PART II - CERTIFICATION

(3) Settled with Audit

(4) Reopened (5) Amended

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

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

I HEREBY CERTIFY that I have read the above certification statement and that I have examined the accompanying electronically filed or manually submitted cost report and the Balance Sheet and Statement of Revenue and Expenses prepared by UNION HOSPITAL, INC. (15-0023) for the cost reporting period beginning 01/01/2018 and ending 12/31/2018 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		

number of times reopened = 0-9.

			Title	XVIII			
Cost Center Description		Title V	Part A	Part B	HI T	Title XIX	
	<u> </u>	1. 00	2.00	3. 00	4. 00	5. 00	
	PART III - SETTLEMENT SUMMARY						
1.00	Hospi tal	0	563, 518	835, 933	0	-1, 223, 036	1.00
2.00	Subprovi der - IPF	0	0	0		0	2.00
3.00	Subprovi der - I RF	0	19, 920	-3		0	3.00
5.00	Swing bed - SNF	0	0	0		0	5.00
6.00	Swing bed - NF	0				0	6.00
200.00	Total	0	583, 438	835, 930	0	-1, 223, 036	200.00

Date

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

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

Health Financial Systems UNION HOSPITAL, INC. In Lieu of Form CMS-2552-10 HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA Provider CCN: 15-0023 Peri od: Worksheet S-2 From 01/01/2018 Part I Date/Time Prepared: 12/31/2018 5/29/2019 1:11 pm 3.00 4.00 Hospital and Hospital Health Care Complex Address: Street: 1606 NORTH SEVENTH ST 1.00 PO Box: 1.00 Ci ty: TERRE HAUTE State: IN 2.00 Zip Code: 47804-County: VIGO 2.00 Component Name CCN CBSA Provi der Date Payment System (P, T, 0, or N) Certi fi ed Number Number Type XVIII XIX 1.00 2.00 3.00 4.00 5.00 6.00 | 7.00 | 8.00 Hospital and Hospital-Based Component Identification: 3.00 Hospi tal UNION HOSPITAL, INC. 150023 45460 01/01/1966 Ν Р 0 3.00 1 Subprovi der - IPF 4.00 4.00 Subprovi der - IRF 5.00 MEDICAL REHAB 15T023 45460 5 09/01/1989 N Ρ 0 5.00 Subprovi der - (Other) 6.00 6.00 Swing Beds - SNF 7.00 7.00 Swing Beds - NF 8.00 8.00 9.00 Hospital -Based SNF 9.00 10.00 Hospi tal -Based NF 10.00 Hospi tal -Based OLTC 11 00 11 00 12.00 Hospital -Based HHA 12.00 13.00 Separately Certified ASC 13.00 14.00 Hospi tal -Based Hospi ce 14.00 15.00 Hospital -Based Health Clinic - RHC 15.00 16.00 Hospital-Based Health Clinic - FQHC 16.00 17.00 Hospital -Based (CMHC) I 17.00 18.00 Renal Dialysis 18 00 19.00 Other 19.00 From To: 1.00 2.00 12/31/2018 20.00 Cost Reporting Period (mm/dd/yyyy) 01/01/2018 20 00 21.00 Type of Control (see instructions) 21.00 2 1.00 2. 00 3. 00 Inpatient PPS Information Does this facility qualify and is it currently receiving payments for Υ Ν 22.00 disproportionate share hospital adjustment, in accordance with 42 CFR \$412.106? In column 1, enter "Y" for yes or "N" for no. Is this facility subject to 42 CFR Section §412.106(c)(2)(Pickle amendment hospital?) In column 2, enter "Y" for yes or "N" for no. Did this hospital receive interim uncompensated care payments for this Ν Ν 22.01 cost reporting period? Enter in column 1, "Y" for yes or "N" for no for the portion of the cost reporting period occurring prior to October 1. Enter in column 2, "Y" for yes or "N" for no for the portion of the cost reporting period occurring on or after October 1. (see instructions) 22.02 Is this a newly merged hospital that requires final uncompensated care Ν Ν 22.02 payments to be determined at cost report settlement? (see instructions) Enter in column 1, "Y" for yes or "N" for no, for the portion of the cost reporting period prior to October 1. Enter in column 2, "Y" for yes or "N" for no, for the portion of the cost reporting period on or after October 1. 22.03 Did this hospital receive a geographic reclassification from urban to Ν Ν N 22 03 rural as a result of the OMB standards for delineating statistical areas adopted by CMS in FY2015? Enter in column 1, "Y" for yes or "N" for no for the portion of the cost reporting period prior to October 1. Enter in column 2, "Y" for yes or "N" for no for the portion of the cost reporting period occurring on or after October 1. (see instructions) Does this hospital contain at least 100 but not more than 499 beds (as counted in accordance with 42 CFR 412.105)? Enter in column 3, "Y" for yes or "N" for no.
23.00 Which method is used to determine Medicaid days on lines 24 and/or 25 23 00 N below? In column 1, enter 1 if date of admission, 2 if census days, or 3 if date of discharge. Is the method of identifying the days in this cost reporting period different from the method used in the prior cost reporting period? In column 2, enter "Y" for yes or "N" for no. In-State Out-of 0ther In-State Out-of Medi cai d Medi cai d Medi cai d State State HMO days Medi cai d eligible Medi cai d Medi cai d paid days days unpai d paid days el i gi bl e unpai d days 1.00 3. 00 4. 00 5.00 6.00 2.00 24.00 If this provider is an IPPS hospital, enter the 854 7, 747 1, 031 360 3, 434 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.

ealth Financial Systems UNION IOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DA	HOSPI TAL,	INC. Provider CC	N: 15-0023	Period: From 01/			orm CMS-: heet S-2	
						Date/	Time Pre	
	In-State	In-State	Out-of	Out-of	Medi ca		<u>2019 1:1</u> Other	1 pm
	Medi cai d	Medi cai d	State	State	HMO da	ys Me	edi cai d	
	pai d days	eligible unpaid	Medicaid paid days	Medicaid eligible			days	
		days	paru uays	unpai d				
	1. 00	2. 00	3. 00	4. 00	5. 00		6. 00	
25.00 If this provider is an IRF, enter the in-state	0	311	21	34	1	149		25.0
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.				IIrhan/	 'Rural S	Date	of Geogr	
					. 00		. 00	
6.00 Enter your standard geographic classification (not wa		at the be	ginning of	the	1			26.0
cost reporting period. Enter "1" for urban or "2" for 7.00 Enter your standard geographic classification (not wa		s at the en	d of the co	st	1			27.0
reporting period. Enter in column 1, "1" for urban or					'			27.0
enter the effective date of the geographic reclassifi								
5.00 If this is a sole community hospital (SCH), enter the effect in the cost reporting period.	number of	f periods S	CH status i	n	0			35.0
critect in the cost reporting period.				Begi r	nni ng:	End	di ng:	
					. 00	2.	. 00	
6.00 Enter applicable beginning and ending dates of SCH st of periods in excess of one and enter subsequent date		script line	36 for num	ber				36.0
7.00 If this is a Medicare dependent hospital (MDH), enter		er of perio	ds MDH stat	us	O			37.0
is in effect in the cost reporting period.		·			-			
7.01 Is this hospital a former MDH that is eligible for th								37.0
accordance with FY 2016 OPPS final rule? Enter "Y" fo instructions)	r yes or	N FOR NO.	(see					
8.00 If line 37 is 1, enter the beginning and ending dates	of MDH st	tatus. If li	ine 37 is					38.0
greater than 1, subscript this line for the number of	periods i	n excess o	f one and					
enter subsequent dates.					′/N	V	//N	
					. 00		. 00	
9.00 Does this facility qualify for the inpatient hospital					N		N	39.0
hospitals in accordance with 42 CFR §412.101(b)(2)(i) 1 "Y" for yes or "N" for no. Does the facility meet t				mn				
accordance with 42 CFR 412.101(b)(2)(i), (ii), or (ii	i)? Enter	in column :	ılıs III 2 "Y" for v	es				
or "N" for no. (see instructions)								
0.00 Is this hospital subject to the HAC program reduction "N" for no in column 1, for discharges prior to Octob					N		N	40.0
no in column 2, for discharges on or after October 1.			yes or in	101				
	`	•		•	V	XVII		
Prospective Payment System (PPS)-Capital					1. 00	2.00	3.00	
5.00 Does this facility qualify and receive Capital paymen	t for disp	proporti ona	te share in	accordanc	ce N	Y	N	45.0
with 42 CFR Section §412.320? (see instructions)		·						1 40.6
6.00 Is this facility eligible for additional payment exce pursuant to 42 CFR §412.348(f)? If yes, complete Wkst								
	I D+ I				N	N	N	
IPT. TII.	. L, Pt. I				I	N	N	
Pt. III. 7.00 s this a new hospital under 42 CFR §412.300(b) PPS c	•	II and Wks	t. L-1, Pt.	I through	I	N N	N	46.0
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7.00 Is this a new hospital under 42 CFR §412.300(b) PPS c 8.00 Is the facility electing full federal capital payment Teaching Hospitals 6.00 Is this a hospital involved in training residents in or "N" for no. 7.00 If line 56 is yes, is this the first cost reporting p GME programs trained at this facility? Enter "Y" for is "Y" did residents start training in the first mont for yes or "N" for no in column 2. If column 2 is "Y "N", complete Wkst. D, Parts III & IV and D-2, Pt. II 8.00 If line 56 is yes, did this facility elect cost reimb defined in CMS Pub. 15-1, chapter 21, §2148? If yes, 9.00 Are costs claimed on line 100 of Worksheet A? If yes 0.00 Are you claiming nursing and allied health education any programs that meet the criteria under §413.85? (apital? E ? Enter " approved (eriod duri yes or "N h of this ", complet i, if appli ursement f complete W , complete (NAHE) cossee instru	II and Wks Enter "Y for Y" for yes GME programs ng which re " for no in cost report te Workshee cable. For physicia Wkst. D-5. E Wkst. D-2	t. L-1, Pt. r yes or "N or "N" for s? Enter " esidents in n column 1. ting period t E-4. If c ans' servic , Pt. I. NAHE 413.8 Y/N	I through "for no. no. Y" for yes approved If column? Enter " olumn 2 is es as Works Lin	N N N N N N N N N N N N N N N N N N N	Pass-Qualif Crit	N N Through Fication erion	46. C 47. C 48. C 56. C 57. C
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Is this a new hospital under 42 CFR §412.300(b) PPS classes the facility electing full federal capital payment Teaching Hospitals Is this a hospital involved in training residents in or "N" for no. If line 56 is yes, is this the first cost reporting p GME programs trained at this facility? Enter "Y" for is "Y" did residents start training in the first mont for yes or "N" for no in column 2. If column 2 is "Y" "N", complete Wkst. D, Parts III & IV and D-2, Pt. II If line 56 is yes, did this facility elect cost reimb defined in CMS Pub. 15-1, chapter 21, §2148? If yes, 19.00 Are costs claimed on line 100 of Worksheet A? If yes on the costs claimed on line 100 of Worksheet A? If yes instructions) If line 60 is yes, complete columns 2 and 3 for each instructions) If line 60 is yes, complete columns 2 and 3 for each instructions)	apital? E ? Enter " approved (eriod duri yes or "N h of this ", complete , if appli ursement f complete W , complete (NAHE) cos	Enter "Y for Yes Enter "Y for Yes Enter "Y for Yes EME programmed of the Programmed	t. L-1, Pt. r yes or "N or "N" for s? Enter " esidents in n column 1. ting period t E-4. If c ans' servic , Pt. I. NAHE 413.8 Y/N	I through "for no. no. Y" for yes approved If column? Enter " olumn 2 is es as Works Lin	N N N N N N N N N N N N N N N N N N N	Pass-Toualif Crit Cc	Through Fication ode	46. 0 47. 0 48. 0 56. 0 57. 0 58. 0 59. 0
1.7.00 Is this a new hospital under 42 CFR §412.300(b) PPS color Is the facility electing full federal capital payment Teaching Hospitals 1.8.00 Is this a hospital involved in training residents in or "N" for no. If line 56 is yes, is this the first cost reporting programs trained at this facility? Enter "Y" for is "Y" did residents start training in the first mont for yes or "N" for no in column 2. If column 2 is "Y" "N", complete Wkst. D, Parts III & IV and D-2, Pt. II If line 56 is yes, did this facility elect cost reimb defined in CMS Pub. 15-1, chapter 21, §2148? If yes, 9.00 Are costs claimed on line 100 of Worksheet A? If yes	apital? E? Enter " approved (eriod duri yes or "N h of this ", complet ", if appli ursement f complete W , complete (NAHE) cos see instru program. (II and Wks Enter "Y for Y" for yes SME program: ng which re " for no i. " for no i. cost repor te Workshee cable. for physicia Wkst. D-5. Wkst. D-5. E Wkst. D-2	t. L-1, Pt. r yes or "N or "N" for s? Enter " esidents in n column 1. ting period t E-4. If c ans' servic , Pt. I. NAHE 413.8 Y/N	I through "for no. no. Y" for yes approved If column? Enter " olumn 2 is es as Works Lin	N N N N N N N N N N N N N N N N N N N	Pass- Qual if Cri t	Through Fication cerion ode .00	46. 0 47. 0 48. 0 56. 0 57. 0 58. 0 59. 0

Health Financial Systems UNION HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DA			FAL, INC.	CN: 15-0023	In Lieu Period: From 01/01/2018 To 12/31/2018	Date/Time Pre	pared:
		Y/N	IME	Direct GME	I ME	5/29/2019 1:1 Direct GME	1 pm
		1.00	2. 00	3.00	4. 00	5. 00	
	Did your hospital receive FTE slots under ACA section 5503? Enter "Y" for yes or "N" for no in column 1. (see instructions) Enter the average number of unweighted primary care	N			0.00		61.00
	FTEs from the hospital's 3 most recent cost reports ending and submitted before March 23, 2010. (see instructions)						
	Enter the current year total unweighted primary care FTE count (excluding OB/GYN, general surgery FTEs, and primary care FTEs added under section 5503 of ACA). (see instructions)						61.02
61. 03	Enter the base line FTE count for primary care and/or general surgery residents, which is used for determining compliance with the 75% test. (see instructions)						61.03
	Enter the number of unweighted primary care/or surgery allopathic and/or osteopathic FTEs in the current cost reporting period (see instructions).						61.04
61. 05	Enter the difference between the baseline primary and/or general surgery FTEs and the current year's primary care and/or general surgery FTE counts (line 61.04 minus line 61.03). (see instructions)						61.05
61.06	Enter the amount of ACA §5503 award that is being used for cap relief and/or FTEs that are nonprimary care or general surgery. (see instructions)						61.06
		Pro	ogram Name	Program Cod	IME FTE Count	Unweighted Direct GME FTE Count	
61 10	Of the FTEs in line 61.05, specify each new program		1. 00	2. 00	3. 00	4.00	61. 10
61. 20	specialty, if any, and the number of FTE residents for each new program. (see instructions) Enter in column 1, the program name. Enter in column 2, the program code. Enter in column 3, the IME FTE unweighted count. Enter in column 4, the direct GME FTE unweighted count. Of the FTEs in line 61.05, specify each expanded program specialty, if any, and the number of FTE residents for each expanded program. (see instructions) Enter in column 1, the program name. Enter in column 2, the program code. Enter in column 3, the IME FTE unweighted count.				0. 00		61. 20
						1. 00	
62, 00	ACA Provisions Affecting the Health Resources and Sel Enter the number of FTE residents that your hospital				eriod for which	0.00	62.00
	your hospital received HRSA PCRE funding (see instructions and instructions) for the number of FTE residents that rotated from a during in this cost reporting period of HRSA THC progressions and the second transfer of the second	ctions) a Teachi gram. (:	ing Health Cer see instructio	nter (THC) in			62. 01
63. 00	Has your facility trained residents in nonprovider se "Y" for yes or "N" for no in column 1. If yes, comple	ettings	during this c			Y	63.00
				Unwei ghted FTEs Nonprovi der Si te	Unweighted FTEs in Hospital	Ratio (col. 1/ (col. 1 + col. 2))	
	Section 5504 of the ACA Base Year FTE Residents in No	onnrovi	der Settings	1.00 -This base ve	2.00	3.00	
64. 00	section 5504 of the ACA Base Year FIE Residents in No period that begins on or after July 1, 2009 and before Enter in column 1, if line 63 is yes, or your facilit in the base year period, the number of unweighted nor resident FTEs attributable to rotations occurring in settings. Enter in column 2 the number of unweighted resident FTEs that trained in your hospital. Enter in of (column 1 divided by (column 1 + column 2)). (see	re June ty train n-priman all non d non-po n column	30, 2010. ned residents ry care nprovider rimary care n 3 the ratio	O.			64.00

Health Financial Systems UNION HOSPITAL, INC. In Lieu of Form CMS-2552-10 HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA Provi der CCN: 15-0023 Peri od: Worksheet S-2 From 01/01/2018 Part I Date/Time Prepared: 12/31/2018 5/29/2019 1:11 pm Program Name Program Code Unwei ghted Unwei ghted Ratio (col. 3/ (col. 3 + FTEs FTEs in 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 li is yes, or your facility UH FAMILY MEDICINE 1201711131 0. 91 20. 14 0.043230 65.00 if line 63 RESI DENCY trained residents in the base year period, the program name associated with primary care FTEs for each primary care program in which you trained residents. Enter in column 2, the program code. Enter in column 3, the number of unweighted primary care FTE residents attributable to rotations occurring in all non-provider settings. Enter in column 4, the number of unweighted primary care resident FTEs that trained in your hospital. Enter in column 5, the ratio of (column 3 divided by (column 3 + column 4)). (see instructions) Unwei ghted Unwei ghted Ratio (col. 1/ (col. 1 + col. 2)) FTEs in FTFs Hospi tal Nonprovi der Si te 2. 00 3. 00 1 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. FTEs FTEs in 3/(col. 3 +col. 4)) Nonprovi der Hospi tal Si te 1.00 2.00 3. 00 4. 00 5. 00 67.00 Enter in column 1, the program UH FAMILY MEDICINE 1201711131 19. 40 0.076190 67.00 1. 60 name associated with each of RESI DENCY your primary care programs in which you trained residents. Enter in column 2, the program code. Enter in column 3, the number of unweighted primary care FTE residents attributable to rotations occurring in all non-provider settings. Enter in column 4, the number of unweighted primary care resident FTEs that trained in your hospital. Enter in column 5, the ratio of (column 3 divided by (column 3 + column 4)). (see instructions) 1.00 2.00 3.00 Inpatient Psychiatric Facility PPS Is this facility an Inpatient Psychiatric Facility (IPF), or does it contain an IPF subprovider? 70.00 70.00 N Enter "Y" for yes or "N" for no. If line 70 is yes: Column 1: Did the facility have an approved GME teaching program in the most 71.00 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.

75.00

(see instructions)

Inpatient Rehabilitation Facility PPS

subprovider? Enter "Y" for yes and "N"

75.00 Is this facility an Inpatient Rehabilitation Facility (IRF), or does it contain an IRF

OSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA Provider CCN: 15-0023	Peri od: From 01/01/2018 To 12/31/2018		epared:
6.00 If line 75 is yes: Column 1: Did the facility have an approved GME teaching program recent cost reporting period ending on or before November 15, 2004? Enter "Y" for younger to column 2: Did this facility train residents in a new teaching program in accordance (CFR 412.424 (d)(1)(iii)(D)? Enter "Y" for yes or "N" for no. Column 3: If column 2 indicate which program year began during this cost reporting period. (see instructions)	es or "N" for ance with 42 is Y,		76.00
Long Term Care Hospital PPS		1.00	
O.00 Is this a long term care hospital (LTCH)? Enter "Y" for yes and "N" for no. 1.00 Is this a LTCH co-located within another hospital for part or all of the cost repor "Y" for yes and "N" for no. TEFRA Providers	ting period? Enter	N N	80. 00 81. 00
Is this a new hospital under 42 CFR Section §413.40(f)(1)(i) TEFRA? Enter "Y" for 56.00 Did this facility establish a new Other subprovider (excluded unit) under 42 CFR Section §413.40(f)(1)(ii)? Enter "Y" for yes and "N" for no.		N	85. 00 86. 00
7.00 Is this hospital an extended neoplastic disease care hospital classified under sect 1886(d)(1)(B)(vi)? Enter "Y" for yes or "N" for no.		N	87.00
Title V and XIX Services	V 1.00	XI X 2. 00	
0.00 Does this facility have title V and/or XIX inpatient hospital services? Enter "Y" for yes or "N" for no in the applicable column.	or N	Y	90.0
1.00 Is this hospital reimbursed for title V and/or XIX through the cost report either in full or in part? Enter "Y" for yes or "N" for no in the applicable column.		N	91.0
2.00 Are title XIX NF patients occupying title XVIII SNF beds (dual certification)? (see instructions) Enter "Y" for yes or "N" for no in the applicable column. 3.00 Does this facility operate an ICF/IID facility for purposes of title V and XIX? Enter		N N	92.0
"Y" for yes or "N" for no in the applicable column. 4.00 Does title V or XIX reduce capital cost? Enter "Y" for yes, and "N" for no in the	N	N	94.0
applicable column. 5.00 If line 94 is "Y", enter the reduction percentage in the applicable column. 6.00 Does title V or XIX reduce operating cost? Enter "Y" for yes or "N" for no in the applicable column.	0. 00 N	0. 00 N	95. 0 96. 0
7.00 If line 96 is "Y", enter the reduction percentage in the applicable column. 8.00 Does title V or XIX follow Medicare (title XVIII) for the interns and residents pos stepdown adjustments on Wkst. B, Pt. I, col. 25? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.		0. 00 Y	97. 0 98. 0
8.01 Does title V or XIX follow Medicare (title XVIII) for the reporting of charges on W C, Pt. I? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 title XIX.		Y	98. 0
8.02 Does title V or XIX follow Medicare (title XVIII) for the calculation of observation bed costs on Wkst. D-1, Pt. IV, line 89? Enter "Y" for yes or "N" for no in column for title V, and in column 2 for title XIX.		Y	98.0
B. 03 Does title V or XIX follow Medicare (title XVIII) for a critical access hospital (C. reimbursed 101% of inpatient services cost? Enter "Y" for yes or "N" for no in colum 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 reimbursed 101% of outpatient services cost? Enter "Y" for yes or "N" for no in column 1 for title V, in column 2 for title XIX.	N and	N	98.0
B.05 Does title V or XIX follow Medicare (title XVIII) and add back the RCE disallowance Wkst. C, Pt. I, col. 4? Enter "Y" for yes or "N" for no in column 1 for title V, and column 2 for title XIX.		Y	98.0
B.06 Does title V or XIX follow Medicare (title XVIII) when cost reimbursed for Wkst. D, Pts. I through IV? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX. Rural Providers	Y	Y	98.0
D5.00 Does this hospital qualify as a CAH? D6.00 If this facility qualifies as a CAH, has it elected the all-inclusive method of pay	ment N		105. 0 106. 0
for outpatient services? (see instructions) 07.00 If this facility qualifies as a CAH, is it eligible for cost reimbursement for I&R training programs? Enter "Y" for yes or "N" for no in column 1. (see instructions) yes, the GME elimination is not made on Wkst. B, Pt. I, col. 25 and the program is reimbursed. If yes complete Wkst. D-2, Pt. II.			107. 0
one initial sea. If yes complete wist. 0-2, Ft. 11. one is this a rural hospital qualifying for an exception to the CRNA fee schedule? See CFR Section §412.113(c). Enter "Y" for yes or "N" for no.	42 N		108. 0

alth Financial Systems UNION HOSPIT OSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA		CN: 15-0023 P	eri od:		Worksheet	
STITAL AND HOSTITAL HEALTH GARE COMMERCA I DENTITION TO DATA	Trovider	F	rom 01/01/ o 12/31/	'2018 '2018	Part I Date/Time	e Prepare
	Physi cal	Occupati onal	Speec	h	5/29/2019 Respi rat	ory
09.00 f this hospital qualifies as a CAH or a cost provider, are therapy services provided by outside supplier? Enter "Y"	1. 00 N	2. 00 N	3. 00 N		4. 00 N	109
for yes or "N" for no for each therapy.						
0.00 Did this hospital participate in the Rural Community Hospita	al Demonstrat	ion project (84	L10A		1. 00 N	110
Demonstration) for the current cost reporting period? Enter complete Worksheet E, Part A, lines 200 through 218, and Wo applicable.	"Y" for yes o	r "N" for no. I	f yes,	5		
4 001 5 11 1 5 11 11 11 11 11 11 11 11 11 11	II. Familia	0	1.00		2. 00	111
1.00 f this facility qualifies as a CAH, did it participate in Health Integration Project (FCHIP) demonstration for this c "Y" for yes or "N" for no in column 1. If the response to c integration prong of the FCHIP demo in which this CAH is pa Enter all that apply: "A" for Ambulance services; "B" for a for tele-health services.	ost reporting olumn 1 is Y, rticipating i	period? Enter enter the n column 2.	N			111
				1.00	2.00 3	3. 00
Miscellaneous Cost Reporting Information 5.00 Is this an all-inclusive rate provider? Enter "Y" for yes o	r "N" for no	in column 1. If	column 1	N		0 115
is yes, enter the method used (A, B, or E only) in column 2 3 either "93" percent for short term hospital or "98" percent psychiatric, rehabilitation and long term hospitals provide Pub. 15-1, chapter 22, §2208.1.	nt for long t rs) based on	erm care (inclu the definition	ıdes			
6.00 Is this facility classified as a referral center? Enter "Y" 7.00 Is this facility legally-required to carry malpractice insuno.			"N" for	Y		110
3.00 s the malpractice insurance a claims-made or occurrence po claim-made. Enter 2 if the policy is occurrence.	licy? Enter 1	if the policy	is	1		118
		Premi ums	Losses	S	Insuran	ice
		1.00	2. 00		3. 00	
8.01 List amounts of malpractice premiums and paid losses:		1. 00 541, 57		0	3. 00	0 118
		541, 57	1.00		3. 00	
3.02 Are malpractice premiums and paid losses reported in a cost Administrative and General? If yes, submit supporting schemand amounts contained therein.		541, 57 than the	7			118
3.02 Are malpractice premiums and paid losses reported in a cost Administrative and General? If yes, submit supporting schemand amounts contained therein.	dule listing	than the cost centers	1.00			111
3.02 Are malpractice premiums and paid losses reported in a cost Administrative and General? If yes, submit supporting schemand amounts contained therein. 9.00 DO NOT USE THIS LINE 10.00 Is this a SCH or EACH that qualifies for the Outpatient Hole §3121 and applicable amendments? (see instructions) Enter in "N" for no. Is this a rural hospital with < 100 beds that qualified Hold Harmless provision in ACA §3121 and applicable amendments.	dule listing d Harmless pr n column 1, " ualifies for	than the cost centers ovision in ACA Y" for yes or the Outpatient	1. 00 N		2. 00	11:
3.02 Are malpractice premiums and paid losses reported in a cost Administrative and General? If yes, submit supporting scherand amounts contained therein. 7.00 DO NOT USE THIS LINE 7.00 Is this a SCH or EACH that qualifies for the Outpatient Hole §3121 and applicable amendments? (see instructions) Enter in "N" for no. Is this a rural hospital with < 100 beds that qualifies for the Outpatient Hole §3121 and applicable amendments? (see instructions) Enter in "N" for no. Is this a rural hospital with < 100 beds that qualifies for the Outpatient of the Normal Sale of the Normal	dule listing d Harmless pr n column 1, " ualifies for nts? (see ins	than the cost centers ovision in ACA Y" for yes or the Outpatient tructions)	1. 00 N		2. 00	118
Administrative and General? If yes, submit supporting scherand amounts contained therein. O ODD NOT USE THIS LINE O OIS this a SCH or EACH that qualifies for the Outpatient Hole §3121 and applicable amendments? (see instructions) Enter in "N" for no. Is this a rural hospital with < 100 beds that qualifies for the Outpatient Hole §3121 and applicable amendments? (see instructions) Enter in "N" for no. Is this a rural hospital with < 100 beds that qualifies for the Outpatient Hole §3121 and applicable amendments? (see instructions) Enter in "N" for no. O Did this facility incur and report costs for high cost implipatients? Enter "Y" for yes or "N" for no.	dule listing d Harmless pr n column 1, " ualifies for nts? (see ins antable devic	than the cost centers ovision in ACA Y" for yes or the Outpatient tructions) es charged to 3(w)(3) of the	1. 00 N		2. 00	111
Administrative and General? If yes, submit supporting scherand amounts contained therein. O OD NOT USE THIS LINE O OOIS this a SCH or EACH that qualifies for the Outpatient Hole §3121 and applicable amendments? (see instructions) Enter in "N" for no. Is this a rural hospital with < 100 beds that qualifies for the Outpatient Hole §3121 and applicable amendments? (see instructions) Enter in "N" for no. Is this a rural hospital with < 100 beds that qualifies for the Outpatient Hole §3121 and applicable amendments. "N" for no. Is this a rural hospital with < 100 beds that qualifies for in column 2, "Y" for yes or "N" for no. O OD Id this facility incur and report costs for high cost imple patients? Enter "Y" for yes or "N" for no. O OD Does the cost report contain healthcare related taxes as de Act?Enter "Y" for yes or "N" for no in column 1. If column the Worksheet A line number where these taxes are included.	dule listing d Harmless pr n column 1, " ualifies for nts? (see ins antable devic	than the cost centers ovision in ACA Y" for yes or the Outpatient tructions) es charged to 3(w)(3) of the	1. 00 N		2. 00	111
Administrative and General? If yes, submit supporting sche and amounts contained therein. On ODD NOT USE THIS LINE On OD Is this a SCH or EACH that qualifies for the Outpatient Hole \$3121 and applicable amendments? (see instructions) Enter in "N" for no. Is this a rural hospital with < 100 beds that qualifies for the Outpatient Hole \$3121 and applicable amendments? (see instructions) Enter in "N" for no. Is this a rural hospital with < 100 beds that qualifies for the Outpatient Hole \$3121 and applicable amendments? "N" for no. Is this a rural hospital with < 100 beds that qualifies for the Outpatient in the Inter in column 2, "Y" for yes or "N" for no. On OD Id this facility incur and report costs for high cost implipatients? Enter "Y" for yes or "N" for no. On OD Does the cost report contain healthcare related taxes as de Act? Enter "Y" for yes or "N" for no in column 1. If column the Worksheet A line number where these taxes are included. Transplant Center Information To OD Does this facility operate a transplant center? Enter "Y" for "Y" for the cost of the cost	dule listing d Harmless pr n column 1, " ualifies for nts? (see ins antable devic fined in §190 1 is "Y", ent	than the cost centers ovision in ACA Y" for yes or the Outpatient tructions) es charged to 3(w)(3) of the er in column 2	1. 00 N		2. 00	118 119 120 121 122
Administrative and General? If yes, submit supporting scherand amounts contained therein. On ODD NOT USE THIS LINE On OD Is this a SCH or EACH that qualifies for the Outpatient Hole \$3121 and applicable amendments? (see instructions) Enter in "N" for no. Is this a rural hospital with < 100 beds that qualifies for the Outpatient Hole \$3121 and applicable amendments? (see instructions) Enter in "N" for no. Is this a rural hospital with < 100 beds that qualifies for the Outpatient Hole \$3121 and applicable amendments? "N" for no. Is this a rural hospital with < 100 beds that qualifies for the Outpatient in the Worksheet and Theorem Tool with the Yes on "N" for no. On OD Does the cost report contain healthcare related taxes as de Act? Enter "Y" for yes or "N" for no in column 1. If column the Worksheet Aline number where these taxes are included. Transplant Center Information Tool Does this facility operate a transplant center? Enter "Y" for yes, enter certification date(s) (mm/dd/yyyy) below.	dule listing d Harmless pr n column 1, " ualifies for nts? (see ins antable devic fined in §190 1 is "Y", ent	than the cost centers ovision in ACA Y" for yes or the Outpatient tructions) es charged to 3(w)(3) of the er in column 2	1. 00 N		2. 00	118 111 120 121 122
Administrative and General? If yes, submit supporting scherand amounts contained therein. O OD NOT USE THIS LINE O OO Is this a SCH or EACH that qualifies for the Outpatient Hole §3121 and applicable amendments? (see instructions) Enter in "N" for no. Is this a rural hospital with < 100 beds that qualifies for the Outpatient Hole §3121 and applicable amendments? (see instructions) Enter in "N" for no. Is this a rural hospital with < 100 beds that qualifies for the Outpatient Hole §3121 and applicable amendments? In the Information in ACA §3121 and applicable amendments. O OD Id this facility incur and report costs for high cost implications? Enter "Y" for yes or "N" for no. O OD Does the cost report contain heal theare related taxes as de Act?Enter "Y" for yes or "N" for no in column 1. If column the Worksheet A line number where these taxes are included. Transplant Center Information O OD Does this facility operate a transplant center? Enter "Y" for yes, enter certification date(s) (mm/dd/yyyy) below. O O If this is a Medicare certified kidney transplant center, ein column 1 and termination date, if applicable, in column.	dule listing d Harmless pr n column 1, " ualifies for nts? (see ins antable devic fined in §190 1 is "Y", ent or yes and "N nter the cert 2.	than the cost centers ovision in ACA Y" for yes or the Outpatient tructions) es charged to 3(w)(3) of the er in column 2 " for no. If ification date	1. 00 N		2. 00	118 1118 120 121 122 121 121
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Administrative and General? If yes, submit supporting scherand amounts contained therein. On ODD NOT USE THIS LINE On OIS this a SCH or EACH that qualifies for the Outpatient Hole §3121 and applicable amendments? (see instructions) Enter in "N" for no. Is this a rural hospital with < 100 beds that qualifier in the Hole Hold Harmless provision in ACA §3121 and applicable amendments. On OD Did this facility incur and report costs for high cost implipatients? Enter "Y" for yes or "N" for no. On OD Does the cost report contain healthcare related taxes as de Act?Enter "Y" for yes or "N" for no in column 1. If column the Worksheet A line number where these taxes are included. Transplant Center Information On OD Does this facility operate a transplant center? Enter "Y" for yes, enter certification date(s) (mm/dd/yyyy) below. On OT this is a Medicare certified kidney transplant center, en in column 1 and termination date, if applicable, in column 3.00 of this is a Medicare certified liver transplant center, en in column 1 and termination date, if applicable, in column 3.00 of this is a Medicare certified liver transplant center, en in column 1 and termination date, if applicable, in column 3.00 of this is a Medicare certified liver transplant center, en in column 1 and termination date, if applicable, in column 3.00 of this is a Medicare certified liver transplant center, en in column 1 and termination date, if applicable, in column 3.00 of this is a Medicare certified liver transplant center, en in column 1 and termination date, if applicable, in column 3.00 of this is a Medicare certified liver transplant center, en in column 1 and termination date, if applicable, in column 3.00 of this is a Medicare certified liver transplant center, en in column 1 and termination date, if applicable, in column 3.00 of this is a Medicare certified liver transplant center, en in column 1 and termination date, if applicable, in column 3.00 of the column 2 and termination date, if applicable, in column 3.00 of the column 3.00 of	dule listing d Harmless pr n column 1, " ualifies for nts? (see ins antable devic fined in §190 1 is "Y", ent or yes and "N nter the cert 2. ter the certi 2. ter the certi 2.	than the cost centers ovision in ACA Y" for yes or the Outpatient tructions) es charged to 3(w)(3) of the er in column 2 " for no. If ification date fication date fication date	1. 00 N		2. 00	118 111 120 121 122 121 121 121
Administrative and General? If yes, submit supporting scherand amounts contained therein. On OD NOT USE THIS LINE On OD NOT USE THIS LINE On OD Is this a SCH or EACH that qualifies for the Outpatient Hole §3121 and applicable amendments? (see instructions) Enter in "N" for no. Is this a rural hospital with < 100 beds that qualifies for the Outpatient Hole §3121 and applicable amendments? (see instructions) Enter in "N" for no. Is this a rural hospital with < 100 beds that qualifies for the Outpatient Hole §3121 and applicable amendments. In the Interior of the Inte	dule listing d Harmless pr n column 1, " ualifies for nts? (see ins antable devic fined in §190 1 is "Y", ent or yes and "N nter the cert 2. ter the certi 2. ter the certi 2. er the certif	than the cost centers ovision in ACA Y" for yes or the Outpatient tructions) es charged to 3(w)(3) of the er in column 2 " for no. If ification date fication date ication date ir column date ir the column date in the col	1. 00 N		2. 00	118 119 120 122 122 126 127 128
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and amounts contained therein. 9.00 DO NOT USE THIS LINE 0.00 Is this a SCH or EACH that qualifies for the Outpatient Hole \$3121 and applicable amendments? (see instructions) Enter in "N" for no. Is this a rural hospital with < 100 beds that question Hold Harmless provision in ACA \$3121 and applicable amendmenter in column 2, "Y" for yes or "N" for no. 1.00 Did this facility incur and report costs for high cost implipatients? Enter "Y" for yes or "N" for no. 2.00 Does the cost report contain healthcare related taxes as de Act?Enter "Y" for yes or "N" for no in column 1. If column the Worksheet A line number where these taxes are included. Transplant Center Information 5.00 Does this facility operate a transplant center? Enter "Y" for yes, enter certification date(s) (mm/dd/yyyy) below. 6.00 If this is a Medicare certified kidney transplant center, en in column 1 and termination date, if applicable, in column 2. 7.00 If this is a Medicare certified liver transplant center, en in column 1 and termination date, if applicable, in column 9. 9.00 If this is a Medicare certified liver transplant center, en in column 1 and termination date, if applicable, in column 9. 9.01 If this is a Medicare certified lung transplant center, entincolumn 1 and termination date, if applicable, in column 2. 1.00 If this is a Medicare certified lung transplant center, date in column 1 and termination date, if applicable, in column 2. 1.00 If this is a Medicare certified intestinal transplant center, date in column 1 and termination date, if applicable, in column 2. 1.00 If this is a Medicare certified intestinal transplant center, date in column 1 and termination date, if applicable, in column 1.	dule listing d Harmless pr n column 1, " ualifies for nts? (see ins antable devic fined in §190 1 is "Y", ent or yes and "N nter the cert 2. ter the certi 2. ter the certi 2. er the certif enter the ce lumn 2. ter the certi lumn 2. ter the certi 2. ter the certi	than the cost centers ovision in ACA Y" for yes or the Outpatient tructions) es charged to 3(w)(3) of the er in column 2 " for no. If ification date fication date ir cation date ir rtification certification date	1. 00 N		2. 00	118 119 120 122 122 126 127 128 129 130 131
8.02 Are malpractice premiums and paid losses reported in a cost Administrative and General? If yes, submit supporting scherand amounts contained therein. 9.00 DO NOT USE THIS LINE 0.00 Is this a SCH or EACH that qualifies for the Outpatient Hole §3121 and applicable amendments? (see instructions) Enter in "N" for no. Is this a rural hospital with < 100 beds that qualifies for the Outpatient Hole §3121 and applicable amendments? (see instructions) Enter in "N" for no. Is this a rural hospital with < 100 beds that qualifies for the Outpatient Hole §3121 and applicable amendments. In the Interview of the Hole Hold Harmless provision in ACA §3121 and applicable amendments. Interview of the Hold Harmless provision in ACA §3121 and applicable amendments. Interview of the Hold Harmless of "N" for no. 1.00 Did this facility incur and report costs for high cost implipatients? Enter "Y" for yes or "N" for no. 2.00 Does the cost report contain healthcare related taxes as de Act?Enter "Y" for yes or "N" for no in column 1. If column the Worksheet A line number where these taxes are included. Transplant Center Information 5.00 Does this facility operate a transplant center? Enter "Y" for yes, enter certification date(s) (mm/dd/yyyy) below. 6.00 If this is a Medicare certified kidney transplant center, en in column 1 and termination date, if applicable, in column 1. 8.00 If this is a Medicare certified liver transplant center, en in column 1 and termination date, if applicable, in column 1. 9.00 If this is a Medicare certified lung transplant center, entitied in column 1 and termination date, if applicable, in column 2. 0.00 If this is a Medicare certified pancreas transplant center, date in column 1 and termination date, if applicable, in column 1. 0.00 If this is a Medicare certified intestinal transplant center, date in column 1 and termination date, if applicable, in column 1. 0.00 If this is a Medicare certified intestinal transplant center, date in column 1 and termination date, if applicable, in column 1.	dule listing d Harmless pr n column 1, " ualifies for nts? (see ins antable devic fined in §190 1 is "Y", ent or yes and "N nter the certi 2. ter the certi 2. ter the certi 2. er the certi 2. ter the certi 4. ter the certi 5. ter the certi 6. ter the certi 7. ter the certi 8.	than the cost centers ovision in ACA Y" for yes or the Outpatient tructions) es charged to 3(w)(3) of the er in column 2 " for no. If ification date fication date ication date ir trification certification fication date	1. 00 N		2. 00	1116 1116 1216 122 122 124 126 126 136 137

ealth Financial Systems HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX		OSPITAL, INC.	CCN: 15-0023	B Peri od		u of Form CMS Worksheet S	
USPITAL AND HUSPITAL HEALTH CARE COMPLEX	T TOENTIFICATION DATA	Provider	JCN. 15-002	From O	1/01/2018 2/31/2018	Part I Date/Time Pi 5/29/2019 1:	repared
					1.00	2. 00	
40.00 Are there any related organization chapter 10? Enter "Y" for yes or "I are claimed, enter in column 2 the	N" for no in column 1	. If yes, and hom	e office c		1. 00 Y	15H043	140.0
1.00		2. 00			3. 00		
If this facility is part of a chair office and enter the home office or			ough 143 t	he name ar	nd address	of the home	
11.00 Name: UNION HOSPITAL, INC.	Contractor's Name	e: WI SCONSIN PHYSI SERVICES	CI ANS Contr	actor's Nu	umber: 0810	1	141.
I2.00 Street:1606 NORTH SEVENTH ST I3.00 City: TERRE HAUTE	PO Box: State:	I N	Zip C	ada.	4780	4	142. 143.
S. OUCITY. TERRE HAUTE	State.	I IV	ZIPC	oue.	4760	4	143.
						1. 00	
4.00 Are provider based physicians' cost	ts included in Worksh	eet A?				Y	144.
					1. 00	2.00	
5.00 If costs for renal services are cla	aimed on Wkst. A, lin	e 74, are the cos	ts for		11 00	2.00	145.
inpatient services only? Enter "Y" no, does the dialysis facility incl period? Enter "Y" for yes or "N" f 66.00 Has the cost allocation methodology Enter "Y" for yes or "N" for no in yes, enter the approval date (mm/do	lude Medicare utiliza for no in column 2. y changed from the pro column 1. (See CMS Po	tion for this cos eviously filed co	t reportin st report?	g	N		146.
7.00Was there a change in the statistic	aal basis? Entan "V"	for you or "N" fo	n no			1. 00	147.
18.00Was there a change in the statistic						N N	147.
9.00 Was there a change to the simplific				for no.		N	149.
		Part A	Part		itle V	Title XIX	_
Does this facility contain a provide	der that qualifies fo	1.00	2.00		3.00	4.00 er of costs	
or charges? Enter "Y" for yes or "I							
55.00 Hospi tal		N	N		N	N	155.
6.00 Subprovi der - IPF 7.00 Subprovi der - IRF		N N	N N		N N	N N	156. 157.
58. OOSUBPROVI DER		14	"		IV	IN	158.
59. 00 SNF		N	N		N	N	159.
50. 00 HOME HEALTH AGENCY		N	N N		N	N	160.
51. 00 CMHC			l N		N	N	161.
						1. 00	
Multicampus 55.00ls this hospital part of a Multicar	mous hospital that ha	s one or more cam	nuses in d	ifferent (`R\$As?	N	165.
Enter "Y" for yes or "N" for no.	iipus nospi tai that na	3 one of more can	puses in u	i i i ci ci ci c	DONS:	14	103.
	Name	County	State	Zip Code		FTE/Campus	
6.00 If line 165 is yes, for each	0	1. 00	2. 00	3. 00	4. 00	5. 00	00 166.
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. (30 100.
						1. 00	
) inconting in the Am	eri can Recovery a	nd Rei nves	tment Act		1.00	
Health Information Technology (HIT			"N" for n	O.	or the	Υ	167. 0168.
8.00 If this provider is a CAH (line 105	under §1886(n)? Ento 5 is "Y") and is a me	aningful user (li	ne 167 is	1), 01110	i the		
57.00 s this provider a meaningful user 58.00 of this provider is a CAH (line 105 reasonable cost incurred for the HI 58.01 of this provider is a CAH and is no	under §1886(n)? Ento 5 is "Y") and is a me 1T assets (see instruc ot a meaningful user,	aningful user (li ctions) does this provid	er qualify	for a har			168.
67.00 s this provider a meaningful user 68.00 If this provider is a CAH (line 108 reasonable cost incurred for the HI 68.01 If this provider is a CAH and is no exception under §413.70(a)(6)(ii)? 69.00 If this provider is a meaningful us	under §1886(n)? Ento 5 is "Y") and is a men 15 assets (see instru- 15 a meaningful user, 16 Enter "Y" for yes or 16 ser (line 167 is "Y")	aningful user (li ctions) does this provid "N" for no. (see	er qualify instructi	for a har ons)	dshi p	9.	168. (99169. (
57.00 s this provider a meaningful user 58.00 If this provider is a CAH (line 105 reasonable cost incurred for the HI 58.01 If this provider is a CAH and is no exception under §413.70(a)(6)(ii)?	under §1886(n)? Ento 5 is "Y") and is a men 15 assets (see instru- 15 a meaningful user, 16 Enter "Y" for yes or 16 ser (line 167 is "Y")	aningful user (li ctions) does this provid "N" for no. (see	er qualify instructi	for a har ons) is "N"),	dshi p	9. [.] Endi ng	
67.00 s this provider a meaningful user 68.00 If this provider is a CAH (line 108 reasonable cost incurred for the HI 68.01 If this provider is a CAH and is no exception under §413.70(a)(6)(ii)? 69.00 If this provider is a meaningful us	under §1886(n)? Ento 5 is "Y") and is a med 1T assets (see instru- ot a meaningful user, Enter "Y" for yes or ser (line 167 is "Y") ns)	aningful user (li ctions) does this provid "N" for no. (see and is not a CAH	er qualify instructi (line 105	for a harons) is "N"),	dship enter the		99169.

Health Financial Systems	In Lieu of Form CMS-2552-1					
HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDEN	ITIFICATION DATA		Worksheet S-2)		
			From 01/01/2018 To 12/31/2018	Date/Time Pre	nared:	
			10 12/31/2010	5/29/2019 1: 1		
			1. 00	2. 00		
171.00 If line 167 is "Y", does this provider h	nave any days for indiv	iduals enrolled in	N	C	171. 00	
section 1876 Medicare cost plans reporte	section 1876 Medicare cost plans reported on Wkst. S-3, Pt. I, line 2, col. 6? Enter					
"Y" for yes and "N" for no in column 1.	If column 1 is yes, en	nter the number of section	on			
1876 Medicare days in column 2. (see ins	structions)					

Heal th	Financial Systems UNION HOSPI	TAL. INC.		In Lie	u of Form CMS-	2552-10
	AL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE	Provider Co		Period: From 01/01/2018	Worksheet S-2	epared:
				Y/N	Date	I I pili
				1.00	2. 00	
	General Instruction: Enter Y for all YES responses. Enter Mmm/dd/yyyy format. COMPLETED BY ALL HOSPITALS Provider Organization and Operation	N for all NO re	esponses. Ent	er all dates in	the	
1. 00	Has the provider changed ownership immediately prior to the	e beginning of	the cost	N		1.00
	reporting period? If yes, enter the date of the change in o	column 2. (see				
			1. 00	2.00	V/I 3. 00	
2. 00	Has the provider terminated participation in the Medicare Program? If yes, enter in column 2 the date of termination and in column 3, "V" for voluntary or "I" for involuntary.					
3.00	Is the provider involved in business transactions, including contracts, with individuals or entities (e.g., chain home commedical supply companies) that are related to the provide officers, medical staff, management personnel, or members of directors through ownership, control, or family and other relationships? (see instructions)	offices, drug der or its of the board	Y			3.00
			Y/N	Туре	Date	
	Financial Data and Reports		1. 00	2.00	3. 00	
4. 00 5. 00	Column 1: Were the financial statements prepared by a Cerra Accountant? Column 2: If yes, enter "A" for Audited, "C" for "R" for Reviewed. Submit complete copy or enter date avacclumn 3. (see instructions) If no, see instructions. Are the cost report total expenses and total revenues difference.	for Compiled, ailable in	Y	A		4.00
	those on the filed financial statements? If yes, submit red	conciliation.				
				Y/N 1. 00	Legal Oper. 2.00	
	Approved Educational Activities			1.00	2.00	
6.00	Column 1: Are costs claimed for nursing school? Column 2: the legal operator of the program?	3	he provider i			6.00
7. 00 8. 00	Are costs claimed for Allied Health Programs? If "Y" see in Were nursing school and/or allied health programs approved cost reporting period? If yes, see instructions.		d during the	Y N		7. 00 8. 00
9. 00	Are costs claimed for Interns and Residents in an approved program in the current cost report? If yes, see instruction		cal education	Y		9. 00
10. 00	Was an approved Intern and Resident GME program initiated cost reporting period? If yes, see instructions.	or renewed in	the current	N		10.00
11. 00	Are GME cost directly assigned to cost centers other than I Teaching Program on Worksheet A? If yes, see instructions.	I & R in an App	proved 	N	Y/N	11.00
					1. 00	
40.00	Bad Debts				.,	10.00
	Is the provider seeking reimbursement for bad debts? If yes If line 12 is yes, did the provider's bad debt collection period? If yes, submit copy.			ost reporting	Y N	12. 00 13. 00
14. 00	If line 12 is yes, were patient deductibles and/or co-payme Bed Complement	ents waived? I	fyes, see in	structi ons.	N	14.00
15. 00	Did total beds available change from the prior cost report		yes, see ins		Y t B	15.00
		Y/N	Date	Y/N	Date	
	DS&D Data	1.00	2. 00	3. 00	4. 00	
16. 00	PS&R Data Was the cost report prepared using the PS&R Report only? If either column 1 or 3 is yes, enter the paid-through date of the PS&R Report used in columns 2 and 4. (see	Y	04/01/2019	Y	04/01/2019	16. 00
17. 00	Was the cost report prepared using the PS&R Report for totals and the provider's records for allocation? If either column 1 or 3 is yes, enter the paid-through date	N		N		17.00
18. 00	in columns 2 and 4. (see instructions) If line 16 or 17 is yes, were adjustments made to PS&R Report data for additional claims that have been billed but are not included on the PS&R Report used to file this	N		N		18. 00
19. 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 information? If yes, see instructions.	N		N		19.00

lealth Financial Systems UNION HOS	SPITAL, INC.		In Lie	u of Form CMS	S-2552-1		
HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE	Provi der C	CN: 15-0023	Peri od: From 01/01/2018 To 12/31/2018		repared		
	Descri	iption	Y/N	Y/N	. TT piii		
1	(0	1.00	3. 00			
20.00 If line 16 or 17 is yes, were adjustments made to PS&R Report data for Other? Describe the other adjustments:			N	N	20.0		
	Y/N	Date	Y/N	Date			
	1. 00	2.00	3.00	4. 00			
21.00 Was the cost report prepared only using the provider's records? If yes, see instructions.	N		N		21.0		
				1. 00			
COMPLETED BY COST REIMBURSED AND TEFRA HOSPITALS ONLY (E	XCEPT CHILDRENS I	HOSPI TALS)					
Capital Related Cost							
22.00 Have assets been relifed for Medicare purposes? If yes,				N	22. 0		
3.00 Have changes occurred in the Medicare depreciation expen reporting period? If yes, see instructions.	ise due to apprais	sars made du	ring the cost	N	23. 0		
Were new leases and/or amendments to existing leases ent lf yes, see instructions	ered into during	this cost r	eporting period?	N	24.0		
5.00 Have there been new capitalized leases entered into duri	ng the cost repo	rting period	? If yes, see	N	25. 0		
instructions. 26.00 Were assets subject to Sec.2314 of DEFRA acquired during	ı the cost report	ina period?	If ves. see	N	26.0		
i nstructi ons.	,	3 1	,				
(7.00 Has the provider's capitalization policy changed during copy.	the cost reportin	ng period? i	r yes, submit	N	27.0		
Interest Expense 8.00 Were new Loans, mortgage agreements or Letters of credit	entered into du	ring the cos	t reporting	N	28. 0		
period? If yes, see instructions.		Ü					
9.00 Did the provider have a funded depreciation account and/ treated as a funded depreciation account? If yes, see in		ebt Service	Reserve Fund)	N	29. (
0.00 Has existing debt been replaced prior to its scheduled m instructions.							
1.00 Has debt been recalled before scheduled maturity without instructions.	issuance of new	debt? If ye	s, see	N	31. (
Purchased Services 2.00 Have changes or new agreements occurred in patient care	sorvi cos furni sh	od through c	ontractual	N	32.0		
arrangements with suppliers of services? If yes, see ins	structions.	•					
3.00 If line 32 is yes, were the requirements of Sec. 2135.2 no, see instructions.	appired pertainii	ng to compet	ITIVE blading? IT	N	33. (
Provi der-Based Physi ci ans							
4.00 Are services furnished at the provider facility under an	ı arrangement witl	h provider-b	ased physicians?	N	34.0		
If yes, see instructions. 5.00 If line 34 is yes, were there new agreements or amended	existing agreeme	nts with the	provi der-based	N	35. (
physicians during the cost reporting period? If yes, see	Instructions.		Y/N	Date			
			1.00	2. 00			
Home Office Costs							
6.00 Were home office costs claimed on the cost report? 7.00 If line 36 is yes, has a home office cost statement been	n prepared by the	home office	? Y Y		36. 0 37. 0		
If yes, see instructions. 3.00 If line 36 is yes , was the fiscal year end of the home	office different	from that c	f N		38.		
the provider? If yes, enter in column 2 the fiscal year 9.00 If line 36 is yes, did the provider render services to o			s, N		39.		
see instructions.	•	,					
0.00 If line 36 is yes, did the provider render services to t instructions.	he home office?	If yes, see	N		40. (
	00	2.	00				
	Report Preparer Contact Information						
Cost Report Preparer Contact Information	CAPOLVN		CHADLLN				
1.00 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		41.0		
1.00 Enter the first name, last name and the title/position held by the cost report preparer in columns 1, 2, and 3, respectively. 2.00 Enter the employer/company name of the cost report		_C	CHAPLI N		41. (
1.00 Enter the first name, last name and the title/position held by the cost report preparer in columns 1, 2, and 3, respectively.	BLUE & CO., LL	LC	CHAPLI N CCHAPLI N@BLUEA	NDCO, COM			

Heal th	Financial Systems U	INI ON HOSPI	TAL, INC.	In Lie	eu of Form CMS-2552-10		
HOSPI T	AL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIC	NNAI RE	Provi der CCN: 15-0023	Peri od: From 01/01/2018			
				To 12/31/2018	Date/Time Pre 5/29/2019 1:1		
			3. 00				
	Cost Report Preparer Contact Information						
41.00	Enter the first name, last name and the title/po	sition	SENIOR MANAGER			41.00	
	held by the cost report preparer in columns 1, 2	, and 3,					
	respecti vel y.						
42.00	Enter the employer/company name of the cost repo	rt				42.00	
	preparer.						
43.00	Enter the telephone number and email address of	the cost				43.00	
	report preparer in columns 1 and 2, respectively	_					

| Period: | Worksheet S-3 | From 01/01/2018 | Part | To | 12/31/2018 | Date/Time Prepared: Health Financial SystemsUNIONHOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA Provider CCN: 15-0023

						To	12/31/2018	Date/Time Pre 5/29/2019 1:1	
								I/P Days /	, p
								0/P Visits /	
								Tri ps	
	Component	Worksheet A	No.	. of Beds	Bed Days		CAH Hours	Title V	
		Line Number			Available				
1.00	The state All the A Belle Code on E. C. 7 and	1. 00		2.00	3.00		4. 00	5. 00	1.00
1. 00	Hospital Adults & Peds. (columns 5, 6, 7 and	30. 00		182	66, 43	0	0. 00	0	1.00
	8 exclude Swing Bed, Observation Bed and Hospice days) (see instructions for col. 2								
	for the portion of LDP room available beds)								
2. 00	HMO and other (see instructions)								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			182	66, 43	0	0.00	0	7.00
	beds) (see instructions)								
8.00	INTENSIVE CARE UNIT	31.00		36	13, 14	0	0.00	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	I NTENSI VE NURSERY	35. 00		15	5, 47	5	0. 00	0	12.00
13.00	NURSERY	43. 00						0	13.00
14. 00	Total (see instructions)			233	85, 04	5	0. 00	0	14.00
15. 00	CAH visits							0	15. 00
16. 00	SUBPROVIDER - I PF								16.00
17. 00	SUBPROVIDER - IRF	41. 00		22	8, 03	0		0	17.00
18.00	SUBPROVI DER								18.00
19.00	SKILLED NURSING FACILITY								19.00
20.00	NURSING FACILITY								20.00
21. 00 22. 00	OTHER LONG TERM CARE								21. 00 22. 00
23. 00	HOME HEALTH AGENCY AMBULATORY SURGICAL CENTER (D. P.)								23.00
24. 00	HOSPICE								24.00
24. 00	HOSPICE (non-distinct part)	30.00							24. 00
25. 00	CMHC - CMHC	30.00							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)	07.00		255				O	27.00
28. 00	Observation Bed Days			200				0	28.00
29. 00	Ambulance 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		0			32.00
32. 01	Total ancillary labor & delivery room						ļ		32. 01
	outpatient days (see instructions)								
	LTCH non-covered days								33. 00
33. 01	LTCH site neutral days and discharges		l		l				33. 01

Provider CCN: 15-0023

				''	0 12/31/2010	5/29/2019 1: 1	
		I /P Days	/ O/P Visits	/ Trins	Full Time I	Equi val ents	, p
		171 bays	7 071 113113	/ 111 p3	Turi iriic i	Lqui vai cirt3	
	Component	Title XVIII	Title XIX	Total All	Total Interns	Employees On	
	Component	II ti C XVIII	TI LIC XIX	Patients	& Residents	Payrol I	
		6. 00	7. 00	8. 00	9. 00	10.00	
1. 00	Hospital Adults & Peds. (columns 5, 6, 7 and	21, 941	624	43, 229	7. 00	10.00	1.00
1.00	8 exclude Swing Bed, Observation Bed and	21, 741	024	45, 227			1.00
	Hospice days) (see instructions for col. 2						
	for the portion of LDP room available beds)						
2. 00	HMO and other (see instructions)	3, 742	12, 528				2.00
3. 00	HMO IPF Subprovider	3, 742	12, 320				3.00
4. 00	HMO IRF Subprovider	0	515				4.00
5. 00	•	0	0	0			5.00
	Hospital Adults & Peds. Swing Bed SNF	U	0	0			6.00
6.00	Hospital Adults & Peds. Swing Bed NF	21 041	-	_			
7. 00	Total Adults and Peds. (exclude observation	21, 941	624	43, 229			7. 00
0 00	beds) (see instructions)	2 404	0	4 215			0.00
8.00	INTENSIVE CARE UNIT	3, 606	U	6, 215			8.00
9.00	CORONARY CARE UNIT						9.00
10.00	BURN INTENSIVE CARE UNIT						10.00
11.00	SURGICAL INTENSIVE CARE UNIT						11.00
12. 00	I NTENSI VE NURSERY	0	57	4, 126			12.00
13. 00	NURSERY		171	3, 196			13.00
14. 00	Total (see instructions)	25, 547	852		21. 00	1, 431. 07	14.00
15. 00	CAH visits	0	0	0			15. 00
16. 00	SUBPROVIDER - IPF						16.00
17. 00	SUBPROVI DER - I RF	2, 252	0	3, 677	0. 00	18. 77	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)			104			24. 10
25.00	CMHC - CMHC						25.00
26.00	RURAL HEALTH CLINIC						26. 00
26. 25	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0.00	0.00	26. 25
27.00	Total (sum of lines 14-26)				21.00	1, 449. 84	27. 00
28.00	Observation Bed Days		0	10, 916			28. 00
29.00	Ambul ance Trips	0					29. 00
30.00	Employee discount days (see instruction)			0			30.00
31.00	Employee discount days - IRF			0			31.00
32.00	Labor & delivery days (see instructions)	0	46	81			32.00
32. 01	Total ancillary labor & delivery room			264			32. 01
	outpatient days (see instructions)						
33.00	LTCH non-covered days	o					33.00
	LTCH site neutral days and discharges	0					33. 01
		. '	'	•	•	•	•

Provider CCN: 15-0023

| Peri od: | Worksheet S-3 | From 01/01/2018 | Part I | To 12/31/2018 | Date/Time Prepared:

				10) 12/31/2018	Date/IIMe Pre 5/29/2019 1:1	
		Full Time	'	Di sch	arges		
		Equi val ents			,		
	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		0	6, 071	222	14, 958	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)			796	3, 486		2.00
3. 00	HMO IPF Subprovider				0		3.00
4. 00	HMO IRF Subprovider				32		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
	beds) (see instructions)						
8. 00	I NTENSI VE CARE UNIT						8. 00
9. 00	CORONARY CARE UNIT						9. 00
10.00	BURN INTENSIVE CARE UNIT						10.00
11. 00	SURGICAL INTENSIVE CARE UNIT						11.00
12.00	I NTENSI VE NURSERY						12.00
13.00	NURSERY						13.00
14.00	Total (see instructions)	0.00	0	6, 071	222	14, 958	14.00
15. 00	CAH visits						15.00
16. 00	SUBPROVIDER - I PF		_		_		16. 00
17.00	SUBPROVI DER - I RF	0. 00	0	170	0	264	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	0.00					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
33. 00	outpatient days (see instructions)						33. 00
	LTCH non-covered days			0			
33. U I	LTCH site neutral days and discharges			ı O			33. 01

UNI ON HOSPITAL, INC.

Provider CCN: 15-0023 | Period: From 01/01/2018 | From 01/01/2018 | To 12/31/2018 | Date/Time Prepared: 5/29/2019 1:11 pm |

Wkst. A Line | Amount | Reclassificat | Adjusted | Paid Hours | Average | Health Financial Systems
HOSPITAL WAGE INDEX INFORMATION

		Wkst. A Line Number	Amount Reported	Reclassificat ion of	Sal ari es	Paid Hours Related to	Average Hourly Wage	
				Salaries (from Wkst. A-6)	(col.2 ± col. 3)	Salaries in col. 4	(col. 4 ÷ col. 5)	
	PART II - WAGE DATA	1. 00	2. 00	3.00	4. 00	5. 00	6. 00	
	SALARI ES							
1. 00	Total salaries (see instructions)	200. 00	91, 617, 467	0	91, 617, 467	2, 961, 525. 00	30. 94	1. 00
2. 00	Non-physician anesthetist Part		0	0	0	0. 00	0. 00	2. 00
3. 00	Non-physician anesthetist Part B		0	0	0	0. 00	0. 00	3. 00
4. 00	Physician-Part A - Administrative		488, 743	0	488, 743	3, 162. 00	154. 57	4. 00
4. 01 5. 00	Physicians - Part A - Teaching Physician and Non Physician-Part B		0 3, 760, 603			0. 00 12, 454. 00		4. 01 5. 00
6. 00	Non-physician-Part B for hospital-based RHC and FQHC		0	О	0	0. 00	0.00	6. 00
7. 00	services Interns & residents (in an approved program)	21. 00	0	1, 329, 060	1, 329, 060	43, 680. 00	30. 43	7. 00
7. 01	Contracted interns and residents (in an approved		0	О	0	0. 00	0. 00	7. 01
8. 00	programs) Home office and/or related organization personnel		0	0	0	0. 00	0. 00	8. 00
9. 00 10. 00	SNF Excluded area salaries (see	44. 00	0 14, 800, 311	0 -1, 993, 536	0 12, 806, 775	0. 00 230, 969. 00		
	instructions) OTHER WAGES & RELATED COSTS							
11. 00	Contract Labor: Direct Patient Care		6, 759, 830	0	6, 759, 830	124, 876. 00	54. 13	11. 00
12. 00	Contract labor: Top level management and other		0	0	0	0. 00	0. 00	12.00
	management and administrative services							
13. 00	Contract Labor: Physician-Part A - Administrative		924, 556	0	924, 556	6, 700. 00	137. 99	13.00
14. 00	Home office and/or related organization salaries and wage-related costs		0	0	0	0. 00	0. 00	14. 00
14. 01	Home office salaries		15, 634, 141	0	15, 634, 141	414, 211. 00		14. 01
14. 02 15. 00	Related organization salaries Home office: Physician Part A		0	0	0	0. 00 0. 00		14. 02 15. 00
15.00	- Administrative		O			0.00	0.00	13.00
16. 00	Home office and Contract Physicians Part A - Teaching		0	0	0	0. 00	0. 00	16. 00
17 00	WAGE-RELATED COSTS Wage-related costs (core) (see		21, 828, 151	0	21, 828, 151			17. 00
18. 00	instructions) Wage-related costs (core) (see		21, 020, 131		,			18. 00
	(see instructions)		0 400 447		0.400.447			
19. 00 20. 00	Excluded areas Non-physician anesthetist Part A		3, 102, 417 0	0	3, 102, 417 0			19. 00 20. 00
21. 00	Non-physician anesthetist Part B		0	0	0			21. 00
22. 00	Physician Part A - Administrative		101, 288	0	101, 288			22. 00
22. 01 23. 00	Physician Part A - Teaching Physician Part B		0 743, 410	0	0 743, 410			22. 01 23. 00
24.00	Wage-related costs (RHC/FQHC)		0	ő	0			24.00
25. 00	Interns & residents (in an approved program)		270, 031	0	270, 031			25. 00
25. 50 25. 51	Home office wage-related (core) Related organization		4, 849, 962	0				25. 50 25. 51
	wage-related (core)		0	0				25. 51
25. 52	Home office: Physician Part A - Administrative - wage-related (core)		0					∠ວ. 5∠
25. 53	Home office & Contract Physicians Part A - Teaching -		0	0	0			25. 53
	wage-related (core)							

Provi der CCN: 15-0023

| In Lieu of Form CMS-2552-10 | Period: | Worksheet S-3 | From 01/01/2018 | Part II | To | 12/31/2018 | Date/Time Prepared:

					T	o 12/31/2018	Date/Time Pre 5/29/2019 1:1	
		Wkst. A Line	Amount	Recl assi fi cat	Adjusted	Pai d Hours	Average	ı pili
		Number	Reported	i on of	Sal ari es	Related to	Hourly Wage	
				Sal ari es	(col.2 ± col.	Salaries in	(col . 4 ÷	
				(from Wkst.	3)	col. 4	col . 5)	
				` A-6)	ĺ		ĺ	
		1. 00	2. 00	3. 00	4. 00	5. 00	6. 00	
	OVERHEAD COSTS - DIRECT SALARI	ES						
26.00	Employee Benefits Department	4. 00	177, 854	642, 038	819, 892	31, 592. 00	25. 95	26.00
27.00	Administrative & General	5. 00	7, 078, 942	-446, 875	6, 632, 067	243, 346. 00	27. 25	27.00
28.00	Administrative & General under		1, 760, 645	0	1, 760, 645	7, 863. 00	223. 92	28. 00
	contract (see inst.)							
29. 00	Maintenance & Repairs	6. 00	0	0	0	0. 00	0. 00	29. 00
30.00	Operation of Plant	7. 00	70, 428	0	70, 428	3, 271. 00	21. 53	30.00
31.00	Laundry & Linen Service	8. 00	666, 952	0	666, 952	41, 873. 00	15. 93	31.00
32.00	Housekeepi ng	9. 00	1, 998, 813	0	1, 998, 813	147, 290. 00	13. 57	32.00
33.00	Housekeeping under contract		0	0	0	0. 00	0. 00	33.00
	(see instructions)							
34.00	Di etary	10. 00	1, 554, 903	-1, 243, 605	311, 298	21, 502. 00	14. 48	34.00
35.00	Dietary under contract (see		851, 208	0	851, 208	11, 320. 00	75. 20	35.00
	instructions)							
36.00	Cafeteri a	11. 00	108, 923	1, 236, 738	1, 345, 661	93, 441. 00		36.00
37.00	Maintenance of Personnel	12. 00	0	0	0	0. 00	0. 00	37.00
38. 00	Nursing Administration	13. 00	1, 939, 989	0	1, 939, 989	37, 905. 00	51. 18	38. 00
39. 00	Central Services and Supply	14. 00	0	0	0	0. 00	0. 00	39. 00
40.00	Pharmacy	15. 00	0	0	0	0. 00	0. 00	40.00
41.00	Medical Records & Medical	16. 00	2, 668, 484	0	2, 668, 484	124, 951. 00	21. 36	41.00
	Records Li brary							
42.00	Social Service	17. 00	0	0	0	0.00		42.00
43.00	Other General Service	18. 00	0	0	0	0. 00	0. 00	43.00

Health Financial Systems		UNI ON HOSPI	TAL, INC.		In Lie	u of Form CMS-2	2552-10
HOSPITAL WAGE INDEX INFORMATION			Provi der C		Peri od:	Worksheet S-3	
					From 01/01/2018 To 12/31/2018	Date/Time Pre 5/29/2019 1:1	
	Worksheet A	Amount	Recl assi fi cat	Adj usted	Pai d Hours	Average	
	Line Number	Reported	ion of	Sal ari es	Related to	Hourly Wage	
			Sal ari es	(col.2 ± col.	Salaries in	(col. 4 ÷	
			(from	3)	col. 4	col. 5)	
			Worksheet				
			A-6)				
	1. 00	2. 00	3. 00	4.00	5. 00	6. 00	
PART III - HOSPITAL WAGE INDEX	SUMMARY						
4 00 11 1 1 /		00 4/0 747	1 000 0/0	00 400 / 5	7 0 004 574 00	00 10	1 4 00

Health Financial Systems	UNION HOSPITAL, INC.	In Lieu of Form CMS-2552-10
HOSPITAL WAGE RELATED COSTS	Provi der CCN: 15-0023	Period: Worksheet S-3 From 01/01/2018 Part IV
		To 12/31/2018 Date/Time Prepared

	To 12/31/2018	B Date/Time Prep 5/29/2019 1:1	
		Amount	, p
		Reported	
		1.00	
	PART IV - WAGE RELATED COSTS		
	Part A - Core List		1
	RETI REMENT COST		1
1.00	401K Employer Contributions	3, 008, 263	1.00
2.00	Tax Sheltered Annuity (TSA) Employer Contribution	o	2.00
3.00	Nonqualified Defined Benefit Plan Cost (see instructions)	o	3.00
4.00	Qualified Defined Benefit Plan Cost (see instructions)	7, 580, 811	4.00
	PLAN ADMINISTRATIVE COSTS (Paid to External Organization)		1
5.00	401K/TSA Plan Administration fees	0	5.00
6.00	Legal /Accounting/Management Fees-Pension Plan	0	6.00
7.00	Employee Managed Care Program Administration Fees	0	7.00
	HEALTH AND INSURANCE COST		
8.00	Health Insurance (Purchased or Self Funded)	0	8.00
8. 01	Health Insurance (Self Funded without a Third Party Administrator)	0	8. 01
8. 02	Health Insurance (Self Funded with a Third Party Administrator)	8, 591, 496	8. 02
8. 03	Health Insurance (Purchased)	0	8. 03
9.00	Prescription Drug Plan	0	9. 00
10.00	Dental, Hearing and Vision Plan	-85, 907	
11. 00	Life Insurance (If employee is owner or beneficiary)	46, 796	
12.00	Accident Insurance (If employee is owner or beneficiary)	0	12.00
13.00	Disability Insurance (If employee is owner or beneficiary)	109, 096	
14.00	Long-Term Care Insurance (If employee is owner or beneficiary)	0	14.00
15. 00	'Workers' Compensation Insurance	280, 772	15. 00
16. 00	Retirement Health Care Cost (Only current year, not the extraordinary accrual required by FASB 106.	0	16.00
	Non cumulative portion)		
47.00	TAXES		47.00
17.00	FICA-Employers Portion Only	6, 336, 350	•
18.00	Medicare Taxes - Employers Portion Only	0	18.00
19. 00	Unempl oyment Insurance	24, 918	
20. 00	State or Federal Unemployment Taxes	0	20.00
04 00	OTHER		04.00
21. 00	Executive Deferred Compensation (Other Than Retirement Cost Reported on Lines 1 through 4 above. (see	0	21.00
22.00	instructions))		22.00
22. 00	Day Care Cost and Allowances Tuition Reimbursement	152.702	22. 00 23. 00
23. 00 24. 00		152, 702	
24. UU	Total Wage Related cost (Sum of lines 1 -23) Part B - Other than Core Related Cost	26, 045, 297	24.00
25 00	OTHER WAGE RELATED COSTS (SPECIFY)		25. 00
25.00	TOTHER WIND REPUTED GOOD (SECULITY)	١	25.00

Health Financial Systems	UNION HOSPITAL, INC.	In Lie	u of Form CMS-2552-10
HOSPITAL CONTRACT LABOR AND BENEFIT COST			Worksheet S-3 Part V Date/Time Prepared: 5/29/2019 1:11 pm
Cost Contor Doscription		Contract	Ponofit Cost

		10 12/31/2018	5/29/2019 1:1	
	Cost Center Description	Contract	Benefit Cost	, p
		Labor		
		1. 00	2. 00	
	PART V - Contract Labor and Benefit Cost			
	Hospital and Hospital-Based Component Identification:			
1.00	Total facility's contract labor and benefit cost	0	0	1.00
2.00	Hospi tal	0	0	2.00
3.00	Subprovi der - I PF			3.00
4.00	Subprovi der - I RF	0	0	4.00
5. 00	Subprovi der - (Other)	0	0	5.00
6. 00	Swing Beds - SNF	0	0	6.00
7.00	Swing Beds - NF	0	0	7.00
8.00	Hospi tal -Based SNF			8.00
9.00	Hospi tal -Based NF			9. 00
10.00	Hospi tal -Based OLTC			10.00
11. 00	Hospi tal -Based HHA			11.00
12. 00	Separately Certified ASC			12.00
13. 00	Hospi tal -Based Hospi ce			13.00
14. 00	Hospital-Based Health Clinic RHC			14.00
15. 00	Hospital-Based Health Clinic FQHC			15. 00
16.00	Hospi tal -Based-CMHC			16.00
17. 00	Renal Dialysis			17. 00
18. 00	Other	0	0	18. 00

near tr	Financial Systems UNION HOSPITAL,	LNC		Inlie	u of Form CMS-2	552-10	
HOSPI 7		rovi der CCI	N: 15-0023	Peri od:	Worksheet S-10		
				From 01/01/2018	D=+= /T: D		
				To 12/31/2018	Date/Time Prep 5/29/2019 1:1		
					1. 00		
	Uncompensated and indigent care cost computation				1.00		
1.00	Cost to charge ratio (Worksheet C, Part I line 202 column 3 divi	ided by li	ne 202 colum	n 8)	0. 219399	1.00	
	Medicaid (see instructions for each line)						
2.00	Net revenue from Medicaid				53, 447, 029 Y	2. 00 3. 00	
3. 00 4. 00	"						
5. 00	If line 4 is no, then enter DSH and/or supplemental payments from			ai u :	N -20, 582, 792	4. 00 5. 00	
6. 00	Medicaid charges	om wear ear	4		247, 445, 121	6. 00	
7.00	Medicaid cost (line 1 times line 6)				54, 289, 212	7.00	
8.00	Difference between net revenue and costs for Medicaid program (line 7 minu	us sum of li	nes 2 and 5; if	21, 424, 975	8.00	
	<pre>< zero then enter zero) Children's Health Insurance Program (CHIP) (see instructions for</pre>	s acab line	- \				
9. 00	Net revenue from stand-alone CHIP	each iiii	=)		51, 258	9. 00	
10.00	Stand-alone CHIP charges				142, 495	10.00	
11.00	Stand-alone CHIP cost (line 1 times line 10)				31, 263	11.00	
12.00	Difference between net revenue and costs for stand-alone CHIP (line 11 mi	nus line 9;	if < zero then	0	12.00	
	enter zero) Other state or local government indigent care program (see insti	custions fo	ar oach line	\			
13. 00	Net revenue from state or local indigent care program (Not included in the care program (Not included in the care program (Not included in the care program in the car				0	13. 00	
14. 00	Charges for patients covered under state or local indigent care				ő	14. 00	
	10)						
15.00	State or local indigent care program cost (line 1 times line 14)	0	15. 00 16. 00				
16. 00							
	13; if < zero then enter zero) Grants, donations and total unreimbursed cost for Medicaid, CHIF	and state	e/Local indi	gent care progra	ms (see		
	instructions for each line)						
17.00	Private grants, donations, or endowment income restricted to ful				0		
18. 00 19. 00	Government grants, appropriations or transfers for support of he Total unreimbursed cost for Medicaid, CHIP and state and local			c (cum of lines	21, 424, 975	18. 00 19. 00	
17.00	8, 12 and 16)	That gent (care program	s (suii oi iiiles	21, 424, 975	19.00	
	1-1		Uni nsured	Insured	Total (col. 1		
			pati ents	notionto			
		-		patients	+ col . 2)		
	Uncompanyated Caro (see instructions for each line)		1.00	2.00	+ col . 2) 3.00		
20 00	Uncompensated Care (see instructions for each line) Charity care charges and uninsured discounts for the entire faci	ility		2.00	3. 00	20, 00	
20. 00	Uncompensated Care (see instructions for each line) Charity care charges and uninsured discounts for the entire faci (see instructions)	ility	1.00	2.00	3. 00	20.00	
20. 00 21. 00	Charity care charges and uninsured discounts for the entire faci (see instructions) Cost of patients approved for charity care and uninsured discounts			2. 00	3. 00		
21. 00	Charity care charges and uninsured discounts for the entire faci (see instructions) Cost of patients approved for charity care and uninsured discount instructions)	nts (see	17, 646, 36	2. 00 66 6, 485, 660 65 6, 485, 660	3. 00 24, 132, 026 10, 357, 255	21. 00	
	Charity care charges and uninsured discounts for the entire faci (see instructions) Cost of patients approved for charity care and uninsured discounts	nts (see	17, 646, 36	2. 00	3. 00		
21. 00	Charity care charges and uninsured discounts for the entire faci (see instructions) Cost of patients approved for charity care and uninsured discountinstructions) Payments received from patients for amounts previously written	nts (see	17, 646, 36	2. 00 6, 485, 660 0 0 0	3. 00 24, 132, 026 10, 357, 255	21. 00 22. 00	
21. 00 22. 00	Charity care charges and uninsured discounts for the entire faci (see instructions) Cost of patients approved for charity care and uninsured discount instructions) Payments received from patients for amounts previously written of charity care	nts (see	17, 646, 36 3, 871, 59	2. 00 6, 485, 660 0 0 0	3. 00 24, 132, 026 10, 357, 255 0 10, 357, 255	21. 00 22. 00	
21. 00 22. 00 23. 00	Charity care charges and uninsured discounts for the entire fact (see instructions) Cost of patients approved for charity care and uninsured discourinstructions) Payments received from patients for amounts previously written charity care Cost of charity care (line 21 minus line 22)	nts (see	17, 646, 36 3, 871, 59 3, 871, 59	2. 00 6, 485, 660 0 0 05 6, 485, 660	3. 00 24, 132, 026 10, 357, 255 0 10, 357, 255	21. 00 22. 00 23. 00	
21. 00 22. 00 23. 00 24. 00	Charity care charges and uninsured discounts for the entire fact (see instructions) Cost of patients approved for charity care and uninsured discourinstructions) Payments received from patients for amounts previously written charity care Cost of charity care (line 21 minus line 22) Does the amount on line 20 column 2, include charges for patient imposed on patients covered by Medicaid or other indigent care	nts (see off as t days beyoprogram?	17, 646, 36 3, 871, 59 3, 871, 59 ond a Length	2.00 6, 485, 660 6, 485, 660 0 0 6, 485, 660 0 stay limit	3. 00 24, 132, 026 10, 357, 255 0 10, 357, 255	21. 00 22. 00 23. 00 24. 00	
21. 00 22. 00 23. 00 24. 00	Charity care charges and uninsured discounts for the entire fact (see instructions) Cost of patients approved for charity care and uninsured discour instructions) Payments received from patients for amounts previously written charity care Cost of charity care (line 21 minus line 22) Does the amount on line 20 column 2, include charges for patient imposed on patients covered by Medicaid or other indigent care of the line 24 is yes, enter the charges for patient days beyond the	nts (see off as t days beyoprogram?	17, 646, 36 3, 871, 59 3, 871, 59 ond a Length	2.00 6, 485, 660 6, 485, 660 0 0 6, 485, 660 0 stay limit	3. 00 24, 132, 026 10, 357, 255 0 10, 357, 255	21. 00 22. 00 23. 00	
21. 00 22. 00 23. 00 24. 00	Charity care charges and uninsured discounts for the entire fact (see instructions) Cost of patients approved for charity care and uninsured discourinstructions) Payments received from patients for amounts previously written charity care Cost of charity care (line 21 minus line 22) Does the amount on line 20 column 2, include charges for patient imposed on patients covered by Medicaid or other indigent care	t days beyoprogram?	17, 646, 36 3, 871, 59 3, 871, 59 ond a Length	2.00 6, 485, 660 6, 485, 660 0 0 6, 485, 660 0 stay limit	3. 00 24, 132, 026 10, 357, 255 0 10, 357, 255 1. 00 N	21. 00 22. 00 23. 00 24. 00	
21. 00 22. 00 23. 00 24. 00 25. 00	Charity care charges and uninsured discounts for the entire fact (see instructions) Cost of patients approved for charity care and uninsured discourinstructions) Payments received from patients for amounts previously written ocharity care Cost of charity care (line 21 minus line 22) Does the amount on line 20 column 2, include charges for patient imposed on patients covered by Medicaid or other indigent care if I line 24 is yes, enter the charges for patient days beyond the stay limit Total bad debt expense for the entire hospital complex (see ins.)	t days beyong program? e indigent tructions) (see insti	17, 646, 36 3, 871, 59 3, 871, 59 ond a Length care progra	2.00 6, 485, 660 6, 485, 660 0 0 6, 485, 660 0 stay limit	3. 00 24, 132, 026 10, 357, 255 0 10, 357, 255 1. 00 N 0 38, 765, 832 1, 966, 309	21. 00 22. 00 23. 00 24. 00 25. 00 26. 00 27. 00	
21. 00 22. 00 23. 00 24. 00 25. 00 26. 00 27. 00 27. 01	Charity care charges and uninsured discounts for the entire fact (see instructions) Cost of patients approved for charity care and uninsured discourinstructions) Payments received from patients for amounts previously written charity care Cost of charity care (line 21 minus line 22) Does the amount on line 20 column 2, include charges for patient imposed on patients covered by Medicaid or other indigent care if line 24 is yes, enter the charges for patient days beyond the stay limit Total bad debt expense for the entire hospital complex (see instead care reimbursable bad debts for the entire hospital complex (see Medicare allowable bad debts for the entire hospital complex (see	t days beyong program? e indigent tructions) (see insti	17, 646, 36 3, 871, 59 3, 871, 59 ond a Length care progra	2.00 6, 485, 660 6, 485, 660 0 0 6, 485, 660 0 stay limit	3. 00 24, 132, 026 10, 357, 255 0 10, 357, 255 1. 00 N 0 38, 765, 832 1, 966, 309 3, 025, 092	21. 00 22. 00 23. 00 24. 00 25. 00 26. 00 27. 00 27. 01	
21. 00 22. 00 23. 00 24. 00 25. 00 26. 00 27. 00 27. 01 28. 00	Charity care charges and uninsured discounts for the entire fact (see instructions) Cost of patients approved for charity care and uninsured discount instructions) Payments received from patients for amounts previously written of charity care Cost of charity care (line 21 minus line 22) Does the amount on line 20 column 2, include charges for patient imposed on patients covered by Medicaid or other indigent care if line 24 is yes, enter the charges for patient days beyond the stay limit Total bad debt expense for the entire hospital complex (see insomedicare reimbursable bad debts for the entire hospital complex (see Medicare allowable bad debts for the entire hospital complex (see Non-Medicare bad debt expense (see instructions)	t days beyong program? e indigent tructions) (see instructions)	17, 646, 36 3, 871, 59 3, 871, 59 ond a Length care progra ructions)	2.00 6, 485, 660 6, 485, 660 0	3. 00 24, 132, 026 10, 357, 255 0 10, 357, 255 1. 00 N 0 38, 765, 832 1, 966, 309 3, 025, 092 35, 740, 740	21. 00 22. 00 23. 00 24. 00 25. 00 26. 00 27. 00 27. 01 28. 00	
21. 00 22. 00 23. 00 24. 00 25. 00 26. 00 27. 00 27. 01 28. 00 29. 00	Charity care charges and uninsured discounts for the entire fact (see instructions) Cost of patients approved for charity care and uninsured discount instructions) Payments received from patients for amounts previously written of charity care Cost of charity care (line 21 minus line 22) Does the amount on line 20 column 2, include charges for patient imposed on patients covered by Medicaid or other indigent care of line 24 is yes, enter the charges for patient days beyond the stay limit Total bad debt expense for the entire hospital complex (see insome Medicare reimbursable bad debts for the entire hospital complex (see Non-Medicare bad debt expense (see instructions) Cost of non-Medicare and non-reimbursable Medicare bad debt expense	t days beyong program? e indigent tructions) (see instructions)	17, 646, 36 3, 871, 59 3, 871, 59 ond a Length care progra ructions)	2.00 6, 485, 660 6, 485, 660 0	3. 00 24, 132, 026 10, 357, 255 0 10, 357, 255 1. 00 N 0 38, 765, 832 1, 966, 309 3, 025, 092 35, 740, 740 8, 900, 266	21. 00 22. 00 23. 00 24. 00 25. 00 26. 00 27. 00 27. 01 28. 00 29. 00	
21. 00 22. 00 23. 00 24. 00 25. 00 27. 00 27. 01 28. 00 29. 00 30. 00	Charity care charges and uninsured discounts for the entire fact (see instructions) Cost of patients approved for charity care and uninsured discount instructions) Payments received from patients for amounts previously written of charity care Cost of charity care (line 21 minus line 22) Does the amount on line 20 column 2, include charges for patient imposed on patients covered by Medicaid or other indigent care if line 24 is yes, enter the charges for patient days beyond the stay limit Total bad debt expense for the entire hospital complex (see insomedicare reimbursable bad debts for the entire hospital complex (see Medicare allowable bad debts for the entire hospital complex (see Non-Medicare bad debt expense (see instructions)	t days beyond the second that	17, 646, 36 3, 871, 59 3, 871, 59 ond a Length care progra ructions)	2.00 6, 485, 660 6, 485, 660 0	3. 00 24, 132, 026 10, 357, 255 0 10, 357, 255 1. 00 N 0 38, 765, 832 1, 966, 309 3, 025, 092 35, 740, 740	21. 00 22. 00 23. 00 24. 00 25. 00 26. 00 27. 01 28. 00 29. 00 30. 00	

	STELCATION AND ADJUSTMENTS OF TOLAL DALANCE O	UNI UN HUSPI I	Provi der C	CNI. 1E 0022	Peri od:	Worksheet A	2332-10
RECLAS	SSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE O	JF EXPENSES	Provider C	1	rom 01/01/2018		
					To 12/31/2018	Date/Time Pre 5/29/2019 1:1	
	Cost Center Description	Sal ari es	Other	Total (col. 1	Recl assi fi cat	Reclassi fi ed	T piii
	·			+ col. 2)	i ons (See	Tri al Bal ance	
					A-6)	(col. 3 +-	
		1. 00	2. 00	3. 00	4. 00	<u>col. 4)</u> 5. 00	
	GENERAL SERVICE COST CENTERS	1.00	2.00	3.00	4.00	5.00	
1.00	00100 NEW CAP REL COSTS-BLDG & FLXT		13, 866, 123	13, 866, 123	6, 006, 408	19, 872, 531	1.00
2.00	00200 NEW CAP REL COSTS-MVBLE EQUIP		9, 680, 239			12, 295, 226	2.00
4.00	00400 EMPLOYEE BENEFITS DEPARTMENT	177, 854	16, 547			3, 489, 627	
5. 01	00540 NONPATI ENT TELEPHONES 00550 DATA PROCESSI NG	521, 538	342, 804			864, 342 0	
5. 02 5. 03	00560 PURCHASING RECEIVING AND STORES	0	0	(0	
5. 04	00570 ADMITTING	1, 045, 521	401, 225	1, 446, 746	0	1, 446, 746	
5. 05	00580 CASHI ERI NG/ACCOUNTS RECEI VABLE	0	0		0	0	1
5.06	00590 OTHER ADMIN AND GENERAL	5, 511, 883	32, 213, 867			28, 377, 279	
7.00	00700 OPERATION OF PLANT	70, 428	699, 235			769, 663	
8. 00 9. 00	00800 LAUNDRY & LI NEN SERVI CE 00900 HOUSEKEEPI NG	666, 952 1, 998, 813	383, 488 1, 188, 839			1, 050, 440 3, 187, 652	
10.00	01000 DI ETARY	1, 554, 903	2, 731, 633			864, 979	
11. 00	01100 CAFETERI A	108, 923	147, 384			3, 670, 997	1
13.00	01300 NURSING ADMINISTRATION	1, 939, 989	249, 288	2, 189, 27	0	2, 189, 277	
16. 00	01600 MEDICAL RECORDS & LIBRARY	2, 668, 484	1, 139, 663			3, 808, 147	
21.00	02100 &R SERVICES-SALARY & FRINGES APPRVD 02200 &R SERVICES-OTHER PRGM COSTS APPRVD	0	0	9	.,		
22. 00 23. 00	02300 PARAMED ED PRGM		0	(2, 235, 010 138, 461	2, 235, 010 138, 461	
23. 00	02341 OTHER MED ED	625, 931	77, 789	703, 720		775, 790	
23. 02	02301 PARAMED ED PRGM	0	0			138, 461	
	INPATIENT ROUTINE SERVICE COST CENTERS						
30.00		21, 074, 338	6, 352, 617			26, 087, 623	
31. 00 35. 00	03100 INTENSIVE CARE UNIT 02040 INTENSIVE NURSERY	4, 197, 355 1, 898, 761	1, 205, 186 1, 485, 856			5, 477, 195 3, 434, 177	
41. 00	04100 SUBPROVI DER – I RF	1, 160, 378	906, 283			2, 110, 829	
43.00	04300 NURSERY	0	32			1, 177, 849	
	ANCILLARY SERVICE COST CENTERS						
50.00	05000 OPERATING ROOM	2, 749, 519	17, 913, 203			12, 281, 745	
50. 01	05001 CARDI AC SURGERY	1, 873, 903	2, 263, 360			3, 970, 153	
50. 02 51. 00	05002 WVSC 05100 RECOVERY ROOM	0 1, 509, 891	13, 773, 893 312, 326			12, 115, 414 1, 822, 217	
51. 02	05101 0/P TREATMENT ROOM	330, 924	93, 776			424, 700	
52.00	05200 DELIVERY ROOM & LABOR ROOM	2, 796, 428	2, 784, 043			5, 580, 471	
54.00	05400 RADI OLOGY-DI AGNOSTI C	3, 719, 243	3, 689, 784			7, 132, 105	
55.00	05500 RADI OLOGY-THERAPEUTI C	362, 025	4, 877, 366			5, 239, 391	
56. 00 57. 00	05600 RADI OI SOTOPE 05700 CT SCAN	327, 100 1, 101, 078	1, 207, 268 1, 167, 696			1, 534, 368 2, 268, 774	1
58. 00	05800 MAGNETIC RESONANCE IMAGING (MRI)	592, 122	1, 125, 330			1, 717, 452	
59.00	05900 CARDI AC CATHETERI ZATI ON	2, 145, 816	20, 893, 338				
60.00	06000 LABORATORY	O	9, 211, 511	9, 211, 51		9, 211, 511	
	06200 WHOLE BLOOD & PACKED RED BLOOD CELLS	0	1, 332, 919				
66.00	06500 RESPI RATORY THERAPY 06600 PHYSI CAL THERAPY	2, 658, 159	1, 003, 656 4, 617, 119			3, 661, 815 4, 617, 119	
66. 01	06601 PSYCHI ATRI C/PSYCHOLOGI CAL SERVI CES		4,017,119	4,017,11		4,017,117	1
66. 02	1 1	o	3, 671, 789			3, 671, 789	1
67. 00	06700 OCCUPATI ONAL THERAPY	0	0	(0	0	
68.00	06800 SPEECH PATHOLOGY	0	710, 527			710, 527	
69. 00 69. 01	06900 ELECTROCARDI OLOGY 06901 CARDI AC REHAB	528, 333 263, 150	9, 671, 993 39, 156			10, 200, 326 302, 306	
70.00	07000 ELECTROENCEPHALOGRAPHY	2, 714, 854	753, 136			3, 467, 990	
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	2, 711, 001	850, 346			850, 346	
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0	0			14, 028, 995	
73.00	07300 DRUGS CHARGED TO PATIENTS	4, 313, 634	47, 404, 282			48, 609, 628	
76. 00	03020 RENAL ACUTE	0	1, 443, 005	1, 443, 005	5 0	1, 443, 005	76. 00
90. 00	OUTPATIENT SERVICE COST CENTERS 09000 CLINIC	178, 135	42, 004	220, 139		220, 139	90.00
90.00	09000 PATIENT NUTRITION	238, 851	35, 339			274, 190	
90. 07	09007 WOUND CLINIC	309, 450	863, 872			1, 173, 322	
91.00	09100 EMERGENCY	4, 668, 799	8, 113, 832	12, 782, 63°	0	12, 782, 631	91.00
92. 00	09200 OBSERVATION BEDS (NON-DISTINCT PART)						92.00
118. 00	SPECIAL PURPOSE COST CENTERS SUBTOTALS (SUM OF LINES 1 through 117)	78, 603, 465	232, 953, 967	311, 557, 432	3, 211, 932	214 740 244	110 00
118.00	NONREIMBURSABLE COST CENTERS	78, 603, 465	232, 953, 967	311, 557, 432	2 3, 211, 932	314, 769, 364]118.00
190.00	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	(0	0	190. 00
194.00	07950 RURAL HEALTH	1, 190, 326	2, 124, 909			3, 446, 623	1
	07951 RENTAL PROPERTY	0	48, 973				194.01
	207954 FAMILY PRACTICE 307952 WELLNESS	4, 964, 059	2, 647, 630 0			3, 931, 689 433, 184	
	107955 PHYSI CI AN PRACTI CES	6, 400, 074	7, 418, 726		,	13, 818, 800	
	07953 SYCAMORE SPORTS MED	12, 200	1, 037, 056				

Health Financial Systems	UNI ON HOSPI	TAL LNC		In lie	u of Form CMS-	2552-10
RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE C		Provi der Co	CN: 15-0023	Peri od:	Worksheet A	
				From 01/01/2018		
				To 12/31/2018	Date/Time Pre	
					5/29/2019 1:1	1 pm
Cost Center Description	Sal ari es	0ther	Total (col. 1	Recl assi fi cat	Recl assi fi ed	
			+ col . 2)	i ons (See	Trial Balance	
				A-6)	(col. 3 +-	
					col. 4)	
	1. 00	2.00	3.00	4. 00	5. 00	
194. 07 07956 PSYCHI ATRI C/PSYCHOLOGI CAL SERVI CES	447, 343	82, 103	529, 44	-96, 504	432, 942	194. 07
200.00 TOTAL (SUM OF LINES 118 through 199)	91, 617, 467	246, 313, 364	337, 930, 83	1 0	337, 930, 831	200.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES

Provi der CCN: 15-0023

Peri od: Worksheet A From 01/01/2018 To 12/31/2018 Date/Time Prepared:

5/29/2019 1:11 pm Cost Center Description Adjustments Net Expenses (See A-8) For Allocation 6. 00 7.00 GENERAL SERVICE COST CENTERS 1.00 00100 NEW CAP REL COSTS-BLDG & FIXT -4, 439, 942 15, 432, 589 1.00 00200 NEW CAP REL COSTS-MVBLE EQUIP 2.00 -1, 049, 318 11, 245, 908 2.00 00400 EMPLOYEE BENEFITS DEPARTMENT 13, 157, 764 16, 647, 391 4 00 4 00 5.01 00540 NONPATIENT TELEPHONES 39, 346 903, 688 5.01 00550 DATA PROCESSING 12, 664, 020 5.02 12, 664, 020 5.02 1, 527, 196 5.03 00560 PURCHASING RECEIVING AND STORES 1, 527, 196 5.03 00570 ADMITTING 5.04 1, 446, 746 5.04 5.05 00580 CASHI ERI NG/ACCOUNTS RECEI VABLE 5, 720, 343 5, 720, 343 5.05 5.06 00590 OTHER ADMIN AND GENERAL -7, 264, 726 21, 112, 553 5.06 00700 OPERATION OF PLANT 8, 626, 094 7.00 9, 395, 757 7.00 00800 LAUNDRY & LINEN SERVICE 1, 045, 292 8.00 -5, 148 8.00 9.00 00900 HOUSEKEEPI NG -134, 905 3, 052, 747 9.00 10.00 01000 DI ETARY -893, 334 -28, 355 10.00 11. 00 01100 CAFETERIA -1, 084, 927 2, 586, 070 11.00 13.00 01300 NURSING ADMINISTRATION 1, 459, 799 3, 649, 076 13.00 01600 MEDICAL RECORDS & LIBRARY 3, 956, 689 16.00 148, 542 16.00 02100 I&R SERVICES-SALARY & FRINGES APPRVD 21.00 1, 444, 990 21.00 02200 I&R SERVICES-OTHER PRGM COSTS APPRVD 22 00 -119, 028 2, 115, 982 22 00 02300 PARAMED ED PRGM 138, 461 23.00 23.00 02341 OTHER MED ED 23. 01 -547, 041 228, 749 23.01 02301 PARAMED ED PRGM 138, 461 23.02 0 23.02 INPATIENT ROUTINE SERVICE COST CENTERS 30.00 03000 ADULTS & PEDIATRICS 0 26, 087, 623 30.00 03100 INTENSIVE CARE UNIT 31.00 5, 477, 195 31.00 02040 I NTENSI VE NURSERY -1, 103, 919 35.00 2, 330, 258 35.00 41.00 04100 SUBPROVI DER - I RF -677, 135 1, 433, 694 41.00 04300 NURSERY 43.00 1, 177, 849 43.00 ANCILLARY SERVICE COST CENTERS 50.00 05000 OPERATING ROOM -2, 108, 383 50.00 10, 173, 362 50.01 05001 CARDI AC SURGERY -2, 302, 123 1,668,030 50.01 50.02 05002 WVSC -1, 143, 689 10, 971, 725 50.02 1, 830, 331 51. 00 05100 RECOVERY ROOM 8, 114 51 00 424, 700 05101 0/P TREATMENT ROOM 51.02 51.02 05200 DELIVERY ROOM & LABOR ROOM -2, 130, 537 3, 449, 934 52.00 05400 RADI OLOGY-DI AGNOSTI C 54.00 -293, 021 6, 839, 084 54.00 55 00 05500 RADI OLOGY-THERAPEUTI C 5, 239, 391 55 00 0 1,534,368 56.00 05600 RADI 0I SOTOPE 0 56.00 57. 00 05700 CT SCAN 221, 811 2, 490, 585 57.00 58.00 05800 MAGNETIC RESONANCE IMAGING (MRI) 53.059 1, 770, 511 58.00 05900 CARDI AC CATHETERI ZATI ON 59.00 138, 420 19, 355, 145 59.00 60.00 06000 LABORATORY -183, 070 9, 028, 441 60.00 62.00 06200 WHOLE BLOOD & PACKED RED BLOOD CELLS 1, 332, 919 62.00 0 06500 RESPIRATORY THERAPY 65 00 3, 661, 815 65 00 0 66.00 06600 PHYSI CAL THERAPY -1, 905, 381 2, 711, 738 66.00 66.01 06601 PSYCHI ATRI C/PSYCHOLOGI CAL SERVI CES 66.01 06602 0/P PHYSI CAL THERAPY -1, 337, 895 2, 333, 894 66.02 66.02 06700 OCCUPATI ONAL THERAPY 1, 833, 367 1,833,367 67.00 67.00 68.00 06800 SPEECH PATHOLOGY 68, 636 779, 163 68.00 06900 ELECTROCARDI OLOGY 10, 319, 161 69.00 118,835 69.00 06901 CARDI AC REHAB 69.01 1.864 304, 170 69.01 07000 ELECTROENCEPHALOGRAPHY 70 00 -2.684.708 783. 282 70 00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS -2, 201 848, 145 71.00 72.00 07200 IMPL. DEV. CHARGED TO PATIENTS 14, 028, 995 72.00 07300 DRUGS CHARGED TO PATIENTS 48, 374 73.00 48, 658, 002 73.00 76.00 03020 RENAL ACUTE 1, 443, 005 76.00 OUTPATIENT SERVICE COST CENTERS 09000 CLI NI C 90.00 220, 139 90.00 271, 817 90.05 09005 PATIENT NUTRITION -2.37390.05 90.07 09007 WOUND CLINIC 5,620 1, 178, 942 90.07 91.00 09100 EMERGENCY -6, 228, 101 6, 554, 530 91.00 09200 OBSERVATION BEDS (NON-DISTINCT PART) 92.00 92.00 SPECIAL PURPOSE COST CENTERS 118.00 SUBTOTALS (SUM OF LINES 1 through 117) 8, 200, 299 322, 969, 663 118.00 NONREI MBURSABLE COST CENTERS 190.00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN 190.00 194.00 07950 RURAL HEALTH 0 3, 446, 623 194. 00 194. 01 07951 RENTAL PROPERTY 0 194. 01 48, 973 194. 02 07954 FAMILY PRACTICE 0 3, 931, 689 194.02 194. 03 07952 WELLNESS 433, 184 194.03 0 194. 04 07955 PHYSI CI AN PRACTI CES -600, 215 13, 218, 585 194.04 194.06 07953 SYCAMORE SPORTS MED -994, 616 54, 640 194.06 194. 07 07956 PSYCHI ATRI C/PSYCHOLOGI CAL SERVI CES 194. 07 432, 942

Health Financial Systems		UNION HOSPITAL, INC.			In Lieu of Form CMS-2552-10		
RECLASSIFICATION AND ADJUSTMENTS	OF TRIAL BALANCE	OF EXPENSES	Provi der Co	CN: 15-0023	Peri od:	Worksheet A	
					From 01/01/2018		
					To 12/31/2018	Date/Time Pre	
						5/29/2019 1: 1	1 pm
Cost Center Descript	i on	Adjustments	Net Expenses				
		(See A-8)	For				
			Allocation				
		6. 00	7. 00				
200.00 TOTAL (SUM OF LINES	118 through 199)	6, 605, 468	344, 536, 299				200.00

Heal th Financial SystemsUNION HOSPITAL, INC.In Lieu of Form CMS-2552-10RECLASSIFICATIONSProvider CCN: 15-0023Period: From 01/01/2018Worksheet A-6

Date/Time Prepared: 12/31/2018 5/29/2019 1:11 pm Increases Cost Center Li ne # Sal ary 0ther 2.00 3.00 4.00 5.00 B - PARAMED 1.00 PARAMED ED PRGM 23.00 109, 596 28, 865 1.00 2.00 PARAMED ED PRGM 23. 02 109, 596 28, 865 2.00 219, 192 57, 730 - FITNESS ACTIVITY 1.00 EMPLOYEE BENEFITS DEPARTMENT 4. 00 121, 908 40, 596 1.00 1<u>94.</u> 03 2.00 WELLNESS 324, 967 108, 217 2.00 446, 875 148, 813 D - CLAY CITY RURAL HEALTH 1.00 RURAL HEALTH 194.00 0 55, 306 1.00 55, 306 - CORK MEDICAL RURAL HEALTH 1.00 RURAL HEALTH 194. 00 27, 435 1.00 27, 435 - HOUSE NURSE ASSISTANT 1.00 INTENSIVE CARE UNIT 31.00 67, 748 6, 906 1.00 2.00 INTENSIVE NURSERY 35.00 44, 976 4, 584 2.00 41. 00 3.00 SUBPROVIDER - IRF 40,082 4,086 3.00 152, 806 15, 576 EMPLOYEE ACCESS 1.00 EMPLOYEE BENEFITS DEPARTMENT 81, 539 14, 965 4.00 1.00 81, 539 14, 965 TUBE FEEDING 1.00 ADULTS & PEDIATRICS 30. 00 6, 867 1.00 6, 867 I - FAMILY MEDICINE 1.00 I&R SERVICES-SALARY & 21.00 1, 329, 060 115, 930 1.00 FRI NGES APPRVD I&R SERVICES-OTHER PRGM 2.00 22.00 1, 232, 885 1,002,125 2.00 COSTS APPRVD 2, 561, 945 1, 118, 055 J - LOBBY PHARMACY 1.00 EMPLOYEE BENEFITS DEPARTMENT 4.00 438, 591 2, 597, 627 1.00 2, 597, 627 438, 591 K - IMPLANTABLE DEVICES 1.00 IMPL. DEV. CHARGED TO 72. 00 14, 028, 995 1.00 PATI ENTS 2.00 0.00 0 0 2.00 3.00 0 0 0.00 3.00 4.00 0.00 4.00 ō 14, 028, 995 - INTEREST NEW CAP REL COSTS-BLDG & 1.00 1.00 0 6, 137, 796 1.00 FI XT 2.00 NEW CAP REL COSTS-MVBLE 2.00 2, 614, 987 2.00 EQUI P ō 8, 752, 783 N - NURSERY 1.00 43.00 989, 688 188, 129 1.00 NURSERY 989, 688 188, 129 O - PHARMACY PARAMED 1.00 OTHER MED ED 23. 01 65, 707 6, 363 1.00 65, 707 6, 363 P - BRAZIL MEDICAL CENTER 1.00 RURAL HEALTH 194.00 48.647 1.00 48, 647 - CAFE RECLASS 2, 177, 952 CAFETERI A 11.00 1.00 1, 236, 738 1.00 1, 236, 738 2, 177, 952

6, 199, 948

29, 238, 376

500.00

500.00 Grand Total: Increases

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

| Peri od: | Worksheet A-6 | From 01/01/2018 | To 12/31/2018 | Date/Time Prepared:

					10	5/29/201	9 1:11 pm
		Decreases					
	Cost Center	Li ne #	Sal ary	0ther	Wkst. A-7 Ref.		
	6.00	7. 00	8. 00	9. 00	10.00		
1. 00	B - PARAMED RADI OLOGY-DI AGNOSTI C	54.00	219, 192	57, 730	0		1.00
2.00	RADI OLOGI - DI AGNOSTI C	0.00	217, 172	57, 730			2.00
2.00			219, 192	_{57, 730}			2.00
	C - FITNESS ACTIVITY	•			'		
1.00	OTHER ADMIN AND GENERAL	5. 06	446, 875	148, 813	0		1.00
2.00		0.00	0	0			2. 00
	0		446, 875	148, 813			
1 00	D - CLAY CITY RURAL HEALTH	4 00		FF 00/			4.00
1. 00	NEW CAP REL COSTS-BLDG &	1. 00	O	55, 306	9		1.00
		+	+	55, 306	 		
	E - CORK MEDICAL RURAL HEALTH	4		33, 300	1		
1.00	NEW CAP REL COSTS-BLDG &	1. 00	0	27, 435	9		1.00
	FIXT						
	0		0	27, 435			
	F - HOUSE NURSE ASSISTANT						
1.00	ADULTS & PEDIATRICS	30. 00	152, 806	15, 576			1.00
2.00		0.00	0	0	0		2.00
3. 00		0.00	00 152, 806	15, 576	<u> </u>		3. 00
	G - EMPLOYEE ACCESS		132, 600	15, 576			
1.00	PSYCHI ATRI C/PSYCHOLOGI CAL	194. 07	81, 539	14, 965	0		1.00
	SERVI CES		, , , , , ,				
	0		81, 539	14, 965	5		
	H - TUBE FEEDING						
1. 00	DI ETARY	10. 00	<u>6, 8</u> 67	0			1.00
	0		6, 867	0)		
1 00	I - FAMILY MEDICINE	194. 02	2 5/1 045	1, 118, 055	0		1 00
1. 00 2. 00	FAMILY PRACTICE	0.00	2, 561, 945	1, 118, 055			1. 00 2. 00
2.00		0.00	2, 561, 945	1, 118, 055			2.00
	J - LOBBY PHARMACY		2, 301, 743	1, 110, 000	<u> </u>		
1.00	DRUGS CHARGED TO PATIENTS	73. 00	438, 591	2, 597, 627	0		1.00
	0		438, 591	2, 597, 627			
	K - IMPLANTABLE DEVICES						
1.00	OPERATING ROOM	50.00	0	8, 380, 977	1		1.00
2.00	CARDI AC SURGERY	50. 01	0	167, 110			2. 00
3. 00	WVSC	50. 02	0	1, 658, 479			3. 00
4. 00	CARDI AC CATHETERI ZATI ON	59. 00	0	3, 822, 429			4. 00
	U - INTEREST		0	14, 028, 995			
1.00	OTHER ADMIN AND GENERAL	5. 06	ol	8, 752, 783	11		1.00
2. 00	OTTER ADMIN AND GENERAL	0.00	Ö	0, 732, 703	1		2.00
	0			8, 752, 783			
	N - NURSERY						
1.00	ADULTS & PEDIATRICS	30.00	989, 688	188, 129			1.00
	0		989, 688	188, 129)		
	O - PHARMACY PARAMED						
1. 00	DRUGS CHARGED TO PATIENTS	73. 00	6 <u>5, 7</u> 07	<u>6, 3</u> 63			1.00
	U D DDAZILI MEDICAL CENTED		65, 707	6, 363			
1 00	P - BRAZIL MEDICAL CENTER NEW CAP REL COSTS-BLDG &	1. 00	0	10 417	9		1 00
1. 00	FIXT	1.00	٩	48, 647	9		1.00
		+		48, 647	 		
	Q - CAFE RECLASS		٩	10, 047			
1. 00	DI ETARY	10. 00	1, 236, 738	2, 177, 952	. 0		1.00
	0 — — — — —		1, 236, 738	2, 177, 952			
500.00	Grand Total: Decreases		6, 199, 948	29, 238, 376			500.00

| Period: | Worksheet A-7 | From 01/01/2018 | Part | To 12/31/2018 | Date/Time Prepared: Health Financial Systems
RECONCILIATION OF CAPITAL COSTS CENTERS UNION HOSPITAL, INC. Provider CCN: 15-0023

				Io	12/31/2018	Date/lime Pre 5/29/2019 1:1	
				Acqui si ti ons		3/29/2019 1.1	ı pili
		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	17, 194, 721	353, 180	0	353, 180	0	1.00
2.00	Land Improvements	19, 881, 045	241, 434	0	241, 434	0	2.00
3.00	Buildings and Fixtures	334, 126, 340	7, 606, 514	0	7, 606, 514	0	3.00
4.00	Building Improvements	2, 251, 290	6, 912	0	6, 912	0	4.00
5.00	Fixed Equipment	0	0	0	0	0	5.00
6.00	Movable Equipment	161, 253, 292	9, 199, 341	0	9, 199, 341	7, 360, 942	6.00
7.00	HIT designated Assets	0	0	0	0	0	7.00
8.00	Subtotal (sum of lines 1-7)	534, 706, 688	17, 407, 381	0	17, 407, 381	7, 360, 942	8.00
9.00	Reconciling Items	0	0	0	0	0	9.00
10.00	Total (line 8 minus line 9)	534, 706, 688	17, 407, 381	0	17, 407, 381	7, 360, 942	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	17, 547, 901	0				1.00
2. 00	Land Improvements	20, 122, 479	0				2.00
3.00	Buildings and Fixtures	341, 732, 854	0				3.00
4. 00	Building Improvements	2, 258, 202	0				4.00
5. 00	Fixed Equipment	0	0				5.00
6. 00	Movable Equipment	163, 091, 691	0				6.00
7.00	HIT designated Assets	0	0				7.00
8.00	Subtotal (sum of lines 1-7)	544, 753, 127	0				8.00
9.00	Reconciling Items	0	0				9.00
10.00	Total (line 8 minus line 9)	544, 753, 127	0				10.00

Heal th	Financial Systems	UNI ON HOSPI	TAL, INC.		In Lieu of Form CMS-2552-10			
RECONG	CILIATION OF CAPITAL COSTS CENTERS		Provi der C	CN: 15-0023	Peri od: From 01/01/2018 To 12/31/2018		pared:	
			SL	JMMARY OF CAP	TAL I	0,2,,201, 1.1		
	Cost Center Description	Depreciation	Lease	Interest	Insurance	Taxes (see		
					(see	instructions)		
					instructions)			
		9. 00	10. 00	11. 00	12.00	13.00		
	PART II - RECONCILIATION OF AMOUNTS FROM WOR	KSHEET A, COLUM	MN 2, LINES 1 a	and 2				
1.00	NEW CAP REL COSTS-BLDG & FIXT	13, 866, 123	0		0 0	0	1.00	
2.00	NEW CAP REL COSTS-MVBLE EQUIP	9, 680, 239	0		0 0	0	2.00	
3.00	Total (sum of lines 1-2)	23, 546, 362	0		0 0	0	3.00	
		SUMMARY 0	F CAPI TAL					
	Cost Center Description	Other	Total (1)					
		Capi tal -Rel at	(sum of cols.					
		ed Costs (see	9 through 14)					
		instructions)						
		14. 00	15. 00					
	PART II - RECONCILIATION OF AMOUNTS FROM WOR	KSHEET A, COLUM	MN 2, LINES 1 a	and 2				
1.00	NEW CAP REL COSTS-BLDG & FIXT	0	13, 866, 123				1.00	
2.00	NEW CAP REL COSTS-MVBLE EQUIP	0	9, 680, 239				2.00	
3.00	Total (sum of lines 1-2)	0	23, 546, 362				3. 00	

Health Financial Systems	UNI ON HOSPI	TAL, INC.		In Lie	u of Form CMS-2	2552-10
RECONCILIATION OF CAPITAL COSTS CENTERS		Provi der Co		Period: From 01/01/2018 To 12/31/2018	Worksheet A-7 Part III Date/Time Pre 5/29/2019 1:1	pared:
	COMI	PUTATION OF RAT	TI 0S	ALLOCATION OF	OTHER CAPITAL	
Cost Center Description	Gross Assets	Capi tal i zed	Gross Assets		Insurance	
		Leases	for Ratio	instructions)		
			(col. 1 -			
	1, 00	2.00	col . 2) 3.00	4. 00	5. 00	
PART III - RECONCILIATION OF CAPITAL COSTS C		2.00	3.00	4.00	3.00	
1.00 NEW CAP REL COSTS-BLDG & FLXT	381, 661, 436	0	381, 661, 43	6 0. 700614	0	1.00
2.00 NEW CAP REL COSTS-MVBLE EQUIP	163, 091, 691	0	163, 091, 69	0. 299386	0	2.00
3.00 Total (sum of lines 1-2)	544, 753, 127		544, 753, 12			3.00
	ALLOCA ⁻	TION OF OTHER (CAPI TAL	SUMMARY O	OF CAPITAL	
Cost Center Description	Taxes	0ther	Total (sum of	Depreciation	Lease	
		Capi tal -Rel at				
	/ 00	ed Costs	through 7)	0.00	10.00	
PART III - RECONCILIATION OF CAPITAL COSTS C	6. 00	7. 00	8.00	9. 00	10.00	
1.00 NEW CAP REL COSTS-BLDG & FIXT	ENTERS O	Ι ο		0 9, 616, 111	0	1. 00
2. 00 NEW CAP REL COSTS-MVBLE EQUIP	0	0		0 8, 767, 817	0	2.00
3.00 Total (sum of lines 1-2)	Ö	l o		0 18, 383, 928		3.00
		SL	JMMARY OF CAPI	TAL		
Cost Center Description	Interest	Insurance	Taxes (see	0ther	Total (2)	
		(see	instructions)			
		instructions)		ed Costs (see	9 through 14)	
	11 00	12.00	13.00	instructions)	15. 00	
PART III - RECONCILIATION OF CAPITAL COSTS C	11.00 ENTERS	12.00	13.00	14. 00	15.00	
1.00 NEW CAP REL COSTS-BLDG & FLXT	5, 816, 478	0		0 0	15, 432, 589	1. 00
2. 00 NEW CAP REL COSTS-MVBLE EQUIP	2, 478, 091		1	o o		2. 00
3.00 Total (sum of lines 1-2)	8, 294, 569			0 0	, , , , , , ,	
	•	•		*	•	

ADJUST	MENIS TO EXPENSES			Provider CCN: 15-0023	Period: From 01/01/2018 To 12/31/2018	Worksheet A-8 Date/Time Pre 5/29/2019 1:1	pared:
			To	Expense Classification of From Which the Amount is			
	Cost Center Description	Basi s/Code	Amount	Cost Center	Li ne #	Wkst. A-7	
	·	(2) 1. 00	2. 00	3.00	4. 00	Ref. 5. 00	
1. 00	Investment income - NEW CAP	В	-321, 318 NE	W CAP REL COSTS-BLDG &	1.00	11	1.00
2. 00	REL COSTS-BLDG & FIXT (chapter 2) Investment income - NEW CAP	В	-136, 896 NE	XT EW CAP REL COSTS-MVBLE	2.00	11	2.00
3. 00	REL COSTS-MVBLE EQUIP (chapter 2) Investment income - other		O	QUI P	0. 00	0	3.00
4. 00	(chapter 2) Trade, quantity, and time	В	-9 43207	THER ADMIN AND GENERAL	5. 06	0	
	discounts (chapter 8)					0	
5. 00	Refunds and rebates of expenses (chapter 8)	В		JRCHASING RECEIVING AND TORES	5. 03	0	5.00
6. 00	Rental of provider space by suppliers (chapter 8)		0		0. 00	0	6.00
7. 00	Tel ephone servi ces (pay stati ons excluded) (chapter	А	-18, 031 NO	ONPATIENT TELEPHONES	5. 01	0	7. 00
8. 00	21) Television and radio service		О		0.00	0	8. 00
9. 00	(chapter 21) Parking lot (chapter 21)		o		0. 00	0	9. 00
10.00	Provider-based physician adjustment	A-8-2	-19, 386, 568			0	10.00
11. 00	Sale of scrap, waste, etc.		0		0. 00	0	11.00
12. 00	(chapter 23) Related organization transactions (chapter 10)	A-8-1	58, 098, 898			0	
13. 00 14. 00	Laundry and linen service Cafeteria-employees and guests	В	0 -1, 600, 917 C <i>F</i>	AFETERI A	0. 00 11. 00	0	
15. 00	Rental of quarters to employee and others	·	0		0. 00	0	15.00
16. 00	Sale of medical and surgical supplies to other than patients	А		EDICAL SUPPLIES CHARGED TO ATLENTS	71.00	0	16. 00
17. 00	Sale of drugs to other than	А	-8, 231 DF	RUGS CHARGED TO PATIENTS	73. 00	0	17. 00
18. 00	patients Sale of medical records and	В	-8, 342 ME	EDICAL RECORDS & LIBRARY	16. 00	0	18.00
19. 00	abstracts Nursing and allied health		0		0. 00	0	19.00
17.00	education (tuition, fees,				0.00	0	17.00
20. 00	books, etc.) Vending machines	А	-13, 166 OF	PERATION OF PLANT	7. 00	0	20.00
21. 00	Income from imposition of interest, finance or penalty charges (chapter 21)		0		0. 00	0	21.00
22. 00	Interest expense on Medicare overpayments and borrowings to repay Medicare overpayments		0		0. 00	0	22.00
23. 00	Adjustment for respiratory therapy costs in excess of	A-8-3	ORE	SPI RATORY THERAPY	65. 00		23. 00
24. 00	limitation (chapter 14) Adjustment for physical therapy costs in excess of	A-8-3	OPH	HYSI CAL THERAPY	66. 00		24.00
25. 00	limitation (chapter 14) Utilization review - physicians' compensation		0 **	** Cost Center Deleted ***	* 114.00		25. 00
26. 00	(chapter 21) Depreciation - NEW CAP REL COSTS-BLDG & FIXT			EW CAP REL COSTS-BLDG &	1.00	0	26. 00
27. 00	Depreciation - NEW CAP REL		ONE	EW CAP REL COSTS-MVBLE	2. 00	0	27. 00
28. 00	COSTS-MVBLE EQUIP Non-physician Anesthetist			QUIP ** Cost Center Deleted ***	* 19.00		28.00
29. 00	Physicians' assistant	4.0.0	0	CLIDATI ONAL TUEDADV	0.00	0	
	Adjustment for occupational therapy costs in excess of limitation (chapter 14)	A-8-3		CCUPATI ONAL THERAPY	67.00		30.00
30. 99	Hospice (non-distinct) (see instructions)		OAL	DULTS & PEDIATRICS	30. 00		30. 99

-16, 290 DELIVERY ROOM & LABOR ROOM

-1, 750 OTHER ADMIN AND GENERAL

-14, 211 MEDICAL RECORDS & LIBRARY

-2, 152 EMPLOYEE BENEFITS DEPARTMENT

-493, 481 DRUGS CHARGED TO PATIENTS

-135, 573 OTHER ADMIN AND GENERAL

-3,190,957 NEW CAP REL COSTS-BLDG &

-20, 582, 792 OTHER ADMIN AND GENERAL

-15, 771 DRUGS CHARGED TO PATIENTS

-6, 000 HOUSEKEEPI NG

FI XT

-907, 726 DI ETARY

6, 605, 468

-105, 343 OPERATION OF PLANT

-15, 801 OTHER ADMIN AND GENERAL

52.00

5.06

5.06

16.00

73.00

4.00

9.00

7.00

5 06

10.00

73.00

5.06

1.00

45.40

45.42

45.43

45.44

45.45

45.47

45.48

45.49

46 00

46.01

46.02

0 46.03

46.04

50.00

0

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

В

R

В

В

В

В

В

В

B

Α

В

В

Α

(2) Basis for adjustment (see instructions)

AP&S A/P PD SPACE/EQUIP RENT R

WVHC ST ANN/ASH PHARMACY REVEN

TOTAL (sum of lines 1 thru 49)

(Transfer to Worksheet A, column 6, line 200.)

45.40

45.42

45.43

45.44

45.45

45.47

45.48

45.49

46 00

46.01

46.02

46.03

46.04

50.00

CHILD BIRTH CLASS

EDUCATION SERVICES

EMPLOYEE BENEFITS

TRANSCRI PTI ON

HOUSEKEEPI NG

MAPLE CENTER

DIETARY EXPENSE

LANDSBAUM

VHA

HAF

CONTINUING EDUCATION

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

B. Amount Received - if cost cannot be determined.

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

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

STATEMENT OF COSTS OF SERVICES FROM RELATED ORGANIZATIONS AND HOME Provider CCN: 15-0023 Peri od: From 01/01/2018 To 12/31/2018 Date/Time Prepared: 5/29/2019 1: 11 pm Peri od: Worksheet A-8-1 OFFICE COSTS

						5/29/2019 1:1	1 pm
	Li ne No.	Cost Center		Expense Items	Amount of	Amount	
					Allowable Cost	Included in	
						Wks. A, column	
						5	
	1. 00	2. 00		3. 00	4. 00	5. 00	
		MENTS REQUIRED AS A RESULT OF	TRAI	NSACTIONS WITH RELATED O	RGANIZATIONS OF	R CLAIMED HOME	
1. 00	OFFICE COSTS:	OTHER MED ED	PARA	MED		547, 041	1. 00
		l -			0		
2.00		NEW CAP REL COSTS-BLDG & FIX			0	1, 671, 395	2.00
3.00		NEW CAP REL COSTS-MVBLE EQUI			0	7, 617, 926	3.00
4. 00		l .		OFFI CE	0	136, 956	4.00
4. 01				OFFICE	0	10, 513	4. 01
4. 02		l .		OFFICE	0	393, 232	4. 02
4. 03		NEW CAP REL COSTS-BLDG & FIX			1, 530, 821	0	4. 03
4.04		NEW CAP REL COSTS-MVBLE EQUI			6, 706, 503	0	4.04
4.05		EMPLOYEE BENEFITS DEPARTMENT			13, 513, 117	0	4.05
4.06	5. 01	NONPATIENT TELEPHONES	HOME	OFFI CE	198, 983	0	4.06
4.07	5. 02	DATA PROCESSING	HOME	OFFI CE	13, 289, 573	0	4.07
4.08	5. 03	PURCHASING RECEIVING AND STO	HOME	OFFI CE	1, 726, 580	0	4.08
4.09	5. 05	CASHI ERI NG/ACCOUNTS RECEI VAB	HOME	OFFI CE	5, 720, 343	0	4.09
4. 10	5. 06	OTHER ADMIN AND GENERAL	HOME	OFFI CE	14, 362, 021	0	4. 10
4. 11	7.00	OPERATION OF PLANT	HOME	OFFI CE	9, 978, 777	o	4. 11
4. 12	9. 00	HOUSEKEEPI NG	HOME	OFFI CE	360, 295	O	4. 12
4. 13	10.00	DI ETARY	HOME	OFFI CE	313, 200	o	4. 13
4. 14	11.00	CAFETERI A	номе	OFFI CE	540, 607	ol	4. 14
4. 15			номе	OFFICE	1, 459, 799	o	4. 15
4. 16				OFFI CE	171, 095	0	4. 16
4. 17		l l		OFFI CE	134, 320	o	4. 17
4. 18	50. 01	CARDI AC SURGERY	номе	OFFI CE	6, 028	ol	4. 18
4. 19	50. 02	wvsc	номе	OFFI CE	88, 238	o	4. 19
4. 20	51.00	RECOVERY ROOM	номе	OFFI CE	8, 114	o	4. 20
4. 21	54.00			OFFI CE	194, 369	o	4. 21
4. 22	57.00	CT SCAN	номе	OFFI CE	221, 811	o	4. 22
4. 23	58.00	MAGNETIC RESONANCE IMAGING (HOME	OFFI CE	53, 059	o	4. 23
4. 24	59.00	CARDI AC CATHETERI ZATI ON	HOME	OFFI CE	139, 420	o	4. 24
4. 25	66.00	PHYSI CAL THERAPY	номе	OFFI CE	19, 290	o	4. 25
4. 26	•	l .		OFFICE	12, 412	o	4. 26
4. 27				OFFICE	14, 353	0	4. 27
4. 28				OFFICE	5, 105	Ö	4. 28
4. 29		l .		OFFICE	109, 495	Ö	4. 29
4. 30		l .		OFFICE	1, 864	0	4. 30
4. 31		l .		OFFICE	12, 156	Ö	4. 31
4. 32				OFFICE	565, 857	0	4. 32
4. 33				OFFICE	5, 620	Ö	4. 33
4. 36		ł		N THERAPIES	2, 444, 306	4, 368, 977	4. 36
4. 37		ł .		N THERAPIES	1, 572, 929	2, 923, 236	4. 37
4. 38		ł .		N THERAPIES	1, 819, 014	2, 723, 230	4. 38
4. 39		ł .		N THERAPIES	646, 912	583, 381	4. 39
4. 40		ł .		N THERAPIES	040, 712	600, 215	4. 40
4. 40		ł .		N THERAPIES		994, 616	4. 40
5. 00	174.00	F	0	THERAITES	77, 946, 386		5. 00
	amounts on lines 1-4 (and sub			formed in detail to Worl			3.00

* 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			
						l		
	Symbol (1)	Name	Percentage of	Name	Percentage of			
			Ownershi p		Ownershi p			
	1.00	2. 00	3. 00	4. 00	5. 00			
B. INTERRELATIONSHIP TO RELATED ORGANIZATION(S) AND/OR HOME OFFICE:								

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

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

6. 00	G		O. OO UNI ON HOSPI TAL	100.00	6.00
7.00	G		O. OO UNI ON THERAPY	100.00	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:				

Heal th	Financial Systems	UNI ON HOSP	PITAL, INC. In L			eu of Form CMS-2552-1	
	ENT OF COSTS OF SERVICES FROM	RELATED ORGANIZATIONS AND HO	ME Provider (CCN: 15-0023	Peri od:	Worksheet A-8	3-1
OFFICE	COSTS				From 01/01/2018 To 12/31/2018		
				Rel ated Orgai	nization(s) and/o	or Home Office	·
	Symbol (1)	Name	Percentage of	1	Vame	Percentage of	
			Ownershi p			Ownershi p	
	1. 00	2. 00	3. 00	4	4. 00	5. 00	

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

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

						6.5	0550 40
	<u>Financial Syst</u> NT OF COSTS OF		UNI ON HOSPITA RELATED ORGANI ZATI ONS AND HOME	L, INC. Provider CCN: 15-0023	Period:	u of Form CMS- Worksheet A-	
OFFICE	COSTS				From 01/01/2018 To 12/31/2018	Date/Time Pr	epared:
	Net	Wkst. A-7 Ref.				5/29/2019 1:	
	Adjustments						
	(col. 4 minus col. 5)*						
	6. 00	7. 00					
	A. COSTS INCUF OFFICE COSTS:	RRED AND ADJUSTI	MENTS REQUIRED AS A RESULT OF TR	ANSACTIONS WITH RELATED	ORGANI ZATI ONS OR	CLAIMED HOME	
1. 00	-547, 041	0					1.00
2.00	-1, 671, 395	· ·					2.00
3. 00 4. 00	-7, 617, 926 -136, 956						3. 00 4. 00
4. 01	-10, 513	0					4. 01
4. 02 4. 03	-393, 232 1, 530, 821						4. 02 4. 03
4. 04	6, 706, 503						4. 04
4. 05	13, 513, 117	1					4.05
4. 06 4. 07	198, 983 13, 289, 573	1					4. 06 4. 07
4. 08	1, 726, 580						4. 08
4. 09 4. 10	5, 720, 343 14, 362, 021	1					4. 09 4. 10
4. 11	9, 978, 777	0					4. 11
4. 12	360, 295 313, 200	1					4. 12
4. 13 4. 14	540, 607	1					4. 13 4. 14
4. 15	1, 459, 799	1					4. 15
4. 16 4. 17	171, 095 134, 320	1					4. 16 4. 17
4. 18	6, 028	0					4. 18
4. 19 4. 20	88, 238 8, 114						4. 19 4. 20
4. 20	194, 369	1					4. 20
4. 22	221, 811	1					4. 22
4. 23 4. 24	53, 059 139, 420						4. 23 4. 24
4. 25	19, 290	0					4. 25
4. 26 4. 27	12, 412 14, 353						4. 26 4. 27
4. 28	5, 105	1					4. 28
4. 29	109, 495	1					4. 29
4. 30 4. 31	1, 864 12, 15 <i>6</i>	1					4. 30 4. 31
4. 32	565, 857	0					4. 32
4. 33 4. 36	5, 620 -1, 924, 671						4. 33 4. 36
4. 37	-1, 350, 307	1					4. 37
4. 38 4. 39	1, 819, 014 63, 531	1					4. 38 4. 39
4. 40	-600, 215	1					4. 40
4. 41	-994, 61 <i>6</i>	1					4. 41
5.00 * The	58,098,898 amounts on Lin		L oscripts as appropriate) are tra	nsferred in detail to Wo	orksheet A column	6 lines as	5. 00
appropr	i ate. Posi ti ve	amounts increas	se cost and negative amounts dec	rease cost.For related o	organization or ho	me office cos	
has not		o Worksheet A, anization(s)	columns 1 and/or 2, the amount	allowable should be indi	cated in column 4	of this part	
	0	ome Office					
	Type of	Busi ness					
	6	00					
			TED ORGANIZATION(S) AND/OR HOME	OFFICE:			
			nority granted under section 181 t B of this worksheet.	4(b)(1) of the Social Se	ecurity Act, requi	res that you	furni sh
			ters for Medicare and Medicaid S				
			acilities, and supplies furnishe as determined under section 1861				
			e cost report is considered inco	mplete and not acceptabl	e for purposes of	claiming	
	sement under t HOME OFFICE	THE AVIII.					6. 00
7. 00	THERAPI ES						7. 00
8. 00 9. 00							8. 00 9. 00
10.00							10.00
100.00							100.00

Health Financial Systems	UNI ON HOSPI TAL	TAL, INC. In Lieu of Form CMS-				
STATEMENT OF COSTS OF SERVICES FROM	Provider CCN: 15-0023	Peri od: From 01/01/2018	Worksheet A-8	-1		
OFFICE COSTS				Date/Time Pre 5/29/2019 1:1	pared: 1 pm	
Related Organization(s) and/or Home Office						
Type of Business						
6.00						

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

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

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

Peri od: From 01/01/2018 To 12/31/2018 Date/Ti me Prepared: 5/29/2019 1:11 pm

	Wkst. A Line #		Total	Professi onal	Provi der		Physi ci an/Prov	П
		I denti fi er	Remuneration	Component	Component		ider Component Hours	
	1.00	2.00	3. 00	4. 00	5. 00	6. 00	7. 00	
1. 00	22. 00	I&R SERVICES-OTHER PRGM COSTS APPRVD	825, 824	0	825, 824	211, 500	6, 951	1. 00
2.00	35. 00	INTENSIVE NURSERY	1, 103, 919	1, 103, 919		237, 100	0	2.00
3. 00		SUBPROVI DER - I RF	709, 010		•	211, 500	425	3.00
4. 00		OPERATING ROOM	2, 259, 406			246, 400	141	4.00
5.00		CARDI AC SURGERY	2, 308, 151			246, 400	0	5.00
6. 00 7. 00	50.02	DELIVERY ROOM & LABOR ROOM	1, 231, 927			246, 400 246, 400	0	6. 00 7. 00
7. 00 8. 00		RADI OLOGY-DI AGNOSTI C	2, 114, 247 509, 634			246, 400 271, 900	167	7. 00 8. 00
9. 00		CARDI AC CATHETERI ZATI ON	1, 000			260, 300	0	9. 00
10. 00		LABORATORY	617, 000			197, 500	4, 570	
11.00		ELECTROCARDI OLOGY	-11, 640		•	197, 500	0	11.00
12.00	70. 00	ELECTROENCEPHALOGRAPHY	2, 696, 864	2, 696, 864	0	179, 000	0	12.00
13.00	90. 05	PATIENT NUTRITION	4, 000	0	4, 000	211, 500	16	13.00
14.00	91. 00	EMERGENCY	6, 277, 657			211, 500	1, 578	
200.00			20, 646, 999					200.00
	Wkst. A Line #		Unadjusted RCE		Cost of		Physician Cost	
		l denti fi er	Limit	Unadjusted RCE Limit	Memberships & Continuing	Component Share of col.	of Malpractice Insurance	
				LIIIII	Education	12	Trisui ance	
	1. 00	2.00	8. 00	9. 00	12. 00	13. 00	14. 00	
1. 00		I&R SERVICES-OTHER PRGM	706, 796			0	0	1. 00
		COSTS APPRVD						
2.00		INTENSIVE NURSERY	0		_	0	27	2.00
3. 00		SUBPROVI DER - I RF	43, 215			0	0	3. 00
4. 00		OPERATING ROOM	16, 703			0	0	4.00
5.00	50. 01	CARDI AC SURGERY	0	0	10, 529	0	48, 870	
6. 00 7. 00		DELIVERY ROOM & LABOR ROOM		0	0	0	0	6. 00 7. 00
8. 00		RADI OLOGY-DI AGNOSTI C	21, 830	1, 092	2, 617	128	5, 825	8. 00
9. 00		CARDI AC CATHETERI ZATI ON	21,030	1,072	2,017	0	0, 020	9. 00
10. 00		LABORATORY	433, 930	21, 697	0	Ö	0	10.00
11.00		ELECTROCARDI OLOGY	0	0	0	0	54	11.00
12.00	70. 00	ELECTROENCEPHALOGRAPHY	0	0	2, 819	0	87, 931	12.00
13.00		PATIENT NUTRITION	1, 627	81	0	0	0	13.00
14. 00	91. 00	EMERGENCY	160, 455			0	395	14.00
200.00	MI	01.01(8)	1, 384, 556			128	143, 102	200.00
	Wkst. A Line #	Cost Center/Physician Identifier	Provider Component	Adjusted RCE Limit	RCE Di sal I owance	Adjustment		
		i denti i i ei	Share of col.	LIIIII	Di Sai i Owance			
			14					
	1. 00	2. 00	15. 00	16. 00	17. 00	18. 00		
1. 00	22. 00	I &R SERVI CES-OTHER PRGM COSTS APPRVD	0	706, 796	119, 028	119, 028		1. 00
2. 00	35. 00	INTENSIVE NURSERY	0	0	0	1, 103, 919		2.00
3. 00		SUBPROVI DER - I RF	0	43, 215	0	677, 135		3.00
4.00	50. 00	OPERATING ROOM	0	16, 703	37, 297	2, 242, 703		4.00
5.00		CARDI AC SURGERY	0	0	0	2, 308, 151		5.00
6. 00	50. 02		0					6. 00
7.00		DELIVERY ROOM & LABOR ROOM	0		_	2, 114, 247		7.00
8. 00		RADI OLOGY-DI AGNOSTI C	286		2, 756	487, 390		8.00
9. 00 10. 00		CARDI AC CATHETERI ZATI ON LABORATORY	0 0		0 183, 070	1, 000 183, 070		9. 00 10. 00
11. 00		ELECTROCARDI OLOGY	11	433, 930		-9, 340		11.00
12.00		ELECTROENCEPHALOGRAPHY	0			2, 696, 864		12.00
13. 00		PATIENT NUTRITION			-	2, 373		13. 00
14.00		EMERGENCY	3			6, 228, 101		14.00
200.00			300	1, 384, 984	344, 524	19, 386, 568		200.00

| Period: | Worksheet B | From 01/01/2018 | Part | To | 12/31/2018 | Date/Time Prepared: Health Financial Systems
COST ALLOCATION - GENERAL SERVICE COSTS Provi der CCN: 15-0023

						o 12/31/2018	Date/Time Pre	pared:
				CAPI TAL REI	LATED COSTS		5/29/2019 1:1	I pm
		Cost Center Description	Not Exposes	NEW BLDG &	NEW MVBLE	EMPLOYEE	NONPATI ENT	
		cost center bescription	Net Expenses for Cost	FIXT	EQUI P	BENEFITS	TELEPHONES	
			Allocation			DEPARTMENT		
			(from Wkst A col. 7)					
			0	1. 00	2. 00	4. 00	5. 01	
1 00		AL SERVICE COST CENTERS	45 400 500	15 100 500	ı	1		4 00
1. 00 2. 00		NEW CAP REL COSTS-BLDG & FIXT NEW CAP REL COSTS-MVBLE EQUIP	15, 432, 589 11, 245, 908	15, 432, 589	11, 245, 908			1. 00 2. 00
4.00		EMPLOYEE BENEFITS DEPARTMENT	16, 647, 391	82, 409				4. 00
5. 01		NONPATI ENT TELEPHONES	903, 688	10, 340		l i	1, 101, 732	5. 01
5. 02 5. 03		DATA PROCESSING PURCHASING RECEIVING AND STORES	12, 664, 020 1, 527, 196	0			0	5. 02 5. 03
5. 04	1	ADMI TTI NG	1, 446, 746	48, 192			39, 504	5. 04
5. 05		CASHI ERI NG/ACCOUNTS RECEI VABLE	5, 720, 343	207 144		020.244	101 022	5. 05
5. 06 7. 00		OTHER ADMIN AND GENERAL OPERATION OF PLANT	21, 112, 553 9, 395, 757	307, 144 5, 270, 575			101, 833 62, 329	5. 06 7. 00
8.00	00800	LAUNDRY & LINEN SERVICE	1, 045, 292	94, 244	209, 260	123, 562	15, 802	8. 00
9. 00 10. 00		HOUSEKEEPI NG	3, 052, 747	24, 364			7, 023	9.00
11. 00		DI ETARY CAFETERI A	-28, 355 2, 586, 070	172, 750 123, 267			26, 336 0	10. 00 11. 00
13.00	01300	NURSING ADMINISTRATION	3, 649, 076	37, 396	5, 254	359, 410	7, 901	13.00
16. 00 21. 00		MEDICAL RECORDS & LIBRARY	3, 956, 689	83, 149			26, 336	16.00
21.00	1	I&R SERVICES-SALARY & FRINGES APPRVD I&R SERVICES-OTHER PRGM COSTS APPRVD	1, 444, 990 2, 115, 982	0			0	21. 00 22. 00
23. 00	02300	PARAMED ED PRGM	138, 461	0	C	20, 304	0	23. 00
23. 01		OTHER MED ED	228, 749	11, 332			0	23. 01
23. 02		PARAMED ED PRGM I ENT ROUTINE SERVICE COST CENTERS	138, 461	0		20, 304	0	23. 02
30.00	03000	ADULTS & PEDIATRICS	26, 087, 623	2, 951, 245			150, 120	
31. 00 35. 00		INTENSIVE CARE UNIT INTENSIVE NURSERY	5, 477, 195 2, 330, 258	361, 837 61, 885			25, 458 15, 802	31. 00 35. 00
41.00		SUBPROVI DER - I RF	2, 330, 236 1, 433, 694	242, 741			27, 214	41.00
43.00	04300	NURSERY	1, 177, 849	11, 930			3, 511	
50. 00		LARY SERVICE COST CENTERS OPERATING ROOM	10, 173, 362	641, 123	1, 816, 830	509, 387	71, 986	50. 00
50. 00	1	CARDI AC SURGERY	1, 668, 030	28, 330			5, 267	50. 00
50. 02	05002		10, 971, 725	472, 607		l .	0	50. 02
51. 00 51. 02		RECOVERY ROOM O/P TREATMENT ROOM	1, 830, 331 424, 700	22, 538 376, 569			15, 802 23, 703	51. 00 51. 02
52. 00	1	DELIVERY ROOM & LABOR ROOM	3, 449, 934	370, 309			20, 191	52.00
54.00	1	RADI OLOGY-DI AGNOSTI C	6, 839, 084	497, 034			94, 810	54.00
55. 00 56. 00		RADI OLOGY-THERAPEUTI C RADI OI SOTOPE	5, 239, 391 1, 534, 368	415, 396 138, 502			35, 993 0	55. 00 56. 00
57. 00		CT SCAN	2, 490, 585	34, 185			6, 145	57. 00
58.00		MAGNETIC RESONANCE IMAGING (MRI)	1, 770, 511	40, 811			3, 511	58.00
59. 00 60. 00		CARDI AC CATHETERI ZATI ON LABORATORY	19, 355, 145 9, 028, 441	519, 257 0			29, 848 7, 023	
62. 00		WHOLE BLOOD & PACKED RED BLOOD CELLS	1, 332, 919	0			0	
65.00	1	RESPIRATORY THERAPY	3, 661, 815	78, 317			12, 290	
66. 00 66. 01	1	PHYSI CAL THERAPY PSYCHI ATRI C/PSYCHOLOGI CAL SERVI CES	2, 711, 738	159, 750 0			20, 191 0	66. 00 66. 01
66. 02		O/P PHYSICAL THERAPY	2, 333, 894	0			878	66. 02
67.00	1	OCCUPATIONAL THERAPY	1, 833, 367	26, 095			4, 389	
68. 00 69. 00	1	SPEECH PATHOLOGY ELECTROCARDI OLOGY	779, 163 10, 319, 161	51, 749 50, 065		l	878 3, 511	68. 00 69. 00
69. 01		CARDI AC REHAB	304, 170	102, 838			5, 267	69. 01
70.00		ELECTROENCEPHALOGRAPHY	783, 282	23, 687			14, 924	
71. 00 72. 00		MEDICAL SUPPLIES CHARGED TO PATIENTS IMPL. DEV. CHARGED TO PATIENTS	848, 145 14, 028, 995	89, 900 0			12, 290 0	71. 00 72. 00
73. 00	07300	DRUGS CHARGED TO PATIENTS	48, 658, 002	326, 031			43, 894	
76. 00		RENAL ACUTE	1, 443, 005	55, 480	7, 933	0	3, 511	76. 00
90. 00		TIENT SERVICE COST CENTERS CLINIC	220, 139	10, 986	T c	33, 002	0	90. 00
90.05	09005	PATIENT NUTRITION	271, 817	30, 376	1, 672	44, 250	0	90. 05
90.07		WOUND CLINIC	1, 178, 942	140, 894			11, 412	90.07
91. 00 92. 00		EMERGENCY OBSERVATION BEDS (NON-DISTINCT PART)	6, 554, 530	378, 851	307, 630	864, 960	55, 306	91. 00 92. 00
	SPECI	AL PURPOSE COST CENTERS	\ 					
118.00		SUBTOTALS (SUM OF LINES 1 through 117) IMBURSABLE COST CENTERS	322, 969, 663	14, 978, 946	10, 912, 317	14, 748, 312	1, 012, 189	118. 00
190.00		GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	C	ol	0	190. 00
194.00	07950	RURAL HEALTH	3, 446, 623	0	C	220, 525	878	194. 00
		RENTAL PROPERTY FAMILY PRACTICE	48, 973 3, 931, 689	0 188, 867	7, 523 201, 308		0 62, 329	194. 01 194. 02
174. UZ	- 01704	I TIMO I TOL	3, 731, 009	100,007	201,300	1 440, 020	02, 329	1177.02

Health Financial Systems	UNI ON HOSPI	UNION HOSPITAL, INC.			In Lieu of Form CMS-2552-10			
COST ALLOCATION - GENERAL SERVICE COSTS		Provi der CO		Peri od:	Worksheet B			
				From 01/01/2018 To 12/31/2018				
		CAPITAL REL	LATED COSTS					
Cost Center Description	Net Expenses	NEW BLDG &	NEW MVBLE	EMPLOYEE	NONPATI ENT			
	for Cost	FLXT	EQUI P	BENEFI TS	TELEPHONES			
	Allocation			DEPARTMENT				
	(from Wkst A							
	col. 7)							
	0	1. 00	2. 00	4. 00	5. 01			
194. 03 07952 WELLNESS	433, 184	219, 668		0 60, 205	0	194. 03		
194. 04 07955 PHYSI CLAN PRACTI CES	13, 218, 585	0	121, 64	4 1, 185, 703	19, 313	194. 04		
194.06 07953 SYCAMORE SPORTS MED	54, 640	0	20	6 2, 260	0	194. 06		
194. 07 07956 PSYCHI ATRI C/PSYCHOLOGI CAL SERVI CES	432, 942	45, 108	2, 91	0 67, 770	7, 023	194. 07		
200.00 Cross Foot Adjustments						200.00		
201.00 Negative Cost Centers		0		0 0	0	201.00		
202.00 TOTAL (sum lines 118 through 201)	344, 536, 299	15, 432, 589	11, 245, 90	8 16, 729, 800	1, 101, 732	202.00		

In Lieu of Form CMS-2552-10

Period: Worksheet B
From 01/01/2018 Part I
To 12/31/2018 Date/Time Prepared: 5/29/2019 1:11 pm

				'	0 12/31/2010	5/29/2019 1:1	
	Cost Center Description	DATA	PURCHASI NG	ADMI TTI NG	CASHI ERI NG/AC	Subtotal	
		PROCESSI NG	RECEIVING AND		COUNTS		
		F 00	STORES	F 04	RECEI VABLE	FA 0F	
	GENERAL SERVICE COST CENTERS	5. 02	5. 03	5. 04	5. 05	5A. 05	
1.00	00100 NEW CAP REL COSTS-BLDG & FLXT						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	12, 664, 020					5. 02
5. 03	00560 PURCHASING RECEIVING AND STORES	0	1, 527, 196				5. 03
5. 04	00570 ADMI TTI NG	0	6, 337	1, 741, 712			5. 04
5. 05	00580 CASHI ERI NG/ACCOUNTS RECEI VABLE	0	0	0	5, 720, 343		5. 05
5. 06	00590 OTHER ADMIN AND GENERAL	22, 534	17	0	0	22, 561, 855	5.06
7. 00	00700 OPERATION OF PLANT	0	862	0	o	15, 040, 765	7. 00
8. 00	00800 LAUNDRY & LINEN SERVICE	0		0	o	1, 489, 748	
9. 00	00900 HOUSEKEEPI NG	0	2, 086	0	0	3, 545, 866	1
10.00	01000 DI ETARY	214, 072		0	0	775, 268	
11. 00	01100 CAFETERI A	0	o	0	o	2, 969, 123	11.00
13. 00	01300 NURSING ADMINISTRATION	0	o	0	o	4, 059, 037	13. 00
	01600 MEDICAL RECORDS & LIBRARY	518, 278	189	o o	o	5, 106, 446	1
	02100 &R SERVICES-SALARY & FRINGES APPRVD	0	0	0	o	1, 691, 217	21.00
	02200 &R SERVICES-OTHER PRGM COSTS APPRVD	0	o	0	o	2, 344, 391	22. 00
	02300 PARAMED ED PRGM	0	o	0	0	158, 765	23. 00
23. 01	02341 OTHER MED ED	0	o	0	0	276, 081	23. 01
	02301 PARAMED ED PRGM	0	o	0	0	158, 765	
	INPATIENT ROUTINE SERVICE COST CENTERS				- 1		
30.00	03000 ADULTS & PEDIATRICS	7, 086, 893	322, 085	311, 572	411, 117	42, 009, 168	30.00
31.00	03100 INTENSIVE CARE UNIT	833, 752		83, 033	95, 699	8, 383, 292	
35.00	02040 INTENSIVE NURSERY	180, 271	20, 352	64, 470	74, 305	3, 256, 244	35.00
41.00	04100 SUBPROVI DER - I RF	0				2, 006, 844	1
43.00	04300 NURSERY	0			12, 222	1, 407, 128	1
	ANCILLARY SERVICE COST CENTERS						
50.00	05000 OPERATING ROOM	360, 541	36, 234	320, 016	684, 783	14, 614, 262	50.00
50. 01	05001 CARDI AC SURGERY	0	149, 812	21, 493	24, 892	2, 438, 797	50. 01
50. 02	05002 WVSC	0	437, 828	400	449, 827	12, 877, 502	50.02
51.00	05100 RECOVERY ROOM	33, 801	34, 415	10, 706	41, 365	2, 314, 349	51.00
51.02	05101 O/P TREATMENT ROOM	0	12, 775	73	8, 175	981, 359	51.02
52.00	05200 DELIVERY ROOM & LABOR ROOM	338, 008	62, 967	57, 528	84, 510	5, 222, 094	52.00
54.00	05400 RADI OLOGY-DI AGNOSTI C	709, 816	14, 619	47, 005	232, 089	10, 214, 128	54.00
55.00	05500 RADI OLOGY-THERAPEUTI C	0	635	5, 976	173, 312	6, 322, 141	55.00
56.00	05600 RADI 0I SOTOPE	22, 534	1, 196	3, 197	44, 849	2, 261, 379	56.00
57.00	05700 CT SCAN	0	45, 653	50, 664	220, 599	3, 052, 431	57.00
58.00	O5800 MAGNETIC RESONANCE IMAGING (MRI)	0	1, 070	8, 605	52, 783	2, 085, 545	58.00
59.00	05900 CARDI AC CATHETERI ZATI ON	383, 075	18, 272	104, 096	387, 427	21, 364, 751	59.00
60.00	06000 LABORATORY	0	0	158, 526	384, 379	9, 578, 369	60.00
62.00	06200 WHOLE BLOOD & PACKED RED BLOOD CELLS	0	0	8, 043	12, 167	1, 353, 129	62.00
65.00	06500 RESPI RATORY THERAPY	157, 737	24, 161	69, 985	91, 396	4, 993, 482	65.00
66.00	06600 PHYSI CAL THERAPY	259, 139	510	23, 659	48, 303	3, 254, 003	66. 00
66. 01	06601 PSYCHI ATRI C/PSYCHOLOGI CAL SERVI CES	0	0	0	0	0	66. 01
66. 02	06602 0/P PHYSICAL THERAPY	0	1, 029	0	31, 083	2, 453, 546	
67.00	06700 OCCUPATI ONAL THERAPY	0	0	18, 043	35, 946	1, 923, 413	67.00
68.00	06800 SPEECH PATHOLOGY	0	53	3, 786	12, 784	849, 763	68. 00
69.00	06900 ELECTROCARDI OLOGY	214, 072			304, 220	12, 257, 521	69. 00
	06901 CARDI AC REHAB	33, 801	350		5, 179	548, 373	69. 01
	07000 ELECTROENCEPHALOGRAPHY	0			18, 757	1, 465, 084	70.00
	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	179	2, 623	3, 294	1, 281, 896	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0	0	29, 762	82, 810	14, 141, 567	72.00
	07300 DRUGS CHARGED TO PATIENTS	236, 605		153, 303	1, 075, 727	51, 379, 200	73.00
76. 00	03020 RENAL ACUTE	0	9, 200	10, 448	13, 805	1, 543, 382	76. 00
	OUTPATIENT SERVICE COST CENTERS						
90.00	09000 CLI NI C	0			2, 947	267, 292	90.00
	09005 PATIENT NUTRITION	0			794	349, 129	1
	09007 WOUND CLINIC	0		21	28, 650	1, 462, 135	90. 07
	09100 EMERGENCY	991, 489	142, 013	98, 023	554, 768	9, 947, 570	1
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)					0	92.00
	SPECIAL PURPOSE COST CENTERS						
118.00	, ,	12, 596, 418	1, 520, 995	1, 741, 712	5, 720, 343	320, 037, 595	118.00
	NONREI MBURSABLE COST CENTERS						1
	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0		190. 00
	07950 RURAL HEALTH	0		0	0	3, 669, 970	1
	07951 RENTAL PROPERTY	0	1	0	0		194. 01
	07954 FAMILY PRACTICE	0	444	0	0	4, 829, 662	194. 02
	07952 WELLNESS	0	· -	0	0	713, 057	194. 03
	07955 PHYSICIAN PRACTICES	22, 534	3, 791	0	0	14, 571, 570	
	07953 SYCAMORE SPORTS MED	0	0	0	0		194. 06
194. 07	07956 PSYCHI ATRI C/PSYCHOLOGI CAL SERVI CES	45, 068	22	0	0	600, 843	194. 07

Health Financial Systems	UNI ON HOSPI	TAL, INC.		In Lieu	u of Form CMS-	2552-10
COST ALLOCATION - GENERAL SERVICE COSTS		Provider Co		Peri od: From 01/01/2018 To 12/31/2018	Worksheet B Part I Date/Time Pre 5/29/2019 1:1	
Cost Center Description	DATA PROCESSI NG	PURCHASI NG RECEI VI NG AND STORES	ADMI TTI NG	CASHI ERI NG/AC COUNTS RECELVABLE	Subtotal	·

5.03

1, 527, 196

5.04

0 1, 741, 712

5. 05

0 5, 720, 343

5A. 05

0 200. 00 0 201. 00 344, 536, 299 202. 00

5. 02

0 12, 664, 020

200. 00 201. 00 202. 00

Cross Foot Adjustments Negative Cost Centers TOTAL (sum lines 118 through 201)

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 15-0023

Peri od: Worksheet B From 01/01/2018 Part I To 12/31/2018 Date/Time Prepared:

5/29/2019 1:11 pm Cost Center Description OTHER ADMIN OPERATION OF LAUNDRY & HOUSEKEEPI NG DI ETARY AND GENERAL PLANT LINEN SERVICE 9. 00 5.06 10.00 7.00 8.00 GENERAL SERVICE COST CENTERS 1.00 00100 NEW CAP REL COSTS-BLDG & FIXT 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 5.02 00550 DATA PROCESSING 5.02 00560 PURCHASING RECEIVING AND STORES 5.03 5.03 5 04 00570 ADMITTING 5 04 00580 CASHI ERI NG/ACCOUNTS RECEI VABLE 5.05 5.05 22, 561, 855 00590 OTHER ADMIN AND GENERAL 5.06 5.06 7.00 00700 OPERATION OF PLANT 1,053,952 16, 094, 717 7.00 00800 LAUNDRY & LINEN SERVICE 156, 151 1, 750, 290 104.391 8 00 8 00 9.00 00900 HOUSEKEEPI NG 248, 469 40, 368 118, 206 3, 952, 909 9.00 54, 325 10.00 01000 DI ETARY 286, 224 9,768 71, 166 1, 196, 751 10.00 01100 CAFETERI A 208, 055 204, 237 50, 781 11.00 C 11.00 0 01300 NURSING ADMINISTRATION 61, 960 0 15, 406 13.00 284, 429 0 13.00 16.00 01600 MEDICAL RECORDS & LIBRARY 357, 824 137, 766 0 34, 254 0 16.00 02100 I &R SERVICES-SALARY & FRINGES APPRVD 118, 509 21.00 0 0 21.00 02200 I&R SERVICES-OTHER PRGM COSTS APPRVD 164, 279 0 22.00 0 22.00 0 0 02300 PARAMED ED PRGM 0 23 00 11, 125 0 0 23.00 02341 OTHER MED ED 19, 346 0 0 23.01 23.01 18, 776 4, 668 02301 PARAMED ED PRGM 23.02 11, 125 0 23.02 INPATIENT ROUTINE SERVICE COST CENTERS 30.00 03000 ADULTS & PEDIATRICS 2, 943, 708 4, 889, 830 607, 125 1, 215, 801 897, 395 30.00 149, 063 31.00 03100 INTENSIVE CARE UNIT 587, 442 599, 517 71, 752 128, 468 31.00 02040 INTENSIVE NURSERY 35.00 228, 175 102, 536 7.597 25, 494 35.00 0 04100 SUBPROVI DER - I RF 41.00 140, 626 402, 190 7, 122 100,000 76, 009 41.00 19, 767 04300 NURSERY 98,602 4, 915 43.00 43.00 0 ANCILLARY SERVICE COST CENTERS 50.00 05000 OPERATING ROOM 1, 024, 065 1.062.258 102, 545 264.119 0 50.00 50.01 05001 CARDI AC SURGERY 170, 894 46, 939 28 11,671 0 50.01 50.02 05002 WVSC 902, 365 783, 049 106, 266 194, 696 0 50.02 51.00 05100 RECOVERY ROOM 162, 173 37, 343 84,656 9, 285 51.00 0 05101 0/P TREATMENT ROOM 68.767 623, 925 8, 979 155, 132 88, 670 51.02 51.02 52.00 05200 DELIVERY ROOM & LABOR ROOM 365, 928 617, 640 74,095 153, 569 30 52.00 05400 RADI OLOGY-DI AGNOSTI C 715, 735 54.00 823, 521 53, 637 204, 759 0 54.00 05500 RADI OLOGY-THERAPEUTI C 55.00 443, 011 688, 258 20.279 171, 128 55.00 0 57, 058 05600 RADI OI SOTOPE 229, 480 56.00 158, 462 9, 162 0 56.00 56, 640 14, 083 57.00 05700 CT SCAN 213, 893 0 57.00 05800 MAGNETIC RESONANCE IMAGING (MRI) 58.00 146, 140 67,618 52,608 16,813 0 58.00 59 00 05900 CARDIAC CATHETERIZATION 1, 497, 092 860, 342 59, 235 213, 914 6, 179 59 00 06000 LABORATORY 60.00 671, 185 0 0 60.00 0 06200 WHOLE BLOOD & PACKED RED BLOOD CELLS 94, 818 0 62.00 62.00 0 65.00 06500 RESPIRATORY THERAPY 349, 908 129, 761 32, 264 0 65.00 C 06600 PHYSI CAL THERAPY 228, 018 11, 548 66.00 264, 684 65, 811 0 66.00 66.01 06601 PSYCHI ATRI C/PSYCHOLOGI CAL SERVI CES 0 66.01 0 66.02 06602 0/P PHYSICAL THERAPY 171, 927 30, 933 0 0 66.02 06700 OCCUPATI ONAL THERAPY 134, 779 43, 236 10, 750 67.00 0 67.00 C 06800 SPEECH PATHOLOGY 21, 319 59, 545 68.00 85, 742 0 68.00 69.00 06900 ELECTROCARDI OLOGY 858, 921 82, 952 23, 293 20,625 0 69.00 69.01 06901 CARDI AC REHAB 38, 426 170, 389 525 42, 365 69.01 0 07000 ELECTROENCEPHALOGRAPHY 9, 758 70 00 70 00 102,663 39, 246 0 5.534 71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 89,826 148, 953 0 37,036 0 71.00 07200 IMPL. DEV. CHARGED TO PATIENTS 990, 942 0 72.00 0 72.00 07300 DRUGS CHARGED TO PATIENTS 3, 600, 435 540, 191 134, 312 0 73.00 73.00 0 03020 RENAL ACUTE 91, 922 76.00 108, 149 5, 981 22, 855 0 76.00 OUTPATIENT SERVICE COST CENTERS 90.00 90.00 09000 CLI NI C 18,730 18, 202 0 4,526 0 09005 PATIENT NUTRITION 90.05 90.05 24.465 50.329 12, 514 0 0 90.07 09007 WOUND CLINIC 102, 456 233, 444 15, 216 58, 043 0 90.07 156, 072 91.00 09100 EMERGENCY 697,056 255, 987 0 91.00 627, 706 92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART) 92.00 SPECIAL PURPOSE COST CENTERS
SUBTOTALS (SUM OF LINES 1 through 117) 20, 845, 156 1, 742, 077 3, 766, 025 1, 196, 751 118. 00 118.00 15, 343, 092 NONREI MBURSABLE COST CENTERS 190.00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN 194.00 07950 RURAL HEALTH 0 190.00 C 0 257, 166 870 0 0 194, 00 C 0 194.01 194. 01 07951 RENTAL PROPERTY 3, 959 0 0 194. 02 07954 FAMILY PRACTICE 338, 429 312, 927 0 194.02 1, 120 77.806 194. 03 07952 WELLNESS 49, 966 363, 961 90.495 0 194.03 \cap 194. 04 07955 PHYSICIAN PRACTICES 0 194. 04 1, 021, 074 C 6, 223 0 194.06 07953 SYCAMORE SPORTS MED 4,002 0 194.06 C 0 194. 07 07956 PSYCHI ATRI C/PSYCHOLOGI CAL SERVI CES 0 194.07 42, 103 74, 737 0 18, 583 200.00 200.00 Cross Foot Adjustments

Health Financial Systems	UNI ON HOSPI	TAL, INC.		In Lie	u of Form CMS-	2552-10
COST ALLOCATION - GENERAL SERVICE COSTS		Provi der C		Peri od:	Worksheet B	
				From 01/01/2018	Part I	
				To 12/31/2018	Date/Time Pre	epared:
					5/29/2019 1:1	1 pm
Cost Center Description	OTHER ADMIN	OPERATION OF	LAUNDRY &	HOUSEKEEPI NG	DI ETARY	
	AND GENERAL	PLANT	LINEN SERVIC	E		
	5. 06	7. 00	8. 00	9. 00	10.00	
201.00 Negative Cost Centers	0	C		0 0	0	201.00
202.00 TOTAL (sum lines 118 through 201)	22, 561, 855	16, 094, 717	1, 750, 29	3, 952, 909	1, 196, 751	202.00

In Lieu of Form CMS-2552-10

Period: Worksheet B
From 01/01/2018 Part I
To 12/31/2018 Date/Time Prepared: 5/29/2019 1:11 pm Provider CCN: 15-0023

					1		5/29/2019 1: 1	
						INTERNS &	RESI DENTS	
		Cost Center Description	CAFETERI A	NURSI NG	MEDI CAL	SERVI CES-SALA		
				ADMI NI STRATI O N	RECORDS & LI BRARY	RY & FRINGES	R PRGM COSTS	
	OFNED	ALL CERVILOR COCT OF MITTERS	11. 00	13. 00	16. 00	21. 00	22. 00	
1. 00		AL SERVICE COST CENTERS NEW CAP REL COSTS-BLDG & FIXT						1.00
2. 00	1	NEW CAP REL COSTS-MVBLE EQUIP						2.00
4.00	1	EMPLOYEE BENEFITS DEPARTMENT						4. 00
5. 01 5. 02	1	NONPATI ENT TELEPHONES DATA PROCESSI NG						5. 01 5. 02
5. 02	1	PURCHASING RECEIVING AND STORES						5.02
5.04	00570	ADMI TTI NG						5. 04
5. 05		CASHI ERI NG/ACCOUNTS RECEI VABLE						5.05
5. 06 7. 00		OTHER ADMIN AND GENERAL OPERATION OF PLANT						5. 06 7. 00
8. 00		LAUNDRY & LINEN SERVICE						8.00
9. 00		HOUSEKEEPI NG						9.00
10. 00 11. 00		DI ETARY CAFETERI A	3, 432, 196					10. 00 11. 00
13. 00		NURSING ADMINISTRATION	55, 491	4, 476, 323				13.00
16.00	01600	MEDICAL RECORDS & LIBRARY	183, 242	0	5, 819, 532			16. 00
21.00		I &R SERVICES-SALARY & FRINGES APPRVD	64, 028	0	0	1, 873, 754	l	21.00
22. 00 23. 00		I&R SERVICES-OTHER PRGM COSTS APPRVD PARAMED ED PRGM	13, 110 6, 098	0	0		2, 521, 780	22. 00 23. 00
23. 01		OTHER MED ED	19, 208		0			23. 01
23. 02		PARAMED ED PRGM	6, 098	0	0			23. 02
30. 00		I ENT ROUTINE SERVICE COST CENTERS ADULTS & PEDIATRICS	1, 112, 862	2, 013, 882	359, 619	889, 824	1, 197, 567	30. 00
31. 00	1	INTENSIVE CARE UNIT	186, 900		98, 418	007,024	1, 177, 307	31.00
35.00		I NTENSI VE NURSERY	80, 492		76, 416	40, 203	54, 107	35. 00
41. 00 43. 00		SUBPROVI DER	57, 320 47, 259		15, 817 12, 569	0	0 0	41. 00 43. 00
43.00		LARY SERVICE COST CENTERS	41, 239	69, 590	12, 309	0	0	43.00
50.00	05000	OPERATING ROOM	160, 679		704, 241	117, 929	158, 713	50. 00
50. 01	05001 05002	CARDI AC SURGERY	21, 648	23, 700 0	25, 599	0	0	50. 01 50. 02
50. 02 51. 00	1	RECOVERY ROOM	73, 175	138, 729	462, 609 42, 540	0		51.00
51. 02	1	O/P TREATMENT ROOM	13, 720	26, 012	8, 407	0	0	51. 02
52.00		DELIVERY ROOM & LABOR ROOM	136, 898		86, 911	208, 162	280, 153	52.00
54. 00 55. 00	1	RADI OLOGY-DI AGNOSTI C RADI OLOGY-THERAPEUTI C	180, 193 15, 245	0	238, 683 178, 237	41, 096 22, 037	55, 309 29, 659	54. 00 55. 00
56.00		RADI OI SOTOPE	12, 501	0	46, 123	0	27,037	56.00
57. 00		CT SCAN	44, 515	0	226, 867	0	0	57. 00
58. 00 59. 00		MAGNETIC RESONANCE IMAGING (MRI)	24, 392	0	54, 283	10 721	14 429	58. 00 59. 00
60.00		CARDI AC CATHETERI ZATI ON LABORATORY	103, 969 0	0	398, 436 395, 301	10, 721 0	14, 428 0	60.00
62.00	1	WHOLE BLOOD & PACKED RED BLOOD CELLS	0	0	12, 513	0	0	62.00
65.00		RESPI RATORY THERAPY	117, 994		93, 993	28, 589		
66. 00 66. 01		PHYSI CAL THERAPY PSYCHI ATRI C/PSYCHOLOGI CAL SERVI CES	0	0	49, 675 0	0	0	
66. 02		O/P PHYSICAL THERAPY	0	Ö	31, 966	50, 924	68, 535	
67.00	1	OCCUPATIONAL THERAPY	0	0	36, 968	0	0	67.00
68. 00 69. 00		SPEECH PATHOLOGY ELECTROCARDI OLOGY	0 39, 941	0	13, 147 312, 865	0 17, 868	0 24, 047	68. 00 69. 00
69. 01		CARDI AC REHAB	12, 196	- 1	5, 326	0	24,047	69. 01
70.00		ELECTROENCEPHALOGRAPHY	27, 440	0	19, 290	21, 144	28, 456	
71. 00 72. 00		MEDICAL SUPPLIES CHARGED TO PATIENTS IMPL. DEV. CHARGED TO PATIENTS	0	0	3, 387 85, 163	0	0	71. 00 72. 00
73.00		DRUGS CHARGED TO PATTENTS	134, 763	· · · · · · · · · · · · · · · · · · ·	1, 106, 122	15, 188		
76. 00	03020	RENAL ACUTE	. 0	0	14, 197	0	0	76. 00
90. 00		TIENT SERVICE COST CENTERS	6, 098	11, 561	3, 031	0	0	90. 00
90.05		PATIENT NUTRITION	10, 671	20, 231	817	0	Ö	90.05
90. 07	1	WOUND CLINIC	14, 330	27, 168	29, 464	14, 890	l .	
91. 00 92. 00		EMERGENCY OBSERVATION BEDS (NON-DISTINCT PART)	254, 892	483, 239	570, 532	220, 669	296, 986	91. 00 92. 00
92.00		AL PURPOSE COST CENTERS						72.00
118. 00)	SUBTOTALS (SUM OF LINES 1 through 117)	3, 237, 368	4, 476, 323	5, 819, 532	1, 699, 244	2, 286, 916	118. 00
190. 00		IMBURSABLE COST CENTERS GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190. 00
194.00	07950	RURAL HEALTH	0	Ö	0	ő	0	194. 00
		RENTAL PROPERTY	0	0	0	0		194. 01
		FAMILY PRACTICE WELLNESS	55, 796 0	0	0	174, 510 0		194. 02 194. 03
		PHYSICIAN PRACTICES	139, 032		0	0	l e	194. 04
-								

Health Financial Systems	UNION HOSPITAL, INC.	In Lieu of Form CMS-2552-10
COST ALLOCATION - GENERAL SERVICE COSTS	Provi der CCN: 15-0023	Peri od: Worksheet B From 01/01/2018 Part I To 12/31/2018 Date/Time Prepared:

						5/29/2019 1:1	1 pm
					INTERNS &	RESI DENTS	
	Cost Center Description	CAFETERI A	NURSI NG	MEDI CAL	SERVI CES-SALA	SERVI CES-OTHE	
			ADMI NI STRATI O	RECORDS &	RY & FRINGES	R PRGM COSTS	
			N	LI BRARY			
		11. 00	13. 00	16.00	21.00	22. 00	
194.06 07953	SYCAMORE SPORTS MED	0	0	0	0	0	194.06
194. 07 07956	PSYCHI ATRI C/PSYCHOLOGI CAL SERVI CES	0	0	0	0	0	194.07
200. 00	Cross Foot Adjustments				0	0	200.00
201. 00	Negative Cost Centers	0	0	0	0	0	201.00
202 00	TOTAL (sum lines 118 through 201)	3 432 196	4 476 323	5 810 532	1 873 754	2 521 780	202 00

| Period: | Worksheet B | From 01/01/2018 | Part | To | 12/31/2018 | Date/Time Prepared: Health Financial Systems
COST ALLOCATION - GENERAL SERVICE COSTS Provi der CCN: 15-0023

					To	12/31/2018		
		Cost Center Description	PARAMED ED	OTHER MED ED	PARAMED ED	Subtotal	Intern &	ı piii
			PRGM		PRGM		Residents Cost & Post	
							Stepdown	
			23. 00	23. 01	23. 02	24. 00	Adjustments 25.00	
		AL SERVICE COST CENTERS	20. 00	20. 01	20.02	21.00	20.00	
1. 00 2. 00		NEW CAP REL COSTS-BLDG & FIXT NEW CAP REL COSTS-MVBLE EQUIP						1.00 2.00
4. 00		EMPLOYEE BENEFITS DEPARTMENT						4.00
5. 01	1	NONPATI ENT TELEPHONES						5. 01
5. 02 5. 03	1	DATA PROCESSING PURCHASING RECEIVING AND STORES						5. 02 5. 03
5. 04		ADMITTING						5. 04
5. 05 5. 06	1	CASHIERING/ACCOUNTS RECEIVABLE OTHER ADMIN AND GENERAL						5. 05 5. 06
7.00	00700	OPERATION OF PLANT						7. 00
8. 00 9. 00	1	LAUNDRY & LINEN SERVICE HOUSEKEEPING						8. 00 9. 00
10.00	01000	DI ETARY						10. 00
11. 00 13. 00	1	CAFETERIA NURSING ADMINISTRATION						11. 00 13. 00
16. 00	1	MEDICAL RECORDS & LIBRARY						16.00
21.00		I &R SERVICES-SALARY & FRINGES APPRVD						21.00
22. 00 23. 00		I&R SERVICES-OTHER PRGM COSTS APPRVD PARAMED ED PRGM	175, 988					22. 00 23. 00
23. 01	02341	OTHER MED ED	•	374, 495				23. 01
23. 02		PARAMED ED PRGM I ENT ROUTINE SERVICE COST CENTERS			175, 988			23. 02
30.00	03000	ADULTS & PEDIATRICS	0	1		58, 136, 781	-2, 087, 391	30. 00
31. 00 35. 00		INTENSIVE CARE UNIT INTENSIVE NURSERY	0	0	0	10, 559, 189 4, 023, 866	0 -94, 310	31.00 35.00
41. 00		SUBPROVI DER - I RF	0	Ö		2, 914, 599	0	41.00
43. 00		NURSERY LARY SERVICE COST CENTERS	0	0	0	1, 679, 836	0	43. 00
50.00		OPERATING ROOM	0	0	0	18, 513, 437	-276, 642	50.00
50. 01	1	CARDI AC SURGERY	0	0	0	2, 739, 276	0	50.01
50. 02 51. 00	05002 05100	RECOVERY ROOM	0	0	0	15, 326, 487 2, 862, 250	0	50. 02 51. 00
51. 02	1	O/P TREATMENT ROOM	0	0	0	1, 974, 971	0	51.02
52. 00 54. 00	1	DELIVERY ROOM & LABOR ROOM RADIOLOGY-DIAGNOSTIC	175, 988	0	0 175, 988	7, 405, 019 12, 879, 037	-488, 315 -96, 405	52. 00 54. 00
55.00	05500	RADI OLOGY-THERAPEUTI C	0	0	0	7, 889, 995	-51, 696	55. 00
56. 00 57. 00	1	RADI OI SOTOPE CT SCAN	0	0	0	2, 774, 165 3, 608, 429	0	56. 00 57. 00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	Ö	0	2, 447, 399	0	58. 00
59. 00 60. 00	1	CARDI AC CATHETERI ZATI ON LABORATORY	0	0	0	24, 529, 067 10, 644, 855	-25, 149 0	59. 00 60. 00
62.00		WHOLE BLOOD & PACKED RED BLOOD CELLS	0	o o	0	1, 460, 460	Ö	62.00
65.00	1	RESPI RATORY THERAPY PHYSI CAL THERAPY	0	0		5, 992, 561	-67, 065	
66. 00 66. 01		PSYCHI ATRI C/PSYCHOLOGI CAL SERVI CES	0	0	0	3, 873, 739 0	0	66. 01
66. 02	1	O/P PHYSICAL THERAPY	0	0	0	2, 807, 831	-119, 459	66.02
67. 00 68. 00	1	OCCUPATI ONAL THERAPY SPEECH PATHOLOGY	0	0	0	2, 149, 146 1, 029, 516	0	67. 00 68. 00
69.00		ELECTROCARDI OLOGY	0	0	0	13, 638, 033	-41, 915	
69. 01 70. 00		CARDI AC REHAB ELECTROENCEPHALOGRAPHY	0	0	0	817, 600 1, 718, 615	0 -49, 600	
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	1, 561, 098	0	71.00
72. 00 73. 00	1	IMPL. DEV. CHARGED TO PATIENTS DRUGS CHARGED TO PATIENTS	0	0 374, 495	0	15, 217, 672 57, 523, 066	0 -35, 628	72. 00 73. 00
76. 00	03020	RENAL ACUTE	0	0		1, 786, 486	0	76. 00
90. 00		TIENT SERVICE COST CENTERS	0	0	0	329, 440	0	90.00
90. 05	09005	PATIENT NUTRITION	0	O	0	468, 156	0	90. 05
90. 07 91. 00		WOUND CLINIC EMERGENCY	0	0	0	1, 977, 186 13, 510, 709	-34, 930 -517, 655	
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)				13, 310, 707	0	
118. 00		AL PURPOSE COST CENTERS SUBTOTALS (SUM OF LINES 1 through 117)	175, 988	374, 495	175, 988	316, 769, 972	-3, 986, 160	110 00
110.00		IMBURSABLE COST CENTERS	175, 700	374, 493	173, 700	310, 709, 972	-3, 780, 100	1118.00
	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	_		3 039 004		190.00
		RURAL HEALTH RENTAL PROPERTY	0	0	0	3, 928, 006 60, 455		194. 00 194. 01
194. 02	07954	FAMILY PRACTICE	0	0	0	6, 025, 114	-409, 374	194. 02
		WELLNESS PHYSICIAN PRACTICES	0	0	0	1, 217, 479 15, 737, 899		194. 03 194. 04
	,	1 1 1 1		·	·	-, -,,-,,		

Health Financial Systems	UNI ON HOSPI	TAL, INC.		In Lieu of Form CMS-2552-10			
COST ALLOCATION - GENERAL SERVICE COSTS		Provi der Co		Period: From 01/01/2018	Worksheet B Part I		
				To 12/31/2018			
Cost Center Description	PARAMED ED	OTHER MED ED	PARAMED ED	Subtotal	Intern &		
	PRGM		PRGM		Resi dents		
					Cost & Post		
					Stepdown		
					Adjustments		
	23. 00	23. 01	23. 02	24. 00	25.00		
194.06 07953 SYCAMORE SPORTS MED	0	0		0 61, 108	0	194. 06	
194. 07 07956 PSYCHI ATRI C/PSYCHOLOGI CAL SERVI CES	0	0		0 736, 266	0	194. 07	
200.00 Cross Foot Adjustments	0	0		0 0	0	200.00	
201.00 Negative Cost Centers	0	0		0 0	0	201.00	
202.00 TOTAL (sum lines 118 through 201)	175, 988	374, 495	175, 98	344, 536, 299	-4, 395, 534	202. 00	

Health Financial Systems
COST ALLOCATION - GENERAL SERVICE COSTS In Lieu of Form CMS-2552-10 UNION HOSPITAL, INC.

Peri od: Worksheet B
From 01/01/2018 Part I
To 12/31/2018 Date/Time Prepared: 5/29/2019 1:11 pm Provider CCN: 15-0023

		5/29/2019 1:11 pm	
Cost Center Description	Total	0,2,72017 11 2	
	26. 00		
GENERAL SERVICE COST CENTERS			
1.00 O0100 NEW CAP REL COSTS-BLDG & FLXT		1.0	00
2.00 O0200 NEW CAP REL COSTS-MVBLE EQUIP			00
4.00 00400 EMPLOYEE BENEFITS DEPARTMENT			00
5. 01 00540 NONPATI ENT TELEPHONES			01
5. 02 00550 DATA PROCESSI NG			02
5. 03 00560 PURCHASING RECEIVING AND STORES			03
5. 04 00570 ADMI TTI NG			04
5. 05 00580 CASHI ERI NG/ACCOUNTS RECEI VABLE			05
5.06 O0590 OTHER ADMIN AND GENERAL			06
7.00 O0700 OPERATION OF PLANT			00
8.00 00800 LAUNDRY & LINEN SERVICE			00
9. 00 00900 HOUSEKEEPI NG			00
10. 00 01000 DI ETARY		10.4	
11. 00 01100 CAFETERI A		11.4	
13.00 O1300 NURSING ADMINISTRATION		13.4	
16.00 O1600 MEDICAL RECORDS & LIBRARY		16.	
21.00 02100 1 &R SERVICES-SALARY & FRINGES APPRVD		21.	
22.00 02200 I&R SERVICES-OTHER PRGM COSTS APPRVD		22.	
23.00 02300 PARAMED ED PRGM		23.4	
23. 01 02341 0THER MED ED		23.4	
23. 02 02301 PARAMED ED PRGM		23.	02
INPATIENT ROUTINE SERVICE COST CENTERS			
30. 00 03000 ADULTS & PEDI ATRI CS	56, 049, 390	30.	
31.00 03100 I NTENSI VE CARE UNI T	10, 559, 189	31.4	
35. 00 02040 I NTENSI VE NURSERY	3, 929, 556	35.	
41. 00 04100 SUBPROVI DER - I RF	2, 914, 599	41.4	
43. 00 04300 NURSERY	1, 679, 836	43.	00
ANCILLARY SERVICE COST CENTERS			
50.00 05000 OPERATING ROOM	18, 236, 795	50.4	
50. 01 05001 CARDI AC SURGERY	2, 739, 276	50.4	
50. 02 05002 WVSC	15, 326, 487	50.	
51. 00 05100 RECOVERY ROOM	2, 862, 250	51.	
51. 02 05101 0/P TREATMENT ROOM	1, 974, 971	51.	
52.00 O5200 DELIVERY ROOM & LABOR ROOM	6, 916, 704	52.	
54. 00 05400 RADI OLOGY-DI AGNOSTI C	12, 782, 632	54.	
55. 00 05500 RADI OLOGY-THERAPEUTI C	7, 838, 299	55.	
56. 00 05600 RADI OI SOTOPE	2, 774, 165	56.	
57. 00 05700 CT SCAN	3, 608, 429	57.	
58. 00 05800 MAGNETIC RESONANCE I MAGING (MRI)	2, 447, 399	58.	
59. 00 05900 CARDI AC CATHETERI ZATI ON	24, 503, 918	59.	
60. 00 06000 LABORATORY	10, 644, 855	60.	
62. 00 06200 WHOLE BLOOD & PACKED RED BLOOD CELLS	1, 460, 460	62.	
65. 00 06500 RESPI RATORY THERAPY	5, 925, 496	65.	
66. 00 06600 PHYSI CAL THERAPY	3, 873, 739	66.	
66. 01 06601 PSYCHI ATRI C/PSYCHOLOGI CAL SERVI CES	0	66.	
66. 02 06602 0/P PHYSI CAL THERAPY	2, 688, 372	66.	
67. 00 06700 OCCUPATI ONAL THERAPY	2, 149, 146	67.	
68. 00 06800 SPEECH PATHOLOGY	1, 029, 516	68.	
69. 00 06900 ELECTROCARDI OLOGY	13, 596, 118	69.	
69. 01 06901 CARDI AC REHAB	817, 600	69.	
70. 00 07000 ELECTROENCEPHALOGRAPHY	1, 669, 015	70.	
71. 00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	1, 561, 098	71.	
72. 00 07200 IMPL. DEV. CHARGED TO PATIENTS	15, 217, 672	72.	
73. 00 07300 DRUGS CHARGED TO PATIENTS	57, 487, 438	73.	
76. 00 03020 RENAL ACUTE	1, 786, 486	76.	UU
OUTPATIENT SERVICE COST CENTERS	202 11-		00
90. 00 09000 CLI NI C	329, 440	90.	
90. 05 09005 PATI ENT NUTRI TI ON	468, 156	90.	
90. 07 09007 WOUND CLINIC	1, 942, 256	90.	
91. 00 09100 EMERGENCY	12, 993, 054	91.	
92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART)		92.	UÜ
SPECIAL PURPOSE COST CENTERS	T		
118.00 SUBTOTALS (SUM OF LINES 1 through 117)	312, 783, 812	118.	OO
NONREI MBURSABLE COST CENTERS			00
190.00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	190.	
194. 00 07950 RURAL HEALTH	3, 928, 006	194.	
194. 01 07951 RENTAL PROPERTY	60, 455	194.	
194. 02 07954 FAMILY PRACTICE	5, 615, 740	194.	
194. 03 07952 WELLNESS	1, 217, 479	194.	
194. 04 07955 PHYSI CI AN PRACTI CES	15, 737, 899	194.	
194.06 07953 SYCAMORE SPORTS MED	61, 108	194.	
194. 07 07956 PSYCHI ATRI C/PSYCHOLOGI CAL SERVI CES	736, 266	194.	
200.00 Cross Foot Adjustments	0	200.	
201.00 Negative Cost Centers	0	201.	00

Health Financial Systems	UNION HOSPITA	L, INC.	In Lie	u of Form CMS-	2552-10
COST ALLOCATION - GENERAL SERVICE COSTS		Provider CCN: 15-0023	Peri od:	Worksheet B	
			From 01/01/2018		
			To 12/31/2018	Date/Time Pre	
				5/29/2019 1:1	1 pm
Cost Center Description	Total				
	26. 00				
202.00 TOTAL (sum lines 118 through 201)	340, 140, 765				202.00

| In Lieu of Form CMS-2552-10 | Period: | Worksheet B | From 01/01/2018 | Part II | To 12/31/2018 | Date/Time Prepared: | To 12/31/2018 | Date/Tim Health Financial Systems
ALLOCATION OF CAPITAL RELATED COSTS Provider CCN: 15-0023

Cart Centur Description					Io	12/31/2018	Date/lime Pre 5/29/2019 1:1	
Assigned New FIXT				CAPI TAL REI	LATED COSTS		0/2//2017 1.1	ļ pili
Assigned New FIXT								
Company Comp		Cost Center Description				Subtotal		
CALESMAL SERVICE COST CANYERS 1.00 2.00 26 4.00 1.00 2.00 26 4.00 1.00 2.00				FIXI	EQUIP			
O							DELAKTIMENT	
1.00 1.00				1. 00	2.00	2A	4. 00	
2.00 0.0000 NEW CAP PEL COSTS-WINGLE SOUT								
0.000 0.000 DIANT CHEFT FEED REPORTERS 0 0 0 0 0 0 0 0 0								1
5.01 0.0040 NOMPATIENT TELEPHONES 0 10, 340 0 0 0 0 0 0 0 0 0				00.400		00.400	00.400	1
5.02 0.0550 DATA PROCESSING 0 0 0 0 0 0 0 0 0		1 1	0	•		·		•
5.03 0.0560 PURCHASIN RECEIVING AND STORES 0 0 0 0 0 0 0 0 5.03								
5.00 0.0570 ASMITTING 5.251 48,102 7.234 60,670 955 5.05 0.0580			l o	-	-	- 1		
5.06 OSSMO OFFREY ADMIN AND GENERAL 57,704 307,114 79,410 5,907,77 64 7.00 00700 OFFREY ADMIN AND GENERAL 28,308 5,270,575 29,00 307,000 00800 AURIONES FEPTING 15,331 94,244 209,220 318,886 609 8.00 11,100 0085 000 0085 0085 000 0085	5.04		5, 251	48, 192	7, 236	60, 679	955	5. 04
7.00 0.0000 OPERATION OF PLANT 28. 30.88 5.270.575 298.194 5.997.077 64 7.000			0	· ·	-	0	_	•
0.000 0.0000 DISTARPY 0.000 0.000 DISTARPY 0.000 0.000 DISTARPY 0.000 0.000 DISTARPY 0.662 172,750 332,645 511,031 284 10,00 10.000 DISTARPY 0.0000 0.0000 0.0000 0.0000 0.0000 0.0000 0.0000 0.0000 0.0000 0.0000 0.0000			1					•
9.00 0.0900 MUSEKEPT INS			1					•
10.00 01000 DETARY 5.636 172,750 332,645 511,031 294 10.00 13.00 01300 NURSING ADMINISTRATION 1,247 37,396 5.254 43,897 1,771 13.00 13.00 01000 NURSING ADMINISTRATION 1,247 37,396 5.254 43,897 1,771 13.00 12.10 02.00 1			1					•
11.00 0 11000 (APELERIA)			1					•
13.00 01300 MURSIN ASMIN IN STRATION 1, 247 37, 396 5, 254 43, 897 1, 771 13.00		1	1					1
21.00 02100 IAR SERVICES-SALARY & FRINCES APPRVD 0 0 0 0 1,126 22.00 02200 IAR SERVICES-COTHER PROM COSTS APPRVD 0 0 0 0 0 0 1.26 22.00 02200 PARAMEDE DE PROM 0 0 0 0 0 0 1.26 23.00 1.26	13.00	01300 NURSING ADMINISTRATION	1, 247					13.00
22.00 02200 RASSERVICES-OTHER PROM COSTS APPRVD 0 0 0 0 0 0 1.02 2.00 0.00 0 0 0 0 0 0 0			9, 041	83, 149	27, 431	119, 621		1
23.00		· · · · · · · · · · · · · · · · · · ·	0	0	- 1	- 1		
23.01 02341 OTHER MED ED 0 11,332 5.6 11,388 177 23.01 23.01 23.02 23.01 PRAMED ED PREW 0 0 0 0 0 23.02 23.02 23.01 PRAMED ED PREW 0 0 0 0 0 0 23.02 23.02 23.01 23.02 23.02 23.02 23.00 23.00 03.00 OULTS & PEDIATRIC S 163,181 2,951,245 994,606 4,109,032 18,165 30.00 31.00 03000 INTENSI VE CARE UNIT 238,164 361,837 602,042 1,202,043 3,994 31.00 30.00 03000 INTENSI VE CARE UNIT 238,164 361,837 602,042 1,202,043 3,994 31.00 41.00			0	0	- 1	0		
23. Q2 Q2301 PARAMED ED PROM Q Q Q Q Q Q Q Q Q			0	11 222	-	11 288		
INPATI ENT ROUTI NE SERVICE COST CENTERS								
31.00 03100 INTENSIVE CARE UNIT 238, 164 361, 837 602, 042 1, 202, 043 3, 894 31.00 03500 DATON UNISSERY 5, 452 61, 885 148, 79 216, 134 1,775 35.00 1,000	20.02		<u> </u>		<u> </u>	<u> </u>	100	20.02
135.00	30.00	03000 ADULTS & PEDIATRICS	163, 181	2, 951, 245	994, 606	4, 109, 032	18, 165	30.00
14. 00 04100 SUBPROVI DER - I RF 10, 290 242, 741 40, 540 293, 571 1, 996 41, 00				· ·	· ·			
A3. 00 04300 MURSERY 0 11, 930 7, 658 19, 588 904 42. 00					· ·			•
MICHARY SERVICE COST CENTERS So. 00 So. 00 OPERATI IN ROOM S0. 01 So. 00 OSCOO OPERATI IN ROOM S0. 01 So. 00 OSCOO OPERATI IN ROOM S0. 01 So. 00 OSCOO OPERATI IN ROOM S0. 02 S0. 00 OSCOO OSCOO OSCOO C0. 00 OSCOO C0. 00 OSCOO O								•
50.00 OSCOOO OPERATI NG ROOM 842, 222 641, 123 1, 816, 830 3, 300, 175 2, 510 50.00 50.01 OSCOO CARDI AC SURGERY 43, 805 28, 330 139, 806 265, 941 1, 711 50.01 50.02 OSCOO WSC 429, 227 472, 607 545, 115 1, 446, 949 0 50.02 0SCOO PROVERY ROOM 2, 361 22, 538 45, 663 70, 562 1, 379 51.00 51.00 OSCOO PROVERY ROOM 2, 361 22, 538 45, 663 70, 562 1, 379 51.00 51.00 OSCOO PROVERY ROOM 2, 361 50.00 3100 PROVERY ROOM 41.00 41.11 50.01 41.11 50.01 41.11 50.01 41.11 50.01 41.11 50.01 41.11 50.01 41.11 50.01 41.11 50.01 41.11 50.01 41.11 50.01 51.00 51.00 ELOVERY ROOM 41.00 60.00 ELOVERY ROOM 41.00 60.00	43.00		<u> </u>	11, 730	7,030	17, 500	704	43.00
50.00 05000 CARDIA C SURGERY 43, 805 28, 330 193, 806 265, 941 1, 711 50.0 50.00 20000 WISCE 429, 227 472, 607	50.00		842, 222	641, 123	1, 816, 830	3, 300, 175	2, 510	50.00
51.00 05100 RECOVERY ROOM		I I						
STOCK OSTON OSTO				472, 607	545, 115	1, 446, 949	0	50. 02
S2-00 05200 DELI VERY ROOM & LABOR ROOM 11, 165 372, 775 318, 104 702, 044 2, 553 52.00			1					•
54.00 05400 RADI OLOGY-DI AGNOSTI C 606, 694 497, 034 1, 131, 238 2, 234, 966 3, 196 54.00 55.00 05500 RADI OLOGY-THERAPEUTI C 871, 470 415, 396 384, 368 1, 671, 234 331 55.00 56.00 05600 RADI OLOGY-THERAPEUTI C 228, 011 138, 502 456, 133 822, 646 299 56.00 57.00 05700 CT SCAN 322, 538 34, 185 610 357, 333 1, 005 57.00 58.00 05800 MAGNETI C RESONANCE IMAGING (MRI) 521, 893 40, 811 98, 555 661, 259 541 58.00 59.00 05900 CARDIA C CATHETERI ZATI ON 138, 470 519, 257 170, 089 827, 816 1, 959 59.00 60.00 06000 LABORATORY 00 0 0 0 0 0 0 0 62.00 06200 MAGNETI C RESONANCE IMAGING (MRI) 138, 470 519, 257 170, 089 827, 816 1, 959 59.00 62.00 06200 MAGNETI C RESONANCE IMAGING (MRI) 138, 470 0 0 0 0 0 0 0 0 62.00 06200 MAGNETI C RESONANCE IMAGING (MRI) 138, 470 0 0 0 0 0 0 0 0 0			1					1
55.00 05500 RADIO I SOTOPE STITLE STIT		· · · · · · · · · · · · · · · · · · ·	1					1
56. 00 0500			1					
57.00 05700 CT SCAN 322, 538 34, 185 610 357, 333 1, 005 57.00			1					
59.00 05900 CARDI AC CATHETERI ZATION 138, 470 519, 257 170, 089 827, 816 1, 959 59, 00	57.00						1, 005	57.00
60.00 06000 LABORATORY 0 0 0 0 0 0 0 0 0			1					1
62. 00 06200 WHOLE BLOOD & PACKED RED BLOOD CELLS 0 0 0 0 0 0 0 62. 00 65. 00 06500 RESPI RATORY THERAPY 122, 187 78, 317 405, 320 605, 824 2, 427 66. 00 66. 00 06600 PHYSI CAL THERAPY 3, 290 159, 750 30, 713 193, 753 0 66. 00 66. 01 06601 PSYCHI ATRI C/PSYCHOLOGI CAL SERVI CES 0 0 0 0 0 0 0 66. 01 66. 02 06600 OF PHYSI CAL THERAPY 370, 693 0 86, 662 457, 355 0 66. 02 67. 00 06700 0CCUPATI ONAL THERAPY 370, 693 0 86, 662 457, 355 0 66. 02 68. 00 06600 SPECCH PATHOLOGY 41, 775 51, 749 1, 350 94, 874 0 68. 00 69. 00 06900 ELECTROCARDI OLOGY 279, 460 50, 065 1, 221, 507 1, 551, 032 482 69, 00 69. 01 06901 CARDI AC REHAB 0 102, 838 47, 679 150, 517 240 69, 01 70. 00 07000 ELECTROENCEPHALOGRAPHY 20, 254 23, 687 115, 127 159, 068 2, 479 70. 00 71. 00 07100 MEDI CAL SUPPLIES CHARGED TO PATI ENTS 0 89, 900 325, 465 415, 365 0 71. 00 72. 00 07200 IMPL DEV. CHARGED TO PATI ENTS 0 89, 900 325, 465 415, 365 0 71. 00 73. 00 07300 DRUGS CHARGED TO PATI ENTS 815, 971 326, 031 150, 422 1, 292, 424 3, 480 73. 00 76. 00 03020 RENAL ACUTE 1, 247 55, 480 7, 933 64, 660 0 76. 00 79. 00 09000 CLINI C 0 10, 986 0 10, 986 163 90. 00 79. 00 09000 ELERGENCY 47, 867 378, 851 307, 630 734, 348 4, 263 91. 00 79. 00 09000 DESERVATI ON BEDS (NON-DI STI NCT PART) 47, 867 378, 851 307, 630 734, 348 4, 263 91. 00 79. 00 09200 OSERVATI ON BEDS (NON-DI STI NCT PART) 47, 867 378, 851 307, 630 734, 348 4, 263 91. 00 79. 00 09200 OSERVATI ON BEDS (NON-DI STI NCT PART) 47, 867 378, 851 307, 630 734, 348 4, 263 91. 00 79. 00 09200 OSERVATI ON BEDS (NON-DI STI NCT PART) 47, 867 378, 851 307, 630 573, 4348 4, 263 91. 00 79. 00 09200 OSERVATI ON BEDS (NON-DI STI NCT PART) 47, 867 378,			138, 470					1
65.00 06500 RESPI RATORY THERAPY 122, 187 78, 317 405, 320 605, 824 2, 427 65, 00 66.00 06600 PHYSI CAL THERAPY 3, 290 159, 750 30, 713 193, 753 0 66, 00 66.01 06601 PSYCHI ATRI C/PSYCHOLOGI CAL SERVI CES 0 0 0 0 0 0 0 66.02 06602 O/P PHYSI CAL THERAPY 370, 693 0 86, 662 457, 355 0 66, 01 67.00 06700 0CCUPATI ONAL THERAPY 0 0 26, 095 5, 573 31, 668 0 67, 00 68.00 06800 SPEECH PATHOLOGY 41, 775 51, 749 1, 350 94, 874 0 68, 00 69.01 06900 ELECTROCARDI OLOGY 279, 460 50, 065 1, 221, 507 1, 551, 032 482 69, 00 69.01 06901 CARDIA C REHAB 0 102, 838 47, 679 150, 517 240 69, 01 70.00 07000 ELECTROCARDI OLOGY 20, 254 23, 687 115, 127 159, 068 2, 479 70, 00 71.00 07100 MEDI CAL SUPPLIES CHARGED TO PATI ENTS 0 89, 900 325, 465 415, 365 0 71, 00 72.00 07200 MPLD L DEV. CHARGED TO PATI ENTS 0 89, 900 325, 465 415, 365 0 72, 00 73.00 07300 DRUGS CHARGED TO PATI ENTS 815, 971 326, 031 150, 422 1, 292, 424 3, 480 73, 00 74.00 03020 RENAL ACUTE 1, 247 55, 480 7, 933 64, 660 0 76, 00 75.00 09000 CLI NI C 0 10, 986 163 90, 00 76.00 09000 DEPATI ENT SERVI CE COST CENTERS 140, 984 26, 665 170, 009 283 90, 07 79.00 09000 DEREGENCY 47, 867 378, 851 307, 630 734, 348 4, 263 91, 00 79.00 09000 OSERVALTION BEDS (NON-DISTINCT PART) SPECIAL PURPOSE COST CENTERS 140, 984 26, 665 170, 009 283 90, 07 79.00 09000 OSERVALTION BEDS (NON-DISTINCT PART) SPECIAL PURPOSE COST CENTERS 140, 984 26, 665 170, 009 283 90, 07 79.00 09000 OSERVALTION BEDS (NON-DISTINCT PART) 0 0 0 0 0 0 0 1, 087 194, 00 794.00 07950 RURAL HEALTH 0 0 0 0 0 0 1, 087 194, 00 794.00 07950 RURAL HEALTH 0 0 0 0 0 0 0 1, 087 194, 00 794.00 07951 FAMILY PRACTICE 162, 323 188, 867 201,			0	-	_	- 1		1
66. 00 06600 PHYSI CAL THERAPY 3, 290 159, 750 30, 713 193, 753 0 66. 00 66. 01 06601 PSYCHI ATRI C/PSYCHOLOGI CAL SERVI CES 0 0 0 0 0 0 66. 02 06602 07P PHYSI CAL THERAPY 370, 693 0 86, 662 457, 355 0 66. 02 06602 06700 0CCUPATI ONAL THERAPY 0 26, 095 5, 573 31, 668 0 67. 00 06700 0CCUPATI ONAL THERAPY 0 26, 095 5, 573 31, 668 0 68. 00 06800 PEECH PATHOLOGY 41, 775 51, 749 1, 350 94, 874 0 68. 00 06900 ELECTROCARDI OLOGY 279, 460 50, 065 1, 221, 507 1, 551, 032 482 69, 00 69. 01 06901 CARDI AC REHAB 0 102, 838 47, 679 150, 517 240 69, 01 70. 00 07000 CARDI AC REHAB 0 102, 838 47, 679 150, 517 240 69, 01 71. 00 07100 MEDICAL SUPPLIES CHARGED TO PATI ENTS 0 89, 900 325, 465 415, 365 0 71, 00 72. 00 07200 IMPL. DEV. CHARGED TO PATI ENTS 0 89, 900 325, 465 415, 365 0 71, 00 73. 00 07300 DRUGS CHARGED TO PATI ENTS 815, 971 326, 031 150, 422 1, 292, 424 3,480 73, 00 74. 00 07300 DRUGS CHARGED TO PATI ENTS 815, 971 326, 031 150, 422 1, 292, 424 3,480 73, 00 75. 00 07000 CLI NI C 1, 247 55, 480 7, 933 64, 660 0 76. 00 0000 CLI NI C 0 0 0 0 0 77. 00 07000 CLI NI C 0 0 0 0 79. 00 07000 CLI NI C 2, 450 140, 894 26, 665 170, 009 283 90. 07 791. 00 07000 DEMERGENCY 47, 867 378, 851 307, 630 734, 348 4, 263 91. 00 792. 00 09000 DEMERGENCY 47, 867 378, 851 307, 630 734, 348 4, 263 91. 00 792. 00 09000 DEMERGENCY 47, 867 378, 851 307, 630 734, 348 4, 263 91. 00 792. 00 09000 DEMERGENCY 47, 867 378, 851 307, 630 734, 348 4, 263 91. 00 792. 00 09000 DEMERGENCY 47, 867 378, 851 307, 630 734, 348 4, 263 91. 00 792. 00 09000 DEMERGENCY 47, 867 378, 851 307, 630 734, 348 4, 263 91. 00 792. 00 09000 DEMERGENCY 47, 867 378, 851 307			122 187			- 1		
66. 01 06601 PSYCHIATRI C/PSYCHOLOGI CAL SERVI CES 0 0 0 0 0 0 0 0 66. 01								
67. 00 06700 OCCUPATI ONAL THERAPY 0 26, 095 5, 573 31, 668 0 67. 00 68. 00 06800 SPEECH PATHOLOGY 41, 775 51, 749 1, 350 94, 874 0 68. 00 69. 00 06900 ELECTROCARDI OLOGY 279, 460 50, 065 1, 221, 507 1, 551, 032 482 69. 00 69. 01 06901 CARDI AC REHAB 0 102, 838 47, 679 150, 517 240 69. 01 70. 00 07000 ELECTROENCEPHALOGRAPHY 20, 254 23, 687 115, 127 159, 068 2, 479 70. 00 71. 00 07100 MEDI CAL SUPPLIES CHARGED TO PATIENTS 0 89, 900 325, 465 415, 365 0 71. 00 72. 00 07200 IMPL DEV. CHARGED TO PATIENTS 0 89, 900 325, 465 415, 365 0 71. 00 73. 00 07300 DRUGS CHARGED TO PATIENTS 815, 971 326, 031 150, 422 1, 292, 424 3, 480 73. 00 76. 00 03020 RENAL ACUTE 1, 247 55, 480 7, 933 64, 660 0 76. 00 000 09000 CLI NI C 0 0 0 0 0 000 09000 PATIENT SERVICE COST CENTERS 90. 00 09000 PATIENT NUTRI TI ON 0 30, 376 1, 672 32, 048 218 90. 05 90. 07 09007 WOUND CLI NI C 2, 450 140, 894 26, 665 170, 009 283 90. 07 91. 00 09100 DERGERICY 47, 867 378, 851 307, 630 734, 348 4, 263 90. 07 92. 00 09200 OBSERVATI ON BEDS (NON-DI STI NCT PART) 800 14, 978, 946 10, 912, 317 32, 156, 702 72, 644 18. 00 NONREI MBURSABLE COST CENTERS 190. 00 19000 GI FT, FLOWER, COFFEE SHOP & CANTEEN 0 0 0 0 0 0 194. 00 07951 RENTAL PROPERTY 0 0 0 0 0 0 194. 00 07951 RENTAL PROPERTY 0 0 0 0 0 194. 00 07951 FAMIL PRACTICE 162, 323 188, 867 201, 308 552, 498 2, 193 194. 00 194. 00 07954 FAMIL PRACTICE 162, 323 188, 867 201, 308 552, 498 2, 193 194. 00 194. 01 07954 RENTAL PROPERTY 0 0 0 0 50 0 0 0 0	66. 01	06601 PSYCHI ATRI C/PSYCHOLOGI CAL SERVI CES	O	0			0	
68. 00 06800 SPEECH PATHOLOGY 41, 775 51, 749 1, 350 94, 874 0 68. 00 69. 00 06900 ELECTROCARDI OLOGY 279, 460 50, 065 1, 221, 507 1, 551, 032 482 69. 00 06901 CARDI AC REHAB 0 0102, 838 447, 679 150, 517 240 69. 01 70. 00 70. 00 ELECTROENCEPHALOGRAPHY 20, 254 23, 687 115, 127 159, 068 2, 479 70. 00 71. 00 71. 00 71. 00 MEDI CAL SUPPLI ES CHARGED TO PATI ENTS 0 89, 900 325, 465 415, 365 0 71. 00 72. 00 72. 00 1MPL. DEV. CHARGED TO PATI ENTS 0 0 0 0 0 72. 00 72. 00 73. 00 07300 DRUGS CHARGED TO PATI ENTS 815, 971 326, 031 150, 422 1, 292, 424 3, 480 73. 00 76. 00 76. 00 09000 ELECTROENCEPHALOGRAPHY 20, 254 23, 687 115, 127 159, 068 2, 479 70. 00 70.		I I	370, 693	0				
69. 00 06900 ELECTROCARDI OLOGY 279, 460 50, 065 1, 221, 507 1, 551, 032 482 69. 00 69. 01 06901 CARDI AC REHAB 0 102, 838 47, 679 150, 517 240 69. 01 70. 00 07000 ELECTROENCEPHALOGRAPHY 20, 254 23, 687 115, 127 159, 068 2, 479 70. 00 71. 00 07100 MEDI CAL SUPPLIES CHARGED TO PATI ENTS 0 89, 900 325, 465 415, 365 0 71. 00 72. 00 07200 IMPL. DEV. CHARGED TO PATI ENTS 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0			0					
69. 01 06901 CARDI AC REHAB 0 102, 838 47, 679 150, 517 240 69. 01			1					
70.00 07000 ELECTROENCEPHALOGRAPHY 20, 254 23, 687 115, 127 159, 068 2, 479 70.00 71.00 71.00 MEDI CAL SUPPLI ES CHARGED TO PATI ENTS 0 89, 900 325, 465 415, 365 0 71.00 72.00 72.00 MPL. DEV. CHARGED TO PATI ENTS 0 0 0 0 0 72.00 73.00 DRUGS CHARGED TO PATI ENTS 815, 971 326, 031 150, 422 1, 292, 424 3, 480 73.00 76.00 03020 RENAL ACUTE 1, 247 55, 480 7, 933 64, 660 0 76.00 0000 CLI NI C 0 10, 986 0 10, 986 163 90.00 90.05 09005 PATI ENT SERVI CE COST CENTERS 90.05 09005 PATI ENT NUTRI TI ON 0 30, 376 1, 672 32, 048 218 90.05 90.07 09007 WOUND CLI NI C 2, 450 140, 894 26, 665 170, 009 283 90.07 91.00 09100 EMERGENCY 47, 867 378, 851 307, 630 734, 348 4, 263 91.00 92.00 09200 DSSERVATI ON BEDS (NON-DI STI NCT PART) 92.00 NONREI MBURSABLE COST CENTERS 90.05 09005 RIVAL LINES 1 through 117 6, 265, 439 14, 978, 946 10, 912, 317 32, 156, 702 72, 644 118.00 NONREI MBURSABLE COST CENTERS 90.00			279, 400 N					1
71. 00			20, 254					•
73. 00		07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	· ·			0	71.00
76. 00 03020 RENAL ACUTE 1, 247 55, 480 7, 933 64, 660 0 76. 00			0	-		- 1		
90. 00 09000 CLI NI C 0 10, 986 0 10, 986 163 90. 00 90. 05 09005 PATI ENT NUTRI TI ON 0 30, 376 1, 672 32, 048 218 90. 05 90. 07 09007 WOUND CLI NI C 2, 450 140, 894 26, 665 170, 009 283 90. 07 91. 00 09100 EMERGENCY 47, 867 378, 851 307, 630 734, 348 4, 263 91. 00 92. 00 09200 OBSERVATI ON BEDS (NON-DI STI NCT PART) 92. 00 SPECIAL PURPOSE COST CENTERS 118. 00 SUBTOTALS (SUM OF LINES 1 through 117) 6, 265, 439 14, 978, 946 10, 912, 317 32, 156, 702 72, 644 118. 00 NONREI MBURSABLE COST CENTERS 190. 00 19000 GI FT, FLOWER, COFFEE SHOP & CANTEEN 0 0 0 0 0 194. 00 07950 RURAL HEALTH 0 0 0 0 0 194. 01 07951 RENTAL PROPERTY 0 0 0 7, 523 7, 523 0 194. 02 07954 FAMI LY PRACTI CE 162, 323 188, 867 201, 308 552, 498 2, 193 194. 02								
90. 00 09000 CLINIC 0 10, 986 0 10, 986 163 90. 00 90. 05 09005 PATIENT NUTRITION 0 30, 376 1, 672 32, 048 218 90. 05 90. 07 09007 WOUND CLINIC 2, 450 140, 894 26, 665 170, 009 283 90. 07 91. 00 09100 EMERGENCY 47, 867 378, 851 307, 630 734, 348 4, 263 91. 00 92. 00 SERVATION BEDS (NON-DISTINCT PART) 92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART) 92. 00 SUBTOTALS (SUM OF LINES 1 through 117) 6, 265, 439 14, 978, 946 10, 912, 317 32, 156, 702 72, 644 118. 00 NONREI MBURSABLE COST CENTERS 190. 00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN 0 0 0 0 190. 00 194. 00 07950 RURAL HEALTH 0 0 0 0 0 1, 087 194. 00 194. 01 07951 RENTAL PROPERTY 0 0 0 7, 523 7, 523 0 194. 01 194. 02 07954 FAMILY PRACTICE 162, 323 188, 867 201, 308 552, 498 2, 193 194. 02	/6. 00		1, 247	55, 480	7, 933	64, 660	0	76.00
90. 05 09005 PATI ENT NUTRITION 0 30, 376 1, 672 32, 048 218 90. 05 90. 07 09007 WOUND CLINIC 2, 450 140, 894 26, 665 170, 009 283 90. 07 91. 00 09100 EMERGENCY 47, 867 378, 851 307, 630 734, 348 4, 263 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) 6, 265, 439 14, 978, 946 10, 912, 317 32, 156, 702 72, 644 118. 00 NONREI MBURSABLE COST CENTERS 190. 00 79000 GIFT, FLOWER, COFFEE SHOP & CANTEEN 0 0 0 0 0 1, 087 194. 00 194. 01 07951 RENTAL PROPERTY 0 0 0 7, 523 7, 523 0 194. 01 194. 02 07954 FAMILY PRACTICE 162, 323 188, 867 201, 308 552, 498 2, 193 194. 02	90 00			10 986	0	10 986	163	90 00
90. 07 09007 WOUND CLINIC 2, 450 140, 894 26, 665 170, 009 283 90. 07 91. 00 09100 EMERGENCY 47, 867 378, 851 307, 630 734, 348 4, 263 91. 00 92. 00 SPECIAL PURPOSE COST CENTERS								1
92. 00 09200 0BSERVATI ON BEDS (NON-DISTINCT PART) 92. 00 SPECIAL PURPOSE COST CENTERS 118. 00 SUBTOTALS (SUM OF LINES 1 through 117) 6, 265, 439 14, 978, 946 10, 912, 317 32, 156, 702 72, 644 118. 00 NONREI MBURSABLE COST CENTERS 0 0 0 0 190. 00 1		I I	2, 450					
SPECIAL PURPOSE COST CENTERS SUBTOTALS (SUM OF LINES 1 through 117) 6, 265, 439 14, 978, 946 10, 912, 317 32, 156, 702 72, 644 118. 00		09100 EMERGENCY	1				4, 263	1
118. 00 SUBTOTALS (SUM OF LINES 1 through 117) 6, 265, 439 14, 978, 946 10, 912, 317 32, 156, 702 72, 644 118. 00	92. 00					0		92.00
NONRE MBURSABLE COST CENTERS 190. 00 19000 GI FT, FLOWER, COFFEE SHOP & CANTEEN 0 0 0 0 190. 00 190. 00 194. 00 194. 01 07950 RURAL HEALTH 0 0 0 0 0 0 1, 087 194. 00 194. 01 07951 RENTAL PROPERTY 0 0 0 7, 523 7, 523 0 194. 01 194. 02 07954 FAMILY PRACTICE 162, 323 188, 867 201, 308 552, 498 2, 193 194. 02 194. 02 194. 02 194. 04 194	110 00		/ 2/F 420	14 070 04/	10 010 017	22 15/ 702	70 (44	110 00
190. 00 19000 GI FT, FLOWER, COFFEE SHOP & CANTEEN 0 0 0 0 0 190. 00 194. 00 07950 RURAL HEALTH 0 0 0 0 0 0 194. 00 194. 01 07951 RENTAL PROPERTY 0 0 7, 523 7, 523 0 194. 01 194. 02 07954 FAMILY PRACTICE 162, 323 188, 867 201, 308 552, 498 2, 193 194. 02	118.00		0, 205, 439	14, 978, 946	10, 912, 317	32, 156, 702	12,644	Ji 18. UU
194. 00 07950 RURAL HEALTH 0 0 0 0 1,087 194. 00 194. 01 07951 RENTAL PROPERTY 0 0 7,523 7,523 0 194. 01 194. 02 07954 FAMI LY PRACTICE 162, 323 188, 867 201, 308 552, 498 2, 193 194. 02	190.00		O	0	0	ol	0	190. 00
194. 02 07954 FAMI LY PRACTI CE 162, 323 188, 867 201, 308 552, 498 2, 193 194. 02	194.00	07950 RURAL HEALTH			0	- 1		
			0	0				
194. U3 U1952 WELLINESS U 219, 668 0 219, 668 297 194. 03		· · · · · · · · · · · · · · · · · · ·	1					
	194.03	3 U/952 WELLNESS	0	219, 668	<u> </u> 0	219, 668	297	1194.03

Health Financial Systems	UNI ON HOSPI	TAL, INC.		In Lie	u of Form CMS-2	2552-10
ALLOCATION OF CAPITAL RELATED COSTS		Provi der CO		Peri od:	Worksheet B	
				From 01/01/2018 To 12/31/2018	Date/Time Pre	
					5/29/2019 1:1	1 pm
		CAPI TAL REL	_ATED COSTS			
Cost Center Description	Di rectly	NEW BLDG &	NEW MVBLE	Subtotal	EMPLOYEE	
	Assigned New	FLXT	EQUI P		BENEFITS	
	Capi tal				DEPARTMENT	
	Related Costs					
	0	1.00	2.00	2A	4. 00	
194. 04 07955 PHYSICIAN PRACTICES	484, 708	0	121, 64	4 606, 352	5, 843	194. 04
194.06 07953 SYCAMORE SPORTS MED	0	0	20	6 206	11	194.06
194. 07 07956 PSYCHI ATRI C/PSYCHOLOGI CAL SERVI CES	3, 654	45, 108	2, 91	0 51, 672	334	194. 07
200.00 Cross Foot Adjustments				0		200.00
201.00 Negative Cost Centers		0		0 0	0	201.00
202.00 TOTAL (sum lines 118 through 201)	6, 916, 124	15, 432, 589	11, 245, 90	8 33, 594, 621	82, 409	202.00

| In Lieu of Form CMS-2552-10 | Period: | Worksheet B | From 01/01/2018 | Part II | To 12/31/2018 | Date/Time Prepared: | To 12/31/2018 | Date/Tim

Cost Center Description NONPATIENT DATA PURCHASING ADM		5/29/2019 1:1	
	II TTI NG	CASHI ERI NG/AC	ı pııı
TELEPHONES PROCESSING RECEIVING AND		COUNTS	
5. 01 5. 02 5. 03 5	5. 04	RECEI VABLE 5. 05	
GENERAL SERVICE COST CENTERS	3. 04	5.05	
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 101, 898 5. 02 00550 DATA PROCESSI NG 0 0			5. 01 5. 02
5. 03 00560 PURCHASI NG RECEIVING AND STORES 0 0 0			5. 02
5. 04 00570 ADMI TTI NG 3, 654 0	65, 288		5. 04
5. 05 00580 CASHI ERI NG/ACCOUNTS RECEI VABLE 0 0 0	0	0	5.05
5. 06 00590 OTHER ADMI N AND GENERAL 9, 418 0 0	0	0	5. 06
7. 00 00700 0PERATION OF PLANT 5, 765 0 0 8. 00 00800 LAUNDRY & LINEN SERVICE 1, 461 0 0	0	0	7. 00 8. 00
8. 00 00800 LAUNDRY & LI NEN SERVI CE 1, 461 0 0 0 0 0 0 0 0 0	0	0	9. 00
10. 00 01000 DI ETARY 2, 436 0	0	ő	10.00
11. 00 01100 CAFETERI A 0 0 0	0	0	11.00
13.00 01300 NURSI NG ADMINISTRATION 731 0 0	0	0	13.00
16. 00 01600 MEDI CAL RECORDS & LI BRARY 2, 436 0 0	0	0	16.00
21. 00 02100 1 &R SERVI CES-SALARY & FRI NGES APPRVD 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	0	0	21. 00 22. 00
23. 00 02300 PARAMED ED PRGM 0 0 0	0	0	23. 00
23. 01 02341 0THER MED ED 0 0 0	0	o	23. 01
23. 02 02301 PARAMED ED PRGM 0 0	0	0	23.02
INPATIENT ROUTINE SERVICE COST CENTERS			
30. 00 03000 ADULTS & PEDI ATRI CS	11, 636	0	30.00
31. 00 03100 I NTENSI VE CARE UNI T 2, 355 0 0 0 0 35. 00 02040 I NTENSI VE NURSERY 1, 461 0 0	3, 101 2, 408	0	31. 00 35. 00
41. 00 04100 SUBPROVI DER - I RF 2,517 0	498	ő	41.00
43. 00 04300 NURSERY 325 0 0	396	0	43.00
ANCILLARY SERVICE COST CENTERS			
50. 00 05000 0PERATI NG ROOM 6, 658 0 0 50. 01 05001 CARDI AC SURGERY 487 0 0	12, 194	0	50.00
50. 01 05001 CARDI AC SURGERY	803 15	0	50. 01 50. 02
51. 00 05100 RECOVERY ROOM	400	0	51.00
51. 02 05101 0/P TREATMENT ROOM 2, 192 0 0	3	o	51. 02
52.00 05200 DELIVERY ROOM & LABOR ROOM 1,867 0 0	2, 148	0	52.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C 8, 769 0 0	1, 755	0	54.00
55. 00 05500 RADI OLOGY-THERAPEUTI C 3, 329 0 0	223	0	55.00
56. 00 05600 RADI 0I SOTOPE 0 0 0 57. 00 05700 CT SCAN 568 0 0 0	119 1, 892	0	56. 00 57. 00
58. 00 05800 MAGNETI C RESONANCE I MAGI NG (MRI) 325 0	321	0	58. 00
59. 00 05900 CARDI AC CATHETERI ZATI ON 2, 761 0 0	3, 888	ő	59.00
60. 00 06000 LABORATORY 650 0 0	5, 920	0	60.00
62. 00 06200 WHOLE BLOOD & PACKED RED BLOOD CELLS 0 0 0	300	0	62.00
65. 00 06500 RESPI RATORY THERAPY	2, 614	0	65.00
66. 00 06600 PHYSI CAL THERAPY	884 0	0	66. 00 66. 01
66. 02 06602 0/P PHYSI CAL THERAPY 81 0 0	0	0	66. 02
67. 00 06700 0CCUPATI ONAL THERAPY 406 0	674	ő	67.00
68. 00 06800 SPEECH PATHOLOGY 81 0 0	141	0	68.00
69. 00 06900 ELECTROCARDI OLOGY 325 0 0	1, 739	0	69.00
69. 01 06901 CARDI AC REHAB 487 0 0 0 0 0 0 0 0 0	13	0	69. 01 70. 00
70. 00 07000 ELECTROENCEPHALOGRAPHY	217 98	0	70.00
72. 00 07200 IMPL. DEV. CHARGED TO PATIENTS 0 0 0	1, 111	ő	72.00
73.00 07300 DRUGS CHARGED TO PATIENTS 4,060 0 0	5, 725	0	73.00
76. 00 03020 RENAL ACUTE 325 0 0	390	0	76.00
OUTPATIENT SERVICE COST CENTERS		-	00.00
90. 00 09000 CLI NI C	0	0	90. 00 90. 05
90. 05 09005 PATTENT NOTRETTON	1	0	90. 05 90. 07
91. 00 09100 EMERGENCY 5, 115 0	3, 661	ő	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) 93,616 0 0	65, 288	0	118. 00
NONREI MBURSABLE COST CENTERS			100 00
190. 00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN 0 0 0 194. 00 0 7950 RURAL HEALTH 81 0	0	•	190. 00 194. 00
194. 00 07950 RORAL HEALTH 0 0 0 0	0		194.00
194. 02 07954 FAMI LY PRACTI CE 5, 765 0	0		194. 02
194. 03 07952 WELLNESS 0 0 0	0	•	194. 03
194. 04 07955 PHYSI CI AN PRACTI CES 1, 786 0	0		194.04
194. 06 07953 SYCAMORE SPORTS MED 0 0 0 194. 07 07956 PSYCHI ATRI C/PSYCHOLOGI CAL SERVI CES 650 0 0	0		194. 06 194. 07
174. 0/10/700/1 310/11 ATRI 0/1 310/10L001 OAL 3ERVI 0L3 030/1 0/1 0/1 0/1	0	υĮ	174.07

Health Financial Systems	UNI ON HOSPI TA	L, INC.		In Lie	u of Form CMS-2552-10
ALLOCATION OF CAPITAL RELATED COSTS		Provi der CC		Peri od: From 01/01/2018 To 12/31/2018	Worksheet B Part II Date/Time Prepared: 5/29/2019 1:11 pm
Cost Center Description	NONPATIENT	DATA	PURCHASI NG	ADMITTI NG	CASHLERI NG/AC

						5/29/2019 I: I	ı pm
	Cost Center Description	NONPATI ENT	DATA	PURCHASI NG	ADMI TTI NG	CASHI ERI NG/AC	
		TELEPHONES	PROCESSI NG	RECEIVING AND		COUNTS	
				STORES		RECEI VABLE	
		5. 01	5. 02	5. 03	5. 04	5. 05	
200.00	Cross Foot Adjustments						200.00
201.00	Negative Cost Centers	0	0	0	0	0	201.00
202.00	TOTAL (sum lines 118 through 201)	101, 898	0	0	65, 288	0	202.00

In Lieu of Form CMS-2552-10

Period: Worksheet B
From 01/01/2018 Part II
To 12/31/2018 Date/Time Prepared: 5/29/2019 1:11 pm

						5/29/2019 1:1	
Cost	Center Description	OTHER ADMIN	OPERATION OF	LAUNDRY &	HOUSEKEEPI NG	DI ETARY	
		AND GENERAL 5.06	7. 00	LINEN SERVICE 8.00	9. 00	10.00	
GENERAL SE	ERVICE COST CENTERS	5. 00	7.00	0.00	9.00	10.00	
	CAP REL COSTS-BLDG & FIXT						1.00
	CAP REL COSTS-MVBLE EQUIP						2.00
	OYEE BENEFITS DEPARTMENT						4. 00
1	ATIENT TELEPHONES						5. 01
1 1	PROCESSING						5.02
5. 03 00560 PURC 5. 04 00570 ADMI	CHASING RECEIVING AND STORES						5. 03 5. 04
1	II ERI NG/ACCOUNTS RECEI VABLE						5.04
1 1	R ADMIN AND GENERAL	458, 390					5.06
1 1	ATION OF PLANT	21, 418	5, 624, 324				7.00
8. 00 00800 LAUN	DRY & LINEN SERVICE	2, 121	54, 567	377, 643			8.00
9. 00 00900 HOUS		5, 049	14, 107	1	· .		9. 00
10. 00 01000 DI ET		1, 104	100, 022	1	l ' '	605, 561	10.00
11. 00 01100 CAFE		4, 228	71, 371	i	_,	0	11.00
	ING ADMINISTRATION CAL RECORDS & LIBRARY	5, 780 7, 272	21, 652 48, 143	1	633 1, 407	0	13. 00 16. 00
1 1	SERVICES-SALARY & FRINGES APPRVD	2, 408	40, 143	i	1, 407	0	21.00
1 1	SERVICES-OTHER PRGM COSTS APPRVD	3, 338	0	Ö	o	0	22.00
I I	MED ED PRGM	226	0	Ō	Ö	0	23. 00
23. 01 02341 OTHE	R MED ED	393	6, 561	0	192	0	23. 01
	MED ED PRGM	226	0	0	0	0	23. 02
	ROUTINE SERVICE COST CENTERS	50.004	1 700 75/	100.001		45.4.007	
1	TS & PEDIATRICS	59, 821	1, 708, 756		49, 946	454, 086	30.00
	NSIVE CARE UNIT	11, 938 4, 637	209, 502 35, 831		6, 124 1, 047	65, 005 0	31. 00 35. 00
1 1	PROVIDER - IRF	2, 858	140, 546		4, 108	38, 461	41.00
43. 00 04300 NURS		2, 004	6, 907		202	0	43.00
	SERVICE COST CENTERS	27 00 1	0, 707				10.00
50. 00 05000 OPER	ATING ROOM	20, 811	371, 208	22, 125	10, 850	0	50.00
	I AC SURGERY	3, 473	16, 403		l .	0	50. 01
50. 02 05002 WVSC		18, 338	273, 638	1		0	50.02
51. 00 05100 RECO		3, 296	13, 049	1	l .	0	51.00
1 1	TREATMENT ROOM VERY ROOM & LABOR ROOM	1, 397 7, 436	218, 032 215, 835	1	6, 373 6, 309	44, 867 15	51. 02 52. 00
1 1	OLOGY-DI AGNOSTI C	14, 545	287, 781	1		0	54.00
1 1	OLOGY-THERAPEUTI C	9, 003	240, 513	1		0	55.00
56. 00 05600 RADI		3, 220	80, 192	1	2, 344	0	56.00
57.00 05700 CT S	CAN	4, 347	19, 793	0	579	0	57.00
	IETIC RESONANCE IMAGING (MRI)	2, 970	23, 629	1	691	0	58. 00
	I AC CATHETERI ZATI ON	30, 423	300, 648	1	8, 788	3, 127	59.00
60. 00 06000 LAB0		13, 640	0		0	0	60.00
	LE BLOOD & PACKED RED BLOOD CELLS PIRATORY THERAPY	1, 927 7, 111	45, 345	0	1, 325	0	62. 00 65. 00
	I CAL THERAPY	4, 634	92, 494	1		0	66.00
1 1	CHI ATRI C/PSYCHOLOGI CAL SERVI CES	0	0		2,,01	0	66. 01
	PHYSI CAL THERAPY	3, 494	0	6, 674	0	0	66.02
	PATI ONAL THERAPY	2, 739	15, 109	0	442	0	67.00
	CH PATHOLOGY	1, 210	29, 963	1	876	0	68. 00
	TROCARDI OLOGY	17, 455	28, 988		l .	0	69.00
69. 01 06901 CARD		781	59, 543	1	· .	0	69. 01
1 1	TROENCEPHALOGRAPHY CAL SUPPLIES CHARGED TO PATIENTS	2, 086 1, 825	13, 715 52, 052		401 1, 521	0	70. 00 71. 00
1	DEV. CHARGED TO PATIENTS	20, 138	52, 052		1, 321	0	72.00
	S CHARGED TO PATIENTS	73, 062	188, 771	0	5, 518	0	73.00
76. 00 03020 RENA		2, 198	32, 122	1, 291	939	0	76.00
OUTPATI ENT	SERVICE COST CENTERS						
90. 00 09000 CLI N		381	6, 361		186	0	90.00
	ENT NUTRITION	497	17, 588	1	514	0	90.05
90. 07 09007 WOUN		2, 082	81, 577			0	90.07
91. 00 09100 EMER 92. 00 09200 OBSE	RVATION BEDS (NON-DISTINCT PART)	14, 165	219, 353	55, 232	6, 412	0	91. 00 92. 00
	JRPOSE COST CENTERS						72.00
	OTALS (SUM OF LINES 1 through 117)	423, 505	5, 361, 667	375, 870	154, 712	605, 561	118.00
	RSABLE COST CENTERS	0, 000	2,23.,307	2.3,370		220,001	1
190. 00 19000 GI FT	, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0		190. 00
194. 00 07950 RURA		5, 226	0	188	0		194. 00
194. 01 07951 RENT		80	0	0	0		194. 01
194. 02 07954 FAMI		6, 877	109, 353	1	l		194. 02
194. 03 07952 WELL 194. 04 07955 PHYS		1, 015	127, 187	0 1, 343	3, 718		194. 03 194. 04
194. 04 07955 PHYS		20, 750 81	0	1, 343	l .		194.04
	CHI ATRI C/PSYCHOLOGI CAL SERVI CES	856	26, 117		763		194.00
	s Foot Adjustments	550	20, 117		, 55	O	200.00
	-	·		1			·

Health Fina	ncial Systems	UNI ON HOSPI	TAL, INC.		In Lie	u of Form CMS-2	2552-10
ALLOCATI ON	OF CAPITAL RELATED COSTS		Provi der C			Worksheet B Part II Date/Time Pre 5/29/2019 1:1	
	Cost Center Description	OTHER ADMIN	OPERATION OF	LAUNDRY &	HOUSEKEEPI NG	DI ETARY	

						5/29/2019 1:1	1 pm
	Cost Center Description	OTHER ADMIN	OPERATION OF	LAUNDRY &	HOUSEKEEPI NG	DI ETARY	
		AND GENERAL	PLANT	LINEN SERVICE			
		5. 06	7. 00	8. 00	9. 00	10.00	
201.00	Negative Cost Centers	0	0	0	0	14, 348	201.00
202. 00	TOTAL (sum lines 118 through 201)	458, 390	5, 624, 324	377, 643	162, 389	619, 909	202.00

Health Financial Systems
ALLOCATION OF CAPITAL RELATED COSTS

ALLOCA	ATION OF CAPITAL RELATED COSTS		Provi der CC	F	eriod: rom 01/01/2018 o 12/31/2018		norod:
				'		5/29/2019 1: 1 RESI DENTS	1 pm
	Cost Center Description	CAFETERI A	NURSI NG ADMI NI STRATI O N	MEDI CAL RECORDS & LI BRARY	SERVI CES-SALA RY & FRI NGES	SERVICES-OTHE R PRGM COSTS	
		11. 00	13. 00	16. 00	21.00	22. 00	
1.00 2.00 4.00 5.01 5.02 5.03 5.04 5.05 7.00 8.00 9.00 10.00 11.00 16.000 21.00	01100 CAFETERIA 01300 NURSI NG ADMINI STRATI ON 01600 MEDI CAL RECORDS & LI BRARY	212, 664 3, 438 11, 354 3, 967	77, 902 0	192, 669 0	7,588		1. 00 2. 00 4. 00 5. 01 5. 02 5. 03 5. 04 5. 05 5. 06 7. 00 8. 00 9. 00 10. 00 11. 00 13. 00 16. 00 21. 00
	02200 &R SERVICES-OTHER PRGM COSTS APPRVD 02300 PARAMED ED PRGM 02341 OTHER MED ED 02301 PARAMED ED PRGM INPATIENT ROUTINE SERVICE COST CENTERS	812 378 1, 190 378	0 0 634 0	0 0 0 0		5, 276	1
30. 00 31. 00 35. 00 41. 00 43. 00	03100 NTENSIVE CARE UNIT 02040 NTENSIVE NURSERY 04100 SUBPROVI DER - RF	68, 956 11, 581 4, 987 3, 552 2, 928	35, 049 6, 167 2, 656 1, 891 1, 559	11, 941 3, 268 2, 537 525 417			30. 00 31. 00 35. 00 41. 00 43. 00
62. 00 65. 00 66. 00 66. 01 66. 02 67. 00 68. 00 69. 01 70. 00 71. 00 72. 00 73. 00 76. 00	05000 OPERATING ROOM 05001 CARDIAC SURGERY 05002 WYSC 05100 RECOVERY ROOM 05101 O/P TREATMENT ROOM 05200 DELIVERY ROOM & LABOR ROOM 05400 RADIOLOGY-DIAGNOSTIC 05500 RADIOLOGY-THERAPEUTIC 05600 RADIOLOGY-THERAPEUTIC 05600 RADIOLOGY-THERAPEUTIC 05600 RADIOLOGY-THERAPEUTIC 05900 CARDIAC CATHETERIZATION 05900 CARDIAC CATHETERIZATION 06000 LABORATORY 06200 WHOLE BLOOD & PACKED RED BLOOD CELLS 06500 RESPIRATORY THERAPY 06600 PHYSICAL THERAPY 06600 PHYSICAL THERAPY 06600 OPPHYSICAL THERAPY 06600 OPPHYSICAL THERAPY 06600 SPEECH PATHOLOGY 06900 ELECTROCARDIOLOGY 06901 CARDIAC REHAB 07000 ELECTROCARDIOLOGY 06901 CARDIAC REHAB 07000 ELECTROCARDIOLOGY 06901 CARDIAC REHAB 07000 ELECTROENCEPHALOGRAPHY 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 07200 IMPL. DEV. CHARGED TO PATIENTS 07300 DRUGS CHARGED TO PATIENTS 03020 RENAL ACUTE	9, 956 1, 341 0 4, 534 850 8, 482 11, 165 945 775 2, 758 1, 511 6, 442 0 0 7, 311 0 0 0 7, 311 756 1, 700 0 8, 350 0 378	5, 301 412 0 2, 414 453 4, 517 0 0 0 0 0 0 3, 621 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	23, 384 850 15, 360 1, 413 279 2, 886 7, 925 5, 918 1, 531 7, 533 1, 802 13, 126 415 3, 121 1, 649 0 1, 061 1, 227 437 10, 388 177 641 112 2, 828 36, 167 471			50. 00 50. 01 50. 02 51. 02 51. 02 52. 00 54. 00 55. 00 56. 00 57. 00 60. 00 62. 00 66. 00 66. 01 66. 02 67. 00 68. 00 69. 01 70. 00 71. 00 72. 00 73. 00 76. 00
90. 05 90. 07 91. 00 92. 00	09007 WOUND CLINIC 09100 EMERGENCY	661 888 15, 793	352 473 8, 410	27 978 18, 944			90. 05 90. 07 91. 00 92. 00
118.00		200, 592	77, 902	192, 669	0	0	118. 00
194. 00 194. 00 194. 00 194. 00	0 19000 GI FT, FLOWER, COFFEE SHOP & CANTEEN 0 07950 RURAL HEALTH 1 07951 RENTAL PROPERTY 2 07954 FAMILY PRACTICE 3 07952 WELLNESS 4 07955 PHYSICIAN PRACTICES	0 0 0 3, 457 0 8, 615	0 0 0 0 0	0 0 0 0 0			190. 00 194. 00 194. 01 194. 02 194. 03 194. 04

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

						5/29/2019 1:1	1 pm
					INTERNS &	RESI DENTS	
	Cost Center Description	CAFETERI A	NURSI NG	MEDI CAL	SERVI CES-SALA	SERVI CES-OTHE	
			ADMI NI STRATI O	RECORDS &	RY & FRINGES	R PRGM COSTS	
			N	LI BRARY			
		11. 00	13. 00	16.00	21.00	22. 00	
194.06 0795	SYCAMORE SPORTS MED	0	0	0			194.06
194. 07 0795	66 PSYCHI ATRI C/PSYCHOLOGI CAL SERVI CES	0	0	0			194.07
200.00	Cross Foot Adjustments				7, 588	5, 276	200.00
201.00	Negative Cost Centers	0	0	0	0	0	201.00
202.00	TOTAL (sum lines 118 through 201)	212, 664	77. 902	192, 669	7, 588	5. 276	202.00

Health Financial Systems In Lieu of Form CMS-2552-10 UNION HOSPITAL, INC. ALLOCATION OF CAPITAL RELATED COSTS Provider CCN: 15-0023 Peri od: Worksheet B From 01/01/2018 Part II Date/Time Prepared: 12/31/2018 5/29/2019 1:11 pm Cost Center Description PARAMED ED OTHER MED ED PARAMED ED Subtotal Intern & PRGM PRGM Resi dents Cost & Post Stepdown Adjustments 23. 00 23. 01 23.02 24.00 25. 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 NONPATI ENT 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 00590 OTHER ADMIN AND GENERAL 5.06 5.06 00700 OPERATION OF PLANT 7.00 7.00 8.00 00800 LAUNDRY & LINEN SERVICE 8.00 00900 HOUSEKEEPI NG 9.00 9.00 01000 DI ETARY 10.00 10.00 11. 00 01100 CAFETERIA 11.00 01300 NURSING ADMINISTRATION 13.00 13.00 01600 MEDICAL RECORDS & LIBRARY 16,00 16,00 21.00 02100 I &R SERVICES-SALARY & FRINGES APPRVD 21.00 02200 I&R SERVICES-OTHER PRGM COSTS APPRVD 22.00 22.00 02300 PARAMED ED PRGM 704 23.00 23.00 02341 OTHER MED ED 23.01 20, 535 23.01 23.02 02301 PARAMED ED PRGM 704 23.02 INPATIENT ROUTINE SERVICE COST CENTERS 30 00 03000 ADULTS & PEDIATRICS 6 672 262 n 30.00 03100 INTENSIVE CARE UNIT 31.00 1, 540, 459 0 31.00 35. 00 02040 I NTENSI VE NURSERY 275, 112 0 35.00 04100 SUBPROVI DER - I RF 41.00 491, 160 0 41.00 04300 NURSERY 43.00 35, 230 0 43.00 ANCILLARY SERVICE COST CENTERS 50.00 05000 OPERATING ROOM 3, 785, 172 0 50.00 50.01 05001 CARDI AC SURGERY 291, 906 0 50.01 05002 WVSC 50 02 50.02 1, 785, 226 0 05100 RECOVERY ROOM 51.00 117, 154 0 51.00 05101 0/P TREATMENT ROOM 51.02 728, 402 0 52.00 05200 DELIVERY ROOM & LABOR ROOM 970, 079 0 05400 RADI OLOGY-DI AGNOSTI C 2, 590, 087 54.00 0 55.00 05500 RADI OLOGY-THERAPEUTI C 1, 942, 901 0 56.00 05600 RADI OI SOTOPE 913, 103 0 05700 CT SCAN 57.00 395, 808 0 05800 MAGNETIC RESONANCE IMAGING (MRI) 58.00 704, 400 0 59.00 05900 CARDIAC CATHETERIZATION 1, 211, 863 0 06000 LABORATORY 33, 336 60.00 0 06200 WHOLE BLOOD & PACKED RED BLOOD CELLS 62.00 2.642 0 65.00 06500 RESPIRATORY THERAPY 679, 836 0 66.00 06600 PHYSI CAL THERAPY 300, 477 06601 PSYCHI ATRI C/PSYCHOLOGI CAL SERVI CES 66.01 0 06602 0/P PHYSICAL THERAPY 66.02 468, 665 0 67.00 06700 OCCUPATIONAL THERAPY 52, 265 0 06800 SPEECH PATHOLOGY 68.00 127, 582 0 06900 ELECTROCARDI OLOGY 1, 618, 757 69.00 0 69.01 06901 CARDI AC REHAB 214, 367 0 07000 ELECTROENCEPHALOGRAPHY 182, 881 0 71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 472, 110 0 07200 I MPL. DEV. CHARGED TO PATIENTS 72.00 24, 077 0 07300 DRUGS CHARGED TO PATIENTS 73.00 1,621,349 0 03020 RENAL ACUTE 76.00 102, 396 0 OUTPATIENT SERVICE COST CENTERS 90.00 09000 CLI NI C 18, 757 0 09005 PATIENT NUTRITION 90.05 51, 905 0 09007 WOUND CLINIC 90.07 263, 014 0 91 00 09100 EMERGENCY 1,085,696 0 09200 OBSERVATION BEDS (NON-DISTINCT PART) 92.00 0 SPECIAL PURPOSE COST CENTERS SUBTOTALS (SUM OF LINES 1 through 117) 118.00 0 0 0 31, 770, 436

Health Financial Systems	UNION HOSPITAL, INC.			In Lieu of Form CMS-2552-10			
ALLOCATION OF CAPITAL RELATED COSTS		Provi der CO	Provider CCN: 15-0023		Worksheet B		
				From 01/01/2018			
				To 12/31/2018	Date/Time Pre		
					5/29/2019 1:1	1 pm	
Cost Center Description	PARAMED ED	OTHER MED ED	PARAMED ED	Subtotal	Intern &		
	PRGM		PRGM		Resi dents		
					Cost & Post		
					Stepdown		
					Adjustments		
	23. 00	23. 01	23. 02	24.00	25.00		
194.06 07953 SYCAMORE SPORTS MED				298	0	194.06	
194. 07 07956 PSYCHI ATRI C/PSYCHOLOGI CAL SERVI CES				80, 392	0	194. 07	
200.00 Cross Foot Adjustments	704	20, 535	70	34, 807	0	200.00	
201.00 Negative Cost Centers	0	0		0 14, 348	0	201.00	
202.00 TOTAL (sum lines 118 through 201)	704	20, 535	70	33, 594, 621	0	202. 00	

Health Financial Systems
ALLOCATION OF CAPITAL RELATED COSTS UNION HOSPITAL, INC.

Provider CCN: 15-0023

			5/29/2019 1:	
	Cost Center Description	Total	0,2,7,201,711	T
		26. 00		
	SENERAL SERVICE COST CENTERS			
	00100 NEW CAP REL COSTS-BLDG & FLXT			1.00
1	00200 NEW CAP REL COSTS-MVBLE EQUIP			2.00
1	00400 EMPLOYEE BENEFITS DEPARTMENT			4.00
	00540 NONPATI ENT TELEPHONES			5. 01
1	00550 DATA PROCESSING			5. 02
1	00560 PURCHASING RECEIVING AND STORES			5.03
4	00570 ADMITTING 00580 CASHIERING/ACCOUNTS RECEIVABLE			5.04
1	00590 OTHER ADMIN AND GENERAL			5. 05 5. 06
	00700 OPERATION OF PLANT			7.00
	00800 LAUNDRY & LINEN SERVICE			8.00
1	00900 HOUSEKEEPI NG			9. 00
4	01000 DI ETARY			10.00
1	01100 CAFETERI A			11.00
1	01300 NURSING ADMINISTRATION			13.00
16.00	01600 MEDICAL RECORDS & LIBRARY			16.00
21.00	02100 I&R SERVICES-SALARY & FRINGES APPRVD			21.00
22.00	02200 I&R SERVICES-OTHER PRGM COSTS APPRVD			22. 00
	02300 PARAMED ED PRGM			23. 00
	02341 OTHER MED ED			23. 01
-	02301 PARAMED ED PRGM			23. 02
	NPATIENT ROUTINE SERVICE COST CENTERS	, ,== =		4
1	03000 ADULTS & PEDIATRICS	6, 672, 262		30.00
1	03100 NTENSI VE CARE UNI T	1, 540, 459		31.00
1	02040 I NTENSI VE NURSERY	275, 112		35.00
1	04100 SUBPROVI DER – I RF	491, 160		41. 00 43. 00
<u> </u>	04300 NURSERY NNCILLARY SERVICE COST CENTERS	35, 230		43.00
	D5000 OPERATING ROOM	3, 785, 172		50.00
4	05001 CARDI AC SURGERY	291, 906		50.00
	05002 WVSC	1, 785, 226		50.02
1	05100 RECOVERY ROOM	117, 154		51.00
1	05101 0/P TREATMENT ROOM	728, 402		51.02
1	05200 DELIVERY ROOM & LABOR ROOM	970, 079		52.00
1	D5400 RADI OLOGY-DI AGNOSTI C	2, 590, 087		54.00
55.00	05500 RADI OLOGY-THERAPEUTI C	1, 942, 901		55.00
56.00	05600 RADI OI SOTOPE	913, 103		56.00
57.00	05700 CT SCAN	395, 808		57.00
1	D5800 MAGNETIC RESONANCE IMAGING (MRI)	704, 400		58. 00
1	05900 CARDI AC CATHETERI ZATI ON	1, 211, 863		59. 00
1	06000 LABORATORY	33, 336		60.00
	06200 WHOLE BLOOD & PACKED RED BLOOD CELLS	2, 642		62.00
	06500 RESPI RATORY THERAPY	679, 836		65.00
	06600 PHYSI CAL THERAPY	300, 477		66.00
1	06601 PSYCHI ATRI C/PSYCHOLOGI CAL SERVI CES 06602 O/P PHYSI CAL THERAPY	0 468, 665		66. 01 66. 02
	06700 OCCUPATIONAL THERAPY	52, 265		67.00
	06800 SPEECH PATHOLOGY	127, 582		68.00
	06900 ELECTROCARDI OLOGY	1, 618, 757		69.00
1	06901 CARDI AC REHAB	214, 367		69. 01
	07000 ELECTROENCEPHALOGRAPHY	182, 881		70.00
4	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	472, 110		71. 00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	24, 077		72.00
	07300 DRUGS CHARGED TO PATIENTS	1, 621, 349		73. 00
	03020 RENAL ACUTE	102, 396		76. 00
	OUTPATIENT SERVICE COST CENTERS			4
	09000 CLI NI C	18, 757		90.00
	09005 PATIENT NUTRITION	51, 905		90.05
	09007 WOUND CLINIC	263, 014		90.07
	09100 EMERGENCY 09200 OBSERVATION BEDS (NON-DISTINCT PART)	1, 085, 696		91. 00 92. 00
	SPECIAL PURPOSE COST CENTERS			92.00
118. 00	SUBTOTALS (SUM OF LINES 1 through 117)	31, 770, 436		118. 00
-	IONREI MBURSABLE COST CENTERS	51, 110, 430		1, 10, 00
	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	O		190. 00
	07950 RURAL HEALTH	6, 582		194. 00
	07951 RENTAL PROPERTY	7, 603		194. 01
	07954 FAMILY PRACTICE	683, 581		194. 02
	07952 WELLNESS	351, 885		194. 03
	07955 PHYSICIAN PRACTICES	644, 689		194. 04
	07953 SYCAMORE SPORTS MED	298		194. 06
	07956 PSYCHI ATRI C/PSYCHOLOGI CAL SERVI CES	80, 392		194. 07
200.00	Cross Foot Adjustments	34, 807		200. 00
201.00	Negative Cost Centers	14, 348		201.00

Health Financial Systems	UNION HOSPIT	AL, INC.	In Lieu of Form CMS-2552-10			
ALLOCATION OF CAPITAL RELATED COSTS		Provider CCN: 15-0023	Peri od: From 01/01/2018 To 12/31/2018	Worksheet B Part II Date/Time Pre 5/29/2019 1:1		
Cost Center Description	Total					
	26. 00					
202.00 TOTAL (sum lines 118 through 201)	33, 594, 621				202. 00	

	ALLOCATION - STATISTICAL BASIS	ON ON HOSELE	Provi der Co	CN: 15-0023 P	eri od:	Worksheet B-1	
				F T	rom 01/01/2018 o 12/31/2018	Date/Time Pre	pared:
		CAPITAL RELA	ATED COSTS			5/29/2019 1:1	1 pm
		CAPITAL RELA	ATED COSTS				
	Cost Center Description	NEW BLDG &	NEW MVBLE	EMPLOYEE	NONPATI ENT	DATA	
		FIXT (NEW TOTAL	EQUIP (NEW EQUIP	BENEFITS DEPARTMENT	TELEPHONES (PHONES)	PROCESSI NG (DEVI CES)	
		SQ FT)	DEPRN)	(GROSS	(THONES)	(DEVICES)	
		,		SALARI ES)			
	GENERAL SERVICE COST CENTERS	1.00	2. 00	4. 00	5. 01	5. 02	
1. 00	00100 NEW CAP REL COSTS-BLDG & FLXT	980, 539					1.00
2.00	00200 NEW CAP REL COSTS-MVBLE EQUIP		3, 597, 934				2.00
4.00	00400 EMPLOYEE BENEFITS DEPARTMENT	5, 236	0				4.00
5. 01 5. 02	00540 NONPATI ENT TELEPHONES 00550 DATA PROCESSI NG	657	29, 140 0	521, 538 0		1, 124	5. 01 5. 02
5. 03	00560 PURCHASING RECEIVING AND STORES	O	0	Ö	0	0	1
5.04	00570 ADMI TTI NG	3, 062	2, 315		1	0	
5. 05	00580 CASHI ERI NG/ACCOUNTS RECEI VABLE 00590 OTHER ADMI N AND GENERAL	0 19, 515	0 25, 406	ľ	ا م ا	0	5. 05 5. 06
5. 06 7. 00	00700 OPERATION OF PLANT	334, 876	95, 406 95, 402			0	
8. 00	00800 LAUNDRY & LINEN SERVICE	5, 988	66, 949			0	1
9. 00	00900 HOUSEKEEPI NG	1, 548	28, 582			0	
10. 00 11. 00	01000 DI ETARY 01100 CAFETERI A	10, 976 7, 832	106, 424 3, 354			19 0	1
13. 00	01300 NURSING ADMINISTRATION	2, 376	1, 681			0	
16. 00	01600 MEDICAL RECORDS & LIBRARY	5, 283	8, 776			46	
21.00		0	0			0	
22. 00 23. 00	O2200 1 & R SERVICES-OTHER PRGM COSTS APPRVD O2300 PARAMED ED PRGM	0	0	1, 232, 885 109, 596		0	
23. 00	02341 OTHER MED ED	720	18			0	
	02301 PARAMED ED PRGM	O	0			0	1
20.00	INPATIENT ROUTINE SERVICE COST CENTERS	407 540	240 007	40,000,744	474	400	
30.00	03000 ADULTS & PEDI ATRI CS 03100 INTENSI VE CARE UNI T	187, 513 22, 990	318, 207 192, 613			629 74	1
35. 00	02040 I NTENSI VE NURSERY	3, 932	47, 605			16	
41.00	04100 SUBPROVI DER - I RF	15, 423	12, 970			0	
43. 00	04300 NURSERY ANCI LLARY SERVI CE COST CENTERS	758	2, 450	989, 688	4	0	43.00
50. 00	05000 OPERATING ROOM	40, 735	581, 263	2, 749, 519	82	32	50.00
50. 01	05001 CARDI AC SURGERY	1, 800	62, 005			0	1
50. 02	05002 WVSC	30, 028	174, 400			0	
51. 00 51. 02	O5100 RECOVERY ROOM O5101 O/P TREATMENT ROOM	1, 432 23, 926	14, 609 23, 693			3	51. 00 51. 02
52. 00	05200 DELIVERY ROOM & LABOR ROOM	23, 685	101, 772			30	
	05400 RADI OLOGY-DI AGNOSTI C	31, 580	361, 920	3, 500, 051	108	63	
55.00	05500 RADI OLOGY-THERAPEUTI C	26, 393	122, 972			0	
56. 00 57. 00	05600	8, 800 2, 172	145, 932 195			2	1
58.00	05800 MAGNETIC RESONANCE IMAGING (MRI)	2, 593	31, 531	592, 122	4	0	58. 00
	05900 CARDI AC CATHETERI ZATI ON	32, 992	54, 417	2, 145, 816		34	•
60. 00 62. 00	O6000 LABORATORY O6200 WHOLE BLOOD & PACKED RED BLOOD CELLS	0	0	0	8	0	1
65.00	06500 RESPIRATORY THERAPY	4, 976	129, 675	2, 658, 159		14	1
66.00	06600 PHYSI CAL THERAPY	10, 150	9, 826		23	23	
66. 01	06601 PSYCHI ATRI C/PSYCHOLOGI CAL SERVI CES	0	0	0	0	0	
66. 02 67. 00	06602 0/P PHYSICAL THERAPY 06700 OCCUPATIONAL THERAPY	0 1, 658	27, 726 1, 783		I	0	
68.00	06800 SPEECH PATHOLOGY	3, 288	432		1	0	1
69. 00	06900 ELECTROCARDI OLOGY	3, 181	390, 800			19	
69. 01 70. 00	06901 CARDI AC REHAB 07000 ELECTROENCEPHALOGRAPHY	6, 534	15, 254 36, 833			3	1
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	1, 505 5, 712	104, 127	2, 714, 854 0	17	0	71.00
72. 00	07200 IMPL. DEV. CHARGED TO PATIENTS	0	0	Ö	0	0	1
73.00	07300 DRUGS CHARGED TO PATIENTS	20, 715	48, 125			21	
76. 00	03020 RENAL ACUTE OUTPATIENT SERVICE COST CENTERS	3, 525	2, 538	0	4	0	76.00
90.00		698	0	178, 135	0	0	90.00
90.05	09005 PATIENT NUTRITION	1, 930	535			0	
90.07	09007 WOUND CLINIC 09100 EMERGENCY	8, 952	8, 531	309, 450		0	
91.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	24, 071	98, 421	4, 668, 799	63	88	91. 00 92. 00
. 2. 00	SPECIAL PURPOSE COST CENTERS						1 2.00
118.00		951, 716	3, 491, 207	79, 607, 122	1, 153	1, 118	118.00
190 00	NONREI MBURSABLE COST CENTERS 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	O	0	190. 00
	07950 RURAL HEALTH		0				194.00
194. 01	07951 RENTAL PROPERTY	0	2, 407	0	0	0	194. 01
194. 02	207954 FAMILY PRACTICE	12, 000	64, 405	2, 402, 114	71	0	194. 02

Health Financial Systems	UNION HOSPITA	L, INC.		In Lie	u of Form CMS-2	2552-10
COST ALLOCATION - STATISTICAL BASIS				Period: From 01/01/2018	Worksheet B-1	
				To 12/31/2018	Date/Time Pre 5/29/2019 1:1	
	CAPITAL RELAT	TED COSTS				
Cost Center Description	NEW BLDG & FIXT (NEW TOTAL	NEW MVBLE EQUIP (NEW EQUIP	EMPLOYEE BENEFITS DEPARTMENT	NONPATI ENT TELEPHONES (PHONES)	DATA PROCESSI NG (DEVI CES)	

						3/29/2019 1.1	I DIII
		CAPITAL REL	ATED COSTS				
	Cost Center Description	NEW BLDG &	NEW MVBLE	EMPLOYEE	NONPATI ENT	DATA	
		FI XT	EQUI P	BENEFITS	TELEPHONES	PROCESSI NG	
		(NEW TOTAL	(NEW EQUIP	DEPARTMENT	(PHONES)	(DEVICES)	
		SQ FT)	DEPRN)	(GROSS			
				SALARI ES)			
		1. 00	2.00	4. 00	5. 01	5. 02	
	03 07952 WELLNESS	13, 957	0	324, 967	0		194. 03
	04 07955 PHYSI CI AN PRACTI CES	0	38, 918				194. 04
	06 07953 SYCAMORE SPORTS MED	0	66	12, 200			194. 06
	07 07956 PSYCHI ATRI C/PSYCHOLOGI CAL SERVI CES	2, 866	931	365, 804	8	4	194. 07
200.	, ,						200. 00
201.	1 1 3						201. 00
202.	N N	15, 432, 589	11, 245, 908	16, 729, 800	1, 101, 732	12, 664, 020	202. 00
	Part I)						
203.		15. 738883	3. 125657			11, 266. 921708	1
204.	N N			82, 409	101, 898	0	204. 00
	Part II)						
205.				0. 000913	81. 193625	0. 000000	205.00
206.							206. 00
007	(per Wkst. B-2)						007.00
207.							207. 00
	Parts III and IV)	[1

	ALLOCATION - STATISTICAL BASIS	ONI ON TIOSI I I	Provi der C	CN: 15-0023 P	eri od:	Worksheet B-1	
				F	rom 01/01/2018 o 12/31/2018	Date/Time Pre	pared.
						5/29/2019 1: 1	1 pm
	Cost Center Description	PURCHASI NG	ADMITTING		Reconciliatio	OTHER ADMIN	
		RECEIVING AND STORES	(I NPATI ENT CHARGES)	COUNTS RECEI VABLE	n	AND GENERAL (ACCUM.	
		(REQUISITIO)	ornato25)	(GROSS		COST)	
				CHARGES)			
	GENERAL SERVICE COST CENTERS	5. 03	5. 04	5. 05	5A. 06	5. 06	
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 5. 02	00540 NONPATI ENT TELEPHONES 00550 DATA PROCESSI NG	-					5. 01 5. 02
5. 03	00560 PURCHASING RECEIVING AND STORES	6, 517, 860					5. 03
5.04	00570 ADMI TTI NG	27, 045	500, 375, 303				5. 04
5. 05	00580 CASHI ERI NG/ACCOUNTS RECEI VABLE	0 71	0	1, 425, 639, 936		221 074 444	5.05
5. 06 7. 00	00590 OTHER ADMIN AND GENERAL 00700 OPERATION OF PLANT	3, 680	0	0	, ,	321, 974, 444 15, 040, 765	1
8. 00	00800 LAUNDRY & LINEN SERVICE	6, 779	0	Ö		1, 489, 748	1
9. 00	00900 HOUSEKEEPI NG	8, 903	0	0		3, 545, 866	1
10.00	01000 DI ETARY	632	0	0	_	775, 268	1
11. 00 13. 00	01100 CAFETERI A 01300 NURSI NG ADMI NI STRATI ON	1 0	0			2, 969, 123 4, 059, 037	
	01600 MEDI CAL RECORDS & LI BRARY	805	Ō	Ö		5, 106, 446	
21. 00		0	0	0		1, 691, 217	
22. 00 23. 00		0	0	0		2, 344, 391 158, 765	1
23. 00	02341 OTHER MED ED	0	0			276, 081	
	02301 PARAMED ED PRGM	0	0			•	
	INPATIENT ROUTINE SERVICE COST CENTERS	1 074 (45	00 50/ 070	100 171 700		40.000.140	
30.00	03000 ADULTS & PEDIATRICS 03100 INTENSIVE CARE UNIT	1, 374, 615 486, 988	89, 506, 370 23, 853, 175			42, 009, 168 8, 383, 292	
	02040 I NTENSI VE NURSERY	86, 861	18, 520, 671			3, 256, 244	
41.00		49, 206	3, 833, 384	3, 833, 384	o		
43.00	04300 NURSERY	0	3, 046, 300	3, 046, 300	0	1, 407, 128	43.00
50. 00	ANCILLARY SERVICE COST CENTERS 05000 OPERATING ROOM	154, 642	91, 959, 181	170, 683, 809	O	14, 614, 262	50.00
50. 01	05001 CARDI AC SURGERY	639, 379	6, 174, 282			2, 438, 797	1
50. 02	05002 WVSC	1, 868, 566	115, 000			12, 877, 502	1
51.00	1	146, 878	3, 075, 523			2, 314, 349	1
51. 02 52. 00	O5101 O/P TREATMENT ROOM O5200 DELIVERY ROOM & LABOR ROOM	54, 521 268, 737	21, 041 16, 526, 263			981, 359 5, 222, 094	1
54. 00		62, 392	13, 503, 301			10, 214, 128	
55. 00	05500 RADI OLOGY-THERAPEUTI C	2, 712	1, 716, 804			6, 322, 141	
56. 00 57. 00	05600 RADI 0I SOTOPE 05700 CT SCAN	5, 103 194, 841	918, 335 14, 554, 325			2, 261, 379 3, 052, 431	
58. 00		4, 568	2, 472, 011			2, 085, 545	
59. 00	05900 CARDI AC CATHETERI ZATI ON	77, 981	29, 903, 907			21, 364, 751	
	06000 LABORATORY	0	45, 540, 480			9, 578, 369	
62. 00 65. 00	06200 WHOLE BLOOD & PACKED RED BLOOD CELLS 06500 RESPIRATORY THERAPY	103, 114	2, 310, 660 20, 104, 840			1, 353, 129 4, 993, 482	
66. 00	06600 PHYSI CAL THERAPY	2, 176	6, 796, 661	12, 039, 593		3, 254, 003	
66. 01	06601 PSYCHI ATRI C/PSYCHOLOGI CAL SERVI CES	0	0	0	0	0	66. 01
66. 02	06602 0/P PHYSICAL THERAPY	4, 390	0 F 102 242	7, 747, 569		2, 453, 546	
67. 00 68. 00	06700 OCCUPATI ONAL THERAPY 06800 SPEECH PATHOLOGY	227	5, 183, 242 1, 087, 537			1, 923, 413 849, 763	
69. 00	06900 ELECTROCARDI OLOGY	2, 315	13, 375, 936			12, 257, 521	
69. 01	06901 CARDI AC REHAB	1, 495	96, 875			548, 373	
70. 00 71. 00	07000 ELECTROENCEPHALOGRAPHY 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	2, 289 766	1, 668, 055 753, 469			1, 465, 084 1, 281, 896	
71.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0	8, 549, 902			14, 141, 567	
73. 00	07300 DRUGS CHARGED TO PATIENTS	123, 730	44, 039, 880			51, 379, 200	73. 00
76. 00		39, 266	3, 001, 565	3, 440, 924	0	1, 543, 382	76. 00
90 00	OUTPATIENT SERVICE COST CENTERS O9000 CLINIC	918	960	734, 585	O	267, 292	90.00
90. 05	09005 PATIENT NUTRITION	941	0			349, 129	1
90. 07	09007 WOUND CLINIC	77, 766	6, 000	7, 141, 026	0	1, 462, 135	90. 07
91.00		606, 093	28, 159, 368	138, 277, 217	0	9, 947, 570	1
92. 00	09200 OBSERVATION BEDS (NON-DISTINCT PART) SPECIAL PURPOSE COST CENTERS						92.00
118. 00		6, 491, 392	500, 375, 303	1, 425, 639, 936	-22, 561, 855	297, 475, 740	118.00
	NONREI MBURSABLE COST CENTERS						
	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0			190.00
	0/07950 RURAL HEALTH 1/07951 RENTAL PROPERTY	8, 297	0	0		3, 669, 970 56, 496	194.00
	207954 FAMILY PRACTICE	1, 896	0	Ö		4, 829, 662	1
	3 07952 WELLNESS	0	0			713, 057	
194.04	4 07955 PHYSICIAN PRACTICES	16, 179	0	0	0	14, 571, 570	194.04

Health Financial Systems	UNION HOSPI	TAL, INC.		In Lie	u of Form CMS-2	2552-10
COST ALLOCATION - STATISTICAL BASIS		Provi der C		Peri od:	Worksheet B-1	
				From 01/01/2018		
				To 12/31/2018	Date/Time Pre	
					5/29/2019 1:1	1 pm
Cost Center Description	PURCHASI NG	ADMITTING	CASHI ERI NG/A	Reconciliatio	OTHER ADMIN	
	RECEIVING AND	(I NPATI ENT	COUNTS	n	AND GENERAL	
	STORES	CHARGES)	RECEI VABLE		(ACCUM.	
	(REQUISITIO)		(GROSS		COST)	
	,		CHAPGES)			

	Cost Center Description	PURCHASI NG RECEI VI NG AND STORES (REQUI SI TI 0)	ADMITTING (INPATIENT CHARGES)	CASHI ERI NG/AC COUNTS RECEI VABLE (GROSS CHARGES)	Reconciliatio n	OTHER ADMIN AND GENERAL (ACCUM. COST)	
		5. 03	5. 04	5. 05	5A. 06	5. 06	
194. 06 07953	SYCAMORE SPORTS MED	1	0	0	0	57, 106	194.06
194. 07 07956	PSYCHI ATRI C/PSYCHOLOGI CAL SERVI CES	95	0	0	0	600, 843	194. 07
200. 00	Cross Foot Adjustments						200.00
201. 00	Negative Cost Centers						201.00
202. 00	Cost to be allocated (per Wkst. B, Part I)	1, 527, 196	1, 741, 712	5, 720, 343		22, 561, 855	202.00
203. 00	Unit cost multiplier (Wkst. B, Part I)	0. 234309	0. 003481	0. 004012		0. 070073	203. 00
204. 00	Cost to be allocated (per Wkst. B, Part II)	0	65, 288	0		458, 390	204. 00
205. 00	Unit cost multiplier (Wkst. B, Part	0. 000000	0. 000130	0. 000000		0. 001424	205. 00
206. 00	NAHE adjustment amount to be allocated (per Wkst. B-2)						206. 00
207. 00	NAHE unit cost multiplier (Wkst. D, Parts III and IV)						207. 00

COST	ALLOCATION - STATISTICAL BASIS		Provi der Co	F	eriod: rom 01/01/2018 o 12/31/2018	Date/Time Pre	pared:
	Cost Center Description	OPERATION OF PLANT (NEW TOTAL SQ FT)	LAUNDRY & LI NEN SERVI CE (LI NEN)	HOUSEKEEPING (NEW TOTAL SQ FT)	DI ETARY (DI ETARY)	5/29/2019 1: 1 CAFETERI A (FTE)	I pm
		7. 00	8.00	9. 00	10.00	11. 00	
1 00	GENERAL SERVICE COST CENTERS						1 00
1. 00 2. 00 4. 00 5. 01 5. 02 5. 03 5. 04 5. 05 7. 00 8. 00 9. 00 11. 00 13. 00 16. 00 21. 00 22. 00 23. 00 23. 01 23. 02	00100 NEW CAP REL COSTS-BLDG & FIXT 00200 NEW CAP REL COSTS-BUBG & FIXT 00200 NEW CAP REL COSTS-MVBLE EQUIP 00400 EMPLOYEE BENEFITS DEPARTMENT 00540 NONPATIENT TELEPHONES 00550 DATA PROCESSING 00560 PURCHASING RECEIVING AND STORES 00570 ADMITTING 00580 CASHIERING/ACCOUNTS RECEIVABLE 00590 OTHER ADMIN AND GENERAL 00700 OPERATION OF PLANT 00800 LAUNDRY & LINEN SERVICE 00900 HOUSEKEEPING 01000 DIETARY 01100 CAFETERIA 01300 NURSING ADMINISTRATION 01600 MEDICAL RECORDS & LIBRARY 02100 I&R SERVICES-SALARY & FRINGES APPRVD 02200 I&R SERVICES-OTHER PRGM COSTS APPRVD 02301 PARAMED ED PRGM 02301 PARAMED ED PRGM	617, 193 5, 988 1, 548 10, 976 7, 832 2, 376 5, 283 0 0 0 720	1, 186, 331 80, 119 6, 621 0 0 0 0 0 0	10, 976	162, 109 0 0 0 0 0 0 0	11, 257 182 601 210 43 20 63 20	13. 00 16. 00 21. 00 22. 00 23. 00 23. 01
30. 00	I NPATI ENT ROUTI NE SERVI CE COST CENTERS 03000 ADULTS & PEDI ATRI CS	187, 513	411, 503	187, 513	121, 559	3, 650	30.00
31. 00	03100 INTENSIVE CARE UNIT	22, 990	48, 633	22, 990	17, 402	613	31.00
35. 00 41. 00	02040 I NTENSI VE NURSERY 04100 SUBPROVI DER - I RF	3, 932 15, 423				264 188	
43.00	04300 NURSERY	758	•	758		155	1
.0.00	ANCILLARY SERVICE COST CENTERS	,,,,		, , , ,	, , , , , , , , , , , , , , , , , , ,		1 .0.00
50.00	05000 OPERATING ROOM	40, 735				527	
50. 01 50. 02 51. 00 51. 02 52. 00 54. 00 55. 00 57. 00 60. 00 62. 00 66. 00 66. 01 66. 02 67. 00 68. 00	OSOO1 CARDI AC SURGERY OSOO2 WVSC OS100 RECOVERY ROOM OS101 O/P TREATMENT ROOM OS200 DELI VERY ROOM & LABOR ROOM OS400 RADI OLOGY-DI AGNOSTI C OS500 RADI OLOGY-THERAPEUTI C OS600 RADI OI SOTOPE OS700 CT SCAN OS800 MAGNETI C RESONANCE I MAGI NG (MRI) OS900 CARDI AC CATHETERI ZATI ON O6000 LABORATORY O6200 WHOLE BLOOD & PACKED RED BLOOD CELLS O6500 RESPI RATORY THERAPY O6601 PSYCHI ATRI C/PSYCHOLOGI CAL SERVI CES O6602 O/P PHYSI CAL THERAPY O6603 OSCUPATI ONAL THERAPY O6800 SPEECH PATHOLOGY OS900 ELECTROCARDI OLOGY OS900 OS900 OS900 OS900 OS900 OS900 OS900 OS900 OS900 OS900 OS900 OS900 OS900 OS900 OS900 OS900 OS900 OS900 OS900 OS900 OS900 OS900 OS900 OS900 OS900 OS900 OS900 OS900 OS900 OS900 OS900 OS900 OS900 OS900 OS900 OS900 OS900 OS900 OS900 OS900 OS900 OS900 OS900 OS900 OS900	1, 800 30, 028 1, 432 23, 926 23, 685 31, 580 26, 393 8, 800 2, 172 2, 593 32, 992 0 4, 976 10, 150 0 1, 658 3, 288	72, 026 57, 379 6, 086 50, 221 36, 355 13, 745 6, 210 0 35, 657 40, 149 0 0 7, 827 0 20, 966 0	30, 028 1, 432 23, 926 23, 685 31, 580 26, 393 8, 800 2, 172 2, 593 32, 992 0 4, 976 10, 150 0 1, 658 3, 288	0 0 12,011 4 0 0 0 0 837 0 0 0 0 0	71 0 240 45 449 591 50 41 146 80 341 0 0 387 0 0	50. 02 51. 00 51. 02 52. 00 54. 00 55. 00 56. 00 57. 00 59. 00 60. 00 62. 00 66. 01 66. 02 67. 00 68. 00
69. 00 69. 01	O6900 ELECTROCARDI OLOGY O6901 CARDI AC REHAB	3, 181 6, 534				131 40	
70. 00	07000 ELECTROENCEPHALOGRAPHY	1, 505	1	1, 505		90	
71. 00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	5, 712	0	5, 712		0	
72. 00 73. 00	07200 IMPL. DEV. CHARGED TO PATIENTS 07300 DRUGS CHARGED TO PATIENTS	20, 715	1	0 20, 715		0 442	
73. 00 76. 00	03020 RENAL ACUTE	3, 525				442	
2. 00	OUTPATIENT SERVICE COST CENTERS						
90. 00 90. 05 90. 07 91. 00 92. 00	09000 CLINIC 09005 PATIENT NUTRITION 09007 WOUND CLINIC 09100 EMERGENCY 09200 OBSERVATION BEDS (NON-DISTINCT PART) SPECIAL PURPOSE COST CENTERS	698 1, 930 8, 952 24, 071	0 10, 313		0	20 35 47 836	90. 05 90. 07
118.00	SUBTOTALS (SUM OF LINES 1 through 117)	588, 370	1, 180, 764	580, 834	162, 109	10, 618	118. 00
190 00	NONREIMBURSABLE COST CENTERS 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	O	0] 190. 00
194. 00 194. 01 194. 02	07950 RURAL HEALTH 07951 RENTAL PROPERTY 207954 FAMILY PRACTICE	0 0 12, 000 13, 957	0 759	0	0	0 0 183	194. 00 194. 01 194. 02 194. 03
	07955 PHYSI CI AN PRACTI CES	13, 957	l .			456	194. 04
	07953 SYCAMORE SPORTS MED	0		1			194.06

Health Fina	ncial Systems	UNI ON HOSPI	TAL, INC.		In Lieu of Form CMS-2552-10		
COST ALLOCA	TION - STATISTICAL BASIS		Provi der Co		Peri od: From 01/01/2018	Worksheet B-1	
					To 12/31/2018		
	Cost Center Description	OPERATION OF	LAUNDRY &	HOUSEKEEPI NO		CAFETERI A	
			LINEN SERVICE		(DI ETARY)	(FTE)	
		(NEW TOTAL	(LI NEN)	SQ FT)			
		SQ FT)					
		7. 00	8. 00	9. 00	10.00	11. 00	
	PSYCHI ATRI C/PSYCHOLOGI CAL SERVI CES	2, 866	0	2, 86	6 0	0	194. 07
200. 00	Cross Foot Adjustments						200. 00
201.00	Negative Cost Centers						201.00
202. 00	Cost to be allocated (per Wkst. B, Part I)	16, 094, 717	1, 750, 290	3, 952, 90	1, 196, 751	3, 432, 196	202. 00
203.00	Unit cost multiplier (Wkst. B, Part I)	26. 077284	1. 475381	6. 48382	5 7. 382385	304. 894377	203.00
204. 00	Cost to be allocated (per Wkst. B, Part II)	5, 624, 324	377, 643	162, 38	619, 909	212, 664	204.00
205. 00	Unit cost multiplier (Wkst. B, Part	9. 112748	0. 318329	0. 26636	3. 735517	18. 891712	205. 00
206. 00	NAHE adjustment amount to be allocated (per Wkst. B-2)						206. 00
207. 00	NAHE unit cost multiplier (Wkst. D, Parts III and IV)						207. 00

Health Financial Systems
COST ALLOCATION - STATISTICAL BASIS Provider CCN: 15-0023

					Į I	0 12/31/2018	Date/lime Pre 5/29/2019 1:1	
				<u> </u>	INTERNS &	RESI DENTS		1
		Cost Center Description	NURSI NG	MEDI CAL	SERVI CES-SALA	SERVI CES-OTHE	PARAMED ED	
		cost center bescription	ADMI NI STRATI O	RECORDS &	RY & FRINGES	R PRGM COSTS	PRGM	
			N	LI BRARY	(INTERNS)	(INTERNS)	(PARAMED	
			(TIME SPENT)	(TOTAL REVENUE)			RADI OLOGY)	
			13. 00	16. 00	21.00	22. 00	23. 00	
		AL SERVICE COST CENTERS						
1.00		NEW CAP REL COSTS-BLDG & FIXT NEW CAP REL COSTS-MVBLE EQUIP						1.00
2. 00 4. 00	1	EMPLOYEE BENEFITS DEPARTMENT						2.00 4.00
5. 01		NONPATI ENT TELEPHONES						5. 01
5. 02	1	DATA PROCESSING						5. 02
5. 03 5. 04		PURCHASING RECEIVING AND STORES ADMITTING						5. 03 5. 04
5. 05		CASHI ERI NG/ACCOUNTS RECEI VABLE						5.05
5.06	00590	OTHER ADMIN AND GENERAL						5.06
7.00		OPERATION OF PLANT						7.00
8. 00 9. 00	1	LAUNDRY & LINEN SERVICE HOUSEKEEPING						8. 00 9. 00
10.00	1	DI ETARY						10.00
11.00	1	CAFETERI A						11.00
13. 00 16. 00		NURSING ADMINISTRATION MEDICAL RECORDS & LIBRARY	7, 744	1, 410, 327, 400				13. 00 16. 00
21. 00	1	I &R SERVICES-SALARY & FRINGES APPRVD	o	0				21.00
22. 00	02200	I&R SERVICES-OTHER PRGM COSTS APPRVD	o	0		6, 292		22. 00
23. 00		PARAMED ED PRGM	0	0			100	1
23. 01 23. 02		OTHER MED ED PARAMED ED PRGM	63	0	1			23. 01 23. 02
20.02		IENT ROUTINE SERVICE COST CENTERS	9					20.02
30.00	1	ADULTS & PEDIATRICS	3, 484	87, 159, 186			0	
31. 00 35. 00		INTENSIVE CARE UNIT INTENSIVE NURSERY	613 264	23, 853, 175 18, 520, 671			0	
41. 00		SUBPROVI DER – I RF	188	3, 833, 384		1	0	41.00
43.00	04300	NURSERY	155	3, 046, 300		0	0	43.00
50. 00		LARY SERVICE COST CENTERS OPERATING ROOM	527	170, 683, 809	396	396	0	50.00
50. 00	1	CARDI AC SURGERY	41	6, 204, 282		I .	0	50.00
50. 02	05002		o	112, 120, 408	1		0	50. 02
51.00	1	RECOVERY ROOM	240	10, 310, 225			0	51.00
51. 02 52. 00		O/P TREATMENT ROOM DELIVERY ROOM & LABOR ROOM	45 449	2, 037, 584 21, 064, 224			0	51. 02 52. 00
54. 00	1	RADI OLOGY-DI AGNOSTI C	0	57, 848, 633			100	54.00
55.00		RADI OLOGY-THERAPEUTI C	0	43, 198, 460			0	55.00
56. 00 57. 00		RADI OI SOTOPE CT SCAN	0	11, 178, 699 54, 984, 741			0	56. 00 57. 00
58. 00	1	MAGNETIC RESONANCE IMAGING (MRI)	o	13, 156, 306			0	58.00
59. 00		CARDI AC CATHETERI ZATI ON	0	96, 567, 151			0	59. 00
		LABORATORY WHOLE BLOOD & PACKED RED BLOOD CELLS	0	95, 807, 439			0	ı
	1	RESPIRATORY THERAPY	360	3, 032, 666 22, 780, 685			0	1
66. 00	06600	PHYSI CAL THERAPY	0	12, 039, 593		I I	0	66.00
66. 01	1	PSYCHI ATRI C/PSYCHOLOGI CAL SERVI CES	0	7 747 540	0		0	66. 01
66. 02 67. 00		O/P PHYSICAL THERAPY OCCUPATIONAL THERAPY		7, 747, 569 8, 959, 676		171	0	66. 02 67. 00
68. 00	06800	SPEECH PATHOLOGY	o	3, 186, 410	1		0	68.00
69.00		ELECTROCARDI OLOGY	0	75, 827, 557			0	69.00
69. 01 70. 00	1	CARDI AC REHAB ELECTROENCEPHALOGRAPHY	0	1, 290, 879 4, 675, 292		0 71	0	69. 01 70. 00
		MEDICAL SUPPLIES CHARGED TO PATIENTS	Ö	820, 988	•	I .	0	71.00
72. 00		IMPL. DEV. CHARGED TO PATIENTS	0	20, 640, 502			0	72.00
73. 00 76. 00		DRUGS CHARGED TO PATIENTS RENAL ACUTE	377	267, 959, 141 3, 440, 924		51 0	0	73. 00 76. 00
70.00		TIENT SERVICE COST CENTERS	<u> </u>	3, 440, 724		<u> </u>	0	70.00
90.00	09000	CLINIC	20	734, 585			0	
90.05		PATIENT NUTRITION	35	198, 013			0	
90. 07 91. 00		WOUND CLINIC EMERGENCY	47 836	7, 141, 026 138, 277, 217		I	0	90. 07 91. 00
		OBSERVATION BEDS (NON-DISTINCT PART)		100, 277, 217	/	, , ,	· ·	92.00
	SPECI	AL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1 through 117) IMBURSABLE COST CENTERS	7, 744	1, 410, 327, 400	5, 706	5, 706	100	118. 00
190.00		GIFT, FLOWER, COFFEE SHOP & CANTEEN	O	0	0	O	0	190. 00
194.00	07950	RURAL HEALTH	0	0				194. 00
		RENTAL PROPERTY FAMILY PRACTICE	0	0				194. 01 194. 02
174.02	101754	i i i i i i i i i i i i i i i i i i i	<u> </u>	0	1 380	1 300	0	11 / 4. 02

Health Financial Systems	UNION HOSPITAL, INC.	In Lieu of Form CMS-2552-1		
COST ALLOCATION - STATISTICAL BASIS		Peri od: Worksheet B-1 From 01/01/2018 To 12/31/2018 Date/Time Prepared:		

				T	o 12/31/2018	Date/Time Pre 5/29/2019 1:1	
				INTERNS &	RESI DENTS	3/2//2017 1.1	i piii
	Cost Center Description	NURSI NG	MEDI CAL		SERVI CES-OTHE	PARAMED ED	
		ADMI NI STRATI O	RECORDS &	RY & FRINGES	R PRGM COSTS	PRGM	
		N	LI BRARY	(INTERNS)	(INTERNS)	(PARAMED	
		(TIME	(TOTAL			RADI OLOGY)	
		SPENT)	REVENUE)	04.00	00.00	00.00	
101 00 07050	WELLNESS	13. 00	16. 00	21.00	22.00	23. 00	101.00
194. 03 07952		0	0		0		194. 03
	PHYSI CI AN PRACTI CES	0	0	0	0		194.04
1 1	SYCAMORE SPORTS MED	0	0	0	0		194. 06
	PSYCHI ATRI C/PSYCHOLOGI CAL SERVI CES	0	0	0	0	0	194. 07
	Cross Foot Adjustments						200.00
1 1	Negative Cost Centers						201. 00
	Cost to be allocated (per Wkst. B,	4, 476, 323	5, 819, 532	1, 873, 754	2, 521, 780	175, 988	202. 00
1 1	Part I)						
1 1	Unit cost multiplier (Wkst. B, Part I)	578. 037577	0. 004126				1
	Cost to be allocated (per Wkst. B,	77, 902	192, 669	7, 588	5, 276	704	204. 00
1 1	Part II)						
	Unit cost multiplier (Wkst. B, Part	10. 059659	0. 000137	1. 205976	0. 838525	7. 040000	205. 00
1 1	11)						
206. 00	NAHE adjustment amount to be allocated					0	206. 00
	(per Wkst. B-2)						
	NAHE unit cost multiplier (Wkst. D,					0. 000000	207. 00
	Parts III and IV)						

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

COST ALLOCATION - STATISTICAL BASIS Provider CCN: 15-0023 Peri od: Worksheet B-1 From 01/01/2018 12/31/2018 Date/Time Prepared: 5/29/2019 1:11 pm Cost Center Description OTHER MED ED PARAMED ED (ASSI GNED PRGM TIME) (PARAMED RADI OLOGY) 23. 01 23.02 GENERAL SERVICE COST CENTERS 00100 NEW CAP REL COSTS-BLDG & FIXT 1.00 1.00 2 00 00200 NEW CAP REL COSTS-MVBLE EQUIP 2 00 4.00 00400 EMPLOYEE BENEFITS DEPARTMENT 4.00 00540 NONPATIENT TELEPHONES 5.01 5.01 5.02 00550 DATA PROCESSING 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 00590 OTHER ADMIN AND GENERAL 5.06 5.06 00700 OPERATION OF PLANT 7 00 7.00 8.00 00800 LAUNDRY & LINEN SERVICE 8.00 9.00 00900 HOUSEKEEPI NG 9.00 01000 DI ETARY 10.00 10.00 11.00 01100 CAFETERI A 11.00 13.00 01300 NURSING ADMINISTRATION 13.00 16.00 01600 MEDICAL RECORDS & LIBRARY 16.00 02100 I&R SERVICES-SALARY & FRINGES APPRVD 21 00 21 00 22.00 02200 I&R SERVICES-OTHER PRGM COSTS APPRVD 22.00 02300 PARAMED ED PRGM 23.00 23.00 02341 OTHER MED ED 100 23.01 23.01 02301 PARAMED ED PRGM 23.02 100 23.02 INPATIENT ROUTINE SERVICE COST CENTERS 03000 ADULTS & PEDIATRICS 0 30.00 03100 INTENSIVE CARE UNIT 0 31.00 0 31 00 02040 INTENSIVE NURSERY 0 35.00 0 35.00 41.00 04100 SUBPROVI DER - I RF 0 41.00 0 43.00 04300 NURSERY 0 0 43.00 ANCILLARY SERVICE COST CENTERS 50. 00 | 05000 OPERATING ROOM 0 0 50.00 05001 CARDI AC SURGERY 50.01 0000000000000000000000000 0 50.01 05002 WVSC 50 02 0 50 02 05100 RECOVERY ROOM 51.00 0 51.00 51.02 05101 0/P TREATMENT ROOM 0 51.02 52.00 05200 DELIVERY ROOM & LABOR ROOM 0 52.00 54 00 05400 RADI OLOGY-DI AGNOSTI C 100 54 00 05500 RADI OLOGY-THERAPEUTI C 55.00 0 55.00 56.00 05600 RADI OI SOTOPE 56.00 57.00 05700 CT SCAN 0 57.00 05800 MAGNETIC RESONANCE IMAGING (MRI) 0 58 00 58 00 59.00 05900 CARDI AC CATHETERI ZATI ON 0 59.00 60.00 06000 LABORATORY 0 60.00 06200 WHOLE BLOOD & PACKED RED BLOOD CELLS 0 62.00 62.00 06500 RESPIRATORY THERAPY 65.00 0 65.00 66.00 06600 PHYSI CAL THERAPY 0 66.00 66.01 06601 PSYCHI ATRI C/PSYCHOLOGI CAL SERVI CES 0 66.01 06602 0/P PHYSICAL THERAPY 0 66.02 66.02 06700 OCCUPATI ONAL THERAPY 67.00 0 67 00 68.00 06800 SPEECH PATHOLOGY 68.00 06900 ELECTROCARDI OLOGY 69.00 0 69.00 06901 CARDI AC REHAB 69.01 0 69.01 70.00 07000 ELECTROENCEPHALOGRAPHY 0 70.00 71 00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 0 0 71.00 0 07200 IMPL. DEV. CHARGED TO PATIENTS 72.00 72.00 0 07300 DRUGS CHARGED TO PATIENTS 73.00 100 0 73.00 03020 RENAL ACUTE 76.00 0 0 76.00 OUTPATIENT SERVICE COST CENTERS 90.00 09000 CLI NI C 0 0 90.00 09005 PATIENT NUTRITION 90.05 0 0 90.05 90.07 09007 WOUND CLINIC 0 0 90.07 0 91.00 09100 EMERGENCY 0 91.00 09200 OBSERVATION BEDS (NON-DISTINCT PART) 92.00 92.00 SPECIAL PURPOSE COST CENTERS SUBTOTALS (SUM OF LINES 1 through 117)
NONREIMBURSABLE COST CENTERS 118.00 100 100 118.00 190.00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN 190.00 0 Ω 194.00 07950 RURAL HEALTH 0 0 194.00 194. 01 07951 RENTAL PROPERTY 0 0 0 194.01 194. 02 07954 FAMILY PRACTICE 0 194. 02 194. 03 07952 WELLNESS 0 194.03 194. 04 07955 PHYSICIAN PRACTICES 0 194.04 0

194.06

194.06 07953 SYCAMORE SPORTS MED

Health Financial Systems	UNION HOSPITAL, INC.	In Lieu of Form CMS-2552-10
COST ALLOCATION - STATISTICAL BASIS	Provi der CCN: 15-0023	Peri od: From 01/01/2018 To 12/31/2018 Date/Time Prepared: 5/29/2019 1:11 pm

					5/29/2019 1:1	1 pm
	Cost Center Description	OTHER MED ED	PARAMED ED			
		(ASSI GNED	PRGM			
		TIME)	(PARAMED			
			RADI OLOGY)			
		23. 01	23. 02			
194.07	07956 PSYCHI ATRI C/PSYCHOLOGI CAL SERVI CES	0	0			194. 07
200.00	Cross Foot Adjustments					200.00
201.00	Negative Cost Centers					201.00
202.00	Cost to be allocated (per Wkst. B,	374, 495	175, 988			202.00
	Part I)					
203.00	Unit cost multiplier (Wkst. B, Part I)	3, 744. 950000	1, 759. 880000			203.00
204.00	Cost to be allocated (per Wkst. B,	20, 535	704			204.00
	Part II)					
205. 00	Unit cost multiplier (Wkst. B, Part	205. 350000	7. 040000			205.00
	11)					
206. 00	NAHE adjustment amount to be allocated	0	0			206.00
	(per Wkst. B-2)					
207.00	NAHE unit cost multiplier (Wkst. D,	0. 000000	0. 000000)		207.00
	Parts III and IV)					
·						

				o 12/31/2018	Date/Time Pre 5/29/2019 1:1	pared:
		Title	xVIII	Hospi tal	PPS	ι μιι
		11110	AVIII	Costs	113	
Cost Center Description	Total Cost	Therapy Limit	Total Costs	RCE	Total Costs	
5551 551161 55551 PT 511	(from Wkst.	Adj.	10141 00010	Di sal I owance	.014. 00010	
	B, Part I,					
	col. 26)					
	1. 00	2.00	3.00	4. 00	5. 00	
INPATIENT ROUTINE SERVICE COST CENTERS						
30. 00 03000 ADULTS & PEDIATRICS	56, 049, 390		56, 049, 390	0	56, 049, 390	30.00
31.00 03100 INTENSIVE CARE UNIT	10, 559, 189		10, 559, 189	o	10, 559, 189	31.00
35. 00 02040 I NTENSI VE NURSERY	3, 929, 556		3, 929, 556	o	3, 929, 556	35.00
41. 00 04100 SUBPROVI DER - 1 RF	2, 914, 599		2, 914, 599		2, 914, 599	41.00
43. 00 04300 NURSERY	1, 679, 836		1, 679, 836	o	1, 679, 836	43.00
ANCILLARY SERVICE COST CENTERS						
50.00 05000 OPERATING ROOM	18, 236, 795		18, 236, 795	37, 297	18, 274, 092	50.00
50. 01 05001 CARDI AC SURGERY	2, 739, 276		2, 739, 276	o	2, 739, 276	50. 01
50. 02 05002 WVSC	15, 326, 487		15, 326, 487	o	15, 326, 487	50. 02
51.00 05100 RECOVERY ROOM	2, 862, 250		2, 862, 250	o	2, 862, 250	51.00
51.02 05101 0/P TREATMENT ROOM	1, 974, 971		1, 974, 971	o	1, 974, 971	51.02
52.00 05200 DELIVERY ROOM & LABOR ROOM	6, 916, 704		6, 916, 704	o	6, 916, 704	52.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	12, 782, 632		12, 782, 632	2, 756	12, 785, 388	54.00
55. 00 05500 RADI OLOGY-THERAPEUTI C	7, 838, 299		7, 838, 299	0	7, 838, 299	55.00
56. 00 05600 RADI 0I SOTOPE	2, 774, 165		2, 774, 165	0	2, 774, 165	56.00
57.00 05700 CT SCAN	3, 608, 429		3, 608, 429	0	3, 608, 429	57.00
58.00 05800 MAGNETIC RESONANCE I MAGING (MRI)	2, 447, 399		2, 447, 399	0	2, 447, 399	58.00
59. 00 05900 CARDI AC CATHETERI ZATI ON	24, 503, 918		24, 503, 918	0	24, 503, 918	59.00
60. 00 06000 LABORATORY	10, 644, 855		10, 644, 855	183, 070	10, 827, 925	60.00
62.00 06200 WHOLE BLOOD & PACKED RED BLOOD CELLS	1, 460, 460		1, 460, 460	0	1, 460, 460	62.00
65. 00 06500 RESPIRATORY THERAPY	5, 925, 496	0	5, 925, 496	0	5, 925, 496	65.00
66. 00 06600 PHYSI CAL THERAPY	3, 873, 739	0		0	3, 873, 739	66. 00
66. 01 06601 PSYCHI ATRI C/PSYCHOLOGI CAL SERVI CES	0	0			0	66. 01
66. 02 06602 0/P PHYSI CAL THERAPY	2, 688, 372	0	_, -,,		2, 688, 372	66. 02
67. 00 06700 OCCUPATI ONAL THERAPY	2, 149, 146	0	_, ,		2, 149, 146	
68.00 06800 SPEECH PATHOLOGY	1, 029, 516	0	1,02,,0.0		1, 029, 516	
69. 00 06900 ELECTROCARDI OLOGY	13, 596, 118		13, 596, 118		13, 596, 118	
69. 01 06901 CARDI AC REHAB	817, 600		817, 600		817, 600	
70. 00 07000 ELECTROENCEPHALOGRAPHY	1, 669, 015		1, 669, 015		1, 669, 015	
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	1, 561, 098		1, 561, 098		1, 561, 098	
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	15, 217, 672		15, 217, 672		15, 217, 672	
73.00 07300 DRUGS CHARGED TO PATIENTS	57, 487, 438		57, 487, 438		57, 487, 438	
76. 00 03020 RENAL ACUTE	1, 786, 486		1, 786, 486	0	1, 786, 486	76. 00
OUTPATIENT SERVICE COST CENTERS			1			
90. 00 09000 CLI NI C	329, 440		329, 440		329, 440	
90. 05 09005 PATI ENT NUTRI TI ON	468, 156		468, 156		470, 529	
90. 07 09007 WOUND CLI NI C	1, 942, 256		1, 942, 256		1, 942, 256	
91. 00 09100 EMERGENCY	12, 993, 054		12, 993, 054		12, 993, 054	
92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	11, 299, 916	_	11, 299, 916		11, 299, 916	
200.00 Subtotal (see instructions)	324, 083, 728	0			324, 309, 224	
201.00 Less Observation Beds	11, 299, 916	_	11, 299, 916		11, 299, 916	
202.00 Total (see instructions)	312, 783, 812	0	312, 783, 812	225, 496	313, 009, 308	J2U2. UU

Date/Time Prepared: 12/31/2018 5/29/2019 1:11 pm Title XVIII Hospi tal PPS Charges Total (col. 6 Cost or Other Cost Center Description Inpati ent Outpati ent TEFRA + col. 7) Ratio Inpati ent Ratio 6. 00 7.00 8.00 9.00 10.00 INPATIENT ROUTINE SERVICE COST CENTERS 30.00 03000 ADULTS & PEDIATRICS 87, 159, 186 87, 159, 186 30.00 31.00 03100 INTENSIVE CARE UNIT 23, 853, 175 23, 853, 175 31.00 02040 INTENSIVE NURSERY 35.00 18, 520, 671 18, 520, 671 35.00 41.00 04100 SUBPROVI DER - I RF 3.833.384 3, 833, 384 41.00 04300 NURSERY 43.00 3, 046, 300 3, 046, 300 43.00 ANCILLARY SERVICE COST CENTERS 50 00 05000 OPERATING ROOM 91, 959, 181 78, 724, 628 170, 683, 809 0.106845 0.000000 50.00 05001 CARDI AC SURGERY 6, 174, 282 6, 204, 282 50.01 30,000 0.441514 0.000000 50.01 112, 005, 408 112, 120, 408 0.000000 50.02 05002 WVSC 115,000 0.136697 50 02 51.00 05100 RECOVERY ROOM 3, 075, 523 7, 234, 702 10, 310, 225 0.277613 0.000000 51.00 51.02 05101 0/P TREATMENT ROOM 21, 041 2, 016, 543 2, 037, 584 0.969271 0.000000 51.02 05200 DELIVERY ROOM & LABOR ROOM 21, 064, 224 52 00 16, 526, 263 4, 537, 961 0.328363 0.000000 52 00 54.00 05400 RADI OLOGY-DI AGNOSTI C 13, 503, 301 44, 345, 332 57, 848, 633 0.220967 0.000000 54.00 05500 RADI OLOGY-THERAPEUTI C 0. 181449 55 00 1, 716, 804 41, 481, 656 43, 198, 460 0.000000 55.00 05600 RADI OI SOTOPE 11, 178, 699 0.000000 56,00 918, 335 10, 260, 364 0. 248165 56,00 05700 CT SCAN 14, 554, 325 57 00 40, 430, 416 54, 984, 741 0.065626 0.000000 57 00 05800 MAGNETIC RESONANCE IMAGING (MRI) 2, 472, 011 10, 684, 295 13, 156, 306 0.186025 0.000000 58.00 58.00 05900 CARDI AC CATHETERI ZATI ON 59.00 29, 903, 907 66, 663, 244 96, 567, 151 0. 253750 0.000000 59.00 50, 266, 959 06000 LABORATORY 45, 540, 480 95.807.439 60.00 0.111107 0.000000 60.00 62.00 06200 WHOLE BLOOD & PACKED RED BLOOD CELLS 2, 310, 660 722,006 3, 032, 666 0. 481576 0.000000 62.00 65.00 06500 RESPIRATORY THERAPY 20, 104, 840 2, 675, 845 22, 780, 685 0.260111 0.000000 65.00 06600 PHYSI CAL THERAPY 6, 796, 661 5, 242, 932 12, 039, 593 0.321750 0.000000 66.00 66.00 06601 PSYCHI ATRI C/PSYCHOLOGI CAL SERVI CES 66.01 0 0.000000 0.000000 66.01 66.02 06602 0/P PHYSI CAL THERAPY 0 7, 747, 569 7, 747, 569 0.346996 0.000000 66.02 06700 OCCUPATI ONAL THERAPY 5, 183, 242 3, 776, 434 8, 959, 676 0. 239869 67.00 0.000000 67.00 68.00 06800 SPEECH PATHOLOGY 1, 087, 537 2,098,873 3, 186, 410 0. 323096 0.000000 68.00 06900 ELECTROCARDI OLOGY 13, 375, 936 62, 451, 621 75, 827, 557 0.179303 69.00 0.000000 69.00 69. 01 06901 CARDI AC REHAB 96, 875 1, 194, 004 1, 290, 879 0.633367 0.000000 69.01 70.00 07000 ELECTROENCEPHALOGRAPHY 1, 668, 055 3,007,237 4, 675, 292 0.356986 0.000000 70.00 71 00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 753 469 67, 519 820. 988 1 901487 0.000000 71 00 07200 IMPL. DEV. CHARGED TO PATIENTS 72.00 8, 549, 902 12,090,600 20, 640, 502 0.737272 0.000000 72.00 07300 DRUGS CHARGED TO PATIENTS 44, 039, 880 223, 919, 261 267, 959, 141 0. 214538 0.000000 73.00 73.00 03020 RENAL ACUTE 76.00 3,001,565 439, 359 3, 440, 924 0. 519188 0.000000 76.00 OUTPATIENT SERVICE COST CENTERS 90.00 09000 CLI NI C 960 733, 625 734, 585 0.448471 0.000000 90.00 09005 PATIENT NUTRITION 198, 013 198, 013 0.000000 90.05 2. 364269 90.05 90 07 09007 WOUND CLINIC 6,000 7, 135, 026 7, 141, 026 0. 271986 0.000000 90.07 91.00 09100 EMERGENCY 28, 159, 368 110, 117, 849 138, 277, 217 0.093964 0.000000 91.00 2, 347, 184 92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART) 12, 965, 352 15, 312, 536 0. 737952 0.000000 92.00 200.00 Subtotal (see instructions) 500, 375, 303 925, 264, 633 1, 425, 639, 936 200.00 201.00 Less Observation Beds 201. 00 202.00 Total (see instructions) 500, 375, 303 925, 264, 633 1, 425, 639, 936 202.00

Health Financial Systems	UNION HOSPITAL, INC.	In Lie	u of Form CMS-2552-10
COMPUTATION OF RATIO OF COSTS TO CHARGES	Provi der CCN: 15-0023	From 01/01/2018	Worksheet C Part I Date/Time Prepared:

			10 12/31/2018	5/29/2019 1:	
		Title XVIII	Hospi tal	PPS	тт рііі
Cost Center Description	PPS Inpatient				
	Ratio				
	11. 00				
INPATIENT ROUTINE SERVICE COST CENTERS					
30. 00 03000 ADULTS & PEDIATRICS					30.00
31.00 03100 INTENSIVE CARE UNIT					31.00
35. 00 02040 INTENSIVE NURSERY					35.00
41. 00 04100 SUBPROVI DER - I RF					41.00
43. 00 04300 NURSERY					43.00
ANCILLARY SERVICE COST CENTERS					
50. 00 05000 OPERATING ROOM	0. 107064				50.00
50. 01 05001 CARDI AC SURGERY	0. 441514				50. 01
50. 02 05002 WVSC	0. 136697				50.02
51.00 05100 RECOVERY ROOM	0. 277613				51.00
51.02 05101 0/P TREATMENT ROOM	0. 969271				51.02
52.00 05200 DELIVERY ROOM & LABOR ROOM	0. 328363				52.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	0. 221015				54.00
55. 00 05500 RADI OLOGY-THERAPEUTI C	0. 181449				55.00
56. 00 05600 RADI 01 SOTOPE	0. 248165				56.00
57. 00 05700 CT SCAN	0. 065626				57.00
58.00 05800 MAGNETIC RESONANCE IMAGING (MRI)	0. 186025				58.00
59. 00 05900 CARDI AC CATHETERI ZATI ON	0. 253750				59.00
60. 00 06000 LABORATORY	0. 113018				60.00
62.00 06200 WHOLE BLOOD & PACKED RED BLOOD CELLS	0. 481576				62.00
65. 00 06500 RESPIRATORY THERAPY	0. 260111				65.00
66. 00 06600 PHYSI CAL THERAPY	0. 321750				66.00
66. 01 06601 PSYCHI ATRI C/PSYCHOLOGI CAL SERVI CES	0. 000000				66. 01
66. 02 06602 0/P PHYSI CAL THERAPY	0. 346996				66. 02
67. 00 06700 OCCUPATI ONAL THERAPY	0. 239869				67.00
68.00 06800 SPEECH PATHOLOGY	0. 323096				68.00
69. 00 06900 ELECTROCARDI OLOGY	0. 179303				69.00
69. 01 06901 CARDI AC REHAB	0. 633367				69. 01
70. 00 07000 ELECTROENCEPHALOGRAPHY	0. 356986				70.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	1. 901487				71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0. 737272				72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	0. 214538				73.00
76. 00 03020 RENAL ACUTE	0. 519188				76.00
OUTPATIENT SERVICE COST CENTERS					
90. 00 09000 CLI NI C	0. 448471				90.00
90. 05 09005 PATIENT NUTRITION	2. 376253				90. 05
90. 07 09007 WOUND CLINIC	0. 271986				90. 07
91. 00 09100 EMERGENCY	0. 093964				91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	0. 737952				92.00
200.00 Subtotal (see instructions)					200.00
201.00 Less Observation Beds					201.00
202.00 Total (see instructions)					202.00
202.00 Total (See Instructions)					J202. 0

Title XIX Hospital Cost					o 12/31/2018	Date/Time Pre 5/29/2019 1:1	pared:
Total Cost			Ti +I	e XIX	Hosni tal		т рііі
INPATIENT ROUTINE SERVICE COST CENTERS 1.00 2.00 3.00 4.00 5.00			11 (1	i iii		0031	
INPATIENT ROUTINE SERVICE COST CENTERS Part I , col . 26) 2.00 3.00 4.00 5.00	Cost Center Description	Total Cost	Therapy Limit	Total Costs		Total Costs	
INPATIENT ROUTINE SERVICE COST CENTERS 1.00 2.00 3.00 4.00 5.00	555t 5511t61 5555t (pt. 611		1	10141 00010		.014. 00010	
INPATI ENT ROUTINE SERVICE COST CENTERS		7					
INPATIENT ROUTINE SERVICE COST CENTERS 1.00 2.00 3.00 4.00 5.00							
INPATIENT ROUTINE SERVICE COST CENTERS			2, 00	3, 00	4. 00	5. 00	
30.00 03000 ADULTS & PEDIATRICS 56, 049, 390 56, 049, 390 0 56, 049, 390 30, 00 31, 00 310, 00 310, 00 10 1 1 1 1 1 1 1 1	INPATIENT ROUTINE SERVICE COST CENTERS						
33.00 03100 INTENSI WE CARE UNIT 10, 559, 189 10, 559, 189 0 10, 559, 189 31 0.00 30, 000 O4100 INTENSI WE NURSERY 3, 929, 556 3, 929, 556 0 3, 929, 556 53 50 0.00 O4100 SUBRROVI DER - 1 IFF 2, 914, 599 2, 914, 599 0 2, 914, 599 41, 00 04100 SUBRROVI DER - 1 IFF 2, 914, 599 2, 914, 599 0 2, 914, 599 41, 00 04100 SUBRROVI DER - 1 IFF 2, 914, 599 2, 914, 599 0 2, 914, 599 41, 00 04100 SUBRROVI DER - 1 IFF 2, 914, 599 2, 914, 599 0 2, 914, 599 41, 00 04100 SUBROVI DER - 1 IFF 2, 914, 599 2, 914, 599 0 2, 914, 599 41, 00 04100 SUBROVI DER - 1 IFF 2, 914, 599 2, 914, 599 0 2, 914, 599 41, 00 04100 SUBROVI DER - 1 IFF 2, 914, 599 2, 914, 599 0 2, 914, 599 2, 914, 599 0 2, 914, 599 2, 914, 599 2, 914, 599 0 2, 914, 599 2, 914, 599 0 2, 914, 599 3, 914, 914, 914 2, 914, 914, 914 2, 914, 914, 914 2, 914, 914, 914 2, 914, 914, 914 2, 914, 914, 914 2, 914, 914, 914 2, 914, 914, 914 2, 914, 914, 914 2, 914, 914, 914, 914, 914, 914, 914, 914		56, 049, 390		56, 049, 390	0	56, 049, 390	30.00
35.00					1		
41 .00							
A3. 00 OASOO NURSERY 1, 679, 836 1, 679, 836 0 1, 679, 836 33, 00							
ANCILLARY SERVICE COST CENTERS							
SOLO	ANCILLARY SERVICE COST CENTERS		<u> </u>				
50.02 0500		18, 236, 795		18, 236, 795	37, 297	18, 274, 092	50.00
50.02 0500	50. 01 05001 CARDI AC SURGERY	2, 739, 276		2, 739, 276	o	2, 739, 276	50. 01
51.00 05100 RECOVERY ROOM 2, 862, 250 2, 862, 250 0, 0510 07P TREATMENT ROOM 1, 974, 971 1, 974, 971 1, 974, 971 51.02 0510 07P TREATMENT ROOM 1, 974, 971 1, 974, 971 0, 1, 974, 971 51.02 05200 DELI VERY ROOM & LABOR ROOM 6, 916, 704 6, 916, 704 0, 6, 916, 704 52.00 05200 DELI VERY ROOM & LABOR ROOM 6, 916, 704 6, 916, 704 0, 6, 916, 704 52.00 05200 DELI VERY ROOM & LABOR ROOM 6, 916, 704 6, 916, 704 0, 6, 916, 704 52.00 05500 RODI OLOGY-THERAPEUTI C 7, 83, 838, 829 7, 838, 299 0, 7							
51.02 05101 0/P TREATMENT ROOM		1 ' '			1		51.00
52.00 05200 DELIVERY ROOM & LABOR ROOM 6, 916, 704 12, 782, 632 2, 756 12, 783, 388 54. 00 05500 RADI OLOGY-DI AGNOSTIC 12, 782, 632 7, 838, 299 0, 7,							
54.00 05400 RADI OLOGY-THERAPEUTI C 12, 782, 632 12, 782, 632 2, 756 12, 783, 388 54, 00 55.00 05500 RADI OLOGY-THERAPEUTI C 7, 838, 299 7, 838, 299 0 7, 838, 299 55.00 65.00 05600 RADI OLOGY-THERAPEUTI C 7, 838, 299 5, 00 05600 RADI OLOGY-THERAPEUTI C 7, 838, 299 5, 00 05600 RADI OLOGY-THERAPEUTI C 2, 774, 165 2, 774, 165 0 2, 774, 165 56.00 05600 RADI OLOGY-THERAPEUTI C 2, 774, 165 0 2, 774, 165 0 2, 774, 165 56.00 05600 RADI OLOGY-THERAPEUTI C 2, 774, 165 0 2, 774, 165 0 2, 774, 165 56.00 05600 RADI OLOGY-THERAPEUTI C 2, 477, 399 0 2, 447, 399 0 2, 688, 378 0 0 2, 497, 496 0 5, 925, 496 0 5, 925, 496 0 5, 925, 496 0 5, 925, 496 0 5, 925, 496 0 5, 925, 496 0 5, 925, 496 0 5, 925, 496 0 5, 925, 496 0 5, 925, 496 0 66.01 06601 PSYCHI ATRI C/PSYCHOLOGI CAL SERVI CES 0 0 0 0 0 0 0 0 0							1
55. 00 05500 RADI OLOGY-THERAPEUTI C 7, 838, 299 7, 838, 299 0 7, 838, 299 55. 00 56. 00 05500 RADI OI SOTOPE 2, 774, 165 2, 774, 165 0 2, 774, 165 56. 00 57. 00 05700 CT SCAN 3, 608, 429 3, 608, 429 0 2, 473, 399 0 2, 473, 399 0 2, 473, 399 0 2, 473, 399 0 2, 473, 399 0 2, 473, 399 0 2, 473, 399 0 2, 473, 399 0 2, 473, 399 0 2, 473, 399 0 2, 473, 399 0 2, 473, 399 0 2, 473, 399 0 2, 473, 399 0 2, 473, 399 0 2, 473, 399 0 2, 473, 399 0 2, 474, 489 0 2, 474, 489 0 2, 474, 489 0 2, 474, 489 0 2, 474, 489 0 2, 474, 489 0 2, 474, 489 0 2, 474, 489 0 2, 474, 489 0 2, 474, 489 0 2, 474, 489 0 2, 474, 489 0 2, 474, 489 0 2, 474, 489 0							
56. 00 05600 RADI OI SOTOPE 2, 774, 165 2, 774, 165 0 2, 774, 165 56. 00							
57. 00 05700 CT SCAN 3, 608, 429 2, 447, 399 2, 447, 399 0 2, 447, 399 58. 00 05800 05800 CARDIAC CATHETERIZATION 24, 503, 918 24, 503, 918 0 24, 50							56.00
58.00 05800 MAGNETI C RESONANCE I IMAGI NG (MRI) 2, 447, 399 2, 447, 399 0 2, 447, 399 58.00 59.00 05900 CARDI AC CATHETER ZATI ON 24, 503, 918 24, 503, 918 0 24, 503, 918 59.00 60.00 06000 LABORATORY 10, 644, 855 10, 644, 855 183, 070 10, 827, 925 60.00 62.00 06200 WHOLE BLOOD & PACKED RED BLOOD CELLS 1, 460, 460 1, 460, 460 0 1, 460, 460 0 65.00 05600 RESPI RATORY THERAPY 5, 925, 496 0 5, 925, 496 0 66.01 06601 PSYCHI ATRI C/PSYCHOLOGI CAL SERVI CES 0 0 0 0 0 66.01 06601 PSYCHI ATRI C/PSYCHOLOGI CAL SERVI CES 0 0 0 0 66.02 06602 O/P PHYSI CAL THERAPY 2, 688, 372 0 2, 688, 372 0 2, 688, 372 67.00 05700 OCUPATI ONAL THERAPY 2, 149, 146 0 2, 14							1
59.00 05900 CARDI AC CATHETERIZATION 24, 503, 918 24, 503, 918 0 24, 503, 918 59.00 60.00 06000 LABORATORY 10, 644, 855 10, 644, 855 183, 070 10, 827, 925 60.00 62.00 06200 WHOLE BLOOD & PACKED RED BLOOD CELLS 1, 460, 460 1, 460, 460 0 1, 460, 460 0 0, 1460, 460 65.00 06500 RESPI RATORY THERAPY 5, 925, 496 0 5, 925, 496 65.00 66.01 06601 PSYCHI ATRI C/PSYCHOLOGI CAL SERVI CES 0 0 0 0 0 66.01 06601 PSYCHI ATRI C/PSYCHOLOGI CAL SERVI CES 0 0 0 0 66.01 06601 PSYCHI ATRI C/PSYCHOLOGI CAL SERVI CES 0 0 0 0 66.01 06602 O/P PHYSI CAL THERAPY 2, 149, 146 0 2, 149, 146 0 67.00 06700 0CCUPATI ONAL THERAPY 2, 149, 146 0 2, 149, 146 0 68.00 06800 SPEECH PATHOLOGY 1, 029, 516 0 1, 029, 516 0 69.01 06900 ELECTROCARDI OLOGY 13, 596, 118 13, 596, 118 0 69.01 06901 CARDI AC REHAB 817, 600 07000 ELECTROCARDI OLOGY 1, 669, 015 0, 669, 015 71.00 07000 MEDI CAL SUPPLIES CHARGED TO PATI ENTS 1, 561, 098 1, 561, 098 0 1, 561, 098 1, 561, 098 0 72.00 07000 MEDI CAL SUPPLIES CHARGED TO PATI ENTS 15, 217, 672 15, 217, 672 0 15, 217, 672 0 73.00 07300 RIVEL SCHARGED TO PATI ENTS 15, 217, 672 15, 217, 672 0 15, 217, 672 0 74.00 07000 CLECTROEARDI OLOGY 1, 786, 486 1, 786, 486 0 1, 786, 486 76.00 75.00 07000 CLINIC 0 09000 CLINIC 09000 00000 00000 00000 00000 00000 000000							
60. 00 06000 LABORATORY 10, 644, 855 10, 644, 855 183, 070 10, 827, 925 60. 00 62.00 06200 WHOLE BLOOD & PACKED RED BLOOD CELLS 1, 460, 460 1, 460, 460 0 1, 460, 460 62.00 65.00 06500 RESPI RATORY THERAPY 3, 873, 739 0 3, 873, 739 0 3, 873, 739 0 0, 5, 925, 496 65.00 06600 PHYSI CAL THERAPY 3, 873, 739 0 0 0 0 0 0 0 0 0			l e				
62.00 06200 WHOLE BLOOD & PACKED RED BLOOD CELLS 1,460,460 1,460,460 0 1,460,460 65.00 65.00 06500 RESPI RATORY THERAPY 5,925,496 0 5,925,496 0 5,925,496 0 66.00 06600 PHYSI CAL THERAPY 3,873,739 0 3,873,739 0 0 66.01 06601 PSYCHI ATRI C/PSYCHOLOGI CAL SERVI CES 0 0 0 66.01 06602 O/P PHYSI CAL THERAPY 2,688,372 0 2,688,372 0 2,688,372 67.00 06700 OCCUPATI ONAL THERAPY 2,149,146 0 2,149,146 0 2,149,146 0 2,149,146 0 1,029,516 0 68.00 06800 SPEECH PATHOLOGY 13,596,118 13,596,118 0 13,596,118 0 13,596,118 0 69.01 06901 CARDI AC REHAB 817,600 817,600 0 817,600 69.01 69.01 07000 ELECTROENCEPHALOGRAPHY 1,669,015 1,669,015 0 1,669,015 0 71.00 07100 MEDI CAL SUPPLIES CHARGED TO PATI ENTS 1,561,098 1,561,098 0 1,561,098 1,561,098 1,561,098 1,561,098 1,760,098 1,760,098 1,760,090 1,7							
65. 00 06500 RESPI RATORY THERAPY 5, 925, 496 0 5, 925, 496 0 5, 925, 496 66. 00 66. 00 06600 PHYSI CAL THERAPY 3, 873, 739 0 0 0 0 0 0 0 0 0							
66. 00 06600 PHYSI CAL THERAPY 3,873,739 0 3,873,739 0 0 0 0 0 0 0 0 0			0			5, 925, 496	65.00
66. 01 06601 PSYCHIATRI C/PSYCHOLOGI CAL SERVI CES 0 0 0 0 0 0 66. 01 66. 02 066002 07P PHYSI CAL THERAPY 2,688,372 0 2,688,372 0 2,688,372 0 2,688,372 66. 02 67. 00 06700 0CCUPATI ONAL THERAPY 2,149,146 0 0 0,00 0 0 0 0 0 0	66. 00 06600 PHYSI CAL THERAPY		0			3, 873, 739	66.00
67. 00 06700 OCCUPATI ONAL THERAPY 2, 149, 146 0 2, 149, 146 0 0 2, 149, 146 67. 00 68. 00 06800 SPEECH PATHOLOGY 1, 029, 516 0 1, 029, 516 0 1, 029, 516 68. 00 69. 00 6900 ELECTROCARDI OLOGY 13, 596, 118 0 13, 596,	66. 01 06601 PSYCHI ATRI C/PSYCHOLOGI CAL SERVI CES		0				
68. 00	66. 02 06602 0/P PHYSI CAL THERAPY	2, 688, 372	0	2, 688, 372	0	2, 688, 372	66. 02
68. 00	67. 00 06700 OCCUPATI ONAL THERAPY	2, 149, 146	0	2, 149, 146	o	2, 149, 146	67.00
69. 00 06900 ELECTROCARDI OLOGY 13, 596, 118 13, 596, 118 0 13, 596, 118 69. 00 69. 01 06901 CARDI AC REHAB 817, 600 817, 600 69. 01 070. 00 070. 00 ELECTROENCEPHALOGRAPHY 1, 669, 015 1, 669, 015 0 1, 669, 015 0 1, 669, 015 0 1, 669, 015 0 1, 669, 015 0 1, 669, 015 0 1, 669, 015 0 1, 669, 015 0 1, 669, 015 0 1, 669, 015 0 1, 669, 015 0 1, 669, 015 0 1, 669, 015 0 1, 669, 015 0 1, 669, 015 0 1, 669, 015 0 1, 669, 015 0 072.00 IMPL. DEV. CHARGED TO PATI ENTS 15, 217, 672 15, 217, 672 0 15, 217, 672 72. 00 07300 DRUGS CHARGED TO PATI ENTS 57, 487, 438 57, 487, 438 0 57, 487, 438 30 07, 487, 438 0 57, 487, 438 0 57, 487, 438 73. 00 07300 RENAL ACUTE 1, 786, 486 0 1, 786, 486 0 1, 786, 486 0 0 1, 786, 486 0 0 0 09000 CLI NI C 09000 CLI NI C 09000 CLI NI C 09000 EMERGENCY 09000 EMERGENCY 09100 EMERGENCY 09100 09100 EMERGENCY 09200 09200 085ERVATI ON BEDS (NON-DI STI NCT PART) 09200 09200 085ERVATI ON BEDS (NON-DI STI NCT PART) 09200 09200 085ERVATI ON BEDS (NON-DI STI NCT PART) 09200 09200 085ERVATI ON BEDS (NON-DI STI NCT PART) 09200			0				
70. 00 07000 ELECTROENCEPHALOGRAPHY 1, 669, 015 1, 669, 015 0 1, 669, 015 70. 00 71. 00 07100 MEDI CAL SUPPLI ES CHARGED TO PATI ENTS 1, 561, 098 1, 561, 098 0 1, 561, 098 71. 00 72. 00 07200 IMPL. DEV. CHARGED TO PATI ENTS 15, 217, 672 15, 217, 672 0 15, 217, 672 72. 00 73. 00 07300 DRUGS CHARGED TO PATI ENTS 57, 487, 438 57, 487, 438 0 57, 487, 438 0 57, 487, 438 73. 00 70. 00 03020 RENAL ACUTE 0 1, 786, 486 0 1, 786, 486 76. 00 00TPATI ENT SERVI CE COST CENTERS 0 329, 440 0 329, 440 90. 00 90. 05 09005 PATI ENT NUTRI TI ON 468, 156 468, 156 2, 373 470, 529 90. 05 90. 07 09007 WOUND CLI NI C 1, 942, 256 1, 942, 256 0 1, 942, 256 90. 07 90. 09 09100 EMERGENCY 12, 993, 054 12, 993, 054 12,	69. 00 06900 ELECTROCARDI OLOGY			13, 596, 118	o		
71. 00	69. 01 06901 CARDI AC REHAB	817, 600		817, 600	o	817, 600	69. 01
72. 00 07200 MPL. DEV. CHARGED TO PATIENTS 15, 217, 672 15, 217, 672 0 15, 217, 672 72. 00 7300 DRUGS CHARGED TO PATIENTS 57, 487, 438 57, 487, 438 0 57, 487, 438 73. 00 76. 00 03020 RENAL ACUTE 1,786, 486 1,786, 486 0 1,786, 486 76. 00 0000 CLINIC 09000 CLINIC 09000 CLINIC 09000 CLINIC 09000 CLINIC 09000	70. 00 07000 ELECTROENCEPHALOGRAPHY	1, 669, 015		1, 669, 015	0	1, 669, 015	70.00
73. 00 07300 DRUGS CHARGED TO PATIENTS 57, 487, 438 57, 487, 438 0 57, 487, 438 73. 00 76. 00 03020 RENAL ACUTE 1,786, 486 1,786, 486 0 1,786, 486 76. 00 00000 00000 00000 00000 00000 00000 00000 00000 000000	71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	1, 561, 098		1, 561, 098	o	1, 561, 098	71.00
76. 00 03020 RENAL ACUTE 1, 786, 486 1, 786, 486 0 1, 786, 486 76. 00 0000 CUINIC 329, 440 0 0 329, 440 90. 00 9000 CUINIC 329, 440 468, 156 468, 156 2, 373 470, 529 90. 05 90. 07 90007 WOUND CLINIC 1, 942, 256 1, 942, 256 0 1, 942, 256 0 1, 942, 256 0 1, 942, 256 90. 07 92. 00 09100 EMERGENCY 12, 993, 054 12, 993, 054 12, 993, 054 11, 299, 916 11, 299, 916 92. 00 9200 OBSERVATION BEDS (NON-DISTINCT PART) 11, 299, 916 11, 299, 916 11, 299, 916 92. 00 09100 EMERGENCY 11, 299, 916 11, 299, 916 11, 299, 916 92. 00 09100 EMERGENCY 11, 299, 916 11, 299, 916 11, 299, 916 92. 00 09100 EMERGENCY 11, 299, 916 11, 299, 916 11, 299, 916 92. 00 09100 EMERGENCY 11, 299, 916 11, 299, 916 92. 00 09100 EMERGENCY 11, 299, 916 92. 00 09200 EMERGENCY 11, 299, 916 11, 299, 916 11, 299, 916 92. 00 09100 EMERGENCY 11, 299, 916 92. 00 09200 EMERGENCY 11, 290, 916 92. 0	72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	15, 217, 672		15, 217, 672	. 0	15, 217, 672	72.00
OUTPATIENT SERVICE COST CENTERS 90. 00 09000 CLINIC 329, 440 329, 440 0 329, 440 90. 00 90. 05 09005 PATIENT NUTRITION 468, 156 468, 156 2, 373 470, 529 90. 05 90. 07 09007 WOUND CLINIC 1, 942, 256 1, 942, 256 0 1, 942, 256 90. 07 91. 00 09100 EMERGENCY 12, 993, 054 12, 993, 054 0 12, 993, 054 91. 00 92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART) 11, 299, 916 11, 299, 916 11, 299, 916 225, 496 324, 309, 224 200. 00 201. 00 Less Observation Beds 11, 299, 916 11, 299, 916 11, 299, 916 201. 00	73.00 07300 DRUGS CHARGED TO PATIENTS	57, 487, 438		57, 487, 438	o	57, 487, 438	73.00
90. 00 09000 CLI NI C 329, 440 329, 440 90. 00 90. 05 09005 PATI ENT NUTRI TI ON 468, 156 468, 156 2, 373 470, 529 90. 05 90. 07 09007 WOUND CLI NI C 1, 942, 256 1, 942, 256 0 1, 942, 256 0 1, 942, 256 0 12, 993, 054 12, 993, 054 12, 993, 054 12, 993, 054 11, 299, 916 11, 299, 916 200. 00 Subtotal (see instructions) 324, 083, 728 0 324, 083, 728 225, 496 324, 309, 224 200. 00 201. 00 Less Observation Beds 11, 299, 916 201. 00	76. 00 03020 RENAL ACUTE	1, 786, 486		1, 786, 486	o	1, 786, 486	76.00
90. 05 09005 PATIENT NUTRITION 468, 156 468, 156 2, 373 470, 529 90. 05 90. 07 90. 07 90. 07 90. 07 90. 07 90. 00 90. 0	OUTPATIENT SERVICE COST CENTERS						
90. 07 09007 WOUND CLINIC 1,942,256 1,942,256 0 1,942,256 90. 07 09100 EMERGENCY 12,993,054 12,993,054 11,299,916 11,299,916 11,299,916 200. 00 Subtotal (see instructions) 324,083,728 201. 00 12,993,054 0 12,993,054 91. 00 11,299,916 201. 00 201.	90. 00 09000 CLI NI C	329, 440		329, 440	0	329, 440	90.00
91. 00 09100 EMERGENCY 12, 993, 054 12, 993, 054 11, 299, 916 11, 299, 916 11, 299, 916 200. 00 201. 00 Less Observation Beds 11, 299, 916 11, 299, 916 201. 00 201. 00 202. 00 203. 00	90.05 09005 PATIENT NUTRITION	468, 156		468, 156	2, 373	470, 529	90. 05
92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART) 11, 299, 916 11, 299, 916 200. 00 Subtotal (see instructions) 201. 00 Less Observation Beds 11, 299, 916 11, 299, 916 21, 299, 916 201. 00 11, 299, 916 201. 00	90. 07 09007 WOUND CLINIC	1, 942, 256		1, 942, 256	o	1, 942, 256	90. 07
200. 00 Subtotal (see instructions) 324,083,728 0 324,083,728 225,496 324,309,224 200.00 201. 00 Less Observation Beds 11,299,916 11,299,916 11,299,916 11,299,916	91. 00 09100 EMERGENCY	12, 993, 054		12, 993, 054	. 0	12, 993, 054	91.00
201. 00 Less Observation Beds 11, 299, 916 11, 299, 916 11, 299, 916 201. 00	92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	11, 299, 916		11, 299, 916		11, 299, 916	92.00
	200.00 Subtotal (see instructions)	324, 083, 728	0	324, 083, 728	225, 496	324, 309, 224	200.00
202.00 Total (see instructions) 312,783,812 0 312,783,812 225,496 313,009,308 202.00	201.00 Less Observation Beds	11, 299, 916		11, 299, 916	,	11, 299, 916	201.00
	202.00 Total (see instructions)	312, 783, 812	0	312, 783, 812	225, 496	313, 009, 308	202.00

| Peri od: | Worksheet C | From 01/01/2018 | Part | To 12/31/2018 | Date/Time Prepared:

					10 12/31/2010	5/29/2019 1:1	
			Ti tl	e XIX	Hospi tal	Cost	
			Charges				
	Cost Center Description	Inpatient	Outpati ent	Total (col. (Cost or Other	TEFRA	
	, , , , , , , , , , , , , , , , , , ,			+ col. 7)	Ratio	I npati ent	
				ĺ		Rati o	
		6. 00	7. 00	8.00	9. 00	10.00	
	INPATIENT ROUTINE SERVICE COST CENTERS				•		
30.00	03000 ADULTS & PEDIATRICS	87, 159, 186		87, 159, 18	5		30.00
31.00	03100 INTENSIVE CARE UNIT	23, 853, 175		23, 853, 17	5		31.00
	02040 INTENSIVE NURSERY	18, 520, 671		18, 520, 67			35.00
41.00	04100 SUBPROVI DER - I RF	3, 833, 384		3, 833, 38			41.00
	04300 NURSERY	3, 046, 300		3, 046, 30			43.00
	ANCILLARY SERVICE COST CENTERS						
	05000 OPERATING ROOM	91, 959, 181	78, 724, 628	170, 683, 80	9 0. 106845	0.000000	50.00
50. 01	05001 CARDI AC SURGERY	6, 174, 282	30, 000			0. 000000	50. 01
	05002 WVSC	115, 000	112, 005, 408			0.000000	l
	05100 RECOVERY ROOM	3, 075, 523	7, 234, 702			0. 000000	1
	05101 0/P TREATMENT ROOM	21, 041	2, 016, 543			0. 000000	1
	05200 DELIVERY ROOM & LABOR ROOM	16, 526, 263	4, 537, 961			0. 000000	•
54.00	05400 RADI OLOGY-DI AGNOSTI C	13, 503, 301	44, 345, 332			0. 000000	1
55. 00	05500 RADI OLOGY-THERAPEUTI C	1, 716, 804	41, 481, 656			0. 000000	1
56. 00	05600 RADI OI SOTOPE	918, 335	10, 260, 364			0.000000	1
	05700 CT SCAN	14, 554, 325	40, 430, 416			0.000000	
	05800 MAGNETIC RESONANCE IMAGING (MRI)	2, 472, 011	10, 684, 295			0.000000	1
	05900 CARDI AC CATHETERI ZATI ON	29, 903, 907	66, 663, 244			0.000000	1
	06000 LABORATORY	45, 540, 480	50, 266, 959			0.000000	1
	06200 WHOLE BLOOD & PACKED RED BLOOD CELLS	2, 310, 660	722, 006			0.000000	
65. 00	06500 RESPIRATORY THERAPY	1 1				0.000000	1
	06600 PHYSI CAL THERAPY	20, 104, 840 6, 796, 661	2, 675, 845			0.000000	1
	06601 PSYCHI ATRI C/PSYCHOLOGI CAL SERVI CES	1	5, 242, 932				1
		0	7 747 540		0.000000	0.000000	
	06602 0/P PHYSI CAL THERAPY	F 102 242	7, 747, 569			0.000000	
	06700 OCCUPATI ONAL THERAPY	5, 183, 242	3, 776, 434			0.000000	1
	06800 SPEECH PATHOLOGY	1, 087, 537	2, 098, 873			0.000000	1
	06900 ELECTROCARDI OLOGY	13, 375, 936	62, 451, 621			0.000000	
	06901 CARDI AC REHAB	96, 875	1, 194, 004			0.000000	
	07000 ELECTROENCEPHALOGRAPHY	1, 668, 055	3, 007, 237			0. 000000	1
	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	753, 469	67, 519			0. 000000	1
	07200 I MPL. DEV. CHARGED TO PATIENTS	8, 549, 902	12, 090, 600			0. 000000	72.00
	07300 DRUGS CHARGED TO PATIENTS	44, 039, 880	223, 919, 261			0. 000000	73.00
	03020 RENAL ACUTE	3, 001, 565	439, 359	3, 440, 92	4 0. 519188	0. 000000	76. 00
	OUTPATIENT SERVICE COST CENTERS						
	09000 CLI NI C	960	733, 625			0.000000	1
	09005 PATIENT NUTRITION	0	198, 013			0. 000000	•
	09007 WOUND CLINIC	6, 000	7, 135, 026			0. 000000	90. 07
	09100 EMERGENCY	28, 159, 368	110, 117, 849			0. 000000	1
	09200 OBSERVATION BEDS (NON-DISTINCT PART)	2, 347, 184	12, 965, 352			0. 000000	
200.00	1 1	500, 375, 303	925, 264, 633	1, 425, 639, 93	6		200. 00
201.00	l l						201. 00
202.00	Total (see instructions)	500, 375, 303	925, 264, 633	1, 425, 639, 93	6		202. 00

Health Financial Systems	UNION HOSPITAL, INC.	In Lieu	u of Form CMS-2552-10
COMPUTATION OF RATIO OF COSTS TO CHARGES	Provi der CCN: 15-0023	From 01/01/2018	Worksheet C Part I Date/Time Prepared:

Title XIX Hospital Co	30.00 31.00 35.00 41.00
Ratio 11.00	31. 00 35. 00 41. 00
Ratio 11.00	31. 00 35. 00 41. 00
INPATIENT ROUTINE SERVICE COST CENTERS	31. 00 35. 00 41. 00
30. 00 03000 ADULTS & PEDIATRICS 31. 00 03100 INTENSIVE CARE UNIT 35. 00 02040 INTENSIVE NURSERY	31. 00 35. 00 41. 00
31.00 03100 INTENSIVE CARE UNIT 35.00 02040 INTENSIVE NURSERY	31. 00 35. 00 41. 00
35. 00 02040 I NTENSI VE NURSERY	35. 00 41. 00
	41.00
41. 00 04100 SUBPROVI DER - RF	•
43. 00 04300 NURSERY	43. 00
ANCILLARY SERVICE COST CENTERS	
50. 00 05000 OPERATI NG ROOM 0. 000000	50.00
50. 01 05001 CARDI AC SURGERY 0. 000000	50. 01
50. 02 05002 WVSC 0. 000000	50. 02
51. 00 05100 RECOVERY ROOM 0. 000000	51.00
51. 02 05101 0/P TREATMENT ROOM 0. 000000	51.02
52.00 05200 DELI VERY ROOM & LABOR ROOM 0.000000	52.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C 0. 000000	54.00
55. 00 05500 RADI OLOGY-THERAPEUTI C 0. 000000	55. 00
56. 00 05600 RADI 0I SOTOPE 0. 000000	56.00
57. 00 05700 CT SCAN 0. 000000	57.00
58.00 05800 MAGNETIC RESONANCE IMAGING (MRI) 0.000000	58. 00
59. 00 05900 CARDI AC CATHETERI ZATI ON 0. 000000	59. 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
66. 01 06601 PSYCHI ATRI C/PSYCHOLOGI CAL SERVI CES 0. 000000	66. 01
66. 02 06602 0/P PHYSI CAL THERAPY 0. 000000	66. 02
67. 00 06700 OCCUPATI ONAL THERAPY 0. 000000	67. 00
68. 00 06800 SPEECH PATHOLOGY 0. 000000	68. 00
69. 00 06900 ELECTROCARDI OLOGY 0. 000000	69. 00
69. 01 06901 CARDI AC REHAB 0. 000000	69. 01
70. 00 07000 ELECTROENCEPHALOGRAPHY 0. 000000	70. 00
71.00 O7100 MEDICAL SUPPLIES CHARGED TO PATIENTS 0.000000	71. 00
72. 00 07200 I MPL. DEV. CHARGED TO PATIENTS 0. 000000	72. 00
73.00 07300 DRUGS CHARGED TO PATIENTS 0.000000	73. 00
76. 00 03020 RENAL ACUTE 0. 000000	76. 00
OUTPATIENT SERVICE COST CENTERS	
90. 00 09000 CLI NI C 0. 000000	90.00
90. 05 09005 PATI ENT NUTRI TI ON	90.05
90. 07 09007 WOUND CLINI C 0. 000000	90. 07
91. 00 09100 EMERGENCY	91.00
92. 00 09200 085ERVATI ON BEDS (NON-DI STI NCT PART) 0. 000000	92.00
200.00 Subtotal (see instructions)	200.00
201.00 Less Observation Beds	201.00
202.00 Total (see instructions)	202.00

Health Financial Systems	UNI ON HOSPI	TAL, INC.		In Lie	u of Form CMS-2	2552-10
APPORTIONMENT OF INPATIENT ROUTINE SERVICE CAPITA	L COSTS	Provi der C		Period: From 01/01/2018 To 12/31/2018	Date/Time Pre 5/29/2019 1:1	pared: 1 pm
		Title	XVIII	Hospi tal	PPS	
Cost Center Description	Capi tal	Swing Bed	Reduced	Total Patient	Per Diem	
	Related Cost	Adjustment	Capi tal	Days	(col. 3 /	
	(from Wkst.		Related Cost		col. 4)	
	B, Part II,		(col. 1 -			
	col. 26)		col. 2)			
	1. 00	2. 00	3.00	4. 00	5. 00	
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00 ADULTS & PEDIATRICS	6, 672, 262	0	6, 672, 26	2 54, 145	123. 23	30.00
31.00 INTENSIVE CARE UNIT	1, 540, 459		1, 540, 45	9 6, 215	247. 86	31.00
35. 00 INTENSIVE NURSERY	275, 112		275, 11	2 4, 126	66. 68	35.00
41.00 SUBPROVIDER - IRF	491, 160	0	491, 16	0 3, 677	133. 58	41.00
43. 00 NURSERY	35, 230		35, 23	0 3, 196	11. 02	43.00
200.00 Total (lines 30 through 199)	9, 014, 223		9, 014, 22	3 71, 359		200.00
Cost Center Description	I npati ent	Inpatient				
	Program days	Program				
		Capital Cost				
		(col. 5 x				
		col. 6)				
	6. 00	7. 00				
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00 ADULTS & PEDIATRICS	21, 941	2, 703, 789				30.00
31.00 INTENSIVE CARE UNIT	3, 606	893, 783				31.00
35. 00 I NTENSI VE NURSERY	0	0				35.00
41. 00 SUBPROVI DER - I RF	2, 252	300, 822				41.00
43. 00 NURSERY	0	0)			43.00
200.00 Total (lines 30 through 199)	27, 799	3, 898, 394	.[200. 00

near the Financial Systems	UNI UN HUSPI			III LI E	u or Form CM3-2	2332-10
APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITA	AL COSTS	Provi der Co	CN: 15-0023	Peri od:	Worksheet D	
				From 01/01/2018		
				To 12/31/2018	Date/Time Pre	pared:
					5/29/2019 1:1	1 pm
			XVIII	Hospi tal	PPS	
Cost Center Description	Capi tal	Total Charges			Capital Costs	
	Related Cost	(from Wkst.	to Charges	Program	(column 3 x	
	(from Wkst.	C, Part I,	(col. 1 ÷	Charges	column 4)	
	B, Part II,	col. 8)	col. 2)			
	col. 26)		,			
	1.00	2. 00	3.00	4. 00	5. 00	
ANCILLARY SERVICE COST CENTERS						
50. 00 05000 OPERATING ROOM	3, 785, 172	170, 683, 809	0. 02217	7 49, 227, 859	1, 091, 726	50.00
50. 01 05001 CARDI AC SURGERY	291, 906					
50. 02 05002 WVSC	1, 785, 226					
51. 00 05100 RECOVERY ROOM	117, 154					
51. 02 05101 0/P TREATMENT ROOM	728, 402					
52.00 05200 DELIVERY ROOM & LABOR ROOM	970, 079					
54. 00 05400 RADI OLOGY-DI AGNOSTI C	2, 590, 087					54.00
55. 00 05500 RADI OLOGY-THERAPEUTI C	1, 942, 901	43, 198, 460	0. 04497	6 891, 239	40, 084	55.00
56. 00 05600 RADI 0I SOTOPE	913, 103	11, 178, 699	0. 08168	2 419, 621	34, 275	56.00
57. 00 05700 CT SCAN	395, 808	54, 984, 741	0.00719	9 8, 005, 389	57, 631	57.00
58.00 05800 MAGNETIC RESONANCE IMAGING (MRI)	704, 400					58.00
59. 00 05900 CARDI AC CATHETERI ZATI ON	1, 211, 863		0. 01254			
60. 00 06000 LABORATORY	33, 336					
62.00 06200 WHOLE BLOOD & PACKED RED BLOOD CELLS	2, 642					1
65. 00 06500 RESPIRATORY THERAPY	679, 836					65.00
66. 00 06600 PHYSI CAL THERAPY	300, 477					
66. 01 06601 PSYCHI ATRI C/PSYCHOLOGI CAL SERVI CES	0		0. 00000		_	66. 01
66. 02 06602 0/P PHYSI CAL THERAPY	468, 665				ľ	66. 02
67. 00 06700 OCCUPATI ONAL THERAPY	52, 265					
68. 00 06800 SPEECH PATHOLOGY	127, 582	3, 186, 410	0.04003	9 393, 573	15, 758	68.00
69. 00 06900 ELECTROCARDI OLOGY	1, 618, 757	75, 827, 557	0. 02134	8 7, 340, 966	156, 715	69.00
69. 01 06901 CARDI AC REHAB	214, 367	1, 290, 879	0. 16606	3 54, 103	8, 985	69. 01
70. 00 07000 ELECTROENCEPHALOGRAPHY	182, 881	4, 675, 292	0. 03911	6 947, 956	37, 080	70.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	472, 110					
72. 00 07200 I MPL. DEV. CHARGED TO PATIENTS	24, 077		0. 00116			1
73. 00 07300 DRUGS CHARGED TO PATIENTS	1, 621, 349				· ·	
76. 00 03020 RENAL ACUTE	102, 396	3, 440, 924	0. 02975	8 1, 958, 485	58, 281	76.00
OUTPATIENT SERVICE COST CENTERS	T			.1 _	_	
90. 00 09000 CLI NI C	18, 757				-	90.00
90. 05 09005 PATIENT NUTRITION	51, 905				_	90. 05
90. 07 09007 WOUND CLINIC	263, 014					
91. 00 09100 EMERGENCY	1, 085, 696	138, 277, 217	0. 00785	2 15, 247, 369	119, 722	91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	1, 345, 176					92.00
200.00 Total (lines 50 through 199)		1, 289, 227, 220		182, 665, 664		
1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1		,	'			

Health Financial Systems	UNI ON HOSPI	TAL INC		In lie	u of Form CMS-:	2552_10
APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PA		TS Provider C		Period: From 01/01/2018 To 12/31/2018	Worksheet D Part III Date/Time Pre 5/29/2019 1:1	epared:
			XVIII	Hospi tal	PPS	
Cost Center Description	Nursing School Post-Stepdown Adjustments	Nursi ng School	Post-Stepdow Adjustments		All Other Medical Education Cost	
	1A	1.00	2A	2. 00	3. 00	
30. 00	0 0 0 0 0 0	0 0 0		0 0 0 0 0 0 0 0 0 0	0 0 0 0	31. 00 35. 00 41. 00 43. 00
200.00 Total (lines 30 through 199) Cost Center Description	Swing-Bed Adjustment Amount (see instructions)	Total Costs (sum of cols. 1 through 3, minus col. 4)	Total Patien Days	0 0 t Per Diem (col. 5 ÷ col. 6)	O Inpatient Program Days	200.00
	4. 00	5. 00	6. 00	7. 00	8. 00	
30. 00 03000 ADULTS & PEDIATRICS 31. 00 03100 INTENSIVE CARE UNIT 35. 00 02040 INTENSIVE NURSERY 41. 00 04100 SUBPROVIDER - IRF 43. 00 04300 NURSERY 200. 00 Total (lines 30 through 199)	0	0 0 0 0 0	6, 21 4, 12 3, 67 3, 19	5 0. 00 6 0. 00 7 0. 00 6 0. 00	3, 606 0 2, 252 0	31. 00 35. 00 41. 00
Cost Center Description	Inpatient Program Pass-Through Cost (col. 7 x col. 8) 9.00					
30.00 03000 ADULTS & PEDIATRICS 31.00 03100 INTENSIVE CARE UNIT 35.00 02040 INTENSIVE NURSERY 041.00 04100 SUBPROVIDER - IRF 1.00 04300 NURSERY 200.00 Total (lines 30 through 199)	0 0 0 0 0					30. 00 31. 00 35. 00 41. 00 43. 00 200. 00

Health Financial Systems UNION HOSPITAL, INC. In Lieu of Form CMS-	-2552-10
APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS Provider CCN: 15-0023 Period: Worksheet D From 01/01/2018 To 12/31/2018 Date/Time Pr	onorod.

5/29/2019 1:11 pm Title XVIII Hospi tal PPS Cost Center Description Non Physician Nursi ng Nursi ng Allied Health Allied Health Anestheti st School Post-Stepdown School Post-Stepdown Cost Adjustments Adjustments 1. 00 2.00 ЗА 3.00 ANCILLARY SERVICE COST CENTERS 05000 OPERATING ROOM 50 00 50 00 0 0 000000000000000000000000000 0 05001 CARDI AC SURGERY 0 50.01 0 0 50.01 0 50.02 05002 WVSC 0 0 50.02 05100 RECOVERY ROOM 0 0 51.00 0 0 0 51.00 05101 0/P TREATMENT ROOM 0 0 51.02 51.02 0 52.00 05200 DELIVERY ROOM & LABOR ROOM 0 0 52.00 54.00 05400 RADI OLOGY-DI AGNOSTI C 0 0 351, 976 54.00 05500 RADI OLOGY-THERAPEUTI C 0 55.00 0 55.00 0 05600 RADI OI SOTOPE 0 56.00 56.00 0 0 57.00 05700 CT SCAN 0 0 57.00 58.00 05800 MAGNETIC RESONANCE IMAGING (MRI) 0 58.00 05900 CARDIAC CATHETERIZATION 0 0 59.00 59.00 0 0 60.00 06000 LABORATORY 0 60.00 62.00 06200 WHOLE BLOOD & PACKED RED BLOOD CELLS 62.00 06500 RESPIRATORY THERAPY 0 0 65.00 0 65.00 0 06600 PHYSI CAL THERAPY 66.00 0 0 66.00 06601 PSYCHI ATRI C/PSYCHOLOGI CAL SERVI CES 66.01 0 0 66.01 06602 0/P PHYSICAL THERAPY 0 66.02 66.02 0 06700 OCCUPATI ONAL THERAPY 0 0 67.00 67.00 06800 SPEECH PATHOLOGY 0 0 68.00 0 68.00 69.00 06900 ELECTROCARDI OLOGY 0 0 69.00 06901 CARDI AC REHAB 69.01 69.01 0 70.00 07000 ELECTROENCEPHALOGRAPHY 0 Ω 70.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 0 0 71.00 0 71.00 72.00 07200 IMPL. DEV. CHARGED TO PATIENTS 0 0 72.00 07300 DRUGS CHARGED TO PATIENTS 0 0 o 73.00 0 374, 495 73.00 03020 RENAL ACUTE 0 0 0 0 76.00 0 76.00 OUTPATIENT SERVICE COST CENTERS 90.00 90.00 09000 CLI NI C 000000 0 0 0 09005 PATIENT NUTRITION 0 90.05 0 0 0 0 0 90.05 09007 WOUND CLINIC 0 90.07 90.07 0 91.00 09100 EMERGENCY 0 0 0 91.00 0 92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART)

0

0 92.00

726, 471 200. 00

0

Total (lines 50 through 199)

200.00

5/29/2019 1:11 pm Title XVIII Hospi tal All Other Cost Center Description Total Cost Total Total Charges Ratio of Cost to Charges Medi cal (sum of cols. Outpati ent (from Wkst. Educati on 1, 2, 3, and Cost (sum of C, Part I, (col. 5 ÷ Cost 4) col s. 2, 3, col. 8) col. 7) and 4) 4. 00 7. 00 5.00 6.00 8.00 ANCILLARY SERVICE COST CENTERS 50 00 50 00 05000 OPERATING ROOM 170, 683, 809 0.000000 05001 CARDI AC SURGERY 0 6, 204, 282 0.000000 50.01 50.01 50.02 05002 WVSC 0000000000000000000000000 0 0 112, 120, 408 0.000000 50.02 05100 RECOVERY ROOM 10, 310, 225 51.00 0 0 0.000000 51.00 05101 0/P TREATMENT ROOM 0 51.02 r 2, 037, 584 0.000000 51.02 05200 DELIVERY ROOM & LABOR ROOM 21, 064, 224 0.000000 52.00 05400 RADI OLOGY-DI AGNOSTI C 351, 976 351, 976 57, 848, 633 0.006084 54.00 54.00 05500 RADI OLOGY-THERAPEUTI C 43, 198, 460 55.00 0 0.000000 55.00 C 56.00 05600 RADI OI SOTOPE C 0 11, 178, 699 0.000000 56.00 57.00 05700 CT SCAN 54, 984, 741 0.000000 57.00 58.00 05800 MAGNETIC RESONANCE IMAGING (MRI) 0 0 13, 156, 306 0.000000 58.00 05900 CARDI AC CATHETERI ZATI ON 0 96, 567, 151 0.000000 59.00 C 59.00 60.00 06000 LABORATORY 95, 807, 439 0.000000 60.00 62.00 06200 WHOLE BLOOD & PACKED RED BLOOD CELLS 0 0 3, 032, 666 0.000000 62.00 06500 RESPIRATORY THERAPY 0 22, 780, 685 0.000000 65.00 0 65.00 66.00 06600 PHYSI CAL THERAPY 12, 039, 593 0.000000 66.00 06601 PSYCHI ATRI C/PSYCHOLOGI CAL SERVI CES 0 0.000000 66.01 66.01 0 06602 0/P PHYSICAL THERAPY 7, 747, 569 0.000000 66.02 66.02 06700 OCCUPATI ONAL THERAPY 0 67.00 8, 959, 676 0.000000 67.00 68.00 06800 SPEECH PATHOLOGY 0 3, 186, 410 0.000000 68.00 69.00 06900 ELECTROCARDI OLOGY 75, 827, 557 0.000000 69.00 1, 290, 879 69 01 06901 CARDI AC REHAB 0 0 0.000000 69 01 07000 ELECTROENCEPHALOGRAPHY 0 70.00 C 4, 675, 292 0.000000 70.00 71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 0 820, 988 0.000000 71.00 0 07200 IMPL. DEV. CHARGED TO PATIENTS 72.00 0 20, 640, 502 0.000000 72.00 07300 DRUGS CHARGED TO PATIENTS 73.00 374, 495 374, 495 267, 959, 141 0.001398 73 00 03020 RENAL ACUTE 76.00 3, 440, 924 0.000000 76.00 OUTPATIENT SERVICE COST CENTERS 90.00 09000 CLI NI C 0 734, 585 0.000000 90.00 09005 PATIENT NUTRITION 0 0 0 0.000000 90.05 0 198, 013 90.05 90.07 09007 WOUND CLINIC 0 0 7, 141, 026 0.000000 90.07 91. 00 09100 EMERGENCY 138, 277, 217 0.000000 91.00 92.00 | 09200 | OBSERVATION BEDS (NON-DISTINCT PART) 0 0 15, 312, 536 0.000000 92.00

0

726, 471

726, 471

1, 289, 227, 220

200.00

200.00

Total (lines 50 through 199)

Health Financial Systems	UNI ON HOSPITAL	UNION HOSPITAL, INC.		In Lieu of Form CMS-2552-10	
APPORTIONMENT OF INPATIENT/OUTPATIENT THROUGH COSTS	ANCILLARY SERVICE OTHER PASS	Provi der CCN: 15-0023	From 01/01/2018	Worksheet D Part IV Date/Time Prepared	

THROUGH COSTS			To	12/31/2018	Date/Time Pre 5/29/2019 1:1	pared: 1 pm	
			Title	XVIII	Hospi tal	PPS	
	Cost Center Description	Outpati ent	I npati ent	I npati ent	Outpati ent	Outpati ent	
		Ratio of Cost	Program	Program	Program	Program	
		to Charges	Charges	Pass-Through	Charges	Pass-Through	
		(col. 6 ÷	•	Costs (col. 8	, and the second	Costs (col. 9	
		col. 7)		x col. 10)		x col. 12)	
		9. 00	10. 00	11.00	12.00	13.00	
	ANCILLARY SERVICE COST CENTERS						
50.00	05000 OPERATING ROOM	0. 000000	49, 227, 859	0	24, 284, 718	0	50.00
50.01	05001 CARDI AC SURGERY	0. 000000	3, 198, 814	0	29, 037	0	50. 01
50.02	05002 WVSC	0. 000000	109, 991	0	33, 309, 304	0	50.02
51.00	05100 RECOVERY ROOM	0. 000000	1, 777, 300	0	2, 056, 515	0	51.00
51.02	05101 O/P TREATMENT ROOM	0. 000000	290	0	908, 323	0	51.02
52.00	05200 DELIVERY ROOM & LABOR ROOM	0. 000000	35, 910	0	21, 085	0	52.00
54.00	05400 RADI OLOGY-DI AGNOSTI C	0. 006084	7, 935, 180	48, 278	13, 545, 300	82, 410	54.00
55.00	05500 RADI OLOGY-THERAPEUTI C	0. 000000	891, 239	0	20, 583, 640	0	55.00
56.00	05600 RADI OI SOTOPE	0. 000000	419, 621	0	3, 973, 562	0	56.00
57.00	05700 CT SCAN	0. 000000	8, 005, 389	0	13, 025, 828	0	57.00
58.00	05800 MAGNETIC RESONANCE IMAGING (MRI)	0. 000000	1, 186, 262	0	3, 312, 536	0	58. 00
59.00	05900 CARDI AC CATHETERI ZATI ON	0. 000000	13, 826, 489	O	27, 281, 092	0	59.00
60.00	06000 LABORATORY	0. 000000	23, 495, 655		12, 337, 192	0	60.00
62.00	06200 WHOLE BLOOD & PACKED RED BLOOD CELLS	0. 000000	1, 200, 279	0	354, 170	0	62.00
65.00	06500 RESPIRATORY THERAPY	0. 000000	9, 835, 202	0	836, 649	0	65.00
66.00	06600 PHYSI CAL THERAPY	0. 000000	3, 106, 852	0	126, 891	0	66.00
66. 01	06601 PSYCHI ATRI C/PSYCHOLOGI CAL SERVI CES	0. 000000	0	o	0	0	66. 01
66. 02	06602 0/P PHYSI CAL THERAPY	0. 000000	0	O	0	0	66. 02
67.00	06700 OCCUPATI ONAL THERAPY	0. 000000	1, 819, 929	O	79, 051	0	67.00
68.00	06800 SPEECH PATHOLOGY	0. 000000	393, 573		27, 437	0	68.00
69.00	06900 ELECTROCARDI OLOGY	0. 000000	7, 340, 966	0	23, 711, 939	0	69.00
69. 01	06901 CARDI AC REHAB	0. 000000	54, 103	O	720, 890	0	69. 01
70.00	07000 ELECTROENCEPHALOGRAPHY	0. 000000	947, 956	O	847, 154	0	70.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0. 000000	409, 342	O	32, 365	0	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0. 000000	5, 895, 730	O	5, 947, 589	0	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0. 001398	23, 694, 438	33, 125	114, 996, 666	160, 765	73.00
76.00	03020 RENAL ACUTE	0. 000000	1, 958, 485	0	239, 508	0	76.00
	OUTPATIENT SERVICE COST CENTERS						
90.00	09000 CLI NI C	0. 000000	0	0	527, 612	0	90.00
90.05	09005 PATIENT NUTRITION	0. 000000	0	O	142, 250	0	90.05
90. 07	09007 WOUND CLINIC	0. 000000	5, 344	0	2, 859, 688	0	90. 07
91.00	09100 EMERGENCY	0. 000000	15, 247, 369	0	24, 772, 222	0	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0. 000000	646, 097	0	4, 850, 560	0	92.00
200.00	Total (lines 50 through 199)		182, 665, 664	81, 403	335, 740, 773	243, 175	200. 00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST Provider CCN: 15-0023 Peri od: Worksheet D From 01/01/2018 Part V Date/Time Prepared: 12/31/2018 5/29/2019 1:11 pm Title XVIII Hospi tal PPS Charges Costs PPS Services Cost Center Description Cost to PPS Cost Cost Charge Ratio Rei mbursed Rei mbursed Rei mbursed (see inst.) Services (see From Servi ces Services Not Worksheet C, inst.) Subject To Subject To Part I, col. Ded. & Coins. Ded. & Coins. 9 (see inst.) (see inst.) 1. 00 2.00 5.00 3.00 4.00 ANCILLARY SERVICE COST CENTERS 05000 OPERATING ROOM 50.00 0. 106845 24, 284, 718 2, 594, 701 50.00 05001 CARDI AC SURGERY 0 0 50.01 0.441514 29, 037 50.01 12,820 4, 553, 282 50.02 05002 WVSC 0. 136697 33, 309, 304 50.02 51.00 05100 RECOVERY ROOM 0. 277613 2, 056, 515 0 0 570, 915 51.00 05101 0/P TREATMENT ROOM 0.969271 908, 323 0 0 880, 411 51.02 51.02 0 52.00 05200 DELIVERY ROOM & LABOR ROOM 0.328363 21, 085 0 6, 924 52.00 0 54.00 05400 RADI OLOGY-DI AGNOSTI C 0. 220967 13, 545, 300 2, 993, 064 54.00 55.00 05500 RADI OLOGY-THERAPEUTI C 0. 181449 20, 583, 640 0 0 0 3, 734, 881 55.00 0 56.00 05600 RADI OI SOTOPE 3, 973, 562 986, 099 0. 248165 56.00 0 05700 CT SCAN 854, 833 57.00 0.065626 13, 025, 828 57.00 58.00 05800 MAGNETIC RESONANCE IMAGING (MRI) 0.186025 3, 312, 536 616, 215 58.00 05900 CARDI AC CATHETERI ZATI ON 0 59.00 0. 253750 27, 281, 092 0 0 6, 922, 577 59.00 06000 LABORATORY 12, 337, 192 0 1, 370, 748 60 00 0 111107 60 00 0 62.00 06200 WHOLE BLOOD & PACKED RED BLOOD CELLS 0.481576 354, 170 170, 560 62.00 65.00 06500 RESPIRATORY THERAPY 0. 260111 836, 649 0 0 217, 622 65.00 0 0 66.00 06600 PHYSI CAL THERAPY 0. 321750 126, 891 40,827 66.00 0 06601 PSYCHI ATRI C/PSYCHOLOGI CAL SERVI CES 0 0.000000 66.01 C 0 66 01 0 66.02 06602 0/P PHYSI CAL THERAPY 0.346996 0 66.02 06700 OCCUPATI ONAL THERAPY 0. 239869 79, 051 0 18, 962 67.00 0 0 68.00 06800 SPEECH PATHOLOGY 0.323096 27, 437 8,865 68.00 0 23, 711, 939 06900 ELECTROCARDI OLOGY 0.179303 4, 251, 622 69 00 69 00 o 69. 01 06901 CARDI AC REHAB 0.633367 720, 890 456, 588 69.01 07000 ELECTROENCEPHALOGRAPHY 847, 154 0 0 302, 422 70.00 0.356986 70.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 1. 901487 0 0 61, 542 71.00 32, 365 71.00 07200 IMPL. DEV. CHARGED TO PATIENTS 5, 947, 589 0 4, 384, 991 72.00 0.737272 0 72.00 73.00 07300 DRUGS CHARGED TO PATIENTS 0. 214538 114, 996, 666 0 88, 882 24, 671, 155 73.00 76.00 03020 RENAL ACUTE 0.519188 239, 508 0 124, 350 76.00 OUTPATIENT SERVICE COST CENTERS 90.00 09000 CLI NI C 0. 448471 527, 612 0 236, 619 90.00 09005 PATIENT NUTRITION 142, 250 0 90.05 2.364269 0 336, 317 90.05 90.07 09007 WOUND CLINIC 0. 271986 2, 859, 688 0 0 777, 795 90.07 0.093964 0 91. 00 | 09100 | EMERGENCY 24, 772, 222 246 2, 327, 697 91.00 92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART) 0.737952 4, 850, 560 0 3, 579, 480 92.00

335, 740, 773

335, 740, 773

0

0

0

89, 128

89, 128

68, 064, 884 200. 00

68, 064, 884 202. 00

201. 00

200.00

201.00

202.00

Subtotal (see instructions)

Only Charges

Less PBP Clinic Lab. Services-Program

Net Charges (line 200 - line 201)

Health Financial Systems	UNION HOSPITAL, INC.	In Lieu of Form CMS-2552-10
APPORTIONMENT OF MEDICAL,	OTHER HEALTH SERVICES AND VACCINE COST Provider CCN:	15-0023

				To 12/31/2018	Date/Time Pre 5/29/2019 1:1	pared: 1 pm
		Title	XVIII	Hospi tal	PPS	
	Cos	sts				
Cost Center Description	Cost	Cost				
, and the second	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 OPERATI NG ROOM	0	0				50.00
50. 01 05001 CARDI AC SURGERY	0	0				50. 01
50. 02 05002 WVSC	0	0				50. 02
51.00 05100 RECOVERY ROOM	0	0				51.00
51.02 05101 0/P TREATMENT ROOM	0	0				51.02
52.00 05200 DELIVERY ROOM & LABOR ROOM	0	0				52.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	0	0				54.00
55. 00 05500 RADI OLOGY-THERAPEUTI C	0	0				55.00
56. 00 05600 RADI 0I SOTOPE	0	0				56.00
57. 00 05700 CT SCAN	0	0				57.00
58.00 05800 MAGNETIC RESONANCE I MAGING (MRI)	0	0				58. 00
59. 00 05900 CARDI AC CATHETERI ZATI ON	0	0				59.00
60. 00 06000 LABORATORY	0	0				60.00
62.00 06200 WHOLE BLOOD & PACKED RED BLOOD CELLS	0	0				62.00
65. 00 06500 RESPI RATORY THERAPY	0	0				65.00
66. 00 06600 PHYSI CAL THERAPY	0					66. 00
66. 01 06601 PSYCHI ATRI C/PSYCHOLOGI CAL SERVI CES	0	0				66. 01
66. 02 06602 0/P PHYSICAL THERAPY	0	0				66. 02
67. 00 06700 OCCUPATI ONAL THERAPY	0	0	l .			67.00
68. 00 06800 SPEECH PATHOLOGY	0	0				68. 00
69. 00 06900 ELECTROCARDI OLOGY	0	0				69. 00
69. 01 06901 CARDI AC REHAB	0	0				69. 01
70. 00 07000 ELECTROENCEPHALOGRAPHY	0	0				70.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0				71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0		ı			72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	0					73.00
76. 00 03020 RENAL ACUTE	0	0				76. 00
OUTPATIENT SERVICE COST CENTERS						1
90. 00 09000 CLI NI C	0		•			90.00
90. 05 09005 PATI ENT NUTRI TI ON	0					90. 05
90. 07 09007 WOUND CLINIC	0	_	1			90. 07
91. 00 09100 EMERGENCY	0		1			91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	0	_	1			92.00
200.00 Subtotal (see instructions)	0	19, 092				200. 00
201.00 Less PBP Clinic Lab. Services-Program	0					201.00
Only Charges						L
202.00 Net Charges (line 200 - line 201)	0	19, 092	l			202.00

Health Financial Systems	UNI ON HOSPI	TAL LNC		In lie	u of Form CMS-2	2552-10
APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPIT.		Provi der C	CN: 15-0023	Peri od:	Worksheet D	1002 10
				From 01/01/2018	Part II	
		· ·	CCN: 15-T023	To 12/31/2018	Date/Time Pre 5/29/2019 1:1	pared: 1 pm
			e XVIII	Subprovi der - I RF	PPS	
Cost Center Description	Capi tal	Total Charges			Capital Costs	
	Related Cost	(from Wkst.	to Charges	Program	(column 3 x	
	(from Wkst.	C, Part I,	(col. 1 ÷	Charges	column 4)	
	B, Part II,	col. 8)	col. 2)			
	col . 26)					
	1. 00	2.00	3. 00	4. 00	5. 00	
ANCILLARY SERVICE COST CENTERS		1				
50. 00 05000 OPERATI NG ROOM	3, 785, 172		1	•	2, 612	50.00
50. 01 05001 CARDI AC SURGERY	291, 906				392	1
50. 02 05002 WVSC	1, 785, 226		1		4	50. 02
51.00 05100 RECOVERY ROOM	117, 154		1	•	68	
51. 02 05101 0/P TREATMENT ROOM	728, 402		1		0	51.02
52. 00 05200 DELIVERY ROOM & LABOR ROOM	970, 079				0	
54. 00 05400 RADI OLOGY-DI AGNOSTI C	2, 590, 087		1	•	3, 251	54.00
55. 00 05500 RADI OLOGY-THERAPEUTI C	1, 942, 901		1		0	55.00
56. 00 05600 RADI 0I SOTOPE	913, 103		1	•	373	56.00
57. 00 05700 CT SCAN	395, 808		1	•	438	
58.00 05800 MAGNETIC RESONANCE IMAGING (MRI)	704, 400		1	•	862	
59. 00 05900 CARDI AC CATHETERI ZATI ON	1, 211, 863		1	•	224	
60. 00 06000 LABORATORY	33, 336		1		110	
62.00 06200 WHOLE BLOOD & PACKED RED BLOOD CELLS	2, 642		1	•	7	62.00
65. 00 06500 RESPIRATORY THERAPY	679, 836				7, 934	65.00
66. 00 06600 PHYSI CAL THERAPY	300, 477				27, 640	•
66. 01 06601 PSYCHI ATRI C/PSYCHOLOGI CAL SERVI CES	0	-	0.0000		0	66. 01
66. 02 06602 0/P PHYSI CAL THERAPY	468, 665				0	
67. 00 06700 OCCUPATI ONAL THERAPY	52, 265		1	,	6, 735	67.00
68.00 06800 SPEECH PATHOLOGY	127, 582		1	•	12, 846	ı
69. 00 06900 ELECTROCARDI OLOGY	1, 618, 757		1	•	1, 430	ı
69. 01 06901 CARDI AC REHAB	214, 367				0	
70. 00 07000 ELECTROENCEPHALOGRAPHY	182, 881		1		874	70.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	472, 110		1	•	1, 053	1
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	24, 077		1		0	72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	1, 621, 349				2, 705	73.00
76. 00 03020 RENAL ACUTE	102, 396	3, 440, 924	0. 02975	58 173, 198	5, 154	76.00
OUTPATIENT SERVICE COST CENTERS						
90. 00 09000 CLI NI C	18, 757		1		0	
90. 05 09005 PATI ENT NUTRI TI ON	51, 905				0	
90. 07 09007 WOUND CLINIC	263, 014				0	90. 07
91. 00 09100 EMERGENCY	1, 085, 696			•	154	91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	0	,		•	0	92.00
200.00 Total (lines 50 through 199)	22, 756, 213	1, 289, 227, 220	1	4, 222, 023	74, 866	200. 00

Health Financial Systems	UNI ON HOSPI				u of Form CMS-2	<u> 2552-10</u>
APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLA THROUGH COSTS	RY SERVICE OTHER PAS		CN: 15-0023 CCN: 15-T023	Peri od: From 01/01/2018 To 12/31/2018		pared:
		Title	XVIII	Subprovi der -	PPS	<u>. p</u>
Cost Center Description	Non Physician Anesthetist Cost	Nursi ng School Post-Stepdown Adjustments	Nursi ng School	Allied Health Post-Stepdown Adjustments	Allied Health	
	1.00	2A	2.00	3A	3. 00	
ANCILLARY SERVICE COST CENTERS	.1					
50. 00 05000 0PERATING ROOM 50. 01 05001 CARDIAC SURGERY 50. 02 05002 WVSC	0 0	0 0		0 0 0	0 0	50. 00 50. 01 50. 02
51. 00 05100 RECOVERY ROOM 51. 02 05101 0/P TREATMENT ROOM 52. 00 05200 DELI VERY ROOM & LABOR ROOM	0	0 0 0		0 0 0	0 0	51. 00 51. 02 52. 00
54. 00 05400 RADI OLOGY-DI AGNOSTI C 55. 00 05500 RADI OLOGY-THERAPEUTI C 56. 00 05600 RADI OI SOTOPE	0	0 0		0 0 0	351, 976 0 0	54. 00 55. 00 56. 00
57. 00 05700 CT SCAN 58. 00 05800 MAGNETI C RESONANCE I MAGI NG (MRI) 59. 00 05900 CARDI AC CATHETERI ZATI ON 60. 00 06000 LABORATORY	0	0 0		0 0 0 0 0	0 0	57. 00 58. 00 59. 00 60. 00
60. 00 06000 LABORATORY 62. 00 06200 WHOLE BLOOD & PACKED RED BLOOD CE 65. 00 06500 RESPIRATORY THERAPY 66. 00 06600 PHYSICAL THERAPY	ELLS 0	0 0 0		0 0 0 0 0 0	0 0 0	62. 00 65. 00 66. 00
66. 01 06601 PSYCHI ATRI C/PSYCHOLOGI CAL SERVI CE 66. 02 06602 0/P PHYSI CAL THERAPY 67. 00 06700 0CCUPATI ONAL THERAPY	S 0 0	0		0 0	0 0	66. 01 66. 02 67. 00
68. 00 06800 SPEECH PATHOLOGY 69. 00 06900 ELECTROCARDI OLOGY 69. 01 06901 CARDI AC REHAB	0	0		0 0	0 0	68. 00 69. 00 69. 01
70.00 07000 ELECTROENCEPHALOGRAPHY 71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	ENTS 0	0		0 0 0 0	0	70. 00 71. 00 72. 00
73. 00 O7300 DRUGS CHARGED TO PATIENTS 76. 00 O3020 RENAL ACUTE OUTPATIENT SERVICE COST CENTERS	0 0	0		0 0	374, 495 0	73. 00 76. 00
90. 00 09000 CLI NI C 90. 05 09005 PATI ENT NUTRI TI ON 90. 07 09007 WOUND CLI NI C 91. 00 09100 EMERGENCY	0 0	0 0 0 0		0 0 0 0 0 0	0 0 0 0	90. 00 90. 05 90. 07 91. 00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PA 200.00 Total (lines 50 through 199)	ART) 0	0		0 0	0	92.00

APPORT I ONENT OF I NPATI ENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS Provider CCN: 15-0023 Component CCN: 15-0023 For outpatient To 12/31/2018 Date/Time Prepa Service Cost Center Description All Other Medical Education Cost (Sum of cols. 1, 2, 3, and 4) Cost (Sum of cols. 2, 3, and 2, 3, and 4) Cost (Sum of cols. 2, 3, and 2, 3, and 4) Cost (Sum of cols. 2, 3, and	Health Financial Systems	III ON HOSDI	TAL LNC		In Lio	u of Form CMS	2552 10
THROUGH COSTS			<u>·</u>	CN: 15_0023			2332-10
Component CCI: 15-T023 To 12/31/2018 Date/Time Preps First Preps		KVIOL OTHER TAS				Part IV	
Cost Center Description			· ·			5/29/2019 1:1	
Medical Education Cost (sum of col s. f. 2, 3, and 4) Cost (sum of col s. 2, 3, and 4) Cost (sum of col s. 2, 3, and 4) Col s. (col . 5) Col .				XVIII	I RF		
Education 1, 2, 3, and Cost (sum of col s, 2) C, Part I, col 8) Col 5 * col 7)	Cost Center Description						
Cost 4) cols 2, 2, 3 col 8 col 7)							
ANCILLARY SERVICE COST CENTERS				7			
ANCILLARY SERVICE COST CENTERS		Cost	4)		col. 8)	col. 7)	
ANCILLARY SERVICE COST CENTERS							
50. 00 05000 05001 CARDI AC SURGERY 0 0 0 0 0 0 0 0 0		4. 00	5. 00	6.00	7. 00	8. 00	
SO .01 OSOOT CARDI AC SURGERY O O O O O O O O O O O O O O O O O O				T			
Solid Soli		1	1	1			
51.00 05100 RECOVERY ROOM 0 0 0 0 10, 310, 225 0.000000 55.00 05100 07 TREATMENT ROOM 0 0 0 0 2, 037, 584 0.000000 55.00 05200 DELI VERY ROOM & LABOR ROOM 0 0 0 0 2, 037, 584 0.000000 55.00 05200 DELI VERY ROOM & LABOR ROOM 0 0 0 0 0 0 0 0 0				1			
51.02 05101 0/P TREATMENT ROOM 0 0 0 0 2, 037, 584 0.000000 52.00 05200 DELI VERY ROOM & LABOR ROOM 0 0 0 0 0 21, 064, 224 0.000000 54.00 05400 RADIO LOGY-DI AGNOSTI C 0 351, 976 351, 976 57, 848, 633 0.006084 55.00 05500 RADIO LOGY-THERAPEUTI C 0 0 0 0 43, 198, 460 0.000000 56.00 05500 RADIO LOGY-THERAPEUTI C 0 0 0 0 11, 178, 699 0.000000 57.00 05700 CT SCAN 0 0 0 0 54, 984, 741 0.000000 57.00 05700 CT SCAN 0 0 0 0 13, 156, 306 0.000000 59.00 05700 CARDIAC ELESONANCE IMAGING (MRI) 0 0 0 0 0 13, 156, 306 0.000000 59.00 05900 CARDIAC CATHETERI ZATI ON 0 0 0 0 96, 567, 151 0.000000 60.00 06000 LABORATORY 0 0 0 0 95, 807, 439 0.000000 60.00 06000 LABORATORY 0 0 0 0 0 3, 032, 666 0.000000 60.00 06600 PHYSI CAL THERAPY 0 0 0 0 0 12, 039, 593 0.000000 60.00 06600 PHYSI CAL THERAPY 0 0 0 0 0 12, 039, 593 0.000000 60.00 06600 PHYSI CAL THERAPY 0 0 0 0 0 0.00000 60.00 06000 06000 06700 00 00 0			ľ	1			
S2.00 05200 DELIVERY ROOM & LABOR ROOM 0 0 0 21, 064, 224 0.000000 54, 00 0.000000 54, 00 0.000000 55, 00 0.0000000 0.000000 0.000000 0.000000 0.000000 0.000000 0.0000000 0.0000000 0.0000000 0.0000000 0.0000000 0.0000000 0.0000000 0.00000000		1	1	•			
54. 00	· ·	-	1				
55. 00 05500 RADI OLOGY-THERAPEUTI C 0 0 0 43, 198, 460 0.000000 5 56.00 0.000000 5 56.00 0 0 0 11, 178, 699 0.000000 5 56.00 0.000000 5 57.00 0.05700 CT SCAN 0 0 0 59.90 0.000000 5 59.90 0.000000 5 0 0 0 11, 178, 699 0.000000 5 58.00 0.000000 5 0 0 0 0 59.90 0.000000 5 0 0 0 0 0 0.000000 5 0 0.000000 5 0 0 0 0 0.000000 5 0 0 0 0.000000 5 0 0 0 0.000000 5 0 0 0.000000 5 0 0 0 0.000000 5 0				1			
56. 00 05600 RADI OI SOTOPE 0 0 0 11, 178, 699 0.000000 57. 00 05700 CT SCAN 0 0 0 0 0 54, 984, 741 0.000000 58. 00 05800 MAGNETI C RESONANCE IMAGI NG (MRI) 0 0 0 0 13, 156, 306 0.000000 59. 00 05900 CARDI AC CATHETERI ZATI ON 0 0 0 0 96, 567, 151 0.000000 59. 00 00 0 0 0 0 0 0 0			351, 976				
57. 00 05700 CT SCAN 0 0 0 0 54,984,741 0.000000 58.00 MAGNETI C RESONANCE IMAGING (MRI) 0 0 0 0 13,156,306 0.000000 59.00 05900 CARDI AC CATHETERI ZATI ON 0 0 0 0 96,567,151 0.000000 59.00 05900 CARDI AC CATHETERI ZATI ON 0 0 0 0 96,567,151 0.000000 60.00 06000 LABORATORY 0 0 0 0 95,807,439 0.000000 60.00 06000 LABORATORY 0 0 0 0 3,032,666 0.000000 60.00 60.00 06000 MHOLE BLOOD & PACKED RED BLOOD CELLS 0 0 0 0 3,032,666 0.000000 60.00 60.00 0.00000 60.00 60.00 0.00000 60.00 0.00000 60.00 0.00000 60.00 0.00000 60.00 0.00000 60.00 0.00000 60.00 0.00000 60.00 0.00000 60.00 0.00000 60.00 0.000000 60.00 0.00000 60.00000 0.00000 0.000000 0.000000 0.000000 0.000000 0.000000 0.000000 0.000000 0.000000 0.000000 0.000000 0.000000 0.000000 0.000000 0.000000 0.000000 0.0000000 0.00000000		1		•			
58. 00 05800 MAGNETIC RESONANCE I MAGI NG (MRI) 0 0 0 13, 156, 306 0.000000 59. 00 05900 CARDI AC CATHETERI ZATI ON 0 0 0 96, 567, 151 0.000000 50. 00 0.00000 50. 00 0.00000 50. 00 0.000000 50. 0000000 50. 0000000000		-	1				
59. 00 05900 CARDI AC CATHETERI ZATI ON 0 0 96, 567, 151 0.000000 560, 000 0.000000 560, 0000000 560, 000 0.000000 560, 000 0.000000 560, 000 0.000000 560, 0000000 560, 000 0.000000 560, 0000000 560, 0000000 560, 0000000 560, 0000000 560, 0000000 560, 0000000 560, 0000000 560, 0000000 560, 0000000 560, 0000000 560, 0000000 560, 0000000 560, 0000000 560, 00000000 560, 00000000 560, 00000000 560, 0000000000000000000000000000000000		1	ı	•			
60. 00 06000 LABORATORY 0 0 0 0 95, 807, 439 0.000000 6200 WHOLE BLOOD & PACKED RED BLOOD CELLS 0 0 0 0 3, 032, 666 0.000000 65. 00 0 0 0 3, 032, 666 0.000000 66. 00 0 0 0 0 22, 780, 685 0.000000 66. 00 0 0 0 0 22, 780, 685 0.000000 66. 00 0 0 0 0 0 0 0 0 0 0.000000 66. 00 0 0 0			ľ				
62. 00 06200 WHOLE BLOOD & PACKED RED BLOOD CELLS 0 0 0 3, 032, 666 0.000000 665. 00 06500 RESPI RATORY THERAPY 0 0 0 0 22, 780, 685 0.000000 666. 00 06600 PHYSI CAL THERAPY 0 0 0 0 12, 039, 593 0.000000 666. 01 06601 PSYCHI ATRI C/PSYCHOLOGI CAL SERVI CES 0 0 0 0 0 7, 747, 569 0.000000 666. 02 06602 0/P PHYSI CAL THERAPY 0 0 0 0 7, 747, 569 0.000000 666. 02 0/P PHYSI CAL THERAPY 0 0 0 0 0 7, 747, 569 0.000000 668. 00 06700 0CCUPATI ONAL THERAPY 0 0 0 0 0 8, 959, 676 0.000000 668. 00 06800 SPEECH PATHOLOGY 0 0 0 0 3, 186, 410 0.000000 669. 00 06900 ELECTROCARDI OLOGY 0 0 0 0 75, 827, 557 0.000000 669. 01 06901 CARDI AC REHAB 0 0 0 0 75, 827, 557 0.000000 669. 01 06901 CAL SUPPLI ES CHARGED TO PATI ENTS 0 0 0 0 820, 988 0.000000 773. 00 07300 DRUGS CHARGED TO PATI ENTS 0 0 0 0 0 374, 495 374, 495 267, 959, 141 0.001398 776. 00 07300 DRUGS CHARGED TO PATI ENTS 0 0 0 0 0 734, 585 0.000000 773. 00 07300 DRUGS CHARGED TO PATI ENTS 0 0 0 0 0 734, 585 0.000000 770. 00 07000 CLI NI C 0 0 0 0 198, 013 0.000000 99. 07 09007 WOUND CLI NI C 0 0 0 0 7, 141, 026 0.000000 99. 07 09007 WOUND CLI NI C 0 0 0 0 7, 141, 026 0.000000 99. 07 09007 WOUND CLI NI C 0 0 0 0 7, 141, 026 0.000000 99. 07 09007 WOUND CLI NI C 0 0 0 0 7, 141, 026 0.000000 99. 07							
65. 00 06500 RESPIRATORY THERAPY 0 0 0 0 12, 780, 685 0.000000 66. 00 06600 PHYSI CAL THERAPY 0 0 0 0 0 12, 039, 593 0.000000 66. 01 06601 PSYCHI ATRI C/PSYCHOLOGI CAL SERVI CES 0 0 0 0 0 0.000000 66. 01 06601 PSYCHI ATRI C/PSYCHOLOGI CAL SERVI CES 0 0 0 0 0 0 0.000000 66. 02 06602 0/P PHYSI CAL THERAPY 0 0 0 0 0 7, 747, 569 0.000000 67. 00 06700 0CCUPATI ONAL THERAPY 0 0 0 0 0 8, 959, 676 0.000000 67. 00 0 0 8, 959, 676 0.000000 68. 00 0 0 0 3, 186, 410 0.000000 69. 00 0 0 3, 186, 410 0.000000 69. 00 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0		-					
66. 00 06600 PHYSI CAL THERAPY 0 0 0 0 12, 039, 593 0.000000 66. 01 06601 PSYCHI ATRI C/PSYCHOLOGI CAL SERVI CES 0 0 0 0 0 0.000000 66. 02 06602 07P PHYSI CAL THERAPY 0 0 0 0 7, 747, 569 0.000000 66. 02 06602 07P PHYSI CAL THERAPY 0 0 0 0 8, 959, 676 0.000000 66. 00 06700 00 00 00 00 00 0							1
66. 01		0	1				
66. 02 06602 0/P PHYSI CAL THERAPY 0 0 0 7,747,569 0.000000 66. 00 06700 0		0	1				1
67. 00 06700 0CCUPATI ONAL THERAPY 0 0 0 0 8,959,676 0.000000 68.00 06800 SPECH PATHOLOGY 0 0 0 0 3,186,410 0.000000 69.00 06900 ELECTROCARDI OLOGY 0 0 0 0 75,827,557 0.000000 69.01 06901 CARDI AC REHAB 0 0 0 0 1,290,879 0.000000 69.01 07000 ELECTROENCEPHALOGRAPHY 0 0 0 0 4,675,292 0.000000 771.00 07100 MEDI CAL SUPPLI ES CHARGED TO PATI ENTS 0 0 0 0 820,988 0.000000 772.00 07200 IMPL. DEV. CHARGED TO PATI ENTS 0 0 0 0 0 20,640,502 0.000000 773.00 07300 DRUGS CHARGED TO PATI ENTS 0 0 374,495 374,495 267,959,141 0.001398 776.00 03020 RENAL ACUTE 0 0 0 3,440,924 0.000000 778.00 09000 CLI NI C 0 0 0 0 0 0 0 0 0		-					
68. 00 06800 SPEECH PATHOLOGY 0 0 0 3, 186, 410 0.000000 69. 00 06900 ELECTROCARDI OLOGY 0 0 0 0 75, 827, 557 0.000000 69. 01 06901 CARDI AC REHAB 0 0 0 0 1, 290, 879 0.000000 69. 01 07000 ELECTROECEPHALOGRAPHY 0 0 0 0 4, 675, 292 0.000000 77. 00 07100 MEDI CAL SUPPLIES CHARGED TO PATI ENTS 0 0 0 0 820, 988 0.000000 77. 00 07200 IMPL. DEV. CHARGED TO PATI ENTS 0 0 0 0 0 0.00000 77. 00 07300 DRUGS CHARGED TO PATI ENTS 0 0 0 0 0 0.00000 77. 00 07300 DRUGS CHARGED TO PATI ENTS 0 0 0 0 0 0.000000 77. 00 07000 07000 070000000 0700000000				•			1
69. 00	· · · · · · · · · · · · · · · · · · ·	0	1				
69. 01 06901 CARDI AC REHAB 0 0 0 1, 290, 879 0.000000 670.00 07000 ELECTROENCEPHALOGRAPHY 0 0 0 0 4, 675, 292 0.000000 771.00 07100 MEDI CAL SUPPLI ES CHARGED TO PATI ENTS 0 0 0 0 820, 988 0.000000 772.00 07200 IMPL. DEV. CHARGED TO PATI ENTS 0 0 0 0 20, 640, 502 0.000000 773.00 07300 DRUGS CHARGED TO PATI ENTS 0 0 374, 495 374, 495 267, 959, 141 0.001398 774.00 0.000000 0 0 0 0 0 0		0	ľ				1
70. 00		0	0	•			
71. 00	· · · · · · · · · · · · · · · · · · ·	0	0	•			
72. 00 07200 IMPL. DEV. CHARGED TO PATIENTS 0 0 0 20, 640, 502 0.000000 73. 00 07300 DRUGS CHARGED TO PATIENTS 0 374, 495 374, 495 267, 959, 141 0.001398 76. 00 03020 RENAL ACUTE 0 0 0 0 3, 440, 924 0.000000 70 0734, 585 0.000000 70 0734, 585 0.000000 70 0734, 585 0.000000 70 0734, 585 0.000000 70 0734, 585 0.0000000 0734, 585 0.000000 0.000000 0734, 585 0.000000 0.000000 0.000000 0.000000 0.000000 0.0000000 0.00000000		0	ľ	•			1
73. 00 07300 DRUGS CHARGED TO PATIENTS 0 374, 495 374, 495 267, 959, 141 0.001398 76. 00 03020 RENAL ACUTE 0 0 0 0 3, 440, 924 0.000000 77. 0000000 79. 00 09000 CLINIC 0 0 0 0 0 0 0 0 0.000000 99. 00 09000 PATIENT NUTRITION 0 0 0 0 0 0 0.000000 99. 00 09000 CLINIC 0 0 0 0 0 0 0 0.000000 99. 00 09000			1	•			1
76. 00 03020 RENAL ACUTE 0 0 0 3,440,924 0.000000 7 0UTPATIENT SERVICE COST CENTERS 90. 00 09000 CLINIC 0 0 0 734,585 0.000000 9 90. 05 09005 PATIENT NUTRITION 0 0 0 198,013 0.000000 9 90. 07 09007 WOUND CLINIC 0 0 0 7,141,026 0.000000 9		-	ľ				
OUTPATIENT SERVICE COST CENTERS 90.00 00 00 734,585 0.000000 90.05 09005 PATIENT NUTRITION 0 0 0 198,013 0.000000 90.07 09007 WOUND CLINIC 0 0 0 7,141,026 0.000000 90.07 0900							
90. 00 09000 CLINIC 0 0 0 734,585 0.000000 90. 05 09005 PATIENT NUTRITION 0 0 0 198,013 0.000000 90. 07 09007 WOUND CLINIC 0 0 0 0 7,141,026 0.000000 90. 07 09007 0		0	0		0 3, 440, 924	0. 000000	76.00
90. 05 09005 PATIENT NUTRITION 0 0 198, 013 0.000000 9 90. 07 09007 WOUND CLINIC 0 0 7, 141, 026 0.000000 9			·	ı	.1		
90. 07 09007 WOUND CLINIC 0 0 7, 141, 026 0. 000000 9							
				1			
91. 00 09100 EMERGENCY 0 0 138, 277, 217 0. 000000 9	· · · · · · · · · · · · · · · · · · ·						
		1	1				
92. 00 09200 OBSERVATI ON BEDS (NON-DISTINCT PART) 0 0 15, 312, 536 0.000000 9				1	, ,		1
200.00 Total (Lines 50 through 199) 0 726,471 726,471 1,289,227,220 20	200.00 Total (lines 50 through 199)	0	726, 471	726, 47	1 1, 289, 227, 220		200. 00

Health Financial Systems	UNI ON HOSPI TA		ON 45 0000		u of Form CMS-2	2552-10
APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SE	RVICE OTHER PASS	Provi der C	UN: 15-0023	Peri od: From 01/01/2018	Worksheet D Part IV	
THROUGH COSTS		Component	CCN: 15-T023	To 12/31/2018		
			XVIII	Subprovi der – I RF	PPS	
Cost Center Description	Outpati ent	Inpati ent	I npati ent	Outpati ent	Outpati ent	
	Ratio of Cost	Program	Program	Program	Program	
	to Charges	Charges	Pass-Through		Pass-Through	
	(col. 6 ÷		Costs (col.	8	Costs (col. 9	
	col. 7)		x col. 10)		x col. 12)	
	9. 00	10. 00	11. 00	12. 00	13.00	
ANCILLARY SERVICE COST CENTERS						
50. 00 05000 OPERATI NG ROOM	0. 000000	117, 777		0	0	
50. 01 05001 CARDI AC SURGERY	0. 000000	8, 335		0	0	
50. 02 05002 WVSC	0. 000000	243		0	0	
51. 00 05100 RECOVERY ROOM	0. 000000	6, 004		0	0	51.00
51.02 05101 0/P TREATMENT ROOM	0. 000000	0		0	0	
52.00 05200 DELIVERY ROOM & LABOR ROOM	0. 000000	0		0	0	
54. 00 05400 RADI OLOGY-DI AGNOSTI C	0. 006084	72, 604	44		0	
55. 00 05500 RADI OLOGY-THERAPEUTI C	0. 000000	0		0	0	55.00
56. 00 05600 RADI 0I SOTOPE	0. 000000	4, 570		0	0	
57. 00 05700 CT SCAN	0. 000000	60, 813		0	0	57.00
58.00 05800 MAGNETIC RESONANCE I MAGING (MRI)	0. 000000	16, 102		0 0	0	58.00
59. 00 05900 CARDI AC CATHETERI ZATI ON	0. 000000	17, 873		0 0	0	59.00
60. 00 06000 LABORATORY	0. 000000	317, 195		0 0	0	60.00
62.00 06200 WHOLE BLOOD & PACKED RED BLOOD CELLS	0. 000000	8, 585		0 0	0	62.00
65. 00 06500 RESPIRATORY THERAPY	0. 000000	265, 860		0 0	0	65.00
66. 00 06600 PHYSI CAL THERAPY	0. 000000	1, 107, 514		0 0	0	66.00
66. 01 06601 PSYCHI ATRI C/PSYCHOLOGI CAL SERVI CES	0. 000000	0		0 0	0	66. 01
66. 02 06602 0/P PHYSI CAL THERAPY	0. 000000	0		0 0	0	66. 02
67. 00 06700 OCCUPATI ONAL THERAPY	0. 000000	1, 154, 593		0 0	0	67.00
68. 00 06800 SPEECH PATHOLOGY	0. 000000	320, 842		0 0	0	68.00
69. 00 06900 ELECTROCARDI OLOGY	0. 000000	66, 988		0 0	0	69.00
69. 01 06901 CARDI AC REHAB	0. 000000	0		0 0	0	69. 01
70. 00 07000 ELECTROENCEPHALOGRAPHY	0. 000000	22, 346		0 0	0	70.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0. 000000	1, 832		0 0	0	71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0. 000000	0	ı	0 0	0	72.00
73. 00 07300 DRUGS CHARGED TO PATIENTS	0. 001398	447, 035	62	5 0	0	73.00
76. 00 03020 RENAL ACUTE	0. 000000	173, 198		0 0	0	76.00
OUTPATIENT SERVICE COST CENTERS						
90. 00 09000 CLI NI C	0. 000000	0		0 0	0	90.00
90. 05 09005 PATIENT NUTRITION	0. 000000	0		0 0	0	
90. 07 09007 WOUND CLINIC	0. 000000	0		0 0	0	
91. 00 09100 EMERGENCY	0. 000000	19, 607		0 424	Ö	
92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	0. 000000	12, 107		0 0	Ö	
200.00 Total (lines 50 through 199)	0.000000	4, 222, 023		-		200.00
1		.,, 520	., 00	121		,

111.11	Figure 1 Control	THE ON LINCOL	TAL LING			G F OHG .	0550 40
	Financial Systems IONMENT OF MEDICAL, OTHER HEALTH SERVICES AND	UNI ON HOSPI D VACCI NE COST	Provi der C		Period: From 01/01/2018 To 12/31/2018	u of Form CMS-: Worksheet D Part V Date/Time Pre 5/29/2019 1:1	pared:
			Title	XVIII	Subprovi der - I RF	PPS	
	·			Charges		Costs	
	Cost Center Description	Cost to	PPS	Cost	Cost	PPS Services	
	000 00 00 00 00 00 00 00 00 00 00 00 00	Charge Ratio	Rei mbursed	Rei mbursed	Rei mbursed	(see inst.)	
		From	Services (see	Servi ces	Services Not	(000 111011)	
		Worksheet C,	inst.)	Subject To	Subject To		
		Part I, col.	11131.)	Ded. & Coins			
		9		(see inst.)	(see inst.)		
		1.00	2.00	3.00	4.00	5. 00	
	ANCILLARY SERVICE COST CENTERS	1.00	2.00	3.00	4.00	5.00	
50.00	05000 OPERATING ROOM	0. 106845	Ο		0 0	0	50.00
50. 00	05001 CARDI AC SURGERY	0. 441514	0		0 0	0	00.00
	05002 WVSC	0. 136697				0	50.01
	05100 RECOVERY ROOM	0. 130097			0	0	
	l l		1		0	0	51.00
51. 02	05101 O/P TREATMENT ROOM	0. 969271	0		0	0	51.02
52.00	05200 DELIVERY ROOM & LABOR ROOM	0. 328363			0	0	52.00
	05400 RADI OLOGY-DI AGNOSTI C	0. 220967	0		0	0	54.00
	05500 RADI OLOGY-THERAPEUTI C	0. 181449			0	0	55.00
56. 00	05600 RADI OI SOTOPE	0. 248165			0	0	56.00
57.00	05700 CT SCAN	0. 065626			0	0	57.00
	05800 MAGNETIC RESONANCE IMAGING (MRI)	0. 186025			0	0	
59.00	05900 CARDI AC CATHETERI ZATI ON	0. 253750			0	0	59. 00
60.00	06000 LABORATORY	0. 111107	0		0	0	60.00
62.00	06200 WHOLE BLOOD & PACKED RED BLOOD CELLS	0. 481576	0		0	0	62.00
65.00	06500 RESPI RATORY THERAPY	0. 260111	0		0	0	65.00
66.00	06600 PHYSI CAL THERAPY	0. 321750	0		0	0	66.00
	06601 PSYCHI ATRI C/PSYCHOLOGI CAL SERVI CES	0. 000000	0		0	0	66. 01
66. 02	06602 0/P PHYSI CAL THERAPY	0. 346996	0		0	0	66. 02
67.00	06700 OCCUPATI ONAL THERAPY	0. 239869	0		0	0	67.00
68.00	06800 SPEECH PATHOLOGY	0. 323096	0		0	0	68.00
69.00	06900 ELECTROCARDI OLOGY	0. 179303	0		0 0	0	69.00
69. 01	06901 CARDI AC REHAB	0. 633367	0		0 0	0	69. 01
70.00	07000 ELECTROENCEPHALOGRAPHY	0. 356986	0		0 0	0	70.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	1. 901487	0		0 0	0	71.00
	07200 IMPL. DEV. CHARGED TO PATIENTS	0. 737272	0		0 0	0	1
73.00	07300 DRUGS CHARGED TO PATIENTS	0. 214538			0 670	0	73.00
76.00	03020 RENAL ACUTE	0. 519188			0 0	0	1
	OUTDATIENT CEDVICE COCT CENTEDS			•	-		1

0. 448471

2. 364269

0. 271986 0. 093964

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40 202.00

201. 00

0

0

40 91.00

0 92.00

03020 RENAL ACUTE
OUTPATIENT SERVICE COST CENTERS

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

Subtotal (see instructions)

Less PBP Clinic Lab. Services-Program
Only Charges

Net Charges (line 200 - line 201)

09005 PATIENT NUTRITION

09007 WOUND CLINIC

90.00

90.05

90.07

200.00

201.00

202.00

09000 CLI NI C

91. 00 09100 EMERGENCY

		cial Systems	UNI ON HOSPI				eu of Form CMS-	-2552-10
APPORT	I ONMEN	NT OF MEDICAL, OTHER HEALTH SERVICES AND	D VACCINE COST	Provi de	r CCN: 15-0023		Worksheet D	
				Compone	nt CCN: 15-T02	From 01/01/2018 To 12/31/2018		
				Ti	tle XVIII	Subprovi der - I RF	PPS	
			Cos	sts				
		Cost Center Description	Cost	Cost				
			Rei mbursed	Rei mburse				
			Servi ces	Services N				
			Subject To Ded. & Coins.	Subject T Ded. & Coi				
				(see inst.				
			(see inst.) 6.00	7. 00	.)_			
	ANCLL	LARY SERVICE COST CENTERS	0.00	7.00				_
50. 00		OPERATING ROOM	0		O			50.00
50. 00	1	CARDI AC SURGERY		l l	o			50.00
50. 01	05001			1	o			50.01
	1	RECOVERY ROOM		•	ol			51.00
		O/P TREATMENT ROOM	-	l .	1			•
	1		0	l l	0			51.02
52. 00 54. 00		DELIVERY ROOM & LABOR ROOM		l .	0			52. 00 54. 00
		RADI OLOGY-DI AGNOSTI C RADI OLOGY-THERAPEUTI C		l .	o			55.00
56. 00	1	RADI OLOGI - THERAPEUTI C		•	0			56.00
57. 00	1	CT SCAN		l .	0			57.00
58. 00	1	MAGNETIC RESONANCE IMAGING (MRI)		l .	ol			58.00
		CARDIAC CATHETERIZATION		l l	ol			59.00
		LABORATORY		l .	ol			60.00
62. 00		WHOLE BLOOD & PACKED RED BLOOD CELLS		l l	o			62.00
		RESPIRATORY THERAPY		l l	o			65.00
66. 00	1	PHYSI CAL THERAPY		l .	o			66.00
66. 01	1	PSYCHI ATRI C/PSYCHOLOGI CAL SERVI CES		I .	o			66. 01
		O/P PHYSICAL THERAPY		I .	o			66. 02
67. 00	1	OCCUPATIONAL THERAPY	0	I .	o			67.00
68. 00		SPEECH PATHOLOGY	0	l l	o			68.00
	1	ELECTROCARDI OLOGY	0	l .	o			69.00
69. 01		CARDI AC REHAB	0		o			69. 01
70. 00	1	ELECTROENCEPHALOGRAPHY	0		0			70.00
		MEDICAL SUPPLIES CHARGED TO PATIENTS	0)	О			71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0)	О			72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0)	144			73.00
76.00		RENAL ACUTE	0)	О			76.00
	OUTPA	TIENT SERVICE COST CENTERS	'					
90.00		CLI NI C	0		0			90.00
90. 05	09005	PATIENT NUTRITION	0	o[О			90.05
90. 07		WOUND CLINIC	0		O			90. 07
	1	EMERGENCY	0		O			91.00
92.00	1	OBSERVATION BEDS (NON-DISTINCT PART)	0	o j	O			92.00
200.00		Subtotal (see instructions)	0		144			200.00
201.00)	Less PBP Clinic Lab. Services-Program	0					201.00
	1	Only Charges						1

144

202.00

202.00

Subtotal (see instructions)
Less PBP Clinic Lab. Services-Program
Only Charges
Net Charges (line 200 - line 201)

	Financial Systems UNION HOSPITA ATION OF INPATIENT OPERATING COST	Provider CCN: 15-0023	Peri od:	u of Form CMS-2 Worksheet D-1	
COMPU	ATTON OF INPATIENT OPERATING COST	Provider CCN: 15-0023	From 01/01/2018 To 12/31/2018	Date/Time Pre	pared:
		Title XVIII	Hospi tal	5/29/2019 1:1 PPS	1 pm
	Cost Center Description	THE AVIII	1103pi tai	113	
				1. 00	
	PART I - ALL PROVIDER COMPONENTS INPATIENT DAYS				-
1. 00	Inpatient days (including private room days and swing-bed da	vs excluding newborn)		54, 145	1.00
2. 00	Inpatient days (including private room days, excluding swing			54, 145	
3.00	Private room days (excluding swing-bed and observation bed d		rivate room days,	0	3.00
4 00	do not complete this line.			40,000	4 00
4. 00 5. 00	Semi-private room days (excluding swing-bed and observation Total swing-bed SNF type inpatient days (including private ro		or 21 of the cost	43, 229 0	4. 00 5. 00
5.00	reporting period	bolli days) trii odgir becellibi	er or the cost	U	3.00
6. 00	Total swing-bed SNF type inpatient days (including private re	oom days) after December	31 of the cost	0	6.00
	reporting period (if calendar year, enter 0 on this line)				
7. 00	Total swing-bed NF type inpatient days (including private ro	om days) through Decembe	r 31 of the cost	0	7.00
8. 00	reporting period Total swing-bed NF type inpatient days (including private ro	om days) after December	31 of the cost	0	8.00
3. 00	reporting period (if calendar year, enter 0 on this line)	on days) arter becember :	or the cost	U	8.00
9. 00	Total inpatient days including private room days applicable	to the Program (excluding	g swing-bed and	21, 941	9. 00
	newborn days)				
10. 00	Swing-bed SNF type inpatient days applicable to title XVIII		room days)	0	10.00
11. 00	through December 31 of the cost reporting period (see instru- Swing-bed SNF type inpatient days applicable to title XVIII		room days) after	0	11.00
11.00	December 31 of the cost reporting period (if calendar year,		days) arter	O	11.00
12. 00	Swing-bed NF type inpatient days applicable to titles V or X		te room days)	0	12.00
	through December 31 of the cost reporting period				40.00
13. 00	Swing-bed NF type inpatient days applicable to titles V or X after December 31 of the cost reporting period (if calendar)			0	13.00
14. 00	Medically necessary private room days applicable to the Prog			0	14.00
15. 00	Total nursery days (title V or XIX only)	(0	
16.00	Nursery days (title V or XIX only)			0	16.00
47.00	SWING BED ADJUSTMENT		. 6. 11 1	0.00	47.00
17. 00	Medicare rate for swing-bed SNF services applicable to service reporting period	ces through December 31 (or the cost	0. 00	17. 00
18. 00	Medicare rate for swing-bed SNF services applicable to servi	ces after December 31 of	the cost	0.00	18.00
	reporting period				
19. 00	Medicaid rate for swing-bed NF services applicable to service	es through December 31 o	f the cost	0.00	19. 00
20 00	reporting period	oo often December 21 of	the cost	0.00	20.00
20. 00	Medicaid rate for swing-bed NF services applicable to service reporting period	es arter becember 31 or	the cost	0. 00	20.00
21. 00	Total general inpatient routine service cost (see instruction	ns)		56, 049, 390	21.00
22. 00	Swing-bed cost applicable to SNF type services through December		ting period (line		1
	5 x line 17)			_	
23. 00	Swing-bed cost applicable to SNF type services after Decembe	r 31 of the cost reporti	ng period (line 6	0	23. 00
24. 00	x line 18) Swing-bed cost applicable to NF type services through Decemb	er 31 of the cost report	ing period (line	0	24.00
21.00	7 x line 19)	or or the cost report	ring perrou (rrine	· ·	21.00
25. 00	Swing-bed cost applicable to NF type services after December	31 of the cost reporting	g period (line 8	0	25. 00
	x line 20)				0, 00
26.00	Total swing-bed cost (see instructions)	(line 21 minus line 24)		0	26.00
27. 00	General inpatient routine service cost net of swing-bed cost PRIVATE ROOM DIFFERENTIAL ADJUSTMENT	(TITIE ZI III IIUS TITIE 20)		56, 049, 390	27.00
28. 00	General inpatient routine service charges (excluding swing-be	ed and observation bed c	narges)	0	28. 00
29. 00	Private room charges (excluding swing-bed charges)		- '	0	29. 00
30.00	Semi-private room charges (excluding swing-bed charges)	11 202		0	
31.00	General inpatient routine service cost/charge ratio (line 27	÷ line 28)		0.000000	
32. 00 33. 00	Average private room per diem charge (line 29 ÷ line 3) Average semi-private room per diem charge (line 30 ÷ line 4)			0. 00 0. 00	
34. 00	Average per diem private room charge differential (line 32 m	inus line 33)(see instru	ctions)	0.00	1
	Average per diem private room cost differential (line 34 x L		,		35 00

3.00	Private room days (excluding swing-bed and observation bed days). If you have only private room days,	0	3. 00
4 00	do not complete this line.	40,000	4 00
4.00	Semi-private room days (excluding swing-bed and observation bed days) Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost	43, 229	4.00
5. 00	reporting period	0	5. 00
6. 00	Total swing-bed SNF type inpatient days (including private room days) after December 31 of the cost	0	6. 00
0.00	reporting period (if calendar year, enter 0 on this line)	O	0.00
7. 00	Total swing-bed NF type inpatient days (including private room days) through December 31 of the cost	0	7. 00
7.00	reporting period	J	7.00
8. 00	Total swing-bed NF type inpatient days (including private room days) after December 31 of the cost	0	8. 00
	reporting period (if calendar year, enter 0 on this line)		
9.00	Total inpatient days including private room days applicable to the Program (excluding swing-bed and	21, 941	9. 00
	newborn days)		
10.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days)	0	10.00
	through December 31 of the cost reporting period (see instructions)		
11. 00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) after	0	11. 00
40.00	December 31 of the cost reporting period (if calendar year, enter 0 on this line)		40.00
12. 00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days)	0	12.00
12 00	through December 31 of the cost reporting period	0	13. 00
13. 00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	U	13.00
14. 00	Medically necessary private room days applicable to the Program (excluding swing-bed days)	0	14. 00
	Total nursery days (title V or XIX only)	0	15. 00
	Nursery days (title V or XIX only)	0	
10.00	SWING BED ADJUSTMENT	0	10.00
17. 00	Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost	0.00	17. 00
	reporting period		
18.00	Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost	0.00	18.00
	reporting period		
19.00	Medicaid rate for swing-bed NF services applicable to services through December 31 of the cost	0.00	19.00
	reporting period		
20.00	Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost	0. 00	20.00
	reporting period		
21. 00	Total general inpatient routine service cost (see instructions)	56, 049, 390	
22. 00	Swing-bed cost applicable to SNF type services through December 31 of the cost reporting period (line	0	22. 00
22.00	5 x line 17)	0	22.00
23. 00	Swing-bed cost applicable to SNF type services after December 31 of the cost reporting period (line 6 x line 18)	U	23. 00
24. 00	Swing-bed cost applicable to NF type services through December 31 of the cost reporting period (line	0	24. 00
24.00	7 x line 19)	O	24.00
25.00	Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8	0	25. 00
	x line 20)	_	
26.00	Total swing-bed cost (see instructions)	0	26.00
27.00	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)	56, 049, 390	27.00
	PRIVATE ROOM DIFFERENTIAL ADJUSTMENT		
	General inpatient routine service charges (excluding swing-bed and observation bed charges)	0	28. 00
	Private room charges (excluding swing-bed charges)	0	29. 00
30.00	Semi-private room charges (excluding swing-bed charges)	0	30.00
31. 00	General inpatient routine service cost/charge ratio (line 27 ÷ line 28)	0. 000000	
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)	0. 00	
	Average per diem private room charge differential (line 32 minus line 33)(see instructions)		34.00
	Average per diem private room cost differential (line 34 x line 31)		35.00
	Private room cost differential adjustment (line 3 x line 35)	0	36.00
37. 00	General inpatient routine service cost net of swing-bed cost and private room cost differential (line	56, 049, 390	37. 00
	27 minus line 36)		
	PART II - HOSPITAL AND SUBPROVIDERS ONLY DDOCDAM INDATIENT OPERATING COST RECORE DASS THROUGH COST AD HISTMENTS		
38. 00	PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS Adjusted general inpatient routine service cost per diem (see instructions)	1 025 17	38. 00
38.00	Program general inpatient routine service cost per diem (see instructions)	1, 035. 17 22, 712, 665	
	Medically necessary private room cost applicable to the Program (line 14 x line 35)	22, 712, 665	40. 00
	Total Program general inpatient routine service cost (line 39 + line 40)	22, 712, 665	
41.00	Total Trogram general Tipatrent routine service cost (Time 37 + Time 40)	22, 112, 003	71.00

Heal th	Financial Systems	UNION HOSPIT	ΓAL, ΙΝC.		In Lie	u of Form CMS-2	2552-10
COMPUT	TATION OF INPATIENT OPERATING COST		Provi der Co		Peri od: From 01/01/2018	Worksheet D-1	
					To 12/31/2018		
			_	XVIII	Hospi tal	PPS	
	Cost Center Description	Total	Total	Average Per Diem (col. 1	Program Days	Program Cost (col. 3 x	
		Inpatient Cost	Inpatient Days	÷ col. 2)		col . 4)	
		1. 00	2.00	3.00	4. 00	5. 00	
42.00	NURSERY (title V & XIX only)	0	0	0.0	0 0	0	42.00
40.00	Intensive Care Type Inpatient Hospital Units	40 550 400	. 045	1 (00 0	0 00	/ 40/ 500	40.00
43. 00 44. 00	INTENSIVE CARE UNIT CORONARY CARE UNIT	10, 559, 189	6, 215	1, 698. 9	3, 606	6, 126, 522	43. 00 44. 00
45. 00	BURN INTENSIVE CARE UNIT						45. 00
46. 00	SURGICAL INTENSIVE CARE UNIT						46.00
47. 00	I NTENSI VE NURSERY	3, 929, 556	4, 126	952. 3	9 0	0	47. 00
	Cost Center Description					1.00	
48. 00	Program inpatient ancillary service cost (Wk	st D-3 col 3	Line 200)			1. 00 35, 657, 723	48. 00
	Total Program inpatient costs (sum of lines			ons)		64, 496, 910	
50.00	PASS THROUGH COST ADJUSTMENTS Pass through costs applicable to Program input	atient routine	servi ces (fro	m Wkst. D, sur	n of Parts I and	3, 597, 572	50. 00
51. 00		ationt ancillar	ny sorvi sos (fi	rom Wkst D	sum of Dorts II	3, 301, 662	51.00
31.00	and IV)		y services (ii	TOIII WKSt. D, S	Sum of Parts II	3, 301, 002	31.00
52.00	Total Program excludable cost (sum of lines	,	Lotod -	olales sure	antint!	6, 899, 234	
53. 00	Total Program inpatient operating cost exclumedical education costs (line 49 minus line		lated, non-pny	ysician anesti	netist, and	57, 597, 676	53. 00
	TARGET AMOUNT AND LIMIT COMPUTATION	32)					
54.00	Program di scharges					0	
55. 00	Target amount per discharge					0.00	
56. 00 57. 00	Target amount (line 54 x line 55) Difference between adjusted inpatient operat	ing cost and ta	raet amount (1	line 56 minus	line 53)	0	56. 00 57. 00
58. 00	Bonus payment (see instructions)	ing cost and ta	rget amount (i	THE 50 III HUS	11116 33)		58.00
59. 00	Lesser of lines 53/54 or 55 from the cost re	porting period	endi ng 1996, เ	updated and co	ompounded by the		
	market basket		1.1.1.1.			0.00	
60. 00 61. 00	Lesser of lines 53/54 or 55 from prior year of line 53/54 is less than the lower of lines				the amount by	0.00	60. 00 61. 00
61.00	which operating costs (line 53) are less than						01.00
	amount (line 56), otherwise enter zero (see						
62.00		0					
63. 00							
64.00	PROGRAM INPATIENT ROUTINE SWING BED COST 00 Medicare swing-bed SNF inpatient routine costs through December 31 of the cost reporting period (See						
65. 00	<pre>instructions)(title XVIII only) Medicare swing-bed SNF inpatient routine cos</pre>	ts after Decemb	er 31 of the (rost renorting	neriod (See	0	65. 00
	instructions)(title XVIII only)				, , ,		
66. 00	Total Medicare swing-bed SNF inpatient routil CAH (see instructions)	ne costs (line	64 plus line (65)(title XVII	I only). For	0	66. 00
67. 00	j ,	e costs through	December 31	of the cost re	eporting period	0	67. 00
68. 00	(line 12 x line 19) Title V or XIX swing-bed NF inpatient routing	e costs after D	ecember 31 of	the cost repo	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 + line	- 68)		0	69. 00
	PART III - SKILLED NURSING FACILITY, OTHER NU	JRSING FACILITY	, AND ICF/IID	ONLY			
70.00	Skilled nursing facility/other nursing facil						70.00
71. 00 72. 00	Adjusted general inpatient routine service of		ine 70 ÷ line	2)			71.00
72.00	Program routine service cost (line 9 x line Medically necessary private room cost applications)		(line 14 x li	ine 35)			72. 00 73. 00
74. 00	Total Program general inpatient routine serv			,			74.00
75. 00	Capital-related cost allocated to inpatient	routine service	costs (from \	Worksheet B, F	Part II, column		75. 00
76. 00	26, line 45) Per diem capital-related costs (line 75 ÷ li	ne 2)					76. 00
77. 00	Program capital -related costs (line 9 x line						77. 00
	Inpatient routine service cost (line 74 minus			1.3			78.00
79. 00 80. 00	Aggregate charges to beneficiaries for excess			*.	nus lina 70)		79. 00 80. 00
80.00							
82. 00	Inpatient routine service cost limitation ()				81. 00 82. 00
83.00	Reasonable inpatient routine service costs (s)				83.00
84. 00 85. 00	Program inpatient ancillary services (see in:		ine)				84. 00 85. 00
	Utilization review - physician compensation Total Program inpatient operating costs (sum						86.00
	PART IV - COMPUTATION OF OBSERVATION BED PASS						
87.00	Total observation bed days (see instructions		6			10, 916	
88. 00 89. 00	Adjusted general inpatient routine cost per observation bed cost (line 87 x line 88) (see	•	,			1, 035. 17 11, 299, 916	
57.00	(3e)					1 . 1, 2, 7, 710	1 57.00

Health Financial Systems	UNI ON HOSPI	UNION HOSPITAL, INC.			In Lieu of Form CMS-2552-10		
COMPUTATION OF INPATIENT OPERATING COST		Provi der CO		Peri od: From 01/01/2018	Worksheet D-1		
				To 12/31/2018			
		Title	XVIII	Hospi tal	PPS		
Cost Center Description	Cost	Routine Cost	column 1 ÷	Total	Observation		
		(from line	column 2	Observati on	Bed Pass		
		21)		Bed Cost	Through Cost		
		·		(from line	(col. 3 x		
				89)	col. 4) (see		
					instructions)		
	1. 00	2.00	3. 00	4. 00	5. 00		
COMPUTATION OF OBSERVATION BED PASS THROUGH	COST						
90.00 Capital -related cost	6, 672, 262	56, 049, 390	0. 11904	3 11, 299, 916	1, 345, 176	90.00	
91.00 Nursing School cost	0	56, 049, 390	0.00000	0 11, 299, 916	0	91.00	
92.00 Allied health cost	0	56, 049, 390	0.00000	0 11, 299, 916	0	92.00	
93.00 All other Medical Education	0	56, 049, 390	0.00000	0 11, 299, 916	0	93.00	

Health Financial Systems	UNION HOSPITAL, INC.	In Lie	u of Form CMS-2552-10
COMPUTATION OF INPATIENT OPERATING COST	Provi der CCN: 15-0023	Peri od: From 01/01/2018	Worksheet D-1
	Component CCN: 15-T023		
	Title XVIII	Subprovi der -	PPS
		IRF	

		II LIE AVIII	I RF		
	Cost Center Description				
	PART I - ALL PROVIDER COMPONENTS			1. 00	
	I NPATI ENT DAYS				
1. 00	Inpatient days (including private room days and swing-bed day			3, 677	1. 00
2.00	Inpatient days (including private room days, excluding swing-			3, 677	2.00
3. 00	Private room days (excluding swing-bed and observation bed da do not complete this line.	ys). IT you have only pr	ivate room days,	0	3. 00
4.00	Semi-private room days (excluding swing-bed and observation b	ed days)		3, 677	4.00
5.00	Total swing-bed SNF type inpatient days (including private ro	om days) through Decembe	r 31 of the cost	0	5. 00
6. 00	reporting period Total swing-bed SNF type inpatient days (including private ro	om days) after December	21 of the cost	0	6. 00
6.00	reporting period (if calendar year, enter 0 on this line)	olli days) al tel becellbei	31 OF THE COST	U	0.00
7.00	Total swing-bed NF type inpatient days (including private roo	m days) through December	31 of the cost	0	7. 00
0.00	reporting period	m daya) after December 2	1 of the cost	0	0.00
8. 00	Total swing-bed NF type inpatient days (including private roo reporting period (if calendar year, enter 0 on this line)	ili days) arter beceiliber 3	i or the cost	U	8. 00
9. 00	Total inpatient days including private room days applicable t	o the Program (excluding	swing-bed and	2, 252	9. 00
40.00	newborn days)				40.00
10. 00	Swing-bed SNF type inpatient days applicable to title XVIII o through December 31 of the cost reporting period (see instruc		oom days)	0	10. 00
11. 00	Swing-bed SNF type inpatient days applicable to title XVIII o		oom days) after	0	11.00
	December 31 of the cost reporting period (if calendar year, e	nter 0 on this line)			
12. 00	Swing-bed NF type inpatient days applicable to titles V or XI	X only (including privat	e room days)	0	12.00
13. 00	through December 31 of the cost reporting period Swing-bed NF type inpatient days applicable to titles V or XI	X only (including privat	e room days)	0	13. 00
	after December 31 of the cost reporting period (if calendar y	ear, enter O on this lin	e)	-	
14.00	Medically necessary private room days applicable to the Progr	am (excluding swing-bed	days)	0	14.00
15. 00 16. 00	Total nursery days (title V or XIX only) Nursery days (title V or XIX only)			0	15. 00 16. 00
10.00	SWING BED ADJUSTMENT			0	10.00
17. 00	Medicare rate for swing-bed SNF services applicable to servic	es through December 31 o	f the cost	0.00	17. 00
10.00	reporting period		+1	0.00	10.00
18. 00	Medicare rate for swing-bed SNF services applicable to servic reporting period	es after December 31 of	the cost	0. 00	18. 00
19. 00	Medicaid rate for swing-bed NF services applicable to service	s through December 31 of	the cost	0.00	19. 00
00.00	reporting period			0.00	00.00
20. 00	Medicaid rate for swing-bed NF services applicable to service reporting period	s after December 31 of t	he cost	0. 00	20. 00
21. 00	Total general inpatient routine service cost (see instruction	s)		2, 914, 599	21.00
22. 00	Swing-bed cost applicable to SNF type services through Decemb	er 31 of the cost report	ing period (line	0	22. 00
23. 00	5 x line 17) Swing-bed cost applicable to SNF type services after December	21 of the cost reportin	a ported (line A	0	23. 00
23.00	x line 18)	31 of the cost reportin	ig period (Title 0	O	23.00
24.00	Swing-bed cost applicable to NF type services through Decembe	r 31 of the cost reporti	ng period (line	0	24.00
05.00	7 x line 19)	04 . 6 . 11			05.00
25. 00	Swing-bed cost applicable to NF type services after December x line 20)	31 of the cost reporting	period (line 8	0	25. 00
26.00	Total swing-bed cost (see instructions)			0	26.00
27. 00	General inpatient routine service cost net of swing-bed cost	(line 21 minus line 26)		2, 914, 599	27. 00
28. 00	PRIVATE ROOM DIFFERENTIAL ADJUSTMENT General inpatient routine service charges (excluding swing-be	d and observation had ch	argos)	0	28. 00
29. 00	Private room charges (excluding swing-bed charges)	d and observation bed ch	lai yes)	0	29.00
30.00	Semi -pri vate room charges (excluding swing-bed charges)			0	30.00
31.00	General inpatient routine service cost/charge ratio (line 27	÷ line 28)		0.000000	31.00
32.00	Average private room per diem charge (line 29 ÷ line 3)			0. 00	32.00
33. 00	Average semi-private room per diem charge (line 30 ÷ line 4)			0. 00	33.00
34.00	Average per diem private room charge differential (line 32 mi		tions)	0. 00	34.00
35.00	Average per diem private room cost differential (line 34 x li	ne 31)		0. 00	35.00
36.00	Private room cost differential adjustment (line 3 x line 35)			0	36. 00
37. 00	General inpatient routine service cost net of swing-bed cost	and private room cost di	fferential (line	2, 914, 599	37.00
	27 minus line 36)				
	PART II - HOSPITAL AND SUBPROVIDERS ONLY	ICTMENTS			
20 00	PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJ		Ţ	702 //	20 00
38. 00 39. 00	Adjusted general inpatient routine service cost per diem (see Program general inpatient routine service cost (line 9 x line			792.66	38. 00 39. 00
40.00	Medically necessary private room cost applicable to the Progr			1, 785, 070 0	40.00
41.00	Total Program general inpatient routine service cost (line 39			1, 785, 070	
00	,	,	ı	., . 55, 576	

	Financial Systems	UNION HOSPIT			In Lie	u of Form CMS-2	2552-10
COMPUT	TATION OF INPATIENT OPERATING COST			CN: 15-0023	Period: From 01/01/2018	Worksheet D-1	
			·	CCN: 15-T023	To 12/31/2018	5/29/2019 1:1	
			Title	e XVIII	Subprovi der - I RF	PPS	
	Cost Center Description	Total Inpatient Cost	Total Inpatient Days	Average Per Diem (col. ÷ col. 2)	Program Days	Program Cost (col. 3 x col. 4)	
		1. 00	2.00	3. 00	4.00	5. 00	
42. 00	NURSERY (title V & XIX only) Intensive Care Type Inpatient Hospital Units	0	C	0. (00 0	0	42.00
43.00	INTENSIVE CARE UNIT	0	C	0. (00 0	0	
44. 00 45. 00	CORONARY CARE UNIT BURN INTENSIVE CARE UNIT			1			44. 00 45. 00
46. 00	SURGICAL INTENSIVE CARE UNIT		_			_	46. 00
47.00	INTENSIVE NURSERY Cost Center Description	0	C	0. (00 0	0	47.00
10.00	·					1.00	40.00
48. 00 49. 00	Program inpatient ancillary service cost (Wk: Total Program inpatient costs (sum of lines			ons)		1, 112, 861 2, 897, 931	48. 00 49. 00
50. 00	PASS THROUGH COST ADJUSTMENTS Pass through costs applicable to Program inpo	ationt routing	convices (fro	m Wkst D su	m of Dorte L and	300, 822	50.00
30.00							
51. 00	Pass through costs applicable to Program inpand IV)		y services (f	rom Wkst. D,	sum of Parts II	75, 933	
52. 00 53. 00	Total Program excludable cost (sum of lines ! Total Program inpatient operating cost exclu		lated non-ph	vsician anest	hetist and	376, 755 2, 521, 176	
00.00	medical education costs (line 49 minus line		rated, non pri		noti st, una	2, 021, 170	00.00
54. 00	TARGET AMOUNT AND LIMIT COMPUTATION Program discharges					0	54.00
55. 00	Target amount per discharge						55.00
56. 00 57. 00	Target amount (line 54 x line 55) Difference between adjusted inpatient operat	ing cost and ta	rget amount (line 56 minus	line 53)	0	56. 00 57. 00
58.00 Bonus payment (see instructions)						0	58.00
59.00 Lesser of lines 53/54 or 55 from the cost reporting period ending 1996, updated and compounded by the market basket						0.00	59.00
60.00 Lesser of lines 53/54 or 55 from prior year cost report, updated by the market basket 61.00 If line 53/54 is less than the lower of lines 55, 59 or 60 enter the lesser of 50% of the amount by					0.00	1	
which operating costs (line 53) are less than expected costs (lines 54 x 60), or 1% of the target					O	01.00	
62. 00	amount (line 56), otherwise enter zero (see instructions) 62.00 Relief payment (see instructions)					0	62. 00
	Allowable Inpatient cost plus incentive payments	ent (see instru	ctions)			0	1
64. 00	PROGRAM INPATIENT ROUTINE SWING BED COST Medicare swing-bed SNF inpatient routine cost instructions) (title XVIII only)	ts through Dece	mber 31 of th	e cost report	ing period (See	0	64. 00
65. 00	, , , , , , , , , , , , , , , , , , , ,	ts after Decemb	er 31 of the	cost reportin	g period (See	0	65. 00
66. 00	Total Medicare swing-bed SNF inpatient routil CAH (see instructions)	ne costs (line	64 plus line	65)(title XVI	II only). For	0	66. 00
67. 00	Title V or XIX swing-bed NF inpatient routing (line 12 x line 19)	e costs through	December 31	of the cost r	eporting period	0	67. 00
68. 00	Title V or XIX swing-bed NF inpatient routing (line 13 x line 20)	e costs after D	ecember 31 of	the cost rep	orting period	0	68. 00
69. 00	Total title V or XIX swing-bed NF inpatient					0	69. 00
70. 00	PART III - SKILLED NURSING FACILITY, OTHER NU Skilled nursing facility/other nursing facil)		70.00
71.00	Adjusted general inpatient routine service of		ine 70 ÷ line	2)			71.00
72. 00 73. 00	Program routine service cost (line 9 x line Medically necessary private room cost applications)	•	(line 14 x l	ine 35)			72. 00 73. 00
74. 00 75. 00	Total Program general inpatient routine serv Capital-related cost allocated to inpatient			•	Dart II column		74. 00 75. 00
75.00	26, line 45)	routine service	COSTS (TIOIII	worksneet b,	rait II, cordiiii		
76. 00 77. 00	Per diem capital-related costs (line 75 ÷ li Program capital-related costs (line 9 x line						76. 00 77. 00
78.00	Inpatient routine service cost (line 74 minus	s line 77)					78. 00
79. 00 80. 00	Aggregate charges to beneficiaries for excess Total Program routine service costs for compa				nus line 79)		79. 00 80. 00
81.00	Inpatient routine service cost per diem limi	tati on		,	, i		81.00
82. 00 83. 00	Inpatient routine service cost limitation (I Reasonable inpatient routine service costs (* .				82. 00 83. 00
84.00	Program inpatient ancillary services (see in	structions)					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 PASS	S THROUGH COST	- '			^	
87. 00 88. 00	Total observation bed days (see instructions Adjusted general inpatient routine cost per	diem (line 27 ÷	line 2)				88. 00
89. 00	Observation bed cost (line 87 x line 88) (see	e instructions)				0	89. 00

Health Financial Systems	UNI ON HOSPI	TAL, INC.		In Lie	u of Form CMS-2	2552-10
COMPUTATION OF INPATIENT OPERATING COST		Provi der CO		Peri od:	Worksheet D-1	
		Component (CCN: 15-T023	From 01/01/2018 To 12/31/2018		
		Title	XVIII	Subprovi der -	PPS	
				I RF		
Cost Center Description	Cost	Routine Cost	column 1 ÷	Total	Observation	
		(from line	column 2	Observati on	Bed Pass	
		21)		Bed Cost	Through Cost	
		·		(from line	(col. 3 x	
				89)	col. 4) (see	
					instructions)	
	1. 00	2.00	3. 00	4. 00	5. 00	
COMPUTATION OF OBSERVATION BED PASS THROUGH	COST					
90.00 Capital -related cost	491, 160	2, 914, 599	0. 16851	7 0	0	90.00
91.00 Nursing School cost	0	2, 914, 599	0. 00000	0 0	0	91.00
92.00 Allied health cost	0	2, 914, 599	0. 00000	0 0	0	92.00
93.00 All other Medical Education	0	2, 914, 599	0. 00000	0 0	0	93.00

COMPU	ATION OF INPATIENT OPERATING COST	Provider CCN: 15-0023	Peri od:	Worksheet D-1	
	ATTOM ST THE ATTOM OF EIGHT NO GOOT	17677 del 664. 16 6626	From 01/01/2018 To 12/31/2018	Date/Time Pre 5/29/2019 1:1	pared:
		Title XIX	Hospi tal	Cost	
	Cost Center Description		-	1. 00	
	PART I - ALL PROVIDER COMPONENTS			1.00	
4 00	I NPATI ENT DAYS			54.445	4 00
1. 00 2. 00	Inpatient days (including private room days and swing-bed day Inpatient days (including private room days, excluding swing-			54, 145 54, 145	
3. 00	Private room days (excluding swing-bed and observation bed da		rivate room days,	0	3.00
	do not complete this line.				
4. 00 5. 00	Semi-private room days (excluding swing-bed and observation b Total swing-bed SNF type inpatient days (including private ro		er 31 of the cost	43, 229 0	
3.00	reporting period	om days) trii odgir becemb	er 31 or the cost	O	3.00
6. 00	Total swing-bed SNF type inpatient days (including private ro	om days) after December	31 of the cost	0	6.00
7. 00	reporting period (if calendar year, enter 0 on this line) Total swing-bed NF type inpatient days (including private roo	m days) through Dosombo	r 21 of the cost	0	7.00
7.00	reporting period	iii days) trii ougir beceiibe	i si di the cost	U	7.00
8. 00	Total swing-bed NF type inpatient days (including private roo	m days) after December	31 of the cost	0	8.00
9. 00	reporting period (if calendar year, enter 0 on this line)	a the Dreaman (evaluation	a cui na had and	424	0.00
9.00	Total inpatient days including private room days applicable t newborn days)	o the Program (excrudin	g swifig-bed and	624	9.00
10. 00	Swing-bed SNF type inpatient days applicable to title XVIII o	3 1	room days)	0	10.00
11 00	through December 31 of the cost reporting period (see instruc			0	11 0
11. 00	Swing-bed SNF type inpatient days applicable to title XVIII o December 31 of the cost reporting period (if calendar year, e		room days) arter	0	11.00
12. 00	Swing-bed NF type inpatient days applicable to titles V or XI		te room days)	0	12.00
	through December 31 of the cost reporting period			_	
13. 00	Swing-bed NF type inpatient days applicable to titles V or XI after December 31 of the cost reporting period (if calendar y			0	13.00
14. 00	Medically necessary private room days applicable to the Progr			0	14.00
	Total nursery days (title V or XIX only)	. 5 5	,	3, 196	
16. 00	Nursery days (title V or XIX only)			171	16.00
17. 00	SWING BED ADJUSTMENT Medicare rate for swing-bed SNF services applicable to service	es through December 31	of the cost	0. 00	17.00
	reporting period	G			
18. 00	Medicare rate for swing-bed SNF services applicable to servic	es after December 31 of	the cost	0. 00	18.00
19. 00	reporting period Medicaid rate for swing-bed NF services applicable to service	s through December 31 o	f the cost	0. 00	19.00
	reporting period	<u> </u>			
20. 00	Medicaid rate for swing-bed NF services applicable to service	s after December 31 of	the cost	0. 00	20.00
21 00	reporting period Total general inpatient routine service cost (see instruction	5)		56, 049, 390	21.00
	Swing-bed cost applicable to SNF type services through Decemb		ting period (line		1
	5 x line 17)				
23.00	Swing-bed cost applicable to SNF type services after December x line 18)	31 of the cost reporti	ng perioa (iine 6	0	23.00
24. 00	Swing-bed cost applicable to NF type services through Decembe	r 31 of the cost report	ing period (line	0	24.00
05 00	7 x line 19)	24 . 6 . 11			05.00
25. 00	Swing-bed cost applicable to NF type services after December x line 20)	31 of the cost reportin	g period (line 8	0	25.00
26. 00	Total swing-bed cost (see instructions)			0	26.00
27. 00	General inpatient routine service cost net of swing-bed cost	(line 21 minus line 26)		56, 049, 390	27.00
28 00	PRIVATE ROOM DIFFERENTIAL ADJUSTMENT General inpatient routine service charges (excluding swing-be	d and observation had c	harges)	0	28. 00
29. 00	Private room charges (excluding swing-bed charges)	a and observation bed c	riai ges)	0	ı
30. 00	Semi-private room charges (excluding swing-bed charges)			0	30.00
31.00	General inpatient routine service cost/charge ratio (line 27	÷ line 28)		0.000000	
32. 00 33. 00	Average private room per diem charge (line 29 ÷ line 3) Average semi-private room per diem charge (line 30 ÷ line 4)			0. 00 0. 00	
34. 00	Average per diem private room charge differential (line 32 mi	nus line 33)(see instru	ctions)	0.00	1
35. 00	Average per diem private room cost differential (line 34 x li		ŕ	0. 00	35.00
36.00	Private room cost differential adjustment (line 3 x line 35)	and making the control of the		0	36.00
37.00	General inpatient routine service cost net of swing-bed cost 27 minus line 36)	anu private room cost d	ıırerentıaı (line	56, 049, 390	37.00
	PART II - HOSPITAL AND SUBPROVIDERS ONLY				
	PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJ				
38 00	Adjusted general inpatient routine service cost per diem (see			1, 035. 17	38.00
	Program general inpatient routine service cost (line 9 x line	38)	ı	645, 946	30 00

645, 946

645, 946 41. 00

39.00

40.00

39.00 Program general inpatient routine service cost (line 9 x line 38)

41.00 Total Program general inpatient routine service cost (line 39 + line 40)

40.00 Medically necessary private room cost applicable to the Program (line 14 x line 35)

Heal th	Financial Systems	UNION HOSPIT	AL, INC.		In Lie	u of Form CMS-2	2552-10
	ATION OF INPATIENT OPERATING COST		Provi der CC		eri od:	Worksheet D-1	
					rom 01/01/2018 o 12/31/2018		
			Ti tl	e XIX	Hospi tal	5/29/2019 1:1 Cost	1 pm
	Cost Center Description	Total	Total	Average Per	Program Days	Program Cost	
		Inpati ent	Inpati ent	Diem (col. 1		(col. 3 x	
		1.00	<u>Days</u> 2.00	÷ col. 2) 3.00	4. 00	col. 4) 5.00	
42.00	NURSERY (title V & XIX only)	1, 679, 836	3, 196	525. 61	171	89, 879	42. 00
43. 00	Intensive Care Type Inpatient Hospital Units INTENSIVE CARE UNIT	10, 559, 189	6, 215	1, 698. 98	0	0	43.00
44. 00	CORONARY CARE UNIT	10, 559, 169	6, 215	1, 090. 90	U		44.00
45.00	BURN INTENSIVE CARE UNIT						45.00
46. 00	SURGICAL INTENSIVE CARE UNIT	2 020 554	4 124	952. 39	F-7	E4 204	46.00
47.00	INTENSIVE NURSERY Cost Center Description	3, 929, 556	4, 126	952. 39	57	54, 286	47.00
	·					1. 00	
48. 00	Program inpatient ancillary service cost (Wks			, no)		975, 818	
49.00	Total Program inpatient costs (sum of lines 4 PASS THROUGH COST ADJUSTMENTS	i through 48) (see mstructio	JIIS)		1, 765, 929	49. 00
50.00	Pass through costs applicable to Program inpa	atient routine	services (from	n Wkst. D, sum	of Parts I and	0	50.00
51. 00		stiont ancillar	v corvicos (fr	som Wkst D si	ım of Dorte II	0	51. 00
31.00	and IV)	ittent ancitra	y services (ii	OIII WKSt. D, St	um or Parts II	U	31.00
52.00	Total Program excludable cost (sum of lines 5					0	52.00
53. 00	Total Program inpatient operating cost exclude medical education costs (line 49 minus line 5		lated, non-phy	sician anesthe	etist, and	0	53.00
	TARGET AMOUNT AND LIMIT COMPUTATION)Z)					
	Program di scharges					0	
55. 00 56. 00	Target amount per discharge Target amount (line 54 x line 55)					0. 00 0	55. 00 56. 00
57. 00	Difference between adjusted inpatient operati	ng cost and ta	rget amount (I	ine 56 minus I	ine 53)	0	57.00
58. 00	Bonus payment (see instructions)				·	0	58. 00
59. 00	Lesser of lines 53/54 or 55 from the cost replanted basket	porting period	endi ng 1996, ι	updated and cor	npounded by the	0.00	59. 00
60.00		cost report, up	dated by the m	market basket		0. 00	60. 00
61. 00	If line 53/54 is less than the lower of lines	s 55, 59 or 60	enter the less	ser of 50% of		0	61.00
	which operating costs (line 53) are less than amount (line 56), otherwise enter zero (see i		s (lines 54 x	60), or 1% of	the target		
62.00	Relief payment (see instructions)	noti de ti ens)				0	62.00
63. 00	Allowable Inpatient cost plus incentive payme	ent (see instru	ctions)			0	63.00
64. 00	PROGRAM INPATIENT ROUTINE SWING BED COST Medicare swing-bed SNF inpatient routine cost	ts through Dece	mber 31 of the	e cost reporti	na period (See	0	64. 00
	instructions)(title XVIII only)	Ü		•			
65. 00	Medicare swing-bed SNF inpatient routine costinstructions)(title XVIII only)	ts after Decemb	er 31 of the c	cost reporting	peri od (See	0	65. 00
66. 00	Total Medicare swing-bed SNF inpatient routing	ne costs (line	64 plus line 6	55)(title XVIII	only). For	0	66. 00
	CAH (see instructions)					_	
67. 00	Title V or XIX swing-bed NF inpatient routine (line 12 x line 19)	e costs through	December 31 c	of the cost rep	porting period	0	67. 00
68.00	Title V or XIX swing-bed NF inpatient routing	e costs after D	ecember 31 of	the cost repor	rting period	0	68. 00
40.00	(line 13 x line 20)	couting costs (lino (7 : lino	. (0)			40.00
69. 00	Total title V or XIX swing-bed NF inpatient r PART III - SKILLED NURSING FACILITY, OTHER NU					0	69. 00
70. 00	Skilled nursing facility/other nursing facili	ty/ICF/IID rou	tine service c	cost (line 37)			70. 00
71. 00 72. 00	Adjusted general inpatient routine service co Program routine service cost (line 9 x line 7		ine 70 ÷ line	2)			71. 00 72. 00
73. 00	,		(line 14 x li	ne 35)			73.00
74.00	Total Program general inpatient routine servi	ce costs (line	72 + line 73))			74.00
75. 00	Capital-related cost allocated to inpatient r 26, line 45)	outine service	costs (from W	Vorksheet B, Pa	art II, column		75. 00
76. 00	Per diem capital-related costs (line 75 ÷ lin	ne 2)					76. 00
77. 00	Program capital-related costs (line 9 x line	•					77.00
78. 00 79. 00	Inpatient routine service cost (line 74 minus Aggregate charges to beneficiaries for excess		rovi der record	15)			78. 00 79. 00
80.00	Total Program routine service costs for compa				us line 79)		80.00
81.00	Inpatient routine service cost per diem limit		`				81.00
82. 00 83. 00	Inpatient routine service cost limitation (li Reasonable inpatient routine service costs (s						82. 00 83. 00
84. 00	Program inpatient ancillary services (see ins		-/				84. 00
85.00	Utilization review - physician compensation	•					85.00
86. 00	Total Program inpatient operating costs (sum PART IV - COMPUTATION OF OBSERVATION BED PASS		rougn 85)				86. 00
87. 00	Total observation bed days (see instructions)	1				10, 916	
88.00	Adjusted general inpatient routine cost per of	•	•			1, 035. 17	
07.00	Observation bed cost (line 87 x line 88) (see	- 1113 ti uC ti UIIS)				11, 299, 916	07.00

Health Financial Systems	UNI ON HOSPI	TAL, INC.		In Lie	u of Form CMS-2	2552-10
COMPUTATION OF INPATIENT OPERATING COST		Provi der CO		Peri od:	Worksheet D-1	
				From 01/01/2018 To 12/31/2018		
		Ti tl	e XIX	Hospi tal	Cost	
Cost Center Description	Cost	Routine Cost	column 1 ÷	Total	Observati on	
		(from line	column 2	Observati on	Bed Pass	
		21)		Bed Cost	Through Cost	
		·		(from line	(col. 3 x	
				89)	col. 4) (see	
					instructions)	
	1. 00	2.00	3. 00	4. 00	5. 00	
COMPUTATION OF OBSERVATION BED PASS THROUGH	COST					
90.00 Capital -related cost	6, 672, 262	56, 049, 390	0. 11904	3 11, 299, 916	1, 345, 176	90.00
91.00 Nursing School cost	0	56, 049, 390	0.00000	0 11, 299, 916	0	91.00
92.00 Allied health cost	0	56, 049, 390	0.00000	0 11, 299, 916	0	92.00
93.00 All other Medical Education	0	56, 049, 390	0.00000	0 11, 299, 916	l 0	93.00

	Financial Systems	UNI ON HOSPITAL,				u of Form CMS-2	
INPAII	ENT ANCILLARY SERVICE COST APPORTIONMENT	!	Provider C	CN: 15-0023	Period: From 01/01/2018	Worksheet D-3	
					To 12/31/2018	Date/Time Pre 5/29/2019 1:1	
			Titl∈	XVIII	Hospi tal	PPS	
	Cost Center Description			Ratio of Cos		I npati ent	
				To Charges	Program	Program Costs	
					Charges	(col . 1 x	
				1.00	2.00	col . 2)	
	INPATIENT ROUTINE SERVICE COST CENTERS			1.00	2. 00	3. 00	
30. 00	03000 ADULTS & PEDIATRICS				44, 752, 385		30.00
31. 00	03100 INTENSIVE CARE UNIT				13, 615, 070		31.00
35. 00	02040 I NTENSI VE NURSERY				13, 013, 070		35.00
41.00	04100 SUBPROVI DER - I RF				0		41.00
43.00	04300 NURSERY						43.00
	ANCILLARY SERVICE COST CENTERS			I.			1
50.00	05000 OPERATING ROOM			0. 1070	64 49, 227, 859	5, 270, 531	50.00
50. 01	05001 CARDI AC SURGERY			0. 4415	14 3, 198, 814	1, 412, 321	50. 01
50. 02	05002 WVSC			0. 1366	97 109, 991	15, 035	50.02
51. 00	05100 RECOVERY ROOM			0. 2776	13 1, 777, 300	493, 402	51.00
51. 02	05101 0/P TREATMENT ROOM			0. 9692			51.02
52. 00	05200 DELIVERY ROOM & LABOR ROOM			0. 3283		11, 792	
54. 00	05400 RADI OLOGY-DI AGNOSTI C			0. 2210°		1, 753, 794	
55. 00	05500 RADI OLOGY-THERAPEUTI C			0. 1814	·	161, 714	
56. 00	05600 RADI OI SOTOPE			0. 2481		104, 135	
57.00	05700 CT SCAN			0.0656		-	
58. 00 59. 00	05800 MAGNETIC RESONANCE IMAGING (MRI)			0. 1860:		220, 674	
60.00	05900 CARDI AC CATHETERI ZATI ON 06000 LABORATORY			0. 2537! 0. 1130		3, 508, 472 2, 655, 432	
62.00	06200 WHOLE BLOOD & PACKED RED BLOOD CELLS			0. 1130		578, 026	
65.00	06500 RESPIRATORY THERAPY			0. 2601		2, 558, 244	
66.00	06600 PHYSI CAL THERAPY			0. 3217!		999, 630	
66. 01	06601 PSYCHI ATRI C/PSYCHOLOGI CAL SERVI CES			0. 00000		0	66. 01
66. 02	06602 0/P PHYSI CAL THERAPY			0. 3469		0	66. 02
67. 00	06700 OCCUPATI ONAL THERAPY			0. 2398		436, 545	67.00
68. 00	06800 SPEECH PATHOLOGY			0. 3230		127, 162	68.00
59. 00	06900 ELECTROCARDI OLOGY			0. 17930		1, 316, 257	1
59. 01	06901 CARDI AC REHAB			0. 6333	67 54, 103	34, 267	69. 01
70. 00	07000 ELECTROENCEPHALOGRAPHY			0. 35698	·	338, 407	
71. 00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS			1. 90148		778, 358	
72. 00	07200 I MPL. DEV. CHARGED TO PATIENTS			0. 7372			
73. 00	07300 DRUGS CHARGED TO PATIENTS			0. 2145			
76. 00	03020 RENAL ACUTE			0. 51918	88 1, 958, 485	1, 016, 822	76.00
00 00	OUTPATIENT SERVICE COST CENTERS 09000 CLINIC			0.4404	71	0	00 00
	00000 DATIENT NUTDITION			0. 4484			

2. 376253

0. 271986

0. 093964

0. 737952

5, 344 15, 247, 369

182, 665, 664

182, 665, 664

646, 097

0 90.05

90.07

91.00

92.00

201.00

1, 453 1, 432, 704

476, 789

35, 657, 723 200. 00

90. 05 09005 PATIENT NUTRITION

91. 00 09100 EMERGENCY

09007 WOUND CLINIC

92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)

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

90.07

200.00

201. 00 202. 00

I NPATI EN	IT ANCILLARY SERVICE COST APPORTIONMENT	Provi der C		Peri od:	Worksheet D-3	
		Component		From 01/01/2018 To 12/31/2018		
		Ti tl e	× XVIII	Subprovider -	5/29/2019 1:1 PPS	ı pm
	Cost Center Description		Ratio of Cost	IRF t Inpatient	I npati ent	
	Cost Center Description		To Charges	Program	Program Costs	
			10 onal ges	Charges	(col . 1 x	
					col . 2)	
			1.00	2. 00	3. 00	
	NPATIENT ROUTINE SERVICE COST CENTERS					1
	3000 ADULTS & PEDI ATRI CS			0		30.00
	3100 I NTENSI VE CARE UNI T			0		31.00
	2040 I NTENSI VE NURSERY			0		35.00
	4100 SUBPROVI DER - I RF			2, 317, 430		41.00
	4300 NURSERY					43.00
	NCILLARY SERVICE COST CENTERS 5000 OPERATING ROOM		0. 10706	4 117, 777	12, 610	50.00
	5001 CARDI AC SURGERY		0. 10700		3, 680	
	5002 WSC		0. 13669		33	1
	5100 RECOVERY ROOM		0. 13007		1, 667	
	5101 0/P TREATMENT ROOM		0. 96927		0	
	5200 DELIVERY ROOM & LABOR ROOM		0. 32836		Ö	
	5400 RADI OLOGY-DI AGNOSTI C		0. 22101		16, 047	
	5500 RADI OLOGY-THERAPEUTI C		0. 18144		0	55.00
	5600 RADI 0I SOTOPE		0. 24816		1, 134	56.00
	5700 CT SCAN		0. 06562	60, 813	3, 991	57.00
58.00 0	5800 MAGNETIC RESONANCE IMAGING (MRI)		0. 18602	5 16, 102	2, 995	58.00
59. 00 0	5900 CARDI AC CATHETERI ZATI ON		0. 25375	0 17, 873	4, 535	
	6000 LABORATORY		0. 11301		35, 849	
	6200 WHOLE BLOOD & PACKED RED BLOOD CELLS		0. 48157		4, 134	1
	6500 RESPI RATORY THERAPY		0. 26011		69, 153	1
	6600 PHYSI CAL THERAPY		0. 32175		356, 343	1
	6601 PSYCHI ATRI C/PSYCHOLOGI CAL SERVI CES		0.00000		0	66. 01
	6602 O/P PHYSICAL THERAPY		0. 34699		0	66.02
	6700 OCCUPATIONAL THERAPY 6800 SPEECH PATHOLOGY		0. 23986		276, 951	1
	6900 ELECTROCARDI OLOGY		0. 32309 0. 17930		103, 663 12, 011	
	6901 CARDI AC REHAB		0. 17430		12,011	1
	7000 ELECTROENCEPHALOGRAPHY		0. 35698		7, 977	1
	7100 MEDICAL SUPPLIES CHARGED TO PATIENTS		1. 90148		3, 484	
	7200 IMPL. DEV. CHARGED TO PATIENTS		0. 73727	·	0, 101	72.00
	7300 DRUGS CHARGED TO PATIENTS		0. 21453		95, 906	
	3020 RENAL ACUTE		0. 51918	·	89, 922	
	UTPATIENT SERVICE COST CENTERS				·	1
90.00	9000 CLI NI C		0. 44847	1 0	0	90.00
	9005 PATIENT NUTRITION		2. 37625		0	
	9007 WOUND CLINIC		0. 27198		0	
	9100 EMERGENCY		0. 09396		1, 842	
	9200 OBSERVATION BEDS (NON-DISTINCT PART)		0. 73795		8, 934	
200.00	Total (sum of lines 50 through 94 and 96 through 98)			4, 222, 023	1, 112, 861	
201.00	Less PBP Clinic Laboratory Services-Program only charges	(line 61)		0		201.00
202.00	Net charges (line 200 minus line 201)		1	4, 222, 023		202.00

Health Financial Systems	UNION HOSPITAL, IN	IC.	In Lie	u of Form CMS-2	2552-10
INPATIENT ANCILLARY SERVICE COST APPORTIONMENT	Pro	vider CCN: 15-0023	Peri od: From 01/01/2018	Worksheet D-3	
			To 12/31/2018	Date/Time Pre 5/29/2019 1:1	
		Title XIX	Hospi tal	Cost	
Cost Center Description		Ratio of Co	st Inpatient	I npati ent	
		To Charge	s Program	Program Costs	
			Charges	(col . 1 x	

	Ti tl	e XIX	Hospi tal	Cost	
Cost Center Descripti	on	Ratio of Cost	I npati ent	I npati ent	
		To Charges	Program	Program Costs	
			Charges	(col. 1 x	
				col. 2)	
		1.00	2. 00	3. 00	
INPATIENT ROUTINE SERVICE	COST CENTERS				
30. 00 03000 ADULTS & PEDIATRICS			993, 938		30.00
31.00 03100 INTENSIVE CARE UNIT			277, 739		31.00
35.00 02040 INTENSIVE NURSERY			0		35.00
41. 00 04100 SUBPROVI DER - I RF			63, 040		41.00
43. 00 04300 NURSERY			853, 992		43.00
ANCILLARY SERVICE COST CEN	TERS		·	<u>'</u>	
50. 00 05000 OPERATING ROOM		0. 106845	574, 829	61, 418	50.00
50. 01 05001 CARDI AC SURGERY		0. 441514	. 0	0	50. 01
50. 02 05002 WVSC		0. 136697	0	0	50.02
51.00 05100 RECOVERY ROOM		0. 277613	21, 947	6, 093	1
51. 02 05101 0/P TREATMENT ROOM		0. 969271	0	0	51.02
52. 00 05200 DELI VERY ROOM & LABOI	ROOM	0. 328363	163, 502	-	
54. 00 05400 RADI OLOGY-DI AGNOSTI C		0. 220967	105, 851	23, 390	54.00
55. 00 05500 RADI OLOGY-THERAPEUTI (0. 181449	8, 323		1
56. 00 05600 RADI OI SOTOPE	,	0. 248165	11, 710		
57. 00 05700 CT SCAN		0. 065626	128, 640		57.00
58. 00 05800 MAGNETIC RESONANCE 1	MAGING (MRI)	0. 186025	25, 663		58.00
59. 00 05900 CARDI AC CATHETERI ZATI	ON CMICL)	0. 253750	71, 677		1
60. 00 06000 LABORATORY	ON	0. 111107	527, 179		60.00
62. 00 06200 WHOLE BLOOD & PACKED	PED BLOOD CELLS	0. 481576	26, 318		62.00
65. 00 06500 RESPIRATORY THERAPY	KED DEGOD GEEES	0. 260111	129, 034		1
66. 00 06600 PHYSI CAL THERAPY		0. 321750	61, 887	19, 912	66.00
66. 01 06601 PSYCHI ATRI C/PSYCHOLOG	CLONE SEDVICES	0. 000000	01,007	17, 712	66. 01
66. 02 06602 0/P PHYSICAL THERAPY	STOAL SERVICES	0. 346996	0	0	66.02
67. 00 06700 OCCUPATIONAL THERAPY		0. 239869	55, 496	1	
					1
68. 00 06800 SPEECH PATHOLOGY 69. 00 06900 ELECTROCARDI OLOGY		0. 323096 0. 179303	12, 855 118, 669		68. 00 69. 00
			•		1
	IV.	0. 633367	1, 892		
70. 00 07000 ELECTROENCEPHALOGRAPI		0. 356986	29, 725		•
71.00 07100 MEDI CAL SUPPLI ES CHAI 72.00 07200 MPL. DEV. CHARGED TO		1. 901487	184, 247		
		0. 737272	44, 437		72.00
73. 00 07300 DRUGS CHARGED TO PATI	ENIS	0. 214538	899, 340		73.00
76. 00 03020 RENAL ACUTE	NITEDO	0. 519188	32, 164	16, 699	76. 00
OUTPATIENT SERVICE COST CE	NIERS				
90. 00 09000 CLINIC		0. 448471	0	0	90.00
90. 05 09005 PATI ENT NUTRI TI ON		2. 364269	0	_	90.05
90. 07 09007 WOUND CLINIC		0. 271986	109		
91. 00 09100 EMERGENCY		0. 093964	291, 150		1
92. 00 09200 OBSERVATION BEDS (NOI		0. 737952	0	0	92.00
1 1	50 through 94 and 96 through 98)		3, 526, 644	975, 818	1
1 1	ratory Services-Program only charges (line 61)		0		201. 00
202.00 Net charges (line 200) minus line 201)		3, 526, 644		202. 00

Health Financial Systems	UNION HOSPITAL, INC.	In Lieu	u of Form CMS-2552-10
CALCULATION OF REIMBURSEMENT SETTLEMENT	Provi der CCN: 15-0023		Date/Time Prepared:
	T: +1 - W/// I	11: +-1	5/29/2019 1: 11 pm

		T' 11		5/29/2019 1: 1 PPS	1 pm		
	Title XVIII Hospital						
		1. 00					
1 00	PART A - INPATIENT HOSPITAL SERVICES UNDER IPPS			0	1 00		
1. 00 1. 01	DRG Amounts Other than Outlier Payments DRG amounts other than outlier payments for discharges occurri instructions)	0 43, 768, 588	1. 00 1. 01				
1. 02	DRG amounts other than outlier payments for discharges occurriinstructions)	14, 112, 945	1. 02				
1. 03	DRG for federal specific operating payment for Model 4 BPCI for 1 (see instructions)	0	1. 03				
1. 04	DRG for federal specific operating payment for Model 4 BPCI fo October 1 (see instructions)	0	1. 04				
2. 00 2. 01	Outlier payments for discharges. (see instructions) Outlier reconciliation amount			315, 848 0	2. 00 2. 01		
2. 02	Outlier payment for discharges for Model 4 BPCI (see instructi	ons)		0	2. 02		
3.00	Managed Care Simulated Payments			7, 986, 408	3.00		
4. 00	Bed days available divided by number of days in the cost repor Indirect Medical Education Adjustment			202. 08			
5. 00	FTE count for allopathic and osteopathic programs for the most or before 12/31/1996. (see instructions)				5.00		
6. 00	FTE count for allopathic and osteopathic programs that meet the new programs in accordance with 42 CFR 413.79(e)			0.00	6.00		
7. 00 7. 01	MMA Section 422 reduction amount to the IME cap as specified ι ACA § 5503 reduction amount to the IME cap as specified under			0. 00 0. 00	7. 00 7. 01		
8. 00	cost report straddles July 1, 2011 then see instructions. Adjustment (increase or decrease) to the FTE count for allopat affiliated programs in accordance with 42 CFR 413.75(b), 413.71998), and 67 FR 50069 (August 1, 2002).	0. 00	8.00				
8. 01	The amount of increase if the hospital was awarded FTE cap slope report straddles July 1, 2011, see instructions.	0. 00	8. 01				
8. 02	The amount of increase if the hospital was awarded FTE cap slounder § 5506 of ACA. (see instructions)	0. 00	8. 02				
9. 00	Sum of lines 5 plus 6 minus lines (7 and 7.01) plus/minus line instructions)	es (8, 8,01 and 8,02) (see	12. 22	9. 00		
11.00	FTE count for allopathic and osteopathic programs in the curreFTE count for residents in dental and podiatric programs.	0. 00	10.00 11.00				
12.00	Current year allowable FTE (see instructions)			12. 22 12. 22	•		
14. 00	Total allowable FTE count for the prior year. Total allowable FTE count for the penultimate year if that year otherwise enter zero.	ar ended on or after Sep	tember 30, 1997,	12. 22	•		
15.00	Sum of lines 12 through 14 divided by 3.			12. 22	15.00		
	Adjustment for residents in initial years of the program				16.00		
	Adjustment for residents displaced by program or hospital clos	sure			17.00		
	Adjusted rolling average FTE count Current year resident to bed ratio (line 18 divided by line 4)			12. 22 0. 060471	1		
	Prior year resident to bed ratio (rine to divided by fine 4)	<i>)</i> .		0. 059528	1		
	Enter the lesser of lines 19 or 20 (see instructions)			0. 059528	1		
22.00	IME payment adjustment (see instructions)	1, 851, 514	22. 00				
22. 01	IME payment adjustment - Managed Care (see instructions)			255, 469	22. 01		
23. 00	Indirect Medical Education Adjustment for the Add-on for § 422 Number of additional allopathic and osteopathic IME FTE reside		FR 412. 105	8. 45	23. 00		
24. 00	(f)(1)(iv)(C). IME FTE Resident Count Over Cap (see instructions)			8. 78	24.00		
	If the amount on line 24 is greater than -0-, then enter the linstructions)	8. 45	1				
26. 00	Resident to bed ratio (divide line 25 by line 4)			0. 041815	26. 00		
	IME payments adjustment factor. (see instructions)			0. 011041	1		
28.00	IME add-on adjustment amount (see instructions)	639, 070	28. 00				
28. 01	IME add-on adjustment amount - Managed Care (see instructions)	88, 178	28. 01				
29. 00 29. 01	Total IME payment (sum of lines 22 and 28) Total IME payment - Managed Care (sum of lines 22.01 and 28.01	2, 490, 584 343, 647	1				
20.00	Disproportionate Share Adjustment	At and dame (Constitution	±!>	4.01	20.00		
	Percentage of SSI recipient patient days to Medicare Part A pa	atient days (see instruc	tions)	4. 96	•		
	Percentage of Medicaid patient days (see instructions) Sum of lines 30 and 31			23. 62 28. 58	1		
	Allowable disproportionate share percentage (see instructions))		12. 79	1		
	Disproportionate share adjustment (see instructions)	•		1, 850, 763	1		
			'	,			

Prior 01/01/2018 Part To 10/13/12018 P	/Time Prep /2019 1:1 PPS	pared:
Title XVIII Hospital	/Ti me Prep /2019 1: 1 PPS ter 10/1 2. 00 2, 872, 447 000437490	pared:
Uncompensated Care Adjustment District	PPS fter 10/1 2.00 2,872,447 000437490	1 nm
Uncompensated Care Adjustment Uncompensated Care Adjustment 1.00	ter 10/1 2.00 2,872,447 000437490	Ι μιι
Uncompensated Care Adjustment 1.00	2, 872, 447 000437490	
5. 00 Total uncompensated care amount (see instructions) 6.766, 695, 164 8.2	000437490	
35.02 Hospital uncompensated care payment (If line 34 is zero, enter zero on this line) (see instructions) 35.02 Hospital uncompensated care payment amount (see instructions) 36.03 Pro rata share of the hospital uncompensated care payment amount (see instructions) 37.03 Pro rata share of the hospital uncompensated care payment amount (see instructions) 38.03 Pro rata share of the hospital uncompensated care payment amount (see instructions) 38.03 Pro rata share of the hospital uncompensated care payment amount (see instructions) 38.03 Pro rata share of the hospital uncompensated care payment amount (see instructions) 38.04 Divide Line discharges on Worksheet S-3, Part I excluding discharges (lines 40 through 46) 40.00 Total ESRD Medicare discharges excluding MS-DRGs 652, 682, 683, 684 an 685. (see instructions) 41.00 Total ESRD Medicare covered and paid discharges excluding MS-DRGs 652, 682, 683, 684 an 685. (see instructions) 42.00 Divide Line 41 by Line 40 (if less than 10%, you do not qualify for adjustment) 42.00 Divide Line 41 by Line 40 (if less than 10%, you do not qualify for adjustment) 43.00 Total Medicare ESRD inpatient days excluding MS-DRGs 652, 682, 683, 684 an 685. (see instructions) 44.00 Ratio of average length of stay to one week (line 43 divided by line 41 divided by 7 days) 45.00 Average weekly cost for dialysis treatments (see instructions) 46.00 Total additional payment (line 45 times line 44 times line 41.01) 47.00 Subtotal (see instructions) 48.00 Total payment for inpatient program capital (from Wkst. L. Pt. III, see instructions) 49.00 Total payment for inpatient program capital (from Wkst. L. Pt. III, see instructions) 50.00 Payment for inpatient program capital (from Wkst. L. Pt. III, see instructions) 50.00 Exception payment for inpatient program capital (from Wkst. L. Pt. III, col. 1, line 69) 65.00 Cost of physicians' services in a teaching hospital (see intructions) 65.00 Cost of physicians' services in a teaching hospital (see intructions) 65.00 Cost of physicians' services in a	000437490	25 00
33, 309, 699 instructions 3, 309, 735 instructions 3, 309, 699 instructions 45, 262, 682, 683, 684 instructions 46, 200 instructions 47, 200, 200, 200, 200, 200, 200, 200, 20	1	35. 00 35. 01
35. 03 Pro rata share of the hospital uncompensated care payment amount (see instructions) 2, 475, 473 3, 387, 735 Additional payment for high percentage of ESRD beneficiary discharges (lines 40 through 46)		•
Additional payment for high percentage of ESRD beneficiary of Scharges (lines 40 through 46)	912, 262	35. 03
40. 00 Total Medicare discharges on Worksheet S-3, Part I excluding discharges for MS-DRGS 652, 682, 683, 684 and 685 (see instructions) 10 Total ESRD Medicare discharges excluding MS-DRGS 652, 682, 683, 684 an 685. (see instructions) 11 Total ESRD Medicare covered and paid discharges excluding MS-DRGS 652, 682, 683, 684 and 685. (see instructions) 12 Total ESRD Medicare covered and paid discharges excluding MS-DRGS 652, 682, 683, 684 and 685. (see instructions) 13 Total ESRD Medicare covered and paid discharges excluding MS-DRGS 652, 682, 683, 684 and 685. (see instructions) 14 Total ESRD Medicare ESRD inpatient days excluding MS-DRGS 652, 682, 683, 684 and 685. (see instructions) 15 Total Medicare ESRD inpatient days excluding MS-DRGS 652, 682, 683, 684 and 685. (see instructions) 15 Total Medicare ESRD inpatient days excluding MS-DRGS 652, 682, 683, 684 and 685. (see instructions) 15 Total Medicare ESRD inpatient days excluding MS-DRGS 652, 682, 683, 684 and 685. (see instructions) 15 Total Additional payment (state the sea instructions) 15 Total additional payment (state the sea instructions) 16 Total additional payment (state the sea instructions) 17 Total ESRD Medicare ESRD inpatient operating costs (see instructions) 18 Total payment for inpatient operating costs (see instructions) 19 Total payment for inpatient operating costs (see instructions) 10 Exception payment for inpatient operating costs (see instructions) 10 Exception payment for inpatient operating costs (see instructions) 10 Exception payment for inpatient operating costs (see instructions) 10 Exception payment for inpatient operating costs (see instructions) 11 Estal Es	712, 202	36. 00
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Payment for inpatient program capital (from Wkst. L, Pt. I and Pt. II, as applicable) Exception payment for inpatient program capital (Wkst. L, Pt. III, see instructions) Direct graduate medical education payment (from Wkst. E-4, line 49 see instructions). Nursing and Allied Health Managed Care payment Special add-on payments for new technologies Islet isolation add-on payment Special add-on payment (See instructions). Net organ acquisition cost (Wkst. D-4 Pt. III, col. 1, line 69) Cost of physicians' services in a teaching hospital (see intructions) Routine service other pass through costs (from Wkst. D, Pt. III, column 9, lines 30 through 35). Ancillary service other pass through costs from Wkst. D, Pt. IV, col. 11 line 200) Total (sum of amounts on lines 49 through 58) Primary payer payments Total amount payable for program beneficiaries (line 59 minus line 60) Deductibles billed to program beneficiaries Coinsurance billed to program beneficiaries Allowable bad debts (see instructions) Allowable bad debts (see instructions) Allowable bad debts for dual eligible beneficiaries (see instructions) Allowable bad debts for dual eligible beneficiaries (see instructions) Credits received from manufacturers for replaced devices for applicable to MS-DRGs (see instructions) Outlier payments reconciliation (sum of lines 93, 95 and 96). (For SCH see instructions) OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	nount 1.00	
Payment for inpatient program capital (from Wkst. L, Pt. I and Pt. II, as applicable) Exception payment for inpatient program capital (Wkst. L, Pt. III, see instructions) Direct graduate medical education payment (from Wkst. E-4, line 49 see instructions). Nursing and Allied Health Managed Care payment Special add-on payments for new technologies Islet isolation add-on payment Special add-on payment (See instructions). Net organ acquisition cost (Wkst. D-4 Pt. III, col. 1, line 69) Cost of physicians' services in a teaching hospital (see intructions) Routine service other pass through costs (from Wkst. D, Pt. III, column 9, lines 30 through 35). Ancillary service other pass through costs from Wkst. D, Pt. IV, col. 11 line 200) Total (sum of amounts on lines 49 through 58) Primary payer payments Total amount payable for program beneficiaries (line 59 minus line 60) Deductibles billed to program beneficiaries Coinsurance billed to program beneficiaries Allowable bad debts (see instructions) Allowable bad debts (see instructions) Allowable bad debts for dual eligible beneficiaries (see instructions) Allowable bad debts for dual eligible beneficiaries (see instructions) Credits received from manufacturers for replaced devices for applicable to MS-DRGs (see instructions) Outlier payments reconciliation (sum of lines 93, 95 and 96). (For SCH see instructions) OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	5, 270, 110	49. 00
52.00 Direct graduate medical education payment (from Wkst. E-4, line 49 see instructions). 53.00 Nursing and Allied Health Managed Care payment 54.00 Special add-on payments for new technologies 54.01 Islet isolation add-on payment 55.00 Net organ acquisition cost (Wkst. D-4 Pt. III, col. 1, line 69) 56.00 Cost of physicians' services in a teaching hospital (see intructions) 67.00 Routine service other pass through costs (from Wkst. D, Pt. III, column 9, lines 30 through 35). 68.00 Ancillary service other pass through costs from Wkst. D, Pt. IV, col. 11 line 200) 69.00 Total (sum of amounts on lines 49 through 58) 60.00 Primary payer payments 61.00 Total amount payable for program beneficiaries (line 59 minus line 60) 62.00 Deductibles billed to program beneficiaries 63.00 Coinsurance billed to program beneficiaries 64.00 Allowable bad debts (see instructions) 65.00 Adjusted reimbursable bad debts (see instructions) 66.00 Allowable bad debts for dual eligible beneficiaries (see instructions) 67.00 Subtotal (line 61 plus line 65 minus lines 62 and 63) 68.00 Credits received from manufacturers for replaced devices for applicable to MS-DRGs (see instructions) 69.00 Outlier payments reconciliation (sum of lines 93, 95 and 96). (For SCH see instructions) 70.00 OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	5, 248, 058	
Nursing and Allied Health Managed Care payment Special add-on payments for new technologies Islet isolation add-on payment Source of physicians' services in a teaching hospital (see intructions) Routine service other pass through costs (from Wkst. D, Pt. III, col. 11 line 200) Routine service other pass through costs from Wkst. D, Pt. IV, col. 11 line 200) Total (sum of amounts on lines 49 through 58) Primary payer payments Total amount payable for program beneficiaries (line 59 minus line 60) Deductibles billed to program beneficiaries Coinsurance billed to program beneficiaries Allowable bad debts (see instructions) Allowable bad debts for dual eligible beneficiaries (see instructions) Allowable bad debts for dual eligible beneficiaries (see instructions) Credits received from manufacturers for replaced devices for applicable to MS-DRGs (see instructions) Outlier payments reconciliation (sum of lines 93, 95 and 96). (For SCH see instructions)	0 666, 530	51. 00 52. 00
Islet isolation add-on payment 55.00 Net organ acquisition cost (Wkst. D-4 Pt. III, col. 1, line 69) 56.00 Cost of physicians' services in a teaching hospital (see intructions) 75.00 Routine service other pass through costs (from Wkst. D, Pt. III, column 9, lines 30 through 35). 75.00 Ancillary service other pass through costs from Wkst. D, Pt. IV, col. 11 line 200) 75.00 Total (sum of amounts on lines 49 through 58) 75.00 Primary payer payments 75.00 Deductibles billed to program beneficiaries (line 59 minus line 60) 75.00 Deductibles billed to program beneficiaries 75.00 Deductibles billed to program beneficiaries 75.00 Adjusted reimbursable bad debts (see instructions) 75.00 Allowable bad debts for dual eligible beneficiaries (see instructions) 76.00 Credits received from manufacturers for replaced devices for applicable to MS-DRGs (see instructions) 76.00 OUTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	15, 313	53.00
Net organ acquisition cost (Wkst. D-4 Pt. III, col. 1, line 69) 56.00 Cost of physicians' services in a teaching hospital (see intructions) Routine service other pass through costs (from Wkst. D, Pt. III, column 9, lines 30 through 35). 8.00 Ancillary service other pass through costs from Wkst. D, Pt. IV, col. 11 line 200) 70 Total (sum of amounts on lines 49 through 58) 60.00 Primary payer payments 70 Total amount payable for program beneficiaries (line 59 minus line 60) 80 Deductibles billed to program beneficiaries 70 Coinsurance billed to program beneficiaries 81 Deductibles bad debts (see instructions) 82 Allowable bad debts (see instructions) 83 Allowable bad debts for dual eligible beneficiaries (see instructions) 84 Deductibles debts for dual eligible beneficiaries (see instructions) 85 Deductibles debts for dual eligible beneficiaries (see instructions) 86 Deductibles debts for dual eligible beneficiaries (see instructions) 87 Deductibles debts for dual eligible beneficiaries (see instructions) 88 Deductibles bad debts for dual eligible beneficiaries (see instructions) 89 Deductibles billed to program beneficiaries (see instructions) 80 Deductibles billed to program beneficiaries 80 Deductibles billed to program beneficiaries 81 Deductibles billed to program beneficiaries 81 Deductibles billed to program beneficiaries 82 Deductibles billed to program beneficiaries 83 Deductibles billed to program beneficiaries 84 Deductibles billed to program beneficiaries 85 Deductibles billed to program beneficiaries 86 Deductibles billed to program beneficiaries 87 Deductibles billed to program beneficiaries 87 Deductibles billed to program beneficiaries 87 Deductibles billed to program beneficiaries 88 Deductibles billed to program beneficiaries 98 Deductibles billed to program beneficiaries 99	0	54.00
Cost of physicians' services in a teaching hospital (see intructions) Routine service other pass through costs (from Wkst. D, Pt. III, column 9, lines 30 through 35). Ancillary service other pass through costs from Wkst. D, Pt. IV, col. 11 line 200) Total (sum of amounts on lines 49 through 58) Color Primary payer payments Total amount payable for program beneficiaries (line 59 minus line 60) Deductibles billed to program beneficiaries Coinsurance billed to program beneficiaries Allowable bad debts (see instructions) Adjusted reimbursable bad debts (see instructions) Allowable bad debts for dual eligible beneficiaries (see instructions) Allowable bad debts for dual eligible beneficiaries (see instructions) Credits received from manufacturers for replaced devices for applicable to MS-DRGs (see instructions) Outlier payments reconciliation (sum of lines 93, 95 and 96). (For SCH see instructions) Total (sum of amounts and through 35). Total (sum of lines 30 through 35). Total (sum of lines 40 through 35). Total (sum of lines 30 through 35). Total (sum of lines 30 through 35). Total (sum of lines 40 th	0	54.01
Routine service other pass through costs (from Wkst. D, Pt. III, column 9, lines 30 through 35). 8.00 Ancillary service other pass through costs from Wkst. D, Pt. IV, col. 11 line 200) 759.00 Total (sum of amounts on lines 49 through 58) 8.00 Primary payer payments 8.10 Total amount payable for program beneficiaries (line 59 minus line 60) 8.20 Deductibles billed to program beneficiaries 8.30 Coinsurance billed to program beneficiaries 8.40 Allowable bad debts (see instructions) 8.50 Adjusted reimbursable bad debts (see instructions) 8.60 Allowable bad debts for dual eligible beneficiaries (see instructions) 8.70 Credits received from manufacturers for replaced devices for applicable to MS-DRGs (see instructions) 9.70 OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	0	55. 00 56. 00
Total (sum of amounts on lines 49 through 58) 60.00 Primary payer payments Total amount payable for program beneficiaries (line 59 minus line 60) Deductibles billed to program beneficiaries Coinsurance billed to program beneficiaries Allowable bad debts (see instructions) Adjusted reimbursable bad debts (see instructions) Allowable bad debts for dual eligible beneficiaries (see instructions) Allowable bad debts for dual eligible beneficiaries (see instructions) Coedits received from manufacturers for replaced devices for applicable to MS-DRGs (see instructions) Utilier payments reconciliation (sum of lines 93, 95 and 96). (For SCH see instructions) Total (sum of amounts on lines 49 through 58)	Ö	57.00
60.00 Primary payer payments 61.00 Total amount payable for program beneficiaries (line 59 minus line 60) 62.00 Deductibles billed to program beneficiaries 63.00 Coinsurance billed to program beneficiaries 64.00 Allowable bad debts (see instructions) 65.00 Adjusted reimbursable bad debts (see instructions) 66.00 Allowable bad debts for dual eligible beneficiaries (see instructions) 67.00 Subtotal (line 61 plus line 65 minus lines 62 and 63) 68.00 Credits received from manufacturers for replaced devices for applicable to MS-DRGs (see instructions) 69.00 Outlier payments reconciliation (sum of lines 93, 95 and 96). (For SCH see instructions) 70.00 OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	81, 403	58. 00
61.00 Total amount payable for program beneficiaries (line 59 minus line 60) 62.00 Deductibles billed to program beneficiaries 63.00 Coinsurance billed to program beneficiaries 64.00 Allowable bad debts (see instructions) 65.00 Adjusted reimbursable bad debts (see instructions) 66.00 Allowable bad debts for dual eligible beneficiaries (see instructions) 67.00 Subtotal (line 61 plus line 65 minus lines 62 and 63) 68.00 Credits received from manufacturers for replaced devices for applicable to MS-DRGs (see instructions) 69.00 Outlier payments reconciliation (sum of lines 93, 95 and 96). (For SCH see instructions) 70.00 OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	2, 281, 414	59.00
62.00 Deductibles billed to program beneficiaries 63.00 Coinsurance billed to program beneficiaries 64.00 Allowable bad debts (see instructions) 65.00 Adjusted reimbursable bad debts (see instructions) 66.00 Allowable bad debts for dual eligible beneficiaries (see instructions) 67.00 Subtotal (line 61 plus line 65 minus lines 62 and 63) 68.00 Credits received from manufacturers for replaced devices for applicable to MS-DRGs (see instructions) 69.00 Outlier payments reconciliation (sum of lines 93, 95 and 96). (For SCH see instructions) 70.00 OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	122, 427 2, 158, 987	60. 00 61. 00
63.00 Coinsurance billed to program beneficiaries 64.00 Allowable bad debts (see instructions) 65.00 Adjusted reimbursable bad debts (see instructions) 66.00 Allowable bad debts for dual eligible beneficiaries (see instructions) 67.00 Subtotal (line 61 plus line 65 minus lines 62 and 63) 68.00 Credits received from manufacturers for replaced devices for applicable to MS-DRGs (see instructions) 69.00 Outlier payments reconciliation (sum of lines 93, 95 and 96). (For SCH see instructions) 70.00 OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	5, 662, 764	62.00
64.00 Allowable bad debts (see instructions) 65.00 Adjusted reimbursable bad debts (see instructions) 66.00 Allowable bad debts for dual eligible beneficiaries (see instructions) 67.00 Subtotal (line 61 plus line 65 minus lines 62 and 63) 68.00 Credits received from manufacturers for replaced devices for applicable to MS-DRGs (see instructions) 69.00 Outlier payments reconciliation (sum of lines 93, 95 and 96). (For SCH see instructions) 70.00 OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	52, 565	
65.00 Adjusted reimbursable bad debts (see instructions) 66.00 Allowable bad debts for dual eligible beneficiaries (see instructions) 67.00 Subtotal (line 61 plus line 65 minus lines 62 and 63) 68.00 Credits received from manufacturers for replaced devices for applicable to MS-DRGs (see instructions) 69.00 Outlier payments reconciliation (sum of lines 93, 95 and 96). (For SCH see instructions) 70.00 OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	669, 856	
67.00 Subtotal (line 61 plus line 65 minus lines 62 and 63) 68.00 Credits received from manufacturers for replaced devices for applicable to MS-DRGs (see instructions) 69.00 Outlier payments reconciliation (sum of lines 93, 95 and 96). (For SCH see instructions) 70.00 OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	435, 406	65.00
68.00 Credits received from manufacturers for replaced devices for applicable to MS-DRGs (see instructions) 69.00 Outlier payments reconciliation (sum of lines 93, 95 and 96). (For SCH see instructions) 70.00 OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)		66. 00
69.00 Outlier payments reconciliation (sum of lines 93, 95 and 96). (For SCH see instructions) 70.00 OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	215, 406	67.00
70.00 OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	5, 879, 064	68.00
, , , ,	5, 879, 064 497	69.00
70. 30 Nurai Community Hospital Demonstration Froject (3410A Demonstration) aujustment (See Instructions)	5, 879, 064 497 0	70.00
70.87 Demonstration payment adjustment amount before sequestration	6, 879, 064 497 0 0	70. 50 70. 87
70. 88 SCH or MDH volume decrease adjustment (contractor use only)	5, 879, 064 497 0 0	1
70. 89 Pioneer ACO demonstration payment adjustment amount (see instructions)	5, 879, 064 497 0 0 0 0	l 70 88
70.90 HSP bonus payment HVBP adjustment amount (see instructions)	5, 879, 064 497 0 0	70. 88 70. 89
70.91 HSP bonus payment HRR adjustment amount (see instructions)	5, 879, 064 497 0 0 0 0	
70.92 Bundled Model 1 discount amount (see instructions)	5, 879, 064 497 0 0 0 0	70. 89
70.93 HVBP payment adjustment amount (see instructions)	6, 879, 064 497 0 0 0 0 0 0	70. 89 70. 90 70. 91 70. 92
70.94 HRR adjustment amount (see instructions)	6, 879, 064 497 0 0 0 0 0 0 0 0 0 39, 932	70. 89 70. 90 70. 91 70. 92 70. 93
70.95 Recovery of accelerated depreciation	6, 879, 064 497 0 0 0 0 0 0 0 0 0 39, 932 -162, 209	70. 89 70. 90 70. 91 70. 92 70. 93

ealth Financial Systems UNION HOSPITA CALCULATION OF REIMBURSEMENT SETTLEMENT	Provi der CCN: 15-0023		Peri od: From 01/01/2018 To 12/31/2018	Date/Time Pre 5/29/2019 1:1	
	Title	XVIII	Hospi tal	PPS	
		FFY	(уууу)	Amount	
70.96 Low volume adjustment for federal fiscal year (yyyy) (Enter	in column 0		0	1. 00	70. 96
the corresponding federal year for the period prior to 10/1)	TH COLUMN O		0	U	70.90
20.97 Low volume adjustment for federal fiscal year (yyyy) (Enter the corresponding federal year for the period ending on or a			0	0	70. 97
70.98 Low Volume Payment-3	110/1)			0	70. 98
70.99 HAC adjustment amount (see instructions)				0	70. 99
71.00 Amount due provider (line 67 minus lines 68 plus/minus lines	69 & 70)			66, 756, 290	71.00
71.01 Sequestration adjustment (see instructions)				1, 335, 126	71.0
11.02 Demonstration payment adjustment amount after sequestration				0	
72.00 Interim payments				64, 857, 646	
73.00 Tentative settlement (for contractor use only)	00 70			0	73.00
74.00 Balance due provider/program (line 71 minus lines 71.01, 71. 73)				563, 518	
75.00 Protested amounts (nonallowable cost report items) in accord CMS Pub. 15-2, chapter 1, §115.2	ance with			1, 097, 926	75.00
TO BE COMPLETED BY CONTRACTOR (Lines 90 through 96)					
90.00 Operating outlier amount from Wkst. E, Pt. A, line 2, or sum	of 2.03			0	90.00
plus 2.04 (see instructions) 21.00 Capital outlier from Wkst. L, Pt. I, line 2				0	91.00
21.00 Capital outlier from Wkst. L, Pt. I, line 2 22.00 Operating outlier reconciliation adjustment amount (see inst	ructions)			0	92.00
23.00 Capital outlier reconciliation adjustment amount (see instru				0	93.0
14.00 The rate used to calculate the time value of money (see institution)				0. 00	
75.00 Time value of money for operating expenses (see instructions	0.00				
06.00 Time value of money for capital related expenses (see instru	•			0	96.00
	· · · · · · · · · · · · · · · · · · ·		Prior to 10/1		
HSP Bonus Payment Amount	,	1	Prior to 10/1 1.00	0n/After 10/1 2.00	
HSP Bonus Payment Amount 00.00 HSP bonus amount (see instructions)	,			2. 00	100.00
HSP Bonus Payment Amount 00.00 HSP bonus amount (see instructions) HVBP Adjustment for HSP Bonus Payment			1. 00	2. 00	100.00
00.00 HSP bonus amount (see instructions)			1. 00	2. 00	
00.00 HSP bonus amount (see instructions) HVBP Adjustment for HSP Bonus Payment 01.00 HVBP adjustment factor (see instructions) 02.00 HVBP adjustment amount for HSP bonus payment (see instructions)			1.00	2.00 0 0.0000000000	101. 00
00.00 HSP bonus amount (see instructions) HVBP Adjustment for HSP Bonus Payment 01.00 HVBP adjustment factor (see instructions) 02.00 HVBP adjustment amount for HSP bonus payment (see instructions) HRR Adjustment for HSP Bonus Payment			0.0000000000	2. 00 0 0. 0000000000 0	101. 00 102. 00
00.00 HSP bonus amount (see instructions) HVBP Adjustment for HSP Bonus Payment 01.00 HVBP adjustment factor (see instructions) 02.00 HVBP adjustment amount for HSP bonus payment (see instructions) HRR Adjustment for HSP Bonus Payment 03.00 HRR adjustment factor (see instructions)	ns)		0. 0000000000 0 0. 00000000000	2.00 0 0.000000000 0	101. 00 102. 00 103. 00
00.00 HSP bonus amount (see instructions) HVBP Adjustment for HSP Bonus Payment 01.00 HVBP adjustment factor (see instructions) 02.00 HVBP adjustment amount for HSP bonus payment (see instruction) HRR Adjustment for HSP Bonus Payment 03.00 HRR adjustment factor (see instructions) 04.00 HRR adjustment amount for HSP bonus payment (see instruction)	ns)	(atmost	0.0000000000	2.00 0 0.000000000 0	101. 00 102. 00 103. 00
00.00 HSP bonus amount (see instructions) HVBP Adjustment for HSP Bonus Payment 01.00 HVBP adjustment factor (see instructions) 02.00 HVBP adjustment amount for HSP bonus payment (see instruction) HRR Adjustment for HSP Bonus Payment 03.00 HRR adjustment factor (see instructions) 04.00 HRR adjustment amount for HSP bonus payment (see instruction Rural Community Hospital Demonstration Project (§410A Demons	ns) s) tration) Adju		0. 0000000000 0 0. 00000000000	2.00 0.0000000000 0.0000 0.0000 0	101. 00 102. 00 103. 00 104. 00
00.00 HSP bonus amount (see instructions) HVBP Adjustment for HSP Bonus Payment 01.00 HVBP adjustment factor (see instructions) 02.00 HVBP adjustment amount for HSP bonus payment (see instruction) HRR Adjustment for HSP Bonus Payment 03.00 HRR adjustment factor (see instructions) 04.00 HRR adjustment amount for HSP bonus payment (see instruction) Rural Community Hospital Demonstration Project (§410A Demons) 200.00 Is this the first year of the current 5-year demonstration project.	ns) s) tration) Adju		0. 0000000000 0 0. 00000000000	2.00 0.0000000000 0.0000 0.0000 0	101. 00 102. 00 103. 00 104. 00
00.00 HSP bonus amount (see instructions) HVBP Adjustment for HSP Bonus Payment 01.00 HVBP adjustment factor (see instructions) 02.00 HVBP adjustment amount for HSP bonus payment (see instruction) HRR Adjustment for HSP Bonus Payment 03.00 HRR adjustment factor (see instructions) 04.00 HRR adjustment amount for HSP bonus payment (see instruction Rural Community Hospital Demonstration Project (§410A Demons	ns) s) tration) Adju		0. 0000000000 0 0. 00000000000	2.00 0.0000000000 0.0000 0.0000 0	101. 00 102. 00 103. 00 104. 00
00.00 HSP bonus amount (see instructions) HVBP Adjustment for HSP Bonus Payment 01.00 HVBP adjustment factor (see instructions) 02.00 HVBP adjustment amount for HSP bonus payment (see instructions) HRR Adjustment for HSP Bonus Payment 03.00 HRR adjustment factor (see instructions) 04.00 HRR adjustment amount for HSP bonus payment (see instructions) Rural Community Hospital Demonstration Project (§410A Demons) 200.00 Is this the first year of the current 5-year demonstration production Century Cures Act? Enter "Y" for yes or "N" for no.	ns) s) tration) Adju eriod under		0. 0000000000 0 0. 00000000000	2.00 0.0000000000 0.0000000000 0	101. 00 102. 00 103. 00 104. 00 200. 00
00.00 HSP bonus amount (see instructions) HVBP Adjustment for HSP Bonus Payment 01.00 HVBP adjustment factor (see instructions) 02.00 HVBP adjustment amount for HSP bonus payment (see instructions) HRR Adjustment for HSP Bonus Payment 03.00 HRR adjustment factor (see instructions) 04.00 HRR adjustment factor (see instructions) Rural Community Hospital Demonstration Project (§410A Demons 200.00 Is this the first year of the current 5-year demonstration pone Century Cures Act? Enter "Y" for yes or "N" for no.	ns) s) tration) Adju eriod under		0. 0000000000 0 0. 00000000000	2.00 0.0000000000 0.0000000000 0.0000 0	101. 00 102. 00 103. 00 104. 00 200. 00
00.00 HSP bonus amount (see instructions) HVBP Adjustment for HSP Bonus Payment 01.00 HVBP adjustment factor (see instructions) 02.00 HVBP adjustment amount for HSP bonus payment (see instruction) HRR Adjustment for HSP Bonus Payment 03.00 HRR adjustment factor (see instructions) 04.00 HRR adjustment factor (see instructions) 04.00 HRR adjustment amount for HSP bonus payment (see instruction Rural Community Hospital Demonstration Project (§410A Demons 200.00 Is this the first year of the current 5-year demonstration payment (see instructions) 03.00 Medicare inpatient service costs (from Wkst. D-1, Pt. II, Ii 04.00 Medicare discharges (see instructions) 04.00 Medicare mix adjustment factor (see instructions)	ns) s) tration) Adjueriod under	the 21st	0. 0000000000 0. 00000000000 0	2.00 0.0000000000 0.0000 0.0000 0	101. 00 102. 00 103. 00 104. 00 200. 00
00.00 HSP bonus amount (see instructions) HVBP Adjustment for HSP Bonus Payment 01.00 HVBP adjustment factor (see instructions) 02.00 HVBP adjustment amount for HSP bonus payment (see instruction) HRR Adjustment factor (see instructions) 04.00 HRR adjustment factor (see instructions) 04.00 HRR adjustment factor (see instructions) 04.00 HRR adjustment factor HSP bonus payment (see instruction Rural Community Hospital Demonstration Project (§410A Demons 200.00 Is this the first year of the current 5-year demonstration payment (century Cures Act? Enter "Y" for yes or "N" for no. Cost Reimbursement 01.00 Medicare inpatient service costs (from Wkst. D-1, Pt. II, Ii 02.00 Medicare discharges (see instructions) 03.00 Case-mix adjustment factor (see instructions) Computation of Demonstration Target Amount Limitation (N/A i	ns) s) tration) Adjueriod under	the 21st	0. 0000000000 0. 00000000000 0	2.00 0.0000000000 0.0000 0.0000 0	101. 00 102. 00 103. 00 104. 00 200. 00
100.00 HSP bonus amount (see instructions) HVBP Adjustment for HSP Bonus Payment 101.00 HVBP adjustment factor (see instructions) 102.00 HVBP adjustment amount for HSP bonus payment (see instructions) 103.00 HRR Adjustment factor (see instructions) 104.00 HRR adjustment factor (see instructions) 105.00 HRR adjustment amount for HSP bonus payment (see instructions) 106.00 HRR adjustment amount for HSP bonus payment (see instructions) 107.00 HRR adjustment amount for HSP bonus payment (see instructions) 108.00 HRR adjustment amount for HSP bonus payment (see instructions) 109.00 HRR adjustment factor (see instructions) 109.00 HRR adjustment factor (see instructions) 109.00 Medicare inpatient service costs (from Wkst. D-1, Pt. II, Ii 109.00 Medicare discharges (see instructions) 109.00 Case-mix adjustment factor (see instructions) 100 Computation of Demonstration Target Amount Limitation (N/A in period)	ns) s) tration) Adjueriod under	the 21st	0. 0000000000 0. 00000000000 0	2.00 0.0000000000 0.0000 0.0000 0	101. 00 102. 00 103. 00 104. 00 200. 00 201. 00 202. 00 203. 00
100.00 HSP bonus amount (see instructions) HVBP Adjustment for HSP Bonus Payment 101.00 HVBP adjustment factor (see instructions) 102.00 HVBP adjustment amount for HSP bonus payment (see instructions) 103.00 HRR Adjustment factor (see instructions) 104.00 HRR adjustment amount for HSP bonus payment (see instructions) 104.00 HRR adjustment amount for HSP bonus payment (see instruction Rural Community Hospital Demonstration Project (§410A Demons Rural	ns) s) tration) Adjueriod under	the 21st	0. 0000000000 0. 00000000000 0	2.00 0.0000000000 0.0000 0.0000 0.tration	101. 00 102. 00 103. 00 104. 00 200. 00 201. 00 202. 00 203. 00
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100.00 HSP bonus amount (see instructions) HVBP Adjustment for HSP Bonus Payment 101.00 HVBP adjustment factor (see instructions) 102.00 HVBP adjustment amount for HSP bonus payment (see instruction) 103.00 HRR adjustment for HSP Bonus Payment 103.00 HRR adjustment amount for HSP bonus payment (see instruction) 104.00 HRR adjustment amount for HSP bonus payment (see instruction) 105.00 HRR adjustment amount for HSP bonus payment (see instruction) 106.00 Rural Community Hospital Demonstration Project (§410A Demons) 107.00 Is this the first year of the current 5-year demonstration payment (see instructions) 108.01 Cost Reimbursement 109.02 Medicare inpatient service costs (from Wkst. D-1, Pt. II, Ii 109.02 Medicare discharges (see instructions) 109.03 Case-mix adjustment factor (see instructions) 109.04 OM Medicare target amount 109.05 OM Case-mix adjusted target amount (line 203 times line 204) 109.06 OM Medicare inpatient routine cost cap (line 202 times line 205) 109.07 Adjustment to Medicare Part A Inpatient Reimbursement	ns) s) tration) Adjueriod under ne 49) n first year	the 21st	0. 0000000000 0. 00000000000 0	2.00 0.0000000000 0.0000 0.0000 0	101. 00 102. 00 103. 00 104. 00 200. 00 201. 00 202. 00 203. 00 204. 00 205. 00 206. 00
100.00 HSP bonus amount (see instructions) HVBP Adjustment for HSP Bonus Payment 101.00 HVBP adjustment factor (see instructions) 102.00 HVBP adjustment amount for HSP bonus payment (see instruction) 103.00 HRR Adjustment for HSP Bonus Payment 103.00 HRR adjustment factor (see instructions) 104.00 HRR adjustment amount for HSP bonus payment (see instruction) 104.00 HRR adjustment amount for HSP bonus payment (see instruction) 105.00 Rural Community Hospital Demonstration Project (§410A Demons) 107.00 Is this the first year of the current 5-year demonstration payment (cost Reimbursement) 107.00 Medicare inpatient service costs (from Wkst. D-1, Pt. II, II) 107.00 Medicare discharges (see instructions) 107.00 Medicare discharges (see instructions) 107.00 Case-mix adjustment factor (see instructions) 107.00 Medicare target amount 108.00 Medicare target amount 109.00 Medicare inpatient routine cost cap (line 202 times line 204) 109.00 Medicare inpatient routine cost cap (line 202 times line 204)	ns) s) tration) Adjueriod under ne 49) n first year) tructions)	the 21st	0. 0000000000 0. 00000000000 0	2.00 0.0000000000 0.0000 0.0000 0	101. 00 102. 00 103. 00 104. 00 200. 00 201. 00 202. 00 203. 00 204. 00 205. 00 206. 00
100.00 HSP bonus amount (see instructions) HVBP Adjustment for HSP Bonus Payment 101.00 HVBP adjustment factor (see instructions) 102.00 HVBP adjustment amount for HSP bonus payment (see instruction) 103.00 HRR Adjustment factor (see instructions) 104.00 HRR adjustment amount for HSP bonus payment (see instruction) 104.00 HRR adjustment amount for HSP bonus payment (see instruction) 105.00 HRR adjustment amount for HSP bonus payment (see instruction) 106.00 Rural Community Hospital Demonstration Project (§410A Demons) 107.00 Is this the first year of the current 5-year demonstration payment (century Cures Act? Enter "Y" for yes or "N" for no. 108.10 Cost Reimbursement 109.10 Medicare inpatient service costs (from Wkst. D-1, Pt. II, Ii) 109.10 Medicare discharges (see instructions) 109.10 Case-mix adjustment factor (see instructions) 109.10 Case-mix adjustment factor (see instructions) 109.10 Medicare target amount 109.10 Case-mix adjusted target amount (line 203 times line 204) 109.10 Medicare inpatient routine cost cap (line 202 times line 205 109.10 Medicare inpatient routine cost cap (line 202 times line 205 109.10 Medicare reimpatient routine cost cap (line 209 times line 205 109.10 Medicare reimpatient routine cost cap (line 209 times line 205 109.10 Medicare reimpatient routine cost cap (line 209 times line 209) 109.10 Medicare reimpatient routine cost cap (line 209 times line 205 109.10 Medicare reimpatient routine cost cap (line 209 times line 209) 109.10 Medicare reimpatient routine cost cap (line 209 times line 209) 109.10 Medicare reimpatient routine cost cap (line 209 times line 209) 109.10 Medicare reimpatient routine cost cap (line 209 times line 209) 109.10 Medicare reimpatient routine cost cap (line 209 times line 209) 109.10 Medicare reimpatient routine cost cap (line 209 times line 209) 109.10 Medicare reimpatient routine cost cap (line 209 times line 209) 109.10 Medicare reimpatient routine cost cap (line 209 times line 209) 109.10 Medicare reimpatient routine cost cap (line 209 times line 20	ns) s) tration) Adjueriod under ne 49) n first year) tructions)	the 21st	0. 0000000000 0. 00000000000 0	2.00 0.0000000000 0.0000 0.0000	101. 00 102. 00 103. 00 104. 00 200. 00 201. 00 202. 00 203. 00
HVBP Adjustment for HSP Bonus Payment 01.00 HVBP adjustment factor (see instructions) HVBP adjustment factor (see instructions) HVBP adjustment amount for HSP bonus payment (see instruction) HRR Adjustment for HSP Bonus Payment 03.00 HRR adjustment factor (see instructions) HRR adjustment amount for HSP bonus payment (see instructions) HRR adjustment amount for HSP bonus payment (see instruction Rural Community Hospital Demonstration Project (§410A Demons 200.00) Is this the first year of the current 5-year demonstration payment (see instructions) Cost Reimbursement 101.00 Medicare inpatient service costs (from Wkst. D-1, Pt. II, Ii 102.00 Medicare discharges (see instructions) Computation of Demonstration Target Amount Limitation (N/A in period) 104.00 Medicare target amount 105.00 Case-mix adjustment factor (see instructions) 106.00 Medicare inpatient routine cost cap (line 202 times line 204) 107.00 Medicare inpatient routine cost cap (line 202 times line 204) 108.00 Medicare Part A Inpatient Reimbursement 109.00 Medicare Part A inpatient service costs (from Wkst. E, Pt. A 209.00 Adjustment to Medicare IPPS payments (see instructions) 109.00 Reserved for future use	ns) s) tration) Adjueriod under ne 49) n first year) tructions) , line 59)	the 21st	0. 0000000000 0. 00000000000 0	2.00 0.0000000000 0.0000 0.0000 0	101. 00 102. 00 103. 00 104. 00 200. 00 201. 00 202. 00 203. 00 205. 00 206. 00 207. 00 208. 00 209. 00 210. 00
HVBP Adjustment for HSP Bonus Payment 01.00 HVBP adjustment factor (see instructions) 102.00 HVBP adjustment factor (see instructions) 103.00 HVBP adjustment amount for HSP bonus payment (see instruction) 104.00 HRR adjustment for HSP Bonus Payment 105.00 HRR adjustment factor (see instructions) 106.00 HRR adjustment amount for HSP bonus payment (see instructions) 107.00 HRR adjustment amount for HSP bonus payment (see instructions) 108.00 HRR adjustment amount for HSP bonus payment (see instructions) 109.00 Is this the first year of the current 5-year demonstration payment (see instructions) 109.00 Cost Reimbursement 109.00 Medicare inpatient service costs (from Wkst. D-1, Pt. II, Ii 109.00 Medicare discharges (see instructions) 109.00 Case-mix adjustment factor (see instructions) 109.00 Medicare target amount 109.00 Medicare target amount 109.00 Medicare inpatient routine cost cap (line 202 times line 204) 109.00 Medicare inpatient routine cost cap (line 202 times line 204) 109.00 Medicare Part A Inpatient Reimbursement 109.00 Medicare Part A inpatient service costs (from Wkst. E, Pt. A 209.00 Adjustment to Medicare IPPS payments (see instructions) 109.00 Reserved for future use 109.10 Total adjustment to Medicare IPPS payments (see instructions)	ns) s) tration) Adjueriod under ne 49) n first year) tructions) , line 59)	the 21st	0. 0000000000 0. 00000000000 0	2.00 0.0000000000 0.0000 0.0000 0	101. 00 102. 00 103. 00 104. 00 200. 00 201. 00 202. 00 203. 00 205. 00 206. 00 207. 00 208. 00 209. 00
100.00 HSP bonus amount (see instructions) HVBP Adjustment for HSP Bonus Payment 101.00 HVBP adjustment factor (see instructions) 102.00 HVBP adjustment amount for HSP bonus payment (see instruction) 103.00 HRR adjustment for HSP Bonus Payment 103.00 HRR adjustment factor (see instructions) 104.00 HRR adjustment amount for HSP bonus payment (see instruction Rural Community Hospital Demonstration Project (§410A Demons Rural Community Hospital Demonstrations) 105.00 Medicare inpatient service costs (from Wkst. D-1, Pt. II, Ii Deriod) 106.00 Medicare discharges (see instructions) 107.00 Medicare target amount (see instructions) 108.00 Medicare target amount (line 203 times line 204) 108.01 Medicare inpatient routine cost cap (line 202 times line 204) 109.02 Medicare Part A Inpatient Reimbursement 109.03 Medicare Part A inpatient Reimbursement 109.04 Medicare Part A inpatient service costs (from Wkst. E, Pt. A Rural Payment (see instructions) 109.04 Medicare Part A inpatient service costs (from Wkst. E, Pt. A Rural Payment (see instructions) 109.05 Medicare Payment to Medicare IPPS payments (see instructions) 109.06 Medicare IPPS payments (see instructions) 109.07 Medicare IPPS payments (see instructions) 109.08 Medicare IPPS payments (see instructions) 109.09 Medicare IPPS payments (see instructions) 109.00 Medicare IPPS payments (see instructions)	ns) s) tration) Adjueriod under ne 49) n first year) tructions) , line 59)	the 21st	0. 0000000000 0. 00000000000 0	2.00 0.0000000000 0.0000 0.0000 0.tration	101. 00 102. 00 103. 00 104. 00 200. 00 201. 00 202. 00 203. 00 204. 00 205. 00 206. 00 207. 00 208. 00 210. 00 211. 00
100.00 HSP bonus amount (see instructions) HVBP Adjustment for HSP Bonus Payment 101.00 HVBP adjustment factor (see instructions) 102.00 HVBP adjustment amount for HSP bonus payment (see instruction) 103.00 HRR adjustment for HSP Bonus Payment 103.00 HRR adjustment amount for HSP bonus payment (see instruction) 104.00 HRR adjustment amount for HSP bonus payment (see instruction) 105.00 HRR adjustment amount for HSP bonus payment (see instruction) 106.00 Rural Community Hospital Demonstration Project (§410A Demons) 107.00 Is this the first year of the current 5-year demonstration payment (see instructions) 108.00 Cost Reimbursement 109.00 Medicare inpatient service costs (from Wkst. D-1, Pt. II, Ii 109.00 Medicare discharges (see instructions) 109.00 Case-mix adjustment factor (see instructions) 109.00 Case-mix adjustment factor (see instructions) 109.00 Case-mix adjusted target amount (line 203 times line 204) 109.00 Medicare inpatient routine cost cap (line 202 times line 205) 109.00 Adjustment to Medicare Part A Inpatient Reimbursement 109.00 Adjustment to Medicare IPPS payments (see instructions) 109.00 Reserved for future use 109.00 Reserved for future use 109.00 Total adjustment to Medicare Part A IPPS payments (from line	ns) s) tration) Adjueriod under ne 49) n first year) tructions) , line 59)	the 21st	0. 0000000000 0. 00000000000 0	2.00 0.0000000000 0.0000 0.0000	101. 00 102. 00 103. 00 104. 00 200. 00 201. 00 203. 00 204. 00 205. 00 206. 00 207. 00 208. 00 209. 00 210. 00 211. 00
100.00 HSP bonus amount (see instructions) HVBP Adjustment for HSP Bonus Payment 101.00 HVBP adjustment factor (see instructions) 102.00 HVBP adjustment amount for HSP bonus payment (see instruction) 103.00 HRR adjustment for HSP Bonus Payment 103.00 HRR adjustment factor (see instructions) 104.00 HRR adjustment amount for HSP bonus payment (see instruction Rural Community Hospital Demonstration Project (§410A Demons Rural Community Hospital Demonstrations) 105.00 Medicare inpatient service costs (from Wkst. D-1, Pt. II, Ii Deriod) 106.00 Medicare discharges (see instructions) 107.00 Medicare target amount (see instructions) 108.00 Medicare target amount (line 203 times line 204) 108.01 Medicare inpatient routine cost cap (line 202 times line 204) 109.02 Medicare Part A Inpatient Reimbursement 109.03 Medicare Part A inpatient Reimbursement 109.04 Medicare Part A inpatient service costs (from Wkst. E, Pt. A Rural Payment (see instructions) 109.04 Medicare Part A inpatient service costs (from Wkst. E, Pt. A Rural Payment (see instructions) 109.05 Medicare Payment to Medicare IPPS payments (see instructions) 109.06 Medicare IPPS payments (see instructions) 109.07 Medicare IPPS payments (see instructions) 109.08 Medicare IPPS payments (see instructions) 109.09 Medicare IPPS payments (see instructions) 109.00 Medicare IPPS payments (see instructions)	ns) s) tration) Adjuteriod under ne 49) n first year) tructions) , line 59)	of the curre	0. 0000000000 0. 00000000000 0	2.00 0.0000000000 0.0000 0.0000	101. 0 102. 0 103. 0 104. 0 200. 0 201. 0 202. 0 203. 0 204. 0 205. 0 206. 0 207. 0 208. 0 209. 0 210. 0

Health Financial Systems	_, INC.		In Lieu of Form CMS-2552-1		
LOW VOLUME CALCULATION EXHIBIT 4		Provider CCN:		Peri od:	Worksheet E Part A Exhibit 4
					Date/Time Prepared:
					5/29/2019 1: 11 pm
		T: ±1 - V	\/I I I	11	DDC

					10	1270172010	5/29/2019 1:1	
		W 10 E D			XVIII	Hospi tal	PPS	
		W/S E, Part A line	Amounts (from E, Part A)	Pre/Post Entitlement	Period Prior to 10/01	Peri od On/After 10/01	Total (Col 2 through 4)	
1 00	Inno.	0	1. 00	2. 00	3. 00	4. 00	5. 00	4 00
1. 00	DRG amounts other than outlier payments		0	0	0	0	0	
1. 01	DRG amounts other than outlier payments for discharges occurring prior to October 1	1. 01	43, 768, 588	0	43, 768, 588		43, 768, 588	1. 01
1. 02	DRG amounts other than outlier payments for discharges occurring on or after October	1. 02	14, 112, 945	0		14, 112, 945	14, 112, 945	1. 02
1. 03	DRG for Federal specific operating payment for Model 4 BPCI occurring prior to October 1	1. 03	0	0	0		0	1. 03
1. 04	DRG for Federal specific operating payment for Model 4 BPCI occurring on or after	1. 04	0	0		0	0	1. 04
2. 00	October 1 Outlier payments for discharges (see instructions)	2. 00	315, 848	0	224, 453	91, 395	315, 848	2. 00
2. 01	Outlier payments for discharges for Model 4 BPCI	2. 02	0	0	0	0	0	2. 01
3. 00	Operating outlier reconciliation	2. 01	0	0	0	0	0	3. 00
4. 00	Managed care simulated payments	3. 00	7, 986, 408	0	5, 973, 394	2, 013, 014	7, 986, 408	4. 00
	Indirect Medical Education Adj		0.050500	0.050500	0.050500	0.050500		
5. 00	Amount from Worksheet E, Part A, line 21 (see instructions)	21. 00	0. 059528	0. 059528		0. 059528		5.00
6.00	IME payment adjustment (see instructions)	22.00	1, 851, 514	0	,,	451, 445	1, 851, 514	6.00
6. 01	IME payment adjustment for managed care (see instructions)	22. 01	255, 469	0		0	255, 469	6. 01
	Indirect Medical Education Adj							
7. 00	IME payment adjustment factor (see instructions)	27. 00	0. 011041	0. 011041		0. 011041		7. 00
8. 00	IME adjustment (see instructions)	28. 00	639, 070	0	483, 249	155, 821	639, 070	8. 00
8. 01	IME payment adjustment add on for managed care (see instructions)	28. 01	88, 178	0	65, 952	22, 226	88, 178	8. 01
9. 00	Total IME payment (sum of lines 6 and 8)	29. 00	2, 490, 584	0	1, 883, 318	607, 266	2, 490, 584	9. 00
9. 01	Total IME payment for managed care (sum of lines 6.01 and 8.01)	29. 01	343, 647	0	321, 421	22, 226	343, 647	9. 01
	Disproportionate Share Adjustm							
10. 00	Allowable disproportionate share percentage (see instructions)	33. 00	0. 1279	0. 1279	0. 1279	0. 1279		10.00
11. 00	Disproportionate share adjustment (see instructions)	34. 00	1, 850, 763	0	1, 399, 501	451, 262	1, 850, 763	11. 00
11. 01	Uncompensated care payments Additional payment for high pe	36.00 rcentage of ES	3, 387, 735 RD beneficiary	0 di scharges	2, 475, 473	912, 262	3, 387, 735	11. 01
12. 00	Total ESRD additional payment (see instructions)	46. 00	0	0	0	0	0	12.00
13. 00 14. 00	Subtotal (see instructions) Hospital specific payments (completed by SCH and MDH, small rural hospitals only.)	47. 00 48. 00	65, 926, 463 0	0	49, 751, 333 0	16, 175, 130 0	65, 926, 463 0	13. 00 14. 00
15. 00	(see instructions) Total payment for inpatient operating costs (see	49. 00	66, 270, 110	0	50, 072, 754	16, 197, 356	66, 270, 110	15. 00
16. 00	instructions) Payment for inpatient program capital (from Wkst. L, Pt. I,	50. 00	5, 248, 058	0	3, 970, 784	1, 277, 274	5, 248, 058	16. 00
17. 00	if applicable) Special add-on payments for	54. 00	0	0	0	0	0	17. 00
17. 01 17. 02	new technologies Net organ aquisition cost Credits received from	68. 00	497	0	497	O	497	17. 01 17. 02
	manufacturers for replaced devices for applicable MS-DRGs							

Heal th	Financial Systems		UNI ON HOSPI	TAL. INC.		In Lie	u of Form CMS-:	2552-10
	LUME CALCULATION EXHIBIT 4	5.11 5.11 1.10 5.1 1.		Provider CCN: 15-0023		Period: From 01/01/2018 To 12/31/2018	Worksheet E Part A Exhibi Date/Time Pre 5/29/2019 1:1	t 4 pared:
					XVIII	Hospi tal	PPS	
		· ·	Amounts (from	Pre/Post	Peri od Pri or		Total (Col 2	
		l i ne	E, Part A)	Entitlement	to 10/01	0n/After 10/01	through 4)	
		0	1. 00	2. 00	3. 00	4. 00	5. 00	
18. 00	Capital outlier reconciliation adjustment amount (see instructions)	93. 00	0	0		0 0	0	18. 00
19. 00	SUBTOTAL			0	54, 044, 03	17, 474, 630	71, 518, 665	19. 00
		W/S L, line	(Amounts from L)					
		0	1. 00	2. 00	3. 00	4. 00	5. 00	
20.00	Capital DRG other than outlier		4, 712, 456	0	3, 564, 17	70 1, 148, 286	4, 712, 456	
20. 01	Model 4 BPCI Capital DRG other than outlier	1. 01	0	0		0 0	0	20. 01
21.00	Capital DRG outlier payments	2. 00	63, 886	0	49, 84	14, 044	63, 886	
21. 01	Model 4 BPCI Capital DRG outlier payments	2. 01	0	0		0 0	0	21. 01
22. 00	Indirect medical education percentage (see instructions)	5. 00	0. 0405	0. 0405	0. 040	0. 0405		22. 00
23. 00	Indirect medical education adjustment (see instructions)	6. 00	190, 854	0	144, 34	46, 506	190, 854	23. 00
24. 00	, ,	10. 00	0. 0596	0. 0596	0. 059	0. 0596		24.00
25. 00	Disproportionate share adjustment (see instructions)	11. 00	280, 862	0	212, 42	68, 438	280, 862	25. 00
26. 00	Total prospective capital payments (see instructions)	12. 00	5, 248, 058	0	3, 970, 78	1, 277, 274	5, 248, 058	26. 00
		W/S E, Part A						
		line	E, Part A)					
		0	1. 00	2. 00	3. 00	4. 00	5. 00	
27. 00 28. 00	Low volume adjustment factor Low volume adjustment (transfer amount to Wkst. E,	70. 96			0. 00000	0.000000	0	27. 00 28. 00
29. 00	Pt. A, line) Low volume adjustment (transfer amount to Wkst. E,	70. 97				0	0	29. 00
100.00	Pt. A, line) Transfer low volume		Υ					100. 00
	adjustments to Wkst. E, Pt. A.]			I.	I	I

HOSPI T	AL ACQUIRED CONDITION (HAC) REDUCTION CALCULA	ATION EXHIBIT 5	Provider Co	CN: 15-0023	Period: From 01/01/2018 To 12/31/2018		pared:
			Title	XVIII	Hospi tal	PPS	
		Wkst. E, Pt. A, line	Amt. from Wkst. E, Pt. A)	Period to 10/01	Period on after 10/01	Total (cols. 2 and 3)	
		0	1.00	2.00	3.00	4. 00	
1. 00	DRG amounts other than outlier payments	1. 00					1.00
1. 01	DRG amounts other than outlier payments for	1. 01	43, 768, 588	43, 768, 58	8	43, 768, 588	1. 01
1. 02	discharges occurring prior to October 1 DRG amounts other than outlier payments for	1. 02	14, 112, 945		14, 112, 945	14, 112, 945	1. 02
1. 03	discharges occurring on or after October 1 DRG for Federal specific operating payment for Model 4 BPCI occurring prior to October	1. 03	0		0	0	1.03
1. 04	DRG for Federal specific operating payment for Model 4 BPCI occurring on or after October 1	1. 04	O		0	0	1. 04
2. 00	Outlier payments for discharges (see instructions)	2. 00	315, 848	224, 45	91, 395	315, 848	2. 00
2. 01	Outlier payments for discharges for Model 4 BPCI	2. 02	0		0 0	0	2. 01
3.00	Operating outlier reconciliation	2. 01	0		0 0	0	3.00
4.00	Managed care simulated payments	3. 00	7, 986, 408	5, 385, 70	9 2, 600, 700	7, 986, 409	4.00
5. 00	Indirect Medical Education Adjustment Amount from Worksheet E, Part A, line 21 (see instructions)	21. 00	0. 059528	0. 05952	0. 059528		5. 00
6. 00	IME payment adjustment (see instructions)	22. 00	1, 851, 514	1, 400, 06	9 451, 445	1, 851, 514	6.00
6. 01	IME payment adjustment for managed care (see instructions)		255, 469			255, 469	6. 01
	Indirect Medical Education Adjustment for the						
7. 00	IME payment adjustment factor (see instructions)	27. 00	0. 011041	0. 01104			7. 00
8.00	IME adjustment (see instructions)	28. 00	639, 070	483, 24		639, 070	8.00
8. 01	IME payment adjustment add on for managed care (see instructions)	28. 01	88, 178				8. 01
9. 00 9. 01	Total IME payment (sum of lines 6 and 8) Total IME payment for managed care (sum of lines 6.01 and 8.01)	29. 00 29. 01	2, 490, 584 343, 647	1, 883, 31 231, 74			9. 00 9. 01
	Disproportionate Share Adjustment						
10. 00		33. 00	0. 1279	0. 127	0. 1279		10.00
11. 00	Disproportionate share adjustment (see instructions)	34. 00	1, 850, 763	1, 399, 50	451, 262	1, 850, 763	11.00
11. 01		36. 00	3, 387, 735	2, 475, 47	912, 262	3, 387, 735	11. 01
12. 00	Additional payment for high percentage of ES Total ESRD additional payment (see instructions)	RD beneficiary 46.00	di scharges 0		0 0	0	12.00
13. 00	Subtotal (see instructions)	47. 00	65, 926, 463	49, 751, 33	3 16, 175, 130	65, 926, 463	13.00
14. 00	Hospital specific payments (completed by SCH and MDH, small rural hospitals only.) (see instructions)		03, 720, 403	47, 731, 30	0 0	03, 720, 403	14.00
15. 00	1	49. 00	66, 270, 110	49, 983, 07	16, 287, 035	66, 270, 110	15. 00
16. 00	Payment for inpatient program capital (from Wkst. L, Pt. I, if applicable)	50. 00	5, 248, 058	3, 970, 78	1, 277, 274	5, 248, 058	16. 00
17. 00 17. 01	Special add-on payments for new technologies Net organ acquisition cost	54. 00	0		0 0		17. 01
17. 02	Credits received from manufacturers for replaced devices for applicable MS-DRGs	68. 00	497	49	0		17. 02
18.00	Capital outlier reconciliation adjustment	93. 00	0		0 0	0	18.00

93.00

0

53, 954, 356

0

17, 564, 309

0 18.00

71, 518, 665 19. 00

18.00 Capital outlier reconciliation adjustment amount (see instructions)

19.00 SUBTOTAL

lealth Financial Systems HOSPITAL ACQUIRED CONDITION (HAC) REDUCTION CALCULA	UNION HOSPI TION EXHIBIT 5			Period: From 01/01/2018 To 12/31/2018		t 5 pared:
		Title	XVIII	Hospi tal	PPS	· p
	Wkst. L. line	(Amt. from		1100 1100		
	,	Wkst. L)				
	0	1, 00	2. 00	3. 00	4. 00	
20.00 Capital DRG other than outlier	1. 00	4, 712, 456			4, 712, 456	20, 00
20.01 Model 4 BPCI Capital DRG other than outlier	1. 01	0	-,,	0	0	20. 01
21.00 Capital DRG outlier payments	2. 00	63, 886	49, 84	2 14, 044	63, 886	
21.01 Model 4 BPCI Capital DRG outlier payments	2. 01	03,000	47, 04	0 14,044	03,000	
22.00 Indirect medical education percentage (see	5. 00	0. 0405	0. 040	5 0.0405	U	22.00
instructions)	3.00	0.0403	0. 040	0. 0403		22.00
23.00 Indirect medical education adjustment (see	6. 00	190, 854	144, 34	8 46, 506	190, 854	23.00
instructions)	6.00	190, 854	144, 34	8 40, 500	190, 854	23.00
	10.00	0.0507	0.050	0.050/		24 00
24.00 Allowable disproportionate share percentage (see instructions)	10. 00	0. 0596	0. 059	6 0. 0596		24.00
,	11. 00	200 042	212 42	40 430	200 0/2	25.00
	11.00	280, 862	212, 42	4 68, 438	280, 862	25.00
instructions)	40.00	F 040 0F0	0 070 70	4 077 074	F 040 0F0	0, 00
26.00 Total prospective capital payments (see	12. 00	5, 248, 058	3, 970, 78	4 1, 277, 274	5, 248, 058	26.00
instructions)		(1)				
	Wkst. E, Pt.	(Amt. from				
	A, line	Wkst. E, Pt.				
		A)				
	0	1. 00	2. 00	3. 00	4. 00	
27. 00						27.00
28.00 Low volume adjustment prior to October 1	70. 96	0		0	0	
29.00 Low volume adjustment on or after October 1	70. 97	0		0	0	29.00
30.00 HVBP payment adjustment (see instructions)	70. 93	39, 932	91, 37	8 -51, 446	39, 932	30.00
30.01 HVBP payment adjustment for HSP bonus	70. 90	o		0	0	30.01
payment (see instructions)						
31.00 HRR adjustment (see instructions)	70. 94	-162, 209	-126, 92	7 -35, 282	-162, 209	31.00
31.01 HRR adjustment for HSP bonus payment (see	70. 91	0	•	0	0	
instructions)]			_	
1 2 2 2 2					(Amt. to	
					Wkst. E, Pt.	
					A)	
	0	1.00	2. 00	3, 00	4. 00	
32.00 HAC Reduction Program adjustment (see	70. 99			0 0	0	32.00
instructions)	, 5. , ,			٦		32.00
100.00 Transfer HAC Reduction Program adjustment to		N				100.00
Wkst. E, Pt. A.	i					1.00.00

Health Financial Systems	UNION HOSPITAL, INC.	In Lieu	u of Form CMS-2552-10
CALCULATION OF REIMBURSEMENT SETTLEMENT			Worksheet E Part B Date/Time Prepared: 5/29/2019 1:11 pm
	Ti +1 o V/// I I	Hospi tal	DDC

		10 12/31/2010	5/29/2019 1: 1	
	Title XVIII	Hospi tal	PPS	. р
		'		
			1. 00	
	PART B - MEDICAL AND OTHER HEALTH SERVICES			
1. 00	Medical and other services (see instructions)		19, 092	1.00
2. 00	Medical and other services reimbursed under OPPS (see instructions)		67, 821, 709	2.00
3. 00	OPPS payments		66, 006, 509	3.00
4.00	Outlier payment (see instructions)		22, 941	4.00
4. 01	Outlier reconciliation amount (see instructions)		0 000	4.0
5. 00 6. 00	Enter the hospital specific payment to cost ratio (see instructions) Line 2 times line 5		0.000	5. 00 6. 00
7. 00	Sum of lines 3, 4, and 4.01, divided by line 6		0. 00	7. 0
8. 00	Transitional corridor payment (see instructions)		0.00	8. 0
9. 00	Ancillary service other pass through costs from Wkst. D, Pt. IV, col. 13, line 200		243, 175	9. 0
10.00	Organ acquisitions		0	10. 0
11. 00	Total cost (sum of lines 1 and 10) (see instructions)		19, 092	11.0
	COMPUTATION OF LESSER OF COST OR CHARGES			
	Reasonabl e charges			
	Ancillary service charges		89, 128	
	Organ acquisition charges (from Wkst. D-4, Pt. III, col. 4, line 69)		0	13.0
14. 00	Total reasonable charges (sum of lines 12 and 13)		89, 128	14.0
45.00	Customary charges			4- 0
	Aggregate amount actually collected from patients liable for payment for services on		0	15.00
16. 00	Amounts that would have been realized from patients liable for payment for services o	n a chargebasis	0	16. 0
17. 00	had such payment been made in accordance with 42 CFR §413.13(e) Ratio of line 15 to line 16 (not to exceed 1.000000)		0. 000000	17. 0
	Total customary charges (see instructions)		89, 128	
	Excess of customary charges over reasonable cost (complete only if line 18 exceeds li	ne 11) (see	70, 036	
	instructions)	, (,	
20.00	Excess of reasonable cost over customary charges (complete only if line 11 exceeds li	ne 18) (see	0	20.0
	instructions)			
21.00	Lesser of cost or charges (see instructions)		19, 092	21.0
	Interns and residents (see instructions)		0	22. 0
	Cost of physicians' services in a teaching hospital (see instructions)		0	23.0
24. 00	Total prospective payment (sum of lines 3, 4, 4.01, 8 and 9)		66, 272, 625	24. 0
25 00	COMPUTATION OF REIMBURSEMENT SETTLEMENT		0	25.0
	Deductibles and coinsurance amounts (for CAH, see instructions) Deductibles and Coinsurance amounts relating to amount on line 24 (for CAH, see instr	ustions)	0 12, 154, 540	25. 0 26. 0
	Subtotal [(lines 21 and 24 minus the sum of lines 25 and 26) plus the sum of lines 22	'	54, 137, 177	27. 0
27.00	instructions)	ana 25] (366	34, 137, 177	27.0
28. 00	Direct graduate medical education payments (from Wkst. E-4, line 50)		674, 499	28. 0
	ESRD direct medical education costs (from Wkst. E-4, line 36)		0	29.0
30.00	Subtotal (sum of lines 27 through 29)		54, 811, 676	30.0
31.00	Primary payer payments		7, 369	31.0
32.00	Subtotal (line 30 minus line 31)		54, 804, 307	32.0
	ALLOWABLE BAD DEBTS (EXCLUDE BAD DEBTS FOR PROFESSIONAL SERVICES)			
	Composite rate ESRD (from Wkst. I-5, line 11)		0	33.0
	Allowable bad debts (see instructions)		2, 331, 068	
	Adjusted reimbursable bad debts (see instructions)		1, 515, 194	
	Allowable bad debts for dual eligible beneficiaries (see instructions) Subtotal (see instructions)		1, 646, 235 56, 319, 501	
			-220	
	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)		0	39.0
	Pioneer ACO demonstration payment adjustment (see instructions)		Ŭ	39. 5
	Demonstration payment adjustment amount before sequestration		0	39. 9
	Partial or full credits received from manufacturers for replaced devices (see instruc	tions)	ő	39. 9
	RECOVERY OF ACCELERATED DEPRECIATION	,	0	39. 9
40.00	Subtotal (see instructions)		56, 319, 721	40. C
40. 01	Sequestration adjustment (see instructions)		1, 126, 394	40. C
	Demonstration payment adjustment amount after sequestration		0	40. C
41.00	Interim payments		54, 357, 394	41. C
42.00	Tentative settlement (for contractors use only)		0	42.0
	Balance due provider/program (see instructions)		835, 933	
		chapter 1,	0	44.0
	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2,			
	§115. 2	·		
44. 00	§115.2 TO BE COMPLETED BY CONTRACTOR			00.0
44. 0090. 00	§115.2 TO BE COMPLETED BY CONTRACTOR Original outlier amount (see instructions)	,	0	90.0
90. 00 91. 00	§115.2 TO BE COMPLETED BY CONTRACTOR Original outlier amount (see instructions) Outlier reconciliation adjustment amount (see instructions)		0	91.0
90. 00 91. 00 92. 00	§115.2 TO BE COMPLETED BY CONTRACTOR Original outlier amount (see instructions)	· ·	-	91.0

Health Financial Systems	UNION HOSPITAL, INC.	In Lieu	u of Form CMS-2552-10
CALCULATION OF REIMBURSEMENT SETTLEMENT	Provi der CCN: 15-0023	Peri od:	Worksheet E
	Component CCN: 15-T023	From 01/01/2018 To 12/31/2018	
	'		5/29/2019 1:11 pm
	Title XVIII	Subprovi der -	PPS
		IDE	

		Title XVIII	Subprovi der – I RF	PPS	
	· ·		IKF		
	DADT D. MEDICAL AND OTHER HEALTH CERVICES			1. 00	
1. 00	PART B - MEDICAL AND OTHER HEALTH SERVICES Medical and other services (see instructions)			144	1. 00
2. 00	Medical and other services reimbursed under OPPS (see instruc	tions)		40	2.00
3. 00	OPPS payments			287	3.00
4. 00 4. 01	Outlier payment (see instructions) Outlier reconciliation amount (see instructions)			0	4. 00 4. 01
5. 00	Enter the hospital specific payment to cost ratio (see instru	ictions)		0. 000	5. 00
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
8.00	Transitional corridor payment (see instructions)	IV and 12 line 200		0	8.00
9. 00 10. 00	Ancillary service other pass through costs from Wkst. D, Pt. Organ acquisitions	1V, Col. 13, 111le 200		0	9. 00 10. 00
11. 00	Total cost (sum of lines 1 and 10) (see instructions)			144	11. 00
	COMPUTATION OF LESSER OF COST OR CHARGES				
10.00	Reasonable charges			/70	10.00
12. 00 13. 00		ine 69)		670	12. 00 13. 00
	Total reasonable charges (sum of lines 12 and 13)	1116 07)		670	
	Customary charges				
15.00	1 33 3			0	15.00
16. 00	Amounts that would have been realized from patients liable for had such payment been made in accordance with 42 CFR §413.13(on a chargebasis	0	16. 00
17. 00	Ratio of line 15 to line 16 (not to exceed 1.000000)			0. 000000	17. 00
18. 00	Total customary charges (see instructions)			670	18. 00
19. 00	Excess of customary charges over reasonable cost (complete on	ly if line 18 exceeds li	ne 11) (see	526	19. 00
20. 00	<pre>instructions) Excess of reasonable cost over customary charges (complete on</pre>	lvifline 11 exceeds li	ne 18) (see	0	20. 00
20.00	instructions)	ing in time in exceeds in	110 10) (300	G	20.00
	U Lesser of cost or charges (see instructions)				21.00
	Interns and residents (see instructions)	rueti ese)		0	22.00
	00 Cost of physicians' services in a teaching hospital (see instructions) 00 Total prospective payment (sum of lines 3, 4, 4.01, 8 and 9)				23. 00 24. 00
200	COMPUTATION OF REIMBURSEMENT SETTLEMENT	287	21100		
	0 Deductibles and coinsurance amounts (for CAH, see instructions)				25. 00
26.00					26.00
27. 00	Subtotal [(lines 21 and 24 minus the sum of lines 25 and 26) instructions)	prus the sum of fittes 22	and 23] (See	431	27. 00
28. 00	Direct graduate medical education payments (from Wkst. E-4, I	ine 50)		0	28. 00
	ESRD direct medical education costs (from Wkst. E-4, line 36)			0	29. 00
30.00	Subtotal (sum of lines 27 through 29)			431 0	30. 00 31. 00
31. 00 32. 00	Primary payer payments Subtotal (line 30 minus line 31)			431	32.00
02.00	ALLOWABLE BAD DEBTS (EXCLUDE BAD DEBTS FOR PROFESSIONAL SERVI	CES)		101	02.00
	Composite rate ESRD (from Wkst. I-5, line 11)			0	33.00
	Allowable bad debts (see instructions) Adjusted reimbursable bad debts (see instructions)			0	34. 00 35. 00
36. 00	, , , , , , , , , , , , , , , , , , , ,	ructions)		0	36.00
	Subtotal (see instructions)			431	37. 00
	MSP-LCC reconciliation amount from PS&R			0	38. 00
39. 00 39. 50				0	39. 00 39. 50
39. 97	Pioneer ACO demonstration payment adjustment (see instruction Demonstration payment adjustment amount before sequestration	15)		0	39. 30
39. 98	Partial or full credits received from manufacturers for repla	ced devices (see instru	ctions)	0	39. 98
39. 99	RECOVERY OF ACCELERATED DEPRECIATION			0	39. 99
40.00				431	40.00
40. 01 40. 02				9	40. 01 40. 02
41. 00				425	41.00
42.00	O Tentative settlement (for contractors use only)			0	42.00
43.00	, , ,			-3	43.00
44. 00	Protested amounts (nonallowable cost report items) in accorda §115.2	ince with CMS Pub. 15-2,	chapter I,	0	44. 00
	TO BE COMPLETED BY CONTRACTOR				
	Original outlier amount (see instructions)			0	90.00
	Outlier reconciliation adjustment amount (see instructions)			0	91.00
92. 00 93. 00				0.00	92. 00 93. 00
	Total (sum of lines 91 and 93)				94.00
			'	'	•

Health Financial Systems UNANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED UNION HOSPITAL, INC. In Lieu of Form CMS-2552-10

| Peri od: | Worksheet E-1 | From 01/01/2018 | Part | | To | 12/31/2018 | Date/Time Prepared: | Provider CCN: 15-0023

				10 12/31/2010	5/29/2019 1:1	
		Ti tl e	e XVIII	Hospi tal	PPS	
		Inpatier	nt Part A	Part A Part		
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount	
		1.00	2.00	3.00	4. 00	
1. 00	Total interim payments paid to provider		63, 861, 61		52, 797, 165	1. 00
2. 00	Interim payments payable on individual bills, either			o	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	12/31/2018	933, 12		1, 560, 229	3. 01
3. 02		08/21/2018	62, 90		0	3. 02
3. 03			l	0	0	3. 03
3. 04			l	0	0	3. 04
3.05				0	0	3. 05
	Provi der to Program					
3. 50	ADJUSTMENTS TO PROGRAM		1	0	0	3.50
3. 51			1	0	0	3. 51
3. 52 3. 53			l	0		3. 52 3. 53
3. 54			1	0		3. 54
3. 99	Subtotal (sum of lines 3.01-3.49 minus sum of lines		996, 02	~	1, 560, 229	3. 99
3. 77	3. 50-3. 98)		770,02	7	1, 300, 229	3.77
4.00	Total interim payments (sum of lines 1, 2, and 3.99)		64, 857, 64	6	54, 357, 394	4. 00
00	(transfer to Wkst. E or Wkst. E-3, line and column as		0.700770.1		01/00//0/1	
	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		II.	0	0	5. 01
5. 02			l	0	0	5. 02
5. 03	Dec. 1 Lea Le Decesion			0	0	5. 03
5. 50	Provider to Program TENTATIVE TO PROGRAM		1	0	0	5. 50
5. 50	TENTATIVE TO PROGRAM		II.	0		5. 50
5. 52				0		5. 52
5. 99	Subtotal (sum of lines 5.01-5.49 minus sum of lines		1	0		5. 99
J. 77	5. 50-5. 98)		1			3. 77
6.00	Determined net settlement amount (balance due) based on					6. 00
	the cost report. (1)					
6. 01	SETTLEMENT TO PROVIDER		563, 51	8	835, 933	6. 01
6. 02	SETTLEMENT TO PROGRAM		1	0	0	6. 02
7. 00	Total Medicare program liability (see instructions)		65, 421, 16		55, 193, 327	7. 00
				Contractor	NPR Date	
			0	Number 1.00	(Mo/Day/Yr)	
8. 00	Name of Contractor		U	1.00	2.00	8. 00
0.00	INAME OF COULT ACTO			- [1	0.00

	Financial Systems UNION HOSPI				u of Form CMS-2	552-1
ANALY:	SIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED	Provider Component (CN: 15-0023 CCN: 15-T023	Peri od: From 01/01/2018 To 12/31/2018		
		Title	XVIII	Subprovi der -	PPS	і рііі
		Inpatien	t Part A	Par	t B	
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount	
		1. 00	2. 00	3. 00	4. 00	
1. 00 2. 00	Total interim payments paid to provider 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, write "NONE" or enter a zero		3, 439, 0	0	425 0	1. 00 2. 00
3. 00	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
3. 01	ADJUSTMENTS TO PROVIDER			0	0	3. 0
3. 01	ADJUSTIMENTS TO PROVIDER			0	0	3. 0
3. 03				Ö	ő	3. 0
3. 04 3. 05				0	0 0	3. 0 3. 0
	Provider to Program					
3. 50	ADJUSTMENTS TO PROGRAM			0	0	3. 5
5. 51				0	0	3.5
. 52 . 53				0	0	3. 5 3. 5
s. 53 S. 54				0	0	3. 5
3. 99	Subtotal (sum of lines 3.01-3.49 minus sum of lines			0	0	3. 9
	3. 50-3. 98)					0. ,
1. 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)		3, 439, 0	40	425	4. 0
	TO BE COMPLETED BY CONTRACTOR					
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)					5.0
	Program to Provider					
. 01	TENTATI VE TO PROVI DER			0	0	5. 0
5. 02				Ö	Ö	5. 0
5. 03				0	o	5. C

5. 50

5.51

5.52

5. 99

6.00

6.01

6.02

7.00

8. 00

0

0

0

0

NPR Date

(Mo/Day/Yr)

2. 00

0 0 0

Contractor

Number

1. 00

19, 920

3, 458, 960

0

Provider to Program
TENTATIVE TO PROGRAM

the cost report. (1)
SETTLEMENT TO PROVIDER

SETTLEMENT TO PROGRAM

5. 50-5. 98)

8.00 Name of Contractor

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

Total Medicare program liability (see instructions)

Determined net settlement amount (balance due) based on

5. 50

5. 51

5. 52

5. 99

6.00

6.01

6. 02

7. 00

Heal th	Financial Systems UNION HOSPITA	AL, INC.	In Lie	u of Form CMS-	2552-10
CALCUI	ATION OF REIMBURSEMENT SETTLEMENT FOR HIT	Provider CCN: 15-0023	Peri od:	Worksheet E-1	
			From 01/01/2018		
			To 12/31/2018	Date/Time Pre 5/29/2019 1:1	
		Title XVIII	Hospi tal	PPS	Прії
		THE XVIII	1103pi tai	113	
				1. 00	
	TO BE COMPLETED BY CONTRACTOR FOR NONSTANDARD COST REPORTS				
	HEALTH INFORMATION TECHNOLOGY DATA COLLECTION AND CALCULATIO	N			1
1.00	Total hospital discharges as defined in AARA §4102 from Wkst	. S-3, Pt. I col. 15 lin	e 14		1.00
2.00					2.00
3.00	3.00 Medicare HMO days from Wkst. S-3, Pt. I, col. 6. line 2				
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	10.00 Calculation of the HIT incentive payment after sequestration (see instructions)				
	INPATIENT HOSPITAL SERVICES UNDER THE IPPS & CAH				
30.00	Initial/interim HIT payment adjustment (see instructions)				30.00
	31.00 Other Adjustment (specify)				31.00
32.00	Balance due provider (line 8 (or line 10) minus line 30 and	line 31) (see instructio	ns)		32.00

Health Financial Systems	UNION HOSPITAL, INC.	In Lio	u of Form CMS-2	0552 10
CALCULATION OF REIMBURSEMENT SETTLEMENT		Peri od:	Worksheet E-3	
		From 01/01/2018	Part III	
	Component CCN: 15-T023	To 12/31/2018	Date/lime Pre 5/29/2019 1:1	pared: 1 pm
	Title XVIII	Subprovi der -	PPS	
		I RF		
			1. 00	
PART III - MEDICARE PART A SERVICES - IRF PPS				

	, IRF		
		1. 00	
	PART III - MEDICARE PART A SERVICES - IRF PPS	1.00	
1.00	Net Federal PPS Payment (see instructions)	3, 348, 973	1.00
2. 00	Medicare SSI ratio (IRF PPS only) (see instructions)	0. 0358	
3. 00	Inpatient Rehabilitation LIP Payments (see instructions)	176, 826	3.00
4.00	Outlier Payments	20, 141	4.00
5. 00	Unweighted intern and resident FTE count in the most recent cost reporting period ending on or prior to November 15, 2004 (see instructions)	21. 00	5. 00
5. 01	Cap increases for the unweighted intern and resident FTE count for residents that were displaced by program or hospital closure, that would not be counted without a temporary cap adjustment under 42 CFR §412.424(d)(1)(iii)(F)(1) or (2) (see instructions)	0. 00	5. 01
6.00	New Teaching program adjustment. (see instructions)	0. 00	6. 00
7. 00	Current year's unweighted FTE count of I&R excluding FTEs in the new program growth period of a "new	0. 00	7. 00
	teaching program" (see instructions)		
8. 00	Current year's unweighted I&R FTE count for residents within the new program growth period of a "new teaching program" (see instructions)	0. 00	8. 00
9.00	Intern and resident count for IRF PPS medical education adjustment (see instructions)	0.00	9. 00
10.00	Average Daily Census (see instructions)	10. 073973	
11.00	Teaching Adjustment Factor (see instructions)	0. 000000	
12.00	Teaching Adjustment (see instructions)	0	12.00
13. 00 14. 00	Total PPS Payment (see instructions)	3, 545, 940 0	13. 00 14. 00
15.00	Nursing and Allied Health Managed Care payments (see instruction) Organ acquisition (DO NOT USE THIS LINE)	١	15.00
16. 00		o	
17. 00	Subtotal (see instructions)	3, 545, 940	
18. 00	·	0,010,710	18.00
19. 00		3, 545, 940	
20.00		28, 140	
21.00	Subtotal (line 19 minus line 20)	3, 517, 800	21.00
22.00		5, 025	22.00
23.00	Subtotal (line 21 minus line 22)	3, 512, 775	23. 00
24.00	Allowable bad debts (exclude bad debts for professional services) (see instructions)	24, 168	
25. 00	Adjusted reimbursable bad debts (see instructions)	15, 709	
26. 00	,	13, 342	
27. 00		3, 528, 484	27. 00
28. 00	Direct graduate medical education payments (from Wkst. E-4, line 49)	0	28.00
29. 00		1, 067	
30. 00 31. 00	Outlier payments reconciliation	0	30. 00 31. 00
31. 50	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY) Pioneer ACO demonstration payment adjustment (see instructions)	0	31.00
31. 99	Demonstration payment adjustment (see First detrois)	0	31. 99
32. 00	Total amount payable to the provider (see instructions)	3, 529, 551	
32. 01	Sequestration adjustment (see instructions)	70, 591	
32. 02	Demonstration payment adjustment amount after sequestration	0	32. 02
33. 00		3, 439, 040	
34.00	Tentative settlement (for contractor use only)	0	34.00
35.00	Balance due provider/program (line 32 minus lines 32.01, 32.02, 33, and 34)	19, 920	35. 00
36. 00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2	0	36. 00
50	TO BE COMPLETED BY CONTRACTOR		
	Original outlier amount from Wkst. E-3, Pt. III, line 4	20, 141	50.00
	Outlier reconciliation adjustment amount (see instructions)	0	51.00
	The rate used to calculate the Time Value of Money		52.00
აა. 00	Time Value of Money (see instructions)	. U	53.00

Health Financial Systems	UNION HOSPITAL, INC.	In Lie	u of Form CMS-2552-10
CALCULATION OF REIMBURSEMENT SETTLEMENT	Provi der CCN: 15-0023		Worksheet E-3 Part VII Date/Time Prepared: 5/29/2019 1:11 pm

			To 12/31/2018	Date/Time Pre 5/29/2019 1:1	
		Title XIX	Hospi tal	Cost	. р
			I npati ent	Outpati ent	
			1. 00	2.00	
	PART VII - CALCULATION OF REIMBURSEMENT - ALL OTHER HEALTH SERV	VICES FOR TITLES V OR XI	X SERVICES		
	COMPUTATION OF NET COST OF COVERED SERVICES				1
1.00	Inpatient hospital/SNF/NF services		1, 765, 929		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)		1, 765, 929	0	4.00
5.00	Inpatient primary payer payments		0		5. 00
6.00	Outpati ent pri mary payer payments			0	6.00
7.00	Subtotal (line 4 less sum of lines 5 and 6)		1, 765, 929	0	7. 00
	COMPUTATION OF LESSER OF COST OR CHARGES				1
	Reasonabl e Charges]
8.00	Routine service charges		2, 188, 709		8. 00
9.00	Ancillary service charges		3, 526, 644	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)		5, 715, 353	0	12.00
	CUSTOMARY CHARGES				
13.00	Amount actually collected from patients liable for payment for	services on a charge	0	0	13.00
	basis				
14. 00	Amounts that would have been realized from patients liable for		0 ا	0	14. 00
	a charge basis had such payment been made in accordance with 4	2 CFR §413.13(e)			
15. 00	Ratio of line 13 to line 14 (not to exceed 1.000000)		0. 000000	0. 000000	
16. 00	Total customary charges (see instructions)		5, 715, 353	0	
17. 00	Excess of customary charges over reasonable cost (complete only	y if line 16 exceeds	3, 949, 424	0	17. 00
40.00	line 4) (see instructions)	16114			10.00
18. 00	Excess of reasonable cost over customary charges (complete only	y it line 4 exceeds line	0	0	18. 00
10 00	16) (see instructions)			0	19.00
19. 00 20. 00	Interns and Residents (see instructions) Cost of physicians' services in a teaching hospital (see instru	uati ana)	0	0	
21. 00	Cost of covered services (enter the lesser of line 4 or line 1		1, 765, 929	0	
21.00	PROSPECTIVE PAYMENT AMOUNT - Lines 22 through 26 must only be			0	21.00
22 00	Other than outlier payments	compreted for 113 provid	0	0	22. 00
	Outlier payments		o o	0	
	Program capital payments		o o	O	24.00
	Capital exception payments (see instructions)		Ö		25.00
26. 00			0	0	
27. 00	Subtotal (sum of lines 22 through 26)		0	0	
	,		0	0	
29. 00	Titles V or XIX (sum of lines 21 and 27)		1, 765, 929	0	
	COMPUTATION OF REIMBURSEMENT SETTLEMENT		.,		
30.00	Excess of reasonable cost (from line 18)		0	0	30.00
31.00	Subtotal (sum of lines 19 and 20, plus 29 minus lines 5 and 6)		1, 765, 929	0	31.00
32.00	Deducti bl es		0	0	32.00
33.00	Coinsurance		0	0	33.00
34.00	Allowable bad debts (see instructions)		0	0	34.00
35.00	Utilization review		0		35. 00
36.00	Subtotal (sum of lines 31, 34 and 35 minus sum of lines 32 and	33)	1, 765, 929	0	36.00
37.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)		0	0	37.00
38.00	Subtotal (line 36 ± line 37)		1, 765, 929	0	38. 00
	Direct graduate medical education payments (from Wkst. E-4)		0		39. 00
	Total amount payable to the provider (sum of lines 38 and 39)		1, 765, 929	0	
41.00			2, 988, 965	0	
42.00	Balance due provider/program (line 40 minus line 41)		-1, 223, 036	0	
43.00	Protested amounts (nonallowable cost report items) in accordance	ce with CMS Pub 15-2,	0	0	43.00
	chapter 1, §115.2				

I RECT	Financial Systems UNION HOSPITAL GRADUATE MEDICAL EDUCATION (GME) & ESRD OUTPATIENT DIRECT	L, INC. Provider C	CN: 15-0023	Peri od:	u of Form CMS-2 Worksheet E-4	
	L EDUCATION COSTS			From 01/01/2018 To 12/31/2018	Date/Time Prep 5/29/2019 1:1	pared
		Title	XVIII	Hospi tal	PPS	
					1. 00	
	COMPUTATION OF TOTAL DIRECT GME AMOUNT					
00	Unweighted resident FTE count for allopathic and osteopathic ending on or before December 31, 1996.	programs for	r cost report	ing periods	14. 92	1.
00 00	Unweighted FTE resident cap add-on for new programs per 42 CF Amount of reduction to Direct GME cap under section 422 of MM		(1) (see inst	ructions)	0. 00 0. 00	2. (3. (
01	Direct GME cap reduction amount under ACA §5503 in accordance instructions for cost reporting periods straddling 7/1/2011)		R §413.79 (m)	. (see	0.00	3.
00	Adjustment (plus or minus) to the FTE cap for allopathic and GME affiliation agreement (42 CFR §413.75(b) and § 413.79 (f)		programs due	e to a Medicare	0. 00	4.
01	ACA Section 5503 increase to the Direct GME FTE Cap (see instant straddling 7/1/2011)		r cost report	ing periods	0. 00	4.
02	ACA Section 5506 number of additional direct GME FTE cap slot periods straddling 7/1/2011)	s (see ins	tructions for	cost reporting	0. 00	4.
. 00	FTE adjusted cap (line 1 plus line 2 minus line 3 and 3.01 pl 4.02 plus applicable subscripts	us or minus	line 4 plus	lines 4.01 and	14. 92	5.
. 00	Unweighted resident FTE count for allopathic and osteopathic records (see instructions)	programs for	r the current	year from your	21. 00	6.
. 00	Enter the lesser of line 5 or line 6		D	211	14. 92	7.
			Primary Card	e 0ther 2.00	Total 3.00	
00	Weighted FTE count for physicians in an allopathic and osteop	oathi c	21. (21. 00	8.
00	program for the current year. If line 6 is less than 5 enter the amount from line 8, otherwind multiply line 8 times the result of line 5 divided by the amount from line 8 times the result of line 5 divided by the amount from line 8 times the result of line 5 divided by the amount from line 8 times the result of line 5 divided by the amount from line 8 times the result of line 5 divided by the amount from line 8.		14. 9	92 0.00	14. 92	9.
0. 00	6. Weighted dental and podiatric resident FTE count for the curr	ent year		0. 00		10.
0. 01	Unweighted dental and podiatric resident FTE count for the cu	ırrent year	14.	0.00		10.
2. 00	Total weighted FTE count Total weighted resident FTE count for the prior cost reportir instructions)	ng year (see	14. ⁹ 14. ⁹			11. 12.
3. 00	Total weighted resident FTE count for the penultimate cost reyear (see instructions)	eporti ng	14. 9			13.
1. 00 5. 00	Rolling average FTE count (sum of lines 11 through 13 divided Adjustment for residents in initial years of new programs	d by 3).	14.9			14. 15.
5. 01	Unweighted adjustment for residents in initial years of new p	orograms	0. (15.
5. 00 5. 01	Adjustment for residents displaced by program or hospital cloud unweighted adjustment for residents displaced by program or h		0. (0. (16. 16.
7. 00	closure Adjusted rolling average FTE count		14.			17.
3. 00 9. 00	Per resident amount Approved amount for resident costs		127, 193. 3 1, 897, 73		1, 897, 724	18. 19.
					1. 00	
0. 00	Additional unweighted allopathic and osteopathic direct GME F Sec. 413.79(c)(4)	TE resident	cap slots re	eceived under 42	5. 75	20.
1.00	Direct GME FTE unweighted resident count over cap (see instru				6. 08	
2. 00 3. 00	Allowable additional direct GME FTE Resident Count (see instr Enter the locality adjustment national average per resident a		instructions)		5. 75 101, 086. 71	
4. 00	Multiply line 22 time line 23		, , , , , , , , , , , , , , , , , , , ,		581, 249	
. 00	Total direct GME amount (sum of lines 19 and 24)		I ppati opt	Managed care	2, 478, 973	25.
			Inpatient Part A	Managed care		
	COMPUTATION OF PROGRAM PATIENT LOAD		1.00	2.00	3. 00	
5. 00	Inpatient Days (see instructions)		27, 79	99 3, 742		26.
7. 00	Total Inpatient Days (see instructions)		57, 3			27.
8.00	Ratio of inpatient days to total inpatient days		0. 4849			28. 29.
9. 00 0. 00	Program direct GME amount Reduction for direct GME payments for Medicare Advantage		1, 202, 0	31 161, 812 22, 864		29. 30.
	Net Program direct GME amount		1	, , , , ,	1, 341, 029	

Heal th	Financial Systems UNION HOSPITAL	LNC.	In lie	u of Form CMS-2	2552-10	
	DIRECT GRADUATE MEDICAL EDUCATION (GME) & ESRD OUTPATIENT DIRECT Provider CCN: 15-0023 Period:					
	MEDICAL EDUCATION COSTS From 01/01/201 To 12/31/201					
		Title XVIII	Hospi tal	PPS		
				1. 00		
	DIRECT MEDICAL EDUCATION COSTS FOR ESRD COMPOSITE RATE - TITL EDUCATION COSTS)	•		I CAL		
32. 00	Renal dialysis direct medical education costs (from Wkst. B, and 94)	Pt. I, sum of col. 20 a	nd 23, lines 74	0	32.00	
33.00	Renal dialysis and home dialysis total charges (Wkst. C, Pt.	I, col. 8, sum of lines	74 and 94)	0	33.00	
34.00	Ratio of direct medical education costs to total charges (lir	ne 32 ÷ line 33)		0.000000	34.00	
35.00	0 Medicare outpatient ESRD charges (see instructions)			0	35.00	
36.00	Medicare outpatient ESRD direct medical education costs (line 34 x line 35)			0	36.00	
	APPORTIONMENT BASED ON MEDICARE REASONABLE COST - TITLE XVIII ONLY					
	Part A Reasonable Cost					
37.00	Reasonable cost (see instructions)			67, 394, 841		
38.00	Organ acquisition costs (Wkst. D-4, Pt. III, col. 1, line 69)			0		
	Cost of physicians' services in a teaching hospital (see inst	ructions)		0		
	Primary payer payments (see instructions)			122, 427		
41. 00	0 Total Part A reasonable cost (sum of lines 37 through 39 minus line 40)			67, 272, 414	41.00	
	Part B Reasonable Cost		T			
42.00				68, 084, 160		
43.00	Primary payer payments (see instructions)				43.00	
	0 Total Part B reasonable cost (line 42 minus line 43)			68, 076, 791		
	0 Total reasonable cost (sum of lines 41 and 44)			135, 349, 205		
	Ratio of Part A reasonable cost to total reasonable cost (line 41 ÷ line 45)			0. 497029		
47.00	Ratio of Part B reasonable cost to total reasonable cost (lin			0. 502971	47. 00	
40.00	ALLOCATION OF MEDICARE DIRECT GME COSTS BETWEEN PART A AND PA	KI B		4 044 000	40.00	
	Total program GME payment (line 31)	(and instructions)		1, 341, 029		
	Part A Medicare GME payment (line 46 x 48) (title XVIII only)			666, 530		
50.00	Part B Medicare GME payment (line 47 x 48) (title XVIII only)	(See Thistructions)	l	674, 499	30.00	

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

Health Financial Systems

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

Worksheet G
B Date/Time Prepared:
5/29/2019 1:11 pm

Purpose Fund Fund		· · · · · · · · · · · · · · · · · · ·	General Fund	Speci fi c	Endowment	Plant Fund	I pili
CURRENT ASSETS				Purpose Fund	Fund		
1.00		CURRENT ACCETC	1.00	2. 00	3. 00	4. 00	
2.00 Temporary Investments	1 00		64 922 806		٥	0	1 00
3.00			04, 722, 000		-1		2.00
4.00 Accounts receivable 46, 461,797 0 0 0 0 5.00		1	0	_	-1		
5.00			46, 461, 797	0	o		4.00
1.00	5.00	Other receivable	0	0	0	0	5.00
Repair of expenses	6.00	Allowances for uncollectible notes and accounts receivable	0	0	0		6.00
9.00 Other current assets 0 0 0 0 9.0 11.00 Total current assets (sum of lines 1-10) 98,461,733 0 0 0 11.0					0		
10.00 Due from other Funds 0 0 0 0 0 10.0			-17, 958, 620	0	0		1
11.0 Total current assets (sum of lines 1-10) 98, 461, 733 0 0 0 11.6			0	0	0		
FIXED ASSETS			00 461 722	_	0		
12.00 Land Improvements	11.00		70, 401, 733	l ol	<u> </u>	0	11.00
14.0 Accumulated depreciation 0 0 0 0 14.0 15.00 Buildings 343,991,056 0 0 0 15.0 16.00 Accumulated depreciation -302,629,734 0 0 0 15.0 16.00 Accumulated depreciation -302,629,734 0 0 0 15.0 16.00 Accumulated depreciation 0 0 0 0 15.0 17.00 Leasehold improvements 0 0 0 0 0 15.0 18.00 Accumulated depreciation 0 0 0 0 0 17.0 19.00 Fixed equipment 0 0 0 0 0 0 19.00 Accumulated depreciation 0 0 0 0 0 21.00 Accumulated depreciation 0 0 0 0 0 22.00 Accumulated depreciation 0 0 0 0 0 23.00 Agior movable equipment 163,091,691 0 0 0 0 24.00 Accumulated depreciation 0 0 0 0 0 25.00 Accumulated depreciation 0 0 0 0 25.00 Minor equipment depreciable 0 0 0 0 0 26.00 Accumulated depreciation 0 0 0 0 27.00 HIT designated Assets 0 0 0 0 0 28.00 Accumulated depreciation 0 0 0 0 29.00 Minor equipment-nondepreciable 0 0 0 0 29.01 Minor equipment-nondepreciable 0 0 0 0 29.02 Minor equipment-nondepreciable 0 0 0 0 29.03 Minor equipment-nondepreciable 0 0 0 0 29.04 Minor equipment-nondepreciable 0 0 0 29.05 Minor equipment-nondepreciable 0 0 0 29.01 Minor equipment-nondepreciable 0 0 0 29.02 Minor equipment-nondepreciable 0 0 0 29.03 Minor equipment-nondepreciable 0 0 0 29.04 Minor equipment-nondepreciable 0 0 0 29.05 Minor equipment Minor equipme	12.00		37, 670, 380	0	0	0	12.00
15. 0			0		O	0	13.00
16. 0 Accumulated depreciation	14.00	Accumulated depreciation	0		0	0	14.00
17.00 Leasehold improvements 0 0 0 0 17.6 18.00 Accumul atted depreciation 0 0 0 0 18.6 19.00 Fixed equipment 0 0 0 0 0 20.00 Accumul atted depreciation 0 0 0 0 21.00 Automobiles and trucks 0 0 0 0 0 22.00 Accumulated depreciation 0 0 0 0 23.00 Major movable equipment 163,091,691 0 0 0 23.6 24.00 Accumulated depreciation 0 0 0 0 0 25.00 Min or equipment depreciation 0 0 0 0 0 26.00 Accumulated depreciation 0 0 0 0 27.00 HIT designated Assets 0 0 0 0 28.00 Accumulated depreciation 0 0 0 29.00 Min or equipment-nondepreciable 0 0 0 0 29.00 Min or equipment-nondepreciable 0 0 0 0 30.00 TOTAL Truck assets (sum of lines 12-29) 242,123,393 0 0 0 31.00 Investments 0 0 0 0 32.00 Deposits on leases 0 0 0 0 33.00 Due from owners/officers 0 0 0 0 34.00 Other assets (sum of lines 31-34) 85,477,076 0 0 0 35.00 Total other assets (sum of lines 31-34) 85,477,076 0 0 0 36.00 Total assets (sum of lines 11, 30, and 35) 426,062,202 0 0 0 37.00 Accounts payable 29,936,952 0 0 0 36.6 CURRENT LIABILITIES 0 0 0 0 37.00 Accounts payable (short term) 0 0 0 0 40.00 Notes and loans payable (short term) 0 0 0 0 40.00 Other current liabilities (sum of lines 37 thru 44) 52,310,301 0 0 0 47.00 Notes payable 0 0 0 0				0	0		
18. 00 Accumul atted depreciation 0 0 0 0 18.6			-302, 629, 734	0	0		1
19.00 Fixed equipment 0		· •	0	0	0		17.00
20. 00 Accumul ated depreciation 0 0 0 0 0 20.00		·	0	0	U O		
21.00 Automobiles and trucks		Accumulated depreciation	0	0	0		20.00
22.00 Accumulated depreciation 0 0 0 0 22.0			0	0	0		21.00
23. 00 Maj or movable equipment			l o	o o	Ö		22.00
25.00 Minor equipment depreciable 0 0 0 0 0 0 25.00 26.00 Accumulated depreciation 0 0 0 0 0 26.00 27.00 HIT designated Assets 0 0 0 0 0 0 27.00 Minor equipment-nondepreciable 0 0 0 0 0 0 0 27.00 Minor equipment-nondepreciable 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0			163, 091, 691	0	Ö		23. 00
26.00 Accumulated depreciation	24.00	Accumul ated depreciation	0	0	О	0	24.00
27. 00 HIT designated Assets 0 0 0 0 0 0 27. 0 28. 00 Accumulated depreciation 0 0 0 0 0 28. 0 0 0 0 0 0 29. 0 30. 00 Total fixed assets (sum of lines 12-29) 0	25.00	Mi nor equi pment depreciable	0	0	0	0	25. 00
28.00 Accumulated depreciation		·	0	0	0		26. 00
29.00 Minor equipment-nondepreciable 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0			0	0	0		27.00
30.00 Total fixed assets (sum of lines 12-29) 242,123,393 0 0 0 0 30.00 OTHER ASSETS			0	0	0		
OTHER ASSETS 31.00 Investments 0 0 0 0 0 0 31.0			0	_	0		
31.00 Investments 0 0 0 0 0 31.00 32.00 Deposits on leases 0 0 0 0 0 32.00 33.00 Due from owners/officers 0 0 0 0 0 32.00 34.00 Other assets 85,477,076 0 0 0 0 34.00 35.00 Total other assets (sum of lines 31-34) 85,477,076 0 0 0 0 35.00 36.00 Total assets (sum of lines 11, 30, and 35) 426,062,202 0 0 0 0 CURRENT LIABILITIES	30.00		242, 123, 373	<u> </u>	<u> </u>	0	30.00
32.00 Deposits on leases 0 0 0 0 32.00 33.00 Due from owners/officers 0 0 0 0 0 34.00 Other assets 0 0 0 0 35.00 Total other assets (sum of lines 31-34) 85,477,076 0 0 0 36.00 Total assets (sum of lines 11, 30, and 35) 426,062,202 0 0 0 37.00 Accounts payable 29,936,952 0 0 0 38.00 Payroll taxes payable 20,790,014 0 0 0 39.00 Payroll taxes payable 0 0 0 0 40.00 Notes and loans payable (short term) 0 0 0 0 41.00 Deferred income 0 0 0 0 42.00 Accelerated payments 0 0 0 0 43.00 Due to other funds 0 0 0 0 44.00 Other current liabilities 1,583,335 0 0 0 44.00 Other current liabilities (sum of lines 37 thru 44) 52,310,301 0 0 0 46.00 Mortgage payable 0 0 0 0 0 47.00 Notes payable 0 0 0 0 48.00 Notes payable 0 0 0 0 49.00 Notes payable 0 0 0 0 40.00 0 0 0 0 40.00 0 0 0 0 40.00 0 0 0 0 40.00 0 0 0 40.00 0 0 0 40.00 0 0 0 40.00 0 0 0 40.00 0 0 0 40.00 0 0 0 40.00 0 0 0 40.00 0 0 40.00 0 0 0 40.00 0 0	31.00		0	0	ol	0	31.00
34.00 Other assets 85, 477, 076 0 0 0 34.00 35.00 Total other assets (sum of lines 31-34) 85, 477, 076 0 0 0 35.00 36.00 Total assets (sum of lines 11, 30, and 35) 426, 062, 202 0 0 0 36.00 37.00 Accounts payable 29, 936, 952 0 0 0 37.00 38.00 Sal aries, wages, and fees payable 20, 790, 014 0 0 0 38.00 39.00 Payroll taxes payable 0 0 0 0 0 39.00 40.00 Notes and loans payable (short term) 0 0 0 0 0 0 0 40.00 41.00 Deferred income 0	32.00	Deposits on Leases	0	0	0	0	
35.00 Total other assets (sum of lines 31-34) 85,477,076 0 0 0 35.00 36.00 Total assets (sum of lines 11, 30, and 35) 426,062,202 0 0 0 36.00 CURRENT LIABILITIES	33.00	Due from owners/officers	0	0	0	0	33.00
36.00 Total assets (sum of lines 11, 30, and 35) 426,062,202 0 0 0 36.00					0		34.00
CURRENT LIABILITIES 37.00 Accounts payable 29,936,952 0 0 0 37.00 38.00 Salaries, wages, and fees payable 20,790,014 0 0 0 0 38.00 39.00 Payroll taxes payable 0 0 0 0 0 0 39.00 40.00 Notes and loans payable (short term) 0 0 0 0 0 0 40.00 41.00 Deferred income 0 0 0 0 0 41.00 42.00 Accelerated payments 0 0 0 0 0 42.00 43.00 Due to other funds 0 0 0 0 0 43.00 44.00 Other current liabilities 1,583,335 0 0 0 0 44.00 45.00 Constant of the current liabilities (sum of lines 37 thru 44) 52,310,301 0 0 0 0 0 45.00 Constant of the current liabilities 46.00 Mortgage payable 0 0 0 0 0 47.00 Notes payable 0 0 0 0 0 0 47.00 0 0 0 0 0 0 0 0 0					-1		35.00
37. 00 Accounts payable 29, 936, 952 0 0 0 37. 0 38. 00 Salaries, wages, and fees payable 20, 790, 014 0 0 0 38. 0 39. 00 Payroll taxes payable 0 0 0 0 0 39. 0 40. 00 Notes and loans payable (short term) 0 0 0 0 0 0 0 40. 0 41. 00 Deferred income 0 0 0 0 0 0 0 41. 0 42. 00 Accelerated payments 0	36.00		426, 062, 202	0	U	0	36.00
38.00 Salaries, wages, and fees payable 20,790,014 0 0 0 38.00 39.00 Payroll taxes payable 0 0 0 0 0 39.00 40.00 Notes and loans payable (short term) 0 0 0 0 0 0 0 40.00 41.00 Deferred income 0 0 0 0 0 0 41.00 42.00 Accelerated payments 0	37 00		29 936 952	0	٥	0	37 00
39.00 Payrol I taxes payable 0 0 0 0 39.00 40.00 Notes and loans payable (short term) 0 0 0 0 0 40.00 41.00 Deferred income 0 0 0 0 0 41.00 42.00 Accelerated payments 0 0 0 0 0 42.0 43.00 Due to other funds 0 0 0 0 0 0 43.0 44.00 Other current liabilities 1,583,335 0 0 0 0 44.0 45.00 Total current liabilities (sum of lines 37 thru 44) 52,310,301 0 0 0 0 0 45.0 LONG TERM LIABILITIES 0 0 0 0 0 0 0 46.0 47.00 Notes payable 0					0		
41.00 Deferred income 0 0 0 0 41.0 42.00 Accelerated payments 0 0 0 0 0 42.0 43.00 Due to other funds 0 0 0 0 0 43.0 44.00 Other current liabilities 1,583,335 0 0 0 0 44.0 45.00 LONG TERM LIABILITIES 45.0 0 0 0 0 0 0 46.0 47.00 Notes payable 0 0 0 0 0 0 47.0			0		O		39.00
42.00 Accelerated payments 0 0 0 0 0 42.00 43.00 Due to other funds 0 0 0 0 0 43.00 44.00 Other current liabilities 1,583,335 0 0 0 0 44.00 45.00 LONG TERM LIABILITIES 46.00 Mortgage payable 0 0 0 0 46.00 47.00 Notes payable 0 0 0 0 0	40.00	Notes and Loans payable (short term)	0	0	o	0	40.00
43.00 Due to other funds 0 0 0 0 43.00 44.00 Other current liabilities 1,583,335 0 0 0 44.00 45.00 Total current liabilities (sum of lines 37 thru 44) 52,310,301 0 0 0 45.00 LONG TERM LIABILITIES 46.00 Mortgage payable 0 0 0 0 46.00 47.00 Notes payable 0 0 0 0 0	41.00		0	0	0	0	41.00
44.00 Other current liabilities 1,583,335 0 0 0 44.00 45.00 Total current liabilities (sum of lines 37 thru 44) 52,310,301 0 0 0 45.00 LONG TERM LIABILITIES 46.00 Mortgage payable 0 0 0 0 0 46.00 47.00 Notes payable 0 0 0 0 0 47.00			0				42.00
45.00 Total current liabilities (sum of lines 37 thru 44) 52,310,301 0 0 0 45.00 LONG TERM LIABILITIES 46.00 Mortgage payable 0 0 0 0 0 46.00 47.00 Notes payable 0 0 0 0 0 47.00			0	0	0		1
LONG TERM LIABILITIES 46. 00 Mortgage payable 0 0 0 0 46. 0 47. 00 Notes payable 0 0 0 0 0 47. 0					0		
46. 00 Mortgage payable 0 0 0 0 46. 0 47. 00 Notes payable 0 0 0 0 47. 0	45.00		52, 310, 301	U	υ	0	45.00
47.00 Notes payable 0 0 0 0 47.0	46 00		0	0	0	0	46.00
			0	_	o		
48.00 Unsecured Toans 0 0 0 0 48.0		' '	0	0	Ö	0	
49.00 Other long term liabilities 250,674,490 0 0 0 49.0	49.00	Other long term liabilities	250, 674, 490	0	0	0	49.00
		Total long term liabilities (sum of lines 46 thru 49)			0		50.00
	51.00		302, 984, 791	0	0	0	51.00
CAPITAL ACCOUNTS	F0 00		400 077 444				F0 00
			123, 077, 411	1			52.00
		' ' '					53. 00 54. 00
					0		55.00
					o O		56.00
		1			١	0	
58.00 Plant fund balance - reserve for plant improvement, 0 58.00		Plant fund balance - reserve for plant improvement,					58. 00
repl acement, and expansion		1 .					
					0		
60.00 Total liabilities and fund balances (sum of lines 51 and 426,062,202 0 0 0 60.0 59)	60.00		426, 062, 202		O	0	60.00
		1~./	I	ı	ı		I

UNION HOSPITAL, INC.

In Lieu of Form CMS-2552-10
Period: Worksheet G-1
From 01/01/2018 Health Financial Systems
STATEMENT OF CHANGES IN FUND BALANCES Provider CCN: 15-0023

					rom 01/01/2018 Fo 12/31/2018	Date/Time Pre 5/29/2019 1:1	
		Genera	I Fund	Speci al Pu	urpose Fund	Endowment Fund	, p
1. 00	Fund balances at beginning of period	1. 00	2. 00 109, 567, 347	3. 00	4. 00	5. 00	1.00
2. 00	Net income (loss) (from Wkst. G-3, line 29)		13, 510, 064				2.00
3. 00	Total (sum of line 1 and line 2)		123, 077, 411	1	0		3. 00
4.00	Additions (credit adjustments) (specify)	0		(0	
5.00		0			1	0	
6. 00 7. 00		0					
8. 00		0				Ö	
9.00		0		c		0	9. 00
10.00	Total additions (sum of line 4-9)				0	l	10.00
11. 00 12. 00	Subtotal (line 3 plus line 10) Deductions (debit adjustments) (specify)	0	123, 077, 411		0	0	11. 00 12. 00
13. 00	beductions (debit adjustiments) (specify)	0					
14. 00		0				Ö	
15.00		0		c		0	
16.00		0		C		0	
17. 00 18. 00	Total deductions (sum of lines 12-17)	0	,		0	0	17. 00 18. 00
19. 00	Fund balance at end of period per balance		123, 077, 411		0		19.00
	sheet (line 11 minus line 18)				_		
		Endowment	PI ant	Fund			
		Fund					
		6. 00	7.00	8. 00	_		
1.00	Fund balances at beginning of period	0		C)		1.00
2. 00 3. 00	Net income (loss) (from Wkst. G-3, line 29) Total (sum of line 1 and line 2)	0					2. 00 3. 00
4. 00	Additions (credit adjustments) (specify)	0	0				4.00
5. 00	, , , , , , , , , , , , , , , , , , ,		O				5.00
6.00			0				6. 00
7. 00 8. 00			0				7. 00 8. 00
9. 00			0				9.00
10. 00	Total additions (sum of line 4-9)	0					10.00
11.00	Subtotal (line 3 plus line 10)	0		c			11.00
12.00	Deductions (debit adjustments) (specify)		0				12.00
13. 00 14. 00			0				13. 00 14. 00
15. 00			0				15.00
16. 00			Ö				16.00
17. 00			0				17. 00
18.00	Total deductions (sum of lines 12-17)	0					18.00
19. 00	Fund balance at end of period per balance sheet (line 11 minus line 18)	0		C)		19. 00
	1	1	ı	1	1		

UNION HOSPITAL, INC.

Health Financial Systems
STATEMENT OF PATLENT REVENUES AND OPERATING EXPENSES Provider CCN: 15-0023

			To 12/31/2018	Date/Time Pre	
	Coot Contan Decement on	I nnoti ont	Outpati ent	5/29/2019 1:1 Total	ı pm
	Cost Center Description	I npati ent 1.00	2. 00	3. 00	
	PART I - PATIENT REVENUES	1.00	2.00	3.00	
	General Inpatient Routine Services				
1. 00	Hospi tal	90, 205, 48	6	90, 205, 486	1.00
2. 00	SUBPROVI DER - I PF	70, 203, 40		70, 200, 400	2.00
3. 00	SUBPROVI DER - I RF	3, 833, 38	4	3, 833, 384	3.00
4. 00	SUBPROVI DER	3, 033, 30		3, 033, 304	4.00
5. 00	Swing bed - SNF		0	0	5.00
6. 00	Swing bed - NF	•	Ď	Ö	6.00
7. 00	SKILLED NURSING FACILITY				7.00
8. 00	NURSI NG FACI LI TY				8.00
9. 00	OTHER LONG TERM CARE				9. 00
10.00	Total general inpatient care services (sum of lines 1-9)	94, 038, 87	0	94, 038, 870	1
	Intensive Care Type Inpatient Hospital Services		-		
11.00	INTENSIVE CARE UNIT	42, 373, 84	5	42, 373, 846	11.00
12.00	CORONARY CARE UNIT				12.00
13.00	BURN INTENSIVE CARE UNIT				13.00
14.00	SURGICAL INTENSIVE CARE UNIT				14.00
15.00	I NTENSI VE NURSERY		O	0	15.00
16.00	Total intensive care type inpatient hospital services (sum of lines	42, 373, 84	6	42, 373, 846	16.00
	11-15)				
17.00	Total inpatient routine care services (sum of lines 10 and 16)	136, 412, 71	5	136, 412, 716	17. 00
18.00	Ancillary services	333, 444, 07	5 794, 119, 768	1, 127, 563, 843	18. 00
19. 00	Outpati ent servi ces	30, 508, 51	2 131, 154, 865		19. 00
20.00	RURAL HEALTH CLINIC		0	0	20.00
21.00	FEDERALLY QUALIFIED HEALTH CENTER		0	0	21.00
22. 00	HOME HEALTH AGENCY				22. 00
23. 00	AMBULANCE SERVICES				23. 00
24. 00	CMHC				24. 00
25. 00	AMBULATORY SURGICAL CENTER (D. P.)				25. 00
26. 00	HOSPI CE				26. 00
27. 00	PHYSI CI AN REVENUE	4, 753, 76			27. 00
27. 01	PHYSI CI AN PRACTI CES		2, 717	2, 717	27. 01
28. 00	Total patient revenues (sum of lines 17-27)(transfer column 3 to Wkst.	505, 119, 06	943, 522, 855	1, 448, 641, 924	28. 00
	G-3, line 1) PART II - OPERATING EXPENSES				
29. 00	Operating expenses (per Wkst. A, column 3, line 200)		337, 930, 831		29. 00
30.00	HOME OFFICE	67, 788, 38			30.00
31. 00	THOME OTTICE)		31.00
32. 00			o o		32.00
33. 00		1	Ď	•	33.00
34. 00			o O		34.00
35. 00			0		35.00
36. 00	Total additions (sum of lines 30-35)		67, 788, 387		36.00
37.00	DEDUCT (SPECIFY)				37.00
38. 00			o O		38. 00
39.00			0		39.00
40.00			0		40.00
41.00			O		41.00
42.00	Total deductions (sum of lines 37-41)		0		42.00
43.00	Total operating expenses (sum of lines 29 and 36 minus line 42)(transfe	er	405, 719, 218		43.00
	to Wkst. G-3, line 4)				

	Financial Systems	UNION HOSPITAL, INC.		u of Form CMS-2	<u> 2552-10</u>
STATE	MENT OF REVENUES AND EXPENSES	Provi der CCN: 15-0023	Peri od: From 01/01/2018	Worksheet G-3	
			To 12/31/2018	Date/Time Prep 5/29/2019 1:1	
				1. 00	
1.00	Total patient revenues (from Wkst. G-2, Part			1, 448, 641, 924	1.00
2. 00	Less contractual allowances and discounts on	pati ents' accounts		1, 008, 199, 694	2.00
3.00	Net patient revenues (line 1 minus line 2)			440, 442, 230	3.00
4.00	Less total operating expenses (from Wkst. G-2			405, 719, 218	4.00
5. 00	Net income from service to patients (line 3 m	ninus line 4)		34, 723, 012	5. 00
,	OTHER I NCOME		1		,
6. 00	Contributions, donations, bequests, etc			0	6.00
7.00	Income from investments			0	7.00
8.00	Revenues from telephone and other miscellaneo	ous communication services		0	8.00
9.00	Revenue from television and radio service			0	9.00
10.00	Purchase di scounts			0	10.00
11. 00 12. 00	Rebates and refunds of expenses			0	11. 00 12. 00
13. 00	Parking lot receipts Revenue from laundry and linen service			0	12.00
14. 00	Revenue from meals sold to employees and gues	rte.		0	14.00
15. 00		515		0	15.00
16. 00	3 1	online to other than nationts		0	16.00
17. 00				0	17.00
18.00	ů .			0	18.00
19. 00				0	19.00
20.00	· · · · · · · · · · · · · · · · · · ·			0	20.00
21.00		id danteen		0	21.00
22. 00	Rental of hospital space			0	22. 00
23. 00	Governmental appropriations			ő	23.00
24. 00	OTHER I NCOME			15, 194, 328	
24. 01	TRANSFERS AND OTHER ALLOCATED			1, 461, 948	
24. 02				2, 163, 853	
24. 03				783, 260	
24. 04	UNREALIZED GAIN/LOSS ON INVESTMENTS			-4, 324, 417	24. 04
24. 05				-81, 271	24. 05
24. 06				1, 383, 005	
25. 00	Total other income (sum of lines 6-24)			16, 580, 706	25. 00
	Total (line 5 plus line 25)			51, 303, 718	
27. 00	OTHER EXPENSES			37, 793, 654	
28. 00	Total other expenses (sum of line 27 and subs	scripts)		37, 793, 654	28. 00
	Net income (or loss) for the period (line 26			13, 510, 064	

Heal th	Financial Systems UNION HOSPI	TAL, INC.	In Lie	u of Form CMS-2	2552-10
CALCUL	ATION OF CAPITAL PAYMENT	Provider CCN: 15-0023	Peri od: From 01/01/2018 To 12/31/2018		
	<u> </u>	Title XVIII	Hospi tal	PPS	
				1. 00	
	PART I - FULLY PROSPECTIVE METHOD		<u> </u>	1.00	
	CAPITAL FEDERAL AMOUNT				1
1. 00	Capital DRG other than outlier			4, 712, 456	1.00
1. 01	Model 4 BPCI Capital DRG other than outlier			0	1
2.00	Capital DRG outlier payments			63, 886	2.00
2. 01	Model 4 BPCI Capital DRG outlier payments			0	
3.00	Total inpatient days divided by number of days in the cost	reporting period (see ins	tructi ons)	146. 99	
4. 00	Number of interns & residents (see instructions)			20. 67	
5.00	Indirect medical education percentage (see instructions)		4	4. 05	1
6. 00	Indirect medical education adjustment (multiply line 5 by 1.01)(see instructions)	the sum of lines I and I.U	i, columns i and	190, 854	6.00
7. 00	Percentage of SSI recipient patient days to Medicare Part	A patient days (Worksheet	E, part A line	4. 96	7.00
	30) (see instructions)				
8. 00	Percentage of Medicaid patient days to total days (see ins	tructions)		23. 62	
9. 00 10. 00	Sum of lines 7 and 8 Allowable disproportionate share percentage (see instruction	ana)		28. 58 5. 96	
11. 00	Disproportionate share adjustment (see instructions)	ons)		280, 862	
	Total prospective capital payments (see instructions)			5, 248, 058	
12.00	Total prospective capital payments (see mistractions)			3, 240, 030	12.00
				1. 00	
	PART II - PAYMENT UNDER REASONABLE COST				
1.00	Program inpatient routine capital cost (see instructions)			0	
2.00	Program inpatient ancillary capital cost (see instructions)		0	
3.00	Total inpatient program capital cost (line 1 plus line 2)			0	
4. 00 5. 00	Capital cost payment factor (see instructions) Total inpatient program capital cost (line 3 x line 4)			0	
5.00	Total impatrent program capital cost (fine 3 x fine 4)			0	3.00
				1. 00	
4 00	PART III - COMPUTATION OF EXCEPTION PAYMENTS				
1.00	Program inpatient capital costs (see instructions)	anasa (asa i natruati ana)		0	
2. 00 3. 00	Program inpatient capital costs for extraordinary circumstance program inpatient capital costs (line 1 minus line 2)	ances (see Fristructions)		0	
4. 00	Applicable exception percentage (see instructions)			0.00	
5. 00	Capital cost for comparison to payments (line 3 x line 4)			0.00	
6. 00	Percentage adjustment for extraordinary circumstances (see	instructions)		0.00	
7.00	Adjustment to capital minimum payment level for extraordina	ary circumstances (line 2	x line 6)	0	7.00
8.00	Capital minimum payment level (line 5 plus line 7)			0	8.00
9.00	Current year capital payments (from Part I, line 12, as ap			0	
10.00	Current year comparison of capital minimum payment level to			0	
11. 00	Carryover of accumulated capital minimum payment level over Worksheet L, Part III, line 14)	r capital payment (from pr	ior year	0	11.00
12.00	Net comparison of capital minimum payment level to capital			0	
13.00	Current year exception payment (if line 12 is positive, en			0	
14. 00	Carryover of accumulated capital minimum payment level over	r capital payment for the	following period	0	14.00
15 00	(if line 12 is negative, enter the amount on this line)	:+		_	15 00
15.00	Current year allowable operating and capital payment (see Current year operating and capital costs (see instructions			0	
	Current year exception offset amount (see instructions))			17.00
17.00	pour one year exception or set amount (see instructions)			ı	1 17.00