PART II - CERTIFICATION

(3) Settled with Audit

(4) Reopened (5) Amended

use only

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

CERTIFICATION BY CHIEF FINANCIAL OFFICER OR ADMINISTRATOR OF PROVIDER(S)

I HEREBY CERTIFY that I have read the above certification statement and that I have examined the accompanying electronically filed or manually submitted cost report and the Balance Sheet and Statement of Revenue and Expenses prepared by UNION HOSPITAL, INC. (15-0023) for the cost reporting period beginning 01/01/2017 and ending 12/31/2017 and to the best of my knowledge and belief, this report and statement are true, correct, complete and prepared from the books and records of the provider in accordance with applicable instructions, except as noted. I further certify that I am familiar with the laws and regulations regarding the provision of health care services, and that the services identified in this cost report were provided in compliance with such laws and regulations.

] I have read and agree with the above certification statement. I certify that I intend my electronic signature on this certification statement to be the legally binding equivalent of my original signature.

(Si gned)					
	Offi cer	or Adm	i ni strator	of Provide	er(s)
					. ,
Title					
ппе					

number of times reopened = 0-9.

			Ti tle XVIII				
	Cost Center Description	Title V	Part A	Part B	HI T	Title XIX	
		1. 00	2. 00	3. 00	4. 00	5. 00	
	PART III - SETTLEMENT SUMMARY						
1.00	Hospi tal	0	-127, 178	103, 669	0	-180, 552	1.00
2.00	Subprovi der - I PF	0	0	0		0	2.00
3.00	Subprovi der - I RF	0	55, 327	5		0	3.00
5.00	Swing bed - SNF	0	0	0		0	5.00
6.00	Swing bed - NF	0				0	6.00
200.00	Total	0	-71, 851	103, 674	0	-180, 552	200. 00

Date

The above amounts represent "due to" or "due from" the applicable program for the element of the above complex indicated.

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

Health Financial Systems UNION HOSPITAL, INC. In Lieu of Form CMS-2552-10 HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA Provider CCN: 15-0023 Peri od: Worksheet S-2 From 01/01/2017 Part I Date/Time Prepared: 12/31/2017 5/30/2018 2:18 pm 3.00 4.00 Hospital and Hospital Health Care Complex Address: Street: 1606 NORTH SEVENTH ST 1.00 PO Box: 1.00 Ci ty: TERRE HAUTE State: IN Zip Code: 47804-2.00 County: VIGO 2.00 Component Name CCN CBSA Provi der Date Payment System (P, Certi fi ed T, 0, or N) Number Number Type XVIII XIX 1.00 2.00 3.00 4.00 5.00 6.00 | 7.00 | 8.00 Hospital and Hospital-Based Component Identification: 3.00 Hospi tal UNION HOSPITAL, INC. 150023 45460 01/01/1966 Ν Р 0 3.00 1 Subprovi der - IPF 4.00 4.00 5.00 Subprovi der - IRF MEDICAL REHAB 15T023 45460 5 09/01/1989 N Ρ 0 5.00 Subprovi der - (Other) 6.00 6.00 7.00 Swing Beds - SNF 7.00 Swing Beds - NF 8.00 8.00 9.00 Hospital -Based SNF 9.00 10.00 Hospi tal -Based NF 10.00 Hospi tal -Based OLTC 11 00 11 00 12.00 Hospital -Based HHA 12.00 13.00 Separately Certified ASC 13.00 Hospi tal -Based Hospi ce 14.00 14.00 15.00 Hospital -Based Health Clinic - RHC 15 00 16.00 Hospital-Based Health Clinic - FQHC 16.00 17.00 Hospital -Based (CMHC) I 17.00 18.00 Renal Dialysis 18 00 19.00 Other 19.00 From To: 1.00 2.00 20.00 Cost Reporting Period (mm/dd/yyyy) 01/01/2017 12/31/2017 20 00 Type of Control (see instructions) 21.00 2 Inpatient PPS Information Does this facility qualify and is it currently receiving payments for disproportionate N 22.00 22.00 share hospital adjustment, in accordance with 42 CFR §412.106? In column 1, enter "Y" for yes or "N" for no. Is this facility subject to 42 CFR Section §412.106(c)(2)(Pickle amendment hospital?) In column 2, enter "Y" for yes or "N" for no. Did this hospital receive interim uncompensated care payments for this cost reporting Ν Ν 22.01 period? Enter in column 1, "Y" for yes or "N" for no for the portion of the cost reporting period occurring prior to October 1. Enter in column 2, "Y" for yes or "N" for no for the portion of the cost reporting period occurring on or after October 1. (see instructions) Is this a newly merged hospital that requires final uncompensated care payments to be Ν Ν 22.02 determined at cost report settlement? (see instructions) Enter in column 1, "Y" for yes or "N" for no, for the portion of the cost reporting period prior to October 1. Enter in column 2, "Y" for yes or "N" for no, for the portion of the cost reporting period on or after October 1. 22.03 Did this hospital receive a geographic reclassification from urban to rural as a result 22.03 Ν of the OMB standards for delineating statistical areas adopted by CMS in FY2015? Enter in column 1, "Y" for yes or "N" for no for the portion of the cost reporting period prior to October 1. Enter in column 2, "Y" for yes or "N" for no for the portion of the cost reporting period occurring on or after October 1. (see instructions) Does this hospital contain at least 100 but not more than 499 beds (as counted in accordance with 42 CFR 412.105)? Enter in column 3, "Y" for yes or "N" for no. 23.00 Which method is used to determine Medicaid days on lines 24 and/or 25 below? In column 3 N 23.00 1, enter 1 if date of admission, 2 if census days, or 3 if date of discharge. Is the method of identifying the days in this cost reporting period different from the method enter "Y" for yes or used in the prior cost reporting period? In column 2 "N" for no In-State In-State Out-of Medi cai d Out-of 0ther Medicai d Medi cai d State State HMO days Medi cai d paid days Medi cai d Medi cai d el i gi bl e days unpai d pai d days el i gi bl e days unpai d 3.00 6.00 1 00 4. 00 5. 00 2.00 24.00 If this provider is an IPPS hospital, enter the 1,032 8, 181 n 1, 556 3, 791 24.00 in-state Medicaid paid days in column 1, in-state Medicaid eligible unpaid days in column 2, out-of-state Medicaid paid days in column 3, out-of-state Medicaid eligible unpaid days in column 4, Medicaid HMO paid and eligible but unpaid days in column 5, and other Medicaid days in column 6.

0

317

0

42

181

25.00

25.00 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.

	TAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DA		Provider CC		eri od:		worksheet S-2	
				To	rom 01/01/20 o 12/31/20		Part I Date/Time Pre	
					Urhan/Rural	ς	5/30/2018 2:1 Date of Geogr	
					1. 00		2.00	
26. 00	Enter your standard geographic classification (not wa cost reporting period. Enter "1" for urban or "2" for			ginning of the		1		26.00
27. 00	Enter your standard geographic classification (not wareporting period. Enter in column 1, "1" for urban or	age) sta "2" fo	atus at the en or rural. If a			1		27.00
35. 00	enter the effective date of the geographic reclassifilf this is a sole community hospital (SCH), enter the effect in the cost reporting period.			CH status in		0		35. 00
	jorrest in the east reporting period.				Begi nni ng	:	Endi ng:	
24 00	Enter applicable beginning and ending dates of SCH st	totus (Subscript Line	24 for number	1.00		2. 00	36.00
	of periods in excess of one and enter subsequent date If this is a Medicare dependent hospital (MDH), enter	es.	•			0		37.00
37. 01	is in effect in the cost reporting period. Is this hospital a former MDH that is eligible for th				N			37. 01
20.00	accordance with FY 2016 OPPS final rule? Enter "Y" for instructions) If line 37 is 1, enter the beginning and ending dates	,		•				38.00
36. 00	greater than 1, subscript this line for the number of enter subsequent dates.							36.00
					Y/N 1.00		Y/N 2.00	
39. 00							N N	39.00
	hospitals in accordance with 42 CFR §412.101(b)(2)(i) for yes or "N" for no. Does the facility meet the mil with 42 CFR 412.101(b)(2)(i) or (ii)? Enter in column instructions)	eage re	equirements in	accordance				
40. 00	Is this hospital subject to the HAC program reduction "N" for no in column 1, for discharges prior to Octob no in column 2, for discharges on or after October 1.		N		N	40.00		
		•	,		1	V . 00	XVIII XIX 2.00 3.00	
	Prospective Payment System (PPS)-Capital					. 00	7 2.00 3.00	
	Does this facility qualify and receive Capital paymer with 42 CFR Section §412.320? (see instructions) Is this facility eligible for additional payment exce					N N	Y N	45. 00 46. 00
+0.00	pursuant to 42 CFR §412.348(f)? If yes, complete Wkst Pt. III.					IV		40.00
	Is this a new hospital under 42 CFR §412.300(b) PPS of the facility electing full federal capital payment Teaching Hospitals					N N	N N	47. 00 48. 00
56. 00	Is this a hospital involved in training residents in or "N" for no.	approv	ed GME program	s? Enter "Y"	for yes	Υ		56. 00
57. 00	If line 56 is yes, is this the first cost reporting pGME programs trained at this facility? Enter "Y" for is "Y" did residents start training in the first montfor yes or "N" for no in column 2. If column 2 is "N	yes on th of th (", comp	r "N" for no i nis cost repor olete Workshee	n column 1. If ting period?	column 1 Enter "Y"	N		57.00
58 00	"N", complete Wkst. D, Parts III & IV and D-2, Pt. II If line 56 is yes, did this facility elect cost reimb			ans' services	as	N		58.00
	defined in CMS Pub. 15-1, chapter 21, §2148? If yes,	comple	te Wkst. D-5.					
59. 00	Are costs claimed on line 100 of Worksheet A? If yes	s, comp	lete Wkst. D-2	, Pt. I. NAHE 413.85	Worksheet	N A	Pass-Through	59.00
				Y/N	Li ne #		Qualification Criterion Code	
				1.00	2. 00		3. 00	
50. 00	Are you claiming nursing and allied health education any programs that meet the criteria under §413.85?	` ,		Y				60.00
	If line 60 is yes, complete columns 2 and 3 for each instructions)	prograi	m. (see		23	. 01	1	60. 01
	0.02 If line 60 is yes, complete columns 2 and 3 for each program. (see instructions)						1	60. 02
50. 03	If line 60 is yes, complete columns 2 and 3 for each instructions)			Di saad OHE		. 02		60. 03
		Y/N	I ME	Direct GME	IME		Direct GME	
61 00	Did your hospital receive FTE slots under ACA	1.00 N	2. 00	3. 00	4. 00	. 00	5. 00	61.00
	section 5503? Enter "Y" for yes or "N" for no in column 1. (see instructions)	IN				, 00	0.00	
51. 01	Enter the average number of unweighted primary care FTEs from the hospital's 3 most recent cost reports							61.01

OSPI T	Financial Systems AL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION D		TAL, INC. Provider C	CN: 15-0023	Peri od:	u of Form CMS-2 Worksheet S-2	
			11011461		From 01/01/2017 To 12/31/2017	Part I Date/Time Pre 5/30/2018 2:1	pare
		Y/N	I ME	Direct GME	I ME	Direct GME	D pii
		1. 00	2. 00	3. 00	4. 00	5. 00	
	Enter the current year total unweighted primary care FTE count (excluding OB/GYN, general surgery FTEs, and primary care FTEs added under section 5503 of ACA). (see instructions)						61.
	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.
	Enter the number of unweighted primary care/or surgery allopathic and/or osteopathic FTEs in the current cost reporting period (see instructions).						61.
. 05	Enter the difference between the baseline primary and/or general surgery FTEs and the current year's primary care and/or general surgery FTE counts (line	•					61.
. 06	61.04 minus line 61.03). (see instructions) Enter the amount of ACA §5503 award that is being used for cap relief and/or FTEs that are nonprimary care or general surgery. (see instructions)						61.
		Pro	ogram Name	Program Code	Unweighted IME FTE Count	Unweighted Direct GME FTE Count	
	Of the FTEs in line 61.05, specify each new program		1. 00	2.00	3. 00	4.00	
. 20	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. Of the FTEs in line 61.05, specify each expanded program specialty, if any, and the number of FTE residents for each expanded program. (see instructions) Enter in column 1, the program name. Enter in column 2, the program code. Enter in column 3, the IME FTE unweighted count. Enter in column 4, the direct GME FTE unweighted count.				0. 00	0. 00	61.
						1.00	
	ACA Provisions Affecting the Health Resources and Se	ervi ces	Admi ni strati o	n (HRSA)		1.00	
	Enter the number of FTE residents that your hospital your hospital received HRSA PCRE funding (see instru Enter the number of FTE residents that rotated from	ictions)				0.00	
	during in this cost reporting period of HRSA THC pro				.o your nospital	0.00	02
	Teaching Hospitals that Claim Residents in Nonproviders your facility trained residents in nonproviders			act reporting	noriod? Entor	Υ	63
. 00	"Y" for yes or "N" for no in column 1. If yes, compl					T	03
				Unwei ghted	Unwei ghted	Ratio (col.	
				FTEs Nonprovider Site	FTEs in Hospital	1/ (col. 1 + col. 2))	
			-l C	1.00	2.00	3.00	
	C+: FEOA -6 +b- ACA D V FTF D V			- INIC DOCA VA	ar is vour cost	reporting	I
	Section 5504 of the ACA Base Year FTE Residents in N			- IIII 3 Dase ye	, J.,	3	
1. 00	period that begins on or after July 1, 2009 and before Enter in column 1, if line 63 is yes, or your faciling in the base year period, the number of unweighted no resident FTEs attributable to rotations occurring in settings. Enter in column 2 the number of unweighter resident FTEs that trained in your hospital. Enter in column 2 the number of unweighter has been settings.	ore June ty trai on-prima a all no ed non-p n colum	e 30, 2010. ned residents ry care nprovider rimary care n 3 the ratio	0. (_,		64
1. 00	period that begins on or after July 1, 2009 and befor Enter in column 1, if line 63 is yes, or your facili in the base year period, the number of unweighted no resident FTEs attributable to rotations occurring in settings. Enter in column 2 the number of unweighte	ty trai on-prima all no d non-p n colum	e 30, 2010. ned residents ry care nprovider rimary care n 3 the ratio		_,		64

2. 00

4. 00

1. 00

Health Financial Systems UNION HOSPITAL, INC. In Lieu of Form CMS-2552-10 HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA Provider CCN: 15-0023 Peri od: Worksheet S-2 From 01/01/2017 Part I 12/31/2017 Date/Time Prepared: 5/30/2018 2:18 pm Program Name Program Code Unwei ghted Unwei ghted Ratio (col. FTĔs FTEs in 3/ (col. 3 + col. 4)) Nonprovi der Hospi tal Si te 1.00 2.00 3.00 4.00 5.00 65.00 Enter in column 1, if line 63 is yes, or your facility 0. 043230 65. 00 UH FAMILY MEDICINE 1201711131 0. 91 20. 14 RESI DENCY trained residents in the base year period, the program name associated with primary care FTEs for each primary care program in which you trained residents. Enter in column 2, the program code. Enter in column 3, the number of unweighted primary care FTE residents attributable to rotations occurring in all non-provider settings. Enter in column 4, the number of unweighted primary care resident FTEs that trained in your hospital. Enter in column 5, the ratio of (column 3 divided by (column 3 + column 4)). (see instructions) Unwei ghted Unwei ghted Ratio (col. 1/ (col . 1 + col . 2)) FTEs in FTFs Nonprovi der Hospi tal Si te 1.00 2. 00 3. 00 Section 5504 of the ACA Current Year FTE Residents in Nonprovider Settings--Effective for cost reporting periods beginning on or after July 1, 2010 Enter in column 1 the number of unweighted non-primary care resident 0.00 0.00 0.000000 66.00 FTEs attributable to rotations occurring in all nonprovider settings. Enter in column 2 the number of unweighted non-primary care resident FTEs that trained in your hospital. Enter in column 3 the ratio of (column 1 divided by (column 1 + column 2)). (see instructions) Program Name Program Code Unwei ghted Unwei ghted Ratio (col. FTĔs 3/ (col. 3 + FTEs in Nonprovi der col. 4)) Hospi tal Si te 1. 00 2.00 3. 00 4. 00 5.00 67.00 Enter in column 1, the program UH FAMILY MEDICINE 1201711131 2. 09 18. 99 0.099146 67.00 name associated with each of RESI DENCY your primary care programs in which you trained residents. Enter in column 2, the program code. Enter in column 3, the number of unweighted primary care FTE residents attributable to rotations occurring in all non-provider settings. Enter in column 4, the number of unweighted primary care resident FTEs that trained in your hospital. Enter in column 5, the ratio of (column 3 divided by (column 3 + column 4)). (see instructions)

	1.00	2.00	3. 00	
Inpatient Psychiatric Facility PPS				
70.00 Is this facility an Inpatient Psychiatric Facility (IPF), or does it contain an IPF subprovider?	N			70.00
Enter "Y" for yes or "N" for no.				
71.00 If line 70 is yes: Column 1: Did the facility have an approved GME teaching program in the most			0	71.00
recent cost report filed on or before November 15, 2004? Enter "Y" for yes or "N" for no. (see				
42 CFR 412.424(d)(1)(iii)(c)) Column 2: Did this facility train residents in a new teaching				
program in accordance with 42 CFR 412.424 (d)(1)(iii)(D)? Enter "Y" for yes or "N" for no.				
Column 3: If column 2 is Y, indicate which program year began during this cost reporting period.				
(see instructions)				
Inpatient Rehabilitation Facility PPS				
75.00 Is this facility an Inpatient Rehabilitation Facility (IRF), or does it contain an IRF	Υ			75.00
subprovi der? Enter "Y" for yes and "N" for no.				

SPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA Provid	der CCN: 15-0023	Peri od:	Worksheet S	S-2552 S-2
3 7 1 1 2 1 1 3 1 1 3 1 1 2 1 1 1 1 1 1 1 1		From 01/01/2017 To 12/31/2017	Part I	Prepare
·		1.0		
.00 If line 75 is yes: Column 1: Did the facility have an approved GME t	eaching program i	n the most Y		_
recent cost reporting period ending on or before November 15, 2004? no. Column 2: Did this facility train residents in a new teaching pr CFR 412.424 (d)(1)(iii)(D)? Enter "Y" for yes or "N" for no. Column indicate which program year began during this cost reporting period.	Enter "Y" for yes ogram in accordan 3: If column 2 is	or "N" for ce with 42 Y,		,,,,
			1. 00	
Long Term Care Hospital PPS .00 Is this a long term care hospital (LTCH)? Enter "Y" for yes and "N"	for no		N	80.
.00 Is this a LTCH co-located within another hospital for part or all of "Y" for yes and "N" for no. TEFRA Providers		ng period? Enter		81.
.00 Is this a new hospital under 42 CFR Section §413.40(f)(1)(i) TEFRA? .00 Did this facility establish a new Other subprovider (excluded unit)			N	85. 86.
\$413.40(f)(1)(ii)? Enter "Y" for yes and "N" for no. 1s this hospital an extended neoplastic disease care hospital classi 1886(d)(1)(B)(vi)? Enter "Y" for yes or "N" for no.	fied under sectio	n	N	87.
[1000(d)/(1/(d)/(1/) = 1/00 1/00		V 1. 00	XI X 2. 00	
Title V and XIX Services				
.00 Does this facility have title V and/or XIX inpatient hospital service yes or "N" for no in the applicable column.			Y	90.
.00 Is this hospital reimbursed for title V and/or XIX through the cost full or in part? Enter "Y" for yes or "N" for no in the applicable of	olumn.	N	N N	91
ON Are title XIX NF patients occupying title XVIII SNF beds (dual certinstructions) Enter "Y" for yes or "N" for no in the applicable column.	mn.		N	92
OO Does this facility operate an ICF/IID facility for purposes of title "Y" for yes or "N" for no in the applicable column.			N	93
00 Does title V or XIX reduce capital cost? Enter "Y" for yes, and "N" applicable column.		N	N	94
00 If line 94 is "Y", enter the reduction percentage in the applicable 00 Does title V or XIX reduce operating cost? Enter "Y" for yes or "N" applicable column.		0. 00 N	0. 00 N	95 96
00 If line 96 is "Y", enter the reduction percentage in the applicable 00 Does title V or XIX follow Medicare (title XVIII) for the interns ar stepdown adjustments on Wkst. B, Pt. I, col. 25? Enter "Y" for yes column 1 for title V, and in column 2 for title XIX.	d residents post	0. 00 Y	0. 00 Y	97 98
O1 Does title V or XIX follow Medicare (title XVIII) for the reporting C, Pt. I? Enter "Y" for yes or "N" for no in column 1 for title V, a title XIX.			Y	98
O2 Does title V or XIX follow Medicare (title XVIII) for the calculation bed costs on Wkst. D-1, Pt. IV, line 89? Enter "Y" for yes or "N" for title V, and in column 2 for title XIX.		Y	Y	98
O3 Does title V or XIX follow Medicare (title XVIII) for a critical accreimbursed 101% of inpatient services cost? Enter "Y" for yes or "N" for title V, and in column 2 for title XIX.			N	98
O4 Does title V or XIX follow Medicare (title XVIII) for a CAH reimburs outpatient services cost? Enter "Y" for yes or "N" for no in column in column 2 for title XIX.		d N	N	98
05 Does title V or XIX follow Medicare (title XVIII) and add back the R Wkst. C, Pt. I, col. 4? Enter "Y" for yes or "N" for no in column 1 column 2 for title XIX.			Y	98
06 Does title V or XIX follow Medicare (title XVIII) when cost reimburs Pts. I through IV? Enter "Y" for yes or "N" for no in column 1 for t column 2 for title XIX. Rural Providers		Y	Y	98
5.00 Does this hospital qualify as a CAH?		N		105
o.00 on the statility qualifies as a CAH, has it elected the all-inclusive for outpatient services? (see instructions)	re method of payme	nt N		106
.00 If this facility qualifies as a CAH, is it eligible for cost reimbur training programs? Enter "Y" for yes or "N" for no in column 1. (see yes, the GME elimination is not made on Wkst. B, Pt. I, col. 25 and	instructions) If			107
reimbursed. If yes complete Wkst. D-2, Pt. II. 3.00 s this a rural hospital qualifying for an exception to the CRNA fee	schedule? See 4	2 N		108

Health Financial Systems UNION HOSPITAL, INC. In Lieu of Form CMS-2552-10 HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA Provi der CCN: 15-0023 Peri od: Worksheet S-2 From 01/01/2017 Part I Date/Time Prepared: 12/31/2017 5/30/2018 2:18 pm Physi cal Occupati onal Speech Respi ratory 1. 00 2. 00 3. 00 4. 00 109.00 If this hospital qualifies as a CAH or a cost provider, are Ν Ν Ν Ν 109.00 therapy services provided by outside supplier? Enter for yes or "N" for no for each therapy. 1.00 110.00 Did this hospital participate in the Rural Community Hospital Demonstration project (§410A Demonstration) for the current cost reporting period? Enter "Y" for yes or "N" for no. If yes 110 00 N complete Worksheet E, Part A, lines 200 through 218, and Worksheet E-2, lines 200 through 215, as appl i cabl e. 1.00 2.00 111.00|f this facility qualifies as a CAH, did it participate in the Frontier Community Ν 111.00 Health Integration Project (FCHIP) demonstration for this cost reporting period? Enter Y" for yes or "N" for no in column 1. If the response to column 1 is Y, enter the integration prong of the FCHIP demo in which this CAH is participating in column 2. Enter all that apply: "A" for Ambulance services; "B" for additional beds; and/or "C" for tele-health services. 1.00 2.00 3.00 Miscellaneous Cost Reporting Information 115.00|Is this an all-inclusive rate provider? Enter "Y" for yes or "N" for no in column 1. If column 1 Ν 0 115.00 is yes, enter the method used (A, B, or E only) in column 2. If column 2 is "E", enter in column 3 either "93" percent for short term hospital or "98" percent for long term care (includes psychiatric, rehabilitation and long term hospitals providers) based on the definition in CMS Pub. 15-1, chapter 22, §2208.1. 116.00 s this facility classified as a referral center? Enter "Y" for yes or "N" for no. 116.00 117.00|s this facility legally-required to carry malpractice insurance? Enter "Y" for yes or "N" for Υ 117.00 no. 118.00 118.00 s the malpractice insurance a claims-made or occurrence policy? Enter 1 if the policy is claim-made. Enter 2 if the policy is occurrence. Premi ums Losses Insurance 1. 00 2.00 3.00 0118.01 118.01 List amounts of mal practice premiums and paid losses: 928, 586 1. 00 2.00 118.02 Are mal practice premiums and paid losses reported in a cost center other than the 118. 02 Ν Administrative and General? If yes, submit supporting schedule listing cost centers and amounts contained therein. 119.00 DO NOT USE THIS LINE 119 00 120.00|s this a SCH or EACH that qualifies for the Outpatient Hold Harmless provision in ACA Ν Ν 120.00 §3121 and applicable amendments? (see instructions) Enter in column 1, "Y" for yes or 'N" for no. Is this a rural hospital with < 100 beds that qualifies for the Outpatient Hold Harmless provision in ACA §3121 and applicable amendments? (see instructions) Enter in column 2, "Y" for yes or "N" for no. 121.00|Did this facility incur and report costs for high cost implantable devices charged to 121.00 patients? Enter "Y" for yes or "N" for no. 122.00 Does the cost report contain healthcare related taxes as defined in §1903(w)(3) of the Ν 122.00 Act?Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y", enter in column 2 the Worksheet A line number where these taxes are included. Transplant Center Information 125.00 Does this facility operate a transplant center? Enter "Y" for yes and "N" for no. If Ν 125.00 yes, enter certification date(s) (mm/dd/yyyy) below. 126.00 of this is a Medicare certified kidney transplant center, enter the certification date 126.00 in column 1 and termination date, if applicable, in column 2. 127.00|If this is a Medicare certified heart transplant center, enter the certification date 127.00 in column 1 and termination date, if applicable, in column 2. 128.00 of this is a Medicare certified liver transplant center, enter the certification date 128.00 in column 1 and termination date, if applicable, in column 2. 129.00|If this is a Medicare certified lung transplant center, enter the certification date in 129, 00 column 1 and termination date, if applicable, in column 2. 130.00 If this is a Medicare certified pancreas transplant center, enter the certification 130.00 date in column 1 and termination date, if applicable, in column 2. 131.00 If this is a Medicare certified intestinal transplant center, enter the certification 131.00 date in column 1 and termination date, if applicable, in column 2. 132.00 If this is a Medicare certified islet transplant center, enter the certification date 132.00 in column 1 and termination date, if applicable, in column 2. 133.00 If this is a Medicare certified other transplant center, enter the certification date 133.00 in column 1 and termination date, if applicable, in column 2. 134.00 of this is an organ procurement organization (OPO), enter the OPO number in column 1 134 00 and termination date, if applicable, in column 2. All Providers

	X IDENTIFICATION DA	ATA	Provi der CCI	N: 15-0023	From C	: 1/01/2017 2/31/2017	Worksheet S- Part I Date/Time Pr 5/30/2018 2:	epared:
						1. 00	2. 00	_
40.00 Are there any related organization chapter 10? Enter "Y" for yes or " are claimed, enter in column 2 the	N" for no in column	n 1. If ye	es, and home	office co		Y	15H043	140. 00
1.00		2. 00				3. 00		
If this facility is part of a chai office and enter the home office c 41.00 Name: UNION HOSPITAL, INC.		contract Name: WISCO	or number. DNSIN PHYSICI					141.00
42.00 Street: 1606 NORTH SEVENTH ST 43.00 Ci ty: TERRE HAUTE	PO Box: State:	SERVI I N	CES	Zi p Co	ode:	4780	4	142. 00 143. 00
•							1.00	
44.00 Are provider based physicians' cos	ts included in Worl	ksheet A?					1. 00 Y	144.0
45.00 of costs for renal services are clinpatient services only? Enter "Y" no, does the dialysis facility inc	for yes or "N" for Lude Medicare utili	r no in co ization fo	olumn 1. If o	column 1 i		1.00	2. 00	145. 00
period? Enter "Y" for yes or "N" 46.00Has the cost allocation methodolog Enter "Y" for yes or "N" for no in yes, enter the approval date (mm/d	y changed from the column 1. (See CM:	previ ousl S Pub. 15			lf	N		146. 00
							1. 00	
47.00 Was there a change in the statisti							N	147.0
48.00 Was there a change in the order of 49.00 Was there a change to the simplifi					for no.		N N	148. C
The second secon			Part A	Part E		itle V	Title XIX	
Does this facility contain a provi	der that qualifies	for an A	1.00	2.00	ication	3.00	4.00	
or charges? Enter "Y" for yes or "								
55.00 Hospi tal			N N	N N		N N	N	155. 0 156. 0
56.00 Subprovi der - IPF 57.00 Subprovi der - IRF 58.00 SUBPROVI DER			N I	N		N	N N	150. 0 157. 0 158. 0
59. 00 SNF			N	N		N	N	159. 0
60.00HOME HEALTH AGENCY 61.00CMHC			N	N N		N N	N N	160. C
61. 00 CMITC				IN		IV	IV	161.0
Mul +i compue							1. 00	
Multicampus	mpus hospital that	has one o	or more campu	uses in di	fferent (BSAs?	N	165. 0
65.00 Is this hospital part of a Multica Enter "Y" for yes or "N" for no.							ETE (O	
	Name		County		Zip Code	CBSA	FTE/Campus	
65.00 Is this hospital part of a Multica 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)	Name O		County 1.00		Zi p Code 3.00	CBSA 4. 00	5. 00	00 166. 0
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)	0		1.00	2.00	3.00	_	5. 00	00 166. C
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) Health Information Technology (HIT 67.00 Is this provider a meaningful user	0) incentive in the under §1886(n)? I 5 is "Y") and is a	· American Enter "Y" meaningfi	Recovery and for yes or "ul user (line	d Rei nvest	3.00	4.00	5. 00	167. 0
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) Health Information Technology (HIT 67.00 Is this provider a meaningful user 68.00 If this provider is a CAH (line 10 reasonable cost incurred for the H 68.01 If this provider is a CAH and is n exception under §413.70(a)(6)(ii)? 69.00 If this provider is a meaningful user	0 incentive in the under §1886(n)? Is "Y") and is a IT assets (see insot a meaningful use Enter "Y" for yes ser (line 167 is "	American Enter "Y" meaningfu tructions er, does or "N" fo	Recovery and for yes or "ul user (line) this provider or no. (see i	d Reinvest "N" for no e 167 is " qualify nstructio	3.00 3.00 ment Act . Y"), ente	4.00	5. 00 0. (167. 0 0168. 0 168. 0
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) Health Information Technology (HIT 67.00 Is this provider a meaningful user 68.00 If this provider is a CAH (line 10 reasonable cost incurred for the H If this provider is a CAH and is n exception under §413.70(a)(6)(ii)?	0 incentive in the under §1886(n)? Is "Y") and is a IT assets (see insot a meaningful use Enter "Y" for yes ser (line 167 is "	American Enter "Y" meaningfu tructions er, does or "N" fo	Recovery and for yes or "ul user (line) this provider or no. (see i	d Reinvest "N" for no e 167 is " qualify nstructio	3.00 a. 00 a. 00 y"), entering for a harring is "N"),	4.00	5. 00 0. (167. 0 0168. 0 168. 0 168. 0

Health Financial Systems UNION HO							MS-2552-10
HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA	Peri od:	Worksheet	S-2				
					From 01/01/2017 o 12/31/2017		
					1. 00	2. 00	
171.00 If line 167 is "Y", does this provider have any days for					N		0 171. 00
section 1876 Medicare cost plans reported on Wkst. S-3, Pt. I, line 2, col. 6? Enter							
"Y" for yes and "N" for no in column 1. If column 1 is yes, enter the number of section 1876 Medicare days in column 2. (see instructions)							

Heal th	Financial Systems UNION HOSPI	TAL. INC.		In Lie	u of Form CMS-	2552-10
	AL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE	Provi der C		Peri od:	Worksheet S-2	
				rom 01/01/2017 o 12/31/2017		epared:
				V/ /NI	5/30/2018 2:1	18 pm
				Y/N 1. 00	2. 00	
	General Instruction: Enter Y for all YES responses. Enter	N for all NO re	esponses. Ente			
	mm/dd/yyyy format.		<u> </u>			
	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		1.00
	reporting period? If yes, enter the date of the change in					
			Y/N	Date	V/I	
2. 00	Has the provider terminated participation in the Medicare	Program? If	1. 00 N	2. 00	3. 00	2.00
2.00	yes, enter in column 2 the date of termination and in colu					2.00
	voluntary or "I" for involuntary.					
3. 00	Is the provider involved in business transactions, includi contracts, with individuals or entities (e.g., chain home		Y			3. 00
	or medical supply companies) that are related to the provi					
	officers, medical staff, management personnel, or members	of the board				
	of directors through ownership, control, or family and oth	er similar				
	relationships? (see instructions)		Y/N	Type	Date	
			1. 00	2. 00	3. 00	
	Financial Data and Reports				I	
4. 00	Column 1: Were the financial statements prepared by a Cer Accountant? Column 2: If yes, enter "A" for Audited, "C"		Y	Α		4.00
	or "R" for Reviewed. Submit complete copy or enter date av	ailable in				
	column 3. (see instructions) If no, see instructions.					
5. 00	Are the cost report total expenses and total revenues diff		N			5. 00
	those on the filed financial statements? If yes, submit re	CONCITTATION.		Y/N	Legal Oper.	
				1. 00	2. 00	
,	Approved Educational Activities				Г	
6. 00	Column 1: Are costs claimed for nursing school? Column 2: the legal operator of the program?	If yes, is the	he provider is	N		6. 00
7. 00	Are costs claimed for Allied Health Programs? If "Y" see i	nstructi ons.		Υ		7.00
8. 00	Were nursing school and/or allied health programs approved	and/or renewed	d during the	N		8. 00
9. 00	cost reporting period? If yes, see instructions. Are costs claimed for Interns and Residents in an approved	araduato modi	cal oducation	Y		9.00
7. 00	program in the current cost report? If yes, see instruction		car education	'		7.00
10.00	Was an approved Intern and Resident GME program initiated		the current	N		10.00
11. 00	cost reporting period? If yes, see instructions. Are GME cost directly assigned to cost centers other than	I º Din on An	proved	N		11.00
11.00	Teaching Program on Worksheet A? If yes, see instructions.		pi oved	IN		11.00
					Y/N	
	D. J. D. L. L.				1. 00	
12 00	Bad Debts Is the provider seeking reimbursement for bad debts? If ye	s see instruc	tions		Y	12.00
	If line 12 is yes, did the provider's bad debt collection			st reporting	N	13.00
	period? If yes, submit copy.					
14.00	If line 12 is yes, were patient deductibles and/or co-paym Bed Complement	ents waived? I	f yes, see ins	tructi ons.	N N	14. 00
15. 00	Did total beds available change from the prior cost report	ing period? If	yes, see inst	ructions.	Y	15. 00
			t A		t B	
		Y/N 1,00	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?	Y	04/04/2018	Υ	04/04/2018	16.00
	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 instructions)					
17. 00	Was the cost report prepared using the PS&R Report for	N		N		17.00
	totals and the provider's records for allocation? If					
	either column 1 or 3 is yes, enter the paid-through date					
18. 00	in columns 2 and 4. (see instructions) If line 16 or 17 is yes, were adjustments made to PS&R	N		N		18. 00
	Report data for additional claims that have been billed	.,		.,		.5.55
	but are not included on the PS&R Report used to file this					
19. 00	cost report? If yes, see instructions.	N		N		19.00
19.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for corrections of other PS&R Report	IN IN		N		19.00
	information? If yes, see instructions.					

Property	Health Financial Systems UNION HOSP				u of Form CM				
20.00 If line 16 or 17 is yes, were adjustments made to PSSR 0 1,00 3,00	HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE	Provi der C	CN: 15-0023		Part II Date/Time P	repared			
Report data for Other? Describe the other adjustments:		Descri	pti on	Y/N					
Report data for Other? Describe the other adjustments: V/N Date Y/N Date DATE Y/N Date Y/N Date Y/N Date DATE Y/N Date DATE Y/N Date DATE Y/N Date DATE Y/N		()	1. 00	3. 00				
21.00 Was the cost report prepared only using the provider's 1.00 2.00 3.00 4.00				N	N	20.0			
Was the cost report prepared only using the provider's records? If yes, see instructions. 1.00	noper c data for other book to the other daj dotmente.								
COMPLETED BY COST REIMBURSED AND TEFRA HOSPITALS ONLY (EXCEPT CHILDRENS HOSPITALS) Capital Related Cost 1.00 Completed By Cost Relimbursed And Tefra Hospitals Only (Except Childrens Hospitals) 2.00 Have changes occurred in the Medicare purposes? If yes, see instructions N N N N N N N N N N N N N	21.00 Was the cost report propared only using the provider's		2.00		4.00	21.0			
COMPLETED BY COST RELIMBURSED AND TERRA HOSPITALS ONLY (EXCEPT CHILDRENS HOSPITALS) Capital Related Cost Capital Related Cost Capital Related Cost Allow assets been relifed for Medicare purposes? If yes, see instructions 3.0 blave changes occurred in the Medicare depreciation expense due to appraisals made during the cost reporting period? If yes, see instructions. 14.00 Were new leases and/or amendments to existing leases entered into during this cost reporting period? If yes, see No. 16.00 lave there been new capital ized leases entered into during the cost reporting period? If yes, see No. 16.00 lave there been new capital ized leases entered into during the cost reporting period? If yes, see No. 16.00 lave there been new capital ized leases entered into during the cost reporting period? If yes, see No. 16.00 lave there been new capital ized leases entered into during the cost reporting period? If yes, see No. 16.00 lave there been new capital ized leases entered into during the cost reporting period? If yes, see No. 16.00 lase the provider's capitalization policy changed during the cost reporting period? If yes, see No. 16.00 lease the provider have a funded depreciation account? If yes, see instructions instructions in the provider have a funded depreciation account? If yes, see instructions No. 16.00 lase sets ting debt been replaced prior to its scheduled maturity with new debt? If yes, see No. 16.00 lase sets ting debt been replaced prior to its scheduled maturity with new debt? If yes, see No. 16.00 lase sets ting debt been replaced prior to its scheduled maturity with new debt? If yes, see No. 16.00 lase sets ting debt been replaced prior to its scheduled maturity with new debt? If yes, see No. 16.00 lase sets ting debt been replaced prior to its scheduled maturity with new debt? If yes, see No. 16.00 lase sets ting debt been replaced prior to its scheduled maturity with new debt? If yes, see No. 16.00 lase sets ting been replaced prior to its scheduled maturity with new debt? If yes, see No. 16.00 l		IN .		IN .		21.0			
2.00 Have assets been relifed for Medicare purposes? If yes, see instructions 3.30 Have changes occurred in the Medicare depreciation expense due to appraisals made during the cost reporting period? If yes, see instructions 4.00 Were new Leases and/or amendments to existing Leases entered into during this cost reporting period? If yes, see instructions 5.00 Have there been new capitalized leases entered into during the cost reporting period? If yes, see instructions 6.00 Were assets subject to Sec. 2314 of DEFRA acquired during the cost reporting period? If yes, see Instructions 6.00 Were assets subject to Sec. 2314 of DEFRA acquired during the cost reporting period? If yes, see Instructions 6.00 Were assets subject to Sec. 2314 of DEFRA acquired during the cost reporting period? If yes, see Instructions 6.00 Were new Loans, mortgage agreements or letters of credit entered into during the cost reporting period? If yes, see instructions 6.00 Were new Loans, mortgage agreements or letters of credit entered into during the cost reporting period? If yes, see instructions 6.00 Were new Loans, mortgage agreements or letters of credit entered into during the cost reporting period? If yes, see instructions 6.00 Were new Loans, mortgage agreements or letters of credit entered into during the cost reporting period? If yes, see instructions 6.00 Were new Loans, mortgage agreements or letters of credit entered into during the cost reporting period? If yes, see instructions 6.00 Were new Loans, mortgage agreements or letters of credit entered into during the cost reporting period? If yes, see Instructions 6.00 Were new Loans, mortgage agreements occurred in patient care services furnished through contractual arrangements with suppliers of services? If yes, see instructions 6.00 Were honges or new agreements occurred in patient care services furnished through contractual arrangements with suppliers of services? If yes, see instructions 6.00 Were home office were the requirements of Sec. 2135. 2 applied pertaining to competit					1.00				
12.00 Nave assets been relifed for Medicare purposes? If yes, see instructions N		CEPT CHILDRENS I	HOSPI TALS)						
Name changes occurred in the Medicare depreciation expense due to appraisals made during the cost reporting period? If yes, see instructions Name changes occurred in the Medicare depreciation expense due to appraisals made during the cost reporting period? If yes, see instructions Name changes occurred in the Medicare depreciation during the cost reporting period? If yes, see instructions. Name changes occurred in the cost reporting period? If yes, see instructions. Name changes occurred in the cost reporting period? If yes, see instructions. Name changes occurred in the cost reporting period? If yes, submit components are considered as a funded depreciation account and/or bond funds (Debt Service Reserve Fund) treated as a funded depreciation account? If yes, see instructions Name changes or new agreements occurred in patient care services furnished through contractual arrangements with suppliers of services? If yes, see instructions. Name changes or new agreements occurred in patient care services furnished through contractual arrangements with suppliers of services? If yes, see instructions. Name changes or new agreements occurred in patient care services furnished through contractual arrangements with suppliers of services? If yes, see instructions. Name changes or new agreements occurred in patient care services furnished through contractual arrangements with suppliers of services? If yes, see instructions. Name changes or new agreements occurred in patient care services furnished through contractual arrangements with suppliers of services? If yes, see instructions. Name changes or new agreements occurred in patient care services furnished through contractual arrangements with suppliers of services? If yes, see instructions. Name changes or new agreements occurred in patient care services furnished through contractual arrangements with the provider-based physicians? Name changes or new agreements occurred in patient patients of the provider-based physicians? Name changes of th		!			N.				
Were new leases and/or amendments to existing leases entered into during this cost reporting period? N			sals made du	uring the cost	l	22. 0 23. 0			
If yes, see instructions N									
instructions. 8. 00 Were assets subject to Sec. 2314 of DEFRA acquired during the cost reporting period? If yes, see Instructions. 8. 01 Has the provider's capitalization policy changed during the cost reporting period? If yes, submit Noopy. 9. 02 Wore new loans, mortgage agreements or letters of credit entered into during the cost reporting Period? If yes, see Instructions. 9. 00 Did the provider have a funded depreciation account and/or bond funds (Debt Service Reserve Fund) Notate as a funded depreciation account? If yes, see Instructions. 10. 00 Has existing debt been replaced prior to lits scheduled maturity with new debt? If yes, see Notate	If yes, see instructions	9				24.0			
instructions. 7. 00 Has the provider's capitalization policy changed during the cost reporting period? If yes, submit copy. Interest Expense 8. 00 Were new loans, mortgage agreements or letters of credit entered into during the cost reporting period? If yes, see instructions. 9. 00 Did the provider have a funded depreciation account and/or bond funds (Debt Service Reserve Fund) treated as a funded depreciation account? If yes, see instructions. 10. 00 Has existing debt been replaced prior to its scheduled maturity with new debt? If yes, see N instructions. 11. 00 Have changes or new agreements occurred in patient care services furnished through contractual arrangements with suppliers of services? If yes, see instructions. 12. 00 Have changes or new agreements occurred in patient care services furnished through contractual arrangements with suppliers of services? If yes, see instructions. 13. 00 If line 32 is yes, were the requirements of Sec. 2135. 2 applied pertaining to competitive bidding? If no, see instructions. 14. 00 Are services furnished at the provider facility under an arrangement with provider-based physicians? 15. 00 If line 34 is yes, were there new agreements or amended existing agreements with the provider-based N physicians during the cost reporting period? If yes, see instructions. 16. 00 Were home office costs claimed on the cost report? 17. 00 If line 36 is yes, has a home office cost statement been prepared by the home office? 18. 00 If line 36 is yes, has a home office cost statement been prepared by the home office? 18. 00 If line 36 is yes, was the fiscal year end of the home office if yes, see instructions. 18. 00 If line 36 is yes, was the fiscal year end of the home office? 19. 00 If line 36 is yes, was the fiscal year end of the home office? If yes, see instructions. 19. 01 If line 36 is yes, did the provider render services to other chain components? If yes, see instructions. 19. 02 If line 36 is yes, did the provider render services to other chain components? If y	'	g the cost repo	rting period	d? IT yes, see	IN IN	25.0			
Name	, ,	the cost report	ng period?	If yes, see	N	26.0			
Interest Expense 8.00 Were new Loans, mortgage agreements or letters of credit entered into during the cost reporting N period? If yes, see instructions N period? If yes, see instructions N treated as a funded depreciation account? If yes, see instructions N treated as a funded depreciation account? If yes, see instructions N treated as a funded depreciation account? If yes, see instructions N last existing debt been replaced prior to its scheduled maturity with new debt? If yes, see N Instructions N last debt been recalled before scheduled maturity without issuance of new debt? If yes, see N Instructions N Purchased Services N Instructions N Purchased Services N N Purchased Services N Purchased Services N Purchased Services N N Purchased N Purchased Services N Purchased Services N N Purchased Services N N Purchased Services N N Purchased Services N Pu	7.00 Has the provider's capitalization policy changed during the	ne cost reporti	ng period? I	f yes, submit	N	27. C			
period? If yes, see instructions. 9.00 Did the provider have a funded depreciation account and/or bond funds (Debt Service Reserve Fund) treated as a funded depreciation account? If yes, see instructions 9.00 Has existing debt been replaced prior to its scheduled maturity with new debt? If yes, see	Interest Expense								
Did the provider have a funded depreciation account and/or bond funds (Debt Service Reserve Fund) treated as a funded depreciation account? If yes, see instructions.		entered into du	ring the cos	st reporting	N	28.0			
Name	9.00 Did the provider have a funded depreciation account and/or		ebt Service	Reserve Fund)	N	29. 0			
Has debt been recalled before scheduled maturity without issuance of new debt? If yes, see instructions.	0.00 Has existing debt been replaced prior to its scheduled mat		debt? If ye	es, see	N	30.0			
Purchased Services Have changes or new agreements occurred in patient care services furnished through contractual arrangements with suppliers of services? If yes, see instructions. 3.00 If line 32 is yes, were the requirements of Sec. 2135.2 applied pertaining to competitive bidding? If Nono, see instructions. Provider-Based Physicians 4.00 Are services furnished at the provider facility under an arrangement with provider-based physicians? If yes, see instructions. 5.00 If line 34 is yes, were there new agreements or amended existing agreements with the provider-based physicians during the cost reporting period? If yes, see instructions. Y/N Date 1.00 2.00 Home Office Costs 6.00 Were home office costs claimed on the cost report? 7.00 If line 36 is yes, has a home office cost statement been prepared by the home office? Yelfyes, see instructions. 8.00 If line 36 is yes, was the fiscal year end of the home office different from that of the provider? If yes, enter in column 2 the fiscal year end of the home office. 9.00 If line 36 is yes, did the provider render services to other chain components? If yes, see instructions. 1.00 2.00 Cost Report Preparer Contact Information 1.00 LANDON HACKETT held by the cost report preparer in columns 1, 2, and 3, respectively. Enter the employer/company name of the cost report preparer. BLUE & CO., LLC	1.00 Has debt been recalled before scheduled maturity without i	ssuance of new	debt? If ye	es, see	N	31. (
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Health Fin	nancial Systems	UNI ON HOSPI	TAL, INC.		In Lieu of Form CMS-2552-10			
HOSPI TAL A	AND HOSPITAL HEALTH CARE REIMBURSEMENT	QUESTI ONNAI RE	Provi der	CCN: 15-0023	Peri od: From 01/01/2017	Worksheet S-2 Part II	!	
						Date/Time Pre	pared:	
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| Peri od: | Worksheet S-3 | From 01/01/2017 | Part | To 12/31/2017 | Date/Time Prepared: Heal th Fi nancial SystemsUNIONHOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA Provi der CCN: 15-0023

Component Worksheet A No. of Beds Red Days Available No. of Beds Red Days Available No. of Beds Red Days Title V No. of Beds Red Days Red						1	o 12/31/2017	Date/Time Pre 5/30/2018 2:1	
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32.00 Labor & delivery days (see instructions) 32.01 Total ancillary labor & delivery room outpatient days (see instructions) 33.00 LTCH non-covered days 32.00 0 0 0 32.01 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	30.00	Employee discount days (see instruction)							30.00
32.01 Total ancillary labor & delivery room outpatient days (see instructions) 33.00 LTCH non-covered days 32.01	31.00	Employee discount days - IRF						1	31.00
outpati ent days (see i nstructions) 33.00 LTCH non-covered days 33.00	32.00				0)		32.00
33.00 LTCH non-covered days 33.00	32. 01	Total ancillary labor & delivery room							32. 01
		outpatient days (see instructions)							
33.01 LTCH site neutral days and discharges									
	33. 01	LTCH site neutral days and discharges						1	33. 01

| Peri od: | Worksheet S-3 | From 01/01/2017 | Part I | To 12/31/2017 | Date/Time Prepared: Provider CCN: 15-0023

				1	0 12/31/2017	5/30/2018 2:1	
		I/P Davs	/ O/P Visits	/ Tri ps	Full Time I	Equi val ents	J Pill
			, ,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,				
	Component	Title XVIII	Title XIX	Total All	Total Interns	Employees On	
	·			Pati ents	& Residents	Payrol I	
		6. 00	7. 00	8. 00	9. 00	10.00	
1.00	Hospital Adults & Peds. (columns 5, 6, 7 and	24, 848	1, 027	49, 041			1.00
	8 exclude Swing Bed, Observation Bed and						
	Hospice days)(see instructions for col. 2						
	for the portion of LDP room available beds)						
2.00	HMO and other (see instructions)	3, 706	13, 439				2. 00
3. 00	HMO IPF Subprovider	0	0	l			3. 00
4. 00	HMO IRF Subprovider	0	540				4. 00
5. 00	Hospital Adults & Peds. Swing Bed SNF	0	0				5. 00
6. 00	Hospital Adults & Peds. Swing Bed NF		0	_			6. 00
7. 00	Total Adults and Peds. (exclude observation	24, 848	1, 027	49, 041			7. 00
	beds) (see instructions)		_				
8. 00	I NTENSI VE CARE UNIT	4, 297	0	7, 320			8. 00
9.00	CORONARY CARE UNIT						9.00
10.00	BURN INTENSIVE CARE UNIT						10.00
11.00	SURGICAL INTENSIVE CARE UNIT						11.00
12.00	I NTENSI VE NURSERY	0	0				12.00
13.00	NURSERY	00 445	0	0, 1,,	04.04	4 450 00	13.00
14.00	Total (see instructions)	29, 145	1, 027		21. 04	1, 450. 00	
15.00	CAH visits	O	0	0			15.00
16.00	SUBPROVI DER - I PF	0.404		0 400	0.00	40.00	16.00
17.00	SUBPROVI DER - I RF	2, 194	0	3, 432	0. 00	18. 06	1
18.00	SUBPROVI DER						18.00
19.00	SKILLED NURSING FACILITY						19.00
20.00	NURSING FACILITY						20. 00 21. 00
21.00	OTHER LONG TERM CARE						21.00
22. 00 23. 00	HOME HEALTH AGENCY						23.00
	AMBULATORY SURGICAL CENTER (D. P.)						
24. 00 24. 10	HOSPICE HOSPICE (non-distinct part)	0	0	162			24. 00 24. 10
25. 00	CMHC - CMHC	۷	U	102			25. 00
26. 00	RURAL HEALTH CLINIC						26.00
26. 25	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0. 00	0.00	
27. 00	Total (sum of lines 14-26)	o o	U	0	21. 04		
28. 00	Observation Bed Days		0	9, 706		1, 400.00	28.00
29. 00	Ambulance Trips	0	O	7, 700			29.00
30. 00	Employee discount days (see instruction)	ď		0			30.00
31. 00	Employee discount days (see Fristraction)			0			31.00
32. 00	Labor & delivery days (see instructions)	0	94				32.00
32. 01	Total ancillary labor & delivery room	Ĭ	74	249			32. 01
32.01	outpatient days (see instructions)						32.01
33. 00	LTCH non-covered days	o					33.00
	LTCH site neutral days and discharges	O					33. 01
	, ,	-1		•	1	•	

Provider CCN: 15-0023

				10) 12/31/201/	Date/IIMe Pre 5/30/2018 2:1	
		Full Time		Di sch	arges		
		Equi val ents					
	Component	Nonpai d	Title V	Title XVIII	Title XIX	Total All	
		Workers	10.00	10.00	11.00	Pati ents	
1 00	Tu	11. 00	12. 00	13.00	14.00	15. 00	1.00
1. 00	Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and		0	6, 653	187	16, 055	1. 00
	Hospice days) (see instructions for col. 2						
	for the portion of LDP room available beds)						
2. 00	HMO and other (see instructions)			721	3, 060		2.00
3. 00	HMO IPF Subprovi der			721	3, 000		3.00
4. 00	HMO IRF Subprovider				37		4.00
5. 00	Hospital Adults & Peds. Swing Bed SNF				0,		5. 00
6. 00	Hospital Adults & Peds. Swing Bed NF						6.00
7.00	Total Adults and Peds. (exclude observation						7. 00
	beds) (see instructions)						
8.00	INTENSIVE CARE UNIT						8.00
9.00	CORONARY CARE UNIT						9. 00
10.00	BURN INTENSIVE CARE UNIT						10.00
11. 00	SURGICAL INTENSIVE CARE UNIT						11. 00
12.00	I NTENSI VE NURSERY						12.00
13. 00	NURSERY						13.00
14. 00	Total (see instructions)	0.00	0	6, 653	187	16, 055	14.00
15.00	CAH visits						15.00
16.00	SUBPROVIDER - I PF	0.00	0	1/0	0	27/	16.00
17. 00 18. 00	SUBPROVI DER	0.00	0	169	0	276	17. 00 18. 00
19. 00	SKILLED NURSING FACILITY						19.00
20. 00	NURSING FACILITY						20.00
21. 00	OTHER LONG TERM CARE						21.00
22. 00	HOME HEALTH AGENCY						22. 00
23. 00	AMBULATORY SURGICAL CENTER (D. P.)						23. 00
24.00	HOSPI CE						24.00
24. 10	HOSPICE (non-distinct part)						24. 10
25.00	CMHC - CMHC						25.00
26.00	RURAL HEALTH CLINIC						26. 00
26. 25	FEDERALLY QUALIFIED HEALTH CENTER	0.00					26. 25
27. 00	Total (sum of lines 14-26)	0.00					27. 00
28. 00	Observation Bed Days						28. 00
29. 00	Ambul ance Tri ps						29. 00
30.00	Employee discount days (see instruction)						30.00
31.00	Employee discount days - IRF						31.00
32.00	Labor & delivery days (see instructions)						32.00
32. 01	Total ancillary labor & delivery room outpatient days (see instructions)						32. 01
33. 00	LTCH non-covered days			0			33. 00
	LTCH site neutral days and discharges			0			33. 01
55.51	1 = 1 = 1 = 1 = 1 = 1 = 1 = 1 = 1 = 1 =	ı I		١	1		30.01

Health Financial Systems
HOSPITAL WAGE INDEX INFORMATION Provi der CCN: 15-0023

						o 12/31/2017	Date/Time Pre 5/30/2018 2:1	
		Wkst. A Line Number	Amount Reported	Reclassificat ion of Salaries (from Wkst.	Adjusted Salaries (col.2 ± col. 3)	Paid Hours Related to Salaries in col. 4	Average Hourly Wage (col. 4 ÷ col. 5)	ο μιι
		1. 00	2. 00	A-6) 3. 00	4. 00	5. 00	6. 00	
	PART II - WAGE DATA SALARIES							
1.00	Total salaries (see	200. 00	92, 802, 566	0	92, 802, 566	3, 052, 723. 00	30. 40	1.00
2. 00	instructions) Non-physician anesthetist Part		0	o	C	0. 00	0. 00	2. 00
3. 00	Non-physician anesthetist Part		0	О	C	0.00	0.00	3. 00
4. 00	Physician-Part A - Administrative		0	О	C	0. 00	0. 00	4.00
4. 01 5. 00	Physicians - Part A - Teaching Physician and Non		831, 859 3, 343, 522		1			4. 01 5. 00
6. 00	Physician-Part B Non-physician-Part B for hospital-based RHC and FQHC		0	o	C	0. 00	0. 00	6. 00
7. 00	services Interns & residents (in an approved program)	21. 00	0	1, 312, 958	1, 312, 958	43, 680. 00	30. 06	7. 00
7. 01	Contracted interns and residents (in an approved		0	O	C	0. 00	0. 00	7. 01
8. 00	programs) Home office and/or related organization personnel		0	O	C	0.00	0. 00	8. 00
9. 00 10. 00	SNF Excluded area salaries (see instructions)	44. 00	0 14, 028, 230	-1, 989, 259	12, 038, 971	0. 00 216, 237. 00		
11. 00	OTHER WAGES & RELATED COSTS Contract labor: Direct Patient		7, 963, 398	0	7, 963, 398	146, 080. 00	54. 51	11.00
12. 00	Care Contract labor: Top level		0	0				12.00
	management and other management and administrative services							
13. 00	Contract Labor: Physician-Part A - Administrative		802, 101	O	802, 101	6, 878. 00	116. 62	13. 00
14. 00	Home office and/or related orgainzation salaries and wage-related costs		0	0	C	0.00	0.00	14.00
14. 01	Home office salaries		19, 615, 413	О	19, 615, 413	-		14. 01
14. 02 15. 00	Related organization salaries Home office: Physician Part A - Administrative		0	0) C			14. 02 15. 00
16. 00	Home office and Contract Physicians Part A - Teaching		0	0	C	0. 00	0. 00	16. 00
	WAGE-RELATED COSTS Wage-related costs (core) (see		28, 347, 042		28, 347, 042	•		17.00
18. 00	instructions) Wage-related costs (other)		0	0				18. 00
19. 00 20. 00	(see instructions) Excluded areas Non-physician anesthetist Part		3, 595, 858	0	3, 595, 858			19. 00 20. 00
21. 00	A Non-physician anesthetist Part		0	0)		21.00
22. 00	B Physician Part A -		0	0	C			22. 00
22. 01	Administrative Physician Part A - Teaching		237, 895	0	237, 895	j		22. 01
23.00			792, 966	0	792, 966			23.00
24. 00 25. 00	Wage-related costs (RHC/FQHC) Interns & residents (in an		0 483, 363		483, 363	3		24. 00 25. 00
25. 50	approved program) Home office wage-related		0	0				25. 50
25. 51	(core) Related organization		0	0	C			25. 51
25. 52	wage-related (core) Home office: Physician Part A - Administrative -		0	O	C)		25. 52
25. 53	wage-related (core) Home office & Contract Physicians Part A - Teaching -		0	0	C			25. 53
	wage-related (core)			l	I	I	l	l

Provider CCN: 15-0023

| Peri od: | Worksheet S-3 | From 01/01/2017 | Part II | To 12/31/2017 | Date/Time Prepared:

	5/30/2018 2:1	
Wkst. A Line Amount Reclassificat Adjusted Paid Hours	Average	
Number Reported ion of Salaries Related to	Hourly Wage	
Sal ari es (col. 2 ± col. Sal ari es in	(col. 4 ÷	
(from Wkst. 3) col. 4	col. 5)	
A-6)		
1.00 2.00 3.00 4.00 5.00	6. 00	
OVERHEAD COSTS - DI RECT SALARI ES		
26. 00 Employee Benefits Department 4. 00 238, 912 562, 064 800, 976 31, 264. 00	25. 62	26.00
27. 00 Administrative & General 5. 00 7, 323, 630 -462, 858 6, 860, 772 252, 754. 00	27. 14	27.00
28.00 Administrative & General under 1,939,656 0 1,939,656 27,287.00	71. 08	28.00
contract (see inst.)		
29. 00 Maintenance & Repairs 6. 00 0 0 0 0. 00	0. 00	29.00
30.00 Operation of Plant 7.00 1,766,493 0 1,766,493 67,540.00	26. 15	30.00
31.00 Laundry & Linen Service 8.00 641,428 0 641,428 41,152.00	15. 59	31.00
32. 00 Housekeepi ng 9. 00 1, 915, 963 0 1, 915, 963 141, 898. 00	13. 50	32.00
33.00 Housekeepi ng under contract 0 0 0 0 0.00	0. 00	33.00
(see instructions)		
34. 00 Di etary 10. 00 1, 850, 315 -1, 491, 631 358, 684 23, 320. 00	15. 38	34.00
35.00 Di etary under contract (see 0 0 0 0 0 0 0 0 0 0	0. 00	35.00
instructions)		
36. 00 Cafeteria 11. 00 114, 049 1, 484, 614 1, 598, 663 105, 155. 00		36.00
37. 00 Mai ntenance of Personnel 12. 00 0 0 0 0 0. 00		37.00
38.00 Nursing Administration 13.00 1,643,063 0 1,643,063 33,977.00	48. 36	38.00
39.00 Central Services and Supply 14.00 0 0 0 0 0.00	0. 00	39.00
40.00 Pharmacy 15.00 0 0 0 0.00	0. 00	40.00
41.00 Medical Records & Medical 16.00 1,884,409 0 1,884,409 84,041.00	22. 42	41.00
Records Li brary		
42. 00 Soci al Servi ce 17. 00 0 0 0 0. 00		42.00
43.00 Other General Service 18.00 0 0 0 0.00	0. 00	43.00

Health Financial Systems	UNION HOSPITAL, INC.	In Lieu of Form CMS-2552-10
HOSPITAL WAGE INDEX INFORMATION	Provi der CCN: 15-0023	Peri od: Worksheet S-3 From 01/01/2017 Part III To 12/31/2017 Date/Time Prepared:

					1	0 12/31/201/	5/30/2018 2:1	
		Worksheet A	Amount	Recl assi fi cat	Adjusted	Pai d Hours	Average	
		Line Number	Reported	ion of	Sal ari es	Related to	Hourly Wage	
			·	Sal ari es	(col.2 ± col.	Salaries in	(col. 4 ÷	
				(from	3)	col. 4	col. 5)	
				Worksheet				
				A-6)				
		1. 00	2. 00	3. 00	4. 00	5. 00	6. 00	
	PART III - HOSPITAL WAGE INDEX	SUMMARY						
1.00	Net salaries (see		90, 566, 841	-1, 312, 958	89, 253, 883	3, 009, 991. 00	29. 65	1.00
	instructions)							
2.00	Excluded area salaries (see		14, 028, 230	-1, 989, 259	12, 038, 971	216, 237. 00	55. 67	2.00
	instructions)							
3.00	Subtotal salaries (line 1		76, 538, 611	676, 301	77, 214, 912	2, 793, 754. 00	27. 64	3.00
	minus line 2)							
4.00	Subtotal other wages & related		28, 380, 912	0	28, 380, 912	571, 701. 00	49. 64	4.00
	costs (see inst.)							
5.00	Subtotal wage-related costs		28, 347, 042	0	28, 347, 042	0. 00	36. 71	5. 00
	(see inst.)							
6.00	Total (sum of lines 3 thru 5)		133, 266, 565	676, 301	133, 942, 866	3, 365, 455. 00	39. 80	6.00
7.00	Total overhead cost (see		19, 317, 918	92, 189	19, 410, 107	808, 388. 00	24. 01	7. 00
	instructions)							

Health Financial Systems	UNION HOSPITAL, INC.	In Lieu	u of Form CMS-2552-10
HOSPITAL WAGE RELATED COSTS	Provi der CCN: 15-0023	Peri od: From 01/01/2017	Worksheet S-3 Part IV
		To 12/21/2017	Dato/Timo Propared:

	To 12/31/201	17 Date/Time Pre 5/30/2018 2:1	
		Amount	
		Reported	
		1. 00	
	PART IV - WAGE RELATED COSTS		
	Part A - Core List		
	RETI REMENT COST		
1.00	401K Employer Contributions	2, 775, 963	1.00
2.00	Tax Sheltered Annuity (TSA) Employer Contribution	0	2.00
3.00	Nonqualified Defined Benefit Plan Cost (see instructions)	0	3.00
4.00	Qualified Defined Benefit Plan Cost (see instructions)	13, 931, 178	4.00
	PLAN ADMINISTRATIVE COSTS (Paid to External Organization)		
5.00	401K/TSA Plan Administration fees	0	5.00
6.00	Legal /Accounting/Management Fees-Pension Plan	0	6.00
7.00	Employee Managed Care Program Administration Fees	0	7.00
	HEALTH AND INSURANCE COST		
8.00	Health Insurance (Purchased or Self Funded)	10, 198, 196	8.00
8. 01	Health Insurance (Self Funded without a Third Party Administrator)	0	8. 01
8. 02	Health Insurance (Self Funded with a Third Party Administrator)	0	8. 02
8.03	Health Insurance (Purchased)	0	8. 03
9.00	Prescription Drug Plan	0	9.00
10.00	Dental, Hearing and Vision Plan	-618, 257	10.00
11.00	Life Insurance (If employee is owner or beneficiary)	46, 226	11.00
12.00	Accident Insurance (If employee is owner or beneficiary)	0	12.00
13.00	Disability Insurance (If employee is owner or beneficiary)	101, 673	13.00
14.00	Long-Term Care Insurance (If employee is owner or beneficiary)	0	14.00
15.00	'Workers' Compensation Insurance	244, 118	15.00
16.00	Retirement Health Care Cost (Only current year, not the extraordinary accrual required by FASB 106.	0	16.00
	Non cumulative portion)		
	TAXES		
17.00	FICA-Employers Portion Only	6, 506, 071	17.00
18.00	Medicare Taxes - Employers Portion Only	0	18.00
19.00	Unempl oyment Insurance	63, 386	19.00
20.00	State or Federal Unemployment Taxes	0	20.00
	OTHER		
21.00	Executive Deferred Compensation (Other Than Retirement Cost Reported on Lines 1 through 4 above. (s	ee 0	21.00
	instructions))		
22.00	Day Care Cost and Allowances	0	22.00
23.00	Tuition Reimbursement	208, 571	23.00
24.00	Total Wage Related cost (Sum of lines 1 -23)	33, 457, 125	24.00
	Part B - Other than Core Related Cost		
25. 00	OTHER WAGE RELATED COSTS (SPECIFY)	0	25. 00

HOSPITAL CONTRACT LABOR AND BENEFIT COST Provider CCN: 15-0023 Period: From 01/01/2017 To 12/31/2017 Part V Date/Time Prepa 5/30/2018 2: 18 Cost Center Description Contract Labor	Health Financial Systems	UNION HOSPITAL, INC.	In Lie	u of Form CMS-2	2552-10
	HOSPITAL CONTRACT LABOR AND BENEFIT COST		From 01/01/2017	Part V Date/Time Pre	pared:
1,00 2,00	Cost Center Description		Labor		

	Cost Center Description	Contract Labor	Benefit Cost	
		1. 00	2. 00	
	PART V - Contract Labor and Benefit Cost			
	Hospital and Hospital-Based Component Identification:			
1.00	Total facility's contract labor and benefit cost	7, 963, 398	33, 457, 125	1.00
2.00	Hospi tal	7, 963, 398	33, 457, 125	2.00
3.00	Subprovi der - IPF			3.00
4.00	Subprovi der - IRF	0	0	4.00
5.00	Subprovi der - (0ther)	0	0	5.00
6.00	Swing Beds - SNF	0	0	6.00
7.00	Swing Beds - NF	0	0	7.00
8.00	Hospi tal -Based SNF			8.00
9.00	Hospi tal -Based NF			9.00
10.00	Hospi tal -Based OLTC			10.00
11. 00	Hospi tal -Based HHA			11.00
12.00	Separately Certified ASC			12.00
13. 00	Hospi tal -Based Hospi ce			13.00
14.00	Hospital-Based Health Clinic RHC			14.00
15. 00	Hospital-Based Health Clinic FQHC			15.00
16.00	Hospi tal -Based-CMHC			16.00
17. 00	Renal Di al ysi s			17.00
18. 00	Other	0	0	18. 00

	alth Financial Systems UNION HOSPITAL, INC. In Lieu of Form CMS					552-10		
	HOSPITAL UNCOMPENSATED AND INDIGENT CARE DATA Provider CCN: 15-0023 Period:							
	From 01/01/2017							
	To 12/31/2017 [
	1.00							
	Uncompensated and indigent care cost computation							
1.00	Cost to charge ratio (Worksheet C, Part I line 202 column 3 divi	ded by li	ne 202 colum	n 8)	0. 236147	1.00		
	Medicaid (see instructions for each line)							
2.00	Net revenue from Medicaid				49, 763, 336	2.00		
3. 00 4. 00	Did you receive DSH or supplemental payments from Medicaid? If line 3 is yes, does line 2 include all DSH and/or supplementa	l novmont	s from Modic	ni dO	Y N	3. 00 4. 00		
5. 00	If line 4 is no, then enter DSH and/or supplemental payments fro			ai u :	15, 798, 150	5. 00		
6. 00	Medical d charges	iii wcai cai	u		253, 782, 840	6. 00		
7. 00	Medicaid cost (line 1 times line 6)				59, 930, 056	7. 00		
8.00	Difference between net revenue and costs for Medicaid program (I	ine 7 min	us sum of li	nes 2 and 5; if	0	8.00		
	< zero then enter zero)							
	Children's Health Insurance Program (CHIP) (see instructions for	each lin	e)					
9.00	Net revenue from stand-alone CHIP				58, 723	9.00		
10.00	Stand-alone CHIP charges Stand-alone CHIP cost (line 1 times line 10)				211, 400	10. 00 11. 00		
11. 00 12. 00	Difference between net revenue and costs for stand-alone CHIP (I	ine 11 mi	nus line 0:	if / zero then	49, 921 0	12.00		
12.00	enter zero)		nus iine 7,	ri < zero then	٥	12.00		
	Other state or local government indigent care program (see instr	uctions fo	or each line)				
13.00	Net revenue from state or local indigent care program (Not inclu	ded on li	nes 2, 5 or	9)	0	13.00		
14.00						14.00		
	10)							
15.00	State or local indigent care program cost (line 1 times line 14)		(1.1	45	0	15. 00 16. 00		
16. 00	Difference between net revenue and costs for state or local indi 13; if < zero then enter zero)	gent care	program (11	ne 15 minus iine	0	16.00		
	Grants, donations and total unreimbursed cost for Medicaid, CHIP and state/local indigent care programs (see							
	instructions for each line)							
17. 00						17.00		
18.00						18.00		
19. 00	.00 Total unreimbursed cost for Medicaid , CHIP and state and local indigent care programs (sum of lines 8, 12 and 16)					19. 00		
	Uni nsured I nsured Total (col. 1							
	patients patients + col. 2							
	1.00 2.00							
00.00	Uncompensated Care (see instructions for each line)		40 570 00	0 (04 4/4	47, 200, 474	00.00		
20. 00	Charity care charges and uninsured discounts for the entire faci	IITY	13, 578, 30	0 2, 631, 161	16, 209, 461	20. 00		
21. 00	(see instructions) Cost of patients approved for charity care and uninsured discounts (see 3,206,475 2,631,161				5, 837, 636	21 00		
21.00	instructions)					21.00		
22 00	Douments resilved from noticents for amounts provided by weitten a	0						
22. 00	Payments received from patients for amounts previously written o					22. 00		
	charity care	45						
23. 00			3, 206, 47	5 2, 631, 161	5, 837, 636			
	charity care		3, 206, 47	5 2, 631, 161	5, 837, 636			
23. 00	charity care Cost of charity care (line 21 minus line 22)				5, 837, 636	23. 00		
23. 00	charity care Cost of charity care (line 21 minus line 22) Does the amount on line 20 column 2, include charges for patient	days bey			5, 837, 636			
23. 00	charity care Cost of charity care (line 21 minus line 22)	days bey	ond a length	of stay limit	5, 837, 636	23.00		
23. 00	charity care Cost of charity care (line 21 minus line 22) Does the amount on line 20 column 2, include charges for patient imposed on patients covered by Medicaid or other indigent care p If line 24 is yes, enter the charges for patient days beyond the stay limit	days bey rogram? i ndi gent	ond a Length	of stay limit	5, 837, 636 1. 00 N	23.00		
23. 00 24. 00 25. 00 26. 00	charity care Cost of charity care (line 21 minus line 22) Does the amount on line 20 column 2, include charges for patient imposed on patients covered by Medicaid or other indigent care p If line 24 is yes, enter the charges for patient days beyond the stay limit Total bad debt expense for the entire hospital complex (see inst	days bey rogram? i ndi gent ructi ons)	ond a Length care progra	of stay limit	5, 837, 636 1. 00 N 0 25, 142, 386	23. 00 24. 00 25. 00 26. 00		
23. 00 24. 00 25. 00 26. 00 27. 00	charity care Cost of charity care (line 21 minus line 22) Does the amount on line 20 column 2, include charges for patient imposed on patients covered by Medicaid or other indigent care p If line 24 is yes, enter the charges for patient days beyond the stay limit Total bad debt expense for the entire hospital complex (see inst Medicare reimbursable bad debts for the entire hospital complex	days bey rogram? indigent ructions) (see inst	ond a Length care progra	of stay limit	5, 837, 636 1. 00 N 0 25, 142, 386 972, 435	23. 00 24. 00 25. 00 26. 00 27. 00		
23. 00 24. 00 25. 00 26. 00 27. 00 27. 01	charity care Cost of charity care (line 21 minus line 22) Does the amount on line 20 column 2, include charges for patient imposed on patients covered by Medicaid or other indigent care p If line 24 is yes, enter the charges for patient days beyond the stay limit Total bad debt expense for the entire hospital complex (see inst Medicare reimbursable bad debts for the entire hospital complex Medicare allowable bad debts for the entire hospital complex (see	days bey rogram? indigent ructions) (see inst	ond a Length care progra	of stay limit	5, 837, 636 1. 00 N 0 25, 142, 386 972, 435 1, 496, 053	23. 00 24. 00 25. 00 26. 00 27. 00 27. 01		
23. 00 24. 00 25. 00 26. 00 27. 00 27. 01 28. 00	charity care Cost of charity care (line 21 minus line 22) Does the amount on line 20 column 2, include charges for patient imposed on patients covered by Medicaid or other indigent care p If line 24 is yes, enter the charges for patient days beyond the stay limit Total bad debt expense for the entire hospital complex (see inst Medicare reimbursable bad debts for the entire hospital complex Medicare allowable bad debts for the entire hospital complex (se Non-Medicare bad debt expense (see instructions)	days bey rogram? indigent ructions) (see inst e instruc	ond a length care progra ructions) tions)	of stay limit m's length of	5, 837, 636 1. 00 N 0 25, 142, 386 972, 435 1, 496, 053 23, 646, 333	23. 00 24. 00 25. 00 26. 00 27. 00 27. 01 28. 00		
23. 00 24. 00 25. 00 26. 00 27. 00 27. 01 28. 00 29. 00	charity care Cost of charity care (line 21 minus line 22) Does the amount on line 20 column 2, include charges for patient imposed on patients covered by Medicaid or other indigent care p If line 24 is yes, enter the charges for patient days beyond the stay limit Total bad debt expense for the entire hospital complex (see inst Medicare reimbursable bad debts for the entire hospital complex (see Mon-Medicare bad debt expense (see instructions) Cost of non-Medicare and non-reimbursable Medicare bad debt expense	days bey rogram? indigent ructions) (see inst e instruc	ond a length care progra ructions) tions)	of stay limit m's length of	5, 837, 636 1. 00 N 0 25, 142, 386 972, 435 1, 496, 053	23. 00 24. 00 25. 00 26. 00 27. 00 27. 01 28. 00 29. 00		
23. 00 24. 00 25. 00 26. 00 27. 00 27. 01 28. 00 29. 00 30. 00	charity care Cost of charity care (line 21 minus line 22) Does the amount on line 20 column 2, include charges for patient imposed on patients covered by Medicaid or other indigent care p If line 24 is yes, enter the charges for patient days beyond the stay limit Total bad debt expense for the entire hospital complex (see inst Medicare reimbursable bad debts for the entire hospital complex Medicare allowable bad debts for the entire hospital complex (se Non-Medicare bad debt expense (see instructions)	days bey rogram? indigent ructions) (see inst e instruc	ond a length care progra ructions) tions)	of stay limit m's length of	5, 837, 636 1, 00 N 0 25, 142, 386 972, 435 1, 496, 053 23, 646, 333 6, 107, 629	23. 00 24. 00 25. 00 26. 00 27. 00 27. 01 28. 00 29. 00 30. 00		

		ATION AND ADJUSTMENTS OF TRIAL BALANCE O	F EXPENSES	Provi der C	CN: 15-0023 F	eri od:	Worksheet A	1002 10
					F	rom 01/01/2017 o 12/31/2017	Date/Time Pre	pared:
		Cost Center Description	Colorino	Other		Recl assi fi cat	5/30/2018 2: 1 Recl assi fi ed	8 pm
		cost center bescription	Sal ari es	otner.	+ col . 2)	i ons (See	Tri al Bal ance	
					,	A-6)	(col. 3 +-	
			1. 00	2.00	2.00	4.00	col . 4)	
	GENER	AL SERVICE COST CENTERS	1.00	2. 00	3. 00	4. 00	5. 00	
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT		13, 120, 970	13, 120, 970		19, 365, 145	1.00
2.00		NEW CAP REL COSTS-MVBLE EQUIP	000 010	6, 520, 805			9, 129, 317	2.00
4. 00 5. 01		EMPLOYEE BENEFITS DEPARTMENT NONPATIENT TELEPHONES	238, 912 556, 346	21, 864 400, 334			3, 330, 332 956, 680	
5. 02		DATA PROCESSING	0	0	1		0	5. 02
5. 03		PURCHASING RECEIVING AND STORES	0	0	C	0	0	5. 03
5. 04 5. 05		ADMITTING CASHIERING/ACCOUNTS RECEIVABLE	1, 388, 011	823, 679	2, 211, 690	0	2, 211, 690 0	5. 04 5. 05
5. 06		OTHER ADMIN AND GENERAL	5, 379, 273	28, 142, 707	33, 521, 980	-	23, 921, 700	ł
7.00	00700	OPERATION OF PLANT	1, 766, 493	8, 403, 050		0	10, 169, 543	7. 00
8. 00		LAUNDRY & LINEN SERVICE	641, 428	401, 468			1, 042, 896	
9. 00 10. 00		HOUSEKEEPI NG DI ETARY	1, 915, 963 1, 850, 315	1, 190, 508 1, 734, 434			3, 106, 471 681, 499	
11. 00		CAFETERI A	114, 049	203, 228				
13. 00		NURSING ADMINISTRATION	1, 643, 063	275, 633			1, 918, 696	
16. 00 17. 00		MEDICAL RECORDS & LIBRARY SOCIAL SERVICE	1, 884, 409	1, 231, 501 0			3, 115, 910 0	ı
21. 00		I&R SERVICES-SALARY & FRINGES APPRVD	0	0		_	1, 419, 840	
22. 00	02200	I&R SERVICES-OTHER PRGM COSTS APPRVD	О	0	C	2, 287, 974	2, 287, 974	22. 00
23. 00		PARAMED ED PRGM OTHER MED ED	E40 031	40 047		,	138, 461	
23. 01 23. 02		PARAMED ED PRGM	540, 031 0	68, 867 0			678, 106 138, 461	1
	I NPAT	TENT ROUTINE SERVICE COST CENTERS	-,	-			,	
30.00		ADULTS & PEDIATRICS	21, 105, 865	7, 550, 852			27, 297, 010	
31. 00 35. 00		INTENSIVE CARE UNIT INTENSIVE NURSERY	4, 606, 946 1, 755, 388	1, 456, 595 959, 508			6, 147, 493 2, 754, 360	
41. 00		SUBPROVI DER – I RF	1, 117, 719	268, 202			1, 425, 282	
43. 00		NURSERY	0	0	c	1, 223, 927	1, 223, 927	43.00
50. 00		LARY SERVICE COST CENTERS OPERATING ROOM	2, 836, 154	17, 675, 030	20, 511, 184	-7, 875, 738	12, 635, 446	50.00
50. 00		CARDI AC SURGERY	2, 030, 134	3, 002, 980			4, 558, 013	
50. 02	05002		0	12, 535, 280	12, 535, 280	-832, 979	11, 702, 301	50. 02
51. 00 51. 02		RECOVERY ROOM O/P TREATMENT ROOM	1, 643, 588 1, 902, 474	328, 494			1, 972, 082	
51.02		DELIVERY ROOM & LABOR ROOM	2, 807, 421	663, 050 2, 781, 374			2, 565, 524 5, 588, 795	
54.00	05400	RADI OLOGY-DI AGNOSTI C	3, 693, 568	3, 503, 753	7, 197, 321	-276, 922	6, 920, 399	54.00
55.00		RADI OLOGY-THERAPEUTI C RADI OI SOTOPE	408, 205	4, 651, 156			5, 059, 361	
56. 00 57. 00		CT SCAN	341, 605 1, 024, 138	947, 249 1, 114, 302			1, 288, 854 2, 138, 440	
58. 00		MAGNETIC RESONANCE IMAGING (MRI)	517, 143	1, 242, 506	1, 759, 649		1, 759, 649	58. 00
59.00		CARDI AC CATHETERI ZATI ON	833, 448	19, 431, 336			16, 837, 722	
60. 00 62. 00	06000	LABORATORY WHOLE BLOOD & PACKED RED BLOOD CELLS	0	9, 417, 201 1, 250, 323			9, 417, 201 1, 250, 323	1
65. 00		RESPI RATORY THERAPY	2, 556, 184	1, 059, 060	3, 615, 244	0	3, 615, 244	
66.00		PHYSI CAL THERAPY	0	4, 535, 724			4, 535, 724	
66. 01 66. 02	1	PSYCHIATRIC/PSYCHOLOGICAL SERVICES O/P PHYSICAL THERAPY	0	0 3, 330, 896		-	0 3, 330, 896	66. 01 66. 02
67. 00		OCCUPATIONAL THERAPY	Ö	0, 330, 670	3, 330, 370	o o	0, 330, 676	67.00
68. 00	1	SPEECH PATHOLOGY	0	679, 010			679, 010	1
69. 00 69. 01		ELECTROCARDI OLOGY CARDI AC REHAB	1, 219, 276 263, 312	2, 605, 330 45, 765			3, 824, 606 309, 077	
70. 00		ELECTROENCEPHALOGRAPHY	2, 081, 271	708, 990			2, 790, 261	1
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	895, 819			895, 819	71. 00
72.00		IMPL. DEV. CHARGED TO PATIENTS	0	0			12, 623, 290	
73. 00 76. 00		DRUGS CHARGED TO PATIENTS RENAL ACUTE	4, 239, 686 0	45, 950, 331 1, 630, 606			47, 314, 844 1, 630, 606	1
70.00		TIENT SERVICE COST CENTERS	<u> </u>	1, 000, 000	1,000,000	,	1, 000, 000	70.00
90.00	1	CLINIC	174, 635	39, 313			213, 948	1
90. 05 90. 07		PATIENT NUTRITION WOUND CLINIC	306, 948 285, 543	43, 469 943, 337			350, 417 1, 228, 880	1
91.00		EMERGENCY	4, 750, 732	7, 347, 867			12, 098, 599	
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)			, , , , , ,			92.00
110 00	-	AL PURPOSE COST CENTERS	00 433 007	224 422 757	D 201 F/F 042	2 222 012	204 700 (54	110 00
118.00		SUBTOTALS (SUM OF LINES 1 through 117) IMBURSABLE COST CENTERS	80, 432, 086	221, 133, 756	301, 565, 842	3, 223, 812	304, 789, 654] 18.00
	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0		0	0	190. 00
		RURAL HEALTH	1, 333, 998	1, 935, 460			3, 375, 468	1
		RENTAL PROPERTY FAMILY PRACTICE	0 4, 885, 029	133, 368 2, 770, 993			133, 368 3, 948, 208	
194. 03	07952	WELLNESS	0	2,770,443			469, 895	
194. 04	07955	PHYSICIAN PRACTICES	5, 744, 032	8, 430, 848	14, 174, 880	0	14, 174, 880	194. 04
								

Health Financial Systems	UNION HOSPITAL, INC.			In Lieu of Form CMS-2552-10			
RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE C	F EXPENSES	Provi der Co		Peri od:	Worksheet A		
				From 01/01/2017			
			-	Γο 12/31/2017			
					5/30/2018 2:1	8 pm	
Cost Center Description	Sal ari es	0ther	Total (col. 1	Recl assi fi cat	Recl assi fi ed		
			+ col. 2)	ions (See	Trial Balance		
				A-6)	(col. 3 +-		
					col. 4)		
	1. 00	2.00	3. 00	4. 00	5. 00		
194.06 07953 SYCAMORE SPORTS MED	12, 850	978, 874	991, 72	1 0	991, 724	194.06	
194. 07 07956 PSYCHI ATRI C/PSYCHOLOGI CAL SERVI CES	394, 571	89, 644	484, 215	-91, 903	392, 312	194. 07	
200.00 TOTAL (SUM OF LINES 118 through 199)	92, 802, 566	235, 472, 943	328, 275, 509	9 0	328, 275, 509	200.00	

 Health Financial
 Systems
 UNION HO

 RECLASSIFICATION
 AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES

Provider CCN: 15-0023

Peri od: From 01/01/2017 To 12/31/2017 Date/Time Prepared: 5/30/2018 2:18 pm

				5/30/2018 2: 1	8 pm
	Cost Center Description	Adjustments	Net Expenses		
		(See A-8)	For		
		4 00	Allocation 7.00		
	GENERAL SERVICE COST CENTERS	6. 00	7.00		
1. 00	00100 NEW CAP REL COSTS-BLDG & FIXT	-3, 669, 525	15, 695, 620		1.00
2. 00	00200 NEW CAP REL COSTS-MVBLE EQUIP	-593, 508	8, 535, 809	1	2.00
4. 00	00400 EMPLOYEE BENEFITS DEPARTMENT	31, 218, 755	34, 549, 087		4.00
5. 01	00540 NONPATI ENT TELEPHONES	-55, 962	900, 718	l control of the cont	5. 01
5. 02	00550 DATA PROCESSING	14, 247, 395	14, 247, 395	l e e e e e e e e e e e e e e e e e e e	5. 02
5.03	00560 PURCHASING RECEIVING AND STORES	1, 641, 061	1, 641, 061		5. 03
5.04	00570 ADMI TTI NG	0	2, 211, 690		5. 04
5.05	00580 CASHI ERI NG/ACCOUNTS RECEI VABLE	6, 045, 019	6, 045, 019		5. 05
5.06	00590 OTHER ADMIN AND GENERAL	-3, 863, 256	20, 058, 444		5.06
7.00	00700 OPERATION OF PLANT	-696, 518	9, 473, 025		7.00
8.00	00800 LAUNDRY & LINEN SERVICE	-5, 033	1, 037, 863		8. 00
9.00	00900 HOUSEKEEPI NG	-138, 281	2, 968, 190		9. 00
10.00	01000 DI ETARY	-174, 776	506, 723		10.00
11. 00	01100 CAFETERI A	-1, 645, 585	1, 547, 945		11.00
13.00	01300 NURSI NG ADMINI STRATI ON	1, 583, 904	3, 502, 600		13.00
16. 00	01600 MEDICAL RECORDS & LIBRARY	202, 306	3, 318, 216		16. 00
17. 00	01700 SOCIAL SERVICE	0	0	I .	17.00
21. 00	02100 I &R SERVI CES-SALARY & FRI NGES APPRVD	0	1, 419, 840		21.00
22. 00	02200 I &R SERVICES-OTHER PRGM COSTS APPRVD	-119, 673	2, 168, 301		22.00
23. 00	02300 PARAMED ED PRGM	0	138, 461		23.00
23. 01	02341 OTHER MED ED	-476, 785	201, 321	l control of the cont	23. 01 23. 02
23. 02	02301 PARAMED ED PRGM INPATIENT ROUTINE SERVICE COST CENTERS	0	138, 461		23.02
30. 00	03000 ADULTS & PEDIATRICS	0	27, 297, 010		30.00
31. 00	03100 INTENSIVE CARE UNIT	0	6, 147, 493		31.00
35. 00	02040 I NTENSI VE NURSERY	-548, 000	2, 206, 360		35.00
41. 00	04100 SUBPROVI DER – I RF	-348, 000	1, 425, 282		41.00
43. 00	04300 NURSERY	0	1, 423, 202	l e e e e e e e e e e e e e e e e e e e	43.00
43.00	ANCILLARY SERVICE COST CENTERS	<u> </u>	1,225,727		45.00
50.00	05000 OPERATI NG ROOM	-1, 989, 660	10, 645, 786		50.00
50. 01	05001 CARDI AC SURGERY	-2, 500, 569	2, 057, 444		50. 01
50. 02	05002 WVSC	-1, 128, 079	10, 574, 222		50. 02
51.00	05100 RECOVERY ROOM	4, 365	1, 976, 447	l e e e e e e e e e e e e e e e e e e e	51.00
51. 02	05101 O/P TREATMENT ROOM	0	2, 565, 524		51.02
52.00	05200 DELIVERY ROOM & LABOR ROOM	-2, 073, 078	3, 515, 717		52.00
54.00	05400 RADI OLOGY-DI AGNOSTI C	-448, 123	6, 472, 276		54.00
55.00	05500 RADI OLOGY-THERAPEUTI C	0	5, 059, 361		55.00
56.00	05600 RADI OI SOTOPE	-10, 850	1, 278, 004		56.00
57.00	05700 CT SCAN	295, 024	2, 433, 464		57.00
58.00	05800 MAGNETIC RESONANCE IMAGING (MRI)	69, 881	1, 829, 530		58. 00
59.00	05900 CARDI AC CATHETERI ZATI ON	-1, 564, 772	15, 272, 950		59. 00
60.00	06000 LABORATORY	-183, 070	9, 234, 131		60.00
62. 00	06200 WHOLE BLOOD & PACKED RED BLOOD CELLS	0	1, 250, 323		62.00
65. 00	06500 RESPI RATORY THERAPY	0	3, 615, 244		65.00
66.00	06600 PHYSI CAL THERAPY	-1, 908, 183	2, 627, 541	•	66.00
66. 01	06601 PSYCHI ATRI C/PSYCHOLOGI CAL SERVI CES	0	0		66. 01
	06602 0/P PHYSICAL THERAPY	-1, 237, 371	2, 093, 525		66.02
67.00	06700 OCCUPATI ONAL THERAPY	1, 717, 128 79, 076	1, 717, 128	•	67. 00 68. 00
68. 00 69. 00	06800 SPEECH PATHOLOGY 06900 ELECTROCARDI OLOGY	2, 919	758, 086 3, 827, 525	•	69.00
69. 01	06901 CARDI AC REHAB	3, 566	3, 827, 323		69.01
70. 00	07000 ELECTROENCEPHALOGRAPHY	-2, 189, 149	601, 112	1	70.00
71. 00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	-4, 412	891, 407		71.00
72. 00	07200 I MPL. DEV. CHARGED TO PATIENTS	0	12, 623, 290	i e	72.00
73. 00	07300 DRUGS CHARGED TO PATIENTS	-359, 702	46, 955, 142		73.00
	03020 RENAL ACUTE	0	1, 630, 606		76.00
	OUTPATIENT SERVICE COST CENTERS	. 9	, , , , , , ,	·	1
90.00	09000 CLI NI C	0	213, 948		90.00
90.05	09005 PATIENT NUTRITION	-2, 818	347, 599		90.05
90. 07	09007 WOUND CLINIC	3, 684	1, 232, 564		90. 07
91.00	09100 EMERGENCY	-1, 024, 736	11, 073, 863		91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)				92.00
	SPECIAL PURPOSE COST CENTERS				1
118.00		28, 502, 609	333, 292, 263		118. 00
	NONREI MBURSABLE COST CENTERS				1
	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	•	190. 00
	07950 RURAL HEALTH	0	3, 375, 468		194. 00
	07951 RENTAL PROPERTY	0	133, 368		194. 01
	07954 FAMILY PRACTICE	0	3, 948, 208		194. 02
	3 07952 WELLNESS	0	469, 895		194. 03
	107955 PHYSI CI AN PRACTI CES	-600, 215	13, 574, 665	l control of the cont	194.04
194.06	5 07953 SYCAMORE SPORTS MED	-906, 458	85, 266		194. 06

Health Financial Systems	UNI ON HOSPI	TAL, INC.		In Lieu	of Form CMS-	2552-10
RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE (MENTS OF TRIAL BALANCE OF EXPENSES		CN: 15-0023	Peri od: From 01/01/2017	Worksheet A	
					5/30/2018 2:1	18 pm
Cost Center Description	Adjustments	Net Expenses				
	(See A-8)	For				
		Allocation				
	6. 00	7.00	1			
194. 07 07956 PSYCHI ATRI C/PSYCHOLOGI CAL SERVI CES	0	392, 312	2			194. 07
200.00 TOTAL (SUM OF LINES 118 through 199)	26, 995, 936	355, 271, 445	i			200.00

Health Financial Systems RECLASSIFICATIONS UNION HOSPITAL, INC. In Lieu of Form CMS-2552-10 Provider CCN: 15-0023

| Peri od: | Worksheet A-6 | From 01/01/2017 | To 12/31/2017 | Date/Time Prepared:

						10	/30/2018 2:18 pm
B			Increases			-	
B PARAMED							
1.00 PARAMED ED PROM 23.00 109, 596 28, 865 2.00 PARAMED ED PROM 23.00 109, 596 28, 865 2.00 PARAMED ED PROM 23.00 219, 192 57, 730 2.00			3. 00	4. 00	5. 00		
2.00 PARAMED ED PROM	4 00		22 22	400 50/	00.045		1.00
0		1	I				
C - FINNESS ACTIVITY	2.00	PARAMED ED PRGM					2.00
1.00 EMPLOYER BENEFITS DEPARTMENT 4.00 123,861 47,877 303,898 2.00 1.0		U		219, 192	57, 730		
MELLNESS 194.03 338.997 130.898 2.00	1 00		4 00	122 0/1	47 007		1 00
0			I				•
D	2.00	WELLINESS — — — — —	194.03				2.00
1.00		D CLAY CLTY DUDAL HEALTH		402, 838	178, 725		
O	1 00		104 00	٥	44 001		1 00
1. 00 RURAL HEALTH 194,00 0 20,719 1.00	1.00	NORAL HEALTH	194.00				1.00
1.00		E CORK MEDICAL BURAL HEALTH		UU	40, 001		
O	1 00		104 00		20. 710		1 00
1. 00 INTENSIVE CARE UNISE ASSISTANT 31. 00 76, 768 7, 184 1. 00 INTENSIVE NURSERY 35. 00 36, 087 3, 377 2. 00 O O O O O O O O O	1.00	O TORAL TILALITI					1.00
NTENSIVE CARE UNIT 31.00 76.768 7.184 1.00 2.00 1.00 35.992 3.368 3.377 2.00 3.00 3.00 35.992 3.368 3.377 3.00 3.00 35.992 3.368 3.00 3.00 35.992 3.368 3.00 3.00 35.992 3.368 3.00 3.00 35.992 3.368 3.00 3.00 35.992 3.368 3.00 3		E HOUSE NUIDSE ASSISTANT		<u> </u>	20, 717		
NTERSIVE NURSERY 35.00 36.087 3,377 3.00 3.00 0.00 3.00 0.00 3.00 0.00 3.00 0.00 3.00 3.00 0.00 3.00	1 00		31 00	76 768	7 19/		1 00
SUSPENDI DER - LRF							
O							
1. 00 EMPLOYEE BENEFITS DEPARTMENT 4. 00 74, 889 17, 014	3.00	O TRI	41.00		$- \frac{3,300}{13,020}$		3.00
1.00 EMPLOYEE BENEFITS DEPARTMENT		G - EMPLOYEE ACCESS		140, 040	13, 727		
O	1 00		4 00	74 889	17 014		1 00
H - TUBE FEEDING	1.00	O DENETTIS DEL ARTIMENT					1.00
1.00		H - TURE FEEDING		74,007	17,014		
O	1 00		30.00	7 017	10 080		1 00
1. FAMILY MEDICINE	1.00	n TEDIATRICS					1.00
1.00		L - FAMILY MEDICINE		7,017	17, 700		
FRI NGES APPRVD 1, 258, 646 1, 029, 328 2, 00 1, 258, 646 1, 029, 328 2, 00 1, 258, 646 1, 029, 328 2, 00 1, 1, 136, 210 1, 136, 210	1 00		21 00	1 312 058	106 882		1 00
1.00 Lar Services-Other PRGM 22.00 1,258,646 1,029,328 2.00 0 2,571,604 1,136,210 1.00 D Lobby Pharmacy 1.00 D L	1.00		21.00	1, 312, 730	100, 002		1.00
COSTS APPRVD 0 0 1.00 2.571,604 1.136,210 J - LOBBY PHARMACY EMPLOYEE BENEFITS DEPARTMENT 0 363,314 2.442,651 0 1.00 K - IMPLANTABLE DEVICES 1.00 IMPL. DEV. CHARGED TO PATIENTS 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.	2 00		22 00	1 258 646	1 029 328		2 00
1. 00	2.00		22.00	1,200,010	., 027, 020		2.00
1.00 EMPLOYEE BENEFITS DEPARTMENT 4.00 363, 314 2.442, 651		0		2.571.604	1. 136. 210		
1.00 EMPLOYEE BENEFITS DEPARTMENT 4.00 363, 314 2,442,651		J - LOBBY PHARMACY	<u> </u>	, . ,	,,		
C	1.00		4. 00	363, 314	2, 442, 651		1.00
1. 00							
PATIENTS		K - IMPLANTABLE DEVICES			<u> </u>		
2.00 3.00 0.00 0.00 0.00 0.00 0.00 0.00	1.00	IMPL. DEV. CHARGED TO	72.00	0	12, 623, 290		1.00
3.00		PATI ENTS					
4.00	2.00		0. 00	0	0		2. 00
1.00 NEW CAP REL COSTS-BLDG & 1.00 0 6,350,185 1.00	3.00			0	0		3.00
L - INTEREST 1. 00 NEW CAP REL COSTS-BLDG & 1. 00 0 6, 350, 185 2. 00 NEW CAP REL COSTS-MVBLE 2. 00 0 2, 608, 512 EQUI P 0 0 0 8, 958, 697 N - NURSERY 1. 00 NURSERY 0 999, 050 224, 877 0 - PHARMACY PARAMED 1. 00 OTHER MED ED 23. 01 63, 052 6, 156 0 63, 052 6, 156 P - BRAZI L MEDI CAL CENTER 1. 00 RURAL HEALTH 194. 00 0 39, 290 0 - CAFE RECLASS 1. 00 CAFETERI A 11. 00 1, 484, 614 1, 391, 639 1. 00 CAFETERI A 11. 00 1, 484, 614 1, 391, 639 1. 00 TOTALS	4.00		0.00		0		4.00
1. 00				0	12, 623, 290		
FIXT 2. 00							
2. 00 NEW CAP REL COSTS-MVBLE	1.00	NEW CAP REL COSTS-BLDG &	1. 00	0	6, 350, 185		1.00
EQUI P							
1.00 NURSERY 1.00 999,050 224,877 0 999,05	2.00		2. 00	0	2, 608, 512		2.00
N - NURSERY		EQUI P					
1. 00 NURSERY 43. 00 999, 050 224, 877 0 999, 050 224, 877 0 999, 050 224, 877 0 - PHARMACY PARAMED 1. 00 OTHER MED ED 23. 01 63, 052 6, 156 0 1. 00 63, 052 6, 156 0 1. 00 RURAL HEALTH 194. 00 0 39, 290 0 0 39, 290 0 0 - CAFE RECLASS 1. 00 CAFETERIA 11. 00 1, 484, 614 1, 391, 639 70 1. 00 70 70 70 70 70 70 70 70 70 70 70 70		0		0	8, 958, 697		
0 999, 050 224, 877 0 - PHARMACY PARAMED 1. 00 OTHER MED ED 23. 01 63, 052 6, 156 0 1. 00 0 63, 052 6, 156 P - BRAZI L MEDI CAL CENTER 1. 00 RURAL HEALTH 194. 00 0 39, 290 0 1. 00 0 39, 290 0 0 39, 290 0 - CAFE RECLASS 1. 00 CAFETERI A 11. 00 1, 484, 614 1, 391, 639 10. 00 TOTALS 1. 484, 614 1, 391, 639 1. 00							
0 - PHARMACY PARAMED 1. 00 OTHER MED ED	1. 00	NURSERY	4300				1.00
1. 00 OTHER MED ED 23. 01 63, 052 6, 156 0 1. 00 63, 052 6, 156 0 1.		0		999, 050	224, 877		
0 63,052 6,156 P - BRAZI L MEDI CAL CENTER 1.00 RURAL HEALTH 194.00 0 39,290 0 0 39,290 0 - CAFE RECLASS 1.00 CAFETERI A 11.00 1,484,614 1,391,639 TOTALS 1,484,614 1,391,639							
P - BRAZI L MEDI CAL CENTER	1. 00	OTHER MED ED	<u>23.</u> 01	63, 052			1.00
1. 00 RURAL HEALTH 194. 00 0 39, 290 0 0 39, 290 1. 00 0 39, 290 1. 00 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0		U DATE AND THE RESTRICT		63, 052	6, 156		
0 39, 290 Q - CAFE RECLASS 1. 00 CAFETERI A 11. 00 1, 484, 614 1, 391, 639 TOTALS 1, 484, 614 1, 391, 639							
0 - CAFE RECLASS 1. 00 CAFETERI A 11. 00 1, 484, 614 1, 391, 639 1. 00 TOTALS 1, 484, 614 1, 391, 639	1. 00	RURAL HEALTH	1 <u>94.</u> 00				1.00
1. 00 CAFETERI A 11. 00 1, 484, 614 1, 391, 639 1. 00 TOTALS 1, 484, 614 1, 391, 639		0		0	39, 290		
TOTALS 1, 484, 614 1, 391, 639							
	1.00		<u>11.</u> 00	<u>1, 484, 614</u>			1.00
500.00 Grand Total: Increases 6,394,438 27,176,908 500.00							
	500.00	Userand Total: Increases		6, 394, 438	27, 176, 908		500. 00

Health Financial Systems RECLASSIFICATIONS UNION HOSPITAL, INC. In Lieu of Form CMS-2552-10 Provider CCN: 15-0023

| Peri od: | Worksheet A-6 | From 01/01/2017 | To 12/31/2017 | Date/Time Prepared:

					. 10	5/30/2018	
		Decreases		·			
	Cost Center	Li ne #	Sal ary	0ther	Wkst. A-7 Ref.		
	6. 00	7. 00	8. 00	9. 00	10. 00		
1. 00	B - PARAMED RADI OLOGY-DI AGNOSTI C	54.00	210 102	E7 720	O		1.00
2.00	RADI OLOGY - DI AGNOSTI C	0.00	219, 192	57, 730			2.00
2.00			219, 192	_{57,730}			2.00
	C - FITNESS ACTIVITY		2177172	0.7,700	1		
1.00	OTHER ADMIN AND GENERAL	5. 06	462, 858	178, 725	0		1.00
2.00		0.00	0	0	0		2.00
	0		462, 858	178, 725			
	D - CLAY CITY RURAL HEALTH	4 00		47.004			
1. 00	NEW CAP REL COSTS-BLDG &	1. 00	O	46, 001	9		1.00
	FIXT	+	+	46, 001	 		ŀ
	E - CORK MEDICAL RURAL HEALTH	<u> </u>	<u> </u>	40,001			
1. 00	NEW CAP REL COSTS-BLDG &	1.00	O	20, 719	9		1.00
	FLXT						
	0		0	20, 719			
	F - HOUSE NURSE ASSISTANT						
1.00	ADULTS & PEDIATRICS	30.00	148, 848	13, 929			1.00
2.00		0.00	0	0	0		2.00
3. 00			148, 848	13, 929	 		3.00
	G - EMPLOYEE ACCESS		140, 040	13, 929			
1. 00	PSYCHI ATRI C/PSYCHOLOGI CAL	194. 07	74, 889	17, 014	0		1.00
	SERVI CES		,	,			
			74, 889				
	H - TUBE FEEDING						
1.00	DI ETARY	10. 00	<u>7, 0</u> 17	1 <u>9, 9</u> 80			1.00
	0		7, 017	19, 980			
1 00	I - FAMILY MEDICINE	194. 02	2, 571, 604	1 12/ 210	O		1 00
1. 00 2. 00	FAMILY PRACTICE	0.00	2, 5/1, 604	1, 136, 210	0		1. 00 2. 00
2.00			2, 571, 604				2.00
	J - LOBBY PHARMACY		2, 0, 1, 00 1	1, 100, 210			
1.00	DRUGS CHARGED TO PATIENTS	73. 00	363, 314	2, 442, 651	0		1.00
	0		363, 314	2, 442, 651			
	K - IMPLANTABLE DEVICES						
1.00	OPERATING ROOM	50. 00	0	7, 875, 738			1.00
2. 00	CARDI AC SURGERY	50. 01	0	487, 511			2.00
3.00	WVSC	50. 02	0	832, 979			3.00
4. 00	CARDI AC CATHETERI ZATI ON	<u>59.</u> 00	0	3, 427, 062			4.00
	L - INTEREST		U	12, 623, 290			
1.00	OTHER ADMIN AND GENERAL	5. 06	ol	8, 958, 697	11		1.00
2. 00	John Mark Mark Mark Mark Mark Mark Mark Mark	0.00	o	0,700,077	1		2.00
				8, 958, 697			
	N - NURSERY						
1.00	ADULTS & PEDIATRICS	30.00	999, 050	22 <u>4, 8</u> 77			1.00
	0		999, 050	224, 877			
	O - PHARMACY PARAMED				T		
1. 00	DRUGS CHARGED TO PATIENTS		63,052	<u>6, 1</u> 56			1.00
	P - BRAZIL MEDICAL CENTER		63, 052	6, 156	<u> </u>		
1. 00	NEW CAP REL COSTS-BLDG &	1.00	0	39, 290	9		1.00
1.00	FIXT	1.00	٩	39, 290			1.00
	0	+		39, 290	 		1
	Q - CAFE RECLASS		31	2., 2.0	·		
1.00	DI ETARY	10.00	1, 484, 614	1, 391, 639			1.00
	TOTALS		1, 484, 614	1, 391, 639			
500.00	Grand Total: Decreases	T	6, 394, 438	27, 176, 908			500.00

| Period: | Worksheet A-7 | From 01/01/2017 | Part | To 12/31/2017 | Date/Time Prepared: Health Financial Systems
RECONCILIATION OF CAPITAL COSTS CENTERS UNION HOSPITAL, INC. Provider CCN: 15-0023

				To	12/31/2017	Date/Time Pre	
				Acqui si ti ons		5/30/2018 2:1	8 piii
		Beginning	Purchases	Donati on	Total	Disposals and	
		Bal ances	i di cilases	Donation	Total	Retirements	
		1, 00	2. 00	3. 00	4. 00	5. 00	
	PART I - ANALYSIS OF CHANGES IN CAPITAL ASSE		2.00	0.00		0.00	
1.00	Land	17, 863, 364	132, 346	0	132, 346	646, 573	1.00
2.00	Land Improvements	19, 756, 841	400, 352		400, 352		
3.00	Buildings and Fixtures	361, 642, 985	4, 262, 500	0	4, 262, 500	443, 445	3.00
4.00	Building Improvements	4, 010, 951	1, 091, 458		1, 091, 458	50, 649	4.00
5.00	Fixed Equipment	0	0	0	0	0	5.00
6.00	Movable Equipment	154, 217, 988	34, 630, 696	0	34, 630, 696	13, 564, 453	6.00
7.00	HIT designated Assets	0	0	0	0	0	7.00
8.00	Subtotal (sum of lines 1-7)	557, 492, 129	40, 517, 352	0	40, 517, 352	14, 711, 330	8. 00
9.00	Reconciling Items	o	0	0	0	0	9.00
10.00	Total (line 8 minus line 9)	557, 492, 129	40, 517, 352	0	40, 517, 352	14, 711, 330	10.00
		Endi ng	Fully				
		Bal ance	Depreci ated				
			Assets				
		6. 00	7. 00				
	PART I - ANALYSIS OF CHANGES IN CAPITAL ASSE						
1.00	Land	17, 349, 137	0				1.00
2.00	Land Improvements	20, 150, 983	0				2.00
3. 00	Buildings and Fixtures	365, 462, 040	0				3.00
4. 00	Building Improvements	5, 051, 760	0				4.00
5. 00	Fixed Equipment	0	0				5.00
6.00	Movable Equipment	175, 284, 231	0				6.00
7.00	HIT designated Assets	0	0				7. 00
8.00	Subtotal (sum of lines 1-7)	583, 298, 151	0				8. 00
9.00	Reconciling Items	0	0				9. 00
10.00	Total (line 8 minus line 9)	583, 298, 151	0				10.00

Heal th	Financial Systems	UNI ON HOSPI	TAL, INC.		In Lie	u of Form CMS-2	2552-10
RECON	CILIATION OF CAPITAL COSTS CENTERS		Provider Co		Period: From 01/01/2017 To 12/31/2017		pared:
			Sl	JMMARY OF CAPI	TAL		
	Cost Center Description	Depreciation	Lease	Interest	Insurance (see instructions)	Taxes (see instructions)	
		9. 00	10. 00	11. 00	12.00	13.00	
	PART II - RECONCILIATION OF AMOUNTS FROM WOR	KSHEET A, COLUM	MN 2, LINES 1 a	and 2			
1.00	NEW CAP REL COSTS-BLDG & FIXT	11, 314, 940	0	1, 806, 03	0 0	0	1.00
2.00	NEW CAP REL COSTS-MVBLE EQUIP	6, 520, 805	0		0 0	0	2.00
3.00	Total (sum of lines 1-2)	17, 835, 745	0	1, 806, 03	0 0	0	3.00
		SUMMARY O	F CAPITAL				
	Cost Center Description	Other	Total (1)				
		Capi tal -Rel at	(sum of cols.				
		ed Costs (see	9 through 14)				
		instructions)					
		14. 00	15. 00				
	PART II - RECONCILIATION OF AMOUNTS FROM WOR	KSHEET A, COLUM	MN 2, LINES 1 a	and 2			
1.00	NEW CAP REL COSTS-BLDG & FIXT	0	13, 120, 970		·	·	1.00
2.00	NEW CAP REL COSTS-MVBLE EQUIP	0	6, 520, 805				2.00
3. 00	Total (sum of lines 1-2)	0	19, 641, 775				3.00

Health Financial Systems	UNI ON HOSPI	TAL, INC.		In Lie	u of Form CMS-2	2552-10
RECONCILIATION OF CAPITAL COSTS CENTERS		Provi der C		Period: From 01/01/2017 To 12/31/2017		pared:
	COM	PUTATION OF RA	TIOS	ALLOCATION OF	OTHER CAPITAL	·
Cost Center Description	Gross Assets	Capi tal i zed	Gross Assets		Insurance	
		Leases	for Ratio (col. 1 -	instructions)		
	1.00	0.00	col . 2)	4.00	5.00	
PART III - RECONCILIATION OF CAPITAL COSTS C	1. 00	2.00	3.00	4. 00	5. 00	
1.00 NEW CAP REL COSTS-BLDG & FLXT	408, 013, 920	0	408, 013, 92	0. 699495	0	1.00
2.00 NEW CAP REL COSTS-MVBLE EQUIP	175, 284, 231	Ö	1			2. 00
3.00 Total (sum of lines 1-2)	583, 298, 151	0	583, 298, 15	1. 000000	0	3. 00
	ALLOCA ⁻	TION OF OTHER (CAPI TAL	SUMMARY C	F CAPITAL	
Cost Center Description	Taxes	0ther	Total (sum of	Depreciation	Lease	
		Capi tal -Rel at				
		ed Costs	through 7)			
DART III DECONOLILIATION OF CARLTAL COCTO	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	1 0	ı	7 (0((00	0	1. 00
2.00 NEW CAP REL COSTS-BLDG & FIXT	0	1		0 7, 686, 680 0 5, 987, 794		2.00
3.00 Total (sum of lines 1-2)	0	1		0 13, 674, 474		3.00
o. oo proton (sum or rrines r z)		·	JMMARY OF CAPI			0.00
Cost Center Description	Interest	Insurance	Taxes (see	0ther	Total (2)	
		(see	instructions)			
		instructions)		ed Costs (see instructions)	9 through 14)	
	11. 00	12. 00	13.00	14.00	15. 00	
PART III - RECONCILIATION OF CAPITAL COSTS C						
1.00 NEW CAP REL COSTS-BLDG & FLXT	8, 008, 940			0 0		1.00
2.00 NEW CAP REL COSTS-MVBLE EQUIP	2, 548, 015			0 0	-,,	2.00
3.00 Total (sum of lines 1-2)	10, 556, 955	0	1	0 0	24, 231, 429	3. 00

	JUSTMENTS TO EXPENSES			Provi der CCN: 15-0023	Period: From 01/01/2017 To 12/31/2017	Worksheet A-8 Date/Time Prepared: 5/30/2018 2:18 pm		
			Т	Expense Classification o o/From Which the Amount is				
	Cost Center Description	Basi s/Code	Amount	Cost Center	Li ne #	Wkst. A-7		
	·	(2) 1. 00	2. 00	3.00	4.00	Ref. 5.00		
1. 00	Investment income - NEW CAP	В	-147, 275 N	EW CAP REL COSTS-BLDG &	1.00	11	1.00	
ľ	REL COSTS-BLDG & FIXT (chapter 2)		F	IXT				
2. 00	Investment income - NEW CAP REL COSTS-MVBLE EQUIP (chapter	В		EW CAP REL COSTS-MVBLE QUIP	2. 00	11	2.00	
3. 00	2) Investment income - other		О		0.00	0	3. 00	
4. 00	(chapter 2) Trade, quantity, and time	В	-9. 778P	URCHASING RECEIVING AND	5. 03	0	4.00	
	discounts (chapter 8)		S	TORES				
5. 00	Refunds and rebates of expenses (chapter 8)	В		URCHASING RECEIVING AND TORES	5. 03	0	5.00	
6. 00	Rental of provider space by suppliers (chapter 8)		0		0.00	0	6. 00	
7. 00	Telephone services (pay stations excluded) (chapter	А	-20, 354 N	ONPATI ENT TELEPHONES	5. 01	0	7. 00	
8. 00	21) Tel evi si on and radi o servi ce		О		0. 00	0	8. 00	
9. 00	(chapter 21) Parking Lot (chapter 21)		o		0.00	0	9.00	
10. 00	Provi der-based physician adjustment	A-8-2	-14, 993, 468			0		
11. 00	Sale of scrap, waste, etc.		О		0.00	0	11.00	
12. 00	(chapter 23) Related organization	A-8-1	67, 914, 015			0	12.00	
13. 00	transactions (chapter 10) Laundry and linen service		0		0.00	0	13.00	
14. 00	Cafeteria-employees and guests	В	-1, 474, 723 C	AFETERI A	11. 00	0	14.00	
15. 00	Rental of quarters to employee and others		O		0.00	0	15. 00	
16. 00	Sale of medical and surgical supplies to other than patients	А		EDICAL SUPPLIES CHARGED TO ATIENTS	71.00	0	16. 00	
17. 00	Sale of drugs to other than	А	-7, 290 D	RUGS CHARGED TO PATIENTS	73. 00	0	17. 00	
18. 00	patients Sale of medical records and	В	-5, 748 M	EDICAL RECORDS & LIBRARY	16. 00	0	18. 00	
19. 00	abstracts Nursing and allied health		0		0.00	0	19.00	
. , , , ,	education (tuition, fees,				0.00	J		
20. 00	books, etc.) Vending machines	Α	-13, 3240	PERATION OF PLANT	7. 00	0	20.00	
21. 00	Income from imposition of interest, finance or penalty		0		0.00	0	21.00	
22. 00	charges (chapter 21) Interest expense on Medicare overpayments and borrowings to		0		0.00	0	22. 00	
23. 00	repay Medicare overpayments Adjustment for respiratory therapy costs in excess of	A-8-3	OR	ESPI RATORY THERAPY	65. 00		23. 00	
24. 00	limitation (chapter 14) Adjustment for physical therapy costs in excess of	A-8-3	0 P	HYSI CAL THERAPY	66. 00		24. 00	
25. 00	limitation (chapter 14) Utilization review - physicians' compensation		0 *	** Cost Center Deleted ***	114. 00		25. 00	
26. 00	(chapter 21) Depreciation - NEW CAP REL		OlN	EW CAP REL COSTS-BLDG &	1. 00	0	26. 00	
27. 00	COSTS-BLDG & FIXT Depreciation - NEW CAP REL		F	IXT EW CAP REL COSTS-MVBLE	2. 00	0		
	COSTS-MVBLE EQUIP		E	QUI P		U		
28. 00 29. 00	Non-physician Anesthetist Physicians' assistant		0 * 0	** Cost Center Deleted **	19.00	0	28. 00 29. 00	
30. 00	Adjustment for occupational therapy costs in excess of limitation (chapter 14)	A-8-3	olo	CCUPATI ONAL THERAPY	67. 00		30.00	
30. 99	Hospice (non-distinct) (see instructions)		OA	DULTS & PEDIATRICS	30. 00		30. 99	

				To	o 12/31/2017	Date/Time Pre 5/30/2018 2:1	
				Expense Classification on	Worksheet A	37 307 2010 2. 1	O piii
				To/From Which the Amount is	to be Adjusted		
					,		
	Cost Center Description	Basi s/Code	Amount	Cost Center	Li ne #	Wkst. A-7	
		(2)				Ref.	
	Tana a sa	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						
00.00	limitation (chapter 14)				0.00	_	00.00
32. 00	CAH HIT Adjustment for		0		0. 00	0	32.00
33. 00	Depreciation and Interest	_	4.12	NEW CAP REL COSTS-MVBLE	2. 00	9	22 00
33.00	TELEPHONE DEPRECIATION	A	-043	EQUIP	2.00	9	33.00
34. 00	VENDING HOUSEKEEPING	А	-20 082	HOUSEKEEPI NG	9. 00	0	34.00
35. 00	MEALS SOLD	В	-37, 052		10. 00	0	1
36. 00	VISITORS MEALS	A		CAFETERI A	11. 00	0	
38. 00	LAB - BLDG	В		NEW CAP REL COSTS-BLDG &	1. 00	9	
30.00	END DEDO			FIXT	1.00	,	30.00
39. 00	LAB - ADMINISTRATION	В		OTHER ADMIN AND GENERAL	5. 06	0	39. 00
40. 00	LAB - LAUNDRY	В	1	LAUNDRY & LINEN SERVICE	8. 00	0	
41. 00	LAB - HOUSEKEEPING	В		HOUSEKEEPI NG	9. 00	0	
42. 00		В		OPERATION OF PLANT	7. 00	0	
42. 01	HAMILTON CENTER OPERATION OF	A	1	OPERATION OF PLANT	7. 00	0	
	PLANT						
45.00	HAMILTON CENTER NUTRITION	Α	-266, 193	DI ETARY	10. 00	0	45.00
45. 01	FITNESS ACTIVITY	В		EMPLOYEE BENEFITS DEPARTMENT	4. 00	0	45. 01
45. 02	EQUI PMENT RENTAL	В	-7, 533	NEW CAP REL COSTS-MVBLE	2. 00	9	45. 02
				EQUI P			
45. 03	UHF - HOUSEKEEPING	Α	-1, 107	HOUSEKEEPI NG	9. 00	0	45. 03
45.04	MI SCELLANEOUS	В	-786, 668	OTHER ADMIN AND GENERAL	5. 06	0	45.04
45. 05	CATERI NG	В	-17, 167	CAFETERI A	11. 00	0	45. 05
45.06	MANAGEMENT SERVICES	В	-24, 000	OTHER ADMIN AND GENERAL	5. 06	0	45. 06
45. 08	OTHER RENTAL	В		OPERATION OF PLANT	7. 00	0	45. 08
45. 09	PHYSICIAN EQUIPMENT REVENUE	В		OPERATION OF PLANT	7. 00	0	
45. 24	UHF - ADMINISTRATION	В		OTHER ADMIN AND GENERAL	5. 06	0	
45. 26	LOBBY PHARMACY	В		EMPLOYEE BENEFITS DEPARTMENT	4. 00	0	
45. 27	LOBBYI NG COSTS	A		OTHER ADMIN AND GENERAL	5. 06	0	
45. 29	AP&S REVENUE	В		NEW CAP REL COSTS-BLDG &	1. 00	9	45. 29
45 00	ADOC DEVENUE		1	FIXT			45 00
45. 32	AP&S REVENUE	В		DATA PROCESSING	5. 02	0	
45. 37	COH REVENUE	В		NEW CAP REL COSTS-BLDG &	1. 00	9	45. 37
45 00	COLL DEVENUE		1	FIXT	F 04	_	45 00
45. 38	COH REVENUE	В		NONPATIENT TELEPHONES	5. 01	0	
45. 39	PHYSICIAN RENTAL	A		NEW CAP REL COSTS-BLDG & FLXT	1. 00	9	45. 39
45. 40	PHYSICIAN RENTAL	А		OPERATION OF PLANT	7. 00	0	45. 40
	1	_		NEW CAP REL COSTS-BLDG &	ı	9	
45. 42	ACCELLIATED DEFRECTATION	A		FIXT	1. 00	9	75.42
45. 43	CHILD BIRTH CLASS	В	1	DELIVERY ROOM & LABOR ROOM	52. 00	0	45. 43
45. 44		В		OTHER ADMIN AND GENERAL	5. 06	0	
45. 45	EDUCATION SERVICES	В		OTHER ADMIN AND GENERAL	5. 06	0	
45. 47	1	В		MEDICAL RECORDS & LIBRARY	16. 00	0	
45. 48	VHA	В		DRUGS CHARGED TO PATIENTS	73. 00	0	
45. 49	EMPLOYEE BENEFITS	В		EMPLOYEE BENEFITS DEPARTMENT	4. 00	0	
46. 00	1	В		EMPLOYEE BENEFITS DEPARTMENT	4. 00	0	
46. 02	HOUSEKEEPI NG	В		HOUSEKEEPI NG	9. 00	0	1
46. 03		В		OPERATION OF PLANT	7. 00	0	
46. 04	MAPLE CENTER	В	1	OTHER ADMIN AND GENERAL	5. 06	0	
46. 07	PROF SUPPORT UHS	В	1	OTHER ADMIN AND GENERAL	5. 06	0	
46. 08	AP&S A/P PD SPACE/EQUIP RENT R			NEW CAP REL COSTS-BLDG &	1. 00	9	1
				FIXT			
46. 10	WVHC ST ANN/ASH PHARMACY REVEN	В	-23, 726	DRUGS CHARGED TO PATIENTS	73. 00	0	46. 10
46. 11	HAF	Α		OTHER ADMIN AND GENERAL	5. 06	0	
50.00	` '		26, 995, 936				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.

STATEMENT OF COSTS OF SERVICES FROM RELATED ORGANIZATIONS AND HOME Provider CCN: 15-0023 Period: From 01/01/2017 To 12/31/2017 Date/Time Prepared: 5/30/2018 2: 18 pm

					5/30/2018 2:1	8 pm
	Li ne No.	Cost Center	Expense Items	Amount of	Amount	
				Allowable Cost	Included in	
					Wks. A, column	
					5	
	1. 00	2. 00	3. 00	4.00	5. 00	
		MENTS REQUIRED AS A RESULT OF	TRANSACTIONS WITH RELATED O	RGANI ZATI ONS OF	R CLAIMED HOME	
	OFFICE COSTS:	I	I	_		
1.00			PARAMED	0	476, 785	1.00
2. 00		NEW CAP REL COSTS-BLDG & FIX		0	1, 539, 311	2.00
3.00	1	NEW CAP REL COSTS-MVBLE EQUI		0	4, 262, 540	3.00
4. 00	1	1	HOME OFFICE	0	233, 941	4. 00
4. 01		l .	HOME OFFICE	0	1, 420, 547	4. 01
4. 02		l .	HOME OFFICE	0	354, 244	4. 02
4. 03		NEW CAP REL COSTS-BLDG & FIX		1, 408, 268	0	4.03
4.04		NEW CAP REL COSTS-MVBLE EQUI		3, 737, 705	0	4.04
4. 05	4. 00	EMPLOYEE BENEFITS DEPARTMENT	HOME OFFICE	31, 559, 779	0	4.05
4. 06	5. 01	NONPATIENT TELEPHONES	HOME OFFICE	202, 983	0	4.06
4.07	5. 02	DATA PROCESSING	HOME OFFICE	14, 892, 762	0	4.07
4.08	5. 03	PURCHASING RECEIVING AND STO	HOME OFFICE	1, 818, 531	0	4. 08
4.09	5. 05	CASHI ERI NG/ACCOUNTS RECEI VAB	HOME OFFICE	6, 045, 019	0	4.09
4. 10	5. 06	OTHER ADMIN AND GENERAL	HOME OFFICE	12, 998, 108	0	4. 10
4. 11	7. 00	OPERATION OF PLANT	HOME OFFICE	2, 885, 601	0	4.11
4. 12	9. 00	HOUSEKEEPI NG	HOME OFFICE	324, 087	0	4. 12
4. 13	10.00	DI ETARY	HOME OFFICE	128, 469	0	4. 13
4. 14	11.00	CAFETERI A	HOME OFFICE	213, 683	0	4.14
4. 15	13. 00	NURSING ADMINISTRATION	HOME OFFICE	1, 583, 904	0	4. 15
4. 16	16.00	MEDICAL RECORDS & LIBRARY	HOME OFFICE	223, 957	0	4. 16
4. 17	50.00	OPERATING ROOM	HOME OFFICE	91, 887	0	4. 17
4. 18	50. 01	CARDI AC SURGERY	HOME OFFICE	4, 584	0	4. 18
4. 19	50. 02	WVSC	HOME OFFICE	54, 571	0	4. 19
4. 20	51.00	RECOVERY ROOM	HOME OFFICE	4, 365	0	4. 20
4. 21	54.00	RADI OLOGY-DI AGNOSTI C	HOME OFFICE	187, 141	0	4. 21
4. 22	57. 00	CT SCAN	HOME OFFICE	295, 024	0	4. 22
4. 23	58. 00	MAGNETIC RESONANCE IMAGING (HOME OFFICE	69, 881	0	4. 23
4. 24	59.00	CARDIAC CATHETERIZATION	HOME OFFICE	282, 194	0	4. 24
4. 25	66.00	PHYSI CAL THERAPY	HOME OFFICE	25, 122	0	4. 25
4. 26	66. 02	O/P PHYSICAL THERAPY	HOME OFFICE	14, 364	0	4. 26
4. 27			HOME OFFICE	17, 959	0	4. 27
4. 28	68.00	SPEECH PATHOLOGY	HOME OFFICE	6, 780	0	4. 28
4. 29	69.00	ELECTROCARDI OLOGY	HOME OFFICE	87, 987	0	4. 29
4. 30	69. 01	CARDI AC REHAB	HOME OFFICE	3, 566	0	4.30
4. 31		l .	HOME OFFICE	21, 751	0	4. 31
4. 32			HOME OFFICE	570, 636	0	4.32
4. 33		ł	HOME OFFICE	3, 684	0	4.33
4. 34	l control of the cont		PLANT SALARIES	0	642, 721	4.34
4. 36	l control of the cont	PHYSI CAL THERAPY	UNI ON THERAPI ES	2, 377, 266	4, 310, 571	4. 36
4. 37		F	UNI ON THERAPI ES	1, 359, 022	2, 610, 757	4.37
4. 38			UNI ON THERAPI ES	1, 699, 169	0	4.38
4. 39		ł .	UNI ON THERAPI ES	641, 500	569, 204	4.39
4. 40	l control of the cont		UNI ON THERAPI ES	0	600, 215	4.40
4. 41		F	UNI ON THERAPI ES	0	906, 458	4. 41
5. 00	0		0	85, 841, 309	17, 927, 294	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	
					1
Symbol (1)	Name	Percentage of	Name	Percentage of	
		Ownershi p		Ownershi p	
1. 00	2. 00	3. 00	4. 00	5. 00	
B. INTERRELATIONSHIP TO RELAT	TED ORGANIZATION(S) AND/OR HO	ME OFFICE:			

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

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

6. 00	G	0. 00 UNI ON HOSPI TAL 100. 00	6.00
7. 00	G	0. 00 UNI ON THERAPY 100. 00	7.00
8. 00		0.00	8.00
9. 00		0.00	9.00
10.00		0.00	10.00

STATEME OFFI CE		RELATED ORGANIZATIONS AND HO	ME Provider (CCN: 15-0023	Period: From 01/01/2017 To 12/31/2017	Worksheet A-8 Date/Time Pro 5/30/2018 2:	epared:
				Related Organ	anization(s) and/or Home Office		
	Symbol (1)	Name	Percentage of Ownership	N	lame	Percentage of Ownership	
	1. 00	2. 00	3. 00	4	1. 00	5. 00	
	G. Other (financial or non-financial) specify:	OTHER					100.00

UNION HOSPITAL, INC.

In Lieu of Form CMS-2552-10

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

Health Financial Systems

- 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.

5.00 67,914,015 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.

4.38

4.39

4.40

4.41

 t book pooted to not notice the	our amile i dianet 2, the amount arronable chould be interested in contain i 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.

Termbur Schieff under trette AVIII.					
6. 00	HOME OFFICE	6.00			
7.00	THERAPI ES	7.00			
8.00		8.00			
9.00		9.00			
10.00		10.00			
100.00		100.00			

4.38

4.39

4.40

4.41

1, 699, 169

-600, 215

-906, 458

72, 296

0

0

0

Health Financial Systems	UNI ON HOSPI TAI	In Lieu of Form CMS-2552-10		
STATEMENT OF COSTS OF SERVICES FROM	RELATED ORGANIZATIONS AND HOME	Provi der CCN: 15-0023	Peri od:	Worksheet A-8-1
OFFICE COSTS			From 01/01/2017 To 12/31/2017	Date/Time Prepared: 5/30/2018 2:18 pm
Related Organization(s) and/or Home Office				
Type of Business				
6.00				

- (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
- 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.

Peri od: From 01/01/2017 To 12/31/2017 Date/Time Prepared: 5/30/2018 2:18 pm

							5/30/2018 2: 1	8 pm
	Wkst. A Line #		Total	Professi onal	Provi der	RCE Amount	Physi ci an/Prov	
		I denti fi er	Remuneration	Component	Component		ider Component	
							Hours	
	1. 00	2. 00	3. 00	4. 00	5. 00	6. 00	7. 00	
1. 00	22. 00	I&R SERVICES-OTHER PRGM	831, 859	0	831, 859	211, 500	7, 004	1. 00
		COSTS APPRVD						
2. 00		I NTENSI VE NURSERY	548, 000	548, 000		237, 100	0	2. 00
3.00	41. 00	SUBPROVI DER - I RF	88, 125	0	88, 125	211, 500	1, 175	3.00
4.00	50.00	OPERATING ROOM	2, 098, 250	2, 044, 250	54, 000	246, 400	141	4.00
5.00	50. 01	CARDI AC SURGERY	2, 505, 153	2, 505, 153	0	246, 400	0	5.00
6.00	50. 02	WVSC	1, 182, 650	1, 182, 650	0	246, 400	0	6.00
7.00	52. 00	DELIVERY ROOM & LABOR ROOM	2, 063, 490	2, 063, 490	0	246, 400	0	7. 00
8.00	54.00	RADI OLOGY-DI AGNOSTI C	635, 264	635, 264	0	271, 900	0	8. 00
9. 00	56. 00	RADI OI SOTOPE	10, 850	10, 850	0	271, 900	0	9. 00
10.00	59. 00	CARDIAC CATHETERIZATION	1, 846, 966	1, 846, 966	0	260, 300	0	10.00
11.00		LABORATORY	617, 000		617, 000		4, 570	11.00
12.00	69. 00	ELECTROCARDI OLOGY	95, 710		11, 200	197, 500	112	12.00
13.00		ELECTROENCEPHALOGRAPHY	2, 210, 900		0	179, 000	0	13.00
14. 00		DRUGS CHARGED TO PATIENTS	493, 283		0	211, 500	0	14. 00
15. 00		PATIENT NUTRITION	4, 750		4, 750		19	
16. 00		EMERGENCY	1, 051, 762		27, 026			16. 00
200.00	71.00	E.II.E.R.G.E.R.G.	16, 284, 012		1, 633, 960	· ·	13, 882	
200.00	Wkst. A Line #	Cost Center/Physician	Unadjusted RCE		Cost of		Physician Cost	
	WKSt. A LITIC #	I denti fi er	Li mi t	Unadjusted RCE			of Malpractice	
		Tueller Tref		Li mi t	Continuing	Share of col.	Insurance	
					Education	12	Trisur arice	
	1.00	2.00	8. 00	9. 00	12. 00	13. 00	14. 00	
1. 00		I &R SERVICES-OTHER PRGM	712, 186		0		0	1. 00
1.00	22.00	COSTS APPRVD	712,100	00,007	J	Ŭ	Ĭ	1.00
2. 00	35.00	INTENSIVE NURSERY	1	0	0	0	32	2. 00
3. 00		SUBPROVI DER - I RF	119, 477	5, 974	0	0	0	3. 00
4. 00		OPERATING ROOM	16, 703		0	o O	0	4. 00
5. 00		CARDI AC SURGERY	10, 709	000	0	0	47, 110	
6. 00	50.01			0	0	0	0	6. 00
7. 00		DELIVERY ROOM & LABOR ROOM		0	0	0	0	7. 00
8. 00		RADI OLOGY-DI AGNOSTI C		0	0	0	5, 820	8. 00
9. 00		RADI OLOGI - DI AGNOSTI C			0	0	5, 820	9. 00
					0	0	312	
10.00		CARDI AC CATHETERI ZATI ON	422 020		0	0		
11.00		LABORATORY	433, 930		0	0	0	11.00
12.00		ELECTROCARDI OLOGY	10, 635	1	_	0	63	12.00
13.00		ELECTROENCEPHALOGRAPHY	0	0	0	0	88, 381	
14.00		DRUGS CHARGED TO PATIENTS	1 000	0	0	0	0	14.00
15.00		PATIENT NUTRITION	1, 932		0	0	0	15.00
16.00	91.00	EMERGENCY	87, 549		0	0	150	
200.00		0 1 0 1 (5)	1, 382, 412		0	0	141, 868	200.00
	Wkst. A Line #		Provi der	Adjusted RCE	RCE	Adjustment		
		I denti fi er	Component	Limit	Di sal I owance			
			Share of col.					
	1.00	2.00	14	1/ 00	47.00	40.00		
4.00	1.00	2.00	15. 00	16.00	17. 00	18. 00		1 00
1. 00		I &R SERVICES-OTHER PRGM	0	712, 186	119, 673	119, 673		1. 00
0.00		COSTS APPRVD				F 40, 000		0.00
2.00		I NTENSI VE NURSERY	0		0	548, 000		2.00
3.00		SUBPROVI DER – I RF	0			0		3.00
4.00		OPERATING ROOM	0		37, 297	2, 081, 547		4.00
5. 00		CARDI AC SURGERY	0	· ·	0	2, 505, 153		5. 00
6. 00	50. 02		0	0	0	1, 182, 650		6. 00
7. 00		DELIVERY ROOM & LABOR ROOM	0		0	2, 063, 490		7. 00
8. 00		RADI OLOGY-DI AGNOSTI C	0	· ·	0	635, 264		8. 00
9. 00		RADI OI SOTOPE	0	0	0	10, 850		9. 00
10.00		CARDIAC CATHETERIZATION	0	0	0	1, 846, 966		10.00
11. 00		LABORATORY	0	433, 930	183, 070	183, 070		11. 00
12.00		ELECTROCARDI OLOGY	7	10, 642	558	85, 068		12.00
13.00		ELECTROENCEPHALOGRAPHY	0	0	0	2, 210, 900		13.00
14.00		DRUGS CHARGED TO PATIENTS	0	0	0	493, 283		14.00
15.00		PATIENT NUTRITION	0	1, 932	2, 818	2, 818		15. 00
16.00	91. 00	EMERGENCY	4	87, 553	0	1, 024, 736		16.00
200.00			11	1, 382, 423	343, 416	14, 993, 468		200.00

| Period: | Worksheet B | From 01/01/2017 | Part | To | 12/31/2017 | Date/Time Prepared: Health Financial Systems
COST ALLOCATION - GENERAL SERVICE COSTS Provi der CCN: 15-0023

					o 12/31/2017		pared:
			CAPI TAL REI	LATED COSTS		5/30/2018 2:1	8 pili
	Coot Conton Decement on	Not Evnences	NEW DLDC 0	NEW MADLE	EMBL OVEE	NONDATI ENT	
	Cost Center Description	Net Expenses for Cost	NEW BLDG & FLXT	NEW MVBLE EQUIP	EMPLOYEE BENEFITS	NONPATI ENT TELEPHONES	
		Allocation			DEPARTMENT		
		(from Wkst A					
		col. 7) 0	1. 00	2.00	4. 00	5. 01	
	GENERAL SERVICE COST CENTERS						
1. 00 2. 00	00100 NEW CAP REL COSTS-BLDG & FLXT	15, 695, 620 8, 535, 809	15, 695, 620	•			1.00 2.00
2. 00 4. 00	00200 NEW CAP REL COSTS-MVBLE EQUIP 00400 EMPLOYEE BENEFITS DEPARTMENT	34, 549, 087	83, 418	8, 535, 809 0	1		4.00
5. 01	00540 NONPATIENT TELEPHONES	900, 718	10, 671			1, 199, 105	5. 01
5. 02	00550 DATA PROCESSING	14, 247, 395	0		1	0	5. 02
5. 03 5. 04	00560 PURCHASING RECEIVING AND STORES 00570 ADMITTING	1, 641, 061 2, 211, 690	0 49, 732	ı	-	0 42, 996	5. 03 5. 04
5. 05	00580 CASHI ERI NG/ACCOUNTS RECEI VABLE	6, 045, 019	0	0, 110	1	0	5. 05
5. 06	00590 OTHER ADMIN AND GENERAL	20, 058, 444	301, 626			110, 834	5. 06
7. 00 8. 00	00700 OPERATION OF PLANT 00800 LAUNDRY & LINEN SERVICE	9, 473, 025 1, 037, 863	5, 438, 971 97, 256			67, 838 17, 198	7. 00 8. 00
9. 00	00900 HOUSEKEEPI NG	2, 968, 190	86, 292				9.00
10.00	01000 DI ETARY	506, 723	178, 269	273, 386	135, 126	28, 664	10.00
11.00	01100 CAFETERI A	1, 547, 945	127, 205			0	11.00
13. 00 16. 00	01300 NURSI NG ADMI NI STRATI ON 01600 MEDI CAL RECORDS & LI BRARY	3, 502, 600 3, 318, 216	38, 590 85, 805			8, 599 28, 664	13. 00 16. 00
17. 00	01700 SOCIAL SERVICE	0	0			0	17. 00
21.00	02100 &R SERVICES-SALARY & FRINGES APPRVD	1, 419, 840	0	1		0	21.00
22. 00 23. 00	02200 1&R SERVICES-OTHER PRGM COSTS APPRVD 02300 PARAMED ED PRGM	2, 168, 301 138, 461	0	0		0	22. 00 23. 00
23. 00	02341 OTHER MED ED	201, 321	11, 694			0	23. 00
23. 02	02301 PARAMED ED PRGM	138, 461	0			0	23. 02
30. 00	O3000 ADULTS & PEDIATRICS	27, 297, 010	3, 054, 196	844, 382	7, 545, 716	163, 385	30.00
31.00	03100 INTENSIVE CARE UNIT	6, 147, 493	3, 034, 190			27, 708	31.00
35. 00	02040 I NTENSI VE NURSERY	2, 206, 360	46, 776			17, 198	35. 00
41.00	04100 SUBPROVI DER – I RF	1, 425, 282	240, 719				41.00
43. 00	04300 NURSERY ANCILLARY SERVICE COST CENTERS	1, 223, 927	63, 781	7, 112	377, 589	3, 822	43.00
50.00	05000 OPERATING ROOM	10, 645, 786	661, 608	1, 498, 972	1, 071, 920	78, 348	50. 00
50. 01	05001 CARDI AC SURGERY	2, 057, 444	29, 235			5, 733	50. 01
50. 02 51. 00	05002 WVSC 05100 RECOVERY ROOM	10, 574, 222 1, 976, 447	487, 707 23, 258			0 17, 198	50. 02 51. 00
51. 02	05101 0/P TREATMENT ROOM	2, 565, 524	346, 664			25, 797	51. 02
52.00	05200 DELIVERY ROOM & LABOR ROOM	3, 515, 717	337, 910			21, 976	52.00
54. 00 55. 00	05400 RADI OLOGY-DI AGNOSTI C 05500 RADI OLOGY-THERAPEUTI C	6, 472, 276 5, 059, 361	530, 049 428, 668				54. 00 55. 00
56. 00	05600 RADI OI SOTOPE	1, 278, 004	47, 328				56.00
57. 00	05700 CT SCAN	2, 433, 464	35, 277			6, 688	57.00
58. 00 59. 00	05800 MAGNETIC RESONANCE IMAGING (MRI) 05900 CARDIAC CATHETERIZATION	1, 829, 530 15, 272, 950	42, 115 271, 140			3, 822 32, 486	58. 00 59. 00
60.00	06000 LABORATORY	9, 234, 131	271, 140			7, 644	
62.00	06200 WHOLE BLOOD & PACKED RED BLOOD CELLS	1, 250, 323	0		1	0	62. 00
65. 00	06500 RESPI RATORY THERAPY 06600 PHYSI CAL THERAPY	3, 615, 244	34, 660			13, 376	65.00
66. 00 66. 01	06601 PSYCHI ATRI C/PSYCHOLOGI CAL SERVI CES	2, 627, 541 0	164, 854 0		1	21, 976 0	66. 00 66. 01
66. 02	06602 0/P PHYSI CAL THERAPY	2, 093, 525	0			955	66. 02
67.00	06700 OCCUPATI ONAL THERAPY	1, 717, 128	26, 929			4, 777	67.00
68. 00 69. 00	06800 SPEECH PATHOLOGY 06900 ELECTROCARDI OLOGY	758, 086 3, 827, 525	53, 403 21, 195		0 460, 823	955 3, 822	68. 00 69. 00
69. 01	06901 CARDI AC REHAB	312, 643	116, 941			5, 733	69. 01
70.00	07000 ELECTROENCEPHALOGRAPHY	601, 112	24, 444			16, 243	•
71. 00 72. 00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 07200 IMPL. DEV. CHARGED TO PATIENTS	891, 407 12, 623, 290	92, 773 0			13, 376 0	71.00 72.00
73. 00		46, 955, 142	208, 577	1	_	47, 773	73.00
76. 00	03020 RENAL ACUTE	1, 630, 606	57, 252	988	0	3, 822	76. 00
90. 00	OUTPATIENT SERVICE COST CENTERS O9000 CLINIC	213, 948	3, 541	Ι	66, 003	0	90.00
90.00	09000 PATIENT NUTRITION	347, 599	31, 347			0	90.00
90. 07	09007 WOUND CLINIC	1, 232, 564	63, 327	17, 138	107, 921	12, 421	90. 07
91.00	09100 EMERGENCY 09200 OBSERVATION BEDS (NON-DISTINCT PART)	11, 073, 863	390, 955	230, 520	1, 795, 532	60, 194	91.00
92. UU	SPECIAL PURPOSE COST CENTERS						92.00
118.00	SUBTOTALS (SUM OF LINES 1 through 117)	333, 292, 263	14, 819, 556	8, 163, 006	30, 829, 216	1, 101, 648	118. 00
100.00	NONREI MBURSABLE COST CENTERS					OFF	100.00
	019000 GIFT, FLOWER, COFFEE SHOP & CANTEEN 007950 RURAL HEALTH	0 3, 375, 468	0		1		190. 00 194. 00
	07951 RENTAL PROPERTY	133, 368	0				194. 01

Health Financial Systems	UNION HOSPITAL, INC.	In Lieu of Form CMS-2552-10
COST ALLOCATION - GENERAL SERVICE COSTS	Provi der CCN: 15-0023	Peri od: From 01/01/2017 To 12/31/2017 Worksheet B Part I Date/Time Prepared:

					5/30/2018 2:1	8 pm
		CAPITAL REL	ATED COSTS			
Cost Center Description	Net Expenses	NEW BLDG &	NEW MVBLE	EMPLOYEE	NONPATI ENT	
	for Cost	FLXT	EQUI P	BENEFI TS	TELEPHONES	
	Allocation			DEPARTMENT		
	(from Wkst A					
	col. 7)					
	0	1.00	2. 00	4. 00	5. 01	
194. 02 07954 FAMILY PRACTICE	3, 948, 208	602, 098	186, 262	874, 355	67, 838	194. 02
194. 03 07952 WELLNESS	469, 895	227, 417	0	128, 123	0	194. 03
194. 04 07955 PHYSI CI AN PRACTI CES	13, 574, 665	0	123, 512	2, 170, 948	21, 020	194. 04
194.06 07953 SYCAMORE SPORTS MED	85, 266	0	594	4, 857	0	194.06
194. 07 07956 PSYCHI ATRI C/PSYCHOLOGI CAL SERVI CES	392, 312	46, 549	4, 544	120, 823	7, 644	194. 07
200.00 Cross Foot Adjustments						200.00
201.00 Negative Cost Centers		0	0	0	0	201.00
202.00 TOTAL (sum lines 118 through 201)	355, 271, 445	15, 695, 620	8, 535, 809	34, 632, 505	1, 199, 105	202.00

In Lieu of Form CMS-2552-10

Period: Worksheet B
From 01/01/2017 Part I
To 12/31/2017 Date/Time Prepared: 5/30/2018 2:18 pm

					1	0 12/31/2017	5/30/2018 2: 1	
		Cost Center Description	DATA	PURCHASI NG	ADMITTI NG	CASHI ERI NG/AC	Subtotal	
			PROCESSI NG	RECEIVING AND		COUNTS		
			5. 02	STORES 5. 03	5. 04	RECEI VABLE 5. 05	5A. 05	
	GENER	AL SERVICE COST CENTERS	5. 02	5.03	5. 04	5.05	5A. U5	
1. 00		NEW CAP REL COSTS-BLDG & FLXT						1.00
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP						2.00
4.00		EMPLOYEE BENEFITS DEPARTMENT						4.00
5. 01		NONPATI ENT TELEPHONES						5. 01
5. 02		DATA PROCESSING	14, 247, 395					5. 02
5. 03	1	PURCHASING RECEIVING AND STORES	0	1, 641, 061	2 020 /27			5.03
5. 04 5. 05	1	ADMITTING CASHIERING/ACCOUNTS RECEIVABLE	0	1, 176 0	2, 838, 637 0			5. 04 5. 05
5. 06		OTHER ADMIN AND GENERAL	25, 351	65			22, 431, 030	5.06
7. 00		OPERATION OF PLANT	20,001	648	Ö		15, 874, 588	7.00
8.00		LAUNDRY & LINEN SERVICE	0	2, 275	0	0	1, 568, 637	8.00
9.00		HOUSEKEEPI NG	0	4, 631	0		3, 883, 753	9. 00
10. 00	1	DI ETARY	240, 837	97	0		1, 363, 102	1
11.00		CAFETERI A	0	2	0		2, 295, 214	11.00
13. 00 16. 00	1	NURSING ADMINISTRATION	E02 070	0 30	0 0		4, 175, 800	1
17. 00		MEDICAL RECORDS & LIBRARY SOCIAL SERVICE	583, 078 0	0	0	0	4, 745, 166 0	16. 00 17. 00
21. 00		I&R SERVICES-SALARY & FRINGES APPRVD	0	0	0	0	1, 916, 070	•
22. 00		I&R SERVICES-OTHER PRGM COSTS APPRVD	0	0	Ö		2, 644, 004	1
23.00	02300	PARAMED ED PRGM	0	0	0	0	179, 882	1
23. 01		OTHER MED ED	0	0	0		301, 920	
23. 02		PARAMED ED PRGM	0	0	0	0	179, 882	23. 02
20.00		I ENT ROUTINE SERVICE COST CENTERS	7 072 074	2/0.0/7	F00 007	4/2.0/0	40 210 505	20.00
30. 00 31. 00		ADULTS & PEDIATRICS INTENSIVE CARE UNIT	7, 972, 964 937, 996				48, 210, 595 10, 141, 213	1
35. 00		I NTENSI VE NURSERY	202, 810				3, 443, 584	1
41. 00	1	SUBPROVI DER – I RF	0	15, 173			2, 216, 252	1
43.00		NURSERY	0	0			1, 725, 320	1
		LARY SERVICE COST CENTERS						
50.00	1	OPERATI NG ROOM	405, 620	66, 652	506, 431		15, 691, 702	50.00
50. 01 50. 02	05001	CARDI AC SURGERY	0	372, 146 9, 583	36, 597 0		3, 425, 395 11, 943, 077	50. 01 50. 02
51.00	1	RECOVERY ROOM	38, 027	40, 970			2, 791, 968	1
51. 02		O/P TREATMENT ROOM	00,027	34, 825			3, 845, 937	51.02
52.00		DELIVERY ROOM & LABOR ROOM	380, 269		93, 459		5, 871, 756	•
54.00	05400	RADI OLOGY-DI AGNOSTI C	798, 564	21, 235	64, 986	235, 361	10, 524, 107	54.00
55.00		RADI OLOGY-THERAPEUTI C	0	810			6, 234, 721	55.00
56. 00	1	RADI OI SOTOPE	25, 351	1, 768			1, 682, 068	•
57.00		CT SCAN	0	61, 268		298, 775	3, 325, 003	57.00
58. 00 59. 00		MAGNETIC RESONANCE IMAGING (MRI) CARDIAC CATHETERIZATION	430, 971	1, 322 11, 116			2, 355, 578 17, 110, 713	1
60.00		LABORATORY	430, 971	0			9, 928, 468	1
62. 00	1	WHOLE BLOOD & PACKED RED BLOOD CELLS	0	0	13, 482		1, 277, 883	1
65.00		RESPI RATORY THERAPY	177, 459	36, 351	90, 959		5, 338, 075	1
66.00	06600	PHYSI CAL THERAPY	291, 539	837	61, 711	53, 481	3, 248, 762	66.00
66. 01		PSYCHI ATRI C/PSYCHOLOGI CAL SERVI CES	0	_	_	- 1	0	
66. 02	1	O/P PHYSICAL THERAPY	0	834			2, 177, 730	1
67. 00 68. 00		OCCUPATIONAL THERAPY SPEECH PATHOLOGY	0	0	28, 627 6, 867		1, 820, 367 834, 849	67. 00 68. 00
69.00		ELECTROCARDI OLOGY	240, 837	5, 863			5, 042, 269	1
69. 01	1	CARDI AC REHAB	38, 027	259			599, 869	
70.00		ELECTROENCEPHALOGRAPHY	0	1, 162			1, 544, 215	1
71. 00	1	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	4, 021	4, 086		1, 277, 633	71.00
72. 00		IMPL. DEV. CHARGED TO PATIENTS	0	0			12, 736, 406	
73.00		DRUGS CHARGED TO PATIENTS	266, 188				50, 507, 724	
76. 00		RENAL ACUTE TIENT SERVICE COST CENTERS	0	15, 358	18, 163	16, 919	1, 743, 108	76. 00
90.00		CLINIC	0	0	8	3, 096	286, 596	90.00
90.05		PATIENT NUTRITION	0	54			497, 488	1
90. 07		WOUND CLINIC	0	19, 040	111	30, 337	1, 482, 859	90. 07
91.00	1	EMERGENCY	1, 115, 454	190, 500	164, 859	592, 777	15, 614, 654	
92. 00		OBSERVATION BEDS (NON-DISTINCT PART)					0	92.00
118. 00		AL PURPOSE COST CENTERS SUBTOTALS (SUM OF LINES 1 through 117)	14, 171, 342	1, 631, 456	2, 838, 637	6, 045, 019	328, 056, 992	118 00
110.00		IMBURSABLE COST CENTERS	14, 171, 342	1,031,430	2, 030, 037	0, 043, 017	320, 030, 772	1110.00
	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0				190. 00
		RURAL HEALTH	0	3, 431	0		3, 934, 391	1
		RENTAL PROPERTY	0	0	0		139, 950	1
		FAMILY PRACTICE	0	16	0		5, 678, 777	1
		WELLNESS PHYSICIAN PRACTICES	25, 351	0 6, 110			825, 435 15, 921, 606	
		SYCAMORE SPORTS MED	25, 351				90, 717	
	,	1		<u> </u>		, <u> </u>	. =1	

Health Financial Systems	UNI ON HOSPI TAL, INC.	In Lieu of Form CMS-2552-10
COST ALLOCATION - GENERAL SERVICE COSTS	Provi der CCN: 15-0023	Peri od: Worksheet B From 01/01/2017 Part I To 12/31/2017 Date/Time Prepared:

						5/30/2018 2:1	8 pm
	Cost Center Description	DATA	PURCHASI NG	ADMI TTI NG	CASHI ERI NG/AC	Subtotal	
		PROCESSI NG	RECEIVING AND		COUNTS		
			STORES		RECEI VABLE		
		5. 02	5. 03	5. 04	5. 05	5A. 05	
194. 07 0795	6 PSYCHI ATRI C/PSYCHOLOGI CAL SERVI CES	50, 702	48	0	0	622, 622	194. 07
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)	14, 247, 395	1, 641, 061	2, 838, 637	6, 045, 019	355, 271, 445	202.00

In Lieu of Form CMS-2552-10

Period: Worksheet B
From 01/01/2017 Part I
To 12/31/2017 Date/Time Prepared: 5/30/2018 2:18 pm

Description						72/31/2017	5/30/2018 2:1	
		Cost Center Description				HOUSEKEEPI NG	DI ETARY	
CONTROL STRVICT COST CENTERS						9.00	10.00	
2.00 OCCOOL NEW CAP MEEL COSTS-MINELE CEUT P 4.00 OCCOOL NEW OPER STATE THE PROBLEMS 5.01 OCCOOL NEW OF THE PROBLEMS 5.02 OCCOOL NEW OF THE PROBLEMS 5.03 OCCOOL NEW OF THE PROBLEMS 5.04 OCCOOL NEW OF THE PROBLEMS 5.04 OCCOOL NEW OF THE PROBLEMS 5.05 OCCOOL NEW OF THE PROBLEMS 5.06 OCCOOL NEW OF THE PROBLEMS 5.07 OCCOOL NEW OF THE PROBLEMS 5.07 OCCOOL NEW OF THE PROBLEMS 5.08 OCCOOL NEW OF THE PROBLEMS 5.09 OCCOOL NEW OF THE PROBLEMS 5.00 OCCO		GENERAL SERVICE COST CENTERS	0.00	71.00	0.00	71 00	10.00	
4 - 00 COMPONENT FOR PRIFETY TO PERATEWEY								•
5. 01 00504 NONPATIENT TELEPRONES 5. 01 00505 DATA PROCESSIN N. S. 01 0050 CONTROL PROCESSIN N. S. 02 0050 CONTROL PROCESSIN N								•
5.02 0.0550 DATA PROCESSING								•
1.00 10-bed PURCHASHISH SECELY NG AND STORES								•
0.0500 DOSPO SMITTH NO		1						•
5.05 0.0590 CASH IER IN CARCOUNTS RECEIVABLE 22, 431, 030 16, 944, 42 17, 000 18, 000 10, 000 19, 140 10 0 P FLANT 10, 000 150, 147, 149 10, 000 10,								1
5.06 0.0500 OTHER ABIN AND CEMERAL 22.431, 030 16. 944, 424 1.845, 317 4.416, 991 7.00 0.00700 0.0047110 or PT-1470 7.00 0.00700 0.004710 0.00 0.0000 0.004710 0.00 0.0000 0.004710 0.00 0.0000 0.004710 0.00 0.0000 0.004710 0.00 0.0000 0.004710 0.00 0.0000 0.004710 0.00 0.0000 0.004710 0.00 0.0000 0.004710 0.00 0.0000 0.004710		1 1						1
0.00 00700 00700		1 1	22, 431, 030					1
0.000 0.0000 0.0000 0.00000 0.00000 0.00000 0.00000 0.00000 0.00000 0.00000 0.00000 0.00000 0.000000 0.00000000	7.00	1 1						7. 00
10.00 10.000 DETARY	8.00	00800 LAUNDRY & LINEN SERVICE	105, 715	167, 965	1, 842, 317			8.00
11.00 0 1100 (CAFFERIA 154, 481 219, 690 0 58, 374 0 11.00		1 1				4, 418, 091		1
13.00 01300 NURSINC ADMINISTRATION 281,420 66,647 0 17,709 0 13.00								1
16.00		1 1			1			ı
17.00 01700 01700 01700 0 0 0 0 0 0 0 17.00		1 1			_			1
21.00 0 2000 BA SERVICES-SALARY & FINKES APPRVD 129, 130		1 1	319, 791					1
22.00 02200 RAY SERVICES-OTHER PRIM COSTS APPRVD 178, 187 0 0 0 0 0 22.00 0 0 0 0 0 23.00 0230		1	129 130	_	0	0	_	1
23.00				_	o o	Ö	_	
23 02 PARAMED ED PRICK				_	0	0	0	1
INPATI ENT ROUTH NE SERVICE COST CENTERS 3, 249, 057 5, 274, 749 650, 758 1, 401, 556 1, 414, 928 30, 00 30, 00 3010 AULTS & PEDIATRICS 3, 249, 057 5, 274, 749 650, 758 1, 401, 556 1, 414, 928 30, 00 30, 00 3010 INTENSIVE CARE UNIT 683, 447 644, 876 97, 152 1717, 351 209, 831 31, 00 35, 00	23. 01	02341 OTHER MED ED		20, 196	0	5, 366	0	23. 01
30 00 30000 ADULTS & PEDIATRICS 3, 249, 057 5, 274, 749 650, 758 1, 401, 556 1, 414, 928 30, 00 310 0 0 0 1 1 1 1 1 2 2 2 2 3 3 3 0 0 3 5 0 0 0 0 0 0 0 0 0	23. 02	02301 PARAMED ED PRGM	12, 123	0	0	0	0	23. 02
33.00 0.3100 INTENSI VE CARE UNIT 683, 447 644, 876 97, 152 171, 351 209, 831 31.00 0.35.00 0.00 INTENSI VE NUISSERY 232, 073 80, 785 7, 77 71, 465 0.35.00 35.00 0.4100 SUBPROVI DER - I RF 149, 360 415, 733 11, 059 110, 465 99, 384 41, 0.00 43.00 4								
15. 00 02040 INTERSIVE NURSERY								1
41.00 04100 SUBROWI DER - I RF 149, 360 415, 733 11, 059 110, 465 98, 384 41, 00 430, 00 430, 00 110, 005 0 50, 00 50								1
ABOON MARCHERY SERVICE COST CENTERS								1
MOLILLARY SERVICE COST CENTERS		1 1						•
50.00	43.00		110, 274	110, 133	U	29, 209	U	43.00
50.00 05000 CARDIN AC SURGERY 220, 848 50, 491 47 13, 416 0 50, 01 50.00 05000 WSC WSC 804, 880 842, 294 11, 721 223, 807 0 50, 00 51.00 05100 RECOVERY ROOM 188, 159 40, 168 75, 174 10, 673 0 51.00 51.00 51.00 05100 PACKET RATINET ROOM 29, 189 598, 705 65, 765 159, 083 122, 965 51.00 52.00 05200 DELIVERY ROOM & LABOR ROOM 395, 715 583, 586 80, 674 155, 065 41 52.00 64.00 05400 RADIOLOGY-HERAPEUTIC 420, 177 740, 331 24, 040 196, 714 0 55.00 65.00 05500 RADIOLOGY-HERAPEUTIC 420, 177 740, 331 24, 040 196, 714 0 55.00 65.00 05500 RADIOLOGY-HERAPEUTIC 133, 360 811, 739 7, 189 21, 719 0 56.00 65.00 05500 RADIOLOGY-HERAPEUTIC 133, 360 811, 739 7, 189 21, 719 0 56.00 65.00 05500 RADIOLOGY-HERAPEUTIC 133, 360 811, 739 7, 189 21, 719 0 56.00 65.00 05500 RADIOLOGY-HERAPEUTIC 153, 440 468, 272 15, 849 124, 042 81, 749 72, 734 71, 722 19, 320 81, 700 85.00 05900 MARCHETIC RESONANCE IMAGING (MRI) 158, 749 72, 734 51, 222 19, 320 0 80, 60 60, 6	50 00		1 057 511	1 142 629	116 090	303 609	0	50 00
50.00 05000 WOVE DECOVERY ROOM 188, 159 40, 168 75, 174 10, 673 0 51, 00 51, 00 5100 05101 07 PREATMENT ROOM 259, 189 598, 705 65, 765 159, 083 122, 965 51, 02 52, 00 0500 DELI VERY ROOM & LABOR ROOM 395, 715 583, 586 80, 674 434, 238 0 54, 00 55, 00 0500 REDOVER VINERAPEUTI C 420, 177 40, 321 50, 474 243, 238 0 54, 00 0500 0500 RADIOLOCY-THERAPEUTI C 420, 177 40, 321 424, 040 196, 714 0 55, 00 55, 00 0500 RADIOLOCY-THERAPEUTI C 420, 177 40, 321 424, 040 196, 714 0 55, 00 55, 00 0500 RADIOLOCY-THERAPEUTI C 420, 177 40, 321 424, 040 196, 714 0 55, 00 56, 00 0500 RADIOLOCY-THERAPEUTI C 113, 360 81, 739 7, 189 21, 719 0 56, 00 57, 00 5700 CTSONO CTSONO 224, 082 09, 255 0 0 16, 189 0 57, 00 58, 00 05800 MAGNETI C RESONANCE I MAGI NG (MRI) 158, 749 72, 734 51, 222 19, 326 0 58, 00 05800 MAGNETI C RESONANCE I MAGI NG (MRI) 158, 749 72, 734 51, 222 19, 326 0 58, 00 0 0 0 0 0 0 0 0 0		1						•
51.02 05101 0/P TREATMENT ROOM 259, 189 598, 705 66, 765 159, 083 122, 965 11.02 12.00 1							0	•
S2.00 05200 DELIVERY ROOM & LABOR ROOM 395, 715 583, 586 80, 674 155, 065 41 82 00	51.00	05100 RECOVERY ROOM	188, 159	40, 168	75, 174	10, 673	0	51.00
S4. 00 05400 RADIO LOGY-DI AGNOSTIC 709, 251 915, 421 50, 474 243, 238 0 54, 00 50. 00 05500 RADIO LOGY-THERAPEUTIC 420, 177 740, 331 24, 040 196, 714 0 55, 00 55. 00 05600 RADIO I SOTOPE 113, 360 81, 739 7, 189 21, 719 0 56, 60 05700 CT SCAN 224, 082 60, 925 15, 849 124, 425 8, 569 58, 00 05700 CT SCAN 1, 153, 142 468, 272 15, 849 124, 425 8, 569 59, 00 060, 00 06000 LABORATORY 669, 109 0 0 0 0 0 0 0 0 0	51. 02	05101 0/P TREATMENT ROOM	259, 189	598, 705	65, 765	159, 083	122, 965	51.02
55.00						155, 065	41	1
56.00 05600 RADIO I SOTOPE 113, 360 81, 739 7, 189 21, 719 0 56, 00								1
57.00 05700 CT SCAN 224, 082 60, 925 0 16, 189 0 57. 00 58.00 05800 MAGNETIC RESONANCE I MAGI NG (MRI) 158, 749 72, 734 51, 222 19, 326 0 58. 00 59.00 05900 CARDI AC CATHETERI ZATI ON 1, 153, 142 468, 272 15, 849 124, 425 8, 569 59. 00 60.00 06600 LABORATORY 669, 109 0 0 0 0 0 0 61.00 06600 LABORATORY 1HERAPY 359, 749 59, 859 0 15, 905 0 65. 00 66.01 06600 PHYSI CAL THERAPY 359, 749 284, 710 13, 658 75, 651 0 66. 00 66.01 06600 PHYSI CAL THERAPY 218, 944 284, 710 13, 658 75, 651 0 66. 00 66.02 06600 OFFICIAL THERAPY 122, 680 46, 507 0 12, 358 0 67. 00 67.00 06700 0500 0700 0700 0 0 0 0 68.00 06600 SPECTH PATHOLOGY 56, 263 92, 229 0 24, 506 0 68. 00 69.00 06900 ELECTROCARDI OLOGY 339, 814 36, 606 14, 368 9, 727 0 69. 00 69.01 06900 ELECTROCARDI OLOGY 339, 814 36, 606 14, 368 9, 727 0 69. 00 69.01 06900 ELECTROCARDI OLOGY 339, 814 36, 606 14, 368 9, 727 0 69. 00 69.01 06900 ELECTROCARDI OLOGY 339, 814 36, 606 14, 368 9, 727 0 69. 00 69.01 06900 ELECTROCARDI OLOGY 339, 814 36, 606 14, 368 9, 727 0 69. 00 69.01 06900 ELECTROCARDI OLOGY 339, 814 36, 606 14, 368 9, 727 0 69. 00 69.01 06900 ELECTROCARDI OLOGY 339, 814 36, 606 14, 368 9, 727 0 69. 00 69.01 06900 ELECTROCARDI OLOGY 339, 814 36, 606 14, 368 9, 727 0 69. 00 69.01 06900 ELECTROCARDI OLOGY 339, 814 36, 606 14, 368 9, 727 0 69. 00 69.01 06900 ELECTROCARDI OLOGY 339, 814 36, 606 14, 368 9, 727 0 69. 00 69.01 06900 ELECTROCARDI OLOGY 339, 814 36, 606 349, 817 349, 817 349, 817 349, 817 349, 817 69.01 06900 07000								1
58.00 05800 MAGNETIC RESONANCE I IMAGI NG (MRI) 15.86, 749 72, 734 51, 222 19, 326 0 58.00 05900 CARDIA CA CATHETERI ZATI ON 1, 153, 142 468, 272 15, 849 124, 425 8, 569 59, 00 06.00 06000 LABORATORY 669, 109 0 0 0 0 0 0 0 0 0							_	1
59,00		1 1					0	1
60.0 06000 LABORATORY 669, 109 0 0 0 0 0 0 0 0 0							9 560	1
62.00 06200 WHOLE BLOOD & PACKED RED BLOOD CELLS 86, 120 0 0 0 0 0 62.00 65.00 06500 RESPI RATORY THERAPY 359, 749 59, 859 0 15, 905 0 65.00 66.01 06600 PHYSI CAL THERAPY 218, 944 284, 710 13, 658 75, 651 0 66.00 66.01 06600 PHYSI CAL THERAPY 218, 944 0 0 0 0 0 0 0 0 66.02 06600 CPYSYCHI ATRI C/PSYCHOLOGI CAL SERVI CES 0 0 0 0 0 0 0 0 66.01 06600 CPYSYCHI ATRI C/PSYCHOLOGI CAL SERVI CES 0 0 0 0 0 0 0 0 66.02 06600 CPYSYCHI ATRI C/PSYCHOLOGI CAL SERVI CES 0 0 0 0 0 0 0 0 66.01 06600 CPYSYCHI ATRI C/PSYCHOLOGI CAL SERVI CES 0 0 0 0 0 0 0 0 67.00 06900 CCUPATI ONAL THERAPY 122, 680 46, 507 0 12, 358 0 0 0 68.00 06800 SPEECH PATHOLOGY 339, 814 36, 606 14, 368 9, 727 0 69, 00 69.01 06900 ELECTROCARDI OLOGY 339, 814 36, 606 14, 368 9, 727 0 69, 00 69.01 06901 CARDI AC REHAB 40, 427 201, 962 539 53, 664 0 69, 00 69.01 06901 CARDI AC REHAB 40, 427 201, 962 539 53, 664 0 69, 00 69.02 07100 MEDI CAL SUPPLIES CHARGED TO PATI ENTS 86, 104 160, 223 147 42, 573 0 71, 00 71.00 07100 MEDI CAL SUPPLIES CHARGED TO PATI ENTS 858, 345 0 0 0 0 0 72, 00 72.00 07300 DRUGS CHARGED TO PATI ENTS 858, 345 0 0 0 95, 715 0 73, 00 74.00 07300 DRUGS CHARGED TO PATI ENTS 3, 403, 782 360, 222 0 95, 715 0 73, 00 75.00 07300 DRUGS CHARGED TO PATI ENTS 3, 403, 782 360, 222 0 95, 715 0 73, 00 76.00 03000 RENAL ACUTE 17, 473 98, 877 7, 577 26, 273 0 76, 00 79.00 09000 DATI ENT NUTRI TI I ON 33, 527 54, 137 0 14, 385 0 90, 00 90.05 09005 PATI ENT NUTRI TI ON 33, 527 54, 137 0 14, 385 0 90, 00 90.05 09005 PATI ENT NUTRI TI ON 33, 527 54, 137 0 14, 385 0 90, 00 90.07 09007 WOUND CLI NI C 19, 100 90, 00 194, 00 91.00 090								1
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67. 00 06700 OCCUPATI ONAL THERAPY 122, 680 46, 507 0 12, 358 0 67. 00 68. 00 06800 SPECCH PATHOLOGY 56, 263 92, 229 0 24, 506 0 68. 00 69. 00 06900 ELECTROCARDI OLOGY 339, 814 36, 606 14, 368 9, 727 0 69. 00 69. 01 06901 CARDI AC REHAB 40, 427 201, 962 539 53, 664 0 69. 01 70. 00 07000 ELECTROENCEPHALOGRAPHY 104, 069 42, 216 3, 191 11, 217 0 70. 00 71. 00 07100 MEDICAL SUPPLIES CHARGED TO PATI ENTS 86, 104 160, 223 147 42, 573 0 71. 00 72. 00 07200 IMPL. DEV. CHARGED TO PATI ENTS 858, 345 0 0 0 0 0 72. 00 73. 00 07300 DRUGS CHARGED TO PATI ENTS 3, 403, 782 360, 222 0 95, 715 0 73. 00 76. 00 03020 RENUAL ACUTE 117, 473 98, 877 7, 577 26, 273 0 76. 00 00TPATI ENT SERVI CE COST CENTERS 90. 05 090005 PATI ENT NUTRI TI ION 33, 527 54, 137 0 14, 385 0 90. 05 90. 07 09000 CLI NI C 99, 934 109, 368 19, 434 29, 060 0 90. 05 90. 07 09000 EMERGENCY 1,052, 318 675, 199 239, 623 179, 408 0 91. 00 92. 00 DSEENVATI ON BEDS (NON-DI STI NCT PART) SPECI AL PURPOSE COST CENTERS 118. 00 SUBTOTALS (SUM OF LINES 1 through 117) 20, 596, 966 15, 431, 420 1, 832, 948 4, 016, 069 1, 854, 718 118. 00 194. 00 07950 RURAL HEALTH 265, 150 0 0 0 0 194. 01 194. 01 07951 RENTAL PROPERTY 9, 432 0 0 0 0 0 194. 01 194. 02 07954 FAMIL LY PRACTI CE 362, 362, 370 392, 760 0 104, 361 0 194. 02 194. 04 07955 PHYSI CI AN PRACTI CES 1, 073, 005 0 6, 844 0 0 0 0 194. 04 194. 04 07955 PHYSI CI AN PRACTI CES 6, 6114 0 0 0 0 0 0 0 0 0 194. 06 07950 SYCAMORE SPORTS MED	66. 01	06601 PSYCHI ATRI C/PSYCHOLOGI CAL SERVI CES	0	0		0	0	
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91. 00 09100 EMERGENCY 09200 OBSERVATI ON BEDS (NON-DISTINCT PART) 1,052,318 675,199 239,623 179,408 0 91.00 92.00 92.00 SPECIAL PURPOSE COST CENTERS 118.00 SUBTOTALS (SUM OF LINES 1 through 117) 20,596,966 15,431,420 1,832,948 4,016,069 1,854,718 118.00 NONRE! MBURSABLE COST CENTERS 190.00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN 265,150 0 1,003 0 0 194.00 194.01 194.01 197.01 194.02 197.01 1								
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NONRET MBURSABLE COST CENTERS 190. 00 19000 GI FT, FLOWER, COFFEE SHOP & CANTEEN 64 0 0 0 0 190. 00 194. 00 07950 RURAL HEALTH 265, 150 0 1,003 0 0 194. 00 194. 01 07951 RENTAL PROPERTY 9, 432 0 0 0 0 0 194. 02 07954 FAMI LY PRACTI CE 382, 710 1,039, 852 1,522 276, 300 0 194. 01 194. 03 07952 WELLNESS 55, 629 392, 760 0 104, 361 0 194. 03 194. 04 07955 PHYSI CI AN PRACTI CES 1,073, 005 0 6,844 0 0 194. 04 194. 06 07953 SYCAMORE SPORTS MED 6,114 0 0 0 0 194. 06 199. 00 0 0 0 0 0 0 199. 00 0 0 0 0 0 199. 00 0 0 0 0 199. 00 0 0 0 0 199. 00 0 0 0 0 199. 00 0 0 0 0 199. 00 0 0 0 199. 00 0 0 0 199. 00 0 0 0 199. 00 0 0 0 199. 00 0 0 0 199. 00 0 0 0 199. 00 0 0 0 199. 00 0 0 199. 00 0 0 199. 00 0 0 199. 00 0 0 199. 00 0 0 199. 00 0 0 199. 00 0 0 199. 00 0 0 199. 00 0 199. 00 0 0 199. 00 0 199. 00 0 0 199. 00 0 199. 00 0 199. 00 0 199. 00 0 199. 00 0 199. 00 0 199. 00 0 199. 00 0 199. 00	110 00		20 504 044	15 421 420	1 022 040	1 014 040	1 OE / 710	110 00
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	194. 07	0/956 PSYCHI ATRI C/PSYCHOLOGI CAL SERVI CES	41, 960	80, 392	0	21, 361	0	194. 07

Health Financial Systems
UNION HOSPITAL, INC.
In Lieu of Form CMS-2552-10

COST ALLOCATION - GENERAL SERVICE COSTS
Provider CCN: 15-0023
From 01/01/2017
To 12/31/2017
Date/Time Prepared:

						5/30/2018 2: 1	8 pm
	Cost Center Description	OTHER ADMIN	OPERATION OF	LAUNDRY &	HOUSEKEEPI NG	DI ETARY	
		AND GENERAL	PLANT	LINEN SERVICE			
		5. 06	7.00	8.00	9. 00	10.00	
200.00	Cross Foot Adjustments						200.00
201.00	Negative Cost Centers	0	0	0	0	0	201.00
202.00	TOTAL (sum lines 118 through 201)	22, 431, 030	16, 944, 424	1, 842, 317	4, 418, 091	1, 854, 718	202.00

Health Financial Systems
COST ALLOCATION - GENERAL SERVICE COSTS | Peri od: | Worksheet B | From 01/01/2017 | Part I | To 12/31/2017 | Date/Time Prepared: Provider CCN: 15-0023

COST Centrer Description					Ic	12/31/2017	Date/lime Pre 5/30/2018 2:1	
CAPITERIAN ANJESING ANJESIN								
FAMPRIAL SERVICE COST CENTERS 11.00 13.00 16.00 17.00 21.00 1.00								
		Cost Center Description	CAFETERI A					
						SERVI CE	RY & FRINGES	
1.00			11 00			17 00	21 00	
2.00 00000 NEW CAP REL COSTS-MANUE SOULP 2.00 3.00		GENERAL SERVICE COST CENTERS	11.00	13.00	10.00	17.00	21.00	
4.00 00400 DEPLOYEE BEREFITS DEPARTMENT	1.00	00100 NEW CAP REL COSTS-BLDG & FIXT						1.00
5.01 100-404 NON-PATTENT TELEPHONES 5.01 5.	2.00	1						2. 00
5.00 00500 DIRNAY PRICESSING 5.00 5.00 00500 DIRNAY STREET WINS AND STORES 5.00 60500 DIRNAY STREET WINS AND STORES 5.00 DIRNAY STREET WINS AND STORES 5.00 DIRNAY STREET WINS AND STRE								1
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0.0570 ADMITTING								1
5.05 0.0580 CASH ERINK ZACCOUNTS RECEIVABLE								
0.00900 OTHER JOHN AND CENERAL								1
0.0000 0.00000 0.00000 0.00000 0.00000 0.00000 0.00000 0.00000 0.00000 0.00000 0.00000 0.00000 0.00000 0.00000 0.00000 0.00000 0.000000 0.00000000		1						1
9.00 0.0900 INJERSEPT NO.	7. 00							1
10.00 01000 DETARY	8. 00							8. 00
11.00 01100 CAFETERIA 2,727,959								1
13.00 1300 IMESI NC ADMINI STRATION 39, 160 4, 580, 736 13.00 10.00 10.00 10.00 10.00 17			0 707 050					1
16.00 01-000 MEDICAL, RECORDS & LIBRARY 97, OSB 0 5.349, 581 0 0 0 0 0 17.00 170.00								1
17.00 01700 SOCIAL SERVICE 0 0 0 0 0 17.00				4, 580, 736				1
21.00 02100 IAS SERVICES-SALARY & FRINGES APPRVD 50, 451 0 0 0 0 2,095,691 21, 00 23 00 23			,	0		0	,	1
22.00 02000 IAR SERVICES-OTHER PROM COSTS APPRVD 10, 571 0 0 0 22.00 23.00 23.00 23.01 02341 OTHER MED ED 12, 773 15, 118 0 0 0 23.00			50, 451	ő			1	1
13.01 02341 OTHER NED ED 12, 073 15, 118 0 0 0 23.01				0			,	
23.0 0 2301 PARAMED ED PROM 4, 805 0 0 0 23.0	23.00	02300 PARAMED ED PRGM	4, 805	0	0	0)	23.00
INPATI ENT ROUTH NE SERVICE COST CENTERS 885, 294 1,940,698 385,632 0 766,444 30.00 31.00 31.00 31.00 31.00 31.00 31.00 31.00 31.00 1NTENSIVE CARE UNIT 173,696 424,422 93,447 0 18,899 35.00 31.00 31.00 41.0				15, 118			1	1
0.00 0.0000 ADULTS & PEDIATRICS 885, 294 1,940,698 335,632 0 766,444 30,00 31.00 31.00 31.00 31.00 35.00 0.0040 INTENSIVE CARE UNIT 173,696 424,422 93,447 0 0 31.00 35.00 0.0040 INTENSIVE NURSERY 59,100 144,460 58,611 0 18,899 35.00 41.00 41.00 410.0	23. 02		4, 805	0	0	0		23. 02
31.00 33100 INTENSIVE CARE UNIT 173,696 424,422 93,447 0 0 31.00 30.00 30.00 30.00 175.00 17	20.00		005 004	4 040 (00	205 (20			1 00 00
15. 00 02040 INTENSIVE NURSERY 59, 100 144, 460 58, 611 0 18, 899 35, 00 043, 00 04300 NURSERY 38, 199 89, 028 19, 348 0 0 0 43, 00 04300 NURSERY 38, 199 89, 028 19, 348 0 0 0 43, 00 05000 0								
41.00 04100 SUBPROVI DER - I IRF 43, 484 123, 183 13, 568 0 0 0 41, 00								
19								
MOCILLARY SERVICE COST CENTERS 12,200 302,919 699,435 0 90,204 50.00 50.00 05000 0PERATIN ROOM 128,290 302,919 27,436 33,492 0 0 0 50.01 50.02 505002 WSCC 0 0 0 40,4649 0 0 50.01 50.02 505002 WSCC 0 0 0 40,4649 0 0 50.01 50.02 505002 WSCC 0 0 0 40,4649 0 0 50.02 51.00							•	1
50. 01 05001 CARDIAC SURGERY 19, 219			·	·	,		'	
50, 02 05002 WSC 0 0 404, 649 0 0 50, 02		1						1
51.00			19, 219	27, 436				1
10			(2, 222	125 002			1	
Section Continue		1					1	1
54 00 05400 RADIOLOGY-DIAGNOSTIC 142, 464 0 209, 560 0 31, 498 54, 00 55. 00 550. 00 550. 00 550. 00 550. 00 560. 00 716, 715, 725 0 14, 699 55, 00 550. 00 560. 00 716, 715, 725 0 31, 825 0 14, 699 55, 00 570.								1
55.00 05500 RADIO LOGY-THERAPEUTIC								1
57.00 05700 07 SCAN 05800 05800 05800 05800 05800 05800 05800 05800 05800 05800 05800 05800 06800 05800 05800 05800 05800 05800 05800 05800 06800 05800 05800 05800 05800 05800 05800 05800 06800 05800 05800 05800 05800 05800 05800 05800 06800 058000 058000 058000 058000 058000 058000 058000 058000 058000 058000 058000								1
S8.00 05900 AGRONAMCRE I MAGING (MRI) 16, 817 0 62, 425 0 0 58.00	56.00	05600 RADI 0I SOTOPE	12, 252	0	31, 825	0	0	56.00
59.00 059000 059000 05900 05900 05900 05900 05900 05900 05900 05			34, 595	0	263, 432	0	0	57.00
60.00 06000 LABORATORY 0 0 380, 239 0 0 60.00				0				
62.00 06200 WHOLE BLOOD & PACKED RED BLOOD CELLS 0 0 12,413 0 0 62.00 65.00 06500 RESPI RATORY THERAPY 92,974 217,250 72,530 0 31,498 62.00 66.01 06600 PHYSI CAL THERAPY 0 0 0 0 0 0 0 66.01 06601 PSYCHI ATRI C/PSYCHOLGGI CAL SERVI CES 0 0 0 0 0 0 0 66.01 06600 PHYSI CAL THERAPY 0 0 0 0 0 0 0 66.02 06600 PHYSI CAL THERAPY 0 0 0 0 0 0 0 67.00 06000 PHYSI CAL THERAPY 0 0 0 0 0 0 68.00 06000 DELETRO CONTROLOGY 0 0 0 0 0 68.00 06000 DELETRO CARDI OLOGY 0 0 0 0 0 69.00 06900 ELECTRO CARDI OLOGY 56,217 0 124,885 0 2,100 69.00 69.01 06901 CARDI AC REHAB 9,850 0 5,061 0 0 69.01 70.00 07000 ELECTRO ENCEPHALOGRAPHY 19,219 0 30,873 0 6,300 70.00 71.00 07100 MEDI CAL SUPPLIES CHARGED TO PATI ENTS 0 0 0 3,162 0 0 71.00 72.00 07200 IMPL DEV. CHARGED TO PATI ENTS 0 0 0 0 0 0 73.00 07300 RENAL ACUTE 0 0 0 0 0 0 74.00 03020 RENAL ACUTE 0 0 0 0 0 0 75.00 07300 BURGE CHARGED TO PATI ENTS 109,070 197,653 1,030,804 0 29,398 73.00 76.00 03020 RENAL ACUTE 0 0 0 0 0 0 76.00 09000 CLINIC 4,805 11,198 2,730 0 327,577 0.00 76.00 09000 EMERGENCY 205,408 460,817 522,657 0 220,484 76.00 09000 DESERVATI ON BEDS (NON-DISTINCT PART) 50000 0 0 0 0 76.00 09000 DESERVATI ON BEDS (NON-DISTINCT PART) 50000 0 0 0 0 76.00 09000 SERVATI ON BEDS (NON-DISTINCT PART) 0 0 0 0 76.00 09000 SERVATI ON BEDS (NON-DISTINCT PART) 0 0 0 0 0 76.00 09000 09000 EMERGENCY 0 0 0 0 0 76.00 09000 09000 EMERGENCY 0 0 0 0 0 76.00 09000				0				
65. 00 06500 RESPI RATORY THERAPY 92, 974 217, 250 72, 530 0 31, 498 65. 00 66. 00 06600 PHYSI CAL THERAPY 0 0 0 0 0 0 66. 01 06601 PSYCHI ATRI C/PSYCHOLOGI CAL SERVI CES 0 0 0 0 0 66. 01 06601 PSYCHI ATRI C/PSYCHOLOGI CAL SERVI CES 0 0 0 0 66. 01 06601 PSYCHI ATRI C/PSYCHOLOGI CAL SERVI CES 0 0 0 0 67. 00 06700 0CCUPATI ONAL THERAPY 0 0 0 26, 957 0 67, 195 66. 02 67. 00 06700 0CCUPATI ONAL THERAPY 0 0 0 12, 724 0 0 68. 00 68. 00 06800 SPECH PATHOLOGY 0 0 124, 885 0 2, 100 69. 00 69. 00 06900 LECTROCARDI OLOGY 56, 217 0 124, 885 0 2, 100 69. 00 69. 01 06901 CARDI AC REHAB 9, 850 0 5, 061 0 0 69. 01 70. 00 07000 ELECTROCENCEPHALOGRAPHY 19, 219 0 30, 873 0 6, 300 70. 00 71. 00 07100 MEDI CAL SUPPLIES CHARGED TO PATI ENTS 0 0 3, 162 0 0 71. 00 72. 00 07200 IMPL DEV. CHARGED TO PATI ENTS 0 0 0 0 0 0 72. 00 07300 DRUGS CHARGED TO PATI ENTS 109, 070 197, 653 1, 030, 804 0 29, 398 73. 00 73. 00 07300 DRUGS CHARGED TO PATI ENTS 109, 070 197, 653 1, 030, 804 0 29, 398 73. 00 74. 00 09000 CLI NI C 0 0 0 0 0 0 90. 00 09000 CLI NI C 0 0 0 0 0 0 90. 07 09000 DRENAL ACUTE 0 0 0 14, 917 0 0 76. 00 90. 07 09000 DRENAL ACUTE 0 0 0 0 0 0 90. 07 09000 DRERGENCY 205, 408 460, 817 522, 657 0 220, 484 91. 00 09200 OBSERVATI ON BEDS (NON-DI STI NCT PART) 90. 00 09200 OBSERVATI ON BEDS (NON-DI STI NCT PART) 90. 00 09200 OBSERVATI ON BEDS (NON-DI STI NCT PART) 90. 00 19000 GI FT. FLOWER, COFFEE SHOP & CANTEEN 0 0 0 0 0 91. 00 097951 RENTAL PROPERTY 0 0 0 0 0 91. 00 097951 FAMILY PRACTICE 41, 802 0 0 0 0 91. 00 097951 FAMILY PRACTICE 41, 802 0 0 0 0 91. 00 097951 FAMILY PRACTICE 41, 802 0 0 0 0			0	0				1
66. 00 06600 PHYSI CAL THERAPY			92 974	· · · · · · · · · · · · · · · · · · ·	. = ,			
66. 01 06601 PSYCHIATRI C/PSYCHOLOGI CAL SERVI CES 0 0 0 0 0 0 66. 01 66. 02 06602 06700 0602 07P PHYSI CAL THERAPY 0 0 0 0 0 0 0 0 0 67. 00 06700 0602 07P 07P 07P 07P 0 0 0 0 0 0 0 0 68. 00 06800 SPEECH PATHOLOGY 0 0 0 12, 724 0 0 0 68. 00 69. 00 06900 ELECTROCARDI OLOGY 56, 217 0 124, 885 0 2, 100 69. 00 69. 01 06901 CARDI ACR REHAB 9, 850 0 5, 061 0 0 69. 01 70. 00 07000 ELECTROENCEPHALOGRAPHY 19, 219 0 30, 873 0 6, 300 71. 00 07100 MEDI CAL SUPPLIES CHARGED TO PATIENTS 0 0 0 0 0 0 72. 00 07200 IMPL. DEV. CHARGED TO PATIENTS 0 0 0 0 0 0 73. 00 07300 DRUGS CHARGED TO PATIENTS 109, 070 197, 653 1, 030, 804 0 29, 398 73. 00 76. 00 03020 RENAL ACUTE 0 0 14, 917 0 0 00 00TPATIENT SERVICE COST CENTERS 90. 05 09005 PATIENT NUTRITION 11, 532 25, 756 780 0 32, 7, 577 90. 05 90. 07 09007 WOUND CLINIC 10, 571 29, 116 26, 748 0 35, 697 91. 00 09100 EMERGENCY 205, 408 460, 817 522, 657 0 220, 484 91. 00 09100 EMERGENCY 205, 408 460, 817 522, 657 0 220, 484 91. 00 09100 EMERGENCY 205, 408 460, 817 522, 657 0 220, 484 91. 00 09000 GIFT, FLOWER, COFFEE SHOP & CANTEEN 0 0 0 0 0 194. 00 194. 00 07950 RURAL HEALTH 0 0 0 0 0 0 194. 00 194. 00 07951 RENTAL PROPERTY 0 0 0 0 0 0 194. 00 194. 00 07951 RENTAL PROPERTY 0 0 0 0 0 0 194. 00 194. 00 07951 RENTAL PROPERTY 0 0 0 0 0 230, 984 194. 00 194. 00 07951 RENTAL PROPERTY 0 0 0 0 0 0 0 0 194. 00 07951 RENTAL PROPERTY 0 0 0 0 0 0 0 0 194. 00 07951 RENTAL PROPERTY 0 0 0 0 0 0 0 0 0 194. 00 07951 RENTAL PROPERTY 0 0 0 0 0 0 0 0 194. 00 07951 RENTAL PROPERTY 0 0 0 0 0 0 0 0 0			72, 774	· · · · · · · · · · · · · · · · · · ·		-		
67. 00 06700 0CCUPATI ONAL THERAPY 0 0 0 33, 704 0 0 67. 00 68. 00 06800 SPECH PATHOLOGY 0 0 12, 724 0 0 68. 00 69. 00 06900 ELECTROCARDI OLOGY 56, 217 0 124, 885 0 2, 100 69. 01 06901 CARDI AC REHAB 9, 850 0 5, 061 0 0 69. 00 70. 00 07000 ELECTROENCEPHALOGRAPHY 19, 219 0 30, 873 0 6, 300 71. 00 07100 MEDI CAL SUPPLIES CHARGED TO PATIENTS 0 0 0 0 0 72. 00 07200 IMPL DEV. CHARGED TO PATIENTS 0 0 0 0 0 73. 00 07300 DRUGS CHARGED TO PATIENTS 109, 070 197, 653 1, 030, 804 0 29, 398 76. 00 03020 RENAL ACUTE 0 0 14, 917 0 0 79. 00 09000 CLINIC 4, 805 11, 198 2, 730 0 327, 577 90. 05 09005 PATIENT SERVICE COST CENTERS 90. 00 09000 PATIENT NUTRITION 11, 532 25, 756 780 0 4, 200 90. 05 90. 07 09007 WOUND CLINIC 10, 571 29, 116 26, 748 0 35, 697 90. 00 09100 EMERGENCY 205, 408 460, 817 522, 657 0 220, 484 91. 00 09100 EMERGENCY 205, 408 460, 817 522, 657 0 220, 484 91. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART) SPECIAL PURPOSE COST CENTERS 118. 00 SUBTOTALS (SUM OF LINES 1 through 117) 2, 576, 606 4, 580, 736 5, 349, 581 0 1, 864, 667 194. 00 07950 RURAL HEALTH 0 0 0 0 0 0 194. 00 07951 RENTAL PROPERTY 0 0 0 0 0 194. 00 07954 FANILY PRACTICE 41, 802 0 0 0 0 194. 00 07954 FANILY PRACTICE 41, 802 0 0 0 0 194. 00 07954 FANILY PRACTICE 41, 802 0 0 0 0 194. 00 07954 FANILY PRACTICE 41, 802 0 0 0 0 194. 00 07954 FANILY PRACTICE 41, 802 0 0 0 0 194. 00 07954 FANILY PRACTICE 41, 802 0 0 0 0 0 194. 00 07954 FANILY PRACTICE 41, 802 0 0 0 0 194. 00 07954 FANILY PRACTICE 41, 802 0 0 0 0 0 194. 00 07954 FANILY PRACTICE 41, 802 0 0 0 0 194. 00 07954 FANILY PRACTICE 41, 802 0 0 0 0			0	0			1	1
68. 00 06800 SPEECH PATHOLOGY 0 0 12,724 0 0 68. 00 69. 00 06900 ELECTROCARDI OLOGY 56, 217 0 124, 885 0 2, 100 69. 01 06901 CARDI AC REHAB 9, 850 0 5, 061 0 0 69, 01 70. 00 07000 ELECTROENCEPHALOGRAPHY 19, 219 0 30, 873 0 6, 300 71. 00 07100 MEDI CAL SUPPLIES CHARGED TO PATIENTS 0 0 0 3, 162 0 0 71. 00 72. 00 07200 IMPL. DEV. CHARGED TO PATIENTS 109, 070 197, 653 1, 030, 804 0 29, 398 73. 00 73. 00 07300 DRUGS CHARGED TO PATIENTS 109, 070 197, 653 1, 030, 804 0 29, 398 73. 00 76. 00 07300 DRUGS CHARGED TO PATIENTS 109, 070 197, 653 1, 030, 804 0 29, 398 73. 00 76. 00 09000 CLI NI C 0 0 0 14, 917 0 0 0 70. 00 09000 CLI NI C 0 0 0 0 0 0 70. 00 09000 PATIENT NUTRI TI ON 11, 532 25, 756 780 0 327, 577 90. 05 70. 00 09000 WOUND CLI NI C 10, 571 29, 116 26, 748 0 35, 697 90. 07 79. 00 09000 09000 09000 09000 09000 09000 09000 09000 79. 00 09000 09000 09000 09000 09000 09000 79. 00 09000 09000 09000 09000 09000 09000 79. 00 09000 09000 09000 09000 09000 79. 00 09000 09000 09000 09000 09000 79. 00 09000 09000 09000 09000 09000 79. 00 09000 09000 09000 09000 09000 79. 00 09000 09000 09000 09000 09000 79. 00 09000 09000 09000 09000 09000 79. 00 09000 09000 09000 09000 09000 79. 00 09000 09000 09000 09000 09000 79. 00 09000 09000 09000 09000 09000 79. 00 09000 09000 09000 09000 09000 79. 00 09000 09000 09000 09000 09000 79. 00 09000 09000 09000 09000 09000 09000 79. 00 09000 09000 09000 09000 09000 09000 79. 00 09000 09000 09000 09000 09000 09000 09000 79. 00 09000 09000 09000 09000 09000 09000 09000 79. 00 09000 09000 09000 09000 09000 09000 09000 09000 090	66. 02	06602 0/P PHYSICAL THERAPY	0	0	26, 957	0	67, 195	66. 02
69. 00 06900 ELECTROCARDI OLOGY 56, 217 0 124, 885 0 2, 100 69. 00 69. 01 06901 CARDI AC REHAB 9, 850 0 5, 061 0 0 69. 01 70. 00 07000 ELECTROENCEPHALOGRAPHY 19, 219 0 30, 873 0 6, 300 71. 00 07100 MEDI CAL SUPPLIES CHARGED TO PATI ENTS 0 0 3, 162 0 0 72. 00 07200 IMPL. DEV. CHARGED TO PATI ENTS 0 0 0 0 0 73. 00 07300 DRUGS CHARGED TO PATI ENTS 109, 070 197, 653 1, 030, 804 0 29, 398 73. 00 76. 00 07300 RENAL ACUTE 0 0 14, 917 0 0 0 70. 00 0000 CLI NI C 4, 805 11, 198 2, 730 0 327, 577 90. 00 79. 00 09000 CLI NI C 4, 805 11, 198 2, 730 0 327, 577 90. 00 79. 07 09007 WOUND CLI NI C 10, 571 29, 116 26, 748 0 35, 697 90. 07 79. 00 09100 EMERGENCY 205, 408 460, 817 522, 657 0 220, 484 91. 00 79. 00 O9200 DSSERVATI ON BEDS (NON-DI STI NCT PART) 92. 00 70 SPECI AL PURPOSE COST CENTERS 100 0 0 0 0 0 70 190. 00 GIFT, FLOWER, COFFEE SHOP & CANTEEN 0 0 0 0 0 0 794. 00 07950 RURAL HEALTH 0 0 0 0 0 0 194. 00 794. 00 07951 RENTAL PROPERTY 0 0 0 0 0 0 0 794. 00 07954 FAMI LY PRACTICE 41, 802 0 0 0 0 795. 00 07954 FAMI LY PRACTICE 41, 802 0 0 0 0 795. 00 07950 FAMI LY PRACTICE 41, 802 0 0 0 795. 00 07950 07954 FAMI LY PRACTICE 41, 802 0 0 0 795. 00 07950 07954 FAMI LY PRACTICE 41, 802 0 0 0 796. 00 00 0 0 0 0 797. 00 00 00 00 0 0 0 798. 00 07950 07954 FAMI LY PRACTICE 41, 802 0 0 0 799. 00 00 00 0 0 0 799. 00 07950 07954 FAMI LY PRACTICE 41, 802 0 0 0 799. 00 07950			0	0		0		
69. 01 06901 CARDI AC REHAB 9,850 0 5,061 0 0 69. 01			0	0		0	1	
70. 00 07000 ELECTROENCEPHALOGRAPHY 19, 219 0 30, 873 0 6, 300 70. 00 71. 00 71. 00 MEDI CAL SUPPLIES CHARGED TO PATIENTS 0 0 3, 162 0 0 71. 00 72. 00 72. 00 1MPL DEV. CHARGED TO PATIENTS 0 0 0 0 0 72. 00 73. 00 07300 DRUGS CHARGED TO PATIENTS 109, 070 197, 653 1, 030, 804 0 29, 398 73. 00 76. 00 03020 RENAL ACUTE 0 0 14, 917 0 0 76. 00 0 0 0 0 0 0 0 0 0				0		0	1	1
71. 00						0		1
72. 00				0		0		1
73. 00 07300 DRUGS CHARGED TO PATIENTS 109,070 197,653 1,030,804 0 29,398 73. 00 03020 RENAL ACUTE 0 0 0 14,917 0 0 0 76. 00 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0			0	ő		0		
90. 00 09000 CLI NI C 4, 805 11, 198 2, 730 0 327, 577 90. 00 90. 05 90. 05 90. 05 90. 05 90. 05 90. 05 90. 07 90. 07 90. 07 90. 07 90. 07 90. 07 90. 07 90. 07 90. 07 90. 08 90. 07 90. 08 90. 07 90. 08 90. 07 90. 08 90. 07 90. 08 90. 07 90. 08 90. 07 90. 08 90. 07 90. 08 90.			109, 070	197, 653	1, 030, 804			
90. 00	76.00	03020 RENAL ACUTE	0	0	14, 917	0	0	76. 00
90. 05								
90. 07 09007 WOUND CLINI C 10, 571 29, 116 26, 748 0 35, 697 90. 07 91. 00 09100 EMERGENCY 205, 408 460, 817 522, 657 0 220, 484 91. 00 92. 00 92. 00 SPECIAL PURPOSE COST CENTERS								1
91. 00						0		
92. 00 09200 0BSERVATI ON BEDS (NON-DISTINCT PART) 92. 00 SPECIAL PURPOSE COST CENTERS 118. 00 SUBTOTALS (SUM OF LINES 1 through 117) 2,576,606 4,580,736 5,349,581 0 1,864,667 118. 00 NONREI MBURSABLE COST CENTERS 0 0 0 0 0 190. 00 190. 00 190. 00 190. 00 190. 00 190. 00 190. 00 194. 00 194. 00 194. 01 195.						0		1
SPECIAL PURPOSE COST CENTERS SPECIAL PURPOSE COST CENTERS SUBTOTALS (SUM OF LINES 1 through 117) 2,576,606 4,580,736 5,349,581 0 1,864,667 118.00 NONREI MBURSABLE COST CENTERS SUBTOTALS (SUM OF LINES 1 through 117) 2,576,606 4,580,736 5,349,581 0 1,864,667 118.00 NONREI MBURSABLE COST CENTERS SUBTOTAL PROPERTY SUBTOTAL PROPE			200, 408	400, 017	522, 057	Ü	, 220, 484	1
118. 00 SUBTOTALS (SUM OF LINES 1 through 117) 2, 576, 606 4, 580, 736 5, 349, 581 0 1, 864, 667 118. 00 NONREI MBURSABLE COST CENTERS 190. 00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN 0 0 0 0 0 190. 00 194. 00 194. 00 194. 01 194. 01 194. 01 194. 01 194. 01 194. 02 1975 FAMILY PRACTICE 41, 802 0 0 0 0 230, 984 194. 02	72.00							72.00
NONREIMBURSABLE COST CENTERS 190.00 19000 GFT, FLOWER, COFFEE SHOP & CANTEEN 0 0 0 0 190.00 194.00 194.00 07950 RURAL HEALTH 0 0 0 0 0 194.00 194.01 194.02 07951 RENTAL PROPERTY 0 0 0 0 0 194.01 194.02 07954 FAMILY PRACTICE 41,802 0 0 0 230,984 194.02 0 0 0 0 0 0 0 0 0	118.00		2, 576, 606	4, 580, 736	5, 349, 581	0	1, 864, 667	118. 00
194. 00 07950 RURAL HEALTH 0 0 0 0 194. 00 194. 01 07951 RENTAL PROPERTY 0 0 0 0 0 194. 01 194. 02 07954 FAMI LY PRACTI CE 41, 802 0 0 0 230, 984 194. 02								
194. 01 07951 RENTAL PROPERTY 0 0 0 0 194. 01 194. 01 194. 02 07954 FAMILY PRACTICE 41, 802 0 0 0 230, 984 194. 02			0	0		0	1	1
194. 02 07954 FAMILY PRACTICE 41, 802 0 0 0 230, 984 194. 02			0	0		0		
			0	0	· ·	0		
1 0 0 0 0 0 194.03					· ·			
	174.00	7 07,702 #EEENEOO	0	<u> </u>	1 0		·1 0	11 /4. 00

Health Financial Systems	UNI ON HOSPI TA	L, INC.		In Lie	u of Form CMS-	2552-10
COST ALLOCATION - GENERAL SERVICE COSTS		Provi der CO	CN: 15-0023	Peri od: From 01/01/2017 To 12/31/2017	Worksheet B Part I Date/Time Pre 5/30/2018 2:1	

						5/30/2018 2: 1	8 pm
						INTERNS &	
						RESI DENTS	
	Cost Center Description	CAFETERI A	NURSI NG	MEDI CAL	SOCI AL	SERVI CES-SALA	
			ADMI NI STRATI O	RECORDS &	SERVI CE	RY & FRINGES	
			N	LI BRARY			
		11. 00	13. 00	16. 00	17. 00	21. 00	
194. 04 07955	5 PHYSICIAN PRACTICES	97, 779	0	0	0	0	194. 04
194. 06 07953	3 SYCAMORE SPORTS MED	0	0	0	0	0	194. 06
194. 07 07956	6 PSYCHI ATRI C/PSYCHOLOGI CAL SERVI CES	11, 772	0	0	0	0	194. 07
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, 727, 959	4, 580, 736	5, 349, 581	0	2, 095, 651	202. 00

Health Financial Systems
COST ALLOCATION - GENERAL SERVICE COSTS | Peri od: | Worksheet B | From 01/01/2017 | Part I | To 12/31/2017 | Date/Time Prepared: Provider CCN: 15-0023

					10	12/31/2017	Date/lime Pre 5/30/2018 2:1	
			INTERNS &	<u> </u>				
		Cost Center Description	RESI DENTS SERVI CES-OTHE	PARAMED ED	OTHER MED ED	PARAMED ED	Subtotal	
		cost center bescription	R PRGM COSTS	PRGM	OTTIER WED ED	PRGM	Subtotal	
			22. 00	23. 00	23. 01	23. 02	24. 00	
1. 00		AL SERVICE COST CENTERS						1.00
2.00	1	NEW CAP REL COSTS-BLDG & FLXT NEW CAP REL COSTS-MVBLE EQUIP						2.00
4. 00	1	EMPLOYEE BENEFITS DEPARTMENT						4.00
5. 01		NONPATIENT TELEPHONES						5. 01
5. 02		DATA PROCESSING PURCHASING RECEIVING AND STORES						5. 02 5. 03
5. 03 5. 04	1	ADMITTING						5.03
5. 05		CASHI ERI NG/ACCOUNTS RECEI VABLE						5. 05
5.06	1	OTHER ADMIN AND GENERAL						5. 06
7.00	1	OPERATION OF PLANT						7.00
8. 00 9. 00	1	LAUNDRY & LINEN SERVICE HOUSEKEEPING						8. 00 9. 00
10.00		DI ETARY						10.00
11. 00	1	CAFETERI A						11. 00
13. 00 16. 00		NURSI NG ADMI NI STRATI ON MEDI CAL RECORDS & LI BRARY						13. 00 16. 00
17. 00	1	SOCIAL SERVICE						17.00
21. 00		I&R SERVICES-SALARY & FRINGES APPRVD						21.00
22. 00	1	I&R SERVICES-OTHER PRGM COSTS APPRVD	2, 832, 762					22. 00
23. 00 23. 01		PARAMED ED PRGM OTHER MED ED		196, 810				23. 00 23. 01
23. 01	1	PARAMED ED PRGM			375, 920	196, 810		23. 01
20.02		IENT ROUTINE SERVICE COST CENTERS				1707010		20.02
30.00	1	ADULTS & PEDIATRICS	1, 036, 032	0		0	65, 215, 743	30.00
31. 00 35. 00	1	INTENSIVE CARE UNIT INTENSIVE NURSERY	0 25, 546	0	-	0	12, 639, 435 4, 092, 293	1
41.00	1	SUBPROVI DER - I RF	25, 540	0	· ·	0	3, 181, 488	•
43.00	1	NURSERY	0	0		ō	2, 127, 591	43.00
		LARY SERVICE COST CENTERS				_1		
50. 00 50. 01	1	OPERATING ROOM CARDIAC SURGERY	122, 053	0		0	19, 654, 532 3, 800, 794	50. 00 50. 01
50. 01	05001	l e e e e e e e e e e e e e e e e e e e	0	0		0	14, 336, 428	1
51.00		RECOVERY ROOM	o	0	Ō	ō	3, 326, 046	1
51. 02	1	O/P TREATMENT ROOM	0	0	0	0	5, 365, 741	1
52. 00 54. 00	1	DELIVERY ROOM & LABOR ROOM RADIOLOGY-DIAGNOSTIC	278, 167 42, 577	0 196, 810		0 196, 810	8, 004, 668 13, 262, 210	1
55.00	1	RADI OLOGY-THERAPEUTI C	19, 869	190, 810		190, 810	7, 818, 498	1
56.00	1	RADI OI SOTOPE	0	0	0	o	1, 950, 152	1
57.00	1	CT SCAN	0	0	0	0	3, 924, 226	1
58. 00 59. 00	1	MAGNETIC RESONANCE IMAGING (MRI) CARDIAC CATHETERIZATION	14, 192	0	0	0	2, 736, 851 19, 350, 612	1
60.00		LABORATORY	14, 192	0		o o	10, 977, 816	1
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	0	0	0	О	1, 376, 416	1
65.00		RESPI RATORY THERAPY	42, 577	0		0	6, 230, 417	
66. 00 66. 01	06600	PHYSI CAL THERAPY PSYCHI ATRI C/PSYCHOLOGI CAL SERVI CES	2, 838 0	0		0	3, 893, 817 0	
66. 02		0/P PHYSICAL THERAPY	90, 830	0	-	ő	2, 539, 269	
67.00		OCCUPATI ONAL THERAPY	O	0	0	О	2, 035, 616	
68.00		SPEECH PATHOLOGY	0	0	0	0	1, 020, 571	
69. 00 69. 01	1	ELECTROCARDI OLOGY CARDI AC REHAB	2, 838	0	0	0	5, 628, 824 911, 372	1
70.00	1	ELECTROENCEPHALOGRAPHY	8, 515	0	o	o	1, 769, 815	•
71. 00	1	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	O	1, 569, 842	
72.00		IMPL. DEV. CHARGED TO PATIENTS	0	0	275 020	0	13, 594, 751	1
		DRUGS CHARGED TO PATIENTS RENAL ACUTE	39, 738	0		0	56, 150, 026 2, 008, 225	1
70.00		TIENT SERVICE COST CENTERS	<u> </u>		<u> </u>	<u> </u>	2, 000, 220	70.00
	09000	CLINIC	442, 796	0	0	0	1, 102, 757	1
		PATIENT NUTRITION	5, 677	0	0	0	647, 482	1
90. 07 91. 00		WOUND CLINIC EMERGENCY	48, 253 298, 036	0	0	0	1, 891, 040 19, 468, 604	1
		OBSERVATION BEDS (NON-DISTINCT PART)	270,030	O		Ĭ	17, 400, 004	92.00
	SPECI	AL PURPOSE COST CENTERS						
118. 00		SUBTOTALS (SUM OF LINES 1 through 117)	2, 520, 534	196, 810	375, 920	196, 810	323, 603, 968	118. 00
190 00		IMBURSABLE COST CENTERS GIFT, FLOWER, COFFEE SHOP & CANTEEN	Ol	0	0	ol	1 019	190. 00
		RURAL HEALTH		0	Ö	ő	4, 200, 544	1
		RENTAL PROPERTY	0	0	0	О	149, 382	1
		FAMILY PRACTICE	312, 228	0	0	0	7, 964, 175 1, 279, 195	
		WELLNESS PHYSI CI AN PRACTI CES	0	0	0	0	1, 378, 185 17, 099, 234	
		1	<u>, </u>		,	9	, , , 251	

Health Financial Systems	UNION HOSPIT	AL, INC.		In Lieu of Form CMS-2552-10			
COST ALLOCATION - GENERAL SERVICE COSTS		Provi der Co	CN: 15-0023	Peri od: From 01/01/2017 To 12/31/2017	Worksheet B Part I Date/Time Pre 5/30/2018 2:1		
	LNTEDNC 0	·			•		

						5/30/2018 2:1	8 pm
		INTERNS &					
		RESI DENTS					
	Cost Center Description	SERVI CES-OTHE	PARAMED ED	OTHER MED ED	PARAMED ED	Subtotal	
		R PRGM COSTS	PRGM		PRGM		
		22. 00	23. 00	23. 01	23. 02	24.00	
194.0607	953 SYCAMORE SPORTS MED	0	0	0	0	96, 831	194.06
194. 07 07	956 PSYCHI ATRI C/PSYCHOLOGI CAL SERVI CES	0	0	0	0	778, 107	194. 07
200.00	Cross Foot Adjustments	0	0	0	0	0	200.00
201. 00	Negative Cost Centers	0	0	0	0	0	201.00
202.00	TOTAL (sum lines 118 through 201)	2, 832, 762	196, 810	375, 920	196, 810	355, 271, 445	202.00

UNION HOSPITAL, INC. In Lieu of Form CMS-2552-10

Health Financial Systems
COST ALLOCATION - GENERAL SERVICE COSTS | Peri od: | Worksheet B | From 01/01/2017 | Part I | To 12/31/2017 | Date/Time Prepared: Provider CCN: 15-0023

COST Center Description					10	12/31/2017	Date/lime 5/30/2018	
CONTRACT STRENGT COST CENTERS 20 0 26,000		Cost Center Description	Intern &	Total				
Adjustments								
10			•					
CREATION SERVICE DOST CERTIENS				26.00				
2.00 00000 NEW CAP REL COSTS-IMPRIE SUIJ		GENERAL SERVICE COST CENTERS	20.00	20.00				
4.00 00-000 DEPLOYEE BEREFITS DEPARTMENT	1.00	00100 NEW CAP REL COSTS-BLDG & FIXT						1.00
5.01 00546 NORPATIENT TELEPHONES		1 1						•
0.0050 DATA PROCESSING								•
5 0.03 000500 PURCHASING RECEIVING AND STORES 5 .03 5 .05 000500 CASHI FENR CACCUINTS PRICTIVARIE 5 .05 5 .06 000500 CASHI FENR CACCUINTS PRICTIVARIE 5 .05 6 .00 000500 CASHI FENR CACCUINTS PRICTIVARIE 5 .05 7 .00 000500 CASHI FENR CACCUINTS PRICTIVARIE 7 .05 8 .00 000500 CASHI FENR CACCUINTS SERVICE 8 .00 9 .00 000500 CASHI FENR CACCUINTS SERVICE 9 .00 10 .00 010500 CASHI FENR CACCUINTS SERVICE 9 .00 10 .00 010500 CASHI FENR CACCUINTS SERVICE 11 .00 11 .00 010500 CASHI FENR CACCUINTS SERVICE 12 .00 12 .00 010500 CASHI FENR CACCUINTS SERVICE 12 .00 12 .00 010500 CASHI FENR CACCUINTS SERVICE 12 .00 12 .00 010500 CASHI FENR CACCUINTS SERVICE 12 .00 12 .00 010500 CASHI FENR CACCUINTS SERVICE 12 .00 12 .00 010500 CASHI FENR CACCUINTS SERVICE 12 .00 12 .00 010500 CASHI FENR CACCUINTS SERVICE 12 .00 12 .00 010500 CASHI FENR CACCUINTS SERVICE 12 .00 12 .00 010500 CASHI FENR CACCUINTS SERVICE 12 .00 12 .00 010500 CASHI FENR CACCUINTS SERVICE 12 .00 12 .00 010500 CASHI FENR CACCUINTS SERVICE 12 .00 12 .00 010500 CASHI FENR CACCUINTS SERVICE 12 .00 12 .00 010500 CASHI FENR CACCUINTS SERVICE 12 .00 13 .00 010500 CASHI FENR CACCUINTS SERVICE 12 .00 13 .00 010500 CASHI FENR CACCUINTS SERVICE 12 .00 13 .00 010500 CASHI FENR CACCUINTS SERVICE 12 .00 13 .00 010500 CASHI FENR CACCUINTS SERVICE 12 .00 14 .00 010500 CASHI FENR CACCUINTS SERVICE 12 .00 15 .00 010500 CASHI FENR CACCUINTS SERVICE 12 .00 15 .00 010500 CASHI FENR CACCUINTS SERVICE 12 .00 15 .00 010500 CASHI FENR CACCUINTS SERVICE 12 .00 15 .00 010500 CASHI FENR CACCUINTS SERVICE 12 .00 15 .00 010500 CASHI FENR CACCUINTS SERVICE 12 .00 15 .00 010500 CASHI FENR CACCUINTS SERVICE 12 .00 15 .00 010500 CASHI FENR CACCUINTS SERVICE 12 .00 15 .00 010500 CASHI FENR CACCUINTS SERVICE 12 .00 15 .00 010500 CASHI FENR CACCUINTS SERVICE 12 .00 15 .00 010500 CASHI FEN		1 1						•
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5.05 0.0580 CASHIERING / ACCOUNTS RECEIVABLE 5.06 0.0070 OPERATION OF PLANT 7.00 7.0		1 1						•
5.06 OSSOO OTHER ABUN AND GENERAL 5.06 7.00 7.0		1 1						1
8.00 00000 LAURDRY X 1 I NEW SERVICE 9.00 0		1 1						1
9.00 00900 00900 0015FERPI NG		00700 OPERATION OF PLANT						7. 00
10.00 10000 DETARY		1						•
11.00 01000 CAFETERIA		1						•
13.00 1300 MURSING ADMINISTRATION		1						•
16.00 1600 MEDICAL RECORDS & LIBRARY								
17.00 17.0		1 1						•
22.00	17.00	01700 SOCIAL SERVICE						17. 00
23.00		1						•
23.01 02341 OTHER NED ED PROW 23.02 02301 PARAMEDE D PARAMEDE D PROW 24.02 PARAMED D PROW 24.02 PARAMEDE D PROW 24.02 PARAMED D PROW 24.02 PARAMEDE D PROW 24.02 PARAMED D PROW 24.02 PARAMED D PROW 24.02								•
23.0								•
INPATI ENT ROUTH NE SERVICE COST CENTERS 30.00 03.00 ADULTS & PEDIATRICS 31.00 31.00 31.00 03100 ADULTS & PEDIATRICS 35.00 31.00 31.00 1NTERSIYE CARE UNIT 0 12, 639, 435 31.00 31.00 31.00 31.00 1NTERSIYE VINUSERY -44, 445 4, 047, 848 35.00 41.00								•
30.00	23.02							25.02
35.00	30.00		-1, 802, 476	63, 413, 267				30.00
1.00 04100 SUBPROVIDER - IRF 0 2,127,591 43.00 43.00 04200 MIRSERY 0 2,127,591 43.00 43.00 04200 MIRSERY 0 0 2,127,591 43.00 43.00 04200 OPERATI NG ROOM -212,347 19,442,185 50.00 50.00 50.00 OPERATING ROOM -212,347 19,442,185 50.00 50.00 CARDI AC SURGERY 0 18,306,426 50.00 50.00 50.00 CARDI AC SURGERY 0 14,336,426 50.00	31.00	03100 INTENSIVE CARE UNIT	0	12, 639, 435				31.00
A3. 00 04300 NURSERY 0 2,127,591 3 00		1 1	-44, 445	4, 047, 848				•
ANCILLARY SERVICE COST CENTERS 50.00		1 1	ĭ,					•
50.00	43.00		0	2, 127, 591				43.00
50. 01 05001 CARDIAC SURGERY 0 3, 800, 794 50. 01	50.00		-212 347	19 442 185				50.00
51.00 05100 RECOVERY ROOM 0 3, 326, 046 51.00		1 1	0					•
51.02 05101 0/F TREATMENT ROOM	50. 02	05002 WVSC	О	14, 336, 428				50. 02
52.00		1 1	0					1
54.00		1 1	0					•
55.00 05500 RADIO LOGY-THERAPEUTI C -34,568 7,783,930 55.00 56.00 65600 RADIO TSOTOPE 0 1,950 152 56.00 57.00 65.00 65600 RADIO RADIO TSOTOPE 0 3,924,226 57.00 57.00 58.00 65800 RADIO TSOTOPE 0 0.978,850 0.9800 CARDIAC CATHETERI ZATION -24,691 19,325,921 59.00 60.00 06000 CARDIAC CATHETERI ZATION -24,691 19,325,921 60.00 06000 CARDIAC CATHETERI ZATION -74,075 6.156,342 65.00 65.00 06000 PHYSI CAL THERAPY -74,075 6.156,342 65.00 66.00 06000 PHYSI CAL THERAPY -74,075 6.156,342 66.00 66.01 06601 PSYCHI ATRI C/PSYCHOLOGI CAL SERVI CES 0 0.9800 06000 PSYCHI ATRI C/PSYCHOLOGI CAL SERVI CES 0 0.9000 06000 06000 050000 0500000 050000 0500000 0500000 0500000 0500000 0500000 05000000 050000000 0500000000		1						•
56. 00 05000 05700 05700 CT SCAN 0 3,924,226 55. 00 57. 00 05700 CT SCAN 0 3,924,226 55. 00 55. 00 05900 CARDIA C CATHETERI ZATI ON -24,691 19,325,921 59. 00 05900 CARDIA C CATHETERI ZATI ON -24,691 19,325,921 59. 00 05900 CARDIA C CATHETERI ZATI ON -24,691 19,325,921 59. 00 05000 LABORATORY -0 10,977,816 60. 00 05000 LABORATORY -1 05. 00 05000 LABORATORY -1 05. 00 05000 RESPIRATORY THERAPY -74,075 6,156,342 65. 00 05000 RESPIRATORY THERAPY -4,938 3,888,879 66. 00 06600 PHYSI CAL THERAPY -4,938 3,888,879 66. 00 06600 PHYSI CAL THERAPY -18,025 2,381,244 66. 02 06000 05000 VPHYSI CAL THERAPY -18,025 2,381,244 66. 02 06000 05000 VPHYSI CAL THERAPY -18,025 2,381,244 66. 02 06000 05000 VPHYSI CAL THERAPY -18,025 2,381,244 66. 02 06000 05000 VPHYSI CAL THERAPY -18,025 2,381,244 66. 02 06000 05000 SPECH PATHOLOGY 0 1,020,571 68. 00 05000 SPECH PATHOLOGY 0 1,020,571 68. 00 05000 SPECH PATHOLOGY -4,938 5,623,886 69. 00 06900 ELECTROCARDIOLOGY -4,938 5,623,886 69. 01 05001 CARDIA C REHAB 0 11,375,000 07000 ELECTROCHORDEHPHALOGRAPHY -14,815 1,755,000 70. 00 07000 ELECTROCHORDEHPHALOGRAPHY -14,815 1,755,000 070. 00 07000 ELE		1 1						•
57.00 05700 CT SCAN 05800 MAGNETI C RESONANCE I MAGING (MRI) 0 2, 736, 851 55.00 58.00 05900 CARDI AC CATHETERI ZATI ON -24, 691 19, 325, 921 59.00 60.00 06000 LABORATORY 0 10, 977, 816 60.00 60.00 60.000 LABORATORY 0 10, 977, 816 62.00 60.00 60.00 F. CORONINO 60.00		1						•
59.00 05900 05900 05900 CARDI AC CATHETERI ZATI ON -24, 691 19, 325, 921 60.00 06000 LABORATORY 0 10, 977, 816 62.00 06200 WHOLE BLOOD & PACKED RED BLOOD CELLS 0 1, 376, 416 62.00 06500 RESPI RATORY THERAPY -74, 075 6, 156, 342 65.00 06600 PHYSI CAL THERAPY -4, 938 3, 888, 879 66.00 06600 PHYSI CAL THERAPY -4, 938 3, 888, 879 66.01 06600 06000 PHYSI CAL THERAPY -158, 025 2, 381, 244 66.02 06700 060000 060000 060000 060000 060000 060000 060000 060000 060000 0600000 060000000 0600000000	57.00		0					57.00
60.00 06000 06000 06000 06000 06000 0620			0					•
62. 00 06200 WHOLE BLOOD & PACKED RED BLOOD CELLS 0 1, 376, 416 62. 00 65. 00 06500 RESPI RATORY THERAPY -74, 075 6, 156, 342 65. 00 66. 01 06600 PHYSI CAL THERAPY -4, 938 3, 888, 879 66. 00 66. 01 06601 PSYCHI ATRI C/PSYCHOLGGI CAL SERVI CES 0 0 0 0 0 0 0 0 0								•
65. 00 06500 RESPIRATORY THERAPY		1 1	= 1					ı
66. 00 06600 PHYSI CAL THERAPY -4, 938 3, 888, 879 66. 00 06601 06601 06601 06601 06601 06601 06601 06601 06602 0/P PHYSI CAL THERAPY -158, 025 2, 381, 244 66. 02 06602 0/P PHYSI CAL THERAPY -158, 025 2, 381, 244 66. 02 06602 0/P PHYSI CAL THERAPY 0 2, 035, 616 67. 00 06900 0CCUPATI ONAL THERAPY 0 1, 020, 571 68. 00 06900 06900 0ELECTROCARDI OLOGY 0 1, 020, 571 069. 00 06900 06			-					•
66. 01 06601 PSYCHI ATRI C/PSYCHOLOGI CAL SERVI CES 0 0 0 66. 01 66. 02 06602 06700 06CUPATI ONAL THERAPY -158, 025 2, 381, 244 66. 02 67. 00 06700 06CUPATI ONAL THERAPY 0 2, 035, 616 67. 00 68. 00 06800 SPEECH PATHOLOGY 0 1, 020, 571 68. 00 69. 00 06900 ELECTROCARDI OLOGY -4, 938 5, 623, 886 69. 01 69. 01 06901 CARDI AC REHAB 0 911, 372 69. 01 70. 00 07000 ELECTROENCEPHAL OGRAPHY -14, 815 1, 755, 000 71. 00 71. 00 07100 MEDI CAL SUPPLIES CHARGED TO PATIENTS 0 13, 594, 751 72. 00 72. 00 07200 IMPL. DEV. CHARGED TO PATIENTS 0 13, 594, 751 72. 00 73. 00 07300 DRUGS CHARGED TO PATIENTS -69, 136 56, 080, 890 73. 00 76. 00 03020 RENAL ACUTE 0 2, 008, 225 76. 00 0017PATIENT SERVICE COST CENTERS -700, 373 332, 384 90. 05 90. 05 09005 PATIENT NUTRI TI ON -9, 877 637, 605 90. 05 90. 07 09007 WOUND CLI NI C -770, 373 332, 384 90. 05 90. 07 09007 WOUND CLI NI C -783, 950 1, 807, 090 90. 07 91. 00 09100 EMERGENCY -518, 520 18, 950, 084 91. 00 92. 00 SPECI AL PURPOSE COST CENTERS -818, 520 18, 950, 084 91. 00 92. 00 SPECI AL PURPOSE COST CENTERS -818, 520 18, 950, 084 91. 00 92. 00 SPECI AL PURPOSE COST CENTERS -100, 00 194. 00 07950 RURAL HEALTH 0 4, 200, 544 194. 01 194. 01 07951 RENTAL PROPERTY 0 149, 382 194. 01 194. 02 07954 FANIL HEALTH 0 4, 200, 544 194. 01 194. 02 07954 FANIL HEALTH 0 149, 382 194. 01								
67. 00 06700 06CUPATI ONAL THERAPY 0 2,035,616 68. 00 06800 SPECH PATHOLOGY 0 1,020,571 68. 00 06900 SPECH PATHOLOGY 0 1,020,571 68. 00 06900 SPECH PATHOLOGY 0 1,020,571 68. 00 06901 CARDI AC REHAB 0 911,372 69. 01 07000 CARDI AC REHAB 0 911,372 69. 01 07000 SELECTROENCEPHALOGRAPHY -14,815 1,755,000 70. 00 07000 SELECTROENCEPHALOGRAPHY -14,815 1,755,000 70. 00 07000 SELECTROENCEPHALOGRAPHY -14,815 1,755,000 71. 00 07100 MEDI CAL SUPPLIES CHARGED TO PATIENTS 0 13,594,751 72. 00 07200 IMPL. DEV. CHARGED TO PATIENTS 0 13,594,751 72. 00 07300 DRUGS CHARGED TO PATIENTS -69,136 56,080,890 73. 00 07300 DRUGS CHARGED TO PATIENTS 0 2,008,225 76. 00 03020 RENAL ACUTE 0 2,008,225 76. 00 09000 CLINIC -770,373 332,384 90. 00 90. 00 9000 DRUGS CHARGED TO PATIENTS -9,877 637,605 90. 05 90. 05 90. 05 PATIENT SURVICE COST CENTERS 90. 00 9000 DRUGS CHARGED TO PATIENTS 0 90. 00 90. 00 90. 00 90. 00 90. 00 09000 DRUGS CHARGED TO PATIENTS 0 90. 00 90. 00 90. 00 09000 DRUGS CHARGED TO PATIENTS 0 90. 00 90. 00 09000 DRUGS CHARGED TO PATIENTS 0 90. 00 9			0	o				•
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70. 00 07000 CLECTROENCEPHALOGRAPHY -14, 815 1,755,000 70. 00 71. 00 77.			-4, 930 0					
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76. 00 03020 RENAL ACUTE 0 2, 008, 225 76. 00 OUTPATIENT SERVICE COST CENTERS 90. 00 09005 CLI NI C -770, 373 332, 384 90. 00 90. 05 09005 PATIENT NUTRITION -9, 877 637, 605 90. 05 90. 07 09007 WOUND CLI NI C -83, 950 1, 807, 090 90. 07 91. 00 09100 EMERGENCY -518, 520 18, 950, 084 91. 00 92. 00 09200 OBSERVATI ON BEDS (NON-DISTINCT PART) 0 92. 00 SPECIAL PURPOSE COST CENTERS 118. 00 SUBTOTALS (SUM OF LINES 1 through 117) -4, 385, 201 319, 218, 767 18. 00 190. 00 19000 GI FT, FLOWER, COFFEE SHOP & CANTEEN 0 1, 019 194. 00 07950 RURAL HEALTH 0 4, 200, 544 194. 00 194. 01 07951 RENTAL PROPERTY 0 149, 382 194. 01 194. 02 07954 FAMILY PRACTICE -543, 212 7, 420, 963			0					
OUTPATI ENT SERVI CE COST CENTERS O9000 CLI NI C								
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90. 05	90 00		-770 373	332 384				90 00
90. 07 91. 00 91. 00 91. 00 92		1 1						•
92. 00 09200 0BSERVATI ON BEDS (NON-DISTINCT PART) 0 92. 00								
SPECIAL PURPOSE COST CENTERS				18, 950, 084				
118. 00 SUBTOTALS (SUM OF LINES 1 through 117) -4, 385, 201 319, 218, 767 NONREI MBURSABLE COST CENTERS 190. 00 19000 GI FT, FLOWER, COFFEE SHOP & CANTEEN 0 1, 019 194. 00 07950 RURAL HEALTH 0 4, 200, 544 194. 01 07951 RENTAL PROPERTY 0 149, 382 194. 01 194. 02 07954 FAMI LY PRACTICE -543, 212 7, 420, 963 194. 02	92. 00		0					92.00
NONREI MBURSABLE COST CENTERS 190. 00 19000 GI FT, FLOWER, COFFEE SHOP & CANTEEN 0 1, 019 194. 00 07950 RURAL HEALTH 0 4, 200, 544 194. 01 07951 RENTAL PROPERTY 0 149, 382 194. 02 07954 FAMI LY PRACTICE -543, 212 7, 420, 963	110 00		-4 385 201	310 210 747				118 00
190. 00 19000 GI FT, FLOWER, COFFEE SHOP & CANTEEN 0 1,019 190. 00 194. 00 07950 RURAL HEALTH 0 4,200,544 194. 00 194. 01 07951 RENTAL PROPERTY 0 149, 382 194. 01 194. 02 07954 FAMILY PRACTICE -543, 212 7, 420, 963 194. 02	110.00		-4, 300, 201	317, 210, 707				110.00
194. 00 07950 RURAL HEALTH 0 4, 200, 544 194. 00 194. 01 07951 RENTAL PROPERTY 0 149, 382 194. 01 194. 02 07954 FAMI LY PRACTI CE -543, 212 7, 420, 963 194. 02	190.00		ol	1, 019				190. 00
194. 02 07954 FAMILY PRACTICE -543, 212 7, 420, 963 194. 02	194.00	07950 RURAL HEALTH	O					194. 00
			0					
174. U3 U/702 WELLINE33 U 1,3/8, 185 [194. U3								
	174. 03	0 07732 WELLINE33	ΟĮ	1,3/6, 185				1174. U3

Health Financial Systems	UNI ON HOSPIT	UNION HOSPITAL, INC.			In Lieu of Form CMS-2552-10			
COST ALLOCATION - GENERAL SERVICE COSTS		Provi der Co	CN: 15-0023	Period: From 01/01/2017 To 12/31/2017	Worksheet B Part I Date/Time Prepared:			
					5/30/2018 2:18 pm			
Cost Center Description	Intern &	Total						
	Resi dents							
	Cost & Post							
	Stepdown							
	Adjustments							
	25. 00	26. 00						
194. 04 07955 PHYSI CI AN PRACTI CES	0	17, 099, 234			194. 04			
194.06 07953 SYCAMORE SPORTS MED	0	96, 831			194. 06			
194. 07 07956 PSYCHI ATRI C/PSYCHOLOGI CAL SERVI CES	0	778, 107			194. 07			
200.00 Cross Foot Adjustments	o	0			200.00			
201.00 Negative Cost Centers	O	0			201.00			
202.00 TOTAL (sum lines 118 through 201)	-4, 928, 413	350, 343, 032			202.00			

| In Lieu of Form CMS-2552-10 | Period: | Worksheet B | From 01/01/2017 | Part II | To 12/31/2017 | Date/Time Prepared: | Part | Health Financial Systems
ALLOCATION OF CAPITAL RELATED COSTS Provider CCN: 15-0023

					Io	12/31/2017	Date/lime Pre 5/30/2018 2:1	
				CAPI TAL REI	LATED COSTS		7 007 2010 2. 1	о ріп
		Overland Bernelland	D	NEW DIDO 0	NEW MADE		EMPL OVEE	
		Cost Center Description	Directly Assigned New	NEW BLDG & FLXT	NEW MVBLE EQUIP	Subtotal	EMPLOYEE BENEFITS	
			Capi tal	FIXI	EQUIP		DEPARTMENT	
			Related Costs					
			0	1. 00	2. 00	2A	4. 00	
4 00		AL SERVICE COST CENTERS						4 00
1. 00 2. 00	1	NEW CAP REL COSTS-BLDG & FIXT NEW CAP REL COSTS-MVBLE EQUIP						1. 00 2. 00
4. 00		EMPLOYEE BENEFITS DEPARTMENT	0	83, 418	0	83, 418	83, 418	4.00
5. 01		NONPATI ENT TELEPHONES	o	10, 671		88, 117	507	5. 01
5.02		DATA PROCESSING	O	0		0	0	5. 02
5. 03	1	PURCHASING RECEIVING AND STORES	0	0		0	0	5. 03
5. 04 5. 05		ADMITTING CASHIERING/ACCOUNTS RECEIVABLE	64, 308	49, 732 0		122, 486	1, 264 0	5. 04 5. 05
5. 06	1	OTHER ADMIN AND GENERAL	25, 890	301, 626	-	404, 074	4, 477	5.06
7. 00	1	OPERATION OF PLANT	15, 378	5, 438, 971		5, 680, 812	1, 609	7. 00
8.00		LAUNDRY & LINEN SERVICE	5, 720	97, 256		274, 594	584	8. 00
9.00		HOUSEKEEPI NG	1, 552	86, 292		180, 705	1, 745	9.00
10. 00 11. 00	1	DI ETARY CAFETERI A	3, 626 0	178, 269 127, 205		455, 281 142, 617	326 1, 457	10. 00 11. 00
13. 00		NURSING ADMINISTRATION	820	38, 590		44, 428	1, 496	
16. 00		MEDICAL RECORDS & LIBRARY	9, 041	85, 805		112, 010	1, 716	
17. 00	1	SOCIAL SERVICE	0	0		0	0	17. 00
21.00		I &R SERVICES-SALARY & FRINGES APPRVD	0	0	- 1	0	1, 196	21.00
22. 00 23. 00		I&R SERVICES-OTHER PRGM COSTS APPRVD PARAMED ED PRGM	0	0		0	1, 146 100	22. 00 23. 00
23. 00		OTHER MED ED		11, 694	-	11, 999	213	
23. 02		PARAMED ED PRGM	o	0		0	100	23. 02
		IENT ROUTINE SERVICE COST CENTERS			,			
30.00		ADULTS & PEDIATRICS	127, 733	3, 054, 196		4, 026, 311	18, 150	30.00
31. 00 35. 00	1	INTENSIVE CARE UNIT INTENSIVE NURSERY	180, 640 1, 994	373, 398 46, 776		1, 004, 260 167, 899	4, 265 1, 631	31. 00 35. 00
41. 00		SUBPROVI DER – I RF	6, 784	240, 719		282, 493	1, 051	41.00
43.00		NURSERY	0	63, 781		70, 893	910	43.00
		LARY SERVICE COST CENTERS						
50.00	1	OPERATING ROOM	835, 925	661, 608		2, 996, 505	2, 583	50.00
50. 01 50. 02	05001	CARDI AC SURGERY	32, 444 430, 105	29, 235 487, 707		182, 664 1, 339, 946	1, 860 0	50. 01 50. 02
51.00	1	RECOVERY ROOM	1, 601	23, 258		49, 624	1, 497	51.00
51. 02		O/P TREATMENT ROOM	2, 793	346, 664		489, 065	1, 732	51.02
52.00		DELIVERY ROOM & LABOR ROOM	11, 165	337, 910		618, 731	2, 557	52.00
54. 00 55. 00		RADI OLOGY-DI AGNOSTI C RADI OLOGY-THERAPEUTI C	486, 706	530, 049 428, 668		2, 002, 066	3, 164 372	54. 00 55. 00
56. 00		RADI OLOGI - MERAFLUTT C	877, 564 63, 263	47, 328		1, 673, 111 270, 240	311	56.00
57. 00		CT SCAN	322, 656	35, 277		358, 432	933	
58. 00		MAGNETIC RESONANCE IMAGING (MRI)	521, 967	42, 115		759, 269	471	58. 00
59.00		CARDI AC CATHETERI ZATI ON	144, 211	271, 140		571, 221	759	59.00
60.00		LABORATORY WHOLE BLOOD & PACKED RED BLOOD CELLS	3, 591 0	0		3, 591 0	0	
65. 00		RESPIRATORY THERAPY	0	34, 660		356, 319	2, 328	
66. 00		PHYSI CAL THERAPY	289, 108	164, 854		480, 785	0	66.00
66. 01	1	PSYCHI ATRI C/PSYCHOLOGI CAL SERVI CES	0	0		0	0	66. 01
66. 02	1	O/P PHYSICAL THERAPY	3, 903	0 0 0 0 0 0		55, 745	0	66.02
67. 00 68. 00		OCCUPATIONAL THERAPY SPEECH PATHOLOGY	360, 118	26, 929 53, 403		31, 609 414, 627	0	67. 00 68. 00
69. 00		ELECTROCARDI OLOGY	40, 661	21, 195		339, 651	1, 110	
69. 01		CARDI AC REHAB	112, 887	116, 941		250, 325	240	
70.00		ELECTROENCEPHALOGRAPHY	445	24, 444		99, 900	1, 895	
71.00	1	MEDICAL SUPPLIES CHARGED TO PATIENTS	18, 560	92, 773		379, 716	0	71.00
72. 00 73. 00		IMPL. DEV. CHARGED TO PATIENTS DRUGS CHARGED TO PATIENTS	0 15, 409	0 208, 577	_	0 328, 931	0 3, 473	72. 00 73. 00
76. 00		RENAL ACUTE	800, 097	57, 252		858, 337	0, 473	76.00
	OUTPA	TIENT SERVICE COST CENTERS		·				
90.00		CLINIC	0	3, 541		3, 541	159	
90.05		PATIENT NUTRITION	1, 387	31, 347		34, 326	280	
90. 07 91. 00		WOUND CLINIC EMERGENCY	2, 607	63, 327 390, 955		80, 465 624, 082	260 4, 326	
		OBSERVATION BEDS (NON-DISTINCT PART)	2,007	070, 700	200, 020	02 1, 002	1, 020	92.00
		AL PURPOSE COST CENTERS						
118.00)	SUBTOTALS (SUM OF LINES 1 through 117)	5, 822, 659	14, 819, 556	8, 163, 006	28, 805, 221	74, 253	118. 00
100.00		IMBURSABLE COST CENTERS		^		ما	^	100 00
		GIFT, FLOWER, COFFEE SHOP & CANTEEN RURAL HEALTH	0 42, 693	0	- 1	0 94, 002		190. 00 194. 00
		RENTAL PROPERTY	219, 229	0		225, 811		194. 01
		FAMILY PRACTICE	534	602, 098		788, 894		194. 02
			·		·			

Health Financial Systems	UNION HOSPITAL, INC.	In Lieu	of Form CMS-2552-10
ALLOCATION OF CAPITAL RELATED COSTS	Provi der CCN: 15-0023	From 01/01/2017 To 12/31/2017	Worksheet B Part II Date/Time Prepared: 5/30/2018 2:18 pm

					5/30/2018 2:1	8 pm
		CAPI TAL REL	_ATED COSTS			
Cost Center Description	Di rectly	NEW BLDG &	NEW MVBLE	Subtotal	EMPLOYEE	
	Assigned New	FLXT	EQUI P		BENEFI TS	
	Capi tal				DEPARTMENT	
	Related Costs					
	0	1.00	2.00	2A	4. 00	
194. 03 07952 WELLNESS	0	227, 417	0	227, 417	309	194. 03
194. 04 07955 PHYSI CLAN PRACTICES	167, 220	0	123, 512	290, 732	5, 231	194. 04
194.06 07953 SYCAMORE SPORTS MED	0	0	594	594	12	194. 06
194. 07 07956 PSYCHI ATRI C/PSYCHOLOGI CAL SERVI CES	503, 111	46, 549	4, 544	554, 204	291	194. 07
200.00 Cross Foot Adjustments				0		200.00
201.00 Negative Cost Centers		0	0	0	0	201.00
202.00 TOTAL (sum lines 118 through 201)	6, 755, 446	15, 695, 620	8, 535, 809	30, 986, 875	83, 418	202. 00

| In Lieu of Form CMS-2552-10 | Period: | Worksheet B | From 01/01/2017 | Part II | To 12/31/2017 | Date/Time Prepared: | Part |

					10	0 12/31/2017	Date/lime Pre 5/30/2018 2:1	
		Cost Center Description	NONPATI ENT	DATA	PURCHASI NG	ADMITTI NG	CASHI ERI NG/AC	-
			TELEPHONES	PROCESSI NG	RECEIVING AND		COUNTS	
			5. 01	5. 02	STORES 5. 03	5. 04	RECEI VABLE 5. 05	
	GENER.	AL SERVICE COST CENTERS	0.01	0.02	0.00	0.01	0.00	
1.00		NEW CAP REL COSTS-BLDG & FIXT						1.00
2.00	1	NEW CAP REL COSTS-MVBLE EQUIP						2.00
4. 00 5. 01	1	EMPLOYEE BENEFITS DEPARTMENT NONPATIENT TELEPHONES	88, 624					4. 00 5. 01
5. 02		DATA PROCESSING	0	0				5. 02
5.03		PURCHASING RECEIVING AND STORES	0	0	0			5. 03
5. 04		ADMITTING	3, 178	0	_	126, 928		5.04
5. 05 5. 06		CASHIERING/ACCOUNTS RECEIVABLE OTHER ADMIN AND GENERAL	8, 192	0	_	0	0	5. 05 5. 06
7. 00	1	OPERATION OF PLANT	5, 014	0	_	0	0	7.00
8. 00	1	LAUNDRY & LINEN SERVICE	1, 271	0		0	0	8.00
9. 00		HOUSEKEEPI NG	565	0	_	0	0	9.00
10.00	1	DI ETARY CAFETERI A	2, 119	0		0	0	10.00
11. 00 13. 00	1	NURSING ADMINISTRATION	0 636	0	_	0	0	11. 00 13. 00
16. 00	1	MEDICAL RECORDS & LIBRARY	2, 119	0	1	0	ő	16.00
17. 00		SOCIAL SERVICE	0	0	0	0	0	17. 00
21.00		I &R SERVICES-SALARY & FRINGES APPRVD	0	0	0	0	0	21.00
22. 00 23. 00	1	I&R SERVICES-OTHER PRGM COSTS APPRVD PARAMED ED PRGM	0	0	0	0	0	22. 00 23. 00
23. 00	1	OTHER MED ED	o o	0	0	0	0	23. 00
23. 02	1	PARAMED ED PRGM	o	0	0	0	0	1
		IENT ROUTINE SERVICE COST CENTERS						
30. 00 31. 00		ADULTS & PEDIATRICS INTENSIVE CARE UNIT	12, 072 2, 048	0		22, 325 5, 847	0	30. 00 31. 00
35.00		INTENSIVE CARE UNIT	1, 271	0		3, 672	0	35.00
41. 00		SUBPROVI DER – I RF	2, 189	0		850	ő	41.00
43.00		NURSERY	282	0	0	1, 212	0	43.00
FO 00		LARY SERVICE COST CENTERS OPERATING ROOM	5, 791	0	0	22.704	0	 FO 00
50. 00 50. 01	1	CARDI AC SURGERY	5, 791 424	0		22, 796 1, 634	0	
50. 02	05002		0	0	1	0	ő	50. 02
51.00		RECOVERY ROOM	1, 271	0		632	0	51.00
51. 02	1	O/P TREATMENT ROOM	1, 907	0		89	0	51.02
52. 00 54. 00	1	DELIVERY ROOM & LABOR ROOM RADIOLOGY-DIAGNOSTIC	1, 624 7, 627	0	0	4, 173 2, 902	0	52. 00 54. 00
55. 00	1	RADI OLOGY-THERAPEUTI C	2, 895	0		520	0	55.00
56.00	1	RADI OI SOTOPE	0	0	0	213	0	56.00
57.00	1	CT SCAN	494	0	_	4, 552	0	57. 00
58. 00 59. 00		MAGNETIC RESONANCE IMAGING (MRI) CARDIAC CATHETERIZATION	282 2, 401	0		775 7, 448	0	58. 00 59. 00
60.00		LABORATORY	565	0		11, 405	0	60.00
62. 00	1	WHOLE BLOOD & PACKED RED BLOOD CELLS	0	0	Ö	602	Ö	62.00
65. 00		RESPI RATORY THERAPY	989	0	0	4, 061	0	65.00
66.00		PHYSI CAL THERAPY	1, 624	0		2, 755 0	0	66.00
		PSYCHIATRIC/PSYCHOLOGICAL SERVICES O/P PHYSICAL THERAPY	0 71	0		0	0	00.0.
67. 00		OCCUPATI ONAL THERAPY	353	0		1, 278	ő	67.00
68. 00		SPEECH PATHOLOGY	71	0	0	307	0	68. 00
69.00		ELECTROCARDI OLOGY	282	0	0	2, 848	0	69.00
69. 01 70. 00	1	CARDI AC REHAB ELECTROENCEPHALOGRAPHY	424 1, 200	0	0	23 833	0	69. 01 70. 00
		MEDICAL SUPPLIES CHARGED TO PATIENTS	989	0	ő	182	ő	ı
72.00		IMPL. DEV. CHARGED TO PATIENTS	O	0	0	1, 969	0	
	1	DRUGS CHARGED TO PATIENTS	3, 531	0		12, 848	0	
76. 00		RENAL ACUTE TIENT SERVICE COST CENTERS	282	0	0	811	0	76.00
90.00		CLINIC	0	0	0	0	0	90.00
90. 05	1	PATIENT NUTRITION	0	0	0	0	0	90. 05
	1	WOUND CLINIC	918	0	0	5	0	
		EMERGENCY OBSERVATION BEDS (NON-DISTINCT PART)	4, 449	0	0	7, 361	0	91.00 92.00
72.00		AL PURPOSE COST CENTERS						72.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	81, 420	0	0	126, 928	0	118. 00
100.00		MBURSABLE COST CENTERS	7-1					100.00
		GIFT, FLOWER, COFFEE SHOP & CANTEEN RURAL HEALTH	71	0		0		190. 00 194. 00
		RENTAL PROPERTY	o	0		0		194. 00
194. 02	07954	FAMILY PRACTICE	5, 014	0	o	0	0	194. 02
		WELLNESS	0	0	0	0		194. 03
		PHYSICIAN PRACTICES SYCAMORE SPORTS MED	1, 554	0	0	0		194. 04 194. 06
1 74. 00	101700	OTO WHOLE OF ORTO MED	Ο _Ι		<u>ı</u> <u>U</u>	0	<u> </u>	11 /7. 00

Health Financial Systems

UNION HOSPITAL, INC.

In Lieu of Form CMS-2552-10

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 15-0023

Peri od:
From 01/01/2017
To 12/31/2017
Date/Time Prepared:
From 02/01/2017
To 12/31/2017
Date/Time Prepared:
From 03/01/2017
Date/Time Prepared:

						5/30/2018 2:1	8 pm
	Cost Center Description	NONPATI ENT	DATA	PURCHASI NG	ADMI TTI NG	CASHI ERI NG/AC	
		TELEPHONES	PROCESSI NG	RECEIVING AND		COUNTS	
				STORES		RECEI VABLE	
		5. 01	5. 02	5. 03	5. 04	5. 05	
194. 07 079	56 PSYCHI ATRI C/PSYCHOLOGI CAL SERVI CES	565	0	0	0	0	194. 07
200.00	Cross Foot Adjustments						200.00
201.00	Negative Cost Centers	0	0	0	0	0	201.00
202.00	TOTAL (sum lines 118 through 201)	88, 624	0	0	126, 928	0	202. 00

Health Financial Systems
ALLOCATION OF CAPITAL RELATED COSTS

Provi der CCN: 15-0023

In Lieu of Form CMS-2552-10

Period: Worksheet B
From 01/01/2017 Part II
To 12/31/2017 Date/Time Prepared: 5/30/2018 2:18 pm

					5/30/2018 2:1	
Cost Center Description	OTHER ADMIN	OPERATION OF	LAUNDRY &	HOUSEKEEPI NG	DI ETARY	
	AND GENERAL 5. 06	PLANT 7. 00	LINEN SERVICE 8.00	9. 00	10.00	
GENERAL SERVICE COST CENTERS	5.00	7.00	8.00	9.00	10.00	
1.00 O0100 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 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 00590 OTHER ADMIN AND GENERAL	416, 743					5.06
7. 00 00700 OPERATION OF PLANT	19, 875	5, 707, 310	1			7.00
8. 00 00800 LAUNDRY & LINEN SERVICE	1, 964	56, 575		l :		8.00
9. 00 00900 HOUSEKEEPI NG	4, 862	50, 197			E40 700	9.00
10. 00 01000 DI ETARY 11. 00 01100 CAFETERI A	1, 707	103, 702		l ' '	569, 789 0	10.00
13.00 01300 NURSI NG ADMINI STRATION	2, 874 5, 228	73, 997 22, 449		3, 442 1, 044	0	13.00
16. 00 01600 MEDICAL RECORDS & LIBRARY	5, 228	49, 914	•	2, 322	0	16.00
17. 00 01700 SOCIAL SERVICE	0,741	1 47, 714	0	2, 322	0	17.00
21. 00 02100 1 &R SERVICES-SALARY & FRINGES APPRVD	2, 399	0			0	21.00
22. 00 02200 L&R SERVICES-OTHER PRGM COSTS APPRVD	3, 310	0	0		0	22.00
23. 00 02300 PARAMED ED PRGM	225	0	0		0	23.00
23. 01 02341 OTHER MED ED	378	6, 803	0	316	0	23. 01
23. 02 02301 PARAMED ED PRGM	225	0	0	0	0	23. 02
INPATIENT ROUTINE SERVICE COST CENTERS			•	'		
30. 00 03000 ADULTS & PEDIATRICS	60, 360	1, 776, 665	118, 325	82, 655	434, 681	30.00
31.00 03100 INTENSIVE CARE UNIT	12, 697	217, 211	17, 665	10, 105	64, 462	31.00
35. 00 02040 I NTENSI VE NURSERY	4, 311	27, 210	1, 413	1, 266	0	35.00
41. 00 04100 SUBPROVI DER - I RF	2, 775	140, 030	2, 011	6, 514	30, 225	41.00
43. 00 04300 NURSERY	2, 160	37, 102	0	1, 726	0	43.00
ANCILLARY SERVICE COST CENTERS						
50. 00 05000 OPERATI NG ROOM	19, 646				0	50.00
50. 01 05001 CARDI AC SURGERY	4, 289	17, 006		791	0	50. 01
50. 02 05002 WVSC	14, 953	283, 706			0	50.02
51. 00 05100 RECOVERY ROOM	3, 496	13, 530		l :	0	51.00
51. 02 05101 0/P TREATMENT ROOM	4, 815	201, 659			37, 776	
52. 00 05200 DELI VERY ROOM & LABOR ROOM	7, 351	196, 567			13	
54. 00 05400 RADI OLOGY-DI AGNOSTI C 55. 00 05500 RADI OLOGY-THERAPEUTI C	13, 176	308, 337		· .	0	
55. 00 05500 RADI OLOGY-THERAPEUTI C 56. 00 05600 RADI OI SOTOPE	7, 806 2, 106	249, 362 27, 532		11, 601 1, 281	0	55. 00 56. 00
57. 00 05700 CT SCAN	4, 163	20, 521		l ' '	0	57.00
58.00 05800 MAGNETIC RESONANCE IMAGING (MRI)	2, 949	24, 499		l .	0	58.00
59. 00 05900 CARDI AC CATHETERI ZATI ON	21, 423	157, 726			2, 632	
60. 00 06000 LABORATORY	12, 430	137,720	2,002	7, 550	0	60.00
62.00 06200 WHOLE BLOOD & PACKED RED BLOOD CELLS	1, 600	0	0	o	0	
65. 00 06500 RESPIRATORY THERAPY	6, 683	20, 162	1	938	0	65.00
66. 00 06600 PHYSI CAL THERAPY	4, 067	95, 898		4, 461	0	66.00
66. 01 06601 PSYCHI ATRI C/PSYCHOLOGI CAL SERVI CES	0	0	0	0	0	66. 01
66.02 06602 0/P PHYSICAL THERAPY	2, 727	0	5, 417	o	0	66. 02
67. 00 06700 OCCUPATI ONAL THERAPY	2, 279	15, 665	0	729	0	67.00
68.00 06800 SPEECH PATHOLOGY	1, 045	31, 065	0	1, 445	0	68. 00
69. 00 06900 ELECTROCARDI OLOGY	6, 313	12, 330	2, 613	574	0	69. 00
69. 01 06901 CARDI AC REHAB	751	68, 026		· · ·	0	69. 01
70. 00 07000 ELECTROENCEPHALOGRAPHY	1, 933	14, 219			0	70.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	1, 600	53, 967	1	2, 511	0	71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	15, 946	0	1		0	72.00
73. 00 07300 DRUGS CHARGED TO PATIENTS	63, 261	121, 332		-,	0	73.00
76. 00 03020 RENAL ACUTE	2, 182	33, 304	1, 378	1, 549	0	76.00
OUTPATIENT SERVICE COST CENTERS	350	2.040	_	0/1	^	00.00
90. 00 09000 CLINIC 90. 05 09005 PATIENT NUTRITION	359 623	2, 060 18, 235		96 848	0	
90. 07 09007 WOUND CLINIC	1, 857	36, 838			0	
91. 00 09100 EMERGENCY	19, 550	227, 424			0	91.00
92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	17, 550	227, 424	43, 371	10, 360	U	92.00
SPECIAL PURPOSE COST CENTERS			l .			72.00
118.00 SUBTOTALS (SUM OF LINES 1 through 117)	382, 670	5, 197, 691	333, 285	236, 835	569, 789	118 00
NONREI MBURSABLE COST CENTERS	552, 670	3, 177, 071	555, 205	200, 000	557, 757	1
190. 00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	1	n	0	nl	n	190. 00
194. 00 07950 RURAL HEALTH	4, 926	n n	182	o		194.00
194. 01 07951 RENTAL PROPERTY	175	Ö	0	l I		194. 01
194. 02 07954 FAMILY PRACTICE	7, 110	350, 249	277	16, 294		194. 02
194. 03 07952 WELLNESS	1, 033	132, 292		· · · · · · · · · · · · · · · · · · ·		194. 03
194.04 07955 PHYSICIAN PRACTICES	19, 934	0				194. 04
194.06 07953 SYCAMORE SPORTS MED	114	0	0	l I		194. 06
194. 07 07956 PSYCHI ATRI C/PSYCHOLOGI CAL SERVI CES	780	27, 078	0	1, 260	0	194. 07
						

Health Financial Systems

UNION HOSPITAL, INC.

In Lieu of Form CMS-2552-10

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 15-0023

Period:
From 01/01/2017
To 12/31/2017

To 12/31/2017

Propagate

Systems

Provider CCN: 15-0023

Period:
From 01/01/2017
To 12/31/2017

To 12/31/2017

From 01/01/2017
To 12/31/2017

From 01/01/2017
To 12/31/2017

From 01/01/2017
To 12/31/2017

						5/30/2018 2:1	8 pm
	Cost Center Description	OTHER ADMIN	OPERATION OF	LAUNDRY &	HOUSEKEEPI NG	DI ETARY	
		AND GENERAL	PLANT	LINEN SERVICE			
		5. 06	7. 00	8. 00	9. 00	10.00	
200.00	Cross Foot Adjustments						200.00
201.00	Negative Cost Centers	0	0	0	0	0	201.00
202. 00	TOTAL (sum lines 118 through 201)	416, 743	5, 707, 310	334, 988	260, 543	569, 789	202.00

Health Financial Systems
ALLOCATION OF CAPITAL RELATED COSTS Provider CCN: 15-0023

| In Lieu of Form CMS-2552-10 | Period: | Worksheet B | From 01/01/2017 | Part II | To 12/31/2017 | Date/Time Prepared: | Part |

					lo	12/31/2017	Date/lime Pre 5/30/2018 2:1	
							INTERNS &	
		Cost Center Description	CAFETERI A	NURSI NG	MEDI CAL	SOCI AL	RESI DENTS SERVI CES-SALA	
		cost center bescription	CAFETERIA	ADMI NI STRATI O	RECORDS &	SERVI CE	RY & FRINGES	
				N	LI BRARY			
	OFNER	AL CERVI OF COCT OFNITERS	11. 00	13. 00	16. 00	17. 00	21. 00	
1. 00		AL SERVICE COST CENTERS NEW CAP REL COSTS-BLDG & FLXT						1.00
2. 00		NEW CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5. 01		NONPATI ENT TELEPHONES						5. 01
5. 02 5. 03		DATA PROCESSING PURCHASING RECEIVING AND STORES						5. 02 5. 03
5. 04		ADMITTING						5. 04
5. 05	1	CASHI ERI NG/ACCOUNTS RECEI VABLE						5. 05
5.06	1	OTHER ADMIN AND GENERAL						5.06
7. 00	4	OPERATION OF PLANT						7.00
8. 00 9. 00		LAUNDRY & LINEN SERVICE HOUSEKEEPING						8. 00 9. 00
10. 00		DI ETARY						10.00
11.00	01100	CAFETERI A	224, 387					11. 00
13.00	1	NURSING ADMINISTRATION	3, 221	78, 502				13.00
16. 00 17. 00	1	MEDICAL RECORDS & LIBRARY	7, 983 0	0	182, 005 0	0		16. 00 17. 00
21. 00	1	SOCIAL SERVICE I&R SERVICES-SALARY & FRINGES APPRVD	4, 150	0		0	7, 745	
22. 00		I&R SERVICES-OTHER PRGM COSTS APPRVD	869	Ö	O	0	,,,,,	22. 00
23. 00		PARAMED ED PRGM	395	ł		0		23. 00
23. 01		OTHER MED ED	1, 067	259	0	0		23. 01
23. 02		PARAMED ED PRGM TENT ROUTINE SERVICE COST CENTERS	395	0	0	0		23. 02
30.00		ADULTS & PEDIATRICS	72, 821	33, 259	13, 105	0		30.00
31.00	1	INTENSIVE CARE UNIT	14, 287	7, 274	3, 176	0		31.00
35.00		I NTENSI VE NURSERY	4, 861	2, 476		0		35.00
41. 00 43. 00		SUBPROVI DER - I RF NURSERY	3, 577 3, 142	i .	461 658	0		41. 00 43. 00
10.00		LARY SERVICE COST CENTERS	0, 112	1,020	000			10.00
50.00	1	OPERATING ROOM	10, 552		23, 770	0		50.00
50. 01	1	CARDI AC SURGERY	1, 581 0	470 0		0		50.01
50. 02 51. 00	1	WVSC RECOVERY ROOM	5, 118		13, 752 1, 077	0		50. 02 51. 00
51. 02	1	O/P TREATMENT ROOM	6, 225	1		0		51.02
52.00	4	DELIVERY ROOM & LABOR ROOM	8, 655	l .		0		52.00
54.00	4	RADI OLOGY THERAPEUT C	11, 718	l		0		54.00
55. 00 56. 00		RADI OLOGY-THERAPEUTI C RADI OI SOTOPE	1, 186 1, 008	l	5, 218 1, 082	0		55. 00 56. 00
57. 00	1	CT SCAN	2, 846	l	8, 953	0		57.00
58.00		MAGNETIC RESONANCE IMAGING (MRI)	1, 383	0	2, 121	0		58. 00
59.00	1	CARDI AC CATHETERI ZATI ON	2, 154	0	14, 231	0		59.00
60. 00 62. 00	1	LABORATORY WHOLE BLOOD & PACKED RED BLOOD CELLS	0	0	12, 922 422	0		60. 00 62. 00
		RESPI RATORY THERAPY	7, 648	· -		0		65.00
66. 00	06600	PHYSI CAL THERAPY	0	0		0		66. 00
66. 01	1	PSYCHI ATRI C/PSYCHOLOGI CAL SERVI CES	0	0	0	0		66. 01
66. 02 67. 00		O/P PHYSICAL THERAPY OCCUPATIONAL THERAPY	0	0	916 1, 145	0		66. 02 67. 00
68. 00		SPEECH PATHOLOGY	0	Ö	432	0		68.00
69. 00	06900	ELECTROCARDI OLOGY	4, 624	0	4, 244	0		69. 00
69. 01		CARDI AC REHAB	810	0	172	0		69. 01
70. 00 71. 00		ELECTROENCEPHALOGRAPHY MEDICAL SUPPLIES CHARGED TO PATIENTS	1, 581	0	1, 049 107	0		70. 00 71. 00
72.00	1	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0		72.00
73.00	1	DRUGS CHARGED TO PATIENTS	8, 972	3, 387	35, 233	0		73.00
76. 00		RENAL ACUTE	0	0	507	0		76. 00
90. 00		TIENT SERVICE COST CENTERS	395	192	93	0		90.00
90.00		PATIENT NUTRITION	949	ŀ	27	0		90.00
90. 07	09007	WOUND CLINIC	869	l	909	0		90. 07
91.00	1	EMERGENCY	16, 896	7, 897	17, 762	0		91.00
92. 00		OBSERVATION BEDS (NON-DISTINCT PART)						92.00
118.00		AL PURPOSE COST CENTERS SUBTOTALS (SUM OF LINES 1 through 117)	211, 938	78, 502	182, 005	0	0	118. 00
	NONRE	IMBURSABLE COST CENTERS	., . 30					
		GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0		190.00
		RURAL HEALTH RENTAL PROPERTY	0	0	0	0		194. 00 194. 01
		FAMILY PRACTICE	3, 438	0	0	0		194.01
		WELLNESS	0		- 1	0	<u> </u>	194. 03

Health Financial Systems	UNION HOSPITA	L, INC.		In Lie	u of Form CMS-:	2552-10
ALLOCATION OF CAPITAL RELATED COSTS		Provider (CCN: 15-0023	Peri od: From 01/01/2017 To 12/31/2017	Worksheet B Part II Date/Time Pre 5/30/2018 2:1	
					INTERNS &	

						3/30/2010 2.1	o piii
						INTERNS &	
						RESI DENTS	
	Cost Center Description	CAFETERI A	NURSI NG	MEDI CAL	SOCI AL	SERVI CES-SALA	
			ADMI NI STRATI O	RECORDS &	SERVI CE	RY & FRINGES	
			N	LI BRARY			
		11. 00	13. 00	16.00	17. 00	21. 00	
194. 04 07955	PHYSICIAN PRACTICES	8, 043	0	0	0		194.04
194. 06 07953	SYCAMORE SPORTS MED	0	0	0	0		194.06
194. 07 07956	PSYCHI ATRI C/PSYCHOLOGI CAL SERVI CES	968	0	0	0		194. 07
200. 00	Cross Foot Adjustments					7, 745	200.00
201.00	Negative Cost Centers	0	0	0	0	0	201.00
202.00	TOTAL (sum lines 118 through 201)	224, 387	78, 502	182, 005	0	7, 745	202.00

Health Financial Systems
ALLOCATION OF CAPITAL RELATED COSTS Provider CCN: 15-0023

					To	12/31/2017	Date/Time Pre 5/30/2018 2:1	
			INTERNS &	<u> </u>			1 0, 00, 20.0 2	J
	Cook Cooker December		RESI DENTS	DADAMED ED	OTHER MED ED	DADAMED ED	Ch. + - + - 1	
	Cost Center Description		SERVICES-OTHE R PRGM COSTS	PARAMED ED PRGM	OTHER MED ED	PARAMED ED PRGM	Subtotal	
			22. 00	23. 00	23. 01	23. 02	24. 00	
	GENERAL SERVICE COST CENTERS							
1. 00	00100 NEW CAP REL COSTS-BLDG 8							1.00
2.00	00200 NEW CAP REL COSTS-MVBLE							2.00
4. 00 5. 01	00400 EMPLOYEE BENEFITS DEPART 00540 NONPATIENT TELEPHONES	IVIENI						4. 00 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 RECE	IVABLE						5.05
5. 06 7. 00	00700 OPERATION OF PLANT							5. 06 7. 00
8. 00	00800 LAUNDRY & LINEN SERVICE							8.00
9. 00	00900 HOUSEKEEPI NG							9.00
10.00	1 1							10.00
11. 00 13. 00	1 1							11.00
16. 00	1 1	PY						16.00
17. 00	1 1	••						17. 00
21. 00								21.00
22. 00	1	COSTS APPRVD	5, 325	700				22.00
23. 00 23. 01	02300 PARAMED ED PRGM 02341 OTHER MED ED			720	21, 035			23. 00 23. 01
23. 01	1				21,033	720		23. 02
	INPATIENT ROUTINE SERVICE COST	T CENTERS				-,		
	03000 ADULTS & PEDIATRICS						6, 670, 729	1
31.00							1, 363, 297	1
35. 00 41. 00	1						218, 002 474, 287	1
43.00	1 1						119, 611	1
	ANCILLARY SERVICE COST CENTERS	S					,	
50.00	1						3, 510, 713	1
50. 01	05001 CARDI AC SURGERY						211, 882	1
50. 02 51. 00	1 1						1, 686, 960 92, 702	1
51. 00	1 1						769, 257	1
52.00	1 1	MOO					870, 597	1
54.00	1 1						2, 379, 634	1
55.00	1 1						1, 956, 442	1
56. 00 57. 00	1 1						305, 080 401, 849	
58. 00	1 1	NG (MRI)					802, 203	
59. 00	1 1	` ,					790, 215	59. 00
60.00	1 1						40, 913	1
62. 00 65. 00	1 1	BLOOD CELLS					2, 624	1
66. 00							405, 316 593, 676	
66. 01		L SERVICES					0	1
66. 02	06602 0/P PHYSICAL THERAPY						64, 876	66. 02
67.00							53, 058	1
68. 00 69. 00	06800 SPEECH PATHOLOGY 06900 ELECTROCARDI OLOGY						448, 992 374, 589	1
69. 00							324, 034	
	07000 ELECTROENCEPHALOGRAPHY						123, 851	
71. 00							439, 099	1
	07200 IMPL. DEV. CHARGED TO PA						17, 915	1
73.00	07300 DRUGS CHARGED TO PATIENT 03020 RENAL ACUTE	S					586, 612 898, 350	
70.00	OUTPATIENT SERVICE COST CENTER	RS					676, 330	70.00
90.00	09000 CLI NI C						6, 895	90.00
	09005 PATIENT NUTRITION						55, 729	1
90.07	1 1						127, 868	1
	09100 EMERGENCY 09200 OBSERVATION BEDS (NON-DI	STINCT DART)					983, 898	91. 00 92. 00
72.00	SPECIAL PURPOSE COST CENTERS	SITINCT FART)						72.00
118.00		1 through 117)	0	0	0	0	28, 171, 755	118. 00
	NONREI MBURSABLE COST CENTERS	<u> </u>						
190.00	0 19000 GIFT, FLOWER, COFFEE SHO	P & CANTEEN						190.00
	0 07950 RURAL HEALTH 1 07951 RENTAL PROPERTY						100, 325 225, 986	
	2 07951 RENTAL PROPERTY						1, 173, 383	
194. 03	3 07952 WELLNESS						367, 205	194. 03
	4 07955 PHYSICIAN PRACTICES						326, 738	194. 04

Health Financial Systems	UNION HOSPI	TAL, INC.	In Lie	u of Form CMS-2	2552-10
ALLOCATION OF CAPITAL RELATED COSTS		Provi der C	Period: From 01/01/2017 To 12/31/2017	Worksheet B Part II Date/Time Pre 5/30/2018 2:1	
	I NTERNS & RESI DENTS				

						5/30/2018 2:1	8 pm
		INTERNS &					
		RESI DENTS					
	Cost Center Description	SERVI CES-OTHE	PARAMED ED	OTHER MED ED	PARAMED ED	Subtotal	
		R PRGM COSTS	PRGM		PRGM		
		22. 00	23. 00	23. 01	23. 02	24. 00	
194.06 07953	SYCAMORE SPORTS MED					720	194.06
194. 07 07956	PSYCHI ATRI C/PSYCHOLOGI CAL SERVI CES					585, 146	194. 07
200. 00	Cross Foot Adjustments	5, 325	720	21, 035	720	35, 545	200.00
201. 00	Negative Cost Centers	0	0	0	0	0	201.00
202. 00	TOTAL (sum lines 118 through 201)	5, 325	720	21, 035	720	30, 986, 875	202.00

UNION HOSPITAL, INC.

Health Financial Systems In Lieu of Form CMS-2552-10 ALLOCATION OF CAPITAL RELATED COSTS Provider CCN: 15-0023 Peri od: Worksheet B From 01/01/2017 Part II Date/Time Prepared: 12/31/2017 5/30/2018 2:18 pm Cost Center Description Intern & Total Resi dents Cost & Post Stepdown Adjustments 25. 00 26.00 GENERAL SERVICE COST CENTERS 00100 NEW CAP REL COSTS-BLDG & FIXT 00200 NEW CAP REL COSTS-MVBLE EQUIP 1.00 1.00 2.00 2 00 4.00 00400 EMPLOYEE BENEFITS DEPARTMENT 4.00 00540 NONPATIENT TELEPHONES 5.01 5.01 00550 DATA PROCESSING 5.02 5.02 00560 PURCHASING RECEIVING AND STORES 5.03 5.03 5.04 00570 ADMITTING 5.04 5.05 00580 CASHI ERI NG/ACCOUNTS RECEI VABLE 5.05 5.06 00590 OTHER ADMIN AND GENERAL 5.06 00700 OPERATION OF PLANT 7.00 7.00 8.00 00800 LAUNDRY & LINEN SERVICE 8.00 00900 HOUSEKEEPI NG 9.00 9.00 01000 DI ETARY 10.00 10.00 11. 00 01100 CAFETERIA 11.00 13.00 01300 NURSING ADMINISTRATION 13.00 01600 MEDICAL RECORDS & LIBRARY 16.00 16,00 17. 00 | 01700 | SOCIAL SERVICE 17.00 02100 I&R SERVICES-SALARY & FRINGES APPRVD 21.00 21.00

Health Financial Systems	UNION HOSPITAL, INC.			In Lieu of Form CMS-2552-10		
ALLOCATION OF CAPITAL RELATED COSTS		Provider CC	CN: 15-0023	Peri od: From 01/01/2017 To 12/31/2017	Worksheet B Part II Date/Time Prepared: 5/30/2018 2:18 pm	
Cost Center Description	Intern & Residents Cost & Post Stepdown Adjustments	Total				
	25. 00	26. 00				
194. 04 07955 PHYSI CI AN PRACTI CES	0	326, 738			194. 04	
194.06 07953 SYCAMORE SPORTS MED	o	720			194. 06	
194. 07 07956 PSYCHI ATRI C/PSYCHOLOGI CAL SERVI CES	0	585, 146			194. 07	
200.00 Cross Foot Adjustments	0	35, 545			200. 00	
201.00 Negative Cost Centers	0	0			201. 00	
202.00 TOTAL (sum lines 118 through 201)	0	30, 986, 875			202. 00	

		TION - STATISTICAL BASIS	ONI ON TIOSI I I	Provi der C	CN: 15-0023 F	Peri od:	Worksheet B-1	
					F	From 01/01/2017 Fo 12/31/2017	Date/Time Pre	pared:
			CAPITAL RELA	ATED COSTS			5/30/2018 2:1	8 pm
		Cost Center Description	NEW BLDG & FLXT	NEW MVBLE EQUIP	EMPLOYEE	NONPATI ENT	DATA PROCESSI NG	
			(NEW TOTAL	(NEW EQUIP	BENEFITS DEPARTMENT	TELEPHONES (PHONES)	(DEVICES)	
			SQ FT)	DEPRN)	(GROSS			
		•	1. 00	2. 00	SALARI ES) 4. 00	5. 01	5. 02	
		AL SERVICE COST CENTERS		2.00	1.00	0.01	0. 02	
1.00		NEW CAP REL COSTS MADE FOLLO	966, 375	2 224 020				1.00
2. 00 4. 00		NEW CAP REL COSTS-MVBLE EQUIP EMPLOYEE BENEFITS DEPARTMENT	5, 136	3, 334, 039 0	i	5		2. 00 4. 00
5. 01	1	NONPATI ENT TELEPHONES	657	30, 250				5. 01
5. 02		DATA PROCESSING	0	0	1	0	1, 124	
5. 03 5. 04		PURCHASING RECEIVING AND STORES ADMITTING	0 3, 062	3, 299	1, 393, 595	-	0	
5. 05		CASHI ERI NG/ACCOUNTS RECEI VABLE	0	0	(0	0	1
5.06		OTHER ADMIN AND GENERAL	18, 571	29, 903			2	5.06
7. 00 8. 00		OPERATION OF PLANT LAUNDRY & LINEN SERVICE	334, 876 5, 988	88, 455 67, 033			0	
9. 00		HOUSEKEEPI NG	5, 313	36, 271		8	0	1
10.00		DI ETARY	10, 976	106, 783			19	1
11. 00 13. 00	1	CAFETERIA NURSING ADMINISTRATION	7, 832 2, 376	6, 020 1, 960			0	
		MEDICAL RECORDS & LIBRARY	5, 283	6, 704			46	1
		SOCIAL SERVICE	0	0	1		0	
21. 00 22. 00		I&R SERVICES-SALARY & FRINGES APPRVD I&R SERVICES-OTHER PRGM COSTS APPRVD	0	0	1, 318, 240 1, 263, 710		0	
23. 00		PARAMED ED PRGM	Ö	Ö			0	1
23. 01		OTHER MED ED	720	119			0	
23. 02		PARAMED ED PRGM I ENT ROUTINE SERVICE COST CENTERS	0	0	110, 036	5 0	0	23. 02
	03000	ADULTS & PEDIATRICS	188, 046	329, 811	20, 045, 307	7 171	629	30.00
		INTENSIVE CARE UNIT	22, 990	175, 854			74	1
35. 00 41. 00		INTENSIVE NURSERY SUBPROVIDER - IRF	2, 880 14, 821	46, 531 13, 667			16 0	1
43. 00		NURSERY	3, 927	2, 778			0	
FO 00		LARY SERVICE COST CENTERS OPERATING ROOM	40. 725	E0E 400	2 047 54	1 02	32	1 50 00
50. 00 50. 01		CARDIAC SURGERY	40, 735 1, 800	585, 490 47, 256			0	1
50. 02	05002	1	30, 028	164, 883	1		0	
51. 00 51. 02		RECOVERY ROOM O/P TREATMENT ROOM	1, 432 21, 344	9, 673 54, 530			3	1
		DELIVERY ROOM & LABOR ROOM	20, 805	105, 326			30	
		RADI OLOGY-DI AGNOSTI C	32, 635	384, 857			63	
55. 00 56. 00		RADI OLOGY-THERAPEUTI C RADI OI SOTOPE	26, 393 2, 914	143, 301 62, 358			0 2	
57. 00	05700	CT SCAN	2, 172	195	1, 028, 258		0	•
		MAGNETIC RESONANCE IMAGING (MRI)	2, 593	76, 239			0	1
59. 00 60. 00		CARDI AC CATHETERI ZATI ON LABORATORY	16, 694	60, 882	836, 80		34 0	1
62.00		WHOLE BLOOD & PACKED RED BLOOD CELLS	Ö	Ö			0	1
65. 00	1	RESPI RATORY THERAPY	2, 134	125, 638			14	1
66. 00 66. 01		PHYSI CAL THERAPY PSYCHI ATRI C/PSYCHOLOGI CAL SERVI CES	10, 150	10, 477 0			23 0	1
66. 02	1	O/P PHYSICAL THERAPY	Ö	20, 249			0	1
67.00		OCCUPATI ONAL THERAPY	1, 658	1, 828	1	5	0	
68. 00 69. 00		SPEECH PATHOLOGY ELECTROCARDI OLOGY	3, 288 1, 305	432 108, 505	1	1	0 19	
69. 01	1	CARDI AC REHAB	7, 200	8, 006			3	1
70.00		ELECTROENCEPHALOGRAPHY	1, 505	29, 299			0	
71. 00 72. 00	1	MEDICAL SUPPLIES CHARGED TO PATIENTS IMPL. DEV. CHARGED TO PATIENTS	5, 712 0	104, 829		14	0	
		DRUGS CHARGED TO PATIENTS	12, 842	40, 991	3, 828, 662		21	1
76. 00		RENAL ACUTE	3, 525	386	() 4	0	76.00
90. 00		TIENT SERVICE COST CENTERS	218	0	175, 338	3 0	0	90.00
90. 05	09005	PATIENT NUTRITION	1, 930	622	308, 183	0	0	90.05
90.07		WOUND CLINIC	3, 899	6, 694			0	
91. 00 92. 00		EMERGENCY OBSERVATION BEDS (NON-DISTINCT PART)	24, 071	90, 040	4, 769, 845	63	88	91.00 92.00
	SPECI	AL PURPOSE COST CENTERS						1
118. 00		SUBTOTALS (SUM OF LINES 1 through 117) MBURSABLE COST CENTERS	912, 436	3, 188, 424	81, 898, 116	1, 153	1, 118	118.00
190. 00		GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0) 1	0	190.00
194.00	07950	RURAL HEALTH	0	20, 041			0	194. 00
194. 01	ηυ/951	RENTAL PROPERTY	0	2, 571	1 (0	0	194. 01

Health Financial Systems	UNION HOSPITAL, INC.	In Lieu of Form CMS-2552-10
COST ALLOCATION - STATISTICAL BASIS	Provi der CCN: 15-0023	Period: Worksheet B-1

CAPITAL RELATED COSTS NEW MVBLE FIXT (NEW FOUTAL SO FT) NEW BLDG & FIXT (NEW FO					Ţ	o 12/31/2017	Date/Time Pre 5/30/2018 2:1	
FIXT (NEW TOTAL SQ FT) SUPPRIN SQ FT) SENEFITS DEPARTMENT (GROSS SALARIES) SALARIES) SALARIES SA			CAPI TAL REL	ATED COSTS				
194. 02 07954 FAMILY PRACTICE 37, 071 72, 753 2, 322, 732 71 0 194. 02 194. 03 07952 WELLNESS 14, 002 0 340, 361 0 0 194. 03 194. 04 07955 PHYSICIAN PRACTICES 0 48, 243 5, 767, 141 22 2 194. 04 194. 06 07953 SYCAMORE SPORTS MED 0 232 12, 902 0 0 194. 06 194. 07 194. 08 194. 07 194. 08 194. 09		Cost Center Description	FIXT (NEW TOTAL	EQUIP (NEW EQUIP	BENEFITS DEPARTMENT (GROSS	TELEPHONES	PROCESSI NG	
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194. 06 07953 SYCAMORE SPORTS MED 194. 07 07956 PSYCHIATRIC/PSYCHOLOGICAL SERVICES 200. 00 Cross Foot Adjustments Negative Cost Centers 202. 00 Cost to be allocated (per Wkst. B, Part I) 203. 00 Unit cost multiplier (Wkst. B, Part II) 205. 00 Unit cost multiplier (Wkst. B, Part II) 206. 00 NAHE adjustment amount to be allocated (per Wkst. B, Part II) 207. 00 NAHE unit cost multiplier (Wkst. B, Part II) 208. 00 NAHE unit cost multiplier (Wkst. B, Part II) 209. 00 NAHE unit cost multiplier (Wkst. B, Part II) 200. 00 NAHE unit cost multiplier (Wkst. B, Part III) 200. 00 NAHE unit cost multiplier (Wkst. B, Part IIIIIIIIIIIIIIIIIIIIIIIIIIIIIIIIIIII			14, 002	0	340, 361	0	0	194. 03
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207.00 NAHE unit cost multiplier (Wkst. D, 207.00	206. 00	NAHE adjustment amount to be allocated						206. 00
	207. 00							207. 00

Cost Center Description	UNION HOSPITAL, INC. In Lieu of Form CMS-2552-	N 45 0000 D		UNI ON HOSPIT	ealth Financial Systems
SAME STATE COST CENTER DESCRIPTION RECEIVED AND	To 12/31/2017 Date/Time Prepared	Fro	Provider CC		OST ALLOCATION - STATISTICAL BASIS
RECEI VIN & AND CANERAL (CROSS STORES STORES STORES (REGUISITIO) CHARGES) RECEI VARIE (CROSS STORES (REGUISITIO) FACE (MARGES) SA. 06 S. 0	5/30/2018 2: 18 pm	CACILLEDI NC (AC L	ADMITTING	DIDCHASING	Cost Contar Description
STORES CREQUISTITIO CHARGES) CHARGES CROSS					Cost Center Description
CHARGES CONTINUENCE CONT	STORES CHARGES) RECEIVABLE (ACCUM.	RECEI VABLE	,	STORES	
CEMERAL SERVICE COST CENTERS 1.00 00100 NEW CAP REL COSTS-BLIGS & FIXT 0.00 00200 NEW CAP REL COSTS-MUELE EQUIP 4.00 00400 EMPLOYEE BENEFIT SDEPARTMENT 5.01 00540 NONPATIENT TELEPHONES 5.01 00540 NONPATIENT TELEPHONES 5.01 00540 NONPATIENT TELEPHONES 5.01 00540 NONPATIENT TELEPHONES 5.01 00540 PRICALSIAN RECEIVING AND STORES 5.147, 315 5.04 00570 ADM ITTING 0.0570 ADM ITTING 0.05				(REQUISITIO)	
EMBERAL SERVICE COST CENTES			5. 04	5. 03	
2.00 00200 NEW CAP REL COSTS-AMBLE EQUIP					
4.00 00-0400 EMPLOYEE BENEFITS DEPARTMENT			-		
5. 01 000540 NOMPATI ENT TELEPHONES 5. 02 000560 DATA PROCESSIN ING 5. 03 000560 PURCINASIN ING RECEI VING AND STORES 5. 04 000570 ADMITTINS 5. 05 000580 CASH ERING/ACCOUNTS RECEI VABLE 7. 00 00700 OPERATION OF PLANT 7. 00 00700 OPERATION					
5. 03 00560 PURCHASI NG RECEI VING AND STORES 5, 147, 315 5. 04 00570 ADMITTING 5. 05 00580 CASHI BRINK/ACCOUNTS RECEI VABLE 7. 00 007000 00700 00700 00700 00700 007000 007000 007000 007000 007000 007000 007000 007000 007000 0070000 0070000 00700000 00700000000	5.0				
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5.06 OSSOO CASHLERI NGY-ACCOUNTS RECEI VABLE 0 0 1, 351, 779, 671 0 -22, 431, 030 332, 804, 815 5 6 0 0 0 0 0 0 0 0 15, 874, 5881 5 0 0 0 0 0 0 0 15, 874, 5881 5 0 0 0 0 0 0 15, 874, 5881 5 0 0 0 0 0 0 0 15, 874, 5881 5 0 0 0 0 0 0 0 0 0			512 171 004		
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8. 00 00800 LAUNDRY & LINEN SERVICE 7, 135 0 0 0 1, 568, 637 8, 97 9, 00 00900 HOUSEKEEP ING 14, 526 0 0 0 0 3, 883, 753 10, 00 01000 DIETARY 305 0 0 0 0 1, 363, 102 11 11, 00 01100 CAFETERIA 5 0 0 0 0 0 2, 295, 214 11 11, 00 01100 CAFETERIA 5 0 0 0 0 0 2, 295, 214 11 13, 00 01300 NURSI INS ADMINISTRATI ON 0 0 0 0 0 0 4, 745, 166 17, 00 1700 SOCIAL SERVI CE 0 0 0 0 0 0 0 0 0		-			
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30. 00 03000 ADULTS & PEDIATRICS 1,160,430 90,384,493 103,526,014 0 48,210,595 33 35 00 03000 INTENSIVE CARE UNIT 619,067 23,672,902 23,672,902 0 10,141,213 31 35 00 02040 INTENSIVE NURSERY 80,044 14,864,635 14,864,635 0 3,443,584 35 41,00 04100 SUBPROVI DER - I RF 47,591 3,441,108 3,441,108 0 2,216,252 41 43,00 40,906,956 4,906,956		0	0	0	
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66. 00 06600 PHYSI CAL THERAPY 2, 626 11, 155, 366 11, 958, 997 0 3, 248, 762 66. 01 06601 PSYCHI ATRI C/PSYCHOLOGI CAL SERVI CES 0 0 0 0 0 666. 02 06602 0/P PHYSI CAL THERAPY 2, 616 0 6, 836, 654 0 2, 177, 730 667. 00 06700 0CCUPATI ONAL THERAPY 0 5, 174, 738 8, 547, 786 0 1, 820, 367 67.					
66. 01 06601 PSYCHI ATRI C/PSYCHOLOGI CAL SERVI CES 0 0 0 0 66 66. 02 06602 0/P PHYSI CAL THERAPY 2,616 0 6,836,654 0 2,177,730 66 67. 00 06700 0CCUPATI ONAL THERAPY 0 5,174,738 8,547,786 0 1,820,367 67 67 67 67 67 67 67					
67. 00 06700 OCCUPATI ONAL THERAPY 0 5, 174, 738 8, 547, 786 0 1, 820, 367 67	AL SERVICES 0 0 0 0 66.0	0	0	0	6. 01 06601 PSYCHI ATRI C/PSYCHOLOGI CAL SERVI CES
			0 E 174 730	2, 616	
68. 00 06800 SPEECH PATHOLOGY 0 1, 241, 398 3, 227, 110 0 834, 849 68				0	
69. 00 06900 ELECTROCARDI OLOGY 18, 391 11, 530, 985 31, 444, 614 0 5, 042, 269 69	18, 391 11, 530, 985 31, 444, 614 0 5, 042, 269 69. 0	31, 444, 614			9. 00 06900 ELECTROCARDI OLOGY
				l l	
76. 00 03020 RENAL ACUTE 48, 171 3, 283, 182 3, 783, 243 0 1, 743, 108 OUTPATIENT SERVICE COST CENTERS		3, 783, 243	3, 283, 182	48, 171	
		692, 316	1, 408	0	
			-	l l	
		132, 553, 656	29, 801, 000	347, 317	
SPECIAL PURPOSE COST CENTERS					
	1 through 117) 5, 117, 192 513, 171, 904 1, 351, 779, 671 -22, 431, 030 305, 625, 962 118. (1, 351, 779, 671	513, 171, 904	5, 117, 192	
NONREI MBURSABLE COST CENTERS	OP & CANTEEN 0 0 955 190.0	0	n	n	
		-	Ö	- 1	
		-		- 1	
		-			
1 of of of 020, 400 174	1 -1 -1 -1 -1 -1 -1 -1 -1 -1 -1 -1 -1 -1	3	<u> </u>	<u>. </u>	

Health Financial Systems	UNION HOSPITA	L, INC.		In Lie	u of Form CMS-2	2552-10
COST ALLOCATION - STATISTICAL BASIS		Provi der C			Worksheet B-1	
				From 01/01/2017		
				To 12/31/2017	Date/Time Pre	
					5/30/2018 2: 1	8 pm
Cost Contor Doscription	DUDCHASTAIC	ADMITTI NC	CACHLEDI NC /A	Poconciliatio	OTHED ADMIN	

				''	0 12/31/2017	5/30/2018 2: 1	
	Cost Center Description	PURCHASI NG	ADMI TTI NG	CASHI ERI NG/AC	Reconciliatio	OTHER ADMIN	
		RECEIVING AND	(I NPATI ENT	COUNTS	n	AND GENERAL	
		STORES	CHARGES)	RECEI VABLE		(ACCUM.	
		(REQUISITIO)		(GROSS		COST)	
		,		CHARGES)		ŕ	
		5. 03	5. 04	5. 05	5A. 06	5. 06	
194.04	07955 PHYSICIAN PRACTICES	19, 163	0	0	0	15, 921, 606	194.04
194. 06	07953 SYCAMORE SPORTS MED	0	0	0	0	90, 717	194. 06
194. 07	07956 PSYCHI ATRI C/PSYCHOLOGI CAL SERVI CES	150	0	0	0	622, 622	194. 07
200.00	Cross Foot Adjustments						200. 00
201.00	Negative Cost Centers						201. 00
202.00	Cost to be allocated (per Wkst. B,	1, 641, 061	2, 838, 637	6, 045, 019		22, 431, 030	202. 00
	Part I)						
203.00	Unit cost multiplier (Wkst. B, Part I)	0. 318819	0. 005532	0.004472		0.067393	203. 00
204.00	Cost to be allocated (per Wkst. B,	0	126, 928	0		416, 743	204. 00
	Part II)						
205.00	Unit cost multiplier (Wkst. B, Part	0. 000000	0. 000247	0.000000		0. 001252	205. 00
	11)						
206.00	NAHE adjustment amount to be allocated						206. 00
	(per Wkst. B-2)						
207.00	NAHE unit cost multiplier (Wkst. D,						207. 00
	Parts III and IV)						

COST	Cost Center Description		Provi der C		eriod: rom 01/01/2017 o 12/31/2017	Worksheet B-1 Date/Time Pre	
	Cost Center Description				12/01/201/		
		OPERATION OF	LAUNDRY &	HOUSEKEEPI NG	DI ETARY	5/30/2018 2: 1	8 pm
	oost conten bescription	PLANT	LI NEN SERVI CE	(NEW TOTAL	(DI ETARY	CAFETERI A (FTE)	
		(NEW TOTAL	(LINEN)	SQ FT)	(5121/11(1)	(112)	
		SQ FT)		,			
		7. 00	8. 00	9. 00	10.00	11. 00	
4 00	GENERAL SERVICE COST CENTERS	T					
1. 00 2. 00	00100 NEW CAP REL COSTS-BLDG & FLXT						1.00 2.00
4. 00	OO200 NEW CAP REL COSTS-MVBLE EQUIP OO400 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 ADMITTING						5. 04
5. 05	00580 CASHI ERI NG/ACCOUNTS RECEI VABLE						5. 05
5.06	00590 OTHER ADMIN AND GENERAL						5. 06
7.00	00700 OPERATION OF PLANT	604, 073	ł				7.00
8. 00 9. 00	00800 LAUNDRY & LI NEN SERVI CE 00900 HOUSEKEEPI NG	5, 988	1				8. 00 9. 00
10.00	01000 DI ETARY	5, 313 10, 976	l .	592, 772 10, 976	181, 166		10.00
11. 00	01100 CAFETERI A	7, 832			0	11, 355	ł
13. 00	01300 NURSI NG ADMI NI STRATI ON	2, 376	ł	2, 376	Ö	163	13.00
16.00	01600 MEDICAL RECORDS & LIBRARY	5, 283		5, 283	0	404	16.00
17.00	01700 SOCIAL SERVICE	0	0	0	0	0	17.00
21. 00	02100 I &R SERVICES-SALARY & FRINGES APPRVD	0	0	0	0	210	21.00
22. 00	02200 I &R SERVICES-OTHER PRGM COSTS APPRVD	0	0	0	0	44	22.00
23. 00	02300 PARAMED ED PRGM	0	0	0	0	20	23.00
23. 01 23. 02	O2341 OTHER MED ED O2301 PARAMED ED PRGM	720	l	720 0	0	54 20	23. 01 23. 02
23.02	INPATIENT ROUTINE SERVICE COST CENTERS	0		0	U	20	23.02
30.00	03000 ADULTS & PEDI ATRI CS	188, 046	412, 569	188, 046	138, 208	3, 685	30.00
31. 00	03100 I NTENSI VE CARE UNI T	22, 990	l .			723	
35.00	02040 I NTENSI VE NURSERY	2, 880	4, 926	2, 880	0	246	35.00
41.00	04100 SUBPROVI DER - I RF	14, 821	7, 011	14, 821	9, 610	181	41.00
43.00	04300 NURSERY	3, 927	0	3, 927	0	159	43.00
EO 00	ANCILLARY SERVICE COST CENTERS	40.725	72 500	40.725	٥	E24	 EO OO
50. 00 50. 01	05000 OPERATI NG ROOM 05001 CARDI AC SURGERY	40, 735 1, 800			0	534 80	50. 00 50. 01
50. 01	05002 WVSC	30, 028	l e		0	0	50.02
51.00	05100 RECOVERY ROOM	1, 432	l .		Ö	259	51.00
51.02	05101 0/P TREATMENT ROOM	21, 344	l .		12, 011	315	51.02
52.00	05200 DELIVERY ROOM & LABOR ROOM	20, 805	51, 146	20, 805	4	438	52.00
54.00	05400 RADI OLOGY-DI AGNOSTI C	32, 635	l .		0	593	54.00
55.00	O5500 RADI OLOGY-THERAPEUTI C	26, 393			0	60	55.00
56. 00 57. 00	05600 RADI OI SOTOPE 05700 CT SCAN	2, 914 2, 172	l .		0	51 144	56. 00 57. 00
58. 00	05800 MAGNETIC RESONANCE IMAGING (MRI)	2, 172			0	70	58.00
59. 00	05900 CARDI AC CATHETERI ZATI ON	16, 694	l .		837	109	59.00
60.00	06000 LABORATORY	0	1		0	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	2, 134	l	2, 134	0	387	65.00
66.00	06600 PHYSI CAL THERAPY	10, 150	8, 659		0	0	66.00
66. 01	06601 PSYCHI ATRI C/PSYCHOLOGI CAL SERVI CES	0	10,000	0	0	0	66. 01
66. 02 67. 00	O6602 O/P PHYSICAL THERAPY O6700 OCCUPATIONAL THERAPY	0 1, 658	18, 888 0	1, 658	0	0	66. 02 67. 00
68. 00	06800 SPEECH PATHOLOGY	3, 288		3, 288	0	0	68.00
69.00	06900 ELECTROCARDI OLOGY	1, 305	l		Ö	234	69.00
69. 01	06901 CARDI AC REHAB	7, 200			0	41	69. 01
70.00	07000 ELECTROENCEPHALOGRAPHY	1, 505	2, 023	1, 505	0	80	70.00
71. 00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	5, 712	93		0	0	71.00
72. 00	07200 I MPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	12, 842	l	12, 842	0	454	73.00
76. 00	03020 RENAL ACUTE OUTPATIENT SERVICE COST CENTERS	3, 525	4, 804	3, 525	0	0	76.00
90.00	09000 CLINIC	218	0	218	0	20	90.00
90. 05	09005 PATIENT NUTRITION	1, 930	l e	1, 930	Ö	48	90.05
90. 07	09007 WOUND CLINIC	3, 899			0	44	90.07
91.00	09100 EMERGENCY	24, 071	151, 917	24, 071	0	855	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)						92.00
440.00	SPECIAL PURPOSE COST CENTERS	T 550 404	4 4/0 050	F00 000	404 477	40.705	140.00
118.00	,	550, 134	1, 162, 059	538, 833	181, 166	10, 725	118.00
190 00	NONREIMBURSABLE COST CENTERS 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	O	0	190. 00
	07950 RURAL HEALTH	0	1		0		194.00
	07951 RENTAL PROPERTY	0	0	o	o		194. 01
	07954 FAMILY PRACTICE	37, 071	965		o		194. 02
	07952 WELLNESS	14, 002	1 0	14, 002	0		194. 03 194. 04
194. 03	07955 PHYSICIAN PRACTICES	0	l	0	O		

Health Financial Systems UNION HOSPITAL, INC. In Lieu of Form CMS-25							2552-10
COST ALLOCA	TION - STATISTICAL BASIS		Provi der C		Peri od:	Worksheet B-1	
					From 01/01/2017 To 12/31/2017		
	Cost Center Description	OPERATION OF		HOUSEKEEPI NG		CAFETERI A	
		PLANT	LINEN SERVICE	,	(DI ETARY)	(FTE)	
		(NEW TOTAL	(LINEN)	SQ FT)			
		SQ FT)					
		7. 00	8. 00	9. 00	10.00	11. 00	
194. 06 07953	SYCAMORE SPORTS MED	0	0		0	0	194. 06
194. 07 07956	PSYCHI ATRI C/PSYCHOLOGI CAL SERVI CES	2, 866	0	2, 86	6 0	49	194. 07
200.00	Cross Foot Adjustments						200.00
201. 00	Negative Cost Centers						201.00
202. 00	Cost to be allocated (per Wkst. B, Part I)	16, 944, 424	1, 842, 317	4, 418, 09	1 1, 854, 718	2, 727, 959	202.00
203. 00	Unit cost multiplier (Wkst. B, Part I)	28. 050292	1. 577328	7. 45327	2 10. 237672	240. 242977	203.00
204. 00	Cost to be allocated (per Wkst. B, Part II)	5, 707, 310	334, 988	260, 54	3 569, 789	224, 387	204. 00
205. 00	Unit cost multiplier (Wkst. B, Part	9. 448047	0. 286805	0. 43953	3. 145121	19. 761074	205. 00
206. 00	NAHE adjustment amount to be allocated (per Wkst. B-2)						206. 00
207. 00	NAHE unit cost multiplier (Wkst. D, Parts III and IV)						207. 00

Health Financial Systems
COST ALLOCATION - STATISTICAL BASIS Peri od: From 01/01/2017 To 12/31/2017 Date/Time Prepared: 5/30/2018 2:18 pm Provider CCN: 15-0023

					LATERIC 0	5/30/2018 2: 1	
					INTERNS &	RESI DENTS	
	Cost Center Description	NURSI NG	MEDI CAL	SOCI AL	SERVI CES-SALA	SERVI CES-OTHE	
		ADMI NI STRATI O	RECORDS &	SERVI CE	RY & FRINGES	R PRGM COSTS	
		N (TIME	LI BRARY (TOTAL	(# REFERRALS)	(INTERNS)	(INTERNS)	
		SPENT)	REVENUE)	KLI LKKALS)			
		13. 00	16. 00	17. 00	21. 00	22. 00	
1 00	GENERAL SERVICE COST CENTERS	ı					1 00
1. 00 2. 00	00100 NEW CAP REL COSTS-BLDG & FIXT 00200 NEW CAP REL COSTS-MVBLE EQUIP						1.00 2.00
4. 00	00400 EMPLOYEE BENEFITS DEPARTMENT						4.00
5. 01	00540 NONPATIENT TELEPHONES						5. 01
5. 02	00550 DATA PROCESSING						5. 02
5. 03 5. 04	00560 PURCHASING RECEIVING AND STORES 00570 ADMITTING						5. 03 5. 04
5. 05	00580 CASHI ERI NG/ACCOUNTS RECEI VABLE						5. 05
5.06	00590 OTHER ADMIN AND GENERAL						5.06
7. 00 8. 00	00700 OPERATION OF PLANT						7.00
9. 00	00800 LAUNDRY & LI NEN SERVI CE 00900 HOUSEKEEPI NG						8. 00 9. 00
10.00	01000 DI ETARY						10.00
11.00	01100 CAFETERI A						11.00
13. 00 16. 00	01300 NURSING ADMINISTRATION 01600 MEDICAL RECORDS & LIBRARY	8, 181	1, 356, 875, 160				13. 00 16. 00
17. 00	01700 SOCIAL SERVICE	0	1, 336, 673, 160	_			17.00
21. 00	02100 I &R SERVICES-SALARY & FRINGES APPRVD	0	Ö	Ö			21.00
22. 00	02200 I&R SERVICES-OTHER PRGM COSTS APPRVD	0	0	0		998	
23. 00 23. 01	02300 PARAMED ED PRGM	0	0	0			23. 00
	O2341 OTHER MED ED O2301 PARAMED ED PRGM	27	0	0			23. 01 23. 02
20.02	INPATIENT ROUTINE SERVICE COST CENTERS		<u> </u>				20.02
30.00	03000 ADULTS & PEDIATRICS	3, 466				365	
31.00	03100 NTENSIVE CARE UNIT	758		0		l .	31.00
35. 00 41. 00	02040 I NTENSI VE NURSERY 04100 SUBPROVI DER - I RF	258 220	14, 864, 635 3, 441, 108			9	35. 00 41. 00
43. 00	04300 NURSERY	159	4, 906, 956				43.00
	ANCILLARY SERVICE COST CENTERS						
50. 00 50. 01	05000 OPERATING ROOM 05001 CARDIAC SURGERY	541 49	177, 386, 588 8, 608, 252			i e	50. 00 50. 01
50. 01	05001 CARDI AC SURGERT	0	102, 624, 729			l e	50.01
51.00	05100 RECOVERY ROOM	225	8, 039, 090		_		51.00
51. 02	05101 O/P TREATMENT ROOM	366					51.02
52. 00 54. 00	05200 DELIVERY ROOM & LABOR ROOM 05400 RADIOLOGY-DIAGNOSTIC	430	22, 289, 184 53, 147, 284			l	1
55. 00	05500 RADI OLOGY-THERAPEUTI C	0	38, 937, 919		_	7	55.00
56.00	05600 RADI OI SOTOPE	0	8, 071, 387	0	0	0	56.00
57. 00	05700 CT SCAN	0	66, 810, 076		_	0	57.00
58. 00 59. 00	05800 MAGNETI C RESONANCE I MAGING (MRI) 05900 CARDI AC CATHETERI ZATI ON	0	15, 831, 773 106, 204, 714		_	l .	58. 00 59. 00
	06000 LABORATORY	0				1	60.00
	06200 WHOLE BLOOD & PACKED RED BLOOD CELLS	0	3, 148, 106	0		l	
65.00	06500 RESPI RATORY THERAPY	388			_	l	
66. 00 66. 01	06600 PHYSI CAL THERAPY 06601 PSYCHI ATRI C/PSYCHOLOGI CAL SERVI CES	0	11, 958, 994 0		-	1 0	66. 00 66. 01
66. 02	06602 0/P PHYSI CAL THERAPY	0	6, 836, 654		_	32	66.02
67. 00	06700 OCCUPATI ONAL THERAPY	0	8, 547, 786		0	l	67.00
68. 00	06800 SPEECH PATHOLOGY	0	3, 227, 110		_	1	68.00
69. 00 69. 01	06900 ELECTROCARDI OLOGY 06901 CARDI AC REHAB	0	31, 672, 590 1, 283, 545		-	1 0	69. 00 69. 01
70. 00	07000 ELECTROENCEPHALOGRAPHY	0	7, 829, 895		3	3	70.00
	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	802, 001	0	0	0	71.00
72.00	07200 I MPL. DEV. CHARGED TO PATIENTS	0	0	_	_	0	72.00
	07300 DRUGS CHARGED TO PATIENTS 03020 RENAL ACUTE	353	261, 571, 943 3, 783, 243			14 0	73. 00 76. 00
70.00	OUTPATIENT SERVICE COST CENTERS		0,700,210				70.00
	09000 CLI NI C	20	692, 316			l	1
90.05	09005 PATIENT NUTRITION	46	197, 862			2	90.05
90. 07 91. 00	09007 WOUND CLINIC 09100 EMERGENCY	52 823				17 105	1
92. 00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	323	102, 000, 000		103	103	92.00
	SPECIAL PURPOSE COST CENTERS						
118.00	. 9 /	8, 181	1, 356, 875, 160	0	888	888	118. 00
190 00	NONREIMBURSABLE COST CENTERS 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190. 00
194.00	07950 RURAL HEALTH	0				0	194. 00
194. 01	07951 RENTAL PROPERTY	0	o			0	194. 01

Health Financial Systems	UNION HOSPITAL, INC.	In Lieu of Form CMS-2552-10
COST ALLOCATION - STATISTICAL BASIS	Provi der CCN: 15-0023	Peri od:

				T	o 12/31/2017	Date/Time Pre 5/30/2018 2:1	
					INTERNS &	RESI DENTS	
	Cost Center Description	NURSI NG ADMI NI STRATI O N (TI ME	MEDI CAL RECORDS & LI BRARY (TOTAL	SOCI AL SERVI CE (# REFERRALS)	SERVI CES-SALA RY & FRI NGES (I NTERNS)	SERVI CES-OTHE R PRGM COSTS (INTERNS)	
		SPENT)	REVENUE)	1121 21110120)			
		13. 00	16. 00	17. 00	21.00	22. 00	
194. 02 07954	FAMILY PRACTICE	0	0	0	110	110	194. 02
194. 03 07952		0	0	0	0		194. 03
	PHYSICIAN PRACTICES	0	0	0	0		194. 04
	SYCAMORE SPORTS MED	0	0	0	0		194. 06
	PSYCHI ATRI C/PSYCHOLOGI CAL SERVI CES	0	0	0	0		194. 07
200. 00	Cross Foot Adjustments						200. 00
201. 00	Negative Cost Centers						201.00
202. 00	Cost to be allocated (per Wkst. B, Part I)	4, 580, 736	5, 349, 581	0	2, 095, 651	2, 832, 762	202. 00
203. 00	Unit cost multiplier (Wkst. B, Part I)	559. 923726	0. 003943	0. 000000	2, 099. 850701	2, 838. 438878	203. 00
204. 00	Cost to be allocated (per Wkst. B, Part II)	78, 502	182, 005	0	7, 745	5, 325	204. 00
205. 00	Unit cost multiplier (Wkst. B, Part	9. 595648	0. 000134	0. 000000	7. 760521	5. 335671	205. 00
206. 00	NAHE adjustment amount to be allocated (per Wkst. B-2)						206. 00
207. 00	NAHE unit cost multiplier (Wkst. D, Parts III and IV)						207. 00

Health Financial Systems
COST ALLOCATION - STATISTICAL BASIS UNION HOSPITAL, INC. In Lieu of Form CMS-2552-10

Peri od: Worksheet B-1 From 01/01/2017 To 12/31/2017 Date/Time Prepared: 5/30/2018 2:18 pm Provider CCN: 15-0023

				10	5/30/2018 2:	
	Cost Center Description	PARAMED ED	OTHER MED ED	PARAMED ED		
		PRGM	(ASSI GNED	PRGM		
		(PARAMED	TIME)	(PARAMED		
		RADI OLOGY) 23. 00	23. 01	RADI OLOGY) 23. 02		
(GENERAL SERVICE COST CENTERS	23.00	23.01	23.02		
	00100 NEW CAP REL COSTS-BLDG & FLXT					1.00
2.00	00200 NEW CAP REL COSTS-MVBLE EQUIP					2.00
4.00	DO400 EMPLOYEE BENEFITS DEPARTMENT					4.00
1	00540 NONPATI ENT TELEPHONES					5. 01
	DO550 DATA PROCESSING					5.02
	DO560 PURCHASING RECEIVING AND STORES					5.03
1	DO570 ADMITTING DO580 CASHIERING/ACCOUNTS RECEIVABLE					5. 04 5. 05
	00590 OTHER ADMIN AND GENERAL					5.06
	00700 OPERATION OF PLANT					7.00
8.00	DO800 LAUNDRY & LINEN SERVICE					8.00
9.00	00900 HOUSEKEEPI NG					9. 00
	D1000 DI ETARY					10.00
1	D1100 CAFETERI A					11.00
	D1300 NURSI NG ADMI NI STRATI ON					13.00
	D1600 MEDICAL RECORDS & LIBRARY D1700 SOCIAL SERVICE					16. 00 17. 00
1	D2100 &R SERVICES-SALARY & FRINGES APPRVD					21.00
1	D2200 I&R SERVICES-OTHER PRGM COSTS APPRVD					22.00
	D2300 PARAMED ED PRGM	100				23.00
23. 01	02341 OTHER MED ED		100			23. 01
_	D2301 PARAMED ED PRGM			100		23. 02
_	NPATIENT ROUTINE SERVICE COST CENTERS	_		_		
	03000 ADULTS & PEDIATRICS	0	0			30.00
	D3100 I NTENSI VE CARE UNI T D2040 I NTENSI VE NURSERY	0	0			31. 00 35. 00
	04100 SUBPROVI DER - I RF	0	0			41.00
	04300 NURSERY	0	0			43.00
_	ANCILLARY SERVICE COST CENTERS					10.00
50.00	05000 OPERATING ROOM	0	0	0		50.00
	D5001 CARDI AC SURGERY	0	0	0		50. 01
1	05002 WVSC	0	0	_		50. 02
	D5100 RECOVERY ROOM	0	0	_		51.00
	D5101 O/P TREATMENT ROOM	0	0	0		51.02
	D5200 DELIVERY ROOM & LABOR ROOM D5400 RADIOLOGY-DIAGNOSTIC	100	0	0 100		52. 00 54. 00
	D5500 RADI OLOGY-THERAPEUTI C	0	0	0		55.00
1	D5600 RADI OI SOTOPE	0	0	Ö		56.00
57.00	D5700 CT SCAN	0	0	0		57.00
	D5800 MAGNETIC RESONANCE IMAGING (MRI)	0	0	0		58.00
1	D5900 CARDI AC CATHETERI ZATI ON	0	0	0		59.00
	06000 LABORATORY	0	0	0		60.00
	D6200 WHOLE BLOOD & PACKED RED BLOOD CELLS D6500 RESPIRATORY THERAPY	0	0] 0] 0		62. 00 65. 00
	06600 PHYSI CAL THERAPY	0	0			66.00
	06601 PSYCHI ATRI C/PSYCHOLOGI CAL SERVI CES	0	0	Ö		66. 01
	06602 O/P PHYSICAL THERAPY	0	0	0		66. 02
67.00	06700 OCCUPATI ONAL THERAPY	0	0	0		67.00
	D6800 SPEECH PATHOLOGY	0	0	0		68. 00
	06900 ELECTROCARDI OLOGY	0	0	0		69.00
	06901 CARDI AC REHAB	0	0	0		69. 01
	D7000 ELECTROENCEPHALOGRAPHY D7100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0		70. 00 71. 00
	07200 IMPL. DEV. CHARGED TO PATIENTS	0	0	0		72.00
	07300 DRUGS CHARGED TO PATIENTS	0	100			73.00
	03020 RENAL ACUTE	0	0			76.00
C	OUTPATIENT SERVICE COST CENTERS					
	09000 CLI NI C	0	0			90.00
	09005 PATIENT NUTRITION	0	0	0		90.05
	09007 WOUND CLINIC	0	0	0		90.07
	D9100 EMERGENCY D9200 OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0		91. 00 92. 00
-	SPECIAL PURPOSE COST CENTERS					92.00
118. 00	SUBTOTALS (SUM OF LINES 1 through 117)	100	100	100		118.00
-	NONREI MBURSABLE COST CENTERS		100	130		1
	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0		190. 00
194.00	07950 RURAL HEALTH	0	0	0		194. 00
	07951 RENTAL PROPERTY	0	0	0		194. 01
10/ 02/0	D7954 FAMILY PRACTICE	0	0	0		194. 02 194. 03
				l 0		11111 A A
194. 03	07952 WELLNESS 07955 PHYSICIAN PRACTICES	0	0	0		194.03

Health Financial Systems

UNION HOSPITAL, INC.

In Lieu of Form CMS-2552-10

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 15-0023
Form 01/01/2017
To 12/31/2017
Prepared:

PARAMED ED PRCM (PARAMED ED PRCM (PARA						5/30/2018 2:18 pm
CPARAMED RADIOLOGY RADIOLOGY RADIOLOGY		Cost Center Description	PARAMED ED	OTHER MED ED	PARAMED ED	
RADI OLOGY RADI OLOGY 23.00 23.01 23.02			PRGM	(ASSI GNED	PRGM	
194.06 07953 SYCAMORE SPORTS MED 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0			(PARAMED	TIME)	(PARAMED	
194. 06 07953 SYCAMORE SPORTS MED 194. 06 194. 07 194. 08 194.			RADI OLOGY)		RADI OLOGY)	
194. 07 07956 PSYCHIATRIC/PSYCHOLOGICAL SERVICES 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0			23. 00	23. 01	23. 02	
200.00 201.00 Negative Cost Centers 202.00 Cost to be allocated (per Wkst. B, Part I) 203.00 Unit cost multiplier (Wkst. B, Part II) 205.00 Unit cost multiplier (Wkst. B, Part I) 206.00 NAHE adjustment amount to be allocated (per Wkst. B, P) 207.00 NAHE unit cost multiplier (Wkst. D, 0.000000 Cross Foot Adjustments 200.00 201.00 201.00 201.00 201.00 202.00 1, 968.100000 1, 968.100000 1, 968.100000 210.350000 7, 200000 7, 200000 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	194. 06 07953	SYCAMORE SPORTS MED	0	0	(194. 06
201.00 202.00 Cost to be allocated (per Wkst. B, Part I) 203.00 Unit cost multiplier (Wkst. B, Part I) 204.00 Cost to be allocated (per Wkst. B, Part I) 205.00 Unit cost multiplier (Wkst. B, Part I) 205.00 Unit cost multiplier (Wkst. B, Part I) 206.00 NAHE adjustment amount to be allocated (per Wkst. B, Part I) 207.00 NAHE unit cost multiplier (Wkst. D, O.000000	194. 07 07956	PSYCHI ATRI C/PSYCHOLOGI CAL SERVI CES	0	0	(194. 07
202.00	200. 00	Cross Foot Adjustments				200.00
Part I) Unit cost multiplier (Wkst. B, Part I) 203.00 Cost to be allocated (per Wkst. B, Part I) 205.00 Unit cost multiplier (Wkst. B, Part I) 206.00 NAHE adjustment amount to be allocated (per Wkst. B, Part I) 206.00 NAHE unit cost multiplier (Wkst. D, 0.000000 0.000000 0.000000 0.000000 0.000000	201. 00	Negative Cost Centers				201.00
203.00 Unit cost multiplier (Wkst. B, Part I) 1,968.100000 3,759.200000 1,968.100000 203.00 204.00 Cost to be allocated (per Wkst. B, Part II) 720 21,035 720 205.00 Unit cost multiplier (Wkst. B, Part II) 7.200000 210.350000 7.200000 11) NAHE adjustment amount to be allocated (per Wkst. B-2) 0 0 0 207.00 NAHE unit cost multiplier (Wkst. D, 0.000000 0.000000 0.000000 0.000000	202. 00	Cost to be allocated (per Wkst. B,	196, 810	375, 920	196, 810	202.00
204.00 Cost to be allocated (per Wkst. B, Part II) 205.00 Unit cost multiplier (Wkst. B, Part II) 206.00 NAHE adjustment amount to be allocated (per Wkst. B-2) NAHE unit cost multiplier (Wkst. D, O.000000 0.000000 0.000000 0.000000 0.000000 207.00 2		Part I)				
Part II) Unit cost multiplier (Wkst. B, Part 7.200000 210.350000 7.200000 205.00	203. 00	Unit cost multiplier (Wkst. B, Part I)	1, 968. 100000	3, 759. 200000	1, 968. 100000	203. 00
205.00 Unit cost multiplier (Wkst. B, Part II) 7.200000 210.350000 7.200000 206.00 NAHE adjustment amount to be allocated (per Wkst. B-2) 0 0 0 0 207.00 NAHE unit cost multiplier (Wkst. D, O.000000 0.000000 0.000000 0.000000	204.00	Cost to be allocated (per Wkst. B,	720	21, 035	720	204.00
206.00 NAHE adjustment amount to be allocated 0 0 0 0 206.00 (per Wkst. B-2) NAHE unit cost multiplier (Wkst. D, 0.000000 0.000000 0.000000 207.00		Part II)				
206.00 NAHE adjustment amount to be allocated (per Wkst. B-2) 0<	205. 00	Unit cost multiplier (Wkst. B, Part	7. 200000	210. 350000	7. 200000	205. 00
(per Wkst. B-2) 207.00 NAHE unit cost multiplier (Wkst. D, 0.000000 0.000000 0.000000 207.00		11)				
207.00 NÄHE unit cost multiplier (Wkst. D, 0.000000 0.000000 0.000000 207.00	206. 00	NAHE adjustment amount to be allocated	0	0	(206.00
		(per Wkst. B-2)				
Parts III and IV)	207. 00	NAHE unit cost multiplier (Wkst. D,	0. 000000	0. 000000	0. 000000	207. 00
		Parts III and IV)				

				o 12/31/2017	Date/Time Pre 5/30/2018 2:1	pared:
		Title	xVIII	Hospi tal	PPS	о рііі
		11110	AVIII	Costs	113	
Cost Center Description	Total Cost	Therapy Limit	Total Costs	RCE	Total Costs	
oost denter bescription	(from Wkst.	Adj.	10141 00313	Di sal I owance	10141 00313	
	B, Part I,					
	col . 26)					
	1. 00	2.00	3.00	4. 00	5. 00	
INPATIENT ROUTINE SERVICE COST CEN	TERS					
30. 00 03000 ADULTS & PEDIATRICS	63, 413, 267	'	63, 413, 267	0	63, 413, 267	30.00
31.00 03100 INTENSIVE CARE UNIT	12, 639, 435		12, 639, 435		12, 639, 435	
35. 00 02040 NTENSI VE NURSERY	4, 047, 848	1	4, 047, 848		4, 047, 848	
41. 00 04100 SUBPROVI DER - I RF	3, 181, 488	3	3, 181, 488	0	3, 181, 488	41.00
43. 00 04300 NURSERY	2, 127, 591		2, 127, 591	0	2, 127, 591	43.00
ANCILLARY SERVICE COST CENTERS		•				
50. 00 05000 OPERATING ROOM	19, 442, 185	5	19, 442, 185	37, 297	19, 479, 482	50.00
50. 01 05001 CARDI AC SURGERY	3, 800, 794		3, 800, 794	. 0	3, 800, 794	50. 01
50. 02 05002 WVSC	14, 336, 428	3	14, 336, 428	0	14, 336, 428	50. 02
51. 00 05100 RECOVERY ROOM	3, 326, 046		3, 326, 046	0	3, 326, 046	51.00
51. 02 05101 0/P TREATMENT ROOM	5, 365, 741	I .	5, 365, 741		5, 365, 741	51.02
52.00 05200 DELIVERY ROOM & LABOR ROOM	7, 520, 716		7, 520, 716		7, 520, 716	52.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	13, 188, 135		13, 188, 135			
55. 00 05500 RADI OLOGY-THERAPEUTI C	7, 783, 930		7, 783, 930	0	7, 783, 930	55.00
56. 00 05600 RADI OI SOTOPE	1, 950, 152		1, 950, 152	0	1, 950, 152	56.00
57. 00 05700 CT SCAN	3, 924, 226		3, 924, 226	0	3, 924, 226	57.00
58.00 05800 MAGNETIC RESONANCE IMAGING (M	IRI) 2, 736, 851		2, 736, 851	0	2, 736, 851	58.00
59. 00 05900 CARDI AC CATHETERI ZATI ON	19, 325, 921		19, 325, 921	0	19, 325, 921	59.00
60. 00 06000 LABORATORY	10, 977, 816		10, 977, 816	183, 070	11, 160, 886	60.00
62.00 06200 WHOLE BLOOD & PACKED RED BLOO	D CELLS 1, 376, 416		1, 376, 416	0	1, 376, 416	62.00
65. 00 06500 RESPIRATORY THERAPY	6, 156, 342	2 0	6, 156, 342	. 0	6, 156, 342	65.00
66. 00 06600 PHYSI CAL THERAPY	3, 888, 879	0	3, 888, 879	0	3, 888, 879	66.00
66. 01 06601 PSYCHI ATRI C/PSYCHOLOGI CAL SEF	VI CES C	0	0	0	0	66. 01
66. 02 06602 0/P PHYSI CAL THERAPY	2, 381, 244	0	2, 381, 244	0	2, 381, 244	66. 02
67. 00 06700 OCCUPATI ONAL THERAPY	2, 035, 616	0	2, 035, 616	0	2, 035, 616	67.00
68.00 06800 SPEECH PATHOLOGY	1, 020, 571	0	1, 020, 571	0	1, 020, 571	68.00
69. 00 06900 ELECTROCARDI OLOGY	5, 623, 886		5, 623, 886	558	5, 624, 444	69.00
69. 01 06901 CARDI AC REHAB	911, 372	2	911, 372	0	911, 372	69. 01
70. 00 07000 ELECTROENCEPHALOGRAPHY	1, 755, 000		1, 755, 000	0	1, 755, 000	70.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO F	ATI ENTS 1, 569, 842	2	1, 569, 842	0	1, 569, 842	71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENT	S 13, 594, 751		13, 594, 751	0	13, 594, 751	72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	56, 080, 890		56, 080, 890	0	56, 080, 890	73.00
76. 00 03020 RENAL ACUTE	2, 008, 225	5	2, 008, 225	0	2, 008, 225	76.00
OUTPATIENT SERVICE COST CENTERS						
90. 00 09000 CLI NI C	332, 384		332, 384	0	332, 384	90.00
90.05 09005 PATIENT NUTRITION	637, 605	5	637, 605	2, 818	640, 423	90. 05
90. 07 09007 WOUND CLINIC	1, 807, 090		1, 807, 090	0	1, 807, 090	90. 07
91. 00 09100 EMERGENCY	18, 950, 084		18, 950, 084	0	18, 950, 084	91.00
92.00 09200 OBSERVATION BEDS (NON-DISTING			10, 476, 948		10, 476, 948	
200.00 Subtotal (see instructions)	329, 695, 715	l control of the cont		·		
201.00 Less Observation Beds	10, 476, 948	l control of the cont	10, 476, 948		10, 476, 948	
202.00 Total (see instructions)	319, 218, 767	' 0	319, 218, 767	223, 743	319, 442, 510	202.00

| Peri od: | Worksheet C | From 01/01/2017 | Part I | Date/Time | Prepared: | Provider CCN: 15-0023

					0 12/31/2017	5/30/2018 2:1	
			Title	XVIII	Hospi tal	PPS	о ріп
			Charges				
	Cost Center Description	Inpatient	Outpati ent	Total (col. 6	Cost or Other	TEFRA	
				+ col. 7)	Ratio	I npati ent	
						Rati o	
		6. 00	7. 00	8. 00	9. 00	10.00	
	NPATIENT ROUTINE SERVICE COST CENTERS						
	D3000 ADULTS & PEDIATRICS	89, 814, 823		89, 814, 823			30.00
	03100 INTENSIVE CARE UNIT	23, 672, 902		23, 672, 902			31.00
	02040 INTENSIVE NURSERY	14, 864, 635		14, 864, 635	5		35.00
	04100 SUBPROVI DER - I RF	3, 441, 108		3, 441, 108			41.00
-	04300 NURSERY	4, 906, 956		4, 906, 956			43.00
	ANCILLARY SERVICE COST CENTERS						
	O5000 OPERATING ROOM	91, 587, 356	77, 546, 243			0. 000000	50.00
	05001 CARDI AC SURGERY	6, 615, 455	378, 792			0. 000000	50. 01
	05002 WVSC	0	100, 498, 844			0. 000000	50. 02
	05100 RECOVERY ROOM	2, 559, 572	5, 479, 518			0. 000000	51.00
	05101 0/P TREATMENT ROOM	358, 322	2, 436, 864			0. 000000	51. 02
	D5200 DELIVERY ROOM & LABOR ROOM	16, 894, 310	5, 394, 874			0. 000000	52.00
	D5400 RADI OLOGY-DI AGNOSTI C	11, 747, 204	40, 882, 726			0. 000000	54.00
	05500 RADI OLOGY-THERAPEUTI C	2, 105, 483	36, 781, 123			0. 000000	55.00
	D5600 RADI OI SOTOPE	861, 175	7, 210, 212			0. 000000	56.00
	05700 CT SCAN	18, 431, 055	48, 379, 021			0. 000000	57.00
	05800 MAGNETIC RESONANCE IMAGING (MRI)	3, 135, 891	12, 695, 882			0. 000000	58.00
	05900 CARDI AC CATHETERI ZATI ON	30, 154, 036	71, 448, 761			0. 000000	59.00
	06000 LABORATORY	46, 175, 249	50, 258, 640			0. 000000	60.00
	06200 WHOLE BLOOD & PACKED RED BLOOD CELLS	2, 437, 041	711, 065			0. 000000	62.00
	06500 RESPI RATORY THERAPY	16, 442, 324	1, 952, 332			0. 000000	65.00
	06600 PHYSI CAL THERAPY	11, 155, 366	803, 631			0. 000000	66.00
	06601 PSYCHI ATRI C/PSYCHOLOGI CAL SERVI CES	0	0	`	0.00000	0. 000000	66. 01
	06602 0/P PHYSI CAL THERAPY	0	6, 836, 654			0. 000000	66. 02
	06700 OCCUPATI ONAL THERAPY	5, 174, 738	3, 373, 048			0.000000	67.00
	06800 SPEECH PATHOLOGY	1, 241, 398	1, 985, 712			0.000000	68.00
	06900 ELECTROCARDI OLOGY	11, 530, 985	19, 913, 629			0.000000	69. 00 69. 01
	06901 CARDI AC REHAB 07000 ELECTROENCEPHALOGRAPHY	92, 441	1, 191, 104 1, 321, 835			0. 000000 0. 000000	70.00
	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	3, 370, 500 738, 545				0.000000	70.00
	07200 IMPL. DEV. CHARGED TO PATIENTS	7, 971, 187	63, 456 7, 462, 320			0.000000	71.00
	07300 DRUGS CHARGED TO PATTENTS	52, 016, 527	209, 555, 416			0.000000	72.00
	03020 RENAL ACUTE	3, 283, 182	500, 061			0.000000	76. 00
	DUTPATIENT SERVICE COST CENTERS	3, 203, 102	300, 001	3, 703, 243	0. 550621	0.000000	76.00
	09000 CLINIC	1, 408	690, 908	692, 316	0. 480104	0. 000000	90. 00
	09005 PATIENT NUTRITION	1, 400	197, 862			0. 000000	90.05
	09007 WOUND CLINIC	20, 000	6, 763, 717			0.000000	90.03
	D9100 EMERGENCY	29, 801, 060	102, 751, 996			0.000000	
	09200 OBSERVATION BEDS (NON-DISTINCT PART)	569, 670	13, 141, 521			0.000000	
200.00	Subtotal (see instructions)	513, 171, 904		1, 351, 779, 671		0.000000	200.00
200.00	Less Observation Beds	313, 171, 704	030,007,707	1, 331, 777, 071			200.00
202.00	Total (see instructions)	513, 171, 904	838 607 767	1, 351, 779, 671			201.00
202.00	Total (300 Histi dottons)	313, 171, 704	550, 501, 101	1 1, 331, 777, 071	1	l	202.00

Health Financial Systems	UNION HOSPITAL, INC.	In Lieu of Form CMS-2552-10
COMPUTATION OF RATIO OF COSTS TO CHARGES	Provi der CCN: 15-0023	Peri od: Worksheet C From 01/01/2017 Part I To 12/31/2017 Date/Time Prepared:

			10 12/31/2017	5/30/2018 2:18 pm
		Title XVIII	Hospi tal	PPS
Cost Center Description	PPS Inpatient			
· ·	Ratio			
	11. 00			
INPATIENT ROUTINE SERVICE COST CENTERS				
30. 00 03000 ADULTS & PEDIATRICS				30.00
31.00 03100 INTENSIVE CARE UNIT				31.00
35. 00 02040 I NTENSI VE NURSERY				35.00
41. 00 04100 SUBPROVI DER - I RF				41.00
43. 00 04300 NURSERY				43.00
ANCILLARY SERVICE COST CENTERS				
50. 00 05000 OPERATING ROOM	0. 115172			50.00
50. 01 05001 CARDI AC SURGERY	0. 543417			50.01
50. 02 05002 WVSC	0. 142653			50.02
51. 00 05100 RECOVERY ROOM	0. 413734			51.00
51. 02 05101 0/P TREATMENT ROOM	1. 919636			51. 02
52.00 05200 DELIVERY ROOM & LABOR ROOM	0. 337415			52.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	0. 250582			54.00
55. 00 05500 RADI OLOGY-THERAPEUTI C	0. 200170			55.00
56. 00 05600 RADI 0I SOTOPE	0. 241613			56.00
57. 00 05700 CT SCAN	0. 058737			57.00
58.00 05800 MAGNETIC RESONANCE IMAGING (MRI)	0. 172871			58.00
59. 00 05900 CARDI AC CATHETERI ZATI ON	0. 190211			59.00
60. 00 06000 LABORATORY	0. 115736			60.00
62.00 06200 WHOLE BLOOD & PACKED RED BLOOD CELL				62.00
65. 00 06500 RESPIRATORY THERAPY	0. 334681			65. 00
66. 00 06600 PHYSI CAL THERAPY	0. 325184			66.00
66. 01 06601 PSYCHI ATRI C/PSYCHOLOGI CAL SERVI CES	0. 000000			66. 01
66. 02 06602 0/P PHYSI CAL THERAPY	0. 348305			66. 02
67. 00 06700 OCCUPATI ONAL THERAPY	0. 238145			67.00
68.00 06800 SPEECH PATHOLOGY	0. 316249			68. 00
69. 00 06900 ELECTROCARDI OLOGY	0. 178868			69.00
69. 01 06901 CARDI AC REHAB	0. 710043			69. 01
70. 00 07000 ELECTROENCEPHALOGRAPHY	0. 374014			70.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	S 1. 957407			71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0. 880859			72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	0. 214399			73.00
76. 00 03020 RENAL ACUTE	0. 530821			76.00
OUTPATIENT SERVICE COST CENTERS				
90. 00 09000 CLI NI C	0. 480104			90.00
90.05 09005 PATIENT NUTRITION	3. 236715			90.05
90. 07 09007 WOUND CLINIC	0. 266386			90. 07
91. 00 09100 EMERGENCY	0. 142962			91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART	0. 764117			92.00
200.00 Subtotal (see instructions)				200.00
201.00 Less Observation Beds				201. 00
202.00 Total (see instructions)				202. 00
				•

Date/Time Prepared: 12/31/2017 5/30/2018 2:18 pm Title XIX Hospi tal Cost Costs Cost Center Description Total Cost Therapy Limit Total Costs RCF 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 & PEDIATRICS 63, 413, 267 63, 413, 267 0 63, 413, 267 30.00 03100 INTENSIVE CARE UNIT 12, 639, 435 0 31.00 12, 639, 435 12, 639, 435 31.00 35.00 02040 INTENSIVE NURSERY 4, 047, 848 4, 047, 848 0 4, 047, 848 35.00 04100 SUBPROVI DER - I RF 3, 181, 488 3, 181, 488 41.00 3, 181, 488 0 41 00 43.00 04300 NURSERY 2, 127, 591 2, 127, 591 2, 127, 591 43.00 ANCILLARY SERVICE COST CENTERS 19, 442, 185 19, 479, 482 50.00 05000 OPERATING ROOM 19, 442, 185 37, 297 50.00 05001 CARDI AC SURGERY 50.01 3, 800, 794 3, 800, 794 3, 800, 794 50 01 50.02 05002 WVSC 14, 336, 428 14, 336, 428 0 14, 336, 428 50.02 51.00 05100 RECOVERY ROOM 3, 326, 046 3, 326, 046 0 3, 326, 046 51.00 05101 0/P TREATMENT ROOM 5, 365, 741 0 51.02 5, 365, 741 5, 365, 741 51.02 05200 DELIVERY ROOM & LABOR ROOM 52.00 7, 520, 716 7, 520, 716 0 7, 520, 716 52.00 54.00 05400 RADI OLOGY-DI AGNOSTI C 13, 188, 135 13, 188, 135 13, 188, 135 54.00 0 55.00 05500 RADI OLOGY-THERAPEUTI C 7, 783, 930 7, 783, 930 7, 783, 930 55.00 0 1, 950, 152 05600 RADI OI SOTOPE 1, 950, 152 1, 950, 152 56,00 56,00 57.00 05700 CT SCAN 3, 924, 226 3, 924, 226 3, 924, 226 57.00 05800 MAGNETIC RESONANCE IMAGING (MRI) 2, 736, 851 2, 736, 851 0 2, 736, 851 58.00 58.00 05900 CARDI AC CATHETERI ZATI ON 19, 325, 921 19, 325, 921 0 19, 325, 921 59.00 59.00 10, 977, 816 10, 977, 816 60.00 06000 LABORATORY 183, 070 11, 160, 886 60.00 62.00 06200 WHOLE BLOOD & PACKED RED BLOOD CELLS 1, 376, 416 1, 376, 416 0 1, 376, 416 62.00 06500 RESPIRATORY THERAPY 65.00 6, 156, 342 6, 156, 342 0 6, 156, 342 65.00 3, 888, 879 66 00 06600 PHYSI CAL THERAPY 0 3, 888, 879 0 3, 888, 879 66 00 06601 PSYCHI ATRI C/PSYCHOLOGI CAL SERVI CES 0 66.01 0 0 0 66.01 06602 0/P PHYSICAL THERAPY 2, 381, 244 2, 381, 244 0 2, 381, 244 66.02 66.02 67.00 06700 OCCUPATIONAL THERAPY 2, 035, 616 0 2, 035, 616 ol 2, 035, 616 67.00 06800 SPEECH PATHOLOGY 0 68.00 1,020,571 1, 020, 571 1, 020, 571 68.00 69.00 06900 ELECTROCARDI OLOGY 5, 623, 886 5, 623, 886 558 5, 624, 444 69.00 06901 CARDI AC REHAB 911, 372 69.01 911, 372 911, 372 0 69.01 70 00 07000 ELECTROENCEPHALOGRAPHY 1, 755, 000 1 755 000 0 1, 755, 000 70 00 |07100|MEDICAL SUPPLIES CHARGED TO PATIENTS 0 71.00 1, 569, 842 1, 569, 842 1, 569, 842 71.00 07200 IMPL. DEV. CHARGED TO PATIENTS 13, 594, 751 13, 594, 751 0 13, 594, 751 72.00 72.00 73.00 07300 DRUGS CHARGED TO PATIENTS ol 56, 080, 890 56, 080, 890 56, 080, 890 73.00 03020 RENAL ACUTE 2,008,225 2,008,225 0 2, 008, 225 76.00 76.00 OUTPATIENT SERVICE COST CENTERS 332, 384 90.00 332, 384 09000 CLI NI C 332, 384 90.00 90.05 09005 PATIENT NUTRITION 637, 605 637, 605 2, 818 640, 423 90.05 1, 807, 090

18, 950, 084

10, 476, 948

10, 476, 948

319, 218, 767

329, 695, 715

1, 807, 090

18, 950, 084

10, 476, 948

329, 919, 458 200. 00

10, 476, 948 201. 00

319, 442, 510 202. 00

90 07

91.00

92.00

0

0

223, 743

223, 743

1,807,090

18, 950, 084

10, 476, 948

10, 476, 948

329, 695, 715

319, 218, 767

0

09007 WOUND CLINIC

09200 OBSERVATION BEDS (NON-DISTINCT PART)

Subtotal (see instructions)

Less Observation Beds

Total (see instructions)

09100 EMERGENCY

90 07

91.00

92.00

200.00

201.00

202.00

| Peri od: | Worksheet C | From 01/01/2017 | Part I | To 12/31/2017 | Date/Time Prepared:

					10 12/31/2017	5/30/2018 2:1	
			Ti tl	e XIX	Hospi tal	Cost	
			Charges				
	Cost Center Description	Inpatient	Outpati ent	Total (col. 6	Cost or Other	TEFRA	
				+ col. 7)	Rati o	I npati ent	
				,		Ratio	
		6. 00	7. 00	8. 00	9. 00	10.00	
	INPATIENT ROUTINE SERVICE COST CENTERS				'		
30.00	03000 ADULTS & PEDIATRICS	89, 814, 823		89, 814, 82	3		30.00
31.00	03100 INTENSIVE CARE UNIT	23, 672, 902		23, 672, 90	2		31.00
35.00	02040 I NTENSI VE NURSERY	14, 864, 635		14, 864, 63	5		35.00
41.00	04100 SUBPROVI DER - I RF	3, 441, 108		3, 441, 108	3		41.00
43.00	04300 NURSERY	4, 906, 956		4, 906, 95	5		43.00
	ANCILLARY SERVICE COST CENTERS						
50.00	05000 OPERATING ROOM	91, 587, 356	77, 546, 243	169, 133, 59	0. 114952	0.000000	50.00
50.01	05001 CARDI AC SURGERY	6, 615, 455	378, 792		0. 543417	0.000000	50. 01
50.02	05002 WVSC	0	100, 498, 844	100, 498, 84	0. 142653	0.000000	50. 02
51.00	05100 RECOVERY ROOM	2, 559, 572	5, 479, 518	8, 039, 090	0. 413734	0.000000	51.00
51.02	05101 O/P TREATMENT ROOM	358, 322	2, 436, 864	2, 795, 186	1. 919636	0.000000	51.02
52.00	05200 DELIVERY ROOM & LABOR ROOM	16, 894, 310	5, 394, 874	22, 289, 18	0. 337415	0.000000	52.00
54.00	05400 RADI OLOGY-DI AGNOSTI C	11, 747, 204	40, 882, 726	52, 629, 930	0. 250582	0.000000	54.00
55.00	05500 RADI OLOGY-THERAPEUTI C	2, 105, 483	36, 781, 123	38, 886, 60	0. 200170	0.000000	55.00
56.00	05600 RADI OI SOTOPE	861, 175	7, 210, 212	8, 071, 38 ⁻	0. 241613	0.000000	56.00
57.00	05700 CT SCAN	18, 431, 055	48, 379, 021	66, 810, 07	0. 058737	0.000000	57.00
58.00	05800 MAGNETIC RESONANCE IMAGING (MRI)	3, 135, 891	12, 695, 882	15, 831, 77	0. 172871	0.000000	58. 00
59.00	05900 CARDI AC CATHETERI ZATI ON	30, 154, 036	71, 448, 761	101, 602, 79	0. 190211	0.000000	59.00
60.00	06000 LABORATORY	46, 175, 249	50, 258, 640	96, 433, 889	0. 113838	0.000000	60.00
62.00	06200 WHOLE BLOOD & PACKED RED BLOOD CELLS	2, 437, 041	711, 065	3, 148, 10	0. 437220	0.000000	62.00
65.00	06500 RESPIRATORY THERAPY	16, 442, 324	1, 952, 332	18, 394, 656	0. 334681	0.000000	65.00
66.00	06600 PHYSI CAL THERAPY	11, 155, 366	803, 631	11, 958, 99 ⁻	0. 325184	0.000000	66.00
66. 01	06601 PSYCHI ATRI C/PSYCHOLOGI CAL SERVI CES	0	0		0. 000000	0.000000	66. 01
66.02	06602 0/P PHYSI CAL THERAPY	0	6, 836, 654	6, 836, 65	0. 348305	0.000000	66. 02
67.00	06700 OCCUPATI ONAL THERAPY	5, 174, 738	3, 373, 048	8, 547, 78	0. 238145	0.000000	67.00
68.00	06800 SPEECH PATHOLOGY	1, 241, 398	1, 985, 712	3, 227, 110	0. 316249	0.000000	68.00
69.00	06900 ELECTROCARDI OLOGY	11, 530, 985	19, 913, 629	31, 444, 61	0. 178851	0.000000	69.00
69. 01	06901 CARDI AC REHAB	92, 441	1, 191, 104	1, 283, 54	0. 710043	0.000000	69. 01
70.00	07000 ELECTROENCEPHALOGRAPHY	3, 370, 500	1, 321, 835	4, 692, 33!	0. 374014	0.000000	70.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	738, 545	63, 456	802, 00°	1 1. 957407	0.000000	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	7, 971, 187	7, 462, 320	15, 433, 50°	0. 880859	0.000000	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	52, 016, 527	209, 555, 416	261, 571, 94	0. 214399	0.000000	73.00
76.00	03020 RENAL ACUTE	3, 283, 182	500, 061	3, 783, 24	0. 530821	0.000000	76.00
	OUTPATIENT SERVICE COST CENTERS	·					
90.00	09000 CLI NI C	1, 408	690, 908	692, 310	0. 480104	0.000000	90.00
90.05	09005 PATIENT NUTRITION	0	197, 862	197, 86	3. 222473	0. 000000	90. 05
90.07	09007 WOUND CLINIC	20, 000	6, 763, 717	6, 783, 71 ⁻	0. 266386	0.000000	90. 07
91.00	09100 EMERGENCY	29, 801, 060	102, 751, 996	132, 553, 056	0. 142962	0.000000	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	569, 670	13, 141, 521	13, 711, 19 ⁻	0. 764117	0.000000	92.00
200.00	Subtotal (see instructions)	513, 171, 904	838, 607, 767	1, 351, 779, 67	1		200.00
201.00	Less Observation Beds						201.00
202.00	Total (see instructions)	513, 171, 904	838, 607, 767	1, 351, 779, 67 ⁻	1		202. 00

Health Financial Systems	UNION HOSPITAL, INC.	In Lieu of Form CMS-2552-10
COMPUTATION OF RATIO OF COSTS TO CHARGES	Provi der CCN: 15-0023	Period: Worksheet C From 01/01/2017 Part I To 12/31/2017 Date/Time Prepared:

				To 12/31/2017	Date/Time Prepa 5/30/2018 2:18	ıred: pm
			Title XIX	Hospi tal	Cost	
	Cost Center Description	PPS Inpatient				
		Ratio				
	LABORT FAIT POLITICAL OFFICE OF AGOT OFFITTED	11. 00				
00 00	INPATIENT ROUTINE SERVICE COST CENTERS					00.0
30.00	03000 ADULTS & PEDIATRICS					30.00
31.00	03100 I NTENSI VE CARE UNI T					31.00
35.00	02040 I NTENSI VE NURSERY					35.0
41.00	04100 SUBPROVI DER - I RF				1	41.0
43. 00	04300 NURSERY					43. 0
-0.00	ANCILLARY SERVICE COST CENTERS	0.000000				
50.00	05000 OPERATING ROOM	0.000000			1	50.0
50. 01	05001 CARDI AC SURGERY	0.000000			1	50.0
50. 02	05002 WVSC	0.000000			1	50. 0
51.00	05100 RECOVERY ROOM	0.000000			1	51.0
51. 02	05101 0/P TREATMENT ROOM	0.000000				51.0
52.00	05200 DELIVERY ROOM & LABOR ROOM	0. 000000			•	52.0
54.00	05400 RADI OLOGY-DI AGNOSTI C	0.000000			l l	54.0
55.00	05500 RADI OLOGY-THERAPEUTI C	0. 000000				55.0
56. 00	05600 RADI OI SOTOPE	0. 000000				56. C
57. 00	05700 CT SCAN	0. 000000				57. C
58. 00	05800 MAGNETIC RESONANCE IMAGING (MRI)	0. 000000				58. C
59.00	05900 CARDI AC CATHETERI ZATI ON	0. 000000				59. C
60.00	06000 LABORATORY	0. 000000				60.0
62.00	06200 WHOLE BLOOD & PACKED RED BLOOD CELLS	0. 000000				62.0
65.00	06500 RESPI RATORY THERAPY	0.000000				65.0
66.00	06600 PHYSI CAL THERAPY	0.000000			l l	66.0
66. 01	06601 PSYCHI ATRI C/PSYCHOLOGI CAL SERVI CES	0. 000000				66. C
66. 02	06602 0/P PHYSI CAL THERAPY	0.000000				66. C
67.00	06700 OCCUPATI ONAL THERAPY	0.000000			•	67. C
68.00	06800 SPEECH PATHOLOGY	0.000000			•	68. C
59.00	06900 ELECTROCARDI OLOGY	0.000000				69.0
59. 01	06901 CARDI AC REHAB	0.000000				69. C
70.00	07000 ELECTROENCEPHALOGRAPHY	0.000000			•	70. C
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0.000000			•	71. C
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0.000000				72. C
73.00	07300 DRUGS CHARGED TO PATIENTS	0.000000				73. C
76. 00		0. 000000				76. 0
00 00	OUTPATIENT SERVICE COST CENTERS	0.000000				00 0
90. 00 90. 05	09000 CLINIC	0. 000000				90. 0
90.05	09005 PATIENT NUTRITION	0. 000000				90. 0
	09007 WOUND CLINIC	0. 000000			1	90. 0
91.00	· ·	0. 000000			•	91. 0
92.00	· · · · · · · · · · · · · · · · · · ·	0. 000000			•	92.0
200.00						00.0
201.00	1				l l	01.0
202.00	Total (see instructions)				120	02. 0

Health Financial Systems	UNI ON HOSPI	TAL, INC.		In Lie	u of Form CMS-:	2552-10
APPORTIONMENT OF INPATIENT ROUTINE SERVICE CAP	ITAL COSTS	Provi der Co		Period: From 01/01/2017 To 12/31/2017	Worksheet D Part I Date/Time Pre 5/30/2018 2:1	epared: 8 pm
		Title	XVIII	Hospi tal	PPS	
Cost Center Description	Capital Related Cost (from Wkst.	Swing Bed Adjustment	Reduced Capital Related Cost	Total Patient Days	Per Diem (col. 3 / col. 4)	
	B, Part II,		(col . 1 -			
	col . 26) 1.00	2. 00	col . 2) 3.00	4. 00	5. 00	
INPATIENT ROUTINE SERVICE COST CENTERS	1.00	2.00	3.00	4.00	5.00	
30. 00 ADULTS & PEDIATRICS	6, 670, 729	0	6, 670, 729	9 58, 747	113. 55	30.00
31. 00 INTENSIVE CARE UNIT	1, 363, 297		1, 363, 29			
35. 00 INTENSIVE NURSERY	218, 002		218, 00			
41. 00 SUBPROVIDER - IRF	474, 287	0	474, 28			
43. 00 NURSERY	119, 611	· ·	119, 61		34. 20	
200.00 Total (lines 30 through 199)	8, 845, 926		8, 845, 92			200.00
Cost Center Description	I npati ent	I npati ent				
	Program days	Program Capital Cost (col. 5 x				
		col. 6)				
	6. 00	7. 00				
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00 ADULTS & PEDIATRICS 31.00 INTENSIVE CARE UNIT 35.00 INTENSIVE NURSERY	24, 848 4, 297 0	2, 821, 490 800, 273 0				30. 00 31. 00 35. 00
41.00 SUBPROVIDER - IRF 43.00 NURSERY 200.00 Total (lines 30 through 199)	2, 194 0 31, 339	0				41. 00 43. 00 200. 00

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITA	AL COSTS	Provi der C		Period: From 01/01/2017 To 12/31/2017	Date/Time Pre 5/30/2018 2:1	
			XVIII	Hospi tal	PPS	
Cost Center Description	Capi tal	Total Charges			Capital Costs	
	Related Cost	(from Wkst.	to Charges	Program	(column 3 x	
	(from Wkst.	C, Part I,	(col. 1 ÷	Charges	column 4)	
	B, Part II,	col. 8)	col . 2)			
	col. 26)					
	1. 00	2. 00	3. 00	4. 00	5. 00	
ANCILLARY SERVICE COST CENTERS						
50. 00 05000 OPERATI NG ROOM	3, 510, 713					
50. 01 05001 CARDI AC SURGERY	211, 882					
50. 02 05002 WVSC	1, 686, 960					50.02
51. 00 05100 RECOVERY ROOM	92, 702					51.00
51.02 05101 0/P TREATMENT ROOM	769, 257					51.02
52.00 05200 DELIVERY ROOM & LABOR ROOM	870, 597			·		
54. 00 05400 RADI OLOGY-DI AGNOSTI C	2, 379, 634					
55. 00 05500 RADI OLOGY-THERAPEUTI C	1, 956, 442					
56. 00 05600 RADI OI SOTOPE	305, 080			·		
57.00 05700 CT SCAN	401, 849					
58.00 05800 MAGNETIC RESONANCE IMAGING (MRI)	802, 203					58. 00
59. 00 05900 CARDI AC CATHETERI ZATI ON	790, 215					
60. 00 06000 LABORATORY	40, 913					
62.00 06200 WHOLE BLOOD & PACKED RED BLOOD CELLS	2, 624	3, 148, 106	0. 00083	1, 353, 365	1, 129	62.00
65. 00 06500 RESPIRATORY THERAPY	405, 316	18, 394, 656	0. 02203	8, 468, 998	186, 606	65.00
66. 00 06600 PHYSI CAL THERAPY	593, 676	11, 958, 997	0. 04964	13 3, 258, 255	161, 750	66.00
66. 01 06601 PSYCHI ATRI C/PSYCHOLOGI CAL SERVI CES	0	0	0. 00000	00	0	66. 01
66. 02 06602 0/P PHYSI CAL THERAPY	64, 876	6, 836, 654	0. 00948	39 0	0	66. 02
67. 00 06700 OCCUPATI ONAL THERAPY	53, 058	8, 547, 786	0. 00620	1, 947, 792	12, 090	67.00
68.00 06800 SPEECH PATHOLOGY	448, 992	3, 227, 110	0. 13913	457, 228	63, 615	68. 00
69. 00 06900 ELECTROCARDI OLOGY	374, 589	31, 444, 614	0. 01191	6, 938, 460	82, 658	69. 00
69. 01 06901 CARDI AC REHAB	324, 034	1, 283, 545	0. 25245	52 47, 346	11, 953	69. 01
70. 00 07000 ELECTROENCEPHALOGRAPHY	123, 851	4, 692, 335	0. 02639	890, 184	23, 496	70.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	439, 099	802, 001	0. 54750	346, 682	189, 810	71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	17, 915	15, 433, 507	0. 00116	3, 643, 593	4, 230	72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	586, 612	261, 571, 943	0. 00224	13 27, 298, 373	61, 230	73.00
76. 00 03020 RENAL ACUTE	898, 350	3, 783, 243	0. 23745	2, 270, 175	539, 064	76. 00
OUTPATIENT SERVICE COST CENTERS						1
90. 00 09000 CLI NI C	6, 895	692, 316	0.00995	59 0	0	90.00
90. 05 09005 PATI ENT NUTRI TI ON	55, 729	197, 862	0. 28165	56 0	0	90.05
90. 07 09007 WOUND CLINIC	127, 868				309	90. 07
91. 00 09100 EMERGENCY	983, 898			13, 467, 280	99, 968	91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	1, 102, 123	1				92.00
200.00 Total (lines 50 through 199)	20, 427, 952	1, 215, 079, 247		185, 953, 113	3, 302, 049	200. 00

Health Financial Systems	UNI ON HOSPI	TAL, INC.		In Lie	u of Form CMS-:	2552-10
APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER F		TS Provider C		Period: From 01/01/2017 To 12/31/2017	Worksheet D Part III Date/Time Pre 5/30/2018 2:1	pared:
	_	Title	XVIII	Hospi tal	PPS	
Cost Center Description	Nursi ng School Post-Stepdown Adj ustments	Nursi ng School	Post-Stepdown Adjustments		All Other Medical Education Cost	
	1A	1. 00	2A	2. 00	3. 00	
INPATIENT ROUTINE SERVICE COST CENTERS						
30. 00	0 0 0 0	000000000000000000000000000000000000000		0 0 0 0 0 0 0 0 0 0	0 0 0 0	31.00 35.00 41.00
200.00 Total (lines 30 through 199)		0		0 0		200.00
Cost Center Description	Swing-Bed Adjustment Amount (see instructions)	Total Costs (sum of cols. 1 through 3, minus col. 4)	Total Patien Days	0	Inpatient Program Days	200.00
	4. 00	5. 00	6.00	7. 00	8. 00	
INPATIENT ROUTINE SERVICE COST CENTERS						
30. 00	0	0 0 0 0 0	7, 32 3, 44 3, 43 3, 49	0 0.00 1 0.00 2 0.00 7 0.00	0 2, 194 0	31.00 35.00 41.00
Cost Center Description	Inpatient Program Pass-Through Cost (col. 7 x col. 8) 9.00		70, 43	,	31, 337	200.00
INPATIENT ROUTINE SERVICE COST CENTERS 30.00 03000 ADULTS & PEDIATRICS 31.00 03100 INTENSIVE CARE UNIT 35.00 02040 INTENSIVE NURSERY 41.00 04100 SUBPROVIDER - IRF 43.00 04300 NURSERY 200.00 Total (lines 30 through 199)	0 0 0 0 0 0 0 0					30. 00 31. 00 35. 00 41. 00 43. 00 200. 00

Health Financial Systems	UNION HOSPITAL, INC.	In Lieu of Form CMS-2552-10
APPORTIONMENT OF INPATIENT/OUTPATIENT	ANCILLARY SERVICE OTHER PASS Provider CCN: 15-0	O23 Period: Worksheet D

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 15-0023 | Period: From 01/01/2017 | Part IV Date/Time Prepared: 5/30/2018 2: 18 pm

					10 12/31/201/	5/30/2018 2: 1	
			Title	XVIII	Hospi tal	PPS	
	Cost Center Description	Non Physician	Nursi ng	Nursi ng	Allied Health	Allied Health	
	·	Anestheti st	School	School	Post-Stepdown		
		Cost	Post-Stepdown		Adjustments		
			Adjustments				
		1. 00	2A	2. 00	3A	3. 00	
	ANCILLARY SERVICE COST CENTERS						
50.00	05000 OPERATING ROOM	0	0		0	0	
50. 01	05001 CARDI AC SURGERY	0	0		0	0	50. 01
50.02	05002 WVSC	0	0		0	0	50. 02
51.00	05100 RECOVERY ROOM	0	0		0	0	51.00
51. 02	05101 0/P TREATMENT ROOM	0	0		0	0	51.02
52.00	05200 DELIVERY ROOM & LABOR ROOM	0	0		0	0	52.00
54.00	05400 RADI OLOGY-DI AGNOSTI C	0	0		0	393, 620	54.00
55.00	05500 RADI OLOGY-THERAPEUTI C	0	0		0	0	55.00
56.00	05600 RADI OI SOTOPE	0	0		0	0	56.00
57.00	05700 CT SCAN	0	0		0	0	57.00
58.00	05800 MAGNETIC RESONANCE IMAGING (MRI)	0	0		0	0	58. 00
59.00	05900 CARDI AC CATHETERI ZATI ON	0	0		0	0	59.00
60.00	06000 LABORATORY	0	0		0	0	60.00
62.00	06200 WHOLE BLOOD & PACKED RED BLOOD CELLS	0	0		0	0	62.00
65.00	06500 RESPI RATORY THERAPY	0	0		0	0	65.00
66.00	06600 PHYSI CAL THERAPY	0	0		0	0	66.00
66. 01	06601 PSYCHI ATRI C/PSYCHOLOGI CAL SERVI CES	0	0		0	0	66. 01
66. 02	06602 0/P PHYSI CAL THERAPY	0	0		0	0	66. 02
67.00	06700 OCCUPATI ONAL THERAPY	0	0		0	0	67.00
68.00	06800 SPEECH PATHOLOGY	0	0		0	0	68. 00
69.00	06900 ELECTROCARDI OLOGY	0	0		0	0	69.00
69. 01	06901 CARDI AC REHAB	0	0		0	0	69. 01
70.00	07000 ELECTROENCEPHALOGRAPHY	0	0		0	0	70.00
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	375, 920	73.00
76.00	03020 RENAL ACUTE	0	0		0 0	0	76.00
	OUTPATIENT SERVICE COST CENTERS						
90.00	09000 CLI NI C	0	0		0 0	0	90.00
90.05	09005 PATIENT NUTRITION	0	0		0	0	90. 05
90. 07	09007 WOUND CLINIC	0	0		0	0	90. 07
91.00	09100 EMERGENCY	0	0		0	0	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0			0	0	92.00
200.00	Total (lines 50 through 199)	0	0		0 0	769, 540	200. 00

THROUGH COSTS

					12,01,201,	5/30/2018 2: 1	
			Title	XVIII	Hospi tal	PPS	
	Cost Center Description	All Other	Total Cost	Total	Total Charges	Ratio of Cost	
		Medi cal	(sum of col 1	Outpati ent	(from Wkst.	to Charges	
		Educati on	through col.	Cost (sum of	C, Part I,	(col. 5 ÷	
		Cost	4)	col . 2, 3 and	col . 8)	col. 7)	
				4)			
		4. 00	5. 00	6. 00	7. 00	8. 00	
	ANCILLARY SERVICE COST CENTERS			,			
	05000 OPERATING ROOM	0	0	(
	05001 CARDI AC SURGERY	0	0	(
	05002 WVSC	0	0	(
	05100 RECOVERY ROOM	0	0	(8, 039, 090		
	05101 0/P TREATMENT ROOM	0	0	(_,,		
	05200 DELIVERY ROOM & LABOR ROOM	0	0	(
	05400 RADI OLOGY-DI AGNOSTI C	0	393, 620	393, 620			
	05500 RADI OLOGY-THERAPEUTI C	0	0	(38, 886, 606		
	05600 RADI OI SOTOPE	0	0	(8, 071, 387		
	05700 CT SCAN	0	0	(66, 810, 076		
	05800 MAGNETIC RESONANCE IMAGING (MRI)	0	0	(15, 831, 773		
	05900 CARDI AC CATHETERI ZATI ON	0	0	(101, 602, 797		
60.00	06000 LABORATORY	0	0	(96, 433, 889	0. 000000	60.00
62.00	06200 WHOLE BLOOD & PACKED RED BLOOD CELLS	0	0	(3, 148, 106	0.000000	62.00
65.00	06500 RESPI RATORY THERAPY	0	0	(18, 394, 656	0.000000	65.00
66.00	06600 PHYSI CAL THERAPY	0	0	(11, 958, 997	0.000000	66.00
66. 01	06601 PSYCHI ATRI C/PSYCHOLOGI CAL SERVI CES	0	0	(0	0.000000	66. 01
66. 02	06602 0/P PHYSICAL THERAPY	0	0	(6, 836, 654	0.000000	66. 02
67.00	06700 OCCUPATI ONAL THERAPY	0	0	(8, 547, 786	0.000000	67.00
68. 00	06800 SPEECH PATHOLOGY	0	0	(3, 227, 110	0.000000	68.00
69. 00	06900 ELECTROCARDI OLOGY	0	0	(31, 444, 614	0.000000	69.00
69. 01	06901 CARDI AC REHAB	0	0	(1, 283, 545	0.000000	69. 01
70.00	07000 ELECTROENCEPHALOGRAPHY	0	0	(4, 692, 335	0.000000	70.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	(802, 001	0.000000	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0	0	(15, 433, 507	0.000000	72.00
73.00	07300 DRUGS CHARGED TO PATLENTS	0	375, 920	375, 920	261, 571, 943	0.001437	73.00
76. 00	03020 RENAL ACUTE	o	0	(3, 783, 243	0.000000	76.00
	OUTPATIENT SERVICE COST CENTERS						
90.00	09000 CLI NI C	0	0	(692, 316	0.000000	90.00
90. 05	09005 PATIENT NUTRITION	0	0	(197, 862	0.000000	90. 05
90. 07	09007 WOUND CLINIC	0	0	(6, 783, 717	0.000000	90. 07
91.00	09100 EMERGENCY	0	0	(132, 553, 056	0.000000	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0	0	(13, 711, 191	0.000000	92.00
200.00	Total (lines 50 through 199)	0	769, 540	769, 540	1, 215, 079, 247		200. 00

Health Financial Systems	UNI ON HOSPI TAL,	I NC.	In Lieu	of Form CMS-2552-10
APPORTIONMENT OF INPATIENT/OUTPATIENT	ANCILLARY SERVICE OTHER PASS F	Provider CCN: 15-0023		Worksheet D
THROUGH COSTS			From 01/01/2017	Part IV

TIROUGH COSTS			Ť	o 12/31/2017	Date/Time Pre 5/30/2018 2:1	pared: 8 pm
		Title	XVIII	Hospi tal	PPS	<u> </u>
Cost Center Description	Outpati ent	I npati ent	I npati ent	Outpati ent	Outpati ent	
	Ratio of Cost	Program	Program	Program	Program	
	to Charges	Charges	Pass-Through	Charges	Pass-Through	
	(col. 6 ÷	Ŭ	Costs (col. 8	ŭ	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	57, 286, 252		.,	0	50.00
50. 01 05001 CARDI AC SURGERY	0. 000000	259, 254			0	50. 01
50. 02 05002 WVSC	0. 000000	0	l ~	,,	0	50. 02
51.00 05100 RECOVERY ROOM	0. 000000	1, 505, 390	0	1, 663, 809	0	51.00
51.02 05101 0/P TREATMENT ROOM	0. 000000	160, 064		1, 012, 765	0	51.02
52.00 05200 DELIVERY ROOM & LABOR ROOM	0. 000000	150, 755		146, 985	0	52.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	0. 007479	6, 167, 876	46, 130	8, 619, 556	64, 466	54.00
55. 00 05500 RADI OLOGY-THERAPEUTI C	0. 000000	1, 010, 660	0	20, 429, 947	0	55.00
56. 00 05600 RADI 0I SOTOPE	0. 000000	485, 957	0	4, 418, 840	0	56.00
57.00 05700 CT SCAN	0. 000000	10, 204, 439	0	16, 873, 806	0	57.00
58.00 05800 MAGNETIC RESONANCE I MAGING (MRI)	0. 000000	1, 614, 810	0	3, 887, 724	0	58. 00
59. 00 05900 CARDI AC CATHETERI ZATI ON	0. 000000	12, 653, 986	0	27, 384, 149	0	59.00
60. 00 06000 LABORATORY	0. 000000	24, 049, 523	0	12, 267, 187	0	60.00
62.00 06200 WHOLE BLOOD & PACKED RED BLOOD CELLS	0. 000000	1, 353, 365	0	320, 466	0	62.00
65. 00 06500 RESPIRATORY THERAPY	0. 000000	8, 468, 998	0	748, 337	0	65.00
66. 00 06600 PHYSI CAL THERAPY	0. 000000	3, 258, 255	0	67, 500	0	66.00
66. 01 06601 PSYCHI ATRI C/PSYCHOLOGI CAL SERVI CES	0. 000000	0	0	0	0	66. 01
66. 02 06602 0/P PHYSI CAL THERAPY	0. 000000	0	0	0	0	66. 02
67. 00 06700 OCCUPATI ONAL THERAPY	0. 000000	1, 947, 792	0	46, 562	0	67.00
68.00 06800 SPEECH PATHOLOGY	0. 000000	457, 228	0	14, 989	0	68.00
69. 00 06900 ELECTROCARDI OLOGY	0. 000000	6, 938, 460	0	7, 359, 442	0	69.00
69. 01 06901 CARDI AC REHAB	0. 000000	47, 346	0	673, 005	0	69. 01
70. 00 07000 ELECTROENCEPHALOGRAPHY	0. 000000	890, 184	0	802, 521	0	70.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0. 000000	346, 682	0	24, 821	0	71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0. 000000	3, 643, 593	0	5, 359, 492	0	72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	0. 001437	27, 298, 373	39, 228	109, 752, 124	157, 714	73.00
76. 00 03020 RENAL ACUTE	0. 000000	2, 270, 175	0	290, 542	0	76.00
OUTPATIENT SERVICE COST CENTERS						
90. 00 09000 CLINIC	0. 000000	0	0	633, 013	0	90.00
90. 05 09005 PATIENT NUTRITION	0. 000000	0	0	0	0	90.05
90. 07 09007 WOUND CLINIC	0. 000000	16, 416	0	2, 739, 408	0	90. 07
91. 00 09100 EMERGENCY	0. 000000	13, 467, 280	0		0	91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	0. 000000	0	0	4, 327, 825	0	92.00
200.00 Total (lines 50 through 199)		185, 953, 113	85, 358	310, 501, 584	222, 180	200. 00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST Provider CCN: 15-0023 Peri od: Worksheet D From 01/01/2017 Part V Date/Time Prepared: 12/31/2017 5/30/2018 2:18 pm Title XVIII Hospi tal PPS Charges Costs PPS Services Cost Center Description Cost to PPS Cost Cost Charge Ratio Rei mbursed Rei mbursed Rei mbursed (see inst.) Services (see From Servi ces Services Not Worksheet C, inst.) Subject To Subject To Part I, col. Ded. & Coins. Ded. & Coins. 9 (see inst.) (see inst.) 2.00 5.00 1.00 3.00 4.00 ANCILLARY SERVICE COST CENTERS 05000 OPERATING ROOM 50.00 0. 114952 24, 715, 072 2, 841, 047 50.00 05001 CARDI AC SURGERY 0 50.01 0.543417 374, 225 0 203, 360 50.01 0 50.02 05002 WVSC 0.142653 31, 945, 030 4, 557, 054 50.02 51.00 05100 RECOVERY ROOM 0.413734 1, 663, 809 0 0 688, 374 51.00 05101 0/P TREATMENT ROOM 1. 919636 1, 012, 765 0 0 1, 944, 140 51.02 51.02 0 0. 337415 49, 595 52.00 05200 DELIVERY ROOM & LABOR ROOM 146, 985 0 52.00 0 2, 159, 906 54.00 05400 RADI OLOGY-DI AGNOSTI C 0. 250582 8, 619, 556 54.00 55.00 05500 RADI OLOGY-THERAPEUTI C 0.200170 20, 429, 947 0 0 0 4, 089, 462 55.00 0 1, 067, 649 56.00 05600 RADI OI SOTOPE 0.241613 4, 418, 840 56.00 0 05700 CT SCAN 991, 117 57.00 0.058737 16, 873, 806 57.00 58.00 05800 MAGNETIC RESONANCE IMAGING (MRI) 0.172871 3, 887, 724 672,075 58.00 05900 CARDI AC CATHETERI ZATI ON 27, 384, 149 0 59.00 0.190211 0 0 5, 208, 766 59.00 06000 LABORATORY 0 60 00 0 113838 12 267 187 1, 396, 472 60 00 0 62.00 06200 WHOLE BLOOD & PACKED RED BLOOD CELLS 0.437220 320, 466 140, 114 62.00 65.00 06500 RESPIRATORY THERAPY 0. 334681 748, 337 0 0 250, 454 65.00 0 0 66.00 06600 PHYSI CAL THERAPY 0. 325184 67,500 21, 950 66.00 06601 PSYCHI ATRI C/PSYCHOLOGI CAL SERVI CES 0 0 0.000000 66.01 C 0 66 01 0 0 66.02 06602 0/P PHYSI CAL THERAPY 0.348305 0 66.02 06700 OCCUPATI ONAL THERAPY 0. 238145 46, 562 0 11, 089 67.00 67.00 0 0 4, 740 68.00 06800 SPEECH PATHOLOGY 0.316249 14, 989 68.00 0 06900 ELECTROCARDI OLOGY 7, 359, 442 1, 316, 244 69 00 69 00 0.178851 o 69. 01 06901 CARDI AC REHAB 0.710043 673,005 477, 862 69.01 0. 374014 07000 ELECTROENCEPHALOGRAPHY 802, 521 0 0 300, 154 70.00 70.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 1. 957407 0 0 48, 585 71.00 24, 821 71.00 07200 IMPL. DEV. CHARGED TO PATIENTS 0 5, 359, 492 4, 720, 957 72.00 0.880859 0 72.00 73.00 07300 DRUGS CHARGED TO PATIENTS 0. 214399 109, 752, 124 0 54, 834 23, 530, 746 73.00 76.00 03020 RENAL ACUTE 0.530821 290, 542 0 0 154, 226 76.00 OUTPATIENT SERVICE COST CENTERS 90.00 09000 CLI NI C 0. 480104 633, 013 0 303, 912 90.00 09005 PATIENT NUTRITION 3. 222473 0 90.05 0 90.05 90.07 09007 WOUND CLINIC 0.266386 2, 739, 408 0 0 729, 740 90.07 0 23, 602, 442 91.00 91. 00 | 09100 | EMERGENCY 0.142962 82 3, 374, 252

0.764117

4, 327, 825

310, 501, 584

310, 501, 584

0

0

0

0

54, 916

54, 916

3, 306, 965

64, 561, 007 202. 00

64, 561, 007

92.00

200.00

201. 00

92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART)

Only Charges

Subtotal (see instructions)

Less PBP Clinic Lab. Services-Program

Net Charges (line 200 - line 201)

200.00

201.00

202.00

Heal th FinancialSystemsUNION HOSPIAPPORTIONMENT OFMEDICAL, OTHER HEALTH SERVICES AND VACCINE COST In Lieu of Form CMS-2552-10 UNION HOSPITAL, INC. Provi der CCN: 15-0023

				10 12/31/2017	5/30/2018 2: 1	
		Title	XVIII	Hospi tal	PPS	
	Cos	sts				
Cost Center Description	Cost	Cost				
	Rei mbursed	Rei mbursed				
	Servi ces	Services Not				
	Subject To	Subject To				
	Ded. & Coins.	Ded. & Coins.				
	(see inst.)	(see inst.)				
	6. 00	7. 00				
ANCILLARY SERVICE COST CENTERS						
50.00 05000 OPERATING ROOM	0					50.00
50. 01 05001 CARDI AC SURGERY	0	0				50. 01
50. 02 05002 WVSC	0	0				50. 02
51.00 05100 RECOVERY ROOM	0	0				51.00
51.02 05101 0/P TREATMENT ROOM	0	0				51.02
52.00 05200 DELIVERY ROOM & LABOR ROOM	0	0				52.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	0	0				54.00
55. 00 05500 RADI OLOGY-THERAPEUTI C	0	0				55.00
56. 00 05600 RADI 0I SOTOPE	0	0				56.00
57.00 05700 CT SCAN	0	0				57.00
58.00 05800 MAGNETIC RESONANCE I MAGING (MRI)	0	_				58. 00
59. 00 05900 CARDI AC CATHETERI ZATI ON	0	0				59.00
60. 00 06000 LAB0RAT0RY	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
66. 01 06601 PSYCHI ATRI C/PSYCHOLOGI CAL SERVI CES	0	0				66. 01
66. 02 06602 0/P PHYSI CAL THERAPY	0	_				66. 02
67. 00 06700 OCCUPATI ONAL THERAPY	0	_				67. 00
68.00 06800 SPEECH PATHOLOGY	0	_				68. 00
69. 00 06900 ELECTROCARDI OLOGY	0	0				69.00
69. 01 06901 CARDI AC REHAB	0	0				69. 01
70. 00 07000 ELECTROENCEPHALOGRAPHY	0	0				70.00
71. 00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0				71.00
72. 00 07200 I MPL. DEV. CHARGED TO PATIENTS	0	0				72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	0	, , , , ,				73.00
76. 00 03020 RENAL ACUTE	0	0				76.00
OUTPATIENT SERVICE COST CENTERS		1				
90. 00 09000 CLI NI C	0		•			90.00
90. 05 09005 PATI ENT NUTRI TI ON	0	_				90.05
90. 07 09007 WOUND CLINIC	0	_				90.07
91. 00 09100 EMERGENCY	0	12				91.00
92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART)		11 740				92.00
200.00 Subtotal (see instructions)		11, 768				200.00
201.00 Less PBP Clinic Lab. Services-Program	0					201. 00
Only Charges 202.00 Net Charges (line 200 - line 201)	0	11, 768				202. 00
202.00 Net Charges (Title 200 - Title 201)	1	11, 708	I			1202.00

Health Financial Systems	UNI ON HOSPI	TAL LNC		In lie	u of Form CMS-2	2552-10
APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPIT		Provi der C	CN: 15-0023	Peri od:	Worksheet D	2002 10
THE OWN OF THE PROPERTY OF THE	7.E 000.0			From 01/01/2017	Part II	
		· ·	CCN: 15-T023	To 12/31/2017	Date/Time Pre 5/30/2018 2:1	pared: 8 pm
			e XVIII	Subprovi der - I RF	PPS	
Cost Center Description	Capi tal	Total Charges			Capital Costs	
	Related Cost	(from Wkst.	to Charges	Program	(column 3 x	
	(from Wkst.	C, Part I,	(col . 1 ÷	Charges	column 4)	
	B, Part II,	col. 8)	col . 2)			
	col . 26)					
	1. 00	2.00	3. 00	4. 00	5. 00	
ANCILLARY SERVICE COST CENTERS		1				
50. 00 05000 OPERATING ROOM	3, 510, 713				2, 376	
50. 01 05001 CARDI AC SURGERY	211, 882		1		11	50. 01
50. 02 05002 WVSC	1, 686, 960		1		0	
51. 00 05100 RECOVERY ROOM	92, 702		1	1	94	
51. 02 05101 0/P TREATMENT ROOM	769, 257				345	
52. 00 05200 DELIVERY ROOM & LABOR ROOM	870, 597				9	52.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	2, 379, 634		1		3, 006	1
55. 00 05500 RADI OLOGY-THERAPEUTI C	1, 956, 442				1, 826	1
56. 00 05600 RADI OI SOTOPE	305, 080			1	46	
57. 00 05700 CT SCAN	401, 849				382	
58. 00 05800 MAGNETIC RESONANCE I MAGING (MRI)	802, 203		1	1	826	
59. 00 05900 CARDI AC CATHETERI ZATI ON	790, 215		1	1	38	
60. 00 06000 LABORATORY	40, 913		1	1	132	
62. 00 06200 WHOLE BLOOD & PACKED RED BLOOD CELLS	2, 624		1	1	8	
65. 00 06500 RESPI RATORY THERAPY	405, 316			1	4, 053	1
66. 00 06600 PHYSI CAL THERAPY	593, 676				54, 371	66.00
66. 01 06601 PSYCHI ATRI C/PSYCHOLOGI CAL SERVI CES	0		0.0000		0	
66. 02 06602 0/P PHYSI CAL THERAPY	64, 876				0	
67. 00 06700 OCCUPATI ONAL THERAPY	53, 058				6, 816	1
68. 00 06800 SPEECH PATHOLOGY	448, 992			1	52, 270	1
69. 00 06900 ELECTROCARDI OLOGY	374, 589		1	1	394	
69. 01 06901 CARDI AC REHAB	324, 034				0	
70. 00 07000 ELECTROENCEPHALOGRAPHY	123, 851				619	
71. 00 07100 MEDI CAL SUPPLI ES CHARGED TO PATI ENTS	439, 099		1	1	688	
72. 00 07200 I MPL. DEV. CHARGED TO PATIENTS	17, 915		1		12	
73.00 07300 DRUGS CHARGED TO PATIENTS	586, 612				978	
76. 00 03020 RENAL ACUTE	898, 350	3, 783, 243	0. 23745	55 80, 165	19, 036	76. 00
OUTPATIENT SERVICE COST CENTERS	/ 005	(00.01/	0.0000	-ol	_	00.00
90. 00 09000 CLINIC	6, 895		1		0	
90. 05 09005 PATI ENT NUTRI TI ON	55, 729		1		0	
90. 07 09007 WOUND CLINIC	127, 868				0	
91. 00 09100 EMERGENCY	983, 898			1	76	
92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	10 225 020				0 148, 412	
200.00 Total (lines 50 through 199)	19, 325, 829	1, 215, 079, 247	I	3, 981, 180	148, 412	J∠UU. UU

Health Financial Systems	UNI ON HOSPI				eu of Form CMS-	2552-10
APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLA	RY SERVICE OTHER PAS	S Provider C	CN: 15-0023	Peri od: From 01/01/201	Worksheet D 7 Part IV	
THROUGH COSTS		Component	CCN: 15-T023	To 12/31/201	7 Date/Time Pre 5/30/2018 2:1	epared: 8 pm
		Title	XVIII	Subprovi der -		
Cost Center Description	Non Physician	Nursi ng	Nursi ng	Allied Healt	h Allied Health	
	Anesthetist	School	School	Post-Stepdow		
	Cost	Post-Stepdown		Adjustments		
	1. 00	Adjustments 2A	2.00	3A	3.00	
ANCILLARY SERVICE COST CENTERS	1.00	2/1	2.00	JA JA	3.00	
50. 00 05000 OPERATING ROOM	O	0		0	0 0	50.00
50. 01 05001 CARDI AC SURGERY	o	0		0	0 0	50. 01
50. 02 05002 WVSC	o	0		0	0 0	50. 02
51.00 05100 RECOVERY ROOM	o	0		0	0 0	51.00
51.02 05101 0/P TREATMENT ROOM	0	0		0	0	
52.00 05200 DELIVERY ROOM & LABOR ROOM	0	0		0	0	
54. 00 05400 RADI OLOGY-DI AGNOSTI C	0	0		0	0 393, 620	1
55. 00 05500 RADI OLOGY-THERAPEUTI C	O	0		0	0	
56. 00 05600 RADI OI SOTOPE 57. 00 05700 CT SCAN	0	0		0	0 0	
57. 00 05700 CT SCAN 58. 00 05800 MAGNETIC RESONANCE I MAGING (MRI)		0		0		
59. 00 05900 CARDIAC CATHETERIZATION	Ĭ	0		0		1
60. 00 06000 LABORATORY	l ől	0		0	o o	1
62.00 06200 WHOLE BLOOD & PACKED RED BLOOD CE	LLS O	0		Ö	0 0	
65. 00 06500 RESPIRATORY THERAPY	o	0		0	0 0	65.00
66. 00 06600 PHYSI CAL THERAPY	0	0		0	0 0	66.00
66. 01 06601 PSYCHI ATRI C/PSYCHOLOGI CAL SERVI CE	s 0	0		0	0	66. 01
66. 02 06602 0/P PHYSI CAL THERAPY	0	0		0	0	
67. 00 06700 OCCUPATI ONAL THERAPY	0	0		0	0	
68. 00 06800 SPEECH PATHOLOGY	0	0		0	0	
69. 00 06900 ELECTROCARDI OLOGY 69. 01 06901 CARDI AC REHAB	0	0		0	0 0	
70. 00 07000 ELECTROENCEPHALOGRAPHY		0		0		1
71. 00 07100 MEDICAL SUPPLIES CHARGED TO PATIE	NTS O	0		0		
72. 00 07200 IMPL. DEV. CHARGED TO PATIENTS		0		0	o o	
73. 00 07300 DRUGS CHARGED TO PATIENTS	ol	0		Ö	0 375, 920	
76. 00 03020 RENAL ACUTE	o	0		0	0 0	76.00
OUTPATIENT SERVICE COST CENTERS						
90. 00 09000 CLI NI C	0	0		0	0 0	
90. 05 09005 PATIENT NUTRITION	0	0		0	0	
90. 07 09007 WOUND CLINIC	0	0		0	0	
91. 00 09100 EMERGENCY	0	0		0	0	
92.00 O9200 OBSERVATION BEDS (NON-DISTINCT PA 200.00 Total (lines 50 through 199)	KI) 0	0		0	0 769, 540	
200.00 Total (Tries 50 through 199)	ı Y	0	I	U	UJ /09, 540	<u> </u> 200.00

Health Financial Systems	UNION HOSPI	TAL LNC		Inlie	u of Form CMS-:	2552_10
APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SER			CN: 15-0023	Peri od:	Worksheet D	2552-10
THROUGH COSTS	VIOL OTHER TAG			From 01/01/2017	Part IV	
		·		To 12/31/2017	Date/Time Pre 5/30/2018 2:1	
		Titl€	e XVIII	Subprovi der - I RF	PPS	
Cost Center Description	All Other	Total Cost	Total	Total Charges		
	Medi cal	(sum of col 1		(from Wkst.	to Charges	
	Educati on	through col.	Cost (sum of		(col. 5 ÷	
	Cost	4)	col . 2, 3 and 4)	d col. 8)	col. 7)	
	4. 00	5. 00	6. 00	7. 00	8. 00	
ANCILLARY SERVICE COST CENTERS			2.22			
50. 00 05000 OPERATING ROOM	0	C		0 169, 133, 599	0. 000000	50.00
50. 01 05001 CARDI AC SURGERY	0	C		0 6, 994, 247	0.000000	50. 01
50. 02 05002 WVSC	0	l c		0 100, 498, 844	0.000000	50. 02
51.00 05100 RECOVERY ROOM	0	l c		0 8, 039, 090	0.000000	51.00
51.02 05101 0/P TREATMENT ROOM	0	l c		0 2, 795, 186	0.000000	51.02
52.00 05200 DELIVERY ROOM & LABOR ROOM	0	l c		0 22, 289, 184	0.000000	52.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	0	393, 620	393, 62	52, 629, 930	0. 007479	54.00
55. 00 05500 RADI OLOGY-THERAPEUTI C	0	l c		0 38, 886, 606	0.000000	55.00
56. 00 05600 RADI 0I SOTOPE	0	l c		0 8, 071, 387	0.000000	56.00
57.00 05700 CT SCAN	0	l c		0 66, 810, 076	0.000000	57.00
58.00 05800 MAGNETIC RESONANCE IMAGING (MRI)	0	C		0 15, 831, 773	0.000000	58.00
59. 00 05900 CARDI AC CATHETERI ZATI ON	0	C		0 101, 602, 797	0.000000	59.00
60. 00 06000 LABORATORY	0	C		0 96, 433, 889	0.000000	60.00
62.00 06200 WHOLE BLOOD & PACKED RED BLOOD CELLS	0	C		0 3, 148, 106	0.000000	62.00
65. 00 06500 RESPIRATORY THERAPY	0	C		0 18, 394, 656	0. 000000	65.00
66. 00 06600 PHYSI CAL THERAPY	0	C		0 11, 958, 997	0.000000	66.00
66. 01 06601 PSYCHI ATRI C/PSYCHOLOGI CAL SERVI CES	0	C		0 0	0.000000	66. 01
66. 02 06602 0/P PHYSI CAL THERAPY	0	C		0 6, 836, 654	0.000000	66. 02
67. 00 06700 OCCUPATI ONAL THERAPY	0	C		0 8, 547, 786	0.000000	67.00
68. 00 06800 SPEECH PATHOLOGY	0	C		0 3, 227, 110	0.000000	68.00
69. 00 06900 ELECTROCARDI OLOGY	0	C		0 31, 444, 614	0. 000000	69.00
69. 01 06901 CARDI AC REHAB	0	C)	0 1, 283, 545	0. 000000	69. 01
70. 00 07000 ELECTROENCEPHALOGRAPHY	0	C		0 4, 692, 335	0.000000	70.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	C		0 802, 001	0.000000	71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0	C		0 15, 433, 507	0.000000	72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	0	375, 920	375, 92	0 261, 571, 943	0. 001437	73.00
76. 00 03020 RENAL ACUTE	0	C		0 3, 783, 243	0.000000	76.00
OUTPATIENT SERVICE COST CENTERS						
90. 00 09000 CLI NI C	0		l .	0 692, 316		
90. 05 09005 PATI ENT NUTRI TI ON	0			0 197, 862	0. 000000	
90. 07 09007 WOUND CLINIC	0	C	1	0 6, 783, 717	0. 000000	90. 07
91. 00 09100 EMERGENCY	0	C	1	0 132, 553, 056	0. 000000	91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	0	C	1	0 13, 711, 191	0. 000000	92.00
200.00 Total (lines 50 through 199)	0	769, 540	769, 54	0 1, 215, 079, 247		200.00

Health Fin	ancial Systems	UNION HOSPITA	J INC		In lie	u of Form CMS-:	2552-10
	MENT OF INPATIENT/OUTPATIENT ANCILLARY SE		Provi der C	CN: 15-0023	Peri od:	Worksheet D	2002 10
THROUGH CO				CCN: 15-T023	From 01/01/2017 To 12/31/2017	Part IV Date/Time Pre	pared:
						5/30/2018 2:1	
			Title	· XVIII	Subprovi der - I RF	PPS	
	Cost Center Description	Outpati ent	I npati ent	I npati ent	Outpati ent	Outpati ent	
		Ratio of Cost	Program	Program	Program	Program	
		to Charges	Charges	Pass-Through	9	Pass-Through	
		(col. 6 ÷		Costs (col.	8	Costs (col. 9	
		col. 7)		x col. 10)		x col. 12)	
		9. 00	10. 00	11. 00	12.00	13. 00	
	LLARY SERVICE COST CENTERS						
50.00 0500	OO OPERATING ROOM	0. 000000	114, 460		0 19	0	50.00
	D1 CARDI AC SURGERY	0. 000000	373		0	0	50. 01
50.02 0500	D2 WVSC	0. 000000	0		0 73	0	50. 02
51.00 0510	OO RECOVERY ROOM	0. 000000	8, 151		0	0	51.00
51.02 0510	01 0/P TREATMENT ROOM	0. 000000	1, 254		0	0	51.02
52.00 0520	DO DELIVERY ROOM & LABOR ROOM	0. 000000	235		0	0	52.00
54.00 0540	DO RADI OLOGY-DI AGNOSTI C	0. 007479	66, 480	49	552	4	54.00
55.00 0550	OO RADI OLOGY-THERAPEUTI C	0. 000000	36, 300		0	0	55.00
56.00 0560	DO RADI OI SOTOPE	0. 000000	1, 205		0 0	0	56.00
57.00 0570	DO CT SCAN	0. 000000	63, 455		0 0	0	57.00
58.00 0580	OO MAGNETIC RESONANCE IMAGING (MRI)	0. 000000	16, 293		0 0	0	58.00
	OO CARDI AC CATHETERI ZATI ON	0. 000000	4, 833		0 139	0	59.00
60.00 0600	DO LABORATORY	0. 000000	311, 330		0 3, 674	0	60.00
62.00 0620	OO WHOLE BLOOD & PACKED RED BLOOD CELLS	0. 000000	9, 300		0 0	0	62.00
	OO RESPIRATORY THERAPY	0. 000000	183, 956		0 6, 013	0	65.00
66.00 0660	OO PHYSI CAL THERAPY	0. 000000	1, 095, 248		0 0	0	66.00
1	D1 PSYCHI ATRI C/PSYCHOLOGI CAL SERVI CES	0. 000000	0		0	0	66, 01
	02 0/P PHYSI CAL THERAPY	0. 000000	0		0 0	0	66. 02
	OO OCCUPATIONAL THERAPY	0. 000000	1, 098, 145		0 0	0	67.00
	OO SPEECH PATHOLOGY	0. 000000	375, 690		0 0	Ö	68.00
	DO ELECTROCARDI OLOGY	0. 000000	33, 083		0 116	0	69. 00
	D1 CARDI AC REHAB	0. 000000	00,000		0 4, 420	Ö	69. 01
	DO ELECTROENCEPHALOGRAPHY	0. 000000	23, 437		0 0	0	70.00
	DO MEDICAL SUPPLIES CHARGED TO PATIENTS	0. 000000	1, 256		0 1	0	71.00
	DO IMPL. DEV. CHARGED TO PATIENTS	0. 000000	10, 082		0 0	0	72.00
	DO DRUGS CHARGED TO PATIENTS	0. 001437	436, 163	•	-	2	73.00
	20 RENAL ACUTE	0. 000000	80, 165	•	0 0	0	
	PATIENT SERVICE COST CENTERS	0.000000	00, 103		0 0	U	70.00
	DO CLINIC	0. 000000	0		0 0	0	90.00
	DS PATIENT NUTRITION	0. 000000	0	1	0 0	0	
	DO WOUND CLINIC	0. 000000	0		0 0	0	90.05
	DOLEMERGENCY	0. 000000	10, 286		0 1, 100	0	1
	DO OBSERVATION BEDS (NON-DISTINCT PART)	0. 000000	10, 286	1	0 1, 100	0	
200. 00	Total (lines 50 through 199)	0.000000	3, 981, 180		-	_	200.00
200.00	Total (Titles 50 till bugil 177)	1	3, 701, 100] 1, 12	17, 390	0	1200.00

Health Financial Systems	UNI ON HOSPI	TAL, INC.	In Lie	u of Form CMS-2	2552-10
APPORTIONMENT OF MEDICAL, O	THER HEALTH SERVICES AND VACCINE COST	Provi der CCN: 15-0023	Peri od: From 01/01/2017	Worksheet D	
		Component CCN: 15-T023			
		Title XVIII	Subprovi der -	PPS	
			I RF		
		Charges		Costs	

			Title	· XVIII	Subprovi der -	PPS	
				Charges	I RF	Costs	
	Cost Center Description	Cost to	PPS	Cost	Cost	PPS Services	
	Sect content person	Charge Ratio	Rei mbursed	Rei mbursed	Rei mbursed	(see inst.)	
		From	Services (see		Services Not	()	
		Worksheet C,	inst.)	Subject To	Subject To		
		Part I, col.		Ded. & Coins.	Ded. & Coins.		
		9		(see inst.)	(see inst.)		
	T	1. 00	2. 00	3. 00	4. 00	5. 00	
F0 00	ANCILLARY SERVICE COST CENTERS	0.444050	4.0	1			
50.00	05000 OPERATING ROOM	0. 114952	19		0	2	50.00
50. 01	05001 CARDI AC SURGERY	0. 543417	0		0	0	
50.02	05002 WVSC	0. 142653	73		0	10	
51.00	05100 RECOVERY ROOM	0. 413734 1. 919636	0		0	0	
51. 02 52. 00	05101 0/P TREATMENT ROOM	1	0	•		0	51. 02 52. 00
54.00	O5200 DELI VERY ROOM & LABOR ROOM O5400 RADI OLOGY-DI AGNOSTI C	0. 337415 0. 250582	552			138	•
55.00	05500 RADI OLOGY-THERAPEUTI C	0. 200170	000			130	55.00
56.00	05600 RADI OLOGY - THERAPEUTI C	0. 241613	0			0	56.00
57.00	05700 CT SCAN	0. 058737	0			0	57.00
58. 00	05800 MAGNETIC RESONANCE IMAGING (MRI)	0. 038737	0	•		0	58.00
59. 00	05900 CARDI AC CATHETERI ZATI ON	0. 172071	139	•		26	59.00
60.00	06000 LABORATORY	0. 113838	3, 674			418	•
62. 00	06200 WHOLE BLOOD & PACKED RED BLOOD CELLS	0. 437220	0,074			0	62.00
65. 00	06500 RESPIRATORY THERAPY	0. 334681	6, 013		o o	2, 012	
66. 00	06600 PHYSI CAL THERAPY	0. 325184	0,0.0	1	0	0	66.00
66. 01	06601 PSYCHI ATRI C/PSYCHOLOGI CAL SERVI CES	0. 000000	0		0	Ö	66. 01
66. 02	06602 0/P PHYSI CAL THERAPY	0. 348305	0	1	0	0	66.02
67.00	06700 OCCUPATI ONAL THERAPY	0. 238145	0		0	0	67.00
68.00	06800 SPEECH PATHOLOGY	0. 316249	0		0	0	68.00
69.00	06900 ELECTROCARDI OLOGY	0. 178851	116		0	21	69.00
69. 01	06901 CARDI AC REHAB	0. 710043	4, 420		0	3, 138	69. 01
70.00	07000 ELECTROENCEPHALOGRAPHY	0. 374014	0		0	0	70.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	1. 957407	1		0	2	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0. 880859	0		0	0	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0. 214399	1, 489		79	319	73.00
76.00	03020 RENAL ACUTE	0. 530821	0	(0	0	76.00
	OUTPATIENT SERVICE COST CENTERS						
90.00	09000 CLI NI C	0. 480104	0	(0	0	90.00
90. 05	09005 PATI ENT NUTRI TI ON	3. 222473	0	(0	0	90.05
90. 07	09007 WOUND CLINIC	0. 266386	0		0	0	90. 07
91.00	09100 EMERGENCY	0. 142962	1, 100		0	157	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0. 764117	0		0	0	92.00
200.00	, ,		17, 596		79	6, 243	200.00
201.00					0		201. 00
000 00	Only Charges		47.50			,	000 00
202.00	Net Charges (line 200 - line 201)		17, 596	l (79	6, 243	202. 00

50. 02 05002 WVSC 0 0 55 51. 00 05100 RECOVERY ROOM 0 0 55 51. 02 05101 O/P TREATMENT ROOM 0 0 51 52. 00 05200 DELI VERY ROOM & LABOR ROOM 0 0 0 54. 00 05400 RADI OLOGY-DI AGNOSTI C 0 0 0 55. 00 05500 RADI OLOGY-THERAPEUTI C 0 0 0 56. 00 05600 RADI OL SOTOPE 0 0 0 57. 00 05700 CT SCAN 0 0 0 56 58. 00 05800 MAGNETI C RESONANCE I MAGI NG (MRI) 0 0 0 57 58. 00 05800 MAGNETI C RESONANCE I MAGI NG (MRI) 0 0 0 57 59. 00 05900 CARDI AC CATHETERI ZATI ON 0 0 0 0 60 60. 00 06000 LABORATORY 0 0 0 60	Health Financial Systems	UNI ON HOSPI				u of Form CMS-	2552-10
Cost Center Description	APPORTIONMENT OF MEDICAL, OTHER HEALTH SE	RVICES AND VACCINE COST			From 01/01/2017	Part V Date/Time Pre	epared:
Cost Center Description Cost Cost Reimbursed Services Subject To Ded. & Coins. (See Inst.) Subject To Ded. & Coins. (See Inst.) Ded. & Coins. Ded. & Coins			Ti tl e	e XVIII			о рііі
Rel imbursed Services Servi		Co	sts		I KF		
ANCI LLARY SERVI CE COST CENTERS 50. 00 05000 05000 05001 05001 05001 05001 05001 05001 05001 05001 05001 05001 05001 05001 05001 05001 05001 05001 050000 050000 050000 050000 050000 050000 050000 050000	Cost Center Description	Reimbursed Services Subject To Ded. & Coins. (see inst.)	Reimbursed Services Not Subject To Ded. & Coins. (see inst.)				
50. 00 05000 OPERATI NG ROOM 0 0 0 0 0 0 0 0 0	ANCILLARY SERVICE COST CENTERS	0.00	7.00	<u> </u>			
72. 00 07200 IMPL. DEV. CHARGED TO PATIENTS 0 0 73. 00 07300 DRUGS CHARGED TO PATIENTS 0 17	50. 01 05001 CARDI AC SURGERY 50. 02 05002 WVSC 51. 00 05100 RECOVERY ROOM 51. 02 05101 0/P TREATMENT ROOM 52. 00 05200 DELI VERY ROOM & LABOR ROOM 64. 00 05500 RADI OLOGY-DI AGNOSTI C 05500 RADI OLOGY-THERAPEUTI C 05600 RADI OLOGY-THERAPEUTI C 05700 CT SCAN 68. 00 05800 MAGNETI C RESONANCE IMAGI NG M 69. 00 05900 CARDI AC CATHETERI ZATI ON 06900 CARDI AC CATHETERI ZATI ON 06000 LABORATORY 62. 00 06200 WHOLE BLOOD & PACKED RED BLOO 65. 00 06500 RESPI RATORY THERAPY PSYCHI ATRI C/PSYCHOLOGI CAL SER 06602 06602 07900 0	RI) C C C C C C C C C C C C C C C C C C C					50. 01 50. 02 51. 00 51. 02 52. 00 54. 00 55. 00 56. 00 57. 00 58. 00 62. 00 66. 01 66. 02 67. 00 68. 00 69. 00 69. 01 70. 00
OUTPATIENT SERVICE COST CENTERS	72.00 07200 IMPL. DEV. CHARGED TO PATIENT 73.00 07300 DRUGS CHARGED TO PATIENTS 76.00 03020 RENAL ACUTE	S C	17	,			71.00 72.00 73.00 76.00

0

0

0

17

17

90.00

90.05

90.07

91.00

92.00

200. 00 201. 00

202.00

90. 00 09000 CLI NI C

200.00

201.00

202.00

91. 00 09100 EMERGENCY

90. 05 09005 PATIENT NUTRITION 90. 07 09007 WOUND CLINIC

92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)

Subtotal (see instructions)
Less PBP Clinic Lab. Services-Program
Only Charges

Net Charges (line 200 - line 201)

	Financial Systems UNION HOSPI TION OF INPATIENT OPERATING COST	TAL, INC. Provi der CCN: 15-0023	In Lie	u of Form CMS-2 Worksheet D-1	
00			From 01/01/2017 To 12/31/2017	Date/Time Pre	pared:
		Title XVIII	Hospi tal	5/30/2018 2: 1 PPS	8 pm
	Cost Center Description				
	PART I - ALL PROVIDER COMPONENTS			1. 00	
	NPATIENT DAYS				1
1. 00	Inpatient days (including private room days and swing-bed	days, excluding newborn)		58, 747	1.00
2. 00	Inpatient days (including private room days, excluding swi			58, 747	
3. 00	Private room days (excluding swing-bed and observation bed		rivate room davs.	0	
	do not complete this line.	3			
4. 00	Semi-private room days (excluding swing-bed and observation	n bed days)		49, 041	4.00
5. 00	Total swing-bed SNF type inpatient days (including private	room days) through Decemb	er 31 of the cost	0	5.00
	reporting period				
5. 00	Total swing-bed SNF type inpatient days (including private	room days) after December	31 of the cost	0	6.00
	reporting period (if calendar year, enter 0 on this line)				
7. 00	Total swing-bed NF type inpatient days (including private	room days) through Decembe	er 31 of the cost	0	7. 00
	reporting period				
3. 00	Total swing-bed NF type inpatient days (including private	room days) after December	31 of the cost	0	8. 00
00	reporting period (if calendar year, enter 0 on this line)	and the Breezeway Court Pro-		04.040	0.00
. 00	Total inpatient days including private room days applicable newborn days)	e to the Program (excluding	ig swing-bed and	24, 848	9. 00
0. 00	Newborn days) Swing-bed SNF type inpatient days applicable to title XVII	Lonly (including private	room days)	0	10.00
0.00	through December 31 of the cost reporting period (see inst		1 doill days)	U	10.00
1. 00	Swing-bed SNF type inpatient days applicable to title XVII		room days) after	0	11.00
11.00	December 31 of the cost reporting period (if calendar year		room days) arter	Ü	11.00
12.00	Swing-bed NF type inpatient days applicable to titles V or	XIX only (including priva	ite room davs)	0	12.00
	through December 31 of the cost reporting period	3 (3)	,		
13.00	Swing-bed NF type inpatient days applicable to titles V or	XIX only (including priva	ite room days)	0	13.00
	after December 31 of the cost reporting period (if calenda	r year, enter 0 on this li	ne)		
	Medically necessary private room days applicable to the Pr	ogram (excluding swing-bed	l days)	0	
	Total nursery days (title V or XIX only)			0	
16.00	Nursery days (title V or XIX only)			0	16. 00
	SWING BED ADJUSTMENT				
17. 00	Medicare rate for swing-bed SNF services applicable to ser	vices through December 31	of the cost	0. 00	17.00
10.00	reporting period			0.00	10.00
18.00	Medicare rate for swing-bed SNF services applicable to ser	vices after December 31 of	the cost	0. 00	18. 00
10 00	reporting period	i acc through December 21 a	f the cost	0.00	10.00
9. 00	Medicaid rate for swing-bed NF services applicable to serv reporting period	ices through becember 31 c	or the cost	0. 00	19.00
20. 00	reporting period Medicaid rate for swing-bed NF services applicable to serv	icos after December 21 of	the cost	0.00	20.00
20.00	reporting period	ices arter becember 31 or	the cost	0.00	20.00
21. 00	Total general inpatient routine service cost (see instruct	ions)		63, 413, 267	21.00
	Swing-bed cost applicable to SNF type services through Dec		ting period (line		1
	5 x line 17)		ting ported (iii	·	22.00
23. 00	Swing-bed cost applicable to SNF type services after Decem	ber 31 of the cost reporti	na period (line d	0	23. 00
	x line 18)				
4. 00	Swing-bed cost applicable to NF type services through Dece	mber 31 of the cost report	ing period (line	0	24.00
	7 x line 19)	·			
5. 00	Swing-bed cost applicable to NF type services after Decemb	er 31 of the cost reportin	g period (line 8	0	25. 00
	x line 20)				
6.00	Total swing-bed cost (see instructions)			0	26, 00

PART 1 - ALL PROFILES COMPONENTS New Teach Components New Teac		Cost Center Description	1.00	
IMPATE INT DAYS		DADT I. ALL DROWLDED COMPONENTS	1. 00	
Inpatient days (including private room days and seing-bed days, excluding newborn) 58,747 1,00				
Inipatient days (including private room days, excluding saing-bed and nesborn days) 1. Flyou have only private room days. 0. 3. 0. 0 0. 0. 0. 0. 0. 0. 0. 0. 0. 0. 0. 0. 0.	1 00		E0 7 <i>1</i> 7	1 00
2.00 Private room days (excluding swing-bed and observation bed days) 17 you have only private room days 4.00 4				
do not complete this line. 4. 05 Semi-private room days (excituding swing-bed and observation bed days) 5. 00 Total swing-bed SN type inpatient days (including private room days) after December 31 of the cost proporting period (if calendar year, enter 0 on this line) 7. 00 Total swing-bed SN type inpatient days (including private room days) after December 31 of the cost proporting period (if calendar year, enter 0 on this line) 7. 00 Total swing-bed N type inpatient days (including private room days) through December 31 of the cost proporting period (if calendar year, enter 0 on this line) 8. 01 Total swing-bed N type inpatient days (including private room days) after December 31 of the cost proporting period (if calendar year, enter 0 on this line) 9. 02 Total Inpatient days including private room days after December 31 of the cost proporting period (if calendar year, enter 0 on this line) 9. 03 Swing-bed SN type inpatient days applicable to title XVIII only (including private room days) 9. 04 Total Inpatient days applicable to title XVIII only (including private room days) 9. 05 Swing-bed SN type inpatient days applicable to title XVIII only (including private room days) 9. 06 Swing-bed SN type inpatient days applicable to title XVIII only (including private room days) 9. 07 Total Inpatient days applicable to title XVIII only (including private room days) 9. 08 Independent 31 of the cost reporting period (if calendar year, enter 0 on this line) 9. 09 A cost of the cost reporting period (if calendar year, enter 0 on this line) 9. 00 Modicare rate for swing-bed SN services applicable to title xVIII only (including private room days) 9. 16. 00 Total runsvery days (title V or XIX only) 9. 16. 00 Nursery days (title V or XIX only) 9. 17. 00 Modicare rate for swing-bed SN services applicable to services after December 31 of the cost reporting period (in particular year, enter 0 on this line) 9. 00 Modicare rate for swing-bed SN services applicable to services after December 31 of the cost reporting period (line 0 o				
Semi-private room days (excluding swing-bed and observation bed days) 4,041 4,00 500 Total swing-bed SMF type inpatient days (including private room days) after December 31 of the cost 0,00 500 7,	0.00		J	0.00
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7 x line 19) 25.00 Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8	04.00			04.00
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37.00 General inpatient routine service cost net of swing-bed cost and private room cost differential (line 23, 413, 267 27 minus line 36) PART II - HOSPITAL AND SUBPROVIDERS ONLY PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS 38.00 Adjusted general inpatient routine service cost per diem (see instructions) Program general inpatient routine service cost (line 9 x line 38) 40.00 Medically necessary private room cost applicable to the Program (line 14 x line 35) 37.00 26, 413, 267 37.00 37.				
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PART II - HOSPITAL AND SUBPROVIDERS ONLY PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS 38.00 Adjusted general inpatient routine service cost per diem (see instructions) 1,079.43 38.00 Program general inpatient routine service cost (line 9 x line 38) 26,821,677 39.00 Medically necessary private room cost applicable to the Program (line 14 x line 35) 0 40.00	37.00		-3,, 207	
PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS 38.00 Adjusted general inpatient routine service cost per diem (see instructions) 1,079.43 38.00 Program general inpatient routine service cost (line 9 x line 38) 26,821,677 39.00 40.00 Medically necessary private room cost applicable to the Program (line 14 x line 35) 0 40.00		PART II - HOSPITAL AND SUBPROVIDERS ONLY		
38.00 Adjusted general inpatient routine service cost per diem (see instructions) 1,079.43 38.00 Program general inpatient routine service cost (line 9 x line 38) 26,821,677 39.00 Medically necessary private room cost applicable to the Program (line 14 x line 35) 0 40.00				
40.00 Medically necessary private room cost applicable to the Program (line 14 x line 35) 0 40.00	38.00		1, 079. 43	
41.00 Total Program general inpatient routine service cost (line 39 + line 40) 26,821,677 41.00				
	41.00		26, 821, 677	41.00

Heal th	Financial Systems	UNION HOSPI	TAL, INC.		In Lie	u of Form CMS-2	2552-10
COMPUT	TATION OF INPATIENT OPERATING COST		Provi der C		Period: From 01/01/2017	Worksheet D-1	
				-	Го 12/31/2017	5/30/2018 2: 1	
	Cost Center Description	Total	Title Total	Average Per	Hospital Program Days	PPS Program Cost	
	cost center bescription	Inpatient	Inpatient	Diem (col. 1	Frogram bays	(col. 3 x	
		Cost	Days	÷ col . 2)		col . 4)	
42.00	NURSERY (title V & XIX only)	1. 00 0	2.00	3.00	4.00	5. 00	42.00
42.00	Intensive Care Type Inpatient Hospital Units	U _I	0	0.00	<u>)</u>	0	42.00
43.00	INTENSIVE CARE UNIT	12, 639, 435	7, 320	1, 726. 70	4, 297	7, 419, 630	43.00
44. 00	CORONARY CARE UNIT						44.00
45. 00 46. 00	BURN INTENSIVE CARE UNIT SURGICAL INTENSIVE CARE UNIT						45. 00 46. 00
	INTENSIVE NURSERY	4, 047, 848	3, 441	1, 176. 3	0	0	47. 00
	Cost Center Description					1.00	
48. 00	Program inpatient ancillary service cost (Wk	st D-3 col 3	R line 200)			1. 00 35, 231, 068	48. 00
	Total Program inpatient costs (sum of lines			ons)		69, 472, 375	
F0 00	PASS THROUGH COST ADJUSTMENTS		(6	WI I D	C David and a	0 (04 7(0	F0 00
50. 00	Pass through costs applicable to Program inp	attent routine	services (Tro	m wkst. D, Sun	i or Parts i and	3, 621, 763	50.00
51.00	Pass through costs applicable to Program inp	atient ancillar	ry services (f	rom Wkst. D, s	um of Parts II	3, 387, 407	51.00
52. 00	and IV) Total Program excludable cost (sum of lines	50 and 51)				7, 009, 170	52. 00
53.00	Total Program inpatient operating cost exclu	,	elated, non-ph	ysician anesth	etist, and	62, 463, 205	
	medical education costs (line 49 minus line	52)	•				
54 OO	TARGET AMOUNT AND LIMIT COMPUTATION Program discharges					0	54.00
55. 00	Target amount per discharge					0.00	
	Target amount (line 54 x line 55)					0	56.00
57.00	Difference between adjusted inpatient operat	ing cost and ta	arget amount (line 56 minus	line 53)	0	57.00
58. 00 59. 00	Bonus payment (see instructions) Lesser of lines 53/54 or 55 from the cost re	porting period	endi na 1996	undated and co	mpounded by the	0.00	58. 00 59. 00
07.00	market basket	por tring period	charing 1770,	apaarea ana ee	impounded by the		07.00
60.00	Lesser of lines 53/54 or 55 from prior year If line 53/54 is less than the lower of line				*l l	0.00	60.00
61. 00	which operating costs (line 53) are less than					0	61. 00
	amount (line 56), otherwise enter zero (see	instructions)			Ü	_	
62. 00 63. 00	, , ,	ent (see instri	ıcti ons)			0 0	
00.00	PROGRAM INPATIENT ROUTINE SWING BED COST					0	00.00
64. 00	Medicare swing-bed SNF inpatient routine cos	ts through Dece	ember 31 of th	e cost reporti	ng period (See	0	64.00
65. 00	instructions)(title XVIII only) Medicare swing-bed SNF inpatient routine cos	ts after Decemb	per 31 of the	cost reporting	period (See	0	65.00
66. 00	instructions)(title XVIII only) Total Medicare swing-bed SNF inpatient routi	ne costs (line	64 plus line	65)(title XVII	l only). For	0	66.00
67. 00	CAH (see instructions) Title V or XIX swing-bed NF inpatient routin	e costs through	n December 31	of the cost re	porting period	0	67.00
68. 00	(line 12 x line 19) Title V or XIX swing-bed NF inpatient routin	e costs after [December 31 of	the cost repo	rting period	0	68. 00
69. 00	(line 13 x line 20) Total title V or XIX swing-bed NF inpatient	routine costs ([line 67 + line	e 68)		0	69. 00
	PART III - SKILLED NURSING FACILITY, OTHER NI						
70. 00 71. 00	Skilled nursing facility/other nursing facil Adjusted general inpatient routine service c						70. 00 71. 00
72. 00	Program routine service cost (line 9 x line			-/			72.00
73.00	Medically necessary private room cost applic		•				73.00
74. 00 75. 00	Total Program general inpatient routine serv Capital-related cost allocated to inpatient				art II, column		74. 00 75. 00
76. 00	26, line 45) Per diem capital-related costs (line 75 ÷ li	ne 2)					76. 00
77. 00	Program capital -related costs (line 9 x line						77. 00
	Inpatient routine service cost (line 74 minu			-1->			78.00
79. 00 80. 00					us line 79)		79. 00 80. 00
81.00	Inpatient routine service cost per diem limi			(, ,		81.00
82.00	Inpatient routine service cost limitation (I						82.00
83. 00 84. 00	Reasonable inpatient routine service costs (Program inpatient ancillary services (see in		15)				83. 00 84. 00
85. 00	Utilization review - physician compensation		ons)				85.00
86. 00	Total Program inpatient operating costs (sum		rough 85)				86.00
87. 00	PART IV - COMPUTATION OF OBSERVATION BED PASS Total observation bed days (see instructions					9, 706	87. 00
88. 00	Adjusted general inpatient routine cost per	diem (line 27 ÷	,			1, 079. 43	88.00
89. 00	Observation bed cost (line 87 x line 88) (se	e instructions)	1			10, 476, 948	89.00

Health Financial Systems	UNI ON HOSPI	TAL, INC.		In Lie	u of Form CMS-2	2552-10
COMPUTATION OF INPATIENT OPERATING COST		Provi der CO		Peri od:	Worksheet D-1	
				From 01/01/2017 To 12/31/2017	Date/Time Pre 5/30/2018 2:1	pared: 8 pm
		Title	XVIII	Hospi tal	PPS	
Cost Center Description	Cost	Routine Cost	column 1 ÷	Total	Observation	
		(from line	column 2	Observati on	Bed Pass	
		21)		Bed Cost	Through Cost	
				(from line	(col. 3 x	
				89)	col. 4) (see	
					instructions)	
	1. 00	2.00	3. 00	4. 00	5. 00	
COMPUTATION OF OBSERVATION BED PASS THROUGH	COST					
90.00 Capital -related cost	6, 670, 729	63, 413, 267	0. 10519	10, 476, 948	1, 102, 123	90.00
91.00 Nursing School cost	0	63, 413, 267	0.00000	10, 476, 948	0	91.00
92.00 Allied health cost	0	63, 413, 267	0. 00000	10, 476, 948	0	92.00
93.00 All other Medical Education	0	63, 413, 267	0. 00000	10, 476, 948	0	93.00

Health Financial Systems	UNION HOSPITAL, INC.	In Lie	u of Form CMS-2552-10
COMPUTATION OF INPATIENT OPERATING COST	Provi der CCN: 15-0023	Peri od:	Worksheet D-1
		From 01/01/2017	
	Component CCN: 15-T023	To 12/31/2017	
	·		5/30/2018 2:18 pm
	Title XVIII	Subprovi der -	PPS
		I RF	

		I RF		
	Cost Center Description		1 00	
	PART I - ALL PROVIDER COMPONENTS		1. 00	
	INPATIENT DAYS			
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)		3, 432	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)		3, 432	2.00
3. 00	Private room days (excluding swing-bed and observation bed days). If you have only pri	vate room days,	0	3.00
4. 00	do not complete this line. Semi-private room days (excluding swing-bed and observation bed days)		3, 432	4. 00
5. 00	Total swing-bed SNF type inpatient days (including private room days) through December	31 of the cost	3, 432	5. 00
0.00	reporting period	0. 0	Ü	0.00
6.00	Total swing-bed SNF type inpatient days (including private room days) after December 3	31 of the cost	0	6.00
7.00	reporting period (if calendar year, enter 0 on this line)			7 00
7. 00	Total swing-bed NF type inpatient days (including private room days) through December reporting period	31 of the cost	0	7. 00
8. 00	Total swing-bed NF type inpatient days (including private room days) after December 31	of the cost	0	8. 00
	reporting period (if calendar year, enter 0 on this line)			
9. 00	Total inpatient days including private room days applicable to the Program (excluding	swi ng-bed and	2, 194	9. 00
10. 00	newborn days) Swing-bed SNF type inpatient days applicable to title XVIII only (including private ro	om dave)	0	10. 00
10.00	through December 31 of the cost reporting period (see instructions)	Joili days)	U	10.00
11.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private ro	oom days) after	0	11.00
	December 31 of the cost reporting period (if calendar year, enter 0 on this line)			
12. 00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private	e room days)	0	12. 00
13. 00	through December 31 of the cost reporting period Swing-bed NF type inpatient days applicable to titles V or XLX only (including private	room days)	0	13. 00
	after December 31 of the cost reporting period (if calendar year, enter 0 on this line		Ü	.0.00
14.00	Medically necessary private room days applicable to the Program (excluding swing-bed of	lays)	0	
	Total nursery days (title V or XIX only)		0	15.00
16. 00	Nursery days (title V or XIX only) SWING BED ADJUSTMENT		0	16. 00
17. 00	Medicare rate for swing-bed SNF services applicable to services through December 31 of	the cost	0.00	17. 00
	reporting period		0.00	.,, 00
18. 00	Medicare rate for swing-bed SNF services applicable to services after December 31 of t	the cost	0. 00	18. 00
10.00	reporting period	464	0.00	10.00
19. 00	Medicaid rate for swing-bed NF services applicable to services through December 31 of reporting period	the cost	0.00	19. 00
20. 00	Medicaid rate for swing-bed NF services applicable to services after December 31 of th	ne cost	0.00	20. 00
	reporting period			
21. 00	Total general inpatient routine service cost (see instructions)		3, 181, 488	
22. 00	Swing-bed cost applicable to SNF type services through December 31 of the cost reporti 5×1 ine 17)	ng period (line	0	22. 00
23. 00	Swing-bed cost applicable to SNF type services after December 31 of the cost reporting	period (line 6	0	23. 00
	x line 18)			
24. 00	Swing-bed cost applicable to NF type services through December 31 of the cost reportir	ng period (line	0	24.00
25. 00	7 x line 19) Swing-bed cost applicable to NF type services after December 31 of the cost reporting	poriod (line 9	0	25. 00
25.00	x line 20)	perrou (Trile 8	U	23.00
26.00	Total swing-bed cost (see instructions)		0	26.00
27. 00	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)		3, 181, 488	27. 00
20.00	PRI VATE ROOM DI FFERENTI AL ADJUSTMENT		-	20.00
	General inpatient routine service charges (excluding swing-bed and observation bed charges rivate room charges (excluding swing-bed charges)	ir ges)	0	
30.00	Semi-private room charges (excluding swing-bed charges)		0	
31.00	General inpatient routine service cost/charge ratio (line 27 ÷ line 28)		0.000000	
	Average private room per diem charge (line 29 ÷ line 3)		0.00	
33.00	Average semi-private room per diem charge (line 30 ÷ line 4)		0.00	
34. 00 35. 00	Average per diem private room charge differential (line 32 minus line 33)(see instruct Average per diem private room cost differential (line 34 x line 31)	(i ons)	0. 00 0. 00	
36. 00	Private room cost differential adjustment (line 3 x line 35)		0.00	36.00
37. 00	General inpatient routine service cost net of swing-bed cost and private room cost dif	ferential (line	-	
	27 minus line 36)	,		
	PART II - HOSPITAL AND SUBPROVIDERS ONLY			
38. 00	PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS Adjusted general inpatient routine service cost per diem (see instructions)	T	927. 01	38. 00
	Program general inpatient routine service cost per drem (see instructions)		2, 033, 860	
	Medically necessary private room cost applicable to the Program (line 14 x line 35)		0	40.00
41. 00	Total Program general inpatient routine service cost (line 39 + line 40)		2, 033, 860	41.00

Heal th	Financial Systems	UNION HOSPIT	AL, INC.		In Lie	u of Form CMS-2	2552-10
СОМРИТ	ATION OF INPATIENT OPERATING COST			CCN: 15-0023 CCN: 15-T023	Peri od: From 01/01/2017 To 12/31/2017		pared:
			Ti tl	e XVIII	Subprovider -	5/30/2018 2:1 PPS	8 pm
	Cost Center Description	Total Inpatient Cost	Total Inpatient Days	Average Pe Diem (col. ÷ col. 2)		Program Cost (col. 3 x col. 4)	
10.00	NUDCEDY (1:11 - V o VIV - 1)	1. 00	2. 00	3.00	4.00	5. 00	40.00
42.00	NURSERY (title V & XIX only) Intensive Care Type Inpatient Hospital Units	0		0 0.	00 0	0	42.00
43.00	INTENSIVE CARE UNIT	0		0.	00 0	0	
44. 00 45. 00	CORONARY CARE UNIT BURN INTENSIVE CARE UNIT						44. 00 45. 00
46.00	SURGICAL INTENSIVE CARE UNIT				00		46.00
47.00	INTENSIVE NURSERY Cost Center Description	0		0 0.	00 0	0	47. 00
40.00	December 1 and 1 a	-+ 0.21 2	1: 200)			1. 00	10.00
48. 00 49. 00	Program inpatient ancillary service cost (Wk: Total Program inpatient costs (sum of lines			ons)		1, 052, 635 3, 086, 495	1
	PASS THROUGH COST ADJUSTMENTS				a£ Dausta I aus	202 211	F0 00
50. 00	Pass through costs applicable to Program inpa	atient routine s	services (Tro	OM WKST. D, S	um ot Parts I and	303, 211	50.00
51. 00	Pass through costs applicable to Program inpand IV)	atient ancillar	y services (1	from Wkst. D,	sum of Parts II	149, 536	51.00
52.00	Total Program excludable cost (sum of lines!					452, 747	52.00
53. 00	Total Program inpatient operating cost exclude medical education costs (line 49 minus line !	9 1	lated, non-pl	nysician anes	thetist, and	2, 633, 748	53.00
	TARGET AMOUNT AND LIMIT COMPUTATION	32)					1
	Program discharges Target amount per discharge					0 0. 00	1
56. 00	Target amount (line 54 x line 55)					0.00	1
57. 00 58. 00	Difference between adjusted inpatient operations	ing cost and ta	rget amount	(line 56 minu	s line 53)	0	
59.00	Bonus payment (see instructions) Lesser of lines 53/54 or 55 from the cost re	porting period (endi ng 1996,	updated and	compounded by the	-	1
40.00	market basket					0.00	60.00
60. 00 61. 00	If line 53/54 is less than the lower of lines					0.00	1
	which operating costs (line 53) are less that amount (line 56), otherwise enter zero (see		s (lines 54)	x 60), or 1%	of the target		
62.00	Relief payment (see instructions)	ŕ				0	1
63. 00	Allowable Inpatient cost plus incentive paymer PROGRAM INPATIENT ROUTINE SWING BED COST	ent (see instru	ctions)			0	63.00
64. 00	Medicare swing-bed SNF inpatient routine cos	ts through Dece	mber 31 of th	ne cost repor	ting period (See	0	64. 00
65.00	instructions)(title XVIII only) Medicare swing-bed SNF inpatient routine cos	ts after Decembe	er 31 of the	cost reporti	ng period (See	0	65. 00
66. 00	instructions)(title XVIII only) Total Medicare swing-bed SNF inpatient routio	ne costs (line	64 plus line	65)(title XV	III only). For	0	66.00
67. 00	CAH (see instructions) Title V or XIX swing-bed NF inpatient routing	e costs through	December 31	of the cost	reporting period	0	67.00
68. 00	(line 12 x line 19) Title V or XIX swing-bed NF inpatient routing					0	
	(line 13 x line 20)				por tring period		
69.00	Total title V or XIX swing-bed NF inpatient of PART III - SKILLED NURSING FACILITY, OTHER NU					0	69.00
70.00	Skilled nursing facility/other nursing facili	ity/ICF/IID rou	tine service	cost (line 3	7)		70.00
71. 00 72. 00	Adjusted general inpatient routine service of Program routine service cost (line 9 x line	,	ine /o ÷ IIN6	5 2)			71. 00 72. 00
73.00	Medically necessary private room cost applica	able to Program					73. 00
74. 00 75. 00	Total Program general inpatient routine servi Capital-related cost allocated to inpatient				Part II, column		74. 00 75. 00
7/ 00	26, line 45)		•				
76. 00 77. 00	Per diem capital-related costs (line 75 ÷ line Program capital-related costs (line 9 x line						76. 00 77. 00
78.00	Inpatient routine service cost (line 74 minus			. 1. 2			78.00
79. 00 80. 00	Aggregate charges to beneficiaries for excess Total Program routine service costs for compa				inus line 79)		79. 00 80. 00
81.00	Inpatient routine service cost per diem limi	tati on		•	,		81.00
82. 00 83. 00	Inpatient routine service cost limitation (li Reasonable inpatient routine service costs (:						82. 00 83. 00
84.00	Program inpatient ancillary services (see in	structions)					84. 00
85. 00 86. 00	Utilization review - physician compensation						85. 00 86. 00
00.00	Total Program inpatient operating costs (sum PART IV - COMPUTATION OF OBSERVATION BED PASS		ough ob)				00.00
	Total observation bed days (see instructions)		Line 2)			0 00	
	Adjusted general inpatient routine cost per of Observation bed cost (line 87 x line 88) (see		1111e 2)				88. 00 89. 00
		,				-	•

Health Financial Systems	UNI ON HOSPI	TAL, INC.		In Lie	u of Form CMS-2	2552-10
COMPUTATION OF INPATIENT OPERATING COST		Provi der Co		Peri od:	Worksheet D-1	
		Component (CCN: 15-T023	From 01/01/2017 To 12/31/2017		
		Title	XVIII	Subprovi der -	PPS	
				I RF		
Cost Center Description	Cost	Routine Cost	column 1 ÷	Total	Observation	
		(from line	column 2	Observati on	Bed Pass	
		21)		Bed Cost	Through Cost	
		·		(from line	(col. 3 x	
				89)	col. 4) (see	
					instructions)	
	1. 00	2. 00	3. 00	4. 00	5. 00	
COMPUTATION OF OBSERVATION BED PASS THROUGH	COST					
90.00 Capital -related cost	474, 287	3, 181, 488	0. 1490	77 0	0	90.00
91.00 Nursing School cost	0	3, 181, 488	0. 00000	00	0	91.00
92.00 Allied health cost	0	3, 181, 488	0. 00000	00	0	92.00
93.00 All other Medical Education	0	3, 181, 488	0. 00000	00	0	93. 00

Heal th	Financial Systems UNION HOSPITAL,	I NC.	In Lie	u of Form CMS-2	2552-10
COMPUT	ATION OF INPATIENT OPERATING COST	rovi der CCN: 15-0023	Peri od:	Worksheet D-1	
			From 01/01/2017 To 12/31/2017	Date/Time Pre 5/30/2018 2:1	pared: 8 pm
		Title XIX	Hospi tal	Cost	
	Cost Center Description				
	DADT I ALL DOOM DED COMPONENTO			1. 00	
	PART I - ALL PROVIDER COMPONENTS				
1. 00	INPATIENT DAYS Inpatient days (including private room days and swing-bed days,	ovel udi na nowborn)		58, 747	1.00
2.00	Inpatient days (including private room days, excluding swing-bed			58, 747	2.00
3. 00	Private room days (excluding swing-bed and observation bed days)		ivate room days	0	3.00
0.00	do not complete this line.	y. It you have only pr	Tvate room days,	o .	0.00
4.00	Semi-private room days (excluding swing-bed and observation bed	days)		49, 041	4.00
5. 00	Total swing-bed SNF type inpatient days (including private room reporting period	days) through December	er 31 of the cost	0	5. 00
6. 00	Total swing-bed SNF type inpatient days (including private room reporting period (if calendar year, enter 0 on this line)	days) after December	31 of the cost	0	6. 00
7. 00	Total swing-bed NF type inpatient days (including private room (reporting period	days) through December	31 of the cost	0	7. 00
8. 00	Total swing-bed NF type inpatient days (including private room o	days) after December 3	1 of the cost	0	8. 00
9. 00	reporting period (if calendar year, enter 0 on this line) Total inpatient days including private room days applicable to	the Program (excluding	swing-bed and	1, 027	9. 00
10. 00	newborn days) Swing-bed SNF type inpatient days applicable to title XVIII only		oom days)	0	10. 00
11. 00	through December 31 of the cost reporting period (see instruction Swing-bed SNF type inpatient days applicable to title XVIII only	y (Íncluding private r	oom days) after	0	11. 00
12. 00	December 31 of the cost reporting period (if calendar year, ento Swing-bed NF type inpatient days applicable to titles V or XIX of		o room dovo)	0	12.00
12.00	through December 31 of the cost reporting period	only (frictualing privat	e room days)	U	12.00
13.00	Swing-bed NF type inpatient days applicable to titles V or XIX (0	13.00
	after December 31 of the cost reporting period (if calendar year			_	
14.00	Medically necessary private room days applicable to the Program	(excluding swing-bed	days)	0	
15. 00 16. 00	Total nursery days (title V or XIX only) Nursery days (title V or XIX only)			3, 497 0	
10.00	SWING BED ADJUSTMENT			U	10.00
17. 00	Medicare rate for swing-bed SNF services applicable to services	through December 31 c	of the cost	0.00	17. 00
18. 00	reporting period Medicare rate for swing-bed SNF services applicable to services	after December 31 of	the cost	0. 00	18. 00
19. 00	reporting period Medicaid rate for swing-bed NF services applicable to services	through December 31 of	the cost	0. 00	19. 00
20. 00	reporting period Medicaid rate for swing-bed NF services applicable to services a	after December 31 of t	he cost	0. 00	20. 00
	reporting period				
21. 00 22. 00	Total general inpatient routine service cost (see instructions) Swing-bed cost applicable to SNF type services through December		ing period (line	63, 413, 267 0	21. 00 22. 00
23. 00	5 x line 17) Swing-bed cost applicable to SNF type services after December 3	1 of the cost reportir	 ng period (line 6	0	23. 00
24.00	x line 18)	21 of the cost resert:	ng poriod (Line	0	24.00
24. 00	Swing-bed cost applicable to NF type services through December 3 7 x line 19)	·			24.00
25. 00	Swing-bed cost applicable to NF type services after December 31	or the cost reporting	period (line 8	0	25. 00

Impationt days (Including private room days and seing-bed days, excluding newborn) 58, 747 1.00		INPATIENT DAYS		
Inpatient days (Including private room days, excluding saing-bed and newborn days) 0.3.00 Private room days (cock using saing-bed and observation bed days). In you have only private room days (sectual in graphed by the private room days). In you have only private room days and the cost of the cost reporting period (if calendar year, enter 0 on this line) 0.5.00	1.00		58, 747	1.00
do not complete this line. 4.00 Semi-private room days (exectualing swing-bed and observation bed days) Total swing-bed SMF type inpatient days (including private room days) after December 31 of the cost reporting period (if callendar year, enter 0 on this line) 7.00 Total swing-bed SMF type inpatient days (including private room days) after December 31 of the cost reporting period (if callendar year, enter 0 on this line) 7.00 Total swing-bed SMF type inpatient days (including private room days) through December 31 of the cost reporting period of the cost reporting period (if callendar year, enter 0 on this line) 7.00 Total swing-bed SMF type inpatient days (including private room days) after December 31 of the cost reporting period of the cost reporting period (if callendar year, enter 0 on this line) 7.00 Total inpatient days including private room days) after December 31 of the cost reporting period (if callendar year, enter 0 on this line) 7.00 Swing-bed SMF type inpatient days applicable to the Program (excluding swing-bed and next period days) after December 31 of the cost reporting period (if callendar year, enter 0 on this line) 8.00 Swing-bed SMF type inpatient days applicable to thitle XMIII only (including private room days) after December 31 of the cost reporting period (if callendar year, enter 0 on this line) 1.00 Swing-bed SMF type inpatient days applicable to title XMIII only (including private room days) 1.00 Swing-bed SMF type inpatient days applicable to title XMIII only (including private room days) 1.00 Swing-bed SMF type inpatient days applicable to title XMIII only (including private room days) 1.00 Swing-bed NF type inpatient days applicable to title XMIII only (including private room days) 1.00 Swing-bed NF type inpatient days applicable to title XMIII only (including private room days) 1.00 Swing-bed NF type inpatient days applicable to title XMIII only (including private room days) 1.00 Swing-bed NF type inpatient days applicable to title XMIII only (including private	2.00		58, 747	2.00
Semi-private room days (excluding saing-bed and observation bed days) 5.00 Total sing-bed SMF type inpatient days (including private room days) after December 31 of the cost reporting period (including private room days) after December 31 of the cost reporting period (including private room days) after December 31 of the cost reporting period (including private room days) after December 31 of the cost reporting period (including private room days) after December 31 of the cost reporting period (including private room days) after December 31 of the cost reporting period (including private room days) after December 31 of the cost reporting period (including private room days) after December 31 of the cost reporting period (including private room days) after December 31 of the cost reporting period (including private room days) after December 31 of the cost reporting period (including private room days) after December 31 of the cost reporting period (see Instructions) 10.00 Swing-bed SMF type inpatient days applicable to title XVIII only (including private room days) after December 31 of the cost reporting period (including private room days) after December 31 of the cost reporting period (including private room days) after December 31 of the cost reporting period (including private room days) 13.00 Swing-bed MF type inpatient days applicable to title XVIII only (including private room days) 14.00 Swing-bed MF type inpatient days applicable to title XVIII only (including private room days) 15.00 Total nursery days (title v or XIX only) 16.00 Nursery days (title v or XIX only) 16.00 Nursery days (title v or XIX only) 17.00 Swing-bed SMF type proting period (including private room days) 18.00 Medically necessary private room days applicable to services after December 31 of the cost reporting period (including private room days) 18.00 Medically necessary private room days applicable to services after December 31 of the cost reporting period (including private room days) 18.00 Medically after a private room	3.00	Private room days (excluding swing-bed and observation bed days). If you have only private room days,	0	3.00
Total swing-bed SNF type inpatient days (including private room days) after December 31 of the cost reporting period (if cal endar year, enter 0 on this line)		do not complete this line.		
reporting period (if real endar year, enter 0 on this line) 7.00 Total saving-bed SNF type inpatient days (including private room days) after December 31 of the cost reporting period (if real endar year, enter 0 on this line) 8.00 Total saving-bed NF type inpatient days (including private room days) after December 31 of the cost reporting period (if real endar year, enter 0 on this line) 9.00 Total inpatient days including private room days after December 31 of the cost reporting period (if real endar year, enter 0 on this line) 10.00 Swing-bed SNF type inpatient days applicable to this line) 10.00 Swing-bed SNF type inpatient days applicable to this line) 10.00 Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) after through December 31 of the cost reporting period (see instructions) 11.00 Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) after through December 31 of the cost reporting period (including private room days) after 10.00 Swing-bed NF type inpatient days applicable to titles Vor XIX only (including private room days) 11.00 Swing-bed NF type inpatient days applicable to titles Vor XIX only (including private room days) 12.00 Swing-bed NF type inpatient days applicable to titles Vor XIX only (including private room days) 13.00 Swing-bed NF type inpatient days applicable to the Program (excluding swing-bed days) 14.00 Medically necessary private room days applicable to the Program (excluding swing-bed days) 15.00 Normore years (title Vor XIX only) 16.00 Normore years (title Vor XIX only) 17.00 Normore years (title Vor XIX only) 18.00 Medical rate for swing-bed SNF services applicable to services through December 31 of the cost reporting period (including private room days) 18.00 Medical rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period (line 6 2.0 Normore) 18.00 Medical rate for swing-bed SNF services after December 31 of the cost reporting period (line 6 2.0 Nor			· ·	•
Total saing-bed SNF type inpatient days (including private room days) after December 31 of the cost reporting period (if cal endar year, enter 0 on this line) 7.00	5. 00		0	5. 00
reporting period (if calendar year, enter 0 on this line) 7.00 Total swing-bed MF type inpatient days (including private room days) through becember 31 of the cost reporting period (if calendar year, enter 0 on this line) 9.00 Total swing-bed MF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line) 10.00 Swing-bed SMF type inpatient days applicable to the Program (excluding swing-bed and through December 31 of the cost reporting period (see instructions) 11.00 Swing-bed SMF type inpatient days applicable to title XVIII only (including private room days) after 0 period (private room days applicable to title XVIII only (including private room days) after 0 period (private room days applicable to title XVIII only (including private room days) after 0 period (private room days) after 1 period (if calendar year, enter 0 on this line) 1 period (if calendar				
7.00 Total swing-bed NF type inpatient days (including private room days) shrough December 31 of the cost reporting period (if calendar year, enter 0 on this line) 7.00 Total swing-bed NF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line) 7.00 Total inpatient days including private room days applicable to the Program (excluding swing-bed and 1,027 on 10,00 through December 31 of the cost reporting period (see instructions) 7.00 Swing-bed SNF type inpatient days applicable to the Title XVIII only (including private room days) after December 31 of the cost reporting period (see instructions) 7.00 Swing-bed SNF type inpatient days applicable to the Title XVIII only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line) 7.00 Swing-bed NF type inpatient days applicable to the Title XVIII only (including private room days) 7.01 Swing-bed NF type inpatient days applicable to the SVIX only (including private room days) 7.02 Swing-bed NF type inpatient days applicable to the Program (excluding swing-bed days) 7.03 Swing-bed NF type inpatient days applicable to the Program (excluding swing-bed days) 7.04 Total nursery days (title V or XIX only) 7.05 Swing-bed NF type inpatient days applicable to services through December 31 of the cost reporting period (including private room days) 7.06 Swing-bed December 31 of the cost reporting period (including private room days) 7.07 Swing-bed NF type inpatient days applicable to services after December 31 of the cost reporting period (including private room days) 7.00 Swing-bed December 31 of the cost reporting period (including private room days) 7.00 Swing-bed cost applicable to SWF type services after December 31 of the cost reporting period (including swing-bed SWF type services after December 31 of the cost reporting period (including swing-bed cost applicable to NF type services after December 31 of the cost reporting period (inc	6.00		0	6.00
reporting period 8. 00 Total swing-bed NF type inpatient days (including private room days) after becember 31 of the cost reporting period (if calendar year, enter 0 on this line) 9. 00 Total inpatient days including private room days applicable to the Program (excluding swing-bed and newborn days) 10. 00 Secondary type inpatient days applicable to title XVIII only (including private room days) 11. 00 Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) after 0 the December 31 of the cost reporting period (if calendar year, enter 0 on this line) 12. 00 Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) after 0 through becember 31 of the cost reporting period (if calendar year, enter 0 on this line) 13. 00 Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) 0 12. 00 through becember 31 of the cost reporting period (if calendar year, enter 0 on this line) 14. 00 Medically necessary private room days applicable to titles V or XIX only (including private room days) 1 14. 00 Medically necessary private room days applicable to the Program (excluding swing-bed days) 1 14. 00 Medically necessary private room days applicable to the Program (excluding swing-bed days) 1 14. 00 Medically necessary private room days applicable to services through December 31 of the cost 0. 00 17. 00 Medically necessary private room days applicable to services after December 31 of the cost 0. 00 17. 00 Medical care rate for swing-bed SNF services applicable to services after December 31 of the cost 0. 00 17. 00 Medical drate for swing-bed SNF services applicable to services after December 31 of the cost 0. 00 17. 00 Medical drate for swing-bed NF services applicable to services after December 31 of the cost 0. 00 17. 00 17. 00 Medical drate for swing-bed NF services after December 31 of the cost reporting period (line 0. 0. 0. 0. 0. 0. 0. 0. 0. 0. 0. 0. 0.	7 00		0	7 00
Total swing-bed NF type inpatient days (including private room days) after December 31 of the cost reporting period (if Calendar year, enter 0 on this line)	7.00		U	7.00
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PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS 38.00 Adjusted general inpatient routine service cost per diem (see instructions) 1,079.43 38.00 Program general inpatient routine service cost (line 9 x line 38) 1,108,575 39.00 40.00 Medically necessary private room cost applicable to the Program (line 14 x line 35) 0 40.00				
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40.00 Medically necessary private room cost applicable to the Program (line 14 x line 35) 0 40.00				1
				1
41.00 Total Program general impatrent routine service cost (Time 39 + Time 40)				
	41.00	Total Frogram general impatrent routine service cost (ITHE 39 + ITHE 40)	1, 108, 5/5	41.00

Heal th	Financial Systems	UNION HOSPIT	AL, INC.		In Lie	u of Form CMS-2	2552-10
COMPUT	ATION OF INPATIENT OPERATING COST		Provi der Co		Period: From 01/01/2017	Worksheet D-1	
					To 12/31/2017	Date/Time Pre 5/30/2018 2:1	
			_	e XIX	Hospi tal	Cost	
	Cost Center Description	Total Inpatient	Total Inpati ent	Average Per Diem (col. 1	Program Days	Program Cost (col. 3 x	
		Cost	Days	÷ col . 2)		col . 4)	
		1. 00	2. 00	3. 00	4. 00	5. 00	
42. 00	NURSERY (title V & XIX only)	2, 127, 591	3, 497	608. 40	0	0	42.00
43. 00	Intensive Care Type Inpatient Hospital Units INTENSIVE CARE UNIT	12, 639, 435	7, 320	1, 726. 70) 0	0	43.00
44.00	CORONARY CARE UNIT	12,007,100	., 626	1,720.70			44. 00
45.00	BURN INTENSIVE CARE UNIT						45.00
46.00	SURGICAL INTENSIVE CARE UNIT INTENSIVE NURSERY	4, 047, 848	3, 441	1, 176. 36	0		46. 00 47. 00
47.00	Cost Center Description	4, 047, 848	3, 441	1, 170. 30	, 0	0	47.00
10.00						1. 00	10.00
48. 00 49. 00	Program inpatient ancillary service cost (Wk Total Program inpatient costs (sum of lines			nns)		1, 106, 602 2, 215, 177	48. 00 49. 00
17.00	PASS THROUGH COST ADJUSTMENTS	, , ,		,			17.00
50.00	Pass through costs applicable to Program inp	atient routine s	servi ces (from	m Wkst. D, sum	of Parts I and	0	50.00
51.00	Pass through costs applicable to Program inp	atient ancillary	y services (fi	rom Wkst. D, s	um of Parts II	О	51.00
52. 00	and IV) Total Program excludable cost (sum of lines	50 and 51)				o	52. 00
53. 00	Total Program inpatient operating cost exclu		lated, non-ph	ysician anesth	etist, and	0	53.00
	medical education costs (line 49 minus line	52)					
54.00	TARGET AMOUNT AND LIMIT COMPUTATION Program discharges					0	54.00
55. 00	Target amount per discharge					0.00	
	Target amount (line 54 x line 55)					0	56.00
57.00	Difference between adjusted inpatient operat Bonus payment (see instructions)	ing cost and tai	rget amount (I	line 56 minus	line 53)	0	57. 00 58. 00
58. 00 59. 00	Lesser of lines 53/54 or 55 from the cost re	portina period e	endina 1996. i	updated and co	mpounded by the		
	market basket			•			
60. 00 61. 00	Lesser of lines 53/54 or 55 from prior year If line 53/54 is less than the lower of line				the amount by	0.00	60. 00 61. 00
01.00	which operating costs (line 53) are less than						01.00
	amount (line 56), otherwise enter zero (see	instructions)			-		
62. 00 63. 00	Relief payment (see instructions) Allowable Inpatient cost plus incentive paym	ent (see instru	ctions)			0 0	
	PROGRAM INPATIENT ROUTINE SWING BED COST						
64. 00	Medicare swing-bed SNF inpatient routine cos instructions)(title XVIII only)	ts through Decer	mber 31 of the	e cost reporti	ng period (See	0	64. 00
65.00	Medicare swing-bed SNF inpatient routine cos	ts after Decembe	er 31 of the d	cost reporting	period (See	O	65.00
66. 00	<pre>instructions)(title XVIII only) Total Medicare swing-bed SNF inpatient routi</pre>	ne costs (line d	64 plus line (65)(title XVII	I only). For	o	66.00
67. 00	CAH (see instructions) Title V or XIX swing-bed NF inpatient routin	e costs through	December 31 o	of the cost re	porting period	0	67. 00
	(line 12 x line 19)						
68.00	Title V or XIX swing-bed NF inpatient routin (line 13 x line 20)	e costs after De	ecember 31 or	the cost repo	rting period	0	68. 00
69. 00	Total title V or XIX swing-bed NF inpatient PART III - SKILLED NURSING FACILITY, OTHER N					0	69. 00
70.00	Skilled nursing facility/other nursing facil						70.00
71.00	Adjusted general inpatient routine service c		ine 70 ÷ line	2)			71.00
72. 00 73. 00	Program routine service cost (line 9 x line Medically necessary private room cost applic	•	(line 14 x li	ine 35)			72. 00 73. 00
74.00	Total Program general inpatient routine serv		•				74. 00
75. 00	Capital-related cost allocated to inpatient 26, line 45)	routine service	costs (from \	Worksheet B, P	art II, column		75. 00
76. 00	Per diem capital-related costs (line 75 ÷ li	ne 2)					76.00
77. 00	Program capital-related costs (line 9 x line						77.00
78. 00 79. 00	Inpatient routine service cost (line 74 minu Aggregate charges to beneficiaries for exces		rovi der record	ds)			78. 00 79. 00
80.00	Total Program routine service costs for comp			*.	us line 79)		80.00
81.00	Inpatient routine service cost per diem limi						81.00
82. 00 83. 00	Inpatient routine service cost limitation (I Reasonable inpatient routine service costs (82. 00 83. 00
84. 00	Program inpatient ancillary services (see in		-,				84. 00
85.00	Utilization review - physician compensation	(see instruction					85.00
86. 00	Total Program inpatient operating costs (sum PART IV - COMPUTATION OF OBSERVATION BED PASS		rough 85)				86. 00
87. 00	Total observation bed days (see instructions					9, 706	87. 00
88.00	Adjusted general inpatient routine cost per Observation had cost (line 97 x line 99) (see	•	line 2)			1, 079. 43 10, 476, 948	
U7. UU	Observation bed cost (line 87 x line 88) (se	c manuchons)				10,470,748	U7. UU

Health Financial Systems	UNI ON HOSPI	TAL, INC.		In Lie	u of Form CMS-2	2552-10
COMPUTATION OF INPATIENT OPERATING COST		Provi der CO		Peri od:	Worksheet D-1	
				From 01/01/2017 To 12/31/2017	Date/Time Pre 5/30/2018 2:1	
		Ti tl	e XIX	Hospi tal	Cost	
Cost Center Description	Cost	Routine Cost	column 1 ÷	Total	Observation	
		(from line	column 2	Observati on	Bed Pass	
		21)		Bed Cost	Through Cost	
				(from line	(col. 3 x	
				89)	col. 4) (see	
					instructions)	
	1. 00	2.00	3. 00	4. 00	5. 00	
COMPUTATION OF OBSERVATION BED PASS THROUGH	COST					
90.00 Capital -related cost	6, 670, 729	63, 413, 267	0. 10519	5 10, 476, 948	1, 102, 123	90.00
91.00 Nursing School cost	0	63, 413, 267	0.00000	0 10, 476, 948	0	91.00
92.00 Allied health cost	0	63, 413, 267	0. 00000	0 10, 476, 948	0	92.00
93.00 All other Medical Education	0	63, 413, 267	0.00000	0 10, 476, 948	0	93.00

Health Financial Systems	UNION HOSPITAL, INC.	In Lie	u of Form CMS-2552-10
COMPUTATION OF INPATIENT OPERATING COST	Provi der CCN: 15-0023	Peri od: From 01/01/2017	Worksheet D-1
	Component CCN: 15-T023		
	Title XIX	Subprovi der -	Cost
		IRF	

			I RF		
	Cost Center Description		-	1. 00	
	PART I - ALL PROVIDER COMPONENTS			1.00	
	INPATIENT DAYS				
1.00	Inpatient days (including private room days and swing-bed day Inpatient days (including private room days, excluding swing-			3, 432 3, 432	1. 00 2. 00
2. 00 3. 00	Private room days (excluding swing-bed and observation bed da		ivate room days	3, 432	3.00
0.00	do not complete this line.	ус) уси наче с.н.у р.	. varo i com dayo,	· ·	0.00
4.00	Semi-private room days (excluding swing-bed and observation b			3, 432	4. 00
5. 00	Total swing-bed SNF type inpatient days (including private roreporting period	om days) through Decembe	r 31 of the cost	0	5. 00
6. 00	Total swing-bed SNF type inpatient days (including private ro	om days) after December	31 of the cost	0	6. 00
7 00	reporting period (if calendar year, enter 0 on this line)	m daya) through Dagambar	21 of the cost	0	7 00
7. 00	Total swing-bed NF type inpatient days (including private roo reporting period	ili days) through beceiliber	31 Of the Cost	U	7. 00
8. 00	Total swing-bed NF type inpatient days (including private roo	m days) after December 3	1 of the cost	0	8. 00
0.00	reporting period (if calendar year, enter 0 on this line)	- the Discourse (evel)		0	0.00
9. 00	Total inpatient days including private room days applicable t newborn days)	the Program (excluding	Swifig-bed and	0	9. 00
10.00	Swing-bed SNF type inpatient days applicable to title XVIII o	nly (including private r	oom days)	0	10.00
44 00	through December 31 of the cost reporting period (see instruc				44.00
11. 00	Swing-bed SNF type inpatient days applicable to title XVIII o December 31 of the cost reporting period (if calendar year, e		oom days) after	0	11. 00
12. 00	Swing-bed NF type inpatient days applicable to titles V or XI		e room days)	0	12.00
	through December 31 of the cost reporting period				
13. 00	Swing-bed NF type inpatient days applicable to titles V or XI			0	13. 00
14. 00	after December 31 of the cost reporting period (if calendar y Medically necessary private room days applicable to the Progr			0	14.00
15. 00	Total nursery days (title V or XIX only)	am (exercarring emring sear	uayo)	3, 497	
16. 00	Nursery days (title V or XIX only)			0	16. 00
17. 00	SWING BED ADJUSTMENT Medicare rate for swing-bed SNF services applicable to service	os through Dosombor 21 o	f the cost	0.00	17. 00
17.00	reporting period	es through becember 31 o	i the cost	0.00	17.00
18.00	Medicare rate for swing-bed SNF services applicable to servic	es after December 31 of	the cost	0.00	18. 00
19. 00	reporting period Medicaid rate for swing-bed NF services applicable to service	s through Docombor 21 of	the cost	0.00	19. 00
19.00	reporting period	s through becember 31 or	the cost	0.00	19.00
20. 00	Medicaid rate for swing-bed NF services applicable to service reporting period	s after December 31 of t	he cost	0. 00	20. 00
21. 00	Total general inpatient routine service cost (see instruction	s)		3, 181, 488	21. 00
22. 00	Swing-bed cost applicable to SNF type services through Decemb		ing period (line		22. 00
22.00	5 x line 17)	21 -6		0	22.00
23. 00	Swing-bed cost applicable to SNF type services after December x line 18)	31 of the cost reporting	g period (iine 6	0	23. 00
24. 00	Swing-bed cost applicable to NF type services through Decembe	r 31 of the cost reporti	ng period (line	0	24. 00
25. 00	7 x line 19) Swing-bed cost applicable to NF type services after December	31 of the cost reporting	period (line 8	0	25. 00
	x line 20)				
	Total swing-bed cost (see instructions)	(line 21 minus line 24)		2 101 400	26.00
27.00	General inpatient routine service cost net of swing-bed cost PRIVATE ROOM DIFFERENTIAL ADJUSTMENT	(TTHE 21 IIITHUS TTHE 26)		3, 181, 488	27.00
28. 00	General inpatient routine service charges (excluding swing-be	d and observation bed ch	arges)	0	28. 00
	Private room charges (excluding swing-bed charges)			0	29. 00
30.00	Semi-private room charges (excluding swing-bed charges)	11		0	30.00
31.00	General inpatient routine service cost/charge ratio (line 27	÷ line 28)		0.000000	31.00
32. 00 33. 00	Average private room per diem charge (line 29 ÷ line 3) Average semi-private room per diem charge (line 30 ÷ line 4)			0. 00 0. 00	32. 00 33. 00
34. 00	Average per diem private room charge differential (line 32 mi	nue lina 33)(ega instruc	tions)	0.00	
35.00	Average per diem private room cost differential (line 34 x li		11 0113)	0.00	35.00
36.00	Private room cost differential adjustment (line 3 x line 35)	01)		0.00	36.00
37. 00	General inpatient routine service cost net of swing-bed cost	and private room cost di	fferential (line		
	27 minus line 36)	,			
	PART II - HOSPITAL AND SUBPROVIDERS ONLY	ICTMENTS			
20 00	PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJ Adjusted general inpatient routine service cost per diem (see		Г	027 01	38. 00
38. 00 39. 00	Program general inpatient routine service cost per diem (see	,		927. 01 0	38.00
	Medically necessary private room cost applicable to the Progr	•		0	40.00
	Total Program general inpatient routine service cost (line 39			0	

	Financial Systems	UNION HOSPIT			In Lie	u of Form CMS-	2552-10
COMPUT	ATION OF INPATIENT OPERATING COST			CN: 15-0023	Peri od: From 01/01/2017	Worksheet D-1	
			· ·	CCN: 15-T023	To 12/31/2017	Date/Time Pre 5/30/2018 2:1	
			litl	e XIX	Subprovi der - I RF	Cost	
	Cost Center Description	Total Inpatient Cost	Total Inpatient Days	Average Per Diem (col. ÷ col. 2)		Program Cost (col. 3 x col. 4)	
40.00	NUDGEDY (1) 11 - V o VIV - 1	1. 00	2.00	3. 00	4.00	5. 00	40.00
42.00	NURSERY (title V & XIX only) Intensive Care Type Inpatient Hospital Units	0	0	0. (00 0	0	42.00
43. 00 44. 00	INTENSIVE CARE UNIT	0	O	0. (00 0	0	43. 00 44. 00
45. 00	BURN INTENSIVE CARE UNIT						45. 00
	SURGICAL INTENSIVE CARE UNIT	0	0	0. (00	0	46. 00 47. 00
171.00	Cost Center Description		J		50 0		177.00
48. 00	Program inpatient ancillary service cost (Wk	st. D-3, col. 3	, line 200)			1.00	48. 00
49. 00	Total Program inpatient costs (sum of lines - PASS THROUGH COST ADJUSTMENTS			ons)		0	49. 00
50.00	Pass through costs applicable to Program inp	atient routine	servi ces (fro	m Wkst. D, su	m of Parts I and	0	50. 00
51. 00	<pre> </pre>	atient ancillar	y services (f	rom Wkst. D,	sum of Parts II	0	51.00
52. 00	and IV) Total Program excludable cost (sum of lines	50 and 51)				0	52.00
53. 00	Total Program inpatient operating cost exclu	ding capital re	lated, non-ph	ysician anest	hetist, and	0	
	medical education costs (line 49 minus line 1 TARGET AMOUNT AND LIMIT COMPUTATION	52)					
54. 00 55. 00	Program discharges Target amount per discharge						54. 00 55. 00
56. 00	Target amount (line 54 x line 55)					0.00	
57. 00 58. 00	, , , , , , , , , , , , , , , , , , ,						57. 00 58. 00
59. 00	DO Lesser of lines 53/54 or 55 from the cost reporting period ending 1996, updated and compounded by the						59. 00
60. 00	market basket .00 Lesser of lines 53/54 or 55 from prior year cost report, updated by the market basket						60.00
61. 00	61.00 If line 53/54 is less than the lower of lines 55, 59 or 60 enter the lesser of 50% of the amount by which operating costs (line 53) are less than expected costs (lines 54 x 60), or 1% of the target						61.00
	amount (line 56), otherwise enter zero (see		3 (TITIES 54 X	00), 01 1% 0	ine target		
	.00 Relief payment (see instructions) .00 Allowable Inpatient cost plus incentive payment (see instructions)						62. 00 63. 00
	PROGRAM INPATIENT ROUTINE SWING BED COST						64. 00
	instructions)(title XVIII only)						
65. 00	Medicare swing-bed SNF inpatient routine cosinstructions)(title XVIII only)			·		0	65.00
66. 00	Total Medicare swing-bed SNF inpatient routing CAH (see instructions)	ne costs (line	64 plus line	65)(title XVI	II only). For	0	66.00
67. 00	Title V or XIX swing-bed NF inpatient routing (line 12 x line 19)	e costs through	December 31	of the cost r	reporting period	0	67. 00
68. 00	Title V or XIX swing-bed NF inpatient routing	e costs after D	ecember 31 of	the cost rep	orting period	0	68. 00
69. 00	(line 13 x line 20) Total title V or XIX swing-bed NF inpatient	routine costs (line 67 + lin	e 68)		0	69. 00
70. 00	PART III - SKILLED NURSING FACILITY, OTHER NU Skilled nursing facility/other nursing facil				')		70.00
71.00	Adjusted general inpatient routine service co	ost per diem (I			,		71.00
72. 00 73. 00	Program routine service cost (line 9 x line Medically necessary private room cost applications)	*	(line 14 x l	ine 35)			72.00 73.00
74.00	Total Program general inpatient routine serv	ice costs (line	72 + line 73)	Dorst II oolumn		74.00
75. 00	Capital-related cost allocated to inpatient 26, line 45)	routine service	COSTS (TIOIII	worksneet b,	Part II, Corumn		75.00
76. 00 77. 00	Per diem capital-related costs (line 75 ÷ li Program capital-related costs (line 9 x line						76. 00 77. 00
78. 00	Inpatient routine service cost (line 74 minus	s line 77)		-1->			78. 00
79. 00 80. 00	Aggregate charges to beneficiaries for excess Total Program routine service costs for compa				nus line 79)		79. 00 80. 00
81. 00 82. 00	Inpatient routine service cost per diem limi Inpatient routine service cost limitation ()				81. 00 82. 00
83.00	Reasonable inpatient routine service costs (see instruction	* .				83. 00
84. 00 85. 00	Program inpatient ancillary services (see in: Utilization review - physician compensation		ns)				84. 00 85. 00
	Total Program inpatient operating costs (sum	of lines 83 th					86. 00
87. 00	PART IV - COMPUTATION OF OBSERVATION BED PASS Total observation bed days (see instructions))				0	1
88. 00 89. 00	Adjusted general inpatient routine cost per observation bed cost (line 87 x line 88) (see	•	line 2)				88. 00 89. 00
		/				_	

Health Financial Systems	UNI ON HOSPI	TAL, INC.		In Lie	u of Form CMS-2	2552-10
COMPUTATION OF INPATIENT OPERATING COST		Provi der CO	Provi der CCN: 15-0023		Worksheet D-1	
		Component (From 01/01/2017 To 12/31/2017		
		Ti tl	e XIX	Subprovi der -	Cost	
				I RF		
Cost Center Description	Cost	Routine Cost	column 1 ÷	Total	Observation	
		(from line	column 2	Observati on	Bed Pass	
		21)		Bed Cost	Through Cost	
		·		(from line	(col. 3 x	
				89)	col. 4) (see	
					instructions)	
	1. 00	2.00	3. 00	4. 00	5. 00	
COMPUTATION OF OBSERVATION BED PASS THROUGH	COST					
90.00 Capital-related cost	474, 287	3, 181, 488	0. 1490	77 0	0	90.00
91.00 Nursing School cost	0	3, 181, 488	0. 00000	00	0	91.00
92.00 Allied health cost	0	3, 181, 488	0. 00000	00	0	92.00
93.00 All other Medical Education	0	3, 181, 488	0. 00000	00	0	93.00

	Financial Systems UNION I ENT ANCILLARY SERVICE COST APPORTIONMENT	HOSPITAL, INC. Provider C	CN: 15-0023	Peri od:	u of Form CMS-2 Worksheet D-3	
	ENT THOLESANT SERVICE GOOT THE ONLY ON MENT	Trovider of	014. 10 0020	From 01/01/2017		
				To 12/31/2017	Date/Time Pre 5/30/2018 2:1	
		Title	· XVIII	Hospi tal	PPS	<u>о р</u>
	Cost Center Description		Ratio of Cos	t Inpatient	I npati ent	
			To Charges	Program	Program Costs	
				Charges	(col . 1 x	
			1 00	2.00	col . 2)	
	INPATIENT ROUTINE SERVICE COST CENTERS		1. 00	2. 00	3. 00	
30. 00	03000 ADULTS & PEDIATRICS			46, 910, 892		30.00
	03100 I NTENSI VE CARE UNI T			13, 767, 501		31.00
35. 00	02040 I NTENSI VE NURSERY			0		35. 00
41.00	04100 SUBPROVI DER - I RF			0		41.00
43.00	04300 NURSERY					43.00
	ANCILLARY SERVICE COST CENTERS					1
50.00	05000 OPERATING ROOM		0. 11517	72 57, 286, 252	6, 597, 772	50.00
50. 01	05001 CARDI AC SURGERY		0. 54341	17 259, 254	140, 883	50. 01
	l l		0. 14265		0	
51.00	05100 RECOVERY ROOM		0. 41373		622, 831	1
	05101 O/P TREATMENT ROOM		1. 91963		307, 265	
52.00	05200 DELIVERY ROOM & LABOR ROOM		0. 33741	· ·	50, 867	
			0. 25058		1, 545, 559	1
55. 00 56. 00	05500 RADI OLOGY-THERAPEUTI C		0. 20017			
57. 00	05600 RADI 0I SOTOPE		0. 24161 0. 05873	· ·	117, 414 599, 378	1
58. 00	05800 MAGNETIC RESONANCE IMAGING (MRI)		0. 03673		279, 154	1
59. 00	05900 CARDI AC CATHETERI ZATI ON		0. 17207		2, 406, 927	1
60.00	06000 LABORATORY		0. 11573			
62.00	06200 WHOLE BLOOD & PACKED RED BLOOD CELLS		0. 43722		591, 718	1
65.00	06500 RESPIRATORY THERAPY		0. 33468		2, 834, 413	65.00
66.00	06600 PHYSI CAL THERAPY		0. 32518	3, 258, 255	1, 059, 532	66.00
66. 01	06601 PSYCHI ATRI C/PSYCHOLOGI CAL SERVI CES		0. 00000	00	0	66. 01
66. 02	06602 O/P PHYSICAL THERAPY		0. 34830	05	0	66. 02
67.00	06700 OCCUPATI ONAL THERAPY		0. 23814		463, 857	1
68.00	06800 SPEECH PATHOLOGY		0. 31624		144, 598	1
69. 00	06900 ELECTROCARDI OLOGY		0. 1788 <i>6</i>		1, 241, 068	1
69. 01	06901 CARDI AC REHAB		0. 71004	· ·	33, 618	1
70.00	07000 ELECTROENCEPHALOGRAPHY		0. 37401	· ·	332, 941	
	07100 MEDI CAL SUPPLI ES CHARGED TO PATI ENTS		1. 95740		678, 598	1
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS		0. 88085		3, 209, 492	
	07300 DRUGS CHARGED TO PATIENTS		0. 21439			
76. 00	03020 RENAL ACUTE OUTPATIENT SERVICE COST CENTERS		0. 53082	21 2, 270, 175	1, 205, 057	76. 00
90. 00	09000 CLINIC		0. 48010	04 0	0	90.00
90.05	09005 PATIENT NUTRITION		3. 23671		0	
	09007 WOUND CLINIC		0. 26638		4, 373	
	09100 EMERGENCY		0. 14296		1, 925, 309	
	09200 OBSERVATION BEDS (NON-DISTINCT PART)		0.76411			

0.764117

185, 953, 113

35, 231, 068 200. 00 201. 00 202. 00

92.00

200.00 201. 00 202. 00

92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)

Total (sum of lines 50 through 94 and 96 through 98)
Less PBP Clinic Laboratory Services-Program only charges (line 61)
Net charges (line 200 minus line 201)

NPATI ENT	ANCILLARY SERVICE COST APPORTIONMENT	Provi der CO	CN: 15-0023	Peri od:	Worksheet D-3	3
		Component	CCN: 15-T023	From 01/01/2017 To 12/31/2017	Date/Time Pre 5/30/2018 2:1	
		Title	XVIII	Subprovi der - I RF	PPS	о р
	Cost Center Description		Ratio of Cos		I npati ent	
			To Charges	Program Charges	Program Costs (col. 1 x col. 2)	
			1. 00	2. 00	3. 00	
	TIENT ROUTINE SERVICE COST CENTERS					
	O ADULTS & PEDI ATRI CS			0		30.0
	O INTENSIVE CARE UNIT			0		31. (
	O I NTENSI VE NURSERY			0 000 (11		35.0
	O SUBPROVI DER - I RF			2, 223, 614		41.0
	IO NURSERY LLARY SERVICE COST CENTERS					43.0
	O OPERATI NG ROOM		0. 1151	72 114, 460	13, 183	50.0
	1 CARDI AC SURGERY		0. 5434			
	wvsc		0. 1426			1
	RECOVERY ROOM		0. 4137		3, 372	51.
1.02 0510	10/P TREATMENT ROOM		1. 9196	36 1, 254	2, 407	51.
	O DELIVERY ROOM & LABOR ROOM		0. 3374			
	O RADI OLOGY-DI AGNOSTI C		0. 2505			
	O RADI OLOGY-THERAPEUTI C		0. 2001			
	IO RADI OI SOTOPE IO CT SCAN		0. 2416			
	O MAGNETIC RESONANCE IMAGING (MRI)		0. 0587 0. 1728			
9.00 0590	O CARDI AC CATHETERI ZATI ON		0. 1728			
	O LABORATORY		0. 1157			
	O WHOLE BLOOD & PACKED RED BLOOD CELLS		0. 4372			
	O RESPIRATORY THERAPY		0. 3346			1
6.00 0660	O PHYSI CAL THERAPY		0. 3251	1, 095, 248	356, 157	66.
	1 PSYCHI ATRI C/PSYCHOLOGI CAL SERVI CES		0. 0000			1
	2 O/P PHYSICAL THERAPY		0. 3483			
	O OCCUPATI ONAL THERAPY		0. 2381			
	IO SPEECH PATHOLOGY IO ELECTROCARDI OLOGY		0. 3162 0. 1788			
	11 CARDI AC REHAB		0. 7100			
	0 ELECTROENCEPHALOGRAPHY		0. 7100		•	1
	O MEDICAL SUPPLIES CHARGED TO PATIENTS		1. 9574	·		
	O IMPL. DEV. CHARGED TO PATIENTS		0. 8808	·		1
	DRUGS CHARGED TO PATIENTS		0. 2143	99 436, 163	93, 513	73.
	O RENAL ACUTE		0. 5308	21 80, 165	42, 553	76.
	ATIENT SERVICE COST CENTERS					
	O CLINIC		0. 4801			
	5 PATIENT NUTRITION		3. 2367		-	
	17 WOUND CLINIC O EMERGENCY		0. 2663			
	O BSERVATION BEDS (NON-DISTINCT PART)		0. 1429 0. 7641		1, 471 0	1
2.00 0920 00.00	Total (sum of lines 50 through 94 and 96 through 98)		0.7641	3, 981, 180		
01. 00	Less PBP Clinic Laboratory Services-Program only charges	(line 61)		3, 701, 100 N	1, 052, 035	200.
02.00	Net charges (line 200 minus line 201)	(3, 981, 180		202.

Heal th	Financial Systems	UNION HOSPITAL, INC.		In lie	u of Form CMS-2	2552-10
	ENT ANCILLARY SERVICE COST APPORTIONMENT	·		Period: From 01/01/2017 To 12/31/2017		pared:
		Tit	le XIX	Hospi tal	Cost	- p
	Cost Center Description		Ratio of Cos To Charges	t Inpatient	Inpatient Program Costs (col. 1 x col. 2)	
			1.00	2. 00	3. 00	
	INPATIENT ROUTINE SERVICE COST CENTERS		•			
30.00	03000 ADULTS & PEDIATRICS			1, 074, 009		30.00
	03100 INTENSIVE CARE UNIT			300, 114		31.00
35.00	02040 I NTENSI VE NURSERY			0		35.00
41.00	04100 SUBPROVI DER - I RF			68, 118		41.00
43.00	04300 NURSERY			922, 789		43.00
	ANCILLARY SERVICE COST CENTERS					
50.00	05000 OPERATING ROOM		0. 11495	2 621, 138	71, 401	50.00
50. 01	05001 CARDI AC SURGERY		0. 54341	7 0	0	50. 01
	05002 WVSC		0. 14265	3 0	0	50.02
	05100 RECOVERY ROOM		0. 41373	4 23, 715	9, 812	
51. 02	05101 0/P TREATMENT ROOM		1. 91963	6 0	0	51.02
	05200 DELIVERY ROOM & LABOR ROOM		0. 33741		59, 612	52.00
54.00	05400 RADI OLOGY-DI AGNOSTI C		0. 25058		28, 661	
55.00	05500 RADI OLOGY-THERAPEUTI C		0. 20017		1, 800	
	05600 RADI 0I SOTOPE		0. 24161		3, 057	
	05700 CT SCAN		0. 05873			
58. 00	05800 MAGNETIC RESONANCE IMAGING (MRI)		0. 17287	1 27, 730	4, 794	58.00

0. 190211

0.113838

0.437220

0.334681

0.325184

0.000000

0.348305

0. 238145

0.316249

0.178851

0.710043

0.374014

1.957407

0.880859

0. 214399

0.530821

0.480104

3. 222473

0.266386

0.142962

0.764117

77, 451

569, 648

28, 438

139, 429

66, 873

59, 966

13, 891

128, 229

2,044

32, 119

199, 090

48, 017

971, 790

34, 755

314, 605

3, 810, 748

3, 810, 748

118

0

0

14, 732

64,848

12, 434

46,664

21, 746

14, 281

4.393

22, 934

1, 451

12,013

389, 700

42, 296

18, 449

44, 977

0 90.00

31

0 92.00

1, 106, 602 200. 00

208, 351

0

0 66.02

59.00

60.00

62.00

65.00

66.00

66 01

68.00

69.00

69.01

70.00

71 00

72.00

73.00

76.00

90.05

90.07

91.00

201.00

202.00

05900 CARDI AC CATHETERI ZATI ON

06500 RESPIRATORY THERAPY

06602 0/P PHYSICAL THERAPY

06700 OCCUPATI ONAL THERAPY

07000 ELECTROENCEPHALOGRAPHY

07300 DRUGS CHARGED TO PATIENTS

OUTPATIENT SERVICE COST CENTERS

06600 PHYSI CAL THERAPY

06800 SPEECH PATHOLOGY

06900 ELECTROCARDI OLOGY

09005 PATIENT NUTRITION

06901 CARDI AC REHAB

03020 RENAL ACUTE

09007 WOUND CLINIC

09000 CLI NI C

91. 00 09100 EMERGENCY

06200 WHOLE BLOOD & PACKED RED BLOOD CELLS

06601 PSYCHI ATRI C/PSYCHOLOGI CAL SERVI CES

07100 MEDICAL SUPPLIES CHARGED TO PATIENTS

07200 IMPL. DEV. CHARGED TO PATIENTS

92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART)

Net charges (line 200 minus line 201)

Total (sum of lines 50 through 94 and 96 through 98)

Less PBP Clinic Laboratory Services-Program only charges (line 61)

06000 LABORATORY

59.00

60.00

62.00

65.00

66.00

66 01

66.02

67.00

68.00

69.00

69.01

70.00

71 00

72.00

73.00

76.00

90.00

90.05

90.07

200.00

201.00

202.00

INPATIENT A	ncial Systems UNION HOSPITAL NCILLARY SERVICE COST APPORTIONMENT	Provi der Co	CN: 15-0023	Peri od:	u of Form CMS-2 Worksheet D-3	
		Component (CCN: 15-T023	From 01/01/2017 To 12/31/2017	Date/Time Pre 5/30/2018 2:1	
		Ti tl	e XIX	Subprovi der -	Cost	Орш
	Cost Center Description		Ratio of Cos		I npati ent	
			To Charges	Program Charges	Program Costs (col. 1 x	
				onal goo	col . 2)	
			1. 00	2. 00	3. 00	
	IENT ROUTINE SERVICE COST CENTERS ADULTS & PEDIATRICS			O		30.00
	INTENSIVE CARE UNIT			0		31.00
	I NTENSI VE NURSERY			o		35. 0
	SUBPROVI DER - I RF			1		41.00
	NURSERY			o		43.00
	LARY SERVICE COST CENTERS					
	OPERATING ROOM		0. 1149		0	
	CARDI AC SURGERY		0. 5434		0	
50. 02 05002			0. 1426		0	
	RECOVERY ROOM		0. 4137		0	
	O/P TREATMENT ROOM		1. 9196		0	
	DELIVERY ROOM & LABOR ROOM		0. 3374		0	
	RADI OLOGY-DI AGNOSTI C RADI OLOGY-THERAPEUTI C		0. 2505		0	
	RADI OLOGY - THERAPEUTI C		0. 2001 0. 2416		0	1
	CT SCAN		0. 0587	- 1	0	
	MAGNETIC RESONANCE IMAGING (MRI)		0. 1728		0	
	CARDI AC CATHETERI ZATI ON		0. 1720		0	1
	LABORATORY		0. 1138		0	
	WHOLE BLOOD & PACKED RED BLOOD CELLS		0. 4372		0	
	RESPI RATORY THERAPY		0. 3346	81 0	0	65.0
6. 00 06600	PHYSI CAL THERAPY		0. 3251	84 0	0	66.0
	PSYCHI ATRI C/PSYCHOLOGI CAL SERVI CES		0.0000		0	66.0
	O/P PHYSICAL THERAPY		0. 3483		0	
	OCCUPATI ONAL THERAPY		0. 2381		0	
	SPEECH PATHOLOGY		0. 3162		0	
	ELECTROCARDI OLOGY		0. 1788		0	
	CARDI AC REHAB		0. 7100		0	1
1	ELECTROENCEPHALOGRAPHY		0. 3740		0	
	MEDICAL SUPPLIES CHARGED TO PATIENTS IMPL. DEV. CHARGED TO PATIENTS		1. 9574 0. 8808		0	
	DRUGS CHARGED TO PATTENTS		0. 2143		0	
	RENAL ACUTE		0. 5308		0	
	TIENT SERVICE COST CENTERS		0,000			1
	CLINIC		0. 4801	04 0	0	90.0
90. 05 09005	PATIENT NUTRITION		3. 2224		0	
	WOUND CLINIC		0. 2663		0	
1	EMERGENCY		0. 1429		0	
1	OBSERVATION BEDS (NON-DISTINCT PART)		0. 7641		0	
200. 00 201. 00	Total (sum of lines 50 through 94 and 96 through 98) Less PBP Clinic Laboratory Services-Program only charges	(1.1		0	0	200. 0 201. 0

Health Financial Systems	UNI ON HOSPITAL, INC.	In Lieu	u of Form CMS-2552-10
CALCULATION OF REIMBURSEMENT SETTLEMENT	Provi der CCN: 15-0023	Peri od: From 01/01/2017 To 12/31/2017	Worksheet E Part A Date/Time Prepared: 5/30/2018 2:18 pm

		Title XVIII	Hospi tal	5/30/2018 2: 1 PPS	8 pm
				1. 00	
	PART A - INPATIENT HOSPITAL SERVICES UNDER IPPS			1.00	
1. 00 1. 01	DRG Amounts Other than Outlier Payments DRG amounts other than outlier payments for discharges occurring pr	ior to October 1 (see	0 44, 979, 297	1. 00 1. 01
1. 02	instructions) DRG amounts other than outlier payments for discharges occurring on	1 (see	13, 660, 960	1. 02	
1. 03	<pre>instructions) DRG for federal specific operating payment for Model 4 BPCI for dis- 1 (see instructions)</pre>	0	1. 03		
1. 04	DRG for federal specific operating payment for Model 4 BPCI for discontinuous for the second specific operations of the second specific operat	charges occurring	on or after	0	1. 04
2. 00 2. 01	Outlier payments for discharges. (see instructions) Outlier reconciliation amount			410, 601 0	2. 00 2. 01
2. 02 3. 00	Outlier payment for discharges for Model 4 BPCI (see instructions) Managed Care Simulated Payments			0 6, 571, 215	2. 02 3. 00
4. 00	Bed days available divided by number of days in the cost reporting Indirect Medical Education Adjustment	period (see instru	ıcti ons)	205. 28	4. 00
5. 00	FTE count for allopathic and osteopathic programs for the most received before 12/31/1996. (see instructions)	nt cost reporting	period ending on	12. 22	5. 00
6. 00	FTE count for allopathic and osteopathic programs which meet the cr for new programs in accordance with 42 CFR 413.79(e)	iteria for an add-	on to the cap	0.00	6. 00
7. 00 7. 01	MMA Section 422 reduction amount to the IME cap as specified under ACA \S 5503 reduction amount to the IME cap as specified under 42 CFI			0. 00 0. 00	7. 00 7. 01
8. 00	cost report straddles July 1, 2011 then see instructions. Adjustment (increase or decrease) to the FTE count for allopathic allopathic allopathic allopathic accordance with 42 CFR 413.75(b), 413.79(c)(1998), and 67 FR 50069 (August 1, 2002).			0. 00	8. 00
8. 01	The amount of increase if the hospital was awarded FTE cap slots unreport straddles July 1, 2011, see instructions.	der § 5503 of the	ACA. If the cost	0. 00	8. 01
8. 02	The amount of increase if the hospital was awarded FTE cap slots frounder § 5506 of ACA. (see instructions)	om a closed teachi	ng hospital	0.00	8. 02
9. 00	Sum of lines 5 plus 6 minus lines (7 and 7.01) plus/minus lines (8, 8,01 and 8,02) (see instructions)				9. 00
10. 00 11. 00 12. 00	FTE count for allopathic and osteopathic programs in the current year count for residents in dental and podiatric programs. Current year allowable FTE (see instructions)	ar from your recor	rds	21. 04 0. 00 12. 22	11.00
13.00	Total allowable FTE count for the prior year. Total allowable FTE count for the penultimate year if that year end	ed on or after Sep	otember 30, 1997,	12. 22 12. 22	13.00
15. 00	otherwise enter zero. Sum of lines 12 through 14 divided by 3.				15.00
	Adjustment for residents in initial years of the program Adjustment for residents displaced by program or hospital closure				16. 00 17. 00
	Adjusted rolling average FTE count			12. 22	18. 00
	Current year resident to bed ratio (line 18 divided by line 4).			0. 059528	
	Prior year resident to bed ratio (see instructions) Enter the lesser of lines 19 or 20 (see instructions)			0. 056679 0. 056679	
22. 00	,			1, 787, 472	
22. 01	IME payment adjustment - Managed Care (see instructions)			200, 304	
23. 00			CFR 412. 105	8. 45	23. 00
24. 00	<pre>(f)(1)(iv)(C). IME FTE Resident Count Over Cap (see instructions)</pre>			8. 82	24. 00
25. 00	If the amount on line 24 is greater than -0-, then enter the lower (instructions)	of line 23 or line	e 24 (see	8. 45	
26.00	Resident to bed ratio (divide line 25 by line 4)			0. 041163	26.00
27. 00	IME payments adjustment factor. (see instructions)			0. 010871	27.00
	IME add-on adjustment amount (see instructions)			637, 478	
	IME add-on adjustment amount - Managed Care (see instructions)			71, 436	
29. 00 29. 01	Total IME payment (sum of lines 22 and 28) Total IME payment - Managed Care (sum of lines 22.01 and 28.01)			2, 424, 950 271, 740	
30 00	Disproportionate Share Adjustment Percentage of SSI recipient patient days to Medicare Part A patient	days (see instru	rtions)	5. 64	30. 00
	Percentage of Medicaid patient days (see instructions)	adys (see Ilisti ut	, (1 0113)	22. 95	
	Sum of lines 30 and 31			28. 59	
	Allowable disproportionate share percentage (see instructions)			12. 80	
34. 00	Disproportionate share adjustment (see instructions)			1, 876, 489	34.00

llool +h	Financial Cystems	AL INC	المانما	u of Form CMS (DEED 10
	Financial Systems UNION HOSPITA ATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 15-0023	Peri od:	u of Form CMS-2 Worksheet E	2552-10
CALCUL	ATTON OF RETWIDORSEMENT SETTLEMENT	FI OVI del CCN. 15-0025	From 01/01/2017		
			To 12/31/2017	Date/Time Pre	
		T: +1 - W/III	11! +-1	5/30/2018 2: 1	8 pm_
		Title XVIII	Hospi tal Pri or to 10/1	PPS	
			1.00	2.00	
	Uncompensated Care Adjustment		1.00	2.00	
35.00	Total uncompensated care amount (see instructions)		5, 977, 483, 147	6, 766, 695, 164	35.00
35. 01	Factor 3 (see instructions)		0. 000431893	0. 000489116	35.01
35. 02	Hospital uncompensated care payment (If line 34 is zero, ent	er zero on this line) (se	e 2, 581, 633	3, 309, 699	35. 02
	instructions)				
35. 03	Pro rata share of the hospital uncompensated care payment am	,	1, 930, 919		
36.00	Total uncompensated care (sum of columns 1 and 2 on line 35.		2, 765, 145		36. 00
40. 00	Additional payment for high percentage of ESRD beneficiary d Total Medicare discharges on Worksheet S-3, Part I excluding		0		40. 00
40.00	652, 682, 683, 684 and 685 (see instructions)	discharges for ms-blos			40.00
41.00	Total ESRD Medicare discharges excluding MS-DRGs 652, 682,	683, 684 an 685. (see	0		41.00
	instructions)	•			
41. 01	Total ESRD Medicare covered and paid discharges excluding MS	5-DRGs 652, 682, 683, 684	0		41.01
40	an 685. (see instructions)	16.6			40
42.00	Divide line 41 by line 40 (if less than 10%, you do not qual		0.00		42.00
43. 00	Total Medicare ESRD inpatient days excluding MS-DRGs 652, 6 instructions)	982, 683, 684 an 685. (See	9		43. 00
44. 00	Ratio of average length of stay to one week (line 43 divided	lby line 41 divided by 7	0. 000000		44. 00
11.00	days)	i by Title Tr di vided by 7	0.00000		11.00
45.00	Average weekly cost for dialysis treatments (see instruction	ıs)	0.00		45.00
46.00	Total additional payment (line 45 times line 44 times line 4	1.01)	0		46.00
47.00	Subtotal (see instructions)		66, 117, 442		47.00
48. 00	Hospital specific payments (to be completed by SCH and MDH,	small rural hospitals	0		48. 00
	only. (see instructions)			A	
				Amount 1.00	
49. 00	Total payment for inpatient operating costs (see instruction	ne)		66, 389, 182	49. 00
50. 00	Payment for inpatient program capital (from Wkst. L, Pt. I a			5, 314, 361	
51. 00	Exception payment for inpatient program capital (Wkst. L, Pt	• • • •		0	51.00
52.00	Direct graduate medical education payment (from Wkst. E-4, I	ine 49 see instructions).		694, 039	52.00
53.00	Nursing and Allied Health Managed Care payment			4, 513	
54.00	Special add-on payments for new technologies			781	54.00
54. 01		(0)		0	54. 01
55. 00 56. 00	Net organ acquisition cost (Wkst. D-4 Pt. III, col. 1, line Cost of physicians' services in a teaching hospital (see int	•		0	55. 00 56. 00
57. 00	Routine service other pass through costs (from Wkst. D, Pt.		hrough 35)	0	57.00
58. 00	Ancillary service other pass through costs from Wkst. D, Pt.		in ough oo).	85, 358	
59.00	Total (sum of amounts on lines 49 through 58)	,,		72, 488, 234	
60.00	Primary payer payments			15, 005	60.00
61. 00	Total amount payable for program beneficiaries (line 59 minu	ıs line 60)		72, 473, 229	
62.00	Deductibles billed to program beneficiaries			5, 984, 328	
63.00	1 9			163, 100	
	Allowable bad debts (see instructions)			241, 624	
65. 00 66. 00	Adjusted reimbursable bad debts (see instructions) Allowable bad debts for dual eligible beneficiaries (see ins	tructions)		157, 056 683, 990	65. 00 66. 00
67. 00	Subtotal (line 61 plus line 65 minus lines 62 and 63)	structrons)		66, 482, 857	67.00
68. 00	Credits received from manufacturers for replaced devices for	applicable to MS-DRGs (s	ee instructions		
69. 00	Outlier payments reconciliation (sum of lines 93, 95 and 96)	• •		0	69. 00
70.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)			0	70.00
70. 50	Rural Community Hospital Demonstration Project (§410A Demons	, ,	instructions)	0	70. 50
70. 87	Demonstration payment adjustment amount before sequestration	1		0	70. 87
70. 88	SCH or MDH volume decrease adjustment (contractor use only)			0	70.88
70. 89	Pioneer ACO demonstration payment adjustment amount (see ins	STERCTIONS)			70.89
70. 90 70. 91	HSP bonus payment HVBP adjustment amount (see instructions) HSP bonus payment HRR adjustment amount (see instructions)			0	70. 90 70. 91
70. 91 70. 92	, , ,				70. 91 70. 92
70. 92	HVBP payment adjustment amount (see instructions)			54, 565	70. 92
	HRR adjustment amount (see instructions)			-179, 056	
	Recovery of accelerated depreciation				70. 95

	Period: From 01/01/2017 To 12/31/2017	Date/Time Pre 5/30/2018 2:1	
le XVIII	Hospi tal	PPS	
FFY	(уууу)	Amount	_
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		1, 326, 955	
		0	71.0
		65, 147, 953	72.0
		0	73.0
ı		-127, 178	74.0
		1, 187, 122	75.0
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Health Financial Systems

LOW VOLUME CALCULATION EXHIBIT 4 Peri od: Worksheet E From 01/01/2017 To 12/31/2017 Part A Exhibit 4 Date/Time Prepared: 5/30/2018 2: 18 nm Provider CCN: 15-0023

							5/30/2018 2: 1	pareu: 8 pm
					XVIII	Hospi tal	PPS	
		W/S E, Part A line	Amounts (from E, Part A)	Pre/Post Entitlement	Period Prior to 10/01	Peri od On/After 10/01	Total (Col 2 through 4)	
_		0	1. 00	2. 00	3.00	4. 00	5. 00	
1. 00	DRG amounts other than outlier payments	1. 00	0	0	0	0	0	1. 00
1. 01	DRG amounts other than outlier payments for discharges occurring prior to October 1	1. 01	44, 979, 297	0	44, 979, 297		44, 979, 297	1. 01
1. 02	DRG amounts other than outlier payments for discharges occurring on or after October	1. 02	13, 660, 960	0		13, 660, 960	13, 660, 960	1. 02
1. 03	DRG for Federal specific operating payment for Model 4 BPCI occurring prior to October 1	1. 03	0	0	0		0	1. 03
1. 04	DRG for Federal specific operating payment for Model 4 BPCI occurring on or after October 1	1. 04	0	0		0	0	1.04
2. 00	Outlier payments for discharges (see instructions)	2. 00	410, 601	0	391, 306	19, 294	410, 600	2. 00
2. 01	Outlier payments for discharges for Model 4 BPCI	2. 02	0	0	0	0	0	2. 01
3. 00	Operating outlier reconciliation	2. 01	0	0	0	0	0	3. 00
4. 00	Managed care simulated payments	3. 00	6, 571, 215	0	4, 630, 836	1, 940, 379	6, 571, 215	4. 00
5. 00	Amount from Worksheet E, Part	21.00	0. 056679	0. 056679	0. 056679	0. 056679		5. 00
6. 00	A, line 21 (see instructions) IME payment adjustment (see	22. 00	1, 787, 472	0.030079		416, 413	1, 787, 472	6. 00
6. 01	instructions) IME payment adjustment for	22. 01	200, 304	0		0	200, 304	
	managed care (see instructions)							
7. 00	Indirect Medical Education Adju	27.00	0. 010871	0. 010871		0. 010871		7. 00
8. 00	(see instructions) IME adjustment (see	28. 00	637, 478			148, 508	637, 478	
8. 01	instructions) IME payment adjustment add on	28. 01	71, 436			21, 094	71, 436	
	for managed care (see instructions)							
9. 00	Total IME payment (sum of lines 6 and 8)	29. 00	2, 424, 950	0		564, 921	2, 424, 950	
9. 01	Total IME payment for managed care (sum of lines 6.01 and 8.01)	29. 01	271, 740	0	250, 646	21, 094	271, 740	9. 01
	Disproportionate Share Adjustme							
10. 00	Allowable disproportionate share percentage (see instructions)	33. 00	0. 1280	0. 1280	0. 1280	0. 1280		10. 00
11. 00	Disproportionate share adjustment (see instructions)	34. 00	1, 876, 489	0	1, 439, 338	437, 151	1, 876, 489	11. 00
11. 01	Uncompensated care payments	36. 00	2, 765, 145		1, 930, 919	834, 226	2, 765, 145	11. 01
12. 00	Additional payment for high per Total ESRD additional payment (see instructions)	46. 00	O beneficiary	0 o	0	0	0	12. 00
13. 00	Subtotal (see instructions)	47. 00	66, 117, 442	0	50, 600, 890	15, 516, 552	66, 117, 442	13.00
14. 00	Hospital specific payments (completed by SCH and MDH, small rural hospitals only.) (see instructions)	48. 00	0	0	0	0	0	14. 00
15. 00	Total payment for inpatient operating costs (see instructions)	49. 00	66, 389, 182	0	50, 851, 536	15, 537, 646	66, 389, 182	15. 00
16. 00	Payment for inpatient program capital (from Wkst. L, Pt. I, if applicable)	50. 00	5, 314, 361	0	4, 091, 184	1, 223, 177	5, 314, 361	16. 00
17. 00	Special add-on payments for new technologies	54.00	781	0	781	0	781	17. 00
17. 01 17. 02	Net organ aquisition cost Credits received from manufacturers for replaced devices for applicable MS-DRGs	68. 00	10, 636	0	0	O	O	17. 01 17. 02

Heal th	Financial Systems		UNI ON HOSPI	TAL, INC.		In Lie	u of Form CMS-2	2552-10
LOW VO	LUME CALCULATION EXHIBIT 4			Provider CO		Period: From 01/01/2017 To 12/31/2017	Date/Time Pre 5/30/2018 2:1	pared:
					XVIII	Hospi tal	PPS	
		W/S E, Part A line	Amounts (from E, Part A)	Pre/Post Entitlement	Period Prion to 10/01	Peri od On/After 10/01	Total (Col 2 through 4)	
		0	1. 00	2.00	3. 00	4. 00	5. 00	
18. 00	Capital outlier reconciliation adjustment amount (see instructions)	-	0	0	3.00	0 0	0	18. 00
19.00	SUBTOTAL			0	54, 943, 50	16, 760, 823	71, 704, 324	19.00
		W/S L, line	(Amounts from L)				, .,,.	
		0	1. 00	2. 00	3. 00	4. 00	5. 00	
	Capital DRG other than outlier Model 4 BPCI Capital DRG other than outlier		4, 754, 420 0	0	3, 641, 97	79 1, 112, 441 0 0	4, 754, 420 0	1
21. 00 21. 01	Capital DRG outlier payments Model 4 BPCI Capital DRG	2. 00 2. 01	104, 943 0	0	100, 66	67 4, 276 0 0	104, 943 0	21. 00 21. 01
22. 00	outlier payments Indirect medical education percentage (see instructions)	5. 00	0. 0361	0. 0361	0. 036	0. 0361		22. 00
23. 00	Indirect medical education adjustment (see instructions)	6. 00	171, 635	0	131, 4	76 40, 159	171, 635	23. 00
24. 00	Allowable disproportionate share percentage (see instructions)	10. 00	0. 0596	0. 0596	0. 059	96 0. 0596		24.00
25. 00	Disproportionate share adjustment (see instructions)	11. 00	283, 363	0	217, 00	66, 301	283, 363	25. 00
26. 00	Total prospective capital payments (see instructions)	12. 00	5, 314, 361	0	4, 091, 18	1, 223, 177	5, 314, 361	26. 00
		W/S E, Part A						
		line 0	E, Part A) 1.00	2.00	2.00	4.00	F 00	
27. 00	Low volume adjustment factor	U	1.00	2. 00	3. 00 0. 00000	4. 00 0. 000000	5. 00	27. 00
28. 00	Low volume adjustment factor Low volume adjustment (transfer amount to Wkst. E, Pt. A, line)	70. 96			0.00000	0. 000000	0	
29. 00	1	70. 97				0	o	29. 00
100.00	Transfer low volume adjustments to Wkst. E, Pt. A.		Y					100.00

| Peri od: | Worksheet E | From 01/01/2017 | Part A Exhibit 5 | To 12/31/2017 | Date/Time Prepared: Health Financial SystemsUNION HOSPITALHOSPITAL ACQUIRED CONDITION (HAC) REDUCTION CALCULATION EXHIBIT 5 Provider CCN: 15-0023

				T	o 12/31/2017	Date/Time Pre 5/30/2018 2:1	
			Title	XVIII	Hospi tal	PPS	o piii
		Wkst. E, Pt.	Amt. from	Period to	Peri od on	Total (col s.	
		A, line	Wkst. E, Pt.	10/01	after 10/01	2 and 3)	
		·	A)			ĺ	
		0	1.00	2. 00	3. 00	4. 00	
1.00	DRG amounts other than outlier payments	1. 00					1.00
1.01	DRG amounts other than outlier payments for	1. 01	44, 979, 297	44, 979, 297		44, 979, 297	1.01
	discharges occurring prior to October 1						
1. 02	DRG amounts other than outlier payments for	1. 02	13, 660, 960		13, 660, 960	13, 660, 960	1. 02
	discharges occurring on or after October 1						
1. 03	DRG for Federal specific operating payment	1. 03	0	0		0	1. 03
	for Model 4 BPCI occurring prior to October						
1. 04	DDC for Endoral specific apprating payment	1. 04			0	0	1. 04
1. 04	DRG for Federal specific operating payment for Model 4 BPCI occurring on or after	1. 04	U		U	U	1.04
	October 1						
2. 00	Outlier payments for discharges (see	2. 00	410, 601	391, 306	19, 294	410, 600	2.00
2.00	instructions)	2.00	410,001	371, 300	17, 274	410,000	2.00
2. 01	Outlier payments for discharges for Model 4	2. 02	0	0	0	0	2. 01
	BPCI						
3.00	Operating outlier reconciliation	2. 01	0	0	0	0	3.00
4.00	Managed care simulated payments	3. 00	6, 571, 215	4, 630, 836	1, 940, 379	6, 571, 215	4.00
	Indirect Medical Education Adjustment						
5.00	Amount from Worksheet E, Part A, line 21	21. 00	0. 056679	0. 056679	0. 056679		5.00
	(see instructions)						
6.00	IME payment adjustment (see instructions)	22. 00	1, 787, 472			1, 787, 472	6.00
6. 01	IME payment adjustment for managed care (see	22. 01	200, 304	141, 157	59, 147	200, 304	6. 01
	instructions) Indirect Medical Education Adjustment for the	a Add on for Sa	otion 122 of t	L the MMA			
7. 00	IME payment adjustment factor (see	27. 00	0. 010871	0. 010871	0. 010871		7. 00
7.00	instructions)	27.00	0.010071	0.010071	0.010071		7.00
8.00	IME adjustment (see instructions)	28. 00	637, 478	488, 970	148, 508	637, 478	8. 00
8. 01	IME payment adjustment add on for managed	28. 01	71, 436			71, 436	8. 01
	care (see instructions)				·		
9.00	Total IME payment (sum of lines 6 and 8)	29. 00	2, 424, 950	1, 860, 029	564, 921	2, 424, 950	9.00
9. 01	Total IME payment for managed care (sum of	29. 01	271, 740	191, 499	80, 241	271, 740	9. 01
	lines 6.01 and 8.01)						
	Disproportionate Share Adjustment						
10. 00	Allowable disproportionate share percentage	33. 00	0. 1280	0. 1280	0. 1280		10. 00
11. 00	(see instructions) Disproportionate share adjustment (see	34. 00	1, 876, 489	1, 439, 338	437, 151	1, 876, 489	11. 00
11.00	instructions)	34.00	1, 670, 409	1, 437, 330	437, 131	1, 070, 407	11.00
11. 01	Uncompensated care payments	36. 00	2, 765, 145	1, 930, 919	834, 226	2, 765, 145	11. 01
11.01	Additional payment for high percentage of ESI			1, 700, 717	001, 220	2, 700, 110	11.01
12.00	Total ESRD additional payment (see	46. 00	0	0	0	0	12.00
	instructions)						
13.00	Subtotal (see instructions)	47. 00	66, 117, 442	50, 600, 890	15, 516, 552	66, 117, 442	13.00
14.00	Hospital specific payments (completed by SCH	48. 00	0	0	0	0	14.00
	and MDH, small rural hospitals only.) (see						
	instructions)						
15. 00	Total payment for inpatient operating costs	49. 00	66, 389, 182	50, 792, 389	15, 596, 793	66, 389, 182	15.00
14 00	(see instructions)	EO 00	E 21/ 241	4 001 104	1 222 177	E 21/ 2/1	16. 00
16. 00	Payment for inpatient program capital (from Wkst. L, Pt. I, if applicable)	50. 00	5, 314, 361	4, 091, 184	1, 223, 177	5, 314, 361	10.00
17. 00	Special add-on payments for new technologies	54. 00	781	781	0	781	17. 00
17. 01	Net organ acquisition cost	01.00	701	, , ,	Ü	701	17. 01
17. 02	Credits received from manufacturers for	68. 00	10, 636	7, 955	2, 681	10, 636	
- -	replaced devices for applicable MS-DRGs		.,	,	,	-,	-
18.00	Capital outlier reconciliation adjustment	93. 00	0	0	0	0	18.00
	amount (see instructions)						
19. 00	SUBTOTAL			54, 892, 309	16, 822, 651	71, 714, 960	19. 00

Heal th	Financial Systems	UNI ON HOSPI	TAL. INC.		In Li∈	eu of Form CMS-2	2552-10
	AL ACQUIRED CONDITION (HAC) REDUCTION CALCULA				Period: From 01/01/2017 To 12/31/2017	Worksheet E Part A Exhibi	t 5 pared:
			Title	XVIII	Hospi tal	PPS	
		Wkst. L, line	(Amt. from Wkst. L)				
		0	1. 00	2. 00	3. 00	4. 00	
20. 00 20. 01	Capital DRG other than outlier Model 4 BPCI Capital DRG other than outlier	1. 00 1. 01	4, 754, 420 0		79 1, 112, 441		20.00
21. 00	Capital DRG outlier payments	2. 00	104, 943		٩	104, 943	21.00
21. 01 22. 00	Model 4 BPCI Capital DRG outlier payments Indirect medical education percentage (see instructions)	2. 01 5. 00	0. 0361	0. 036	0. 0361	0	21. 01 22. 00
23. 00	Indirect medical education adjustment (see instructions)	6. 00	171, 635	131, 47	40, 159	171, 635	23. 00
24. 00	Allowable disproportionate share percentage (see instructions)	10. 00	0. 0596	0. 059	0. 0596		24.00
25. 00	Disproportionate share adjustment (see instructions)	11. 00	283, 363	217, 06	66, 301	283, 363	25. 00
26. 00	Total prospective capital payments (see instructions)	12. 00	5, 314, 361	4, 091, 18	1, 223, 177	5, 314, 361	26. 00
		Wkst. E, Pt. A, line	(Amt. from Wkst. E, Pt. A)				
		0	1.00	2.00	3. 00	4. 00	
27. 00 28. 00 29. 00	Low volume adjustment prior to October 1 Low volume adjustment on or after October 1	70. 96 70. 97	0		0	0	27. 00 28. 00 29. 00
30.00	HVBP payment adjustment (see instructions)	70. 97 70. 93 70. 90	54, 565	26, 04	28, 521	54, 565	
30. 01	HVBP payment adjustment for HSP bonus payment (see instructions)						
31. 00 31. 01	HRR adjustment (see instructions) HRR adjustment for HSP bonus payment (see instructions)	70. 94 70. 91	-179, 056 0	-139, 44	-39, 616 0 0	-179, 056 0	31. 00 31. 01
						(Amt. to Wkst. E, Pt. A)	
		0	1.00	2.00	3. 00	4. 00	
32. 00	HAC Reduction Program adjustment (see	70. 99			0 0		32.00

100.00

instructions)

100.00 Transfer HAC Reduction Program adjustment to Wkst. E, Pt. A.

Health Financial Systems	UNION HOSPITAL, INC.	In Lieu	u of Form CMS-2552-10
CALCULATION OF REIMBURSEMENT SETTLEMENT	Provi der CCN: 15-0023	Peri od: From 01/01/2017 To 12/31/2017	Worksheet E Part B Date/Time Prepared: 5/30/2018 2:18 pm
	Ti +1 o V/// / /	Hospi tal	DDC

			10 12/31/2017	5/30/2018 2:1	
		Title XVIII	Hospi tal	PPS	Орш
				1. 00	
	PART B - MEDICAL AND OTHER HEALTH SERVICES				
1	Medical and other services (see instructions)			11, 768	
1	Medical and other services reimbursed under OPPS (see instruc	ctions)		64, 338, 827	
3.00	OPPS payments			63, 632, 723	
4. 00	Outlier payment (see instructions)			54, 439	
4. 01	Outlier reconciliation amount (see instructions)	+!>		0	
5. 00 6. 00	Enter the hospital specific payment to cost ratio (see instru Line 2 times line 5	ictions)		0.000	
7. 00	Sum of lines 3, 4, and 4.01, divided by line 6			0 0. 00	
8. 00	Transitional corridor payment (see instructions)			0.00	1
	Ancillary service other pass through costs from Wkst. D, Pt.	IV col 13 line 200		222, 180	1
1	Organ acquisitions	17, 601. 13, 11116 200		0	
1	Total cost (sum of lines 1 and 10) (see instructions)			11, 768	1
	COMPUTATION OF LESSER OF COST OR CHARGES			,	1
	Reasonable charges				Ī
	Ancillary service charges			54, 916	12.0
13.00	Organ acquisition charges (from Wkst. D-4, Pt. III, col. 4, I	ine 69)		0	13.0
14. 00	Total reasonable charges (sum of lines 12 and 13)			54, 916	14.0
	Customary charges				
	Aggregate amount actually collected from patients liable for	. 3	9	0	
16. 00	Amounts that would have been realized from patients liable fo	. ,	n a chargebasis	0	16.0
17 00	had such payment been made in accordance with 42 CFR §413.13((e)		0.000000	17.0
	Ratio of line 15 to line 16 (not to exceed 1.000000)			0. 000000 54, 916	1
	Total customary charges (see instructions) Excess of customary charges over reasonable cost (complete on	olv if line 18 evceeds lin	na 11) (saa	43, 148	1
17.00	instructions)	ily II IIIle 16 exceeds III	ie II) (see	43, 140	19.0
20. 00	Excess of reasonable cost over customary charges (complete on	nlv if line 11 exceeds lin	ne 18) (see	0	20.0
	instructions)	,	, (_	
21. 00	Lesser of cost or charges (see instructions)			11, 768	21.0
22. 00	Interns and residents (see instructions)			0	22.0
23. 00	Cost of physicians' services in a teaching hospital (see inst	ructions)		0	23.0
	Total prospective payment (sum of lines 3, 4, 4.01, 8 and 9)			63, 909, 342	24.0
	COMPUTATION OF REIMBURSEMENT SETTLEMENT				
1	Deductibles and coinsurance (for CAH, see instructions)			0	
1	Deductibles and Coinsurance relating to amount on line 24 (fo	The state of the s	22] (11, 627, 299	1
27.00	Subtotal [(lines 21 and 24 minus the sum of lines 25 and 26) instructions)	prus the sum of fines 22	and 23] (See	52, 293, 811	27.0
28 00	Direct graduate medical education payments (from Wkst. E-4, I	ine 50)		617, 782	28.0
	ESRD direct medical education costs (from Wkst. E-4, line 36)			017,782	1
1	Subtotal (sum of lines 27 through 29)			52, 911, 593	1
1	Primary payer payments			5, 870	
32.00	Subtotal (line 30 minus line 31)			52, 905, 723	32.0
	ALLOWABLE BAD DEBTS (EXCLUDE BAD DEBTS FOR PROFESSIONAL SERVI	CES)			
	Composite rate ESRD (from Wkst. I-5, line 11)			0	
	Allowable bad debts (see instructions)			1, 254, 429	
	Adjusted reimbursable bad debts (see instructions)			815, 379	1
1	Allowable bad debts for dual eligible beneficiaries (see inst	ructions)		807, 349	
1	Subtotal (see instructions) MSP-LCC reconciliation amount from PS&R			53, 721, 102 271	
	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)			0	
1	Pioneer ACO demonstration payment adjustment (see instruction	ns)		0	39.5
	Demonstration payment adjustment amount before sequestration	.5)		0	1
1	Partial or full credits received from manufacturers for repla	nced devices (see instruc	tions)	56, 668	
1	RECOVERY OF ACCELERATED DEPRECIATION	Ç	ĺ	0	1
40.00	Subtotal (see instructions)			53, 720, 831	40.0
40. 01	Sequestration adjustment (see instructions)			1, 074, 417	40.0
	Demonstration payment adjustment amount after sequestration			0	
	Interim payments			52, 542, 745	
	Tentative settlement (for contractors use only)			0	
	Balance due provider/program (see instructions)			103, 669	
	Protested amounts (nonallowable cost report items) in accorda	nnce with CMS Pub. 15-2, o	cnapter 1,	0	44.0
	§115. 2 TO BE COMPLETED BY CONTRACTOR				-
				0	90.0
ĺ					1 7U. L
90.00	Original outlier amount (see instructions)				1
90. 00 91. 00	Original outlier amount (see instructions) Outlier reconciliation adjustment amount (see instructions)			0	91.0
90. 00 91. 00 92. 00	Original outlier amount (see instructions)				91. 0 92. 0

Health Financial Systems	UNION HOSPITAL, INC.	In Lie	u of Form CMS-2552-10
CALCULATION OF REIMBURSEMENT SETTLEMENT	Provi der CCN: 15-0023	Peri od:	Worksheet E
		From 01/01/2017	
	Component CCN: 15-T023	To 12/31/2017	Date/Time Prepared:
	·		5/30/2018 2:18 pm
	Title XVIII	Subprovi der -	PPS
		LDE	

		Title XVIII	Subprovi der - I RF	PPS	
			IKF		
	DADT D. MEDICAL AND OTHER HEALTH CERVICES			1. 00	
1. 00	PART B - MEDICAL AND OTHER HEALTH SERVICES Medical and other services (see instructions)			17	1.00
2. 00	Medical and other services reimbursed under OPPS (see instruc	tions)		6, 237	2.00
3.00	OPPS payments			2, 577	1
4.00	Outlier payment (see instructions)			0	4.00
4. 01 5. 00	Outlier reconciliation amount (see instructions) Enter the hospital specific payment to cost ratio (see instru	ictions)		0 0. 000	4. 01 5. 00
6. 00	Line 2 times line 5	icti (iis)		0.000	6.00
7. 00	Sum of lines 3, 4, and 4.01, divided by line 6			0.00	7. 00
8. 00	Transitional corridor payment (see instructions)			0	8.00
9. 00 10. 00	Ancillary service other pass through costs from Wkst. D, Pt. Organ acquisitions	IV, col. 13, line 200		6	9. 00 10. 00
11. 00	Total cost (sum of lines 1 and 10) (see instructions)			17	11.00
	COMPUTATION OF LESSER OF COST OR CHARGES				
	Reasonable charges				
12. 00 13. 00		ino (0)		79 0	12. 00 13. 00
	Total reasonable charges (sum of lines 12 and 13)	THE 69)		79	1
00	Customary charges				
15. 00	1 33 3		~	0	
16. 00	Amounts that would have been realized from patients liable fo		on a chargebasis	0	16. 00
17. 00	had such payment been made in accordance with 42 CFR §413.13(Ratio of line 15 to line 16 (not to exceed 1.000000)	e)		0. 000000	17. 00
18. 00	Total customary charges (see instructions)			79	18.00
19. 00	Excess of customary charges over reasonable cost (complete on	ly if line 18 exceeds li	ne 11) (see	62	19. 00
20.00	instructions)	l : € : 11 - :	10) (0	20.00
20. 00	Excess of reasonable cost over customary charges (complete on instructions)	ily II IThe II exceeds II	ne 18) (See	0	20. 00
21. 00	Lesser of cost or charges (see instructions)			17	21.00
	Interns and residents (see instructions)			0	22. 00
	Cost of physicians' services in a teaching hospital (see inst	ructions)		0	23.00
24.00	Total prospective payment (sum of lines 3, 4, 4.01, 8 and 9) COMPUTATION OF REIMBURSEMENT SETTLEMENT			2, 583	24.00
25. 00	Deductibles and coinsurance (for CAH, see instructions)			0	25. 00
26. 00	Deductibles and Coinsurance relating to amount on line 24 (fo			509	26. 00
27. 00	'	plus the sum of lines 22	2 and 23] (see	2, 091	27. 00
28. 00	<pre>instructions) Direct graduate medical education payments (from Wkst. E-4, I</pre>	ine 50)		0	28. 00
	ESRD direct medical education costs (from Wkst. E-4, line 36)			0	29.00
30.00	Subtotal (sum of lines 27 through 29)			2, 091	30. 00
31.00				0	31.00
32.00	Subtotal (line 30 minus line 31) ALLOWABLE BAD DEBTS (EXCLUDE BAD DEBTS FOR PROFESSIONAL SERVI	CES)		2, 091	32.00
33. 00	Composite rate ESRD (from Wkst. I-5, line 11)	023)		0	33.00
34.00	Allowable bad debts (see instructions)			0	34.00
	Adjusted reimbursable bad debts (see instructions)			0	35.00
36.00	Allowable bad debts for dual eligible beneficiaries (see inst Subtotal (see instructions)	ructions)		0 2, 091	36. 00 37. 00
	MSP-LCC reconciliation amount from PS&R			2,071	1
39. 00				0	•
39. 50	Pioneer ACO demonstration payment adjustment (see instruction	s)		_	39. 50
39. 97 39. 98	Demonstration payment adjustment amount before sequestration Partial or full credits received from manufacturers for repla	end dovices (see instru	stions)	0	39. 97 39. 98
39. 90	RECOVERY OF ACCELERATED DEPRECIATION	iced devices (see flistruc	Lti olis)	0	39. 90
40. 00				2, 091	1
40. 01	Sequestration adjustment (see instructions)			42	40. 01
40. 02	, , ,			0	40. 02
41. 00 42. 00	Interim payments Tentative settlement (for contractors use only)			2, 044 0	41. 00 42. 00
43. 00	Balance due provider/program (see instructions)			5	43. 00
44.00	Protested amounts (nonallowable cost report items) in accorda	nce with CMS Pub. 15-2,	chapter 1,	0	44.00
	§115. 2				
90 00	TO BE COMPLETED BY CONTRACTOR Original outlier amount (see instructions)			0	90.00
	Outlier reconciliation adjustment amount (see instructions)			0	1
92.00	The rate used to calculate the Time Value of Money			0. 00	92.00
93.00	,			0	
94.00	Total (sum of lines 91 and 93)		l	0	94.00

UNION HOSPITAL, INC. In Lieu of Form CMS-2552-10

Health Financial Systems UNANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED | Peri od: | Worksheet E-1 | From 01/01/2017 | Part I | Date/Time Prepared: | To 12/31/2017 | Date/Time Prep Provider CCN: 15-0023

			1	0 12/31/201/	5/30/2018 2:18	
		Title	: XVIII	Hospi tal	PPS	<u> </u>
		I npati en	it Part A	Par	t B	
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount	
1 00	T	1. 00	2.00	3. 00	4. 00	4 00
1.00	Total interim payments paid to provider		63, 851, 794		51, 015, 744	1.00
2. 00	Interim payments payable on individual bills, either submitted or to be submitted to the contractor for		0		0	2.00
	services rendered in the cost reporting period. If none,					
	write "NONE" or enter a zero					
3.00	List separately each retroactive lump sum adjustment					3.00
0.00	amount based on subsequent revision of the interim rate					0.00
	for the cost reporting period. Also show date of each					
	payment. If none, write "NONE" or enter a zero. (1)					
	Program to Provider					
3. 01	ADJUSTMENTS TO PROVIDER	12/31/2017	1, 296, 159	12/31/2017	1, 527, 001	3. 01
3. 02			0		0	3. 02
3. 03			0		0	3. 03
3. 04			0		0	3.04
3. 05	Dec. 1 Lea Le Decesion		0		0	3.05
3. 50	Provider to Program ADJUSTMENTS TO PROGRAM		0		0	3.50
3. 50	ADJUSTMENTS TO PROGRAM				0	3.50
3. 52			0			3.52
3. 53			0		0	3.53
3. 54			0		0	3.54
3. 99	Subtotal (sum of lines 3.01-3.49 minus sum of lines		1, 296, 159		1, 527, 001	
	3. 50-3. 98)					
4.00	Total interim payments (sum of lines 1, 2, and 3.99)		65, 147, 953		52, 542, 745	4.00
	(transfer to Wkst. E or Wkst. E-3, line and column as					
	appropri ate)					
г оо	TO BE COMPLETED BY CONTRACTOR	I	I			
5. 00	List separately each tentative settlement payment after desk review. Also show date of each payment. If none,					5. 00
	write "NONE" or enter a zero. (1)					
	Program to Provider					
5. 01	TENTATI VE TO PROVI DER		0		0	5.01
5.02			0		0	
5.03			0		0	5. 03
	Provider to Program					
5. 50	TENTATI VE TO PROGRAM		0		0	5. 50
5. 51			0		0	5. 51
5. 52	Cultural (0		0	
5. 99	Subtotal (sum of lines 5.01-5.49 minus sum of lines		0		0	5. 99
6. 00	5.50-5.98) Determined net settlement amount (balance due) based on					6.00
0.00	the cost report. (1)					0.00
6. 01	SETTLEMENT TO PROVIDER		0		103, 669	6. 01
6. 02	SETTLEMENT TO PROGRAM		127, 178		0	6.02
7. 00	Total Medicare program liability (see instructions)		65, 020, 775		52, 646, 414	
				Contractor	NPR Date	
				Number	(Mo/Day/Yr)	
		()	1. 00	2.00	
8. 00	Name of Contractor	(1.00	2.00	8.00

	Financial Systems UNION HOSPI				u of Form CMS-2	2552-10
ANALYS	IS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED	Provi der CO	CN: 15-0023	Peri od:	Worksheet E-1 Part I	
		Component (CN: 15_T023	From 01/01/2017 To 12/31/2017		nared:
		Component	3014. 10 1020	12/01/201/	5/30/2018 2: 18	
		Title	XVIII	Subprovi der – I RF	PPS	•
		Inpatien	t Part A	Par	t B	
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount	
		1.00	2.00	3.00	4. 00	
1.00	Total interim payments paid to provider		3, 268, 1	33	2, 044	1. 00
2. 00	Interim payments payable on individual bills, either			0	0	2.00
	submitted or to be submitted to the contractor for					
	services rendered in the cost reporting period. If none,					
	write "NONE" or enter a zero					
3. 00	List separately each retroactive lump sum adjustment					3.00
	amount based on subsequent revision of the interim rate					
	for the cost reporting period. Also show date of each					
	payment. If none, write "NONE" or enter a zero. (1)					
	Program to Provider					
3. 01	ADJUSTMENTS TO PROVIDER			0	0	3. 01
3. 02				0	0	3. 02
3. 03				0	0	3.03
3. 04				0	0	3.04
3. 05	Dravi dan ta Dragnam			0	0	3.05
3. 50	Provider to Program ADJUSTMENTS TO PROGRAM			0	0	3. 50
3. 50 3. 51	ADJUSTIMENTS TO PROGRAM			0	0	3. 51
3. 52					0	3. 52
3. 52 3. 53					0	3. 52
3. 54				0	0	3. 54
3. 99	Subtotal (sum of lines 3.01-3.49 minus sum of lines			0	0	3. 99
3. 77	3. 50-3. 98)					3. 77
1. 00	Total interim payments (sum of lines 1, 2, and 3.99)		3, 268, 1	33	2, 044	4. 00
1. 00	(transfer to Wkst. E or Wkst. E-3, line and column as		0, 200, 1		2,011	1. 00
	appropri ate)					
	TO BE COMPLETED BY CONTRACTOR					
5. 00	List separately each tentative settlement payment after					5. 00
	desk review. Also show date of each payment. If none,					
	write "NONE" or enter a zero. (1)					
	Program to Provider			,		
. 01	TENTATI VE TO PROVIDER			0	0	5. 01
n. U I	TENTIAL TO TROVIDER					
5. 01 5. 02	TENTITY TO THOUTDEN			Ö	Ö	5. 02

0

0

0

0

2, 049

NPR Date

(Mo/Day/Yr)

2. 00

0 0 0

Contractor

Number

1. 00

55, 327

3, 323, 460

0

5.50

5.51

5.52

5.99

6.00

6.01

6.02

7.00

8.00

Provider to Program
TENTATIVE TO PROGRAM

the cost report. (1)
SETTLEMENT TO PROVIDER

SETTLEMENT TO PROGRAM

5. 50-5. 98)

8.00 Name of Contractor

Subtotal (sum of lines 5.01-5.49 minus sum of lines

Total Medicare program liability (see instructions)

Determined net settlement amount (balance due) based on

5. 50

5. 51

5. 52

5. 99

6.00

6.01

6. 02

7. 00

Heal th	Financial Systems UNION HOSPIT	AL, INC.	In Lie	u of Form CMS-	2552-10
CALCULATION OF REIMBURSEMENT SETTLEMENT FOR HIT Provider CCN: 15-0023 Period: Worksheet E					
			To 12/31/2017		epared:
				5/30/2018 2:	18 pm
		Title XVIII	Hospi tal	PPS	
	TO BE COMPLETED BY CONTRACTOR FOR MONCTANDARD COST DEPORTS			1. 00	
	TO BE COMPLETED BY CONTRACTOR FOR NONSTANDARD COST REPORTS	NA CONTRACTOR OF THE CONTRACTO			
1. 00	HEALTH INFORMATION TECHNOLOGY DATA COLLECTION AND CALCULATION Total hospital discharges as defined in AARA §4102 from Wks		0.14		1.00
2. 00	Medicare days from Wkst. S-3, Pt. I, col. 6 sum of lines 1,		E 14		2.00
3. 00	Medicare HMO days from Wkst. S-3, Pt. I, col. 6. line 2	0-12			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 12			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		Wkst. S-2, Pt. I		7.00
	line 168				
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	n (see instructions)			10.00
	INPATIENT HOSPITAL SERVICES UNDER THE IPPS & CAH				
	Initial/interim HIT payment adjustment (see instructions)				30.00
	Other Adjustment (specify)		,		31.00
32. 00	Balance due provider (line 8 (or line 10) minus line 30 and	line 31) (see instruction	ns)		32.00

Health Financial Systems	UNION HOSPITAL, INC.	In Lie	u of Form CMS-2552-10
CALCULATION OF REIMBURSEMENT SETTLEMENT	Provi der CCN: 15-0023	Peri od: From 01/01/2017	Worksheet E-3
	Component CCN: 15-T023		
	Title XVIII	Subprovi der -	PPS
		I RF	

	IRF		
		1. 00	
	PART III - MEDICARE PART A SERVICES - IRF PPS	1.00	
1. 00	Net Federal PPS Payment (see instructions)	3, 159, 485	1. 00
2. 00	Medicare SSI ratio (IRF PPS only) (see instructions)	0. 0428	2. 00
3.00	Inpatient Rehabilitation LIP Payments (see instructions)	188, 621	3.00
4.00	Outlier Payments	77, 917	4.00
5. 00	Unweighted intern and resident FTE count in the most recent cost reporting period ending on or prior to November 15, 2004 (see instructions)	21. 04	5. 00
5. 01	Cap increases for the unweighted intern and resident FTE count for residents that were displaced by program or hospital closure, that would not be counted without a temporary cap adjustment under 42 CFR §412.424(d)(1)(iii)(F)(1) or (2) (see instructions)	0. 00	5. 01
6.00	New Teaching program adjustment. (see instructions)	0.00	6.00
7. 00	Current year's unweighted FTE count of I&R excluding FTEs in the new program growth period of a "new teaching program" (see instructions)	0. 00	7. 00
8. 00	Current year's unweighted I&R FTE count for residents within the new program growth period of a "new teaching program" (see instructions)	0.00	8. 00
9. 00	Intern and resident count for IRF PPS medical education adjustment (see instructions)	0. 00	9. 00
10.00	Average Daily Census (see instructions)	9. 402740	
11.00	Teaching Adjustment Factor (see instructions)	0. 000000	
12.00	Teaching Adjustment (see instructions)	0	12.00
13.00	Total PPS Payment (see instructions)	3, 426, 023	13.00
14. 00 15. 00	Nursing and Allied Health Managed Care payments (see instruction)	0	14. 00 15. 00
16. 00	Organ acquisition (DO NOT USE THIS LINE) Cost of physicians' services in a teaching hospital (see instructions)	o	16. 00
17. 00	Subtotal (see instructions)	3, 426, 023	
18. 00	Primary payer payments	3, 420, 023	18.00
19. 00		3, 426, 023	
20.00	Deducti bl es	27, 636	20.00
21. 00	Subtotal (line 19 minus line 20)	3, 398, 387	21.00
22. 00		8, 225	
23. 00	Subtotal (line 21 minus line 22)	3, 390, 162	
24. 00	Allowable bad debts (exclude bad debts for professional services) (see instructions)	0	24.00
25. 00		0	25.00
26. 00	Allowable bad debts for dual eligible beneficiaries (see instructions)	o	26.00
27. 00	Subtotal (sum of lines 23 and 25)	3, 390, 162	27.00
28. 00	Direct graduate medical education payments (from Wkst. E-4, line 49)	0	28.00
29. 00	Other pass through costs (see instructions)	1, 124	29. 00
30.00	Outlier payments reconciliation	0	30.00
31. 00		0	31.00
31. 50	Pioneer ACO demonstration payment adjustment (see instructions)	0	31.50
31. 99	Demonstration payment adjustment amount before sequestration	0	31. 99
32. 00	Total amount payable to the provider (see instructions)	3, 391, 286	
32. 01	Sequestration adjustment (see instructions)	67, 826	
32. 02	Demonstration payment adjustment amount after sequestration	0	32. 02
33.00		3, 268, 133	33.00
34.00	Tentative settlement (for contractor use only)	0	34.00
35. 00 36. 00	Balance due provider/program (line 32 minus lines 32.01, 32.02, 33, and 34) Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1,	55, 327 41, 320	35. 00 36. 00
F0 00	§115. 2 TO BE COMPLETED BY CONTRACTOR	77.047	F0 60
	Original outlier amount from Wkst. E-3, Pt. III, line 4	77, 917	50.00
	Outlier reconciliation adjustment amount (see instructions)	0 00	51.00
	The rate used to calculate the Time Value of Money		52.00
JJ. UU	Time Value of Money (see instructions)	٥Į	53.00

Health Financial Systems	UNION HOSPITAL, INC.	In Lieu of Form CMS-2552-10
CALCULATION OF REIMBURSEMENT SETTLEMENT	Provi der CCN: 15-0023	Peri od: Worksheet E-3 From 01/01/2017 To 12/31/2017 Part VII Date/Time Prepared: 5/30/2018 2:18 pm

			10 12/31/2017	5/30/2018 2: 1	
		Title XIX	Hospi tal	Cost	
			Inpatient	Outpati ent	
			1.00	2. 00	
	PART VII - CALCULATION OF REIMBURSEMENT - ALL OTHER HEALTH SEF	RVICES FOR TITLES V OR XI	X SERVICES		
	COMPUTATION OF NET COST OF COVERED SERVICES				1
1.00	Inpatient hospital/SNF/NF services		2, 215, 177		1.00
2.00	Medical and other services			0	2.00
3.00	Organ acquisition (certified transplant centers only)		o		3.00
4.00	Subtotal (sum of lines 1, 2 and 3)		2, 215, 177	0	4.00
5.00	Inpatient primary payer payments		0		5.00
6.00	Outpatient primary payer payments			0	6.00
7.00	Subtotal (line 4 less sum of lines 5 and 6)		2, 215, 177	0	7.00
	COMPUTATION OF LESSER OF COST OR CHARGES				1
	Reasonable Charges]
8.00	Routine service charges		2, 365, 030		8.00
9.00	Ancillary service charges		3, 810, 748	0	9.00
10.00	Organ acquisition charges, net of revenue		0		10.00
11.00	Incentive from target amount computation		0		11.00
12.00	Total reasonable charges (sum of lines 8 through 11)		6, 175, 778	0	12.00
	CUSTOMARY CHARGES				
13.00	Amount actually collected from patients liable for payment for	r services on a charge	0	0	13.00
	basis				
14. 00	Amounts that would have been realized from patients liable for	1 3	0	0	14.00
	a charge basis had such payment been made in accordance with	42 CFR §413.13(e)			
15. 00	Ratio of line 13 to line 14 (not to exceed 1.000000)		0. 000000	0. 000000	
16.00	Total customary charges (see instructions)	1611	6, 175, 778	0	
17. 00	Excess of customary charges over reasonable cost (complete onl	y if line 16 exceeds	3, 960, 601	0	17.00
10.00	line 4) (see instructions)				10.00
18. 00	Excess of reasonable cost over customary charges (complete onl	y if fine 4 exceeds fine		0	18. 00
19. 00	16) (see instructions) Interns and Residents (see instructions)			0	19.00
20.00	Cost of physicians' services in a teaching hospital (see insti	sustions)	0	0	
21. 00	Cost of covered services (enter the lesser of line 4 or line		2, 215, 177	0	
21.00	PROSPECTIVE PAYMENT AMOUNT - Lines 22 through 26 must only be			U	21.00
22. 00	Other than outlier payments	Compreted for 113 provid	0	0	22. 00
23. 00	Outlier payments		0	0	
24. 00	Program capital payments		0	Ŭ	24.00
25. 00	Capital exception payments (see instructions)		0		25.00
26. 00	Routine and Ancillary service other pass through costs		0	0	
27. 00	Subtotal (sum of lines 22 through 26)		0	0	
28. 00	Customary charges (title V or XIX PPS covered services only)		0	0	
29. 00	Titles V or XIX (sum of lines 21 and 27)		2, 215, 177	0	
	COMPUTATION OF REIMBURSEMENT SETTLEMENT				1
30.00	Excess of reasonable cost (from line 18)		0	0	30.00
31.00	Subtotal (sum of lines 19 and 20, plus 29 minus lines 5 and 6))	2, 215, 177	0	31.00
32.00	Deducti bl es		0	0	32.00
33.00	Coi nsurance		0	0	33.00
34.00	Allowable bad debts (see instructions)		0	0	34.00
35.00	Utilization review		0		35.00
36.00	Subtotal (sum of lines 31, 34 and 35 minus sum of lines 32 and	d 33)	2, 215, 177	0	
37.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)		0	0	
38.00	Subtotal (line 36 ± line 37)		2, 215, 177	0	
39. 00	Direct graduate medical education payments (from Wkst. E-4)		0		39.00
40.00	Total amount payable to the provider (sum of lines 38 and 39)		2, 215, 177	0	
41. 00	Interim payments		2, 395, 729	0	
42.00	Balance due provider/program (line 40 minus line 41)		-180, 552	0	
43.00	Protested amounts (nonallowable cost report items) in accordan	nce with CMS Pub 15-2,	0	0	43.00
	chapter 1, §115.2				I

LKECT	Financial Systems UNION HOSPITAL GRADUATE MEDICAL EDUCATION (GME) & ESRD OUTPATIENT DIRECT	L, INC. Provider C	CN: 15-0023	Peri od:	u of Form CMS-2 Worksheet E-4	
	L EDUCATION COSTS			From 01/01/2017 To 12/31/2017	Date/Time Pre 5/30/2018 2:18	pared
		Title	XVIII	Hospi tal	PPS	- Pill
					1. 00	
	COMPUTATION OF TOTAL DIRECT GME AMOUNT					
00	Unweighted resident FTE count for allopathic and osteopathic ending on or before December 31, 1996.	programs for	r cost report	ing periods	14. 92	1.
00 00	Unweighted FTE resident cap add-on for new programs per 42 CF Amount of reduction to Direct GME cap under section 422 of MN		(1) (see inst	ructions)	0. 00 0. 00	2. 3.
01	Direct GME cap reduction amount under ACA §5503 in accordance instructions for cost reporting periods straddling 7/1/2011)		R §413.79 (m)	. (see	0.00	3.
00	Adjustment (plus or minus) to the FTE cap for allopathic and GME affiliation agreement (42 CFR §413.75(b) and § 413.79 (f)		programs due	e to a Medicare	0. 00	4.
01	ACA Section 5503 increase to the Direct GME FTE Cap (see inst straddling 7/1/2011)		r cost report	ing periods	0. 00	4.
02	ACA Section 5506 number of additional direct GME FTE cap slot periods straddling 7/1/2011)	s (see ins	tructions for	cost reporting	0. 00	4.
00	FTE adjusted cap (line 1 plus line 2 minus line 3 and 3.01 pl 4.02 plus applicable subscripts	us or minus	line 4 plus	lines 4.01 and	14. 92	5.
. 00	Unweighted resident FTE count for allopathic and osteopathic records (see instructions)	programs fo	r the current	year from your	21. 04	6.
. 00	Enter the lesser of line 5 or line 6		D	011	14. 92	7.
			Primary Card	e Other 2.00	Total 3. 00	
00	Weighted FTE count for physicians in an allopathic and osteop	oathi c	21. (21. 04	8.
00	program for the current year. If line 6 is less than 5 enter the amount from line 8, otherw multiply line 8 times the result of line 5 divided by the amo		14. 9	92 0.00	14. 92	9.
. 00	6. Weighted dental and podiatric resident FTE count for the curr	ent year		0. 00		10.
. 01	Unweighted dental and podiatric resident FTE count for the cu	ırrent year	14.	0.00		10
. 00	Total weighted FTE count Total weighted resident FTE count for the prior cost reportir instructions)	ng year (see	14. ⁹ 14. ⁹			11 12
. 00	Total weighted resident FTE count for the penultimate cost reyear (see instructions)	eporti ng	14. 9			13
. 00	Rolling average FTE count (sum of lines 11 through 13 divided Adjustment for residents in initial years of new programs	l by 3).	14.9			14 15
. 01	Unweighted adjustment for residents in initial years of new p	programs	0. (15
. 00	Adjustment for residents displaced by program or hospital cloudly unweighted adjustment for residents displaced by program or hoclosure		0. (0. (1		16 16
. 00	Adjusted rolling average FTE count		14.			17
3. 00 9. 00	Per resident amount Approved amount for resident costs		123, 596. (1, 844, 0		1, 844, 062	18. 19.
					1. 00	
0. 00	Additional unweighted allopathic and osteopathic direct GME FSec. 413.79(c)(4)	TE resident	cap slots re	ecei ved under 42	5. 75	20.
1.00	Direct GME FTE unweighted resident count over cap (see instru	,			6. 12	
2. 00 3. 00	Allowable additional direct GME FTE Resident Count (see instr Enter the locally adjustment national average per resident am		nstructions)		5. 75 98, 228. 27	
. 00	Multiply line 22 time line 23	(200	,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,		564, 813	24.
. 00	Total direct GME amount (sum of lines 19 and 24)		Inpati ent	Managed care	2, 408, 875	25.
			Part A	, and the second		
	COMPUTATION OF PROGRAM PATIENT LOAD		1.00	2.00	3. 00	
6. 00	Inpatient Days (see instructions)		31, 3:			26
7.00	Total Inpatient Days (see instructions)		63, 39			27
3. 00 9. 00	Ratio of inpatient days to total inpatient days Program direct GME amount		0. 4943 1, 190, 89	1		28. 29.
0. 00	Reduction for direct GME payments for Medicare Advantage		1, 1,0,0	19, 899		30.
	Net Program direct GME amount		I		1, 311, 821	31

Heal th	Financial Systems UNION HOSPITAL	LNC	In lie	u of Form CMS-2	2552_10
	DIRECT GRADUATE MEDICAL EDUCATION (GME) & ESRD OUTPATIENT DIRECT Provider CCN: 15-0023 Period: Wo				
	AL EDUCATION COSTS		From 01/01/2017 To 12/31/2017		pared:
		Title XVIII	Hospi tal	PPS	
				1. 00	
	DIRECT MEDICAL EDUCATION COSTS FOR ESRD COMPOSITE RATE - TITL EDUCATION COSTS)	•		I CAL	
32. 00	Renal dialysis direct medical education costs (from Wkst. B, and 94)	Pt. I, sum of col. 20 a	nd 23, lines 74	0	32.00
33.00	Renal dialysis and home dialysis total charges (Wkst. C, Pt.	I, col. 8, sum of lines	74 and 94)	0	33.00
34.00	Ratio of direct medical education costs to total charges (lir	ne 32 ÷ line 33)		0.000000	34.00
35.00	Medicare outpatient ESRD charges (see instructions)			0	35.00
36.00	Medicare outpatient ESRD direct medical education costs (line	e 34 x line 35)		0	36.00
	APPORTIONMENT BASED ON MEDICARE REASONABLE COST - TITLE XVIII	ONLY			
	Part A Reasonable Cost				
	Reasonable cost (see instructions)			72, 558, 870	
38. 00	Organ acquisition costs (Wkst. D-4, Pt. III, col. 1, line 69)			0	38. 00
	Cost of physicians' services in a teaching hospital (see inst	ructions)		0	
	Primary payer payments (see instructions)			15, 005	
41. 00	Total Part A reasonable cost (sum of lines 37 through 39 minu	ıs line 40)		72, 543, 865	41.00
40.00	Part B Reasonable Cost			(4.570.005	
42.00				64, 579, 035	
43.00	Primary payer payments (see instructions)			5, 870	
	Total Part B reasonable cost (line 42 minus line 43)			64, 573, 165	
	Total reasonable cost (sum of lines 41 and 44) Ratio of Part A reasonable cost to total reasonable cost (lir	o 41 . Lino 45)		137, 117, 030 0. 529065	
	Ratio of Part A reasonable cost to total reasonable cost (III			0. 529065	
47.00	ALLOCATION OF MEDICARE DIRECT GME COSTS BETWEEN PART A AND PA			0.470935	47.00
48 00	Total program GME payment (line 31)	III D		1, 311, 821	48 00
	Part A Medicare GME payment (line 46 x 48) (title XVIII only)	(see instructions)		694, 039	
	Part B Medicare GME payment (line 47 x 48) (title XVIII only)			617, 782	
55.50	1. 2. 2 2 22. 3 Sinz paymone (1.116 17 X 16) (crtic XVIII only)	(=== :)	'	3, 702	

Health Financial Systems UNION HOSPITAL, INC. In Lieu of Form CMS-2552-10

Health Financial Systems

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

Provider CCN: 15-0023

Peri od: Worksheet G From 01/01/2017 To 12/31/2017 Date/Ti me Prepared: 5/30/2018 2:18 pm

J 37		General Fund	Specific Purpose Fund	Endowment Fund	5/30/2018 2:1 Plant Fund	8 pm
		1.00	2.00	3. 00	4. 00	
	CURRENT ASSETS			_1		
1. 00 2. 00	Cash on hand in banks	48, 680, 738	0	0	0	
3. 00	Temporary investments Notes receivable	0	0	0	0	
4. 00	Accounts receivable	57, 624, 407	0	0	0	
5. 00	Other recei vable	0	O	Ö	0	1
6.00	Allowances for uncollectible notes and accounts receivable	0	0	o	0	6.00
7.00	Inventory	5, 009, 748		0	0	
8. 00	Prepai d expenses	-16, 071, 520	0	0	0	
9.00	Other current assets	0	0	0	0	
10. 00 11. 00	Due from other funds Total current assets (sum of lines 1-10)	95, 243, 373	0	ol Ol	0	10.00 11.00
11.00	FIXED ASSETS	75, 245, 575	J O	<u> </u>	0	111.00
12.00	Land	37, 075, 766	0	O	0	12.00
13.00	Land improvements	0	0	o	0	13.00
14.00	Accumulated depreciation	0	0	o	0	14.00
	Bui I di ngs	336, 377, 630	0	0	0	15. 00
	Accumulated depreciation	-281, 474, 032	0	0	0	16.00
	Leasehold improvements	0	0	0	0	17.00
	Accumulated depreciation	0	0	0	0	18. 00 19. 00
	Fixed equipment Accumulated depreciation		0	0	0	20.00
	Automobiles and trucks	0	0	0	0	21.00
	Accumulated depreciation		0	ő	0	22. 00
	Major movable equipment	161, 253, 292	0	o	0	23.00
	Accumulated depreciation	0	0	o	0	24.00
25.00	Mi nor equi pment depreci abl e	0	0	0	0	25. 00
	Accumulated depreciation	0	0	0	0	26.00
	HIT designated Assets	0	0	0	0	27. 00
	Accumulated depreciation	0	0	0	0	28.00
	Minor equipment-nondepreciable Total fixed assets (sum of lines 12-29)	253, 232, 656	0	0 0	0	
30.00	OTHER ASSETS	255, 252, 050	0	<u> </u>		30.00
31.00	Investments	0	0	0	0	31.00
	Deposits on leases	0	0	o	0	32.00
33.00	Due from owners/officers	0	0	0	0	33. 00
	Other assets	76, 629, 440		0	0	34.00
	Total other assets (sum of lines 31-34)	76, 629, 440		0	0	
36. 00	Total assets (sum of lines 11, 30, and 35) CURRENT LIABILITIES	425, 105, 469	0	0	0	36.00
37 00	Accounts payable	30, 414, 894	0	ol	0	37. 00
	Salaries, wages, and fees payable	21, 789, 721	Ö	o	0	
	Payroll taxes payable	0	0	o	0	39. 00
40.00	Notes and Loans payable (short term)	0	0	0	0	40.00
	Deferred income	0	0	0	0	41.00
	Accel erated payments	0			•	42.00
43.00	Due to other funds	2 00/ 22/	0	0	0	
	Other current liabilities Total current liabilities (sum of lines 37 thru 44)	2, 006, 236 54, 210, 851	1	0	0	
43.00	LONG TERM LIABILITIES	34, 210, 031	0	U _I	0	45.00
46. 00	Mortgage payable	0	0	ol	0	46. 00
47.00	Notes payable	0	0	o	0	1
48.00	Unsecured Loans	0	0	0	0	48. 00
	Other long term liabilities	261, 327, 272		0	0	1
	Total long term liabilities (sum of lines 46 thru 49)	261, 327, 272		0	0	
51. 00	Total liabilities (sum of lines 45 and 50)	315, 538, 123	0	0	0	51.00
52. 00	CAPITAL ACCOUNTS General fund balance	109, 567, 346		1		52.00
53. 00	Specific purpose fund	107, 307, 340	0			53.00
54. 00	Donor created - endowment fund balance - restricted			ol		54.00
55.00	Donor created - endowment fund balance - unrestricted			o		55.00
56.00	Governing body created - endowment fund balance			o		56.00
57. 00	Plant fund balance - invested in plant				0	
58. 00	Plant fund balance - reserve for plant improvement,				0	58. 00
50.00	replacement, and expansion Total fund halances (sum of Lines 52 thru 58)	100 547 244	o	0	0	50.00
59. 00 60. 00	Total fund balances (sum of lines 52 thru 58) Total liabilities and fund balances (sum of lines 51 and	109, 567, 346 425, 105, 469		0	0	
55. 55	59)	120, 100, 407		٩	0	55. 55
				'		•

Health Financial Systems
STATEMENT OF CHANGES IN FUND BALANCES UNION HOSPITAL, INC. Provider CCN: 15-0023

					То	12/31/2017	Date/Time Pre 5/30/2018 2:1	pared: 8 pm
		General	Fund	Speci al	Purpos	se Fund	Endowment Fund	
	I 	1. 00	2. 00	3. 00		4. 00	5. 00	
1.00	Fund balances at beginning of period		95, 272, 824	1		0		1.00
2. 00 3. 00	Net income (loss) (from Wkst. G-3, line 29) Total (sum of line 1 and line 2)		14, 294, 522 109, 567, 346	1		0		2. 00 3. 00
4. 00	Additions (credit adjustments) (specify)		109, 567, 346		0	٩	0	
5. 00	Additions (credit adjustments) (specify)				0		0	1
6. 00		o			Ö		0	
7. 00		o			O		0	
8.00		o			0		0	8.00
9.00		o			0		0	9.00
10.00	Total additions (sum of line 4-9)		0	1		0		10.00
11. 00	Subtotal (line 3 plus line 10)		109, 567, 346			0		11.00
12.00	Deductions (debit adjustments) (specify)	0			0		0	
13.00		0			0		0	
14. 00 15. 00		0			0		0	
16. 00					0		0	1
17. 00					0		0	
18. 00	Total deductions (sum of lines 12-17)		0		Ĭ	0	O	18.00
19. 00	Fund balance at end of period per balance		109, 567, 346			o		19.00
	sheet (line 11 minus line 18)							
		Endowment	PI ant	Fund				
		Fund		I				
		6. 00	7.00	8.00				
1.00	Fund balances at beginning of period	0			0			1.00
2.00	Net income (loss) (from Wkst. G-3, line 29)							2.00
3. 00 4. 00	Total (sum of line 1 and line 2)	0	0		0			3.00
5. 00	Additions (credit adjustments) (specify)		0					4. 00 5. 00
6. 00			0					6.00
7. 00			0					7.00
8. 00			0					8.00
9.00			0	1				9.00
10.00	Total additions (sum of line 4-9)	0			0			10.00
11.00	Subtotal (line 3 plus line 10)	0			0			11.00
12.00	Deductions (debit adjustments) (specify)		0					12.00
13.00			0	1				13.00
14.00			0	1				14.00
15. 00			0					15.00
16.00			0]				16.00
17. 00 18. 00	Total deductions (sum of lines 12-17)		0	1	0			17. 00 18. 00
19. 00	Fund balance at end of period per balance sheet (line 11 minus line 18)	0			0			19.00

UNION HOSPITAL, INC.

| Peri od: | Worksheet G-2 | From 01/01/2017 | Parts | & II | To 12/31/2017 | Date/Time Prepared: Health Financial Systems
STATEMENT OF PATLENT REVENUES AND OPERATING EXPENSES Provider CCN: 15-0023

PABT I - PATIENT REVENUES 1.00 2.00 3.00 1.00 2.00 3.00 1.00 2.00 3.00 1.00 2.00 3.00 1.00 2.00 3.00 1.00 2.00 3.00 1.00 2.00 3.00 1.00 1.00 2.00 3.00 1.00 1.00 2.00 3.00 1.00			1	o 12/31/2017	Date/Time Pre 5/30/2018 2:1	
PART I - PATIENT REVENUES		Cost Center Description	Innatient	Outpatient		o pili
PART I - PATLENT REVENUES General Inpatit ent Routine Services		oust denter beset per on				
Comparison Com		PART I - PATIENT REVENUES	1, 00	2.00	0.00	
2.00 SUBPROVIDER - IPF 3, 441, 108 3, 441, 108 3, 441, 108 4, 00 4, 00 4, 00 5, 00						
3. 00 SUBPROVIDER - IRF 1.00 3. 441, 108 3. 441, 108 4. 00 5. 00 5. 00 5. 00 6. 00 7. 00 5. 00 6. 00 7. 00 5. 00 6. 00 7. 00 5. 00 6. 00 7. 00 5. 00 7. 00 5. 00 7. 00 5. 00 7. 00 5. 00 7. 00 5. 00 7. 00 5. 00 7. 00 5. 00 7. 00 5. 00 7. 00 5. 00 7. 00 5. 00 7. 00 5. 00 7. 00 5. 00 7. 00 5. 00 7. 00 5. 00 7. 00 5. 00 7. 00 5. 00 7. 00	1.00	Hospi tal	94, 721, 779		94, 721, 779	1.00
4. 00	2.00	SUBPROVI DER - I PF				2.00
5. 00	3.00	SUBPROVI DER - I RF	3, 441, 108	1	3, 441, 108	3.00
Swing bed - NF Statistics Statistics Swing bed - NF Swing bed -	4.00	SUBPROVI DER				4.00
7. 00	5.00	Swing bed - SNF)	0	5.00
8. 00 NURSING FACILITY	6.00	Swing bed - NF)	0	6.00
9, 00 OTHER LONG TERM CARE Total general inpatient care services (sum of lines 1-9) 98, 162, 887 98, 162, 887 10. 00	7.00	SKILLED NURSING FACILITY				7.00
10.00 Total general inpatient care services (sum of lines 1-9) 98, 162, 887 98, 162, 887 10.00	8.00	NURSING FACILITY				8.00
Intensive Care Type Inpatient Hospital Services	9.00	OTHER LONG TERM CARE				9. 00
11.00 INTENSIVE CARE UNIT 12.00 CORONARY CARE UNIT 12.00 CORONARY CARE UNIT 13.00 BURN INTENSIVE CARE UNIT 14.00 SURGI CAL I NTENSIVE DATE UNIT SURGI CAL CENTER DATE UNIT SURGI CAL CENTER (D.P.) SURGI C	10.00	Total general inpatient care services (sum of lines 1-9)	98, 162, 887		98, 162, 887	10.00
12. 00 CORONARY CARE UNIT 13. 00 BURN INTENSIVE CARE UNIT 13. 00 BURN INTENSIVE CARE UNIT 14. 864, 635 14. 864, 635 15. 00 15. 00 INTENSIVE NURSERY 14. 864, 635 15. 00 10. 01 INTENSIVE NURSERY 14. 864, 635 15. 00 10. 01 Intensive care type inpatient hospital services (sum of lines 38, 537, 537 38, 537, 537 38, 537, 537 16. 00 10. 01 Intensive care type inpatient hospital services (sum of lines 36, 700, 424 17. 00 10. 01 Intensive care type inpatient hospital services (sum of lines 30, 392, 138 132, 546, 004 153, 938, 142 19. 00 19. 00 RURAL HEALTH CLINIC 0 0 0 0 0 0 0 0 0				_		
13. 00 BURN INTENSIVE CARE UNIT 13. 00 14. 00 14. 00 14. 00 15. 00 17. 00 17. 00 18. 00 18. 00 19. 00 1			23, 672, 902	!	23, 672, 902	
14. 00 SURGICAL INTENSIVE CARE UNIT 15.00 INTENSIVE NURSERY 16.00 Total intensive care type inpatient hospital services (sum of lines 10 and 16) 17.00 Total inpatient routine care services (sum of lines 10 and 16) 18.00 Ancillary services 19.00 Outpatient services 19.00 Outpatient services 19.00 Outpatient services 19.00 Outpatient Agency 20.00 RURAL HEALTH CLINIC 20.00 FEDERALLY QUALIFIED HEALTH CENTER 20.00 OUTPATIENT AGENCY 21.00 OUTPATIENT AGENCY 22.00 AMBULANCE SERVICES 24.00 CMHC 25.00 AMBULATORY SURGICAL CENTER (D.P.) 26.00 OUTPATIENT AGENCY 27.00 PRO FEES 29.00 OUTPATIENT AGENCY 29.00 OUTPAT						
15. 00 INTENSIVE NURSERY Total intensive care type inpatient hospital services (sum of lines 14,864,635 38,537,537 10.00 11-15) 17. 00 Total inpatient routine care services (sum of lines 10 and 16) 136,700,424 17.5,061,763 136,700,424 17.00 136,700,424 136,700,424 136,700,424 136,700,424 1						
16. 00 Total intensive care type inpatient hospital services (sum of lines 10 and 16)						
11-15 136, 700, 424 17.00 136, 700, 424 17.00 136, 700, 424 17.00 136, 700, 424 17.00 136, 700, 424 17.00 136, 700, 424 17.00 136, 700, 424 17.00 136, 700, 424 17.00 18.00 19.00 0.0					• •	
17.00	16. 00		38, 537, 537		38, 537, 537	16. 00
18.00 Ancillary services 346,079,342 715,061,763 1,061,141,105 18.00 19.00 0 0 0 0 153,938,142 19.00 20.00 RURAL HEALTH CLINIC 0 0 0 0 0 0 0 0 20.00 21.00 22.00 HOME OFFICE 0 0 0 0 0 0 0 23.00 24.00 25.00 AMBULANCE SERVICES 2,482,377 20,600,369 23,082,746 27.00 27.00 28.00 70.00 29.0						
19. 00 Outpatient services						
20. 00 RURÂL HEALTH CLINIC 0 0 0 0 20. 00 21. 00 FEDERALLY QUALIFIED HEALTH CENTER 0 0 0 0 22. 00 HOME HEALTH AGENCY 22. 00 23. 00 AMBULANCE SERVICES 24. 00 25. 00 AMBULATORY SURGICAL CENTER (D.P.) 25. 00 26. 00 HOSPICE 26. 00 27. 00 PRO FEES 2, 482, 377 20, 600, 369 23, 082, 746 28. 00 Total patient revenues (sum of lines 17-27) (transfer column 3 to Wkst. 515, 654, 281 859, 208, 136 1, 374, 862, 417 28. 00 G-3, line 1) PART II - OPERATING EXPENSES 29. 00 30. 00 HOME OFFICE 113, 502, 508 31. 00 31. 00 32. 00 33. 00 33. 00 34. 00 35. 00 35. 00 Total additions (sum of lines 30-35) 113, 502, 508 36. 00 Total additions (sum of lines 30-35) 113, 502, 508 37. 00 DEDUCT (SPECIFY) 0 37. 00 38. 00 39. 00 0 39. 00 39. 00 0 39. 00 39. 00 0 39. 00 39. 00 0 39. 00 39. 00 0 39. 00 39. 00 0 39. 00 39. 00 0 39. 00 39. 00 0 39. 00 39. 00 0 39. 00 30. 00 0 0 0 30. 00 0 0 30. 00 0 0 30. 00 0 0 30. 00 0 0 30. 00 0 0 30. 00 0 0 30. 00 0 30. 00 0 0 30. 00 0 0 30. 00 0 0 30. 00 0 30. 00 0 0 30. 00 0 0 30. 00 0 0 30. 00 0 0 30. 00 0 0 30. 00 0 0 30. 00 0 0 30. 00 0 0 30. 00 0 0 30. 00 0 0 30. 00 0 0 30. 00 0 0 30. 00 0 0 30. 00 0 0 30. 00 0 0 0			1 ' '			
21. 00 FEDERALLY QUALIFIED HEALTH CENTER 0 0 0 21. 00 22. 00 23. 00 24. 00				1	• •	
22. 00 HOME HEALTH AGENCY 23. 00 AMBULANCE SERVICES 24. 00 CMHC 25. 00 AMBULATORY SURGICAL CENTER (D.P.) 26. 00 HOSPICE 27. 00 PRO FEES 2, 482, 377 20, 600, 369 23, 082, 746 27. 00 26. 01 Total patient revenues (sum of lines 17-27) (transfer column 3 to Wkst. 515, 654, 281 859, 208, 136 1, 374, 862, 417 28. 00 29. 00 Operating expenses (per Wkst. A, column 3, line 200) 30. 00 HOME OFFICE 30. 00 32. 00 33. 00 34. 00 33. 00 34. 00 35. 00 36. 00 37. 00 38. 00 37. 00 38. 00 39. 00			1	_		
23. 00 24. 00 24. 00 25. 00 26. 00 27. 00 28. 00 29. 00 29. 00 20 20 20 20 20 20 20 20 20 20 20 20 2				0	0	
24. 00 25. 00 26. 00 26. 00 27. 00 28. 00 28. 00 29. 00 29. 00 30. 00 31. 00 32. 00 33. 00 34. 00 35. 00 36. 00 37. 00 38. 00 39. 00 30						
25. 00 AMBULATORY SURGICAL CENTER (D. P.) HOSPICE PRO FEES OTO Total patient revenues (sum of lines 17-27) (transfer column 3 to Wkst. 515, 654, 281 859, 208, 136 1, 374, 862, 417 859, 208, 208, 208, 208, 208, 208, 208, 208						
26. 00 27. 00 27. 00 28. 00 Total patient revenues (sum of lines 17-27) (transfer column 3 to Wkst. Column 3 to Wkst. Column 3 to Wkst. Sister Sist						
27. 00 PRO FEES Total patient revenues (sum of lines 17-27) (transfer column 3 to Wkst. G-3, line 1) PART II - OPERATING EXPENSES 29. 00 30. 00 HOME OFFICE 00 31. 00 32. 00 33. 00 34. 00 35. 00 36. 00 37. 00 38. 00 39. 00 00 113, 502, 508 113, 502, 508 113, 502, 508 113, 502, 508 113, 502, 508 113, 502, 508 113, 502, 508 113, 502, 508 113, 502, 508 113, 502, 508 36. 00 37. 00 38. 00 39. 00						
28. 00 Total patient revenues (sum of lines 17-27) (transfer column 3 to Wkst. G-3, line 1) PART II - OPERATING EXPENSES 29. 00 HOME OFFICE 113, 502, 508 31. 00 32. 00 33. 00 34. 00 35. 00 36. 00 37. 00 38. 00 39. 00 39. 00 39. 00			2 492 277	20 600 260	22 002 746	
G-3, line 1) PART II - OPERATING EXPENSES 29.00 30.00 31.00 31.00 32.00 33.00 33.00 34.00 35.00 36.00 37.00 38.00 38.00 39.00 39.00 39.00						
PART II - OPERATING EXPENSES 29.00	20.00		313, 034, 201	037, 200, 130	1, 374, 002, 417	20.00
29. 00 30. 00 30. 00 31. 00 32. 00 33. 00 33. 00 34. 00 35. 00 36. 00 37. 00 38. 00 39. 00 39. 00 39. 00						
30. 00 HOME OFFICE 113, 502, 508 30. 00 31. 00 32. 00 33. 00 33. 00 33. 00 34. 00 35. 00 36. 00 36. 00 37. 00 38. 00 39. 00 39. 00 39. 00 39. 00 39. 00 39. 00 39. 00 39. 00 30. 00 31. 00 31. 00 32. 00 33. 00 33. 00 33. 00 34. 00 35. 00	29. 00			328, 275, 509		29. 00
31.00 32.00 33.00 34.00 35.00 36.00 37.00 38.00 39.00 31.00 0 32.00 33.00 34.00 35.00 36.00 37.00 38.00 39.00			113, 502, 508			
32.00 33.00 34.00 35.00 36.00 37.00 38.00 39.00 30.00 31.00 32.00 33.00 34.00 35.00 35.00 36.00 37.00 38.00 39.00	31. 00					31.00
34.00 35.00 36.00 37.00 38.00 39.00 34.00 0 113,502,508 36.00 37.00 0 38.00 39.00						
35.00 36.00 37.00 38.00 39.00 35.00 113,502,508 36.00 37.00 38.00 39.00						
36.00 Total additions (sum of lines 30-35) 37.00 DEDUCT (SPECIFY) 38.00 39.00 30.00 31.00 31.00 32.00 33.00 39.00	34.00					34.00
37. 00 DEDUCT (SPECIFY) 0 37. 00 38. 00 39. 00 0 39. 00	35.00			1		35.00
38. 00 39. 00 0 39. 00	36.00	Total additions (sum of lines 30-35)		113, 502, 508		36.00
39.00	37.00	DEDUCT (SPECIFY)		1		37.00
	38.00)		38.00
40.00	39.00					39.00
			1			
41.00						
42.00 Total deductions (sum of lines 37-41) 0 42.00				0		
43.00 Total operating expenses (sum of lines 29 and 36 minus line 42)(transfer 441,778,017 43.00	43.00		nsfer	441, 778, 017		43.00
to Wkst. G-3, line 4)		to wkst. G-3, line 4)	1	l		

	Health Financial Systems UNION HOSPITAL, INC. STATEMENT OF REVENUES AND EXPENSES Provider CCN: 15-0023 Period: W					
STATE	Priorities and expenses Period: W					
			To 12/31/2017			
			L.	5/30/2018 2:1	8 pm	
				1 00		
1 00	Total nations revenues (from Wkst C 2 Port L column 2 Li	no 20)		1. 00 1, 374, 862, 417	1. 00	
1. 00 2. 00	Total patient revenues (from Wkst. G-2, Part I, column 3, li Less contractual allowances and discounts on patients' accou				2. 00	
3. 00	Net patient revenues (line 1 minus line 2)	IIIS		951, 629, 944 423, 232, 473	3. 00	
4. 00	Less total operating expenses (from Wkst. G-2, Part II, line	43)		441, 778, 017	4. 00	
5. 00	Net income from service to patients (line 3 minus line 4)	43)		-18, 545, 544	5. 00	
0.00	OTHER I NCOME			10, 010, 011	0.00	
6. 00	Contributions, donations, bequests, etc			0	6.00	
7.00	Income from investments			0	7.00	
8.00	Revenues from telephone and other miscellaneous communicatio	n services		0	8.00	
9.00	Revenue from television and radio service			0	9.00	
10.00	Purchase di scounts			0	10.00	
11. 00				0	11.00	
12.00				0	12.00	
13. 00	Revenue from Laundry and Linen service			0	13.00	
14. 00	Revenue from meals sold to employees and guests			0	14.00	
15. 00	3 1				15.00	
	Revenue from sale of medical and surgical supplies to other	than patients		0	16. 00	
17.00	1				17.00	
18.00					18.00	
	Tuition (fees, sale of textbooks, uniforms, etc.)				19.00	
20. 00 21. 00				0	20. 00 21. 00	
21.00	Rental of vending machines Rental of hospital space			ŭ	21.00	
23. 00	Governmental appropriations			0	23. 00	
24. 00	OTHER OPERATING			13, 913, 394		
24. 00				10, 498, 411		
	Total other income (sum of lines 6-24)			24, 411, 805		
	Total (line 5 plus line 25)			5, 866, 261		
27. 00				-8, 428, 261		
	Total other expenses (sum of line 27 and subscripts)			-8, 428, 261		
	Net income (or loss) for the period (line 26 minus line 28)			14, 294, 522		
	1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1		'	.,,		

Hoal th	Financial Systems	UNION HOSPITAI	LNC	In lie	u of Form CMS-2	2552_10
	ATION OF CAPITAL PAYMENT	ON NOST TA	Provi der CCN: 15-0023	Period: From 01/01/2017 To 12/31/2017	Worksheet L Parts I-III Date/Time Pre 5/30/2018 2:1	pared:
			Title XVIII	Hospi tal	PPS	
	DART I SULLY PROOPERTING METURE				1. 00	
	PART I - FULLY PROSPECTIVE METHOD					
1. 00	CAPITAL FEDERAL AMOUNT Capital DRG other than outlier				4, 754, 420	1.00
1. 00	Model 4 BPCI Capital DRG other than outlier				4, 754, 420 0	1.00
2. 00	Capital DRG outlier payments				104, 943	2.00
2. 00	Model 4 BPCI Capital DRG outlier payments				104, 743	2.00
3. 00	Total inpatient days divided by number of day	vs in the cost re	enorting period (see ins	tructions)	164. 27	3.00
4. 00	Number of interns & residents (see instruction		sporting period (see ins	11 40 (1 0113)	20. 67	4.00
5. 00	Indirect medical education percentage (see in	,			3. 61	5. 00
6. 00	Indirect medical education adjustment (multip		e sum of lines 1 and 1.0	1. columns 1 and	171, 635	6. 00
	1.01) (see instructions)	, ,				
7. 00	Percentage of SSI recipient patient days to 1 30) (see instructions)	Medicare Part A p	oatient days (Worksheet	E, part A line	5. 64	7. 00
8.00	Percentage of Medicaid patient days to total	days (see instru	ıctions)		22. 95	8. 00
9.00	Sum of lines 7 and 8		•		28. 59	9. 00
10.00	Allowable disproportionate share percentage	(see instructions	s)		5. 96	10.00
11.00	Disproportionate share adjustment (see instru	uctions)			283, 363	11.00
12.00	Total prospective capital payments (see inst	ructions)			5, 314, 361	12.00
	T				1. 00	
4 00	PART II - PAYMENT UNDER REASONABLE COST					1 00
1. 00 2. 00	Program inpatient routine capital cost (see Program inpatient ancillary capital cost (see				0	1. 00 2. 00
3. 00	Total inpatient program capital cost (line 1				0	3.00
4. 00	Capital cost payment factor (see instructions	'			0	4.00
5. 00	Total inpatient program capital cost (line 3	,			0	
0.00	Trotal Tripatricité program capital cost (Trino o	X TTHE 1)				0.00
	DADT III COMPUTATION OF EVOEDTION DAVMENTS				1. 00	
1 00	PART III - COMPUTATION OF EXCEPTION PAYMENTS Program inpatient capital costs (see instruc-	+! ono)			0	1 00
1. 00 2. 00	Program inpatient capital costs (see instruction of the costs for extraordinate of the costs (see instruction of the costs).	,	cos (soo instructions)		0	1.00 2.00
3. 00	Net program inpatient capital costs for extraordi		Les (see mistructions)		0	3.00
4. 00	Applicable exception percentage (see instructions)				0.00	
5. 00	Capital cost for comparison to payments (line				0.00	5.00
6. 00	Percentage adjustment for extraordinary circi	,	nstructions)		0.00	
7. 00	Adjustment to capital minimum payment level	•	,	x line 6)	0.00	
8. 00	Capital minimum payment level (line 5 plus li	,	(1116 2		0	8.00
9. 00	Current year capital payments (from Part I,		cable)		0	9. 00
10.00	Current year comparison of capital minimum pa			less line 9)	0	10.00
11. 00	Carryover of accumulated capital minimum pays Worksheet L. Part III, line 14)				0	11. 00
12.00	Net comparison of capital minimum payment le	vel to capital pa	ayments (line 10 plus li	ne 11)	0	12.00
13.00	Current year exception payment (if line 12 is				0	13.00
14. 00	Carryover of accumulated capital minimum pays (if line 12 is negative, enter the amount on	ment level over o			0	14. 00
15.00	,		structions)		0	15. 00
16.00	, ,	1 2 1	,		0	16.00
17.00	Current year exception offset amount (see in				0	17. 00