Health Financial Systems	UNION HOSPITAL C			u of Form CMS-2552-10
This report is required by law (42 USC 1395g; 42 CF payments made since the beginning of the cost repor				n FORM APPROVED OMB NO. 0938-0050 EXPIRES 03-31-2022
HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX COST REPO	ORT CERTIFICATION	Provider CCN: 15-1326	Period: From 01/01/2019 To 12/31/2019	Worksheet S Parts I-III Date/Time Prepared: 7/9/2020 1:42 pm
PART I - COST REPORT STATUS				
Provider 1. [X] Electronically prepared cost use only 2. [] Manually prepared cost report	t '		Date: 7/9/202	·
3.[0]If this is an amended report 4.[F]Medicare Utilization. Enter '	enter the number c 'F" for full or "L"	of times the provider for low.	resubmitted this o	cost report
use only (1) Ås Submitted 7. Contr (2) Settled without Audit 8. [N]	Received: actor No. Initial Report for Final Report for t	11 this Provider CCN 12).NPR Date: .Contractor's Vend 2.[0]If line 5, cc number of tim	or Code: 4 Jumn 1 is 4: Enter nes reopened = 0-9.
PART II - CERTIFICATION		I		
MISREPRESENTATION OR FALSIFICATION OF ANY INFORMATI ADMINISTRATIVE ACTION, FINE AND/OR IMPRISONMENT UNE PROVIDED OR PROCURED THROUGH THE PAYMENT DIRECTLY OF ADMINISTRATIVE ACTION, FINES AND/OR IMPRISONMENT MA CERTIFICATION BY CHIEF FINANCIAL OFFICER OF	DER FEDERAL LAW. F DR INDIRECTLY OF A NY RESULT.	URTHERMORE, IF SERVI KICKBACK OR WERE OTH	CES IDENTIFIED IN 1	THIS REPORT WERE
			we are had the ear	
I HEREBY CERTIFY that I have read the above electronically filed or manually submitted Expenses prepared by UNION HOSPITAL CLINTON ending 12/31/2019 and to the best of my kno complete and prepared from the books and re except as noted. I further certify that I health care services, and that the services laws and regulations.	cost report and th N (15–1326) for t owledge and belief, ecords of the provi am familiar with t	ne Balance Sheet and the cost reporting pe this report and sta der in accordance wi the laws and regulati	Statement of Revenueriod beginning 01/0 tement are true, co th applicable instr ons regarding the p	ue and D1/2019 and prrect, ructions, provision of
[X]I have read and agree with the above of signature on this certification stater				
	(Si gned)	MATT NEALON		
	(er gried)_		nistrator of Provic	ler(s)
	-	CFO		
	I	itle		
	D	(Dated when repo ate	rt is electronicall	y signed.)
Cost Contor Description	Ti the V	Title XVIII	шт	

	Cost Center Description	Title V	Part A	Part B	HIT	Title XIX	
		1.00	2.00	3.00	4.00	5.00	
	PART III - SETTLEMENT SUMMARY						
1.00	Hospi tal	0	-70, 066	282, 691	0	-11, 578	1.00
2.00	Subprovider - IPF	0	0	0		0	2.00
3.00	Subprovider - IRF	0	0	0		0	3.00
5.00	Swing Bed - SNF	0	40, 860	0		0	5.00
6.00	Swing Bed - NF	0				0	6.00
200.00	Total	0	-29, 206	282, 691	0	-11, 578	200.00

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

PI T	AL AND HOSPITAL HEALTH CARE COMPLEX	IDENTIFICATION DA	TA	Provi d	er CCN	l: 15-1326	Period: From 01/0	01/2019		eet S-2	2
								31/2019	Date/T	ime Pre 20 1:42	
	1.00	2. (00		3.00			4.00	177720.	20 1.42	
_	Hospital and Hospital Health Care Co										ł.,
0	Street: 801 SOUTH MAIN STREET	PO Box: State: II	N 7	in Cod	. 4704						1
0	City: CLINTON	Component Na		ip Code CCN	CBS/		nty: VERMIL er Date		ent Syst	tem (P	<u></u>
				umber	Numbe		Certifi		T, 0, or		
								V	XVIII		
		1.00		2.00	3.00	0 4.00	5.00	6.00	0 7.00	8.00	
0	Hospital and Hospital-Based Componen Hospital	UNION HOSPITAL CL	1	51326	4546	0 1	03/01/20	05 N	0	0	3
0	Subprovi der – TPF	UNI UN HUSFITAL CL		51520	4540		03/01/20				4
0	Subprovi der – IRF										5
C	Subprovider - (Other)										6
C	5	SWING BEDS	1	5Z326	4546	0	03/01/20	05 N	0	0	7
))	Swing Beds - NF										8
))0	Hospital-Based SNF Hospital-Based NF										9.
00 00	Hospital-Based OLTC										111.
00	Hospital -Based HHA										12
0C	Separately Certified ASC										13.
	Hospital-Based Hospice										14
00	Hospital -Based Health Clinic - RHC										15
00 00	Hospital-Based Health Clinic - FQHC Hospital-Based (CMHC) I										16
00	Renal Dialysis										18
	Other										19
							Fre		Tc		
0	Cost Departing Design (mm (dd (uuuu))							00	2.		20
	Cost Reporting Period (mm/dd/yyyy) Type of Control (see instructions)							/2019 2	12/31	/2019	20
								۷			21
						1.00	2.	00	3.	00	1
	Inpatient PPS Information										
00	Does this facility qualify and is it					Ν		N			22
	disproportionate share hospital adju §412.106? In column 1, enter "Y" fo				<						
	facility subject to 42 CFR Section §										
	hospital?) In column 2, enter "Y" fo										
01	Did this hospital receive interim un					N	1	N			22.
	cost reporting period? Enter in colu	mn 1, "Y" for yes	or "N" f	or no t	for						
	the portion of the cost reporting pe Enter in column 2, "Y" for yes or "N										
	reporting period occurring on or aft				JUST						
02	Is this a newly merged hospital that				-e	Ν		N			22.
	payments to be determined at cost re				าร)						
	Enter in column 1, "Y" for yes or "N										
	cost reporting period prior to Octob or "N" for no, for the portion of th										
	October 1.	le cost reporting	period on	u ai							
03	Did this hospital receive a geograph	i c reclassi fi cati	on from u	rban to	5	Ν		N	1	N	22
	rural as a result of the OMB standar										
	adopted by CMS in FY2015? Enter in c										
	for the portion of the cost reportin				er						
	in column 2, "Y" for yes or "N" for reporting period occurring on or aft										
	Does this hospital contain at least				as						
	counted in accordance with 42 CFR 41	2.105)? Enter in	column 3,	"Y" f	or						
	yes or "N" for no.										
00	Which method is used to determine Me						3 1	N			23
	below? In column 1, enter 1 if date if date of discharge. Is the method										
	reporting period different from the				JUST						
	reporting period? In column 2, ente										
			In-State	In-S		Out-of	Out-of	Medi ca)ther	
			Medi cai d	Medio		State	State	HMO da	2	di cai d	
			paid days			Medicaid paid days	Medicaid eligible			days	
				unpa dav		paru uays	unpaid				
			1.00	2.0	-	3.00	4.00	5.00	<u>с с</u>	6.00	1
00	If this provider is an IPPS hospital		(-	0	0	0		0		24
	in-state Medicaid paid days in colum										
	Medicaid eligible unpaid days in col										
	out-of-state Medicaid paid days in c										1
	out_of_state Medicaid eligible upped	a dave in column									
	out-of-state Medicaid eligible unpai 4, Medicaid HMO paid and eligible bu										

	Financial Systems UNION AL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DA	HOSPITAL C	Provider CC	CN: 15-1326	Peri od:	In Lieu	Worksh		
					From 01/0 To 12/3	01/2019 31/2019	Part I Date/T 7/9/202	ime Pre 20 1:42	epareo
		In-State Medicaid paid days	In-State Medicaid eligible unpaid days	Out-of State Medicaid paid days	Out-of State Medicaid eligible unpaid	Medica HMO da	id 0 ys Meo	ther di cai d days	
		1.00	2.00	3.00	4.00	5.00		5.00	1
5. 00	If this provider is an IRF, enter the in-state Medicaid paid days in column 1, the in-state Medicaid eligible unpaid days in column 2, out-of-state Medicaid days in column 3, out-of-state Medicaid eligible unpaid days in column 4, Medicaid HMO paid and eligible but unpaid days in column 5.	0	0	0	0		0		25.
					Urban/F	Rural S 00	Date of 2.		
6.00	Enter your standard geographic classification (not wa		at the be	ginning of t	the	2			26.
	cost reporting period. Enter "1" for urban or "2" for Enter your standard geographic classification (not wa reporting period. Enter in column 1, "1" for urban of enter the effective date of the geographic reclassifi	age) status r "2" for r ication in	ural. If a column 2.	ppl i cabl e,		2			27.
5.00	If this is a sole community hospital (SCH), enter the effect in the cost reporting period.	e number of	periods S	CH status ir	n	0			35.
					Begi n	ni ng: 00	Endi 2.	5	-
. 00	Enter applicable beginning and ending dates of SCH since and enter subsequent date		cript line	36 for numb			2.		36.
. 00	of periods in excess of one and enter subsequent date If this is a Medicare dependent hospital (MDH), enter the in effect in the cost rependent in a period		r of perio	ds MDH statu	ls	0			37.
. 01	is in effect in the cost reporting period. Is this hospital a former MDH that is eligible for the accordance with FY 2016 OPPS final rule? Enter "Y" for instructions)								37
. 00	If line 37 is 1, enter the beginning and ending dates greater than 1, subscript this line for the number of enter subsequent dates.								38
					Y/ 1.		Y/ 2.		
. 00	Does this facility qualify for the inpatient hospital hospitals in accordance with 42 CFR §412.101(b)(2)(i) 1 "Y" for yes or "N" for no. Does the facility meet accordance with 42 CFR 412.101(b)(2)(i), (ii), or (ii) or "N" for no. (see instructions) Is this hospital subject to the HAC program reduction), (ii), or the mileage ii)? Enter	(iii)? En requireme in column	ter in colur nts in 2 "Y" for ye	ume M nn es	J	N	I	39. 40.
. 00	"N" for no in column 1, for discharges prior to Octol no in column 2, for discharges on or after October 1.	ber 1. Ente	r "Y" for				XVIII	XIX	40.
	<u> </u>					1.00	_	3.00	
. 00	Prospective Payment System (PPS)-Capital Does this facility qualify and receive Capital paymen	nt for disp	roportiona	te share in	accordance	e N	N	N	45.
. 00	with 42 CFR Section §412.320? (see instructions) Is this facility eligible for additional payment exco pursuant to 42 CFR §412.348(f)? If yes, complete Wks Pt. III.	•		2		N	N	N	46.
. 00 . 00	Is this a new hospital under 42 CFR §412.300(b) PPS of the facility electing full federal capital payment					N N	N N	N N	47. 48.
. 00	Teaching Hospitals Is this a hospital involved in training residents in "N" for no in column 1. If column 1 is "Y", are you i GME payment reduction? Enter "Y" for yes or "N" for	impacted by	CR 11642						56
00	If line 56 is yes, is this the first cost reporting GME programs trained at this facility? Enter "Y" for is "Y" did residents start training in the first mon for yes or "N" for no in column 2. If column 2 is "Y "N", complete Wkst. D, Parts III & IV and D-2, Pt. I	period duri r yes or "N th of this Y", complet	ng which r " for no i cost repor e Workshee	n column 1. ting period	וד column ? Enter ?	/"			57
00	If line 56 is yes, did this facility elect cost reim defined in CMS Pub. 15-1, chapter 21, §2148? If yes,	bursement f	or physici	ans' service	es as	N			58
00	Are costs claimed on line 100 of Worksheet A? If yes			1		N			59.
				NAHE 413.8 Y/N	35 Worksh Lin	neet A e #	Pass-T Qualifi Crite Co	cation rion	
. 00	Are you claiming nursing and allied health education any programs that meet the criteria under 42 CFR 413 instructions) Enter "Y" for yes or "N" for no in col is "Y", are you impacted by CR 11642 (or subsequent adjustement? Enter "Y" for yes or "N" for no in col	.85? (see Lumn 1. If CR) NAHE MA	column 1	1.00 N	2.	00	3.		60.

OSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DA		Provider CC	F		Worksheet S-2 Part I Date/Time Pre 7/9/2020 1:42	epared:
	Y/N	IME	Direct GME	IME	Direct GME	
	1.00	2.00	3.00	4.00	5.00	
1.00 Did your hospital receive FTE slots under ACA section 5503? Enter "Y" for yes or "N" for no in				0.00	0.00	61.00
column 1. (see instructions) 1.01 Enter the average number of unweighted primary care FTEs from the hospital's 3 most recent cost reports ending and submitted before March 23, 2010. (see						61.0
instructions) 1.02 Enter the current year total unweighted primary care FTE count (excluding OB/GYN, general surgery FTEs, and primary care FTEs added under section 5503 of 1.02 Constructions						61.0
 ACA). (see instructions) 1.03 Enter the base line FTE count for primary care and/or general surgery residents, which is used for determining compliance with the 75% test. (see instructions) 						61.03
1.04 Enter the number of unweighted primary care/or surgery allopathic and/or osteopathic FTEs in the						61.04
current cost reporting period. (see instructions). 1.05 Enter the difference between the baseline primary and/or general surgery FTEs and the current year's primary care and/or general surgery FTE counts (line						61. 05
 61.04 minus line 61.03). (see instructions) 1.06 Enter the amount of ACA §5503 award that is being used for cap relief and/or FTEs that are nonprimary care or general surgery. (see instructions) 						61.00
	Pro	ogram Name	Program Code	Unweighted IME FTE Count	Unweighted Direct GME FTE Count	
1.10 Of the FTEs in line 61.05, specify each new program		1.00	2.00	3.00	4.00) 61.1
 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. 1.20 Of the FTEs in line 61.05, specify each expanded program specialty, if any, and the number of FTE residents for each expanded program. (see instructions) Enter in column 1, the program name. Enter in column 2, the program code. Enter in column 3, the IME FTE unweighted count. 				0.00		61.20
					1.00	-
ACA Provisions Affecting the Health Resources and Ser				ind Care 11.1		(0.0)
 Enter the number of FTE residents that your hospital your hospital received HRSA PCRE funding (see instruct 2.01 Enter the number of FTE residents that rotated from a during in this cost reporting period of HRSA THC product Tables and the set of the second the second the second termination of termination of termination of the second termination of the second termination of termination of termination of the second termination of the second termination of terminatin of terminatin of terminatin of termination of terminatin o	ctions) a Teach gram. (ing Health Cer see instructic	nter (THC) into			62.00
Teaching Hospitals that Claim Residents in Nonprovide 3.00 Has your facility trained residents in nonprovider se "Y" for yes or "N" for no in column 1. If yes, comple	ettings	during this c			N	63.00
			Unweighted FTEs Nonprovider Site	Unweighted FTEs in Hospital	Ratio (col. 1/ (col. 1 + col. 2))	
Section 5504 of the ACA Base Year FTE Residents in No	onprovi	der Settings	1.00 -This base year	2.00	<u> </u>	
4.00 Enter in column 1, if line 63 is yes, or your facilit in the base year period, the number of unweighted nor resident FTEs attributable to rotations occurring in settings. Enter in column 2 the number of unweighted resident FTEs that trained in your hospital. Enter ir of (column 1 divided by (column 1 + column 2)). (see	re June ty trai n-prima all no d non-p n colum	30, 2010. ned residents ry care nprovider rimary care n 3 the ratio	0.00	3		64.00

	EX IDENTIFICATION D	ATA Provider C		eriod: com 01/01/2019	Worksheet S-2 Part I	
			To	12/31/2019	Date/Time Pre 7/9/2020 1:42	epare
	Program Name	Program Code	Unweighted FTEs Nonprovider Site	Unweighted FTEs in Hospital	Ratio (col. 3/ (col. 3 + col. 4))	
-	1.00	2.00	3.00	4.00	5.00	1
.00 Enter in column 1, if line 63 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 3			0.00	0.00	0. 000000	, 65.
divided by (column 3 + column 4)). (see instructions)			Unweighted	Unweighted FTEsin	Ratio (col.	
			FTEs Nonprovider Site	Hospi tal	1/ (col. 1 + col. 2))	
Section 5504 of the ACA Current	Vear ETE Decidente :	n Nonnrovidor Sottin	1.00	2.00	3.00	
beginning on or after July 1, 20		n Nonprovider Settin	igsLitective i	u cust repurt	ing perious	
.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 hospita	unweighted non-prima ccurring in all nonp unweighted non-prima al. Enter in column	provider settings. Try care resident 3 the ratio of	0.00	0.00	0. 000000	66.
00 Enter in column 1 the number of FTEs attributable to rotations of Enter in column 2 the number of	unweighted non-prima ccurring in all nonp unweighted non-prima al. Enter in column	provider settings. Try care resident 3 the ratio of	0.00 Unweighted FTEs Nonprovider Site	0.00 Unweighted FTEs in Hospital	0.000000 Ratio (col. 3/ (col. 3 + col. 4))	
 O0 Enter in column 1 the number of a FTEs attributable to rotations of Enter in column 2 the number of a FTEs that trained in your hospit. (column 1 divided by (column 1 + (column 1 divided by (column 1))) O0 Enter in column 1, the program 	unweighted non-prima ccurring in all nonp unweighted non-prima al. Enter in column column 2)). (see ir	provider settings. mry care resident 3 the ratio of mstructions)	Unweighted FTEs Nonprovider	Unweighted FTEs in Hospital 4.00	Ratio (col. 3/ (col. 3 + col. 4)) 5.00	_
00 Enter in column 1 the number of of FTEs attributable to rotations of Enter in column 2 the number of FTEs that trained in your hospit: (column 1 divided by (column 1 +	unweighted non-prima ccurring in all nonp unweighted non-prima al. Enter in column <u>column 2)). (see ir</u> Program Name	provider settings. mry care resident 3 the ratio of structions) Program Code	Unweighted FTEs Nonprovider Site 3.00	Unweighted FTEs in Hospital 4.00	Ratio (col. 3/ (col. 3 + col. 4)) 5.00	
 O0 Enter in column 1 the number of a FTEs attributable to rotations or Enter in column 2 the number of a FTEs that trained in your hospits (column 1 divided by (column 1 + (column 2 divided by (column 1 divided by (column 1 divided by (column 2 divided by (column 2 divided by (column 3 divided by (column 3 + column 4)). (see instructions) 	unweighted non-prima ccurring in all nonp unweighted non-prima al. Enter in column <u>column 2)). (see ir</u> Program Name <u>1.00</u>	provider settings. mry care resident 3 the ratio of structions) Program Code	Unweighted FTEs Nonprovider Site 3.00	Unweighted FTEs in Hospital 4.00	Rati o (col . 3/ (col . 3 + col . 4)) 5.00 0.000000	
 OD Enter in column 1 the number of a FTEs attributable to rotations or Enter in column 2 the number of a FTEs that trained in your hospit: (column 1 divided by (column 1 + (column 2 divided by column 3 divided by 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 3 divided by (column 3 divided by (column 3 + column 4)). (see instructions) Inpatient Psychiatric Facility P O0 Is this facility an Inpatient Psychiatric Facility P 	unweighted non-prima ccurring in all nonp unweighted non-prima al. Enter in column <u>column 2)). (see ir</u> Program Name <u>1.00</u> <u>1.00</u>	Provi der settings. Inry care resident 3 the ratio of Instructions) Program Code 2.00 2.00 (IPF), or does it con	Unweighted FTEs Nonprovider Site 3.00 0.00	Unwei ghted FTEs in Hospi tal 4.00 0.00 0.00 1.00 provi der? N	Ratio (col. 3/ (col. 3 + col. 4)) 5.00 0.000000 0.000000 0.000000 0.000000 0.0000000 0.0000000 0.0000000 0.0000000 0.0000000 0.0000000 0.0000000 0.0000000 0.0000000 0.0000000 0.0000000 0.0000000 0.00000000	
 Enter in column 1 the number of a FTEs attributable to rotations or Enter in column 2 the number of a FTEs that trained in your hospita (column 1 divided by (column 1 + (column 2 divided by (column 3 + column 4)). (see instructions) 	unweighted non-prima ccurring in all nonp unweighted non-prima al. Enter in column column 2)). (see ir Program Name 1.00 1.00 1.00 PS ychiatric Facility (the facility have a efore November 15, 2 lumn 2: Did this fac R 412.424 (d)(1)(iii cate which program y	TIPF), or does it con approved GME teach (D)? Enter "Y" for	Unweighted FTEs Nonprovider Site 3.00 0.00 tain an IPF subp ing program in yes or "N" for is s in a new teacl yes or "N" for is	Unwei ghted FTEs in Hospi tal 4.00 0.00 0.00 1.00 provi der? N the most no. (see ni ng no.	Ratio (col. 3/ (col. 3 + col. 4)) 5.00 0.000000	

	Period: From 01/01/2019 To 12/31/2019		epared:
	1.0	0 2.00 3.00	-
6.00 If line 75 is yes: Column 1: Did the facility have an approved GME teaching program in recent cost reporting period ending on or before November 15, 2004? Enter "Y" for yes no. Column 2: Did this facility train residents in a new teaching program in accordanc CFR 412.424 (d)(1)(iii)(D)? Enter "Y" for yes or "N" for no. Column 3: If column 2 is indicate which program year began during this cost reporting period. (see instructions)	the most or "N" for e with 42 Y,		76.00
Long Term Care Hospital PPS		1.00	-
 0.00 Is this a long term care hospital (LTCH)? Enter "Y" for yes and "N" for no. 1.00 Is this a LTCH co-located within another hospital for part or all of the cost reportin "Y" for yes and "N" for no. TEFRA Providers 	- N N	80.00 81.00	
 5.00 Is this a new hospital under 42 CFR Section §413.40(f)(1)(i) TEFRA? Enter "Y" for yes 6.00 Did this facility establish a new Other subprovider (excluded unit) under 42 CFR Secti §413.40(f)(1)(ii)? Enter "Y" for yes and "N" for no. 		N	85.00 86.00
7.00 Is this hospital an extended neoplastic disease care hospital classified under section 1886(d)(1)(B)(vi)? Enter "Y" for yes or "N" for no.	I.	Ν	87.00
	V 1.00	XIX 2.00	
Title V and XIX Services	1.00	2.00	
0.00 Does this facility have title V and/or XIX inpatient hospital services? Enter "Y" for yes or "N" for no in the applicable column.	Y	Y	90.00
 1.00 Is this hospital reimbursed for title V and/or XIX through the cost report either in full or in part? Enter "Y" for yes or "N" for no in the applicable column. 2.00 Are title XIX NF patients occupying title XVIII SNF beds (dual certification)? (see 	N	Y N	91.00
instructions) Enter "Y" for yes or "N" for no in the applicable column. 3.00 Does this facility operate an ICF/IID facility for purposes of title V and XIX? Enter	N	N	93.00
"Y" for yes or "N" for no in the applicable column. 4.00 Does title V or XIX reduce capital cost? Enter "Y" for yes, and "N" for no in the	Ν	N	94.00
applicable column. 5.00 If line 94 is "Y", enter the reduction percentage in the applicable column. 6.00 Does title V or XIX reduce operating cost? Enter "Y" for yes or "N" for no in the applicable column.	0. 00 N	0. 00 N	95.00 96.00
 7.00 If line 96 is "Y", enter the reduction percentage in the applicable column. 8.00 Does title V or XIX follow Medicare (title XVIII) for the interns and residents post stepdown adjustments on Wkst. B, Pt. I, col. 25? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX. 	0. 00 Y	0. 00 Y	97.00 98.00
8.01 Does title V or XIX follow Medicare (title XVIII) for the reporting of charges on Wkst C, Pt. I? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.		Y	98.01
8.02 Does title V or XIX follow Medicare (title XVIII) for the calculation of observation bed costs on Wkst. D-1, Pt. IV, line 89? Enter "Y" for yes or "N" for no in column 1	Y	Y	98.02
for title V, and in column 2 for title XIX. 8.03 Does title V or XIX follow Medicare (title XVIII) for a critical access hospital (CAH) reimbursed 101% of inpatient services cost? Enter "Y" for yes or "N" for no in column		Ν	98.03
<pre>for title V, and in column 2 for title XIX. 8.04 Does title V or XIX follow Medicare (title XVIII) for a CAH reimbursed 101% of outpatient services cost? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.</pre>	N	Ν	98.04
8.05 Does title V or XIX follow Medicare (title XVIII) and add back the RCE disallowance or Wkst. C, Pt. I, col. 4? Enter "Y" for yes or "N" for no in column 1 for title V, and i column 2 for title XIX.		Y	98. 0
8.06 Does title V or XIX follow Medicare (title XVIII) when cost reimbursed for Wkst. D, Pts. I through IV? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX. Rural Providers	Y	Y	98.00
05.00Does this hospital qualify as a CAH? 06.00lf this facility qualifies as a CAH, has it elected the all-inclusive method of paymer	rt N		105.00 106.00
for outpatient services? (see instructions) 07.00 Column 1: If line 105 is Y, is this facility eligible for cost reimbursement for L&R training programs? Enter "Y" for yes or "N" for no in column 1. (see instructions) Column 2: If column 1 is Y and line 70 or line 75 is Y, do you train L&Rs in an approved medical education program in the CAH's excluded IPF and/or IRF unit(s)? Enter "Y" for yes or "N" for no in column 2. (see instructions)	Ν		107.00
08.00 ls this a rural hospital qualifying for an exception to the CRNA fee schedule? See 42 (CFR Section §412.113(c). Enter "Y" for yes or "N" for no.	N		108.00

OSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA	Provider (eriod: rom 01/01/2019	Worksheet S- 9 Part I	-2
			o 12/31/2019		
	Physi cal	Occupati onal	Speech	Respi ratory	
09.00 If this hospital qualifies as a CAH or a cost provider, are therapy services provided by outside supplier? Enter "Y" for yes or "N" for no for each therapy.	<u>1.00</u> N	2.00 N	3.00 N	4.00 N	109.0
				1.00	_
10.00 Did this hospital participate in the Rural Community Hospita Demonstration) for the current cost reporting period? Enter " complete Worksheet E, Part A, lines 200 through 218, and Wor applicable.	"Y" for yes o	r "N" for no. I	f yes,	N	110.0
			1.00	2.00	-
11.00 If this facility qualifies as a CAH, did it participate in the Health Integration Project (FCHIP) demonstration for this constrained or the Project (FCHIP) demonstration for the constrained of the FCHIP demo in the Properties of the FCHIP demo in which this CAH is participated and the tender of tender of the tender of tender of the tender of tender	ost reporting olumn 1 is Y, rticipating i	period? Enter enter the n column 2.	N		111. C
		1.00	2.00	3.00	-
12.00 Did this hospital participate in the Pennsylvania Rural Heal demonstration for any portion of the current cost reporting Enter "Y" for yes or "N" for no in column 1. If column 1 is in column 2, the date the hospital began participating in th demonstration. In column 3, enter the date the hospital cea participation in the demonstration, if applicable.	period? s "Y", enter he	N			112.0
Miscellaneous Cost Reporting Information 15.00 Is this an all-inclusive rate provider? Enter "Y" for yes or	r "N" for no	N			0115.0
in column 1. If column 1 is yes, enter the method used (A, E in column 2. If column 2 is "E", enter in column 3 either "G for short term hospital or "98" percent for long term care (psychiatric, rehabilitation and long term hospitals provider the definition in CMS Pub. 15-1, chapter 22, §2208.1.	B, or E only) 93" percent (includes				
16.00 Is this facility classified as a referral center? Enter "Y" "N" for no.	for yes or	N			116.0
IT. 00 Is this facility legally-required to carry malpractice insur "Y" for yes or "N" for no.	rance? Enter	Y			117.0
18.00 Is the malpractice insurance a claims-made or occurrence pol if the policy is claim-made. Enter 2 if the policy is occurr					118.0
		Premi ums	Losses	Insurance	
		1.00	2.00	3.00	_
8.01 List amounts of malpractice premiums and paid losses:		120, 296		0	0118.0
			1.00	2.00	
Administrative and General? If yes, submit supporting scheo and amounts contained therein.			1.00 N	2.00	
Administrative and General? If yes, submit supporting sched and amounts contained therein. 9.00DD NOT USE THIS LINE 0.00 Is this a SCH or EACH that qualifies for the Outpatient Hold §3121 and applicable amendments? (see instructions) Enter in "N" for no. Is this a rural hospital with < 100 beds that qu Hold Harmless provision in ACA §3121 and applicable amendment	dule listing d Harmless pr n column 1, " ualifies for	cost centers ovision in ACA Y" for yes or the Outpatient		2.00 N	119.
Administrative and General? If yes, submit supporting sched and amounts contained therein. 9.00DD NOT USE THIS LINE 0.00 Is this a SCH or EACH that qualifies for the Outpatient Hold §3121 and applicable amendments? (see instructions) Enter in "N" for no. Is this a rural hospital with < 100 beds that qu Hold Harmless provision in ACA §3121 and applicable amendmer Enter in column 2, "Y" for yes or "N" for no.	dule listing d Harmless pr n column 1, " ualifies for nts? (see ins	cost centers ovision in ACA Y" for yes or the Outpatient tructions)	N		119. 120.
Administrative and General? If yes, submit supporting sched and amounts contained therein. 9.00 D0 NOT USE THIS LINE 0.00 Is this a SCH or EACH that qualifies for the Outpatient Hold §3121 and applicable amendments? (see instructions) Enter in "N" for no. Is this a rural hospital with < 100 beds that qu Hold Harmless provision in ACA §3121 and applicable amendment Enter in column 2, "Y" for yes or "N" for no. 1.00 Did this facility incur and report costs for high cost impla patients? Enter "Y" for yes or "N" for no. 2.00 Does the cost report contain healthcare related taxes as def Act?Enter "Y" for yes or "N" for no in column 1. If column 1 the Worksheet A line number where these taxes are included.	dule listing d Harmless pr n column 1, " ualifies for nts? (see ins antable devic fined in §190	cost centers ovision in ACA Y" for yes or the Outpatient tructions) es charged to 3(w)(3) of the	N		119. 120. 121.
Administrative and General? If yes, submit supporting sched and amounts contained therein. 9.00 DO NOT USE THIS LINE 0.00 Is this a SCH or EACH that qualifies for the Outpatient Hold §3121 and applicable amendments? (see instructions) Enter in "N" for no. Is this a rural hospital with < 100 beds that qu Hold Harmless provision in ACA §3121 and applicable amendment Enter in column 2, "Y" for yes or "N" for no. 1.00 Did this facility incur and report costs for high cost impla patients? Enter "Y" for yes or "N" for no. 2.00 Does the cost report contain healthcare related taxes as def Act?Enter "Y" for yes or "N" for no in column 1. If column 1 the Worksheet A line number where these taxes are included. Transplant Center Information 5.00 Does this facility operate a transplant center? Enter "Y" for	dule listing d Harmless pr n column 1, " ualifies for nts? (see ins antable devic fined in §190 1 is "Y", ent	cost centers ovision in ACA Y" for yes or the Outpatient tructions) es charged to 3(w)(3) of the er in column 2	N N Y		119. 1 120. 1 121. 1 122. 1
Administrative and General? If yes, submit supporting sched and amounts contained therein. 9.00 D0 NOT USE THIS LINE 0.00 Is this a SCH or EACH that qualifies for the Outpatient Hold §3121 and applicable amendments? (see instructions) Enter in "N" for no. Is this a rural hospital with < 100 beds that qu Hold Harmless provision in ACA §3121 and applicable amendment Enter in column 2, "Y" for yes or "N" for no. 1.00 Did this facility incur and report costs for high cost implation patients? Enter "Y" for yes or "N" for no. 2.00 Does the cost report contain heal thcare related taxes as def Act?Enter "Y" for yes or "N" for no in column 1. If column 1 the Worksheet A line number where these taxes are included. Transplant Center Information 5.00 Does this facility operate a transplant center? Enter "Y" for yes, enter certification date(s) (mm/dd/yyyy) below. 6.00 If this is a Medicare certified kidney transplant center, er	dule listing d Harmless pr n column 1, " ualifies for nts? (see ins antable devic fined in §190 1 is "Y", ent or yes and "N nter the cert	cost centers ovision in ACA Y" for yes or the Outpatient tructions) es charged to 3(w)(3) of the er in column 2	N N Y N		118. 0 119. 0 120. 0 121. 0 122. 0 125. 0 126. 0
 Administrative and General? If yes, submit supporting sched and amounts contained therein. 9.00 D0 NOT USE THIS LINE 0.00 Is this a SCH or EACH that qualifies for the Outpatient Hold §3121 and applicable amendments? (see instructions) Enter in "N" for no. Is this a rural hospital with < 100 beds that qu Hold Harmless provision in ACA §3121 and applicable amendment Enter in column 2, "Y" for yes or "N" for no. 1.00 Did this facility incur and report costs for high cost implation patients? Enter "Y" for yes or "N" for no. 2.00 Does the cost report contain heal thcare related taxes as def Act?Enter "Y" for yes or "N" for no in column 1. If column 1 the Worksheet A line number where these taxes are included. Transplant Center Information 5.00 Does this facility operate a transplant center? Enter "Y" for yes, enter certification date(s) (mm/dd/yyyy) below. 6.00 If this is a Medicare certified kidney transplant center, ent in column 1 and termination date, if applicable, in column 2. 	dule listing d Harmless pr n column 1, " ualifies for nts? (see ins antable devic fined in §190 1 is "Y", ent or yes and "N nter the cert 2. ter the certi	cost centers ovision in ACA Y" for yes or the Outpatient tructions) es charged to 3(w)(3) of the er in column 2 " for no. If ification date	N N Y N		119. 120. 121. 122. 125. 126.
 Administrative and General? If yes, submit supporting sched and amounts contained therein. 9.00 D0 NOT USE THIS LINE 0.00 Is this a SCH or EACH that qualifies for the Outpatient Hold §3121 and applicable amendments? (see instructions) Enter in "N" for no. Is this a rural hospital with < 100 beds that qu Hold Harmless provision in ACA §3121 and applicable amendment Enter in column 2, "Y" for yes or "N" for no. 1.00 Did this facility incur and report costs for high cost implation patients? Enter "Y" for yes or "N" for no. 2.00 Does the cost report contain heal thcare related taxes as def Act?Enter "Y" for yes or "N" for no in column 1. If column 1 the Worksheet A line number where these taxes are included. Transplant Center Information 5.00 Does this facility operate a transplant center? Enter "Y" for yes, enter certification date(s) (mm/dd/yyyy) below. 6.00 If this is a Medicare certified kidney transplant center, ent in column 1 and termination date, if applicable, in column 2 7.00 If this is a Medicare certified liver transplant center, ent in column 1 and termination date, if applicable, in column 2 	dule listing d Harmless pr n column 1, " ualifies for nts? (see ins antable devic fined in §190 1 is "Y", ent or yes and "N nter the cert 2. ter the certi 2. ter the certi	cost centers ovision in ACA Y" for yes or the Outpatient tructions) es charged to 3(w)(3) of the er in column 2 " for no. If ification date fication date	N N Y N		119. 120. 121. 122. 125. 126. 126.
 Administrative and General? If yes, submit supporting sched and amounts contained therein. 9.00 D0 NOT USE THIS LINE 0.00 Is this a SCH or EACH that qualifies for the Outpatient Hold §3121 and applicable amendments? (see instructions) Enter in "N" for no. Is this a rural hospital with < 100 beds that qu Hold Harmless provision in ACA §3121 and applicable amendment Enter in column 2, "Y" for yes or "N" for no. 1.00 Did this facility incur and report costs for high cost implation patients? Enter "Y" for yes or "N" for no. 2.00 Does the cost report contain heal thcare related taxes as def Act?Enter "Y" for yes or "N" for no in column 1. If column 1 the Worksheet A line number where these taxes are included. Transplant Center Information 5.00 Does this facility operate a transplant center? Enter "Y" for yes, enter certification date(s) (mm/dd/yyyy) below. 6.00 If this is a Medicare certified heart transplant center, ent in column 1 and termination date, if applicable, in column 2 7.00 If this is a Medicare certified liver transplant center, ent in column 1 and termination date, if applicable, in column 2 8.00 If this is a Medicare certified liver transplant center, ent in column 1 and termination date, if applicable, in column 2 9.00 If this is a Medicare certified liver transplant center, ent in column 1 and termination date, if applicable, in column 2 	dule listing d Harmless pr n column 1, " ualifies for nts? (see ins antable devic fined in §190 1 is "Y", ent or yes and "N nter the cert 2. ter the certi 2. ter the certi 2.	cost centers ovision in ACA Y" for yes or the Outpatient tructions) es charged to 3(w)(3) of the er in column 2 " for no. If ification date fication date	N N Y N		119.1 120.1 121.1 122.1 125.1 126.1 127.1 128.1
 and amounts contained therein. 19.00 D0 NOT USE THIS LINE 20.00 Is this a SCH or EACH that qualifies for the Outpatient Hold §3121 and applicable amendments? (see instructions) Enter in "N" for no. Is this a rural hospital with < 100 beds that que Hold Harnless provision in ACA §3121 and applicable amendmer Enter in column 2, "Y" for yes or "N" for no. 21.00 Did this facility incur and report costs for high cost implate patients? Enter "Y" for yes or "N" for no. 22.00 Does the cost report contain heal thcare related taxes as def Act?Enter "Y" for yes or "N" for no in column 1. If column 1 the Worksheet A line number where these taxes are included. Transplant Center Information 25.00 Dist this is a Medicare certified kidney transplant center, ere in column 1 and termination date, if applicable, in column 2 27.00 If this is a Medicare certified liver transplant center, entin column 1 and termination date, if applicable, in column 2 	dule listing d Harmless pr n column 1, " ualifies for nts? (see ins antable devic fined in §190 1 is "Y", ent or yes and "N nter the cert 2. ter the cert 2. ter the cert 2. er the cert function the cert 2.	cost centers ovision in ACA Y" for yes or the Outpatient tructions) es charged to 3(w)(3) of the er in column 2 " for no. If ification date fication date fication date in	N N Y N		119. 120. 121. 122. 125.

	EX IDENTIFICATION DATA	Provider CC	CN: 15-1326	Period: From 01/01/2019		-2
				To 12/31/2019	Date/Time Pr 7/9/2020 1:4	
				1.00	2.00	-
32.00 If this is a Medicare certified i in column 1 and termination date,			ication date		2.00	132.00
 33.00 Removed and reserved 34.00 If this is an organ procurement o and termination date, if applicab 		r the OPO number	in column 1			133.00 134.00
All Providers 40.00 Are there any related organization chapter 10? Enter "Y" for yes or are claimed, enter in column 2 th	"N" for no in column 1.	If yes, and home	office cost	s Y	15H043	140. 0
1.00		2. 00		3.00	1	
If this facility is part of a cha			ough 143 the	name and address	of the home	
office and enter the home office 41.00Name: UNION HOSPITAL, INC.	Contractor name and cont Contractor's Name:		Contract	or's Number: 0810	11	141.0
41. OONAME: UNION HOSPITAL, THC. 42. OOStreet: 1606 NORTH SEVENTH ST	PO Box:	WP5	Contract			141.0
43. 00 Ci ty: TERRE HAUTE		IN	Zip Code	: 4780)4	143.0
		+ 40			1.00	144.0
44.00 Are provider based physicians' co	sts included in Workshee	EL A?			Y	144.0
				1.00	2.00	
45.00 f costs for renal services are c inpatient services only? Enter "Y no, does the dialysis facility in period? Enter "Y" for yes or "N"	" for yes or "N" for no clude Medicare utilizati	in column 1. If	column 1 is			145.00
46.00 Has the cost allocation methodolo Enter "Y" for yes or "N" for no i yes, enter the approval date (mm/	ogy changed from the prev n column 1. (See CMS Pub			f N		146.0
					1.00	_
47.00 Was there a change in the statist					N	147.0
48.00 Was there a change in the order o					N	148.0
49.00 Was there a change to the simplif	ied cost finding method:					
					N Titlo XIX	149.0
		Part A 1.00	Part B 2.00	r no. Title V 3.00	N Title XIX 4.00	149.0
Does this facility contain a prov	vider that qualifies for	Part A 1.00 an exemption fro	Part B 2.00 om the applic	Title V 3.00 ation of the low	Title XIX 4.00 wer of costs	149.0
or charges? Enter "Y" for yes or	vider that qualifies for	Part A 1.00 an exemption fro	Part B 2.00 om the applic	Title V 3.00 ation of the low	Title XIX 4.00 wer of costs	
or charges? Enter "Y" for yes or 55.00 Hospital	vider that qualifies for	Part A 1.00 an exemption fro ponent for Part A	Part B 2.00 om the applic and Part B.	Title V 3.00 ation of the low (See 42 CFR §41	Title XIX 4.00 ver of costs 3.13)	155. 0
or charges? Enter "Y" for yes or 55.00 Hospi tal 56.00 Subprovi der - IPF 57.00 Subprovi der - IRF	vider that qualifies for	Part A 1.00 an exemption fro ponent for Part A N	Part B 2.00 om the applic A and Part B. N	Title V 3.00 ation of the low (See 42 CFR §41 N	Title XIX 4.00 ver of costs 3.13) N	155. 0 156. 0 157. 0
or charges? Enter "Y" for yes or 55.00 Hospi tal 56.00 Subprovi der - IPF 57.00 Subprovi der - IRF 58.00 SUBPROVI DER	vider that qualifies for	Part A 1.00 an exemption fro ponent for Part A N N N	Part B 2.00 Dom the applic A and Part B. N N N	Title V 3.00 ation of the low (See 42 CFR §41 N N N	Title XIX 4.00 er of costs 3.13) N N N	155. 0 156. 0 157. 0 158. 0
or charges? Enter "Y" for yes or 55.00 Hospi tal 56.00 Subprovi der - IPF 57.00 Subprovi der - IRF 58.00 SUBPROVI DER 59.00 SNF	vider that qualifies for	Part A 1.00 an exemption fro ponent for Part A N N N N	Part B 2.00 Dom the applic A and Part B. N N N N	Title V 3.00 ation of the low (See 42 CFR §41 N N N N	Title XIX 4.00 ver of costs 3.13) N N N N	155. 0 156. 0 157. 0 158. 0 159. 0
or charges? Enter "Y" for yes or 55.00 Hospital 56.00 Subprovider - IPF 57.00 Subprovider - IRF 58.00 SUBPROVIDER 59.00 SNF 60.00 HOME HEALTH AGENCY	vider that qualifies for	Part A 1.00 an exemption fro ponent for Part A N N N	Part B 2.00 om the applic A and Part B. N N N N N	Title V 3.00 ation of the low (See 42 CFR §41 N N N N N N	Title XIX 4.00 ver of costs 3.13) N N N N N N	155.0 156.0 157.0 158.0 159.0 160.0
or charges? Enter "Y" for yes or 55.00 Hospital 56.00 Subprovider - IPF 57.00 Subprovider - IRF 58.00 SUBPROVIDER 59.00 SNF 60.00 HOME HEALTH AGENCY	vider that qualifies for	Part A 1.00 an exemption fro ponent for Part A N N N N	Part B 2.00 Dom the applic A and Part B. N N N N	Title V 3.00 ation of the low (See 42 CFR §41 N N N N	Title XIX 4.00 ver of costs 3.13) N N N N N N N N	155.0 156.0 157.0 158.0 159.0 160.0
or charges? Enter "Y" for yes or 55.00 Hospi tal 56.00 Subprovi der - IPF 57.00 Subprovi der - IRF 58.00 SUBPROVI DER 59.00 SNF 60.00 HOME HEALTH AGENCY 61.00 CMHC	vider that qualifies for	Part A 1.00 an exemption fro ponent for Part A N N N N	Part B 2.00 om the applic A and Part B. N N N N N	Title V 3.00 ation of the low (See 42 CFR §41 N N N N N N	Title XIX 4.00 ver of costs 3.13) N N N N N N	155.0 156.0 157.0 158.0 159.0 160.0
or charges? Enter "Y" for yes or 55.00 Hospital 56.00 Subprovider - IPF 57.00 Subprovider - IRF 58.00 SUBPROVIDER 59.00 SNF 60.00 HOME HEALTH AGENCY 61.00 CMHC Multicampus 65.00 Is this hospital part of a Multic	/ider that qualifies for "N" for no for each comp	Part A 1.00 an exemption fro ponent for Part A N N N N N	Part B 2.00 Dm the applic A and Part B. N N N N N N	Title V 3.00 ation of the low (See 42 CFR §41 N N N N N N N	Title XIX 4.00 ver of costs 3.13) N N N N N N N N	155. 0 156. 0 157. 0 158. 0 159. 0 160. 0 161. 0
or charges? Enter "Y" for yes or 55.00 Hospi tal 56.00 Subprovi der - IPF 57.00 Subprovi der - IRF 58.00 SUBPROVI DER 59.00 SNF 60.00 HOME HEALTH AGENCY 61.00 CMHC	/ider that qualifies for "N" for no for each comp ampus hospital that has Name	Part A 1.00 an exemption from ponent for Part A N N N N N N N N N N N N N	Part B 2.00 om the applic A and Part B. N N N N N N N N S N S State Zi	Title V 3.00 ation of the low (See 42 CFR §41 N N N N N N N N N N N N N	Title XIX 4.00 ver of costs 3.13) N N N N N N N N N N N N N	149.00 155.00 156.00 157.00 158.00 159.00 160.00 161.00 165.00 165.00 165.00
or charges? Enter "Y" for yes or 55.00 Hospital 56.00 Subprovider - IPF 57.00 Subprovider - IRF 58.00 SUBPROVIDER 59.00 SNF 60.00 HOME HEALTH AGENCY 61.00 CMHC Multicampus 65.00 Is this hospital part of a Multic Enter "Y" for yes or "N" for no.	/ider that qualifies for "N" for no for each comp ampus hospital that has	Part A 1.00 an exemption from ponent for Part A N N N N N N N N N N	Part B 2.00 om the applic A and Part B. N N N N N N N N S N S State Zi	Title V 3.00 ation of the low (See 42 CFR §41 N N N N N N N N N N N N N	Title XIX 4.00 er of costs 3.13) N N N N N N N N N N N N N	155. 0 156. 0 157. 0 158. 0 159. 0 160. 0 161. 0 165. 0
or charges? Enter "Y" for yes or 55.00 Hospital 56.00 Subprovider - IPF 57.00 Subprovider - IRF 58.00 SUBPROVIDER 59.00 SNF 60.00 HOME HEALTH AGENCY 61.00 CMHC Multicampus 65.00 Is this hospital part of a Multic Enter "Y" for yes or "N" for no. 66.00 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	/ider that qualifies for "N" for no for each comp ampus hospital that has Name	Part A 1.00 an exemption from ponent for Part A N N N N N N N N N N N N N	Part B 2.00 om the applic A and Part B. N N N N N N N N S N S State Zi	Title V 3.00 ation of the low (See 42 CFR §41 N N N N N N N N N N N N N	Title XIX 4.00 er of costs 3.13) N N N N N N N N N N N N N	155. 0 156. 0 157. 0 158. 0 159. 0 160. 0 161. 0 165. 0
or charges? Enter "Y" for yes or 55.00 Hospital 56.00 Subprovider - IPF 57.00 Subprovider - IRF 58.00 SUBPROVIDER 59.00 SNF 60.00 HOME HEALTH AGENCY 61.00 CMHC Multicampus 65.00 Is this hospital part of a Multic Enter "Y" for yes or "N" for no. 66.00 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,	/ider that qualifies for "N" for no for each comp ampus hospital that has Name	Part A 1.00 an exemption from ponent for Part A N N N N N N N N N N N N N	Part B 2.00 om the applic A and Part B. N N N N N N N N S N S State Zi	Title V 3.00 ation of the low (See 42 CFR §41 N N N N N N N N N N N N N	Title XIX 4.00 er of costs 3.13) N N N N N 1.00 N FTE/Campus 5.00 0.0	155. 0 156. 0 157. 0 158. 0 159. 0 160. 0 161. 0 165. 0
or charges? Enter "Y" for yes or 55.00 Hospital 56.00 Subprovider - IPF 57.00 Subprovider - IRF 58.00 SUBPROVIDER 59.00 SNF 60.00 HOME HEALTH AGENCY 61.00 CMHC Multicampus 65.00 Is this hospital part of a Multic Enter "Y" for yes or "N" for no. 66.00 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)	ider that qualifies for "N" for no for each comp ampus hospital that has <u>Name</u> 0	Part A 1.00 an exemption fro ponent for Part A N N N N N N N N N N N N N	Part B 2.00 The applic and Part B. N N N N N N Duses in diffe	Title V 3.00 ation of the low (See 42 CFR §41 N </td <td>Title XIX 4.00 er of costs 3.13) N N N N N N N N N N N N N</td> <td>155. 0 156. 0 157. 0 158. 0 159. 0 160. 0 161. 0 165. 0</td>	Title XIX 4.00 er of costs 3.13) N N N N N N N N N N N N N	155. 0 156. 0 157. 0 158. 0 159. 0 160. 0 161. 0 165. 0
or charges? Enter "Y" for yes or 55.00 Hospital 56.00 Subprovider - IPF 57.00 Subprovider - IRF 58.00 SUBPROVIDER 59.00 SNF 60.00 HOME HEALTH AGENCY 61.00 CMHC Multicampus 65.00 Is this hospital part of a Multic Enter "Y" for yes or "N" for no. 66.00 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	T) incentive in the Amer runder §1886(n)? Enter 05 is "Y") and is a mear	Part A 1.00 an exemption fro ponent for Part A N N N N N N N N N N N N N	Part B 2.00 om the applic A and Part B. N N N N N N N N N N N N N	Title V 3.00 ation of the low (See 42 CFR §41 N N N N N N N N N N N N N	Title XIX 4.00 er of costs 3.13) N N N N N 1.00 N FTE/Campus 5.00 0.0	155. 0 156. 0 157. 0 158. 0 159. 0 160. 0 161. 0

Health Financial Systems	UNI ON HOSPI TAL	CLINTON	In Lie	u of Form CMS-	2552-10
HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX I	DENTIFICATION DATA		Period:	Worksheet S-2	
			From 01/01/2019 To 12/31/2019	Date/Time Pre	nared
			10 12/01/2017	7/9/2020 1:42	
			Begi nni ng	Endi ng	
			1.00	2.00	
170.00 Enter in columns 1 and 2 the EHR begi period respectively (mm/dd/yyyy)			170.00		
			1.00	2.00	
171.00 If line 167 is "Y", does this provide	er have any days for indi	viduals enrolled in	Ν	C	171.00
section 1876 Medicare cost plans repo	orted on Wkst. S-3, Pt. I	, line 2, col. 6? Enter			
"Y" for yes and "N" for no in column	1. If column 1 is yes, en	nter the number of sectio	n		
1876 Medicare days in column 2. (see	instructions)				

HOSPI T	Financial Systems UNION HOSPIT AL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNALRE	Provider C	CN: 15-1326	Peri od:	Worksheet S-	
				From 01/01/2019 To 12/31/2019		
				Y/N	Date	
			-	1.00	2.00	
	General Instruction: Enter Y for all YES responses. Enter M mm/dd/yyyy format.	N TOT ALL NU TO	esponses. Ent	ter all dates in	the	
	COMPLETED BY ALL HOSPITALS Provider Organization and Operation					_
1.00	Has the provider changed ownership immediately prior to the	e beginning of	the cost	N		1.0
	reporting period? If yes, enter the date of the change in a		instructions	· ·		
			Y/N	Date	V/I	_
2.00	Has the provider terminated participation in the Medicare F	Program? If	1.00 N	2.00	3.00	2.0
	yes, enter in column 2 the date of termination and in colur voluntary or "I" for involuntary.	nn 3, "V" for				
3. 00	Is the provider involved in business transactions, includin contracts, with individuals or entities (e.g., chain home of ar medical supply companies) that are related to the provide	offices, drug	Y			3.0
	or medical supply companies) that are related to the provid officers, medical staff, management personnel, or members of of directors through ownership, control, or family and othe	of the board				
	relationships? (see instructions)		N/ /N	Trues	Data	
			Y/N 1.00	Type 2.00	Date 3.00	
	Financial Data and Reports			2.00		
4.00	Column 1: Were the financial statements prepared by a Cert Accountant? Column 2: If yes, enter "A" for Audited, "C" to or "R" for Reviewed. Submit complete copy or enter date available column 2: cost instructions) if no	for Compiled,	Y	A		4. C
5.00	column 3. (see instructions) If no, see instructions. Are the cost report total expenses and total revenues different those on the filed financial statements? If yes, submit rec		Y			5.0
				Y/N	Legal Oper.	
	Approved Educational Activities			1.00	2.00	
5.00	Column 1: Are costs claimed for nursing school? Column 2: the legal operator of the program?	-	he provider i	s N		6.0
7.00 8.00	Are costs claimed for Allied Health Programs? If "Y" see in Were nursing school and/or allied health programs approved cost reporting period? If yes, see instructions.		d during the	N N		7. C 8. C
9.00	Are costs claimed for Interns and Residents in an approved program in the current cost report? If yes, see instruction		cal educatior	N N		9.0
10. 00	Was an approved Intern and Resident GME program initiated (cost reporting period? If yes, see instructions.		the current	Ν		10.0
11.00	Are GME cost directly assigned to cost centers other than I Teaching Program on Worksheet A? If yes, see instructions.	l & R in an Ap	proved	N		11.0
					Y/N 1.00	
	Bad Debts				1	
	Is the provider seeking reimbursement for bad debts? If yes If line 12 is yes, did the provider's bad debt collection p period? If yes, submit copy.			cost reporting	Y N	12.0
	If line 12 is yes, were patient deductibles and/or co-payme Bed Complement		4		N	14. (
5.00	Did total beds available change from the prior cost reporti	<u></u>	yes, see ins t A		T B	15.0
		Y/N	Date	Y/N	Date	
	PS&R Data	1.00	2.00	3.00	4.00	
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 date of the PS&R Report used in columns 2 and 4. (see	Y	03/22/2020	Y	03/22/2020	16.0
17.00	instructions) Was the cost report prepared using the PS&R Report for	Ν		Ν		17.0
	totals and the provider's records for allocation? If either column 1 or 3 is yes, enter the paid-through date in columns 2 and 4. (see instructions)					
18.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for additional claims that have been billed	Ν		Ν		18.0
	but are not included on the PS&R Report used to file this					

	Financial Systems UNION HOSPIT/ AL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNALRE		CCN: 15-1326	Period: From 01/01/2019	u of Form CM Worksheet S	
				To 12/31/2019	Part II Date/Time F 7/9/2020 1:	repared:
		Descr	iption	Y/N	Y/N	12 pm
			0	1.00	3.00	
20.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for Other? Describe the other adjustments:		_	Ν	Ν	20.0
		Y/N	Date	Y/N	Date	
		1.00	2.00	3.00	4.00	
1. 00	Was the cost report prepared only using the provider's records? If yes, see instructions.	N		N		21.0
					1.00	-
	COMPLETED BY COST REIMBURSED AND TEFRA HOSPITALS ONLY (EXCE	PT CHILDRENS	HOSPLTALS)		1.00	
	Capital Related Cost					
2.00	Have assets been relifed for Medicare purposes? If yes, see	e instructions	5		N	22.0
3.00	Have changes occurred in the Medicare depreciation expense			ring the cost	Ν	23.0
	reporting period? If yes, see instructions.			Ũ		
4.00	Were new leases and/or amendments to existing leases entere If yes, see instructions	eporting period?	Ν	24.0		
5.00	Have there been new capitalized leases entered into during instructions.	J	Ν	25.0		
. 00	Were assets subject to Sec. 2314 of DEFRA acquired during the instructions.	5	N	26.0		
27.00	Has the provider's capitalization policy changed during the copy.	e cost reporti	ng period? I	f yes, submit	N	27.0
8. 00	Interest Expense Were new Loans, mortgage agreements or letters of credit en	ntered into du	iring the cos	t reporting	N	28.0
9.00	period? If yes, see instructions. Did the provider have a funded depreciation account and/or treated as a funded depreciation account? If yes, see instr	Reserve Fund)	Ν	29.0		
0.00	Has existing debt been replaced prior to its scheduled matu instructions.		/debt?lfye	s, see	Ν	30. C
1. 00	Has debt been recalled before scheduled maturity without is instructions.	ssuance of new	/debt?lfye	s, see	Ν	31.0
	Purchased Servi ces					
2.00	Have changes or new agreements occurred in patient care ser	rvi ces furni sh	ned through c	ontractual	N	32.0
3. 00	arrangements with suppliers of services? If yes, see instru If line 32 is yes, were the requirements of Sec. 2135.2 app		ng to compet	itive bidding? If	N	33.0
	no, see instructions. Provider-Based Physicians					
4.00	Are services furnished at the provider facility under an ar	crangement wit	h provider-h	asod physicians?	Y	34.0
4.00	If yes, see instructions.	rangement wr		aseu physicians:		54.0
5.00	If line 34 is yes, were there new agreements or amended exi		ents with the	provi der-based	Ν	35.0
	physicians during the cost reporting period? If yes, see in	nstructions.		N/ (b)	Data	_
				Y/N	Date	
	Home Office Costs			1.00	2.00	
6 00	Were home office costs claimed on the cost report?			Y		36.0
	If line 36 is yes, has a home office cost statement been pr	repared by the	home office			30.0
7.00	If yes, see instructions.	cparea by the				57.0
8.00	If line 36 is yes, was the fiscal year end of the home off	ice different	from that o	f N		38.0
	the provider? If yes, enter in column 2 the fiscal year end					
9. 00	If line 36 is yes, did the provider render services to othe see instructions.	er chain compo	onents? If ye	s, N		39.0
0. 00	If line 36 is yes, did the provider render services to the instructions.	home office?	lfyes, see	N		40.0
		1	. 00	2.	00	_
	Cost Report Preparer Contact Information					
1. 00	held by the cost report preparer in columns 1, 2, and 3,	CAROLYN		CHAPLI N		41.0
2.00		BLUE AND CO.,	LLC			42.0
	preparer.					

Health Financial Systems UNION HOSP	ITAL CLINTON	In Lieu	u of Form CMS-	2552-10
HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE	Provider CCN: 15-1326	Period:	Worksheet S-2	
		From 01/01/2019 To 12/31/2019	Part II Date/Time Pre	nared
		10 12/31/2019	7/9/2020 1: 42	pareu. pm
	3.00			
Cost Report Preparer Contact Information				
41.00 Enter the first name, last name and the title/position	SENI OR MANAGER			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.				
43.00 Enter the telephone number and email address of the cost				43.00
report preparer in columns 1 and 2, respectively.				

	n Financial Systems TAL AND HOSPITAL HEALTH CARE COMPLEX STATISTIC	UNION HOSPITA	Provi der C	CN: 15-1326	Peri od:	u of Form CMS-2 Worksheet S-3	
					From 01/01/2019 To 12/31/2019		
						I/P Days / O/P Visits /	
	Component	Worksheet A Line Number	No. of Beds	Bed Days Available	CAH Hours	Trips Title V	
		1.00	2.00	3.00	4.00	5.00	
1.00	Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2 for the portion of LDP room available beds)	30.00	19	6, 9	35 30, 744. 00	0	1.00
2.00 3.00 4.00	HMO and other (see instructions) HMO IPF Subprovider HMO IRF Subprovider						2.00 3.00 4.00
5.00 6.00 7.00	Hospital Adults & Peds. Swing Bed SNF Hospital Adults & Peds. Swing Bed NF Total Adults and Peds. (exclude observation beds) (see instructions)		19	6, 9	35 30, 744. 00	0 0 0	5.00 6.00 7.00
8.00 9.00 10.00 11.00 12.00	I NTENSI VE CARE UNI T CORONARY CARE UNI T BURN I NTENSI VE CARE UNI T SURGI CAL I NTENSI VE CARE UNI T OTHER SPECI AL CARE (SPECI FY)	31.00	6	2, 1	90 6, 288. 00	0	8.00 9.00 10.00 11.00 12.00
13.00 14.00 15.00 16.00 17.00 18.00 19.00 20.00 21.00 22.00 23.00	SUBPROVI DER		25	9, 1	25 37, 032. 00	0 0	13.00 14.00 15.00 16.00 17.00 18.00 19.00 20.00 21.00 22.00 23.00
24.00 24.10 25.00 26.00	HOSPICE HOSPICE (non-distinct part) CMHC - CMHC RURAL HEALTH CLINIC	30.00					24.00 24.10 25.00 26.00
26.00 26.25 27.00 28.00 29.00 30.00 31.00 32.00 32.01	FEDERALLY QUALIFIED HEALTH CENTER Total (sum of lines 14-26)	89.00	25 0		0	0	26.00 26.25 27.00 28.00 29.00 30.00 31.00 32.01
33. 00 33. 01	LTCH non-covered days LTCH site neutral days and discharges						33. 00 33. 01

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTIC	AL DATA	Provider CC	CN: 15-1326	Period: From 01/01/2019 To 12/31/2019	Date/Time Pre	pared:
	I/P Days	/ O/P Visits	/ Trips	Full Time	<u>7/9/2020 1:42</u> Equi val ents	pm
Component	Title XVIII	Title XIX	Total All	Total Interns	Employees On	
	6.00	7.00	Patients 8.00	& Residents 9.00	Payrol I 10.00	
1.00 Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2	743	15	1, 27		10.00	1.00
for the portion of LDP room available beds) 2.00 HMO and other (see instructions) 3.00 HMO IPF Subprovider 4.00 HMO IRF Subprovider	96 0 0	13 0 0				2.00 3.00 4.00
 5.00 Hospital Adults & Peds. Swing Bed SNF 6.00 Hospital Adults & Peds. Swing Bed NF 7.00 Total Adults and Peds. (exclude observation 	186 929	0 0 15		36 37	-	5.00 6.00 7.00
beds) (see instructions) 8.00 INTENSIVE CARE UNIT 9.00 CORONARY CARE UNIT 10.00 BURN INTENSIVE CARE UNIT	143	0	20			8.00 9.00 10.00
11.00 SURGICAL INTENSIVE CARE UNIT 12.00 OTHER SPECIAL CARE (SPECIFY) 13.00 NURSERY 14.00 Total (see instructions) 15.00 CAH visits	1, 072 0	15 0	1, 76	61 0.00	109. 73	11.00 12.00 13.00 14.00 15.00
16.00 SUBPROVIDER - IPF 17.00 SUBPROVIDER - IRF 18.00 SUBPROVIDER 19.00 SKILLED NURSING FACILITY						16.00 17.00 18.00 19.00
20.00 NURSING FACILITY 21.00 OTHER LONG TERM CARE 22.00 HOME HEALTH AGENCY 23.00 AMBULATORY SURGICAL CENTER (D.P.) 24.00 HOSPICE						20.00 21.00 22.00 23.00 24.00
24.10 HOSPICE (non-distinct part) 25.00 CMHC - CMHC 26.00 RURAL HEALTH CLINIC				0		24.10 25.00 26.00
 26. 25 FEDERALLY QUALIFIED HEALTH CENTER 27. 00 Total (sum of lines 14-26) 28. 00 Observation Bed Days 29. 00 Ambulance Trips 	0	0 125	96	0 0.00 0.00 54		
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	0	O				30.00 31.00 32.00 32.01
Outpatient days(see instructions)33.00LTCH non-covered days33.01LTCH site neutral days and discharges	0 0					33.00 33.01

Heal th	Financial Systems UNION HOSPITAL	CLI NTON		In Lie	u of Form CMS-	2552-10	
HOSPI T	AL UNCOMPENSATED AND INDIGENT CARE DATA	Provider CO	CN: 15-1326	Peri od:	Worksheet S-1	0	
				From 01/01/2019 To 12/31/2019			
					7/9/2020 1:42	2 pm	
					1.00		
	Uncompensated and indigent care cost computation				1.00		
1.00	Cost to charge ratio (Worksheet C, Part I line 202 column 3 d	ivided by Li	ne 202 colum	n 8)	0. 324277	1.00	
1.00	Medicaid (see instructions for each line)			11 0)	0. 324277	1.00	
2.00	Net revenue from Medicaid				519, 953	2.00	
3.00	Did you receive DSH or supplemental payments from Medicaid?				N	3.00	
4.00	If line 3 is yes, does line 2 include all DSH and/or suppleme	ai d?		4.00			
5.00	If line 4 is no, then enter DSH and/or supplemental payments				0		
6.00	Medi cai d charges		-		15, 979, 865		
7.00	Medicaid cost (line 1 times line 6)				5, 181, 903		
8.00	Difference between net revenue and costs for Medicaid program	(line 7 mir	nus sum of li	nes 2 and 5; if	4, 661, 950		
	<pre>< zero then enter zero) Children's Health Insurance Program (CHIP) (see instructions</pre>	for each lir	ne)			-	
9.00	Net revenue from stand-al one CHIP				0	9.00	
	Stand-al one CHIP charges				0		
11.00	Stand-alone CHIP cost (line 1 times line 10)				0		
12.00	Difference between net revenue and costs for stand-alone CHIP	(line 11 mi	nus line 9.	if < zero then	0	•	
12.00	enter zero)		nus rine ,		0	12.00	
	Other state or local government indigent care program (see in	structions f	for each line	2)			
13.00					0	13.00	
	Charges for patients covered under state or local indigent ca				C	14.00	
	10)						
15.00	State or local indigent care program cost (line 1 times line	14)			0	15.00	
16.00	Difference between net revenue and costs for state or local i	ndigent care	e program (li	ne 15 minus line	0	16.00	
	13; if < zero then enter zero)						
	Grants, donations and total unreimbursed cost for Medicaid, C	HIP and stat	te/local indi	gent care progra	ams (see		
17.00	instructions for each line)	funding obo			0	17.00	
17.00	Private grants, donations, or endowment income restricted to Government grants, appropriations or transfers for support of						
19.00				e (sum of lines	4, 661, 950		
19.00	8, 12 and 16)	ar murgent	care program	is (suil of filles	4,001,950	19.00	
			Uni nsured	Insured	Total (col. 1		
			patients	patients	+ col. 2)		
			1.00	2.00	3.00		
~~ ~~	Uncompensated Care (see instructions for each line)		1 150 7		4 450 750		
20.00	5 5	acility	1, 459, 7	53 0	1, 459, 753	20.00	
21 00	(see instructions)	aunto (coo	472.2	64 0	472 244	21 00	
21.00	Cost of patients approved for charity care and uninsured disc instructions)	ounts (see	473, 3	04 0	473, 364	21.00	
22.00		n off as		0 0	C	22.00	
22.00	chari ty care			0	0	22.00	
23.00	Cost of charity care (line 21 minus line 22)		473, 3	64 0	473, 364	23.00	
					1.00		
24.00	Does the amount on line 20 column 2, include charges for pati		yond a length	of stay limit	N	24.00	
	imposed on patients covered by Medicaid or other indigent car						
25.00	If line 24 is yes, enter the charges for patient days beyond	the indigent	t care progra	m's length of	0	25.00	
	stay limit				3, 632, 949	26.00	
26.00							
27.00							
27.01							
28.00							
29.00	Cost of non-Medicare and non-reimbursable Medicare bad debt e	xpense (see	instructions	;)	1, 210, 653		
30.00	Cost of uncompensated care (line 23 column 3 plus line 29)				1, 684, 017		
31.00	Total unreimbursed and uncompensated care cost (line 19 plus	line 30)			6, 345, 967	31.00	

Heal th	Financial Systems	UNI ON HOSPI TAL	CLINTON		In Lie	u of Form CMS-2	2552-10
RECLAS	SSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE C	OF EXPENSES	Provider CC		Period:	Worksheet A	
					From 01/01/2019 To 12/31/2019	Date/Time Pre	narod
					10 12/31/2019	7/9/2020 1: 42	
	Cost Center Description	Sal ari es	Other	Total (col. 1	Recl assi fi cat	Recl assi fi ed	
				+ col. 2)	ions (See	Trial Balance	
					A-6)	(col. 3 +-	
		1.00	2.00	2.00	4.00	col. 4)	
	GENERAL SERVICE COST CENTERS	1.00	2.00	3.00	4.00	5.00	
1.00	00100 NEW CAP REL COSTS-BLDG & FIXT		739, 368	739, 36	8 -35, 081	704, 287	1.00
2.00	00200 NEW CAP REL COSTS-BEDG & TTXT		376, 949	376, 94			2.00
4.00	00400 EMPLOYEE BENEFITS DEPARTMENT	0	370, 949		0 0	0	4.00
5.01	00540 NONPATI ENT TELEPHONES	0	29,074	29,07		-	5.01
5.02	00550 DATA PROCESSI NG	0	544, 320	544, 32		544, 320	5.02
5.03	00560 PURCHASING RECEIVING AND STORES	0	34, 432	34, 43		34, 432	5.03
5.04	00570 ADMI TTI NG	378, 502	50, 412	428, 91		428, 914	5.04
5.05	00580 CASHI ERI NG/ACCOUNTS RECEI VABLE	21, 726	261, 827	283, 55	3 0	283, 553	5.05
5.06	00591 ADMI NI STRATI VE AND GENERAL	720, 591	2, 336, 483	3, 057, 07	4 0	3, 057, 074	5.06
7.00	00700 OPERATION OF PLANT	370, 682	753, 855	1, 124, 53	7 0	1, 124, 537	7.00
8.00	00800 LAUNDRY & LINEN SERVICE	0	0		0 0	0	8.00
9.00	00900 HOUSEKEEPI NG	205, 561	63, 049	268, 61	0 0	268, 610	9.00
10.00	01000 DI ETARY	301, 063	225, 714	526, 77	7 -427, 312	99, 465	10.00
11.00	01100 CAFETERI A	0	0		0 427, 312		
13.00	01300 NURSI NG ADMI NI STRATI ON	597, 940	103, 028	700, 96		700, 968	13.00
16.00	01600 MEDI CAL RECORDS & LI BRARY	116, 832	82, 469	199, 30	1 0	199, 301	16.00
	INPATIENT ROUTINE SERVICE COST CENTERS	050 (04		1 500 11		1 500 110	
30.00	03000 ADULTS & PEDIATRICS	852, 604	669, 806	1, 522, 41			30.00
31.00	03100 I NTENSI VE CARE UNI T ANCI LLARY SERVI CE COST CENTERS	434, 234	104, 030	538, 26	4 0	538, 264	31.00
50.00	05000 OPERATI NG ROOM	153, 894	305, 912	459, 80	6 30, 602	490, 408	50.00
51.00	05100 RECOVERY ROOM	124, 388	27, 787	152, 17			51.00
51.00	05101 0/P TREATMENT ROOM	121,000	21,101		0 0	0	51.00
54.00	05400 RADI OLOGY-DI AGNOSTI C	694, 535	712, 403	1, 406, 93	-	1, 406, 938	
56.00	05600 RADI OI SOTOPE	0	668	66		668	56.00
60.00	06000 LABORATORY	0	805, 455	805, 45		805, 455	60.00
62.00	06200 WHOLE BLOOD & PACKED RED BLOOD CELLS	0	25, 013	25, 01	3 0	25, 013	62.00
65.00	06500 RESPI RATORY THERAPY	425, 128	106, 286	531, 41	4 14, 876	546, 290	65.00
66.00	06600 PHYSI CAL THERAPY	0	992, 201	992, 20	1 0	992, 201	66.00
67.00	06700 OCCUPATI ONAL THERAPY	0	7, 135	7, 13	5 0	7, 135	67.00
68.00	06800 SPEECH PATHOLOGY	0	50, 674	50, 67	4 0	50, 674	68.00
69.00	06900 ELECTROCARDI OLOGY	26, 124	330, 404	356, 52		356, 528	1
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	71, 050	71, 05			71.00
72.00	07200 I MPL. DEV. CHARGED TO PATIENTS	0	16, 040	16, 04		16, 040	1
73.00	07300 DRUGS CHARGED TO PATIENTS	242, 809	721, 996	964, 80	5 0	964, 805	73.00
00.00	OUTPATIENT SERVICE COST CENTERS						00.00
90.00	09000 CLINIC 09100 EMERGENCY	0	0		0 0	-	90.00
91.00 92.00		972, 481	2, 651, 797	3, 624, 27	8 23, 100	3, 647, 378	
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART) SPECIAL PURPOSE COST CENTERS						92.00
118.00		6, 639, 094	13, 199, 637	19, 838, 73	1 -36, 279	19, 802, 452	118 00
110.00	NONREI MBURSABLE COST CENTERS	0,037,074	13, 177, 037	17,000,70	1 30,277	17,002,432	110.00
194.00	07950 PHYSICIAN PRACTICES	0	0		0 0	0	194.00
	1 07951 MEDI CAL OFFI CE BUI LDI NG	0	0		36, 279		
	207952 VPCHC	Ó	0		0 0		194.02
200.00	TOTAL (SUM OF LINES 118 through 199)	6, 639, 094	13, 199, 637	19, 838, 73	1 0	19, 838, 731	200.00
						-	

Health Finan	ncial Systems	UNI ON HOSPI T	AL CLINTON		In Lieu of F	orm CMS-2552-10
RECLASSI FI CA	ATION AND ADJUSTMENTS OF TRIAL BALANCE O	OF EXPENSES	Provider CCN: 1		od: Works 01/01/2019	sheet A
				То		/Time Prepared: 2020 1:42 pm
	Cost Center Description	Adjustments	Net Expenses		, ,, ,,	
		(See A-8)	For			
		(Allocation			
CENED	AL SERVICE COST CENTERS	6.00	7.00			
	NEW CAP REL COSTS-BLDG & FIXT	1, 074, 017	1, 778, 304			1.00
	NEW CAP REL COSTS-BEDG & TTAT	1,074,017	375, 751			2.00
	EMPLOYEE BENEFITS DEPARTMENT	1, 147, 467	1, 147, 467			4.00
	NONPATI ENT TELEPHONES	26, 775	55, 849			5.01
	DATA PROCESSI NG	2, 183, 202	2, 727, 522			5.02
5.03 00560	PURCHASING RECEIVING AND STORES	67, 325	101, 757			5.03
5.04 00570	ADMI TTI NG	0	428, 914			5.04
5.05 00580	CASHI ERI NG/ACCOUNTS RECEI VABLE	321, 437	604, 990			5.05
5.06 00591	ADMI NI STRATI VE AND GENERAL	-737, 562	2, 319, 512			5.06
	OPERATION OF PLANT	494, 321	1, 618, 858			7.00
	LAUNDRY & LINEN SERVICE	0	0			8.00
	HOUSEKEEPING	23, 683	292, 293			9.00
	DI ETARY	10, 132	109, 597			10.00
	CAFETERIA	-100, 293	327, 019			11.00
	NURSING ADMINISTRATION	66, 492	767, 460			13.00
	MEDICAL RECORDS & LIBRARY	11, 797	211, 098			16.00
	I ENT ROUTINE SERVICE COST CENTERS	-544, 144	978, 266			30.00
	INTENSIVE CARE UNIT	-544, 144	538, 264			31.00
	LARY SERVICE COST CENTERS	0	550, 204			51.00
	OPERATING ROOM	-34, 614	455, 794			50.00
	RECOVERY ROOM	1, 275	153, 450			51.00
51.01 05101	0/P TREATMENT ROOM	0	0			51.01
54.00 05400	RADI OLOGY-DI AGNOSTI C	14, 836	1, 421, 774			54.00
56.00 05600	RADI OI SOTOPE	0	668			56.00
	LABORATORY	0	805, 455			60.00
	WHOLE BLOOD & PACKED RED BLOOD CELLS	0	25, 013			62.00
	RESPI RATORY THERAPY	0	546, 290			65.00
	PHYSI CAL THERAPY	-358, 634	633, 567			66.00
	OCCUPATIONAL THERAPY	137, 989	145, 124			67.00
	SPEECH PATHOLOGY	-6, 182	44, 492			68.00
		673	357, 201			69.00
	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	2, 472 16, 040			71.00
	DRUGS CHARGED TO PATIENTS	40, 491	1,005,296			73.00
	TIENT SERVICE COST CENTERS	40, 471	1,005,290			/3.00
		0	0			90.00
	EMERGENCY	-55, 556	3, 591, 822			91.00
	OBSERVATION BEDS (NON-DISTINCT PART)	, 000	-, ,			92.00
	AL PURPOSE COST CENTERS	·				
	SUBTOTALS (SUM OF LINES 1 through 117)	3, 784, 927	23, 587, 379			118.00
	IMBURSABLE COST CENTERS					
194.0007950	PHYSI CI AN PRACTI CES	0	0			194.00
	MEDICAL OFFICE BUILDING	0	36, 279			194.01
194.0207952		0	0			194.02
200.00	TOTAL (SUM OF LINES 118 through 199)	3, 784, 927	23, 623, 658			200.00

Heal th	Financial Systems	UNI ON HOSPI T	UNION HOSPITAL CLINTON			In Lieu of Form CMS-2552-10		
RECLAS	RECLASSI FI CATI ONS			Provider C	CCN: 15-1326	Peri od:	Worksheet A-	6
						From 01/01/2019 To 12/31/2019	Date/Time Pr 7/9/2020 1:4	
		Increases						
	Cost Center	Line #	Sal ary	0ther				
	2.00	3.00	4.00	5.00				
	A - CAFETERIA RECLASS							
1.00	CAFETERIA	11.00	244, 217	183, 095				1.00
	0	T	244, 217	183, 095				
	B - DEPRECIATION RECLASS							1
1.00	MEDICAL OFFICE BUILDING	194.01	0	36, 279				1.00
2.00		0.00	0	0				2.00
	0		0	36, 279				1
	C - CENTRAL SUPPLIES RECLASS							
1.00	OPERATING ROOM	50.00	0	30, 602				1.00
2.00	RESPI RATORY THERAPY	65.00	0	14, 876				2.00
3.00	MEDICAL SUPPLIES CHARGED TO	71.00	0	736				3.00
	PATI ENTS							
4.00	EMERGENCY	91.00	0	23, 100				4.00
	0		0	69, 314				
500.00	Grand Total: Increases		244, 217	288, 688				500.00
	•							

Heal th	Financial Systems		UNI ON HOSPI T	AL CLINTON		In Lieu	u of Form CMS	-2552-10
RECLAS	SIFICATIONS			Provider (CCN: 15-1326	Peri od:	Worksheet A-	6
						From 01/01/2019 To 12/31/2019	Date/Time Pr 7/9/2020 1:4	epared: 2 pm
		Decreases						
	Cost Center	Line #	Sal ary	Other	Wkst. A-7 Ref			
	6.00	7.00	8.00	9.00	10.00			
	A - CAFETERIA RECLASS							
1.00	DI ETARY		<u>244, 2</u> 17	18 <u>3, 0</u> 95	·	Q		1.00
	0		244, 217	183, 095				
	B - DEPRECIATION RECLASS							
1.00	NEW CAP REL COSTS-BLDG &	1.00	0	35, 081		9		1.00
	FLXT							
2.00	NEW CAP REL COSTS-MVBLE	2.00	0	1, 198		9		2.00
	EQUI P							
	0		0	36, 279				
	C - CENTRAL SUPPLIES RECLASS				+	- 1		
1.00	MEDI CAL SUPPLI ES CHARGED TO	71.00	0	69, 314		0		1.00
	PATI ENTS							
2.00		0.00	0	0		0		2.00
3.00		0.00	0	0		0		3.00
4.00			0	0	<u> </u>	Q		4.00
	0		0	69, 314				
500.00	Grand Total: Decreases		244, 217	288, 688	i l			500.00

Health Financial Systems				In Lieu of Form CMS-2552-10			
RECONCILIATION OF CAPITAL COSTS CENTERS		Provider CC	CN: 15-1326	Period: From 01/01/2019 To 12/31/2019		pared:	
			Acqui si ti on	S			
	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	339, 822	0		0 0	-	1.00	
2.00 Land Improvements	269, 938	4, 390		0 4, 390		2.00	
3.00 Buildings and Fixtures	11, 779, 148	55, 571		0 55, 571	0	3.00	
4.00 Building Improvements	1, 645, 471	0		0 0	0	4.00	
5.00 Fixed Equipment	0	0		0 0	0	5.00	
6.00 Movable Equipment	6, 960, 479	81, 192		0 81, 192	2, 142	6.00	
7.00 HIT designated Assets	0	0		0 0	0	7.00	
8.00 Subtotal (sum of lines 1-7)	20, 994, 858	141, 153		0 141, 153	2, 142	8.00	
9.00 Reconciling Items	0	0		0 0	0	9.00	
10.00 Total (line 8 minus line 9)	20, 994, 858	141, 153		0 141, 153	2, 142	10.00	
	Endi ng	Ful I y					
	Bal ance	Depreci ated					
		Assets					
	6.00	7.00					
PART I - ANALYSIS OF CHANGES IN CAPITAL ASSE							
1.00 Land	339, 822	0				1.00	
2.00 Land Improvements	274, 328	0				2.00	
3.00 Buildings and Fixtures	11, 834, 719	0				3.00	
4.00 Building Improvements	1, 645, 471	0				4.00	
5.00 Fixed Equipment	0	0				5.00	
6.00 Movable Equipment	7, 039, 529	0				6.00	
7.00 HIT designated Assets	0	0				7.00	
8.00 Subtotal (sum of lines 1-7)	21, 133, 869	0				8.00	
9.00 Reconciling Items	0	0				9.00	
10.00 Total (line 8 minus line 9)	21, 133, 869	0				10.00	

Heal th	Financial Systems	UNI ON HOSPI T	AL CLINTON		In Lie	u of Form CMS-2	2552-10
RECONO	CILIATION OF CAPITAL COSTS CENTERS		Provi der (CCN: 15-1326	Period: From 01/01/2019 To 12/31/2019	Worksheet A-7 Part II Date/Time Pre 7/9/2020 1:42	pared:
		SUMMARY OF CAPITAL					
	Cost Center Description	Depreciation	Lease	Interest	Insurance	Taxes (see	
					(see instructions)	instructions)	
	1	9.00	10.00	11.00	12.00	13.00	
	PART II - RECONCILIATION OF AMOUNTS FROM WOR			and 2			
1.00	NEW CAP REL COSTS-BLDG & FIXT	739, 017		0 35	51 0	0	1.00
2.00	NEW CAP REL COSTS-MVBLE EQUIP	376, 949		0	0 0	0	2.00
3.00	Total (sum of lines 1-2)	1, 115, 966		0 35	51 0	0	3.00
		SUMMARY O	F CAPI TAL				
	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, COLUN	IN 2, LINES 1	and 2			
1.00	NEW CAP REL COSTS-BLDG & FIXT	0	739, 36	•			1.00
2.00	NEW CAP REL COSTS-MVBLE EQUIP	0	376, 94	9			2.00
3.00	Total (sum of lines 1-2)	0	1, 116, 31	7			3.00

Health Financial Systems	UNION HOSPIT	AL CLINTON		In Lie	u of Form CMS-2	552-10
RECONCILIATION OF CAPITAL COSTS CENTERS		Provider C	F	Period: From 01/01/2019 Fo 12/31/2019	Worksheet A-7 Part III Date/Time Pre 7/9/2020 1:42	
	COMF	PUTATION OF RA	TI OS	ALLOCATION OF	OTHER CAPITAL	
Cost Center Description	Gross Assets	Capi tal i zed	Gross Assets	Ratio (see	Insurance	
		Leases	for Ratio	instructions)		
			(col. 1 - col. 2)			
	1.00	2.00	3.00	4,00	5.00	
PART III - RECONCILIATION OF CAPITAL COSTS C	ENTERS			1		
1.00 NEW CAP REL COSTS-BLDG & FIXT	14, 094, 340	0	14, 094, 340	0. 666908	0	1.00
2.00 NEW CAP REL COSTS-MVBLE EQUIP	7, 039, 529		7, 039, 529		0	2.00
3.00 Total (sum of lines 1-2)	21, 133, 869		21, 133, 869		0	3.00
	ALLOCATION OF OTHER CAPITAL SUMMARY OF CAPITAL					
Cost Center Description	Taxes	0ther	Total (sum of	Depreciation	Lease	
		Capital-Relat				
		ed Costs	through 7)			
	6.00	7.00	8.00	9.00	10.00	
PART III - RECONCILIATION OF CAPITAL COSTS C 1.00 NEW CAP REL COSTS-BLDG & FIXT	ENTERS 0	0		1, 778, 304	0	1.00
2.00 NEW CAP REL COSTS-BLOG & FIXT	0			375, 751	0	2.00
3.00 Total (sum of lines 1-2)				2, 154, 055	Ű	3.00
		SI	JMMARY OF CAPI			0.00
Cost Center Description	Interest	Insurance	Taxes (see	Other	Total (2)	
		(see	instructions)	Capi tal -Rel at		
		instructions)		ed Costs (see	9 through 14)	
	11.00	12.00	13.00	instructions) 14.00	15.00	
PART III - RECONCILIATION OF CAPITAL COSTS C		12.00	13.00	14.00	15.00	
1.00 NEW CAP REL COSTS-BLDG & FIXT	0	0	() 0	1, 778, 304	1.00
2. 00 NEW CAP REL COSTS-MVBLE EQUIP	0	Ö		0 0	375, 751	2.00
3.00 Total (sum of lines 1-2)	0	0		0 0	2, 154, 055	3.00
					•	

ADJUSTM	ENTS TO EXPENSES				Period:	Worksheet A-8	
					From 01/01/2019 To 12/31/2019	Date/Time Prep 7/9/2020 1:42	pared:
				Expense Classification or		17972020 1.42	pin
				To/From Which the Amount is	to be Adjusted		
	Cost Center Description	Basi s/Code	Amount	Cost Center	Line #	Wkst. A-7	
		(2)	2.00	3.00	4.00	Ref. 5.00	
	nvestment income - NEW CAP	1.00		NEW CAP REL COSTS-BLDG &	1.00	0	1.0
	REL COSTS-BLDG & FIXT (chapter 2)			FIXT			
2.00	nvestment income - NEW CAP		C	NEW CAP REL COSTS-MVBLE	2.00	0	2.0
	REL COSTS-MVBLE EQUIP (chapter 2)			EQUI P			
	nvestment income – other (chapter 2)	В	-351	NEW CAP REL COSTS-BLDG & FIXT	1.00	11	3.0
. 00 1	Frade, quantity, and time		C		0.00	0	4.0
	discounts (chapter 8) Refunds and rebates of		C		0.00	0	5.0
e	expenses (chapter 8)					-	
	Rental of provider space by suppliers (chapter 8)		C		0.00	0	6.0
. 00 1	Felephone services (pay stations excluded) (chapter		C		0.00	0	7.0
	21)						
	Television and radio service (chapter 21)		C		0.00	0	8.0
.00 F	Parking lot (chapter 21)		C		0.00	0	9.0
	Provider-based physician adjustment	A-8-2	-681, 683			0	10.0
1.00 5	Sale of scrap, waste, etc.		C		0.00	0	11.0
	(chapter 23) Related organization	A-8-1	6, 595, 253			0	12.0
1	transactions (chapter 10)				0.00		
	∟aundry and linen service Cafeteria-employees and guests				0.00 0.00	0	13.0 14.0
	Rental of quarters to employee and others		C		0.00	0	15.0
	Sale of medical and surgical		C		0.00	0	16.0
	supplies to other than Datients						
7.00	Sale of drugs to other than		C		0.00	0	17.0
	batients Sale of medical records and		C		0.00	0	18.0
a	abstracts						
	Nursing and allied health education (tuition, fees,		C		0.00	0	19.0
1	pooks, etc.)		C		0.00	0	20. 0
1. 00 I	/ending machines ncome from imposition of				0.00	0	20.0
	nterest, finance or penalty charges (chapter 21)						
2.00 1	nterest expense on Medicare		C		0.00	0	22.0
	overpayments and borrowings to repay Medicare overpayments						
3.00 A	Adjustment for respiratory	A-8-3	C	RESPI RATORY THERAPY	65.00		23.0
	therapy costs in excess of imitation (chapter 14)						
4.00 A	Adjustment for physical	A-8-3	C	PHYSI CAL THERAPY	66.00		24.0
	therapy costs in excess of imitation (chapter 14)						
	Jtilization review - physicians' compensation		C	*** Cost Center Deleted ***	114.00		25.0
	(chapter 21)						
	Depreciation - NEW CAP REL COSTS-BLDG & FIXT		C	NEW CAP REL COSTS-BLDG &	1.00	0	26.0
7.00 [Depreciation - NEW CAP REL		C	NEW CAP REL COSTS-MVBLE	2.00	0	27.0
	COSTS-MVBLE EQUIP Non-physician Anesthetist		(EQUIP *** Cost Center Deleted ***	19.00		28.0
9.00 F	Physicians'assistant		C		0.00	0	29.0
	Adjustment for occupational therapy costs in excess of	A-8-3	C	OCCUPATI ONAL THERAPY	67.00		30. 0
1	imitation (chapter 14)						
	Hospice (non-distinct) (see nstructions)		C	ADULTS & PEDIATRICS	30.00		30. 9

Health Financial Systems		UNI ON HOSPI T	AL CLINTON	In Lie	u of Form CMS-2	2552-10
ADJUSTMENTS TO EXPENSES			Provider CCN: 15-1326	Peri od:	Worksheet A-8	
				From 01/01/2019 To 12/31/2019	Date/Time Pre	narodi
				10 12/31/2019	7/9/2020 1:42	
			Expense Classification of	on Worksheet A		
			To/From Which the Amount i	s to be Adjusted		
				-		
Cost Center Description	Basi s/Code	Amount	Cost Center	Line #	Wkst. A-7	
cost center bescription	(2)	Allount		Line #	Ref.	
	1.00	2.00	3.00	4.00	5.00	
31.00 Adjustment for speech	A-8-3	0	SPEECH PATHOLOGY	68.00		31.00
pathology costs in excess of						
limitation (chapter 14)						
32.00 CAH HIT Adjustment for	A		NEW CAP REL COSTS-BLDG &	1.00	9	32.00
Depreciation and Interest	_		FIXT			
33.00 CHART FEE REVENUE	В		MEDI CAL RECORDS & LI BRARY	16.00	0	00100
33. 01 MI SCELLANEOUS REVENUE	В		ADMINISTRATIVE AND GENERAL	5.06	0	00.01
33. 02 CAFETERIA REVENUE 33. 03 CATERING REVENUE	B			11.00	0	33.02 33.03
33. 03 CATERING REVENUE 33. 04 VPCHC	A		CAFETERI A HOUSEKEEPI NG	11.00 9.00	0	
33. 04 VPCHC 33. 05 ADVERTI SI NG	B		ADMINISTRATIVE AND GENERAL	9.00 5.06	0	33.04
35. 00 RENTAL REVENUE	B		OPERATION OF PLANT	7.00	0	
36. 00 HAF	A		ADMINISTRATIVE AND GENERAL	5.06	0	36.00
39.00 PHYSICIAN RECRUITMENT	A		ADMINI STRATI VE AND GENERAL	5.06	0	39.00
39. 01 PHYSI CI AN RECRUI TMENT	A		EMERGENCY	91.00	0	39.01
50.00 TOTAL (sum of lines 1 thru 49)		3, 784, 927			-	50.00
(Transfer to Worksheet A,						
column 6, line 200.)						

(1) Description - all chapter references in this column pertain to CMS Pub. 15-1.
(2) Basis for adjustment (see instructions).
A. Costs - if cost, including applicable overhead, can be determined.
B. Amount Received - if cost cannot be determined.
(3) Additional adjustments may be made on lines 33 thru 49 and subscripts thereof.
Note: See instructions for column 5 referencing to Worksheet A-7.

Heal th	Financial Systems	UNI ON HOSPI	TAL CLINTON	In Lie	u of Form CMS-:	2552-10
STATEM OFFICE	ENT OF COSTS OF SERVICES FROM COSTS	RELATED ORGANI ZATI ONS AND HC	ME Provider CCN: 15-1326	Period: From 01/01/2019 To 12/31/2019	Worksheet A-8 Date/Time Pre 7/9/2020 1:42	pared:
	Line No.	Cost Center	Expense Items	Amount of Allowable Cost	Amount Included in	pili
					Wks. A, column 5	
	1.00	2.00	3.00	4,00	5.00	
	A. COSTS INCURRED AND ADJUST					
	OFFICE COSTS:		-			
1.00	1.00	NEW CAP REL COSTS-BLDG & FIX	HOME OFFICE	1, 075, 305	0	1.00
2.00		EMPLOYEE BENEFITS DEPARTMENT	HOME OFFICE	1, 147, 467	0	2.00
3.00		NONPATIENT TELEPHONES	HOME OFFICE	26, 775	0	3.00
3.01		DATA PROCESSING	HOME OFFICE	2, 183, 202	0	3.01
4.00				67, 325	0	4.00
4.01			HOME OFFICE	321, 437	0	4.01
4.02		ADMINISTRATIVE AND GENERAL	HOME OFFICE	1, 023, 674	0	4.02
4.03		OPERATION OF PLANT	HOME OFFICE	652, 157	0	4.03
4.04		HOUSEKEEPI NG	HOME OFFICE	29, 366	0	4.04
4.05		DI ETARY	HOME OFFICE	10, 132	0	4.05
4.06		CAFETERI A	HOME OFFICE	46, 694	0	4.06
4.07		NURSING ADMINISTRATION	HOME OFFICE	66, 492	0	4.07
4.08		MEDICAL RECORDS & LIBRARY	HOME OFFICE	11, 854	0	4.08
4.09		OPERATING ROOM	HOME OFFICE	3, 148	0	4.09
4.10		OPERATING ROOM	HOME OFFICE	10, 580	0	4.10
4.11		RECOVERY ROOM	HOME OFFICE	1, 275	0	4.11
4.12		RADI OLOGY-DI AGNOSTI C	HOME OFFICE	104, 033	0	4.12
4.13		PHYSI CAL THERAPY	HOME OFFICE	39, 722	0	4.13
4.14		OCCUPATI ONAL THERAPY	HOME OFFICE	10, 386	0	4.14
4.15		SPEECH PATHOLOGY	HOME OFFICE	2, 533	0	4.15
4.16		ELECTROCARDI OLOGY	HOME OFFICE	673	0	4.16
4.17		DRUGS CHARGED TO PATIENTS	HOME OFFICE	40, 491	0	4.17
4.18		PHYSI CAL THERAPY	THERAPY	488, 046	886, 402	4.18
4.19		OCCUPATIONAL THERAPY	THERAPY	127,603	0	4.19
4.20		SPEECH PATHOLOGY	THERAPY	31, 127	39, 842	4.20
5.00	0		0	7, 521, 497	926, 244	5.00

* 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				
		Ownership		Ownershi p				
1.00	2.00	3.00	4.00	5.00				
B INTERRELATIONSHIP TO RELATED ORGANIZATION(S) AND/OR HOME OFFICE								

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

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

6.00	G		0.00 UNI ON HOSPI TAL	100.00	6.00
7.00	G		0. 00 UNI ON THERAPY	51.00	7.00
8.00			0.00	0.00	8.00
9.00			0.00	0.00	9.00
10.00			0.00	0.00	10.00
100.00	G. Other (financial or	OTHER			100.00
	non-financial) specify:				

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

A. Individual has financial interest (stockholder, partner, etc.) in both related organization and in provider.

B. Corporation, partnership, or other organization has financial interest in provider.

C. Provider has financial interest in corporation, partnership, or other organization.

D. Director, officer, administrator, or key person of provider or relative of such person has financial interest in related organization.

E. Individual is director, officer, administrator, or key person of provider and related organization.

F. Director, officer, administrator, or key person of related organization or relative of such person has financial interest in provider.

Health Financial Systems UNION HOSPITA	L_CLINTON	In Lie	u of Form CMS-2552-10
STATEMENT OF COSTS OF SERVICES FROM RELATED ORGANIZATIONS AND HOME	Provider CCN: 15-1326	Period: From 01/01/2019	Worksheet A-8-1
OFFICE COSTS			Date/Time Prepared:

			7/9/2020 1: 4.	2 pm
	Net	Wkst. A-7 Ref.		
	Adjustments			
	(col. 4 minus			
	col. 5)*			
	6.00	7.00		
		RED AND ADJUSTM	ENTS REQUIRED AS A RESULT OF TRANSACTIONS WITH RELATED ORGANIZATIONS OR CLAIMED HOME	
	OFFICE COSTS:			1
1.00	1, 075, 305			1.00
2.00	1, 147, 467	0		2.00
3.00	26, 775	0		3.00
3.01	2, 183, 202	0		3.01
4.00	67, 325	0		4.00
4.01	321, 437	0		4.01
4.02	1, 023, 674	0		4.02
4.03	652, 157	0		4.03
4.04	29, 366			4.04
4.05	10, 132	0		4.05
4.06	46, 694	0		4.06
4.07	66, 492	0		4.07
4.08	11, 854	0		4.08
4.09	3, 148	0		4.09
4.10	10, 580	0		4.10
4.11	1, 275	0		4.11
4.12	104, 033	0		4.12
4.13	39, 722	0		4.13
4.14	10, 386	0		4.14
4.15	2, 533	0		4.15
4.16	673	0		4.16
4.17	40, 491	0		4.17
4.18	-398, 356	0		4.18
4.19	127, 603	0		4.19
4.20	-8, 715	0		4.20
5.00	6, 595, 253			5.00

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 ot been posted to Worksheet A, columns 1 and/or 2 the amount allowable should be indicated in column 4 of this par

nas no	been posted to worksheet A,	condinins i and/or z, the amount arrowable should be indicated in condinin 4 or this part.	
	Related Organization(s)		
	and/or Home Office		
	Type of Business		
	6.00		
	B. INTERRELATIONSHIP TO RELA	TED ORGANIZATION(S) AND/OR HOME OFFICE:	

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

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

6.00	HOME OFFICE	6.00
7.00	THERAPY	7.00
8.00		8.00
9.00		9.00
10.00		10.00
9.00 10.00 <u>100.00</u>		100.00

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

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

C. Provider has financial interest in corporation, partnership, or other organization.

D. Director, officer, administrator, or key person of provider or relative of such person has financial interest in related 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 provi der.

	Financial Syste		UNI ON HOSPI	TAL CLINTON			eu of Form CMS-	
PROVI DE	R BASED PHYSIC	I AN ADJUSTMENT		Provider (Period: From 01/01/2019 To 12/31/2019	Date/Time Pre	epared:
	Wkst. A Line #	Cost Center/Physician	Total	Professi onal	Provi der	RCE Amount	7/9/2020 1:42 Physi ci an/Prov	
		I denti fi er	Remuneration	Component	Component		ider Component Hours	
	1.00	2.00	3.00	4.00	5.00	6.00	7.00	
1.00		ADULTS & PEDIATRICS	544, 144		(1.00
2.00		OPERATI NG ROOM	48, 342		C			2.00
3.00		RADI OLOGY-DI AGNOSTI C	89, 197		C			3.00
4.00		EMERGENCY	2, 138, 010		2, 138, 010	0	0	4.00
5.00	0.00		0	0	_, · · · · · · · · · · · · · · · · · · ·		0	5.00
6.00	0.00			0	C		0	6.00
7.00	0.00			0	C	0	0	7.00
8.00	0.00			0	(0	0	8.00
9.00	0.00			0	C	0	0	9.00
10.00	0.00			0	Ċ	0	0	10.00
200.00	0.00		2, 819, 693	, i i i i i i i i i i i i i i i i i i i	2, 138, 010	, s	0	200.00
	Wkst. A Line #	Cost Center/Physician	Unadjusted RCE		Cost of		Physician Cost	200.00
		I denti fi er	Limit	Unadjusted RCE			of Malpractice	
		raciterret		Limit	Conti nui ng	Share of col.	Insurance	
				2	Education	12	i nour anoo	
	1,00	2.00	8,00	9.00	12.00	13.00	14.00	
1.00	30.00	ADULTS & PEDIATRICS	C		C			1.00
2.00		OPERATING ROOM		0	C			2.00
3.00		RADI OLOGY-DI AGNOSTI C		0	C	0	0	3.00
4.00		EMERGENCY		0	C	0	0	4.00
5.00	0.00		0	0	C	0	0	5.00
6.00	0.00		0	0	C	0	0	6.00
7.00	0, 00			0	C	0	0	7.00
8.00	0.00			0	C	0	0	8.00
9.00	0.00			0	C	0	0	
10.00	0.00			0	C	0	0	10.00
200.00				0	C	0	0	200.00
	Wkst. A Line #	Cost Center/Physician	Provi der	Adjusted RCE	RCE	Adjustment		
		I denti fi er	Component	Limit	Di sal I owance			
			Share of col.					
			14					
	1.00	2.00	15.00	16.00	17.00	18.00		
1.00	30.00	ADULTS & PEDIATRICS	C	0	C	544, 144		1.00
2.00	50.00	OPERATING ROOM	0	0	C	48, 342		2.00
3.00	54.00	RADI OLOGY-DI AGNOSTI C	0	0	C	89, 197		3.00
4.00	91.00	EMERGENCY	0	0	C	0		4.00
5.00	0.00		0	0	C	0		5.00
6.00	0.00		0	0	C	0		6.00
7.00	0.00		0	0	C	0		7.00
8.00	0.00		0	0	C	0		8.00
9.00	0.00		0	0	C	0		9.00
10.00	0.00		0	0	C	0		10.00
200.00			0	0	C	681, 683		200.00
	•							

Heal th	Financial Systems	UNI ON HOSPI TA	AL CLINTON		In Lie	u of Form CMS-:	2552-10
COST A	ALLOCATION - GENERAL SERVICE COSTS		Provider CC		Period: From 01/01/2019 To 12/31/2019	Worksheet B Part I Date/Time Pre 7/9/2020 1:42	
			CAPI TAL REL	ATED COSTS		17772020 11 12	
	Cost Center Description	Net Expenses for Cost Allocation (from Wkst A col. 7)	NEW BLDG & FIXT	NEW MVBLE EQUI P	EMPLOYEE BENEFITS DEPARTMENT	NONPATI ENT TELEPHONES	
		0	1.00	2.00	4.00	5. 01	
	GENERAL SERVICE COST CENTERS				-		
1.00	00100 NEW CAP REL COSTS-BLDG & FIXT	1, 778, 304	1, 778, 304				1.00
2.00	00200 NEW CAP REL COSTS-MVBLE EQUIP	375, 751		375, 75			2.00
4.00	00400 EMPLOYEE BENEFITS DEPARTMENT	1, 147, 467	0		0 1, 147, 467		4.00
5.01	00540 NONPATI ENT TELEPHONES	55, 849	2, 385	5, 49		63, 731	5.01
5.02	00550 DATA PROCESSI NG	2, 727, 522	4,656	232, 60		1, 004	5.02
5.03	00560 PURCHASING RECEIVING AND STORES	101, 757	18, 143		0 0	502	5.03
5.04	00570 ADMI TTI NG	428, 914	11, 560	3		1, 756	
5.05	00580 CASHI ERI NG/ACCOUNTS RECEI VABLE	604, 990	6, 835		0 3, 755	1, 255	5.05
5.06	00591 ADMI NI STRATI VE AND GENERAL	2, 319, 512	33, 809	2, 83		3, 513	5.06
7.00	00700 OPERATION OF PLANT	1, 618, 858	492, 819	5, 56		5, 520	7.00
8.00	00800 LAUNDRY & LINEN SERVICE	0	9, 496	13		0	8.00
9.00	00900 HOUSEKEEPI NG	292, 293	8, 991	1, 93		251	9.00
10.00	01000 DI ETARY	109, 597	19, 450	1, 67		251	10.00
11.00	01100 CAFETERI A	327, 019	82, 939	7,14		1, 505	
13.00	01300 NURSI NG ADMI NI STRATI ON	767, 460	31, 698	21		1, 004	•
16.00	01600 MEDICAL RECORDS & LIBRARY	211, 098	20, 070	5	9 20, 193	2,007	16.00
	INPATIENT ROUTINE SERVICE COST CENTERS	L			-		
30.00	03000 ADULTS & PEDIATRICS	978, 266	320, 838	20, 69			
31.00	03100 I NTENSI VE CARE UNI T	538, 264	9, 404	6, 28	9 75, 051	1, 505	31.00
	ANCI LLARY SERVICE COST CENTERS	155 304	20.2/5	15.00		1 505	
50.00	05000 OPERATING ROOM	455, 794	78, 765	45, 83		1,505	
51.00	05100 RECOVERY ROOM	153, 450	43, 786	6, 62		3, 513	51.00
51.01	05101 0/P TREATMENT ROOM	0	100.054		0 0	0	51.01
54.00	05400 RADI OLOGY-DI AGNOSTI C	1, 421, 774	130, 854	7, 20		4, 015	•
56.00		668	20 245		0 0	0	56.00
60.00	06000 LABORATORY	805, 455	39, 245		0 0	1, 505	•
62.00 65.00	06200 WHOLE BLOOD & PACKED RED BLOOD CELLS 06500 RESPI RATORY THERAPY	25, 013 546, 290	0 28, 487	8, 26	0 0 3 73, 477	0 1, 505	62.00 65.00
66.00	06600 PHYSI CAL THERAPY	633, 567	28, 487 77, 503	81		2, 509	66.00
67.00	06700 OCCUPATI ONAL THERAPY	145, 124	65, 186		0 0	1, 756	•
68.00	06800 SPEECH PATHOLOGY	44, 492	8, 808		0 0	502	68.00
69.00	06900 ELECTROCARDI OLOGY	357, 201	9, 610	46		1, 004	
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	2, 472	229		0 4, 515	251	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	16,040	0		0 0	0	72.00
	07300 DRUGS CHARGED TO PATIENTS	1,005,296	23, 258	2, 17		1, 505	73.00
75.00	OUTPATIENT SERVICE COST CENTERS	1,000,270	20,200	2,17	/ 41,700	1, 303	/ 5. 00
90 00	09000 CLINIC	0	0		0 0	0	90.00
	09100 EMERGENCY	3, 591, 822	199, 480				91.00
	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0,071,022	177, 100	17,00	100,070	7,020	92.00
72.00	SPECIAL PURPOSE COST CENTERS	II					72.00
118.00	SUBTOTALS (SUM OF LINES 1 through 117)	23, 587, 379	1, 778, 304	375, 75	1 1, 147, 467	63, 731	118.00
104 00	NONREIMBURSABLE COST CENTERS	o	0		0 0	0	194.00
	07950 PHYSICIAN PRACTICES	36, 279	0		0 0		194.00
	207952 VPCHC	30, 279	0		0 0		194.01
200.00		0	0			0	200.00
200.00			0			0	200.00
201.00		23, 623, 658	1, 778, 304	375, 75	1, 147, 467		201.00
202.00		20, 020, 000	1, 770, 504	575,75	., ., ., ., .,	05,751	1-02.00

Heal th	Financial Systems	UNION HOSPIT	AL CLINTON		In Lieu	u of Form CMS-2	2552-10
COST A	ALLOCATION - GENERAL SERVICE COSTS		Provider CC	N: 15-1326	Peri od: From 01/01/2019 To 12/31/2019	Worksheet B Part I Date/Time Pre	pared:
	Cost Center Description	DATA PROCESSI NG	PURCHASI NG RECEI VI NG AND STORES	ADMI TTI NG	CASHI ERI NG/AC COUNTS RECEI VABLE	<u>7/9/2020 1:42</u> Subtotal	pm
		5. 02	5.03	5.04	5.05	5A. 05	
	GENERAL SERVICE COST CENTERS						
1.00	00100 NEW CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200 NEW CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400 EMPLOYEE BENEFITS DEPARTMENT						4.00
5.01	00540 NONPATI ENT TELEPHONES						5.01
5.02	00550 DATA PROCESSI NG	2, 965, 786					5.02
5.03	00560 PURCHASING RECEIVING AND STORES	0	120, 402				5.03
5.04	00570 ADMI TTI NG	156, 094	2, 239	666, 01	17		5.04
5.05	00580 CASHI ERI NG/ACCOUNTS RECEI VABLE	52, 031	0		0 668, 866		5.05
5.06	00591 ADMINI STRATI VE AND GENERAL	338, 204	105		0 0	2, 822, 520	5.06
7.00	00700 OPERATION OF PLANT	676, 406	41		0 0	2, 863, 272	7.00
8.00	00800 LAUNDRY & LINEN SERVICE	0	0		0 0	9, 632	8.00
9.00	00900 HOUSEKEEPI NG	26, 016	10, 799		0 0	375, 815	9.00
10.00	01000 DI ETARY	26, 016	13		0 0	166, 828	10.00
11.00	01100 CAFETERI A	52, 031	56		0 0	512, 901	11.00
13.00	01300 NURSI NG ADMI NI STRATI ON	104, 063	20		0 0	1, 007, 801	13.00
16.00	01600 MEDI CAL RECORDS & LI BRARY	208, 125	16		0 0	461, 568	16.00
	INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000 ADULTS & PEDI ATRI CS	286, 172		274, 90		2,097,360	30.00
31.00	03100 I NTENSI VE CARE UNI T	26, 016	5, 708	57, 09	7, 429	726, 757	31.00
	ANCI LLARY SERVICE COST CENTERS						
50.00	05000 OPERATING ROOM	104, 063		27, 18		802, 243	50.00
51.00	05100 RECOVERY ROOM	26, 016		84		276, 638	51.00
51.01	05101 0/P TREATMENT ROOM	0	0	(4 7	0 0	0	51.01
54.00	05400 RADI OLOGY-DI AGNOSTI C	234, 141	12, 952	61, 74		2, 186, 482	54.00
56.00	05600 RADI OI SOTOPE	0	1	70 (0 17	686	56.00
60.00	06000 LABORATORY	26, 016		73, 64		1,030,585	60.00
62.00	06200 WHOLE BLOOD & PACKED RED BLOOD CELLS 06500 RESPI RATORY THERAPY	52, 031	0	1,63		27, 437 768, 911	62.00
65.00 66.00	06600 PHYSI CAL THERAPY	104, 063	3, 011 224	44, 17 8, 01		850, 609	65.00 66.00
67.00	06700 OCCUPATI ONAL THERAPY	104, 063		8,0 3,74		222,067	67.00
67.00	06800 SPEECH PATHOLOGY	0	0	3, 72			
69.00	06900 ELECTROCARDI OLOGY	0	0	23, 00		56, 083 429, 429	69.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	23, 00	2 33, 630 4 21	429,429	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0	-		4 21	16,040	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	78, 047	258	49, 45	0	1, 247, 187	73.00
75.00	OUTPATIENT SERVICE COST CENTERS	70, 047	230	47,40	43, 220	1, 247, 107	/ 3.00
90.00	09000 CLINIC	0	0		0 0	0	90.00
91.00	09100 EMERGENCY	390, 235		39, 83		4, 625, 551	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0,0,200	00,100	0,700		0	92.00
72.00	SPECIAL PURPOSE COST CENTERS						72.00
118.00		2, 965, 786	120, 402	666, 01	17 668, 866	23, 587, 379	118.00
	NONREI MBURSABLE COST CENTERS						
194.00	07950 PHYSI CI AN PRACTI CES	0	0		0 0	0	194.00
194.01	07951 MEDICAL OFFICE BUILDING	0	0		0 0	36, 279	194.01
194.02	207952 VPCHC	0	0		0 0	0	194.02
200.00	Cross Foot Adjustments					0	200.00
201.00	Negative Cost Centers	0	0		0 0	0	201.00
202.00	TOTAL (sum lines 118 through 201)	2, 965, 786	120, 402	666, 01	17 668, 866	23, 623, 658	202.00

Heal th	n Financial Systems	UNI ON HOSPI T	AL CLINTON		In Lie	u of Form CMS-	2552-10
COST /	ALLOCATION - GENERAL SERVICE COSTS		Provider C	F	Period: From 01/01/2019 To 12/31/2019	Worksheet B Part I Date/Time Pre	epared.
						7/9/2020 1:42	2 pm
	Cost Center Description	ADMI NI STRATI V E AND GENERAL	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE		DI ETARY	
		5.06	7.00	8.00	9.00	10.00	
	GENERAL SERVICE COST CENTERS				1		1
1.00	00100 NEW CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200 NEW CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400 EMPLOYEE BENEFITS DEPARTMENT						4.00
5.01	00540 NONPATI ENT TELEPHONES						5.01
5.02	00550 DATA PROCESSING						5.02
5.03	00560 PURCHASING RECEIVING AND STORES						5.03
5.04	00570 ADMI TTI NG						5.04
5.05	00580 CASHI ERI NG/ACCOUNTS RECEI VABLE						5.05
5.06	00591 ADMINISTRATIVE AND GENERAL	2, 822, 520					5.06
7.00	00700 OPERATION OF PLANT	388, 520					7.00
8.00	00800 LAUNDRY & LINEN SERVICE	1, 307	25, 559				8.00
9.00	00900 HOUSEKEEPI NG	50, 995	24, 201	2, 946	453, 957		9.00
10.00	01000 DI ETARY	22, 637	52, 354	150	7, 422	249, 391	10.00
11.00	01100 CAFETERI A	69, 596	223, 244	531	31, 650	0	11.00
13.00	01300 NURSING ADMINISTRATION	136, 750	85, 322	0	12, 096	0	13.00
16.00	01600 MEDICAL RECORDS & LIBRARY	62, 631	54, 021	0	7,659	0	16.00
	INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000 ADULTS & PEDIATRICS	284, 593	863, 589	8, 579	9 122, 431	192, 907	30.00
31.00	03100 I NTENSI VE CARE UNI T	98, 614	25, 313	4, 173	3, 589	33, 625	31.00
	ANCILLARY SERVICE COST CENTERS						
50.00	05000 OPERATING ROOM	108, 857	212, 008	1, 132	2 30, 057	0	50.00
51.00	05100 RECOVERY ROOM	37, 537	117, 857	0	16, 709	22, 859	51.00
51.01	05101 0/P TREATMENT ROOM	0	0	0	0 0	0	51.01
54.00	05400 RADI OLOGY-DI AGNOSTI C	296, 686	352, 214	3, 660	49, 934	0	54.00
56.00	05600 RADI OI SOTOPE	93	0	0	0 0	0	56.00
60.00	06000 LABORATORY	139, 841	105, 633	0	14, 976	0	60.00
62.00	06200 WHOLE BLOOD & PACKED RED BLOOD CELLS	3, 723	0	0	0 0	0	62.00
65.00	06500 RESPI RATORY THERAPY	104, 334	76, 678	170	10, 871	0	65.00
66.00	06600 PHYSI CAL THERAPY	115, 420				0	66.00
67.00	06700 OCCUPATI ONAL THERAPY	30, 132	175, 459			0	
68.00	06800 SPEECH PATHOLOGY	7, 610				0	68.00
69.00	06900 ELECTROCARDI OLOGY	58, 270				0	69.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	404	617	0		0	
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	2, 176	0			0	
73.00		169, 232	62, 602			0	
	OUTPATIENT SERVICE COST CENTERS		,		.,		
90.00	09000 CLINIC	0	0		0 0	0	90.00
91.00	09100 EMERGENCY	627, 639				0	
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0217007	000,701	10,0,0	, 0, 122	0	92.00
/2:00	SPECIAL PURPOSE COST CENTERS			1			/2/00
118.0		2, 817, 597	3, 251, 792	36, 498	453, 957	249, 391	1118 00
110.00	NONREI MBURSABLE COST CENTERS	2,017,377	5,251,772	30,470	400,707	277, 371	1 10.00
194 0	007950 PHYSI CLAN PRACTICES	0	0	0	0	0	194.00
	107951 MEDICAL OFFICE BUILDING	4, 923					194.00
	207952 VPCHC	4, 723					194.01
200.0		0			í í	0	200.00
200.0	5	0	_		0	0	200.00
201.0		2, 822, 520	3, 251, 792		° I	249, 391	
202.0	I TOTAL (Sum THES TTO THEOUGH 201)	2,022,020	J, 201, 772	1 30,470	455, 957	247, 371	202.00

Heal th	Financial Systems	UNI ON HOSPI T	AL CLINTON		In Lie	u of Form CMS-:	2552-10
COST A	LLOCATION - GENERAL SERVICE COSTS		Provider CO	CN: 15-1326	Peri od:	Worksheet B	
					From 01/01/2019 To 12/31/2019	Part I Date/Time Pre	narod
					10 12/31/2019	7/9/2020 1: 42	
	Cost Center Description	CAFETERI A	NURSI NG	MEDI CAL	Subtotal	Intern &	
			ADMI NI STRATI O	RECORDS &		Resi dents	
			N	LI BRARY		Cost & Post	
						Stepdown	
		11 00	12.00	1/ 00	24.00	Adjustments	
	GENERAL SERVICE COST CENTERS	11.00	13.00	16.00	24.00	25.00	
1.00	00100 NEW CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200 NEW CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400 EMPLOYEE BENEFITS DEPARTMENT						4.00
5.01	00540 NONPATIENT TELEPHONES						5.01
5.02	00550 DATA PROCESSI NG						5.02
5.03	00560 PURCHASING RECEIVING AND STORES						5.03
5.04	00570 ADMI TTI NG						5.04
5.05	00580 CASHI ERI NG/ACCOUNTS RECEI VABLE						5.05
5.06	00591 ADMI NI STRATI VE AND GENERAL						5.06
7.00							7.00
8.00 9.00	00800 LAUNDRY & LI NEN SERVI CE 00900 HOUSEKEEPI NG						8.00 9.00
9.00 10.00	01000 DI ETARY						10.00
11.00	01100 CAFETERI A	837, 922					11.00
13.00	01300 NURSI NG ADMI NI STRATI ON	87, 552					13.00
16.00	01600 MEDI CAL RECORDS & LI BRARY	31, 917		617, 79	96		16.00
	INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000 ADULTS & PEDIATRICS	168, 417	549, 957	33, 04	41 4, 320, 874	0	30.00
31.00	03100 INTENSIVE CARE UNIT	65, 727	214, 637	6, 80	52 1, 179, 297	0	31.00
	ANCILLARY SERVICE COST CENTERS						-
50.00	05000 OPERATING ROOM	33, 557		31, 44		0	50.00
51.00	05100 RECOVERY ROOM	23, 969		12, 7		0	51.00
51.01 54.00	05101 0/P TREATMENT ROOM 05400 RADI OLOGY-DI AGNOSTI C	122 472	-	170 0	0 0	0	51.01 54.00
56.00	05600 RADI OLOGI - DI AGNOSTI C	133, 472 0		178, 90	52 3, 201, 410 16 795	0	56.00
60.00	06000 LABORATORY	0	-	78, 25		0	60.00
62.00	06200 WHOLE BLOOD & PACKED RED BLOOD CELLS	0	-		32 1, 307, 207	0	62.00
65.00	06500 RESPI RATORY THERAPY	74, 431	0	10, 78		0	65.00
66.00	06600 PHYSI CAL THERAPY	0	0	22, 04		0	66.00
67.00	06700 OCCUPATI ONAL THERAPY	0	0	5, 7	76 458, 309	0	67.00
68.00	06800 SPEECH PATHOLOGY	0	0	1, 40	92, 170	0	68.00
69.00	06900 ELECTROCARDI OLOGY	4, 415		31, 00		0	69.00
71.00	07100 MEDI CAL SUPPLIES CHARGED TO PATIENTS	0	-		20 4, 106	0	71.00
	07200 I MPL. DEV. CHARGED TO PATIENTS	0	-	44 7	0 18, 216	0	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	41, 379	0	41, 7	75 1, 571, 050	0	73.00
90.00	OUTPATIENT SERVICE COST CENTERS	0	0		0 0	0	90.00
90.00 91.00	09100 EMERGENCY	173, 086	-	162, 80		0	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	175,000	304, 727	102, 00	0, 111, 707	0	•
72.00	SPECIAL PURPOSE COST CENTERS						/2.00
118.00		837, 922	1, 329, 521	617, 79	23, 582, 456	0	118.00
	NONREIMBURSABLE COST CENTERS						
194.00	07950 PHYSICIAN PRACTICES	0	0		0 0	0	194.00
	07951 MEDICAL OFFICE BUILDING	0	0		0 41, 202		194.01
	07952 VPCHC	0	0		0 0		194.02
200.00					0		200.00
201.00		0	0	(47.7	0 0		201.00
202.00	TOTAL (sum lines 118 through 201)	837, 922	1, 329, 521	617, 79	23, 623, 658	0	202.00

	ncial Systems	UNI ON HOSPI TAI		In Lieu of Form C	
COST ALLOCA	ATION - GENERAL SERVICE COSTS		Provider CCN: 15-1326	Period: Worksheet	В
				From 01/01/2019 Part I To 12/31/2019 Date/Time	Droparod
				7/9/2020 1	
	Cost Center Description	Total	· ·		
		26.00			
	RAL SERVICE COST CENTERS	1			
	O NEW CAP REL COSTS-BLDG & FIXT				1.0
	O NEW CAP REL COSTS-MVBLE EQUIP				2.0
	O EMPLOYEE BENEFITS DEPARTMENT				4.0
	0 NONPATIENT TELEPHONES				5.0
	O DATA PROCESSING				5.0
	O PURCHASING RECEIVING AND STORES				5.0
					5.0
	O CASHI ERI NG/ACCOUNTS RECEI VABLE				5.0
	1 ADMINISTRATIVE AND GENERAL				5.0
	O OPERATION OF PLANT				7.0
	O LAUNDRY & LINEN SERVICE				8.0
	O HOUSEKEEPI NG				9.0
	0 DI ETARY 0 CAFETERI A				10.0
	O NURSING ADMINISTRATION				11.0
	O MEDICAL RECORDS & LIBRARY				16.0
	TIENT ROUTINE SERVICE COST CENTERS				10.0
	O ADULTS & PEDIATRICS	4, 320, 874			30.0
	O I NTENSI VE CARE UNI T	4, 320, 874			30.0
	LLARY SERVICE COST CENTERS	1, 177, 277			31.0
	O OPERATI NG ROOM	1, 219, 303			50.0
	O RECOVERY ROOM	508, 328			51.0
	1 O/P TREATMENT ROOM	0			51.0
	0 RADI OLOGY-DI AGNOSTI C	3, 201, 410			54.0
	0 RADI OI SOTOPE	795			56.0
	O LABORATORY	1, 369, 287			60.0
	O WHOLE BLOOD & PACKED RED BLOOD CELLS	31, 892			62.0
	O RESPIRATORY THERAPY	1, 046, 177			65.0
	O PHYSI CAL THERAPY	1, 229, 813			66.0
	O OCCUPATI ONAL THERAPY	458, 309			67.0
	O SPEECH PATHOLOGY	92, 170			68.0
	0 ELECTROCARDI OLOGY	553, 470			69.0
	O MEDICAL SUPPLIES CHARGED TO PATIENTS	4, 106			71.0
	O IMPL. DEV. CHARGED TO PATIENTS	18, 216			72.0
	O DRUGS CHARGED TO PATIENTS	1, 571, 050			73.0
	ATIENT SERVICE COST CENTERS	· · · ·			
90.00 0900		0			90.0
91.00 0910		6, 777, 959			91.0
	O OBSERVATION BEDS (NON-DISTINCT PART)				92.0
	AL PURPOSE COST CENTERS				
118.00	SUBTOTALS (SUM OF LINES 1 through 117)	23, 582, 456			118.0
NONRI	EIMBURSABLE COST CENTERS				
194.000795	O PHYSICIAN PRACTICES	0			194.0
	1 MEDICAL OFFICE BUILDING	41, 202			194.0
194. 02 0795	2 VPCHC	0			194.0
200.00	Cross Foot Adjustments	0			200.0
201.00	Negative Cost Centers	0			201.0
202.00	TOTAL (sum lines 118 through 201)	23, 623, 658			202.0

Health Financial Systems	UNION HOSPITA	AL CLINTON		In Lie	u of Form CMS-:	2552-10
ALLOCATION OF CAPITAL RELATED COSTS		Provider CO	CN: 15-1326	Period: From 01/01/2019 To 12/31/2019	Worksheet B Part II Date/Time Pre 7/9/2020 1:42	epared:
		CAPI TAL REL	ATED COSTS		17772020 1.42	
Cost Center Description	Directly Assigned New Capital Related Costs	NEW BLDG & FIXT	NEW MVBLE EQUI P	Subtotal	EMPLOYEE BENEFI TS DEPARTMENT	
	0	1.00	2.00	2A	4.00	
GENERAL SERVICE COST CENTERS						
1.00 00100 NEW CAP REL COSTS-BLDG & FIXT 2.00 00200 NEW CAP REL COSTS-MVBLE EQUIP						1.00 2.00
4.00 00400 EMPLOYEE BENEFITS DEPARTMENT	0	0		0 0	0	4.00
5. 01 00540 NONPATI ENT TELEPHONES	0	2, 385	5,49		0	5.01
5. 02 00550 DATA PROCESSI NG	0	4, 656	232, 60		0	5.02
5. 03 00560 PURCHASING RECEIVING AND STORES	0	18, 143		0 18, 143	0	5.03
5. 04 00570 ADMI TTI NG	0	11, 560	2	36 11, 596	0	5.04
5. 05 00580 CASHI ERI NG/ACCOUNTS RECEI VABLE 5. 06 00591 ADMI NI STRATI VE AND GENERAL	0	6, 835 33, 809	2, 83	0 6,835 34 36,643	0	5.05 5.06
7. 00 00700 OPERATION OF PLANT	0	33, 809 492, 819	2,83 5,56		0	7.00
8.00 00800 LAUNDRY & LI NEN SERVI CE	0	9,496	13		0	8.00
9. 00 00900 HOUSEKEEPI NG	0	8, 991	1, 93		0	9.00
10. 00 01000 DI ETARY	0	19, 450			0	10.00
11. 00 01100 CAFETERI A	0	82, 939			0	11.00
13.00 01300 NURSING ADMINISTRATION	0	31, 698			0	13.00
16.00 01600 MEDICAL RECORDS & LIBRARY	0	20, 070	Ĺ	59 20, 129	0	16.00
INPATIENT ROUTINE SERVICE COST CENTERS						
30. 00 03000 ADULTS & PEDI ATRI CS	0	320, 838			0	30.00
31. 00 03100 I NTENSI VE CARE UNI T	0	9, 404	6, 28	39 15, 693	0	31.00
ANCI LLARY SERVICE COST CENTERS		70.7/5	45.00	104 500	0	50.00
50.00 05000 0PERATING ROOM 51.00 05100 RECOVERY ROOM	0	78, 765 43, 786	45,83 6,62		0	50.00 51.00
51.01 05101 0/P TREATMENT ROOM	0	43,700	0,02	0 50,412	0	51.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	0	130, 854	7,20		0	54.00
56. 00 05600 RADI OI SOTOPE	0	00,001	, 20	0 0	0	56.00
60. 00 06000 LABORATORY	0	39, 245		0 39, 245	0	60.00
62.00 06200 WHOLE BLOOD & PACKED RED BLOOD CELLS	0	0		0 0	0	62.00
65. 00 06500 RESPI RATORY THERAPY	0	28, 487	8, 26	36, 750	0	65.00
66. 00 06600 PHYSI CAL THERAPY	0	77, 503	81	11 78, 314	0	66.00
67.00 06700 OCCUPATI ONAL THERAPY	0	65, 186		0 65, 186	0	67.00
68.00 06800 SPEECH PATHOLOGY	0	8, 808		0 8, 808	0	68.00
69. 00 06900 ELECTROCARDI OLOGY	0	9, 610	46		0	69.00
71.00 07100 MEDI CAL SUPPLI ES CHARGED TO PATI ENTS	0	229		0 229	0	71.00
72. 00 07200 I MPL. DEV. CHARGED TO PATIENTS	0	0	0.1	0 0	0	72.00
73. 00 07300 DRUGS CHARGED TO PATI ENTS OUTPATI ENT SERVI CE COST CENTERS	0	23, 258	2, 17	25, 435	0	73.00
90. 00 09000 CLINIC	0	0		0 0	0	90.00
91. 00 09100 EMERGENCY	0	199, 480	19, 68			
92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	Ű	1777 100	.,,	0		92.00
SPECIAL PURPOSE COST CENTERS	л – л					
118.00 SUBTOTALS (SUM OF LINES 1 through 117)	0	1, 778, 304	375, 75	51 2, 154, 055	0	118.00
NONREI MBURSABLE COST CENTERS				1		
194.00 07950 PHYSI CLAN PRACTI CES	0	0		0 0		194.00
194. 01 07951 MEDICAL OFFICE BUILDING	0	0		0 0		194.01
194.0207952 VPCHC	0	0		0 0	0	194.02
200.00Cross Foot Adjustments201.00Negative Cost Centers		~		0	_	200. 00 201. 00
201.00 Negative cost centers 202.00 TOTAL (sum lines 118 through 201)	О	0 1, 778, 304	375, 75	0 0 51 2, 154, 055		201.00
202.00 TITL (Sum TIMES TO THOUGH 201)	I U	1, 770, 304	375,75	2, 154, 055	0	1202.00

Heal th	Financial Systems	UNI ON HOSPI TA	AL CLINTON		In Lie	u of Form CMS-:	2552-10
	ATION OF CAPITAL RELATED COSTS		Provider C		eriod:	Worksheet B	
					rom 01/01/2019 0 12/31/2019	Part II Date/Time Pre	pared:
						7/9/2020 1:42	
	Cost Center Description	NONPATI ENT TELEPHONES	DATA PROCESSI NG	PURCHASI NG RECEI VI NG AND	ADMI TTI NG	CASHI ERI NG/AC COUNTS	
		TELEPHONES	PROCESSING	STORES		RECEIVABLE	
		5. 01	5.02	5.03	5.04	5. 05	
	GENERAL SERVICE COST CENTERS						
1.00	00100 NEW CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200 NEW CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400 EMPLOYEE BENEFITS DEPARTMENT	7 000					4.00
5. 01 5. 02	00540 NONPATI ENT TELEPHONES 00550 DATA PROCESSI NG	7,882	227 204				5.01
5.02 5.03	00560 PURCHASING RECEIVING AND STORES	124 62	237, 384				5.02 5.03
5.03	00570 ADMITTING	217	12, 494				5.03
5.05	00580 CASHI ERI NG/ACCOUNTS RECEI VABLE	155	4, 165			11, 155	5.05
5.06	00591 ADMI NI STRATI VE AND GENERAL	434	27, 070		-	0	5.06
7.00	00700 OPERATION OF PLANT	683	54, 141			0	7.00
8.00	00800 LAUNDRY & LINEN SERVICE	0	C		0	0	8.00
9.00	00900 HOUSEKEEPI NG	31	2, 082	1, 633	0	0	9.00
10.00	01000 DI ETARY	31	2, 082		0	0	10.00
11.00	01100 CAFETERI A	186	4, 165			0	11.00
13.00	01300 NURSI NG ADMI NI STRATI ON	124	8, 329		0	0	13.00
16.00	01600 MEDICAL RECORDS & LIBRARY	248	16, 659	2	0	0	16.00
~~ ~~	INPATIENT ROUTINE SERVICE COST CENTERS	0.110			10.174	505	
30.00	03000 ADULTS & PEDIATRICS	2, 113	22, 905			595	
31.00	03100 I NTENSI VE CARE UNI T ANCI LLARY SERVI CE COST CENTERS	186	2,082	863	2, 113	124	31.00
50.00	05000 OPERATING ROOM	186	8, 329	4, 302	1,006	567	50.00
51.00	05100 RECOVERY ROOM	434	2,082			230	
51.00	05101 0/P TREATMENT ROOM	0	2,002			200	51.00
54.00	05400 RADI OLOGY-DI AGNOSTI C	497	18, 741	-	-	3, 249	1
56.00	05600 RADI OI SOTOPE	0	C			0	56.00
60.00	06000 LABORATORY	186	2, 082	c 0	2, 726	1, 410	60.00
62.00	06200 WHOLE BLOOD & PACKED RED BLOOD CELLS	0	C	0 0	60	13	62.00
65.00	06500 RESPI RATORY THERAPY	186	4, 165			194	1
66.00	06600 PHYSI CAL THERAPY	310	8, 329			398	1
67.00	06700 OCCUPATI ONAL THERAPY	217	C			104	67.00
68.00	06800 SPEECH PATHOLOGY	62	C		-	25	68.00
69.00	06900 ELECTROCARDI OLOGY	124	0			560	
71.00 72.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 07200 IMPL. DEV. CHARGED TO PATIENTS	31 0	C	-		0	71.00
72.00	07200 TMPL. DEV. CHARGED TO PATIENTS	186	6, 247	-	-	753	
73.00	OUTPATIENT SERVICE COST CENTERS	100	0, 247		1,030	/55	73.00
90.00	09000 CLINIC	0	(C	0	0	90.00
91.00	09100 EMERGENCY	869	31, 235	-	-	2,933	
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)						92.00
	SPECIAL PURPOSE COST CENTERS						1
118.00	SUBTOTALS (SUM OF LINES 1 through 117)	7, 882	237, 384	18, 205	24, 646	11, 155	118.00
	NONREI MBURSABLE COST CENTERS						
	07950 PHYSI CI AN PRACTI CES	0	C				194.00
	07951 MEDICAL OFFICE BUILDING	0	C		-		194.01
	207952 VPCHC	0	C	C	0	0	194.02
200.00 201.00		0	ſ		0	~	200. 00 201. 00
201.00	5	7, 882	237, 384		0		201.00
202.00	I TOTAL (Sum Trics Fro through 201)	7,002	237, 304	1 10, 200	24,040	11, 155	202.00

	Financial Systems	UNI ON HOSPIT			In Lie	u of Form CMS-	2552-10
ALLOCA	ATION OF CAPITAL RELATED COSTS		Provider C		Period: From 01/01/2019	Worksheet B Part II	
					To 12/31/2019	Date/Time Pre	epared:
						7/9/2020 1:42	2 pm
	Cost Center Description	ADMI NI STRATI V E AND GENERAL	OPERATION OF PLANT	LAUNDRY &	HOUSEKEEPING	DI ETARY	
		5.06	7.00	8.00	9.00	10.00	
	GENERAL SERVICE COST CENTERS	0100		0.00	,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,	10100	
1.00	00100 NEW CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200 NEW CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400 EMPLOYEE BENEFITS DEPARTMENT						4.00
5.01	00540 NONPATIENT TELEPHONES						5.01
5.02	00550 DATA PROCESSI NG						5.02
5.03	00560 PURCHASING RECEIVING AND STORES						5.03
5.04	00570 ADMI TTI NG						5.04
5.05	00580 CASHI ERI NG/ACCOUNTS RECEI VABLE						5.05
5.06	00591 ADMI NI STRATI VE AND GENERAL	64, 163					5.06
7.00	00700 OPERATION OF PLANT	8, 833	562, 043				7.00
8.00	00800 LAUNDRY & LINEN SERVICE	30	4, 418	14, 080	D		8.00
9.00	00900 HOUSEKEEPI NG	1, 159	4, 183	1, 136	5 21, 152		9.00
10.00	01000 DI ETARY	515	9, 049	58	3 346	33, 209	10.00
11.00	01100 CAFETERI A	1, 582	38, 586	205	5 1, 475	0	11.00
13.00	01300 NURSING ADMINISTRATION	3, 109	14, 747	(564	0	13.00
16.00	01600 MEDI CAL RECORDS & LI BRARY	1, 424	9, 337	(357	0	16.00
	INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000 ADULTS & PEDIATRICS	6, 470	149, 262	3, 310	5, 702	25, 688	30.00
31.00	03100 INTENSIVE CARE UNIT	2, 242	4, 375	1, 610) 167	4, 477	31.00
	ANCILLARY SERVICE COST CENTERS						
50.00	05000 OPERATING ROOM	2, 475	36, 644			0	
51.00	05100 RECOVERY ROOM	853	20, 371	(779	3, 044	51.00
51.01	05101 0/P TREATMENT ROOM	0	0		0 0	0	
54.00	05400 RADI OLOGY-DI AGNOSTI C	6, 745	60, 877	1, 412		0	
56.00	05600 RADI OI SOTOPE	2	0	(0	56.00
60.00	06000 LABORATORY	3, 179	18, 258	(0 698	0	60.00
62.00	06200 WHOLE BLOOD & PACKED RED BLOOD CELLS	85	0		0 0	0	
65.00	06500 RESPI RATORY THERAPY	2, 372	13, 253			0	65.00
66.00	06600 PHYSI CAL THERAPY	2, 624	36, 057			0	
67.00	06700 OCCUPATI ONAL THERAPY	685	30, 326			0	
68.00	06800 SPEECH PATHOLOGY	173	4, 098	1		0	68.00
69.00	06900 ELECTROCARDI OLOGY	1, 325	4, 471	293		0	
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	9	107			0	
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	49	0		0 0	0	•
73.00	07300 DRUGS CHARGED TO PATIENTS	3, 848	10, 820	(D 414	0	73.00
	OUTPATIENT SERVICE COST CENTERS						
90.00	09000 CLINIC	0	0		-	0	
91.00	09100 EMERGENCY	14, 263	92, 804	4, 202	2 3, 547	0	
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)						92.00
	SPECIAL PURPOSE COST CENTERS	44.054		1	04.450		
118.00		64, 051	562, 043	14, 080	21, 152	33, 209	118.00
104 0	NONREI MBURSABLE COST CENTERS						104 00
	07950 PHYSI CI AN PRACTI CES	0	0				194.00
	07951 MEDICAL OFFICE BUILDING	112	0				194.01
200.00	207952 VPCHC	0	U			0	194.02 200.00
200.00	5	0	0		0	^	200.00
201.00	5	64, 163	562, 043		°		201.00
202.00	I TOTAL (Sum TIMES TTO UN OUGH 201)	04, 103	502,045	1 14,000	21, 102	55, 209	202.00

Heal th	Financial Systems	UNI ON HOSPI T	AL CLINTON		In Lie	u of Form CMS-:	2552-10
ALLOCA	TION OF CAPITAL RELATED COSTS		Provider C	CN: 15-1326	Peri od: From 01/01/2019 To 12/31/2019	Worksheet B Part II Date/Time Pre 7/9/2020 1:42	
	Cost Center Description	CAFETERI A	NURSI NG ADMI NI STRATI O N	MEDI CAL RECORDS & LI BRARY	Subtotal	Intern & Residents Cost & Post Stepdown	
		11.00	13.00	16.00	24.00	Adjustments 25.00	
	GENERAL SERVICE COST CENTERS	11.00	13.00	10.00	24.00	25.00	
1.00	00100 NEW CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200 NEW CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400 EMPLOYEE BENEFITS DEPARTMENT						4.00
5.01	00540 NONPATI ENT TELEPHONES						5.01
5.02	00550 DATA PROCESSING						5.02
5.03	00560 PURCHASING RECEIVING AND STORES						5.03
5.04	00570 ADMI TTI NG						5.04
5.05	00580 CASHI ERI NG/ACCOUNTS RECEI VABLE						5.05
5.06	00591 ADMI NI STRATI VE AND GENERAL						5.06
7.00 8.00	00700 OPERATION OF PLANT 00800 LAUNDRY & LINEN SERVICE						7.00 8.00
8.00 9.00	00900 HOUSEKEEPING						9.00
10.00	01000 DI ETARY						10.00
11.00	01100 CAFETERI A	136, 288					11.00
13.00	01300 NURSI NG ADMI NI STRATI ON	14, 240					13.00
16.00	01600 MEDI CAL RECORDS & LI BRARY	5, 191		53, 34	47		16.00
	INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000 ADULTS & PEDI ATRI CS	27, 393	30, 207	2, 8	52 630, 667	0	30.00
31.00	03100 I NTENSI VE CARE UNI T	10, 690	11, 789	59	92 57,003	0	31.00
	ANCI LLARY SERVICE COST CENTERS		-			-	
50.00	05000 OPERATING ROOM	5, 458		2, 7		0	
51.00	05100 RECOVERY ROOM	3, 899		1, 1(0	
51.01 54.00	05101 0/P TREATMENT ROOM 05400 RADI OLOGY-DI AGNOSTI C	0 21, 709	-	15, 40	0 0 58 273, 330	0	1
56.00	05600 RADI OLOGI - DI AGNOSTI C	21,709		15,40	1 273, 330	0	
60.00	06000 LABORATORY	0	-	6, 75	54 74, 538	0	60.00
62.00	06200 WHOLE BLOOD & PACKED RED BLOOD CELLS	0	-		53 221	0	
65.00	06500 RESPI RATORY THERAPY	12, 106	0	93		0	1
66.00	06600 PHYSI CAL THERAPY	0	0	1, 90	131,000	0	66.00
67.00	06700 OCCUPATI ONAL THERAPY	0	0	49	99 98, 315	0	67.00
68.00	06800 SPEECH PATHOLOGY	0	-		22 13, 473	0	
69.00	06900 ELECTROCARDI OLOGY	718		2,68		0	1
71.00	07100 MEDI CAL SUPPLIES CHARGED TO PATIENTS	0	-		2 382	0	
72.00	07200 I MPL. DEV. CHARGED TO PATIENTS	0	-	2.0	0 49	0	
73.00	07300 DRUGS CHARGED TO PATIENTS OUTPATIENT SERVICE COST CENTERS	6, 730	0	3, 60	59, 908	0	73.00
90.00	09000 CLINIC	0	0		0 0	0	90.00
91.00	09100 EMERGENCY	28, 154	-	14, 05		0	1
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	20,101	011027	,	110,707	0	
	SPECIAL PURPOSE COST CENTERS		I			`	
118.00		136, 288	73, 025	53, 34	47 2, 153, 943	0	118.00
104 00	NONREI MBURSABLE COST CENTERS				0		104 00
	07950 PHYSI CI AN PRACTI CES	0			0 0		194.00 194.01
	07951 MEDICAL OFFICE BUILDING 207952 VPCHC	0			0 112 0 0		194.01 194.02
200.00		0	0		0 0		200.00
200.00		0	0		0 0		201.00
202.00		136, 288	-	53, 34			202.00

Health Financial Systems	UNI ON HOSPI TAL	CLINTON	In Lieu	of Form CMS-2552-10
ALLOCATION OF CAPITAL RELATED COSTS		Provider CCN: 15-1326	Peri od:	Worksheet B
			From 01/01/2019	Part II
			To 12/31/2019	Date/Time Prepared: 7/9/2020 1:42 pm
Cost Center Description	Total		_l	17 77 2020 1. 42 pm
	26.00			
GENERAL SERVICE COST CENTERS				
1.00 00100 NEW CAP REL COSTS-BLDG & FIXT				1.00
2.00 00200 NEW CAP REL COSTS-MVBLE EQUIP				2.00
4.00 00400 EMPLOYEE BENEFITS DEPARTMENT				4.00
5.01 00540 NONPATIENT TELEPHONES				5.01
5. 02 00550 DATA PROCESSI NG				5.02
5. 03 00560 PURCHASI NG RECEI VI NG AND STORE	S			5.03
5. 04 00570 ADMI TTI NG				5.04
5. 05 00580 CASHI ERI NG/ACCOUNTS RECEI VABLE				5.05
5. 06 00591 ADMI NI STRATI VE AND GENERAL				5.06
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
13.00 01300 NURSING ADMINISTRATION				13.00
16.00 01600 MEDICAL RECORDS & LIBRARY				16.00
INPATIENT ROUTINE SERVICE COST CENTE	RS			
30. 00 03000 ADULTS & PEDIATRICS	630, 667			30.00
31.00 03100 INTENSIVE CARE UNIT	57,003			31.00
ANCILLARY SERVICE COST CENTERS				
50.00 05000 OPERATI NG ROOM	188, 118			50.00
51.00 05100 RECOVERY ROOM	84, 309			51.00
51.01 05101 0/P TREATMENT ROOM	0			51.01
54.00 05400 RADI OLOGY-DI AGNOSTI C	273, 330			54.00
56. 00 05600 RADI 0I SOTOPE	3			56.00
60. 00 06000 LABORATORY	74, 538			60.00
62.00 06200 WHOLE BLOOD & PACKED RED BLOOD				62.00
65. 00 06500 RESPI RATORY THERAPY	72, 619			65.00
66.00 06600 PHYSI CAL THERAPY	131,000			66.00
67.00 06700 OCCUPATI ONAL THERAPY	98, 315			67.00
68.00 06800 SPEECH PATHOLOGY	13, 473			68.00
69. 00 06900 ELECTROCARDI OLOGY	21, 271			69.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PA				71.00
72.00 07200 I MPL. DEV. CHARGED TO PATIENTS	49			72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	59, 908			73.00
OUTPATIENT SERVICE COST CENTERS				
90. 00 09000 CLINIC	0			90.00
91.00 09100 EMERGENCY	448, 737			91.00
92. 00 09200 OBSERVATION BEDS (NON-DISTINCT	PART)			92.00
SPECIAL PURPOSE COST CENTERS				110.00
118.00 SUBTOTALS (SUM OF LINES 1 thro	ugh 117) 2, 153, 943			118.00
NONREI MBURSABLE COST CENTERS				104.00
194. 00 07950 PHYSI CI AN PRACTI CES	0			194.00
194. 01 07951 MEDICAL OFFICE BUILDING	112			194.01
194.02 07952 VPCHC	0			194. 02 200. 00
200.00 Cross Foot Adjustments	0			
201.00 Negative Cost Centers 202.00 TOTAL (sum lines 118 through 2				201.00 202.00
202.00 TOTAL (Sum TIMES TIS INFOUGH 2	01) 2,154,055			J202.00

leal th F	inancial Systems	UNI ON HOSPI TA			In Lie	u of Form CMS-	2552-1
COST ALL	_OCATION - STATISTICAL BASIS		Provider CO		Period: From 01/01/2019	Worksheet B-1	
					To 12/31/2019		
		CAPI TAL REL	ATED COSTS			7/9/2020 1:42	2 pm
	Cost Center Description	NEW BLDG &	NEW MVBLE	EMPLOYEE	NONPATI ENT	DATA	
		FIXT (SQ FT)	EQUI P (EQUI P	BENEFI TS DEPARTMENT	TELEPHONES (PHONES)	PROCESSI NG (DEVI CES)	
		(3211)	DEPRN)	(GROSS	(THOMES)	(DEVIOLO)	
				SALARI ES)			
		1.00	2.00	4.00	5. 01	5.02	
	ENERAL SERVICE COST CENTERS 0100 NEW CAP REL COSTS-BLDG & FIXT	77, 531					1.0
	0200 NEW CAP REL COSTS-MVBLE EQUIP	,	364, 855				2.0
	0400 EMPLOYEE BENEFITS DEPARTMENT	0	0	6, 639, 09			4.0
	0540 NONPATI ENT TELEPHONES	104	5, 338		0 254		5.0
	0550 DATA PROCESSING	203	225, 859		0 4	114	
	0560 PURCHASING RECEIVING AND STORES 0570 ADMITTING	791 504	0 35	378, 50	0 2	0	
	0580 CASHI ERI NG/ACCOUNTS RECEI VABLE	298	35 0	21, 72		6	
	0591 ADMI NI STRATI VE AND GENERAL	1, 474	2, 752	720, 59		13	
	0700 OPERATION OF PLANT	21, 486	5, 400	370, 68		26	
	0800 LAUNDRY & LINEN SERVICE	414	132		0 0	0	8.0
	0900 HOUSEKEEPI NG	392	1, 881	205, 56		1	
	1000 DI ETARY	848	1,627	56, 84		1	10.0
	1100 CAFETERIA	3, 616	6, 935	244, 21		2	
	1300 NURSING ADMINISTRATION 1600 MEDICAL RECORDS & LIBRARY	1, 382 875	205 57	597, 94 116, 83		8	13.0
	NPATIENT ROUTINE SERVICE COST CENTERS	075	57	110,03	2 0	0	10.0
	3000 ADULTS & PEDIATRICS	13, 988	20, 099	852, 60	4 68	11	30.0
	3100 I NTENSI VE CARE UNI T	410	6, 107	434, 23	4 6	1	31.0
	NCI LLARY SERVICE COST CENTERS					-	
	5000 OPERATING ROOM	3, 434	44, 505	153, 89		4	
	5100 RECOVERY ROOM 5101 O/P TREATMENT ROOM	1, 909	6, 434	124, 38	8 14 0 0	1	51.0 51.0
	5400 RADI OLOGY-DI AGNOSTI C	5, 705	6, 999	694, 53		9	
	5600 RADI OI SOTOPE	0	0, , , ,		0 0	0	56.0
0.00 0	6000 LABORATORY	1, 711	0		0 6	1	60. C
	6200 WHOLE BLOOD & PACKED RED BLOOD CELLS	0	0		0 0	0	
	6500 RESPI RATORY THERAPY	1, 242	8, 023	425, 12		2	
	6600 PHYSI CAL THERAPY	3, 379	787		0 10	4	66.0
	6700 OCCUPATI ONAL THERAPY 6800 SPEECH PATHOLOGY	2, 842 384	0		0 7	0	
	6900 ELECTROCARDI OLOGY	419	453	26, 12	-	0	
	7100 MEDICAL SUPPLIES CHARGED TO PATIENTS	10	0		0 1	0	
2.00 0	7200 IMPL. DEV. CHARGED TO PATIENTS	0	0	1	0 0	0	72.0
	7300 DRUGS CHARGED TO PATIENTS	1, 014	2, 114	242, 80	9 6	3	73.0
	UTPATIENT SERVICE COST CENTERS		0			0	1
	9000 CLINIC 9100 EMERGENCY	0 8, 697	0 19, 113		0 0 1 28		90.0
	9200 OBSERVATION BEDS (NON-DISTINCT PART)	0,077	17, 113	772,40	20	15	92.0
	PECIAL PURPOSE COST CENTERS						/2.0
18.00	SUBTOTALS (SUM OF LINES 1 through 117)	77, 531	364, 855	6, 639, 09	4 254	114	118.0
	ONREIMBURSABLE COST CENTERS						
	7950 PHYSI CI AN PRACTI CES	0	0		0 0		194.0
	7951 MEDICAL OFFICE BUILDING	0	0		0 0		194.0
94. 02 0 00. 00	7952 VPCHC Cross Foot Adjustments	0	0		0 0	0	194. (200. (
00.00	Negative Cost Centers						200.0
02.00	Cost to be allocated (per Wkst. B,	1, 778, 304	375, 751	1, 147, 46	7 63, 731	2, 965, 786	
	Part I)			, 10	,	, ,	
03.00	Unit cost multiplier (Wkst. B, Part I)	22. 936683	1. 029864	0. 17283	5 250. 909449	26, 015. 666667	203.0
04.00	Cost to be allocated (per Wkst. B,				0 7, 882	237, 384	
	Part II)						0.0-
205.00	Unit cost multiplier (Wkst. B, Part			0. 00000	0 31.031496	2, 082. 315789	205.0
06.00	II) NAHE adjustment amount to be allocated						206.0
	(per Wkst. B-2)						200.0
207.00	NAHE unit cost multiplier (Wkst. D,						207.0
	Parts III and IV)			1	1		1

Heal th	Financial Systems	UNI ON HOSPITA	AL CLINTON		In Lie	u of Form CMS-	2552-10
COST A	LLOCATION - STATISTICAL BASIS		Provider C		Period:	Worksheet B-1	
					From 01/01/2019 To 12/31/2019	Date/Time Pre	pared:
						7/9/2020 1:42	
	Cost Center Description	PURCHASI NG	ADMI TTI NG		Reconciliatio		
		RECEI VI NG AND STORES	(INPATIENT REVENUE)	COUNTS RECEI VABLE	n	E AND GENERAL (ACCUM.	
		(REQUI SI TI 0)	KEVENOE)	(TOTAL		COST)	
		(11240101110)		REVENUE)		0001)	
		5.03	5.04	5.05	5A. 06	5.06	
	GENERAL SERVICE COST CENTERS	1			1		
1.00	00100 NEW CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200 NEW CAP REL COSTS-MVBLE EQUIP						2.00
4.00 5.01	00400 EMPLOYEE BENEFITS DEPARTMENT 00540 NONPATIENT TELEPHONES						4.00 5.01
5.01	00550 DATA PROCESSING						5.01
5.02	00560 PURCHASING RECEIVING AND STORES	259, 361					5.02
5.04	00570 ADMI TTI NG	4, 824	9, 426, 389				5.04
5.05	00580 CASHI ERI NG/ACCOUNTS RECEI VABLE	0	0		3		5.05
5.06	00591 ADMI NI STRATI VE AND GENERAL	226	0	(-2, 822, 520	20, 801, 138	5.06
7.00	00700 OPERATION OF PLANT	88	0	(0 0	2, 863, 272	1
8.00	00800 LAUNDRY & LINEN SERVICE	0	0		0 0	9, 632	1
9.00	00900 HOUSEKEEPI NG	23, 262	0		0	375, 815	1
	01000 DI ETARY 01100 CAFETERI A	28 121	0			166, 828 512, 901	1
	01300 NURSI NG ADMI NI STRATI ON	43	0			1, 007, 801	
	01600 MEDICAL RECORDS & LIBRARY	34	0				
101.00	INPATIENT ROUTINE SERVICE COST CENTERS	0.1		· · · · · · · · · · · · · · · · · · ·	<u> </u>	1017000	10100
30.00	03000 ADULTS & PEDI ATRI CS	35, 076	3, 890, 895	3, 890, 89	5 0	2, 097, 360	30.00
31.00	03100 INTENSIVE CARE UNIT	12, 296	808, 020	808, 020	0 0	726, 757	31.00
	ANCILLARY SERVICE COST CENTERS	1			1		
	05000 OPERATING ROOM	61, 288	384, 736			802, 243	1
	05100 RECOVERY ROOM	15, 281	11, 895			276, 638	1
	05101 0/P TREATMENT ROOM 05400 RADI OLOGY-DI AGNOSTI C	0 27, 900	0 873, 831		0 5 0	0 2, 186, 482	
	05600 RADI OLOGI - DI AGNOSTI C	27,900	0/3, 031			2, 100, 402	1
	06000 LABORATORY	0	1,042,308			1, 030, 585	1
	06200 WHOLE BLOOD & PACKED RED BLOOD CELLS	0	23, 100			27, 437	1
65.00	06500 RESPI RATORY THERAPY	6, 485	625, 190	1, 269, 71	5 0	768, 911	65.00
	06600 PHYSI CAL THERAPY	483	113, 429			850, 609	1
	06700 OCCUPATI ONAL THERAPY	2	53, 018			222, 067	1
	06800 SPEECH PATHOLOGY	0	10, 695			56, 083	1
	06900 ELECTROCARDI OLOGY 07100 MEDI CAL SUPPLI ES CHARGED TO PATI ENTS	0	325, 550			429, 429	1
	07200 IMPL. DEV. CHARGED TO PATIENTS	0	60 0			2, 977 16, 040	1
	07300 DRUGS CHARGED TO PATIENTS	556	699, 903			1, 247, 187	
10100	OUTPATIENT SERVICE COST CENTERS	000	0,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,	1777727	<u> </u>	1/21//10/	/ 01 00
90.00	09000 CLINIC	0	0	(0 0	0	90.00
91.00	09100 EMERGENCY	71, 366	563, 759	19, 171, 78	3 0	4, 625, 551	91.00
	09200 OBSERVATION BEDS (NON-DISTINCT PART)						92.00
	SPECIAL PURPOSE COST CENTERS						
118.00		259, 361	9, 426, 389	72, 748, 24	3 -2, 822, 520	20, 764, 859	118.00
104 00	NONREI MBURSABLE COST CENTERS	0	0			0	194.00
	07950 PHYSICIAN PRACTICES 07951 MEDICAL OFFICE BUILDING	0	0		0 0 0		194.00
	07952 VPCHC	0	0				194.02
200.00		0	0		S S		200.00
201.00							201.00
202.00	Cost to be allocated (per Wkst. B,	120, 402	666, 017	668, 86	5	2, 822, 520	202.00
	Part I)						
203.00		0. 464226	0. 070655			0. 135691	
204.00		18, 205	24, 646	11, 15	5	64, 163	204.00
205 00	Part II)	0.070100	0 000/15	0.00015		0 002005	205 00
205.00	Unit cost multiplier (Wkst. B, Part II)	0. 070192	0. 002615	0.00015	2	0. 003085	205.00
206.00							206.00
200.00	(per Wkst. B-2)						
207.00	NAHE unit cost multiplier (Wkst. D,						207.00
	Parts III and IV)			I			

COST A	Financial Systems ALLOCATION - STATISTICAL BASIS	UNI ON HOSPI T	Provider C	CN: 15-1326	Peri od:	u of Form CMS- Worksheet B-1	
					From 01/01/2019 To 12/31/2019	Date/Time Pre 7/9/2020 1:42	epare
	Cost Center Description	OPERATION OF PLANT (SQ FT)	LAUNDRY & LINEN SERVICE (LINEN)	HOUSEKEEPI NO (NUMBER HOUSED)	G DI ETARY (DI ETARY)	CAFETERI A (FTE)	
		7.00	8.00	9.00	10.00	11.00	
~~	GENERAL SERVICE COST CENTERS			1			• .
. 00 2. 00 4. 00 5. 01	00100 NEW CAP REL COSTS-BLDG & FIXT 00200 NEW CAP REL COSTS-MVBLE EQUIP 00400 EMPLOYEE BENEFITS DEPARTMENT 00540 NONPATIENT TELEPHONES						1. 2. 4. 5.
02	00550 DATA PROCESSING 00560 PURCHASING RECEIVING AND STORES						5.
. 04 . 05 . 06	00570 ADMITTING 00580 CASHIERING/ACCOUNTS RECEIVABLE 00591 ADMINISTRATIVE AND GENERAL						5. 5. 5.
00	00700 OPERATION OF PLANT	52, 671					7
. 00	00800 LAUNDRY & LINEN SERVICE	414	61, 075				8.
. 00	00900 HOUSEKEEPI NG	392	4, 929	51, 80	65		9
0. 00	01000 DI ETARY	848			48 5, 444		10
1.00		3, 616				6, 642	
3.00 5.00	01300 NURSING ADMINISTRATION 01600 MEDICAL RECORDS & LIBRARY	1, 382 875	0		82 0 75 0	694 253	
5. 00	INPATIENT ROUTINE SERVICE COST CENTERS	075	0	0	75 0	203	
0. 00	03000 ADULTS & PEDI ATRI CS	13, 988	14, 356	13, 98	38 4, 211	1, 335	30
I. 00	03100 I NTENSI VE CARE UNI T	410			10 734	521	
	ANCILLARY SERVICE COST CENTERS						
. 00	05000 OPERATING ROOM	3, 434				266	
. 00	05100 RECOVERY ROOM	1, 909	0			190	
. 01	05101 0/P TREATMENT ROOM 05400 RADI OLOGY-DI AGNOSTI C	0	-		0 0 05 0	0 1, 058	
. 00	05600 RADI OLOGY-DI AGNOSTI C	5, 705 0	6, 125 0		0 0	1, US8 0	
). 00	06000 LABORATORY	1, 711	0			0	
2.00	06200 WHOLE BLOOD & PACKED RED BLOOD CELLS	0	0		0 0	0	
5.00	06500 RESPI RATORY THERAPY	1, 242	284	1, 24	42 0	590	
. 00	06600 PHYSI CAL THERAPY	3, 379	5, 866	3, 3	79 0	0	66
. 00	06700 OCCUPATI ONAL THERAPY	2, 842				0	
3.00	06800 SPEECH PATHOLOGY	384	0	-	84 0	0	
. 00	06900 ELECTROCARDI OLOGY	419			19 0	35	
. 00	07100 MEDI CAL SUPPLIES CHARGED TO PATIENTS	10 0			10 0 0 0	0	
2.00	07200 I MPL. DEV. CHARGED TO PATI ENTS 07300 DRUGS CHARGED TO PATI ENTS	1, 014	0		-	0 328	
. 00	OUTPATIENT SERVICE COST CENTERS	1,014	0	1,0	14 0	520	/ /3
0. 00	09000 CLINIC	0	0		0 0	0	90
. 00	09100 EMERGENCY	8, 697	18, 227	8, 69	97 0	1, 372	91
. 00	09200 OBSERVATION BEDS (NON-DISTINCT PART)						92
	SPECIAL PURPOSE COST CENTERS						
8.00		52, 671	61, 075	51, 80	65 5, 444	6, 642	118
	NONREI MBURSABLE COST CENTERS 07950 PHYSI CI AN PRACTI CES	0	0		0 0		194
	07951 MEDICAL OFFICE BUILDING	0			0 0		194
	07952 VPCHC	0	0		0 0		194
0.00		-	_				200
01.00							201
02.00	Part I)	3, 251, 792				837, 922	
)3.00)4.00		61. 737806 562, 043				126. 155074 136, 288	
05.00		10. 670825	0. 230536	0. 40782	6. 100110	20. 519121	205
06. 00	NAHE adjustment amount to be allocated (per Wkst. B-2)						206
07.00	NAHE unit cost multiplier (Wkst. D, Parts III and IV)						207

	Financial Systems LLOCATION - STATISTICAL BASIS	UNION HOSPITA	Provider CCN: 15-	1326 Period: Workshee	CMS-2552-1 + B-1
CU31 A	LEUCATION - STATISTICAL DASIS			From 01/01/2019	e Prepared
	Cost Center Description	NURSI NG ADMI NI STRATI O N (TI ME SPENT) 13.00	MEDI CAL RECORDS & LI BRARY (ASSI GNED TI ME) 16. 00		
	GENERAL SERVICE COST CENTERS	10.00	10.00		
1.00	00100 NEW CAP REL COSTS-BLDG & FIXT				1.0
2.00	00200 NEW CAP REL COSTS-MVBLE EQUIP				2.0
4.00	00400 EMPLOYEE BENEFITS DEPARTMENT				4.0
5.01	00540 NONPATI ENT TELEPHONES				5.0
5.02	00550 DATA PROCESSING				5.0
5.03	00560 PURCHASING RECEIVING AND STORES				5.0
5.04 E.OE	00570 ADMITTING				5.0
5.05 5.06	00580 CASHI ERI NG/ACCOUNTS RECEI VABLE 00591 ADMI NI STRATI VE AND GENERAL				5.0 5.0
7.00	00700 OPERATION OF PLANT				7.0
8.00	00800 LAUNDRY & LI NEN SERVI CE				8.0
9.00	00900 HOUSEKEEPI NG				9.0
	01000 DI ETARY				10.0
11.00	01100 CAFETERI A				11.0
13.00	01300 NURSI NG ADMI NI STRATI ON	67, 146			13.0
16.00	01600 MEDI CAL RECORDS & LI BRARY	0	72, 748, 248		16. 0
	INPATIENT ROUTINE SERVICE COST CENTERS	07.775	0.000.005		
	03000 ADULTS & PEDIATRICS	27, 775	3, 890, 895		30.0
31.00	03100 INTENSIVE CARE UNIT ANCILLARY SERVICE COST CENTERS	10, 840	808, 020		31.0
50 00	05000 OPERATING ROOM	0	3, 703, 392		50.0
	05100 RECOVERY ROOM	0	1, 502, 481		51.0
	05101 0/P TREATMENT ROOM	0	0		51.0
54.00	05400 RADI OLOGY-DI AGNOSTI C	0	21, 072, 246		54.0
	05600 RADI OI SOTOPE	0	1, 828		56.0
	06000 LABORATORY	0	9, 214, 752		60.0
	06200 WHOLE BLOOD & PACKED RED BLOOD CELLS	0	86, 159		62.0
	06500 RESPIRATORY THERAPY	0	1, 269, 715		65.0
	06600 PHYSI CAL THERAPY 06700 OCCUPATI ONAL THERAPY	0	2, 601, 486 680, 175		66. 0 67. 0
	06800 SPEECH PATHOLOGY	0	165, 919		68.0
	06900 ELECTROCARDI OLOGY	0	3, 657, 783		69.0
	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	2, 324		71.0
	07200 IMPL. DEV. CHARGED TO PATIENTS	0	0		72.0
	07300 DRUGS CHARGED TO PATIENTS	0	4, 919, 290		73.0
	OUTPATIENT SERVICE COST CENTERS				
	09000 CLINIC	0	0		90.0
	09100 EMERGENCY	28, 531	19, 171, 783		91.0 92.0
	09200 OBSERVATION BEDS (NON-DISTINCT PART) SPECIAL PURPOSE COST CENTERS				92.0
118.00	SUBTOTALS (SUM OF LINES 1 through 117)	67, 146	72, 748, 248		118.0
	NONREI MBURSABLE COST CENTERS	0,,,,,	. 2,		
194.00	07950 PHYSI CI AN PRACTI CES	0	0		194. 0
194.01	07951 MEDICAL OFFICE BUILDING	0	0		194.0
	07952 VPCHC	0	0		194. 0
200.00	Cross Foot Adjustments				200.0
201.00	Negative Cost Centers	1 000 501	(17.70)		201.0
202.00	Cost to be allocated (per Wkst. B,	1, 329, 521	617, 796		202.0
203.00	Part I) Unit cost multiplier (Wkst. B, Part I)	19. 800450	0. 008492		203.0
203.00 204.00	Cost to be allocated (per Wkst. B,	73, 025	53, 347		203.0
_0 +. 00	Part II)	, 5, 025	55, 57		204.0
205.00	Unit cost multiplier (Wkst. B, Part	1. 087555	0. 000733		205.0
206.00	NAHE adjustment amount to be allocated				206.0
	(per Wkst. B-2)				1
207.00	NAHE unit cost multiplier (Wkst. D,				207.0

Health Financial Systems	UNI ON HOSPI T	AL CLINTON		In Lie	u of Form CMS-2	2552-10
COMPUTATION OF RATIO OF COSTS TO CHARGES			Provider CCN: 15-1326		Worksheet C Part I Date/Time Pre 7/9/2020 1:42	
		Title	XVIII	Hospi tal	Cost	
				Costs		
Cost Center Description	Total Cost	Therapy Limit	Total Costs		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	4, 320, 874		4, 320, 8			
31.00 03100 I NTENSI VE CARE UNI T	1, 179, 297		1, 179, 2	97 0	0	31.00
ANCILLARY SERVICE COST CENTERS			1			
50. 00 05000 OPERATI NG ROOM	1, 219, 303		1, 219, 3			
51.00 05100 RECOVERY ROOM	508, 328		508, 3		0	
51.01 05101 0/P TREATMENT ROOM	0			0 0	0	
54.00 05400 RADI OLOGY-DI AGNOSTI C	3, 201, 410		3, 201, 4		0	54.00
56. 00 05600 RADI OI SOTOPE	795			95 0	0	56.00
60. 00 06000 LABORATORY	1, 369, 287		1, 369, 2		0	60.00
62.00 06200 WHOLE BLOOD & PACKED RED BLOOD CELLS	31, 892		31, 8		0	62.00
65. 00 06500 RESPI RATORY THERAPY	1, 046, 177	0	1, 046, 1		0	65.00
66. 00 06600 PHYSI CAL THERAPY	1, 229, 813	0	1, 229, 8	13 0	0	66.00
67.00 06700 OCCUPATI ONAL THERAPY	458, 309	0	458, 3	09 0	0	67.00
68.00 06800 SPEECH PATHOLOGY	92, 170	0	92, 1	70 0	0	68.00
69. 00 06900 ELECTROCARDI OLOGY	553, 470		553, 4	70 0	0	69.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	4, 106		4, 1	0 0	0	71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	18, 216		18, 2	16 0	0	72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	1, 571, 050		1, 571, 0	50 0	0	73.00
OUTPATIENT SERVICE COST CENTERS			_			
90. 00 09000 CLINIC	0			0 0	0	
91.00 09100 EMERGENCY	6, 777, 959		6, 777, 9	59 0	0	91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	1, 715, 052		1, 715, 0		0	
200.00 Subtotal (see instructions)	25, 297, 508	0	25, 297, 5	0 80	0	200.00
201.00 Less Observation Beds	1, 715, 052		1, 715, 0	52	0	201.00
202.00 Total (see instructions)	23, 582, 456	0	23, 582, 4	56 0	0	202.00

Health Financial Systems	UNI ON HOSPI TA	AL CLINTON		In Lie	u of Form CMS-:	2552-10
COMPUTATION OF RATIO OF COSTS TO CHARGES		Provider C		Period: From 01/01/2019 To 12/31/2019		
	Title XVIII Hospital Co					
		Charges				
Cost Center Description	Inpatient	Outpati ent	Total (col.	6 Cost or Other	TEFRA	
			+ col. 7)	Ratio	I npati ent	
					Ratio	
	6.00	7.00	8.00	9.00	10.00	
INPATIENT ROUTINE SERVICE COST CENTERS						
30. 00 03000 ADULTS & PEDIATRICS	2, 639, 575		2, 639, 57	5		30.00
31.00 03100 INTENSIVE CARE UNIT	666, 292		666, 29	2		31.00
ANCILLARY SERVICE COST CENTERS						
50.00 O5000 OPERATING ROOM	384, 736	3, 282, 812	3, 667, 54		0.000000	
51.00 05100 RECOVERY ROOM	11, 895	1, 463, 770	1, 475, 66		0.000000	
51.01 05101 0/P TREATMENT ROOM	0	0		0 0. 000000	0.000000	51.01
54.00 05400 RADI OLOGY-DI AGNOSTI C	873, 831	20, 198, 415	21, 072, 24	6 0. 151925	0.000000	
56. 00 05600 RADI OI SOTOPE	0	1, 828	1,82	8 0. 434902	0.000000	56.00
60. 00 06000 LABORATORY	1,042,308	8, 172, 444	9, 214, 75	2 0. 148597	0.000000	60.00
62.00 06200 WHOLE BLOOD & PACKED RED BLOOD CELLS	23, 100	63, 059	86, 15	9 0. 370153	0.000000	62.00
65. 00 06500 RESPI RATORY THERAPY	625, 190	644, 525	1, 269, 71	5 0. 823946	0.000000	65.00
66.00 06600 PHYSI CAL THERAPY	113, 429	2, 488, 057	2, 601, 48	6 0. 472735	0.000000	66.00
67.00 06700 OCCUPATI ONAL THERAPY	53, 018	627, 157	680, 17	5 0. 673810	0.000000	67.00
68.00 06800 SPEECH PATHOLOGY	10, 695	155, 224	165, 91	9 0. 555512	0.000000	68.00
69.00 06900 ELECTROCARDI OLOGY	325, 550	3, 332, 233	3, 657, 78	3 0. 151313	0.000000	69.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	60	2, 264	2, 32	4 1. 766781	0.000000	71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0	35, 844	35, 84	4 0. 508202	0.000000	72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	699, 903	4, 219, 387	4, 919, 29	0 0. 319365	0.000000	73.00
OUTPATIENT SERVICE COST CENTERS			_			
90. 00 09000 CLINIC	0	0		0 0. 000000	0.000000	90.00
91.00 09100 EMERGENCY	563, 759	18, 608, 024	19, 171, 78	3 0. 353538	0.000000	91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	7, 463	1, 387, 363	1, 394, 82	6 1. 229581	0.000000	92.00
200.00 Subtotal (see instructions)	8, 040, 804	64, 682, 406	72, 723, 21	0		200.00
201.00 Less Observation Beds						201.00
202.00 Total (see instructions)	8, 040, 804	64, 682, 406	72, 723, 21	0		202.00

Health Financial Systems	UNI ON HOSPI TAL	CLINTON	In Lieu	ı of Form CMS-	2552-10
COMPUTATION OF RATIO OF COSTS TO CHARGES		Provider CCN: 15-1326	Peri od: From 01/01/2019 To 12/31/2019	Worksheet C Part I Date/Time Pre 7/9/2020 1:42	epared: 2 pm
		Title XVIII	Hospi tal	Cost	
Cost Center Description	PPS Inpatient				
	Ratio				
	11.00				
INPATIENT ROUTINE SERVICE COST CENTERS	1				
30. 00 03000 ADULTS & PEDI ATRI CS					30.00
31.00 03100 INTENSIVE CARE UNIT					31.00
ANCILLARY SERVICE COST CENTERS	I				
50.00 05000 OPERATING ROOM	0. 000000				50.00
51.00 05100 RECOVERY ROOM	0. 000000				51.00
51.01 05101 0/P TREATMENT ROOM	0. 000000				51.01
54. 00 05400 RADI OLOGY-DI AGNOSTI C	0. 000000				54.00
56. 00 05600 RADI OI SOTOPE	0. 000000				56.00
60. 00 06000 LABORATORY	0. 000000				60.00
62.00 06200 WHOLE BLOOD & PACKED RED BLOOD CELLS	0. 000000				62.00
65. 00 06500 RESPI RATORY THERAPY	0. 000000				65.00
66. 00 06600 PHYSI CAL THERAPY	0. 000000				66.00
67.00 06700 OCCUPATI ONAL THERAPY	0. 000000				67.00
68.00 06800 SPEECH PATHOLOGY	0. 000000				68.00
69. 00 06900 ELECTROCARDI OLOGY	0. 000000				69.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0. 000000				71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0. 000000				72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	0. 000000				73.00
OUTPATIENT SERVICE COST CENTERS					
90. 00 09000 CLINIC	0. 000000				90.00
91.00 09100 EMERGENCY	0. 000000				91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	0. 000000				92.00
200.00 Subtotal (see instructions)					200.00
201.00 Less Observation Beds					201.00
202.00 Total (see instructions)					202.00

Heal th Financial	Systems	UNION HOSPIT	AL CLINTON		In Lie	eu of Form CMS-:	2552-10
COMPUTATION OF F	RATIO OF COSTS TO CHARGES		Provider CCN: 15-1326		Period: Worksheet (From 01/01/2019 Part I To 12/31/2019 Date/Time F 7/9/2020 1:		
			Titl	e XIX	Hospi tal	Cost	
					Costs		
Cos	t Center Description	Total Cost	Therapy Limit	Total Costs		Total Costs	
		(from Wkst.	Adj.		Di sal I owance		
		B, Part I,					
		col. 26)					
		1.00	2.00	3.00	4.00	5.00	
	ROUTINE SERVICE COST CENTERS	4 220 074		4 220 0	7.4	4 220 074	1 20 00
	LTS & PEDIATRICS	4, 320, 874		4, 320, 8			1
	ENSIVE CARE UNIT	1, 179, 297		1, 179, 2	97 0	1, 179, 297	31.00
50.00 05000 0PE	<u>SERVICE COST CENTERS</u>	1, 219, 303		1, 219, 3	03 0	1, 219, 303	50.00
51.00 05100 REC		508, 328		508, 3		508, 328	
	TREATMENT ROOM	000, 320		500, 5		0 500, 520	1
	I OLOGY-DI AGNOSTI C	3, 201, 410		3, 201, 4	0	3, 201, 410	
56.00 05600 RAD		3, 201, 410			95 O	3, 201, 410	
60.00 06000 LAB		1, 369, 287		1, 369, 2		1, 369, 287	
	LE BLOOD & PACKED RED BLOOD CELLS	31, 892		31, 8		31, 892	1
	PIRATORY THERAPY	1, 046, 177		1, 046, 1		1, 046, 177	
66.00 06600 PHY		1, 229, 813		1, 229, 8		1, 229, 813	1
	UPATI ONAL THERAPY	458, 309		458, 3		458, 309	
68.00 06800 SPE		92, 170		92, 1			68.00
69.00 06900 ELE		553, 470		553, 4		553, 470	
	ICAL SUPPLIES CHARGED TO PATIENTS	4, 106		4, 1			71.00
	L. DEV. CHARGED TO PATIENTS	18, 216		18, 2			72.00
	GS CHARGED TO PATIENTS	1, 571, 050		1, 571, 0		1, 571, 050	
	IT SERVICE COST CENTERS	., ., .,		1 1/0/1/0		1,0,1,000	10100
90.00 09000 CLII		0			0 0	0	90.00
91.00 09100 EME	RGENCY	6, 777, 959		6,777,9	59 0	6, 777, 959	91.00
92.00 09200 OBS	ERVATION BEDS (NON-DISTINCT PART)	1, 715, 052		1, 715, 0	52	1, 715, 052	92.00
	total (see instructions)	25, 297, 508					
	s Observation Beds	1, 715, 052		1, 715, 0		1, 715, 052	
202.00 Tota	al (see instructions)	23, 582, 456	(23, 582, 4	56 0	23, 582, 456	202.00

Health Financial Systems	UNI ON HOSPI TA	AL CLINTON		In Lie	u of Form CMS-:	2552-10
COMPUTATION OF RATIO OF COSTS TO CHARGES		Provider C		Period: From 01/01/2019 To 12/31/2019		
	Title XIX Hospital Cost					
		Charges				
Cost Center Description	Inpatient	Outpati ent		Cost or Other	TEFRA	
			+ col. 7)	Ratio	I npati ent	
					Rati o	
	6.00	7.00	8.00	9.00	10.00	
INPATIENT ROUTINE SERVICE COST CENTERS	т — т		1	T		
30. 00 03000 ADULTS & PEDIATRICS	2, 639, 575		2, 639, 57			30.00
31.00 03100 INTENSIVE CARE UNIT	666, 292		666, 29	2		31.00
ANCILLARY SERVICE COST CENTERS				T		
50.00 O5000 OPERATING ROOM	384, 736	3, 282, 812	3, 667, 54	8 0. 332457	0.000000	
51.00 05100 RECOVERY ROOM	11, 895	1, 463, 770	1, 475, 66	5 0. 344474	0.000000	
51.01 05101 0/P TREATMENT ROOM	0	0		0 0. 000000	0.000000	51.01
54.00 05400 RADI OLOGY-DI AGNOSTI C	873, 831	20, 198, 415	21, 072, 24	6 0. 151925	0.000000	54.00
56. 00 05600 RADI OI SOTOPE	0	1, 828	1, 82	8 0. 434902	0.000000	56.00
60.00 06000 LABORATORY	1,042,308	8, 172, 444	9, 214, 75	2 0. 148597	0.000000	60.00
62.00 06200 WHOLE BLOOD & PACKED RED BLOOD CELLS	23, 100	63, 059	86, 15	9 0. 370153	0.000000	62.00
65. 00 06500 RESPI RATORY THERAPY	625, 190	644, 525	1, 269, 71	5 0. 823946	0.000000	65.00
66.00 06600 PHYSI CAL THERAPY	113, 429	2, 488, 057	2, 601, 48	6 0. 472735	0.000000	66.00
67.00 06700 OCCUPATI ONAL THERAPY	53, 018	627, 157	680, 17	5 0. 673810	0.000000	67.00
68.00 06800 SPEECH PATHOLOGY	10, 695	155, 224	165, 91	9 0. 555512	0.000000	68.00
69.00 06900 ELECTROCARDI OLOGY	325, 550	3, 332, 233	3, 657, 78	3 0. 151313	0.000000	69.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	60	2, 264	2, 32	4 1. 766781	0.000000	71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0	35, 844	35, 84	4 0. 508202	0.000000	72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	699, 903	4, 219, 387	4, 919, 29	0 0. 319365	0.000000	73.00
OUTPATIENT SERVICE COST CENTERS			·			
90. 00 09000 CLINIC	0	0)	0 0. 000000	0.000000	90.00
91.00 09100 EMERGENCY	563, 759	18, 608, 024	19, 171, 78	3 0. 353538	0.000000	91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	7, 463	1, 387, 363	1, 394, 82	6 1. 229581	0. 000000	92.00
200.00 Subtotal (see instructions)	8, 040, 804	64, 682, 406	72, 723, 21	0		200.00
201.00 Less Observation Beds						201.00
202.00 Total (see instructions)	8, 040, 804	64, 682, 406	72, 723, 21	0		202.00

Health Financial Systems	UNI ON HOSPI TAL	CLINTON	In Lieu	u of Form CMS-	2552-10
COMPUTATION OF RATIO OF COSTS TO CHARGES		Provider CCN: 15-1326	Peri od: From 01/01/2019 To 12/31/2019	Worksheet C Part I Date/Time Pre 7/9/2020 1:42	epared: 2 pm
		Title XIX	Hospi tal	Cost	
Cost Center Description	PPS Inpatient				
	Ratio				
	11.00				
INPATIENT ROUTINE SERVICE COST CENTERS					
30. 00 03000 ADULTS & PEDI ATRI CS					30.00
31.00 03100 INTENSIVE CARE UNIT					31.00
ANCILLARY SERVICE COST CENTERS					
50.00 05000 OPERATI NG ROOM	0. 000000				50.00
51.00 05100 RECOVERY ROOM	0. 000000				51.00
51.01 05101 0/P TREATMENT ROOM	0. 000000				51.01
54. 00 05400 RADI OLOGY-DI AGNOSTI C	0. 000000				54.00
56. 00 05600 RADI OI SOTOPE	0. 000000				56.00
60. 00 06000 LABORATORY	0. 000000				60.00
62.00 06200 WHOLE BLOOD & PACKED RED BLOOD CELLS	0. 000000				62.00
65. 00 06500 RESPI RATORY THERAPY	0. 000000				65.00
66. 00 06600 PHYSI CAL THERAPY	0. 000000				66.00
67.00 06700 OCCUPATI ONAL THERAPY	0. 000000				67.00
68.00 06800 SPEECH PATHOLOGY	0. 000000				68.00
69. 00 06900 ELECTROCARDI OLOGY	0. 000000				69.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0. 000000				71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0. 000000				72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	0. 000000				73.00
OUTPATIENT SERVICE COST CENTERS					
90. 00 09000 CLI NI C	0. 000000				90.00
91. 00 09100 EMERGENCY	0. 000000				91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	0. 000000				92.00
200.00 Subtotal (see instructions)					200.00
201.00 Less Observation Beds					201.00
202.00 Total (see instructions)					202.00

Health Financial Systems	UNI ON HOSPI T	AL CLINTON		In Lie	u of Form CMS-2	2552-10
APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITA	AL COSTS	Provider C		Period: From 01/01/2019 To 12/31/2019		
		Title	XVIII	Hospi tal	Cost	
Cost Center Description	Capi tal	Total Charges	Ratio of Cos	t Inpatient	Capital Costs	
	Related Cost	(from Wkst.	to Charges	Program	(column 3 x	
	(from Wkst.	C, Part I,	(col. 1 ÷	Charges	column 4)	
	B, Part II,	col. 8)	col. 2)			
	col. 26)					
	1.00	2.00	3.00	4.00	5.00	
ANCILLARY SERVICE COST CENTERS	T					
50.00 05000 OPERATING ROOM	188, 118				9, 941	
51.00 05100 RECOVERY ROOM	84, 309	1, 475, 665			120	
51.01 05101 0/P TREATMENT ROOM	0	0	0.00000		0	51.01
54. 00 05400 RADI OLOGY-DI AGNOSTI C	273, 330				2, 859	
56. 00 05600 RADI OI SOTOPE	3	1, 828			0	56.00
60. 00 06000 LABORATORY	74, 538				3, 623	
62.00 06200 WHOLE BLOOD & PACKED RED BLOOD CELLS	221	86, 159			51	62.00
65. 00 06500 RESPI RATORY THERAPY	72, 619				18, 466	
66. 00 06600 PHYSI CAL THERAPY	131, 000					
67.00 06700 OCCUPATI ONAL THERAPY	98, 315				3, 490	
68.00 06800 SPEECH PATHOLOGY	13, 473				585	
69. 00 06900 ELECTROCARDI OLOGY	21, 271					
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	382				0	
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	49				0	72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	59, 908	4, 919, 290	0. 01217	8 342, 434	4, 170	73.00
OUTPATIENT SERVICE COST CENTERS						
90. 00 09000 CLINIC	0	0	0. 00000		0	
91.00 09100 EMERGENCY	448, 737				71	
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	250, 326			0 8	0	
200.00 Total (lines 50 through 199)	1, 716, 599	69, 417, 343		1, 820, 407	47, 589	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS Provider CCN: 15-1326 Period: Worksheet D From 01/01/2019 Part IV To 12/31/2019 Date/Time Prepar	
To 12/31/2019 Date/Time Prepar	
7/9/2020 1:42 pm	
Title XVIII Hospital Cost	
Cost Center Description Non Physician Nursing Nursing Allied Health Allied Health	
Anesthetist School School Post-Stepdown	
Cost Post-Stepdown Adjustments	
Adjustments	
1.00 2A 2.00 3A 3.00	
ANCI LLARY SERVICE COST CENTERS	
	. 00
	. 00
	. 01
	. 00
	. 00
	. 00
	. 00
	. 00
	. 00
	. 00
	. 00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 0 0 0 0 71	. 00
72.00 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
OUTPATIENT SERVICE COST CENTERS	
90.00 09000 CLINIC 0 0 0 0 90	. 00
91.00 09100 EMERGENCY 0 0 0 91	. 00
	. 00
200.00 Total (lines 50 through 199) 0 0 0 0 0 0 0	. 00

Health Financial Systems	UNI ON HOSPI T	AL CLINTON		In Lie	u of Form CMS-2	2552-10
APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SEF	RVICE OTHER PAS	S Provider C		Period:	Worksheet D	
THROUGH COSTS				From 01/01/2019 To 12/31/2019		narod
				10 12/31/2019	7/9/2020 1: 42	
		Title	XVIII	Hospi tal	Cost	
Cost Center Description	All Other	Total Cost	Total		Ratio of Cost	
	Medi cal	(sum of cols.	Outpati ent	(from Wkst.	to Charges	
	Education	1, 2, 3, and	Cost (sum of		(col. 5 ÷	
	Cost	4)	cols. 2, 3,	col. 8)	col. 7)	
			and 4)		(see	
					instructions)	
	4.00	5.00	6.00	7.00	8.00	
ANCILLARY SERVICE COST CENTERS						
50.00 05000 OPERATING ROOM	0	0		0 3, 667, 548		
51.00 05100 RECOVERY ROOM	0	0		0 1, 475, 665		
51.01 05101 0/P TREATMENT ROOM	0	0		0 0	0.00000	
54.00 05400 RADI OLOGY-DI AGNOSTI C	0	0		0 21, 072, 246		54.00
56. 00 05600 RADI OI SOTOPE	0	0		0 1, 828		56.00
60. 00 06000 LABORATORY	0	0		0 9, 214, 752		60.00
62.00 06200 WHOLE BLOOD & PACKED RED BLOOD CELLS	0	0		0 86, 159		
65. 00 06500 RESPI RATORY THERAPY	0	0		0 1, 269, 715		
66. 00 06600 PHYSI CAL THERAPY	0	0		0 2, 601, 486		
67.00 06700 OCCUPATI ONAL THERAPY	0	0		0 680, 175		67.00
68.00 06800 SPEECH PATHOLOGY	0	0		0 165, 919		
69.00 06900 ELECTROCARDI OLOGY	0	0		0 3, 657, 783		
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0		0 2, 324		
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0	0		0 35, 844		
73.00 07300 DRUGS CHARGED TO PATIENTS	0	0		0 4, 919, 290	0.00000	73.00
OUTPATIENT SERVICE COST CENTERS		r		-	-	
90. 00 09000 CLINIC	0	0		0 0		
91. 00 09100 EMERGENCY	0	0		0 19, 171, 783		
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	0	0		0 1, 394, 826		
200.00 Total (lines 50 through 199)	0	0		0 69, 417, 343		200.00

Health Financial Systems	UNION HOSPITA			In Lie	u of Form CMS-2	2552-10
APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SE THROUGH COSTS	RVICE OTHER PASS	6 Provider C		Period: From 01/01/2019 To 12/31/2019		
		Title	XVIII	Hospi tal	Cost	
Cost Center Description	Outpati ent	Inpati ent	I npati ent	Outpati ent	Outpati ent	
	Ratio of Cost	Program	Program	Program	Program	
	to Charges	Charges	Pass-Through	Charges	Pass-Through	
	(col. 6 ÷		Costs (col. 8	3	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	193, 809		0 0	0	50.00
51.00 05100 RECOVERY ROOM	0. 000000	2, 100		0 0	0	51.00
51.01 05101 0/P TREATMENT ROOM	0. 000000	0		0 0	0	51.01
54. 00 05400 RADI OLOGY-DI AGNOSTI C	0. 000000	220, 410		0 0	0	54.00
56. 00 05600 RADI OI SOTOPE	0. 000000	0		0 0	0	56.00
60. 00 06000 LABORATORY	0. 000000	447, 883		0 0	0	60.00
62.00 06200 WHOLE BLOOD & PACKED RED BLOOD CELLS	0. 000000	19, 800		0 0	0	62.00
65. 00 06500 RESPI RATORY THERAPY	0. 000000	322, 867		0 0	0	65.00
66. 00 06600 PHYSI CAL THERAPY	0. 000000	63, 688		0 0	0	66.00
67.00 06700 OCCUPATI ONAL THERAPY	0. 000000	24, 143		0 0	0	67.00
68.00 06800 SPEECH PATHOLOGY	0. 000000	7, 205		0 0	0	68.00
69. 00 06900 ELECTROCARDI OLOGY	0. 000000	173, 050		0 0	0	69.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0. 000000	0		0 0	0	71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0. 000000	0		0 0	0	72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	0. 000000	342, 434		o o	0	73.00
OUTPATIENT SERVICE COST CENTERS	· · · · · ·	· · · · · · · · · · · · · · · · · · ·	•			1
90. 00 09000 CLINIC	0.000000	0		0 0	0	90.00
91.00 09100 EMERGENCY	0. 000000	3, 018		o o	0	91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	0. 000000	0		0 0	0	92.00
200.00 Total (lines 50 through 199)		1, 820, 407		0 0	0	200.00

Health Financial Systems	UNI ON HOSPI T	AL CLINTON		In Lie	u of Form CMS-:	2552-10
APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND	VACCINE COST	Provider C	CN: 15-1326	Peri od:	Worksheet D	
				From 01/01/2019 To 12/31/2019	Part V Date/Time Pre	narod
				10 12/31/2019	7/9/2020 1: 42	pareu. pm
		Title	× XVIII	Hospi tal	Cost	
			Charges		Costs	
Cost Center Description	Cost to	PPS	Cost	Cost	PPS Services	
	Charge Ratio	Reimbursed	Reimbursed	Reimbursed	(see inst.)	
		Services (see		Services Not		
	Worksheet C,	inst.)	Subject To	Subject To		
	Part I, col.		Ded. & Coins			
	9		(see inst.)	(see inst.)		
	1.00	2.00	3.00	4.00	5.00	
ANCILLARY SERVICE COST CENTERS						
50.00 05000 OPERATING ROOM	0. 332457		1, 025, 8		0	
51.00 05100 RECOVERY ROOM	0. 344474		594, 8	7 0	0	
51.01 05101 0/P TREATMENT ROOM	0. 000000			0 0	0	51.01
54. 00 05400 RADI OLOGY-DI AGNOSTI C	0. 151925		6, 171, 34	0 556	0	54.00
56. 00 05600 RADI OI SOTOPE	0. 434902			0 0	0	56.00
60. 00 06000 LABORATORY	0. 148597		2, 925, 70	0 0	0	60.00
62.00 06200 WHOLE BLOOD & PACKED RED BLOOD CELLS	0. 370153		59, 19		0	62.00
65. 00 06500 RESPI RATORY THERAPY	0. 823946	0	230, 32	24 0	0	65.00
66. 00 06600 PHYSI CAL THERAPY	0. 472735	0	1, 097, 08	32 0	0	66.00
67.00 06700 OCCUPATI ONAL THERAPY	0. 673810	0	237, 53		0	67.00
68.00 06800 SPEECH PATHOLOGY	0. 555512	0	16, 69	09 0	0	68.00
69. 00 06900 ELECTROCARDI OLOGY	0. 151313	0	1, 383, 73	34 0	0	69.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	1. 766781	0	1, 2	3 0	0	71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0. 508202	0	17, 48	32 0	0	72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	0. 319365	0	1, 365, 35	58 3, 152	0	73.00
OUTPATIENT SERVICE COST CENTERS			•			1
90. 00 09000 CLINIC	0. 000000	0		0 0	0	90.00
91.00 09100 EMERGENCY	0. 353538	0	4, 536, 38	2, 226	0	91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	1. 229581	0	591, 6	5 0	0	92.00
200.00 Subtotal (see instructions)		0	20, 254, 4	73 5, 934	0	200.00
201.00 Less PBP Clinic Lab. Services-Program				0 0		201.00
Only Charges						
202.00 Net Charges (line 200 - line 201)		0	20, 254, 4	5, 934	0	202.00

Health Financial Systems	UNI ON HOSPI T	AL CLINTON		In Lieu	u of Form CMS-	2552-10
APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND	O VACCINE COST	Provider CC		Period: From 01/01/2019 To 12/31/2019	Worksheet D Part V Date/Time Pro 7/9/2020 1:4	
			XVIII	Hospi tal	Cost	
	Cos	sts				
Cost Center Description	Cost	Cost				
	Reimbursed	Reimbursed				
	Servi ces	Services Not				
	Subject To	Subject To				
		Ded. & Coins.				
	(see inst.)	(see inst.)				
	6.00	7.00				
ANCI LLARY SERVI CE COST CENTERS						_
50.00 05000 OPERATI NG ROOM	341, 058					50.00
51.00 05100 RECOVERY ROOM	204, 920					51.00
51.01 05101 0/P TREATMENT ROOM	0	-				51.01
54. 00 05400 RADI OLOGY-DI AGNOSTI C	937, 581	84				54.00
56. 00 05600 RADI OI SOTOPE	0	0				56.00
60. 00 06000 LABORATORY	434, 760					60.00
62.00 06200 WHOLE BLOOD & PACKED RED BLOOD CELLS	21, 910	0				62.00
65. 00 06500 RESPI RATORY THERAPY	189, 775	0				65.00
66. 00 06600 PHYSI CAL THERAPY	518, 629	0				66.00
67.00 06700 OCCUPATI ONAL THERAPY	160, 054	0				67.00
68.00 06800 SPEECH PATHOLOGY	9, 276	0				68.00
69. 00 06900 ELECTROCARDI OLOGY	209, 377	0				69.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	2, 143	0				71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	8, 884	0				72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	436, 048	1,007				73.00
OUTPATIENT SERVICE COST CENTERS						
90. 00 09000 CLINIC	0	0				90.00
91.00 09100 EMERGENCY	1, 603, 784	787				91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	727, 439					92.00
200.00 Subtotal (see instructions)	5, 805, 638	1, 878				200.00
201.00 Less PBP Clinic Lab. Services-Program	0					201.00
Only Charges						
202.00 Net Charges (line 200 - line 201)	5, 805, 638	1, 878				202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST Provider CCN: 15-1326 Component CCN: 15-2326 Period: From 01/01/2019 To 12/31/2019 Worksheet D Pate/Time Prepared: 7/9/2020 1: 42 pm 2020 1: 42 pm Cost Center Description Cost to Crange Ratio From 9 Cost to Charges Cost cost Relinbursed Services inst.) Cost Subject To Ded & Coins. 9 Cost Subject To Ded & Coins. 9 PS Services Services inst.) PS Services Subject To Ded & Coins. (see inst.) Services Subject To Ded & Coins. (see inst.) Solo 4 Solo 5 Solo 5 50.00 05000 (PERATING ROM 0 05100 (RECOVERY ROM 0 05100 (RECOVERY ROM 0 05400 RADI 0LOGY-DIAGNOSTIC 0 00 00 0 0 0 0 0 50.00 50.00 05000 (RENATING ROM 0 05000 RADI 0STOPE 0.332457 0 0 0 0 0 0 51.00 54.00 05400 RADI 0LOGY-DIAGNOSTIC 0.151925 0 <td< th=""><th>Health Financial Systems</th><th>UNI ON HOSPI T</th><th>AL CLINTON</th><th></th><th>In Lie</th><th>u of Form CMS-</th><th>2552-10</th></td<>	Health Financial Systems	UNI ON HOSPI T	AL CLINTON		In Lie	u of Form CMS-	2552-10
Component CCN: 15-Z326 To 12/31/2019 Date/Time Prepared: To Date/Time Prepared: To Cost Center Description Cost to Charge Ratio From Worksheet C, Part I, col. To 12/31/2019 Date/Time Prepared: Cost ANCILLARY SERVICE COST CENTERS Cost to Charge Ratio Services (see inst.) Cost coins. Subject To Ded. & Coins. (see inst.) Cost coins. Ded. & Coins. (see inst.) PPS Ded. & Coins. Ded. & Coins. Subject To Ded. & Coins. PPS Ded. & Coins. Ded. & Coins. Ded. & Coins. For Ded. & Coins. Ded. & Coins. Ded. & Coins. 50:00 0 0 0 0 0 50:00 50:00 0 0 0 0 51:00 51:00 51:01 05:100 05:000 REPARTING ROM 0.332457 0 0 0 0 51:00 56:00 05:400 RADIOLOGY-DI AGNOSTIC 0.151:925 0 0 0 0 0 56:00 66:00 0 0.32437 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND	VACCINE COST	Provider C	CN: 15-1326		Worksheet D	
Ancitization Title XVIII Swing Beds - SNF Cost Cost Center Description Cost to Charge Ratio From C, Part I, col. Title XVIII Swing Beds - SNF Cost Beinbursed Services (see inst.) Reinbursed Services (see inst.) Reinbursed Services (see inst.) Reinbursed Services (see inst.) Reinbursed Services (see inst.) PPS Services (see inst.) 50:00 05000 OPERATING ROOM 0.332457 0 0 0 50.00 50:00 05000 OPERATING ROOM 0.332457 0 0 0 0 51.00 51:00 05100 RECOVERY ROOM 0.344474 0 0 0 51.00 54:00 05400 RADI 0LOCY-DI ARMOSTIC 0.151925 0 0 0 54.00 65:00 065000 LABORATORY 0.148597 0 0 0 66.00 66:00 06500 RESPIRATORY THERAPY 0.434902 0 0 0 66.00 66:00 06500 RESPIRATORY THERAPY 0.472735 0 0 0 66.00 66.00 66.00 66.00			Component				norod.
Ancillary Service Cost Center Description Cost to Charge Ratio From Worksheet C, Part I, col. Title XVIII Swing Beds - SNF Cost Ancillary Service Cost Center Description Cost to Charge Ratio From Worksheet C, Part I, col. Cost (see inst.) Cost Reimbursed Services (see inst.) Cost Subject To Ded. & Coins. (see inst.) Ancillary Service Cost Centers 0 0 0 0 5.00 50.00 05000 0PERATING ROM 000000 0.332457 0 0 0 0 50.00 51.00 05100 APP TREATMENT ROM 0.000000 0.34474 0 0 0 51.00 54.00 05600 RADIOLOGY-DI AGNOSTI C 0.151925 0 0 0 54.00 66.00 05600 RADIOLOGY-DI AGNOSTI C 0.148597 0 0 0 66.00 66.00 06000 LABORATORY 0.823946 0 0 0 66.00 67.00 0.00000 CLOB PACKED RED BLOOD CELLS 0.555512 0 <			component	CCN: 15-2320	10 12/31/2019		
Cost Center Description Cost to Charge Ratio From Worksheet C, Part I, col. PPS Reimbursed Services (see inst.) Cost Reimbursed Services (see inst.) PPS Services (see inst.) ANCILLARY SERVICE COST CENTERS 0			Title	e XVIII	Swing Beds - SNF		
Charge Ratio Reimbursed From Reimbursed Services Reimbursed Services Reimbursed Services Reimbursed Services (see inst.) 9 1.00 2.00 3.00 4.00 5.00 05000 095000 0PFX 0 0 0 5.00 51.00 05100 RECOVERY ROM 0.332457 0 0 0 0 51.00 51.01 05100 RECOVERY ROM 0.344474 0 0 0 0 51.01 51.01 05400 RADI LLARY DEROVERY ROM 0.332457 0 0 0 0 51.01 51.01 05400 RADI LGRY TRATIENT ROM 0.000000 0 </td <td></td> <td></td> <td></td> <td>Charges</td> <td></td> <td>Costs</td> <td></td>				Charges		Costs	
ANCI LLARY SERVICE COST CENTERS Services (see inst.) Services Subject To Ded. & Coins. (see inst.) Subject To Ded. & Coins. (see inst.) 0	Cost Center Description	Cost to	PPS	Cost	Cost	PPS Services	
Morksheet C, Part I, col. inst.) Subject To Ded. & Coins. Subject To Ded. & Coins. 9 1.00 2.00 3.00 4.00 5.00 50.00 05000 OPERATING R00M 0.332457 0 0 0 0 50.00 51.01 05100 RECOVERY R00M 0.344474 0 0 0 0 51.00 51.01 05100 RECOVERY R00M 0.344474 0 0 0 0 51.00 54.00 05400 RADI 0LOGY-DI AGNOSTI C 0.151925 0 0 0 56.00 60.00 06000 LABORATORY 0.148597 0 0 0 66.00 60.00 06500 REDI RATORY THERAPY 0.823946 0 0 0 66.00 61.00 06600 PHYSI CAL THERAPY 0.673810 0 0 0 66.00 66.00 06600 SPEECH PATHOLOGY 0.555512 0 0 0 66.00 66.00 06600 SPEECH PATHOLOGY 0.555512 0 0 0 0		Charge Ratio	Reimbursed	Reimbursed	Reimbursed	(see inst.)	
Part I, col. Ded. & Coins. (see inst.) Ded. & Coins. (see inst.) ANCILLARY SERVICE COST CENTERS 50.00 05000 0PERATING ROOM 0.332457 0 0 0 0 0 50.00 51.00 05100 RECOVERY ROOM 0.344474 0 0 0 0 51.00 51.01 05101 0/P TREATMENT ROOM 0.344474 0 0 0 0 51.01 54.00 05400 RADI 0LOGY-DI AGNOSTI C 0.151925 0 0 0 54.00 66.00 06600 RADI 0LOGY-DI AGNOSTI C 0.148597 0 0 0 66.00 66.00 06500 RESI RATORY THERAPY 0.4829746 0 0 0 65.00 66.00		From	Services (see	Servi ces	Services Not		
9 (see inst.) (see inst.) (see inst.) ANCI LLARY SERVICE COST CENTERS 1.00 2.00 3.00 4.00 5.00 50.00 05000 0PERATING ROOM 0.332457 0 0 0 0 51.00 51.01 0/5 TREATMENT ROOM 0.332457 0 0 0 0 51.00 51.01 0/5 TREATMENT ROOM 0.344474 0 0 0 51.01 54.00 05400 RADI OLOGY-DI AGNOSTI C 0.151925 0 0 0 54.00 56.00 05600 RADI OLOGY-DI AGNOSTI C 0.148597 0 0 0 66.00 60.00 06000 LABORATORY 0.148597 0 0 0 66.00 62.00 06200 WHOLE BLOOD & PACKED RED BLOOD CELLS 0.370153 0 0 0 66.00 64.00 06600 PHYSI CAL THERAPY 0.472735 0 0 0 66.00 67.00 06700 OCUPATI ONAL THERAPY 0.472735 0 0 0 67.00 <td></td> <td></td> <td>inst.)</td> <td>Subject To</td> <td>Subject To</td> <td></td> <td></td>			inst.)	Subject To	Subject To		
Inclusion Inclusion <thinclusion< th=""> <thinclusion< th=""> <thi< td=""><td></td><td>Part I, col.</td><td></td><td>Ded. & Coins</td><td>. Ded. & Coins.</td><td></td><td></td></thi<></thinclusion<></thinclusion<>		Part I, col.		Ded. & Coins	. Ded. & Coins.		
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50.00 05000 OPERATING ROOM 0.332457 0 0 0 0 0 50.00 51.00 05100 RECOVERY ROOM 0.344474 0 0 0 0 51.00 51.00 05100 PREATRENT ROOM 0.344474 0 0 0 0 51.00 51.00 0 0 0 0 51.00 0		1.00	2.00	3.00	4.00	5.00	
51.00 05100 RECOVERY ROOM 0.344474 0 0 0 0 51.00 51.01 05101 0/P TREATMENT ROOM 0.000000 0 0 0 51.01 54.00 05400 RADI OLGGY-DI AGNOSTI C 0.151925 0 0 0 54.00 56.00 05600 RADI OLSOTOPE 0.434902 0 0 0 56.00 60.00 06000 LABORATORY 0.148597 0 0 0 66.00 62.00 06200 WHOLE BLOOD & PACKED RED BLOOD CELLS 0.370153 0 0 0 65.00 65.00 06500 RESPI RATORY THERAPY 0.472735 0 0 0 66.00 66.00 06600 PHYSI CAL THERAPY 0.575512 0 0 0 68.00 69.00 0 0 68.00 69.00 0 0 68.00 69.00 0 0 69.00 0 0 69.00 0 0 0 69.00 0 0 0 71.00 71.00 0 0 </td <td></td> <td></td> <td></td> <td>-</td> <td></td> <td></td> <td></td>				-			
51.01 05101 0/P TREATMENT ROOM 0.000000 0 0 0 51.01 54.00 05400 RADI 0L0CY-DI AGNOSTI C 0.151925 0 0 0 54.00 56.00 05600 RADI 0L0CY-DI AGNOSTI C 0.151925 0 0 0 56.00 56.00 06000 LABORATORY 0.148597 0 0 0 60.00 62.00 06500 RESPI RATORY THERAPY 0.823946 0 0 0 65.00 66.00 06500 RESPI RATORY THERAPY 0.472735 0 0 0 66.00 67.00 06700 0CCUPATI ONAL THERAPY 0.673810 0 0 0 67.00 06800 SPECH PATHOLOGY 0.555512 0 0 0 68.00 69.00 69.00 69.00 69.00 69.00 69.00 69.00 71.00 68.00 69.00 71.00 73.00 0 0 0 73.00 0 0 73.00 73.00 0 0 0 73.00 0 73.00 73.00	50.00 05000 OPERATING ROOM	0. 332457	0		0 0	0	50.00
54.00 05400 RADI OLOGY-DI AGNOSTI C 0.151925 0 0 0 54.00 56.00 05600 RADI OLSOTOPE 0.434902 0 0 0 56.00 60.00 06000 LABORATORY 0.148597 0 0 0 60.00 62.00 06200 WHOLE BLOOD & PACKED RED BLOOD CELLS 0.370153 0 0 0 62.00 65.00 06500 RESPI RATORY THERAPY 0.823946 0 0 0 65.00 66.00 06600 PHYSI CAL THERAPY 0.472735 0 0 0 66.00 67.00 06700 0CUPATI ONAL THERAPY 0.673810 0 0 0 68.00 69.00 06900 ELECTROCARDI OLOGY 0.151313 0 0 0 69.00 71.00 07100 MEDI CAL SUPPLIES CHARGED TO PATI ENTS 1.766781 0 0 0 71.00 72.00 07200 IMPL. DEV. CHARGED TO PATI ENTS 0.319365 0 0 0 72.00 73.00 017100 DUPDAT ENT SERVI	51.00 05100 RECOVERY ROOM	0. 344474	0		0 0	0	51.00
56.00 05600 RADI 0I SOTOPE 0.434902 0 0 0 56.00 60.00 06000 LABORATORY 0.148597 0 0 0 60.00 62.00 06500 RESPI RATORY THERAPY 0.823946 0 0 0 65.00 66.00 06600 PHYSI CAL THERAPY 0.472735 0 0 0 66.00 67.00 06700 OCCUPATI ONAL THERAPY 0.673810 0 0 0 67.00 68.00 06900 ELECTROCARDI OLOGY 0.151313 0 0 0 68.00 69.00 O7200 IMPL. DEV. CHARGED TO PATI ENTS 1.766781 0 0 0 71.00 71.00 07100 MEDI CAL SUPPLIES CHARGED TO PATI ENTS 0.508202 0 0 0 72.00 73.00 07300 DRUGS CHARGED TO PATI ENTS 0.319365 0 0 0 90.00 90.00 91.00 92.00 92.00 92.00 92.00 92.00 92.00 92.00 92.00 92.00 92.00 92.00 92.00 <td>51.01 05101 0/P TREATMENT ROOM</td> <td>0. 000000</td> <td>0</td> <td></td> <td>0 0</td> <td>0</td> <td>51.01</td>	51.01 05101 0/P TREATMENT ROOM	0. 000000	0		0 0	0	51.01
60.00 06000 LABORATORY 0.148597 0 0 0 60.00 62.00 06200 WHOLE BLOOD & PACKED RED BLOOD CELLS 0.370153 0 0 0 62.00 65.00 06500 RESPI RATORY THERAPY 0.823946 0 0 0 65.00 66.00 06600 PHYSI CAL THERAPY 0.472735 0 0 0 66.00 67.00 06700 0CCUPATI ONAL THERAPY 0.673810 0 0 0 67.00 68.00 06800 SPEECH PATHOLOGY 0.555512 0 0 0 68.00 69.00 06900 ELECTROCARDI OLOGY 0.151313 0 0 0 69.00 71.00 07100 MEDI CAL SUPPLI ES CHARGED TO PATI ENTS 1.766781 0 0 0 71.00 73.00 07300 DRUGS CHARGED TO PATI ENTS 0.319365 0 0 0 72.00 74.00 09000 CLI NI C 0.000000 0 0 0 90.00 91.00 92.00 09000 CLI NI C <td>54.00 05400 RADI OLOGY-DI AGNOSTI C</td> <td>0. 151925</td> <td>0</td> <td></td> <td>0 0</td> <td>0</td> <td>54.00</td>	54.00 05400 RADI OLOGY-DI AGNOSTI C	0. 151925	0		0 0	0	54.00
62.00 06200 WHOLE BLOOD & PACKED RED BLOOD CELLS 0.370153 0 0 0 62.00 65.00 06500 RESPI RATORY THERAPY 0.823946 0 0 0 65.00 66.00 06600 PHYSI CAL THERAPY 0.472735 0 0 0 66.00 67.00 06700 0CCUPATI ONAL THERAPY 0.673810 0 0 0 67.00 68.00 06800 SPEECH PATHOLOGY 0.555512 0 0 0 68.00 69.00 06900 ELECTROCARDI OLOGY 0.151313 0 0 0 69.00 71.00 07100 MEDI CAL SUPPLIES CHARGED TO PATI ENTS 1.766781 0 0 0 71.00 72.00 07200 IMPL. DEV. CHARGED TO PATI ENTS 0.508202 0 0 0 72.00 73.00 OT300 DRUGS CHARGED TO PATI ENTS 0.319365 0 0 0 73.00 001PATI ENT SERVICE COST CENTERS 0.000000 0 0 0 0 90.00 91.00 91.00 <t< td=""><td>56. 00 05600 RADI OI SOTOPE</td><td>0. 434902</td><td>0</td><td></td><td>0 0</td><td>0</td><td>56.00</td></t<>	56. 00 05600 RADI OI SOTOPE	0. 434902	0		0 0	0	56.00
65.00 06500 RESPI RATORY THERAPY 0.823946 0 0 0 0 65.00 66.00 06600 PHYSI CAL THERAPY 0.472735 0 0 0 66.00 67.00 06700 0CCUPATI ONAL THERAPY 0.673810 0 0 0 67.00 68.00 06800 SPEECH PATHOLOGY 0.555512 0 0 0 68.00 69.00 06900 ELECTROCARDI OLOGY 0.151313 0 0 0 69.00 71.00 07100 MEDI CAL SUPPLIES CHARGED TO PATI ENTS 1.766781 0 0 0 71.00 72.00 07200 IMPL. DEV. CHARGED TO PATI ENTS 0.508202 0 0 0 72.00 73.00 07300 DRUGS CHARGED TO PATI ENTS 0.319365 0 0 0 73.00 017100 EMERGENCY 0.319365 0 0 0 0 90.00 90.00 OP100 EMERGENCY 0.353538 0 0 0 91.00 92.00 09200 DSERVATI ON BEDS (NON-DI	60. 00 06000 LABORATORY	0. 148597	0		0 0	0	60.00
66.00 06600 PHYSI CAL THERAPY 0.472735 0 0 0 66.00 67.00 06700 OCCUPATI ONAL THERAPY 0.673810 0 0 0 67.00 68.00 06800 SPEECH PATHOLOGY 0.555512 0 0 0 0 68.00 69.00 06900 ELECTROCARDI OLOGY 0.151313 0 0 0 69.00 71.00 07100 MEDI CAL SUPPLIES CHARGED TO PATI ENTS 1.766781 0 0 0 71.00 72.00 07200 IMPL. DEV. CHARGED TO PATI ENTS 0.508202 0 0 0 72.00 73.00 07300 DRUGS CHARGED TO PATI ENTS 0.319365 0 0 0 73.00 0.00 09000 CLINIC 0.000000 0 0 0 90.00 91.00 90.00 09200 DBSERVATI ON BEDS (NON-DI STI NCT PART) 1.229581 0 0 0 92.00 200.00 Subtotal (see instructions) 0 0 0 0 200.00 200.00 201.00 201.00 <td>62.00 06200 WHOLE BLOOD & PACKED RED BLOOD CELLS</td> <td>0. 370153</td> <td>0</td> <td></td> <td>0 0</td> <td>0</td> <td>62.00</td>	62.00 06200 WHOLE BLOOD & PACKED RED BLOOD CELLS	0. 370153	0		0 0	0	62.00
67.00 06700 0CCUPATIONAL THERAPY 0.673810 0 0 0 67.00 68.00 06800 SPEECH PATHOLOGY 0.555512 0 0 0 68.00 69.00 06900 ELECTROCARDIOLOGY 0.151313 0 0 0 69.00 71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 1.766781 0 0 0 71.00 72.00 07200 IMPL. DEV. CHARGED TO PATIENTS 0.508202 0 0 0 72.00 73.00 0 0 0 73.00 0 0 0 73.00 0 0 0 0 73.00 0 0 0 73.00 0 0 0 0 73.00 0 0 0 0 73.00 73.00 0 0 0 0 0 73.00 90.00 0 0 0 0 0 0 0 90.00 91.00 92.00 90.00 91.00 92.00 92.00 92.00 92.00 92.00 92.00 92.00 92.00	65. 00 06500 RESPI RATORY THERAPY	0. 823946	0		0 0	0	65.00
68.00 06800 SPEECH PATHOLOGY 0.555512 0 0 0 68.00 69.00 06900 ELECTROCARDI OLOGY 0.151313 0 0 0 69.00 71.00 07100 MEDI CAL SUPPLI ES CHARGED TO PATI ENTS 1.766781 0 0 0 71.00 72.00 07200 IMPL. DEV. CHARGED TO PATI ENTS 0.508202 0 0 0 72.00 73.00 07300 DRUGS CHARGED TO PATI ENTS 0.319365 0 0 0 73.00 00TPATI ENT SERVICE COST CENTERS 0.000000 0 0 0 0 90.00 90.00 09000 CLINIC 0.000000 0 0 0 91.00 91.00 09100 EMERGENCY 0.353538 0 0 0 91.00 92.00 09200 OBSERVATION BEDS (NON-DI STINCT PART) 1.229581 0 0 0 92.00 200.00 Subtotal (see instructions) 0 0 0 0 201.00 201.00 201.00 201.00 201.00 201.00	66. 00 06600 PHYSI CAL THERAPY	0. 472735	0		0 0	0	66.00
69.00 06900 ELECTROCARDI OLOGY 0.151313 0 0 0 69.00 71.00 07100 MEDI CAL SUPPLIES CHARGED TO PATI ENTS 1.766781 0 0 0 71.00 72.00 07200 IMPL. DEV. CHARGED TO PATI ENTS 0.508202 0 0 0 72.00 73.00 07300 DRUGS CHARGED TO PATI ENTS 0.319365 0 0 0 73.00 001PATI ENT SERVICE COST CENTERS 0.000000 0 0 0 0 0 73.00 90.00 09100 EMERGENCY 0.300000 0 0 0 90.00 91.00 92.00 9200 00 0 0 91.00 92.00 92.00 92.00 0 0 0 92.00 0 0 0 92.00 0 0 0 0 92.00 0 0 0 0 0 200.00 200.00 200.00 200.00 200.00 200.00 200.00 200.00 200.00 201.00 201.00 201.00 201.00 201.00 201.00 201.	67.00 06700 OCCUPATI ONAL THERAPY	0. 673810	0)	0 0	0	67.00
71.00 07100 MEDI CAL SUPPLIES CHARGED TO PATIENTS 1.766781 0 0 0 71.00 72.00 07200 IMPL. DEV. CHARGED TO PATIENTS 0.508202 0 0 0 0 72.00 73.00 07300 DRUGS CHARGED TO PATIENTS 0.319365 0 0 0 73.00 000 09000 CLINIC 0.000000 0 0 0 90.00 90.00 09100 EMERGENCY 0.353538 0 0 0 91.00 92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART) 1.229581 0 0 0 92.00 201.00 Less PBP Clinic Lab. Services-Program Only Charges 0 0 0 201.00 201.00 201.00	68.00 06800 SPEECH PATHOLOGY	0. 555512	0)	0 0	0	68.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS 0.508202 0 0 0 72.00 73.00 73.00 07300 DRUGS CHARGED TO PATIENTS 0.319365 0 0 0 0 73.00 000 00000 CLINIC 0.000000 0 0 0 0 90.00 90.00 09100 EMERGENCY 0.353538 0 0 0 91.00 92.00 085RVATION BEDS (NON-DISTINCT PART) 1.229581 0 0 0 92.00 92.00 200.00 200.00 200.00 200.00 200.00 200.00 200.00 200.00 200.00 200.00 0 0 0 200.00 200.00 201.00 <	69. 00 06900 ELECTROCARDI OLOGY	0. 151313	0)	0 0	0	69.00
73.00 07300 DRUGS CHARGED TO PATIENTS 0.319365 0 0 0 0 73.00 OUTPATIENT SERVICE COST CENTERS 0.000000 0 0 0 0 90.00 90.00 90.00 90.00 90.00 90.00 91.00 90.00 91.00 91.00 91.00 92.00 058ERVATION BEDS (NON-DISTINCT PART) 1.229581 0 0 0 92.00 200.00 200.00 200.00 200.00 200.00 200.00 200.00 200.00 200.00 201.00 0 0 0 201.00 0 201.00 <td< td=""><td>71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS</td><td>1. 766781</td><td>0</td><td></td><td>0 0</td><td>0</td><td>71.00</td></td<>	71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	1. 766781	0		0 0	0	71.00
OUTPATI ENT_SERVICE_COST_CENTERS 90.00 09000 CLINIC 0.000000 0 0 0 90.00 91.00 09100 EMERGENCY 0.353538 0 0 0 91.00 92.00 09200 DBSERVATION BEDS (NON-DISTINCT PART) 1.229581 0 0 0 92.00 200.00 Subtotal (see instructions) 0 0 0 0 200.00 201.00 Less PBP Clinic Lab. Services-Program 0 0 0 201.00	72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0. 508202	0		0 0	0	72.00
90.00 09000 CLINIC 0.00000 0 0 0 0 90.00 91.00 09100 EMERGENCY 0.353538 0 0 0 91.00 92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART) 1.229581 0 0 0 92.00 200.00 Subtotal (see instructions) 0 0 0 0 200.00 201.00 Less PBP Clinic Lab. Services-Program 0 0 0 201.00	73.00 07300 DRUGS CHARGED TO PATIENTS	0. 319365	0		0 0	0	73.00
90.00 09000 CLINIC 0.00000 0 0 0 0 90.00 91.00 09100 EMERGENCY 0.353538 0 0 0 91.00 92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART) 1.229581 0 0 0 92.00 200.00 Subtotal (see instructions) 0 0 0 0 200.00 201.00 Less PBP Clinic Lab. Services-Program 0 0 0 201.00	OUTPATIENT SERVICE COST CENTERS						1
91.00 09100 EMERGENCY 0.353538 0 0 0 91.00 92.00 09200 0BSERVATION BEDS (NON-DISTINCT PART) 1.229581 0 0 0 92.00 200.00 Subtotal (see instructions) 0 0 0 0 200.00 201.00 Less PBP Clinic Lab. Services-Program Only Charges 0 0 0 201.00		0.00000	0		0 0	0	1 90. 00
200.00Subtotal (see instructions)00 <th< td=""><td>91. 00 09100 EMERGENCY</td><td></td><td></td><td></td><td>0 0</td><td>0</td><td>91.00</td></th<>	91. 00 09100 EMERGENCY				0 0	0	91.00
200.00Subtotal (see instructions)00 <th< td=""><td></td><td></td><td>l o</td><td></td><td>0 0</td><td>0</td><td></td></th<>			l o		0 0	0	
201.00 Less PBP Clinic Lab. Services-Program 0 0 201.00 Only Charges 0 0 201.00			0		0 0	0	
Only Charges					0 0		
			0		0 0	0	202.00

Health Financial Systems	UNION HOSPIT	AL CLINTON		In Lieu	u of Form CMS-	2552-10
APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND	VACCINE COST	Provider CC Component (CN: 15-1326 CCN: 15-Z326	Period: From 01/01/2019 To 12/31/2019	Worksheet D Part V Date/Time Pre 7/9/2020 1:42	
		Title	XVIII	Swing Beds - SNF		
	Cos	sts			I	
Cost Center Description	Cost	Cost				
	Reimbursed	Reimbursed				
	Servi ces	Services Not				
	Subject To	Subject To				
	Ded. & Coi ns.	Ded. & Coins.				
	(see inst.)	(see inst.)				
	6.00	7.00				
ANCI LLARY SERVI CE COST CENTERS						
50.00 05000 OPERATI NG ROOM	0	0				50.00
51.00 05100 RECOVERY ROOM	0	0				51.00
51.01 05101 0/P TREATMENT ROOM	0	0				51.01
54.00 05400 RADI OLOGY-DI AGNOSTI C	0	0				54.00
56. 00 05600 RADI OI SOTOPE	0	0				56.00
60. 00 06000 LABORATORY	0	0				60.00
62.00 06200 WHOLE BLOOD & PACKED RED BLOOD CELLS	0	0				62.00
65. 00 06500 RESPI RATORY 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 PATIENTS	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
OUTPATIENT SERVICE COST CENTERS		·				
90. 00 09000 CLINIC	0	0				90.00
91.00 09100 EMERGENCY	0	0				91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	0	0				92.00
200.00 Subtotal (see instructions)	0	0				200.00
201.00 Less PBP Clinic Lab. Services-Program	0					201.00
Only Charges						
202.00 Net Charges (line 200 - line 201)	0	0				202.00

OMPUT.	ATION OF INPATIENT OPERATING COST	Provider CCN: 15-1326	Period:	Worksheet D-1	
			From 01/01/2019 To 12/31/2019	Date/Time Pre 7/9/2020 1:42	
		Title XVIII	Hospi tal	Cost	pin
	Cost Center Description			1.00	
	PART I - ALL PROVIDER COMPONENTS			1.00	
	INPATIENT DAYS Inpatient days (including private room days and swing-bed da	vs excluding newborn)		2, 463	1
	Inpatient days (including private room days and swing bed day Inpatient days (including private room days, excluding swing			2, 403	2
00	Private room days (excluding swing-bed and observation bed d	ays). If you have only p	orivate room days,	0	3
00	do not complete this line.	had dava)		1 076	
00 00	Semi-private room days (excluding swing-bed and observation Total swing-bed SNF type inpatient days (including private r		er 31 of the cost	1, 276 186	45
00	reporting period				
00	Total swing-bed SNF type inpatient days (including private r	oom days) after December	31 of the cost	0	6
00	reporting period (if calendar year, enter 0 on this line) Total swing-bed NF type inpatient days (including private ro	om davs) through Decembe	or 31 of the cost	37	7
00	reporting period	on days) through becenbe	a si oi the cost	57	
00	Total swing-bed NF type inpatient days (including private ro	om days) after December	31 of the cost	0	8
00	reporting period (if calendar year, enter 0 on this line) Total inpatient days including private room days applicable	to the Drogram (oveludin	a swing had and	743	9
00	newborn days) (see instructions)	to the Program (excludin	ig swiftg-bed and	743	9
0. 00	Swing-bed SNF type inpatient days applicable to title XVIII		room days)	186	10
00	through December 31 of the cost reporting period (see instru		noom dovo) often	0	11
1.00	Swing-bed SNF type inpatient days applicable to title XVIII December 31 of the cost reporting period (if calendar year,		room days) arter	0	11
2.00	Swing-bed NF type inpatient days applicable to titles V or X		te room days)	0	12
	through December 31 of the cost reporting period				
8.00	Swing-bed NF type inpatient days applicable to titles V or X after December 31 of the cost reporting period (if calendar			0	13
. 00	Medically necessary private room days applicable to the Prog			0	14
	Total nursery days (title V or XIX only)			0	15
	Nursery days (title V or XIX only)			0	16
	SWING BED ADJUSTMENT Medicare rate for swing-bed SNF services applicable to servi	ces through December 31	of the cost		17
	reporting period				
3. 00	Medicare rate for swing-bed SNF services applicable to servi	ces after December 31 of	the cost		18
9.00	reporting period Medicaid rate for swing-bed NF services applicable to servic	es through December 31 c	of the cost	129. 14	19
0. 00	reporting period Medicaid rate for swing-bed NF services applicable to servic	oc after December 21 of	the cost	129. 14	20
J. UU	reporting period	es al tel December 31 01	the cost	129.14	20
	Total general inpatient routine service cost (see instructio			4, 320, 874	21
2.00	Swing-bed cost applicable to SNF type services through Decem	ber 31 of the cost repor	ting period (line	0	22
3. 00	5 x line 17) Swing-bed cost applicable to SNF type services after Decembe	r 31 of the cost reporti	ng period (line A	0	23
	x line 18)		ng period (rine d	0	
4.00	Swing-bed cost applicable to NF type services through Decemb	er 31 of the cost report	ing period (line	4, 778	24
5.00	7 x line 19) Swing-bed cost applicable to NF type services after December	31 of the cost reportin	a period (line 8	0	25
0.00	x line 20)			0	20
	Total swing-bed cost (see instructions)	(1) 01 1 1 0()		335, 691	
	General inpatient routine service cost net of swing-bed cost PRIVATE ROOM DIFFERENTIAL ADJUSTMENT	(line 21 minus line 26)		3, 985, 183	27
	General inpatient routine service charges (excluding swing-b	ed and observation bed c	harges)	0	28
	Private room charges (excluding swing-bed charges)			0	29
	Semi-private room charges (excluding swing-bed charges)			0	30
	General inpatient routine service cost/charge ratio (line 27 Average private room per diem charge (line 29 ÷ line 3)	÷ TTHE 28)		0. 000000 0. 00	31
	Average semi-private room per diem charge (line 30 ÷ line 4)			0.00	33
	Average per diem private room charge differential (line 32 m	, ,	icti ons)	0.00	
	Average per diem private room cost differential (line 34 x l Private room cost differential adjustment (line 3 x line 35)	ine 31)		0.00 0	35 36
	General inpatient routine service cost net of swing-bed cost	and private room cost o	lifferential (line	-	
	27 minus line 36)				
	PART II - HOSPITAL AND SUBPROVIDERS ONLY				
	PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST AD. Adjusted general inpatient routine service cost per diem (se			1, 779. 10	38
	Program general inpatient routine service cost per drem (se	,		1, 321, 871	39
	Medically necessary private room cost applicable to the Prog	. ,		0	40
. 00	Total Program general inpatient routine service cost (line 3	9 + line 40)		1, 321, 871	41

MPUTATION OF INPATIENT OPERATING COST		AL CLINTON Provider C	CN: 15-1326	Period:	u of Form CMS- Worksheet D-1	
			1	From 01/01/2019 To 12/31/2019		epare
		Title	e XVIII	Hospi tal	Cost	2 pm
Cost Center Description	Total	Total	Average Per	Program Days	Program Cost	
	Inpati ent	Inpatient	Diem (col. 1		(col. 3 x	
	Cost	Days	÷ col. 2)		col. 4)	
	1.00	2.00	3.00	4.00	5.00	10
00 NURSERY (title V & XIX only) Intensive Care Type Inpatient Hospital Uni	te		<u> </u>		<u> </u>	42.
00 INTENSIVE CARE UNIT	1, 179, 297	262	4, 501. 1	3 143	643, 662	2 43.
00 CORONARY CARE UNIT	1, 177, 277	202	4, 501. 1	5 145	043, 002	44
00 BURN I NTENSI VE CARE UNI T						45.
00 SURGI CAL I NTENSI VE CARE UNI T						46
00 OTHER SPECIAL CARE (SPECIFY)						47
Cost Center Description						
					1.00	
00 Program inpatient ancillary service cost (625, 541	
00 Total Program inpatient costs (sum of line	s 41 through 48)	(see instructi	ons)		2, 591, 074	49
PASS THROUGH COST ADJUSTMENTS 00 Pass through costs applicable to Program i	postiont routing	conviloos (fro	wkct D cur	n of Dorte L one	0	50
(111)	inpatrent routine	Services (110	III WKSL. D, SUI	I UI PAILS I ANU	i U	1 50
00 Pass through costs applicable to Program i	npatient ancilla	rv services (f	rom Wkst D «	sum of Parts II	o	51
and IV)	inputriont anorra	j ::::::::::::::::::::::::::::::::::::			Ĩ	
00 Total Program excludable cost (sum of line	s 50 and 51)				0	52
00 Total Program inpatient operating cost exc		elated, non-ph	ysician anesth	netist, and	0	53
medical education costs (line 49 minus lin	e 52)				l	
TARGET AMOUNT AND LIMIT COMPUTATION						
00 Program di scharges					0	
00 Target amount per discharge					0.00	
00 Target amount (line 54 x line 55) 00 Difference between adjusted inpatient oper	ating cost and to	arget emount (Lino E4 minuc	Lino E2)	0	
00 Bonus payment (see instructions)	ating cost and ta	arget amount (TTHE SO INTIUS	TTHE 55)		
00 Lesser of Lines 53/54 or 55 from the cost	reporting period	ending 1996	undated and co	omnounded by the		
market basket	reporting period	chung 1770,		inpounded by the	0.00	
00 Lesser of lines 53/54 or 55 from prior yea	r cost report, up	odated by the	market basket		0.00	0 60
00 If line 53/54 is less than the lower of li				the amount by	0) 61
which operating costs (line 53) are less t	han expected cost	ts (lines 54 x	60), or 1% of	the target		
amount (line 56), otherwise enter zero (se	e instructions)					
00 Relief payment (see instructions)					0	
00 Allowable Inpatient cost plus incentive pa	yment (see instru	uctions)			0) 63
PROGRAM INPATIENT ROUTINE SWING BED COST	acto through Door	ambar 21 of th	a agat raparti	ng pariod (See	220.012	
00 Medicare swing-bed SNF inpatient routine c instructions)(title XVIII only)	osts through Dece		e cost reporti	ng period (see	330, 913	3 64
00 Medicare swing-bed SNF inpatient routine c	osts after Decem	her 31 of the	cost reporting	n period (See	0	65
instructions) (title XVIII only)				, period (dee	Ŭ	
00 Total Medicare swing-bed SNF inpatient rou	tine costs (line	64 plus line	65)(title XVII	I only). For	330, 913	3 66
CAH (see instructions)			, ,	5.		
00 Title V or XIX swing-bed NF inpatient rout	ine costs through	n December 31	of the cost re	eporting period	0) 67
(line 12 x line 19)						
00 Title V or XIX swing-bed NF inpatient rout	ine costs after [December 31 of	the cost repo	orting period	0) 68
(line 13 x line 20)	t routing goata	(line (7 . lin	o (0)		0	
00 Total title V or XIX swing-bed NF inpatien PART III - SKILLED NURSING FACILITY, OTHER					0) 69
00 Skilled nursing facility/other nursing fac				,!		70
00 Adjusted general inpatient routine service						71
00 Program routine service cost (line 9 x lin					1	72
00 Medically necessary private room cost appl		m (line 14 x l	ine 35)		l	73
00 Total Program general inpatient routine se	•		·		l	74
00 Capital-related cost allocated to inpatien	t routine service	e costs (from	Worksheet B, F	art II, column	l	75
26, line 45)					ł	
00 Per diem capital related costs (line 75 ÷					ł	76
00 Program capital-related costs (line 9 x li 00 Inpatient routine service cost (line 74 mi					ł	77
00 Aggregate charges to beneficiaries for exc		orovi der recor	ds)		1	79
00 Total Program routine service costs for co	• •			us line 79)	1	80
00 Inpatient routine service cost per diem li	•				1	81
00 Inpatient routine service cost limitation		1)			l	82
00 Reasonable inpatient routine service costs	•				l	83
00 Program inpatient ancillary services (see	•				l	84
00 Utilization review - physician compensatio					l	85
	um of lines 83 th	nrouah 85)			i	86
00 Total Program inpatient operating costs (s						
PART IV - COMPUTATION OF OBSERVATION BED P.	ASS THROUGH COST					
	ASS THROUGH COST ns)				964 1, 779. 10	

Health Financial Systems	UNI ON HOSPI T	AL CLINTON		In Lie	u of Form CMS-2	2552-10
COMPUTATION OF INPATIENT OPERATING COST		Provider CC		Period: From 01/01/2019	Worksheet D-1	
				To 12/31/2019	Date/Time Pre 7/9/2020 1:42	
		Title	XVIII	Hospi tal	Cost	
Cost Center Description	Cost	Routine Cost	column 1 ÷	Total	Observati on	
		(from line	column 2	Observati on	Bed Pass	
		21)		Bed Cost	Through Cost	
				(from line	(col. 3 x	
				89)	col. 4) (see	
					instructions)	
	1.00	2.00	3.00	4.00	5.00	
COMPUTATION OF OBSERVATION BED PASS THROUGH	COST					
90.00 Capital-related cost	630, 667	4, 320, 874	0. 14595	8 1, 715, 052	250, 326	90.00
91.00 Nursing School cost	0	4, 320, 874	0.00000	0 1, 715, 052	0	91.00
92.00 Allied health cost	0	4, 320, 874	0.00000	0 1, 715, 052	0	92.00
93.00 All other Medical Education	0	4, 320, 874	0.00000	0 1, 715, 052	0	93.00

	ATION OF INPATIENT OPERATING COST	Provider CCN: 15-1326	Period: From 01/01/2019 To 12/31/2019	Worksheet D-1 Date/Time Pre	
		Title XIX		7/9/2020 1:42 Cost	
	Cost Center Description		Hospi tal	1.00	
	PART I - ALL PROVIDER COMPONENTS			1.00	
. 00	INPATIENT DAYS Inpatient days (including private room days and swing-bed da	vs excluding newborn)		2, 463	 1.0
. 00	Inpatient days (including private room days, excluding swing			2, 240	2.0
. 00	Private room days (excluding swing-bed and observation bed d	ays). If you have only p	rivate room days,	0	3.0
. 00	do not complete this line. Semi-private room days (excluding swing-bed and observation	hed days)		1, 276	4.0
. 00	Total swing-bed SNF type inpatient days (including private r		er 31 of the cost	0	5.0
00	reporting period				
. 00	Total swing-bed SNF type inpatient days (including private r reporting period (if calendar year, enter 0 on this line)	oom days) after December	31 OF THE COST	0	6.0
. 00	Total swing-bed NF type inpatient days (including private ro	om days) through Decembe	r 31 of the cost	37	7.0
00	reporting period		21 - 6 + +		
. 00	Total swing-bed NF type inpatient days (including private ro reporting period (if calendar year, enter 0 on this line)	om days) after becember	31 of the cost	0	8.
. 00	Total inpatient days including private room days applicable	to the Program (excludin	g swing-bed and	15	9.
0 00	newborn days) (see instructions) Swing-bed SNF type inpatient days applicable to title XVIII	oply (including private	reem deve)	0	10
0. 00	through December 31 of the cost reporting period (see instru		room days)	0	10.
1. 00	Swing-bed SNF type inpatient days applicable to title XVIII	only (including private	room days) after	0	11.
2 00	December 31 of the cost reporting period (if calendar year, Swing-bed NF type inpatient days applicable to titles V or X		to room days)	0	10
2.00	through December 31 of the cost reporting period	ix only (including priva	te room days)	0	12.
3. 00	Swing-bed NF type inpatient days applicable to titles V or X			0	13.
4 00	after December 31 of the cost reporting period (if calendar Medically necessary private room days applicable to the Prog			0	14
4.00 5.00	Total nursery days (title V or XIX only)	rail (excluding swing-bed	uays)	0	14. 15.
5.00	Nursery days (title V or XIX only)			0	
	SWING BED ADJUSTMENT		- C 11		47
7.00	Medicare rate for swing-bed SNF services applicable to servi reporting period	ces through December 31	or the cost		17.
8.00	Medicare rate for swing-bed SNF services applicable to servi	ces after December 31 of	the cost		18.
9.00	reporting period	an through December 21 a	f the cost	129. 14	10
9.00	Medicaid rate for swing-bed NF services applicable to servic reporting period	es through becember 31 o	the cost	129.14	19.
0. 00	Medicaid rate for swing-bed NF services applicable to servic	es after December 31 of	the cost	129. 14	20.
1.00	reporting period Total general inpatient routine service cost (see instructio	nc)		4, 320, 874	21
2.00	Swing-bed cost applicable to SNF type services through Decem	2	ting period (line		21.
	5 x line 17)				
3. 00	Swing-bed cost applicable to SNF type services after Decembe x line 18)	r 31 of the cost reporti	ng period (line 6	0	23.
4.00	Swing-bed cost applicable to NF type services through Decemb	er 31 of the cost report	ing period (line	4, 778	24.
	7 x line 19)				
5.00	Swing-bed cost applicable to NF type services after December x line 20)	31 of the cost reportin	g period (line 8	0	25.
5. 00	Total swing-bed cost (see instructions)			4, 778	26.
7.00	General inpatient routine service cost net of swing-bed cost	(line 21 minus line 26)		4, 316, 096	27.
	PRIVATE ROOM DIFFERENTIAL ADJUSTMENT General inpatient routine service charges (excluding swing-b	od and obsorvation bod c	harges)	0	28.
> ^^			nai yes)		20.
	Private room charges (excluding swing-bed charges)			0	29.
9.00).00	Private room charges (excluding swing-bed charges) Semi-private room charges (excluding swing-bed charges)			0	30.
. 00 . 00 . 00	Private room charges (excluding swing-bed charges) Semi-private room charges (excluding swing-bed charges) General inpatient routine service cost/charge ratio (line 27	÷line 28)		0 0. 000000	30. 31.
2.00 0.00 .00 2.00	Private room charges (excluding swing-bed charges) Semi-private room charges (excluding swing-bed charges) General inpatient routine service cost/charge ratio (line 27 Average private room per diem charge (line 29 ÷ line 3)	÷line 28)		0 0. 000000 0. 00	30. 31. 32.
9.00 0.00 1.00 2.00 3.00	Private room charges (excluding swing-bed charges) Semi-private room charges (excluding swing-bed charges) General inpatient routine service cost/charge ratio (line 27 Average private room per diem charge (line 29 ÷ line 3) Average semi-private room per diem charge (line 30 ÷ line 4)		ctions)	0 0. 000000 0. 00 0. 00	30. 31. 32. 33.
. 00 . 00 . 00 . 00 . 00 . 00 . 00	Private room charges (excluding swing-bed charges) Semi-private room charges (excluding swing-bed charges) General inpatient routine service cost/charge ratio (line 27 Average private room per diem charge (line 29 ÷ line 3) Average semi-private room per diem charge (line 30 ÷ line 4) Average per diem private room charge differential (line 32 m	inus line 33)(see instru	ctions)	0 0.000000 0.00 0.00 0.00	30. 31. 32. 33. 34.
9.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00	Private room charges (excluding swing-bed charges) Semi-private room charges (excluding swing-bed charges) General inpatient routine service cost/charge ratio (line 27 Average private room per diem charge (line 29 ÷ line 3) Average semi-private room per diem charge (line 30 ÷ line 4) Average per diem private room charge differential (line 32 m Average per diem private room cost differential (line 34 x l	inus line 33)(see instru	ctions)	0 0.000000 0.00 0.00 0.00 0.00	30. 31. 32. 33. 34. 35.
0.00 1.00 2.00 3.00 4.00	Private room charges (excluding swing-bed charges) Semi-private room charges (excluding swing-bed charges) General inpatient routine service cost/charge ratio (line 27 Average private room per diem charge (line 29 ÷ line 3) Average semi-private room per diem charge (line 30 ÷ line 4) Average per diem private room charge differential (line 32 m	inus line 33)(see instru ine 31)		0 0. 000000 0. 00 0. 00 0. 00 0. 00 0	30. 31. 32. 33. 34. 35. 36.
P. 00 D. 00 I. 00 2. 00 3. 00 4. 00 5. 00 5. 00	Private room charges (excluding swing-bed charges) Semi-private room charges (excluding swing-bed charges) General inpatient routine service cost/charge ratio (line 27 Average private room per diem charge (line 29 ÷ line 3) Average semi-private room per diem charge (line 30 ÷ line 4) Average per diem private room charge differential (line 32 m Average per diem private room cost differential (line 34 x l Private room cost differential adjustment (line 3 x line 35) General inpatient routine service cost net of swing-bed cost 27 minus line 36)	inus line 33)(see instru ine 31)		0 0. 000000 0. 00 0. 00 0. 00 0. 00 0	30. 31. 32. 33. 34. 35. 36.
9.00 0.00 1.00 2.00 3.00 4.00 5.00 6.00	Private room charges (excluding swing-bed charges) Semi-private room charges (excluding swing-bed charges) General inpatient routine service cost/charge ratio (line 27 Average private room per diem charge (line 29 ÷ line 3) Average semi-private room per diem charge (line 30 ÷ line 4) Average per diem private room charge differential (line 32 m Average per diem private room cost differential (line 34 x l Private room cost differential adjustment (line 3 x line 35) General inpatient routine service cost net of swing-bed cost 27 minus line 36) PART II - HOSPITAL AND SUBPROVIDERS ONLY	inus line 33)(see instru ine 31) and private room cost d		0 0. 000000 0. 00 0. 00 0. 00 0. 00 0	30. 31. 32. 33. 34. 35. 36.
9.00 0.00 1.00 2.00 3.00 4.00 5.00 6.00 7.00	Private room charges (excluding swing-bed charges) Semi-private room charges (excluding swing-bed charges) General inpatient routine service cost/charge ratio (line 27 Average private room per diem charge (line 29 + line 3) Average semi-private room per diem charge (line 30 + line 4) Average per diem private room cost differential (line 32 m Average per diem private room cost differential (line 34 x l Private room cost differential adjustment (line 3 x line 35) General inpatient routine service cost net of swing-bed cost 27 minus line 36) PART 11 - HOSPITAL AND SUBPROVIDERS ONLY PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST AD.	inus line 33)(see instru ine 31) and private room cost d JUSTMENTS		0 0.00000 0.00 0.00 0.00 0 4,316,096	30. 31. 32. 33. 34. 35. 36. 37.
9.00 0.00 1.00 2.00 3.00 4.00 5.00 6.00 7.00	Private room charges (excluding swing-bed charges) Semi-private room charges (excluding swing-bed charges) General inpatient routine service cost/charge ratio (line 27 Average private room per diem charge (line 29 ÷ line 3) Average semi-private room per diem charge (line 30 ÷ line 4) Average per diem private room charge differential (line 32 m Average per diem private room cost differential (line 34 x l Private room cost differential adjustment (line 3 x line 35) General inpatient routine service cost net of swing-bed cost 27 minus line 36) PART II - HOSPITAL AND SUBPROVIDERS ONLY	inus line 33)(see instru ine 31) and private room cost d JUSTMENTS e instructions)		0 0. 000000 0. 00 0. 00 0. 00 0. 00 0	30. 31. 32. 33. 34. 35. 36. 37. 38.

alth Financial Systems MPUTATION OF INPATIENT OPERATING COST	UNI ON HOSPI T		CN: 15-1326	Peri od:	u of Form CMS- Worksheet D-	
				From 01/01/2019 To 12/31/2019	Date/Time Pro	epare
		Titl	e XIX	Hospi tal	7/9/2020 1:42 Cost	2 pm
Cost Center Description	Total	Total	Average Per		Program Cost	
	I npati ent	Inpatient	Diem (col.	1	(col. 3 x	
	Cost	Days	÷ col. 2)		<u>col. 4)</u>	
	1.00	2.00	3.00	4.00	5.00	12
2.00 NURSERY (title V & XIX only) Intensive Care Type Inpatient Hospital Uni	ts					42.
. 00 INTENSIVE CARE UNIT	1, 179, 297	262	2 4, 501.	13 0	(3 43.
. OO CORONARY CARE UNIT						44.
. OO BURN INTENSIVE CARE UNIT						45.
0. 00 SURGI CAL I NTENSI VE CARE UNI T						46.
7. 00 OTHER SPECIAL CARE (SPECIFY)						47.
Cost Center Description					1.00	
.00 Program inpatient ancillary service cost (Wkst. D-3. col.	3. line 200)			21, 491	48
.00 Total Program inpatient costs (sum of line			ons)		50, 393	
PASS THROUGH COST ADJUSTMENTS	,	`			· · ·	
.00 Pass through costs applicable to Program i	npatient routine	services (fro	m Wkst. D, su	m of Parts I and	(50
.00 Pass through costs applicable to Program i	npatient ancilla	ry services (f	rom Wkst. D,	sum of Parts II	(51
and IV) .00 Total Program excludable cost (sum of line	and 51				ſ	52
8.00 Total Program inpatient operating cost exc		elated, non-ph	ysician anest	hetist, and	-	52
medical education costs (line 49 minus lin						
TARGET AMOUNT AND LIMIT COMPUTATION						
.00 Program discharges						54
0.00 Target amount per discharge					0.00	
.00 Target amount (line 54 x line 55)	ating east and t	arget employet (line E4 minus	Line E2)	(
 .00 Difference between adjusted inpatient oper .00 Bonus payment (see instructions) 	ating cost and ta	arget amount (TTHE SO MITUS	TThe 53)	() 57) 58
. 00 Lesser of Lines 53/54 or 55 from the cost	reporting period	ending 1996	undated and c	ompounded by the		
market basket	ropor tring porrod	ondring 1770,	apuatoa ana e	empeditaed by the	0100	
.00 Lesser of lines 53/54 or 55 from prior yea	ar cost report, u	pdated by the	market basket		0.00) 60
1.00 If line 53/54 is less than the lower of li					() 61
which operating costs (line 53) are less t		ts (lines 54 x	: 60), or 1% c	f the target		
amount (line 56), otherwise enter zero (se 2.00 Relief payment (see instructions)	e instructions)				ſ	62
8.00 Allowable Inpatient cost plus incentive pa	avment (see instru	uctions)				63
PROGRAM INPATIENT ROUTINE SWING BED COST						
.00 Medicare swing-bed SNF inpatient routine of	costs through Dec	ember 31 of th	e cost report	ing period (See	(64
instructions)(title XVIII only)						
5.00 Medicare swing-bed SNF inpatient routine of	costs after Decem	ber 31 of the	cost reportin	g period (See	() 65
instructions)(title XVIII only) 5.00 Total Medicare swing-bed SNF inpatient rou	itino costs (lino	61 plus lino	45) (+i +l o V)/l		ſ	66
CAH (see instructions)	time costs (inne	04 prus rifie	05)(11116 XVI	TT OILLY). TOI	(
7.00 Title V or XIX swing-bed NF inpatient rout	ine costs throug	h December 31	of the cost r	eporting period	C	67
(line 12 x line 19)	5					
3.00 Title V or XIX swing-bed NF inpatient rout	ine costs after	December 31 of	the cost rep	orting period	(68 (
(line 13 x line 20)		(1.1	(0)			
D. 00 Total title V or XIX swing-bed NF inpatien PART III - SKILLED NURSING FACILITY, OTHER					() 69
0.00 Skilled nursing facility/other nursing fac)		70
.00 Adjusted general inpatient routine service				,		71
.00 Program routine service cost (line 9 x lir	ne 71)					72
.00 Medically necessary private room cost appl	0	•				73
. 00 Total Program general inpatient routine se	•		,	Devet II and when		74
.00 Capital-related cost allocated to inpatier 26, line 45)	it routine servic	e costs (Trom	worksneet B,	Part II, COLUMN		75
. 00 Per diem capital-related costs (line 75 ÷	line 2)					76
.00 Program capital -related costs (line 9 x li						77
00 Inpatient routine service cost (line 74 mi						78
.00 Aggregate charges to beneficiaries for exc						79
.00 Total Program routine service costs for co	•	cost limitatio	n (line 78 mi	nus line 79)		80
. 00 Inpatient routine service cost per diem li		1)				81
.00 Inpatient routine service cost limitation .00 Reasonable inpatient routine service costs	•					82
 .00 Reasonable inpatient routine service costs .00 Program inpatient ancillary services (see 		113)				83
. 00 Utilization review - physician compensation		ons)				85
5.00 Total Program inpatient operating costs (s						86
PART IV - COMPUTATION OF OBSERVATION BED F						
7.00 Total observation bed days (see instruction					964	
3.00 Adjusted general inpatient routine cost pe	•				1, 926. 83	
0.00 Observation bed cost (line 87 x line 88)					1, 857, 464	

Health Financial Systems	UNI ON HOSPI T	AL CLINTON		In Lie	u of Form CMS-2	2552-10
COMPUTATION OF INPATIENT OPERATING COST		Provider CO		Period: From 01/01/2019	Worksheet D-1	
				To 12/31/2019		pared: pm
		Titl	e XIX	Hospi tal	Cost	
Cost Center Description	Cost	Routine Cost	column 1 ÷	Total	Observati on	
		(from line	column 2	Observati on	Bed Pass	
		21)		Bed Cost	Through Cost	
				(from line	(col. 3 x	
				89)	col. 4) (see	
					instructions)	
	1.00	2.00	3.00	4.00	5.00	
COMPUTATION OF OBSERVATION BED PASS THROUGH	COST					
90.00 Capital-related cost	630, 667	4, 320, 874	0. 14595	1, 857, 464	271, 112	90.00
91.00 Nursing School cost	0	4, 320, 874	0.00000	0 1, 857, 464	0	91.00
92.00 Allied health cost	0	4, 320, 874	0.00000	0 1, 857, 464	0	92.00
93.00 All other Medical Education	0	4, 320, 874	0.00000	1, 857, 464	0	93.00

Health Financial Systems UNION HOSE	NITAL CLINTON		In Lie	u of Form CMS-:	2552-10
I NPATI ENT ANCI LLARY SERVI CE COST APPORTI ONMENT	Provider C		Period: From 01/01/2019 To 12/31/2019	Worksheet D-3 Date/Time Pre 7/9/2020 1:42	pared:
	Title	XVIII	Hospi tal	Cost	
Cost Center Description		Ratio of Cos	t Inpatient	I npati ent	
		To Charges	Program	Program Costs	
			Charges	(col. 1 x	
				col. 2)	
		1.00	2.00	3.00	
I NPATI ENT ROUTI NE SERVI CE COST CENTERS					
30. 00 03000 ADULTS & PEDI ATRI CS			1, 370, 790		30.00
31. 00 03100 I NTENSI VE CARE UNI T			344, 770		31.00
ANCILLARY SERVICE COST CENTERS					
50. 00 05000 OPERATI NG ROOM		0. 33245	57 193, 809	64, 433	50.00
51.00 05100 RECOVERY ROOM		0. 3444	2, 100	723	51.00
51.01 05101 0/P TREATMENT ROOM		0.0000	0 0	0	51.01
54. 00 05400 RADI OLOGY-DI AGNOSTI C		0. 15192	25 220, 410	33, 486	54.00
56. 00 05600 RADI 0I SOTOPE		0. 43490	02 0	0	56.00
60. 00 06000 LABORATORY		0. 14859	97 447, 883	66, 554	60.00
62.00 06200 WHOLE BLOOD & PACKED RED BLOOD CELLS		0. 37015	53 19, 800	7, 329	62.00
65. 00 06500 RESPI RATORY THERAPY		0. 82394	6 322, 867	266, 025	65.00
66. 00 06600 PHYSI CAL THERAPY		0. 47273	63, 688	30, 108	66.00
67. 00 06700 OCCUPATI ONAL THERAPY		0. 6738	0 24, 143	16, 268	67.00
68.00 06800 SPEECH PATHOLOGY		0. 55551	2 7, 205	4, 002	68.00
69. 00 06900 ELECTROCARDI OLOGY		0. 1513	3 173, 050	26, 185	69.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS		1. 76678	31 0	0	71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS		0. 50820	02 0	0	72.00
73.00 07300 DRUGS CHARGED TO PATIENTS		0. 31936	5 342, 434	109, 361	73.00
OUTPATIENT SERVICE COST CENTERS					1
90. 00 09000 CLINIC		0.0000	0 0	0	90.00
91. 00 09100 EMERGENCY		0. 35353	3, 018	1, 067	91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)		1. 22958	31 0	0	92.00
200.00 Total (sum of lines 50 through 94 and 96 through 98			1, 820, 407	625, 541	200.00
201.00 Less PBP Clinic Laboratory Services-Program only ch	narges (line 61)		0		201.00
202.00 Net charges (line 200 minus line 201)			1, 820, 407		202.00

Health Financial Systems	UNION HOSPITAL CLINTON		In Lie	eu of Form CMS-:	2552-10
INPATIENT ANCILLARY SERVICE COST APPORTIONMENT	Provi de	r CCN: 15-1326	Period:	Worksheet D-3	
	Compone	nt CCN: 15-Z326	From 01/01/2019 To 12/31/2019		narod
	Compone	III CON. 13-2320	10 12/31/2019	7/9/2020 1: 42	
	T	tle XVIII	Swing Beds - SNF		
Cost Center Description		Ratio of Cos		Inpati ent	
		To Charges	5	Program Costs	
			Charges	(col. 1 x	
		1.00	0.00	col . 2)	
INDATIENT DOUTINE CEDVICE COST CENTERS		1.00	2.00	3.00	
30.00 03000 ADULTS & PEDIATRICS					30.00
31. 00 03100 INTENSIVE CARE UNIT			0		30.00
ANCI LLARY SERVICE COST CENTERS			0		31.00
50. 00 05000 OPERATING ROOM		0. 3324	57 35	12	50.00
51. 00 05100 RECOVERY ROOM		0. 3444		0	
51.01 05101 0/P TREATMENT ROOM		0,0000		0	51.01
54.00 05400 RADI OLOGY-DI AGNOSTI C		0. 1519	25 2, 075	315	54.00
56. 00 05600 RADI 0I SOTOPE		0. 4349	02 0	0	56.00
60. 00 06000 LABORATORY		0. 1485	97 25, 927	3, 853	60.00
62.00 06200 WHOLE BLOOD & PACKED RED BLOOD CELLS		0. 3701	53 0	0	62.00
65. 00 06500 RESPI RATORY THERAPY		0. 8239		46, 752	65.00
66. 00 06600 PHYSI CAL THERAPY		0. 4727			
67.00 06700 OCCUPATI ONAL THERAPY		0. 6738			
68.00 06800 SPEECH PATHOLOGY		0. 5555			68.00
69.00 06900 ELECTROCARDI OLOGY		0. 1513			
71.00 07100 MEDI CAL SUPPLIES CHARGED TO PATI ENTS		1. 7667		-	71.00
72.00 07200 I MPL. DEV. CHARGED TO PATIENTS		0. 5082		0	72.00
73.00 O7300 DRUGS CHARGED TO PATIENTS		0. 3193	65 59, 633	19, 045	73.00
0UTPATI ENT SERVI CE COST CENTERS 90. 00 09000 CLI NI C		0.0000	00	0	90.00
90. 00 09000 CLINIC 91. 00 09100 EMERGENCY		0.0000 0.3535		-	90.00
91.00 09100 EMERGENCY 92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)		1. 2295		0	
200.00 Total (sum of lines 50 through 94 and 96	through (18)	1. 2293	187, 666	-	
201.00 Less PBP Clinic Laboratory Services-Prog		51)	107,000	73,020	200.00
202.00 Net charges (line 200 minus line 201)	i all only charges (The		187, 666		202.00
		I	,	I	

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT Provider CCN: 15-1326 Period: From 01/01/2019 To 12/31/2019 Worksheet D-3 Date/Time Prepared: 1/2/3/2019 Cost Center Description Title XIX Hospital Cost INPATIENT ROUTINE SERVICE COST CENTERS Inpatient Program Inpatient Cost Inpatient Program Inpatient Cost Inpatient Program Inpatient Cost Inpatient Cost </th <th>Health Financial Systems</th> <th>UNION HOSPITAL</th> <th>CLI NTON</th> <th></th> <th>In Lie</th> <th>u of Form CMS-2</th> <th>2552-10</th>	Health Financial Systems	UNION HOSPITAL	CLI NTON		In Lie	u of Form CMS-2	2552-10
Impart ent Routi NE SERVICE COST CENTERS Title XIX Hospital Cost Conter Description Inpatient To Charges Inpatient Program Costs (col. 1 x col. 2) 30.00 03000 ADULTS & PEDIATRICS 1.00 2.00 3.00 30.00 03000 INTENSIVE CARE UNIT 11.442 31.00 ANCILLARY SERVICE COST CENTERS 26.670 30.00 0.00 03000 INTENSIVE CARE UNIT 11.442 31.00 ANCILLARY SERVICE COST CENTERS 0.32457 7.227 2.403 50.00 50.00 05000 OPERATING ROOM 0.332457 7.227 2.403 50.00 51.01 05100 RECOVERY ROOM 0.334474 59 20 51.00 54.00 05400 RADI OLGOY-DI AGNOSTIC 0.151925 23.276 3.536 54.00 56.00 065000 RESPI RATORY 0.434902 0 0 56.00 66.00 06600 RESPI RATORY THERAY 0.823946 3.966 3.268 65.00 65.00 06500 RESPI RATORY THERAY 0.472735 254 120 66.00 66.00	I NPATI ENT ANCI LLARY SERVICE COST APPORTI ONMENT		Provider C	CN: 15-1326	From 01/01/2019		
Cost Center Description Ratio of Cost To Charges Inpatient Program Charges Inpatient Program (Costs (col. 1 x) col. 2) 1.00 2.00 3.00 30.00 03000 ADULTS & PEDIATRICS 31.00 2.00 3.00 31.00 03000 INTENSIVE CARE UNIT ANCILLARY SERVICE COST CENTERS 26,670 31.00 31.00 05100 RECOVERY ROOM 0.332457 7,227 2,403 50.00 51.00 05000 QPERATINK ROOM 0.332457 7,227 2,403 51.00 51.01 05100 RECOVERY ROOM 0.344474 59 20 51.00 54.00 05400 RADI OLOGY-DI AGNOSTI C 0.151925 23,276 3,536 54.00 56.00 065000 RESPI RATORY THERAPY 0.434902 0 0 56.00 66.00 06600 RESPI RATORY THERAPY 0.823946 3,966 3,268 65.00 66.00 06600 RESPI RATORY THERAPY 0.472735 254 120 66.00 66.00 06600 SPEECH RATORY THERAPY 0.555512 0 0 66.00 69.00 069					10 12/31/2019		
Investigation To Charges Program (Charges) (Col. 1 x (Col. 2)) 1.00 2.00 3.00 30.00 03000 ADULTS & PEDIATRICS 26,670 30.00 31.00 03000 PERATING ROOM 0.32457 7,227 2,403 50.00 50.00 05000 PERATING ROOM 0.334474 59 20 51.00 51.00 05100 RECOVERY ROOM 0.334474 59 20 51.00 56.00 05000 RECATING ROOM 0.000000 0 0 51.00 51.00 05101 O/P TREATMENT ROOM 0.04474 59 20 51.00 56.00 06000 LABORATORY 0.151925 23.276 3.536 54.00 66.00 06500 RADIO ISOTOPE 0.434902 0 0 0 55.00 67.00 06500 WHOLE BLOOD & PACKED RED BLOOD CELLS 0.370153 315 117 62.00 66.00 06600 PHYSI CAL THERAPY 0.472735 254 1.20 66.00 67.00 06500 RELCH PATHOLOGY 0.555512 0			Ti tl				
INPATI ENT_ROUTI NE_SERVI CE_COST_CENTERS (Col. 1 x col. 2) (Col. 2) 30.00 03000 ADULTS & PEDI ATRI CS 30.00 31.00 03000 INTENSI VE_CARE_UNI T 11,442 ANCI LLARY_SERVI CE_COST_CENTERS 11,442 31.00 50.00 05000 (PERATI NG ROM 0.324471 7,227 2,403 50.00 51.00 05100 (RECOVERY ROM 0.344474 59 20 51.00 51.01 05101 (J/P TREATMENT ROOM 0.344474 59 20 51.00 56.00 05600 (RADI OLOGY-DI AGNOSTI C 0.151925 23.276 3.536 54.00 66.00 06200 (WHOLE BLOOD & PACKED RED BLOOD CELLS 0.370153 315 117 62.00 66.00 06500 (RSPI RATORY THERAPY 0.423946 3.966 3.268 65.00 66.00 06700 (DCUPATI ONAL THERAPY 0.472735 254 120 66.00 67.00 06700 ELECTROCARDI OLOGY 0.555512 0 0 67.00 67.00 71.00 0 73.00 73.00 73.00 73.00	Cost Center Description						
INPATI ENT ROUTI NE SERVI CE COST CENTERS 1.00 2.00 3.00 30.00 03000 ADULTS & PEDI ATRI CS 26.670 30.00 31.00 03100 INTENSI VE CARE UNI T 11,442 31.00 ANCI LLARY SERVI CE COST CENTERS 0.332457 7,227 2,403 50.00 51.00 05100 (PCCWERY ROM 0.3324474 50.00 55.00 51.01 51.00 05100 (PC TREATMENT ROM 0.000000 0 0 51.01 54.00 05400 (RADI OLOGY-DI AGNOSTI C 0.151925 23,276 3,536 54.00 65.00 06500 (RADI OLOGY-DI AGNOSTI C 0.148597 19,357 2,876 60.00 62.00 06500 RADI OLOGY THEARPH 0.148597 19,357 2,876 60.00 65.00 06500 RESPI RATORY 0.148597 19,357 2,876 60.00 66.00 06500 RESPI RATORY THERAPY 0.472735 254 120 66.00 67.00 06000 CLASUPPLIES CHARED TO PATI ENTS 0.53810 0 67.00 67.00 69.00				To Charges	5		
INPATI ENT ROUTINE SERVICE COST CENTERS 0.00 03000 ADULTS & PEDIATRICS 26,670 30.00 31.00 03100 INTENSIVE CARE UNIT 11,442 31.00 ANCI LLARY SERVICE COST CENTERS 0.332457 7,227 2,403 50.00 50.00 05000 OPERATING ROM 0.332457 7,227 2,403 50.00 51.00 05100 RECOVERY ROM 0.344474 59 20 51.00 51.01 05400 RADIOLOGY-DI AGNOSTIC 0.151925 23,276 3,536 54.00 56.00 05600 RADIOLOGY-DI AGNOSTIC 0.148597 19,357 2,876 60.00 60.00 06200 WHOLE BLOOD & PACKED RED BLOOD CELLS 0.370153 315 117 62.00 65.00 0.6000 PHYSICAL THERAPY 0.823946 3,966 3,268 65.00 65.00 66.00 66.00 66.00 66.00 67.00 66.00 67.00 67.00 67.00 67.00 67.00 67.00 67.00 67.00 67.00 67.00 67.00 67.00 67.00 67.00 <t< td=""><td></td><td></td><td></td><td></td><td>Charges</td><td></td><td></td></t<>					Charges		
INPATI ENT ROUTI NE SERVI CE COST CENTERS 2 30.00				1.00	0.00		
30.00 03000 ADULTS & PEDI ATRI CS 26, 670 30.00 31.00 03000 INTENSI VE CARE UNIT 11, 442 31.00 ANCILLARY SERVICE COSST CENTERS 0.332457 7, 227 2, 403 50.00 50.00 05000 (PERATI NG ROOM 0.344474 59 20 51.00 51.01 05100 (RECOVERY ROOM 0.344474 59 20 51.00 54.00 05400 (RADI OLOGY-DI AGNOSTI C 0.151925 23, 276 3, 536 54.00 56.00 05600 (ABORATORY 0.434902 0 0 56.00 60.00 06600 (LABORATORY 0.148597 19, 357 2, 876 60.00 62.00 06600 PHYSI CAL THERAPY 0.472735 254 120 66.00 63.00 06600 PHYSI CAL THERAPY 0.673810 0 67.00 68.00 64.00 06900 ELECTROCARDI OLOGY 0.555512 0 0 68.00 69.00 06900 ELECTROCARDI OLOGY 0.555512 0 0 68.00 69.00 06900 ELECTROCARDI OLOGY 0.558202 0 71.00 72.00 73.00	INDATIENT DOUTINE SEDVICE COST CENTERS			1.00	2.00	3.00	
31.00 03100 INTENSI VE CARE UNIT 11,442 31.00 ANCILLARY SERVICE COST CENTERS 11,442 50.00 51.01 51.01 51.01 51.01 51.01 50.00 51.01 51.01 51.01 50.00 56.00 56.00 56.00 56.00 56.00 56.00 56.00 56.00 56.00 56.00 56.00 56.00 56.00 56.00 56.00 66.00 66.00 66.00 66.00 66.00 66.00 66.00 66.00 66.00 66.00 66.00 66.00 66.00 66.00 67.00 67.00 67.00 67.00 67.00 67.00 67.00 67.00 67.00 67.00 67.00 67.00 6				1	24 (70		20.00
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51.00 05100 RECOVERY ROOM 0.344474 59 20 51.00 51.01 05101 0/5 TREATMENT ROOM 0.000000 0 51.01 54.00 05400 RADI OLOGY-DI AGNOSTI C 0.151925 23,276 3,536 54.00 56.00 05600 RADI OLOGY-DI AGNOSTI C 0.434902 0 0 56.00 60.00 06000 LABORATORY 0.148597 19,357 2,876 60.00 62.00 06200 WHOLE BLOOD & PACKED RED BLOOD CELLS 0.370153 315 117 62.00 65.00 06600 PKSI CAL THERAPY 0.823946 3,966 3,268 65.00 66.00 06600 SPEECH PATHOLOGY 0.472735 254 120 66.00 67.00 06700 CCUPATI ONAL THERAPY 0.555512 0 68.00 69.00 69.00 GF100 MEDI CAL SUPPLIES CHARGED TO PATI ENTS 1.766781 0 0 71.00 71.00 MEDI CAL SUPPLI ES CHARGED TO PATI ENTS 0.508202 0 0 72.00 72.00 72.00 72.00 </td <td></td> <td></td> <td></td> <td>0 3324</td> <td>57 7 227</td> <td>2 403</td> <td>50.00</td>				0 3324	57 7 227	2 403	50.00
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62.00 06200 WHOLE BLOOD & PACKED RED BLOOD CELLS 0.370153 315 117 62.00 65.00 06500 RESPI RATORY THERAPY 0.823946 3,966 3,268 65.00 66.00 06600 PHYSI CAL THERAPY 0.472735 254 120 66.00 67.00 0CCUPATI ONAL THERAPY 0.673810 0 0 67.00 68.00 06800 SPEECH PATHOLOGY 0.555512 0 0 68.00 69.00 06900 ELECTROCARDI OLOGY 0.151313 4,572 692 69.00 71.00 07100 MEDI CAL SUPPLI ES CHARGED TO PATI ENTS 1.766781 0 0 71.00 72.00 07200 IMPL. DEV. CHARGED TO PATI ENTS 0.508202 0 0 72.00 73.00 07300 DRUGS CHARGED TO PATI ENTS 0.300305 0 0 73.00 0017PATI ENT SERVICE COST CENTERS 0.3053538 23,928 8,459 91.00 92.00 09200 OBSERVATI ON BEDS (NON-DI STI NCT PART) 0 0 0 92.00 920.00 0920							1
62.00 06200 WHOLE BLOOD & PACKED RED BLOOD CELLS 0.370153 315 117 62.00 65.00 06500 RESPI RATORY THERAPY 0.823946 3,966 3,268 65.00 66.00 06600 PHYSI CAL THERAPY 0.472735 254 120 66.00 67.00 06700 OCCUPATI ONAL THERAPY 0.673810 0 0 67.00 68.00 06800 SPEECH PATHOLOGY 0.555512 0 0 68.00 69.00 06900 ELECTROCARDI OLOGY 0.151313 4,572 692 69.00 71.00 07100 MEDI CAL SUPPLI ES CHARGED TO PATI ENTS 1.766781 0 0 71.00 72.00 07200 IMPL. DEV. CHARGED TO PATI ENTS 0.508202 0 0 72.00 73.00 07300 DRUGS CHARGED TO PATI ENTS 0.319365 0 0 73.00 01TPATI ENT SERVICE COST CENTERS 0.300000 0 0 91.00 92.00 9200 085ERVATI ON BEDS (NON-DI STI NCT PART) 0.353538 23,928 8,459 91.00 92.00 92.00 92.00	60. 00 06000 LABORATORY			0. 1485	97 19, 357	2,876	60.00
66.00 06600 PHYSI CAL THERAPY 0.472735 254 120 66.00 67.00 06700 0CCUPATI ONAL THERAPY 0.673810 0 0 67.00 68.00 06800 SPEECH PATHOLOGY 0.555512 0 0 68.00 69.00 06900 ELECTROCARDI OLOGY 0.151313 4,572 692 69.00 71.00 07100 MEDI CAL SUPPLIES CHARGED TO PATI ENTS 1.766781 0 0 71.00 72.00 07200 IMPL. DEV. CHARGED TO PATI ENTS 0.508202 0 0 72.00 73.00 07300 DRUGS CHARGED TO PATI ENTS 0.319365 0 0 73.00 01TPATI ENT SERVICE COST CENTERS 0.000000 0 0 90.00 90.00 90.00 09100 EMERGENCY 0.353538 23,928 8,459 91.00 92.00 09200 OBSERVATI ON BEDS (NON-DI STI NCT PART) 0 0 0 92.00 92.00 09200 BERGRINCY 0 0 0 92.00 0 0 0 92.00 <t< td=""><td>62.00 06200 WHOLE BLOOD & PACKED RED BLOOD CELLS</td><td></td><td></td><td>0. 3701</td><td>53 315</td><td></td><td>62.00</td></t<>	62.00 06200 WHOLE BLOOD & PACKED RED BLOOD CELLS			0. 3701	53 315		62.00
67.00 06700 OCCUPATIONAL THERAPY 0.673810 0 67.00 68.00 06800 SPEECH PATHOLOGY 0.555512 0 0 68.00 69.00 06900 ELECTROCARDIOLOGY 0.151313 4,572 692 69.00 71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 1.766781 0 0 71.00 72.00 07300 DRUGS CHARGED TO PATIENTS 0.508202 0 0 72.00 73.00 07300 DRUGS CHARGED TO PATIENTS 0.319365 0 0 73.00 90.00 09000 CLINIC 0.000000 0 0 90.00 91.00 09100 EMERGENCY 0.353538 23,928 8,459 91.00 92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART) 0.29581 0 0 92.00 92.00.00 Total (sum of lines 50 through 94 and 96 through 98) 82,954 21,491 200.00 201.00 Less PBP Clinic Laboratory Services-Program only charges (line 61) 0 201.00 201.00	65. 00 06500 RESPI RATORY THERAPY			0. 82394	46 3, 966	3, 268	65.00
68.00 06800 SPEECH PATHOLOGY 0.555512 0 0 68.00 69.00 06900 ELECTROCARDIOLOGY 0.151313 4,572 692 69.00 71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 1.766781 0 0 71.00 72.00 07200 IMPL. DEV. CHARGED TO PATIENTS 0.508202 0 0 72.00 73.00 07000 RUGS CHARGED TO PATIENTS 0.319365 0 0 73.00 0017001 DEVICE COST CENTERS 0.000000 0 73.00 73.00 90.00 09000 CLINIC 0.000000 0 90.00 91.00 90.00 91.00 90.00 91.00 92.00 9	66. 00 06600 PHYSI CAL THERAPY			0. 4727	35 254	120	66.00
69.00 06900 ELECTROCARDIOLOGY 0.151313 4,572 692 69.00 71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 1.766781 0 0 71.00 72.00 07200 IMPL. DEV. CHARGED TO PATIENTS 0.508202 0 0 72.00 73.00 07300 DRUGS CHARGED TO PATIENTS 0.319365 0 0 73.00 001001 ENTREMENT ENT SERVICE COST CENTERS 0.000000 0 0 73.00 90.00 09100 ELEGROCY 0.353538 23,928 8,459 91.00 92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART) 0.29581 0 0 92.00 200.00 Total (sum of lines 50 through 94 and 96 through 98) 82,954 21,491 200.00 201.00 Less PBP Clinic Laboratory Services-Program only charges (line 61) 0 201.00 201.00	67.00 06700 OCCUPATI ONAL THERAPY			0. 6738	10 0	0	67.00
71.00 07100 MEDI CAL SUPPLIES CHARGED TO PATIENTS 1.766781 0 0 71.00 72.00 07200 IMPL. DEV. CHARGED TO PATIENTS 0.508202 0 0 72.00 73.00 07300 DRUGS CHARGED TO PATIENTS 0.319365 0 0 73.00 OUTPATIENT SERVICE COST CENTERS 0.000000 0 0 90.00 90.00 09100 EMERGENCY 0.353538 23,928 8,459 91.00 92.00 09200 DBSERVATION BEDS (NON-DISTINCT PART) 0 0 0 92.00 200.00 Total (sum of lines 50 through 94 and 96 through 98) 82,954 21,491 200.00 201.00 Less PBP Clinic Laboratory Services-Program only charges (line 61) 0 201.00 201.00	68.00 06800 SPEECH PATHOLOGY			0. 5555		0	68.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS 0.508202 0 0 72.00 73.00 07300 DRUGS CHARGED TO PATIENTS 0.319365 0 0 73.00 0UTPATIENT SERVICE COST CENTERS 0.00000 0 0 90.00 91.00 90.00 0 90.00 90.00 0 0 90.00 90.00 0 90.00 0 0 90.00 0 0 90.00 90.00 0 90.00 0 0 90.00 90.00 0 90.00 90.00 90.00 90.00 0 90.00 90.00 90.00 90.00 90.00 90.00 90.00 90.00 90.00 90.00 90.00 90.00 90.00 90.00 90.00 92.0				0. 1513	13 4, 572	692	
73.00 07300 DRUGS CHARGED TO PATIENTS 0.319365 0 73.00 OUTPATIENT SERVICE COST CENTERS 0.00000 0 0 90.00				1. 76678	31 0	0	71.00
OUTPATI ENT SERVICE COST CENTERS 90.00 09000 CLINIC 0.000000 0 90.00 91.00 09100 EMERGENCY 0.353538 23,928 8,459 91.00 92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART) 1.229581 0 0 92.00 200.00 Total (sum of lines 50 through 94 and 96 through 98) 82,954 21,491 200.00 201.00 Less PBP Clinic Laboratory Services-Program only charges (line 61) 0 201.00						0	
90. 00 09000 CLINIC 0.00000 0 0 90. 00 91. 00 09100 EMERGENCY 0.353538 23, 928 8, 459 91. 00 92. 00 09200 0BSERVATI ON BEDS (NON-DISTINCT PART) 1.229581 0 0 92. 00 200. 00 Total (sum of lines 50 through 94 and 96 through 98) 82, 954 21, 491 200. 00 201. 00 Less PBP Clinic Laboratory Services-Program only charges (line 61) 0 201. 00				0. 3193	65 0	0	73.00
91.00 09100 EMERGENCY 0.353538 23,928 8,459 91.00 92.00 09200 0BSERVATION BEDS (NON-DISTINCT PART) 1.229581 0 0 92.00 200.00 Total (sum of lines 50 through 94 and 96 through 98) 82,954 21,491 200.00 201.00 Less PBP Clinic Laboratory Services-Program only charges (line 61) 0 201.00							
92.00 09200 0BSERVATION BEDS (NON-DISTINCT PART) 1.229581 0 92.00 200.00 Total (sum of lines 50 through 94 and 96 through 98) 82,954 21,491 200.00 201.00 Less PBP Clinic Laboratory Services-Program only charges (line 61) 0 201.00							
200.00 Total (sum of lines 50 through 94 and 96 through 98) 82,954 21,491 200.00 201.00 Less PBP Clinic Laboratory Services-Program only charges (line 61) 0 201.00							1
201.00Less PBP Clinic Laboratory Services-Program only charges (line 61)0201.00		() () ()		1. 2295		-	
202.00 Net charges (The 200 minus The 201) 82,954 202.00		gram only charges	s (II ne 61)		0		1
	202.00 Net charges (The 200 minus line 201)			I	82, 954		202.00

Health Financial Systems UNI	ON HOSPITAL CLINTON		In Lie	u of Form CMS-2	2552-10
INPATIENT ANCILLARY SERVICE COST APPORTIONMENT	Provider CC		Peri od:	Worksheet D-3	
	Component (From 01/01/2019 To 12/31/2019	Date/Time Pre	narod
	component of	JUN. 15-2520	10 12/31/2019	7/9/2020 1: 42	
	Ti tl		Swing Beds - SNF	Cost	
Cost Center Description		Ratio of Cos		Inpati ent	
		To Charges	Program	Program Costs	
			Charges	(col. 1 x	
				col. 2)	
		1.00	2.00	3.00	
I NPATI ENT ROUTI NE SERVI CE COST CENTERS			-		
30. 00 03000 ADULTS & PEDI ATRI CS			0		30.00
31. 00 03100 I NTENSI VE CARE UNI T			0		31.00
ANCI LLARY SERVICE COST CENTERS		0 22245	7 0	0	
50.00 05000 0PERATING ROOM 51.00 05100 RECOVERY ROOM		0. 33245 0. 34447		0	50.00 51.00
		0. 34447		0	51.00
51. 01 05101 0/P TREATMENT ROOM 54. 00 05400 RADI OLOGY-DI AGNOSTI C		0. 15192		0	51.01
56. 00 05600 RADI OLOGY-DI AGNOSTI C		0. 15192		0	54.00
60. 00 06000 LABORATORY		0. 43490		0	60.00
62.00 06200 WHOLE BLOOD & PACKED RED BLOOD CELLS		0. 14839		0	62.00
65. 00 06500 RESPIRATORY THERAPY		0. 82394		0	65.00
66. 00 06600 PHYSI CAL THERAPY		0. 47273		0	66.00
67. 00 06700 OCCUPATI ONAL THERAPY		0. 67381		0	67.00
68. 00 06800 SPEECH PATHOLOGY		0. 55551		0	68.00
69. 00 06900 ELECTROCARDI OLOGY		0. 15131		0	69.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS		1. 76678		0	71.00
72.00 07200 I MPL. DEV. CHARGED TO PATIENTS		0. 50820		0	72.00
73.00 07300 DRUGS CHARGED TO PATIENTS		0. 31936	5 0	0	73.00
OUTPATIENT SERVICE COST CENTERS					
90. 00 09000 CLINIC		0.00000	0 0	0	90.00
91.00 09100 EMERGENCY		0.35353	8 0	0	91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)		1. 22958	1 0	0	
200.00 Total (sum of lines 50 through 94 and 96 th			0		200.00
201.00 Less PBP Clinic Laboratory Services-Program	only charges (line 61)		0		201.00
202.00 Net charges (line 200 minus line 201)			0		202.00

It is 12/31/2001 Display 12 Display 12 It is 2011 It is 2011 Is 2011 Is 2011 Is 2011 In the field and other services (see instructions) 0 <th></th> <th>Financial Systems UNION HOSPITAL ATION OF REIMBURSEMENT SETTLEMENT</th> <th>CLINTON Provider CCN: 15-1326</th> <th>Peri od:</th> <th>u of Form CMS-2 Worksheet E</th> <th>2552-10</th>		Financial Systems UNION HOSPITAL ATION OF REIMBURSEMENT SETTLEMENT	CLINTON Provider CCN: 15-1326	Peri od:	u of Form CMS-2 Worksheet E	2552-10
Litte XVIII isselital Cost PART 6 HEDICAL AND DIFER HALTH SERVICES 1.00 1 1.00 1.00 2.00 Redical and other services (see Instructions) 5.807,915 2.00 Death of and other services (see Instructions) 0.00 0.00 Death of paper. (see Instructions) 0.00 0.01 For For the heaping (see Instructions) 0.000 0.01 Death of the heaping (see Instructions) 0.000 1.00 Death of the heaping (see Instructions) 0.000 1.00 Death of the heaping (see Instructions) 0.0000 1.00 Death of the heaping (see Instructions) 0.00000 1.00 Death of the heaping (see Instructions) 0.000000 1.00 <t< th=""><th></th><th></th><th></th><th>From 01/01/2019 To 12/31/2019</th><th>Date/Time Pre</th><th></th></t<>				From 01/01/2019 To 12/31/2019	Date/Time Pre	
Part B. Part D. Part D. <t< th=""><th></th><th></th><th>Title XVIII</th><th>Hospi tal</th><th></th><th></th></t<>			Title XVIII	Hospi tal		
Part B. Part D. Part D. <t< td=""><td></td><td></td><td></td><td></td><td>1.00</td><td></td></t<>					1.00	
2.20 Medical and other services relationsed under OPS (see instructions) 0 2 0.00 OPS symmits 0 0.01 payments instructions) 0 0.01 Description 0 0.01 payments 0 0.01 Description 0 0 0.01 Description 0 0 0 0.01 Description 0 0 0 0 0.01 Description 0						
3.00 DerS: payment S 0 0.00 Detting recorditation amount (see instructions) 0 4.01 Detting recorditation amount (see instructions) 0 5.01 Sun of lines 3, 4, and 4,00, divided by line 6 0 6.02 Sun of lines 3, 4, and 4,00, divided by line 6 0 7.03 Transitional control payment (see instructions) 0 7.04 Ancil lary service other pays line (see instructions) 0 7.05 Detting recordination (see instructions) 0 7.00 Detting recordination (see instructions) 0 7.00 Detting recordination (see instructions) 0 7.01 Detting recordination (see instructions) 0 7.01 Detting recordination (see instructions) 0 7.02 Detting recordination (see instructions) 0 7.02 Detting recordination (see instructions) 0 7.00 Detting recordination (see instructions) 0 7.00 Detting recordination (see instructions) 0 7.00 Detting recordination (see inst			rtions)			
4.01 OutHier resonalization amount (see instructions) 0						
5.00 Enter the hospital specific payment to cost ratio (see instructions) 0.000 5 7.00 Sum of lines 3, 4, and 6.01, divided by line 6 0.000 7 7.01 Transitional corridon payment (see instructions) 0 0 7.00 Bransitional corridon payment (see instructions) 0 0 7.01 Transitional corridon payment (see instructions) 0 0 7.01 Transitional corridon payment (see instructions) 0 0 7.00 Optimize Jamos Jamo						4.00
6.00 Line 2 times line 5 0 6 7.00 Sum of Lines 3, 4, and 40, 10, divided by Line 6 0.00 7 8.00 Aracillary service charpes through costs from West, D. Pt. IV, col. 13, Line 200 0 7 9.00 Aracillary service charpes 5 807,516 1 0.00 Total cort (dum of lines 1 and 10) (see instructions) 5 807,516 1 0.00 Total cort (dum of lines 1 and 10) (see instructions) 5 807,516 1 0.00 Total cort (dum of lines 1 and 10) (see instructions) 5 807,516 1 0.00 Total cort (dum of lines 1 and 10) (see instructions) 5 807,516 1 0.00 Total cort (dum of lines 1 and 10) (see instructions) 0 14 1 1.00 Total cost (dum of lines 1 and 10) (see instructions) 0 0 0 1.01 Total customery charges (see instructions) 1 0 1 0		, , <i>,</i> , ,	ictions)		-	4.01 5.00
9.00 Transitional corridor payment (see instructions) 0						
9, 00. Ancl Lary service other bass through costs from West. D. Pt. IV, col. 13, Line 200 0						
10.00 Organ acquisitions 0 10 10.00 Organ acquisitions 5.807.516 11 11.00 Total cost (sum of lines 1 and 10) (see instructions) 5.807.516 11 12.00 Ancillary service charges 0 0 12 12.00 Ancillary service charges 0 0 14 13.00 Ancillary service charges 0 14 14.00 Organ acquisitions 0 14 15.00 Aggregate amount actually collected from patients liable for payment for services on a charge basis 0 15 16.00 Amounts that would have been realized from patients liable for payment for services on a charge basis 0 16 17.00 Ratio of line 15 to line 16 (not to exceed 1.000000) 0 0 18 17.00 Ratio of line 35 (see instructions) 0 0.000000 18 17.00 Instructions) 0 0.0000000 18 18 17.00 Instructions) 0 0.020000 18 18 17.00 Instructions) 0 0.020000 18 10 10 12 <t< td=""><td></td><td></td><td>IV col 12 lino 200</td><td></td><td></td><td></td></t<>			IV col 12 lino 200			
COMPUTATION OF LESSER OF COST OR CHARGES 12 Computation of LESSER OF COST OR CHARGES 12 12 Computation acquisition charges (from Wkst. D-4, Pt. 111, col. 4, line 69) 13 14 13 Computation acquisition charges (from patients liable for payment for services on a charge basis had such payment been made in accordance with AL (CR \$413, 13(c)) 15 14 Computation for the second 1.000000 15 15 Computation for the second 1.000000 16 16 Computation for the second 1.000000 16 17 Computation for the second 1.000000 16 18 Computation for the second 1.000000 18 19 Computation for the second 1.000000 18 19 Computation for the second 1.000000 18 19 Excess of customary charges over reasonable cost (complete only if line 18 exceeds line 18) (see instructions) 0 20 Cost of physici and's services in a teaching hospital (see instructions) 0 2 21 Cost of physici and's services in a teaching hospital (see instructions) 0 2 22 Cost of physici and's services on a charge basis of instructions) 0 2 <			TV, COL. 15, THE 200			10.00
December 1 December 2 December 2 <thdecember 2<="" th=""> <thdecember 2<="" th=""> December</thdecember></thdecember>	11.00	Total cost (sum of lines 1 and 10) (see instructions)			5, 807, 516	11.00
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39.00OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)03939.00OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)3939.97Demonstration payment adjustment (see instructions)3939.97Demonstration payment adjustment amount before sequestration3939.99RECOVERY OF ACCELERATED DEPRECIATION039.99RECOVERY OF ACCELERATED DEPRECIATION040.00Subtotal (see instructions)3, 147, 89440.01Sequestration adjustment (see instructions)62, 95840.02Demonstration payment adjustment amount after sequestration040.03Sequestration adjustment-PARHM pass-throughs4041.00Interim payments2, 802, 24541.01Interim payments-PARHM4142.01Tentative settlement (for contractors use only)04243.00Bal ance due provider/program (see instructions)434344.00Protested amounts (nonall owable cost report items) in accordance with CMS Pub. 15-2, chapter 1, \$115.204445.15.2TO BE COMPLETED BY CONTRACTOR04490.00Original outlier amount (see instructions)09091.00Outlier reconciliation adjustment amount (see instructions)09192.00The rate used to calculate the Time Value of Money0.0092		, , ,				37.00 38.00
39.97Demonstration payment adjustment amount before sequestration03939.98Partial or full credits received from manufacturers for replaced devices (see instructions)03939.99RECOVERY OF ACCELERATED DEPRECIATION03940.00Subtotal (see instructions)3, 147, 8944040.01Sequestration adjustment (see instructions)62, 9584040.02Demonstration payment adjustment amount after sequestration04040.03Sequestration adjustment-PARHM pass-throughs4041.00Interim payments2, 802, 2454142.00Tentative settlement (for contractors use only)04243.00Bal ance due provider/program (see instructions)282, 6914343.01Bal ance due provider/program (see instructions)12282, 6914344.00Protested amounts (nonal lowable cost report items) in accordance with CMS Pub. 15-2, chapter 1,445.02Original outlier amount (see instructions)09090.00Original outlier amount (see instructions)09191.00Outlier reconciliation adjustment amount (see instructions)09192.00The rate used to calculate the Time Value of Money0.0092						39.00
39.98Partial or full credits received from manufacturers for replaced devices (see instructions)03939.99RECOVERY OF ACCELERATED DEPRECIATION03940.00Subtotal (see instructions)3,147,894400.01Sequestration adjustment (see instructions)62,9584040.02Demonstration payment adjustment amount after sequestration04040.03Sequestration adjustment-PARHM pass-throughs404041.00Interim payments2,802,2454141.01Interim payments2,802,2454142.00Tentative settlement (for contractors use only)04243.00Bal ance due provider/program (see instructions)434344.00Protested amounts (nonal lowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, TO BE COMPLETED BY CONTRACTOR090.00Original outlier amount (see instructions)09091.00Outlier reconciliation adjustment amount (see instructions)09192.00The rate used to calculate the Time Value of Money0.0092			is)			39.50
39.99RECOVERY OF ACCELERATED DEPRECIATION03940.00Subtotal (see instructions)3,147,8944040.01Sequestration adjustment (see instructions)62,9584040.02Demonstration payment adjustment amount after sequestration04040.03Sequestration adjustment-PARHM pass-throughs4041.00Interim payments2,802,2454141.01Interim payments-PARHM4142.00Tentative settlement (for contractor use only)4243.00Bal ance due provider/program (see instructions)282,69143.01Bal ance due provider/program (see instructions)4344.00Protested amounts (nonal I owable cost report items) in accordance with CMS Pub. 15-2, chapter 1,445115.2To BE COMPLETED BY CONTRACTOR090.00Original outlier amount (see instructions)09091.00Outlier reconciliation adjustment amount (see instructions)09192.00The rate used to calculate the Time Value of Money0.0092			aced devices (see instruc	tions)		
40.01Sequestration adjustment (see instructions)62,9584040.02Demonstration payment adjustment amount after sequestration04040.03Sequestration adjustment-PARHM pass-throughs4041.00Interim payments2,802,2454141.01Interim payments-PARHM242.00Tentative settlement (for contractors use only)04243.00Balance due provider/program (see instructions)282,6914344.00Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, \$115.204470BE COMPLETED BY CONTRACTOR09090.00Original outlier amount (see instructions)09192.00The rate used to calculate the Time Value of Money092						39.99
40.02Demonstration payment adjustment amount after sequestration04040.03Sequestration adjustment-PARHM pass-throughs4041.00Interim payments2,802,24541.01Interim payments-PARHM2,802,24541.02Tentative settlement (for contractors use only)4142.00Tentative settlement (for contractor use only)4243.00Balance due provider/program (see instructions)282,69143.01Balance due provider/program (see instructions)4344.00Protested amounts (nonal lowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2070BE COMPLETED BY CONTRACTOR090.00Original outlier amount (see instructions)091.00Outlier reconciliation adjustment amount (see instructions)092.00The rate used to calculate the Time Value of Money0.00		, , ,				
40.03Sequestration adjustment-PARHM pass-throughs4041.00Interim payments2,802,24541.01Interim payments-PARHM4142.00Tentative settlement (for contractors use only)4242.01Tentative settlement-PARHM (for contractor use only)4243.00Balance due provider/program (see instructions)282,69143.01Balance due provider/program-PARHM (see instructions)4344.00Protested amounts (nonal lowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2070BE COMPLETED BY CONTRACTOR090.00Original outlier amount (see instructions)091.00Outlier reconciliation adjustment amount (see instructions)092.00The rate used to calculate the Time Value of Money0.00						
41.01Interim payments-PARHM4142.00Tentative settlement (for contractors use only)042.01Tentative settlement-PARHM (for contractor use only)4243.00Balance due provider/program (see instructions)282,69143.01Balance due provider/program-PARHM (see instructions)4344.00Protested amounts (nonal lowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, \$115.2044.00Original outlier amount (see instructions)090.00Original outlier amount (see instructions)091.00Outlier reconciliation adjustment amount (see instructions)092.00The rate used to calculate the Time Value of Money0.00						40.03
42.00Tentative settlement (for contractors use only)04242.01Tentative settlement-PARHM (for contractor use only)4243.00Balance due provider/program (see instructions)282,69143.01Balance due provider/program-PARHM (see instructions)4344.00Protested amounts (nonal lowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, \$115.2044.00Original outlier amount (see instructions)090.00Original outlier amount (see instructions)091.00Outlier reconciliation adjustment amount (see instructions)092.00The rate used to calculate the Time Value of Money0.00		1 5			2, 802, 245	
42.01Tentative settlement-PARHM (for contractor use only)4243.00Balance due provider/program (see instructions)282,69143.01Balance due provider/program-PARHM (see instructions)4344.00Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, STI5.2070BE COMPLETED BY CONTRACTOR090.00Original outlier amount (see instructions)091.00Outlier reconciliation adjustment amount (see instructions)092.00The rate used to calculate the Time Value of Money0.00					0	41.01 42.00
43.01 Balance due provider/program-PARHM (see instructions) 43 44.00 Protested amounts (nonal lowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, 0 43 5115.2 TO BE COMPLETED BY CONTRACTOR 0 90.00 Original outlier amount (see instructions) 0 91.00 Outlier reconciliation adjustment amount (see instructions) 0 92.00 The rate used to calculate the Time Value of Money 0.00		· · · · · · · · · · · · · · · · · · ·				42.00
44.00 Protested amounts (nonal lowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, \$115.2 0 44 70 BE COMPLETED BY CONTRACTOR 0 90 90.00 Original outlier amount (see instructions) 0 90 91.00 Outlier reconciliation adjustment amount (see instructions) 0 91 92.00 The rate used to calculate the Time Value of Money 0.00 92					282, 691	
TO BE COMPLETED BY CONTRACTOR90.00Original outlier amount (see instructions)09091.00Outlier reconciliation adjustment amount (see instructions)09192.00The rate used to calculate the Time Value of Money0.0092		Protested amounts (nonallowable cost report items) in accorda	ance with CMS Pub. 15-2,	chapter 1,	0	43.01 44.00
90.00Original outlier amount (see instructions)09091.00Outlier reconciliation adjustment amount (see instructions)09192.00The rate used to calculate the Time Value of Money0.0092						
92.00 The rate used to calculate the Time Value of Money 0.00 92		Original outlier amount (see instructions)				
	92.00 93.00	Time Value of Money (see instructions)				
						94.00

NALY	SIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED	Provider CC		Period: From 01/01/2019 To 12/31/2019	Worksheet E-1 Part I Date/Time Prep 7/9/2020 1:42	pared
		Title		Hospi tal	Cost	
		Inpati en	t Part A	Par	t B	
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount	
		1.00	2,00	3, 00	4,00	
. 00	Total interim payments paid to provider	1100	2, 345, 61		2, 802, 245	1. (
. 00	Interim payments payable on individual bills, either			0	0	2.0
	submitted or to be submitted to the contractor for					
	services rendered in the cost reporting period. If none,					
	write "NONE" or enter a zero					_
. 00	List separately each retroactive lump sum adjustment					3.
	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					
. 01	ADJUSTMENTS TO PROVIDER			0	0	3.
02				0	0	3.
03				0	0	3.
04				0	0	3.
05				0	0	3.
	Provider to Program					
50	ADJUSTMENTS TO PROGRAM			0	0	3.
51				0	0	3.
52				0	0	3.
53 54				0	0	3. 3.
54 99	Subtotal (sum of lines 3.01-3.49 minus sum of lines			0	0	3. 3.
77	3, 50-3, 98)			0	0	J.
00	Total interim payments (sum of lines 1, 2, and 3.99)		2, 345, 61	2	2, 802, 245	4.
	(transfer to Wkst. E or Wkst. E-3, line and column as				,	
	appropri ate)					
	TO BE COMPLETED BY CONTRACTOR					
00	List separately each tentative settlement payment after					5.
	desk review. Also show date of each payment. If none,					
	write "NONE" or enter a zero. (1) Program to Provider					
01	TENTATI VE TO PROVIDER			0	0	5.
02				0	Ő	5.
03				0	0	5.
	Provider to Program	1				
50	TENTATIVE TO PROGRAM			0	0	5.
51				0	0	5.
52				0	0	5.
99	Subtotal (sum of lines 5.01-5.49 minus sum of lines			0	0	5.
00	5.50-5.98) Determined net settlement amount (balance due) based on					4
00	the cost report. (1)					6.
01	SETTLEMENT TO PROVIDER			0	282, 691	6.
02	SETTLEMENT TO PROGRAM		70, 06	-	0	6.
00	Total Medicare program liability (see instructions)		2, 275, 54		3, 084, 936	7.
		1		Contractor	NPR Date	
		C		Number	(Mo/Day/Yr)	
				1.00	2.00	

IALY:	SIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED	Provider CC		Period: From 01/01/2019 To 12/31/2019		
		componente	50N. 15 2520	10 12/31/2017	7/9/2020 1:42	
				<u>Swing Beds - SN</u>		
		Inpatien	t Part A	Pai	rt B	
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount	
		1.00	2.00	3, 00	4.00	<u> </u>
00	Total interim payments paid to provider		379, 54	0	0	1. (
00	Interim payments payable on individual bills, either			0	0	2.0
	submitted or to be submitted to the contractor for					
	services rendered in the cost reporting period. If none,					
~~	write "NONE" or enter a zero					
00	List separately each retroactive lump sum adjustment					3.
	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				1	
01	ADJUSTMENTS TO PROVIDER			0	0	3.
02				0	0	
03				0	0	3.
04				0	0	
05				0	0	3.
	Provider to Program					
50 51	ADJUSTMENTS TO PROGRAM			0	0	
51 52				0	0	
52 53				0		
54				0	0	
99	Subtotal (sum of lines 3.01-3.49 minus sum of lines			0	0	
	3. 50-3. 98)			-		
00	Total interim payments (sum of lines 1, 2, and 3.99)		379, 54	0	0	4.
	(transfer to Wkst. E or Wkst. E-3, line and column as					
	appropriate)					
00	TO BE COMPLETED BY CONTRACTOR List separately each tentative settlement payment after					5.
00	desk review. Also show date of each payment. If none,					5.
	write "NONE" or enter a zero. (1)					
	Program to Provider				1	
01	TENTATI VE TO PROVIDER			0	0	5
02				0	0	
03				0	0	5
- 0	Provider to Program					1 -
50 51	TENTATIVE TO PROGRAM			0	0	
52				0	0	
92 99	Subtotal (sum of lines 5.01–5.49 minus sum of lines			0	0	
	5. 50-5. 98)			0		
00	Determined net settlement amount (balance due) based on					6.
	the cost report. (1)					
01	SETTLEMENT TO PROVIDER		40, 86	0	0	
22	SETTLEMENT TO PROGRAM			0	0	
00	Total Medicare program liability (see instructions)		420, 40	-	0	7.
				Contractor Number	NPR Date (Mo/Day/Yr)	
		0)	1.00	2.00	
		Ĺ	,	1.00	2.00	8.

Heal th	Financial Systems UNION HOSPITAL	_ CLINTON	In Lie	u of Form CMS-	2552-10
CALCUL	ATION OF REIMBURSEMENT SETTLEMENT FOR HIT	Provider CCN: 15-1326	Period: From 01/01/2019 To 12/31/2019		epared:
		Title XVIII	Hospi tal	Cost	
				1.00	
	TO BE COMPLETED BY CONTRACTOR FOR NONSTANDARD COST REPORTS				
	HEALTH INFORMATION TECHNOLOGY DATA COLLECTION AND CALCULATIO	N			
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	Medicare days from Wkst. S-3, Pt. I, col. 6 sum of lines 1,	8-12			2.00
3.00	Medicare HMO days from Wkst. S-3, Pt. I, col. 6. line 2				3.00
4.00	Total inpatient days from S-3, Pt. I col. 8 sum of lines 1,	8-12			4.00
5.00	Total hospital charges from Wkst C, Pt. I, col. 8 line 200				5.00
6.00	Total hospital charity care charges from Wkst. S-10, col. 3	line 20			6.00
7.00	CAH only - The reasonable cost incurred for the purchase of line 168	certified HIT technology	Wkst. S-2, Pt. I		7.00
8.00	Calculation of the HIT incentive payment (see instructions)				8.00
9.00	Sequestration adjustment amount (see instructions)				9.00
10.00	Calculation of the HIT incentive payment after sequestration	(see instructions)			10.00
	INPATIENT HOSPITAL SERVICES UNDER THE IPPS & CAH				
30.00	Initial/interim HIT payment adjustment (see instructions)				30.00
31.00	Other Adjustment (specify)				31.00
32.00	Balance due provider (line 8 (or line 10) minus line 30 and	line 31) (see instructio	ns)		32.00
	• • •		•		

CALCULATI		der CCN: 15-1326 onent CCN: 15-Z326	Period: From 01/01/2019 To 12/31/2019	Worksheet E-2 Date/Time Pre 7/9/2020 1:42	pared:
		Title XVIII	Swing Beds - SNF	Cost	
			Part A 1.00	Part B 2.00	
CON	IPUTATION OF NET COST OF COVERED SERVICES		1.00	2.00	
1.00 Inp	patient routine services - swing bed-SNF (see instructions)		334, 222	0	1.00
3.00 And Par	patient routine services - swing bed-NF (see instructions) cillary services (from Wkst. D-3, col. 3, line 200, for Part A, a rt V, cols. 6 and 7, line 202, for Part B) (For CAH and swing-bed			0	2.00 3.00
3. 01 Nui	structions) rsing and allied health payment-PARHM (see instructions) r diem cost for interns and residents not in approved teaching pr	ogram (see		0.00	3.01 4.00
	structions)		10/	0	FOC
	ogram days terns and residents not in approved teaching program (see instruc	tions)	186	0	5.00 6.00
1	ilization review - physician compensation - SNF optional method o		0	0	7.00
	btotal (sum of lines 1 through 3 plus lines 6 and 7)	5	428, 980	0	8.00
	imary payer payments (see instructions)		0	0	9.00
	btotal (line 8 minus line 9)		428, 980	0	10.00
	ductibles billed to program patients (exclude amounts applicable	to physician	0	0	11.00
	ofessional services) btotal (line 10 minus line 11)		428, 980	0	12.00
	insurance billed to program patients (from provider records) (exc	l ude coi nsurance	0	0	13.00
	r physician professional services)				
	% of Part B costs (line 12 x 80%)			0	14.00
	btotal (see instructions)		428, 980	0	15.00
	HER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)		0	0	16.00 16.50
	oneer ACO demonstration payment adjustment (see instructions) ral community hospital demonstration project (§410A Demonstration) navment	0		16.50
	justment (see instructions)	i) payment	0		10.5
	monstration payment adjustment amount before sequestration		0	0	16.99
	lowable bad debts (see instructions)		0	0	17.00
7.01 Adj	justed reimbursable bad debts (see instructions)		0	0	17.01
	lowable bad debts for dual eligible beneficiaries (see instructio	ns)	0	0	18.00
	tal (see instructions)		428, 980	0	19.00
	questration adjustment (see instructions)		8, 580	0	19.0 [°] 19.02
	monstration payment adjustment amount after sequestration) questration adjustment-PARHM pass-throughs		0	0	19.02
	terim payments		379, 540	0	20.00
	terim payments-PARHM			-	20.0
21.00 Ter	ntative settlement (for contractor use only)		0	0	21.00
1.01 Ter	ntative settlement-PARHM (for contractor use only)				21.01
	lance due provider/program (line 19 minus lines 19.01, 20, and 21)	40, 860	0	22.00
1	lance due provider/program-PARHM (see instructions)				22.0
	otested amounts (nonallowable cost report items) in accordance wi	th CMS Pub. 15-2,	0	0	23.00
	apter 1, §115.2 ral Community Hospital Demonstration Project (§410A Demonstration) Adjustment			
	this the first year of the current 5-year demonstration period u				200.00
	ntury Cures Act? Enter "Y" for yes or "N" for no.				
	st Reimbursement				
	dicare swing-bed SNF inpatient routine service costs (from Wkst.	D-1, Pt. II, line			201.00
	(title XVIII hospital)) dicare swing-bed SNF inpatient ancillary service costs (from Wkst		20		202.00
	0 (title XVIII swing-bed SNF))	. D-3, COL. 3, TH	ie		202.00
1	tal (sum of lines 201 and 202)				203.00
	dicare swing-bed SNF discharges (see instructions)				204.00
Corr	nputation of Demonstration Target Amount Limitation (N/A in first	year of the curre	ent 5-year demons	tration	
	ri od)				
1	dicare swing-bed SNF target amount	ing 204)			205.00 206.00
	dicare swing-bed SNF inpatient routine cost cap (line 205 times I ustment to Medicare Part A Swing-Bed SNF Inpatient Reimbursement				206.00
	ogram reimbursement under the §410A Demonstration (see instructio				207.00
	dicare swing-bed SNF inpatient service costs (from Wkst. E-2, col		1		208.00
	d 3)	., _2 51 11165			
	justment to Medicare swing-bed SNF PPS payments (see instructions	5)			209.00
10.00 Res	served for future use				210.00
	nparision of PPS versus Cost Reimbursement				
15 00 To	tal adjustment to Medicare swing-bed SNF PPS payment (line 209 pl	us line 210) (see			215.00

ALCULAT	TION OF REIMBURSEMENT SETTLEMENT - SWING BEDS	rovider CCN: 15-1326	Period: From 01/01/2019	Worksheet E-	-2
	с	omponent CCN: 15-Z326	To 12/31/2019	Date/Time Pr 7/9/2020 1:4	
		Title XIX	Swing Beds - SNF	Cost	
			Part A 1.00	<u>Part B</u> 2.00	_
C	OMPUTATION OF NET COST OF COVERED SERVICES			2100	
	npatient routine services - swing bed-SNF (see instructions)		0		1.0
	npatient routine services - swing bed-NF (see instructions)		0		2.0
	ncillary services (from Wkst. D-3, col. 3, line 200, for Part .				3.
	Part V, cols. 6 and 7, line 202, for Part B) (For CAH and swing	-bed pass-through, see	9		
	nstructions) lursing and allied health payment-PARHM (see instructions)				3.
	Per diem cost for interns and residents not in approved teaching	a program (see	0.00		4.
	nstructions)	5 F - 5 - C			
	Program days		0		5.
	nterns and residents not in approved teaching program (see ins		0		6.
	Itilization review - physician compensation - SNF optional meth	od only	0		7.
	Subtotal (sum of lines 1 through 3 plus lines 6 and 7) Primary payer payments (see instructions)		0		8. 9.
	Subtotal (line 8 minus line 9)		0		10.
	Neductibles billed to program patients (exclude amounts applica	ble to physician	0		11.
	professional services)				
	Subtotal (line 10 minus line 11)		0		12.
	Coinsurance billed to program patients (from provider records)	(excl ude coi nsurance	0		13.
	for physician professional services)				
	10% of Part B costs (line 12 x 80%)		0		14.
	ubtotal (see instructions))THER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)		0		16.
	Pioneer ACO demonstration payment adjustment (see instructions)		0		16.
	Rural community hospital demonstration project (§410A Demonstra	tion) payment			16.
	djustment (see instructions)	, , , ,			
	emonstration payment adjustment amount before sequestration		0		16.
	Ilowable bad debts (see instructions)		0		17.
	djusted reimbursable bad debts (see instructions) Nlowable bad debts for dual eligible beneficiaries (see instru	ati ana)	0		17.
	otal (see instructions)		0		19.
	sequestration adjustment (see instructions)		0		19.
	Demonstration payment adjustment amount after sequestration)		0		19.
	equestration adjustment-PARHM pass-throughs				19.
1	nterim payments		0		20.
	nterim payments-PARHM				20.
	entative settlement (for contractor use only)		0		21.
	entative settlement-PARHM (for contractor use only) Balance due provider∕program (line 19 minus lines 19.01, 20, an	d 21)	0		21.
	Balance due provider/program-PARHM (see instructions)	u 21)	0		22.
	Protested amounts (nonallowable cost report items) in accordanc	e with CMS Pub. 15-2,	0		23.
С	hapter 1, §115.2				
	ural Community Hospital Demonstration Project (§410A Demonstra		T		
	s this the first year of the current 5-year demonstration peri- century Cures Act? Enter "Y" for yes or "N" for no.	od under the 21st			200.
	ost Reimbursement				_
	ledicare swing-bed SNF inpatient routine service costs (from Wk	st. D-1, Pt. II, line			201.
	6 (title XVIII hospital))				
	ledicare swing-bed SNF inpatient ancillary service costs (from	Wkst. D-3, col. 3, li	ne		202.
	200 (title XVIII swing-bed SNF))				202
	otal (sum of lines 201 and 202) ledicare swing-bed SNF discharges (see instructions)				203. 204.
	omputation of Demonstration Target Amount Limitation (N/A in fi	irst year of the curre	ent 5-vear demons	tration	204.
	eriod)				
)5.00 M	ledicare swing-bed SNF target amount				205.
)6. 00 <u>M</u>	ledicare swing-bed SNF inpatient routine cost cap (line 205 tim	es line 204)			206.
	djustment to Medicare Part A Swing-Bed SNF Inpatient Reimburse		1 1		
	Program reimbursement under the §410A Demonstration (see instru	,	1		207.
	ledicare swing-bed SNF inpatient service costs (from Wkst. E-2, ind 3)	COL. 1, SUM OF LINES	1		208.
	djustment to Medicare swing-bed SNF PPS payments (see instruct	ions)			209.
	Reserved for future use	/			210.
Co	omparision of PPS versus Cost Reimbursement				
5 00 T	otal adjustment to Medicare swing-bed SNF PPS payment (line 20	9 plus line 210) (see			215.

ALCUL	Financial Systems UNION HOSPITAL ATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 15-1326	Peri od:	Worksheet E-3	2552 }
			From 01/01/2019		
			To 12/31/2019	Date/Time Pre 7/9/2020 1:42	
		Title XVIII	Hospi tal	Cost	
				1.00	
	PART V - CALCULATION OF REIMBURSEMENT SETTLEMENT FOR MEDICARE			1.00	
. 00	Inpatient services	- FART A SERVICES - COS	I KLIMDUKJLMLNI	2, 591, 074	1 1
. 00	Nursing and Allied Health Managed Care payment (see instructi	ions)		2,071,071	
. 00	Organ acquisition			0	3
. 00	Subtotal (sum of lines 1 through 3)			2, 591, 074	4
. 00	Primary payer payments			0	5
. 00	Total cost (line 4 less line 5). For CAH (see instructions)			2, 616, 985	6
	COMPUTATION OF LESSER OF COST OR CHARGES				
00	Reasonable charges			0	Ι.
. 00 . 00	Routi ne servi ce charges			0	
. 00	Ancillary service charges Organ acquisition charges, net of revenue			0	
. 00 D. 00	Total reasonable charges			0	
2.00	Customary charges			0	1 '
1.00	Aggregate amount actually collected from patients liable for	payment for services on	a charge basis	0	111
2.00	Amounts that would have been realized from patients liable for			0	12
	had such payment been made in accordance with 42 CFR 413.13(e	e)	-		
3.00	Ratio of line 11 to line 12 (not to exceed 1.000000)			0.00000	
4.00	Total customary charges (see instructions)			0	
5.00	Excess of customary charges over reasonable cost (complete or	nly if line 14 exceeds l	ine 6) (see	0	15
4 00	instructions)	alvifling (avoada li	no 14) (coo	0	14
6. 00	Excess of reasonable cost over customary charges (complete or instructions)	in y 11 11he 6 exceeds 11	ne 14) (See	0	16
7.00	Cost of physicians' services in a teaching hospital (see inst	tructions)		0	17
	COMPUTATION OF REIMBURSEMENT SETTLEMENT			-	
8.00	Direct graduate medical education payments (from Worksheet E-	-4, line 49)		0	18
9.00	Cost of covered services (sum of lines 6, 17 and 18)			2, 616, 985	19
0. 00	Deductibles (exclude professional component)			336, 884	
1.00	Excess reasonable cost (from line 16)			0	
2.00	Subtotal (line 19 minus line 20 and 21)			2, 280, 101	
3.00	Coinsurance			0	1
4.00 5.00	Subtotal (line 22 minus line 23) Allowable bad debts (exclude bad debts for professional servi	(coc) (coc i petructione)		2, 280, 101 64, 439	
5.00	Adjusted reimbursable bad debts (see instructions)			41, 885	
7.00	Allowable bad debts for dual eligible beneficiaries (see inst	tructions)		28, 694	
3.00	Subtotal (sum of lines 24 and 25, or line 26)			2, 321, 986	
9.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)			0	
9.50	Pioneer ACO demonstration payment adjustment (see instruction	ns)		0	29
9.99	Demonstration payment adjustment amount before sequestration			0	29
D. 00	Subtotal (see instructions)			2, 321, 986	
0. 01	Sequestration adjustment (see instructions)			46, 440	
0. 02	Demonstration payment adjustment amount after sequestration			0	
0.03	Sequestration adjustment-PARHM			0 04E /40	30
1.00	Interim payments Interim payments-PARHM			2, 345, 612	31
2.00	Tentative settlement (for contractor use only)			0	
2.00	Tentative settlement-PARHM (for contractor use only)			0	32
3.00	Balance due provider/program (line 30 minus lines 30.01, 30.0	02, 31, and 32)		-70, 066	
3.01	Balance due provider/program-PARHM (lines 2, 3, 18, and 26, n		, and 32.01)	,	33
4.00	Protested amounts (nonallowable cost report items) in accorda			0	
	§115. 2				1

ALCUL	ATION OF REIMBURSEMENT SETTLEMENT P	rovider CCN: 15-1326	Peri od:	Worksheet E-3	3
			From 01/01/2019 To 12/31/2019	Part VII	pare
		Title XIX	Hospi tal	Cost	
		· · · · · · · · · · · · · · · · · · ·	I npati ent	Outpati ent	
			1.00	2.00	
	PART VII - CALCULATION OF REIMBURSEMENT - ALL OTHER HEALTH SERVI	ICES FOR TITLES V OR X	IX SERVICES		
	COMPUTATION OF NET COST OF COVERED SERVICES				
00	Inpatient hospital/SNF/NF services		50, 393		1.
00	Medical and other services			0	
00	Organ acquisition (certified transplant centers only)		0		3.
00	Subtotal (sum of lines 1, 2 and 3)		50, 393	0	
00	Inpatient primary payer payments		0		5.
00	Outpatient primary payer payments		50,000	0	
00	Subtotal (line 4 less sum of lines 5 and 6)		50, 393	0	7.
	COMPUTATION OF LESSER OF COST OR CHARGES Reasonable Charges				+
00	Routine service charges		38, 112		8.
00	Ancillary service charges		82, 954	0	
00	Organ acquisition charges, net of revenue		02, 934	0	10.
. 00	Incentive from target amount computation		0		111.
. 00	Total reasonable charges (sum of lines 8 through 11)		121, 066	0	12.
. 00	CUSTOMARY CHARGES		121,000		1 . 2.
8.00	Amount actually collected from patients liable for payment for	services on a charge	0	0	13.
	basi s	3			
. 00	Amounts that would have been realized from patients liable for	payment for services o	n 0	0	14.
	a charge basis had such payment been made in accordance with 42	CFR §413.13(e)			
. 00	Ratio of line 13 to line 14 (not to exceed 1.000000)		0.00000	0.00000	15
. 00	Total customary charges (see instructions)		121, 066	0	16
. 00	Excess of customary charges over reasonable cost (complete only	if line 16 exceeds	70, 673	0	17
	line 4) (see instructions)				
. 00	Excess of reasonable cost over customary charges (complete only	if line 4 exceeds lin	e 0	0	18
~ ~	16) (see instructions)				1.0
. 00	Interns and Residents (see instructions)		0	0	
. 00	Cost of physicians' services in a teaching hospital (see instru		0	0	
. 00	Cost of covered services (enter the lesser of line 4 or line 16		50, 393	0	21
00	PROSPECTIVE PAYMENT AMOUNT - Lines 22 through 26 must only be co	ompieted for PPS provi		0	1 22
	Other than outlier payments Outlier payments		0	0	
	Program capital payments		0	0	23
	Capital exception payments (see instructions)		0		25
. 00	Routine and Ancillary service other pass through costs		0	0	
. 00	Subtotal (sum of lines 22 through 26)		0	0	
. 00	Customary charges (title V or XIX PPS covered services only)		0	0	
. 00	Titles V or XIX (sum of lines 21 and 27)		50, 393	0	
	COMPUTATION OF REIMBURSEMENT SETTLEMENT		00,070		/
. 00	Excess of reasonable cost (from line 18)		0	0	1 30
. 00	Subtotal (sum of lines 19 and 20, plus 29 minus lines 5 and 6)		50, 393	0	
. 00	Deductibles		0	0	32
. 00	Coinsurance	0	0	33	
. 00	Allowable bad debts (see instructions)		0	0	
00	Utilization review		0	1	35
00	Subtotal (sum of lines 31, 34 and 35 minus sum of lines 32 and 3	33)	50, 393	0	36
	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)		0 50, 393	0	
00	Subtotal (line 36 ± line 37)			0	
00	Direct graduate medical education payments (from Wkst. E-4)				39
. 00	Total amount payable to the provider (sum of lines 38 and 39)		50, 393	0	
. 00	Interim payments		61, 971	0	
	Balance due provider/program (line 40 minus line 41)		-11, 578	0	42
2.00 3.00	Protested amounts (nonallowable cost report items) in accordance			0	43

	E SHEET (If you are nonproprietary and do not maintain sype accounting records, complete the General Fund column	Provider C		eriod: com 01/01/2019 0 12/31/2019	Worksheet G Date/Time Pre	
		General Fund	Specific Purpose Fund	Endowment Fund	7/9/2020 1:42 Plant Fund	pm
	CURRENT ASSETS	1.00	2.00	3.00	4.00	
1.00	Cash on hand in banks	6, 039	0	0	0	1.00
2.00	Temporary investments	0	0	0	0	
3.00	Notes receivable	0	0	0	0	3.00
4.00	Accounts receivable Other receivable	1, 866, 175	0	0	0	
5.00 6.00	Allowances for uncollectible notes and accounts receivable	0	0	0	0	
7.00	Inventory	254, 172	0	0	0	
B. 00	Prepaid expenses	37, 202, 786	0	0	0	8.00
9.00	Other current assets	0	0	0	0	
10.00	Due from other funds	0	0	0	0	10.00
11.00	Total current assets (sum of lines 1-10) FIXED ASSETS	39, 329, 172	0	0	0	11.00
12.00	Land	614, 150	0	0	0	12.00
13.00	Land improvements	011,100	0	0	0	
14.00	Accumulated depreciation	0	0	0	0	14.00
15.00	Bui I di ngs	13, 480, 190	0	0	0	
16.00	Accumulated depreciation	-15, 175, 002	0	0	0	
17.00 18.00	Leasehold improvements Accumulated depreciation	0	0	0	0	17.00 18.00
19.00	Fixed equipment	0	0	0	0	19.00
20.00	Accumulated depreciation	0	0	0	0	20.00
21.00	Automobiles and trucks	0	0	0	0	21.00
22.00	Accumulated depreciation	0	0	0	0	
23.00	Major movable equipment	7,039,529	0	0	0	
24.00 25.00	Accumulated depreciation Minor equipment depreciable	0	0	0	0	
26.00	Accumulated depreciation	0	0	0	0	
27.00	HIT designated Assets	0	0	0	0	27.00
28.00	Accumulated depreciation	0	0	0	0	28.00
29.00	Minor equipment-nondepreciable	0	0	0	0	29.00
30.00	Total fixed assets (sum of lines 12-29)	5, 958, 867	0	0	0	30.00
31.00	OTHER ASSETS Investments	0	0	0	0	31.00
32.00	Deposits on Leases	0	0	0	0	
33.00	Due from owners/officers	0	0	0	0	33.00
34.00	Other assets	0	0	0	0	34.00
35.00	Total other assets (sum of lines 31-34)	0	0	0	0	35.00
36.00	Total assets (sum of lines 11, 30, and 35)	45, 288, 039	0	0	0	36.00
37.00	CURRENT LI ABI LI TI ES Accounts payable	403, 381	0	0	0	37.00
38.00	Salaries, wages, and fees payable	653, 962	0	0	0	
39.00	Payroll taxes payable	0	0	0	0	39.00
	Notes and loans payable (short term)	0	0	0	0	
41.00	Deferred income	0	0	0	0	
42.00 43.00	Accelerated payments Due to other funds	0	0	0	0	42.00 43.00
44.00	Other current liabilities	314, 242	0	0	0	
45.00	Total current liabilities (sum of lines 37 thru 44)	1, 371, 585	0	0	0	
	LONG TERM LIABILITIES					
46.00	Mortgage payable	0	0	0	0	
47.00	Notes payable	0	0	0	0	
48.00 49.00	Unsecured loans Other long term liabilities	0	0	0	0	
50.00	Total long term liabilities (sum of lines 46 thru 49)	0	0	0	0	
51.00	Total liabilities (sum of lines 45 and 50)	1, 371, 585		0	0	51.00
	CAPI TAL ACCOUNTS					
52.00	General fund balance	43, 916, 454				52.00
53.00	Specific purpose fund		0			53.00
54.00 55.00	Donor created - endowment fund balance - restricted Donor created - endowment fund balance - unrestricted			0		54.00 55.00
56.00	Governing body created - endowment fund balance			0		56.00
57.00	Plant fund balance - invested in plant			0	0	
58.00	Plant fund balance - reserve for plant improvement,				0	58.00
	replacement, and expansion	40.04			-	
59.00	Total fund balances (sum of lines 52 thru 58)	43, 916, 454	0	0	0	
60.00	Total liabilities and fund balances (sum of lines 51 and 59)	45, 288, 039	0	0	0	60.0

Heal th	Financial Systems	UNI ON HOSPI TAI	_ CLINTON		In Lie	u of Form CMS	-2552-10
STATEMENT OF CHANGES IN FUND BALANCES			Provider CCN: 15-1326		Period: From 01/01/2019 To 12/31/2019		epared:
		General	Fund	Speci al	Purpose Fund	Endowment Fund	
		1.00	2.00	3.00	4.00	5.00	
$\begin{array}{c} 1.\ 00\\ 2.\ 00\\ 3.\ 00\\ 4.\ 00\\ 5.\ 00\\ 6.\ 00\\ 7.\ 00\\ 8.\ 00\\ 9.\ 00\\ 10.\ 00\\ 11.\ 00\\ 12.\ 00\\ 13.\ 00\\ 14.\ 00\\ 15.\ 00\\ 16.\ 00\\ \end{array}$	Fund balances at beginning of period Net income (loss) (from Wkst. G-3, line 29) Total (sum of line 1 and line 2) Additions (credit adjustments) (specify) Total additions (sum of line 4-9) Subtotal (line 3 plus line 10) Deductions (debit adjustments) (specify)		40, 573, 568 3, 342, 886 43, 916, 454 0 43, 916, 454				1.00 2.00 3.00 4.00 5.00 0.7.00 8.00 9.00 10.00 11.00 0.13.00 11.00 11.00 11.00 11.00 11.00 11.00 11.00 11.00 11.00 12.00 13.00 14.00 15.00 16.00
17.00 18.00 19.00	Total deductions (sum of lines 12–17) Fund balance at end of period per balance sheet (line 11 minus line 18)	0 Endowment Fund	0 43, 916, 454 Pl ant	Fund	0 0 0		0 17.00 18.00 19.00
		6.00	7.00	8.00			
1.00 2.00 3.00 4.00 5.00 6.00 7.00 8.00 9.00	Fund balances at beginning of period Net income (loss) (from Wkst. G-3, line 29) Total (sum of line 1 and line 2) Additions (credit adjustments) (specify)	0	0 0 0 0 0		0		1.00 2.00 3.00 4.00 5.00 6.00 7.00 8.00 9.00
9.00 10.00 11.00 12.00 13.00 14.00 15.00 16.00 17.00 18.00 19.00	Total additions (sum of line 4-9) Subtotal (line 3 plus line 10) Deductions (debit adjustments) (specify) Total deductions (sum of lines 12-17) Fund balance at end of period per balance sheet (line 11 minus line 18)	0 0 0 0	0 0 0 0 0 0		0 0 0		9,00 10,00 11,00 12,00 13,00 14,00 15,00 16,00 17,00 18,00 19,00

STATEN	IENT OF PATIENT REVENUES AND OPERATING EXPENSES	Provider C	CN: 15-1326	Period: From 01/01/20 To 12/31/20		epared:
	Cost Center Description		I npati ent	Outpati ent	Total	
			1.00	2.00	3.00	
	PART I – PATIENT REVENUES					
	General Inpatient Routine Services					
1.00	Hospi tal		2, 639, 5	75	2, 639, 575	1.00
2.00	SUBPROVIDER - IPF					2.00
3.00	SUBPROVIDER – IRF					3.00
4.00	SUBPROVIDER					4.00
5.00	Swing bed - SNF			0	0	
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)		2, 639, 5	75	2, 639, 575	10.00
	Intensive Care Type Inpatient Hospital Services					
	I NTENSI VE CARE UNI T		666, 29	92	666, 292	11.00
12.00	CORONARY CARE UNI T					12.00
13.00	BURN INTENSIVE CARE UNIT					13.00
14.00	SURGICAL INTENSIVE CARE UNIT					14.00
15.00	OTHER SPECIAL CARE (SPECIFY)					15.00
16.00	Total intensive care type inpatient hospital services (sum of	lines	666, 29	92	666, 292	16.00
	11-15)					
17.00	Total inpatient routine care services (sum of lines 10 and 16)		3, 305, 8	67	3, 305, 867	17.00
18.00	Ancillary services		4, 163, 7	15 44, 687, 0	19 48, 850, 734	18.00
19.00	Outpatient services		571, 22	22 19, 995, 3	37 20, 566, 609	19.00
20.00	RURAL HEALTH CLINIC			0	0 0	20.00
21.00	FEDERALLY QUALIFIED HEALTH CENTER			0	0 0	21.00
22.00	HOME HEALTH AGENCY					22.00
23.00	AMBULANCE SERVICES					23.00
24.00	СМНС					24.00
25.00	AMBULATORY SURGICAL CENTER (D. P.)					25.00
26.00	HOSPI CE					26.00
27.00	PHYSICIAN REVENUE			0 25, 0	38 25, 038	27.00
28.00	Total patient revenues (sum of lines 17-27)(transfer column 3	to Wkst.	8, 040, 80	04 64, 707, 4	14 72, 748, 248	28.00
	G-3, line 1)					
	PART II - OPERATING EXPENSES		_			
29.00	Operating expenses (per Wkst. A, column 3, line 200)			19, 838, 7	31	29.00
30.00	ADD (SPECI FY)			0		30.00
31.00				0		31.00
32.00				0		32.00
33.00				0		33.00
34.00				0		34.00
35.00				0		35.00
36.00	Total additions (sum of lines 30-35)				0	36.00
37.00	DEDUCT (SPECIFY)			0		37.00
38.00				0		38.00
39.00				0		39.00
40.00				0		40.0
41.00				0		41.00
42.00	Total deductions (sum of lines 37-41)				0	42.00
43.00	Total operating expenses (sum of lines 29 and 36 minus line 42)(transfer		19, 838, 7	31	43.00
	to Wkst. G-3, line 4)		1		1	

Heal th	Financial Systems	UNI ON HOSPI TAL	CLINTON		In Lie	u of Form CMS-2	2552-10	
	IENT OF REVENUES AND EXPENSES		Provider CCN:	15-1326	Peri od: From 01/01/2019 To 12/31/2019	Worksheet G-3	pared:	
						1.00		
1.00	Total patient revenues (from Wkst. G-2, Par	t L column 3 lir	ne 28)			72, 748, 248	1.00	
2.00	Less contractual allowances and discounts of		,			48, 457, 702	2.00	
3.00								
4.00	Less total operating expenses (from Wkst. (G-2. Part II. line	43)			24, 290, 546 19, 838, 731	3.00 4.00	
5.00	Net income from service to patients (line 3		,			4, 451, 815	5.00	
	OTHER I NCOME					.,,		
6.00	Contributions, donations, bequests, etc					0	6.00	
7.00	Income from investments					0	7.00	
8.00	Revenues from telephone and other miscellar	neous communicatior	i servi ces			0	8.00	
9.00	Revenue from television and radio service					0	9.00	
10.00	Purchase di scounts					0	10.00	
11.00	Rebates and refunds of expenses					0	11.00	
12.00	Parking lot receipts					0	12.00	
13.00	Revenue from Laundry and Linen service					0	13.00	
14.00	Revenue from meals sold to employees and gu	iests				0	14.00	
15.00	Revenue from rental of living quarters					0	15.00	
16.00	Revenue from sale of medical and surgical s	supplies to other t	han patients			0	16.00	
17.00	Revenue from sale of drugs to other than pa					0	17.00	
18.00	Revenue from sale of medical records and at	ostracts				0	18.00	
19.00	Tuition (fees, sale of textbooks, uniforms,					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	OTHER INCOME					359, 348	24.00	
24.01	OTHER					2, 180	24.01	
24.02	CHANGES IN UHF					9, 793	24.02	
24.03	INVESTMENT INCOME					1, 040	24.03	
25.00	Total other income (sum of lines 6-24)					372, 361	25.00	
26.00	Total (line 5 plus line 25)					4, 824, 176		
	ALLOCATED EXPENSES					1, 481, 290		
	Total other expenses (sum of line 27 and su					1, 481, 290		
29.00	Net income (or loss) for the period (line 2	26 minus line 28)				3, 342, 886	29.00	