERVICES 194. 06 07956 HUNTINGTON COLLEGE NURSE	26, 369			0		194. 05 194. 06
194.07 07957 MISC CATERING			n	n		194.00
194. 08 07958 AUTI SM CENTER	0	Ö	Ö	0		194. 08
194. 09 07959 HUNTI NGTON BUA	0	0	0	0		194. 09
200.00 Cross Foot Adjustments						200. 00
201.00 Negative Cost Centers	10 201 200	0	0 740 170	220 422		201.00
202.00 TOTAL (sum lines 118 through 201)	18, 291, 368	0	2, 769, 170	339, 422	1, 166, 320	1202.00

Peri od: Worksheet B From 01/01/2023 Part I To 12/31/2023 Date/Ti me Prepared: 5/23/2024 4: 22 pm

				0 12/31/2023	5/23/2024 4: 2	
Cost Center Description	DI ETARY	CAFETERI A	MAI NTENANCE	NURSI NG	CENTRAL	
			OF PERSONNEL	ADMI NI STRATI O N	SERVICES & SUPPLY	
	10. 00	11. 00	12.00	13.00	14. 00	
GENERAL SERVICE COST CENTERS						
1.00 O0100 CAP REL COSTS-BLDG & FIXT						1.00
2. 00 00200 CAP REL COSTS-MVBLE EQUI P						2.00
4. 00 00400 EMPLOYEE BENEFITS DEPARTMENT						4.00
5. 00 00500 ADMI NI STRATI VE & GENERAL 6. 00 00600 MAI NTENANCE & REPAI RS						5.00
6. 00 00600 MAI NTENANCE & REPAI RS 7. 00 00700 OPERATI ON OF PLANT						6. 00 7. 00
8. 00 00800 LAUNDRY & LI NEN SERVI CE						8.00
9. 00 00900 HOUSEKEEPI NG						9.00
10. 00 01000 DI ETARY	900, 985					10.00
11. 00 01100 CAFETERI A	0	754, 362				11.00
12.00 01200 MAINTENANCE OF PERSONNEL	0	0	C			12.00
13. 00 O1300 NURSI NG ADMI NI STRATI ON	0	12, 244	C	706, 075		13.00
14.00 01400 CENTRAL SERVICES & SUPPLY	0	0	C	0	119, 169	14.00
15. 00 01500 PHARMACY	0	19, 022	C	0	1, 199	15.00
16. 00 01600 MEDICAL RECORDS & LIBRARY	0	0		0	0	16.00
17. 00 01700 SOCI AL SERVI CE 19. 00 01900 NONPHYSI CI AN ANESTHETI STS	0	0		0	0	17. 00 19. 00
20. 00 02000 NURSI NG PROGRAM		0		0	0	20.00
21. 00 02100 I &R SERVICES-SALARY & FRINGES APPRV		0		0	0	21.00
22. 00 02200 Lar Services-Other Prgm Costs Apprv	l ol	0	ĺ	o	Ö	22. 00
INPATIENT ROUTINE SERVICE COST CENTERS	· · · · · · · · · · · · · · · · · · ·					
30. 00 03000 ADULTS & PEDIATRICS	900, 985	145, 673	•		9, 085	30.00
43. 00 04300 NURSERY	0	8, 035	C	18, 044	0	43.00
ANCILLARY SERVICE COST CENTERS		FF 441		124 501	10.005	FO 00
50. 00 05000 OPERATING ROOM 50. 01 05001 OPERATING ROOM	0	55, 441	C	.,	19, 085 0	50. 00 50. 01
52. 00 05200 DELI VERY ROOM & LABOR ROOM		30, 830	1	-	0	50.01
53. 00 05300 ANESTHESI OLOGY		30, 630 N			0	53.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C		62, 861			3, 620	54.00
60. 00 06000 LABORATORY	l o	0	ĺ	-	11	60.00
62.30 06250 BLOOD CLOTTING FOR HEMOPHILIACS	0	0	C	0	0	62.30
65. 00 06500 RESPIRATORY THERAPY	0	39, 081	[c	0	6, 797	65.00
66. 00 06600 PHYSI CAL THERAPY	0	48, 139		0	892	66.00
67. 00 06700 OCCUPATI ONAL THERAPY	0	15, 188		-	0	67.00
68. 00 06800 SPEECH PATHOLOGY	0	12, 478			0	68.00
69. 00 06900 ELECTROCARDI OLOGY	0	3, 080			52.01/	69.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT 72.00 07200 MPL. DEV. CHARGED TO PATIENTS	0	0	C	0	53, 916 0	71. 00 72. 00
73.00 07300 DRUGS CHARGED TO PATIENTS		0		0	0	73.00
76. 97 07697 CARDI AC REHABI LI TATI ON		0			0	76. 97
76. 98 07698 HYPERBARI C OXYGEN THERAPY		0		Ö	2, 902	76. 98
76. 99 07699 LI THOTRI PSY	o	0		o	0	76. 99
77.00 07700 ALLOGENEIC HSCT ACQUISITION	0	0	C	0	0	77. 00
78.00 O7800 CAR T-CELL IMMUNOTHERAPY	0	0	C	0	0	78. 00
OUTPATIENT SERVICE COST CENTERS						
90. 00 09000 CLI NI C	0	6, 427				
91. 00 09100 EMERGENCY	0	74, 439	C	167, 164	9, 147	
92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART OTHER REIMBURSABLE COST CENTERS						92.00
95. 00 O9500 AMBULANCE SERVICES	O	215, 748		0	10, 684	95. 00
102. 00 10200 OPI OI D TREATMENT PROGRAM		213, 740				102.00
SPECIAL PURPOSE COST CENTERS	31			1		.02.00
113. 00 11300 NTEREST EXPENSE						113.00
118.00 SUBTOTALS (SUM OF LINES 1 through 117)	900, 985	748, 686	C	706, 075	118, 095	118. 00
NONREI MBURSABLE COST CENTERS						
190.00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	C	1		190. 00
191. 00 19100 RESEARCH	0	0	C			191. 00
192. 00 19200 PHYSI CLANS' PRI VATE OFFI CES	0	5, 572		-		192.00
194. 00 07950 OCC HEALTH 194. 01 07951 PALN CLINIC	0	0	C	-		194.00
194. 01 07951 PATN CLINIC 194. 02 07952 OCC HEALTH	0	0	C	-		194. 01 194. 02
194. 03 07953 FOUNDATI 0		0		0		194. 02
194. 04 07954 KI DS CAMPUS		0				194. 04
194. 05 07955 COMMUNITY & VOLUNTEER SERVICES		104		0		194. 05
194. 06 07956 HUNTI NGTON COLLEGE NURSE		0		ol ol		194.06
194. 07 07957 MI SC CATERI NG		0		ol ől		194. 07
194. 08 07958 AUTI SM CENTER	0	0		ol		194. 08
194. 09 07959 HUNTI NGTON BUA	0	0	C	o	0	194. 09
200.00 Cross Foot Adjustments						200. 00
201.00 Negative Cost Centers	0	0	C	0		201.00
202.00 TOTAL (sum lines 118 through 201)	900, 985	754, 362	[c	706, 075	119, 169	202. 00

				0 12/31/2023	Date/lime Pre 5/23/2024 4:2	
Cost Center Description	PHARMACY	MEDI CAL	SOCI AL SERVI CE	NONPHYSI CI AN	NURSI NG PROGRAM	
		RECORDS & LI BRARY	SERVICE	ANESTHETI STS	PROGRAM	
OFFICE ASSESSMENT OF ASSESSMEN	15. 00	16. 00	17. 00	19. 00	20. 00	
GENERAL SERVICE COST CENTERS 1. 00 00100 CAP REL COSTS-BLDG & FIXT						1.00
2. 00 00200 CAP REL COSTS-MVBLE EQUIP						2.00
4.00 00400 EMPLOYEE BENEFITS DEPARTMENT					•	4.00
5.00 00500 ADMINISTRATIVE & GENERAL						5.00
6.00 00600 MAI NTENANCE & REPAI RS						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 10. 00 01000 DI ETARY						9.00
11. 00 01100 CAFETERI A						11.00
12. 00 01200 MAI NTENANCE OF PERSONNEL						12.00
13. 00 01300 NURSING ADMINISTRATION						13.00
14.00 01400 CENTRAL SERVICES & SUPPLY						14.00
15. 00 01500 PHARMACY	1, 258, 615					15.00
16.00 01600 MEDICAL RECORDS & LIBRARY	0	39, 910				16.00
17. 00 01700 SOCI AL SERVI CE	0	0	(17.00
19. 00 01900 NONPHYSI CI AN ANESTHETI STS	0	0	(0		19.00
20.00 02000 NURSING PROGRAM 21.00 02100 I&R SERVICES-SALARY & FRINGES APPRV		0			0	20.00
22. 00 02200 1&R SERVICES-OTHER PRGM COSTS APPRV	0	0				22.00
INPATIENT ROUTINE SERVICE COST CENTERS	<u> </u>	<u> </u>		<u> </u>		22.00
30. 00 03000 ADULTS & PEDIATRICS	O	2, 364	(0	0	30.00
43. 00 04300 NURSERY	0	199	(0	0	43.00
ANCILLARY SERVICE COST CENTERS						
50. 00 05000 OPERATI NG ROOM	0	5, 047	(0	
50. 01 05001 OPERATING ROOM	0	0	(-	0	
52. 00 05200 DELI VERY ROOM & LABOR ROOM	0	762	(0	0	
53. 00 05300 ANESTHESI OLOGY 54. 00 05400 RADI OLOGY-DI AGNOSTI C	0	581 5, 802	(0	0	1
60. 00 06000 LABORATORY		5, 802 5, 736		-	0	
62. 30 06250 BLOOD CLOTTING FOR HEMOPHILIACS		3, 730	· ·		0	
65. 00 06500 RESPI RATORY THERAPY	o	1, 372	Ö	-	Ö	1
66. 00 06600 PHYSI CAL THERAPY	o	970	(0	0	1
67. 00 06700 OCCUPATI ONAL THERAPY	0	295	(0	0	67.00
68. 00 06800 SPEECH PATHOLOGY	0	161	(0	0	
69. 00 06900 ELECTROCARDI OLOGY	0	599	(0	1
71. 00 07100 MEDI CAL SUPPLI ES CHARGED TO PATI ENT	0	512	(1	0	
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS 73.00 07300 DRUGS CHARGED TO PATIENTS	1 250 (15	808	(0	0	
73. 00 07300 DRUGS CHARGED TO PATIENTS 76. 97 07697 CARDI AC REHABI LI TATI ON	1, 258, 615	3, 656 0			0	
76. 98 07698 HYPERBARI C OXYGEN THERAPY		668			0	
76. 99 07699 LI THOTRI PSY	l ől	0			0	
77.00 07700 ALLOGENEIC HSCT ACQUISITION	o	0		0	0	1
78.00 07800 CAR T-CELL IMMUNOTHERAPY	O	0	(0	0	78. 00
OUTPATIENT SERVICE COST CENTERS						
90. 00 09000 CLINIC	0	175		0	Ĭ	
91. 00 09100 EMERGENCY	0	6, 802	(0	0	
92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART OTHER REIMBURSABLE COST CENTERS						92.00
95. 00 09500 AMBULANCE SERVI CES	O	3, 401	(0	0	95.00
102. 00 10200 OPI OI D TREATMENT PROGRAM	l ől	0, 101		o o		102.00
SPECIAL PURPOSE COST CENTERS	-1	-		-		1
113. 00 11300 NTEREST EXPENSE						113. 00
118.00 SUBTOTALS (SUM OF LINES 1 through 117)	1, 258, 615	39, 910	(0	0	118. 00
NONREI MBURSABLE COST CENTERS						4
190. 00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	(190.00
191. 00 19100 RESEARCH	0	0	(0		191.00
192. 00 19200 PHYSI CI ANS' PRI VATE OFFI CES 194. 00 07950 OCC HEALTH	0	0	(0		192. 00 194. 00
194. 01 07950 OCC HEALTH 194. 01 07951 PAIN CLINIC		0				194.00
194. 02 07952 OCC HEALTH		0				194. 02
194. 03 07953 FOUNDATI 0	l ol	0		o o		194. 03
194. 04 07954 KIDS CAMPUS	o	0	(0		194.04
194.05 07955 COMMUNITY & VOLUNTEER SERVICES	o	0	(0	0	194. 05
194.06 07956 HUNTI NGTON COLLEGE NURSE	0	0	(0		194. 06
194. 07 07957 MI SC CATERI NG	0	0	(0		194. 07
194. 08 07958 AUTI SM CENTER	0	0	(0		194.08
194. 09 07959 HUNTI NGTON BUA	0	0	(ر آ		194. 09
200.00 Cross Foot Adjustments 201.00 Negative Cost Centers		0	,	0		200. 00 201. 00
202.00 TOTAL (sum lines 118 through 201)	1, 258, 615	39, 910				202.00
(35) (35) (35) (35) (35) (35) (35)	., 200, 010	57, 710	`			,

Health Financial Systems	HUNTINGTON MEMORIAL HOSPITAL	 In Lieu of Form CMS-2552-			
COST ALLOCATION - GENERAL SERVICE COSTS	Provi der (Peri od: From 01/01/2023	Worksheet B		
			Date/Time Pre		
	INTERNS & RESIDENTS			•	

				1	o 12/31/2023	Date/Time Pre 5/23/2024 4:2	
		INTERNS &	RESI DENTS			3/23/2024 4.2	Z piii
	Cost Center Description	RY & FRINGES	SERVI CES-OTHE R PRGM COSTS	Subtotal	Intern & Residents	Total	
		APPRV	APPRV		Cost & Post Stepdown		
					Adjustments		
	GENERAL SERVICE COST CENTERS	21. 00	22. 00	24. 00	25. 00	26. 00	
1. 00	00100 CAP REL COSTS-BLDG & FLXT			1			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 & LINEN SERVICE						8. 00
9.00	00900 HOUSEKEEPI NG 01000 DI ETARY						9.00
10. 00 11. 00	01100 CAFETERI A						10. 00 11. 00
12. 00	01200 MAINTENANCE OF PERSONNEL						12.00
13.00	01300 NURSING ADMINISTRATION						13.00
14. 00 15. 00	O1400 CENTRAL SERVI CES & SUPPLY O1500 PHARMACY						14. 00 15. 00
16. 00	01600 MEDICAL RECORDS & LIBRARY						16.00
17. 00	01700 SOCIAL SERVICE						17. 00
19. 00 20. 00	01900 NONPHYSI CLAN ANESTHETI STS						19.00 20.00
21. 00	O2000 NURSING PROGRAM O2100 I&R SERVICES-SALARY & FRINGES APPRV	C					20.00
22. 00	02200 I &R SERVICES-OTHER PRGM COSTS APPRV		(c				22. 00
	INPATIENT ROUTINE SERVICE COST CENTERS	1		10.500 (0)		10 500 (00	
30. 00 43. 00	03000 ADULTS & PEDI ATRI CS 04300 NURSERY			1			
43.00	ANCI LLARY SERVICE COST CENTERS		ή	, +5+, 27	,,	434, 273	, 43.00
50.00	05000 OPERATING ROOM	C	1			2, 496, 105	50.00
50. 01 52. 00	O5001 OPERATING ROOM O5200 DELIVERY ROOM & LABOR ROOM	C	I	1	1	0 1, 642, 823	50. 01 52. 00
53. 00	05300 ANESTHESI OLOGY					2, 281, 923	
54.00	05400 RADI OLOGY-DI AGNOSTI C	c		5, 421, 376	0	5, 421, 376	54.00
60.00	06000 LABORATORY	C	1	1,,		4, 821, 307	
62. 30 65. 00	06250 BLOOD CLOTTI NG FOR HEMOPHI LI ACS 06500 RESPI RATORY THERAPY	C		1	ή	0 2, 157, 325	62. 30 65. 00
66. 00	06600 PHYSI CAL THERAPY	C		3, 635, 980		3, 635, 980	
67. 00	06700 OCCUPATI ONAL THERAPY	C	C	512, 093		512, 093	
68. 00 69. 00	06800 SPEECH PATHOLOGY 06900 ELECTROCARDI OLOGY			420, 642 164, 667		420, 642 164, 667	1
71. 00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT					1, 029, 950	
72.00	07200 I MPL. DEV. CHARGED TO PATIENTS	C) c			1, 332, 618	
73.00	07300 DRUGS CHARGED TO PATIENTS	C				5, 421, 418	
76. 97 76. 98	O7697 CARDI AC REHABI LI TATI ON O7698 HYPERBARI C OXYGEN THERAPY) C		1	0 1, 613, 816	76. 97 76. 98
	07699 LI THOTRI PSY	C			o	0	
	07700 ALLOGENEIC HSCT ACQUISITION	C	C		0	0	
78.00	07800 CAR T-CELL IMMUNOTHERAPY OUTPATIENT SERVICE COST CENTERS)[) ()	0	78.00
90.00	09000 CLINIC	C	C	363, 378	0	363, 378	90.00
91. 00	09100 EMERGENCY	C) c	4, 493, 100	0	4, 493, 100	
92. 00	O9200 OBSERVATION BEDS (NON-DISTINCT PART OTHER REIMBURSABLE COST CENTERS				0		92.00
95. 00	09500 AMBULANCE SERVICES	C) c	8, 812, 829	0	8, 812, 829	95.00
	10200 OPIOID TREATMENT PROGRAM	C) c	1			102.00
112 00	SPECIAL PURPOSE COST CENTERS	I		1			112 00
118.00	11300 INTEREST EXPENSE SUBTOTALS (SUM OF LINES 1 through 117)	C		57, 558, 228	s o	57, 558, 228	113.00 118.00
	NONREI MBURSABLE COST CENTERS	_	_		-		
	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	C	C	33, 072	0	•	190.00
	19100 RESEARCH 19200 PHYSICIANS' PRIVATE OFFICES			177, 336		0 177, 336	191.00
	07950 OCC HEALTH			17, 350		177, 330	
	07951 PAIN CLINIC	C) c		o		194. 01
	07952 OCC HEALTH	C) 20.02	0		194. 02
	07953 FOUNDATIO 07954 KIDS CAMPUS			20, 834			194. 03 194. 04
194. 05	07955 COMMUNITY & VOLUNTEER SERVICES			83, 564	ı ő	83, 564	194. 05
	07956 HUNTI NGTON COLLEGE NURSE				0		194.06
	07957 MISC CATERING 07958 AUTISM CENTER) C				194. 07 194. 08
	07959 HUNTI NGTON BUA				ol ol		194.08
	·				'		

Heal th Fina	ncial Systems	HUNTINGTON MEMORIAL HOSPITAL			In Lieu of Form CMS-2552-10			
COST ALLOCA	ATION - GENERAL SERVICE COSTS		Provi der C	Provider CCN: 15-0091		Worksheet B		
					From 01/01/2023 To 12/31/2023		enared.	
					12,01,2020	5/23/2024 4: 2	22 pm	
		INTERNS &	RESI DENTS					
	Cook Cooks Brooming to	CEDVILCEC CALA	CEDVI CEC OTHE	C	1 + 0	T-+-1		
	Cost Center Description	SERVI CES-SALA		Subtotal	Intern &	Total		
		RY & FRINGES APPRV	R PRGM COSTS APPRV		Residents Cost & Post			
		APPRV	APPRV		Stepdown			
					Adjustments			
		21. 00	22. 00	24.00	25. 00	26, 00		
200. 00	Cross Foot Adjustments	0	0	21.00	0 0		200.00	
201. 00	Negative Cost Centers	o	0		0 0		201.00	
202.00	TOTAL (sum lines 118 through 201)	0	0	57, 890, 3	00	57, 890, 300	202.00	

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

				To	12/31/2023	Date/Time Pre 5/23/2024 4:2	
			CAPI TAL REI	LATED COSTS		1072072021 1.2	Z piii
	Cost Center Description	Di rectly	BLDG & FIXT	MVBLE EQUIP	Subtotal	EMPLOYEE	
	oost center bescription	Assigned New	DEDO & TIXI	WVDLL EQUIT	Subtotal	BENEFITS	
		Capi tal				DEPARTMENT	
		Related Costs 0	1. 00	2.00	2A	4. 00	
	GENERAL SERVICE COST CENTERS	U	1.00	2.00	ZN	4.00	
1. 00	00100 CAP REL COSTS-BLDG & FLXT						1.00
2. 00 4. 00	00200 CAP REL COSTS-MVBLE EQUIP 00400 EMPLOYEE BENEFITS DEPARTMENT		2, 036		2 024	2 024	2.00 4.00
5. 00	00500 ADMINISTRATIVE & GENERAL	2, 214, 883	118, 495		2, 036 2, 379, 603	2, 036 506	5.00
6. 00	00600 MAI NTENANCE & REPAI RS	0	0	0	0	0	6.00
7.00	00700 OPERATION OF PLANT	0	473, 194	1	497, 091	39	7. 00
8. 00	00800 LAUNDRY & LI NEN SERVI CE	0	9, 704		9, 704	4	8.00
9. 00 10. 00	00900 HOUSEKEEPI NG 01000 DI ETARY	0	7, 899 75, 469	1	12, 322 80, 067	41 31	9. 00 10. 00
11. 00	01100 CAFETERI A	0	17, 124	1	17, 124	26	11.00
12.00	01200 MAINTENANCE OF PERSONNEL	0	0	0	0	0	12.00
13. 00 14. 00	01300 NURSING ADMINISTRATION 01400 CENTRAL SERVICES & SUPPLY	0	0 29, 389	0	0 29, 389	31 0	13. 00 14. 00
15. 00	01500 PHARMACY	0	17, 818	1 1	23, 918	53	15.00
16.00	01600 MEDICAL RECORDS & LIBRARY	0	9, 842	1	9, 842	0	16.00
	01700 SOCIAL SERVICE	0	0	0	0	0	17.00
19. 00 20. 00	01900 NONPHYSI CI AN ANESTHETI STS 02000 NURSI NG PROGRAM	0	0	0	0	0	19. 00 20. 00
21. 00	02100 I &R SERVICES-SALARY & FRINGES APPRV	0	0	0	Ö	0	21.00
22. 00	02200 I&R SERVICES-OTHER PRGM COSTS APPRV	0	0	0	O	0	22. 00
	INPATIENT ROUTINE SERVICE COST CENTERS	1	200 111	170.074	550.040		
30. 00 43. 00	03000 ADULTS & PEDIATRICS 04300 NURSERY	0	•	1	558, 218 1, 574	296 16	30. 00 43. 00
43.00	ANCI LLARY SERVI CE COST CENTERS	<u> </u>	1, 374	0	1, 374	10	43.00
50.00	05000 OPERATING ROOM	0	147, 853	171, 559	319, 412	117	50.00
50. 01	05001 OPERATING ROOM	0	0	0	0	0	50. 01
52. 00 53. 00	05200 DELIVERY ROOM & LABOR ROOM 05300 ANESTHESIOLOGY	0	0	0	0	61 0	52. 00 53. 00
54.00	05400 RADI OLOGY-DI AGNOSTI C	0	185, 310	503, 247	688, 557	121	54.00
60.00	06000 LABORATORY	0	28, 077	0	28, 077	0	60.00
62. 30	06250 BLOOD CLOTTING FOR HEMOPHILIACS	0	0		171 022	0	62.30
65. 00 66. 00	06500 RESPI RATORY THERAPY 06600 PHYSI CAL THERAPY	0	33, 970 401, 628	1	171, 832 465, 819	65 83	65. 00 66. 00
67. 00	06700 OCCUPATI ONAL THERAPY	0	0 1,020	04, 171	0	22	67.00
68. 00	06800 SPEECH PATHOLOGY	0	0	0	o	18	68. 00
69.00	06900 ELECTROCARDI OLOGY	0	0	0	0	7	69.00
71. 00 72. 00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT 07200 IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	71. 00 72. 00
73. 00	07300 DRUGS CHARGED TO PATIENTS	0	Ö	Ö	Ö	6	73.00
76. 97	07697 CARDI AC REHABI LI TATI ON	0	0	0	0	0	76. 97
76. 98 76. 99	07698 HYPERBARI C OXYGEN THERAPY 07699 LI THOTRI PSY	0	31, 147	7, 183	38, 330	30 0	76. 98 76. 99
	07700 ALLOGENEIC HSCT ACQUISITION	0		0	ol	0	1
	07800 CAR T-CELL IMMUNOTHERAPY	0	0	0	ō	0	78. 00
00.00	OUTPATIENT SERVICE COST CENTERS				ما	45	00.00
	09000 CLI NI C 09100 EMERGENCY	0	78, 986	68, 031	147, 017	15 140	•
	09200 OBSERVATION BEDS (NON-DISTINCT PART		70, 700	00,031	0	140	92.00
	OTHER REIMBURSABLE COST CENTERS						
	09500 AMBULANCE SERVICES	0	54, 781		382, 034		95.00
102.00	10200 OPIOID TREATMENT PROGRAM SPECIAL PURPOSE COST CENTERS	U	0	ıl O	0	0	102. 00
113. 00	11300 INTEREST EXPENSE						113.00
118.00		2, 214, 883	2, 112, 440	1, 534, 643	5, 861, 966	2, 029	118. 00
100.00	NONREI MBURSABLE COST CENTERS		0		ما	0	100.00
	1900 GIFT, FLOWER, COFFEE SHOP & CANTEEN 1910 RESEARCH	0	0	0	0		190. 00 191. 00
	19200 PHYSICIANS' PRIVATE OFFICES	0	Ö	1, 154	1, 154		192.00
	07950 OCC HEALTH	0	4, 258	0	4, 258		194. 00
	07951 PAIN CLINIC	0	0	0	0		194. 01
	207952 OCC HEALTH 307953 FOUNDATI O	0	0		0		194. 02 194. 03
	07954 KIDS CAMPUS		ő	Ö	Ö		194. 04
	07955 COMMUNITY & VOLUNTEER SERVICES	0	0	0	o		194. 05
	07956 HUNTI NGTON COLLEGE NURSE 07957 MISC CATERI NG	0	0	0	0		194. 06 194. 07
	07957 MISC CATERING 807958 AUTISM CENTER		0	0	ol Ol		194. 07
194. 09	07959 HUNTI NGTON BUA	0	Ö	o	Ö	0	194. 09
200.00	Cross Foot Adjustments	1			O		200. 00

Health Financial Systems	HUNTINGTON MEMORIAL HOSPITAL			In Lieu of Form CMS-2552-10			
ALLOCATION OF CAPITAL RELATED COSTS		Provi der C	Provider CCN: 15-0091		Worksheet B Part II		
				From 01/01/2023 To 12/31/2023		pared: 2 pm	
		CAPI TAL REI	LATED COSTS				
Cost Center Description	Di rectly Assigned New Capital	BLDG & FIXT	MVBLE EQUIP	Subtotal	EMPLOYEE BENEFITS DEPARTMENT		
	Related Costs						
	0	1. 00	2.00	2A	4. 00		
201.00 Negative Cost Centers		0		0 0	0	201.00	
202.00 TOTAL (sum lines 118 through 201)	2, 214, 883	2, 116, 698	1, 535, 79	7 5, 867, 378	2, 036	202. 00	

In Lieu of Form CMS-2552-10

Period: Worksheet B
From 01/01/2023 Part II
To 12/31/2023 Date/Time Prepared:
5/23/2024 4:22 pm

					5/23/2024 4: 2	
Cost Center Description	ADMINISTRATIV E & GENERAL	MAI NTENANCE & REPAI RS	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPI NG	
	5. 00	6. 00	7. 00	8.00	9. 00	
GENERAL SERVICE COST CENTERS						
1. 00 00100 CAP REL COSTS-BLDG & FIXT 2. 00 00200 CAP REL COSTS-MVBLE EQUIP						1. 00 2. 00
4.00 00400 EMPLOYEE BENEFITS DEPARTMENT			•			4.00
5. 00 00500 ADMINISTRATIVE & GENERAL	2, 380, 109		•			5. 00
6.00 00600 MAINTENANCE & REPAIRS	c	O				6. 00
7.00 O0700 OPERATION OF PLANT	113, 851	0	610, 981			7. 00
8. 00 00800 LAUNDRY & LINEN SERVICE	13, 230	0	3, 893		/	8.00
9. 00 00900 HOUSEKEEPI NG 10. 00 01000 DI ETARY	47, 361 28, 997	0	3, 169 30, 276	-	62, 893 3, 153	9. 00 10. 00
11. 00 01100 CAFETERI A	29, 189		1		715	1
12. 00 01200 MAINTENANCE OF PERSONNEL	27,107	l .	0,070	0	0	12.00
13.00 01300 NURSING ADMINISTRATION	28, 526	0	0	0	0	13.00
14.00 01400 CENTRAL SERVICES & SUPPLY	1, 766	l .	11, 790	0	1, 228	14.00
15. 00 01500 PHARMACY	49, 016		7, 148		744	15.00
16. 00 01600 MEDI CAL RECORDS & LI BRARY 17. 00 01700 SOCI AL SERVI CE	592		3, 949 0	0	411 0	16. 00 17. 00
19. 00 01900 NONPHYSI CLAN ANESTHETI STS			0	0	0	19.00
20. 00 02000 NURSI NG PROGRAM	C	O	Ō	0	0	20.00
21.00 02100 I&R SERVICES-SALARY & FRINGES APPRV	C	0	0	0	0	21.00
22.00 02200 I &R SERVICES-OTHER PRGM COSTS APPRV	C	0	0	0	0	22.00
INPATIENT ROUTINE SERVICE COST CENTERS	220 FE1		155 714	7 525	14 214	20.00
30. 00 03000 ADULTS & PEDI ATRI CS 43. 00 04300 NURSERY	329, 551 16, 347	0 0		7, 535 500		30. 00 43. 00
ANCI LLARY SERVI CE COST CENTERS	10, 347		031	500	00	43.00
50. 00 05000 OPERATING ROOM	75, 876	0	59, 315	4, 991	6, 177	50.00
50. 01 05001 OPERATING ROOM	C		0	0	0	50. 01
52.00 05200 DELIVERY ROOM & LABOR ROOM	62, 359	l .	0	1, 996	l	52.00
53. 00 05300 ANESTHESI OLOGY	93, 795	0	1	0	0	53.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C 60. 00 06000 LABORATORY	198, 064 194, 993	0	74, 342 11, 264	4, 042 0	7, 742 1, 173	54. 00 60. 00
62. 30 06250 BLOOD CLOTTING FOR HEMOPHILIACS	194, 993		11, 204	0	1,1/3	62.30
65. 00 06500 RESPIRATORY THERAPY	82, 740	Ö	13, 628	754	1, 419	65.00
66. 00 06600 PHYSI CAL THERAPY	104, 616	0	161, 123		16, 781	66. 00
67.00 06700 OCCUPATIONAL THERAPY	20, 418	l .	0	0	0	67.00
68. 00 06800 SPEECH PATHOLOGY	16, 775	l .	0	0	0	68.00
69. 00 06900 ELECTROCARDI OLOGY 71. 00 07100 MEDI CAL SUPPLIES CHARGED TO PATIENT	6, 619 40, 107		0	0	0	69. 00 71. 00
72. 00 07100 MEDICAL SUPPLIES CHARGED TO PATTENT	54, 756		0	0		71.00
73. 00 07300 DRUGS CHARGED TO PATIENTS	170, 999	l .	Ö	0	Ö	73.00
76. 97 07697 CARDI AC REHABI LI TATI ON	C	0	0	0	0	76. 97
76. 98 07698 HYPERBARI C OXYGEN THERAPY	62, 883	0	12, 496	0	1, 301	76. 98
76. 99 07699 LI THOTRI PSY	C	0	0	0	0	76. 99
77.00 07700 ALLOGENEIC HSCT ACQUISITION 78.00 07800 CAR T-CELL IMMUNOTHERAPY	C	l .	0	0	0	77. 00 78. 00
OUTPATIENT SERVICE COST CENTERS			<u> </u>			70.00
90. 00 09000 CLINIC	14, 613	0	0	46		90.00
91. 00 09100 EMERGENCY	162, 258	0	31, 688	6, 655	3, 300	91.00
92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART						92.00
OTHER REIMBURSABLE COST CENTERS 95. 00 09500 AMBULANCE SERVICES	244 000		21 077	212	2 200	05.00
102.00 10200 OPLOID TREATMENT PROGRAM	346, 890			312		95. 00 102. 00
SPECIAL PURPOSE COST CENTERS						102.00
113. 00 11300 NTEREST EXPENSE						113.00
118.00 SUBTOTALS (SUM OF LINES 1 through 117	7) 2, 367, 187	0	609, 273	26, 831	62, 715	118. 00
NONREI MBURSABLE COST CENTERS	1	1	1			
190.00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN 191.00 19100 RESEARCH	1, 330	0	_	-		190. 00 191. 00
192. 00 19200 PHYSI CI ANS' PRI VATE OFFI CES	7, 054			0	l e	192.00
194. 00 07950 OCC HEALTH	256	l .	1, 708	0		194.00
194. 01 07951 PAIN CLINIC	C	l .	0	0		194. 01
194. 02 07952 OCC HEALTH	C	0	0	0		194. 02
194. 03 07953 FOUNDATI 0	851	0	0	0	l	194. 03
194. 04 07954 KLDS CAMPUS 194. 05 07955 COMMUNITY & VOLUNTEER SERVICES	3, 431		0	0		194. 04 194. 05
194. 06 07956 HUNTI NGTON COLLEGE NURSE	3, 431		0			194.05
194. 07 07957 MI SC CATERI NG		l o	Ö	0	•	194. 07
194.08 07958 AUTISM CENTER	C	0	0	0		194. 08
194. 09 07959 HUNTI NGTON BUA	C	0	0	0	0	194. 09
200.00 Cross Foot Adjustments	_	_	_		_	200.00
201.00 Negative Cost Centers 202.00 TOTAL (sum lines 118 through 201)	2, 380, 109	0	610, 981	26, 831	l	201.00 202.00
(30) (30) (100) (100) (100)	2,300,107		1 010, 701	20,031	52,073	,_02. 00

Cost Center [Description	DI ETARY	CAFETERI A	MAINTENANCE OF PERSONNEL	NURSI NG ADMI NI STRATI O	5/23/2024 4: 2 CENTRAL SERVICES &	
		10. 00	11. 00	12.00	N 13. 00	SUPPLY 14. 00	
GENERAL SERVICE CO		,					
22. 00 02200 I &R SERVICES	S-MVBLE EQUIP EFITS DEPARTMENT /E & GENERAL & REPAIRS PLANT NEN SERVICE OF PERSONNEL NISTRATION CES & SUPPLY RDS & LIBRARY CE ANESTHETISTS	142, 524 0 0 0 0 0 0 0 0 0 0	53, 924 0 875 0 1, 360 0 0 0 0		- 1	44, 173 444 0 0 0 0 0	1.00 2.00 4.00 5.00 6.00 7.00 8.00 9.00 10.00 11.00 12.00 13.00 14.00 15.00 16.00 17.00 19.00 20.00 21.00
30. 00 03000 ADULTS & PEDI 43. 00 04300 NURSERY		142, 524 0	10, 413 574	0	1	3, 368 0	30. 00 43. 00
ANCILLARY SERVICE		٥	3 063		5 100	7 074	50 00
65. 00 06500 RESPI RATORY 66. 00 06600 PHYSI CAL THEF 67. 00 06700 OCCUPATI ONAL 68. 00 06800 SPEECT PATHOI 69. 00 06900 ELECTROCARDI (71. 00 07100 MEDI CAL SUPPI 72. 00 07200 IMPL. DEV. CI 73. 00 07300 DRUGS CHARGEI 76. 97 07697 CARDI AC REHAF 76. 98 07698 HYPERBARI C 03 76. 99 07699 LI THOTRI PSY 77. 00 07700 ALLOGENEI C HS 78. 00 07800 CAR T-CELL IN 00TPATI ENT SERVI CE 90. 00 09000 CLI NI C 91. 00 09100 EMERGENCY	OM A & LABOR ROOM SY AGNOSTIC NG FOR HEMOPHILIACS THERAPY RAPY THERAPY LOGY DLOGY LIES CHARGED TO PATIENT HARGED TO PATIENTS D TO PATIENTS D TO PATIENTS DILITATION KYGEN THERAPY COST CENTERS BEDS (NON-DISTINCT PART COST CENTERS	0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	3, 963 0 2, 204 0 4, 493 0 0 2, 794 3, 441 1, 086 892 220 0 0 0 0 0 0 459 5, 321	O	0 2,886 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	7, 074 0 0 0 1, 342 4 0 2, 519 331 0 0 0 19, 985 0 0 0 1, 076 0 0 0	91. 00 92. 00
102.00 10200 OPI OID TREATM	MENT PROGRAM	0	15, 424 0	0	· •	3, 960	95. 00 102. 00
NONREI MBURSABLE CO	ENSE JM OF LINES 1 through 117) ST CENTERS	142, 524	53, 519	C	29, 432	43, 775	
190. 00 19000 GI FT, FLOWER, 191. 00 19100 RESEARCH 192. 00 19200 PHYSI CI ANS' F 194. 00 07950 OCC HEALTH 194. 02 07952 OCC HEALTH 194. 03 07953 FOUNDATI O 194. 04 07954 KI DS CAMPUS 194. 05 07955 COMMUNI TY & V 194. 06 07956 HUNTI NGTON CO 194. 07 07957 MI SC CATERINO 194. 08 07958 AUTI SM CENTEF 194. 09 07959 HUNTI NGTON BO 200. 00 Cross Foot AC 201. 00 Negati ve Cost TOTAL (sum li	PRIVATE OFFICES /OLUNTEER SERVICES DLLEGE NURSE GROUPS GROUPS JA JJ ustments	0 0 0 0 0 0 0 0 0 0 0 0 0 0	0 0 398 0 0 0 0 7 0 0 0 0 0			0 75 0 0 53 0 1 0 0 0	190. 00 191. 00 192. 00 194. 00 194. 01 194. 02 194. 03 194. 04 194. 05 194. 06 194. 07 194. 08 194. 09 200. 00 201. 00 202. 00

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

| In Lieu of Form CMS-2552-10 | Peri od: | Worksheet B | From 01/01/2023 | Part II | To 12/31/2023 | Date/Time Prepared: | To 12/31/2023 | Date/Time Prepared: | To 12/31/2024 | Page | Prepared: | To 12/31/2024 | Page | Prepared: | To 12/31/2024 | Page | Prepared: | To 12/31/2024 | Page | Prepared: | To 12/31/2024 | Page | Prepared: | To 12/31/2024 | Page | Prepared: | To 12/31/2024 | Page | Prepared: | To 12/31/2024 | Page | Prepared: | To 12/31/2024 | Page | Prepared: | To 12/31/2024 | Page | Prepared: | To 12/31/2024 | Page | Prepared: | To 12/31/2024 | Page | Prepared: | To 12/31/2024 | Page | Prepared: | To 12/31/2024 | Page | Prepared: | To 12/31/2024 | Page | Prepared: | To 12/31/2024 | Page | Prepared: | To 12/31/2024 | Page | Prepared: | To 12/31/2024 | Page | Prepared: | To 12/31/2024 | Page | Prepared: | To 12/31/2024 | Page | Prepared: | To 12/31/2024 | Page | Prepared: | To 12/31/2024 | Page | Prepared: | To 12/31/2024 | Page | Page | Page | Page | Page | Page | Page | Page | Page | Page | Page | Page | Page | Page | Page | Page | Page | Page | Page | Page | Page | Page | Page | Page | Page | Page | Page | Page | Page | Page | Page | Page | Page | Page | Page | Page | Page | Page | Page | Page | Page | Page | Page | Page | Page | Page | Page | Page | Page | Page | Page | Page | Page | Page | Page | Page | Page | Page | Page | Page | Page | Page | Page | Page | Page | Page | Page | Page | Page | Page | Page | Page | Page | Page | Page | Page | Page | Page | Page | Page | Page | Page | Page | Page | Page | Page | Page | Page | Page | Page | Page | Page | Page | Page | Page | Page | Page | Page | Page | Page | Page | Page | Page | Page | Page | Page | Page | Page | Page | Page | Page | Page | Page | Page | Page | Page | Page | Page | Page | Page | Page | Page | Page | Page | Page | Page | Page | Page | Page | Page | Page | Page | Page | Page | Page | Page | Page | Page | Page | Page | Page | Page | Page | Page | Page | Page | Page | Page | Page | Page | Page | Page | Page | Page | Page | Page | Page |

				0 12/31/2023	Date/lime Pre 5/23/2024 4:2	
Cost Center Description	PHARMACY	MEDI CAL	SOCI AL	NONPHYSI CI AN	NURSI NG	
		RECORDS & LI BRARY	SERVI CE	ANESTHETI STS	PROGRAM	
	15. 00	16. 00	17. 00	19. 00	20.00	
GENERAL SERVICE COST CENTERS						
1. 00 00100 CAP REL COSTS-BLDG & FLXT						1.00
2. 00 00200 CAP REL COSTS-MVBLE EQUIP						2.00
4. 00 00400 EMPLOYEE BENEFITS DEPARTMENT 5. 00 00500 ADMINISTRATIVE & GENERAL						4. 00 5. 00
6. 00 00600 MAI NTENANCE & REPAI RS						6.00
7. 00 00700 OPERATION OF PLANT						7.00
8. 00 00800 LAUNDRY & LINEN SERVICE						8.00
9. 00 00900 HOUSEKEEPI NG						9.00
10. 00 01000 DI ETARY						10.00
11. 00 01100 CAFETERI A						11.00
12.00 01200 MAINTENANCE OF PERSONNEL						12.00
13. 00 O1300 NURSING ADMINISTRATION						13.00
14. 00 01400 CENTRAL SERVICES & SUPPLY						14.00
15. 00 01500 PHARMACY	82, 683	44.704				15.00
16.00 01600 MEDICAL RECORDS & LIBRARY	0	14, 794	,			16.00
17. 00 01700 SOCI AL SERVI CE 19. 00 01900 NONPHYSI CI AN ANESTHETI STS	0	0				17.00
19. 00 01900 NONPHYSI CLAN ANESTHETI STS 20. 00 02000 NURSI NG PROGRAM	0	0		0	C	19.00
21. 00 02100 I&R SERVICES-SALARY & FRINGES APPRV		0		1		21.00
22. 00 02200 &R SERVICES-OTHER PRGM COSTS APPRV		0	ì			22.00
INPATIENT ROUTINE SERVICE COST CENTERS	<u> </u>	<u> </u>		1		1 22.00
30. 00 03000 ADULTS & PEDIATRICS	0	872	(30.00
43. 00 04300 NURSERY	o	73				43.00
ANCILLARY SERVICE COST CENTERS						
50. 00 05000 OPERATING ROOM	0	1, 861	(50.00
50. 01 05001 OPERATING ROOM	0	0	(50. 01
52. 00 05200 DELI VERY ROOM & LABOR ROOM	0	281	(52.00
53. 00 05300 ANESTHESI OLOGY	0	214	9			53.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	0	2, 140	(1		54.00
60.00 06000 LABORATORY 62.30 06250 BLOOD CLOTTING FOR HEMOPHILIACS	0	2, 115 0	l `)		60. 00 62. 30
65. 00 06500 RESPIRATORY THERAPY		506				65.00
66. 00 06600 PHYSI CAL THERAPY		358	l `			66.00
67. 00 06700 OCCUPATI ONAL THERAPY	l öl	109		1		67.00
68. 00 06800 SPEECH PATHOLOGY	l ol	59				68.00
69. 00 06900 ELECTROCARDI OLOGY	o	221				69.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	o	189	(71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	o	298	(72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	82, 683	1, 348	(73.00
76. 97 O7697 CARDI AC REHABI LI TATI ON	0	0				76. 97
76. 98 07698 HYPERBARI C OXYGEN THERAPY	0	247	(76. 98
76. 99 07699 LI THOTRI PSY	0	0	9			76. 99
77. 00 07700 ALLOGENEIC HSCT ACQUISITION	0	0	(77.00
78. 00 07800 CAR T-CELL IMMUNOTHERAPY OUTPATIENT SERVICE COST CENTERS	0	0	(<u>/ </u>		78. 00
90. 00 O9000 CLINIC	O	65	,			90.00
91. 00 09100 EMERGENCY		2, 584		1		91.00
92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART		2, 00 1	· `			92.00
OTHER REIMBURSABLE COST CENTERS	<u>I</u>					72.00
95. 00 09500 AMBULANCE SERVICES	0	1, 254	(95.00
102.00 10200 OPIOID TREATMENT PROGRAM	o	0	(102.00
SPECIAL PURPOSE COST CENTERS						
113.00 11300 INTEREST EXPENSE						113.00
118.00 SUBTOTALS (SUM OF LINES 1 through 117)	82, 683	14, 794	(0	C	118. 00
NONREI MBURSABLE COST CENTERS		_	Г	.T	Г	4
190. 00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0				190.00
191. 00 19100 RESEARCH	0	0	(191.00
192. 00 19200 PHYSI CI ANS' PRI VATE OFFI CES	0	0				192.00
194. 00 07950 0CC HEALTH 194. 01 07951 PALN CLINIC	0	0)			194. 00 194. 01
194. 02 07951 PATN CETNIC 194. 02 07952 OCC HEALTH	0	0				194.01
194. 03 07953 FOUNDATI 0		0				194. 02
194. 04 07954 KI DS CAMPUS		0				194.03
194. 05 07955 COMMUNITY & VOLUNTEER SERVICES		0				194.05
194. 06 07956 HUNTI NGTON COLLEGE NURSE	l ö	0		ó		194.06
194. 07 07957 MI SC CATERI NG	ا م	0				194. 07
194. 08 07958 AUTI SM CENTER	l ől	Ö				194. 08
194. 09 07959 HUNTI NGTON BUA	l ol	0				194. 09
200.00 Cross Foot Adjustments				0		200.00
201.00 Negative Cost Centers	o	0		0		201.00
202.00 TOTAL (sum lines 118 through 201)	82, 683	14, 794	(0	[C	202. 00

	Financial Systems ATION OF CAPITAL RELATED COSTS	HUNTI NGTON MEMO	Provider C	CN: 15_0001 D	<u>In Lie</u> eriod:	u of Form CMS-: Worksheet B	2552-10
ALLOCA	THON OF CAPITAL RELATED COSTS		Frovider C		om 01/01/2023	Part II	pared:
		INTERNS &	RESI DENTS			5/23/2024 4: 2	2 piii
	Cost Center Description	SERVI CES-SALA RY & FRI NGES APPRV	SERVI CES-OTHE R PRGM COSTS APPRV	Subtotal	Intern & Residents Cost & Post Stepdown	Total	
		21. 00	22. 00	24. 00	Adjustments 25.00	26. 00	
	GENERAL SERVICE COST CENTERS	21.00	22.00	24.00	23.00	20.00	
1.00	00100 CAP REL COSTS-BLDG & FIXT						1.00
2. 00 4. 00 5. 00 6. 00 7. 00 8. 00 9. 00 10. 00 11. 00 12. 00	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						2.00 4.00 5.00 6.00 7.00 8.00 9.00 10.00 11.00 12.00
13.00	01300 NURSING ADMINISTRATION						13.00
14. 00 15. 00	01400 CENTRAL SERVI CES & SUPPLY 01500 PHARMACY						14. 00 15. 00
16. 00	01600 MEDICAL RECORDS & LIBRARY						16.00
17.00							17.00
19. 00 20. 00	01900 NONPHYSI CI AN ANESTHETI STS 02000 NURSI NG PROGRAM						19. 00 20. 00
21. 00	02100 I&R SERVICES-SALARY & FRINGES APPRV	0					21.00
22. 00	02200 1&R SERVICES-OTHER PRGM COSTS APPRV INPATIENT ROUTINE SERVICE COST CENTERS		0				22.00
30. 00	03000 ADULTS & PEDIATRICS			1, 238, 343	0	1, 238, 343	30.00
43.00				20, 533	0	20, 533	43.00
50. 00	ANCILLARY SERVICE COST CENTERS 05000 OPERATING ROOM			483, 976	o	483, 976	50.00
50. 01	05001 OPERATING ROOM			0	o	0	50. 01
52. 00 53. 00	05200 DELIVERY ROOM & LABOR ROOM 05300 ANESTHESIOLOGY			69, 787 94, 009	0	69, 787 94, 009	
54.00	05400 RADI OLOGY-DI AGNOSTI C			980, 843	0	980, 843	
60.00	06000 LABORATORY			237, 626	0	237, 626	60.00
62. 30 65. 00	06250 BLOOD CLOTTI NG FOR HEMOPHI LI ACS 06500 RESPI RATORY THERAPY			0 276, 257	0	0 276, 257	62. 30 65. 00
66. 00	06600 PHYSI CAL THERAPY			752, 552	Ö	752, 552	
67.00	06700 OCCUPATIONAL THERAPY			21, 635	0	21, 635	1
68. 00 69. 00	06800 SPEECH PATHOLOGY 06900 ELECTROCARDI OLOGY			17, 744 7, 067	0	17, 744 7, 067	1
71. 00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT			60, 281	0	60, 281	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS 07300 DRUGS CHARGED TO PATIENTS			55, 054 255, 036	0	55, 054 255, 036	72.00
	07697 CARDI AC REHABI LI TATI ON			255, 030	0		76. 97
76. 98	07698 HYPERBARI C OXYGEN THERAPY			116, 363	0	116, 363	
76. 99 77. 00	07699 LITHOTRIPSY 07700 ALLOGENEIC HSCT ACQUISITION			0	0	0	
	07800 CAR T-CELL IMMUNOTHERAPY			o	Ö	0	1
90. 00	OUTPATIENT SERVICE COST CENTERS 09000 CLINIC			15, 479	O	15, 479	90.00
	09100 EMERGENCY			369, 322	0	369, 322	
92. 00	09200 OBSERVATION BEDS (NON-DISTINCT PART				0		92.00
95. 00	OTHER REIMBURSABLE COST CENTERS 09500 AMBULANCE SERVICES			774, 441	0	774, 441	95.00
	10200 OPIOID TREATMENT PROGRAM			0			102.00
112 00	SPECIAL PURPOSE COST CENTERS 11300 INTEREST EXPENSE						113.00
118.00		0	0	5, 846, 348	0	5, 846, 348	
	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN			1, 599	0		190.00
) 19100 RESEARCH) 19200 PHYSI CLANS' PRI VATE OFFI CES			0 8, 688	0		191. 00 192. 00
194.00	07950 OCC HEALTH			6, 400	0	6, 400	194. 00
	07951 PALN CLINIC 07952 OCC HEALTH			0	0		194. 01 194. 02
	307953 FOUNDATI 0			904	0		194. 02
194. 04	07954 KIDS CAMPUS			0	0		194.04
	07955 COMMUNITY & VOLUNTEER SERVICES 07956 HUNTINGTON COLLEGE NURSE			3, 439 0	0 n		194. 05 194. 06
194. 07	07957 MISC CATERING			o o	Ö	0	194. 07
	307958 AUTISM CENTER 07959 HUNTINGTON BUA			0	0		194. 08 194. 09
174. 09	אוטוו וועוטוו אוטוו DUA DUA			ı U	0	0	1174.09

Heal th Fina	ncial Systems	HUNTI NGTON MEMO	RIAL HOSPITAL		In Lie	u of Form CMS-	2552-10
ALLOCATI ON	OF CAPITAL RELATED COSTS		Provi der C	CN: 15-0091	Peri od:	Worksheet B	
					From 01/01/2023 To 12/31/2023		enared:
					12, 01, 2020	5/23/2024 4: 2	22 pm
		INTERNS &	RESI DENTS				
	0	CEDVI OEC CALA	CEDULOEC OTHE		1 . 1	T. 1.1	
	Cost Center Description		SERVI CES-OTHE	Subtotal	Intern &	Total	
		RY & FRINGES			Residents		
		APPRV	APPRV		Cost & Post		
					Stepdown		
		21.22	22.22	0.4.00	Adjustments	07.00	
		21. 00	22. 00	24. 00	25. 00	26. 00	
200. 00	Cross Foot Adjustments	0	0		0 0	0	200.00
201.00	Negative Cost Centers	0	0		0	0	201.00
202. 00	TOTAL (sum lines 118 through 201)	0	0	5, 867, 3	78 0	5, 867, 378	202. 00

COST ALLOCATION - STATISTICAL BASIS Provider CCN: 15-0091 Peri od: Worksheet B-1 From 01/01/2023 12/31/2023 Date/Time Prepared: 5/23/2024 4: 22 pm 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 2.00 935, 868 2.00 00400 EMPLOYEE BENEFITS DEPARTMENT 24, 678, 061 4.00 132 4.00 00500 ADMINISTRATIVE & GENERAL -18, 291, 368 5.00 7, 681 28, 168 6, 264, 346 39, 598, 932 5.00 6.00 00600 MAINTENANCE & REPAIRS 6.00 7.00 00700 OPERATION OF PLANT 30, 673 14, 562 470.544 0 1, 894, 206 7.00 00800 LAUNDRY & LINEN SERVICE 0 220, 107 8 00 629 48 446 8 00 493, 942 00900 HOUSEKEEPI NG 0 9.00 512 2,695 787, 978 9.00 10.00 01000 DI ETARY 4, 892 2, 802 376, 041 0 482, 443 10.00 11.00 01100 CAFETERI A 1, 110 308, 656 0 0 485, 636 11.00 C 01200 MAINTENANCE OF PERSONNEL 12 00 12 00 0 0 0 13.00 01300 NURSING ADMINISTRATION 0 C 367, 604 474, 604 13.00 01400 CENTRAL SERVICES & SUPPLY 1, 905 0 29, 389 14.00 14.00 0 01500 PHARMACY 632, 997 815, 499 15.00 1.155 3.717 15.00 0 01600 MEDICAL RECORDS & LIBRARY 16.00 638 0 9,842 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 PROGRAM 0 0 0 20 00 20 00 Ω 0 02100 I&R SERVICES-SALARY & FRINGES APPRV 21.00 0 C 0 0 0 21.00 02200 I&R SERVICES-OTHER PRGM COSTS APPRV 22.00 0 22.00 INPATIENT ROUTINE SERVICE COST CENTERS 30.00 03000 ADULTS & PEDIATRICS 25, 160 103, 638 3, 566, 009 5, 482, 919 30.00 43.00 04300 NURSERY 191, 919 271, 966 43.00 102 ANCILLARY SERVICE COST CENTERS 05000 OPERATING ROOM 50.00 9. 584 104, 543 1, 410, 165 1, 262, 389 50.00 05001 OPERATING ROOM 0 50.01 0 0 50 01 52.00 05200 DELIVERY ROOM & LABOR ROOM 0 0 1,037,506 52.00 736, 402 05300 ANESTHESI OLOGY 0 53.00 1,560,515 53 00 0 54.00 05400 RADI OLOGY-DI AGNOSTI C 12.012 306, 664 1, 451, 974 3, 295, 294 54.00 06000 LABORATORY 1, 820 60 00 \cap 3, 244, 205 60 00 0 06250 BLOOD CLOTTING FOR HEMOPHILIACS 62.30 62.30 06500 RESPIRATORY THERAPY 65.00 2, 202 84,009 783, 242 0 0 1, 376, 586 65.00 1, 740, 553 06600 PHYSI CAL THERAPY 26, 034 996, 826 66.00 39, 116 66,00 06700 OCCUPATI ONAL THERAPY 67.00 264, 661 339, 698 67.00 68.00 06800 SPEECH PATHOLOGY 0 217, 439 0 0 0 279,088 68.00 06900 ELECTROCARDI OLOGY 0 79, 765 110, 121 69.00 69.00 C 07100 MEDICAL SUPPLIES CHARGED TO PATIENT 0 667, 290 71 00 \cap 71 00 72.00 07200 IMPL. DEV. CHARGED TO PATIENTS 0 C 0 911,003 72.00 73.00 07300 DRUGS CHARGED TO PATIENTS 0 75, 695 0 2, 844, 997 73.00 0 07697 CARDIAC REHABILITATION 76.97 76.97 07698 HYPERBARIC OXYGEN THERAPY 76.98 2,019 4, 377 364, 329 1, 046, 216 76.98 76.99 07699 LI THOTRI PSY 76.99 77.00 07700 ALLOGENEIC HSCT ACQUISITION 0 0 0 77.00 C 0 07800 CAR T-CELL IMMUNOTHERAPY 78.00 0 \cap 0 0 78.00 OUTPATIENT SERVICE COST CENTERS 90.00 09000 CLI NI C 175, 175 0 243, 131 90.00 09100 EMERGENCY 91.00 91.00 5.120 41, 456 1, 684, 846 2, 699, 572 09200 OBSERVATION BEDS (NON-DISTINCT PART 92.00 92.00 OTHER REIMBURSABLE COST CENTERS 09500 AMBULANCE SERVICES 3, 551 199, 418 3, 630, 805 5, 771, 200 95.00 102. 00 10200 OPI OLD TREATMENT PROGRAM 0 102 00 SPECIAL PURPOSE COST CENTERS 113.00 11300 INTEREST EXPENSE 113.00 SUBTOTALS (SUM OF LINES 1 through 117)
NONREIMBURSABLE COST CENTERS 118.00 136, 931 935, 165 24, 591, 828 -18, 291, 368 39, 383, 953 118. 00 190.00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN 0 0 22, 126 190.00 191. 00 19100 RESEARCH 0 0 0 191.00 0 192. 00 19200 PHYSICIANS' PRIVATE OFFICES 0 703 85, 229 0 117, 354 192. 00 194. 00 07950 OCC HEALTH o 4, 258 194.00 276 C 0 194. 01 07951 PAIN CLINIC 0 0 0 0 194. 01 C 194. 02 07952 OCC HEALTH 0 0 194.02 0 0 194. 03 07953 FOUNDATI 0 0 0 0 14, 154 194. 03 194. 04 07954 KIDS CAMPUS C 0 0 0 194, 04 0 194. 05 07955 COMMUNITY & VOLUNTEER SERVICES 1,004 57, 087 194. 05 0 194.06 07956 HUNTI NGTON COLLEGE NURSE 0 0 0 0 194.06 194. 07 07957 MISC CATERING 0 0 194.07 0 0 194. 08 07958 AUTI SM CENTER 0 0 0 194.08 194. 09 07959 HUNTI NGTON BUA 0 0 194.09

Health Financial Systems	HUNTI NGTON MEMO	RIAL HOSPITAL		In Lie	u of Form CMS-2	2552-10
COST ALLOCATION - STATISTICAL BASIS		Provi der C		Period: From 01/01/2023	Worksheet B-1	
					Date/Time Pre 5/23/2024 4:2	
	CAPI TAL REL	ATED COSTS				
Cost Center Description	BLDG & FIXT	MVBLE EQUIP	EMPLOYEE	Reconciliatio		
	(SQUARE FEET)	(DOLLAR VALUE)	BENEFITS DEPARTMENT	n	E & GENERAL (ACCUM. COST)	

		CAPI TAL 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	
200. 00 201. 00 202. 00 203. 00 204. 00	Cross Foot Adjustments Negative Cost Centers Cost to be allocated (per Wkst. B, Part I) Unit cost multiplier (Wkst. B, Part I) Cost to be allocated (per Wkst. B,	2, 116, 698 15. 427041				18, 291, 368 0. 461916 2, 380, 109	203. 00
205. 00	Part II) Unit cost multiplier (Wkst. B, Part II)			0. 000083		0. 060105	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

Heal th Financial Systems

HUNTINGTON MEMORIAL HOSPITAL

Provider CCN: 15-0091

Period:
From 01/01/2023
To 12/31/2023

Pate/Time Prepared:
5/23/2024 4: 22 pm

MAINTENANCE & OPERATION OF LAUNDRY & LINEN SERVICE (POUNDS OF LAUNDRY)

(SQUARE FEET) (SQUARE FEET)

MORKSheet B-1

Date/Time Prepared:
5/23/2024 4: 22 pm

MEMORIAL HOSPITAL

In Lieu of Form CMS-2552-10

Worksheet B-1

Date/Time Prepared:
5/23/2024 4: 22 pm

MINTENANCE & OPERATION OF LAUNDRY & LINEN SERVICE (POUNDS OF LAUNDRY)

6.00 7.00 8.00 9.00 10.00

Cost Center Description	MAINTENANCE & REPAIRS (SQUARE FEET)	OPERATION OF PLANT (SQUARE FEET)	LAUNDRY & LINEN SERVICE (POUNDS OF LAUNDRY)	HOUSEKEEPI NG (SQUARE FEET)	DI ETARY (MEALS SERVED)	2 piii
GENERAL SERVICE COST CENTERS	6. 00	7. 00	8. 00	9. 00	10.00	
1. 00	0 0 0 0 0 0 0 0 0 0 0	98, 721 629 512 4, 892 1, 110 0 1, 905 1, 155 638 0 0 0	0	97, 580 4, 892 1, 110 0 0, 1, 905 1, 155 638 0 0 0	23, 991 0 0 0 0 0 0 0 0 0	1. 00 2. 00 4. 00 5. 00 6. 00 7. 00 8. 00 9. 00 10. 00 11. 00 12. 00 13. 00 14. 00 15. 00 17. 00 19. 00 20. 00 21. 00
30. 00 03000 ADULTS & PEDI ATRI CS 43. 00 04300 NURSERY	0		68, 094 4, 519		23, 991 0	30. 00 43. 00
ANCILLARY SERVICE COST CENTERS 50. 00 05000 OPERATING ROOM 50. 01 05001 OPERATING ROOM 52. 00 05200 DELIVERY ROOM & LABOR ROOM 53. 00 05300 ANESTHESIOLOGY 54. 00 05400 RADIOLOGY-DIAGNOSTIC 60. 00 06000 LABORATORY 62. 30 06250 BLOOD CLOTTING FOR HEMOPHILIACS 65. 00 06500 RESPIRATORY THERAPY 66. 00 06600 PHYSICAL THERAPY 67. 00 06700 OCCUPATIONAL THERAPY 68. 00 06800 SPEECH PATHOLOGY 69. 00 06900 ELECTROCARDIOLOGY 71. 00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT 72. 00 07200 IMPL. DEV. CHARGED TO PATIENTS 73. 00 07300 DRUGS CHARGED TO PATIENTS 76. 97 07697 CARDIAC REHABILITATION 76. 98 07698 HYPERBARIC OXYGEN THERAPY 76. 99 07699 LITHOTRIPSY 77. 00 07800 CAR T-CELL IMMUNOTHERAPY OUTPATIENT SERVICE COST CENTERS	0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	9, 584 0 0 12, 012 1, 820 0 2, 202 26, 034 0 0 0 0 0 0 2, 019 0 0	0 0 6, 812 0 0 0 0 0 0	0	0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	50. 00 50. 01 52. 00 53. 00 54. 00 60. 00 62. 30 65. 00 66. 00 67. 00 68. 00 69. 00 71. 00 72. 00 73. 00 76. 97 76. 98 76. 99 77. 00 78. 00
90. 00 09000 CLI NI C 91. 00 09100 EMERGENCY 92. 00 09200 OBSERVATION BEDS (NON-DI STINCT PART	0		'''		0	
OTHER REIMBURSABLE COST CENTERS 95. 00 09500 AMBULANCE SERVICES 102. 00 10200 OPIOLD TREATMENT PROGRAM	0		2, 820	3, 551 0	0	
SPECIAL PURPOSE COST CENTERS 113.00 11300 INTEREST EXPENSE 118.00 SUBTOTALS (SUM OF LINES 1 through 117) NONREI MBURSABLE COST CENTERS	0		242, 465	97, 304		113. 00 118. 00
190. 00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN 191. 00 19100 RESEARCH 192. 00 19200 PHYSICIANS' PRIVATE OFFICES 194. 00 07950 OCC HEALTH 194. 01 07951 PAIN CLINIC 194. 02 07952 OCC HEALTH 194. 03 07953 FOUNDATIO 194. 04 07954 KIDS CAMPUS 194. 05 07955 COMMUNITY & VOLUNTEER SERVICES 194. 06 07956 HUNTINGTON COLLEGE NURSE 194. 07 07957 MISC CATERING 194. 08 07958 AUTISM CENTER 194. 09 07959 HUNTINGTON BUA Cross Foot Adjustments Negative Cost Centers	0 0 0 0 0 0 0 0 0 0	0	0 0 0 0 0 0 0 0 0 0	0	0 0 0 0 0 0 0 0 0	190. 00 191. 00 192. 00 194. 00 194. 01 194. 02 194. 03 194. 04 194. 05 194. 06 194. 07 194. 08 194. 09 200. 00 201. 00

Health Fina	ncial Systems F	HUNTI NGTON MEMO	RIAL HOSPITAL		In Lie	u of Form CMS-2	2552-10
COST ALLOCA	TION - STATISTICAL BASIS		Provi der C		Peri od:	Worksheet B-1	
					From 01/01/2023 Fo 12/31/2023		
	Cost Center Description	MAINTENANCE &		LAUNDRY &	HOUSEKEEPI NG	DI ETARY	
		REPAI RS	PLANT	LINEN SERVICE	(SQUARE FEET)	(MEALS	
		(SQUARE FEET)	(SQUARE FEET)	,		SERVED)	
				LAUNDRY)			
		6. 00	7. 00	8. 00	9. 00	10. 00	
202. 00	Cost to be allocated (per Wkst. B,	0	2, 769, 170	339, 422	1, 166, 320	900, 985	202. 00
	Part I)						
203. 00	Unit cost multiplier (Wkst. B, Part I)	0. 000000	28. 050465	1. 399880	11. 952449	37. 555125	203.00
204. 00	Cost to be allocated (per Wkst. B,	0	610, 981	26, 83°	62, 893	142, 524	204. 00
	Part II)						
205. 00	Unit cost multiplier (Wkst. B, Part	0. 000000	6. 188967	0. 110659	0. 644528	5. 940728	205.00
	[11]						
206. 00	NAHE adjustment amount to be allocated						206. 00
	(per Wkst. B-2)						
207. 00	NAHE unit cost multiplier (Wkst. D,						207.00
	Parts III and IV)						

Control Center Description Control Con	COST ALLOCATION - STATISTICAL BASIS		Provi der Co		eriod: rom 01/01/2023	Worksheet B-1	
CONTENT CONT							
COSTED SERVICE ST CENTERS 11.00 12.00 13.00 14.00 15.00 15.00 14.00 15.00 15.00 14.00 15.00	Cost Center Description	CAFFTERLA	MAINTENANCE	NURSI NG	CENTRAL		2 pm
NO. NO.	oost contor bescription						
		SERVICE)				REQUIS.)	
13.00 12.00 13.00 14.00 15.00 14.00 15.00			HOUSED)		,		
REMEMBER SERVICE COST CENTERS 1.00 DOTOLOGO PARE LOSTS-MARIE ESUIPMENT 2.00 DOTOCOO PARE LOSTS-MARIE ESUIPMENT 3.00		11 00	12.00			15 00	
1.00	GENERAL SERVICE COST CENTERS	11.00	12.00	13.00	14.00	13.00	
4.00 DOGO DEPLOYEE REFER TS DEPARTEMENT							1.00
5.00 000000 JAMIN INTERTATIVE & CENERAL							
0.00 0.0000 DOCODO DOC	1 1						
7. 00 DOZDO DEFRATION OF PLANT 9. 00 DOZDO DEMONSKEEPIN G 9. 00 DOZDO DEMON	1 1						
8.00 000000 LAMINDRY & LITHEN SERVICE							
9.00 00900 DIUSEKEEP INS	1 1						
11.00 01100 CAFETERIA 406, 323 11.00 11.							9. 00
12.00 01200/MIN INFERMACE OF PERSONNET 0							
13.00 01300 MURSING ADMINISTRATION 6.595 0 169.355 16.00 13.488,438 14.00		406, 323					
14.00 01400 CENTRAL SERVICES & SUPPLY 0 0 0 3,488,438 14.00 15.00 01500 MARINACY 10,246 0 0 0 0 0 0 0 0 16.00 16.00 17.00 1700 0		0 4 505	0	160 255			
15.00 1500 PHABILACY 10,246 0 0 35,007 2,750,100 15.00 17.00		0, 343	0		3 488 438		
10.00 10-000 MEDICAL RECORDS & LIBRARY 0 0 0 0 0 10 0 17.00 1700 00 0 19.00 00 0 19.00 0 19.00 00 19.00 00 19.00 00 19.00 00 19.00 0 0 19.00 00 0 19.00 00 0 19.00 00 0 19.00 00 0 0 0 0 0 0 0 0		10, 246	0			2, 750, 100	
19.00 01900 NOMPHYSICI AN AMESINETISTS	16.00 01600 MEDICAL RECORDS & LIBRARY	0	0	0	o		
20.00 20.00 QUISTS INC PROGRAM 0 0 0 0 0 0 0 0 0		0	0	0	0	0	
21.00	1	0	0	0	0	0	
22.00		0	0	0	0	0	
IMPATI ENT ROUTINE SERVICE COST CENTERS			0) 	0	0	
30.00		<u> </u>		<u> </u>	_I		22.00
MILLIARY SERVICE COST CENTERS		78, 464	0	78, 464	265, 959	0	30.00
50.00		4, 328	0	4, 328	0	0	43.00
50.00		20.040		00.040	EEO (741		F0 00
52.00 05200 DELIVERY ROOM & LABOR ROOM 16,606 0 16,606 0 0 52.00	1 1	· · · · · · · · · · · · · · · · · · ·					
53.00 05300 ANESTHESIOLOGY 0 0 0 0 53.00	1 1	- 1		_	0	-	
60.00 06000 LABORATORY	1 1	0	0	0	o	0	
62. 30 06250 BLODO CLOTTI NG FOR HEMOPHI LIACS 0 0 0 1 0 0 0 6.6. 30 65. 00 06500 BESPIRATORY THERAPY 21, 050 0 0 198, 961 0 65. 00 66. 00 06500 BESPIRATORY THERAPY 25, 929 0 0 0 26, 106 0 66. 00 67. 00 06700 OCCUPATIONAL THERAPY 81, 1811 0 0 0 0 0 0 67. 00 68. 00 06800 SPEECH PATHOLOGY 6, 7211 0 0 0 0 0 0 68. 00 69. 00 06800 SPEECH PATHOLOGY 1, 659 0 0 0 0 0 0 0 69. 00 69. 00 06900 LELECTROCARDI DIOLOGY 1, 659 0 0 0 0 1, 578, 293 0 71. 00 72. 00 0700 MEDICAL SUPPLIES CHARGED TO PATIENT 0 0 0 0 1, 578, 293 0 71. 00 72. 00 07200 IMPL. DEV. CHARGED TO PATIENTS 0 0 0 0 0 0 2, 750, 1700 76. 97 07697 CARDIA CREHABILITATION 0 0 0 0 0 0 2, 750, 1700 76. 98 07699 HYPERBARIC CONTERNAPY 0 0 0 0 84, 958 0 76. 98 76. 99 07699 LITHOTRI PSY 0 0 0 0 84, 958 0 76. 98 76. 99 07699 LITHOTRI PSY 0 0 0 0 0 84, 958 0 76. 98 76. 90 07690 LITHOTRI PSY 0 0 0 0 0 0 0 0 77. 00 770. 00 07700 ALLOGENEIC HISCT ACQUISITION 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	54. 00 05400 RADI OLOGY-DI AGNOSTI C	33, 859	0	0	105, 966	0	54.00
65.00 06500 RESPIRATORY THERAPY 21,050 0 0 198,961 0 65.00 66.00 06600 PHYSI CAL THERAPY 25,929 0 0 26,106 0 66.00 67.00 06700 0CCUPATI ONAL THERAPY 8,181 0 0 0 0 0 0 67.00 68.00 06800 SPEECH PATHOLOGY 6,721 0 0 0 0 0 68.00 69.00 06900 ELECTROCARDI OLOGY 1,659 0 0 0 0 0 69.00 71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT 0 0 0 1,578,293 0 71.00 72.00 07200 IMPL. DEV. CHARGED TO PATIENTS 0 0 0 0 0 0 72.00 73.00 07300 DRUGS CHARGED TO PATIENTS 0 0 0 0 0 0 0 76.97 76.90 07697 CARDIA CREHBAL LITATION 0 0 0 0 0 0 76.98 76.90 07699 LITHORIE PSY 0 0 0 0 84,958 0 76.98 77.00 07700 ALLOGENE IC HISCA CACULI SI TI 0N 0 0 0 0 0 0 0 77.00 78.00 07800 CART -T-CELL IMMUNOTHERAPY 0 0 0 0 0 0 0 0 77.00 79.00 07700 ALLOGENE IC HISCA CACULI SI TI 0N 0 0 0 0 0 0 0 0 79.00 07900 CART -T-CELL IMMUNOTHERAPY 0 0 0 0 0 0 0 0 0 79.00 07900 CART -T-CELL IMMUNOTHERAPY 0 0 0 0 0 0 0 0 79.00 07900 OBERNATION BEDS (NON-DISTINCT PART 0 0 0 0 0 0 0 0 79.00 07900 OBERNATION BEDS (NON-DISTINCT PART 0 0 0 0 0 0 0 0 79.00 07900		0	0	0	332	ū	
66. 00 06-600 PHYSI CAL THERAPY 25, 929 0 0 26, 106 0 66, 00 67, 00 670 06-70	1 1	0	0	0	0	0	
67.00 06700 06700 06700 06700 06700 06700 0680			0	0		0	
68.00 06800 SPECCH PATHOLOGY 0 0 0 0 0 0 0 0 0			0) 	20, 100	0	
69.00 06900 CLECTROCARDIOLOGY 1,659 0 0 0 0 69.00			0	Ö	o	0	
12 00 07200 MPL DEV. CHARGED TO PATIENTS 0 0 0 0 0 0 0 2, 750, 100 73. 0	69. 00 06900 ELECTROCARDI OLOGY	1, 659	0	0	0	0	69. 00
13. 00 07300 DRIGS CHARGED TO PATIENTS 0 0 0 0 2,750,100 73, 00		0	0	0	1, 578, 293	0	
76. 97 07697 CARDI AC REHABILITATION 0 0 0 0 0 0 76. 97 76. 98 07698 HYPERBARIC OXYGEN THERAPY 0 0 0 0 0 0 0 0 76. 99 07699 LITHOTRI PSY 0 0 0 0 0 0 0 0 77. 00 07700 ALLOGENEIC HSCT ACQUISITION 0 0 0 0 0 0 0 0 78. 00 07800 CAT T-CELL I IMMUNOTHERAPY 0 0 0 0 0 0 0 78. 00 07800 CAT T-CELL I IMMUNOTHERAPY 0 0 0 0 0 0 0 78. 00 07800 CAT T-CELL I IMMUNOTHERAPY 0 0 0 0 0 0 0 78. 00 07800 CAT T-CELL I IMMUNOTHERAPY 0 0 0 0 0 0 78. 00 07900 CLINIC 0 0 0 0 0 0 0 0 79. 00 09000 CLINIC 0 0 0 0 0 0 0 79. 00 09000 CLINIC 0 0 0 0 0 0 0 79. 00 09000 08ERVATIO MBEDS (NON-DISTINCT PART 0 0 0 0 0 0 0 79. 00 09000 08ERVATIO MBEDS (NON-DISTINCT PART 0 0 0 0 0 0 0 79. 00 09000 09000 09000 09000 0		0	0	0	0	-	
76. 98 07698 HYPERBARI C OXYGEN THERAPY 0 0 0 0 84,958 0 76,98 76. 99 07699 LI THOTRI PSY 0 0 0 0 0 0 77. 00 07700 ALLOGENEI C HSCT ACQUI SI TI ON 0 0 0 0 0 78. 00 07800 CAR T - CELL I MAUNOTHERAPY 0 0 0 0 0 0 78. 00 07800 CAR T - CELL I MAUNOTHERAPY 0 0 0 0 0 78. 00 07900 CAR T - CELL I MAUNOTHERAPY 0 0 0 0 0 78. 00 07900 CAR T - CELL I MAUNOTHERAPY 0 0 0 0 0 79. 00 09000 CLI NI C 3,462 0 0 22,158 0 90.00 79. 00 09100 DERREENCY 40,095 0 40,095 267,762 0 91.00 79. 00 09200 OBSERVATI ON BEDS (NON-DI STI NCT PART 92.00 79. 00 09500 AMBULANCE SERVI CES 116,209 0 0 312,761 0 95.00 79. 00 09500 OPI OID T REATMENT PROGRAM 0 0 0 0 312,761 0 95.00 79. 00 09500 OPI OID T REATMENT PROGRAM 0 0 0 0 0 79. 00 09000 OFFI T FLOWER, COFFEE SHOP & CANTEEN 790. 00 19000 GFT, FLOWER, COFFEE SHOP & CANTEEN 0 0 169,355 3,457,024 2,750,100 791. 00 19000 GFT, FLOWER, COFFEE SHOP & CANTEEN 0 0 0 21,238 0 90.00 792. 00 19000 OFFI T FLOWER, COFFEE SHOP & CANTEEN 0 0 0 0 0 191.00 791. 00 19000 OFFI T FLOWER, COFFEE SHOP & CANTEEN 0 0 0 0 0 194.00 792. 00 19200 PHYSI CLI NIC C 0 0 0 0 0 194.00 794. 00 07950 OCC HEALTH 0 0 0 0 0 0 194.00 794. 01 07951 AIN CLI NIC C 0 0 0 0 0 0 194.00 794. 02 07952 OCC HEALTH 0 0 0 0 0 0 0 194.00 794. 03 07953 FOUNDATIO 0 0 0 0 0 0 0 194.00 794. 04 07957 MISC CATERI NG 0 0 0 0 0 0 194.00 794. 05 07955 HINTI NGTON COLLEGE NURSE 0 0 0 0 0 0 0 0 0 794. 07 07957 MISC CATERI NG 0 0 0 0 0 0 0 794. 08 07958 HUNTI NGTON BUA 0 0 0 0 0 0 0 794. 09 07959 HUNTI NGTON BUA 0 0 0 0 0 0 795. 00 00 0 0 0 0 0 0 796. 00		0	0	0	U		
76. 99 07699 LTHOTRI PSY 0 0 0 0 0 0 76. 99 77. 00 07700 ALLOGENEI C HSCT ACQUI SITI ON 0 0 0 0 0 0 0 8. 00 07800 CAR T-CELL IMMUNOTHERAPY 0 0 0 0 0 0 0 90. 00 09000 CAR T-CELL IMMUNOTHERAPY 0 0 0 0 0 0 0 90. 00 09000 CLINIC C 3, 462 0 0 0 22, 158 0 90. 00 91. 00 09100 EMERGENCY 40, 095 0 40, 095 267, 762 0 91. 00 92. 00 09200 09SERVATI ON BEDS (NON-DI STI NCT PART 92. 00 95. 00 09500 AMBULANCE SERVI CES 116, 209 0 0 0 0 102. 00 80 102. 00 10200 101 TREATMENT PROGRAM 0 0 0 0 0 0 102. 00 80 80 113. 00 1300 INTEREST EXPENSE 113. 00 81 113. 00 1300 INTEREST EXPENSE 113. 00 81 114. 00 1300 INTEREST EXPENSE 113. 00 81 115. 00 19100 RESEARCH 0 0 0 0 0 1102. 00 81 102. 00 19200 PHYSI CI ANS' PRI VATE OFFICES 3, 001 0 0 5, 914 0 192. 00 81 194. 01 19750 PHYSI CI ANS' PRI VATE OFFICES 3, 001 0 0 5, 914 0 192. 00 81 194. 01 19750 PATS CI ANS' PRI VATE OFFICES 3, 001 0 0 0 0 0 0 194. 01 81 194. 01 19750 102			0	0	84 958	-	
77. 00		Ö	0	Ö			
OUTPATLENT SERVICE COST CENTERS O	77.00 07700 ALLOGENEIC HSCT ACQUISITION	o	0	0	o	0	
90. 00 09000 CLINI C 3,462 0 0 22,158 0 90.00 91. 00 09100 EMERGENCY 40,095 0 40,095 267,762 0 91.00 92. 00 09200 OBSERVATI ON BEDS (NON-DISTINCT PART OFFICES 116,209 0 0 0 312,761 0 92.00 95. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART OFFICES 116,209 0 0 0 0 0 0 0 SPECIAL PURPOSE COST CENTERS 113.00 1300 INTEREST EXPENSE 118.00 1900.00 1910.00 1910.00 192.00 1900 1910.00 192.00 192.00 1900 1910.00 192.00		0	0	0	0	0	78. 00
91. 00 09100 EMERGENCY 09200 OBSERVATION BEDS (NON-DISTINCT PART 092.00 OBSERVATION BEDS (NON-DISTINCT PART 095.00 OBSERVATION	OUTPATIENT SERVICE COST CENTERS	2.4/2			22 150	0	00.00
92. 00 09200 0BSERVATI ON BEDS (NON-DISTINCT PART THEN BURSABLE COST CENTERS 116, 209 0 0 312, 761 0 95. 00					,		
OTHER REIMBURSABLE COST CENTERS 116, 209 0 0 312, 761 0 95. 00 102.00 102.00 107 10 TREATMENT PROGRAM 0 0 0 0 0 0 0 10 10		40, 093	U	40, 093	207, 702	O	
102.00 10200 OPI 0I D TREATMENT PROGRAM O O O O 0 102.00	OTHER REIMBURSABLE COST CENTERS						
113. 00 11300 INTEREST EXPENSE		116, 209					
113. 00		0	0	0	0	0	102. 00
118.00 SUBTOTALS (SUM OF LINES 1 through 117) 403, 266 0 169, 355 3, 457, 024 2, 750, 100 118.00					T		112 00
NONREI MBURSABLE COST CENTERS 190. 00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN 0 0 0 21, 238 0 190. 00 191. 00 19100 RESEARCH 0 0 0 0 0 0 191. 00 19200 PHYSI CI ANS' PRI VATE OFFI CES 3, 001 0 0 5, 914 0 192. 00 194. 00 194. 00 0 0 0 0 0 0 0 194. 00 194. 00 194. 00 194. 00 194. 00 194. 00 0 0 0 0 0 0 0 194. 00		403 266	0	160 355	3 457 024	2 750 100	
190. 00		403, 200		107, 333	3, 437, 024	2, 730, 100	1110.00
192.00 19200 PHYSI CI ANS' PRI VATE OFFI CES 3, 001 0 0 5, 914 0 192.00 194.00 07950 OCC HEALTH 0 0 0 0 0 0 194.00 194.01 194.02 07952 OCC HEALTH 0 0 0 0 0 0 0 194.01 194.02 17952 OCC HEALTH 0 0 0 0 0 0 0 194.01 194.02 17952 OCC HEALTH 0 0 0 0 0 0 0 194.02 194.03 07953 FOUNDATI O 0 0 0 0 0 194.03 194.04 07954 KI DS CAMPUS 0 0 0 0 0 0 194.04 194.05 07955 COMMUNI TY & VOLUNTEER SERVI CES 56 0 0 108 0 194.05 194.06 07956 HUNTI NGTON COLLEGE NURSE 0 0 0 0 0 194.05 194.06 07957 MI SC CATERI NG 0 0 0 0 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 07959 HUNTI NGTON BUA 0 0 0 0 0 0 194.09 07059 OCC HEALTH 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0		0	0	0	21, 238	0	190. 00
194. 00 07950 0CC HEALTH 0 0 0 0 0 194. 00 194. 01 07951 PAI N CLINIC 0 0 0 0 0 194. 02 07952 0CC HEALTH 0 0 0 0 0 194. 03 07953 FOUNDATI 0 0 0 0 194. 04 07954 KI DS CAMPUS 0 0 0 194. 05 07955 COMMUNI TY & VOLUNTEER SERVI CES 56 0 0 194. 06 07956 HUNTI NGTON COLLEGE NURSE 0 0 0 194. 07 07957 MI SC CATERI NG 0 0 0 194. 08 07958 AUTI SM CENTER 0 0 0 194. 09 07959 HUNTI NGTON BUA 0 194. 09 07959 Cross Foot Adjustments 0 0 0 194. 09 07959 0 0 0 0 194. 09 07959 0 0 0 194. 09 07959 0 0 0 0 194. 09 07959 0 0 0 0 194. 09 07959 0 0 0 0 194. 09 07959 0 0 0 0 194. 09 07959 0 0 0 0 194. 09 07959 0 0 0 0 194. 09 07959 0 0 0 0 194. 08 07958 0 0 0 0 0 194. 08 07958 0 0 0 0 0 194. 08 07958 0 0 0 0 0 0 194. 08 07958 0 0 0 0 0 0 0 194. 08 07958 0 0 0 0 0 0 0		0	0	_	0		
194. 01 07951 PAIN CLINIC 0 0 0 0 0 194. 01 194. 02 07952 OCC HEALTH 0 0 0 0 0 0 194. 02 194. 03 07953 FOUNDATI 0 0 0 0 0 0 194. 03 194. 04 07954 KI DS CAMPUS 0 0 0 0 0 194. 04 194. 05 07955 COMMUNI TY & VOLUNTEER SERVI CES 56 0 0 108 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 0 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. 08 194. 09 07959 HUNTI NGTON BUA 0 0 0 0 0 194. 09 200. 00 Cross Foot Adjustments		3, 001	0	_	5, 914		
194. 02 07952 OCC HEALTH 0 0 0 0 0 194. 02 194. 03 07953 FOUNDATI 0 0 0 0 0 4, 154 0 194. 03 194. 04 07954 KI DS CAMPUS 0 0 0 0 0 194. 04 194. 05 07955 COMMUNI TY & VOLUNTEER SERVI CES 56 0 0 108 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 0 0 194. 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 0 194. 09 200. 00 Cross Foot Adjustments		0	0	0	0		
194. 03 07953 FOUNDATI 0 0 0 4, 154 0 194. 03 194. 04 07954 KI DS CAMPUS 0 0 0 0 0 0 194. 04 194. 05 07955 COMMUNI TY & VOLUNTEER SERVI CES 56 0 0 108 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 0 0 194. 07 194. 07 07958 AUTI SM CENTER 0 0 0 0 0 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 0 194. 09 200. 00 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 194. 05 07955 COMMUNI TY & VOLUNTEER SERVI CES 194. 06 07956 HUNTI NGTON COLLEGE NURSE 0 0 0 0 0 0 194. 05 194. 07 07957 MI SC CATERI NG 0 0 0 0 0 0 194. 07 194. 08 07958 AUTI SM CENTER 0 0 0 0 0 0 0 194. 07 194. 09 07959 HUNTI NGTON BUA 0 0 0 0 0 0 194. 07 194. 09 07959 HUNTI NGTON BUA 194. 09 07958 Foot Adjustments		l ő	0	o o	4. 154		
194. 06 07956 HUNTI NGTON COLLEGE NURSE 0 0 0 0 0 194. 06 194. 07 07957 MI SC CATERI NG 0 0 0 0 194. 07 194. 08 07958 AUTI SM CENTER 0 0 0 0 0 194. 08 194. 09 07959 HUNTI NGTON BUA 0 0 0 0 0 194. 09 200. 00 Cross Foot Adjustments 2 200. 00		0	0	O	0		
194. 07 07957 MI SC CATERING 0 0 0 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 0 194. 09 200. 00 Cross Foot Adjustments 0 0 0 0 0 0 194. 09 200. 00		56	0	0	108		
194. 08 07958 AUTI SM CENTER 0 0 0 0 0 194. 08 194. 09 07959 HUNTI NGTON BUA 0 0 0 0 194. 09 200. 00 Cross Foot Adjustments 200. 00	194. 06 07956 HUNTI NGTON COLLEGE NURSE	0	0	0	0		
194.09 07959 HUNTI NGTON BUA 0 0 0 0 194.09 200.00 Cross Foot Adjustments 0 0 0 0 190.00		o o	0	0	0		
200.00 Cross Foot Adjustments 200.00			0	0	0		
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Health Fin	ancial Systems	HUNTINGTON MEMO	RIAL HOSPITAL		In Lie	u of Form CMS-2	2552-10
COST ALLO	CATION - STATISTICAL BASIS		Provi der C		Peri od:	Worksheet B-1	
					From 01/01/2023 Fo 12/31/2023		
	Cost Center Description	CAFETERIA (HOURS OF SERVICE)	MAINTENANCE OF PERSONNEL (NUMBER	NURSI NG ADMI NI STRATI C N	SUPPLY	PHARMACY (COSTED REQUIS.)	
			HOUSED)	(DI RECT NRSI NG HRS)	(COSTED REQUIS.)		
		11. 00	12. 00	13.00	14. 00	15. 00	
202. 00	Cost to be allocated (per Wkst. B, Part I)	754, 362	0	706, 07	119, 169	1, 258, 615	202.00
203.00	Unit cost multiplier (Wkst. B, Part I)	1. 856557	0. 000000	4. 16920 ⁻	0. 034161	0. 457662	203. 00
204. 00	Cost to be allocated (per Wkst. B, Part II)	53, 924	0	29, 43	2 44, 173	82, 683	204. 00
205. 00	Unit cost multiplier (Wkst. B, Part	0. 132712	0. 000000	0. 17378	0. 012663	0. 030065	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

COST ALLOCATION - STATISTICAL BASIS Provider CCN: 15-0091 Peri od: Worksheet B-1 From 01/01/2023 12/31/2023 Date/Time Prepared: 5/23/2024 4:22 pm INTERNS & **RESI DENTS** MEDI CAL SOCI AL NONPHYSI CI AN NURSI NG SERVI CES-SALA Cost Center Description RY & FRINGES RECORDS & **SERVICE ANESTHETISTS PROGRAM** (ASSI GNED (TIME SPENT) **APPRV** LI BRARY (ASSI GNED (GROSS REVE TIME) TIME) (ASSI GNED NUE) TIME) 16. 00 17. 00 19.00 20.00 21.00 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 16.00 283, 896, 045 16.00 17.00 01700 SOCIAL SERVICE 17.00 01900 NONPHYSICIAN ANESTHETISTS 19.00 0 0 19.00 0 02000 NURSI NG PROGRAM 20 00 0 0 20 00 0 02100 I&R SERVICES-SALARY & FRINGES APPRV 21.00 0 C 0 21.00 02200 I&R SERVICES-OTHER PRGM COSTS APPRV 22.00 22.00 INPATIENT ROUTINE SERVICE COST CENTERS 03000 ADULTS & PEDIATRICS 30 00 16, 762, 725 Ω 0 0 0 30 00 0 43.00 04300 NURSERY 1, 408, 947 0 0 0 43.00 ANCILLARY SERVICE COST CENTERS 05000 OPERATING ROOM 35, 797, 075 0 50.00 50.00 C 0 05001 OPERATING ROOM 0 50.01 Ω 0 50.01 0 52.00 05200 DELIVERY ROOM & LABOR ROOM 5, 406, 199 0 0 0 0 52.00 05300 ANESTHESI OLOGY 0 53 00 4, 122, 094 0 0 0 0 0 0 0 0 0 0 0 0 0 53.00 54.00 05400 RADI OLOGY-DI AGNOSTI C 41.148.095 0 0 54.00 0 06000 LABORATORY 0 60 00 40, 677, 330 0 0 60.00 06250 BLOOD CLOTTING FOR HEMOPHILIACS 62.30 62.30 0 06500 RESPIRATORY THERAPY 0 65.00 9, 728, 128 0 0 65.00 0 66.00 06600 PHYSI CAL THERAPY 6, 880, 536 0 66.00 0 06700 OCCUPATI ONAL THERAPY 67.00 2, 090, 876 0 0 67.00 68.00 06800 SPEECH PATHOLOGY 1, 143, 349 0 0 68.00 06900 ELECTROCARDI OLOGY 4, 248, 177 69.00 69.00 3, 630, 581 07100 MEDICAL SUPPLIES CHARGED TO PATIENT 0 71 00 0 71.00 0 72.00 07200 IMPL. DEV. CHARGED TO PATIENTS 5, 730, 461 C 0 72.00 73.00 07300 DRUGS CHARGED TO PATIENTS 25, 927, 170 0 73.00 07697 CARDIAC REHABILITATION 0 0 76.97 0 76.97 07698 HYPERBARIC OXYGEN THERAPY C 0 76.98 4, 740, 552 0 76.98 76.99 07699 LI THOTRI PSY 0 0 76.99 77.00 0 o 07700 ALLOGENEIC HSCT ACQUISITION 0 0 77.00 0 07800 CAR T-CELL IMMUNOTHERAPY 0 78.00 0 0 0 78.00 OUTPATIENT SERVICE COST CENTERS 90.00 09000 CLI NI C 1, 241, 675 0 0 0 0 90.00 09100 EMERGENCY 49, 095, 010 0 ol 91.00 91.00 C 0 09200 OBSERVATION BEDS (NON-DISTINCT PART 92.00 92.00 OTHER REIMBURSABLE COST CENTERS 09500 AMBULANCE SERVICES 24, 117, 065 0 0 95.00 102. 00 10200 OPI OLD TREATMENT PROGRAM 0 0 0 0 102.00 SPECIAL PURPOSE COST CENTERS 113. 00 11300 I NTEREST EXPENSE 113.00 SUBTOTALS (SUM OF LINES 1 through 117)
NONREIMBURSABLE COST CENTERS 118.00 283, 896, 045 0 0 0 0 118.00 190.00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN 0 0 0 0 190, 00 191. 00 19100 RESEARCH 0 0 0 0 191.00 C 192. 00 19200 PHYSICIANS' PRIVATE OFFICES 0 0 0 0 0 0 0 0 0 0 0 0 192.00 194. 00 07950 OCC HEALTH 0 0 194 00 0 194. 01 07951 PAIN CLINIC 0 0 0 194. 01 194. 02 07952 OCC HEALTH 0 0 194.02 194. 03 07953 FOUNDATI 0 0000 0 0 0 194.03 194. 04 07954 KIDS CAMPUS 0 0 0 194.04 194. 05 07955 COMMUNITY & VOLUNTEER SERVICES 0 194.05 0 194.06 07956 HUNTI NGTON COLLEGE NURSE 0 0 0 194.06 194. 07 07957 MISC CATERING 0 0 194, 07 0 194.08 07958 AUTISM CENTER 0 0 0 194.08 194. 09 07959 HUNTI NGTON BUA 0 194.09

Health Financial Systems	HUNTI NGTON MEMORI.	AL HOSPITAL	l i	n Lieu of Form CMS-2552-10
COST ALLOCATION - STATISTICAL BASIS		Provider CCN: 15	From 01/01/	Worksheet B-1 /2023 /2023 Date/Time Prepared: 5/23/2024 4:22 pm
				INTERNS &

						5/23/2024 4: 2	2 pm
						INTERNS &	
						RESI DENTS	
	Cost Center Description	MEDI CAL	SOCI AL	NONPHYSI CI AN	NURSI NG	SERVI CES-SALA	
		RECORDS &	SERVI CE	ANESTHETI STS	PROGRAM	RY & FRINGES	
		LI BRARY	(TIME SPENT)	(ASSI GNED	(ASSI GNED	APPRV	
		(GROSS REVE		TIME)	TIME)	(ASSI GNED	
		NUE)				TIME)	
		16. 00	17. 00	19. 00	20. 00	21. 00	
200.00	Cross Foot Adjustments						200. 00
201.00	Negative Cost Centers						201.00
202. 00	Cost to be allocated (per Wkst. B,	39, 910	0	0	0	0	202. 00
	Part I)						
203. 00	Unit cost multiplier (Wkst. B, Part I)	0. 000141	0. 000000	0.000000	0. 000000	0.000000	203. 00
204.00	Cost to be allocated (per Wkst. B,	14, 794	0	0	0	0	204.00
	Part II)						
205. 00	Unit cost multiplier (Wkst. B, Part	0. 000052	0. 000000	0.000000	0. 000000	0. 000000	205. 00
	11)						
206. 00					0		206. 00
	(per Wkst. B-2)						
207. 00	NAHE unit cost multiplier (Wkst. D,				0. 000000		207. 00
	Parts III and IV)						

Health Financial Systems
COST ALLOCATION - STATISTICAL BASIS In Lieu of Form CMS-2552-10
Worksheet B-1 HUNTINGTON MEMORIAL HOSPITAL Peri od: From 01/01/2023 To 12/31/2023 Date/Ti me Prepared: 5/23/2024 4: 22 pm Provi der CCN: 15-0091

			I NTERNS & RESI DENTS	372372024 4, 2	- Dill
		Cost Center Description	SERVI CES-OTHE		
			R PRGM COSTS APPRV		
			(ASSI GNED TIME)		
			22. 00		
1. 00		AAL SERVICE COST CENTERS CAP REL COSTS-BLDG & FIXT			1.00
2. 00		CAP REL COSTS-MVBLE EQUIP			2.00
4. 00 5. 00	1	EMPLOYEE BENEFITS DEPARTMENT ADMINISTRATIVE & GENERAL			4. 00 5. 00
6.00	1	MAINTENANCE & REPAIRS			6.00
7.00	1	OPERATION OF PLANT			7. 00 8. 00
8. 00 9. 00	1	LAUNDRY & LINEN SERVICE HOUSEKEEPING			9.00
10.00		DIETARY			10.00
11. 00 12. 00	1	CAFETERIA MAINTENANCE OF PERSONNEL			11. 00 12. 00
13.00	1	NURSING ADMINISTRATION			13.00
14. 00 15. 00		CENTRAL SERVICES & SUPPLY PHARMACY			14. 00 15. 00
16.00	01600	MEDICAL RECORDS & LIBRARY			16.00
17. 00 19. 00	1	SOCIAL SERVICE NONPHYSICIAN ANESTHETISTS			17. 00 19. 00
20.00	02000	NURSING PROGRAM			20.00
21. 00 22. 00	1	1&R SERVICES-SALARY & FRINGES APPRV 1&R SERVICES-OTHER PRGM COSTS APPRV	C		21. 00 22. 00
	I NPAT	IENT ROUTINE SERVICE COST CENTERS			
30. 00 43. 00		ADULTS & PEDI ATRI CS NURSERY	C		30. 00 43. 00
	ANCI L	LARY SERVICE COST CENTERS			
50. 00 50. 01		OPERATING ROOM OPERATING ROOM	C		50. 00 50. 01
52.00	05200	DELIVERY ROOM & LABOR ROOM	C		52.00
53. 00 54. 00	1	ANESTHESI OLOGY RADI OLOGY-DI AGNOSTI C	0		53. 00 54. 00
60.00	1	LABORATORY	C		60.00
62. 30 65. 00	1	BLOOD CLOTTING FOR HEMOPHILIACS RESPIRATORY THERAPY	C		62. 30 65. 00
66.00	1	PHYSI CAL THERAPY	C		66.00
67. 00 68. 00		OCCUPATIONAL THERAPY SPEECH PATHOLOGY	C		67. 00 68. 00
69.00		ELECTROCARDI OLOGY	C		69.00
71. 00 72. 00	1	MEDICAL SUPPLIES CHARGED TO PATIENT IMPL. DEV. CHARGED TO PATIENTS	C		71. 00 72. 00
		DRUGS CHARGED TO PATTENTS	C		73.00
76. 97 76. 98		CARDIAC REHABILITATION	C		76. 97
	1	HYPERBARI C OXYGEN THERAPY			76. 98 76. 99
		ALLOGENEIC HSCT ACQUISITION	C		77.00
78.00		CAR T-CELL IMMUNOTHERAPY CTIENT SERVICE COST CENTERS	C	1	78. 00
		CLINIC	C		90.00
		EMERGENCY OBSERVATION BEDS (NON-DISTINCT PART	C		91.00 92.00
	OTHER	REIMBURSABLE COST CENTERS			1 05 00
		AMBULANCE SERVICES OPIOID TREATMENT PROGRAM	C		95. 00 102. 00
	SPECI	AL PURPOSE COST CENTERS			
113.00		INTEREST EXPENSE SUBTOTALS (SUM OF LINES 1 through 117)	C		113. 00 118. 00
100.00		MBURSABLE COST CENTERS			
	1	GIFT, FLOWER, COFFEE SHOP & CANTEEN RESEARCH	C		190. 00 191. 00
192.00	19200	PHYSICIANS' PRIVATE OFFICES			192.00
		OCC HEALTH PAIN CLINIC	0		194. 00 194. 01
194. 02	07952	OCC HEALTH	C		194. 02
	1	FOUNDATIO KIDS CAMPUS	0		194. 03 194. 04
194. 05	07955	COMMUNITY & VOLUNTEER SERVICES	C		194. 05
		HUNTINGTON COLLEGE NURSE MISC CATERING	0		194. 06 194. 07
194. 08	07958	AUTISM CENTER	C		194. 08
194. 09	07959	HUNTI NGTON BUA	[C	1	194. 09

Health Fina	ancial Systems F	HUNTINGTON MEMORI	AL HOSPITAL	In Lieu	u of Form CMS-2552-10
COST ALLOC	ATION - STATISTICAL BASIS		Provider CCN: 15-0091	Peri od:	Worksheet B-1
				From 01/01/2023 To 12/31/2023	Date/Time Prepared: 5/23/2024 4:22 pm
		INTERNS &			
		RESI DENTS			
	Cost Center Description	SERVI CES-OTHE			
		R PRGM COSTS			
		APPRV			
		(ASSI GNED			
		TIME)			
		22. 00			
200. 00	Cross Foot Adjustments				200. 00
201. 00	Negative Cost Centers				201.00
202.00	Cost to be allocated (per Wkst. B,	0			202. 00
	Part I)				
203.00	Unit cost multiplier (Wkst. B, Part I)	0. 000000			203. 00
204.00	Cost to be allocated (per Wkst. B,	0			204. 00
	Part II)				
205.00	Unit cost multiplier (Wkst. B, Part	0. 000000			205.00
	11)				
206.00	NAHE adjustment amount to be allocated				206.00
	(per Wkst. B-2)				
207. 00	NAHE unit cost multiplier (Wkst. D,				207. 00
	Parts III and IV)				
· ·					•

lealth Financial Systems	HUNTI NGTON MEMO	ORI AL HOSPI TAL		In Lie	u of Form CMS-2	2552-10
COMPUTATION OF RATIO OF COSTS TO CHARGES		Provi der Co		Peri od: From 01/01/2023 To 12/31/2023	Worksheet C Part I Date/Time Pre 5/23/2024 4:2	pared: 2 pm
		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						
20 00 02000 ADULTS & DEDLATRICS	10 502 402	1	10 502 40		10 502 402	20 00

				Costs		
Cost Center Description	Total Cost	Therapy Limit	Total Costs	RCE	Total Costs	
·	(from Wkst.	Adj .		Di sal I owance		
	B, Part I,					
	col. 26)					
	1. 00	2.00	3. 00	4. 00	5. 00	
INPATIENT ROUTINE SERVICE COST CENTERS						
30. 00 03000 ADULTS & PEDI ATRI CS	10, 502, 603		10, 502, 603	0	., ,	
43. 00 04300 NURSERY	434, 275		434, 275	0	434, 275	43.00
ANCILLARY SERVICE COST CENTERS						
50.00 05000 OPERATING ROOM	2, 496, 105		2, 496, 105	0	2, 496, 105	
50. 01 05001 OPERATING ROOM	0		0	0	0	50. 01
52.00 05200 DELIVERY ROOM & LABOR ROOM	1, 642, 823		1, 642, 823	0	1, 642, 823	
53. 00 05300 ANESTHESI OLOGY	2, 281, 923		2, 281, 923	0	2, 281, 923	
54. 00 05400 RADI OLOGY-DI AGNOSTI C	5, 421, 376		5, 421, 376	0	5, 421, 376	1
60. 00 06000 LAB0RATORY	4, 821, 307		4, 821, 307	0	4, 821, 307	
62.30 06250 BLOOD CLOTTING FOR HEMOPHILIACS	0		0	0	0	62. 30
65. 00 06500 RESPIRATORY THERAPY	2, 157, 325	0	2, 157, 325	0	2, 157, 325	65.00
66. 00 06600 PHYSI CAL THERAPY	3, 635, 980	0	3, 635, 980	0	3, 635, 980	66.00
67. 00 06700 OCCUPATI ONAL THERAPY	512, 093	0	512, 093	0	512, 093	67.00
68.00 06800 SPEECH PATHOLOGY	420, 642	0	420, 642	0	420, 642	68.00
69. 00 06900 ELECTROCARDI OLOGY	164, 667		164, 667	0	164, 667	69.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	1, 029, 950		1, 029, 950	0	1, 029, 950	71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	1, 332, 618		1, 332, 618	0	1, 332, 618	72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	5, 421, 418		5, 421, 418	0	5, 421, 418	73.00
76. 97 07697 CARDIAC REHABILITATION	0		0	0	0	76. 97
76.98 07698 HYPERBARIC OXYGEN THERAPY	1, 613, 816		1, 613, 816	0	1, 613, 816	76. 98
76. 99 07699 LI THOTRI PSY	0		0	0	0	76. 99
77.00 07700 ALLOGENEIC HSCT ACQUISITION	0		0	0	0	77. 00
78.00 07800 CAR T-CELL IMMUNOTHERAPY	0		0	0	0	78.00
OUTPATIENT SERVICE COST CENTERS						
90. 00 09000 CLI NI C	363, 378		363, 378	0	363, 378	90.00
91. 00 09100 EMERGENCY	4, 493, 100		4, 493, 100	0	4, 493, 100	91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART	2, 787, 760		2, 787, 760		2, 787, 760	92.00
OTHER REIMBURSABLE COST CENTERS						
95. 00 09500 AMBULANCE SERVI CES	8, 812, 829		8, 812, 829	0	8, 812, 829	95.00
102.00 10200 OPIOID TREATMENT PROGRAM	0		0		0	102.00
SPECIAL PURPOSE COST CENTERS						
113. 00 11300 I NTEREST EXPENSE						113.00
200.00 Subtotal (see instructions)	60, 345, 988	0	60, 345, 988	0	60, 345, 988	
201.00 Less Observation Beds	2, 787, 760		2, 787, 760		2, 787, 760	
202.00 Total (see instructions)	57, 558, 228	0	57, 558, 228	0		

Health Financial Systems	HUNTINGTON MEMORIAL HOSPITAL	u of Form CMS-2552-10	
COMPUTATION OF RATIO OF COSTS TO CHARGES	Provi der CCN: 15-0091	From 01/01/2023	Worksheet C Part I Date/Time Prepared:

					To 12/31/2023	Date/Time Pre 5/23/2024 4:2	
			Title	XVIII	Hospi tal	PPS	
			Charges				
	Cost Center Description	I npati ent	Outpati ent	Total (col. (Cost or Other	TEFRA	
				+ col. 7)	Ratio	I npati ent	
						Ratio	
		6. 00	7. 00	8. 00	9. 00	10.00	
	TENT ROUTINE SERVICE COST CENTERS						
	ADULTS & PEDIATRICS	12, 015, 801		12, 015, 80			30.00
43.00 04300		1, 408, 947		1, 408, 94	7		43.00
	LARY SERVICE COST CENTERS						
	OPERATING ROOM	7, 982, 409	27, 814, 666	35, 797, 07			
	OPERATING ROOM	0	0		0. 000000		
	DELIVERY ROOM & LABOR ROOM	5, 406, 199	0	0, 100, 1,			
	ANESTHESI OLOGY	575, 106	3, 546, 988				
	RADI OLOGY-DI AGNOSTI C	4, 014, 288	37, 133, 807				
	LABORATORY	7, 114, 712	33, 562, 618	40, 677, 33			
	BLOOD CLOTTING FOR HEMOPHILIACS	0	0		0. 000000		
65.00 06500	RESPI RATORY THERAPY	1, 660, 696	8, 067, 432	9, 728, 12	8 0. 221762	0. 000000	65.00
66.00 06600	PHYSI CAL THERAPY	692, 914	6, 187, 622	6, 880, 53	6 0. 528444	0. 000000	66.00
67.00 06700	OCCUPATIONAL THERAPY	320, 284	1, 770, 592	2, 090, 87	6 0. 244918	0. 000000	67.00
68.00 06800	SPEECH PATHOLOGY	139, 323	1, 004, 026	1, 143, 34	9 0. 367903	0. 000000	68. 00
	ELECTROCARDI OLOGY	1, 116, 445	3, 131, 732			0. 000000	
71.00 07100	MEDICAL SUPPLIES CHARGED TO PATIENT	677, 133	2, 953, 448	3, 630, 58	1 0. 283687	0. 000000	71.00
	IMPL. DEV. CHARGED TO PATIENTS	695, 230	5, 035, 231	5, 730, 46		0. 000000	72.00
73.00 07300	DRUGS CHARGED TO PATIENTS	4, 938, 720	20, 988, 450	25, 927, 17		0. 000000	73.00
76. 97 07697	CARDIAC REHABILITATION	0	0		0. 000000	0. 000000	76. 97
	HYPERBARIC OXYGEN THERAPY	29, 006	4, 711, 546	4, 740, 55	2 0. 340428	0.000000	76. 98
	LI THOTRI PSY	0	0		0. 000000	0. 000000	76. 99
77.00 07700	ALLOGENEIC HSCT ACQUISITION	0	0		0. 000000	0.000000	77. 00
78.00 07800	CAR T-CELL IMMUNOTHERAPY	0	0		0. 000000	0.000000	78. 00
	ATIENT SERVICE COST CENTERS						
90.00 09000		5, 477	1, 236, 198	1, 241, 67	5 0. 292651	0. 000000	90.00
91.00 09100	EMERGENCY	6, 315, 815	42, 779, 195	49, 095, 01	0. 091518	0.000000	91.00
	OBSERVATION BEDS (NON-DISTINCT PART	0	4, 746, 924	4, 746, 92	4 0. 587277	0. 000000	92.00
	R REIMBURSABLE COST CENTERS						
95.00 09500	AMBULANCE SERVICES	155	24, 116, 910	24, 117, 06	5 0. 365419	0. 000000	95.00
102.00 10200	OPIOID TREATMENT PROGRAM	0	0		0		102.00
	AL PURPOSE COST CENTERS						
	INTEREST EXPENSE						113. 00
200. 00	Subtotal (see instructions)	55, 108, 660	228, 787, 385	283, 896, 04	5		200.00
201.00	Less Observation Beds						201.00
202. 00	Total (see instructions)	55, 108, 660	228, 787, 385	283, 896, 04	5		202.00
		·					

Health Financial Systems	HUNTINGTON MEMORIAL HOSPITAL	In Lie	u of Form CMS-2552-10
COMPUTATION OF RATIO OF COSTS TO CHARGES	Provi der CCN: 15-0091	Peri od: From 01/01/2023 To 12/31/2023	Worksheet C Part I Date/Time Prepared: 5/23/2024 4:22 pm

			10 12/31/2023	5/23/2024 4: 22 pm
		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. 069729			50.00
50. 01 05001 OPERATING ROOM	0. 000000			50. 01
52.00 05200 DELIVERY ROOM & LABOR ROOM	0. 303878			52.00
53. 00 05300 ANESTHESI OLOGY	0. 553583			53.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	0. 131753			54.00
60. 00 06000 LABORATORY	0. 118526			60.00
62.30 06250 BLOOD CLOTTING FOR HEMOPHILIACS	0. 000000			62. 30
65. 00 06500 RESPI RATORY THERAPY	0. 221762			65.00
66. 00 06600 PHYSI CAL THERAPY	0. 528444			66.00
67. 00 06700 OCCUPATI ONAL THERAPY	0. 244918			67.00
68.00 06800 SPEECH PATHOLOGY	0. 367903			68.00
69. 00 06900 ELECTROCARDI OLOGY	0. 038762			69.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0. 283687			71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0. 232550			72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	0. 209102			73.00
76. 97 07697 CARDIAC REHABILITATION	0. 000000			76. 97
76. 98 07698 HYPERBARI C OXYGEN THERAPY	0. 340428			76. 98
76. 99 07699 LI THOTRI PSY	0. 000000			76. 99
77.00 07700 ALLOGENEIC HSCT ACQUISITION	0. 000000			77.00
78.00 07800 CAR T-CELL IMMUNOTHERAPY	0. 000000			78.00
OUTPATIENT SERVICE COST CENTERS				
90. 00 09000 CLI NI C	0. 292651			90.00
91.00 09100 EMERGENCY	0. 091518			91.00
92.00 O9200 OBSERVATION BEDS (NON-DISTINCT PART	0. 587277			92.00
OTHER REIMBURSABLE COST CENTERS				
95. 00 09500 AMBULANCE SERVICES	0. 365419			95.00
102.00 10200 OPIOLD TREATMENT PROGRAM				102.00
SPECIAL PURPOSE COST CENTERS				
113. 00 11300 I NTEREST EXPENSE				113. 00
200.00 Subtotal (see instructions)				200. 00
201.00 Less Observation Beds				201.00
202.00 Total (see instructions)				202.00

Health Financial Systems	HUNTINGTON MEMO	ORIAL HOSPITAL		In Lie	u of Form CMS-2	2552-10
COMPUTATION OF RATIO OF COSTS TO CHARGES		Provi der CO		Peri od: From 01/01/2023 To 12/31/2023	Worksheet C Part I Date/Time Pre 5/23/2024 4:2	
		Ti tl	e XIX	Hospi tal	PPS	
				Costs		
Cost Center Description	Total Cost (from Wkst.	Therapy Limit Adj.	Total Costs	RCE Di sal I owance	Total Costs	

						3/23/2024 4.2	z piii
			Ti tl	e XIX	Hospi tal	PPS	
					Costs		
	Cost Center Description	Total Cost	Therapy Limit	Total Costs	RCE	Total Costs	
	'	(from Wkst.	Adj .		Di sal I owance		
		B, Part I,					
		col . 26)					
		1.00	2.00	3.00	4. 00	5. 00	
	INPATIENT ROUTINE SERVICE COST CENTERS	1.00	2.00	3.00	4.00	3.00	
	03000 ADULTS & PEDIATRICS	10, 502, 603		10, 502, 603	0	10, 502, 603	30.00
	04300 NURSERY			434, 275			
		434, 275		434, 275	U	434, 275	43.00
	ANCILLARY SERVICE COST CENTERS		ı		_		
	05000 OPERATING ROOM	2, 496, 105		2, 496, 105		2, 496, 105	
	05001 OPERATING ROOM	0		0	0	0	50. 01
	05200 DELIVERY ROOM & LABOR ROOM	1, 642, 823		1, 642, 823	0	1, 642, 823	
53.00	05300 ANESTHESI OLOGY	2, 281, 923		2, 281, 923	0	2, 281, 923	53.00
54.00	05400 RADI OLOGY-DI AGNOSTI C	5, 421, 376		5, 421, 376	0	5, 421, 376	54.00
60.00	06000 LABORATORY	4, 821, 307		4, 821, 307	0	4, 821, 307	60.00
62. 30	06250 BLOOD CLOTTING FOR HEMOPHILIACS	0		0	0	0	62. 30
	06500 RESPIRATORY THERAPY	2, 157, 325	0	2, 157, 325	0	2, 157, 325	
	06600 PHYSI CAL THERAPY	3, 635, 980		3, 635, 980		3, 635, 980	
	06700 OCCUPATI ONAL THERAPY	512, 093		512, 093		512, 093	
	06800 SPEECH PATHOLOGY	420, 642		420, 642		420, 642	
	06900 ELECTROCARDI OLOGY	164, 667		164, 667	0	164, 667	
	07100 MEDICAL SUPPLIES CHARGED TO PATIENT				0		
		1, 029, 950		1, 029, 950		1, 029, 950	
	07200 I MPL. DEV. CHARGED TO PATIENTS	1, 332, 618		1, 332, 618		1, 332, 618	
	07300 DRUGS CHARGED TO PATIENTS	5, 421, 418		5, 421, 418	0	5, 421, 418	
	07697 CARDI AC REHABI LI TATI ON	0		0	0	0	76. 97
	07698 HYPERBARIC OXYGEN THERAPY	1, 613, 816		1, 613, 816	0	1, 613, 816	
	07699 LI THOTRI PSY	0		0	0	0	76. 99
77. 00	07700 ALLOGENEIC HSCT ACQUISITION	0		0	0	0	77.00
78. 00	07800 CAR T-CELL IMMUNOTHERAPY	0		0	0	0	78. 00
	OUTPATIENT SERVICE COST CENTERS						1
90.00	09000 CLI NI C	363, 378		363, 378	0	363, 378	90.00
91. 00	09100 EMERGENCY	4, 493, 100		4, 493, 100	0	4, 493, 100	91.00
	09200 OBSERVATION BEDS (NON-DISTINCT PART	2, 787, 760		2, 787, 760		2, 787, 760	
	OTHER REIMBURSABLE COST CENTERS	2,707,700		2,707,700		2,707,700	72.00
	09500 AMBULANCE SERVICES	8, 812, 829		8, 812, 829	0	8, 812, 829	05.00
	10200 OPLOLD TREATMENT PROGRAM	0, 012, 029		0, 612, 629			102.00
						U	102.00
	SPECIAL PURPOSE COST CENTERS						440.00
	11300 INTEREST EXPENSE	/	_		_		113.00
200.00	Subtotal (see instructions)	60, 345, 988		, ,		, ,	
201. 00	Less Observation Beds	2, 787, 760		2, 787, 760		2, 787, 760	
202. 00	Total (see instructions)	57, 558, 228	0	57, 558, 228	0	57, 558, 228	202.00

Health Financial Systems	HUNTINGTON MEMORIAL HOSPITAL	PITAL In Lieu		
COMPUTATION OF RATIO OF COSTS TO CHARGES	Provi der CCN: 15-0091	From 01/01/2023	Worksheet C Part I Date/Time Prepared:	

				1	o 12/31/2023	Date/Time Pre 5/23/2024 4: 2	
			Ti tl	e XIX	Hospi tal	PPS	
			Charges				
	Cost Center Description	Inpati ent	Outpati ent	Total (col. 6 + col. 7)	Cost or Other Ratio	TEFRA Inpatient Ratio	
		6. 00	7. 00	8. 00	9. 00	10.00	
	INPATIENT ROUTINE SERVICE COST CENTERS	<u>. </u>					
30.00	03000 ADULTS & PEDI ATRI CS	12, 015, 801		12, 015, 801			30.00
43.00	04300 NURSERY	1, 408, 947		1, 408, 947	'		43.00
	ANCILLARY SERVICE COST CENTERS						
50.00	05000 OPERATING ROOM	7, 982, 409	27, 814, 666	35, 797, 075		0. 000000	
50. 01	05001 OPERATI NG ROOM	0	0	1		0. 000000	
52.00	05200 DELIVERY ROOM & LABOR ROOM	5, 406, 199	0	5, 406, 199		0. 000000	
53.00	05300 ANESTHESI OLOGY	575, 106	3, 546, 988	4, 122, 094	0. 553583	0. 000000	
54.00	05400 RADI OLOGY-DI AGNOSTI C	4, 014, 288	37, 133, 807	41, 148, 095		0. 000000	
60.00	06000 LABORATORY	7, 114, 712	33, 562, 618	40, 677, 330		0. 000000	
62. 30	06250 BLOOD CLOTTING FOR HEMOPHILIACS	0	0	`	0.00000	0. 000000	
65.00	06500 RESPI RATORY THERAPY	1, 660, 696	8, 067, 432			0. 000000	1
66.00	06600 PHYSI CAL THERAPY	692, 914	6, 187, 622			0. 000000	
67.00	06700 OCCUPATI ONAL THERAPY	320, 284	1, 770, 592	2, 090, 876		0. 000000	
68. 00	06800 SPEECH PATHOLOGY	139, 323	1, 004, 026	1, 143, 349		0. 000000	
69. 00	06900 ELECTROCARDI OLOGY	1, 116, 445	3, 131, 732	4, 248, 177		0. 000000	
71. 00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	677, 133	2, 953, 448			0. 000000	
72.00	07200 I MPL. DEV. CHARGED TO PATIENTS	695, 230	5, 035, 231	5, 730, 461		0. 000000	
73.00	07300 DRUGS CHARGED TO PATIENTS	4, 938, 720	20, 988, 450	25, 927, 170		0. 000000	
76. 97	07697 CARDI AC REHABI LI TATI ON	0	0	(0.00000	0. 000000	
76. 98	07698 HYPERBARI C OXYGEN THERAPY	29, 006	4, 711, 546	4, 740, 552		0. 000000	
76. 99	07699 LI THOTRI PSY	0	0	(0.00000	0. 000000	
		0	0	(0. 000000	
78. 00	07800 CAR T-CELL IMMUNOTHERAPY	0	0	(0.000000	0. 000000	78. 00
	OUTPATIENT SERVICE COST CENTERS						
	09000 CLI NI C	5, 477	1, 236, 198			0. 000000	
	09100 EMERGENCY	6, 315, 815	42, 779, 195				
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART	0	4, 746, 924	4, 746, 924	0. 587277	0. 000000	92.00
	OTHER REIMBURSABLE COST CENTERS						
	09500 AMBULANCE SERVI CES	155	24, 116, 910			0. 000000	
102.00	10200 OPIOID TREATMENT PROGRAM	0	0	()		102.00
	SPECIAL PURPOSE COST CENTERS						
	11300 INTEREST EXPENSE						113. 00
200.00		55, 108, 660	228, 787, 385	283, 896, 045	5		200. 00
201.00	l l						201.00
202.00	Total (see instructions)	55, 108, 660	228, 787, 385	283, 896, 045	5		202.00

Health Financial Systems	HUNTINGTON MEMORIAL HOSPITAL	In Lie	u of Form CMS-2552-10
COMPUTATION OF RATIO OF COSTS TO CHARGES	Provi der CCN: 15-0091	Period: From 01/01/2023 To 12/31/2023	Worksheet C Part I Date/Time Prepared: 5/23/2024 4:22 pm
	T		220

INPATIENT ROUTINE SERVICE COST CENTERS 11.00				10 12,01,2020	5/23/2024 4: 22 pm
Ratio			Title XIX	Hospi tal	
INPATIENT ROUTINE SERVICE COST CENTERS 30.00 30.00 03000 ADULTS & PEDIATRICS 30.00 43.00 04300 NURSERY 43.00 ANCILLARY SERVICE COST CENTERS 50.00 50.01 05000 DEPRATI NG ROOM 0.000000 50.01 50.01 05001 DEPRATI NG ROOM 0.000000 50.01 52.00 05200 DELI VERY ROOM & LABOR ROOM 0.303878 52.00 53.00 05300 ANESTHESI OLOGY 0.553583 53.00 54.00 05400 RADI DLOGY-DI AGNOSTI C 0.131753 54.00 54.00 05400 RADI DLOGY-DI AGNOSTI C 0.131753 54.00 56.00 05600 LABORATORY 0.118526 60.00 66.00 06600 LABORATORY 0.21762 65.00 66.00 06600 RESPIRATORY THERAPY 0.221762 65.00 66.00 06600 PHYSI CAL THERAPY 0.224762 65.00 67.00 06700 OCCUPATI ONAL THERAPY 0.244918 67.00 68.00 06600 SPECCH PATHOLOGY 0.38762 69.00 69.00 06900 SEECH PATHOLOGY 0.38762 69.00 69.00 06900 SEECH PATHOLOGY 0.38762 69.00 69.00 06900 DELECTROCARDI OLOGY 0.38762 69.00 67.00 0700 OCCUPATI ONAL THERAPY 0.234587 71.00 67.00 0700 MEDICAL SUPPLIES CHARGED TO PATHENT 0.283687 71.00 67.00 0700 DRUGS CHARGED TO PATHENT 0.283687 71.00 67.00 0700 MEDICAL SUPPLIES CHARGED TO PATHENT 0.283687 71.00 67.00 0700 DRUGS CHARGED TO PATHENT 0.283687 71.00 67.00 0700 0700 DRUGS CHARGED TO PATHENT 0.283687 71.00 67.00 0700 0700 DRUGS CHARGED TO PATHENT 0.283687 71.00 67.00 0700 0700 DRUGS CHARGED TO PATHENT 0.283687 71.00 67.00 0700 0700 0700 0700 0700	Cost Center Description	PPS Inpatient			
INPATIENT ROUTINE SERVICE COST CENTERS 30.00		Ratio			
30.00 03000 ADULTS & PEDIATRICS 30.00 A3.00		11. 00			
43.00 A3200 MUSERY	INPATIENT ROUTINE SERVICE COST CENTERS				
ANCILLARY SERVICE COST CENTERS 50.00 5000 DEPRATI NG ROOM 0.000000 0.000000 0.000000 0.000000 0.000000 0.000000 0.000000 0.000000 0.000000 0.000000 0.000000 0.000000 0.000000 0.000000 0.000000 0.000000 0.000000 0.0000000 0.0000000 0.0000000 0.0000000 0.0000000 0.00000000					30.00
50.00	43. 00 04300 NURSERY				43.00
50. 01 05001 0PERATI NG ROOM 0.000000 0.000000 0.5200 DELI VERY ROOM & LABOR ROOM 0.303878 52.00 05300 ANESTHESI OLOGY 0.553583 53.00 05300 ANESTHESI OLOGY 0.553583 53.00 05400 RADI OLOGY-DI AGNOSTI C 0.131753 54.00 06400 LABORATORY 0.118526 60.00 06000 LABORATORY 0.118526 60.00 06000 LABORATORY 0.118526 60.00 06000 LABORATORY 0.118526 60.00 06500 RESPI RATORY THERAPY 0.528444 66.00 06600 PHYSI CAL THERAPY 0.528444 66.00 06600 PHYSI CAL THERAPY 0.528444 66.00 06600 PHYSI CAL THERAPY 0.528444 67.00 06600 PHYSI CAL THERAPY 0.244918 67.00 06900 06600 PHYSI CAL THERAPY 0.387693 68.00 06600 SPECH PATHOLOGY 0.367903 68.00 06600 SPECH PATHOLOGY 0.367903 68.00 06900 06900 06900 06900 07100 MEDI CAL SUPPLIES CHARGED TO PATIENT 0.283687 71.00 07200 IMPL. DEV. CHARGED TO PATIENTS 0.232550 72.00 07200 IMPL. DEV. CHARGED TO PATIENTS 0.232550 72.00 73.00 07300 DRUGS CHARGED TO PATIENTS 0.232550 72.00 73.00 07507 CARDI AC REHABILITATION 0.000000 76.99 07697 CARDI AC REHABILITATION 0.000000 76.99 07699 LITHOTIRI PSY 0.340428 76.98 07699 LITHOTIRI PSY 0.0000000 76.99 07090 ALLOGENEIC HSCT ACQUISITION 0.000000 77.00 0700 ALLOGENEIC HSCT ACQUISITION 0.000000 0.000000 0.00000 0.000000 0.00000 0.0000000 0.000000 0.000000 0.000000 0.000000 0.000000 0.000000 0.0000000 0.0000000 0.0000000 0.0000000 0.0000000 0.00000000	ANCILLARY SERVICE COST CENTERS				
52.00 05200 DELI VERY ROOM & LABOR ROOM 0.303878 52.00 05300 ANESTHESI OLOGY 0.553583 53.00 53.00 05400 RADI OLOGY-DI AGNOSTI C 0.131753 54.00 60.00 06000 LABORATORY 0.118526 60.00 62.30 62560 BLODD CLOTTI ING FOR HEMOPHI LI ACS 0.000000 62.30 65.00 66500 RESPI RATORY THERAPY 0.221762 65.00 66.00 06600 PHYSI CAL THERAPY 0.528444 66.00 66.00 06600 PHYSI CAL THERAPY 0.528444 66.00 68.00 06800 SPECH PATHOLOGY 0.367903 68.00 06800 SPECH PATHOLOGY 0.367903 68.00 06800 SPECH PATHOLOGY 0.367903 68.00 06900 ELECTROCARDI OLOGY 0.38762 69.00 71.00 07100 MEDI CAL SUPPLIES CHARGED TO PATI ENTS 0.232550 72.00 07200 IMPL DEV. CHARGED TO PATI ENTS 0.232550 72.00 73.00 73.00 73.00 73.00 73.00 73.00 74	50.00 05000 OPERATING ROOM	0. 069729			50.00
53.00 05300 AMESTHESI OLOGY 0.53583 53.00 05400 RADI OLOGY-DI AGNOSTI C	50. 01 05001 OPERATING ROOM	0. 000000			50. 01
54. 00 05400 ADI OLOGY-DI AGNOSTI C 0. 131753 0. 60.00 06000 LABORATORY 0. 118526 0. 000000 06250 BLOOD CLOTTI ING FOR HEMOPHI LI ACS 0. 000000 06250 BLOOD CLOTTI ING FOR HEMOPHI LI ACS 0. 000000 06250 BLOOD CLOTTI ING FOR HEMOPHI LI ACS 0. 000000 06250 BLOOD CLOTTI ING FOR HEMOPHI LI ACS 0. 000000 06250 BSFPI RATORY THERAPY 0. 221762 065.00 06400 PNST CAL THERAPY 0. 528444 066.00 06400 PNST CAL THERAPY 0. 244918 067.00 06700 0CCUPATI ONAL THERAPY 0. 244918 067.00 06900 ELECTROCARDI OLOGY 0. 367903 06800 SPECCH PATHOLOGY 0. 367903 06800 SPECCH PATHOLOGY 0. 38762 069.00 09000 ELECTROCARDI OLOGY 0. 38762 071.00 07100 MEDI CAL SUPPLIES CHARGED TO PATI ENT 0. 283687 071.00 07100 MEDI CAL SUPPLIES CHARGED TO PATI ENT 0. 232550 072.00 07300 DRUGS CHARGED TO PATI ENTS 0. 232550 073.00 07300 DRUGS CHARGED TO PATI ENTS 0. 209102 07598 HYPERBARI C OXYGEN THERAPY 0. 340428 0. 0000000 0. 0000000 0. 0000000 0. 0000000 0. 0000000 0. 0000000 0. 0000000 0. 0	52.00 05200 DELIVERY ROOM & LABOR ROOM	0. 303878			52.00
60. 00 6000 LABORATORY 0. 118526 60. 00 62. 30 06250 BLOOD CLOTTING FOR HEMOPHILIACS 0. 000000 62. 30 06250 BLOOD CLOTTING FOR HEMOPHILIACS 0. 000000 65. 00 06500 RESPIRATORY THERAPY 0. 221762 65. 00 66. 00 06600 PHYSI CAL THERAPY 0. 528444 66. 00 66. 00 06600 PHYSI CAL THERAPY 0. 244918 66. 00 06800 SPEECH PATHOLOGY 0. 367903 68. 00 06900 CLECTROCARDIOLOGY 0. 367903 68. 00 06900 CLECTROCARDIOLOGY 0. 38762 71. 00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT 0. 283687 71. 00 07200 IMPL. DEV. CHARGED TO PATIENTS 0. 232550 72. 00 07200 IMPL. DEV. CHARGED TO PATIENTS 0. 232550 72. 00 07300 DRUGS CHARGED TO PATIENTS 0. 209102 76. 97 07597 CARDIAC REHABILITATION 0. 000000 76. 97 07597 CARDIAC REHABILITATION 0. 000000 77. 00 07699 LITHOTRIPSY 0. 340428 76. 99 07699 HYPERBARI C 0XYGEN THERAPY 0. 340428 76. 99 07699 LITHOTRIPSY 0. 000000 77. 00 07800 CAR T-CELL IMMUNOTHERAPY 0. 000000 77. 00 07800 CAR T-CELL IMMUNOTHERAPY 0. 000000 77. 00 00000 0000 CLIT IN C 0. 000000 0000 0000 0000 0000 0000 0	53. 00 05300 ANESTHESI OLOGY	0. 553583			53.00
62. 30 06250 BLOOD CLOTTING FOR HEMOPHILIACS 0.000000 0.520762 0.520844 0.521844 0.5284444 0.5284444 0.5284444 0.5284444 0.5284444 0.5284444 0.52844444 0.52844444 0.5284444 0.5284444 0.5284444 0.5284444 0.5284444	54. 00 05400 RADI OLOGY-DI AGNOSTI C	0. 131753			54.00
65. 00	60. 00 06000 LABORATORY	0. 118526			60.00
66. 00 06600 PHYSI CAL THERAPY 0. 528444 66. 00 67. 00 06700 0CCUPATI ONAL THERAPY 0. 244918 67. 00 68. 00 06800 SPECCH PATHOLOGY 0. 367903 68. 00 06800 SPECCH PATHOLOGY 0. 038762 69. 00 07100 MEDI CAL SUPPLIES CHARGED TO PATI ENT 0. 283687 71. 00 07100 MEDI CAL SUPPLIES CHARGED TO PATI ENT 0. 232550 72. 00 07200 IMPL DEV. CHARGED TO PATI ENTS 0. 232550 73. 00 07300 DRUGS CHARGED TO PATI ENTS 0. 209102 73. 00 07697 CARDI AC REHABI LI TATI ON 0. 000000 076. 98 07697 CARDI AC REHABI LI TATI ON 0. 000000 076. 99 LI THOTRI PSY 0. 000000 077. 00 07700 ALLOGENEI C HSCT ACQUI SI TI ON 0. 000000 077. 00 07800 CAR T-CELL IMMUNOTHERAPY 0. 000000 077. 00 000000 000000 000000 000000 000000	62.30 06250 BLOOD CLOTTING FOR HEMOPHILIACS	0. 000000			62. 30
67. 00 06700 OCCUPATIONAL THERAPY 0. 244918 67. 00 68. 00 06800 SPEECH PATHOLOGY 0. 367903 68. 00 69. 00 06900 ELECTROCARDI OLOGY 0. 0. 367903 68. 00 71. 00 07100 MEDI CAL SUPPLIES CHARGED TO PATIENT 0. 283687 71. 00 72. 00 07200 IMPL. DEV. CHARGED TO PATIENTS 0. 232550 72. 00 73. 00 07300 DRUGS CHARGED TO PATIENTS 0. 209102 73. 00 76. 97 07697 CARDI AC REHABI LI TATI ON 0. 000000 76. 99 76. 98 07698 HYPERBARI C 0XYGEN THERAPY 0. 340428 76. 98 76. 99 07699 LI THOTRI PSY 0. 000000 76. 99 77. 00 07700 ALLOGENEI C HSCT ACQUI SI TI ON 0. 000000 77. 00 78. 00 07800 CAR T-CELL IMMUNOTHERAPY 0. 0.000000 78. 00 07800 CAR T-CELL IMMUNOTHERAPY 0. 0. 091518 91. 00 90100 EMERGENCY 0. 0. 991518 91. 00 9100 09100 EMERGENCY 0. 0. 991518 91. 00 92. 00 09200 OBSERVATI ON BEDS (NON-DI STI NCT PART 0. 587277 92. 00 07500 AMBULANCE SERVI CES 0. 365419 102. 00 102. 00 10200 OPI OI D TREATMENT PROGRAM SPECIAL PURPOSE COST CENTERS 113. 00 11300 INTEREST EXPENSE 113. 00 200. 00 Subtotal (see instructions) 200. 00 201. 00 Less Observation Beds 201. 00	65. 00 06500 RESPIRATORY THERAPY	0. 221762			65.00
68. 00	66. 00 06600 PHYSI CAL THERAPY	0. 528444			66.00
69. 00	67. 00 06700 OCCUPATI ONAL THERAPY	0. 244918			67.00
71.00 07100 MEDI CAL SUPPLIES CHARGED TO PATI ENT 0. 283687 71.00 72.00 72.00 72.00 73	68. 00 06800 SPEECH PATHOLOGY	0. 367903			68.00
72. 00	69. 00 06900 ELECTROCARDI OLOGY	0. 038762			69.00
73. 00	71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0. 283687			71.00
76. 97 76. 97 76. 98 76. 98 76. 98 76. 99 77. 00 76. 99 77. 00 77. 00 77. 00 78	72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0. 232550			72.00
76. 98 07698 HYPERBARIC OXYGEN THERAPY 0. 340428 76. 99 07699 LITHOTRIPSY 0. 000000 77. 00 07699 LITHOTRIPSY 0. 000000 77. 00 07800 CAR T-CELL IMMUNOTHERAPY 0. 000000 78. 00 07800 CAR T-CELL IMMUNOTHERAPY 0. 000000 00000 0000 CLINIC 90. 00 09000 CLINIC 90. 00 09100 EMERGENCY 0. 09100 EMERGENCY 0. 09110 EMERGENCY 91. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART 0. 587277 92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART 0. 587277 92. 00 09500 AMBULANCE SERVICES 0. 365419 95. 00 10200 OPIOID TREATMENT PROGRAM SPECIAL PURPOSE COST CENTERS 113. 00 11300 INTEREST EXPENSE 113. 00 Subtotal (see instructions) Less Observation Beds 200. 00 201. 00 Less Observation Beds	73.00 07300 DRUGS CHARGED TO PATIENTS	0. 209102			73.00
76. 99 77. 00 77. 00 77. 00 77. 00 78. 00 78. 00 78. 00 07800 CAR T-CELL IMMUNOTHERAPY 0. 000000 0UTPATI ENT SERVI CE COST CENTERS 90. 00 9000 CLI NI C 90. 00 9000 DEBERGENCY 90. 00 90200 DESERVATI ON BEDS (NON-DISTINCT PART O. 587277) 92. 00 07800 OP100 DESERVATI ON BEDS (NON-DISTINCT PART O. 587277) 95. 00 07800 OP100 DI D TREATMENT PROGRAM SPECI AL PURPOSE COST CENTERS 113. 00 11300 INTEREST EXPENSE 200. 00 Subtotal (see instructions) Less Observation Beds 176. 99 76. 99 77. 00 0. 000000 0. 000000 0. 000000 0. 000000 0. 000000 0. 000000 0. 0000000 0. 0000000 0. 0000000 0. 0000000 0. 00000000	76. 97 07697 CARDIAC REHABILITATION	0. 000000			76. 97
77. 00 07700 ALLOGENEI C HSCT ACQUI SITION 0.000000 0.000000 78. 00 07800 CAR T-CELL IMMUNOTHERAPY 0.000000 0.000000 78. 00 0.000000 0.000000 0.000000 0.000000 0.000000 0.000000 0.000000 0.000000 0.000000 0.000000 0.000000 0.000000 0.000000 0.000000 0.000000 0.0000000 0.0000000 0.0000000 0.00000000	76. 98 07698 HYPERBARIC OXYGEN THERAPY	0. 340428			76. 98
78. 00	76. 99 07699 LI THOTRI PSY	0. 000000			76. 99
OUTPATIENT SERVICE COST CENTERS 90.00 09000 CLINIC 90.00 91.00 09100 EMERGENCY 90.00 91.00 09200 OBSERVATION BEDS (NON-DISTINCT PART 0.587277 92.00 OTHER REIMBURSABLE COST CENTERS 95.00 09500 AMBULANCE SERVICES 0.365419 95.00 10200 OPI 0I D TREATMENT PROGRAM 5PECI AL PURPOSE COST CENTERS 113.00 11300 INTEREST EXPENSE 113.00 200.00 Subtotal (see instructions) 200.00 201.00 Less Observation Beds 201.00	77.00 07700 ALLOGENEIC HSCT ACQUISITION	0. 000000			77. 00
90. 00 09000 CLI NI C 0. 292651 90. 00 91. 00 09100 EMERGENCY 0. 091518 91. 00 92. 00 09200 OBSERVATI ON BEDS (NON-DI STI NCT PART 0. 587277 92. 00 0710200 OPI 0I D TREATMENT PROGRAM 0. 365419 95. 00 09200 OPI 0I D TREATMENT PROGRAM 09200 OPI 0I D TREATMENT 09200 OPI	78.00 07800 CAR T-CELL IMMUNOTHERAPY	0. 000000			78.00
91. 00 09100 EMERGENCY 0. 091518 0. 587277 92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART 0. 587277 0. 07 0. 091518	OUTPATIENT SERVICE COST CENTERS				
92. 00 09200 OBSERVATI ON BEDS (NON-DISTINCT PART 0.587277 92. 00 OTHER REIMBURSABLE COST CENTERS 95. 00 O9500 AMBULANCE SERVI CES 0.365419 95. 00 O200 OPI OI D TREATMENT PROGRAM 102. 00 SPECI AL PURPOSE COST CENTERS 113. 00 INTEREST EXPENSE 113. 00 Subtotal (see instructions) Less Observation Beds 201. 00 201. 00 Control of the contro	90. 00 09000 CLINIC	0. 292651			90.00
OTHER REI MBURSABLE COST CENTERS 95.00 09500 AMBULANCE SERVI CES 0.365419 95.00 102.00 10200 OPI OI D TREATMENT PROGRAM 102.00 SPECI AL PURPOSE COST CENTERS 113.00 11300 INTEREST EXPENSE 113.00 200.00 Subtotal (see instructions) 200.00 Less Observation Beds 201.00	91. 00 09100 EMERGENCY	0. 091518			91.00
95. 00 09500 AMBULANCE SERVICES 0. 365419 95. 00 10200 0PI 0I D TREATMENT PROGRAM 102. 00 SPECI AL PURPOSE COST CENTERS 113. 00 11300 INTEREST EXPENSE Subtotal (see instructions) Less Observation Beds 201. 00	92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART	0. 587277			92.00
102. 00 10200 OPI 0I D TREATMENT PROGRAM 102. 00 SPECI AL PURPOSE COST CENTERS 113. 00 11300 INTEREST EXPENSE 200. 00 Subtotal (see instructions) 200. 00 201. 00 Less Observation Beds 201. 00	OTHER REIMBURSABLE COST CENTERS				
SPECIAL PURPOSE COST CENTERS 113.00 11300 INTEREST EXPENSE 200.00 Subtotal (see instructions) 200.00 201.00 Less Observation Beds 201.00	95. 00 09500 AMBULANCE SERVICES	0. 365419			95.00
113. 00 1130	102.00 10200 OPIOLD TREATMENT PROGRAM				102.00
200. 00 Subtotal (see instructions) 200. 00 201. 00 Less Observation Beds 201. 00	SPECIAL PURPOSE COST CENTERS				
201. 00 Less Observation Beds 201. 00	113. 00 11300 I NTEREST EXPENSE				113.00
	200.00 Subtotal (see instructions)				200.00
202.00 Total (see instructions) 202.00	201.00 Less Observation Beds				201.00
	202.00 Total (see instructions)				202.00

Health Financial Systems	HUNTINGTON MEMORIA	AL HOSPITAL	In Lieu	ı of Form CMS-2552-10
CALCULATION OF OUTPATIENT SERVICE COST TO REDUCTIONS FOR MEDICAID ONLY	CHARGE RATIOS NET OF	Provider CCN: 15-0091	From 01/01/2023	Worksheet C Part II Date/Time Prepared:

					To 12/31/2023	Date/Time Pre 5/23/2024 4: 2	
			Ti tl	e XIX	Hospi tal	PPS	.z piii
	Cost Center Description	Total Cost	Capital Cost	Operating	Capi tal	Operating	
	, , , , , , , , , , , , , , , , , , ,	(Wkst. B,	(Wkst. B,	Cost Net of	Reducti on	Cost	
		Part I, col.	Part II col.	Capital Cost		Reduction	
		26)	26)	(col. 1 -		Amount	
		,	,	col . 2)			
		1. 00	2. 00	3.00	4. 00	5. 00	
	LARY SERVICE COST CENTERS						
	OPERATING ROOM	2, 496, 105	483, 976	2, 012, 12	9 0	0	00.00
	1 OPERATING ROOM	0	0		0	0	
	DELIVERY ROOM & LABOR ROOM	1, 642, 823	69, 787			0	
	ANESTHESI OLOGY	2, 281, 923	94, 009			0	
	RADI OLOGY-DI AGNOSTI C	5, 421, 376	980, 843			0	54.00
	LABORATORY	4, 821, 307	237, 626	4, 583, 68	1 0	0	60.00
	BLOOD CLOTTING FOR HEMOPHILIACS	0	0		0	0	62. 30
65.00 06500	RESPI RATORY THERAPY	2, 157, 325	276, 257	1, 881, 06	0	0	65.00
	PHYSI CAL THERAPY	3, 635, 980	752, 552		0 8	0	66. 00
67.00 06700	OCCUPATIONAL THERAPY	512, 093	21, 635	490, 45	0 8	0	67.00
	SPEECH PATHOLOGY	420, 642	17, 744		0	0	68. 00
	ELECTROCARDI OLOGY	164, 667	7, 067			0	
71.00 07100	MEDICAL SUPPLIES CHARGED TO PATIENT	1, 029, 950	60, 281	969, 66	9 0	0	71.00
	IMPL. DEV. CHARGED TO PATIENTS	1, 332, 618	55, 054	1, 277, 56	4 0	0	72.00
73.00 07300	DRUGS CHARGED TO PATIENTS	5, 421, 418	255, 036	5, 166, 38	2 0	0	73.00
	7 CARDIAC REHABILITATION	0	0		0 0	0	76. 97
76. 98 07698	HYPERBARIC OXYGEN THERAPY	1, 613, 816	116, 363	1, 497, 45	3 0	0	76. 98
76. 99 07699	P LI THOTRI PSY	0	0		0	0	76. 99
77.00 07700	ALLOGENEIC HSCT ACQUISITION	0	0		0	0	77. 00
78.00 07800	CAR T-CELL IMMUNOTHERAPY	0	0		0	0	78. 00
	ATIENT SERVICE COST CENTERS						
90.00 09000		363, 378	15, 479	347, 89	9 0	0	90.00
	D EMERGENCY	4, 493, 100	369, 322			0	
	OBSERVATION BEDS (NON-DISTINCT PART	2, 787, 760	328, 699	2, 459, 06	1 0	0	92.00
	R REIMBURSABLE COST CENTERS						
	AMBULANCE SERVICES	8, 812, 829	774, 441	8, 038, 38			95.00
	OPIOID TREATMENT PROGRAM	0	0		0	0	102.00
	AL PURPOSE COST CENTERS				_		
	INTEREST EXPENSE						113. 00
200. 00	Subtotal (sum of lines 50 thru 199)	49, 409, 110	4, 916, 171				200.00
201. 00	Less Observation Beds	2, 787, 760	328, 699				201.00
202. 00	Total (line 200 minus line 201)	46, 621, 350	4, 587, 472	42, 033, 87	8 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
To 12/31/2023 Date/Time Prepared:

				'	0 12/31/2023	5/23/2024 4: 2	
			Ti tl	e XIX	Hospi tal	PPS	
	Cost Center Description	Cost Net of	Total Charges	Outpati ent			
	·	Capital and	(Worksheet C,	Cost to			
		Operating	Part I,	Charge Ratio			
		Cost	column 8)	(col. 6 /			
		Reducti on		col. 7)			
		6. 00	7. 00	8.00			
	ANCILLARY SERVICE COST CENTERS						
	05000 OPERATING ROOM	2, 496, 105	35, 797, 075	0. 069729			50.00
	05001 OPERATING ROOM	0	_	0.000000			50. 01
	05200 DELIVERY ROOM & LABOR ROOM	1, 642, 823	5, 406, 199	0. 303878			52.00
53.00	05300 ANESTHESI OLOGY	2, 281, 923	4, 122, 094	0. 553583			53.00
54.00	05400 RADI OLOGY-DI AGNOSTI C	5, 421, 376	41, 148, 095	0. 131753			54.00
60.00	06000 LABORATORY	4, 821, 307	40, 677, 330	0. 118526	•		60.00
62. 30	06250 BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0.000000			62. 30
65.00	06500 RESPI RATORY THERAPY	2, 157, 325	9, 728, 128	0. 221762			65.00
66.00	06600 PHYSI CAL THERAPY	3, 635, 980	6, 880, 536	0. 528444			66.00
67.00	06700 OCCUPATI ONAL THERAPY	512, 093	2, 090, 876	0. 244918			67.00
68.00	06800 SPEECH PATHOLOGY	420, 642	1, 143, 349	0. 367903			68.00
69.00	06900 ELECTROCARDI OLOGY	164, 667	4, 248, 177	0. 038762			69. 00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	1, 029, 950	3, 630, 581	0. 283687	1		71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	1, 332, 618	5, 730, 461	0. 232550			72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	5, 421, 418	25, 927, 170	0. 209102			73.00
76. 97	07697 CARDI AC REHABI LI TATI ON	0	0	0.000000			76. 97
76. 98	07698 HYPERBARI C OXYGEN THERAPY	1, 613, 816	4, 740, 552	0. 340428			76. 98
76. 99	07699 LI THOTRI PSY	0	0	0.000000			76. 99
77. 00	07700 ALLOGENEIC HSCT ACQUISITION	0	0	0.000000			77. 00
78.00	07800 CAR T-CELL IMMUNOTHERAPY	0	0	0.000000			78. 00
	OUTPATIENT SERVICE COST CENTERS						
	09000 CLI NI C	363, 378	1, 241, 675	0. 292651			90.00
	09100 EMERGENCY	4, 493, 100	49, 095, 010				91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART	2, 787, 760	4, 746, 924	0. 587277			92.00
	OTHER REIMBURSABLE COST CENTERS						
	09500 AMBULANCE SERVICES	8, 812, 829	24, 117, 065	0. 365419			95.00
102.00	10200 OPIOID TREATMENT PROGRAM	0	0	0.000000			102.00
	SPECIAL PURPOSE COST CENTERS	_					
	11300 I NTEREST EXPENSE						113.00
200.00		49, 409, 110					200.00
201.00		2, 787, 760					201.00
202.00	Total (line 200 minus line 201)	46, 621, 350	270, 471, 297				202.00

Health Financial Systems	HUNTINGTON MEMO	RIAL HOSPITAL		In Lieu of Form CMS-2552-10			
APPORTIONMENT OF INPATIENT ROUTINE SERVICE CAPITAL	APPORTIONMENT OF INPATIENT ROUTINE SERVICE CAPITAL COSTS			Period: From 01/01/2023			
				To 12/31/2023	Date/Time Pre 5/23/2024 4:2		
		Title	: XVIII	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, 238, 343	0	1, 238, 34	6, 495	190. 66	30.00	
43. 00 NURSERY	20, 533		20, 53	735	27. 94	43.00	
200.00 Total (lines 30 through 199)	1, 258, 876		1, 258, 87	5 7, 230		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, 128	215, 064				30.00	
43. 00 NURSERY	0	0				43.00	
200.00 Total (lines 30 through 199)	1, 128	215, 064				200.00	

Health Financial Systems	HUNTINGTON MEMO	DRIAL HOSPITAL		In Lie	eu of Form CMS-2	2552-10
APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPIT	AL COSTS	Provi der C		Period: From 01/01/2023 To 12/31/2023	Date/Time Pre 5/23/2024 4:2	
			XVIII	Hospi tal	PPS	
Cost Center Description	Capital Related Cost (from Wkst. B, Part II, col. 26)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 1 ÷ col. 2)	t Inpatient Program Charges	Capital Costs (column 3 x column 4)	
	1. 00	2.00	3.00	4. 00	5. 00	
ANCILLARY SERVICE COST CENTERS	1.00	2.00	3.00	4.00	3.00	
50. 00 05000 OPERATING ROOM	483, 976	35, 797, 075	0. 01352	0 629, 883	8, 516	50.00
50. 01 05001 OPERATING ROOM	403, 770		0.00000	· ·	0,310	1
52. 00 05200 DELIVERY ROOM & LABOR ROOM	69, 787	1			0	52.00
53. 00 05300 ANESTHESI OLOGY	94, 009				Ö	53.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	980, 843		1		26, 462	54.00
60. 00 06000 LABORATORY	237, 626		1			
62. 30 06250 BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0. 00000		0	62.30
65. 00 06500 RESPIRATORY THERAPY	276, 257	9, 728, 128	1		12, 678	65.00
66. 00 06600 PHYSI CAL THERAPY	752, 552	6, 880, 536	0. 10937	4 221, 146	24, 188	66.00
67. 00 06700 OCCUPATI ONAL THERAPY	21, 635			7 99, 283		67.00
68. 00 06800 SPEECH PATHOLOGY	17, 744	1, 143, 349	0. 01551	9 35, 044	544	68.00
69. 00 06900 ELECTROCARDI OLOGY	7, 067	4, 248, 177	0. 00166	4 343, 001	571	69.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	60, 281	3, 630, 581	0. 01660	4 164, 103	2, 725	71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	55, 054	5, 730, 461	0.00960	7 240, 236	2, 308	72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	255, 036	25, 927, 170	0. 00983	7 1, 097, 305	10, 794	73.00
76. 97 07697 CARDIAC REHABILITATION	0	0	0. 00000	o	0	76. 97
76.98 07698 HYPERBARIC OXYGEN THERAPY	116, 363	4, 740, 552	0. 02454	6 12, 828	315	76. 98
76. 99 07699 LI THOTRI PSY	0	0	0.00000	0 0	0	76. 99
77.00 07700 ALLOGENEIC HSCT ACQUISITION	0	0	0.00000	0 0	0	77.00
78.00 07800 CAR T-CELL IMMUNOTHERAPY	0	0	0.00000	0 0	0	78. 00
OUTPATIENT SERVICE COST CENTERS						
	15 /170	1 2/1 675	0 01246	6 0		l an nn

15, 479 369, 322

328, 699

4, 141, 730

1, 241, 675 49, 095, 010 4, 746, 924

246, 354, 232

0. 012466

0. 007523 0. 069245

1, 797, 123

7, 778, 759

13, 520

90.00 0

91.00

92.00 0

95.00 112, 892 200. 00

90. 00 09000 CLI NI C 91. 00 09100 EMERGENCY

95. 00 O9500 AMBULANCE SERVICES
200. 00 Total (Lines 50

92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART

Total (lines 50 through 199)

Health Financial Systems	HUNTINGTON MEMO	RIAL HOSPITAL		In Lie	u of Form CMS-:	2552-10
APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER P	ASS THROUGH COS	TS Provider C		Period: From 01/01/2023 Fo 12/31/2023		pared: 2 pm
		Title	XVIII	Hospi tal	PPS	
Cost Center Description	Nursi ng	Nursi ng		Allied Health	All Other	
	Program	Program	Post-Stepdowr	Cost	Medi cal	
	Post-Stepdown		Adjustments		Educati on	
	Adjustments				Cost	
	1A	1. 00	2A	2. 00	3. 00	
INPATIENT ROUTINE SERVICE COST CENTERS						
30. 00 03000 ADULTS & PEDIATRICS	0	0)	0	0	30.00
43. 00 04300 NURSERY	0	0)	0	0	43.00
200.00 Total (lines 30 through 199)	0	0	(0	0	200.00
Cost Center Description	Swi ng-Bed	Total Costs	Total Patient	Per Diem	I npati ent	
	Adjustment	(sum of cols.	Days	(col. 5 ÷	Program Days	
	Amount (see	1 through 3,		col. 6)		
		minus col. 4)				
	4. 00	5. 00	6. 00	7. 00	8. 00	
INPATIENT ROUTINE SERVICE COST CENTERS						
30. 00 03000 ADULTS & PEDI ATRI CS	0	0	6, 49		1, 128	
43. 00 04300 NURSERY		0	73			
200.00 Total (lines 30 through 199)		0	7, 23	O	1, 128	200. 00
Cost Center Description	I npati ent					
	Program					
	Pass-Through					
	Cost (col. 7					
	x col. 8)					
	9. 00					
INPATIENT ROUTINE SERVICE COST CENTERS		r				
30. 00 03000 ADULTS & PEDIATRICS	0					30.00
43. 00 04300 NURSERY	0					43.00
200.00 Total (lines 30 through 199)	0					200. 00

Health Financial Systems	HUNTI NGTON MEMORIA	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
THROUGH COSTS			From 01/01/2023	Part IV

THROUGH COSTS 12/31/2023 Date/Time Prepared: 5/23/2024 4: 22 pm Title XVIII Hospi tal Cost Center Description Non Physician Nursi ng Nursi ng Allied Health Allied Health Anesthetist Program Post-Stepdown Program Post-Stepdown Cost Adjustments Adjustments 1. 00 2.00 ЗА 3.00 ANCILLARY SERVICE COST CENTERS 50 00 05000 OPERATING ROOM 0 50.00 0 0 05001 OPERATING ROOM 50.01 50.01 0 0 52.00 05200 DELIVERY ROOM & LABOR ROOM 0 52.00 05300 ANESTHESI OLOGY 0 0 53.00 0 53.00 05400 RADI OLOGY-DI AGNOSTI C 0 0 54.00 54.00 0 60.00 06000 LABORATORY 0 0 60.00 62.30 06250 BLOOD CLOTTING FOR HEMOPHILIACS 0 0 0 62.30 0 06500 RESPIRATORY THERAPY 0 65.00 65.00 0 66.00 06600 PHYSI CAL THERAPY 0 Ω 66.00 0 67.00 06700 OCCUPATI ONAL THERAPY 0 0 67.00 68.00 06800 SPEECH PATHOLOGY 68.00 69.00 06900 ELECTROCARDI OLOGY 0 0 0 69.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT 0 71.00 71.00 0 72.00 07200 IMPL. DEV. CHARGED TO PATIENTS 0 72.00 07300 DRUGS CHARGED TO PATIENTS 0 0 0 73.00 73.00 76. 97 07697 CARDIAC REHABILITATION 0 0 0 76.97 76. 98 07698 HYPERBARIC OXYGEN THERAPY 0 0 76.98 76. 99 07699 LI THOTRI PSY 0 0 0 76. 99 0 77.00 77.00 07700 ALLOGENEIC HSCT ACQUISITION 0 0 07800 CAR T-CELL IMMUNOTHERAPY OUTPATIENT SERVICE COST CENTERS 0 0 0 78.00 0 78.00 90.00 09000 CLI NI C 0 0 90.00 0 0 0 0 ol 91.00 91.00 09100 EMERGENCY 0 0 09200 OBSERVATION BEDS (NON-DISTINCT PART 0 0 92.00 92.00 0 OTHER REIMBURSABLE COST CENTERS 95. 00 09500 AMBULANCE SERVICES 95.00 0 0 0 0 200.00 Total (lines 50 through 199) 0 200.00

Health Financial Systems	HUNTINGTON MEMORIA	In Lieu of Form CMS-2552-10		
APPORTIONMENT OF INPATIENT/OUTPATIENT THROUGH COSTS	ANCI LLARY SERVI CE OTHER PASS	Provider CCN: 15-0091	From 01/01/2023	Worksheet D Part IV Date/Time Prepared: 5/23/2024 4: 22 pm

111100511 00010			Т	o 12/31/2023	Date/Time Pre 5/23/2024 4:2	
		Title	XVIII	Hospi tal	PPS	
Cost Center Description	All Other	Total Cost	Total	Total Charges	Ratio of Cost	
	Medi cal	(sum of cols.	Outpati ent	(from Wkst.	to Charges	
	Educati on	1, 2, 3, and	Cost (sum of	C, Part I,	(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	1	1	35, 797, 075	0. 000000	
50. 01 05001 OPERATING ROOM	0	0	0	0	0. 000000	1
52.00 05200 DELIVERY ROOM & LABOR ROOM	0	0	0	5, 406, 199	0. 000000	
53. 00 05300 ANESTHESI OLOGY	0	0	0	4, 122, 094	0. 000000	
54. 00 05400 RADI OLOGY-DI AGNOSTI C	0	0	0	11,110,070	0. 000000	
60. 00 06000 LABORATORY	0	0	0	40, 677, 330		
62.30 06250 BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0	0	0. 000000	
65. 00 06500 RESPI RATORY THERAPY	0	0	0	9, 728, 128	0. 000000	
66. 00 06600 PHYSI CAL THERAPY	0	0	l ~	6, 880, 536	0. 000000	
67.00 06700 OCCUPATIONAL THERAPY	0	0	0	2, 090, 876	0. 000000	
68.00 06800 SPEECH PATHOLOGY	0	0	0	1, 143, 349		
69. 00 06900 ELECTROCARDI OLOGY	0	0	0	4, 248, 177	0. 000000	
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	3, 630, 581	0. 000000	
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0	0	0	5, 730, 461	0. 000000	
73.00 07300 DRUGS CHARGED TO PATIENTS	0	0	0	25, 927, 170		
76. 97 O7697 CARDIAC REHABILITATION	0	0	0	0	0. 000000	1
76. 98 07698 HYPERBARIC OXYGEN THERAPY	0	0	0	4, 740, 552	0. 000000	1
76. 99 07699 LI THOTRI PSY	0	0	0	0	0. 000000	1
77.00 07700 ALLOGENEIC HSCT ACQUISITION	0	0		0	0. 000000	1
78.00 07800 CAR T-CELL IMMUNOTHERAPY	0	0	0	0	0.000000	78. 00
OUTPATIENT SERVICE COST CENTERS						
90. 00 09000 CLI NI C	0			, , , , , ,	0. 000000	1
91. 00 09100 EMERGENCY	0			,,		1
92.00 O9200 OBSERVATION BEDS (NON-DISTINCT PART	0	0	0	4, 746, 924	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	246, 354, 232		200. 00

Health Financial Systems		HUNTI NGTON MEMOI	RIAL HOSPITAL		In Lieu of Form CMS-2552-10		
APPORTIONMENT OF INPATIENT/OUTPAT THROUGH COSTS	ENT ANCILLARY SE	RVICE OTHER PAS	S Provider C		Period: From 01/01/2023 To 12/31/2023	Worksheet D Part IV Date/Time Pre 5/23/2024 4:2	pared: 2 pm
			Title	: XVIII	Hospi tal	PPS	
Cost Center Descripti	on	Outpatient Ratio of Cost	Inpatient Program	Inpatient Program	Outpatient Program	Outpatient Program	
		to Charges (col. 6 ÷ col. 7)	Charges	Pass-Through Costs (col. 8 x col. 10)		Pass-Through Costs (col. 9 x col. 12)	
		9. 00	10. 00	11. 00	12.00	13.00	

			11116	AVIII	nospi tai	FF3	
	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 OPERATI NG ROOM	0. 000000	629, 883	0	3, 182, 519	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	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, 110, 115	0	5, 207, 859	0	54.00
60.00	06000 LABORATORY	0. 000000	1, 582, 256	0	2, 164, 299	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	446, 436	0	1, 822, 957	0	65.00
66.00	06600 PHYSI CAL THERAPY	0. 000000	221, 146	0	41, 042	0	66.00
67.00	06700 OCCUPATI ONAL THERAPY	0. 000000	99, 283	0	5, 225	0	67.00
68.00	06800 SPEECH PATHOLOGY	0. 000000	35, 044	0	3, 988	0	68.00
69.00	06900 ELECTROCARDI OLOGY	0. 000000	343, 001	0	702, 633	0	69.00
71. 00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0. 000000	164, 103	0	332, 288	0	71.00
72.00	07200 I MPL. DEV. CHARGED TO PATIENTS	0. 000000	240, 236	0	912, 824	0	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0. 000000	1, 097, 305	0	4, 552, 259	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	12, 828	0	389, 720	0	76. 98
76. 99	07699 LI THOTRI PSY	0. 000000	0	0	0	0	76. 99
77. 00	07700 ALLOGENEIC HSCT ACQUISITION	0. 000000	0	0	0	0	77.00
78. 00	07800 CAR T-CELL IMMUNOTHERAPY	0. 000000	0	0	0	0	78. 00
	OUTPATIENT SERVICE COST CENTERS	<u>'</u>					
90.00	09000 CLI NI C	0. 000000	0	0	0	0	90.00
91.00	09100 EMERGENCY	0. 000000	1, 797, 123	0	5, 355, 754	0	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART	0. 000000	0	o	594, 468	0	92.00
	OTHER REIMBURSABLE COST CENTERS	,,					
95.00	09500 AMBULANCE SERVI CES						95.00
200.00	Total (lines 50 through 199)		7, 778, 759	0	25, 267, 835	0	200.00

Health Financial Systems	HUNTI NGTON MEMORIA	AL HOSPITAL	In Lieu	ı of Form CMS-2552-10
APPORTIONMENT OF MEDICAL,	OTHER HEALTH SERVICES AND VACCINE COST	Provi der CCN: 15-0091	Peri od: From 01/01/2023	Worksheet D Part V

12/31/2023 Date/Time Prepared: 5/23/2024 4: 22 pm Title XVIII Hospi tal PPS Charges Costs 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 50.00 0.069729 3, 182, 519 221, 914 05001 OPERATING ROOM 0 0 0 50.01 50.01 0.000000 0 05200 DELIVERY ROOM & LABOR ROOM 52.00 0.303878 C 0 52.00 53.00 05300 ANESTHESI OLOGY 0.553583 0 0 0 53.00 54.00 05400 RADI OLOGY-DI AGNOSTI C 0.131753 5, 207, 859 0 0 0 686, 151 54.00 0 60. nn 06000 LABORATORY 0.118526 2, 164, 299 256, 526 60.00 06250 BLOOD CLOTTING FOR HEMOPHILIACS 62.30 0.000000 0 62.30 65.00 06500 RESPIRATORY THERAPY 0. 221762 1, 822, 957 0 0 0 404, 263 65.00 0 06600 PHYSI CAL THERAPY 0. 528444 41, 042 21,688 66.00 66.00 06700 OCCUPATI ONAL THERAPY 0 0.244918 1, 280 67.00 5, 225 67.00 68.00 06800 SPEECH PATHOLOGY 0.367903 3, 988 1, 467 68.00 06900 ELECTROCARDI OLOGY 702, 633 0 27, 235 69.00 0.038762 0 0 69.00 0 07100 MEDICAL SUPPLIES CHARGED TO PATIENT 94, 266 71 00 0 283687 332 288 71 00 0 72.00 07200 IMPL. DEV. CHARGED TO PATIENTS 0.232550 912, 824 212, 277 72.00 73.00 07300 DRUGS CHARGED TO PATIENTS 0. 209102 4, 552, 259 0 0 951, 886 73.00 07697 CARDIAC REHABILITATION 0 0 76.97 0.000000 76.97 0 07698 HYPERBARI C OXYGEN THERAPY 389, 720 0 0 76. 98 76 98 0.340428 132, 672 07699 LI THOTRI PSY 0 0 76.99 0.000000 C 0 76.99 77.00 07700 ALLOGENEIC HSCT ACQUISITION 0.000000 0 0 0 77.00 07800 CAR T-CELL IMMUNOTHERAPY 78.00 0.000000 0 0 ol 0 78.00 OUTPATIENT SERVICE COST CENTERS 90.00 09000 CLI NI C 0. 292651 0 0 n 90.00 09100 EMERGENCY 0.091518 5, 355, 754 0 0 490, 148 91.00 91.00 09200 OBSERVATION BEDS (NON-DISTINCT PART 0. 587277 594, 468 0 349, 117 92.00 92.00 0 OTHER REIMBURSABLE COST CENTERS 95.00 09500 AMBULANCE SERVICES 0. 365419 0 95.00 200.00 Subtotal (see instructions) 25, 267, 835 0 0 3, 850, 890 200. 00 0 Less PBP Clinic Lab. Services-Program 201.00 0 201. 00 Only Charges 0 0 3, 850, 890 202. 00 202.00 Net Charges (line 200 - line 201) 25, 267, 835

Health Financial Systems	HUNTINGTON MEMORIA	L HOSPITAL	In Lieu	of Form CMS-2552-10
APPORTIONMENT OF MEDICAL, O	OTHER HEALTH SERVICES AND VACCINE COST		From 01/01/2023 To 12/31/2023	Worksheet D Part V Date/Time Prepared: 5/23/2024 4:22 pm

				To 12/31/2023	Date/Time Prepared: 5/23/2024 4: 22 pm	1:
		Title	e XVIII	Hospi tal	PPS	_
	Cos	sts		<u> </u>		
Cost Center Description	Cost	Cost				
	Rei mbursed	Rei mbursed				
	Servi ces	Services Not				
	Subject To	Subject To				
	Ded. & Coins.	Ded. & Coins.				
	(see inst.)	(see inst.)				
	6. 00	7. 00				
ANCILLARY SERVICE COST CENTERS						
50.00 05000 OPERATING ROOM	0	(50.0	00
50. 01 05001 OPERATING ROOM	0	(50.0)1
52.00 05200 DELIVERY ROOM & LABOR ROOM	0	(52.0	00
53. 00 05300 ANESTHESI OLOGY	0	(53.0	00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	0	(54.0	00
60. 00 06000 LABORATORY	0	(60.0	00
62.30 06250 BLOOD CLOTTING FOR HEMOPHILIACS	0	(62. 3	30
65. 00 06500 RESPIRATORY THERAPY	0	(65.0	00
66. 00 06600 PHYSI CAL THERAPY	0	(66.0	00
67. 00 06700 OCCUPATI ONAL THERAPY	0	(67.0	00
68. 00 06800 SPEECH PATHOLOGY	0	(68. 0	00
69. 00 06900 ELECTROCARDI OLOGY	0				69. 0	00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0				71.0	00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0	(72.0	00
73.00 07300 DRUGS CHARGED TO PATIENTS	0				73.0	00
76. 97 07697 CARDIAC REHABILITATION	0				76. 9	9 7
76. 98 07698 HYPERBARIC OXYGEN THERAPY	0				76. 9	98
76. 99 07699 LI THOTRI PSY	0				76. 9	99
77.00 07700 ALLOGENEIC HSCT ACQUISITION	0				77.0	00
78.00 07800 CAR T-CELL IMMUNOTHERAPY	0				78.0	00
OUTPATIENT SERVICE COST CENTERS						
90. 00 09000 CLI NI C	0	(90.0	00
91. 00 09100 EMERGENCY	0				91.0	00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART	0				92.0	00
OTHER REIMBURSABLE COST CENTERS			•			
95. 00 09500 AMBULANCE SERVICES	0				95. 0	00
200.00 Subtotal (see instructions)	0				200. 0	00
201.00 Less PBP Clinic Lab. Services-Program	0				201. 0	00
Only Charges						
202.00 Net Charges (line 200 - line 201)	0	(202. 0	00
					•	

Health Financial Systems	HUNTINGTON MEMO	RIAL HOSPITAL		In Lie	u of Form CMS-2	2552-10
APPORTIONMENT OF INPATIENT ROUTINE SERVICE CAPITAL	COSTS	Provi der C		Period: From 01/01/2023	Worksheet D Part I	
				To 12/31/2023		
		Ti tl	e XIX	Hospi tal	PPS	_ p
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, 238, 343		1, 238, 34			
43. 00 NURSERY	20, 533		20, 53		27. 94	
200.00 Total (lines 30 through 199)	1, 258, 876		1, 258, 87	5 7, 230		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	78	14, 871	•			30.00
43. 00 NURSERY	32	894				43.00
200.00 Total (lines 30 through 199)	110	15, 765				200.00

Health Financial Systems	HUNTINGTON MEMO	ORIAL HOSPITAL		In Lie	eu of Form CMS-2	2552-10
APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPIT	AL COSTS	Provi der C		Period: From 01/01/2023 To 12/31/2023	Date/Time Pre 5/23/2024 4:2	
			e XIX	Hospi tal	PPS	
Cost Center Description	Capital Related Cost (from Wkst. B, Part II,	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 1 ÷ col. 2)	Inpatient Program Charges	Capital Costs (column 3 x column 4)	
	col. 26)	COI. 0)	(01. 2)			
	1. 00	2.00	3.00	4. 00	5. 00	
ANCILLARY SERVICE COST CENTERS	1.00	2.00	3.00	4.00	3.00	
50. 00 05000 OPERATING ROOM	483, 976	35, 797, 075	0. 01352	0 276, 694	3, 741	50.00
50. 01 05001 0PERATING ROOM	0		0.00000		•	50.01
52.00 05200 DELIVERY ROOM & LABOR ROOM	69, 787	5, 406, 199			1, 016	
53. 00 05300 ANESTHESI OLOGY	94, 009				0	53.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	980, 843		1		1, 105	54.00
60. 00 06000 LABORATORY	237, 626	40, 677, 330	0. 00584	2 149, 012	871	60.00
62.30 06250 BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0. 00000	0	0	62. 30
65. 00 06500 RESPIRATORY THERAPY	276, 257	9, 728, 128	0. 02839	8 26, 016	739	65.00
66.00 06600 PHYSI CAL THERAPY	752, 552	6, 880, 536	0. 10937	4 2, 704	296	66.00
67. 00 06700 OCCUPATI ONAL THERAPY	21, 635	2, 090, 876	0. 01034	7 551	6	67.00
68.00 O6800 SPEECH PATHOLOGY	17, 744	1, 143, 349	0. 01551	9 2, 580	40	68. 00
69. 00 06900 ELECTROCARDI OLOGY	7, 067	4, 248, 177	0. 00166	4 3, 382	6	69.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	60, 281	3, 630, 581	0. 01660	4 12, 197	203	71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	55, 054	5, 730, 461	0.00960	7 0	0	72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	255, 036	25, 927, 170	0. 00983	7 100, 662	990	73.00
76. 97 07697 CARDI AC REHABI LI TATI ON	0	0	0.00000	0	0	76. 97
76. 98 07698 HYPERBARIC OXYGEN THERAPY	116, 363	4, 740, 552	0. 02454	6 2, 542	62	76. 98
76. 99 07699 LI THOTRI PSY	0	0	0.00000		0	76. 99
77.00 07700 ALLOGENEIC HSCT ACQUISITION	0	0	0.00000	0	0	77. 00
78.00 O7800 CAR T-CELL IMMUNOTHERAPY	0	0	0.00000	0 0	0	78. 00
OUTPAȚI ENT SERVI CE COST CENTERS						
	15 //70	1 2/1 675	0 01246	6 0	Λ .	

15, 479 369, 322

328, 699

4, 141, 730

1, 241, 675 49, 095, 010 4, 746, 924

246, 354, 232

0. 012466

0. 007523 0. 069245

0

90, 186

791, 600

90.00

91.00

92.00 0

95.00 9, 753 200.00

0

678

90. 00 09000 CLI NI C 91. 00 09100 EMERGENCY

95. 00 O9500 AMBULANCE SERVICES
200. 00 Total (Lines 50

92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART

Total (lines 50 through 199)

Health Financial Systems	HUNTI NGTON MEMO	RIAL HOSPITAL		In Lie	u of Form CMS-2	2552-10
APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER P	ASS THROUGH COS		!	Period: From 01/01/2023 To 12/31/2023		pared: 2 pm
		Ti tl	e XIX	Hospi tal	PPS	
Cost Center Description	Nursi ng	Nursi ng		Allied Health	All Other	
	Program	Program	Post-Stepdown	Cost	Medi cal	
	Post-Stepdown		Adjustments		Educati on	
	Adjustments				Cost	
	1A	1. 00	2A	2. 00	3. 00	
INPATIENT ROUTINE SERVICE COST CENTERS						
30. 00 03000 ADULTS & PEDIATRICS	0	0		0	0	30.00
43. 00 04300 NURSERY	0	0		0	0	43.00
200.00 Total (lines 30 through 199)	0	0	(0	0	200.00
Cost Center Description	Swi ng-Bed	Total Costs	Total Patient	Per Diem	I npati ent	
	Adjustment	(sum of cols.	Days	(col. 5 ÷	Program Days	
	Amount (see	1 through 3,		col . 6)		
		minus col. 4)				
	4. 00	5. 00	6. 00	7. 00	8. 00	
INPATIENT ROUTINE SERVICE COST CENTERS						
30. 00 03000 ADULTS & PEDIATRICS	0	0	6, 49			
43. 00 04300 NURSERY		0	73!			
200.00 Total (lines 30 through 199)		0	7, 230	O	110	200. 00
Cost Center Description	I npati ent					
	Program					
	Pass-Through					
	Cost (col. 7					
	x col. 8)					
	9. 00					
INPATIENT ROUTINE SERVICE COST CENTERS	_					
30. 00 03000 ADULTS & PEDIATRICS	0					30.00
43. 00 04300 NURSERY	0					43.00
200.00 Total (lines 30 through 199)	0					200. 00

Health Financial Systems	HUNTINGTON MEMORIA	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
THROUGH COSTS			From 01/01/2023	Part IV

THROUGH COSTS 12/31/2023 Date/Time Prepared: 5/23/2024 4: 22 pm Title XIX Hospi tal Cost Center Description Non Physician Nursi ng Nursi ng Allied Health Allied Health Anesthetist Program Post-Stepdown Program Post-Stepdown Cost Adjustments Adjustments 1. 00 2.00 ЗА 3.00 ANCILLARY SERVICE COST CENTERS 50 00 05000 OPERATING ROOM 0 50.00 0 0 05001 OPERATING ROOM 50.01 50.01 0 0 52.00 05200 DELIVERY ROOM & LABOR ROOM 0 52.00 05300 ANESTHESI OLOGY 0 0 53.00 0 53.00 05400 RADI OLOGY-DI AGNOSTI C 0 0 54.00 54.00 0 60.00 06000 LABORATORY 0 0 60.00 62.30 06250 BLOOD CLOTTING FOR HEMOPHILIACS 0 0 0 62.30 0 06500 RESPIRATORY THERAPY 0 65.00 65.00 0 06600 PHYSI CAL THERAPY 66.00 0 Ω 66.00 0 67.00 06700 OCCUPATI ONAL THERAPY 0 0 67.00 68.00 06800 SPEECH PATHOLOGY 68.00 69.00 06900 ELECTROCARDI OLOGY 0 0 0 69.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT 0 71.00 71.00 0 72.00 07200 IMPL. DEV. CHARGED TO PATIENTS 0 72.00 07300 DRUGS CHARGED TO PATIENTS 0 0 0 73.00 73.00 76. 97 07697 CARDIAC REHABILITATION 0 0 0 76.97 76. 98 07698 HYPERBARIC OXYGEN THERAPY 0 0 76.98 76. 99 07699 LI THOTRI PSY 0 0 0 76. 99 0 77.00 77.00 07700 ALLOGENEIC HSCT ACQUISITION 0 0 07800 CAR T-CELL IMMUNOTHERAPY OUTPATIENT SERVICE COST CENTERS 0 0 0 78.00 0 78.00 90.00 09000 CLI NI C 0 0 90.00 0 0 0 0 ol 91.00 91.00 09100 EMERGENCY 0 0 09200 OBSERVATION BEDS (NON-DISTINCT PART 0 0 92.00 92.00 0 OTHER REIMBURSABLE COST CENTERS 95. 00 09500 AMBULANCE SERVICES 95.00 0 0 0 0 200.00 Total (lines 50 through 199) 0 200.00

Health Financial Systems	HUNTINGTON MEMORIA	AL HOSPITAL	In Lieu	of Form CMS-2552-10
APPORTIONMENT OF INPATIENT/OUTPATIENT THROUGH COSTS	ANCILLARY SERVICE OTHER PASS	Provi der CCN: 15-0091	Peri od: From 01/01/2023 To 12/31/2023	Worksheet D Part IV Date/Time Prepared:

			1	o 12/31/2023	Date/Time Pre 5/23/2024 4:2	
		Ti tl	e XIX	Hospi tal	PPS	
Cost Center Description	All Other	Total Cost	Total	Total Charges	Ratio of Cost	
	Medi cal	(sum of cols.	Outpati ent	(from Wkst.	to Charges	
	Educati on	1, 2, 3, and	Cost (sum of	C, Part I,	(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		_	1			
50. 00 05000 0PERATING ROOM	0	1	1	35, 797, 075	0. 000000	
50. 01 05001 OPERATI NG ROOM	0	0		0	0. 000000	
52.00 05200 DELIVERY ROOM & LABOR ROOM	0	0		5, 406, 199	0. 000000	
53. 00 05300 ANESTHESI OLOGY	0	0		4, 122, 094	0. 000000	
54. 00 05400 RADI OLOGY-DI AGNOSTI C	0	0	(41, 148, 095	0. 000000	
60. 00 06000 LABORATORY	0	0	(40, 677, 330		
62. 30 06250 BLOOD CLOTTING FOR HEMOPHILIACS	0	0	(0	0. 000000	
65. 00 06500 RESPI RATORY THERAPY	0	0	(9, 728, 128	0. 000000	
66. 00 06600 PHYSI CAL THERAPY	0	0	(6, 880, 536	0. 000000	
67. 00 06700 OCCUPATI ONAL THERAPY	0	0	(2, 090, 876	0. 000000	
68. 00 06800 SPEECH PATHOLOGY	0	0	(1, 143, 349		
69. 00 06900 ELECTROCARDI OLOGY	0	0	(4, 248, 177	0. 000000	
71. 00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	(3, 630, 581	0. 000000	
72. 00 07200 IMPL. DEV. CHARGED TO PATIENTS	0	0	(5, 730, 461	0. 000000	
73. 00 07300 DRUGS CHARGED TO PATIENTS	0	0	(25, 927, 170		
76. 97 O7697 CARDI AC REHABI LI TATI ON	0	0	(0	0. 000000	
76. 98 07698 HYPERBARI C OXYGEN THERAPY	0	0	(4, 740, 552	0. 000000	
76. 99 07699 LI THOTRI PSY	0	0	(0	0. 000000	
77. 00 07700 ALLOGENEIC HSCT ACQUISITION	0	0	1	0	0. 000000	77. 00
78. 00 O7800 CAR T-CELL IMMUNOTHERAPY	0	0	() 0	0. 000000	78. 00
OUTPATIENT SERVICE COST CENTERS				1 044 (75	0.000000	00.00
90. 00 09000 CLI NI C	0	1		, , , , , ,	0. 000000	1
91. 00 09100 EMERGENCY	0					91.00
92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART	0	0	(4, 746, 924	0. 000000	92.00
OTHER REIMBURSABLE COST CENTERS 95. 00 O9500 AMBULANCE SERVICES						05 00
]	244 254 222		95.00
200.00 Total (lines 50 through 199)	0	0	(246, 354, 232		200. 00

Health Financial Systems	HUNTI NGTON MEMORI A	In Lieu	u of Form CMS-2552-10	
APPORTIONMENT OF INPATIENT/OUTPATIENT THROUGH COSTS	ANCILLARY SERVICE OTHER PASS	Provider CCN: 15-0091	From 01/01/2023	Worksheet D Part IV Date/Time Prepared: 5/23/2024 4:22 pm
		Ti tla YIY	Hospi tal	DDS

Title XIX Hospital PPS Cost Center Description Outpatient Ratio of Cost to Charges (col. 6 + col. 7) Inpatient Program Charges (col. 8 + col. 7) Program Charges (col. 8 + col. 7) Program Charges (col. 8 + col. 7) Program Charges (col. 8 + col. 7) Program Charges (col. 8 + col. 7) Program Charges (col. 8 + col. 7) Program Charges (col. 9 + col. 7) Program Charges (col. 9 + col. 7) Program Charges (col. 9 + col. 7) Program Charges (col. 9 + col. 7) Program Charges (col. 9 + col. 7) Program Charges (col. 9 + col. 10) Program Charges (col. 10) Program Charges (col. 9 + col. 10) Program Charges (col. 10) Program Charges (col. 9 + col. 10) Program Charges (col. 10) Program Cha				To	12/31/2023	Date/Time Pre 5/23/2024 4: 2	
Ratio of Cost to Charges (col . 6 + col . 7) Charges (col . 6 + col . 7) Charges (col . 6 + col . 7) Charges (col . 6 + col . 7) Charges (col . 8) X col . 10) Pass-Through (costs (col . 8) X col . 10) The Charges (col . 9) The			Ti tl	e XIX	Hospi tal		
To Charges Col. 6	Cost Center Description		Inpatient	I npati ent	Outpati ent	Outpati ent	
Col. 6 Col. 7 Costs (col. 8 Costs (col. 8 Costs (col. 9 X col. 12)		Ratio of Cost	Program	Program		Program	
Col. 7) x col. 10) x col. 12			Charges		Charges		
ANCILLARY SERVICE COST CENTERS							
ANCILLARY SERVICE COST CENTERS							
50. 00 05000 DFERATI NG ROOM 0.000000 276, 694 0 0 0 0 50. 00		9. 00	10. 00	11. 00	12. 00	13. 00	
50. 01 05001 0PERATING ROOM 0.000000 0.000000 78,734 0.000000 0.000000 0.000000 0.000000 0.000000 0.000000 0.0000000 0.0000000 0.00000000							
52. 00 05200 DELI VERY ROOM & LABOR ROOM 0.000000 78,734 0 0 0 52. 00 53. 00 05300 AMESTHESI DLOCY 0.000000 0 0 0 0 53. 00 05400 RADI OLOGY-DI AGNOSTI C 0.000000 46, 340 0 0 0 0 0 54. 00 60. 00 6			276, 694	0	0	01	
53. 00 05300 ANESTHESI OLOGY 0.000000 0 0 0 53. 00 54. 00 05400 RADI OLOGY-DI AGNOSTI C 0.000000 46, 340 0 0 0 54. 00 60. 00 06000 LABORATORY 0.000000 149, 012 0 0 0 0.00 0 <td></td> <td></td> <td>· ·</td> <td>1 4</td> <td>0</td> <td>01</td> <td></td>			· ·	1 4	0	01	
54. 00 05400 RADI OLOGY-DI AGNOSTI C 0.000000 46, 340 0 0 0 54. 00 60. 00 06000 LABORATORY 0.000000 149, 012 0 0 0 60. 00 62. 30 06250 BLOOD CLOTTI NG FOR HEMOPHI LI ACS 0.000000 0 0 0 0 0 0 62. 30 65. 00 06500 RESPI RATORY THERAPY 0.000000 26, 016 0 0 0 65. 00 66. 00 06600 PHYSI CAL THERAPY 0.000000 27, 704 0 0 0 0 66. 00 67. 00 06700 OCCUPATI ONAL THERAPY 0.000000 551 0 0 0 66. 00 68. 00 06800 SPEECH PATHOLOGY 0.000000 551 0 0 0 67. 00 69. 00 06900 ELECTROCARDI OLOGY 0.000000 3, 382 0 0 0 69. 00 71. 00 07100 MEDI CAL SUPPLIES CHARGED TO PATI ENT 0.000000 12, 197 0 0 0 71. 00 72. 00 07200 IMPL. DEV. CHARGED TO PATI ENTS 0.000000 10, 662 0 0 0 73. 00 73. 00 07300 DRUGS CHARGED TO PATI ENTS 0.000000 100, 662 0 0 0 73. 00 76. 97 07697 CARDI AC REHABI LI TATI ON 0.000000 100, 662 0 0 0 75. 97 76. 98 07699 I HTHOTRI PSY 0.000000 0 0 0 0 0 76. 97 77. 00 07700 ALLOGENEI C HSCT ACQUI SI TI ON 0.000000 0 0 0 0 0 0 77. 00 78. 00 07800 CAR T-CELL I IMMUNOTHERAPY 0.000000 0 0 0 0 0 0 0 0 0 91. 00 09000 EMERGENCY 0.000000 0 0 0 0 0 0 0 0 0 0 91. 00 09000 EMERGENCY 0.000000 0 0 0 0 0 0 0 0 0 0 91. 00 09000 BERVEATION BEDS (NON-DISTINCT PART 0.000000 0 0 0 0 0 0 0 0 0 0 0 92. 00 07500 BRUFERERI BURSABLE COST CENTERS	· · · · · · · · · · · · · · · · · · ·		78, 734	0	0	01	1
60. 00 06000 LABORATORY 0.000000 149, 012 0 0 0 0 60. 00 62. 30 06250 BLOOD CLOTTI NG FOR HEMOPHI LI ACS 0.000000 0 0 0 0 0 0 0 62. 30 65. 00 06500 RESPI RATORY THERAPY 0.000000 26, 016 0 0 0 0 65. 00 66. 00 06600 PHYSI CAL THERAPY 0.000000 2, 704 0 0 0 66. 00 67. 00 06700 0CCUPATI ONAL THERAPY 0.000000 551 0 0 0 67. 00 68. 00 06800 SPECH PATHOLOGY 0.000000 2, 580 0 0 0 0 68. 00 69. 00 06900 ELECTROCARDI OLOGY 0.000000 3, 382 0 0 0 0 68. 00 71. 00 07100 MEDI CAL SUPPLIES CHARGED TO PATI ENT 0.000000 12, 197 0 0 0 0 71. 00 72. 00 07200 IMPL. DEV. CHARGED TO PATI ENTS 0.000000 0 0 0 0 0 72. 00 73. 00 07300 DRUGS CHARGED TO PATI ENTS 0.000000 100, 662 0 0 0 0 73. 00 76. 97 07697 CARDI AC REHABI LI TATI ON 0.000000 100, 662 0 0 0 0 76. 97 76. 98 07698 HYPERBARI C OXYGEN THERAPY 0.000000 2, 542 0 0 0 76. 99 77. 00 07700 ALLOGENEIC HSCT ACQUI SI TI ON 0.000000 0 0 0 0 0 0 78. 00 78. 00 07800 CAR T-CELL I MMUNOTHERAPY 0.000000 0 0 0 0 0 0 78. 00 07800 CAR T-CELL I IMMUNOTHERAPY 0.000000 0 0 0 0 0 0 0 0 0 0 078. 00 09000 CLI NI C 0.000000 0 0 0 0 0 0 0 0 0 0 0 0 0 0791. 00 09000 CBERCATION BEDS (NON-DI STI NCT PART 0.000000 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0			·	1	0	01	
62. 30 06250 BLOOD CLOTTING FOR HEMOPHILIACS 0.000000 0 0 0 0 0 0 62. 30 65. 00 65500 RESPIRATORY THERAPY 0.000000 26, 016 0 0 0 65. 00 66. 00 66. 00 66. 00 66. 00 66. 00 66. 00 66. 00 66. 00 66. 00 66. 00 66. 00 66. 00 66. 00 66. 00 66. 00 66. 00 66. 00 66. 00 67. 00 67. 00 67. 00 67. 00 67. 00 67. 00 67. 00 67. 00 67. 00 67. 00 67. 00 67. 00 68. 00 68. 00 68. 00 68. 00 68. 00 69. 00					0	0	
65. 00			149, 012	0	0	0	
66. 00	62.30 06250 BLOOD CLOTTING FOR HEMOPHILIACS	0. 000000	-	_	0	0	62. 30
67. 00			26, 016	0	0	0	65.00
68. 00		0. 000000			0	0	66.00
69. 00 06900 ELECTROCARDI OLOGY 0.000000 3, 382 0 0 0 0 69.00 71. 00 07100 MEDI CAL SUPPLIES CHARGED TO PATIENT 0.000000 12, 197 0 0 0 0 0 71.00 72. 00 07200 IMPL DEV. CHARGED TO PATIENTS 0.000000 0 0 0 0 0 0 0 72.00 73. 00 07300 DRUGS CHARGED TO PATIENTS 0.000000 100, 662 0 0 0 0 73.00 76. 97 07697 CARDI AC REHABI LI TATI ON 0.000000 0 0 0 0 0 0 76.97 76. 98 07698 HYPERBARI C OXYGEN THERAPY 0.000000 2, 542 0 0 0 0 76.97 76. 99 07699 LI THOTRI PSY 0.000000 0 0 0 0 0 76.99 77. 00 07700 ALLOGENEI C HSCT ACQUI SI TI ON 0.000000 0 0 0 0 0 0 78. 00 07800 CAR T-CELL I IMMUNOTHERAPY 0.000000 0 0 0 0 0 0 77. 00 07800 CAR T-CELL I IMMUNOTHERAPY 0.000000 0 0 0 0 0 0 77. 00 09100 EMERGENCY 0.000000 0 0 0 0 0 0 78. 00 09100 EMERGENCY 0.000000 0 0 0 0 0 0 0 79. 00 09200 OBSERVATI ON BEDS (NON-DI STI NCT PART 0.000000 0 0 0 0 0 0 0 0 0 0 0 0 0	67. 00 06700 OCCUPATI ONAL THERAPY	0. 000000	551	0	0	0	67.00
71. 00	68. 00 06800 SPEECH PATHOLOGY	0. 000000	2, 580	0	0	0	68.00
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 100, 662 0 0 0 0 73. 00 76. 97 07697 CARDI AC REHABI LI TATI ON 0. 000000 0 0 0 0 0 76. 97 76. 98 07698 HYPERBARI C OXYGEN THERAPY 0. 000000 2, 542 0 0 0 0 76. 98 76. 99 07699 LI THOTRI PSY 0. 000000 0 0 0 0 0 76. 98 77. 00 07700 ALLOGENEI C HSCT ACQUI SI TI ON 0. 000000 0 0 0 0 0 77. 00 78. 00 07800 CAR T-CELL I MMUNOTHERAPY 0. 000000 0 0 0 0 0 79. 00 09000 CLI NI C 0. 000000 0 0 0 0 0 79. 00 09100 EMERGENCY 0. 000000 0 0 0 0 0 79. 00 09200 OBSERVATI ON BEDS (NON-DI STI NCT PART 0. 000000 0 0 0 0 70 OTHER REI MBURSABLE COST CENTERS 95. 00 75. 00 09500 AMBULANCE SERVI CES 95. 00	69. 00 06900 ELECTROCARDI OLOGY	0. 000000	3, 382	0	0	0	69. 00
73. 00 07300 DRUGS CHARGED TO PATIENTS 0.000000 100, 662 0 0 0 73. 00 76. 97 07697 CARDI AC REHABILITATI ON 0.000000 0 0 0 0 76. 97 76. 98 07698 HYPERBARI C OXYGEN THERAPY 0.000000 2, 542 0 0 0 0 76. 98 76. 99 07699 LI THOTRI PSY 0.000000 0 0 0 0 0 76. 99 77. 00 07700 ALLOGENEI C HSCT ACQUI SI TI ON 0.000000 0 0 0 0 0 0 78. 00 07800 CAR T-CELL I MMUNOTHERAPY 0.000000 0 0 0 0 0 78. 00 000000 CLI NI C 0.000000 0 0 0 0 90. 00 09100 EMERGENCY 0.000000 90, 186 0 0 0 91. 00 92. 00 09200 OBSERVATI ON BEDS (NON-DI STI NCT PART 0.000000 0 0 0 0 0THER REI MBURSABLE COST CENTERS 95. 00	71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0. 000000	12, 197	0	0	0	71.00
76. 97	72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0. 000000	0	0	0	0	72.00
76. 98	73.00 07300 DRUGS CHARGED TO PATIENTS	0. 000000	100, 662	0	0	0	73.00
76. 99	76. 97 07697 CARDI AC REHABI LI TATI ON	0. 000000	0	0	0	0	76. 97
77. 00 07700 ALLOGENEI C HSCT ACQUI SITION 0.000000 0 0 0 0 77. 00 07800 CAR T-CELL IMMUNOTHERAPY 0.000000 0 0 0 0 78. 00 000000 0 0 0 0 0 0	76. 98 07698 HYPERBARIC OXYGEN THERAPY	0. 000000	2, 542	0	0	0	76. 98
78. 00 07800 CAR T-CELL I MMUNOTHERAPY 0. 000000 0 0 0 0 78. 00	76. 99 07699 LI THOTRI PSY	0. 000000	0	0	0	0	76. 99
OUTPATIENT SERVICE COST CENTERS O	77.00 07700 ALLOGENEIC HSCT ACQUISITION	0. 000000	0	0	0	0	77. 00
90. 00 09000 CLI NI C 0.000000 0 0 0 0 90. 00 91. 00 91. 00 92. 00 09200 OBSERVATI ON BEDS (NON-DI STI NCT PART 0.000000 0 0 0 0 0 92. 00 00 00 00 00 00 00 00	78.00 07800 CAR T-CELL IMMUNOTHERAPY	0. 000000	0	0	0	0	78. 00
91. 00 09100 EMERGENCY 0. 000000 90, 186 0 0 0 91. 00 92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART 0. 000000 0 0 0 0 0 0 0	OUTPATIENT SERVICE COST CENTERS						
92. 00 09200 OBSERVATI ON BEDS (NON-DISTINCT PART 0.0000000 0 0 0 0 0 0 0	90. 00 09000 CLI NI C	0. 000000	0	0	0	0	90.00
OTHER REI MBURSABLE COST CENTERS 95. 00 09500 AMBULANCE SERVI CES 95. 00	91. 00 09100 EMERGENCY	0. 000000	90, 186	0	o	0	91.00
95. 00 09500 AMBULANCE SERVICES 95. 00	92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART	0. 000000	0	0	o	0	92.00
	OTHER REIMBURSABLE COST CENTERS						
200.00 Total (lines 50 through 199) 791,600 0 0 200.00	95. 00 09500 AMBULANCE SERVICES						95.00
	200.00 Total (lines 50 through 199)		791, 600	0	0	0	200.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST Provider CCN: 15-0091 Worksheet D From 01/01/2023 Part V 12/31/2023 Date/Time Prepared: 5/23/2024 4: 22 pm Title XIX Hospi tal PPS Charges Costs 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. Ded. & Coins. Part I, col. 9 (see inst.) (see inst.) 1.00 2.00 5.00 3.00 4.00 ANCILLARY SERVICE COST CENTERS 50.00 05000 OPERATING ROOM 50.00 0.069729 223, 350 05001 OPERATING ROOM 0 50.01 50.01 0.000000 0 0 0 05200 DELIVERY ROOM & LABOR ROOM 0. 303878 0 52.00 0 0 52.00 53.00 05300 ANESTHESI OLOGY 0.553583 0 0 0 53.00 54.00 05400 RADI OLOGY-DI AGNOSTI C 0.131753 0 533, 271 0 54.00 Ol 06000 LABORATORY 60.00 0.118526 534, 459 0 60.00 06250 BLOOD CLOTTING FOR HEMOPHILIACS 62.30 0.000000 0 0 0 62.30 65.00 06500 RESPIRATORY THERAPY 0. 221762 122, 880 0 65.00 66.00 06600 PHYSI CAL THERAPY 0. 528444 0 47, 404 0 66.00 06700 OCCUPATI ONAL THERAPY 99, 445 0.244918 0 67.00 0 67.00 68.00 06800 SPEECH PATHOLOGY 0.367903 0 75, 857 0 68.00 06900 ELECTROCARDI OLOGY 0.038762 69.00 35, 162 0 69.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT 0. 283687 0 19, 700 71.00 71 00 0 19, 903 72.00 07200 IMPL. DEV. CHARGED TO PATIENTS 0.232550 0 0 72.00 73.00 07300 DRUGS CHARGED TO PATIENTS 0. 209102 0 22, 587 0 73.00 07697 CARDIAC REHABILITATION 76. 97 0.000000 0 0 76.97 07698 HYPERBARI C OXYGEN THERAPY 0 76. 98 76 98 0.340428 27, 507 Ω 07699 LI THOTRI PSY 76.99 0.000000 0 0 0 76.99 77.00 07700 ALLOGENEIC HSCT ACQUISITION 0.000000 0 0 0 77.00 07800 CAR T-CELL IMMUNOTHERAPY 78.00 0.000000 0 0 0 0 78.00 OUTPATIENT SERVICE COST CENTERS 90.00 09000 CLI NI C 0. 292651 0 0 0 90.00 09100 EMERGENCY 0.091518 0 1, 309, 840 0 0 91.00 91.00

0.587277

0. 365419

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0

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78, 842

664, 775

3, 814, 982

3, 814, 982

0

0

0

0

92.00

95.00

201.00

0 200.00

0 202.00

0

09200 OBSERVATION BEDS (NON-DISTINCT PART

Subtotal (see instructions)

Less PBP Clinic Lab. Services-Program

Net Charges (line 200 - line 201)

OTHER REIMBURSABLE COST CENTERS

09500 AMBULANCE SERVICES

Only Charges

92.00

95.00

200.00

201.00

202.00

Health Financial Systems	HUNTI NGTON MEMORI A	AL HOSPITAL	In Lieu	u of Form CMS-2552-10
APPORTI ONMENT OF MEDICAL	OTHER HEALTH SERVICES AND VACCINE COST	Provider CCN: 15-0091	Peri od: From 01/01/2023 To 12/31/2023	Worksheet D Part V Date/Time Prepared:

				To 12/31/2023	Date/Time Pro 5/23/2024 4:2	epared: 22 pm
		Ti tl	e XIX	Hospi tal	PPS	
	Cos	sts				
Cost Center Description	Cost	Cost				
	Reimbursed	Rei mbursed				
	Servi ces	Services Not				
	Subject To	Subject To				
		Ded. & Coins.				
	(see inst.)	(see inst.)				
ANCILLARY SERVICE COST CENTERS	6. 00	7. 00				
50. 00 05000 OPERATING ROOM	15, 574	0				50.00
50. 01 05001 OPERATING ROOM	13, 374	0				50.00
52. 00 05200 DELIVERY ROOM & LABOR ROOM	0	0				52.00
53. 00 05300 ANESTHESI OLOGY		0				53.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	70, 260	0				54.00
60. 00 06000 LABORATORY	63, 347	0				60.00
62. 30 06250 BLOOD CLOTTING FOR HEMOPHILIACS	0	0				62. 30
65. 00 06500 RESPI RATORY THERAPY	27, 250	0				65.00
66. 00 06600 PHYSI CAL THERAPY	25, 050	0				66.00
67. 00 06700 OCCUPATI ONAL THERAPY	24, 356	0				67.00
68.00 06800 SPEECH PATHOLOGY	27, 908	0				68.00
69. 00 06900 ELECTROCARDI OLOGY	1, 363	0				69.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	5, 589	0				71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	4, 628	0				72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	4, 723	0				73.00
76. 97 07697 CARDIAC REHABILITATION	0	0				76. 97
76.98 07698 HYPERBARIC OXYGEN THERAPY	9, 364	0				76. 98
76. 99 07699 LI THOTRI PSY	0	0				76. 99
77.00 07700 ALLOGENEIC HSCT ACQUISITION	0	0				77. 00
78.00 07800 CAR T-CELL IMMUNOTHERAPY	0	0				78. 00
OUTPATIENT SERVICE COST CENTERS						
90. 00 09000 CLI NI C	0	0				90.00
91. 00 09100 EMERGENCY	119, 874	0				91.00
92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART	46, 302	0				92. 00
OTHER REIMBURSABLE COST CENTERS 95.00 O9500 AMBULANCE SERVICES	242 021					95.00
	242, 921	0				
200.00 Subtotal (see instructions) 201.00 Less PBP Clinic Lab. Services-Program	688, 509 0	0				200. 00 201. 00
Only Charges	ا					201.00
202.00 Net Charges (line 200 - line 201)	688, 509	0				202.00

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 01/01/2023		
		To 12/31/2023	Date/Time Pre 5/23/2024 4:2	pared: 2 pm
	Title XVIII	Hospi tal	PPS	
Cost Center Description				
			1. 00	
PART I - ALL PROVIDER COMPONENTS				
INPATIENT DAYS				

BART All PRIVINGE COMPANYIS			Title XVIII	Hospi tal	PPS	
PART 1 - ALL PROVIDER CONFORENTS		Cost Center Description		-	1 00	
INPATE INTO AVS		DART I _ ALL PROVIDER COMPONENTS			1.00	
Inpatient days (Including private room days and swing-bed days, excluding newborn)						
Private room days (excluding swing-bed and observation bed days) If you have only private room days 0 3.00	1.00		rs, excluding newborn)		6, 495	1.00
do not complete this 1 inc. 4. 00 Semi-private room days (excluding swing-bed and observation bed days) 5. 00 Total swing-bed SMF type inpatient days (including private room days) after December 31 of the cost 7. 00 Total swing-bed SMF type inpatient days (including private room days) after December 31 of the cost 8. 00 Total swing-bed SMF type inpatient days (including private room days) after December 31 of the cost 9. 00 Total swing-bed SMF type inpatient days (including private room days) through December 31 of the cost 1. 00 Total swing-bed SMF type inpatient days (including private room days) after December 31 of the cost 1. 00 Total swing-bed SMF type inpatient days (including private room days) after December 31 of the cost 1. 00 Swing-bed SMF type inpatient days (including private room days) after December 31 of the cost 1. 00 Swing-bed SMF type inpatient days (including private room days) after December 31 of the cost reporting period (including private room days) after December 31 of the cost reporting period (including private room days) 1. 00 Swing-bed SMF type inpatient days applicable to title XMI1 only (including private room days) after December 31 of the cost reporting period (including private room days) after December 31 of the cost reporting period (including private room days) 1. 00 Swing-bed SMF type inpatient days applicable to title XMI1 only (including private room days) 1. 00 Swing-bed SMF type inpatient days applicable to title XMI1 only (including private room days) 1. 00 Swing-bed SMF type inpatient days applicable to title XMI1 only (including private room days) 1. 00 Swing-bed SMF type inpatient days applicable to title XMI1 only (including private room days) 1. 00 Swing-bed SMF type inpatient days applicable to title XMI1 only (including private room days) 1. 00 Swing-bed SMF type inpatient days applicable to title XMI1 only (including private room days) 1. 00 Swing-bed SMF type inpatient days applicable to services after December 31 of the cost 1. 00 Swing-bed	2.00				6, 495	2.00
Semi-private room days (excluding swing-bed 3M observation bed days) 5.00 Total swing-bed SM type inpatient days (including private room days) after December 31 of the cost reporting period reporting period of the cost room days and the cost reporting period of the cost reporting period (if calendar year, enter 0 on this line) 12.00 Swing-bed SMF type inpatient days applicable to the Program (excluding private room days) after becember 31 of the cost reporting period (if calendar year, enter 0 on this line) 13.00 Swing-bed SMF type inpatient days applicable to the Program (excluding private room days) 14.00 bedically necessary private room days applicable to the Program (excluding private room days) 15.00 forting nursery days (title V or XIX only) 16.00 bedically necessary private room days applicable to services through December 31 of the cost reporting period of the cost reporting period (if calendar year, enter 0 on this line) 16.00 bedically necessary private room days applicable to services through December 31 of the cost reporting period (incord the cost reporting period (incord the cost reporting period (incord the cost reporting period (incord the cost reporting period (incord the cost reporting period (incord the cost reporting period (incord the period period (incord the period period (incord the period (incord	3.00		ys). If you have only pr	rivate room days,	0	3.00
5.00 Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost of 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) 7.00 Total inpatient days (including private room days) through December 31 of the cost reporting period (if calendar year, enter 0 on this line) 8.00 Total saing-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) 9.00 Total inpatient days including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line) 10.00 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) 11.00 Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) 11.00 Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) 12.00 Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) 13.00 Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) 13.00 Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) 13.00 Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) 13.00 Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) 13.00 Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) 13.00 Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) 13.00 Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) 13.00 Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) 13.00 Swing-bed SNF type inpatient days ap	4 00	·	and days)		4 771	4 00
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PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS 38.00 Adjusted general inpatient routine service cost per diem (see instructions) 39.00 Program general inpatient routine service cost (line 9 x line 38) 40.00 Medically necessary private room cost applicable to the Program (line 14 x line 35) 1,617.03 38.00 1,824,010 9.00 40.00		27 minus line 36)		`]		
38.00 Adjusted general inpatient routine service cost per diem (see instructions) 1,617.03 38.00 Program general inpatient routine service cost (line 9 x line 38) 1,824,010 39.00 Medically necessary private room cost applicable to the Program (line 14 x line 35) 0 40.00			HOTHENTO			
39.00 Program general inpatient routine service cost (line 9 x line 38) 40.00 Medically necessary private room cost applicable to the Program (line 14 x line 35) 1,824,010 39.00 0 40.00	30 00			T	1 617 02	38 00
40.00 Medically necessary private room cost applicable to the Program (line 14 x line 35) 0 40.00						
	41. 00	Total Program general inpatient routine service cost (line 39	+ line 40)		1, 824, 010	41.00

7. 00	Total swing-bed NF type inpatient days (including private room days) through December 31 of the cost	0	7.00
8. 00	reporting period Total swing-bed NF type inpatient days (including private room days) after December 31 of the cost	0	8. 00
0.00	reporting period (if calendar year, enter 0 on this line) Total impatient days including private room days applicable to the Program (evaluding swing had and	1 120	9. 00
9. 00	Total inpatient days including private room days applicable to the Program (excluding swing-bed and newborn days) (see instructions)	1, 128	9.00
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) Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) after	0	11. 00
	December 31 of the cost reporting period (if calendar year, enter 0 on this line)		
12. 00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) 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
14 00	after December 31 of the cost reporting period (if calendar year, enter 0 on this line) Medically necessary private room days applicable to the Program (excluding swing-bed days)	0	14. 00
	Total nursery days (title V or XIX only)	0	15. 00
	Nursery days (title V or XIX only)	o o	16. 00
10.00	SWING BED ADJUSTMENT		10.00
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 reporting period	0. 00	18.00
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		00.00
20.00	Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period	0. 00	20. 00
21. 00	Total general inpatient routine service cost (see instructions)	10, 502, 603	21.00
22.00			22.00
	5 x line 17)		
23. 00		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	o	24. 00
	7 x line 19)		
25. 00	Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8 x line 20)	0	25. 00
26.00	Total swing-bed cost (see instructions)	0	26.00
27.00	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)	10, 502, 603	27.00
	PRIVATE ROOM DIFFERENTIAL ADJUSTMENT		
	General inpatient routine service charges (excluding swing-bed and observation bed charges)	0	28.00
	Pri vate room charges (excluding swing-bed charges)	0	29.00
	Semi-private room charges (excluding swing-bed charges)	0 0. 000000	30. 00 31. 00
	General inpatient routine service cost/charge ratio (line 27 ÷ line 28) Average private room per diem charge (line 29 ÷ line 3)	0.00000	31.00
	Average semi-private room per diem charge (line 30 ÷ line 4)	0.00	33. 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	35.00
	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	10, 502, 603	37.00
	27 minus line 36)		
	PART II - HOSPITAL AND SUBPROVIDERS ONLY		
20.00	PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS	1 (17 02	20.00
	Adjusted general inpatient routine service cost per diem (see instructions) Program general inpatient routine service cost (line 9 x line 38)	1, 617. 03 1, 824, 010	38. 00 39. 00
	Medically necessary private room cost applicable to the Program (line 14 x line 35)	1, 824, 010	40.00
	Total Program general inpatient routine service cost (line 39 + line 40)	1, 824, 010	
	1 2 2 3 3 3 3 3 4 4 4 4 4 4 4 4 4 4 4 4 4	., 32 ., 0 10	

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	ATION OF INPATIENT OPERATING COST		Provi der C	CN: 15-0091	Peri od: From 01/01/2023	Worksheet D-1	
					To 12/31/2023	Date/Time Pre 5/23/2024 4:2	
			Title	XVIII	Hospi tal	PPS	.z piii
	Cost Center Description	Total	Total	Average Per	Program Days	Program Cost	
		Inpatient	Inpatient	Diem (col.	1	(col. 3 x	
		1.00	Days 2.00	÷ col . 2) 3.00	4. 00	col . 4) 5.00	
12.00	NURSERY (title V & XIX only)	0	2.00				42.0
	Intensive Care Type Inpatient Hospital Units						1
13.00	INTENSIVE CARE UNIT						43.0
14.00	CORONARY CARE UNIT						44.0
45. 00 46. 00	BURN INTENSIVE CARE UNIT SURGICAL INTENSIVE CARE UNIT						45. 0 46. 0
	OTHER SPECIAL CARE (SPECIFY)						47.0
00	Cost Center Description			L			17.0
	I=					1. 00	
18. 00 18. 01	Program inpatient ancillary service cost (Wk			III lino 10) column 1)	1, 144, 796 0	1
19. 00	Program inpatient cellular therapy acquisition Total Program inpatient costs (sum of lines a	•			r, corumir r)	2, 968, 806	1
17.00	PASS THROUGH COST ADJUSTMENTS	TT through 10. 0	1) (300 111311 4	311 0113)		2, 700, 000	17.0
50.00	Pass through costs applicable to Program inp	atient routine	servi ces (fro	m Wkst. D, su	m of Parts I and	215, 064	50.0
-4 00						440.000	
51. 00	Pass through costs applicable to Program inpand IV)	atient ancillar	y services (†	OM WKST. D,	Sum or Parts II	112, 892	51.0
52. 00	Total Program excludable cost (sum of lines	50 and 51)				327, 956	52.0
53.00	Total Program inpatient operating cost exclu	ding capital re	lated, non-ph	ysician anest	hetist, and	2, 640, 850	
	medical education costs (line 49 minus line	52)					
54 00	TARGET AMOUNT AND LIMIT COMPUTATION Program discharges					0	54.0
55.00	Target amount per discharge					-	55.0
5. 01	Permanent adjustment amount per discharge					0. 00	55.0
5. 02	Adjustment amount per discharge (contractor	J ,					55.0
6.00	Target amount (line 54 x sum of lines 55, 55	· · · · · · · · · · · · · · · · · · ·			11 50)	0	
7. 00 8. 00	Difference between adjusted inpatient operat Bonus payment (see instructions)	ing cost and ta	rget amount (line 56 minus	: IIne 53)	0	57. (58. (
9.00	Trended costs (lesser of line 53 ÷ line 54,	or line 55 from	the cost rep	ortina period	Lendina 1996.		59.0
	updated and compounded by the market basket)			5 1	3		
60.00	Expected costs (lesser of line 53 ÷ line 54,	or line 55 fro	m prior year	cost report,	updated by the	0. 00	60.0
51. 00	market basket) Continuous improvement bonus payment (if lin	e 53 ÷ line 54	is less than	the lowest of	lines 55 nlus	0	61.0
31.00	55.01, or line 59, or line 60, enter the less						01.0
	53) are less than expected costs (lines 54 x	60), or 1 % of	the target a	mount (İine 5	66), otherwise		
52. 00	enter zero. (see instructions)						62.0
53.00	Relief payment (see instructions) Allowable Inpatient cost plus incentive paym	ent (see instru	ctions)				63.0
	PROGRAM INPATIENT ROUTINE SWING BED COST		,				
54. 00		ts through Dece	mber 31 of th	e cost report	ing period (See	0	64.0
55 00	instructions)(title XVIII only) Medicare swing-bed SNF inpatient routine cos	ts after Decemb	er 31 of the	rost renortin	ng neriod (See	0	65.0
55.00	instructions)(title XVIII only)	ts arter becemb	el 31 of the	cost reportin	ig period (See		05.0
66.00	Total Medicare swing-bed SNF inpatient routi	ne costs (line	64 plus line	65)(title XVI	<pre>II only); for</pre>	0	66.0
47 00	CAH, see instructions	o cocto through	Docombox 21	of the cost :-	conorting pari	_	47.0
57. 00	Title V or XIX swing-bed NF inpatient routing (line 12 x line 19)	e cosis inrough	pecelliber 31	or the cost r	eporting period	0	67.0
58. 00	Title V or XIX swing-bed NF inpatient routing	e costs after D	ecember 31 of	the cost rep	orting period	0	68.0
	(line 13 x line 20)		11	(0)			,,,
59. 00	Total title V or XIX swing-bed NF inpatient PART III - SKILLED NURSING FACILITY, OTHER NU					0	69.0
70. 00	Skilled nursing facility/other nursing facil				')		70.0
71. 00	Adjusted general inpatient routine service c		ine 70 ÷ line	2)			71.0
72.00	Program routine service cost (line 9 x line	•	(11)	05)			72.0
4.00	Medically necessary private room cost applications. Total Program general inpatient routine serv		•				73.0
5. 00	Capital -related cost allocated to inpatient	•			Part II. column		75.0
	26, line 45)		,				
6.00	Per diem capital related costs (line 75 ÷ li						76.0
7. 00 8. 00	Program capital-related costs (line 9 x line Inpatient routine service cost (line 74 minus						77.0
9.00			rovi den inecon	ds)			79.0
0. 00	Total Program routine service costs for compa				nus line 79)		80.0
1. 00	Inpatient routine service cost per diem limi	tati on			,		81.0
2.00	Inpatient routine service cost limitation (* .				82.0
3.00	Reasonable inpatient routine service costs (s)				83.0
34. 00 35. 00	Program inpatient ancillary services (see in: Utilization review - physician compensation		ins)				84.0
36.00	Total Program inpatient operating costs (sum						86.0
	PART IV - COMPUTATION OF OBSERVATION BED PASS						1
	Total observation bed days (see instructions					1, 724	1

Health Financial Systems	HUNTINGTON 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 01/01/2023 To 12/31/2023		
		Title	XVIII	Hospi tal	PPS	
Cost Center Description						
					1.00	
89.00 Observation bed cost (line 87 x line 88) (s	ee instructions)			2, 787, 760	89.00
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, 238, 343	10, 502, 603	0. 11790	8 2, 787, 760	328, 699	90.00
91.00 Nursing Program cost	0	10, 502, 603	0.00000	0 2, 787, 760	0	91.00
92.00 Allied health cost	0	10, 502, 603	0.00000	0 2, 787, 760	0	92.00
93.00 All other Medical Education	0	10, 502, 603	0. 00000	0 2, 787, 760	0	93.00

Health Financial Systems	HUNTINGTON MEMORIAL HOSPITAL	In Lie	u of Form CMS-2	2552-10
COMPUTATION OF INPATIENT OPERATING COST	Provi der CCN: 15-0091	Peri od:	Worksheet D-1	
		From 01/01/2023 To 12/31/2023	Date/Time Pre 5/23/2024 4:2	
	Title XIX	Hospi tal	PPS	
Cost Center Description				
			1. 00	
PART I - ALL PROVIDER COMPONENTS				
I NPATI ENT DAYS				
1.00 Inpatient days (including private room day	s and swing-bed days, excluding newborn)		6, 495	1.00
2.00 Inpatient days (including private room day	rs, excluding swing-bed and newborn days)		6, 495	2.00

	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 days, excluding newborn)	6, 495	1.00
2. 00	Inpatient days (including private room days, excluding swing-bed and newborn days)	6, 495	2.00
3. 00	Private room days (excluding swing-bed and observation bed days). If you have only private room days,	0	3.00
4. 00	do not complete this line. Semi-private room days (excluding swing-bed and observation bed days)	4, 771	4. 00
5. 00	Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost	4, 771	5.00
0.00	reporting period	١	0.00
6.00	Total swing-bed SNF type inpatient days (including private room days) after December 31 of the cost	0	6.00
	reporting period (if calendar year, enter 0 on this line)	_	
7. 00	Total swing-bed NF type inpatient days (including private room days) through December 31 of the cost reporting period	0	7. 00
8. 00	Total swing-bed NF type inpatient days (including private room days) after December 31 of the cost	0	8. 00
0.00	reporting period (if calendar year, enter 0 on this line)		0.00
9. 00	Total inpatient days including private room days applicable to the Program (excluding swing-bed and	78	9. 00
40.00	newborn days) (see instructions)	ا	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) 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)	١	
12.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days)	0	12.00
40.00	through December 31 of the cost reporting period	ا	40.00
13. 00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days)	0	13. 00
14. 00	after December 31 of the cost reporting period (if calendar year, enter 0 on this line) 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)	735	
16.00	Nursery days (title V or XIX only)	32	16.00
	SWING BED ADJUSTMENT		
17. 00	Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost	0. 00	17.00
18. 00	reporting period 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	10.00
19.00	Medicaid rate for swing-bed NF services applicable to services through December 31 of the cost	0. 00	19.00
	reporting period		
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)	10, 502, 603	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 ϕ	0	23. 00
24.00	x line 18)		24.00
24. 00	Swing-bed cost applicable to NF type services through December 31 of the cost reporting period (line $ 7 \times $ 1 ine 19)	0	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
	x line 20)		
26. 00	Total swing-bed cost (see instructions)	0	26. 00
27. 00	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)	10, 502, 603	27. 00
28. 00	PRIVATE ROOM DIFFERENTIAL ADJUSTMENT General inpatient routine service charges (excluding swing-bed and observation bed charges)	0	28. 00
29. 00		0	29.00
30. 00	Semi-private room charges (excluding swing-bed charges)	0	30.00
31.00	General inpatient routine service cost/charge ratio (line 27 ÷ line 28)	0. 000000	31.00
32.00	Average private room per diem charge (line 29 ÷ line 3)	0. 00	32.00
33.00	Average semi-private room per diem charge (line 30 ÷ line 4)	0.00	33.00
34. 00 35. 00	Average per diem private room charge differential (line 32 minus line 33)(see instructions) Average per diem private room cost differential (line 34 x line 31)	0. 00 0. 00	34. 00 35. 00
36. 00	Private room cost differential adjustment (line 3 x line 35)	0.00	36.00
37. 00	General inpatient routine service cost net of swing-bed cost and private room cost differential (line		37.00
	27 minus line 36)		
	PART II - HOSPITAL AND SUBPROVIDERS ONLY		
20 00	PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS	1 (17 00	20 00
38. 00 39. 00	Adjusted general inpatient routine service cost per diem (see instructions) Program general inpatient routine service cost (line 9 x line 38)	1, 617. 03 126, 128	
40. 00	Medically necessary private room cost applicable to the Program (line 14 x line 35)	120, 128	40.00
41. 00	Total Program general inpatient routine service cost (line 39 + line 40)	126, 128	

	reporting period (if calendar year, enter 0 on this line)		
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	0	8.00
	reporting period (if calendar year, enter 0 on this line)		
9.00	Total inpatient days including private room days applicable to the Program (excluding swing-bed and	78	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
	through December 31 of the cost reporting period (see instructions)		
11. 00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) after	0	11.00
	December 31 of the cost reporting period (if calendar year, enter 0 on this line)		
12.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days)	0	12.00
	through December 31 of the cost reporting period		
13.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days)	0	13.00
	after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		
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)	735	
16.00	Nursery days (title V or XIX only)	32	16.00
	SWING BED ADJUSTMENT		
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
	reporting period		
19. 00	Medicaid rate for swing-bed NF services applicable to services through December 31 of the cost	0. 00	19. 00
	reporting period		
20.00	Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost	0. 00	20.00
	reporting period		
21. 00	Total general inpatient routine service cost (see instructions)	10, 502, 603	
22. 00	Swing-bed cost applicable to SNF type services through December 31 of the cost reporting period (line	0	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 &	0	23. 00
	x line 18)		
24. 00	Swing-bed cost applicable to NF type services through December 31 of the cost reporting period (line	0	24. 00
	7 x line 19)		
25. 00	Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8	0	25. 00
	x line 20)		
	Total swing-bed cost (see instructions)	0	
27. 00	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)	10, 502, 603	27. 00
	PRIVATE ROOM DIFFERENTIAL ADJUSTMENT		
28. 00	General inpatient routine service charges (excluding swing-bed and observation bed charges)	0	
29. 00	Private 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	
	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	
35. 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	10, 502, 603	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, 617. 03	
	Program general inpatient routine service cost (line 9 x line 38)	126, 128	
	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)	126, 128	41.00

	ATION OF INPATIENT OPERATING COST		Provi der C	1	Period: From 01/01/2023 To 12/31/2023		pared
			Ti +I	e XIX	Hospi tal	5/23/2024 4: 2 PPS	22 pm
	Cost Center Description	Total Inpatient Cost	Total Inpatient Days	Average Per Diem (col. 1 ÷ col. 2)	Program Days	Program Cost (col. 3 x col. 4)	
		1. 00	2. 00	3. 00	4. 00	5. 00	
2. 00	NURSERY (title V & XIX only)	434, 275	735	590. 85	5 32	18, 907	42.
3. 00	Intensive Care Type Inpatient Hospital Units INTENSIVE CARE UNIT			Ī			43.
4. 00	CORONARY CARE UNIT						44.
5. 00	BURN INTENSIVE CARE UNIT						45.
	SURGICAL INTENSIVE CARE UNIT						46.
7. 00	OTHER SPECIAL CARE (SPECIFY)						47.
	Cost Center Description					1.00	
3. 00	Program inpatient ancillary service cost (Wk	st. D-3, col. 3	B, line 200)			109, 028	48.
3. 01	Program inpatient cellular therapy acquisition			III, line 10,	column 1)	0	
9. 00	Total Program inpatient costs (sum of lines	41 through 48.0	01)(see instru	ctions)		254, 063	49.
	PASS THROUGH COST ADJUSTMENTS					45.7/5	
0. 00	Pass through costs applicable to Program inpull!	atient routine	services (froi	n Wkst. D, sum	of Parts I and	15, 765	50.
1.00	Pass through costs applicable to Program inp	atient ancillar	v services (f	rom Wkst. D. s	sum of Parts II	9, 753	51.
	and IV)		<i>y</i> (
2. 00	Total Program excludable cost (sum of lines	,				25, 518	1
3. 00	Total Program inpatient operating cost exclu		elated, non-phy	ysician anesth	etist, and	228, 545	53.
	medical education costs (line 49 minus line ! TARGET AMOUNT AND LIMIT COMPUTATION	52)					-
1. 00	Program di scharges					0	54.
5. 00	Target amount per discharge					0.00	
. 01	Permanent adjustment amount per discharge					0.00	55.
. 02	Adjustment amount per discharge (contractor					0.00	
. 00	Target amount (line 54 x sum of lines 55, 55				50)	0	1
. 00	Difference between adjusted inpatient operat	ing cost and ta	arget amount (ine 56 minus	line 53)	0	
. 00	Bonus payment (see instructions) Trended costs (lesser of line 53 ÷ line 54,	or line 55 from	the cost ren	orting period	ending 1996	0.00	
. 00	updated and compounded by the market basket)	or title 33 from	the cost rep	of tring period	ending 1770,	0.00] 37.
0. 00	Expected costs (lesser of line 53 ÷ line 54,	or line 55 fro	om prior year o	cost report, ι	pdated by the	0.00	60.
. 00	market basket) Continuous improvement bonus payment (if line 55.01, or line 59, or line 60, enter the less					0	61.
	53) are less than expected costs (lines 54 \times	60), or 1 % of	the target a	nount (line 56	o), otherwise		
	enter zero. (see instructions)						/ ,
2.00	Relief payment (see instructions) Allowable Inpatient cost plus incentive paym	ent (see instru	ictions)			0	62. 63.
. 00	PROGRAM INPATIENT ROUTINE SWING BED COST	cite (See Thistite	10 (1 0113)				00.
. 00	Medicare swing-bed SNF inpatient routine cos	ts through Dece	ember 31 of the	e cost reporti	ng period (See	0	64.
	instructions)(title XVIII only)		04 6 11				,_
. 00	Medicare swing-bed SNF inpatient routine cos	ts after Decemb	er 31 of the o	cost reporting	period (See	1	65.
5. 00	<pre>instructions)(title XVIII only) Total Medicare swing-bed SNF inpatient routi</pre>	ne costs (line	64 plus line	65)(title XVII	I only) for	0	66.
	CAH, see instructions			, (377	l	-0.
. 00	Title V or XIX swing-bed NF inpatient routing	e costs through	December 31	of the cost re	porting period	0	67.
	(line 12 x line 19)	o oootCl : 5) o o o m h = 0.4	+ho	unting	_	1,0
3. 00	Title V or XIX swing-bed NF inpatient routing (line 13 x line 20)	e costs arter L	becelliber 31 OT	the cost repo	n tring period	0	68.
. 00	Total title V or XIX swing-bed NF inpatient	routine costs ((line 67 + line	e 68)		0	69.
	PART III - SKILLED NURSING FACILITY, OTHER NU	JRSING FACILITY	, AND ICF/IID	ONLY			
. 00	Skilled nursing facility/other nursing facil						70.
. 00	Adjusted general inpatient routine service of Program routine service cost (line 9 x line		ine /U ÷ line	2)			71.
. 00	Medically necessary private room cost applications		n (line 14 x Li	ine 35)			73
. 00	Total Program general inpatient routine serv		•				74
. 00	Capital-related cost allocated to inpatient	routine service	costs (from	Norksheet B, F	art II, column		75.
	26, line 45)	->					l
00	Program capital related costs (line 75 ÷ line Program capital related costs (line 9 × line	. *					76
00	Program capital-related costs (line 9 x line Inpatient routine service cost (line 74 minus						78
00	Aggregate charges to beneficiaries for excess		provi den recon	ds)			79
00	Total Program routine service costs for compa				ius line 79)		80
00	Inpatient routine service cost per diem limi	tati on			<i>'</i>		81
00	Inpatient routine service cost limitation (•				82
00	Reasonable inpatient routine service costs (ns)				83
00	Program inpatient ancillary services (see in:		ne)				84
. 00	Utilization review - physician compensation Total Program inpatient operating costs (sum						85
). ()()			509.1 00/				1 ~~.
. 00	PART IV - COMPUTATION OF OBSERVATION BED PASS	S THRUUGH CUST					

Health Financial Systems	UNTI NGTON MEMO	RIAL HOSPITAL		In Lie	u of Form CMS-2	2552-10
COMPUTATION OF INPATIENT OPERATING COST		Provi der CC		Peri od:	Worksheet D-1	
				From 01/01/2023 Fo 12/31/2023		
		Title	e XIX	Hospi tal	PPS	
Cost Center Description						
					1.00	
89.00 Observation bed cost (line 87 x line 88) (se	e instructions))			2, 787, 760	89. 00
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, 238, 343	10, 502, 603	0. 11790	2, 787, 760	328, 699	90.00
91.00 Nursing Program cost	0	10, 502, 603	0.00000	2, 787, 760	0	91.00
92.00 Allied health cost	o	10, 502, 603	0.00000	2, 787, 760	0	92.00
93.00 All other Medical Education	О	10, 502, 603	0. 00000	2, 787, 760	0	93.00

NPATI ENT	ANCILLARY SERVICE COST APPORTIONMENT	Provi der C	CN: 15-0091	Peri od: From 01/01/2023 To 12/31/2023	Worksheet D-3 Date/Time Pre 5/23/2024 4:2	epare
		Title	XVIII	Hospi tal	PPS	
	Cost Center Description		Ratio of Cos	st Inpatient	I npati ent	
			To Charges	Program	Program Costs	
				Charges	(col. 1 x	
					col . 2)	
			1.00	2. 00	3. 00	
INPA	ATIENT ROUTINE SERVICE COST CENTERS					
0.00 0300	DO ADULTS & PEDIATRICS			2, 611, 994		30.
3.00 0430	DO NURSERY					43.
ANCI	LLARY SERVICE COST CENTERS					1
0.00	OO OPERATING ROOM		0. 0697	29 629, 883	43, 921	T 50.
0500	O1 OPERATING ROOM		0.0000		0	50.
2.00 0520	DO DELIVERY ROOM & LABOR ROOM		0. 3038	78 0	0	1
	OO ANESTHESI OLOGY		0. 5535		0	
	DO RADI OLOGY-DI AGNOSTI C		0. 1317		146, 261	54.
	DO LABORATORY		0. 1185			
	50 BLOOD CLOTTING FOR HEMOPHILIACS		0.0000		1	1
	00 RESPI RATORY THERAPY		0. 2217			
	DO PHYSI CAL THERAPY		0. 5284			
	OO OCCUPATI ONAL THERAPY		0. 2449			
	OO SPEECH PATHOLOGY		0. 3679			
	00 ELECTROCARDI OLOGY		0. 0387		13, 295	
	00 MEDICAL SUPPLIES CHARGED TO PATIENT		0. 2836			
	OO IMPL. DEV. CHARGED TO PATIENTS		0. 2325			
	DO DRUGS CHARGED TO PATIENTS		0. 2091			
	27 CARDI AC REHABI LI TATI ON		0. 0000		227, 447	1
	98 HYPERBARIC OXYGEN THERAPY		0. 3404			
	99 LI THOTRI PSY		0. 0000		4, 367	
	00 ALLOGENEIC HSCT ACQUISITION		0.0000		0	
	OO CAR T-CELL IMMUNOTHERAPY		0.0000	00 0	0	/8.
	PATIENT SERVICE COST CENTERS		0.2027	F1 0		1
	OO CLINIC		0. 2926		1	1
	DO EMERGENCY		0. 0915			1
	OO OBSERVATION BEDS (NON-DISTINCT PART		0. 5872	77 0	0	92.
	ER REIMBURSABLE COST CENTERS				<u> </u>	٠
	DO AMBULANCE SERVICES					95.
00.00	Total (sum of lines 50 through 94 and 96 through 98)			7, 778, 759	1, 144, 796	1
01.00	Less PBP Clinic Laboratory Services-Program only charg	es (line 61)		0		201.
02.00	Net charges (line 200 minus line 201)		1	7, 778, 759		202

NPATIENT AND	CILLARY SERVICE COST APPORTIONMENT	Provi der C	CN: 15-0091	Peri od: From 01/01/2023 To 12/31/2023	Worksheet D-3 Date/Time Pre 5/23/2024 4:2	epare
		Ti tl	e XIX	Hospi tal	PPS	p
(Cost Center Description		Ratio of Cos		Inpatient	
	'		To Charges		Program Costs	
				Charges	(col. 1 x	
					col . 2)	
			1.00	2. 00	3. 00	
INPATII	ENT ROUTINE SERVICE COST CENTERS		•			
0.00 03000 A	ADULTS & PEDIATRICS			199, 415		30.
3. 00 04300 N	IURSERY			51, 830		43.
	ARY SERVICE COST CENTERS					
	PERATING ROOM		0.0697	29 276, 694	19, 294	50.
0. 01 05001 0	OPERATING ROOM		0.0000	00 0	0	50.
2. 00 05200 1	DELIVERY ROOM & LABOR ROOM		0. 3038	78 78, 734	23, 926	52.
	NESTHESI OLOGY		0. 5535		0	
4. 00 05400 F	RADI OLOGY-DI AGNOSTI C		0. 1317	53 46, 340	6, 105	54.
	ABORATORY		0. 1185		17, 662	
	BLOOD CLOTTING FOR HEMOPHILIACS		0.0000		0	
	RESPI RATORY THERAPY		0. 2217		5, 769	
	PHYSI CAL THERAPY		0. 5284		1, 429	
	OCCUPATI ONAL THERAPY		0. 2449		135	1
	SPEECH PATHOLOGY		0. 3679	03 2, 580	949	68.
	ELECTROCARDI OLOGY		0. 0387		131	
	MEDICAL SUPPLIES CHARGED TO PATIENT		0. 2836		3, 460	71.
	MPL. DEV. CHARGED TO PATIENTS		0. 2325		0	1
	DRUGS CHARGED TO PATIENTS		0. 2091		21, 049	73.
	CARDI AC REHABI LI TATI ON		0.0000		0	
	IYPERBARI C OXYGEN THERAPY		0. 3404		865	
5. 99 07699 L			0.0000		0	1
	ALLOGENEIC HSCT ACQUISITION		0.0000		0	
	CAR T-CELL IMMUNOTHERAPY		0.0000		0	1
	ENT SERVICE COST CENTERS					
0.00 09000 0			0. 2926	51 0	0	90.
	EMERGENCY		0. 0915		8, 254	
	DBSERVATION BEDS (NON-DISTINCT PART		0. 5872		0, 201	1
	REIMBURSABLE COST CENTERS		0.0072	,		1 /2.
	MBULANCE SERVICES					95.
	otal (sum of lines 50 through 94 and 96 through	98)		791, 600	109, 028	
	Less PBP Clinic Laboratory Services-Program only			, , 1, 000	107,020	201.
	let charges (line 200 minus line 201)	charges (True 01)		791, 600		202.

Health Financial Systems	HUNTINGTON MEMORIAL HOSPITAL	In Lieu of Form CMS-2552		
CALCULATION OF REIMBURSEMENT SETTLEMENT	Provi der CCN: 15-0091	From 01/01/2023 To 12/31/2023	Worksheet E Part A Date/Time Prepared: 5/23/2024 4:22 pm	

	Title XVIII	Hospi tal	5/23/2024 4: 2 PPS	2 pm
			1. 00	
	PART A - INPATIENT HOSPITAL SERVICES UNDER IPPS		1.00	
1. 00 1. 01	DRG Amounts Other than Outlier Payments DRG amounts other than outlier payments for discharges occurring prior to October 1 (see instructions)		0 1, 964, 375	1. 00 1. 01
1. 02	DRG amounts other than outlier payments for discharges occurring on or after October 1 (slinstructions)	ee	790, 084	1. 02
1. 03	DRG for federal specific operating payment for Model 4 BPCI for discharges occurring prio 1 (see instructions)	r to October	. 0	1. 03
1. 04	DRG for federal specific operating payment for Model 4 BPCI for discharges occurring on o October 1 (see instructions)	r after	0	1.04
2. 00	Outlier payments for discharges. (see instructions) Outlier reconciliation amount		0	2.00
2. 02 2. 03 2. 04	Outlier payment for discharges for Model 4 BPCI (see instructions) Outlier payments for discharges occurring prior to October 1 (see instructions) Outlier payments for discharges occurring on or after October 1 (see instructions)		0	2. 02 2. 03 2. 04
3. 00 4. 00	Managed Care Simulated Payments Bed days available divided by number of days in the cost reporting period (see instruction)	ne)	0 31. 04	3. 00 4. 00
5. 00	Indirect Medical Education Adjustment FTE count for allopathic and osteopathic programs for the most recent cost reporting period FTE count for allopathic and osteopathic programs for the most recent cost reporting period			5.00
5. 00	or before 12/31/1996. (see instructions) FTE cap adjustment for qualifing hospitals under §131 of the CAA 2021 (see instructions)	ba enaring of	0.00	5. 01
6. 00	FTE count for allopathic and osteopathic programs that meet the criteria for an add-on to new programs in accordance with 42 CFR 413.79(e)	the cap for		6.00
6. 26	Rural track program FTE cap limitation adjustment after the cap-building window closed un the CAA 2021 (see instructions)	der §127 of	0.00	6. 26
7. 00 7. 01	MMA Section 422 reduction amount to the IME cap as specified under 42 CFR §412.105(f)(1)(ACA § 5503 reduction amount to the IME cap as specified under 42 CFR §412.105(f)(1)(iv)(B		0. 00 0. 00	7. 00 7. 01
7. 02	cost report straddles July 1, 2011 then see instructions. Adjustment (increase or decrease) to the hospital's rural track program FTE limitation(s) track programs with a rural track for Medicare GME affiliated programs in accordance with and 87 FR 49075 (August 10, 2022) (see instructions)		0. 00	7. 02
8. 00	Adjustment (increase or decrease) to the FTE count for allopathic and osteopathic program affiliated programs in accordance with 42 CFR 413.75(b), 413.79(c)(2)(iv), 64 FR 26340 (M 1998), and 67 FR 50069 (August 1, 2002).		0.00	8. 00
8. 01	The amount of increase if the hospital was awarded FTE cap slots under § 5503 of the ACA. report straddles July 1, 2011, see instructions.	If the cost	0.00	8. 01
8. 02	The amount of increase if the hospital was awarded FTE cap slots from a closed teaching hunder § 5506 of ACA. (see instructions)		0. 00	8. 02
8. 21	The amount of increase if the hospital was awarded FTE cap slots under §126 of the CAA 20 instructions)		0.00	8. 21
9. 00	Sum of lines 5 and 5.01, plus line 6, plus lines 6.26 through 6.49, minus lines 7 and 7.0 minus line 7.02, plus/minus line 8, plus lines 8.01 through 8.27 (see instructions) FTE count for allopathic and osteopathic programs in the current year from your records	i, plus or	0. 00	9.00
11. 00 12. 00	FTE count for residents in dental and podiatric programs. Current year allowable FTE (see instructions)		0. 00	11.00
13.00	Total allowable FTE count for the prior year.	20 1007	0. 00	13.00
14. 00	Total allowable FTE count for the penultimate year if that year ended on or after Septemb otherwise enter zero.	er 30, 1997,		14.00
	Adjustment for residents in initial years of the program (see instructions)		0. 00	15. 00 16. 00
17. 00 18. 00	Adjustment for residents displaced by program or hospital closure Adjusted rolling average FTE count		0. 00	17. 00 18. 00
19. 00 20. 00	Current year resident to bed ratio (line 18 divided by line 4). Prior year resident to bed ratio (see instructions)		0. 000000 0. 000000	ı
21.00			0. 000000	
22. 00 22. 01	IME payment adjustment (see instructions) IME payment adjustment - Managed Care (see instructions)		0	22. 00 22. 01
23. 00	Indirect Medical Education Adjustment for the Add-on for § 422 of the MMA Number of additional allopathic and osteopathic IME FTE resident cap slots under 42 CFR 4 (f)(1)(iv)(C).	12. 105	0.00	23. 00
24. 00 25. 00	IME FTE Resident Count Over Cap (see instructions) If the amount on line 24 is greater than -O-, then enter the lower of line 23 or line 24	(588	0. 00 0. 00	1
26. 00	instructions) Resident to bed ratio (divide line 25 by line 4)	(300	0. 000000	
27. 00 28. 00	IME payments adjustment factor. (see instructions) IME add-on adjustment amount (see instructions)		0. 000000 0	27. 00 28. 00
28. 01	IME add-on adjustment amount - Managed Care (see instructions)		0	28. 01
29. 00 29. 01	Total IME payment (sum of lines 22 and 28) Total IME payment - Managed Care (sum of lines 22.01 and 28.01)		0	29. 00 29. 01
30. 00	Disproportionate Share Adjustment Percentage of SSI recipient patient days to Medicare Part A patient days (see instruction	s)	3. 53	30.00
31.00	Percentage of Medicaid patient days (see instructions)		26. 41 20. 04	•
32. 00 33. 00	Sum of lines 30 and 31 Allowable disproportionate share percentage (see instructions)		29. 94 12. 00	32. 00 33. 00

	Financial Systems HUNTINGTON MEMORATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 15-0091	Period:	u of Form CMS-2	2552-10
CALCUL	ATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 15-0091	From 01/01/2023 To 12/31/2023	Worksheet E Part A Date/Time Pre	pared:
		Title XVIII	Hospi tal	5/23/2024 4: 2 PPS	2 pm
		THE AVITE	поэрг саг	'	
34 00	Disproportionate share adjustment (see instructions)			1. 00 82, 634	24 00
34.00	proportionate share adjustment (see Tristructions)		Prior to 10/1		34.00
			1. 00	2. 00	
25 00	Uncompensated Care Payment Adjustment		4 074 402 450	E 020 00/ 7E7	25 00
35. 00 35. 01	Total uncompensated care amount (see instructions) Factor 3 (see instructions)		6, 874, 403, 459 0. 000095130	5, 938, 006, 757 0. 000098317	
35. 02	Hospital UCP, including supplemental UCP (see instructions)		653, 962	583, 807	35. 02
35. 03			489, 128	146, 749	
36. 00		dib (li 40 th	635, 877		36.00
40. 00	Additional payment for high percentage of ESRD beneficiary Total Medicare discharges (see instructions)	discharges (lines 40 thro	ougn 46)		40.00
41. 00	Total ESRD Medicare discharges (see instructions)		0		41.00
41.01	Total ESRD Medicare covered and paid discharges (see instru	ctions)	0		41.01
42.00	Divide line 41 by line 40 (if less than 10%, you do not qua	lify for adjustment)	0.00		42.00
43. 00 44. 00	Total Medicare ESRD inpatient days (see instructions)	d by line 41 divided by	7 0. 000000		43. 00 44. 00
44.00	Ratio of average length of stay to one week (line 43 divide days)	a by Title 41 divided by	0.00000		44.00
45.00	Average weekly cost for dialysis treatments (see instruction	ns)	0.00		45.00
	Total additional payment (line 45 times line 44 times line	41. 01)	0		46.00
47. 00	Subtotal (see instructions)		3, 472, 970		47.00
48. 00	Hospital specific payments (to be completed by SCH and MDH, only. (see instructions)	smail rurai nospitais	0		48. 00
	join y. (See Tristractions)			Amount	
	I			1. 00	
49. 00 50. 00	Total payment for inpatient operating costs (see instruction		,)	3, 472, 970	
51.00	Payment for inpatient program capital (from Wkst. L, Pt. I Exception payment for inpatient program capital (Wkst. L, P	• • • • • • • • • • • • • • • • • • • •	*	208, 405 0	51.00
52. 00	Direct graduate medical education payment (from Wkst. E-4,			0	52.00
53.00	Nursing and Allied Health Managed Care payment			0	53.00
54.00	Special add-on payments for new technologies			0	54.00
54. 01 55. 00	Islet isolation add-on payment	40)		0	54. 01 55. 00
55. 01	Net organ acquisition cost (Wkst. D-4 Pt. III, col. 1, line Cellular therapy acquisition cost (see instructions)	: 69)		0	55. 00
56. 00	Cost of physicians' services in a teaching hospital (see in	tructions)		0	56.00
57.00	Routine service other pass through costs (from Wkst. D, Pt.	III, column 9, lines 30	through 35).	0	57.00
58. 00	Ancillary service other pass through costs from Wkst. D, Pt	. IV, col. 11 line 200)		0	
59. 00 60. 00	Total (sum of amounts on lines 49 through 58) Primary payer payments			3, 681, 375 9, 008	
61. 00	Total amount payable for program beneficiaries (line 59 min	us line 60)		3, 672, 367	
62. 00	Deductibles billed to program beneficiaries			439, 278	•
63.00	Coinsurance billed to program beneficiaries			0	63.00
	Allowable bad debts (see instructions)			39, 710	
	Adjusted reimbursable bad debts (see instructions) Allowable bad debts for dual eligible beneficiaries (see in	etructions)		25, 812 4, 945	
67. 00	Subtotal (line 61 plus line 65 minus lines 62 and 63)	structions)		3, 258, 901	67.00
68. 00	Credits received from manufacturers for replaced devices fo	r applicable to MS-DRGs	(see instructions)	0	68.00
69. 00	Outlier payments reconciliation (sum of lines 93, 95 and 96).(For SCH see instruction	ons)	0	69.00
70.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)			0	70.00
70. 50 70. 75	Rural Community Hospital Demonstration Project (§410A Demon N95 respirator payment adjustment amount (see instructions)		e instructions)	0	70. 50 70. 75
70. 75 70. 87	Demonstration payment adjustment amount (see instructions)			0	70. 75
70. 88	SCH or MDH volume decrease adjustment (contractor use only)			0	70. 88
70. 89	Pioneer ACO demonstration payment adjustment amount (see in				70. 89
70. 90	HSP bonus payment HVBP adjustment amount (see instructions)			0	
70. 91	HSP bonus payment HRR adjustment amount (see instructions)			0	70. 91
70. 92 70. 93	Bundled Model 1 discount amount (see instructions) HVBP payment adjustment amount (see instructions)			0	70. 92 70. 93
	, , , , , , , , , , , , , , , , , , , ,			0	70. 93
10. 74	HRR adjustment amount (see instructions) Recovery of accelerated depreciation				

Heal th	Financial Systems HUNTINGTON MEMORIA	AL HOSPITAL		In Lieu	u of Form CMS-2	2552-10
CALCUL	ATION OF REIMBURSEMENT SETTLEMENT	Provi der Co		Peri od:	Worksheet E	
				From 01/01/2023 To 12/31/2023	Part A Date/Time Pre	nared:
				10 12/31/2023	5/23/2024 4: 2	2 pm
		Title	XVIII	Hospi tal	PPS	
			FFY	(уууу)	Amount	
				0	1.00	
70. 96	Low volume adjustment for federal fiscal year (yyyy) (Enter i	n column 0	2	2023	445, 619	70. 96
70. 97	the corresponding federal year for the period prior to 10/1) Low volume adjustment for federal fiscal year (yyyy) (Enter i	n column 0	2	2023	185, 962	70. 97
10. 71	the corresponding federal year for the period ending on or af			.023	105, 702	70.97
70. 98	Low Volume Payment-3	10/1/		0	0	70. 98
	HAC adjustment amount (see instructions)				12, 549	
	Amount due provider (line 67 minus lines 68 plus/minus lines	69 & 70)			3, 877, 933	71.00
71. 01	Sequestration adjustment (see instructions)				77, 559	71. 01
71. 02	Demonstration payment adjustment amount after sequestration				0	71. 02
	Sequestration adjustment-PARHM pass-throughs					71.03
	Interim payments				3, 759, 639	
	Interim payments-PARHM					72. 01
	Tentative settlement (for contractor use only)				0	
	Tentative settlement-PARHM (for contractor use only)	20			40.725	73. 01
74. 00	Balance due provider/program (line 71 minus lines 71.01, 71.073)	12, 72, and			40, 735	74.00
74. 01	Balance due provider/program-PARHM (see instructions)					74. 01
	Protested amounts (nonallowable cost report items) in accorda	nce with			104, 625	1
70.00	CMS Pub. 15-2, chapter 1, §115.2	ince wi tii			101,020	70.00
	TO BE COMPLETED BY CONTRACTOR (lines 90 through 96)		'	'		
90.00	Operating outlier amount from Wkst. E, Pt. A, line 2, or sum	of 2.03			0	90.00
	plus 2.04 (see instructions)					
	Capital outlier from Wkst. L, Pt. I, line 2				0	
	Operating outlier reconciliation adjustment amount (see instr				0	
	Capital outlier reconciliation adjustment amount (see instruc				0	
	The rate used to calculate the time value of money (see instr				0.00	
	Time value of money for operating expenses (see instructions) Time value of money for capital related expenses (see instructions)				0	
90.00	Trille value of money for capital related expenses (see fristruc	tions)		Prior to 10/1	On/After 10/1	90.00
				1.00	2.00	
	HSP Bonus Payment Amount					
100.00	HSP bonus amount (see instructions)			0	0	100.00
	HVBP Adjustment for HSP Bonus Payment					
	HVBP adjustment factor (see instructions)			0. 0000000000	0. 0000000000	
102.00	HVBP adjustment amount for HSP bonus payment (see instruction	s)		0	0	102.00
	HRR Adjustment for HSP Bonus Payment					
	HRR adjustment factor (see instructions)	`		0. 0000	0. 0000	
104.00	HRR adjustment amount for HSP bonus payment (see instructions Rural Community Hospital Demonstration Project (§410A Demonst		iotmont	0	0	104. 00
200 00	Is this the first year of the current 5-year demonstration pe					200. 00
200.00	Century Cures Act? Enter "Y" for yes or "N" for no.	irrod dildei	the 21st			200.00
	Cost Reimbursement					
201.00	Medicare inpatient service costs (from Wkst. D-1, Pt. II, Iir	e 49)				201. 00
	Medicare discharges (see instructions)	•				202. 00
	Case-mix adjustment factor (see instructions)					203.00
203.00	Computation of Demonstration Target Amount Limitation (N/A in					4

HRR Adjustment for HSP Bonus Payment		
103.00 HRR adjustment factor (see instructions)	0.0000	0.0000 103.00
104.00 HRR adjustment amount for HSP bonus payment (see instructions)	0	0 104.00
Rural Community Hospital Demonstration Project (§410A Demonstration) Adjustment		
200.00 Is this the first year of the current 5-year demonstration period under the 21st		200. 00
Century Cures Act? Enter "Y" for yes or "N" for no.		
Cost Reimbursement		
201.00 Medicare inpatient service costs (from Wkst. D-1, Pt. II, line 49)		201.00
202.00 Medicare discharges (see instructions)		202.00
203.00 Case-mix adjustment factor (see instructions)		203. 00
Computation of Demonstration Target Amount Limitation (N/A in first year of the curren	t 5-year demonstra	ti on
peri od)		
204.00 Medicare target amount		204.00
205.00 Case-mix adjusted target amount (line 203 times line 204)		205. 00
206.00 Medicare inpatient routine cost cap (line 202 times line 205)		206. 00
Adjustment to Medicare Part A Inpatient Reimbursement		
207.00 Program reimbursement under the §410A Demonstration (see instructions)		207. 00
208.00 Medicare Part A inpatient service costs (from Wkst. E, Pt. A, line 59)		208. 00
209.00 Adjustment to Medicare IPPS payments (see instructions)		209. 00
210.00 Reserved for future use		210. 00
211.00 Total adjustment to Medicare IPPS payments (see instructions)		211. 00
Comparision of PPS versus Cost Reimbursement		
212.00 Total adjustment to Medicare Part A IPPS payments (from line 211)		212. 00
213.00 Low-volume adjustment (see instructions)		213. 00
218.00 Net Medicare Part A IPPS adjustment (difference between PPS and cost reimbursement)		218. 00
(line 212 minus line 213) (see instructions)		

Health Financial Systems	HUNTINGTON MEMORIAL HOSPITAL	In Lieu of Form CMS-2552-		
CALCULATION OF REIMBURSEMENT SETTLEMENT	Provi der CCN: 15-0091		Worksheet E Part B Date/Time Prepared: 5/23/2024 4:22 pm	

		Title XVIII	Hospi tal	5/23/2024 4: 2 PPS	2 pm
				1.00	
	PART B - MEDICAL AND OTHER HEALTH SERVICES			1.00	
1. 00	Medical and other services (see instructions)			0	1.00
2.00	Medical and other services reimbursed under OPPS (see instruc OPPS or REH payments	tions)		3, 850, 890 3, 645, 817	2. 00 3. 00
3. 00 4. 00	Outlier payment (see instructions)			3, 645, 817	4.00
4. 01	Outlier reconciliation amount (see instructions)			Ö	4. 01
5.00	Enter the hospital specific payment to cost ratio (see instru	ctions)		0. 859	5.00
6.00	Line 2 times line 5			3, 307, 915	6.00
7. 00 8. 00	Sum of lines 3, 4, and 4.01, divided by line 6 Transitional corridor payment (see instructions)			0.00	7. 00 8. 00
9. 00	Ancillary service other pass through costs including REH dire	ct graduate medical educ	cation costs from		9.00
	Wkst. D, Pt. IV, col. 13, line 200				
10. 00 11. 00	Organ acquisitions Total cost (sum of lines 1 and 10) (see instructions)			0	10.00 11.00
11.00	COMPUTATION OF LESSER OF COST OR CHARGES				11.00
	Reasonable charges				
12.00	Ancillary service charges			0	ı
13. 00 14. 00	Organ acquisition charges (from Wkst. D-4, Pt. III, col. 4, I Total reasonable charges (sum of lines 12 and 13)	ine 69)		0	13. 00 14. 00
14.00	Customary charges				14.00
15.00	Aggregate amount actually collected from patients liable for	payment for services on	a charge basis	0	15.00
16. 00	Amounts that would have been realized from patients liable fo		on a chargebasis	0	16. 00
17. 00	had such payment been made in accordance with 42 CFR §413.13(Ratio of line 15 to line 16 (not to exceed 1.000000)	e)		0. 000000	17. 00
18. 00	Total customary charges (see instructions)			0.000000	18.00
19. 00	Excess of customary charges over reasonable cost (complete on	ly if line 18 exceeds li	ne 11) (see	0	19. 00
20.00	instructions)	:£ :== 11====	10) (20.00
20. 00	Excess of reasonable cost over customary charges (complete on instructions)	Ty IT Tine IT exceeds IT	ne 18) (See	0	20.00
21.00	Lesser of cost or charges (see instructions)			0	21.00
22. 00	Interns and residents (see instructions)			0	22.00
23. 00	Cost of physicians' services in a teaching hospital (see inst	ructi ons)		0 0 0 17	23. 00 24. 00
24. 00	Total prospective payment (sum of lines 3, 4, 4.01, 8 and 9) COMPUTATION OF REIMBURSEMENT SETTLEMENT			3, 645, 817	24.00
25.00	Deductibles and coinsurance amounts (for CAH, see instruction	s)		719, 170	25.00
26.00	Deductibles and Coinsurance amounts relating to amount on lin			0	26.00
27. 00	Subtotal [(lines 21 and 24 minus the sum of lines 25 and 26) instructions)	plus the sum of lines 22	2 and 23] (see	2, 926, 647	27. 00
28. 00	Direct graduate medical education payments (from Wkst. E-4, I	ine 50)		o	28. 00
28. 50	REH facility payment amount (see instructions)	•			28. 50
29.00	ESRD direct medical education costs (from Wkst. E-4, line 36)			0	29.00
30. 00 31. 00	Subtotal (sum of lines 27, 28, 28.50 and 29) Primary payer payments			2, 926, 647 357	1
32. 00	Subtotal (line 30 minus line 31)			2, 926, 290	•
	ALLOWABLE BAD DEBTS (EXCLUDE BAD DEBTS FOR PROFESSIONAL SERVI	CES)			
33.00	Composite rate ESRD (from Wkst. I-5, line 11)			0 E1 221	33.00
34. 00 35. 00	Allowable bad debts (see instructions) Adjusted reimbursable bad debts (see instructions)			51, 321 33, 359	•
36. 00	Allowable bad debts for dual eligible beneficiaries (see inst	ructi ons)		28, 270	
37.00	Subtotal (see instructions)			2, 959, 649	1
38. 00 39. 00	MSP-LCC reconciliation amount from PS&R OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)			0	38. 00 39. 00
39. 50	Pioneer ACO demonstration payment adjustment (see instruction	s)			39.50
39. 75	N95 respirator payment adjustment amount (see instructions)	•		0	39. 75
39. 97	Demonstration payment adjustment amount before sequestration			0	39. 97
39. 98 39. 99	Partial or full credits received from manufacturers for repla RECOVERY OF ACCELERATED DEPRECIATION	cea devices (see instruc	CTI ONS)	0	39. 98 39. 99
39. 99 40. 00	Subtotal (see instructions)			2, 959, 649	40.00
40. 01	Sequestration adjustment (see instructions)			59, 193	ı
40. 02	Demonstration payment adjustment amount after sequestration			0	40. 02
40. 03	Sequestration adjustment-PARHM pass-throughs			2 047 741	40.03
41. 00 41. 01	Interim payments Interim payments-PARHM			2, 867, 761	41. 00 41. 01
42. 00	Tentative settlement (for contractors use only)			0	42.00
42. 01	Tentative settlement-PARHM (for contractor use only)				42. 01
43.00	Balance due provider/program (see instructions)			32, 695	1
43. 01 44. 00	43.01 Balance due provider/program-PARHM (see instructions) 44.00 Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1,				43. 01 44. 00
77.00	\$115. 2		Shapter 1,		00
	TO BE COMPLETED BY CONTRACTOR				
90. 00 91. 00	Original outlier amount (see instructions) Outlier reconciliation adjustment amount (see instructions)			0	90. 00 91. 00
91.00	The rate used to calculate the Time Value of Money			0.00	
93. 00	Time Value of Money (see instructions)				93.00

Ith Financial Systems HUNTINGTON MEMORIAL HOSPITAL In Lieu			u of Form CMS-	2552-10	
CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 15-0091	Peri od:	Worksheet E	
			From 01/01/2023		
			To 12/31/2023	Date/Time Pre	pared:
				5/23/2024 4: 2	2 pm
		Title XVIII	Hospi tal	PPS	
				1. 00	
94.00 Total (sum of lines 91 and 93)				0	94.00
				1. 00	
MEDICARE PART B ANCILLARY COSTS					
200.00 Part B Combined Billed Days				0	200.00

| Peri od: | Worksheet E-1 | From 01/01/2023 | Part | | To | 12/31/2023 | Date/Time Prepared: | Provider CCN: 15-0091

				10 12/31/2023	5/23/2024 4: 2	
		Title	e XVIII	Hospi tal	PPS	
		Inpatier	nt Part A	Par	rt 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, 759, 63	9	2, 867, 761	1. 00
2.00	Interim payments payable on individual bills, either			0	0	2.00
	submitted or to be submitted to the contractor for					
	services rendered in the cost reporting period. If none,					
	write "NONE" or enter a zero					
3. 00	List separately each retroactive lump sum adjustment					3. 00
	amount based on subsequent revision of the interim rate					
	for the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					
	Program to Provider					
3. 01	ADJUSTMENTS TO PROVIDER			ol	0	3. 01
3. 02	ADJUSTIMENTS TO TROVIDER			0		3. 02
3. 03				Ö	0	3. 02
3. 04			1	o	0	3. 04
3. 05				Ö	0	3. 05
0.00	Provider to Program			<u> </u>		0.00
3.50	ADJUSTMENTS TO PROGRAM			0	0	3. 50
3. 51				0	0	3. 51
3. 52				0	0	3. 52
3. 53				0	0	3. 53
3.54			1	0	0	3.54
3. 99	Subtotal (sum of lines 3.01-3.49 minus sum of lines			0	0	3. 99
	3. 50-3. 98)					
4. 00	Total interim payments (sum of lines 1, 2, and 3.99)		3, 759, 63	9	2, 867, 761	4. 00
	(transfer to Wkst. E or Wkst. E-3, line and column as					
	appropriate) TO BE COMPLETED BY CONTRACTOR					
5. 00	List separately each tentative settlement payment after					5. 00
5.00	desk review. Also show date of each payment. If none,					3.00
	write "NONE" or enter a zero. (1)					
	Program to Provider					
5. 01	TENTATI VE TO PROVI DER			0	0	5. 01
5.02				0	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		40, 73	5	32, 695	6. 01
6. 02	SETTLEMENT TO PROGRAM			О	0	6. 02
7.00	Total Medicare program liability (see instructions)		3, 800, 37	4	2, 900, 456	7.00
				Contractor	NPR Date	
				Number	(Mo/Day/Yr)	
0.00			0	1. 00	2. 00	0.5
8.00	Name of Contractor				1	8. 00

Heal th	Health Financial Systems HUNTINGTON MEMORIAL HOSPITAL In Lieu			u of Form CMS-	2552-10
CALCU				Worksheet E-1	
			From 01/01/2023 To 12/31/2023		epared:
				5/23/2024 4: 2	
		Title XVIII	Hospi tal	PPS	
				1.00	
	TO DE COMPLETED DV CONTRACTOR FOR MONCTANDARD COCT REPORTS			1. 00	
	TO BE COMPLETED BY CONTRACTOR FOR NONSTANDARD COST REPORTS HEALTH INFORMATION TECHNOLOGY DATA COLLECTION AND CALCULATION	N			+
1. 00	Total hospital discharges as defined in AARA §4102 from Wkst		e 14		1.00
2.00					
3.00 Medicare HMO days from Wkst. S-3, Pt. I, col. 6. line 2					2. 00 3. 00
4.00	Total inpatient days (see instructions)				4.00
5.00	Total hospital charges from Wkst C, Pt. I, col. 8 line 200				5.00
6.00	Total hospital charity care charges from Wkst. S-10, col. 3				6.00
7. 00	CAH only - The reasonable cost incurred for the purchase of	certified HIT technology	Wkst. S-2, Pt. I		7. 00
0.00	line 168				0.00
8. 00 9. 00	Calculation of the HIT incentive payment (see instructions)				8. 00 9. 00
10.00	Sequestration adjustment amount (see instructions) Calculation of the HIT incentive payment after sequestration	(soo instructions)			10.00
10.00	INPATIENT HOSPITAL SERVICES UNDER THE IPPS & CAH	(see Histractions)			10.00
30.00	Initial/interim HIT payment adjustment (see instructions)				30.00
	31.00 Other Adjustment (specify)				
	Balance due provider (line 8 (or line 10) minus line 30 and	line 31) (see instructio	ns)		31. 00 32. 00

Health Financial Systems HUNTINGTON MEMORIAL HOSPITAL In Lieu			u of Form CMS-2	552-10	
			Worksheet E-5		
			From 01/01/2023 To 12/31/2023	Date/Time Prep 5/23/2024 4:22	oared: 2 pm
		Title XVIII		PPS	
				1. 00	
	TO BE COMPLETED BY CONTRACTOR				
1.00	Operating outlier amount from Wkst. E, Pt. A, line 2, or sum	of 2.03 plus 2.04 (see	instructions)	0	1.00
2.00	Capital outlier from Wkst. L, Pt. I, line 2			0	2.00
3.00	Operating outlier reconciliation adjustment amount (see instr	ructions)		0	3.00
4.00 Capital outlier reconciliation adjustment amount (see instructions)				0	4.00
5.00 The rate used to calculate the time value of money (see instructions)				0.00	5.00
6.00 Time value of money for operating expenses (see instructions)				0	6.00
7.00 Time value of money for capital related expenses (see instructions)				0	7.00

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: From 01/01/2023 To 12/31/2023 Date/Time Prepared: 5/23/2024 4:22 pm

UIII y)	<u> </u>				5/23/2024 4: 2	2 pm
		General Fund	Speci fi c	Endowment	Plant Fund	
		1.00	Purpose Fund 2.00	Fund 3. 00	4. 00	
	CURRENT ASSETS					
1. 00	Cash on hand in banks	2, 324		0	0	1.00
2.00	Temporary investments	0	0	0		2.00
3.00	Notes recei vable	22 027 070	0	0	0	3.00
4. 00 5. 00	Accounts receivable Other receivable	23, 837, 978		0	0	4. 00 5. 00
6. 00	Allowances for uncollectible notes and accounts receivable	-12, 907, 037	,	0	0	6.00
7. 00	Inventory	497, 185		0	0	7. 00
8.00	Prepai d expenses	85, 416		0	0	8. 00
9.00	Other current assets	0	0	0	0	9. 00
10.00	Due from other funds	24, 874, 232		0	0	10.00
11. 00	Total current assets (sum of lines 1-10)	36, 390, 098	0	0	0	11.00
12. 00	FIXED ASSETS Land	1 0	ol ol	0	0	12.00
13. 00	Land improvements	651, 731		0	0	13.00
14. 00	Accumulated depreciation	-548, 872		0	ő	14.00
15.00	Bui I di ngs	10, 302, 302		0	0	15.00
16.00	Accumulated depreciation	-3, 602, 696	0	0	0	16.00
17.00	Leasehold improvements	1, 386, 894		0	0	17.00
18. 00	Accumulated depreciation	-650, 234		0	0	18.00
19.00	Fixed equipment	374, 191		0	0	19.00
20. 00 21. 00	Accumulated depreciation Automobiles and trucks	-287, 861		0	0	20. 00 21. 00
22.00	Accumulated depreciation	1, 231, 513 -712, 313		0	0	22.00
23. 00	Major movable equipment	11, 347, 691		0	0	23.00
24. 00	Accumulated depreciation	-8, 543, 673		0	o O	24.00
25. 00	Mi nor equipment depreciable	2, 133, 920		0	0	25. 00
26.00	Accumulated depreciation	-1, 205, 342	. 0	0	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	270, 890		0	0	29.00
30. 00	Total fixed assets (sum of lines 12-29)	12, 148, 141	0	0	0	30.00
31. 00	OTHER ASSETS Investments	48, 557, 103	0	0	0	31.00
32. 00	Deposits on Leases	40, 337, 103		0	Ö	32.00
33. 00	Due from owners/officers	0	o	0	0	33.00
34.00	Other assets	246, 000	0	0	0	34.00
35.00	Total other assets (sum of lines 31-34)	48, 803, 103		0	0	35.00
36. 00	Total assets (sum of lines 11, 30, and 35)	97, 341, 342	. 0	0	0	36.00
27.00	CURRENT LI ABI LI TI ES	1 072 (22	J ol	0	0	1 27 00
37. 00 38. 00	Accounts payable Salaries, wages, and fees payable	1, 073, 623 1, 045, 523		0	0	37. 00 38. 00
39. 00	Payrol I taxes payable	1,043,323		0	0	39.00
40.00	Notes and Loans payable (short term)	286, 749	Ö	0	Ö	40.00
41.00	Deferred income	0	0	0	0	41.00
42.00	Accel erated payments	0)			42.00
43.00	Due to other funds	0	0	0	0	43.00
44.00	Other current liabilities	3, 738, 379		0	0	44.00
45. 00	Total current liabilities (sum of lines 37 thru 44) LONG TERM LIABILITIES	6, 144, 274	. 0	0	0	45. 00
46. 00	Mortgage payable		ol	0	0	46.00
47. 00	Notes payable	440, 033		0	0	47.00
48. 00	Unsecured Loans	0	o o	0		48. 00
49.00	Other long term liabilities	0	0	0	0	49.00
50.00	Total long term liabilities (sum of lines 46 thru 49)	440, 033	0	0		50.00
51.00	Total liabilities (sum of lines 45 and 50)	6, 584, 307	0	0	0	51.00
	CAPITAL ACCOUNTS	00 757 005				
52. 00 53. 00	General fund balance	90, 757, 035				52.00
54.00	Specific purpose fund Donor created - endowment fund balance - restricted		٥	0		53. 00 54. 00
55. 00	Donor created - endowment fund balance - restricted			0		55.00
56.00	Governing body created - endowment fund balance			0		56.00
57. 00	Plant fund balance - invested in plant			9	0	57.00
58.00	Plant fund balance - reserve for plant improvement,				0	58. 00
	replacement, and expansion					
59.00	Total fund balances (sum of lines 52 thru 58)	90, 757, 035		0	0	59.00
60.00	Total liabilities and fund balances (sum of lines 51 and 59)	97, 341, 342	0	0	0	60.00
	J 7 /	I	1		I	I

Provi der CCN: 15-0091

| Peri od: | Worksheet G-1 | From 01/01/2023 | To 12/31/2023 | Date/Time Prepared:

					To	o 12/31/2023	Date/Time Pre 5/23/2024 4:2	
		General	Fund	Speci al	Pu	rpose Fund	Endowment	
							Fund	
		1. 00	2.00	3. 00		4. 00	5. 00	
1. 00	Fund balances at beginning of period	1.00	78, 735, 772			4.00	5.00	1.00
2. 00	Net income (loss) (from Wkst. G-3, line 29)		11, 454, 039					2.00
3. 00	Total (sum of line 1 and line 2)		90, 189, 811			0	•	3.00
4.00	ADDITIONS (CREDIT ADJUSTMENTS)	91, 274			0		0	4.00
5.00	NONALLOWABLE HOME OFFICE INTEREST EX	483, 835			0		0	5. 00
6.00	TRANSFERS	7, 885			0		0	6. 00
7.00		0			0		0	7.00
8. 00 9. 00		0			0		0	8. 00 9. 00
10.00	Total additions (sum of line 4-9)	o _l	582, 994	•	U	0	U	10.00
11. 00	Subtotal (line 3 plus line 10)		90, 772, 805			0		11.00
12. 00	ASSET TRANSFERS	15, 770	70,772,000		0		0	
13.00		0			0		0	13.00
14.00		0			0		0	14.00
15. 00		0			0		0	15.00
16.00		0			0		0	16.00
17. 00 18. 00	Total deductions (sum of lines 12-17)	U	15. 770		U	0	0	17. 00 18. 00
19.00	Fund balance at end of period per balance		90, 757, 035			0		19.00
17.00	sheet (line 11 minus line 18)		70, 707, 000			J		17.00
		Endowment	PI ant	Fund				
		Fund		1				
		6. 00	7. 00	8.00				
1. 00	Fund balances at beginning of period	0			0			1.00
2.00	Net income (loss) (from Wkst. G-3, line 29)							2.00
3.00	Total (sum of line 1 and line 2)	0			0			3.00
4. 00 5. 00	ADDITIONS (CREDIT ADJUSTMENTS) NONALLOWABLE HOME OFFICE INTEREST EX		0					4. 00 5. 00
6. 00	TRANSFERS		0					6.00
7. 00	TRANSI ERS		0					7.00
8. 00			0					8.00
9.00			0					9. 00
10.00	Total additions (sum of line 4-9)	0			0			10.00
11. 00	Subtotal (line 3 plus line 10)	0			0			11.00
12.00	ASSET TRANSFERS		0					12.00
13. 00 14. 00			0					13. 00 14. 00
15.00			0					15.00
16. 00			0					16.00
17. 00			0					17. 00
18.00	Total deductions (sum of lines 12-17)	0			0			18. 00
19. 00	Fund balance at end of period per balance	0			0			19. 00
	sheet (line 11 minus line 18)			I				

| Peri od: | Worksheet G-2 | From 01/01/2023 | Parts | & II | To | 12/31/2023 | Date/Time | Prepared: Health Financial Systems HUNSTATEMENT OF PATIENT REVENUES AND OPERATING EXPENSES Provider CCN: 15-0091

			To 12/31/2023	Date/Time Pre 5/23/2024 4:2	
	Cost Center Description	I npati ent	Outpati ent	Total	Z piii
		1.00	2. 00	3. 00	
	PART I - PATIENT REVENUES				
	General Inpatient Routine Services				
1.00	Hospi tal	12, 348, 00	9	12, 348, 009	1.00
2.00	SUBPROVI DER - I PF				2.00
3.00	SUBPROVI DER - I RF				3.00
4.00	SUBPROVI DER				4.00
5.00	Swing bed - SNF			0	5. 00
6.00	Swing bed - NF			0	6. 00
7. 00	SKILLED NURSING FACILITY				7. 00
8. 00	NURSING FACILITY				8. 00
9. 00	OTHER LONG TERM CARE				9. 00
10.00	Total general inpatient care services (sum of lines 1-9)	12, 348, 00	9	12, 348, 009	10.00
	Intensive Care Type Inpatient Hospital Services	12/010/00	<u> </u>	12/010/00/	
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 INTENSI VE CARE UNI T				14. 00
15. 00	OTHER SPECIAL CARE (SPECIFY)				15.00
16. 00	Total intensive care type inpatient hospital services (sum of lines			0	16. 00
10.00	11-15)			O	10.00
17. 00	Total inpatient routine care services (sum of lines 10 and 16)	12, 348, 00		12, 348, 009	17. 00
18. 00	Ancillary services	42, 487, 06		42, 487, 063	18.00
19. 00	Outpati ent servi ces		204, 670, 475	204, 670, 475	19. 00
20.00	RURAL HEALTH CLINIC	1	0	204, 070, 479	20.00
21. 00	FEDERALLY QUALIFIED HEALTH CENTER	1		0	21.00
22. 00	HOME HEALTH AGENCY		7	U	22.00
23. 00	AMBULANCE SERVICES		24, 116, 910	24, 116, 910	23. 00
24. 00	CMHC		24, 110, 910	24, 110, 910	24.00
25. 00	AMBULATORY SURGICAL CENTER (D. P.)				25. 00
26. 00	HOSPICE				26.00
27. 00	OTHER (SPECIFY)			0	27.00
28. 00	Total patient revenues (sum of lines 17-27)(transfer column 3 to Wkst.	54, 835, 07	2 228, 787, 385	283, 622, 457	28.00
20.00	G-3, line 1)	34, 633, 07	220, 767, 363	203, 022, 437	20.00
	PART II - OPERATING EXPENSES				
29. 00	Operating expenses (per Wkst. A, column 3, line 200)		70, 196, 102		29. 00
30.00	ADD (SPECIFY)		0		30.00
31. 00		1	Ď		31.00
32. 00	HOME OFFICE INTEREST EXPENSE	483, 83	9		32. 00
33. 00	THE STATE OF THE ENDE		o l		33. 00
34. 00		•			34. 00
35. 00		•			35. 00
36. 00	Total additions (sum of lines 30-35)		483, 835		36.00
37. 00	DEDUCT (SPECIFY)		1		37. 00
38. 00	DEDUCT (SI ECITT)	1			38. 00
39. 00		1			39.00
40. 00		1			40.00
41. 00					41.00
41.00	Total deductions (sum of lines 37-41)		ر ا		41.00
42.00	Total operating expenses (sum of lines 29 and 36 minus line 42)(transf	or	70, 679, 937		43.00
43.00	to Wkst. G-3, line 4)	C1	10,017,931		43.00
	10 m3t. 0 0, 1116 4)	ı	1		1

Heal th	Health Financial Systems HUNTINGTON MEMORIAL HOSPITAL In Lieu o				
STATE	MENT OF REVENUES AND EXPENSES	Provider CCN: 15-0091	Peri od:	Worksheet G-3	
			From 01/01/2023 To 12/31/2023	Date/Time Pre 5/23/2024 4:2	
1.00	Table of the second of the sec	11		1.00	1.00
1. 00 2. 00	Total patient revenues (from Wkst. G-2, Part I, column 3,			283, 622, 457	
3. 00	Less contractual allowances and discounts on patients' acc Net patient revenues (line 1 minus line 2)	COUNTS		206, 959, 547 76, 662, 910	
4. 00	Less total operating expenses (from Wkst. G-2, Part II, Ii	no 42)		70, 679, 937	
5. 00	Net income from service to patients (line 3 minus line 4)	He 43)		5, 982, 973	
3.00	OTHER I NCOME			3, 702, 773	3.00
6. 00	Contributions, donations, bequests, etc			0	6.00
7. 00	Income from investments			4, 321, 515	7.00
8. 00	Revenues from telephone and other miscellaneous communication	tion services		0	1
9.00	Revenue from television and radio service			0	9.00
10.00				0	10.00
11.00	1.00 Rebates and refunds of expenses			0	11.00
12.00	Parking lot receipts			0	12.00
13.00	Revenue from Laundry and Linen service			0	1
	Revenue from meals sold to employees and guests			233, 871	14.00
	Revenue from rental of living quarters			0	
	Revenue from sale of medical and surgical supplies to other	er than patients		0	16.00
17. 00	3			64, 258	
	Revenue from sale of medical records and abstracts			0	
	Tuition (fees, sale of textbooks, uniforms, etc.)			0	
	Revenue from gifts, flowers, coffee shops, and canteen			34, 186	
	Rental of vending machines			0	
22. 00	Rental of hospital space			0	
23. 00	Governmental appropriations			0	
24.00	OTHER (SPECIFY)			0	
24. 01	EMS SUBSIDY			501, 176	
24. 02	OTHER OPERATING REVENUE			316, 060	
				0	
	Total other income (sum of lines 6-24)			5, 471, 066	
	Total (line 5 plus line 25) OTHER EXPENSES (SPECIFY)			11, 454, 039 0	1
	Total other expenses (sum of line 27 and subscripts)			0	1

0 28.00 11, 454, 039 29.00

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

	Financial Systems HUNTINGTON MEMORI			u of Form CMS-2	2552-10
CALCUL	ATION OF CAPITAL PAYMENT	Provider CCN: 15-0091	Peri od: From 01/01/2023 To 12/31/2023	Date/Time Pre	
-		Title XVIII	Hospi tal	5/23/2024 4: 2 PPS	2 piii
		THE AVIII	поэрт саг	113	
				1. 00	
	PART I - FULLY PROSPECTIVE METHOD				
	CAPITAL FEDERAL AMOUNT]
1.00	Capital DRG other than outlier			208, 217	1.00
1. 01	Model 4 BPCI Capital DRG other than outlier			0	1. 01
2.00	Capital DRG outlier payments			188	2.00
2. 01	Model 4 BPCI Capital DRG outlier payments			0	
3.00	Total inpatient days divided by number of days in the cost r	eporting period (see inst	ructions)	13. 44	
4. 00	Number of interns & residents (see instructions)			0.00	
5. 00	Indirect medical education percentage (see instructions)			0.00	
6. 00	Indirect medical education adjustment (multiply line 5 by th 1.01)(see instructions)	ne sum of lines 1 and 1.01	, columns 1 and	0	6.00
7. 00	Percentage of SSI recipient patient days to Medicare Part A 30) (see instructions)	patient days (Worksheet E	E, part A line	0. 00	7. 00
8.00	Percentage of Medicaid patient days to total days (see instr	uctions)		0.00	8.00
9.00	Sum of lines 7 and 8	ŕ		0.00	9.00
10.00	Allowable disproportionate share percentage (see instruction	ns)		0.00	10.00
11.00	Disproportionate share adjustment (see instructions)			0	11.00
12.00	Total prospective capital payments (see instructions)			208, 405	12.00
				1. 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)			0	2.00
3.00				0	3.00
4.00	Capital cost payment factor (see instructions)			0	4.00
5.00	Total inpatient program capital cost (line 3 x line 4)			0	5.00
				1. 00	
	PART III - COMPUTATION OF EXCEPTION PAYMENTS			1.00	
1.00	Program inpatient capital costs (see instructions)			0	1.00
2.00	Program inpatient capital costs for extraordinary circumstan	nces (see instructions)		0	2.00
3.00	Net program inpatient capital costs (line 1 minus line 2)	,		0	3.00
4.00	Applicable exception percentage (see instructions)			0.00	4.00
5.00	Capital cost for comparison to payments (line 3 x line 4)			0	5. 00
6.00	Percentage adjustment for extraordinary circumstances (see i	nstructions)		0.00	6.00
7.00	Adjustment to capital minimum payment level for extraordinar	ry circumstances (line 2 >	(line 6)	0	7.00
8.00	Capital minimum payment level (line 5 plus line 7)		·	0	8.00
9.00	Current year capital payments (from Part I, line 12, as appl	i cabl e)		0	9. 00
10.00	Current year comparison of capital minimum payment level to	capital payments (line 8	less line 9)	0	10.00
11. 00	Carryover of accumulated capital minimum payment level over Worksheet L, Part III, line 14)	capital payment (from pri	or year	0	11.00
12.00	Net comparison of capital minimum payment level to capital p	ayments (line 10 plus lir	ne 11)	0	12.00
13.00				0	13.00
14. 00	Carryover of accumulated capital minimum payment level over (if line 12 is negative, enter the amount on this line)	capital payment for the f	following period	0	14.00
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)			Ö	
17. 00	Current year exception offset amount (see instructions)			0	