This report is required by law (42 USC 1395g; 42 CFR 413.20(b)). Failure to report can result in all interim FORM APPROVED payments made since the beginning of the cost reporting period being deemed overpayments (42 USC 1395g). OMB NO. 0938-0050 EXPIRES 03-31-2022 HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX COST REPORT CERTIFICATION | Provider CCN: 15-1326 Worksheet S Peri od: From 01/01/2021 Parts I-III AND SETTLEMENT SUMMARY 12/31/2021 Date/Time Prepared: 5/26/2022 10:52 am PART I - COST REPORT STATUS Provi der 1. [ X ] Electronically prepared cost report Date: 5/26/2022 Time: 10:52 am ] Manually prepared cost report use only Ilf this is an amended report enter the number of times the provider resubmitted this cost report [Medicare Utilization. Enter "F" for full or "L" for low. 4 [1] Cost Report Status
[1] As Submitted
[2] Settled without Audit
[3] Settled with Audit
[4] Date Received:
[5] To. NPR Date:
[6] 10. NPR Date:
[7] 11. Contractor's Vendor Code:
[7] 12. [8] Final Report for this Provider CCN
[9] [8] Final Report for this Provider CCN
[10] NPR Date:
[11] 12. Contractor's Vendor Code:
[12] [9] If line 5, column 1 is 4: Enter
[13] NPR Date:
[14] 12. Contractor's Vendor Code:
[15] 13. NPR Date:
[16] 13. NPR Date:
[17] 14. Contractor's Vendor Code:
[18] 15. Contractor's Vendor Code:
[18] 16. NPR Date:
[19] 17. Contractor's Vendor Code:
[19] 18. Contractor's Vendor Code:
[19] 19. Contractor's Vendor Code:
[19] Contractor use only (3) Settled with Audit number of times reopened = 0-9. (4) Reopened

PART II - CERTIFICATION BY A CHIEF FINANCIAL OFFICER OR ADMINISTRATOR OR PROVIDER(S)

(5) Amended

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

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

I HEREBY CERTIFY that I have read the above certification statement and that I have examined the accompanying electronically filed or manually submitted cost report and submitted cost report and the Balance Sheet and Statement of Revenue and Expenses prepared by UNION HOSPITAL CLINTON (15-1326) for the cost reporting period beginning 01/01/2021 and ending 12/31/2021 and to the best of my knowledge and belief, this report and statement are true, correct, complete and prepared from the books and records of the provider in accordance with applicable instructions, except as noted. I further certify that I am familiar with the laws and regulations regarding the provision of health care services, and that the services identified in this cost report were provided in compliance with such laws and regulations.

	SIGNATURE OF CHIEF FINA	NCIAL OFFICER OR ADMINISTRATOR	CHECKBOX	ELECTRONI C	
		1	2	SI GNATURE STATEMENT	
1	Matt Nealon			I have read and agree with the above certification statement. I certify that I intend my electronic signature on this certification be the legally binding equivalent of my original signature.	1
2	Signatory Printed Name	Matt Nealon			2
3	Signatory Title	CF0			3
4	Date	(Dated when report is electronica			4

		Title	XVIII			
Cost Center Description	Title V	Part A	Part B	HIT	Title XIX	
	1. 00	2.00	3. 00	4. 00	5. 00	
PART III - SETTLEMENT SUMMARY						
1.00 Hospi tal	0	-83, 165	-1, 047, 653	0	-36, 035	1.00
2.00 Subprovi der - IPF	0	0	0		0	2. 00
3.00 Subprovider - IRF	0	0	0		0	3. 00
5.00 Swing Bed - SNF	0	-22, 716	18		0	5. 00
6.00 Swing Bed - NF	0				0	6. 00
200. 00 Total	0	-105, 881	-1, 047, 635	0	-36, 035	200. 00

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

Health Financial Systems
UNION HOSPITAL CLINTON
In Lieu of Form CMS-2552-10
HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA
Provider CCN: 15-1326
| Period: From 01/01/2021 | Part I

HOSPI T	SPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA				F			Period: From 01/01/ To 12/31/	Worksheet S-2 Part I Date/Time Pre 5/26/2022 10:		pared:	
	1.00		2. 00		3. 00			4	1. 00			
	Hospital and Hospital Health Care Co	mplex Ad										
1.00	Street: 801 SOUTH MAIN STREET City: CLINTON		PO Box: State: IN	7in Cod	o. 170	242	Count	v. VEDMILLI	) NI			1. 00 2. 00
2. 00	City: CLINTON	Com	ponent Name	Zip Cod CCN	CB:		Provi der	y: VERMILLI Date		nt Syst	em (P	2.00
		COIII	porierre maille	Number	Num		Type	Certi fi ed		, 0, or		
							. 71-		V	XVIII		
			1. 00	2.00	3.	00	4. 00	5. 00	6. 00		8.00	
	Hospital and Hospital-Based Componer											
3.00	Hospi tal	UNI ON HO	SPITAL CLINTON	151326	454	160	1	03/01/2005	N	0	0	3. 00
4.00	Subprovi der - IPF					ŀ						4.00
5.00	Subprovi der - IRF					ŀ						5.00
6. 00 7. 00	Subprovi der - (Other) Swing Beds - SNF	SWING BE	ns	15Z326	454	160		03/01/2005	N	0	0	6. 00 7. 00
8. 00	Swing Beds - NF	JWING BE	.03	132320	454	100		03/01/2003	114			8.00
9. 00	Hospi tal -Based SNF					İ						9. 00
10.00	Hospi tal -Based NF					l						10.00
11. 00	Hospi tal -Based OLTC											11. 00
12.00	Hospi tal -Based HHA											12.00
13.00	1 '					l						13.00
14. 00 15. 00	Hospi tal-Based Hospi ce Hospi tal-Based Health Clinic - RHC											14. 00 15. 00
16. 00	Hospital-Based Health Clinic - FQHC					1						16.00
17. 00	Hospital -Based (CMHC) I					ŀ						17. 00
18. 00	Renal Dialysis											18. 00
19. 00	Other											19. 00
								From:		To		
								1.00		2. (		
	Cost Reporting Period (mm/dd/yyyy)							01/01/20	021	12/31.	/2021	20.00
21.00	Type of Control (see instructions)							2				21. 00
							1. 00	2. 00		3. (	20	
	Inpatient PPS Information											
22. 00	Does this facility qualify and is it	current	y receiving pay	ments for	-		N	N				22. 00
	disproporti onate share hospi tal adju				₹							
	§412.106? In column 1, enter "Y" fo											
	facility subject to 42 CFR Section § hospital?) In column 2, enter "Y" for			enament								
22. 01	Did this hospital receive interim un			s for thi	S		N	N				22. 01
	cost reporting period? Enter in colu											
	the portion of the cost reporting pe											
	Enter in column 2, "Y" for yes or "N				cost							
22 02	reporting period occurring on or aft Is this a newly merged hospital that				-0		N	N				22. 02
22. 02	payments to be determined at cost re						IV	IN IN				22.02
	Enter in column 1, "Y" for yes or "N				13)							
	cost reporting period prior to Octob				yes							
	or "N" for no, for the portion of th	e cost re	eporting period	on or aft	er							
22.02	October 1.		! 6!!! 6		_		N.					22.02
22. 03	Did this hospital receive a geograph rural as a result of the OMB standar						N	N		N		22. 03
	adopted by CMS in FY2015? Enter in c											
	for the portion of the cost reportin											
	in column 2, "Y" for yes or "N" for											
	reporting period occurring on or aft											
	Does this hospital contain at least											
	counted in accordance with 42 CFR 41 yes or "N" for no.	2. 103) ? 1	Enter in corumn	3, 1 10	ונ							
22. 04	Did this hospital receive a geograph	ic reclas	ssification from	urban to	)		N	N		N	l	22. 04
	rural as a result of the revised OMB											
	adopted by CMS in FY 2021? Enter in											
	for the portion of the cost reportin		er									
	in column 2, "Y" for yes or "N" for reporting period occurring on or aft											
	Does this hospital contain at least				15							
	counted in accordance with 42 CFR 41											
	yes or "N" for no.	/ -	22. 2									
23. 00	Which method is used to determine Me							3 N				23. 00
	below? In column 1, enter 1 if date											
	if date of discharge. Is the method reporting period different from the				UST							
	reporting period? In column 2, enter "Y" for yes or "N" for no.											

40.00	is the racifity electing fair reactal capital payment: Enter 1 for yes of 11 for no.	1.4	14	1.4	40.00
	Teaching Hospitals				
56.00	Is this a hospital involved in training residents in approved GME programs? Enter "Y" for yes or	N			56.00
	"N" for no in column 1. For column 2, if the response to column 1 is "Y", or if this hospital				
	was involved in training residents in approved GME programs in the prior year or penultimate				
	year, and are you are impacted by CR 11642 (or applicable CRs) MA direct GME payment reduction?				
	Enter "Y" for yes; otherwise, enter "N" for no in column 2.				
57. 00	If line 56 is yes, is this the first cost reporting period during which residents in approved				57. 00
	GME programs trained at this facility? Enter "Y" for yes or "N" for no in column 1. If column 1				
	is "Y" did residents start training in the first month of this cost reporting period? Enter "Y"				
	for yes or "N" for no in column 2. If column 2 is "Y", complete Worksheet E-4. If column 2 is				
	"N", complete Wkst. D, Parts III & IV and D-2, Pt. II, if applicable.		1		
58.00	If line 56 is yes, did this facility elect cost reimbursement for physicians' services as	N			58. 00
FO 00	defined in CMS Pub. 15-1, chapter 21, §2148? If yes, complete Wkst. D-5.		-		FO 00
59.00	Are costs claimed on line 100 of Worksheet A? If yes, complete Wkst. D-2, Pt. I.	IN			59. 00

Health Financial Systems UNION HOSPITAL CLINTON In Lieu of Form CMS-2552-10 HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA Provider CCN: 15-1326 Peri od: Worksheet S-2 From 01/01/2021 Part I Date/Time Prepared: 12/31/2021 5/26/2022 10:52 am NAHE 413.85 Worksheet A Pass-Through Qualification Y/N Line # Criterion Code 1.00 2.00 3.00 60.00 Are you claiming nursing and allied health education (NAHE) costs for 60.00 any programs that meet the criteria under 42 CFR 413.85? (see instructions) Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y", are you impacted by CR 11642 (or subsequent CR) NAHE MA payment adjustement? Enter "Y" for yes or "N" for no in column 2 IME IME Direct GME Direct GME 3. 00 4.00 1.00 2.00 5.00 61.00 Did your hospital receive FTE slots under ACA 0.00 0.00 61.00 section 5503? Enter "Y" for yes or "N" for no in column 1. (see instructions) Enter the average number of unweighted primary care 61.01 61.01 FTEs from the hospital's 3 most recent cost reports ending and submitted before March 23, 2010. (see instructions) 61.02 Enter the current year total unweighted primary care 61.02 FTE count (excluding OB/GYN, general surgery FTEs, and primary care FTEs added under section 5503 of ACA). (see instructions) 61.03 Enter the base line FTE count for primary care 61.03 and/or general surgery residents, which is used for determining compliance with the 75% test. (see instructions) Enter the number of unweighted primary care/or 61.04 61.04 surgery allopathic and/or osteopathic FTEs in the current cost reporting period. (see instructions). 61.05 Enter the difference between the baseline primary 61.05 and/or general surgery FTEs and the current year primary care and/or general surgery FTE counts (line 61.04 minus line 61.03). (see instructions) 61.06 Enter the amount of ACA §5503 award that is being 61 06 used for cap relief and/or FTEs that are nonprimary care or general surgery. (see instructions) Program Name Program Code Unweighted IME Unweighted Direct GME FTE FTE Count Count 1.00 2.00 3.00 4.00 61.10 Of the FTEs in line 61.05, specify each new program 0.00 61.10 specialty, if any, and the number of FTE residents for each new program. (see instructions) Enter in column 1, the program name. Enter in column 2, the program code. Enter in column 3, the IME FTE unweighted count. Enter in column 4, the direct GME FTE unweighted count. 61. 20 Of the FTEs in line 61.05, specify each expanded 0.00 0.00 61.20 program specialty, if any, and the number of FTE residents for each expanded program. (see instructions) Enter in column 1, the program name. Enter in column 2, the program code. Enter in column 3, the IME FTE unweighted count. Enter in column 4, the direct GME FTE unweighted count. 1.00 ACA Provisions Affecting the Health Resources and Services Administration (HRSA) 62.00 Enter the number of FTE residents that your hospital trained in this cost reporting period for which 0.00 62.00 your hospital received HRSA PCRE funding (see instructions) Enter the number of FTE residents that rotated from a Teaching Health Center (THC) into your hospital during in this cost reporting period of HRSA THC program. (see instructions) 62.01 0.00 62.01 Teaching Hospitals that Claim Residents in Nonprovider Settings 63.00 Has your facility trained residents in nonprovider settings during this cost reporting period? Enter "Y" for yes or "N" for no in column 1. If yes, complete lines 64 through 67. (see instructions) N 63.00 Unwei ghted Ratio (col. 1/ Unwei ghted FTES FTEs in (col. 1 + col Nonprovi der Hospi tal 2)) Si te 2.00 1.00 3.00 Section 5504 of the ACA Base Year FTE Residents in Nonprovider Settings--This base year is your cost reporting period that begins on or after July 1, 2009 and before June 30, 2010. 64.00 Enter in column 1, if line 63 is yes, or your facility trained residents 0.000000 64.00 0.00 in the base year period, the number of unweighted non-primary care resident FTEs attributable to rotations occurring in all nonprovider 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)

	4)). (see instructions)												
	1.00   2.00   3.00												
	Inpatient Psychiatric Facility PPS												
70.00	Is this facility an Inpatient Ps	sychiatric Facility (I	IPF), or does it conta	ain an IPF subp	rovi der?	N			70. 00				
	Enter "Y" for yes or "N" for no.												
71.00	If line 70 is yes: Column 1: Dic	he most			0	71. 00							
	recent cost report filed on or b	o. (see											
	42 CFR 412.424(d)(1)(iii)(c)) Cc	ni ng											
	program in accordance with 42 CF	R 412.424 (d)(1)(iii)	)(D)? Enter "Y" for ye	es or "N" for r	10.								
	Column 3: If column 2 is Y, indi	cate which program ye	ear began during this	cost reporting	peri od.								
	(see instructions)				-								
	Inpatient Rehabilitation Facilit	ry PPS											
75.00	Is this facility an Inpatient Re	habilitation Facility	y (IRF), or does it co	ntain an IRF		N			75. 00				
	subprovider? Enter "Y" for yes	and "N" for no.											
76.00	If line 75 is yes: Column 1: Dic	I the facility have ar	n approved GME teachir	ng program in t	he most			0	76. 00				
	recent cost reporting period end	ling on or before Nove	ember 15, 2004? Enter	"Y" for yes or	"N" for								
	no. Column 2: Did this facility	train residents in a	new teaching program	in accordance	with 42								
	CFR 412.424 (d)(1)(iii)(D)? Ente	er "Y" for yes or "N"	for no. Column 3: If	column 2 is Y,									
	indicate which program year bega	nn during this cost re	eporting period. (see	instructions)									

divided by (column 3 + column

3PI I.	AL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA	Provider CC	JN: 15-1326	Peri od: From 01/01/2021 To 12/31/2021	Worksheet S Part I Date/Time P 5/26/2022 1	repared	
					1. 00	-	
	Long Term Care Hospital PPS						
. 00	Is this a long term care hospital (LTCH)? Enter "Y" for yes Is this a LTCH co-located within another hospital for part or "Y" for yes and "N" for no.			ng period? Enter	N N	80. 0 81. 0	
. 00 . 00	TEFRA Providers Is this a new hospital under 42 CFR Section §413.40(f)(1)(i) Did this facility establish a new Other subprovider (excluded				N	85. 86.	
	§413.40(f)(1)(ii)? Enter "Y" for yes and "N" for no. Is this hospital an extended neoplastic disease care hospital	cl assi fi ed ι	under section	1	N	87.	
	1886(d)(1)(B)(vi)? Enter "Y" for yes or "N" for no.			V	XI X		
				1. 00	2.00	$\neg$	
	Title V and XIX Services						
	Does this facility have title V and/or XIX inpatient hospital yes or "N" for no in the applicable column.	servi ces? Er	nter "Y" for	Y	Y	90.	
	Is this hospital reimbursed for title V and/or XIX through th full or in part? Enter "Y" for yes or "N" for no in the appli			N	Y	91.	
	Are title XIX NF patients occupying title XVIII SNF beds (dualinstructions) Enter "Y" for yes or "N" for no in the applicab	ıl certificati			N	92.	
. 00	Does this facility operate an ICF/IID facility for purposes o	oes this facility operate an ICF/IID facility for purposes of title V and XIX? Er " for yes or "N" for no in the applicable column.					
. 00	Does title V or XIX reduce capital cost? Enter "Y" for yes, a	and "N" for no	in the	N	N	94.	
. 00	applicable column. If line 94 is "Y", enter the reduction percentage in the appl	icable column	١.	0. 00	0. 00	95.	
. 00	Does title V or XIX reduce operating cost? Enter "Y" for yes applicable column.	or "N" for no	in the	N	N	96.	
	If line 96 is "Y", enter the reduction percentage in the appl			0.00	0.00	97.	
	Does title V or XIX follow Medicare (title XVIII) for the int stepdown adjustments on Wkst. B, Pt. I, col. 25? Enter "Y" fo			Y	Y	98.	
	column 1 for title V, and in column 2 for title XIX. Does title V or XIX follow Medicare (title XVIII) for the rep	orting of cha	arges on Wkst	Y	Υ	98.	
	C, Pt. I? Enter "Y" for yes or "N" for no in column 1 for tit title XIX.	le V, and in	column 2 for	-			
. 02	Does title V or XIX follow Medicare (title XVIII) for the cal bed costs on Wkst. D-1, Pt. IV, line 89? Enter "Y" for yes or			Y	Y	98.	
03	for title V, and in column 2 for title XIX. Does title V or XIX follow Medicare (title XVIII) for a criti reimbursed 101% of inpatient services cost? Enter "Y" for yes				N	98.	
04	for title V, and in column 2 for title XIX. Does title V or XIX follow Medicare (title XVIII) for a CAH r outpatient services cost? Enter "Y" for yes or "N" for no in			N	N	98	
05	in column 2 for title XIX. Does title V or XIX follow Medicare (title XVIII) and add bac Wkst. C, Pt. I, col. 4? Enter "Y" for yes or "N" for no in co	ck the RCE dis Dlumn 1 for ti	sallowance or tle V, and i	n Y	Υ	98.	
	column 2 for title XIX. Does title V or XIX follow Medicare (title XVIII) when cost r			Y	Υ	98	
	Pts. I through IV? Enter "Y" for yes or "N" for no in column column 2 for title XIX.						
	Rural Providers  Does this hospital qualify as a CAH?			Y		105.	
	If this facility qualifies as a CAH, has it elected the all-i	nclusive meth	nod of paymer	1		106.	
7. 00	for outpatient services? (see instructions) Column 1: If line 105 is Y, is this facility eligible for cos training programs? Enter "Y" for yes or "N" for no in column			N		107.	
	Column 2: If column 1 is Y and line 70 or line 75 is Y, do y approved medical education program in the CAH's excluded IPF Enter "Y" for yes or "N" for no in column 2. (see instructions)	ou train I&Rs and/or IRF u	in an				
3. 00	Is this a rural hospital qualifying for an exception to the C CFR Section §412.113(c). Enter "Y" for yes or "N" for no.		dul e? See 42	2 N		108	
	prik Section 9412. 113(c). Linter 1 101 yes of N 101 110.	Physi cal	Occupation		Respi ratory	<u> </u>	
	If this hospital qualifies as a CAH or a cost provider, are therapy services provided by outside supplier? Enter "Y" for yes or "N" for no for each therapy.	1.00 N	2.00 N	3. 00 N	4. 00 N	109.	
	, and a second second property			1			
2 00	Did this bospital participate in the Dural Community Heasital	Domonstrati	n project (	3/10/	1. 00	110.	
	Did this hospital participate in the Rural Community Hospital Demonstration)for the current cost reporting period? Enter "Y				N	110.	

alth Financial Systems UNION HOSPITAL CLINTON SPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA Provider C		ri od:	u of Form CMS Worksheet S-	
		om 01/01/2021	Part I Date/Time Pr	
	10	12/31/2021	5/26/2022 10	): 52
		1 00	2.00	_
.00  f this facility qualifies as a CAH, did it participate in the Frontier C	Community	1. 00 N	2.00	11
Health Integration Project (FCHIP) demonstration for this cost reporting				''
"Y" for yes or "N" for no in column 1. If the response to column 1 is Y,	enter the			
integration prong of the FCHIP demo in which this CAH is participating in				
Enter all that apply: "A" for Ambulance services; "B" for additional beds	; and/or "C"			
for tele-health services.				
	1. 00	2. 00	3.00	
.00 Did this hospital participate in the Pennsylvania Rural Health Model	N			11
demonstration for any portion of the current cost reporting period?				
Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y", enter in column 2, the date the hospital began participating in the				
demonstration. In column 3, enter the date the hospital ceased				
participation in the demonstration, if applicable.				
Miscellaneous Cost Reporting Information				
.00 Is this an all-inclusive rate provider? Enter "Y" for yes or "N" for no	N			0 11
in column 1. If column 1 is yes, enter the method used (A, B, or E only) in column 2. If column 2 is "E", enter in column 3 either "93" percent				
for short term hospital or "98" percent for long term care (includes				
psychiatric, rehabilitation and long term hospitals providers) based on				
the definition in CMS Pub. 15-1, chapter 22, §2208.1.				
.00 Is this facility classified as a referral center? Enter "Y" for yes or	N			11
"N" for no. .00 s this facility legally-required to carry malpractice insurance? Enter	Y			11
"Y" for yes or "N" for no.	'			''
3.00 Is the malpractice insurance a claims-made or occurrence policy? Enter 1	1			11
if the policy is claim-made. Enter 2 if the policy is occurrence.	·			
	Premi ums	Losses	Insurance	
	1. 00	2. 00	3. 00	
3.01 List amounts of malpractice premiums and paid losses:	83, 947	0		0 11
		1. 00	2. 00	-
B.02 Are mal practice premiums and paid losses reported in a cost center other	than the	N N	2.00	11
Administrative and General? If yes, submit supporting schedule listing of				
and amounts contained therein.				
2.00 DO NOT USE THIS LINE	udalan in ACA	N	N	111
0.00  s this a SCH or EACH that qualifies for the Outpatient Hold Harmless pro §3121 and applicable amendments? (see instructions) Enter in column 1, "Y		N	N	12
"N" for no. Is this a rural hospital with < 100 beds that qualifies for t				
Hold Harmless provision in ACA §3121 and applicable amendments? (see inst				
Enter in column 2, "Y" for yes or "N" for no.		Υ		12
Enter in column 2, "Y" for yes or "N" for no00 Did this facility incur and report costs for high cost implantable device	es charged to	'		
Enter in column 2, "Y" for yes or "N" for no.  .00 Did this facility incur and report costs for high cost implantable device patients? Enter "Y" for yes or "N" for no.			5.06	12
Enter in column 2, "Y" for yes or "N" for no.  .00 Did this facility incur and report costs for high cost implantable device patients? Enter "Y" for yes or "N" for no.  2.00 Does the cost report contain healthcare related taxes as defined in §1903	s(w)(3) of the	Y	5. 06	12
Enter in column 2, "Y" for yes or "N" for no.  .00 Did this facility incur and report costs for high cost implantable device patients? Enter "Y" for yes or "N" for no.	s(w)(3) of the		5. 06	12
Enter in column 2, "Y" for yes or "N" for no.  .00 Did this facility incur and report costs for high cost implantable device patients? Enter "Y" for yes or "N" for no.  .00 Does the cost report contain healthcare related taxes as defined in §1903 Act?Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y", enter the Worksheet A line number where these taxes are included.  Transplant Center Information	(w)(3) of the er in column 2	Y	5.06	
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Health Financial Systems UNION HOSPITAL CLINTON In Lieu of Form CMS-2552-10 HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA Provider CCN: 15-1326 Peri od: Worksheet S-2 From 01/01/2021 Part I 12/31/2021 Date/Time Prepared: 5/26/2022 10:52 am 3.00 If this facility is part of a chain organization, enter on lines 141 through 143 the name and address of the home office and enter the home office contractor name and contractor number
Name: UNION HOSPITAL, INC. | Contractor's Name: WPS Contractor's Number: 08101 141 OO Name: UNLON HOSPITAL INC. 141 00 142.00 Street: 1606 NORTH SEVENTH ST PO Box: 142.00 143.00 City: TERRE HAUTE 47804 143. 00 State: Zip Code: 1.00 144.00 Are provider based physicians' costs included in Worksheet A? γ 144. 00 1. 00 2.00 145.00 If costs for renal services are claimed on Wkst. A, line 74, are the costs for 145.00 inpatient services only? Enter "Y" for yes or "N" for no in column 1. If column 1 is no, does the dialysis facility include Medicare utilization for this cost reporting period? Enter "Y" for yes or "N" for no in column 2. 146.00 Has the cost allocation methodology changed from the previously filed cost report? 146.00 Ν Enter "Y" for yes or "N" for no in column 1. (See CMS Pub. 15-2, chapter 40, §4020) If yes, enter the approval date (mm/dd/yyyy) in column 2. 1.00 147.00 Was there a change in the statistical basis? Enter "Y" for yes or "N" for no. 148.00 Was there a change in the order of allocation? Enter "Y" for yes or "N" for no. 147. 00 Ν N 148 00 149.00Was there a change to the simplified cost finding method? Enter "Y" for yes or "N" for no Ν 149.00 Part A Part B Title V Title XIX 1.00 2.00 3.00 4.00 Does this facility contain a provider that qualifies for an exemption from the application of the lower of costs or charges? Enter "Y" for yes or "N" for no for each component for Part A and Part B. (See 42 CFR §413.13) 155.00 Hospi tal Ν N 155.00 156.00 Subprovider - IPF Ν Ν Ν Ν 156.00 157.00 Subprovi der - IRF 157 00 Ν Ν Ν N 158. 00 SUBPROVI DER 158. 00 159.00 SNF Ν Ν Ν Ν 159. 00 160.00 HOME HEALTH AGENCY 160. 00 Ν Ν Ν Ν 161.00 CMHC Ν Ν N 161. 00 1.00 Multicampus 165.00 s this hospital part of a Multicampus hospital that has one or more campuses in different CBSAs? N 165.00 Enter "Y" for yes or "N" for no. Name County State Zip Code CBSA FTE/Campus 0 1.00 2.00 3.00 4.00 5.00 166.00 If line 165 is yes, for each 0.00 166.00 campus enter the name in column O, county in column 1, state in column 2, zip code in column 3, CBSA in column 4, FTE/Campus in column 5 (see instructions) 1.00

reasonable cost incurred for the HIT assets (see instructions)			
168.01 If this provider is a CAH and is not a meaningful user, does this provider qualify for a	hardshi p	N	168. 01
exception under §413.70(a)(6)(ii)? Enter "Y" for yes or "N" for no. (see instructions)			
169.00 If this provider is a meaningful user (line 167 is "Y") and is not a CAH (line 105 is "N	l"), enter the	0.0	00169.00
transition factor. (see instructions)			
	Begi nni ng	Endi ng	
	1. 00	2.00	
170.00 Enter in columns 1 and 2 the EHR beginning date and ending date for the reporting period respectively (mm/dd/yyyy)			170. 00
perrou respectively (min dayyyyy)			
	1. 00	2. 00	
171.00 If line 167 is "Y", does this provider have any days for individuals enrolled in	N		0 171. 00
section 1876 Medicare cost plans reported on Wkst. S-3, Pt. I, line 2, col. 6? Enter			
"Y" for yes and "N" for no in column 1. If column 1 is yes, enter the number of section			
1876 Medicare days in column 2. (see instructions)			

167 00

168.00

Health Information Technology (HIT) incentive in the American Recovery and Reinvestment Act

168.00 If this provider is a CAH (line 105 is "Y") and is a meaningful user (line 167 is "Y"), enter the

167.00 s this provider a meaningful user under §1886(n)? Enter "Y" for yes or "N" for no.

	Financial Systems UNION HOSPIT AL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE		CN: 15-1326	Peri od: From 01/01/2021 To 12/31/2021	w of Form CMS- Worksheet S-2 Part II Date/Time Pre 5/26/2022 10:	2 epared:
	· · · · · · · · · · · · · · · · · · ·			Y/N	Date	32 alli
				1. 00	2. 00	
	General Instruction: Enter Y for all YES responses. Enter N mm/dd/yyyy format. COMPLETED BY ALL HOSPITALS Provider Organization and Operation	lfor all NO re	esponses. Ente			
00	Has the provider changed ownership immediately prior to the	heainnina of	the cost	N		1.0
. 00	reporting period? If yes, enter the date of the change in o	column 2. (see	instructions)			1.0
	<u> </u>		Y/N	Date	V/I	
			1. 00	2. 00	3. 00	
00	Has the provider terminated participation in the Medicare F yes, enter in column 2 the date of termination and in colum voluntary or "I" for involuntary.	nn 3, "V" for	N			2.0
. 00	Is the provider involved in business transactions, includir contracts, with individuals or entities (e.g., chain home or medical 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			3.0
			Y/N	Туре	Date	
			1.00	2. 00	3. 00	
00	Financial Data and Reports					٠.,
. 00	Column 1: Were the financial statements prepared by a Cert Accountant? Column 2: If yes, enter "A" for Audited, "C" for "R" for Reviewed. Submit complete copy or enter date avacolumn 3. (see instructions) If no, see instructions.	for Compiled, ailable in	Y	A		4.0
. 00	Are the cost report total expenses and total revenues diffe		Y			5.0
	those on the filed financial statements? If yes, submit rec	conciliation.		Y/N 1. 00	Legal Oper. 2.00	
	Approved Educational Activities			T		٠
00	Column 1: Are costs claimed for a nursing program? Column	2: If yes, is	the provider	- N		6.0
00 00	is the legal operator of the program? Are costs claimed for Allied Health Programs? If "Y" see in Were nursing programs and/or allied health programs approve		ved during the	N N		7. C
00	cost reporting period? If yes, see instructions.  Are costs claimed for Interns and Residents in an approved program in the current cost report? If yes, see instruction		cal education	N		9. 0
0. 00	Was an approved Intern and Resident GME program initiated of		he current	N		10.0
1. 00	cost reporting period? If yes, see instructions.  Are GME cost directly assigned to cost centers other than I Teaching Program on Worksheet A? If yes, see instructions.	& R in an App	proved	N		11. (
	Treaching Program on worksheet A? IT yes, see this tructions.				Y/N	
					1. 00	
	Bad Debts					
2. 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. ( 13. (
4. 00	If line 12 is yes, were patient deductibles and/or co-payme	ents waived? If	yes, see ins	structi ons.	N	14. (
- 00	Bed Complement	na nomi od 2 l f	voo ooo i not	rueti ene	N	15 6
J. UU	Did total beds available change from the prior cost reporti	,	yes, see inst t A		t B	15. C
		Y/N	Date	Y/N	Date	
		1.00	2.00	3. 00	4. 00	
5. 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	03/10/2022	Y	03/10/2022	16.0
'. 00	instructions) 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. (
3. 00	in columns 2 and 4. (see instructions)	N		N		18. 0
9. 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. 0

OSPI T	AL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE	Provi der C	CN: 15-1326	Peri od: From 01/01/2021	Worksheet S Part II	
				To 12/31/2021		repared
		Descr	i pti on	Y/N	Y/N	O. OZ GI
			0	1. 00	3. 00	
0. 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.
	Report data for other? Describe the other adjustments.	Y/N	Date	Y/N	Date	
		1. 00	2.00	3. 00	4. 00	
. 00	Was the cost report prepared only using the provider's records? If yes, see instructions.	N		N		21.
					1. 00	
	COMPLETED BY COST REIMBURSED AND TEFRA HOSPITALS ONLY (EXCEP	PT CHILDRENS H	OSPI TALS)		1.00	
	Capital Related Cost					
	Have assets been relifed for Medicare purposes? If yes, see				N	22.
. 00	Have changes occurred in the Medicare depreciation expense of reporting period? If yes, see instructions.	due to apprais	sais made dur	ring the cost	N	23.
. 00	Were new leases and/or amendments to existing leases entered If yes, see instructions	eporting period?	N	24.		
. 00	Have there been new capitalized leases entered into during t	'If yes, see	N	25.		
. 00	instructions. Were assets subject to Sec. 2314 of DEFRA acquired during the	f yes, see	N	26.		
. 00	instructions. Has the provider's capitalization policy changed during the	•	0 .		N	27.
	copy. Interest Expense			yes, subilit		
	Were new loans, mortgage agreements or letters of credit ent	tered into dur	ing the cost	reporting	N	28
00	period? If yes, see instructions. Did the provider have a funded depreciation account and/or b	Reserve Fund)	N	29		
00	treated as a funded depreciation account? If yes, see instru Has existing debt been replaced prior to its scheduled matur		debt? If yes	s, see	N	30
00	instructions. Has debt been recalled before scheduled maturity without iss instructions.	suance of new	debt? If yes	s, see	N	31
	Purchased Services					
00	Have changes or new agreements occurred in patient care servarrangements with suppliers of services? If yes, see instruc		ed through co	ontractual	N	32
. 00	If line 32 is yes, were the requirements of Sec. 2135.2 appl no, see instructions.		ng to competi	tive bidding? If	N	33
	Provi der-Based Physi ci ans					
00	Are services furnished at the provider facility under an arr	rangement with	n provi der-ba	sed physicians?	Y	34
00	If yes, see instructions.  If line 34 is yes, were there new agreements or amended exis		nts with the	provi der-based	N	35
	physicians during the cost reporting period? If yes, see ins	structions.		Y/N	Date	
				1. 00	2. 00	
	Home Office Costs					
	Were home office costs claimed on the cost report? If line 36 is yes, has a home office cost statement been pre	oparod by the	homo office	Y		36
	If yes, see instructions.					
00	If line 36 is yes , was the fiscal year end of the home offithe provider? If yes, enter in column 2 the fiscal year end	of the home of	offi ce.			38
	If line 36 is yes, did the provider render services to other see instructions.	•	,			39
00	If line 36 is yes, did the provider render services to the hinstructions.	home office?	If yes, see	N		40
	-	1.	00	2.	00	
	Cost Report Preparer Contact Information					
00	held by the cost report preparer in columns 1, 2, and 3,	CAROLYN		CHAPLI N		41
00	. , , , , , , , , , , , , , , , , , , ,	BLUE AND CO.,	LLC			42
. 00	preparer.  Enter the telephone number and email address of the cost 3	3177137919		CCHAPLI N@BLUEA	NDCO COM	43
00	report preparer in columns 1 and 2, respectively.			CONAL ET NEDEUEA	INDCO. COM	43

Heal th	Financial Systems	UNI ON HOSPITA	AL CLINTON		In Lieu of Form CMS-2552-10				
HOSPI T	AL AND HOSPITAL HEALTH CARE REIMBURSEMENT QU	JESTI ONNAI RE	Provi der CC	CN: 15-1326	Period: From 01/01/202 To 12/31/202		pared:		
		-	3. (	00					
	Cost Report Preparer Contact Information								
41. 00	Enter the first name, last name and the tit held by the cost report preparer in columns respectively.		SENIOR MANAGER				41. 00		
42. 00	Enter the employer/company name of the cost preparer.	report					42. 00		
43. 00	Enter the telephone number and email addres report preparer in columns 1 and 2, respect						43. 00		

| Peri od: | Worksheet S-3 | From 01/01/2021 | Part | | To 12/31/2021 | Date/Time Prepared: 
 Heal th Financial
 Systems
 UNION

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

						То	12/31/2021	Date/Time		
								5/26/2022   /P Days / (		oz alli
								Visits / Tri		
	Component	Worksheet A	No	of Beds	Bed Days		CAH Hours	Title V	μs	
	Component	Line Number	110.	or beas	Avai I abl e		OAIT HOULS	li ti c v		
		1.00		2. 00	3.00		4. 00	5, 00		
1. 00	Hospital Adults & Peds. (columns 5, 6, 7 and	30.00		25		5	728, 905. 00		0	1. 00
	8 exclude Swing Bed, Observation Bed and	00.00		20	'' '-		720, 700. 00		Ū	00
	Hospice days) (see instructions for col. 2									
	for the portion of LDP room available beds)									
2.00	HMO and other (see instructions)									2.00
3.00	HMO I PF 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			25	9, 12	5	728, 905. 00		0	7. 00
	beds) (see instructions)						,			
8.00	INTENSIVE CARE UNIT	31. 00		0		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	OTHER SPECIAL CARE (SPECIFY)									12.00
13.00	NURSERY									13.00
14.00	Total (see instructions)			25	9, 12	5	728, 905. 00		0	14.00
15.00	CAH visits								0	15.00
16.00	SUBPROVIDER - IPF									16.00
17.00	SUBPROVI DER - I RF									17.00
18. 00	SUBPROVI DER									18.00
19. 00	SKILLED NURSING FACILITY									19.00
20.00	NURSING FACILITY									20.00
21. 00	OTHER LONG TERM CARE									21.00
22. 00	HOME HEALTH AGENCY									22.00
23. 00	AMBULATORY SURGICAL CENTER (D. P. )									23.00
24. 00	HOSPI CE									24.00
24. 10	HOSPICE (non-distinct part)	30. 00								24. 10
25. 00	CMHC - CMHC									25.00
26. 00	RURAL HEALTH CLINIC									26.00
26. 25	FEDERALLY QUALIFIED HEALTH CENTER	89. 00							0	26. 25
27. 00	Total (sum of lines 14-26)			25						27. 00
28. 00	Observation Bed Days								0	28. 00
29. 00	Ambul ance Tri ps									29. 00
30.00	Employee discount days (see instruction)									30.00
31. 00	Employee discount days - IRF									31. 00
32. 00	Labor & delivery days (see instructions)			0		0				32.00
32. 01	Total ancillary labor & delivery room									32. 01
	outpatient days (see instructions)									
33.00	LTCH non-covered days									33. 00
33. 01	LTCH site neutral days and discharges		l		l			l		33. 01

 Heal th Financial
 Systems
 UNION

 HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA

Peri od: Worksheet S-3 From 01/01/2021 Part I To 12/31/2021 Date/Time Prepared: 5/26/2022 10:52 am

						5/26/2022 10:	52 am
		I/P Days	5 / O/P Visits	/ Trips	Full Time	Equi val ents	
	Component	Title XVIII	Title XIX	Total All Patients	Total Interns & Residents	Employees On Payroll	
		6. 00	7. 00	8.00	9. 00	10.00	
1. 00	Hospital Adults & Peds. (columns 5, 6, 7 and	821	27	1, 976			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)	211	16				2.00
3.00	HMO IPF Subprovider	0	0				3.00
4.00	HMO I RF Subprovi der	0	0	405			4. 00
5.00	Hospital Adults & Peds. Swing Bed SNF	495	0	495 157			5. 00
6. 00 7. 00	Hospital Adults & Peds. Swing Bed NF Total Adults and Peds. (exclude observation	1, 316	0 27	2, 628			6. 00 7. 00
7.00	beds) (see instructions)	1,310	21	2, 020			7.00
8. 00	INTENSIVE CARE UNIT	0	0	C			8. 00
9. 00	CORONARY CARE UNIT			_			9. 00
10. 00	BURN INTENSIVE CARE UNIT						10.00
11. 00	SURGICAL INTENSIVE CARE UNIT						11. 00
12.00	OTHER SPECIAL CARE (SPECIFY)						12. 00
13.00	NURSERY						13. 00
14.00	Total (see instructions)	1, 316	27	2, 628	0.00	112. 85	14. 00
15. 00	CAH visits	0	0	C			15. 00
16. 00	SUBPROVI DER - I PF						16. 00
17. 00	SUBPROVI DER - I RF						17. 00
18. 00	SUBPROVI DER						18. 00
19.00	SKILLED NURSING FACILITY						19. 00
20.00	NURSING FACILITY						20.00
21. 00 22. 00	OTHER LONG TERM CARE HOME HEALTH AGENCY						21. 00 22. 00
23. 00							23. 00
24. 00	HOSPICE						24.00
24. 10	HOSPICE (non-distinct part)			0			24. 10
25. 00	CMHC - CMHC			· ·			25. 00
26. 00	RURAL HEALTH CLINIC						26. 00
26. 25	FEDERALLY QUALIFIED HEALTH CENTER	0	0	C	0.00	0.00	26. 25
27.00	Total (sum of lines 14-26)				0.00	112. 85	27. 00
28. 00	Observation Bed Days		182	890			28. 00
29. 00	Ambul ance Tri ps	0					29. 00
30. 00				C			30. 00
31. 00	Employee discount days - IRF			C			31. 00
32. 00	Labor & delivery days (see instructions)	0	0	C			32. 00
32. 01	Total ancillary labor & delivery room			C			32. 01
22 00	outpatient days (see instructions)						22 00
33.00	LTCH non-covered days LTCH site neutral days and discharges	0					33. 00 33. 01
JJ. UI	Teron or te neutral days and discharges	١	l		I	I	J 55. UT

Provider CCN: 15-1326

					To 12/31/2021	Date/Time Prep 5/26/2022 10:	
		Full Time Equivalents		Di sc	harges		
	Component	Nonpai d Workers	Title V	Title XVIII	Title XIX	Total All Patients	
		11. 00	12. 00	13. 00	14.00	15. 00	
1. 00 2. 00	Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days) (see instructions for col. 2 for the portion of LDP room available beds) HMO and other (see instructions)		C	58		653	2. 00
3. 00 4. 00 5. 00 6. 00 7. 00	HMO IPF Subprovider HMO IRF Subprovider Hospital Adults & Peds. Swing Bed SNF Hospital Adults & Peds. Swing Bed NF Total Adults and Peds. (exclude observation beds) (see instructions)				0		3. 00 4. 00 5. 00 6. 00 7. 00
8. 00 9. 00 10. 00 11. 00 12. 00 13. 00	INTENSIVE CARE UNIT CORONARY CARE UNIT BURN INTENSIVE CARE UNIT SURGICAL INTENSIVE CARE UNIT OTHER SPECIAL CARE (SPECIFY) NURSERY						8. 00 9. 00 10. 00 11. 00 12. 00 13. 00
14. 00 15. 00 16. 00 17. 00 18. 00 20. 00 21. 00 22. 00 23. 00 24. 00 24. 10 25. 00 26. 00	Total (see instructions) CAH visits SUBPROVIDER - IPF SUBPROVIDER - IRF SUBPROVIDER SKILLED NURSING FACILITY NURSING FACILITY OTHER LONG TERM CARE HOME HEALTH AGENCY AMBULATORY SURGICAL CENTER (D.P.) HOSPICE HOSPICE (non-distinct part) CMHC - CMHC RURAL HEALTH CLINIC	0.00	C	277	7 10	653	14. 00 15. 00 16. 00 17. 00 18. 00 19. 00 20. 00 21. 00 22. 00 23. 00 24. 00 24. 10 25. 00 26. 00
26. 25 27. 00 28. 00 29. 00 30. 00 31. 00 32. 00	FEDERALLY QUALIFIED HEALTH CENTER Total (sum of lines 14-26) Observation Bed Days Ambulance Trips Employee discount days (see instruction) Employee discount days - IRF Labor & delivery days (see instructions) Total ancillary labor & delivery room outpatient days (see instructions)	0. 00 0. 00					26. 25 27. 00 28. 00 29. 00 30. 00 31. 00 32. 00
33. 00 33. 01	LTCH non-covered days LTCH si te neutral days and discharges						33. 00 33. 01

alth Financial Systems UNION HOSPIT SPITAL UNCOMPENSATED AND INDIGENT CARE DATA	Provi der CO	CN: 15-1326	Peri od:	u of Form CMS-2 Worksheet S-10	
			From 01/01/2021	D-+- /T: D	
			To 12/31/2021	Date/Time Pre 5/26/2022 10:	
				1. 00	
Uncompensated and indigent care cost computation					
Cost to charge ratio (Worksheet C, Part I line 202 column 3	3 divided by li	ne 202 columi	n 8)	0. 297077	1
Medicaid (see instructions for each line)  Net revenue from Medicaid				6, 049, 926	2
100   Did you receive DSH or supplemental payments from Medicaid	7			0, 049, 920 N	3
If line 3 is yes, does line 2 include all DSH and/or supple		s from Medica	ai d?	,,,	4
OO   If line 4 is no, then enter DSH and/or supplemental paymen				0	5
Medi cai d charges				23, 107, 386	
Medicaid cost (line 1 times line 6)				6, 864, 673	
Difference between net revenue and costs for Medicaid progr	cam (line 7 min	us sum of lin	nes 2 and 5; if	814, 747	8
<pre>&lt; zero then enter zero) Children's Health Insurance Program (CHIP) (see instruction</pre>	ns for each line	e)			
0 Net revenue from stand-alone CHIP				0	9
00 Stand-alone CHIP charges				0	10
00 Stand-alone CHIP cost (line 1 times line 10)				0	11
00 Difference between net revenue and costs for stand-alone Ch	HIP (line 11 mi	nus line 9; i	if < zero then	0	12
enter zero) Other state or local government indigent care program (see	instructions f	or each line	\		
00 Net revenue from state or local indigent care program (Not				0	13
00 Charges for patients covered under state or local indigent				0	
10)	1 3 .				
00 State or local indigent care program cost (line 1 times lin				0	
00 Difference between net revenue and costs for state or local	indigent care	program (li	ne 15 minus line	0	16
<pre>13; if &lt; zero then enter zero) Grants, donations and total unreimbursed cost for Medicaid,</pre>	CHIP and state	e/Local indio	ment care program	ns (see	
instructions for each line)	omi and state	cz rocar rnar	gent care program	15 (500	
00 Private grants, donations, or endowment income restricted				0	
OO Government grants, appropriations or transfers for support			(	0	
00 Total unreimbursed cost for Medicaid, CHIP and state and I 8, 12 and 16)	ocai indigent	care programs	s (sum or lines	814, 747	19
0, 12 did 10)		Uni nsured	Insured	Total (col. 1	
		pati ents	pati ents	+ col . 2)	
		1. 00	2. 00	3. 00	
Uncompensated Care (see instructions for each line)  OD Charity care charges and uninsured discounts for the entire	a facility	1, 228, 2	53 178, 961	1, 407, 214	20
(see instructions)	raciiity	1, 220, 2	170, 701	1, 407, 214	20
00 Cost of patients approved for charity care and uninsured di	scounts (see	364, 8	86 178, 961	543, 847	21
of cost of patrents approved for charity care and unitisured di					
instructions)					
<pre>instructions) 00 Payments received from patients for amounts previously wri</pre>	tten off as		0 0	0	22
<pre>instructions) 00 Payments received from patients for amounts previously wri- charity care</pre>	tten off as	36/1-8			
<pre>instructions) 00 Payments received from patients for amounts previously wri- charity care</pre>	tten off as	364, 8		543, 847	
<pre>instructions) 00 Payments received from patients for amounts previously wri- charity care</pre>	tten off as	364, 8			
instructions)  Payments received from patients for amounts previously wricharity care  Cost of charity care (line 21 minus line 22)  Does the amount on line 20 column 2, include charges for page 1.	atient days bey		86 178, 961	543, 847	
instructions)  Payments received from patients for amounts previously wricharity care  Cost of charity care (line 21 minus line 22)  Does the amount on line 20 column 2, include charges for paimposed on patients covered by Medicaid or other indigent	atient days bey care program?	ond a Length	86 178,961 of stay limit	543, 847 1. 00 N	23
instructions)  Payments received from patients for amounts previously wricharity care  Cost of charity care (line 21 minus line 22)  Does the amount on line 20 column 2, include charges for paimposed on patients covered by Medicaid or other indigent of line 24 is yes, enter the charges for patient days beyon	atient days bey care program?	ond a Length	86 178,961 of stay limit	543, 847	23
instructions) Payments received from patients for amounts previously wricharity care Cost of charity care (line 21 minus line 22)  Does the amount on line 20 column 2, include charges for paimposed on patients covered by Medicaid or other indigent of the line 24 is yes, enter the charges for patient days beyon stay limit	atient days bey care program? nd the indigent	ond a Length	86 178,961 of stay limit	543, 847 1. 00 N	24 25
instructions)  Payments received from patients for amounts previously writcharity care  Cost of charity care (line 21 minus line 22)  Does the amount on line 20 column 2, include charges for paimposed on patients covered by Medicaid or other indigent of the line 24 is yes, enter the charges for patient days beyon stay limit  Total bad debt expense for the entire hospital complex (see	atient days bey care program? nd the indigent e instructions)	ond a length care progran	86 178,961 of stay limit	543, 847 1. 00 N	23 24 25 26
instructions)  Payments received from patients for amounts previously writcharity care  Cost of charity care (line 21 minus line 22)  Does the amount on line 20 column 2, include charges for paint imposed on patients covered by Medicaid or other indigent of line 24 is yes, enter the charges for patient days beyon stay limit  Total bad debt expense for the entire hospital complex (see Medicare reimbursable bad debts for the entire hospital complex)	atient days bey care program? nd the indigent e instructions) mplex (see inst	ond a length care progran	86 178,961 of stay limit	543, 847 1. 00 N 0 2, 496, 002	23 24 25 26 27
instructions)  Payments received from patients for amounts previously writcharity care  Cost of charity care (line 21 minus line 22)  Does the amount on line 20 column 2, include charges for paimposed on patients covered by Medicaid or other indigent of the line 24 is yes, enter the charges for patient days beyon stay limit  Total bad debt expense for the entire hospital complex (see the complex of the line 24 is yes)  Medicare reimbursable bad debts for the entire hospital complex (see the complex is yes)  Medicare allowable bad debts for the entire hospital complex (see the complex is yes)	atient days bey care program? nd the indigent e instructions) mplex (see inst	ond a length care progran	86 178,961 of stay limit	543, 847  1. 00  N  0  2, 496, 002 97, 740	23 24 25 26 27 27
instructions)  Payments received from patients for amounts previously writcharity care  Cost of charity care (line 21 minus line 22)  Does the amount on line 20 column 2, include charges for paimposed on patients covered by Medicaid or other indigent of line 24 is yes, enter the charges for patient days beyon stay limit  Total bad debt expense for the entire hospital complex (see Medicare 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)  Cost of non-Medicare and non-reimbursable Medicare bad debts	atient days bey care program? nd the indigent e instructions) mplex (see inst ex (see instruc	ond a length care program ructions) tions)	of stay limit	543, 847  1. 00  N  0  2, 496, 002  97, 740  150, 370  2, 345, 632  749, 463	23 24 25 26 27 27 28 29
instructions) Payments received from patients for amounts previously writcharity care Cost of charity care (line 21 minus line 22)  Does the amount on line 20 column 2, include charges for paimposed on patients covered by Medicaid or other indigent of If line 24 is yes, enter the charges for patient days beyon stay limit Total bad debt expense for the entire hospital complex (see On Medicare reimbursable bad debts for the entire hospital complex (see On Medicare bad debt expense (see instructions)	atient days bey care program? nd the indigent e instructions) mplex (see inst ex (see instructions)	ond a length care program ructions) tions)	of stay limit	543, 847  1. 00  N  0  2, 496, 002  97, 740  150, 370  2, 345, 632	233 244 255 26 277 28 29 30

Heal th	Financial Systems	UNI ON HOSPI TAL	CLINTON		In Lie	u of Form CMS-2	2552-10
RECLAS	SSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF	F EXPENSES	Provi der Co	CN: 15-1326	Peri od:	Worksheet A	
					From 01/01/2021		
					To 12/31/2021	Date/Time Pre	
						5/26/2022 10:	52 am
	Cost Center Description	Sal ari es	0ther	Total (col. 1	Reclassi fi cati	Recl assi fi ed	
				+ col . 2)	ons (See A-6)	Trial Balance	
				,	, ,	(col. 3 +-	
						col. 4)	
		1.00	2. 00	3.00	4. 00	5. 00	
	GENERAL SERVICE COST CENTERS						
1.00	00100 NEW CAP REL COSTS-BLDG & FIXT		731, 981	731, 98	1 -20, 165	711, 816	1.00
2.00	00200 NEW CAP REL COSTS-MVBLE EQUIP		382, 039			381, 307	
4.00	00400 EMPLOYEE BENEFITS DEPARTMENT	0	302, 039		0 -732	0	1
	1 1	- 1	-		-	_	
5. 01	00540 NONPATI ENT TELEPHONES	0	665	1		665	
5. 02	00550 DATA PROCESSING	0	370, 514			370, 514	
5.03	00560 PURCHASING RECEIVING AND STORES	0	68, 892	1		68, 892	
5.04	OO570 ADMI TTI NG	448, 253	58, 842	507, 09	5 0	507, 095	
5. 05	00580 CASHI ERI NG/ACCOUNTS RECEI VABLE	3, 052	163, 272	166, 32	4 0	166, 324	5. 05
5.06	00591 ADMINISTRATIVE AND GENERAL	1, 245, 159	2, 155, 151	3, 400, 31	0 0	3, 400, 310	5. 06
7.00	00700 OPERATION OF PLANT	409, 205	763, 693	1, 172, 89	8 ol	1, 172, 898	7. 00
8.00	00800 LAUNDRY & LINEN SERVICE	0	. 0	1	ol ol	0	8.00
9. 00	00900 HOUSEKEEPI NG	225, 451	66, 355	291, 80	6 0	291, 806	
10. 00	01000 DI ETARY	366, 821	217, 096			179, 081	
11. 00	01100 CAFETERI A	0	217,090	1	0 404, 836	404, 836	1
		9	01 220				
13.00	01300 NURSING ADMINISTRATION	759, 606	91, 228			850, 834	
16. 00	01600 MEDI CAL RECORDS & LI BRARY	110, 681	70, 301	180, 98	2 0	180, 982	16. 00
	INPATIENT ROUTINE SERVICE COST CENTERS						
30. 00	03000 ADULTS & PEDIATRICS	1, 885, 204	719, 312			_, -,	
31.00	03100 INTENSIVE CARE UNIT	0	0		0 0	0	31. 00
	ANCILLARY SERVICE COST CENTERS						
50.00	05000 OPERATING ROOM	344, 217	306, 380	650, 59	7 -120, 946	529, 651	50. 00
51.00	05100 RECOVERY ROOM	5, 895	639	6, 53	4 137, 620	144, 154	51.00
51. 01	05101 O/P TREATMENT ROOM	0	0		ol ol	0	51. 01
54.00	05400 RADI OLOGY-DI AGNOSTI C	774, 938	604, 764	1, 379, 70	2 0	1, 379, 702	54.00
56. 00	05600 RADI OI SOTOPE	38, 271	28, 203			66, 474	
60.00	06000 LABORATORY	285, 915	652, 936			938, 851	
62. 00	06200 WHOLE BLOOD & PACKED RED BLOOD CELLS	203, 713	24, 950			24, 950	
65. 00	06500 RESPI RATORY THERAPY	559, 490	133, 600				
66. 00	06600 PHYSI CAL THERAPY	337, 470	803, 367			803, 367	
	1 1	٩					
67. 00	06700 OCCUPATI ONAL THERAPY	0	10, 266			10, 266	
68. 00	06800 SPEECH PATHOLOGY	0	11, 535			11, 535	
69. 00	06900 ELECTROCARDI OLOGY	3, 941	88, 878	1		485, 568	
71. 00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	72, 364	72, 36	4 -72, 364	0	
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0	15, 492	15, 49	2 0	15, 492	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	259, 530	1, 030, 422	1, 289, 95	2 0	1, 289, 952	73. 00
	OUTPATIENT SERVICE COST CENTERS						
90.00	09000 CLI NI C	0	0		0 0	0	90.00
91. 00	09100 EMERGENCY	882, 220	2, 433, 303	3, 315, 52	3 13, 949	_	
92. 00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	002, 220	2, 100, 000	0,010,02	10, 717	0,027,172	92.00
72.00	SPECIAL PURPOSE COST CENTERS						72.00
110 00		0 (07 040	12 07/ 440	20 (04 20	0 20 007	20 ((2 202	110 00
118. 00		8, 607, 849	12, 076, 440	20, 684, 28	9 -20, 897	20, 663, 392	1118.00
404.00	NONREI MBURSABLE COST CENTERS	<u></u>			ما		1.04.00
	07950 PHYSICIAN PRACTICES	0	0		0 0		194. 00
	07951 MEDICAL OFFICE BUILDING	0	0	1	0 20, 897	20, 897	
	07952 VPCHC	0	0	1	이		194. 02
200.00	TOTAL (SUM OF LINES 118 through 199)	8, 607, 849	12, 076, 440	20, 684, 28	9 0	20, 684, 289	200. 00

 
 Health Financial
 Systems
 UNION HOR

 RECLASSIFICATION
 AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES
 Provider CCN: 15-1326

| Period: | Worksheet A | From 01/01/2021 | To 12/31/2021 | Date/Time Prepared: 5/26/2022 10: 52 am

				5/26/2022 10:	52 am
	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	759, 229			1. 00
2.00	00200 NEW CAP REL COSTS-MVBLE EQUIP	0			2. 00
4.00	00400 EMPLOYEE BENEFITS DEPARTMENT	1, 417, 979	1, 417, 979		4. 00
5.01	00540 NONPATIENT TELEPHONES	26, 700			5. 01
5.02	00550 DATA PROCESSING	3, 929, 872	4, 300, 386		5. 02
5.03	00560 PURCHASING RECEIVING AND STORES	64, 891	133, 783		5. 03
5.04	00570 ADMI TTI NG	0	00,,0,0		5. 04
5.05	00580 CASHI ERI NG/ACCOUNTS RECEI VABLE	445, 121	611, 445		5. 05
5.06	00591 ADMINISTRATIVE AND GENERAL	-247, 867	3, 152, 443		5. 06
7. 00	00700 OPERATION OF PLANT	717, 341	1, 890, 239		7. 00
8.00	00800 LAUNDRY & LINEN SERVICE	0	-		8. 00
9.00	00900 HOUSEKEEPI NG	33, 045	324, 851		9. 00
10.00	01000 DI ETARY	11, 644			10. 00
11. 00	01100 CAFETERI A	-83, 646			11. 00
13. 00	01300 NURSING ADMINISTRATION	83, 471	934, 305		13. 00
16. 00	01600 MEDICAL RECORDS & LIBRARY	24, 056	205, 038		16. 00
	INPATIENT ROUTINE SERVICE COST CENTERS				4
30.00	03000 ADULTS & PEDIATRICS	-662, 083			30. 00
31. 00	03100 INTENSIVE CARE UNIT	0	0		31.00
	ANCI LLARY SERVI CE COST CENTERS		T		4
50. 00	05000 OPERATING ROOM	-40, 837		i e e e e e e e e e e e e e e e e e e e	50.00
51. 00	05100 RECOVERY ROOM	1, 989			51.00
51. 01	05101 0/P TREATMENT ROOM	0	0		51. 01
54.00	05400 RADI OLOGY-DI AGNOSTI C	70, 156		l e e e e e e e e e e e e e e e e e e e	54.00
56. 00	05600 RADI OI SOTOPE	0	66, 474	l e e e e e e e e e e e e e e e e e e e	56. 00
60.00	06000 LABORATORY	0	938, 851	l e e e e e e e e e e e e e e e e e e e	60.00
62.00	06200 WHOLE BLOOD & PACKED RED BLOOD CELLS	0	24, 950		62. 00
65. 00	06500 RESPI RATORY THERAPY	000 744	342, 082		65. 00
66.00	06600 PHYSI CAL THERAPY	-328, 711	474, 656		66.00
67. 00	06700 OCCUPATI ONAL THERAPY	114, 185			67. 00
68.00	06800 SPEECH PATHOLOGY	-401	11, 134		68. 00
69.00	06900 ELECTROCARDI OLOGY	765			69. 00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	-		71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0	.0/./2		72. 00
73. 00	07300 DRUGS CHARGED TO PATIENTS	82, 864	1, 372, 816	)	73. 00
00.00	OUTPATIENT SERVICE COST CENTERS 09000 CLINIC				00.00
90.00		0	1	l control of the cont	90.00
91.00		-10, 000	3, 319, 472		91. 00 92. 00
92. 00	09200 OBSERVATION BEDS (NON-DISTINCT PART) SPECIAL PURPOSE COST CENTERS				92.00
110 0		6, 409, 763	27 072 155		110 00
118. 00	9 /	0, 409, 703	27, 073, 155		118. 00
104 0	NONREIMBURSABLE COST CENTERS 07950 PHYSICIAN PRACTICES	0	0		194. 00
	1 07951 MEDICAL OFFICE BUILDING		20, 897		194. 00
	207952 VPCHC		20, 897	·	194. 01
200.00	1	6, 409, 763	1		200. 00
200.00	of the (sould lives the through 199)	0,407,703	27, 094, 002	·I	1200.00

Health Financial Systems

UNION HOSPITAL CLINTON

In Lieu of Form CMS-2552-10

RECLASSIFICATIONS

Provider CCN: 15-1326
From 01/01/2021
To 12/31/2021 Date/Time Prepared:

					To   12/31/2021   Date/Time Pi     5/26/2022 10	repared: D:52 am
		Increases				
	Cost Center	Li ne #	Sal ary	0ther		
	2. 00	3.00	4. 00	5. 00		
	A - CAFETERIA RECLASS					
1.00	CAFETERI A	<u>11.</u> 00	<u>254, 321</u>	15 <u>0, 5</u> 15		1. 00
	0		254, 321	150, 515		
	B - DEPRECIATION RECLASS					
1.00	MEDICAL OFFICE BUILDING	194. 01	0	20, 897		1. 00
2.00		0.00	0_	0		2. 00
	0		0	20, 897		
	C - CENTRAL SUPPLIES RECLASS					
1.00	OPERATING ROOM	50.00	0	16, 674		1. 00
2.00	RESPI RATORY THERAPY	65.00	0	41, 741		2. 00
3.00	EMERGENCY	91.00	0	13, 949		3. 00
	0		0	72, 364		
	D - RECOVERY ROOM					
1.00	RECOVERY ROOM	51.00	78, 013	<u>59, 6</u> 07		1. 00
	0		78, 013	59, 607		
	E - EKG RECLASS					
1.00	ELECTROCARDI OLOGY	69. 00	317, 043	7 <u>5, 7</u> 06		1. 00
	TOTALS		317, 043	75, 706		
500.00	Grand Total: Increases		649, 377	379, 089		500.00

Health Financial Systems

UNION HOSPITAL CLINTON

In Lieu of Form CMS-2552-10

RECLASSIFICATIONS

Provider CCN: 15-1326

Period:
From 01/01/2021

					From 01/01/2021 To 12/31/2021	Date/Time Prep 5/26/2022 10:5	
Decreases							
0 1 0 1		0 1	0.1.1	¬	,		

						5/26/2022 10:	52 am
		Decreases					
	Cost Center	Li ne #	Sal ary	0ther	Wkst. A-7 Ref.		
	6. 00	7. 00	8. 00	9. 00	10.00		
	A - CAFETERIA RECLASS						
1.00	DI ETARY	10.00	254, 321	150, 515		0	1. 00
	0		254, 321	150, 515			
	B - DEPRECIATION RECLASS						
1.00	NEW CAP REL COSTS-BLDG &	1. 00	0	20, 165	(	9	1.00
	FIXT						
2.00	NEW CAP REL COSTS-MVBLE	2. 00	0	732		9	2.00
	EQUI P					_	
	0		0	20, 897			
	C - CENTRAL SUPPLIES RECLASS						
1.00	MEDICAL SUPPLIES CHARGED TO	71. 00	0	72, 364	(	0	1.00
	PATI ENTS						
2.00		0.00	0	0	(	0	2. 00
3.00		0.00		0	(	0	3.00
	0		0	72, 364			
	D - RECOVERY ROOM						
1.00	OPERATING ROOM	50. 00	7 <u>8, 0</u> 13	5 <u>9, 6</u> 07	(	0	1.00
	0		78, 013	59, 607			
	E - EKG RECLASS						
1.00	RESPIRATORY THERAPY	65. 00	317, 043	75, 706	(	0	1. 00
	TOTALS		317, 043	75, 706			
500.00	Grand Total: Decreases		649, 377	379, 089			500.00

RECONCILIATION OF CAPITAL COSTS CENTERS

Provi der CCN: 15-1326

Peri od: Worksheet A-7 From 01/01/2021 Part I 12/31/2021

Date/Time Prepared: 5/26/2022 10:52 am Acqui si ti ons Begi nni ng Di sposal s and Purchases Donati on Total Bal ances Retirements 2.00 3.00 4. 00 5. 00 1 00 PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES 1.00 339, 822 0 1.00 374, 328 0 6, 375 2.00 Land Improvements 6, 375 0 2.00 0 3.00 12, 116, 371 1, 849, 877 1, 849, 877 3.00 Buildings and Fixtures 0 0 4.00 Building Improvements 1, 645, 471 0 4.00 5.00 Fixed Equipment 0 5.00 0 6.00 Movable Equipment 7, 368, 470 602, 158 602, 158 0 6.00 0 7.00 HIT designated Assets 7.00 0 8.00 Subtotal (sum of lines 1-7) 21, 844, 462 2, 458, 410 2, 458, 410 0 8.00 9.00 Reconciling Items 0 0 9.00 Total (line 8 minus line 9) 2, 458, 410 O 2, 458, 410 10.00 10.00 21, 844, 462 0 Endi ng Bal ance Fully Depreci ated Assets 6.00 7.00 PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES 1.00 Land 339, 822 0 1.00 2.00 Land Improvements 380, 703 0 2.00 3.00 Buildings and Fixtures 13, 966, 248 0 3.00 0 4.00 Building Improvements 1, 645, 471 4.00 5.00 Fi xed Equipment 0 5.00 Movable Equipment 0 6.00 7, 970, 628 6.00 7.00 HIT designated Assets 0 7.00 Subtotal (sum of lines 1-7) 8.00 24, 302, 872 0 8.00 9.00 Reconciling Items 9.00 10.00 Total (line 8 minus line 9) 24, 302, 872 0 10.00

Heal th	Financial Systems	UNION HOSPIT	AL CLINTON		In Lie	u of Form CMS-2	2552-10
RECON	CILIATION OF CAPITAL COSTS CENTERS		Provi der C	CN: 15-1326	Peri od:	Worksheet A-7	
					From 01/01/2021 To 12/31/2021	Part II Date/Time Pre	nared:
					10 12/31/2021	5/26/2022 10:	
			Sl	JMMARY OF CAP	I TAL		
	Cost Center Description	Depreciation	Lease	Interest	Insurance (see		
						instructions)	
		9. 00	10. 00	11. 00	12. 00	13. 00	
	PART II - RECONCILIATION OF AMOUNTS FROM WORK	· · · · · · · · · · · · · · · · · · ·	N 2, LINES 1 a	nd 2			
1.00	NEW CAP REL COSTS-BLDG & FLXT	731, 981	0	)	0	0	1. 00
2.00	NEW CAP REL COSTS-MVBLE EQUIP	382, 039	0		0 0	0	2. 00
3.00	Total (sum of lines 1-2)	1, 114, 020	0		0 0	0	3. 00
		SUMMARY O	F CAPITAL				
	Cost Center Description	0ther	Total (1) (sum				
		Capi tal -Relate	of cols. 9				
		d Costs (see	through 14)				
		instructions)					
		14.00	15. 00				
	PART II - RECONCILIATION OF AMOUNTS FROM WORL	KSHEET A, COLUM	N 2, LINES 1 a	nd 2			
1.00	NEW CAP REL COSTS-BLDG & FIXT	0	731, 981				1. 00
2.00	NEW CAP REL COSTS-MVBLE EQUIP	0	382, 039	1			2. 00
3.00	Total (sum of lines 1-2)	0	1, 114, 020	)			3. 00
		•		•			

Heal th	n Financial Systems	UNION HOSPIT	AL CLINTON		In Lie	u of Form CMS-2	2552-10
RECON	CILIATION OF CAPITAL COSTS CENTERS		Provi der C		Period: From 01/01/2021 To 12/31/2021	Worksheet A-7 Part III Date/Time Prep 5/26/2022 10:5	
		COMI	PUTATION OF RA	TIOS	ALLOCATION OF	OTHER CAPITAL	
	Cost Center Description	Gross Assets	Capi tal i zed	Gross Assets		Insurance	
			Leases	for Ratio	instructions)		
				(col . 1 - col 2)			
		1.00	2.00	3.00	4. 00	5. 00	
	PART III - RECONCILIATION OF CAPITAL COSTS CE					0.00	
1.00	NEW CAP REL COSTS-BLDG & FIXT	16, 332, 244	C	16, 332, 24	4 0. 672029	0	1. 00
2.00	NEW CAP REL COSTS-MVBLE EQUIP	7, 970, 628	C	7, 970, 62		0	2.00
3.00	Total (sum of lines 1-2)	24, 302, 872		24, 302, 87			3. 00
		ALLOCA <sup>-</sup>	TION OF OTHER (	CAPI TAL	SUMMARY O	F CAPITAL	
	Cost Center Description	Taxes	Other	Total (sum of	Depreciation	Lease	
			Capi tal -Relate				
			d Costs	through 7)			
	DART LLL DESCRIPTION OF CARLEY COOTS OF	6.00	7. 00	8. 00	9. 00	10.00	
1 00	PART III - RECONCILIATION OF CAPITAL COSTS CENEW CAP REL COSTS-BLDG & FIXT		1		0 1 471 045	0	1. 00
1. 00 2. 00	NEW CAP REL COSTS-BLDG & FIXT	0	}		0 1, 471, 045 0 381, 307	0	2. 00
3.00	Total (sum of lines 1-2)	0	}		0 1, 852, 352	0	3. 00
3.00	Total (Suil of Titles 1-2)	U		JMMARY OF CAPI		U	3.00
			31	JIMINIAKT OF CALL	IAL		
	Cost Center Description	Interest	Insurance (see	Taxes (see	0ther	Total (2) (sum	
			instructions)	instructions)	Capi tal -Rel ate	of cols. 9	
					d Costs (see	through 14)	
					instructions)		
	DART III DECONOLITATION OF CARLTY COOTS OF	11.00	12.00	13. 00	14. 00	15. 00	
1. 00	PART III - RECONCILIATION OF CAPITAL COSTS CENEW CAP REL COSTS-BLDG & FIXT					1 471 045	1. 00
2.00	NEW CAP REL COSTS-BLDG & FIXT	0	1	1	0 0	1, 471, 045 381, 307	2. 00
3.00	Total (sum of lines 1-2)			1	0 0	1, 852, 352	
3.00	Total (Sam of Titles 1-2)	1	1	1	0	1, 002, 302	3.00

Health Financial Systems UNION HOSPITAL CLINTON In Lieu of Form CMS-2552-10 ADJUSTMENTS TO EXPENSES Provider CCN: 15-1326 Peri od: Worksheet A-8 From 01/01/2021 12/31/2021 Date/Time Prepared: 5/26/2022 10:52 am Expense Classification on Worksheet A To/From Which the Amount is to be Adjusted Cost Center Description Basis/Code (2) Amount Cost Center Line # Wkst. A-7 Ref. 1.00 2.00 3.00 4.00 5.00 1.00 Investment income - NEW CAP ONEW CAP REL COSTS-BLDG & 1. 00 1.00 REL COSTS-BLDG & FLXT (chapter IFT XT 2.00 Investment income - NEW CAP ONEW CAP REL COSTS-MVBLE 2.00 2.00 REL COSTS-MVBLE EQUIP (chapter 3 00 Investment income - other В ONEW CAP REL COSTS-BLDG & 3 00 1 00 11 (chapter 2) IFI XT 4.00 Trade, quantity, and time 0.00 4.00 di scounts (chapter 8) Refunds and rebates of 5.00 0.00 5.00 expenses (chapter 8) Rental of provider space by 6.00 0.00 6.00 suppliers (chapter 8) 7.00 Tel ephone services (pay 0.00 7.00 stations excluded) (chapter 21) 8.00 Tel evision and radio service 0 0.00 8.00 0 (chapter 21) 9.00 9.00 Parking lot (chapter 21) 0.00 0 10.00 Provider-based physician A-8-2 -771, 504 10.00 adj ustment 11.00 Sale of scrap, waste, etc. 0.00 11.00 (chapter 23) 8, 927, 969 12.00 Related organization A-8-1 12.00 transactions (chapter 10) 13.00 Laundry and linen service 0.00 13.00 14.00 Cafeteria-employees and guests 0 0.00 14.00 15.00 Rental of quarters to employee 0 0.00 15.00 and others 16.00 Sale of medical and surgical 0.00 16.00 supplies to other than pati ents 17.00 Sale of drugs to other than 0.00 17.00 pati ents Sale of medical records and 18 00 18.00 0 00 abstracts 19.00 Nursing and allied health 0.00 19.00 education (tuition, fees, books, etc.) Vending machines Income from imposition of 20.00 20.00 0.00 21.00 0.0021.00 interest, finance or penalty charges (chapter 21) Interest expense on Medicare 22.00 0.00 22.00 overpayments and borrowings to repay Medicare overpayments Adjustment for respiratory ORESPIRATORY THERAPY 23.00 65 00 23 00 A - 8 - 3therapy costs in excess of limitation (chapter 14) 24.00 Adjustment for physical A-8-3 OPHYSICAL THERAPY 66.00 24.00 therapy costs in excess of limitation (chapter 14) 0 \*\*\* Cost Center Deleted \*\*\* 25.00 25.00 Utilization review -114.00 physicians' compensation (chapter 21) Depreciation - NEW CAP REL ONEW CAP REL COSTS-BLDG & 26.00 1.00 26.00 COSTS-BLDG & FLXT FI XT Depreciation - NEW CAP REL ONEW CAP REL COSTS-MVBLE 27.00 27.00 2.00 COSTS-MVBLE EQUIP EQUI P 0 \*\*\* Cost Center Deleted \*\*\* 28.00 Non-physician Anesthetist 19.00 28 00 Physicians' assistant 29.00 29.00 0.00 30.00 Adjustment for occupational A-8-3 O OCCUPATIONAL THERAPY 67.00 30.00 therapy costs in excess of limitation (chapter 14) 30.99 Hospice (non-distinct) (see OADULTS & PEDIATRICS 30.00 30.99

OSPEECH PATHOLOGY

68.00

31.00

31.00

instructions)

Adjustment for speech

pathology costs in excess of limitation (chapter 14)

A-8-3

Heal th	Financial Systems		UNI ON HOSPIT	AL CLINTON	In Lie	u of Form CMS-2	2552-10
ADJUST	MENTS TO EXPENSES				Peri od:	Worksheet A-8	
					From 01/01/2021 To 12/31/2021	Date/Time Pre 5/26/2022 10:	pared: 52 am
				Expense Classification or	n Worksheet A		
				To/From Which the Amount is	to be Adjusted		
	Cost Center Description	Basi s/Code (2)		Cost Center	Li ne #	Wkst. A-7 Ref.	
		1. 00	2. 00	3.00	4. 00	5. 00	
32.00	CAH HIT Adjustment for	A	-894	NEW CAP REL COSTS-BLDG &	1.00	9	32.00
	Depreciation and Interest			FIXT			
33.00	MI SCELLANEOUS REVENUE	В	-86, 112	ADMINISTRATIVE AND GENERAL	5. 06	0	33. 00
33. 01	CAFETERIA REVENUE	В	-111, 293	CAFETERI A	11. 00	0	33. 01
33. 02	VPCHC	В	-5, 650	HOUSEKEEPI NG	9. 00	0	33. 02
33. 03	ADVERTI SI NG	A	-1, 325	ADMINISTRATIVE AND GENERAL	5. 06	0	33. 03
33. 04	RENTAL REVENUE	В	0	OPERATION OF PLANT	7.00	0	33. 04
	1	1	1	1			

-10, 000 EMERGENCY

6, 409, 763

-1, 509, 206 ADMI NI STRATI VE AND GENERAL

-22, 222 ADMINI STRATI VE AND GENERAL

33.05

35.00

36.00

50.00

5.06

5.06

91.00

column 6, line 200.) (1) Description - all chapter references in this column pertain to CMS Pub. 15-1.

Α

Α

(2) Basis for adjustment (see instructions).

TOTAL (sum of lines 1 thru 49)

(Transfer to Worksheet A,

PHYSICIAN RECRUITMENT

36.00 PHYSICIAN RECRUITMENT

33.05

35.00

50.00

- 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 OFFICE COSTS

Provider CCN: 15-1326

Peri od: Worksheet A-8-1 From 01/01/2021 To 12/31/2021 Date/Time Prepared

Line No.   Cost Center   Expense   tems   Amount of All owable Cost   MRS. A. column   MRS. A. column   Cost   C					To 12/31/2021	Date/Time Pre 5/26/2022 10:	
A. COSTS   INCURRED AND ADJUSTMENTS REQUIRED AS A RESULT OF TRANSACTIONS WITH RELATED ORGANIZATIONS OR CLAIMED		Li ne No.	Cost Center	Expense Items	Amount of		<u>02 am</u>
1.00   2.00   3.00   4.00   5.00		21110 1101	3331 3311131	Expense i teme			
1.00   2.00   3.00   4.00   5.00							
A. COSTS   INCURRED AND ADJUSTMENTS REQUIRED AS A RESULT OF TRANSACTIONS WITH RELATED ORGANIZATIONS OR CLAIMED						5	
HOME OFFICE COSTS:		1. 00	2.00	3. 00	4. 00	5. 00	
1. 00		A. COSTS INCURRED AND ADJUSTA	MENTS REQUIRED AS A RESULT OF	TRANSACTIONS WITH RELATED OR	GANIZATIONS OR	CLAI MED	
2.00 3.00 3.01 3.01 5.02 DATA PROCESSI NG HOME OFFI CE HOME OFFI CE 26,700 3.00 3.01 4.00 5.02 DATA PROCESSI NG HOME OFFI CE 44.5, 121 4.01 5.03 PURCHASI NG RECEI VI NG AND STO HOME OFFI CE 44.5, 121 4.01 5.06 ADMIN ISTRATI VE AND GENERAL HOME OFFI CE 44.5, 121 4.02 4.03 7.00 DERRATION OF PLANT HOME OFFI CE 4.04 7.7, 341 7.00 ODI ETARY HOME OFFI CE 4.05 4.06 11.00 OLI ETARY HOME OFFI CE 4.06 11.00 CAFETERI A HOME OFFI CE 4.07 4.08 4.09 5.00 MURSI NG ADMIN ISTRATION HOME OFFI CE 4.09 5.00 OPERATI NG ROOM HOME OFFI CE 4.11 5.00 MEDI CAL RECORDS & LI BRARY HOME OFFI CE 4.11 5.10 ORECOVERY ROOM HOME OFFI CE 4.11 5.10 ORECOVERY ROOM HOME OFFI CE 4.11 5.10 ORECOVERY ROOM HOME OFFI CE 4.11 6.00 PHYSI CAL THERAPY HOME OFFI CE 4.16 6.00 PHYSI CAL THERAPY HOME OFFI CE 4.17 4.18 6.00 OPERATI ONAL THERAPY HOME OFFI CE 4.20 6.20 7.02 7.04 7.04 7.05 7.07 7.07 7.08 7.09 7.09 7.09 7.09 7.00 ORECOVERY ROOM HOME OFFI CE 7.00 7.00 7.00 7.00 7.00 7.00 7.00 7.0							
3.00 3.01 5.01 NONPATIENT TELEPHONES HOME OFFICE 3, 929, 872 0 3.00 3.01 5.02 DATA PROCESSI NG HOME OFFICE 3, 929, 872 0 3.01 4.00 5.03 PURCHASI NG RECEI VI NG AND STO HOME OFFICE 64, 891 0 4.00 4.01 5.05 CASHI ERI NG/ACCOUNTS RECEI VAB HOME OFFICE 445, 121 0 4.01 4.02 5.06 ADMI NI STRATI VE AND GENERAL HOME OFFICE 1, 370, 998 0 4.02 4.03 7.00 OPERATI ON OF PLANT HOME OFFICE 7,717, 341 0 4.03 4.04 9.00 HOUSEKEEPI NG HOME OFFICE 38, 695 0 4.04 4.05 10.00 DI ETARY HOME OFFICE 38, 695 0 4.04 4.06 11.00 CAFETERI A HOME OFFICE 11, 644 0 4.05 11.00 CAFETERI A HOME OFFICE 27, 647 0 4.05 4.07 13.00 NURSI NG ADMI NI STRATI ON HOME OFFICE 883, 471 0 4.07 4.08 16.00 MEDI CAL RECORDS & LI BRARY HOME OFFICE 883, 471 0 4.07 4.10 50.00 OPERATI NG ROOM HOME OFFICE 6, 744 0 4.09 4.11 51.00 RECOVERY ROOM HOME OFFICE 10, 652 0 4.10 4.11 52.00 OPHYSI CAL THERAPY HOME OFFICE 121, 344 0 4.11 4.13 66.00 PHYSI CAL THERAPY HOME OFFICE 28, 012 4.14 68.00 SPEECH PATHOLOGY HOME OFFICE 82, 8450 0 4.15 4.17 4.18 66.00 PHYSI CAL THERAPY HOME OFFICE 82, 864 4.19 4.20 68.00 SPEECH PATHOLOGY HOME OFFICE 82, 864 4.19 4.20 68.00 SPEECH PATHOLOGY THERAPY HOME OFFICE 82, 864 4.19 4.20 68.00 SPEECH PATHOLOGY THERAPY THERAPY 350, 520 707, 243 4.18 69.00 SPEECH PATHOLOGY THERAPY THERAPY 9, 163 70.00 DRUGS CHARGED TO PATIENTS HOME OFFICE 82, 864 70.00 CCUPATI ONAL THERAPY THERAPY 9, 163 70.00 DRUGS CHARGED TO PATIENTS HOME OFFICE 82, 864 70.00 CCUPATI ONAL THERAPY THERAPY 9, 163 70.00 DRUGS CHARGED TO PATIENTS HOME OFFICE 82, 864 70.00 CCUPATI ONAL THERAPY THERAPY 9, 163 70.00 DRUGS CHARGED TO PATIENTS HOME OFFICE 82, 864 70.00 CCUPATI ONAL THERAPY THERAPY 9, 163 70.00 DRUGS CHARGED TO PATIENTS HOME OFFICE 82, 864 70.00 CCUPATI ONAL THERAPY THERAPY 9, 163 70.00 DRUGS CHARGED TO PATIENTS HOME OFFICE 82, 864 70.00 CCUPATI ONAL THERAPY THERAPY 9, 163 70.00 DRUGS CHARGED TO PATIENTS HOME OFFICE 82, 864 70.00 CCUPATI ONAL THERAPY THERAPY 9, 163 70.00 DRUGS CHARGED TO PATIENTS HOME OFFICE 82, 864 70.00 CCUPATI ONAL THERAPY 1105, 735 70.00 LA 120 71.00 CCUPAT	1.00				760, 123	0	1.00
3. 01	2.00	4. 00	EMPLOYEE BENEFITS DEPARTMENT	HOME OFFICE	1, 417, 979	0	2.00
4.00 4.01 5.03 PURCHASING RECEIVING AND STO HOME OFFICE				HOME OFFICE	26, 700	0	3.00
4. 01 4. 02 4. 03 4. 03 4. 03 7. 00 OPERATI ON OF PLANT 4. 04 4. 05 4. 06 4. 06 4. 07 4. 08 4. 07 4. 08 4. 07 4. 08 4. 09 4. 07 4. 08 4. 09 4. 07 4. 08 4. 09 4. 09 4. 07 4. 08 4. 09 4. 09 4. 07 4. 08 4. 09 4. 10 4. 09 4. 10 4. 09 4. 10 4. 09 4. 10 4. 09 4. 10 4. 09 4. 10 4. 09 4. 10 4. 11 4. 12 4. 13 4. 14 4. 15 4. 00 REDIVEY ROOM 4. 13 4. 14 4. 15 4. 16 6. 00 PHYSI CAL THERAPY 4. 16 6. 00 PHYSI CAL THERAPY 4. 16 6. 00 PHYSI CAL THERAPY 4. 18 6. 00 PHYSI CAL THERAPY 4. 19 6. 00 PHYSI CAL THERAPY 4. 10 6. 00 PHYSI CAL THERAPY 4. 16 6. 00 PHYSI CAL THERAPY 4. 16 6. 00 PHYSI CAL THERAPY 4. 17 73. 00 DRUGS CHARGED TO PATI ENTS 4. 18 6. 00 PHYSI CAL THERAPY 4. 19 6. 00 PHYSI CAL THERAPY 5. 00 OCCUPATI ONAL	3. 01	5. 02	DATA PROCESSING	HOME OFFICE	3, 929, 872	0	3. 01
4. 02	4.00				64, 891	0	4.00
4. 03 4. 04 4. 04 9. 00 HOUSEKEEPING HOME OFFICE 38, 695 0 4. 04 4. 05 4. 06 10. 00 DI ETARY HOME OFFICE 111, 644 0 4. 05 4. 07 13. 00 NURSI NG ADMINISTRATI ON HOME OFFICE 38, 471 0 4. 06 4. 07 4. 08 16. 00 MEDI CAL RECORDS & LI BRARY HOME OFFICE 38, 471 0 4. 07 4. 08 4. 09 50. 00 OPERATI NG ROOM HOME OFFICE 6, 744 0 4. 09 4. 10 50. 00 OPERATI NG ROOM HOME OFFICE 10, 652 0 4. 10 4. 11 51. 00 RECOVERY ROOM HOME OFFICE 11, 344 0 4. 12 4. 13 66. 00 PHYSI CAL THERAPY HOME OFFICE 121, 344 0 4. 13 4. 14 67. 00 OCCUPATI ONAL THERAPY HOME OFFICE 173. 00 DRUGS CHARGED TO PATI ENTS 4. 18 66. 00 PHYSI CAL THERAPY HOME OFFICE 732 0 4. 16 4. 17 73. 00 DRUGS CHARGED TO PATI ENTS HOME OFFICE 82, 864 0 4. 17 4. 18 4. 19 67. 00 OCCUPATI ONAL THERAPY THERAPY THERAPY THERAPY THERAPY 10, 735 10, 796 4. 20	4.01			HOME OFFICE	445, 121	0	4. 01
4. 04	4.02	5. 06	ADMINISTRATIVE AND GENERAL	HOME OFFICE	1, 370, 998	0	4. 02
4. 05 4. 06 4. 06 4. 07 4. 08 4. 09 4. 09 4. 09 4. 09 4. 10 4. 11 4. 12 4. 13 4. 12 4. 13 4. 14 4. 15 4. 16 6. 00 PHYSI CAL THERAPY 4. 15 6. 00 SPEECH PATHOLOGY 4. 16 4. 17 4. 18 4. 19 4. 20 6. 00 SPEECH PATHOLOGY 4. 19 4. 19 4. 20 6. 00 SPEECH PATHOLOGY 4. 10 4. 10 4. 10 4. 07 4. 08 4. 09 4. 09 4. 09 4. 09 4. 09 4. 10 4. 09 4. 10 4. 09 4. 10 4. 11 4. 12 4. 13 4. 14 6. 14 6. 15 6.	4.03	7. 00 OPERATION OF PLANT		HOME OFFICE	717, 341	0	4. 03
4.06 4.07 4.08 11.00 CAFETERIA HOME OFFICE 4.07 4.08 16.00 MEDICAL RECORDS & LIBRARY HOME OFFICE 4.09 4.10 4.10 50.00 OPERATING ROOM HOME OFFICE 4.11 51.00 RECOVERY ROOM HOME OFFICE 51.00 RECOVERY ROOM HOME OFFICE 51.00 RADIOLOGY-DIAGNOSTIC HOME OFFICE 4.13 66.00 PHYSICAL THERAPY HOME OFFICE 51.00 CCUPATIONAL THERAPY HOME OFFICE 524,056 0 4.08 4.09 4.10 4.09 4.10 4.11 51.00 RECOVERY ROOM HOME OFFICE 10,652 0 4.10 4.11 4.12 54.00 RADIOLOGY-DIAGNOSTIC HOME OFFICE 121,344 0 4.12 4.13 66.00 PHYSICAL THERAPY HOME OFFICE 28,012 0 4.13 4.14 67.00 OCCUPATIONAL THERAPY HOME OFFICE 732 0 4.15 4.16 69.00 ELECTROCARDIOLOGY HOME OFFICE 732 0 4.15 4.16 69.00 PHYSICAL THERAPY HOME OFFICE 732 0 4.15 4.16 69.00 PHYSICAL THERAPY HOME OFFICE 732 0 4.15 4.16 69.00 PHYSICAL THERAPY HOME OFFICE 732 0 4.16 4.17 73.00 DRUGS CHARGED TO PATIENTS HOME OFFICE 735 0 4.16 4.17 73.00 DRUGS CHARGED TO PATIENTS HOME OFFICE 735 0 4.16 4.17 73.00 DRUGS CHARGED TO PATIENTS HOME OFFICE 735 0 4.16 736 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	4.04	9. 00	HOUSEKEEPI NG	HOME OFFICE	38, 695	0	4. 04
4. 07       13. 00 NURSI NG ADMI NI STRATI ON       HOME OFFI CE       83, 471       0       4. 07         4. 08       16. 00 MEDI CAL RECORDS & LI BRARY       HOME OFFI CE       24, 056       0       4. 08         4. 09       50. 00 OPERATI NG ROOM       HOME OFFI CE       6, 744       0       4. 09         4. 10       50. 00 OPERATI NG ROOM       HOME OFFI CE       10, 652       0       4. 10         4. 11       51. 00 RECOVERY ROOM       HOME OFFI CE       1, 989       0       4. 11         4. 12       54. 00 RADI OLOGY-DI AGNOSTI C       HOME OFFI CE       121, 344       0       4. 12         4. 13       66. 00 PHYSI CAL THERAPY       HOME OFFI CE       28, 012       0       4. 13         4. 14       67. 00 OCCUPATI ONAL THERAPY       HOME OFFI CE       8, 450       0       4. 14         4. 15       68. 00 SPEECH PATHOLOGY       HOME OFFI CE       732       0       4. 15         4. 16       69. 00 ELECTROCARDI OLOGY       HOME OFFI CE       82, 864       0       4. 16         4. 17       73. 00 DRUGS CHARGED TO PATI ENTS       HOME OFFI CE       82, 864       0       4. 17         4. 18       66. 00 PHYSI CAL THERAPY       THERAPY       350, 520       707, 243	4.05	10.00	DI ETARY	HOME OFFICE	11, 644	0	4. 05
4.08       16.00 MEDI CAL RECORDS & LI BRARY       HOME OFFI CE       24,056       0       4.08         4.09       50.00 OPERATI NG ROOM       HOME OFFI CE       6,744       0       4.09         4.10       50.00 OPERATI NG ROOM       HOME OFFI CE       10,652       0       4.10         4.11       51.00 RECOVERY ROOM       HOME OFFI CE       1,989       0       4.11         4.12       54.00 RADI OLOGY-DI AGNOSTI C       HOME OFFI CE       121,344       0       4.12         4.13       66.00 PHYSI CAL THERAPY       HOME OFFI CE       28,012       0       4.13         4.14       67.00 OCCUPATI ONAL THERAPY       HOME OFFI CE       8,450       0       4.14         4.15       68.00 SPEECH PATHOLOGY       HOME OFFI CE       732       0       4.15         4.16       69.00 ELECTROCARDI OLOGY       HOME OFFI CE       765       0       4.16         4.17       73.00 DRUGS CHARGED TO PATI ENTS       HOME OFFI CE       82,864       0       4.17         4.18       66.00 PHYSI CAL THERAPY       THERAPY       350,520       707,243       4.18         4.19       67.00 OCCUPATI ONAL THERAPY       THERAPY       105,735       0       4.19         4.20	4.06	11. 00	CAFETERI A	HOME OFFICE	27, 647	0	4. 06
4. 09 4. 10 4. 10 50. 00 OPERATI NG ROOM HOME OFFI CE HOME OFFI CE 10, 652 0 4. 10 4. 11 51. 00 RECOVERY ROOM HOME OFFI CE 11, 989 0 4. 11 4. 12 51. 00 RADI OLOGY-DI AGNOSTI C HOME OFFI CE 121, 344 0 4. 12 4. 13 66. 00 PHYSI CAL THERAPY HOME OFFI CE 128, 012 0 4. 13 4. 14 67. 00 OCCUPATI ONAL THERAPY HOME OFFI CE 128, 012 0 4. 14 4. 15 68. 00 SPEECH PATHOLOGY HOME OFFI CE 732 0 4. 15 4. 16 69. 00 ELECTROCARDI OLOGY HOME OFFI CE 732 0 4. 15 4. 17 73. 00 DRUGS CHARGED TO PATI ENTS HOME OFFI CE 82, 864 0 4. 17 4. 18 66. 00 PHYSI CAL THERAPY THERAPY THERAPY THERAPY THERAPY 105, 735 0 4. 19 4. 20 68. 00 SPEECH PATHOLOGY THERAPY THERAPY THERAPY 105, 735 0 4. 19	4.07	13. 00	NURSING ADMINISTRATION	HOME OFFICE	83, 471	0	4. 07
4. 10	4.08	16. 00	MEDICAL RECORDS & LIBRARY	HOME OFFICE	24, 056	0	4. 08
4. 11       51. 00 RECOVERY ROOM       HOME OFFICE       1, 989       0       4. 11         4. 12       54. 00 RADI OLOGY-DI AGNOSTI C       HOME OFFICE       121, 344       0       4. 12         4. 13       66. 00 PHYSI CAL THERAPY       HOME OFFICE       28, 012       0       4. 13         4. 14       67. 00 OCCUPATI ONAL THERAPY       HOME OFFICE       8, 450       0       4. 14         4. 15       68. 00 SPEECH PATHOLOGY       HOME OFFICE       732       0       4. 15         4. 16       69. 00 ELECTROCARDI OLOGY       HOME OFFICE       765       0       4. 16         4. 17       73. 00 DRUGS CHARGED TO PATI ENTS       HOME OFFI CE       82, 864       0       4. 17         4. 18       66. 00 PHYSI CAL THERAPY       THERAPY       350, 520       707, 243       4. 18         4. 19       67. 00 OCCUPATI ONAL THERAPY       THERAPY       105, 735       0       4. 19         4. 20       68. 00 SPEECH PATHOLOGY       THERAPY       9, 163       10, 296       4. 20	4.09	50.00	OPERATING ROOM	HOME OFFICE	6, 744	0	4. 09
4. 12       54. 00 RADI OLOGY - DI AGNOSTI C       HOME OFFI CE       121, 344       0       4. 12         4. 13       66. 00 PHYSI CAL THERAPY       HOME OFFI CE       28, 012       0       4. 13         4. 14       67. 00 OCCUPATI ONAL THERAPY       HOME OFFI CE       8, 450       0       4. 14         4. 15       68. 00 SPEECH PATHOLOGY       HOME OFFI CE       732       0       4. 15         4. 16       69. 00 ELECTROCARDI OLOGY       HOME OFFI CE       765       0       4. 16         4. 17       73. 00 DRUGS CHARGED TO PATI ENTS       HOME OFFI CE       82, 864       0       4. 16         4. 18       66. 00 PHYSI CAL THERAPY       THERAPY       350, 520       707, 243       4. 18         4. 19       67. 00 OCCUPATI ONAL THERAPY       THERAPY       105, 735       0       4. 19         4. 20       68. 00 SPEECH PATHOLOGY       THERAPY       9, 163       10, 296       4. 20	4. 10	50.00	OPERATING ROOM	HOME OFFICE	10, 652	0	4. 10
4. 13     66. 00 PHYSI CAL THERAPY     HOME OFFI CE     28, 012     0     4. 13       4. 14     67. 00 OCCUPATI ONAL THERAPY     HOME OFFI CE     8, 450     0     4. 14       4. 15     68. 00 SPEECH PATHOLOGY     HOME OFFI CE     732     0     4. 15       4. 16     69. 00 ELECTROCARDI OLOGY     HOME OFFI CE     765     0     4. 16       4. 17     73. 00 DRUGS CHARGED TO PATI ENTS     HOME OFFI CE     82, 864     0     4. 17       4. 18     66. 00 PHYSI CAL THERAPY     THERAPY     350, 520     707, 243     4. 18       4. 19     67. 00 OCCUPATI ONAL THERAPY     THERAPY     105, 735     0     4. 19       4. 20     68. 00 SPEECH PATHOLOGY     THERAPY     9, 163     10, 296     4. 20	4. 11	51. 00	RECOVERY ROOM	HOME OFFICE	1, 989	0	4. 11
4. 14     67. 00 OCCUPATI ONAL THERAPY     HOME OFFI CE     8, 450     0     4. 14       4. 15     68. 00 SPEECH PATHOLOGY     HOME OFFI CE     732     0     4. 15       4. 16     69. 00 ELECTROCARDI OLOGY     HOME OFFI CE     765     0     4. 16       4. 17     73. 00 DRUGS CHARGED TO PATI ENTS     HOME OFFI CE     82, 864     0     4. 17       4. 18     66. 00 PHYSI CAL THERAPY     THERAPY     350, 520     707, 243     4. 18       4. 19     67. 00 OCCUPATI ONAL THERAPY     THERAPY     105, 735     0     4. 19       4. 20     68. 00 SPEECH PATHOLOGY     THERAPY     9, 163     10, 296     4. 20	4. 12	54. 00	RADI OLOGY-DI AGNOSTI C	HOME OFFICE	121, 344	0	4. 12
4. 15     68. 00 SPEECH PATHOLOGY     HOME OFFICE     732     0     4. 15       4. 16     69. 00 ELECTROCARDI OLOGY     HOME OFFICE     765     0     4. 16       4. 17     73. 00 DRUGS CHARGED TO PATI ENTS     HOME OFFICE     82, 864     0     4. 17       4. 18     66. 00 PHYSI CAL THERAPY     THERAPY     350, 520     707, 243     4. 18       4. 19     67. 00 OCCUPATI ONAL THERAPY     THERAPY     105, 735     0     4. 19       4. 20     68. 00 SPEECH PATHOLOGY     THERAPY     9, 163     10, 296     4. 20	4.13	66. 00	PHYSI CAL THERAPY	HOME OFFICE	28, 012	0	4. 13
4. 16     69. 00 ELECTROCARDI OLOGY     HOME OFFI CE     765     0     4. 16       4. 17     73. 00 DRUGS CHARGED TO PATI ENTS     HOME OFFI CE     82, 864     0     4. 17       4. 18     66. 00 PHYSI CAL THERAPY     THERAPY     350, 520     707, 243     4. 18       4. 19     67. 00 OCCUPATI ONAL THERAPY     THERAPY     105, 735     0     4. 19       4. 20     68. 00 SPEECH PATHOLOGY     THERAPY     9, 163     10, 296     4. 20	4.14	67. 00	OCCUPATIONAL THERAPY	HOME OFFICE	8, 450	0	4. 14
4. 17     73. 00 DRUGS CHARGED TO PATIENTS     HOME OFFICE     82, 864     0     4. 17       4. 18     66. 00 PHYSI CAL THERAPY     THERAPY     350, 520     707, 243     4. 18       4. 19     67. 00 OCCUPATI ONAL THERAPY     THERAPY     105, 735     0     4. 19       4. 20     68. 00 SPEECH PATHOLOGY     THERAPY     9, 163     10, 296     4. 20	4. 15	68. 00	SPEECH PATHOLOGY	HOME OFFICE	732	0	4. 15
4. 18     66. 00 PHYSI CAL THERAPY     THERAPY     350, 520     707, 243     4. 18       4. 19     67. 00 OCCUPATI ONAL THERAPY     THERAPY     105, 735     0     4. 19       4. 20     68. 00 SPEECH PATHOLOGY     THERAPY     9, 163     10, 296     4. 20	4. 16	69. 00	ELECTROCARDI OLOGY	HOME OFFICE	765	0	4. 16
4. 19     67. 00 OCCUPATI ONAL THERAPY     THERAPY     105, 735     0     4. 19       4. 20     68. 00 SPEECH PATHOLOGY     THERAPY     9, 163     10, 296     4. 20	4. 17	73. 00	DRUGS CHARGED TO PATIENTS	HOME OFFICE	82, 864	0	4. 17
4. 20 68. 00 SPEECH PATHOLOGY THERAPY 9, 163 10, 296 4. 20	4. 18	66. 00	PHYSI CAL THERAPY	THERAPY	350, 520	707, 243	4. 18
	4. 19	67. 00	OCCUPATIONAL THERAPY	THERAPY	105, 735	0	4. 19
<u>5.00 0 9,645,508 717,539 5.00</u>	4. 20	68.00	SPEECH PATHOLOGY	THERAPY	9, 163	10, 296	4. 20
	5.00	0		0	9, 645, 508	717, 539	5. 00

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

The been posted to worksheet h, cordinas i and or 2, the amount arrowable should be that dated in cordinar i or this part.							
			Related Organization(s) and/	or Home Office			
Symbol (1)	Name	Percentage of	Name	Percentage of			
		Ownershi p		Ownershi p			
1. 00	2. 00	3. 00	4. 00	5. 00			
B. INTERRELATIONSHIP TO RELATED ORGANIZATION(S) AND/OR HOME OFFICE:							
	1.00	1.00 2.00	Symbol (1) Name Percentage of Ownership 1.00 2.00 3.00	Symbol (1) Name Percentage of Ownership 1.00 2.00 3.00 4.00	Ownershi p         Ownershi p           1.00         2.00         3.00         4.00         5.00		

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.

			I a calum on Hoop, Tal	100.00	
6.00	[ G		O. OO UNI ON HOSPI TAL	100. 00	6. 00
7.00	G		O. OO UNI ON THERAPY	51. 00	7. 00
8.00			0.00	0. 00	8. 00
9. 00			0.00	0. 00	9. 00
10.00			0.00	0. 00	10.00
		OTHER			100.00
	non-financial) specify:				

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

					To 12/31/2021	Date/Time Prep 5/26/2022 10:5	
	Net	Wkst. A-7 Ref.					
	Adjustments						
	(col. 4 minus						
	col. 5)*						
	6. 00	7. 00					
			MENTS REQUIRED AS A RESULT OF TRA	ANSACTIONS WITH RELATED O	RGANIZATIONS OR (	CLAI MED	
	HOME OFFICE CO						
1.00	760, 123						1.00
2.00	1, 417, 979						2.00
3.00	26, 700						3.00
3. 01	3, 929, 872	0					3. 01
4.00	64, 891	0					4.00
4.01	445, 121	0					4. 01
4.02	1, 370, 998	0					4. 02
4.03	717, 341	0					4. 03
4.04	38, 695	0					4. 04
4.05	11, 644	0					4. 05
4.06	27, 647	0					4.06
4.07	83, 471	0					4. 07
4.08	24, 056	0					4. 08
4.09	6, 744	0					4. 09
4. 10	10, 652	0					4. 10
4. 11	1, 989	0					4. 11
4. 12	121, 344	0					4. 12
4. 13	28, 012	0					4. 13
4.14	8, 450	0					4. 14
4. 15	732	0					4. 15
4. 16	765	0					4. 16
4. 17	82, 864	0					4. 17
4. 18	-356, 723	0					4. 18
4. 19	105, 735						4. 19
4. 20	-1, 133	0					4. 20
5.00	8, 927, 969						5. 00
* The	amaunta an lin	oo 1 4 (ond out	oorinto oo onnronnisto) oro tron	oformed in dotail to Worl	cohoot A column	/ Linco oo	

\* 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.

1100 110 0	boon pooted to normanost m	cordinate a dray or 2, the dimedrit difference should be that cated in cordinate of this part.	
	Rel ated Organization(s)		
	and/or Home Office		
	Type of Business		
	31		
	6. 00		
	B. INTERRELATIONSHIP TO RELAT	TED ORGANIZATION(S) AND/OR HOME OFFICE:	

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

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

1 61 111	oursement under tritle Aviii.	
6. 00	HOME OFFICE	6.00
7.00	THERAPY	7.00
8.00		8.00
9.00		9.00
10. C	0	10.00
100.	00	100.00

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

| Period: | Worksheet A-8-2 | From 01/01/2021 | To 12/31/2021 | Date/Time Prepared: Health Financial Systems
PROVIDER BASED PHYSICIAN ADJUSTMENT Provider CCN: 15-1326

					-	To 12/31/2021	Date/Time Pre 5/26/2022 10:	
	Wkst. A Line #	Cost Center/Physician	Total	Professi onal	Provi der	RCE Amount	Physi ci an/Prov	
		I denti fi er	Remuneration	Component	Component		ider Component	
							Hours	
	1. 00	2. 00	3.00	4.00	5. 00	6. 00	7. 00	
1.00	30.00	ADULTS & PEDIATRICS	662, 083	662, 08	3 C	C	0	1. 00
2.00	50.00	OPERATING ROOM	58, 233	58, 23	3 0	ol c	0	2.00
3.00	54.00	RADI OLOGY-DI AGNOSTI C	51, 188	51, 18	8 0	ol c	0	3.00
4.00		EMERGENCY	1, 964, 343	·	0 1, 964, 343	c c	0	4.00
5. 00	0.00		0		0			1
6. 00	0.00		0		0 0		o o	
7. 00	0.00							1
8. 00	0.00							
9. 00	0.00							1
	0.00						٦ - "	
10.00	0.00		0 725 047	771 50	1 0/4 242	٦	0	
200.00	140 1 4 1 4	0 1 0 1 (B)	2, 735, 847				0	200.00
	Wkst. A Line #	Cost Center/Physician	Unadjusted RCE			Provi der	Physician Cost of Malpractice	
		l denti fi er	Limit		E Memberships &			:
				Limit	Continuing	Share of col.	Insurance	
	1.00	2.00	8.00	9. 00	Education 12.00	12 13. 00	14.00	
1. 00		ADULTS & PEDIATRICS	8.00		0 0			1.00
2. 00		OPERATING ROOM		1	0 0			1
3. 00		RADI OLOGY-DI AGNOSTI C						1
4. 00		EMERGENCY						1
		EMERGENCY	0				1	1
5.00	0.00		0				0	0.00
6.00	0.00		0		U U		0	0.00
7. 00	0.00		0		U U			7.00
8. 00	0.00		0		U U		0	0.00
9.00	0.00		0		0			9.00
10.00	0. 00		0		0		0	
200.00	140 1 4 1 4	0 1 0 1 (B)	0	A !!   1 DOE	0 0	)	0	200.00
	Wkst. A Line #	Cost Center/Physician	Provi der	Adjusted RCE		Adjustment		
		l denti fi er	Component	Limit	Di sal I owance			
			Share of col.					
	1.00	2.00	15. 00	16. 00	17. 00	18. 00	-	
1. 00		ADULTS & PEDIATRICS	0		0 0			1. 00
2. 00		OPERATING ROOM	0		0 0		•	2. 00
3. 00		RADI OLOGY-DI AGNOSTI C	0	1	0 0		•	3.00
4. 00		EMERGENCY		1		01,100		4.00
5. 00	0.00	EMERGENOT			0 0	1		5.00
6. 00	0.00							6.00
7. 00	0.00							7.00
7. 00 8. 00	0.00							8.00
9. 00	0.00							9.00
	0.00				٥			10.00
10.00	0.00				0	٦	'	
200.00	1		0	1	0  0	771, 504	1	200. 00

| Period: | Worksheet B | From 01/01/2021 | Part | To | 12/31/2021 | Date/Time Prepared: Health Financial Systems
COST ALLOCATION - GENERAL SERVICE COSTS Provider CCN: 15-1326

				To	12/31/2021	Date/Time Pre	pared:
			CAPI TAL REI	ATED COSTS		5/26/2022 10:	oz alli
			0711 7 7712 7722	21125 00010			
	Cost Center Description	Net Expenses	NEW BLDG &	NEW MVBLE	EMPLOYEE	NONPATI ENT	
		for Cost	FLXT	EQUI P	BENEFI TS	TELEPHONES	
		Allocation			DEPARTMENT		
		(from Wkst A					
		col . 7) 0	1. 00	2.00	4. 00	5. 01	
	GENERAL SERVICE COST CENTERS	0	1.00	2.00	4.00	5.01	
1.00	00100 NEW CAP REL COSTS-BLDG & FLXT	1, 471, 045	1, 471, 045				1.00
2. 00	00200 NEW CAP REL COSTS-MVBLE EQUIP	381, 307	., ., .,	381, 307			2. 00
4. 00	00400 EMPLOYEE BENEFITS DEPARTMENT	1, 417, 979	0		1, 417, 979		4. 00
5. 01	00540 NONPATI ENT TELEPHONES	27, 365	1, 973		0	33, 377	5. 01
5.02	00550 DATA PROCESSING	4, 300, 386	3, 852	132, 293	0	528	5. 02
5.03	00560 PURCHASING RECEIVING AND STORES	133, 783	15, 008	0	0	264	5. 03
5.04	00570 ADMI TTI NG	507, 095	9, 563	611	73, 841	923	5. 04
5.05	00580 CASHI ERI NG/ACCOUNTS RECEI VABLE	611, 445	5, 654		503	660	5. 05
5.06	00591 ADMINISTRATIVE AND GENERAL	3, 152, 443	27, 967		205, 116	1, 847	5. 06
7.00	00700 OPERATION OF PLANT	1, 890, 239	407, 667	·	67, 409	2, 902	7. 00
8.00	00800 LAUNDRY & LINEN SERVICE	0	7, 855		0	0	8. 00
9.00	00900 HOUSEKEEPI NG	324, 851	7, 438		37, 139	132	9. 00
10.00	01000 DI ETARY	190, 725	25, 975		18, 532	264	10.00
11.00	01100 CAFETERI A	321, 190	58, 723		41, 895	660	11.00
13.00	01300 NURSING ADMINISTRATION	934, 305	26, 222		125, 131	528	13.00
16. 00	01600 MEDICAL RECORDS & LIBRARY I NPATIENT ROUTINE SERVICE COST CENTERS	205, 038	16, 602	56	18, 233	1, 055	16. 00
30. 00	03000 ADULTS & PEDIATRICS	1, 942, 433	273, 182	19, 007	310, 550	9, 760	30.00
31. 00	03100 INTENSIVE CARE UNIT	1, 942, 433	273, 162		310, 550	9,760	31.00
31.00	ANCILLARY SERVICE COST CENTERS	<u> </u>		<u> </u>	<u> </u>	0	31.00
50. 00	05000 OPERATING ROOM	488, 814	61, 076	36, 595	43, 852	792	50. 00
51. 00	05100 RECOVERY ROOM	146, 143	36, 221	4, 575	13, 822	1, 847	51. 00
51. 01	05101 O/P TREATMENT ROOM	0	0	0	0	0	51. 01
54.00	05400 RADI OLOGY-DI AGNOSTI C	1, 449, 858	108, 245	104, 642	127, 656	2, 111	54.00
56.00	05600 RADI OI SOTOPE	66, 474	0	24, 191	6, 304	0	56. 00
60.00	06000 LABORATORY	938, 851	32, 464	3, 535	47, 099	792	60.00
62.00	06200 WHOLE BLOOD & PACKED RED BLOOD CELLS	24, 950	0	0	0	0	62. 00
65.00	06500 RESPI RATORY THERAPY	342, 082	30, 548		39, 939	792	65. 00
66. 00	06600 PHYSI CAL THERAPY	474, 656	64, 112	23	0	1, 319	66. 00
67. 00	06700 OCCUPATI ONAL THERAPY	124, 451	53, 923		0	923	67. 00
68. 00	06800 SPEECH PATHOLOGY	11, 134	7, 286		0	264	68. 00
69. 00	06900 ELECTROCARDI OLOGY	486, 333	7, 950		52, 876	528	69. 00
71.00	07100 MEDI CAL SUPPLI ES CHARGED TO PATI ENTS	15 403	0		0	0	71.00
72. 00 73. 00	07200 IMPL. DEV. CHARGED TO PATIENTS 07300 DRUGS CHARGED TO PATIENTS	15, 492	0 19, 239	_	0 42, 753	0 792	72. 00 73. 00
73.00	OUTPATIENT SERVICE COST CENTERS	1, 372, 816	19, 239	704	42, 733	192	73.00
90. 00	09000 CLINIC	0	0	O	0	0	90.00
91. 00	09100 EMERGENCY	3, 319, 472	162, 300		145, 329	3, 694	91.00
92. 00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	3,317,472	102, 300	25, 541	145, 527	3,074	92.00
72.00	SPECIAL PURPOSE COST CENTERS						72.00
118.00		27, 073, 155	1, 471, 045	381, 169	1, 417, 979	33, 377	118. 00
	NONREI MBURSABLE COST CENTERS	, , , , , , ,	, , , , , , , , , , , , , , , , , , , ,	,	, , , , , ,		
194.00	07950 PHYSICIAN PRACTICES	0	0	138	0	0	194. 00
194. 01	07951 MEDICAL OFFICE BUILDING	20, 897	0	0	0		194. 01
	2 07952 VPCHC	0	0	0	0	0	194. 02
200.00							200. 00
201.00			0	0	0		201. 00
202.00	TOTAL (sum lines 118 through 201)	27, 094, 052	1, 471, 045	381, 307	1, 417, 979	33, 377	202. 00

Health Financial Systems
COST ALLOCATION - GENERAL SERVICE COSTS Provider CCN: 15-1326

| Peri od: | Worksheet B | From 01/01/2021 | Part | To 12/31/2021 | Date/Time Prepared: | To 12/31/2021 | Da

				1	0 12/31/2021	Date/IIme Pre   5/26/2022 10:	
	Cost Center Description	DATA	PURCHASI NG	ADMI TTI NG	CASHI ERI NG/ACC	Subtotal	52 diii
		PROCESSI NG	RECEIVING AND		OUNTS		
			STORES		RECEI VABLE		
		5. 02	5. 03	5. 04	5. 05	5A. 05	
	GENERAL SERVICE COST CENTERS						
1.00	00100 NEW CAP REL COSTS-BLDG & FIXT						1. 00
2.00	00200 NEW CAP REL COSTS-MVBLE EQUIP						2. 00
4.00	00400 EMPLOYEE BENEFITS DEPARTMENT						4. 00
5. 01	00540 NONPATI ENT TELEPHONES						5. 01
5.02	00550 DATA PROCESSING	4, 437, 059					5. 02
5. 03	00560 PURCHASING RECEIVING AND STORES	61, 201	210, 256				5. 03
5.04	00570 ADMI TTI NG	214, 203	3, 567	809, 803			5. 04
5.05	00580 CASHI ERI NG/ACCOUNTS RECEI VABLE	30, 600	0	0	648, 862		5. 05
5.06	00591 ADMINISTRATIVE AND GENERAL	306, 004		0	0	3, 694, 456	5. 06
7.00	00700 OPERATION OF PLANT	214, 203	61	0	0	2, 587, 869	7. 00
8.00	00800 LAUNDRY & LINEN SERVICE	0	0	0	0	7, 985	8. 00
9.00	00900 HOUSEKEEPI NG	61, 201	16, 071	0	0	448, 391	9. 00
10.00	01000 DI ETARY	61, 201	20	0	0	298, 458	10.00
11. 00	01100 CAFETERI A	91, 801	47	0	0	519, 539	11. 00
13.00	01300 NURSING ADMINISTRATION	61, 201	5	0	0	1, 147, 594	13. 00
16.00	01600 MEDICAL RECORDS & LIBRARY	91, 801	21	0	0	332, 806	16. 00
	INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000 ADULTS & PEDIATRICS	1, 071, 014	51, 117	395, 978	50, 190	4, 123, 231	30. 00
31. 00	03100 INTENSIVE CARE UNIT	0	0	0	0	0	31. 00
	ANCILLARY SERVICE COST CENTERS						
50. 00	05000 OPERATING ROOM	428, 406	42, 660	20, 383	26, 923	1, 149, 501	50. 00
51. 00	05100 RECOVERY ROOM	0	0		8, 144	210, 956	51. 00
51. 01	05101 0/P TREATMENT ROOM	0	0	0	0	0	51. 01
54.00	05400 RADI OLOGY-DI AGNOSTI C	428, 406		56, 960	190, 871	2, 490, 882	
56. 00	05600 RADI OI SOTOPE	0	107	960	4, 029	102, 065	56. 00
60.00	06000 LABORATORY	0	59	93, 815	83, 219	1, 199, 834	60.00
62. 00	06200 WHOLE BLOOD & PACKED RED BLOOD CELLS	0	0	1, 000	201	26, 151	62. 00
65. 00	06500 RESPI RATORY THERAPY	244, 803		49, 300	21, 120	747, 606	•
66. 00	06600 PHYSI CAL THERAPY	183, 602	343		15, 250	753, 445	•
67. 00	06700 OCCUPATI ONAL THERAPY	0	0		4, 600	191, 352	67. 00
68. 00	06800 SPEECH PATHOLOGY	0	0	911	399	19, 994	68. 00
69. 00	06900 ELECTROCARDI OLOGY	61, 201	0	11, 566	27, 618	650, 620	
71. 00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	71. 00
72. 00	07200 I MPL. DEV. CHARGED TO PATIENTS	0	0	0	283	15, 775	72. 00
73.00	07300 DRUGS CHARGED TO PATIENTS	244, 803	641	116, 429	53, 508	1, 851, 745	73. 00
	OUTPATIENT SERVICE COST CENTERS						
90.00	09000 CLI NI C	0			0	0	90.00
91. 00	09100 EMERGENCY	581, 408	63, 809	40, 702	162, 507	4, 502, 762	91.00
92. 00	09200 OBSERVATION BEDS (NON-DISTINCT PART)					0	92. 00
440.00	SPECIAL PURPOSE COST CENTERS	4 407 050	040.05/	000.000	(40.0(0)	07 070 047	440.00
118.00		4, 437, 059	210, 256	809, 803	648, 862	27, 073, 017	1118.00
104.00	NONREI MBURSABLE COST CENTERS				O	120	104.00
	0 07950 PHYSI CI AN PRACTI CES	0	0	0	ŭ.		194. 00
	1 07951 MEDICAL OFFICE BUILDING 2 07952 VPCHC		0	0	0	20, 897	194. 01
	i i		١		٩		
200.00	, ,	_		_			200.00
201.00		4 427 050	210.254	000 000	(40.0/2		201. 00
202.00	TOTAL (sum lines 118 through 201)	4, 437, 059	210, 256	809, 803	648, 862	27, 094, 052	1202. UU

COST ALLOCATION - GENERAL SERVICE COSTS

OUTPATIENT SERVICE COST CENTERS

09200 OBSERVATION BEDS (NON-DISTINCT PART)

90.00

91.00

92.00

09000 CLI NI C

09100 EMERGENCY

Provider CCN: 15-1326

Peri od: Worksheet B From 01/01/2021 Part I To 12/31/2021 Date/Ti me Prepared:

 $\cap$ 

89, 830

9, 751

90.00

92.00

0

0 91.00

5/26/2022 10:52 am Cost Center Description ADMINISTRATIVE OPERATION OF LAUNDRY & HOUSEKEEPI NG DI ETARY AND GENERAL PLANT LINEN SERVICE 9.00 10.00 5.06 7.00 8.00 GENERAL SERVICE COST CENTERS 1.00 00100 NEW CAP REL COSTS-BLDG & FLXT 1.00 00200 NEW CAP REL COSTS-MVBLE EQUIP 2.00 2.00 00400 EMPLOYEE BENEFITS DEPARTMENT 4.00 4.00 5.01 00540 NONPATIENT TELEPHONES 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 ERING/ACCOUNTS RECEIVABLE 5.05 5.05 5.06 00591 ADMINISTRATIVE AND GENERAL 3, 694, 456 5.06 7.00 00700 OPERATION OF PLANT 408, 586 2, 996, 455 7 00 00800 LAUNDRY & LINEN SERVICE 8 00 1, 261 23, 552 32 798 8 00 9.00 00900 HOUSEKEEPI NG 70, 794 22, 301 3, 175 544, 661 9.00 10.00 01000 DI ETARY 47, 122 77, 882 284 14, 377 438, 123 10.00 01100 CAFETERI A 82, 027 32, 502 11.00 176, 075 11.00 641 0 01300 NURSING ADMINISTRATION 14, 513 13.00 181, 188 78, 622 C 0 13.00 16.00 01600 MEDICAL RECORDS & LIBRARY 52, 545 49, 779 0 9, 189 0 16.00 INPATIENT ROUTINE SERVICE COST CENTERS 819, 104 30.00 03000 ADULTS & PEDIATRICS 650, 996 438, 123 30.00 10, 976 151, 201 03100 INTENSIVE CARE UNIT 31.00 0 0 31.00 ANCILLARY SERVICE COST CENTERS 50.00 05000 OPERATING ROOM 181, 489 183, 129 896 33, 804 0 50.00 05100 RECOVERY ROOM 33, 307 51.00 108, 603 0 20,047 0 51.00 51.01 05101 0/P TREATMENT ROOM 0 0 51.01 54.00 05400 RADI OLOGY-DI AGNOSTI C 393, 273 324, 558 3,502 59, 911 0 54.00 05600 RADI OI SOTOPE 56.00 16, 115 0 56.00 C 06000 LABORATORY 60.00 189, 436 97, 339 0 17, 968 Λ 60.00 62.00 06200 WHOLE BLOOD & PACKED RED BLOOD CELLS 4, 129 0 0 62.00 06500 RESPIRATORY THERAPY 118, 036 91, 593 16, 907 65.00 238 0 65.00 66.00 06600 PHYSI CAL THERAPY 118.958 192, 231 0 66.00 2,603 35, 485 06700 OCCUPATIONAL THERAPY 67.00 30, 212 161, 681 C 29,845 0 67.00 68.00 06800 SPEECH PATHOLOGY 3, 157 21,846 0 4,033 0 68.00 06900 ELECTROCARDI OLOGY 69.00 102, 723 23, 837 732 4, 400 0 69.00 71 00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 0 71 00 0 0 0 07200 IMPL. DEV. CHARGED TO PATIENTS 72.00 2, 491 0 0 0 72.00 07300 DRUGS CHARGED TO PATIENTS 292, 363 57<u>, 686</u> 0 10, 649 0 73.00

SPECIAL PURPOSE COST CENTERS SUBTOTALS (SUM OF LINES 1 through 117) 438, 123 118. 00 118.00 3, 691, 135 2, 996, 455 32, 798 544, 661 NONREI MBURSABLE COST CENTERS 194. 00 07950 PHYSI CLAN PRACTICES 0 194. 00 22 0 0 194. 01 07951 MEDICAL OFFICE BUILDING 0 194. 01 3.299 0 0 Ω 194. 02 07952 VPCHC 0 0 0 0 194, 02 0 200.00 Cross Foot Adjustments 200.00 201.00 Negative Cost Centers 0 201.00 2, 996, 455 202.00 TOTAL (sum lines 118 through 201) 3, 694, 456 32. 798 438, 123 202. 00 544, 661

710, 927

486, 637

Provider CCN: 15-1326

| Period: | Worksheet B | From 01/01/2021 | Part | To | 12/31/2021 | Date/Time Prepared:

CAFE   ERN A   ADMIN   STRATION   MEDICAL   Subtotal   Residents Cost   Report   Residents Cost   Residents Cost   Report   Residents Cost   Res					To	12/31/2021	Date/Time Prep 5/26/2022 10:	
SENERAL SERVICE COST CENTRES		Cost Center Description			RECORDS &	Subtotal	Intern & Residents Cost & Post Stepdown	<u> </u>
1.00			11. 00	13. 00	16. 00	24. 00	25. 00	
2.00			T					
4.00								
5. 01   00540  NOMPATI ENT TELEPHONES     5. 01   5. 02   00550 DATA PROCESSIN NO   5. 03   5. 03   00560  PURCHASI NG RECEIVING AND STORES   5. 03   5. 03   5. 04   00570  ADMITTIN NO   5. 05   00580  CASHIERING/ACCOUNTS RECEIVABLE   5. 05   00590  CASHIERING/ACCOUNTS RECEIVA								
5. 02   00550   DATA PROCESSI NO   5. 02   5. 03   00560   PURCHÁSTIN RE RECEIVÍ NG AND STORES   5. 03   00560   PURCHÁSTIN RECEIVÍ NG AND STORES   5. 06   5. 06   00591   ADMINISTRATI VE AND GEMERAL   5. 06   00591   ADMINISTRATIVE AND GEMERAL   7. 00   00700   0PERATION OF PLANT   7. 00   0PERATION OF PLA								
5. 03   00560   PURCHASI NG RECEI VIN GAND STORES   5. 03	•							
5.06   OSSBO (CASH IERING/ACCOUNTS RECEIVABLE	5. 03 00560	PURCHASING RECEIVING AND STORES						5. 03
5.06	5. 04 00570	D ADMITTING						5. 04
2.00		l .						
8. 00   00800   LAUINDRY & LINEN SERVICE								
9.00								
10.00   01000   0157ARY								
11. 00								
13. 00			810 784					
16.00     1000   MEDI CAL RECORDS & LI BRARY   25,393   0   469,712   16.00   1   1   1   1   1   1   1   1   1				1 504 837				
INPATI ENT ROUTI NE SERVICE COST CENTERS					469, 712			
331.00   03100   INTENSIVE CARE UNIT			·					
ANCILLARY SERVICE COST CENTERS   S			210, 850		36, 333	7, 309, 111		
50.00			0	0	0	0	0	31. 00
51. 00   05100   RECOVERY ROOM   1, 083   0   5, 896   379, 892   0   51. 00   51. 01   05101   07P TREATMENT ROOM   0   0   0   0   0   51. 01   05101   07P TREATMENT ROOM   0   0   0   0   0   0   0   0   0			F0 700	ما	10 100	4 (07 000	0	F0 00
S1. 01   OS1-01   O/P TREATMENT ROOM								
54. 00   05400   RADI OLOGY-DI AGNOSTI C   126, 004   0   138, 163   3, 536, 293   0   54. 00   56. 00   65600   RADI OLOGY-DI AGNOSTI C   55, 656   0   2, 917   126, 753   0   56. 00   60. 00	•	·				•		
56. 00   05600   RADI OI SOTOPE   S, 656   O   2, 917   126, 753   O   56. 00	•	·	_	-	-	-		
62. 00		·		o				
65. 00   06500   RESPI RATORY THERAPY   31, 411   0   15, 289   1, 021, 080   0   65. 00   66. 00   06600   PHYSI CAL THERAPY   0   0   0   11, 040   1, 113, 762   0   66. 00   67. 00   06700   OCCUPATI ONAL THERAPY   0   0   0   3, 330   416, 420   0   67. 00   68. 00   06800   SPEECH PATHOLOGY   0   0   0   289   49, 319   0   68. 00   69. 00   06900   ELECTROCARDI OLOGY   41, 520   0   19, 993   843, 825   0   69, 00   71. 00   07100   MEDI CAL SUPPLIES CHARGED TO PATIENTS   0   0   0   0   0   0   72. 00   07200   IMPL DEV. CHARGED TO PATIENTS   0   0   0   0   0   0   73. 00   07300   DRUGS CHARGED TO PATIENTS   36, 586   0   38, 735   2, 287, 764   0   73. 00   000   07000   CLINIC   0   0   0   0   0   0   91. 00   09100   EMERGENCY   135, 030   636, 540   117, 642   6, 689, 119   0   91. 00   92. 00   09200   OBSERVATI ON BEDS (NON-DI STI NCT PART)   92. 00   92. 00   07900   DRUGS COST CENTERS   180, 784   1, 504, 837   469, 712   27, 069, 696   0   118. 00   194. 00   07950   PHYSI CI AN PRACTICES   0   0   0   0   0   194. 00   194. 01   07951   MEDI CAL OFFI CE BUI LDI NG   0   0   0   0   0   194. 02   07952   VPCHC   0   0   0   0   0   0   201. 00   Negati ve Cost Centers   0   0   0   0   0   201. 00   Negati ve Cost Centers   0   0   0   0   0   201. 00   Negati ve Cost Centers   0   0   0   0   0   201. 00   Negati ve Cost Centers   0   0   0   0   201. 00   Negati ve Cost Centers   0   0   0   0   201. 00   0   Negati ve Cost Centers   0   0   0   0   201. 00   0   Negati ve Cost Centers   0   0   0   0   201. 00   0   0   0   0   201. 00   0   0   0   0   0   201. 00   0   0   0   0   201. 00   0   0   0   0   200. 00   0   0   0   200. 00   0   0   0   200. 00   0   0   0   200. 00   0   0   0   200. 00   0   0   200. 00   0   0   0   200. 00   0   0   200. 00   0   0   200. 00   0   0   200. 00   0   0   200. 00   0   0   200. 00   0   0   200. 00   0   0   200. 00   0   0   200. 00   0   0   200. 00   0   0   200. 00   0   0   200. 00   0   0   200. 00   0   0   200. 00   0   0   200. 00	60.00 06000	LABORATORY	55, 601	0	60, 244	1, 620, 422	0	60.00
66. 00 06600 PHYSICAL THERAPY 0 0 0 11, 040 1, 113, 762 0 66. 00 67. 00 06700 0CCUPATIONAL THERAPY 0 0 0 3, 330 416, 420 0 67. 00 680. 00 680. 00 SPEECH PATHOLOGY 0 0 0 289 49, 319 0 68. 00 690. 00 06900 ELECTROCARDI OLOGY 41, 520 0 19, 993 843, 825 0 69. 00 71. 00 07100 MEDI CAL SUPPLIES CHARGED TO PATIENTS 0 0 0 0 0 0 0 71. 00 072. 00 07200 IMPL. DEV. CHARGED TO PATIENTS 0 0 0 0 205 18, 471 0 72. 00 07300 DRUGS CHARGED TO PATIENTS 36, 586 0 38, 735 2, 287, 764 0 73. 00 09000 CLI NI C 0 0 0 0 0 0 0 0 0 90. 00 91. 00 09000 CLI NI C 0 0 0 0 0 0 0 0 0 0 91. 00 91. 00 09100 EMERGENCY 135, 030 636, 540 117, 642 6, 689, 119 0 91. 00 92. 00 09200 OBSERVATI ON BEDS (NON-DI STI NCT PART) SPECIAL PURPOSE COST CENTERS 18. 00 0 0 0 0 0 0 0 18. 00 0 18. 00 07950 PHYSI CI AN PRACTICES 0 0 0 0 0 0 0 146. 00 194. 00 194. 01 07951 MEDI CAL OFFI CE BUILDING 0 0 0 0 0 24, 196 0 194. 01 194. 02 07952 VPCHC 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	62.00 06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	0	0	146	30, 426	0	62. 00
67. 00			31, 411	0				
68.00   06800   SPEECH PATHOLOGY   0   0   289   49, 319   0   68.00   69.00   06900   ELECTROCARDI OLOGY   41,520   0   19,993   843,825   0   69.00   71.00   07100   MEDI CAL SUPPLIES CHARGED TO PATIENTS   0   0   0   0   0   72.00   07200   IMPL. DEV. CHARGED TO PATIENTS   0   0   205   18,471   0   72.00   73.00   07300   DRUGS CHARGED TO PATIENTS   36,586   0   38,735   2,287,764   0   73.00   73.00   07300   DRUGS CHARGED TO PATIENTS   36,586   0   38,735   2,287,764   0   73.00   73.00   09000   CLINIC   0   0   0   0   0   0   74.00   09100   EMERGENCY   135,030   636,540   117,642   6,689,119   0   91.00   75.00   09200   OBSERVATION BEDS (NON-DISTINCT PART)   0   92.00   76.00   SUBTOTALS (SUM OF LINES 1 through 117)   810,784   1,504,837   469,712   27,069,696   0   76.00   07950   PHYSI CI AN PRACTICES   0   0   0   0   24,196   0   76.00   07952   VPCHC   0   0   0   0   0   76.00   0   0   0   0   0   77.00   0   0   0   0   78.00   0   0   0   0   79.00   0   0   0   0   79.00   0   0   0   79.00   0   0   0   79.00   0   0   0   79.00   0   0   0   79.00   0   0   79.00   0   0   0   79.00   0   0   79.00   0   0   79.00   0   0   79.00   0   0   79.00   0   0   79.00   0   79.00   0   0   79.00			0	٩			-	
69. 00			0	0		·	-	
71. 00			41 520	0			-	
72. 00			41, 520	0				
73. 00   07300   DRUGS CHARGED TO PATIENTS   36,586   0   38,735   2,287,764   0   73. 00   0   0   0   0   0   0   0   0   0			0	-	-	-		
OUTPATIENT SERVICE COST CENTERS   O		l .	36, 586	· ·		•	-	
90. 00				· · · · · · · · · · · · · · · · · · ·		, , , , , , , , , , , , , , , , , , , ,		
92. 00	90.00 09000	CLI NI C	0	0	0	0	0	90. 00
SPECIAL PURPOSE COST CENTERS   SUBTOTALS (SUM OF LINES 1 through 117)   810, 784   1,504,837   469,712   27,069,696   0 118.00			135, 030	636, 540	117, 642	6, 689, 119		
118.00   SUBTOTALS (SUM OF LINES 1 through 117)   810,784   1,504,837   469,712   27,069,696   0   118.00							0	92. 00
NONREI MBURSABLE COST CENTERS   194. 00   07950   PHYSI CI AN PRACTICES   0 0 0 0 160 0 194. 00   194. 00   194. 01   194. 02   194. 03   194. 0			040 704	4 504 007	4/0 740	07.0/0./0/	0	440.00
194. 00     07950     PHYSI CI AN PRACTICES     0     0     160     0 194. 00       194. 01     07951     MEDI CAL OFFI CE BUI LDI NG     0     0     0     24, 196     0 194. 01       194. 02     07952     VPCHC     0     0     0     0     0 194. 02       200. 00     Cross Foot Adjustments     0     0     0     0     0     0       201. 00     Negative Cost Centers     0     0     0     0     0     0     201. 00			810, 784	1, 504, 837	469, 712	27, 069, 696	0	118.00
194. 01     07951     MEDI CAL OFFICE BUILDING     0     0     24, 196     0     194. 01       194. 02     07952     VPCHC     0     0     0     0     0     194. 02       200. 00     Cross Foot Adjustments     0     0     0     0     0     200. 00       201. 00     Negative Cost Centers     0     0     0     0     0     0     0			0	٥	0	160	0	194 00
194. 02     07952     VPCHC     0     0     0     0     194. 02       200. 00     Cross Foot Adjustments     0     0     0     0     0     200. 00       201. 00     Negative Cost Centers     0     0     0     0     0     0     0     0     0		l control of the cont		- 1				
200.00       Cross Foot Adjustments       0       0 200.00         201.00       Negative Cost Centers       0       0       0       0       0       0       0       201.00	•	·	Ö	o				
		•				0	0	200. 00
202.00   TOTAL (sum lines 118 through 201)   810,784  1,504,837  469,712  27,094,052  0 202.00	•		0	0	9	0		
	202. 00	TOTAL (sum lines 118 through 201)	810, 784	1, 504, 837	469, 712	27, 094, 052	0	202. 00

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

Provider CCN: 15-1326 

			5/26/2022 10	
	Cost Center Description	Total		
	•	26. 00		
	GENERAL SERVICE COST CENTERS			
1.00	00100 NEW CAP REL COSTS-BLDG & FIXT			1. 00
2.00	00200 NEW CAP REL COSTS-MVBLE EQUIP			2. 00
4.00	00400 EMPLOYEE BENEFITS DEPARTMENT			4. 00
5. 01	00540 NONPATIENT TELEPHONES			5. 01
5.02	00550 DATA PROCESSING			5. 02
5.03	00560 PURCHASING RECEIVING AND STORES			5. 03
5.04	00570 ADMI TTI NG			5. 04
5.05	00580 CASHI ERI NG/ACCOUNTS RECEI VABLE			5. 05
5.06	00591 ADMINISTRATIVE AND GENERAL			5. 06
7.00	00700 OPERATION OF PLANT			7. 00
8.00	00800 LAUNDRY & LINEN SERVICE			8. 00
9.00	00900 HOUSEKEEPI NG			9. 00
10.00	01000 DI ETARY			10.00
11. 00	01100 CAFETERI A			11. 00
13.00	01300 NURSING ADMINISTRATION			13. 00
16.00	01600 MEDICAL RECORDS & LIBRARY			16. 00
	INPATIENT ROUTINE SERVICE COST CENTERS			
30.00	03000 ADULTS & PEDIATRICS	7, 309, 111		30. 00
31. 00	03100   NTENSIVE CARE UNIT	0		31. 00
	ANCILLARY SERVICE COST CENTERS			
50.00	05000 OPERATING ROOM	1, 627, 039		50.00
51.00	05100 RECOVERY ROOM	379, 892		51. 00
51. 01	05101 O/P TREATMENT ROOM	0		51. 01
54.00	05400 RADI OLOGY-DI AGNOSTI C	3, 536, 293		54.00
56.00	05600 RADI 0I SOTOPE	126, 753		56. 00
60.00	06000 LABORATORY	1, 620, 422		60.00
62.00	06200 WHOLE BLOOD & PACKED RED BLOOD CELLS	30, 426		62. 00
65.00	06500 RESPI RATORY THERAPY	1, 021, 080		65. 00
66. 00	06600 PHYSI CAL THERAPY	1, 113, 762		66. 00
67. 00	06700 OCCUPATI ONAL THERAPY	416, 420		67. 00
68. 00	06800 SPEECH PATHOLOGY	49, 319		68. 00
69. 00	06900 ELECTROCARDI OLOGY	843, 825		69. 00
71. 00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0		71. 00
72.00	07200 I MPL. DEV. CHARGED TO PATIENTS	18, 471		72. 00
73.00	07300 DRUGS CHARGED TO PATIENTS	2, 287, 764		73. 00
	OUTPATIENT SERVICE COST CENTERS			
	09000 CLI NI C	0		90. 00
91. 00	09100 EMERGENCY	6, 689, 119		91. 00
92. 00	09200 OBSERVATION BEDS (NON-DISTINCT PART)			92. 00
	SPECIAL PURPOSE COST CENTERS			
118.00		27, 069, 696		118. 00
	NONREI MBURSABLE COST CENTERS			
	07950 PHYSICIAN PRACTICES	160		194. 00
	07951 MEDICAL OFFICE BUILDING	24, 196		194. 01
	07952 VPCHC	0		194. 02
200.00	,	0		200. 00
201.00		0		201. 00
202.00	TOTAL (sum lines 118 through 201)	27, 094, 052		202. 00

| Peri od: | Worksheet B | From 01/01/2021 | Part | I | To | 12/31/2021 | Date/Time Prepared: Health Financial Systems
ALLOCATION OF CAPITAL RELATED COSTS Provider CCN: 15-1326

				То	12/31/2021	Date/Time Prep 5/26/2022 10:	
			CAPLTAL REI	LATED COSTS		3/20/2022 10.	oz alli
			CALLIAL KEI	LATED COSTS			
	Cost Center Description	Directly	NEW BLDG &	NEW MVBLE	Subtotal	EMPLOYEE	
		Assigned New	FLXT	EQUI P		BENEFI TS	
		Capi tal				DEPARTMENT	
		Related Costs					
		0	1. 00	2.00	2A	4. 00	
	NERAL SERVICE COST CENTERS						
	100 NEW CAP REL COSTS-BLDG & FIXT						1. 00
	200 NEW CAP REL COSTS-MVBLE EQUIP						2. 00
	400 EMPLOYEE BENEFITS DEPARTMENT	0	0		0	0	4. 00
	540 NONPATI ENT TELEPHONES	0	1, 973		6, 012	0	5. 01
	550 DATA PROCESSING	0	3, 852		136, 145	0	5. 02
	560 PURCHASING RECEIVING AND STORES	0	15, 008		15, 008	0	5. 03
	570 ADMITTING	0	9, 563		10, 174	-	5. 04
	580 CASHI ERI NG/ACCOUNTS RECEI VABLE 591 ADMI NI STRATI VE AND GENERAL	0	5, 654 27, 967		5, 654 29, 030	0	5. 05 5. 06
	700 OPERATION OF PLANT		407, 667		413, 055	0	7.00
	800 LAUNDRY & LINEN SERVICE	0	7, 855		7, 985	0	8. 00
	900 HOUSEKEEPI NG	0	7, 438		8, 997	0	9.00
	000 DI ETARY		25, 975	·	27, 716	0	10.00
	100 CAFETERI A		58, 723		63, 946	Ö	11.00
	300 NURSI NG ADMI NI STRATI ON		26, 222		26, 424	Ö	13. 00
	600 MEDICAL RECORDS & LIBRARY		16, 602	56	16, 658	0	16. 00
	PATIENT ROUTINE SERVICE COST CENTERS	<u> </u>	.0,002	00	. 0, 000	-	
	000 ADULTS & PEDIATRICS	0	273, 182	19, 007	292, 189	0	30.00
	100 INTENSIVE CARE UNIT	o	0		0	0	31. 00
	CILLARY SERVICE COST CENTERS			<u> </u>			
	OOO OPERATING ROOM	0	61, 076	36, 595	97, 671	0	50. 00
51.00 05	100 RECOVERY ROOM	0	36, 221	4, 575	40, 796	0	51. 00
	101 O/P TREATMENT ROOM	0	0	0	0	0	51. 01
	400 RADI OLOGY-DI AGNOSTI C	0	108, 245		212, 887	0	54.00
	600 RADI OI SOTOPE	0	0	24, 191	24, 191	0	56. 00
	000 LABORATORY	0	32, 464		35, 999	0	60.00
	200 WHOLE BLOOD & PACKED RED BLOOD CELLS	0	0	0	0	0	62. 00
	500 RESPI RATORY THERAPY	0	30, 548		39, 991	0	65. 00
	600 PHYSI CAL THERAPY	0	64, 112		64, 135	0	66. 00
	700 OCCUPATI ONAL THERAPY	0	53, 923		53, 923	0	67.00
	800 SPEECH PATHOLOGY	0	7, 286		7, 286	0	68. 00
	900 ELECTROCARDI OLOGY	0	7, 950		10, 498	0	69. 00
	100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	71. 00 72. 00
	200 IMPL. DEV. CHARGED TO PATIENTS 300 DRUGS CHARGED TO PATIENTS	0	19, 239	-	20, 003	0	72.00
	TPATIENT SERVICE COST CENTERS	l o	19, 239	704	20, 003	U	73.00
	000 CLINIC	O	0	O	0	0	90.00
	100 EMERGENCY	0	162, 300		185, 841	0	91.00
	200 OBSERVATION BEDS (NON-DISTINCT PART)		102, 300	23, 341	105, 041	O	92.00
	ECIAL PURPOSE COST CENTERS			<u> </u>			72.00
118. 00	SUBTOTALS (SUM OF LINES 1 through 117)	O	1, 471, 045	381, 169	1, 852, 214	0	118. 00
	NREI MBURSABLE COST CENTERS	<u> </u>	., ., ., .,	00.7.07	., 002, 2	-	
	950 PHYSICIAN PRACTICES	0	0	138	138	0	194. 00
	951 MEDICAL OFFICE BUILDING	o	0		0		194. 01
194. 02 07		0	0	0	0		194. 02
200.00	Cross Foot Adjustments				o		200. 00
201.00	Negative Cost Centers		0	0	o	0	201. 00
202.00	TOTAL (sum lines 118 through 201)	0	1, 471, 045	381, 307	1, 852, 352	0	202. 00

| Peri od: | Worksheet B | From 01/01/2021 | Part | I | To 12/31/2021 | Date/Time Prepared: | To 12/31/2021 Health Financial Systems
ALLOCATION OF CAPITAL RELATED COSTS Provider CCN: 15-1326

				10	12/31/2021	5/26/2022 10:	
	Cost Center Description	NONPATI ENT	DATA	PURCHASI NG	ADMI TTI NG	CASHI ERI NG/ACC	52 diii
	5551 551151 B5551 Pt. 511	TELEPHONES	PROCESSI NG	RECEIVING AND	7.5	OUNTS	
				STORES		RECEI VABLE	
		5. 01	5. 02	5. 03	5. 04	5. 05	
	GENERAL SERVICE COST CENTERS						
1.00	00100 NEW CAP REL COSTS-BLDG & FIXT						1. 00
2.00	00200 NEW CAP REL COSTS-MVBLE EQUIP						2. 00
4.00	00400 EMPLOYEE BENEFITS DEPARTMENT						4. 00
5.01	00540 NONPATIENT TELEPHONES	6, 012					5. 01
5.02	00550 DATA PROCESSING	95	136, 240	)			5. 02
5.03	00560 PURCHASING RECEIVING AND STORES	48	1, 879	16, 935			5. 03
5.04	00570 ADMI TTI NG	166	6, 577	287	17, 204		5. 04
5.05	00580 CASHI ERI NG/ACCOUNTS RECEI VABLE	119	940	0	0	6, 713	5. 05
5.06	00591 ADMINISTRATIVE AND GENERAL	333	9, 396	1	0	0	5. 06
7.00	00700 OPERATION OF PLANT	523	6, 577	5	0	0	7. 00
8.00	00800 LAUNDRY & LINEN SERVICE	o	0	0	0	0	8. 00
9.00	00900 HOUSEKEEPI NG	24	1, 879	1, 294	0	0	9. 00
10.00	01000 DI ETARY	48	1, 879		0	0	10. 00
11. 00	1	119	2, 819	4	0	0	11. 00
13.00	01300 NURSI NG ADMI NI STRATI ON	95	1, 879	o	0	0	13. 00
16. 00		190	2, 819		0	0	16. 00
	INPATIENT ROUTINE SERVICE COST CENTERS		, -	,			
30.00		1, 755	32, 885	4, 117	8, 415	518	30.00
31.00	03100 INTENSIVE CARE UNIT	o	. 0	0	0	0	31. 00
	ANCILLARY SERVICE COST CENTERS						1
50.00	05000 OPERATING ROOM	143	13, 154	3, 436	433	278	50.00
51.00	05100 RECOVERY ROOM	333	0	0	4	84	51. 00
51. 01	05101 O/P TREATMENT ROOM	o	0	0	0	0	51. 01
54.00	05400 RADI OLOGY-DI AGNOSTI C	380	13, 154	1, 783	1, 210	1, 987	54. 00
56.00	05600 RADI OI SOTOPE	o	0	9	20	42	56. 00
60.00	06000 LABORATORY	143	0	5	1, 993	859	60. 00
62.00	06200 WHOLE BLOOD & PACKED RED BLOOD CELLS	o	0	0	21	2	62. 00
65.00	06500 RESPIRATORY THERAPY	143	7, 517	772	1, 047	218	65. 00
66. 00	06600 PHYSI CAL THERAPY	238	5, 638	28	300	157	66. 00
67.00	06700 OCCUPATI ONAL THERAPY	166	O	o	158	47	67. 00
68. 00	06800 SPEECH PATHOLOGY	48	O	o	19	4	68. 00
69. 00	06900 ELECTROCARDI OLOGY	95	1, 879	0	246	285	69. 00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	o	0	0	0	0	71. 00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	o	O	o	0	3	72. 00
73.00	07300 DRUGS CHARGED TO PATIENTS	143	7, 517	52	2, 473	552	73. 00
	OUTPATIENT SERVICE COST CENTERS						
90.00	09000 CLI NI C	0	0	0	0	0	90.00
91.00	09100 EMERGENCY	665	17, 852	5, 138	865	1, 677	91. 00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)						92. 00
	SPECIAL PURPOSE COST CENTERS						
118.0	O SUBTOTALS (SUM OF LINES 1 through 117)	6, 012	136, 240	16, 935	17, 204	6, 713	118. 00
	NONREI MBURSABLE COST CENTERS						
194.0	0 07950 PHYSICIAN PRACTICES	0	0	0	0	0	194. 00
	1 07951 MEDICAL OFFICE BUILDING	0	0	0	0		194. 01
	2 07952 VPCHC	0	0	0	0	0	194. 02
200.0							200. 00
201.0		0	0	0	0	l	201. 00
202. 0	0 TOTAL (sum lines 118 through 201)	6, 012	136, 240	16, 935	17, 204	6, 713	202. 00

| Peri od: | Worksheet B | From 01/01/2021 | Part | I | To | 12/31/2021 | Date/Time Prepared: Health Financial Systems
ALLOCATION OF CAPITAL RELATED COSTS Provider CCN: 15-1326

				To	12/31/2021	Date/Time Pre	
	Cost Center Description	ADMI NI STRATI VE	OPERATION OF	LAUNDRY &	HOUSEKEEPI NG	5/26/2022 10: DI ETARY	oz alli
	cost center bescriptron	AND GENERAL	PLANT	LINEN SERVICE	11003EKEELT 1100	DILIANI	
		5. 06	7. 00	8.00	9. 00	10.00	
	GENERAL SERVICE COST CENTERS	0.00	7.00	0.00	7, 00	101.00	
1.00	00100 NEW CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200 NEW CAP REL COSTS-MVBLE EQUIP						2. 00
4.00	00400 EMPLOYEE BENEFITS DEPARTMENT						4.00
5. 01	00540 NONPATI ENT TELEPHONES						5. 01
5.02	00550 DATA PROCESSING						5. 02
5.03	00560 PURCHASING RECEIVING AND STORES						5. 03
5.04	00570 ADMI TTI NG						5. 04
5.05	00580 CASHI ERI NG/ACCOUNTS RECEI VABLE						5. 05
5.06	00591 ADMINISTRATIVE AND GENERAL	38, 760					5. 06
7.00	00700 OPERATION OF PLANT	4, 286	424, 446				7. 00
8.00	00800 LAUNDRY & LINEN SERVICE	13	3, 336	11, 334			8. 00
9.00	00900 HOUSEKEEPI NG	743	3, 159	1, 097	17, 193		9. 00
10.00	01000 DI ETARY	494	11, 032	98	454	41, 723	10.00
11. 00	01100 CAFETERI A	860	24, 941	221	1, 026	0	11. 00
13.00	01300 NURSING ADMINISTRATION	1, 900	11, 137	0	458	0	13. 00
16.00	01600 MEDICAL RECORDS & LIBRARY	551	7, 051	0	290	0	16. 00
	INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000 ADULTS & PEDIATRICS	6, 828	116, 027	3, 795	4, 773	41, 723	30.00
31. 00	03100 I NTENSI VE CARE UNI T	0	0	0	0	0	31. 00
	ANCILLARY SERVICE COST CENTERS	1					
50. 00	05000 OPERATI NG ROOM	1, 904	25, 940		1, 067	0	
51. 00	05100 RECOVERY ROOM	349	15, 384		633	0	51. 00
51. 01	05101  O/P TREATMENT ROOM	0	0		0	0	51. 01
54. 00	05400 RADI OLOGY-DI AGNOSTI C	4, 125	45, 973		1, 891	0	54. 00
56. 00	05600 RADI OI SOTOPE	169	0	_	0	0	56. 00
60.00	06000 LABORATORY	1, 987	13, 788		567	0	60.00
62. 00	06200 WHOLE BLOOD & PACKED RED BLOOD CELLS	43	0	0	0	0	62.00
65.00	06500 RESPI RATORY THERAPY	1, 238	12, 974		534	0	65. 00
66.00	06600 PHYSI CAL THERAPY	1, 248	27, 229		1, 120	0	66. 00
67. 00	06700 OCCUPATI ONAL THERAPY	317	22, 902	0	942	0	67.00
68.00	06800 SPEECH PATHOLOGY	33	3, 094		127	0	68. 00
69. 00	06900 ELECTROCARDI OLOGY	1, 077	3, 376		139	0	69.00
71. 00	07100 MEDI CAL SUPPLI ES CHARGED TO PATI ENTS	0	0	_	0	0	71.00
72. 00	07200 I MPL. DEV. CHARGED TO PATIENTS	26	0 171	_	0	0	72.00
73. 00	07300 DRUGS CHARGED TO PATIENTS	3, 066	8, 171	0	336	0	73. 00
00 00	OUTPATIENT SERVICE COST CENTERS	0	0	0	ما	0	00 00
90.00	09000 CLINIC	7 440	0		0	0	90.00
91. 00 92. 00	09100 EMERGENCY	7, 468	68, 932	3, 370	2, 836	U	91. 00 92. 00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART) SPECIAL PURPOSE COST CENTERS						92.00
118. 00		38, 725	424, 446	11, 334	17, 193	41, 723	110 00
118.00	NONREI MBURSABLE COST CENTERS	38, 725	424, 440	11, 334	17, 193	41, 723	1118.00
10/ 00	07950 PHYSI CLAN PRACTICES	0	0	0	ol	0	194. 00
	07951 MEDICAL OFFICE BUILDING	35	0		o		194. 00
	207952 VPCHC	33	0		٥		194. 01
200.00	1 1		0		٩	U	200.00
200.00	, ,	n	0	l n	٥	Ω	200.00
202.00		38, 760	424, 446	11, 334	17, 193		202.00
202.00	1 1017/2 (Suil 111103 110 thi bugil 201)	30,700	727, 440	1 11, 334	17, 175	71,723	1202.00

Period: Worksheet B
From 01/01/2021 Part II
To 1/21/21/2021 Part/II me Propagad: Health Financial Systems
ALLOCATION OF CAPITAL RELATED COSTS Provider CCN: 15-1326

				To	12/31/2021	Date/Time Pre 5/26/2022 10:	
	Cost Center Description	CAFETERI A	NURSI NG	MEDI CAL	Subtotal	Intern &	02 4111
	·		ADMI NI STRATI ON	RECORDS &		Residents Cost	
				LI BRARY		& Post	
						Stepdown	
		11 00	12.00	1/ 00	24.00	Adjustments	
	GENERAL SERVICE COST CENTERS	11. 00	13. 00	16. 00	24. 00	25. 00	
1.00	00100 NEW CAP REL COSTS-BLDG & FIXT						1. 00
2.00	00200 NEW CAP REL COSTS-MVBLE EQUIP						2. 00
4.00	00400 EMPLOYEE BENEFITS DEPARTMENT						4.00
5. 01	00540 NONPATIENT TELEPHONES						5. 01
5. 02	00550 DATA PROCESSING						5. 02
5.03	00560 PURCHASING RECEIVING AND STORES						5. 03
5.04	00570 ADMI TTI NG						5. 04
5. 05	00580 CASHI ERI NG/ACCOUNTS RECEI VABLE						5. 05
5. 06 7. 00	00591 ADMINISTRATIVE AND GENERAL 00700 OPERATION OF PLANT						5. 06 7. 00
8.00	00800 LAUNDRY & LINEN SERVICE						8. 00
9. 00	00900 HOUSEKEEPI NG						9. 00
10.00	01000 DI ETARY						10.00
11. 00	01100 CAFETERI A	93, 936					11. 00
13. 00	01300 NURSING ADMINISTRATION	9, 607	51, 500				13. 00
16. 00	01600 MEDICAL RECORDS & LIBRARY	2, 942	0				16. 00
	INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000 ADULTS & PEDIATRICS	24, 430	29, 716	2, 363	569, 534	0	30. 00
31.00	03100 INTENSIVE CARE UNIT	0	0	0	0	0	31. 00
	ANCILLARY SERVICE COST CENTERS						
50. 00	05000 OPERATI NG ROOM	6, 804	0	, ,	152, 406	0	50. 00
51.00	05100 RECOVERY ROOM	125	0		58, 091	0	51.00
51. 01 54. 00	05101 O/P TREATMENT ROOM	14 500	0	_	200 142	0	51. 01 54. 00
56. 00	05400  RADI OLOGY-DI AGNOSTI C 05600  RADI OI SOTOPE	14, 599 655	0	-,	308, 143 25, 276	0	56.00
60.00	06000 LABORATORY	6, 442	0		65, 700	0	60.00
62. 00	06200 WHOLE BLOOD & PACKED RED BLOOD CELLS	0, 442	0	3, 717	75	-	62.00
65. 00	06500 RESPIRATORY THERAPY	3, 639	o o	994	69, 149	0	65. 00
66. 00	06600 PHYSI CAL THERAPY	0	o o		101, 710	Ö	66. 00
67.00	06700 OCCUPATI ONAL THERAPY	0	0	217	78, 672	0	67. 00
68.00	06800 SPEECH PATHOLOGY	0	0	19	10, 630	0	68. 00
69. 00	06900 ELECTROCARDI OLOGY	4, 810	0	1, 300	23, 958	0	69. 00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0		0	Ĭ	71. 00
72. 00	07200 I MPL. DEV. CHARGED TO PATIENTS	0	0		42	0	72. 00
73. 00	07300 DRUGS CHARGED TO PATIENTS	4, 239	0	2, 519	49, 071	0	73. 00
00.00	OUTPATIENT SERVICE COST CENTERS				0	0	00.00
90. 00 91. 00	09000 CLI NI C 09100 EMERGENCY	15 444			220 722	_	90.00
	09200 OBSERVATION BEDS (NON-DISTINCT PART)	15, 644	21, 784	7, 650	339, 722	0	91. 00 92. 00
92.00	SPECIAL PURPOSE COST CENTERS					0	72.00
118. 00		93, 936	51, 500	30, 503	1, 852, 179	0	118. 00
	NONREI MBURSABLE COST CENTERS	70, 700	01,000	30, 300	1,002,117		1110.00
194. 00 07950  PHYSI CI AN PRACTICES 0 0 0 138							194. 00
	07951 MEDICAL OFFICE BUILDING	0	0		35		194. 01
	07952 VPCHC	0	0	0	0	0	194. 02
200.00	Cross Foot Adjustments				0		200. 00
201.00	Negative Cost Centers	0	0	0	0		201. 00
202. 00	TOTAL (sum lines 118 through 201)	93, 936	51, 500	30, 503	1, 852, 352	0	202. 00

Health Financial Systems
ALLOCATION OF CAPITAL RELATED COSTS UNION HOSPITAL CLINTON

| Peri od: | Worksheet B | From 01/01/2021 | Part | I | To 12/31/2021 | Date/Time Prepared: | To 12/31/2021 Provider CCN: 15-1326

	Cost Center Description	Total	0, 20, 2022 10	, o <u>z</u>
	·	26.00		
	GENERAL SERVICE COST CENTERS			
1.00	00100 NEW CAP REL COSTS-BLDG & FIXT			1. 00
2.00	00200 NEW CAP REL COSTS-MVBLE EQUIP			2. 00
4.00	00400 EMPLOYEE BENEFITS DEPARTMENT			4. 00
5.01	00540 NONPATIENT TELEPHONES			5. 01
5.02	00550 DATA PROCESSING			5. 02
5.03	00560 PURCHASING RECEIVING AND STORES			5. 03
5.04	00570 ADMI TTI NG			5. 04
5.05	00580 CASHI ERI NG/ACCOUNTS RECEI VABLE			5. 05
5.06	00591 ADMINISTRATIVE AND GENERAL			5. 06
7.00	00700 OPERATION OF PLANT			7. 00
8.00	00800 LAUNDRY & LINEN SERVICE			8. 00
9.00	00900 HOUSEKEEPI NG			9. 00
10.00	01000 DI ETARY			10.00
11. 00	01100 CAFETERI A			11. 00
13.00	01300 NURSING ADMINISTRATION			13. 00
16. 00				16. 00
	INPATIENT ROUTINE SERVICE COST CENTERS			
30.00	03000 ADULTS & PEDIATRICS	569, 534		30.00
31. 00	03100 INTENSIVE CARE UNIT	0		31. 00
	ANCILLARY SERVICE COST CENTERS	-1		
50.00	05000 OPERATING ROOM	152, 406		50.00
51.00	05100 RECOVERY ROOM	58, 091		51. 00
51. 01	05101 O/P TREATMENT ROOM	0		51. 01
54. 00	05400 RADI OLOGY-DI AGNOSTI C	308, 143		54.00
56. 00	05600 RADI OI SOTOPE	25, 276		56. 00
60. 00	06000 LABORATORY	65, 700		60.00
62. 00	06200 WHOLE BLOOD & PACKED RED BLOOD CELLS	75		62.00
65. 00	06500 RESPIRATORY THERAPY	69, 149		65. 00
66. 00	06600 PHYSI CAL THERAPY	101, 710		66.00
67. 00	06700 OCCUPATI ONAL THERAPY	78, 672		67. 00
68. 00	06800 SPEECH PATHOLOGY	10, 630		68. 00
69. 00	06900 ELECTROCARDI OLOGY	23, 958		69. 00
71. 00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0		71. 00
72. 00	07200 I MPL. DEV. CHARGED TO PATIENTS	42		72. 00
73. 00		49, 071		73. 00
70.00	OUTPATIENT SERVICE COST CENTERS	17,071		70.00
90.00		0		90.00
91. 00	09100 EMERGENCY	339, 722		91. 00
92. 00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	007,722		92. 00
72.00	SPECIAL PURPOSE COST CENTERS			72.00
118. 00		1, 852, 179		118. 00
110.00	NONREI MBURSABLE COST CENTERS	1,032,177		110.00
194.00	07950 PHYSI CI AN PRACTI CES	138		194. 00
	07951 MEDICAL OFFICE BUILDING	35		194. 01
	207952 VPCHC	0		194. 02
200.00		0		200. 00
201.00	3	0		201. 00
202.00	<u> </u>	1, 852, 352		202. 00
202.00	TOTAL (Sum Times The thirough 201)	1,002,002		1202.00

COST ALLOCATION - STATISTICAL BASIS Provider CCN: 15-1326 Peri od: Worksheet B-1 From 01/01/2021 12/31/2021 Date/Time Prepared: 5/26/2022 10:52 am CAPITAL RELATED COSTS Cost Center Description NEW BLDG & NEW MVBLE **EMPLOYEE** NONPATI ENT DATA PROCESSI NG **FOULP** BENEFITS TELEPHONES FIXT (EQUIP (SQ FT) DEPARTMENT (PHONES) (DEVICES) DEPRN) (GROSS SALARI ES) 1.00 2.00 5. 01 5. 02 GENERAL SERVICE COST CENTERS 77, 531 1 00 00100 NEW CAP REL COSTS-BLDG & FIXT 1 00 2.00 00200 NEW CAP REL COSTS-MVBLE EQUIP 386, 435 2.00 4.00 00400 EMPLOYEE BENEFITS DEPARTMENT 8, 607, 849 4.00 00540 NONPATIENT TELEPHONES 4. 093 5 01 104 253 5 01 5.02 00550 DATA PROCESSING 203 134,073 0 145 5.02 5.03 00560 PURCHASING RECEIVING AND STORES 791 5.03 5.04 00570 ADMITTING 504 619 448, 253 5.04 00580 CASHI ERI NG/ACCOUNTS RECEI VABLE 298 5 05 5 05 3 052 5.06 00591 ADMINISTRATIVE AND GENERAL 1, 474 1,077 1, 245, 159 14 10 5.06 00700 OPERATION OF PLANT 21, 486 409, 205 22 7.00 5, 460 7.00 00800 LAUNDRY & LINEN SERVICE 0 8.00 414 132 0 8.00 225, 451 00900 HOUSEKEEPI NG 9 00 392 1, 580 2 9 00 10.00 01000 DI ETARY 1, 369 1,764 112, 500 2 10.00 01100 CAFETERI A 11.00 3,095 5, 293 254, 321 11.00 01300 NURSING ADMINISTRATION 1, 382 4 759, 606 13.00 13.00 205 2 16.00 01600 MEDICAL RECORDS & LIBRARY 875 57 110, 681 8 16.00 INPATIENT ROUTINE SERVICE COST CENTERS 30.00 03000 ADULTS & PEDIATRICS 14, 398 19, 263 1, 885, 204 35 30.00 03100 INTENSIVE CARE UNIT 0 31.00 31.00 0 0 ANCILLARY SERVICE COST CENTERS 37, 087 14 05000 OPERATING ROOM 3, 219 266, 204 50.00 05100 RECOVERY ROOM 1,909 4, 637 0 51.00 51.00 83.908 14 51.01 05101 0/P TREATMENT ROOM 0 51.01 0 54.00 05400 RADI OLOGY-DI AGNOSTI C 5,705 106, 049 774, 938 16 14 54.00 05600 RADI OI SOTOPE 56, 00 24, 516 38, 271 0 0 56.00 6 60.00 06000 LABORATORY 1,711 3, 583 285, 915 0 60.00 06200 WHOLE BLOOD & PACKED RED BLOOD CELLS 62.00 C 0 62.00 06500 RESPIRATORY THERAPY 242, 447 6 65.00 1.610 9.570 65.00 66.00 06600 PHYSI CAL THERAPY 3, 379 23 0 10 66.00 6 06700 OCCUPATIONAL THERAPY 7 67.00 2,842 C 0 0 67.00 68.00 06800 SPEECH PATHOLOGY 384 0 68.00 06900 ELECTROCARDI OLOGY 4 69.00 419 2, 582 320, 984 69.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS o 71.00 71.00 0 0 C 07200 IMPL. DEV. CHARGED TO PATIENTS 0 72.00 0 0 72.00 73.00 07300 DRUGS CHARGED TO PATIENTS 1,014 774 259, 530 8 73.00 OUTPATIENT SERVICE COST CENTERS 90.00 09000 CLI NI C 90.00 0 0 0 91.00 09100 EMERGENCY 8, 554 23, 858 882, 220 28 19 91.00 92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART) 92.00 SPECIAL PURPOSE COST CENTERS SUBTOTALS (SUM OF LINES 1 through 117) 77, 531 253 145 118. 00 386, 295 8, 607, 849 118.00 NONREI MBURSABLE COST CENTERS 194. 00 07950 PHYSICIAN PRACTICES 0 194. 00 0 140 0 0 194. 01 07951 MEDICAL OFFICE BUILDING 0 0 0 0 194. 01 C 0 194. 02 194. 02 07952 VPCHC O 0 C 0 200.00 Cross Foot Adjustments 200.00 Negative Cost Centers 201.00 201. 00 4, 437, 059 202. 00 202.00 Cost to be allocated (per Wkst. B, 1, 417, 979 1.471.045 381.307 33.377 Part I) 131. 924901 30, 600. 406897 203. 00 203 00 Unit cost multiplier (Wkst. B, Part I) 18. 973636 0.986730 0.164731 136, 240 204. 00 204.00 Cost to be allocated (per Wkst. B, 6,012 Part II) 205.00 Unit cost multiplier (Wkst. B, Part 0.000000 23 762846 939. 586207 205. 00 II)206.00 NAHE adjustment amount to be allocated 206 00 (per Wkst. B-2) 207.00 NAHE unit cost multiplier (Wkst. D, 207.00 Parts III and IV)

Health Financial Systems
COST ALLOCATION - STATISTICAL BASIS Provider CCN: 15-1326 Peri od: Worksheet B-1 From 01/01/2021 To 12/31/2021 Date/Time Prepared:

				To	12/31/2021	Date/Time Pre	
	Cost Center Description	PURCHASI NG	ADMI TTI NG	CASHI ERI NG/ACC	Reconciliation	5/26/2022 10: ADMI NI STRATI VF	
		RECEIVING AND	(I NPATI ENT	OUNTS		AND GENERAL	
		STORES	REVENUE)	RECEI VABLE		(ACCUM.	
		(REQUISITIO)		(TOTAL REVENUE)		COST)	
		5. 03	5. 04	5. 05	5A. 06	5. 06	
	GENERAL SERVICE COST CENTERS	0.00	0.01	0.00	07.1. 00	0.00	
1.00	00100 NEW CAP REL COSTS-BLDG & FIXT						1.00
	00200 NEW CAP REL COSTS-MVBLE EQUIP						2. 00
	00400 EMPLOYEE BENEFITS DEPARTMENT						4. 00
	00540 NONPATIENT TELEPHONES 00550 DATA PROCESSING						5. 01 5. 02
	00560 PURCHASING RECEIVING AND STORES	350, 918					5. 02
	00570 ADMITTING	5, 954	14, 505, 411				5. 04
	00580 CASHI ERI NG/ACCOUNTS RECEI VABLE	0	0				5. 05
5.06	00591 ADMINISTRATIVE AND GENERAL	26	0	0	-3, 694, 456	23, 399, 596	5. 06
	00700 OPERATION OF PLANT	101	0	0	0	2, 587, 869	1
	00800 LAUNDRY & LINEN SERVICE	0	0	0	0	7, 985	1
1	00900 H0USEKEEPI NG 01000 DI ETARY	26, 822	0	0	0	448, 391	9.00
1	D1100 CAFETERI A	34 78	0	0	0	298, 458 519, 539	1
4	01300 NURSI NG ADMINI STRATI ON	9	0	0	0	1, 147, 594	1
	01600 MEDICAL RECORDS & LIBRARY	35	0		0	332, 806	1
	NPATIENT ROUTINE SERVICE COST CENTERS					, , , , , , , , , , , , , , , , , , , ,	
	D3000 ADULTS & PEDIATRICS	85, 314	7, 092, 941	7, 094, 976	0	4, 123, 231	30. 00
	03100 INTENSIVE CARE UNIT	0	0	0	0	0	31. 00
	ANCILLARY SERVICE COST CENTERS D5000 OPERATING ROOM	74 000	0/5 405	2 205 200	ما	4 440 504	
	D5100 RECOVERY ROOM	71, 200	365, 105 3, 646		0	1, 149, 501 210, 956	50. 00 51. 00
	D5100 RECOVERT ROOM D5101 O/P TREATMENT ROOM		3, 040 0		0	210, 936	1
	D5400 RADI OLOGY-DI AGNOSTI C	36, 940	1, 020, 268	1	0	2, 490, 882	1
4	05600 RADI OI SOTOPE	179	17, 191		o	102, 065	1
60.00	06000 LABORATORY	99	1, 680, 432	11, 764, 068	0	1, 199, 834	60.00
	06200 WHOLE BLOOD & PACKED RED BLOOD CELLS	0	17, 916		0	26, 151	1
4	06500 RESPI RATORY THERAPY	15, 988	883, 074		0	747, 606	1
4	06600 PHYSI CAL THERAPY	572	253, 270		0	753, 445	1
	06700 OCCUPATI ONAL THERAPY 06800 SPEECH PATHOLOGY		133, 535 16, 313		0	191, 352 19, 994	1
4	06900 ELECTROCARDI OLOGY		207, 169		0	650, 620	1
	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	l o	0		Ö	0	71. 00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	o	0	39, 991	0	15, 775	72. 00
	07300 DRUGS CHARGED TO PATIENTS	1, 070	2, 085, 488	7, 564, 020	0	1, 851, 745	73. 00
	OUTPATIENT SERVICE COST CENTERS	1					00.00
	09000 CLINIC 09100 EMERGENCY	104 407	720.043		0	0 4 E02 742	
	09200 OBSERVATION BEDS (NON-DISTINCT PART)	106, 497	729, 063	22, 972, 411	U	4, 502, 762	91.00
-	SPECIAL PURPOSE COST CENTERS						72.00
118. 00	SUBTOTALS (SUM OF LINES 1 through 117)	350, 918	14, 505, 411	91, 725, 959	-3, 694, 456	23, 378, 561	118. 00
1	NONREI MBURSABLE COST CENTERS						
194. 00	07950 PHYSICIAN PRACTICES	0	0	0	0	138	194. 00
	07951 MEDICAL OFFICE BUILDING	0	0	0	0		194. 01
200.00	07952 VPCHC	0	0	0	0	0	194. 02
200.00	Cross Foot Adjustments Negative Cost Centers						200. 00 201. 00
201.00	Cost to be allocated (per Wkst. B,	210, 256	809, 803	648, 862		3, 694, 456	
202.00	Part I)	2.0,200	007,000	0.10, 002		0,0,1,100	202.00
203.00	Unit cost multiplier (Wkst. B, Part I)	0. 599160	0. 055828	0. 007074		0. 157885	203. 00
204. 00	Cost to be allocated (per Wkst. B,	16, 935	17, 204	6, 713		38, 760	204. 00
205 00	Part II)	0.040050	0.001107	0.000070		0.001/5/	205 20
205. 00	Unit cost multiplier (Wkst. B, Part	0. 048259	0. 001186	0. 000073		0. 001656	205.00
206. 00	NAHE adjustment amount to be allocated						206. 00
	(per Wkst. B-2)						
207. 00	NAHE unit cost multiplier (Wkst. D,						207. 00
	Parts III and IV)						

Health Financial Systems

UNION HOSPITAL CLINTON

In Lieu of Form CMS-2552-10

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 15-1326

Period:
From 01/01/2021
To 12/31/2021

Date/Time Prepared:
5/26/2022 10: 52 am

COST Center Description

OPERATION OF LAUNDRY & HOUSEKEEPING DIETARY CAFETERIA

				To	12/31/2021	Date/Time Pre 5/26/2022 10:	
	Cost Center Description	OPERATION OF	LAUNDRY &	HOUSEKEEPI NG	DI ETARY	CAFETERI A	32 alli
	·	PLANT	LINEN SERVICE	`	(DI ETARY)	(FTE)	
		(SQ FT)	(LI NEN)	HOUSED)	10.00	44.00	
G	ENERAL SERVICE COST CENTERS	7. 00	8. 00	9. 00	10.00	11.00	
	10100 NEW CAP REL COSTS-BLDG & FIXT						1.00
	0200 NEW CAP REL COSTS-MVBLE EQUIP						2. 00
4.00 0	0400 EMPLOYEE BENEFITS DEPARTMENT						4. 00
	0540 NONPATI ENT TELEPHONES						5. 01
	10550 DATA PROCESSING						5. 02
	10560 PURCHASING RECEIVING AND STORES 10570 ADMITTING						5. 03 5. 04
	10570 ADMITTING						5. 05
	0591 ADMINISTRATIVE AND GENERAL						5. 06
7.00 0	0700 OPERATION OF PLANT	52, 671					7. 00
	0800 LAUNDRY & LINEN SERVICE	414	63, 684	1			8. 00
	10900 HOUSEKEEPI NG	392	6, 165	1	7 447		9.00
	11000 DI ETARY 11100 CAFETERI A	1, 369 3, 095	551 1, 244		7, 417 O	6, 737	10.00
	11300 NURSING ADMINISTRATION	1, 382	1, 244	1	o	689	1
	11600 MEDI CAL RECORDS & LI BRARY	875	Ö	1	o	211	16. 00
11	NPATIENT ROUTINE SERVICE COST CENTERS						1
	3000 ADULTS & PEDIATRICS	14, 398		1	7, 417	1, 752	1
	3100   INTENSI VE CARE UNI T	0	0	0	0	0	31. 00
	NCILLARY SERVICE COST CENTERS 15000 OPERATING ROOM	3, 219	1, 739	3, 219	ol	488	50.00
	15100 RECOVERY ROOM	1, 909			0	9	51.00
	5101 O/P TREATMENT ROOM	0	Ö	0	o	0	
	5400 RADI OLOGY-DI AGNOSTI C	5, 705	6, 800	5, 705	О	1, 047	54.00
	5600 RADI OI SOTOPE	0	0		0	47	1
	6000 LABORATORY	1, 711	0	.,	0	462	1
	16200 WHOLE BLOOD & PACKED RED BLOOD CELLS 16500 RESPI RATORY THERAPY	1, 610	0 462		0	0 261	62. 00 65. 00
	16600 PHYSI CAL THERAPY	3, 379			0	201	1
	6700 OCCUPATI ONAL THERAPY	2, 842	0,001	1	o	0	1
	6800 SPEECH PATHOLOGY	384	0	1	0	0	68. 00
	6900 ELECTROCARDI OLOGY	419	1, 422	1	0	345	1
	17100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0		0	0	
	17200 IMPL. DEV. CHARGED TO PATIENTS 17300 DRUGS CHARGED TO PATIENTS	1, 014	0		0	0 304	
	UTPATIENT SERVICE COST CENTERS	1,014	0	1, 014	<u> </u>	304	73.00
	99000 CLI NI C	0	0	0	0	0	90. 00
91.00 0	9100 EMERGENCY	8, 554	18, 934	8, 554	o	1, 122	91. 00
	9200 OBSERVATION BEDS (NON-DISTINCT PART)						92. 00
	PECIAL PURPOSE COST CENTERS	F2 /71	(2, (04	F1 0/F	7 417	/ 727	110 00
118. 00	SUBTOTALS (SUM OF LINES 1 through 117) ONREI MBURSABLE COST CENTERS	52, 671	63, 684	51, 865	7, 417	6, /3/	118. 00
	7950 PHYSI CI AN PRACTI CES	0	0	0	ol	0	194. 00
	17951 MEDICAL OFFICE BUILDING	0	0	1	Ō		194. 01
194. 02 0	7952 VPCHC	0	0	0	O	0	194. 02
200.00	Cross Foot Adjustments						200. 00
201.00	Negative Cost Centers	0.00/.455	00 700	544 (/4	400 400	040 704	201. 00
202. 00	Cost to be allocated (per Wkst. B, Part I)	2, 996, 455	32, 798	544, 661	438, 123	810, 784	202.00
203. 00	Unit cost multiplier (Wkst. B, Part I)	56. 890034	0. 515012	10. 501514	59. 070109	120. 347929	203 00
204.00	Cost to be allocated (per Wkst. B,	424, 446		1	41, 723		204. 00
	Part II)						
205. 00	Unit cost multiplier (Wkst. B, Part	8. 058438	0. 177972	0. 331495	5. 625320	13. 943298	205. 00
206. 00							206. 00
200.00	(per Wkst. B-2)						200.00
207. 00	NAHE unit cost multiplier (Wkst. D,						207. 00
	Parts III and IV)						

Health Financial Systems UNION HOSPITAL CLINTON In Lieu of Form CMS-2552-10

COST ALLOCATION - STATISTICAL BASIS Provider CCN: 15-1326 Peri od: Worksheet B-1 From 01/01/2021 12/31/2021 Date/Time Prepared: 5/26/2022 10:52 am Cost Center Description NURSI NG MEDI CAL ADMI NI STRATI ON RECORDS & LI BRARY (ASSI GNED (TIME SPENT) TIME) 13.00 16.00 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 00400 EMPLOYEE BENEFITS DEPARTMENT 4.00 4.00 00540 NONPATIENT TELEPHONES 5.01 5.01 00550 DATA PROCESSING 5.02 5.02 5.03 00560 PURCHASING RECEIVING AND STORES 5.03 5.04 00570 ADMITTING 5.04 5.05 00580 CASHI ERI NG/ACCOUNTS RECEI VABLE 5.05 00591 ADMINISTRATIVE 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 01300 NURSING ADMINISTRATION 13.00 55, 192 13.00 01600 MEDICAL RECORDS & LIBRARY 91, 725, 959 16 00 16 00 INPATIENT ROUTINE SERVICE COST CENTERS 30.00 03000 ADULTS & PEDIATRICS 31, 846 7, 094, 976 30.00 03100 INTENSIVE CARE UNIT 31.00 31.00 ANCILLARY SERVICE COST CENTERS 50.00 05000 OPERATING ROOM 3, 805, 889 50.00 51. 00 | 05100 RECOVERY ROOM 0 1, 151, 250 51.00 05101 0/P TREATMENT ROOM 51.01 0000000000 51.01 05400 RADI OLOGY-DI AGNOSTI C 26, 983, 299 54 00 54 00 56.00 05600 RADI OI SOTOPE 569, 542 56.00 06000 LABORATORY 11, 764, 068 60.00 60.00 06200 WHOLE BLOOD & PACKED RED BLOOD CELLS 62.00 28. 454 62.00 06500 RESPIRATORY THERAPY 2, 985, 530 65.00 65.00 66.00 06600 PHYSI CAL THERAPY 2, 155, 771 66.00 06700 OCCUPATIONAL THERAPY 67.00 650, 292 67.00 68.00 06800 SPEECH PATHOLOGY 56, 357 68.00 06900 ELECTROCARDI OLOGY 69 00 3, 904, 109 69 00 0 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 71.00 71.00 07200 IMPL. DEV. CHARGED TO PATIENTS 0 39, 991 72.00 72.00 07300 DRUGS CHARGED TO PATIENTS 73.00 0 7, 564, 020 73.00 OUTPATIENT SERVICE COST CENTERS 90.00 09000 CLI NI C 90.00 91.00 09100 EMERGENCY 23, 346 22, 972, 411 91.00 09200 OBSERVATION BEDS (NON-DISTINCT PART) 92.00 92.00 SPECIAL PURPOSE COST CENTERS SUBTOTALS (SUM OF LINES 1 through 117) 55, 192 91, 725, 959 118.00 NONREI MBURSABLE COST CENTERS 194. 00 07950 PHYSICIAN PRACTICES 0 0 194.00 194. 01 07951 MEDICAL OFFICE BUILDING 0 0 194. 01 194. 02 07952 VPCHC 0 0 194. 02 Cross Foot Adjustments 200. 00 200.00 201.00 Negative Cost Centers 201.00 202.00 Cost to be allocated (per Wkst. B, 1,504,837 469, 712 202.00 Part I) 203.00 Unit cost multiplier (Wkst. B, Part I) 0.005121 203.00 27. 265491 204.00 Cost to be allocated (per Wkst. B, 51,500 30, 503 204.00 Part II) Unit cost multiplier (Wkst. B, Part 0. 933106 0.000333 205.00 205.00 H) 206 00 NAHE adjustment amount to be allocated 206. 00 (per Wkst. B-2) 207 00 NAHE unit cost multiplier (Wkst. D, 207 00 Parts III and IV)

Health Financial Systems	UNI ON HOSPITAL	CLINTON	In Lie	u of Form CMS-2552-10
COMPUTATION OF RATIO OF COSTS TO CHARGES		Provider CCN: 15-1326	Peri od:	Worksheet C

COMPUTATION OF RATIO OF COSTS TO CHARGES		Provider Co	F	Period: From 01/01/2021 Fo 12/31/2021	Worksheet C Part I Date/Time Pre 5/26/2022 10:	pared: 52 am	
			Title	XVIII	Hospi tal	Cost	
					Costs		
	Cost Center Description	Total Cost	Therapy Limit	Total Costs	RCE	Total Costs	
		(from Wkst. B,	Adj .		Di sal I owance		
		Part I, col.					
		26)					
		1.00	2. 00	3. 00	4. 00	5. 00	
	INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000 ADULTS & PEDIATRICS	7, 309, 111		7, 309, 11	1 0	0	30. 00
31.00	03100 INTENSIVE CARE UNIT	0		(	0	0	31.00
	ANCILLARY SERVICE COST CENTERS						
50.00	05000 OPERATING ROOM	1, 627, 039		1, 627, 039	9 0	0	50.00
51.00	05100 RECOVERY ROOM	379, 892		379, 892	2 0	0	51.00
51. 01	05101 0/P TREATMENT ROOM	0		(	0	0	51. 01
54.00	05400 RADI OLOGY-DI AGNOSTI C	3, 536, 293		3, 536, 293	0	0	54.00
56.00	05600 RADI 0I SOTOPE	126, 753		126, 753	0	0	56. 00
60.00	06000 LABORATORY	1, 620, 422		1, 620, 422	2 0	0	60.00
62.00	06200 WHOLE BLOOD & PACKED RED BLOOD CELLS	30, 426		30, 426	6 0	0	62.00
65.00	06500 RESPI RATORY THERAPY	1, 021, 080	0	1, 021, 080	0	0	65. 00
66. 00	06600 PHYSI CAL THERAPY	1, 113, 762	0	1, 113, 762	0	0	66. 00
67. 00	06700 OCCUPATI ONAL THERAPY	416, 420	0	416, 420	0	0	67. 00
68. 00	06800 SPEECH PATHOLOGY	49, 319	0	49, 319	9 0	0	68. 00
69. 00	06900 ELECTROCARDI OLOGY	843, 825		843, 825	5 0	0	69. 00
71. 00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	o		(	0	0	71. 00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	18, 471		18, 47°	1 0	0	72. 00
73.00	07300 DRUGS CHARGED TO PATIENTS	2, 287, 764		2, 287, 764	1 0	0	73. 00
	OUTPATIENT SERVICE COST CENTERS			•			1
90. 00	09000 CLI NI C	0		(	0	0	90.00
91. 00	09100 EMERGENCY	6, 689, 119		6, 689, 119	9 0	0	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	1, 925, 862		1, 925, 862	2	0	92.00
200.00		28, 995, 558	0			0	200.00
201.00	,	1, 925, 862		1, 925, 862			201.00
202.00		27, 069, 696	0				202. 00

Health Financial Systems	UNI ON HOSPI T	AL CLINTON		In Lie	u of Form CMS-	2552-10
COMPUTATION OF RATIO OF COSTS TO CHARGES		Provi der C		Period: From 01/01/2021 To 12/31/2021	Worksheet C Part I Date/Time Pre 5/26/2022 10:	
		Title	XVIII	Hospi tal	Cost	
		Charges				
Cost Center Description	I npati ent	Outpati ent	Total (col. 6	Cost or Other	TEFRA	
		·	+ col. 7)	Ratio	I npati ent	
			,		Rati o	
	6. 00	7. 00	8.00	9. 00	10.00	
INPATIENT ROUTINE SERVICE COST CENTERS						
20 00 02000 ADULTS & DEDLATRICS	5 101 702		5 101 70	2		1 20 00

			11 (10	/(VIII	nospi tui	0031	
			Charges				
	Cost Center Description	I npati ent	Outpati ent	,	Cost or Other	TEFRA	
				+ col. 7)	Ratio	I npati ent	
						Rati o	
		6.00	7. 00	8. 00	9. 00	10. 00	
	IPATIENT ROUTINE SERVICE COST CENTERS						
	3000 ADULTS & PEDIATRICS	5, 101, 782		5, 101, 782			30. 00
	3100 INTENSIVE CARE UNIT	0		0			31. 00
	ICILLARY SERVICE COST CENTERS						
	OPERATING ROOM	344, 302	3, 461, 587			0. 000000	
	5100 RECOVERY ROOM	20, 803	1, 101, 599	1, 122, 402		0. 000000	
	5101 0/P TREATMENT ROOM	0	0	0	0. 000000	0. 000000	
	5400 RADI OLOGY-DI AGNOSTI C	1, 020, 268	25, 963, 031			0. 000000	
	5600 RADI OI SOTOPE	17, 191	552, 351	·			
	6000 LABORATORY	1, 680, 432	10, 083, 636			0. 000000	
	3200 WHOLE BLOOD & PACKED RED BLOOD CELLS	17, 916	10, 538	·		0.000000	
	5500 RESPIRATORY THERAPY	883, 074	2, 102, 456	2, 985, 530		0.000000	
	6600 PHYSI CAL THERAPY	253, 270	1, 902, 501			0.000000	
67. 00   06	5700 OCCUPATI ONAL THERAPY	133, 535	516, 757	650, 292	0. 640358	0.000000	67. 00
68. 00   06	S800 SPEECH PATHOLOGY	16, 313	40, 044	56, 357	0. 875118	0.000000	68. 00
69. 00 06	5900 ELECTROCARDI OLOGY	207, 169	3, 696, 940	3, 904, 109	0. 216138	0.000000	69. 00
71.00 07	7100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0.000000	0.000000	71. 00
72. 00   07	7200 IMPL. DEV. CHARGED TO PATIENTS	0	39, 991	39, 991	0. 461879	0.000000	72. 00
73.00 07	7300 DRUGS CHARGED TO PATIENTS	2, 085, 488	5, 478, 532	7, 564, 020	0. 302453	0.000000	73. 00
	JTPATIENT SERVICE COST CENTERS						
	9000 CLI NI C	0	0	0	0.000000	0.000000	
91.00 09	P100 EMERGENCY	729, 063	22, 243, 348	22, 972, 411	0. 291181	0.000000	91.00
92. 00 09	9200 OBSERVATION BEDS (NON-DISTINCT PART)	2, 925	1, 413, 199	1, 416, 124	1. 359953	0.000000	92. 00
200.00	Subtotal (see instructions)	12, 513, 531	78, 606, 510	91, 120, 041			200. 00
201.00	Less Observation Beds						201. 00
202.00	Total (see instructions)	12, 513, 531	78, 606, 510	91, 120, 041			202. 00

Health Financial Systems	UNION HOSPITAL CLINTON	In Lie	u of Form CMS-2552-10
COMPUTATION OF RATIO OF COSTS TO CHARGES	Provi der CCN: 15-1326		Worksheet C Part I Date/Time Prepared: 5/26/2022 10:52 am

					5/26/2022 10:52 am
			Title XVIII	Hospi tal	Cost
	Cost Center Description	PPS Inpatient			
		Ratio			
		11. 00			
	INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000 ADULTS & PEDI ATRI CS				30.00
31.00	03100 INTENSIVE CARE UNIT				31. 00
	ANCILLARY SERVICE COST CENTERS				
50.00	05000 OPERATI NG ROOM	0. 000000			50.00
51.00	05100 RECOVERY ROOM	0. 000000			51.00
51. 01	05101 O/P TREATMENT ROOM	0. 000000			51. 01
54.00	05400 RADI OLOGY-DI AGNOSTI C	0. 000000			54.00
56.00	05600 RADI OI SOTOPE	0. 000000			56.00
60.00	06000 LABORATORY	0. 000000			60.00
62.00	06200 WHOLE BLOOD & PACKED RED BLOOD CELLS	0. 000000			62. 00
65.00	06500 RESPI RATORY THERAPY	0. 000000			65. 00
66.00	06600 PHYSI CAL THERAPY	0. 000000			66. 00
67.00	06700 OCCUPATI ONAL THERAPY	0. 000000			67. 00
68. 00	06800 SPEECH PATHOLOGY	0. 000000			68. 00
69. 00	06900 ELECTROCARDI OLOGY	0. 000000			69. 00
71. 00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0. 000000			71. 00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0. 000000			72. 00
73.00	07300 DRUGS CHARGED TO PATIENTS	0. 000000			73. 00
	OUTPATIENT SERVICE COST CENTERS				
90.00	09000 CLI NI C	0. 000000			90.00
91.00	09100 EMERGENCY	0. 000000			91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0. 000000			92. 00
200.00	Subtotal (see instructions)				200. 00
201.00	Less Observation Beds				201. 00
202.00	Total (see instructions)				202. 00

Health Financial Systems	UNION HOSPITA	L CLINTON		In Lie	u of Form CMS-2	2552-10
COMPUTATION OF RATIO OF COSTS TO CHARGES		Provi der CC	CN: 15-1326	Peri od: From 01/01/2021 To 12/31/2021	Worksheet C Part I Date/Time Pre 5/26/2022 10:	
		Ti tl	e XIX	Hospi tal	Cost	
				Costs		
0 1 0 1 0 1 11	<del>-</del>   -		+	505	T	

				Ť	o 12/31/2021	Date/Time Pre 5/26/2022 10:	
			Titl	e XIX	Hospi tal	Cost	
					Costs		
	Cost Center Description	Total Cost	Therapy Limit	Total Costs	RCE	Total Costs	
		(from Wkst. B,	Adj .		Di sal I owance		
		Part I, col.					
		26)					
	LABORE ENT. DOUTENE OFFICE OF COOK OFFICE	1.00	2. 00	3. 00	4. 00	5. 00	
00.00	I NPATI ENT ROUTI NE SERVI CE COST CENTERS	7 000 444		7 000 444		7 000 444	00.00
30.00	03000 ADULTS & PEDI ATRI CS	7, 309, 111		7, 309, 111	1	7, 309, 111	1
31. 00	03100   NTENSIVE CARE UNIT	0		L	0	0	31. 00
FO 00	ANCILLARY SERVICE COST CENTERS  05000 OPERATING ROOM	1 (27 020		1 (27 020	, ol	1 (07 000	
50. 00 51. 00	05100 RECOVERY ROOM	1, 627, 039 379, 892		1, 627, 039 379, 892		1, 627, 039 379, 892	1
51.00	05100 RECOVERY ROOM 05101 0/P TREATMENT ROOM	3/9,892		3/9, 892		379, 892	51.00
54. 00	05400 RADI OLOGY-DI AGNOSTI C	3, 536, 293		3, 536, 293		3, 536, 293	
56. 00	05600 RADI OLOGI - DI AGNOSTI C	126, 753		126, 753		126, 753	
60.00	06000 LABORATORY	1, 620, 422		1, 620, 422		1, 620, 422	1
62. 00	06200 WHOLE BLOOD & PACKED RED BLOOD CELLS	30, 426		30, 426		30, 426	1
65. 00	06500 RESPIRATORY THERAPY	1, 021, 080	0	1, 021, 080		1, 021, 080	
66. 00	06600 PHYSI CAL THERAPY	1, 113, 762	0	1, 113, 762		1, 113, 762	
67. 00	06700 OCCUPATI ONAL THERAPY	416, 420	0	416, 420		416, 420	1
68. 00	06800 SPEECH PATHOLOGY	49, 319	0	49, 319		49, 319	
69. 00	06900 ELECTROCARDI OLOGY	843, 825		843, 825		843, 825	
71. 00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0		C	o	0	71. 00
72. 00	07200 I MPL. DEV. CHARGED TO PATIENTS	18, 471		18, 471	0	18, 471	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	2, 287, 764		2, 287, 764	0	2, 287, 764	73. 00
	OUTPATIENT SERVICE COST CENTERS						
90.00	09000 CLI NI C	0		C	0	0	90.00
91.00	09100 EMERGENCY	6, 689, 119		6, 689, 119	0	6, 689, 119	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	1, 925, 862		1, 925, 862	2	1, 925, 862	
200.00		28, 995, 558	0	,,		28, 995, 558	
201.00	I I	1, 925, 862		1, 925, 862		1, 925, 862	
202.00	Total (see instructions)	27, 069, 696	0	27, 069, 696	0	27, 069, 696	202. 00

lealth Financial Systems	UNION HOSPIT	AL CLINTON		In Lie	u of Form CMS-2	2552-10
COMPUTATION OF RATIO OF COSTS TO CHARGES		Provi der C			Worksheet C Part I Date/Time Pre 5/26/2022 10:	pared: 52 am
		Ti tl	e XIX	Hospi tal	Cost	
·		Charges		·		
Cost Center Description	I npati ent	Outpati ent	Total (col. 6 + col. 7)	Cost or Other Ratio	TEFRA Inpati ent	
					Ratio	
	6, 00	7.00	8, 00	9. 00	10.00	

		11.61	CAIA	nospi tui	0031	
		Charges				
Cost Center Description	I npati ent	Outpati ent	Total (col. 6	Cost or Other	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 & PEDI ATRI CS	5, 101, 782		5, 101, 782			30. 00
31.00 03100 INTENSIVE CARE UNIT	0		0			31. 00
ANCILLARY SERVICE COST CENTERS						
50.00   05000   OPERATING ROOM	344, 302	3, 461, 587	3, 805, 889	0. 427506	0.000000	50.00
51.00   05100   RECOVERY ROOM	20, 803	1, 101, 599	1, 122, 402	0. 338463	0.000000	51.00
51.01   05101   0/P TREATMENT ROOM	0	0	0	0.000000	0.000000	51. 01
54. 00   05400   RADI OLOGY-DI AGNOSTI C	1, 020, 268	25, 963, 031	26, 983, 299	0. 131055	0.000000	
56. 00   05600   RADI 0I SOTOPE	17, 191	552, 351	569, 542	0. 222553	0.000000	56. 00
60. 00   06000   LABORATORY	1, 680, 432	10, 083, 636	11, 764, 068	0. 137743	0.000000	60.00
62.00 06200 WHOLE BLOOD & PACKED RED BLOOD CELLS	17, 916	10, 538	28, 454	1. 069305	0.000000	62. 00
65. 00 06500 RESPI RATORY THERAPY	883, 074	2, 102, 456	2, 985, 530	0. 342010	0.000000	65. 00
66. 00 06600 PHYSI CAL THERAPY	253, 270	1, 902, 501	2, 155, 771	0. 516642	0.000000	66. 00
67. 00 06700 OCCUPATI ONAL THERAPY	133, 535	516, 757	650, 292	0. 640358	0.000000	67. 00
68.00 O6800 SPEECH PATHOLOGY	16, 313	40, 044	56, 357	0. 875118	0.000000	68. 00
69. 00 06900 ELECTROCARDI OLOGY	207, 169	3, 696, 940	3, 904, 109	0. 216138	0.000000	69. 00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0.000000	0.000000	71. 00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0	39, 991	39, 991	0. 461879	0.000000	72. 00
73.00 O7300 DRUGS CHARGED TO PATIENTS	2, 085, 488	5, 478, 532	7, 564, 020	0. 302453	0.000000	73. 00
OUTPATIENT SERVICE COST CENTERS						
90. 00 09000 CLI NI C	0	0	0	0.000000	0.000000	90. 00
91. 00   09100   EMERGENCY	729, 063	22, 243, 348	22, 972, 411	0. 291181	0.000000	91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	2, 925	1, 413, 199	1, 416, 124	1. 359953	0.000000	92. 00
200.00 Subtotal (see instructions)	12, 513, 531	78, 606, 510	91, 120, 041			200.00
201.00 Less Observation Beds						201. 00
202.00 Total (see instructions)	12, 513, 531	78, 606, 510	91, 120, 041			202. 00

Health Financial Systems	UNION HOSPITAL CLINTON	In Lie	u of Form CMS-2552-10
COMPUTATION OF RATIO OF COSTS TO CHARGES	Provi der CCN: 15-1326		Worksheet C Part I Date/Time Prepared: 5/26/2022 10:52 am
	Ti +Lo VIV	Hospi tal	Cost

				5/26/2022 10:52 am	
			Title XIX	Hospi tal	Cost
	Cost Center Description	PPS Inpatient			
		Ratio			
		11. 00			
	INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000 ADULTS & PEDI ATRI CS				30.00
31.00	03100 INTENSIVE CARE UNIT				31.00
	ANCILLARY SERVICE COST CENTERS				
50.00	05000 OPERATING ROOM	0. 000000			50.00
51.00	05100 RECOVERY ROOM	0. 000000			51.00
51. 01	05101 O/P TREATMENT ROOM	0. 000000			51. 01
54.00	05400 RADI OLOGY-DI AGNOSTI C	0. 000000			54. 00
56.00	05600 RADI OI SOTOPE	0. 000000			56. 00
60.00	06000 LABORATORY	0. 000000			60.00
62.00	06200 WHOLE BLOOD & PACKED RED BLOOD CELLS	0. 000000			62. 00
65.00	06500 RESPIRATORY THERAPY	0. 000000			65. 00
66.00	06600 PHYSI CAL THERAPY	0. 000000			66. 00
67.00	06700 OCCUPATI ONAL THERAPY	0. 000000			67. 00
68.00	06800 SPEECH PATHOLOGY	0. 000000			68. 00
69.00	06900 ELECTROCARDI OLOGY	0. 000000			69. 00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0. 000000			71. 00
72.00	07200 I MPL. DEV. CHARGED TO PATIENTS	0. 000000			72. 00
73.00	07300 DRUGS CHARGED TO PATIENTS	0. 000000			73. 00
	OUTPATIENT SERVICE COST CENTERS				
90.00	09000 CLI NI C	0. 000000			90.00
91.00	09100 EMERGENCY	0. 000000			91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0. 000000			92. 00
200.00	Subtotal (see instructions)				200. 00
201.00	Less Observation Beds				201. 00
202.00	Total (see instructions)				202. 00

Health Financial Systems	UNION HOSPIT	AL CLINTON		In Lie	eu of Form CMS-2	2552-10
APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITA	AL COSTS	Provi der C		Period: From 01/01/2021 To 12/31/2021	Worksheet D Part II Date/Time Pre 5/26/2022 10:	pared: 52 am
		Title	XVIII	Hospi tal	Cost	
Cost Center Description	Capi tal	Total Charges		t Inpatient	Capital Costs	
		(from Wkst. C,		Program	(column 3 x	
	(from Wkst. B,	· ·	(col. 1 ÷ col	. Charges	column 4)	
	Part II, col.	8)	2)			
	26)					
	1.00	2.00	3. 00	4. 00	5. 00	
ANCILLARY SERVICE COST CENTERS						
50.00   05000   OPERATING ROOM	152, 406					
51.00  05100   RECOVERY ROOM	58, 091	1, 122, 402			369	
51.01  05101 0/P TREATMENT ROOM	0	0	0.00000	0 0	0	51. 01
54. 00   05400   RADI OLOGY-DI AGNOSTI C	308, 143	26, 983, 299			1, 582	54.00
56. 00   05600   RADI 0I SOTOPE	25, 276	569, 542	0. 04438	5, 278	234	56. 00
60. 00   06000   LABORATORY	65, 700	11, 764, 068	0. 00558	541, 512	3, 024	60.00
62.00 06200 WHOLE BLOOD & PACKED RED BLOOD CELLS	75	28, 454	0.00263	6 1, 470	4	62. 00
65. 00 06500 RESPIRATORY THERAPY	69, 149	2, 985, 530	0. 02316	1 259, 927	6, 020	65. 00
66. 00 06600 PHYSI CAL THERAPY	101, 710	2, 155, 771	0. 04718	55, 577	2, 622	66. 00
67. 00 06700 OCCUPATI ONAL THERAPY	78, 672	650, 292	0. 12097	9 22, 207	2, 687	67. 00
68.00 06800 SPEECH PATHOLOGY	10, 630	56, 357	0. 18861	9 6, 345	1, 197	68. 00
69. 00 06900 ELECTROCARDI OLOGY	23, 958	3, 904, 109	0.00613	7 96, 544	592	69. 00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0.00000	0 0	0	71. 00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	42	39, 991	0.00105	0	0	72. 00
73.00 07300 DRUGS CHARGED TO PATIENTS	49, 071	7, 564, 020	0. 00648	660, 014	4, 282	73. 00
OUTPATIENT SERVICE COST CENTERS						
00 00 00000 CLINIC	0	0	0 00000	0		00 00

339, 722 150, 065

1, 432, 710

22, 972, 411 1, 416, 124

86, 018, 259

0.000000

0. 014788

0. 105969

6, 034

1, 868, 534

0 90.00

25, 424 200. 00

89 91.00 0 92.00

90. 00 09000 CLI NI C

91. 00 09100 EMERGENCY

92. 00 | O9200 | OBSERVATION BEDS (NON-DISTINCT PART) 200. 00 | Total (lines 50 through 199)

Health Financial Systems	UNI ON HOSPI TAI	_ CLINTON		In Lie	u of Form CMS-2	2552-10
APPORTIONMENT OF INPATIENT/OUTPATIENT / THROUGH COSTS	ANCILLARY SERVICE OTHER PASS	Provider Co	CN: 15-1326	Peri od: From 01/01/2021 To 12/31/2021	Worksheet D Part IV Date/Time Prep 5/26/2022 10:	
		Title	xVIII	Hospi tal	Cost	
Cost Center Description	Non Physician	Nursi ng	Nursi ng	Allied Health		

				10 12/31/2021	5/26/2022 10:	
		Ti tl e	e XVIII	Hospi tal	Cost	
Cost Center Description	Non Physician	Nursi ng	Nursi ng	Allied Health	Allied Health	
	Anestheti st	Program	Program	Post-Stepdown		
	Cost	Post-Stepdown		Adjustments		
		Adjustments				
	1. 00	2A	2. 00	3A	3. 00	
ANCILLARY SERVICE COST CENTERS						
50. 00   05000   OPERATI NG ROOM	0	0	)	0	0	50. 00
51.00   05100   RECOVERY ROOM	0	0	)	0	0	51. 00
51.01  05101 0/P TREATMENT ROOM	0	0	)	0	0	51. 01
54. 00   05400   RADI OLOGY-DI AGNOSTI C	0	0	)	0	0	54. 00
56. 00   05600   RADI 0I SOTOPE	0	0	)	0	0	56. 00
60. 00   06000   LABORATORY	0	0	)	0	0	60.00
62.00 06200 WHOLE BLOOD & PACKED RED BLOOD CELLS	0	0	)	0	0	62. 00
65. 00  06500   RESPI RATORY THERAPY	0	0	)	0	0	65. 00
66. 00   06600   PHYSI CAL THERAPY	0	0	)	0	0	66. 00
67. 00  06700 OCCUPATI ONAL THERAPY	0	0	)	0	0	67. 00
68.00   06800   SPEECH PATHOLOGY	0	0	)	0	0	68. 00
69. 00   06900   ELECTROCARDI OLOGY	0	0	)	0	0	69. 00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	)	0	0	71. 00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0	0	)	0	0	72. 00
73.00 O7300 DRUGS CHARGED TO PATIENTS	0	0	)	0 0	0	73. 00
OUTPATIENT SERVICE COST CENTERS						
90. 00   09000   CLI NI C	0	0	)	0	0	90. 00
91. 00   09100   EMERGENCY	0	0	)	0	0	91. 00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	0			0	0	
200.00   Total (lines 50 through 199)	0	0	)	0 0	0	200. 00

Heal th	Financial Systems	UNION HOSPIT	AL CLINTON		In lie	u of Form CMS-2	2552-10
APPORT	TOMMENT OF INPATIENT/OUTPATIENT ANCILLARY SEA TH COSTS				Period: From 01/01/2021 To 12/31/2021	Worksheet D Part IV	pared:
			Title	e XVIII	Hospi tal	Cost	
	Cost Center Description	All Other	Total Cost	Total	Total Charges	Ratio of Cost	
		Medi cal	(sum of cols.	Outpati ent	(from Wkst. C,	to Charges	
		Education Cost	1, 2, 3, and	Cost (sum of	Part I, col.	(col. 5 ÷ col.	
			4)	col s. 2, 3,	8)	7)	
				and 4)		(see	
						instructions)	
		4.00	5. 00	6. 00	7. 00	8. 00	
	ANCILLARY SERVICE COST CENTERS						
50.00	05000   OPERATI NG ROOM	0	0		0 3, 805, 889		
51.00	05100 RECOVERY ROOM	0	0		0 1, 122, 402		
51. 01	05101 0/P TREATMENT ROOM	0	0		0	0. 000000	51. 01
54.00	05400   RADI OLOGY-DI AGNOSTI C	0	0		0 26, 983, 299	0.000000	54. 00
56.00	05600  RADI OI SOTOPE	0	0		0 569, 542	0.000000	56. 00
60.00	06000 LABORATORY	0	0		0 11, 764, 068	0.000000	60.00
62.00	06200 WHOLE BLOOD & PACKED RED BLOOD CELLS	0	0		0 28, 454	0.000000	62.00
65.00	06500 RESPI RATORY THERAPY	0	0		0 2, 985, 530	0.000000	65. 00
66.00	06600 PHYSI CAL THERAPY	0	0		0 2, 155, 771	0.000000	66.00
67.00	06700 OCCUPATI ONAL THERAPY	0	0		0 650, 292	0.000000	67. 00
68.00	06800 SPEECH PATHOLOGY	0	0		0 56, 357	0.000000	68. 00
69.00	06900 ELECTROCARDI OLOGY	0	0		0 3, 904, 109	0.000000	69. 00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0		0 0	0.000000	71. 00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0	0		0 39, 991	0.000000	72. 00
73.00	07300 DRUGS CHARGED TO PATIENTS	0	0		0 7, 564, 020	0.000000	73. 00
	OUTPATIENT SERVICE COST CENTERS	•		•	•		
00 00	00000 CLINIC	0	0	1	0 0	0.000000	00 00

0 0 0 0 0 0 0 0 0

22, 972, 411 1, 416, 124 86, 018, 259 0.000000

0. 000000 91. 00 0. 000000 92. 00

200. 00

90. 00 09000 CLI NI C

91.00 | 09100| EMERGENCY 92.00 | 09200| OBSERVATION BEDS (NON-DISTINCT PART) 200.00 | Total (lines 50 through 199)

	Financial Systems	UNI ON HOSPI TA		ON 15 1007		eu of Form CMS-2	2332-10
	TIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SEF	RVICE UTHER PASS	Provider Co		Peri od: From 01/01/2021	Worksheet D Part IV	
THRUUC	SH COSTS				To 12/31/2021	Date/Time Pre	pared:
						5/26/2022 10:	
			Title	XVIII	Hospi tal	Cost	
	Cost Center Description	Outpati ent	I npati ent	Inpatient	Outpati ent	Outpati ent	
		Ratio of Cost	Program	Program	Program	Program	
		to Charges	Charges	Pass-Through		Pass-Through	
		(col. 6 ÷ col.		Costs (col.	8	Costs (col. 9	
		7)		x col. 10)		x col. 12)	
	T	9. 00	10.00	11. 00	12.00	13. 00	
	ANCILLARY SERVICE COST CENTERS						1
50.00	05000 OPERATI NG ROOM	0. 000000	67, 982		0	0	
51. 00	05100 RECOVERY ROOM	0. 000000	7, 125		0	0	51.00
51. 01	05101 0/P TREATMENT ROOM	0. 000000	0		0	0	51. 01
54.00	05400  RADI OLOGY-DI AGNOSTI C	0. 000000	138, 519		0	0	54.00
56.00	05600 RADI OI SOTOPE	0. 000000	5, 278		0	0	56. 00
60.00	06000 LABORATORY	0. 000000	541, 512		0	0	60.00
62.00	06200 WHOLE BLOOD & PACKED RED BLOOD CELLS	0. 000000	1, 470		0	0	62.00
65.00	06500 RESPI RATORY THERAPY	0. 000000	259, 927		0	0	65.00
66.00	06600 PHYSI CAL THERAPY	0. 000000	55, 577		0	0	66. 00
67.00	06700 OCCUPATI ONAL THERAPY	0. 000000	22, 207		0	0	67.00
68.00	06800 SPEECH PATHOLOGY	0. 000000	6, 345		0	0	68. 00
69.00	06900 ELECTROCARDI OLOGY	0. 000000	96, 544		0	0	69. 00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0. 000000	0		0	0	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0. 000000	0		0 0	0	72. 00
73.00	07300 DRUGS CHARGED TO PATIENTS	0. 000000	660, 014		0 0	0	73. 00
	OUTPATIENT SERVICE COST CENTERS						1
90.00	09000 CLI NI C	0. 000000	0		0 0	0	90.00
91.00	09100 EMERGENCY	0. 000000	6, 034		0 0	0	91.00
02 00	00200 ORSEDVATION REDS (NON_DISTINCT DART)	0.000000		1	0	١	92 00

0. 000000 0. 000000

6, 034 0

1, 868, 534

0 0 0

0 91.00 0 92.00 0 200.00

92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART)
200. 00 Total (lines 50 through 199)

Health Financial Systems	UNION HOSPIT	AL CLINTON		In Lieu of Form CMS-2552-10		
APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND	VACCINE COST	Provi der Co		Peri od:	Worksheet D	
				From 01/01/2021 To 12/31/2021	Part V	narad.
				To 12/31/2021	Date/Time Pre 5/26/2022 10:	
		Title	XVIII	Hospi tal	Cost	<u> </u>
			Charges	•	Costs	
Cost Center Description	Cost to Charge	PPS Reimbursed	Cost	Cost	PPS Services	
		Services (see	Rei mbursed	Rei mbursed	(see inst.)	
	Worksheet C,	inst.)	Servi ces	Services Not		
	Part I, col. 9		Subject To	Subject To		
			Ded. & Coins.	Ded. & Coins.		
			(see inst.)	(see inst.)		
	1.00	2.00	3. 00	4. 00	5. 00	
ANCILLARY SERVICE COST CENTERS						
50. 00   05000   OPERATI NG ROOM	0. 427506		795, 543	·	0	50. 00
51. 00   05100   RECOVERY ROOM	0. 338463		330, 272	2 0	0	51.00
51.01 05101 0/P TREATMENT ROOM	0. 000000	l .	(	0	0	51. 01
54. 00   05400   RADI OLOGY-DI AGNOSTI C	0. 131055		6, 426, 270	0	0	54.00
56. 00   05600   RADI 0I SOTOPE	0. 222553	0	106, 76	0	0	56. 00
60. 00  06000 LABORATORY	0. 137743	0	2, 750, 587	7 0	0	60.00
62.00 06200 WHOLE BLOOD & PACKED RED BLOOD CELLS	1. 069305	0	7, 473	0	0	62.00
65. 00 06500 RESPIRATORY THERAPY	0. 342010	0	666, 450	0	0	65. 00
66. 00 06600 PHYSI CAL THERAPY	0. 516642	0	728, 153	0	0	66.00
67. 00 06700 OCCUPATI ONAL THERAPY	0. 640358	0	131, 927	0	0	67.00
68. 00 06800 SPEECH PATHOLOGY	0. 875118	0	5, 254	1 0	0	68. 00
69. 00 06900 ELECTROCARDI OLOGY	0. 216138	0	1, 150, 334	1 0	0	69. 00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0. 000000	0	(	o	0	71. 00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0. 461879	0	13, 810	o	0	72. 00
73.00 07300 DRUGS CHARGED TO PATIENTS	0. 302453	0	2, 219, 854	18, 422	0	73. 00
OUTPATIENT SERVICE COST CENTERS						
90. 00 09000 CLI NI C	0. 000000	0	(	0	0	90.00
91. 00   09100   EMERGENCY	0. 291181	0	3, 989, 074	1 0	0	91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	1. 359953	0	431, 174	1 0	0	92. 00
200.00 Subtotal (see instructions)		0	19, 752, 936	44, 091	0	200. 00
201.00 Less PBP Clinic Lab. Services-Program				0		201. 00
Only Charges						
202.00 Net Charges (line 200 - line 201)		О О	19, 752, 936	44, 091	0	202. 00

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

From 01/01/2021 Part V
To 12/31/2021 Date/Time Prepared: 5/26/2022 10:52 am Title XVIII Hospi tal Cost Costs Cost Center Description Cost Cost Rei mbursed Rei mbursed Servi ces Services Not Subject To Subject To Ded. & Coins. Ded. & Coins. (see inst.) (see inst.) 7.00 6.00 ANCILLARY SERVICE COST CENTERS 50.00 05000 OPERATING ROOM 340, 099 10, 974 50.00 51.00 05100 RECOVERY ROOM 111, 785 51.00 51. 01 05101 0/P TREATMENT ROOM 0 51. 01 05400 RADI OLOGY-DI AGNOSTI C 54.00 842, 195 0 54.00 56. 00 05600 RADI 0I SOTOPE 23, 760 56.00 0 60.00 06000 LABORATORY 378.874 60.00 06200 WHOLE BLOOD & PACKED RED BLOOD CELLS 0 62.00 7.991 62.00 65.00 06500 RESPIRATORY THERAPY 227, 933 65.00 06600 PHYSI CAL THERAPY 376, 194 66.00 66.00 06700 OCCUPATIONAL THERAPY 84, 481 67 00 67 00 4, 598 68.00 06800 SPEECH PATHOLOGY 0 68.00 69.00 06900 ELECTROCARDI OLOGY 248, 631 0 69.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 71.00 0 71.00 07200 I MPL. DEV. CHARGED TO PATIENTS 6, 379 72.00 0 72.00 73.00 07300 DRUGS CHARGED TO PATIENTS 671, 402 5, 572 73.00 OUTPATIENT SERVICE COST CENTERS 90.00 09000 CLI NI C 90.00 0 1, 161, 543 91.00 09100 EMERGENCY 91.00 0 92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART) 586, 376 92.00 200.00 Subtotal (see instructions) 5, 072, 241 16, 546 200.00 Less PBP Clinic Lab. Services-Program 201.00 201.00 Only Charges 202.00 Net Charges (line 200 - line 201) 202. 00 5, 072, 241 16, 546

Health Financial Systems	UNI ON HOSPI TAL	CLINTON		In Lieu of Form CMS-2552-10
ADDODTIONMENT OF MEDICAL	OTHER HEALTH SERVICES AND VACCINE COST	Providor CCN: 15 1226	Pari ad:	Workshoot D

Health Financial Systems			UNION HOSPITAL CLINTON			In Lieu of Form CMS-2552-10			
APPORT	APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND		VACCINE COST	Provider Component		Period: From 01/01/2021 To 12/31/2021	Worksheet D Part V Date/Time Pre 5/26/2022 10:		
					Ti tl e	XVIII	Swing Beds - SNF	Cost	
						Charges		Costs	
	(	Cost Center Description			PPS Reimbursed		Cost	PPS Services	
				Ratio From	Services (see	Rei mbursed	Rei mbursed	(see inst.)	
				Worksheet C,	inst.)	Servi ces	Servi ces Not		
				Part I, col. 9		Subject To	Subj ect To		
						Ded. & Coins			
						(see inst.)	(see inst.)		
				1. 00	2.00	3. 00	4. 00	5. 00	
		ARY SERVICE COST CENTERS			1	ı			
		OPERATING ROOM		0. 427506			0	0	
		RECOVERY ROOM		0. 338463			0	0	51.00
		O/P TREATMENT ROOM		0. 000000			0	0	51. 01
54.00		RADI OLOGY-DI AGNOSTI C		0. 131055			0	0	54.00
56. 00		RADI OI SOTOPE		0. 222553	l .		0	0	56. 00
60.00		LABORATORY		0. 137743			0	0	60.00
62.00		WHOLE BLOOD & PACKED RED BLOO	DD CELLS	1. 069305			0	0	62.00
65. 00		RESPI RATORY THERAPY		0. 342010			0	0	65.00
66. 00		PHYSI CAL THERAPY		0. 516642			0	0	66.00
67. 00		OCCUPATIONAL THERAPY		0. 640358			0	0	67. 00
		SPEECH PATHOLOGY		0. 875118	l .		0	0	68. 00
		ELECTROCARDI OLOGY		0. 216138	l .		0	0	69. 00
		MEDICAL SUPPLIES CHARGED TO F		0. 000000			0	0	71.00
		IMPL. DEV. CHARGED TO PATIENT	5	0. 461879			0 1//	0	72.00
73. 00		DRUGS CHARGED TO PATIENTS		0. 302453	0		0 166	0	73. 00
90. 00	09000 (	TIENT SERVICE COST CENTERS		0. 000000		1	0 0	0	90.00
		EMERGENCY		0. 291181	0		0	0	90.00
		EMERGENCI OBSERVATION BEDS (NON-DISTINO	יד האחד)	1. 359953				0	ı
200.00		observation beds (non-distinc Subtotal (see instructions)	I PARI)	1. 309953			0 166	ľ	200.00
200.00		Less PBP Clinic Lab. Services	Drogram				100	0	200.00
201.00		only Charges	s-i i ugi alli						201.00
202.00		Net Charges (line 200 - line	201)		0		0 166	0	202. 00

Health Financial Systems	UNI ON HOSPI TAL	CLINTON	In Lie	u of Form CMS-2552-10
APPORTIONMENT OF MEDICAL,	OTHER HEALTH SERVICES AND VACCINE COST	Provider CCN: 15-1326 Component CCN: 15-Z326	From 01/01/2021	
		Title XVIII	Swina Beds - SNF	Cost

		Component	CCN: 15-Z326		12/31/		Date/Time Pr 5/26/2022 10	
	_	Title	XVIII	Swi ng	Beds -	- SNF	Cost	
	Co:	sts						
Cost Center Description	Cost	Cost						
	Rei mbursed	Reimbursed						
	Servi ces	Servi ces Not						
	Subj ect To	Subject To						
	Ded. & Coins.	Ded. & Coins.						
	(see inst.)	(see inst.)						
	6. 00	7. 00						
ANCI LLARY SERVI CE COST CENTERS		1						
50.00   05000   OPERATING ROOM	0	0						50. 00
51. 00   05100   RECOVERY ROOM	0	0						51. 00
51.01  05101 0/P TREATMENT ROOM	0	0						51. 01
54. 00   05400   RADI OLOGY-DI AGNOSTI C	0	0						54. 00
56. 00   05600   RADI 0I SOTOPE	0	0						56. 00
60. 00   06000   LABORATORY	0	0						60.00
62.00 06200 WHOLE BLOOD & PACKED RED BLOOD CELLS	0	0						62. 00
65. 00 06500 RESPI RATORY THERAPY	0	0						65. 00
66. 00 06600 PHYSI CAL THERAPY	0	0						66. 00
67. 00  06700 OCCUPATI ONAL THERAPY	0	0						67. 00
68. 00   06800   SPEECH PATHOLOGY	0	0						68. 00
69. 00   06900   ELECTROCARDI OLOGY	0	0						69. 00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0						71. 00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0	0						72. 00
73.00 O7300 DRUGS CHARGED TO PATIENTS	0	50						73. 00
OUTPATIENT SERVICE COST CENTERS	_							
90. 00  09000   CLI NI C	0	0						90. 00
91. 00   09100   EMERGENCY	0	0						91. 00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	0	0						92. 00
200.00 Subtotal (see instructions)	0	50						200. 00
201.00 Less PBP Clinic Lab. Services-Program	0							201. 00
Only Charges								
202.00   Net Charges (line 200 - line 201)	0	50						202. 00

Health Financial Systems	UNION HOSPITAL CLINTON	In Lie	eu of Form CMS-2552-10
COMPUTATION OF INPATIENT OPERATING COST	Provi der CC	From 01/01/2021	Worksheet D-1  Date/Time Prepared: 5/26/2022 10: 52 am
	Title	XVIII Hospital	Cost

				5/26/2022 10:	52 am
	Coot Contan Decemintion	Title XVIII	Hospi tal	Cost	
	Cost Center Description			1. 00	
	PART I - ALL PROVIDER COMPONENTS			1.00	
	I NPATI ENT DAYS				
1.00	Inpatient days (including private room days and swing-bed days			3, 518	1.00
2.00	Inpatient days (including private room days, excluding swing-b	2, 866	2. 00		
3. 00	Private room days (excluding swing-bed and observation bed day	/s). If you have only pr	ivate room days,	0	3. 00
4. 00	do not complete this line.  Semi-private room days (excluding swing-bed and observation be	od dave)		1, 976	4. 00
5. 00	Total swing-bed SNF type inpatient days (including private room		r 31 of the cost	495	5.00
3.00	reporting period	m days) trii odgii becciibe	31 01 116 6031	175	3.00
6.00	Total swing-bed SNF type inpatient days (including private roo	om days) after December	31 of the cost	0	6. 00
	reporting period (if calendar year, enter 0 on this line)	3 .			
7. 00	Total swing-bed NF type inpatient days (including private room	n days) through December	31 of the cost	157	7. 00
0.00	reporting period		4 6 11		0.00
8. 00	Total swing-bed NF type inpatient days (including private room reporting period (if calendar year, enter 0 on this line)	n days) after December 3	or the cost	0	8. 00
9. 00	Total inpatient days including private room days applicable to	the Program (eycluding	swing_hed and	821	9. 00
7. 00	newborn days) (see instructions)	The Program (exertaining	Swifig bed and	021	7.00
10.00	Swing-bed SNF type inpatient days applicable to title XVIII or	nly (including private r	oom days)	495	10.00
	through December 31 of the cost reporting period (see instruct		-		
11. 00	Swing-bed SNF type inpatient days applicable to title XVIII or		oom days) after	0	11. 00
12.00	December 31 of the cost reporting period (if calendar year, er				10.00
12. 00	Swing-bed NF type inpatient days applicable to titles V or XI) through December 31 of the cost reporting period	confy (including privat	e room days)	0	12. 00
13. 00	Swing-bed NF type inpatient days applicable to titles V or XI)	( only (including privat	e room days)	0	13. 00
.0.00	after December 31 of the cost reporting period (if calendar ye			ا	
14.00	Medically necessary private room days applicable to the Progra	am (excluding swing-bed	days)	0	14. 00
15. 00	Total nursery days (title V or XIX only)			0	15. 00
16. 00	Nursery days (title V or XIX only)			0	16. 00
17.00	SWING BED ADJUSTMENT		C +1+		17.00
17. 00	Medicare rate for swing-bed SNF services applicable to service reporting period	es through December 31 o	r the cost		17. 00
18. 00	Medicare rate for swing-bed SNF services applicable to service	es after December 31 of	the cost		18. 00
.0.00	reporting period				
19. 00	Medicaid rate for swing-bed NF services applicable to services	231. 10	19. 00		
	reporting period				
20. 00	Medicaid rate for swing-bed NF services applicable to services	s after December 31 of t	he cost	231. 10	20. 00
21. 00	reporting period Total general inpatient routine service cost (see instructions	:)		7, 309, 111	21. 00
22. 00	Swing-bed cost applicable to SNF type services through December		ing period (line	0	22. 00
	5 x line 17)			- 1	
23. 00	Swing-bed cost applicable to SNF type services after December	31 of the cost reportin	g period (line 6	0	23. 00
	x line 18)				
24. 00	Swing-bed cost applicable to NF type services through December $7 \times 1$ ine 19)	31 of the cost reporti	ng period (line	36, 283	24.00
25. 00	Swing-bed cost applicable to NF type services after December 3	31 of the cost reporting	neriod (line 8	0	25. 00
20.00	x line 20)	or the cost reporting	perrou (rriie o	١	20.00
26.00	Total swing-bed cost (see instructions)			1, 107, 409	26. 00
27. 00	General inpatient routine service cost net of swing-bed cost (	(line 21 minus line 26)		6, 201, 702	27. 00
	PRI VATE ROOM DI FFERENTI AL ADJUSTMENT		` ` `		
28. 00	General inpatient routine service charges (excluding swing-bed	and observation bed ch	arges)	0	28. 00
29. 00 30. 00	Private room charges (excluding swing-bed charges) Semi-private room charges (excluding swing-bed charges)			0	29. 00 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)	11116 20)		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 mir	nus line 33)(see instruc	tions)	0.00	34. 00
35.00					35. 00
36.00	Private room cost differential adjustment (line 3 x line 35)				36.00
37. 00	General inpatient routine service cost net of swing-bed cost a	and private room cost di	fferential (line	6, 201, 702	37. 00
	27 minus line 36) PART II - HOSPITAL AND SUBPROVIDERS ONLY				
	PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJU	ISTMENTS			
38. 00	Adjusted general inpatient routine service cost per diem (see			2, 163. 89	38. 00
39. 00	Program general inpatient routine service cost (line 9 x line	•		1, 776, 554	39. 00
40.00	Medically necessary private room cost applicable to the Progra	am (line 14 x line 35)		0	40. 00
41. 00	Total Program general inpatient routine service cost (line 39	+ line 40)		1, 776, 554	41.00

Heal th	Financial Systems UNION HOSPITAL CLINTON In Lie	eu of Form CMS-2	2552-10
COMPUT	ATION OF INPATIENT OPERATING COST Provider CCN: 15-1326 Period: From 01/01/2021	Worksheet D-1	
	To 12/31/2021	Date/Time Prep	
	Title XVIII Hospital	5/26/2022 10:5 Cost	52 am_
	Cost Center Description Total Total Average Per Program Days	Program Cost	
	Inpatient Cost   Inpatient Days   Diem (col. 1 ÷   col. 2)	(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		42. 00
43.00	INTENSIVE CARE UNIT   0   0   0.00   0	0	43. 00
44. 00 45. 00	CORONARY CARE UNIT		44. 00 45. 00
46. 00			46. 00
47. 00	OTHER SPECIAL CARE (SPECIFY)		47. 00
	Cost Center Description	1.00	
48. 00	Program inpatient ancillary service cost (Wkst. D-3, col. 3, line 200)	486, 596	
49. 00	Total Program inpatient costs (sum of lines 41 through 48)(see instructions)  PASS THROUGH COST ADJUSTMENTS	2, 263, 150	49. 00
50.00	Pass through costs applicable to Program inpatient routine services (from Wkst. D, sum of Parts I and	0	50. 00
51. 00		o	51. 00
31.00	and IV)	l	31.00
52.00	Total Program excludable cost (sum of lines 50 and 51)	0	52.00
53. 00	Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)	0	53. 00
E 4 00	TARGET AMOUNT AND LIMIT COMPUTATION		oo
54. 00 55. 00	Program discharges Target amount per discharge	0.00	
56.00	Target amount (line 54 x line 55)	0	56. 00
57. 00 58. 00	Difference between adjusted inpatient operating cost and target amount (line 56 minus line 53) Bonus payment (see instructions)	0	57. 00 58. 00
59. 00	Lesser of lines 53/54 or 55 from the cost reporting period ending 1996, updated and compounded by the	0.00	
60. 00	market basket Lesser of lines 53/54 or 55 from prior year cost report, updated by the market basket	0.00	60. 00
61. 00		0.00	61. 00
	which operating costs (line 53) are less than expected costs (lines 54 x 60), or 1% of the target amount (line 56), otherwise enter zero (see instructions)		
62. 00	o	62. 00	
63. 00	0	63. 00	
64. 00	PROGRAM INPATIENT ROUTINE SWING BED COST  Medicare swing-bed SNF inpatient routine costs through December 31 of the cost reporting period (See	1, 071, 126	64. 00
65. 00	instructions)(title XVIII only) Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (See	o	65. 00
65.00	instructions) (title XVIII only)		65.00
66. 00	Total Medicare swing-bed SNF inpatient routine costs (line 64 plus line 65)(title XVIII only). For CAH (see instructions)	1, 071, 126	66. 00
67. 00		o	67. 00
68. 00	(line 12 x line 19) Title V or XIX swing-bed NF inpatient routine costs after December 31 of the cost reporting period		68. 00
00.00	(line 13 x line 20)		08.00
69. 00	Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68)  PART III - SKILLED NURSING FACILITY, OTHER NURSING FACILITY, AND ICF/IID ONLY	0	69. 00
70. 00	Skilled nursing facility/other nursing facility/ICF/IID routine service cost (line 37)		70. 00
71.00	Adjusted general inpatient routine service cost per diem (line 70 ÷ line 2)		71.00
72. 00 73. 00	Program routine service cost (line 9 x line 71) Medically necessary private room cost applicable to Program (line 14 x line 35)		72. 00 73. 00
74. 00	Total Program general inpatient routine service costs (line 72 + line 73)		74. 00
75. 00	Capital-related cost allocated to inpatient routine service costs (from Worksheet B, Part II, column 26, line 45)		75. 00
76. 00	Per diem capital-related costs (line 75 ÷ line 2)		76. 00
77. 00 78. 00	Program capital-related costs (line 9 x line 76) Inpatient routine service cost (line 74 minus line 77)		77. 00 78. 00
79. 00	Aggregate charges to beneficiaries for excess costs (from provider records)		79. 00
80. 00 81. 00	Total Program routine service costs for comparison to the cost limitation (line 78 minus line 79) Inpatient routine service cost per diem limitation		80. 00 81. 00
82. 00	Inpatient routine service cost per drein frim tatron Inpatient routine service cost limitation (line 9 x line 81)		82. 00
83.00	Reasonable inpatient routine service costs (see instructions)		83.00
84. 00 85. 00	Program inpatient ancillary services (see instructions) Utilization review - physician compensation (see instructions)		84. 00 85. 00
86. 00	Total Program inpatient operating costs (sum of lines 83 through 85)		86. 00
87. 00	PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST  Total observation bed days (see instructions)	890	87. 00
88. 00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)	2, 163. 89	88. 00
89. 00	Observation bed cost (line 87 x line 88) (see instructions)	1, 925, 862	89.00

Health Financial Systems	UNI ON HOSPITA	AL CLINTON		In Lie	u of Form CMS-2	2552-10
COMPUTATION OF INPATIENT OPERATING COST		Provi der CO		Peri od:	Worksheet D-1	
				From 01/01/2021		
				To 12/31/2021	Date/Time Prep 5/26/2022 10:	
		Title	XVIII	Hospi tal	Cost	JZ 4111
Cost Center Description	Cost	Routine Cost	column 1 ÷	Total	Observati on	
cost center bescription						
		(from line 21)	column 2	Observati on	Bed Pass	
				Bed Cost (from	Through Cost	
				line 89)	(col. 3 x 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	569, 534	7, 309, 111	0. 07792	1 1, 925, 862	150, 065	90.00
91.00 Nursing Program cost	0	7, 309, 111	0.00000	0 1, 925, 862	0	91.00
92.00 Allied health cost	0	7, 309, 111	0. 00000	0 1, 925, 862	0	92.00
93.00 All other Medical Education	0	7, 309, 111	0.00000	0 1, 925, 862	0	93. 00

Health Financial Systems	UNION HOSPITAL CLINTON	In Lie	u of Form CMS-2552-10
COMPUTATION OF INPATIENT OPERATING COST	Provi der CCN: 15-1326	Peri od: From 01/01/2021	Worksheet D-1
			Date/Time Prepared: 5/26/2022 10:52 am
	Title XIX	Hospi tal	Cost

Mail   - ALL PROFIDES COMPONENTS   1.00					5/26/2022 10:	52 am
			Title XIX	Hospi tal	Cost	
PART   - ALL PROVIDER COMPONENTS   PART     - ALL PROVIDER COMPONENTS   PART     - ALL PROVIDER COMPONENTS		Cost Center Description				
MPATERT MAYS   1.00					1. 00	
Impationt days (including private room days and swing-bed days, excluding newborn)   3,518   1,000   1,000   1,000   1,000   2,866   2,000   1,000   2,866   2,000   1,000   2,866   2,000						
Impatt on tabys (including private room days, excluding saring-bed and nebborn days)   2,866   2,000   3,00   And record days (excluding saring-bed and observation bed days). If you have only private room days, (excluding saring-bed and observation bed days)   1						
Private room days (excluding swing-bed and observation bed days). If you have only private room days.   0   3.00	1.00				3, 518	1
do not complete this line.  4. 00 Selle-private room days (secluding swing-bed and observation bed days) through Becember 31 of the cost 495 5.00 10 total swing bed SNI type inpatient days (including private room days) after December 31 of the cost 495 5.00 7.00 10 total swing bed SNI type inpatient days (including private room days) after December 31 of the cost 497 7.00 10 total swing-bed SNI type inpatient days (including private room days) through Becember 31 of the cost 497 7.00 10 total swing-bed SNI type inpatient days (including private room days) through December 31 of the cost 497 7.00 10 total swing-bed SNI type inpatient days (including private room days) after December 31 of the cost 497 7.00 10 10 10 10 10 10 10 10 10 10 10 10 1	2.00				2, 866	2. 00
5.00 Total swing-bed SR type inpatient days (including private room days) through December 31 of the cost reporting period reporting period of the cost reporting	3.00		ys). If you have only pr	vate room days,	0	3. 00
Total   swing-bed SNF type inpatient days (including private room days) after December 31 of the cost   Cost						
reporting period of the submished SNF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)  7.00  7.0						1
10   Total swing-bed SNF type inpatient days (including private room days) after December 31 of the cost reporting period (if cal endar year, enter 0 on this line)   7.00   7.	5.00		om days) through Decembe	r 31 of the cost	495	5. 00
reporting period (if calendar year, enter 0 on this ilne)   157    7.00   Total swing-bed Mi rype inpatient days (including private room days) through becember 31 of the cost   157    7.00   Total swing-bed Mi rype inpatient days (including private room days) after December 31 of the cost   0    8.00   10    10						
1.00 Total swing-bed NF type inpatient days (including private room days) through December 31 of the cost properting period of Total swing-bed NF type inpatient days (including private room days) after December 31 of the cost properting period (if calendar year, enter 0 on this line)  1.00 Total inpatient days including private room days applicable to the Program (excluding swing-bed and private room days)  1.00 Swing-bed SNF type inpatient days applicable to the the Program (excluding swing-bed and through December 31 of the cost reporting period (see instructions)  1.00 Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) after December 31 of the cost reporting period (see instructions)  1.00 Swing-bed NF type inpatient days applicable to title XVIII only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)  1.00 Swing-bed NF type inpatient days applicable to title XVIII only (including private room days)  1.01 Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days)  1.02 Swing-bed NF type inpatient days applicable to title XVIII only (including private room days)  1.03 Swing-bed NF type inpatient days applicable to title XVIII only (including private room days)  1.02 Total nursery days (title V or XIX only)  1.03 Swing-bed NF type inpatient days applicable to the Program (excluding swing-bed days)  1.04 Swing-bed NF type inpatient days applicable to services through December 31 of the cost reporting period (including private room days)  1.05 Swing-bed NF type inpatient days applicable to services after December 31 of the cost reporting period (including private room days)  1.06 Swing-bed NF type services applicable to services after December 31 of the cost reporting period (including private room days)  1.07 Swing-bed Cost applicable to SNF type services after December 31 of the cost reporting period (line 8 x III ne 1)  2.08 Swing-bed Cost applicable to SNF typ	6.00		om days) after December :	31 of the cost	0	6. 00
reporting period  7 reporting period  8 .00 Total swing-bed NF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)  9 .00 Total inpatient days including private room days applicable to the Program (excluding swing-bed and newborn days) (see instructions)  10 .00 Swing-bed SNF type Inpatient day applicable to title XVIII only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)  12 .00 Swing-bed SNF type Inpatient days applicable to title XVIII only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)  13 .00 Swing-bed SNF 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)  14 .00 Swing-bed SNF type inpatient days applicable to titles V or XIX only (including private room days) 1 including after December 31 of the cost reporting period (if calendar year, enter 0 on this line)  14 .00 Including the type inpatient days applicable to titles V or XIX only (including private room days) 1 including after December 31 of the cost reporting period (if real entar year, enter 0 on this line)  15 .00 Including the type inpatient days applicable to the Program (excluding swing-bed days) 1 including the private room days applicable to services through December 31 of the cost reporting period  16 .00 Medical rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period  17 .00 Medical rate for swing-bed SNF services after December 31 of the cost reporting period (line 8 x line 17)  28 .00 Swing-bed cost applicable to SNF type services after December 31 of the cost reporting period (line 8 x line 18)  29 .00 Swing-bed cost applicable to SNF type services after December 31 of the cost reporting period (line 6 x line 18)  29 .00 Swing-bed cost applicable to S						
10   10   10   10   10   10   10   10	7.00		m days) through December	31 of the cost	15/	7.00
reporting period (if calendar year, enter 0 on this line)  70. Total inpatient days including perivate room days applicable to the Program (excluding swing-bed and newborn days) (see instructions)  10.00 Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) after through December 31 of the cost reporting period (see instructions)  11.00 Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) after through December 31 of the cost reporting period (see instructions)  12.00 Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) after on through December 31 of the cost reporting period  13.00 Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) after of through December 31 of the cost reporting period (if calendary year, enter 0 on this line)  14.00 Medically necessary private room days applicable to the Program (excluding swing-bed days)  16.00 Nursery days (title V or XIX only)  17.00 Swing-Bod NF type (title V or XIX only)  18.00 Nursery days (title V or XIX only)  18.00 Nursery days (title V or XIX only)  18.00 Medically necessary private room days applicable to services through December 31 of the cost reporting period  18.00 Medical care rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period  19.00 Medical care rate for swing-bed NF services applicable to services after December 31 of the cost reporting period  20.00 Medical drate for swing-bed NF services applicable to services after December 31 of the cost reporting period (line Swing-bed cost applicable to SNF type services through December 31 of the cost reporting period (line Swing-bed cost applicable to SNF type services after December 31 of the cost reporting period (line Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line Swing-bed cost applicable to NF type services after December 31 of the cost r	0.00			1 -6		0.00
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newborn days) (see Instructions)   0   10.00   5   10.00   5   10.00   5   10.00   5   10.00   5   10.00   5   10.00   5   10.00   5   10.00   5   10.00   5   10.00   5   10.00   5   10.00	0.00		the Dreamam (eveluding	cwing had and	27	0.00
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through December 31 of the cost reporting period (see instructions)  1.00 Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)  1.00 Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days)  1.00 Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days)  1.00 Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days)  1.00 Medically Inecessary private room days applicable to the Program (excluding swing-bed days)  1.00 Medical In unservy days (title V or XIX only)  1.00 Medicaler rate for swing-bed SNF services applicable to services through December 31 of the cost reporting period  1.00 Medicaler rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period  1.00 Medical drate for swing-bed NF services applicable to services after December 31 of the cost reporting period  1.00 Medical drate for swing-bed NF services applicable to services after December 31 of the cost reporting period  1.00 Medical drate for swing-bed NF services applicable to services after December 31 of the cost reporting period (and drate for swing-bed NF services applicable to services after December 31 of the cost reporting period (and reporting per	10 00		alv (including private r	nom days)	ا م ا	10 00
11.00 Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) after become a contribution of the cost reporting period (if calendary year, enter 0 on this line)  12.00 Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days)  13.00 Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days)  14.00 Medically necessary private room days applicable to titles V or XIX only (including private room days)  15.00 Medically necessary private room days applicable to the Program (excluding swing-bed days)  16.00 Nursery days (title V or XIX only)  17.00 Nursery days (title V or XIX only)  18.00 Nursery days (title V or XIX only)  19.00 Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost reporting period of the cost period period of the period	10.00			Join days)	ا	10.00
December 31 of the cost reporting period (if calendar year, enter 0 on this line)  12.00 Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days)  13.00 Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days)  14.00 Medical line in patient days applicable to the Program (excluding swing-bed days)  15.00 Total nursery days (title V or XIX only)  16.00 No Nursery days (title V or XIX only)  17.00 Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost reporting period  18.00 Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period  19.00 Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period  19.00 Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period  20.00 Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period  21.00 Total general inpatient routine service cost (see instructions)  22.00 Swing-bed cost applicable to SNF type services through December 31 of the cost reporting period (line by 1) of the cost applicable to SNF type services through December 31 of the cost reporting period (line by 1) of the cost applicable to SNF type services after December 31 of the cost reporting period (line by 1) of the cost applicable to SNF type services after December 31 of the cost reporting period (line by 1) of the cost applicable to SNF type services after December 31 of the cost reporting period (line by 1) of the cost applicable to SNF type services after December 31 of the cost reporting period (line by 1) of the cost applicable to SNF type services after December 31 of the cost reporting period (line by 1) of the cost applicable to SNF type services after December 31 of the cost reporting period (line by 1) of the cost applicable to SNF type services after December 31 of the cost	11 00			nom davs) after	ا م ا	11 00
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through December 31 of the cost reporting period  31.00 Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days)  41.00 Medically necessary private room days applicable to the Program (excluding swing-bed days)  51.00 Total nursery days (title V or XIX only)  61.00 No Unservery days (title V or XIX only)  61.00 No Unservery days (title V or XIX only)  71.00 Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost reporting period  81.00 No Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period  81.00 No Medicader rate for swing-bed NF services applicable to services after December 31 of the cost reporting period  81.00 No Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period  81.00 No Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost  81.00 No Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost  81.00 No Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost  81.00 No Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost  81.00 No Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period (line solution solution)  91.00 No Medicaid rate for swing-bed NF services after December 31 of the cost reporting period (line solution)  91.00 No Medicaid rate for swing-bed cost (see instructions)  91.00 No Medicaid rate for swing-bed cost (see instructions)  91.00 No Medicaid rate for swing-bed cost (see instructions)  91.00 No Medicaid rate for swing-bed cost (see instructions)  91.00 No Medicaid rate for swing-bed cost (see instructions)  91.00 No Medicaid rate for swing-bed charges)  91.00 No Medicaid rate for swing-bed charges (excluding swing-bed and observation bed charges)  91.00 No Medicaid rate for swing-bed charges (	12.00			e room days)	0	12.00
13.00   Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days)   0   15.00	.2.00		t only (morearing private	o i oom dayo,	ا	12.00
after December'31 of the cost reporting period (if calendar year, enter 0 on this line)   14.00   14.00   15	13.00		only (including private	e room davs)	0	13.00
15.00   Total nursery days (title V or XIX only)   0   16.00		after December 31 of the cost reporting period (if calendar ye	ear, enter O on this line	e)		
16.00 Nursery days (title v or XIX only)  With BED ADJUSTMENT  17.00 Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost reporting period (local drate for swing-bed SNF services applicable to services after December 31 of the cost reporting period (local drate for swing-bed NF services applicable to services after December 31 of the cost reporting period (local drate for swing-bed NF services applicable to services after December 31 of the cost (local drate for swing-bed NF services applicable to services after December 31 of the cost (local drate for swing-bed NF services applicable to services after December 31 of the cost (local drate for swing-bed NF services applicable to services after December 31 of the cost (local drate for swing-bed SNF services applicable to services after December 31 of the cost (local drate for swing-bed cost applicable to SNF type services through December 31 of the cost reporting period (line (local drate for swing-bed cost applicable to SNF type services after December 31 of the cost reporting period (line (local drate for swing-bed cost applicable to SNF type services after December 31 of the cost reporting period (line (local drate for swing-bed cost applicable to SNF type services after December 31 of the cost reporting period (line	14.00	Medically necessary private room days applicable to the Progra	am (excluding swing-bed	days)	0	14. 00
SWING BED ADJUSTMENT	15.00	Total nursery days (title V or XIX only)		<b>3</b> ,	0	15. 00
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reporting period  Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period (and card rate for swing-bed NF services applicable to services through December 31 of the cost (and card rate for swing-bed NF services applicable to services after December 31 of the cost (and card rate for swing-bed NF services applicable to services after December 31 of the cost (and card rate for swing-bed NF services applicable to services after December 31 of the cost (and card rate for swing-bed NF services applicable to services after December 31 of the cost reporting period (and card rate for swing-bed cost applicable to SNF type services through December 31 of the cost reporting period (line for particular service) (and services after December 31 of the cost reporting period (line for particular service) (and services after December 31 of the cost reporting period (line for particular service) (and services after December 31 of the cost reporting period (line for particular service) (and services after December 31 of the cost reporting period (line for particular service) (and services after December 31 of the cost reporting period (line for particular service) (and services after December 31 of the cost reporting period (line for particular service) (and services after December 31 of the cost reporting period (line for particular service) (and service) (and services after December 31 of the cost reporting period (line for particular service) (and serv		SWING BED ADJUSTMENT				1
18. 00   Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period   19. 00   19. 0	17.00	Medicare rate for swing-bed SNF services applicable to service	es through December 31 o	f the cost		17. 00
reporting period Medicald rate for swing-bed NF services applicable to services through December 31 of the cost reporting period reporting period (line for swing-bed NF services applicable to services after December 31 of the cost (line 21 minus line 26) (line 27 minus line 28) (line 27 minus line 28) (line 29 minus line 28) (line 29 minus line 28) (line 23 minus line 28) (line 29 minus line 28) (line 24 minus line 28) (line 29 minus line 30) (line 27 minus line 36) (line 3 must line 38) (line 34 minus line 39) (line 37 minus line 39) (line 39 minus li		reporting period				
19. 00   Medical d rate for swing-bed NF services applicable to services through December 31 of the cost reporting period   20. 00   20.	18.00	Medicare rate for swing-bed SNF services applicable to service	es after December 31 of	the cost		18. 00
reporting period  20. 00 Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period  21. 00 Total general inpatient routine service cost (see instructions)  22. 00 Swing-bed cost applicable to SNF type services through December 31 of the cost reporting period (line 5 x line 17)  23. 00 Swing-bed cost applicable to SNF type services after December 31 of the cost reporting period (line 6 0 23. 00 x line 18)  24. 00 Swing-bed cost applicable to NF type services through December 31 of the cost reporting period (line 6 0 24. 00 x line 18)  25. 00 Swing-bed cost applicable to NF type services through December 31 of the cost reporting period (line 8 0 25. 00 x line 29)  26. 00 Total swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8 0 25. 00 x line 20)  26. 00 Total swing-bed cost (see instructions)  27. 00 Total swing-bed cost (see instructions)  28. 00 Total swing-bed cost (see instructions)  29. 00 Total swing-bed cost (see instructions)  20. 00 Total swing-bed cost (see ins						
20. 00 Medical drate for swing-bed NF services applicable to services after December 31 of the cost reporting period (1 of 10 tal general inpatient routine service cost (see instructions) (2 of 10 tal general inpatient routine service cost (see instructions) (2 of 10 tal general inpatient routine services through December 31 of the cost reporting period (line 5 of 11 of 11 of 12 of 10 tal general inpatient routine services after December 31 of the cost reporting period (line 6 of 12 of 10 of 11 of 11 of 12 of 1	19. 00		0.00	19. 00		
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21.00   Total general inpatient routine service cost (see instructions)   21.00   Swing-bed cost applicable to SNF type services through December 31 of the cost reporting period (line 5 x line 17)   22.00   Swing-bed cost applicable to SNF type services after December 31 of the cost reporting period (line 6 x line 18)   24.00   Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 6 x line 18)   24.00   Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 7 x line 19)   24.00   25.00   Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8 x line 20)   25.00   Swing-bed cost (see instructions)   1,076,467   26.00   27.0	20. 00		s after December 31 of t	ne cost	0.00	20.00
22.00   Swing-bed cost applicable to SNF type services through December 31 of the cost reporting period (line 5 x line 17)   23.00   Swing-bed cost applicable to SNF type services after December 31 of the cost reporting period (line 6 x line 18)   24.00   Swing-bed cost applicable to NF type services through December 31 of the cost reporting period (line 6 x line 19)   25.00   Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8 x line 20)   26.00   Total swing-bed cost (see instructions)   1,076,467   26.00   Total swing-bed cost (see instructions)   1,076,467   27.00   General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)   6,232,644   27.00   PRIVATE ROMD DIFFERENTIAL ADJUSTMENT   0   28.00   Semi-private room charges (excluding swing-bed and observation bed charges)   0   29,00   30.00   Semi-private room charges (excluding swing-bed charges)   0   29,00   31.00   General inpatient routine service cost/charge ratio (line 27 + line 28)   0   0,000000   31.00   General inpatient routine service cost/charge ratio (line 27 + line 28)   0   0,000000   31.00   Average private room per diem charge (line 29 + line 3)   0   0,000000   32.00   Average per diem private room cost differential (line 30 + line 4)   0   0,000   33.00   Average per diem private room cost differential (line 34 x line 31)   0   0,000   35.00   Average per diem private room cost differential (line 34 x line 31)   0   0,000   37.00   O   Private room cost differential (line 3 x line 35)   0   0,000   38.00   Average per diem private room cost differential (line 3 x line 35)   0   0,000   37.00   O   Private room cost differential (line 3 x line 35)   0   0,000   38.00   Average per diem private room cost differential (line 3 x line 35)   0   0,000   38.00   Private room cost differential (line 3 x line 35)   0   0,000   38.00   O   Private room cost differential (line 3 x line 35)   0   0,000   38.00   O   O   O   O   O   O   O   O   O	04 00	, , , , , , , , , , , , , , , , , , , ,	`		7 000 444	04 00
5 x line 17) Swing-bed cost applicable to SNF type services after December 31 of the cost reporting period (line 6 x line 18)  24.00 Swing-bed cost applicable to NF type services through December 31 of the cost reporting period (line 7 x line 19)  25.00 Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8 x line 20)  26.00 Total swing-bed cost (see instructions) Ceneral inpatient routine service cost net of swing-bed cost (line 21 minus line 26) PRIVATE ROOM DIFFERENTIAL ADJUSTMENT  28.00 Ceneral inpatient routine service charges (excluding swing-bed and observation bed charges) Ceneral inpatient routine service charges (excluding swing-bed charges) Ceneral inpatient routine service charges (excluding swing-bed charges) Ceneral inpatient routine service charges (excluding swing-bed charges) Ceneral inpatient routine service cost. (line 27 * line 28) Ceneral inpatient routine service cost. (line 29 * line 3) Ceneral inpatient routine service cost. (line 29 * line 3) Ceneral inpatient routine service cost. (line 29 * line 3) Ceneral inpatient routine service cost. (line 29 * line 3) Ceneral inpatient routine service cost. (line 29 * line 3) Ceneral inpatient routine service cost. (line 34 * line 31) Ceneral inpatient routine service cost. (line 34 * line 31) Ceneral inpatient routine service cost. (line 34 * line 31) Ceneral inpatient routine service cost. (line 34 * line 31) Ceneral inpatient routine service cost. (line 34 * line 31) Ceneral inpatient routine service cost. (line 34 * line 31) Ceneral inpatient routine service cost. (line 34 * line 31) Ceneral inpatient routine service cost. (line 34 * line 31) Ceneral inpatient routine service cost. (line 34 * line 31) Ceneral inpatient routine service cost. (line 34 * line 31) Ceneral inpatient routine service cost. (line 34 * line 31) Ceneral inpatient routine service cost. (line 34 * line 31) Ceneral inpatient routine service cost. (line 34 * line 31) Ceneral inpatient routine service cost. (line 34 * line 35) C						
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x line 18)  24.00 Swing-bed cost applicable to NF type services through December 31 of the cost reporting period (line 7 x line 19)  25.00 Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8 x line 20)  26.00 Total swing-bed cost (see instructions)  27.00 General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)  28.00 General inpatient routine service cost net of swing-bed and observation bed charges)  29.00 Private room charges (excluding swing-bed charges)  30.00 Semi-private room charges (excluding swing-bed charges)  30.00 Semi-private room charges (excluding swing-bed charges)  30.00 Average private room per diem charge (line 29 + line 3)  30.00 Average per diem private room per diem charge (line 30 + line 4)  31.00 Average per diem private room cost differential (line 32 minus line 33) (see instructions)  32.00 Average per diem private room cost differential (line 34 x line 31)  33.00 Private room cost differential all (line 34 x line 31)  34.00 Average per diem private room cost net of swing-bed cost and private room cost differential (line 6, 232, 644)  35.00 Average per diem private room cost net of swing-bed cost and private room cost differential (line 6, 232, 644)  36.00 Private room cost differential service cost net of swing-bed cost and private room cost differential (line 6, 232, 644)  37.00 General inpatient routine service cost net of swing-bed cost and private room cost differential (line 6, 232, 644)  38.00 Adjusted general inpatient routine service cost per diem (see instructions)  38.00 Adjusted general inpatient routine service cost per diem (see instructions)  38.00 Program general inpatient routine service cost (line 9 x line 38)  40.00 Medically necessary private room cost applicable to the Program (line 14 x line 35)  40.00 Medically necessary private room cost applicable to the Program (line 14 x line 35)	22 00	l	21 of the cost reporting	a ported (line 4	, l	22.00
24.00 Swing-bed cost applicable to NF type services through December 31 of the cost reporting period (line 7 x line 19) 25.00 Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8 0 25.00 x line 20) 26.00 Total swing-bed cost (see instructions) 27.00 General inpatient routine service cost net of swing-bed cost (line 21 minus line 26) 28.00 PRIVATE ROOM DIFFERENTIAL ADJUSTMENT 28.00 General inpatient routine service charges (excluding swing-bed and observation bed charges) 29.00 Private room charges (excluding swing-bed charges) 30.00 Semi-private room charges (excluding swing-bed charges) 31.00 General inpatient routine service cost/charge ratio (line 27 ÷ line 28) 32.00 Average periote room per diem charge (line 29 ÷ line 3) 33.00 Average semi-private room per diem charge (line 30 ÷ line 4) 34.00 Average per diem private room charge differential (line 32 minus line 33)(see instructions) 35.00 Average per diem private room cost differential (line 3 x line 31) 36.00 Private room cost differential dijustment (line 3 x line 35) 37.00 General inpatient routine service cost net of swing-bed cost and private room cost differential (line 3 x line 35) 38.00 Agiusted general inpatient routine service cost per diem (see instructions) 38.00 Adjusted general inpatient routine service cost per diem (see instructions) 38.00 Adjusted general inpatient routine service cost per diem (see instructions) 38.00 Medically necessary private room cost applicable to the Program (line 14 x line 35) 40.00 Medically necessary private room cost applicable to the Program (line 14 x line 35) 40.00 Average general inpatient routine service cost applicable to the Program (line 14 x line 35) 40.00 Average general inpatient routine service cost applicable to the Program (line 14 x line 35) 40.00 Average semi-private room cost applicable to the Program (line 14 x line 35) 40.00 Average semi-private room cost applicable to the Program (line 14 x line 35)	23.00		31 of the cost reporting	g period (iiile o	ا	23.00
7 x line 19)  25.00  26.00  26.00  7 x line 20)  27.00  28.00  29.00  29.00  20	24 00		21 of the cost reportion	na period (line	ا م ا	24 00
25.00   Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8 x line 20)   x line 20)   25.00   x line 20)   1,076,467   26.00   27.00   General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)   6,232,644   27.00   PRI VATE ROOM DIFFERENTIAL ADJUSTMENT   28.00   General inpatient routine service charges (excluding swing-bed and observation bed charges)   0 29.00   28.00   Pri vate room charges (excluding swing-bed charges)   0 29.00   30.00   Semi-private room charges (excluding swing-bed charges)   0 29.00   31.00   General inpatient routine service cost/charge ratio (line 27 ÷ line 28)   0.000000   31.00   32.00   33.00   Average private room per diem charge (line 29 ÷ line 3)   0.000000   33.00   33.00   Average semi-private room per diem charge (line 30 ÷ line 4)   0.00   33.00   34.00   Average per diem private room cost differential (line 32 x line 31)   0.00   35.00   36.00   Private room cost differential adjustment (line 34 x line 31)   0.00   35.00   37.00   General inpatient routine service cost net of swing-bed cost and private room cost differential (line 4, 27 minus line 36)   2, 174,68   38.00   Adjusted general inpatient routine service cost (line 9 x line 38)   58,716   39.00   40.00   Medically necessary private room cost diplicable to the Program (line 14 x line 35)   0 40.00   40.0	24.00		31 of the cost reporting	ig period (Title	ا	24.00
x line 20)  26. 00 Total swing-bed cost (see instructions) Ceneral inpatient routine service cost net of swing-bed cost (line 21 minus line 26) PRI VATE ROOM DIFFERENTIAL ADJUSTMENT  28. 00 General inpatient routine service charges (excluding swing-bed and observation bed charges) Ceneral inpatient routine service charges (excluding swing-bed and observation bed charges) Ceneral inpatient routine service charges (excluding swing-bed charges) Ceneral inpatient routine service cost/charge ratio (line 27 ÷ line 28) Ceneral inpatient routine service cost/charge ratio (line 27 ÷ line 28) Ceneral inpatient routine service cost/charge ratio (line 27 ÷ line 28) Ceneral inpatient routine service cost/charge ratio (line 30 ÷ line 4) Ceneral inpatient routine service cost differential (line 30 ÷ line 4) Ceneral inpatient routine service cost differential (line 32 minus line 33) (see instructions) Ceneral inpatient routine service cost differential (line 34 x line 31) Ceneral inpatient routine service cost net of swing-bed cost and private room cost differential (line 6, 232, 644) Ceneral inpatient routine service cost net of swing-bed cost and private room cost differential (line 6, 232, 644) Ceneral inpatient routine service cost net of swing-bed cost and private room cost differential (line 6, 232, 644) Ceneral inpatient routine service cost net of swing-bed cost and private room cost differential (line 6, 232, 644) Ceneral inpatient routine service cost per diem (see instructions) Ceneral inpatient routine service cost per diem (see instructions) Ceneral inpatient routine service cost per diem (see instructions) Ceneral inpatient routine service cost per diem (see instructions) Ceneral inpatient routine service cost per diem (see instructions) Ceneral inpatient routine service cost per diem (see instructions) Ceneral inpatient routine service cost per diem (see instructions) Ceneral inpatient routine service cost per diem charges Ceneral inpatient routine service cost per diem charges Ceneral inpatient routine service	25 00		31 of the cost reporting	period (line 8	0	25 00
Total swing-bed cost (see instructions)  27.00 General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)  28.00 General inpatient routine service charges (excluding swing-bed and observation bed charges)  29.00 Private room charges (excluding swing-bed charges)  30.00 General inpatient routine service charges (excluding swing-bed charges)  30.00 General inpatient routine service cost/charge ratio (line 27 ÷ line 28)  30.00 Average private room per diem charge (line 29 ÷ line 3)  30.00 Average semi-private room per diem charge (line 30 ÷ line 4)  Average per diem private room cost differential (line 32 minus line 33)(see instructions)  30.00 Average per diem private room cost differential (line 34 x line 31)  30.00 General inpatient routine service cost net of swing-bed cost and private room cost differential (line 27 minus line 36)  PART II - HOSPITAL AND SUBPROVI DERS ONLY PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS  38.00 Adjusted general inpatient routine service cost (line 9 x line 38)  Medically necessary private room cost applicable to the Program (line 14 x line 35)  1, 076, 467 6, 232, 644 27.00 28.00 29.00 20	20.00		or an and dear raper ring	po ou ( o	ا	20.00
27. 00   General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)   6, 232, 644   PRI VATE ROOM DIFFERENTIAL ADJUSTMENT   28. 00   General inpatient routine service charges (excluding swing-bed and observation bed charges)   0   28. 00   29. 00   29. 00   29. 00   29. 00   30. 00   Semi-private room charges (excluding swing-bed charges)   0   29. 00   30. 00	26.00				1, 076, 467	26. 00
PRI VATE ROOM DIFFERENTIAL ADJUSTMENT  28.00 General inpatient routine service charges (excluding swing-bed and observation bed charges)  29.00 Pri vate room charges (excluding swing-bed charges)  30.00 Semi-pri vate room charges (excluding swing-bed charges)  31.00 General inpatient routine service cost/charge ratio (line 27 ÷ line 28)  32.00 Average pri vate room per diem charge (line 29 ÷ line 3)  33.00 Average semi-pri vate room per diem charge (line 30 ÷ line 4)  34.00 Average per diem pri vate room charge differential (line 32 minus line 33) (see instructions)  35.00 Average per diem pri vate room cost differential (line 34 x line 31)  36.00 Pri vate room cost differential (line 3 x line 35)  37.00 General inpatient routine service cost net of swing-bed cost and pri vate room cost differential (line 6, 232, 644 27 minus line 36)  PART II - HOSPITAL AND SUBPROVIDERS ONLY  PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS  38.00 Adjusted general inpatient routine service cost per diem (see instructions)  39.00 Program general inpatient routine service cost (line 9 x line 38)  58,716 39.00  40.00 Medically necessary pri vate room cost applicable to the Program (line 14 x line 35)  0 28.00  28.00  29.00  20.00  20.00  30			(line 21 minus line 26)			1
28. 00 29. 00 29. 00 29. 00 30			,			
30.00 Semi-private room charges (excluding swing-bed charges) 31.00 General inpatient routine service cost/charge ratio (line 27 ÷ line 28) 32.00 Average private room per diem charge (line 29 ÷ line 3) 33.00 Average semi-private room per diem charge (line 30 ÷ line 4) 34.00 Average per diem private room charge differential (line 32 minus line 33)(see instructions) 35.00 Average per diem private room cost differential (line 34 x line 31) 36.00 Private room cost differential adjustment (line 3 x line 35) 37.00 General inpatient routine service cost net of swing-bed cost and private room cost differential (line 6, 232, 644)  37.00 PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS  38.00 Adjusted general inpatient routine service cost (line 9 x line 38)  9 Program general inpatient routine service cost (line 9 x line 38)  10 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	28. 00		d and observation bed ch	arges)	0	28. 00
31.00 General inpatient routine service cost/charge ratio (line 27 ÷ line 28)  32.00 Average private room per diem charge (line 29 ÷ line 3)  32.00 Average semi-private room per diem charge (line 30 ÷ line 4)  34.00 Average per diem private room cost differential (line 32 minus line 33)(see instructions)  35.00 Average per diem private room cost differential (line 34 x line 31)  36.00 Private room cost differential adjustment (line 3 x line 35)  37.00 General inpatient routine service cost net of swing-bed cost and private room cost differential (line 6, 232, 644)  37.00 PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS  Adjusted general inpatient routine service cost per diem (see instructions)  38.00 Program general inpatient routine service cost (line 9 x line 38)  58.716 39.00 Medically necessary private room cost applicable to the Program (line 14 x line 35)  0.0000000000000000000000000000000000	29.00	Private room charges (excluding swing-bed charges)			0	29. 00
32.00 Average private room per diem charge (line 29 ÷ line 3) 32.00 Average semi-private room per diem charge (line 30 ÷ line 4) 33.00 Average semi-private room per diem charge (line 30 ÷ line 4) 34.00 Average per diem private room charge differential (line 32 minus line 33) (see instructions) 35.00 Average per diem private room cost differential (line 34 x line 31) 36.00 Private room cost differential adjustment (line 3 x line 35) 37.00 General inpatient routine service cost net of swing-bed cost and private room cost differential (line 6, 232, 644) 37.00 PART II - HOSPITAL AND SUBPROVIDERS ONLY PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS 38.00 Adjusted general inpatient routine service cost (line 9 x line 38) 39.00 Medically necessary private room cost applicable to the Program (line 14 x line 35) 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	30.00	Semi-private room charges (excluding swing-bed charges)			0	30.00
33.00 Average semi-private room per diem charge (line 30 ÷ line 4)  34.00 Average per diem private room charge differential (line 32 minus line 33) (see instructions)  35.00 Average per diem private room cost differential (line 34 x line 31)  36.00 Private room cost differential adjustment (line 3 x line 35)  37.00 General inpatient routine service cost net of swing-bed cost and private room cost differential (line 6, 232, 644)  27 minus line 36)  PART II - HOSPITAL AND SUBPROVIDERS ONLY  PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS  38.00 Adjusted general inpatient routine service cost (line 9 x line 38)  Program general inpatient routine service cost (line 9 x line 38)  Medically necessary private room cost applicable to the Program (line 14 x line 35)  0.00 33.00  0.00 34.00  36.00 35.00  36.00  37.00 Eneral inpatient routine service cost per diem (see instructions)  2, 174.68 38.00  39.00 Medically necessary private room cost applicable to the Program (line 14 x line 35)  0.00 40.00	31.00	General inpatient routine service cost/charge ratio (line 27	: line 28)		0.000000	31.00
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 Average per diem private room cost differential (line 34 x line 31)  36. 00 Private room cost differential adjustment (line 3 x line 35)  37. 00 General inpatient routine service cost net of swing-bed cost and private room cost differential (line 6, 232, 644)  Adjusted general inpatient routine service cost per diem (see instructions)  38. 00 Program general inpatient routine service cost (line 9 x line 38)  40. 00 Medically necessary private room cost applicable to the Program (line 14 x line 35)  0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	32.00	Average private room per diem charge (line 29 ÷ line 3)			0.00	32. 00
35.00 Average per diem private room cost differential (line 34 x line 31)  36.00 Private room cost differential adjustment (line 3 x line 35)  37.00 General inpatient routine service cost net of swing-bed cost and private room cost differential (line 6, 232, 644 27 minus line 36)  PART II - HOSPITAL AND SUBPROVIDERS ONLY  PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS  38.00 Adjusted general inpatient routine service cost per diem (see instructions)  Program general inpatient routine service cost (line 9 x line 38)  40.00 Medically necessary private room cost applicable to the Program (line 14 x line 35)  0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	33.00	Average semi-private room per diem charge (line 30 ÷ line 4)	0.00	33. 00		
36.00 Private room cost differential adjustment (line 3 x line 35)  37.00 General inpatient routine service cost net of swing-bed cost and private room cost differential (line 6, 232, 644 37.00 PART II - HOSPITAL AND SUBPROVIDERS ONLY PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS  38.00 Adjusted general inpatient routine service cost per diem (see instructions)  39.00 Program general inpatient routine service cost (line 9 x line 38)  40.00 Medically necessary private room cost applicable to the Program (line 14 x line 35)  36.00 6, 232, 644 77.00	34.00	Average per diem private room charge differential (line 32 min	0.00	34.00		
37.00 General inpatient routine service cost net of swing-bed cost and private room cost differential (line 6, 232, 644 27 minus line 36)  PART II - HOSPITAL AND SUBPROVIDERS ONLY  PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS  Adjusted general inpatient routine service cost per diem (see instructions)  Program general inpatient routine service cost (line 9 x line 38)  40.00 Medically necessary private room cost applicable to the Program (line 14 x line 35)  37.00  6, 232, 644  37.00  8, 232, 644  37.00  9, 232, 644  37.00  10, 232, 644  10, 232,	35.00	Average per diem private room cost differential (line 34 x li	0.00	35. 00		
27 minus line 36) PART II - HOSPITAL AND SUBPROVIDERS ONLY PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS  38.00 Adjusted general inpatient routine service cost per diem (see instructions) 2, 174.68 38.00 39.00 Program general inpatient routine service cost (line 9 x line 38) 58, 716 39.00 40.00 Medically necessary private room cost applicable to the Program (line 14 x line 35) 0 40.00						•
PART II - HOSPITAL AND SUBPROVIDERS ONLY PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS  38.00 Adjusted general inpatient routine service cost per diem (see instructions)  2, 174.68 38.00  39.00 Program general inpatient routine service cost (line 9 x line 38)  58, 716 39.00  40.00 Medically necessary private room cost applicable to the Program (line 14 x line 35)  0 40.00	37.00		and private room cost di	fferential (line	6, 232, 644	37. 00
PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS  38.00 Adjusted general inpatient routine service cost per diem (see instructions)  2, 174.68 38.00  39.00 Program general inpatient routine service cost (line 9 x line 38)  58,716 39.00  40.00 Medically necessary private room cost applicable to the Program (line 14 x line 35)  0 40.00						
38.00 Adjusted general inpatient routine service cost per diem (see instructions)  2, 174.68 38.00  39.00 Program general inpatient routine service cost (line 9 x line 38)  58,716 39.00  40.00 Medically necessary private room cost applicable to the Program (line 14 x line 35)  0 40.00						
39.00 Program general inpatient routine service cost (line 9 x line 38) 40.00 Medically necessary private room cost applicable to the Program (line 14 x line 35) 58,716 39.00 40.00						
40.00 Medically necessary private room cost applicable to the Program (line 14 x line 35) 0 40.00						ı
		9 9	•			1
41. 00   Total Program general impatient routine service cost (Tine 39 + Tine 40)		, , , , , , , , , , , , , , , , , , , ,	*			1
	41.00	liotal Program general inpatient routine service cost (line 39	+ iine 40)		58, /16	41.00

<u>H</u> eal th	Financial Systems UNION HOSPITAL CLINTON In L	ieu of Form CMS-2	<u>255</u> 2-10
COMPUT	FATION OF INPATIENT OPERATING COST Provider CCN: 15-1326 Period: From 01/01/20.	Worksheet D-1	
	To 12/31/20.	21 Date/Time Pre	
	Title XIX Hospital	5/26/2022 10: S Cost	oz allı
	Cost Center Description Total Total Average Per Program Day		
	Inpati ent Cost   Inpati ent Days   Di em (col. 1 ÷   col. 2)	(col. 3 x col. 4)	
40.00	1.00 2.00 3.00 4.00	5. 00	40.00
42.00	NURSERY (title V & XIX only) Intensive Care Type Inpatient Hospital Units		42. 00
43.00	INTENSIVE CARE UNIT 0 0 0.00	0 0	43. 00
44.00	CORONARY CARE UNIT BURN INTENSIVE CARE UNIT		44. 00 45. 00
46. 00			46. 00
47. 00	OTHER SPECIAL CARE (SPECIFY)		47. 00
	Cost Center Description	1. 00	
48. 00		33, 505	
49. 00	Total Program inpatient costs (sum of lines 41 through 48)(see instructions)  PASS THROUGH COST ADJUSTMENTS	92, 221	49. 00
50.00	Pass through costs applicable to Program inpatient routine services (from Wkst. D, sum of Parts I ar	nd 0	50. 00
51. 00	III   Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II	0	51. 00
01.00	and IV)		
52. 00 53. 00	Total Program excludable cost (sum of lines 50 and 51) Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and	0	52. 00 53. 00
55.00	medical education costs (line 49 minus line 52)		55.00
E4 00	TARGET AMOUNT AND LIMIT COMPUTATION Program discharges	0	54. 00
55.00		0.00	
56.00		0	56.00
57. 00 58. 00		0	57. 00 58. 00
59. 00	Lesser of lines 53/54 or 55 from the cost reporting period ending 1996, updated and compounded by the		
60. 00	market basket Lesser of lines 53/54 or 55 from prior year cost report, updated by the market basket	0.00	60. 00
61. 00		0	61. 00
62. 00	0		
63. 00	0	63. 00	
64.00	PROGRAM INPATIENT ROUTINE SWING BED COST  Medicare swing-bed SNF inpatient routine costs through December 31 of the cost reporting period (See	9 0	64. 00
65. 00	instructions)(title XVIII only) Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (See	0	65. 00
	instructions)(title XVIII only)		
66. 00	Total Medicare swing-bed SNF inpatient routine costs (line 64 plus line 65)(title XVIII only). For CAH (see instructions)	0	66. 00
67. 00	Title V or XIX swing-bed NF inpatient routine costs through December 31 of the cost reporting period	0	67. 00
68. 00	(line 12 x line 19) Title V or XIX swing-bed NF inpatient routine costs after December 31 of the cost reporting period	0	68. 00
	(line 13 x line 20)		
69. 00	Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68)  PART III - SKILLED NURSING FACILITY, OTHER NURSING FACILITY, AND ICF/IID ONLY	0	69. 00
70. 00	Skilled nursing facility/other nursing facility/ICF/IID routine service cost (line 37)		70. 00
71. 00 72. 00			71. 00 72. 00
73. 00	Medically necessary private room cost applicable to Program (line 14 x line 35)		73. 00
74. 00 75. 00	Total Program general inpatient routine service costs (line 72 + line 73)		74. 00 75. 00
75.00	Capital-related cost allocated to inpatient routine service costs (from Worksheet B, Part II, column 26, line 45)	1	75.00
76.00			76.00
77. 00 78. 00			77. 00 78. 00
79. 00	Aggregate charges to beneficiaries for excess costs (from provider records)		79. 00
80. 00 81. 00	Total Program routine service costs for comparison to the cost limitation (line 78 minus line 79) Inpatient routine service cost per diem limitation	-	80. 00 81. 00
82. 00	Inpatient routine service cost limitation (line 9 x line 81)		82. 00
83. 00 84. 00	Reasonable inpatient routine service costs (see instructions)  Program inpatient ancillary services (see instructions)		83. 00 84. 00
85. 00			85. 00
86. 00	Total Program inpatient operating costs (sum of lines 83 through 85) PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST		86. 00
87. 00		890	87. 00
88.00		2, 174. 68	
07.00	Observation bed cost (line 87 x line 88) (see instructions)	1, 935, 465	07.00

Health Financial Systems	UNI ON HOSPITA	AL CLINTON		In Lie	u of Form CMS-2	2552-10
COMPUTATION OF INPATIENT OPERATING COST		Provi der CC		Peri od:	Worksheet D-1	
				From 01/01/2021 To 12/31/2021	Date/Time Prep 5/26/2022 10:	
		Ti tl	e XIX	Hospi tal	Cost	
Cost Center Description	Cost	Routine Cost	column 1 ÷	Total	Observation	
		(from line 21)	column 2	Observati on	Bed Pass	
				Bed Cost (from	Through Cost	
				line 89)	(col. 3 x 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	569, 534	7, 309, 111	0. 07792	1 1, 935, 465	150, 813	90.00
91.00 Nursing Program cost	0	7, 309, 111	0.00000	0 1, 935, 465	0	91.00
92.00 Allied health cost	0	7, 309, 111	0.00000	0 1, 935, 465	0	92.00
93.00 All other Medical Education	0	7, 309, 111	0.00000	0 1, 935, 465	0	93.00

	nncial Systems UNION HOSPITAL C ANCILLARY SERVICE COST APPORTIONMENT		CN: 15-1326	Peri od:	u of Form CMS-2 Worksheet D-3	
INPAILENI /	ANCILLARY SERVICE COST APPORTIONMENT	Provider C		From 01/01/2021	WOLKSHEET D-3	
				To 12/31/2021	Date/Time Pre	
					5/26/2022 10:	<u>52 am</u>
		Title	XVIII	Hospi tal	Cost	
	Cost Center Description		Ratio of Cos		Inpatient	
			To Charges	Program	Program Costs	
				Charges	(col. 1 x col. 2)	
			1.00	2. 00	3. 00	
ΙΝΡΔ	TIENT ROUTINE SERVICE COST CENTERS		1.00	2.00	3.00	
	O ADULTS & PEDIATRICS			1, 707, 840		30.00
	O INTENSIVE CARE UNIT			1, 707, 010		31. 00
	LLARY SERVICE COST CENTERS		I.			1
	O OPERATING ROOM		0. 42750	67, 982	29, 063	50.00
51.00 0510	O RECOVERY ROOM		0. 33846	7, 125	2, 412	51.00
51. 01 0510	10/P TREATMENT ROOM		0. 00000	00	0	51. 01
54.00 0540	O RADI OLOGY-DI AGNOSTI C		0. 13105	138, 519	18, 154	54.00
	O RADI OI SOTOPE		0. 22255	5, 278	1, 175	56.00
	O LABORATORY		0. 13774		74, 589	
	WHOLE BLOOD & PACKED RED BLOOD CELLS		1. 06930			
	O RESPI RATORY THERAPY		0. 34201		88, 898	
	O PHYSI CAL THERAPY		0. 51664		28, 713	
	O OCCUPATI ONAL THERAPY		0. 64035		14, 220	
	O SPEECH PATHOLOGY		0. 87511	· ·		
	O ELECTROCARDI OLOGY		0. 21613		20, 867	
	MEDICAL SUPPLIES CHARGED TO PATIENTS		0.00000		0	1
	O IMPL. DEV. CHARGED TO PATIENTS		0. 46187		100 (22	
	ODRUGS CHARGED TO PATIENTS ATIENT SERVICE COST CENTERS		0. 30245	660, 014	199, 623	73. 00
	O CLINIC		0.00000	00	0	90.00
	O EMERGENCY		0.00000		1, 757	
	O OBSERVATION BEDS (NON-DISTINCT PART)		1. 35995		1,757	1
200.00	Total (sum of lines 50 through 94 and 96 through 98)		1. 33993	1, 868, 534	486, 596	
201.00	Less PBP Clinic Laboratory Services-Program only charges	(Line 61)		1,000,004		201.00
202. 00	Net charges (line 200 minus line 201)	(1110 01)	I	1, 868, 534		202. 00

Health Fina	ncial Systems UNION HOSPITAL C	NOTALI		In lie	eu of Form CMS-:	2552_10
		Provider C	CN: 15-1326	Peri od:	Worksheet D-3	
		Component	CCN: 15-Z326	From 01/01/2021 To 12/31/2021	Date/Time Pre 5/26/2022 10:	
		Title		Swing Beds - SNF		
	Cost Center Description		Ratio of Cos	10.00	I npati ent	
			To Charges	Program	Program Costs	
				Charges	(col. 1 x col.	
					2)	
LNDA	THENT POUTLING CERVILOG COCT CENTERS		1. 00	2. 00	3. 00	
	TIENT ROUTINE SERVICE COST CENTERS		1			20.00
	O ADULTS & PEDIATRICS O INTENSIVE CARE UNIT					30. 00 31. 00
	LLARY SERVICE COST CENTERS					31.00
	O OPERATING ROOM		0. 42750	1, 083	463	50.00
	O RECOVERY ROOM		0. 33846		0	51.00
	1 O/P TREATMENT ROOM		0. 00000		0	51.00
	O RADI OLOGY-DI AGNOSTI C		0. 1310		1	
	O RADI OI SOTOPE		0. 2225!		0	56.00
1	O LABORATORY		0. 13774		8, 714	60.00
62. 00 0620	O WHOLE BLOOD & PACKED RED BLOOD CELLS		1. 06930	882	943	62.00
65. 00 0650	O RESPI RATORY THERAPY		0. 3420	96, 983	33, 169	65. 00
66. 00 0660	O PHYSI CAL THERAPY		0. 51664	110, 533	57, 106	66.00
67. 00 0670	O OCCUPATIONAL THERAPY		0. 6403	68, 290	43, 730	67. 00
	O SPEECH PATHOLOGY		0. 8751		3, 624	
	0 ELECTROCARDI OLOGY		0. 21613		719	
	O MEDICAL SUPPLIES CHARGED TO PATIENTS		0. 00000		0	
	O IMPL. DEV. CHARGED TO PATIENTS		0. 46187		0	72. 00
	O DRUGS CHARGED TO PATIENTS		0. 3024	53 44, 925	13, 588	73. 00
	ATIENT SERVICE COST CENTERS			1	_	
90. 00 0900			0. 00000		ľ	
	O EMERGENCY		0. 29118		0	
	O OBSERVATION BEDS (NON-DISTINCT PART)		1. 3599		0	
200.00	Total (sum of lines 50 through 94 and 96 through 98)	(Line (1)		417, 227	165, 175	200.00
201. 00 202. 00	Less PBP Clinic Laboratory Services-Program only charges Net charges (line 200 minus line 201)	(Tine 61)		417 227		201.00
202.00	Thet charges (Title 200 millius Title 201)		I	417, 227	I	1202.00

Health Financial Systems UNION HOSPITAL	CLINTON		In Li∈	eu of Form CMS-	2552-10
INPATIENT ANCILLARY SERVICE COST APPORTIONMENT	Provi der C	CN: 15-1326	Peri od:	Worksheet D-3	
			From 01/01/2021 To 12/31/2021	Date/Time Pre 5/26/2022 10:	
	Titl	e XIX	Hospi tal	Cost	
Cost Center Description		Ratio of Cos		I npati ent	
		To Charges	Program	Program Costs	
			Charges	(col. 1 x col.	
		1.00	0.00	2)	
LADATI DALTI DOUTI NE CEDIU CE COCT CENTEDO		1.00	2. 00	3. 00	
I NPATI ENT ROUTI NE SERVI CE COST CENTERS		1	(0.715		20.00
30. 00   03000   ADULTS & PEDI ATRI CS			62, 715	l .	30.00
31.00 O3100 INTENSIVE CARE UNIT ANCILLARY SERVICE COST CENTERS			0		31. 00
50, 00 05000 OPERATING ROOM		0. 42750	06 18, 043	7, 713	50.00
51. 00   05100   RECOVERY ROOM		0. 3384		1, 7, 713	
51. 01   05100   RECOVERT ROOM 51. 01   05101   0/P   TREATMENT ROOM		0. 00000		0	
54. 00   05400   RADI OLOGY - DI AGNOSTI C		0. 1310			54.00
56. 00   05600   RADI OI SOTOPE		0. 2225!		0,001	56.00
60. 00   06000   LABORATORY		0. 1377			
62.00 06200 WHOLE BLOOD & PACKED RED BLOOD CELLS		1. 06930			62.00
65. 00 06500 RESPIRATORY THERAPY		0. 3420		3, 747	
66. 00 06600 PHYSI CAL THERAPY		0. 5166		463	1
67. 00 06700 OCCUPATI ONAL THERAPY		0. 6403!		0	
68. 00   06800   SPEECH PATHOLOGY		0. 8751		0	68. 00
69. 00 06900 ELECTROCARDI OLOGY		0. 2161:	38 5, 416	1, 171	69. 00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS		0.0000	00	0	71. 00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS		0. 4618	79 0	0	72. 00
73.00 07300 DRUGS CHARGED TO PATIENTS		0. 3024	53 0	0	73. 00
OUTPATIENT SERVICE COST CENTERS					
90. 00   09000   CLI NI C		0.00000			
91. 00   09100   EMERGENCY		0. 29118		9, 926	91.00
92.00 O9200 OBSERVATION BEDS (NON-DISTINCT PART)		1. 3599		0	, 2. 00
200.00 Total (sum of lines 50 through 94 and 96 through 98)			144, 529	33, 505	200. 00
201.00 Less PBP Clinic Laboratory Services-Program only charges	s (line 61)		0		201. 00
202.00 Net charges (line 200 minus line 201)		l	144, 529		202. 00

Health Financial Systems UNION HOSPITAL (	CLINTON		ln lie	u of Form CMS-	2552-10
INPATIENT ANCILLARY SERVICE COST APPORTIONMENT	Provi der C	CN: 15-1326	Peri od:	Worksheet D-3	
		CCN: 15-Z326	From 01/01/2021 To 12/31/2021	Date/Time Pre 5/26/2022 10:	pared:
	Ti tl		Swing Beds - SNF		
Cost Center Description		Ratio of Cos		I npati ent	
		To Charges	Program	Program Costs	
			Charges	(col. 1 x col.	
		1.00	0.00	2)	
INDATIONE CONTINUE CO		1.00	2. 00	3. 00	
I NPATI ENT ROUTI NE SERVI CE COST CENTERS		1			20.00
30. 00   03000   ADULTS & PEDI ATRI CS 31. 00   03100   I NTENSI VE CARE UNI T					30. 00 31. 00
ANCI LLARY SERVI CE COST CENTERS					31.00
50, 00 05000 OPERATING ROOM		0. 42750	06 0	0	50.00
51. 00   05100   RECOVERY ROOM		0. 33846		0	
51. 01   05101   0/P   TREATMENT   ROOM		0.0000		0	
54. 00   05400   RADI OLOGY-DI AGNOSTI C		0. 1310		0	
56. 00   05600   RADI OI SOTOPE		0. 2225!		0	
60. 00   06000   LABORATORY		0. 13774		0	
62.00 06200 WHOLE BLOOD & PACKED RED BLOOD CELLS		1. 06930		0	
65. 00 06500 RESPIRATORY THERAPY		0. 3420		0	65.00
66. 00 06600 PHYSI CAL THERAPY		0. 51664	12 0	0	66. 00
67. 00 06700 OCCUPATI ONAL THERAPY		0. 6403	58 0	0	67. 00
68. 00 06800 SPEECH PATHOLOGY		0. 8751 <sup>2</sup>	18 0	0	68. 00
69. 00 06900 ELECTROCARDI OLOGY		0. 21613	38 0	0	69. 00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS		0.00000	00	0	71. 00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS		0. 46187		0	72. 00
73.00 O7300 DRUGS CHARGED TO PATIENTS		0. 3024	53 0	0	73. 00
OUTPATIENT SERVICE COST CENTERS					
90. 00 09000 CLI NI C		0.00000		_	
91. 00   09100   EMERGENCY		0. 29118		0	
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)		1. 3599	53 0	0	1 /2.00
200.00 Total (sum of lines 50 through 94 and 96 through 98)			0	0	200. 00
201.00 Less PBP Clinic Laboratory Services-Program only charges	(line 61)		0		201. 00
202.00   Net charges (line 200 minus line 201)		I	0		202. 00

	Title XVIII	Hospi tal	5/26/2022 10: Cost	52 am_
		nospi tui	0031	
	DART D. HEDI ON AND OTHER HEALTH OFFINA OF		1. 00	
1. 00	PART B - MEDICAL AND OTHER HEALTH SERVICES  Medical and other services (see instructions)		5, 088, 787	1. 00
2. 00	Medical and other services (see First detrois)  Medical and other services reimbursed under OPPS (see instructions)		0,000,707	2.00
3. 00	OPPS payments		0	3. 00
4.00	Outlier payment (see instructions)		0	4. 00
4. 01	Outlier reconciliation amount (see instructions)		0	4. 01
5.00	Enter the hospital specific payment to cost ratio (see instructions)		0.000	5.00
6. 00 7. 00	Line 2 times line 5 Sum of lines 3, 4, and 4.01, divided by line 6		0.00	6. 00 7. 00
8. 00	Transitional corridor payment (see instructions)		0.00	8.00
9. 00	Ancillary service other pass through costs from Wkst. D, Pt. IV, col. 13, line 20	)	0	9. 00
10.00	Organ acqui si ti ons		0	10.00
11. 00			5, 088, 787	11. 00
	COMPUTATION OF LESSER OF COST OR CHARGES			
12. 00	Reasonable charges Ancillary service charges		0	12. 00
13. 00			0	13.00
14.00			0	14. 00
	Customary charges			
15. 00			0	15.00
16. 00	Amounts that would have been realized from patients liable for payment for service had such payment been made in accordance with 42 CFR §413.13(e)	es on a chargebasis	0	16. 00
17. 00			0. 000000	17. 00
18. 00	· · · · · · · · · · · · · · · · · · ·		0.00000	18.00
19. 00		s line 11) (see	0	19. 00
	instructions)			
20. 00		s line 18) (see	0	20. 00
21. 00	instructions) Lesser of cost or charges (see instructions)		5, 139, 675	21. 00
22. 00	g ,		0	22. 00
23. 00			0	23. 00
24. 00			0	24. 00
25. 00	COMPUTATION OF REIMBURSEMENT SETTLEMENT  Deductibles and coinsurance amounts (for CAH, see instructions)		79, 838	25. 00
26. 00	· · · · · · · · · · · · · · · · · · ·	nstructions)	3, 221, 229	26. 00
27. 00	, , ,		1, 838, 608	
	instructions)			
28. 00			0	28. 00
29. 00 30. 00	,		0 1, 838, 608	29. 00 30. 00
31. 00	, , ,		1, 006	31.00
32. 00			1, 837, 602	
	ALLOWABLE BAD DEBTS (EXCLUDE BAD DEBTS FOR PROFESSIONAL SERVICES)		,	
33. 00			0	33.00
34. 00 35. 00	· ·		144, 662 94, 030	34. 00 35. 00
36. 00	, ,		0	36.00
37. 00			1, 931, 632	37. 00
38. 00			0	38. 00
39. 00			0	39. 00
39. 50 39. 97	,		0	39. 50 39. 97
39. 97		tructions)	0	39. 97
39. 99	,	401. 5.1.5)	0	39. 99
40.00			1, 931, 632	40. 00
40. 01			0	40. 01
40. 02			0	40. 02
40. 03 41. 00	, ,		2, 979, 285	40. 03 41. 00
41. 00			2, 7/7, 203	41. 00
42. 00			0	42. 00
42. 01				42. 01
43. 00			-1, 047, 653	
43. 01		2 chanton 1	_	43. 01
44. 00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15 §115.2	-z, cnapter i,	0	44. 00
	TO BE COMPLETED BY CONTRACTOR			
90. 00			0	90. 00
91. 00	· · · · · · · · · · · · · · · · · · ·		0	91.00
92.00			0.00	
93. 00 94. 00	Time Value of Money (see instructions) Total (sum of lines 91 and 93)		0 0	93. 00 94. 00
00	1			

| Peri od: | Worksheet E-1 | From 01/01/2021 | Part | To 12/31/2021 | Date/Time Prepared: | 5/26/2022 10: 52 am Health Financial Systems UNANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED Provider CCN: 15-1326

					5/26/2022 10: 5	52 am
			XVIII	Hospi tal	Cost	
		Inpatien	it Part A	Par	rt B	
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount	
		1. 00	2. 00	3. 00	4. 00	
1.00	Total interim payments paid to provider		2, 059, 31	4	2, 979, 285	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		1	o	0	3. 01
3. 02	ADJUSTIMENTS TO TROVIDER			0		3. 02
3. 02				0		3. 02
3. 04				0		3. 04
3. 05				0		3. 05
3.03	Provider to Program		'	J		3. 03
3.50	ADJUSTMENTS TO PROGRAM			O	0	3. 50
3. 51	7. BOOG THIE TO THOUSE WHI			o o	l ol	3. 51
3. 52				0	o	3. 52
3. 53					o	3. 53
3.54			İ	o o	0	3. 54
3. 99	Subtotal (sum of lines 3.01-3.49 minus sum of lines			O	o	3. 99
	3. 50-3. 98)					
4.00	Total interim payments (sum of lines 1, 2, and 3.99)		2, 059, 31	4	2, 979, 285	4.00
	(transfer to Wkst. E or Wkst. E-3, line and column as					
	appropri ate)					
	TO BE COMPLETED BY CONTRACTOR					
5.00	List separately each tentative settlement payment after					5. 00
	desk review. Also show date of each payment. If none,					
	write "NONE" or enter a zero. (1)					
5. 01	Program to Provider TENTATIVE TO PROVIDER		T .		1 0	5. 01
5. 01	TENTATIVE TO PROVIDER			0		5. 01
5. 02				0		5. 02
5.05	Provider to Program		<u> </u>	<u> </u>		3. 03
5. 50	TENTATI VE TO PROGRAM			O	1 0	5. 50
5. 51	TELLINITE IS TROOM WI			0	0	5. 51
5. 52				0	0	5. 52
5. 99	Subtotal (sum of lines 5.01-5.49 minus sum of lines			0	l ő	5. 99
	5. 50-5. 98)					
6.00	Determined net settlement amount (balance due) based on					6. 00
	the cost report. (1)					
6.01	SETTLEMENT TO PROVIDER			O	0	6. 01
6.02	SETTLEMENT TO PROGRAM		83, 16	5	1, 047, 653	6. 02
7.00	Total Medicare program liability (see instructions)		1, 976, 14	9	1, 931, 632	7. 00
				Contractor	NPR Date	
				Number	(Mo/Day/Yr)	
0.00			)	1. 00	2. 00	
8.00	Name of Contractor					8. 00

Health Financial Systems UNANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED 

		Component	CCN. 13-Z320	10 12/31/2021	5/26/2022 10:	
		Title	XVIII S	wing Beds - SNF		
			t Part A	Par	t B	
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount	
		1.00	2.00	3. 00	4. 00	
1.00	Total interim payments paid to provider		1, 142, 20	7	33	1. 00
2. 00	Interim payments payable on individual bills, either submitted or to be submitted to the contractor for services rendered in the cost reporting period. If none, write "NONE" or enter a zero		(	D	0	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 PROVI DER	12/31/2021	126, 400		0	3. 01
3. 02	THE STATE OF THE TREET.	127 0 17 202 1		ol .		3. 02
3. 03					0	3. 03
3.04					0	3. 04
3.05					0	3. 05
	Provider to Program					
3.50	ADJUSTMENTS TO PROGRAM			D	0	3. 50
3. 51					0	3. 51
3. 52		ļ			0	3. 52
3. 53				1	0	3. 53
3. 54			(	-	0	3. 54
3. 99	Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98)		126, 400		0	3. 99
4. 00	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Wkst. E or Wkst. E-3, line and column as appropriate)		1, 268, 60	7	33	4. 00
	TO BE COMPLETED BY CONTRACTOR		l .			
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		(	D	0	5. 01
5. 02				D	0	5. 02
5.03			(		0	5. 03
F F0	Provi der to Program	1	1	J		
5.50	TENTATI VE TO PROGRAM				0	5. 50
5. 51 5. 52					0	5. 51 5. 52
5. 99	Subtotal (sum of lines 5.01-5.49 minus sum of lines					5. 99
3. 77	5. 50-5. 98)		\			3. 77
6. 00	Determined net settlement amount (balance due) based on the cost report. (1)					6. 00
6. 01	SETTLEMENT TO PROVIDER				18	6. 01
6. 02	SETTLEMENT TO PROGRAM		22, 710	5	0	6. 02
7.00	Total Medicare program liability (see instructions)		1, 245, 89		51	
	, , , , , , , , , , , , , , , , , , , ,		.,, 0,	Contractor Number	NPR Date (Mo/Day/Yr)	
		(	)	1. 00	2.00	
8. 00	Name of Contractor					8. 00
	•	•		•		

Heal th	Financial Systems UNION HOSPITAL	_ CLINTON	In Lie	u of Form CMS-	2552-10
	CALCULATION OF REIMBURSEMENT SETTLEMENT FOR HIT  Provider CCN: 15-1326 From 01/01/2021 To 12/31/2021 E				
		Title XVIII	Hospi tal	Cost	
				1. 00	
	TO BE COMPLETED BY CONTRACTOR FOR NONSTANDARD COST REPORTS				1
	HEALTH INFORMATION TECHNOLOGY DATA COLLECTION AND CALCULATION				
1. 00	Total hospital discharges as defined in AARA §4102 from Wkst.				1. 00
2. 00	Medicare days (Wkst. S-3, Pt. I, col. 6, sum of lines 1, and	8 through 12, and plus f	for cost		2. 00
	reporting periods beginning on or after 10/01/2013, line 32)				
3. 00	Medicare HMO days from Wkst. S-3, Pt. I, col. 6. line 2				3. 00
4. 00	Total inpatient days (Wkst. S-3, Pt. I, col. 8, sum of lines	1, and 8 through 12, and	I plus for cost		4. 00
	reporting periods beginning on or after 10/01/2013, line 32)				
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				6. 00
7. 00	CAH only - The reasonable cost incurred for the purchase of	certified HII technology	Wkst. S-2, Pt. I		7. 00
0.00	line 168				0.00
8. 00	Calculation of the HIT incentive payment (see instructions)				8. 00
9.00	Sequestration adjustment amount (see instructions)				9. 00
10.00 Calculation of the HIT incentive payment after sequestration (see instructions)					10.00
	I NPATI ENT HOSPI TAL SERVI CES UNDER THE I PPS & CAH				30.00
	30.00  Initial/interim HIT payment adjustment (see instructions)				
	31.00 Other Adjustment (specify)				
32. 00	32.00 Balance due provider (line 8 (or line 10) minus line 30 and line 31) (see instructions)				

ALCULATION OF REIMBURSEMENT SETTLEMENT - SWING BEDS | Provider CCN: 15-1326 | Period: From 01/01/2021 | To 12/31/2021 | Date/Time Prepared: 5/26/2022 10: 52 am

		Component CCN: 15-2326	10 12/31/2021	5/26/2022 10:	
		Title XVIII	Swing Beds - SNF		
			Part A	Part B	
			1. 00	2. 00	
1 00	COMPUTATION OF NET COST OF COVERED SERVICES		1 001 027	0	1 00
1. 00 2. 00	Inpatient routine services - swing bed-SNF (see instructions) Inpatient routine services - swing bed-NF (see instructions)		1, 081, 837	0	1. 00 2. 00
3.00	Ancillary services (from Wkst. D-3, col. 3, line 200, for Part	· A and sum of Wkst D	166, 827	51	3.00
0.00	Part V, cols. 6 and 7, line 202, for Part B) (For CAH and swir	The state of the s		01	0.00
	instructions)	3			
3. 01	Nursing and allied health payment-PARHM (see instructions)				3. 01
4.00	Per diem cost for interns and residents not in approved teachi	ng program (see		0. 00	4. 00
E 00	instructions)		495	0	5. 00
5. 00 6. 00	Program days Interns and residents not in approved teaching program (see in	etructions)	493	0	6.00
7. 00	Utilization review - physician compensation - SNF optional met		0	O	7. 00
8.00	Subtotal (sum of lines 1 through 3 plus lines 6 and 7)		1, 248, 664	51	8.00
9.00	Primary payer payments (see instructions)		0	0	9. 00
10.00	Subtotal (line 8 minus line 9)		1, 248, 664	51	10.00
11. 00	Deductibles billed to program patients (exclude amounts applic	able to physician	0	0	11. 00
40.00	professional services)				
12.00	Subtotal (line 10 minus line 11)	(avaluda asi nauranaa	1, 248, 664	51 0	12.00
13. 00	Coinsurance billed to program patients (from provider records) for physician professional services)	(exclude collisurance	2, 773	U	13. 00
14. 00	80% of Part B costs (line 12 x 80%)			0	14. 00
15. 00	Subtotal (see instructions)		1, 245, 891	51	
16.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)		0	0	16. 00
16. 50	Pioneer ACO demonstration payment adjustment (see instructions	5)			16. 50
16. 55	Rural community hospital demonstration project (§410A Demonstr	ation) payment	0		16. 55
47.00	adjustment (see instructions)				4, 00
16. 99 17. 00	Demonstration payment adjustment amount before sequestration Allowable bad debts (see instructions)		0	0	16. 99 17. 00
17. 00	Adjusted reimbursable bad debts (see instructions)		0	0	17. 00
18. 00	Allowable bad debts for dual eligible beneficiaries (see instr	ructions)	0	0	18. 00
19. 00	Total (see instructions)	461.66)	1, 245, 891	51	
19. 01	Sequestration adjustment (see instructions)		0	0	19. 01
19. 02	Demonstration payment adjustment amount after sequestration)		0	0	19. 02
19. 03	Sequestration adjustment-PARHM pass-throughs				19. 03
19. 25	Sequestration for non-claims based amounts (see instructions)		0	0	19. 25
20.00	Interim payments		1, 268, 607	33	
20. 01 21. 00	Interim payments-PARHM Tentative settlement (for contractor use only)		0	0	20. 01 21. 00
21. 00	Tentative settlement (for contractor use only)		0	0	21.00
22. 00	Balance due provider/program (line 19 minus lines 19.01, 19.02	2 19 25 20 and 21)	-22, 716	18	
22. 01	Balance due provider/program-PARHM (see instructions)	17. 20, 20, and 21,	22,7.10		22. 01
23. 00	Protested amounts (nonallowable cost report items) in accordan	nce with CMS Pub. 15-2,	0	0	23. 00
	chapter 1, §115.2				]
	Rural Community Hospital Demonstration Project (§410A Demonstr				
200.00	Is this the first year of the current 5-year demonstration per	riod under the 21st			200. 00
	Century Cures Act? Enter "Y" for yes or "N" for no.  Cost Reimbursement				
201 00	Medicare swing-bed SNF inpatient routine service costs (from W	/kst D-1 Pt II line			201. 00
201.00	66 (title XVIII hospital))	mest. B 1, 1 t. 11, 111e			201.00
202.00	Medicare swing-bed SNF inpatient ancillary service costs (from	n Wkst. D-3, col. 3, lin	е		202. 00
	200 (title XVIII swing-bed SNF))				
	Total (sum of lines 201 and 202)				203. 00
204.00	Medicare swing-bed SNF discharges (see instructions)				204. 00
	Computation of Demonstration Target Amount Limitation (N/A in	first year of the curre	nt 5-year demonst	ration	
205 00	period) Medicare swing-bed SNF target amount				205. 00
	Medicare swing-bed SNF inpatient routine cost cap (line 205 ti	mes line 204)			206. 00
200.00	Adjustment to Medicare Part A Swing-Bed SNF Inpatient Reimburs				200.00
207. 00	Program reimbursement under the §410A Demonstration (see instr				207. 00
	Medicare swing-bed SNF inpatient service costs (from Wkst. E-2	-	1		208. 00
	and 3)				
	Adjustment to Medicare swing-bed SNF PPS payments (see instruc	ctions)			209. 00
210.00	Reserved for future use				210. 00
215 00	Comparision of PPS versus Cost Reimbursement Total adjustment to Medicare swing-bed SNF PPS payment (line 2	200 plus line 210) (5			215 00
∠15.UC	instructions)	to plus line 210) (see			215. 00
	1113t1 40t1 0113 <i>)</i>		1		ı

CALCULATION OF REIMBURSEMENT SETTLEMENT - SWING BEDS

Provider CCN: 15-1326 | Period: From 01/01/2021 | To 12/31/2021 | Date/Time Prepared: 5/26/2022 10: 52 am

		Component CCN: 15-2326	10 12/31/2021	Date/II me Prepared   5/26/2022 10:52 am
		Title XIX	Swing Beds - SNF	
			Part A	Part B
			1. 00	2. 00
C	COMPUTATION OF NET COST OF COVERED SERVICES			
	Inpatient routine services - swing bed-SNF (see instructions)		0	1.
	Inpatient routine services - swing bed-NF (see instructions)		0	2.
	Ancillary services (from Wkst. D-3, col. 3, line 200, for Part	The state of the s	0	3.
	Part V, cols. 6 and 7, line 202, for Part B) (For CAH and swing	j-bed pass-through, see		
1	instructions)			2
1	Nursing and allied health payment-PARHM (see instructions)	a program (coo	0.00	3.
	Per diem cost for interns and residents not in approved teachir instructions)	ig program (see	0.00	4.
1	Program days		0	5.
1	Interns and residents not in approved teaching program (see ins	tructions)		6.
	Utilization review - physician compensation - SNF optional meth	*	Ö	7.
- 1	Subtotal (sum of lines 1 through 3 plus lines 6 and 7)	iod om y	Ö	8.
- 1	Primary payer payments (see instructions)		Ö	9.
	Subtotal (line 8 minus line 9)		Ö	10.
1	Deductibles billed to program patients (exclude amounts applica	hle to physician	Ö	11.
	professional services)	ibi c to physician	Ĭ	11.
1 '	Subtotal (line 10 minus line 11)		o	12.
	Coinsurance billed to program patients (from provider records)	(exclude coinsurance	o	13.
	for physician professional services)	(6,0) 440 60, 1164, 41166		
- 1	80% of Part B costs (line 12 x 80%)		o	14.
	Subtotal (see instructions)		o	15.
	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)		0	16.
	Pioneer ACO demonstration payment adjustment (see instructions)			16.
	Rural community hospital demonstration project (§410A Demonstra			16.
	adjustment (see instructions)	, p-5		
	Demonstration payment adjustment amount before sequestration		o	16.
1	Allowable bad debts (see instructions)		o	17.
17. 01	Adjusted reimbursable bad debts (see instructions)		o	17.
18. 00	Allowable bad debts for dual eligible beneficiaries (see instru	ıcti ons)	o	18.
19. 00	Total (see instructions)		o	19.
19. 01	Sequestration adjustment (see instructions)		o	19.
19. 02	Demonstration payment adjustment amount after sequestration)		o	19.
19. 03	Sequestration adjustment-PARHM pass-throughs			19.
19. 25	Sequestration for non-claims based amounts (see instructions)		o	19.
20. 00	Interim payments		o	20.
20. 01	Interim payments-PARHM			20.
21. 00	Tentative settlement (for contractor use only)		0	21.
21. 01	Tentative settlement-PARHM (for contractor use only)			21.
22. 00	Balance due provider/program (line 19 minus lines 19.01, 19.02,	19. 25, 20, and 21)	0	22.
22. 01	Balance due provider/program-PARHM (see instructions)			22.
	Protested amounts (nonallowable cost report items) in accordance	e with CMS Pub. 15-2,	0	23.
	chapter 1, §115.2			
	Rural Community Hospital Demonstration Project (§410A Demonstra	<u> </u>		
	Is this the first year of the current 5-year demonstration peri	od under the 21st		200.
	Century Cures Act? Enter "Y" for yes or "N" for no.			
	Cost Reimbursement		1 1	201
	Medicare swing-bed SNF inpatient routine service costs (from Wk	St. D-1, Pt. II, line		201.
	66 (title XVIII hospital))	Wko+ D 2 col 2 lin		202
	Medicare swing-bed SNF inpatient ancillary service costs (from	WKST. D-3, COL. 3, IIIn	e	202.
	200 (title XVIII swing-bed SNF)) Total (sum of lines 201 and 202)			203.
1	, ,			204.
	Medicare swing-bed SNF discharges (see instructions) Computation of Demonstration Target Amount Limitation (N/A in f	irst year of the surre	nt E voor domonot	
	period)	irst year or the curren	iit 5-year delilorist	Tation
	Medicare swing-bed SNF target amount			205.
	Medicare swing bed SNF inpatient routine cost cap (line 205 time)	nes line 204)		206.
	Adjustment to Medicare Part A Swing-Bed SNF Inpatient Reimburse			200.
	Program reimbursement under the §410A Demonstration (see instru			207.
	Medicare swing-bed SNF inpatient service costs (from Wkst. E-2,		1	208.
	and 3)	cor. I, sum of filles	·	200.
	Adjustment to Medicare swing-bed SNF PPS payments (see instruct	ions)		209.
	Reserved for future use			210.
	Comparision of PPS versus Cost Reimbursement			210.
10	Joinpart St. Of TTO VOI 343 GOST ROTHIDAT SCHIOTT			
	Total adjustment to Medicare swing-bed SNF PPS payment (line 20	9 nlus line 210) (caa	I	215.

Health Financial Systems	UNION HOSPITAL CLINTON	In Lie	u of Form CMS-2552-10
CALCULATION OF REIMBURSEMENT SETTLEMENT	Provi der CCN: 15-1326		Worksheet E-3 Part V Date/Time Prepared: 5/26/2022 10:52 am

3.00   Organ acquisition   0   3.00   Subtotal (sum of lines 1 through 3)   2, 263, 150   4.00   5.00   Primary payer payments   0   5.00   6.00   Total cost (line 4 less line 5). For CAH (see instructions)   2, 285, 782   6.00   COMPUTATION OF LESSER OF COST OR CHARGES   COMPUTATION OF LIBRUPAST COMPUTATION OF LIBRUPAST SETTLEMENT   COMPUTATION OF REINBURSEMENT SETTLEMENT   COMPUTATION					5/26/2022 10:	52 am_
PART V - CALCULATION OF BEI MURISSMENT SETTLEMENT FOR MEDICARE PART A SERVICES - COST REIMBURSSMENT			Title XVIII	Hospi tal	Cost	
PART V - CALCULATION OF BEI MURISSMENT SETTLEMENT FOR MEDICARE PART A SERVICES - COST REIMBURSSMENT						
Inpatient services   2,263,150   1.00   2.00   3.					1. 00	
Nursing and Allied Health Managed Care payment (see instructions)   0   2.00   3.00   0   0   0   0   0   0   0   0   0			PART A SERVICES - COST	REIMBURSEMENT		
Organ acquisition	1.00	Inpatient services			2, 263, 150	1.00
Subtotal (sum of lines 1 through 3)   2, 263, 180   4, 00   5. 00   7. 00			ons)			2.00
Primarry payer payments   2, 285, 782   0.0	3.00	Organ acquisition			0	
Total cost (fline 4 less line 5), For CAH (see instructions)   2, 285, 782   6.00	4.00	Subtotal (sum of lines 1 through 3)			2, 263, 150	4.00
COMPUTATION OF LESSER OF COST OR CHARGES	5.00	Primary payer payments			0	5. 00
Reasonable charges   0   7.00   8.00   Ancil lary service charges   0   8.00   8.00   Ancil lary service charges   0   8.00   0.00	6.00				2, 285, 782	6.00
Note   Note						
8.00						
0		,				
10.00   Total reasonable charges     0   0.00		, ,				
Customary charges         Customary charges           11. 00         Aggregate amount actually collected from patients liable for payment for services on a charge basis         0         11. 00           12. 00         Amounts that would have been realized from patients liable for payment for services on a charge basis         0         12. 00           13. 00         Ratio of line II to line 12 (not to exceed 1.000000)         0.000000         13. 00           14. 00         Total customary charges (see instructions)         0         14.00           15. 00         Excess of customary charges over reasonable cost (complete only if line 14 exceeds line 6) (see instructions)         0         15.00           16. 00         Excess of reasonable cost over customary charges (complete only if line 6 exceeds line 14) (see instructions)         0         16.00           17. 00         Cost of physicians' services in a teaching hospital (see instructions)         0         0         16.00           18. 00         Cost of physicians' services (sum of lines 6, 17 and 18)         2, 285, 782         19.00           19. 00         Cost of covered services (sum of lines 6, 17 and 18)         2, 2, 285, 782         19.00           19. 00         Excess reasonable cost (from line 16)         0         1, 975, 778         22.00           22. 00         Subtotal (line 2z minus line 23)         1, 975, 778		, , ,				
11.00   Aggregate amount actually collected from patients liable for payment for services on a charge basis   0   11.00	10. 00				0	10.00
12. 00   Amounts that would have been realized from patients Liable for payment for services on a charge basis had such payment been made in accordance with M2 CFR 413.13(e)   0.000000   13. 00   14. 00   101al customary charges (see instructions)   0.000000   13. 00   14. 00   101al customary charges (see instructions)   0.14. 00   101al customary charges over reasonable cost (complete only if line 14 exceeds line 6) (see Instructions)   15. 00   16. 00   Excess of customary charges over reasonable cost (complete only if line 6 exceeds line 14) (see Instructions)   0.0000000000000000000000000000000000					_	
had such payment been made in accordance with 42 CFR 413.13(e)   0.000000   13.00   13.00   14.00   15.00   16.10   16.11   11.01   11.01   12.00   10.000000   13.00   14.00   15.0		1 33 3	3	9		
13.00	12.00	· ·	1 3	n a charge basis	0	12.00
14.00   Total customary charges (see instructions)   0   14.00   15.00   Excess of customary charges over reasonable cost (complete only if line 14 exceeds line 6) (see   0   15.00   16.00	40.00				0 000000	40.00
15.00   Excess of Customary Charges over reasonable cost (complete only if line 14 exceeds line 6) (see instructions)   16.00   16.00   16.00   17.0						
Instructions   Excess of reasonable cost over customary charges (complete only if line 6 exceeds line 14) (see instructions)   17. 00   17. 00   17. 00   17. 00   18. 00   18. 00   19. 00			! &   ! 44	() (		
16.00   Excess of reasonable cost over customary charges (complete only if line 6 exceeds line 14) (see instructions)   17.00   17.00   17.00   17.00   17.00   18.00   19.0	15.00		y IT Time 14 exceeds IT	ne 6) (See	U	15.00
17. 00   Cost of physicians' services in a teaching hospital (see instructions)   0   17. 0	16 00	l	vifling 6 avende lin	0 14) (600	0	16 00
17. 00	10.00		y II IIIle o exceeds IIII	e 14) (See	U	10.00
COMPUTATION OF REIMBURSEMENT SETTLEMENT   18.00   18.00   19	17 00		ructions)		0	17 00
18. 00	17.00		deti ons)		0	17.00
19.00       Cost of covered services (sum of lines 6, 17 and 18)       2, 285, 782       19.00         20.00       Deductibles (exclude professional component)       310,004       20.00         21.00       Excess reasonable cost (from line 16)       0 21.00         22.00       Subtotal (line 19 minus line 20 and 21)       1, 975, 778       22.00         23.00       Coinsurance       3, 339       23.00         24.00       Subtotal (line 22 minus line 23)       1, 972, 439       24.00         25.00       All owable bad debts (exclude bad debts for professional services) (see instructions)       5, 708       25.00         26.00       Adjusted reimbursable bad debts (see instructions)       3, 710       26.00         28.00       Subtotal (sum of lines 24 and 25, or line 26)       1, 976, 149       28.00         29.00       OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)       0 29.00         29.50       Ponoer- ACO demonstration payment adjustment (see instructions)       0 29.00         29.98       Recovery of accelerated depreciation.       0 29.96         29.99       Demonstration payment adjustment amount before sequestration       0 29.96         30.01       Sequestration adjustment (see instructions)       0 30.01         30.02       Sequestration payment adjustment amount after sequestration <td>18 00</td> <td></td> <td>line 49)</td> <td></td> <td>0</td> <td>18 00</td>	18 00		line 49)		0	18 00
20.00   Deductibles (exclude professional component)   310,004   20.00   21.00   Excess reasonable cost (from line 16)   0   21.00   21.00   22.00   23.00   Coinsurance   3,339   23.00   24.00   Subtotal (line 19 minus line 20 and 21)   3,972,439   24.00   25.00   Allowable bad debts (exclude bad debts for professional services) (see instructions)   5,708   25.00   26.00   Adjusted reimbursable bad debts (see instructions)   3,710   26.00   27.00   27.00   Allowable bad debts for dual eligible beneficiaries (see instructions)   3,710   26.00   27.00   28.00   Subtotal (sum of lines 24 and 25, or line 26)   27.00   29.00   OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)   29.90   Pioneer ACO demonstration payment adjustment (see instructions)   0   29.50   29.90			.,			
21. 00   Excess reasonable cost (from line 16)   0   21. 00   22. 00   3. 00   23. 00   24. 00   3. 30   23. 00   25. 00   3. 00   25. 00   3. 00   25. 00   3. 00   25. 00   3. 00   25. 00   3. 00   25. 00   3. 00   25. 00   3. 00   25. 00   3. 00   25. 00   3. 00   25. 00   3. 00   25. 00   3. 00   25. 00   3. 00   25. 00   3. 00   25. 00   3. 00   25. 00						
22. 00       Subtotal (line 19 minus line 20 and 21)       1,975,778       22. 00         23. 00       Coinsurance       3,339       23. 00         24. 00       Subtotal (line 22 minus line 23)       1,972,439       24. 00         25. 00       Allowable bad debts (exclude bad debts for professional services) (see instructions)       5,08       25. 00         26. 00       Adjusted reimbursable bad debts (see instructions)       3,710       26. 00         27. 00       Allowable bad debts for dual eligible beneficiaries (see instructions)       0,70       27. 00         28. 00       Subtotal (sum of lines 24 and 25, or line 26)       1,976,149       28. 00         29. 00       OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)       0       29. 00         29. 99       Pomener ACO demonstration payment adjustment (see instructions)       0       29. 50         29. 99       Recovery of accelerated depreciation.       0       29. 99         29. 99       Demonstration payment adjustment amount before sequestration       0       29. 99         30. 01       Sequestration adjustment (see instructions)       1,976,149       30. 00         30. 02       Demonstration payment adjustment amount after sequestration       0       30. 01         31. 01       Interim payments       2,059,314       31.						
23. 00 Coinsurance 24. 00 Subtotal (line 22 minus line 23) 25. 00 Allowable bad debts (exclude bad debts for professional services) (see instructions) 27. 00 Adjusted reimbursable bad debts (see instructions) 28. 00 Subtotal (sum of lines 24 and 25, or line 26) 29. 00 OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY) 29. 00 OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY) 29. 98 Recovery of accelerated depreciation. 29. 99 Demonstration payment adjustment amount before sequestration 29. 99 Demonstration payment adjustment amount before sequestration 3, 339 23. 00 1, 972, 439 24. 00 2, 500 27. 00 27. 00 28. 00 Coinsurance 3, 710 26. 00 27. 00 28. 00 Coinsurance 3, 710 26. 00 29. 00 29. 00 29. 00 29. 00 29. 00 29. 00 29. 00 29. 00 29. 00 29. 00 29. 90 29. 90 29. 90 29. 90 29. 90 29. 90 20. 20 29. 90 20. 20 20.	22. 00				1, 975, 778	22. 00
25. 00 Allowable bad debts (exclude bad debts for professional services) (see instructions) 26. 00 Adjusted reimbursable bad debts (see instructions) 27. 00 Allowable bad debts for dual eligible beneficiaries (see instructions) 28. 00 Subtotal (sum of lines 24 and 25, or line 26) 29. 00 OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY) 29. 50 Pi oneer ACO demonstration payment adjustment (see instructions) 29. 98 Recovery of accelerated depreciation. 29. 99 Demonstration payment adjustment amount before sequestration 30. 00 Subtotal (see instructions) 30. 01 Sequestration adjustment (see instructions) 30. 02 Demonstration payment adjustment amount after sequestration 30. 03 Sequestration adjustment (see instructions) 30. 04 Interim payments 30. 05 Interim payments 30. 06 Interim payments 30. 07 Tentative settlement (for contractor use only) 30. 08 Bal ance due provider/program (lines 2, 3, 18, and 26, minus lines 30.03, 31.01, and 32.01) 31. 00 Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1,		· · · · · · · · · · · · · · · · · · ·				
25. 00 Allowable bad debts (exclude bad debts for professional services) (see instructions) 26. 00 Adjusted reimbursable bad debts (see instructions) 27. 00 Allowable bad debts for dual eligible beneficiaries (see instructions) 28. 00 Subtotal (sum of lines 24 and 25, or line 26) 29. 00 OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY) 29. 50 Pi oneer ACO demonstration payment adjustment (see instructions) 29. 98 Recovery of accelerated depreciation. 29. 99 Demonstration payment adjustment amount before sequestration 30. 00 Subtotal (see instructions) 30. 01 Sequestration adjustment (see instructions) 30. 02 Demonstration payment adjustment amount after sequestration 30. 03 Sequestration adjustment (see instructions) 30. 04 Interim payments 30. 05 Interim payments 30. 06 Interim payments 30. 07 Tentative settlement (for contractor use only) 30. 08 Bal ance due provider/program (lines 2, 3, 18, and 26, minus lines 30.03, 31.01, and 32.01) 31. 00 Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1,	24.00	Subtotal (line 22 minus line 23)			1, 972, 439	24.00
27. 00       Allowable bad debts for dual eligible beneficiaries (see instructions)       0       27. 00         28. 00       Subtotal (sum of lines 24 and 25, or line 26)       1,976,149       28. 00         29. 00       OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)       0       29. 00         29. 50       Pioneer ACO demonstration payment adjustment (see instructions)       0       29. 98         29. 98       Recovery of accelerated depreciation.       0       29. 98         29. 99       Subtotal (see instructions)       0       29. 99         30. 01       Sequestration adjustment (see instructions)       0       30. 01         30. 02       Demonstration payment adjustment amount after sequestration       0       30. 02         30. 03       Sequestration adjustment -PARHM       0       30. 02         31. 00       Interim payments       2, 059, 314       31. 00         31. 01       Tentative settlement (for contractor use only)       31. 01         32. 00       Balance due provider/program (line 30 minus lines 30. 01, 30. 02, 31, and 32)       -83, 165       33. 00         33. 01       Balance due provider/program-PARHM (lines 2, 3, 18, and 26, minus lines 30. 03, 31. 01, and 32. 01)       -83, 165       33. 01         34. 00       Protested amounts (nonallowable cost report items) in accordance with C	25.00		ces) (see instructions)			
28.00       Subtotal (sum of lines 24 and 25, or line 26)       1,976,149       28.00         29.00       OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)       0 29.00         29.50       Pioneer ACO demonstration payment adjustment (see instructions)       0 29.50         29.98       Recovery of accelerated depreciation.       0 29.98         29.99       Demonstration payment adjustment amount before sequestration       0 29.99         30.01       Sequestration adjustment (see instructions)       1,976,149       30.00         30.02       Demonstration payment adjustment amount after sequestration       0 30.01       30.01         30.02       Demonstration payment adjustment amount after sequestration       0 30.02         30.03       Sequestration adjustment-PARHM       30.03         31.01       Interim payments       2,059,314       31.00         31.01       Tentative settlement (for contractor use only)       31.01         32.01       Tentative settlement (for contractor use only)       32.01         33.00       Balance due provider/program (line 30 minus lines 30.01, 30.02, 31, and 32)       -83,165       33.00         34.00       Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1,       0 34.00	26.00	Adjusted reimbursable bad debts (see instructions)			3, 710	26. 00
29. 00 OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)  29. 50 Pi oneer ACO demonstration payment adjustment (see instructions)  29. 98 Recovery of accelerated depreciation.  29. 99 Demonstration payment adjustment amount before sequestration  30. 00 Subtotal (see instructions)  30. 01 Sequestration adjustment (see instructions)  30. 02 Demonstration payment adjustment amount after sequestration  30. 02 Sequestration adjustment (see instructions)  30. 03 Sequestration adjustment-PARHM  30. 03  31. 00 Interim payments  1. Interim payments  2. 059, 314  31. 00  32. 01 Tentative settlement (for contractor use only)  32. 01 Tentative settlement-PARHM (for contractor use only)  33. 00 Bal ance due provider/program (line 30 minus lines 30.01, 30.02, 31, and 32)  33. 01 Bal ance due provider/program-PARHM (lines 2, 3, 18, and 26, minus lines 30.03, 31.01, and 32.01)  34. 00 Protested amounts (nonal lowable cost report items) in accordance with CMS Pub. 15-2, chapter 1,	27.00	Allowable bad debts for dual eligible beneficiaries (see instr	ructions)		0	27. 00
29. 50 Pi oneer ACO demonstration payment adjustment (see instructions)  29. 98 Recovery of accelerated depreciation.  29. 99 Demonstration payment adjustment amount before sequestration  30. 01 Sequestration adjustment (see instructions)  30. 01 Demonstration payment adjustment amount after sequestration  30. 01 Demonstration payment adjustment amount after sequestration  30. 02 Demonstration payment adjustment amount after sequestration  30. 03 Recovery of accelerated depreciation.  30. 02 Perpendicular of the payment adjustment amount after sequestration.  30. 01 Demonstration payment adjustment amount after sequestration.  30. 02 Demonstration payment adjustment amount after sequestration.  30. 02 Demonstration adjustment amount after sequestration.	28.00	Subtotal (sum of lines 24 and 25, or line 26)			1, 976, 149	28. 00
29. 98 Recovery of accelerated depreciation.  29. 99 29. 99 30. 00 Subtotal (see instructions)  30. 01 Sequestration adjustment (see instructions)  30. 02 Demonstration payment adjustment amount after sequestration  30. 02 Sequestration adjustment amount after sequestration  30. 03 Sequestration adjustment amount after sequestration  30. 03 Sequestration adjustment-PARHM  31. 00 Interim payments  Interim payments  Interim payments-PARHM  31. 01 Tentative settlement (for contractor use only)  32. 00 Tentative settlement (for contractor use only)  33. 00 Bal ance due provider/program (line 30 minus lines 30.01, 30.02, 31, and 32)  33. 01 Bal ance due provider/program-PARHM (lines 2, 3, 18, and 26, minus lines 30.03, 31.01, and 32.01)  34. 00 Protested amounts (nonal lowable cost report items) in accordance with CMS Pub. 15-2, chapter 1,	29.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)			0	29. 00
29. 99 Demonstration payment adjustment amount before sequestration 30. 00 Subtotal (see instructions) 30. 01 Sequestration adjustment (see instructions) 30. 02 Demonstration payment adjustment amount after sequestration 30. 03 Sequestration adjustment amount after sequestration 30. 03 Sequestration adjustment-PARHM 30. 00 Interim payments 31. 01 Interim payments-PARHM 32. 00 Tentative settlement (for contractor use only) 32. 01 Tentative settlement-PARHM (for contractor use only) 33. 00 Balance due provider/program (line 30 minus lines 30. 01, 30. 02, 31, and 32) 33. 01 Balance due provider/program-PARHM (lines 2, 3, 18, and 26, minus lines 30. 03, 31. 01, and 32. 01) 34. 00 Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1,	29. 50	Pioneer ACO demonstration payment adjustment (see instructions	5)		0	29. 50
30.00 Subtotal (see instructions)  30.01 Sequestration adjustment (see instructions)  30.02 Demonstration payment adjustment amount after sequestration  30.03 Sequestration adjustment-PARHM  30.03 30.03 31.00 Interim payments  31.01 Interim payments-PARHM  32.00 Tentative settlement (for contractor use only)  32.01 Tentative settlement-PARHM (for contractor use only)  33.00 Balance due provider/program (line 30 minus lines 30.01, 30.02, 31, and 32)  33.01 Balance due provider/program-PARHM (lines 2, 3, 18, and 26, minus lines 30.03, 31.01, and 32.01)  34.00 Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1,  1, 976, 149 30.00  30.01  30.02  30.03  3.02  30.03  31.01  31.00  32.00  32.00  32.00  32.00  32.00  33.01  33.01	29. 98	Recovery of accelerated depreciation.			0	29. 98
30. 01 Sequestration adjustment (see instructions)  30. 02 Demonstration payment adjustment amount after sequestration  30. 03 Sequestration adjustment-PARHM  31. 00 Interim payments  31. 01 Interim payments-PARHM  32. 00 Tentative settlement (for contractor use only)  32. 01 Tentative settlement-PARHM (for contractor use only)  33. 00 Balance due provider/program (line 30 minus lines 30. 01, 30. 02, 31, and 32)  33. 01 Balance due provider/program-PARHM (lines 2, 3, 18, and 26, minus lines 30. 03, 31. 01, and 32. 01)  34. 00 Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1,  0 30. 01  30. 02  30. 03	29. 99	Demonstration payment adjustment amount before sequestration				
30. 02 Demonstration payment adjustment amount after sequestration  30. 02 Sequestration adjustment-PARHM  31. 00 Interim payments  31. 01 Interim payments-PARHM  32. 00 Tentative settlement-PARHM (for contractor use only)  32. 01 Tentative settlement-PARHM (for contractor use only)  33. 00 Balance due provider/program (line 30 minus lines 30.01, 30.02, 31, and 32)  33. 01 Balance due provider/program-PARHM (lines 2, 3, 18, and 26, minus lines 30.03, 31.01, and 32.01)  34. 00 Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1,  0 30. 02  30. 02  30. 03  30. 03  31. 00  31. 00  32. 01  32. 01  33. 01  34. 00	30.00	Subtotal (see instructions)			1, 976, 149	30. 00
30.03 Sequestration adjustment-PARHM 30.03 31.00 Interim payments Interim payments-PARHM 2, 059, 314 31.00 31.01 Tentative settlement (for contractor use only) 32.01 Tentative settlement-PARHM (for contractor use only) 32.01 Balance due provider/program (line 30 minus lines 30.01, 30.02, 31, and 32) -83, 165 33.00 33.01 Balance due provider/program-PARHM (lines 2, 3, 18, and 26, minus lines 30.03, 31.01, and 32.01) -83, 165 33.01 34.00 Protested amounts (nonal lowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, 0 34.00	30. 01	Sequestration adjustment (see instructions)				
31.00 Interim payments  31.01 Interim payments-PARHM  31.01 Tentative settlement (for contractor use only)  32.01 Tentative settlement-PARHM (for contractor use only)  33.00 Balance due provider/program (line 30 minus lines 30.01, 30.02, 31, and 32)  33.01 Balance due provider/program-PARHM (lines 2, 3, 18, and 26, minus lines 30.03, 31.01, and 32.01)  34.00 Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1,  2,059,314 31.00 31.01 32.00 32.00 32.01 32.01 32.01 33.01 32.01					0	
31. 01   Interim payments-PARHM   31. 01   32. 00   Tentative settlement (for contractor use only)   0   32. 00   32. 01   Tentative settlement-PARHM (for contractor use only)   32. 01   33. 00   Balance due provider/program (line 30 minus lines 30. 01, 30. 02, 31, and 32)   -83, 165   33. 00   33. 01   Balance due provider/program-PARHM (lines 2, 3, 18, and 26, minus lines 30. 03, 31. 01, and 32. 01)   33. 01   Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1,   0   34. 00		, ,				
32.00 Tentative settlement (for contractor use only) 32.01 Tentative settlement-PARHM (for contractor use only) 33.00 Balance due provider/program (line 30 minus lines 30.01, 30.02, 31, and 32) 33.01 Balance due provider/program-PARHM (lines 2, 3, 18, and 26, minus lines 30.03, 31.01, and 32.01) 34.00 Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, 0 34.00					2, 059, 314	
32.01 Tentative settlement-PARHM (for contractor use only) 33.00 Balance due provider/program (line 30 minus lines 30.01, 30.02, 31, and 32) 33.01 Balance due provider/program-PARHM (lines 2, 3, 18, and 26, minus lines 30.03, 31.01, and 32.01) 34.00 Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, 0 34.00						
33.00 Balance due provider/program (line 30 minus lines 30.01, 30.02, 31, and 32)  33.01 Balance due provider/program-PARHM (lines 2, 3, 18, and 26, minus lines 30.03, 31.01, and 32.01)  34.00 Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1,  0 34.00					0	
33.01 Balance due provider/program-PARHM (lines 2, 3, 18, and 26, minus lines 30.03, 31.01, and 32.01) 34.00 Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, 0 34.00						
34.00 Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, 0 34.00		1 3 1			-83, 165	
[§115. 2	34. 00		nce with CMS Pub. 15-2,	chapter 1,	0	34.00
		3110. 2				I

Health Financial Systems	UNION HOSPITAL CLINTON	In Lieu of Form CMS-2552-10
CALCULATION OF REIMBURSEMENT SETTLEMENT	Provi der CCN: 15-1326	Peri od: Worksheet E-3
		From 01/01/2021   Part VII
		To 12/31/2021   Data/Time Prepared:

			To 12/31/2021	Date/Time Pre 5/26/2022 10:	pared: 52 am
		Title XIX	Hospi tal	Cost	<u> </u>
			Inpati ent	Outpati ent	
			1, 00	2. 00	
	PART VII - CALCULATION OF REIMBURSEMENT - ALL OTHER HEALTH SERVI	CES FOR TITLES V OR XI	X SERVICES		
	COMPUTATION OF NET COST OF COVERED SERVICES				
1.00	Inpatient hospital/SNF/NF services		92, 221		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)		92, 221	0	4. 00
5.00	Inpatient primary payer payments		0		5. 00
6.00	Outpatient primary payer payments			0	6. 00
7.00	Subtotal (line 4 less sum of lines 5 and 6)		92, 221	0	7. 00
	COMPUTATION OF LESSER OF COST OR CHARGES				
	Reasonabl e Charges				
8.00	Routine service charges		62, 715		8. 00
9.00	Ancillary service charges		144, 529	0	9. 00
10.00	Organ acquisition charges, net of revenue		0		10.00
11.00	Incentive from target amount computation		0	0	11.00
12. 00	Total reasonable charges (sum of lines 8 through 11)		207, 244	0	12. 00
13. 00	CUSTOMARY CHARGES	and an a shares		0	12 00
13.00	Amount actually collected from patients liable for payment for s	services on a charge	0	Ü	13. 00
14.00	Amounts that would have been realized from patients liable for p	navment for services on	0	0	14. 00
14.00	a charge basis had such payment been made in accordance with 42		٩	Ü	14.00
15. 00	Ratio of line 13 to line 14 (not to exceed 1.000000)	OTR 3413. 13(C)	0. 000000	0. 000000	15. 00
16. 00	Total customary charges (see instructions)		207, 244	0.000000	16. 00
17. 00	Excess of customary charges over reasonable cost (complete only	if line 16 exceeds	115, 023	0	17. 00
	line 4) (see instructions)				
18.00	Excess of reasonable cost over customary charges (complete only	if line 4 exceeds line	o	0	18. 00
	16) (see instructions)				
19.00	Interns and Residents (see instructions)		0	0	19. 00
20.00	Cost of physicians' services in a teaching hospital (see instruc		0	0	20. 00
21.00	Cost of covered services (enter the lesser of line 4 or line 16)		92, 221	0	21. 00
	PROSPECTIVE PAYMENT AMOUNT - Lines 22 through 26 must only be co	ompleted for PPS provid			
22. 00	1 3		0	0	
	Outlier payments		0	0	23. 00
24. 00	Program capital payments		0		24.00
	Capital exception payments (see instructions)		0	0	25. 00
	Routine and Ancillary service other pass through costs		0	0	26. 00
28. 00	Subtotal (sum of lines 22 through 26) Customary charges (title V or XIX PPS covered services only)		0	0	27. 00 28. 00
	Titles V or XIX (sum of lines 21 and 27)		92, 221	0	29. 00
29.00	COMPUTATION OF REIMBURSEMENT SETTLEMENT		72, 221	0	29.00
30 00	Excess of reasonable cost (from line 18)		O	0	30.00
31. 00	Subtotal (sum of lines 19 and 20, plus 29 minus lines 5 and 6)		92, 221	0	31. 00
32. 00	Deductibles		72, 221	0	32. 00
33. 00	Coinsurance		o	0	33. 00
34. 00			o	0	34. 00
35. 00	Utilization review		o		35. 00
36. 00	Subtotal (sum of lines 31, 34 and 35 minus sum of lines 32 and 3	33)	92, 221	0	36. 00
37.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	•	0	0	37. 00
38.00	Subtotal (line 36 ± line 37)		92, 221	0	38. 00
39.00	Direct graduate medical education payments (from Wkst. E-4)		o		39. 00
40.00			92, 221	0	40. 00
41.00			128, 256	0	41. 00
42.00	Balance due provider/program (line 40 minus line 41)		-36, 035	0	42. 00
43.00	Protested amounts (nonallowable cost report items) in accordance	e with CMS Pub 15-2,	0	0	43.00
	chapter 1, §115.2				

Health Financial Systems UNION HOSPITAL CLINTON In Lieu of Form CMS-2552-10

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

Provi der CCN: 15-1326 | Peri od: From 01/01/2021

d: Worksheet G 01/01/2021 12/31/2021 Date/Time Prepared:

5/26/2022 10:52 am Speci fi c Endowment Fund General Fund Plant Fund Purpose Fund 1.00 3.00 4.00 2.00 CURRENT ASSETS 6, 393 1.00 Cash on hand in banks 0 0 0 1.00 Temporary investments 0 0 2.00 0 2.00 3.00 Notes receivable 0 0 0 0 0 3.00 0 4 00 2, 389, 899 4 00 Accounts receivable 0 5.00 Other receivable 0 0 5.00 6.00 Allowances for uncollectible notes and accounts receivable 180, 448 6.00 0 7.00 Inventory 373, 459 0 0 7.00 0 8.00 Prepaid expenses 58, 166, 472 0 8.00 0 9.00 Other current assets 0 9.00 10 00 Due from other funds 0 0 0 10 00 Total current assets (sum of lines 1-10) 0 0 11.00 61, 116, 671 0 11 00 FIXED ASSETS 12.00 Land 720, 525 0 0 0 12.00 Land improvements 0 13.00 0 0 0 0 0 0 0 0 0 0 0 0 0 13.00 οl Accumulated depreciation 14.00 0 14.00 15.00 Bui I di ngs 13, 966, 248 0 0 15.00 16.00 Accumulated depreciation -17, 340, 818 16.00 0 17.00 Leasehold improvements 17.00 0 0 18 00 Accumulated depreciation C 0 18 00 Fi xed equipment 19.00 19.00 0 20.00 Accumulated depreciation 0 0 20.00 0 21.00 Automobiles and trucks C 0 21.00 22.00 Accumulated depreciation 0 22.00 23.00 Major movable equipment 7, 970, 628 0 23.00 Accumulated depreciation 24.00 24.00 0 25.00 Mi nor equi pment depreci able C Λ 25, 00 26.00 Accumulated depreciation C 0 0 26.00 27.00 HIT designated Assets 0 0 0 0 27.00 0 28.00 Accumulated depreciation 0 0 28.00 0 29.00 Mi nor equi pment-nondepreci abl e 0 29.00 30.00 Total fixed assets (sum of lines 12-29) 5, 316, 583 0 30.00 OTHER ASSETS 31 00 Investments O 0 0 31 00 0 0 32.00 Deposits on Leases C 0 32.00 Due from owners/officers 0 0 0 0 33.00 33.00 0 34.00 Other assets 0 0 34.00 0 0 Total other assets (sum of lines 31-34) 35.00 0 35, 00 66, 433, 254 36.00 Total assets (sum of lines 11, 30, and 35) 0 0 0 36.00 CURRENT LIABILITIES 37 00 794 262 O 0 n 37 00 Accounts payable 0 0 38.00 Salaries, wages, and fees payable 922, 595 0 38.00 0 Payroll taxes payable 0 39.00 39.00 0 40.00 Notes and Loans payable (short term) 0 0 40.00 0 0 Deferred income 41 00 41 00 Ω 0 42.00 Accelerated payments 0 42.00 43.00 Due to other funds 0 0 0 43.00 Other current liabilities 0 0 44.00 656, 213 0 44.00 Total current liabilities (sum of lines 37 thru 44) 0 0 45.00 2, 373, 070 0 45.00 ONG TERM LIABILITIES 46.00 Mortgage payable 0 46.00 0 0 47.00 Notes payable 0 0 47.00 48 00 Unsecured Loans C 0 0 0 48 00 Other long term liabilities 0 0 49.00 49.00 0 50 00 Total long term liabilities (sum of lines 46 thru 49) 0 0 0 50.00 Total liabilities (sum of lines 45 and 50) 2, 373, 070 51.00 0 0 0 51.00 CAPITAL ACCOUNTS 52.00 General fund balance 64, 060, 184 52.00 53.00 Specific purpose fund 0 53.00 Donor created - endowment fund balance - restricted Donor created - endowment fund balance - unrestricted 54.00 0 54.00 55.00 0 55.00 56.00 Governing body created - endowment fund balance 0 56.00 Plant fund balance - invested in plant Plant fund balance - reserve for plant improvement, 57.00 57.00 0 58.00 0 58.00 replacement, and expansion 59.00 Total fund balances (sum of lines 52 thru 58) 64, 060, 184 0 59.00 Total liabilities and fund balances (sum of lines 51 and 60.00 66, 433, 254 0 0 0 60.00

UNION HOSPITAL CLINTON

Period: Worksheet G-1 Health Financial Systems
STATEMENT OF CHANGES IN FUND BALANCES Provider CCN: 15-1326

					To		Date/Time Pro 5/26/2022 10:	epar 52	ed:
		General	Fund	Speci al	Pu	rpose Fund	Endowment Fund	1	
		1.00	2. 00	3. 00		4. 00	5. 00		
1.00	Fund balances at beginning of period		52, 630, 640			0			1.00
2. 00 3. 00	Net income (loss) (from Wkst. G-3, line 29) Total (sum of line 1 and line 2)	1	11, 429, 544 64, 060, 184			0			2. 00 3. 00
4. 00	Additions (credit adjustments) (specify)	0	04, 000, 104		0	O			4. 00
5.00		0			0		C		5. 00
6.00		0			0		C		5. 00
7. 00 8. 00					0				7. 00 3. 00
9. 00		0			0				9. 00
10.00	Total additions (sum of line 4-9)		0			0			0. 00
11. 00	Subtotal (line 3 plus line 10)		64, 060, 184			0			1. 00
12. 00 13. 00	Deductions (debit adjustments) (specify)	0			0				2. 00 3. 00
14. 00					0				4. 00
15. 00		O			0		C		5. 00
16. 00		0			0		C		5. 00
17. 00 18. 00	Total deductions (sum of lines 12-17)	0	0		0	0	C		7. 00 3. 00
19. 00	Fund balance at end of period per balance	1	64, 060, 184			0			9. 00
	sheet (line 11 minus line 18)								
		Endowment Fund	PI ant	Fund					
		6.00	7. 00	8. 00					
1.00	Fund balances at beginning of period	0			0				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		Ŭ				4. 00
5.00			0						5. 00
6.00			0						5. 00
7. 00 8. 00			0						7. 00 3. 00
9. 00			0						9. 00
10.00	Total additions (sum of line 4-9)	o			0				0. 00
11.00	Subtotal (line 3 plus line 10)	0			0				1.00
12. 00 13. 00	Deductions (debit adjustments) (specify)		0						2. 00 3. 00
14. 00		1	0						4. 00
15. 00			0						5. 00
16.00			0						5. 00
17. 00 18. 00	Total deductions (sum of lines 12-17)		0		0				7. 00 3. 00
19. 00	Fund balance at end of period per balance sheet (line 11 minus line 18)	o			0				9. 00

Health Financial Systems
STATEMENT OF PATIENT REVENUES AND OPERATING EXPENSES Provider CCN: 15-1326

		[7	o 12/31/2021	Date/Time Prep 5/26/2022 10:	
	Cost Center Description	I npati ent	Outpati ent	Total	<u></u>
	'	1.00	2. 00	3. 00	
	PART I - PATIENT REVENUES				
	General Inpatient Routine Services				
1.00	Hospi tal	5, 440, 464	1	5, 440, 464	1. 00
2.00	SUBPROVI DER - I PF				2. 00
3.00	SUBPROVI DER - I RF				3. 00
4.00	SUBPROVI DER				4. 00
5.00	Swing bed - SNF			0	5. 00
6.00	Swing bed - NF		)	0	6. 00
7.00	SKILLED NURSING FACILITY				7. 00
8.00	NURSING FACILITY				8. 00
9.00	OTHER LONG TERM CARE				9. 00
10. 00	Total general inpatient care services (sum of lines 1-9)	5, 440, 464	ļ.	5, 440, 464	10. 00
	Intensive Care Type Inpatient Hospital Services				
11. 00	INTENSIVE CARE UNIT		)	0	11. 00
12.00	CORONARY CARE UNIT				12.00
13.00	BURN INTENSIVE CARE UNIT				13.00
14.00	SURGI CAL INTENSI VE CARE UNI T				14.00
15. 00	OTHER SPECIAL CARE (SPECIFY)			0	15. 00
16. 00	Total intensive care type inpatient hospital services (sum of lines		)	0	16. 00
17 00	11-15)	E 440 46		E 440 444	17 00
17. 00	Total inpatient routine care services (sum of lines 10 and 16)	5, 440, 464		5, 440, 464	17. 00 18. 00
18. 00 19. 00	Ancillary services	6, 102, 691 729, 063		62, 689, 237 22, 990, 340	
20. 00	Outpatient services RURAL HEALTH CLINIC	129,003		22, 990, 340	20.00
21. 00	FEDERALLY QUALIFIED HEALTH CENTER		_	0	21. 00
21.00	HOME HEALTH AGENCY		J	U	22.00
23. 00	AMBULANCE SERVICES				23. 00
24. 00	CMHC				24. 00
25. 00	AMBULATORY SURGICAL CENTER (D. P. )				25. 00
26. 00	HOSPICE				26. 00
27. 00	PROFESSI ONAL FEES	580, 716	25, 202	605, 918	27. 00
28. 00	Total patient revenues (sum of lines 17-27)(transfer column 3 to Wkst.	12, 852, 934		91, 725, 959	28. 00
20.00	G-3, line 1)	12,002,70	70,073,023	71, 725, 757	20.00
	PART II - OPERATING EXPENSES				
29. 00	Operating expenses (per Wkst. A, column 3, line 200)		20, 684, 289		29. 00
30. 00	ADD (SPECIFY)				30.00
31. 00					31. 00
32. 00					32. 00
33. 00					33. 00
34.00					34.00
35.00					35. 00
36.00	Total additions (sum of lines 30-35)		0		36. 00
37.00	DEDUCT (SPECIFY)				37. 00
38. 00					38. 00
39. 00					39. 00
40.00					40. 00
41.00			)		41. 00
42.00	Total deductions (sum of lines 37-41)		0		42. 00
43.00	Total operating expenses (sum of lines 29 and 36 minus line 42)(transfer		20, 684, 289		43.00
	to Wkst. G-3, line 4)				

	<u> </u>	INI ON HOSPITAL CLINTON		u of Form CMS-2	
STATEMENT OF REVENUES AND EXPENSES		Provi der CCN: 15-1326	Peri od: From 01/01/2021	Worksheet G-3	
			To 12/31/2021	Date/Time Prep 5/26/2022 10:	
				1. 00	
1. 00	Total patient revenues (from Wkst. G-2, Part I,			91, 725, 959	
2.00	Less contractual allowances and discounts on patients' accounts			58, 433, 574	
3.00	Net patient revenues (line 1 minus line 2)			33, 292, 385	
4.00	Less total operating expenses (from Wkst. G-2, Part II, line 43)			20, 684, 289	
5. 00	Net income from service to patients (line 3 minu	us line 4)		12, 608, 096	5.00
	OTHER I NCOME			_	
6.00	Contributions, donations, bequests, etc			0	
7.00	Income from investments			0	
8.00	Revenues from telephone and other miscellaneous	communication services		0	
9.00	Revenue from television and radio service			0	
10.00	Purchase di scounts			0	
	Rebates and refunds of expenses			0	
	Parking lot receipts				12.00
	Revenue from laundry and linen service			0	1
	Revenue from meals sold to employees and guests			0	
	Revenue from rental of living quarters	4		0	
	Revenue from sale of medical and surgical suppli				16. 00 17. 00
	Revenue from sale of drugs to other than patient Revenue from sale of medical records and abstrac			0	
				0	
	Tuition (fees, sale of textbooks, uniforms, etc.	•		,	1
	Revenue from gifts, flowers, coffee shops, and c Rental of vending machines	canteen		0	
	Rental of hospital space			0	
	Governmental appropriations			Ĭ	
24. 00	OTHER OPERATING INCOME			0 555, 478	
	CHANGES IN UHF				24.00
	INVESTMENT INCOME			4, 38 I 845	1
	COVID-19 PHE Funding			0 845	
25. 00	Total other income (sum of lines 6-24)			560, 704	
	Total (line 5 plus line 25)			13, 168, 800	
	OTHER EXPENSES			1, 739, 256	
	Total other expenses (sum of line 27 and subscri	ntc)		1, 739, 256 1, 739, 256	
∠o. ∪∪	Floral other expenses (Sum of Fine 27 and Subscri	pisj		1, 137, 230	<sub>1</sub> ∠o. ∪∪