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 01/01/2022 Parts I-III AND SETTLEMENT SUMMARY 12/31/2022 Date/Time Prepared: 5/18/2023 11:36 am PART I - COST REPORT STATUS Provi der 1. [X] Electronically prepared cost report Date: 5/18/2023 Time: 11:36 am Manually prepared cost report use only If this is an amended report enter the number of times the provider resubmitted this cost report Medicare Utilization. Enter "F" for full, "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 01/01/2022 and ending 12/31/2022 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	Jean	ne Wickens	Y	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	HI T	Title XIX	
		1. 00	2.00	3. 00	4. 00	5. 00	
	PART III - SETTLEMENT SUMMARY						
1.00	HOSPI TAL	0	226, 810	33, 028	0	0	1.00
2.00	SUBPROVI DER - I PF	0	0	0		0	2.00
3.00	SUBPROVI DER - I RF	0	0	0		0	3.00
5.00	SWING BED - SNF	0	0	0		0	5.00
6.00	SWING BED - NF	0				0	6.00
200.00	TOTAL	0	226, 810	33, 028	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.

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA Provider CCN: 15-0091 Peri od: Worksheet S-2 From 01/01/2022 Part I Date/Time Prepared: 12/31/2022 5/18/2023 11:36 am 3.00 4.00 Hospital and Hospital Health Care Complex Address: Street: 2001 STULTS ROAD 1.00 PO Box: 1.00 State: IN 2.00 City: HUNTINGTON Zi p Code: 46750 County: HUNTINGTON 2.00 Component Name CCN CBSA Provi der Date Payment System (P, T, 0, or N)
V | XVIII | XIX Certi fi ed Number Number Type 1.00 2.00 3.00 4.00 5.00 6.00 | 7.00 | 8.00 Hospital and Hospital-Based Component Identification: 3.00 HUNTINGTON MEMORIAL 150091 99915 07/01/1966 Ν 3.00 HOSPI TAI Subprovi der - IPF 4.00 4.00 5.00 Subprovi der - IRF 5.00 6.00 Subprovider - (Other) 6.00 Swing Beds - SNF 7 00 7 00 Swing Beds - NF 8.00 8.00 9.00 Hospital-Based SNF 9.00 10.00 Hospi tal -Based NF 10.00 11.00 Hospi tal -Based OLTC 11.00 12.00 Hospital -Based HHA 12.00 Separately Certified ASC 13.00 13.00 Hospi tal -Based Hospi ce 14.00 14.00 Hospital -Based Health Clinic - RHC 15 00 15 00 16.00 Hospital -Based Health Clinic - FQHC 16.00 17.00 Hospital -Based (CMHC) I 17.00 18.00 Renal Dialysis 18.00 19.00 Other 19.00 From 1.00 2.00 20.00 Cost Reporting Period (mm/dd/yyyy) 01/01/2022 12/31/2022 20.00 21.00 Type of Control (see instructions) 2 21.00 1.00 2.00 3.00 Inpatient PPS Information 22.00 Does this facility qualify and is it currently receiving payments for Υ N 22.00 disproportionate share hospital adjustment, in accordance with 42 CFR \$412.106? In column 1, enter "Y" for yes or "N" for no. Is this facility subject to 42 CFR Section §412.106(c)(2)(Pickle amendment hospital?) In column 2, enter "Y" for yes or "N" for no. Did this hospital receive interim UCPs, including supplemental UCPs, for 22.01 Ν Ν this cost reporting period? Enter in column 1, "Y" for yes or "N" for no for the portion of the cost reporting period occurring prior to October

1. Enter in column 2, "Y" for yes or "N" for no for the portion of the cost reporting period occurring on or after October 1. (see instructions) Is this a newly merged hospital that requires a final UCP to be Ν Ν 22.02 determined at cost report settlement? (see instructions) Enter in column 1, "Y" for yes or "N" for no, for the portion of the cost reporting period prior to October 1. Enter in column 2, "Y" for yes or "N" for no, for the portion of the cost reporting period on or after October 1. 22.03 Did this hospital receive a geographic reclassification from urban to 22.03 Ν Ν Ν rural as a result of the OMB standards for delineating statistical areas adopted by CMS in FY2015? Enter in column 1, "Y" for yes or "N" for no for the portion of the cost reporting period prior to October 1. Enter in column 2, "Y" for yes or "N" for no for the portion of the cost reporting period occurring on or after October 1. (see instructions) Does this hospital contain at least 100 but not more than 499 beds (as counted in accordance with 42 CFR 412.105)? Enter in column 3, "Y" for 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.

25. 00	4, Medicaid HMO paid and eligible but unpaid days in column 5, and other Medicaid days in column 6. If this provider is an IRF, enter the in-state Medicaid paid days in column 1, the in-state Medicaid paid days in column 1, the in-state out-of-state Medicaid eligible unpaid days in column 3, out-of-state Medicaid eligible unpaid days in column 4, Medicaid HMO paid and eligible but unpaid days in column 5.	0		0	0	0		0			25. 00
					-	Urban/F		SDate			4
26. 00	Enter your standard geographic classification (not w	age) status	s at the b	eginning o	f the	1.	00	2	2. 00)	26.00
	cost reporting period. Enter "1" for urban or "2" fo Enter your standard geographic classification (not w reporting period. Enter in column 1, "1" for urban o	r rural. age) status	s at the e	nd of the	cost			2			27. 00
35. 00	enter the effective date of the geographic reclassif If this is a sole community hospital (SCH), enter th effect in the cost reporting period.	ication in	column 2.					0			35.00
	periode in the coot ropertring period.					Begi n		E	ndi n		
26 00	Enter applicable beginning and ending dates of SCH s	tatue Sube	ecript lin	o 26 for n	umbor	1.	00		2. 00)	36.00
30.00	of periods in excess of one and enter subsequent dat		script iiii	e 30 101 111	ullibei						30.00
	If this is a Medicare dependent hospital (MDH), ente is in effect in the cost reporting period. Is this hospital a former MDH that is eligible for t		·		1			0			37. 00 37. 01
	accordance with FY 2016 OPPS final rule? Enter "Y" finstructions)	for yes or "	'N" for no	. (see							
38. 00	If line 37 is 1, enter the beginning and ending date greater than 1, subscript this line for the number o enter subsequent dates.										38.00
						Υ/			Y/N		
39. 00	Does this facility qualify for the inpatient hospita	l navmont s	adiustmont	for low w	ol umo	1.			2. 00 Y)	39.00
39.00	hospitals in accordance with 42 CFR §412.101(b)(2)(i 1 "Y" for yes or "N" for no. Does the facility meet accordance with 42 CFR 412.101(b)(2)(i), (ii), or (i), (ii), or the mileage	r (iii)? E e requirem	nter in co ents in	lumn	'			'		37.00
40. 00	or "N" for no. (see instructions) Is this hospital subject to the HAC program reductio "N" for no in column 1, for discharges prior to Octo no in column 2, for discharges on or after October 1	ber 1. Ente	er "Y" for			١	′		N		40.00
	,	. (000					V			XIX	
	Prospective Payment System (PPS)-Capital						1. (00 2.	00	3. 00	
	Does this facility qualify and receive Capital payme with 42 CFR Section §412.320? (see instructions)								N	N	45. 00
46. 00	Is this facility eligible for additional payment exc pursuant to 42 CFR §412.348(f)? If yes, complete Wks Pt. III.						N	ı	N	N	46.00
	Is this a new hospital under 42 CFR §412.300(b) PPS					r no.	N		N	N	47.00
48. 00	Is the facility electing full federal capital paymen Teaching Hospitals	it? Enter "	'Y" for ye	s or "N" f	or no.		N		N	N	48. 00
56. 00	Is this a hospital involved in training residents in periods beginning prior to December 27, 2020, enter cost reporting periods beginning on or after Decembe the instructions. For column 2, if the response to cinvolved in training residents in approved GME progrand are you are impacted by CR 11642 (or applicable	"Y" for yes or 27, 2020, column 1 is cams in the CRs) MA dir	s or "N" f under 42 "Y", or i prior yea	or no in co CFR 413.75 f this hosp r or penul	olumn 8(b)(2 pital timate	1. For see was year,	- N	I			56.00
57.00	"Y" for yes; otherwise, enter "N" for no in column 2 For cost reporting periods beginning prior to Decemb is this the first cost reporting period during which at this facility? Enter "Y" for yes or "N" for no i residents start training in the first month of this "N" for no in column 2. If column 2 is "Y", complet complete Wkst. D, Parts III & IV and D-2, Pt. II, if beginning on or after December 27, 2020, under 42 CF which month(s) of the cost report the residents were	er 27, 2020 residents n column 1. cost report e Worksheet applicable R 413.77(e	in approv If colum ting perio t E-4. If e. For cos)(1)(iv)	ed GME pro in 1 is "Y", d? Enter ' column 2 is t reporting and (v), re	grams , did "Y" fo s "N", g peri egardl	trained or yes d ods ess of	or	I			57.00

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 01/01/2022 Part I Date/Time Prepared: 12/31/2022 5/18/2023 11: 36 am 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 Are costs claimed on line 100 of Worksheet A? If yes, complete Wkst. D-2 59.00 NAHE 413.85 Worksheet A Pass-Through Y/N Line # Qualification 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

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

63.00

Health Financial Systems	HUNTI NGTO	ON MEMORIAL HOSPITAL		In Lie	u of Form CMS-	2552-10
HOSPITAL AND HOSPITAL HEALTH CARE COMP	LEX IDENTIFICATION DA	ATA Provider C		eriod: rom 01/01/2022	Worksheet S-2 Part I	!
				o 12/31/2022	Date/Time Pre	
			Unwei ghted	Unwei ghted	5/18/2023 11: Ratio (col.	30 alli
			FTEs	FTEs in	1/ (col. 1 +	
			Nonprovider Site	Hospi tal	col. 2))	
			1.00	2. 00	3. 00	-
Section 5504 of the ACA Base Yea						
period that begins on or after J 64.00 Enter in column 1, if line 63 is			0.00	0.00	0. 000000	64.00
in the base year period, the num resident FTEs attributable to ro settings. Enter in column 2 the resident FTEs that trained in yo	tations occurring in number of unweighte ur hospital. Enter i	all nonprovider d non-primary care n column 3 the ratio				
of (column 1 divided by (column	1 + column 2)). (see Program Name	Program Code	Unwei ghted	Unwei ghted	Ratio (col.	
	11 Ogi alii Naile	1 rogram code	FTEs	FTEs in	3/ (col. 3 +	
			Nonprovi der	Hospi tal	col . 4))	
	1 00	2.00	Si te	4.00	F 00	
65.00 Enter in column 1, if line 63	1. 00	2.00	3.00	4.00	5. 00 0. 000000	65.00
is yes, or your facility trained residents in the base year period, the program name associated with primary care FTEs for each primary care program in which you trained residents. Enter in column 2, the program code. Enter in column 3, the number of unweighted primary care FTE residents attributable to rotations occurring in all non-provider settings. Enter in column 4, the number of unweighted primary care resident FTEs that trained in your hospital. Enter in column 5, the ratio of (column 3 divided by (column 3 + column 4)). (see instructions)			Unwei ghted FTEs	Unweighted FTEs in	Ratio (col. 1/ (col. 1 +	65.00
			Nonprovi der Si te	Hospi tal	col . 2))	
Section 5504 of the ACA Current	Voar ETE Docidonto :	n Nonnrovidor Cottin	1.00	2.00	3.00	
beginning on or after July 1, 20		ii Nonprovider Settin	gsEffective	roi cost report	ing perrous	
66.00 Enter in column 1 the number of FTEs attributable to rotations of Enter in column 2 the number of FTEs that trained in your hospit	ccurring in all nonp unweighted non-prima	rovider settings. ry care resident	0.00	0.00	0. 000000	66.00
(column 1 divided by (column 1 +						
	Program Name	Program Code	Unwei ghted FTEs Nonprovi der	Unwei ghted FTEs in Hospi tal	Ratio (col. 3/ (col. 3 + col. 4))	
	1. 00	2.00	Si te 3. 00	4. 00	5. 00	
67.00 Enter in column 1, the program	1.00	2.00	0.00			67.00
name associated with each of your primary care programs in which you trained residents. Enter in column 2, the program code. Enter in column 3, the number of unweighted primary care FTE residents attributable to rotations occurring in all non-provider settings. Enter in column 4, the number of unweighted primary care resident FTEs that trained in your hospital. Enter in column 5, the ratio of (column 3 divided by (column 3 + column 4)). (see instructions)						

JUSPI IAL AN	ncial Systems HUNTINGTON MEMORIA D HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA	Provider CCN: 15		eriod: rom 01/01/20:	Worl 22 Par 22 Date	sheet I e/Time	t S-2 e Pre	2552-10 pared: 36 am
						1. 00		
68.00 For a	t GME in Accordance with the FY 2023 IPPS Final Rule, 87 cost reporting period beginning prior to October 1, 202 o apply the new DGME formula in accordance with the FY 2 st 10, 2022)?	2, did you obtain	permi ssi	on from your		N		68. 00
				1.	00 2.	00 3	3. 00	
	ient Psychiatric Facility PPS is facility an Inpatient Psychiatric Facility (IPF), or	does it contain a	n IPF sub	provi der?	N			70.00
71.00 f li recen 42 CF progr Colum (see	"Y" for yes or "N" for no. ne 70 is yes: Column 1: Did the facility have an approve t cost report filed on or before November 15, 2004? Ent R 412.424(d)(1)(iii)(c)) Column 2: Did this facility tra am in accordance with 42 CFR 412.424 (d)(1)(iii)(D)? Ent n 3: If column 2 is Y, indicate which program year began instructions) ient Rehabilitation Facility PPS	er "Y" for yes or in residents in a er "Y" for yes or	"N" for new teac "N" for	no. (see hi ng no.			0	71.00
75.00 Is th	is facility an Inpatient Rehabilitation Facility (IRF),	or does it contai	n an IRF		N			75. 00
76.00 If li recen no. C CFR 4	ovider? Enter "Y" for yes and "N" for no. ne 75 is yes: Column 1: Did the facility have an approve t cost reporting period ending on or before November 15, olumn 2: Did this facility train residents in a new teac 12.424 (d)(1)(iii)(D)? Enter "Y" for yes or "N" for no. ate which program year began during this cost reporting	2004? Enter "Y" hing program in a Column 3: If colu	for yes o ccordance mn 2 is Y	r "N" for with 42			0	76. 00
						1. 00		
80.00 Is th 81.00 Is th "Y" f	Term Care Hospital PPS is a long term care hospital (LTCH)? Enter "Y" for yes is a LTCH co-located within another hospital for part or or yes and "N" for no.		reporti ng	period? Ent	er	N N		80. 00 81. 00
85.00 Is th 86.00 Did t	Providers is a new hospital under 42 CFR Section §413.40(f)(1)(i) his facility establish a new Other subprovider (excluded 40(f)(1)(ii)? Enter "Y" for yes and "N" for no.				D.	N		85. 00 86. 00
87.00 Is th	is hospital an extended neoplastic disease care hospital d)(1)(B)(vi)? Enter "Y" for yes or "N" for no.	classified under	secti on			N		87.00
11000	ay (1) (b) (v1) . Enter 1 101 yes of N 101 110.			Approved for Permanent Adjustment (Y/N)	A _l Pe	mber oprove rmane ustme 2.00	ed ent	
amoun 89. (n 1: Is this hospital approved for a permanent adjustmen t per discharge? Enter "Y" for yes or "N" for no. If yes see instructions)						0	88. 00
Col um	n 2: Enter the number of approved permanent adjustments.	Wkst	. A Line No.	Effective Date	Pe Adj Am	oprove rmane ustme ount l	nt ent Per	
89. 00 Col um	n 1: If line 88, column 1 is Y, enter the Worksheet A li		1.00	2. 00		3. 00		89. 00
on wh	ich the per discharge permanent adjustment approval was n 2: Enter the effective date (i.e., the cost reporting ning date) for the permanent adjustment to the TEFRA tar ischarge.	based. peri od	0.00				J	89.00
begin per d		n+ +0 +h0						
begin per d Colum	n 3: Enter the amount of the approved permanent adjustme target amount per discharge.	nt to the				VIV		
begin per d Colum TEFRA	n 3: Enter the amount of the approved permanent adjustme target amount per discharge.	nt to the		V 1.00		XI X 2. 00		
begin per d Colum TEFRA Title 90. 00 Does	n 3: Enter the amount of the approved permanent adjustme target amount per discharge. V and XIX Services this facility have title V and/or XIX inpatient hospital		"Y" for					90.00
begin per d Colum TEFRA Title 90.00 Does yes o 91.00 Is th	n 3: Enter the amount of the approved permanent adjustme target amount per discharge. V and XIX Services this facility have title V and/or XIX inpatient hospital r "N" for no in the applicable column. is hospital reimbursed for title V and/or XIX through the	services? Enter		1.00		2. 00		90.00
begin per d Colum TEFRA 90.00 Does yes o 91.00 Is the full 92.00 Are t	n 3: Enter the amount of the approved permanent adjustme target amount per discharge. V and XIX Services this facility have title V and/or XIX inpatient hospital r "N" for no in the applicable column. is hospital reimbursed for title V and/or XIX through thor in part? Enter "Y" for yes or "N" for no in the applitile XIX NF patients occupying title XVIII SNF beds (dua	services? Enter e cost report eit cable column. I certification)?	her in	1. 00 N		2. 00 Y		
begin per d Colum TEFRA 90.00 Does yes o 91.00 Is th full 92.00 Are t instr 93.00 Does	n 3: Enter the amount of the approved permanent adjustme target amount per discharge. V and XIX Services this facility have title V and/or XIX inpatient hospital r "N" for no in the applicable column. is hospital reimbursed for title V and/or XIX through thor in part? Enter "Y" for yes or "N" for no in the applititle XIX NF patients occupying title XVIII SNF beds (duauctions) Enter "Y" for yes or "N" for no in the applicable this facility operate an ICF/IID facility for purposes of the standard process o	services? Enter e cost report eit cable column. I certification)? Ie column.	her in (see	1. 00 N		2. 00 Y N		91.00
begin per d Colum TEFRA 90.00 Does yes o 91.00 Is th full 92.00 Are t instra 93.00 "Y" f	n 3: Enter the amount of the approved permanent adjustme target amount per discharge. V and XIX Services this facility have title V and/or XIX inpatient hospital r "N" for no in the applicable column. is hospital reimbursed for title V and/or XIX through th or in part? Enter "Y" for yes or "N" for no in the applititle XIX NF patients occupying title XVIII SNF beds (dua uctions) Enter "Y" for yes or "N" for no in the applicable.	services? Enter e cost report eit cable column. I certification)? Ie column. f title V and XIX	her in (see ? Enter	1.00 N N		Y N N		91. 00 92. 00
begin per d Colum TEFRA 90.00 Does yes o 91.00 Is the full 92.00 Are t instr 93.00 Does "Y" f 94.00 Does appli 95.00 If li	n 3: Enter the amount of the approved permanent adjustme target amount per discharge. V and XIX Services this facility have title V and/or XIX inpatient hospital r "N" for no in the applicable column. is hospital reimbursed for title V and/or XIX through thor in part? Enter "Y" for yes or "N" for no in the appliitle XIX NF patients occupying title XVIII SNF beds (duauctions) Enter "Y" for yes or "N" for no in the applicability operate an ICF/IID facility for purposes of yes or "N" for no in the applicable column.	services? Enter e cost report eit cable column. I certification)? le column. f title V and XIX nd "N" for no in icable column.	her in (see ? Enter the	1.00 N N		Y N N N		91. 00 92. 00 93. 00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA	_ HOSPITAL Provider CO	:N: 15-0091	In_Lieu Period:	u of Form CMS- Worksheet S-2	
OSTITAL AND HOSTITAL HEALTH GARL GOWN LEX TELEVITION BATA	Trovider oc		From 01/01/2022 To 12/31/2022	Part I	epared:
			V	XI X	Jo din
08.00 Does title V or XIX follow Medicare (title XVIII) for the inter	rne and rac	i donts post	1. 00 N	2. 00 Y	98.00
stepdown adjustments on Wkst. B, Pt. I, col. 25? Enter "Y" for column 1 for title V, and in column 2 for title XIX.			IV.	r	90.00
B.01 Does title V or XIX follow Medicare (title XVIII) for the report C, Pt. I? Enter "Y" for yes or "N" for no in column 1 for title title XIX.				Y	98. 0°
3.02 Does title V or XIX follow Medicare (title XVIII) for the calculated bed costs on Wkst. D-1, Pt. IV, line 89? Enter "Y" for yes or 'for title V, and in column 2 for title XIX.			N	Υ	98. 02
3.03 Does title V or XIX follow Medicare (title XVIII) for a critical reimbursed 101% of inpatient services cost? Enter "Y" for yes a for title V, and in column 2 for title XIX.				N	98. 03
3.04 Does title V or XIX follow Medicare (title XVIII) for a CAH reloutpatient services cost? Enter "Y" for yes or "N" for no in coin column 2 for title XIX.			N	N	98. 04
3.05 Does title V or XIX follow Medicare (title XVIII) and add back Wkst. C, Pt. I, col. 4? Enter "Y" for yes or "N" for no in colucol umn 2 for title XIX.				Υ	98. 0
8.06 Does title V or XIX follow Medicare (title XVIII) when cost rei Pts. I through IV? Enter "Y" for yes or "N" for no in column 1 column 2 for title XIX.			N	Y	98.00
Rural Providers					
15.00 Does this hospital qualify as a CAH? 16.00 If this facility qualifies as a CAH, has it elected the all-incorport for outpatient services? (see instructions)	clusive met	hod of paymen	t		105.00
07.00 Column 1: If line 105 is Y, is this facility eligible for cost training programs? Enter "Y" for yes or "N" for no in column 1. Column 2: If column 1 is Y and line 70 or line 75 is Y, do you approved medical education program in the CAH's excluded IPF a	. (see ins u train I&R and/or IRF	tructions) s in an			107.00
Enter "Y" for yes or "N" for no in column 2. (see instructions 08.00 st this a rural hospital qualifying for an exception to the CRI CFR Section §412.113(c). Enter "Y" for yes or "N" for no.		dul e? See 42	N		108. 0
	Physi cal	Occupati onal		Respi ratory	
09.00 f this hospital qualifies as a CAH or a cost provider, are	1. 00 N	2. 00	3. 00	4. 00	109.0
therapy services provided by outside supplier? Enter "Y" for yes or "N" for no for each therapy.					
It of yes of in to the fact therapy.					
Toll yes of in tol no for each therapy.				1.00	
10.00 Did this hospital participate in the Rural Community Hospital I Demonstration)for the current cost reporting period? Enter "Y" complete Worksheet E, Part A, lines 200 through 218, and Worksl	for yes or	"N" for no.	lf yes,	1. 00 N	110.0
10.00 Did this hospital participate in the Rural Community Hospital I Demonstration) for the current cost reporting period? Enter "Y"	for yes or	"N" for no.	If yes, ugh 215, as	N	110.00
10.00 Did this hospital participate in the Rural Community Hospital I Demonstration) for the current cost reporting period? Enter "Y" complete Worksheet E, Part A, lines 200 through 218, and Worksl applicable.	for yes or heet E-2, I	"N" for no. ines 200 thro	If yes, ugh 215, as		
10.00 Did this hospital participate in the Rural Community Hospital I Demonstration) for the current cost reporting period? Enter "Y" complete Worksheet E, Part A, lines 200 through 218, and Worksl applicable.	for yes or heet E-2, I Frontier C reporting mn 1 is Y, cipating in	"N" for no. ines 200 thro ommunity period? Enter enter the column 2.	If yes, ugh 215, as 1.00	N	
10.00 Did this hospital participate in the Rural Community Hospital I Demonstration) for the current cost reporting period? Enter "Y" complete Worksheet E, Part A, lines 200 through 218, and Worksl applicable. 11.00 If this facility qualifies as a CAH, did it participate in the Health Integration Project (FCHIP) demonstration for this cost "Y" for yes or "N" for no in column 1. If the response to colum integration prong of the FCHIP demo in which this CAH is partic Enter all that apply: "A" for Ambulance services; "B" for addi-	for yes or heet E-2, I Frontier C reporting mn 1 is Y, cipating in	"N" for no. i nes 200 thro ommunity period? Enter enter the column 2.; and/or "C"	If yes, ugh 215, as	N 2. 00	110.00
10.00 Did this hospital participate in the Rural Community Hospital Demonstration) for the current cost reporting period? Enter "Y" complete Worksheet E, Part A, lines 200 through 218, and Workslapplicable. 11.00 If this facility qualifies as a CAH, did it participate in the Health Integration Project (FCHIP) demonstration for this cost "Y" for yes or "N" for no in column 1. If the response to columintegration prong of the FCHIP demo in which this CAH is participate all that apply: "A" for Ambulance services; "B" for addition tele-health services. 12.00 Did this hospital participate in the Pennsylvania Rural Health (PARHM) demonstration for any portion of the current cost reporperiod? Enter "Y" for yes or "N" for no in column 1. If columin "Y", enter in column 2, the date the hospital began participated demonstration. In column 3, enter the date the hospital ceased	Frontier C reporting mn 1 is Y, cipating in tional beds Model rting mn 1 is ing in the	"N" for no. ines 200 thro ommunity period? Enter enter the column 2.	If yes, ugh 215, as 1.00	N	1111.00
 0.00 Did this hospital participate in the Rural Community Hospital In Demonstration) for the current cost reporting period? Enter "Y" complete Worksheet E, Part A, lines 200 through 218, and Workshapplicable. 1.00 If this facility qualifies as a CAH, did it participate in the Health Integration Project (FCHIP) demonstration for this cost "Y" for yes or "N" for no in column 1. If the response to columnintegration prong of the FCHIP demo in which this CAH is participate all that apply: "A" for Ambulance services; "B" for addition tele-health services. 2.00 Did this hospital participate in the Pennsylvania Rural Health (PARHM) demonstration for any portion of the current cost reporting? Enter "Y" for yes or "N" for no in column 1. If column "Y", enter in column 2, the date the hospital began participated demonstration. In column 3, enter the date the hospital ceased participation in the demonstration, if applicable. 3.00 Did this hospital participate in the Community Health Access and Transformation (CHART) model for any portion of the current contemporating period? Enter "Y" for yes or "N" for no. 	Frontier C reporting mn 1 is Y, cipating in tional beds Model rting mn 1 is ing in the d nd Rural	ommunity period? Enter enter the column 2. ; and/or "C"	If yes, ugh 215, as	N 2. 00	111.0
10.00 Did this hospital participate in the Rural Community Hospital In Demonstration) for the current cost reporting period? Enter "Y" complete Worksheet E, Part A, lines 200 through 218, and Workshapplicable. 11.00 If this facility qualifies as a CAH, did it participate in the Health Integration Project (FCHIP) demonstration for this cost "Y" for yes or "N" for no in column 1. If the response to column integration prong of the FCHIP demo in which this CAH is participate all that apply: "A" for Ambulance services; "B" for additional for tele-health services. 12.00 Did this hospital participate in the Pennsylvania Rural Health (PARHM) demonstration for any portion of the current cost reporting? Enter "Y" for yes or "N" for no in column 1. If column "Y", enter in column 2, the date the hospital began participated demonstration. In column 3, enter the date the hospital ceased participation in the demonstration, if applicable. 13.00 Did this hospital participate in the Community Health Access and Transformation (CHART) model for any portion of the current content o	Frontier C reporting mn 1 is Y, cipating in tional beds Model rting mn 1 is ing in the d nd Rural st N" for no or E only) percent cludes	ommunity period? Enter enter the column 2. ; and/or "C"	If yes, ugh 215, as	2. 00 3. 00	111.0
Demonstration) for the current cost reporting period? Enter "Y" complete Worksheet E, Part A, lines 200 through 218, and Workslapplicable. 11.00 If this facility qualifies as a CAH, did it participate in the Health Integration Project (FCHIP) demonstration for this cost "Y" for yes or "N" for no in column 1. If the response to columintegration prong of the FCHIP demo in which this CAH is participate all that apply: "A" for Ambulance services; "B" for addifor tele-health services. 12.00 Did this hospital participate in the Pennsylvania Rural Health (PARHM) demonstration for any portion of the current cost reporting period? Enter "Y" for yes or "N" for no in column 1. If columing, the date the hospital began participated demonstration. In column 3, enter the date the hospital ceased participation in the demonstration, if applicable. 13.00 Did this hospital participate in the Community Health Access and Transformation (CHART) model for any portion of the current cost reporting period? Enter "Y" for yes or "N" for no. Miscellaneous Cost Reporting Information 15.00 Is this an all-inclusive rate provider? Enter "Y" for yes or "I in column 1. If column 1 is yes, enter the method used (A, B, c) in column 2. If column 1 is yes, enter the method used (A, B, c) in column 2. If column 2 is "E", enter in column 3 either "93" for short term hospital or "98" percent for long term care (inc psychiatric, rehabilitation and long term hospitals providers) the definition in CMS Pub. 15-1, chapter 22, §2208.1.	Frontier C reporting mn 1 is Y, cipating in tional beds Model rting mn 1 is ing in the d nd Rural st N" for no or E only) percent cludes based on	"N" for no. i nes 200 thro ommunity period? Enter enter the column 2. ; and/or "C"	If yes, ugh 215, as	2. 00 3. 00	111.00
10.00 Did this hospital participate in the Rural Community Hospital I Demonstration) for the current cost reporting period? Enter "Y" complete Worksheet E, Part A, lines 200 through 218, and Workslapplicable. 11.00 If this facility qualifies as a CAH, did it participate in the Health Integration Project (FCHIP) demonstration for this cost "Y" for yes or "N" for no in column 1. If the response to columintegration prong of the FCHIP demoin which this CAH is participate all that apply: "A" for Ambulance services; "B" for addition tele-health services. 12.00 Did this hospital participate in the Pennsylvania Rural Health (PARHM) demonstration for any portion of the current cost reporting period? Enter "Y" for yes or "N" for no in column 1. If columing "Y", enter in column 2, the date the hospital began participated demonstration. In column 3, enter the date the hospital ceased participation in the demonstration, if applicable. 13.00 Did this hospital participate in the Community Health Access and Transformation (CHART) model for any portion of the current contemporation period? Enter "Y" for yes or "N" for no. Miscellaneous Cost Reporting Information 15.00 Is this an all-inclusive rate provider? Enter "Y" for yes or "I in column 1. If column 1 is yes, enter the method used (A, B, of in column 2. If column 2 is "E", enter in column 3 either "93" for short term hospital or "98" percent for long term care (in psychiatric, rehabilitation and long term hospitals providers) the definition in CMS Pub. 15-1, chapter 22, §2208. 1.	Frontier C reporting mn 1 is Y, cipating in tional beds Model rting mn 1 is ing in the d N" for no or E only) percent cludes based on r yes or	"N" for no. i nes 200 thro ommunity period? Enter enter the column 2. ; and/or "C" 1.00 N	If yes, ugh 215, as	2. 00 3. 00	

Enter "Y" for yes or "N" for no in column 1. (See CMS Pub. 15-2, chapter 40, §4020) If

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

Health Financial Systems			AL HOSPITAL				eu of Form CMS	
HOSPITAL AND HOSPITAL HEALTH CARE COMPLE	EX IDENTIFICATION DATA	Α	Provi der CC	CN: 15-0091		riod: om 01/01/2022 12/31/2022		epared:
							1.00	4
147.00 Was there a change in the statist	ical hasis? Enter "V"	for ve	es or "N" for	no			1.00 N	147. 0
148.00 Was there a change in the order of	f allocation? Enter "\	Y" for	ves or "N" f	or no			N N	148. 0
149.00 Was there a change to the simplif					for n	0.	N N	149. 0
			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								
155. 00 Hospi tal			N	N		N	N	155. 0
156.00 Subprovi der - IPF			N	N		N	N	156. 0
157.00 Subprovi der - I RF			N	l N		N	N	157. 0
158. 00 SUBPROVI DER				ļ				158. 0
159.00 SNF 160.00 HOME HEALTH AGENCY		-	N N	N N		N N	N N	159. 0 160. 0
161. OOLCMHC			IN	I N		N N	N N	161. 0
rot. dojewnie				I IV		IV	1.00	101.0
Multicampus							1.00	
165.00 Is this hospital part of a Multica Enter "Y" for yes or "N" for no.	ampus hospital that ha	as one	or more camp	uses in d	i ffere	nt CBSAs?	N	165. 0
, , , , , , , , , , , , , , , , , , , ,	Name		County	State	Zip C	ode CBSA	FTE/Campus	
	0		1. 00	2.00	3. 0	0 4.00	5. 00	
166.00 If line 165 is yes, for each campus enter the name in column 0, county in column 1, state in column 2, zip code in column 3, CBSA in column 4, FTE/Campus in column 5 (see instructions)							0.0	00 166. 0
							1.00	
Health Information Technology (HI						Act		
167.00 s this provider a meaningful use	05 is "Y") and ís a mo	eani ngf	ful user (lin			enter the	Y	167. 00 168. 00
reasonable cost incurred for the 68.01 If this provider is a CAH and is exception under §413.70(a)(6)(ii)	not a meaningful user,	, does	this provide			hardshi p		168. 0
169.00 If this provider is a meaningful transition factor. (see instruction	user (line 167 is "Y")					"), enter the	9. 9	99169. 0
						Begi nni ng	Endi ng	
						1. 00	2. 00	1
170.00 Enter in columns 1 and 2 the EHR period respectively (mm/dd/yyyy)	peginning date and end	ding da	ate for the r	eporti ng				170. 0
						1. 00	2. 00	
171.00 If line 167 is "Y", does this prosection 1876 Medicare cost plans "Y" for yes and "N" for no in column 2. (reported on Wkst. S-3, umn 1. If column 1 is	, Pt. I	, line 2, co	I. 6? Ent		N		0171.0

Heal th	Financial Systems HUNTINGTON MEMO	ORIAI 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 01/01/2022 To 12/31/2022		epared:
				V/ /NI	5/18/2023 11:	
				Y/N 1.00	2. 00	
	PART II - HOSPITAL AND HOSPITAL HEATHCARE COMPLEX REIMBURS					
	General Instruction: Enter Y for all YES responses. Enter 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
	perfecting perfect. It yes, enter the date of the enange in	001 diii1 2. (300	Y/N	Date	V/I	
2.00	Handbarran dan kami akan maki dan ki a ki a ki a Madi ana	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, includi contracts, 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 oth relationships? (see instructions)	er similar				
	relationships: (see mistructions)		Y/N	Туре	Date	
	I		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	03/17/2021	4.00
4.00	Accountant? Column 2: If yes, enter "A" for Audited, "C"	for Compiled,	'	A	03/17/2021	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 diff	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
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.		G			
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
	Treaching Trogram on worksheet A: Tr yes, see That detrons.				Y/N	
					1. 00	
12 00	Bad Debts Is the provider seeking reimbursement for bad debts? If ye	s saa instruc	ti one		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 coinsur instructions.	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 t A		L N Tt B	15. 00
		Y/N	Date	Y/N	Date	
		1.00	2.00	3. 00	4. 00	
1/ 00	PS&R Data	T N		N.	ı	1, 00
16.00	Was the cost report prepared using the PS&R Report only? If either column 1 or 3 is yes, enter the paid-through	N		N		16.00
	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	04/30/2021	Υ	04/30/2021	17.00
17.00	totals and the provider's records for allocation? If	ľ	04/30/2021	1	047 307 202 1	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		Y		18.00
10.00	Report data for additional claims that have been billed	,		'		10.00
	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
17.00	Report data for corrections of other PS&R Report	.,		14		'
	information? If yes, see instructions.	l	I		l	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 C	CN: 15-0091	Peri od: From 01/01/2022 To 12/31/2022	Worksheet S-2 Part II Date/Time Pre 5/18/2023 11:	epared:
			iption	Y/N	Y/N	
20. 00	If line 16 or 17 is yes, were adjustments made to PS&R		0	1. 00 N	3. 00 N	20.00
20.00	Report data for Other? Describe the other adjustments:			IN	IN	20.00
		Y/N	Date	Y/N	Date	
04.00	Two states and the state of the	1.00	2. 00	3.00	4. 00	04.00
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 (EXC					
22. 00	Capital Related Cost Have assets been relifed for Medicare purposes? If yes, se			22.00		
23. 00	Have changes occurred in the Medicare depreciation expense			ring the cost		23.00
	reporting period? If yes, see instructions.					
24. 00	Were new leases and/or amendments to existing leases enter If yes, see instructions	9				24. 00
25. 00	Have there been new capitalized leases entered into during instructions.	, the cost repo	rting period?	? If yes, see		25. 00
26. 00	Were assets subject to Sec. 2314 of DEFRA acquired during t instructions.	he cost report	ing period? I	f yes, see		26. 00
27. 00	Has the provider's capitalization policy changed during th copy.	ne cost reporti	ng period? If	yes, submit		27. 00
28. 00	Interest Expense Were new Loans, mortgage agreements or letters of credit e	entered into du	ring the cost	t reporting		28. 00
	period? If yes, see instructions.					
29. 00	Did the provider have a funded depreciation account and/or		ebt Service F	Reserve Fund)		29. 00
30. 00	treated as a funded depreciation account? If yes, see inst Has existing debt been replaced prior to its scheduled mat instructions.		debt? If yes	s, see		30.00
31. 00	Has debt been recalled before scheduled maturity without i instructions.	ssuance of new	debt? If yes	s, see		31.00
32. 00	Purchased Services Have changes or new agreements occurred in patient care se	ervices furnish	ed through co	ontractual		32.00
33. 00	arrangements with suppliers of services? If yes, see instr If line 32 is yes, were the requirements of Sec. 2135.2 ap		ng to competi	tive bidding? If	•	33. 00
	no, see instructions. Provider-Based Physicians					+
34.00	Were services furnished at the provider facility under an	arrangement wi	th provider-k	pased physicians?	1	34.00
	If yes, see instructions.					
35.00	If line 34 is yes, were there new agreements or amended ex physicians during the cost reporting period? If yes, see i		nts with the	provi der-based		35.00
	<u> </u>			Y/N	Date	
	No. 1066; Cooks			1. 00	2. 00	
36 00	Home Office Costs Were home office costs claimed on the cost report?			Υ		36.00
	If line 36 is yes, has a home office cost statement been p If yes, see instructions.	repared by the	home office?			37.00
38. 00	If line 36 is yes, was the fiscal year end of the home of the provider? If yes, enter in column 2 the fiscal year en			e N		38. 00
39. 00				s, N		39. 00
40. 00	If line 36 is yes, did the provider render services to the instructions.		40.00			
					00	
	Cost Report Preparer Contact Information	1.	00	2.	00	
41. 00	Enter the first name, last name and the title/position held by the cost report preparer in columns 1, 2, and 3,	SHANNON		ECENBARGER		41.00
42. 00	respectively. Enter the employer/company name of the cost report	PARKVIEW HEALT	TH SYSTEM, IN	c.		42.00
43. 00	preparer. Enter the telephone number and email address of the cost	(260) 373-8457	7	SHANNON. ECENBAI	RGFR@PARKVI FW	43.00
10.00	report preparer in columns 1 and 2, respectively.	(200) 370 0437		COM	COLINGI ANNI LW.	13.00

Heal th	Financial Systems HUNTINGTON	ORIAL HOSPI	TAL	In Lieu of Form CMS-2552-					
HOSPI T	AL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE		Provi d	ler CCN: 15-0091	eri od:	Worksheet S-2	2		
					rom 01/01/2022 o 12/31/2022	Part II Date/Time Pre	enared:		
					 0 12/31/2022	5/18/2023 11:	36 am		
				3. 00					
	Cost Report Preparer Contact Information								
41.00	Enter the first name, last name and the title/position		DI RECTOR,	REI MBURSEMENT			41.00		
	held by the cost report preparer in columns 1, 2, and	3,							
	respecti vel y.								
42.00	Enter the employer/company name of the cost report						42.00		
	preparer.						1		
43.00	Enter the telephone number and email address of the co	st					43.00		
	report preparer in columns 1 and 2, respectively.								

 Heal th Fi nancial
 Systems
 HUNTINGTO

 HOSPITAL
 AND
 HOSPITAL
 HEALTH CARE
 COMPLEX
 STATISTICAL
 DATA
 | Peri od: | Worksheet S-3 | From 01/01/2022 | Part | To | 12/31/2022 | Date/Time Prepared: Provi der CCN: 15-0091

						То	12/31/2022	Date/Time Pre 5/18/2023 11:	
								I/P Days /	00 4
								0/P Visits /	
								Tri ps	
	Component	Worksheet A	No	o. of Beds	Bed Days		CAH Hours	Title V	
		Li ne No.			Avai I abl e				
	DART I CTATICTICAL DATA	1. 00		2. 00	3. 00		4. 00	5. 00	
1. 00	PART I - STATISTICAL DATA Hospital Adults & Peds. (columns 5, 6, 7 and	30.00		36	12 14	0	0. 00	0	1. 00
1.00	8 exclude Swing Bed, Observation Bed and	30.00		36	13, 14	U	0.00	Ü	1.00
	Hospice days)(see instructions for col. 2								
	for the portion of LDP room available beds)								
2. 00	HMO and other (see instructions)								2.00
3. 00	HMO IPF Subprovider								3.00
4. 00	HMO IRF Subprovider								4. 00
5. 00	Hospital Adults & Peds. Swing Bed SNF							0	5. 00
6. 00	Hospital Adults & Peds. Swing Bed NF							0	6.00
7. 00	Total Adults and Peds. (exclude observation			36	13, 14	0	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	0. 00	0	14.00
15.00	CAH visits							0	15.00
16.00	SUBPROVIDER - IPF								16.00
17.00	SUBPROVI DER - I RF								17.00
18.00	SUBPROVI DER								18.00
19. 00	SKILLED NURSING FACILITY								19.00
20.00	NURSING FACILITY								20.00
21. 00	OTHER LONG TERM CARE								21.00
22. 00	HOME HEALTH AGENCY								22.00
23.00	AMBULATORY SURGICAL CENTER (D. P.)								23.00
24. 00	HOSPI CE								24.00
24. 10	HOSPICE (non-distinct part)	30. 00							24. 10
25. 00	CMHC - CMHC								25.00
26.00	RURAL HEALTH CLINIC								26.00
26. 25	FEDERALLY QUALIFIED HEALTH CENTER	89. 00						0	
27. 00	Total (sum of lines 14-26)			36				_	27. 00
28. 00	Observation Bed Days							0	28. 00
29. 00	Ambul ance Trips								29. 00
30.00	Employee discount days (see instruction)								30.00
31.00	Employee discount days - IRF			0		0			31.00
32.00	Labor & delivery days (see instructions)			U		U			32.00
32. 01	Total ancillary labor & delivery room								32. 01
33. 00	outpatient days (see instructions) LTCH non-covered days								33. 00
33. 00	LTCH non-covered days LTCH site neutral days and discharges								33.00
	Temporary Expansion COVID-19 PHE Acute Care	30.00		0		О		0	
5 1. 00	1. Simple dry Expension South 17 The house sale	30.00	ı	O ₁	l	٦,	ļ	O	51.00

 Health Financial Systems
 HUNTINGTO

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

Peri od: Worksheet S-3 From 01/01/2022 Part I To 12/31/2022 Date/Ti me Prepared: 5/18/2023 11:36 am

						5/18/2023 11:	36 am
	·	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	982	118	4, 182			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, 496	1, 126				2.00
3.00	HMO IPF Subprovider	0	0				3.00
4.00	HMO IRF Subprovider	0	0				4.00
5.00	Hospital Adults & Peds. Swing Bed SNF	0	0	0			5.00
6.00	Hospital Adults & Peds. Swing Bed NF		0				6.00
7.00	Total Adults and Peds. (exclude observation	982	118	4, 182			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		25	605			13.00
14.00	Total (see instructions)	982	143	4, 787	0. 00	225. 13	14.00
15.00	CAH vi si ts	0	0	0			15.00
16.00	SUBPROVIDER - IPF						16.00
17.00	SUBPROVIDER - IRF						17.00
18.00	SUBPROVI DER						18.00
19.00	SKILLED NURSING FACILITY						19.00
20.00	NURSING FACILITY						20.00
21.00	OTHER LONG TERM CARE						21.00
22.00	HOME HEALTH AGENCY						22.00
23.00	AMBULATORY SURGICAL CENTER (D. P.)						23.00
24.00	HOSPI CE						24.00
24. 10	HOSPICE (non-distinct part)			71			24. 10
25.00	CMHC - CMHC						25.00
26.00	RURAL HEALTH CLINIC						26.00
26. 25	FEDERALLY QUALIFIED HEALTH CENTER	o	0	0	0.00	0.00	26. 25
27.00	Total (sum of lines 14-26)				0.00	225. 13	27.00
28.00	Observation Bed Days		30	1, 872			28. 00
29.00	Ambul ance Trips	o					29. 00
30.00	Employee discount days (see instruction)			0			30.00
31.00	Employee discount days - IRF			0			31.00
32.00	Labor & delivery days (see instructions)	o	79	122			32.00
32. 01	Total ancillary labor & delivery room			0			32. 01
	outpatient days (see instructions)						
33.00	LTCH non-covered days	O					33.00
	LTCH site neutral days and discharges	o					33. 01
	Temporary Expansion COVID-19 PHE Acute Care	O	0	0			34.00
	• • • •	. '	'	•	'	•	•

| Peri od: | Worksheet S-3 | From 01/01/2022 | Part | To 12/31/2022 | Date/Time Prepared: Provider CCN: 15-0091

Full Time Equivalents Title V					11	0 12/31/2022	5/18/2023 11:	
Figur valents Nonpaid Title V Title XVIII Title XIX Partients Partients Nonpaid Title V Nonpaid Title V Partients Partient			Full Time		Di sch	arges	07 107 2020 111	00 4
Component			Equi val ents			3		
PART I - STATISTICAL DATA		Component		Title V	Title XVIII	Title XIX	Total All	
PART I - STATISTICAL DATA 1.00			Workers				Pati ents	
Hospital Adults & Peds. (columns 5, 6, 7 and 8 8 exclude Swing Bed, Observation Bed and Hospice days) (see instructions for col. 2 for the portion of LIPP room available beds) 469 350 2.00			11. 00	12. 00	13.00	14. 00	15. 00	
8 exclude Swing Bed, Observation Bed and Hospice days) (see instructions for col. 2 for the portion of LOP room available beds) 2.00 HNO and other (see instructions) 3.00 HNO IPF Subprovider 4.00 HNO IPF Subprovider 5.00 Hospital Adults & Peds. Swing Bed SNF 6.00 Hospital Adults & Peds. Swing Bed SNF 7.00 Total Adults and Peds (exclude observation beds) (see instructions) 8.00 INTENSIVE CARE UNIT 9.00 OWNARY CARE UNIT 10.00 BURN INTENSIVE CARE UNIT 11.00 OWNARY CARE UNIT 12.00 OTHER SPECIAL CARE (SPECIFY) 13.00 OWNARY CARE UNIT 10.00 SUBPROVIDER - IPF 11.00 SUBPROVIDER - IPF 11.00 SUBPROVIDER - IPF 11.00 SUBPROVIDER - IRF 12.00 OWNARY CARE UNIT 13.00 OWNARY CARE UNIT 14.00 Total (see instructions) 15.00 CAR VI sists 16.00 SUBPROVIDER - IRF 17.00 SUBPROVIDER - IRF 18.00 SUBPROVIDER SWING FACILITY 19.00 OWNARY CARE UNIT 20.00 OWNARY CARE UNIT 21.00 OWNARY CARE UNIT 22.00 OWNARY CARE UNIT 23.00 OWNARY CARE UNIT 24.10 OWNARY CARE UNIT 25.00 OWNARY CARE UNIT 26.00 OWNARY OWNARY OWNARY OWNARY CARE UNIT 27.00 SUBPROVIDER - IPF 28.00 OWNARY OWN								
Hospi ce days) (see instructions for col. 2 7	1.00			C	296	37	1, 514	1.00
For the portion of LDP room available beds) 2.00 3.00 3.00 3.00 3.00 4.69 350 2.00 3.00 3.00 4.00								
2.00 HMO and other (see instructions) 469 350 2.00 4.00 HMO IPF Subprovi der 0 3.00 4.00 HMO IPF Subprovi der 0 0 4.00 5.00 Hospi tal Adult is & Peds. Swing Bed SNF 6.00 Hospi tal Adult is & Peds. Swing Bed NF 7.00 Hospi tal Adult is & Peds. Swing Bed NF 7.00 Hospi tal Adult is & Peds. Swing Bed NF 7.00 Hospi tal Adult is & Peds. Swing Bed NF 7.00 Hospi tal Adult is & Peds. Swing Bed NF 7.00 Hospi tal Adult is & Peds. Swing Bed NF 7.00 Hospi tal Adult is and Peds. (exclude observation beds) (see instructions) 9.00 7.00 Hospi tal Adult is and Peds. (exclude observation beds) (see instructions) 9.00 7.00 Hospi tal Adult is and Peds. (exclude observation beds) 9.00 7.00 BURN INTENSIVE CARE UNIT 9.00 7.00 OTHER SPECIAL CARE (SPECIFY) 10.00 7.00 OTHER SPECIAL CARE (SPECIFY) 11.00 7.00 OTHER SPECIAL CARE (SPECIFY) 12.00 7.00 OTHER SPECI								
MNO IPF Subprovi der								
MO I RF Subprovider					469			
5.00 Hospital Adults & Peds. Swing Bed SNF 6.00 7.		•				-		
6.00 Hospital Adults & Peds. Swing Bed NF 7.00 Total Adults and Peds. (exclude observation beds) (see instructions) 8.00 1NTENSIVE CARE UNIT 8.00 10.00 BURN INTENSIVE CARE UNIT 9.00 10.00 BURN INTENSIVE CARE UNIT 10.00 10.00 BURN INTENSIVE CARE UNIT 11.00 12.00 12.00 14.00 Total (see instructions) 0.00						0		
Total Adults and Peds. (exclude observation beds) (see instructions)								
Deds) (see instructions) Some content of the co		, ,						
8. 00 INTENSIVE CARE UNIT	7. 00	`						7. 00
9.00 CORONARY CARE UNIT 10.00 10	0.00							0.00
10.00 BURN INTENSIVE CARE UNIT								
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 0 296 37 1,514 14.00 15.00 16.00 SUBPROVIDER - IPF 16.00 16.00 SUBPROVIDER - IPF 17.00 18.00 19.								
12.00 OTHER SPECIAL CARE (SPECIFY) 12.00 13.00 NURSERY 14.00 Total (see instructions) 0.00 0 296 37 1,514 14.00 15.00 CAH visits 16.00 SUBPROVIDER - IPF 16.00 SUBPROVIDER - IRF 16.00 SUBPROVIDER - IRF 18.00 19.00 STILLED NURSING FACILITY 18.00 19.00 STILLED NURSING FACILITY 20.00 21.00 OTHER LONG TERM CARE 22.00 HOME HEALTH AGENCY 21.00 22.00 AMBULATORY SURGICAL CENTER (D.P.) 23.00 24.10 HOSPICE (non-distinct part) 25.00 CMHC - CMHC 26.00 CMR2 - CMHC 26.00 CMB2 - CMB2 CMB2 - CMB2 - CMB2 CMB2 - CMB2 - CMB2 CMB2 - CMB2 - CMB2 - CMB2 CMB2 - CM								
13. 00 NURSERY								
14.00 Total (see instructions)								
15. 00 CAH visits 16. 00 SUBPROVI DER - IPF 17. 00 SUBPROVI DER - IPF 17. 00 SUBPROVI DER - IRF 18. 00 SUBPROVI DER 19. 00 SKI LLED NURSI NG FACI LITY 19. 00 SKI LLED NURSI NG FACI LITY 20. 00 NURSI NG FACI LITY 21. 00 OTHER LONG TERM CARE 22. 00 HOME HEALTH AGENCY 23. 00 AMBULATORY SURGI CAL CENTER (D. P.) 24. 00 HOSPI CE 24. 10 HOSPI CE 24. 10 HOSPI CE 25. 00 CMHC - CMHC 26. 00 RURAL HEALTH CLINIC 26. 00 RURAL HEALTH CLINIC 27. 00 Total (sum of lines 14-26) 29. 00 Observation Bed Days 29. 00 Ambul ance Trips 30. 00 Empl oyee discount days (see instruction) 31. 00 Empl oyee discount days (see instructions) 32. 01 Total ancillary labor & delivery room outpatient days (see instructions) 33. 00 LTCH site neutral days and discharges 15. 00 16. 00 16. 00 16. 00 17. 00 18. 00 18. 00 19. 00 19. 00 10.		1	0.00	_	204	27	1 514	
16. 00 SUBPROVI DER - I PF 17. 00 SUBPROVI DER - I RF 18. 00 SUBPROVI DER 19. 00 SKI LLED NURSI NG FACI LI TY 20. 00 NURSI NG FACI LI TY 21. 00 OTHER LONG TERM CARE 22. 00 HOME HEALTH AGENCY 23. 00 AMBULATORY SURGI CAL CENTER (D. P.) 24. 00 HOSPI CE (non-distinct part) 25. 00 CMHC - CMHC 26. 00 RURAL HEALTH CLINI C 26. 00 RURAL HEALTH CLINI C 26. 00 RURAL HEALTH CURSIED HEALTH CENTER 27. 00 Total (sum of lines 14-26) 28. 00 Observati on Bed Days 29. 00 Ambul ance Tri ps 30. 00 Employee discount days (see instruction) 31. 00 Employee discount days (see instructions) 30. 00 Itotal ancillary labor & delivery room outpatient days (see instructions) 31. 00 LTCH site neutral days and discharges 30. 00 Subrovered days 30. 01 LTCH site neutral days and discharges		1	0.00	C	290	37	1, 514	
17. 00 SUBPROVIDER - IRF 17. 00 18. 00 SUBPROVIDER 18. 00 18. 00 SKILLED NURSING FACILITY 19. 00 NURSING FACILITY 20. 00 NURSING FACILITY 20. 00 OTHER LONG TERM CARE 21. 00 22. 00 HOME HEALTH AGENCY 23. 00 AMBULATORY SURGICAL CENTER (D.P.) 23. 00 24. 00 HOSPICE 24. 00 24. 00 HOSPICE 24. 10 HOSPICE (non-distinct part) 24. 10 25. 00 CMHC - CMHC 26. 00 RURAL HEALTH CLINIC 26. 00 RURAL HEALTH CLINIC 26. 00 RURAL HEALTH CENTER 0. 00 26. 25 FEDERALLY QUALIFIED HEALTH CENTER 0. 00 27. 00 28. 00 00 00 00 00 00 00 00		4						
18. 00 SUBPROVI DER 18. 00 19. 00 SKI LLED NURSING FACILITY 20. 00 NURSING FACILITY 20. 00 21. 00 OTHER LONG TERM CARE 21. 00 22. 00 HOME HEALTH AGENCY 22. 00 23. 00 HOME HEALTH AGENCY 23. 00 HOSPI CE 24. 00 HOSPI CE 24. 10 HOSPI CE 24. 10 25. 00 CMHC - CMHC 25. 00 26. 25 27. 00 Total (sum of lines 14-26) 26. 25 27. 00 Observation Bed Days 28. 00 29. 00 Ambul ance Trips 29. 00 29. 00 Ambul ance Trips 29. 00 29. 00 29. 00 20. 00								
19. 00		4						
20.00 NURSING FACILITY 20.00 21.00 21.00 22.00 22.00 22.00 23.00 24.00 25.00 24.00 25.00 24.00 25.		4						
21.00 OTHER LONG TERM CARE 22.00 HOME HEALTH AGENCY 23.00 AMBULATORY SURGICAL CENTER (D. P.) 24.00 HOSPICE 24.10 HOSPICE (non-distinct part) 25.00 CMHC - CMHC 26.25 FEDERALLY QUALIFIED HEALTH CENTER 26.25 FEDERALLY QUALIFIED HEALTH CENTER 27.00 Observation Bed Days 28.00 Observation Bed Days 29.00 Ambulance Trips 30.00 Employee discount days (see instruction) 31.00 Employee discount days (see instructions) 32.01 Total ancillary labor & delivery room outpatient days (see instructions) 33.00 LTCH non-covered days 33.01 LTCH site neutral days and discharges								
22.00 23.00		1						
23.00 AMBULATORY SURGICAL CENTER (D.P.) 24.00 HOSPICE		1						
24.00 HOSPICE 24.10 HOSPICE (non-distinct part) 25.00 CMHC - CMHC 26.00 RURAL HEALTH CLINIC 27.00 Total (sum of lines 14-26) 28.00 Observation Bed Days 29.00 Ambulance Trips 29.00 Employee discount days (see instruction) 29.00 Employee discount days - IRF 29.00 Labor & delivery days (see instructions) 20.01 Total ancillary labor & delivery room outpatient days (see instructions) 20.01 LTCH non-covered days 21.00 LTCH non-covered days 22.00 Assume the control of the c		1						
24. 10 HOSPICE (non-distinct part) 25. 00 CMHC - CMHC 26. 00 RURAL HEALTH CLINIC 26. 00 FEDERALLY QUALIFIED HEALTH CENTER 27. 00 Total (sum of lines 14-26) 28. 00 Observation Bed Days 29. 00 Ambulance Trips 29. 00 30. 00 Employee discount days (see instruction) 31. 00 Employee discount days - IRF 32. 00 Labor & delivery days (see instructions) 32. 01 Total ancillary labor & delivery room outpatient days (see instructions) 33. 00 LTCH non-covered days 33. 01 LTCH site neutral days and discharges								
25.00 CMHC - CMHC 26.00 RURAL HEALTH CLINIC 26.00 RURAL HEALTH CLINIC 26.00 FEDERALLY QUALIFIED HEALTH CENTER 26.25 FEDERALLY QUALIFIED HEALTH CENTER 27.00 Total (sum of lines 14-26) 28.00 Observation Bed Days 29.00 Ambul ance Trips 29.00 Employee discount days (see instruction) 31.00 Employee discount days - IRF 31.00 Labor & delivery days (see instructions) 32.01 Total ancillary labor & delivery room outpatient days (see instructions) 33.00 LTCH non-covered days 33.00 LTCH site neutral days and discharges		•						
26.00 RURAL HEALTH CLINIC 26.25 FEDERALLY QUALIFIED HEALTH CENTER 27.00 Total (sum of lines 14-26) 28.00 Observation Bed Days 29.00 Ambul ance Trips 29.00 Employee discount days (see instruction) 29.00 Employee discount days - IRF 20.00 Labor & delivery days (see instructions) 31.00 Employee discount days (see instructions) 32.01 Total ancillary labor & delivery room outpatient days (see instructions) 31.00 LTCH non-covered days 31.00 LTCH site neutral days and discharges								25. 00
27.00								
28.00 Observation Bed Days 29.00 Ambulance Trips 30.00 Employee discount days (see instruction) 31.00 Employee discount days - IRF 32.00 Labor & delivery days (see instructions) 32.01 Total ancillary labor & delivery room outpatient days (see instructions) 33.00 LTCH non-covered days 33.01 LTCH site neutral days and discharges 28.00 29.00 30.00 30.00 30.00 31.00 31.00 32.01 33.00 33.01			0.00					
28.00 Observation Bed Days 29.00 Ambulance Trips 30.00 Employee discount days (see instruction) 31.00 Employee discount days - IRF 32.00 Labor & delivery days (see instructions) 31.00 Total ancillary labor & delivery room outpatient days (see instructions) 31.00 LTCH non-covered days 31.00 LTCH site neutral days and discharges 28.00 29.00 29.00 30.00	27.00	Total (sum of lines 14-26)	0.00					27. 00
30.00 Employee discount days (see instruction) 31.00 Employee discount days - IRF 32.00 Labor & delivery days (see instructions) 32.01 Total ancillary labor & delivery room outpatient days (see instructions) LTCH non-covered days 33.00 LTCH site neutral days and discharges 30.00 31.00 31.00 31.00 32.00 32.01 33.00 33.00	28.00	1						28. 00
31.00 Employee discount days - IRF 32.00 Labor & delivery days (see instructions) 32.01 Total ancillary labor & delivery room outpatient days (see instructions) 33.00 LTCH non-covered days 33.01 LTCH site neutral days and discharges 31.00 32.00 32.01 0 33.00	29.00	Ambul ance Trips						29.00
32.00 Labor & delivery days (see instructions) 32.01 Total ancillary labor & delivery room outpatient days (see instructions) 33.00 LTCH non-covered days 33.01 LTCH site neutral days and discharges 32.00 32.01 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	30.00	Employee discount days (see instruction)						30.00
32.01 Total ancillary labor & delivery room outpatient days (see instructions) 33.00 LTCH non-covered days 33.01 LTCH site neutral days and discharges 32.01 33.00 33.01	31.00	Employee discount days - IRF						31.00
outpati ent days (see i nstructions) 33.00 LTCH non-covered days 33.01 LTCH si te neutral days and discharges 0 33.01	32.00	Labor & delivery days (see instructions)						32.00
33.00 LTCH non-covered days 0 33.00 33.01 LTCH si te neutral days and discharges 0 33.01	32. 01	Total ancillary labor & delivery room						32.01
33.01 LTCH site neutral days and discharges 0 33.01		outpatient days (see instructions)						
	33.00	LTCH non-covered days						33.00
34.00 Temporary Expansion COVID-19 PHE Acute Care					0			
	34. 00	Temporary Expansion COVID-19 PHE Acute Care			[34.00

| Peri od: | Worksheet S-3 | From 01/01/2022 | Part | I | To | 12/31/2022 | Date/Time Prepared: Health Financial Systems
HOSPITAL WAGE INDEX INFORMATION Provi der CCN: 15-0091

					Т	o 12/31/2022	Date/Time Pre 5/18/2023 11:	pared: 36 am
		Wkst. A Line	Amount	Reclassi fi cat	Adj usted	Paid Hours	Average	00 4
		Number	Reported	i on of Sal ari es	Sal ari es (col. 2 ± col.	Related to Salaries in	Hourly Wage (col. 4 ÷	
				(from Wkst.	3)	col. 4	col . 5)	
		1. 00	2. 00	A-6) 3.00	4.00	5. 00	6. 00	
	PART II - WAGE DATA							
1. 00	SALARIES Total salaries (see	200.00	18, 644, 780	4, 465, 626	23, 110, 406	594, 204. 33	38. 89	1.00
	instructions)							
2. 00	Non-physician anesthetist Part A		0	0	0	0. 00	0.00	2.00
3.00	Non-physician anesthetist Part		0	0	0	0. 00	0. 00	3. 00
4. 00	B Physician-Part A -		0	0	0	0. 00	0.00	4.00
4 01	Administrative		0			0.00	0.00	4 01
4. 01 5. 00	Physicians - Part A - Teaching Physician and Non		0	0	0	0. 00 0. 00	l e	
	Physician-Part B							
6. 00	Non-physician-Part B for hospital-based RHC and FQHC services		0	0	0	0.00	0.00	6. 00
7. 00	Interns & residents (in an	21. 00	0	0	0	0. 00	0.00	7. 00
7. 01	approved program) Contracted interns and		0	0	0	0. 00	0.00	7. 01
	residents (in an approved programs)		_	_				
8. 00	Home office and/or related organization personnel		4, 465, 626	0	4, 465, 626	97, 108. 94	45. 99	8.00
9. 00	SNF	44.00	0	0	0		l	
10. 00	Excluded area salaries (see instructions)		3, 238, 411	202, 894	3, 441, 305	125, 484. 75	27. 42	10.00
	OTHER WAGES & RELATED COSTS				<u> </u>			
11. 00	Contract Labor: Direct Patient Care		0	0	0	0. 00	0.00	11.00
12.00	Contract Labor: Top Level		0	О	0	0. 00	0.00	12.00
	management and other management and administrative services							
13.00	Contract Labor: Physician-Part		0	О	0	0. 00	0.00	13. 00
14. 00	A - Administrative Home office and/or related		0	0	0	0. 00	0.00	14.00
	organization salaries and							
14. 01	wage-related costs Home office salaries		4, 465, 626	0	4, 465, 626	97, 108. 94	45. 99	14. 01
14. 02	Related organization salaries		0	0	0	0. 00	0.00	
15. 00	Home office: Physician Part A - Administrative		0	0	0	0. 00	0.00	15. 00
16. 00	Home office and Contract		0	0	0	0. 00	0. 00	16. 00
16. 01	Physicians Part A - Teaching Home office Physicians Part A		0	0	0	0. 00	0.00	16. 01
	- Teachi ng							
16. 02	Home office contract Physicians Part A - Teaching		0	0	0	0. 00	0.00	16. 02
47.00	WAGE-RELATED COSTS		5 1/0 100		- 1/0 100			17.00
17. 00	Wage-related costs (core) (see instructions)		5, 163, 433	0	5, 163, 433			17.00
18. 00	Wage-related costs (other) (see instructions)							18. 00
19. 00	Excluded areas		1, 390, 756	О	1, 390, 756			19.00
20. 00	Non-physician anesthetist Part		0	0	0			20.00
21. 00	Non-physician anesthetist Part		0	0	0			21. 00
22. 00	Physician Part A -		0	0	0			22. 00
22. 01	Administrative Physician Part A - Teaching		Ω	0	0			22. 01
23. 00	Physician Part B		0	0	0			23.00
24. 00 25. 00	Wage-related costs (RHC/FQHC) Interns & residents (in an		0	0	0			24. 00 25. 00
	approved program)		· ·					
25. 50	Home office wage-related (core)		1, 501, 965	0	1, 501, 965			25. 50
25. 51	Related organization		0	0	0			25. 51
25. 52	wage-related (core) Home office: Physician Part A		0	0	n			25. 52
	- Administrative -		_					
	wage-related (core)			I	I	I	I	I

HOSPITAL WAGE INDEX INFORMATION Provider CCN: 15-0091 Peri od: Worksheet S-3 From 01/01/2022 Part II Date/Time Prepared: 12/31/2022 5/18/2023 11:36 am Wkst. A Line Amount Recl assi fi cat Adj usted Paid Hours Average Hourly Wage (col. 4 ÷ col. 5) Number Sal ari es Related to Reported ion of (col. 2 ± col. Sal ari es Salaries in (from Wkst. 3) col. 4 A-6) 1.00 2.00 3.00 4.00 5.00 6.00 25.53 Home office: Physicians Part A 0 25. 53 0 - Teaching - wage-related (core) OVERHEAD COSTS - DIRECT SALARIES 26.00 Employee Benefits Department 4.00 1, 757, 788 -1, 757, 788 0.00 0. 00 26.00 27.00 Administrative & General 5.00 1, 295, 027 4, 553, 500 5, 848, 527 107, 400. 52 54.46 27.00 28.00 0.00 0.00 28.00 Administrative & General under contract (see inst.) 29.00 Maintenance & Repairs 6.00 0.00 0.00 29.00 30.00 Operation of Plant 7.00 391, 034 43, 144 434, 178 13, 301. 26 32. 64 30.00 . Laundry & Linen Service 8.00 52, 509 2, 352. 00 22. 33 31.00 31.00 52, 509 20. 99 32.00 444, 325 Housekeepi ng 9.00 447, 464 -3, 139 21, 170. 31 32.00 33.00 Housekeeping under contract 0.00 0.00 33.00 (see instructions) 34.00 Dietary 10.00 607, 305 -263, 992 343, 313 14, 260. 28 24.07 34.00 Dietary under contract (see 35.00 C 0.00 0.00 35.00 instructions) 36.00 Cafeteri a 11.00 0 330, 998 330, 998 14, 113. 00 23. 45 36.00 0.00 37.00 Maintenance of Personnel 12.00 0.00 37.00 Nursing Administration 49. 03 38.00 38.00 13.00 378, 649 41.777 420, 426 8, 574. 00 39.00 Central Services and Supply 14.00 0.00 0.00 39.00 609, 910 10, 885. 00 40.00 Pharmacy 15.00 0 609, 910 56.03 40.00 Medical Records & Medical Records Library 41.00 16.00 0 0 0 0.00 0.00 41.00

0

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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

near th	lear th i mancial Systems hown will work at hospital the titled of form cws-2552-10								
HOSPI T	AL WAGE INDEX INFORMATION			Provi der Co		Period: From 01/01/2022 Fo 12/31/2022		pared:	
		Worksheet A	Amount	Recl assi fi cat	Adjusted	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							
1.00	Net salaries (see		14, 179, 154	4, 465, 626	18, 644, 780	497, 095. 39	37. 51	1.00	
	instructions)								
2.00	Excluded area salaries (see		3, 238, 411	202, 894	3, 441, 305	125, 484. 75	27. 42	2.00	
	instructions)								
3.00	Subtotal salaries (line 1		10, 940, 743	4, 262, 732	15, 203, 47	371, 610. 64	40. 91	3.00	
	minus line 2)								
4.00	Subtotal other wages & related		4, 465, 626	0	4, 465, 626	97, 108. 94	45. 99	4.00	
	costs (see inst.)								
5.00	Subtotal wage-related costs		6, 665, 398	0	6, 665, 398	0.00	43. 84	5.00	
	(see inst.)								
6.00	Total (sum of lines 3 thru 5)		22, 071, 767	4, 262, 732	26, 334, 499	468, 719. 58	56. 18	6.00	
7.00	Total overhead cost (see		5, 487, 177	2, 997, 009	8, 484, 186	192, 056. 37	44. 18	7.00	
	instructions)			1	l		1		

instructions)

Health Financial Systems	HUNTINGTON MEMORIAL HOSPITAL	In Lie	u of Form CMS-2552-10
HOSPITAL WAGE RELATED COSTS	Provi der CCN: 15-0091	Peri od: From 01/01/2022	Worksheet S-3
			Data/Time Dropared

	To 12/31/2022	Date/Time Pre 5/18/2023 11:	
		Amount	50 am
		Reported	
		1. 00	
	PART IV - WAGE RELATED COSTS		
	Part A - Core List		1
	RETI REMENT COST		1
1.00	401K Employer Contributions	0	1.00
2.00	Tax Sheltered Annuity (TSA) Employer Contribution	396, 788	2.00
3.00	Nonqualified Defined Benefit Plan Cost (see instructions)	1, 227, 687	3.00
4.00	Qualified Defined Benefit Plan Cost (see instructions)	0	4.00
	PLAN ADMINISTRATIVE COSTS (Paid to External Organization)		
5.00	401K/TSA Plan Administration fees	0	5.00
6.00	Legal /Accounting/Management Fees-Pension Plan	2, 896	6.00
7.00	Employee Managed Care Program Administration Fees	61, 709	7.00
	HEALTH AND INSURANCE COST		1
8. 00	Health Insurance (Purchased or Self Funded)	0	8.00
8. 01	Health Insurance (Self Funded without a Third Party Administrator)	0	8. 01
8. 02	Health Insurance (Self Funded with a Third Party Administrator)	2, 517, 325	8. 02
8. 03	Health Insurance (Purchased)	0	8. 03
9.00	Prescription Drug Plan	686, 464	9.00
10.00	Dental, Hearing and Vision Plan	79, 487	10.00
11. 00	Life Insurance (If employee is owner or beneficiary)	15, 448	11.00
12.00	Accident Insurance (If employee is owner or beneficiary)	0	12.00
13.00	Disability Insurance (If employee is owner or beneficiary)	61, 083	13.00
14.00	Long-Term Care Insurance (If employee is owner or beneficiary)	0	14.00
15. 00	'Workers' Compensation Insurance	9, 128	15.00
16.00	Retirement Health Care Cost (Only current year, not the extraordinary accrual required by FASB 106.	0	16.00
	Noncumul ative portion)		l
	TAXES		
	FICA-Employers Portion Only	1, 423, 582	17. 00
	Medicare Taxes - Employers Portion Only	0	18. 00
19. 00	Unempl oyment Insurance	0	19.00
20.00	State or Federal Unemployment Taxes	0	20.00
	OTHER		l
21.00	Executive Deferred Compensation (Other Than Retirement Cost Reported on Lines 1 through 4 above. (See	49, 449	21.00
	instructions))		1
22.00	Day Care Cost and Allowances	0	22. 00
23.00	Tuition Reimbursement	23, 143	23. 00
24.00	Total Wage Related cost (Sum of lines 1 -23)	6, 554, 189	24. 00
	Part B - Other than Core Related Cost		l
25.00	OTHER WAGE RELATED COSTS (SPECIFY)		25. 00

Health Financial Systems	HUNTINGTON MEMORIAL HOSPITAL	In Lieu	eu of Form CMS-2552-10	
HOSPITAL CONTRACT LABOR AND BENEFIT COST	Provi der CCN: 15-0091	Peri od: From 01/01/2022	Worksheet S-3 Part V	

		110111011/2022		
		To 12/31/2022		
	Cook Cooker Description	0	5/18/2023 11:	36 am
	Cost Center Description	Contract	Benefit Cost	
		Labor	0.00	
		1. 00	2. 00	
	PART V - Contract Labor and Benefit Cost			1
	Hospital and Hospital-Based Component Identification:			
1. 00	Total facility's contract labor and benefit cost	0	0	1.00
2. 00	Hospi tal	0	0	2.00
3.00	SUBPROVI DER - I PF			3.00
4.00	SUBPROVI DER - I RF			4.00
5.00	Subprovi der - (Other)	0	0	5.00
6.00	Swing Beds - SNF	0	0	6.00
7.00	Swing Beds - NF	0	0	7. 00
8.00	SKILLED NURSING FACILITY			8.00
9.00	NURSING FACILITY			9.00
10.00	OTHER LONG TERM CARE I			10.00
11.00	Hospi tal -Based HHA			11.00
12.00	AMBULATORY SURGICAL CENTER (D. P.) I			12.00
13.00	Hospi tal -Based Hospi ce			13.00
14.00	Hospital-Based Health Clinic RHC			14.00
15. 00	Hospital - Based Health Clinic FOHC			15.00
	Hospi tal -Based-CMHC			16.00
17. 00	RENAL DI ALYSI S I			17.00
18. 00	Other	0	0	18.00
13.00	Totales	ı o	O	1 10.00

IIUSFI	n Financial Systems HUNTINGTON MEMORIAL F TAL UNCOMPENSATED AND INDIGENT CARE DATA Pr	ovider CC	N: 15-0091	Peri od:	u of Form CMS-2 Worksheet S-10		
10011	THE GROOMIN ENGINEED AND THEIR GENT GARLE BATTA	ovider oo		From 01/01/2022			
				To 12/31/2022	Date/Time Pre 5/18/2023 11:		
					1. 00		
	Uncompensated and indigent care cost computation						
. 00	Cost to charge ratio (Worksheet C, Part I line 202 column 3 divi	ded by li	ne 202 colum	n 8)	0. 209083	1.0	
. 00	Medicaid (see instructions for each line) Net revenue from Medicaid				5, 179, 923	2.0	
3. 00	Did you receive DSH or supplemental payments from Medicaid?				5, 179, 925 Y	3.0	
. 00	If line 3 is yes, does line 2 include all DSH and/or supplementa	al pavment	s from Medic	ai d?	Ϋ́	4.0	
. 00	If line 4 is no, then enter DSH and/or supplemental payments fro				0		
. 00	Medi cai d charges				28, 994, 309		
. 00	Medicaid cost (line 1 times line 6)				6, 062, 217		
. 00	Difference between net revenue and costs for Medicaid program (I < zero then enter zero)	ine / min	us sum of li	nes 2 and 5; if	882, 294	8.0	
	Children's Health Insurance Program (CHIP) (see instructions for	each lin	e)			<u> </u>	
. 00	Net revenue from stand-alone CHIP	00011 1111	<u> </u>		20, 150	9.0	
0. 00	Stand-alone CHIP charges				71, 927	10.0	
1. 00	Stand-alone CHIP cost (line 1 times line 10)				15, 039		
2. 00	Difference between net revenue and costs for stand-alone CHIP (I	ine 11 mi	nus line 9;	if < zero then	0	12.0	
	enter zero) Other state or local government indigent care program (see instr	ructions f	or each line	\			
3. 00	Net revenue from state or local indigent care program (Not inclu				6, 584, 055	13.0	
4. 00	Charges for patients covered under state or local indigent care			,	32, 757, 897	•	
	10)						
5.00	State or local indigent care program cost (line 1 times line 14)				6, 849, 119		
6. 00	Difference between net revenue and costs for state or local indi	gent care	program (li	ne 15 minus line	265, 064	16.0	
	13; if < zero then enter zero) Grants, donations and total unreimbursed cost for Medicaid, CHIP and state/local indigent care programs (see						
	instructions for each line)	ana stat	criccal indi-	gent care progre			
7. 00		9	,		0		
18.00	Government grants, appropriations or transfers for support of ho				0	18.0	
19. 00	Total unreimbursed cost for Medicaid , CHIP and state and local 8, 12 and 16)	i nai gent	care program	s (sum or lines	1, 147, 358	19.0	
	joj iz ana ioj		Uni nsured	Insured	Total (col. 1		
			pati ents	pati ents	+ col . 2)		
			1. 00	2. 00	3. 00		
0. 00	Uncompensated Care (see instructions for each line) Charity care charges and uninsured discounts for the entire faci	Li tv	3, 109, 21	3 1, 078, 690	4, 187, 903	l an r	
.0. 00	(see instructions)	iity	3, 109, 21	1,076,090	4, 107, 703	20.0	
1.00	Cost of patients approved for charity care and uninsured discoun	nts (see	650, 08	1, 078, 690	1, 728, 774	21.0	
	instructions)	,					
22. 00	Payments received from patients for amounts previously written of	off as		0	0	22.0	
	charity care Cost of charity care (line 21 minus line 22)		650, 08	1, 078, 690	1 720 774	22 0	
2 00	cost of charity care (fille 21 millius fille 22)		030, 00	1,076,090	1, 728, 774	23.0	
23.00					1. 00		
3. 00							
	Does the amount on line 20 column 2, include charges for patient	t days bey	ond a Length	of stay limit	N	24.0	
4. 00	imposed on patients covered by Medicaid or other indigent care p	orogram?	· ·	, and the second			
24. 00	imposed on patients covered by Medicaid or other indigent care p If line 24 is yes, enter the charges for patient days beyond the	orogram?	· ·	, and the second	N O	24. 0 25. 0	
24. 00	imposed on patients covered by Medicaid or other indigent care p If line 24 is yes, enter the charges for patient days beyond the stay limit	orogram? e indigent	· ·	, and the second	0	25. 0	
24. 00 25. 00 26. 00	imposed on patients covered by Medicaid or other indigent care p If line 24 is yes, enter the charges for patient days beyond the stay limit Total bad debt expense for the entire hospital complex (see inst	orogram? e indigent tructions)	care progra	, and the second	0 3, 709, 841	25. 0 26. 0	
24. 00 25. 00 26. 00 27. 00	imposed on patients covered by Medicaid or other indigent care p If line 24 is yes, enter the charges for patient days beyond the stay limit	orogram? e indigent tructions) (see inst	care progra	, and the second	0	25. 0 26. 0 27. 0	
24. 00 25. 00 26. 00 27. 00 27. 01 28. 00	imposed on patients covered by Medicaid or other indigent care possible line 24 is yes, enter the charges for patient days beyond the stay limit. Total bad debt expense for the entire hospital complex (see instance) Medicare reimbursable bad debts for the entire hospital complex (Medicare allowable bad debts for the entire hospital complex (See Non-Medicare bad debt expense (see instructions)	orogram? e indigent tructions) (see inst ee instruc	care progra ructions) tions)	m's length of	0 3, 709, 841 41, 698 64, 150 3, 645, 691	25. 0 26. 0 27. 0 27. 0 28. 0	
24. 00 25. 00 26. 00 27. 00 27. 01 28. 00 29. 00	imposed on patients covered by Medicaid or other indigent care possible line 24 is yes, enter the charges for patient days beyond the stay limit. Total bad debt expense for the entire hospital complex (see instance) Medicare reimbursable bad debts for the entire hospital complex (Medicare allowable bad debts for the entire hospital complex (See Non-Medicare bad debt expense (see instructions) Cost of non-Medicare and non-reimbursable Medicare bad debt expense.	orogram? e indigent tructions) (see inst ee instruc	care progra ructions) tions)	m's length of	0 3, 709, 841 41, 698 64, 150 3, 645, 691 784, 704	25. 0 26. 0 27. 0 27. 0 28. 0 29. 0	
24. 00 25. 00 26. 00 27. 00 27. 01 28. 00 29. 00 30. 00	imposed on patients covered by Medicaid or other indigent care possible line 24 is yes, enter the charges for patient days beyond the stay limit. Total bad debt expense for the entire hospital complex (see instance) Medicare reimbursable bad debts for the entire hospital complex (Medicare allowable bad debts for the entire hospital complex (See Non-Medicare bad debt expense (see instructions)	program? e indigent tructions) (see inst ee instruc ense (see	care progra ructions) tions)	m's length of	0 3, 709, 841 41, 698 64, 150 3, 645, 691	25. 0 26. 0 27. 0 27. 0 28. 0 29. 0 30. 0	

RECLASSIFICATION AND ADJUSTMENTS OF TELLS RAI ANCHOR FOR POPPINES COST Center Description Solaries Cost Center Description Solaries Cost Center Description Solaries Cost Center Description Solaries 1.00 2.00 3.00 4.00 1.00 3.00 4.00 1.00 1.00 3.00 4.00 1.00 1.00 3.00 3.00 4.00 1.00 3.00 3.00 4.00 1.00 3.00 1.00 3.00 3.00 4.00 1.00 3.00 3.00 3.00 4.00 1.00 3.00 3.00 3.00 3.00 4.00 1.00 3.0	Heal th	Financial Systems	HUNTI NGTON MEMORI	AL HOSPITAL		In Lie	u of Form CMS-	2552-10
Cost Center Description	RECLAS	SIFICATION AND ADJUSTMENTS OF TRIAL BALANCE	OF EXPENSES	Provi der C	CN: 15-0091	Peri od:	Worksheet A	
Cost Center Description							Date/Time Pre	
		Cost Center Description	Sal ari es	Other		ions (See	Reclassified Trial Balance	
DEBISER SERVICE COST CENTERS			1.00	2.00	2.00	4.00		
1.00 100/00 CAP REL DOSTS-BLOG & FIXT 2, 093, 327 1, 00 2, 000 1, 000		CENEDAL SERVICE COST CENTERS	1.00	2.00	3.00	4.00	5.00	
2.00 00000 CARP REL DOSTS-WARLE EQUIP 1,093_215 1,093_215 4,0361 1,193_757 2,00 0 0 00000 CARPEL CORTS-WARLE EQUIP 1,257_788 6,258_607 2,160_781 1,793_7788 6,258_607 2,160_781 1,793_7788 6,258_607 2,160_781 1,793_7788 6,258_607 2,160_781 1,793_7788 6,258_607 2,160_781 1,793_7788 6,258_607 2,160_781 1,793_7788 6,258_607 2,160_781 1,793_7788 6,258_607 2,160_781 1,793_7788 6,258_607 2,160_781 1,793_7788 6,258_607 2,160_781 1,793_7788 6,258_607 2,160_781 1,793_7788 6,258_607 2,160_781 1,793_7788 6,258_607 2,160_781 1,793_7788 6,258_607 2,160_781 1,793_7788 6,258_607 1,793_7788	1 00			2 010 421	2 010 42	1 52 911	2 063 332	1 00
3.00 00000 OTHER CAP REL COSTS 0 0 3 0 0 0 0 0 0 0		1					l	1
4.00 00000 Delivary Cere BERKETT'S DEPARTWENT 1,757,788 6,288,695 4,00 0.00				0,070,210			1	
5.00			1, 757, 788	6, 258, 695	8, 016, 48	3 -1, 757, 788	6, 258, 695	1
7.00 DO ODDOOL OF PRATTON OF PLANT 391, 034 865, 488 1, 256, 522 43, 144 1, 299, 660 7, 80 0.00 CORDOOL HUMSINEETP ININ 447, 484 141, 274 1, 274 142, 274 52, 50 17, 283 2, 20 10, 200 0.00 CORDO HUMSINEETP ININ 447, 484 143, 277 142, 274 15, 275, 671 31, 399 88, 287 9, 20 1.1 CORDO HUMSINEETP ININ 447, 484 143, 207 60, 100, 30 574, 583 9, 20 10, 20 1.2 CORDO HUMSINEETR AND HUMSING ADMINISTRATION 378, 649 6, 141 385, 653 411, 777 427, 461 12, 20 1.4 CO 1000 CONTRAL STRING CTS & SURPLY 609, 70 154, 685 764, 595 6 754, 595 754,	5.00	00500 ADMINISTRATIVE & GENERAL	1, 295, 027	23, 267, 391	24, 562, 41	-11, 398	24, 551, 020	5.00
8.00 0.06800 LAURDRY & LI NEN SERVI CE 0 145, 274 145, 277 52, 509 1977, 783 8.00 10.00 10.00 DIETARY 607, 305 423, 056 1.000, 361 -507, 529 522, 832 10.00 10.00 DIETARY 607, 305 423, 056 1.000, 361 -507, 529 522, 832 10.00 10.00 DIETARY 607, 305 423, 056 1.000, 361 -507, 529 522, 832 10.00 10.00 DIETARY 607, 305 423, 056 1.000, 361 -507, 529 522, 832 10.00 10.00 DIETARY 607, 305	6.00		0	0		0	0	6.00
9.00 0.000 DUISEREEPING		1	391, 034					1
10.00 01000 DETARY			0				l	1
11.00 01100 CAFTERIA 0 0 0 574,536 574,535 17.00 12.00 13.00 MIRSING ADMINISTRATION 378,649 6,914 385,563 41,777 427,340 13.00 13.00 CIVINAL SERVICE COST ENTERS 154,686 764,595			1 1				l	1
12 00 13200 MAINTENANCE OF PERSONNEL 0			1 1	423, 050	1		l	1
13.00 01300 NURSING ADMINISTRATION 378, 649 6, 914 395, 563 41, 777 427, 340 013.00 10.00 10.00 10.00 01.00				0				1
14.00 0 1400 CENTRAL SERVICES & SUPPLY 0 0 0 0 0 14.00 0 0 14.00 16.00 0 16.00 0 16.00 0 16.00 0 16.00 0 16.00 0 16.00 0 16.00 0 16.00 0 16.00 0 16.00 0 16.00 0 16.00 0 16.00 0 16.00 0 16.00 0 16.00 0 17.00 17.00 17.00 17.00 17.00 17.00 0			378, 649	6. 914	385. 56	-	1	1
15.00 01500 PHARMACY 6.09, 910 154, 685 764, 595 0 764, 596 15.00 17.00			0	0	100,00	0	0	1
17.00 01700 SOCIAL SERVICE 0 0 0 0 0 0 17.00	15.00	01500 PHARMACY	609, 910	154, 685	764, 59	5 0	764, 595	15.00
19.00 01900 MORPHYSICI AN AMESTHETISTS			0	0		0	0	16.00
20.00 0.0000 MURSING PROGRAM 0 0 0 0 0 0 0 0 0 0		· · · · · · · · · · · · · · · · · · ·	0	0	1	0	0	
21.00			0	0	1	0	0	
22.00 02300 RAY SERVICES—OTHER PROM COSTS APPRV 0 0 0 0 0 0 23.00 23.00 03.00 DARABLE DE DE PROM(SPECI FY) 0 0 0 0 0 0 23.00 23.00 03.00 DARABLE DE DE PROM(SPECI FY) 0 0 0 0 0 0 23.00 23.00 03.00 DARABLE DE DE PROM(SPECI FY) 0 0 0 0 0 0 0 23.00 23.00 03.00 DARABLE DE DE PROM(SPECI FY) 0 0 0 0 0 0 0 0 0			0	0		0	0	
23.00 02300 PARAMED ED PROM-CEPECI FYY 0 0 0 0 0 23.00			0	0		0	0	
INPATI ENT ROUTINE SERVICE COST CENTERS 3,726,630 1,261,514 4,988,144 -599,307 4,388,837 30.00 30.00 A000 AURITS & PEDIATRICS 5.00 0 0 185,705 185,705 43.00 30.00 A000 AURITS & PEDIATRICS 5.00 0 0 0 0 0 0 0 0 0				0		0		
30.00 03000 ADULTS & PEDIATRICS 3, 726, 630 1, 261, 514 4, 986, 144 -599, 307 4, 388, 837 30.00 ADULTS & PEDIATRICS 0 0 18, 755 185, 705 18, 705	23.00				'	5 5		25.00
## AMOLILARY SERVICE COST CENTERS 50. 00 DOSODO DEPRATING ROMON 1, 257, 318 617, 799 1, 875, 177 138, 723 2, 013, 840 50, 01 50. 01 SOCODI OPERATING ROMON 0 0 0 0 0 50, 01 50. 01 SOCODI DELIVERY ROMON & LABOR ROMON 0 0 92, 790 92, 8790 52, 00 53. 00 0550D DELIVERY ROMON & LABOR ROMON 0 1, 253, 037 1, 253, 037 0 1, 233, 037 53, 00 53. 00 0550D ANESTHESIOLOGY 0 1, 253, 037 1, 253, 037 1, 253, 037 0 1, 233, 037 53, 00 60. 00 0650D ARBORTORY 266 2, 895, 848 2, 895, 750 29 2, 895, 759 60, 00 0 0 0 0 0 62. 30 06250D BLOOD CLOTTIN OF OR HEMOPHILIACS 0 0 0 0 0 0 0 65. 00 0650D BLOOD CLOTTIN OF OR HEMOPHILIACS 0 0 0 0 0 0 65. 00 0650D PHYSICAL THERAPY 1, 205, 339 51, 027 1, 256, 366 335, 614 920, 752 66. 00 66. 00 0660D PHYSICAL THERAPY 1, 205, 339 51, 027 1, 256, 366 335, 614 920, 752 67. 00 67. 00 0670D OCCUPATIONAL THERAPY 0 0 0 0 257, 005 257, 005 67. 00 69. 00 0690D ELECTROCARDIOLOGY 0 0 0 0 0 0 69. 00 0690D ELECTROCARDIOLOGY 0 0 0 0 0 0 69. 00 0720D IMPLE DEV. CHARGED TO PATIENTS 0 0 0 0 0 0 69. 00 0720D IMPLE DEV. CHARGED TO PATIENTS 0 0 0 0 0 0 69. 00 0720D IMPLE DEV. CHARGED TO PATIENTS 0 2, 600, 889 2, 600, 889 2, 600, 883, 584 883, 584 69. 0769P ALLOGENER DEV. PHYSICAL THERAPY 262, 014 453, 231 715, 245 28, 999 744, 154 76, 89 76. 99 0769P ALLOGENER DEV. PHYSICAL THERAPY 262, 014 453, 231 715, 245 28, 999 744, 154 76, 89 76. 99 0769P ALLOGENER DEV. PHYSICAL THERAPY 262, 014 453, 231 715, 245 28, 999 744, 154 76, 89 76. 90 0769P ALLOGENER DEV. PHYSICAL THERAPY 262, 014 453, 231 715, 245 28, 999 744, 154 76, 89 76. 90 0769P ALLOGENER DEV. PHYSICAL THERAPY 1, 434, 395 249, 956 1, 684, 351 158, 261 1, 842, 612 91. 00 76. 00 0700D OBSERVATION BEDS (NON-DISTINCT PART 1,	30.00		3, 726, 630	1, 261, 514	4, 988, 14	4 -599, 307	4, 388, 837	30.00
50. 00	43.00	04300 NURSERY	0	0	(185, 705	185, 705	43.00
50. 01						_		
52.00 05200 DELLYERY ROOM & LABOR ROOM 0 0 0 928,790 928,790 52.00			1, 257, 318	617, 799	1, 875, 11			1
53.00 06300 ARSTHESI OLOGY 0 1, 253, 037 1, 253, 037 0 1, 253, 037 53, 00 0.00		1	0	0	1	-	1	1
54.00 05400 RADIOLOGY-DIAGNOSTIC 1, 217, 360 599, 078 1, 816, 438 134, 315 1, 950, 753 54.00 0			0	1 252 027	1 252 02			1
60.00			1 217 360					
62.30 06250 BLOOD CLOTTING FOR HEMOPHILIACS 0 0 0 0 0 0 0 0 0								
66 00 06600 PHYSI CAL THERAPY 1, 205, 339 51, 027 1, 256, 366 -335, 614 920, 752 66. 00 67. 00 67.00 6270 00 00 00 00 00 00 00		1	0			0	0	
67 00 06700 06700 06200 06800 0883.584 06800 0883.584 0883.	65.00	06500 RESPI RATORY THERAPY	677, 093	148, 187	825, 28	74, 705	899, 985	65.00
68.00 06800 SPECH PATHOLOGY 0 0 0 0 0 211,597 211,597 88.00 06900 06900 LECTROCARDI OLOGY 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0		1	1, 205, 339	51, 027	1, 256, 36		l	1
69. 00 06900			0	0	1			1
17. 00			0	0		211, 597		1
72. 00 07200 IMPL DEV. CHARGED TO PATIENTS 0 0 0 0 883,584 883,584 2. 00				1 420 202	1 420 20	002 504		1
73.00 07300 DRUGS CHARGED TO PATLENTS 0 2,060,989 2,060,989 67,293 2,128,282 73.00 76.97 O7697 CARDI AC REHABI LITATION 0 0 0 0 0 0 0 76.98 07698 HYPERBARIC OXYGEN THERAPY 262,014 453,231 715,245 28,909 744,154 76,98 76.99 07699 LITHOTRI PSY 0 0 0 0 0 0 0 0 77.00 O700 ALLOGEMEIC HSCT ACQUISITION 0 0 0 0 0 0 0 0 0				1, 439, 202	1, 437, 20.		l	1
76. 97 07697 CARDI AC REHABILLITATION 0 0 0 0 0 0 76. 97 76. 98 07698 HYPERBARIC OXYGEN THERAPY 262, 014 453, 231 715, 245 28, 909 744, 154 76. 98 77. 00 07699 LITHOTRI PSY 0 0 0 0 0 0 0 0 77. 00 07700 ALLOGENEIC HSCT ACQUISITION 0 0 0 0 0 0 0 90. 00 09000 CLINIC 138, 777 16, 521 155, 298 15, 312 170, 610 91. 00 09000 CLINIC 1, 434, 395 249, 956 1, 684, 351 158, 261 1, 842, 612 92. 00 09000 ORDER VARIATION BEDS (NON-DISTINCT PART 0 0 0 0 0 0 10. 00 09000 0. 0 0 0 0 0 0 0 10. 00 09000 0. 0 0 0 0 0 10. 00 09000 0. 0 0 0 0 0 10. 00 09000 0. 0 0 0 0 10. 00 09000 0. 0 0 0 0 10. 00 09000 0. 0 0 0 10. 00 09000 0. 0 0 0 10. 00 09000 0. 0 0 10. 00 09000 0. 0 0 10. 00 09000 0. 0 0 10. 00 09000 0. 0 0 10. 00 09000 0. 0 0 10. 00 09000 0. 0 0 10. 00 09000 0. 0 0 10. 00 09000 0. 0 0 10. 00 0. 0 0 0 10. 00 0. 0 0 0 10. 00 0. 0 0 0 10. 00 0. 0 0 10. 00			0	2, 060, 989	2, 060, 98			
76. 98 07698 INTPERBARIC OXYGEN THERAPY 262, 014 453, 231 715, 245 28, 909 744, 154 76, 98 76. 99 07699 LI HOTRI PSY 0 0 0 0 0 0 0 0 0 0 77. 00 07700 ALLOGENEIC HSCT ACQUISITION 0 0 0 0 0 0 0 0 0 0 77. 00 07700 ALLOGENEIC HSCT ACQUISITION 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0			0	0	,			
77. 00 07700 ALLOGENEIC HSCT ACQUI SITION 0 0 0 0 0 0 0 0 0			262, 014	453, 231	715, 24	5 28, 909		
OUTPATT ENT SERVICE COST CENTERS 138, 777 16, 521 155, 298 15, 312 170, 610 90. 00 90.			0	0	1	0	·	
90. 00 09000 CLINIC 138,777 16,521 155,298 15,312 170,610 90. 00 91. 00 09100 EMERGENCY 1,434,395 249,956 1,684,351 158,261 1,842,612 91. 00 92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART 92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART 92. 00 09500 AMBULANCE SERVICES 3,154,133 655,670 3,809,803 193,596 4,003,399 95. 00 102. 00 OD	77. 00	07700 ALLOGENEI C HSCT ACQUI SI TI ON	0	0		0 0	0	77. 00
91. 00 09100 EMERGENCY 1, 434, 395 249, 956 1, 684, 351 158, 261 1, 842, 612 91. 00 92.00 0BSERVATI ON BEDS (NON-DISTINCT PART 92. 00 00 00 00 00 00 00 00	00 00	OOOOO CLINIC	120 777	16 521	155 20	0 15 212	170 610	00.00
92. 00 OTHER REI MBURSABLE COST CENTERS 95. 00 OSSOCI AMBULANCE SERVI CES 102. 00 OSSOCI AMBULANCE SERVI CES 103. 102. 00 OSSOCI AMBULANCE SERVI CES 103. 00 OSSOCI AMBULANCE SERVI CES 104. 00 OSSOCI AMBULANCE SERVI CES 105. 00 OSSOCI AMBULANCE SERVI CES 106. 00 OSSOCI AMBULANCE SERVI CES 107. 00 OSSOCI AMBULANCE SERVI CES 108. 00 OSSOCI AMBULANCE SERVI CES 109. 00 OSSOCI CENTERS 109. 00 OSSOCI AMBULANCE SERVI CES 109. 00 OSSOCI CESTER O							1	1
OTHER REIMBURSABLE COST CENTERS 3, 154, 133 655, 670 3, 809, 803 193, 596 4, 003, 399 95. 00 102.00 102.00 102.00 10 TREATMENT PROGRAM 0 0 0 0 0 0 0 0 0			1, 101, 070	2.77,700	1,001,00		1,012,012	
102. 00 102.00 102.00 102.00 102.00 102.00 103.00		· ·						
SPECIAL PURPOSE COST CENTERS 113.00 11300 INTEREST EXPENSE 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0		1	3, 154, 133	655, 670	3, 809, 80	3 193, 596		1
113.00	102.00		0	0		0	0	102.00
181. 00 SUBTOTALS (SUM OF LINES 1 through 117) 18,560,502 46,072,041 64,632,543 -9,298 64,623,245 118. 00	112 00							112 00
NONRE MBURSABLE COST CENTERS 190. 00 19000 GI FT. FLOWER, COFFEE SHOP & CANTEEN 0 23, 768 23, 768 0 23, 768 190. 00			18 560 502	46 072 041	64 632 54		l .	1
190. 00 19000 GFT, FLOWER, COFFEE SHOP & CANTEEN 0 23, 768 0 637 0 637 191. 00 19100 RESEARCH 0 637 191. 00 19100 RESEARCH 0 637 191. 00 637 637 0 637 191. 00 19200 PHYSI CI ANS' PRI VATE OFFI CES 74, 668 9, 832 84, 500 8, 238 92, 738 192. 00 19200 PHYSI CI ANS' PRI VATE OFFI CES 74, 668 9, 832 84, 500 8, 238 92, 738 192. 00 0 0 0 0 0 0 194. 00 194. 00 194. 01 07951 PAI N CLI NI C 0 0 0 0 0 0 0 0 194. 00 194. 00 194. 01 07952 OCC HEALTH 0 0 0 0 0 0 0 0 0 194. 02 194. 03 07953 FOUNDATI O 0 69, 145 69, 145 0 69, 145 0 69, 145 194. 03 194. 04 07954 KI DS CAMPUS 0 0 0 0 0 0 0 0 0 0 194. 04 194. 05 07955 COMMUNI TY & VOLUNTEER SERVI CES 9, 610 67, 427 77, 037 1, 060 78, 097 194. 05 194. 06 07956 HUNTI NGTON COLLEGE NURSE 0 0 0 0 0 0 194. 06 194. 06 194. 07 07957 MI SC CATERI NG 0 0 0 0 0 0 0 194. 08 194. 09 07959 HUNTI NGTON BUA	110.00) 18, 300, 302	40, 072, 041	04, 032, 34	5 -7, 270	04, 023, 243	1110.00
191. 00 19100 RESEARCH 0 637 637 0 637 191. 00 192. 00 19200 PHYSI CI ANS' PRI VATE OFFI CES 74, 668 9, 832 84, 500 8, 238 92, 738 192. 00 194. 00 07950 OCC HEALTH 0 0 0 0 0 0 194. 00 194. 01 07951 PAI N CLI NI C 0 0 0 0 0 0 0 194. 01 194. 02 07952 OCC HEALTH 0 0 0 0 0 0 0 0 194. 01 194. 03 07953 FOUNDATI 0 0 69, 145 69, 145 0 69, 145 0 69, 145 194. 03 194. 04 07954 KI DS CAMPUS 0 0 0 0 0 0 0 194. 02 194. 05 07955 COMMUNI TY & VOLUNTEER SERVI CES 9, 610 67, 427 77, 037 1, 060 78, 097 194. 05 194. 06 07956 HUNTI NGTON COLLEGE NURSE 0 0 0 0 0 0 194. 06 194. 07 07957 MI SC CATERI NG 0 0 0 0 0 0 0 194. 07 194. 08 07958 AUTI SM CENTER 0 0 0 0 0 0 0 194. 09 194. 09 07959 HUNTI NGTON BUA	190.00		0	23, 768	23, 76	8 0	23, 768	190. 00
194. 00 07950 OCC HEALTH 0 0 0 0 0 0 194. 00 194. 01 07951 PAIN CLINIC 0 0 0 0 0 0 194. 01 194. 02 07952 OCC HEALTH 0 0 0 0 0 0 194. 01 194. 03 07953 FOUNDATI 0 0 69, 145 69, 145 0 69, 145 0 69, 145 194. 03 194. 04 07954 KI DS CAMPUS 0 0 0 0 0 0 0 194. 04 194. 05 07955 COMMUNI TY & VOLUNTEER SERVICES 9, 610 67, 427 77, 037 1, 060 78, 097 194. 05 194. 06 07956 HUNTI NGTON COLLEGE NURSE 0 0 0 0 0 0 0 194. 06 194. 08 07958 AUTI SM CENTER 0 0 0 0 0 0 0 194. 08 194. 09 07959 HUNTI NGTON BUA			0	637	63	7 0	637	191.00
194. 01 07951 PAIN CLINIC 0 0 0 0 0 194. 01 194. 02 194. 02 07952 OCC HEALTH 0 0 0 0 0 0 194. 02 194. 03 07953 FOUNDATI 0 0 69, 145 69, 145 0 69, 145 194. 03 194. 05 07955 COMMUNI TY & VOLUNTEER SERVI CES 9, 610 67, 427 77, 037 1, 060 78, 097 194. 05 194. 06 07956 HUNTI NGTON COLLEGE NURSE 0 0 0 0 0 0 194. 06 194. 07 194. 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. 08 194. 09 07959 HUNTI NGTON BUA			74, 668	9, 832	84, 50	8, 238		
194. 02 07952 OCC HEALTH 0 0 0 0 0 0 194. 02 194. 03 07953 FOUNDATI 0 0 69, 145 69, 145 0 69, 145 194. 03 194. 04 07954 KI DS CAMPUS 0 0 0 0 0 0 0 194. 04 194. 05 07955 COMMUNI TY & VOLUNTEER SERVI CES 9, 610 67, 427 77, 037 1, 060 78, 097 194. 05 194. 06 07956 HUNTI NGTON COLLEGE NURSE 0 0 0 0 0 0 194. 06 194. 07 07957 MI SC CATERI NG 0 0 0 0 0 0 194. 06 194. 09 07959 HUNTI SM CENTER 0 0 0 0 0 0 0 194. 08 194. 09 07959 HUNTI NGTON BUA			0	0	1	-	l e	
194. 03 07953 FOUNDATI 0 0 69, 145 09 0 0 0 0 0 194. 03 194. 04 07954 KI DS CAMPUS 0 0 0 0 0 0 0 194. 04 07954 COMMUNI TY & VOLUNTEER SERVI CES 9, 610 67, 427 77, 037 1, 060 78, 097 194. 05 194. 07 07957 MI SC CATERI NG 0 0 0 0 0 194. 08 07958 AUTI SM CENTER 0 0 0 0 0 0 194. 08 194. 09 07959 HUNTI NGTON BUA			0	0	1	0	l e	
194. 04 07954 KI DS CAMPUS 194. 05 07955 COMMUNITY & VOLUNTEER SERVICES 194. 06 07956 HUNTI NGTON COLLEGE NURSE 194. 07 07957 MI SC CATERI NG 194. 08 07958 AUTI SM CENTER 194. 09 07959 HUNTI NGTON BUA 0 0 0 0 0 194. 04 0 194. 05 194. 06 194. 07 194. 08 194. 09 07959 HUNTI NGTON BUA			0	40 145	40.14	0	l e	
194. 05 07955 COMMUNITY & VOLUNTEER SERVICES 9, 610 67, 427 77, 037 1, 060 78, 097 194. 05 194. 06 07956 HUNTI NGTON COLLEGE NURSE 0 0 0 0 0 194. 06 194. 07 194. 08 07958 AUTISM CENTER 0 0 0 0 0 194. 08 194. 09 07959 HUNTI NGTON BUA				09, 145 0	09, 14	0		
194. 06 07956 HUNTI NGTON COLLEGE NURSE			9 610	67 427	77 03	1 060		
194. 07 07957 MISC CATERING			7, 010	07, 427	,,,03	0 1,000		
194. 08 07958 AUTI SM CENTER			Ō	Ō		o o	l	
	194. 08	07958 AUTISM CENTER	0	0		0	0	194. 08
200.00 TOTAL (SUM OF LINES 118 through 199) 18,644,780 46,242,850 64,887,630 0 64,887,630 200.00		l l	0	0	1			
	200.00	TOTAL (SUM OF LINES 118 through 199)	18, 644, 780	46, 242, 850	64, 887, 63	0 (0	64, 887, 630	200.00

Provi der CCN: 15-0091

Period: Worksheet A From 01/01/2022 To 12/31/2022 Date/Time Prepared: 5/18/2023 11:36 am

				5/18/2023 11:	
	Cost Center Description	Adjustments	Net Expenses		
		(See A-8)	For		
		/ 00	Allocation		
	GENERAL SERVICE COST CENTERS	6. 00	7. 00		_
1. 00	00100 CAP REL COSTS-BLDG & FLXT	615, 062	2, 678, 394		1.00
2. 00	00200 CAP REL COSTS-MVBLE EQUIP	644, 763			2.00
3.00	00300 OTHER CAP REL COSTS	0 11,700	0	l e e e e e e e e e e e e e e e e e e e	3.00
4.00	00400 EMPLOYEE BENEFITS DEPARTMENT	-3, 208	6, 255, 487	,	4.00
5.00	00500 ADMINISTRATIVE & GENERAL	-10, 429, 303		1	5.00
6.00	00600 MAINTENANCE & REPAIRS	0	0		6.00
7.00	00700 OPERATION OF PLANT	-2, 326	1, 297, 340		7.00
8.00	00800 LAUNDRY & LINEN SERVICE	0	197, 783		8. 00
9. 00	00900 HOUSEKEEPI NG	0	589, 532		9. 00
10.00	01000 DI ETARY	-4, 529			10.00
11.00	01100 CAFETERI A	-418, 418	156, 117 0	l e e e e e e e e e e e e e e e e e e e	11.00
12. 00 13. 00	01200 MAINTENANCE OF PERSONNEL 01300 NURSING ADMINISTRATION	0	427, 340		12. 00 13. 00
14. 00	01400 CENTRAL SERVICES & SUPPLY	0	427, 340		14.00
15. 00	01500 PHARMACY	-55, 897	708, 698		15.00
16. 00	01600 MEDI CAL RECORDS & LI BRARY	33, 077	700,070		16.00
17. 00	01700 SOCIAL SERVICE	Ö	Ö		17. 00
19. 00	01900 NONPHYSI CI AN ANESTHETI STS	Ö	Ö		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 I&R SERVICES-OTHER PRGM COSTS APPRV	0	0		22. 00
23.00	02300 PARAMED ED PRGM-(SPECIFY)	0	0		23. 00
	INPATIENT ROUTINE SERVICE COST CENTERS				4
30.00	03000 ADULTS & PEDIATRICS	26, 632	4, 415, 469		30.00
43. 00	04300 NURSERY	0	185, 705)	43.00
EO 00	ANCILLARY SERVICE COST CENTERS	1 252 027	740.002	, i	F0 00
50. 00 50. 01	05000 OPERATI NG ROOM 05001 OPERATI NG ROOM	-1, 253, 037 0	760, 803 0		50. 00 50. 01
52. 00	05200 DELIVERY ROOM & LABOR ROOM		928, 790		52.00
53. 00	05300 ANESTHESI OLOGY	0	1, 253, 037		53.00
54. 00	05400 RADI OLOGY-DI AGNOSTI C	-487	1, 950, 266		54.00
60.00	06000 LABORATORY	0	1		60.00
62. 30	06250 BLOOD CLOTTING FOR HEMOPHILIACS	0	0		62. 30
65.00	06500 RESPIRATORY THERAPY	0	899, 985		65.00
66.00	06600 PHYSI CAL THERAPY	-23, 023	897, 729		66.00
67. 00	06700 OCCUPATI ONAL THERAPY	0	257, 005		67.00
68. 00	06800 SPEECH PATHOLOGY	0	211, 597		68. 00
69. 00	06900 ELECTROCARDI OLOGY	0	0		69.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0			71.00
72. 00 73. 00	07200 IMPL. DEV. CHARGED TO PATIENTS 07300 DRUGS CHARGED TO PATIENTS	0	883, 584		72. 00 73. 00
76. 97	07300 DRUGS CHARGED TO PATTENTS	0	2, 128, 282		76. 97
76. 98	07698 HYPERBARI C OXYGEN THERAPY		744, 154		76. 98
76. 99	07699 LI THOTRI PSY	0			76. 99
77. 00	07700 ALLOGENEIC HSCT ACQUISITION	Ö	ł	l e e e e e e e e e e e e e e e e e e e	77. 00
	OUTPATIENT SERVICE COST CENTERS	<u> </u>	<u>'</u>	1	1
90.00		0	170, 610		90.00
91. 00	09100 EMERGENCY	-45, 216	1, 797, 396		91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART				92.00
	OTHER REIMBURSABLE COST CENTERS	T		T	4
95.00		-12, 098			95.00
102.00	10200 OPIOID TREATMENT PROGRAM	0	0)	102. 00
112 0	SPECIAL PURPOSE COST CENTERS	1 0		N.	112 00
113.00) 11300 INTEREST EXPENSE) SUBTOTALS (SUM OF LINES 1 through 117)	0 -10, 961, 085		l .	113. 00 118. 00
116.0	NONREI MBURSABLE COST CENTERS	-10, 901, 003	33,002,100	<u>/ </u>	1110.00
190 0	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	Ο	23, 768		190. 00
	19100 RESEARCH	0	637		191.00
	19200 PHYSICIANS' PRIVATE OFFICES	Ö	92, 738		192.00
	07950 OCC HEALTH	0	0		194.00
	07951 PAIN CLINIC	0	Ö		194. 01
194. 0	07952 OCC HEALTH	0	0		194. 02
194.0	07953 FOUNDATI O	0	69, 145	5	194. 03
	07954 KIDS CAMPUS	0	0		194. 04
	07955 COMMUNITY & VOLUNTEER SERVICES	0	78, 097	1	194. 05
	07956 HUNTI NGTON COLLEGE NURSE	0	0		194.06
	7 07957 MI SC CATERI NG	0	0)	194. 07
	3 07958 AUTI SM CENTER	0	J 5		194.08
	707959 HUNTI NGTON BUA	10.041.005	52 024 545		194. 09
200. 00	TOTAL (SUM OF LINES 118 through 199)	-10, 961, 085	53, 926, 545	⁷ l	200. 00

						e/IIme Prepared: 3/2023 11:36 am
		Increases			1	57 2020 11: 00 um
	Cost Center	Li ne #	Sal ary	Other		
	2.00	3.00	4. 00	5. 00		
	A - CAFETERIA & CATERING					
1.00	CAFETERI A	11. 00	330, 998	243, 537		1.00
			330, 998	243, 537		
	B - INTEREST RECLASSIFICATION					
1.00		0.00	0_	0		1.00
	0		0	0		
	C - INSURANCE RECLASS					
1.00	CAP REL COSTS-BLDG & FIXT	1.00	0	52, 911		1.00
2.00	CAP REL COSTS-MVBLE EQUIP	2. 00	0	<u>46, 3</u> 61		2. 00
	0		0	99, 272		
	E - LAUNDRY RECLASS					
1.00	LAUNDRY & LINEN SERVICE		5 <u>2, 5</u> 09	0		1.00
	0		52, 509	0		
	F - HOME OFFICE SALARY RECLAS	S				
1.00	ADMI NI STRATI VE & GENERAL		<u>4, 465, 6</u> 26	0		1.00
	0		4, 465, 626	0		
	G - PTO & BENEFITS RECLASS					
1.00	ADMINISTRATIVE & GENERAL	5. 00	87, 874	0		1.00
2.00	OPERATION OF PLANT	7. 00	43, 144	0		2.00
3.00	HOUSEKEEPI NG	9. 00	49, 370	0		3.00
4.00	DI ETARY	10. 00	67, 006	0		4. 00
5.00	NURSING ADMINISTRATION	13. 00	41, 777	0		5. 00
7.00	ADULTS & PEDIATRICS	30. 00	515, 188	0		7. 00
8.00	OPERATI NG ROOM	50. 00	138, 723	0		8. 00
9. 00	RADI OLOGY-DI AGNOSTI C	54. 00	134, 315	0		9. 00
10.00	LABORATORY	60. 00	29	0		10.00
11. 00	RESPI RATORY THERAPY	65. 00	74, 705	0		11.00
12. 00	PHYSI CAL THERAPY	66. 00	132, 988	0		12.00
13.00	DRUGS CHARGED TO PATIENTS	73. 00	67, 293	0		13.00
14. 00	HYPERBARI C OXYGEN THERAPY	76. 98	28, 909	0		14.00
15. 00	CLINIC	90. 00	15, 312	0		15.00
16. 00	EMERGENCY	91. 00	158, 261	0		16.00
17. 00	AMBULANCE SERVICES	95. 00	193, 596	0		17.00
18. 00	PHYSICIANS' PRIVATE OFFICES	192. 00	8, 238	0		18.00
19. 00	COMMUNITY & VOLUNTEER	194. 05	1, 060	0		19.00
	SERVI CES	+				
	U LAMBI ANTE		1, 757, 788	0		
1 00	H - IMPLANTS	72.00	ما	002 504		1.00
1. 00	IMPL. DEV. CHARGED TO	72. 00	0	883, 584		1.00
	PATI ENTS	+				
	I - OB RECLASS		υ	883, 584		
1. 00	NURSERY	43. 00	143, 351	42, 354		1.00
2. 00	DELIVERY ROOM & LABOR ROOM	52. 00	716, 961	211, 829		2.00
2.00	O LADOK KOOM		860, 312	21 <u>1, 829</u> 254, 183		2.00
	J - THERAPY RECLASS		000, 312	254, 105		
1. 00	OCCUPATI ONAL THERAPY	67. 00	246, 567	10, 438		1.00
2. 00	SPEECH PATHOLOGY	68. 00	203, 003	8, 594		2.00
2.00	0		449, 570	$\frac{19,032}{19,032}$		2.00
500 00	Grand Total: Increases	+	7, 916, 803	1, 499, 608		500.00
555.00	Jo. a.i.a. 70 tall. 11101 04303	1	7, 710, 303	1, 177, 000		1 000.00

					То	12/31/2022	Date/Time Prepared: 5/18/2023 11:36 am
		Decreases					
	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	33 <u>0, 9</u> 98	24 <u>3, 5</u> 37			1.00
	0		330, 998	243, 537			
	B - INTEREST RECLASSIFICATION		.1				
1. 00		000	0_	0	0		1.00
	U LNCUBANCE DECLACE		O	0)		
1 00	C - INSURANCE RECLASS	F 00	ما	00.070	10		1 00
1. 00 2. 00	ADMINISTRATIVE & GENERAL	5. 00	0	99, 272	12		1.00
2.00				<u></u> 0			2.00
	E - LAUNDRY RECLASS		·	99, 212			
1. 00	HOUSEKEEPI NG	9. 00	52, 509	0	0		1.00
1.00	0		52, 509				1.00
	F - HOME OFFICE SALARY RECLAS	S	32, 307		′		
1.00	ADMINISTRATIVE & GENERAL	5. 00	0	4, 465, 626	0		1.00
1.00	0		 _	4, 465, 626			1.00
	G - PTO & BENEFITS RECLASS		<u> </u>	17 1007 020			
1.00	EMPLOYEE BENEFITS DEPARTMENT	4. 00	1, 757, 788	0	0		1.00
2.00		0.00	0	0			2.00
3.00		0.00	О	0	0		3.00
4.00		0.00	0	0	0		4.00
5.00		0.00	O	0	0		5. 00
7.00		0. 00	0	0	0		7. 00
8.00		0. 00	0	0	0		8. 00
9.00		0.00	0	0	0		9.00
10.00		0. 00	0	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			14.00
15. 00		0.00	0	0			15. 00
16.00		0.00	0	0	1		16.00
17. 00		0.00	0	0			17. 00
18. 00 19. 00		0. 00 0. 00	U O	0	1		18. 00 19. 00
19.00				0			19.00
	H - IMPLANTS		1, 757, 760	0			
1.00	MEDICAL SUPPLIES CHARGED TO	71. 00	0	883, 584	0		1, 00
1.00	PATI ENT	71.00	ď	000, 004			1.00
		+		883, 584			
	I - OB RECLASS		-1				
1.00	ADULTS & PEDIATRICS	30. 00	860, 312	254, 183	0		1.00
2.00		0.00	0	0	1		2.00
		- $ -$	860, 312	254, 183			
	J - THERAPY RECLASS						
1.00	PHYSI CAL THERAPY	66. 00	449, 570	19, 032	2 0		1.00
2.00		0.00	0	0			2.00
	0		449, 570	19, 032			
500.00	Grand Total: Decreases		3, 451, 177	5, 965, 234			500.00

Provider CCN: 15-0091

				10	12/31/2022	5/18/2023 11:	
				Acqui si ti ons			
		Begi nni ng	Purchases	Donati on	Total	Disposals and	
		Bal ances				Retirements	
		1. 00	2. 00	3. 00	4. 00	5. 00	
	PART I - ANALYSIS OF CHANGES IN CAPITAL ASSE	T BALANCES					
1. 00	Land	0	0	0	0	0	1.00
2. 00	Land Improvements	625, 461	20, 520		20, 520	0	2.00
	Buildings and Fixtures	10, 098, 058	74, 980	0	74, 980	0	3.00
	Building Improvements	32, 500	0	0	0	0	4.00
	Fixed Equipment	2, 024, 291	162, 103		162, 103	0	5.00
	Movable Equipment	15, 777, 987	373, 215		373, 215	219, 442	6.00
	HIT designated Assets	3, 027, 668	66, 855		66, 855	0	7.00
	Subtotal (sum of lines 1-7)	31, 585, 965	697, 673	0	697, 673	219, 442	8.00
	Reconciling Items	3, 255, 352	0	0	0	0	9. 00
10. 00	Total (line 8 minus line 9)	28, 330, 613	697, 673	0	697, 673	219, 442	10.00
		Endi ng	Ful l y				
		Bal ance	Depreci ated				
			Assets				
		6. 00	7. 00				
	PART I - ANALYSIS OF CHANGES IN CAPITAL ASSE	I BALANCES					
1. 00	Land	0					1.00
2. 00	Land Improvements	645, 981	414, 646				2.00
	Buildings and Fixtures	10, 173, 038	1, 283, 279				3.00
	Building Improvements	32, 500	0				4.00
	Fi xed Equipment	2, 186, 394	210, 823				5.00
	Movabl e Equi pment	15, 931, 760	9, 308, 298				6.00
	HIT designated Assets	3, 094, 523	0				7. 00
	Subtotal (sum of lines 1-7)	32, 064, 196	11, 217, 046				8.00
	Reconciling Items	3, 255, 352	0				9.00
10. 00	Total (line 8 minus line 9)	28, 808, 844	11, 217, 046				10.00

Heal th	n Financial Systems	HUNTINGTON MEMO	RIAL HOSPITAL		In Lieu of Form CMS-2552-10			
RECON	CILIATION OF CAPITAL COSTS CENTERS		Provi der Co		Period: Worksheet A-7 From 01/01/2022 Part II			
						Date/Time Pre	pared:	
						5/18/2023 11:	36 am	
			SL	JMMARY OF CAPI	TAL			
	Cost Center Description	Depreciation	Lease	Interest	Insurance	Taxes (see		
		·			(see	instructions)		
					instructions)	ŕ		
		9. 00	10.00	11.00	12.00	13.00		
PART II - RECONCILIATION OF AMOUNTS FROM WORKSHEET A, COLUMN 2, LINES 1 and 2								
1.00	CAP REL COSTS-BLDG & FIXT	2, 010, 421	0		0 0	0	1.00	
2.00	CAP REL COSTS-MVBLE EQUIP	1, 093, 215	0		0 0	0	2.00	
3.00	Total (sum of lines 1-2)	3, 103, 636	0		0 0	0	3.00	
		SUMMARY 0	F CAPITAL					
	Cost Center Description	Other	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	KSHEET A, COLUM	MN 2, LINES 1 a	and 2				
1.00	CAP REL COSTS-BLDG & FIXT	0	2, 010, 421				1.00	
2.00	CAP REL COSTS-MVBLE EQUIP	0	1, 093, 215				2.00	
3.00	Total (sum of lines 1-2)	0	3, 103, 636				3.00	

Heal th	n Financial Systems	HUNTINGTON MEMO	RIAL HOSPITAL		In Lieu of Form CMS-2552-10			
RECON	CILIATION OF CAPITAL COSTS CENTERS		Provi der Co		Period: From 01/01/2022 To 12/31/2022		pared:	
		COMI	PUTATION OF RAT	TI 0S	ALLOCATION OF	OTHER CAPITAL		
	Cost Center Description	Gross Assets	Capi tal i zed	Gross Assets		Insurance		
			Leases	for Ratio	instructions)			
				(col. 1 -				
		1. 00	2.00	col . 2)	4.00	F 00		
	PART III - RECONCILIATION OF CAPITAL COSTS O		2.00	3.00	4. 00	5. 00		
1. 00	CAP REL COSTS-BLDG & FIXT	13, 037, 914	0	13, 037, 91	0. 409410	0	1.00	
2. 00	CAP REL COSTS-MVBLE EQUIP	19, 026, 285	l .				2.00	
3. 00	Total (sum of lines 1-2)	32, 064, 199					3.00	
	, , , ,	ALLOCATION OF OTHER CAPITAL				F CAPITAL		
	Cost Center Description	Taxes		Total (sum of	Depreciation	Lease		
			Capi tal -Rel at					
		(00	ed Costs	through 7)	0.00	10.00		
	PART III - RECONCILIATION OF CAPITAL COSTS O	6. 00	7.00	8.00	9. 00	10.00		
1. 00	CAP REL COSTS-BLDG & FIXT	ENTERS	0		0 3, 816, 297	-1, 190, 814	1.00	
2. 00	CAP REL COSTS-BEDG & TTXT	0	0		0 1, 741, 480		2.00	
3. 00	Total (sum of lines 1-2)	0	0		5, 557, 777		3.00	
		-	SL	JMMARY OF CAPI		.,		
	Cost Center Description	Interest	Insurance	Taxes (see	0ther	Total (2)		
			(see	instructions)	Capi tal -Rel at			
			instructions)		ed Costs (see	9 through 14)		
		11. 00	12. 00	13.00	instructions) 14.00	15. 00		
	PART III - RECONCILIATION OF CAPITAL COSTS O		12.00	13.00	14.00	15.00		
1. 00	CAP REL COSTS-BLDG & FLXT	0	52, 911		0 0	2, 678, 394	1.00	
2. 00	CAP REL COSTS-MVBLE EQUIP	-3, 502			o o		2.00	
3.00	Total (sum of lines 1-2)	-3, 502			0		3.00	
		*		-				

7123031	MENTO TO EXILENCES			Treviaer con. 16 co/1	From 01/01/2022 To 12/31/2022		
			_	Expense Classification o		5/18/2023 11:	36 am_
			10	/From Which the Amount is	s to be Adjusted		
	Cost Center Description	Basi s/Code	Amount	Cost Center	Li ne #	Wkst. A-7	
	cost center bescription	(2)				Ref.	
1. 00	Investment income - CAP REL	1. 00	2. 00 0 CA	3.00 P REL COSTS-BLDG & FLXT	4. 00	5. 00 0	1.00
2. 00	COSTS-BLDG & FIXT (chapter 2) Investment income - CAP REL	В	-3, 502 CA	P REL COSTS-MVBLE EQUIP	2. 00	11	2. 00
3. 00	COSTS-MVBLE EQUIP (chapter 2) Investment income - other		0		0.00	0	3. 00
4. 00	(chapter 2) Trade, quantity, and time		0		0. 00	0	4. 00
	discounts (chapter 8)		0				
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	6. 00
7. 00	Tel ephone services (pay stations excluded) (chapter	А	-16, 244 AD	MINISTRATIVE & GENERAL	5. 00	0	7. 00
8. 00	21) Tel evi si on and radi o servi ce	A	-2. 326 OP	ERATION OF PLANT	7. 00	0	8. 00
9. 00	(chapter 21) Parking Lot (chapter 21)		_,		0. 00	0	9. 00
10.00	Provi der-based physi ci an	A-8-2	-1, 308, 468		0.00	0	10. 00
11. 00	adjustment Sale of scrap, waste, etc.		0		0. 00	0	11.00
12. 00	(chapter 23) Related organization	A-8-1	-7, 893, 529			0	12. 00
13. 00	transactions (chapter 10) Laundry and linen service		0		0.00	0	13. 00
14. 00 15. 00	Cafeteria-employees and guests Rental of quarters to employee		-117, 488 CA 0	FETERI A	11. 00 0. 00	0	14. 00 15. 00
16. 00	and others Sale of medical and surgical		0		0. 00	0	16. 00
10.00	supplies to other than patients				0.00	Ŭ	10.00
17. 00	Sale of drugs to other than		O		0. 00	0	17. 00
18. 00	patients Sale of medical records and		0		0.00	0	18. 00
19. 00	abstracts Nursing and allied health		0		0. 00	0	19. 00
	education (tuition, fees, books, etc.)						
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
22.00	repay Medicare overpayments	A-8-3	ODE	SPI RATORY THERAPY	45.00		23. 00
23. 00	Adjustment for respiratory therapy costs in excess of	A-0-3	OKE	SPIRATURY THERAPY	65. 00		23.00
24. 00	limitation (chapter 14) Adjustment for physical	A-8-3	ОРН	YSI CAL THERAPY	66. 00		24. 00
	therapy costs in excess of limitation (chapter 14)						
25. 00	Utilization review - physicians' compensation		0 **	* Cost Center Deleted ***	114. 00		25. 00
26. 00	(chapter 21) Depreciation - CAP REL		O CA	P REL COSTS-BLDG & FIXT	1. 00	0	26. 00
27. 00	COSTS-BLDG & FIXT Depreciation - CAP REL			P REL COSTS-MVBLE EQUIP	2. 00	0	27. 00
	COSTS-MVBLE EQUIP					O	
28. 00 29. 00	Non-physician Anesthetist Physicians' assistant		0	NPHYSICIAN ANESTHETISTS	19. 00 0. 00	0	
30. 00	Adjustment for occupational therapy costs in excess of	A-8-3	oloc	CUPATI ONAL THERAPY	67. 00		30.00
30. 99	limitation (chapter 14) Hospice (non-distinct) (see		OIAD	ULTS & PEDIATRICS	30. 00		30. 99
	instructions)		5,10				

					12/31/2022	Date/lime Pre 5/18/2023 11:	pared:
				Expense Classification on	Worksheet A	37 107 2023 11.	30 alli
				To/From Which the Amount is			
				TOTT OIL WITCH THE AMOUNT 13	to be haj astea		
	Cost Center Description	Basis/Code	Amount	Cost Center	Li ne #	Wkst. A-7	
	0001 0011101 20001 1 p 11 011	(2)	711104111	0001 0011101	21110 #	Ref.	
		1.00	2. 00	3.00	4. 00	5. 00	
31. 00	Adjustment for speech	A-8-3		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	Α	-3, 208	EMPLOYEE BENEFITS DEPARTMENT	4. 00	0	33. 01
33. 02	RENT EXPENSE OFFSET	A	-206, 547	CAP REL COSTS-BLDG & FIXT	1.00	10	33. 02
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 & FIXT	1.00	10	33. 04
33. 05	RENT EXPENSE OFFSET	Α	0	CAP REL COSTS-BLDG & FIXT	1. 00	10	33. 05
33.06	PHYSICIAN RECRUITMENT	A	-14, 583	ADMINISTRATIVE & GENERAL	5. 00	0	33.06
33. 07	SELF INSURANCE	Α	0		0.00	0	33. 07
33. 08	GUEST MEAL OFFSET	Α	0	CAFETERI A	11. 00	0	1
33. 09	AHA-IHA LOBBYING OFFSET	Α		ADMINISTRATIVE & GENERAL	5. 00	0	33. 09
33. 10	LOBBYING OFFSET	Α		ADMINISTRATIVE & GENERAL	5. 00	0	1
33. 11	LIQUOR OFFSET	Α		ADMINISTRATIVE & GENERAL	5. 00	0	33. 11
33. 12	OTHER OPERATING REVENUE	В		ADMINISTRATIVE & GENERAL	5. 00	0	1
33. 13	OTHER OPERATING REVENUE	В		DI ETARY	10. 00	0	33. 13
33. 14	OTHER OPERATING REVENUE	В		CAFETERI A	11. 00	0	33. 14
33. 15	OTHER OPERATING REVENUE	В		NURSING ADMINISTRATION	13. 00	0	33. 15
33. 16	OTHER OPERATING REVENUE	В		PHARMACY	15. 00	0	33. 16
33. 17	OTHER OPERATING REVENUE	В		ADULTS & PEDIATRICS	30.00	0	33. 17
33. 18	OTHER OPERATING REVENUE	В		RADI OLOGY-DI AGNOSTI C	54.00	0	33. 18
33. 19	OTHER OPERATING REVENUE	В		RESPIRATORY THERAPY	65. 00	0	
33. 20	OTHER OPERATING REVENUE	В		PHYSI CAL THERAPY	66.00	0	33. 20
33. 21	OTHER OPERATING REVENUE	В		DRUGS CHARGED TO PATIENTS	73. 00	0	33. 21
33. 22	OTHER OPERATING REVENUE	В		EMERGENCY	91. 00	0	33. 22
33. 23	OTHER OPERATING REVENUE	В		OPERATION OF PLANT	7. 00	0	
33. 24	DEPRECIATION	A		CAP REL COSTS-BLDG & FIXT	1. 00	9	1
33. 25	DEPRECIATION	A		CAP REL COSTS-MVBLE EQUIP	2. 00	9	33. 25
33. 26	TELEMETRY COSTS	A		ADULTS & PEDIATRICS	30. 00	0	ı
33. 27	PHYSICIAN ADMINISTRATION	A		ADMINISTRATIVE & GENERAL	5. 00	0	33. 27
00. 27	SALARI ES	, ,	10, 700	A SENERALE	0.00	Ü	00.27
33. 28	PPG SERVI CES-OFFSET	Α	0	ADMINISTRATIVE & GENERAL	5. 00	0	33. 28
33. 29	REMOVE HAF FEES FROM EXPENSE	A		ADMINISTRATIVE & GENERAL	5. 00	0	ı
33. 30	OTHER ADJUSTMENTS (SPECIFY)		_, _,,		0. 00	0	
55.50	(3)				3.00	O	55.50
33. 31	OTHER ADJUSTMENTS (SPECIFY)		0		0.00	0	33. 31
55. 51	(3)				3.00	O	55.51
33. 32	OTHER ADJUSTMENTS (SPECIFY)		0		0.00	0	33. 32
00.02	(3)				3.00	O	55. 52
50.00	TOTAL (sum of lines 1 thru 49)		-10, 961, 085				50.00
00	(Transfer to Worksheet A,		12, 70., 300				
	column 6, line 200.)						
(1) D-				- CMC DL 1E 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:

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

line 12.

- A. Individual has financial interest (stockholder, partner, etc.) in both related organization and in provider. B. Corporation, partnership, or other organization has financial interest in provider.
- 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	u of Form CMS	S-2552-10	
STATEME OFFICE		SERVICES FROM	RELATED ORGANI ZATI O	ONS AND HOME	Provi der	CCN: 15-0091	Peri od: From 01/01/2022	Worksheet A	-8-1
							To 12/31/2022	Date/Time P 5/18/2023 1	
		Wkst. A-7 Ref.							
	Adjustments								
	(col. 4 minus								
	col. 5)*								
	6. 00	7.00							
	A. COSTS INCURI	RED AND ADJUSTM	MENTS REQUIRED AS A	RESULT OF TR	ANSACTI ONS	S WITH RELATED	ORGANI ZATI ONS OR	CLAIMED HOME	
	OFFICE COSTS:								
1.00	1, 054, 665	0							1.00
2.00	-8, 377, 272	0							2. 00
3.00	-570, 922	0							3.00
4. 00	0	0							4.00
5. 00	-7, 893, 529								5.00
* The	amounts on line	es 1-4 (and sub	oscripts as appropri	ate) are trai	nsferred i	n detail to Wo	orksheet A, column	6, lines as	
appropr	i ate. Posi ti ve a	amounts increas	se cost and negative	amounts deci	rease cost	. For related o	organization or ho	me office co	st which
			columns 1 and/or 2,						
	Related Orga	ani zati on(s)							
	and/or Ho	me Office							
	Type of	Busi ness							

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

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

6. 00	HOME OFFICE	6.00
7.00		7.00
8.00		8.00
9.00		9.00
10.00		10.00
7. 00 8. 00 9. 00 10. 00 100. 00		100.00

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

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

6. 00

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

 D. Director, officer, administrator, or key person of provider or relative of such person has financial interest in related organi zati on.
- E. Individual is director, officer, administrator, or key person of provider and related organization.
- F. Director, officer, administrator, or key person of related organization or relative of such person has financial interest in

| Period: | Worksheet A-8-2 | From 01/01/2022 | To 12/31/2022 | Date/Time Prepared: Provi der CCN: 15-0091

							Т	o 12/31/2022	Date/Time Pro 5/18/2023 11:	epared:
	Wkst. A Line #	Cost	Center/Physi ci an	Total	Professi onal	Provi der		RCE Amount	Physi ci an/Prov	
			l denti fi er	Remuneration	Component	Component			ider Component	
						· ·			Hours	
	1. 00		2. 00	3. 00	4.00	5. 00		6. 00	7. 00	
1.00	50. 00 DR			1, 253, 037			0	239, 400	0	
2.00	91. 00 DR			43, 333			0	0	0	2.00
3.00	95. 00 DR	. C		12, 098	12, 09	8	0	0	0	3.00
4.00	0.00			0		0	0	0	0	
5.00	0.00			0		0	0	0	0	5.00
6.00	0. 00			0		0	0	0	0	6.00
7.00	0. 00			0		0	0	0	0	,
8.00	0. 00			0		0	0	0	0	8. 00
9. 00	0. 00			0		0	0	0	0	9. 00
10.00	0. 00			0		0	0	0	0	10.00
200.00				1, 308, 468			0		0	200.00
	Wkst. A Line #	Cost	Center/Physi ci an	Unadjusted RCE					Physician Cost	
			l denti fi er	Limit		E Memberships			of Malpractice	
					Limit	Conti nui ng		Share of col.	Insurance	
						Educati on		12		
	1. 00		2. 00	8. 00	9. 00	12. 00		13. 00	14. 00	
1. 00	50. 00 DR			0	•	0	0	0		
2. 00	91. 00 DR			0		0	0	0		
3.00	95. 00 DR	. C		0		0	0	0		
4.00	0.00			0		0	0	0	0	
5. 00	0.00			0		0	0	0	0	
6. 00	0.00			0		0	0	0	0	
7.00	0.00			0		0	0	0	0	7.00
8. 00	0.00			0		0	0	0	0	
9.00	0.00			0		0	0	0	0	,
10.00	0. 00			0		0	0	0	0	
200.00	Wkst. A Line #	Coot	Center/Physician	Provi der	Adjusted RCE	RCE	-0	Adjustment	U	200.00
	WKSt. A LITTE #	COST	I denti fi er	Component	Limit	Di sal I owanc	_	Auj us tillerit		
			rdentiffer	Share of col.	Limit	DI Sai i Owalic	.6			
				14						
	1.00		2.00	15. 00	16. 00	17. 00		18. 00		
1. 00	50. 00 DR	. A		0		0	0	1, 253, 037		1.00
2.00	91. 00 DR	. В		0		0	0	43, 333		2.00
3.00	95. 00 DR	. C		0		0	0	12, 098		3.00
4.00	0.00			0		0	0	0		4.00
5. 00	0.00			0		0	0	0		5.00
6.00	0.00			0		0	0	0		6.00
7.00	0.00			0		0	0	0		7. 00
8.00	0.00			0		0	0	0		8. 00
9.00	0.00			0		0	0	0		9. 00
10.00	0. 00			0		0	0	0		10.00
200.00				0		0	0	1, 308, 468		200.00

Health Financial Systems

HUNTINGTON MEMORIAL HOSPITAL

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 15-0091
Period:
From 01/01/2022
To 12/31/2022
Part I
Date/Time Prepared:
5/18/2023 11: 36 am

CAPITAL RELATED COSTS

Cost Center Description

Net Expenses for Cost
BLDG & FIXT | MVBLE EQUIP | EMPLOYEE BENEFITS

	CAPITAL RELATED COSTS				5/18/2023 11:	36 am
		CAPITAL REI	LATED COSTS			
Cost Center Description	Net Expenses	BLDG & FIXT	MVBLE EQUIP	EMPLOYEE	Subtotal	
·	for Cost			BENEFITS		
	Allocation			DEPARTMENT		
	(from Wkst A					
	col. 7)					
OFNEDAL CEDIMOR COCT OFNEDC	0	1. 00	2. 00	4. 00	4A	
GENERAL SERVICE COST CENTERS 1. 00 00100 CAP REL COSTS-BLDG & FIXT	2, 678, 394	2, 678, 394				1.00
1. 00 00100 CAP REL COSTS-BLDG & FLXT 2. 00 00200 CAP REL COSTS-MVBLE EQUIP	1, 784, 339	2,070,394	1, 784, 339			2.00
4. 00 00400 EMPLOYEE BENEFITS DEPARTMENT	6, 255, 487	2, 577		6, 258, 064		4.00
5. 00 00500 ADMI NI STRATI VE & GENERAL	14, 121, 717	149, 939		1, 583, 719	15, 914, 717	5. 00
6. 00 00600 MAINTENANCE & REPAIRS	0	0	0	0	0	6. 00
7. 00 00700 OPERATION OF PLANT	1, 297, 340	598, 761	56, 494	117, 571	2, 070, 166	7. 00
8.00 00800 LAUNDRY & LINEN SERVICE	197, 783	12, 279		14, 219	224, 281	8. 00
9. 00 00900 HOUSEKEEPI NG	589, 532	9, 995	4, 926	120, 319	724, 772	9. 00
10. 00 01000 DI ETARY	518, 303	95, 496	5, 849	92, 966	712, 614	10.00
11. 00 01100 CAFETERI A	156, 117	21, 668	0	89, 631	267, 416	11. 00
12.00 01200 MAINTENANCE OF PERSONNEL	0	0	0	0	0	12.00
13. 00 01300 NURSI NG ADMI NI STRATI ON	427, 340	0	0	113, 847	541, 187	13. 00
14. 00 01400 CENTRAL SERVICES & SUPPLY	0	37, 187	1	0	37, 187	14.00
15. 00 01500 PHARMACY	708, 698	22, 547		165, 158	896, 403	15.00
16.00 01600 MEDICAL RECORDS & LIBRARY	0	12, 454		0	12, 454	16.00
17. 00 01700 SOCIAL SERVICE 19. 00 01900 NONPHYSICIAN ANESTHETISTS	0	0		0	0	17. 00 19. 00
20. 00 02000 NURSI NG PROGRAM	0	0		0	0	20.00
21. 00 02100 &R SERVICES-SALARY & FRINGES APPRV	0	0		0	0	21.00
22. 00 02200 &R SERVICES-OTHER PRGM COSTS APPRV	0	0		0	0	22.00
23. 00 02300 PARAMED ED PRGM- (SPECIFY)	0	0	0	0	0	23. 00
INPATIENT ROUTINE SERVICE COST CENTERS			<u> </u>	<u> </u>	<u> </u>	20.00
30. 00 03000 ADULTS & PEDIATRICS	4, 415, 469	491, 144	211, 325	915, 678	6, 033, 616	30.00
43. 00 04300 NURSERY	185, 705	1, 991	0	38, 818	226, 514	43.00
ANCILLARY SERVICE COST CENTERS						
50.00 05000 OPERATING ROOM	760, 803	187, 088	214, 655	378, 034	1, 540, 580	50.00
50. 01 05001 OPERATI NG ROOM	0	0	0	0	0	50. 01
52. 00 05200 DELI VERY ROOM & LABOR ROOM	928, 790	0	0	194, 146	1, 122, 936	52.00
53. 00 05300 ANESTHESI OLOGY	1, 253, 037	0	205 (00	2// 020	1, 253, 037	53.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C 60. 00 06000 LABORATORY	1, 950, 266	234, 484		366, 020	2, 936, 450	54.00
62. 30 06250 BLOOD CLOTTING FOR HEMOPHILIACS	2, 895, 779	35, 528 0		80	2, 931, 387 0	60. 00 62. 30
65. 00 06500 RESPIRATORY THERAPY	899, 985	42, 985	1	203, 579	1, 235, 236	65.00
66. 00 06600 PHYSI CAL THERAPY	897, 729	508, 205		240, 667	1, 761, 868	66.00
67. 00 06700 OCCUPATI ONAL THERAPY	257, 005	000, 200	0	66, 768	323, 773	67.00
68. 00 06800 SPEECH PATHOLOGY	211, 597	0	o	54, 971	266, 568	68. 00
69. 00 06900 ELECTROCARDI OLOGY	0	0	O	0	0	69. 00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	555, 618	0	0	0	555, 618	71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	883, 584	0	0	0	883, 584	72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	2, 128, 282	0	0	18, 222	2, 146, 504	73. 00
76. 97 07697 CARDI AC REHABI LI TATI ON	0	0	0	0	0	76. 97
76. 98 07698 HYPERBARI C OXYGEN THERAPY	744, 154	39, 413	8, 649	78, 779	870, 995	76. 98
76. 99 07699 LI THOTRI PSY	0	0	0	0	0	76. 99
77. 00 07700 ALLOGENEI C HSCT ACQUI SI TI ON	0	0	0	0	0	77. 00
90. 00 OUTPATIENT SERVICE COST CENTERS 90. 00 OP000 CLINIC	170, 610	0		41, 726	212, 336	90.00
91. 00 09100 EMERGENCY	1, 797, 396	99, 947	91, 770	431, 275		91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART	1,777,370	77, 747	71,770	451, 275	2, 420, 300	92.00
OTHER REIMBURSABLE COST CENTERS					<u> </u>	72.00
95. 00 09500 AMBULANCE SERVI CES	3, 991, 301	69, 318	537, 472	906, 532	5, 504, 623	95.00
102.00 10200 OPIOID TREATMENT PROGRAM	0	0	0	0	0	102.00
SPECIAL PURPOSE COST CENTERS						
113.00 11300 INTEREST EXPENSE						113. 00
118.00 SUBTOTALS (SUM OF LINES 1 through 117)	53, 662, 160	2, 673, 006	1, 780, 116	6, 232, 725	53, 627, 210	118. 00
NONREI MBURSABLE COST CENTERS	00.7(0				20.7/2	400 00
190.00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	23, 768	0	0	0	23, 768	
191. 00 19100 RESEARCH 192. 00 19200 PHYSI CI ANS' PRI VATE OFFI CES	637	0	4 222	22.450		191.00
194.00 07950 0CC HEALTH	92, 738	5, 388	4, 223	22, 450	119, 411	194.00
194. 01 07951 PALN CLINIC	0	o, see		0		194.00
194. 02 07952 OCC HEALTH		0		٥		194. 01
194. 03 07953 FOUNDATI 0	69, 145	0		0	69, 145	
194. 04 07954 KIDS CAMPUS	0,143	n		n		194. 03
194. 05 07955 COMMUNITY & VOLUNTEER SERVICES	78, 097	o	ا	2, 889	80, 986	
194. 06 07956 HUNTI NGTON COLLEGE NURSE	0	Ö	o o	0		194. 06
194. 07 07957 MI SC CATERING	0	0	0	o		194. 07
194.08 07958 AUTISM CENTER	0	0	0	o		194. 08
194. 09 07959 HUNTI NGTON BUA	0	0	0	0	0	194. 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		Peri od: From 01/01/2022			
				To 12/31/2022	Date/Time Pre 5/18/2023 11:	epared: 36 am	
		CAPI TAL REI	LATED 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 Cross Foot Adjustments 201.00 Negative Cost Centers		0		0 0		200. 00 201. 00	
202.00 TOTAL (sum lines 118 through 201)	53, 926, 545	2, 678, 394	1, 784, 33	6, 258, 064	53, 926, 545	202.00	

Provider CCN: 15-0091

Peri od: Worksheet B From 01/01/2022 Part I To 12/31/2022 Date/Time Prepared: 5/18/2023 11: 36 am

				12/31/2022	5/18/2023 11: 36 am	
Cost Center Description	ADMI NI STRATI V		OPERATION OF	LAUNDRY &	HOUSEKEEPI NG	
	E & GENERAL 5. 00	REPAI RS 6. 00	PLANT 7. 00	LINEN SERVICE 8.00	9. 00	
GENERAL SERVICE COST CENTERS	3.00	6.00	7.00	6.00	9.00	_
1. 00 O0100 CAP REL COSTS-BLDG & FLXT					1.0	O
2.00 00200 CAP REL COSTS-MVBLE EQUIP					2.0	
4.00 00400 EMPLOYEE BENEFITS DEPARTMENT					4.0	
5. 00 00500 ADMINISTRATIVE & GENERAL	15, 914, 717				5. 0	
6.00 00600 MAINTENANCE & REPAIRS	0	0			6.0	0
7.00 00700 OPERATION OF PLANT	866, 733	0	2, 936, 899		7.0	0
8.00 00800 LAUNDRY & LINEN SERVICE	93, 902	0	18, 712	336, 895	8.0	0
9. 00 00900 HOUSEKEEPI NG	303, 446	0	15, 232	0	1, 043, 450 9. 0	0
10. 00 01000 DI ETARY	298, 356	0	145, 534	0	52, 312 10. 0	10
11. 00 01100 CAFETERI A	111, 961	0	33, 022	0	11, 870 11. 0	10
12.00 01200 MAINTENANCE OF PERSONNEL	0	0	0	0	0 12.0	10
13.00 O1300 NURSING ADMINISTRATION	226, 583	0	0	0	0 13.0	10
14.00 01400 CENTRAL SERVICES & SUPPLY	15, 569	0	56, 673	0	20, 371 14. 0	0
15. 00 01500 PHARMACY	375, 304	0	34, 361	0	12, 351 15. 0	
16.00 01600 MEDICAL RECORDS & LIBRARY	5, 214	0	18, 980	0	6, 822 16. 0	
17. 00 01700 SOCIAL SERVICE	0	0	0	0	0 17.0	
19. 00 01900 NONPHYSI CI AN ANESTHETI STS	0	0	0	0	0 19.0	
20.00 02000 NURSI NG PROGRAM	0	0	0	0	0 20.0	
21. 00 02100 L&R SERVI CES-SALARY & FRINGES APPRV	0	0	0	0	0 21.0	
22. 00 02200 1 &R SERVI CES-OTHER PRGM COSTS APPRV	0	0	0	0	0 22.0	
23. 00 02300 PARAMED ED PRGM-(SPECIFY)	0	U	0	0	0 23.0	·O
I NPATI ENT ROUTI NE SERVI CE COST CENTERS	2 524 145		740 407	7/ 502	240,042, 20,0	
30. 00 03000 ADULTS & PEDI ATRI CS 43. 00 04300 NURSERY	2, 526, 145	0		76, 583 7, 540	· · · · · · · · · · · · · · · · · · ·	
43. 00 O4300 NURSERY ANCI LLARY SERVICE COST CENTERS	94, 836	U	3, 034	7, 540	1, 091 43. 0	·U
50. 00 05000 OPERATING ROOM	645, 007	0	285, 119	72, 195	102, 484 50. 0	ın
50. 01 05001 OPERATING ROOM	045,007	0	203, 119	72, 1 9 3	0 50.0	
52. 00 05200 DELIVERY ROOM & LABOR ROOM	470, 149	0	0	30, 095	0 52.0	
53. 00 05300 ANESTHESI OLOGY	524, 619	0	0	30, 073	0 53.0	
54. 00 05400 RADI OLOGY-DI AGNOSTI C	1, 229, 427	0	357, 351	60, 034	128, 448 54. 0	
60. 00 06000 LABORATORY	1, 227, 307	Ő	54, 144	00,001	19, 462 60. 0	
62. 30 06250 BLOOD CLOTTING FOR HEMOPHILIACS	0	Ő	0 1, 111	0	0 62.3	
65. 00 06500 RESPI RATORY THERAPY	517, 166	0	65, 508	0	23, 547 65. 0	
66. 00 06600 PHYSI CAL THERAPY	737, 655	o	774, 500	0	278, 386 66. 0	
67. 00 06700 OCCUPATI ONAL THERAPY	135, 557	o	0	0	0 67.0	
68. 00 06800 SPEECH PATHOLOGY	111, 606	0	0	0	0 68.0	
69. 00 06900 ELECTROCARDI OLOGY	0	0	0	0	0 69.0	
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	232, 625	0	0	0	0 71.0	0
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	369, 937	0	0	0	0 72.0	10
73.00 07300 DRUGS CHARGED TO PATIENTS	898, 694	0	0	0	0 73.0	10
76. 97 07697 CARDI AC REHABILI TATI ON	0	0	0	0	0 76.9	7
76. 98 07698 HYPERBARIC OXYGEN THERAPY	364, 666	0	60, 064	0	21, 590 76. 9	8
76. 99 07699 LI THOTRI PSY	0	0	0	0	0 76.9	9
77.00 07700 ALLOGENEIC HSCT ACQUISITION	0	0	0	0	0 77.0	0
OUTPATIENT SERVICE COST CENTERS						
90. 00 09000 CLINIC	88, 900	0	0	1, 394	0 90.0	
91. 00 09100 EMERGENCY	1, 013, 363	0	152, 317	89, 054		
92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART					92.0	0
OTHER REIMBURSABLE COST CENTERS	0.004.445		105 (10		07.070	
95. 00 09500 AMBULANCE SERVI CES	2, 304, 665		· ·			
102.00 10200 OPI OLD TREATMENT PROGRAM SPECIAL PURPOSE COST CENTERS	0	0	0	0	0 102. 0	·O
113. 00 11300 I NTEREST EXPENSE					113. 0	10
118.00 SUBTOTALS (SUM OF LINES 1 through 117)	15, 789, 392	0	2, 928, 688	336, 895		
NONREI MBURSABLE COST CENTERS	13, 707, 372	0	2, 720, 000	330, 073	1,040,477	U
190. 00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	9, 951	0	0	0	0 190. 0	ıO
191. 00 19100 RESEARCH	267	0		0	0 191.0	
192. 00 19200 PHYSI CLANS' PRI VATE OFFI CES	49, 995		_	0	0 192. 0	
194. 00 07950 OCC HEALTH	2, 256		8, 211	0	2, 951 194. 0	
194. 01 07951 PAIN CLINIC	0	0	0,211	0	0 194. 0	
194. 02 07952 OCC HEALTH	0	ő	ا م	ol	0 194. 0	
194. 03 07953 FOUNDATI 0	28, 949	o	o o	0	0 194. 0	
194. 04 07954 KIDS CAMPUS	0	o	0	o	0 194. 0	
194.05 07955 COMMUNITY & VOLUNTEER SERVICES	33, 907	0	0	o	0 194. 0	
194. 06 07956 HUNTI NGTON COLLEGE NURSE	0	0	0	o	0 194. 0	
194. 07 07957 MI SC CATERI NG	0	0	0	o	0 194. 0	17
194.08 07958 AUTISM CENTER	0	0	0	o	0 194. 0	18
194. 09 07959 HUNTI NGTON BUA	0	0	0	0	0 194. 0	
200.00 Cross Foot Adjustments					200. 0	
201.00 Negative Cost Centers	0	0	0	0	0 201. 0	
202.00 TOTAL (sum lines 118 through 201)	15, 914, 717	0	2, 936, 899	336, 895	1, 043, 450 202. 0	0

Provider CCN: 15-0091

Peri od: Worksheet B From 01/01/2022 Part I To 12/31/2022 Date/Time Prepared: 5/18/2023 11: 36 am

Cost Center Description	DI ETARY	CAFETERI A	MAI NTENANCE	NURSI NG	5/18/2023 11: 36 CENTRAL	
3337 33.1(3) 23331 7 3.1	51217111	0/11 E / E/17 / 1	OF PERSONNEL	ADMI NI STRATI O	SERVI CES & SUPPLY	
	10. 00	11. 00	12.00	13.00	14.00	
GENERAL SERVICE COST CENTERS				1		1 00
1. 00 00100 CAP REL COSTS-BLDG & FLXT 2. 00 00200 CAP REL COSTS-MVBLE EQUIP						1. 00 2. 00
4. 00 00400 EMPLOYEE BENEFITS DEPARTMENT						4.00
5. 00 00500 ADMI NI STRATI VE & GENERAL						5.00
6. 00 00600 MAI NTENANCE & REPAI RS						6.00
7. 00 00700 0PERATION OF PLANT					•	7. 00
8. 00 00800 LAUNDRY & LINEN SERVICE					•	8.00
9. 00 00900 HOUSEKEEPI NG						9. 00
10. 00 01000 DI ETARY	1, 208, 816					10.00
11. 00 01100 CAFETERI A	1, 200, 010	424, 269				11. 00
12. 00 01200 MAI NTENANCE OF PERSONNEL	0	424, 209	_			12.00
13. 00 01300 NURSI NG ADMI NI STRATI ON	0	8, 631		776, 401		13.00
14. 00 01400 CENTRAL SERVICES & SUPPLY	0	0, 031		770, 401		14.00
15. 00 01500 PHARMACY	0	10, 957				15. 00
16. 00 01600 MEDI CAL RECORDS & LI BRARY	0	10, 737		١		16. 00
17. 00 01700 SOCIAL SERVICE	0	0		ا ا		17. 00
19. 00 01900 NONPHYSI CLAN ANESTHETI STS	0	0				19.00
20. 00 02000 NURSI NG PROGRAM	0	0			- 1	20.00
21.00 02100 1&R SERVICES-SALARY & FRINGES APPRV	0	0				20.00
22. 00 02200 1&R SERVICES-OTHER PRGM COSTS APPRV	0	0				
1 1	0	0				22.00
23.00 O2300 PARAMED ED PRGM-(SPECIFY) I NPATIENT ROUTINE SERVICE COST CENTERS	υ	U		ıl U	0 2	23. 00
	1 200 014	79, 686	C	247 100	10, 271 3	30. 00
1 1	1, 208, 816 0					
43.00 04300 NURSERY ANCI LLARY SERVI CE COST CENTERS	U	3, 474	0	15, 136	0 4	43. 00
	٥	24 120	0	140 705	20.250 5	-0.00
	0	34, 130				50.00
50. 01 05001 0PERATING ROOM	0	17 272	0	1	•	50. 01
52. 00 05200 DELIVERY ROOM & LABOR ROOM	0	17, 373	0	75, 695		52.00
53. 00 05300 ANESTHESI OLOGY	0	25 (15			•	53.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	0	35, 615	0	-		54.00
60. 00 06000 LABORATORY	0	12	0	-	•	50.00
62. 30 06250 BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0	-		52. 30
65. 00 06500 RESPIRATORY THERAPY	0	21, 887	0	0		65.00
66. 00 06600 PHYSI CAL THERAPY	0	24, 554		0		66.00
67. 00 06700 OCCUPATI ONAL THERAPY	0	8, 011	0	0		67.00
68. 00 06800 SPEECH PATHOLOGY	0	6, 596		0		68.00
69. 00 06900 ELECTROCARDI OLOGY	0	0	0	0		59.00
71. 00 07100 MEDI CAL SUPPLI ES CHARGED TO PATI ENT	0	0	0	0		71. 00
72. 00 07200 IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0		72.00
73. 00 07300 DRUGS CHARGED TO PATIENTS	0	0	0	0		73.00
76. 97 07697 CARDI AC REHABI LI TATI ON	0	0	0	0		76. 97
76. 98 07698 HYPERBARI C OXYGEN THERAPY	0	0	0	0	•	76. 98
76. 99 07699 LI THOTRI PSY	0	0	0	0		76. 99
77. 00 07700 ALLOGENEIC HSCT ACQUISITION	0	0	0	0	0 7	77. 00
OUTPATIENT SERVICE COST CENTERS	_1		_			
90. 00 09000 CLI NI C	0	3, 492		1		90.00
91. 00 09100 EMERGENCY	0	43, 531	0	189, 667		91.00
92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART					9	92.00
OTHER REIMBURSABLE COST CENTERS	_1		_			
95. 00 09500 AMBULANCE SERVI CES	0	122, 219		I I		95.00
102.00 10200 OPI OI D TREATMENT PROGRAM	0	0	0	0	0 10	02.00
SPECIAL PURPOSE COST CENTERS			T	1		
113. 00 11300 I NTEREST EXPENSE						13.00
118.00 SUBTOTALS (SUM OF LINES 1 through 117)	1, 208, 816	420, 168	0	776, 401	128, 543 11	18. 00
NONREI MBURSABLE COST CENTERS						
190.00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0		995 19	
191. 00 19100 RESEARCH	0	0	0	-		91. 00
192. 00 19200 PHYSI CLANS' PRI VATE OFFI CES	0	3, 030	0	0	258 19	
194. 00 07950 OCC HEALTH	0	0	0	0		94.00
194. 01 07951 PAIN CLINIC	0	0	0	0	0 19	94. 01
194. 02 07952 OCC HEALTH	0	0	0	0		94. 02
194. 03 07953 FOUNDATI 0	0	644	0	0		94. 03
194.04 07954 KIDS CAMPUS	0	0	0	0		94.04
194. 05 07955 COMMUNITY & VOLUNTEER SERVICES	O	427	O			94. 05
194.06 07956 HUNTINGTON COLLEGE NURSE	o	0	0	ol		94.06
194. 07 07957 MISC CATERING	o	0	O	o	0 19	94. 07
194.08 07958 AUTISM CENTER	o	0	0	o	0 19	94. 08
194. 09 07959 HUNTI NGTON BUA	o	0	0	o		94. 09
200.00 Cross Foot Adjustments						00.00
201.00 Negative Cost Centers	o	0	O	o	0 20	01.00
202.00 TOTAL (sum lines 118 through 201)	1, 208, 816	424, 269	O	776, 401		
·	•	'		•	· ·	

Provider CCN: 15-0091

Peri od: Worksheet B From 01/01/2022 Part I To 12/31/2022 Date/Time Prepared:

				10 12/31/2022	Date/lime Pre 5/18/2023 11:	
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				T		1
1.00 00100 CAP REL COSTS-BLDG & FIXT 2.00 00200 CAP REL COSTS-MVBLE EQUIP						1.00
4. 00 00400 EMPLOYEE BENEFITS DEPARTMENT						4.00
5. 00 00500 ADMINISTRATIVE & GENERAL						5.00
6. 00 00600 MAINTENANCE & REPAIRS						6.00
7.00 00700 OPERATION OF PLANT						7.00
8.00 00800 LAUNDRY & LINEN SERVICE						8. 00
9. 00 00900 HOUSEKEEPI NG						9. 00
10. 00 01000 DI ETARY						10.00
11. 00 01100 CAFETERI A						11.00
12. 00 01200 MAI NTENANCE OF PERSONNEL						12.00
13. 00 01300 NURSI NG ADMI NI STRATI ON 14. 00 01400 CENTRAL SERVI CES & SUPPLY						13. 00 14. 00
15. 00 01500 PHARMACY	1, 331, 158					15. 00
16. 00 01600 MEDI CAL RECORDS & LI BRARY	1, 331, 130	43, 470				16.00
17. 00 01700 SOCIAL SERVICE		0	(17. 00
19. 00 01900 NONPHYSI CI AN ANESTHETI STS	Ö	0	(0		19.00
20. 00 02000 NURSI NG PROGRAM	o	0	(0	20.00
21.00 02100 I&R SERVICES-SALARY & FRINGES APPRV	o	0	(21.00
22.00 02200 I&R SERVICES-OTHER PRGM COSTS APPRV	0	0	(22. 00
23. 00 O2300 PARAMED ED PRGM-(SPECIFY)	0	0	(23. 00
INPATIENT ROUTINE SERVICE COST CENTERS				.1		4
30. 00 03000 ADULTS & PEDI ATRI CS	0	3, 144	(0	1
43. 00 04300 NURSERY ANCI LLARY SERVI CE COST CENTERS	0	179	(0	0	43.00
50. 00 05000 OPERATING ROOM	O	5, 654	(0	0	50.00
50. 00 05000 0FERATING ROOM 50. 01 05001 0PERATING ROOM		5, 054			0	
52. 00 05200 DELIVERY ROOM & LABOR ROOM		893	ì		0	
53. 00 05300 ANESTHESI OLOGY	o	707	(0	0	
54. 00 05400 RADI OLOGY-DI AGNOSTI C	o	6, 511	(0	0	54.00
60. 00 06000 LABORATORY	o	6, 130	(0	0	60.00
62.30 06250 BLOOD CLOTTING FOR HEMOPHILIACS	0	0	(0	0	62. 30
65. 00 06500 RESPI RATORY THERAPY	0	1, 722	-	0	0	
66. 00 06600 PHYSI CAL THERAPY	0	1, 004	(1	0	
67. 00 06700 OCCUPATI ONAL THERAPY	0	322	(1	0	
68. 00 06800 SPEECH PATHOLOGY	0	138	(0	0	1
69. 00 06900 ELECTROCARDI OLOGY 71. 00 07100 MEDI CAL SUPPLI ES CHARGED TO PATI ENT		0 581			0	
72. 00 07200 IMPL. DEV. CHARGED TO PATIENTS		910			0	
73. 00 07300 DRUGS CHARGED TO PATTENTS	1, 331, 158	3, 839			0	
76. 97 07697 CARDI AC REHABI LI TATI ON	1, 331, 130	0, 037		ĭ	0	
76. 98 07698 HYPERBARI C OXYGEN THERAPY	l ől	529		o o	0	
76. 99 07699 LI THOTRI PSY	o	0	,	0	0	1
77.00 07700 ALLOGENEIC HSCT ACQUISITION	O	0	(0	0	77. 00
OUTPATIENT SERVICE COST CENTERS						
90. 00 09000 CLINIC	0	173		0		
91. 00 09100 EMERGENCY	0	7, 196	(0	0	1
92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART						92.00
OTHER REIMBURSABLE COST CENTERS 95. 00 09500 AMBULANCE SERVICES	0	3, 838		0	0	95.00
102.00 10200 OPLOID TREATMENT PROGRAM		ა, იაი 0				102.00
SPECIAL PURPOSE COST CENTERS	<u> </u>	<u> </u>		0	0	1102.00
113. 00 11300 NTEREST EXPENSE						113.00
118.00 SUBTOTALS (SUM OF LINES 1 through 117)	1, 331, 158	43, 470	(0	0	118.00
NONREI MBURSABLE COST CENTERS						1
190.00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	(0		190.00
191. 00 19100 RESEARCH	0	0	(0		191. 00
192.00 19200 PHYSICIANS' PRIVATE OFFICES	0	0	(0		192.00
194. 00 07950 OCC HEALTH	0	0	(0		194. 00
194. 01 07951 PAIN CLINIC	0	0	(0		194. 01
194. 02 07952 OCC HEALTH	0	0	(0		194. 02
194. 03 07953 FOUNDATI 0 194. 04 07954 KI DS CAMPUS	U	0	(194. 03 194. 04
194.05 07955 COMMUNITY & VOLUNTEER SERVICES	0	0				194. 04
194.06 07956 HUNTINGTON COLLEGE NURSE		0				194.05
194. 07 07957 MI SC CATERI NG		0				194.00
194. 08 07958 AUTI SM CENTER	ا	n		0		194. 08
194. 09 07959 HUNTI NGTON BUA	l ől	n		o o		194. 09
200.00 Cross Foot Adjustments				0	0	200.00
201.00 Negative Cost Centers	o	o	(0		201.00
202.00 TOTAL (sum lines 118 through 201)	1, 331, 158	43, 470	(0	0	202.00

Health Financial Systems
COST ALLOCATION - GENERAL SERVICE COSTS | Peri od: | Worksheet B | From 01/01/2022 | Part | To 12/31/2022 | Date/Time Prepared: Provider CCN: 15-0091

			'	0 12/31/2022	Date/lime Pre 5/18/2023 11:	
	INTERNS &	RESI DENTS				
Cost Center Description	SERVI CES-SALA	SERVI CES-OTHE	PARAMED ED	Subtotal	Intern &	
odst denter beserretten	RY & FRI NGES	R PRGM COSTS	PRGM	Subtotai	Resi dents	
	APPRV	APPRV			Cost & Post	
					Stepdown Adjustments	
	21. 00	22. 00	23. 00	24. 00	25. 00	
GENERAL SERVICE COST CENTERS						
1. 00 00100 CAP REL COSTS-BLDG & FIXT						1.00
2.00 00200 CAP REL COSTS-MVBLE EQUIP 4.00 00400 EMPLOYEE BENEFITS DEPARTMENT			1			2.00 4.00
5. 00 00500 ADMI NI STRATI VE & GENERAL						5.00
6.00 00600 MAINTENANCE & REPAIRS						6.00
7.00 00700 OPERATION OF PLANT						7. 00
8. 00 00800 LAUNDRY & LINEN SERVICE						8.00
9. 00 00900 HOUSEKEEPI NG 10. 00 01000 DI ETARY			1			9. 00 10. 00
11. 00 01100 CAFETERI A						11.00
12.00 01200 MAINTENANCE OF PERSONNEL						12.00
13.00 01300 NURSING ADMINISTRATION						13.00
14. 00 01400 CENTRAL SERVI CES & SUPPLY						14.00
15. 00 01500 PHARMACY 16. 00 01600 MEDI CAL RECORDS & LI BRARY						15. 00 16. 00
17. 00 01700 SOCIAL SERVICE						17.00
19.00 01900 NONPHYSICIAN ANESTHETISTS						19.00
20. 00 02000 NURSI NG PROGRAM						20.00
21. 00 02100 1 &R SERVICES-SALARY & FRINGES APPRV	C	1				21.00
22.00 02200 1&R SERVICES-OTHER PRGM COSTS APPRV 23.00 02300 PARAMED ED PRGM-(SPECIFY)		0	0			22. 00 23. 00
INPATIENT ROUTINE SERVICE COST CENTERS						23.00
30. 00 03000 ADULTS & PEDIATRICS	C	0	0	11, 302, 999	0	30.00
43. 00 04300 NURSERY	C	0	0	351, 804	0	43.00
ANCILLARY SERVICE COST CENTERS	1			0.054.000		
50. 00 05000 0PERATI NG ROOM 50. 01 05001 0PERATI NG ROOM	C	l l		, ,	0	50. 00 50. 01
52. 00 05200 DELIVERY ROOM & LABOR ROOM			1	1, 717, 141	0	52.00
53. 00 05300 ANESTHESI OLOGY	C	o o	Ö	1, 778, 363	0	53.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	C	0	0	4, 758, 051	0	54.00
60. 00 06000 LABORATORY	C	0	0	4, 238, 455	0	60.00
62.30 06250 BLOOD CLOTTING FOR HEMOPHILIACS 65.00 06500 RESPIRATORY THERAPY	C	0	0	1 070 027	0	62.30
65. 00 06500 RESPI RATORY THERAPY 66. 00 06600 PHYSI CAL THERAPY				1, 870, 837 3, 579, 072	0	65. 00 66. 00
67. 00 06700 OCCUPATI ONAL THERAPY		o o	o o	467, 663	0	67.00
68.00 06800 SPEECH PATHOLOGY	C	0	0	384, 908	0	68. 00
69. 00 06900 ELECTROCARDI OLOGY	C	0	0	0	0	69.00
71. 00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	850, 671	0	71.00
72.00 O7200 IMPL. DEV. CHARGED TO PATIENTS 73.00 O7300 DRUGS CHARGED TO PATIENTS			0	1, 254, 431 4, 380, 195	0	72. 00 73. 00
76. 97 07697 CARDI AC REHABI LI TATI ON		o o	Ö		0	76. 97
76. 98 07698 HYPERBARIC OXYGEN THERAPY	C	0	0	1, 320, 599	0	76. 98
76. 99 07699 LI THOTRI PSY	C		0		0	76. 99
77. 00 07700 ALLOGENEI C HSCT ACQUI SI TI ON	C) 0	0	0	0	77. 00
90. 00 OUTPATIENT SERVICE COST CENTERS 90. 00 OP000 CLINIC) 0	0	306, 992	0	90.00
91. 00 09100 EMERGENCY		I	1		0	91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART					0	92.00
OTHER REIMBURSABLE COST CENTERS			1			
95. 00 09500 AMBULANCE SERVICES	C	l control of the cont	•		0	95. 00 102. 00
102. 00 10200 OPI OLD TREATMENT PROGRAM SPECIAL PURPOSE COST CENTERS		n o	<u> </u>	l ol	U	102.00
113. 00 11300 NTEREST EXPENSE						113.00
118.00 SUBTOTALS (SUM OF LINES 1 through 117)	C	0	0	53, 485, 365	0	118.00
NONREI MBURSABLE COST CENTERS						
190.00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	C	0	0	34, 714		190.00
191. 00 19100 RESEARCH 192. 00 19200 PHYSI CLANS' PRI VATE OFFI CES	0		0	904 172, 694		191. 00 192. 00
194. 00 07950 OCC HEALTH	0			18, 806		194.00
194. 01 07951 PAIN CLINIC	C	o o	Ö	0		194. 01
194. 02 07952 OCC HEALTH	C	0	0	0	0	194. 02
194. 03 07953 FOUNDATI 0	C	0	0	98, 738		194. 03
194.04 07954 KIDS CAMPUS		0		115 224		194. 04 194. 05
194. 05 07955 COMMUNI TY & VOLUNTEER SERVI CES 194. 06 07956 HUNTI NGTON COLLEGE NURSE				115, 324 0		194. 05
194. 07 07957 MISC CATERING						194.00
194.08 07958 AUTISM CENTER		o	0	o	0	194. 08
194. 09 07959 HUNTI NGTON BUA	c	0	0	o	0	194. 09

Health Financial Systems	HUNTI NGTON MEMOR	IAL HOSPITAL		In Lieu of Form CMS-2552-10		
COST ALLOCATION - GENERAL SERVICE COSTS		Provi der Co		Peri od:	Worksheet B	
				From 01/01/2022 To 12/31/2022		nared.
					5/18/2023 11:	36 am
	INTERNS & R	RESI DENTS				
Cost Center Description	SERVI CES-SALA S		PARAMED ED	Subtotal	Intern &	
	RY & FRINGES	R PRGM COSTS	PRGM		Resi dents	
	APPRV	APPRV			Cost & Post	
					Stepdown	
					Adjustments	
	21. 00	22. 00	23. 00	24.00	25. 00	
200.00 Cross Foot Adjustments	0	0		0 0	0	200. 00
201.00 Negative Cost Centers	o	0		0 0	0	201.00
202.00 TOTAL (sum lines 118 through 201)	O	0		0 53, 926, 545	0	202. 00

Peri od: Worksheet B From 01/01/2022 Part I To 12/31/2022 Date/Time Prepared: 5/18/2023 11: 36 am Provider CCN: 15-0091

		5/18/2023 11: 36 am
Cost Center Description	Total	
	26. 00	
GENERAL SERVI CE COST CENTERS		
1.00 O0100 CAP REL COSTS-BLDG & FLXT		1.00
2. 00 00200 CAP REL COSTS-MVBLE EQUI P		2.00
4. 00 00400 EMPLOYEE BENEFITS DEPARTMENT 5. 00 00500 ADMINISTRATIVE & GENERAL		4.00
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 01300 NURSING ADMINISTRATION		13.00
14.00 01400 CENTRAL SERVICES & SUPPLY		14.00
15. 00 01500 PHARMACY		15.00
16.00 01600 MEDICAL RECORDS & LIBRARY		16.00
17. 00 01700 SOCIAL SERVICE		17. 00
19. 00 01900 NONPHYSI CI AN ANESTHETI STS		19.00
20. 00 02000 NURSI NG PROGRAM		20.00
21. 00 02100 L&R SERVICES-SALARY & FRINGES APPRV		21.00
22. 00 02200 1&R SERVICES-OTHER PRGM COSTS APPRV		22.00
23. 00 O2300 PARAMED ED PRGM-(SPECIFY) INPATIENT ROUTINE SERVICE COST CENTERS		23.00
30. 00 O3000 ADULTS & PEDIATRICS	11, 302, 999	30.00
43. 00 04300 NURSERY	351, 804	43.00
ANCI LLARY SERVI CE COST CENTERS	331,004	45.00
50. 00 05000 OPERATING ROOM	2, 854, 233	50.00
50. 01 05001 OPERATI NG ROOM	0	50. 01
52.00 05200 DELIVERY ROOM & LABOR ROOM	1, 717, 141	52.00
53. 00 05300 ANESTHESI OLOGY	1, 778, 363	53.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	4, 758, 051	54.00
60. 00 06000 LABORATORY	4, 238, 455	60.00
62.30 06250 BLOOD CLOTTING FOR HEMOPHILIACS	0	62.30
65. 00 06500 RESPI RATORY THERAPY	1, 870, 837	65.00
66. 00 06600 PHYSI CAL THERAPY	3, 579, 072	66.00
67. 00 06700 OCCUPATI ONAL THERAPY	467, 663	67. 00
68. 00 06800 SPEECH PATHOLOGY	384, 908	68.00
69. 00 06900 ELECTROCARDI OLOGY	0 0 0 0 0	69.00
71. 00 07100 MEDI CAL SUPPLI ES CHARGED TO PATI ENT	850, 671	71.00
72.00 O7200 IMPL. DEV. CHARGED TO PATIENTS 73.00 O7300 DRUGS CHARGED TO PATIENTS	1, 254, 431 4, 380, 195	72. 00 73. 00
76. 97 07697 CARDI AC REHABI LI TATI ON	4, 360, 193	75.00
76. 98 07698 HYPERBARI C OXYGEN THERAPY	1, 320, 599	76. 97
76. 99 07699 LI THOTRI PSY	0	76. 99
77. 00 07700 ALLOGENEIC HSCT ACQUISITION	o	77.00
OUTPATIENT SERVICE COST CENTERS	- 1	
90. 00 09000 CLI NI C	306, 992	90.00
91. 00 09100 EMERGENCY	3, 977, 255	91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART		92.00
OTHER REIMBURSABLE COST CENTERS		
95. 00 09500 AMBULANCE SERVI CES	8, 091, 696	95.00
102. 00 10200 OPI OI D TREATMENT PROGRAM	0	102. 00
SPECIAL PURPOSE COST CENTERS		110.00
113. 00 11300 INTEREST EXPENSE	E0 40E 0/E	113.00
118.00 SUBTOTALS (SUM OF LINES 1 through 117)	53, 485, 365	118. 00
NONREI MBURSABLE COST CENTERS 190. 00 19000 GI FT, FLOWER, COFFEE SHOP & CANTEEN	34, 714	190.00
191. 00 19100 RESEARCH	904	190.00
192. 00 19200 PHYSI CLANS' PRI VATE OFFI CES	172, 694	192.00
194. 00 07950 OCC HEALTH	18, 806	194.00
194. 01 07951 PAIN CLINIC	0	194. 01
194. 02 07952 OCC HEALTH	0	194. 02
194. 03 07953 FOUNDATI 0	98, 738	194. 03
194. 04 07954 KIDS CAMPUS	0	194. 04
194. 05 07955 COMMUNITY & VOLUNTEER SERVICES	115, 324	194. 05
194. 06 07956 HUNTI NGTON COLLEGE NURSE	0	194. 06
194. 07 07957 MI SC CATERI NG	0	194. 07
194.08 07958 AUTISM CENTER	0	194. 08
194. 09 07959 HUNTI NGTON BUA	0	194. 09
200.00 Cross Foot Adjustments	0	200.00
201.00 Negative Cost Centers	0	201. 00
202.00 TOTAL (sum lines 118 through 201)	53, 926, 545	202.00

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

				Io	12/31/2022	Date/lime Pre 5/18/2023 11:	
			CAPI TAL REI	LATED COSTS		07 107 2020 11.	oo alii
	Cost Center Description	Di rectly Assigned New Capital	BLDG & FIXT	MVBLE EQUIP	Subtotal	EMPLOYEE BENEFITS DEPARTMENT	
		Related Costs				JEI / III CIIII EI CI	
		0	1. 00	2. 00	2A	4. 00	
1 00	GENERAL SERVICE COST CENTERS						1 00
1. 00 2. 00 4. 00 5. 00	00100 CAP REL COSTS-BLDG & FIXT 00200 CAP REL COSTS-MVBLE EQUIP 00400 EMPLOYEE BENEFITS DEPARTMENT 00500 ADMINISTRATIVE & GENERAL	0 2, 342, 057	2, 577 149, 939	1	2, 577 2, 551, 338	2, 577 644	1. 00 2. 00 4. 00 5. 00
6. 00 7. 00	00600 MAINTENANCE & REPAIRS 00700 OPERATION OF PLANT	0	0 598, 761	0 56, 494	0 655, 255	0 49	6. 00 7. 00
8. 00	00800 LAUNDRY & LINEN SERVICE	o o	12, 279	1	12, 279	6	8. 00
9. 00	00900 HOUSEKEEPI NG	0	9, 995	1	14, 921	50	9. 00
10. 00 11. 00	ł I	0	95, 496 21, 669	1	101, 345	38 37	10. 00 11. 00
12. 00	ł I	0	21, 668		21, 668 0	0	12.00
13. 00		0	Ö	Ö	o	47	13. 00
14.00	I I	0	37, 187	1	37, 187	0	14.00
15.00	ł I	0	22, 547		22, 547	68	15.00
16. 00 17. 00	ł I	0	12, 454	0	12, 454	0	16. 00 17. 00
19. 00		0	0	Ö	o	0	19. 00
20. 00	I I	0	0	0	0	0	20.00
21. 00	l l	0	0	0	0	0	21.00
22. 00	l l	0	0	0	0	0	22.00
23. 00	INPATIENT ROUTINE SERVICE COST CENTERS) U	U	<u>U</u>	<u> </u>	0	23. 00
30. 00		0	491, 144	211, 325	702, 469	379	30. 00
43.00		0	1, 991	0	1, 991	16	43.00
EO 00	ANCILLARY SERVICE COST CENTERS		107 000	214 (55	401 742	15/	E0 00
50. 00 50. 01		0	187, 088 0	214, 655	401, 743	156 0	50. 00 50. 01
52. 00		l o	o	Ö	ő	80	52. 00
53.00	l l	0	0	0	0	0	53.00
54.00		0	234, 484		620, 164	151	54.00
60. 00 62. 30	1 I	0	35, 528	0	35, 528	0	60. 00 62. 30
65. 00		0	42, 985	88, 687	131, 672	84	65. 00
66.00	l l	0	508, 205	1	623, 472	100	66.00
67. 00	I I	0	0	0	0	28	67.00
68. 00 69. 00	ł I	0	0	0	0	23 0	68. 00 69. 00
71. 00	I I	0	Ö	Ö	o	0	71. 00
72. 00		0	0	0	0	0	72.00
73.00		0	0	0	0	8	73.00
76. 97 76. 98	I I	0	0 20 413	0 8, 649	0 48, 062	0 33	76. 97 76. 98
	07699 LI THOTRI PSY	0	39, 413 0	0, 049	46, 002	0	76. 96 76. 99
	07700 ALLOGENEIC HSCT ACQUISITION	0	0	ō	O	0	77. 00
	OUTPATIENT SERVICE COST CENTERS		_	1 -1			
90. 00 91. 00	l l	0	99, 947	91, 770	0 191, 717	17 178	90. 00 91. 00
91.00			99, 947	91,770	191, 717	170	91.00
72.00	OTHER REIMBURSABLE COST CENTERS				<u> </u>		72.00
	09500 AMBULANCE SERVI CES	0	69, 318	537, 472	606, 790	375	
102. 0	0 10200 OPIOID TREATMENT PROGRAM SPECIAL PURPOSE COST CENTERS	0	0	0	0	0	102. 00
113. 0	0 11300 INTEREST EXPENSE						113. 00
118. 0	l l	2, 342, 057	2, 673, 006	1, 780, 116	6, 795, 179	2, 567	118. 00
	NONREI MBURSABLE COST CENTERS						
	0 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0		190.00
	10 19100 RESEARCH 10 19200 PHYSICIANS'PRIVATE OFFICES	0	0	4, 223	4, 223		191. 00 192. 00
	007950 OCC HEALTH	0	5, 388		5, 388		194. 00
	07951 PAIN CLINIC	0	0	0	0		194. 01
	2 07952 OCC HEALTH	0	0	0	O		194. 02
	13 07953 FOUNDATI 0	0	0	0	O		194. 03 194. 04
	14 07954 KIDS CAMPUS 15 07955 COMMUNITY & VOLUNTEER SERVICES		0		0		194. 04 194. 05
	6 07956 HUNTI NGTON COLLEGE NURSE		Ö		ol	0	194. 06
194.0	17 07957 MISC CATERING	0	0	0	O	0	194. 07
	8 07958 AUTI SM CENTER	0	0	0	ō		194. 08
194. 0 200. 0	9 07959 HUNTINGTON BUA O Cross Foot Adjustments	0	0		0	0	194. 09 200. 00
	- 1 st ood t ook hay as timorres	1 1	<u> </u>	<u> </u>	<u> </u>		

Health Financial Systems	HUNTI NGTON MEMO	HUNTINGTON MEMORIAL HOSPITAL			In Lieu of Form CMS-2552-10		
ALLOCATION OF CAPITAL RELATED COSTS		Provi der C		Peri od:	Worksheet B Part II		
				From 01/01/2022 To 12/31/2022			
		CAPI TAL REI	LATED COSTS				
Cost Center Description	Di rectl y	BLDG & FIXT	MVBLE EQUIP	Subtotal	EMPLOYEE		
	Assigned New				BENEFI TS		
	Capi tal				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, 342, 057	2, 678, 394	1, 784, 33	9 6, 804, 790	2, 577	202. 00	

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 15-0091

Peri od: Worksheet B From 01/01/2022 Part II To 12/31/2022 Date/Time Prepared:

5/18/2023 11:36 am Cost Center Description ADMINISTRATIV MAINTENANCE & OPERATION OF LAUNDRY & HOUSEKEEPI NG E & GENERAL **REPAIRS PLANT** LINEN SERVICE 5.00 6.00 7.00 9.00 8.00 GENERAL SERVICE COST CENTERS 1.00 00100 CAP REL COSTS-BLDG & FLXT 1.00 00200 CAP REL COSTS-MVBLE EQUIP 2.00 2.00 4 00 00400 EMPLOYEE BENEFITS DEPARTMENT 4 00 00500 ADMINISTRATIVE & GENERAL 5.00 2, 551, 982 5.00 6.00 00600 MAINTENANCE & REPAIRS 6.00 7.00 00700 OPERATION OF PLANT 138, 985 0 794, 289 7.00 00800 LAUNDRY & LINEN SERVICE 15 058 5, 061 32, 404 8 00 8 00 Ω 9.00 00900 HOUSEKEEPI NG 48,659 C 4, 119 67, 749 9.00 3, 396 01000 DI ETARY 47, 843 39, 360 10.00 10.00 11.00 01100 CAFETERI A 17, 954 0 8, 931 0 771 11.00 01200 MAINTENANCE OF PERSONNEL 0 12 00 Ω C 0 0 12.00 13.00 01300 NURSING ADMINISTRATION 36, 334 0 0 13.00 C 14.00 01400 CENTRAL SERVICES & SUPPLY 2, 497 15, 327 0 1, 323 14.00 0 01500 PHARMACY 60, 182 9, 293 15.00 0 802 15.00 01600 MEDICAL RECORDS & LIBRARY 16.00 836 C 5.133 443 16.00 0 17.00 01700 SOCIAL SERVICE 0 0 0 17.00 01900 NONPHYSICIAN ANESTHETISTS 0 0 19 00 0 0 19.00 0 02000 NURSING PROGRAM 20.00 0 0 0 20.00 0 02100 I&R SERVICES-SALARY & FRINGES APPRV 0 21 00 0 C 0 0 21.00 02200 I&R SERVICES-OTHER PRGM COSTS APPRV 0 0 22.00 0 0 22.00 02300 PARAMED ED PRGM-(SPECIFY) 23.00 0 0 23.00 INPATIENT ROUTINE SERVICE COST CENTERS 30.00 03000 ADULTS & PEDIATRICS 405, 056 0 202, 432 7, 366 17, 468 30.00 43.00 04300 NURSERY 15, 207 0 821 725 71 43.00 ANCILLARY SERVICE COST CENTERS 50 00 05000 OPERATING ROOM 103, 430 r 77, 111 6,944 6,654 50.00 05001 OPERATING ROOM 50.01 50.01 0 0 0 52.00 05200 DELIVERY ROOM & LABOR ROOM 75, 391 0 0 2, 895 52.00 0 05300 ANESTHESI OLOGY 53.00 84, 125 0 0 0 53.00 54.00 05400 RADI OLOGY-DI AGNOSTI C 197, 144 C 96,646 5, 774 8.340 54.00 60.00 06000 LABORATORY 196, 805 14,643 1, 264 60.00 06250 BLOOD CLOTTING FOR HEMOPHILIACS 0 0 62.30 0 0 62.30 06500 RESPIRATORY THERAPY 82 930 17.717 1.529 65.00 C 0 65.00 66.00 06600 PHYSI CAL THERAPY 118, 287 C 209, 465 0 18,074 66.00 06700 OCCUPATIONAL THERAPY 0 67.00 21, 737 0 0 67.00 0 68.00 06800 SPEECH PATHOLOGY 17,897 0 68.00 0 06900 ELECTROCARDI OLOGY 69.00 C 0 0 69.00 71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT 37, 303 0 0 0 0 71.00 72.00 07200 IMPL. DEV. CHARGED TO PATIENTS 0 59, 321 0 0 72.00 73 00 07300 DRUGS CHARGED TO PATIENTS 0 O 0 73 00 144.110 0 07697 CARDIAC REHABILITATION 0 76.97 C 0 0 76.97 76. 98 07698 HYPERBARIC OXYGEN THERAPY 16, 244 0 1, 402 76.98 58.476 76. 99 07699 LI THOTRI PSY C ol 0 76.99 0 C 07700 ALLOGENEIC HSCT ACQUISITION 77.00 77 00 0 0 0 0 0 OUTPATIENT SERVICE COST CENTERS 90.00 09000 CLI NI C 14, 256 0 134 0 90.00 09100 EMERGENCY 91.00 162, 498 41.194 8.566 3, 555 91.00 09200 OBSERVATION BEDS (NON-DISTINCT PART 92.00 92.00 OTHER REIMBURSABLE COST CENTERS 09500 AMBULANCE SERVICES 2, 465 95.00 369.564 28.571 0 102.00 10200 OPI OI D TREATMENT PROGRAM 0 102.00 0 0 SPECIAL PURPOSE COST CENTERS 113.00 11300 INTEREST EXPENSE 113.00 SUBTOTALS (SUM OF LINES 1 through 117)
NONREIMBURSABLE COST CENTERS 118.00 0 792, 068 32, 404 67, 557 118. 00 2, 531, 885 190.00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN 1, 596 0 190. 00 0 191. 00 19100 RESEARCH 0 0 0 191.00 43 0 192.00 19200 PHYSICIANS' PRIVATE OFFICES 0 0 192.00 8.017 0 0 194.00 07950 OCC HEALTH 362 Ω 2 221 192 194.00 194. 01 07951 PAIN CLINIC 0 0 0 194. 01 0 0 194. 02 07952 OCC HEALTH 0 0 0 194.02 0 0 194. 03 07953 FOUNDATI 0 0 194.03 0 0 4,642 194. 04 07954 KIDS CAMPUS 0 C 0 194.04 0 194. 05 07955 COMMUNITY & VOLUNTEER SERVICES 0 194.05 5, 437 0 194.06 07956 HUNTI NGTON COLLEGE NURSE 0 0 0 194.06 0 194. 07 07957 MISC CATERING C 0 0 194, 07 0 194. 08 07958 AUTI SM CENTER 0 0 194.08 0 C 0 194. 09 07959 HUNTI NGTON BUA 0 194. 09 0 C 0 Cross Foot Adjustments 200.00 200.00 201.00 Negative Cost Centers 0 201, 00 C 202.00 TOTAL (sum lines 118 through 201) 2, 551, 982 0 794, 289 32, 404 67, 749 202. 00

Provider CCN: 15-0091

In Lieu of Form CMS-2552-10

Period: Worksheet B
From 01/01/2022 Part II
To 12/31/2022 Date/Time Prepared:
5/18/2023 11:36 am

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194. 03 07953 FOUNDATI 0 0 75 0 0 0 194. 03 194. 04 194. 04 19754 KI DS CAMPUS 0 0 0 0 0 194. 04 194. 05 19755 COMMUNI TY & VOLUNTEER SERVI CES 0 50 0 0 0 194. 06 194. 06 19756 HUNTI NGTON COLLEGE NURSE 0 0 0 0 0 194. 06 194. 07 19757 MI SC CATERI NG 0 0 0 0 194. 08 19758 AUTI SM CENTER 0 0 0 0 0 194. 08 19759 HUNTI NGTON BUA 0 0 0 0 0 194. 08 1975 Foot Adjustments 200. 00 0 0 0 0 0 194. 09 194. 09 194. 09 194. 09 1959 HUNTI NGTON BUA 0 0 0 0 0 0 194. 09 194. 09 194. 09 194. 09 1959 HUNTI NGTON BUA 0 0 0 0 0 0 194. 09 194. 09 194. 09 194. 09 1959 HUNTI NGTON BUA 0 0 0 0 0 0 194. 09 194. 09 194. 09 1959 HUNTI NGTON BUA 0 0 0 0 0 0 194. 09 194. 09 194. 09 1959 HUNTI NGTON BUA 0 0 0 0 0 0 194. 09 1959 HUNTI NGTON BUA 0 0 0 0 0 0 1950. 00 0 0 0 1950. 00 0 0 0 1950. 00 0 0 0 1950. 00 0 0 0 0 1950. 00 0 0 0 0 1950. 00 0 0 0 1950. 00 0 0 0 0 1950. 00 0 0 0 0 1950. 00 0 0 0 0 1950. 00 0 0 0 1950. 00 0 0 0 1950. 00 0 0 0 1950. 00 0 0 0 1950. 00 0 0 0 1950. 00 0 0 0 1950. 00 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0			0	0	C	0		
194. 04 07954 KIDS CAMPUS 194. 05 07955 COMMUNITY & VOLUNTEER SERVICES 194. 06 07956 HUNTI NGTON COLLEGE NURSE 0 0 0 0 0 0 194. 06 194. 07 07957 MISC CATERING 0 0 0 0 0 0 194. 07 194. 08 07958 AUTISM CENTER 0 0 0 0 0 0 0 194. 08 194. 09 07959 HUNTI NGTON BUA 200. 00 Cross Foot Adjustments 201. 00 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		
194. 05 07955 COMMUNITY & VOLUNTEER SERVICES 0 50 0 0 2 194. 05 194. 06 07956 HUNTINGTON COLLEGE NURSE 0 0 0 0 0 194. 06 194. 07 07957 MISC CATERING 0 0 0 0 0 194. 07 194. 08 07958 AUTISM CENTER 0 0 0 0 0 0 194. 08 194. 09 07959 HUNTINGTON BUA 0 0 0 0 0 194. 09 200. 00 Cross Foot Adjustments 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0			0			0		
194. 06 07956 HUNTI NGTON COLLEGE NURSE 0 0 0 0 0 194. 06 194. 07 07957 MI SC CATERI NG 0 0 0 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. 09 200. 00 Cross Foot Adjustments 0 0 0 0 0 0 0 0 201. 00 201. 00 Negative Cost Centers 0 0 0 0 0 0 0 0 0 201. 00			0			0		
194. 07 07957 MISC CATERING 194. 08 07958 AUTISM CENTER 0 0 0 0 0 0 194. 08 194. 09 07959 HUNTINGTON BUA 200. 00 Cross Foot Adjustments 201. 00 Negative Cost Centers 0 0 0 0 0 0 0 194. 09 200. 00 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0			0	50		0		
194.08 07958 AUTISM CENTER 0 0 0 0 194.08 194.09 07959 HUNTINGTON BUA 0 0 0 0 194.09 200.00 Cross Foot Adjustments 201.00 Negative Cost Centers 0 0 0 0 0 0 0 0 0 201.00			0	0] 0		
194.09 07959 HUNTINGTON BUA 0 0 0 194.09 200.00 Cross Foot Adjustments 201.00 Negative Cost Centers 0 0 0 0 0 0 0 0 201.00				0				
200.00 Cross Foot Adjustments 200.00 201.00 Negative Cost Centers 0 0 0 0 0 0 0 0 0				0				
201.00 Negative Cost Centers 0 0 0 0 0 201.00			١	0	1	ή	0	
207.00 TOTAL (c)m Lings 119 through 201) 101.003 40.241 0 27.205 57.244.002.00				0	_	ار	0	
- ZUZ. VOL - LIVIME COUNTITUES TO UNIQUEIZUTZ 191. 9871 - 49.30 UL - 37.3851 - 56.3341707 UU		sum lines 118 through 201)	191, 982	49, 361		37, 385		
	, [, , , , , , , , , ,	. , , 301		3.,300	33,301	,

Health Financial Systems
ALLOCATION OF CAPITAL RELATED COSTS

Provi der CCN: 15-0091

				lo 12/31/2022	Date/lime Pre 5/18/2023 11:	
Cost Center Description	PHARMACY	MEDI CAL RECORDS &	SOCI AL SERVI CE	NONPHYSI CI AN ANESTHETI STS	NURSI NG PROGRAM	
	45.00	LI BRARY	17.00	10.00	20.00	
GENERAL SERVICE COST CENTERS	15. 00	16. 00	17. 00	19. 00	20. 00	
1. 00 O0100 CAP REL COSTS-BLDG & FLXT						1.00
2.00 O0200 CAP REL COSTS-MVBLE EQUIP						2.00
4.00 00400 EMPLOYEE BENEFITS DEPARTMENT						4.00
5. 00 00500 ADMINISTRATIVE & GENERAL						5. 00
6.00 00600 MAINTENANCE & REPAIRS						6.00
7.00 00700 OPERATION OF PLANT						7.00
8. 00 00800 LAUNDRY & LINEN SERVICE						8.00
9. 00 00900 HOUSEKEEPI NG						9.00
10. 00 01000 DI ETARY						10.00
11. 00 01100 CAFETERI A						11.00
12. 00 01200 MAI NTENANCE OF PERSONNEL						12.00
13. 00 01300 NURSI NG ADMI NI STRATI ON						13.00
14. 00 O1400 CENTRAL SERVICES & SUPPLY	04.040					14.00
15. 00 01500 PHARMACY	94, 940	10.0//				15.00
16. 00 01600 MEDI CAL RECORDS & LI BRARY	0	18, 866	,			16.00
17. 00 01700 SOCI AL SERVI CE 19. 00 01900 NONPHYSI CI AN ANESTHETI STS	0	0	(17.00
20. 00 02000 NURSI NG PROGRAM		0				1
21. 00 02100 1&R SERVICES-SALARY & FRINGES APPRV		0				21.00
22. 00 02200 &R SERVICES-OTHER PRGM COSTS APPRV		0				22. 00
23. 00 02300 PARAMED ED PRGM- (SPECIFY)		0				23. 00
I NPATIENT ROUTINE SERVICE COST CENTERS	<u></u>	J		21	l	25.00
30. 00 03000 ADULTS & PEDIATRICS	O	1, 368	(30.00
43. 00 04300 NURSERY	o	78				43. 00
ANCILLARY SERVICE COST CENTERS	-1			-		1
50. 00 05000 OPERATING ROOM	0	2, 461	(50.00
50. 01 05001 OPERATING ROOM	o	0	(50. 01
52.00 05200 DELIVERY ROOM & LABOR ROOM	o	389	(52.00
53. 00 05300 ANESTHESI OLOGY	0	308	(53.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	0	2, 834	(54.00
60. 00 06000 LABORATORY	0	2, 668	(60.00
62.30 06250 BLOOD CLOTTING FOR HEMOPHILIACS	0	0	(62. 30
65. 00 06500 RESPI RATORY THERAPY	0	749	(65.00
66. 00 06600 PHYSI CAL THERAPY	0	437	(1		66. 00
67. 00 06700 OCCUPATI ONAL THERAPY	0	140	(1		67. 00
68. 00 06800 SPEECH PATHOLOGY	0	60	(68. 00
69. 00 06900 ELECTROCARDI OLOGY	0	0	(69.00
71. 00 07100 MEDI CAL SUPPLI ES CHARGED TO PATI ENT	0	253	(71.00
72. 00 07200 IMPL. DEV. CHARGED TO PATIENTS	0	396				72.00
73. 00 07300 DRUGS CHARGED TO PATIENTS 76. 97 07697 CARDIAC REHABILITATION	94, 940	1, 671	(73.00
76. 97 07697 CARDI AC REHABI LI TATI ON 76. 98 07698 HYPERBARI C OXYGEN THERAPY	0	0	ì			76. 97 76. 98
76. 99 07699 LI THOTRI PSY		230 0				76. 98
77. 00 07700 ALLOGENEIC HSCT ACQUISITION		0				77. 00
OUTPATIENT SERVICE COST CENTERS	<u> </u>	0		21		17.00
90. 00 09000 CLI NI C	0	75	(90.00
91. 00 09100 EMERGENCY		3, 078				91.00
92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART		0, 0, 0	Ì			92.00
OTHER REIMBURSABLE COST CENTERS	, , , , , , , , , , , , , , , , , , ,			·		
95. 00 09500 AMBULANCE SERVICES	0	1, 671	(95.00
102.00 10200 OPIOID TREATMENT PROGRAM	o	0	(102.00
SPECIAL PURPOSE COST CENTERS						
113. 00 11300 I NTEREST EXPENSE						113. 00
118.00 SUBTOTALS (SUM OF LINES 1 through 117)	94, 940	18, 866	(0	C	118.00
NONREI MBURSABLE COST CENTERS				_		
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 OCC HEALTH	0	0	(194. 00
194. 01 07951 PAIN CLINIC	0	0	(194. 01
194. 02 07952 OCC HEALTH	0	0	(ال		194. 02
194. 03 07953 FOUNDATI 0	0	0		ار		194. 03
194. 04 07954 KI DS CAMPUS	0	0	(را ا		194.04
194. 05 07955 COMMUNITY & VOLUNTEER SERVICES	0	0	(ار		194.05
194.06 07956 HUNTINGTON COLLEGE NURSE		0				194. 06 194. 07
194.07 07957 MISC CATERING 194.08 07958 AUTISM CENTER		0				194. 07
194. 08 07958 AUTI SM CENTER 194. 09 07959 HUNTI NGTON BUA		0				194. 08
200.00 Cross Foot Adjustments	١	U		<u></u>		200.00
201.00 Regative Cost Centers		0	,			201.00
202.00 TOTAL (sum lines 118 through 201)	94, 940	18, 866				202.00
202. 00 TOTAL (Sum Triles 110 till ough 201)	, , , , , , , , , , , , , , , , , , , ,	10, 000	1	-1	1	1202.00

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

			1	0 12/31/2022	Date/lime Pre 5/18/2023 11:	
	INTERNS &	RESI DENTS			10, 10, 2020 11.	00 4
Cost Center Description	SERVI CES-SALA RY & FRI NGES APPRV	SERVI CES-OTHE R PRGM COSTS APPRV	PARAMED ED PRGM	Subtotal	Intern & Residents Cost & Post Stepdown	
					Adjustments	
	21. 00	22. 00	23. 00	24.00	25. 00	
GENERAL SERVICE COST CENTERS						
1. 00 00100 CAP REL COSTS-BLDG & FIXT 2. 00 00200 CAP REL COSTS-MVBLE EQUIP 4. 00 00400 EMPLOYEE BENEFITS DEPARTMENT 5. 00 00500 ADMINISTRATIVE & GENERAL						1.00 2.00 4.00 5.00
6. 00 00600 MAI NTENANCE & REPAI RS 7. 00 00700 OPERATI ON OF PLANT 8. 00 00800 LAUNDRY & LI NEN SERVI CE 9. 00 00900 HOUSEKEEPI NG 10. 00 01000 DI ETARY						6.00 7.00 8.00 9.00
11. 00 01100 CAFETERI A						11.00
12.00 01200 MAINTENANCE OF PERSONNEL						12.00
13.00 01300 NURSING ADMINISTRATION						13.00
14. 00 01400 CENTRAL SERVICES & SUPPLY						14.00
15. 00 01500 PHARMACY 16. 00 01600 MEDI CAL RECORDS & LI BRARY						15. 00 16. 00
17. 00 01700 SOCIAL SERVICE						17.00
19. 00 01900 NONPHYSICIAN ANESTHETISTS						19.00
20. 00 02000 NURSI NG PROGRAM						20.00
21.00 02100 I &R SERVICES-SALARY & FRINGES APPRV	0					21.00
22. 00 02200 L&R SERVICES-OTHER PRGM COSTS APPRV		0				22.00
23. 00 O2300 PARAMED ED PRGM-(SPECIFY) INPATIENT ROUTINE SERVICE COST CENTERS			0			23.00
30. 00 03000 ADULTS & PEDIATRICS				1, 558, 967	0	30.00
43. 00 04300 NURSERY				20, 042	0	43.00
ANCILLARY SERVICE COST CENTERS	I .	1	1			
50.00 05000 OPERATING ROOM 50.01 05001 OPERATING ROOM				618, 466	0	50. 00 50. 01
52. 00 05200 DELIVERY ROOM & LABOR ROOM				84, 421	0	52.00
53. 00 05300 ANESTHESI OLOGY				84, 433	0	53.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C				937, 026	0	54.00
60. 00 06000 LABORATORY				250, 915	0	60.00
62. 30 06250 BLOOD CLOTTING FOR HEMOPHILIACS 65. 00 06500 RESPIRATORY THERAPY		•		0 239, 731	0	62. 30 65. 00
66. 00 06600 PHYSI CAL THERAPY				973, 172	0	66.00
67. 00 06700 OCCUPATI ONAL THERAPY				22, 837	0	67.00
68. 00 06800 SPEECH PATHOLOGY				18, 747	0	68.00
69.00 06900 ELECTROCARDI OLOGY 71.00 07100 MEDI CAL SUPPLIES CHARGED TO PATI ENT				64 200	0	69. 00 71. 00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT 72.00 07200 IMPL. DEV. CHARGED TO PATIENTS				64, 398 59, 717	0	71.00
73. 00 07300 DRUGS CHARGED TO PATIENTS				240, 729	0	73.00
76. 97 07697 CARDI AC REHABI LI TATI ON				o	0	76. 97
76. 98 07698 HYPERBARI C OXYGEN THERAPY				125, 643	0	76. 98
76. 99 O7699 LITHOTRIPSY 77. 00 O7700 ALLOGENEIC HSCT ACQUISITION				0	0	76. 99 77. 00
OUTPATIENT SERVICE COST CENTERS				l ol		77.00
90. 00 09000 CLI NI C				15, 190	0	90.00
91. 00 09100 EMERGENCY				428, 017	0	91.00
92. 00 O9200 OBSERVATION BEDS (NON-DISTINCT PART OTHER REIMBURSABLE COST CENTERS					0	92.00
95. 00 09500 AMBULANCE SERVI CES				1, 029, 184	0	95.00
102. 00 10200 OPI OI D TREATMENT PROGRAM				0		102.00
SPECIAL PURPOSE COST CENTERS						
113. 00 11300 INTEREST EXPENSE				, 774 (05		113.00
118.00 SUBTOTALS (SUM OF LINES 1 through 117) NONREIMBURSABLE COST CENTERS	0	0	0	6, 771, 635	0	118. 00
190. 00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN				2, 028	0	190. 00
191. 00 19100 RESEARCH			•	43		191.00
192.00 19200 PHYSICIANS' PRIVATE OFFICES				12, 714		192.00
194. 00 07950 0CC HEALTH 194. 01 07951 PALN CLINIC				8, 163		194.00
194. 01 07951 PATN_CLINIC 194. 02 07952 0CC_HEALTH				0		194. 01 194. 02
194. 03 07953 FOUNDATI 0				4, 717		194. 03
194. 04 07954 KI DS CAMPUS				O	0	194. 04
194. 05 07955 COMMUNITY & VOLUNTEER SERVICES				5, 490		194.05
194. 06 07956 HUNTINGTON COLLEGE NURSE 194. 07 07957 MISC CATERING				0		194. 06 194. 07
194. 08 07958 AUTISM CENTER						194.07
194. 09 07959 HUNTI NGTON BUA				Ö		194. 09
·						

Health Financial Systems HUNTINGTON MEMORIA			L HOSPITAL In Lie			u of Form CMS-2552-10	
ALLOCATION OF CAPITAL RELATED COSTS		Provi der Co	CN: 15-0091	Peri od:	Worksheet B		
				From 01/01/2022 To 12/31/2022		nared:	
				10 12/31/2022	5/18/2023 11:	36 am	
	INTERNS & F	RESI DENTS					
Cost Center Description	SERVI CES-SALA		PARAMED ED	Subtotal	Intern &		
	RY & FRINGES	R PRGM COSTS	PRGM		Resi dents		
	APPRV	APPRV			Cost & Post		
					Stepdown		
					Adjustments		
	21. 00	22. 00	23. 00	24.00	25. 00		
200.00 Cross Foot Adjustments	0	0		0 0	0	200. 00	
201.00 Negative Cost Centers	0	0		0 0	0	201.00	
202.00 TOTAL (sum lines 118 through 201)	0	0		0 6, 804, 790	0	202. 00	

In Lieu of Form CMS-2552-10

| Period: | Worksheet B | From 01/01/2022 | Part II |
| To | 12/31/2022 | Date/Time | Prepared: | 5/18/2023 | 11:36 am Provider CCN: 15-0091

				5/18/2023 11:	
		Cost Center Description	Total 26. 00		
	GENER	AL SERVICE COST CENTERS	20.00		
1.00		CAP REL COSTS-BLDG & FIXT			1.00
2.00	1	CAP REL COSTS-MVBLE EQUIP			2.00
4.00		EMPLOYEE BENEFITS DEPARTMENT			4.00
5.00	1	ADMINISTRATIVE & GENERAL			5.00
6. 00 7. 00	1	MAINTENANCE & REPAIRS OPERATION OF PLANT			6. 00 7. 00
8. 00	1	LAUNDRY & LINEN SERVICE			8.00
9. 00	1	HOUSEKEEPI NG			9.00
10.00		DI ETARY			10.00
11.00	01100	CAFETERI A			11.00
12.00	01200	MAINTENANCE OF PERSONNEL			12.00
13.00	1	NURSING ADMINISTRATION			13.00
14.00	1	CENTRAL SERVICES & SUPPLY			14.00
15.00	1	PHARMACY			15.00
16. 00 17. 00	1	MEDICAL RECORDS & LIBRARY SOCIAL SERVICE			16. 00 17. 00
19.00		NONPHYSICIAN ANESTHETISTS			19.00
20. 00		NURSI NG PROGRAM			20.00
21.00	1	I&R SERVICES-SALARY & FRINGES APPRV			21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRV			22. 00
23.00	02300	PARAMED ED PRGM-(SPECIFY)			23. 00
		IENT ROUTINE SERVICE COST CENTERS			
30.00	1	ADULTS & PEDIATRICS	1, 558, 967		30.00
43. 00		NURSERY CERTIFICATION OF COST CENTERS	20, 042		43.00
EO 00		LARY SERVICE COST CENTERS OPERATING ROOM	410 144		E0 00
50. 00 50. 01	1	OPERATING ROOM	618, 466		50. 00 50. 01
52. 00	1	DELIVERY ROOM & LABOR ROOM	84, 421		52. 00
53. 00	1	ANESTHESI OLOGY	84, 433		53.00
54.00	1	RADI OLOGY-DI AGNOSTI C	937, 026		54.00
60.00	1	LABORATORY	250, 915		60.00
62. 30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0		62. 30
65.00		RESPI RATORY THERAPY	239, 731		65.00
66. 00	1	PHYSI CAL THERAPY	973, 172		66. 00
67. 00	1	OCCUPATI ONAL THERAPY	22, 837		67.00
68.00	1	SPEECH PATHOLOGY	18, 747		68.00
69. 00 71. 00	1	ELECTROCARDIOLOGY MEDICAL SUPPLIES CHARGED TO PATIENT	0 64, 398		69. 00 71. 00
71.00	1	IMPL. DEV. CHARGED TO PATIENTS	59, 717		71.00
73. 00		DRUGS CHARGED TO PATIENTS	240, 729		73.00
76. 97		CARDI AC REHABI LI TATI ON	0		76. 97
76. 98		HYPERBARIC OXYGEN THERAPY	125, 643		76. 98
76. 99	07699	LI THOTRI PSY	0		76. 99
77. 00		ALLOGENEIC HSCT ACQUISITION	0		77. 00
		TIENT SERVICE COST CENTERS	45 400		
	1	CLINIC EMERGENCY	15, 190		90.00
		OBSERVATION BEDS (NON-DISTINCT PART	428, 017		91.00
72.00		REIMBURSABLE COST CENTERS			72.00
95.00		AMBULANCE SERVICES	1, 029, 184		95.00
102.00	10200	OPIOID TREATMENT PROGRAM	0		102.00
		AL PURPOSE COST CENTERS			
	1	INTEREST EXPENSE			113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	6, 771, 635		118. 00
100 00		IMBURSABLE COST CENTERS GIFT, FLOWER, COFFEE SHOP & CANTEEN	2 020		100 00
		RESEARCH	2, 028 43		190. 00 191. 00
	1	PHYSICIANS' PRIVATE OFFICES	12, 714		192.00
		OCC HEALTH	8, 163		194.00
		PAIN CLINIC	0		194. 01
	1	OCC HEALTH	o		194. 02
	1	FOUNDATI O	4, 717		194. 03
		KIDS CAMPUS	0		194. 04
		COMMUNITY & VOLUNTEER SERVICES	5, 490		194. 05
		HUNTI NGTON COLLEGE NURSE	0		194.06
		MI SC CATERI NG	0		194. 07
		AUTISM CENTER HUNTINGTON BUA	0		194. 08 194. 09
200.00		Cross Foot Adjustments	0		200.00
200.00		Negative Cost Centers	0		201.00
202.00	1	TOTAL (sum lines 118 through 201)	6, 804, 790		202.00
			1		•

COST ALLOCATION - STATISTICAL BASIS Provider CCN: 15-0091 Peri od: Worksheet B-1 From 01/01/2022 12/31/2022 Date/Time Prepared: 5/18/2023 11:36 am CAPITAL RELATED COSTS BLDG & FIXT MVBLE EQUIP **EMPLOYEE** Reconciliatio ADMINISTRATIV Cost Center Description (SQUARE FEET) (DOLLAR BENEFITS F & GENERAL n DEPARTMENT (ACCUM. COST) VALUE) (GROSS SALARI ES) 1. 00 2.00 4.00 5A 5. 00 GENERAL SERVICE COST CENTERS 1.00 00100 CAP REL COSTS-BLDG & FLXT 137, 207 1 00 00200 CAP REL COSTS-MVBLE EQUIP 2.00 896, 588 2.00 00400 EMPLOYEE BENEFITS DEPARTMENT 23, 110, 406 4.00 132 4.00 00500 ADMINISTRATIVE & GENERAL 5.00 29,818 5, 848, 527 7, 681 -15, 914, 717 38, 011, 828 5.00 6.00 00600 MAINTENANCE & REPAIRS 6.00 7.00 00700 OPERATION OF PLANT 30, 673 28, 387 434, 178 0 2, 070, 166 7.00 00800 LAUNDRY & LINEN SERVICE 0 8.00 8 00 629 52 509 224 281 00900 HOUSEKEEPI NG 0 9.00 512 2, 475 444, 325 724, 772 9.00 10.00 01000 DI ETARY 4, 892 2, 939 343, 313 712, 614 10.00 11.00 01100 CAFETERI A 1, 110 330, 998 0 0 267, 416 11.00 C 01200 MAINTENANCE OF PERSONNEL 12 00 12 00 0 C 0 0 13.00 01300 NURSING ADMINISTRATION 0 C 420, 426 541, 187 13.00 01400 CENTRAL SERVICES & SUPPLY 1, 905 0 14.00 37, 187 14.00 0 01500 PHARMACY 609, 910 896, 403 15.00 1.155 15.00 0 01600 MEDICAL RECORDS & LIBRARY 16.00 638 12, 454 16.00 17.00 01700 SOCIAL SERVICE 0 0 0 17.00 0 01900 NONPHYSICIAN ANESTHETISTS 19.00 0 0 0 0 19.00 0 ol 02000 NURSING PROGRAM 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 0 0 22.00 0 0 22.00 23.00 02300 PARAMED ED PRGM-(SPECIFY) 0 0 0 23.00 INPATIENT ROUTINE SERVICE COST CENTERS 30.00 03000 ADULTS & PEDIATRICS 25, 160 106, 186 3, 381, 506 0 6, 033, 616 30.00 04300 NURSERY 43.00 102 143, 351 226, 514 43.00 ANCILLARY SERVICE COST CENTERS 05000 OPERATING ROOM 50 00 9.584 107, 859 1, 396, 041 0 1, 540, 580 50 00 50.01 05001 OPERATING ROOM 0 50.01 05200 DELIVERY ROOM & LABOR ROOM 0 52.00 0 716, 961 1, 122, 936 52 00 53.00 05300 ANESTHESI OLOGY 0 53.00 1, 253, 037 0 05400 RADI OLOGY-DI AGNOSTI C 54 00 12.012 193, 795 1, 351, 675 2, 936, 450 54 00 06000 LABORATORY 2, 931, 387 60.00 1,820 295 60.00 62.30 06250 BLOOD CLOTTING FOR HEMOPHILIACS 0 0 0 0 62.30 06500 RESPIRATORY THERAPY 44, 563 65.00 2, 202 751, 798 1, 235, 236 65.00 66.00 06600 PHYSI CAL THERAPY 26, 034 57, 919 888, 757 1, 761, 868 66.00 67.00 06700 OCCUPATI ONAL THERAPY 246, 567 0 0 323, 773 67.00 06800 SPEECH PATHOLOGY 0 68.00 203.003 266, 568 68.00 06900 ELECTROCARDI OLOGY 0 69.00 C \cap 69 00 71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT 0 C 0 0 555, 618 71.00 72.00 07200 IMPL. DEV. CHARGED TO PATIENTS 0 0 883, 584 72.00 0 07300 DRUGS CHARGED TO PATIENTS 0 0 73.00 67.293 2, 146, 504 73.00 07697 CARDIAC REHABILITATION 76.97 0 \cap Ω 76.97 76. 98 07698 HYPERBARIC OXYGEN THERAPY 2.019 4.346 290, 923 870, 995 76.98 76. 99 o 07699 LI THOTRI PSY 76.99 C 0 07700 ALLOGENEIC HSCT ACQUISITION 77.00 0 \cap 0 0 77.00 OUTPATIENT SERVICE COST CENTERS 90.00 09000 CLI NI C 154, 089 0 212, 336 90.00 09100 EMERGENCY 91.00 91.00 5.120 1, 592, 656 2, 420, 388 46, 112 09200 OBSERVATION BEDS (NON-DISTINCT PART 92.00 92.00 OTHER REIMBURSABLE COST CENTERS 09500 AMBULANCE SERVICES 3, 551 270, 067 3, 347, 729 5, 504, 623 95.00 102. 00 10200 OPI OID 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, 931 894, 466 23, 016, 830 -15, 914, 717 37, 712, 493 118. 00 190.00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN 0 0 23, 768 190. 00 191. 00 19100 RESEARCH 0 0 0 637 191.00 192. 00 19200 PHYSICIANS' PRIVATE OFFICES 0 2.122 82, 906 0 119, 411 192. 00 194. 00 07950 OCC HEALTH 0 5, 388 194. 00 276 194. 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 69, 145 194. 03 194. 04 07954 KIDS CAMPUS C 0 0 0 194, 04 0 194. 05 07955 COMMUNITY & VOLUNTEER SERVICES 10,670 80, 986 194. 05 0 194.06 07956 HUNTI NGTON COLLEGE NURSE 0 0 0 0 194.06 194. 07 07957 MISC CATERING 0 0 194.07 C 0 194. 08 07958 AUTI SM CENTER 0 0 194.08 194. 09 07959 HUNTI NGTON BUA 0 0 194.09

Health Financial Systems	HUNTINGTON MEMOR	RLAL HOSPLTAL		In Lie	u of Form CMS-2	2552-10
COST ALLOCATION - STATISTICAL BASIS		Provi der CO		Peri od: From 01/01/2022	Worksheet B-1	
				To 12/31/2022	Date/Time Pre 5/18/2023 11:	
	CAPITAL REL	ATED COSTS				
Cost Center Description	BLDG & FLXT (SQUARE FEET)	MVBLE EQUIP (DOLLAR	EMPLOYEE BENEFITS	Reconciliatio n	ADMINISTRATIV E & GENERAL	

		CAPITAL RELATED 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. 00 205. 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, Part II) Unit cost multiplier (Wkst. B, Part II)	2, 678, 394 19. 520826				l .	203. 00 204. 00
206. 00	NAHE adjustment amount to be allocated (per Wkst. B-2)						206. 00
207. 00	NÄHE unit cost multiplier (Wkst. D, Parts III and IV)						207. 00

Health Financial Systems HUNTINGTON MEMORIAL HOSPITAL In Lieu of Form CMS-2552-10 COST ALLOCATION - STATISTICAL BASIS Provider CCN: 15-0091 Peri od: Worksheet B-1 From 01/01/2022 12/31/2022 Date/Time Prepared: 5/18/2023 11:36 am Cost Center Description MAINTENANCE & OPERATION OF LAUNDRY & HOUSEKEEPI NG DI ETARY LINEN SERVICE (SQUARE FEET) (MEALS **REPAIRS** PLANT (SQUARE FEET) (SQUARE FEET) (POUNDS OF SERVED) LAUNDRY) 6. 00 7. 00 9. 00 10.00 8.00 GENERAL SERVICE COST CENTERS 00100 CAP REL COSTS-BLDG & FIXT 1.00 1.00 2 00 00200 CAP REL COSTS-MVBLE EQUIP 2 00 4.00 00400 EMPLOYEE BENEFITS DEPARTMENT 4.00 00500 ADMINISTRATIVE & GENERAL 5.00 5.00 6.00 00600 MAINTENANCE & REPAIRS 0 6.00 00700 OPERATION OF PLANT 7.00 98.721 7 00 0 8.00 00800 LAUNDRY & LINEN SERVICE 629 234, 386 8.00 9.00 00900 HOUSEKEEPI NG 0 0 512 0 97, 580 9 00 01000 DI ETARY 4, 892 4.892 21, 554 10.00 0 10.00 01100 CAFETERI A 0 11.00 1, 110 1, 110 Λ 11.00 12.00 01200 MAINTENANCE OF PERSONNEL 00000000 0 12.00 13.00 01300 NURSING ADMINISTRATION 0 0 13.00 01400 CENTRAL SERVICES & SUPPLY 1, 905 1, 905 14.00 0 14.00 0 15.00 01500 PHARMACY 1, 155 0 1, 155 0 15.00 16.00 01600 MEDICAL RECORDS & LIBRARY 638 638 16.00 01700 SOCIAL SERVICE 17.00 C 0 0 17.00 0 01900 NONPHYSICIAN ANESTHETISTS 0 19 00 19 00 C 0 0 20.00 02000 NURSING PROGRAM C 0 0 0 20.00 02100 | &R SERVICES-SALARY & FRINGES APPRV 0 0 21.00 C 0 0 21.00 02200 I&R SERVICES-OTHER PRGM COSTS APPRV 0 0 22.00 22.00 C 0 02300 PARAMED ED PRGM-(SPECIFY) 23.00 n 0 23.00 INPATIENT ROUTINE SERVICE COST CENTERS 03000 ADULTS & PEDIATRICS 30.00 0 25, 160 53, 281 25, 160 21, 554 30.00 43.00 04300 NURSERY 0 43 00 102 5.246 102 0 ANCILLARY SERVICE COST CENTERS 50.00 05000 OPERATING ROOM 0 9, 584 50, 228 9, 584 0 50.00 0 50.01 05001 OPERATING ROOM 0 C C 0 50.01 05200 DELIVERY ROOM & LABOR ROOM 52.00 C 20, 938 0 0 52.00 0 53.00 05300 ANESTHESI OLOGY C 0 0 53.00 05400 RADI OLOGY-DI AGNOSTI C 54.00 0 0 12, 012 41, 767 12,012 0 54.00 60 00 06000 LABORATORY 1, 820 1, 820 60 00 0 0 06250 BLOOD CLOTTING FOR HEMOPHILIACS 62.30 0 0 62.30 06500 RESPIRATORY THERAPY 00000000 2, 202 0 2, 202 0 65.00 65.00 06600 PHYSI CAL THERAPY 66.00 26, 034 0 26,034 0 66.00 06700 OCCUPATI ONAL THERAPY O 67 00 C 0 0 67 00 68.00 06800 SPEECH PATHOLOGY C 0 0 0 68.00 06900 ELECTROCARDI OLOGY 0 69.00 69.00 71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT 0 0 ol 0 71.00 07200 IMPL. DEV. CHARGED TO PATIENTS 0 72 00 0 0 0 72 00 73.00 07300 DRUGS CHARGED TO PATIENTS C 0 0 73.00 76.97 07697 CARDIAC REHABILITATION 0 0 0 76.97 07698 HYPERBARI C OXYGEN THERAPY 0 76.98 2.019 0 2.019 0 76.98 07699 LI THOTRI PSY 76. 99 0 76. 99 0 0 0 07700 ALLOGENEIC HSCT ACQUISITION 77.00 0 77.00 OUTPATIENT SERVICE COST CENTERS 90.00 09000 CLINIC 0 970 90.00 0 09100 EMERGENCY 91.00 0 5, 120 61, 956 5.120 0 91.00 09200 OBSERVATION BEDS (NON-DISTINCT PART 92.00 92.00 OTHER REIMBURSABLE COST CENTERS 09500 AMBULANCE SERVICES 95.00 95.00 0 3, 551 0 3, 551 0 102.00 10200 OPIOID TREATMENT PROGRAM 0 102.00 SPECIAL PURPOSE COST CENTERS

113.001	1300 INTEREST EXPENSE						113.00
118. 00	SUBTOTALS (SUM OF LINES 1 through 117)	0	98, 445	234, 386	97, 304	21, 554	118.00
N	ONREI MBURSABLE COST CENTERS						
190. 00 1	9000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190. 00
191.001	9100 RESEARCH	0	0	0	0	0	191. 00
192. 00 1	9200 PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192.00
194.000	7950 OCC HEALTH	0	276	0	276	0	194. 00
194. 01 0	7951 PAIN CLINIC	0	0	0	0	0	194. 01
194. 02 0	7952 OCC HEALTH	0	0	0	0	0	194. 02
194.030	17953 FOUNDATI O	0	0	0	0	0	194. 03
194.040	7954 KIDS CAMPUS	0	0	0	0	0	194. 04
194.050	7955 COMMUNITY & VOLUNTEER SERVICES	0	0	0	0	0	194. 05
194.060	17956 HUNTI NGTON COLLEGE NURSE	0	0	0	0	0	194. 06
194. 07 C	17957 MISC CATERING	0	0	0	0	0	194. 07
194.080	7958 AUTISM CENTER	0	0	0	0	0	194. 08
194.090	17959 HUNTI NGTON BUA	0	0	0	0	0	194. 09
200.00	Cross Foot Adjustments						200. 00
201.00	Negative Cost Centers						201. 00

Heal th	Financial Systems F	HUNTI NGTON MEMO	RIAL HOSPITAL		In Lie	u of Form CMS-2	2552-10
COST ALLOCATION - STATISTICAL BASIS			Provi der Co		Period: From 01/01/2022	Worksheet B-1	
					Γο 12/31/2022	Date/Time Pre 5/18/2023 11:	
	Cost Center Description	MAINTENANCE &	OPERATION OF	LAUNDRY &	HOUSEKEEPI NG	DI ETARY	
		REPAI RS	PLANT	LINEN SERVICE	(SQUARE FEET)	(MEALS	
		(SQUARE FEET)	(SQUARE FEET)	(POUNDS OF		SERVED)	
				LAUNDRY)			
		6. 00	7. 00	8. 00	9. 00	10. 00	
202.00	Cost to be allocated (per Wkst. B,	0	2, 936, 899	336, 895	1, 043, 450	1, 208, 816	202. 00
	Part I)						
203.00	Unit cost multiplier (Wkst. B, Part I)	0. 000000	29. 749486	1. 437351	10. 693277	56. 083140	203. 00
204.00	Cost to be allocated (per Wkst. B,	0	794, 289	32, 404	67, 749	191, 982	204.00
	Part II)						
205.00	Unit cost multiplier (Wkst. B, Part	0. 000000	8. 045796	0. 138251	0. 694292	8. 907024	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)						

COST ALLOCATION - STATISTICAL BASIS		Provi der Co		eriod: com 01/01/2022	Worksheet B-1	
			To			pared:
Cost Center Description	CAFETERI A	MAI NTENANCE	NURSI NG	CENTRAL	5/18/2023 11: PHARMACY	36 am
occi conton basen per an	(HOURS OF	OF PERSONNEL	ADMI NI STRATI O	SERVICES &	(COSTED	
	SERVI CE)	(NUMBER	N	SUPPLY	REQUIS.)	
		HOUSED)	(DIRECT NRSING HRS)	(COSTED REQUIS.)		
	11. 00	12. 00	13. 00	14. 00	15. 00	
GENERAL SERVICE COST CENTERS						
1. 00 00100 CAP REL COSTS-BLDG & FLXT 2. 00 00200 CAP REL COSTS-MVBLE EQUIP						1. 00 2. 00
4. 00 00400 EMPLOYEE BENEFITS DEPARTMENT						4.00
5. 00 00500 ADMINI STRATI VE & GENERAL						5.00
6. 00 00600 MAI NTENANCE & REPAI RS						6.00
7. 00 00700 0PERATION OF PLANT 8. 00 00800 LAUNDRY & LINEN SERVICE						7. 00 8. 00
9. 00 00900 HOUSEKEEPI NG						9.00
10. 00 01000 DI ETARY						10.00
11. 00 01100 CAFETERI A	421, 464					11.00
12. 00 01200 MAINTENANCE OF PERSONNEL 13. 00 01300 NURSING ADMINISTRATION	0 8, 574	0	177, 015			12. 00 13. 00
14. 00 01400 CENTRAL SERVICES & SUPPLY	0, 374	0	177,013	3, 020, 510		14.00
15. 00 01500 PHARMACY	10, 885	0	Ö	41, 467	2, 060, 989	15. 00
16. 00 01600 MEDI CAL RECORDS & LI BRARY	0	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	0	17. 00 19. 00
20. 00 02000 NURSI NG PROGRAM	0	0	0	0	0	20.00
21. 00 02100 I &R SERVI CES-SALARY & FRI NGES APPRV	o	0	Ö	Ö	0	21.00
22.00 02200 I&R SERVICES-OTHER PRGM COSTS APPRV	0	0	0	0	0	22. 00
23. 00 02300 PARAMED ED PRGM- (SPECIFY) INPATIENT ROUTINE SERVICE COST CENTERS	0	0	0	0	0	23. 00
30. 00 03000 ADULTS & PEDIATRICS	79, 159	0	79, 159	239, 019	0	30.00
43. 00 04300 NURSERY	3, 451	0		0	0	43.00
ANCILLARY SERVICE COST CENTERS				.== =.=1		
50. 00 05000 OPERATING ROOM 50. 01 05001 OPERATING ROOM	33, 904 0	0	33, 904	473, 763	0	50. 00 50. 01
52. 00 05200 DELIVERY ROOM & LABOR ROOM	17, 258	0	17, 258	ő	0	52.00
53. 00 05300 ANESTHESI OLOGY	0	0	0	o	0	53.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	35, 380	0	0	98, 084	0	54.00
60.00 06000 LABORATORY 62.30 06250 BLOOD CLOTTING FOR HEMOPHILIACS	12	0	0	305	0	60. 00 62. 30
65. 00 06500 RESPIRATORY THERAPY	21, 742	0	Ö	134, 286	0	65.00
66. 00 06600 PHYSI CAL THERAPY	24, 392	0	0	25, 721	0	66. 00
67. 00 06700 OCCUPATI ONAL THERAPY	7, 958	0	0	0	0	67.00
68. 00 06800 SPEECH PATHOLOGY 69. 00 06900 ELECTROCARDI OLOGY	6, 552 0	0	0	0	0	68. 00 69. 00
71. 00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	Ö	0	Ö	1, 439, 202	0	71.00
72.00 07200 I MPL. DEV. CHARGED TO PATIENTS	0	0	0	o	0	72. 00
73. 00 07300 DRUGS CHARGED TO PATIENTS	0	0	0	0	2, 060, 989	73.00
76.97 O7697 CARDIAC REHABILITATION 76.98 O7698 HYPERBARIC OXYGEN THERAPY	0	0	0	64, 115	0	76. 97 76. 98
76. 99 07699 LI THOTRI PSY	Ö	0	Ö	01,110	0	76. 99
77.00 07700 ALLOGENEIC HSCT ACQUISITION	0	0	0	0	0	77. 00
OUTPATIENT SERVICE COST CENTERS 90. 00 09000 CLINIC	3, 469	0	O	16, 217	0	90.00
91. 00 09100 EMERGENCY	43, 243	0		162, 642	0	91.00
92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART	.5,5	_	,	,		92.00
OTHER REIMBURSABLE COST CENTERS				204 440		
95.00 09500 AMBULANCE SERVICES 102.00 10200 OPIOID TREATMENT PROGRAM	121, 411 0	0		296, 443 0	0	95. 00 102. 00
SPECIAL PURPOSE COST CENTERS	<u> </u>		<u> </u>	<u> </u>		102.00
113. 00 11300 I NTEREST EXPENSE						113. 00
118.00 SUBTOTALS (SUM OF LINES 1 through 117) NONREIMBURSABLE COST CENTERS	417, 390	0	177, 015	2, 991, 264	2, 060, 989	118. 00
190. 00 19000 GLFT, FLOWER, COFFEE SHOP & CANTEEN	O	0	O	23, 148	0	190. 00
191. 00 19100 RESEARCH	o	0	Ö	0		191. 00
192. 00 19200 PHYSI CLANS' PRI VATE OFFI CES	3, 010	0	0	6, 012		192.00
194. 00 07950 0CC HEALTH 194. 01 07951 PALN CLINI C	0	0	0	0		194. 00 194. 01
194. 02 07951 PATN CETNIC 194. 02 07952 OCC HEALTH	0	0	0	0		194.01
194. 03 07953 FOUNDATI 0	640	0	Ö	ō		194. 03
194. 04 07954 KIDS CAMPUS	0	0	0	O		194.04
194. 05 07955 COMMUNITY & VOLUNTEER SERVICES	424	0	0	86		194. 05 194. 06
194.06 07956 HUNTI NGTON COLLEGE NURSE 194.07 07957 MISC CATERI NG		0	0	O O		194.06
194. 08 07958 AUTI SM CENTER		0	0	ő	0	194. 08
194. 09 07959 HUNTI NGTON BUA	0	0	0	О	0	194. 09
200.00 Cross Foot Adjustments 201.00 Negative Cost Centers						200. 00 201. 00
201. 00 megative cost centers	ı l		I	l		1201.00

Heal th Fina	ancial Systems	HUNTINGTON MEMO	RIAL HOSPITAL		In Lie	u of Form CMS-2	2552-10
COST ALLOC	ATION - STATISTICAL BASIS		Provi der CCN: 15-0091		Peri od: From 01/01/2022	Worksheet B-1	
					To 12/31/2022		
	Cost Center Description	CAFETERI A	MAI NTENANCE	NURSI NG	CENTRAL	PHARMACY	
		(HOURS OF	OF PERSONNEL	ADMI NI STRATI	SERVICES &	(COSTED	
		SERVI CE)	(NUMBER	N	SUPPLY	REQUIS.)	
			HOUSED)	(DI RECT	(COSTED		
				NRSING HRS)	REQUIS.)		
		11. 00	12. 00	13.00	14.00	15. 00	
202. 00	Cost to be allocated (per Wkst. B, Part I)	424, 269	0	776, 40	129, 800	1, 331, 158	202.00
203.00	Unit cost multiplier (Wkst. B, Part I)	1. 006655	0. 000000	4. 38607	5 0. 042973	0. 645883	203.00
204. 00	Cost to be allocated (per Wkst. B, Part II)	49, 361	0	37, 38	56, 334	94, 940	204. 00
205. 00	Unit cost multiplier (Wkst. B, Part	0. 117118	0. 000000	0. 21119	0. 018650	0. 046065	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 01/01/2022 12/31/2022 Date/Time Prepared: 5/18/2023 11:36 am INTERNS & **RESI DENTS** MEDI CAL SOCI AL NONPHYSI CI AN NURSI NG SERVI CES-SALA Cost Center Description RY & FRINGES RECORDS & SERVI CE **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 255, 809, 749 16.00 16.00 17.00 01700 SOCIAL SERVICE 17.00 01900 NONPHYSICIAN ANESTHETISTS 19.00 0 0 0 19.00 02000 NURSI NG PROGRAM 0 20 00 20 00 Ω 0 02100 I&R SERVICES-SALARY & FRINGES APPRV 21.00 0 0 0 21.00 02200 I&R SERVICES-OTHER PRGM COSTS APPRV 0 22.00 22.00 23.00 02300 PARAMED ED PRGM-(SPECIFY) 0 23.00 INPATIENT ROUTINE SERVICE COST CENTERS 30.00 03000 ADULTS & PEDIATRICS 18, 492, 627 0 0 0 0 30.00 04300 NURSERY 1, 050, 668 0 0 43.00 43.00 0 0 ANCILLARY SERVICE COST CENTERS 05000 OPERATING ROOM 50 00 50.00 33, 255, 933 0 0 0 50.01 05001 OPERATING ROOM 0 0 0 0 50.01 05200 DELIVERY ROOM & LABOR ROOM 0 0 52.00 5, 254, 859 0 52.00 53.00 05300 ANESTHESI OLOGY 4, 156, 236 0 0 0 0 0 0 0 0 0 0 0 53.00 0 05400 RADI OLOGY-DI AGNOSTI C 0 54 00 38, 300, 893 0 0 54 00 06000 LABORATORY 36, 060, 742 60.00 60.00 0 06250 BLOOD CLOTTING FOR HEMOPHILIACS 0 62.30 0 0 62.30 06500 RESPIRATORY THERAPY 0 65.00 10, 126, 586 0 65.00 0 66.00 06600 PHYSI CAL THERAPY 5, 905, 608 0 0 66.00 67.00 06700 OCCUPATI ONAL THERAPY 1, 894, 215 0 0 67.00 06800 SPEECH PATHOLOGY 68.00 813.313 68.00 06900 ELECTROCARDI OLOGY 0 69.00 0 69.00 0 71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT 3, 415, 794 C 0 71.00 72.00 07200 IMPL. DEV. CHARGED TO PATIENTS 5, 354, 944 0 0 0 72.00 07300 DRUGS CHARGED TO PATIENTS 22, 581, 368 0 0 0 73.00 73.00 07697 CARDIAC REHABILITATION C 0 76.97 0 76.97 76. 98 07698 HYPERBARIC OXYGEN THERAPY 3, 111, 118 0 0 76.98 76. 99 o 07699 LI THOTRI PSY 0 0 0 76.99 07700 ALLOGENEIC HSCT ACQUISITION 77.00 0 0 0 0 77.00 OUTPATIENT SERVICE COST CENTERS 90.00 09000 CLI NI C 1, 018, 993 0 0 0 90.00 09100 EMERGENCY 0 ol 91.00 91.00 42, 441, 167 C 0 09200 OBSERVATION BEDS (NON-DISTINCT PART 92.00 92.00 OTHER REIMBURSABLE COST CENTERS 09500 AMBULANCE SERVICES 22, 574, 685 0 0 95.00 102. 00 10200 OPI OID 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 118.00 255, 809, 749 0 0 0 118.00 0 190.00 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 0 194.07 0 194. 08 07958 AUTI SM CENTER 0 0 194.08 194. 09 07959 HUNTI NGTON BUA 0 194.09

Health Financial Systems	HUNTINGTON MEMORIAL HOSPITAL	In Lieu of Form CMS-2552-10
COST ALLOCATION - STATISTICAL BASIS	Provi der CCN: 15-0091	Peri od: Worksheet B-1
		To 12/31/2022 Date/Time Prepared:

					0 12/31/2022	5/18/2023 11:	
						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,	43, 470	0	0	0	0	202. 00
	Part I)						
203. 00	Unit cost multiplier (Wkst. B, Part I)	0. 000170		0. 000000	0. 000000		
204. 00	Cost to be allocated (per Wkst. B,	18, 866	0	0	0	0	204. 00
	Part II)						
205. 00	Unit cost multiplier (Wkst. B, Part	0. 000074	0. 000000	0. 000000	0. 000000	0. 000000	205. 00
	11)						
206. 00	NAHE adjustment amount to be allocated				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 HUNTINGTON MEMORIAL HOSPITAL In Lieu of Form CMS-2552-10

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 15-0091 | Period: From 01/01/2022 To 12/31/2022 | Date/Time Prepared: 5/18/2023 11: 36 am

						5/18/2023 11:36 am
			I NTERNS & RESI DENTS			
		Cost Center Description	SERVI CES-OTHE	PARAMED ED		
			R PRGM COSTS	PRGM		
			APPRV (ASSI GNED	(ASSI GNED TIME)		
			TIME)			
	OFNED	AL CERVI OF COCT OFNITERS	22. 00	23. 00		
1. 00		AL SERVICE COST CENTERS CAP REL COSTS-BLDG & FIXT				1.00
2. 00	1	CAP REL COSTS-MVBLE EQUIP				2.00
4. 00		EMPLOYEE BENEFITS DEPARTMENT				4.00
5. 00 6. 00	1	ADMINISTRATIVE & GENERAL MAINTENANCE & REPAIRS				5. 00 6. 00
7. 00		OPERATION OF PLANT				7.00
8.00	1	LAUNDRY & LINEN SERVICE				8.00
9.00	1	HOUSEKEEPI NG				9.00
10. 00 11. 00	1	DI ETARY CAFETERI A				10.00
	1	MAINTENANCE OF PERSONNEL				12.00
		NURSING ADMINISTRATION				13. 00
	1	CENTRAL SERVICES & SUPPLY PHARMACY				14. 00 15. 00
		MEDICAL RECORDS & LIBRARY				16.00
17. 00	1	SOCIAL SERVICE				17. 00
	1	NONPHYSI CI AN ANESTHETI STS				19.00
20. 00 21. 00		NURSING PROGRAM I&R SERVICES-SALARY & FRINGES APPRV				20.00
	1	I &R SERVICES-OTHER PRGM COSTS APPRV	0			22.00
23. 00		PARAMED ED PRGM-(SPECIFY)		0		23. 00
30. 00		TIENT ROUTINE SERVICE COST CENTERS ADULTS & PEDIATRICS	0	0		30.00
43. 00		NURSERY	0	Ö		43.00
		LARY SERVICE COST CENTERS	_	_	1	
50. 00 50. 01	1	OPERATING ROOM OPERATING ROOM	0	0		50. 00 50. 01
52. 00		DELIVERY ROOM & LABOR ROOM	0	Ö		52.00
53.00	1	ANESTHESI OLOGY	0	0	1	53.00
54. 00 60. 00	1	RADI OLOGY-DI AGNOSTI C LABORATORY	0	0		54. 00 60. 00
62. 30		BLOOD CLOTTING FOR HEMOPHILIACS	0	0		62. 30
65.00		RESPI RATORY THERAPY	0	0		65. 00
66.00	1	PHYSI CAL THERAPY	0	0		66.00
67. 00 68. 00	1	OCCUPATIONAL THERAPY SPEECH PATHOLOGY	0	0		67. 00 68. 00
69. 00	1	ELECTROCARDI OLOGY	Ö	0		69. 00
	1	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0		71.00
		IMPL. DEV. CHARGED TO PATIENTS DRUGS CHARGED TO PATIENTS	0	0)	72. 00 73. 00
76. 97	1	CARDI AC REHABI LI TATI ON	0	Ö		76. 97
76. 98	1	HYPERBARIC OXYGEN THERAPY	0	0		76. 98
	1	LITHOTRIPSY ALLOGENEIC HSCT ACQUISITION	0	0		76. 99 77. 00
77.00		TIENT SERVICE COST CENTERS	0		<u>, </u>	77.00
		CLINIC	0	0	l .	90.00
		EMERGENCY OBSERVATION BEDS (NON-DISTINCT PART	0	0		91. 00 92. 00
9 2.00		REIMBURSABLE COST CENTERS				72.00
	1	AMBULANCE SERVICES	0	0	1	95.00
102.00		OPIOID TREATMENT PROGRAM AL PURPOSE COST CENTERS	0	0)	102. 00
113.00		INTEREST EXPENSE				113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	0	0)	118. 00
190 00		IMBURSABLE COST CENTERS GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0		190. 00
		RESEARCH	0	Ö		191. 00
	1	PHYSICIANS' PRIVATE OFFICES	0	0	l control of the cont	192.00
		OCC HEALTH PAIN CLINIC	0	0		194. 00 194. 01
	1	OCC HEALTH	0	0		194. 02
		FOUNDATI O	0	0	1	194. 03
		KIDS CAMPUS COMMUNITY & VOLUNTEER SERVICES	0	0		194. 04 194. 05
		HUNTINGTON COLLEGE NURSE	0	l o		194. 05
194. 07	07957	MISC CATERING	o	0		194. 07
	1	AUTISM CENTER	0	0	l .	194. 08
194.09	101429	HUNTI NGTON BUA	<u> </u>	0	<u>'</u>	194. 09

Health Financial Systems	HUNTINGTON MEMORIAL HOSPITAL	In Lieu of Form CMS-2552-10		
COST ALLOCATION - STATISTICAL BASIS	Provi der CCN: 15-0091	Peri od: From 01/01/2022 To 12/31/2022 Date/Time Prepared: 5/18/2023 11: 36 am		

				5/18/2023 11: 36 am
	Cost Center Description	I NTERNS & RESI DENTS SERVI CES-OTHE R PRGM COSTS APPRV (ASSI GNED TIME)	PARAMED ED PRGM (ASSI GNED TIME)	
		22. 00	23. 00	
200. 00 201. 00 202. 00	Cross Foot Adjustments Negative Cost Centers Cost to be allocated (per Wkst. B,	0	0	200. 00 201. 00 202. 00
203. 00 204. 00	Part I) Unit cost multiplier (Wkst. B, Part I) Cost to be allocated (per Wkst. B, Part II)	0. 000000 0	0. 000000 0	203. 00 204. 00
205. 00	Unit cost multiplier (Wkst. B, Part	0. 000000	0. 000000	205. 00
206. 00	NAHE adjustment amount to be allocated (per Wkst. B-2)		0	206.00
207. 00	NAHE unit cost multiplier (Wkst. D, Parts III and IV)		0. 000000	207.00

Health 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 C		Period: From 01/01/2022 To 12/31/2022	Worksheet C Part I Date/Time Pre 5/18/2023 11:	
		Title	XVIII	Hospi tal	PPS	
				Costs		
Cost Center Description	Total Cost (from Wkst. B, Part I, col. 26)	Therapy Limit Adj.	Total Costs	RCE Di sal I owance	Total Costs	
	1, 00	2.00	3.00	4. 00	5. 00	
INPATIENT ROUTINE SERVICE COST CENTERS						
30. 00 03000 ADULTS & PEDIATRICS	11, 302, 999)	11, 302, 99	0	11, 302, 999	30.00
43. 00 04300 NURSERY	351, 804		351, 80	04 0	351, 804	43.00
ANCILLARY SERVICE COST CENTERS		·			·	1

Health Financial Systems	HUNTINGTON MEMORIAL HOSPITAL	In Lieu of Form C	MS-2552-10
COMPUTATION OF RATIO OF COSTS TO CHARGES	Provi der CCN: 15-0091	Peri od: Worksheet From 01/01/2022 Part I To 12/31/2022 Date/Time	Prepared:

					Γο 12/31/2022	Date/Time Pre 5/18/2023 11:	pared:
			Title	XVIII	Hospi tal	PPS	<u> </u>
			Charges				
	Cost Center Description	Inpatient	Outpati ent	Total (col. 6	Cost or Other	TEFRA	
	'	'	'	+ col . 7)	Rati o	Inpati ent	
				<u> </u>		Rati o	
		6. 00	7. 00	8. 00	9. 00	10.00	
	INPATIENT ROUTINE SERVICE COST CENTERS						
30. 00	03000 ADULTS & PEDIATRICS	12, 240, 424		12, 240, 424	4		30.00
43.00	04300 NURSERY	1, 050, 668		1, 050, 668	3		43.00
	ANCILLARY SERVICE COST CENTERS						1
50.00	05000 OPERATING ROOM	5, 900, 148	27, 355, 785	33, 255, 933	0. 085826	0.000000	50.00
50. 01	05001 OPERATING ROOM	O	0	(0. 000000	0.000000	50. 01
52.00	05200 DELIVERY ROOM & LABOR ROOM	5, 254, 859	0	5, 254, 859	0. 326772	0.000000	52.00
53. 00	05300 ANESTHESI OLOGY	467, 428	3, 688, 808	4, 156, 236	0. 427878	0.000000	53.00
54.00	05400 RADI OLOGY-DI AGNOSTI C	3, 278, 476	35, 022, 417	38, 300, 893	0. 124228	0.000000	54.00
60.00	06000 LABORATORY	5, 408, 642	30, 652, 100	36, 060, 742	0. 117537	0.000000	60.00
62. 30	06250 BLOOD CLOTTING FOR HEMOPHILIACS	0	0	(0. 000000	0.000000	62. 30
65. 00	06500 RESPI RATORY THERAPY	2, 061, 864	8, 064, 722	10, 126, 586	0. 184745	0.000000	65.00
66. 00	06600 PHYSI CAL THERAPY	550, 433	5, 355, 175	5, 905, 608	0. 606046	0.000000	66.00
67. 00	06700 OCCUPATI ONAL THERAPY	325, 656	1, 568, 559	1, 894, 215	0. 246890	0.000000	67.00
68. 00	06800 SPEECH PATHOLOGY	83, 046	730, 267		0. 473259	0.000000	68.00
69. 00	06900 ELECTROCARDI OLOGY	0	0		0. 000000	0.000000	69.00
71. 00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	774, 425	2, 641, 369	3, 415, 794	0. 249040	0.000000	71.00
72. 00	07200 IMPL. DEV. CHARGED TO PATIENTS	906, 326	4, 448, 618	5, 354, 94	0. 234257	0.000000	72.00
73. 00	07300 DRUGS CHARGED TO PATIENTS	4, 865, 999	17, 715, 369	22, 581, 368	0. 193974	0.000000	73.00
76. 97	07697 CARDI AC REHABI LI TATI ON	0	0	(0. 000000	0.000000	76. 97
76. 98	07698 HYPERBARI C OXYGEN THERAPY	33, 298	3, 077, 820	3, 111, 118	0. 424477	0.000000	76. 98
76. 99	07699 LI THOTRI PSY	0	0		0. 000000	0.000000	76. 99
77. 00	07700 ALLOGENEIC HSCT ACQUISITION	O	0	(0. 000000	0.000000	77.00
	OUTPATIENT SERVICE COST CENTERS	,					1
90. 00	09000 CLI NI C	5, 999	1, 012, 994	1, 018, 993	0. 301270	0.000000	90.00
91. 00	09100 EMERGENCY	4, 306, 700	38, 134, 467	42, 441, 16	0. 093712	0.000000	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART	0	6, 252, 203	6, 252, 203	0. 559016	0.000000	92.00
	OTHER REIMBURSABLE COST CENTERS						1
95.00	09500 AMBULANCE SERVICES	0	22, 574, 685	22, 574, 685	0. 358441	0.000000	95.00
102.00	10200 OPIOID TREATMENT PROGRAM	O	0	(102.00
	SPECIAL PURPOSE COST CENTERS						1
113.00	11300 NTEREST EXPENSE						113. 00
200.00	Subtotal (see instructions)	47, 514, 391	208, 295, 358	255, 809, 749	9		200.00
201.00	Less Observation Beds						201.00
202. 00	Total (see instructions)	47, 514, 391	208, 295, 358	255, 809, 749	9		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 01/01/2022 To 12/31/2022	Worksheet C Part I Date/Time Prepared: 5/18/2023 11:36 am

				5/18/2023 11:36 am
		Title XVIII	Hospi tal	PPS
Cost Center Description	PPS Inpatient			
	Ratio			
	11. 00			
INPATIENT ROUTINE SERVICE COST CENTERS				
30. 00 03000 ADULTS & PEDIATRICS				30.00
43. 00 04300 NURSERY				43.00
ANCILLARY SERVICE COST CENTERS				
50. 00 05000 OPERATING ROOM	0. 085826			50.00
50. 01 05001 OPERATING ROOM	0. 000000			50. 01
52.00 05200 DELIVERY ROOM & LABOR ROOM	0. 326772			52.00
53. 00 05300 ANESTHESI OLOGY	0. 427878			53.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	0. 124228			54.00
60. 00 06000 LABORATORY	0. 117537			60.00
62.30 06250 BLOOD CLOTTING FOR HEMOPHILIACS	0. 000000			62. 30
65. 00 06500 RESPIRATORY THERAPY	0. 184745			65.00
66. 00 06600 PHYSI CAL THERAPY	0. 606046			66.00
67. 00 06700 OCCUPATI ONAL THERAPY	0. 246890			67.00
68.00 06800 SPEECH PATHOLOGY	0. 473259			68.00
69. 00 06900 ELECTROCARDI OLOGY	0. 000000			69.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0. 249040			71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0. 234257			72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	0. 193974			73.00
76. 97 07697 CARDIAC REHABILITATION	0. 000000			76. 97
76. 98 07698 HYPERBARI C OXYGEN THERAPY	0. 424477			76. 98
76. 99 07699 LI THOTRI PSY	0. 000000			76. 99
77.00 07700 ALLOGENEIC HSCT ACQUISITION	0. 000000			77.00
OUTPATIENT SERVICE COST CENTERS				
90. 00 09000 CLI NI C	0. 301270			90.00
91. 00 09100 EMERGENCY	0. 093712			91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART	0. 559016			92.00
OTHER REIMBURSABLE COST CENTERS				
95. 00 09500 AMBULANCE SERVICES	0. 358441			95.00
102.00 10200 OPI OID TREATMENT PROGRAM				102.00
SPECIAL PURPOSE COST CENTERS	<u>'</u>			
113. 00 11300 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		Period: From 01/01/2022 To 12/31/2022	Worksheet C Part I Date/Time Pre 5/18/2023 11:	pared: 36 am
		Ti tl	e XIX	Hospi tal	PPS	
				Costs		
Cost Center Description	Total Cost (from Wkst. B, Part I, col. 26)	Therapy Limit Adj.	Total Costs	RCE Di sal I owance	Total Costs	
	1. 00	2.00	3.00	4. 00	5. 00	
INPATIENT ROUTINE SERVICE COST CENTERS	<u> </u>					
20 00 02000 ADULTS & DEDLATRICS	11 202 000		44 000 00		11 202 000	1 ~~ ~~

		11 (1	e vi v	nospi tai	FF3	
				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	11, 302, 999		11, 302, 999	0	11, 302, 999	30.00
43. 00 04300 NURSERY	351, 804		351, 804	0	351, 804	43.00
ANCILLARY SERVICE COST CENTERS						
50. 00 05000 OPERATING ROOM	2, 854, 233		2, 854, 233	0	2, 854, 233	50.00
50. 01 05001 OPERATING ROOM	0		0	0	0	50. 01
52.00 05200 DELIVERY ROOM & LABOR ROOM	1, 717, 141		1, 717, 141	0	1, 717, 141	52.00
53. 00 05300 ANESTHESI OLOGY	1, 778, 363		1, 778, 363		1, 778, 363	53.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	4, 758, 051		4, 758, 051	0	4, 758, 051	54.00
60. 00 06000 LABORATORY	4, 238, 455		4, 238, 455	0	4, 238, 455	60.00
62.30 06250 BLOOD CLOTTING FOR HEMOPHILIACS	0		0	0	0	62.30
65. 00 06500 RESPIRATORY THERAPY	1, 870, 837	0	1, 870, 837	0	1, 870, 837	65.00
66. 00 06600 PHYSI CAL THERAPY	3, 579, 072	0	3, 579, 072	0	3, 579, 072	66.00
67. 00 06700 OCCUPATI ONAL THERAPY	467, 663	0	467, 663	0	467, 663	67.00
68. 00 06800 SPEECH PATHOLOGY	384, 908	0	384, 908	0	384, 908	68.00
69. 00 06900 ELECTROCARDI OLOGY	0		0	0	0	69.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	850, 671		850, 671	0	850, 671	71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	1, 254, 431		1, 254, 431	0	1, 254, 431	72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	4, 380, 195		4, 380, 195	0	4, 380, 195	73.00
76. 97 07697 CARDI AC REHABI LI TATI ON	0		0	0	0	76. 97
76. 98 07698 HYPERBARI C OXYGEN THERAPY	1, 320, 599		1, 320, 599	0	1, 320, 599	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
OUTPATIENT SERVICE COST CENTERS						1
90. 00 09000 CLI NI C	306, 992		306, 992	0	306, 992	90.00
91. 00 09100 EMERGENCY	3, 977, 255		3, 977, 255	0	3, 977, 255	91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART	3, 495, 080		3, 495, 080		3, 495, 080	92.00
OTHER REIMBURSABLE COST CENTERS						1
95. 00 09500 AMBULANCE SERVICES	8, 091, 696		8, 091, 696	0	8, 091, 696	95. 00
102.00 10200 OPIOID TREATMENT PROGRAM	0	l .	0			102.00
SPECIAL PURPOSE COST CENTERS		•				
113. 00 11300 NTEREST EXPENSE						113.00
200.00 Subtotal (see instructions)	56, 980, 445	0	56, 980, 445	0	56, 980, 445	200.00
201.00 Less Observation Beds	3, 495, 080		3, 495, 080		3, 495, 080	
202.00 Total (see instructions)	53, 485, 365					
	•	•	•			•

Health Financial Systems	HUNTINGTON MEMORIAL HOSPITAL	In Lieu	u of Form CMS-2552-10
COMPUTATION OF RATIO OF COSTS TO CHARGES	Provi der CCN: 15-0091	From 01/01/2022	Worksheet C Part I Date/Time Prepared:

			Т	o 12/31/2022	Date/Time Pre 5/18/2023 11:	
		Ti tl	e XIX	Hospi tal	PPS	
		Charges		·		
Cost Center Description	Inpati ent	Outpati ent	Total (col. 6	Cost or Other	TEFRA	
, and the second se	'	'	+ col. 7)	Rati o	I npati ent	
			ĺ		Rati o	
	6. 00	7. 00	8. 00	9. 00	10.00	
INPATIENT ROUTINE SERVICE COST CENTERS			•	'		
30. 00 03000 ADULTS & PEDIATRICS	12, 240, 424		12, 240, 424			30.00
43. 00 04300 NURSERY	1, 050, 668		1, 050, 668	3		43.00
ANCILLARY SERVICE COST CENTERS						
50.00 05000 OPERATING ROOM	5, 900, 148	27, 355, 785	33, 255, 933	0. 085826	0.000000	50.00
50. 01 05001 OPERATING ROOM	O	0	l c	0. 000000	0.000000	50. 01
52.00 05200 DELIVERY ROOM & LABOR ROOM	5, 254, 859	0	5, 254, 859	0. 326772	0.000000	52.00
53. 00 05300 ANESTHESI OLOGY	467, 428	3, 688, 808	4, 156, 236	0. 427878	0.000000	53.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	3, 278, 476	35, 022, 417	38, 300, 893	0. 124228	0.000000	54.00
60. 00 06000 LABORATORY	5, 408, 642	30, 652, 100	36, 060, 742	0. 117537	0.000000	60.00
62.30 06250 BLOOD CLOTTING FOR HEMOPHILIACS	O	0	C	0. 000000	0.000000	62. 30
65. 00 06500 RESPI RATORY THERAPY	2, 061, 864	8, 064, 722	10, 126, 586	0. 184745	0.000000	65.00
66. 00 06600 PHYSI CAL THERAPY	550, 433	5, 355, 175			0.000000	
67. 00 06700 OCCUPATI ONAL THERAPY	325, 656	1, 568, 559		0. 246890	0.000000	67.00
68. 00 06800 SPEECH PATHOLOGY	83, 046	730, 267		0. 473259	0.000000	68.00
69. 00 06900 ELECTROCARDI OLOGY	O	0		0. 000000	0.000000	69.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	774, 425	2, 641, 369	3, 415, 794	0. 249040	0.000000	71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	906, 326	4, 448, 618	5, 354, 944	0. 234257	0.000000	72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	4, 865, 999	17, 715, 369	22, 581, 368	0. 193974	0.000000	73.00
76. 97 07697 CARDI AC REHABI LI TATI ON	O	0	C	0. 000000	0.000000	76. 97
76. 98 07698 HYPERBARI C OXYGEN THERAPY	33, 298	3, 077, 820	3, 111, 118	0. 424477	0.000000	76. 98
76. 99 07699 LI THOTRI PSY	O	0	C	0. 000000	0.000000	76. 99
77.00 07700 ALLOGENEIC HSCT ACQUISITION	o	0	l c	0. 000000	0.000000	77.00
OUTPATIENT SERVICE COST CENTERS						
90. 00 09000 CLI NI C	5, 999	1, 012, 994	1, 018, 993	0. 301270	0.000000	90.00
91. 00 09100 EMERGENCY	4, 306, 700	38, 134, 467	42, 441, 167	0. 093712	0.000000	91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART	O	6, 252, 203	6, 252, 203	0. 559016	0.000000	92.00
OTHER REIMBURSABLE COST CENTERS						
95. 00 09500 AMBULANCE SERVICES	0	22, 574, 685	22, 574, 685	0. 358441	0.000000	95.00
102.00 10200 OPI OI D TREATMENT PROGRAM	O	0				102.00
SPECIAL PURPOSE COST CENTERS						
113. 00 11300 NTEREST EXPENSE						113.00
200.00 Subtotal (see instructions)	47, 514, 391	208, 295, 358	255, 809, 749)		200.00
201.00 Less Observation Beds						201.00
202.00 Total (see instructions)	47, 514, 391	208, 295, 358	255, 809, 749)		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 01/01/2022 To 12/31/2022	Worksheet C Part I Date/Time Prepared: 5/18/2023 11:36 am
	Title XIX	Hospi tal	PPS

				5/18/2023 11:36 am
		Title XIX	Hospi tal	PPS
Cost Center Description	PPS Inpatient			
	Ratio			
	11. 00			
INPATIENT ROUTINE SERVICE COST CENTERS				
30. 00 03000 ADULTS & PEDI ATRI CS				30.00
43. 00 04300 NURSERY				43.00
ANCILLARY SERVICE COST CENTERS				
50.00 05000 OPERATING ROOM	0. 085826			50.00
50. 01 05001 OPERATING ROOM	0. 000000			50. 01
52.00 05200 DELIVERY ROOM & LABOR ROOM	0. 326772			52.00
53. 00 05300 ANESTHESI OLOGY	0. 427878			53.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	0. 124228			54.00
60. 00 06000 LABORATORY	0. 117537			60.00
62.30 06250 BLOOD CLOTTING FOR HEMOPHILIACS	0. 000000			62. 30
65. 00 06500 RESPIRATORY THERAPY	0. 184745			65.00
66. 00 06600 PHYSI CAL THERAPY	0. 606046			66.00
67. 00 06700 OCCUPATI ONAL THERAPY	0. 246890			67.00
68. 00 06800 SPEECH PATHOLOGY	0. 473259			68.00
69. 00 06900 ELECTROCARDI OLOGY	0. 000000			69.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0. 249040			71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0. 234257			72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	0. 193974			73.00
76. 97 07697 CARDIAC REHABILITATION	0. 000000			76. 97
76. 98 07698 HYPERBARIC OXYGEN THERAPY	0. 424477			76. 98
76. 99 07699 LI THOTRI PSY	0. 000000			76. 99
77.00 07700 ALLOGENEIC HSCT ACQUISITION	0. 000000			77. 00
OUTPATIENT SERVICE COST CENTERS				
90. 00 09000 CLI NI C	0. 301270			90.00
91. 00 09100 EMERGENCY	0. 093712			91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART	0. 559016			92.00
OTHER REIMBURSABLE COST CENTERS				
95. 00 09500 AMBULANCE SERVICES	0. 358441			95.00
102.00 10200 OPIOID TREATMENT PROGRAM				102.00
SPECIAL PURPOSE COST CENTERS				
113.00 11300 INTEREST EXPENSE		·		113.00
200.00 Subtotal (see instructions)				200.00
201.00 Less Observation Beds				201.00
202.00 Total (see instructions)				202.00

Health Financial Systems	HUNTI NGTON MEMORI A	AL HOSPITAL	In Lieu	u of Form CMS-2552-10
CALCULATION OF OUTPATIENT SERVICE COST	TO CHARGE RATIOS NET OF	Provi der CCN: 15-0091	Peri od: From 01/01/2022	Worksheet C
REDUCTIONS FOR MEDICALD ONLY				Date/Time Prepared

REDUCTIONS FOR MEDICALD UNLY				o 12/31/2022	Date/Time Pre 5/18/2023 11:	
		Ti tl	e XIX	Hospi tal	PPS	30 aiii
Cost Center Description	Total Cost	Capital Cost	Operating	Capi tal	Operating	
·	(Wkst. B,	(Wkst. B,	Cost Net of	Reduction	Cost	
	Part I, col.	Part II col.	Capital Cost		Reducti on	
	26)	26)	(col. 1 -		Amount	
			col. 2)			
	1. 00	2. 00	3. 00	4. 00	5. 00	
ANCILLARY SERVICE COST CENTERS	0.054.000		0 005 7/5	ا ما		
50. 00 05000 OPERATING ROOM	2, 854, 233	i .	2, 235, 767	0	0	50.00
50. 01 05001 OPERATING ROOM	0	0	((() ()	0	0	50. 01
52. 00 05200 DELIVERY ROOM & LABOR ROOM	1, 717, 141	84, 421	1, 632, 720		0	52.00
53. 00 05300 ANESTHESI OLOGY	1, 778, 363				0	53.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	4, 758, 051				0	54.00
60. 00 06000 LABORATORY	4, 238, 455	250, 915	3, 987, 540		0	60.00
62. 30 06250 BLOOD CLOTTING FOR HEMOPHILIACS	1 070 007	0 220 721	1 (21 10)) U	0	62.30
65. 00 06500 RESPIRATORY THERAPY	1, 870, 837		1, 631, 106		0	65.00
66. 00 06600 PHYSI CAL THERAPY	3, 579, 072				0	66.00
67. 00 06700 OCCUPATI ONAL THERAPY 68. 00 06800 SPEECH PATHOLOGY	467, 663		444, 826		0	67.00
	384, 908	18, 747	366, 161	J	0	68. 00 69. 00
	050 471	(4.200	704 27		0	
71. 00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	850, 671	64, 398			· ·	71.00
72. 00 07200 IMPL. DEV. CHARGED TO PATIENTS	1, 254, 431				0	72.00
73.00 O7300 DRUGS CHARGED TO PATIENTS 76.97 O7697 CARDIAC REHABILITATION	4, 380, 195	240, 729	4, 139, 466		0	73. 00 76. 97
	1 220 500	105 (40	1 104 054) U	ŭ	
76. 98 O7698 HYPERBARI C OXYGEN THERAPY 76. 99 O7699 LI THOTRI PSY	1, 320, 599	125, 643	1, 194, 956		0	76. 98 76. 99
77. 00 07700 ALLOGENEIC HSCT ACQUISITION	0	0			0	76. 99
OUTPATIENT SERVICE COST CENTERS	0) U	U	17.00
90. 00 09000 CLINIC	306, 992	15, 190	291, 802	ol	0	90.00
91. 00 09100 EMERGENCY	3, 977, 255				0	91.00
92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART	3, 495, 080				0	92.00
OTHER REIMBURSABLE COST CENTERS	0, 1,0,000	1027007	0/010/02	<u> </u>		72.00
95. 00 09500 AMBULANCE SERVI CES	8, 091, 696	1, 029, 184	7, 062, 512	. o	0	95.00
102.00 10200 OPIOID TREATMENT PROGRAM	0	0	, , , , ,		0	102.00
SPECIAL PURPOSE COST CENTERS	<u>'</u>					
113. 00 11300 I NTEREST EXPENSE						113.00
200.00 Subtotal (sum of lines 50 thru 199)	45, 325, 642	5, 674, 685	39, 650, 957	' ol	0	200.00
201.00 Less Observation Beds	3, 495, 080	482, 059	3, 013, 021	0	0	201.00
202.00 Total (line 200 minus line 201)	41, 830, 562	5, 192, 626	36, 637, 936	ol ol	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
REDUCTIONS FOR MEDICALD ONLY Provider CCN: 15-0091
To 12/31/2022 Date/Time Prepared:

				10 12/31/2022	5/18/2023 11: 36	
		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						
50. 00 05000 OPERATING ROOM	2, 854, 233	33, 255, 933	0. 08582	26	!	50.00
50. 01 05001 OPERATING ROOM	0	0	0. 00000	00	!	50.01
52.00 05200 DELIVERY ROOM & LABOR ROOM	1, 717, 141	5, 254, 859	0. 32677	72	!	52.00
53. 00 05300 ANESTHESI OLOGY	1, 778, 363	4, 156, 236	0. 42787	78	!	53.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	4, 758, 051	38, 300, 893	0. 12422	28	!	54.00
60. 00 06000 LABORATORY	4, 238, 455	36, 060, 742	0. 11753	37		60.00
62.30 06250 BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0. 00000	00		62.30
65. 00 06500 RESPIRATORY THERAPY	1, 870, 837	10, 126, 586	0. 18474	15		65.00
66. 00 06600 PHYSI CAL THERAPY	3, 579, 072	5, 905, 608	0. 60604	16		66.00
67. 00 06700 OCCUPATI ONAL THERAPY	467, 663	1, 894, 215	0. 24689	90		67.00
68.00 06800 SPEECH PATHOLOGY	384, 908			59		68.00
69. 00 06900 ELECTROCARDI OLOGY	0	0	0. 00000	00		69.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	850, 671	3, 415, 794	0. 24904	10	-	71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	1, 254, 431	5, 354, 944	0. 23425	57	-	72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	4, 380, 195	22, 581, 368	0. 19397	74	-	73.00
76. 97 07697 CARDI AC REHABI LI TATI ON	0	0	0. 00000	00	-	76. 97
76. 98 07698 HYPERBARIC OXYGEN THERAPY	1, 320, 599	3, 111, 118	0. 42447	77		76. 98
76. 99 07699 LI THOTRI PSY	0	0		00		76. 99
77.00 07700 ALLOGENEIC HSCT ACQUISITION	0	0	0. 00000	00		77.00
OUTPATIENT SERVICE COST CENTERS	<u>'</u>		<u>'</u>			
90. 00 09000 CLI NI C	306, 992	1, 018, 993	0. 30127	70		90.00
91. 00 09100 EMERGENCY	3, 977, 255	42, 441, 167	0. 0937	12	•	91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART	3, 495, 080	6, 252, 203	0. 5590°	16	•	92.00
OTHER REIMBURSABLE COST CENTERS						
95. 00 09500 AMBULANCE SERVICES	8, 091, 696	22, 574, 685	0. 35844	11		95.00
102.00 10200 OPIOID TREATMENT PROGRAM	0	0	0. 00000	00	11	02.00
SPECIAL PURPOSE COST CENTERS						
113. 00 11300 I NTEREST EXPENSE					1	13.00
200.00 Subtotal (sum of lines 50 thru 199)	45, 325, 642	242, 518, 657			21	.00.00
201.00 Less Observation Beds	3, 495, 080	0			21	01.00
202.00 Total (line 200 minus line 201)	41, 830, 562	242, 518, 657			21	02.00

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		Peri od:	Worksheet D	
				From 01/01/2022		
				To 12/31/2022	Date/Time Pre 5/18/2023 11:	pared: 36 am
		Title	XVIII	Hospi tal	PPS	<u> </u>
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, 558, 967	0	1, 558, 96	7 6, 054	257. 51	30.00
43. 00 NURSERY	20, 042		20, 04	2 605	33. 13	43.00
200.00 Total (lines 30 through 199)	1, 579, 009		1, 579, 00	6, 659		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	982	252, 875				30.00
43. 00 NURSERY	0	0				43.00
200.00 Total (lines 30 through 199)	982	252, 875				200.00

Health Financial Systems	HUNTI NGTON MEMORI AL	L HOSPI TAL	In Lieu	of Form CMS-2552-10
ADDODTIONMENT OF INDATIONS AN	NCLLLADY SEDVICE CADITAL COSTS	Providor CCN: 15 0001	Port od:	Workshoot D

Health Financial Systems	HUNTI NGTON MEMO	RIAL HOSPITAL		In Lie	u of Form CMS-2	2552-10
APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPIT	AL COSTS	Provider Co		Period: From 01/01/2022 To 12/31/2022		
			XVIII	Hospi tal	PPS	
Cost Center Description	Capi tal	Total Charges		t Inpatient	Capital Costs	
	Related Cost	(from Wkst.	to Charges	Program	(column 3 x	
	(from Wkst.	C, Part I,	(col . 1 ÷	Charges	column 4)	
	B, Part II,	col. 8)	col . 2)			
	col . 26)					
ANOLILIADY OFFICE OF CONT. OFFITEDO	1. 00	2. 00	3. 00	4. 00	5. 00	
ANCILLARY SERVICE COST CENTERS	(10.4//	22 255 222	0.04050	T F 4 F 000	10 100	F0 00
50. 00 05000 OPERATING ROOM	618, 466	33, 255, 933			10, 139	
50. 01 05001 0PERATI NG ROOM	0	0	0.0000		0	
52. 00 05200 DELIVERY ROOM & LABOR ROOM	84, 421	5, 254, 859			0	52.00
53. 00 05300 ANESTHESI OLOGY	84, 433	4, 156, 236			0 050	53.00
54. 00 05400 RADI OLOGY - DI AGNOSTI C	937, 026	38, 300, 893				
60. 00 06000 LABORATORY	250, 915	36, 060, 742				60.00
62. 30 06250 BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0.0000		0	62.30
65. 00 06500 RESPIRATORY THERAPY	239, 731	10, 126, 586			8, 296	65.00
66. 00 06600 PHYSI CAL THERAPY 67. 00 06700 OCCUPATI ONAL THERAPY	973, 172	5, 905, 608			31, 663	66. 00 67. 00
	22, 837	1, 894, 215			1, 433	
68. 00 06800 SPEECH PATHOLOGY 69. 00 06900 ELECTROCARDI OLOGY	18, 747	813, 313			509	68. 00 69. 00
71. 00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	64, 398	0 3, 415, 794			0 4, 379	71.00
72.00 07700 MEDICAL SUPPLIES CHARGED TO PATIENT		5, 354, 944				
73.00 07300 DRUGS CHARGED TO PATIENTS	59, 717 240, 729					
73.00 07300 DRUGS CHARGED TO PATTENTS 76. 97 07697 CARDI AC REHABI LI TATI ON	240, 729	22, 581, 368 0	1		11, 734 0	76. 97
76. 98 07698 HYPERBARI C OXYGEN THERAPY	125, 643	3, 111, 118			0	76. 97
76. 99 07699 LI THOTRI PSY	125, 643	3, 111, 118 0	1		0	76. 98
77. 00 07700 ALLOGENEIC HSCT ACQUISITION	0	0			0	1
OUTPATIENT SERVICE COST CENTERS	_l		0.00000	0	U	17.00
90. 00 09000 CLINIC	15, 190	1, 018, 993	0. 01490	07	0	90.00
91. 00 09100 EMERGENCY	428, 017	42, 441, 167	l .		11, 685	
92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART	482, 059	6, 252, 203	·		11,000	
OTHER REIMBURSABLE COST CENTERS	402,037	0, 202, 203	0.07710	0	0	/2.00
95. 00 09500 AMBULANCE SERVICES						95.00
200.00 Total (lines 50 through 199)	4, 645, 501	219, 943, 972		6, 510, 216	119, 661	

Health Financial Systems	HUNTINGTON MEMO	RIAL HOSPITAL		In Lie	u of Form CMS-2	2552-10
APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER	R PASS THROUGH COS	TS Provider C	F	Period: From 01/01/2022 To 12/31/2022	Date/Time Pre 5/18/2023 11:	
		Title	XVIII	Hospi tal	PPS	
Cost Center Description	Nursi ng	Nursi ng	Allied Health	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	C	0	0	30.00
43. 00 04300 NURSERY	O	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)		
	instructions)	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, 054	0.00	982	30.00
43. 00 04300 NURSERY		0	605	0.00	0	43.00
200.00 Total (lines 30 through 199)		0	6, 659		982	200.00
Cost Center Description	I npati ent			"	<u> </u>	
	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)						200.00
1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1	,					

Health Financial Systems	HUNTI NGTON MEMORIA	AL HOSPITAL	In Lieu	ı of Form CMS-2552-10
APPORTIONMENT OF INPATIENT/OUTPATIEN	T ANCILLARY SERVICE OTHER PASS	Provi der CCN: 15-0091	Peri od:	Worksheet D
TUDOUGU COCTC			From 01/01/2022	Dart IV

THROUG	H COSTS				From 01/01/2022 To 12/31/2022		
				XVIII	Hospi tal	PPS	
	Cost Center Description	Non Physician	Nursi ng	Nursi ng	Allied Health	Allied Health	
		Anesthetist	Program	Program	Post-Stepdown		
		Cost	Post-Stepdown		Adjustments		
			Adjustments				
		1. 00	2A	2. 00	3A	3. 00	
	ANCILLARY SERVICE COST CENTERS						1
	05000 OPERATING ROOM	0	0		0	0	00.00
	05001 OPERATING ROOM	0	0		0	0	50. 01
52.00	05200 DELIVERY ROOM & LABOR ROOM	0	0		0	0	52.00
53.00	05300 ANESTHESI OLOGY	0	0		0	0	53.00
54.00	05400 RADI OLOGY-DI AGNOSTI C	0	0		0	0	54.00
	06000 LABORATORY	0	0		0	0	60.00
	06250 BLOOD CLOTTING FOR HEMOPHILIACS	0	0		0	0	62. 30
	06500 RESPI RATORY THERAPY	0	0		0	0	65.00
	06600 PHYSI CAL THERAPY	0	0		0	0	66.00
	06700 OCCUPATI ONAL THERAPY	0	0		0	0	67.00
68.00	06800 SPEECH PATHOLOGY	0	0		0	0	68. 00
69.00	06900 ELECTROCARDI OLOGY	0	0		0	0	69. 00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0	0		0	0	71.00
	07200 IMPL. DEV. CHARGED TO PATIENTS	0	0		0	0	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0	0		0	0	73.00
76. 97	07697 CARDI AC REHABI LI TATI ON	0	0		0 0	0	76. 97
76. 98	07698 HYPERBARIC OXYGEN THERAPY	0	0		0 0	0	76. 98
76. 99	07699 LI THOTRI PSY	0	0		0 0	0	76. 99
77.00	07700 ALLOGENEIC HSCT ACQUISITION	0	0		0 0	0	77.00
	OUTPATIENT SERVICE COST CENTERS						
90.00	09000 CLI NI C	0	0		0 0	0	90.00
91.00	09100 EMERGENCY	0	0		0	0	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART	0			0	0	92.00
	OTHER REIMBURSABLE COST CENTERS						
95.00	09500 AMBULANCE SERVI CES						95. 00
200.00	Total (lines 50 through 199)	0	0		0	0	200.00

Health Financial Systems	HUNTI NGTON MEMORI A	AL HOSPITAL	In Lieu	u of Form CMS-2552-10
APPORTIONMENT OF INPATIENT/OUTPATIENT THROUGH COSTS	ANCILLARY SERVICE OTHER PASS	Provi der CCN: 15-0091	Peri od: From 01/01/2022 To 12/31/2022	Worksheet D Part IV Date/Time Prepared: 5/18/2023 11:36 am
		T' 11 . \\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\	11	20

				1	o 12/31/2022	Date/Time Pre 5/18/2023 11:	pared: 36 am
			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	_		1	00.055.000		
1	O5000 OPERATING ROOM	0	0	0	33, 255, 933		1
1	05001 OPERATING ROOM	0	0	0	0	0. 000000	
	D5200 DELIVERY ROOM & LABOR ROOM	0	0	0	5, 254, 859		
	05300 ANESTHESI OLOGY	0	0	0	4, 156, 236		
4	D5400 RADI OLOGY-DI AGNOSTI C	0	0	0	38, 300, 893		1
	D6000 LABORATORY	0	0	0	36, 060, 742		
	06250 BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0	0	0. 000000	
	06500 RESPI RATORY THERAPY	0	0	0	10, 126, 586		
	06600 PHYSI CAL THERAPY	0	0	0	5, 905, 608		
	06700 OCCUPATI ONAL THERAPY	0	0	0	1, 894, 215		1
	06800 SPEECH PATHOLOGY	0	0	0	813, 313		
	06900 ELECTROCARDI OLOGY	0	0	0	0	0. 000000	
	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	3, 415, 794		1
	07200 IMPL. DEV. CHARGED TO PATIENTS	0	0	0	5, 354, 944		
	07300 DRUGS CHARGED TO PATIENTS	0	0	0	22, 581, 368		
	07697 CARDIAC REHABILITATION	0	0	0	0	0. 000000	1
	07698 HYPERBARIC OXYGEN THERAPY	0	0	0	3, 111, 118		
4	07699 LI THOTRI PSY	0	0	0	0	0. 000000	1
	07700 ALLOGENEIC HSCT ACQUISITION	0	0	0	0	0. 000000	77. 00
	DUTPATIENT SERVICE COST CENTERS						
	09000 CLI NI C	0	0	0	· · ·		1
	09100 EMERGENCY	0	0	0			
	09200 OBSERVATION BEDS (NON-DISTINCT PART	0	0	0	6, 252, 203	0. 000000	92.00
	OTHER REIMBURSABLE COST CENTERS						1
	09500 AMBULANCE SERVICES						95.00
200.00	Total (lines 50 through 199)	0	0	0	219, 943, 972		200.00

Health Financial Systems	HUNTINGTON MEMORIA	AL HOSPITAL		In Lie	u of Form CMS-2	2552-10
APPORTIONMENT OF INPATIENT/OUTPATIENT AND THROUGH COSTS	CILLARY SERVICE OTHER PASS	Provi der CC		Period: From 01/01/2022 To 12/31/2022	Worksheet D Part IV Date/Time Pre 5/18/2023 11:	
		Title	XVIII	Hospi tal	PPS	
Cost Center Description	Outpatient Ratio of Cost to Charges	Inpatient Program Charges	Inpatient Program Pass-Through	Outpatient Program Charges	Outpatient Program Pass-Through	

			Title	XVIII	Hospi tal	PPS	
	Cost Center Description	Outpati ent	I npati ent	Inpati ent	Outpati ent	Outpati ent	
	oost center bescription	Ratio of Cost	Program	Program	Program	Program	
		to Charges	Charges	Pass-Through	Charges	Pass-Through	
		(col . 6 ÷	onal goo	Costs (col. 8	onal goo	Costs (col. 9	
		col. 7)		x col. 10)		x col. 12)	
		9. 00	10. 00	11. 00	12.00	13. 00	
	ANCILLARY SERVICE COST CENTERS						
50.00	05000 OPERATING ROOM	0. 000000	545, 203	0	4, 077, 413	0	50.00
50. 01	05001 OPERATING ROOM	0. 000000	0	0	0	0	50. 01
52.00	05200 DELIVERY ROOM & LABOR ROOM	0. 000000	0	0	0	0	52.00
53.00	05300 ANESTHESI OLOGY	0. 000000	0	0	0	0	53.00
54.00	05400 RADI OLOGY-DI AGNOSTI C	0. 000000	1, 064, 768	0	5, 626, 184	0	54.00
60.00	06000 LABORATORY	0. 000000	1, 303, 099	0	4, 973, 923	0	60.00
62.30	06250 BLOOD CLOTTING FOR HEMOPHILIACS	0. 000000	0	0	0	0	62.30
65.00	06500 RESPI RATORY THERAPY	0. 000000	350, 456	0	908, 968	0	65.00
66.00	06600 PHYSI CAL THERAPY	0. 000000	192, 141	0	0	0	66.00
67.00	06700 OCCUPATI ONAL THERAPY	0. 000000	118, 902	0	0	0	67.00
68.00	06800 SPEECH PATHOLOGY	0. 000000	22, 092	0	0	0	68.00
69.00	06900 ELECTROCARDI OLOGY	0. 000000	0	0	0	0	69.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0. 000000	232, 246	0	550, 509	0	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0. 000000	422, 013	0	1, 152, 083	0	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0. 000000	1, 100, 693	0	4, 472, 409	0	73.00
76. 97	07697 CARDI AC REHABI LI TATI ON	0. 000000	0	0	0	0	76. 97
76. 98	07698 HYPERBARI C OXYGEN THERAPY	0. 000000	0	0	0	0	76. 98
76. 99	07699 LI THOTRI PSY	0. 000000	0	0	0	0	76. 99
77.00	07700 ALLOGENEIC HSCT ACQUISITION	0. 000000	0	0	0	0	77. 00
	OUTPATIENT SERVICE COST CENTERS						
90.00	09000 CLI NI C	0. 000000	0	0	0	0	90.00
91.00	09100 EMERGENCY	0. 000000	1, 158, 603	0	4, 900, 351	0	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART	0. 000000	0	0	399, 641	0	92.00
	OTHER REIMBURSABLE COST CENTERS						
95.00	09500 AMBULANCE SERVI CES						95. 00
200.00	Total (lines 50 through 199)		6, 510, 216	0	27, 061, 481	0	200. 00

Health Financial Systems	HUNTI NGTON MEMORI A	AL HOSPITAL	In Lieu	of Form CMS-2552-10
APPORTIONMENT OF MEDICAL,	OTHER HEALTH SERVICES AND VACCINE COST	Provider CCN: 15-0091		Worksheet D
			From 01/01/2022	Part V

To 12/31/2022 Date/Time Prepared: To 12/31/2022 Date/Time Prepared: To 12/31/2023 Date/Time Prepared:					rom 01/01/2022		
Cost Center Description					To 12/31/2022	Date/lime Pre	pared:
Cost Center Description			Ti tl e	7 X//111	Hosni tal		30 alli
Cost to Charge Ratio From Worksheet C, Part I, col. PPS Rel mbursed Services (see Inst.) Subject To Ded. & Coins. (see Inst.) Subject To Ded. & Coins. (see Inst.) Subject To Ded. & Coins. (see Inst.) (see			11110		nospi tai		
Charge Ratio From Worksheet C, Part I, col. 9 Services (see Subject To Ded. & Colns. (see inst.) Services (Subject To Ded. & Colns. (see inst.) Subject To Ded. & Colns.	Cost Center Description	Cost to	PPS		Cost		
Services Services Services Services Services Services Services Subject To Ded. & Coins. See Inst. Ded. & See Ins	oost conten boschiption						
North Name						(000 111011)	
Part I , col . Ded. & Coins See inst.) Ded. & Coins See inst.) Ded. & Coins See inst.							
9 (see inst.) (see inst.)							
NACLILARY SERVICE COST CENTERS 1.00 2.00 3.00 4.00 5.00		· ·					
50. 00 05000 0PERATI NG ROOM 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0		1. 00	2.00			5. 00	
50. 01 05001 0FERATI NG ROOM 0.000000 0.000000 0.000000 0.000000 0.000000 0.000000 0.0000000 0.0000000 0.00000000	ANCILLARY SERVICE COST CENTERS				•		
52. 00 05200 DELI VERY ROOM & LABOR ROOM 0. 326772 0 0 0 0 52. 00 53. 00 05300 AMESTHESI LOGY 0. 427878 0 0 0 0 53. 00 64. 00 05400 RADI OLOGY-DI AGNOSTI C 0. 124228 5, 626, 184 0 0 698, 930 54. 00 60. 00 06000 LABORATORY 0. 117537 4, 973, 923 0 0 584, 620 60. 00 62. 30 06250 BLOOD CLOTTI NG FOR HEMOPHI LI ACS 0. 0000000 0 0 0 584, 620 60. 00 65. 00 06500 RESPI RATORY THERAPY 0. 184745 908, 968 0 0 167, 927 65. 00 66. 00 06600 PHYSI CAL THERAPY 0. 246890 0 0 0 0 66. 00 67. 00 06700 OCCUPATI ONAL THERAPY 0. 246890 0 0 0 0 67. 00 68. 00 06900 ELECTROCARDI OLOGY 0. 243259 0 </td <td>50.00 O5000 OPERATING ROOM</td> <td>0. 085826</td> <td>4, 077, 413</td> <td>(</td> <td>0</td> <td>349, 948</td> <td>50.00</td>	50.00 O5000 OPERATING ROOM	0. 085826	4, 077, 413	(0	349, 948	50.00
53.00 05300 ANESTHESI OLOGY 0.427878 0 0 0 0 53.00	50. 01 05001 OPERATING ROOM	0. 000000	0		0	0	50. 01
54. 00	52.00 05200 DELIVERY ROOM & LABOR ROOM	0. 326772	0		0	0	52.00
60.00 06000 LABORATORY 0.117537 4,973,923 0 0 584,620 60.00 62.30 06250 BLOOD CLOTTING FOR HEMOPHILIACS 0.000000 0 0 0 0 0 65.00 06500 RESPIRATORY THERAPY 0.184745 908,968 0 0 167,927 65.00 66.00 06600 PHYSI CAL THERAPY 0.606046 0 0 0 0 0 67.00 06700 OCCUPATI ONAL THERAPY 0.246890 0 0 0 0 0 68.00 06900 CELECTROCARDI OLOGY 0.000000 0 0 0 0 69.00 06900 ELECTROCARDI OLOGY 0.000000 0 0 0 0 71.00 07100 MEDI CAL SUPPLI ES CHARGED TO PATI ENT 0.249040 550,509 0 0 137,099 71.00 72.00 07200 IMPL DEV. CHARGED TO PATI ENTS 0.234257 1,152,083 0 0 269,884 72.00 76.97 07697 CARDI AC REHABI LI TATI ON 0.000000 0 0 0 0 867,531 73.00 76.98 07699 CARDI AC REHABI LI TATI ON 0.000000 0 0 0 0 0 76.99 07699 LI THOTRI PSY 0.424477 0 0 0 0 0 76.99 77.00 07700 ALLOGENEIC HISCT ACQUISITION 0.000000 0 0 0 0 0 0 00100 THER REINBURS ABLE COST CENTERS 90.00 09000 CLI NI C 0.0301270 0 0 0 0 459,222 91.00 91.00 09100 EMERGENCY 0.093712 4,900,351 0 0 459,222 91.00 92.00 09200 OBSERVATI ON BEDS (NON-DISTINCT PART 0.559016 399,641 0 0 223,406 92.00 001100 ONLOGE CENTERS 0.000000 0 0 0 0 0 0010 CHARTEMURS ABLE COST CENTERS 0.000000 0 0 0 0 0 0010 CHARGED SERVICES 0.358441 0 0 0 3,758,567 000 0010 CHARGED SERVICES 0.358441 0 0 0 3,758,567 000 0010 CHARGED SERVICES 0.000000 0 0 0 0 0010 CHARGED TO PATI ENTS SERVICES 0.000000 0 0 0 0 0010 CHARGED TO PATI ENTS SERVICES 0.000000 0 0 0 0 0010 0.00000 0 0 0 0 0 0 0010 0.00000 0 0 0 0 0 0 0010 070	53. 00 05300 ANESTHESI OLOGY	0. 427878	0		0	0	53.00
62. 30	54. 00 05400 RADI OLOGY-DI AGNOSTI C	0. 124228	5, 626, 184		o	698, 930	54.00
62. 30 06250 BLOOD CLOTTING FOR HEMOPHILIACS 0.000000 0 0 0 62. 30 65. 00 06500 RESPIRATORY THERAPY 0.184745 908, 968 0 0 167, 927 65. 00 66. 00 06600 PHYSICAL THERAPY 0.606046 0 0 0 0 67. 00 06700 0CCUPATI ONAL THERAPY 0.246890 0 0 0 0 67. 00 68. 00 06800 SPEECH PATHOLOGY 0.473259 0 0 0 0 68. 00 69. 00 06900 ELECTROCARDI OLOGY 0.000000 0 0 0 0 69. 00 71. 00 07100 MEDI CAL SUPPLIES CHARGED TO PATIENT 0.249040 550, 509 0 0 137, 099 71. 00 72. 00 07200 IMPL. DEV. CHARGED TO PATIENTS 0.234257 1, 152, 083 0 0 269, 884 72. 00 73. 00 07300 DRUGS CHARGED TO PATIENTS 0.193974 4, 472, 409 0 0 867, 531 73. 00 76. 97 07697 CARDI AC REHABILITATION 0.000000 0 0 0 76. 97 76. 98 07698 HYPERBARI C OXYGEN THERAPY 0.424477 0 0 0 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 0 90. 00 09100 EMERGENCY 0.301270 0 0 0 459, 222 91. 00 90. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART 0.559016 399, 641 0 0 223, 406 92. 00 09500 AMBULANCE SERVICES 0.358441 0 0 233, 406 90. 00 OBSERVATION BEDS (NON-DISTINCT PART 0.559016 399, 641 0 0 3, 758, 567 90. 00 ODITION Charges 0 0 0 0 0 90. 00 0 0 0 0 0 90. 00 0 0 0 0 0 90. 00 0 0 0 0 0 90. 00 0 0 0 90. 00 0 0 0	60. 00 06000 LABORATORY	0. 117537	4, 973, 923		o	584, 620	60.00
66. 00	62.30 06250 BLOOD CLOTTING FOR HEMOPHILIACS	0. 000000			o	0	62. 30
67. 00 06700 OCCUPATIONAL THERAPY 0. 246890 0 0 0 0 0 0 67. 00 68. 00 06800 SPEECH PATHOLOGY 0. 473259 0 0 0 0 0 0 68. 00 69. 00 06900 ELECTROCARDIOLOGY 0. 0000000 0 0 0 0 0 68. 00 07. 00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT 0. 249040 550, 509 0 0 137, 099 71. 00 72. 00 07200 IMPL. DEV. CHARGED TO PATIENTS 0. 234257 1, 152, 083 0 0 269, 884 72. 00 73. 00 07300 DRUGS CHARGED TO PATIENTS 0. 193974 4, 472, 409 0 0 867, 531 73. 00 76. 97 07697 CARDIAC REHABILITATION 0. 0000000 0 0 0 0 0 76. 97 76. 98 07698 HYPERBARIC OXYGEN THERAPY 0. 424477 0 0 0 0 0 76. 99 77. 00 07699 LITHOTRIPSY 0. 000000 0 0 0 0 0 0 76. 99 77. 00 07700 ALLOGENEIC HSCT ACQUISITION 0. 0000000 0 0 0 0 0 0 0 0 0 0 0 0 0 0	65. 00 06500 RESPIRATORY THERAPY	0. 184745	908, 968	(0	167, 927	65.00
68. 00	66. 00 06600 PHYSI CAL THERAPY	0. 606046	0	(0	0	66.00
69. 00 06900 ELECTROCARDI OLOGY 0.000000 0 0 0 0 69.00 71. 00 07100 MEDI CAL SUPPLIES CHARGED TO PATIENT 0.249040 550,509 0 0 137,099 71.00 72. 00 07200 IMPL. DEV. CHARGED TO PATIENTS 0.234257 1,152,083 0 0.269,884 72.00 73. 00 07300 DRUGS CHARGED TO PATIENTS 0.193974 4,472,409 0 0.867,531 73.00 76. 97 07697 CARDI AC REHABI LI TATI ON 0.000000 0 0 0 0 0 76. 98 07698 HYPERBARI C OXYGEN THERAPY 0.424477 0 0 0 0 0 76. 99 07699 LI THOTRI PSY 0.000000 0 0 0 0 77. 00 0700 ALLOGENEI C HSCT ACQUI SI TI ON 0.000000 0 0 0 90. 00 09100 EMERGENCY 0.093712 4,900,351 0 0 459,222 91.00 91. 00 09200 DRSERVATI ON BEDS (NON-DI STI NCT PART 0.559016 399,641 0 0 223,406 92. 00 09500 AMBULANCE SERVI CES 0.358441 0 0 3,758,567 95. 00 Only Charges 0 0 0 0 0 90100 Less PBP Cl inic Lab. Servi ces-Program 0 0 0 0 90100 Charges 0 0 0 0 90100 00100 00100 00100 00100 90100 00100 00100 00100 00100 90100 00100 00100 00100 00100 90100 00100 00100 00100 00100 90100 00100 00100 00100 00100 90100 00100 00100 00100 00100 90100 00100 00100 00100 00100 00100 90100 00100 00100 00100 00100 00100 90100 00100 00100 00100 00100 00100 00100 90100 001000 00100 00100 00100 00100 00100 00100 00100 0010	67. 00 06700 OCCUPATI ONAL THERAPY	0. 246890	0	(0	0	67.00
71. 00	68. 00 06800 SPEECH PATHOLOGY	0. 473259	0	(0	0	68.00
72. 00 07200 IMPL. DEV. CHARGED TO PATIENTS 0. 234257 1, 152, 083 0 0 269, 884 72. 00 73. 00 07300 DRUGS CHARGED TO PATIENTS 0. 193974 4, 472, 409 0 0 867, 531 73. 00 76. 97 07697 CARDI AC REHABI LI TATI ON 0. 0000000 0 0 0 0 0 76. 97 76. 98 07698 HYPERBARI C OXYGEN THERAPY 0. 424477 0 0 0 0 0 0 0 76. 98 76. 99 07699 LI THOTRI PSY 0. 0000000 0 0 0 0 0 0	69. 00 06900 ELECTROCARDI OLOGY	0. 000000	0	(0	0	69.00
73. 00 07300 DRUGS CHARGED TO PATIENTS 0. 193974 4, 472, 409 0 0 867, 531 73. 00 76. 97 76. 97 76. 98 07697 CARDI AC REHABILITATION 0. 000000 0 0 0 0 76. 97 76. 98 07698 HYPERBARI C OXYGEN THERAPY 0. 424477 0 0 0 0 0 76. 98 76. 99 07699 LI THOTRI PSY 0. 000000 0 0 0 0 0 0 0	71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0. 249040	550, 509	(0	137, 099	71.00
76. 97	72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0. 234257	1, 152, 083	(0	269, 884	72.00
76. 98	73.00 07300 DRUGS CHARGED TO PATIENTS	0. 193974	4, 472, 409	(0	867, 531	73.00
76. 99 07699 LI THOTRI PSY 0.000000 0 0 0 0 76. 99 77. 00 07700 ALLOGENEI C HSCT ACQUI SI TI ON 0.000000 0 0 0 0 0 OUTPATI ENT SERVI CE COST CENTERS 90. 00 09000 CLI NI C 0.301270 0 0 0 0 0 0 91. 00 09100 EMERGENCY 0.093712 4,900,351 0 0 459,222 91. 00 92. 00 09200 OBSERVATI ON BEDS (NON-DI STI NCT PART 0.559016 399,641 0 0 223,406 OTHER REI MBURSABLE COST CENTERS 95. 00 09500 AMBULANCE SERVI CES 0.358441 0 95. 00 200. 00 Subtotal (see instructions) 27,061,481 0 0 3,758,567 200. 00 201. 00 Cli Ni C 0.000000 0 0 0 201. 00 Cli Ni C 0.000000 0 0 O	76. 97 07697 CARDI AC REHABI LI TATI ON	0. 000000	0	(0	0	76. 97
77. 00 07700 ALLOGENEI C HSCT ACQUI SI TI ON 0.000000 0 0 0 0 0 0 0	76. 98 07698 HYPERBARI C OXYGEN THERAPY	0. 424477	0	(0	0	76. 98
OUTPATIENT SERVICE COST CENTERS OUTPATIENT SERVICES OUTPATIENT SER	76. 99 07699 LI THOTRI PSY	0. 000000	0	(0	0	76. 99
90. 00 09000 CLINIC 0.301270 0 0 0 0 90. 00 91. 00 09100 EMERGENCY 0.093712 4,900,351 0 0 459,222 91. 00 92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART 0.559016 399,641 0 0 223,406 92. 00 OTHER REIMBURSABLE COST CENTERS 0.358441 0 95. 00 95. 00 Subtotal (see instructions) 27,061,481 0 0 3,758,567 200. 00 201. 00 Less PBP Clinic Lab. Services-Program 0 0 0 201. 00 Only Charges	77.00 07700 ALLOGENEIC HSCT ACQUISITION	0. 000000	0	(0	0	77.00
91. 00 09100 EMERGENCY 0. 093712 4, 900, 351 0 0 459, 222 91. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART 0. 559016 399, 641 0 0 223, 406 92. 00 000	OUTPATIENT SERVICE COST CENTERS						
92. 00 09200 0BSERVATI ON BEDS (NON-DISTINCT PART 0. 559016 399, 641 0 0 223, 406 92. 00	90. 00 09000 CLI NI C	0. 301270	0	(0	0	90.00
OTHER REIMBURSABLE COST CENTERS 95.00	91. 00 09100 EMERGENCY	0. 093712	4, 900, 351	(0	459, 222	91.00
95. 00	92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART	0. 559016	399, 641	(0	223, 406	92.00
200.00 Subtotal (see instructions) 27,061,481 0 0 3,758,567 200.00 201.00 0 0 0 0 0 0 0 0 0	OTHER REIMBURSABLE COST CENTERS]
201.00 Less PBP Clinic Lab. Services-Program 0 0 201.00 Only Charges	95. 00 09500 AMBULANCE SERVICES	0. 358441		()		95.00
Only Charges	200.00 Subtotal (see instructions)		27, 061, 481		0	3, 758, 567	200.00
Only Charges	201.00 Less PBP Clinic Lab. Services-Program				0		201.00
202.00 Net Charges (line 200 - line 201) 27,061,481 0 0 3,758,567 202.00	Only Charges						
	202.00 Net Charges (line 200 - line 201)		27, 061, 481	(0	3, 758, 567	202. 00

Health Financial Systems	HUNTI NGTON MEMO	ORI AL HOSPI TAL		In Lieu	u of Form CMS-	2552-10
APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES A	AND VACCINE COST	Provi der C	CN: 15-0091	Peri od: From 01/01/2022 To 12/31/2022	Worksheet D Part V Date/Time Pre 5/18/2023 11:	
		Title	: XVIII	Hospi tal	PPS	
·	Co	sts				
Cost Center Description	Cost	Cost				
	Rei mbursed	Rei mbursed				
	Servi ces	Servi ces Not				
	Subject To	Subject To				
	Ded. & Coins.	Ded. & Coins.				
						4

		Cos	sts		
	Cost Center Description	Cost	Cost		
		Rei mbursed	Rei mbursed		
		Servi ces	Servi ces Not		
		Subject To	Subject To		
		Ded. & Coins.	Ded. & Coins.		
		(see inst.)	(see inst.)		
		6. 00	7. 00		
	ANCILLARY SERVICE COST CENTERS				
50.00	05000 OPERATI NG ROOM	0	0		50.00
50. 01	05001 OPERATING ROOM	0	0		50. 01
52.00	05200 DELIVERY ROOM & LABOR ROOM	0	0		52.00
53.00	05300 ANESTHESI OLOGY	0	0		53.00
54.00	05400 RADI OLOGY-DI AGNOSTI C	0	0		54.00
60.00	06000 LABORATORY	0	0		60.00
62. 30	06250 BLOOD CLOTTING FOR HEMOPHILIACS	0	0		62. 30
65.00	06500 RESPIRATORY THERAPY	0	0		65.00
66.00	06600 PHYSI CAL THERAPY	0	0		66.00
67.00	06700 OCCUPATI ONAL THERAPY	0	0		67.00
68.00	06800 SPEECH PATHOLOGY	0	0		68. 00
69.00	06900 ELECTROCARDI OLOGY	0	0		69. 00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0	0		71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0	0		72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0	0		73.00
76. 97	07697 CARDI AC REHABI LI TATI ON	0	0		76. 97
76. 98	07698 HYPERBARI C OXYGEN THERAPY	0	0		76. 98
76. 99	07699 LI THOTRI PSY	0	0		76. 99
77. 00	07700 ALLOGENEIC HSCT ACQUISITION	0	0		77. 00
	OUTPATIENT SERVICE COST CENTERS				1
90.00	09000 CLI NI C	0	0		90.00
91.00	09100 EMERGENCY	0	0		91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART	0	0		92.00
	OTHER REIMBURSABLE COST CENTERS	,		·	1
95.00	09500 AMBULANCE SERVI CES	0			95.00
200.00		0	0		200.00
201.00	,	0			201.00
	Only Charges	1			
202.00		0	0		202.00
		1	'	1	•

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		Peri od:	Worksheet D	
				From 01/01/2022		
				To 12/31/2022	Date/Time Pre 5/18/2023 11:	pared: 36 am
-		Ti tl	e XIX	Hospi tal	PPS	<u> </u>
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, 558, 967	0	1, 558, 96	7 6, 054	257. 51	30.00
43. 00 NURSERY	20, 042		20, 04	2 605	33. 13	43.00
200.00 Total (lines 30 through 199)	1, 579, 009		1, 579, 00	6, 659		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	118					30.00
43. 00 NURSERY	25	828				43.00
200.00 Total (lines 30 through 199)	143	31, 214				200.00

Health Financial Systems	HUNTINGTON MEMORIA	HUNTINGTON MEMORIAL HOSPITAL In Lieu of Form		u of Form CMS-2552-10
ADDODTIONMENT OF INDATIONS AN	NCLLLADV SEDVICE CADITAL COSTS	Providor CCN: 15 0001	Pari ad:	Workshoot D

Health Financial Systems	HUNTI NGTON MEMO	RIAL HOSPITAL		In Lie	u of Form CMS-2	2552-10
APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPIT	TAL COSTS	Provider Co		Period: From 01/01/2022 To 12/31/2022	Date/Time Pre 5/18/2023 11:	pared: 36 am
			e XIX	Hospi tal	PPS	
Cost Center Description	Capi tal	Total Charges			Capital Costs	
	Related Cost	(from Wkst.	to Charges	Program	(column 3 x	
	(from Wkst.	C, Part I,	(col. 1 ÷	Charges	column 4)	
	B, Part II,	col. 8)	col . 2)			
	col . 26)					
ANOTHER DESIGNATION OF THE PROPERTY OF THE PRO	1. 00	2. 00	3. 00	4. 00	5. 00	
ANCILLARY SERVICE COST CENTERS	(10.4//	22 255 222	0.04056	2 22 252	(000	F0 00
50. 00 05000 OPERATING ROOM	618, 466					
50. 01 05001 OPERATING ROOM	0	0	0.00000		0	50.01
52. 00 05200 DELIVERY ROOM & LABOR ROOM	84, 421	5, 254, 859			2, 259	
53. 00 05300 ANESTHESI OLOGY	84, 433				0	53.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	937, 026				1, 172	54.00
60. 00 06000 LABORATORY	250, 915				965	
62. 30 06250 BLOOD CLOTTING FOR HEMOPHILIACS	0	_	0.00000		0	62.30
65. 00 06500 RESPIRATORY THERAPY	239, 731	10, 126, 586			759	65.00
66. 00 06600 PHYSI CAL THERAPY	973, 172	5, 905, 608			2, 345	
67. 00 06700 OCCUPATI ONAL THERAPY	22, 837	1, 894, 215				67.00
68. 00 06800 SPEECH PATHOLOGY	18, 747	813, 313			22	68.00
69. 00 06900 ELECTROCARDI OLOGY	0	0 415 704	0.00000		0	69.00
71. 00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	64, 398			·		71.00
72. 00 07200 IMPL. DEV. CHARGED TO PATIENTS	59, 717	5, 354, 944			0	72.00
73. 00 07300 DRUGS CHARGED TO PATIENTS	240, 729	22, 581, 368				
76. 97 O7697 CARDI AC REHABI LI TATI ON	125 (42	0	0.00000		0	76. 97
76. 98 O7698 HYPERBARI C OXYGEN THERAPY	125, 643	3, 111, 118			0	76. 98
76. 99 07699 LI THOTRI PSY	0	0	0.00000		0 0	76. 99
77. 00 07700 ALLOGENEIC HSCT ACQUISITION OUTPATIENT SERVICE COST CENTERS	1 0	0	0.00000	0	0	77. 00
90. 00 09000 CLINIC	15, 190	1, 018, 993	0. 01490	7 0	0	90.00
91. 00 09000 CLINI C 91. 00 09100 EMERGENCY	428, 017				_	
	482, 059				000	91.00
92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART OTHER REIMBURSABLE COST CENTERS	482,059	6, 252, 203	0. 07710	0	0	92.00
95. 00 09500 AMBULANCE SERVICES						95.00
200.00 Total (lines 50 through 199)	4, 645, 501	219, 943, 972		1, 008, 191	17, 433	

Health Financial Systems	HUNTI NGTON MEMO	RIAL HOSPITAL		In Lie	u of Form CMS-:	2552-10
APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER	PASS THROUGH COS	STS Provider C	1	Period: From 01/01/2022 Fo 12/31/2022		pared: 36 am
		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 & PEDI ATRI CS	0	0	(0	0	
43. 00 04300 NURSERY	0	0	(0	0	1 .0.00
200.00 Total (lines 30 through 199)	0	0	(0		200.00
Cost Center Description	Swi ng-Bed	Total Costs	Total Patient		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	
I NPATI ENT ROUTI NE SERVI CE COST CENTERS			1			
30. 00 03000 ADULTS & PEDI ATRI CS	0	0	6, 05			
43. 00 04300 NURSERY		0	605			
200.00 Total (lines 30 through 199)		0	6, 659	9	143	200.00
Cost Center Description	I npati ent					
	Program					
	Pass-Through					
	Cost (col. 7					
	x col. 8)					
INDATIONT DOUTING CODYLOG COCT CONTEDC	9. 00					
30.00 NOTE OF THE SERVICE COST CENTERS 30.00 O3000 ADULTS & PEDIATRICS	1 0	I				30.00
43. 00 03000 ADULTS & PEDIATRICS	0					43.00
43.00 04300 NUKSERY 200.00 Total (lines 30 through 199)						200.00
200.00 Total (Tries 30 through 199)	1	l				1200.00

Health Financial Systems	HUNTI NGTON MEMORIA	AL HOSPITAL	In Lieu	ı of Form CMS-2552-10
APPORTIONMENT OF INPATIENT/OUTPATIEN	T ANCILLARY SERVICE OTHER PASS	Provi der CCN: 15-0091	Peri od:	Worksheet D
TUDOUGU COCTC			From 01/01/2022	Dart IV

THROUG	SH COSTS				From 01/01/2022 To 12/31/2022	Date/Time Pre 5/18/2023 11:	
			Ti tl	e XIX	Hospi tal	PPS	
	Cost Center Description	Non Physician	Nursi ng	Nursi ng	Allied Health	Allied Health	
		Anesthetist	Program	Program	Post-Stepdown		
		Cost	Post-Stepdown		Adjustments		
			Adjustments				
		1. 00	2A	2. 00	3A	3. 00	
	ANCILLARY SERVICE COST CENTERS						
	05000 OPERATING ROOM	0	0		0	0	00.00
	05001 OPERATING ROOM	0	0		0	0	50. 01
52.00	05200 DELIVERY ROOM & LABOR ROOM	0	0		0	0	52.00
53.00	05300 ANESTHESI OLOGY	0	0		0	0	53.00
54.00	05400 RADI OLOGY-DI AGNOSTI C	0	0		0	0	54.00
	06000 LABORATORY	0	0		0	0	60.00
	06250 BLOOD CLOTTING FOR HEMOPHILIACS	0	0		0	0	62. 30
65.00	06500 RESPI RATORY THERAPY	0	0		0	0	65.00
	06600 PHYSI CAL THERAPY	0	0		0	0	66. 00
67.00	06700 OCCUPATI ONAL THERAPY	0	0		0	0	67.00
68.00	06800 SPEECH PATHOLOGY	0	0		0	0	68. 00
69.00	06900 ELECTROCARDI OLOGY	0	0		0	0	69. 00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0	0		0	0	71.00
	07200 I MPL. DEV. CHARGED TO PATIENTS	0	0		0	0	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0	0		0	0	73.00
76. 97	07697 CARDI AC REHABI LI TATI ON	0	0		0 0	0	76. 97
76. 98	07698 HYPERBARIC OXYGEN THERAPY	0	0		0 0	0	76. 98
76. 99	07699 LI THOTRI PSY	0	0		0 0	0	76. 99
77.00	07700 ALLOGENEIC HSCT ACQUISITION	0	0		0 0	0	77. 00
	OUTPATIENT SERVICE COST CENTERS						
90.00	09000 CLI NI C	0	0		0 0	0	90.00
91.00	09100 EMERGENCY	0	0		0 0	0	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART	0			0	0	92.00
	OTHER REIMBURSABLE COST CENTERS						
95.00	09500 AMBULANCE SERVICES						95.00
200.00	Total (lines 50 through 199)	0	0		0	0	200.00

Health Financial Systems	HUNTI NGTON MEMORIA	AL HOSPITAL	In Lieu	u of Form CMS-2552-10
APPORTIONMENT OF INPATIENT/OUTPATIENT THROUGH COSTS	ANCILLARY SERVICE OTHER PASS	Provi der CCN: 15-0091	From 01/01/2022	Worksheet D Part IV Date/Time Prepared: 5/18/2023 11:36 am

THROUG	on CO313				o 12/31/2022	Date/Time Pre 5/18/2023 11:	
			Ti tl	e XIX	Hospi tal	PPS	00 am
	Cost Center Description	All Other	Total Cost	Total		Ratio of Cost	
	'	Medi cal	(sum of cols.	Outpati ent	(from Wkst.	to Charges	
		Educati on	1, 2, 3, and	Cost (sum of	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						
	05000 OPERATING ROOM	0	0	(33, 255, 933		
50. 01	05001 OPERATI NG ROOM	0	0	(0	0. 000000	
52.00	05200 DELIVERY ROOM & LABOR ROOM	0	0	(5, 254, 859		
53.00	05300 ANESTHESI OLOGY	0	0	(4, 156, 236	0.000000	
54.00	05400 RADI OLOGY-DI AGNOSTI C	0	0	(38, 300, 893		
60.00	06000 LABORATORY	0	0	(36, 060, 742		
62. 30	06250 BLOOD CLOTTING FOR HEMOPHILIACS	0	0	(0	0.000000	
65.00	06500 RESPI RATORY THERAPY	0	0	(10, 126, 586		
66.00	06600 PHYSI CAL THERAPY	0	0	(5, 905, 608		
67.00	06700 OCCUPATI ONAL THERAPY	0	0	(1, 894, 215		
68.00	06800 SPEECH PATHOLOGY	0	0	(813, 313		
	06900 ELECTROCARDI OLOGY	0	0	(0	0.000000	
	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	(3, 415, 794		
	07200 I MPL. DEV. CHARGED TO PATIENTS	0	0	(5, 354, 944		
	07300 DRUGS CHARGED TO PATIENTS	0	0	(22, 581, 368		
76. 97	07697 CARDI AC REHABI LI TATI ON	0	0	(0	0.000000	76. 97
	07698 HYPERBARI C OXYGEN THERAPY	0	0	(3, 111, 118		
	07699 LI THOTRI PSY	0	0	(0	0.000000	76. 99
77.00	07700 ALLOGENEIC HSCT ACQUISITION	0	0	(0	0.000000	77. 00
	OUTPATIENT SERVICE COST CENTERS						
	09000 CLI NI C	0	0	(1, 018, 993		
91.00	09100 EMERGENCY	0	0	(42, 441, 167	0.000000	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART	0	0	(6, 252, 203	0.000000	92.00
	OTHER REIMBURSABLE COST CENTERS						
	09500 AMBULANCE SERVICES						95.00
200.00	Total (lines 50 through 199)	0	0	(219, 943, 972		200. 00

Health Financial Systems	HUNTI NGTON MEMORI	AL HOSPITAL	In Lieu	ı of Form CMS-2552-10
APPORTIONMENT OF INPATIENT/OUTPATIE	NT ANCILLARY SERVICE OTHER PASS	Provider CCN: 15-0091		Worksheet D
THROUGH COSTS			From 01/01/2022	Part IV

	CH COSTS	RVICE UTHER PASS	Provider Co		From 01/01/2022 To 12/31/2022	Part IV Date/Time Pre 5/18/2023 11:	
				e XIX	Hospi tal	PPS	
	Cost Center Description	Outpati ent	I npati ent	Inpatient	Outpati ent	Outpati ent	
		Ratio of Cost	Program	Program	Program	Program	
		to Charges	Charges	Pass-Through		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						
		0. 000000	370, 053		0	0	50.00
	05001 OPERATI NG ROOM	0. 000000	0		0	0	50. 01
	05200 DELIVERY ROOM & LABOR ROOM	0. 000000	140, 631		0	0	52.00
	05300 ANESTHESI OLOGY	0. 000000	0		0	0	53.00
	05400 RADI OLOGY-DI AGNOSTI C	0. 000000	47, 918		0	0	54.00
	06000 LABORATORY	0. 000000	138, 717		0	0	60.00
	06250 BLOOD CLOTTING FOR HEMOPHILIACS	0. 000000	0		0	0	62. 30
	06500 RESPI RATORY THERAPY	0. 000000	32, 082		0	0	65.00
	06600 PHYSI CAL THERAPY	0. 000000	14, 231		0	0	66.00
	06700 OCCUPATI ONAL THERAPY	0. 000000	7, 095		0	0	67.00
	06800 SPEECH PATHOLOGY	0. 000000	972		0	0	68. 00
	06900 ELECTROCARDI OLOGY	0. 000000	0		0	0	69. 00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0. 000000	31, 445		0	0	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0. 000000	0		0	0	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0. 000000	139, 188		0	0	73.00
76. 97	07697 CARDIAC REHABILITATION	0. 000000	0		0	0	76. 97
76. 98	07698 HYPERBARI C OXYGEN THERAPY	0. 000000	0		0	0	76. 98
76. 99	07699 LI THOTRI PSY	0. 000000	0		0	0	76. 99
77.00	07700 ALLOGENEIC HSCT ACQUISITION	0. 000000	0		0	0	77. 00
	OUTPATIENT SERVICE COST CENTERS						
90.00	09000 CLI NI C	0. 000000	0		0 0	0	90.00
91.00	09100 EMERGENCY	0. 000000	85, 859		0	0	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART	0. 000000	0		0	0	92.00
	OTHER REIMBURSABLE COST CENTERS						
95.00	09500 AMBULANCE SERVICES						95.00
200.00	Total (lines 50 through 199)		1, 008, 191		0	0	200. 00

Health Financial Systems	HUNTI NGTON MEMORI.	In Lieu	u of Form CMS-2552-10	
APPORTIONMENT OF MEDICAL,	OTHER HEALTH SERVICES AND VACCINE COST	Provi der CCN: 15-0091	Peri od:	Worksheet D

To 12/31/2022 Date/Time Prepared: 5/18/2023 11:36 am Title XIX Hospi tal PPS Costs Charges PPS Services PPS 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 3.00 4.00 5.00 ANCILLARY SERVICE COST CENTERS 50.00 05000 OPERATING ROOM 477, 078 50.00 0.085826 05001 OPERATING ROOM 0.000000 0 50.01 0 50.01 0 05200 DELIVERY ROOM & LABOR ROOM 0. 326772 0 52.00 0 0 52.00 53.00 05300 ANESTHESI OLOGY 0. 427878 0 0 0 53.00 54.00 05400 RADI OLOGY-DI AGNOSTI C 0. 124228 0 419, 812 54.00 06000 LABORATORY 380, 776 60.00 0.117537 0 0 0 60.00 06250 BLOOD CLOTTING FOR HEMOPHILIACS 0 62.30 0.000000 0 0 0 62.30 65.00 06500 RESPIRATORY THERAPY 0. 184745 65.00 0 66.00 06600 PHYSI CAL THERAPY 0.606046 0 87, 399 0 66.00 0 06700 OCCUPATI ONAL THERAPY 0. 246890 71, 818 67.00 67.00 0 68.00 06800 SPEECH PATHOLOGY 0.473259 79, 363 0 68.00 06900 ELECTROCARDI OLOGY 0.000000 69.00 69.00 0 07100 MEDICAL SUPPLIES CHARGED TO PATIENT 0. 249040 41, 941 71.00 71 00 72.00 07200 IMPL. DEV. CHARGED TO PATIENTS 0. 234257 9, 439 0 72.00 73.00 07300 DRUGS CHARGED TO PATIENTS 0.193974 0 93, 763 0 73.00 07697 CARDIAC REHABILITATION 0.000000 76. 97 0 0 76.97 0 76. 98 07698 HYPERBARI C OXYGEN THERAPY 0 76. 98 0 424477 0 0 Ω 07699 LI THOTRI PSY 76.99 0.000000 0 0 0 76.99 07700 ALLOGENEIC HSCT ACQUISITION 0.000000 0 77.00 OUTPATIENT SERVICE COST CENTERS 90.00 90.00 09000 CLINIC 0. 301270 0 0 0 0 91.00 09100 EMERGENCY 0.093712 0 774, 208 0 91.00 92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART 0.559016 0 0 75, 736 0 92.00 OTHER REIMBURSABLE COST CENTERS 95 00 95 00 09500 AMBULANCE SERVICES 0.358441 0 0 200.00 Subtotal (see instructions) 0 2, 511, 333 0 200.00 Less PBP Clinic Lab. Services-Program 0 201.00 201.00 Only Charges 0 0 202.00 202.00 Net Charges (line 200 - line 201) 2, 511, 333

Health Financial Systems	HUNTI NGTON MEM	ORIAL HOSPITAL		In Lieu	u of Form CMS-2	2552-10
APPORTIONMENT OF MEDICAL, OTHER HEALTH SERV	ICES AND VACCINE COST	Provi der Co	CN: 15-0091	Peri od: From 01/01/2022 To 12/31/2022	Worksheet D Part V Date/Time Pre 5/18/2023 11:	pared: 36 am
		Ti tl	e XIX	Hospi tal	PPS	
	Co	sts				
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				

		L COS	SIS	
	Cost Center Description	Cost	Cost	
		Rei mbursed	Rei mbursed	
		Servi ces	Servi ces Not	
		Subject To	Subject To	
		Ded. & Coins.	Ded. & Coins.	
		(see inst.)	(see inst.)	
		6. 00	7. 00	
	ANCILLARY SERVICE COST CENTERS			
	0.00 05000 OPERATING ROOM	0	40, 946	50.00
50	0.01 05001 OPERATING ROOM	0	0	50. 01
52	2.00 05200 DELIVERY ROOM & LABOR ROOM	0	0	52.00
53	B. 00 05300 ANESTHESI OLOGY	0	0	53.00
54	. 00 05400 RADI OLOGY-DI AGNOSTI C	0	52, 152	54.00
60). 00 06000 LABORATORY	0	44, 755	60.00
62	2.30 06250 BLOOD CLOTTING FOR HEMOPHILIACS	0	0	62. 30
65	5. 00 06500 RESPIRATORY THERAPY	0	0	65.00
66	o. 00 06600 PHYSI CAL THERAPY	0	52, 968	66.00
67	7. 00 06700 OCCUPATI ONAL THERAPY	0	17, 731	67.00
68	3. 00 06800 SPEECH PATHOLOGY	0	37, 559	68. 00
69	P. 00 06900 ELECTROCARDI OLOGY	0	0	69.00
71	. 00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0	10, 445	71.00
72	2.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0	2, 211	72.00
73	8.00 07300 DRUGS CHARGED TO PATIENTS	0	18, 188	73.00
76	o. 97 07697 CARDI AC REHABI LI TATI ON	0	0	76. 97
76	o. 98 07698 HYPERBARIC OXYGEN THERAPY	0	0	76. 98
76	o. 99 07699 LI THOTRI PSY	0	0	76. 99
77	7.00 07700 ALLOGENEIC HSCT ACQUISITION	0	0	77. 00
	OUTPATIENT SERVICE COST CENTERS			1
90	0. 00 09000 CLI NI C	0	0	90.00
91	. 00 09100 EMERGENCY	0	72, 553	91.00
92	2.00 09200 OBSERVATION BEDS (NON-DISTINCT PART	0	42, 338	92.00
	OTHER REIMBURSABLE COST CENTERS			7
95	5. 00 09500 AMBULANCE SERVICES	0		95. 00
20	00.00 Subtotal (see instructions)	0	391, 846	200.00
20	11.00 Less PBP Clinic Lab. Services-Program	0		201.00
	Only Charges			
20	Net Charges (line 200 - line 201)	0	391, 846	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 01/01/2022	Worksheet D-1	
		To 12/31/2022	Date/Time Pre 5/18/2023 11:	
	Title XVIII	Hospi tal	PPS	
Cost Center Description				
			1. 00	
PART I - ALL PROVIDER COMPONENTS				

		Title XVIII	Hospi tal	PPS	
	Cost Center Description				
	DART I ALL PROVIDER COMPONENTO			1. 00	
	PART I - ALL PROVIDER COMPONENTS				
1. 00	INPATIENT DAYS Inpatient days (including private room days and swing-bed day	es eveluding newborn)		6, 054	1.00
2. 00	Inpatient days (including private room days, excluding swing-			6, 054	2.00
3. 00	Private room days (excluding swing-bed and observation bed days)		ivate room days	0,034	3.00
0.00	do not complete this line.	je, jed nate em j pr	. vato . com dayo,	٦	0.00
4.00	Semi-private room days (excluding swing-bed and observation b	ed days)		4, 182	4.00
5.00	Total swing-bed SNF type inpatient days (including private ro	om days) through Decembe	r 31 of the cost	0	5. 00
	reporting period				
6. 00	Total swing-bed SNF type inpatient days (including private ro	om days) after December	31 of the cost	0	6. 00
7 00	reporting period (if calendar year, enter 0 on this line)	m daya) thraugh Dagambar	21 of the cost	0	7 00
7. 00	Total swing-bed NF type inpatient days (including private roc reporting period	ili days) trii dugir beceilber	31 Of the Cost	٥	7. 00
8. 00	Total swing-bed NF type inpatient days (including private roo	m days) after December 3	1 of the cost	0	8. 00
0.00	reporting period (if calendar year, enter 0 on this line)	iii days) arter becember o	i di the cost	Ĭ	0.00
9.00	Total inpatient days including private room days applicable t	o the Program (excluding	swi ng-bed and	982	9. 00
	newborn days) (see instructions)				
10. 00	Swing-bed SNF type inpatient days applicable to title XVIII o		oom days)	0	10.00
11 00	through December 31 of the cost reporting period (see instruc				11 00
11. 00	Swing-bed SNF type inpatient days applicable to title XVIII of December 31 of the cost reporting period (if calendar year, e		bom days) arter	0	11. 00
12. 00	Swing-bed NF type inpatient days applicable to titles V or XI		e room days)	0	12. 00
12.00	through December 31 of the cost reporting period	X only (Therading private	c room days)	١	12.00
13.00	Swing-bed NF type inpatient days applicable to titles V or XI	X only (including private	e room days)	0	13.00
	after December 31 of the cost reporting period (if calendar y				
14.00	Medically necessary private room days applicable to the Progr	am (excluding swing-bed	days)	0	14.00
15.00	Total nursery days (title V or XIX only)			0	15.00
16. 00	Nursery days (title V or XIX only)			0	16. 00
17 00	SWING BED ADJUSTMENT	as through Dasambar 21 a	f the cost	0.00	17 00
17. 00	Medicare rate for swing-bed SNF services applicable to service reporting period	es through becember 31 0	i the cost	0.00	17. 00
18. 00	Medicare rate for swing-bed SNF services applicable to service	es after December 31 of	the cost	0.00	18. 00
	reporting period				
19.00	Medicaid rate for swing-bed NF services applicable to service	s through December 31 of	the cost	0. 00	19.00
	reporting period				
20. 00	Medicaid rate for swing-bed NF services applicable to service	s after December 31 of t	he cost	0. 00	20. 00
21 00	reporting period	6)		11, 302, 999	21. 00
21. 00 22. 00	Total general inpatient routine service cost (see instruction Swing-bed cost applicable to SNF type services through Decemb		ing period (line		22.00
22.00	5 x line 17)	cr 31 or the cost report	ing period (iiid	١	22.00
23.00	Swing-bed cost applicable to SNF type services after December	31 of the cost reporting	g period (line 6	0	23.00
	x line 18)	•			
24. 00	Swing-bed cost applicable to NF type services through Decembe	r 31 of the cost reporti	ng period (line	0	24. 00
05.00	7 x line 19)	24 . 6 . 11			05.00
25. 00	Swing-bed cost applicable to NF type services after December x line 20)	31 of the cost reporting	period (line 8	0	25. 00
26. 00	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)		11, 302, 999	
	PRI VATE ROOM DI FFERENTI AL ADJUSTMENT	(****** = * ****** = ****** = ***		,	
28.00	General inpatient routine service charges (excluding swing-be	d and observation bed ch	arges)	0	28. 00
29. 00	Private room charges (excluding swing-bed charges)			0	
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	
32.00	Average private room per diem charge (line 29 ÷ line 3)			0.00	•
33.00	Average semi-private room per diem charge (line 30 ÷ line 4) Average per diem private room charge differential (line 32 mi	nuo line 22) (coe instrue	+: 000)	0.00	•
34. 00 35. 00	Average per diem private room cost differential (line 34 x li	, ,	11 0113)	0. 00 0. 00	
36.00	Private room cost differential adjustment (line 3 x line 35)	110 01)		0.00	36.00
37. 00	General inpatient routine service cost net of swing-bed cost	and private room cost di	fferential (line	11, 302, 999	
	27 minus line 36)				
	PART II - HOSPITAL AND SUBPROVIDERS ONLY				
	PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJ				
38.00	Adjusted general inpatient routine service cost per diem (see	*		1, 867. 03	
39.00	Program general inpatient routine service cost (line 9 x line Medically necessary private room cost applicable to the Progr			1, 833, 423	
40. 00 41. 00	Total Program general inpatient routine service cost (line 39			0 1, 833, 423	40. 00 41. 00
- 1. 00	Trotal Trogram general impatrent routine service cost (Illie 37	11110 70)		1, 000, 420	T 1. 00

Ith Financial Systems PUTATION OF INPATIENT OPERATING COST		Provi der (Period: From 01/01/2022	w of Form CMS-2 Worksheet D-1	
				Γο 12/31/2022	Date/Time Pre 5/18/2023 11:	
Cost Contor Decement on	Total		e XVIII	Hospi tal	PPS	
Cost Center Description	Total I npati ent	Total I npati ent	Average Per Diem (col. 1	Program Days	Program Cost (col. 3 x	
	Cost 1.00	2. 00	÷ col. 2) 3.00	4.00	col . 4) 5.00	
OO NURSERY (title V & XIX only)	0		0.00			42
Intensive Care Type Inpatient Hospital	Uni ts				Ī	142
OO INTENSIVE CARE UNIT OO CORONARY CARE UNIT						43
OO BURN INTENSIVE CARE UNIT						45
00 SURGICAL INTENSIVE CARE UNIT						46
00 OTHER SPECIAL CARE (SPECIFY)						47.
Cost Center Description					1. 00	
00 Program inpatient ancillary service co	st (Wkst. D-3, col.	3, line 200)			1, 032, 010	48
01 Program inpatient cellular therapy acc	uisition cost (Works	heet D-6, Part		column 1)	0	
OO Total Program inpatient costs (sum of	lines 41 through 48.	01)(see instru	ctions)		2, 865, 433	49
PASS THROUGH COST ADJUSTMENTS OD Pass through costs applicable to Progr	am innatient routine	services (fro	nm Wkst D sum	of Parts I and	252, 875	50
III)	am riipatrent routine	301 11 003 (110	iii wast. b, saiii	or runts r une	202, 070	
00 Pass through costs applicable to Progr	am inpatient ancilla	ry services (f	rom Wkst. D, s	um of Parts II	119, 661	51
and IV) Total Program excludable cost (sum of	lines EO and E1)				372, 536	
00 Total Program excludable cost (sum of 00 Total Program inpatient operating cost		elated. non-ph	ıvsician anesth	etist, and	2, 492, 897	
medical education costs (line 49 minus					_,,]
TARGET AMOUNT AND LIMIT COMPUTATION						ļ
00 Program discharges 00 Target amount per discharge					0.00	
01 Permanent adjustment amount per discha	rae				0.00	
02 Adjustment amount per discharge (contr	O .				0.00	1
00 Target amount (line 54 x sum of lines	55, 55.01, and 55.02)			0	56
00 Difference between adjusted inpatient	operating cost and to	arget amount (line 56 minus	line 53)	0	
OO Bonus payment (see instructions)	o E4 on line EE from	m +bc coc+ ror	anting paried	anding 1004	0.00	
On Trended costs (lesser of line 53 ÷ line updated and compounded by the market be		ii the cost rep	of tring period	ending 1990,	0.00	1 39
00 Expected costs (lesser of line 53 ÷ li		om prior year	cost report, u	pdated by the	0.00	60
market basket)	1 C 1			Li ee		
00 Continuous improvement bonus payment (55.01, or line 59, or line 60, enter t 53) are less than expected costs (line	he lesser of 50% of	the amount by	which operatin	g costs (line	0	61
enter zero. (see instructions)						
00 Relief payment (see instructions) 00 Allowable Inpatient cost plus incentiv	ra navmant (saa instri	uctions)			0	
PROGRAM INPATIENT ROUTINE SWING BED CO		uc (1 0113)				1 00
00 Medicare swing-bed SNF inpatient routi	ne costs through Dec	ember 31 of th	e cost reporti	ng period (See	0	64
instructions)(title XVIII only)	t£t D	21 - - +				65
00 Medicare swing-bed SNF inpatient routi instructions)(title XVIII only)	ne costs after Decemi	ber 31 of the	cost reporting	perrou (see		00
00 Total Medicare swing-bed SNF inpatient	routine costs (line	64 plus line	65)(title XVII	I only); for	l o	66
CAH, see instructions		L D	-6 +1		_	,_
On Title V or XIX swing-bed NF inpatient (line 12 x line 19)	routine costs through	n vecember 31	or the cost re	porting period	0	67
00 Title V or XIX swing-bed NF inpatient	routine costs after	December 31 of	the cost repo	rting period	0	68
(line 13 x line 20)			·	- •		
00 Total title V or XIX swing-bed NF inpa PART III - SKILLED NURSING FACILITY, 0		`			0	69
00 Skilled nursing facility/other nursing						70
00 Adjusted general inpatient routine ser						71
OO Program routine service cost (line 9 x	•					72
00 Medically necessary private room cost 00 Total Program general inpatient routin	0	•				73
00 Capital -related cost allocated to inpa				art II, column		75
26, line 45)		•	•			
OO Per diem capital related costs (line 7						76
00 Program capital - related costs (line 9 00 Inpatient routine service cost (line 7	•					77
00 Aggregate charges to beneficiaries for		provi der recor	·ds)			79
00 Total Program routine service costs for				us line 79)		80
00 Inpatient routine service cost per die	m limitation			,		81
00 Inpatient routine service cost limitat	,	•				82
On Reasonable inpatient routine service of		ns)				83
00 Program inpatient ancillary services (00 Utilization review - physician compens		nns)				84
00 Total Program inpatient operating cost						86
PART IV - COMPUTATION OF OBSERVATION B	ED PASS THROUGH COST	<i>,</i>				
00 Total observation bed days (see instru					1, 872	

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 01/01/2022 To 12/31/2022	Date/Time Pre 5/18/2023 11:	pared: 36 am_
		Title	XVIII	Hospi tal	PPS	
Cost Center Description						
					1. 00	
89.00 Observation bed cost (line 87 x line 88) (se	e instructions)			3, 495, 080	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	
		ŕ		(from line	(col. 3 x	
				89)	col. 4) (see	
				ŕ	instructions)	
	1. 00	2. 00	3. 00	4. 00	5. 00	
COMPUTATION OF OBSERVATION BED PASS THROUGH	COST					
90.00 Capital -related cost	1, 558, 967	11, 302, 999	0. 13792	5 3, 495, 080	482, 059	90.00
91.00 Nursing Program cost	0	11, 302, 999	0.00000	0 3, 495, 080	0	91.00
92.00 Allied health cost	0	11, 302, 999	0. 00000	0 3, 495, 080	0	92.00
93.00 All other Medical Education	0	11, 302, 999	0. 00000	0 3, 495, 080	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: From 01/01/2022	Worksheet D-1	
		To 12/31/2022	Date/Time Pre 5/18/2023 11:	
	Title XIX	Hospi tal	PPS	
Cost Center Description				
			1. 00	
PART I - ALL PROVIDER COMPONENTS				
I NPATI ENT DAYS				1
1.00 Inpatient days (including private room	days and swing-bed days, excluding newborn)		6, 054	1.00
1 . 3 . 3 .		1		

	Title XIX Hospital	PPS	
	Cost Center Description	1. 00	
	PART I - ALL PROVIDER COMPONENTS		
	INPATIENT DAYS		
1. 00 2. 00	Inpatient days (including private room days and swing-bed days, excluding newborn) Inpatient days (including private room days, excluding swing-bed and newborn days)	6, 054 6, 054	1. 00 2. 00
3. 00	Private room days (excluding swing-bed and observation bed days). If you have only private room days, do not complete this line.	0, 034	3.0
4. 00 5. 00	Semi-private room days (excluding swing-bed and observation bed days) Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost	4, 182 0	4. 00 5. 00
6. 00	reporting period Total swing-bed SNF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	6. 0
7. 00	Total swing-bed NF type inpatient days (including private room days) through December 31 of the cost reporting period	0	7.0
8. 00	Total swing-bed NF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	8. 0
9. 00	Total inpatient days including private room days applicable to the Program (excluding swing-bed and newborn days) (see instructions)	118	9.0
10. 00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) through December 31 of the cost reporting period (see instructions)	0	
11.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	11.0
12. 00 13. 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 Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days)	0	12.00
	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	
15. 00	Total nursery days (title V or XIX only)	605	
16. 00	Nursery days (title V or XIX only) SWING BED ADJUSTMENT	25	16.0
17. 00	Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost reporting period	0. 00	17.0
18. 00	Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period	0. 00	
19. 00	Medicaid rate for swing-bed NF services applicable to services through December 31 of the cost reporting period		19.0
20. 00	Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period	0.00	
21. 00 22. 00	Total general inpatient routine service cost (see instructions) Swing-bed cost applicable to SNF type services through December 31 of the cost reporting period (line 5 x line 17)	11, 302, 999 0	21. 0 22. 0
23. 00	Swing-bed cost applicable to SNF type services after December 31 of the cost reporting period (line 6 x line 18)	0	23. 0
24. 00	Swing-bed cost applicable to NF type services through December 31 of the cost reporting period (line 7×1 line 19)	0	24.0
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. 0
26. 00 27. 00	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)	0 11, 302, 999	
28. 00	PRIVATE ROOM DIFFERENTIAL ADJUSTMENT General inpatient routine service charges (excluding swing-bed and observation bed charges)	0	28.0
	Private room charges (excluding swing-bed charges)	0	29.0
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	1
	Average private room per diem charge (line 29 + line 3)	0. 00	
33. 00	Average semi-private room per diem charge (line 30 ÷ line 4)	0. 00	
34. 00	Average per diem private room charge differential (line 32 minus line 33)(see instructions)	0. 00	34.0
35. 00	Average per diem private room cost differential (line 34 x line 31)	0.00	35.0
36. 00	Private room cost differential adjustment (line 3 x line 35)	0	36.0
37. 00	General inpatient routine service cost net of swing-bed cost and private room cost differential (line 27 minus line 36)	11, 302, 999	37.0
	PART II - HOSPITAL AND SUBPROVIDERS ONLY		
	DDOCDAM INDATIENT ODEDATING COST DECODE DASS TUDQUICU COST AD HISTMENTS		
	PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS	1 0/7 00	20 0
38. 00	Adjusted general inpatient routine service cost per diem (see instructions)	1, 867. 03	
		1, 867. 03 220, 310 0	1

6. 00	Total swing-bed SNF type inpatient days (including private room days) after December 31 of the cost	0	6. 00
7 00	reporting period (if calendar year, enter 0 on this line)		7 00
7. 00	Total swing-bed NF type inpatient days (including private room days) through December 31 of the cost	0	7. 00
0.00	reporting period	0	0.00
8. 00	Total swing-bed NF type inpatient days (including private room days) after December 31 of the cost	٥Į	8. 00
9. 00	reporting period (if calendar year, enter 0 on this line) Total inpatient days including private room days applicable to the Program (excluding swing-bed and	118	9. 00
9.00	newborn days) (see instructions)	110	9.00
10.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days)	0	10.00
10.00	through December 31 of the cost reporting period (see instructions)	ĭ	10.00
11. 00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) after	ol	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)	o	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	14.00
15.00	Total nursery days (title V or XIX only)		15.00
16. 00	Nursery days (title V or XIX only)	25	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
40.00	reporting period		40.00
18. 00	Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost	0. 00	18. 00
10 00	reporting period	0.00	10.00
19. 00	Medicaid rate for swing-bed NF services applicable to services through December 31 of the cost	0.00	19. 00
20. 00	reporting period Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost	0.00	20.00
20.00	reporting period	0.00	20.00
21. 00	Total general inpatient routine service cost (see instructions)	11, 302, 999	21 00
22. 00	Swing-bed cost applicable to SNF type services through December 31 of the cost reporting period (line		22. 00
22.00	5 x 1 ine 17)	ĭ	22.00
23.00		ol	23.00
	x line 18)		
24.00	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	0	25.00
	x line 20)		
26. 00	Total swing-bed cost (see instructions)	0	26.00
27. 00	3 · · · · · · · · · · · · · · · · · · ·	11, 302, 999	27. 00
	PRIVATE ROOM DIFFERENTIAL ADJUSTMENT	_	
28. 00	General inpatient routine service charges (excluding swing-bed and observation bed charges)	0	
29. 00	Pri vate room charges (excluding swing-bed charges)	0	29. 00 30. 00
30. 00 31. 00	Semi-private room charges (excluding swing-bed charges) General inpatient routine service cost/charge ratio (line 27 ÷ line 28)	0. 000000	
31.00	Average private room per diem charge (line 29 ÷ line 3)		32.00
32.00	Average semi-private room per diem charge (line 30 ÷ line 4)		32.00
34. 00	Average per diem private room charge differential (line 32 minus line 33)(see instructions)		34.00
35. 00	Average per diem private room cost differential (line 34 x line 31)		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		
07.00	27 minus line 36)	11,002,777	07.00
	PART II - HOSPITAL AND SUBPROVIDERS ONLY		
	PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS		
38.00		1, 867. 03	38.00
	Program general inpatient routine service cost (line 9 x line 38)	220, 310	
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)	220, 310	41.00

OMPUT	ATION OF INPATIENT OPERATING COST		Provider Co	1	Period: From 01/01/2022 Fo 12/31/2022		pared
			Ti +I	e XIX	Hospi tal	5/18/2023 11: PPS	36 ar
	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)	351, 804	605	581. 49	9 25	14, 537	42. (
3. 00	Intensive Care Type Inpatient Hospital Units INTENSIVE CARE UNIT						43.0
4. 00	CORONARY CARE UNIT						44.
5. 00	BURN INTENSIVE CARE UNIT					•	45.0
	SURGICAL INTENSIVE CARE UNIT						46.0
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	3, line 200)			159, 611	48. (
3. 01	Program inpatient cellular therapy acquisiti				column 1)	0	
9. 00	Total Program inpatient costs (sum of lines	41 through 48.C	01)(see instru	ctions)		394, 458	49.
0. 00	PASS THROUGH COST ADJUSTMENTS Pass through costs applicable to Program inp	ationt routing	convices (from	m Wks+ D sum	of Dorte L and	31, 214	50.
). 00	[111]	atrent routine	services (110	II WKSt. D, Suii	I OI PAILS I AIIC	31, 214	30.1
1.00	Pass through costs applicable to Program inp	atient ancillar	ry services (f	rom Wkst. D, s	um of Parts II	17, 433	51.0
	and IV)		•				
2.00	Total Program excludable cost (sum of lines	,				48, 647	1
3. 00	Total Program inpatient operating cost exclumedical education costs (line 49 minus line		elated, non-ph	ysician anestr	etist, and	345, 811	53.
	TARGET AMOUNT AND LIMIT COMPUTATION	32)					
1. 00	Program di scharges					0	54.
5. 00	Target amount per discharge					0. 00	55.
5. 01	Permanent adjustment amount per discharge					0. 00	1
. 02	Adjustment amount per discharge (contractor					0.00	1
. 00	Target amount (line 54 x sum of lines 55, 55 Difference between adjusted inpatient operat			ine 56 minus	line 53)	0	56. 57.
. 00	Bonus payment (see instructions)	ing cost and te	inger amount (THE 30 III Hus	11116 33)	0	58.
. 00	Trended costs (lesser of line 53 ÷ line 54,	or line 55 from	the cost rep	orting period	ending 1996,	0.00	
	updated and compounded by the market basket)		·		•		
). 00	Expected costs (lesser of line 53 ÷ line 54,	or line 55 fro	om prior year	cost report, u	pdated by the	0. 00	60.
1.00	market basket) Continuous improvement bonus payment (if lin 55.01, or line 59, or line 60, enter the les 53) are less than expected costs (lines 54 x	ser of 50% of t	the amount by	which operatir	g costs (line	0	61.
	enter zero. (see instructions)					_	
2.00	Relief payment (see instructions)	ont (coo instru	ictions)			0	62.
5. 00	Allowable Inpatient cost plus incentive paym PROGRAM INPATIENT ROUTINE SWING BED COST	ent (see mstrt	ictions)			0	03.
. 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)	Ü		·			
5. 00	Medicare swing-bed SNF inpatient routine cos	ts after Decemb	per 31 of the o	cost reporting	period (See	0	65.
5. 00	instructions)(title XVIII only) Total Medicare swing-bed SNF inpatient routi	ne costs (line	64 nlus line	45)(title XVII	I only): for	0	66.
. 00	CAH, see instructions	110 00313 (11110	or prus rine .	30) (11 11 0 7111	1 0111 377, 101	Ŭ	00.
. 00	Title V or XIX swing-bed NF inpatient routin	e costs through	December 31	of the cost re	porting period	0	67.
	(line 12 x line 19)						
3. 00	Title V or XIX swing-bed NF inpatient routin (line 13 x line 20)	e costs arter L	becelliber 31 OT	the cost repo	iring 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 N		•				
. 00	Skilled nursing facility/other nursing facil						70.
.00	Adjusted general inpatient routine service c Program routine service cost (line 9 x line		ine /o ÷ line	۷)			71.
. 00	Medically necessary private room cost applic		n (line 14 x li	ne 35)			73.
. 00	Total Program general inpatient routine serv	ice costs (line	e 72 + line 73)			74.
. 00	Capital-related cost allocated to inpatient	routine service	e costs (from \	Worksheet B, F	art II, column		75.
00	26, line 45) Per diem capital-related costs (line 75 ÷ li	ne 2)					76.
00	Program capital-related costs (line 9 x line	. *					77
00	Inpatient routine service cost (line 74 minu						78
00	Aggregate charges to beneficiaries for exces						79
00	Total Program routine service costs for comp		cost limitatio	n (line 78 min	us line 79)		80
00	Inpatient routine service cost per diem limi						81
. 00	Inpatient routine service cost limitation (I Reasonable inpatient routine service costs (•				82. 83.
	Program inpatient ancillary services (see in		13)				84.
	Utilization review - physician compensation		ons)				85.
. 00	Total Program inpatient operating costs (sum						86.
	PART IV - COMPUTATION OF OBSERVATION BED PASS						
	Total observation bed days (see instructions					1, 872	

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 01/01/2022 To 12/31/2022		
		Ti tl	e XIX	Hospi tal	PPS	
Cost Center Description						
					1. 00	
89.00 Observation bed cost (line 87 x line 88)	(see instructions)			3, 495, 080	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	GH COST					
90.00 Capital -related cost	1, 558, 967	11, 302, 999	0. 13792	5 3, 495, 080	482, 059	90.00
91.00 Nursing Program cost	0	11, 302, 999	0. 00000	0 3, 495, 080	0	91.00
92.00 Allied health cost	0	11, 302, 999	0. 00000	0 3, 495, 080	0	92.00
93.00 All other Medical Education	0	11, 302, 999	0. 00000	0 3, 495, 080	0	93.00

NPATI EN	NT ANCILLARY SERVICE COST APPORTIONMENT	Provi der C	CN: 15-0091	Peri od:	Worksheet D-3	i
				From 01/01/2022 To 12/31/2022	Data /Tima Dra	
				To 12/31/2022	Date/Time Pre 5/18/2023 11:	
		Titl∈	XVIII	Hospi tal	PPS	
	Cost Center Description		Ratio of Cos		I npati ent	
			To Charges	9	Program Costs	
				Charges	(col . 1 x	
					col . 2)	-
	ADATI ENT. DOUTINE CEDALOF COCT. OF NITEDO		1.00	2. 00	3. 00	-
_	NPATIENT ROUTINE SERVICE COST CENTERS		ı	0.050.074		1
	3000 ADULTS & PEDI ATRI CS			2, 359, 274		30.
	14300 NURSERY NCILLARY SERVICE COST CENTERS					43.
	15000 OPERATING ROOM		0. 0858	26 545, 203	46, 793	50.
	15001 OPERATING ROOM		0.0000		40, 793	
	15200 DELIVERY ROOM & LABOR ROOM		0. 3267		0	
	5300 ANESTHESI OLOGY		0. 4278		0	53.
	5400 RADI OLOGY-DI AGNOSTI C		0. 1242			
	16000 LABORATORY		0. 1175		153, 162	
	16250 BLOOD CLOTTING FOR HEMOPHILIACS		0.0000		0	
	6500 RESPI RATORY THERAPY		0. 1847		64, 745	
	16600 PHYSI CAL THERAPY		0. 6060		116, 446	
	06700 OCCUPATI ONAL THERAPY		0. 2468		29, 356	
3.00 0	6800 SPEECH PATHOLOGY		0. 4732	59 22, 092	10, 455	68.
9.00 0	6900 ELECTROCARDI OLOGY		0.0000		0	69.
1.00 0	7100 MEDICAL SUPPLIES CHARGED TO PATIENT		0. 2490	40 232, 246	57, 839	71.
	7200 IMPL. DEV. CHARGED TO PATIENTS		0. 2342	57 422, 013	98, 859	72.
	7300 DRUGS CHARGED TO PATIENTS		0. 1939	74 1, 100, 693	213, 506	73.
	17697 CARDIAC REHABILITATION		0.0000		0	
	17698 HYPERBARIC OXYGEN THERAPY		0. 4244		0	
	17699 LI THOTRI PSY		0.0000		0	76.
	17700 ALLOGENEIC HSCT ACQUISITION		0.0000	00 0	0	77.
	UTPATIENT SERVICE COST CENTERS					4
	9000 CLI NI C		0. 3012			
	19100 EMERGENCY		0.0937			
	9200 OBSERVATION BEDS (NON-DISTINCT PART		0. 5590	16 0	0	92.
	THER REI MBURSABLE COST CENTERS					۱ ۵۰
	19500 AMBULANCE SERVICES			/ 510 01/	1 000 010	95.
00.00	Total (sum of lines 50 through 94 and 96 through 98)	(line (1)		6, 510, 216		
01. 00 02. 00	Less PBP Clinic Laboratory Services-Program only charges Net charges (line 200 minus line 201)	s (Tine 61)		4 E10 214		201.
JZ. UU	INEL Charges (Time 200 milinus Time 201)		I	6, 510, 216		202

NPATI ENT	ANCILLARY SERVICE COST APPORTIONMENT	Provi der C	CN: 15-0091	Peri od:	Worksheet D-3	,
				From 01/01/2022 To 12/31/2022	Date/Time Pre	pared
					5/18/2023 11:	
		Ti tl	e XIX	Hospi tal	PPS	
	Cost Center Description		Ratio of Cos		I npati ent	
			To Charges		Program Costs	
				Charges	(col . 1 x	
			1.00	2.00	col . 2) 3.00	1
LNDA	ATIENT ROUTINE SERVICE COST CENTERS		1.00	2.00	3.00	_
	DO ADULTS & PEDIATRICS			282, 011		30.0
	NURSERY			55, 450		43. (
	LLARY SERVICE COST CENTERS			33, 430		45.0
	OO OPERATING ROOM		0. 0858	26 370, 053	31, 760	50.0
	01 OPERATING ROOM		0.0000		01,700	
	DO DELIVERY ROOM & LABOR ROOM		0. 3267		45. 954	
	OO ANESTHESI OLOGY		0. 4278		0	
1	DO RADI OLOGY-DI AGNOSTI C		0. 1242		5, 953	54.
0.00 0600	DO LABORATORY		0. 1175		16, 304	60.
2. 30 0625	50 BLOOD CLOTTING FOR HEMOPHILIACS		0.0000	00 0	0	62.
5. 00 0650	DO RESPIRATORY THERAPY		0. 1847	45 32, 082	5, 927	65.
6.00 0660	DO PHYSI CAL THERAPY		0. 6060	46 14, 231	8, 625	66.
7.00 0670	OO OCCUPATIONAL THERAPY		0. 2468		1, 752	67. (
	OO SPEECH PATHOLOGY		0. 4732		460	
	00 ELECTROCARDI OLOGY		0.0000		0	1
	DO MEDICAL SUPPLIES CHARGED TO PATIENT		0. 2490		7, 831	
	DO IMPL. DEV. CHARGED TO PATIENTS		0. 2342		0	
	DO DRUGS CHARGED TO PATIENTS		0. 1939		26, 999	
-	P7 CARDI AC REHABI LI TATI ON		0.0000		0	
	98 HYPERBARI C OXYGEN THERAPY		0. 4244		0	1 .
	PO ALLOCENELS USET ASSUUSITION		0.0000		0	1
	DO ALLOGENEIC HSCT ACQUISITION PATIENT SERVICE COST CENTERS		0.0000	00 0	0	77.
0.00 0900			0. 3012	70 0	0	90.
	DO EMERGENCY		0. 3012		8, 046	
	OO OBSERVATION BEDS (NON-DISTINCT PART		0. 5590		0,040	1
	ER REIMBURSABLE COST CENTERS		0.5590	10 0	0	72.
	OO AMBULANCE SERVICES					95.
00.00	Total (sum of lines 50 through 94 and 96 through 98)			1, 008, 191	159, 611	
01.00	Less PBP Clinic Laboratory Services-Program only charges	(line 61)		1,000,171		201.
02.00	Net charges (line 200 minus line 201)	, (TINC OI)		1, 008, 191		202.

Health Financial Systems	HUNTINGTON MEMORIAL HOSPITAL	In Li eu	u of Form CMS-2552-10
CALCULATION OF REIMBURSEMENT SETTLEMENT	Provi der CCN: 15-0091	From 01/01/2022 To 12/31/2022	Worksheet E Part A Date/Time Prepared: 5/18/2023 11:36 am

		Title XVIII	Hospi tal	5/18/2023 11: PPS	36 am_
			ļ	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 instructions)	g prior to October 1 (see	0 1, 322, 259	1. 00 1. 01
1. 02	DRG amounts other than outlier payments for discharges occurring instructions)	g on or after October	1 (see	750, 271	1. 02
1. 03	DRG for federal specific operating payment for Model 4 BPCI for 1 (see instructions)	di scharges occurri ng	prior to October	0	1. 03
1. 04	DRG for federal specific operating payment for Model 4 BPCI for October 1 (see instructions)	di scharges occurri ng	on or after	0	1. 04
2. 00 2. 01	Outlier payments for discharges. (see instructions) Outlier reconciliation amount			0	2. 00 2. 01
2. 02	Outlier payment for discharges for Model 4 BPCI (see instruction Outlier payments for discharges occurring prior to October 1 (see	ee instructions)		0	2. 02
2. 04 3. 00 4. 00	Outlier payments for discharges occurring on or after October 1 Managed Care Simulated Payments Bed days available divided by number of days in the cost reporti	,	uctions)	0 0 30. 68	2. 04 3. 00 4. 00
	Indirect Medical Education Adjustment				
5. 00 5. 01	FTE count for allopathic and osteopathic programs for the most of before 12/31/1996. (see instructions) FTE cap adjustment for qualifing hospitals under §131 of the CAP			0. 00	5. 00 5. 01
6. 00	FTE count for allopathic and osteopathic programs that meet the new programs in accordance with 42 CFR 413.79(e)			0.00	6. 00
6. 26	Rural track program FTE cap limitation adjustment after the cap- the CAA 2021 (see instructions)	-building window close	d under §127 of	0. 00	6. 26
7. 00 7. 01	MMA Section 422 reduction amount to the IME cap as specified und ACA § 5503 reduction amount to the IME cap as specified under 4:			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 track programs with a rural track for Medicare GME affiliated pr and 87 FR 49075 (August 10, 2022) (see instructions)			0. 00	7. 02
8. 00	Adjustment (increase or decrease) to the FTE count for allopathiaffiliated programs in accordance with 42 CFR 413.75(b), 413.79(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 report straddles July 1, 2011, see instructions.	s under § 5503 of the	ACA. If the cost	0. 00	8. 01
8. 02	The amount of increase if the hospital was awarded FTE cap slots under \S 5506 of ACA. (see instructions)			0. 00	8. 02
8. 21	The amount of increase if the hospital was awarded FTE cap slots instructions)		,	0.00	8. 21
9. 00	Sum of lines 5 and 5.01, plus line 6, plus lines 6.26 through 6. minus line 7.02, plus/minus line 8, plus lines 8.01 through 8.2 FTE count for allopathic and osteopathic programs in the current	7 (see instructions)		0. 00	9. 00
	FTE count for residents in dental and podiatric programs. Current year allowable FTE (see instructions)	. year 110m your recor	us	0. 00	11.00
13.00	Total allowable FTE count for the prior year.		t 20 1007	0. 00	13.00
	Total allowable FTE count for the penultimate year if that year otherwise enter zero.	ended on or after Sep	otember 30, 1997,		14.00
16. 00	Sum of lines 12 through 14 divided by 3. Adjustment for residents in initial years of the program (see in Adjustment for residents displaced by program or hospital closures.	-		0. 00	15. 00 16. 00 17. 00
18. 00	Adjusted rolling average FTE count	е		0. 00	18. 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	
	Enter the lesser of lines 19 or 20 (see instructions)			0. 000000	
22. 00 22. 01	IME payment adjustment (see instructions) IME payment adjustment - Managed Care (see instructions)			0	
23. 00	Indirect Medical Education Adjustment for the Add-on for § 422 c Number of additional allopathic and osteopathic IME FTE residen		FR 412. 105	0.00	23. 00
24. 00 25. 00	<pre>(f)(1)(iv)(C). IME FTE Resident Count Over Cap (see instructions) If the amount on line 24 is greater than -0-, then enter the low</pre>	wor of line 22 or line	24 (500	0. 00 0. 00	
26. 00	instructions) Resident to bed ratio (divide line 25 by line 4)	vei of fille 25 of fille	: 24 (See	0. 000000	
27. 00	IME payments adjustment factor. (see instructions)			0. 000000	27. 00
	IME add-on adjustment amount (see instructions) IME add-on adjustment amount - Managed Care (see instructions)			0	28. 00 28. 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 pati	ent days (see instruc	etions)	2. 90	30.00
31.00	Percentage of Medicaid patient days (see instructions)	,	ŕ	27. 46	31.00
	Sum of lines 30 and 31 Allowable disproportionate share percentage (see instructions)			30. 36 12. 00	32. 00 33. 00

CALCUI	n Financial Systems HUNTINGTON MEMOR			u of Form CMS-2	2552-10
0.	LATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 15-0091	Peri od: From 01/01/2022 To 12/31/2022		pared:
		Title William	11	5/18/2023 11:	36 am
		Title XVIII	Hospi tal	PPS	
				1. 00	
34.00	Disproportionate share adjustment (see instructions)		Dri or to 10/1	62, 176	34.00
			Prior to 10/1 1.00	2. 00	
	Uncompensated Care Payment Adjustment				
35.00	,			6, 874, 063, 173	
35. 01 35. 02	Factor 3 (see instructions) Hospital UCP, including supplemental UCP (If line 34 is zero	o enter zero on this line	0. 000086318 e) 620, 327	0. 000095135 653, 964	
33. 02	(see instructions)	o, enter zero on this init	020, 327	033, 704	33.02
35. 03		UCP (see instructions)	463, 970	164, 835	35. 03
36. 00	Total UCP adjustment (sum of columns 1 and 2 on line 35.03)		628, 805		36.00
40. 00	Additional payment for high percentage of ESRD beneficiary of Total Medicare discharges (see instructions)	discharges (lines 40 throi	ugh 46) 0		 40. 00
41.00			0		41.00
41. 01	Total ESRD Medicare covered and paid discharges (see instruc	ctions)	0		41. 01
42.00	Divide line 41 by line 40 (if less than 10%, you do not qual	lify for adjustment)	0. 00		42.00
43.00	Total Medicare ESRD inpatient days (see instructions)		0		43.00
44. 00	Ratio of average length of stay to one week (line 43 divided days)	d by line 41 divided by /	0. 000000		44.00
45. 00		ns)	0. 00		45. 00
46.00	1 3 1	41. 01)	0		46.00
47.00	,		2, 763, 511		47.00
48. 00	Hospital specific payments (to be completed by SCH and MDH, only. (see instructions)	small rural hospitals	0		48. 00
	only. (see Tristi detions)			Amount	
				1. 00	
49. 00		•		2, 763, 511	
50.00)	156, 569 0	
51. 00 52. 00				0	51.00 52.00
53.00		Title 47 see Thisti detrons).		Ö	53.00
54.00				0	54.00
54. 01	Islet isolation add-on payment			0	54. 01
55.00	, ,	69)		0	55.00
55. 01 56. 00		tructions)		0	55. 01 56. 00
57.00			through 35)	0	57.00
58. 00			em ough oo).	0	58.00
59. 00		•		2, 920, 080	59.00
60.00				1, 437	
61.00	1 3 1 3	us line 60)		2, 918, 643	
62. 00 63. 00	. 9			362, 169 0	
	Allowable bad debts (see instructions)			14, 792	
65.00				9, 615	1
66.00	,	structions)		7, 149	
67.00	Subtotal (line 61 plus line 65 minus lines 62 and 63)	A CONTRACTOR OF THE PROPERTY OF		2, 566, 089	
68.00	· ·			0	68. 00 69. 00
	,). (101 301 3ee 1113ti deti ol	13)	0	70.00
69. 00 70. 00		stration) adjustment (see	instructions)	0	70. 50
70. 00 70. 50	Rural Community Hospital Demonstration Project (§410A Demons				70. 75
70. 00 70. 50 70. 75	N95 respirator payment adjustment amount (see instructions)			0	l
70. 00 70. 50 70. 75 70. 87	N95 respirator payment adjustment amount (see instructions) Demonstration payment adjustment amount before sequestration			0	
70. 00 70. 50 70. 75 70. 87 70. 88	N95 respirator payment adjustment amount (see instructions) Demonstration payment adjustment amount before sequestration SCH or MDH volume decrease adjustment (contractor use only)	n			70. 88
70. 00 70. 50 70. 75 70. 87 70. 88 70. 89	N95 respirator payment adjustment amount (see instructions) Demonstration payment adjustment amount before sequestration SCH or MDH volume decrease adjustment (contractor use only) Pioneer ACO demonstration payment adjustment amount (see instructions)	n		0	70. 88 70. 89
70. 00 70. 50 70. 75 70. 87 70. 88	N95 respirator payment adjustment amount (see instructions) Demonstration payment adjustment amount before sequestration SCH or MDH volume decrease adjustment (contractor use only) Pioneer ACO demonstration payment adjustment amount (see instructions)	n		0	70. 88 70. 89 70. 90
70. 00 70. 50 70. 75 70. 87 70. 88 70. 89 70. 90	N95 respirator payment adjustment amount (see instructions) Demonstration payment adjustment amount before sequestration SCH or MDH volume decrease adjustment (contractor use only) Pioneer ACO demonstration payment adjustment amount (see instructions) HSP bonus payment HVBP adjustment amount (see instructions)	n		0	70. 88 70. 89 70. 90 70. 91
70. 00 70. 50 70. 75 70. 87 70. 88 70. 89 70. 90 70. 91	N95 respirator payment adjustment amount (see instructions) Demonstration payment adjustment amount before sequestration SCH or MDH volume decrease adjustment (contractor use only) Pioneer ACO demonstration payment adjustment amount (see instructions) HSP bonus payment HVBP adjustment amount (see instructions) HSP bonus payment HRR adjustment amount (see instructions) Bundled Model 1 discount amount (see instructions) HVBP payment adjustment amount (see instructions)	n		0 0 0	70. 88 70. 89 70. 90 70. 91 70. 92 70. 93

Heal th	Financial Systems HUNTINGTON MEMOR	IAL HOSPITAL		In Lie	u of Form CMS-2	2552-10
CALCULA	NTION OF REIMBURSEMENT SETTLEMENT	Provi der C	CN: 15-0091	Period: From 01/01/2022 To 12/31/2022	Date/Time Pre	
		Ti +l c	· XVIII	Hospi tal	5/18/2023 11: PPS	30 alli
		11110		' (yyyy)	Amount	
				0	1. 00	
70. 96	Low volume adjustment for federal fiscal year (yyyy) (Enter the corresponding federal year for the period prior to 10/1			2022	284, 487	70. 96
	Low volume adjustment for federal fiscal year (yyyy) (Enter the corresponding federal year for the period ending on or a	in column 0		2023	138, 955	70. 97
	Low Volume Payment-3	,			0	70. 98
70. 99	HAC adjustment amount (see instructions)				18, 999	70. 99
71.00	Amount due provider (line 67 minus lines 68 plus/minus lines	s 69 & 70)			2, 970, 532	71.00
71. 01	Sequestration adjustment (see instructions)				37, 428	71.01
	Demonstration payment adjustment amount after sequestration				0	71.02
	Sequestration adjustment-PARHM or CHART pass-throughs					71.03
	Interim payments				2, 706, 294	
	Interim payments-PARHM or CHART				_	72. 01
	Tentative settlement (for contractor use only)				0	
	Tentative settlement-PARHM or CHART (for contractor use on				227 010	73.01
74. 00	Balance due provider/program (line 71 minus lines 71.01, 71. 73)	. U2, 72, and			226, 810	74.00
74. 01	Balance due provider/program-PARHM or CHART (see instruction	ns)				74. 01
75.00	Protested amounts (nonallowable cost report items) in accord	dance with			80, 974	75.00
	CMS Pub. 15-2, chapter 1, §115.2					
	TO BE COMPLETED BY CONTRACTOR (lines 90 through 96)		1			4
	Operating outlier amount from Wkst. E, Pt. A, line 2, or sur	m of 2.03			0	90.00
	plus 2.04 (see instructions) Capital outlier from Wkst. L, Pt. I, line 2				0	91.00
	Operating outlier reconciliation adjustment amount (see ins	tructions)			0	
	Capital outlier reconciliation adjustment amount (see instri				0	
	The rate used to calculate the time value of money (see ins				0.00	
	Time value of money for operating expenses (see instructions	,			0	
	Time value of money for capital related expenses (see instr				Ö	
		,	'	Prior to 10/1	On/After 10/1	
				1. 00	2. 00	
	HSP Bonus Payment Amount					
	HSP bonus amount (see instructions)			0	0	100.00
	HVBP Adjustment for HSP Bonus Payment					4
	HVBP adjustment factor (see instructions)			0. 0000000000	0. 0000000000	
	HVBP adjustment amount for HSP bonus payment (see instruction	ons)		0	0	102.00
	HRR Adjustment for HSP Bonus Payment			0.0000	0.0000	100.00
	HRR adjustment factor (see instructions))		0.0000	0. 0000	
	HRR adjustment amount for HSP bonus payment (see instruction Rural Community Hospital Demonstration Project (§410A Demons		uctmont	0	0	104. 00
	Is this the first year of the current 5-year demonstration					200.00
200.00	Century Cures Act? Enter "Y" for yes or "N" for no.	berroa anaer	the 213t			200.00
	Cost Reimbursement					
	Medicare inpatient service costs (from Wkst. D-1, Pt. II, Ii	ine 49)				201.00
	Medicare discharges (see instructions)	/				202.00
	Case-mix adjustment factor (see instructions)					203.00
	Computation of Demonstration Target Amount Limitation (N/A i	n first year	of the curre	ent 5-year demons	trati on	
	peri od)					
	Medicare target amount					204 00

TO BE COMPLETED BY CONTRACTOR (Lines 90 through 96)			1
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)			
91.00 Capital outlier from Wkst. L, Pt. I, line 2		ol	91.00
92.00 Operating outlier reconciliation adjustment amount (see instructions)		l ol	92.00
93.00 Capital outlier reconciliation adjustment amount (see instructions)		l ol	93.00
94.00 The rate used to calculate the time value of money (see instructions)		0.00	94.00
95.00 Time value of money for operating expenses (see instructions)		0	
96.00 Time value of money for capital related expenses (see instructions)		0	
70. 00 Time value of money for capital for a capital for	Prior to 10/1		70.00
	1. 00	2. 00	
HSP Bonus Payment Amount	1 00	2.00	
100.00 HSP bonus amount (see instructions)	0	0	100.00
HVBP Adjustment for HSP Bonus Payment			
101.00 HVBP adjustment factor (see instructions)	0. 0000000000	0. 0000000000	101.00
102.00 HVBP adjustment amount for HSP bonus payment (see instructions)	0		102.00
HRR Adjustment for HSP Bonus Payment		_	
103.00HRR adjustment factor (see instructions)	0.0000	0.0000	103.00
104.00 HRR adjustment amount for HSP bonus payment (see instructions)	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 cu	rrent 5-vear demons		200.00
period)	arrent e gear demend		
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)		l .	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	t)	l .	218.00
(line 212 minus line 213) (see instructions)			
1	ı l		

Health Financial Systems	HUNTINGTON MEMORIAL HOSPITAL	In Lie	u of Form CMS-2552-10
CALCULATION OF REIMBURSEMENT SETTLEMENT	Provi der CCN: 15-0091	Peri od: From 01/01/2022 To 12/31/2022	Worksheet E Part B Date/Time Prepared: 5/18/2023 11:36 am

	Title XVIII Hosp	i tal	5/18/2023 11: PPS	36 am_
		rtai		
	DADT D. HEDLOAL AND OTHER HEALTH CERVICES		1. 00	
1. 00	PART B - MEDICAL AND OTHER HEALTH SERVICES Medical and other services (see instructions)		0	1.00
2. 00	Medical and other services reimbursed under OPPS (see instructions)		3, 758, 567	2.00
3. 00	OPPS payments		3, 527, 726	
4.00	Outlier payment (see instructions)		5, 235	
4. 01	Outlier reconciliation amount (see instructions)		0	4. 01
5. 00 6. 00	Enter the hospital specific payment to cost ratio (see instructions) Line 2 times line 5		0. 859 3, 228, 609	5. 00 6. 00
7. 00	Sum of lines 3, 4, and 4.01, divided by line 6		0.00	
8. 00	Transitional corridor payment (see instructions)		0	
9. 00	Ancillary service other pass through costs from Wkst. D, Pt. IV, col. 13, line 200		0	9. 00
10.00			0	10.00
11. 00			0	11. 00
	COMPUTATION OF LESSER OF COST OR CHARGES Reasonable charges			
12. 00			0	12.00
13.00	Organ acquisition charges (from Wkst. D-4, Pt. III, col. 4, line 69)		0	13.00
14.00			0	14.00
15 00	Customary charges Aggregate amount actually collected from patients liable for payment for services on a charge	, basi s	0	15. 00
15. 00 16. 00				
10.00	had such payment been made in accordance with 42 CFR §413.13(e)	gebasis		10.00
17. 00	Ratio of line 15 to line 16 (not to exceed 1.000000)		0.000000	17. 00
18. 00			0	
19. 00		see	0	19. 00
20. 00	instructions) Excess of reasonable cost over customary charges (complete only if line 11 exceeds line 18) (see	o	20. 00
20.00	instructions)	000		20.00
21.00	g ,		0	
22. 00	· · · · · · · · · · · · · · · · · · ·		0	
23. 00 24. 00			0 3, 532, 961	
24.00	COMPUTATION OF REIMBURSEMENT SETTLEMENT		3, 532, 401	24.00
25.00			710, 372	25. 00
26. 00	Deductibles and Coinsurance amounts relating to amount on line 24 (for CAH, see instructions)		0	26. 00
27. 00	, , ,	(see	2, 822, 589	27. 00
28. 00	instructions) Direct graduate medical education payments (from Wkst. E-4, line 50)		o	28. 00
29. 00				29.00
30. 00			2, 822, 589	
31.00	Primary payer payments		773	31.00
32. 00			2, 821, 816	32.00
22 00	ALLOWABLE BAD DEBTS (EXCLUDE BAD DEBTS FOR PROFESSIONAL SERVICES) Composite rate ESRD (from Wkst. I-5, line 11)		0	33. 00
34. 00			49, 358	
35.00	· · · · · · · · · · · · · · · · · · ·		32, 083	
36. 00	, , ,		33, 987	
37.00			2, 853, 899	37. 00 38. 00
38. 00 39. 00				39.00
39. 50				39. 50
39. 75			0	39. 75
39. 97			0	39. 97
39. 98	, , , , , , , , , , , , , , , , , , , ,		0	
39. 99 40. 00			0 2, 853, 899	39. 99 40. 00
40. 01	Sequestration adjustment (see instructions)		35, 959	
40. 02			0	40. 02
40. 03				40. 03
41.00			2, 784, 912	
41. 01 42. 00			0	41. 01 42. 00
42. 00	Tentative settlement-PARHM or CHART (for contractor use only)		l "l	42.00
43. 00			33, 028	
43. 01	, , , , , , , , , , , , , , , , , , , ,			43. 01
44. 00		1,	0	44. 00
	§115. 2 TO BE COMPLETED BY CONTRACTOR			
90. 00	Original outlier amount (see instructions)		0	90.00
91. 00			Ö	
92.00			1	92.00
93.00			0	93. 00 94. 00
74. UU	Total (sum of lines 91 and 93)		۱	74.00

Health Financial Systems	HUNTINGTON MEMORIA	L HOSPITAL	In Lieu	of Form CMS	-2552-10
CALCULATION OF REIMBURSEMENT SETTLEMENT			Peri od:	Worksheet E	
			From 01/01/2022		
			To 12/31/2022		
				5/18/2023 11	:36 am_
		Title XVIII	Hospi tal	PPS	
				1. 00	
MEDICARE PART B ANCILLARY COSTS					
200.00 Part B Combined Billed Days					0 200. 00

Health Financial Systems HUNTING ANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED Peri od: Worksheet E-1
From 01/01/2022 Part I
To 12/31/2022 Date/Time Prepared: 5/18/2023 11:36 am Provider CCN: 15-0091

					5/18/2023 11:	36 am
			XVIII	Hospi tal	PPS	
		Inpati en	it 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		2, 706, 294		2, 784, 912	1.00
2.00	Interim payments payable on individual bills, either			1	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	T	1		_	
3. 01	ADJUSTMENTS TO PROVIDER		0		0	3. 01
3. 02			0		0	3.02
3. 03			0		0	3. 03
3. 04			0		0	3.04
3. 05	Dec. 1 Lea Le Berreire		0		0	3. 05
0 50	Provi der to Program		1			0.50
3. 50	ADJUSTMENTS TO PROGRAM		0		0	3. 50
3. 51 3. 52						3. 51
3. 52 3. 53						3. 52 3. 53
3. 53						3. 53
3. 99	Subtotal (sum of lines 3.01-3.49 minus sum of lines					3. 99
3. 77	3. 50-3. 98)				0	3. 77
4. 00	Total interim payments (sum of lines 1, 2, and 3.99)		2, 706, 294		2, 784, 912	4. 00
4.00	(transfer to Wkst. E or Wkst. E-3, line and column as		2,700,274		2,704,712	4.00
	appropriate)					
	TO BE COMPLETED BY CONTRACTOR			"	<u>'</u>	
5.00	List separately each tentative settlement payment after					5.00
	desk review. Also show date of each payment. If none,					
	write "NONE" or enter a zero. (1)					
	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	1		1		
5. 50	TENTATI VE TO PROGRAM		0		0	5. 50
5. 51			0		0	5. 51
5. 52	Cultural (2000 26 1) 222 E 01 E 10 1 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2		0		0	5. 52
5. 99	Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98)		C		0	5. 99
6.00	Determined net settlement amount (balance due) based on					6.00
	the cost report. (1)					
6. 01	SETTLEMENT TO PROVIDER		226, 810		33, 028	6. 01
6.02	SETTLEMENT TO PROGRAM		0		0	6. 02
7.00	Total Medicare program liability (see instructions)		2, 933, 104		2, 817, 940	7.00
				Contractor	NPR Date	
				Number	(Mo/Day/Yr)	
	In the second se	()	1. 00	2. 00	
8.00	Name of Contractor					8. 00

Heal th	Financial Systems HUNTINGTON MEMORIA	AL HOSPITAL	In Lie	u of Form CMS-	-2552-10
CALCUL	ATION OF REIMBURSEMENT SETTLEMENT FOR HIT	Provider CCN: 15-0091	Peri od:	Worksheet E-	1
			From 01/01/2022 To 12/31/2022	Part II Date/Time Pr	oparod:
			10 12/31/2022	5/18/2023 11	
		Title XVIII	Hospi tal	PPS	
	<u> </u>				
				1.00	
	TO BE COMPLETED BY CONTRACTOR FOR NONSTANDARD COST REPORTS				4
	HEALTH INFORMATION TECHNOLOGY DATA COLLECTION AND CALCULATION				
1. 00	Total hospital discharges as defined in AARA §4102 from Wkst.	S-3, Pt. I col. 15 lin	e 14		1.00
2. 00					2.00
	3.00 Medicare HMO days from Wkst. S-3, Pt. I, col. 6. line 2				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 I				6.00
7. 00	CAH only - The reasonable cost incurred for the purchase of c	certified HII technology	Wkst. S-2, Pt. I		7. 00
0.00	line 168				0.00
8. 00	Calculation of the HIT incentive payment (see instructions)				8.00
9.00	Sequestration adjustment amount (see instructions)	(!tt!)			9.00
10. 00	Calculation of the HIT incentive payment after sequestration	(see instructions)			10.00
20.00	INPATIENT HOSPITAL SERVICES UNDER THE IPPS & CAH				30.00
	Initial/interim HIT payment adjustment (see instructions)				31.00
	Other Adjustment (specify)	ino 21) (soo instructio	nc)		32.00
32.00	Balance due provider (line 8 (or line 10) minus line 30 and l	The 31) (See Thistruction	115)		J 32.00

Heal th			u of Form CMS-2	552-10	
OUTLI E	R RECONCILIATION AT TENTATIVE SETTLEMENT	Provider CCN: 15-0091	Peri od:	Worksheet E-5	
			From 01/01/2022 To 12/31/2022	Date/Time Prep 5/18/2023 11:3	
		Title XVIII		PPS	30 aiii
				1. 00	
	TO BE COMPLETED BY CONTRACTOR				
1.00	Operating outlier amount from Wkst. E, Pt. A, line 2, or su	m 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 ins	tructions)		0	3.00
4.00	Capital outlier reconciliation adjustment amount (see instr	uctions)		0	4.00
5.00	The rate used to calculate the time value of money (see ins	tructions)		0.00	5.00
6.00	Time value of money for operating expenses (see instruction	s)		0	6.00
7.00	Time value of money for capital related expenses (see instr	uctions)		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

Peri od: From 01/01/2022 To 12/31/2022 Date/Time Prepared: 5/18/2023 11: 36 am

——————————————————————————————————————	<u> </u>				5/18/2023 11:	36 am
		General Fund	Specific Purpose Fund	Endowment Fund	Plant Fund	
		1.00	2.00	3. 00	4. 00	
	CURRENT ASSETS					
1.00	Cash on hand in banks	2, 324		0	0	
2.00	Temporary investments	0	0	0		1
3. 00 4. 00	Notes recei vabl e Accounts recei vabl e	24, 671, 619	0	0	0	3. 00 4. 00
5. 00	Other receivable	24,071,019		0	0	5.00
6. 00	Allowances for uncollectible notes and accounts receivable	-15, 934, 143	1	0	0	
7. 00	Inventory	420, 816		0	0	7. 00
8.00	Prepai d expenses	-10, 534	0	0	0	
9. 00	Other current assets	0	0	0	0	
10.00	Due from other funds	19, 698, 023		0	0	
11. 00	Total current assets (sum of lines 1-10) FIXED ASSETS	28, 848, 105	0	0	0	11.00
12. 00	Land	1 0	0	0	0	12.00
13. 00	Land improvements	645, 981		0	0	13.00
14. 00	Accumulated depreciation	-526, 425		0	0	14.00
15.00	Bui I di ngs	10, 173, 038	0	0	0	15.00
16.00	Accumulated depreciation	-3, 270, 576	0	0	0	16.00
17. 00	Leasehold improvements	1, 457, 481		0	0	17.00
18.00	Accumulated depreciation	-921, 247		0	0	18.00
19. 00 20. 00	Fixed equipment	336, 828 -269, 901		0	0	19. 00 20. 00
21.00	Accumulated depreciation Automobiles and trucks	1, 273, 427		0	0	21.00
22. 00	Accumulated depreciation	-1, 081, 266		0	0	22.00
23. 00	Major movable equipment	13, 125, 445		0	0	23.00
24. 00	Accumulated depreciation	-10, 823, 615	1	0	0	24. 00
25.00	Mi nor equi pmen't depreci abl e	2, 075, 082		0	0	25. 00
26.00	Accumulated depreciation	-1, 093, 008	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	70, 904		0	0	29.00
30. 00	Total fixed assets (sum of lines 12-29) OTHER ASSETS	11, 172, 148	0	0	0	30.00
31. 00	Investments	44, 214, 026	ol ol	0	0	31.00
32. 00	Deposits on Leases	0	o o	0	Ö	32.00
33.00	Due from owners/officers	0	0	0	0	33.00
34.00	Other assets	253, 692		0	0	34.00
35.00	Total other assets (sum of lines 31-34)	44, 467, 718		0	0	35.00
36. 00	Total assets (sum of lines 11, 30, and 35)	84, 487, 971	0	0	0	36.00
37. 00	CURRENT LIABILITIES Accounts payable	1, 252, 984	. 0	0	0	37.00
38.00	Salaries, wages, and fees payable	1, 039, 707		0	0	38.00
39. 00	Payrol I taxes payable	1,037,707		0	0	
40. 00	Notes and Loans payable (short term)	192, 590	Ö	0	0	
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	2, 932, 763		0	0	1
45. 00	Total current liabilities (sum of lines 37 thru 44) LONG TERM LIABILITIES	5, 418, 044	. 0	0	0	45.00
46. 00	Mortgage payable	1	ol ol	0	0	46.00
47. 00	Notes payable	334, 155		0	0	
48. 00	Unsecured Loans	0	Ö	0		
49.00	Other long term liabilities	0	0	0	0	49. 00
50.00	Total long term liabilities (sum of lines 46 thru 49)	334, 155	0	0		50.00
51. 00	Total liabilities (sum of lines 45 and 50)	5, 752, 199	0	0	0	51.00
F0 00	CAPI TAL ACCOUNTS	70 705 770				F0 00
52. 00 53. 00	General fund balance Specific purpose fund	78, 735, 772	0			52. 00 53. 00
54. 00	Donor created - endowment fund balance - restricted		J	0		54.00
55. 00	Donor created - endowment fund balance - unrestricted			0		55.00
56. 00	Governing body created - endowment fund balance			0		56.00
57.00	Plant fund balance - invested in plant				0	57.00
58. 00	Plant fund balance - reserve for plant improvement,				0	58. 00
FO 05	replacement, and expansion	70 705		_	_	F0 00
59.00	Total fund balances (sum of lines 52 thru 58)	78, 735, 772		0	0	59.00
60.00	Total liabilities and fund balances (sum of lines 51 and 59)	84, 487, 971		0		60.00
	1~``	I	1		ı	I

STATEMENT OF CHANGES IN FUND BALANCES

Provider CCN: 15-0091

Peri od: Worksheet G-1 From 01/01/2022 To 12/31/2022 Date/Time Prepared:

5/18/2023 11:36 am General Fund Special Purpose Fund Endowment Fund 5.00 1. 00 2.00 3. 00 4.00 1.00 Fund balances at beginning of period 81, 778, 681 0 1.00 Net income (loss) (from Wkst. G-3, line 29) -3, 613, 831 2.00 2.00 3.00 Total (sum of line 1 and line 2) 78, 164, 850 ol 3.00 4.00 NONALLOWABLE HOME OFFICE INTEREST EX 570, 922 4.00 0 5.00 0 5.00 0 6.00 0 0 0 0 6.00 0 7.00 0 7.00 8.00 0 8.00 9.00 0 9.00 10.00 Total additions (sum of line 4-9) 570, 922 0 10.00 Subtotal (line 3 plus line 10) 78, 735, 772 0 11.00 11.00 12.00 Deductions (debit adjustments) (specify) 0 12.00 000000 13.00 0 13.00 14.00 0 0 14.00 15.00 0 15.00 16.00 0 16.00 17.00 17.00 18.00 Total deductions (sum of lines 12-17) 18.00 0 Fund balance at end of period per balance 78, 735, 772 19.00 19.00 sheet (line 11 minus line 18) Endowment Plant Fund Fund 6.00 8.00 7.00 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 Total (sum of line 1 and line 2) 0 0 3.00 3.00 NONALLOWABLE HOME OFFICE INTEREST EX 4.00 4.00 5.00 0 5.00 6.00 0 6.00 0 7.00 7.00 8.00 0 8.00 9.00 0 9.00 Total additions (sum of line 4-9) 0 10.00 10.00 11.00 Subtotal (line 3 plus line 10) 0 11.00 Deductions (debit adjustments) (specify) 12.00 12.00 13.00 0 13.00 14.00 0 14.00 15.00 15.00 16.00 0 16.00 17.00 17.00 C Total deductions (sum of lines 12-17) 18.00 0 18.00 Fund balance at end of period per balance 0 0 19.00 sheet (line 11 minus line 18)

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

		1	0 12/31/2022	Date/Time Pre 5/18/2023 11:	
	Cost Center Description	I npati ent	Outpati ent	Total	oo aiii
		1.00	2. 00	3. 00	
	PART I - PATIENT REVENUES				
	General Inpatient Routine Services				1
1.00	Hospi tal	9, 886, 445		9, 886, 445	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	Swi ng bed - SNF	0		0	5.00
6.00	Swing bed - NF	0		0	6.00
7.00	SKILLED NURSING FACILITY				7. 00
8.00	NURSING FACILITY				8.00
9.00	OTHER LONG TERM CARE				9. 00
10.00	Total general inpatient care services (sum of lines 1-9)	9, 886, 445		9, 886, 445	10.00
	Intensive Care Type Inpatient Hospital Services				
11. 00	INTENSIVE CARE UNIT				11.00
12.00	CORONARY CARE UNIT				12.00
13.00	BURN INTENSIVE CARE UNIT				13.00
	SURGI CAL I NTENSI VE CARE UNI T				14.00
15. 00	OTHER SPECIAL CARE (SPECIFY)				15.00
16. 00	Total intensive care type inpatient hospital services (sum of lines	0		0	16. 00
	11-15)				
17. 00	Total inpatient routine care services (sum of lines 10 and 16)	9, 886, 445		9, 886, 445	1
18. 00	Ancillary services	35, 409, 903		35, 409, 903	1
	Outpati ent servi ces	0	185, 720, 673	185, 720, 673	•
20. 00	RURAL HEALTH CLINIC	0	· ·	0	
21. 00	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	21.00
22. 00	HOME HEALTH AGENCY				22.00
23. 00	AMBULANCE SERVICES	0	22, 574, 685	22, 574, 685	1
24. 00	CMHC				24.00
25. 00	AMBULATORY SURGICAL CENTER (D. P.)				25. 00
26. 00	HOSPI CE				26.00
27. 00	OTHER (SPECIFY)	45 00/ 0/0	0	0	27. 00
28. 00	Total patient revenues (sum of lines 17-27)(transfer column 3 to Wkst.	45, 296, 348	208, 295, 358	253, 591, 706	28. 00
	G-3, line 1)				
29. 00	PART II - OPERATING EXPENSES Operating expenses (per Wkst. A, column 3, line 200)		64, 887, 630		29. 00
30.00	PROVISION FOR B/D	3, 657, 555			30.00
31. 00	HOME OFFICE INTEREST EXPENSE	570, 922			31.00
32. 00	HOWE OFFICE INTEREST EXPENSE	370, 922			32.00
33. 00					33.00
34. 00					34.00
35. 00					35.00
36. 00	Total additions (sum of lines 30-35)	9	4, 228, 477		36.00
37. 00	DEDUCT (SPECIFY)	0	4, 220, 477		37.00
38. 00	DEBOCT (SILECTITY)	0			38.00
39. 00					39.00
40. 00					40.00
41. 00					41.00
42. 00	Total deductions (sum of lines 37-41)		n		42.00
43. 00	Total operating expenses (sum of lines 29 and 36 minus line 42)(transfe	er	69, 116, 107		43.00
.5. 50	to Wkst. G-3, line 4)	•	0,,,10,		10.00
		•	'		'

Hoal +b	Financial Systems HUNTINGTON MEMORIA	AL HOSDITAL	In Lie	u of Form CMS-2	DEE2 10
	Financial Systems HUNTINGTON MEMORIA ENT OF REVENUES AND EXPENSES	Provider CCN: 15-0091	Peri od:	Worksheet G-3	
SIAIL	ENT OF REVENUES AND EXITENSES	110VI del CCN. 13-0071	From 01/01/2022	WOI KSHEET U-3	
			To 12/31/2022		
				5/18/2023 11:	36 am
				4.00	
1 00	Total and the first of the firs	00)		1.00	1 00
1.00	Total patient revenues (from Wkst. G-2, Part I, column 3, lir			253, 591, 706	1.00
2.00	Less contractual allowances and discounts on patients' accour	ITS		184, 333, 880	2.00
3.00	Net patient revenues (line 1 minus line 2)	40)		69, 257, 826	3.00
4.00	Less total operating expenses (from Wkst. G-2, Part II, line	43)		69, 116, 107	
5. 00	Net income from service to patients (line 3 minus line 4)			141, 719	5.00
, 00	OTHER I NCOME				, 00
6. 00	Contributions, donations, bequests, etc			0	6.00
7.00	Income from investments			-5, 616, 409	7.00
8.00	Revenues from telephone and other miscellaneous communication	n servi ces		0	8.00
9.00	Revenue from television and radio service			0	9.00
10.00	Purchase discounts			0	10.00
11. 00	Rebates and refunds of expenses			0	11.00
12. 00	Parking lot receipts			0	12.00
	Revenue from Laundry and Linen service			0	13.00
	Revenue from meals sold to employees and guests			305, 459	
	Revenue from rental of living quarters			0	15. 00
	Revenue from sale of medical and surgical supplies to other t	than patients		0	16. 00
	Revenue from sale of drugs to other than patients			0	17.00
	Revenue from sale of medical records and abstracts			0	18. 00
19. 00	Tuition (fees, sale of textbooks, uniforms, etc.)			0	19.00
20. 00	Revenue from gifts, flowers, coffee shops, and canteen			0	20.00
21.00	Rental of vending machines			0	21.00
22. 00	Rental of hospital space			0	22.00
23.00	Governmental appropriations			0	23.00
24.00	EMS SUBSIDY			474, 470	24.00
24. 01	OTHER OPERATING REVENUE			1, 080, 930	24. 01
24. 50	COVI D-19 PHE Fundi ng			0	24.50
25 00	Total other income (sum of lines 6.24)			2 755 550	25 00

-3, 755, 550

-3, 613, 831

-3, 613, 831 29.00

50 25.00 31 26.00 0 27.00 0 28.00

24.50 COVID-19 PHE Funding
25.00 Total other income (sum of lines 6-24)
26.00 Total (line 5 plus line 25)
27.00 OTHER EXPENSES (SPECIFY)
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)

	ATION OF CAPITAL PAYMENT	Provi der CCN: 15-0091	Peri od: From 01/01/2022 To 12/31/2022		
			To 12/31/2022		pared:
1.00		Title XVIII	Hospi tal	PPS	30 alli
1 00			110001 tu		
				1. 00	
	PART I - FULLY PROSPECTIVE METHOD				1
	CAPITAL FEDERAL AMOUNT Capital DRG other than outlier			154 704	1 00
1. 00 1. 01	Model 4 BPCI Capital DRG other than outlier			154, 726 0	1
2. 00	Capital DRG outlier payments			1, 843	1
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	tructions)	11. 79	3.00
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	e sum of lines 1 and 1.0°	I, columns 1 and	0	6. 00
7. 00	1.01)(see instructions) Percentage of SSI recipient patient days to Medicare Part A	nationt days (Workshoot)	nart Aline	0. 00	7.00
7.00	30) (see instructions)	patrent days (worksheet i	, part A Title	0.00	7.00
8. 00	Percentage of Medicaid patient days to total days (see instr	ructions)		0. 00	8.00
9.00	Sum of lines 7 and 8	•		0. 00	9. 00
	Allowable disproportionate share percentage (see instruction	s)		0. 00	
11.00	Disproportionate share adjustment (see instructions)			0	
12.00	Total prospective capital payments (see instructions)			156, 569	12.00
				1. 00	
	PART II - PAYMENT UNDER REASONABLE COST				
1.00	Program inpatient routine capital cost (see instructions)			0	
2.00	Program inpatient ancillary capital cost (see instructions)			0	
3.00	Total inpatient program capital cost (line 1 plus line 2)			0	
4. 00 5. 00	Capital cost payment factor (see instructions) Total inpatient program capital cost (line 3 x line 4)			0	
5.00	Total Tripatient program capital cost (Trie 3 x Trie 4)			U	3.00
				1. 00	
	PART III - COMPUTATION OF EXCEPTION PAYMENTS				
1.00	Program inpatient capital costs (see instructions)	ess (see i petrusti ess)		0	1
2. 00 3. 00	Program inpatient capital costs for extraordinary circumstan Net program inpatient capital costs (line 1 minus line 2)	ices (see mistructions)		0	
4. 00	Applicable exception percentage (see instructions)			0. 00	
5. 00	Capital cost for comparison to payments (line 3 x line 4)			0.00	
6. 00	Percentage adjustment for extraordinary circumstances (see i	nstructions)		0.00	
7.00	Adjustment to capital minimum payment level for extraordinar	y 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	,		0	
10.00	Current year comparison of capital minimum payment level to			0	
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			0	
13.00	Current year exception payment (if line 12 is positive, ente			0	
14.00	Carryover of accumulated capital minimum payment level over	capital payment for the 1	Following period	0	14.00
	(if line 12 is negative, enter the amount on this line)	estructions)		0	15 00
15 00	Current year allowable operating and capital payment (see in	ISTI UCTI ONS)		_	
15. 00 16. 00	Current year operating and capital costs (see instructions)		l	01	16.00