	required by law (42 USC 1395				
payments made	since the beginning of the co	st reporting period being	, deemed overpayments	s (42 USC 1395g).	OMB NO. 0938-0050
					EXPIRES 05-31-2019
HOSPITAL AND H	OSPITAL HEALTH CARE COMPLEX C	OST REPORT CERTIFICATION	Provider CCN: 15-132	26 Peri od:	Worksheet S
AND SETTLEMENT	SUMMARY			From 01/01/2017	Parts I-III
700 SETTELMENT				To 12/31/2017	Date/Time Prepared:
					5/30/2018 1:50 pm
PART I - COST	REPORT STATUS				
Provi der	1. [ X ] Electronically filed	cost report		Date: 5/30/20	018 Time: 1:50 pm
use only	2. [ ] Manually submitted co	st report			
	3. [ 0 ] If this is an amended	report enter the number	of times the provide	er resubmitted this o	cost report
	4. [ F ] Medicare Utilization.				
Contractor	5. [ 1 ]Cost Report Status	6. Date Received:		10. NPR Date:	
use only	(1) Ås Submitted	7. Contractor No.		11. Contractor's Vende	or Code: 4
use om y	(2) Settled without Audit	8. [ N ] Initial Report fo	r this Provider CCN	12. [ 0 ] If line 5, co	olumn 1 is 4: Enter
	(3) Settled with Audit	9. N Final Report for	this Provider CCN	number of tim	mes reopened = 0-9.
	(4) Reopened	·			
	(5) Amended				

## PART II - CERTIFICATION

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 CLINTON (15-1326) 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)
	Officer or Administrator of Provider(s)
	Title
	Date

	·		Title	XVIII			
	Cost Center Description	Title V	Part A	Part B	HI T	Title XIX	
		1. 00	2.00	3. 00	4. 00	5. 00	
	PART III - SETTLEMENT SUMMARY						
1.00	Hospi tal	0	662, 790	822, 081	0	15, 737	1.00
2.00	Subprovider - IPF	0	0	0		0	2.00
3.00	Subprovider - IRF	0	0	0		0	3.00
5.00	Swing bed - SNF	0	26, 370	0		0	5. 00
6.00	Swing bed - NF	0				0	6.00
200.00	Total	0	689, 160	822, 081	0	15, 737	200.00

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

Health Financial Systems UNION HOSPITAL CLINTON In Lieu of Form CMS-2552-10 HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA Provider CCN: 15-1326 Peri od: Worksheet S-2 From 01/01/2017 Part I Date/Time Prepared: 12/31/2017 5/30/2018 1:49 pm 3.00 4.00 Hospital and Hospital Health Care Complex Address: Street: 801 SOUTH MAIN STREET 1.00 1.00 PO Box: State: IN County: VERMILLION 2.00 City: CLINTON Zip Code: 47842-2.00 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 CLINTON 151326 45460 03/01/2005 Ν 3.00 Subprovi der - IPF 4.00 4.00 Subprovi der - IRF 5.00 5 00 Subprovi der - (Other) 6.00 6.00 Swing Beds - SNF 7.00 SWING BEDS 15Z326 45460 03/01/2005 N 0 0 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 Hospi tal -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 Hospital-Based Health Clinic - FQHC 16.00 16.00 17.00 Hospital -Based (CMHC) I 17.00 18.00 Renal Dialysis 18 00 19.00 Other 19.00 From To: 2.00 1.00 20.00 Cost Reporting Period (mm/dd/yyyy) 01/01/2017 12/31/2017 20 00 Type of Control (see instructions) 21.00 Inpatient PPS Information Does this facility qualify and is it currently receiving payments for disproportionate N 22.00 22.00 N 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. 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 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 used in the prior cost reporting period? In column 2, enter "Y" for yes or "N" for no.

	In-State	In-State	Out-of	Out-of	Medicaid	Other	
	Medicai d	Medi cai d	State	State	HMO days	Medi cai d	
	paid days	el i gi bl e	Medi cai d	Medi cai d		days	
		unpai d	paid days	el i gi bl e			
		days		unpai d			
	1.00	2. 00	3. 00	4. 00	5. 00	6. 00	
24.00 If this provider is an IPPS hospital, enter the	0	0	0	0	0	0	24.00
in-state Medicaid paid days in column 1, in-state							
Medicaid eligible unpaid days in column 2,							
out-of-state Medicaid paid days in column 3,							
out-of-state Medicaid eligible unpaid days in column							
4, Medicaid HMO paid and eligible but unpaid days in							
column 5, and other Medicaid days in column 6.							
25.00 If this provider is an IRF, enter the in-state	0	0	o	0	0		25. 00
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.							
pand and original but dispute days in condimit or	I		1			'	1

In Lieu of Form CMS-2552-10 Health Financial Systems UNION HOSPITAL CLINTON HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA Provider CCN: 15-1326 Peri od: Worksheet S-2 From 01/01/2017 Part I Date/Time Prepared: 12/31/2017 5/30/2018 1:49 pm Urban/Rural S Date of Geogr 2.00 1.00 26.00 Enter your standard geographic classification (not wage) status at the beginning of the cost reporting period. Enter "1" for urban or "2" for rural. 26.00 Enter your standard geographic classification (not wage) status at the end of the cost reporting period. Enter in column 1, "1" for urban or "2" for rural. If applicable, 27.00 enter the effective date of the geographic reclassification in column 2. If this is a sole community hospital (SCH), enter the number of periods SCH status in 35.00 35.00 effect in the cost reporting period. Begi nni ng: Endi ng: 1.00 2.00 36.00 Enter applicable beginning and ending dates of SCH status. Subscript line 36 for number 36.00 of periods in excess of one and enter subsequent dates. 37.00 | If this is a Medicare dependent hospital (MDH), enter the number of periods MDH status 37.00 is in effect in the cost reporting period. Is this hospital a former MDH that is eligible for the MDH transitional payment in 37.01 Ν 37.01 accordance with FY 2016 OPPS final rule? Enter "Y" for yes or "N" for no. (see instructions) 38.00 | If line 37 is 1, enter the beginning and ending dates of MDH status. If line 37 is 38.00 greater than 1, subscript this line for the number of periods in excess of one and enter subsequent dates. Y/N Y/N 1.00 2.00 39.00 Does this facility qualify for the inpatient hospital payment adjustment for low volume 39.00 Ν N hospitals in accordance with 42 CFR §412.101(b)(2)(i) or (ii)? Enter in column 1 "Y" for yes or "N" for no. Does the facility meet the mileage requirements in accordance with 42 CFR 412.101(b)(2)(i) or (ii)? Enter in column 2 "Y" for yes or "N" for no. (see instructions) 40.00 | Is this hospital subject to the HAC program reduction adjustment? Enter "Y" for yes or Ν Ν 40.00 "N" for no in column 1, for discharges prior to October 1. Enter "Y" for yes or "N" for no in column 2, for discharges on or after October 1. (see instructions) XVIII XIX 1.00 2.00 | 3.00 Prospective Payment System (PPS)-Capital 45.00 Does this facility qualify and receive Capital payment for disproportionate share in accordance N N N 45.00 with 42 CFR Section §412.320? (see instructions) 46.00 Is this facility eligible for additional payment exception for extraordinary circumstances N N N 46 00 pursuant to 42 CFR §412.348(f)? If yes, complete Wkst. L, Pt. III and Wkst. L-1, Pt. I through Is this a new hospital under 42 CFR §412.300(b) PPS capital? Enter "Y for yes or "N" for no. 47.00 Ν 47.00 Is the facility electing full federal capital payment? Enter "Y" for yes or "N" for no. Ν 48.00 Ν Ν Teaching Hospitals Is this a hospital involved in training residents in approved GME programs? Enter "Y" for yes Ν 56.00 or "N" for no. 57.00 If line 56 is yes, is this the first cost reporting period during which residents in approved 57.00 GME programs trained at this facility? Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y" did residents start training in the first month of this cost reporting period? Enter "Y" for yes or "N" for no in column 2. If column 2 is "Y", complete Worksheet E-4. If column 2 is "N", complete Wkst. D, Parts III & IV and D-2, Pt. II, if applicable. 58.00 If line 56 is yes, did this facility elect cost reimbursement for physicians' services as 58.00 defined in CMS Pub. 15-1, chapter 21, §2148? If yes, complete Wkst. D-5. 59.00 Are costs claimed on line 100 of Worksheet A? If yes, complete Wkst. D-2 P† 59.00 NAHE 413.85 Worksheet A Pass-Through Y/N Line # Qualification Cri teri on Code 1. 00 2. 00 3. 00 60.00 Are you claiming nursing and allied health education (NAHE) costs for 60.00 Ν (see instructions) any programs that meet the criteria under §413.85? Direct GME IMF Direct GME Y/N IMF 2. 00 1.00 3.00 4.00 5.00 61.00 Did your hospital receive FTE slots under ACA 0.00 0.00 61.00 section 5503? Enter "Y" for yes or "N" for no in column 1. (see instructions) Enter the average number of unweighted primary care 61.01 FTEs from the hospital's 3 most recent cost reports ending and submitted before March 23, 2010. (see instructions) 61.02 Enter the current year total unweighted primary care 61.02 FTE count (excluding OB/GYN, general surgery FTEs, and primary care FTEs added under section 5503 of ACA). (see instructions) 61.03 Enter the base line FTE count for primary care 61.03 and/or general surgery residents, which is used for determining compliance with the 75% test. (see instructions)

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFI			IIA	Provi der C	UN: 15-1326	Peri od: From 01/01/2017 To 12/31/2017	Worksheet S-2 Part I Date/Time Pre 5/30/2018 1:4	pared:
			Y/N	IME	Direct GME	I ME	Direct GME	7 piii
			1.00	2. 00	3.00	4. 00	5. 00	1
	Enter the number of unweighted p surgery allopathic and/or osteop current cost reporting period.(s Enter the difference between the	athic FTEs in the ee instructions).						61.04
1. 06	and/or general surgery FTEs and primary care and/or general surg 61.04 minus line 61.03). (see in Enter the amount of ACA §5503 amused for cap relief and/or FTEs	ery FTE counts (line structions) ard that is being						61.06
	care or general surgery. (see in							
			Pro	ogram Name	Program Cod	e Unweighted IME FTE Count	Unweighted Direct GME FTE Count	
(1.10				1. 00	2. 00	3. 00	4.00	
	Of the FTEs in line 61.05, speci specialty, if any, and the numbe for each new program. (see instr column 1, the program name. Ente program code. Enter in column 3, unweighted count. Enter in colum FTE unweighted count.	r of FTE residents uctions) Enter in r in column 2, the the IME FTE				0.00	0.00	61.10
	Of the FTEs in line 61.05, speci program specialty, if any, and t residents for each expanded prog instructions) Enter in column 1, Enter in column 2, the program of 3, the IME FTE unweighted count the direct GME FTE unweighted count	he number of FTE ram. (see the program name. ode. Enter in column Enter in column 4,				0.00	0. 00	61. 20
							1. 00	
	ACA Provisions Affecting the Hea Enter the number of FTE resident your hospital received HRSA PCRE	s that your hospital	trai ned			eriod for which	0.00	62.00
	Enter the number of FTE resident during in this cost reporting pe Teaching Hospitals that Claim Re	s that rotated from a riod of HRSA THC pro	a Teachi gram. (s	<u>see instructio</u>		to your hospital	0.00	62. 01
	Has your facility trained reside "Y" for yes or "N" for no in col	nts in nonprovider se	ettings	during this d			N	63.00
	1 101 yes 61 N 101 110 111 ear	umir r. rr yes, compre	210 1111	es of through	Unwei ghted FTEs Nonprovi der	Unweighted FTEs in	Ratio (col. 1/ (col. 1 + col. 2))	
					Si te 1.00	2. 00	3.00	-
	Section 5504 of the ACA Base Yea	r FTE Residents in No	onprovi	der Settings-				
	period that begins on or after s Enter in column 1 if line 63 is				0.	0.00	0. 000000	64 nr
	64.00 Enter in column 1, if line 63 is yes, or your facility trained residents 0.00 0.00 0.000 in the base year period, the number of unweighted non-primary care resident FTEs attributable to rotations occurring in all nonprovider settings. Enter in column 2 the number of unweighted non-primary care						3. 000000	37.00
	resident FTEs that trained in yo of (column 1 divided by (column							
		Program Name		ogram Code	Unwei ghted FTEs Nonprovi der	FTEs in	Ratio (col. 3/ (col. 3 + col. 4))	
					Si te	noopi tai	001. 177	

Health Financial Systems UNION HOSPITAL CLINTON In Lieu of Form CMS-2552-10 HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA Provi der CCN: 15-1326 Peri od: Worksheet S-2 From 01/01/2017 Part I 12/31/2017 Date/Time Prepared: 5/30/2018 1:49 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 0.000000 65.00 0.00 0. 00 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 0. 00 0. 00 0.000000 67.00 name associated with each of your primary care programs in which you trained residents. Enter in column 2, the program code. Enter in column 3, the number of unweighted primary care FTE residents attributable to rotations occurring in all non-provider settings. Enter in column 4, the number of unweighted primary care resident FTEs that trained in your hospital. Enter in column 5, the ratio of (column 3 divided by (column 3 + column 4)). (see instructions)

	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	N			75.00
subprovi der? Enter "Y" for yes and "N" for no.				

OSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA Pro	vider CCN: 15-1326	Period: From 01/01/ To 12/31/	′2017 ′2017	Worksheet S- Part I Date/Time Pr 5/30/2018 1:	repared:
			1.00	2.00 3.00	5
6.00 If line 75 is yes: Column 1: Did the facility have an approved GMI recent cost reporting period ending on or before November 15, 200-no. Column 2: Did this facility train residents in a new teaching CFR 412.424 (d)(1)(iii)(D)? Enter "Y" for yes or "N" for no. Columindicate which program year began during this cost reporting periods.	4? Enter "Y" for yes program in accordam nn 3: If column 2 is	s or "N" for nce with 42 s Y,		0	76. 0
Long Term Care Hospital PPS				1. 00	_
0.00 Is this a long term care hospital (LTCH)? Enter "Y" for yes and "1.00 Is this a LTCH co-located within another hospital for part or all "Y" for yes and "N" for no.  TEFRA Providers		ng period? I	Enter	N N	80. 0 81. 0
5.00 Is this a new hospital under 42 CFR Section §413.40(f)(1)(i) TEFR. 6.00 Did this facility establish a new Other subprovider (excluded unif §413.40(f)(1)(ii)? Enter "Y" for yes and "N" for no.			no.	N	85. 0 86. 0
7.00 Is this hospital an extended neoplastic disease care hospital clast 1886(d)(1)(B)(vi)? Enter "Y" for yes or "N" for no.	ssified under sectio	on		N	87.0
		V		XIX	
THE WALL WILL COLUMN		1.00		2. 00	1
Title V and XIX Services  0.00 Does this facility have title V and/or XIX inpatient hospital services	vices? Enter "Y" for	- Y		N	90.0
yes or "N" for no in the applicable column.  1.00 Is this hospital reimbursed for title V and/or XIX through the co		N		N	91.0
full or in part? Enter "Y" for yes or "N" for no in the applicable 2.00 Are title XIX NF patients occupying title XVIII SNF beds (dual cell instructions) Enter "Y" for yes or "N" for no in the applicable of	rtification)? (see			N	92.0
3.00 Does this facility operate an ICF/IID facility for purposes of ti- "Y" for yes or "N" for no in the applicable column.		- N		N	93.0
4.00 Does title V or XIX reduce capital cost? Enter "Y" for yes, and "I applicable column.	N" for no in the	N		N	94.0
5.00   If line 94 is "Y", enter the reduction percentage in the applicable 6.00   Does title V or XIX reduce operating cost? Enter "Y" for yes or "I applicable column.		0. 00 N		0. 00 N	95. C
7.00 If line 96 is "Y", enter the reduction percentage in the applicable 8.00 Does title V or XIX follow Medicare (title XVIII) for the interns 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.	and residents post	0. 00 Y		0. 00 Y	97. 0 98. 0
8.01 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, title XIX.				Υ	98.0
B.O2 Does title V or XIX follow Medicare (title XVIII) for the calcula 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.	tion of observation for no in column 1	Y		Υ	98.0
B. 03 Does title V or XIX follow Medicare (title XVIII) for a critical a reimbursed 101% of inpatient services cost? Enter "Y" for yes or for title V, and in column 2 for title XIX.				N	98.0
3.04 Does title V or XIX follow Medicare (title XVIII) for a CAH reimboutpatient services cost? Enter "Y" for yes or "N" for no in columin column 2 for title XIX.		nd N		N	98. (
3.05 Does title V or XIX follow Medicare (title XVIII) and add back the Wkst. C, Pt. I, col. 4? Enter "Y" for yes or "N" for no in column column 2 for title XIX.				Υ	98. (
3.06 Does title V or XIX follow Medicare (title XVIII) when cost reimbut Pts. I through IV? Enter "Y" for yes or "N" for no in column 1 for column 2 for title XIX.  Rural Providers	· ·	Y		Y	98.0
D5.00 Does this hospital qualify as a CAH? D6.00 If this facility qualifies as a CAH, has it elected the all-inclus	sive method of paymo	ent N			105. 0 106. 0
for outpatient services? (see instructions) 07.00  If this facility qualifies as a CAH, is it eligible for cost reiml training programs? Enter "Y" for yes or "N" for no in column 1. (syes, the GME elimination is not made on Wkst. B, Pt. I, col. 25 and reimbursed. If yes complete Wkst. D-2, Pt. II.	see instructions) I1				107.0
08.00  s this a rural hospital qualifying for an exception to the CRNA	fee schedule? See	12 N			108.0

All Providers

HOSPITAL AND HOSPITAL HEALTH CARE COMPLE	X IDENTIFICATION DATA	AL CLINTON Provider CCN	: 15-1326			Worksheet S- Part I Date/Time Pr	epared:
						5/30/2018 1:	49 pm
					1. 00	2.00	-
40.00 Are there any related organization chapter 10? Enter "Y" for yes or "	N" for no in column 1. If	yes, and home	office co		Υ	15H043	140. 0
are claimed, enter in column 2 the	2. C		i ons)		3. 00		
If this facility is part of a chai			gh 143 th	e name a		of the home	
office and enter the home office of 41.00 Name: UNION HOSPITAL, INC.		actor number.			lumber: 0810		141. 0
42.00 Street: 1606 NORTH SEVENTH ST	PO Box:						142.0
43.00 Ci ty: TERRE HAUTE	State: IN	l	Zip Co	de:	4780	14	143.0
						1.00	_
44.00 Are provider based physicians' cos	ts included in Worksheet	A?				Y	144.0
					1. 00	2. 00	
45.00  f costs for renal services are clinpatient services only? Enter "Y" no, does the dialysis facility incperiod? Enter "Y" for yes or "N" 46.00 Has the cost allocation methodoloc	for yes or "N" for no ir lude Medicare utilization for no in column 2.	n column 1. If con for this cost	olumn 1 i: reporting		N		145. 0
Enter "Y" for yes or "N" for no in yes, enter the approval date (mm/c	column 1. (See CMS Pub.			lf			
						1. 00	
47.00 Was there a change in the statisti	cal basis? Enter "Y" for	yes or "N" for	no.			N	147. 0
18.00 Was there a change in the order of						N	148. 0
19.00Was there a change to the simplifi	ed cost finding method? E				T: 11 - 1/	N Till VIV	149. (
		Part A 1.00	Part B 2.00	1	Ti tle V 3.00	Title XIX 4.00	
Does this facility contain a provi	der that qualifies for an			ication			
or charges? Enter "Y" for yes or "							
55. 00 Hospi tal	·	N	N		N	N	155. C
56.00 Subprovi der - IPF		N	N		N	N	156.0
57.00 Subprovider - IRF		N	N		N	N	157.0
58. OO SUBPROVI DER 59. OO SNF		N	N		N	N.	158. 0 159. 0
60.00 HOME HEALTH AGENCY		N N	N N		N N	N N	160.0
61. OOCMHC		IN I	N		N	N	161.0
51. 00 0mm				I			
Mul ti campus						1.00	
65.00 is this hospital part of a Multica Enter "Y" for yes or "N" for no.	mpus hospital that has or	ne or more campu:	ses in di	fferent	CBSAs?	N	165.0
, , , , , , , , , , , , , , , , , , , ,	Name	County		Zip Code		FTE/Campus	
	0	1. 00	2. 00	3. 00	4. 00	5. 00	
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)						0.0	00 166. 0
						1.00	
Health Information Technology (HI	) incentive in the Americ	can Recovery and	Rei nvest	ment Act		1.00	
57.00 s this provider a meaningful user 58.00 f this provider is a CAH (line 10	under §1886(n)? Enter " 5 is "Y") and is a meanir	Y" for yes or " ngful user (line	N" for no			Y	167. 0 0168. 0
reasonable cost incurred for the F68.01 If this provider is a CAH and is reception under §413.70(a)(6)(ii)?	ot a meaningful user, doe 'Enter "Y" for yes or "N"	es this provider for no. (see i	nstructio	ns)	•	N	168.0
69.00  f this provider is a meaningful ι transition factor. (see instruction		ııs not a CAH (	ııne 105	ıs "N"),	enter the	0.0	00169.0
(33 1.31 401)	-,			В	egi nni ng	Endi ng	
70.00 Enter in columns 1 and 2 the EHR b	oginning data and andi	data for the	norti ra	01	1.00 1/01/2017	2. 00 12/31/2017	170. 0
		DOLL THE LE		1 ()	170172017	· 12/31/201/	I / U. (

Health Financial Systems	UNION HOSPITAL	CLINTON	In Lie	u of Form CMS-	2552-10
HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTI	FICATION DATA		Peri od:	Worksheet S-2	)
			From 01/01/2017 To 12/31/2017	Date/Time Pre	naradi
			10 12/31/2017	5/30/2018 1: 4	
			1. 00	2. 00	
171.00 If line 167 is "Y", does this provider have	ve any days for indi	viduals enrolled in	N	C	171. 00
section 1876 Medicare cost plans reported					
"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 insti	ructions)				

	Financial Systems UNION HOSPITA AL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE	Provi der C	CN: 15-1326	In Lie Period:	Worksheet S-	
				From 01/01/2017	Part II	
				To 12/31/2017	5/30/2018 1:	
				Y/N	Date	
				1. 00	2. 00	
	General Instruction: Enter Y for all YES responses. Enter N	for all NO re	esponses. Ent	er all dates in	the	
	mm/dd/yyyy format. COMPLETED BY ALL HOSPITALS					
	Provider Organization and Operation					
	Has the provider changed ownership immediately prior to the	beginning of	the cost	N		1.
	reporting period? If yes, enter the date of the change in co					''
			Y/N	Date	V/I	
			1.00	2. 00	3. 00	
00	Has the provider terminated participation in the Medicare P		N			2.
	yes, enter in column 2 the date of termination and in column voluntary or "I" for involuntary.	11 3, V 101				
00	Is the provider involved in business transactions, including	a management	Υ			3.
	contracts, with individuals or entities (e.g., chain home o					-
	or medical supply companies) that are related to the provide					
	officers, medical staff, management personnel, or members o					
	of directors through ownership, control, or family and othe	r similar				
	relationships? (see instructions)		Y/N	Typo	Date	
			1.00	7ype 2. 00	3. 00	
	Financial Data and Reports		1.00	2.00	0.00	
0	Column 1: Were the financial statements prepared by a Cert	ified Public	Υ	Α	04/19/2018	4.
	Accountant? Column 2: If yes, enter "A" for Audited, "C" for					
	or "R" for Reviewed. Submit complete copy or enter date ava	ilable in				
0	column 3. (see instructions) If no, see instructions. Are the cost report total expenses and total revenues diffe	ront from	Y			5.
0	those on the filed financial statements? If yes, submit rec		'			5
	those on the fired friancial statements in job, submit for			Y/N	Legal Oper.	
				1. 00	2. 00	
	Approved Educational Activities					
0	Column 1: Are costs claimed for nursing school? Column 2:	If yes, is the	ne provider i	s N		6.
0	the legal operator of the program?  Are costs claimed for Allied Health Programs? If "Y" see in:	structions		N		7
0	Were nursing school and/or allied health programs approved a		d during the	N N		8
	cost reporting period? If yes, see instructions.	and/or renewed	a dairing the	14		0.
0	Are costs claimed for Interns and Residents in an approved	graduate medi	cal education	N		9.
	program in the current cost report? If yes, see instruction					
00	Was an approved Intern and Resident GME program initiated o	r renewed in	the current	N		10
00	cost reporting period? If yes, see instructions.  Are GME cost directly assigned to cost centers other than I	8. Din an An	around	N		11
00	Teaching Program on Worksheet A? If yes, see instructions.	a k ili ali Api	Ji oved	ĮN.		''
	readining 11 ogram on norkaneet 11. 11 yes, see matract detrons.				Y/N	
					1. 00	
	Bad Debts					
	Is the provider seeking reimbursement for bad debts? If yes				Y	12
00	If line 12 is yes, did the provider's bad debt collection p	olicy change o	during this c	ost reporting	N	13
00	period? If yes, submit copy. If line 12 is yes, were patient deductibles and/or co-payme	nte wai vod2 la	Evos soo in	etructions	N	14
	Bed Complement	iits wai veu: I	yes, see iii	Structions.	<u> </u>	- 14
	Did total beds available change from the prior cost reporting	ng period? If	yes, see ins	tructions.	N	15
			t A		t B	
		Y/N	Date	Y/N	Date	
	DCAD D. L.	1. 00	2. 00	3. 00	4. 00	
	PS&R Data Was the cost report prepared using the PS&R Report only?	Y	04/04/2018	Y	04/04/2018	16
00	If either column 1 or 3 is yes, enter the paid-through	'	047 047 2010	'	04/04/2010	'0
	date of the PS&R Report used in columns 2 and 4 (see					
	instructions)					
00	Was the cost report prepared using the PS&R Report for	N		N		17
	totals and the provider's records for allocation? If					
	either column 1 or 3 is yes, enter the paid-through date					
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	1 V		IN		'°
	but are not included on the PS&R Report used to file this					
			I	1	I	
	cost report? If yes, see instructions.					- 1
00	cost report? If yes, see instructions.  If line 16 or 17 is yes, were adjustments made to PS&R  Report data for corrections of other PS&R Report	N		N		19.

Heal th	Financial Systems UNION HOSPIT	TAL CLINTON		In Lie	u of Form CM	S-2552-10
	AL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE		CN: 15-1326	Period: From 01/01/2017 To 12/31/2017	Worksheet S Part II Date/Time F 5/30/2018 1	S-2 Prepared:
			iption	Y/N	Y/N	
20. 00	If line 16 or 17 is yes, were adjustments made to PS&R		0	1. 00 N	3. 00 N	20.00
20.00	Report data for Other? Describe the other adjustments:			IN	IN	20.00
		Y/N	Date	Y/N	Date	
04.00	III	1.00	2. 00	3.00	4. 00	21.00
21. 00	Was the cost report prepared only using the provider's records? If yes, see instructions.	N		N		21.00
					1. 00	
	COMPLETED BY COST REIMBURSED AND TEFRA HOSPITALS ONLY (EXC	EPT CHILDRENS	HOSPI TALS)			
22.00	Capi tal Related Cost	- !+			N.	
22. 00 23. 00	Have assets been relifed for Medicare purposes? If yes, se Have changes occurred in the Medicare depreciation expense			ring the cost	N N	22. 00 23. 00
20.00	reporting period? If yes, see instructions.	due to apprai	Sar S made ad	Tring the cost		20.00
24. 00	Were new leases and/or amendments to existing leases enter If yes, see instructions	ed into during	this cost re	eporting period?	N	24. 00
25. 00	Have there been new capitalized leases entered into during	, the cost repo	rting period	? If yes, see	N	25. 00
26. 00	instructions. Were assets subject to Sec. 2314 of DEFRA acquired during t	he cost report	ing period?	lf ves see	N	26.00
20.00	instructions.	ine cost report	ing period.	11 903, 300		20.00
27. 00	Has the provider's capitalization policy changed during th copy.	ne cost reporti	ng period? I	f yes, submit	N	27. 00
	Interest Expense					
28. 00	Were new loans, mortgage agreements or letters of credit e period? If yes, see instructions.	entered into du	ring the cos	t reporting	N	28. 00
29. 00	Did the provider have a funded depreciation account and/or	N	29. 00			
30. 00	treated as a funded depreciation account? If yes, see inst Has existing debt been replaced prior to its scheduled mat	N	30.00			
	instructions.					
31. 00	Has debt been recalled before scheduled maturity without i instructions.	ssuance of new	debt? If yes	s, see	N	31.00
32. 00	Purchased Services Have changes or new agreements occurred in patient care se	ervi ces furni sh	ed through c	ontractual	N	32.00
	arrangements with suppliers of services? If yes, see instr	uctions.	Ü			
33. 00	If line 32 is yes, were the requirements of Sec. 2135.2 ap no, see instructions.	plied pertaini	ng to compet	itive bidding? If	N	33.00
	Provi der-Based Physi ci ans					
34.00		rrangement wit	h provi der-b	ased physicians?	Υ	34.00
35 00	If yes, see instructions. If line 34 is yes, were there new agreements or amended ex	risting agreeme	nts with the	nrovi der-hased	N	35.00
	physicians during the cost reporting period? If yes, see i		THE WITH THE	<u>'</u>		
				Y/N 1. 00	2. 00	
	Home Office Costs			1.00	2.00	
36. 00	Were home office costs claimed on the cost report?			Y		36.00
37. 00	If line 36 is yes, has a home office cost statement been p	repared by the	home office	? Y		37.00
38. 00	If yes, see instructions. If line 36 is yes, was the fiscal year end of the home of			f N		38. 00
39. 00	the provider? If yes, enter in column 2 the fiscal year en If line 36 is yes, did the provider render services to oth			s, N		39. 00
40. 00	see instructions. If line 36 is yes, did the provider render services to the	home office?	If ves see	N		40. 00
	instructions.	Tiome office:	11 yes, see	14		40.00
		1.	00	2.	00	
	Cost Report Preparer Contact Information					
41. 00	Enter the first name, last name and the title/position held by the cost report preparer in columns 1, 2, and 3,	CAROLYN		CHAPLI N		41.00
42. 00	respectively. Enter the employer/company name of the cost report	BLUE AND CO.,	LLC			42.00
43. 00	preparer. Enter the telephone number and email address of the cost	3177137919		CCHAPLI N@BLUEA	NDCO COM	43.00
13. 00	report preparer in columns 1 and 2, respectively.	,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,		SOUTH ETHICALDER	.500. OOW	13.00

Health Financial Systems UNION HOS	PITAL CLINTON	In Lie	u of Form CMS-2	552-10
HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE	Provi der CCN: 15-1326	Peri od: From 01/01/2017 To 12/31/2017	Worksheet S-2 Part II Date/Time Prep 5/30/2018 1:49	pared:
	3.00			
Cost Report Preparer Contact Information	0.00			
Enter the first name, last name and the title/position held by the cost report preparer in columns 1, 2, and 3 respectively.	SENI OR MANAGER			41.00
42.00 Enter the employer/company name of the cost report preparer.				42. 00
43.00 Enter the telephone number and email address of the cos report preparer in columns 1 and 2, respectively.	t			43. 00

| Period: | Worksheet S-3 | From 01/01/2017 | Part | To | 12/31/2017 | Date/Time Prepared: 
 Heal th Financial
 Systems
 UNION I

 HOSPITAL
 AND
 HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA
 Provi der CCN: 15-1326

					1	o 12/31/2017	Date/Time Pre 5/30/2018 1:4	
							1/P Days /	, biii
							0/P Visits /	
							Tri ps	
	Component	Worksheet A	No	. of Beds	Bed Days	CAH Hours	Title V	
		Line Number			Avai I abl e			
1 00	Here's total Addition A Body Continues 5 ( 7 and	1. 00		2.00	3. 00	4.00	5. 00	1.00
1. 00	Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and	30.00		19	6, 935	37, 440. 00	0	1.00
	Hospice days) (see instructions for col. 2							
	for the portion of LDP room available beds)							
2. 00	HMO and other (see instructions)							2.00
3. 00	HMO IPF Subprovi der							3.00
4. 00	HMO IRF Subprovider							4.00
5. 00	Hospital Adults & Peds. Swing Bed SNF						0	5.00
6.00	Hospital Adults & Peds. Swing Bed NF						0	6.00
7.00	Total Adults and Peds. (exclude observation			19	6, 935	37, 440. 00	0	7.00
	beds) (see instructions)							
8.00	INTENSIVE CARE UNIT	31.00		6	2, 190	6, 792. 00	0	8. 00
9.00	CORONARY CARE UNIT							9. 00
10.00	BURN INTENSIVE CARE UNIT							10.00
11. 00	SURGICAL INTENSIVE CARE UNIT							11.00
12.00	OTHER SPECIAL CARE (SPECIFY)							12.00
13.00	NURSERY			0.5				13.00
14.00	Total (see instructions)			25	9, 125	44, 232. 00	0	14.00
15.00	CAH visits						0	15.00
16.00	SUBPROVIDER - I PF							16. 00 17. 00
17. 00 18. 00	SUBPROVI DER - I RF SUBPROVI DER							18.00
19. 00	SKILLED NURSING FACILITY							19.00
20. 00	NURSING FACILITY							20.00
21.00	OTHER LONG TERM CARE							21.00
22. 00	HOME HEALTH AGENCY							22.00
23. 00	AMBULATORY SURGICAL CENTER (D. P. )							23. 00
24. 00	HOSPI CE							24.00
24. 10	HOSPICE (non-distinct part)	30.00						24. 10
25.00	CMHC - CMHC							25. 00
26.00	RURAL HEALTH CLINIC							26. 00
26. 25	FEDERALLY QUALIFIED HEALTH CENTER	89. 00					0	26. 25
27.00	Total (sum of lines 14-26)			25				27. 00
28. 00	Observation Bed Days						0	
29. 00	Ambul ance Trips							29. 00
30.00	Employee discount days (see instruction)							30.00
31.00	Employee discount days - IRF							31.00
32.00	Labor & delivery days (see instructions)			0	(	'		32.00
32. 01	Total ancillary labor & delivery room							32. 01
33. 00	outpatient days (see instructions) LTCH non-covered days							33.00
	LTCH non-covered days LTCH site neutral days and discharges							33.00
55.01	Lion of the heath at days and at scharges	I			I	1 1		1 33.01

 Heal th Financial
 Systems
 UNION I

 HOSPITAL
 AND
 HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA

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

				''	0 12/31/2017	5/30/2018 1: 4	
		I/P Davs	/ O/P Visits	/ Trips	Full Time	Equi val ents	
	Component	Title XVIII	Title XIX	Total All	Total Interns	Employees On	
				Pati ents	& Residents	Payrol I	
		6. 00	7.00	8. 00	9. 00	10.00	
1.00	Hospital Adults & Peds. (columns 5, 6, 7 and	918	19	1, 560			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)	83	130				2.00
3.00	HMO IPF Subprovider	0	0				3.00
4.00	HMO IRF Subprovider	0	0				4.00
5.00	Hospital Adults & Peds. Swing Bed SNF	97	0	98			5.00
6.00	Hospital Adults & Peds. Swing Bed NF		0	0			6. 00
7.00	Total Adults and Peds. (exclude observation	1, 015	19	1, 658			7.00
	beds) (see instructions)						
8.00	INTENSIVE CARE UNIT	156	0	283			8. 00
9. 00	CORONARY CARE UNIT						9. 00
10. 00	BURN INTENSIVE CARE UNIT						10.00
11. 00	SURGI CAL INTENSI VE CARE UNI T						11.00
12.00	OTHER SPECIAL CARE (SPECIFY)						12.00
13.00	NURSERY						13.00
14.00	Total (see instructions)	1, 171	19	1, 941	0. 00	124. 62	1
15. 00	CAH visits	0	0	0			15.00
16.00	SUBPROVI DER - I PF						16.00
17.00	SUBPROVI DER - I RF						17.00
18.00	SUBPROVI DER						18.00
19.00	SKILLED NURSING FACILITY						19.00
20.00	NURSING FACILITY						20.00
21. 00	OTHER LONG TERM CARE						21.00
22. 00	HOME HEALTH AGENCY						22.00
23. 00	AMBULATORY SURGICAL CENTER (D. P. )						23.00
24. 00	HOSPI CE		0	0			24.00
24. 10	HOSPICE (non-distinct part)	0	0	0			24. 10
25. 00 26. 00	CMHC - CMHC						25. 00 26. 00
	RURAL HEALTH CLINIC	0	0	0	0.00	0.00	
26. 25 27. 00	FEDERALLY QUALIFIED HEALTH CENTER	٩	۷	U	0.00		
	Total (sum of lines 14-26)		o	571	0.00	124. 02	1
28. 00 29. 00	Observation Bed Days	0	۷	5/1			28. 00 29. 00
30.00	Ambulance Trips Employee discount days (see instruction)	۷		0			30.00
31. 00	Employee discount days (see l'istruction)			0			31.00
32. 00	Labor & delivery days (see instructions)	0	o	0			32.00
32. 00	Total ancillary labor & delivery room	٩	٩	0			32.00
32.01	outpatient days (see instructions)			U			32.01
33. 00	LTCH non-covered days	o					33.00
	LTCH site neutral days and discharges	0					33.00
55.01	Eron Si to neutrar days and discharges	١	l		l	I	1 33.01

| Period: | Worksheet S-3 | From 01/01/2017 | Part | To | 12/31/2017 | Date/Time Prepared: Provi der CCN: 15-1326

				To	12/31/2017	Date/Time Pre 5/30/2018 1:4	
		Full Time Equivalents	<u> </u>	Di sch	arges		
	Component	Nonpai d	Title V	Title XVIII	Title XIX	Total All	
	·	Workers				Pati ents	
		11. 00	12. 00	13. 00	14. 00	15. 00	
1.00	Hospital Adults & Peds. (columns 5, 6, 7 and		(	424	6	678	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)			24	35		2.00
3. 00	HMO I PF Subprovi der				0		3.00
4. 00	HMO I RF Subprovi der				0		4.00
5. 00	Hospital Adults & Peds. Swing Bed SNF						5.00
6. 00	Hospital Adults & Peds. Swing Bed NF						6.00
7. 00	Total Adults and Peds. (exclude observation						7. 00
0.00	beds) (see instructions)						0.00
8.00	I NTENSI VE CARE UNI T						8. 00 9. 00
9.00	CORONARY CARE UNIT						
10.00	BURN INTENSIVE CARE UNIT						10.00
11.00	SURGICAL INTENSIVE CARE UNIT						11. 00 12. 00
12.00	OTHER SPECIAL CARE (SPECIFY)						
13. 00 14. 00	NURSERY	0. 00	(	424	,	678	13. 00 14. 00
15. 00	Total (see instructions) CAH visits	0.00	(	424	6	0/8	15.00
16. 00	SUBPROVIDER - IPF						16.00
17. 00	SUBPROVIDER - I PF						17.00
18. 00	SUBPROVI DER						18.00
19. 00	SKILLED NURSING FACILITY						19.00
20. 00	NURSING FACILITY						20.00
21. 00	OTHER LONG TERM CARE						21.00
22. 00	HOME HEALTH AGENCY						22.00
23. 00	AMBULATORY SURGICAL CENTER (D. P. )						23. 00
24. 00	HOSPI CE						24.00
24. 10	HOSPICE (non-distinct part)						24. 10
25. 00	CMHC - CMHC						25.00
26. 00	RURAL HEALTH CLINIC						26.00
26. 25	FEDERALLY QUALIFIED HEALTH CENTER	0. 00					26. 25
27. 00	Total (sum of lines 14-26)	0.00					27. 00
28. 00	Observation Bed Days						28. 00
29.00	Ambul ance Trips						29. 00
30.00	Employee discount days (see instruction)						30.00
31.00	Employee discount days - IRF						31.00
32.00	Labor & delivery days (see instructions)						32. 00
32. 01	Total ancillary labor & delivery room						32. 01
	outpatient days (see instructions)						
33.00	LTCH non-covered days			0			33. 00
33. 01	LTCH site neutral days and discharges			0			33. 01

OSPI 7	Financial Systems UNION HOSPITAL CLI TAL UNCOMPENSATED AND INDIGENT CARE DATA Pr	ovider CCN: 15-		Peri od:	u of Form CN Worksheet		
			F	rom 01/01/2017			
			1	o 12/31/2017	Date/Time   5/30/2018		
					1. 00		
	Uncompensated and indigent care cost computation				1.00		
00	Cost to charge ratio (Worksheet C, Part I line 202 column 3 divi	ded by line 20	2 column	8)	0. 3342	221	1.
	Medicaid (see instructions for each line)						
00	Net revenue from Medicaid				1, 069, 4	135	2.
00	Did you receive DSH or supplemental payments from Medicaid?						3.
00	If line 3 is yes, does line 2 include all DSH and/or supplementa		m Medica	i d?			4.
00	If line 4 is no, then enter DSH and/or supplemental payments fro	m Medicaid			47.000.5	0	5.
00 00	Medicaid charges Medicaid cost (line 1 times line 6)				17, 088, 5 5, 711, 3		6. 7.
00	Difference between net revenue and costs for Medicaid program (I	ina 7 minus su	m of lin	as 2 and 5: if	4, 641, 9		8.
00	<pre>&lt; zero then enter zero)</pre>	THE 7 III HUS SU	01 1111	es 2 and 5, 11	4, 041,	/24	0.
	Children's Health Insurance Program (CHIP) (see instructions for	each line)					
00	Net revenue from stand-alone CHIP	•				0	9.
. 00						0	10
. 00	Stand-alone CHIP cost (line 1 times line 10)					0	11
. 00	Difference between net revenue and costs for stand-alone CHIP (I	ine 11 minus I	ine 9; i	f < zero then		0	12
	<pre>enter zero) Other state or local government indigent care program (see instr</pre>	uctions for on	ch lino)				
00	Net revenue from state or local indigent care program (Not inclu					0	13
. 00	Charges for patients covered under state or local indigent care					o	14
	10)	p9 (				-	
. 00	State or local indigent care program cost (line 1 times line 14)					0	15
. 00	Difference between net revenue and costs for state or local indi	gent care prog	ıram (lin	e 15 minus line	•	0	16
	13; if < zero then enter zero)						
	Grants, donations and total unreimbursed cost for Medicaid, CHIP instructions for each line)	and state/loc	ai indig	ent care progra	ims (see		
. 00						0	17.
	Government grants, appropriations or transfers for support of ho					0	18.
00	Total unreimbursed cost for Medicaid, CHIP and state and local 8, 12 and 16)	indigent care	programs	(sum of lines	4, 641, 9	724	19.
	o, 12 diu 10)	llni	nsured	Insured	Total (col.	1	
			tients	patients	+ col . 2)	.	
		,	1. 00	2.00	3. 00		
	Uncompensated Care (see instructions for each line)			_			
0. 00	Charity care charges and uninsured discounts for the entire faci (see instructions)	lity 1	1, 766, 077	0	1, 766, 0	)77	20.
. 00	Cost of patients approved for charity care and uninsured discoun	ts (see	590, 260	0	590, 2	260	21.
	instructions)						
2. 00	Payments received from patients for amounts previously written o	ff as	(	0		0	22.
	charity care		E00 240		E00 1		22
. 00	Cost of charity care (line 21 minus line 22)		590, 260	0	590, 2	200	23.
					1. 00		
. 00	Does the amount on line 20 column 2, include charges for patient	days beyond a	length	of stay limit			24.
	imposed on patients covered by Medicaid or other indigent care p			•			
. 00	If line 24 is yes, enter the charges for patient days beyond the	indigent care	program	's length of		0	25.
	stay limit						٠.
	Total bad debt expense for the entire hospital complex (see inst Medicare reimbursable bad debts for the entire hospital complex	•	000)		3, 312, 9		
		•			484, 2 745, 0		
. 00	· · ·					JUUI	27.
. 00 . 01	Medicare allowable bad debts for the entire hospital complex (se	e instructions	•)				20
7. 00 7. 01 8. 00	Medicare allowable bad debts for the entire hospital complex (se Non-Medicare bad debt expense (see instructions)				2, 567, 9	10	
6. 00 7. 00 7. 01 8. 00 9. 00 0. 00	Medicare allowable bad debts for the entire hospital complex (se					910	28. 29. 30.

Heal th	Financial Systems	UNION HOSPITAL	CLINTON		In Lie	u of Form CMS-2	2552-10
RECLAS	SSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE O	F EXPENSES	Provi der Co	CN: 15-1326 P	eri od:	Worksheet A	
					rom 01/01/2017 o 12/31/2017	Date/Time Pre 5/30/2018 1:4	
	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	
	GENERAL SERVICE COST CENTERS						
1.00	00100 NEW CAP REL COSTS-BLDG & FIXT		741, 879	741, 879	-36, 859	705, 020	1.00
2.00	00200 NEW CAP REL COSTS-MVBLE EQUIP		287, 686	287, 686	-1, 576	286, 110	2.00
4.00	00400 EMPLOYEE BENEFITS DEPARTMENT	O	0	0	0	0	4.00
5. 01	00540 NONPATI ENT TELEPHONES	0	43, 445	43, 445	0	43, 445	5. 01
5. 02	00550 DATA PROCESSING	0	776, 135	776, 135	0	776, 135	5. 02
5.03	00560 PURCHASING RECEIVING AND STORES	0	68, 636	68, 636	0	68, 636	5. 03
5.04	00570 ADMI TTI NG	388, 235	128, 127	516, 362	o	516, 362	5. 04
5.05	00580 CASHI ERI NG/ACCOUNTS RECEI VABLE	21, 622	287, 364	308, 986		308, 986	5. 05
5.06	00591 ADMINI STRATI VE AND GENERAL	677, 077	1, 410, 534		o	2, 087, 611	5.06
7.00	00700 OPERATION OF PLANT	366, 491	707, 077	1, 073, 568	o	1, 073, 568	7. 00
8. 00	00800 LAUNDRY & LINEN SERVICE	0	588	588		588	8. 00
9. 00	00900 HOUSEKEEPI NG	218, 706	84, 701	303, 407		303, 407	9. 00
10.00	01000 DI ETARY	315, 419	233, 599			103, 139	10.00
11. 00	01100 CAFETERI A	0	0	0		445, 879	11. 00
13. 00	01300 NURSING ADMINISTRATION	525, 794	93, 555	619, 349		619, 349	13.00
16. 00	01600 MEDI CAL RECORDS & LI BRARY	185, 453	104, 744	290, 197		290, 197	16. 00
10.00	INPATIENT ROUTINE SERVICE COST CENTERS	100, 100	101, 711	270, 177	<u> </u>	270, 177	10.00
30. 00	03000 ADULTS & PEDI ATRI CS	1, 006, 588	536, 692	1, 543, 280	0	1, 543, 280	30.00
31. 00	03100 INTENSIVE CARE UNIT	689, 928	133, 364			823, 292	31.00
01.00	ANCILLARY SERVICE COST CENTERS	007, 720	100,001	020, 272	<u> </u>	020, 272	01.00
50.00	05000 OPERATING ROOM	355, 989	388, 079	744, 068	20, 900	764, 968	50.00
51.00	05100 RECOVERY ROOM	40, 759	3, 304	44, 063		44, 063	51.00
51. 01	05101 0/P TREATMENT ROOM	160, 224	40, 833			201, 057	51. 01
54.00	05400 RADI OLOGY-DI AGNOSTI C	658, 867	763, 263	1, 422, 130	-	1, 422, 160	
56. 00	05600 RADI OI SOTOPE	000,007	98, 853	98, 853		98, 853	
60.00	06000 LABORATORY	0	832, 541	832, 541		832, 541	60.00
62. 00	06200 WHOLE BLOOD & PACKED RED BLOOD CELLS	0	30, 973	30, 973	-	30, 973	62.00
65.00	06500 RESPIRATORY THERAPY	413, 277	115, 081	528, 358		533, 238	
66.00	06600 PHYSI CAL THERAPY	113, 277	1, 344, 339		· ·	1, 344, 339	66.00
67. 00	06700 OCCUPATI ONAL THERAPY	0	7, 986	7, 986		7, 986	67.00
68. 00	06800 SPEECH PATHOLOGY	0	45, 526			45, 526	68.00
69.00	06900 ELECTROCARDI OLOGY	98, 491	111, 330			209, 821	69.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	70, 471	65, 272	65, 272		7, 688	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0	03, 272	03, 272		7,000	72.00
73. 00	07300 DRUGS CHARGED TO PATIENTS	405, 845	811, 015		-	1, 220, 609	73.00
73.00	OUTPATIENT SERVICE COST CENTERS	+03, 0+3	011,013	1, 210, 000	3, 747	1, 220, 007	73.00
90.00	09000 CLINIC	0	0	0	0	0	90.00
91.00	09100 EMERGENCY	1, 196, 356	2, 085, 542	_	-	3, 309, 923	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	1, 170, 000	2,000,012	0,201,070	20,020	0,007,720	92.00
72.00	SPECIAL PURPOSE COST CENTERS						72.00
118.00		7, 725, 121	12, 382, 063	20, 107, 184	-38, 435	20, 068, 749	118 00
	NONREI MBURSABLE COST CENTERS	,,,20,121	. 2, 302, 303	23, 107, 104	33, 733	25, 500, 147	
194.00	07950 PHYSI CI AN PRACTI CES	47, 199	103, 523	150, 722	0	150, 722	194. 00
	07951 MEDICAL OFFICE BUILDING	0	0			38, 435	
	07952 VPCHC	ol	0	ĺ	0		194. 02
200.00		7, 772, 320	12, 485, 586	20, 257, 906		20, 257, 906	
	, (: -:::::::::	.,.,2,020	, .00, 000	,, 700	١	,, , , , , , , , , , , , , , , , ,	

Health FinancialSystemsUNION HOSRECLASSIFICATIONAND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES Provi der CCN: 15-1326 

				10 12/31/201	5/30/2018 1:49 pm
	Cost Center Description	Adjustments	Net Expenses		37 307 20 TO 1. 47 Pill
		(See A-8)	For		
		, ,	Allocation		
		6. 00	7. 00		
<u>-</u>	GENERAL SERVICE COST CENTERS				
1.00	00100 NEW CAP REL COSTS-BLDG & FIXT	642, 713	1, 347, 733		1.00
2.00	00200 NEW CAP REL COSTS-MVBLE EQUIP	0	286, 110		2.00
4.00	00400 EMPLOYEE BENEFITS DEPARTMENT	2, 643, 172	2, 643, 172		4.00
5. 01	00540 NONPATI ENT TELEPHONES	30, 958	74, 403		5. 01
5. 02	00550 DATA PROCESSING	2, 157, 424	2, 933, 559		5. 02
5.03	00560 PURCHASING RECEIVING AND STORES	112, 794	181, 430		5. 03
5.04	00570 ADMI TTI NG	0	516, 362		5. 04
5. 05	00580 CASHI ERI NG/ACCOUNTS RECEI VABLE	322, 847	631, 833	1	5. 05
5.06	00591 ADMINI STRATI VE AND GENERAL	-308, 399	1, 779, 212		5.06
7.00	00700 OPERATION OF PLANT	117, 534	1, 191, 102		7.00
8.00	00800 LAUNDRY & LINEN SERVICE	0	588	1	8.00
9. 00	00900 HOUSEKEEPI NG	22, 931	326, 338	1	9. 00
10.00	01000 DI ETARY	3, 947	107, 086		10.00
11. 00	01100 CAFETERI A	-157, 056			11.00
13. 00	01300 NURSI NG ADMINI STRATI ON	83, 353	702, 702		13.00
16. 00	01600 MEDICAL RECORDS & LIBRARY	11, 783	301, 980		16. 00
	INPATIENT ROUTINE SERVICE COST CENTERS			1	
30. 00	03000 ADULTS & PEDI ATRI CS	-460, 792			30.00
31. 00	03100 I NTENSI VE CARE UNI T	0	823, 292		31.00
	ANCILLARY SERVICE COST CENTERS	1			
50. 00	05000 OPERATING ROOM	-35, 338	· ·	1	50.00
51.00	05100 RECOVERY ROOM	103	44, 166	1	51.00
51. 01	05101   0/P TREATMENT ROOM	0	,	1	51. 01
54.00	05400 RADI OLOGY-DI AGNOSTI C	1, 921	1, 424, 081	•	54.00
56.00	05600 RADI OI SOTOPE	0	98, 853	1	56.00
60.00	06000 LABORATORY	0	832, 541	1	60.00
62.00	06200 WHOLE BLOOD & PACKED RED BLOOD CELLS	0	30, 973		62. 00
65.00	06500 RESPI RATORY THERAPY	0	533, 238		65.00
66.00	06600 PHYSI CAL THERAPY	-792, 329		•	66.00
67.00	06700 OCCUPATI ONAL THERAPY	132, 905		1	67.00
68. 00	06800 SPEECH PATHOLOGY	-15, 457	30, 069	1	68.00
69.00	06900 ELECTROCARDI OLOGY	7, 823	217, 644	1	69.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	7, 688		71.00
72.00	07200 I MPL. DEV. CHARGED TO PATIENTS	0 25 271	1 255 000		72.00
73. 00	07300 DRUGS CHARGED TO PATIENTS	35, 371	1, 255, 980	<u>'</u>	73.00
00 00	OUTPATIENT SERVICE COST CENTERS  09000 CLINIC	0		J	00.00
90. 00 91. 00	09100 EMERGENCY	0	-	1	90.00
		0	3, 309, 923		
92. 00	09200 OBSERVATION BEDS (NON-DISTINCT PART)				92. 00
110 00	SPECIAL PURPOSE COST CENTERS	4 550 200	24 424 057	.1	110.00
118.00		4, 558, 208	24, 626, 957		118. 00
104 00	NONREIMBURSABLE COST CENTERS 07950 PHYSICIAN PRACTICES		150 700	ıl —	104.00
	NOT950 PHYSICIAN PRACTICES	0			194. 00 194. 01
	107951 MEDICAL OFFICE BUILDING		38, 435	1	194.01
200.00		4, 558, 208		1	200.00
200. U	TIDIAL (SUM OF LINES TO UNIOUGH 199)	4, 330, 208	24,010,114	'I	<sub> </sub> 200.00

Heal th Financial Systems

UNION HOSPITAL CLINTON

In Lieu of Form CMS-2552-10

RECLASSIFICATIONS

Provider CCN: 15-1326

Period: From 01/01/2017
From 01/01/2017
To 12/31/2017
Date/Time Prepared:

					То	12/31/2017	Date/Time Pr 5/30/2018 1:	repared:
		Increases					1.	
	Cost Center	Li ne #	Sal ary	Other				
	2. 00	3. 00	4. 00	5. 00				
	A - CAFETERIA RECLASS							
1.00	CAFETERI A	11. 00	<u>256, 1</u> 64	18 <u>9, 7</u> 15	5			1.00
	0		256, 164	189, 715	5			
	B - DEPRECIATION RECLASS							
1.00	MEDICAL OFFICE BUILDING	194. 01	0	38, 435	i			1.00
2.00		0. 00	0	0	)			2.00
	0		0	38, 435	5			
	C - CENTRAL SUPPLIES RECLASS							
1. 00	OPERATING ROOM	50. 00		20, 900				1.00
2. 00	RADI OLOGY-DI AGNOSTI C	54. 00		30				2.00
3. 00	RESPI RATORY THERAPY	65. 00	0	4, 880	)			3. 00
4. 00	MEDICAL SUPPLIES CHARGED TO	71. 00	0	11, 143	3			4. 00
	PATI ENTS							
5. 00	DRUGS CHARGED TO PATIENTS	73. 00	i	3, 749				5. 00
6. 00	EMERGENCY	<u> </u>	0	2 <u>8, 0</u> 25				6. 00
	TOTALS		0	68, 727				
500.00	Grand Total: Increases		256, 164	296, 877	1			500.00

UNION HOSPITAL CLINTON
Provider CCN: 15-1326 Period: Health Financial Systems RECLASSIFICATIONS In Lieu of Form CMS-2552-10 Worksheet A-6

ILULASS	OTT CATTONS			Frovider	JCIN. 13-1320	From 01/01/2017	WOLKSHEET A-C	,
						To 12/31/2017		
		Decreases						
	Cost Center	Li ne #	Sal ary	0ther	Wkst. A-7 Ref	: .		
	6. 00	7. 00	8. 00	9. 00	10.00			
	A - CAFETERIA RECLASS							
. 00	DI ETARY	10. 00	256, 164	189, 715		0		1.00
	0		256, 164	189, 715				
	B - DEPRECIATION RECLASS							
. 00	NEW CAP REL COSTS-BLDG &	1. 00	0	36, 859		9		1.00
	FI XT							
2. 00	NEW CAP REL COSTS-MVBLE	2. 00	0	1, 576		9		2.00
	EQUI P							

	Cost Center	Li ne #	Salary	Other	WKSt. A-/ Ref.		
	6. 00	7. 00	8. 00	9. 00	10.00		
	A - CAFETERIA RECLASS						
1.00	DI ETARY	10. 00	256, 164	189, 715	0		1.00
	0		256, 164	189, 715			
	B - DEPRECIATION RECLASS						
1.00	NEW CAP REL COSTS-BLDG &	1. 00	0	36, 859	9		1.00
	FLXT						
2.00	NEW CAP REL COSTS-MVBLE	2. 00	o	1, 576	9		2.00
	EQUI P						
	0 — — — — — —	- $  1$	<sub>0</sub>	38, 435			
	C - CENTRAL SUPPLIES RECLASS						
1.00	MEDICAL SUPPLIES CHARGED TO	71. 00	0	68, 727	0		1.00
	PATI ENTS						
2.00		0. 00	0	0	0		2.00
3.00		0.00	0	0	0		3.00
4.00		0.00	o	0	0		4.00
5.00		0.00	o	0	0		5.00
6.00		0.00	o	0	0		6.00
	TOTALS		0				
500.00	Grand Total: Decreases		256, 164	296, 877		50	00.00
	•				'	'	

Health Financial Systems
RECONCILIATION OF CAPITAL COSTS CENTERS UNION HOSPITAL CLINTON

Provider CCN: 15-1326

				To	12/31/2017	Date/Time Pre 5/30/2018 1:4	
	·			Acqui si ti ons		, ., .,	
		Begi nni ng	Purchases	Donati on	Total	Disposals and	
		Bal ances				Retirements	
		1. 00	2.00	3. 00	4. 00	5. 00	
	PART I - ANALYSIS OF CHANGES IN CAPITAL ASSE	T BALANCES					
1.00	Land	339, 822	0	0	0	0	1.00
2.00	Land Improvements	269, 938	0	0	0	0	2.00
3.00	Buildings and Fixtures	11, 545, 480	233, 668	0	233, 668	0	3.00
4.00	Building Improvements	1, 645, 471	0	0	0	0	4.00
5.00	Fixed Equipment	0	0	0	0	0	5.00
6.00	Movable Equipment	5, 777, 868	1, 079, 437	0	1, 079, 437	18, 213	6.00
7.00	HIT designated Assets	0	0	0	0	0	7. 00
8.00	Subtotal (sum of lines 1-7)	19, 578, 579	1, 313, 105	0	1, 313, 105	18, 213	8. 00
9.00	Reconciling Items	0	0	0	0	0	9. 00
10.00	Total (line 8 minus line 9)	19, 578, 579	1, 313, 105	0	1, 313, 105	18, 213	10.00
		Endi ng	Ful I y				
		Bal ance	Depreci ated				
			Assets				
		6. 00	7. 00				
	PART I - ANALYSIS OF CHANGES IN CAPITAL ASSE						
1.00	Land	339, 822	0				1.00
2.00	Land Improvements	269, 938	0				2.00
3.00	Buildings and Fixtures	11, 779, 148	0				3.00
4.00	Building Improvements	1, 645, 471	0				4. 00
5.00	Fixed Equipment	0	0				5.00
6.00	Movable Equipment	6, 839, 092	0				6. 00
7.00	HIT designated Assets	0	0				7. 00
8. 00	Subtotal (sum of lines 1-7)	20, 873, 471	0				8. 00
9.00	Reconciling Items	0	0				9. 00
10.00	Total (line 8 minus line 9)	20, 873, 471	0				10.00

Hoal th	Financial Systems	UNION HOSPIT	AL CLINTON		Inlie	u of Form CMS-2	2552_10
	CILIATION OF CAPITAL COSTS CENTERS	ONI ON TIOSITI	Provi der Co		Peri od: From 01/01/2017	Worksheet A-7	
					To 12/31/2017	Date/Time Pre 5/30/2018 1:4	pared: 9 pm
			SUMMARY OF CAPITAL				
	Cost Center Description	Depreciation	Lease	Interest	Insurance	Taxes (see	
					(see	instructions)	
					instructions)		
		9. 00	10. 00	11. 00	12.00	13. 00	
PART II - RECONCILIATION OF AMOUNTS FROM WORKSHEET A, COLUMN 2, LINES 1 and 2							
1.00	NEW CAP REL COSTS-BLDG & FIXT	741, 080	0	79	9 0	0	1.00
2.00	NEW CAP REL COSTS-MVBLE EQUIP	287, 686	0		0 0	0	2.00
3.00	Total (sum of lines 1-2)	1, 028, 766	0	79	9 0	0	3.00
		SUMMARY 0	F CAPITAL				
	Cost Center Description	0ther	Total (1)				
		Capi tal -Rel at					
		ed Costs (see	9 through 14)				
		instructions)					
		14. 00	15. 00				
	PART II - RECONCILIATION OF AMOUNTS FROM WOR	KSHEET A, COLU					
1.00	NEW CAP REL COSTS-BLDG & FIXT	0	741, 879				1.00
2.00	NEW CAP REL COSTS-MVBLE EQUIP	0	287, 686				2.00
2 00	Total (our of lines 1 2)	1	1 000 5/5	I			2 00

0 0

741, 879 287, 686 1, 029, 565

2.00

MCRI F32 - 14. 2. 164. 1

3.00 Total (sum of lines 1-2)

Health Finan	cial Systems	UNION HOSPIT	AL CLINTON		In Lie	u of Form CMS-2	2552-10
RECONCI LI ATI	ON OF CAPITAL COSTS CENTERS		Provi der C		Period: From 01/01/2017 To 12/31/2017		pared:
		COMI	PUTATION OF RAT	TI 0S	ALLOCATION OF	OTHER CAPITAL	
	Cost Center Description	Gross Assets	Capi tal i zed	Gross Assets	Ratio (see	Insurance	
			Leases	for Ratio	instructions)		
				(col. 1 -			
		1. 00	2.00	col . 2) 3.00	4.00	5. 00	
DADT I	II - RECONCILIATION OF CAPITAL COSTS C		2.00	3.00	4.00	5.00	
	AP REL COSTS-BLDG & FLXT	14, 034, 379	1	14, 034, 37	9 0. 672355	0	1. 00
	AP REL COSTS-MVBLE EQUIP	6, 839, 092		6, 839, 09		_	2. 00
	(sum of lines 1-2)	20, 873, 471		20, 873, 47			3. 00
	,	ALLOCATION OF OTHER CAPITAL				F CAPITAL	
				I=			
	Cost Center Description	Taxes	Other	Total (sum of	f Depreciation	Lease	
			Capi tal -Rel at ed Costs	cols. 5 through 7)			
		6. 00	7.00	8. 00	9. 00	10.00	
PART I	II - RECONCILIATION OF CAPITAL COSTS C		7.00	0.00	7. 00	10.00	
	AP REL COSTS-BLDG & FLXT	0	0		0 1, 347, 733	0	1.00
2. 00 NEW C	AP REL COSTS-MVBLE EQUIP	0	0		0 286, 110	0	2.00
3. 00 Total	(sum of lines 1-2)	0	0		0 1, 633, 843	0	3.00
			SL	JMMARY OF CAPI	TAL		
	Cost Center Description	Interest	Insurance	Taxes (see	0ther	Total (2)	
	·		(see	instructions)	Capi tal -Rel at		
			instructions)		ed Costs (see	9 through 14)	
					instructions)		
		11. 00	12. 00	13. 00	14. 00	15. 00	
	II - RECONCILIATION OF CAPITAL COSTS C			1		1 247 722	1 00
	AP REL COSTS-BLDG & FIXT AP REL COSTS-MVBLE EQUIP	0	1	1	0 0	1, 347, 733 286, 110	1. 00 2. 00
4	(sum of lines 1-2)	0	-		0 0		
3.00   10tai	(3diii 01 111163 1-2)	1	1	I	0	1, 033, 043	3.00

Provider CCN: 15-1326 Worksheet A-8 From 01/01/2017 12/31/2017 Date/Time Prepared: 5/30/2018 1:49 pm Expense Classification on Worksheet A To/From Which the Amount is to be Adjusted Basis/Code Cost Center Line # Cost Center Description Amount Wkst. A-7 (2) Ref. 1. 00 2.00 3.00 4.00 5.00 1.00 Investment income - NEW CAP ONEW CAP REL COSTS-BLDG & 1.00 1.00 REL COSTS-BLDG & FIXT (chapter lfi xt 2.00 Investment income - NEW CAP ONEW CAP REL COSTS-MVBLE 2.00 2.00 REL COSTS-MVBLE EQUIP (chapter EQUI P -799 NEW CAP REL COSTS-BLDG & 3.00 Investment income - other В 1.00 11 3.00 (chapter 2) FLXT 4.00 Trade, quantity, and time O 0.00 4.00 discounts (chapter 8) Refunds and rebates of 5.00 0.00 5.00 expenses (chapter 8) 6 00 Rental of provider space by 0 00 6 00 suppliers (chapter 8) 7.00 Tel ephone services (pay 0.00 7.00 stations excluded) (chapter 21) 8.00 Television and radio service 8.00 0.00 0 (chapter 21) Parking lot (chapter 21) 9.00 0.00 9.00 10.00 Provi der-based physician A-8-2 -583, 194 10.00 adjustment Sale of scrap, waste, etc. 11.00 0 0.00 11.00 (chapter 23) 12.00 Related organization A-8-1 6, 601, 613 12.00 transactions (chapter 10) 13.00 Laundry and linen service 0.00 13.00 0 Cafeteria-employees and guests 14 00 0 0 00 O 14 00 0 15.00 Rental of quarters to employee 0.00 15.00 and others Sale of medical and surgical 16.00 16.00 0.00 supplies to other than pati ents 17.00 Sale of drugs to other than 17.00 0 0.00 pati ents 18.00 Sale of medical records and 0.00 18.00 abstracts 19.00 Nursing and allied health 19.00 0.00 0 education (tuition, fees, books, etc.) 20.00 Vending machines 0.00 20.00 21.00 Income from imposition of 0.00 21.00 interest, finance or penalty charges (chapter 21) 22.00 Interest expense on Medicare 0.00 22.00 overpayments and borrowings to repay Medicare overpayments 23.00 Adjustment for respiratory ORESPIRATORY THERAPY 65.00 23.00 A-8-3 therapy costs in excess of limitation (chapter 14) 24. 00 Adjustment for physical A-8-3 OPHYSICAL THERAPY 66.00 24.00 therapy costs in excess of limitation (chapter 14) 0 \*\*\* Cost Center Deleted \*\*\* 25.00 Utilization review -114.00 25.00 physicians' compensation (chapter 21) 26.00 Depreciation - NEW CAP REL ONEW CAP REL COSTS-BLDG & 1.00 26.00 COSTS-BLDG & FLXT
Depreciation - NEW CAP REL IFI XT ONEW CAP REL COSTS-MVBLE 27.00 27.00 2.00 COSTS-MVBLE EQUIP FOUL P 28.00 Non-physician Anesthetist 0 \*\*\* Cost Center Deleted \*\*\* 19.00 28.00 Physicians' assistant 29.00 29.00 0.00 Adjustment for occupational A-8-3 O OCCUPATIONAL THERAPY 30.00 30.00 67.00 therapy costs in excess of limitation (chapter 14) 30.99 Hospice (non-distinct) (see OADULTS & PEDIATRICS 30.00 30.99 instructions)

Heal th	Financial Systems		UNION HOSPIT	AL CLINTON	In Lie	u of Form CMS-2	2552-10
ADJUST	MENTS TO EXPENSES				Peri od:	Worksheet A-8	
					From 01/01/2017 To 12/31/2017	Date/Time Pre 5/30/2018 1:4	
				Expense Classification o	n Worksheet A		
				To/From Which the Amount is	to be Adjusted		
	Cost Center Description	Basi s/Code	Amount	Cost Center	Li ne #	Wkst. A-7	
	cost center bescription	(2)	AIIIOUTT	Cost Center	LITTE #	Ref.	
		1. 00	2. 00	3.00	4. 00	5. 00	
31. 00	Adjustment for speech	A-8-3		SPEECH PATHOLOGY	68. 00	0.00	31.00
01100	pathology costs in excess of	,, o o		6. 226 17.1116266.	33. 33		0 00
	limitation (chapter 14)						
32.00	CAH HIT Adjustment for	Α	-12, 366	NEW CAP REL COSTS-BLDG &	1. 00	9	32.00
	Depreciation and Interest			FIXT			
33.00	MI SCELLANEOUS REVENUE	В	-23, 761	ADMINISTRATIVE AND GENERAL	5. 06	0	33.00
33. 01	CAFETERIA REVENUE	В	-176, 104	CAFETERI A	11. 00	0	33. 01
33. 02	CATERING REVENUE	В	-2, 228	CAFETERI A	11. 00	0	33. 02
35.00	ADVERTI SI NG	Α		ADMINISTRATIVE AND GENERAL	5. 06	0	35.00
36.00	VPCHC	В		HOUSEKEEPI NG	9. 00	0	36.00
39.00	RENTAL REVENUE	В		OPERATION OF PLANT	7. 00	0	39.00
42.00	HAF	Α		ADMINISTRATIVE AND GENERAL	5. 06	0	42.00
43.00	PHYSICIAN RECRUITMENT	Α	· ·	ADMINISTRATIVE AND GENERAL	5. 06	0	43.00
50.00	TOTAL (sum of lines 1 thru 49)		4, 558, 208				50.00
	(Transfer to Worksheet A,						
	column 6, line 200.)						L

<sup>(1)</sup> 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: 15-1326 Peri od: OFFICE COSTS

Worksheet A-8-1 From 01/01/2017

UITICL	. 00313				To 12/31/2017	Date/Time Pre 5/30/2018 1:4	
	Li ne No.	Cost Center		Expense Items	Amount of	Amount	
					Allowable Cost		
						Wks. A, column	
						5	
	1. 00	2. 00		3. 00	4. 00	5. 00	
	A. COSTS INCURRED AND ADJUST	MENTS REQUIRED AS A RESULT OF	TRA	NSACTIONS WITH RELATED (	ORGANIZATIONS OR	CLAIMED HOME	
	OFFICE COSTS:						
1. 00		NEW CAP REL COSTS-BLDG & FIX			655, 878	0	1.00
2.00		EMPLOYEE BENEFITS DEPARTMENT			2, 643, 172	0	2.00
3.00				OFFI CE	30, 958	0	3.00
4.00				OFFI CE	2, 157, 424	0	4.00
4. 01		PURCHASING RECEIVING AND STO			112, 794	0	4.01
4. 02	5. 05	CASHI ERI NG/ACCOUNTS RECEI VAB	HOME	OFFI CE	322, 847	0	4.02
4.03			HOME	OFFI CE	802, 110	0	4.03
4.04				OFFI CE	268, 513	0	4.04
4.05	9. 00	HOUSEKEEPI NG	HOME	OFFI CE	30, 157	0	4.05
4.06	10.00	DI ETARY	HOME	OFFI CE	3, 947	0	4.06
4.07	11.00	CAFETERI A	HOME	OFFI CE	21, 276	0	4.07
4. 08	13. 00	NURSING ADMINISTRATION	HOME	OFFI CE	83, 353	0	4.08
4.09	16.00	MEDICAL RECORDS & LIBRARY	HOME	OFFI CE	11, 783	0	4.09
4. 10	50.00	OPERATING ROOM	HOME	OFFI CE	2, 812	0	4.10
4. 11	51.00	RECOVERY ROOM	HOME	OFFI CE	103	O	4. 11
4. 12	54.00	RADI OLOGY-DI AGNOSTI C	HOME	OFFI CE	86, 055	O	4. 12
4. 13	66.00	PHYSI CAL THERAPY	HOME	OFFI CE	5, 415	O	4. 13
4. 14	67.00	OCCUPATIONAL THERAPY	HOME	OFFI CE	1, 610	O	4. 14
4. 15	68.00	SPEECH PATHOLOGY	HOME	OFFI CE	323	O	4. 15
4. 16	69.00	ELECTROCARDI OLOGY	HOME	OFFI CE	7, 941	0	4. 16
4. 17	73.00	DRUGS CHARGED TO PATIENTS	HOME	OFFI CE	35, 371	0	4. 17
4. 18	66.00	PHYSI CAL THERAPY	THER	APY	441, 523	1, 239, 267	4. 18
4. 19		OCCUPATI ONAL THERAPY	THER	APY	131, 295	0	4. 19
4. 20		SPEECH PATHOLOGY	THER	APY	26, 331	42, 111	4. 20
5.00	0		0		7, 882, 991	1, 281, 378	5.00

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

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

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

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

6. 00	G		0.00	UNI ON HOSPI TAL	100.00	6.00
7.00	G		0.00	UNI ON THERAPY	51.00	7.00
8.00			0.00		0.00	8.00
9. 00			0.00		0.00	9.00
10.00			0.00		0.00	10.00
100.00	G. Other (financial or	OTHER				100.00
	non-financial) specify:					

- (1) Use the following symbols to indicate interrelationship to related organizations:
- A. Individual has financial interest (stockholder, partner, etc.) in both related organization and in provider. B. Corporation, partnership, or other organization has financial interest in provider.
- C. Provider has financial interest in corporation, partnership, or other organization.
- D. Director, officer, administrator, or key person of provider or relative of such person has financial interest in related
- 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

				Date/Time Prepared: 5/30/2018 1:49 pm
	Net	Wkst. A-7 Ref.		
	Adjustments			
	(col. 4 minus			
	col. 5)*			
	6. 00	7. 00		
		RED AND ADJUSTN	IENTS REQUIRED AS A RESULT OF TRANSACTIONS WITH RELATED ORGANIZATIONS OR C	LAIMED HOME
	OFFICE COSTS:			
1. 00	655, 878			1.00
2.00	2, 643, 172			2.00
3.00	30, 958			3.00
4.00	2, 157, 424			4.00
4. 01	112, 794			4. 01
4. 02	322, 847			4. 02
4.03	802, 110			4. 03
4.04	268, 513			4. 04
4.05	30, 157			4. 05
4.06	3, 947			4.06
4.07	21, 276			4. 07
4. 08	83, 353			4. 08
4. 09	11, 783			4. 09
4. 10	2, 812			4. 10
4. 11	103			4. 11
4. 12	86, 055			4. 12
4. 13	5, 415	0		4. 13
4. 14	1, 610			4. 14
4. 15	323			4. 15
4. 16	7, 941			4. 16
4. 17	35, 371	0		4. 17
4. 18	-797, 744	0		4. 18
4. 19	131, 295			4. 19
4. 20	-15, 780			4. 20
5. 00	6, 601, 613			5. 00
* The	amounts on Lin	os 1_4 (and sub	scripts as appropriate) are transferred in detail to Worksheet A. column (	6 lines as

\* 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		
Type of Business		
6. 00		
B. INTERRELATIONSHIP TO RELAT	TED ORGANIZATION(S) AND/OR HOME OFFICE:	

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

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

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

- (1) Use the following symbols to indicate interrelationship to related organizations:
- A. Individual has financial interest (stockholder, partner, etc.) in both related organization and in provider.
- B. Corporation, partnership, or other organization has financial interest in provider.
- C. Provider has financial interest in corporation, partnership, or other organization.
- D. Director, officer, administrator, or key person of provider or relative of such person has financial interest in related organization
- E. Individual is director, officer, administrator, or key person of provider and related organization.
- F. Director, officer, administrator, or key person of related organization or relative of such person has financial interest in provider.

Health Financial Systems
PROVIDER BASED PHYSICIAN ADJUSTMENT Provider CCN: 15-1326

West. A Line   Cost Center/Physic an Identifier   Remuneration								To 12/31/2017	Date/Time Pre 5/30/2018 1:4	
1.00		Wkst. A Line #						RCE Amount	ider Component	
1.00		1 00	2 00	3 00		4 00	5.00	6.00		
2.00	1 00									1 00
3. 00							_	1	_	
4. 00					1			1	_	1
5.00								Ö	0	1
Continuing   Con								0	0	1
8. 00				0	d	-	0	Ō	0	1
8. 00				0	d	0	C	Ō	0	
10.00				0	d	0	C	Ō	0	
10.00	9. 00	0.00		0	d	0	C	0	0	9. 00
Wikst. A Line #   Cost Center/Physician I dentifier   Unadjusted RCE   Limit   Unadjusted RCE   Unadj	10.00	0.00		0	ıl .	0	C	0	0	10.00
Identifier	200.00			2, 371, 650	d	583, 194	1, 788, 456	,	0	200.00
1.00		Wkst. A Line #	Cost Center/Physician	Unadjusted RCE	5 P	ercent of	Cost of	Provi der	Physician Cost	
1.00			I denti fi er				Memberships &	Component	of Mal practice	
1.00						Limit		Share of col.	Insurance	
1.00							Educati on			
2. 00				8. 00						
3. 00   54. 00   RADI OLOGY-DI AGNOSTI C   0   0   0   0   0   0   3. 00   4. 00   69. 00   ELECTROCARDI OLOGY   0   0   0   0   0   4. 00   5. 00   91. 00   EMERGENCY   0   0   0   0   0   0   6. 00   0. 00   0   0   0   0   0   7. 00   0. 00   0   0   0   0   0   0   8. 00   0. 00   0   0   0   0   0   0   9. 00   0. 00   0   0   0   0   0   10. 00   0. 00   0   0   0   0   0   00   0   0   0				0	ıl .	-	_	1	_	1
4. 00 69. 00 ELECTROCARDI OLOGY 0 0 0 0 0 0 0 0 5. 00 5. 00 91. 00 EMERGENCY 0 0 0 0 0 0 0 0 0 5. 00 6. 00 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0				0	ıl .	-	_	1	_	1
5. 00         91. 00 EMERGENCY         0				0	1	-	I -	1	_	
6. 00				0	1	Ū		1	1	
7. 00				0	1	0	C	0	0	
8. 00				0	1	0	C	0	0	
9. 00				0	1	0	C	0	0	
10.00				0	1	0	C	0	0	
New York   Cost Center/Physician   Provider   Component   Share of col.   14				0	1	0	C	1	0	4
Wkst. A Line #   Cost Center/Physician I dentifier   Provider Component Share of col.   14   Disallowance   D		0.00		0	1	0	C	1	·	
I denti fi er				0	1	0	C		0	200.00
Share of col.   14		Wkst. A Line #						Adjustment		
14			i denti fi er			LIMIT	Disaliowance			
1.00         2.00         15.00         16.00         17.00         18.00           1.00         30.00 ADULTS & PEDI ATRI CS         0         0         0         460,792         1.00           2.00         50.00 OPERATI NG ROOM         0         0         0         38,150         2.00           3.00         54.00 RADI OLOGY-DI AGNOSTI C         0         0         0         84,134         3.00           4.00         69.00 ELECTROCARDI OLOGY         0         0         0         118         4.00           5.00         91.00 EMERGENCY         0         0         0         0         5.00										
1.00         30.00 ADULTS & PEDIATRICS         0         0         460,792         1.00           2.00         50.00 OPERATING ROOM         0         0         0         38,150         2.00           3.00         54.00 RADI OLOGY-DI AGNOSTI C         0         0         0         84,134         3.00           4.00         69.00 ELECTROCARDI OLOGY         0         0         0         118         4.00           5.00         91.00 EMERGENCY         0         0         0         0         5.00		1 00	2 00			16 00	17 00	18 00		
2. 00         50. 00 OPERATING ROOM         0         0         38, 150         2. 00           3. 00         54. 00 RADI OLOGY-DI AGNOSTI C         0         0         0         84, 134         3. 00           4. 00         69. 00 ELECTROCARDI OLOGY         0         0         0         118         4. 00           5. 00         91. 00 EMERGENCY         0         0         0         0         5. 00	1 00									1 00
3. 00   54. 00 RADI OLOGY-DI AGNOSTI C   0   0   84, 134   3. 00   4. 00   69. 00   ELECTROCARDI OLOGY   0   0   0   118   4. 00   5. 00   91. 00   EMERGENCY   0   0   0   0   5. 00				0		-	_	,	•	
4. 00 69. 00 ELECTROCARDI OLOGY 0 0 118 4. 00 5. 00 91. 00 EMERGENCY 0 0 0 5. 00				0		-	_			
5. 00 91. 00 EMERGENCY 0 0 0 5. 00				0		Ū				4
						0		1	•	
	6. 00	0.00		0		0		j o	1	6.00
7.00				1 0		0		1	1	1
8.00				1 0		0	1	1	1	
9.00				l n		-	_	1		
10.00 0 0.00 0 0 0 0 0 10.00				ا م		0	ĺ	ا ا		
200.00		]		ĺ		0		583, 194		1

| Period: | Worksheet B | From 01/01/2017 | Part | To | 12/31/2017 | Date/Time Prepared: Provi der CCN: 15-1326

				To	12/31/2017	Date/Time Pre	pared:
			CAPI TAL REI	ATED COSTS		5/30/2018 1:4	9 piii
			0,11 1 1,12 1,21	21125 00010			
	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)					
	OFNEDAL CERVILOE COCT OFNEDC	0	1. 00	2. 00	4. 00	5. 01	
1 00	GENERAL SERVICE COST CENTERS  OO100 NEW CAP REL COSTS-BLDG & FIXT	1, 347, 733	1, 347, 733		T		1 00
1. 00 2. 00	00200 NEW CAP REL COSTS-BLDG & FIXT	1, 347, 733	1, 347, 733	286, 110			1.00 2.00
4.00	00400 EMPLOYEE BENEFITS DEPARTMENT	2, 643, 172	0		2, 643, 172		4.00
5. 01	00540 NONPATIENT TELEPHONES	74, 403	1, 802		2, 043, 172	96, 280	5. 01
5. 02	00550 DATA PROCESSING	2, 933, 559	3, 517	20,073	ol	741	5. 02
5. 02	00560 PURCHASING RECEIVING AND STORES	181, 430	13, 704	87, 321	o	1, 111	5.02
5. 04	00570 ADMITTING	516, 362	8, 731	702	132, 029	2, 222	5. 04
5. 05	00580 CASHI ERI NG/ACCOUNTS RECEI VABLE	631, 833	5, 163		7, 353	1, 481	5. 05
5. 06	00591 ADMINISTRATIVE AND GENERAL	1, 779, 212	25, 536	8, 516	230, 257	5, 555	5. 06
7. 00	00700 OPERATION OF PLANT	1, 191, 102	372, 231	7, 148	124, 634	7, 776	7. 00
8. 00	00800 LAUNDRY & LINEN SERVICE	588	7, 172		O	0	8. 00
9.00	00900 HOUSEKEEPI NG	326, 338	6, 791	3, 551	74, 376	370	9.00
10.00	01000 DI ETARY	107, 086	16, 233	1, 911	20, 151	370	10.00
11.00	01100 CAFETERI A	288, 823	61, 103	8, 146	87, 115	2, 222	11.00
13.00	01300 NURSING ADMINISTRATION	702, 702	23, 942	302	178, 809	1, 481	13.00
16.00	01600 MEDICAL RECORDS & LIBRARY	301, 980	15, 159	177	63, 068	3, 333	16.00
	INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000 ADULTS & PEDIATRICS	1, 082, 488	242, 333	· ·	342, 315	27, 033	30.00
31. 00	03100   NTENSI VE CARE UNI T	823, 292	7, 103	32, 371	234, 627	2, 222	31.00
FO 00	ANCILLARY SERVICE COST CENTERS 05000 OPERATING ROOM	720 (20	51, 713	31, 947	101 0/0	2, 592	50.00
50. 00 51. 00	05100 RECOVERY ROOM	729, 630 44, 166	51, 713		121, 063 13, 861	2, 592 741	50.00
51.00	05100 RECOVERT ROOM	201, 057	27, 858		54, 488	4, 073	51.00
54. 00	05400 RADI OLOGY-DI AGNOSTI C	1, 424, 081	98, 836		224, 064	4, 814	54.00
56. 00	05600 RADI OI SOTOPE	98, 853	4, 556		0	370	56.00
60. 00	06000 LABORATORY	832, 541	29, 642		ol	1, 852	60.00
62.00	06200 WHOLE BLOOD & PACKED RED BLOOD CELLS	30, 973	0		o	0	62.00
65.00	06500 RESPIRATORY THERAPY	533, 238	17, 740	10, 622	140, 545	2, 592	65.00
66.00	06600 PHYSI CAL THERAPY	552, 010	58, 539	1, 492	o	4, 073	66.00
67.00	06700 OCCUPATI ONAL THERAPY	140, 891	49, 236	0	o	2, 962	67.00
68.00	06800 SPEECH PATHOLOGY	30, 069	6, 653	0	0	741	68. 00
69. 00	06900 ELECTROCARDI OLOGY	217, 644	7, 259	471	33, 494	1, 852	69.00
71. 00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	7, 688	17, 602		0	370	71.00
72. 00	07200 IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73. 00	07300 DRUGS CHARGED TO PATIENTS	1, 255, 980	17, 567	1, 065	138, 018	2, 222	73. 00
90. 00	OUTPATIENT SERVICE COST CENTERS  O9000 CLINIC	O			ما		90.00
90.00	09100 EMERGENCY	3, 309, 923	0 144, 797	-	0 406, 854	0 11, 109	90.00
91.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	3, 309, 923	144, 797	13, 700	400, 654	11, 109	91.00
72.00	SPECIAL PURPOSE COST CENTERS				l		72.00
118.00		24, 626, 957	1, 347, 733	286, 110	2, 627, 121	96, 280	118 00
	NONREI MBURSABLE COST CENTERS		., ,				
194.00	07950 PHYSI CI AN PRACTI CES	150, 722	0	0	16, 051	0	194. 00
	07951 MEDICAL OFFICE BUILDING	38, 435	0		0		194. 01
194. 02	07952 VPCHC	o	0	0	О	0	194. 02
200.00							200. 00
201.00	1 1 3		0	0	0		201. 00
202.00	TOTAL (sum lines 118 through 201)	24, 816, 114	1, 347, 733	286, 110	2, 643, 172	96, 280	202. 00

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

				1'	0 12/31/2017	5/30/2018 1: 4	
	Cost Center Description	DATA	PURCHASI NG	ADMI TTI NG	CASHI ERI NG/AC	Subtotal	, p
		PROCESSI NG	RECEIVING AND		COUNTS		
			STORES		RECEI VABLE		
		5. 02	5. 03	5. 04	5. 05	5A. 05	
	GENERAL SERVICE COST CENTERS						
1.00	00100 NEW CAP REL COSTS-BLDG & FIXT						1.00
2. 00	00200 NEW CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400 EMPLOYEE BENEFITS DEPARTMENT						4. 00
	00540 NONPATI ENT TELEPHONES						5. 01
	00550 DATA PROCESSING	2, 937, 817					5. 02
	00560 PURCHASING RECEIVING AND STORES	0	283, 566				5. 03
5. 04	00570 ADMITTING	135, 592	484	796, 122			5. 04
5. 05	00580 CASHI ERI NG/ACCOUNTS RECEI VABLE	45, 197	0	0	691, 027		5. 05
5.06	00591 ADMINISTRATIVE AND GENERAL	293, 782	182	0	0	2, 343, 040	5.06
7. 00	00700 OPERATION OF PLANT	587, 562	38	0	0	2, 290, 491	7.00
	00800 LAUNDRY & LINEN SERVICE	0	186	0	0	8, 341	8.00
	00900 HOUSEKEEPI NG	22, 599	22, 846	0	0	456, 871	9.00
10.00	01000 DI ETARY	22, 599	15	0	0	168, 365	10.00
11. 00	01100 CAFETERI A	45, 197	65	0	0	492, 671	11.00
13.00	01300 NURSING ADMINISTRATION	90, 394	5	0	0	997, 635	13.00
16.00	01600 MEDICAL RECORDS & LIBRARY	180, 789	13	0	0	564, 519	16.00
	INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000 ADULTS & PEDIATRICS	248, 585	35, 972	226, 088	34, 245	2, 260, 840	30.00
	03100 INTENSIVE CARE UNIT	22, 599	23, 503	52, 409	8, 762	1, 206, 888	31.00
	ANCILLARY SERVICE COST CENTERS						
	05000 OPERATING ROOM	90, 394	76, 526	99, 565	49, 512	1, 252, 942	50.00
	05100 RECOVERY ROOM	0	0	3, 107	1, 801	70, 640	
	05101 O/P TREATMENT ROOM	22, 599	17, 858	628	9, 029	340, 020	
	05400 RADI OLOGY-DI AGNOSTI C	203, 387	23, 593	80, 676	186, 363	2, 274, 052	
	05600 RADI OI SOTOPE	0	239	1, 801	4, 878	110, 697	
	06000 LABORATORY	22, 599		87, 704	82, 829	1, 057, 167	60.00
	06200 WHOLE BLOOD & PACKED RED BLOOD CELLS	0	0	3, 417	831	35, 221	
	06500 RESPI RATORY THERAPY	45, 197	7, 546	41, 760	8, 732	807, 972	
	06600 PHYSI CAL THERAPY	90, 394	634	10, 429	24, 635	742, 206	
	06700 OCCUPATI ONAL THERAPY	0	0	2, 433	7, 326	202, 848	1
	06800 SPEECH PATHOLOGY	0	0	454	1, 469	39, 386	1
	06900 ELECTROCARDI OLOGY	0	353	29, 271	27, 328	317, 672	
	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	1, 081	238	26, 979	
	07200 I MPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
	07300 DRUGS CHARGED TO PATIENTS	67, 796	1, 602	108, 725	52, 543	1, 645, 518	73.00
	OUTPATIENT SERVICE COST CENTERS						00.00
	09000 CLI NI C	000.070	0	0	0	0	90.00
	09100 EMERGENCY	338, 979	70, 697	46, 574	189, 563	4, 534, 196	
	09200 OBSERVATION BEDS (NON-DISTINCT PART)					0	92.00
118. 00	SPECIAL PURPOSE COST CENTERS  SUBTOTALS (SUM OF LINES 1 through 117)	2, 576, 240	282, 357	796, 122	690, 084	24, 247, 177	110 00
	NONREIMBURSABLE COST CENTERS	2, 576, 240	282, 357	190, 122	090, 084	24, 247, 177	1118.00
	07950 PHYSI CI AN PRACTI CES	361, 577	1, 209	0	943	530, 502	104 00
	07951 MEDICAL OFFICE BUILDING	301, 377	1, 209	0	0	38, 435	
	07952 VPCHC	0		0			194. 01
200.00	· · · · · · · · · · · · · · · · · · ·	0		0	١		200.00
200.00	Negative Cost Centers	0	n	0	0		201.00
201.00		2, 937, 817	283, 566	796, 122	ا	24, 816, 114	
202.00	1101/12 (Suill Filles File till ougil 201)	2, 737, 017	200, 300	1,70,122	071,027	27,010,114	1202.00

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

				''	0 12/31/2017	5/30/2018 1: 4	
	Cost Center Description	ADMI NI STRATI V	OPERATION OF	LAUNDRY &	HOUSEKEEPI NG	DI ETARY	, p
	, , , , , , , , , , , , , , , , , , ,	E AND GENERAL	PLANT	LINEN SERVICE			
		5. 06	7. 00	8. 00	9. 00	10.00	
	GENERAL SERVICE COST CENTERS						
1.00	00100 NEW CAP REL COSTS-BLDG & FLXT						1.00
2.00	00200 NEW CAP REL COSTS-MVBLE EQUIP					1	2.00
4.00	00400 EMPLOYEE BENEFITS DEPARTMENT					1	4.00
5. 01	00540 NONPATI ENT TELEPHONES					1	5. 01
5. 02	00550 DATA PROCESSING					1	5. 02
5. 03	00560 PURCHASING RECEIVING AND STORES					1	5.03
5. 04	00570 ADMI TTI NG					1	5. 04
5. 05	00580 CASHI ERI NG/ACCOUNTS RECEI VABLE					1	5. 05
5. 06	00591 ADMI NI STRATI VE AND GENERAL	2, 343, 040				1	5.06
7. 00	00700 OPERATION OF PLANT	238, 807	2, 529, 298			1	7. 00
8. 00	00800 LAUNDRY & LINEN SERVICE	870	20, 693	1		1	8.00
9. 00	00900 HOUSEKEEPI NG	47, 633	19, 593	1	526, 768	1	9.00
10.00	01000 DI ETARY	17, 554	46, 833		9, 912	242, 740	
11. 00	01100 CAFETERI A	51, 366	0 40,033	1	7, 712	242, 740	1
13. 00	01300 NURSING ADMINISTRATION	104, 013	69, 075	1	14, 619	0	13.00
16. 00	01600 MEDICAL RECORDS & LIBRARY	58, 857	43, 734	1	9, 256	0	ı
10.00	I NPATI ENT ROUTI NE SERVI CE COST CENTERS	30, 037	43, 734	1 0	9, 230	U	10.00
30. 00	03000 ADULTS & PEDIATRICS	235, 715	699, 150	7, 896	147, 966	186, 548	30.00
	03100   NTENSIVE CARE UNIT	125, 830		,		31, 845	31.00
31.00	ANCI LLARY SERVICE COST CENTERS	120, 630	20, 493	3, 370	4, 337	31, 040	31.00
50. 00	05000 OPERATING ROOM	130, 632	149, 197	1, 502	31, 576	0	50.00
51.00	05100 RECOVERY ROOM	7, 365	15, 045		3, 184	0	51.00
51. 00	05101 0/P TREATMENT ROOM	35, 450	80, 371	0	17, 010	24, 347	51.00
54. 00	05400 RADI OLOGY-DI AGNOSTI C	237, 093	285, 148	· ·		24, 347	54.00
56. 00	05600 RADI OI SOTOPE	11, 541	13, 145		2, 782	0	56.00
60.00	06000 LABORATORY	110, 220	85, 520	1	18, 099	0	60.00
62. 00	06200 WHOLE BLOOD & PACKED RED BLOOD CELLS	3, 672	05, 520	1	18, 044	0	62.00
65. 00	06500 RESPIRATORY THERAPY	84, 239	51, 182	_		0	65.00
66. 00	06600 PHYSI CAL THERAPY	77, 382	168, 890	1	35, 743	0	66.00
67. 00	06700 OCCUPATI ONAL THERAPY	21, 149	142, 049	2,704	30, 063	0	67.00
68. 00	06800 SPEECH PATHOLOGY	4, 106	19, 193	· ·	4, 062	0	68.00
69. 00	06900 ELECTROCARDI OLOGY	33, 120	· ·	1	.,	0	69.00
71. 00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	2, 813	20, 943 50, 782		4, 432 10, 747	0	71.00
71.00	07200 IMPL. DEV. CHARGED TO PATIENTS	2, 613	50, 762	1		0	72.00
72.00	07300 DRUGS CHARGED TO PATIENTS	171, 562	50, 682	0	_	0	73.00
73.00	OUTPATIENT SERVICE COST CENTERS	171, 302	30, 062		10, 726	0	73.00
90. 00	09000 CLINIC	0	0	0	O	0	90.00
91.00	09100 EMERGENCY	472, 734	417, 751	7, 876		0	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	472,734	417,751	7,670	00, 412	U	92.00
72.00	SPECIAL PURPOSE COST CENTERS						72.00
118.00		2, 283, 723	2, 469, 469	29, 904	514, 106	242, 740	118 00
110.00	NONREI MBURSABLE COST CENTERS	2, 203, 723	2, 407, 407	27, 704	314, 100	242, 740	1110.00
194 00	07950 PHYSI CI AN PRACTI CES	55, 310	0	0	0	0	194. 00
	07951 MEDICAL OFFICE BUILDING	4, 007	59, 829		_		194. 01
	07952 VPCHC	0	0	ő	0		194. 02
200.00	1 1	1					200.00
201.00	1 1	0	0	0	ol		201.00
202.00		2, 343, 040	2, 529, 298	29, 904	526, 768	242, 740	202.00
		•	•	•		•	•

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

				10	12/31/2017	Date/lime Pre 5/30/2018 1:4	
	Cost Center Description	CAFETERI A	NURSI NG	MEDI CAL	Subtotal	Intern &	) piii
	, , , , , , , , , , , , , , , , , , ,		ADMI NI STRATI O	RECORDS &		Resi dents	
			N	LI BRARY		Cost & Post	
						Stepdown	
						Adjustments	
	CENEDAL CEDVICE COCT CENTEDO	11. 00	13. 00	16. 00	24. 00	25. 00	
1. 00	GENERAL SERVICE COST CENTERS O0100 NEW CAP REL COSTS-BLDG & FIXT						1.00
2. 00	00200 NEW CAP REL COSTS-BLDG & FTXT						2.00
4. 00	00400 EMPLOYEE BENEFITS DEPARTMENT						4.00
5. 01	00540 NONPATI ENT TELEPHONES						5. 01
5. 02	00550 DATA PROCESSING						5. 02
5. 03	00560 PURCHASING RECEIVING AND STORES						5. 03
5.04	00570 ADMITTING						5. 04
5.05	00580 CASHI ERI NG/ACCOUNTS RECEI VABLE						5. 05
5.06	00591 ADMINISTRATIVE AND GENERAL						5.06
7.00	00700 OPERATION OF PLANT						7. 00
8.00	00800 LAUNDRY & LINEN SERVICE						8. 00
9. 00	00900 HOUSEKEEPI NG						9. 00
10.00	01000 DI ETARY						10.00
11.00	01100 CAFETERI A	544, 360					11.00
13.00	01300 NURSING ADMINISTRATION	40, 650					13.00
16. 00	01600 MEDICAL RECORDS & LIBRARY INPATIENT ROUTINE SERVICE COST CENTERS	27, 612	0	703, 978			16. 00
30. 00	03000 ADULTS & PEDIATRICS	105, 569	452, 285	34, 933	4, 130, 902	0	30.00
31. 00	03100 I NTENSI VE CARE UNI T	53, 821	230, 467	8, 938	1, 686, 189	0	
01.00	ANCILLARY SERVICE COST CENTERS	00,021	200, 107	0, 700	1,000,107		01.00
50.00	05000 OPERATING ROOM	33, 295	0	50, 507	1, 649, 651	0	50.00
51.00	05100 RECOVERY ROOM	3, 744	0	1, 837	101, 815	0	51.00
51.01	05101 O/P TREATMENT ROOM	15, 377	64, 956	9, 210	586, 741	0	51.01
54.00	05400 RADI OLOGY-DI AGNOSTI C	70, 001	0	190, 106	3, 119, 281	0	54.00
56.00	05600 RADI 0I SOTOPE	0	0		143, 141	0	56.00
60.00	06000 LABORATORY	0	0	84, 493	1, 355, 499	0	60.00
62.00	06200 WHOLE BLOOD & PACKED RED BLOOD CELLS	0	0	848	39, 741	0	62.00
65.00	06500 RESPI RATORY THERAPY	40, 249		8, 907	1, 003, 619	0	65.00
66.00	06600 PHYSI CAL THERAPY	0	0	,	1, 052, 055	0	66.00
67. 00 68. 00	06700 OCCUPATI ONAL THERAPY 06800 SPEECH PATHOLOGY	0	0	7, 473	403, 582	0	67. 00 68. 00
69.00	06900 ELECTROCARDI OLOGY	8, 090		1, 499 27, 877	68, 246 412, 649	0	69.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0, 0 <del>9</del> 0	0	, -	91, 564	0	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0	0		71, 304	0	72.00
73. 00	07300 DRUGS CHARGED TO PATIENTS	32, 627	o o		1, 964, 714	0	73.00
	OUTPATIENT SERVICE COST CENTERS	,			,		
90.00	09000 CLI NI C	0	0	0	0	0	90.00
91.00	09100 EMERGENCY	111, 654	478, 284	193, 402	6, 304, 309	0	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)					0	92.00
	SPECIAL PURPOSE COST CENTERS						
118. 00		542, 689	1, 225, 992	703, 978	24, 113, 698	0	118. 00
404.0	NONREI MBURSABLE COST CENTERS				507 400		
	07950 PHYSI CI AN PRACTI CES	1, 671	0		587, 483		194.00
	07951   MEDICAL OFFICE BUILDING   07952   VPCHC	0	0		114, 933		194. 01 194. 02
200.00			0	0	0		200.00
200.00	1 1	_			O O		200.00
201.00		544, 360	1, 225, 992	703, 978	24, 816, 114		201.00
202.00	1.5 (3dm 111165 116 till 3dgil 201)	311,300	1,220,772	, , , , , , , , , , , ,	21,010,111	O	-52.00

Health Financial Systems
COST ALLOCATION - GENERAL SERVICE COSTS In Lieu of Form CMS-2552-10 UNION HOSPITAL CLINTON Provider CCN: 15-1326

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

			5/30/2018 1	
	Cost Center Description	Total		
	·	26. 00		
	GENERAL SERVICE COST CENTERS			
1.00	00100 NEW CAP REL COSTS-BLDG & FIXT			1.00
2.00	00200 NEW CAP REL COSTS-MVBLE EQUIP			2. 00
4.00	00400 EMPLOYEE BENEFITS DEPARTMENT			4.00
5. 01	00540 NONPATI ENT TELEPHONES			5. 01
5.02	00550 DATA PROCESSING			5. 02
5.03	00560 PURCHASING RECEIVING AND STORES			5. 03
5.04	00570 ADMI TTI NG			5. 04
5.05	00580 CASHI ERI NG/ACCOUNTS RECEI VABLE			5. 05
5.06	00591 ADMINISTRATIVE AND GENERAL			5. 06
7.00	00700 OPERATION OF PLANT			7. 00
8.00	00800 LAUNDRY & LINEN SERVICE			8. 00
9.00	00900 HOUSEKEEPI NG			9. 00
10.00	01000 DI ETARY			10.00
11. 00	01100 CAFETERI A			11.00
13.00	01300 NURSING ADMINISTRATION			13.00
16.00	01600 MEDICAL RECORDS & LIBRARY			16. 00
	INPATIENT ROUTINE SERVICE COST CENTERS			
30.00	03000 ADULTS & PEDIATRICS	4, 130, 902		30.00
31.00	03100 INTENSIVE CARE UNIT	1, 686, 189		31.00
	ANCILLARY SERVICE COST CENTERS			
50.00	05000 OPERATING ROOM	1, 649, 651		50.00
51.00	05100 RECOVERY ROOM	101, 815		51.00
51. 01	05101 O/P TREATMENT ROOM	586, 741		51. 01
54.00	05400 RADI OLOGY-DI AGNOSTI C	3, 119, 281		54.00
56.00	05600 RADI OI SOTOPE	143, 141		56.00
60.00	06000 LABORATORY	1, 355, 499		60.00
62.00	06200 WHOLE BLOOD & PACKED RED BLOOD CELLS	39, 741		62.00
65.00	06500 RESPI RATORY THERAPY	1, 003, 619		65.00
66.00	06600 PHYSI CAL THERAPY	1, 052, 055		66.00
67.00	06700 OCCUPATI ONAL THERAPY	403, 582		67.00
68. 00	06800 SPEECH PATHOLOGY	68, 246		68. 00
69. 00	06900 ELECTROCARDI OLOGY	412, 649		69. 00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	91, 564		71.00
72.00	07200 I MPL. DEV. CHARGED TO PATIENTS	0		72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	1, 964, 714		73.00
	OUTPATIENT SERVICE COST CENTERS			
	09000 CLI NI C	0		90.00
91. 00	09100 EMERGENCY	6, 304, 309		91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)			92. 00
	SPECIAL PURPOSE COST CENTERS			
118.00		24, 113, 698		118. 00
	NONREI MBURSABLE COST CENTERS			
	07950 PHYSICIAN PRACTICES	587, 483		194. 00
	07951 MEDICAL OFFICE BUILDING	114, 933		194. 01
	07952 VPCHC	0		194. 02
200.00	,	0		200. 00
201.00		0		201.00
202.00	TOTAL (sum lines 118 through 201)	24, 816, 114		202.00

| In Lieu of Form CMS-2552-10 | Peri od: | Worksheet B | From 01/01/2017 | Part II | To 12/31/2017 | Date/Time Prepared: | To 12/31/2017 | T Health Financial Systems
ALLOCATION OF CAPITAL RELATED COSTS Provider CCN: 15-1326

				10	12/31/2017	5/30/2018 1: 4	
			CAPITAL RELATED COSTS			0,00,2010 11 1	, p
	Cost Center Description	Directly	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	
	GENERAL SERVICE COST CENTERS						
	00100 NEW CAP REL COSTS-BLDG & FIXT						1. 00
	00200 NEW CAP REL COSTS-MVBLE EQUIP						2.00
	00400 EMPLOYEE BENEFITS DEPARTMENT	0	0	-	0	0	4.00
	00540 NONPATI ENT TELEPHONES	0	1, 802		21, 877	0	5. 01
	00550 DATA PROCESSING	0	3, 517		3, 517	0	5. 02
	00560 PURCHASING RECEIVING AND STORES	0	13, 704		101, 025	0	5. 03
	00570 ADMI TTI NG	0	8, 731	702	9, 433	0	5. 04
	00580 CASHI ERI NG/ACCOUNTS RECEI VABLE	0	5, 163		5, 163	0	5. 05
	00591 ADMI NI STRATI VE AND GENERAL	0	25, 536		34, 052	0	5.06
	00700 OPERATION OF PLANT	0	372, 231	7, 148	379, 379	0	7.00
	00800 LAUNDRY & LINEN SERVICE	0	7, 172		7, 567	0	8.00
	00900 HOUSEKEEPI NG	0	6, 791		10, 342	0	9.00
	01000 DI ETARY	0	16, 233		18, 144	0	10.00
	01100 CAFETERI A	0	61, 103		69, 249	0	11.00
13.00	01300 NURSI NG ADMI NI STRATI ON	0	23, 942		24, 244	0	13.00
16. 00	01600 MEDICAL RECORDS & LIBRARY	0	15, 159	177	15, 336	0	16. 00
30. 00	INPATIENT ROUTINE SERVICE COST CENTERS 03000 ADULTS & PEDIATRICS	O	242, 333	21, 781	264, 114	0	30. 00
	03100 INTENSIVE CARE UNIT		242, 333 7, 103		39, 474	0	30.00
	ANCILLARY SERVICE COST CENTERS	J U	7, 103	32, 371	39, 474	U	31.00
	05000 OPERATING ROOM	l ol	51, 713	31, 947	83, 660	0	50. 00
	05100 RECOVERY ROOM		5, 215		6, 964	0	51.00
	05101 0/P TREATMENT ROOM		27, 858		30, 288	0	51. 01
	05400 RADI OLOGY-DI AGNOSTI C		98, 836		127, 074	0	54.00
	05600 RADI OI SOTOPE		4, 556		4, 556	0	56.00
	06000 LABORATORY	o	29, 642		29, 642	0	60.00
	06200 WHOLE BLOOD & PACKED RED BLOOD CELLS	o	0		0	0	62.00
	06500 RESPIRATORY THERAPY	o	17, 740	10, 622	28, 362	0	65.00
	06600 PHYSI CAL THERAPY	o	58, 539		60, 031	0	66.00
67. 00	06700 OCCUPATI ONAL THERAPY	o	49, 236	0	49, 236	0	67.00
68. 00	06800 SPEECH PATHOLOGY	o	6, 653	0	6, 653	0	68.00
	06900 ELECTROCARDI OLOGY	o	7, 259		7, 730	0	69.00
71. 00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	o	17, 602	0	17, 602	0	71.00
72. 00	07200 IMPL. DEV. CHARGED TO PATIENTS	o	0	0	0	0	72.00
73. 00	07300 DRUGS CHARGED TO PATIENTS	o	17, 567	1, 065	18, 632	0	73.00
OUTPATIENT SERVICE COST CENTERS							
90. 00	09000 CLI NI C	0	0	0	0	0	90.00
91.00	09100 EMERGENCY	0	144, 797	15, 700	160, 497	0	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)				0		92.00
	SPECIAL PURPOSE COST CENTERS						
118. 00	SUBTOTALS (SUM OF LINES 1 through 117)	0	1, 347, 733	286, 110	1, 633, 843	0	118. 00
	NONRE MBURSABLE COST CENTERS						
						194. 00	
	07951 MEDICAL OFFICE BUILDING	0	0		0		194. 01
	07952 VPCHC	0	0	0	0		194. 02
200.00	Cross Foot Adjustments				0		200.00
201.00	Negative Cost Centers		0	0	0		201. 00
202. 00	TOTAL (sum lines 118 through 201)	0	1, 347, 733	286, 110	1, 633, 843	0	202. 00

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

				To	12/31/2017	Date/Time Pre 5/30/2018 1:4	
	Cost Center Description	NONPATI ENT	DATA	PURCHASI NG	ADMI TTI NG	CASHI ERI NG/AC	7 DIII
	occi contor bosci pri on	TELEPHONES	PROCESSI NG	RECEIVING AND	7.5	COUNTS	
				STORES		RECEI VABLE	
		5. 01	5. 02	5. 03	5. 04	5. 05	
	GENERAL SERVICE COST CENTERS						
1.00	00100 NEW CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200 NEW CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400 EMPLOYEE BENEFITS DEPARTMENT						4.00
5. 01	00540 NONPATIENT TELEPHONES	21, 877					5. 01
5.02	00550 DATA PROCESSING	168	3, 685				5. 02
5.03	00560 PURCHASING RECEIVING AND STORES	252	0	101, 277			5. 03
5.04	00570 ADMI TTI NG	505	170	173	10, 281		5. 04
5.05	00580 CASHI ERI NG/ACCOUNTS RECEI VABLE	337	57	0	0	5, 557	5. 05
5.06	00591 ADMINISTRATIVE AND GENERAL	1, 262	369	65	0	0	5.06
7.00	00700 OPERATION OF PLANT	1, 767	738	14	0	0	7. 00
8.00	00800 LAUNDRY & LINEN SERVICE	0	0	66	0	0	8. 00
9.00	00900 HOUSEKEEPI NG	84	28	8, 159	0	0	9. 00
10.00	01000 DI ETARY	84	28	5	0	0	10.00
11.00	01100 CAFETERI A	505	57	23	О	0	11.00
13.00	01300 NURSING ADMINISTRATION	337	113	2	o	0	13.00
16.00	01600 MEDICAL RECORDS & LIBRARY	757	227	5	o	0	16.00
	INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000 ADULTS & PEDIATRICS	6, 142	312	12, 848	2, 917	276	30.00
31.00	03100 INTENSIVE CARE UNIT	505	28		677	71	31.00
	ANCILLARY SERVICE COST CENTERS						
50.00	05000 OPERATING ROOM	589	113	27, 332	1, 286	399	50.00
51.00	05100 RECOVERY ROOM	168	0	0	40	15	51.00
51.01	05101 O/P TREATMENT ROOM	926	28	6, 378	8	73	51.01
54.00	05400 RADI OLOGY-DI AGNOSTI C	1, 094	255	8, 427	1, 042	1, 501	54.00
56.00	05600 RADI OI SOTOPE	84	0	85	23	39	56.00
60.00	06000 LABORATORY	421	28	0	1, 133	667	60.00
62.00	06200 WHOLE BLOOD & PACKED RED BLOOD CELLS	0	0	0	44	7	62.00
65.00	06500 RESPIRATORY THERAPY	589	57	2, 695	540	70	65.00
66.00	06600 PHYSI CAL THERAPY	926	113	226	135	198	66.00
67.00	06700 OCCUPATI ONAL THERAPY	673	0	0	31	59	67.00
68.00	06800 SPEECH PATHOLOGY	168	0	0	6	12	68. 00
69.00	06900 ELECTROCARDI OLOGY	421	0	126	378	220	69.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	84	0	0	14	2	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	505	85	572	1, 405	423	73.00
	OUTPATIENT SERVICE COST CENTERS						
90.00	09000 CLI NI C	0	0	0	0	0	90.00
91.00	09100 EMERGENCY	2, 524	425	25, 250	602	1, 517	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)						92.00
	SPECIAL PURPOSE COST CENTERS						
118.00		21, 877	3, 231	100, 845	10, 281	5, 549	118. 00
	NONREI MBURSABLE COST CENTERS						
	07950 PHYSICIAN PRACTICES	0	454		0	_	194. 00
	07951 MEDICAL OFFICE BUILDING	0	0	-	0		194. 01
	07952 VPCHC	0	0	0	0	0	194. 02
200.00	1 1						200. 00
201.00	9	0	0	0	0		201. 00
202.00	TOTAL (sum lines 118 through 201)	21, 877	3, 685	101, 277	10, 281	5, 557	202. 00

Health Financial Systems
ALLOCATION OF CAPITAL RELATED COSTS Provider CCN: 15-1326

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

				11	0 12/31/201/	Date/lime Pre   5/30/2018 1:4	
	Cost Center Description	ADMI NI STRATI V	OPERATION OF	LAUNDRY &	HOUSEKEEPI NG	DI ETARY	Pill
	oost content boson per on	E AND GENERAL	PLANT	LINEN SERVICE	HOUSEREELTHO	DI EI/II(I	
		5. 06	7. 00	8. 00	9. 00	10.00	
	GENERAL SERVICE COST CENTERS			0.00			
1.00	00100 NEW CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200 NEW CAP REL COSTS-MVBLE EQUIP						2.00
4. 00	00400 EMPLOYEE BENEFITS DEPARTMENT						4.00
5. 01	00540 NONPATI ENT TELEPHONES						5. 01
5. 02	00550 DATA PROCESSING						5. 02
5. 03	00560 PURCHASING RECEIVING AND STORES						5.03
5. 04	00570 ADMITTING						5. 04
5. 05	00580 CASHI ERI NG/ACCOUNTS RECEI VABLE						5.05
5. 06	00591 ADMINISTRATIVE AND GENERAL	35, 748					5.06
7. 00	00700 OPERATION OF PLANT	3, 644	385, 542				7.00
8. 00	00800 LAUNDRY & LINEN SERVICE	13	3, 154				8.00
9. 00	00900 HOUSEKEEPI NG	727	2, 987		23, 292		9.00
10.00	01000 DI ETARY	268			438	26, 133	
11. 00	01100 CAFETERI A	784	7, 139 0		430	20, 133	11.00
13.00		1, 587	10, 529			0	1
	01300 NURSING ADMINISTRATION	898			646 409	-	
16. 00	01600 MEDI CAL RECORDS & LI BRARY	898	6, 666	U	409	0	16. 00
30. 00	I NPATI ENT ROUTI NE SERVI CE COST CENTERS 03000 ADULTS & PEDI ATRI CS	3, 597	106, 571	2, 850	6, 545	20, 084	30.00
					192		1
31. 00	03100   INTENSIVE CARE UNIT	1, 920	3, 124	1, 289	192	3, 428	31.00
50. 00	ANCILLARY SERVICE COST CENTERS 05000 OPERATING ROOM	1, 993	22, 742	543	1, 396	0	50.00
51.00	05100 RECOVERY ROOM	1, 993	2, 742		1, 390	0	51.00
51.00	05100 RECOVERT ROOM 05101 O/P TREATMENT ROOM	541	12, 251	0	752	2, 621	51.00
54. 00	1 1						54.00
	05400 RADI OLOGY-DI AGNOSTI C	3, 618	43, 465		2, 668	0	1
56.00	05600 RADI OI SOTOPE	176	2, 004		123	0	
60.00	06000 LABORATORY	1, 682	13, 036		800	0	
62.00	06200 WHOLE BLOOD & PACKED RED BLOOD CELLS	56	0		0	0	62.00
65.00	06500 RESPI RATORY THERAPY	1, 285	7, 802		479	0	65.00
66.00	06600 PHYSI CAL THERAPY	1, 181	25, 744		1, 580	0	66.00
67.00	06700 OCCUPATI ONAL THERAPY	323	21, 653		1, 329	0	67.00
68.00	06800 SPEECH PATHOLOGY	63	2, 926		180	0	68.00
69.00	06900 ELECTROCARDI OLOGY	505	3, 192		196	0	69.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	43	7, 741		475	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	2, 618	7, 725	0	474	0	73.00
00.00	OUTPATIENT SERVICE COST CENTERS						00.00
90.00	09000 CLINIC	0	0	_	0	0	90.00
91.00	09100 EMERGENCY	7, 209	63, 678	2, 845	3, 909	0	91.00
92. 00	09200 OBSERVATION BEDS (NON-DISTINCT PART)						92.00
440.00	SPECIAL PURPOSE COST CENTERS	04.040	07/ 400	10.000	00.700	0/ 400	440.00
118.00	1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1	34, 843	376, 422	10, 800	22, 732	26, 133	118. 00
104.00	NONREI MBURSABLE COST CENTERS	044			٥	0	104 00
	07950 PHYSI CI AN PRACTI CES	844	0 120		0		194.00
	07951 MEDICAL OFFICE BUILDING	61	9, 120		560		194. 01
	207952 VPCHC	0	0	0	0	0	194. 02
200.00	, ,	_	_	_		^	200.00
201.00		0 740	0	10 000	00		201.00
202.00	TOTAL (sum lines 118 through 201)	35, 748	385, 542	10, 800	23, 292	26, 133	202. 00

In Lieu of Form CMS-2552-10
Period: Worksheet B
From 01/01/2017 Part II Health Financial Systems
ALLOCATION OF CAPITAL RELATED COSTS Provi der CCN: 15-1326

				To	12/31/2017	Date/Time Pre 5/30/2018 1:4	
	Cost Center Description	CAFETERI A	NURSI NG	MEDI CAL	Subtotal	Intern &	
			ADMI NI STRATI O	RECORDS &		Resi dents	
			N	LI BRARY		Cost & Post	
						Stepdown	
		11. 00	13. 00	14 00	24.00	Adjustments 25.00	
GF	ENERAL SERVICE COST CENTERS	11.00	13.00	16. 00	24.00	25.00	
	0100 NEW CAP REL COSTS-BLDG & FLXT						1.00
2.00 00	D200 NEW CAP REL COSTS-MVBLE EQUIP						2.00
4.00 00	D400 EMPLOYEE BENEFITS DEPARTMENT						4.00
5. 01 00	0540 NONPATIENT TELEPHONES						5. 01
5. 02 00	D550 DATA PROCESSING						5. 02
	D560 PURCHASING RECEIVING AND STORES						5. 03
	D570 ADMI TTI NG						5. 04
	D580 CASHI ERI NG/ACCOUNTS RECEI VABLE						5. 05
	D591 ADMINISTRATIVE AND GENERAL						5. 06
	O700 OPERATION OF PLANT						7.00
	D800 LAUNDRY & LINEN SERVICE						8.00
	0900 HOUSEKEEPI NG						9.00
	1000 DI ETARY	70 705					10.00
	1100 CAFETERI A	70, 735					11.00
	1300 NURSI NG ADMI NI STRATI ON	5, 282					13.00
	1600 MEDICAL RECORDS & LIBRARY NPATIENT ROUTINE SERVICE COST CENTERS	3, 588	0	27, 886			16. 00
	3000 ADULTS & PEDIATRICS	13, 718	15, 767	1, 383	457, 124	0	30.00
	3100 INTENSIVE CARE UNIT	6, 994		354	74, 484	0	
	NCILLARY SERVICE COST CENTERS	0, 774	0,054	334	7 4, 404	J	31.00
	5000 OPERATING ROOM	4, 326	0	1, 999	146, 378	0	50.00
51.00 05	5100 RECOVERY ROOM	487	0	73	10, 293	0	51.00
51. 01 05	5101 O/P TREATMENT ROOM	1, 998	2, 264	365	58, 493	0	51.01
54. 00 05	5400 RADI OLOGY-DI AGNOSTI C	9, 096	o	7, 525	206, 680	0	54.00
	5600 RADI OI SOTOPE	0	0	197	7, 287	0	56.00
60.00 0	6000 LABORATORY	0	0	3, 345	50, 754	0	60.00
	6200 WHOLE BLOOD & PACKED RED BLOOD CELLS	0	0	34	141	0	
	6500 RESPI RATORY THERAPY	5, 230	1	353	47, 548	0	
1	6600 PHYSI CAL THERAPY	0	0	995	92, 106	0	66.00
	6700 OCCUPATI ONAL THERAPY	0	0	296	73, 600	0	67.00
1	6800 SPEECH PATHOLOGY	0	0	59	10, 067	0	68.00
	6900 ELECTROCARDI OLOGY	1, 051 0	0	1, 104	15, 109	0	
	7100 MEDICAL SUPPLIES CHARGED TO PATIENTS 7200 IMPL. DEV. CHARGED TO PATIENTS	0	0		25, 971 0	0	1
	7300 DRUGS CHARGED TO PATIENTS	4, 240			38, 801	0	1
	JTPATIENT SERVICE COST CENTERS	4, 240	0	2, 122	30, 001	0	73.00
	9000 CLINIC	0	0	0	0	0	90.00
	9100 EMERGENCY	14, 508			307, 311	0	1
92.00	9200 OBSERVATION BEDS (NON-DISTINCT PART)					0	92.00
	PECIAL PURPOSE COST CENTERS						1
118. 00	SUBTOTALS (SUM OF LINES 1 through 117)	70, 518	42, 740	27, 886	1, 622, 147	0	118. 00
NO	ONREI MBURSABLE COST CENTERS						1
	7950 PHYSICIAN PRACTICES	217	0		1, 955		194.00
	7951 MEDICAL OFFICE BUILDING	0	0	0	9, 741		194. 01
1	7952 VPCHC	0	0	0	0		194. 02
200.00	Cross Foot Adjustments	•			0		200.00
201.00	Negative Cost Centers	0	0	0	1 (22 042		201.00
202. 00	TOTAL (sum lines 118 through 201)	70, 735	42, 740	27, 886	1, 633, 843	0	202. 00

Health Financial Systems
ALLOCATION OF CAPITAL RELATED COSTS UNION HOSPITAL CLINTON Provider CCN: 15-1326

			5/30/2018 1:4	49 pm
	Cost Center Description	Total		
		26. 00		
	GENERAL SERVICE COST CENTERS			
1.00	00100 NEW CAP REL COSTS-BLDG & FIXT			1.00
2.00	00200 NEW CAP REL COSTS-MVBLE EQUIP			2.00
4.00	00400 EMPLOYEE BENEFITS DEPARTMENT			4.00
5. 01	00540 NONPATIENT TELEPHONES			5. 01
5.02	00550 DATA 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	00591 ADMINISTRATIVE AND GENERAL			5. 06
7.00	00700 OPERATION OF PLANT			7. 00
8.00	00800 LAUNDRY & LINEN SERVICE			8. 00
9.00	00900 HOUSEKEEPI NG			9. 00
10.00	01000 DI ETARY			10.00
11.00	01100 CAFETERI A			11.00
13.00	01300 NURSING ADMINISTRATION			13.00
16.00	01600 MEDICAL RECORDS & LIBRARY			16.00
	INPATIENT ROUTINE SERVICE COST CENTERS			
30.00	03000 ADULTS & PEDIATRICS	457, 124		30.00
31.00	03100 INTENSIVE CARE UNIT	74, 484		31.00
	ANCILLARY SERVICE COST CENTERS			
50.00	05000 OPERATING ROOM	146, 378		50.00
51.00	05100 RECOVERY ROOM	10, 293		51.00
51.01	05101 O/P TREATMENT ROOM	58, 493		51.01
54.00	05400 RADI OLOGY-DI AGNOSTI C	206, 680		54.00
56.00	05600 RADI OI SOTOPE	7, 287		56.00
60.00	06000 LABORATORY	50, 754		60.00
62.00	06200 WHOLE BLOOD & PACKED RED BLOOD CELLS	141		62.00
65.00	06500 RESPIRATORY THERAPY	47, 548		65.00
66.00	06600 PHYSI CAL THERAPY	92, 106		66.00
67.00	06700 OCCUPATI ONAL THERAPY	73, 600		67.00
68.00	06800 SPEECH PATHOLOGY	10, 067		68.00
69.00	06900 ELECTROCARDI OLOGY	15, 109		69.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	25, 971		71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0		72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	38, 801		73.00
	OUTPATIENT SERVICE COST CENTERS			
90.00	09000 CLI NI C	0		90.00
91.00	09100 EMERGENCY	307, 311		91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)			92.00
	SPECIAL PURPOSE COST CENTERS			
118.00	SUBTOTALS (SUM OF LINES 1 through 117)	1, 622, 147		118. 00
	NONREI MBURSABLE COST CENTERS			
194.00	07950 PHYSICIAN PRACTICES	1, 955		194. 00
194. 01	07951 MEDICAL OFFICE BUILDING	9, 741		194. 01
194. 02	07952 VPCHC	0		194. 02
200.00	Cross Foot Adjustments	0		200.00
201.00		o		201.00
202.00	TOTAL (sum lines 118 through 201)	1, 633, 843		202.00

COST ALLOCATION - STATISTICAL BASIS Provider CCN: 15-1326 Peri od: Worksheet B-1 From 01/01/2017 12/31/2017 Date/Time Prepared: 5/30/2018 1:49 pm CAPITAL RELATED COSTS Cost Center Description NEW BLDG & NEW MVBLE **EMPLOYEE** NONPATI ENT DATA PROCESSI NG **FOULP BENEFITS** TELEPHONES FLXT (EQUIP DEPARTMENT (PHONES) (DEVICES) (SQ FT) DEPRN) (GROSS SALARI ES) 1. 00 2.00 4.00 5. 01 5. 02 GENERAL SERVICE COST CENTERS 1.00 00100 NEW CAP REL COSTS-BLDG & FIXT 77, 794 1 00 00200 NEW CAP REL COSTS-MVBLE EQUIP 2.00 275, 078 2.00 00400 EMPLOYEE BENEFITS DEPARTMENT 7, 772, 320 4.00 4.00 00540 NONPATIENT TELEPHONES 104 5.01 19, 301 260 5.01 5.02 00550 DATA PROCESSING 203 0 130 5.02 83, 955 5.03 00560 PURCHASING RECEIVING AND STORES 791 0 5.03 C 00570 ADMITTING 504 388, 235 5 04 675 6 6 5 04 00580 CASHI ERI NG/ACCOUNTS RECEI VABLE 5.05 298 21, 622 2 5.05 5.06 00591 ADMINISTRATIVE AND GENERAL 1, 474 8, 188 677, 077 15 13 5.06 7.00 00700 OPERATION OF PLANT 21, 486 6,872 366, 491 21 26 7.00 00800 LAUNDRY & LINEN SERVICE 8 00 8 00 414 380 0 0 00900 HOUSEKEEPI NG 9.00 392 3, 414 218, 706 1 9.00 01000 DI ETARY 937 1,837 59, 255 10.00 10.00 01100 CAFETERI A 11.00 3.527 7.832 256, 164 6 2 11.00 01300 NURSING ADMINISTRATION 13 00 1, 382 290 525, 794 4 4 13 00 16.00 01600 MEDICAL RECORDS & LIBRARY 875 170 185, 453 9 8 16.00 INPATIENT ROUTINE SERVICE COST CENTERS 20. 941 30 00 13, 988 1 006 588 73 30.00 03000 ADULTS & PEDIATRICS 11 03100 INTENSIVE CARE UNIT 31.00 410 31, 123 689, 928 31.00 ANCILLARY SERVICE COST CENTERS 50.00 05000 OPERATING ROOM 2, 985 30, 715 355, 989 4 50.00 05100 RECOVERY ROOM 301 40, 759 2 0 51.00 51.00 1, 682 51.01 05101 0/P TREATMENT ROOM 1,608 2, 336 160, 224 11 51.01 05400 RADI OLOGY-DI AGNOSTI C 54.00 5,705 27, 149 658, 867 13 9 54.00 05600 RADI OI SOTOPE 56,00 263 1 0 56,00 0 06000 LABORATORY 5 60.00 1, 711 60.00 62.00 06200 WHOLE BLOOD & PACKED RED BLOOD CELLS 0 0 62.00 C 06500 RESPIRATORY THERAPY 10, 212 7 65 00 1 024 413, 277 65.00 06600 PHYSI CAL THERAPY 3.379 4 66.00 1, 434 11 66,00 0 06700 OCCUPATI ONAL THERAPY 67 00 2.842 r 0 8 0 67 00 06800 SPEECH PATHOLOGY 384 2 68.00 68.00 0 5 69.00 06900 ELECTROCARDI OLOGY 419 453 98, 491 0 69.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 71.00 71.00 1,016 0 0 07200 IMPL. DEV. CHARGED TO PATIENTS 72.00 0 0 72.00 73.00 07300 DRUGS CHARGED TO PATIENTS 1,014 1,024 405, 845 3 73.00 OUTPATIENT SERVICE COST CENTERS 90.00 09000 CLI NI C 90.00 0 Ω 91.00 09100 EMERGENCY 8, 358 15,095 1, 196, 356 30 15 91.00 92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART) 92.00 SPECIAL PURPOSE COST CENTERS SUBTOTALS (SUM OF LINES 1 through 117) 77, 794 275, 078 7, 725, 121 114 118. 00 118.00 260 NONREI MBURSABLE COST CENTERS 194. 00 07950 PHYSICIAN PRACTICES 0 47, 199 0 16 194. 00 194. 01 07951 MEDICAL OFFICE BUILDING 0 194. 01 0 C 0 0 194. 02 07952 VPCHC 0 C 0 0 0 194.02 200.00 Cross Foot Adjustments 200.00 201.00 Negative Cost Centers 201. 00 202.00 Cost to be allocated (per Wkst. B, 1, 347, 733 286, 110 2, 643, 172 96, 280 2, 937, 817 202. 00 Part I) 203.00 Unit cost multiplier (Wkst. B, Part I) 17. 324382 1.040105 0.340075 370. 307692 22, 598. 592308 203. 00 3, 685 204. 00 204.00 Cost to be allocated (per Wkst. B, 21.877 Part II) 0.000000 28. 346154 205. 00 205.00 Unit cost multiplier (Wkst. B, Part 84 142308 II) 206.00 NAHE adjustment amount to be allocated 206.00 (per Wkst. B-2) 207 00 NAHE unit cost multiplier (Wkst. D, 207 00 Parts III and IV)

COST ALLOCATION - STATISTICAL BASIS Provider CCN: 15-1326 Peri od: Worksheet B-1 From 01/01/2017 12/31/2017 Date/Time Prepared: 5/30/2018 1:49 pm Cost Center Description PURCHASI NG ADMITTI NG CASHIERING/AC Reconciliatio ADMI NI STRATI V COUNTS E AND GENERAL RECEIVING AND (INPATIENT n STORES REVENUE) RECEI VABLE (ACCUM. (REQUISITIO) (TOTAL COST) REVENUE' 5.03 5.04 5.05 5A. 06 5.06 GENERAL SERVICE COST CENTERS 00100 NEW CAP REL COSTS-BLDG & FIXT 1.00 1.00 00200 NEW CAP REL COSTS-MVBLE EQUIP 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 5.03 320, 795 5.03 5.04 00570 ADMITTING 548 9, 685, 346 5.04 5.05 00580 CASHI ERI NG/ACCOUNTS RECEI VABLE 72, 291, 633 5.05 0 00591 ADMINISTRATIVE AND GENERAL 206 -2, 343, 040 22, 473, 074 5.06 5.06 Ω  $\cap$ 7.00 00700 OPERATION OF PLANT 43 C 0 2, 290, 491 7.00 8.00 00800 LAUNDRY & LINEN SERVICE 210 0 0 8, 341 8.00 00900 HOUSEKEEPI NG 0 0 456, 871 9.00 9.00 25.845 0 01000 DI ETARY 0 0 10.00 17 C 168, 365 10.00 11.00 01100 CAFETERI A 73 C 0 0 492, 671 11.00 13.00 01300 NURSING ADMINISTRATION C 0 0 997, 635 13.00 6 01600 MEDICAL RECORDS & LIBRARY 16.00 15  $\cap$ 0 564, 519 16.00 INPATIENT ROUTINE SERVICE COST CENTERS 30.00 03000 ADULTS & PEDIATRICS 40, 695 2, 750, 563 3, 582, 459 2, 260, 840 30.00 03100 INTENSIVE CARE UNIT 637, 587 26, 589 916,600 0 1, 206, 888 31.00 31.00 ANCILLARY SERVICE COST CENTERS 50.00 05000 OPERATING ROOM 86, 573 1, 211, 268 5, 179, 668 0 1, 252, 942 50.00 51.00 05100 RECOVERY ROOM 37, 793 188, 400 0 70,640 51.00 51 01 051010/P TREATMENT ROOM 20, 202 7,638 944 505 0 340 020 51 01 05400 RADI OLOGY-DI AGNOSTI C 0 54.00 26, 691 981, 468 19, 496, 066 2, 274, 052 54.00 56.00 05600 RADI OI SOTOPE 270 21, 907 510, 326 0 110, 697 56.00 0 60.00 06000 LABORATORY 0 1,066,969 8,665,049 1, 057, 167 60.00 0 06200 WHOLE BLOOD & PACKED RED BLOOD CELLS 86, 984 62 00 0 41 574 35, 221 62 00 65.00 06500 RESPIRATORY THERAPY 8.537 508, 032 913, 445 807, 972 65.00 06600 PHYSI CAL THERAPY 126, 877 2, 577, 198 0 742, 206 66.00 717 66.00 0 06700 OCCUPATI ONAL THERAPY 67.00 0 29,600 766, 377 202, 848 67.00 06800 SPEECH PATHOLOGY 39, 386 0 5. 522 153, 694 68 00 68 00 o 69.00 06900 ELECTROCARDI OLOGY 399 356, 094 2, 858, 839 317, 672 69.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 0 26, 979 71.00 13, 149 24, 892 71.00 72.00 07200 IMPL. DEV. CHARGED TO PATIENTS ol 72.00 0 0 07300 DRUGS CHARGED TO PATIENTS 1,812 1, 322, 704 5, 496, 745 1, 645, 518 73.00 0 73.00 OUTPATIENT SERVICE COST CENTERS 90.00 09000 CLI NI C 0 90 00 09100 EMERGENCY 79, 979 19, 831, 775 566, 601 91.00 91.00 4, 534, 196 09200 OBSERVATION BEDS (NON-DISTINCT PART) 92.00 92.00 SPECIAL PURPOSE COST CENTERS SUBTOTALS (SUM OF LINES 1 through 117) 9, 685, 346 -2, 343, 040 21, 904, 137 118. 00 319, 427 72, 193, 022 118.00 NONREI MBURSABLE COST CENTERS 194. 00 07950 PHYSICIAN PRACTICES 1, 368 98, 611 530, 502 194. 00 194. 01 07951 MEDICAL OFFICE BUILDING 0 0 38, 435 194. 01 0 194. 02 07952 VPCHC 0 194. 02 0 0 0 0 200.00 Cross Foot Adjustments 200. 00 201.00 Negative Cost Centers 201.00 202.00 Cost to be allocated (per Wkst. B, 283, 566 796, 122 691, 027 2, 343, 040 202. 00 Part I) 0. 104260 203. 00 203.00 Unit cost multiplier (Wkst. B, Part I) 0.883948 0.082199 0.009559 204.00 Cost to be allocated (per Wkst. B, 101, 277 10, 281 5.557 35, 748 204. 00 Part II) 205.00 Unit cost multiplier (Wkst. B, Part 0.315706 0.001062 0.000077 0. 001591 205. 00 II)206.00 NAHE adjustment amount to be allocated 206.00 (per Wkst. B-2) NAHE unit cost multiplier (Wkst. D, 207.00 207.00 Parts III and IV)

Health Financial Systems
COST ALLOCATION - STATISTICAL BASIS UNION HOSPITAL CLINTON In Lieu of Form CMS-2552-10 Provi der CCN: 15-1326 Peri od: From 01/01/2017 To 12/31/2017 Worksheet B-1 Date/Time Prepared: 5/30/2018 1:49 pm Cost Center Description OPERATION OF PLANT LAUNDRY & HOUSEKEEPI NG (NUMBER DI ETARY (DI ETARY) CAFETERI A

		PLANT (SQ FT)	LINEN SERVICE (LINEN)	(NUMBER HOUSED)	(DI ETARY)	(FTE)	
		7. 00	8. 00	9. 00	10.00	11. 00	
	GENERAL SERVICE COST CENTERS						
1.00	00100 NEW CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200 NEW CAP REL COSTS-MVBLE EQUIP						2.00
4. 00	00400 EMPLOYEE BENEFITS DEPARTMENT						4. 00
5. 01	00540 NONPATI ENT TELEPHONES						5. 01
5. 02	00550 DATA PROCESSING						5. 02
5. 03	00560 PURCHASING RECEIVING AND STORES						5.03
5. 04 5. 05	00570 ADMITTING 00580 CASHIERING/ACCOUNTS RECEIVABLE						5. 04 5. 05
5. 06	00591 ADMINISTRATIVE AND GENERAL						5.06
7. 00	00700 OPERATION OF PLANT	50, 604					7. 00
8. 00	00800 LAUNDRY & LINEN SERVICE	414	63, 015				8.00
9. 00	00900 HOUSEKEEPI NG	392	5, 628	49, 798			9. 00
10.00	01000 DI ETARY	937	160	937	5, 633		10.00
11.00	01100 CAFETERI A	0	681	0	0	8, 142	11.00
13.00	01300 NURSING ADMINISTRATION	1, 382	o	1, 382	0	608	13.00
16.00	01600 MEDICAL RECORDS & LIBRARY	875	0	875	0	413	16.00
	INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000 ADULTS & PEDIATRICS	13, 988	16, 638	13, 988	4, 329	1, 579	30.00
31. 00	03100   I NTENSI VE CARE UNI T	410	7, 522	410	739	805	31.00
F0 00	ANCILLARY SERVICE COST CENTERS	0.005	0.4(/	2 205	ام	100	F0 00
50.00	05000 OPERATING ROOM	2, 985	3, 166	2, 985	0	498	50.00
51. 00 51. 01	05100 RECOVERY ROOM   05101 O/P TREATMENT ROOM	301	0	301	0	56	51. 00 51. 01
54. 00	05400 RADI OLOGY-DI AGNOSTI C	1, 608 5, 705	5, 337	1, 608 5, 705	565 0	230 1, 047	54.00
56. 00	05600 RADI OLOGI - DI AGNOSTI C	263	0, 337	263	0	1, 047	56.00
60.00	06000 LABORATORY	1, 711	Ö	1, 711	0	0	60.00
62. 00	06200 WHOLE BLOOD & PACKED RED BLOOD CELLS	0	ol	0	o	0	62.00
65. 00	06500 RESPI RATORY THERAPY	1, 024	501	1, 024	o	602	65.00
66.00	06600 PHYSI CAL THERAPY	3, 379	5, 699	3, 379	0	0	66.00
67.00	06700 OCCUPATI ONAL THERAPY	2, 842	o	2, 842	0	0	67.00
68.00	06800 SPEECH PATHOLOGY	384	0	384	0	0	68. 00
69. 00	06900 ELECTROCARDI OLOGY	419	1, 086	419	0	121	69. 00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	1, 016	0	1, 016	0	0	71.00
72.00	07200 I MPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
/3.00	07300 DRUGS CHARGED TO PATIENTS	1, 014	0	1, 014	0	488	73.00
90. 00	OUTPATIENT SERVICE COST CENTERS  09000 CLINIC	0	ol	O	ol	0	90.00
91. 00	09100 EMERGENCY	8, 358	16, 597	8, 358	0	1, 670	
	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0, 330	10, 377	0, 330	ď	1,070	92.00
72.00	SPECIAL PURPOSE COST CENTERS						72.00
118.00		49, 407	63, 015	48, 601	5, 633	8, 117	118. 00
	NONREI MBURSABLE COST CENTERS						
	07950 PHYSICIAN PRACTICES	0	0	0	0		194. 00
	07951 MEDICAL OFFICE BUILDING	1, 197	0	1, 197	0		194. 01
	07952 VPCHC	0	0	0	0	0	194. 02
200.00	, , , , , , , , , , , , , , , , , , , ,						200.00
201.00		2 520 200	20, 004	F2/ 7/0	242 740	E44 2/0	201.00
202. 00	Cost to be allocated (per Wkst. B, Part I)	2, 529, 298	29, 904	526, 768	242, 740	544, 360	202.00
203. 00	1 1	49. 982175	0. 474554	10. 578096	43. 092491	66. 858266	203 00
204.00		385, 542	10, 800	23, 292	26, 133		204.00
20 00	Part II)	333,012		20,272	20, 100	. 5, 766	
205.00	Unit cost multiplier (Wkst. B, Part	7. 618805	0. 171388	0. 467730	4. 639269	8. 687669	205.00
206.00							206. 00
207.00	(per Wkst. B-2)						207.00
207. 00	NAHE unit cost multiplier (Wkst. D, Parts III and IV)						207. 00
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Health Financial Systems UNION HOSPITAL CLINTON In Lieu of Form CMS-2552-10

COST ALLOCATION - STATISTICAL BASIS Provider CCN: 15-1326 Peri od: Worksheet B-1 From 01/01/2017 12/31/2017 Date/Time Prepared: 5/30/2018 1:49 pm Cost Center Description NURSI NG MEDI CAL RECORDS & ADMI NI STRATI O LI BRARY N (TIME (ASSI GNED SPENT) TIME) 13.00 16.00 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 00591 ADMINISTRATIVE AND GENERAL 5.06 5.06 7.00 00700 OPERATION OF PLANT 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 01300 NURSING ADMINISTRATION 13.00 89, 029 13.00 01600 MEDICAL RECORDS & LIBRARY 72, 193, 022 16.00 16.00 INPATIENT ROUTINE SERVICE COST CENTERS 03000 ADULTS & PEDIATRICS 30.00 32, 844 3, 582, 459 30.00 03100 INTENSIVE CARE UNIT 31.00 16, 736 916, 600 31.00 ANCILLARY SERVICE COST CENTERS 50.00 05000 OPERATING ROOM 0 5, 179, 668 50.00 51. 00 05100 RECOVERY ROOM 0 188, 400 51.00 05101 0/P TREATMENT ROOM 51 01 4.717 944 505 51 01 05400 RADI OLOGY-DI AGNOSTI C 54.00 0 19, 496, 066 54.00 56. 00 05600 RADI 0I SOTOPE 0 510, 326 56.00 06000 LABORATORY 0 60.00 8,665,049 60.00 06200 WHOLE BLOOD & PACKED RED BLOOD CELLS 0000000 62 00 86. 984 62 00 06500 RESPIRATORY THERAPY 65.00 913, 445 65.00 06600 PHYSI CAL THERAPY 2, 577, 198 66.00 66.00 06700 OCCUPATI ONAL THERAPY 67.00 766, 377 67.00 68.00 06800 SPEECH PATHOLOGY 153, 694 68.00 69.00 06900 ELECTROCARDI OLOGY 2, 858, 839 69.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 71.00 24, 892 71.00 72.00 07200 IMPL. DEV. CHARGED TO PATIENTS 0 C 72.00 07300 DRUGS CHARGED TO PATIENTS 5, 496, 745 73.00 0 73.00 OUTPATIENT SERVICE COST CENTERS 90.00 09000 CLI NI C 90.00 09100 EMERGENCY 91.00 34, 732 91.00 19, 831, 775 09200 OBSERVATION BEDS (NON-DISTINCT PART) 92.00 92.00 SPECIAL PURPOSE COST CENTERS SUBTOTALS (SUM OF LINES 1 through 117) 89, 029 72, 193, 022 118. 00 118.00 NONREI MBURSABLE COST CENTERS 194. 00 07950 PHYSICIAN PRACTICES 0 0 194.00 194. 01 07951 MEDICAL OFFICE BUILDING 0 0 194.01 194. 02 07952 VPCHC 194. 02 0 0 200.00 Cross Foot Adjustments 200.00 201.00 Negative Cost Centers 201.00 202.00 Cost to be allocated (per Wkst. B, 1, 225, 992 703, 978 202.00 Part I) 203.00 Unit cost multiplier (Wkst. B, Part I) 13.770704 0.009751 203.00 204.00 Cost to be allocated (per Wkst. B, 42,740 27,886 204.00 Part II) 205.00 Unit cost multiplier (Wkst. B, Part 0. 480068 0.000386 205.00 II)NAHE adjustment amount to be allocated 206.00 206.00 (per Wkst. B-2) NAHE unit cost multiplier (Wkst. D, 207.00 207.00

Parts III and IV)

Health Financial Systems	UNION HOSPITAL CLINTON	In Lieu of Form CMS-2552-10
COMPUTATION OF RATIO OF COSTS TO CHARGES	Provi der CCN: 15-1326	Period: Worksheet C

		Trovider of	F	From 01/01/2017 From 12/31/2017	Part I Date/Time Pre 5/30/2018 1:4	
		Title	XVIII	Hospi tal	Cost	
				Costs		
Cost Center Description		Therapy Limit	Total Costs	RCE	Total Costs	
	(from Wkst.	Adj .		Di sal I owance		
	B, Part I,					
	col . 26)					
	1. 00	2. 00	3. 00	4. 00	5. 00	
INPATIENT ROUTINE SERVICE COST CENTERS						
30. 00   03000   ADULTS & PEDI ATRI CS	4, 130, 902		4, 130, 902		0	
31. 00 03100 I NTENSI VE CARE UNI T	1, 686, 189		1, 686, 189	9 0	0	31.00
ANCILLARY SERVICE COST CENTERS						
50.00   05000   OPERATING ROOM	1, 649, 651		1, 649, 651	1 0	0	50.00
51.00   05100   RECOVERY ROOM	101, 815		101, 815	5 0	0	51.00
51.01  05101 0/P TREATMENT ROOM	586, 741		586, 74	0	0	51.01
54. 00   05400   RADI OLOGY-DI AGNOSTI C	3, 119, 281		3, 119, 281	0	0	54.00
56. 00   05600   RADI 01 SOTOPE	143, 141		143, 141	0	0	56.00
60. 00  06000 LABORATORY	1, 355, 499		1, 355, 499	9 0	0	60.00
62.00 06200 WHOLE BLOOD & PACKED RED BLOOD CELLS	39, 741		39, 74	0	0	62.00
65. 00 06500 RESPIRATORY THERAPY	1, 003, 619	0	1, 003, 619	9 0	0	65.00
66. 00   06600 PHYSI CAL THERAPY	1, 052, 055	0	1, 052, 055	5 0	0	66.00
67. 00 06700 OCCUPATI ONAL THERAPY	403, 582	0	403, 582	2 0	0	67.00
68.00 06800 SPEECH PATHOLOGY	68, 246	0	68, 246	6 0	0	68. 00
69. 00 06900 ELECTROCARDI OLOGY	412, 649		412, 649	9 0	0	69. 00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	91, 564		91, 564	1 0	0	71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0		(	0	0	72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	1, 964, 714		1, 964, 714	1 0	0	73.00
OUTPATIENT SERVICE COST CENTERS						
90. 00 09000 CLI NI C	0		(	0	0	90.00
91. 00 09100 EMERGENCY	6, 304, 309		6, 304, 309	9 0	0	91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	1, 058, 206		1, 058, 206	5	0	92.00
200.00 Subtotal (see instructions)	25, 171, 904	0	25, 171, 904	1 0	0	200.00
201.00 Less Observation Beds	1, 058, 206		1, 058, 206	5	0	201.00
202.00 Total (see instructions)	24, 113, 698	0	24, 113, 698	0	0	202.00
			•	,	•	•

UNION HOSPITAL CLINTON	In Lie	u of Form CMS-2552-10
Provi der CCN: 15-1		Worksheet C
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				Fo 12/31/2017	Date/Time Pre 5/30/2018 1:4	
		Title	XVIII	Hospi tal	Cost	
·		Charges				
Cost Center Description	I npati ent	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	
INPATIENT ROUTINE SERVICE COST CENTERS						
30. 00 03000 ADULTS & PEDIATRICS	2, 776, 229		2, 776, 229		  -	30.00
31.00 03100 INTENSIVE CARE UNIT	916, 600		916, 600	)		31.00
ANCILLARY SERVICE COST CENTERS			T			
50. 00   05000   OPERATI NG ROOM	1, 208, 168	3, 968, 400			0. 000000	50.00
51. 00   05100   RECOVERY ROOM	37, 793	150, 607	•		0. 000000	51.00
51. 01   05101   0/P   TREATMENT   ROOM	7, 638	909, 638	•		0. 000000	51. 01
54. 00   05400   RADI OLOGY-DI AGNOSTI C	981, 468	18, 514, 329			0. 000000	54.00
56. 00   05600   RADI OI SOTOPE	21, 907	488, 419			0. 000000	56.00
60. 00   06000   LABORATORY	1, 066, 969	7, 598, 080			0. 000000	60.00
62.00 06200 WHOLE BLOOD & PACKED RED BLOOD CELLS	41, 574	45, 410			0. 000000	62.00
65. 00 06500 RESPI RATORY THERAPY	508, 032	405, 413			0. 000000	65.00
66. 00 06600 PHYSI CAL THERAPY	126, 877	2, 450, 321	2, 577, 198		0. 000000	66. 00
67. 00  06700 OCCUPATI ONAL THERAPY	29, 600	736, 777	•		0. 000000	67.00
68.00   06800   SPEECH PATHOLOGY	5, 522	148, 172	•		0. 000000	68. 00
69. 00 06900 ELECTROCARDI OLOGY	356, 094	2, 481, 635			0. 000000	69. 00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	16, 249	11, 743	27, 992		0. 000000	71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0	0	(	0.000000	0. 000000	72.00
73.00 O7300 DRUGS CHARGED TO PATIENTS	1, 322, 704	4, 174, 041	5, 496, 745	0. 357432	0.000000	73.00
OUTPATIENT SERVICE COST CENTERS						
90. 00  09000   CLI NI C	0	0	(	0. 000000	0. 000000	90.00
91. 00   09100   EMERGENCY	566, 601	19, 265, 174			0. 000000	91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	14, 096	796, 673	•		0. 000000	92.00
200.00 Subtotal (see instructions)	10, 004, 121	62, 144, 832	72, 148, 953	3		200. 00
201.00 Less Observation Beds						201. 00
202.00 Total (see instructions)	10, 004, 121	62, 144, 832	72, 148, 953	3		202.00

Health Financial Systems	UNION HOSPITAL	CLINTON	In Lieu	u of Form CMS-2	2552-10
COMPUTATION OF RATIO OF COSTS TO CHARGES		Provider CCN: 15-1326		Worksheet C Part I Date/Time Pre 5/30/2018 1:4	pared: 9 pm
		Title XVIII	Hospi tal	Cost	
Cost Center Description	PPS Inpatient				
	Rati o				
	11. 00				
INPATIENT ROUTINE SERVICE COST CENTERS					
30. 00 03000 ADULTS & PEDIATRICS					30.00
31.00 03100 INTENSIVE CARE UNIT					31.00

	Cost Center Description	PPS Inpatient	
		Ratio	
		11. 00	
	ATIENT ROUTINE SERVICE COST CENTERS		
30.00 030	00 ADULTS & PEDIATRICS		30.00
	OO INTENSIVE CARE UNIT		31.00
	ILLARY SERVICE COST CENTERS		
1	OO OPERATING ROOM	0. 000000	50.00
	OO RECOVERY ROOM	0. 000000	51.00
	01 0/P TREATMENT ROOM	0. 000000	51. 01
	00 RADI OLOGY-DI AGNOSTI C	0. 000000	54.00
1	00 RADI 0I SOTOPE	0. 000000	56.00
1	00 LABORATORY	0. 000000	60.00
	00 WHOLE BLOOD & PACKED RED BLOOD CELLS	0. 000000	62.00
1	00 RESPI RATORY THERAPY	0. 000000	65.00
	00 PHYSI CAL THERAPY	0. 000000	66. 00
	00 OCCUPATI ONAL THERAPY	0. 000000	67.00
	00 SPEECH PATHOLOGY	0. 000000	68.00
	00 ELECTROCARDI OLOGY	0. 000000	69. 00
	00 MEDICAL SUPPLIES CHARGED TO PATIENTS	0. 000000	71.00
	OO IMPL. DEV. CHARGED TO PATIENTS	0. 000000	72. 00
	00 DRUGS CHARGED TO PATIENTS	0. 000000	73. 00
	PATIENT SERVICE COST CENTERS		
	00 CLI NI C	0. 000000	90.00
	OO EMERGENCY	0. 000000	91.00
	OO OBSERVATION BEDS (NON-DISTINCT PART)	0. 000000	92.00
200. 00	Subtotal (see instructions)		200.00
201. 00	Less Observation Beds		201.00
202. 00	Total (see instructions)		202.00

Health Financial Systems	UNION HOSPITAL CLINTON	In Lieu of Form CMS-2552-10
COMPUTATION OF RATIO OF COSTS TO CHARGES	Provi der CCN: 15-1326	Peri od: Worksheet C From 01/01/2017 Part I To 12/31/2017 Date/Time Prepared:

				j	o 12/31/2017	Date/Time Pre 5/30/2018 1:4	
			Ti tl	e XIX	Hospi tal	Cost	
					Costs		
	Cost Center Description	Total Cost T	Therapy Limit	Total Costs	RCE	Total Costs	
		(from Wkst.	Adj .		Di sal I owance		
		B, Part I,					
		col . 26)					
		1. 00	2. 00	3. 00	4. 00	5. 00	
	INPATIENT ROUTINE SERVICE COST CENTERS						
	03000 ADULTS & PEDIATRICS	4, 130, 902		4, 130, 902		4, 130, 902	
31. 00	03100 INTENSIVE CARE UNIT	1, 686, 189		1, 686, 189	9 0	1, 686, 189	31.00
	ANCILLARY SERVICE COST CENTERS						
	05000 OPERATING ROOM	1, 649, 651		1, 649, 651		1, 649, 651	
		101, 815		101, 815		101, 815	
	05101 O/P TREATMENT ROOM	586, 741		586, 741		586, 741	
	05400 RADI OLOGY-DI AGNOSTI C	3, 119, 281		3, 119, 281		3, 119, 281	
	05600 RADI OI SOTOPE	143, 141		143, 141		143, 141	
		1, 355, 499		1, 355, 499		1, 355, 499	
	06200 WHOLE BLOOD & PACKED RED BLOOD CELL			39, 741		39, 741	
	06500 RESPI RATORY THERAPY	1, 003, 619	0	1, 003, 619		1, 003, 619	1
	06600 PHYSI CAL THERAPY	1, 052, 055	0	1, 052, 055		1, 052, 055	
	06700 OCCUPATI ONAL THERAPY	403, 582	0	403, 582		403, 582	
	06800 SPEECH PATHOLOGY	68, 246	0	68, 246		68, 246	
	06900 ELECTROCARDI OLOGY	412, 649		412, 649		412, 649	
		S 91, 564		91, 564	0	91, 564	
	07200 IMPL. DEV. CHARGED TO PATIENTS	0		(	0	0	72.00
73. 00	07300 DRUGS CHARGED TO PATIENTS	1, 964, 714		1, 964, 714	l 0	1, 964, 714	73.00
	OUTPATIENT SERVICE COST CENTERS						
	09000 CLI NI C	0		(	0	0	
	09100 EMERGENCY	6, 304, 309		6, 304, 309		6, 304, 309	
	09200 OBSERVATION BEDS (NON-DISTINCT PART	·   · · ·		1, 058, 206		1, 058, 206	
200.00		25, 171, 904	0	25, 171, 904		25, 171, 904	
201.00		1, 058, 206		1, 058, 206		1, 058, 206	
202.00	O Total (see instructions)	24, 113, 698	0	24, 113, 698	8  0	24, 113, 698	202.00

Health Financial Systems	UNION HOSPITAL CLINTON	In Lieu of Form CMS-2552-1	10
COMPUTATION OF RATIO OF COSTS TO CHARGES	Provi der CCN: 15-1326	Period: Worksheet C	_
		From 01/01/2017 Part I	

						To 12/31/2017	Date/Time Pre 5/30/2018 1:4	
				Ti tl	Hospi tal	Cost		
				Charges				
	С	ost Center Description	Inpatient	Outpati ent		Cost or Other	TEFRA	
					+ col. 7)	Rati o	I npati ent	
							Ratio	
	I		6. 00	7. 00	8. 00	9. 00	10. 00	
		ENT ROUTINE SERVICE COST CENTERS						
		DULTS & PEDIATRICS	2, 776, 229		2, 776, 22			30.00
31. 00		NTENSI VE CARE UNIT	916, 600		916, 60	0		31.00
		ARY SERVICE COST CENTERS	1 000 1/0	0.010.100		0 040477		
		PERATING ROOM	1, 208, 168	3, 968, 400			0. 000000	1
		ECOVERY ROOM	37, 793	150, 607			0. 000000	
		/P TREATMENT ROOM	7, 638	909, 638			0. 000000	
54.00		ADI OLOGY-DI AGNOSTI C	981, 468	18, 514, 329			0. 000000	
56. 00		ADI OI SOTOPE	21, 907	488, 419			0. 000000	
		ABORATORY	1, 066, 969	7, 598, 080			0. 000000	
		HOLE BLOOD & PACKED RED BLOOD CELLS	41, 574	45, 410			0. 000000	
		ESPI RATORY THERAPY	508, 032	405, 413			0. 000000	1
66. 00		PHYSI CAL THERAPY	126, 877	2, 450, 321			0. 000000	
		CCUPATI ONAL THERAPY	29, 600	736, 777			0. 000000	
		PEECH PATHOLOGY	5, 522	148, 172			0. 000000	
		LECTROCARDI OLOGY	356, 094	2, 481, 635			0. 000000	
		IEDICAL SUPPLIES CHARGED TO PATIENTS	16, 249	11, 743	27, 99		0. 000000	1
		MPL. DEV. CHARGED TO PATIENTS	0	0		0. 000000	0. 000000	
73. 00		RUGS CHARGED TO PATIENTS	1, 322, 704	4, 174, 041	5, 496, 74	0. 357432	0. 000000	73. 00
		ENT SERVICE COST CENTERS						
	09000 C		0	0		0. 000000	0. 000000	
		MERGENCY	566, 601	19, 265, 174			0. 000000	1
		BSERVATION BEDS (NON-DISTINCT PART)	14, 096	796, 673			0. 000000	1
200.00	1 1	Subtotal (see instructions)	10, 004, 121	62, 144, 832	72, 148, 95	3		200.00
201.00		ess Observation Beds						201.00
202.00	) T	otal (see instructions)	10, 004, 121	62, 144, 832	72, 148, 95	3		202.00

Health Financial Systems	UNION HOSPITAL	CLINTON	In lie	u of Form CMS-:	2552-10
COMPUTATION OF RATIO OF COSTS TO CHARGES	0.0000000000000000000000000000000000000	Provi der CCN: 15-1326	Peri od: From 01/01/2017 To 12/31/2017	Worksheet C Part I	pared:
		Title XIX	Hospi tal	Cost	
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
ANCILLARY SERVICE COST CENTERS					
50. 00 05000 OPERATING ROOM	0. 000000				50.00
51.00   05100   RECOVERY ROOM	0. 000000				51.00
51.01  05101 0/P TREATMENT ROOM	0. 000000				51. 01
54. 00   05400   RADI OLOGY-DI AGNOSTI C	0. 000000				54.00
56. 00   05600   RADI 0I SOTOPE	0. 000000				56.00
60. 00  06000 LABORATORY	0. 000000				60.00
62.00 06200 WHOLE BLOOD & PACKED RED BLOOD CELLS	0. 000000				62.00
65. 00   06500   RESPI RATORY THERAPY	0. 000000				65.00
66. 00   06600 PHYSI CAL THERAPY	0. 000000				66.00

0.000000

0. 000000

0.000000

0.000000

0.000000

0.000000

0. 000000

0. 000000 0. 000000 67.00

68.00

69.00

71.00

72.00

73.00

90.00

91.00

92.00

200.00

201.00

202.00

67. 00 06700 OCCUPATI ONAL THERAPY

71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS

07200 IMPL. DEV. CHARGED TO PATIENTS 07300 DRUGS CHARGED TO PATIENTS

92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)

Total (see instructions)

Less Observation Beds

Subtotal (see instructions)

OUTPATIENT SERVICE COST CENTERS

68.00 06800 SPEECH PATHOLOGY

09000 CLI NI C

91. 00 09100 EMERGENCY

72.00

73.00

90.00

200.00

201.00

202.00

69. 00 06900 ELECTROCARDI OLOGY

Health Financial Systems	UNION HOSPITAL	CLINTON	In Lieu	of Form CMS-2552-10
APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL	_ COSTS	Provider CCN: 15-1326	Peri od:	Worksheet D

APPORT	APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS		Fi		Period: From 01/01/2017 To 12/31/2017	Worksheet D Part II Date/Time Prepared 5/30/2018 1:49 pm	
			Title	XVIII	Hospi tal	Cost	
	Cost Center Description	Capi tal	Total Charges	Ratio of Cos	t Inpatient	Capital Costs	
	·	Related Cost	(from Wkst.	to Charges	Program	(column 3 x	
		(from Wkst.	C, Part I,	(col. 1 ÷	Charges	column 4)	
		B, Part II,	col. 8)	col. 2)			
		col. 26)					
		1. 00	2. 00	3.00	4. 00	5. 00	
	ANCILLARY SERVICE COST CENTERS						
50.00	05000 OPERATING ROOM	146, 378	5, 176, 568	0. 02827	7 403, 359	11, 406	50.00
	05100 RECOVERY ROOM	10, 293	188, 400	0. 05463	4 17, 185	939	51.00
51. 01	05101 0/P TREATMENT ROOM	58, 493		0. 06376	8 0	0	51. 01
54.00	05400 RADI OLOGY-DI AGNOSTI C	206, 680	19, 495, 797	0. 01060	1 296, 700	3, 145	54.00
56.00	05600 RADI 0I SOTOPE	7, 287	510, 326	0. 01427	9 13, 719	196	56.00
	06000 LABORATORY	50, 754	8, 665, 049	0. 00585	7 492, 073	2, 882	60.00
	06200 WHOLE BLOOD & PACKED RED BLOOD CELLS	141	86, 984	0. 00162	1 25, 726	42	62.00
65.00	06500 RESPI RATORY THERAPY	47, 548	913, 445	0. 05205	3 287, 415	14, 961	65.00
66.00	06600 PHYSI CAL THERAPY	92, 106	2, 577, 198	0. 03573	9 68, 896	2, 462	66.00
67.00	06700 OCCUPATI ONAL THERAPY	73, 600	766, 377	0. 09603	6 15, 378	1, 477	67.00
68.00	06800 SPEECH PATHOLOGY	10, 067	153, 694	0. 06550	0 3, 195	209	68.00
69. 00	06900 ELECTROCARDI OLOGY	15, 109	2, 837, 729	0. 00532	4 240, 577	1, 281	69.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	25, 971	27, 992	0. 92780	1 15, 696	14, 563	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0	0	0. 00000	0 0	0	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	38, 801	5, 496, 745	0. 00705	9 697, 253	4, 922	73.00
	OUTPATIENT SERVICE COST CENTERS						
90.00	09000 CLI NI C	0	0	0.00000	0 0	0	90.00
91.00	09100 EMERGENCY	307, 311	19, 831, 775	0. 01549	6 19, 623	304	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	117, 101	810, 769	0. 14443	2 0	0	92.00
200.00	Total (lines 50 through 199)	1, 207, 640	68, 456, 124		2, 596, 795	58, 789	200.00

Health Financial Systems	CLI NTON	of Form CMS-2552-10		
APPORTIONMENT OF INPATIENT/OUTPATIENT	ANCILLARY SERVICE OTHER PASS	Provi der CCN: 15-1326	Peri od:	Worksheet D
THROUGH COSTS			From 01/01/2017	Part IV

THROUGH COSTS 12/31/2017 Date/Time Prepared: 5/30/2018 1:49 pm Title XVIII Hospi tal Cost Nursi ng Cost Center Description Non Physician Nursi ng Allied Health Allied Health Anesthetist School Post-Stepdown School Post-Stepdown Adjustments Cost Adjustments 1. 00 2.00 ЗА 3.00 ANCILLARY SERVICE COST CENTERS 50.00 05000 OPERATING ROOM 0 50.00 05100 RECOVERY ROOM 51.00 51.00 0 0 51.01 05101 O/P TREATMENT ROOM 0 51.01 05400 RADI OLOGY-DI AGNOSTI C 0 54.00 0 0 0 0 54.00 0 05600 RADI OI SOTOPE 56.00 0 56.00 60.00 06000 LABORATORY 0 60.00 62.00 06200 WHOLE BLOOD & PACKED RED BLOOD CELLS 0 0 0 62.00 0 06500 RESPIRATORY THERAPY 0 65.00 65.00 0 01 66.00 06600 PHYSI CAL THERAPY Ω 66.00 0 67.00 06700 OCCUPATIONAL THERAPY 0 0 67.00 68.00 06800 SPEECH PATHOLOGY 0 0 0 68.00 69.00 06900 ELECTROCARDI OLOGY 0 0 69.00 0 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 0 71.00 71.00 0 72.00 07200 IMPL. DEV. CHARGED TO PATIENTS 0 0 0 72.00 07300 DRUGS CHARGED TO PATIENTS 0 0 73.00 73.00 OUTPATIENT SERVICE COST CENTERS 90. 00 09000 CLINIC 0 0 0 90.00 91. 00 09100 EMERGENCY 0 0 0 0 0 91.00 0 92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART) 92.00 0 0 200.00 200.00 Total (lines 50 through 199)

Health Financial Systems	UNION HOSPITAL CLINTON	In Lieu of Form CMS-2552-10
APPORTIONMENT OF INPATIENT/OUTPATIENT	ANCILLARY SERVICE OTHER PASS   Provider CCN: 15-1326	Peri od: Worksheet D
TURQUOU COOTO		From 01/01/2017   Dort IV

THROUGH COSTS From 01/01/201/| Part IV To 12/31/2017 | Date/Time Prepared: 5/30/2018 1:49 pm Title XVIII Hospi tal Cost Cost Center Description All Other Total Cost Total Total Charges Ratio of Cost to Charges Medi cal (sum of col 1 Outpati ent (from Wkst. Educati on C, Part I, (col. 5 ÷ through col Cost (sum of Cost 4) col. 2, 3 and col. 8) col. 7) 4. 00 5.00 6.00 7. 00 8. 00 ANCILLARY SERVICE COST CENTERS 50 00 05000 OPERATING ROOM 0.000000 50 00 5, 176, 568 51. 00 | 05100 | RECOVERY ROOM 0 0 0 0 0 0 0 0 0 0 0 188, 400 0.000000 51.00 05101 0/P TREATMENT ROOM 0 0 917, 276 0.000000 51.01 51.01 05400 RADI OLOGY-DI AGNOSTI C 0 0 19, 495, 797 0.000000 54.00 54.00 05600 RADI OI SOTOPE 0.000000 56.00 510, 326 56.00 60.00 06000 LABORATORY 0 0 8, 665, 049 0.000000 60.00 62.00 06200 WHOLE BLOOD & PACKED RED BLOOD CELLS 0 86, 984 0.000000 62.00 0.000000 06500 RESPIRATORY THERAPY 0 0 913, 445 65.00 65.00 06600 PHYSI CAL THERAPY 0 0 66.00 2, 577, 198 0.000000 66.00 67.00 06700 OCCUPATI ONAL THERAPY 766, 377 0.000000 67.00 0 68.00 06800 SPEECH PATHOLOGY 0 153, 694 0.000000 68.00 2, 837, 729 0 06900 ELECTROCARDI OLOGY 0 0.000000 69.00 69.00 71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 0 27, 992 0.000000 71.00 07200 IMPL. DEV. CHARGED TO PATIENTS 0 0 0 0.000000 72.00 72.00 07300 DRUGS CHARGED TO PATIENTS 73.00 0 0 5, 496, 745 0.000000 73.00 OUTPATIENT SERVICE COST CENTERS 09000 CLI NI C 0 0.000000 90.00 0 0 0 0 0 91.00 09100 EMERGENCY 0 19, 831, 775 0.000000 91.00 ΟJ 92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART) 810, 769 0.000000 92.00 200.00 Total (lines 50 through 199) 0 68, 456, 124 200.00

Health Fi	inancial Systems	UNION HOSPITA	L CLINTON		In Lie	eu of Form CMS-2	2552-10
	NMENT OF INPATIENT/OUTPATIENT ANCILLARY SE				eriod: rom 01/01/2017	Worksheet D	
	00010			Т	o 12/31/2017	Date/Time Pre 5/30/2018 1:4	
				XVIII	Hospi tal	Cost	
	Cost Center Description	Outpati ent	I npati ent	I npati ent	Outpati ent	Outpati ent	
		Ratio of Cost	Program	Program	Program	Program	
		to Charges	Charges	Pass-Through	Charges	Pass-Through	
		(col. 6 ÷		Costs (col. 8		Costs (col. 9	
		col. 7)		x col. 10)		x col. 12)	
		9. 00	10. 00	11. 00	12.00	13.00	
	NCILLARY SERVICE COST CENTERS			,			
50.00 05	5000 OPERATING ROOM	0. 000000	403, 359		0	0	50.00
	5100 RECOVERY ROOM	0. 000000	17, 185	0	0	0	51.00
	5101 0/P TREATMENT ROOM	0. 000000	0	1	0	0	0
	5400 RADI OLOGY-DI AGNOSTI C	0. 000000	296, 700		0	0	
56.00 05	5600 RADI OI SOTOPE	0. 000000	13, 719		0	0	56.00
	6000 LABORATORY	0. 000000	492, 073	0	0	0	1 00.00
	6200 WHOLE BLOOD & PACKED RED BLOOD CELLS	0. 000000	25, 726	0	0	0	62.00
65.00 06	6500 RESPI RATORY THERAPY	0. 000000	287, 415	0	0	0	65.00
66.00 06	6600 PHYSI CAL THERAPY	0. 000000	68, 896	0	0	0	66.00
67.00 06	6700 OCCUPATI ONAL THERAPY	0. 000000	15, 378	0	0	0	67.00
68.00 06	5800 SPEECH PATHOLOGY	0. 000000	3, 195	0	0	0	68. 00
69.00 06	6900 ELECTROCARDI OLOGY	0. 000000	240, 577	0	0	0	69. 00
71.00 07	7100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0. 000000	15, 696	0	0	0	71.00
72. 00 07	7200 IMPL. DEV. CHARGED TO PATIENTS	0. 000000	0	0	0	0	72.00
73. 00 07	7300 DRUGS CHARGED TO PATIENTS	0. 000000	697, 253	0	0	0	73.00
OL	JTPATIENT SERVICE COST CENTERS						Ī
90.00	9000 CLI NI C	0. 000000	0	0	0	0	90.00
91.00 09	9100 EMERGENCY	0. 000000	19, 623	0	0	0	91.00
92.00 09	9200 OBSERVATION BEDS (NON-DISTINCT PART)	0. 000000	0	0	0	0	92.00
200. 00	Total (lines 50 through 199)		2, 596, 795	0	0	0	200.00
	-	•					

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST Provi der CCN: 15-1326 Peri od: Worksheet D From 01/01/2017 Part V 12/31/2017 Date/Time Prepared: 5/30/2018 1:49 pm Title XVIII Hospi tal Cost Charges Costs PPS PPS Services Cost Center Description Cost to Cost Cost Charge Ratio Rei mbursed Rei mbursed Rei mbursed (see inst.) From Services (see Servi ces Services Not Worksheet C, inst.) Subject To Subject To Ded. & Coins. Ded. & Coins. Part I, col. 9 (see inst.) (see inst.) 1.00 2.00 4. 00 5.00 3.00 ANCILLARY SERVICE COST CENTERS 50.00 05000 OPERATING ROOM 1, 383, 827 50.00 0. 318677 05100 RECOVERY ROOM 0.540419 0 51.00 52, 867 51.00 0 0 05101 0/P TREATMENT ROOM 0.639656 0 51.01 476, 376 0 51.01 54.00 05400 RADI OLOGY-DI AGNOSTI C 0. 159998 6, 156, 772 183 0 54.00 56.00 05600 RADI OI SOTOPE 0. 280489 173, 664 0 0 56.00 06000 LABORATORY 2, 963, 493 0 60.00 0.156433 0 60.00 06200 WHOLE BLOOD & PACKED RED BLOOD CELLS 62.00 0.456877 27, 266 0 0 62.00 65.00 06500 RESPIRATORY THERAPY 1. 098719 107, 014 0 65.00 0 66.00 06600 PHYSI CAL THERAPY 0.408217 1, 019, 651 0 66.00 06700 OCCUPATI ONAL THERAPY 0.526610 67.00 67.00 214, 582 0 68.00 06800 SPEECH PATHOLOGY 0.444038 15, 283 0 0 68.00 06900 ELECTROCARDI OLOGY 0. 145415 1, 048, 857 o 0 69.00 69.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 3. 271077 0 9, 771 0 71.00 71 00 0 72.00 07200 IMPL. DEV. CHARGED TO PATIENTS 0.000000 0 0 0 72.00 73.00 07300 DRUGS CHARGED TO PATIENTS 0. 357432 0 1, 934, 327 2, 415 0 73.00 OUTPATIENT SERVICE COST CENTERS 90.00 0.000000 0 0 90.00 09000 CLINIC 0 09100 EMERGENCY 91.00 91.00 0.317889 0 5, 134, 657 1, 272 0 92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART) 1. 305188 511, 963 0 92.00 0 200.00 200.00 Subtotal (see instructions) 0 21, 230, 370 3,870 Less PBP Clinic Lab. Services-Program 201.00 201.00 Only Charges 202.00 Net Charges (line 200 - line 201) 0 21, 230, 370 3, 870 0 202.00

Health Financial Systems	UNION HOSPITAL	CLINTON	In Lieu of Form CMS-2552-10
APPORTIONMENT OF MEDICAL,	OTHER HEALTH SERVICES AND VACCINE COST	Provider CCN: 15-1326	Period: Worksheet D

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND	) VACCINE COST	Provider Ci	UN: 15-1326	From 01/01/2017 To 12/31/2017	Part V Date/Time Pr 5/30/2018 1:	
		Title	XVIII	Hospi tal	Cost	
	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.)				
ANOLILIARY OFFICE OCCUPANTED	6. 00	7. 00				
ANCILLARY SERVICE COST CENTERS	440.004		1			
50. 00   05000   OPERATING ROOM	440, 994		ł			50.00
51. 00   05100   RECOVERY ROOM	28, 570					51.00
51. 01   05101   0/P TREATMENT ROOM	304, 717					51. 01
54. 00   05400   RADI OLOGY-DI AGNOSTI C	985, 071					54.00
56. 00   05600   RADI OI SOTOPE	48, 711					56.00
60. 00 06000 LABORATORY	463, 588					60.00
62.00 06200 WHOLE BLOOD & PACKED RED BLOOD CELLS	12, 457					62.00
65. 00 06500 RESPIRATORY THERAPY	117, 578					65.00
66. 00 06600 PHYSI CAL THERAPY	416, 239					66.00
67. 00 06700 OCCUPATI ONAL THERAPY	113, 001					67.00
68. 00 06800 SPEECH PATHOLOGY	6, 786					68. 00
69. 00 06900 ELECTROCARDI OLOGY	152, 520					69.00
71. 00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	31, 962	1				71.00
72. 00 07200 IMPL. DEV. CHARGED TO PATIENTS	0	0 0/3				72.00
73. 00 O7300 DRUGS CHARGED TO PATIENTS	691, 390	863				73. 00
90.00 OUTPATIENT SERVICE COST CENTERS	0	0				90.00
91. 00   09100  EMERGENCY	1, 632, 251		1			91.00
92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	1					92.00
200.00 Subtotal (see instructions)	668, 208 6, 114, 043	l e				200.00
201.00 Less PBP Clinic Lab. Services-Program	0, 114, 043	1, 290				200.00
Only Charges						201.00
202.00 Net Charges (line 200 - line 201)	6, 114, 043	1, 296				202. 00
202.00	0, 114, 043	1, 270	I			1202.00

Health Financial Systems	UNION HOSPITAL	In Lieu of Form CMS-2552-10		
APPORTIONMENT OF MEDICAL.	OTHER HEALTH SERVICES AND VACCINE COST	Provider CCN: 15-1326	Peri od:	Worksheet D

From 01/01/2017 Part V
To 12/31/2017 Date/Time Prepared: Component CCN: 15-Z326 5/30/2018 1:49 pm Title XVIII Swing Beds - SNF Cost Charges Costs PPS PPS Services Cost Center Description Cost to Cost Cost Charge Ratio Rei mbursed Rei mbursed Rei mbursed (see inst.) From Services (see Servi ces Services Not Worksheet C, inst.) Subject To Subject To Ded. & Coins. Ded. & Coins. Part I, col. (see inst.) 9 (see inst.) 2.00 5. 00 1.00 3.00 4. 00 ANCILLARY SERVICE COST CENTERS 50.00 05000 OPERATING ROOM 50.00 0. 318677 0 05100 RECOVERY ROOM 0.540419 0 0 0 0 0 0 0 0 0 0 0 0 51.00 51.00 0 05101 0/P TREATMENT ROOM 0.639656 51.01 0 51.01 0 54.00 05400 RADI OLOGY-DI AGNOSTI C 0. 159998 0 0 54.00 56.00 05600 RADI OI SOTOPE 0. 280489 0 0 56.00 01 06000 LABORATORY 0 60.00 0.156433 0 60.00 06200 WHOLE BLOOD & PACKED RED BLOOD CELLS 0 62.00 0. 456877 0 62.00 65.00 06500 RESPIRATORY THERAPY 1. 098719 65.00 0 66.00 06600 PHYSI CAL THERAPY 0.408217 0 66.00 06700 OCCUPATI ONAL THERAPY 0. 526610 0 67.00 67.00 0 68.00 06800 SPEECH PATHOLOGY 0.444038 0 68.00 69.00 06900 ELECTROCARDI OLOGY 0. 145415 0 0 69.00 0 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 3. 271077 0 71.00 71 00 0 0 72.00 07200 IMPL. DEV. CHARGED TO PATIENTS 0.000000 0 0 72.00 73.00 07300 DRUGS CHARGED TO PATIENTS 0. 357432 0 0 0 73.00 OUTPATIENT SERVICE COST CENTERS 90.00 0. 000000 0 0 0 90.00 09000 CLI NI C 0 0 0 0 0 09100 EMERGENCY 0. 317889 91.00 91.00 0 0 92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART) 1. 305188 0 92.00 0 0 200.00 200.00 Subtotal (see instructions) 0 Less PBP Clinic Lab. Services-Program 0 201.00 201.00 Only Charges 202.00 Net Charges (line 200 - line 201) 0 0 202.00

Health Financial Systems	UNION HOSPITA	AL CLINTON		In L	ieu of Form CMS-2	2552-10
APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND	VACCINE COST	Provi der C	CN: 15-1326	Peri od: From 01/01/20	Worksheet D	
		Component	CCN: 15-Z326		17 Date/Time Pre 5/30/2018 1:4	
		Title	e XVIII	Swing Beds - S	SNF Cost	
	Cos	ts		· · -		
Cost Center Description	Cost	Cost				

			Component	CCN: 15-Z326	То	12/31/	2017	Date/Time Pro 5/30/2018 1:	
			Ti tl e	e XVIII	Swi na	Beds -	SNF	Cost	
		Cos	sts						
	Cost Center Description	Cost	Cost	1					
	·	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
51. 00	05100 RECOVERY ROOM	0	(	)					51.00
51. 01	05101 O/P TREATMENT ROOM	0	(	)					51. 01
54.00	05400 RADI OLOGY-DI AGNOSTI C	0	(	)					54.00
56. 00	05600  RADI OI SOTOPE	0	(	)					56. 00
60.00	06000 LABORATORY	0	(	)					60.00
62. 00	06200 WHOLE BLOOD & PACKED RED BLOOD CELLS	0	(	)					62.00
65. 00	06500 RESPI RATORY THERAPY	0	(	)					65. 00
66. 00	06600 PHYSI CAL THERAPY	0	(	)					66.00
67.00	06700 OCCUPATI ONAL THERAPY	0	(	)					67. 00
68. 00	06800 SPEECH PATHOLOGY	0	(	)					68. 00
	06900 ELECTROCARDI OLOGY	0	(	)					69. 00
	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	(	)					71. 00
	07200 I MPL. DEV. CHARGED TO PATIENTS	0	(	)					72.00
73. 00	07300 DRUGS CHARGED TO PATIENTS	0	(	)					73. 00
	OUTPATIENT SERVICE COST CENTERS								
	09000 CLI NI C	0	(	)					90.00
	09100 EMERGENCY	0	(	)					91.00
	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0	(	)					92.00
200.00	,	0	(	)					200.00
201.00		0							201.00
	Only Charges								
202.00	Net Charges (line 200 - line 201)	0	(	)					202.00

Health Financial Systems	UNION HOSPITAL	CLINTON	In Lie	u of Form CMS-2	2552-10
COMPUTATION OF INPATIENT OPERATING COST		Provi der CCN: 15-1326	Period: From 01/01/2017	Worksheet D-1	
				Date/Time Pre 5/30/2018 1:4	
		Title XVIII	Hospi tal	Cost	
Cost Center Description					
				1. 00	

Cost Center Description    1.00			Title XVIII	Hospi tal	5/30/2018 1: 4 Cost	9 pm
NAME TELL MASS   NAME		Cost Center Description	THE AVIII	1103pi tui	0031	
INPACTENT DAYS		DADT I ALL DON'T DED COMPONENTO			1. 00	
Impatient days (including private room days and swing-bed days, excluding newborn)   2,229   1,00						
Private room days (excluding swing-bed and observation bed days). If you have only private room days. do do not complete this line.  4.00 Semi-private room days (excluding self-gibed and observation bed days).  5.00 Total swing-bed SMF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendary 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 calendary 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).  8.00 Iotal 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).  9.00 reporting period (if calendar year, enter 0 on this line).  10.00 Swing-bed SMF type inpatient days applicable to the Program (excluding saing-bed and newborn days).  11.00 Swing-bed SMF type inpatient days applicable to title XVII and iy (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line).  12.00 Swing-bed SMF type inpatient days applicable to title XVII and iy (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line).  13.00 Swing-bed SMF type inpatient days applicable to title XVII and iy (including private room days).  14.00 Medical processers 31 of the cost reporting period (if calendar year, enter 0 on this line).  15.00 Total swing-bed SMF type inpatient days applicable to sitle SV vXIX and iy (including private room days).  16.00 Total swing-bed SMF type inpatient days applicable to title SV vXIX and iy (including private room days).  17.00 Medical room to the cost reporting period (if calendar year, enter 0 on this line).  18.00 Medical room to the cost reporting period (if calendar year, enter 0 on this line).  18.00 Me	1. 00		rs, excluding newborn)		2, 229	1.00
do not complete this line.  4. 00 Semi-private room days (accideding swing-bed and observation bed days)  7. 01 Total swing-bod Sit 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 swing-bod Sit 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 swing-bod Type inpatient days (including private room days) through December 31 of the cost reporting period (if calendar year, enter 0 on this line)  7. 00 Total swing-bod Sit 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 Swing-bod Sit type inpatient days applicable to the Program (excluding swing-bod and newborn days)  8. 00 Total Inpatient days applicable to title XVIII only (including private room days) after one observed days)  9. 01 Swing-bod Sit type inpatient days applicable to title XVIII only (including private room days) after one observed days are swing-bod Sit type inpatient days applicable to title XVIII only (including private room days) after one observed by through December 31 of the cost reporting period (if calendar year, enter 0 on this line)  12. 00 Swing-bod Sit type inpatient days applicable to title XVIII only (including private room days)  13. 00 Swing-bod Sit type inpatient days applicable to title View of XX only (including private room days)  14. 00 Swing-bod Mit type inpatient days applicable to sitles View XX only (including private room days)  15. 00 Swing-bod Mit type inpatient days applicable to titles View XX only (including private room days)  16. 00 Nursery days (citle View XX XX only (including private room days)  17. 00 Swing-bod Mit type inpatient days applicable to services after December 31 of the cost reporting period (including private room days)  18. 00 Swing-bod Mit type inpatient days applicable to services after December 31 of t					· ·	1
5.00 Total swin,p-ded SKF type inpatient days (including private room days) after December 31 of the cost reporting period reporting period of the cost reporting	3.00		iys). If you have only pr	rivate room days,	0	3.00
Total swing-bed SNF type inpatient days (including private room days) after December 31 of the cost of coporting period in the cost period period in the cost of t	4 00	•	and days)		1 560	4 00
report ing period (1° calendar year, enter 0 on this line)  7.00 Total swing-bed SNF type inpatient days (including private room days) after December 31 of the cost of reporting period (1° calendar year, enter 0 on this line)  8.00 Total swing-bed NF type inpatient days (including private room days) through December 31 of the cost open control period (1° calendar year, enter 0 on this line)  9.00 Total inpatient days including private room days after December 31 of the cost open control period (1° calendar year, enter 0 on this line)  10.00 Swing-bed SNF type inpatient days applicable to the Program (excluding swing-bed and newborn days)  11.00 Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days)  12.00 Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days)  13.00 Swing-bed SNF type inpatient days applicable to titles Vor XXX only (including private room days)  13.00 Swing-bed SNF type inpatient days applicable to titles Vor XXX only (including private room days)  13.00 Swing-bed SNF type inpatient days applicable to titles Vor XXX only (including private room days)  14.00 Swing-bed SNF type inpatient days applicable to titles Vor XXX only (including private room days)  15.00 Swing-bed SNF type inpatient days applicable to titles Vor XXX only (including private room days)  16.00 SNE type bed SNF type inpatient days applicable to titles Vor XXX only (including private room days)  17.00 Swing-bed SNF type inpatient days applicable to titles Vor XXX only (including private room days)  18.00 SNE type bed SNF type inpatient days applicable to titles Vor XXX only (including private room days)  18.00 SNE type bed SNF type inpatient days applicable to services through 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 applicable to SNF type services after December 31 of the cos				er 31 of the cost		ı
reporting period (if calendar year, enter 0 on this line) 7.00 Total as ing-bed NF type inpatient days (including private room days) through December 31 of the cost reporting period (if calendar year, enter 0 on this line) 9.00 9.00 9.00 9.00 9.00 9.00 9.00 9.0					1	
7.00 Total swing-bed NF type inpatient days (including private room days) through Becember 31 of the cost preporting period (if calendar year, enter 0 on this line) 10.00 Swing-bed SNF type inpatient days (including private room days) after December 31 of the cost properting period (if calendar year, enter 0 on this line) 10.00 Swing-bed SNF type inpatient days applicable to the Program (excluding swing-bed and private room days) 11.00 Swing-bed SNF type inpatient days applicable to the ital XVIII only (including private room days) 11.00 Swing-bed SNF type inpatient days applicable to the trial XVIII only (including private room days) 11.00 Swing-bed SNF type inpatient days applicable to the trial XVIII only (including private room days) 11.00 Swing-bed SNF type inpatient days applicable to the trial XVIII only (including private room days) 11.00 Swing-bed NF type inpatient days applicable to the trial XVII only (including private room days) 12.00 Swing-bed NF type inpatient days applicable to the trial XVI only (including private room days) 12.00 Swing-bed NF type inpatient days applicable to tritle XV or XIX only (including private room days) 13.00 Swing-bed NF type inpatient days applicable to tritle XV or XIX only (including private room days) 14.00 Swing-bed NF type inpatient days applicable to tritle XV or XIX only (including private room days) 15.00 Total nursery days (tritle V or XIX only) 16.00 Nursery days (tritle V or XIX only) 17.00 Nursery days (tritle V or XIX only) 18.00 Nursery days (tritle V or XIX only) 18.00 Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period (including private room days) 18.00 Medicare rate for swing-bed NF services applicable to services after December 31 of the cost reporting period (including private room days) 18.00 Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period (including private room days) 18.00 Medicare rate for swing-bed SNF services applicable t	6.00		oom days) after December	31 of the cost	0	6. 00
reporting period  8. 00 Total swing-bed NF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)  9. 00 Total inpatient days including private room days applicable to the Program (excluding swing-bed and newborn days)  10. 00 Swing-bed Smiler 31 of the cost reporting period (see Instructions)  11. 00 Swing-bed Smiler 31 of the cost reporting period (see Instructions)  12. 00 Swing-bed Smiler 31 of the cost reporting period (see Instructions)  13. 00 Swing-bed Smiler 31 of the cost reporting period (see Instructions)  14. 00 Swing-bed Smiler 31 of the cost reporting period (see Instructions)  15. 00 Swing-bed Smiler 31 of the cost reporting period (see Instructions)  16. 00 Swing-bed Smiler 31 of the cost reporting period (see Instructions)  17. 00 Swing-bed Smiler 31 of the cost reporting period (see Instructions)  18. 00 Swing-bed Smiler 31 of the cost reporting period (see Instructions)  19. 01 Swing-bed Smiler 31 of the cost reporting period (see Instructions)  19. 02 Swing-bed Smiler 31 of the cost reporting period (see Instructions)  19. 02 Swing-bed Smiler 31 of the cost reporting period (see Instructions)  19. 03 Swing-bed Smiler 31 of the cost reporting period (see Instructions)  19. 00 Swing-bed Smiler 31 of the cost reporting period (see Instructions)  19. 00 Swing-bed Smiler 32 Sm	7 00		d th D	. 21 -6 +1+		7 00
7 Total swing-bed NF type inpatient days (including private room days) after December 31 of the cost periting period (if cal endar year, enter 0 on this line) 10 newborn days. Proprint days including private room days applicable to the Program (excluding swing-bed and proprint days) 10 newborn days. Proprint days applicable to title XVIII only (including private room days) 27 no. 0 Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) after 10 no. 0 Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) after 11 no. 0 Swing-bed NF type inpatient days applicable to distinct XVIII only (including private room days) after 12 no. 0 wing-bed NF type inpatient days applicable to the room days) 12 no. 0 wing-bed NF type inpatient days applicable to title XVIII only (including private room days) 12 no. 0 wing-bed NF type inpatient days applicable to title XV or XX only (including private room days) 12 no. 0 wing-bed NF type inpatient days applicable to title XV or XX only (including private room days) 12 no. 0 wing-bed NF type inpatient days applicable to title XV or XX only (including private room days) 13 no. 0 wing-bed NF type inpatient days applicable to title XV or XX only (including private room days) 14 no. 0 wing-bed NF type inpatient days applicable to title XV or XX only (including private room days) 15 no. 0 wing-bed NF type inpatient days applicable to title XV or XX only (including private room days) 15 no. 0 wing-bed NF type inpatient days applicable to title XV or XX only (including private room days) 15 no. 0 wing-bed NF type inpatient days applicable to title XV or XX only (including private room days) 15 no. 0 wing-bed NF type bed NF type services applicable to services through December 31 of the cost wing-bed wing-bed NF type services applicable to services after December 31 of the cost reporting period (line 8 no. 0 wing-bed cost applicable to NF type services through December 31 of the cost reporting period (line 8 no.	7.00		om days) through becember	31 of the cost	 	7.00
reporting period (if calendar year, enter 0 on this line) 0.00 Total inpatient days including private room days applicable to the Program (excluding saing-bed and newborn days) 10.00 Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) 11.00 Exember 31 of the cost reporting period (see instructions) 11.00 Exember 31 of the cost reporting period (see instructions) 11.00 Exember 31 of the cost reporting period (see instructions) 12.00 Swing-bed SNF type inpatient days applicable to titles V or XIX only (including private room days) 12.00 Swing-bed SNF type inpatient days applicable to titles V or XIX only (including private room days) 13.00 Swing-bed SNF type inpatient days applicable to titles V or XIX only (including private room days) 13.00 Swing-bed SNF type inpatient days applicable to titles V or XIX only (including private room days) 13.00 Swing-bed SNF type inpatient days applicable to titles V or XIX only (including private room days) 14.00 Medically necessary private room days applicable to the Program (excluding swing-bed days) 15.00 Total nursery days (title V or XIX only) 16.00 Noursery days (title V or XIX only) 17.00 SWING-BED ADUSTRIAN 17.00 SWING-BED ADUSTRIAN 17.00 Medically necessary private room days applicable to services through December 31 of the cost reporting period (including private room days) 18.00 Medically necessary private room days applicable to services through 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 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 (line 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	8. 00		om days) after December 3	31 of the cost	0	8. 00
newborn days    10.00		reporting period (if calendar year, enter 0 on this line)				
10.00   Swing-bed SMF type Inpatient days applicable to title XVIII only (Including private room days)   97   10.00	9. 00		to the Program (excluding	g swing-bed and	918	9. 00
through December 31 of the cost reporting period (see instructions)  1.00 Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) after 0 11.00 Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) 0 12.00 Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) 0 13.00 Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) 0 13.00 Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) 0 14.00 Medically inecessary private room days applicable to the Program (excluding swing-bed days) 0 14.00 No Interest V or XIX only (including private room days) 0 14.00 No Interest V or XIX only (including private room days) 0 14.00 No Interest V or XIX only (including private room days) 0 14.00 No Interest V or XIX only (including private room days) 0 14.00 No Interest V or XIX only (including private room days) 0 14.00 No Interest V or XIX only (including private room days) 0 14.00 No Interest V or XIX only (including private room days) 0 14.00 No Interest V or XIX only (including private room days) 0 14.00 No Interest V or XIX only (including private room days) 0 14.00 No Interest V or XIX only (including private room days) 0 14.00 No Interest V or XIX only (including private room days) 0 14.00 No Interest V or XIX only (including private room days) 0 14.00 No Interest V or XIX only (including private room days 0 14.00 No Interest V or XIX only (including private room days 0 14.00 No Interest V or XIX only (including private room days 0 14.00 No Interest V or XIX only (including private room days 0 14.00 No Interest V or XIX only (including private room days 0 14.00 No Interest V or XIX only (including private room days 0 14.00 No Interest V or XIX only (including private room days 0 14.00 No Interest V or XIX only (including Private No Interest V or XIX only (including Private No Interest V or XIX only (including Pri	10 00	, ,	nly (including private r	coom days)	07	10 00
11.00 Swing-bed SNF type Inpatient days applicable to title XVIII only (Including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line) 12.00 Swing-bed NF type inpatient days applicable to titles V or XIX only (Including private room days) 13.00 Swing-bed NF type inpatient days applicable to titles V or XIX only (Including private room days) 14.00 Medically necessary private room days applicable to titles V or XIX only (Including private room days) 16.00 Nursery days (title V or XIX only) 16.00 Nursery days (title V or XIX only) 17.00 Nursery days (title V or XIX only) 18.00 Nursery days (title V or XIX only) 19.00 Nursery days (tit	10.00			oom days)	· · · · · · · · · · · · · · · · · · ·	10.00
12.00   Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days)   0   12.00	11. 00			oom days) after	0	11.00
through December 31 of the cost reporting period  13.00 Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days)  14.00 Medically necessary private room days applicable to the Program (excluding swing-bed days)  15.00 Total nursery days (title V or XIX only)  16.00 Novery days (title V or XIX only)  17.00 Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost reporting period  18.00 Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period  18.00 Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period  19.00 Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period  20.00 Medicard rate for swing-bed NF services applicable to services after December 31 of the cost reporting period  21.00 Total general inpatient routine service cost (see instructions)  22.00 Swing-bed cost applicable to SNF type services through December 31 of the cost reporting period (line Sing-bed cost applicable to SNF type services after December 31 of the cost reporting period (line Sing-bed cost applicable to SNF type services through December 31 of the cost reporting period (line Sing-bed cost applicable to SNF type services after December 31 of the cost reporting period (line Sing-bed cost applicable to SNF type services after December 31 of the cost reporting period (line Sing-bed cost applicable to SNF type services after December 31 of the cost reporting period (line Sing-bed cost applicable to SNF type services after December 31 of the cost reporting period (line Sing-bed cost applicable to SNF type services after December 31 of the cost reporting period (line Sing-bed cost SNF type services after December 31 of the cost reporting period (line Sing-bed cost SNF type services after December 31 of the cost reporting period (line Sing-bed Cost SNF type service shrough December 31 of the cost report						
3. 00   Swing-bed NF type inpatient days applicable to titles V or XIX only (Including private room days)   14. 00   14. 00   14. 00   15. 00   16. 00   1	12. 00		X only (including privat	te room days)	01	12.00
after December 31 of the cost reporting period (if calendar year, enter 0 on this line)   14,00   15.00   10   10   10   10   10   10   10	13 00		X only (including privat	e room days)	0	13 00
14.00   Medically necessary private room days applicable to the Program (excluding swing-bed days)   0   14.00   0   15.00   0   10.00   10.00						10.00
16. 00 Nursery days (title v or XIX only)  17. 00 Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost reporting period (19. 00 Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period (19. 00 Medicare rate for swing-bed NF services applicable to services after December 31 of the cost (19. 00 Medicare rate for swing-bed NF services applicable to services after December 31 of the cost (19. 00 Medicare rate for swing-bed NF services applicable to services after December 31 of the cost (19. 00 Medicare rate for swing-bed NF services applicable to services after December 31 of the cost (19. 00 Medicare rate for swing-bed NF services applicable to services after December 31 of the cost (19. 00 Medicare rate for swing-bed NF services applicable to services after December 31 of the cost (19. 00 Medicare rate for swing-bed to services after December 31 of the cost reporting period (19. 00 Medicare rate for swing-bed cost applicable to SNF type services after December 31 of the cost reporting period (19. 00 Medicare rate for swing-bed cost applicable to SNF type services after December 31 of the cost reporting period (19. 00 Medicare rate for swing-bed cost (19. 00 Medicare rate for swing-bed charges) (19. 00 Medicare for sw		Medically necessary private room days applicable to the Progr			0	1
SWING BED ADJUSTMENT  17. 00  Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost reporting period reporting period services applicable to services after December 31 of the cost reporting period services applicable to services after December 31 of the cost reporting period services applicable to services after December 31 of the cost reporting period services applicable to services after December 31 of the cost reporting period services applicable to services after December 31 of the cost reporting period services applicable to SNF type services through December 31 of the cost reporting period services applicable to SNF type services through December 31 of the cost reporting period services applicable to SNF type services through December 31 of the cost reporting period services after 17 services after December 31 of the cost reporting period services after 18 services after December 31 of the cost reporting period services after 18 services after December 31 of the cost reporting period services after 18 services after December 31 of the cost reporting period services after 19 services after December 31 of the cost reporting period services after 19 services after December 31 of the cost reporting period services after 19 services after December 31 of the cost reporting period services after 19 services after December 31 of the cost reporting period services after 19 services after December 31 of the cost reporting period services after 19 services after December 31 of the cost reporting period services after 19 services after December 31 of the cost reporting period services after 19 service 20 services after December 31 of the cost reporting period service after 19 services after December 31 of the cost reporting period service 3 services after 19 service 20 services after December 31 of the cost reporting period services after 19 service service 20 services after December 31 of the cost reporting service 3 services after 19 service 20 services after 19 service 20					- 1	
17. 00 Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost reporting period Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period reporting period	16. 00				0	16.00
reporting period Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period 19.00 Medicald rate for swing-bed NF services applicable to services through December 31 of the cost reporting period 20.00 Medicald rate for swing-bed NF services applicable to services after December 31 of the cost cost of the cost reporting period 20.00 Medicald rate for swing-bed NF services applicable to services after December 31 of the cost cost (see instructions) 21.00 Total general inpatient routine service cost (see instructions) 22.00 Swing-bed cost applicable to SNF type services through December 31 of the cost reporting period (line 5 x line 17) 23.00 X line 19) 24.00 Swing-bed cost applicable to SNF type services after December 31 of the cost reporting period (line 6 x line 28) 25.00 X line 19) 26.00 Swing-bed cost applicable to NF type services through December 31 of the cost reporting period (line 8 x line 29) 26.00 Total swing-bed cost (see instructions) 27.00 Experimental Swing-bed cost (see instructions) 28.00 Total swing-bed cost (see instructions) 29.00 Total swing-bed cost (see instructions) 39.00 General inpatient routine service cost net of swing-bed cost (line 21 minus line 26) 39.00 Semi-private room charges (excluding swing-bed charges) 39.00 Average perivate room per diem charge (line 29 + line 3) 39.00 Average peridem private room charge (line 29 + line 3) 39.00 Average peridem private room charge (line 30 + line 4) 39.00 Program general inpatient routine service cost per diem (see instructions) 39.00 Program general inpatient routine service cost per diem (see instructions) 39.00 Program general inpatient routine service cost per diem (see instructions) 39.00 Program general inpatient routine service cost per diem (see instructions) 39.00 Program general inpatient routine service cost per diem (see instructions) 39.00 Program general inpatient routine service cost per diem (see instructions) 39.00 Program general inpatient routine service cost per diem (se	17 00		res through December 31 (	of the cost		17 00
18.00   Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period   155.02   19.00   19.00   Medicald rate for swing-bed NF services applicable to services through December 31 of the cost reporting period   20.00   Medicald rate for swing-bed NF services applicable to services after December 31 of the cost reporting period   21.00   Total general inpatient routine service cost (see instructions)   4,130,902   21.00   22.00   Swing-bed cost applicable to SNF type services through December 31 of the cost reporting period (line 5 x line 17)   53.00   Swing-bed cost applicable to SNF type services after December 31 of the cost reporting period (line 6 x line 18)   24.00   24.00   25.00   25.00   26.00   27.00   27.00   27.00   28	17.00		ies till odgir becomber or c	71 1110 0031		17.00
19.00   Medicald rate for swing-bed NF services applicable to services through December 31 of the cost reporting period   155.02   19.00   20.00   2	18.00	Medicare rate for swing-bed SNF services applicable to servic	es after December 31 of	the cost		18. 00
reporting period  Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period (20.00)  Total general inpatient routine service cost (see instructions)  10 Total general inpatient routine service cost (see instructions)  11 Total general inpatient routine service cost (see instructions)  12 No Swing-bed cost applicable to SNF type services through December 31 of the cost reporting period (line of x line 17)  13 No Swing-bed cost applicable to SNF type services after December 31 of the cost reporting period (line of x line 18)  14 No Swing-bed cost applicable to NF type services through December 31 of the cost reporting period (line of x line 19)  15 No Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line of x line 20)  16 No Total swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line of x line 20)  17 No Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line of x line 20)  18 No No Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line of x line 20)  18 No	40.00		. The same by December 24 and	2.11	455.00	10.00
20.00   Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period   21.00   20.00	19.00	1.	es through December 31 of	the cost	155. 02	19.00
reporting period Total general inpatient routine service cost (see instructions)  22.00  22.00  23.00  24.100  25.	20. 00		es after December 31 of 1	the cost	0.00	20.00
22.00 Swing-bed cost applicable to SNF type services through December 31 of the cost reporting period (line 5 x line 17)  23.00 Swing-bed cost applicable to SNF type services after December 31 of the cost reporting period (line 6 x line 18)  24.00 Swing-bed cost applicable to NF type services through December 31 of the cost reporting period (line 7 x line 19)  25.00 Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8 x line 20)  26.00 Total swing-bed cost (see instructions)  27.00 General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)  28.00 General inpatient routine service charges (excluding swing-bed and observation bed charges)  29.00 Private room charges (excluding swing-bed charges)  30.00 Semi-private room charges (excluding swing-bed charges)  31.00 General inpatient routine service cost/charge ratio (line 27 + line 28)  32.00 Average perivate room per diem charge (line 29 + line 3)  33.00 Average per diem private room cost differential (line 30 + line 4)  34.00 Average per diem private room cost differential (line 34 x line 31)  35.00 Average per diem private room cost differential (line 34 x line 31)  36.00 Private room cost differential dijustment (line 3 x line 35)  37.00 General inpatient routine service cost net of swing-bed cost and private room cost differential (line 3, 949, 284)  37.00 Program general inpatient routine service cost (line 9 x line 38)  38.00 Adjusted general inpatient routine service cost per diem (see instructions)  38.00 Adjusted general inpatient routine service cost (line 9 x line 38)  38.00 Medically necessary private room cost applicable to the Program (line 14 x line 35)  40.00 Medically necessary private room cost applicable to the Program (line 14 x line 35)		1.				
5 x line 17)  23.00 Swing-bed cost applicable to SNF type services after December 31 of the cost reporting period (line of x line 18)  24.00 Swing-bed cost applicable to NF type services through December 31 of the cost reporting period (line of 7 x line 19)  25.00 Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line of 8 x line 20)  25.00 Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line of 8 x line 20)  26.00 Total swing-bed cost (see instructions)  27.00 General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)  28.00 General inpatient routine service charges (excluding swing-bed and observation bed charges)  29.00 Private ROOM DIFFERENTIAL ADJUSTMENT  29.00 General inpatient routine service charges (excluding swing-bed charges)  30.00 Semi-private room charges (excluding swing-bed charges)  30.00 Semi-private room charges (excluding swing-bed charges)  30.00 Semi-private room per diem charge (line 29 ÷ line 27 ÷ line 28)  30.00 Average private room per diem charge (line 29 ÷ line 3)  30.00 Average semi-private room per diem charge (line 30 ÷ line 4)  30.00 Average per diem private room charge differential (line 32 minus line 33) (see instructions)  30.00 Average per diem private room cost differential (line 34 x line 31)  30.00 Private room cost differential adjustment (line 3 x line 35)  31.00 General inpatient routine service cost net of swing-bed cost and private room cost differential (line 3, 949, 284)  37.00 General inpatient routine service cost per diem (see instructions)  30.00 Adjusted general inpatient routine service cost per diem (see instructions)  30.00 Adjusted general inpatient routine service cost per diem (see instructions)  30.00 Medically necessary private room cost applicable to the Program (line 14 x line 35)  40.00 Medically necessary private room cost applicable to the Program (line 14 x line 35)						1
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x line 18)  24.00 Swing-bed cost applicable to NF type services through December 31 of the cost reporting period (line 7 x line 19)  25.00 Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8 0 25.00 x line 20)  26.00 Total swing-bed cost (see instructions)  27.00 General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)  28.00 General inpatient routine service charges (excluding swing-bed and observation bed charges)  29.00 Private room charges (excluding swing-bed charges)  30.00 Semi-private room charges (excluding swing-bed charges)  30.00 Semi-private room charges (excluding swing-bed charges)  30.00 Average private room per diem charge (line 29 + line 3)  30.00 Average semi-private room per diem charge (line 30 + line 4)  34.00 Average per diem private room charge differential (line 32 minus line 33) (see instructions)  36.00 Average per diem private room cost differential (line 3 x line 31)  37.00 General inpatient routine service cost net of swing-bed cost and private room cost differential (line 3, 949, 284)  38.00 Adjusted general inpatient routine service cost per diem (see instructions)  38.00 Adjusted general inpatient routine service cost per diem (see instructions)  38.00 Medically necessary private room cost applicable to the Program (line 14 x line 35)  40.00 Medically necessary private room cost applicable to the Program (line 14 x line 35)	23. 00	·	31 of the cost reportin	ng period (line 6	) o	23. 00
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25.00 Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8 x line 20)  26.00 Total swing-bed cost (see instructions)  27.00 General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)  28.00 PRI VATE ROOM DIFFERENTIAL ADJUSTMENT  28.00 General inpatient routine service charges (excluding swing-bed and observation bed charges)  29.00 Private room charges (excluding swing-bed charges)  30.00 Semi-private room charges (excluding swing-bed charges)  30.00 Semi-private room charges (excluding swing-bed charges)  30.00 General inpatient routine service cost/charge ratio (line 27 + line 28)  30.00 Average private room per diem charge (line 29 + line 3)  30.00 Average semi-private room per diem charge (line 30 + line 4)  30.00 Average per diem private room charge differential (line 32 minus line 33) (see instructions)  30.00 Average per diem private room cost differential (line 34 x line 31)  30.00 Private room cost differential adjustment (line 3 x line 35)  31.00 General inpatient routine service cost net of swing-bed cost and private room cost differential (line 3, 949, 284)  32.00 Adjusted general inpatient routine service cost per diem (see instructions)  33.00 Adjusted general inpatient routine service cost per diem (see instructions)  34.00 Program general inpatient routine service cost per diem (see instructions)  35.00 Adjusted general inpatient routine service cost per diem (see instructions)  36.00 Program general inpatient routine service cost per diem (see instructions)  37.00 Medically necessary private room cost applicable to the Program (line 14 x line 35)  40.00 Medically necessary private room cost afferential total program (line 14 x line 35)  40.00 Medically necessary private room cost afferential total program (line 14 x line 35)  40.00 Medically necessary private room cost afferential total program (line 14 x line 35)	24. 00		er 31 of the cost reporti	ng period (line	01	24.00
x line 20)  26. 00 Total swing-bed cost (see instructions)  27. 00 General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)  28. 00 PRIVATE ROOM DIFFERENTIAL ADJUSTMENT  28. 00 General inpatient routine service charges (excluding swing-bed and observation bed charges)  29. 00 Private room charges (excluding swing-bed charges)  30. 00 Semi-private room charges (excluding swing-bed charges)  30. 00 General inpatient routine service cost/charge ratio (line 27 ÷ line 28)  31. 00 General inpatient routine service cost/charge ratio (line 27 ÷ line 28)  32. 00 Average private room per diem charge (line 29 ÷ line 3)  33. 00 Average semi-private room per diem charge (line 30 ÷ line 4)  34. 00 Average per diem private room cost differential (line 32 minus line 33)(see instructions)  35. 00 Average per diem private room cost differential (line 34 x line 31)  36. 00 Private room cost differential adjustment (line 3 x line 35)  37. 00 General inpatient routine service cost net of swing-bed cost and private room cost differential (line 3, 949, 284, 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)  38. 00 Medically necessary private room cost applicable to the Program (line 14 x line 35)  0 40. 00	25 00	/	31 of the cost reporting	neriod (line 8	l 0	25 00
26.00 Total swing-bed cost (see instructions) 27.00 General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)  RI VATE ROOM DIFFERNTIAL ADJUSTMENT  28.00 General inpatient routine service charges (excluding swing-bed and observation bed charges)  29.00 Private room charges (excluding swing-bed charges)  30.00 Semi-private room charges (excluding swing-bed charges)  30.00 Semi-private room charges (excluding swing-bed charges)  30.00 General inpatient routine service cost/charge ratio (line 27 + line 28)  30.00 Average private room per diem charge (line 29 + line 3)  30.00 Average semi-private room per diem charge (line 30 + line 4)  30.00 Average per diem private room cost differential (line 32 minus line 33)(see instructions)  30.00 Average per diem private room cost differential (line 34 x line 31)  30.00 Average per diem private room cost differential (line 3 x line 35)  30.00 Frivate room cost differential adjustment (line 3 x line 35)  30.00 General inpatient routine service cost net of swing-bed cost and private room cost differential (line 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)  39.00 Program general inpatient routine service cost (line 9 x line 38)  40.00 Medically necessary private room cost applicable to the Program (line 14 x line 35)  40.00 Medically necessary private room cost applicable to the Program (line 14 x line 35)	23.00		of the cost reporting	g perrou (Trile o	1	23.00
PRI VATE ROOM DIFFERENTIAL ADJUSTMENT  General inpatient routine service charges (excluding swing-bed and observation bed charges)  9. 00 Pri vate room charges (excluding swing-bed charges)  10 29. 00  10 29. 00  10 29. 00  11 0 29. 00  12 0 29. 00  13 0 00  14 0 00  15 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	26. 00	Total swing-bed cost (see instructions)				
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29.00 Private room charges (excluding swing-bed charges)  30.00 Semi-private room charges (excluding swing-bed charges)  31.00 General inpatient routine service cost/charge ratio (line 27 ÷ line 28)  32.00 Average private room per diem charge (line 29 ÷ line 3)  33.00 Average semi-private room per diem charge (line 30 ÷ line 4)  34.00 Average per diem private room charge differential (line 32 minus line 33) (see instructions)  35.00 Average per diem private room cost differential (line 34 x line 31)  36.00 Private room cost differential adjustment (line 3 x line 35)  37.00 General inpatient routine service cost net of swing-bed cost and private room cost differential (line 3, 949, 284)  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)  39.00 Program general inpatient routine service cost (line 9 x line 38)  40.00 Medically necessary private room cost applicable to the Program (line 14 x line 35)  0 29.00  29.00  30.00  30.00  30.00  30.00  30.00  31.00  32.00  32.00  33.00  34.00  35.00  36.00  37.00  37.00  38.00  39.00  Adjusted general inpatient routine service cost per diem (see instructions)  38.00  40.00	20 00		d and observation had sk	argos)	0	20 00
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35.00 Average per diem private room cost differential (line 34 x line 31)  36.00 Private room cost differential adjustment (line 3 x line 35)  37.00 General inpatient routine service cost net of swing-bed cost and private room cost differential (line 3, 949, 284 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)  39.00 Program general inpatient routine service cost (line 9 x line 38)  40.00 Medically necessary private room cost applicable to the Program (line 14 x line 35)  0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0			nua lina 22) (ass instru	+: ana)		
36.00 Private room cost differential adjustment (line 3 x line 35) 37.00 General inpatient routine service cost net of swing-bed cost and private room cost differential (line 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)  39.00 Program general inpatient routine service cost (line 9 x line 38)  40.00 Medically necessary private room cost applicable to the Program (line 14 x line 35)  36.00 36.00 37.0				ti ons)		1
37.00 General inpatient routine service cost net of swing-bed cost and private room cost differential (line 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)  79.00 Program general inpatient routine service cost (line 9 x line 38)  40.00 Medically necessary private room cost applicable to the Program (line 14 x line 35)  37.00 And Inpatient routine service cost per diem (see instructions)  1,853.25 All 1,701,284 All 1,701,		,	31)			1
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)  1,853.25 38.00 Program general inpatient routine service cost (line 9 x line 38)  1,701,284 39.00 Medically necessary private room cost applicable to the Program (line 14 x line 35)  0 40.00		General inpatient routine service cost net of swing-bed cost	and private room cost di	fferential (line		•
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40.00 Medically necessary private room cost applicable to the Program (line 14 x line 35) 0 40.00						1
41.00   Total Program general inpatient routine service cost (line 39 + line 40)   1,701,284   41.00		Medically necessary private room cost applicable to the Progr	ram (line 14 x line 35)		0	40.00
	41. 00	Total Program general inpatient routine service cost (line 39	+ line 40)		1, 701, 284	41.00

	Financial Systems	UNION HOSPITA				u of Form CMS-2	
COMPUT	ATION OF INPATIENT OPERATING COST		Provider C		Peri od: From 01/01/2017	Worksheet D-1	
					To 12/31/2017	Date/Time Pre 5/30/2018 1:4	pared: 9 pm
				XVIII	Hospi tal	Cost	
	Cost Center Description	Total Inpatient	Total Inpatient	Average Per Diem (col. 1	Program Days	Program Cost (col. 3 x	
		Cost	Days	÷ col . 2)		col . 4)	
12.00	NUDCEDY (+: +I - V 0 VIVI .)	1. 00	2. 00	3. 00	4. 00	5. 00	42.00
42.00	NURSERY (title V & XIX only) Intensive Care Type Inpatient Hospital Units						42.00
43.00	INTENSIVE CARE UNIT	1, 686, 189	283	5, 958. 2	7 156	929, 490	1
44.00	CORONARY CARE UNIT BURN INTENSIVE CARE UNIT						44.00
45. 00 46. 00							45. 00 46. 00
	OTHER SPECIAL CARE (SPECIFY)						47. 00
	Cost Center Description					1. 00	
48. 00	Program inpatient ancillary service cost (Wk	st. D-3, col. 3	, line 200)			973, 093	48. 00
49. 00	Total Program inpatient costs (sum of lines	41 through 48)(	see instructi	ons)		3, 603, 867	49. 00
50. 00	PASS THROUGH COST ADJUSTMENTS  Pass through costs applicable to Program inp	ationt routine	sarvicas (fro	ım Wket D eiii	m of Darts I and	0	50.00
30.00		atrent routine	Scrvrccs (110	m wkst. b, su	ii or rarts r and	Ĭ	30.00
51. 00	Pass through costs applicable to Program inp	atient ancillar	ry 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		lated, non-ph	ysician anest	netist, and	0	
	medical education costs (line 49 minus line TARGET AMOUNT AND LIMIT COMPUTATION	52)					
54. 00	Program di scharges					0	54.00
55.00	Target amount per discharge					0.00	1
56. 00 57. 00	Target amount (line 54 x line 55) Difference between adjusted inpatient operat	ing cost and ta	ract amount (	lino 56 minus	lino 52)	0	
58. 00	Bonus payment (see instructions)	ing cost and ta	inger amount (	Title 50 illitius	111le 53)	0	1
59. 00	Lesser of lines 53/54 or 55 from the cost re	porting period	endi ng 1996,	updated and c	ompounded by the	0.00	59. 00
60. 00	market basket Lesser of lines 53/54 or 55 from prior year	cost report un	ndated by the	market hasket		0.00	60.00
	If line 53/54 is less than the lower of line				the amount by	0.00	1
	which operating costs (line 53) are less tha		s (lines 54 x	60), or 1% o	f the target		
amount (line 56), otherwise enter zero (see instructions) 62.00 Relief payment (see instructions)							62.00
63.00 Allowable Inpatient cost plus incentive payment (see instructions)							63.00
64. 00	PROGRAM INPATIENT ROUTINE SWING BED COST Medicare swing-bed SNF inpatient routine cos	ts through Dece	mher 31 of th	e cost report	ing period (See	179, 765	64.00
01.00	instructions)(title XVIII only)	to through book		ie cost report	ing period (see	177,700	01.00
65. 00	Medicare swing-bed SNF inpatient routine cos instructions)(title XVIII only)	ts after Decemb	er 31 of the	cost reporting	g period (See	0	65.00
66. 00	Total Medicare swing-bed SNF inpatient routi	ne costs (line	64 plus line	65)(title XVI	II only). For	179, 765	66.00
<b>.</b>	CAH (see instructions)			6.11			
67. 00	Title V or XIX swing-bed NF inpatient routin (line 12 x line 19)	e costs through	December 31	or the cost r	eporting period	0	67.00
68. 00	Title V or XIX swing-bed NF inpatient routin	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
07.00	PART III - SKILLED NURSING FACILITY, OTHER N						07.00
70.00	Skilled nursing facility/other nursing facil	•		•	)		70.00
71. 00 72. 00	Adjusted general inpatient routine service c Program routine service cost (line 9 x line		ine 70 ÷ iine	: 2)			71. 00 72. 00
73.00	Medically necessary private room cost applic	abĺe to Program					73.00
74. 00 75. 00	Total Program general inpatient routine serv Capital-related cost allocated to inpatient	•		,	Dort II column		74. 00 75. 00
73.00	26, line 45)	Toutine service	: COSTS (110III	worksneet b,	Part II, Corumni		75.00
76. 00	Per diem capital-related costs (line 75 ÷ li						76.00
77. 00 78. 00	Program capital-related costs (line 9 x line Inpatient routine service cost (line 74 minu						77. 00 78. 00
79. 00	Aggregate charges to beneficiaries for exces		rovi der recor	ds)			79.00
80.00	Total Program routine service costs for comp		ost limitatio	n (line 78 mi	nus line 79)		80.00
81. 00 82. 00	Inpatient routine service cost per diem limi Inpatient routine service cost limitation (I		)				81. 00 82. 00
83.00	Reasonable inpatient routine service costs (	see instruction	* .				83.00
84.00	Program inpatient ancillary services (see in		ine)				84.00
85. 00 86. 00	Utilization review - physician compensation Total Program inpatient operating costs (sum	•					85. 00 86. 00
	PART IV - COMPUTATION OF OBSERVATION BED PAS	S THROUGH COST				-	
87. 00 88. 00	Total observation bed days (see instructions Adjusted general inpatient routine cost per	•	· line 2)			571 1, 853. 25	87. 00 88. 00
	Observation bed cost (line 87 x line 88) (se		,			1, 058, 206	1
		,				-	•

Health Financial Systems	UNION HOSPIT	AL CLINTON		In Lie	u of Form CMS-2	2552-10
COMPUTATION OF INPATIENT OPERATING COST		Provi der CC	Provider CCN: 15-1326		Worksheet D-1	
				From 01/01/2017 To 12/31/2017	Date/Time Pre 5/30/2018 1:4	
		Title	XVIII	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	457, 124	4, 130, 902	0. 11066	0 1, 058, 206	117, 101	90.00
91.00 Nursing School cost	0	4, 130, 902	0.00000	0 1, 058, 206	0	91.00
92.00 Allied health cost	0	4, 130, 902	0.00000	0 1, 058, 206	0	92.00
93.00 All other Medical Education	0	4, 130, 902	0.00000	0 1, 058, 206	0	93.00

Health Financial Systems	UNION HOSPITAL CLINTON	In Lieu	u of Form CMS-2	552-10
COMPUTATION OF INPATIENT OPERATING COST		Peri od: From 01/01/2017	Worksheet D-1	
			Date/Time Prep 5/30/2018 1:49	
	Title XIX	Hospi tal	Cost	, p
Cost Center Description				

		Title XIX	Hospi tal	5/30/2018 1: 4 Cost	9 piii
	Cost Center Description				
	PART I - ALL PROVIDER COMPONENTS			1. 00	
	INPATIENT DAYS				
1.00	Inpatient days (including private room days and swing-bed day	s, excluding newborn)		2, 229	1.00
2.00	Inpatient days (including private room days, excluding swing-			2, 131	2.00
3. 00	Private room days (excluding swing-bed and observation bed da	ys). If you have only pr	ivate room days,	0	3. 00
4. 00	do not complete this line.  Semi-private room days (excluding swing-bed and observation b	ed days)		1, 560	4.00
5. 00	Total swing-bed SNF type inpatient days (including private ro		r 31 of the cost		5.00
	reporting period				
6.00	Total swing-bed SNF type inpatient days (including private ro	om days) after December	31 of the cost	0	6. 00
7 00	reporting period (if calendar year, enter 0 on this line)	m daya) +brayab Dagambar	21 of the cost	0	7.00
7. 00	Total swing-bed NF type inpatient days (including private roo reporting period	iii days) trirough beceiliber	31 OF the Cost	0	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
	reporting period (if calendar year, enter 0 on this line)	•			
9. 00	Total inpatient days including private room days applicable t	o the Program (excluding	swing-bed and	19	9. 00
10. 00	newborn days) Swing-bed SNF type inpatient days applicable to title XVIII o	nly (including private r	nom days)	0	10.00
10.00	through December 31 of the cost reporting period (see instruc		oom days)		10.00
11. 00	Swing-bed SNF type inpatient days applicable to title XVIII o		oom days) after	0	11.00
40.05	December 31 of the cost reporting period (if calendar year, e			_	40.00
12. 00	Swing-bed NF type inpatient days applicable to titles V or XI through December 31 of the cost reporting period	x only (including privat	e room days)	0	12. 00
13. 00	, 3	X onlv (includina privat	e room davs)	0	13.00
10.00	after December 31 of the cost reporting period (if calendar y			· ·	
14.00	Medically necessary private room days applicable to the Progr	am (excluding swing-bed	days)	0	14.00
15.00	Total nursery days (title V or XIX only)			0	15.00
16. 00	Nursery days (title V or XIX only) SWING BED ADJUSTMENT			0	16. 00
17 00	Medicare rate for swing-bed SNF services applicable to servic	es through December 31 c	if the cost		17. 00
00	reporting period	oo iii ougii boodiiiboi o'i o			
18. 00	Medicare rate for swing-bed SNF services applicable to servic	es after December 31 of	the cost		18. 00
10 00	reporting period	a through December 21 of	: +bc ccc+	0.00	19.00
19. 00	Medicaid rate for swing-bed NF services applicable to service 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	s after December 31 of t	he cost	0.00	20.00
	reporting period				
21. 00	Total general inpatient routine service cost (see instruction			4, 130, 902	
22. 00	Swing-bed cost applicable to SNF type services through Decemb $5 \times 1$ ine 17)	er 31 or the cost report	ing period (iine	0	22. 00
23. 00	Swing-bed cost applicable to SNF type services after December	31 of the cost reportin	g period (line 6	0	23. 00
	x line 18)	•			
24. 00	] 3 11 31	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	21 of the cost reporting	poriod (line 9	0	25. 00
25.00	x line 20)	31 of the cost reporting	perrou (Trile 8	U	25.00
26.00				181, 618	
27. 00	General inpatient routine service cost net of swing-bed cost	(line 21 minus line 26)		3, 949, 284	27. 00
20 00	PRIVATE ROOM DIFFERENTIAL ADJUSTMENT	d and observation had ab	arac)	0	20 00
28.00	General inpatient routine service charges (excluding swing-be Private room charges (excluding swing-bed charges)	u anu observation bed Cr	iai ges)	0	28. 00 29. 00
30.00	Semi - pri vate room charges (excluding swing-bed charges)			Ö	30.00
31. 00	General inpatient routine service cost/charge ratio (line 27	÷ line 28)		0. 000000	
32.00	Average private room per diem charge (line 29 ÷ line 3)			0.00	
33.00	Average semi-private room per diem charge (line 30 ÷ line 4)	nuo lino 22) ( !!	ti ono)	0.00	
34. 00 35. 00	Average per diem private room charge differential (line 32 mi Average per diem private room cost differential (line 34 x li	, ,	tions)	0. 00 0. 00	
36.00	Private room cost differential adjustment (line 3 x line 35)	110 01)		0.00	36.00
37. 00	General inpatient routine service cost net of swing-bed cost	and private room cost di	fferential (line		37.00
	27 minus line 36)	·			
	PART II - HOSPITAL AND SUBPROVIDERS ONLY	UCTMENTS			
38. 00	PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJ Adjusted general inpatient routine service cost per diem (see			1, 853. 25	38.00
39.00	Program general inpatient routine service cost per drem (see	•		35, 212	
40.00	Medically necessary private room cost applicable to the Progr	*		00,212	40.00
41. 00	Total Program general inpatient routine service cost (line 39	+ line 40)		35, 212	41.00

	Financial Systems	UNION HOSPITA				u of Form CMS-2	
COMPUT	ATION OF INPATIENT OPERATING COST		Provi der C	CN: 15-1326	Period: From 01/01/2017 To 12/31/2017	Worksheet D-1 Date/Time Pre	
				VI.V		5/30/2018 1:4	9 pm
	Cost Center Description	Total	Total	e XIX Average Per	Hospital Program Days	Cost Program Cost	
	<u>'</u>	Inpatient	I npati ent	Diem (col. 1		(col. 3 x	
		1.00	2. 00	÷ col . 2) 3.00	4.00	col . 4) 5.00	
42. 00	NURSERY (title V & XIX only)		=:			2.22	42.00
43. 00	Intensive Care Type Inpatient Hospital Units INTENSIVE CARE UNIT	1, 686, 189	283	5, 958. 2	27 0	0	43.00
44. 00	CORONARY CARE UNIT	1, 000, 107	200	, 3,755.2			44.00
45. 00	BURN INTENSIVE CARE UNIT SURGICAL INTENSIVE CARE UNIT						45. 00 46. 00
	OTHER SPECIAL CARE (SPECIFY)						47.00
	Cost Center Description				<u>.</u>	1 00	
48. 00	Program inpatient ancillary service cost (Wk	st. D-3, col. 3	, line 200)			1. 00 24, 972	48. 00
49. 00	Total Program inpatient costs (sum of lines	41 through 48)(	see instructi	ons)		60, 184	49. 00
50. 00	PASS THROUGH COST ADJUSTMENTS  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	Pass through costs applicable to Program inp and IV)	atient ancillar	ry services (f	rom Wkst. D,	sum of Parts II	0	51.00
52.00	Total Program excludable cost (sum of lines					0	
53. 00	Total Program inpatient operating cost exclu medical education costs (line 49 minus line		elated, non-ph	ysician anest	hetist, and	0	53.00
	TARGET AMOUNT AND LIMIT COMPUTATION	52)					
	Program discharges Target amount per discharge					0.00	
56. 00	Target amount (line 54 x line 55)					0.00	1
	Difference between adjusted inpatient operat	ing cost and ta	irget amount (	line 56 minus	line 53)	0	
58. 00 59. 00	Bonus payment (see instructions) Lesser of lines 53/54 or 55 from the cost re	portina period	endi na 1996.	updated and c	ompounded by the	0.00	
	market basket		0	•			
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					0.00	1
000	which operating costs (line 53) are less tha	n expected cost					000
amount (line 56), otherwise enter zero (see instructions) 62.00 Relief payment (see instructions)						0	62.00
63.00 Allowable Inpatient cost plus incentive payment (see instructions)							63.00
64. 00	PROGRAM INPATIENT ROUTINE SWING BED COST Medicare swing-bed SNF inpatient routine cos	ts through Dece	ember 31 of th	e cost report	ing period (See	0	64.00
	instructions)(title XVIII only)	Ü		•			
65. 00	Medicare swing-bed SNF inpatient routine cos instructions)(title XVIII only)	ts after Decemb	er 31 of the	cost reportin	g period (See	0	65.00
66. 00	Total Medicare swing-bed SNF inpatient routi	ne costs (line	64 plus line	65)(title XVI	II only). For	0	66. 00
67. 00	CAH (see instructions) Title V or XIX swing-bed NF inpatient routin	e costs through	December 31	of the cost r	eporting period	0	67.00
40.00	(line 12 x line 19)	o occto often D	lacamban 21 af	the east ron	orting ported		40.00
68. 00	Title V or XIX swing-bed NF inpatient routin (line 13 x line 20)	e costs after L	ecember 31 01	the cost rep	ortring period		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 72. 00	Adjusted general inpatient routine service c Program routine service cost (line 9 x line		ine 70 ÷ line	2)			71. 00 72. 00
73. 00	Medically necessary private room cost applic		(line 14 x l	ine 35)			73.00
74.00	Total Program general inpatient routine serv	•		,	David III. aaliima		74.00
75. 00	Capital-related cost allocated to inpatient 26, line 45)	routine service	costs (trom	worksneet B,	Part II, column		75. 00
76.00	Per diem capital-related costs (line 75 ÷ li						76.00
77. 00 78. 00	Program capital-related costs (line 9 x line Inpatient routine service cost (line 74 minu						77. 00 78. 00
79. 00	Aggregate charges to beneficiaries for exces	, ,		,	70)		79.00
80. 00 81. 00	Total Program routine service costs for comp Inpatient routine service cost per diem limi		ost limitatio	n (IIne 78 mi	nus line 79)		80.00
82.00	Inpatient routine service cost limitation (I	ine 9 x line 81	* .				82.00
83. 00 84. 00	Reasonable inpatient routine service costs ( Program inpatient ancillary services (see in		ıs)				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					571	87.00
88.00	Adjusted general inpatient routine cost per	diem (line 27 ÷	,			1, 853. 25	1
07.00	Observation bed cost (line 87 x line 88) (se	e mstructions)				1, 058, 206	09.00

Health Financial Systems	UNION HOSPIT	UNION HOSPITAL CLINTON			In Lieu of Form CMS-25!		
COMPUTATION OF INPATIENT OPERATING COST		Provi der CC		Peri od: From 01/01/2017	Worksheet D-1		
					Date/Time Pre 5/30/2018 1:4		
		Ti tl e	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	457, 124	4, 130, 902	0. 11066	0 1, 058, 206	117, 101	90.00	
91.00 Nursing School cost	0	4, 130, 902	0.00000	0 1, 058, 206	0	91.00	
92.00 Allied health cost	0	4, 130, 902	0.00000	0 1, 058, 206	0	92.00	
93.00 All other Medical Education	O	4, 130, 902	0.00000	0 1, 058, 206	0	93.00	

	Financial Systems UNION HOSPITAL CL				u of Form CMS-2	
INPATIE	NT ANCILLARY SERVICE COST APPORTIONMENT Pr	rovider C	CN: 15-1326	Peri od:	Worksheet D-3	
				From 01/01/2017 To 12/31/2017	Date/Time Pre 5/30/2018 1:4	
		Title	XVIII	Hospi tal	Cost	
	Cost Center Description		Ratio of Cos		I npati ent	
			To Charges		Program Costs	
				Charges	(col . 1 x	
			4 00	0.00	col . 2)	
- I	NDATI ENT DOUTINE CEDVI CE COCT CENTEDO		1.00	2. 00	3. 00	
-	NPATI ENT ROUTI NE SERVI CE COST CENTERS D3000 ADULTS & PEDI ATRI CS			1, 588, 436		30.00
1	D3100 INTENSIVE CARE UNIT			350, 625		31.00
_	ANCILLARY SERVICE COST CENTERS			330, 623		31.00
	D5000 OPERATI NG ROOM		0. 31867	77 403, 359	128, 541	50.00
	D5100 RECOVERY ROOM		0. 5404	•	9, 287	
	D5101 O/P TREATMENT ROOM		0. 63965		0	51.01
	D5400 RADI OLOGY-DI AGNOSTI C		0. 15999		47, 471	54.00
56.00	05600 RADI 0I S0T0PE		0. 28048	13, 719	3, 848	56.00
60.00	D6000 LABORATORY		0. 15643	492, 073	76, 976	60.00
62.00	D6200 WHOLE BLOOD & PACKED RED BLOOD CELLS		0. 45687	77 25, 726	11, 754	62.00
65.00	D6500 RESPIRATORY THERAPY		1. 09871	9 287, 415	315, 788	65.00
	D6600 PHYSI CAL THERAPY		0. 40821			
	06700 OCCUPATI ONAL THERAPY		0. 52661			
	D6800 SPEECH PATHOLOGY		0. 44403			1
	D6900 ELECTROCARDI OLOGY		0. 14541			
	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS		3. 27107		51, 343	
	07200 IMPL. DEV. CHARGED TO PATIENTS		0.00000		0	
	07300 DRUGS CHARGED TO PATIENTS		0. 35743	697, 253	249, 221	73.00
	DUTPATIENT SERVICE COST CENTERS D9000  CLINIC		0.00000	20	0	90.00
	D9100 EMERGENCY		0. 00000		6, 238	
	D9200 OBSERVATION BEDS (NON-DISTINCT PART)		1. 30518		0, 238	1
200.00	Total (sum of lines 50 through 94 and 96 through 98)		1. 30310	2, 596, 795		
200.00	Less PBP Clinic Laboratory Services-Program only charges (	line 61)		2, 370, 773 N		201.00
202.00	Net charges (line 200 minus line 201)	1110 01)		2, 596, 795		202.00
_02.00	J.		1	2,0,0,1,0	1	

Hool th Fina	ncial Systems UNION HOSPITAL	CLINTON		In Lie	u of Form CMS-2	2552 10
	INCI ANCI LLARY SERVICE COST APPORTIONMENT	Provi der C	CN: 15-1326	Peri od:	Worksheet D-3	
			CCN: 15-Z326	From 01/01/2017 To 12/31/2017		narod:
		Component	CCN. 15-Z320	10 12/31/2017	5/30/2018 1: 4	
		Title		Swing Beds - SNF		
	Cost Center Description		Ratio of Cos	1 1 1 1 1 1 1	I npati ent	
			To Charges	Program	Program Costs	
				Charges	(col. 1 x	
					col. 2)	
			1. 00	2. 00	3. 00	
	TIENT ROUTINE SERVICE COST CENTERS		1		I	
	O ADULTS & PEDI ATRI CS			0		30.00
	O INTENSIVE CARE UNIT			0		31.00
	LLARY SERVICE COST CENTERS		0.040/	77 407		
	O OPERATING ROOM		0. 3186		34	
	O RECOVERY ROOM		0. 5404		0	
	1 O/P TREATMENT ROOM		0. 63965		0	51.01
4	O RADI OLOGY-DI AGNOSTI C		0. 15999			54.00
	O RADI OI SOTOPE		0. 28048		0	
	O LABORATORY		0. 15643			60.00
	O WHOLE BLOOD & PACKED RED BLOOD CELLS		0. 4568			1
	O RESPIRATORY THERAPY		1. 0987			1
	O PHYSI CAL THERAPY O OCCUPATI ONAL THERAPY		0. 4082° 0. 5266°			1
	O SPEECH PATHOLOGY		0. 5266			1
	O ELECTROCARDI OLOGY		0. 4440.			69.00
	O MEDICAL SUPPLIES CHARGED TO PATIENTS		3. 2710			
	O I MPL. DEV. CHARGED TO PATIENTS		0.00000		, , ,	1
	O DRUGS CHARGED TO PATIENTS		0. 35743			
	ATIENT SERVICE COST CENTERS		0.3374	27,000	7,003	73.00
	O CLINIC		0.00000	00 0	0	90.00
	O EMERGENCY		0. 31788		0	
	O OBSERVATION BEDS (NON-DISTINCT PART)		1, 30518		0	
200.00	Total (sum of lines 50 through 94 and 96 through 98)		1. 30310	95, 536	_	200.00
201.00	Less PBP Clinic Laboratory Services-Program only charges	s (line 61)		75, 550		201.00
202.00	Net charges (line 200 minus line 201)	5 (1110 01)		95, 536		202.00
202.00	The charges (Title 200 millios Title 201)		I	75, 550	I	1202.00

Heal th Fi	nancial Systems UNION HOSPITAL CL	_I NTON		In Lie	u of Form CMS-2	<u> 2552-10</u>
I NPATI EN	T ANCILLARY SERVICE COST APPORTIONMENT	rovider C	CN: 15-1326	Peri od:	Worksheet D-3	
				From 01/01/2017 To 12/31/2017	Date/Time Pre 5/30/2018 1:4	
		Ti tl	e XIX	Hospi tal	Cost	
	Cost Center Description		Ratio of Cos		I npati ent	
			To Charges	Program	Program Costs	
				Charges	(col . 1 x	
			1.00	2.00	col . 2)	
LNI	PATIENT ROUTINE SERVICE COST CENTERS		1.00	2. 00	3. 00	
	1000 ADULTS & PEDIATRICS			27, 522		30.00
	1100 INTENSIVE CARE UNIT			9, 145		31.00
	CILLARY SERVICE COST CENTERS			7, 143		31.00
	OOO OPERATING ROOM		0. 3186	77 21, 906	6, 981	50.00
	100 RECOVERY ROOM		0. 5404	·	376	51.00
	101 0/P TREATMENT ROOM		0. 6396!		0	51.01
	4400 RADI OLOGY-DI AGNOSTI C		0. 1599		3, 035	54.00
56.00 05	600 RADI OI SOTOPE		0. 28048		55	56.00
60.00 06	000 LABORATORY		0. 1564	17, 351	2,714	60.00
62.00 06	200 WHOLE BLOOD & PACKED RED BLOOD CELLS		0. 4568		52	62.00
65. 00 06	500 RESPI RATORY THERAPY		1. 0987	19 4, 165	4, 576	65.00
66. 00 06	600 PHYSI CAL THERAPY		0. 4082	17 240	98	66.00
67.00 06	0700 OCCUPATI ONAL THERAPY		0. 5266	10 0	0	67.00
	800 SPEECH PATHOLOGY		0. 4440	38 0	0	68.00
	900 ELECTROCARDI OLOGY		0. 1454	·	332	69. 00
	100 MEDICAL SUPPLIES CHARGED TO PATIENTS		3. 2710		399	
	200 IMPL. DEV. CHARGED TO PATIENTS		0. 00000		0	72.00
	300 DRUGS CHARGED TO PATIENTS		0. 3574	32 0	0	73. 00
	TPATIENT SERVICE COST CENTERS			20		
	OOO CLINIC		0.0000		0	90.00
	1100 EMERGENCY		0. 3178		6, 354	
92. 00 09 200. 00	1200 OBSERVATION BEDS (NON-DISTINCT PART)		1. 30518		0 24, 972	92.00
200.00	Total (sum of lines 50 through 94 and 96 through 98) Less PBP Clinic Laboratory Services-Program only charges	(Lino 61)		86, 033		200.00
201.00	Net charges (line 200 minus line 201)	(IIIIe 61)		86, 033		201.00
202.00	INET Charges (Title 200 IIII has Title 201)		I	00, 033		J202.00

Health Financial Systems UNIO	N HOSPITAL CLINTON		Inlio	u of Form CMS-2	2552 10
INPATIENT ANCILLARY SERVICE COST APPORTIONMENT	Provi der Co	CN: 15-1326	Peri od:	Worksheet D-3	
THE ATTENT AND LEARN DERVISE GOOD AND OKTO DIMENT			From 01/01/2017		
	Component	CCN: 15-Z326	To 12/31/2017	Date/Time Pre 5/30/2018 1:4	
	Ti tl	e XIX	Swing Beds - SNF		9 рііі
Cost Center Description		Ratio of Cos		I npati ent	
,		To Charges		Program Costs	
			Charges	(col. 1 x	
			Ŭ	col . 2)	
		1.00	2. 00	3. 00	
INPATIENT ROUTINE SERVICE COST CENTERS					
30. 00   03000   ADULTS & PEDI ATRI CS			0		30.00
31. 00 03100 INTENSIVE CARE UNIT			0		31.00
ANCILLARY SERVICE COST CENTERS					
50.00   05000   OPERATING ROOM		0. 31867		0	
51.00   05100   RECOVERY ROOM		0. 54041		0	
51.01  05101 0/P TREATMENT ROOM		0. 63965		0	
54. 00   05400   RADI OLOGY-DI AGNOSTI C		0. 15999		0	
56. 00   05600   RADI 0I SOTOPE		0. 28048		0	56.00
60. 00   06000   LABORATORY		0. 15643		0	
62.00 06200 WHOLE BLOOD & PACKED RED BLOOD CELLS		0. 45687		0	
65. 00 06500 RESPI RATORY THERAPY		1. 09871		0	
66. 00 06600 PHYSI CAL THERAPY		0. 40821		0	
67. 00 06700 OCCUPATI ONAL THERAPY		0. 52661		0	
68. 00 06800 SPEECH PATHOLOGY		0. 44403		0	
69. 00 06900 ELECTROCARDI OLOGY		0. 14541		0	
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS		3. 27107		0	
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS		0.00000		0	72.00
73. 00 07300 DRUGS CHARGED TO PATIENTS		0. 35743	2 0	0	73. 00
OUTPATIENT SERVICE COST CENTERS					
90. 00   09000   CLI NI C		0.00000		0	
91. 00   09100   EMERGENCY		0. 31788		0	
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)		1. 30518	0	0	
200.00 Total (sum of lines 50 through 94 and 96 thro			0		200.00
201.00 Less PBP Clinic Laboratory Services-Program o	nly charges (line 61)		0		201.00
202.00 Net charges (line 200 minus line 201)		l	0		202. 00

Health Financial Systems	UNION HOSPITAL CLINTON	In Lie	u of Form CMS-2552-10
CALCULATION OF REIMBURSEMENT SETTLEMENT	Provi der CCN: 15-1326		Worksheet E Part B Date/Time Prepared: 5/30/2018 1:49 pm

Part B WEDICAL AND OTHER HEAT THIS SERVICES   1.00				127 017 2017	5/30/2018 1: 4	9 pm
Next B - MeDical, AMO OTHER MEATH SERVICES   0.00			Title XVIII	Hospi tal		
Next B - MeDical, AMO OTHER MEATH SERVICES   0.00						
					1.00	
Medical and other services reliabursed under OPPS (see Instructions)		PART B - MEDICAL AND OTHER HEALTH SERVICES				
0.00   0PPS payments   0   3.00   0	1.00	Medical and other services (see instructions)			6, 115, 339	1.00
0 Unit in Figwent (see instructions)	2.00	Medical and other services reimbursed under OPPS (see instruc	tions)		0	2.00
0.00000000000000000000000000000000000	3.00	OPPS payments			0	3.00
0.00   0.00	4.00	Outlier payment (see instructions)			0	4.00
Line 2 times line 5	4. 01	Outlier reconciliation amount (see instructions)			0	4. 01
Line 2 times line 5	5.00	Enter the hospital specific payment to cost ratio (see instru	ictions)		0.000	5.00
1.00   Content	6.00	Line 2 times line 5			0	6.00
	7.00	Sum of lines 3, 4, and 4.01, divided by line 6			0.00	7. 00
0.00   Organ acquisitions   0.10 0.00	8.00	Transitional corridor payment (see instructions)			0	8. 00
0.00   Organ acquisitions   0.10 0.00	9.00	, , , , , , , , , , , , , , , , , , , ,	IV, col. 13, line 200		0	9.00
COMPUTATION OF LESSER OF COST OR CHARCES					0	10.00
COMPUTATION OF LESSER OF COST OR CHARCES	11.00	Total cost (sum of lines 1 and 10) (see instructions)			6, 115, 339	11.00
Reasonable charges						
2.00   Ancil lary service charges   0   12.00   13.00   10.01   10.0						
13.00   Organ acquisition charges (from Wist. D-4, Pt. III, col. 4, line 69)   0.13.00   0.14.	12.00				0	12.00
1.0   Total reasonable charges (sum of lines 12 and 13)			ine 69)		0	13.00
Customary charges   15.00   Agrogate amount actually collected from patients	14.00		,		0	14.00
15.00   Aggregate amount actually collected from patients liable for payment for services on a charge basis   0   15.00						
16.00   Amounts that would have been realized from patients liable for payment for services on a chargebasis   0   16.00   Nation of line 15 to line 16 (not to exceed 1.000000)   17.00   18.10   18.10   18.10   19.00   1	15.00		payment for services on	a charge basis	0	15. 00
had such payment been made in accordance with 42 CFR \$413.13(e)					0	
17.00				3		
18. 00   Total customary charges (see instructions)   0   18. 00   18. 00   19. 00   10. 00	17. 00		.=/		0.000000	17. 00
19. 00   Excess of customary charges over reasonable cost (complete only if line 18 exceeds line 11) (see   0   19. 00		,				
Instructions		,	lv if line 18 exceeds l	ine 11) (see	0	
Instructions			3	, (		
Instructions	20.00	Excess of reasonable cost over customary charges (complete on	ly if line 11 exceeds l	ine 18) (see	0	20.00
22.00   Interns and residents (see instructions)   0   22.00   23.00   23.00   23.00   24.00   7   25.00   7   25.00				, ,		
23. 00   Cost of physicians' services in a teaching hospital (see instructions)   0   23. 00   24. 00   COMPUTATION OF REINBURSEMENT SETILEMENT   Deductibles and coinsurance (for CAH, see instructions)   3. 636, 824   26. 00   Deductibles and coinsurance relating to amount on line 24 (for CAH, see instructions)   3. 636, 824   26. 00   27. 00   Subtotal ((lines 21 and 24 minus the sum of lines 25 and 26) plus the sum of lines 22 and 23] (see instructions)   0. 28. 00   2. 477, 796   27. 00   10. 00   29. 00	21.00	Lesser of cost or charges (see instructions)			6, 176, 492	21.00
Total prospective payment (sum of lines 3, 4, 4.01, 8 and 9)	22.00	Interns and residents (see instructions)			0	22. 00
Total prospective payment (sum of lines 3, 4, 4.01, 8 and 9)	23.00	Cost of physicians' services in a teaching hospital (see inst	ructions)		0	23.00
COMPUTATION OF REIMBURSEMENT SETTLEMENT   Deductibles and coinsurance (for CAH, see instructions)   3, 61, 872   25, 00   26. 00   Deductibles and coinsurance relating to amount on line 24 (for CAH, see instructions)   3, 636, 824   26, 00   27. 00   Subtotal [(lines 21 and 24 minus the sum of lines 25 and 26) plus the sum of lines 22 and 23] (see   2, 477, 796   27, 00   28. 00   Direct graduate medical education payments (from Wkst. E-4, line 50)   0   28, 00   29. 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, 477, 673   30, 00   31. 00   Primary payer payments   159   31, 00   32. 00   Subtotal (line 30 minus line 31)   2, 477, 637   32, 00   33. 00   Composite rate ESRD (from Wkst. I-5, line 11)   0   34, 00   Allowable bad debts (see instructions)   451, 326   35, 00   34. 00   Allowable bad debts (see instructions)   451, 326   35, 00   35. 00   Allowable bad debts for dual eligible beneficiaries (see instructions)   694, 347   36, 00   36. 00   Allowable bad debts for dual eligible beneficiaries (see instructions)   694, 347   36, 00   37. 00   Subtotal (see instructions)   2, 928, 963   37, 00   38. 00   MSP-LCC reconciliation amount from PS&R   0   39, 90   39. 90   OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)   0   39, 90   39. 97   Demonstration payment adjustment (see instructions)   0   39, 97   39. 98   Partial or full credits received from manufacturers for replaced devices (see instructions)   0   39, 97   40. 00   Demonstration payment adjustment amount before sequestration   0   39, 97   40. 00   Demonstration payment adjustment mount after sequestration   0   40, 00   40. 01   Sequestration adjustment (see instructions)   2, 228, 963   40, 00   40. 02   Demonstration payment adjustment mount after sequestration   0   40, 00   41. 00   Demonstration payment adjustment mount after sequestration   0   40, 00   41. 00   Demonstration payment adjustment mount after sequestration   0   40, 00   41. 00   Prot		, , ,	•		0	24.00
25.00   Deductible s and coin surrance (for CAH, see instructions)   61,872   25.00						
26.00   Deductibles and Coi nsurance relating to amount on line 24 (for CAH, see instructions)   3, 636, 824   26.00     27.00   Subtotal [(lines 21 and 24 minus the sum of lines 25 and 26) plus the sum of lines 22 and 23] (see linstructions)   0 28.00     27.00   Direct graduate medical education payments (from Wkst. E-4, line 50)   0 28.00     28.00   Direct graduate medical education costs (from Wkst. E-4, line 36)   0 29.00     29.00   ESRD direct medical education costs (from Wkst. E-4, line 36)   0 29.00     30.00   Subtotal (sum of lines 27 through 29)   2, 477, 796   30.00     30.00   Subtotal (line 30 minus line 31)   2, 477, 637     40.00   Subtotal (line 30 minus line 31)   2, 477, 637     41.00   Allowable BAD DEBTS (EXCLUSE BAD DEBTS FOR PROFESSIONAL SERVICES)   694, 347   34.00     34.00   Allowable bad debts (see instructions)   694, 347   34.00     35.00   Allowable bad debts (see instructions)   694, 347   36.00     36.00   Allowable bad debts for dual eligible beneficiaries (see instructions)   694, 347   36.00     38.00   MSP-LCC reconciliation amount from PS&   2, 928, 963   30.00     39.00   OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)   0 39.00     39.90   Pioneer ACO demonstration payment adjustment (see instructions)   39.90     39.99   RECOVERY OF ACCELERATED DEPRECIATION   0 39.99     40.00   Sequestration adjustment amount before sequestration   0 39.99     40.00   Subtotal (see instructions)   2, 928, 963   39.99     40.00   Subtotal (see instructions)   0 40.00     50.00   Tentative settlement (for contractors use only)   0 2, 008, 303   0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	25.00				61, 872	25. 00
27.00   Subtotal [(lines 21 and 24 minus the sum of lines 25 and 26) plus the sum of lines 22 and 23] (see   1,477,796   2,700   1,700   2,477,796   2,700   2,800   2,900   2,800   2,900   2,800   2,900	26.00	· · · · · · · · · · · · · · · · · · ·	r CAH, see instructions	)		
Instructions	27.00					
29.00   ESRD direct medical education costs (from Wkst. E-4, line 36)   29.00   30.0		instructions)		- '		
30.00   Subtotal (sum of lines 27 through 29)   2, 477, 796   30.00   71	28.00	Direct graduate medical education payments (from Wkst. E-4, I	ine 50)		0	28. 00
31.00   Primary payer payments   159   31.00   32.00   Subtotal (I ine 30 minus line 31)   2,477,637   32.00   ALLOWABLE BAD DEBTS (EXCLUDE BAD DEBTS FOR PROFESSIONAL SERVICES)   33.00   Composite rate ESRD (from Wkst. I - 5, line 11)   0   33.00   33.00   34.00   Allowable bad debts (see instructions)   451,326   35.00   36.00   Allowable bad debts for dual eligible beneficiaries (see instructions)   694,347   34.00   37.00   Subtotal (see instructions)   694,347   36.00   37.00   Subtotal (see instructions)   2,928,963   37.00   38.00   MSP-LCC reconciliation amount from PS&R   2,928,963   37.00   39.00   39.50   39.97   39.50   39.97	29.00	ESRD direct medical education costs (from Wkst. E-4, line 36)			0	29. 00
32.00   Subtotal (ine 30 minus line 31)   ALLOWABLE BAD DEBTS (EXCLUDE BAD DEBTS FOR PROFESSIONAL SERVICES)   32.00	30.00	Subtotal (sum of lines 27 through 29)			2, 477, 796	30.00
ALLOWABLE BAD DEBTS (EXCLUDE BAD DEBTS FOR PROFESSIONAL SERVICES)   33.00   Composite rate ESRD (from Wkst. I-5, line 11)   0   33.00     34.00   All lowable bad debts (see instructions)   694, 347   34.00     35.00   Adjusted reimbursable bad debts (see instructions)   451, 326   35.00     36.00   All lowable bad debts for dual eligible beneficiaries (see instructions)   694, 347   36.00     37.00   Subtotal (see instructions)   2,928, 963   37.00     38.00   MSP-LCC reconciliation amount from PS&R   0   38.00     39.00   OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)   0   39.00     39.50   Pioneer ACO demonstration payment adjustment (see instructions)   39.97     39.97   Demonstration payment adjustment amount before sequestration   0   39.97     39.98   Partial or full credits received from manufacturers for replaced devices (see instructions)   0   39.99     40.00   Subtotal (see instructions)   2,928,963   40.00     40.01   Sequestration adjustment (see instructions)   58,579   40.01     40.02   Demonstration payment adjustment amount after sequestration   0   40.02     41.00   Interim payments   2,048,303   41.00     42.00   Tentative settlement (for contractors use only)   0   42.00     43.00   Balance due provider/program (see instructions)   822,081   43.00     44.00   Protested amounts (nonall owable cost report items) in accordance with CMS Pub. 15-2, chapter 1,   0   44.00     5115.2   10   BE COMPLETED BY CONTRACTOR   0   90.00     90.00   Ottlier reconciliation adjustment amount (see instructions)   0   91.00     90.00   Ottlier reconciliation adjustment amount (see instructions)   0   90.00     90.00   Time Value of Money (see instructions)   0   93.00	31.00	Pri mary payer payments			159	31.00
33.00   Composite rate ESRD (from Wkst. I - 5, line 11)	32.00				2, 477, 637	32.00
34.00   Allowable bad debts (see instructions)   694, 347   34.00   35.00   Adjusted reimbursable bad debts (see instructions)   451, 326   35.00   36.00   Allowable bad debts for dual eligible beneficiaries (see instructions)   694, 347   36.00   37.00   Subtotal (see instructions)   2, 928, 963   37.00   38.00   MSP-LCC reconciliation amount from PS&R   0   38.00   39.00   OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)   0   39.00   39.50   Pi oneer ACO demonstration payment adjustment (see instructions)   39.97   Partial or full credits received from manufacturers for replaced devices (see instructions)   0   39.97   39.99   Partial or full credits received from manufacturers for replaced devices (see instructions)   0   39.98   39.99   RECOVERY OF ACCELERATED DEPRECIATION   0   39.98   39.99   RECOVERY OF ACCELERATED DEPRECIATION   0   39.99   40.00   Sequestration adjustment (see instructions)   2, 928, 963   40.00   40.01   40.0		ALLOWABLE BAD DEBTS (EXCLUDE BAD DEBTS FOR PROFESSIONAL SERVI	CES)			
35.00   Adjusted reimbursable bad debts (see instructions)   451, 326   35.00   30.00   Allowable bad debts for dual eligible beneficiaries (see instructions)   694, 347   36.00   37.00   Subtotal (see instructions)   2, 928, 963   37.00   38.00   MSP-LCC reconciliation amount from PS&R   0   38.00   39.00   OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)   0   39.00   39.50   Pioneer ACO demonstration payment adjustment (see instructions)   0   39.97   39.98   Partial or full credits received from manufacturers for replaced devices (see instructions)   0   39.98   39.99   RECOVERY OF ACCELERATED DEPRECIATION   0   39.99   40.00   Subtotal (see instructions)   58,579   40.01   40.02   41.00   Interim payment adjustment amount after sequestration   2, 928, 963   40.00   40.02   41.00   Interim payment adjustment amount after sequestration   40.02   41.00   Interim payment (for contractors use only)   81.00   82,081   43.00   44.00   Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1,					0	33.00
36.00       Allowable bad debts for dual eligible beneficiaries (see instructions)       694,347       36.00         37.00       Subtotal (see instructions)       2,928,963       37.00         38.00       MSP-LCC reconciliation amount from PS&R       0       38.00         39.00       OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)       0       39.00         39.50       Pioneer ACO demonstration payment adjustment (see instructions)       39.50         39.97       Partial or full credits received from manufacturers for replaced devices (see instructions)       0       39.97         39.99       RECOVERY OF ACCELERATED DEPRECIATION       0       39.99         40.01       Sequestration adjustment (see instructions)       2,928,963       30.00         40.01       Sequestration adjustment (see instructions)       0       39.97         40.02       Interim payments       2,928,963       30.00         42.00       Balance due provider/program (see instructions)       0       40.02         41.00       Balance due provider/program (see instructions)       822,081       43.00         44.00       Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, stills.2       0       40.02         70.00       Demonstration adjustment amount (see instructions)       0 <t< td=""><td>34.00</td><td>Allowable bad debts (see instructions)</td><td></td><td></td><td>694, 347</td><td>34.00</td></t<>	34.00	Allowable bad debts (see instructions)			694, 347	34.00
37.00   Subtotal (see instructions)   2,928,963   37.00   38.00   MSP-LCC reconciliation amount from PS&R   0   38.00   39.00   39.00   39.50   39.50   39.97   39.97   39.98   RECOVERY OF ACCELERATED DEPRECIATION   0   39.98   39.99   39.90   3		Adjusted reimbursable bad debts (see instructions)			451, 326	35.00
38.00 MSP-LCC reconciliation amount from PS&R 39.00 OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY) 39.50 Pioneer ACO demonstration payment adjustment (see instructions) 39.97 Demonstration payment adjustment amount before sequestration 39.97 Partial or full credits received from manufacturers for replaced devices (see instructions) 39.99 RECOVERY OF ACCELERATED DEPRECIATION 39.99 RECOVERY OF ACCELERATED DEPRECIATION 39.99 (a) 00 Subtotal (see instructions) 2, 928, 963 (a) 00 Demonstration payment adjustment amount after sequestration 40.01 Sequestration adjustment (see instructions) 40.02 Demonstration payment adjustment amount after sequestration 41.00 Interim payments 42.00 Tentative settlement (for contractors use only) 43.00 Balance due provider/program (see instructions) 44.00 Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, 91.00 41.00 Original outlier amount (see instructions) 42.00 Time value of Money (see instructions) 43.00 The rate used to calculate the Time Value of Money 44.00 Time Value of Money (see instructions) 45.00 Time Value of Money (see instructions) 46.00 Og 38.00 Og 3	36.00	Allowable bad debts for dual eligible beneficiaries (see inst	ructions)			
39.00 OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY) 39.50 Pioneer ACO demonstration payment adjustment (see instructions) 39.77 Demonstration payment adjustment amount before sequestration 39.87 Partial or full credits received from manufacturers for replaced devices (see instructions) 39.98 RECOVERY OF ACCELERATED DEPRECIATION 40.00 Subtotal (see instructions) 40.01 Sequestration adjustment (see instructions) 40.02 Demonstration payment adjustment amount after sequestration 40.02 Interim payments 41.00 Interim payments 42.00 Tentative settlement (for contractors use only) 43.00 Bal ance due provider/program (see instructions) 44.00 Protested amounts (nonal lowable cost report items) in accordance with CMS Pub. 15-2, chapter 1,  \$\frac{\fr					2, 928, 963	
39.50 39.97 39.98 39.99 RECOVERY OF ACCELERATED DEPRECIATION  Subtotal (see instructions)  Demonstration payment adjustment amount before sequestration  Sequestration of full credits received from manufacturers for replaced devices (see instructions)  Subtotal (see instructions)  Sequestration adjustment (see instructions)  Demonstration payment adjustment amount after sequestration  Demonstration payment adjustment amount after sequestration  10 40.02 1nterim payments  11 trentative settlement (for contractors use only)  Also only be alance due provider/program (see instructions)  Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, spilos.  10 90.00 11 trereconciliation adjustment amount (see instructions)  Original outlier amount (see instructions)  Outlier reconciliation adjustment amount (see instructions)  The rate used to calculate the Time Value of Money  Time Value of Money (see instructions)  O 39.97  39.98  39.90		MSP-LCC reconciliation amount from PS&R			0	
39. 97 39. 98 39. 99 RECOVERY OF ACCELERATED DEPRECIATION 0 39. 98 40. 00 Subtotal (see instructions) 0 2, 928, 963 40. 01 Sequestration adjustment (see instructions) 0 2, 928, 963 40. 02 Demonstration payments adjustment amount after sequestration 1 1nterim payments 1 2, 048, 303 41. 00 42. 00 43. 00 44. 00 Protested amounts (nonal lowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, 0 91. 00 91. 00 91. 00 91. 00 92. 00 The rate used to calculate the Time Value of Money 1 39. 97 1 39. 97 2 39. 98 39. 97 39. 98 39. 98 39. 99 RECOVERY OF ACCELERATED DEPRECIATION 0 39. 98 39. 98 39. 98 39. 99 10 39. 98 39. 98 39. 99 10 39. 98 10 30. 99 10 40. 00 10 40. 00 10 40. 00 10 40. 00 10 40. 00 10 40. 00 10 40. 00 10 40. 00 10 40. 00 10 40. 00 10 40. 00 10 40. 00 10 40. 00 10 40. 00 10 40. 00 10 40. 00 10 40. 00 10 40. 00 10 40. 00 10 40	39. 00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)			0	39. 00
39.98 Partial or full credits received from manufacturers for replaced devices (see instructions)  39.98 RECOVERY OF ACCELERATED DEPRECIATION  40.00 Subtotal (see instructions)  50.39.99  40.00 Subtotal (see instructions)  50.00 Interim payment adjustment amount after sequestration  60.00 Subtotal (see instructions)  60.00 Subtotal (see instructions)  60.00 Pomonstration payment adjustment amount after sequestration  60.00 Pomonstration payment adjustment amount (see instructions)  60.42.00 Pomonstration payment adjustment amount (see instructions)  70.00 Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, spin adjustment amount (see instructions)  70.00 Pomonstration payment adjustment amount (see instructions)  70.00 Subtotal (see instructions)  70.00 Pomonstration payment adjustment amount (see instructions)  70.00 Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, spin adjustment amount (see instructions)  70.00 Original outlier amount (see instructions)  70.00 Outlier reconciliation adjustment amount (see instructions)  70.00 Pomonstration payment adjustment amount (see instructions)  70.00 Outlier reconciliation adjustment amount (see instructions)  70.00 Pomonstration payment adjustment amount (see instructions)  70.00	39. 50	Pioneer ACO demonstration payment adjustment (see instruction	is)			39. 50
39. 99   RECOVERY OF ACCELERATED DEPRECIATION   0   39. 99   40. 00   Subtotal (see instructions)   2, 928, 963   40. 00   40. 01   Sequestration adjustment (see instructions)   58, 579   40. 01   40. 02   41. 00   42. 00   42. 00   43. 00   44	39. 97	Demonstration payment adjustment amount before sequestration			0	39. 97
40.00   Subtotal (see instructions)   2, 928, 963   40.00   40.01   Sequestration adjustment (see instructions)   58, 579   40.01   40.02   Demonstration payment adjustment amount after sequestration   0   40.02   41.00   Interim payments   2, 048, 303   41.00   42.00   Tentative settlement (for contractors use only)   2, 048, 303   41.00   43.00   Balance due provider/program (see instructions)   822, 081   43.00   44.00   Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1,   0   44.00   Silfs. 2   0   70   Demonstration payment   0   90.00   71   Original outlier amount (see instructions)   0   91.00   71   Outlier reconciliation adjustment amount (see instructions)   0   91.00   72.00   The rate used to calculate the Time Value of Money   0   93.00   73   Outlier of Money (see instructions)   0   93.00   74   Outlier reconciliation adjustment amount (see instructions)   0   93.00   75   Outlier reconciliation adjustment amount (see instructions)   0   93.00   76   Outlier reconciliation adjustment amount (see instructions)   0   93.00   77   Outlier reconciliation adjustment amount (see instructions)   0   93.00   78   Outlier reconciliation adjustment amount (see instructions)   0   93.00   79   Outlier reconciliation adjustment amount (see instructions)   0   93.00	39. 98	Partial or full credits received from manufacturers for repla	ced devices (see instru	ctions)	0	39. 98
40.01 Sequestration adjustment (see instructions) 40.02 Demonstration payment adjustment amount after sequestration 41.00 Interim payments 42.00 Tentative settlement (for contractors use only) 43.00 Bal ance due provider/program (see instructions) 44.00 Protested amounts (nonal lowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, 5115.2 70 BE COMPLETED BY CONTRACTOR  90.00 Original outlier amount (see instructions) 91.00 Outlier reconciliation adjustment amount (see instructions) 92.00 The rate used to calculate the Time Value of Money 93.00 Time Value of Money (see instructions) 93.00 Time Value of Money (see instructions) 94.00 Outlier reconciliation adjustment amount (see instructions) 93.00 Time Value of Money (see instructions) 94.00 Outlier reconciliation adjustment amount (see instructions) 94.00 Outlier reconciliation adjustment amount (see instructions) 95.00 Outlier reconciliation adjustment amount (see instructions) 97.00 Outlier reconciliation adjustment amount (see instructions)	39. 99	RECOVERY OF ACCELERATED DEPRECIATION			0	39. 99
40.02 Demonstration payment adjustment amount after sequestration  1 Interim payments  2 CO48, 303 41.00  42.00 Tentative settlement (for contractors use only)  43.00 Balance due provider/program (see instructions)  Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1,  5115.2  TO BE COMPLETED BY CONTRACTOR  Original outlier amount (see instructions)  0 Utilier reconciliation adjustment amount (see instructions)  1 Outlier reconciliation adjustment amount (see instructions)  1 Outlier reconciliation adjustment amount (see instructions)  2 Outlier reconciliation adjustment amount (see instructions)  3 Outlier reconciliation adjustment amount (see instructions)  40.00 Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1,  6 Outlier amount (see instructions)  90.00 Outlier reconciliation adjustment amount (see instructions)  91.00 The rate used to calculate the Time Value of Money  92.00 Time Value of Money (see instructions)  93.00 Time Value of Money (see instructions)	40.00	Subtotal (see instructions)			2, 928, 963	40.00
41.00   Interim payments   2,048,303   41.00   42.00   43.00   Bal ance due provider/program (see instructions)   822,081   43.00   44.00   Protested amounts (nonal lowable cost report items) in accordance with CMS Pub. 15-2, chapter 1,   0   44.00	40. 01	, , , , , , , , , , , , , , , , , , ,			58, 579	40. 01
42.00 Tentative settlement (for contractors use only)  43.00 Balance due provider/program (see instructions)  44.00 Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, 0 44.00    91.50 Original outlier amount (see instructions)  91.00 Outlier reconciliation adjustment amount (see instructions)  92.00 The rate used to calculate the Time Value of Money  93.00 Time Value of Money (see instructions)  1 0 42.00    94.00 Outlier reconciliation adjustment amount (see instructions)  99.00 Outlier reconciliation adjustment amount (see instructions)	40. 02					40. 02
43.00 Balance due provider/program (see instructions)  44.00 Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, 0 44.00    91.00 Original outlier amount (see instructions)  91.00 Outlier reconciliation adjustment amount (see instructions)  92.00 The rate used to calculate the Time Value of Money  93.00 Time Value of Money (see instructions)  93.00 Outlier reconciliation adjustment amount (see instructions)  93.00 Time Value of Money (see instructions)  93.00 Outlier reconciliation adjustment amount (see instructions)  93.00 Outlier reconciliation adjustment amount (see instructions)  94.00 Outlier reconciliation adjustment amount (see instructions)  95.00 Outlier reconciliation adjustment amount (see instructions)  97.00 Outlier reconciliation adjustment amount (see instructions)	41.00					41.00
44.00 Protested amounts (nonal lowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, 0 \$\frac{\\$115.2}{\\$10 BE COMPLETED BY CONTRACTOR}\$  90.00 Original outlier amount (see instructions) 0 0utlier reconciliation adjustment amount (see instructions) 0 91.00 The rate used to calculate the Time Value of Money (see instructions) 0 93.00 Time Value of Money (see instructions) 0 93.00	42.00					
\$115.2 TO BE COMPLETED BY CONTRACTOR  90.00 Original outlier amount (see instructions) 0 vullier reconciliation adjustment amount (see instructions) 0 vullier vulli	43.00					43.00
TO BE COMPLETED BY CONTRACTOR  90.00 Original outlier amount (see instructions)  91.00 Outlier reconciliation adjustment amount (see instructions)  92.00 The rate used to calculate the Time Value of Money  93.00 Time Value of Money (see instructions)  0 90.00  91.00  92.00  93.00 Time Value of Money (see instructions)  0 93.00	44.00				0	44.00
90.00 Original outlier amount (see instructions) 91.00 Outlier reconciliation adjustment amount (see instructions) 92.00 The rate used to calculate the Time Value of Money 93.00 Time Value of Money (see instructions) 90.00 91.00 91.00 92.00 93.00 93.00						
91.00 Outlier reconciliation adjustment amount (see instructions)  92.00 The rate used to calculate the Time Value of Money  93.00 Time Value of Money (see instructions)  0 91.00  92.00  93.00						
92.00 The rate used to calculate the Time Value of Money 93.00 Time Value of Money (see instructions) 0.00 92.00 0 93.00						
93.00 Time Value of Money (see instructions) 0 93.00						
					1	
94.00   Iotal (sum of lines 91 and 93)   0   94.00		,				
	94. 00	IOTAL (SUM OF LINES 91 and 93)			1 01	94.00

In Lieu of Form CMS-2552-10

| Period: | Worksheet E-1 |
| From 01/01/2017 | Part |
| To 12/31/2017 | Date/Time Prepared: | 5/30/2018 1:49 pm | Health Financial Systems UNIANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED Provi der CCN: 15-1326

					5/30/2018 1:4	9 pm
		Title	: XVIII	Hospi tal	Cost	
		Inpatier	t Part A	Par	rt B	
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount	
		1. 00	2, 00	3.00	4, 00	
1. 00	Total interim payments paid to provider		2, 417, 09	97	2, 048, 303	1.00
2. 00	Interim payments payable on individual bills, either submitted or to be submitted to the contractor for services rendered in the cost reporting period. If none,		2,, 6,	O	0	2. 00
3. 00	write "NONE" or enter a zero List separately each retroactive lump sum adjustment amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1) Program to Provider					3.00
2 01		07/00/0017	150.00	vol		2 01
3. 01 3. 02 3. 03 3. 04 3. 05	ADJUSTMENTS TO PROVIDER	07/28/2017		0 0 0 0	0 0 0	3. 01 3. 02 3. 03 3. 04 3. 05
	Provider to Program		•	<u>'</u>		
3. 50 3. 51 3. 52	ADJUSTMENTS TO PROGRAM			0 0 0	0 0	3. 50 3. 51 3. 52
3. 53 3. 54				0	0 0	3. 53 3. 54
3. 99	Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98)		153, 30		0	3. 99
4. 00	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Wkst. E or Wkst. E-3, line and column as appropriate) TO BE COMPLETED BY CONTRACTOR		2, 570, 39	7	2, 048, 303	4.00
5. 00	List separately each tentative settlement payment after desk review. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					5. 00
	Program to Provider					
5. 01	TENTATI VE TO PROVI DER			0	0	5. 01
5. 02				0	0	5.02
5.03				0	0	5.03
	Provider to Program					
5.50	TENTATI VE TO PROGRAM			0	0	5.50
5. 51				0	0	5. 51
5. 52				0	0	5. 52
5. 99	Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98)			0	0	5. 99
6. 00	Determined net settlement amount (balance due) based on the cost report. (1)					6. 00
6. 01	SETTLEMENT TO PROVIDER		662, 79	00	822, 081	6. 01
6. 02	SETTLEMENT TO PROGRAM		l .	0	0	6. 02
7.00	Total Medicare program liability (see instructions)		3, 233, 18	37	2, 870, 384	7. 00
				Contractor Number	NPR Date (Mo/Day/Yr)	
		(	)	1. 00	2. 00	
8.00	Name of Contractor					8.00

Health Financial Systems UNIANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED UNION HOSPITAL CLINTON In Lieu of Form CMS-2552-10 Peri od: Worksheet E-1
From 01/01/2017 Part I
To 12/31/2017 Date/Time Prepared: 5/30/2018 1: 49 pm Provi der CCN: 15-1326 Component CCN: 15-Z326 Title XVIII Swing Beds - SNF Cost Inpatient Part A Part B mm/dd/yyyy Amount mm/dd/yyyy Amount 1.00 3.00 4.00

		11.00	00	0.00	11 00	
1.00	Total interim payments paid to provider		195, 772		0	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			0		0	3.05
	Provider to Program					
3. 50	ADJUSTMENTS TO PROGRAM		0		0	3.50
3. 51			0		0	3. 51
3. 52			0		0	3.52
3. 53			0		0	3.53
3.54			0		0	3.54
3. 99	Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98)		0		0	3. 99
4. 00	Total interim payments (sum of lines 1, 2, and 3.99)		195, 772		0	4.00
	(transfer to Wkst. E or Wkst. E-3, line and column as		,			
	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					
5. 01	TENTATI VE TO PROVI DER		0		0	5.01
5.02			0		0	5.02
5.03			0		0	5.03
	Provider to Program					
5.50	TENTATI VE TO PROGRAM		0		0	5.50
5. 51			0		0	5. 51
5. 52			0		0	5.52
5. 99	Subtotal (sum of lines 5.01-5.49 minus sum of lines		0		0	5. 99
	5. 50-5. 98)					
6.00	Determined net settlement amount (balance due) based on					6.00
	the cost report. (1)					
6. 01	SETTLEMENT TO PROVIDER		26, 370		0	6. 01
6. 02	SETTLEMENT TO PROGRAM		0		0	6.02
7. 00	Total Medicare program liability (see instructions)		222, 142		0	7.00
			, :=	Contractor	NPR Date	
				Number	(Mo/Day/Yr)	
		0		1. 00	2.00	
8. 00	Name of Contractor					8. 00
		•				

Heal th	Financial Systems UNION HOSPITAL	_ CLINTON	In Lie	u of Form CMS-	2552-10	
CALCUL	CALCULATION OF REIMBURSEMENT SETTLEMENT FOR HIT Provider CCN: 15-1326 Period: W					
			From 01/01/2017 To 12/31/2017	Part II   Date/Time Pre	narod:	
			10 12/31/2017	5/30/2018 1: 4		
		Title XVIII	Hospi tal	Cost		
				1. 00		
	TO BE COMPLETED BY CONTRACTOR FOR NONSTANDARD COST REPORTS				4	
	HEALTH INFORMATION TECHNOLOGY DATA COLLECTION AND CALCULATIO				1.00	
1.00 Total hospital discharges as defined in AARA §4102 from Wkst. S-3, Pt. I col. 15 line 14						
2.00 Medicare days from Wkst. S-3, Pt. I, col. 6 sum of lines 1, 8-12					2.00	
3.00 Medicare HMO days from Wkst. S-3, Pt. I, col. 6. line 2					3.00	
4.00	Total inpatient days from S-3, Pt. I col. 8 sum of lines 1,	8-12			4. 00	
5.00	Total hospital charges from Wkst C, Pt. I, col. 8 line 200				5.00	
6.00	Total hospital charity care charges from Wkst. S-10, col. 3	line 20			6.00	
7.00	CAH only - The reasonable cost incurred for the purchase of	certified HIT technology	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	(see instructions)			10.00	
	INPATIENT HOSPITAL SERVICES UNDER THE IPPS & CAH					
30.00	Initial/interim HIT payment adjustment (see instructions)				30.00	
31.00	Other Adjustment (specify)				31.00	
32.00 Balance due provider (line 8 (or line 10) minus line 30 and line 31) (see instructions)					32.00	
		, ,	'		•	

Health Financial Systems	UNI ON HOSPI TAL	CLINTON	In Lie	u of Form CMS-2552-10
CALCULATION OF REIMBURSEMENT SETTLEMENT -	SWING BEDS	Provider CCN: 15-1326	Peri od:	Worksheet E-2
			From 01/01/2017	
		Component CCN: 15-Z326	To 12/31/2017	Date/Time Prepared:
				5/30/2018 1:49 pm
		T	0 1 0 1 0115	<u> </u>

		Component Con. 13-2320	10 12/31/2017	5/30/2018 1: 4	
		Title XVIII	Swing Beds - SNF	Cost	
			Part A	Part B	
			1.00	2. 00	
	COMPUTATION OF NET COST OF COVERED SERVICES				
1.00	Inpatient routine services - swing bed-SNF (see instructions)		181, 563	0	
2.00	Inpatient routine services - swing bed-NF (see instructions)				2.00
3.00	Ancillary services (from Wkst. D-3, col. 3, line 200, for Par	t A, and sum of Wkst. D,	49, 226	0	3.00
	Part V, cols. 6 and 7, line 202, for Part B) (For CAH, see in:				
4. 00	Per diem cost for interns and residents not in approved teach	ing program (see		0. 00	4.00
	instructions)				
5.00	Program days		97	0	
6.00	Interns and residents not in approved teaching program (see in			0	
7. 00	Utilization review - physician compensation - SNF optional me	thod only	000 700		7.00
8.00	Subtotal (sum of lines 1 through 3 plus lines 6 and 7)		230, 789	0	
9.00	Primary payer payments (see instructions)		220 700	0	
10.00	Subtotal (line 8 minus line 9)		230, 789	0	
11. 00	Deductibles billed to program patients (exclude amounts appli	cable to physician	o o	0	11.00
12. 00	professional services) Subtotal (line 10 minus line 11)		230, 789	0	12.00
13. 00	Coinsurance billed to program patients (from provider records	) (oveludo coi neuranco	4, 113	0	
13.00	for physician professional services)	(exclude collisulance	4, 113	U	13.00
14. 00	80% of Part B costs (line 12 x 80%)			0	14.00
	Subtotal (enter the lesser of line 12 minus line 13, or line	14)	226, 676	0	1
16. 00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	17)	220, 070	0	
16. 50	Pioneer ACO demonstration payment adjustment (see instructions	5)		Ü	16. 50
16. 55	Rural community hospital demonstration project (§410A Demonstr		0		16. 55
10.00	adjustment (see instructions)	ration, payment			10.00
16. 99	Demonstration payment adjustment amount before sequestration		0	0	16. 99
	Allowable bad debts (see instructions)		o	0	1
	Adjusted reimbursable bad debts (see instructions)		0	0	17. 01
	Allowable bad debts for dual eligible beneficiaries (see instr	ructions)	0	0	18. 00
	Total (see instructions)	ŕ	226, 676	0	19.00
19. 01	Sequestration adjustment (see instructions)		4, 534	0	19. 01
19. 02	Demonstration payment adjustment amount after sequestration)		0	0	19. 02
20.00	Interim payments		195, 772	0	20.00
21.00	Tentative settlement (for contractor use only)		0	0	21.00
22.00	Balance due provider/program (line 19 minus lines 19.01, 20,	and 21)	26, 370	0	22. 00
23.00	Protested amounts (nonallowable cost report items) in accordan	nce with CMS Pub. 15-2,	0	0	23. 00
	chapter 1, §115.2				
	Rural Community Hospital Demonstration Project (§410A Demonstr	ration) Adjustment			
200.00	Is this the first year of the current 5-year demonstration pe	riod under the 21st			200. 00
	Century Cures Act? Enter "Y" for yes or "N" for no.				
201 00	Cost Reimbursement	Mko+ D 1 D+ II lino			201 00
201.00	Medicare swing-bed SNF inpatient routine service costs (from )	wkst. D-1, Pt. II, IIne			201.00
202.00	66 (title XVIII hospital))  Medicare swing-bed SNF inpatient ancillary service costs (from	m Wks+ D 2 col 2 lir			202. 00
202.00	200 (title XVIII swing-bed SNF))	III WKSt. D-3, COI. 3, III	ie		202.00
3U3 UU	Total (sum of lines 201 and 202)				203. 00
	Medicare swing-bed SNF discharges (see instructions)				204.00
204.00	Computation of Demonstration Target Amount Limitation (N/A in	first year of the curre	nt 5-vear demons		204.00
	period)	Tribe your or the ourse	ort o year demons	tratron	
205.00	Medicare swing-bed SNF target amount				205. 00
	Medicare swing-bed SNF inpatient routine cost cap (line 205 t	imes line 204)			206. 00
	Adjustment to Medicare Part A Swing-Bed SNF Inpatient Reimburs	sement			1
207.00	Program reimbursement under the §410A Demonstration (see inst				207. 00
208.00	Medicare swing-bed SNF inpatient service costs (from Wkst. E-:	2, col. 1, sum of lines	1		208.00
	and 3)				
209.00	Adjustment to Medicare swing-bed SNF PPS payments (see instru	ctions)			209. 00
210.00	Reserved for future use				210. 00
	Comparision of PPS versus Cost Reimbursement				
215.00	Total adjustment to Medicare swing-bed SNF PPS payment (line 2	209 plus line 210) (see			215. 00
	instructions)				

Health Financial Systems	UNION HOSPITAL	CLINTON	In Lieu	of Form CMS-2552-10
CALCULATION OF REIMBURSEMENT SETTLEMENT -	SWING BEDS	Provi der CCN: 15-1326	Period: From 01/01/2017	Worksheet E-2
		Component CCN: 15-Z326		Date/Time Prepared: 5/30/2018 1:49 pm

		Component CCN: 15-2326	10 12/31/2017	5/30/2018 1:	
		Title XIX	Swing Beds - SNF		
			Part A	Part B	
			1. 00	2. 00	
	COMPUTATION OF NET COST OF COVERED SERVICES				
1.00	Inpatient routine services - swing bed-SNF (see instructions)		0		1.00
2.00	Inpatient routine services - swing bed-NF (see instructions)		0		2.00
3. 00	Ancillary services (from Wkst. D-3, col. 3, line 200, for Part		0		3.00
4 00	Part V, cols. 6 and 7, line 202, for Part B) (For CAH, see ins	•	0.00		4 00
4. 00	Per diem cost for interns and residents not in approved teachi instructions)	ng program (see	0.00		4.00
5. 00	Program days				5.00
6. 00	Interns and residents not in approved teaching program (see in	nstructions)			6.00
7. 00	Utilization review - physician compensation - SNF optional met				7.00
8. 00	Subtotal (sum of lines 1 through 3 plus lines 6 and 7)		o		8.00
9. 00	Primary payer payments (see instructions)		o		9.00
10.00	Subtotal (line 8 minus line 9)		0		10.00
11.00	Deductibles billed to program patients (exclude amounts applic	cable to physician	0		11.00
	professional services)	. ,			
12.00	Subtotal (line 10 minus line 11)		0		12.00
13.00	Coinsurance billed to program patients (from provider records)	) (exclude coinsurance	0		13.00
	for physician professional services)				
14. 00	80% of Part B costs (line 12 x 80%)		0		14. 00
	Subtotal (enter the lesser of line 12 minus line 13, or line 1	14)	0		15.00
16. 00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)		0		16.00
	Pioneer ACO demonstration payment adjustment (see instructions				16. 50
16. 55	Rural community hospital demonstration project (§410A Demonstr	ration) payment			16. 55
16. 99	adjustment (see instructions)				16. 99
	Demonstration payment adjustment amount before sequestration Allowable bad debts (see instructions)		0		17.00
	Adjusted reimbursable bad debts (see instructions)		0		17. 00
	Allowable bad debts for dual eligible beneficiaries (see instructions)	cuctions)	0		18.00
	Total (see instructions)	4011 0113)			19.00
	Sequestration adjustment (see instructions)		o		19. 01
	Demonstration payment adjustment amount after sequestration)		0		19. 02
20.00	Interim payments		0		20.00
21.00	Tentative settlement (for contractor use only)		0		21.00
22.00	Balance due provider/program (line 19 minus lines 19.01, 20, a	and 21)	0		22.00
23.00	Protested amounts (nonallowable cost report items) in accordan	nce with CMS Pub. 15-2,	0		23. 00
	chapter 1, §115.2				_
	Rural Community Hospital Demonstration Project (§410A Demonstr				
200.00	Is this the first year of the current 5-year demonstration per	riod under the 21st			200.00
	Century Cures Act? Enter "Y" for yes or "N" for no.				
201 00	Cost Reimbursement Medicare swing-bed SNF inpatient routine service costs (from V	Wkst D 1 Dt II line			201.00
201.00	66 (title XVIII hospital))	NKSt. D-1, Pt. 11, Title			201.00
202 00	Medicare swing-bed SNF inpatient ancillary service costs (from	m Wkst D_3 col 3 lin			202. 00
202.00	200 (title XVIII swing-bed SNF))	" WKSt. D 3, COI. 3, III			202.00
203.00	Total (sum of lines 201 and 202)				203. 00
	Medicare swing-bed SNF discharges (see instructions)				204.00
	Computation of Demonstration Target Amount Limitation (N/A in	first year of the curre	nt 5-year demons	tration	
	peri od)		•		
205.00	Medicare swing-bed SNF target amount				205. 00
206.00	Medicare swing-bed SNF inpatient routine cost cap (line 205 ti				206. 00
	Adjustment to Medicare Part A Swing-Bed SNF Inpatient Reimburs				
	Program reimbursement under the §410A Demonstration (see instr	*			207. 00
208.00	Medicare swing-bed SNF inpatient service costs (from Wkst. E-2	2, col. 1, sum of lines	1		208. 00
	and 3)				000.55
	Adjustment to Medicare swing-bed SNF PPS payments (see instruc	CTI ons)			209.00
210.00	Reserved for future use				210. 00
215 00	Comparision of PPS versus Cost Reimbursement Total adjustment to Medicare swing-bed SNF PPS payment (line 2	200 plus line 210) (			215 00
∠15. UU	instructions)	209 prus rine 210) (See			215. 00
	princti deti ons)		1 1		1

Health Financial Systems	UNION HOSPITAL CL	_I NTON		In Lieu	u of Form CMS-2	2552-10
CALCULATION OF REIMBURSEMENT SETTLEMENT	P	Provider CCN:	15-1326	From 01/01/2017	Worksheet E-3 Part V Date/Time Pre 5/30/2018 1:4	pared:
		Title X\	/111	Hospi tal	Cost	
					4 00	

		Title XVIII	Hospi tal	Cost	7 рііі
				1. 00	
	PART V - CALCULATION OF REIMBURSEMENT SETTLEMENT FOR MEDICARE	PART A SERVICES - COST	REI MBURSEMENT		
1.00	Inpatient services			3, 603, 867	1.00
2.00	Nursing and Allied Health Managed Care payment (see instructi	ons)		0	2.00
3.00	Organ acquisition	,		0	3.00
4.00	Subtotal (sum of lines 1 through 3)			3, 603, 867	4. 00
5.00	Primary payer payments			0	5.00
6.00	Total cost (line 4 less line 5). For CAH (see instructions)			3, 639, 906	6.00
	COMPUTATION OF LESSER OF COST OR CHARGES				
	Reasonabl e charges				
7.00	Routine service charges			0	7.00
8.00	Ancillary service charges			0	8.00
9.00	Organ acquisition charges, net of revenue			0	9. 00
10.00	Total reasonable charges			0	10.00
	Customary charges				
11. 00	Aggregate amount actually collected from patients liable for		J	0	
12.00	Amounts that would have been realized from patients liable fo	. 3	n a charge basis	0	12.00
	had such payment been made in accordance with 42 CFR 413.13(e	)			
13.00	Ratio of line 11 to line 12 (not to exceed 1.000000)			0. 000000	
14.00	Total customary charges (see instructions)		() (	0	
15. 00					15. 00
1/ 00	instructions)	l ! &   ! == / ====	- 14) (		1/ 00
16. 00	Excess of reasonable cost over customary charges (complete on instructions)	Ty IT Time 6 exceeds ITM	le 14) (See	0	16. 00
17. 00	Cost of physicians' services in a teaching hospital (see inst	ructions)		o	17. 00
17.00	COMPUTATION OF REIMBURSEMENT SETTLEMENT	r de tr ons)		0	17.00
18. 00	Direct graduate medical education payments (from Worksheet E-	4 line 49)		0	18. 00
19. 00	Cost of covered services (sum of lines 6, 17 and 18)	.,		3, 639, 906	
20.00	Deductibles (exclude professional component)			373, 660	
21. 00	Excess reasonable cost (from line 16)			0	
22. 00	Subtotal (line 19 minus line 20 and 21)			3, 266, 246	
23.00	Coinsurance			0	
24.00	Subtotal (line 22 minus line 23)			3, 266, 246	24.00
25.00	Allowable bad debts (exclude bad debts for professional servi	ces) (see instructions)		50, 653	25. 00
26.00	Adjusted reimbursable bad debts (see instructions)			32, 924	26.00
27.00	Allowable bad debts for dual eligible beneficiaries (see inst	ructi ons)		50, 653	27.00
28.00	Subtotal (sum of lines 24 and 25, or line 26)			3, 299, 170	28. 00
29.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)			0	29. 00
29. 50	Pioneer ACO demonstration payment adjustment (see instruction	s)		0	29. 50
29. 99	Demonstration payment adjustment amount before sequestration			0	
30.00				3, 299, 170	
30. 01				65, 983	
30. 02	Demonstration payment adjustment amount after sequestration			0	
31. 00	Interim payments			2, 570, 397	
32. 00				0	32.00
33.00				662, 790	
34.00	Protested amounts (nonallowable cost report items) in accorda	nce with CMS Pub. 15-2,	cnapter 1,	0	34.00
	§115. 2				

Health Financial Systems	UNION HOSPITAL CLINTON	In Lieu of Form CMS-2552-10
CALCULATION OF REIMBURSEMENT SETTLEMENT	Provi der CCN: 15-1326	Period: Worksheet E-3 From 01/01/2017 Part VII To 12/31/2017 Date/Time Prepared: 5/30/2018 1.49 pm

			o 12/31/2017	Date/lime Pre   5/30/2018 1:4			
		Title XIX	Hospi tal	Cost	<u> </u>		
			Inpatient	Outpati ent			
			1. 00	2. 00			
	PART VII - CALCULATION OF REIMBURSEMENT - ALL OTHER HEALTH SERV	ICES FOR TITLES V OR XI	X SERVICES				
	COMPUTATION OF NET COST OF COVERED SERVICES						
1.00	Inpatient hospital/SNF/NF services		60, 184		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)		60, 184	0	4.00		
5.00	Inpatient primary payer payments		o		5.00		
6.00	Outpatient primary payer payments			0	6.00		
7.00	Subtotal (line 4 less sum of lines 5 and 6)		60, 184	0	7. 00		
	COMPUTATION OF LESSER OF COST OR CHARGES						
	Reasonabl e Charges						
8.00	Routine service charges		36, 667		8. 00		
9.00	Ancillary service charges		86, 033	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)		122, 700	0	12.00		
	CUSTOMARY CHARGES						
13.00	Amount actually collected from patients liable for payment for	services on a charge	0	0	13.00		
	basi s						
14. 00	Amounts that would have been realized from patients liable for		0	0	14.00		
	a charge basis had such payment been made in accordance with 42 CFR §413.13(e)						
15.00				0. 000000			
16.00	Total customary charges (see instructions)	161146	122, 700 62, 516	0	16.00		
17. 00				0	17. 00		
10 00	line 4) (see instructions)	, if line 4 evecede line		0	10 00		
18. 00	Excess of reasonable cost over customary charges (complete only	rifiline 4 exceeds line	0	0	18. 00		
10 00	16) (see instructions)		0	0	19.00		
19. 00 20. 00	Interns and Residents (see instructions)	uctions)	0	0	20.00		
21. 00			60, 184	0	21.00		
21.00	Cost of covered services (enter the lesser of line 4 or line 16)  PROSPECTIVE PAYMENT AMOUNT - Lines 22 through 26 must only be completed for PPS provide		· · · · · · · · · · · · · · · · · · ·	0	21.00		
22 00	Other than outlier payments	ompreted for FF3 provid	0	0	22.00		
	Outlier payments			0	23.00		
24. 00			Ö	O	24.00		
	Capital exception payments (see instructions)				25. 00		
26. 00	Routine and Ancillary service other pass through costs		Ö	0	26.00		
	Subtotal (sum of lines 22 through 26)		o	0	27. 00		
28. 00	Customary charges (title V or XIX PPS covered services only)		o	0	28. 00		
	Titles V or XIX (sum of lines 21 and 27)		60, 184	0			
	COMPUTATION OF REIMBURSEMENT SETTLEMENT						
30.00	Excess of reasonable cost (from line 18)		0	0	30.00		
31.00			60, 184	0	31.00		
32.00			o	0	32.00		
33.00	Coinsurance		o	0	33.00		
34.00	Allowable bad debts (see instructions)		o	0	34.00		
35.00	, ,				35.00		
36.00	Subtotal (sum of lines 31, 34 and 35 minus sum of lines 32 and 33)			0	36.00		
37.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)		0	0	37.00		
38.00	Subtotal (line 36 ± line 37)			0	38. 00		
39. 00	Direct graduate medical education payments (from Wkst. E-4)				39. 00		
40.00	Total amount payable to the provider (sum of lines 38 and 39)			0	40.00		
41.00	Interim payments			0	41.00		
42.00	Balance due provider/program (line 40 minus line 41)	15, 737	0	42.00			
43.00	Protested amounts (nonallowable cost report items) in accordance	0	0	43.00			
	chapter 1, §115.2						

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: 15-1326

Peri od: From 01/01/2017 To 12/31/2017 Date/Time Prepared: 5/30/2018 1:49 pm

Pur pose Fund Fund	(y)				1270172017	5/30/2018 1: 4	9 pm
CURRENT ASSETS			General Fund			Plant Fund	
Cosh on hand in banks			1.00			4. 00	
Temporary Investments			,,,				
Notes receivable   0	1		-656	- 1	0	0	
Accounts receivable   2,416,162   0   0   0   0   0   0   0   0   0	1		) 	_	0	0	
Other receivable	1		2 416 162	١	0	0	
All owances for uncollectible notes and accounts receivable   0   0   0   0   0   0   0   0   0			2, 110, 102	0	0	0	
Prepaid Expenses	- 1		Ō	Ö	0	0	
Other current assets	- 1		315, 872	0	0	0	7.00
10.00   Due From other Funds			28, 875, 083	0	0	0	8.00
11.00   Total current assets (sum of lines 1-10)   31,606,461   0   0	- 1		0	0	0	0	
FIXED ASSETS			0		0	0	
12.00   Land improvements			31, 606, 461	] 0	0	0	11.00
13.00   Land Improvements			600 760		0	0	12.00
14.00   Accumulated depreciation   0   0   0   0   0   0   0   13,424,619   0   0   0   10.00   Accumulated depreciation   -12,908,997   0   0   0   0   0   0   0   0   0			009,760 1		_	0	
15.00   Buildings   13.424.619   0   0   0   17.00   Leasehold improvements   12.908.997   0   0   0   0   0   0   0   0   0		•	0	-	_	-	
16.00   Accumul ated depreciation   -12.908.97   0   0   0   18.00   Accumul ated depreciation   0   0   0   0   0   0   0   0   0			13, 424, 619	- 1	0	Ö	
18.00   Accumul ated depreciation   0   0   0   0   0   0   0   0   0					0	0	
19.00   Fixed equipment   0   0   0   0   0   0   0   0   0	.00 L	_easehold improvements	0	0	0	0	17.00
20.00   Accumulated depreciation   0   0   0   0   0   0   0   0   0	. 00 A	Accumulated depreciation	0	0	0	0	18.00
21.00		· ·	0	0	0	0	1
22.00   Accumul ated depreciation   0   0   0   0   0   0   0   0   0		•	0	0	0	0	
23.00 Major movable equipment 4.00 Accumulated depreciation 5.00 Minor equipment depreciable 6.839,092 0.00 O 5.00 Minor equipment depreciable 0.00 O 5.00 Minor equipment depreciable 0.00 O 5.00 Minor equipment despreciable 0.00 O 5.00 Minor equipment despreciable 0.00 O 5.00 O 5.00 Minor equipment despreciable 0.00 O 5.00 O 5.00 Minor equipment despreciable 0.00 O 5.00 O 5.00 Minor equipment-nondepreciable 0.00 O 5.00 Minor equipment-nondepreciable 0.00 O 5.00 Minor equipment-nondepreciable 0.00 O 5.00 O 5.00 Minor equipment-nondepreciable 0.00 O 5.00 Minor equipment-nondepreciable-nondepreciable-nondepreciable-nondepreciable-nondepreciable-nondepreciable-nondepreciable-nondepreciable-nondepreciable-non			0	-	0	0	
24.00 Accumulated depreciation		•	6 920 002	-	0	0	
25.00   Minor equipment depreciable   0   0   0   0   0   0   0   0   0			0, 039, 092 0	1	0	0	
26. 00 Accumul ated depreciation	- 1	·	0		0	0	
17.00   HIT designated Assets   0   0   0   0   0   0   0   0   0		Accumulated depreciation	0	0	0	0	
28. 00   Accumula fed depreciation   0   0   0   0   0   0   0   0   0			Ō	Ö	0	0	
Total fixed assets (sum of lines 12-29)   7,964,474   0   0   0   OTHER ASSETS			0	0	0	0	28.00
OTHER ASSETS   Investments   0   0   0   0   0   0   0   0   0	. 00 N	Mi nor equi pment-nondepreci abl e	0	0	0	0	29.00
31.00   Investments   0   0   0   0   0   0   0   0   0			7, 964, 474	0	0	0	30.00
32.00   Deposits on leases   0   0   0   0   0   0   0   0   0							
33.00   Due from owners/officers   0   0   0   0   34.00   Other assets   Sum of lines 31-34   0   0   0   0   0   0   0   0   0	- 1		0		0	0	
34,00   Other assets   0   0   0   0   0   0   0   0   0			0	0	0	0	
35.00   Total other assets (sum of lines 31-34)   0   0   0   0   0   0   0   0   0	- 1		0	0	0	0	
Total assets (sum of lines 11, 30, and 35)   39,570,935   0   0			Ö	Ö	0	0	
37. 00   Accounts payable   700, 209   0   0   0   38. 00   Sal aries, wages, and fees payable   1,082,055   0   0   0   0   0   0   0   0   0	. 00 T	Total assets (sum of lines 11, 30, and 35)	39, 570, 935	0	0	0	36.00
38. 00   Salaries, wages, and fees payable   1,082,055   0   0   0   0   0   0   0   0   0							
39.00   Payrol   taxes payable   0   0   0   0   0   0   0   0   0					_		1
40.00 Notes and Loans payable (short term) 0 0 0 0 0 0 0 0 0 1 0 0 0 0 0 0 0 0 0			1, 082, 055		0	0	
41.00   Deferred income   0			0	0	0	0	1
42.00   Accelerated payments   0   0   0   0   0   0   0   0   0			0	0	0	0	
43.00 Due to other funds  44.00 Other current liabilities  Total current liabilities (sum of lines 37 thru 44)  45.00 LONG TERM LIABILITIES  46.00 Mortgage payable  Notes payable  Unsecured loans  One of the long term liabilities (sum of lines 46 thru 49)  Total liabilities (sum of lines 45 and 50)  Total liabilities (sum of lines 46 thru 49)  Total liabilities (sum of lines 45 and 50)  Total liabilities (sum of lines 46 thru 49)  Total liabilities (sum of lines 45 and 50)  Total liabilities (sum of lines 46 thru 49)  Total liabilities (sum of lines 46 thru 49)  Total liabilities (sum of lines 45 and 50)  Total liabilities (sum of lines 46 thru 49)  Total liabilities (sum of lines 46 thru 49)  Total liabilities (sum of lines 45 and 50)  Total liabilities (sum of lines 46 thru 49)  Total liabilities (sum of lines 45 and 50)  Total liabilities (sum of lines 46 thru 49)  Total liabilities (sum of lines 45 and 50)  Total liabilities (sum of lines 46 thru 49)  Total liabilities (sum of lines 45 and 50)  Total liabilities (s	- 1		0	U	U	0	42.00
44.00 Other current liabilities	- 1	. 3	0	0	0	0	1
LONG TERM LIABILITIES			-315, 344	Ö	0	0	
46.00   Mortgage payable   0   0   0   0   0   0   0   0   0	. 00 T	Total current liabilities (sum of lines 37 thru 44)	1, 466, 920	0	0	0	45.00
47.00 Notes payable 0 0 0 0 0 48.00 Unsecured Loans 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	L	ONG TERM LIABILITIES					
48.00 Unsecured Loans		9 9 1 9	0	0	-	0	
49.00 Other long term liabilities 50.00 Total long term liabilities (sum of lines 46 thru 49) 51.00 Total liabilities (sum of lines 45 and 50)  CAPITAL ACCOUNTS  52.00 General fund balance 53.00 Specific purpose fund 54.00 Donor created - endowment fund balance - restricted 55.00 Donor created - endowment fund balance - unrestricted 60 Governing body created - endowment fund balance 57.00 Plant fund balance - invested in plant Plant fund balance - reserve for plant improvement, replacement, and expansion			0		-		
50.00 Total long term liabilities (sum of lines 46 thru 49) 2, 269, 548 0 0 0 CAPITAL ACCOUNTS  52.00 General fund balance 53.00 Specific purpose fund 54.00 Donor created - endowment fund balance - restricted 55.00 Governing body created - endowment fund balance 57.00 Plant fund balance - invested in plant 58.00 Plant fund balance - reserve for plant improvement, replacement, and expansion	- 1		0	-		0	
51.00 Total liabilities (sum of lines 45 and 50)  CAPITAL ACCOUNTS  52.00 General fund balance  Specific purpose fund  54.00 Donor created - endowment fund balance - restricted  55.00 Donor created - endowment fund balance - unrestricted  Governing body created - endowment fund balance  75.00 Plant fund balance - invested in plant  Plant fund balance - reserve for plant improvement, replacement, and expansion	- 1	9			_	0	1
CAPITAL ACCOUNTS  52.00 General fund balance 53.00 Specific purpose fund 54.00 Donor created - endowment fund balance - restricted 55.00 Donor created - endowment fund balance - unrestricted 56.00 Governing body created - endowment fund balance 57.00 Plant fund balance - invested in plant 58.00 Plant fund balance - reserve for plant improvement, replacement, and expansion	- 1	· · · · · · · · · · · · · · · · · · ·			-	-	
52.00 General fund balance  53.00 Specific purpose fund  54.00 Donor created - endowment fund balance - restricted  55.00 Donor created - endowment fund balance - unrestricted  56.00 Governing body created - endowment fund balance  57.00 Plant fund balance - invested in plant  58.00 Plant fund balance - reserve for plant improvement, replacement, and expansion			3, 730, 400	0	<u> </u>	0	31.00
53.00 Specific purpose fund 54.00 Donor created - endowment fund balance - restricted 55.00 Donor created - endowment fund balance - unrestricted 66.00 Governing body created - endowment fund balance 77.00 Plant fund balance - invested in plant 78.00 Plant fund balance - reserve for plant improvement, replacement, and expansion			35, 834, 467				52.00
55.00 Donor created - endowment fund balance - unrestricted 60 Governing body created - endowment fund balance 75.00 Plant fund balance - invested in plant 758.00 Plant fund balance - reserve for plant improvement, replacement, and expansion	- 1					•	53.00
56.00 Governing body created - endowment fund balance 57.00 Plant fund balance - invested in plant 58.00 Plant fund balance - reserve for plant improvement, replacement, and expansion	. 00 D	Donor created - endowment fund balance - restricted			0		54.00
57.00 Plant fund balance - invested in plant 58.00 Plant fund balance - reserve for plant improvement, replacement, and expansion	. 00 D	Donor created - endowment fund balance - unrestricted			0		55.00
58.00 Plant fund balance - reserve for plant improvement, replacement, and expansion	- 1	0 3			0		56.00
repl acement, and expansi on		•				0	
						0	58.00
			25 024 447		0	0	59.00
60.00 Total liabilities and fund balances (sum of lines 51 and 39,570,935)					0	0	
59)			07, 370, 733		J		55.00

Health Financial Systems
STATEMENT OF CHANGES IN FUND BALANCES UNION HOSPITAL CLINTON In Lieu of Form CMS-2552-10

Period: Worksheet G-1 From 01/01/2017 Provider CCN: 15-1326

					To 12/31/2017	Date/Time Pre 5/30/2018 1:4	
		General	Fund	Special F	Purpose Fund	Endowment Fund	
		1. 00	2. 00	3.00	4. 00	5. 00	
1. 00 2. 00 3. 00 4. 00 5. 00 6. 00 7. 00 8. 00	Fund balances at beginning of period Net income (loss) (from Wkst. G-3, line 29) Total (sum of line 1 and line 2) Additions (credit adjustments) (specify)	0 0 0	35, 385, 203 449, 264 35, 834, 467		0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	0 0 0 0	1. 00 2. 00 3. 00 4. 00 5. 00 6. 00 7. 00 8. 00
9. 00 10. 00 11. 00 12. 00 13. 00 14. 00 15. 00 16. 00 17. 00 18. 00	Total additions (sum of line 4-9) Subtotal (line 3 plus line 10) Deductions (debit adjustments) (specify)  Total deductions (sum of lines 12-17) Fund balance at end of period per balance sheet (line 11 minus line 18)	0 0 0 0 0	0 35, 834, 467 0 35, 834, 467		0 0 0 0 0 0 0 0	0 0 0 0 0	9. 00 10. 00 11. 00 12. 00 13. 00 14. 00 15. 00 16. 00 17. 00 18. 00 19. 00
		Endowment Fund	PI ant	Fund			
		6. 00	7. 00	8. 00			
1. 00 2. 00 3. 00 4. 00 5. 00 6. 00 7. 00 8. 00 9. 00	Fund balances at beginning of period Net income (loss) (from Wkst. G-3, line 29) Total (sum of line 1 and line 2) Additions (credit adjustments) (specify)	0	0 0 0 0		0		1. 00 2. 00 3. 00 4. 00 5. 00 6. 00 7. 00 8. 00 9. 00
10. 00 11. 00 12. 00 13. 00 14. 00 15. 00 16. 00 17. 00 18. 00	Total additions (sum of line 4-9) Subtotal (line 3 plus line 10) Deductions (debit adjustments) (specify)  Total deductions (sum of lines 12-17)	0 0	0 0 0 0 0		0		10.00 11.00 12.00 13.00 14.00 15.00 16.00 17.00
19. 00	Fund balance at end of period per balance sheet (line 11 minus line 18)	o			0		19. 00

| 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 Provi der CCN: 15-1326

Cost Center Description
PART I - PATIENT REVENUES   Ceneral Inpatient Routine Services
PART I - PATIENT REVENUES   General Inpati ent Routine Services   1.00   Hospital   2,776,229   2,776,229   2,776,229   2.00   1.00   2.00   1.00   2.00
1.00
2 00 SUBPROVIDER - IPF 3.00 3.00 SUBPROVIDER - IRF 4.00 5.00 3.00 SUBPROVIDER 5.00 SWing bed - SNF 6.00 SWing bed - SNF 7.00 9.00 9.00 9.00 9.00 9.00 9.00 9.00
3.00 SUBPROVIDER - IRF 4.00 SUBPROVIDER 5.00 Swing bed - SNF 6.00 Swing bed - SNF 7.00 SKILLED NURSING FACILITY 8.00 NURSING FACILITY 9.00 Total general inpatient care services (sum of lines 1-9) 2,776,229 2,776,229 10.00  Intensive Care Type Inpatient Hospital Services 11.00 NITENSIVE CARE UNIT 916,600 916,600 11.00  INTENSIVE CARE UNIT 916,600 916,600 11.00  INTENSIVE CARE UNIT 1 916,600 916,600 15.00  INTENSIVE CARE UNIT 1 916,600 0 916,600 15.00  IN
4.00 SUBPROVIDER Swing bed - SNF 0 0 SWing bed - SNF 0 0 SKILLED NURSING FACILITY 9.00 OTHER LONG TERM CARE 1.00 OTHER SPECIAL CARE UNIT 1.00 OTHER SPECIAL CARE (SPECIFY) 1.00 OTHER SPECIAL CARE UNIT 1.0 OTHER SPECIAL CARE UNIT 1.0 OTHER SPECIAL CARE (SPECIFY) 1.00 OTHER SPECIAL CARE UNIT 1.0 OTHER SPECIAL CARE (SPECIFY) 1.00 OTHER SPECIAL CARE (SPECIFY) 1.00 OTHER SPECIAL CARE UNIT 1.0 OTHER SPECIAL CAR
5. 00   Swing bed - SNF   0   0   0   0   0   0   0   0   0
5. 00   Swing bed - SNF   0   0   0   5. 00
6. 00
7. 00   SKILLED NURSING FACILITY
8.00   NURSING FACILITY   Superior   Super
9.00   OTHER LONG TERM CARE   Total general inpatient care services (sum of lines 1-9)   2, 776, 229   2, 776, 229   10.00
10.00   Total general inpatient care services (sum of lines 1-9)   2,776,229   2,776,229   10.00
Intensive Care Type Inpatient Hospital Services
11.00   INTENSIVE CARE UNIT   916,600   916,600   12.00   12
12.00 CORONARY CARE UNIT 13.00 BURN INTENSIVE CARE UNIT 14.00 SURGICAL INTENSIVE CARE UNIT 15.00 Total intensive care type inpatient hospital services (sum of lines 916,600 15.00 16.00 17.11.15) 17.00 Total inpatient routine care services (sum of lines 10 and 16) 3, 692, 829 42, 079, 885 47, 813, 890 18.00 40.00 EDEPHRATION OF SERVICES (SUM OF LINES 10 And 16) 5, 733, 695 42, 079, 885 47, 813, 890 18.00 19.00 Uniquatient services (SUM OF LINES 10 And 16) 5, 733, 695 42, 079, 885 47, 813, 890 18.00 19.00 Uniquatient services (SUM OF LINES 10 And 16) 5, 733, 695 42, 079, 885 47, 813, 890 18.00 19.00 Uniquatient services (SUM OF LINES 10 AND LINES 10
13. 00 BURN INTENSIVE CARE UNIT 14. 00 SURGICAL INTENSIVE CARE UNIT 15. 00 OTHER SPECIAL CARE (SPECIFY) 16. 00 Total intensive care type inpatient hospital services (sum of lines 11-15) 17. 00 Total inpatient routine care services (sum of lines 10 and 16) 18. 00 Ancillary services 19. 00 Ancillary services 19. 00 Qutpatient services 20. 00 HOME HEALTH CLINIC 21. 00 FEDERALLY QUALIFIED HEALTH CENTER 22. 00 Qutpatient services 23. 00 AMBULANCE SERVICES 24. 00 QUTPATIENT SURGICAL CENTER (D.P.) 25. 00 AMBULANCE SERVICES 26. 00 QUTPATIENT SURGICAL CENTER (D.P.) 27. 00 PRO FEES 27. 00 PRO FEES 28. 00 Total patient revenues (sum of lines 17-27) (transfer column 3 to Wkst. 10, 007, 221 62, 284, 412 72, 291, 633 28. 00 QUTPATIENT SURGICAL S
14.00   SURGICAL INTENSIVE CARE UNIT   14.00   15.00   OTHER SPECIAL CARE (SPECIFY)   16.00   Total intensive care type inpatient hospital services (sum of lines   916,600   11-15)   16.00   11-15)   17.00   Total inpatient routine care services (sum of lines   10 and   16)   3,692,829   3,692,829   17.00   18.00   19.00   0 utpatient services   57.33,695   42,079,885   47,813,580   18.00   0 utpatient services   580,697   20,061,847   20,642,544   19.00   20.00   21.00   RURAL HEALTH CLINIC   0   0   0   0   0   0   0   0   0
15. 00 OTHER SPECIAL CARE (SPECIFY) 16. 00 Total intensive care type inpatient hospital services (sum of lines 11-15) 17. 00 Total inpatient routine care 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
16.00 Total intensive care type inpatient hospital services (sum of lines 11-15) 17.00 Total inpatient routine care services (sum of lines 10 and 16) 18.00 Ancillary services 18.00 Ancillary services 19.00 Outpatient services
11-15) Total inpatient routine care services (sum of lines 10 and 16) 3, 692, 829 18. 00 Ancillary services 19. 00 Outpatient services 80, 697 20. 00 RURAL HEALTH CLINIC 0 O O O O O O O O O O O O O O O O O O O
17. 00 Total inpatient routine care services (sum of lines 10 and 16) 3, 692, 829 17. 00 18. 00 Ancillary services 0 Outpatient services 19. 00 Quipatient services 19. 00 RURAL HEALTH CLINIC 19. 00 FEDERALLY QUALIFIED HEALTH CENTER 19. 00 Quipatient SERVICES 20. 00 HOME HEALTH AGENCY 23. 00 AMBULANCE SERVICES 24. 00 CMHC 25. 00 AMBULATORY SURGICAL CENTER (D. P.) 26. 00 PRO FEES 27. 00 PRO FEES 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 30. 00 3
18. 00
19. 00
20. 00 RURÂL HEALTH CLINIC 0 0 0 0 0 20. 00 21. 00 FEDERALLY QUALIFIED HEALTH CENTER 0 0 0 21. 00 22. 00 HOME HEALTH AGENCY 22. 00 23. 00 AMBULANCE SERVICES 23. 00 24. 00 CMHC 25. 00 AMBULATORY SURGICAL CENTER (D. P.) 25. 00 26. 00 HOSPICE 0 142, 680 142, 680 27. 00 28. 00 Total patient revenues (sum of lines 17-27)(transfer column 3 to Wkst. 10, 007, 221 62, 284, 412 72, 291, 633 28. 00  29. 00 Operating expenses (per Wkst. A, column 3, line 200)  20. 00 31. 00 32. 00 0 0 33. 00 32. 00 0 0 0 33. 00 32. 00 0 0 0 0 33. 00 33. 00 32. 00
21. 00 FEDERALLY QUALIFIED HEALTH CENTER 0 0 0 0 21. 00 22. 00 23. 00 HOME HEALTH AGENCY 23. 00 AMBULANCE SERVICES 23. 00 CMHC 25. 00 AMBULATORY SURGICAL CENTER (D. P.) 26. 00 HOSPICE 27. 00 PRO FEES 0 142, 680 142, 680 27. 00 28. 00 Total patient revenues (sum of lines 17-27)(transfer column 3 to Wkst. 10, 007, 221 62, 284, 412 72, 291, 633 28. 00 G-3, line 1)  PART II - OPERATING EXPENSES 29. 00 ADD (SPECIFY) 0 30. 00 31. 00 32. 00 0 32. 00 0 0 33. 00 32. 00 0 32. 00 0 0 33. 00 32. 00 0 0 33. 00 33.
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 0 142,680 142,680 22.00 28.00 Total patient revenues (sum of lines 17-27)(transfer column 3 to Wkst. 10,007,221 62,284,412 72,291,633 28.00  29.00 Operating expenses (per Wkst. A, column 3, line 200) 30.00 ADD (SPECIFY) 0 30.00 31.00 32.00
23. 00
24.00   CMHC   25.00   AMBULATORY SURGICAL CENTER (D.P.)   25.00   26.00   26.00   26.00   27.00   27.00   28.00   27.00   27.00   28.00   27.00   28.
25. 00 AMBULATORY SURGICAL CENTER (D.P.) 26. 00 HOSPICE 27. 00 PRO FEES 0 142, 680 142, 680 27. 00 28. 00 Total patient revenues (sum of lines 17-27)(transfer column 3 to Wkst. 10,007,221 62,284,412 72,291,633 28. 00  PART II - OPERATING EXPENSES  Operating expenses (per Wkst. A, column 3, line 200) 30. 00 ADD (SPECIFY)  Operating expenses (per Wkst. A, column 3, line 200) 31. 00 32. 00  25. 00 26. 00 27. 00 28. 00 37. 00 37. 00 38. 00 31. 00 32. 00
26. 00 HOSPICE PRO FEES 0 142, 680 27. 00 28. 00 Total patient revenues (sum of lines 17-27)(transfer column 3 to Wkst. 10, 007, 221 62, 284, 412 72, 291, 633 28. 00  PART II - OPERATING EXPENSES 0 29. 00 30. 00 ADD (SPECIFY) 0 30. 00 31. 00 32. 00 32. 00
27. 00 PRO FEES 28. 00 Total patient revenues (sum of lines 17-27)(transfer column 3 to Wkst.   10,007,221   62,284,412   72,291,633   28. 00    PART II - OPERATING EXPENSES  29. 00 Operating expenses (per Wkst. A, column 3, line 200)   20,257,906   30. 00   31. 00   32. 00   0   32. 00   0   32. 00
28.00 Total patient revenues (sum of lines 17-27)(transfer column 3 to Wkst. 10,007,221 62,284,412 72,291,633 28.00 G-3, line 1)  PART II - OPERATING EXPENSES  Operating expenses (per Wkst. A, column 3, line 200) 20,257,906 30.00 31.00 32.00 0 0 32.00
G-3, line 1) PART II - OPERATING EXPENSES  29. 00 Operating expenses (per Wkst. A, column 3, line 200) 30. 00 ADD (SPECIFY)  0 30. 00 31. 00 32. 00
PART II - OPERATING EXPENSES  29.00 Operating expenses (per Wkst. A, column 3, line 200)
29. 00 Operating expenses (per Wkst. A, column 3, line 200) 20, 257, 906 29. 00 30. 00 31. 00 32. 00 20. 00 31. 00 32. 00 32. 00 33. 00 33. 00 33. 00 33. 00 33. 00 33. 00 33. 00
30. 00   ADD (SPECIFY)
31. 00 32. 00 31. 00 32. 00
32.00
33.00
551.55
36.00   Total additions (sum of lines 30-35)
37.00   DEDUCT (SPECIFI)
39. 00   0   39. 00   40. 00   40. 00
43.00 Total operating expenses (sum of lines 29 and 36 minus line 42)(transfer 20, 257, 906 43.00
to Wkst. G-3, line 4)

	<u> </u>	UNION HOSPITAL			u of Form CMS-2	
STATEMENT OF REVENUES AND EXPENSES Provider CCN: 15-13			Provi der CCN: 15-1326	Peri od:	Worksheet G-3	
	From 01/01/2017 To 12/31/2017					
					1. 00	
1.00	Total patient revenues (from Wkst. G-2, Part I				72, 291, 633	
2.00	Less contractual allowances and discounts on p	atients' accoun	ts		49, 917, 258	
3.00	Net patient revenues (line 1 minus line 2)	5	10)		22, 374, 375	
4.00	Less total operating expenses (from Wkst. G-2,	·	43)		20, 257, 906	
5. 00	Net income from service to patients (line 3 mi	nus line 4)			2, 116, 469	5.00
6. 00	OTHER INCOME				0	4 00
7. 00	Contributions, donations, bequests, etc Income from investments				0	
8. 00	Revenues from telephone and other miscellaneous	c communication	coryl coc		0	1
9. 00	Revenue from television and radio service	S Communication	ser vi ces		0	
10.00	Purchase di scounts				0	
	Rebates and refunds of expenses				0	
	Parking lot receipts				0	
	Revenue from Laundry and Linen service				0	
	Revenue from meals sold to employees and guest	c			0	
	Revenue from rental of living quarters	3			0	
	Revenue from sale of medical and surgical supp	lies to other t	han nationts		0	
	Revenue from sale of drugs to other than patie		nan patrents			17.00
	Revenue from sale of medical records and abstra				0	
	Tuition (fees, sale of textbooks, uniforms, et				0	
	Revenue from gifts, flowers, coffee shops, and				0	
21.00	Rental of vending machines	Carreceri			0	
22. 00	Rental of hospital space				0	
	Governmental appropriations				0	1
	OTHER REVENUE				400, 773	
24. 01	NON OPERATING					24. 01
	INTEREST INCOME				3, 006	
25. 00	Total other income (sum of lines 6-24)				408, 779	
	Total (line 5 plus line 25)				2, 525, 248	
	ALLOCATED EXPENSES				2, 075, 984	
	Total other expenses (sum of line 27 and subsc	ripts)			2, 075, 984	
	Net income (or loss) for the period (line 26 m	' '			449, 264	